

# **Executive Director's Report**

## **Health Services Cost Review Commission**

### **October 14, 2015**

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

At the Commission's September 9, 2015 public meeting, Ronald R. Peterson, President of the Johns Hopkins Hospital and Health System, on behalf of a panel of several hospital representatives and the Maryland Hospital Association, proposed that the HSCRC provide up to \$40 million through hospital rates to establish about 1,000 entry level health care jobs in areas of extreme poverty and unemployment. This proposal came about as a result of the unrest in Baltimore City and the belief that employment is an important element needed to change the current situation. Hospitals are among the largest employers in Baltimore City as well as in other areas of the State that have pockets of extreme poverty and unemployment. The Health Job Opportunity Program Proposal (the Proposal) seeks to create community-based jobs that can contribute to improved community health as well as hospital jobs that create employment opportunities in economically challenged areas.

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

The work group members and other commenters expressed their appreciation for the leadership in bringing forward this proposal. There were many letters of support as well. (The Proposal and comment letters received to date are attached to this report.)

Following is a general summary of comments:

- Several commenters expressed the view that if the Commission were to take on a program of this nature, it would be very important to define success. Success would need to be framed not only in creating jobs, but also in the context of the New All Payer Model and Triple Aim of improving care, improving health, and lowering costs.
  - A program that could not meet those requirements might be better implemented outside of the rate system.

- Proposers of the Program indicated that evaluative criteria should be developed and that if the Program was not meeting those criteria, that it should be discontinued.
  - Because the jobs are entry level and for untrained workers, there was an indication that it might take some time to evaluate the impact on health and costs. Whether the jobs could be filled and the workers maintained could be determined much sooner.
- Several commenters felt that it would be important to focus on jobs outside of hospitals, such as Community Health Workers. The concern was expressed that the reduction of avoidable utilization in hospitals might reduce the need for some of the hospital jobs that were referred to in the Proposal.
  - One of the Academic Medical Centers felt that its utilization would not decrease with potentially avoidable utilization, but would encounter a backfill as out of state volumes increased or other referrals could be served.
  - One commenter expressed concern about the need for training of Community Health Workers, making sure they were prepared to be in the community working with frail and severely ill patients. (Note that there was a work group that recently produced a set of recommendations regarding Community Health Workers.) More design and structure would need to be in place.
- Several commenters felt that infrastructure adjustments already provided to hospitals, or the additional amount that is slated for award in January 2016, were already focused on similar activities, and that this effort would be duplicative.
  - Proposers responded that the infrastructure funds were already committed in their budgets for other purposes, and that a new source of funding is needed for rapid deployment of additional jobs.
  - Commenters indicated that a Return on Investment should be expected, similar to the recent infrastructure increases approved by the Commission.
- It was also suggested that other funding sources be considered for Program implementation.
  - The proposers indicated that this might slow the process down, or detract from the level of possible implementation and impact.
- Several commenters indicated that if the Proposal were to move forward, much more detailed design work needs to take place.
  - One suggestion was to ask the hospitals to organize an effort with other stakeholders and experts to further develop potential design criteria
  - Another commenter indicated that the Commission staff might take this on and organize a work group to develop the program

- One commenter expressed concerns about accountability to payers, including the need for a return on investment

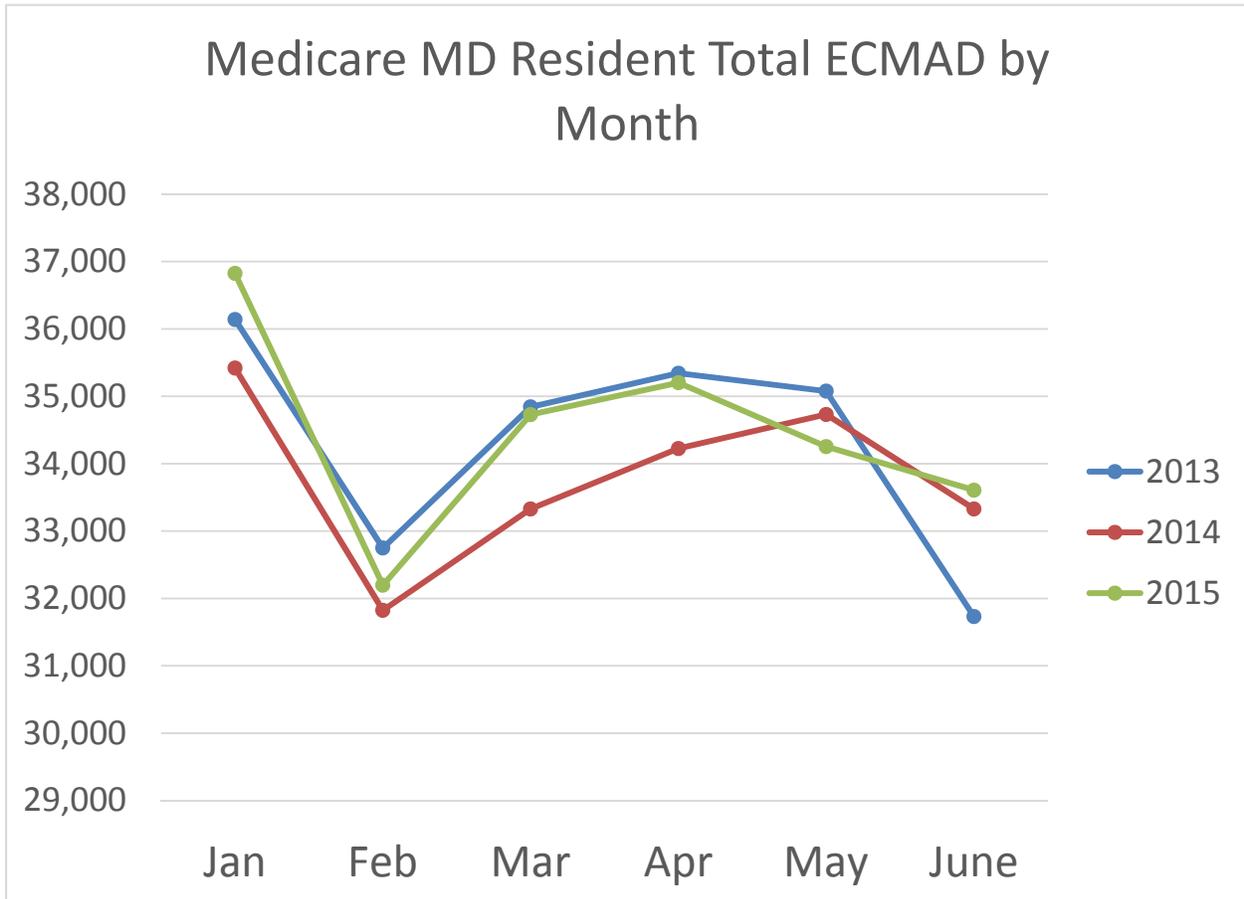
Staff is currently considering all oral and written comments received to date and will report back to the Commission at the November meeting.

