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522nd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
September 9, 2015

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

1. **Update on Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Authority General Provisions Article, §3-104, and 3-305(b)(7)**

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

1. **Review of the Minutes from the Public Meeting and Executive Session on August 12, 2015**
2. **Executive Director's Report**
3. **New Model Monitoring**
4. **Docket Status – Cases Closed**
   2298A – MedStar Health
   2299A – MedStar Health
   2301R – Holy Cross Hospital
   2302A – University of Maryland Medical Center
   2305A – University of Maryland Medical Center
5. **Docket Status – Cases Open**
   2300R – Washington Adventist Hospital
   2303R – Frederick Memorial Hospital
   2304N – UM St. Joseph Medical Center
   2306A- University of Maryland Medical Center
6. **Summary of the Certificate of Need Related Capital Adjustment Process**
7. **Draft Recommendations on Revisions to the Quality Based Reimbursement Program for Rate Year 2018**
8. **Market Shift Update**
9. **Overview of the Health Employment Program Proposal**
10. **Report of the Consumer Engagement Task Force**
11. **Report of the Consumer Outreach Task Force**

12. **Summary of FY 2014 Community Benefits Report**

13. **Hearing and Meeting Schedule**

Closed Session Minutes
of the
Health Services Cost Review Commission

August 12, 2015

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

1. Update on Contract and Modeling of the All-Payer Model vis-à-vis the All-Payer Model Contract;
2. Consultation with Legal Counsel on Contested Case Implications;

The Closed Session was called to order at 12:09 p.m. and held under authority of - §§ 3-104 and 3-305(b) (7) of the General Provisions Article.

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

In attendance representing Staff were Donna Kinzer, David Romans, Steve Ports, and Dennis Phelps.

Also attending was Stan Lustman, Commission Counsel.

Item One

David Romans, Director-Payment Reform and Innovation, presented and the Commission discussed an updated analysis of Medicare per beneficiary data. Authority: General Provisions Article, § 3-104.

Item Two

Stan Lustman, Commission Counsel, outlined and reviewed and the Commission discussed the legal process associated with Contested Cases. Authority: General Provisions Article, § 3-305(b) (7).

Item Three

Donna Kinzer, Executive Director, advised the Commission on the need for strategic planning moving forward with the Model. Authority: General Provisions Article, § 3-104.

The Closed Session was adjourned at 1:08 p.m.

MINUTES OF THE
521th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

August 12, 2015

Chairman John Colmers called the public meeting to order at 12:09 pm. Commissioners George H. Bone, M.D, Stephen F. Jencks, M.D., MPH, Jack C. Keane, and Thomas Mullen were also in attendance. Herbert S. Wong, Ph.D., joined the meeting via telephone. Upon motion made by Commissioner Jencks and seconded by Commissioner Mullen, the meeting was moved to Executive Session. Chairman reconvened the public meeting at 1:15 pm.

REPORT OF THE AUGUST 12, 2015 EXECUTIVE SESSION

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the August 12, 2015 Executive Session.

ITEM I
REVIEW OF THE MINUTES FROM JUNE 10, 2015 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the June 10, 2015 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, stated that the Centers for Medicare and Medicaid Services (CMS) issued its hospital inpatient prospective payment system (IPPS) final rule for fiscal year 2016 beginning October 1, 2015. The final rule will increase rates by 0.9% after accounting for inflation and other adjustments required by law. This increase is approximately .2% lower than the staff preliminary estimate noted in its June recommendation. After accounting for a Disproportionate Share reduction of 1.0%, the inpatient update would be expected to be less than a 0.1% increase. Ms. Kinzer noted that staff estimated an outpatient hospital increase for Medicare of approximately 1.9%. Under the proposed rule for CY 2016 for the hospital outpatient prospective payment system (OPPS), there would be a net decrease in OPPS payments of 0.2%. The net decrease largely results from a proposed 2.0 percentage point cut intended to account for CMS overestimation of the amount of packaged laboratory payments under OPPS, which caused an overpayment for hospital outpatient payments in 2014.

Ms. Kinzer noted that the Office of the Actuary has released updates to the estimates of hospital revenue increases per beneficiary in connection with the update of the Trustees Annual Report. Staff used the estimates from the President's Budget estimates.

Ms. Kinzer noted that while the rate increases for Medicare are lower than initial estimates used by staff, the per beneficiary figures are in line with staff estimates.

Ms. Kinzer discussed two changes emerging from CMS relative to provider payment direction, which will affect us in Maryland as we move forward in working with partners outside as well as inside the hospital.

The first change was that in April 2015, the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) was signed into law. This law permanently eliminated the use of the Sustainable Growth Rate formula, a mechanism originally created to control spending on Medicare physician services. MACRA revised Medicare physician payments using a new quality driven payment system to move from volume based payments to value based payments. Physicians will be able to receive additional payment updates for participating in alternative payment models. HSCRC and other stakeholders will explore how Maryland's transformation strategies affect Medicare physician payments in order to align hospital and physician incentives.

The second change was that on July 14, 2015, CMS released a proposed payment rule for the Medicare Comprehensive Care for Joint Replacement (CCJR) model. This is a bundled payment model for major lower extremity joint replacements (LEJR). In this 5 year demonstration program, hospitals would be responsible for the LEJR episodes of care of Medicare fee for service beneficiaries, with the episode covering hospitalization through recovery, defined as 90 days post discharge. Hospitals in 75 Metropolitan Statistical Areas (MSAs) would be required to participate in the model. If the model program is adopted as final, it would be effective for discharges on or after January 1, 2016 unless otherwise noted.

Staff will work with stakeholders to craft comments on the proposed payment rule and request data to evaluate opportunities for Maryland patients. Staff will also requests to have access to the same tools offered in the demonstration program, while considering how this proposed rule fits into a broader picture for improving health in the State.

Ms. Kinzer noted that in the last several months, staff has worked diligently with stakeholders to develop a transformation plan built on four pillars of activities for clinical improvement: statewide infrastructure, alignment, care coordination and integration, and consumer engagement. To build further momentum with the Model, the HSCRC will work with stakeholders to move forward with key alignment issues.

In order to implement the Model fully, Maryland will need some waivers relative to such things as fraud and abuse that are typically granted to ACOs across the country. The Center of Medicare and Medicaid Innovation (CMMI) has agreed to work with us in determining how to put these waivers in place with our current Al-Payer Model. Staff is providing CMMI with additional information to support waivers in four areas that focus on being able to develop and implement: Pay for Performance programs, gainsharing programs, care coordination activities among physicians, hospitals, and nursing homes, and to provide for access to Medicare abuse and care coordination data similar to the data available to ACOs.

Ms. Kinzer next reported on the status of the planning and implementation of care coordination and alignment activities. Ms. Kinzer noted that at the May 2015 Commission meeting staff reported on the availability of Budget Reconciliation and Financing Act (BRFA) funds to support the success of the All-Payer Model. Of these funds $11.5 million will be provided to the Chesapeake Regional Information System for our Patients (CRISP) to fund expanded IT and analytic infrastructure as well as consulting support for implementation of care coordination and alignment activities. In addition, staff reported that budgets of $495,000, $1.08 million, and $0.9 million for state-level infrastructure planning, the regional transformation process, and the development of alignment strategies were reviewed and approved by staffs of DHMH, HSCRC, and MHCC. A third budget of $6.2 million, supporting the development of a statewide integrated care and care coordination infrastructure, has been approved by the Executive Committee of CRISP.

Ms. Kinzer noted that Staff and consultants are focused on transformation support activities relative to regional planning grants and infrastructure planning and implementation activities. These include: Learning Collaboratives, Webinars, Shared site for resources and Individual Consultation.

Ms. Kinzer stated that Staff has finalized the calculations for the market shift adjustments for all inpatient and outpatient services, except for radiation therapy, infusion and chemotherapy for inclusion in the rate year 2016 global budget. The revenue shifted under this calculation is approximately $28 million. Staff is in the process of reviewing a preliminary calculation completed for cancer services. Staff hopes to finalize a market shift calculation for these services by September. The market shift calculation, exclusive of oncology services, is being incorporated into FY 2016 rate orders. Dr. Sule Gerovich will report to the Commission on the final details at the September Commission meeting.

Ms. Kinzer reported that the Board of Dimensions' Healthcare System announced that it agreed to an innovative approach to enhance the health of the population served by Laurel Regional Hospital. The System will be reducing the scope and complexity of inpatient services, while simultaneously constructing a comprehensive ambulatory medical facility dedicated to preventative care that reduces avoidable healthcare. The new facility will cost approximately $24 million, which will include emergency services, outpatient surgery and comprehensive diagnostic imaging. The new hospital will be built on the existing hospital campus by 2018.

Ms. Kinzer noted that Staff is currently focused on the following activities:

- Completing the rate orders for rate year 2016
- Continuing the focus on waivers, alignment models, and state level, regional and hospital transformation planning and implementation.
- Reviewing Certificate of Need (CON) and rate application that have been filed.
- Beginning work on updates to value-based performance measures, including efficiency measures.
- Staff will released an RFP for support of the Phase 2 development and application

process with CMMI, which will focus on transitioning the All-Payer Model to a greater focus on the total cost of care.

ITEM III
CHESAPEAKE REGIONAL HEALTH SYSTEM FOR OUR PATIENTS (CRISP) REPORT ON INTEGRATED CARE NETWORK INFRASTRUCTURE

Dr. Mark Kelemen, Senior Vice President and Chief Medical Information Officer at the University of Maryland Medical School, and Mr. David Horrocks, CRISP President and CEO updated the Commission on the CRISP work plan (See "ICN Infrastructure Tools and Services Update on Progress" on the HSCRC website).

Mr. Horrocks characterized the work plan to develop the integrated care network infrastructure as expanding the scope and capabilities of current operations and extending the access to services to additional providers.

To oversee the development and implementation of the work plan, CRISP established a steering committee, chaired by Dr. Kelemen, and including hospital organization representatives with responsibilities in clinical integration/population health management and information technology from Johns Hopkins HealthCare LLC, Anne Arundel Health System, Advanced Health Collaborative, MedStar Health System and the Maryland Hospital Association. Other members of the steering committee include representatives from the Prince George's County Department of Health, Columbia Medical Practice, Erickson Living, the Advisory Board Company, and the Maryland Health Care Commission. The steering committee has organized the work plan into seven project activities;

- Ambulatory Connectivity- The project aims to achieve bi-directional connectivity with ambulatory practices, long-term care, and other health providers.
- Data Router- enables sending relevant patient level data to the health care organizations by normalizing health records, determine whether a patent/provider relationship exists, and verifying patient consent.
- Clinical Portal Enhancements- Enhancing existing clinical portal with new elements, including care profile, a link to a provider directory, and information on other known patient/provider relationships and patient risk scores.
- Notification and Alerting- New tools integrated within existing work flows to alert providers to relevant care events
- Reporting and Analytics- Expands existing reporting capabilities to support many more case managers and ambulatory practices.
- Basic Care Management Software- Current scope is planning only, as advisors help determine an appropriate path.
- Practice Transformation- Current scope is planning only, as advisors help determine an appropriate path.

Mr. Horrocks and Dr. Kelemen also shared timelines and goals with the Commission and will periodically update the Commission on work plan progress

ITEM IV
NEW MODEL MONITORING

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

Mr. Romans reported that for the twelve months ended June 30, 2015, All-Payer total gross revenue increased by 2.00% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 2.51%; this translates to a per capita growth of 1.85%. All-Payer gross revenue for non-Maryland residents decreased by 2.96%.

Mr. Romans reported that for the six months of the calendar year ended June 30, 2015, All-Payer total gross revenue increased by 2.19% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 2.63%; this translates to a per capita growth of 2.06%. All-Payer gross revenue for non-Maryland residents decreased by 2.28%.

Mr. Romans reported that for the twelve months ended June 30, 2015, Medicare Fee-For-Service gross revenue increased by 2.92% over the same period in FY 2014. Medicare Fee-For-Service for Maryland residents increased by 3.70%; this translates to a per capita growth of 0.44%. Maryland Fee-For-Service gross revenue for non-residents decreased by 5.39%.

Mr. Romans reported that for the six months of the calendar year ended June 30, 2015, Medicare Fee-For-Service gross revenue increased by 3.83%. Medicare Fee-For-Service for Maryland residents increased by 4.61%; this translates to a per capita growth of 1.25 %. Maryland Fee-For-Service gross revenue for non-residents decreased by 4.75%.

According to Mr. Romans, for the twelve months of the fiscal year ended June 30, 2015, unaudited average operating profit for acute hospitals was 3.19%. The median hospital profit was 4.36%, with a distribution of 1.89% in the 25th percentile and 6.89% in the 75th percentile. Rate Regulated profits were 5.86%.

Dr. Alyson Schuster, Associate Director Performance Measurement, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon Potentially Preventable Complications (PPCs) data and discharges through March 2015 and readmission data on discharges through May 2015.

Readmissions

- The All-Payer risk adjusted readmission rate was 12.89 % for the period of January 2014 to May 2015. This is a cumulative decrease of 6.46% from the January 2013 risk adjusted readmission rate.

- The Medicare Fee for Service risk adjusted readmission rate was 13.73% for the period January 2014 to May 2015 YTD. This is an accumulated decrease of 5.60% from the January 2013 risk adjusted readmission rate.
- Based on the New-Payer Model, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction incentive program has set the goals for hospitals to reduce their risk adjusted readmission rate by 9.3% during CY2015 compared to CY2013. Currently, only 14 out of 46 hospitals have reduced their risk adjusted rate by more than 9.3%.

Potentially Preventable Complications

- The All-Payer risk adjusted PPC rate was 0.85 for March 2015 YTD. This is a decrease of 14.42% from the March 2014 YTD risk adjusted PPC rate.
- The Medicare Fee for Service risk adjusted PPC rate was 0.99 for March 2015 YTD. This is a decrease of 11.96% from the August 2014 YTD risk adjusted PPC rate.

ITEM V
DOCKET STATUS CASES CLOSED

NONE

ITEM VI
DOCKET STATUS- OPEN CASES

2298A- MedStar Health

MedStar Health filed an application on June 2, 2015 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") requesting approval to continue to participate in a global rate arrangement for orthopedic services with MAMSI for one year beginning September 1, 2015.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for orthopedic services for one year beginning September 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2299A- MedStar Health

MedStar Health filed an application on June 2, 2015 on behalf of Union Memorial Hospital (the "Hospital") requesting approval to continue to participate in a global rate arrangement for cardiovascular services with Kaiser Foundation Health Plan of the Mid-Atlantic Inc. for one year beginning August 1, 2015.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for cardiovascular services for one year beginning August 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2302A- University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital) filed an application on June 18, 2015 requesting approval to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with Maryland Physicians Care for one year beginning August 23, 2015.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services services for one year beginning August 23, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2305A- University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital) filed an application on July 30, 2015 requesting approval to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with Interlink Health Services for one year beginning November 1, 2015.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services services for one year beginning November 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2301R- Holy Cross Hospital

On June 12, 2015 Holy Cross (the "Hospital") submitted a partial rate application to the Commission requesting that the Hospital's Medical Surgical Intensive Care (MIS) and Coronary Care (CCU) approved rates be combined effective July 1, 2015 utilizing FY 2016 approved volumes and revenues.

After reviewing the Hospital application, Staff recommended the following:

- That the Hospital be allowed to collapse its CCU rate into its MIS rate effective July 1,

2015;
- That FY 2016 approved volume and revenue will be utilized to calculate the combined rate; and
- That no change be made to the Hospital's Global Budget Revenue.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
REPORT OF THE COMSUMER ENGAGEMENT TASK FORCE

Ms. Hillery Tsumba, Primary Care Coalition of Montgomery County, presented an update to the Commission on the activities of the HSCRC Consumer Engagement Taskforce (CETF) (See "HSCRC Consumer Engagement Taskforce Preliminary Report- Promoting Patient – Centered Approaches in the New All Payer Model" on the HSCRC website).

Ms. Tsumba outlined the goals of the CETF. They are as follows:

- Establish a consumer centered health care delivery system with an ongoing role for consumers to participate in the design and implementation of policies and procedures at all levels.
- Engage, educate, and activate people who use or are potential users of health services for their own health care to promote efficient and effective use of the health care system.

Ms. Tsumba also reviewed the communications strategy of the CETF and the development of materials for implementation from a consumer centered approach.

The next steps of the CETF are to:

- Identify and Address Gaps in Information or Learnings
- Finalize Communication Strategy
- Finalize and Submit Report to Commission

CETF will finalize and submit the report to the Commission at the September public meeting

ITEM VIII
MARYLAND HEALTH CARE COMMISSION ON STATUS OF CERTIFICATE OF NEED APPLICATIONS

Mr. Paul Parker, Director Center for Health Care Facilities Planning and Development for the Maryland Health Care Commission (MHCC) presented an update on pending hospital projects before the MHCC (See " Proposed Hospital Capital Projects: 2012 -2015" on the HSCRC website).

ITEM IX
LEGAL REPORT

Regulations

Final Action

Notification of Certain Financial Transactions – COMAR 10.37.01.08

The purpose of this action is to conform to the requirements set forth in Ch. 263, Acts of 2014, effective July 1, 2014, that require hospitals to notify the Commission, in writing, within 30 days before executing any financial transaction, contract, or other agreement that would result in more than 50 percent of all corporate voting rights or governance reserve powers being transferred to or assumed by another person or entity. This proposed regulatory change appeared in the May 1, 2015 issue of the Maryland Register (42:9 Md. R. 651)

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

Proposed Action

Update to Accounting and Budget Manual – COMAR 10.37.01.02

The purpose of this action is to update the Commission's Accounting and Budget Manual with Supplement 23, which has been incorporated by reference.

The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register.

Rate Application and Approval Procedures- COMAR 10.37.10.07-1

The purpose of this action is to conform to legislation passed in the 2015 General Assembly, which establishes that outpatient services associated with the federal 340B Program and that meet certain criteria shall be considered provided "at the hospital" and, therefore. subject to HSCRC rate jurisdiction.

The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register.

Rate Application and Approved Procedures- COMAR 10.37.10

The purpose of this action is to assure that rate applications are submitted in easily readable formats.

The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register.

ITEM X
HEARING AND MEETING SCHEDULE

September 9, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
October 14, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:35 pm.

Executive Director's Report

Health Services Cost Review Commission

September 9, 2015

All-Payer Model Implementation

Embarking on Year 2 of Model implementation, the HSCRC has worked closely with stakeholders to develop strategies on four key pillars of activity for clinical improvement: statewide infrastructure, alignment, care coordination and integration, and consumer engagement.

Last month, we heard from CRISP regarding statewide infrastructure activities. We also heard from one of the consumer task forces. This month, we will hear from consumer task forces for a second time and receive a status report on regional partnership activities.

The HSCRC staff has released the RFP for Competitive Implementation Plans, after gaining stakeholder input, relative to the .25% that the Commission approved for FY 2016. This amount will be added to rates based on a review of applications to be submitted. Competitive transformation implementation awards are intended to support investments and activities related to partnerships, strategies, progress, and vision for care coordination and provider alignment in the State. Competitive transformation implementation awards will be available to any Maryland acute care or specialty hospital that submits a successful bid. Applicants will need to show current readiness to implement as well as a short term impact on reducing avoidable utilization, improving quality, improving coordination of care, and achieving a return on investment. The aggregate amount available for these awards is up to 0.25% of statewide revenue. More information can be found at:

http://www.hscrc.maryland.gov/rfp-implement.cfm

Staff has also released to hospitals and stakeholders the reporting requirements for the Strategic Hospital Transformation Plans (STP) that are due on December 7, 2015. These plans will describe each hospital's short-term and long-term strategy to support the goals of the all-payer model, particularly as they related to care coordination, care transitions and alignment.

http://www.hscrc.maryland.gov/documents/HSCRC_PolicyDocumentsReports/PolicyClarification/2015/20150828-Strategic-Plan-Final-memo-v1.pdf

I want to thank Steve Ports for his tremendous efforts in working with the transformation support process and getting this RFP to completion.

Analytics Progress

HSCRC staff, CRISP, the St. Paul Group (HSCRC's case mix data vendor), and SSS (HSCRC's Medicare data vendor) have been working together to develop and execute strategies to make analytic information more readily available for care coordination and monitoring.

- CRISP has been working on patient level reporting, including the production of analytic data with flags of Potentially Avoidable Utilization. These data should be available in a "trial" format in October. This effort is focused on bringing analytics and information to support care coordination enhancements. This allows for leveraging analytic information that is used for both regulatory purposes by HSCRC and for care coordination and monitoring purposes by providers and payers.
- St. Paul will develop preliminary and final quarterly reports of market shift. These will be provided to all hospitals. We will release a timeline for this process in the near term.
- HSCRC staff has been working on utilization trend analysis that combines data from hospitals' case-mix data, and includes analytic information added to the case-mix data by CRISP, The St. Paul's Group, and HSCRC staff. Staff will begin presenting some of this data to the Commission today.
- HSCRC staff and SSS have been working on reconciling the Medicare claims and enrollment data used to support the Medicare savings calculation requirement under the All Payer Model. We are pleased to report that the reconciliation process is now complete. We expect that CMMI will release results in the near term.

The HSCRC staff, CRISP, and our vendors have made significant progress in advancing analytics to support implementation of the Model. The HSCRC staff strategy is to engage CRISP and vendor support for executing these data and monitoring reports so that we can meet the needs of providers and payers as well as our regulatory needs. We look forward to receiving feedback on this process and needs from the stakeholders.

Many of our staff as well as stakeholders have been involved in this effort, which has required a great deal of coordination and teamwork. I want to especially thank Sule Gerovich and David Romans for their efforts in moving this process forward. It is now HSCRC staff's intention to focus analytic efforts on the Total Cost of Care, Cost and Utilization Per Capita, Episode costs, advancing outcomes, performance and efficiency measures, and improving current models. In executing this effort, we will need to work closely with MHCC (the APCD data sets), DHMH-Medicaid, and Medicare data. Progress in these areas is needed for measuring success under

the existing All Payer Model as well as preparing for increased focus on total cost of care, comprehensive outcomes, and opportunities for improvement outside of hospitals.

Performance and Efficiency Measurement

As indicated above, HSCRC staff is preparing to work with stakeholders on evaluation and development of performance measures. These will include HSCRC's quality programs, risk adjustment approaches for attainment measures for readmissions and other PAUs, and appropriate efficiency and productivity measures for the new All Payer Model.

HSCRC has awarded a multi-year contract for professional services support of these efforts. The organization process for this work has begun, and we are in the process of fleshing out a work plan for this effort.

ICD-10

ICD-10 implementation is due to take place beginning October 1, 2015. Hospitals and payers have been busily preparing for implementation. HSCRC staff has interacted with MHA work groups and has discussed implementation readiness with the Maryland Insurance Administration. While hospitals and payers have made strides in readiness, there is concern that physicians are not uniformly well prepared for implementation. Also, HFMA reported in August that CMS Results for the final round of preparedness testing for the ICD-10 code set switch showed stagnant acceptance rates below the Medicare average.

The third round of end-to-end Medicare claims testing achieved an 87 percent acceptance rate, which was similar to the 88 percent rate achieved in the second round of testing, reported in June. However, the results continued to lag behind the average 95 percent to 98 percent standard fee-for-service Medicare claim acceptance rates.

HSCRC staff will stay in close contact with MHA and the Maryland Insurance Administration during implementation. If we become aware of situations where claims are not being processed, we will take appropriate steps in conjunction with the MIA.

The performance measures consultant recently engaged by HSCRC will work with us to evaluate the impact of ICD-10 on our data. It is possible that we will experience increased data resubmission or data lags resulting from the conversion.

Planning and Implementation of Integrated Care Network (ICN) Activities

Funding Administration

Staff and CRISP have executed addenda to the prior MOU that detailed the initial 90-day planning process for state level ICN infrastructure and support. These addenda are temporary so that work may begin and vendors may be obtained to continue the progress that has been made thus far. Staff will continue to work with CRISP to help in the development of the products or deliverables, timelines, benchmarks, and dashboards for continued transparency and accountability related to the ICN infrastructure and support, initially budgeted at $6.2 million.

Staff Focus

HSCRC staff is currently focused on the following activities:

- Completing the rate orders for rate year 2016. Many rate orders have been issued. All hospitals have received files with draft revenue and rate calculations. Several rate orders have not been issued because we are still awaiting some adjustments that require data from hospitals. There will be a final reconciliation of GBR/TPR and rate compliance, QBR performance, and the oncology market shift adjustment. We will update the budgets and rate orders as needed once these calculations are finalized.
- Reviewing radiation therapy, infusion and chemotherapy market shift adjustments with stakeholders.
- Continuing the focus on waivers, alignment models, and state level, regional and hospital transformation planning and implementation.
- Reviewing Certificate of Need (CON) and rate applications that have been filed.
- Moving forward on updates to value-based performance measures, including efficiency measures.
- Turning to focus on per capita costs and total cost of care, for purposes of monitoring and also to progress toward a focus on outcomes and cost across the health care system.
- As previously reported, staff has released an RFP for support of the Phase 2 application development and application process with CMMI, which will be focused on transitioning the All-Payer Model to a greater focus on the total cost of care.

Summary of Interim Reports of the Regional Transformation Planning Grants

Nancy Jaeckels Kamp and Deborah Gracey of Health Management Associates will summarize the interim reports of the Regional Transformation Planning Grants.

Maryland Health Services Cost Review Commission

Interim Reports Summary
Regional Partnerships for Transformation

September 9, 2015

Regional Partnerships Overview

- The 8 Regional Partnerships have each been given 60 hours of individual consulting time. Each RP has a "Point of Contact" who serves as a guide and resource to help RPs identify areas of need for use of their 60 hours and to bring in subject matter experts as needed. Each RP also has a point of contact assigned from CRISP.
- In addition to individual TA, the Regional Partnerships and all hospitals have been invited to participate in a series of bi-weekly, topic-specific webinars and an interactive Learning Collaborative. Six webinars have been given so far specific to the framework for transformation:
  - Kick-off to the framework needed for transformational change
  - Understanding data resources and performance metrics and electronic tools for coordination (three individual webinars around these topics)
  - Governance structures
  - Care coordination
- Regional Partnerships have also been invited to participate in a three-part, in-person Learning Collaborative hosted at MHA. Two have already been held in June and August.

Highlights from the TA Points of Contact

- The Points of Contact have helped with relationship building and served in a general communication role, aiding regional partnerships with connectivity, understanding and the building of their plan as driven by the HSCRC and DHMH planning process grant
- Most common technical assistance needed from RPs:
  - Governance structure development
  - Aid in strategic initiatives and infrastructure development
  - Research and summaries of best practices, i.e., care coordination models, BHI models, transitions of care
  - Financial and incentive modeling
  - Providing other specific resources of information

Interim Report Themes

Number and Type of Meetings Held

- The organization and structures vary among Regional Partnerships. Number and types of meetings depend on complexity of planning structure.
- Common elements include:
  - Core Project Team to manage and drive the planning process, at least bi-weekly meetings
  - Advisory or Steering Committee, at least bi-monthly meetings
- Additional meetings (depending on RP):
  - Board meetings: 3-7 meetings
  - Topic-specific Task Forces or Subcommittees: 2-6 meetings. Topics include care coordination, data, community and provider engagement, model design, pharmacy, behavioral health, sustainability
  - Provider Focus Groups
  - Planning Retreats

Organizations and Person Involved in Planning Process

- Hospital Partners – generally leading the planning process
- County Representatives - Health Departments, LHIC, Social Services, Office on Aging and Disability Services
- Provider groups – MedChi, Emergency Medicine reps
- Community partners are frequently engaged in planning activities, with representation on Advisory Committee and/or sub-committees.
- Consultants – data analysis, project management, payment modeling
- State Technical Assistance – CRISP, HMA

Data Reviewed to Help in Decision-Making Process

- Community Health Needs Assessment - Disease prevalence and burden within region
- CRISP and Hospital systems - High-utilizer data, population and patient level data.
- Additional Data Sources:
  - Qualitative data from clinicians through focus groups, MedChi and Medical Society surveys, EMS
  - Medicare data from VHQC, MSSPs, and other sources
  - Office on Aging and Disability case load and trend data
  - SHIP

Briefly Describe the Planning Process Thus Far

- Building the culture and working relationships needed for a true regional partnership to function – working together to first align multiple hospitals and build trust, then community partner expansion
- Identifying fundamental aspects of shared work, overlap and efficiencies
- Creating organizational committee structures for planning process and for long-term

List of Decisions Made Related to Delivery and Financing Model

- Create strategy for physician engagement in first phase and implementation of physician alignment through initiatives and incentives
- Need marketing plan for care management model to patients
- Clear method to track saving generated and use part for sustainable program funding
- Identification of vendors for care coordination or build yourself and use of CCM process and payment- understanding the relationships and connectivity

What Gaps/Barriers Have Been Identified, if Any

- Sharing patient level data across hospitals and other partners
  - Compliance with HIPPA, creating DUAs, BAAs
  - Access and timeliness of data
  - Obtaining data from non-hospital partners
- Timeline for building new partnerships and resources needed to ensure effective collaboration and completion of plans due
- Ability to achieve financial and practice alignment across partners, especially with PCP and other physicians

Next Steps – RPs Plans for Implementation

- Explore and formalize governance structures
  - Include and expand coalition to new partners
- Develop and implement operational plans addressing staff resources and needed infrastructure
- Modify existing care management models in place or secure care management vendors
- Seek additional revenue and funding streams that will support RP and service lines
- Future plans for RPs to engage:
  - Patients and family care-givers
  - Additional community physicians and county social service agencies

Next Steps – Ongoing Technical Assistance

- Routine communications, ongoing guidance and technical assistance continues to be offered for the regional partnerships as needed.
- Five more topic specific webinars coming over the next few months. Upcoming webinar schedule:
  - Consumer Education and Outreach: September 10
  - Behavioral Health Integration Models: September 24
  - Physician Alignment: October 8
  - October 22 and November 12: Topics TBD
- The last Learning Collaborative is scheduled for Nov. 5.

Appendix: Additional Detail from Interim Reports

Additional Detail from Interim Reports

Key Stakeholders/ Community Partners

- The Coordinating Center
- Provider Groups – EMS, Assisted Living Facilities, SNFs, CHCs/FQHCs, Community physicians, home health care, behavioral health
- County Service and Transit
- Partnership for Children, Youth, and Families
- CBOs – Esperanza Center, Health Care for the Homeless, Sisters Together Reaching
- NGO/Faith-based organizations

Additional Detail from Interim Reports

Progress and Decisions Made Thus Far for Planning

- Understanding and working with CRISP on areas to help with data and tools
- Identifying overlap of provision of services and efficiencies
- Building trust and expanding coalition
- Defined clear scope of work and SMART goals
- Decision on structural governance needed
- Changes in interventions and approach based on realizations of shared patients across hospitals and need for collaboration
- Best practices and spread models identified
- CRISP as the engine for new levels of communication
- Data and incorporating social determinants of health
- Physician focus groups to test interventions
- More clearly defined target high utilizer population

List of Decisions Made Related to Delivery and Financing Model

- Development of transition and chronic disease clinic
- Care management bonus based on enrolling and follow-up management of patients and ultimately outcomes (reducing readmissions)
- Engage ED and community-based physicians to decrease PAUs
- Expanded use of CRISP
- Use of CCM code/fee and creating the infrastructure to perform
- Use of Behavioral health as part of care management strategy

Additional Detail from Interim Reports

What Gaps/Barriers Have Been Identified, if Any

- Physician engagement – PCP, ED physicians and specialty providers
- Data capabilities
  - Alignment with and across EMRs
  - Risk assessment and care plans
  - Identification of providers working with specific patients
- Lack of coordination and leveraging of existing care management/coordination across partners
- Timeframe challenging particularly in light of evolving information and data capabilities

Plans for Implementation

- Continue regular meeting schedule in place during planning process to review cases, metrics, report cards and identify opportunities for expansion across partners
- Focus on provider and physician engagement
- Invest in behavioral health expansion and capacity
- Seek consultation and TA as needed
- Continue to identify and problem-solve regarding gaps and barriers
- Standardize processes and workflows across partners
- Maintain current decision making advisory committee structures in place
  - Include any new partners identified in existing structures

Monitoring Maryland Performance

Financial Data

Year to Date thru July 2015

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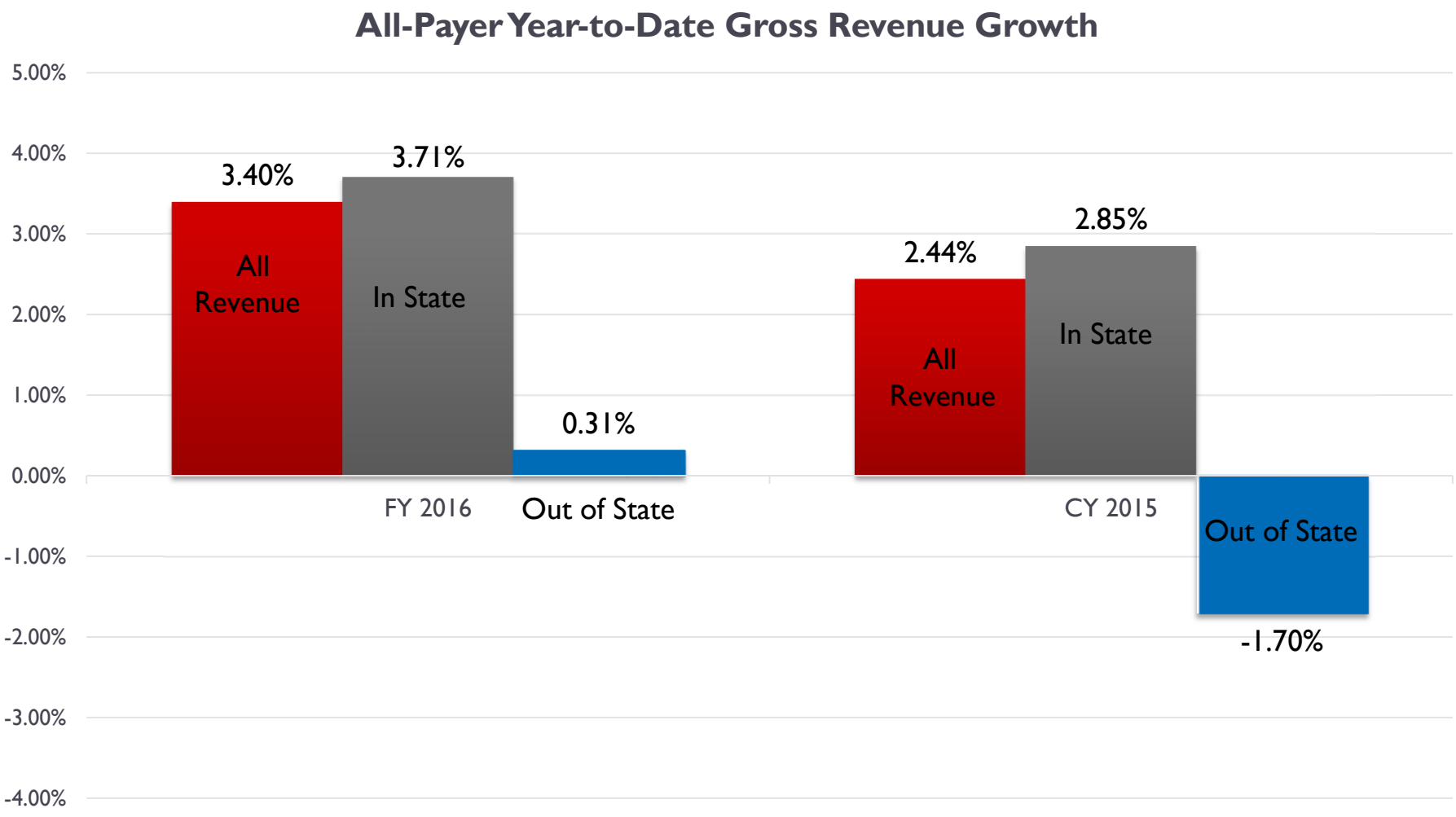
Gross All Payer Revenue Growth

Year to Date (thru July 2015) Compared to Same Period in Prior Year



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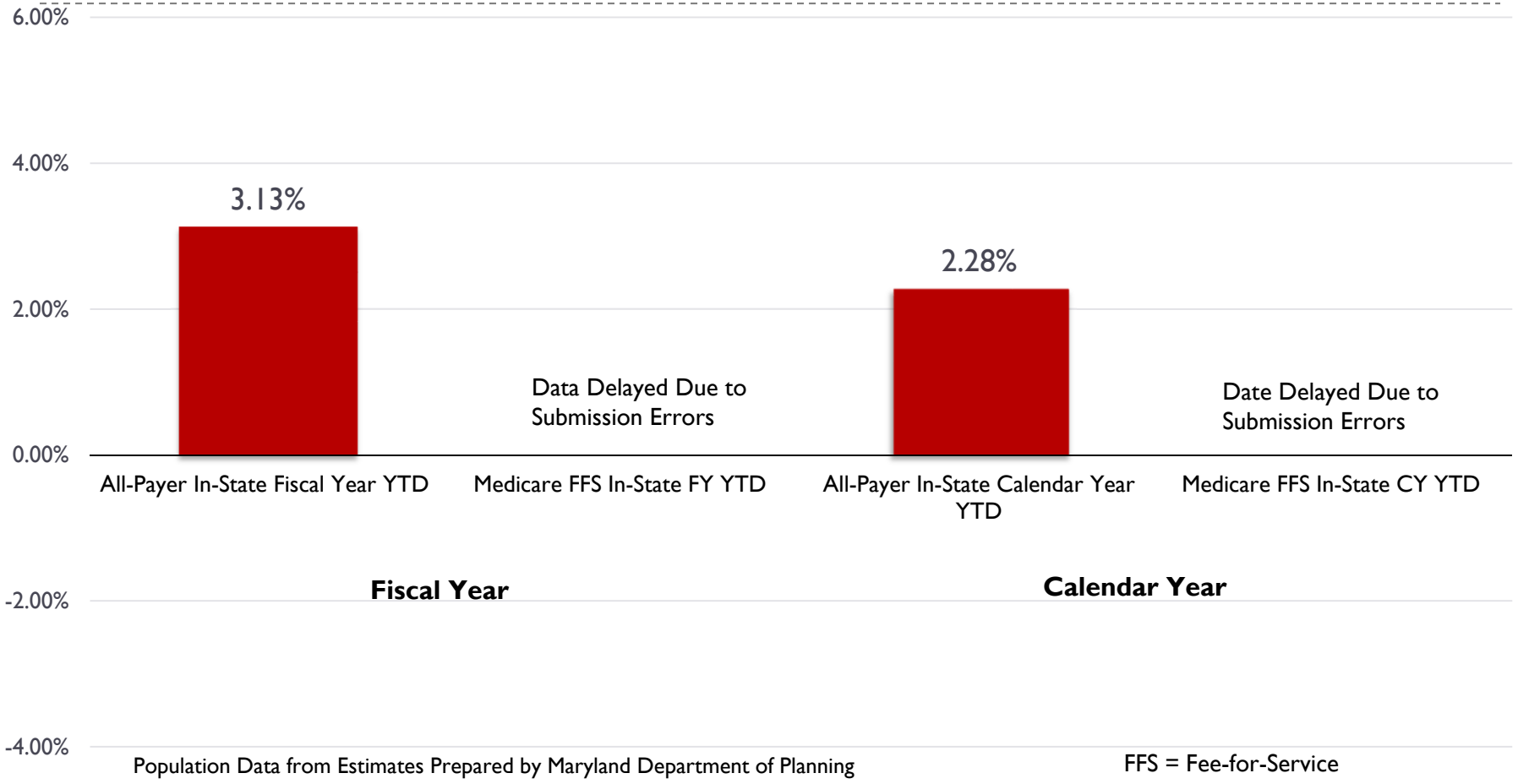
Per Capita Growth Rates
Fiscal Year 2016 and Calendar Year 2015



- **Calendar and Fiscal Year trends to date are below All-Payer Model Guardrail for per capita growth.**

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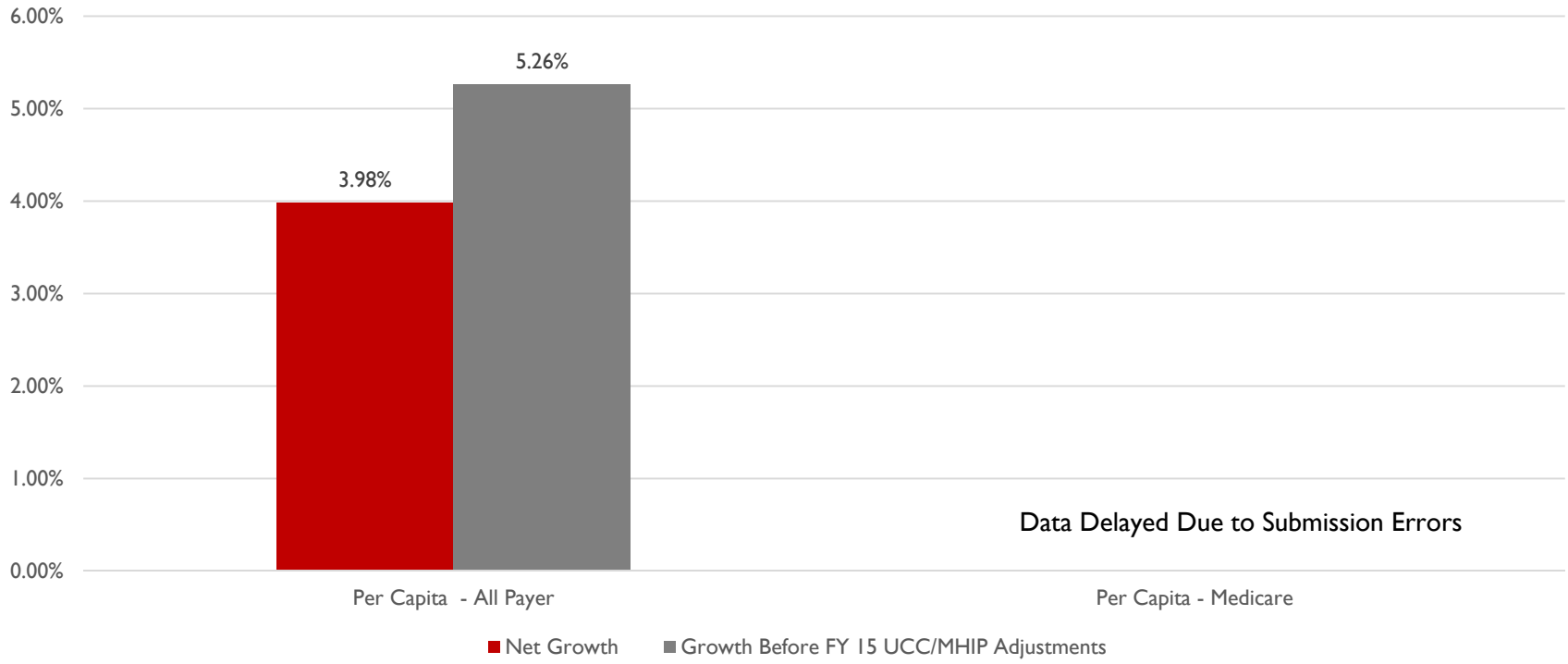
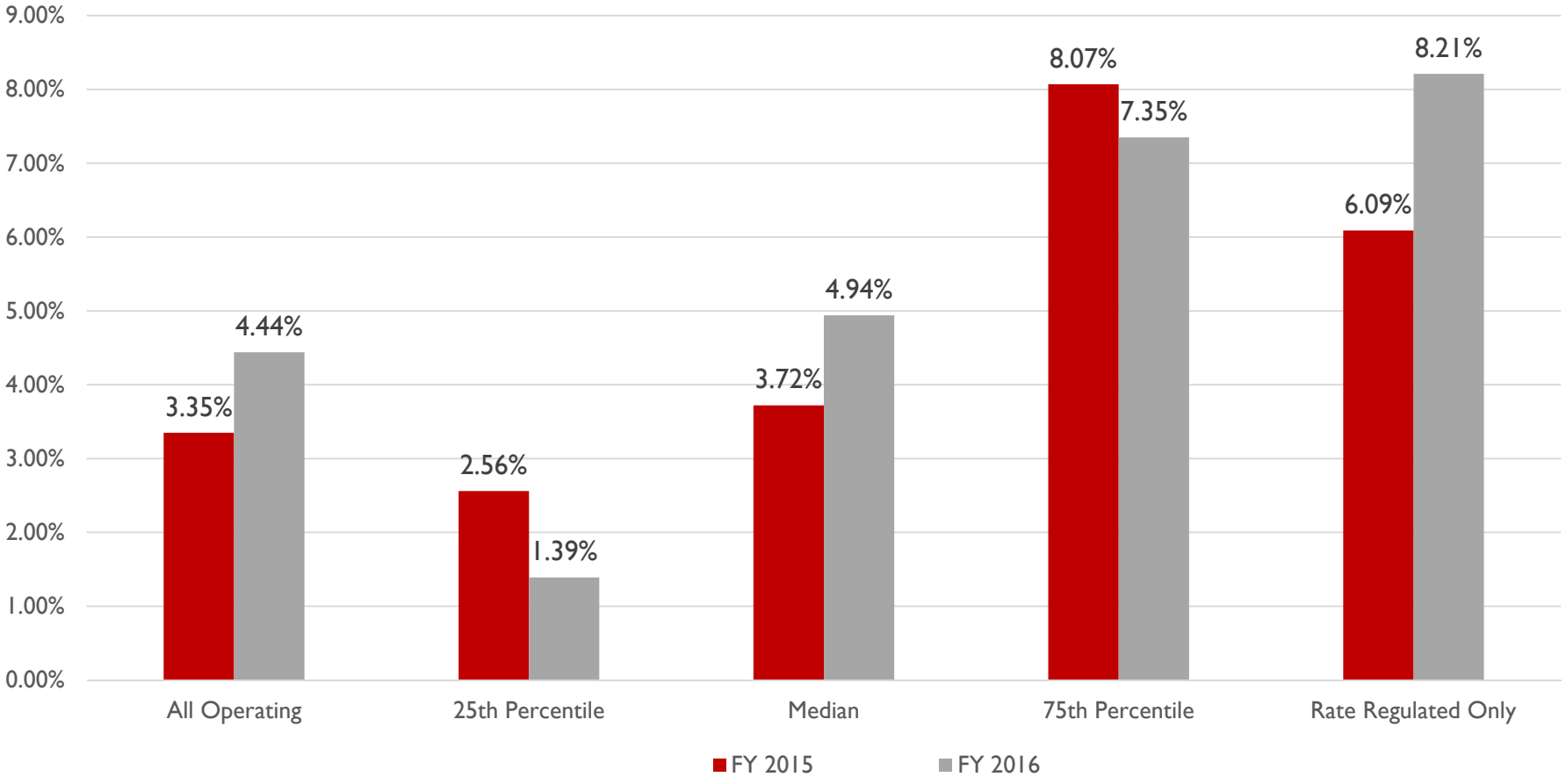
Per Capita Growth – Actual and Underlying Growth

CY 2015 Year to Date Compared to Same Period in Base Year (2013)



- Two year per capita growth rate is well below maximum allowable growth rate of 7.29% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY 15 & FY 16 revenue decreases that were budget neutral for hospitals. 1.09% revenue decrease offset by reduction in MHIP assessment and hospital bad debts in FY 15. Additional 1.41% adjustment in FY 16 due to further reductions to hospital bad debts and elimination of MHIP assessment.

Operating Profits: Fiscal 2016 Year to Date (July) Compared to Same Period in FY 2015



- Year to date FY 2016 unaudited hospital operating profits improved compared to the same period in FY 2015.