## **Medicare Volume Increases**

The HSCRC staff has been paying attention to Medicare growth in charges and utilization. There has been an uptick in Medicare volumes, and this is likely to affect Medicare savings. The Commission will need to monitor the situation closely and consider whether any special actions or changes in policies are warranted. From fiscal year 2013 to 2014, there were increases in orthopedic surgery and oncology service lines for Medicare patients, but these increases were more than offset by decreases in avoidable utilization such as readmissions and PQI admissions, with a net reduction in Equivalent Case Mix Adjusted Discharges (ECMADs). (ECMADs account for both inpatient and outpatient volumes of services using an assigned weight for each case). From FY 2014 to FY 2015, there were larger increases in orthopedic surgery and oncology for Medicare patients, and there was a modest reduction in readmissions. However, there was an increase in PQI admissions as well as other medical admissions. The result was an increase of 2.09% in ECMADs for FY 2015. The rate adjustments provided by the Commission on July 1, 2014 and July 1, 2015 are based on the assumption that Medicare per capita growth will be lower than the All Payer growth by about 2%. However, the uptick in Medicare volumes has narrowed the differential. The calendar year per capita growth per resident in All Payer revenue through August 2016 versus the same period in 2015 was 2.5%. The Medicare growth for the same period was 1.71%, with the gap at .79% rather than the projected 2%. The chart below shows the monthly trend in utilization for January through June of each of the preceding three calendar years. (This chart is not adjusted for the growth in Medicare beneficiaries, which is approximately 3% per year.) 2015 ECMADs were higher than 2014 in all but one month and were higher than the 2013 figures in 2 months.

The success of the model is dependent on reducing avoidable utilization. Hospitals will need to accelerate their efforts to reduce avoidable utilization in order to achieve the volume levels that support the savings requirements for Medicare. HSCRC staff notes that a number of planning efforts are underway, and some hospitals have implemented significant interventions. However, there is significant work to scale the efforts necessary to reduce avoidable utilization, including working more closely with primary care physicians to coordinate care and address chronic conditions more effectively, implementing comprehensive care coordination for high needs and complex patients, and working with post-acute and long term care facilities to reduce avoidable hospitalizations.

HSCRC staff is evaluating our ECMAD data closely together with preliminary national data we receive from CMMI. At the same time Medicare hospital utilization increased, we are also noting an increase in payments to SNF providers. HSCRC staff will investigate these two trends and consider the implications.



### Value Based Purchasing Exemption

CMS has granted Maryland an exemption from the national Medicare Value Based Purchasing Program for FY 2016. CMS notes that Maryland significantly lags national performance in patient experience of care in the Hospital Consumer Assessment of Healthcare Providers and Systems surveys. As a result of this lagging performance, HSCRC has assigned a higher proportion of the weighting to this domain and increased the amount of revenue at risk for this program.

## Staff Focus

HSCRC staff is currently focused on the following activities:

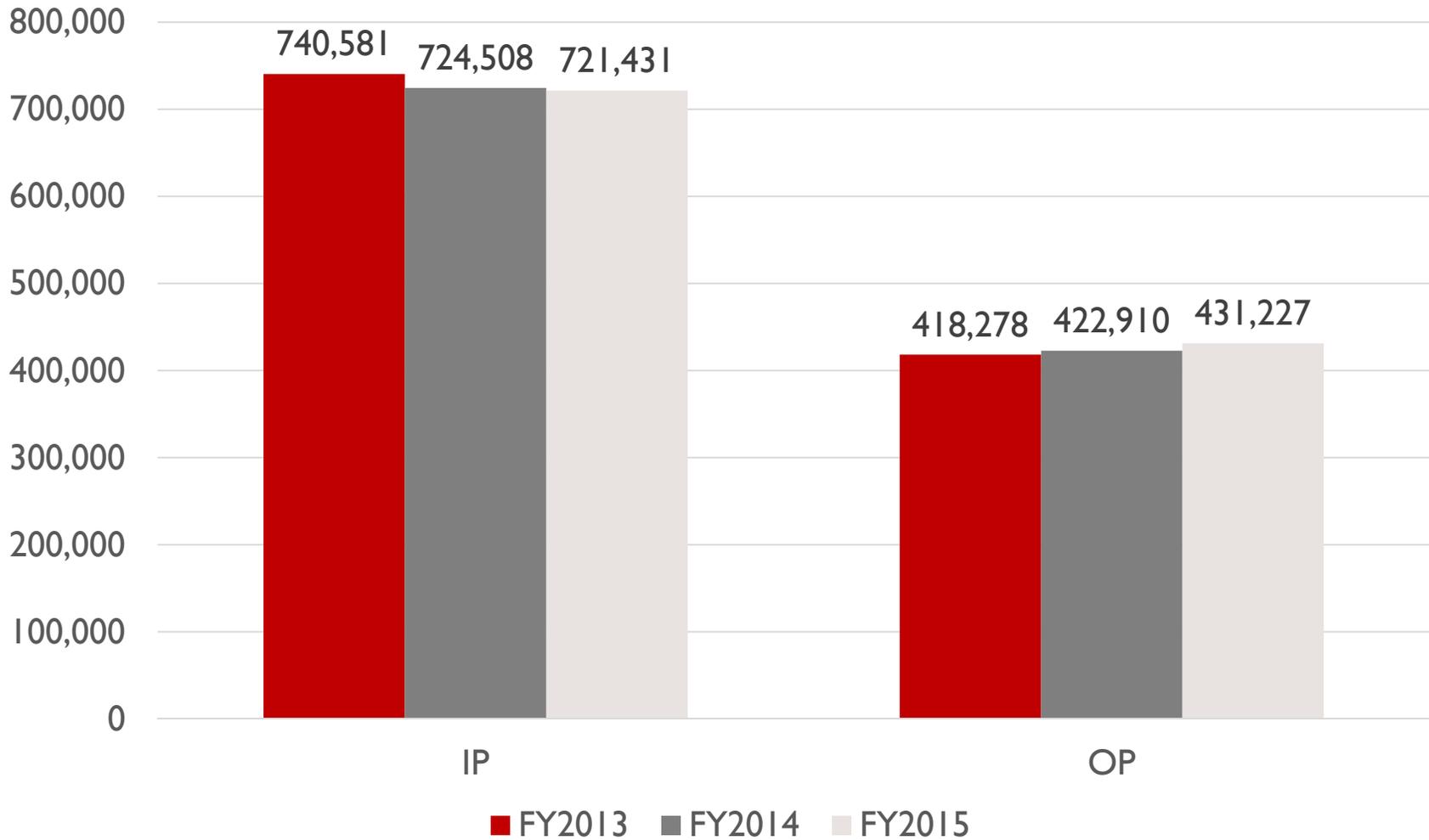
- Issuing amended rate orders that adjust for final reconciliation of GBR/TPR and rate compliance and QBR performance.
- Reviewing radiation therapy, infusion and chemotherapy market shift adjustments with stakeholders. It appears that we are reaching resolution for the 2016 adjustment, although the stakeholders and HSCRC will focus on refinements for rate year 2017.
- Reviewing Certificate of Need (CON) 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.
- Preparing to finalize and implement a stakeholder process that will be executed together with DHMH and other agencies, focused on developing a vision for Phase 2 of the All Payer Model and developing interim approaches that will provide progression toward Phase 2. Medicaid is evaluating formation of an ACO-like model for dual eligible enrollees (beneficiaries with both Medicare and Medicaid coverage). This process will be combined with the stakeholder process for progressing of the All Payer Model.
- Staff is evaluating proposals received for support of the Phase 2 application development and application process with CMMI, together with other state agencies.