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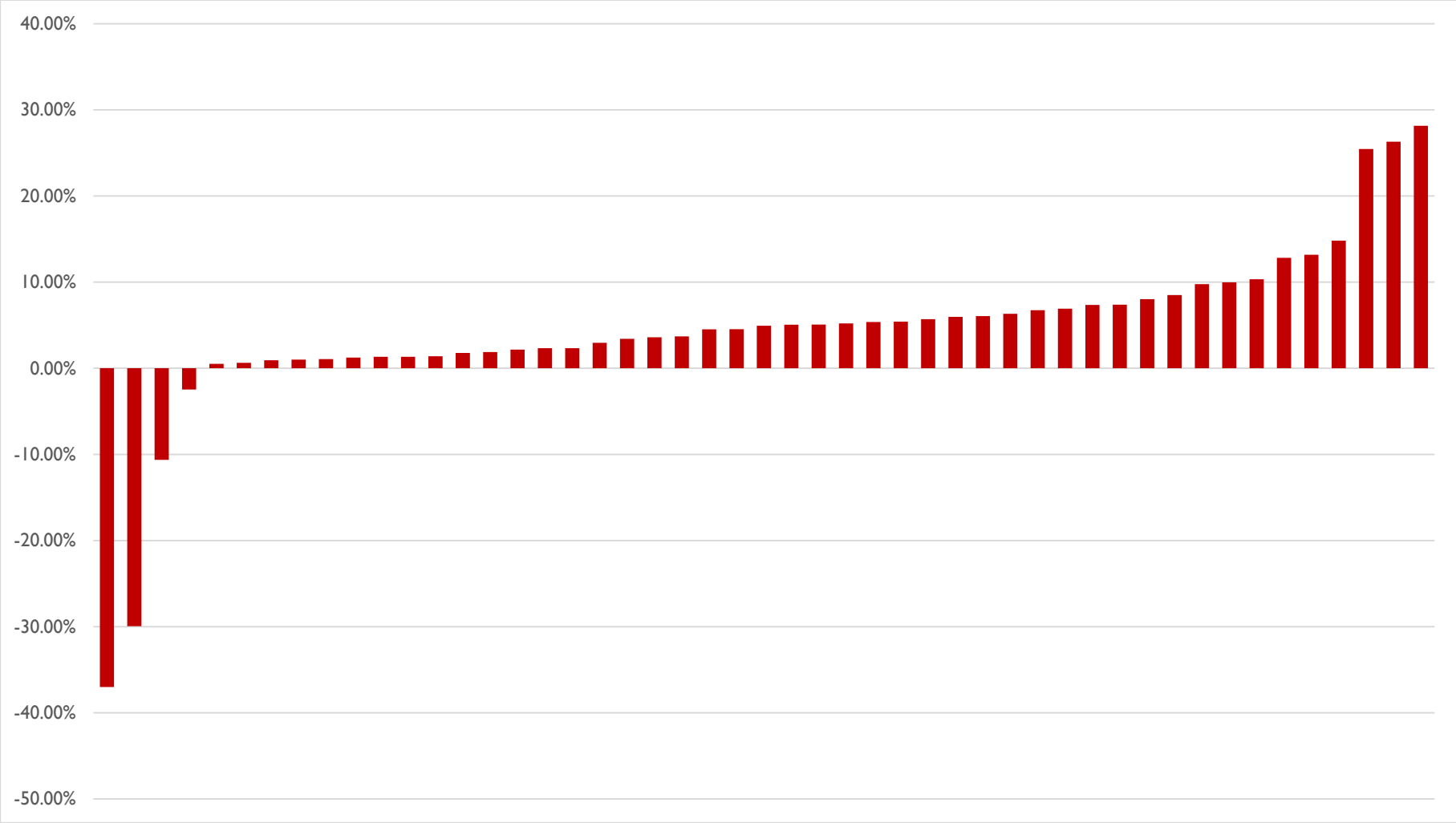
Operating Profits by Hospital

Fiscal 2016 Year to Date (July)



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Purpose of Monitoring Maryland Performance

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

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

Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 and Fiscal 2016 rely on Maryland Department of Planning projections of population growth of .56% for FY 16 and .56% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

Monitoring Maryland Performance
Preliminary Utilization Analytics

FY2013-FY2015

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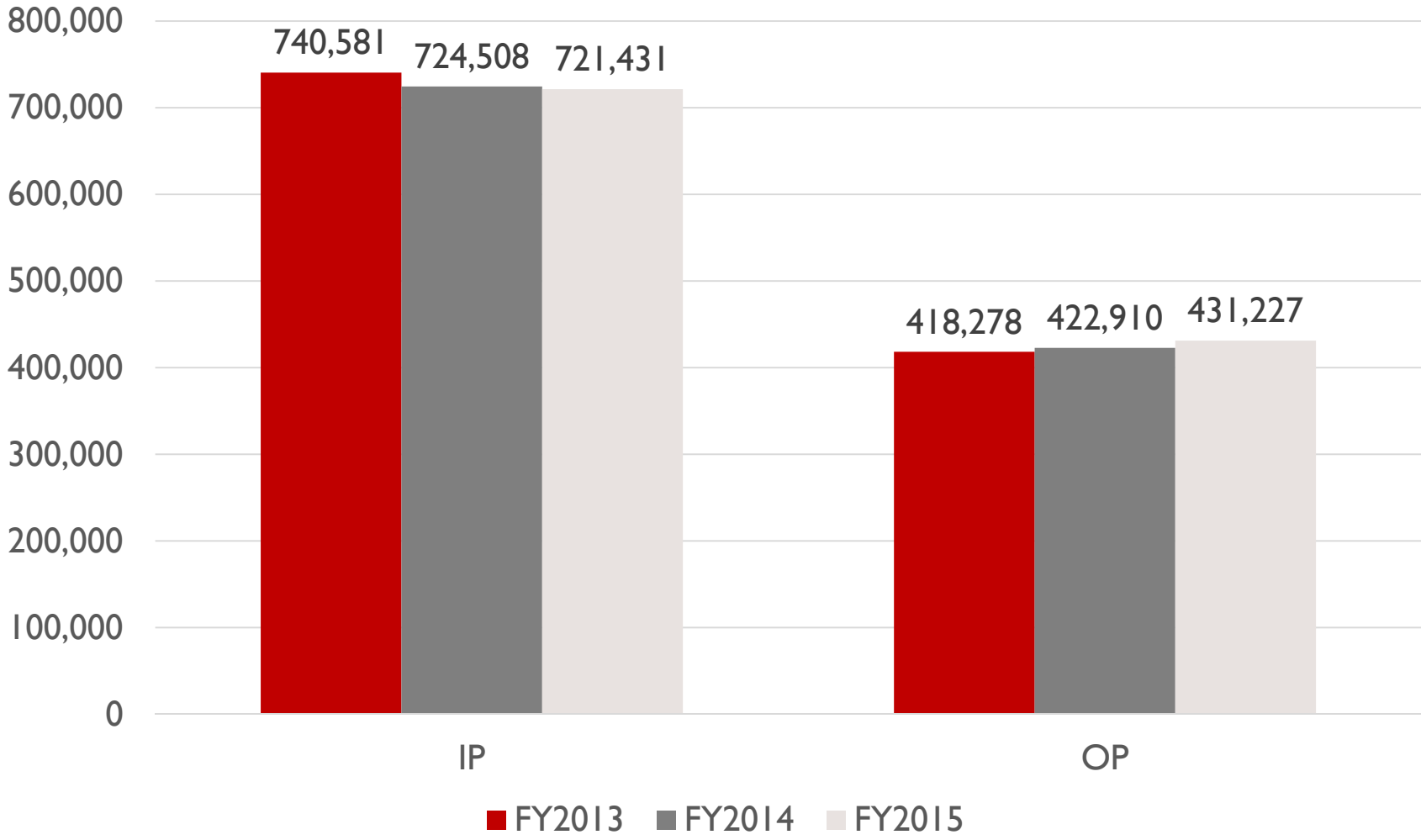
Health Services Cost Review Commission

Utilization Analytics

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

All-Payer Inpatient(IP) and Outpatient (OP) ECMAD Trend



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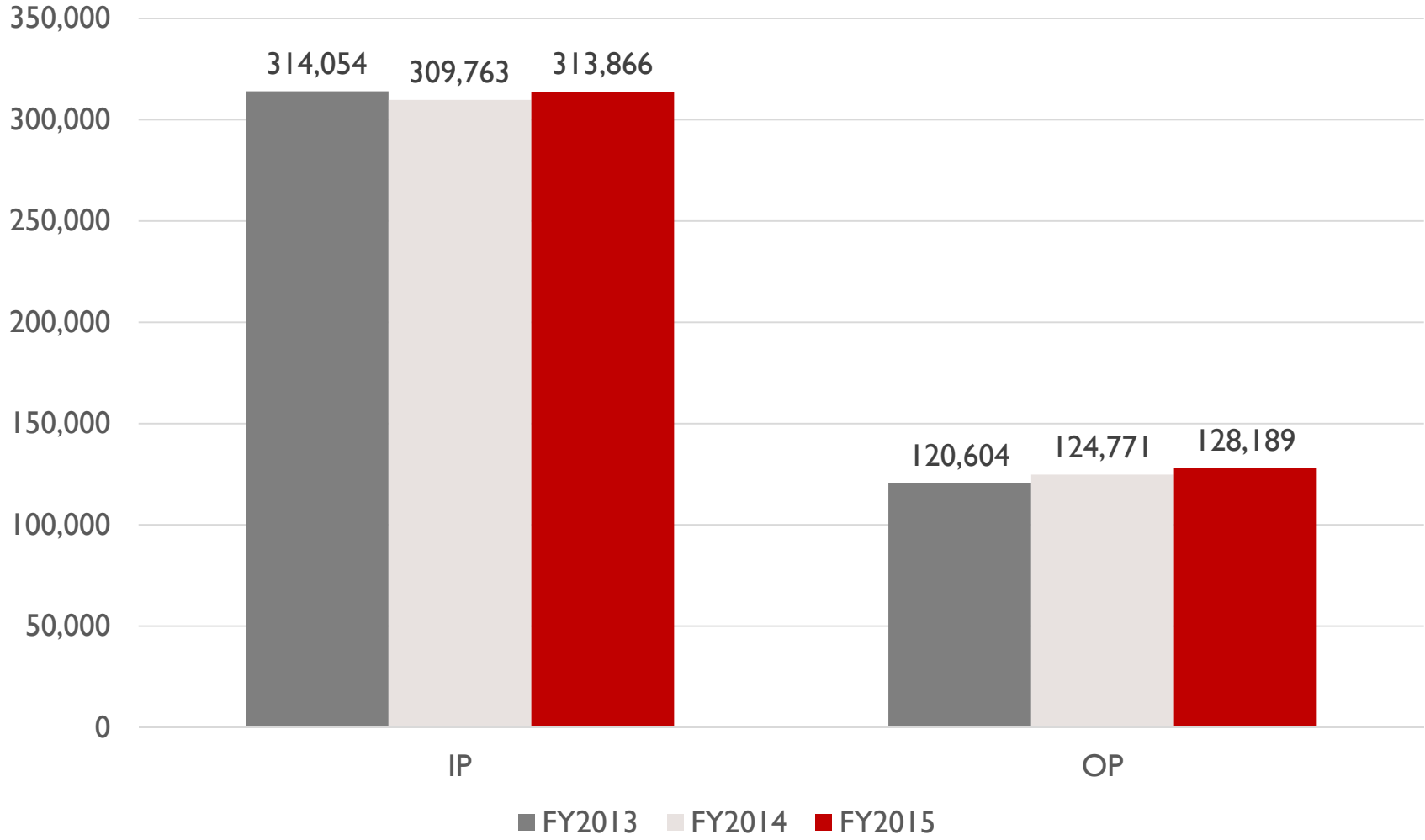
Medicare All-Payer Inpatient(IP) and Outpatient (OP) ECMAD Trend



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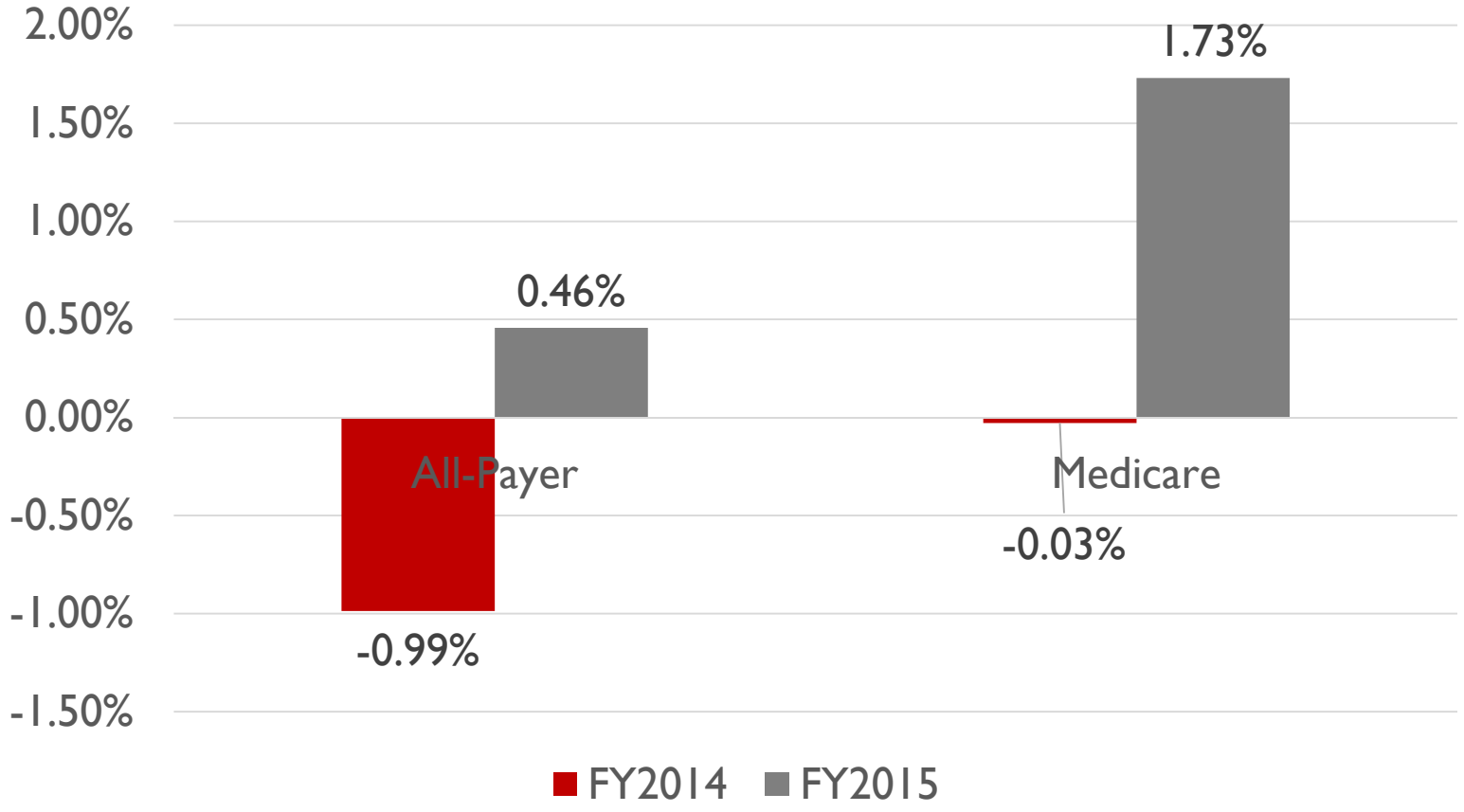
Annual Percent Growth Rate-Total ECMAD



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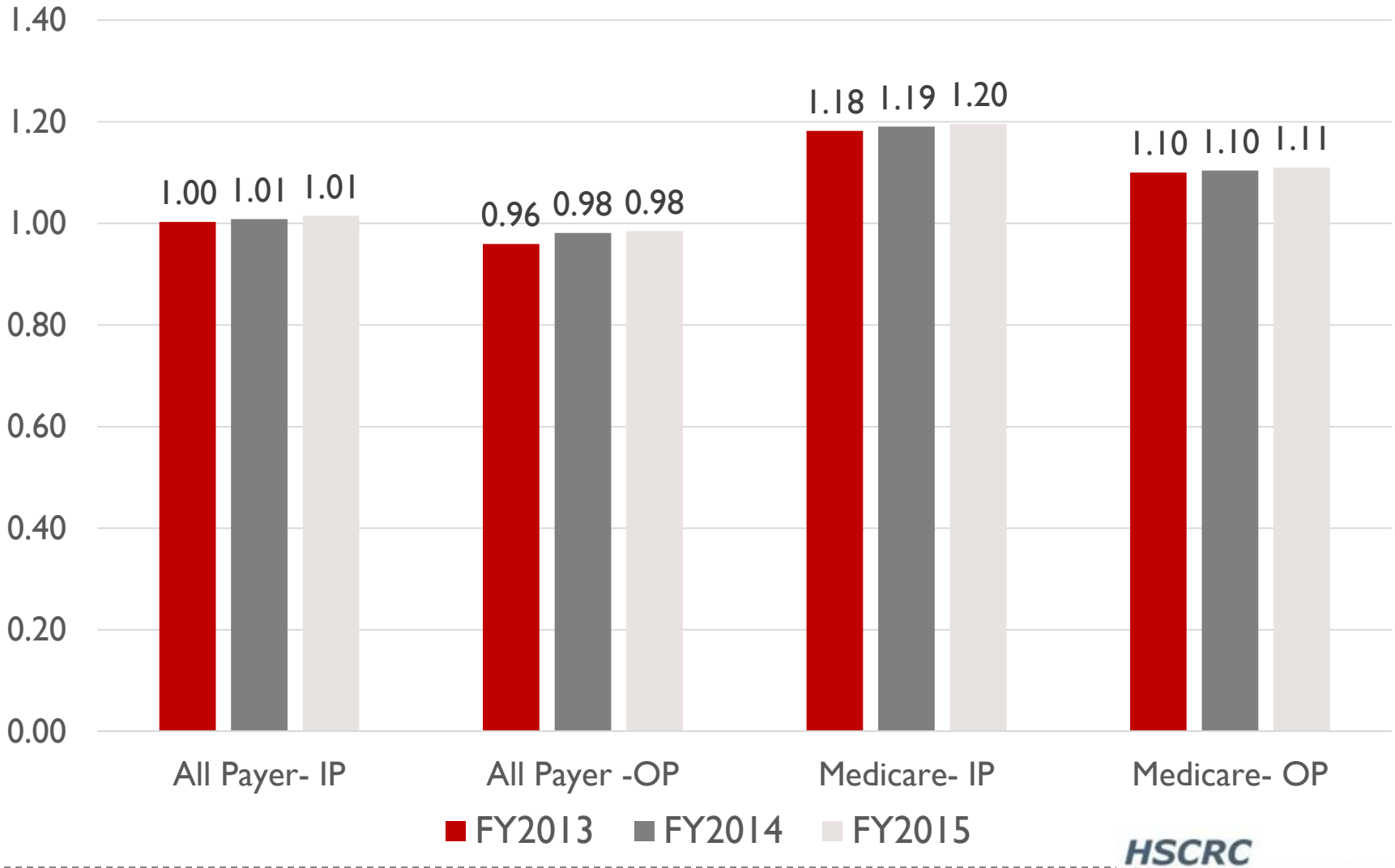
Case-mix Index Trends by Payer



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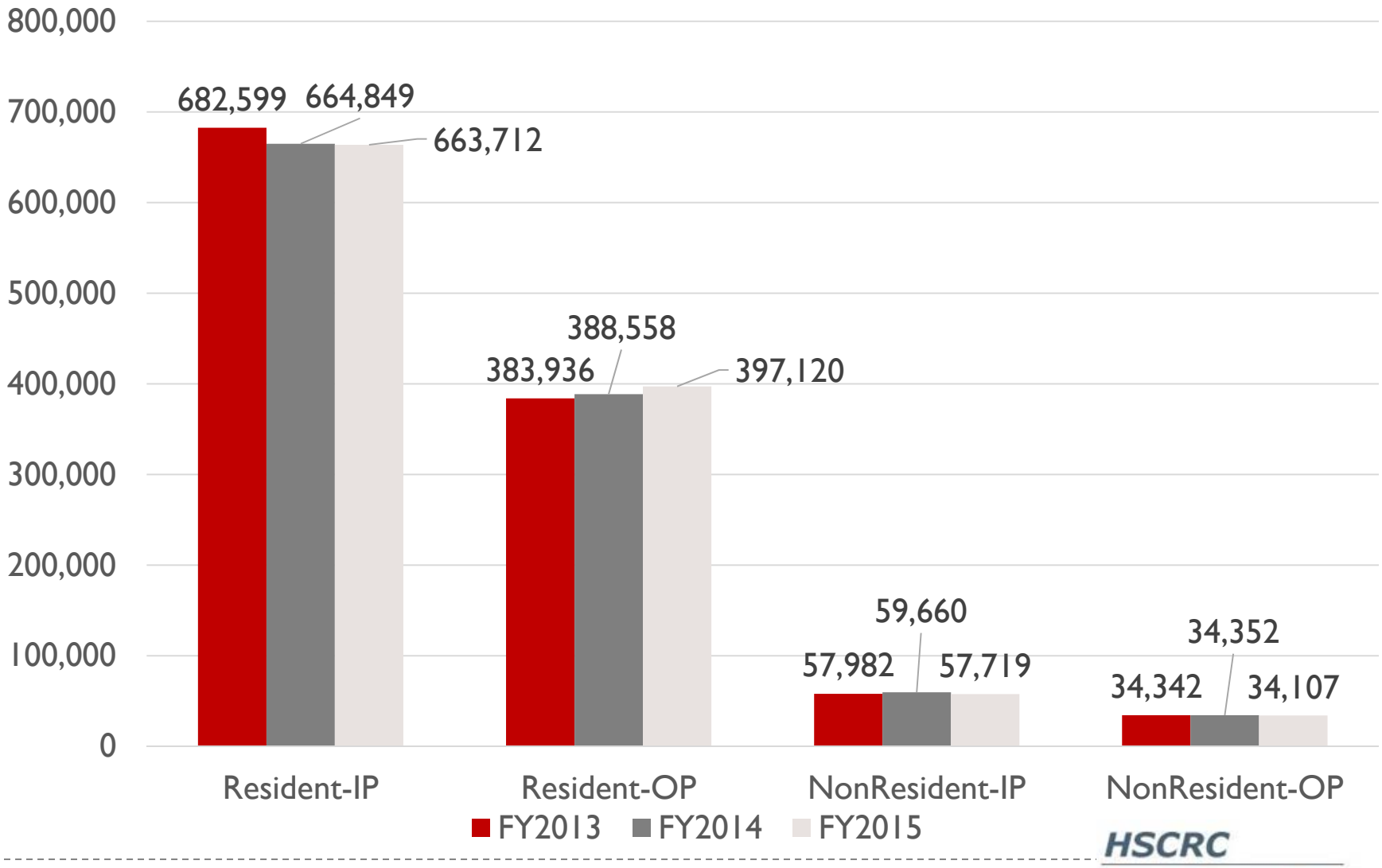
All-Payer ECMAD Trends by Resident Status



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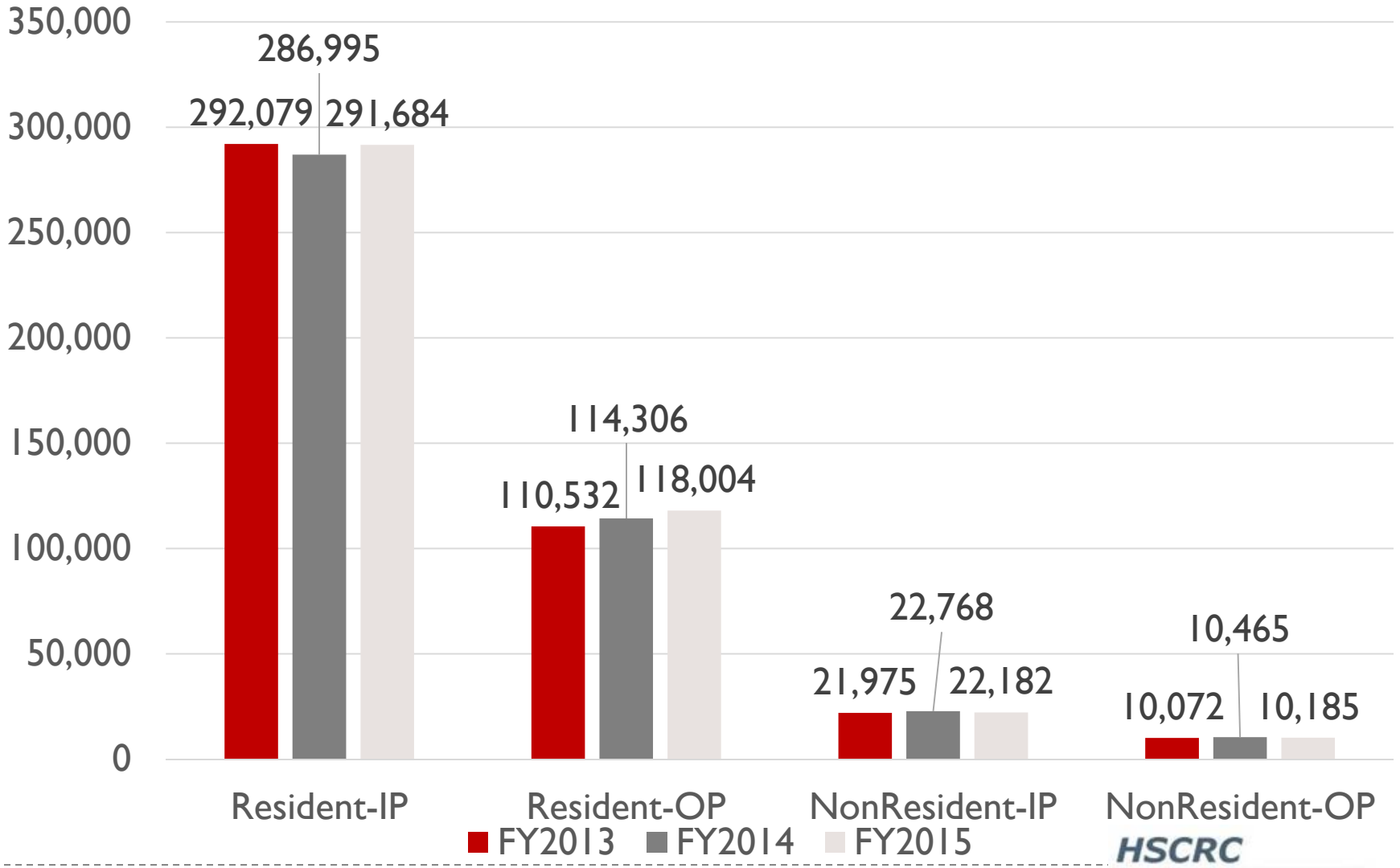
Medicare ECMAD Trends by Resident Status



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Service Line Definitions

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

All Payer MD Resident Inpatient Service Line Distribution

Rank	Service Line	FY2015 ECMAD	% Total ECMAD
1	Readmission	90,377	8%
2	Orthopedic Surgery	89,403	8%
3	General Surgery	55,793	5%
4	PQI	51,112	4%
5	Obstetrics/Delivery	43,783	4%
6	Infectious Disease	36,593	3%
7	Gastroenterology	31,628	3%
8	Neurology	24,922	2%
9	Pulmonary	24,192	2%
10	Cardiothoracic Surgery	21,311	2%
11	Cardiology	18,642	2%
12	Psychiatry_IP	18,150	2%
13	Neonatology	16,908	1%
14	Ventilator Support	14,918	1%
15	Invasive Cardiology	14,015	1%
16	Categorical Exclusions_IP	13,263	1%
17	Neurological Surgery	11,655	1%
18	Rehabilitation	11,176	1%
19	Oncology_IP	11,101	1%
20	Newborn	9,607	1%

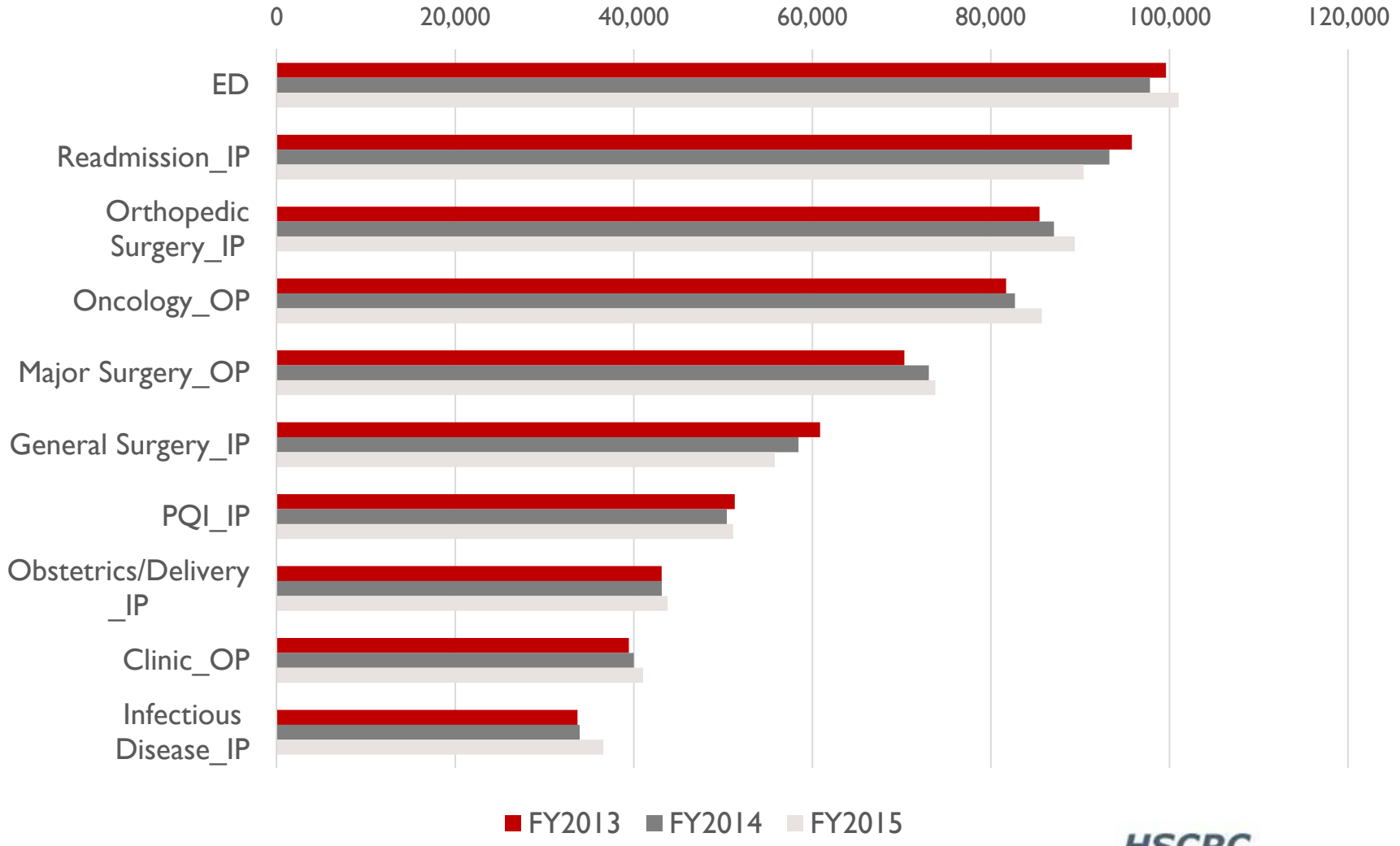
Inpatient Service Lines-Continued

Rank	Service Line	FY2015 ECMAD	% Total ECMAD
21	Vascular Surgery	9,492	1%
22	Nephrology	9,075	1%
23	General Medicine	9,050	1%
24	Spinal Surgery	8,967	1%
25	Urological Surgery	6,632	1%
26	Gynecological Surgery	5,664	0%
27	Hematology	5,606	0%
28	Endocrinology Surgery	5,417	0%
29	Thoracic Surgery	5,242	0%
30	Trauma	5,218	0%
31	Orthopedics	5,013	0%
32	Endocrinology	4,360	0%
33	Myocardial Infarction	3,713	0%
34	Rheumatology	3,647	0%
35	EP/Chronic Rhythm Mgmt	3,434	0%
36	Substance Abuse	3,296	0%
37	Otolaryngology	3,234	0%
38	ENT Surgery	3,177	0%
39	HIV	2,385	0%
40	Other Obstetrics	2,180	0%
41	Injuries/complic. of prior care	2,046	0%
42	Dermatology	1,934	0%
43	Urology	1,513	0%
44	Gynecology	725	0%
45	Unassigned_IP	493	0%
46	Dental	427	0%
47	Diabetes	402	0%
48	Ophthalmology	381	0%
49	Ophthalmologic Surg	148	0%

All Payer MD Resident Outpatient Service Line Distribution

Rank	Service Line	FY2015 ECMAD	% Total ECMAD
1	ED	101,018	9%
2	Rad/Inf/Chemo	85,694	7%
3	Major Surgery	73,774	6%
4	Clinic	41,033	4%
5	Cardiovascular	27,943	2%
6	Radiology	26,419	2%
7	Minor Surgery	24,473	2%
8	Other	13,884	1%
9	CT/MRI/PET	10,894	1%
10	Psychiatry	8,637	1%
11	Rehab & Therapy	7,835	1%
12	Lab	4,806	0%
13	Drugs	2,228	0%
14	Unassigned	1,522	0%
15	Pathology	1,067	0%

All-Payer MD Resident Largest 10 Service Line Trends



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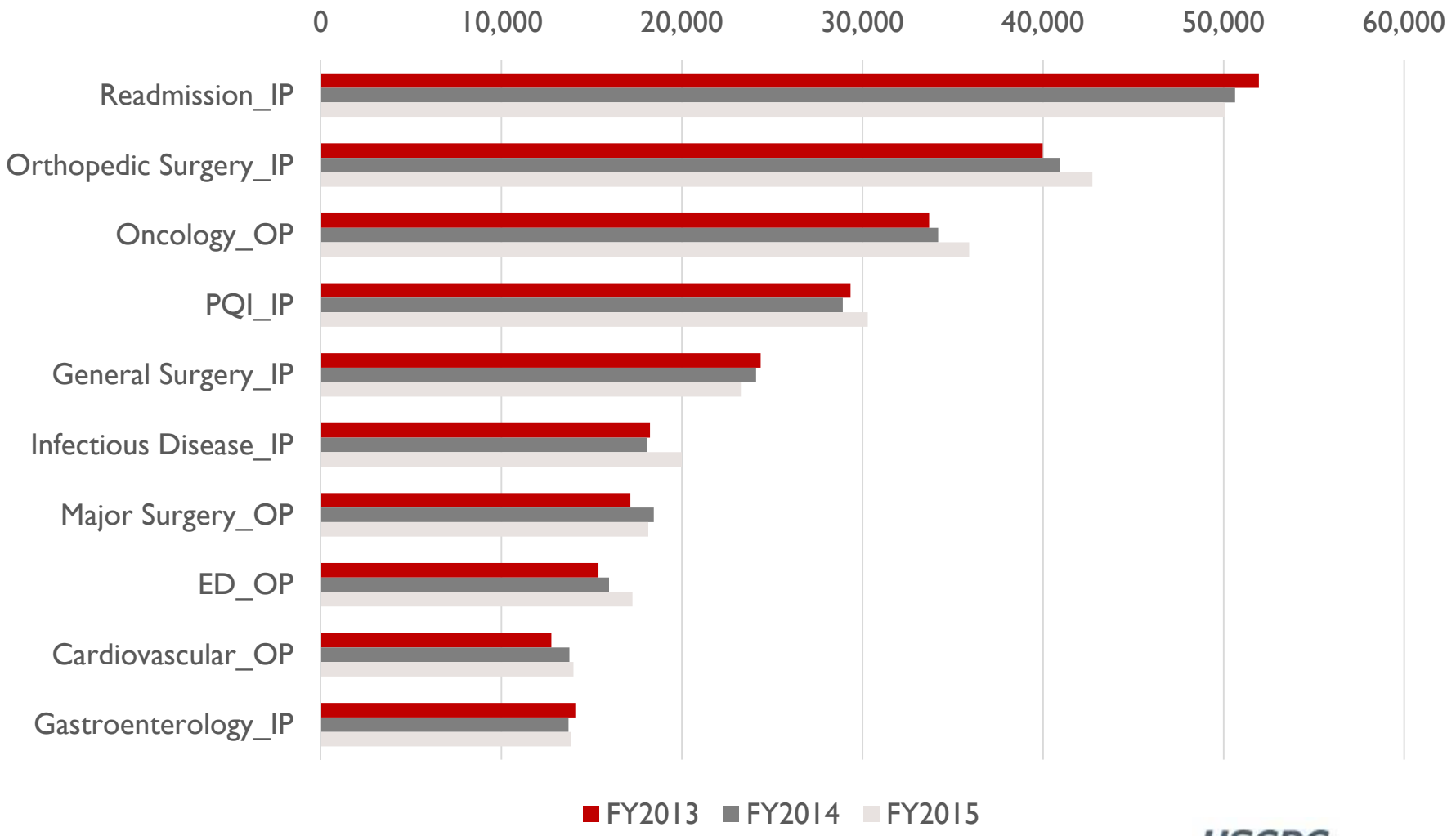
Medicare MD Resident Largest 10 Service Line Trends



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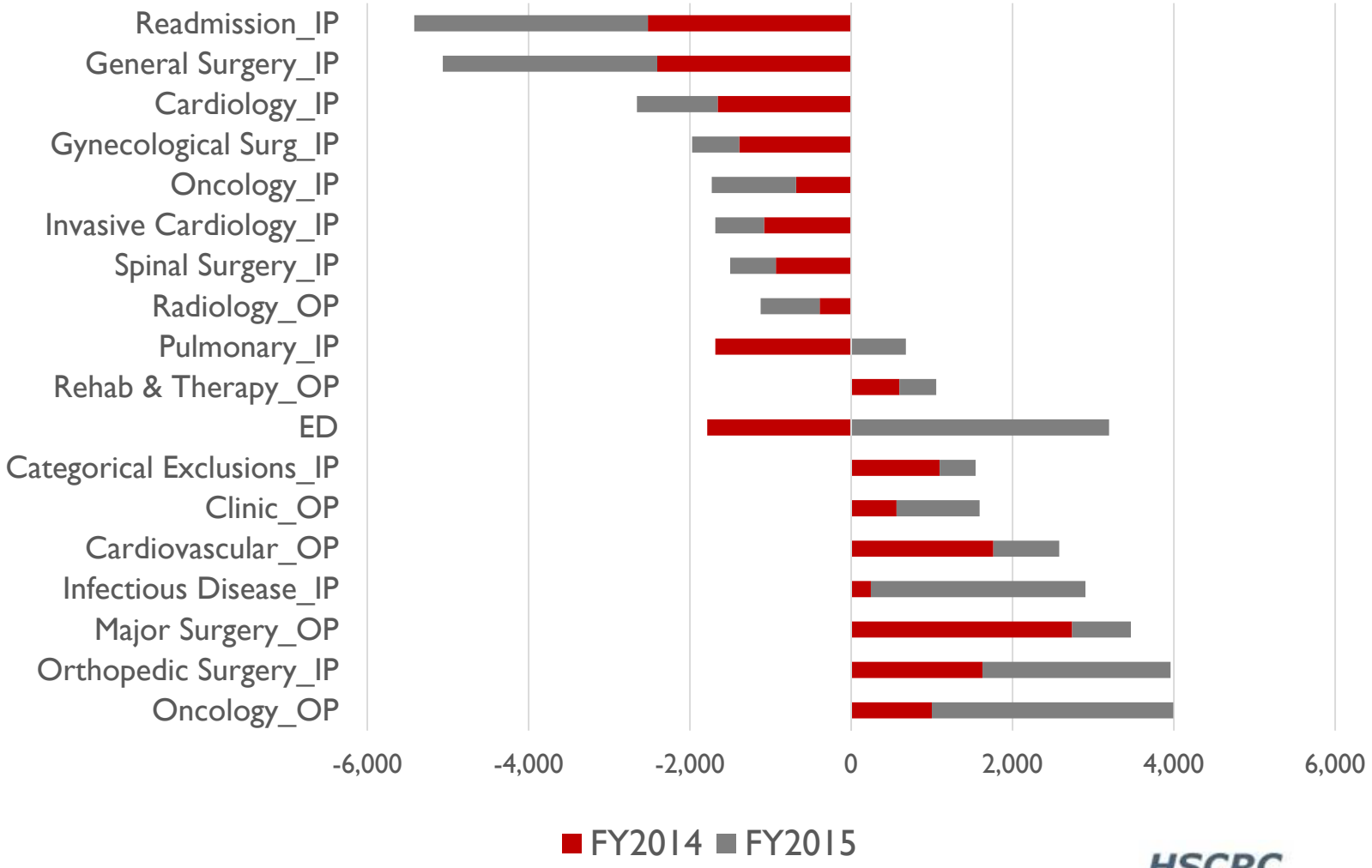
All-Payer MD Resident Service Lines with Largest Net Changes FY15 vs FY13



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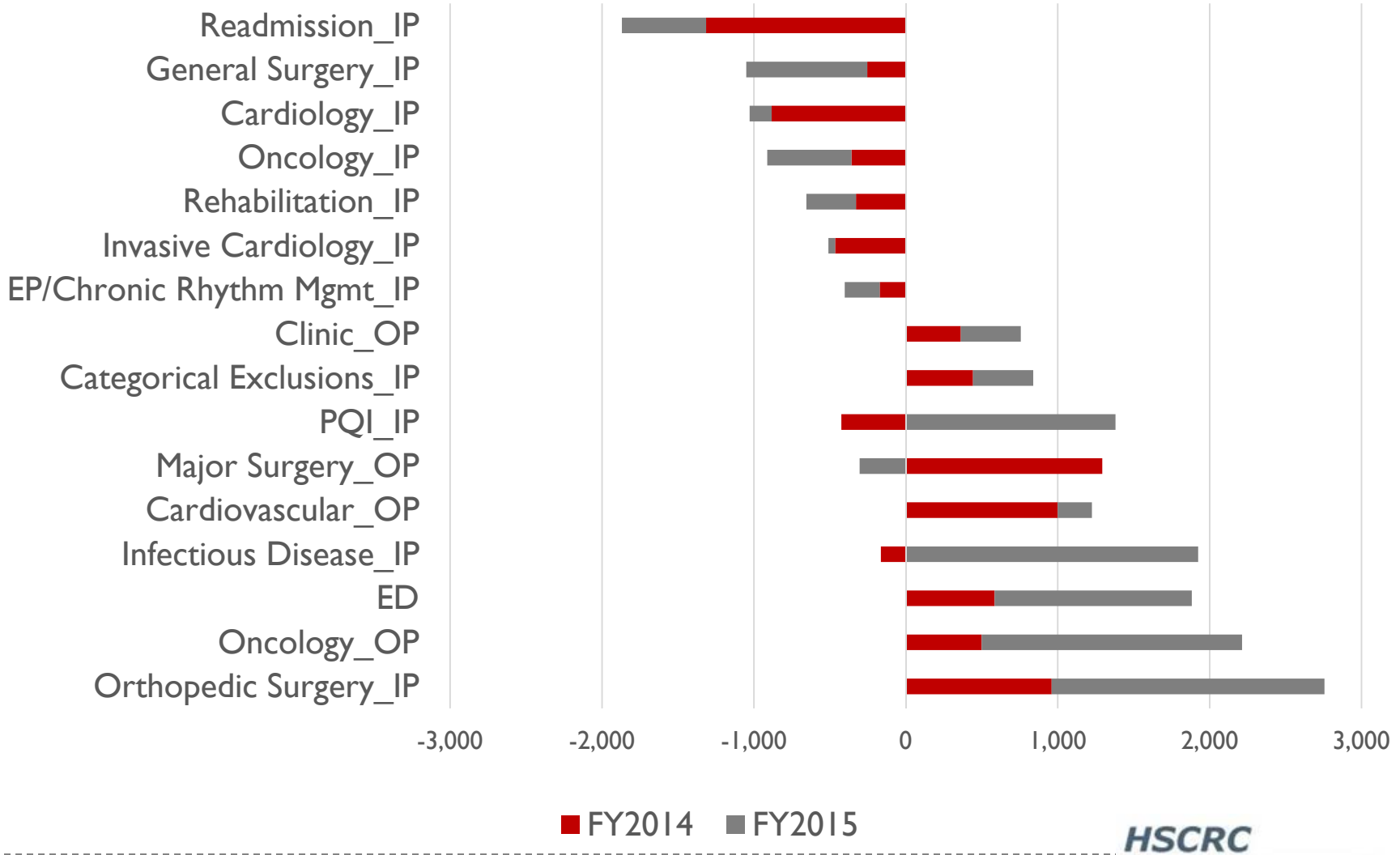
Medicare MD Resident Service Lines with Largest Net Changes FY15 vs FY13



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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 2, 2015

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
2300R	Washington Adventist Hospital	6/8/2015	9/8/2015	11/5/2015	Capital	GS	OPEN
2303R	Frederick Memorial Hospital	7/10/2015	9/8/2015	12/7/2015	FULL	JS	OPEN
2304N	UM St. Joseph Medical Center	7/17/2015	9/8/2015	12/14/2015	CCU/DEF	CK	OPEN
2306A	University of Maryland Medical Center	8/28/2015	N/A	N/A	ARM	DNP	OPEN
2307A	Maryland Physician Care	8/31/2015	N/A	N/A	ARM	SP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION *		**COMMISSION**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2015**
MEDICAL CENTER *		**FOLIO: 2116**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2306A**

Staff Recommendation

September 9, 2015

I. INTRODUCTION

University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on August 28, 2015 for an alternative method of rate determination pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for solid organ transplant and blood and bone marrow transplants for one year with Aetna Health, Inc. beginning October 1, 2015.

II. OVERVIEW OF THE APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

Based on the Hospital's favorable performance, staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ transplant, and blood and bone marrow transplant services, for a one year period beginning October 1, 2015. The Hospital will need to file a renewal application to be considered for continued participation.

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

Partial Rate Application for Capital

September 9, 2015

HSCRC
Health Services Cost Review Commission

Partial Rate Application for Capital

- **What it does:**
  - Allows a hospital that is undertaking a major capital project to request an increase to rates to finance a portion of the project

- **Who is eligible?**
  - Any hospital that has filed a Certificate of Need (CON) request with the Maryland Health Care Commission (MHCC)
    - The project must be a major renovation or relocation, defined as having a total project cost that is at least 50% of the hospital's total approved revenue for the year

Partial Rate Application for Capital

- **Why is it allowed?**
  - As part of the CON process, the HSCRC must comment on the financial feasibility of the project
    - The feasibility may be dependent on the HSCRC's approval of rate increases at the time of the project's completion
    - Allows HSCRC to review and approve future increases so that the feasibility may be better estimated

Partial Rate Application for Capital

- **What is used?**
  - Blended Reasonableness of Charges (ROC) Methodology, adopted June 2010, with modifications
    - Incorporates outpatient charge per visit (CPV) with inpatient charge per case
    - Hospitals are divided into peer groups:
      - Urban
      - Non-urban teaching hospitals
      - Suburban and rural non-teaching hospitals
      - Special Hopkins & University Group

Partial Rate Application for Capital

- **Adjustments included in the Modified ROC:**
  - Compares the hospital with its peer group standard, comprehensive charge target (CCT) adjusted for the following:
    - **Mark-up**: Commission approved markups over costs that reflect the payer differential and uncompensated care built into each hospital's rate structure
    - **Direct Strips** (Direct Medical Education, Nurse Education, and Trauma): Remove partial costs of resident salaries, nurse education costs and incremental costs of trauma services of hospitals with trauma centers
    - **Labor Market**: Adjustment for differing labor costs in various markets
    - **Case Mix**: Adjustment accounts for differences in average patient acuity across hospitals
    - **Capital**: Costs for a hospital are partially recognized
    - **Indirect Medical Education**: Adjustment for inefficiencies and unmeasured patient acuity associated with teaching programs
    - **Disproportionate Share**: Adjustment for differences in hospital costs for treating relatively high number of poor and indigent patients

Partial Rate Application for Capital

- **Normal adjustments to convert to the Inter-hospital Cost Comparison (ICC)**
  - Remove regulated profit percent
  - Remove additional 2% productivity adjustment (not done as part of the Partial Rate Application for Capital)
  - Peer group average becomes the standard

Partial Rate Application for Capital

- **Adjustments to the standard**
  - Same as those made for each hospital when developing standards
    - Disproportionate Share
    - Indirect Medical Education
    - Capital
    - Case Mix
    - Labor Market
    - Direct Strips
    - Mark-Ups

Partial Rate Application for Capital

- If the adjusted standard is **less than** the current approved:
  - The percentage difference is offset to the future capital adjustment

- If adjusted standard is **more than** the current approved:
  - No additional amount is added to the calculation of future capital adjustment

Partial Rate Application for Capital

- **Future adjustment allowed for capital:**
  - 50% of the hospital's depreciation and interest (D&I) as a percentage of total cost (after addition of project D&I)
  - 50% of the peer group's average depreciation and interest as a percentage of total cost

Partial Rate Application for Capital

- **Example:**

	D&I	Total Cost	% D&I
Hospital's current depreciation and interest	$7,000,000	$100,000,000	7.00%
Hospital's project depreciation and interest	$6,000,000	$6,000,000	
	$13,000,000	$106,000,000	12.26%
Peer group depreciation and interest as a percentage of total cost			9%

Allowed % for Capital	50%	x	12.26%	=	6.13%
	50%	x	9.00%	=	4.50%
					10.63%

Partial Rate Application for Capital

- **Example:** Final adjustment
  - Allowed Capital % 10.63%
  - Current Capital % - 7.00%
    - Difference 3.63%
  - Adjustment from ICC (minus only) 0%
  - Final Capital % 3.63%

  - Approved revenue for current period $115,000,000
  - Additional capital adjustment $4,174,500

This amount will be added to rates when the project is completed and the hospital begins to record additional depreciation and interest

Future Issues

- Volume Growth
  - Previously reimbursed actual volume growth at 85% Variable Cost Factor (VCF)
  - Current policy only provides 50% VCF on market shift and population/demographic growth

- Other Avenues for Financing Major Capital Projects
  - Cash from operations (prior, future)
  - Philanthropy
  - Sale of bonds- how much and how do we finance?

Future Issues

- Efficiency of Prices
  - Previous ROC and ICC adjusted for only differences in prices, which were considered reasonable or necessary to compare one hospital to another

- Efficiency Bands Around Prices, which should consider:
  - Quality measures
  - Per capita efficiency levels
  - Potentially Avoidable Utilization

Draft Recommendation for Updating the Quality-Based Reimbursement Program for FY 2018

September 9, 2015

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

This document contains the draft staff recommendations for updating the Quality-Based Reimbursement (QBR) Program for FY 2018 for consideration at the September 9, 2019 Public Commission Meeting. Public comments should be sent to Dianne Feeney at the above address or by e-mail at Dianne.Feeney@Maryland.gov. For full consideration, comments must be received by October 1, 2015.

A. INTRODUCTION

The Health Services Cost Review Commission (HSCRC) quality-based measurement initiatives, including the scaling methodologies and magnitudes of revenue "at risk" for these programs, are important policy tools for providing strong incentives for hospitals to improve their quality performance over time. HSCRC implemented the first hospital payment adjustments for the Quality-Based Reimbursement (QBR) Program performance in July 2009. Current Commission policy calls for measurement of hospital performance scores across clinical process of care, outcome and patient experience of care domains, and scaling of hospital performance results in allocating rewards and penalties based on performance.

"Scaling" for QBR refers to the differential allocation of a pre-determined portion of base-regulated hospital inpatient revenue based on assessment of the quality of hospital performance. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year; these scaled amounts are applied on a "one-time" basis (and are not considered permanent revenue).

For fiscal year (FY) 2018, HSCRC staff draft recommendations include adjusting the weights and updating the measurement domains to be as consistent as possible with the CMS Value-Based Purchasing (VBP) Program and holding steady the amount of total hospital revenue at risk for scaling for the QBR Program.

B. BACKGROUND

1. Centers for Medicare & Medicaid Services (CMS) VBP Program

The Patient Protection and Affordable Care Act of 2010 requires CMS to fund the aggregate Hospital VBP incentive payments by reducing the base operating diagnosis-related group (DRG) payment amounts that determine the Medicare payment for each hospital inpatient discharge. The law set the reduction at 1 percent in FY 2013 and mandates it to rise incrementally to 2 percent by FY 2017.

CMS implemented the VBP Program with hospital payment adjustments beginning in October 2013. For the federal fiscal year (FFY) 2017 (October 1, 2016 to September 30, 2017) Hospital VBP Program, CMS measures include the following four domains of hospital performance with 2 percent of Medicare hospital payments "at risk":

- Clinical care: process of care weighted at 5 percent and outcomes weighted at 25 percent
- Patient experience of care (HCAHPS survey measure) weighted at 25 percent
- Efficiency/Medicare spending per beneficiary weighted at 25 percent
- Safety weighted at 20 percent

HSCRC staff note that, for the VBP Program for FY 2017, CMS has added Health Safety Network ("CDC-NHSN") Clostridium Difficile and Methicillin-Resistant Staphylococcus Aureus measures, as well as the Elective Delivery Prior to 39 Completed Weeks Gestation measure.

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

For the QBR Program for state FY 2017 rates, as approved, the HSCRC will: weight the clinical process measures at 5 percent of the final score, the outcomes and safety domains more heavily at 50 percent combined, and the patient experience of care measures at 45 percent; as well as scale a maximum penalty of 2 percent of approved base hospital inpatient revenue. The program uses the CMS/Joint Commission core process measures also used for the VBP Program, clinical outcome measures, "patient experience of care" Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and safety measures. The weighting for each domain compared with the CMS VBP program are illustrated below in Figure 1.

Figure 1. Final Measure Domain Weights for the CMS Hospital VBP and Maryland QBR Programs for FY 2017

	Clinical • **Outcomes (Mortality)** • **Process**	**Patient Experience**	**Safety**	**Efficiency**
CMS VBP	• 25 percent • 5 percent	25%	20%	25%
Maryland QBR	• 15 percent • 5 percent	45%	35%	N/A

HSCRC staff have worked with stakeholders over the last three years to align the QBR measures with the VBP Program where feasible, and to align the list of process of care measures, threshold and benchmark values, and time lag periods with those used by CMS,[1] allowing HSCRC to use the data submitted directly to CMS. This alignment has also occurred with the magnitude of revenue "at risk" for the two programs. Maryland has not yet developed and implemented an efficiency measure as part of the QBR Program, but it does apply a Potentially Avoidable Utilization adjustment to hospital global budgets, as well as a shared savings adjustment based on hospitals' readmission rates. HSCRC staff will also work with stakeholders to develop a new efficiency measure that incorporates population-based cost outcomes.

3. Value-Based Purchasing Exemption Provisions

Under the previous waiver, VBP exemptions had been requested and granted for FYs 2013, 2014, and 2015.

The CMS FY 2015 Inpatient Prospective Payment stated that, although the exemption from the Hospital VBP Program no longer applies, Maryland hospitals will not be participating in the

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

Hospital VBP Program because §1886(o) of the Act and its implementing regulations have been waived for purposes of the model, subject to the terms of the agreement.

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

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

For FY 2016 under the new All-Payer Model, HSCRC staff submitted an exemption request and received approval on August 27, 2015 from the CMS Center for Medicare and Medicaid Innovation (see Appendix I).

C. ASSESSMENT

1. FY 2016 Performance Results

Staff analyzed changes in performance on the QBR and VBP measures used for FY 2016 performance for Maryland versus the United States for October 2013 through September 2014 compared with the base period. Figure 2 below lists each of the measures used for the VBP and QBR Programs. As the data indicate, Maryland has performed and continues to perform similarly to the nation on the clinical process of care measures but better than the nation on the 30-day condition-specific mortality measures. For the Safety infection measures, Maryland has performed and continues to perform better than the nation on the CLABSI measure; for the other infection measures, Maryland appears to perform worse than the nation, and this may be in part due to limited hospital participation in reporting the data for these measures as hospitals were continuing to align their reporting with Medicare requirements. With exception of the "Discharge Information" measure—for which Maryland is on par with the nation—Maryland has lagged and continues to lag behind the nation on the HCAHPS measures. Final QBR payment scaling for FY 2016 rate year is provided in Appendix II.