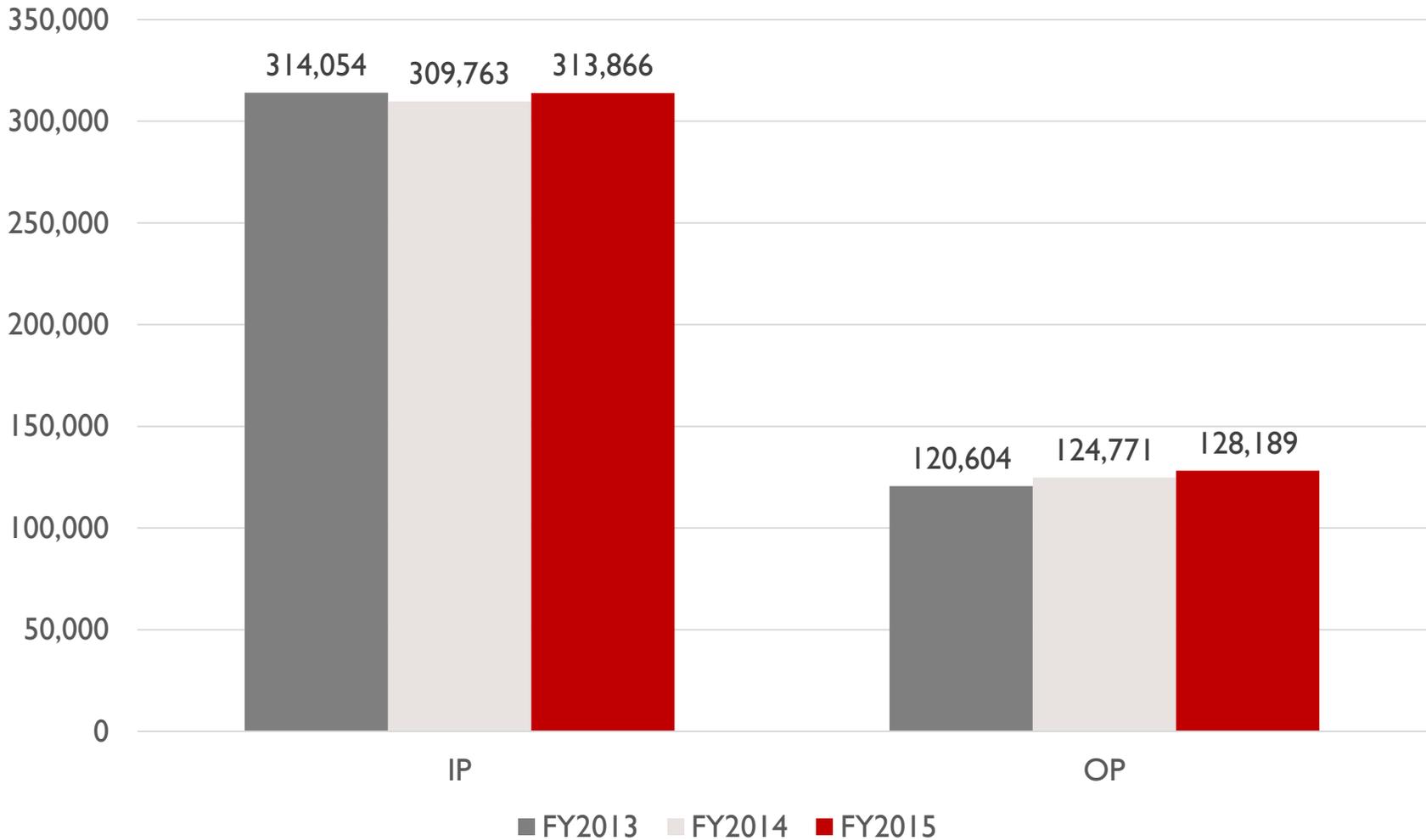
# Monitoring Maryland Performance Preliminary Utilization Analytics