Figure 2. QBR Measures Change for Maryland versus U.S.

	Maryland Base	Maryland Current	Difference	US Base	US Current	Difference	MD-US Difference in Base	MD-US Difference in Current
CLINICAL PROCESS OF CARE								
AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival	NA	NA	NA	61%	60%	-1	NA	NA
PN 6 Initial antibiotic selection for CAP immunocompetent pt	96%	98%	2%	95%	96%	1%	1%	2%
SCIP 2 Received prophylactic Abx consistent with recommendations	98%	99%	1%	100%	99%	-1%	-2%	0%
SCIP 3 Prophylactic Abx discontinued w/in 24 hrs of surgery end time or 48 hrs for cardiac surgery	98%	98%	0%	98%	98%	0%	0%	0%
SCIP 9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2	96%	99%	3%	100%	98%	-2%	-4%	1%
SCIP-Card 2 Pre-admission beta-blocker and perioperative period beta blocker	97%	98%	1%	100%	98%	-2%	-3%	0%
SCIP VTE2 Received VTE prophylaxis within 24 hrs prior to or after surgery	98%	99%	1%	98%	99%	1%	0%	0%
IMM-2 Influenza Immunization	93%	96%	3%	88%	93%	5%	5%	3%
OUTCOMES								
Mortality								
Observed Mortality Inpatient All Cause (Maryland All Payer)	3.45%	2.50%	-0.95%	NA	NA	NA	NA	NA
30-day mortality, AMI (Medicare)*	14.75%	14.50%	-0.25%	15.20%	14.90%	-0.30%	-0.45%	-0.40%
30-day mortality, heart failure (Medicare)*	10.79%	10.90%	0.11%	11.70%	11.90%	0.20%	-0.91%	-1.00%
30-day mortality, pneumonia (Medicare)*	10.81%	10.85%	0.04%	11.90%	11.90%	0.00%	-1.09%	-1.05%
Safety/Complications								
AHRQ PSI composite (Maryland All Payer)	0.862	0.647	NA	NA	NA	NA	NA	NA
CLABSI	0.532	0.527	NA	1	1	NA	-46.8%	-47.30%
CAUTI	2.327	1.659	NA	1	1	NA	132.7%	65.90%
SSI Colon	0.768	1.055	NA	1	1	NA	-23.2%	5.50%
SSI Abdominal Hysterectomy	1.751	1.281	NA	1	1	NA	75.1%	28.10%
MRSA	NA	1.344	NA	NA	1	NA	NA	34.40%
C.diff.	NA	1.15	NA	NA	1	NA	NA	15.00%
PATIENT EXPERIENCE OF CARE - HCAHPS								
Communication with nurses	75%	76%	1%	78%	79%	1%	-3%	-3%
Communication with doctors	78%	78%	0%	81%	82%	1%	-3%	-4%
Responsiveness of hospital staff	60%	60%	0%	67%	68%	1%	-7%	-8%
Pain management	68%	67%	-1%	71%	71%	0%	-3%	-4%
Communication about medications	60%	60%	0%	64%	65%	1%	-4%	-5%
Cleanliness and quietness	61.0%	61.5%	0.5%	66.5%	68.0%	1.5%	-5.5%	-6.5%
Discharge information	84%	86%	2%	85%	86%	1%	-1%	0%
Overall rating of hospital	65%	65%	0%	70%	71%	1%	-5%	-6%

2. FY 2018 VBP and QBR Measures, Performance Standards, and Domain Weighting

HSCRC staff examined measures finalized for the CMS VBP Program for FY 2018 in the 2016 CMS Inpatient Prospective Payment System (IPPS) Final Rule, as well as those in the potential pool for the QBR Program for 2018. Appendix III details the measures by domain and the available published performance standards for each measure. It also indicates the measures that will be included in the VBP and QBR Programs. Staff note that one process of care measure remains—PC-01 Elective Delivery Before 39 Weeks Gestation—and is now part of the Safety domain that also comprises the CDC NHSN measures.

In proposing updated measure domain weights based on the VBP measure domain weights published in the CMS IPPS Final Rule, staff considered the following:

- The measures and domains available for adoption in the QBR rate year FY 2018
- Maryland's continued need to improve on the HCAHPS measures, and addition of the Care Transition (CTM-3) measure, an area of critical importance to the All-Payer Model success
- Number of measures in each domain, for example the Clinical Care domain comprising only the inpatient all-cause mortality measure, different number of measures for each hospital in Safety domain due to low cell sizes for some of the measures

Figure 4 below illustrates the CMS VBP final domain weights for FY 2018 and the QBR proposed domain weights for FY 2018 compared to the domain weights from FY 2017.

Figure 3. Final Measure Domain Weights for the CMS Hospital VBP Program and Proposed Domain Weights for the QBR Program, FY 2018

	Clinical Care	**Patient experience of Care/ Care Coordination**	Safety	Efficiency
QBR FY 2017	15% (1 measure- mortality) 5% (clinical process measures)	45% (8 measures- HCAHPS)	35% (3 infection measures, PSI)	PAU
Proposed QBR FY 2018	15% (1 measure- mortality)	50% (9 measures- HCAHPS + CTM)	35% (8 measures- Infection, PSI, PC -01)	PAU
CMS VBP FY 2018	25% (3 measures- condition specific mortality	25% (9 measures- HCAHPS + CTM)	25% (8 measures- Infection, PSI, PC -01)	25%

Staff circulated the draft recommendation via e-mail to the members of the QBR Subgroup of the Performance Measurement Workgroup and had a discussion about the draft at the in-person meeting on August 24, 2015. Hospital representatives and Maryland Hospital Association (MHA) staff voiced their concerns that 50 percent weighting of the Patient Experience/Care Coordination domain was too high, and that this area has proved difficult to improve upon. In their correspondence of August 27, 2015, approving the FY 2016 VBP Exemption (Appendix I), the Innovation Center notes Maryland's significantly lagged performance on HCAHPS and supports increasing the weighting by 5 percent. Hospital representatives and MHA staff also noted that it would be useful to analyze to what extent small sizes impacted the number of measures that may be used for QBR on a hospital-specific basis in the Safety domain. Staff modeled FY 2016 performance data in their analysis and found that the vast majority of hospitals had data for 7 or 8 measures out of 8 in the Safety domain (See Appendix IV). Staff will use CMS rules for minimum measure requirements for scoring a domain and for readjusting domain weighting if a measurement domain is missing for a hospital. Staff will also score hospitals on attainment only for any measures obtained from the CMS Hospital Compare website where only performance period data is available (i.e., base period data is missing such that improvement cannot be assessed). Furthermore, hospitals that are missing both base period and performance period data on Hospital Compare will receive a score of zero for that measure. Hospitals are strongly encouraged to review and contact CMS with any concerns related to preview data or issues with posting data to Hospital Compare, and to alert HSCRC staff in a timely manner if issues cannot be resolved. Hospitals will be required to have scores on at least 2 out of 3 of the QBR Domains to be included in the program.

Staff note again that the established revenue "at risk" magnitude for the CMS VBP Program is set at 2 percent for 2017.

A memo summarizing the updates to the QBR methodology, base period data, and preset revenue adjustment scale will be sent to the hospitals shortly after CY 2014 data is available on Hospital Compare (estimated release mid-October 2015).

D. RECOMMENDATIONS

For the QBR Program, staff provide the following draft recommendations:

1. Continue to allocate 2 percent of hospital-approved inpatient revenue for QBR performance in FY 2018 to be finalized by the Aggregate Revenue "at risk" recommendation.
2. Adjust measurement domain weights to include: 50 percent for Patient Experience/Care Transition, 35 percent for Safety, and 15 percent for Clinical Care.

APPENDIX I. CMS INNOVATION CENTER CORRESPONDENCE APPROVING THE FY 2016 VBP EXEMPTION REQUEST

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Administrato
Washington, D.C. 20201

August 27, 2015

Ms. Donna Kinzer
Executive Director, Maryland Health Services Cost Review Commission
State of Maryland Department of Health and Mental Hygiene
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Kinzer:

Thank you for your letter, on behalf of the State of Maryland, requesting an exemption from the FY 2016 Hospital Value-Based Purchasing (VBP) Program. As you know, Section 4(e) of the Maryland All-Payer Model Agreement provides that CMS will waive the VBP Program requirements for Maryland hospitals, as set out in Section 1886(o) of the Social Security Act and implementing regulations at 42 CFR 412.160 - 412.167, provided that the State submits "an annual report to the Secretary that provides satisfactory evidence that a similar program in the State for Regulated Maryland Hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under 1886(o) of the Act."

The Centers for Medicare & Medicaid Services (CMS) has reviewed your exemption request and supporting documentation. We officially grant the State of Maryland's exemption request for its hospitals as authorized by Section 1886(o)(I)(C)(iv) of the Act based on the fact that the Maryland program achieved or exceeded patient health outcomes measured in the Hospital VBP Program. CMS has also determined that the Maryland program meets the cost savings requirement for exemption from the Hospital VBP Program for FY 2015 because both programs reward high performers in a revenue-neutral manner.

Last year, when approving your request for an exemption from the Hospital VBP Program for FY 2014, we noted that your state's performance in the Patient Experience of Care domain significantly lagged behind national medium performance levels, and we strongly encouraged you to take steps to improve performance in that domain. Maryland's performance continues to lag behind the nation in Patient Experience of Care, however, as you indicated in your exemption request, you have assigned comparatively more weight to Hospital Consumer Assessment of Healthcare Providers and Systems performance in the Maryland program, and you are considering increasing that weight by an additional 5%. We support these efforts to improve Patient Experience of Care and we are eager to assist you in helping hospitals improve in this domain by other means.

Should you have any questions, please do not hesitate to contact the Maryland All Payer Model Team.

Sincerely,

Patrick Conway, MD, MSc

Acting Principal Deputy Administrator, CMS

Chief Medical Officer, CMS

Deputy Administrator for Innovation and Quality, CMS

Director, Center for Medicare and Medicaid Innovation

APPENDIX II. FINAL QBR PROGRAM PAYMENT SCALING FOR RY 2016

HOSPITAL ID	HOSPITAL NAME	FY 2015 PERMANENT INPATIENT REVENUE*	QBR FINAL POINTS	SCALING BASIS	REVENUE IMPACT OF SCALING	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING	REVENUE NEUTRAL ADJUSTED PERCENT
A	B	C	D	E	F = C*E	G	H=(C+G)/C-1
210003	PRINCE GEORGE	$176,633,176.79	0.204	-1.000%	-$1,766,332	-$1,766,332	-1.000%
210024	UNION MEMORIAL	$239,732,514.10	0.236	-0.848%	-$2,032,700	-$2,032,700	-0.848%
210013	BON SECOURS	$75,937,921.77	0.237	-0.842%	-$639,466	-$639,466	-0.842%
210017	GARRETT COUNTY	$18,608,187.37	0.243	-0.811%	-$150,839	-$150,839	-0.811%
210061	ATLANTIC GENERAL	$38,616,312.78	0.262	-0.721%	-$278,422	-$278,422	-0.721%
210010	DORCHESTER	$23,804,066.20	0.300	-0.536%	-$127,696	-$127,696	-0.536%
210062	SOUTHERN MARYLAND	$161,253,765.94	0.306	-0.506%	-$815,828	-$815,828	-0.506%
210056	GOOD SAMARITAN	$178,635,337.98	0.316	-0.457%	-$817,238	-$817,238	-0.457%
210023	ANNE ARUNDEL	$308,739,340.58	0.324	-0.420%	-$1,297,299	-$1,297,299	-0.420%
210034	HARBOR	$122,412,281.84	0.337	-0.355%	-$434,912	-$434,912	-0.355%
210015	FRANKLIN SQUARE	$282,129,811.54	0.338	-0.351%	-$990,065	-$990,065	-0.351%
210004	HOLY CROSS	$319,832,140.30	0.347	-0.309%	-$989,139	-$989,139	-0.309%
210057	SHADY GROVE	$231,030,091.92	0.366	-0.215%	-$497,403	-$497,403	-0.215%
210055	LAUREL REGIONAL	$77,138,956.35	0.369	-0.203%	-$156,364	-$156,364	-0.203%
210038	UMMC MIDTOWN	$137,603,928.30	0.370	-0.199%	-$273,596	-$273,596	-0.199%
210060	FT. WASHINGTON	$17,901,765.04	0.373	-0.183%	-$32,819	-$32,819	-0.183%
210016	WASHINGTON ADVENTIST	$160,049,372.87	0.379	-0.153%	-$245,350	-$245,350	-0.153%
210018	MONTGOMERY GENERAL	$87,866,457.56	0.387	-0.117%	-$102,775	-$102,775	-0.117%
210011	ST. AGNES	$238,960,906.16	0.390	-0.099%	-$236,680	-$236,680	-0.099%
210022	SUBURBAN	$182,880,097.32	0.391	-0.095%	-$174,048	-$174,048	-0.095%
210002	UNIVERSITY OF MARYLAND	$869,783,533.93	0.392	-0.089%	-$777,220	-$777,220	-0.089%
210035	CHARLES REGIONAL	$76,417,733.97	0.399	-0.057%	-$43,855	-$43,855	-0.057%
210001	MERITUS	$188,367,775.67	0.415	0.020%	$37,886	$23,050	0.012%
210037	EASTON	$95,655,306.19	0.420	0.045%	$42,869	$26,081	0.027%
210019	PENINSULA REGIONAL	$232,896,407.52	0.439	0.139%	$323,230	$196,651	0.084%
210040	NORTHWEST	$141,883,177.42	0.446	0.169%	$240,213	$146,144	0.103%
210051	DOCTORS COMMUNITY	$136,010,793.59	0.446	0.169%	$230,271	$140,095	0.103%
210039	CALVERT	$67,061,372.88	0.447	0.174%	$116,461	$70,854	0.106%
210005	FREDERICK MEMORIAL	$190,475,900.63	0.455	0.216%	$411,978	$250,644	0.132%
210029	HOPKINS BAYVIEW MED CTR	$354,237,613.19	0.460	0.239%	$845,105	$514,157	0.145%
210006	HARFORD	$46,774,506.17	0.461	0.245%	$114,535	$69,683	0.149%
210030	CHESTERTOWN	$29,287,619.34	0.462	0.250%	$73,134	$44,494	0.152%
210048	HOWARD COUNTY	$167,430,726.52	0.476	0.318%	$531,634	$323,443	0.193%
210044	G.B.M.C.	$200,727,664.89	0.478	0.327%	$656,806	$399,596	0.199%
210032	UNION HOSPITAL OF CECIL COUNT	$67,638,499.19	0.488	0.375%	$253,429	$154,185	0.228%
210008	MERCY	$232,326,849.10	0.504	0.453%	$1,052,795	$640,513	0.276%
210012	SINAI	$428,400,532.05	0.505	0.456%	$1,953,758	$1,188,653	0.277%
210009	JOHNS HOPKINS	$1,303,085,115.22	0.512	0.490%	$6,390,980	$3,888,230	0.298%
210033	CARROLL COUNTY	$136,537,812.51	0.516	0.510%	$696,104	$423,505	0.310%
210028	ST. MARY	$69,990,405.25	0.525	0.554%	$387,680	$235,862	0.337%
210049	UPPER CHESAPEAKE HEALTH	$153,131,633.20	0.531	0.583%	$892,707	$543,117	0.355%
210043	BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,797.59	0.552	0.684%	$1,533,183	$932,778	0.416%
210063	UM ST. JOSEPH	$230,010,193.37	0.609	0.961%	$2,209,908	$1,344,493	0.585%
210027	WESTERN MARYLAND HEALTH SYSTEM	$182,494,313.32	0.657	1.192%	$2,175,921	$1,323,816	0.725%
	Statewide	**$8,904,474,715**			**$8,290,541**	**$0**	0.000%

***FY 2015 Permanent IP Revenue = FY 2015 Total GBR Revenue + out of state and other non-GBR revenue x percent inpatient revenue from FY 2013**

				Rewards	21,170,587	0.608	ratio of rewards/penalties
		Average Score	41.07%	Penalties	-12,880,046		

APPENDIX III FY2018 VBP AND QBR MEASURES AND PERFORMANCE BENCHMARKS AND THRESHOLDS

Measure ID	Description	Achievement threshold	Benchmark
Safety			
CAUTI	National Healthcare Safety Network Catheter-associated Urinary Tract Infection Outcome Measure.	0.906	0
CLABSI	National Healthcare Safety Network Central Line-associated Bloodstream Infection Out- come Measure.	0.369	0
CDI (new QBR FY 2018)	National Healthcare Safety Network Facility- wide Inpatient Hospital-onset *Clostridium difficile* Infection Outcome Measure.	0.794	0.002
MRSA bacteremia (new QBR FY 2018)	National Healthcare Safety Network Facility- wide Inpatient Hospital-onset Methicillin-re- sistant *Staphylococcus aureus* Bacteremia Outcome Measure.	0.767	0
PSI–90 (VBP)	Patient safety for selected indicators (com- posite).	0.577321	0.397051
	American College of Surgeons—Centers for Disease Control and Prevention Har- monized Procedure Specific Surgical Site Infection Outcome Measure.		
PSI-90 (QBR)	All-Payer	TBD	TBD
Colon and Abdominal	• Colon	• 0.824	• 0.000
Hysterectomy SSI	• Abdominal Hysterectomy	• 0.710	• 0.000
PC–01	Elective Delivery before 39 weeks	0.020408	0
Clinical Care Measures			
MORT–30–AMI	Hospital 30-Day, All-Cause, Risk-Standard- ized Mortality Rate Following Acute Myo- cardial Infarction Hospitalization *.	0.851458	0.871669
MORT–30–HF	Hospital 30-Day, All-Cause, Risk-Standard- ized Mortality Rate Following Heart Fail- ure *.	0.881794	0.903985
MORT–30–PN	Hospital 30-Day, All-Cause, Risk-Standard- ized Mortality Rate Following Pneumonia Hospitalization *.	0.882986	0.908124
(VBP Only, condition specific measures not in QBR)			
Mortality	Inpatient All-Payer, All Cause	TBD	TBD
(MARYLAND)			
Efficiency and Cost Reduction Measure			
MSPB–1 (not included in QBR)	Payment-Standardized Medicare Spending per Beneficiary	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period.	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period.
Patient and Caregiver-Centered Experience of Care/Care Coordination	Floor (percent)	Achievement threshold (percent)	Benchmark (percent)
Communication with Nurses	55.27	78.52	86.68
Communication with Doctors	57.39	80.44	88.51
Responsiveness of Hospital Staff	38.4	65.08	80.35
Pain Management	52.19	70.2	78.46
Communication about Medicines	43.43	63.37	73.66
Hospital Cleanliness & Quietness	40.05	65.6	79
Discharge Information	62.25	86.6	91.63
3-Item Care Transition	25.21	51.45	62.44
Overall Rating of Hospital	37.67	70.23	84.58

APPENDIX IV. HOSPITAL SPECIFIC COUNTS OF SAFETY DOMAIN MEASURES MODELED USING FY 2016 PERFORMANCE DATA

Hosp ID	Hospital Name	CLABSI	CAUTI	SSI-Colon	SSI-Hysterectomy*	MRSA	C. diff	PC -01	PSI-90 (CY14)	Count of Measures
210001	MERITUS MEDICAL CENTER	0.586	1.057	0	0	0.939	1.196	Not Available	0.399	7
210002	UNIVERSITY OF MARYLAND MEDICAL CENTER	0.54	2.353	2.437	0	2.191	1.274	1	0.722	8
210003	PRINCE GEORGES HOSPITAL CENTER	0.236	0.06	1.599	<1 predicted	2.004	0.549	20	0.733	7
210004	HOLY CROSS HOSPITAL	0.888	1.407	0.112	1.787	0.604	1.127	1	0.779	8
210005	FREDERICK MEMORIAL HOSPITAL	1.037	0.854	1.914	0.988	3.174	0.724	4	0.920	8
210006	UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL	<1 predicted	1.696	<1 predicted	Not Applicable	<1 predicted	0.441	shorter/no cases met criteria	0.800	3
210008	MERCY MEDICAL CENTER INC	0.431	1.654	1.029	1.93	1.445	1.086	8	0.917	8
210009	JOHNS HOPKINS HOSPITAL, THE	0.628	1.179	1.642	2.944	1.598	1.06	0	0.819	8
210011	SAINT AGNES HOSPITAL	0.678	1.64	0	0	0.216	1.759	0	0.646	8
210012	SINAI HOSPITAL OF BALTIMORE	0.855	4.465	1.418	3.088	1.382	1.071	Not Available	0.660	7
210013	BON SECOURS HOSPITAL	0.455	2.508	<1 predicted	Not Applicable	0.896	0.943	Not Available	0.656	5
210015	MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	0.524	2.648	0.422	0.519	1.012	1.315	0	0.653	8
210016	ADVENTIST HEALTHCARE WASHINGTON ADVENTIST HOSPITAL	0.164	0.679	1.869	0.707	0.422	1.695	6	0.768	8
210017	GARRETT COUNTY MEMORIAL HOSPITAL	<1 predicted	<1 predicted	<1 predicted	<1 predicted	<1 predicted	0.788	4	1.059	3
210018	MEDSTAR MONTGOMERY MEDICAL CENTER	0	0.831	0.827	0	0.637	0.653	0	1.134	8
210019	PENINSULA REGIONAL MEDICAL CENTER	0.127	3.135	0.539	1.036	2.268	1.495	0	0.447	8
210022	SUBURBAN HOSPITAL	0.194	1.548	0	1.653	1.202	1.962	Not Available	0.770	7
210023	ANNE ARUNDEL MEDICAL CENTER	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	2	0.705	2
210024	MEDSTAR UNION MEMORIAL HOSPITAL	0.116	0.239	0.56	0	1.738	0.869	shorter/no cases met criteria	1.011	7
210027	WESTERN MARYLAND REGIONAL MEDICAL CENTER	0	2.102	1.928	<1 predicted	0.56	1.529	0	0.663	7
210028	MEDSTAR SAINT MARY'S HOSPITAL	0	1.543	0	<1 predicted	2.298	1.342	0	0.741	7
210029	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	0.383	1.818	<1 predicted	1.289	2.468	1.011	0	0.510	7
210030	UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	<1 predicted	<1 predicted	<1 predicted	<1 predicted	<1 predicted	0.946	shorter/no cases met criteria	excluded due	1
210032	UNION HOSPITAL OF CECIL COUNTY	<1 predicted	<1 predicted	1.852	<1 predicted	<1 predicted	1.425	10	0.742	4
210033	CARROLL HOSPITAL CENTER	0	1.142	0.221	0	0.805	1.103	0	0.546	8
210034	MEDSTAR HARBOR HOSPITAL	0.417	1.387	0	0.548	0.52	0.569	shorter/too few cases to report	0.703	7
210035	UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	0.455	0	0	<1 predicted	0	1.4	0	0.668	7
210037	UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	<1 predicted	0.831	1.818	<1 predicted	0	0.374	3	0.894	6
210038	UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	1.359	0.538	<1 predicted	<1 predicted	<1 predicted	0.867	shorter/no cases met criteria	1.092	4
210039	CALVERT MEMORIAL HOSPITAL	<1 predicted	<1 predicted	<1 predicted	<1 predicted	0	0.962	8	1.022	4
210040	NORTHWEST HOSPITAL CENTER	0.335	2.636	1.664	<1 predicted	1.025	0.887	shorter/no cases met criteria	0.630	6
210043	UNIVERITY OF MD BALTO WASHINGTON MEDICAL CENTER	0	2.051	1.798	0	<1 predicted	1.448	2	0.626	7
210044	GREATER BALTIMORE MEDICAL CENTER	0.792	0.278	1.582	1.001	0.842	0.992	1	0.720	8
210045	EDWARD MCCREADY MEMORIAL HOSPITAL	Measures does not apply for this reporting period	Measures does not apply for this reporting period	Results not available for this reporting period	Not Applicable	<1 predicted	<1 predicted	Not Available	excluded due	0
210048	HOWARD COUNTY GENERAL HOSPITAL	0.236	1.143	0	0.932	0.347	1.004	2	0.808	8
210049	UNIVERSITY OF M D UPPER CHESAPEAKE MEDICAL CENTER	0	3.052	1.145	<1 predicted	1.175	0.669	3	0.509	7
210051	DOCTORS' COMMUNITY HOSPITAL	0.207	0.214	<1 predicted	0	0	1.192	Not Available	1.027	6
210055	LAUREL REGIONAL MEDICAL CENTER	0.774	0	<1 predicted	<1 predicted	1.819	0.723	Not Available	0.658	5
210056	MEDSTAR GOOD SAMARITAN HOSPITAL	0.683	0.274	1.99	<1 predicted	0.389	1.727	shorter/no cases met criteria	0.694	6
210057	ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER	0.428	1.01	0.699	0	2.007	1.404	4	0.681	8
210060	FORT WASHINGTON HOSPITAL	<1 predicted	<1 predicted	<1 predicted	<1 predicted	<1 predicted	0	Not Available	0.831	2
210061	ATLANTIC GENERAL HOSPITAL	<1 predicted	<1 predicted	0.587	<1 predicted	<1 predicted	0.485	Not Available	1.125	3
210062	MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	0.297	0	0	0	2.234	1.508	4	0.774	8
210063	UNIVERSITY OF MARYLAND ST JOSEPH MEDICAL CENTER	Not Available	Not Available	Not Available	Not Applicable	Not Available	Not Available	3	0.469	2
	Statewide								Average	6.045454545
									Median	7
									Minimum	0
									Maximum	8

*SSI-hystertectomy values shaded in grey are from MHCC. These are hospitals that with 12 months of data are estimated to have >1 predicted but currently have < 1 predicted in the 9 months of data on CMS Hospital Compare

Maryland Health Services Cost Review Commission

Market Shift Adjustments Update
09/09/2015

Market Shift Adjustments

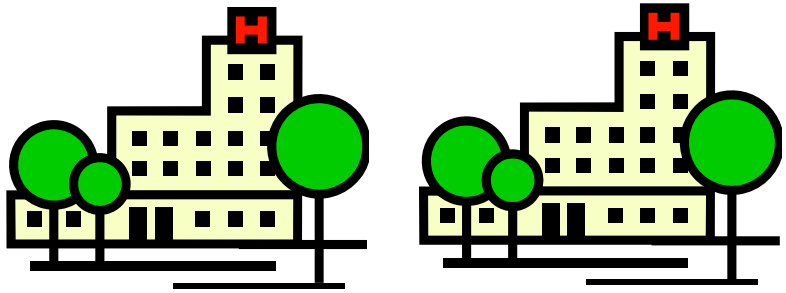
- Market shift adjustment should not undermine the incentives to reduce avoidable utilization

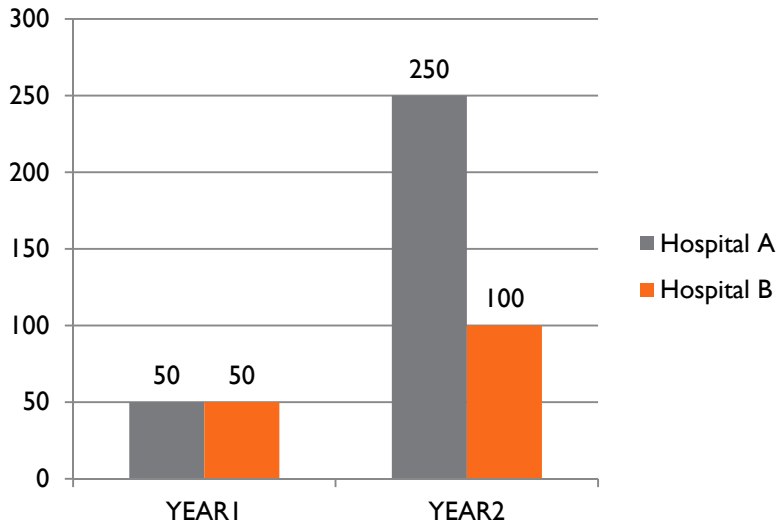
- Market shift adjustment should provide necessary resources for services shifted to another hospital

- Calculations are based on
  - 66 inpatient and outpatient service lines
  - Zip codes and county level
  - Excludes Potentially Avoidable Utilization (Readmissions and PQIs*)
  - Hospital service line average charge per ECMAD**
  - 50% variable cost factor applied

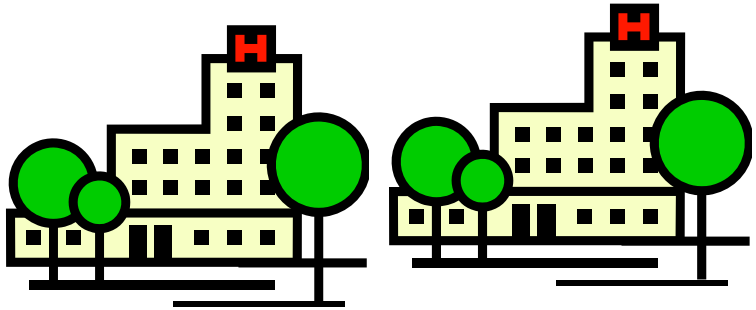
*AHRQ Prevention Quality Indicators
**Equivalent CaseMix Adjusted Discharges

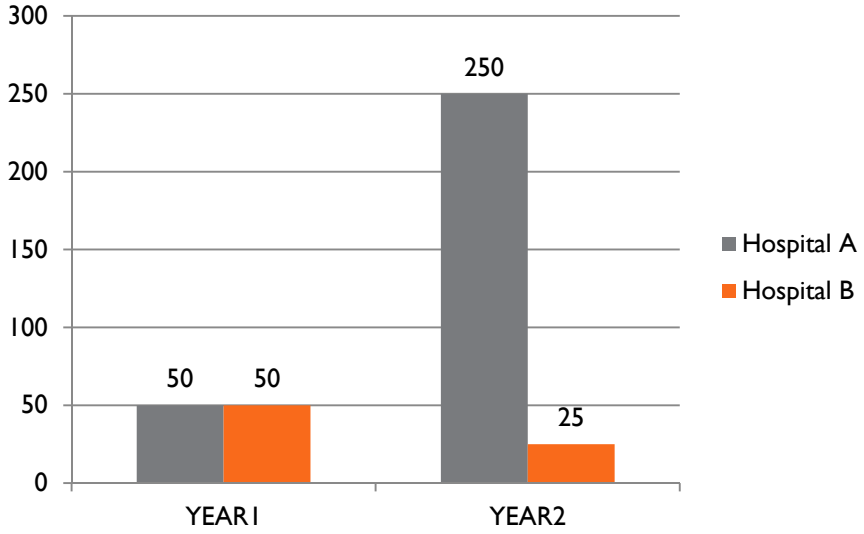
Market Share vs. Market Shift





Market Shift Adjustment=0





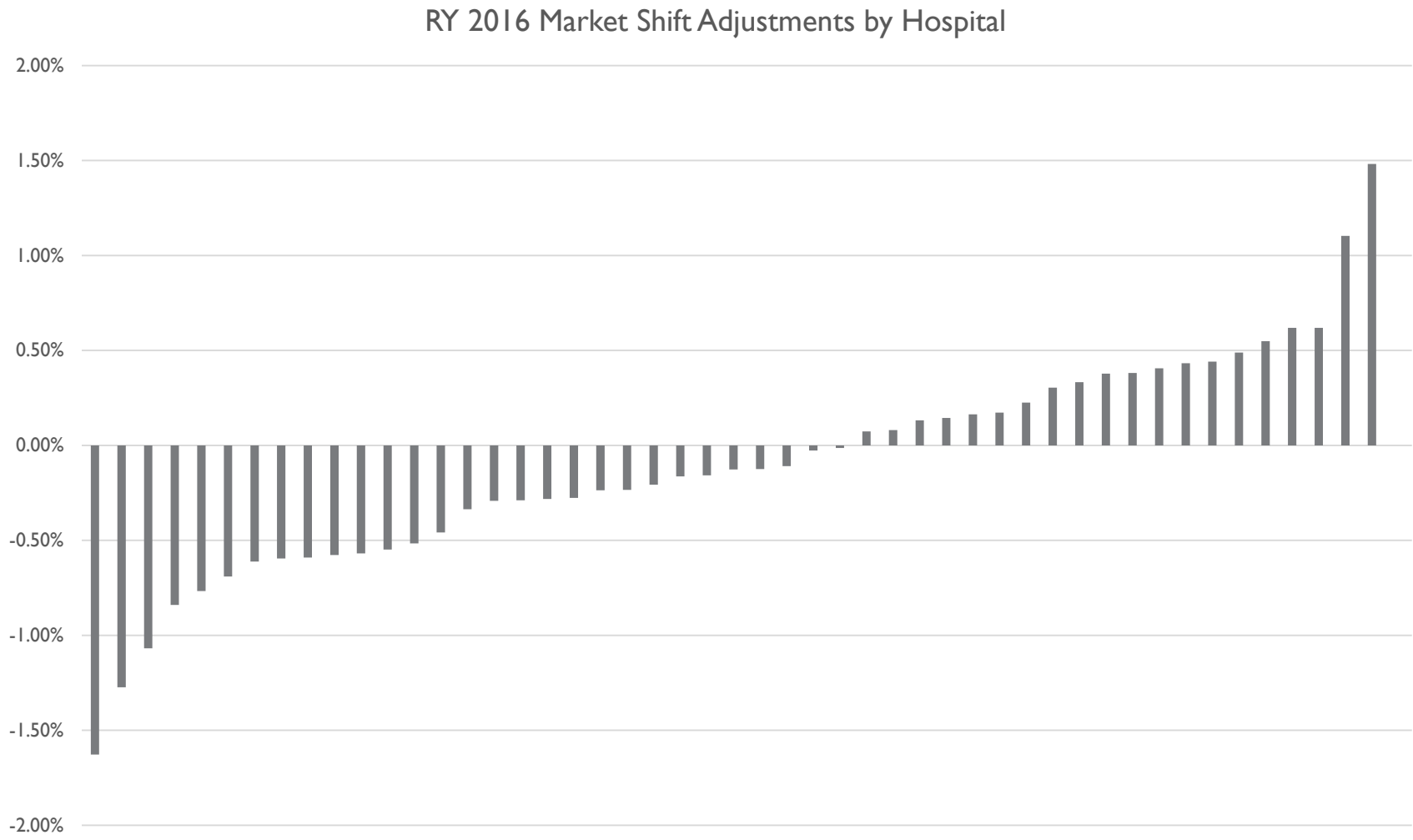
Market Shift Adjustment=25

RY 2016 Statewide Impact*

Statewide Impact	FY 16 Market Shift Adjustment Results
A	B
Grand Net Total	**$756,341**
Positive Adjustment Total	$27,741,411
Negative Adjustment Total	-$28,497,752
Absolute Adjustment Total	$56,239,163

*excludes oncology/radiation therapy/infusion service line and other manual adjustments

RY 2016 Hospital Level Impact as % of Revenue



Technical Report and Reference Materials

http://www.hscrc.state.md.us/gbr-adjustments.cfm

Infusion/Chemotherapy/Radiation Therapy

- Consolidated billing creates a challenge to measure unit of service
- HSCRC staff aggregated records for the same patients at a single hospital into a single measurement unit
- Assignment of highest EAPG* and weights are under review

*3M Enhanced Ambulatory Patient Grouping System

Health Jobs Opportunity Program

Health Services Cost Review Commission

September 9, 2015

Maryland Hospital Association

Health Jobs Opportunity Program

- What is being proposed?
- Why it is needed?
- How it is funded?

Health Jobs Opportunity Program

What is it?

- Up to 1,000 hospital based jobs
- Targeted at high unemployment and poverty zip codes in Baltimore City and throughout state
- Entry level positions with opportunity for advancement
- Includes support services and job readiness training

Health Jobs Opportunity Program

Why is it needed?

- Recent civil unrest in Baltimore City highlighted the sense of hopelessness in disadvantaged communities based on lack of employment opportunities
- Poverty contributes to poor health; improving the economic stability of certain communities will improve the health of the population hospitals serve

Health Jobs Opportunity Program

Role of the hospitals

- Hospitals are the largest private sector employers in the Baltimore City and in many counties throughout the state
- Hospitals are capable of large scale hiring, particularly for entry level positions; hope that other major employers will follow our lead
- Hospitals will serve as model for other industries

Health Jobs Opportunity Program

Targeted Hospital Workforce Development

- Community Health Workers
- Certified Application Counselors
- Peer Recovery Support Specialists

Health Jobs Opportunity Program

Applications must:

- Demonstrate that additional positions are needed and are incremental
- Detail a plan to recruit employees from designated high poverty and unemployment zip codes
- Include proposed competitive wages, benefits and education and enrichment opportunities
- Describe existing or planned programs for employees to improve work skills
- Describe the role new positions will play in meeting goals of the waiver
- Detail job readiness and skills training necessary to prepare individuals for successful employment
- Detail employee retention strategies
- Other requirements to be developed by HSCRC staff

Health Jobs Opportunity Program

Funding

- Capped at 0.25% of statewide revenue ($40m)
- HSCRC develops criteria for proposals
- Hospitals voluntarily submit application to HSCRC
- Our view: Awarded funds will be collected by hospital through permanent rate increases

Health Job Opportunity Program

September 9, 2015

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BACKGROUND

The model waiver brings unprecedented employment challenges to Maryland hospitals. Maryland hospitals have committed to improving the overall health of the patients they serve beyond the four walls of the hospital. A shift in focus from care delivered within the hospital setting to community based care requires a broader hospital employment base such as community health workers, health care enrollment specialists and peer support specialists. Currently this employment base needs to be fostered and expanded and there are few resources available to support the long-term development of this workforce.

Recent civil unrest and rioting in Baltimore City triggered by the death of Freddie Gray demonstrated the urgent need to address the issues of social inequality in Baltimore City. A contributing factor to social inequality in the city is the lack of stable, entry level employment with opportunities for career advancement. The April 2015 unemployment rate in Baltimore City was 7.4%, compared to the statewide rate of 4.9%, with some areas of city facing unemployment rates as high as 17%.[1] Since 1970, more than 60,000 manufacturing jobs in the Baltimore metropolitan area have been lost due to plant closures such as Bethlehem Steel, Western Electric, Proctor & Gamble, General Motors, and Solo Cup. The elimination of manufacturing jobs, along with the general recession, has caused a severe lack of opportunity for unskilled workers to obtain adequate employment.

In addition to high rates of unemployment, Baltimore City also faces extreme poverty levels. Most recent U.S Census Bureau data indicate that as of 2013, 23.8% of Baltimore City residents live at or below the poverty level, compared to 9.8% statewide.[2] In some areas of the city, the rate of those living below the poverty level is as high at 40.5%.[3] The median household income for Baltimore City is $41,385 compared to $73,538 statewide.[4] However, it is important to note that city's median household income is not indicative of the widespread poverty plaguing the city since this number is offset by very wealthy areas within the city such Guilford, Roland Park and Homeland. Some zip codes within Baltimore City have median household income as low as $25,500.[5] Nearly 40% of Baltimore City residents are Medicaid eligible and current Medicaid enrollment for the city tops 242,000, which exceeds any other jurisdiction in the state.[6] In

[1] Maryland Department of Labor Licensing and Regulation; "Local Area Unemployment Statistics", http://www.dllr.state.md.us/lmi/laus/ American Community Survey (2015).
[2] U.S. Census Bureau; "State and County Quick Facts – Poverty Level" http://quickfacts.census.gov/qfd/states/24/24510.html (2015).
[3] U.S. Census Bureau; "American Community Survey, Easy Stats" http://www.census.gov/acs/www/data/data-tables-and-tools/easy-stats/ (2015).
[4] U.S Census Bureau; "State and County Quick Facts – Median Household Income" http://www.census.gov/quickfacts/table/PST045214/24,00 (2015).
[5] Bureau of Labor Statistics U.S. Department of Labor "Baltimore Area Employment" http://www.bls.gov/regions/mid-atlantic/news-release/areaemployment_baltimore.htm (2015).
[6] Department of Health and Mental Hygiene; "Maryland Medicaid e-Health Statistics – County"; http://www.md-medicaid.org/eligibility/ (2015).

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Baltimore City public schools, 86% of students qualify for free and reduced school meals, compared to 45% statewide,[7] again a statistic that exceeds any other jurisdiction in the state.

These data illustrate the employment and income disparities in Baltimore City. The inability to obtain employment with opportunity for growth contributes to the cycle of poverty and inequality for many. As city manufacturing employment has nearly disappeared, employment in the health and education fields has grown. Manufacturing represents 5.1% of city employment; health and education represents 30.6%. As solutions to the social inequities facing Baltimore City are explored, there must be a recognition of the evolving employment landscape. Failure to create sustainable opportunities that are consistent with industry change will result in continued social and economic instability for Baltimore City. There is significant opportunity for hospitals to bring more stability to the environment in Baltimore City but funds will be needed. The financial burden of increased hospital rates will be appropriately shared with other businesses and major employers as well as public payers who will directly benefit from a stable civil and business environment in Baltimore City. Hospitals are interested in retaining good employees and in improving the job skills of these employees.

POOR HEALTH AND POVERTY

The correlation between poverty and poor health is widely recognized. A Health Affairs policy brief noted that people who have limited education or income or who live in poor neighborhoods have worse health and health care compared to those who are better educated or financially better off. Adults living at or below the federal poverty level are more than five times as likely to say they are in poor or fair health compared to those whose incomes are four times the federal poverty level.[8] The health disparities associated with poverty contribute significant costs to the health care system. Recent analysis estimates that 30% of direct medical costs for minorities are excess costs due to health inequities and that the economy loses an estimated $309 billion per year due to the direct and indirect costs of health disparities.[9]

Despite being recognized as one of the wealthiest states in the nation, Maryland residents also experience health disparities associated with low income. According to a number of measures, Maryland is one of the highest performing states in the nation with the 3rd highest median household income, two of the nation's top medical schools, and 10th lowest rate of smoking. Despite these successes, Maryland continues to lag behind other states on a number of key health indicators. The state ranks 43rd in infant mortality, 35th in infectious diseases, 33rd in

[7] Annie E. Casey Foundation Kids Count; "Students Receiving Free and Reduced School Meals" http://datacenter.kidscount.org/ (2015).
[8] Health Affairs; "Achieving Equity in Health" http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=53 (October 6, 2011).
[9] Kaiser Family Foundation; "Disparities in Health and Health Care: Five Key Questions and Answers"http://kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and- answers/ (November 30, 2012).

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health outcomes, and 33rd regarding geographic health disparities.[10] The statistics for Baltimore City are even more discouraging. Baltimore City experiences higher mortality rates and burden of disease than both the rest of Maryland, and the overall US population.[11] A commonly quoted statistic notes that residents in Guilford have a life expectancy of nearly 20 years longer than residents of Greenmount East.[12] Income plays a significant role in the health outcomes of Baltimore City residents, with the level of income directly affecting overall health and mortality. According the most recent Baltimore City Health Disparities Report Card, if all Baltimore residents had equal opportunity to good health by using income as a sole determinant of mortality 50.1% of deaths city wide could potentially be averted.[13] The distribution of disparities based on race, gender, education and income highlights opportunities for more targeted efforts that can assist in achieving better health outcomes for all Baltimore residents.[14] A hospital employment program targeted at the most economically disadvantaged areas of Baltimore City presents an opportunity to improve health and mortality rates through increased education and income levels. This targeted approach is also consistent with the population health goals of the waiver; because of the deep connection between health and income, improving the economic status of the population will improve the overall health of the population hospitals serve.

ROLE OF HOSPITALS

Hospitals are the largest employers in many jurisdictions through the state, including Baltimore City. In fact, over half of Baltimore City's largest employers are hospitals.[15] Hospitals offer a variety of entry level positions with no to minimal education requirements that range from food service to community health. Hospital based jobs offer competitive salaries with robust benefits. Some hospitals such as Johns Hopkins and University of Maryland Medical System offer tuition assistance for both employees and their dependents.

The Hospitals and the HSCRC collaborated with the Centers for Medicare and Medicaid Services to modernize the Maryland Medicare all-payer waiver. This collaborative agreement

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[10] DHMH; "Health Disparities Workgroup Final Report" http://www.dhmh.maryland.gov/mhqcc/Documents/Health-Disparities-Workgroup-Report-1-12-2012.pdf (January 2012).

[11] Baltimore City Health Department; "Baltimore City Health Disparities Report Card 2013", page 3 http://health.baltimorecity.gov/sites/default/files/Health%20Disparities%20Report%20Card%20FINAL%2024-Apr-14.pdf (2013).

[12] Baltimore City Health Department; "Life Expectancy at Birth" http://health.baltimorecity.gov/sites/default/files/Life-expectancy-2013.pdf (2013).

[13] Baltimore City Health Department; "Baltimore City Health Disparities Report Card 2013", page 17 http://health.baltimorecity.gov/sites/default/files/Health%20Disparities%20Report%20Card%20FINAL%2024-Apr-14.pdf (2013).

[14] Baltimore City Health Department; "Life Expectancy at Birth", page 20. http://health.baltimorecity.gov/sites/default/files/Life-expectancy-2013.pdf (2013).

[15] Department of Labor, Licensing and Regulation; "Baltimore City - Major Employer Lists - March 2013" https://mwejobs.maryland.gov/admin/gsipub/htmlarea/uploads/Major%20Employer_Baltimore%20City%202013.htm (2015).

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transformed the way Maryland hospitals deliver care as of January 1, 2014. Under the modernized waiver hospitals are restructuring how they provide care by developing strategies that help individuals stay healthy, reduce readmissions, prevent avoidable adverse incomes and lower costs. As hospitals strive to meet the goals of the modernized waiver, the focus of care shifts from the hospital to the community. Community based care is often perceived as investments in "strategies" to address chronic conditions, care coordination, and integrated systems of care. Unarguably, these investments are essential to improving the health of the local population; however these investments alone cannot achieve the broader goal of improved population health if the underlying issues of chronic unemployment and devastating poverty are not also addressed.

As hospitals assume a greater role in the health of the community, with appropriate resources, hospitals are prepared to create additional entry level employment opportunities for local residents and to increase investments in community health workers (CHWs). Under the new CMS Waiver agreement hospitals are no longer paid for volume growth in hospital based patient services. Use of highly specialized and costly inpatient services is strictly monitored and funding is limited. Consequently, hospitals are implementing strategies to appropriately provide patient services in lower cost settings, such as outpatient hospital services or in non-hospital community health centers. Also, strategies are being developed to provide care coordination services and wellness programs in the community and in patient homes to prevent illness progression and the need for expensive emergency care. There is no direct payment mechanism for community based services which are essential to effectively implement population health management plans. The HSCRC has provided funds to support this function but more resources are needed to address the severe situations in high poverty neighborhoods in Baltimore City. These recent changes in HSCRC payment methodology and the strategies needed to accomplish the financial goals of population health management have caused hospitals to restructure their workforce to be more in touch with the patient and the broader community before acute illnesses occur. While hospitals have gradually emerged as the city's largest employers, under the modernized waiver, hospitals are faced with unprecedented challenges. Under the new CMS Waiver agreement hospital revenue is controlled by the HSCRC under a hospital specific Global Budgeted Revenue (GBR) agreement. Under this new rate methodology hospitals need to operate annually within a fixed revenue budget. Without special funding by the HSCRC there is very little opportunity to improve hospital services such as housekeeping, security, food service, etc. where many low skilled employees are engaged.

Hospitals and Workforce Development

Community Health Workers: Community Health Workers (CHWs), also referred to as community health advocates, lay health educators, community health representatives, peer health promoters, and community health outreach workers, are increasingly being seen as an important resource for combating health disparities by promoting and supporting healthy

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behaviors in underserved communities.[16] Hospitals have already begun to help foster this new workforce that serves as a connector between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate health care. The utilization of CHWs to assist with care management and prevention activities will assist hospitals in meeting the financial and quality targets under the new model waiver. In response to House Bill 856/Senate Bill 592, Chapter 259 of the Acts of 2014, the Maryland Department of Health and Mental Hygiene (DHMH) and the Maryland Insurance Administration (MIA) established the Workgroup on Workforce Development for Community Health Workers (CHWs) to study and make recommendations regarding workforce development for CHWs in Maryland. While the draft report of this workgroup made substantial recommendations regarding the training and certification of CHWs, the workgroup made no recommendation about reimbursement of CHWs. Instead the workgroup stated that multiple payment sources should be explored, including promoting direct hiring of and/or contractual payment to CHWs by providers operating in risk-based payment structures, such as hospitals under the All Payer Model.[17] While hospitals are already serving a key role in the development of Maryland's community health workforce, without a reimbursement structure for CHWs, additional resources are needed to hire, recruit, train and retain this workforce that has been identified as essential to meeting the goals of both the Affordable Care Act (ACA) and the modernized waiver. Innovative employment models are needed because "The use of CHWs in Maryland is likely to increase in the coming years as the state's health system continues to transform."[18] CHWs have the potential to assist the transformation of our fragmented health care system towards a more holistic type of care, centered on the total needs of the individual patient and embedded in the community and culture in which the patient lives. CHWs can support individual and population health because, as culturally competent mediators between health providers and the members of diverse communities, they are uniquely well placed for promoting the use of primary and follow-up care for preventing and managing disease.[19]

Certified Application Counselors: The ACA created opportunities for hospitals to serve a greater role in assisting patients with obtaining health care coverage either through Medicaid or an Exchange based Qualified Health Plan through the Certified Application Counselor (CAC) program. Currently, few Maryland hospitals are Application Counselor Sponsoring Entities employing certified application counselors. CACs educate patients about insurance options and facilitate enrollment. Hospitals are responsible for the cost of training, educating and employing CACs. Some hospitals have begun to deploy CACs out in the community to assist patients in health care enrollment. The costs associated with employing CACs has deterred many hospitals from developing robust CAC programs. As the Maryland Health Benefit

[16] Institute of Medicine, 2002, and Patient Protection and Affordable Care Act, 42 U.S.C. §§ 5313, 10501(c) (2010).
[17] Draft Workgroup on Workforce Development for Community Health Workers Final Report to the Maryland General Assembly by the Maryland Department of Health and Mental Hygiene and Maryland Insurance Administration (2015).
[18] *Id.*
[19] *Id.*

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Exchange reduces call center hours, and the scope and funding for Connector and Navigator program are reduced, there will be an increased need for hospital based CACs to assist individuals with Medicaid eligibility and Qualified Health Plan enrollment. Community based CACs would allow for hospitals to assist individuals in health plan enrollment before the individual's health rises to a crisis in need of emergent or inpatient care. Community based CACs would assist hospitals in meeting the population health targets of the waiver by facilitating health care insurance coverage before someone enters the doors of the hospital. With appropriate health care coverage, individuals are able to seek health care in the most appropriate setting, ultimately reducing hospital bad debt, uncompensated care and inappropriate emergency department utilization.

Peer Recovery Support Specialists: Individuals with behavioral health issues often suffer from many other chronic conditions and have significantly increased health care costs. Treatment costs for patients with chronic medical and comorbid behavioral health conditions can be 2-3 times higher than those without the comorbid behavioral health condition. Nationally these costs are estimated to be $293 billion in 2012.[20] Individuals with serious mental illness die, on average, 25 years earlier than the general population. Patients with mental illness discharged from acute hospitals have higher rates of readmissions and patients with substance use disorder are among the highest-risk populations for medical and psychiatric readmissions. Behavioral health patients suffering from multiple health conditions, may lack a strong support system or may not adhere to treatment regimens; factors that impede recovery and increase the likelihood that they will return to the hospital.[21] In Baltimore City, there are an estimated 18,916 heroin users.[22] In Maryland, the number of overdose deaths associated with heroin increased by 21% between 2013 and 2014.[23] Baltimore City experienced a 28% increase over the same time period.[24] These numbers represent one of the most devastating outcomes of addiction and highlight the importance of this issue right now.[25] These statistics represent both the need and the opportunity to improve care and lower costs for those suffering from behavioral health disorders. Disease management programs promise cost containment while significantly improving the quality of care for enrollees with behavioral health disorders. One of the primary means by which this is achieved is through peer support.[26]

Peer recovery support services are delivered by people who have not only experienced mental health issues or substance use disorder but who have also experienced recovery. Peer recovery

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[20] Milliman American Psychiatric Report, Economic Impact of Integrated Medical-Behavioral Healthcare, page 4.
[21] Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, page 3 (January 2012).
[22] Baltimore Mayor's Heroin Treatment & Prevention Task Force Report, page 17. http://health.baltimorecity.gov/sites/default/files/Task%20force%20report_071015_Full.pdf (July 2015).
[23] *Id.*
[24] *Id.*
[25] *Id.*, page 19.
[26] Center for Health Care Strategies, Disease Management for Chronic Behavioral Health and Substance Use Disorders, Suzanne Gelber, PhD; Richard H. Dougherty, PhD, page29. (2006).

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support services help people become and stay engaged in the recovery process and reduce the likelihood of a relapse. Because these recovery services are delivered by peers who have been successful in the recovery process, these services represent a message of hope as well as wealth of experiential knowledge. Peer recovery services can effectively extend the reach of treatment beyond the clinical setting into the community of those seeking to achieve or sustain recovery.[27] Peer support is widely recognized in the medical field as a valuable compliment to professional medical and social interventions. Improved outcomes are particularly notable when peer support services are provided to people with chronic conditions. Peer recovery support services can fill a need often noted by treatment providers for services to support recovery after an individual leaves a treatment program. Peer recovery support services can serve as a vital link between systems that treat behavioral health disorders in a clinical setting and the larger communities in which people seeking to achieve and sustain recovery live.[28] Peer-delivered services have been proven to generate superior outcomes in terms of engagement of "difficult-to-reach" clients, reduced rates of hospitalization and days spent as inpatient, and decreased substance use among persons with co-occurring substance use disorders.[29] Currently in Maryland, peer support specialists are either grant funded or volunteer based, making this highly valued workforce underutilized. The Maryland Addictions and Behavioral-health Professional Certification Board has established certification and education standards so that peers in both mental health and substance use disorder can become Certified Peer Recovery Specialists. This certification process creates the ideal platform for hospitals to expand the peer support workforce to help address the goals of the waiver through reduced costs and readmission rates while improving quality of treatment for those suffering from behavioral health disorders.

HEALTH CARE WORKFORCE DEMANDS AND CHALLENGES

According to the Baltimore Regional Talent Development Pipeline Study, healthcare has been the strongest growth industry over the past decade and is expected to add the most new jobs.[30] Projections of the healthcare job creation in Maryland expect the health care sector to add around 75,000 jobs by 2020.[31] Within this industry growth, there is an expected demand for over 20,000 new job openings for workers with an education level at or below a high school diploma or equivalent. [32] *Career Pathways* is a workforce development approach that uses sector based strategies that provide low skilled adults with a clear sequence of education and training courses, combined with comprehensive wrap-around support services that lead to

[27] U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Abuse Treatment; "What Are Peer Recovery Support Services?", page 1 (2009).
[28] *Id*., page 10.
[29] Davidson L., Bellamy C., Guy, K., & Miller R.; "Peer support among persons with severe mental illnesses: A review of evidence and experience." World Psychiatry, 11(2): http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363389/ (2012).
[30] Baltimore Regional Talent Development Pipeline Study 2013, page 47 (2013).
[31] *Id.*, page 48.
[32] *Id.*, page 109.

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careers in a particular industry sector.[33] Certain health care occupations, such as medical assistants and technicians have been identified by *Career Pathways* as good targets for opportunity because hiring demand will exceed the number of new qualified workers entering the labor market in these occupations. Without a more robust training system for these occupations, Baltimore's healthcare employers will likely be forced to look outside the region to find qualified workers.[34]

The Maryland Health Care Reform Coordinating Council, Health Care Workforce Workgroup also identified opportunities for establishing a lay network of health workers. The Workgroup noted that a network of lay health workers recruited from within the respective communities being served would help to increase the likelihood that medically underserved residents gain access to appropriate and timely health information and primary care services. The workgroup also noted that lay health workers also represent a potential pool of future clinical and allied health providers.[35]

One of the recommendations to meet the health care workforce challenges of Baltimore City is the creation of partnerships between education and the public and private sectors.[36] A partnership between the state, Maryland hospitals, and existing educational providers creates an opportunity to develop a unique and targeted approach for recruitment, training, hiring, retention and advancement of individuals from disadvantaged communities for a career in health care.

HSCRC HISTORY IN ADDRESSING WORKFORCE ISSUES

The Nurse Support I Program and the Nurse Support II Program (NSP Programs) represent the success of the hospitals, payers and state collaborating to respond to a workforce crisis in the state. The NSP Programs were created to address a growing nursing shortage in Maryland. The NSP Programs are funded annually through a modest increase in regulated hospital rates. Hospitals submit proposals to the HSCRC for approval of funding. NSP proposals are aimed to improve education attainment, retention and recruitment, improved practice environment, and increased workforce within the nursing profession. Funding for proposals to achieve the goals of the NSP Programs include: mentoring, extern and intern opportunities, educational opportunities and scholarships, leadership development, career advancement, new technology, and minority recruitment and retention.

While the goal of the NSP Programs was to increase the number of nurses in Maryland, the Programs' success has exceeded expectations and received widespread recognition. Maryland

[33] *Id.*, page 5.
[34] *Id.*, pages 16-17.
[35] Maryland Health Care Reform Coordinating Council, "Health Care Workforce Workgroup, White Paper", page 16 (October 31, 2010).
[36] The Talent Development Pipeline Study, Prepared by the Baltimore Workforce Investment Board's Committee on Training and Post-Secondary Education, page 50 (2010).

DRAFT

nurse workforce increased 38% between 2008-2012 while nationally, the nursing workforce increase was only 28%.[37] Between 2008-2013, Maryland nursing graduates increased by 43%, compared to 20% nationally.[38] The NSP Programs have also been credited with improved patient care, safety and satisfaction.[39] The NSP Programs have also been linked to significant cost savings. According to the HSCRC Wage and Salary Survey, Maryland hospitals decreased their dependence on agency nurses by 68%, saving close to $106 million between FY 2007 and FY 2011.[40]

NSP Programs have received international recognition for excellence in workforce development. The NSP II Program has been referenced and highlighted in nursing and health care journals in multiple publications at the national level.[41] Additionally, approval of the NSP Programs have consistently received unanimous support from HSCRC commissioners. The support and acclaim of the NSP Programs is not surprising considering the success of the NSP Programs in addressing a workforce crisis as well improving patient care and reducing costs. The NSP Programs serve as a model for the development of a health care employment program targeted at economically disadvantaged communities.

PROGRAM REQUEST

Hospitals request that the HSCRC establish a Program effective January 1, 2016 to provide up to $40 million per year for the purpose of funding a program that will allow for the expansion of up to 1,000 hospital employed positions to be hired from low income, high unemployment areas for the purpose of:

(1) Improving the overall socioeconomic determinants of health community by providing entry level stable employment with advancement opportunities; and
(2) Expanding the community health workforce to assist hospitals in improving population health.

PROPOSED HSCRC FUNDING METHODOLOGY

All hospitals will be eligible to submit proposals for funding of new positions created to hire residents from designated areas. Hospital specific applications must:

(1) Demonstrate that additional positions are needed and that the new positions are incremental, rather than replacing existing positions.
    - Potential job categories include:
        - Community health workers
        - Medicaid and Maryland Health Benefit Exchange enrollment assisters

[37] *Id.*
[38] HSCRC Final Recommendation on the NSPII Program, January 14, 2015.
[39] HSCRC Draft Report on Nurse Support I Activities for FY 2007-FY 2013.
[40] *Id.*
[41] HSCRC Draft Recommendation: Nurse Support II Program, May 2013.

DRAFT

    - Peer support specialists
    - Environmental services
    - Dietary functions
    - Nurse Assistants
    - Escort/Messenger functions
    - Security
    - Transportation
- Similar to the NSP Programs Funding can be used for:
    - Mentoring and internship
    - Education
    - Skills enhancement
    - Outreach
    - Other approved innovative proposals that meet the goals of the program

(2) Detail a plan to recruit employees from designated zip codes throughout the state that have either unemployment rates that are 10% or greater, or have 20% or more residents below the poverty level.
(3) Include proposed competitive wages, benefits and educational and enrichment opportunities.
(4) Describe the various hospital programs in place or planned to be available for employees to improve work skills, including education programs, tuition assistance, and any additional resources provided to employees to assist with career advancement.
(5) Describe the role the new positions will play in assisting hospitals in meeting the targets of the model waiver.
(6) Indicate expected program implementation timing.
(7) Detail any job readiness and job skills training necessary to prepare individuals for successful employment.
(8) Detail any incumbent worker training necessary to advance individuals currently in entry level jobs to new positions, so long as new positions are created.
(9) Detail employee retention strategies.

- HSCRC would establish a program review panel (similar to the Nurse Education Support Program) to determine which hospital applications should be funded.
- HSCRC staff will determine the amount to be funded for each hospital under the Program.
- The HSCRC staff and hospitals shall collaborate to identify and calculate savings under the Program.
- HSCRC staff will keep track of amounts funded to assure that no more than $40 million is included annually in hospital rates.

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- HSCRC staff will adjust annual audit procedures to assure each hospital accurately accounts for program costs.
- HSCRC approved rate increases granted under the Program will permanently adjust the hospital's Global Budgeted Revenue base. Revenue provided to a hospital from the Program will not be counted against the hospital's cost structure for hospital productivity comparison purposes, such as the former ROC methodology.

In approving proposal HSCRC staff and Commissioners shall take into account proposal that:

- Partner with or enhance existing workforce development programs and organizations or leverage existing workforce grant and funding opportunities.
- Align with existing health care innovations already underway in Maryland such as Regional Partnerships for Health System Transformation Grants, Health Enterprise Zones, and the State Innovation Model.

Hospitals receiving any grants from the program will be required to submit biannual reports to the HSCRC detailing the number of incremental employees hired, program actual costs compared to the HSCRC rate increase granted to fund the program. On an annual basis a reconciliation will be made between the amount granted in rates and the actual program costs, and an adjustment will be made to the GBR in the next rate year. Like the NSP Programs, this Program should be regularly adjusted and updated to meet the goals of the Program.

SUMMARY

Under the modernized waiver, hospitals have assumed a greater role in improving the health of the communities they serve, however, traditional health care alone is not sufficient to address the chronic poor health facing many communities. A number of studies have linked poverty to higher levels of cancer, infant mortality, cardiovascular disease, diabetes, and other diseases and conditions. As hospitals develop strategies to address population health, they must look at strategies to address the root causes of poor health, including poverty. According to the World Bank, "the most important contributor to changes in moderate poverty has been the growth in labor income."[42]

An employment program can serve as a model that both addresses the underlying condition of poverty contributing to poor health in many communities, as well as provide resources to expand the community health workforce. Hospitals in Maryland are uniquely positioned to help in this process.

Any additional costs to the state through increased rates will largely be offset by reductions in residents utilizing public programs such as Medicaid and additional tax revenue from the new jobs. Additionally, the benefit to the employment base in the City of having increased

[42] The World Bank; "World Bank Policy Research Working Paper 6414, Is Labor Income Responsible for Poverty Reduction?" http://econ.worldbank.org (2013).

DRAFT

community stability is both a short and long-term net positive. While there is tremendous appreciation of the need to constrain health care costs, success of the model waiver is already being touted. Within the first year of operating under the remodeled waiver, Maryland hospitals have exceeded the financial targets. Per capita hospital spending was about 1.47% for calendar year 2014, well below the 3.58% annual CMS limit. Additionally, while the target for the first year of the waiver was zero, Medicare savings of approximately $90 million were realized. The actions of the HSCRC and Maryland hospitals have created savings that allow for flexibility to increase hospital spending without jeopardizing the waiver in any way. Investments in hospitals based jobs for Baltimore City residents would not in any way threaten the ability of the Maryland hospital system to meet the targets of the remodeled waiver. Investing in hospital based Baltimore City jobs is both fiscally prudent and socially responsible. While the Program is intended to address the immediate crisis facing Baltimore City, pockets of poverty exist throughout Maryland. The Program should be developed to make funding available for any hospital seeking to hire employees from any zip code that is plagued with high rates of unemployment and poverty.

APPENDICES

A. Letters of Support:
    a. The Honorable Senator Barbara Mikulski
    b. The Honorable Congressman Elijah Cummings
    c. The Honorable Congresswoman Donna Edwards
    d. The Honorable Congressman Dutch Ruppersberger
    e. The Honorable Congressman John Sarbanes
    f. The Honorable Congressman Chris Van Hollen
    g. The Honorable Senate President Thomas V. Mike Miller, Jr. & The Honorable Speaker of the House Michael E. Busch
    h. The Honorable Delegate Peter Hammen, Chair Health and Government Operations Committee
    i. The Honorable Delegate Maggie McIntosh, Chair Appropriations Committee
    j. The Honorable Mayor Stephanie Rawlings-Blake
B. Map: Baltimore City, Percent of Population Unemployed and Looking for Work
C. Map: Median Income in Baltimore City
D. Map: Percent of Households Living Below the Poverty Line
E. Map: Percent of Households Earning Less than $25,000
F. Johns Hopkins Training Programs for Lower Income Employees
G. University of Maryland Medical System Training Programs for Lower Income Employees
H. LifeBridge Training Programs for Lower Income Employees
I. Mercy Medical Center Workforce Development
J. Johns Hopkins Policy for Community Based Certified Application Counselors

DRAFT

BARBARA A. MIKULSKI
MARYLAND

COMMITTEES:

APPROPRIATIONS

HEALTH, EDUCATION, LABOR, AND PENSIONS

United States Senate

WASHINGTON, DC 20510–2003

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September 1, 2015

Mr. John M. Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2254

Dear Mr. Colmers:

Your office will soon be receiving a proposal from Maryland's hospitals to create a hospital-led employment program that hires from communities with high rates of poverty and unemployment. I am writing to express my strong support for the proposal and to urge you to give it every favorable consideration.

As outlined in the proposal, poverty is a contributing factor to poor health. A hospital employment program that targets impoverished communities not only improves the economic stability of the communities, this effort will also have a positive impact on the overall health of these communities. Because Maryland's All-Payer Model Agreement shifts hospital care towards a population health approach we believe this program is consistent with the Model Agreement.

I strongly support this collaborative and innovative approach toward population based health. Thank you for your consideration.

Sincerely,

Barbara A. Mikulski

Barbara A. Mikulski
United States Senator

BAM:wbk

ELIJAH E. CUMMINGS
7TH DISTRICT, MARYLAND

RANKING MEMBER, COMMITTEE ON
OVERSIGHT AND GOVERNMENT REFORM

RANKING MEMBER,
SELECT COMMITTEE ON BENGHAZI

COMMITTEE ON
TRANSPORTATION AND INFRASTRUCTURE
SUBCOMMITTEE ON COAST
GUARD AND MARITIME TRANSPORTATION
SUBCOMMITTEE ON
RAILROADS, PIPELINES, AND HAZARDOUS
MATERIALS

JOINT ECONOMIC COMMITTEE

Congress of the United States
House of Representatives
Washington, DC 20515

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www.house.gov/cummings

August 27, 2015

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

Dear Chairman Colmers:

I am writing to express support for the proposal from Maryland's hospitals to create a hospital-led employment program that hires from communities with high rates of poverty and unemployment.

As outlined in the proposal, poverty is a contributing factor to poor health. A hospital employment program that targets impoverished communities would not only improve economic stability, it would also have a positive impact on community health. Because Maryland's All-Payer Model Agreement shifts hospital care toward a population health approach, I believe this program is consistent with the Model Agreement.

I hope that you will give this proposal every reasonable consideration.

Sincerely,

Elijah E. Cummings
Member of Congress

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DONNA F. EDWARDS
4TH DISTRICT, MARYLAND

HOUSE COMMITTEE ON
SCIENCE, SPACE, AND TECHNOLOGY
SUBCOMMITTEE ON THE ENVIRONMENT
SUBCOMMITTEE ON SPACE, RANKING MEMBER

HOUSE COMMITTEE ON
TRANSPORTATION AND INFRASTRUCTURE
SUBCOMMITTEE ON ECONOMIC DEVELOPMENT,
PUBLIC BUILDINGS, AND EMERGENCY MANAGEMENT
SUBCOMMITTEE ON HIGHWAYS AND TRANSIT
SUBCOMMITTEE ON WATER RESOURCES
AND ENVIRONMENT

Congress of the United States
House of Representatives
Washington, DC 20515–2004

September 2, 2015

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

Dear Chairman Colmers:

I am writing to express support for the proposal from Maryland's hospitals to create a hospital-led employment program that hires from communities with high rates of poverty and unemployment. Maryland may be one of the wealthiest states in the nation, but we continue to experience health disparities associated with low income. Further, empirical evidence has shown that the inability to obtain employment with growth opportunities consistently contributes to the cycle of poverty.

A hospital employment program that targets impoverished communities not only improves the economic stability of those communities, but also will have a positive impact on the overall physical health of these communities.

As you know, hospitals are some of the largest employers in many of Maryland's diverse communities, and I support a program that will hire thousands of Marylanders from low-income, high-unemployment zip codes. Because Maryland's All-Payer Model Agreement shifts hospital care towards a population health approach, I believe this program is consistent with the Model Agreement.

I strongly support this collaborative and innovative approach toward population based health care.

Sincerely,

Donna F. Edwards
Member of Congress

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DONNA F. EDWARDS
4TH DISTRICT, MARYLAND

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SUBCOMMITTEE ON THE ENVIRONMENT
SUBCOMMITTEE ON SPACE, RANKING MEMBER

HOUSE COMMITTEE ON
TRANSPORTATION AND INFRASTRUCTURE
SUBCOMMITTEE ON ECONOMIC DEVELOPMENT,
PUBLIC BUILDINGS, AND EMERGENCY MANAGEMENT
SUBCOMMITTEE ON HIGHWAYS AND TRANSIT
SUBCOMMITTEE ON WATER RESOURCES
AND ENVIRONMENT

Congress of the United States
House of Representatives
Washington, DC 20515–2004

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

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C.A. DUTCH RUPPERSBERGER
2ND DISTRICT, MARYLAND

REPLY TO:

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PERMANENT SELECT COMMITTEE
ON INTELLIGENCE
RANKING MEMBER

Congress of the United States
House of Representatives
Washington, DC 20515–2002

August 31, 2015

Mr. John Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Colmers:

I am writing to express my support for Johns Hopkins' proposal to create a hospital-led employment program that hires from communities with high rates of poverty and unemployment. This program was modeled on Maryland's Nursing Support Program, which alleviated a severe nursing shortage and saved the state over $100 million by reducing hospitals' dependence on contract nurses. Johns Hopkins' current proposal aims to create 1,000 jobs with a budget of less than $40 million per year using a portion of the "cushion" from Maryland's All-Payer Model Agreement.

The correlation between poverty and poor health is widely recognized. As some of the state's largest employers and community anchors, hospitals are uniquely positioned to address both of these issues. A hospital employment program that targets impoverished communities will improve not only the economic stability but also the overall health of these communities. As hospitals shift their focus to providing holistic, community-based care, this employment program will address the underlying causes of poverty and provide resources to expand the community health workforce.

I strongly support this collaborative and innovative approach toward population-based health care and I hope you will give this proposal serious consideration. Thank you very much for your attention to this matter.

Sincerely,

C.A. Dutch Ruppersberger

C.A. Dutch Ruppersberger
Member of Congress

CADR:ng

JOHN P. SARBANES
3RD DISTRICT, MARYLAND

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House of Representatives
Washington, DC 20515–2003

www.sarbanes.house.gov

September 1, 2015

Mr. John Colmers
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215-2254

Dear Mr. Colmers:

I am writing to express my strong support for the proposal submitted to the Health Services Cost Review Commission (HSCRC) by Maryland's hospitals. The proposal will create a health employment program which will utilize funds to hire healthcare professionals from communities with high rates of poverty and unemployment within Baltimore City.

Tens of thousands of manufacturing jobs in the Baltimore metropolitan area have been lost over the last 40 years. This loss has resulted in a critical need of new entry level employment with opportunities for career advancement. This employment program will allow for the expansion of up to 1,000 hospital employed positions to be hired from low income, high unemployment areas. A hospital employment program that targets impoverished communities will improve the economic stability of the entire city.

The proposed employment program is consistent with the Maryland All-Payer Model Agreement that shifts hospital care towards a population health approach. Hospitals in Maryland are uniquely positioned to help in this process. While the program is intended to address the immediate issues facing Baltimore City, this endeavor will create a model that can be applied to any community in need of employment opportunities.

I ask that you give all appropriate consideration to the health employment program proposal to HSCRC.

Sincerely,

John P. Sarbanes
Member of Congress

JPS/jl

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CHRIS VAN HOLLEN
8TH DISTRICT, MARYLAND

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www.vanhollen.house.gov

August 26, 2015

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

Dear Chairman Colmers:

I am writing to express my strong support for the efforts of Johns Hopkins University Hospital and other Maryland hospitals to create a hospital-led employment program that hires residents of communities with high rates of poverty and unemployment.

Funding for this proposal will enable this collaborative hospital employment program to develop career pathways to jobs in the high growth healthcare industry for un- and under-employed Maryland residents of communities experiencing high rates of poverty. Hospitals provide a variety of entry-level positions that offer competitive salaries and benefits. Not only will this employment program improve the economic stability of the communities, but it will also have a positive impact on the overall health of these communities.

The proposed program is a collaborative and innovative approach toward population-based health care. I urge you to give it your most serious consideration.

Sincerely,

Chris Van Hollen
Member of Congress

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

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THOMAS V. MIKE MILLER, JR.
PRESIDENT OF THE SENATE

MICHAEL E. BUSCH
SPEAKER OF THE HOUSE

THE MARYLAND GENERAL ASSEMBLY
STATE HOUSE
ANNAPOLIS, MARYLAND 21401-1991

September 9, 2015

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

Dear Chairman Colmers:

As the presiding officers of the Maryland General Assembly, we offer our full support of the Hospital Employment Program.

The success of Maryland's unique hospital rate setting system is not only a source of pride for the State, it is also a platform for innovations that improve the health of Maryland's residents. We believe the Hospital Employment program represents a broad based collaboration that addresses the social and economic conditions that contribute to poor health. Creating an employment path for Maryland's most economically disadvantaged communities will not only bring stability and improved health to those communities but it will also improve the overall quality of living for all Marylanders.

We applaud all those involved in this innovative approach to population health. Thank you for your time and consideration.

Sincerely,

Thomas V. Mike Miller, Jr.
Senate President

Michael E. Busch
Speaker of the House

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

PETER A. HAMMEN
46th Legislative District
Baltimore City

Chair
Health and Government
Operations Committee

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THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

September 9, 2015

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

Dear Chairman Colmers:

I am writing to express my strong support of the Hospital Employment Program. As Chairman of the House Health and Government Operations Committee, I work with committee members to shape health policy for our state. As we work to meet the goals of Maryland's All-Payer Model Agreement, we must look to new sources of partnership and innovation. The Hospital Employment Program aligns with the new All-Payer Model Agreement's focus on population health by creating community-based jobs targeting overall population health. This program utilizes our unique waiver system to improve economic and health outcomes for the pockets of Maryland that need stability most. As a representative of Baltimore City I welcome the opportunity to support a program poised to provide significant support to City residents. Additionally, this targeted employment program, focused on the State's most disadvantaged communities, has the potential to produce savings from improved overall community health.

The Maryland All-Payer Model Agreement provides Maryland with the unique opportunity for innovation. The Hospital Employment Program is a strong example of the type of collaboration we need to be successful under the new agreement. I strongly support this innovative approach to population health.

Sincerely,

Peter A. Hammen

Peter A. Hammen

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

MAGGIE MCINTOSH
Legislative District 43
Baltimore City

Chair
Appropriations Committee

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The Maryland House of Delegates
ANNAPOLIS, MARYLAND 21401

September 9, 2015

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

Dear Chairman Colmers:

As Chair of the Maryland General Assembly House Committee on Appropriations, I am writing to express my support of the Hospital Employment Program. This program aims to improve the health, economy and stability of some of the state's most disadvantaged communities through a targeted employment program that offers hospital-based jobs to those who need them most.

The success of Maryland's unique hospital rate setting system is not only a source of pride for the State, it is also a platform for innovations that improve the health of Maryland's residents. I believe the Hospital Employment program represents a broad based collaboration that addresses the social and economic conditions that contribute to poor health. Creating an employment path for Maryland's most economically disadvantaged communities will not only bring stability and improved health to those communities but it will also improve the overall quality of living for all Marylanders. I applaud all those involved for this innovative approach to population health.

Sincerely,

Maggie L. McIntosh

cc: Herbert Wong, PhD, Vice Chairman
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Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

STEPHANIE RAWLINGS-BLAKE
MAYOR

100 Holliday Street, Room 250
Baltimore, Maryland 21202

September 9, 2015

Mr. John M. Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, Maryland 21211

Dear Chairman Colmers:

I am writing to express my enthusiastic support of the Hospital Employment Program. This program represents the widespread collaboration between the City, the State, Maryland's hospitals, business leaders and insurers to address health and income disparities within the most disadvantaged communities. Given the number of qualifying zip codes that meet the criteria of the program, these efforts will make a substantial difference in improving the quality of life for may Baltimore City residents.

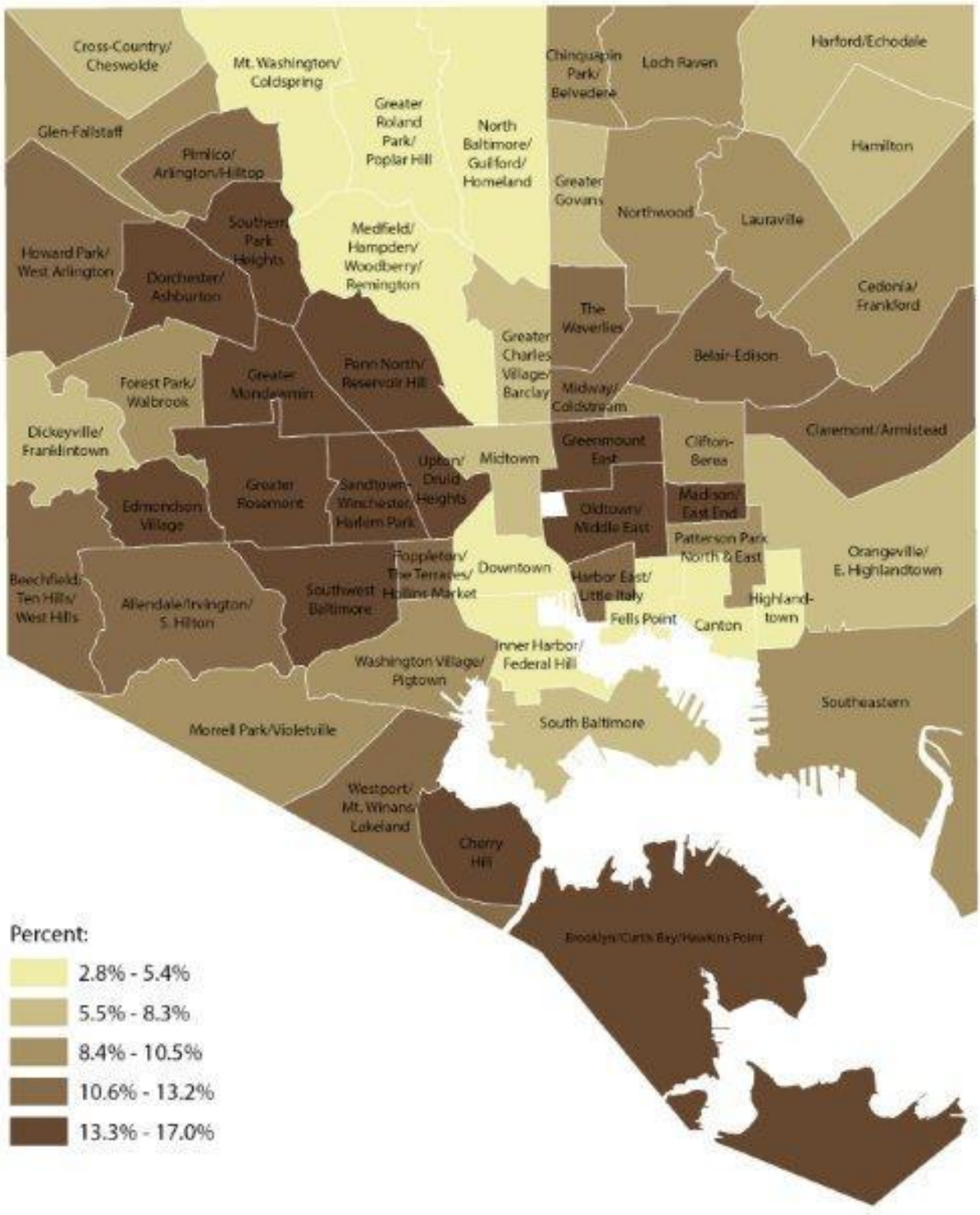
If you have any questions, please contact Kaliope Parthemos on (410) 396-4876 or Kaliope.parthemos@baltimoremorecity.gov .

Sincerely,

Stephanie Rawlings-Blake
Mayor
City of Baltimore

Cc: Kaliope Parthemos, Chief of Staff
Dr. Leana Wen, Baltimore City Health Commissioner
Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

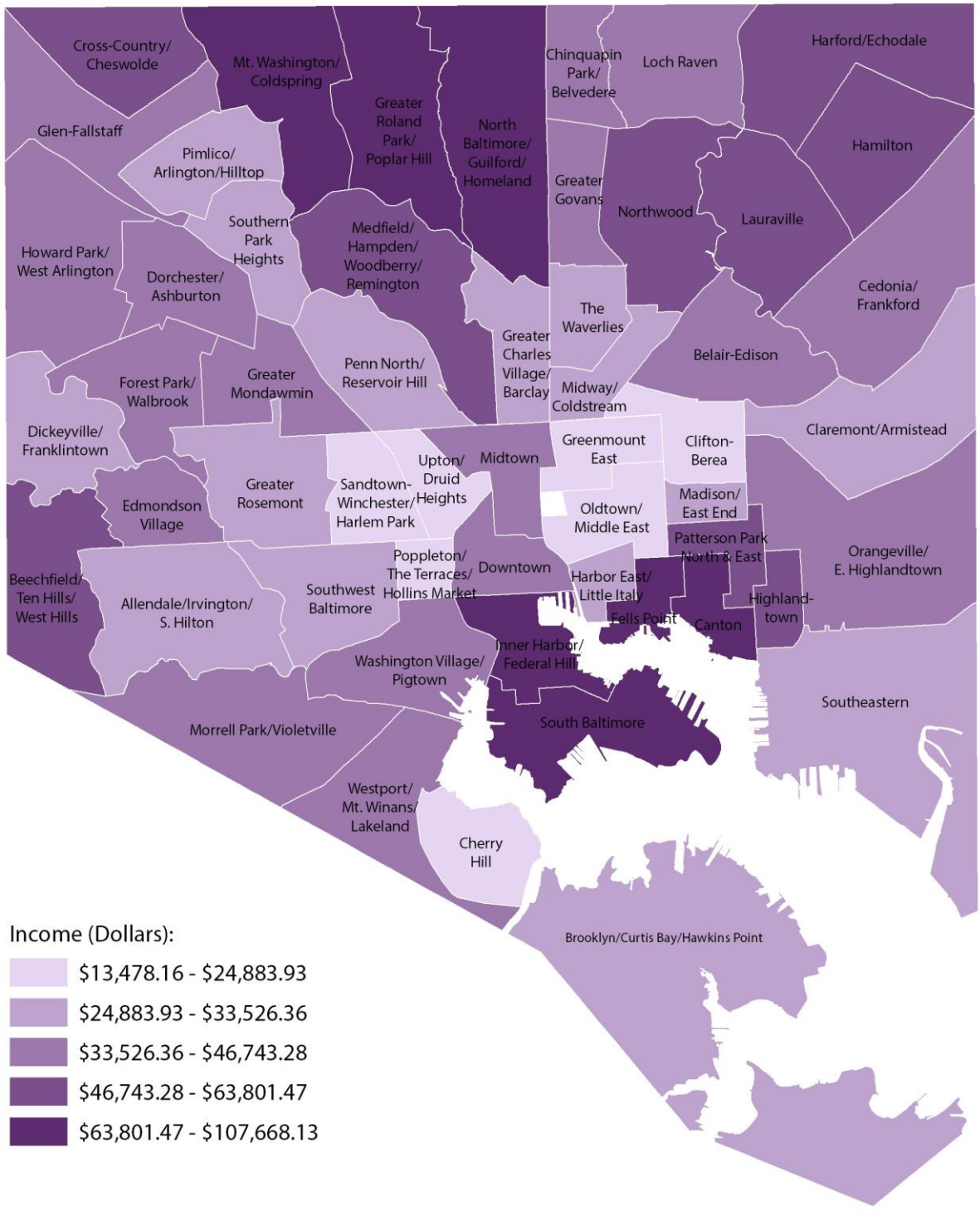
Percent of the Population Aged 16-64 that is Unemployed and Looking for Work, 2009-2013



Map created by BNIA-JFI, 2015

Source: American Community Survey

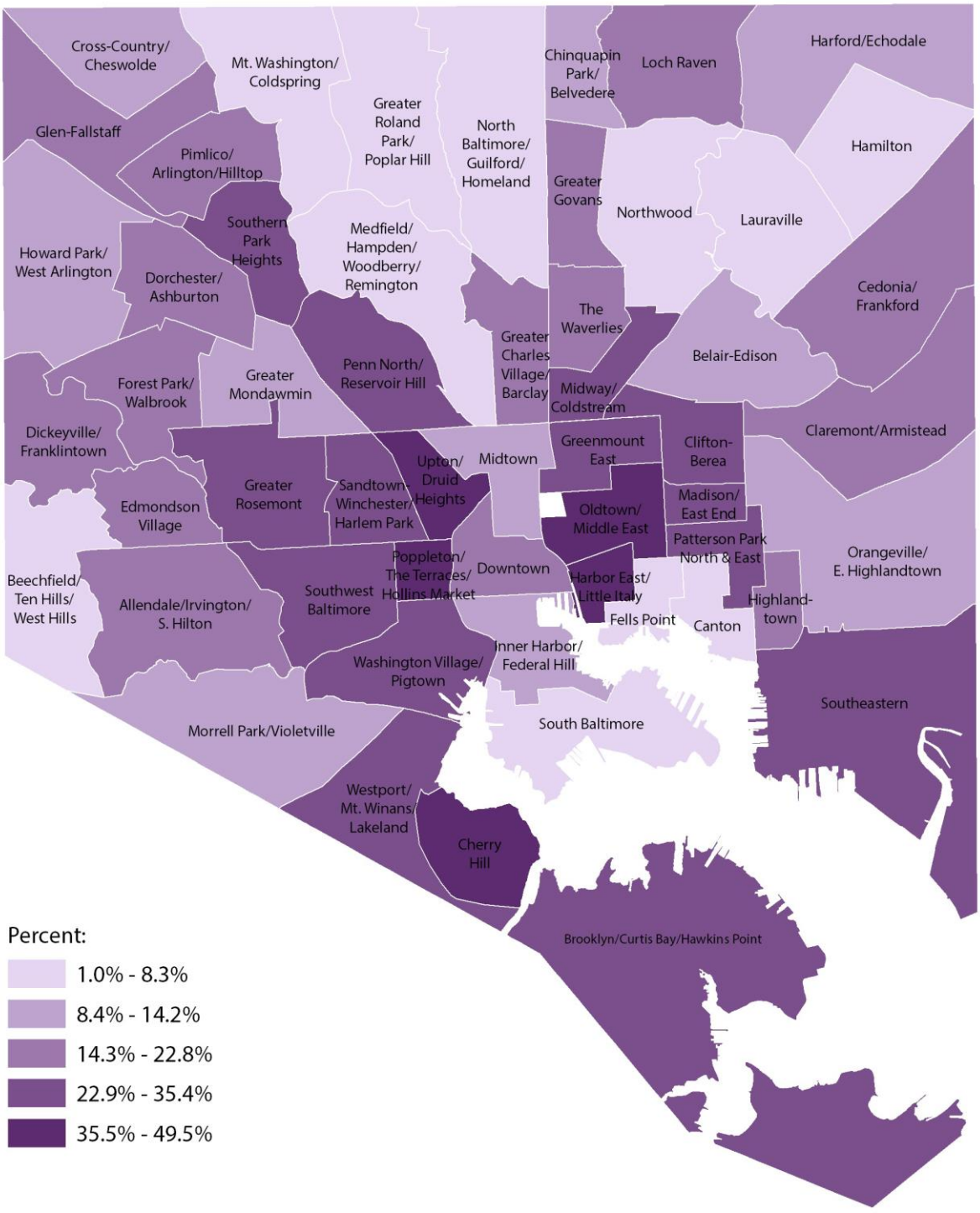
Median Household Income, 2009-2013



Map created by BNIA-JFI, 2015

Source: United States Census Bureau

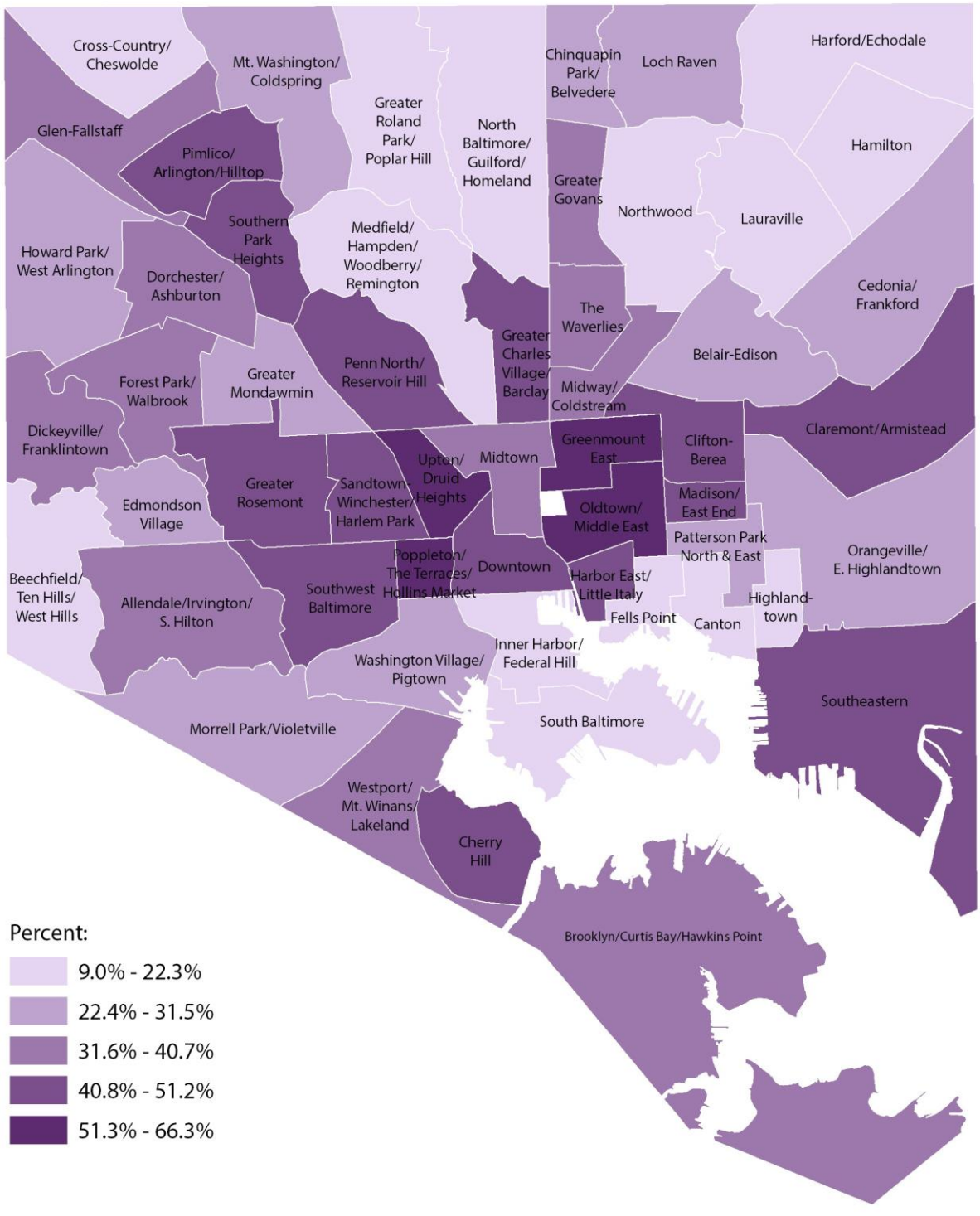
Percent of Households Living Below the Poverty Line, 2009-2013



Map created by BNIA-JFI, 2015

Source: United States Census Bureau

Percent of Households Earning Less than $25,000, 2009-2013



Map created by BNIA-JFI, 2015

Source: United States Census Bureau

PROJECT REACH: RESOURCES AND EDUCATION FOR THE ADVACEMENT OF CAREERS AT HOPKINS

The Office of Strategic Workforce Planning encompasses workforce development programs targeted to current employees through Project REACH, and community adults & youth through Community Education Programs.

Project R.E.A.C.H. (Resources and Education for the Advancement of Careers at Hopkins) is an Incumbent Worker Career Acceleration Program funded by Johns Hopkins Health Systems. This project is designed to help current Johns Hopkins Health System (JHHS) employees acquire the skills and knowledge to fill vacant healthcare occupations with a focus on those that are experiencing critical and chronic shortages. A few features of this program include: assessments of basic skills and career interest for eligible applicants, the assignment of career coaches, and salary release support for most participants (only for those pursuing school on a full-time basis).

Project R.E.A.C.H. offers:

- Assists JH departments with specialized training coordination (ie: JHHC medical coding training)
- Salary-release support for approved trainings (16 hrs/wk during training)
- Coaching (educational / job / work-life balance)
- Career & Educational Assessments
- Career transition services for individuals experiencing a reduction in force

Education & Training Programs

REACH/CEP programs support current employees who may be preparing for career advancement opportunities in any healthcare occupations. We also partner with Hopkins departments/programs (ie: Skills Enhancement, Joint Training Council, & Tuition Assistance) and community organizations to support a broad range of courses from GED and college preparation to medical terminology and computer basics. Many of our programs are supported through partnership with local government, community-based organizations and community colleges.

While any Health System employee may receive coaching services from Project REACH, to be considered for the program's salary release support feature, employees must meet the following requirements:

- Current JHHS employee with full-time status (40 hr/wk; 1 FTE)
- Full-time permanent employment for at least one year **prior** to submission of application
- Must have completed the Project REACH application
- Must have secured a manager recommendation
- Have achieved minimum rating of "2"' (met expectations) on your most recent annual appraisal. You also must not have received a score of "1" (needs improvement) for any area on your annual appraisal
- Cannot be in active discipline (verbal or written for job performance &/or attendance) and must remain in good standing throughout the Project REACH process
- Must be actively employed (physically present and able to perform job duties) in department at all times
- Must have completed all educational program pre-requisites

- Be a US citizen (must submit a copy of *social security card* and a valid Maryland driver's license or Motor Vehicle Identification Card)
- *Graduated High School or have earned a G.E.D*
- Provide a copy the acceptance letter to the educational program (must be on school letterhead or printed from your student portal bearing your name and the school's URL.
- Provide a copy of current transcript
- Provide a copy of the course outline/plan of study from the enrolled program (must be on school letterhead or printed from your student portal bearing your name and the school's URL).
- Provide a current professional resume
- Must be willing to sign a service commitment agreement

Some Training Offerings
Here is a list (not all inclusive) of the training programs we have and currently supported.

- Surgical Technician
- Medical Technician
- Medical Technologist
- Clinical Technician
- Registered Nursing (Project LINC)
- Radiology Technician
- Respiratory Therapist
- Pharmacy Technician

Listed below are a few Hopkins employees who have been served by the program. Each successfully completed the program and experience a promotion/career advancement as a result of their educational attainment.

- Eric Hill* – started with REACH in 2009 as a Rehab Tech and wanted to become a Physical Therapist. By August of 2010 with REACH salary release support he completed his training and secured a position as a Physical Therapist at Johns Hopkins.

- Marta Meier* - started receiving REACH salary release support in 2010 while working as a Clinical Associate taking Surgical Technician courses at BCCC. She completed her education securing her Associates degree and passing her Surgical Technician certification in 2012. She now works in the Pediatrics Operating Room.

- Deshane Redd* – started in the Housekeeping department at Hopkins in 1988/1989 and spent a long time pursuing his education towards becoming a Respiratory Therapist. In 2005 he worked with REACH receiving the salary release support that assisted in his completing the program by 2007 and starting his Respiratory Therapist career at Hopkins.

- Brandi Loveless – started with REACH in 2012 receiving salary release support in the LINC registered nursing training program while she was working as a receivables supervisor. She completed her nursing program and started working as an RN in 2013 on the Nelson 3 unit at Hopkins.

Pathways to Success….Making the Career Connection

Career Advancement for UMMC Staff

UMMC employees are supported with their development through our Pathways to Success Program which focuses on removing academic barriers. Through assessment-guided enrichment programs (College Prep) workers are afforded the opportunity to prepare for college enrollment. Participants in our college prep program are given a strong foundation to help them cope with the rigors of college thereby avoiding the pitfalls of the remedial vacuum to which many students succumb. Deficits in computer skills are also addressed. As many employees attempt to navigate their career paths lack of computer skills can be a limiting factor. Our basic computer and Microsoft Office training addresses these skill gaps. Pulling this all together is career coaching, a vital component of the development process. Everyone has access to experienced career development specialist who assists with the enhancement of soft skills necessary to acquire and maintain employment. Coaches also help clients develop, Individualized Development Plans (IDPs), which map the most effective course to attaining career goals. To augment the process, employees can access The Employee Tuition Reimbursement Program which provides financial assistance to those who wish to pursue courses of study related to their employment, upgrade their care of patients, and prepare for advancement. During FY15, over 400 staff participated in career/skill building programs.

Community Partnerships

UMMC provides opportunities for unemployed or underemployed community members, who possess the aptitude and passion for health care, offering gainful employment at the medical center. These prospective employees are identified through a variety of partnerships with stakeholders in the community. Recruiting quality workers from the community supplies replacements as incumbents become upwardly mobile and fulfill their career goals. This is a win for all parties involved.

These are a few examples of how our Pathways to Success programs have helped individuals make a career connection:

T'Andria Moore – was introduced to healthcare as an Healthcare Careers Alliance intern at UMMC. After her internship she tried her hand at several positions before deciding that she wanted to be a Pharmacy Technician. In December 2014 that dream became reality as she became certified through UMMC's Pharm Tech Training program.

Kenisha Patterson – Kenisha's initial contact with UMMC was in 2011, via the Health Care Careers Alliance Program. After her internship she secured a job as a mail clerk. It was always her wish to become a Pharmacy Technician. In June of 2014 she entered UMMC's Pharm Tech program and is now a certified and working in the main pharmacy at the medical center.

Christine Frank- Christine became employed with the University of Maryland Medical Center January 2014 as a Room Attendant and started using Career Development Services within 6 months of working (July of 2014). She strongly aspired to utilize her transferrable skills and healthcare background to benefit another department. She took computer classes, attended essential skills classes, and received intensive career coaching to develop her resume and sharpen her interviewing skills.

Life Bridge Health

As the largest, most comprehensive respected provider of health-related services to the people of the northwest Baltimore region, LifeBridge Health is a model of excellence for both employees and the surrounding community. Each facility promotes physical, emotional, intellectual, social and spiritual health by offering a variety of onsite health and wellness programs. In 2010, LifeBridge Health was honored to receive the James W. Rouse Diversity Award from the Chesapeake Human Resources Association, which is given to organizations that exemplify world-class leadership in their efforts to promote diversity through programs and initiatives.

In addition to our focus on employee health, satisfaction and diversity, we also encourage our employees to pursue career advancement. We offer career counseling and tuition assistance for our employees. Our coaches work with employees who are interested in moving up. We coach them around career paths, assist them with their resumes and applications, and facilitate enrollment in educational programs. Tuition assistance is also available, mainly for degree seeking programs.

Workforce Development at Mercy Medical Center

Mercy Medical Center offers a comprehensive set of programs and benefits for workforce development and career advancement to all of its employees. Many of the programs are specifically focused on creating new opportunity ladders for professional growth for entry level workers though increased access to education, mentorship, and general skills-building.

- Career Ladders Program – Provides opportunities for staff to grow within department/division (increased skills/experience/role leads to increased wages & title).
    - Clinical Nurse ladder
    - Patient Access Representatives
    - Physical Therapy
    - Environmental Services (lead & supervisory roles)
    - Materials Management (lead & supervisory roles)
    - Food Services (lead & supervisory roles)
    - Centers of Excellence (varies by practice)
- Tuition Assistance Program (up to $6,500 annually)
    - Mercy also offers Pre-paid tuition options for lower-paid eligible employees (benefits-eligible employee earning $21/hour or less
- Continuing Education Program – reimbursement for non-credited college courses, workshop and other educational programs. Also covers expenses related to acquiring or maintaining certification related to one's job.
- Adult Education Program (part-time, RSM role) – provides free tutoring for GED preparation, and core academic skills (literacy, writing and math skills).
- Computer Training Program – free courses offered throughout the year on basic and advance level in various office software products that are a critical career skill in most workplace environments
- Career Coaching Program– consults with entry-level staff to provide guidance on education opportunities to gain advancement.
- Nurse Mentor Program
    - Coordinates Nurse Residency Program for new nurse graduates to ensure growth and retention, including training, workshops, and regular meetings to solicit feedback
    - Nursing Support Tech Development (program in development)
        - Will work with Patient Service Representatives and entry-level staff on opportunities to development into Nursing Support Tech role

Johns Hopkins Health System

Medicaid Re-determination Project

The Affordable Care Act (ACA) included the expansion of Medicaid to adults with no children as well as the FAC population. The effective date of this expansion was January 1, 2014 and all Maryland Residents who previously qualified for the minimal PAC (Primary Adult Care) coverage were awarded full Medicaid Benefits. Each year Medicaid requires recipients to be re-determined to continue their Medicaid eligibility. With the number of new enrollees and the change in the re-determination process (the re-determination must be done on line with documentation uploaded where necessary) it is very challenging for the Medicaid eligible population to complete. Johns Hopkins has found that significant segments of the expanded Medicaid population, consisting primarily of those recipients who are not actively suffering from illness, are challenged with completing the re-determination process. Many do not have computer access or knowledge for the redetermination process. The Maryland Health Benefit Exchange, its call center, and its Connector entities often have long wait periods that deter individuals from completing the process.

Since January 2015, the number of re-determination requests have been extremely large; 100,000 between January and April 2015 with another 90,000 expected in September 2015. To assist the patients within our community to complete the new process we have partnered with our vendors and the Johns Hopkins Health Plan. We have secured locations within the community to meet with patients and assist them in completing the process. Johns Hopkins vendors and Certified Application Counselor staff will be staffing numerous locations within East Baltimore and East Baltimore County that are served by the Johns Hopkins Hospital and the Johns Hopkins Bayview Medical Center and the Johns Hopkins Community Physicians Groups to assist members of those communities to re-enroll in Medicaid or initiate a new application as appropriate. This effort allows Johns Hopkins to assist individuals residing in the communities we serve with gaining health care coverage while they are healthy, rather than assisting them only when they are sick enough to come the hospitals. Our Program also allows us to assist individuals with Qualified Health Plan Enrollment. Should your organization or group have need of such assistance please contact Sandra Johnson, Senior Director of Patient Financial Services of the Johns Hopkins health System at 443-997-0001 or sjohn187@jhmi.edu.