FY2013-FY2015

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

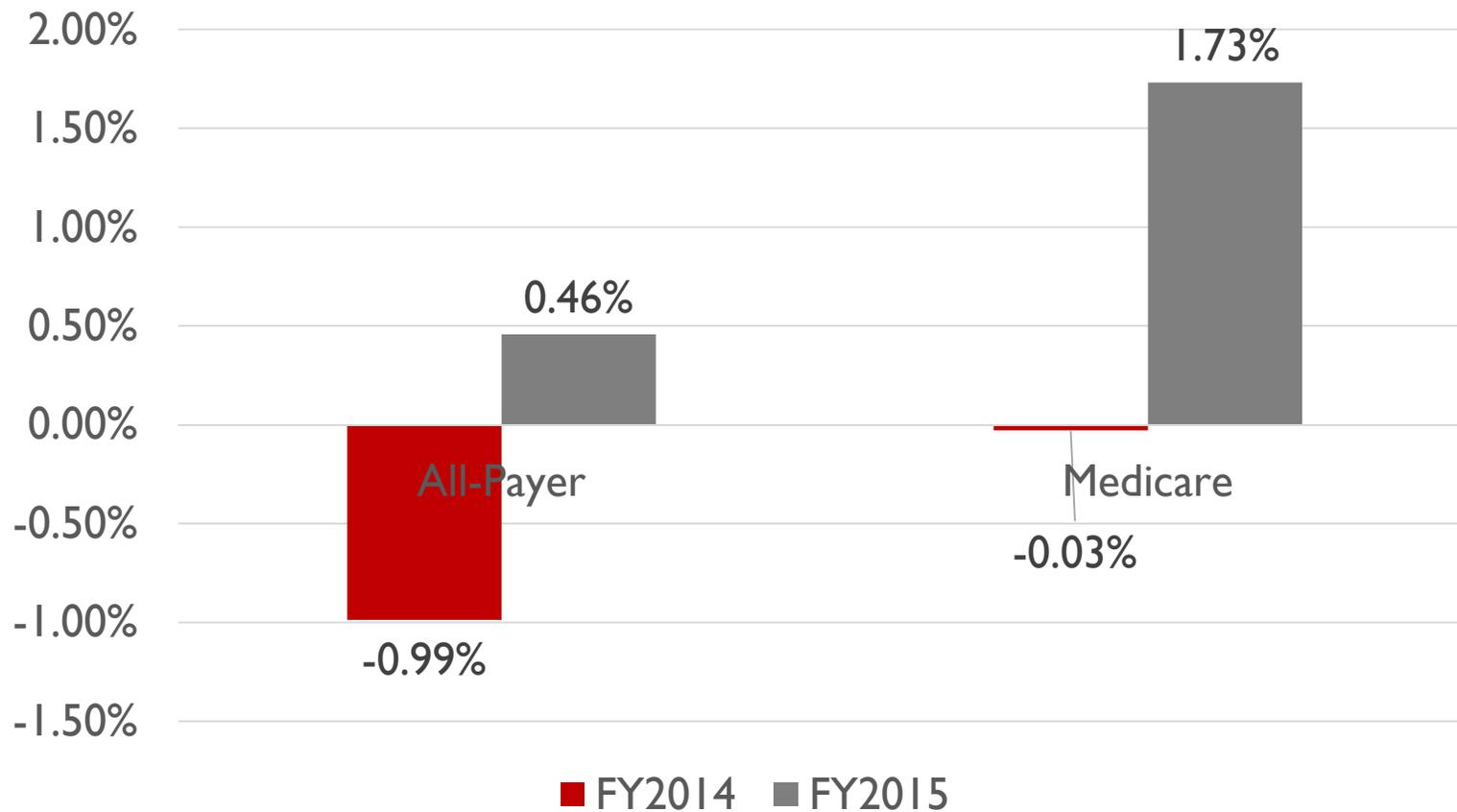


# Medicare All-Payer Inpatient(IP) and Outpatient (OP) ECMAD Trend

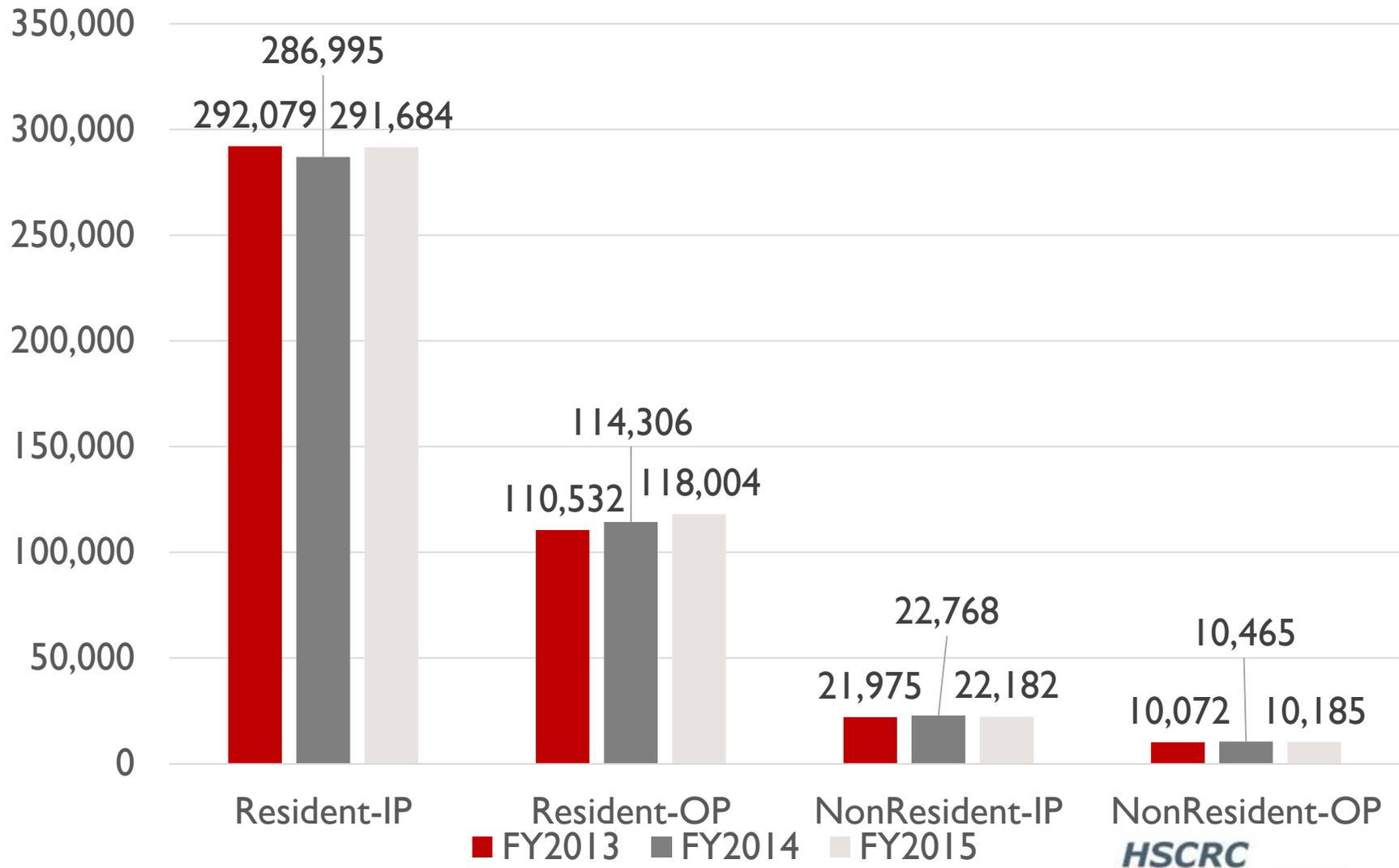


# Annual Percent Growth Rate-Total ECMAD

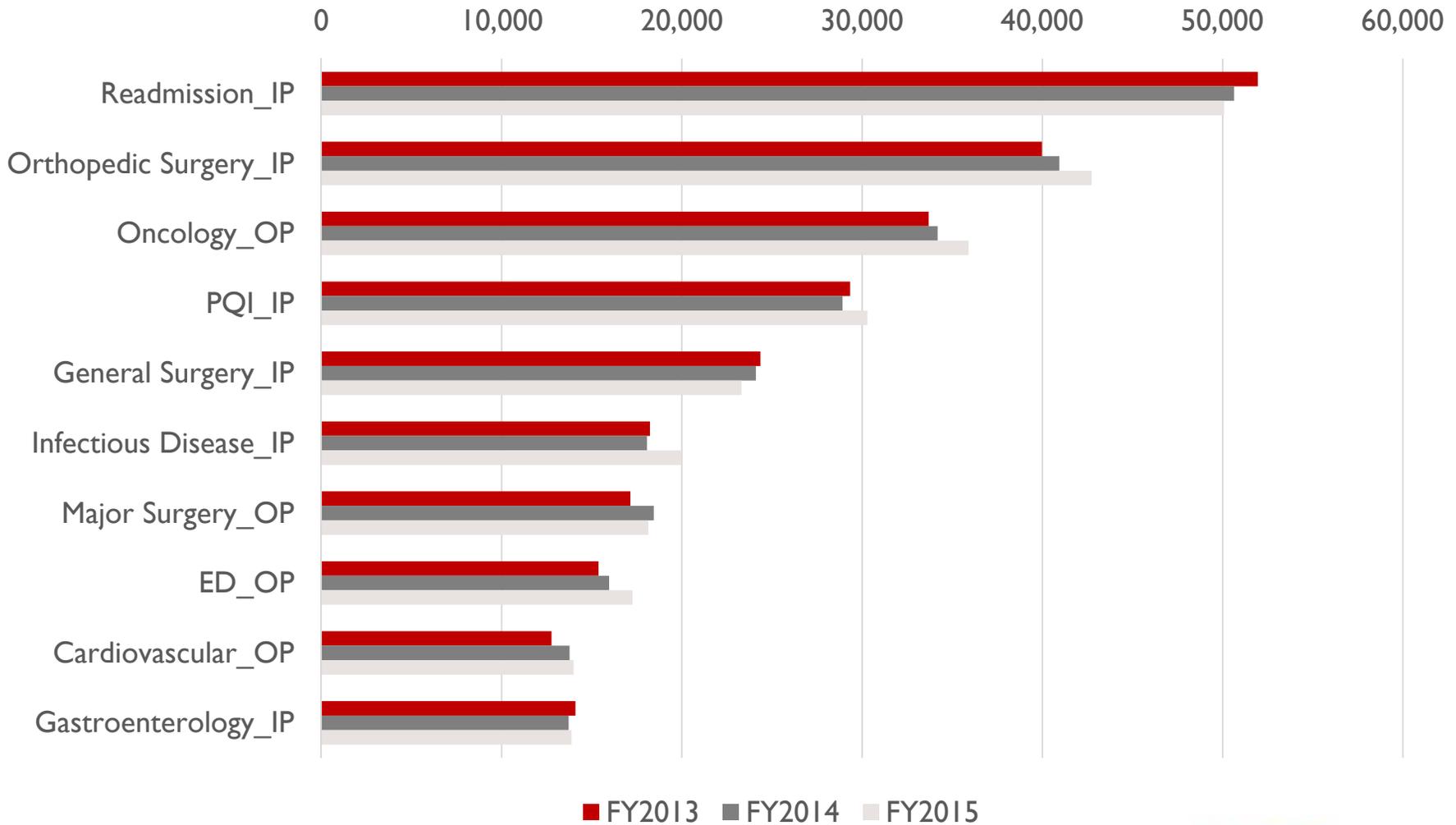
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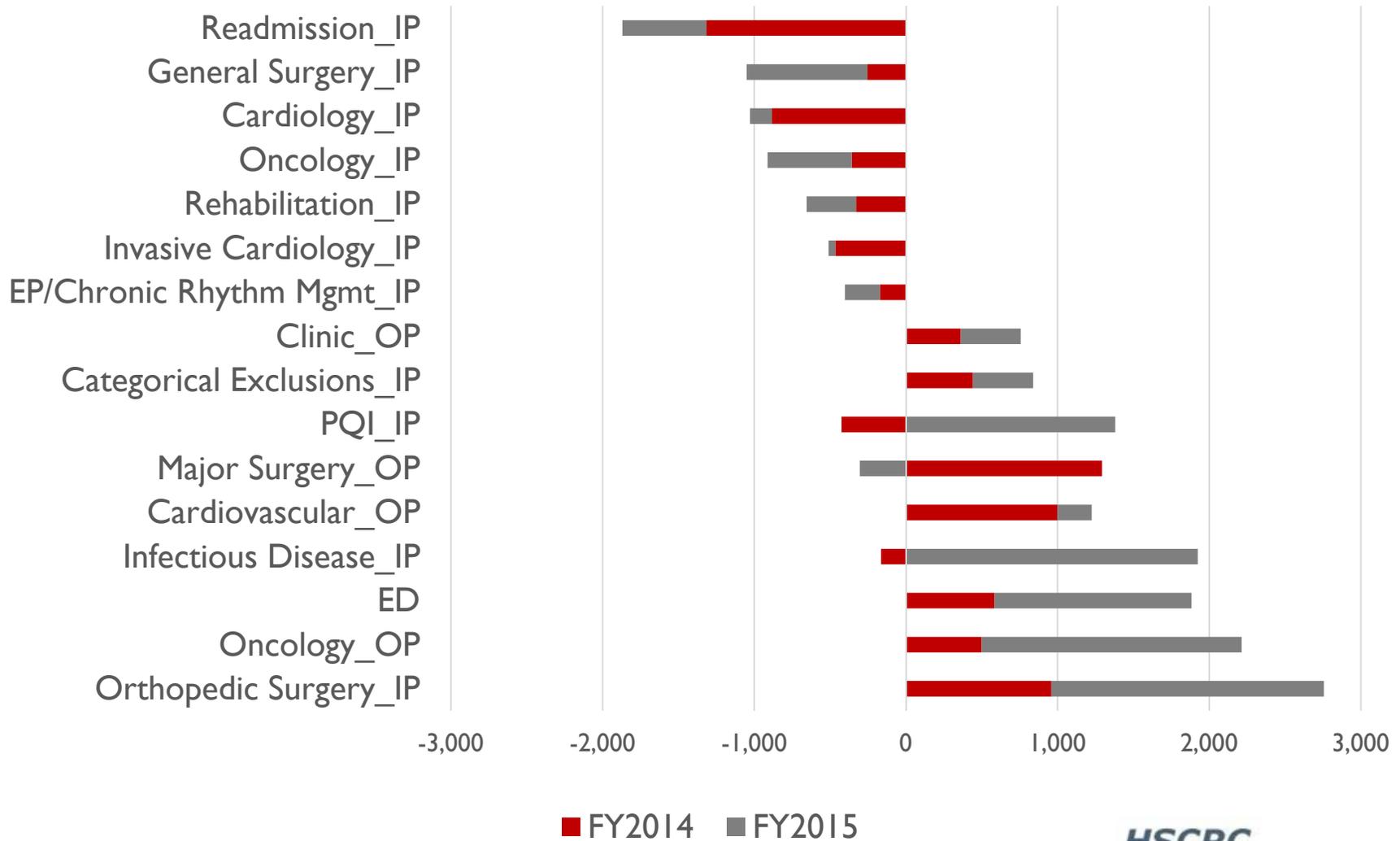
# Medicare ECMAD Trends by Resident Status