Health Services Cost Review Commission

Consumer Engagement Task Force: Final Report

September 9, 2015

Leni Preston, Task Force Chair
Hillery Tsumba, Task Force Member

Task Force Members

Task Force:

- Leni Preston, Chair – Maryland Women's Coalition for Health Care Reform
- Linda Aldoory, Herschel Horowitz Center for Health Literacy, University of Maryland
- Barbara Brookmyer, Frederick County Health Officer
- Kim Burton, Mental Health Association of Maryland
- Tammy Bresnahan, AARP
- Michelle Clark, Maryland Rural Health Association
- Shannon Hines, Kaiser Permanente
- Donna Jacobs, University of Maryland Medical System
- Michelle LaRue, CASA DE MARYLAND
- Karen Ann Lichtenstein, The Coordinating Center
- Susan Markley, HealthCare Access Maryland
- Suzanne Schlattman, Health Care for All!, MCHI
- Novella Tascoe, Keswick Multi-Care
- Hillery Tsumba Primary Care Coalition of Montgomery County
- Gary Vogan, Holy Cross Hospital

Staff: Dianne Feeney & Steve Ports, HSCRC; Theressa Lee, MHCC; & Tiffany Tate, Consultant

HSCRC Consumer Engagement Task Force
January – September 2015

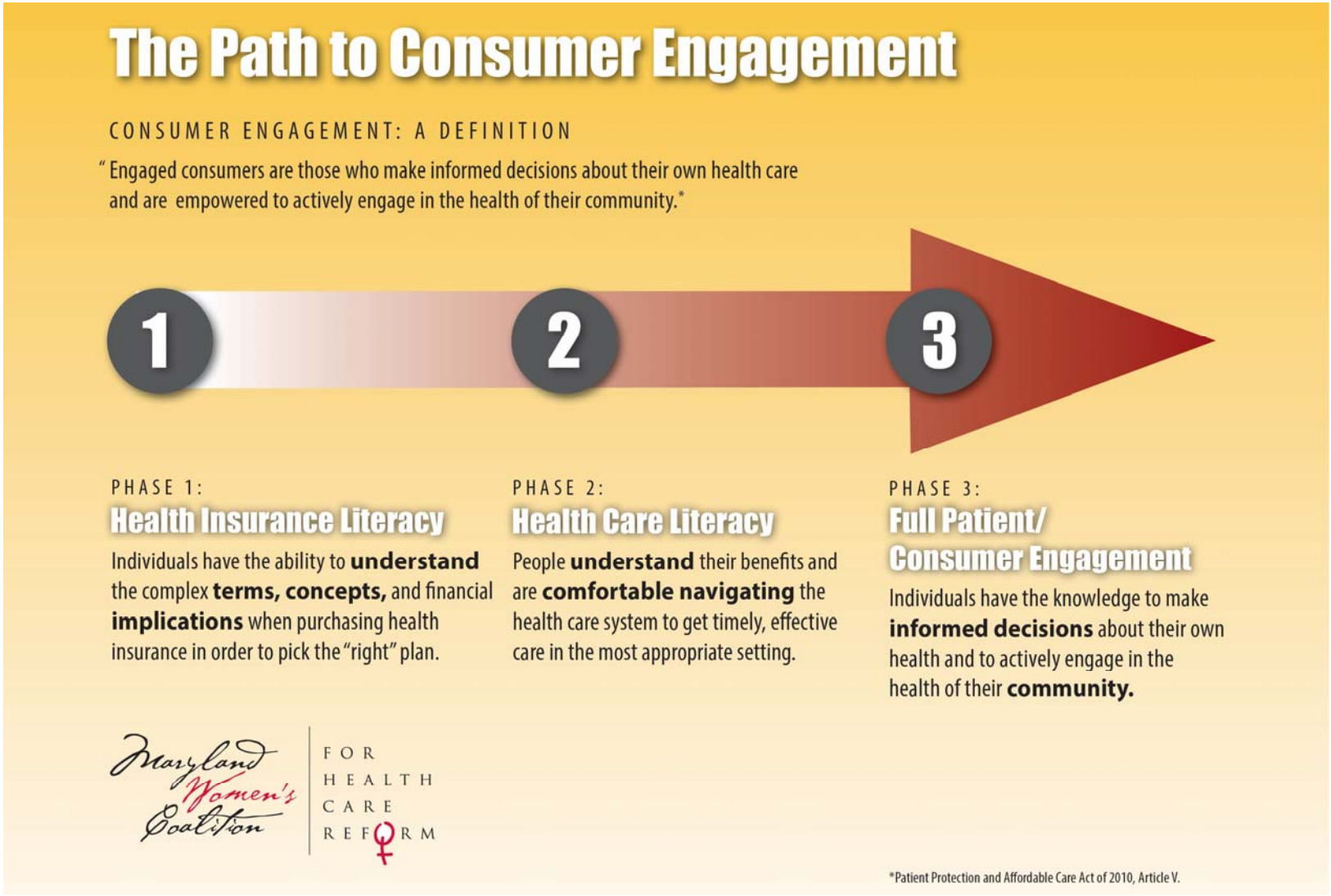
Charge 1

- Provide rationale for health literacy and consumer engagement within the context of the New All-Payer Model (NAPM)
- Define audiences, identify messages, and propose engagement strategies as appropriate, including:
  - Systemic adjustments
  - Education and communication strategies

Charge 2

- Advise decision-makers, regulators, etc. on the impact of system transformation on individual and community health issues
- Provide guidance for ensuring an appropriate and consumer-friendly communications process
- Make recommendations for enhanced ways for consumers to provide feedback and for hospitals to act on that input

Consumer Engagement – Get It!



Consumer Engagement: Benefits to Consumers & the Community

Engaged consumers may experience:

- Improved understanding about their health condition, related treatment options, & how to access the appropriate services to optimally manage their health
- Improved relationships with health care providers
- Improved experience and satisfaction with their health care
- Personal sense of value, ownership, and influence in health care decision-making
- High quality health care
- An informed, responsive, and more efficient, health care system

Consumer Engagement: Benefits to Health Care Providers & Institutions

Providers & institutions that meaningfully engage the consumer can experience:

- Patients' improved understanding of their medical condition(s) and treatment options resulting in improved outcomes and more efficient use of resources.
- Greater confidence that their programs meet the needs of consumers and communities, including those with unique cultural or social needs
- Improved relationships and cooperative partnerships with the individuals and communities they serve
- Streamlined processes for receiving information and insight from the community and applying the insights to inform policy decisions

Consumer Engagement: Recommended Mission

Foster a health care system driven by a culture of robust and meaningful consumer engagement that addresses the Triple Aim:

- improving the patient experience, including quality and satisfaction
- improving health of populations
- reducing per capita cost of health care

Consumer Engagement: Themes

- Clear call to action – at the right time, in the right place and from the right person
- Engagement is dependent on individual's input and perception that their actions have an impact
- Individuals' motives are different than institutions' – identifying the motivating factors is key for both groups
- Health care information should be disseminated and consumer engagement activities should be led by sources that consumers trust
- Sensitivity to diversity and the multitude of cultural differences is critical
- Requires extraordinary commitment from health care leadership at all levels
- Ideally, consumers should be engaged, both prior to, and at the point of contact with the health care system
- A more robust and consumer-friendly feedback process (i.e. concerns, complaints and commendations) is needed
- Advanced directives planning is indicative of consumer engagement

Consumer Engagement: Strategic Communications Goals

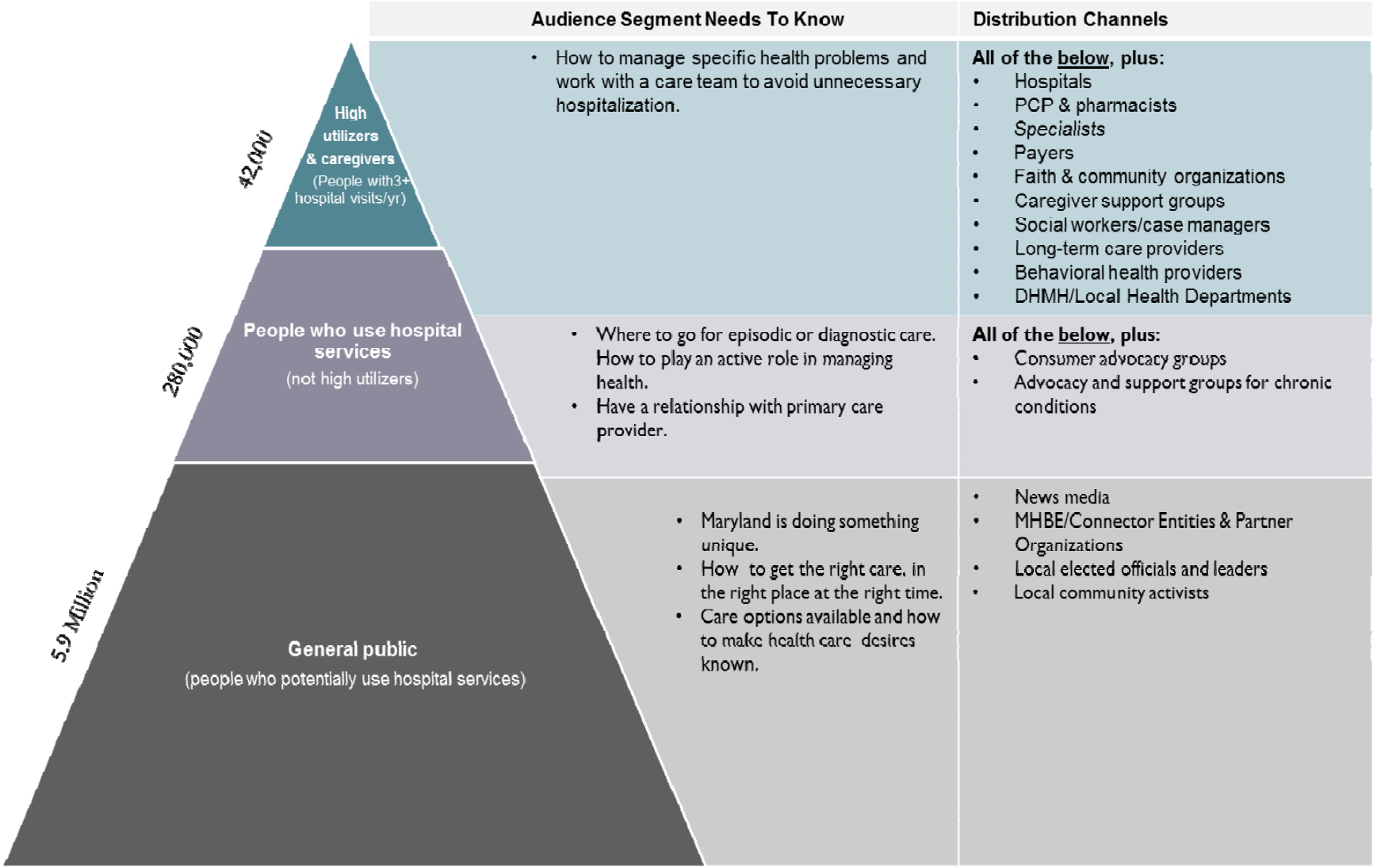
Goal #1

- Establish a person-centered health care delivery system with an ongoing role for consumers to participate in the design and implementation of policies and procedures at all levels.

Goal #2

- Engage, educate, and activate people who use, or are potential users of, hospital services in their own health care in order to promote efficient and effective use of the health care system

Audiences & Messengers



Task Force Recommendations

1. Allow for meaningful, ongoing role for consumers at the HSCRC through continued representation of Commissioner(s) with primary consumer interest, and through a newly created standing advisory committee with diverse representation.
2. In collaboration with key stakeholders, develop a statewide public education campaign specific to the NAPM that is part of a broader campaign to promote health and wellness.
3. Convene an interagency task force, with consumer representation, to oversee the public education campaign including the development of related consumer-oriented information.

Task Force Recommendations

4. Provide options and opportunities that support regular, longitudinal and effective consumer engagement in the development of policies, procedures, and programs by hospitals, health care providers, health care payers, and government.
5. In coordination with the SAC, the MHCC and other key stakeholders, consider development of a Consumer Gold Star system for hospitals based upon consumer engagement standards.
6. Define Community Benefit dollars to include consumer engagement initiatives and promote these dollars for this use, particularly for those supporting vulnerable populations.

Task Force Recommendations

7. Continue to encourage and incentivize independent and collaborative approaches to support people who are at risk of becoming high utilizers.
8. Encourage hospitals to provide current, consistent, and transparent information on average procedure costs using the data made readily available by the Maryland Health Care Commission (www.marylandqmdc.org) and new pricing transparency tools being created, and make this available on NAPM and/or other appropriate website(s).
9. Include discussions about patient and family decision-making and preferences about advanced directives in the context of consumer engagement and educating consumers.

Measuring Consumer Engagement

- Currently few validated metrics or tools that could directly and comprehensively evaluate the impact of consumer engagement on health outcomes, patient experience or satisfaction, provider satisfaction, improved program design decision-making, access, or utilization.
- Propose an initial non-exhaustive set of measures which could be adopted from currently available resources:
  - Existing data sources (e.g., Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Medicare claims, CRISP encounter information),
  - Suggested some that are not currently collected (e.g., the Communication Climate Assessment Toolkit (C-CAT)).
- Propose others where there are currently measurement gaps, for example:
  - HSCRC Standing Advisory Committee
  - Patient Family Advisory Committees at hospitals

Multi-Agency & Multi-Stakeholder Engagement: HSCRC Role

True consumer engagement promises tremendous benefit to the people who use health services as well as health care providers and institutions. Successful consumer engagement requires proactive and committed leadership. It is imperative that the HSCRC embraces a continued leadership role to promote a coordinated, collaborative and person-centered health care system.

Questions

- Leni Preston, Maryland Women's Coalition for Health Care Reform leni@mdchcr.org
- Hillery Tsumba, Primary Care Coalition of Montgomery County
- hillery_tsumba@primarycarecoalition.org

MARYLAND
Health Services Cost
Review Commission

Final Report

Health Services Cost Review Commission
Consumer Engagement Task Force

September 9, 2015

Contents

I. Executive Summary

In December 2014, the Maryland Health Services Cost Review Commission (HSCRC) established a Consumer Outreach and Engagement Workgroup to explore opportunities for and challenges in engaging consumers in the state's New All-Payer Model (NAPM), a unique health care delivery system transformation initiative. The workgroup was composed of two task forces: the Consumer Outreach Task Force and the Consumer Engagement Task Force. This report represents the work of the Consumer Engagement Task Force (CETF), which was charged with developing recommendations on strategies to engage consumers at multiple levels in the NAPM. The CETF met from January through September 2015. A list of the members can be found in Appendix A.

At its core, the NAPM has the goal of achieving the "Triple Aim" of: (1) improving the patient experience, including quality and satisfaction; (2) improving health of populations; and (3) reducing the per capita cost of health care.[1] Through its exploration, the CETF concluded that, to achieve the Triple Aim, consumers must have access to a health care delivery system that is reflective of their needs and preferences and equips them to be fully engaged in and take ownership of their health and health care. Moreover, the CETF maintains that the HSCRC must assume a leadership role in promoting and supporting the multi-stakeholder collaboration and commitment required to develop such a system.

> *True consumer engagement promises tremendous benefit to the people who use health services, as well as to health care providers and institutions. Successful consumer engagement requires proactive and committed leadership. It is imperative that the HSCRC embraces a continued leadership role to promote a coordinated, collaborative, and person-centered health care system.*

To enable this level of consumer engagement, the CETF recommended vision and mission statements, as well as goals and objectives for the HSCRC and other stakeholders seeking to transform the health system. The goals are viewed as essential to consumer participation and, therefore, the success of the system as it is reoriented to be more responsive to consumers' needs as both "patients" and "clients." Extensive effort is needed to ensure that consumers understand this reorientation so they can make informed decisions and engage in the personal lifestyle changes, self-care, and system design that are essential to health system transformation.

Benefits of Consumer Engagement to Consumers and the Community

Engaging consumers in health care delivery system design and personal decision-making can produce substantial and enduring benefits for the individual, community, and overall health care system. Fully engaged consumers may experience:

- Improved understanding about their health condition, its related treatment options, and how to access the appropriate services to optimally manage their health
- Improved relationships with health care providers

[1] Framework developed by the Institute for Healthcare Improvement can be found at: http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx; last accessed 9/4/15.

- Improved experience and satisfaction with their health care
- Personal sense of value, ownership, and influence in health care decision-making
- High-quality health care
- An informed, responsive, and more efficient health care system

Benefits of Consumer Engagement to Health Care Providers and Institutions

Because person-centered systems must be created and, presumably, funded by institutions, it is imperative that hospitals appreciate the potential benefit to their operation and commit to consumer engagement processes. Institutions that meaningfully engage the consumer can experience:

- Patients' improved understanding of their medical condition(s) and treatment options, resulting in improved outcomes and more efficient use of resources
- Greater confidence that their programs meet the needs of consumers and communities, including those with unique cultural or social needs
- Improved relationships and cooperative partnerships with the individuals and communities they serve
- Streamlined processes for receiving information and insight from the community and applying that insight to inform policy decisions

Communications Strategy: The Mission and Primary Goals

A set of nine principles, detailed later in this report, serve as guidelines for consumer engagement. Our mission is to foster a health care system driven by a culture of robust and meaningful consumer engagement that addresses the Triple Aim.

The CETF established two strategic goals, each with accompanying objectives, to support the recommended mission for consumer engagement activities.

Goal #1
Establish a person-centered health care delivery system with an ongoing role for consumers to participate in the design and implementation of policies and procedures at all levels.

Goal #2
Engage, educate, and activate people who use or are potential users of hospital services in their own health care in order to promote efficient and effective use of the health care system.

Principal Recommendations

This report places each of the recommendations below into a larger strategic context substantively outlined in this report. The recommendations include:

1. Allow for a meaningful, ongoing role for consumers at HSCRC through continued representation of Commissioner(s) with primary consumer interest, and through a newly created standing advisory committee with diverse representation.
2. In collaboration with key stakeholders, develop a statewide public education campaign specific to the NAPM that is part of a broader campaign to promote health and wellnes.
3. Convene an interagency task force that allows consumer to participate in the design and implementation of a statewide public education campaign
4. Provide options and opportunities that support regular, longitudinal, and effective consumer engagement in the development of policies, procedures, and programs by hospitals, health care providers, health care payers, and government.
5. In coordination with the HSCRC Standing Advisory Committee (SAC), the Maryland Health Care Commission (MHCC) and other key stakeholders, consider development of a Consumer Gold Star system for hospitals based on consumer engagement standards.
6. Define Community Benefit dollars to include consumer engagement initiatives and promote these dollars for this use, particularly for those supporting vulnerable populations.
7. Continue to encourage and incentivize independent and collaborative approaches to support people who are at risk of becoming high utilizers.
8. Encourage hospitals to provide current, consistent, and transparent information on average procedure costs using the data made readily available by the MHCC (www.marylandqmdc.org) and new pricing transparency tools being created, and make this available on the NAPM's website and/or other appropriate websites.
9. Include discussions about patient and family decision-making and preferences about advanced directives in the context of consumer engagement and educating consumers.

II. Statement of Purpose

The Maryland Health Services Cost Review Commission ("HSCRC" or "the Commission") created the Consumer Outreach and Engagement Workgroup to complete an exploration that would provide the Commission guidance on incorporating a consumer engagement approach in its efforts to implement the New All-Payer Model (NAPM). The Workgroup was composed of two Task Forces—the Consumer Outreach Task Force and the Consumer Engagement Task Force (CETF)—with the rationale that each would perform distinct yet complementary tasks to provide a comprehensive assessment and approach for involving consumers in planning and evaluating the impact of health system transformation.

The CETF was composed of 15 representatives from consumer advocacy groups, professional associations, local public health, community-based organizations, and health service providers. (A complete listing of the members is provided in Appendix A.).

A. CETF Charges

The CETF had two separate but related charges:

1. Provide a rationale for health literacy and consumer engagement within the context of the NAPM—and related reform initiatives—that includes core principles of consumer engagement, key audiences and messages that will motivate them, and opportunities for reaching these audiences. This work should reflect the work of the Community Outreach Task Force and other HSCRC workgroups, including Care Coordination and Performance Measurement.

2. Address avenues/strategies to provide consumers with ways to: (i) engage with decision makers, regulators, and others on the impact on individual and/or community health issues of the design and implementation of the reform initiatives and principally the NAPM; and (ii) ensure an appropriate and consumer-friendly communications process for those directly impacted by the NAPM's goals.

The purpose of this report is to provide the HSCRC with recommendations on the overall approach, goals, and objectives essential to promoting consumer engagement that will enable successful implementation of the NAPM. The report guides and supports the HSCRC's patient-centered focus and inclusive approach to the design and implementation of this unique model. The HSCRC commissioned this work in full recognition of the central role that consumers—both current and potential users of hospital services—have on its ultimate success. In compiling its recommendations, the CETF considered the complexity of the task; racial, social, cultural, and educational diversity of the target audiences; multiplicity of current and potential stakeholders and the opportunities for their engagement through different avenues and at different levels; potential messengers; and the core messages that can be incorporated in next-phase development of a full Communications Plan.

B. CETF Methodology

The CETF employed a holistic approach in fulfilling its responsibility to the HSCRC. At its initial meetings, the CETF reached consensus on a set of definitions and core principles upon which to predicate its work (see Appendix B). Next, it conducted a research phase through a survey of literature and presentations that included national research and trends and Maryland-specific initiatives related to concepts relevant to implementation of the NAPM and consumer engagement. A summary of its exploration is provided in Appendix C. The full CETF met monthly, and a subgroup met on a more frequent basis. A second subgroup—composed of representatives from the Consumer Outreach Task Force and the CETF—ensured that the work of the task forces was aligned.

C. Vision and Mission

To guide its own work, and that of the HSCRC, the CETF proposes a broad and *aspirational* vision and mission grounded in the need to create an effective communications strategy.

> ***Vision:*** A fully coordinated, integrated health care system in which all Marylanders can achieve optimal health.
>
> ***Mission:*** Foster a health care system driven by a culture of robust and meaningful consumer engagement that addresses the Triple Aim, as evidenced by:
>
> - Ongoing consumer participation in system decisions
> - Improved individual and population health
> - Improved experiences with the health care system
> - Efficient use of health care resources and reduced costs

III. Background

In January 2014, the HSCRC began implementation of the NAPM, a new hospital reimbursement system that is unique to Maryland and recognized as a national model. The result of an agreement with the Center for Medicare and Medicaid Innovation (CMMI), the NAPM provides an exciting opportunity to address a prevailing theme in health care—the Triple Aim—while maintaining and improving Maryland's unique system. The NAPM's goals to improve health outcomes, enhance quality and patient satisfaction, and reduce per capita health care costs across the system will directly and positively affect Maryland residents. Achieving these goals will require consumers who are currently and potentially affected by transformation across the health care system to be better informed and fully engaged in their own health care and have a meaningful role in the design of the health care system.

Consumers do not distinguish between initiatives overseen by different agencies and organizations. Therefore, the HSCRC must continue to foster partnerships to implement an effective, cohesive, and all-encompassing consumer engagement approach. This would align the numerous initiatives currently underway to transform and modernize Maryland's health care system.

The NAPM is but one of the building blocks Maryland has in place to ensure its residents have access to both coverage and care. Examples of other programs include, but are not limited to, the Maryland Health Benefit Exchange (MHBE), the Chesapeake Regional Information System for our Patients (CRISP) (the state's Health Information Exchange), the Maryland Health Care Commission's (MHCC's) Health Care Quality Reports, and Maryland Health Homes for individuals with chronic conditions. The design, implementation, and oversight of the various initiatives and opportunities to modernize health care rest with multiple agencies and organizations; however, they are part of an integrated approach to reforming the health care system whose overall success rests, in part, on the success of each individual component. A proactive approach to informing and engaging all stakeholders—including consumers—is essential to the success of each program and especially important to the overall success of the NAPM.

IV. Introduction to Consumer Engagement

Consumer Engagement, a relatively new concept being applied nationally and in Maryland's health care system, has evolved from the longer standing concept of "patient engagement. " The limited yet growing body of work on the topic falls short of arriving at a standard definition for "consumer" or offering a common distinction between "patient" and "consumer." For the purposes of this report, "patient" will be defined as a person who directly interacts with health care providers and services about personal health concerns. "Consumer" will be defined as a person who is a current or potential user of health services.[2] Consumers may be those who make decisions about accessing health care for themselves or loved ones, including choosing among health plans, services, and health care providers.

With the passage of the Affordable Care Act and the innovative approaches it encourages, the concept of "consumer engagement" is now considered and applied broadly. Other countries are more advanced in this area, with Australia emerging as a global leader in consumer engagement in health care. In its 2012 report, *Consumer and Community Engagement Framework,* Health Consumers Queensland discusses the value of engaging consumers in designing health care systems and offers specific ways consumers can be included in this effort. The report asserts that:

"Effective engagement is embedded in an organisation's [sic] culture and practice. It informs health service organisations about the needs of the people who use their services and people who may be potential users of services who may, for different reasons, experience barriers to access. It is a mechanism that can enable health service organisations to better plan, design and deliver services that meet the needs of the people who use them, to gather feedback about initiatives and reforms that will impact upon service delivery and to monitor the quality and safety of providers to deliver improved services for consumers, their families and carers [sic]."

Generally, there are two schools of thought in the consumer engagement arena. One focuses on activities aimed at influencing behavior change in individuals to increase their level of "activation" in managing their health and health care, while the other focuses on identifying structural and procedural enhancements that can create an environment in which consumers have ready access to information, support, and resources that enable them to be actively involved in their own health and health care. Given the context in which this exploration was solicited, the CETF chose to emphasize the second framework due to its interdependence with the first one.

Types of Consumer Engagement

In the emerging field of consumer engagement, three categories of engagement are routinely considered as ways to meaningfully involve consumers in optimizing and reforming health care. They include:

- **Information and Education:** This refers to creating and making accessible to consumers information that they understand and can act upon to make informed health care decisions for themselves or an individual for whom they are providing care.

[2] Health Consumers Queensland. (2012). *Consumer and Community Engagement Framework.*

- **Advisory Capacity:** This type of engagement entails enlisting consumers in an advisory capacity to provide input on programs and services. In this role, consumers may influence decision-making.
- **Feedback Process:** This category of engagement formally secures feedback from consumers about experiences as a patient or caregiver. This solicited or unsolicited information can be used to refine or create programs and services.

A. Benefits of Consumer Engagement

There is an emerging consensus in the health policy community that informed and engaged consumers are vital to achieving the Triple Aim. The expectation is that when consumers are armed with the right information, they will demand high-quality services from their providers, choose treatment options wisely, access care in appropriate locations, and become active participants and self-managers of their own health and health care.[3] Moreover, these informed and engaged consumers can have a positive impact on the design of the delivery system model.

There is a paucity of research that quantifies the impact of consumer engagement. However, as the field continues to expand, the CETF anticipates more research results similar to a 2012 study of Medicaid beneficiaries that found that patients who lack the skills to manage their health care incur costs 8 to 12 percent higher than those who are highly engaged in their care, even after adjusting for health status and other factors.[4] These findings are corroborated by innumerable anecdotal reports on the benefits individuals and the health care system realize as a result of consumer involvement.

Benefits to Consumers and the Community

Engaging consumers in health care design and decision-making can produce substantial, enduring benefits for the individual, community, and the health care system. Individuals who have the resources and mechanisms to be engaged experience:

- Improved understanding about their health condition, its related treatment options, and how to access the appropriate services to optimally manage their health
- Improved relationships with health care providers
- Improved experience and satisfaction with their health care experience
- Personal sense of value, ownership, and influence in health care decision-making
- High-quality health care
- An informed, responsive, and more efficient, health care system

[3] Academy Health Care. (2007). *Improving Quality Health Care: The Role of Consumer Engagement.*
[4] Institute for Patient- and Family-Centered Care. (2014). *Individual and Family Engagement in the Medicaid Population: Emerging Best Practices and Recommendations.*

Benefits to Health Care Providers and Institutions

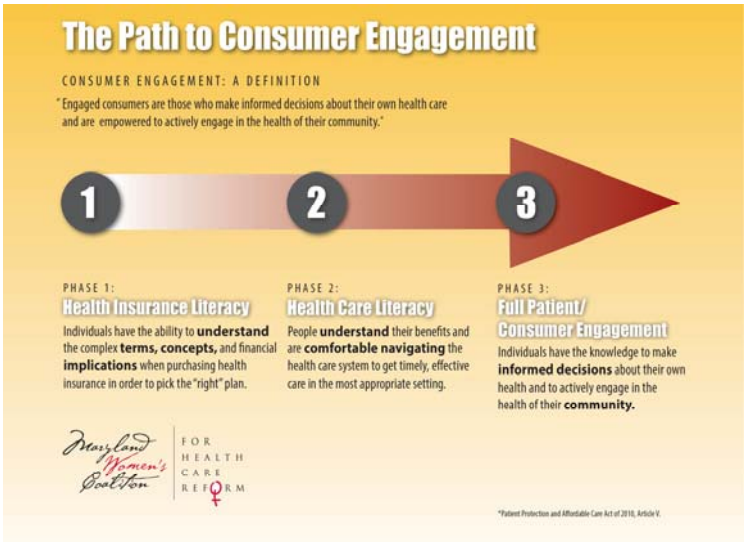
Because person-centered systems must be created and presumably funded by institutions, it is imperative that they appreciate the potential benefit to their operation and commit to consumer engagement processes. Institutions that meaningfully engage the consumer can experience:

- Greater confidence that their programs meet the needs of consumers—particularly those with unique needs—as well as the community at large
- Improved relationships and cooperative partnerships with the individuals and communities they serve
- Streamlined processes for receiving information and insight from the community and applying that insight to inform policy decisions
- More efficient use of health services by informed, empowered consumers
- Reduced privacy concerns, which are top-of-mind issues for consumers
- The enhanced opportunity for care coordination for patients

B. The Path to Consumer Engagement

The CETF's work was predicated on a recognition that consumer engagement is a process that begins with an individual's level of health literacy. The Institute of Medicine defines health literacy as "the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions." Nationwide, it is estimated that 80 million Americans have low health literacy, which can be linked to poor health outcomes.[5]

Figure 1. Path to Consumer Engagement



As illustrated in Figure 1, the second step along the path to engagement is "health care literacy."[6] This, with health insurance, is often incorporated into the broader term of "health literacy." However, it can be useful to separate out these two concepts becuase research shows that serious impediments may remain after someone becomes insured. A survey of Health Insurance Marketplace Assister Programs found that 90 percent of newly-insured individuals nationwide report post-enrollment

[5] Berkman, Nancy D., Stacey L. Sheridan, Katrina E. Donahue, David J. Halpern, and Karen Crotty. 2011. "Low Health literacy and Health Outcomes: An Updated Systematic Review." *Annals of Internal Medicine* 155 (2): 97–107.
[6] Source: Maryland Women's Coalition for Health Care Reform.

problems with their insurance and 44 percent of newly-insured people report that they do not know how to use their insurance. [7]

The final step to consumer engagement is predicated on an understanding that individuals who have become "health care aware" through insurance and care literacy are now prepared to take full ownership of their own health in partnership with their providers. It is possible that these consumers will also be empowered to positively impact the health within their communities.

C. Current State of Consumer Engagement Infrastructure

The CETF's independent research, internal professional expertise, and insights gained from subject matter experts led to the conclusion that Maryland's health care system currently requires a significantly improved infrastructure and integration of programs to support a statewide consumer engagement effort. There are, however, elements of consumer engagement that can be found at all levels in the state. Examples provided below include tools hospitals are currently using, and longer standing community partnerships of "Total Patient Revenue" hospitals where consumer engagement has been at the center. These examples—as well as many other hospital, state, local, community, payer, etc. programs and initiatives in the state—can be leveraged to form the foundation for the vital infrastructure and coordinated growth of successful consumer engagement programs needed to advance the NAPM.

Examples: Hospital Consumer Engagement Tools

- Patient and Family Advisory Councils (PFACs) composed of patients, family members, clinicians, staff, and administrators. PFACs provide a structure to receive and respond to consumer input. The Agency for Healthcare Research and Quality (AHRQ) asserts that PFACs are one of the most effective strategies for involving families and patients in the design of care. PFACs do not exercise fiduciary or ultimate decision-making over an institution. However, they can provide valuable input into areas such as program development, implementation and evaluation, capital projects, staff selection, and clinical tools and practices.[8]
- An individual's knowledge of Patients' Rights.
- Knowledge of, and access to, a formal process to provide feedback (concerns, complaints, and recommendations) that can be used to address immediate concerns but also to provide a basis for future governance and operating decisions.

In April of 2015, the CETF conducted a survey of the websites of Maryland's 46 acute care hospitals with the purpose of evaluating the ease with which consumers could access information regarding the three areas above. While it is understood that more hospitals currently may have all three of these elements available, the findings highlight opportunities for improvement. Figure 2 below summarizes the findings.

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[7] Kaiser Family Foundation *Survey of Health Insurance Marketplace Assister Programs: A First Look at Consumer Assistance under the Affordable Care Act*

[8] AHRQ Guide to Patient and Family Engagement found at:
http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/howtogetstarted/index.html
Last access 9/3/15.

Figure 2. Hospital Website Survey of Consumer Engagement Tools

Consumer Engagement Elements	Number of Institutions
Patient Rights	39
Formal Complaint and Response Process	27
Patient & Family Advisory Council (PFAC)	7
Possess All Three	5

The CETF was also briefed by the Maryland Hospital Association on its 2013 hospital survey, which included a question regarding the presence of a PFAC in their institution. Of the 30 respondents, 40 percent said they had a PFAC; 40 percent said they did not; and 20 percent said they had no plans to establish a PFAC.

Consumer Engagement in Total Patient Revenue (TPR) Community Partnerships

Prior to the NAPM, several Maryland hospitals operating under a similar "Total Patient Revenue (TPR)" reimbursement model chose community partnerships and patient engagement to achieve their goals. Presentations and conversations with hospital and public health staff found that there are thriving programs and collaborative partnerships around the state that embody consumer engagement elements. Some examples include: (1) a program in Carroll County that utilizes a coalition of community members, community-based organizations, and health care providers to address mental health issues; (2) a Lower Shore (Worchester, Wicomico, and Somerset Counties) diabetes management program that involves a partnership between the community and health care providers; and (3) an initiative in a Western Maryland institution that utilized patient feedback to improve discharge planning.

D. Consumer Engagement Guiding Principles

To develop the specific objectives, strategies, and metrics that are the substance of this report, the CETF agreed to a core set of principles to advance the mission to "foster a health care system driven by a culture of robust and meaningful consumer engagement that addresses the Triple Aim." The CETF recommends that the HSCRC adopt the following guiding principles.

Principles

- **Participation:** People and communities participate and are involved in decision-making about the health care system.
- **Person-centered:** Engagement strategies and processes are centered on people and communities and personal preferences.
- **Accessible and Inclusive:** The needs of people and communities, particularly those who may experience barriers to effective engagement, are considered when determining steps to enhance accessibility and inclusion.
- **Partnership:** People, including health care providers, community, and health-related organizations work in partnership.

- **Diversity:** The engagement process values and supports the diversity of people, cultures, and communities.
- **Mutual Respect and Value:** Engagement is undertaken with mutual respect and the valuing of others' experiences and contributions.
- **Support:** People and communities are provided with the support and opportunities they need to engage in a meaningful way with the health care system.
- **Influence:** Consumer and community engagement influences health policy, planning, and system reform, and feedback is provided about how the engagement has influenced outcomes.
- **Continuous Improvement:** The engagement of people and communities are reviewed on an on-going basis and evaluated to drive continuous improvement.

V. Developing a Consumer Engagement Communication Strategy

Given the complexity and timeframe for the completion of the CETF's work, it was determined that one of the most productive and useful outcomes would be to provide the HSCRC with a strategic structure on which to build a full communications plan. The following provides such a structure specific to the NAPM. However, as stated above, there should be an integration of communications strategies across Maryland's multiple reform initiatives.

An NAPM-specific communications plan should be developed to build on the strategies proposed by the CETF, which should be considered as one element of a fully-integrated and coordinated statewide health care awareness campaign.

The following discussion provides the key elements of the Communications Plan. The full document can be found in Appendix D.

> *For consumers to engage and remain engaged, their involvement experience must be positive and their impact visible.*

A. Prioritizing the Audiences and Defining the Distribution Channels

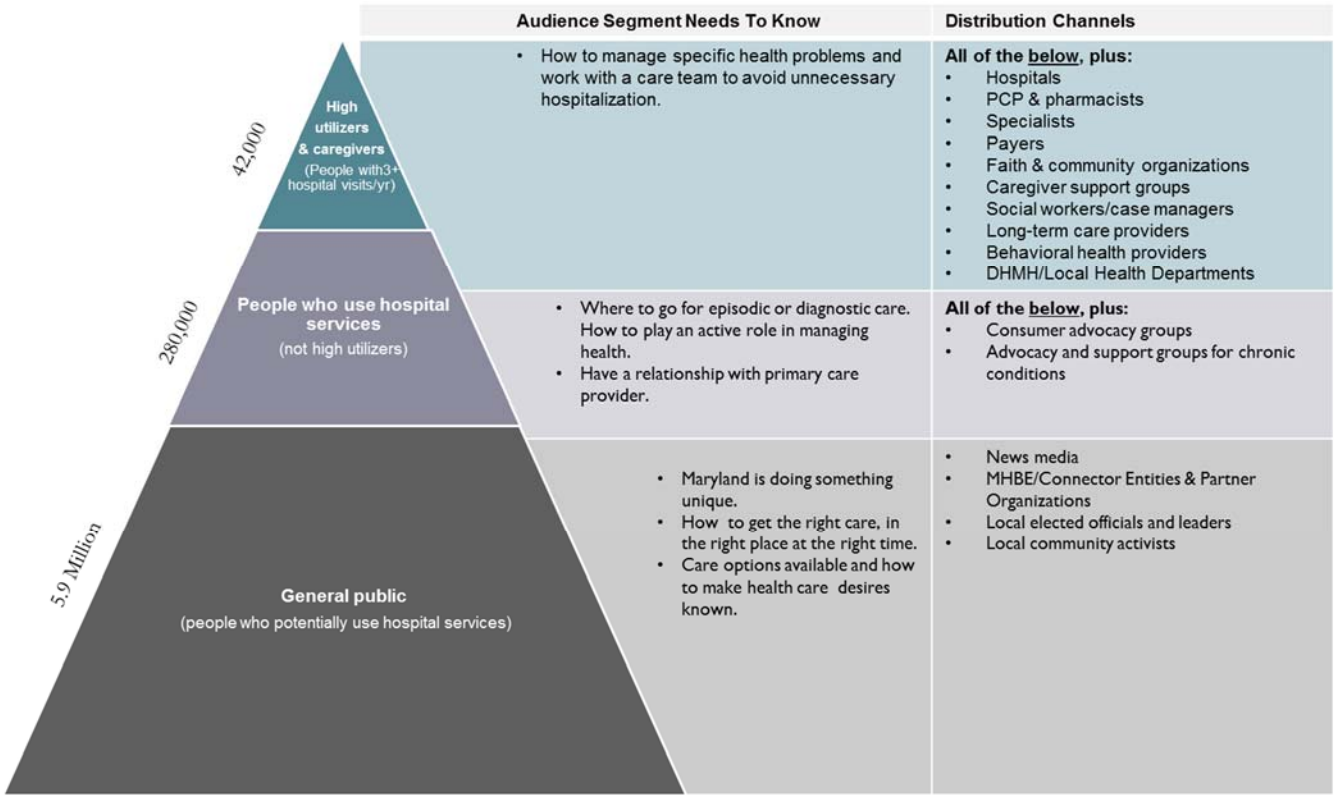
The CETF focused first on identifying target audiences. Given the definition of "consumers" as people who are current or potential users of health services, the CETF recognized that all Marylanders are among the target audiences for this initiative. The CETF segmented the audiences into three groups based on the frequency and level of their interactions with the health care system. Next, CETF worked to (1) articulate messages that might inspire the necessary behavior changes among each audience groups and (2) identify the messengers well-positioned to reach each audience segment.

Figure 3 below illustrates this segmentation noted above. It is important to note that the primary NAPM audiences—those who use the hospitals more than three times in a year—will be exposed to

a set of general messages designed for all audiences in addition to targeted messages focused on the behaviors that should be encouraged specifically within the primary target.

Based on the themes identified through this exploration, the CETF compiled an extensive group of messengers and/or distribution channels for each of the three audience segments. Figure 3 provides examples for each group; a more complete list can be found in Appendix D (the Communication Strategy). During the development of a communications plan, this list would be further refined to ensure the most effective communication avenues and positive outcomes.

Figure 3. Consumer Engagement Communication Audiences and Distribution Channels



B. A Consumer-Centered Approach to Material Development

The CETF recommends minimum standards for developing consumer-oriented materials in support of the NAPM and other related reform initiatives. Because all residents could potentially use hospital services, it is critical to adopt policies to tailor materials so they resonate and will be understood by the various segments. The considerations listed below should ensure the cultural and linguistic appropriateness of materials created, as well as the accessibility and usefulness of materials provided by government agencies, hospitals, health and social services providers, insurance carriers, and others.

Minimum Considerations for Material Development

- Consumer representatives are involved in developing materials

- Surveys and/or focus groups are used to solicit consumer feedback on the design, format, and final language of materials prior to mass production
- Materials reflect the cultural and linguistic diversity of the populations served
- Health literacy experts are involved in the development of materials to ensure that basic health literacy and Culturally and Linguistically Appropriate Services (CLAS) standards were followed in the development of materials
- Materials for consumers are written at or below a 6th grade reading level
- All electronic materials are Section 508 compliant, so they are presented in a manner that is accessible to audiences with disabilities or limitations
- All information is available in at least one format that is appropriate for all ability types
- All information is available in at least one format that is appropriate for all literacy levels (audio and video recordings or reading assistance for people who cannot read)
- All information is available in print, online, and mobile formats, allowing each consumer to select the format that is most helpful to him/her

C. Consumer Communications Strategy Recommended Goals and Objectives

Effective consumer engagement requires that individuals *own* their own health and health care, and that the HSCRC take ownership of a proactive consumer engagement plan that supports its commitment to a person-centered health care system. Therefore, it is imperative that the HSCRC embraces the principles, goals, objectives, and strategies outlined in the following recommendations and assumes a leadership role in implementing the overall communication strategy.

Goal #1

Establish a person-centered health care delivery system with an ongoing role for consumers to participate in the design and implementation of policies and procedures at all levels.

Objective 1.1 Create connections among government, hospitals, health care providers, community-based organizations, and individuals in the development of policies, procedures, and programs that will improve health outcomes and patient satisfaction while lowering system costs.

Objective 1.2 Engage, educate, and activate people who use hospital services in health policy, planning, service delivery, and evaluation at service and agency levels to ensure ongoing consumer support of and participation in health system decisions.

Goal #2

Engage, educate, and activate people who use or are potential users of hospital services in their own health care in order to promote efficient and effective use of the health care system.

Objective 2.1 Provide people who use or are potential users of hospital services with the information and resources needed to become health care aware consumers who are actively engaged in their own health care.

Objective 2.2 Support consumers' decision-making by providing clear, culturally and linguistically appropriate, and actionable information and opportunities for effective interactions with health care professionals.

Objective 2.3 Educate consumers about the most appropriate settings to receive care.

Objective 2.4 Support consumers in the appropriate use of care planning and self-management tools.

D. Strategies and Tactics

The following strategies and tactics are described below based on the stakeholder group that would have primary accountability for implementation. Each of these is directly linked to the objectives and strategies discussed in much greater detail in Appendix D.

For All Stakeholders

- Develop a statewide public education campaign to promote health and wellness and give consumers a sense of ownership of their health

For Policy Makers

- Foster a consumer-centered health care system with policies and procedures informed by stakeholder involvement

For Hospitals and Providers

- Incentivize hospitals to support patients' and caregivers' ability to manage their own care, including access to community based health care resources

For Consumers

- Provide consumers with the information, tools, and resources they need to make informed decisions and fully comprehend how to better manage their care
- Create a sense of ownership and involvement in the NAPM for the prime audiences by educating Marylanders about the NAPM and instilling pride and excitement that Maryland is creating a unique model of delivery system transformation
- Engage local and regional news media to distribute frequent updates about the NAPM to their audiences

E. Budget Estimate for Statewide NAPM Communication Strategy

To provide the HSCRC with an initial estimate of the required budget for a statewide NAPM-focused communications strategy, the CETF obtained cost estimates from two marketing and communications firms. These estimates ranged from $1.2 to $2.4 million for the initial campaign development and rollout. Both firms noted that the exact budget would vary based on the final scope of work and the extent/geographic coverage of any media buy associated with a campaign.

The CETF also undertook preliminary research to determine the cost of care interventions that support consumer engagement in both rural and urban settings. Because of the differences in the population, needs, and cost of living in various communities throughout the state, the cost of care interventions varies from place to place. The CETF notes that many of the proposed care interventions are underway in some parts of the state and are being considered by Regional Transformation Initiatives in other parts of the state.

Greater specificity will be required to develop a full project budget and funding resources. This would have to be based on the scope of work, the financial incentives and obligations of key stakeholders, and the range of funding options.

Two factors should be taken into account when considering both the communications and care interventions aspects of the budget. One factor is the potential to leverage the work currently under way through the Transformation Planning Grants and other hospital and community-based initiatives, as well as future grant opportunities. The second factor is the innovative approach Maryland is taking to delivery system reform with the NAPM. This should provide a range of funding opportunities that would include state-based agencies and organizations, foundations, and local and national entities.

VI. Evaluating Consumer Engagement

As previously mentioned, consumer engagement in health care is an emerging field. Consequently, the CETF was unable to locate validated metrics or tools that could directly and comprehensively evaluate the impact of consumer engagement on health outcomes, patient experience or satisfaction, provider satisfaction, improved program design decision-making, access, or utilization.

There are some measures that are currently available or that can be more readily developed with existing or potential data sources on the identified consumer engagement goal and objective "impact" areas, and there are areas where measures must be developed. Therefore, as illustrated in Figure 4, the CETF provides for consideration an initial non-exhaustive set of measures that could be adopted from:

- Existing data sources (e.g., Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS], Medicare claims, CRISP encounter information)
- Developed potential sources but not currently collected (e.g., the Communication Climate Assessment Toolkit (C-CAT))
- New sources that could potentially address the identified goals and objectives in which there are measurement gaps (e.g., HSCRC standing advisory committee, Patient Family Advisory Committees at hospitals)

It is important to note that there may be a "many to many" relationship for the candidate measures and the goals and objectives with which they are listed.

Figure 4. Potential Measures of Consumer Engagement

Goals and Objectives	Possible Measure(s)	Notes
Goal 1:Establish a consumer-centered health care delivery system with an ongoing role for consumers to participate in the design and implementation of policies and procedures at all levels.	HSCRC Consumer centered advisory committee	Suggestion to establish a standing advisory committee similar that of the Maryland Health Benefit Exchange
Objective 1. Create connections among government, hospitals, health care providers, community-based organizations, and individuals in the development of policies, procedures, and programs that will improve health outcomes, and patient satisfaction while lowering system costs.	Hospital meaningful use of Patient Family Advisory Committees	New measure to be developed Need to define "meaningful"
Objective 2. Engage, educate, and activate people who use hospital services in health policy, planning, service delivery and evaluation at service and agency levels to ensure ongoing consumer support of and participation in Health System decisions.	HCAHPS question on consumer overall rating of hospitals	HCAHPS in use since 2012
Goal 2:Engage, educate, and activate people who use or are potential users of hospital services in their own health care in order to promote efficient and effective use of the health care system.	HCAHPS CTM-3 Questions 1-The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital. 2-When I left the hospital, I had a good understanding of the things I was responsible for in managing my health 3-When I left the hospital, I clearly understood the purpose for taking each of my medications.	CTM-3 currently in use (since January 2014)
Objective 1. Provide people who use or are potential users of hospital services with the information and resources needed to become health care aware consumers who are actively engaged in their own health care.	For users of hospital services: • # of individuals with personal health records • Volume of materials disseminated about options for engaging in care For potential users of hospital services: • Visits to NAPM websites tools provided • Number of subscribers to telehealth resources • Posts/comments on NAPM related articles • Volume of sharing of NAPM news articles, etc.	New measures need to be developed. Need to determine universe of websites, and electronic resources we want to monitor.
Objective 2. Support consumers' decision-making by providing clear, culturally and linguistically appropriate, and actionable information and opportunities for effective interactions with health care professionals.	1-measuring each of health literacy, language services and individual engagement related to patient-centered communication, (0-100 score_ derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit 2-HCAHPS questions- Consumer ratings on communications with doctors and nurses, and responsiveness of hospital staff	1-CCAT would be a new survey to implement in the state 2-HCAHPS in use since 2012 Monitor for increase in percentages
Objective 3. Educate consumers about the most appropriate settings to receive care.	1-HCAHPS questions- Consumer rating of Discharge Information they received 2-Prevention Quality Indicators(PQI)- hospitalizations for ambulatory sensitive conditions	1-HCAHPS in use since 2012-monitor for increase in percentage 2-PQI measures currently in use in Maryland- monitor for decrease 3-NAPM measure (Medicare only- claims)

Goals and Objectives	Possible Measure(s)	Notes
	3-Appointment within 7 days after hospital stay 4- Person discharged where primary provider notified	4- NAPM measure (CRISP collects)
Objective 4. Support consumers in the appropriate use of care planning and self-management tools.	1-HCAHPS questions- Consumer rating of Communication About Medicines 2-Care plan usage for identified high risk target populations 3-Percentage of patients with chart documentation of advanced directives 4-Claims for advanced directive discussions	1-HCAHPS in use since 2012- monitor for increase in percentage 2-New measure to be developed and implemented- monitor for increase in percentage 3-New measure to be implemented in the state. Could build upon the current law that requires Medical Order for Life Sustaining Treatment (MOLST). Derived from EHR. Monitor for increase in percentages by hospital over time 4-CPT code 99497 covers a discussion of advance directives with the patient, a family member, or surrogate up to 30 minutes. The add-code of 99498 covers an additional 30 minutes of discussion. In July 2015 CMS proposed to cover these discussions for Medicare patients.

VII. Compelling Consumer Engagement Themes

The overarching themes and concepts that emerged during the research phase largely informed the CETF's recommendations. The themes include:

- Consumer engagement efforts must offer a clear call to action. Consumers' continued engagement is dependent on their input and perception that their actions have an impact.
- Because individuals' motives are different than institutions' motives, successful engagement efforts must ascertain the motivating factors for both groups.
- Health care information should be disseminated and consumer engagement activities should be led by sources that consumers trust.
- Sensitivity to diversity and the multitude of cultural differences are critical in engagement efforts.
- Consumer engagement requires extraordinary commitment from health care leadership at all levels.
- Ideally, consumers should be engaged, both prior to and at the point of contact with the health care system.
- A more robust and consumer-friendly feedback process (i.e., concerns, complaints, and commendations) is needed.
- Advanced directives planning is indicative of consumer engagement.

VIII. Recommendations

The HSCRC holds an important leadership role in influencing statewide adoption of meaningful consumer engagement in the use and design of the health care system. Based on extensive exploration of the current state of, and opportunities for, consumer engagement, the CETF makes the following recommendations. These are presented as specific activities the HSCRC can undertake to foster a person-centered, collaborative, coordinated system in Maryland.

1. Allow for continued meaningful, ongoing role for consumers at the HSCRC:
    a. Include continued representation of Commissioner(s) with primary consumer interest.
    b. Create an HSCRC Standing Advisory Committee (SAC) with representation that reflects the gender, racial, ethnic and geographic diversity of the state and a diverse cross-section of consumers, consumer advocates, relevant subject matter experts, and other stakeholders (see the MHBE and the Maryland Medicaid Advisory Committee [MMAC] as examples). In addition to providing expertise in the area of consumer engagement, the SAC would advise on the NAPM implementation, including evaluation of responsiveness to consumer feedback (concerns, complaints and commendations), and ensure that there is a clear infrastructure and process to provide the SAC with information from hospital patient advisory councils and other policy making boards, as well as providers and organizations working with potentially impacted consumers.

2. In collaboration with key stakeholders, develop a statewide public education campaign specific to the NAPM that is part of a broader campaign to promote health and wellnes.