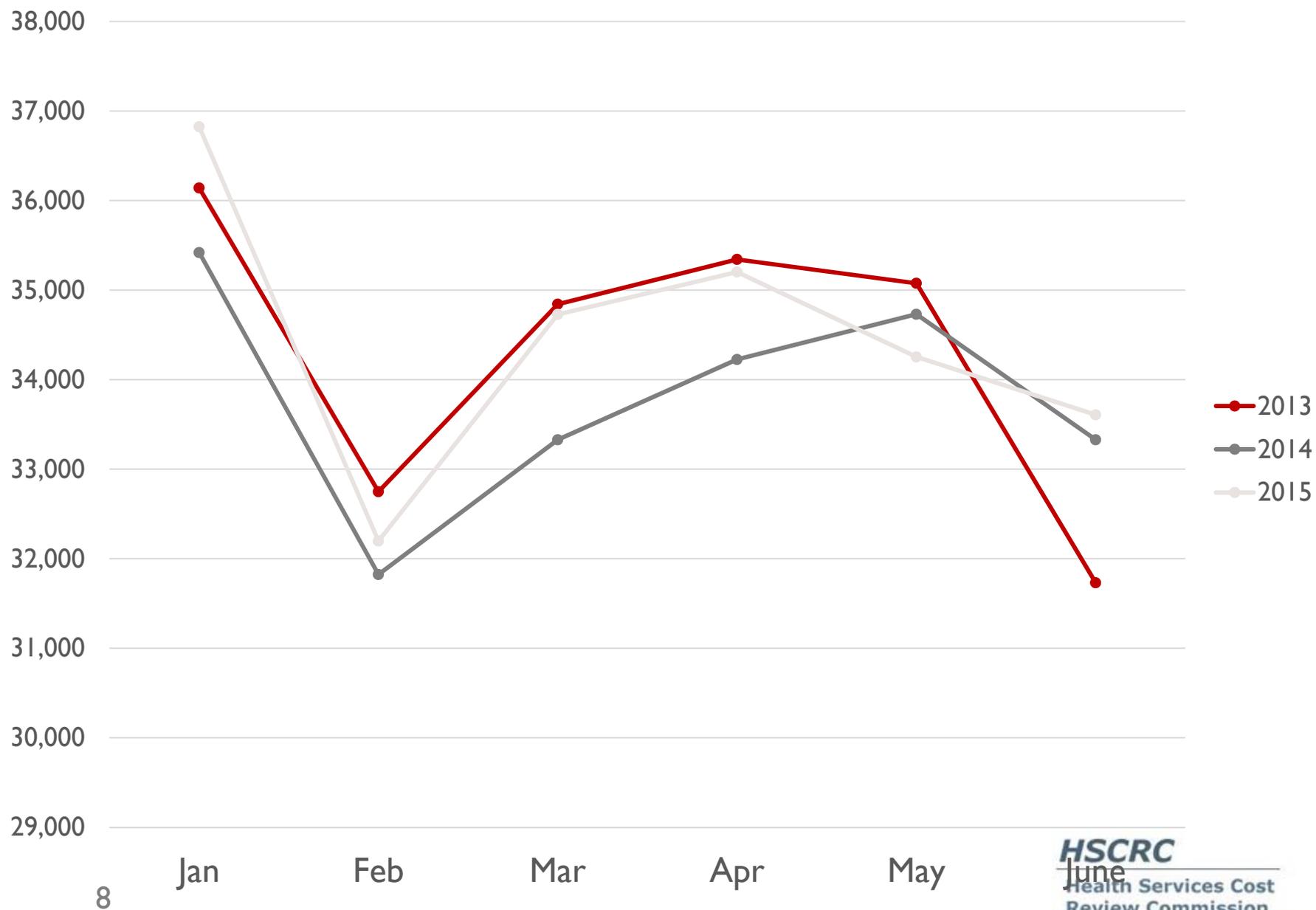
# Medicare MD Resident Largest 10 Service Line Trends



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



# Medicare MD Resident Total ECMAD by Month--Calendar Year



# Utilization Analytics

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

# Service Line Definitions

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

BARBARA A. MIKULSKI  
MARYLAND

COMMITTEES:

APPROPRIATIONS

HEALTH, EDUCATION, LABOR,  
AND PENSIONS

## United States Senate

WASHINGTON, DC 20510-2003

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  
United States Senator

BAM:wbk

IN REPLY PLEASE REFER TO  
OFFICE INDICATED:

- 901 SOUTH BOND STREET, SUITE 310  
BALTIMORE, MD 21231  
(410) 962-4510  
VOICE/TDD: (410) 962-4512
- 60 WEST STREET, SUITE 202  
ANNAPOLIS, MD 21401-2448  
(410) 263-1805  
BALTIMORE: (410) 269-1650
- 6404 IVY LANE, SUITE 406  
GREENBELT, MD 20770-1407  
(301) 345-5517
- 32 WEST WASHINGTON STREET  
ROOM 203  
HAGERSTOWN, MD 21740-4804  
(301) 797-2826
- THE PLAZA GALLERY BUILDING  
212 MAIN STREET, SUITE 200  
SALISBURY, MD 21801-2403  
(410) 546-7711

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

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

2230 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515-2007  
(202) 225-4741  
FAX: (202) 225-3178

DISTRICT OFFICES:  
1010 PARK AVENUE  
SUITE 105  
BALTIMORE, MD 21201-5037  
(410) 685-9199  
FAX: (410) 685-9399

754 FREDERICK ROAD  
CATONSVILLE, MD 21228-4504  
(410) 719-8777  
FAX: (410) 455-0110

8267 MAIN STREET  
ROOM 102  
ELLCOTT CITY, MD 21043-9903  
(410) 465-8259  
FAX: (410) 465-8740

[www.house.gov/cummings](http://www.house.gov/cummings)

DONNA F. EDWARDS  
4TH DISTRICT, MARYLAND

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

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

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

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

5001 SILVER HILL ROAD  
SUITE 106  
SUITLAND, MARYLAND 20746  
TELEPHONE: (301) 516-7601  
FAX: (301) 516-7608

2445 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515-2004  
TELEPHONE: (202) 225-8699  
FAX: (202) 225-8714

877 BALTIMORE ANNAPOLIS BOULEVARD  
RITCHIE COURT OFFICE BUILDING  
UNIT 101  
SEVERNA PARK, MD 21146  
TELEPHONE: (410) 421-8061  
FAX: (410) 421-8065

DONNA F. EDWARDS  
4TH DISTRICT, MARYLAND

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

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

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

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

5001 SILVER HILL ROAD  
SUITE 106  
SUITLAND, MARYLAND 20746  
TELEPHONE: (301) 516-7601  
FAX: (301) 516-7608

2445 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515-2004  
TELEPHONE: (202) 225-8699  
FAX: (202) 225-8714

877 BALTIMORE ANNAPOLIS BOULEVARD  
RITCHIE COURT OFFICE BUILDING  
UNIT 101  
SEVERNA PARK, MD 21146  
TELEPHONE: (410) 421-8061  
FAX: (410) 421-8065

REPLY TO:

2416 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515  
(202) 225-3061  
FAX: (202) 225-3094

375 WEST PADONIA ROAD, SUITE 200  
TIMONIUM, MD 21093  
(410) 628-2701  
FAX: (410) 628-2708

[www.dutch.house.gov](http://www.dutch.house.gov)

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 Ruppensberger  
Member of Congress

CADR:ng

**Congress of the United States**  
**House of Representatives**  
**Washington, DC 20515-2003**  
[www.sarbanes.house.gov](http://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

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

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



*Joy*

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:

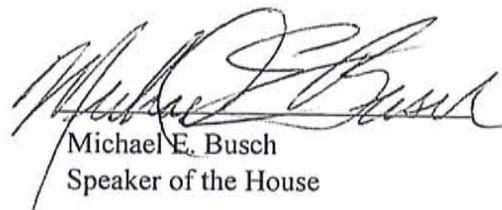
As the presiding officers of the Maryland General Assembly, we offer our full support of the Hospital Employment Program.