3. Convene an interagency task force that allows consumers to participate in the design and implementation of a statewide public education campaign. As its foundation, this would have the advancement of consumer engagement and ownership in individuals' health with the use of the CETF's Communication Strategy as the foundation. Its charge and activities should be coordinated with the proposed SAC to ensure consumer representation. Moreover, it should be in coordination with the Maryland Department of Health and Mental Hygiene, Department of Human Resources, the MHBE, the MHCC, and all other relevant state agencies producing consumer-oriented information regarding engagement with the health care system.

4. Provide options and opportunities that support regular, longitudinal, and effective consumer engagement in the development of policies, procedures, and programs by hospitals, health care providers, health care payers, and government.

5. In coordination with the SAC, the MHCC and other key stakeholders, consider development of a Consumer Gold Star system for hospitals based on consumer engagement standards to include:
    a. Websites that reflect a commitment to consumer engagement and appropriate service to the community
    b. Educating patients about their rights
    c. An effective and meaningful consumer feedback process that includes access to

information and a process for prompt and substantive responses to consumer concerns

d. Multiple opportunities for patients/consumers to participate in patient and family advisory councils and other hospital policy board

6. Define Community Benefit dollars to include consumer engagement initiatives and promote these dollars for this use, particularly for those supporting vulnerable populations

7. Continue to encourage and incentivize independent and collaborative approaches to support people who are at risk of becoming high utilizers such as:
    a. Medication therapy management.
    b. Motivational interviewing.
    c. Health coaches.
    d. Peer support specialists for behavioral health and other special populations.
    e. Community clinical teams doing in home assessments.
    f. Incorporate clear simple case/care management screening during discharge that covers social and health aspects necessary for a successful care transition. Ensure that active listening and "teach back" methods are used during this screening.
    g. Emergency Department-based patient navigation that connects patients with appropriate community based resources (primary care, behavioral health care, social work case management, etc.).
    h. Collaboration with current recipients of Regional Transformation Planning Grants and future grantees to encourage them to engage consumers in developing their transformation plans.

8. Encourage hospitals to provide current, consistent, and transparent information on average procedure costs using the data made readily available by the MHCC (www.marylandqmdc.org) and new pricing transparency tools being created, and make this available on NAPM and/or other appropriate website(s).

9. Include discussions about patient and family decision-making and preferences about advanced directives in the context of educating and engaging consumers.

IX. Acknowledgements

The CETF commends the HSCRC Commissioners for their understanding of the value of engaging consumers at all levels. Their commitment to this effort has been both meaningful and substantive and stands as a model for other state reform efforts. We also wish to recognize the leadership of Donna Kinzer and to thank the HSCRC staff. In particular, Steve Ports and Dianne Feeney have made critical contributions to the work of the CETF and to the content of this report. Theressa Lee of the MHCC also deserves recognition for her expertise and insights and her dedication to the concept of consumer engagement. In addition, the CETF's work would not have been possible without the able assistance of Tiffany Tate, project consultant.

This report represents not an end, but rather a beginning, to ensure that consumers are fully engaged not only in their own health, but also in the evolution and success of Maryland's NAPM. The members of the CETF are grateful for the opportunity to inform that process and are committed to supporting this effort as we move forward.

APPENDIX A. CETF Member Roster

Leni Preston, Chair
Chair/Executive Director
Maryland Women's Coalition for Health Care Reform

Linda Aldoory
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Tammy Bresnahan
Associate State Director of Advocacy
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Barbara Brookmyer
Health Officer,
Frederick County Health Department

Kim Burton
Director of Older Adult Programs
Mental Health Association of Maryland

Michelle Clark
Executive Director
Maryland Rural Health Association

Shannon Hines
Senior Director, Health Education/Health Promotion/Women's Health
Kaiser Permanente MAS

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Senior Vice President,
Government and Regulatory Affairs
University of Maryland Medical System

Michelle LaRue
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CASA DE MARYLAND

Karen Ann Lichtenstein
CEO/President
The Coordinating Center

Susan Markley
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HealthCare Access Maryland

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Gary Vogan
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APPENDIX B. CETF Methodology

Through its exploration of the existing literature both within and outside the United States, the CETF agreed to a definition of consumer engagement, collected data and information on the current state of consumer engagement infrastructure in Maryland, identified strategies to implement consumer-centric communication strategy, and devised metrics that can be used measure the impact of this consumer engagement activities.

The CETF met at least monthly to expand their knowledge about consumer engagement and monitor progress towards the two charges. A subgroup, composed of members and interested professionals, met more frequently to collaborate on more involved activities of the workgroup. Finally, a few members from the CETF were represented on a subgroup that also included representatives from the Consumer Outreach Task Force. It was the role of this combined group to ensure alignment between the individual taskforces.

The CETF responded to the limited evidence-based on consumer engagement by seeking information and insight from individuals and organizations that had expertise or experience in related areas. These entities presented at task force and subgroup meetings and participated in e-mail discussions and one-on-one conversations. Below are the areas for which the subject matter experts and independent research provided the CETF's insight and guidance.

Expertise and Perspectives Explored

- Consumer Advocacy
- Care Coordination
- Population Health Management
- Health Care Quality Report
- Consumer Engagement in Total Patient Revenue (TPR) environment
- Geographic Targeting
- Patient/Consumer Engagement Infrastructures in Hospital Settings
- Disposition of Consumer Complaints by Hospital and Government Entities
- Online Resources to Support
- Performance Measures to Assess Consumer/Patient Engagement
- Consumers

APPENDIX C. Consumer Engagement Definitions and Principles

Health Services Cost Review Commission
New All-Payer Model: Consumer Engagement Taskforce
Proposed Useful Definitions and Principles

==========

The following are based on the Consumer and Community Engagement Framework[1] developed by Health Consumers Queensland and are proposed here as a basis for consumer engagement.

Proposed Useful Definitions

Consumers: Consumers are defined as current or potential users of health services. This may include family members as well as those who provide care in an unpaid capacity.

***Community*:** Community refers to groups of people or organizations with a common local or regional interest in health. There are three primary ways in which a community may be formed: (1) geographic boundaries (neighborhood, region, etc.); (2) interests such as patients, health care providers, industry sector, profession, etc.; and/or (3) specific issue such as improvements to public health or groups that share cultural backgrounds, religions, or language(s).

***Consumer Engagement*:** Consumer engagement informs broader community engagement. Health consumers are people who actively participate in their own health care and, more broadly, in health policy, planning, service delivery and evaluation at service and agency levels.

***Community Engagement*:** Community engagement refers to the connections between government, communities and citizens in the development of policies, programs, services, and projects. It encompasses a wide variety of government community interactions, ranging from information sharing to community consultation and, in some instances, active participation in government decision-making. It incorporates public participation, with individuals being empowered to contribute in decisions affecting their lives, through acquisition of skills, knowledge, and experience.

[1] The full document can be found at http://www.health.qld.gov.au/hcq/publications/consumerengagement

Proposed Principles - Consumer and Community Engagement

#1 - Participation: People and communities participate and are involved in decision-making about the health care system.

#2 - Person-centered: Engagement strategies and processes are centered on people and communities.

#3 - Accessible and Inclusive: The needs of people and communities, particularly those who may experience barriers to effective engagement, are considered when determining steps to enhance accessibility and inclusion.

***#4 - Partnership*:** People, including health care providers, community, and health-related organizations work in partnership.

#5 - Diversity: The engagement process values and supports the diversity of people and communities.

***#6 - Mutual Respect and Value*:** Engagement is undertaken with mutual respect and the valuing of others' experiences and contributions.

#7 - Support: People and communities are provided with the support and opportunities they need to engage in a meaningful way with the health care system.

#8 - Influence: Consumer and community engagement influences health policy, Planning, and system reform, and feedback is provided about how the engagement has influenced outcomes.

#9 - Continuous Improvement: The engagement of people and communities are reviewed on an on-going basis and evaluated to drive continuous improvement.

APPENDIX D. Communication Strategy

Maryland All Payer Model
Consumer Engagement Communication Strategy

Developed by the Consumer Engagement Task Force
September 9, 2015

Audiences and Messages

It is imperative to recognize that:

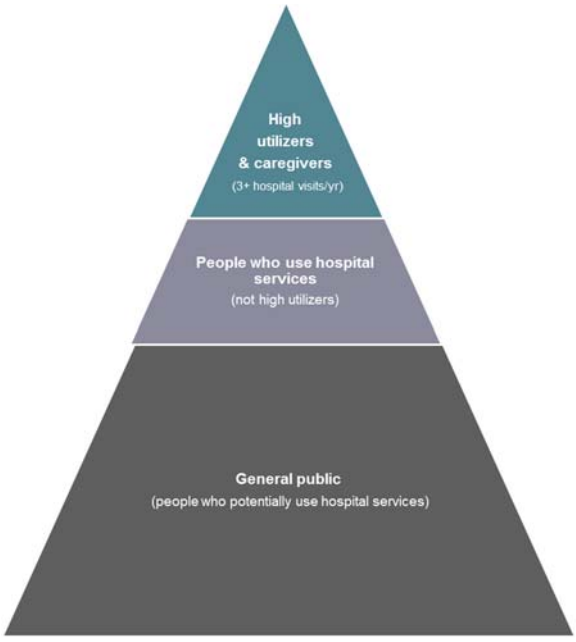
- Consumers/patients who have appropriate information about disease prevention and tools targeted for their specific circumstances will have better health outcomes with lower costs to the system.
- Individualized engagement is critical. Meet the patient where they are and consider their cultural background, literacy level, and prior experience with the health care system.
- Trust, dialogue, collaboration, and shared decision-making with consumers produce better outcomes.
- "Health literate" consumers are more likely to make wise decisions and adopt a healthy lifestyle

Audience Segmentation

All Marylanders are among the target audiences for this initiative. Target audiences are segmented based on their priority and include:

- People who are frequent users of hospital services (three or more hospital visits per year), and who need to know how to manage specific health problems and work with a care team to avoid hospitalization.
- People who use hospital services, but are not frequent users, and need to know where to go for episodic or diagnostic care; how to play an active role in managing health; and, how to establish a relationship with a primary care provider.
- The general public, who are potential users of hospital services and need to become aware of the care options available; know how to access timely and appropriate health services; be prepared to make their health care desires known; and understand that their actions can impact a unique initiative taking place in Maryland.

Figure 1: Target Audience Segmentation



Next steps are to articulate messages that will motivate the specific behavior change needed among each audience segment and identify the messengers well positioned to reach each audience group.

Messaging Framework

The messaging framework illustrated below in Figure 2 is based upon the audience pyramid and conveys key information and concepts to share with consumers in order to increase their engagement with the health system and, ultimately incentivize and empower them to be more active in their health. The messaging framework for each audience builds upon itself and channels messages to audiences based on their priority so that people who frequently use hospital services,

who require a greater level of engagement, will receive specific information tailored for them in addition to the more general information people who use hospital services but aren't frequent users, and the general public.

These proposed messages were developed in coordination with the findings of the focus groups and community forums conducted by the Consumer Outreach Task Force. The messaging framework does not represent the final language to be used on communications materials, rather it outlines the concepts to be shared with consumers in order to heighten their awareness of the NAPM and evolving health care system transformation, increase their engagement with the health care system, and motivate them to take a more active role in self-management.

Figure 2. Messaging Framework Audiences and Potential Messages

Audience	Potential Messages
All • General public • People who use hospital services • High utilizers	• Maryland is doing something unique and *you* are a part of it. • There is an agency that sets the rates hospitals are paid. *Concept*: Hospitals do not have the freedom to set their own pricing. . • Transformation of the health care delivery system should help you to get the right care, in the right place, at the right time. • Your health. Your life. – Your hospital is here to help you be as healthy as possible. o Prevention is the most affordable care - see your doctor, eat healthy, live well. o Teamwork among hospital and in the community, will make it easier for you to get care. o Know where to get the care that best meets your needs (you might pay more if you get care in the wrong setting). o Make good decisions by being informed about the cost of your health care and your financial responsibility o Shop for health care that meets your needs. o Shop for health care quality; high cost does not always equal high quality care. o You can control who sees your health information. o Use the tools that are available to help make health care decisions that are best for you.

Audience	Potential Messages

Primary & Secondary
• People who use hospital services (not high utilizers)
• High utilizers (3+ hospital visits/yr)
	• Create a plan to get healthy and stay healthy
	• Be active in managing your own health
	• Find a trusted person to help manage your care
	• Make sure a trusted person knows how you want to be cared for if you can't make decisions for yourself.
	• Have a relationship with your primary care provider
	• Before you leave the hospital make sure you have a plan and understand:
	  o What you should do when you leave the hospital
	  o Who you should call if you have a problem ***when you leave*** the hospital
	  o Who you should call ***before*** you go to the hospital again
	  o Where to go if you need help looking after yourself
	• Know what might cause your readmission to the hospital
	• Know how to access the support and services you need to keep you from having to go back to the hospital

Primary High Utilizers (3+ hospital visits/yr)	• You and your care team manage your health to stay out of the hospital • Stay involved in managing your own health care • Create a trusted relationship with your providers • Understand your care options

Messengers and Distribution Channels

Figure 3 below, while not providing a wholly inclusive list, illustrates the breadth of opportunities to engage with patients and consumers.

Figure 3. Audiences and Key Messengers/Opportunities

Audience	Key Messengers
Primary High utilizers Caregivers/Guardians	• Hospitals o Medical staff o Hospital volunteers and clergy o Discharge planners o Case Managers/Patient navigators o Billing office o Web-based resources • Payers • Community health workers • Community health clinics • Faith and other community-based organizations • Rehabilitation centers • Home health • Pharmacists • Primary care physicians • Caregiver support groups • Urgent care providers • Social workers/case managers • Long-term care facilities/providers • Rehabilitation facilities/providers • Behavioral health providers • DHMH/Local Health Departments • DSS offices • Department of Aging • Maryland Access Point • Philanthropic Foundations

Audience	Key Messengers
Secondary People who use hospital services	**All of the above plus:** • Consumer advocacy groups • Advocacy and support groups for chronic conditions • ER waiting rooms (to reduce inappropriate use)
All General public	**All of the above plus:** • News media (traditional and online including local newspapers, magazines, and radio stations) • Faith and other community-based organizations (materials, meetings, health fairs, etc.) • Urgent care providers • MHBE/Connector Entities & Partner Organizations • Members of town and county councils • Local community activists

Strategies and Tactics for Consumer Engagement

Strategies must be applied at all levels in order to maximize the potential for successfully achieving a health care system with a culture of consumer engagement and all the benefits that brings. The text below outlines the strategies and tactics that can be undertaken by all stakeholders as well as at the policy maker, provider and consumer levels.

A note about reaching vulnerable populations:

This document provides recommendations for general consumer engagement. It is critical to note that effective engagement of some populations may require specialized efforts beyond what is proposed in this document. This includes people with severe mental illness, active substance

For All Stakeholders

Develop a statewide public education campaign to promote consumer ownership of their own health and wellness.

- Coordinate with the Department of Health and Mental Hygiene, Department of Human Resources, Maryland Health Benefit Exchange, Maryland Health Care Commission, and all other relevant state agencies producing consumer oriented information regarding engagement with the health care system.
- Create an inter-agency task-force that includes consumer representatives, convened by HSCRC to design and facilitate the campaign. Its charge and activities should be coordinated with the proposed HSCRC Standing Advisory Committee.

- Establish a descriptive, compelling, and memorable brand for the NAPM including a logo with visual style guidelines (colors, fonts, imagery, etc.) and tagline with consistent supporting messages (see Messaging Framework)
- Ensure that all "official" consumer engagement materials are branded with core visual elements and messages
- Develop standard materials as templates that can be customized with branding and sub messages specific to diverse stakeholders including hospitals, primary care practices, specialty care practices, advocacy and support groups for chronic conditions, etc.
- To the extent possible, develop materials with a neutral appearance that complements the branding and visual style guides of as many hospitals as possible.(Be realistic about the extent to which this is possible, if branding styles are too disparate complement the look and feel of MHA materials.)
- Encourage hospitals, social service providers, consumer advocates, etc. to localize NAPM materials as appropriate for the distinct communities they serve while being careful not to compromise the brand.

For Policy Makers

Foster a consumer-centered health care system with policies and procedures informed by stakeholder involvement:

- Continue to foster representation on the Health Services and Cost Review Commission (HSCRC) whose principal role is to represent the interests of consumers.
- Create an HSCRC standing advisory committee with representation that reflects the gender, racial, ethnic and geographic diversity of the state and a diverse cross-section of consumer groups and other stakeholders (see MHBE and MMAC as examples). The purpose would be to advise on the NAPM implementation, including evaluation of responsiveness to consumer feedback (concerns, complaints and commendations, and ensuring that there is a clear infrastructure and process to provide the Committee with information from hospital patient advisory councils and other policy making boards, as well as providers and organizations working with potentially impacted consumers. [or targeted populations]
- Educate consumers and consumer groups about how to effectively impact: NAPM implementation, including opportunities to serve on and/or interact with HSCRC SAC and hospital patient and family advisory councils, and/or other hospital policy boards
- Promote standardizing hospitals' process for receiving feedback from consumers, including for comments, complaints and commendations
- Establish data systems to aggregate and analyze consumer feedback in a timely and transparent fashion
- Ensure that there is a meaningful evaluation of and response to complaints at the agency level.
- Continue to provide incentives to support regular, longitudinal and effective consumer engagement in the development of policies, procedures, and programs by hospitals, health care providers, health care payers, and government.

- Develop and distribute information about how to provide consumer feedback for both state agencies and hospitals - in multiple formats (print and electronic) and that is culturally and linguistically appropriate for diverse populations
- Promote hospitals' providing multiple opportunities for consumers, representing the diversity of its community, to provide meaningful input on hospital policies such as Patient and Family Advisory Councils or seats on relevant policymaking bodies.
- In coordination with the SAC, develop and promote a Consumer *Gold Star* system for hospitals based upon consumer engagement standards may include:
  - websites that reflect a commitment to consumer engagement and appropriate service to the community
  - ensuring that patients understand their rights
  - the consumer feedback process, including access to information and process for prompt and meaningful responses to consumer concerns
  - multiple opportunities for patients/consumers to participate in patient and family advisory councils and other hospital policy boards

For Hospitals and Providers

Incentivize hospitals to support patients and care-givers ability to manage their own care, including access to community based health care resources

- Incentivize ongoing collaborations between hospitals and community-based organizations including health and social services organizations, faith communities, neighborhood associations, fraternal organizations (rotary clubs, lions clubs, masons, etc.) and other groups working to better their communities
- Promote the use of Community Benefit dollars to advance consumer engagement initiatives, particularly for those supporting vulnerable populations
- Incorporate clear simple case management screening during discharge that covers social *and* health aspects necessary for a successful care transition. Ensure active listening and teach back methods are used during this screening.
- Reward independent and collaborative approaches to support patients who are at risk of becoming high utilizers such as:
  - Medication therapy management
  - Motivational interviewing
  - Health coaches
  - Peer support specialists for behavioral health and other special populations
  - Community clinical teams doing in home assessments
- Encourage and reward Emergency Department based patient navigation that connects patients with appropriate community based resources (primary care, behavioral health care, social work case management, etc.).
- Require hospitals to provide current, consistent, and transparent information on average procedure costs using the data made readily available by the Maryland Health Care Commission

(www.marylandqmdc.org) and new pricing transparency tools being created, and make this available on NAPM and/or other appropriate website(s)

- Collaborate with current recipients of Regional Transformation Planning Grants, and future grantees to encourage them to engage consumers in developing their transformation plans.

For Consumers

A. Provide consumers (patients, caregivers, etc.) with the information and resources they need to make wise decisions and better manage their care.

- Educate and empower consumers to seek care in the most appropriate setting for their needs. Inform consumers about appropriate vs. inappropriate use of hospital services and provide realistic community-based alternatives.
- Develop patient informed care planning resources to promote personal responsibility for care including advance directive assistance, power of attorney for healthcare, etc.
- Provide patients and caregivers with a care-transitions roadmap that illustrates each step of the care transition and directs consumers to helpful community-based health and social service resources.
- Create a comprehensive, searchable guide to community-based resources (print and online) and allocate resources to keep this up to date. The guide should include the name and description of services as well as operating hours, average cost of services, payer types etc.
- Provide consumers with a *health care passport* to complement electronic data transfer. The health care passport will be a hard copy document that consumers can use to keep track of their health records including lists of health care providers, procedures, medications, vaccinations, etc. (Relying 100% on electronic health records and CRISP leaves out the most important person in the care team, the patient!)
- Incentivize hospitals and providers to offer consumers the option of electronic resources such as tele health, SMS follow up reminders, patient portals, health apps, etc. to help patients and caregivers participate more actively in self-care.
- Work with CRISP et al, to develop clear communication materials about the HIE, including one consent form that can be used for any hospital or community provider.
- Employ Singh Index of neighborhood disadvantage to identify localized communities with high rates of hospital readmission. Focus engagement strategies for high utilizers and care givers on these areas.

B. Create a sense of ownership and involvement in the NAPM for the prime audiences by educating Marylanders about the NAPM and instilling pride and excitement that Maryland is creating a unique model of delivery system transformation

- Create a NAPM-specific website to serve as a single online resource that includes information on NAPM progress and successes as well as information directly relevant to consumers with links from that site to appropriate external resources, such as MHCC.
    - Use simple, memorable web addresses and links that are optimized for search engines.
    - Ensure that the front-end of this website appears sleek and easy to navigate, avoid

adding information to a crowded existing site.

- Raise awareness of the NAPM and involve the public in the countdown.
- Modify display of state dashboard showing progress toward meeting NAPM goals so that it is meaningful to consumers (similar to a fundraising campaign). Promote this dashboard so that the public can easily find it.
- Mobilize grass-roots consumer advocates and community organizers and partners to act as "ambassadors" for the NAPM throughout the state in their home communities.

C. Engage local and regional news media to distribute frequent updates about the NAPM to their audiences

- Distribute frequent news releases and host press events to highlight NAPM successes, challenges; and, opportunities for consumer engagement.
- Issue frequent "report cards" illustrating progress toward meeting NAPM goals. Use this as a mechanism to celebrate successes and be transparent and forthcoming about challenges, possible solutions, and impact on consumers.
- Develop talking points and engage people who command public attention as "champions" to talk about the NAPMs goals for improved quality of care and patient experience to their captive audiences and local communities (elected officials, community activists, local athletes and celebrities, business leaders, faith leaders, etc.).

APPENDIX E. Resource List

American Hospital Association- Strategies for Leadership: Patient and Family Centered Care
http://www.aha.org/advocacy-issues/quality/strategies-patientcentered.shtml

Agency for Healthcare Research and Quality – Patient & Family Engagement
www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/modules/patfamilyengagement/index.html

Center for Advancing Health

Patient Engagement
http://www.cfah.org/engagement/

A New Definition of Patient Engagement: What is Engagement and Why is it Important
http://www.cfah.org/pdfs/CFAH_Engagement_Behavior_Framework_current.pdf

Centers for Medicare and Medicaid Services– From Coverage to Care
https://marketplace.cms.gov/technical-assistance-resources/c2c.html

Consumers Union

Engaging Consumers on Health Care Costs & Value Issues
http://consumersunion.org/research/engaging-consumers-on-health-care-cost-and-value-issues/

Consumer Attitudes Toward Health Care Costs, Value, and System Reforms: A Review of the Literature
http://consumersunion.org/research/consumer-attitudes-toward-health-care-costs-value-and-system-reforms-a-review-of-the-literature/

Health Affairs Blog. "The Time is Now for a Consumer Health Movement."
http://healthaffairs.org/blog/2015/09/03/the-time-is-now-for-a-consumer-health-movement/

Institute for Patient and Family Centered Care- Patient and Family Advisory Committee Toolkit and other resources
http://www.ipfcc.org/tools/index.html

Maryland Citizens' Health Initiative Education Fund ("MCHI")/Health Care for All
http://healthcareforall.com/

Maryland Women's Coalition for Healthcare Reform- Checklists
www.mdhealthcarereform.org

University of Maryland Extension – Smart Choice for Health Insurance
http://extension.umd.edu/insure

University of Maryland – Horowitz Center for Health Literacy
http://sph.umd.edu/center/hchl

Urban Institute - Health Literacy
http://hrms.urban.org/briefs/Low-Levels-of-Self-Reported-Literacy-and-Numeracy.html

Consumer Outreach Taskforce Report

Maryland Citizens' Health Initiative Education Fund, Inc.
Vincent DeMarco
September 2015

Rationale

- Marylanders are unaware of the state's unique and long-standing status as an all-payer state or of the new state/federal agreement that is further transforming the health system in Maryland.
- Consumer engagement in these efforts is crucial to make Maryland's new system a success.

Task force members

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Carmela Coyle, MHA
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Tiffany Tate, Consultant
Nikki Highsmith Vernick, Horizon Foundation
Rev. Fred Weimert, Central Maryland Ecumenical Council

Forums

- Format
  - Welcome from host
  - Presentation by HSCRC/MHA
  - Local panel of stakeholders
  - Presentation of Faith Community Health Network concept
  - Q&A
  - Evaluations

Forums

Number of forums	11	
Number of participants	800+	
Evaluation response rate	42%1	
Presenters	• HSCRC • Local Health Improvement Coalitions • Hospitals and health systems • Community health providers	• Health Departments • Faith communities • MCHI • Foundations
Attendees	• Consumers • Government agencies • Community groups • Providers/provider groups	• Hospitals/health systems • Faith-based • Civic organizations • Union Members
Constituents of Attendees	• Diverse populations/minorities • Seniors • Low-income populations • Immigrants • Chronically Ill	• Children • Families • Caregivers • Parishioners • Healthcare providers and workers

1 Excluding Lower Easter shore, which did not have evaluation forms.

Consumer Feedback

- Consumers are eager for more information
  - **Timely**
    - Prior to hospitalization
    - Design phase/launch of care coordination programs
  - **Consistent**
    - Esp. in areas with competing providers
  - **Available in multiple formats**
    - Primary care providers, faith leaders
    - Traditional news outlets
    - Social media

Recommendations

- Periodically convene stakeholders and consumers to provide updates on the progress of health system transformation
- Continue to give consumers a voice in the transformation of Maryland's health system
- Encourage local leaders to develop and join a dynamic Faith Community Health Network
- Collaborate to educate primary care providers on—and engage them in—health system transformation
- Maximize communications with consumers via traditional and new media

Thank you!

Vincent DeMarco, President

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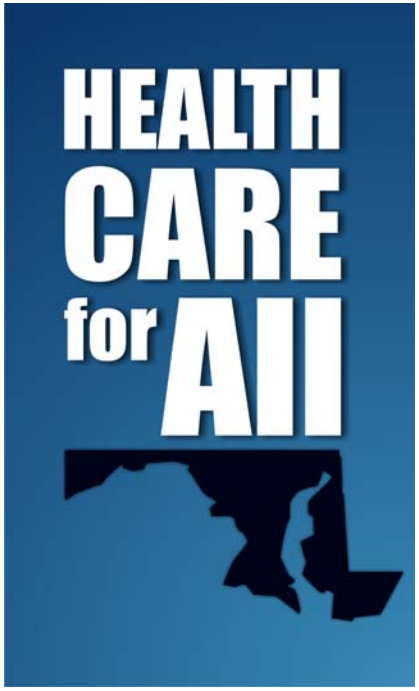

A NEW DAY FOR HEALTHCARE IN MARYLAND

HSCRC Consumer Outreach Task Force Report

Maryland Citizens' Health Initiative Education Fund, Inc.
August 2015

Maryland Citizens' Health Initiative Education Fund, Inc.
2600 St. Paul St.
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Executive Summary

As leader of the Health Services Cost Review Commission's (HSCRC) Consumer Outreach Task Force (Appendix A), over the past seven months the Maryland Citizens' Health Initiative Education Fund, Inc. (MCHI) has collaborated with Local Health Improvement Coalitions (LHIC), health departments, hospitals, local community and faith leaders, and the Maryland Hospital Association (MHA) to hold eleven public forums all across the state about health system transformation.

Over 800 Marylanders representing over 300 community, health, faith, business, government, union, and policy organizations have heard the message that their local hospitals, healthcare providers, and community-based organizations are working together to help Marylanders be as healthy as possible. Feedback shows that Marylanders are unaware of the state's unique and long-standing status as an all-payer state or of the new state/federal agreement that is further transforming the health system in Maryland. Once informed, however, consumers are eager to be engaged. They want a clear call to action and follow-up steps for ongoing collaboration.

This report details MCHI's rationale for the forums and our process, themes in the consumer feedback and our recommendations. We also include region-specific summaries and broad themes for local application and analysis. The recommendations to the HSCRC for continued outreach to consumers are summarized below and described in detail on Page 10 of this report. This guidance is based on our work and on consumer feedback gathered from communities across the state.

Recommendations to the HSCRC for Continued Consumer Outreach

1. Periodically convene stakeholders and consumers to provide updates on the progress of health system transformation
2. Continue to give consumers a voice in the transformation of Maryland's health system
3. Encourage local leaders to develop and join a dynamic Faith Community Health Network
4. Collaborate to educate primary care providers on—and engage them in—health system transformation
5. Maximize communications with consumers via traditional and new media

As a leading consumer advocacy organization, MCHI has laid a strong foundation upon which deeper consumer involvement in health system transformation in communities across the state can be built. We are committed to further supporting these efforts as our health care system continues to evolve. We have greatly appreciated the HSCRC's support of the work detailed in this report and look forward to continuing this fruitful collaboration to ensure that Maryland's reformed health care system is built upon the needs and interests of all Maryland health care consumers.

Summary

Number of forums	11	
Number of participants	800+	
Evaluation response rate	42%[1]	
Presenters	• HSCRC • Local Health Improvement Coalitions • Hospitals and health systems • Community health providers	• Health Departments • Faith communities • MCHI • Foundations
Attendees	• Consumers • Government agencies • Community groups • Providers/provider groups	• Hospitals/health systems • Faith-based • Civic organizations • Union Members
Constituents of Attendees	• Diverse populations/minorities • Seniors • Low-income populations • Immigrants • Chronically Ill	• Children • Families • Caregivers • Parishioners • Healthcare providers and workers

Rationale

Hospitals in Maryland have new incentives to prevent unnecessary hospital admissions and readmissions, and provide even higher quality of care to their patients by strengthening their relationships with their local communities.[2] The intended results are better outcomes for patients, healthier people, lower costs, lower health care costs per capita and a health care system that is easier for consumers to navigate. In order to maintain this new system, Maryland must achieve ambitious goals that have been set by the Centers for Medicare and Medicaid Services.

Consumer engagement in these efforts is crucial to make Maryland's new system a success. During these eleven forums, representatives from the health care delivery system received feedback from health agencies, providers and consumers to help define organizational

[1] Excluding Lower Easter shore, which did not have evaluation forms.

[2] The new incentives are part of a five-year demonstration project that the state of Maryland and Maryland hospitals entered into with the federal government's Centers for Medicare and Medicaid Services. This demonstration project is one of a kind in the nation.

priorities, address current problems, and develop and strengthen new relationships. At the same time, consumers and their caregivers learned more about how to understand their newly modified health delivery system and the incentives that it creates to integrate their care. The meetings also addressed how the system is using their feedback for continued quality improvement.

Process

To arrange forums, MCHI collaborated with local health departments and hospitals through LHICs and MHA. We also reached out to our current coalition partners and did more broad-based outreach to local groups. These collaborations were critical to ensure that the forums were tailored to the specific needs of the local communities. We joined existing meetings wherever possible, which resulted in greater participation and allowed us to build relationships with new partners.

To ensure high turnout, MCHI and local partners invited their coalitions and networks through email, social media and phone calls. Outreach to faith communities, vulnerable older adults and their caregivers, and community groups were prioritized. People who expressed an interest in attending were encouraged to share the invitation with others who might be interested. As a result, over 800 people from more than 300 organizations participated. See Appendix B for a full list of organizations.

The most common format for the forums was as follows:

- Welcome by the local host(s) and MCHI;
- Presentation on the new Maryland health care landscape by a representative of the Health Services Cost Review Commission (HSCRC) or MHA;

- Local panel of representatives from hospitals, health departments and/or community organizations;
- Presentation on the Maryland Faith Community Health Network by MCHI and a faith leader often from the Baltimore Washington Conference of the United Methodist Church (BWCUMC);
- Q&A and discussion with the attendees.

Evaluation forms were collected as attendees left. These forms evolved based on feedback from the HSCRC Consumer Engagement Taskforce as each forum was completed. For forums that were integrated into the agendas of LHIC meetings in very rural areas, there were shorter presentations and discussions. Following every forum, participants who provided their email addresses received a link to minutes, agendas, and presentations from the forums.

Region	People	State presenters	Local presenters
Howard Co.	130	HSCRC, MCHI, BWCUMC	Howard County Local Health Improvement Coalition, Howard County Health Department, Howard County General Hospital, MD Health Care Innovations Collaborative, Horizon Foundation
Prince George's Co.	90	HSCRC, MCHI	Collective Empowerment, Prince George's Health Department, Dimensions Health Care System, MedStar Southern Maryland Hospital Center
Northern MD	69	HSCRC, MCHI, BWCUMC	Carroll County Health Department, Carroll Hospital Center, Partnership for a Healthier Carroll County
Lower Shore	30	HSCRC, MCHI	Tri County Health Improvement Coalition
Mid Shore	37	MCHI	Mid Shore Health Improvement Coalition
Southern MD	65	DHMH, MHA, MCHI, BWCUMC	Health Partners Free Clinic, Charles County Health Department
Western MD	25	HSCRC, MCHI	Cumberland Ministerial Association, Western Maryland Health System, St. John's Lutheran Church, Western MD Health System, Allegany County Health Department
Baltimore Co.	70	HSCRC, MCHI	Baltimore County Health Department, GBMC, LifeBridge Health, MedStar Health
Montgomery Co.	73	HSCRC, MCHI, BWCUMC	Holy Cross Health, Adventist Health Care, Suburban Hospital, MedStar Montgomery
Anne Arundel Co.	65	HSCRC, MCHI	Anne Arundel County Health Department, University of Maryland Baltimore Washington Medical Center, Anne Arundel Medical Center, United Christian Clergy of Anne Arundel County, Keswick Community Health Services
Baltimore City	160	HSCRC, MCHI, BWCUMC	Bon Secours Hospital, Central Baptist Church of Baltimore, Baltimore City Health Department, Johns Hopkins Bayview Medical Center, MedStar Health, St. Agnes Hospital

Hospitals discussed existing and potential new partnerships with other hospitals and community health providers, many of which were made possible through Community Health Resources Commission (CHRC) grants. The CHRC has prioritized supporting efforts that involve intensive care coordination for at-risk populations and awarded a number of grants that are designed to expand access and help reduce avoidable hospital costs. Several of these grantees, such as Anne Arundel Medical Center, Medstar Union Memorial Hospital, the Allegany County Health Department, and multiple Local Health Improvement Coalitions, spoke at the forums.

Consumer feedback was collected in multiple ways to identify themes from as many participants as possible, including minutes, observations, conversations with attendees and evaluation forms. Minutes are available online and summaries of the evaluation forms were written for forums that utilized them. Although the evaluation form response rate was relatively high at 42%, these forms alone do not form a complete picture. They evolved over time and no testing (e.g. cognitive debriefing) was conducted due to lack of time.

Feedback from Consumers and Local Leaders

Understanding the Health Care System is Empowering

Forum participants overwhelmingly found the information useful and, based on evaluations, had never heard of Maryland's unique health care landscape before. Participants described health system transformation as a system in which health care providers work together to help keep the public healthy. Consumers and local leaders are willing and ready to take a deeper dive with their local health care providers on how to improve local health systems. It is clear that consumers understand that they have a stake in the success of this major policy experiment and felt empowered by having a voice at these regional discussions. Learning more about what is happening in Maryland left them feeling empowered personally, socially, physically and financially.

Personally and Socially Empowering

While many of the people who participated in the forums have a professional interest in the health and well-being of the community, many acknowledged a personal interest in the success of our unique health care system as well. During discussions, participants were quick to identify community challenges and resources to address social determinants of health, challenges accessing primary care, behavioral health services, culturally and linguistically appropriate services, housing and nutrition. They were excited for new opportunities to form partnerships with hospital systems.

"FAITH COMMUNITY HEALTH NURSES ARE THERE FOR THEIR CONGREGATIONS AND THEIR BROADER COMMUNITIES."

Becky Boeckman, Director of Pastoral Care at First United Methodist Church in Laurel

People of faith were intrigued and expressed interest in supporting this work. Faith Community Health Nurses were particularly interested in working with hospitals; they saw themselves as natural allies in building a bridge to the communities a hospital serves. Following the forums many provided their contact information specifically to stay in touch about developing a local Faith Community Health Network.

Physically and Financially Empowering

Hospitals discussed existing and potential new partnerships with other hospitals and community health providers to improve care coordination. Consumers personally responded positively to the idea of broader access to preventive care and new resources in the community

that can help them be well and stay healthy. Consumers also appreciated the financial advantages of accessing timely care in their communities rather than stressful and costly ER visits. In the midst of these changes, consumers appreciated learning about the role played by the HSCRC as an independent agency overseeing Maryland's health system transformation.

Consumers Want More Information

Consumers want more easy-to-understand information about how they can use new health care resources and fully leverage new resources under the demonstration project to preserve their health and save costs. Communication should be timely, consistent and available in a variety of formats from trusted sources. There is a separate HSCRC consumer engagement taskforce working on communication strategies and messages that would help consumers utilize the new system appropriately.

Timely Information

In evaluations, consumers voiced a preference for learning about new developments in health care now and whenever there is a major development or new program from which they might benefit. Many requested follow-up meetings or regular updates over the course of the five-year demonstration project.

Consistent Information

Consumers want information that is consistent and centralized. Consumers in areas where there is great competition among providers were more likely to express feeling overwhelmed by different streams of messaging and less able to take action (an example would be multiple poorly coordinated case managers or care coordinators through different programs working with the same patient). Discussion time in these areas was often used for consumers to clarify what partnerships and programs already existed. As we learned from the experience with the ten rural Total Patient Revenue hospitals (a precursor to the new demonstration project) where local stakeholders collaborate and coordinate consistent messaging, consumers are better able to take part in the work being done at the system level and have more prior awareness of Maryland's unique health care landscape.

Information Available in a Variety of Formats

There was wide variation in how forum participants preferred to receive information about health system transformation. Many identified their primary care providers and faith leaders as

an important source of information. These local leaders are therefore important allies, not only in successful implementation of population health programs, but in their roles as trusted messengers to consumers.

> "WE ALL NEED TO WORK HARD TO REACH PATIENTS IN THE WAY THAT WORKS BEST FOR THEM. THEY CARE ABOUT THEIR HEALTH."
>
> Community Health Worker, Baltimore County

In addition, consumers are very interested in receiving information from a wide variety of other outlets, including social media, websites, TV and radio commercials, public meetings, and their hospitals. In order to meet consumers' needs, information should be distributed in all of these formats.

Recommendations

These forums were an exciting and productive first step in engaging consumers in health system transformation. Now state and local organizations can continue this work by collaborating to provide easy-to-understand information that is consistent and available in a wide variety of formats, and to continuously integrate and respond to consumers' experiences.

The unifying message should emphasize that health care providers are working together to keep the public healthy, and that it is empowering to learn how the health care system can help consumers with health and costs. Below are recommendations we believe will build on these forums to make sure the consumer voice is heard in health system transformation in Maryland. Making these recommendations a reality will require additional financial resources.

It is anticipated that the recommendations from this task force will combine with the recommendations of the HSCRC's Consumer Engagement Task Force to provide a comprehensive picture of the current state of consumer outreach and engagement and specific guidance for engaging consumers and creating a health care environment that supports consumers' full, informed participation in managing their health and health care.

1. Periodically convene stakeholders and consumers to provide updates on the progress of health system transformation

The forums MCHI held across the state have laid the foundation for future consumer outreach and involvement in health system transformation. Consumers value having local forums and want to continue the conversation. It may be helpful to have panels of consumers speak directly about how health system transformation has affected them. MCHI is uniquely positioned to build on this progress and provide the continued consumer input that is necessary to make health system transformation a success in Maryland. MCHI can continue to lead this effort in close partnership with those leaders with whom we co-hosted these forums.

2. Continue to give consumers a voice in the transformation of Maryland's health system

As the success of the forums demonstrated, MCHI is the right organization to continue giving Maryland consumers a voice in health system transformation. Over 750 faith, community, labor, business and health care groups from across the state are part of our Healthy Maryland Initiative coalition, representing hundreds of thousands of Marylanders of all walks of life. (See list in Appendix C). As we did with the forums, we can reach out to these organizations and other groups throughout Maryland to educate them about what health system transformation means and get their input on how it can work best for Marylanders.

MCHI can continue to represent consumer/stakeholder voices on various taskforces, workgroups and committees and maintain and leverage relationships with stakeholders to

support HSCRC's outreach and engagement of various consumer groups. MCHI can also commission polling and focus groups to broadly determine public attitudes on health system transformation in Maryland.

3. Encourage local leaders to develop and join a dynamic Faith Community Health Network

At each of our forums consumers expressed strong interest in closer collaboration among local health and faith institutions. The Faith Community Health Network will be piloted this November at LifeBridge Health. MCHI will track and report the network's impact on population health outcomes to inform similar efforts across the state.

4. Collaborate to educate primary care providers on and engage them in health system transformation

Health care providers, especially primary care providers, will be important partners in making health system transformation a success. Focus groups and information sessions specifically designed for providers may provide valuable insight on how best to engage and mobilize these partners. Because MCHI led a similar effort for consumers and has strong ties with provider organizations such as MedChi and others, we can lead this undertaking.

5. Maximize communications with consumers via traditional and new media

Consumers are eager for more information on health system transformation. MCHI can work with the HSCRC and other key partners through traditional and new media to maximize coverage of local partnerships—such as the Faith Community Health Network—and to raise consumer awareness, utilization of and involvement in these efforts. The HSCRC and MHCC consumer-facing websites are strong tools for centralized communication and call-to-action for consumers. The agencies may also want to consider developing a social media strategy to communicate directly with consumers. This social media campaign could be enhanced through partnerships with MCHI, MHA, and other local organizations that have broad reach through social media, email lists and website publications.

As a part of this communications strategy, MCHI suggests that health delivery systems and providers collect and share stories from consumers about real-life examples of how health system transformation benefits them. Stories humanize programs and provide easy-to-understand information to consumers about how to take care of their health. Stories can be conveyed in any number of different formats (publications, social media, videos, consumer panels, radio ads, etc.), making them useful tools to reach consumers through all available channels.

Regional Trends and Consumer Feedback

Howard County Forum
January 22, 2015 at 8:30AM
Oakland Mills Interfaith Center, Columbia

"In the midst of all the national and state policy changes that have led to historic health care reforms, we're reminded in Maryland that all health care is local."
– Nikki Highsmith Vernick, The Horizon Foundation

Over 120 participants joined in the forum in January at a meeting convened by the Local Health Improvement Coalition.

Local primary care providers were well represented among the group and expressed great interest in deeper collaboration to support local health system transformation under the demonstration project. They also described the impressive impact of having the Community Care Team work with their patients, suggesting that this program be continued or expanded.

Faith Community Nurses and other local caregivers are also eager to engage. One neighborhood caregiver relayed a story about several frustrations trying to get the information she needed to help care for ailing neighbors who had identified her as their key caregiver. The CEO of Howard County General Hospital indicated that the hospital is committed to protecting patient privacy, and will be taking a hard look at how to improve their partnerships with outside care providers, both within and beyond the medical field.

We congratulate Howard County for their recent award of a Regional Transformation Partnership Grant. The work of the partnership appears to address the feedback from this forum—that local providers and faith community nurses are interested and important allies in achieving the success of the demonstration project, and that the Local Health Improvement Coalition is a great convener.

As the efforts advance the regional transformation partnership and related Faith Community Health Network based out of Healthy Howard, MCHI is happy to work with local partners to highlight successes and continue to inform and engage county residents in this important work.

Prince George's County Forum
February 6, 2015 8:30AM
Sanctuary at Kingdom Square, Capital Heights

Nearly 100 participants attended the forum convened by the Collective Empowerment Group, a powerful faith-based, grassroots organization that is active in the region. There was great interest in the information being shared, since most were hearing about the demonstration project, Health Enterprise Zones and other programs for the first time. Their interest, energy and role as trusted messengers in the county make them important allies in improving public health. In their evaluation forms, they expressed great interest in a follow-up meeting or at least more regular updates on local progress. They also expressed great interest in the possibility of locally implementing the Faith Community Health Network.

The great news that the Southern Maryland Coalition for Health System Transformation received funding to support community-based collaboration and planning for regional population health interventions presents an opportunity for deeper engagement with these trusted community leaders. The planning group is currently conducting an inventory of faith based entities in the region and identifying ministries that may be able to better support high need, high cost patients. Engaging these faith leaders in that process will be critical to success.

As the efforts advance the regional transformation partnership and related Faith Community Health Network, MCHI is happy to work with local partners to highlight successes and to inform and engage county residents in this important work. In maximizing the impact of these communications, participants recommended featuring more client testimonials to describe program impact rather than just statistics. This approach may be more motivating to the target audience.

Carroll County Forum
February 11, 2015 8:30AM
Carroll Hospital Center, Westminster

"What…do you think the average person would be interested to learn?"
"How important the community is to this process."
"How it is more affordable to be treated outside of the hospital and how the hospital is helping make health care more affordable." – Forum Participants

Over 60 local residents participated in the forum. Unlike in other forums, about half were already familiar with Maryland's unique health care landscape, perhaps because the hospital had entered into this payment structure agreement with HSCRC prior to the statewide roll-out and because many of the participants were already working closely with the health department, hospital and Partnership for a Healthier Carroll County. In the evaluations, there was encouragement to include other community health nonprofits/agencies who are "boots on the ground" serving target populations and delivering care.

The group was informed, engaged and eager for ongoing discussion about local developments under the demonstration project. They appreciated the use of client stories in describing the impact of the new approach to health care. A hospital representative described how the hospital helped a family get a better heating system so that the family's woodstove stopped triggering a child's asthma. Forum participants suggested engaging the local business community in this work and deepening the scope of community benefits reporting to include social determinants of health, including issues related to homelessness. They also expressed great interest in the Faith Community Health Network.

As a direct result of the tremendous community interest expressed at this forum, LifeBridge Health (Carroll, Northwest and Sinai hospitals) will be piloting the Faith Community Health Network. MCHI is thrilled to be working with LifeBridge Health and local faith leaders on this important effort. This region is a great example of strong, dynamic community-hospital partnerships and has much to share with other regions where these relationships may be less developed.

Lower Shore Forum
February 25, 2015 9:00AM
Somerset County Health Department, Westover
(No picture available.)

About 30 local residents participated in the Tri-County Local Health Improvement Coalition Meeting which served as the public forum for this region. Unlike other forums, no evaluations were collected due to the meeting format. General sentiment expressed at the forum and in the minutes reflected broad familiarity with the global budgeting due to prior experience with the model prior to statewide roll-out. There was great interest in how this might support better access to mental and behavioral health locally. The region recently was awarded an Opioid Misuse Prevention Grant from the federal government that can support the goals of the demonstration project and vice-versa. There was discussion about the RFP for Regional Transformation Partnerships, but because the eligibility criteria specified minimum population requirements, the participants were disappointed and felt that they would not qualify.

The region is doing great work to partner across county lines—something that is often easier said than done. Other systems can benefit from the experience and knowledge gained from the region's developments under previous global budgets. Additional funding opportunities to address the unique needs and interests of rural communities should be considered.

Midshore Forum
March 9, 2015
Queen Anne's County Health Department, Centreville

About 40 local residents attended the Mid Shore Health Improvement Coalition meeting that graciously served as the public forum for this region. Based on the evaluations collected, about half of the participants had already heard about the changes under the demonstration project and half had not.

The majority of respondents felt that after attending the forum the best way to describe health system transformation in Maryland was that "hospitals, health care providers and community-based organizations would be working together to help Marylanders be as healthy as possible." They wanted to be more knowledgeable about health care services and options that can improve their health and save costs. Most wanted to get this information from their provider and in follow-up public meetings. They also prefer to get this information immediately, rather than waiting until they are in the hospital or when another program is started. The majority of those who submitted evaluations serve minorities and low-income families.

Consumers are eager for more transparency and information about health care services and what they can do to support their own health care. Sharing information via multiple channels, especially via trusted messengers like primary care providers and faith leaders, as well as print and online can help meet consumers where they are and build stronger community partnerships necessary to improve population health.

Some consumers expressed concerns about losing their local hospital. Embracing deeper partnerships with the Local Health Improvement Coalition, providers and faith leaders and providing more information about these changes as other regions have done may help address consumers' concerns.

Southern Maryland Forum
April 20, 2015 6:00PM
St. Charles High School Auditorium, Waldorf

"What is the best way to describe Maryland's health system transformation?"
"Reducing ER visits by using community resources."—Forum participant

The forum attracted 65 residents from Charles, St. Mary and Calvert Counties, in part thanks to special guest Secretary of Health Van Mitchell and a unique opportunity to view an installment of the AIDS quilt on display in the gymnasium. This was the only forum where no local hospitals chose to participate in a formal role, although many attended and brought their staff.

Based on the evaluations collected, about three quarters of the participants learned about the demonstration project for the first time at this forum and they were eager for more information. They expressed interest in "growing more primary care providers" and expanding access to telemedicine. They appreciated knowing that hospitals, healthcare providers and community-based organizations will be working together to help Marylanders be as healthy as possible and that they have new incentives to keep people healthy. They encouraged hospitals to consult "front-line workers" before creating or changing programs. Specifically they encouraged health care providers to enlist the support of Administrative Care Coordination Unit workers in local health departments who often work with vulnerable patients. There was also strong interest in the Faith Community Health Network.

Unlike in other regions, the majority of evaluations indicated social media as the preferred source for new information about health system transformation.

As the efforts described at the forum progress locally, MCHI can work with local partners to highlight successes and continue to engage county residents in this important work, particularly via our strong social media channels.

Western Maryland Forum
April 22, 2015
Western Maryland Health Systems, Cumberland 11:00AM
(No picture available.)

About 25 people attended this meeting thanks to the Cumberland Ministerial Association and Western Maryland Health Systems graciously opening their regular meeting to the public. Because this region has been operating as a Total Patient Revenue hospital for the past five years, the aim of this forum was to learn about their process and highlight progress.

Of those who completed evaluations, most were aware of the unique changes to Maryland's health system and said that the best way to describe it was that hospitals have an added incentive to keep people healthy. This sentiment was strongly reiterated by the HSCRC presentation as well as the presentation by a local physician on the creation of a new Accountable Care Organization.

Consumers and faith leaders were interested in getting more information about this work as soon as new programs are available to them (as opposed to when they are admitted to the hospital). They want to learn about it from their health care providers and other (low-tech) resources.

Western Maryland should trumpet its successes. Other health systems can learn a lot by the region's example engaging community partners and improving population health under global budgets. A pastor and doctor participated in the subsequent meeting of the Cumberland Ministerial Association to discuss the Faith Community Health Network in detail. There may be very fertile ground to create such a network locally. MCHI will be piloting the model with LifeBridge Health with rural, suburban and urban sites this fall and will share lessons learned from this pilot in the spring that may be useful.

Baltimore County Forum
June 2, 2015 8:30AM
Sheppard Pratt Conference Center, Towson

"What can help you have a more active role in your health care?"
"A unified message from partnership groups across hospital systems and government." – Forum participant

About 70 people participated in the public forum at Sheppard Pratt Conference Center. Of those who completed evaluations, slightly more than three quarters were unfamiliar with Maryland's unique hospital system prior to attending this forum. They were interested in learning that it creates a system where all health care providers work together to help keep the public healthy, although they stressed the importance of having a unified message across major stakeholders in order to clearly communicate with consumers.

They are interested in being more active in and knowledgeable about their own health care, and felt that more easy-to-understand information about their disease or condition would best help them achieve that goal. They most wanted to get updated information about local developments under the demonstration project via local news outlets and social media (as opposed to getting the information from their primary care provider or when they are admitted to the hospital). Faith leaders, community leaders and health care providers alike expressed great interest in the Faith Community Health Network.

It was a pleasure working with the Baltimore Local Health Improvement Coalition to host the forum. Continued deep engagement of Baltimore County hospitals in the coalition may help facilitate consistent, clear, easy-to-understand information to and from consumers who can most benefit from the changes under Maryland's Health System Transformation project. MCHI can help promote communications via earned and social media to ensure that pertinent information is reaching these consumers in the manner they prefer. MCHI is thrilled to be working with Northwest Hospital as a part of the LifeBridge pilot of the Faith Community Health Network this fall.

Montgomery County Public Forum
June 15, 2015 5:00PM
Holy Cross Hospital, Silver Spring

"In Maryland, there are still a lot of disparities. I hope this work will help address those disparities." – Rev. Louise Malbon Reddix, forum participant

This forum was unique for several reasons. First, Holy Cross Hospital and the Primary Care Coalition had previously hosted a public forum on this topic. Second, they had just learned that the HSCRC had awarded a $400,000 planning grant for a new collaborative called Nexus Montgomery to help spur collaboration across community partners to improve population health. And finally, both Washington Adventist Hospital and Holy Cross hospitals have long established, strong faith community nursing programs, making the presentation on the faith community health network particularly of interest and leading to strong turn-out among local Faith Community Nurses at the forum.

In all, about 70 people attended the forum. Of those who returned evaluations, most had never heard about Maryland's unique health care landscape or health system transformation before. They appreciated that the demonstration project as described enhances the overall healthcare system by improving the quality of care and reducing costs and they expect to see hospitals, health care providers and community and faith based organizations working together to help Marylanders be as healthy as possible. They would like to be more knowledgeable about healthcare services and options that can help improve their health and save costs, and are interested in serving on advisory boards to help hospitals and the state understand how health system transformation is impacting health care consumers.

They also want more easy-to-understand information about their disease or condition and want to get this information (as well as information about local developments under the demonstration project) from their health care provider, when at the hospital, through TV/radio and at public meetings.

The unique richness and diversity of this region presents many opportunities as well as challenges in promoting population health. MCHI can help promote awareness of the great work of the Nexus Montgomery project via earned media, collaborating with local primary care providers with MedChi and/or sharing what we learn from our pilot of the Faith Community Health Network with LifeBridge.

Anne Arundel County Forum
June 24, 2015 8:30AM
Rams Head LIVE!, Hanover

"The faith community has and will always have a holistic approach to caring for people and we look forward to being involved as these partnerships and alignments take shape." – Bishop Larry Lee Thomas, forum presenter

About 65 people participated in the forum, which was co-hosted with Healthy Anne Arundel as a part of their regular meeting. A majority of these participants had no prior knowledge of Maryland's unique health system transformation efforts according to collected evaluations. The forum followed the recent announcement of a major grant award from the HSCRC to the Bay Area Transformation Coalition that includes county hospitals, public agencies, nursing homes, clinics and providers.

Many local community and faith based organizations were present and volunteered their services to support the goals of health system transformation including programs for the elderly, immigrants and low-income county residents. They appreciated that the demonstration project aims to enhance the overall healthcare system by improving the quality of care and reducing costs. They expect to see hospitals, health care providers and community-based organizations working together to help Marylanders be as healthy as possible. They would like to be more knowledgeable about healthcare services and options that can help improve their health and help save costs and are interested in getting this information from their primary care provider.

There is great enthusiasm and interest in ongoing conversations with the community about local developments in health care. Another public forum, perhaps announcing new opportunities under the planning grant or to share its results, may be appropriate. The location for this forum was not ideal due to some significant IT/noise challenges and we can help facilitate another location that may be a better fit for the purpose of the meeting. Specific outreach to primary care providers and faith leaders to engage them as trusted partners and messengers may also be fruitful.

Baltimore City Forum
July 7, 2015 6:00PM
Central Baptist Church, Baltimore

"If you want to go fast, go alone. If you want to go far, go together." African proverb quoted by Dr. Sam Ross, Bon Secours CEO

This was the final forum and was standing-room-only with over 160 participants. Like prior forums, it was co-hosted as a part of a regular quarterly series of public forums that Bon Secours Hospital convenes. Many participants were local community residents affiliated with the church and neighborhood that hosted the event. Others were partners from the Health Enterprise Zone initiative and other related efforts, as well as members of MCHI's Health Care for All! Coalition from across Baltimore.

There was significant discussion of social determinants of health, perhaps owing to recent unrest in the area. Based on the evaluations that were collected, we learned that 81% of respondents had never heard about the demonstration project or Maryland's unique hospital system before. They felt the best way to describe it was that it creates a system where all health care providers work together to keep the public healthy and that it enhances the overall healthcare system by improving the quality of care and reducing costs. They saw it as an opportunity to "address root causes of health disparities by addressing social determinants of health." They expressed concerns about costs, especially for prescription drugs. They're eager for more information and want to get that information from their health care provider. The Faith Community Health Network received a tremendously positive response.

Congratulations on the successful awards for regional transformation partnerships that have been awarded in this region! The goal to share lessons learned and resources across hospitals to promote population health and reduce avoidable utilization holds tremendous promise, as the region's hospitals all have much to share and learn. MCHI's coalition can be an ally in engaging and sharing information with trusted messengers. We will be piloting the Faith Community Health Network with LifeBridge Health and local faith leaders this fall and hope to eventually expand to other interested institutions.

Special Thanks

These forums would not have been possible without the tremendous support from the HSCRC, our coalition and our funders. Thank you to all of those individuals and organizations who share our commitment to strengthening consumer voices to improve consumers' access to quality affordable health care. Below are those who were integral to the success of this effort.

Individuals:

Dr. Dianna Abney
Matey Barker
Dr. Gregory Branch
Barbra Brookmeyer
Judith Carmichael
Dr. Jinlene Chan
Annice Cody
Renee Cohen
John Colmers
Dr. Darnell Cooper
Carmela Coyle
Christine Crabbs
Pam Creekmur
Danielle DaSilva
Lesa Diehl
Cheri Ebaugh
Nancy Forlifer
Dorothy Fox
Patrick Garrett
Dr. Rohit Gulati
Darcy Haldeman
Dr. Dan Hale
Joyce Hendrick
Kathleen Imhoff
Tricia Isennock
Rev. Dianne Johnson
Rev. Manfred Kaseman
Kevin Kelby
Dr. Niharika Khanna
Donna Kinzer
Heather Kirby
Jennifer LaMade
Bill Lebold
Della Leister
Beverly Lofton
Mark Luckner
Rev. Anthony Maclin
Susan Markley
Michele Martz
Sec. Van Mitchell
Pastor Rodney Morton
Chrisie Mulcahy
Andi Mullin
Patrick Mutch
Karen Olscamp
Becky Paesch
Steve Ports
Leni Preston
Dr. Irance Reddix
Barb Rodgers
David Romans
Dr. Sam Ross
Dr. Maura Rossman,
Robert Rothstein
Sharon Sanders
T.J. Senker
Kevin Sexton
Glenn Schneider
Rabbi Stephen Sniderman
Steve Snelgrove
Dr. Leeland Spencer
Tormod Svensson
Novella Tascoe
Tiffany Tate
Dr. Henry Taylor
Bishop Larry Lee Thomas
Nikki Highsmith Vernick
Gary Vogan
Dr. Leana Wen
Paula Widerlite
Darleen Won
Ms. Cristine Wray

Organizations: 1199SEIU, AARP, Baltimore County Health Department/Baltimore County Health Coalition, Bon Secours Health System, Central Baptist Church, Charles County Health Department, Collective Empowerment Group, Community Catalyst, Community Health Resources Commission, Cumberland Ministerial Alliance, Healthy Anne Arundel, Holy Cross Hospital, Howard County Local Health Improvement Coalition, Mid-Shore Health Improvement Coalition, NAACP, NAMI, Nexus Montgomery, Partnership for a Healthier Carroll County, Tri-County Health Improvement Coalition

Funders: Community Catalyst ACA Implementation Fund, Consumer Health Foundation, Horizon Foundation, Jacob and Hilda Blaustein Foundation

Staff: Vincent DeMarco, Matthew Celentano, Stephanie Klapper and Suzanne Schlattman

Interns: Sara Philippe, Jack Sheehy, Abeer Hamid, Kelleigh Eastman

Appendix A – List of Consumer Outreach Taskforce members

Appendix B – List of organizations represented at regional forums

Appendix C – List of Healthy Maryland Initiative Coalition members

Appendix A

HSCRC Consumer Outreach Taskforce Members

Tresa Ballard	Communications Director, AARP Maryland
Tammy Bresnahan	Associate State Director of Advocacy, AARP Maryland
Darren Brownlee	President, National Association of Health Services, Baltimore Chapter
Carmela Coyle	President & CEO, Maryland Hospital Association
Vinny DeMarco	President, Health Care for All
Patrick Dooley	University of Maryland Medical System
Stan Dorn	Senior Fellow, Urban Institute
Michaeline Fedder	Government Relations Director, American Heart Association
Diane Feeney	Health Services Cost Review Commission
Sandy Ferguson	Dir. Social Justice & Missions, Balt-Wash Conference of The United Methodist Church
Isabelle Firth	President, LifeSpan Network
Hank Greenberg	State Director, AARP, Maryland
Dr. Dan Hale	Special Advisor, Office of the President Johns Hopkins Bayview
Rev. Diane Johnson	Collective Empowerment Group
Theressa Lee	Maryland Health Care Commission
Pat Lippold	Vice President for Political Action, 1199 SEIU United Health Care Workers East
Mark Luckner	Executive Director, Community Health Resources Commission
Susan Markley	Vice President of Business Development, HealthCare Access Maryland
Bishop Douglas Miles	Co-Chairman, BUILD
Fran Phillips	Consultant, Community Health Resources Commission

Leni Preston	Chair, Maryland Women's Coalition for Health Care Reform
Thomas Pruski	Director, Health Ministries Association
Lynn Quincy	Assistant Director Health Policy Reform, Consumers Union
Steve Raabe	Founder and President, OpinionWorks
Reverend Irance Reddix	Pastor, St. John's United Methodist Church
Dr. Maura Rossman	Health Officer, Howard County Health Department
Susan Roy	Director of Chaplain Services, University of Maryland Medical System
David Simon	Senior Writer, Maryland Hospital Association
Glenn Schneider	Chief Program Officer, Horizon Foundation
Gerald Stansbury	President, NAACP, Maryland
Terry Staudenmaier	Program Officer, Abell Foundation
Tiffany Tate	Consultant
Nikki Highsmith Vernick	President & CEO, Horizon Foundation
Reverend Fred Weimert	Pastor, Central Maryland Ecumenical Council

Appendix B

Organizations Represented at Regional Forums

Howard County

Amerigroup Corporation
Anne Arundel, Howard, and Prince George's County Medical Societies
Association of Community Services
Baha'i Community
Baltimore Washington Conference, United Methodist Church (BWCUMC)
British American Auto Care
Build Haiti Foundation
Calvary/Centennial Memorial United Methodist
Centennial Medical Group
Chase Brexton Health Services
City of Baltimore Health Department
Columbia Assn. Sr. Advisory
Columbia Association
Columbia Medical Practice
Columbia Presbyterian
Delta Sigma Thea
Dorsey Emmanual United Methodist Church
Evergreen Health Care
Family & Nursing Care
First UMC Laurel
HC Drug Free
HCCA
Health Promotion on Call
Healthy Howard
Horizon Foundation
Howard Community College
Howard County Citizens Association
Howard County Dental Association
Howard County Department of Citizen Services
Howard County DSS
Howard County Health Department
Howard County Local Health Improvement Coalition
Howard County Mental Health Authority
Howard County NAACP
Howard County Public School System
Johns Hopkins
Judy Center Partnership
Long and Foster Realtors
Maryland DHMH
Maryland Hunger Solutions
Maryland Pediatrics
Maryland University of Integrative Health
Meals on Wheels of Central MD
MHCC
PATH
Primary Care Coalition of Montgomery County
PRJ
The ARC Howard County
Transition Howard County
Unitarian Universalist Congregation of Columbia
Walgreens
We Promote Health
Well Being Medical Care
Wesley Theological Seminary

Prince George's County

A CTIS, Program
American Cancer Society Cancer Action Network, Inc.
AMERIGROUP
Antioch Baptist Church of Clinton
Assembly of Petworth
Baltimore Washington Conference, United Methodist Church
Behavioral Health Navigators Center, Inc.
University of Maryland School of Medicine & Shock Trauma Center
Collective Empowerment Group (representatives from many faith communities)
Dimensions Healthcare System
DIO and Vice President of Medical Affairs, Prince George's Hospital Center
Edward E. Smith & Associates
Family Services, Inc.
Government Affairs
Health Insurance Commission
Healthy Kinder, Inc
Heart to Hand, Inc.
March of Dimes
Maryland Insurance Administration Consumer Education and Advocacy Unit
MD Women's Coalition for Health Care Reform
MedStar Health
NAACP of Prince George's County
NAMI Prince George's County
Office of Prince George's County Executive Rushern L. Baker, III
Prince George's County Council
Prince George's County Department of Social Services
Priority Partners of Johns Hopkins
Regulatory Compliance Government Affairs
Seabury Resources for Aging

Northern MD

Access Carroll, Inc.
Asian American Center of Frederick
BWCUMC
Caring Carroll
Carrol County Health Department
Carroll County Commission of Aging and Disabilities
Carroll County Public Schools Student Services Department
Carroll Hospital Center
Frederick Community Action Agency
Frederick County Health Department
Frederick Regional Health System
Gale Recovery, Inc.
Gaudenzia
Get Connected Family Resource Center
Health Care is a Human Right MD Frederick County
Maryland Women's Coalition for Health Reform
MD DHMH
Mental Health Association of Frederick County
Mission of Mercy
NAMI Carroll County
Partnership for Healthier Carroll County
UMCC
University of Maryland School of Nursing Office of Environmental Health
VHQC

Lower Eastern Shore

Choptank Community Health Systems
Crisfield Clinic
McCready Memorial Hospital
Amerigroup
Somerset County Health Department

Wicomico County Health Department
Worcester County Health Department

Mid Shore

Associated Black Charities-Dorchester County
Caroline and Kent County Health Departments
Choptank Community Health Systems
Crossroads Community, Inc
Eastern Shore Area Health Education
Mid Shore Health Improvement Coalition
Mid Shore Mental Health Services
Queen Anne County Health Department
Regional Opioid Misuse Prevent Grant Group
Shore Health Systems

Southern MD

University of Maryland Charles Regional Medical Center
1199 SEIU
American Red Cross
Angel's Watch Shelter
BWCUMC
Calvert County Branch of the NAACP
Calvert Memorial Hospital
Catholic Charities - Angel's Watch Shelter
Center for Children, Inc.
Charles County Department of Health
Charles County Dept of Community Services
Charles County Freedom Landing
Charles County Branch of NAACP
Charlotte Hall Veterans Home
Community Catalyst
DHMH
Free Gospel Church of Bryan's Road
Greater Baden Medical Services, Inc
Health Partners, Inc.
Healthcare Solutions
Hospice of Charles County, Inc.
Journey of Faith Church in Waldorf
Kadie Pro Health
Maryland Rural Health Association
Maryland Hospital Association
Maryland Women's Coalition for Health Reform
Missionary Baptist Church and House to House Bible Ministries
NAMI Southern Maryland
Radiance Health Services
Senator Cardin's office
SMTCCAC Inc. Head Start
Spring Dell Center, Inc
St. Charles High School
St. Mary's Adult Medical Day Care
St. Mary's County Health Department
The Gospel Church of Bryans Road
UM CRMC
University of Maryland Charles Regional Medical Center
University of Maryland Extension-Charles County
Working out Wonders, Inc.

Western MD

A D Naylor & CO, INC
Allegany County Health Department
Cumberland Ministerial Association
Centenary/Zion United Methodist Churches
Healthy Howard
NAACP
Rural Area Enrollment Network
Tri-State Community Health Center
United Way
Western MD Health System

Baltimore County

1199 SEIU
Adult Evaluation and Review Services
Alpha&Omega Counseling Consultation Svcs. LLC
Anthem, Inc.
Baltimore County DHHS
Baltimore County Department of Health- Behavioral Health
Baltimore County Department of Planning
Baltimore County DSS
Baltimore County Executive Office
Baltimore County Medical Association
Baltimore County NAACP
Baltimore County Public Libraries
Board of Child Care
BWCUMC
Carroll Hospital Center
Chase Brexton
College of Health Professions
Communicable Disease Control Baltimore County Department of Health
Delegate Clarence Lam
Diane Kretzschmar's parish nurse support group
Empowerment Temple's Health and Wellness Ministry
Family Health Center
Friendship Baptist Church
GBMC HealthCare System
Gilchrist Hospice
Good Shepherd United Methodist Church
Heal the Sick Program
LifeBridge Health
Lochearn Improvement Association
Lutherville Community Association
Maryland Academy of Family Physicians Family Health Center
Maryland Health Connection
Maryland Legislature
Maryland Rural Health Association
Maryland State Advisory Council on Physical Fitness
MD Logix
MDCCC AmeriCorps VISTA
MedStar Franklin Square Medical Center
New All Saints Church-Health Committee
Northwest Hospital
Office of Senator Ben Cardin
Ombudsman Program Baltimore County Department of Aging
Planning and Administration, Baltimore County Department of Planning
Priority Partners
Progressive Health Group Inc
Prologue Inc
Riverside Health
Sacred Heart Parish
Sinai/Northwest Hospital
St. Clare Medical Outreach
St. Johns Methodist Church
Stella Maris Hospice and HomeCare
Stella Maris Senior Day Center
Stephens OMT, Inc.
University of Maryland School of Medicine Department of Epidemiology and Public Health
Wesley Theological Seminary
White Oak Health Care
Y of Central Maryland

Montgomery County

AAUW, Holy Cross

Adventist Health Care
Adventist HealthCare from the Center for Health Equity and Wellness
Advocates for Children and Youth
African American Health Program of Mont. Co.
American Cancer Society, Inc.
Baltimore City League of Women Voters
Brooke Grove Foundation
Brooke Grove Retirement
CASA
Catholic Charities
Center for Public & Nonprofit Leadership
Collingswood Nursing and Rehabilitation Center
Emmanuel Brinklow SDA Church
Georgetown University
Glen Ridge SDA Church
Health Programs Delivery
Help Africa Inc.
Holy Cross Health
Homeless Services
Institute for Public Health Innovation, MC DHHS
Interfaith Community Liaison for Montgomery County
Interfaith Works
McInnis & Associates Consulting, LLC
MD Women's Health Coalition
MedStar Montgomery Medical Center
Montgomery County DHHS
Montgomery Health Care Action
NAACP Montgomery County
NAMI Montgomery County
NMS Healthcare
OFA
Primary Care Coalition of Montgomery County
River Road Unitarian Church
RRUUC
St Francis of Assisi RC Church
St. Francis of Assisi Parish
St. Johns United Methodist Church
Suburban Hospital
Universalist Unitarian
Wesley Seminary
Maryland Women's Coalition for Health Reform

Anne Arundel County

2-1-1 Maryland/United Way Helpline
AAMC
AMERIGROUP - Provider Solution
Amerigroup Community Care
Anne Arundel County Department of Aging and Disabilities
Anne Arundel County Department of Health
Anne Arundel County Health Officer
Anne Arundel County Mental Health Agency
Anne Arundel Medical Center
Asbury Broadneck United Methodist Church
Baltimore Washington Medical Center
BWMC
DeCesaris Cancer Center
First UM Laurel
Greater Annapolis Family Center Y
Health Policy Research Consortium
IMAGE Center of Maryland
Keswick Community Health Services
Maryland Department of Aging
Maryland Naturopathic Doctors Association
Medi Rents and Sales
MedStar Family Choice
MHAMD
Mount Olive AME Church
NAACP
New Life Fellowship Int. Ministries
OFA
Office of Councilman Andrew C. Pruski
Office of County Executive Steven R. Schuh
Office of U.S. Senator Ben Cardin
Owensville Primary Care
Pathways
Reilly Benefits, Inc.
Sarah's House
Seeds 4 Success
Spencerville Adventist Church
St Anne's Episcopal Parish
Student Services, AACPS
United Healthcare
United Methodist Men
United Way of Central Maryland
University of Maryland Baltimore Washington Medical Center
Y of Central Maryland

Baltimore City

1199 SEIU
Advocates for Children and Youth
Adrian Harpool Associates
All Saints Church
Attorney General Office
Baltimore Alliance for Careers in Healthcare
Baltimore City Council
Baltimore City Cancer Program
Baltimore City Health Department
Behavioral Health System Baltimore
Bon Secours Health System
CARA plans
Central Baptist Church
DHMH
Enoch Pratt/Families USA Bound
FSO, Inc
God's Church
HPRC A CTIS Program
Job Opportunities Task Force
Johns Hopkins Bayview Medical Center
Johns Hopkins School of Public Health
Johnson & Johnson
LifeBridge Health
Matthew A. Henson Neighborhood Association
Maryland Environmental Health Network
Maryland Health Connection
MD General Assembly
MDCCC AmeriCorps VISTA
Medstar Health
NAACP Cecil County
NAACP Maryland
New Saint Mark Baptist Church
Recovery in Community
Sen. Ben Cardin's office
Seniors Helping Seniors
St. Agnes Hospital
St. John AME Church
St. Johns Methodist Church
Timothy Baptist Church
UMB\Southwest Partnership
Union Memorial Hospital
United Way of Central MD
UMMC Midtown Campus
WBC Community Development Corporation

Appendix C

MCHI's Healthy Maryland Initiative Coalition Members

June 5, 2015 – 760 Endorsers

Statewide and Regional

1199 SEIU United Health Care Workers East
AARP Maryland
Abilities Network
Action on Smoking and Health (ASH)
Advocates for Children and Youth
American Academy of Family Physicians
American Academy of Pediatrics, Maryland Chapter
American Baptist Churches - South
American Cancer Society – South Atlantic Division
American College of Physicians, Maryland Chapter
American Federation of Teachers - Maryland
American Heart Association
American Jewish Congress, Maryland Chapter
American Lung Association of Maryland
American Minority Contractors' Association, Inc.
Asian American Anti-Smoking Foundation
Baltimore Healthy Start, Inc.
Baltimore Intersection
Baltimore Jewish Council
Baltimore Medical System
Baltimore Washington Conference Board of Church & Society
Baltimore Washington Conference of the United Methodist Church
Baltimoreans United In Leadership Development (B.U.I.L.D.)
Baptist Deacons Conference of Baltimore
Baptist Ministers Conference of Baltimore
Campaign for Tobacco Free Kids
Cancer Support Foundation, Inc.
CASA de Maryland
Central Atlantic Conference of the United Church of Christ
Central Maryland Ecumenical Council
Chesapeake Climate Action Network
Chesapeake Quarterly Meeting – Religious Society of Friends (Quakers)
Church Women United in Maryland – Executive Council
Coalition for a Healthy Maryland
Collective Empowerment Group, Inc.
Columbia Union Conference of the Seventh-day Adventist Church
Community Behavioral Health Association of Maryland
Community Health Integrated Partnership
Delaware Maryland Synod, Evangelical Lutheran Church in America
Ecumenical Leaders Group (ELG)
Emmanuel
Episcopal Diocese of Maryland
Episcopal Diocese of Washington
Friends of Lower Beaverdam Creek
Funeral Directors and Morticians Association of Maryland
Greater Baden Medical Services, Inc.
Greater Baltimore Urban League
Habitat for Humanity of the Chesapeake
Health Care Access Maryland
Health Care for the Homeless
Institutes for Behavioral Resources, Inc.
Interdenominational Ministerial Alliance
Interfaith Works
Jewish Community Relations Council
Johns Hopkins Pediatric Liver Center
Latino Providers Network
Lili Amsel Children's Foundation
March of Dimes, MD National Capital Area Chapter
Maryland Academy of Family Physicians
Maryland Assembly on School-Based Health Care
Maryland Association of County Health Officers
Maryland Association of Student Councils
Maryland Citizens Against State Executions
Maryland Consumer Rights Coalition
Maryland Dental Hygienists' Association
Maryland Environmental Health Network
Maryland Federation of Chapters, National Active and Retired Federal Employees' Association (NARFE)
Maryland Group Against Smoker's Pollution
Maryland Healthy Eating and Active Lifestyle Coalition (HEAL)
Maryland Hospital Association
Maryland Legislative Agenda for Women
Maryland Multicultural Youth Centers
Maryland Non-Profits
Maryland Nurses Association
Maryland PIRG
Maryland Public Health Association
Maryland Rural Health Association
Maryland State Conference NAACP
Maryland State Education Association
Maryland/District of Columbia Society For Respiratory Care
Mautner Project: The National Lesbian Health Organization
MedChi, The Maryland State Medical Society
Medicaid Matters!
Mid-Atlantic Association of Community Health Centers
Mid-Atlantic P.A.N.D.A. (Prevent Abuse & Neglect through Dental Awareness)
Morgan State University School of Community Health and Policy
NAMI Lower Shore
NAMI Maryland
NAMI Metropolitan Baltimore
NAMI Southern Maryland
National Action Network – Greater Baltimore Chapter
National Association of Social Workers – Maryland Chapter
National Congress of Black Women – Greater Baltimore Chapter
National Council on Alcoholism &Drug Dependence – Maryland Chapter
National Society of Pershing Rifles Alumni Association
National Tobacco Independence Campaign
Nurse Practitioners Association of Maryland
Oncology Nursing Society
Organizing for Action Maryland
Pan African Collective
Pastors' Conference of Baltimore
People Encouraging People
Planned Parenthood of Maryland
Presbytery of Baltimore
Progressive Baptist Convention of Maryland
Progressive Maryland
Pure Potential Enterprises
R.E.S.P.E.C.T.

REACH
Safe and Sound Campaign
SEIU Local 400
SEIU Maryland/DC State Council
Top Ladies of Distinction
UFCW Local 400
Unitarian Universalist Legislative Ministry of Maryland
United Baptist Missionary Convention
United Christian Clergy Alliance
United Council of Christian Community Churches of Maryland
United Seniors of Maryland
Women Accepting Responsibility
Women's Suburban Democratic Club

Anne Arundel County

Abby Bay Designs
All In His Hands Barbershop
Annapolis Book Store
Annapolis Ice Cream
Annapolis Interdenominational Ministerial Alliance
Annapolis Post Box, Inc.
Annapolis Running Shop
Anne Arundel County Medical Society
Anne Arundel Medical Center Care Management
Asbury Broadneck United Methodist Church
Asbury Town Neck United Methodist Church
Asbury United Methodist Church
Aurora Gallery
BE Home
Beefalo Bob's
The Big Cheese
Blue Crab Antiques
Cager Counseling Service
Caspersen Floral Design
Chez Amis Bed & Breakfast
Classy Image
Creative Impressions
Deliverance Temple Sanctuary Ministries
Dr. Saad Kuwanja Medical Practice
Dream Helpers Global Mission
Emmanuel Temple of Praise
Empowering Believers Church
Eyes on Main
First Lady's Salon
Fresh Start Church
Fun of All! Tours
Girl Scouts Troop 61
Granny Family Care
Hands of Hope
Iglesia Misionera Masque Vencedora Band
In His Hands Ministry
It's Just That Good
James B. Hyman, PHO, Inc.
Jeanie's Salon & Day Spa, Inc.
Jesus Love Temple
John Wesley United Methodist Church of Glen Burnie
Judah Temple Ministries
Kingdom Celebration Center
Kingdom Life Church
Lifegate Chapel
Light of the World
Light of the World Family Ministries
Madison Boutique
Magothy United Methodist Church of the Deaf
Margaret Johnson Mary Kay Beauty
Mary & Blanche!
Matrix Design Build
McNeill's Day Care
Men 2 Men
Metropolitan United Methodist Church
Mount Olive African Methodist Episcopal Church
Mount Zion United Methodist Church
Mount Zion United Methodist Church - Magothy
MRT, LLC
Ms. Granny's Family Child Care
My Body Count
NAACP – Anne Arundel County Branch
NAMI Anne Arundel County
Nano
Natalie Silitch Folk Art
New Hope Sabbath Christian Center
New Life Fellowship
New Pslamist Church
NLACS
Oliver's
One Accord Apostolic Church
Opportunities Industrialization Center of Anne Arundel County, Inc.
Owensville Primary Care, Inc.
The Pink Crab
Potomac Physicians
Rejoice TV
re:Source
Return to Oz Consignments
Rhena Word Worship & Praise Center
Richardson Trucking, LLC
Rose of Sharon Church
Saint Matthew's United Methodist Church
Scittino's Groceries & Meats
Servants Ministry, Inc.
Severn School Student Council
Shear Bella Beauty Salon
Silas First Baptist of Severna Park
Smoke Free Holy Ground
Stevens Hardware
Straight Way Apostolic Temple
Suzanne's Florist, Inc.
Tammy Loves Us, Inc.
Treasure Island
Union Memorial United Methodist Church
The Pizza Shop, Inc.
The Unknown Artist
Viet-Thai Paradise Restaurant
Vivo!
Wayman Good Hope A.M.E. Church

Baltimore City

AARP 4636
The ANA Group, LLC
Antioch Ever Increasing Faith International Church, Inc.
Apostolic Ministerial Alliance, Inc.
Arcadia Improvement Association
Ark Church
Austin Consulting
Baltimore City Council
Baltimore City Young Democrats
Baltimore Ethical Society
Baltimore Medical System, Inc.
Baptist Ministers Night Conference
Berean Baptist Church
Big Brothers Big Sisters of the Greater Chesapeake
Black CORDZ Barbershop
Bmore Fit Body Posse, LLC
Bolton Street Synagogue
Brown, Goldstein & Levy, LLP
Brown Memorial Park Avenue Presbyterian Church
BUILD Fellowship - Tabitha's House
Cadet Martial Arts & Fitness
Callegary & Steedman, P.A.
Canaan Missionary Baptist Church
Charm City Clinic, Inc.
Chase-Brexton Health Services, Inc.
Chemical People Task Force of Cherry Hill
Child First Authority, Inc.
Christian Community Church of God
Church of the Holy Nativity
City Temple of Baltimore
Community Assistance Network
Concord Baptist Church
Cookie Lee Jewelry
Destiny Baptist Church
Dream Hair Lounge
Dynamic Deliverance Cathedral
Eastern Technical High School Student Council
First Apostolic Faith Gospel Tabernacle
First Mount Carmel Christian Community Church
Freedom Temple AME Zion Church
Friendship Baptist Church
From Bankruptcy to Bounty Worldwide Ministries
Garden of Prayer Baptist Church
Gateway to Beauty
Gennuso Barber Shop
Gethsemane African Methodist Episcopal Church
Gillis Memorial Christian Community Church
God's Grace Apostolic Faith
God's Women of Promise, Inc.
Gordon's Florist
Govans Ecumenical Development Corporation
Greater Bethlehem Temple
Greater Homewood Interfaith Alliance
Greater St. John Baptist Church
Greater St. Peter Church of God

Harbor Pediatrics
Highrock Baptist Church
Historic Saint Paul Community Baptist Church
Holy Comforter Lutheran Church
Holy Rock Christian Community Church
Homebody Fitness
Homewood Friends Meeting
Hope Community Ministries
Hopkins United Methodist Church
HR Construction
Hunting Ridge Presbyterian Church
Infinite Biomedical Technologies, LLC
Interfaith Association of Roland Park
The Intersection
Intrepid Foundation for Urban Youth Empowerment
Joan Carpenter - Mary Kay
KBC Fanci Fixins
Kerygma Ministries
Kidz Nite Inn
King's Landing Women's Service Club
Koinonia Baptist Church
Koinonia Baptist Daycare
Lake Evesham Community Association
Lewis Grocery
Lin's Loving Care Assisted Living
Livingston Construction
Mandarin Taste
Maryland Group Faculty Practice
Memorial Baptist Church
Men and Families Center
Messiah Lutheran Church
Midtown Edmondson Avenue Improvement Association
Missey's Desserts
Mount Lebanon Baptist Church
Mount Olive Holy Evangelist Church
Mount Sinai Baptist Church
Muslim Community Cultural Center of Baltimore
NAACP – Baltimore City Branch
NAACP – Baltimore City Health Committee
New All Saints Catholic Church
New Antioch Baptist Church
New Christian Memorial Church
New Faith Deliverance
New Hope Baptist Church
New Joy Church and Ministry
New Life Kingdom Ministry
New Light A.M.E. Zion Church
New Pleasant Grove Missionary Baptist Church
Northeast Community Organization (NECO)
Old Goucher Business Alliance
Park Heights Community Health Alliance
People's Community Health Centers, Inc.
Perkins Square Baptist Church
Phi Beta Sigma Fraternity, Inc.
Pilgrim Temple Church, Inc.
Prince of Peace Baptist Church
Progressive First Baptist Church
Project PLASE (People Lacking Ample Shelter and Employment)
Project Safe Haven
Rehoboth Church of God in Christ
Refuge of the Cross Church of Christ
Restoration Community Church
Resurrection Ministry
Save Another Youth, Inc.
SBC Outreach
Sharon Bond - Avon
Shiloh Christian Community Church Sisters Together and Reaching, Inc.
Small Office Solutions
Snoball Hut
Some New Creations
Souls for Christ
Spanner In the Works, LLC
St. Edward Roman Catholic Church
St. Elizabeth of Hungary Roman Catholic Church
St. Joseph Freewill Baptist Church
St. Matthew Church
St. Matthew's Gospel Tabernacle Church
St. Matthew's New Life United Methodist Church
St. Vincent de Paul Church – Peace & Justice Committee
Stony Run Friends Meeting
Stop the Violence Coalition
Tastefully Simple
Techs 4IT, Inc.
The Children's Mission, Inc.
The Holy One of Israel Ministries, Inc.
The Lord's Church
The Lord's Church Ministries
The New Good Samaritan Baptist Church
Time Printers
Total Health Care, Inc.
Traffic Managers, Inc.
Treatment Resources for Youth, Inc.
Trinity Baptist Church
Trinity Baptist Church – Health Ministry
Union Baptist Church
Union Baptist Head Start
Victory Missionary Baptist Church
Village Baptist Church
Will's Barbershop
Wilson Park Christian Community Church
Winston Avenue Baptist Church
Zion Baptist Church
Zion Baptist Church of Christ

Baltimore and Harford Counties

A Better Way
Against the Grain
All American Tag & Title
ASAS
Asbury United Methodist Church
At Event Planning
Atwaters
Awaken the Spirit Wellness
Baltimore County Medical Association
Baltimore County Young Democrats
Baltimore Network of the Esimorp Coalition
Bodyworks Tannery
Business Plans, LLC
Café Di Roma
Caton Auto Clinic
Caton Auto Clinic Fleet Center
Caton Auto Clinic Maintenance Shop
Catonsville Car Center
Catonsville Chamber of Commerce
Catonsville Custom Framing
Children's Home Athletic Department
Constellation Design Group, Inc.
Dealysa Agency
Diane's Dinette
Dings N Things
Doris' Closet Consignment
Douggie's
Downtown Massage Therapists
Dr. David Hoffman Dental Practice
Dr. Neeraj Verma Medical Practice
Dundalk Pediatric Associates
Empowerment Temple
Floor Matt, LLC
Glencoe Auto
Goody's Folkart
Hairoglyphics
Halethorpe Liquors
Hamis Yoga
Harford County Regional Association of Student Councils
Head Graphics
Hill's Car Service
Holy Comforter Lutheran
Indiana Floor, Inc.
IRC, Inc.
Isaiah Baptist Church
Iskcon Baltimore
Larry Goodwin & the Divine Shepherds
Larry's Quality Cuts
Lee Myles Transmissions
Lemon Meringue Thrift & Gift
Lighthouse, Inc.
Lily's Bridal
McDonals
Michael A. Zwaig, PA
NAACP – Baltimore County Branch
NAACP – Harford County Branch
NAMI Harford County
NARFE Chapter 1936
New Harford Democratic Club
New Life Fellowship
New Royal Baptist Church
Objects Found
Oella Physical Therapy
Park Moving and Storage, Inc.
Park School Student Senate
The Parks Agency
Peason Travel Service
Performance Collision
Renewed Hope Church
Robinson Consulting

The Session of Brown Memorial Woodbrook Presbyterian Church
Shulman & Associates, Inc.
Sigman & Summerfield Association, Inc.
Sister's Treasures
Southwest Baltimore County Democrat Club
Speed's Cycle
Staub Art Studio
Timothy Taylor Homes Services, Inc.
Towson Unitarian Universalist Church
Towson University Wellness Center
Traci Lynn Fashion Jewlery
TRG Networking, Inc.
Trucking & Transportation, Inc.
Village Elders Senior Shopping Service

Eastern Shore (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicimico, Worcester Counties)
Alpha Cleaning Systems
Associated Black Charities of Cambridge
Brooklett's Place Talbot Senior Center
Cambridge Church of Christ
Family Care of Easton, LLD
Family & Friends of Asbury & Green Chapel, Inc.
Great Event Planners
Kent County High School Student Government Association
Mount Zoar AME Church
NAACP – Caroline County Branch
NAACP – Cecil County Branch
NAACP – Dorchester County Branch
NAACP –Kent County Branch
NAACP – Queen Anne's County Branch
NAACP – Somerset County Branch
NAACP – Talbot County Branch
NAACP – Wicomico County Branch #7028
NAACP –Worcester County Branch
NAMI Cecil County
New St. John's United Methodist Church
Samuel T. Hensley Elks Lodge #974
Scott's United Methodist Church
Talbot County Democratic Forum
Talbot County Democratic Women's Club
Talbot County Health Department
Talbot Partnership for Alcohol and Other Drug Abuse Prevention
Upper Shore Aging, Inc.
West Cecil Health Center, Inc.
Wicomico County Medical Society
Wicomico Neighborhood Congress

Frederick County
Asian American Center of Frederick
Frederick County Medical Society
Frederick Keys Baseball Club
Mental Health Association of Frederick County
NAACP – Frederick County Branch
NAMI Frederick County
Opal Ridge Dental
Smoke Free Maryland Coalition – Frederick County
Women's Democratic League of Frederick County
Unitarian Universalist Congregation of Frederick – Social and Environmental Just ice Committee
United Democrats of Frederick County

Howard County
American Renal
Ardinger Consultants & Associates (ACA)
Artists and Frames
Association of Community Services
Bethany United Methodist Church
British American Auto Care, Inc.
Child Health Foundation
Columbia Church of God in Christ
Columbia Democratic Club
Columbia Personal Trainer Charlotte Lysic
Elite SFN
Ellicott City Dialysis
Emilia's Acrobatics Gymnastics and Cheerleading
Emory United Methodist Church
Excel Cleaners
Fit and Healthy You with Dr. Ali
Fox's Firearms
Genesis Arts, LLC
Granite Tutorial
Grassroots Crisis Intervention Center, Inc.
Healthy Howard
Howard County Association of Student Councils
Howard County Cancer and Tobacco Coalition
Howard County Medical Society
Howard County Student Government Association
James Ferry Photography
Kernal Mission Church
Kristie's Salon and Barber
Kyoto Day Spa
Let There be Rock Schools
Lights Out Gym
Lord is My Shepard Baptist Church
M.L. Smith Electric, Inc.
Moving by Faith Cleaning Service, LLC
NAACP – Howard County Branch
NAMI Howard County
New Hope Seventh-day Adventist Church
No Excuses Fitness
One For All Dance Academy, LLC
Patapsco Friends Meeting
Pinky Nails
Roll Up N Dye
Snowden River Liquor
Spring Water Designs Quilting
Springfield Presbyterian Church
St. John United Methodist/Presbyteria n Church
Twig
Variations, Inc.
Vickey's Nails
US Carpet

Montgomery County
Adventist HealthCare
African American Health Program – Montgomery County Health & Human Services
Am Kolel
Art Saunders Consulting, Inc.
Bethel World Outreach Church
Bethesda Cares, Inc.
Boy Scouts of Takoma Park
Charles E Smith Jewish Day School Student Council
Citi Center, Inc.
Community Clinic, Inc.
Dr. Karen Fleischer Medical Practice
Dr. Mauricio Cortina Medical Practice
Fernand Body Shop
Flamingo Terrace Enterprises, Inc.
Go Mom Go
Hughes United Methodist Church
Illuminata Healing Arts
JBA Coaching Services, LLC
Long Branch Neighborhood Initiative
Montgomery County Junior Council, Student Councils
Montgomery County Region, Student Councils
Montgomery Health Care Action
Montrose View Psychotherapy Associates, LLC
Morse Enterprises, Inc.
NAACP – Montgomery County Branch
NAMI Montgomery County
NARFE Chapter 1892 – Aspen Hill
NARFE Chapter 0581 -- Gaithersburg
Oak Grove AME Zion Church
Ocean's Away
River Road Unitarian Universalist Congregation – Social Justice Council
Robin Richmond Music
Robin Richmond Yoga & Massage
Salem Gospel Ministries
Sandy Spring Friends School Student

Government Association
Smoke Free Promenade
Somah American Community Association
Suburban Video
Takoma Park Home Learning Network
Takoma Parents & Kids
Takoma Plays
Woman's Democratic Club of Montgomery County, MD
Women on a Mission
Coalition, Inc.

Prince George's County
AD/HD Health & Wellness Coaching
Affordable Behavioral Consultants (ABC), Inc.
Afrique Caribbe International
American Caner Society's Volunteer Prince George's Leadership Council
American Medical Student Association –University of Maryland Chapter
AmpVita, LLC
Ancestral Knowledge
Antioch Baptist of Clinton
Art Works Now
Artistic Nails
Beth Shalom AME Zion Church
Bowie One Barbershop
Boy Scout Troop 257
Bridge to Health Care, Inc.
Camp Fire Patuxent
Casa Blanca Bakery
Center Point Baptist Church
Chef Lou's Desserts
Cheverly Boys & Girls Club
Cheverly Community Market
Cheverly Meals on Wheels
Cheverly STEM Education Center
Cheverly Weekday Nursery
Cheverly Weekday Security
Cheverly United Methodist Church
Cheverly Woman's Club
Cheverly Young Actors Guild
Christ Kingdom Church
Christian Community Presbyterian Church
Church of the Great Commission
Crossover Church Food Pantry
Curves of Greenbelt
Darlene Terrell Artistic Designs
Deaf Ministry of Greater Mt. Nebo AME Church
Deciduous Dave's Walking Sticks and Stuff
Disciples of Christ Christian Church Ministry
Dr. Joel Lang Financial Planning
Ebenezer AME Church
El Buen Gusto
Electronic Center
Empire Cleaners
Flexin Car Club
G – 12 Youth
Empowerment Center
G&G Heating and Cooling
Galbraith AME Zion Church
Gayle Electric
General Accounting & Tax Services
Girl Scouts Troop 437
Girl Scouts Troop 3443
Greater Mount Nebo AME Church
Greenbelt Dental Care, P.C.
Generous Joe's Deli
Greenbelt Sportsplex
Hair Afrique
Haircut 2000
Healthy Futures Family Program
Highland Park Christian Academy
Insurance USA Corporation
Jitterbug Construction LLC
Jones, Mitchell and Associates, LLC
Kentland Civic Association
King David Productions
Latin American Youth Center
Laurel Advocacy and Referral Services (LARS), Inc.
Lee's Nail Day Spa
Livin' the Light, LLC
Living Faith Baptist Church and International Ministries
Living Word Bible Fellowship
Majestik Events
Manorstone Security
Marlboro Meadows Baptist Church
Maryland Center at Bowie State University
Master Sivananda's Institute for Yoga and Health
Merino Home Improvement Corporation
Mighty Men of Strength, Inc.
Mitchellville Florist
Mobilizing Communities
Mount Zion AME Church
My Cell Phone Repairs
NAACP – Prince George's County Branch
NAMI Prince George's County
New Deal Cafe
New Hope Baptist Church
NJR Auto Services
Prince George's County Council
Prince George's County Medical Society
Prince George's Regional Association of Student Government
Rainbow 1627
Realty 1, Inc.
The Sanctuary at Kingdom Square
SIDS Educational Services, Inc.
Social Action Committee, Paint Branch Unitarian Universalist Church
Sport Outlet
St. Vincent Pallotti High School SGA
Take Charge Juvenile Program
Tonya Rodgers Health Ministry
Touch As Art
University Liquor
Vina Fabrics
Vine Corps, Inc.
Visiting Angels
Volunteers of America – Prince George's County Chapter
Woodland Job Corps Center

Southern Maryland (Calvert, Charles, St. Mary's Counties)
9 Pearls Production
Abuja International Foods
Calvert Association of Student Councils
Checks Cashed & More Wireless Expo
Choptican High School Student Government Association
Country Nutrition
Dee's Wild Bird Lovers
Direct Auto Brokerage, LLC
DWI Services Inc. DBA The Carol M. Porto Treatment Center
Esperanza Middle School Student Government Association
Family Med's, Inc.
Fancy Vans Mobility
Father Andrew White Student Council Association
Feli's Salon & Spa
Good Shepard United Methodist Church
HB Medical & Wellness Care
House of Pop Culture
John's Automotive & Transmission
La Plata United Methodist Church
Leonardtown High School Student Government Association
Lucky PALS
Margaret Brent Middle School Student Government Association
Melbourne One Hair Studio
Mike's Chicken & Ribs
NAACP – Calvert County Branch
NAACP – Charles County Branch
NAACP - St. Mary's County Branch
NARFE Chapter 1260
New Horizon Child Development Center
Real Deal Boutique
Oeufs Auto
Patuxent High School Student Government
Q's Barbering
Real Deal Boutique
Southern Maryland Pawn Brokers, LLC
St. Mary's Association of Student Councils
St. Mary's Ryken Student Government Association
TW Racing
Vogel's Flowers
Waldorf RC & Hobbies
Waldorf Shoe Repair
Waldorf Signs, Inc.
Waldorf Trucking
Yori's Cleaners
Young's Auto Service

Western Maryland (Allegany, Carroll, Garrett, Washington Counties)

A.D. Naylor & Co., Inc.
Allegany County Association of Student Councils
Church Women United in Washington County – Executive Council
First Missionary Baptist Church
Mountain Laurel Medical Center, Inc.
NAACP – Allegany County Chapter
NAACP – Carroll County Branch
NAACP – Garrett County Branch
NAACP – Washington County Branch
NAMI Allegany County
NAMI Carroll County
NAMI Garrett County
NAMI Washington County
Phi Alpha – McDaniel College Chapter

HSCRC
2014 CBR Findings

Steve Ports, Principal Deputy Director

Findings from FY 2014 Summary Report

- FY14 – total of 52 hospitals: 46 acute and 6 specialty hospitals
- FY13 – total of 47 hospitals: 46 acute and 1 specialty hospital

- Reported Total Community Benefits
  - FY 14 – $1.5 billion
  - FY 13 – $1.5 billion

- CBR Dollars as a Percentage of Hospital Operating Expenses
  - FY 14 –10.62% - Ranging from 2.61% to 27.46% with an average of 10.47%
  - FY 13 –11.05% - Ranging from 3.12% to 24.06% with an average of 11.12%

- Staff Hours Dedicated to CB
  - FY 14– Average 1514 hours
  - FY 13 – Average 1699 hours

Offsetting Charity Care, DME, and NSPI

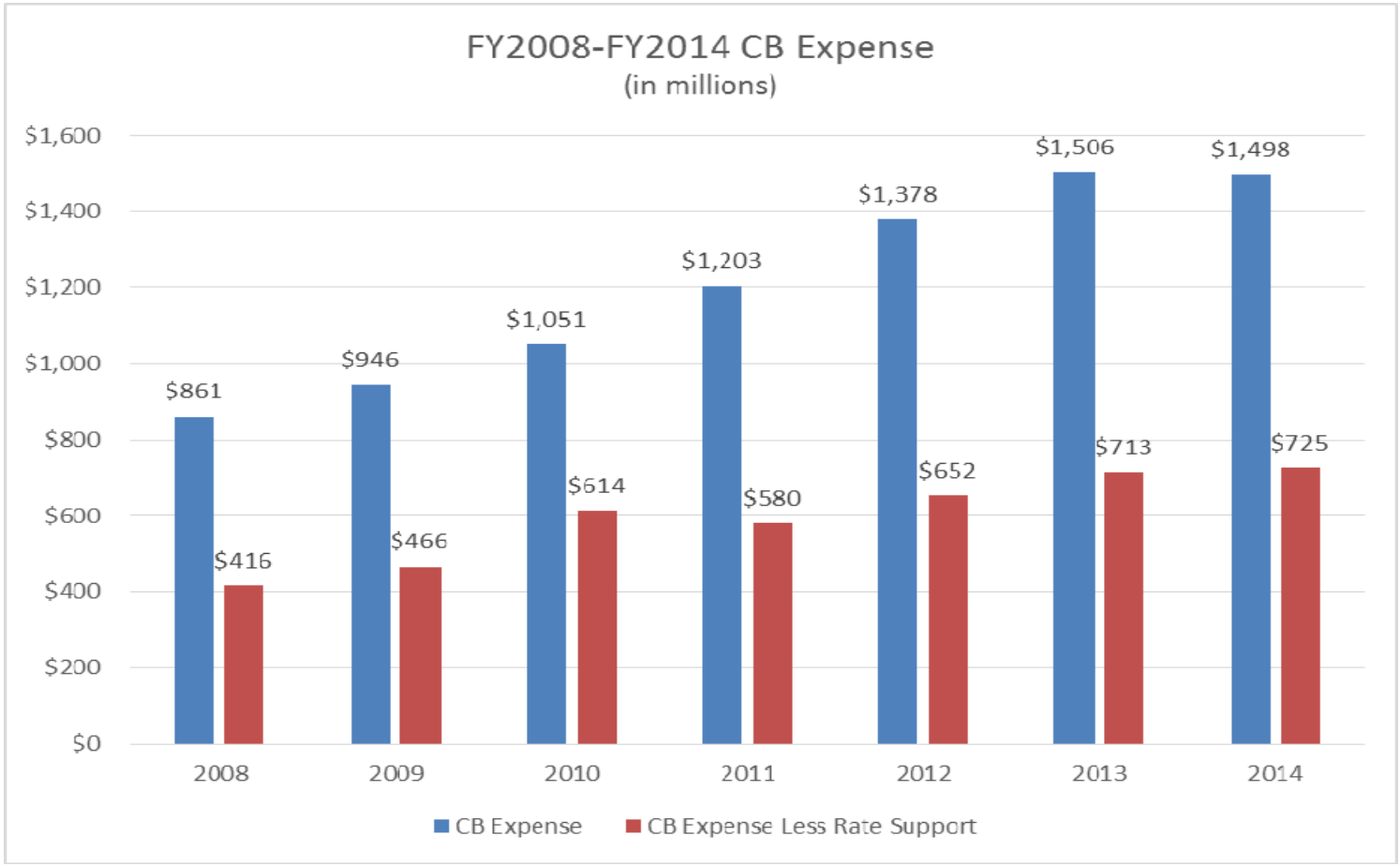
- 2014 Charity Care DME and NSPI Rate Funding:
  - Charity Care - $463.9 million
  - DME - $294.4 million
  - NSPI - $15.1 million

- Total Net Community Benefit Expenditures
  - 2014 - $724.7 million (5.14% of expenses)
  - 2013 - $712.4 million (5.23% of expenses)

- In FY 14 Hospitals provided $19.9 million more in charity care than was provided in rates – down from $54.6 million in FY13.
  - Due to increase in insured population?