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,

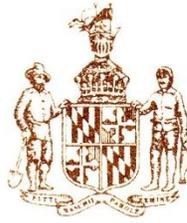
  
Thomas V. Mike Miller, Jr.  
Senate President

  
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



*Annapolis Office*  
The Maryland House of Delegates  
6 Bladen Street, Room 241  
Annapolis, Maryland 21401  
410-841-3770  
800-492-7122 Ext. 3770

*District Office*  
821 S. Grundy Street  
Baltimore, Maryland 21224  
410-342-3142

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,

A handwritten signature in cursive script that reads "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



The Maryland House of Delegates  
6 Bladen Street, Room 121  
Annapolis, Maryland 21401  
410-841-3407 · 301-858-3407  
800-492-7122 Ext. 3407  
Fax 410-841-3416 · 301-858-3416  
Maggie.McIntosh@house.state.md.us

*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  
George H. Bone, MD  
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 many Baltimore City residents.

If you have any questions, please contact Kaliopé Parthemos on (410) 396-4876 or [Kaliopé.parthemos@baltimoremorecity.gov](mailto:Kaliopé.parthemos@baltimoremorecity.gov).

Sincerely,

Stephanie Rawlings-Blake  
Mayor  
City of Baltimore

Cc: Kaliopé 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



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

*Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary*

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September 8, 2015

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

Dear Chairman Colmers:

The Department has reviewed the Health Employment Program document prepared by the Maryland Hospital Association. In short, the proposal will build into hospital rates \$40 million in additional funds to hire about 1,000 workers. The types of workers include community health workers, Medicaid and Health Benefit Exchange enrollment assistors, peer support specialists, as well as more traditional hospital employees, including environmental services, dietary staff, nursing assistants, escorts, and security personnel. We are writing to express our concern about the Health Employment Program and urge the HSCRC to conduct a comprehensive review of the hospital proposal before moving forward.

#### **A Mechanism Already Exists for Funding this Initiative**

The HSCRC has already made infrastructure adjustments to the hospitals rates totaling almost \$200 million. These adjustments are not one-time adjustments; rather, they have been built permanently into hospital global budgets. Hospitals will receive these infrastructure monies every year unless the Commission takes action to end it.

The HSCRC built a 0.325 percent infrastructure adjustment into global budgets for FY 2014 and FY 2015, for a cumulative amount of roughly \$100 million. Another 0.4 percent infrastructure adjustment was built into FY 2016 rates, and the hospitals have the potential to receive another 0.25 percent adjustment starting January 1, 2016. The additional 0.25 percent will be competitive, meaning that a hospital's ability to receive the additional 0.25 percent will depend on the quality of the hospital proposal or plan submitted on December 1, 2015. Nothing precludes the hospitals from submitting a proposal that includes a Health Employment Program. The estimated impact on the FY 2016 infrastructure adjustment is \$100 million, meaning that in FY 2016 and every year thereafter, hospitals will receive \$200 million in additional infrastructure monies.

#### **Costs Will Not Be Offset Without Return on Investment from Hospital Global Budgets**

We disagree that the savings will be largely offset from fewer people utilizing public programs such as Medicaid. Under federal eligibility requirements, and depending a number

of factors, including the income, cost of other coverage offered and household size of the individuals participating, they or their family members could remain eligible for Medicaid.

Additionally, during our Community Health Workers workgroup sessions, many participants questioned whether additional Community Health Workers would have the opposite effect on the Medicaid budget—that is, create more opportunities to enroll individuals on Medicaid. In the past, the Department has seen the utilization of Community Health Workers as a way to better coordinate care for our high cost populations more effectively. We believe, notwithstanding the potential outreach impact that additional Community Health Workers could result in additional savings to the overall program. A large component of those savings would come from hospital services. The proposal does not mention any of these savings being passed onto payers through a reduction in future hospital global budget revenues. Without a formula in place for payers to realize a return on investment accrued by the savings achieved by hospitals, there will be no offsetting of costs.

Applicants for the competitive 0.25 infrastructure rate increase are required to submit a calculation for the expected return on investment for their proposed interventions; should a separate Hospital Employment Program be created, it is the Department's position that a similar costing exercise should be produced.

#### **Proposal Lacks Accountability to the Payers**

The proposal outlines that hospitals receiving monies through the Health Employment Program will be required to submit biannual reports to HSCRC detailing the incremental employees hired and the costs associated with these hires. The proposal does not include a process where payers can provide feedback and recommendations on the new positions or the program in general. Medicaid pays for roughly 20 percent of hospital charges in Maryland. In other words, Medicaid will pay roughly \$8 million of the \$40 million proposal annually. The Department wants to ensure that an equal portion of any monies is devoted to employees who benefit the Medicaid population. The current proposal lacks this feedback mechanism or any measures to evaluate the program's impact.

The Department looks forward to working with the HSCRC on his important initiative. Please contact Shannon McMahon, Deputy Secretary of Health Care Financing at 410-767-5807 should you have any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Van T. Mitchell', with a stylized flourish at the end.