FY2008-FY2014 Community Benefit Expenditures

- Increase from $861 million to $1.5 billion



Narrative Highlights

- Top Health Needs to be addressed by hospitals - Identified through CHNA process:
    - Heart Disease
    - Obesity
    - Behavioral/Mental Health/Substance Abuse
    - Diabetes
    - Access to Care
    - Cancer

- Prevalent unmet health needs identified but not to be addressed by hospitals.
    - Behavioral/Mental Health/Substance Abuse
    - Transportation
    - Cancer
    - Safe Housing
    - Dental Health

Observations

- Dollars and effort toward CB has continued to grow but the total amount has appeared to level off in FY 2014 (however net CB continues to grow)
- Reductions in the percentage of charity care may impact the total amount invested in CB
- The quality of the narrative reporting is getting better but still room for improvement
  - Describing information gaps impacting ability to assess needs of community
  - Describing process and methods to conduct CHNA's
  - Prioritizing community needs with criteria
  - Explanation of unmet needs
- Strategic transformation planning and partnerships will likely provide more information to address these issues in future

Maryland Hospital Community Benefit Report: FY 2014

September 9, 2015

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

Table of Contents

INTRODUCTION

Each year, the Maryland Health Services Cost Review Commission (HSCRC) collects community benefit information from individual hospitals to compile into a publicly available, statewide Community Benefit Report (CBR). Current year and previous CBRs submitted by the individual hospitals are available on the HSCRC's website.

This summary report provides background information on hospital community benefits and the history of CBRs in Maryland. It is followed by an overview of the data and narrative reporting for fiscal year (FY) 2014, which includes, for the first time, reporting from Maryland specialty hospitals. It concludes with a summary of data reports from the past eleven years. Additional information regarding hospital rate support, community benefit data for each hospital, and the breakdown of costs by community benefit activity is included as attachments.

Background

Section 501(c)(3) of the Internal Revenue Code (IRC) identifies as tax-exempt, organizations that are organized and operated exclusively for specific purposes including religious, charitable, scientific, and educational purposes.[1] Nonprofit hospitals receive many benefits from their tax-exempt status. They are generally exempted from federal income and unemployment taxes, as well as state and local income, property, and sales taxes. In addition, they are allowed to raise funds through tax-deductible donations and tax-exempt bond financing.

Originally, the Internal Revenue Service (IRS) considered hospitals to be "charitable" if they provided charity care to the extent of their financial ability to do so.[2] However, in 1969, the IRS issued Revenue Ruling 69-545, which modified the "charitable" standard to focus on "community benefits" rather than "charity care."[3] Under this IRS ruling, nonprofit hospitals were required to provide benefits to the community in order to be considered charitable. This created the "community benefit standard," which is necessary for hospitals to satisfy in order to qualify for tax-exempt status.

In March 2010, Congress passed the Patient Protection and Affordable Care Act (ACA).[4] Section 9007 of the ACA established IRC §501(r), which identifies additional requirements for hospitals that seek to maintain tax-exempt status. Every §501(c)(3) hospital, whether independent or part of a hospital system, must conduct a community health needs assessment (CHNA) at least once every three years in order to maintain its tax-exempt status and avoid an annual penalty of up to $50,000.[5] The first CHNA was due by the end of FY 2013. Each assessment must incorporate

[1] 26 U.S.C. §501(c)(3)
[2] Rev. Ruling 56-185, 1956-1 C.B. 202.
[3] Rev. Ruling 69-545, 1969-2 C.B. 117.
[4] The Patient Protection and Affordable Care Act, P.L. 111-148 (2010),as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152.
[5] 26 U.S.C. §501(r)(3); 26 U.S.C. §4959

input from individuals who represent the broad interests of the community served, including those with special knowledge or expertise in public health, and the assessment must be made widely available to the public.[6] An implementation strategy describing how a hospital plans to meet the community's health needs must be included, as well as a description of what the hospital has done historically to address its community's needs.[7] Furthermore, the hospital must identify any needs that have not been met by the hospital and explain why those needs have not been addressed. Tax-exempt hospitals must report this information on Schedule H of the IRS 990 forms.

The Maryland CBR process was adopted by the Maryland General Assembly in 2001,[8] with FY 2004 established as the first data collection period. Under Maryland law, the CBR must include the hospital's mission statement, a list of the hospital's initiatives, and the cost of each community benefit initiative. It must also include the objectives of each community benefit initiative, a description of efforts taken to evaluate the effectiveness of the initiatives, a description of gaps in the availability of specialist providers, and a description of the hospital's efforts to track and reduce health disparities in the community.[9]

The HSCRC worked with the Maryland Hospital Association (MHA), interested hospitals, local health departments, and health policy organizations and associations on the details and format of the CBR. In developing the format for data collection, the group drew heavily on the experience of the Voluntary Hospitals of America community benefit process, which possessed, at the time, more than ten years of voluntary hospital community benefit reporting experience across many states. The resulting data reporting spreadsheet and instructions were used by Maryland hospitals to submit the FY 2004 data to the HSCRC in January 2005. The HSCRC's first CBR, detailing FY 2004 data, was published in July 2005. The HSCRC continues to work with the MHA, public health officials, individual hospitals, and other stakeholders to further improve the reporting process and refine the definitions, as needed. The data collection process offers an opportunity for each Maryland nonprofit hospital to critically review and report the activities it has designed to benefit the community.

The FY 2014 report represents the HSCRC's eleventh year of reporting on Maryland hospital community benefit data.

Definition of Community Benefits

Maryland law defines a "community benefit" (CB) as an activity that is intended to address community needs and priorities, primarily through disease prevention and improvement of health status, including:[10]

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[6] 26 U.S.C. §501(r)(3)(B)
[7] 26 U.S.C. §501(r)(3)(A)
[8] Health-General Article §19-303 Maryland Annotated Code
[9] Health-General Article §19-303(a)(3) Maryland Annotated Code
[10] Health-General Article §19-303(c)(2) Maryland Annotated Code

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

As evidenced in the individual reports, Maryland hospitals provide a broad range of health services to meet the needs of their communities, often receiving partial or no compensation. These activities, however, are expected from Maryland's 46 acute, and 8 specialty, nonprofit hospitals in return for their tax-exempt status.

ANALYSIS

Following are highlights of the FY 2014 data reporting and narrative reporting.

FY 2014 Data Reporting Highlights

The reporting period for this CBR is July 1, 2013, through June 30, 2014. Hospitals submitted their individual CBRs to the HSCRC by December 15, 2014. Audited financial statements were used to calculate costs for each of the community benefit categories in the data reports. Of the 54 nonprofit hospitals in Maryland, 52 submitted individual data reports. Two hospital systems, University of Maryland Shore Regional Health and the University of Maryland Upper Chesapeake Health, each submitted narratives covering both hospitals in their system. Shore Health submitted a single narrative covering both the University of Maryland Shore Medical Center at Easton and the University of Maryland Shore Medical Center at Dorchester. Upper Chesapeake Health submitted a single CBR covering both the University of Maryland Upper Chesapeake Medical Center and the University of Maryland Harford Memorial Hospital.

As shown in Table 1, Maryland hospitals provided approximately $1.5 billion dollars in total community benefit activities in FY 2014 (the same total as in FY 2013). This total comprises $483.8 million in charity care, $420.5 million in health professions education, $393.6 million in mission-driven health care services (subsidized health services), $86.3 million in community health services, $59.3 million in unreimbursed Medicaid cost, $17.5 million in community-building activities, $16.5 million in financial contributions, $10 million in research activities, $8.5 million in community benefit operations, and $2.1 million in foundation-funded community benefits (see Table 1). These totals include hospital reported indirect costs, which vary by hospital and by category from a fixed dollar amount to a calculated percentage of the hospital's reported direct costs.

Table 1. Total Community Benefits

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit Expenses	Percentage of Total Community Benefit Expenditures	Net Community Benefit Expense Less Rate Support	Percentage of Total Community Benefit Expenditures without Rate Support
Charity Care *	0	0	$483,833,108	32.3%	$19,924,270	2.7%
Health Professions Education *	6,594,984	225,260	$420,486,081	28.1%	$110,938,100	15.3%
Mission-Driven Health Services	2,553,469	858,131	$393,614,096	26.3%	$393,614,096	54.3%
Community Health Services	1,012,490	13,494,384	$86,287,120	5.8%	$86,287,120	11.9%
Unreimbursed Medicaid Cost	0	0	$59,270,451	4.0%	$59,270,451	8.2%
Community Building	177,077	583,447	$17,530,347	1.2%	$17,530,347	2.4%
Financial Contributions	46,548	178,978	$16,484,643	1.1%	$16,484,643	2.3%
Research	128,704	4,440	$9,998,833	0.7%	$9,998,833	1.4%
Community Benefit Operations	78,722	1,561	$8,529,825	0.6%	$8,529,825	1.2%
Foundation-Funded Community Benefits	40,924	13,702	$2,090,806	0.1%	$2,090,806	0.3%
Total	**10,632,917**	**15,359,902**	**$1,498,125,311**	**100.0%**	**$724,668,492**	**100.0%**

(*) Indicates category adjusted for rate support (direct medical education, Nurse Support Program I, and charity care)

In Maryland, the costs of uncompensated care (including charity care and bad debt) and graduate medical education are built into the rates for which hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC rates include amounts for nurse support programs provided at Maryland hospitals. These costs are, in essence, “passed-through”

to the purchasers and payers of hospital care. To comply with IRS form 990 requirements and avoid accounting confusion among programs that are not funded by hospital rate setting, the HSCRC requests that hospitals not submit revenue included in rates as offsetting revenue on the CBR worksheet. Attachment I details the amounts that are included in rates and funded by all payers for charity care, direct graduate medical education, and nurse support programs in FY 2014.

As noted, the HSCRC includes a provision in hospital rates for uncompensated care; this includes charity care, which is a considered to be a community benefit. It also includes bad debt, which is not considered to be a community benefit. Attachment I shows that $463.9 million in charity care was provided through Maryland hospital rates in FY 2014, which was funded by all payers. When offset by the $483.8 million in charity care reported by hospitals, the net amount of charity care provided by the hospitals was $19.9 million.

Another social cost funded through Maryland's rate-setting system is the cost of graduate medical education, generally for interns and residents who are trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (direct medical education, DME), which include the residents' and interns' wages and benefits, faculty supervisory expenses, and allocated overhead. The HSCRC's annual cost report quantifies the DME costs of physician training programs at Maryland hospitals. In FY 2014, DME costs totaled $294.4 million.

The HSCRC's Nurse Support Program I (NSPI) is aimed at addressing the short- and long-term nursing shortage impacting Maryland hospitals. In FY 2014, $15.1 million was provided in hospital rate adjustments for NSPI. See Attachment I for detailed information about funding provided to specific hospitals.

When the reported community benefit costs for Maryland hospitals are offset by rate support, the net community benefits provided in FY 2014 totaled $724.7 million, or 5.14 percent of total hospital operating expenses.[11] This is an increase from the $712.4 million in net benefits provided in FY 2013, which totaled 5.2 percent of hospital operating expenses (see Attachment II for additional detail).

Table 2 shows the breakdown of staff hours, number of encounters, and expenditures for health professions education by activity. The education of physicians and medical students comprises the majority of expenses in the category of health professions education, totaling $362.4 million. The second most expensive is the education of nurses and nursing students at $31.8 million and the third is the education of other health professionals, with $19.7 million.

[11] FY 2014 includes 5 additional specialty hospitals versus FY 2013.

Table 2. Health Professions Education Activities

Health Professions Education	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Physicians and Medical Students	5,597,736	32,558	$ 362,397,942
Nurses and Nursing Students	552,129	99,058	$ 31,826,084
Other Health Professionals	337,606	63,913	$ 19,662,486
Other	96,404	28,748	$ 3,838,063
Scholarships and Funding for Professional Education	11,110	947	$ 2,761,506
Total	**6,594,984**	**225,260**	**$ 420,486,081**

Table 3 provides a breakdown of staff hours, number of encounters, and expenditures for community health services by activity. Health care support services comprise the largest portion of expenses in the category of community health services, with $33.3 million. Community health education is the second most expensive with $23.1 million, and community-based clinical services is the third most expensive with $10.5 million.

For additional detail and a description of subcategories of the remaining community benefit categories, see Attachment III – FY 2014 Hospital Community Benefit Aggregate Data.

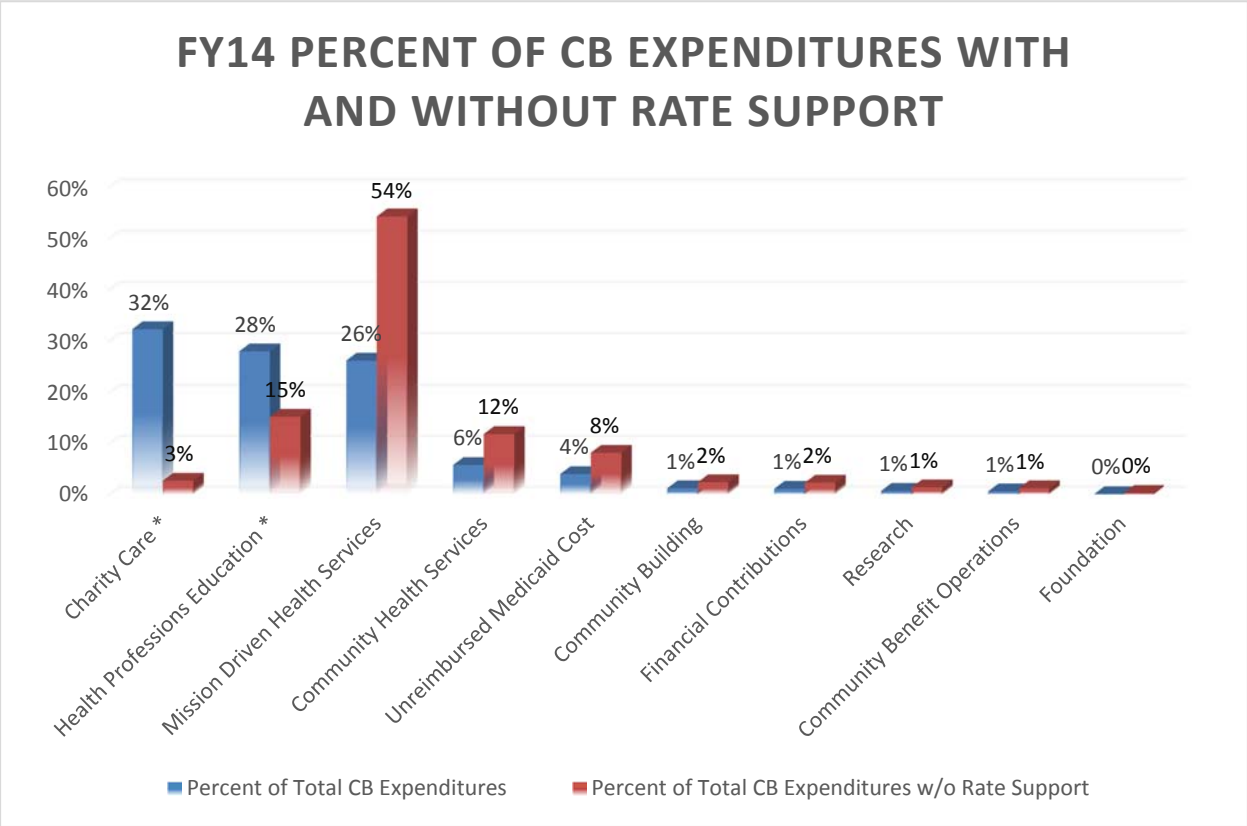
Table 3. Community Health Services Activities

Community Health Services	Number of Staff Hours	Number of Encounters	Net Community Benefit Expense
Health Care Support Services	233,587	193,063	$ 33,298,581
Community Health Education	275,495	12,608,953	$ 23,083,885
Community-Based Clinical Services	294,224	367,537	$ 10,537,173
Other	73,023	58,416	$ 8,011,395
Free Clinics	33,733	58,062	$ 5,141,824
Screenings	32,692	80,129	$ 2,293,163
Self-Help	25,129	68,568	$ 1,625,214
Support Groups	12,852	30,068	$ 1,043,498
Mobile Units	28,262	10,104	$ 873,520
One-Time and Occasionally Held Clinics	3,494	19,484	$ 378,865
Total	**1,012,490**	**13,494,384**	**$ 86,287,120**

The distribution of expenses by category is significantly impacted by rate offsetting. Figure 1 shows expenditures in each community benefit category as a percentage of total expenditures. Charity care, health professions education, and mission-driven health services represent the majority of the expenses, at 32 percent, 28 percent, and 26 percent, respectively. Figure 1 also shows the percentage of expenditures by category without rate support, which changes the configuration significantly: Mission-driven health services becomes the category with the highest

percentage of expenditures, at 54 percent. Health professions education follows with 15 percent of expenditures, and community health services comprises 12 percent of expenditures.

Figure 1. Percentage of Community Benefit Expenditures by Category with and without Rate Support



*Rate supported expenditures

Utilizing the data reported, Attachment II - FY 2014 Community Benefit Analysis compares hospitals on the total amount of community benefits reported, the amount of community benefits recovered through HSCRC-approved rate supports (charity care, direct medical education, and nurse support), and the number of staff and staff hours dedicated to community benefit operations. On average, in FY 2014, 1,514 staff hours were dedicated to community benefit operations, a decrease of 19 percent from 1,848 staff hours in FY 2013. Seven hospitals reported zero staff hours dedicated to community benefit operations, compared with four hospitals reporting zero staff hours during FY 2013. The HSCRC continues to encourage hospitals to incorporate community benefit operations into their overall strategic planning.

The total amount of community benefit expenditures as a percentage of total operating expenses ranges from 2.61 percent to 27.46 percent, with an average percentage of 10.47. This is a decrease from an average of 11.12 percent in FY 2013. Twenty-two hospitals report providing benefits in excess of 10 percent of their operating expenses, compared with 23 hospitals in FY

2013. In addition, 17 hospitals report providing benefits between 7.5 percent and 10 percent of their operating expenses, compared with 15 hospitals in FY 2013.

FY 2014 Narrative Reporting Highlights

In FY 2014, hospitals were again asked to answer narrative questions regarding their community benefit programs. The questions were developed, in part, to create a standard reporting format for all hospitals. This uniformity provided readers of the individual hospital reports with more information than was previously available and allowed for comparisons across hospitals. When possible, the narrative guidelines were aligned with IRS form 990, schedule H, in an effort to provide as much consistency as is practicable in reporting at the state and federal levels.

The HSCRC also considers the narrative guidelines to be a mechanism for assisting hospitals in critically reviewing their community benefit programs. Examination of the effectiveness of major program initiatives enables hospitals to better determine which programs are achieving the desired results and which are not. The point scoring system used previously to evaluate community benefit narrative reports was eliminated for FY 2014, and a new evaluation tool was created that increases the level of detail in the evaluations provided to each hospital. It is expected that this change will allow hospitals to improve future reports and increase consistency among all hospital reports in the future.

Fifty-two hospitals provided their CHNAs, but they varied significantly in length and the content and quality of the descriptions provided. The CHNA covers six topics: community served, information gaps, CHNA process and methods, prioritized needs, third-party collaboration, and facilities and resources available. For example, 44 hospitals provided clear descriptions of their community served and how it was determined, whereas eight hospitals did not provide clear descriptions or definitions. Only 15 hospitals clearly described information gaps that affect the hospitals' ability to assess the health needs of their community. Sixteen hospitals identified a gap within one area of data collection, but did not provide a detailed description of the information gaps. Twenty-one hospitals did not make any reference to information gaps.

Only 13 hospitals provided clear descriptions of the process and methods used to conduct their CHNAs and included sources, dates of data, and other information. Thirty-nine hospitals failed to include the names and titles of input providers, dates of data collection, or data from primary data collection methods. Only one hospital provided a prioritized description of all of the community health needs and the process and criteria used in prioritizing the needs. Seventeen hospitals provided a prioritized description of the top needs selected for implementation of initiatives, but not all identified needs. Thirty-four hospitals failed to provide their identified needs in any priority order or failed to describe the process used in prioritizing their needs. Most hospitals contracted with a third party to assist with the CHNA and clearly described the qualifications of the third party, whereas 21 hospitals did not contract with a third party. Twenty-one hospitals provided a description of existing health care facilities and other resources within the community to meet needs identified through the CHNA, whereas the remaining hospitals only provided part of this information.

Fifty-one hospitals provided an implementation strategy that clearly described how the hospital plans to meet the identified needs, although two of these hospitals' implementation strategies did not match the needs outlined in their community benefit narrative report. Thirty-eight hospitals identified and justified their unmet needs, whereas five hospitals did not provide explanations for all of their unmet needs. Two hospitals did not clearly define their unmet needs, and one hospital reported that it had no unmet needs. Similar to the CHNAs, the quality and level of detail in the hospitals' community benefit initiatives varied greatly.

FY 2004 – FY 2014 ELEVEN-YEAR SUMMARY

FY 2014 marks the eleventh year since the inception of the CBR. In FY 2004, community benefit expenses represented $586.5 million, or 6.9 percent of operating expenses. In FY 2014, these expenses represented $1.5 billion, or 10.6 percent of operating expenses. As Maryland hospitals have increasingly focused on implementation of cost- and quality-improvement strategies, an increasing percentage of operating expenses has been directed toward community benefit initiatives.

The reporting requirement for revenue offsets and rate support has changed since the inception of the CBR in FY 2004. For consistency purposes, the following figures illustrate community benefit expenses from FY 2008 through FY 2014. Figures 2A and 2B show the trend of community benefit expenses with and without rate support. On average, approximately 50 percent of the expenses have been reimbursed through the rate setting system.

Figure 2A. FY 2008 – FY 2014 Community Benefit Expenses with and without Rate Support

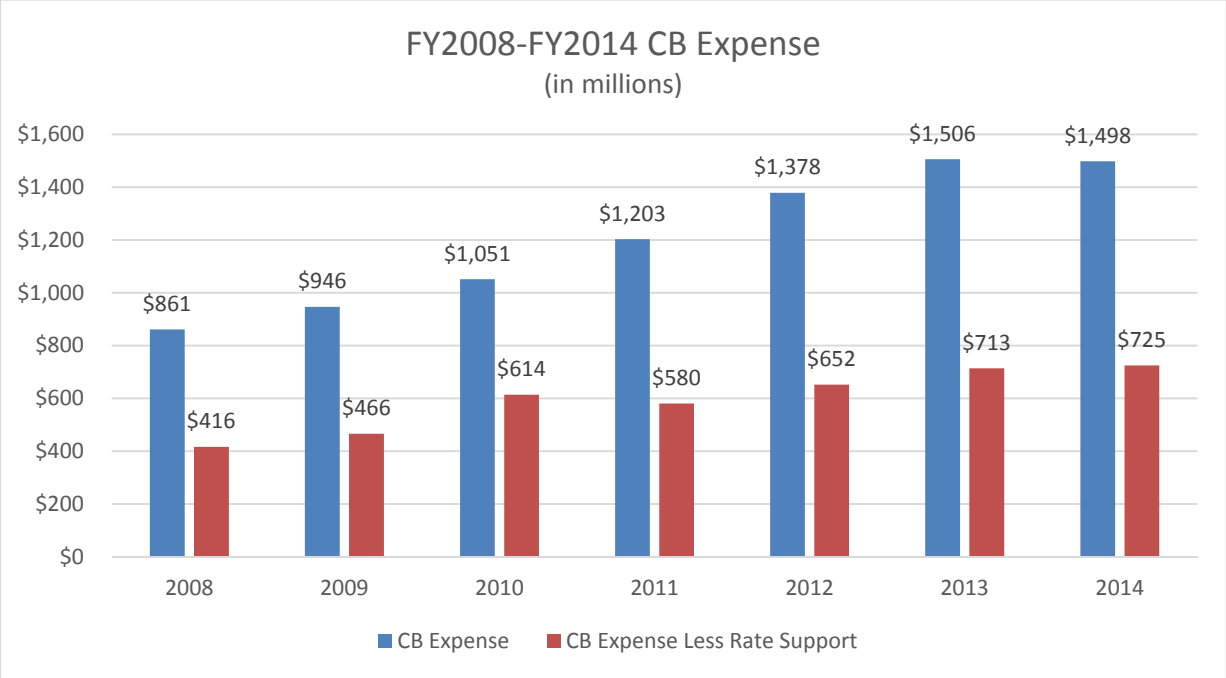
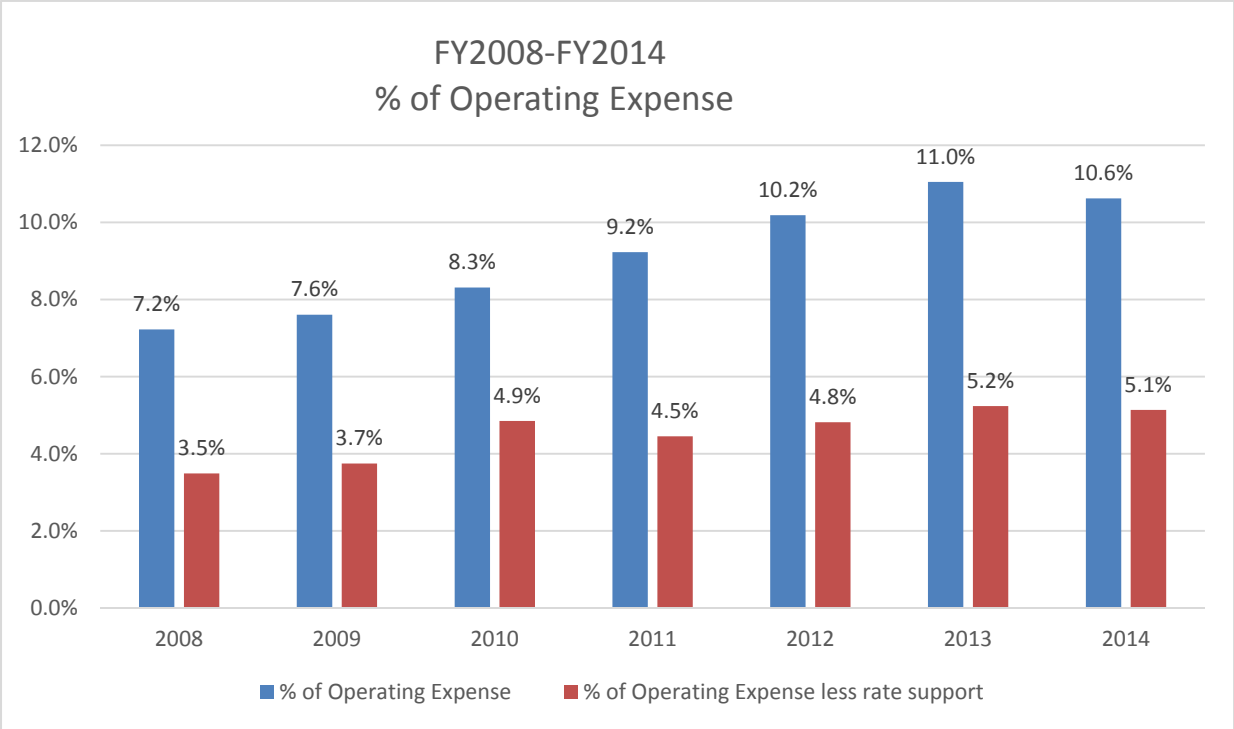


Figure 2B. FY 2008 – FY 2014 Percentage of Community Benefit Operating Expenses with and without Rate Support



CHANGES TO FY 2015 REPORTING REQUIREMENTS

The changes to Maryland's hospital narrative reporting requirements have resulted in more detailed narrative reports. For FY 2015, the community benefit administration section requires detailed explanations for each question rather than a "yes" or "no" response. A community benefit external collaboration section was also added to address hospital collaboration with external organizations, such as community-based organizations and local health departments, to perform activities to improve their community's health and conduct the CHNA. These changes and the elimination of the point scoring system will allow the HSCRC to send more detailed evaluations to hospitals, which in turn will assist them in submitting more consistent community benefit reports in the future. The HSCRC will continue to modify the community benefit reporting requirements to enhance consistency and improve evaluations.

Attachment I - Hospitals FY 2014 Funding for Nurse Support Program I, Direct Medical Education, and Charity Care

Hospital Name	Nurse Support Program I (NSPI)	Direct Medical Education (DMI)	Charity Care in Rates	Total Rate Support
Meritus Medical Center	$ 295,465	-	$ 7,505,016	$ 7,800,481
UMMC*	$ 1,420,398	$ 91,440,450	$ 73,498,009	$ 166,358,857
Dimensions Prince Georges Hospital Center	$ 255,904	$ 3,988,330	$ 17,544,927	$ 21,789,161
Holy Cross Hospital	$ 453,732	$ 2,757,760	$ 25,676,243	$ 28,887,735
Frederick Memorial	$ 334,410	-	$ 11,690,942	$ 12,025,352
UM Harford Memorial	$ 104,451	-	$ 3,046,391	$ 3,150,843
Mercy Medical Center	$ 459,266	$ 4,675,330	$ 21,375,445	$ 26,510,041
Johns Hopkins Hospital	$ 1,851,352	$ 103,050,920	$ 34,749,786	$ 139,652,057
UM Shore Medical Dorchester	$ 59,360	-	$ 1,760,573	$ 1,819,933
St. Agnes	$ 401,564	$ 6,888,070	$ 9,860,633	$ 17,150,268
LifeBridge Sinai	$ 676,603	$ 15,265,590	$ 12,231,834	$ 28,174,027
Bon Secours	$ 130,652	-	$ 11,914,216	$ 12,044,868
MedStar Franklin Square	$ 477,082	$ 7,574,040	$ 17,181,539	$ 25,232,661
Adventist Washington Adventist	$ 260,716	-	$ 12,237,739	$ 12,498,455
Garrett County Hospital	$ 42,710	-	$ 3,045,380	$ 3,088,090
MedStar Montgomery General	$ 165,915	-	$ 5,404,355	$ 5,570,270
Peninsula Regional	$ 414,766	-	$ 11,675,563	$ 12,090,329
Suburban Hospital	$ 272,892	$ 314,920	$ 4,354,574	$ 4,942,386
Anne Arundel Medical Center	$ 523,717	-	$ 4,779,088	$ 5,302,805
MedStar Union Memorial	$ 422,531	$ 11,238,490	$ 13,694,623	$ 25,355,644
Western Maryland Health System	$ 308,556	-	$ 10,507,545	$ 10,816,101
MedStar St. Mary's Hospital	$ 151,897	-	$ 4,606,886	$ 4,758,783
Johns Hopkins Bayview Medical Center	$ 584,860	$ 21,979,800	$ 19,315,954	$ 41,880,614
UM Shore Medical Chestertown	$ 65,052	-	$ 1,619,812	$ 1,684,863
Union Hospital of Cecil County	$ 148,428	-	$ 3,466,914	$ 3,615,342
Carroll Hospital Center	$ 243,424	-	$ 3,885,617	$ 4,129,042
MedStar Harbor Hospital	$ 209,694	$ 4,402,330	$ 10,513,303	$ 15,125,328
UM Charles Regional Medical Center	$ 126,394	-	$ 2,019,045	$ 2,145,439
UM Shore Medical Easton	$ 184,648	-	$ 4,330,984	$ 4,515,632
UM Midtown	$ 185,438	$ 4,245,770	$ 12,068,847	$ 16,500,055
Calvert Hospital	$ 135,741	-	$ 6,787,442	$ 6,923,183
Lifebridge Northwest Hospital	$ 238,730	-	$ 5,797,834	$ 6,036,564

Hospital Name	Nurse Support Program I (NSPI)	Direct Medical Education (DMI)	Charity Care in Rates	Total Rate Support
UM Baltimore Washington	$ 381,065	$ 421,820	$ 10,211,355	$ 11,014,241
GBMC	$ 426,432	$ 5,078,600	$ 4,352,953	$ 9,857,986
McCready	$ 17,710	-	$ 647,065	$ 664,775
Howard County Hospital	$ 275,202	-	$ 7,117,813	$ 7,393,015
UM Upper Chesapeake	$ 283,588	-	$ 5,072,096	$ 5,355,684
Doctors Community	$ 214,285	-	$ 12,025,485	$ 12,239,770
Dimensions Laurel Regional Hospital	$ 118,724	-	$ 4,544,597	$ 4,663,321
Fort Washington Medical Center	$ 46,176	-	$ 3,281,075	$ 3,327,251
Atlantic General	$ 95,474	-	$ 2,452,495	$ 2,547,970
MedStar Southern Maryland	$ 249,258	-	$ 3,383,194	$ 3,632,453
UM St. Joseph	$ 354,786	-	$ 4,751,548	$ 5,106,334
UM Rehabilitation and Ortho Institute	$ 117,995	$ 3,801,620	$ 863,428	$ 4,783,044
MedStar Good Samaritan	$ 311,855	$ 4,767,170	$ 7,018,282	$ 12,097,308
Adventist Shady Grove Hospital	$ 348,706	-	$ 10,040,391	$ 10,389,097
Lifebridge Levindale	$ 52,499	-	-	$ 52,499
Adventist Rehab of Maryland	$ 51,233	-	-	$ 51,233
Adventist Behavioral Health at Eastern Shore	-	-	-	$ -
Sheppard Pratt	$ 140,136	$ 2,436,050	-	$ 2,576,186
Adventist Behavioral Health Rockville	-	$ 80,000	-	$ 80,000
Mt. Washington Pediatrics	$ 49,447	-	-	$ 49,447
Total	$ 15,140,921	$ 294,407,060	$ 463,908,838	$ 773,456,820

*Contains both UMMC and Shock Trauma

Attachment II – FY 2014 Community Benefit Analysis

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Net CB Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates	Net CB (minus charity Care, DME, NSPI in Rates) as % of Total Operating Expense	CB Reported Charity Care
Meritus Medical Center	0	828	$292,347,127	$23,844,610	8.16%	$7,800,481	$16,044,128	5.49%	$7,993,597
UMMC	8,288	1,164	$1,305,636,000	$201,474,942	15.43%	$166,358,857	$35,116,085	2.69%	$55,444,257
Dimensions Prince Georges Hospital Center	1,678	160	$217,477,100	$59,720,405	27.46%	$21,789,161	$37,931,244	17.44%	$15,861,400
Holy Cross Hospital	3,293	5,776	$390,575,586	$55,856,400	14.30%	$28,887,735	$26,968,665	6.90%	$30,739,060
Frederick Memorial	2,110	0	$319,313,000	$30,580,563	9.58%	$12,025,352	$18,555,211	5.81%	$14,227,000
UM Harford Memorial	875	941	$80,416,000	$8,026,523	9.98%	$3,150,843	$4,875,680	6.06%	$3,428,179
Mercy Medical Center	3920	2,785	$426,907,600	$61,821,825	14.48%	$26,510,041	$35,311,784	8.27%	$24,885,600
Johns Hopkins Hospital	0	7,063	$1,928,280,000	$188,270,622	9.76%	$139,652,057	$48,618,565	2.52%	$32,721,000
UM Shore Medical Dorchester	627	375	$39,674,000	$5,394,100	13.60%	$1,819,933	$3,574,167	9.01%	$2,305,000
St. Agnes	2,690	0	$392,471,132	$26,869,027	6.85%	$17,150,268	$9,718,760	2.48%	$11,750,468
LifeBridge Sinai	4,612	5,971	$669,579,000	$58,776,319	8.78%	$28,174,027	$30,602,292	4.57%	$12,880,700
Bon Secours	785	0	$119,439,002	$22,271,852	18.65%	$12,044,868	$10,226,984	8.56%	$12,073,632
MedStar Franklin Square	3,309	3,360	$469,241,214	$35,491,348	7.56%	$25,232,661	$10,258,687	2.19%	$13,581,700
Adventist Washington Adventist*	1389	1,432	$217,791,712	$38,552,255	17.70%	$12,498,455	$26,053,799	11.96%	$14,404,325
Garrett County Hospital	344	80	$38,194,377	$4,687,445	12.27%	$3,088,090	$1,599,356	4.19%	$3,225,760
MedStar Montgomery General	1,166	0	$141,655,632	$9,749,053	6.88%	$5,570,270	$4,178,783	2.95%	$4,722,141
Peninsula Regional	2,538	184	$368,170,415	$35,900,136	9.75%	$12,090,329	$23,809,807	6.47%	$13,261,500
Suburban Hospital	1,753	1,797	$225,204,531	$21,432,492	9.52%	$4,942,386	$16,490,105	7.32%	$4,501,300
Anne Arundel Medical Center	4,136	1,440	$514,545,000	$36,050,991	7.01%	$5,302,805	$30,748,186	5.98%	$5,688,100
MedStar Union Memorial	2,256	0	$394,669,299	$42,190,902	10.69%	$25,355,644	$16,835,258	4.27%	$13,169,128
Western Maryland Health System	2,141	324	$282,308,921	$36,523,850	12.94%	$10,816,101	$25,707,749	9.11%	$14,413,981
MedStar St. Mary's Hospital	1,277	9,370	$131,503,457	$10,240,708	7.79%	$4,758,783	$5,481,925	4.17%	$3,430,456
Johns Hopkins Bayview Medical Center	3,367	1,256	$530,603,000	$58,159,948	10.96%	$41,880,614	$16,279,333	3.07%	$22,183,000

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Net CB Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates	Net CB (minus charity Care, DME, NSPI in Rates) as % of Total Operating Expense	CB Reported Charity Care
UM Shore Medical Chestertown	374	500	$47,354,000	$7,895,987	16.67%	$1,684,863	$6,211,124	13.12%	$2,067,000
Union Hospital of Cecil County	1,109	2,179	$146,635,757	$10,648,111	7.26%	$3,615,342	$7,032,769	4.80%	$3,064,396
Carroll Hospital Center	2,027	2,080	$209,384,000	$16,040,970	7.66%	$4,129,042	$11,911,928	5.69%	$3,355,681
MedStar Harbor Hospital	1,241	177	$189,700,114	$22,372,526	11.79%	$15,125,328	$7,247,198	3.82%	$6,997,842
UM Charles Regional Medical Center	0	1,622	$108,755,000	$9,583,933	8.81%	$2,145,439	$7,438,494	6.84%	$1,864,000
UM Shore Medical Easton	1,292	820	$160,829,000	$15,078,264	9.38%	$4,515,632	$10,562,633	6.57%	$5,828,000
UM Midtown	1,120	1,188	$178,869,000	$35,810,878	20.02%	$16,500,055	$19,310,823	10.80%	$14,755,634
Calvert Hospital	1,400	183	$119,481,772	$19,895,054	16.65%	$6,923,183	$12,971,872	10.86%	$7,010,751
Lifebridge Northwest Hospital	1,607	583	$212,164,000	$17,551,055	8.27%	$6,036,564	$11,514,492	5.43%	$6,203,971
UM Baltimore Washington	2,909	104	$319,031,000	$31,234,487	9.79%	$11,014,241	$20,220,246	6.34%	$13,307,038
GBMC	2,559	4,370	$381,697,000	$18,320,492	4.80%	$9,857,986	$8,462,507	2.22%	$4,337,420
McCready	250	30	$14,682,491	$758,175	5.16%	$664,775	$93,400	0.64%	$572,384
Howard County Hospital	1,671	803	$231,080,000	$21,136,745	9.15%	$7,393,015	$13,743,730	5.95%	$6,010,720
UM Upper Chesapeake	2,037	2,197	$236,718,000	$15,009,652	6.34%	$5,355,684	$9,653,968	4.08%	$4,956,053
Doctors Community	1,466	2,200	$176,796,204	$18,627,103	10.54%	$12,239,770	$6,387,333	3.61%	$14,726,686
Dimensions Laurel Regional Hospital	743	160	$104,245,600	$15,661,030	15.02%	$4,663,321	$10,997,709	10.55%	$4,507,400
Ft. Washington	417	0	$38,620,727	$2,222,903	5.76%	$3,327,251	-$1,104,348	-2.86%	$1,614,129
Atlantic General	835	158	$101,574,098	$14,249,336	14.03%	$2,547,970	$11,701,367	11.52%	$3,594,293
MedStar Southern Maryland	1,638	7,807	$219,466,790	$10,833,218	4.94%	$3,632,453	$7,200,765	3.28%	$3,582,453
UM St. Joseph	2,332	0	$310,933,000	$35,667,680	11.47%	$5,106,334	$30,561,346	9.83%	$7,375,769
Lifebridge Levindale	832	520	$74,832,811	$1,955,388	2.61%	$52,499	$1,902,889	2.54%	$767,401
UM Rehabilitation and Ortho Institute	686	728	$102,736,500	$11,513,710	11.21%	$4,783,044	$6,730,666	6.55%	$841,000
MedStar Good Samaritan	0	1,788	$303,307,419	$24,043,260	7.93%	$12,097,308	$11,945,952	3.94%	$7,581,945

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Net CB Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates	Net CB (minus charity Care, DME, NSPI in Rates) as % of Total Operating Expense	CB Reported Charity Care
Adventist Rehab of Maryland*	414	170	$33,160,122	$1,792,947	5.41%	$51,233	$1,741,714	5.25%	$756,000
Adventist Behavioral Health at Eastern Shore*	131	42	$9,317,745	$1,084,396	11.64%	-	$1,084,396	11.64%	$161,347
Sheppard Pratt	2,485	395	$198,270,704	$12,705,185	6.41%	$2,576,186	$10,128,999	5.11%	$8,367,519
Adventist Behavioral Health Rockville*	395	146	$33,990,541	$4,309,098	12.68%	$80,000	$4,229,098	12.44%	$2,546,393
Mt. Washington Pediatrics	650	1,677	$50,042,312	$1,567,465	3.13%	$49,447	$1,518,018	3.03%	$173,338
Shady Grove*	2027	1,790	$295,844,877	$28,669,946	9.69%	$10,389,097	$18,280,849	6.18%	$10,015,261
Totals	**77,805**	**78,722**	**$14,105,523,690**	**$1,498,125,311**	**10.62%**	**$773,456,820**	**$724,668,492**	**5.14%**	**$483,833,108**
Averages	**1,729**	**1,514**			**10.47%**			**6.18%**	

* The Adventist Hospital System has requested and received permission to report their community benefit activities on a calendar year basis to allow them to more accurately reflect their true activities during the community benefit cycle. The numbers listed in the "Total in Rates for Charity Care, DME, and NSPI*" column reflect the HSCRC's activities for FY 2014 and therefore are different from the numbers reported by the Adventist Hospitals.

Attachment III - FY 2014 Hospital Community Benefit Aggregate Data

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Unreimbursed Medicaid Cost								
T00	Medicaid Costs							
T99	**Medicaid Assessments**	**0**	**0**	**$ 373,183,714**	**$ 1,225,750**	**$ 315,139,013**	**$ 59,270,451**	**$ 58,044,701**
Community Health Services								
A10	Community Health Education	275,495	12,608,953	$ 16,009,920	$ 8,928,580	$ 1,854,615	$ 23,083,885	$ 14,155,305
A11	Support Groups	12,852	30,068	$ 697,438	$ 357,667	$ 11,607	$ 1,043,498	$ 685,831
A12	Self-Help	25,129	68,568	$ 1,560,401	$ 843,538	$ 778,726	$ 1,625,214	$ 781,675
A20	Community-Based Clinical Services	294,224	367,537	$ 13,456,136	$ 4,105,502	$ 7,024,464	$ 10,537,173	$ 6,431,672
A21	Screenings	32,692	80,129	$ 1,604,903	$ 897,952	$ 209,692	$ 2,293,163	$ 1,395,211
A22	One-Time and Occasionally Held Clinics	3,494	19,484	$ 338,809	$ 101,124	$ 61,067	$ 378,865	$ 277,742
A23	Free Clinics	33,733	58,062	$ 4,419,729	$ 2,191,789	$ 1,469,694	$ 5,141,824	$ 2,950,035
A24	Mobile Units	28,262	10,104	$ 1,298,417	$ 498,561	$ 923,458	$ 873,520	$ 374,959
A30	Health Care Support Services	233,587	193,063	$ 23,848,131	$ 11,398,249	$ 1,947,798	$ 33,298,581	$ 21,900,333
A40	Other	27,191	47,462	$ 3,367,343	$ 1,422,320	$ 62,631	$ 4,727,032	$ 3,304,712
A41	Other	43,752	8,045	$ 2,985,269	$ 81,657	-	$ 3,066,926	$ 2,985,269
A42	Other	2,080	2,909	$ 133,479	$ 83,958	-	$ 217,437	$ 133,479
A99	**Total**	**1,012,490**	**13,494,384**	**$ 69,719,974**	**$ 30,910,898**	**$ 14,343,752**	**$ 86,287,120**	**$ 55,376,222**
Health Professions Education								
B1	Physicians and Medical Students	5,597,736	32,558	$ 292,186,105	$ 70,211,837	$ -	$ 362,397,942	$ 292,186,105
B2	Nurses and Nursing Students	552,129	99,058	$ 25,911,056	$ 6,226,543	$ 311,515	$ 31,826,084	$ 25,599,541
B3	Other Health Professionals	337,606	63,913	$ 16,015,672	$ 3,990,109	$ 343,295	$ 19,662,486	$ 15,672,377

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
B4	Scholarships and Funding for Professional Education	11,110	947	$ 2,700,403	$ 61,103	-	$ 2,761,506	$ 2,700,403
B50	Other	90,291	25,219	$ 3,193,463	$ 324,381	$ 11,938	$ 3,505,906	$ 3,181,525
B51	Other	1,089	483	$ 1,835,855	$ 242,032	$ 2,029,982	$ 47,905	$ (194,127)
B52	Other	2,384	3,016	$ 158,637	$ 43,289	$ 96,984	$ 104,942	$ 61,653
B53	Other	2,640	66	$ 111,069	$ 68,241	-	$ 179,310	$ 111,069
B99	**Total**	**6,594,984**	**225,260**	**$ 342,112,260**	**$ 81,167,535**	**$ 2,793,714**	**$ 420,486,081**	**$ 339,318,546**
	Mission-Driven Health Services							
C.	**Mission-Driven Health Services Total**	**30,377**	**15,680**	**$ 6,168,660**	**$ 1,953,170**	**$ 1,933,811**	**$ 6,188,019**	**$ 4,234,849**
	Research							
D1	Clinical Research	85,220	4,423	$ 10,853,505	$ 2,741,850	$ 6,694,353	$ 6,901,002	$ 4,159,152
D2	Community Health Research	8,082	17	$ 644,356	$ 301,510	$ 14,000	$ 931,866	$ 630,356
D3	Other	35,402	0	$ 1,754,352	$ 411,612	$ -	$ 2,165,964	$ 1,754,352
D99	**Total**	**128,704**	**4,440**	**$ 13,252,213**	**$ 3,454,973**	**$ 6,708,353**	**$ 9,998,833**	**$ 6,543,860**
	Financial Contributions							
E1	Cash Donations	1,558	30,176	$ 9,789,828	$ 31,011	$ 7,996	$ 9,812,843	$ 9,781,832
E2	Grants	45	53	$ 580,060	$ 68,105	$ 259,435	$ 388,730	$ 320,625
E3	In-Kind Donations	39,574	143,639	$ 5,515,496	$ 323,566	$ 211,206	$ 5,627,856	$ 5,304,290
E4	Cost of Fund Raising for Community Programs	5,372	5,110	$ 520,723	$ 134,491	-	$ 655,214	$ 520,723
E99	**Total**	**46,548**	**178,978**	**$ 16,406,108**	**$ 557,173**	**$ 478,637**	**$ 16,484,643**	**$ 15,927,471**
	Community Building Activities							
F1	Physical Improvements and Housing	7,917	307,927	$ 3,584,407	$ 199,302	$ 2,690,625	$ 1,093,083	$ 893,782

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
F2	Economic Development	2,099	4,824	$ 690,819	$ 411,177	$ 361,691	$ 740,305	$ 329,128
F3	Support System Enhancements	66,859	23,704	$ 3,628,701	$ 1,787,213	$ 648,463	$ 4,767,451	$ 2,980,238
F4	Environmental Improvements	6,176	601	$ 913,922	$ 535,969	$ 1,500	$ 1,448,392	$ 912,422
F5	Leadership Development and Training for Community Members	5,979	2,868	$ 234,184	$ 139,434	$ -	$ 373,618	$ 234,184
F6	Coalition Building	18,055	16,841	$ 1,341,048	$ 749,249	$ 19,065	$ 2,071,232	$ 1,321,983
F7	Community Health Improvement Advocacy	11,536	4,314	$ 1,352,464	$ 741,594	$ 6,356	$ 2,087,702	$ 1,346,107
F8	Workforce Enhancement	45,936	56,556	$ 2,490,081	$ 1,459,469	$ 373,262	$ 3,576,288	$ 2,116,819
F9	Other	11,320	165,763	$ 876,146	$ 417,685	$ 4,352	$ 1,289,479	$ 871,794
F10	Other	1,200	48	$ 54,000	$ 28,798	$ -	$ 82,798	$ 54,000
	Total	**177,077**	**583,447**	**15,165,772**	**6,469,890**	**4,105,314**	**17,530,347**	**11,060,458**
	Community Benefit Operations							
G1	Dedicated Staff	74,157	1,166	$ 4,872,178	$ 2,366,265	$ 20,811	$ 7,217,632	$ 4,851,367
G2	Community health and health assets assessments	2,811	202	$ 223,424	$ 103,979	$ 21,406	$ 305,997	$ 202,018
G3	Other Resources	1,747	193	$ 623,540	$ 243,684	$ 44	$ 867,180	$ 623,496
G4	Other	7	0	$ 144	$ 91	-	$ 235	$ 144
G5	Other	0	0	$ 85,194	$ 53,587	-	$ 138,781	$ 85,194
	Total	**78,722**	**1,561**	**5,804,480**	**2,767,606**	**42,261**	**8,529,825**	**5,762,219**
	Charity Care							
H	**Charity Care (report total only)**							**$483,833,108**
	Foundation-Funded Community Benefits							
J1	Community Services	3,805	2,349	$ 1,038,696	$ 69,066	$ 592,644	$ 515,118	$ 446,052
J2	Community Building	37,119	11,353	$ 1,594,158	$ 17,358	$ 46,091	$ 1,565,425	$ 1,548,067
J3	Other	0	0	$ 10,264	-	-	$ 10,264	$ 10,264

Maryland Hospital Community Benefit Report: FY 2014

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
J99	**Total**	**40,924**	**13,702**	**$2,643,118**	**$86,424**	**$638,735**	**$2,090,806**	**$2,004,383**
Total Hospital Community Benefit								
T99	Medicaid Assessments	0	0	$ 373,183,714	$ 1,225,750	$ 315,139,013	$ 59,270,451	$ 58,044,701
A	Community Health Services	1,012,490	13,494,384	$ 69,719,974	$ 30,910,898	$ 14,343,752	$ 86,287,120	$ 55,376,222
B	Health Professions Education	6,594,984	225,260	$ 342,112,260	$ 81,167,535	$ 2,793,714	$ 420,486,081	$ 339,318,546
C	Mission-Driven Health Services	2,553,469	858,131	$ 465,107,383	$ 105,386,289	$ 176,879,576	$ 393,614,096	$ 288,227,807
D	Research	128,704	4,440	$ 13,252,213	$ 3,454,973	$ 6,708,353	$ 9,998,833	$ 6,543,860
E	Financial Contributions	46,548	178,978	$ 16,406,108	$ 557,173	$ 478,637	$ 16,484,643	$ 15,927,471
F	Community Building	177,077	583,447	$ 15,165,772	$ 6,469,890	$ 4,105,314	$ 17,530,347	$ 11,060,458
G	Community Benefit Operations	78,722	1,561	$ 5,804,480	$ 2,767,606	$ 42,261	$ 8,529,825	$ 5,762,219
H	Charity Care	0	0	$ 483,833,108	-	-	$ 483,833,108	$ 483,833,108
J	Foundation-Funded Community Benefits	40,924	13,702	$ 2,643,118	$ 86,424	$ 638,735	$ 2,090,806	$ 2,004,383
K99	**Community Hospital Benefit Total**	**10,632,917**	**15,359,902**	**$ 1,787,228,131**	**$ 232,026,537**	**$ 521,129,356**	**$1,498,125,311**	**$ 1,266,098,774**
	Total Operating Expenses	**$14,105,523,690**						
	Percentage of Operating Expenses with Indirect Cost	**10.62%**						
	Percentage of Operating Expenses without Indirect Cost	**8.98%**						

State of Maryland
Department of Health and Mental Hygiene

John M. Colmers
Chairman

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

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M.D.

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Donna Kinzer
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David Romans
Director
Payment Reform
and Innovation

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

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

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **September 9, 2015**

RE: **Hearing and Meeting Schedule**

October 14, 2015	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
November 18, 2015	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

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

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

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