Van T. Mitchell  
Secretary



# Monitoring Maryland Performance Financial Data

Year to Date thru August 2015



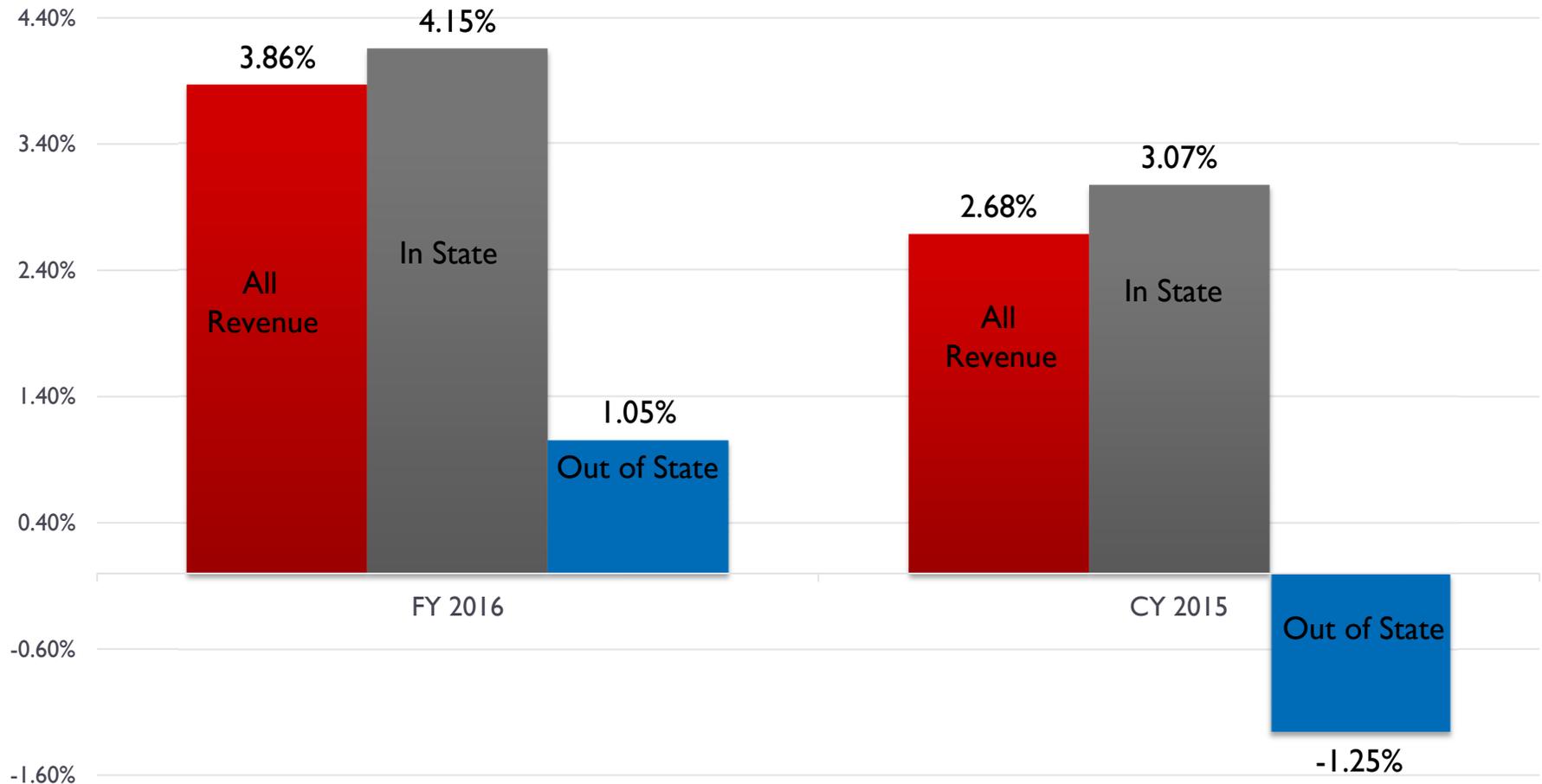
**HSCRC**

Health Services Cost  
Review Commission

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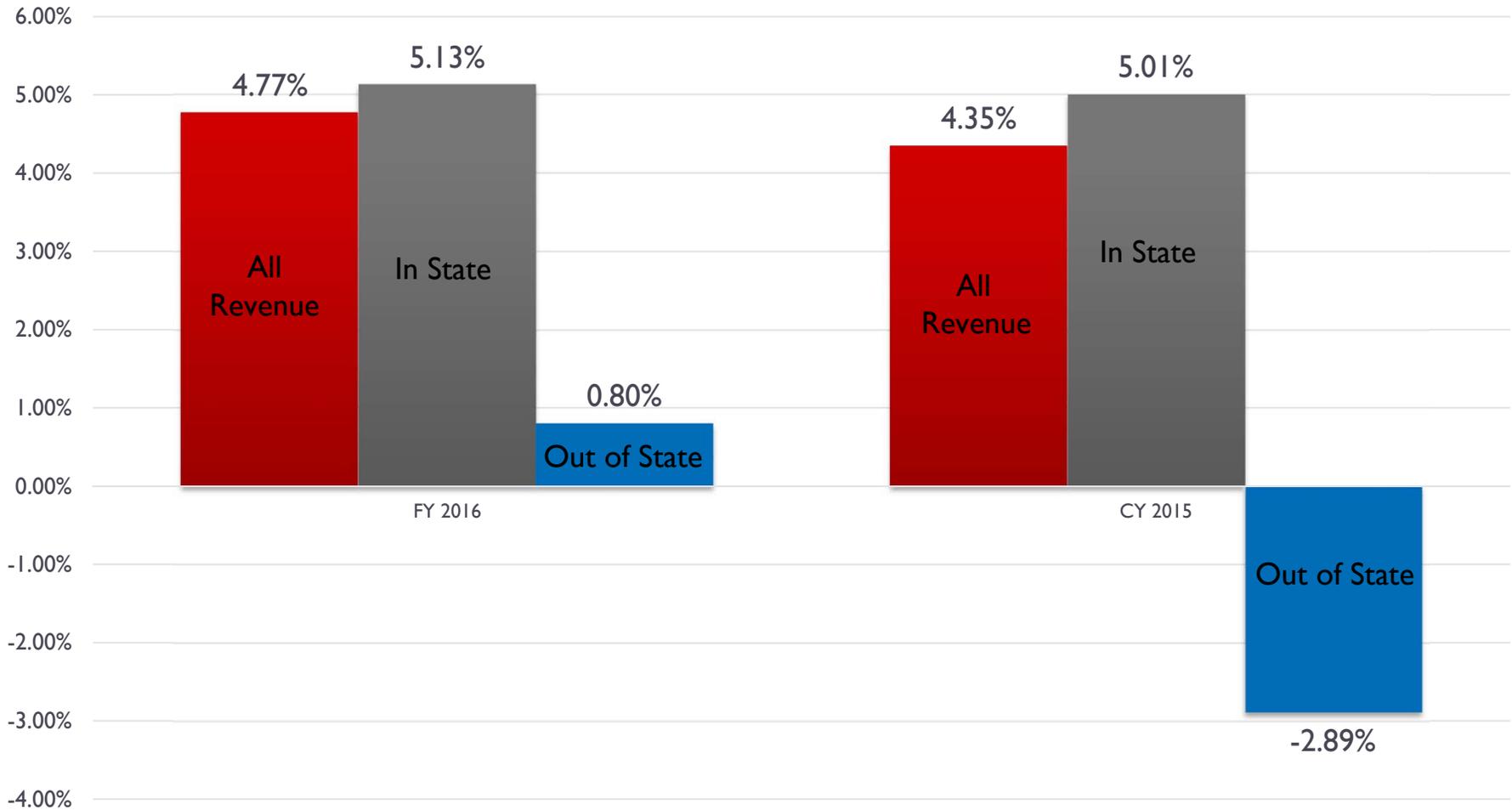
# Gross All Payer Revenue Growth

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

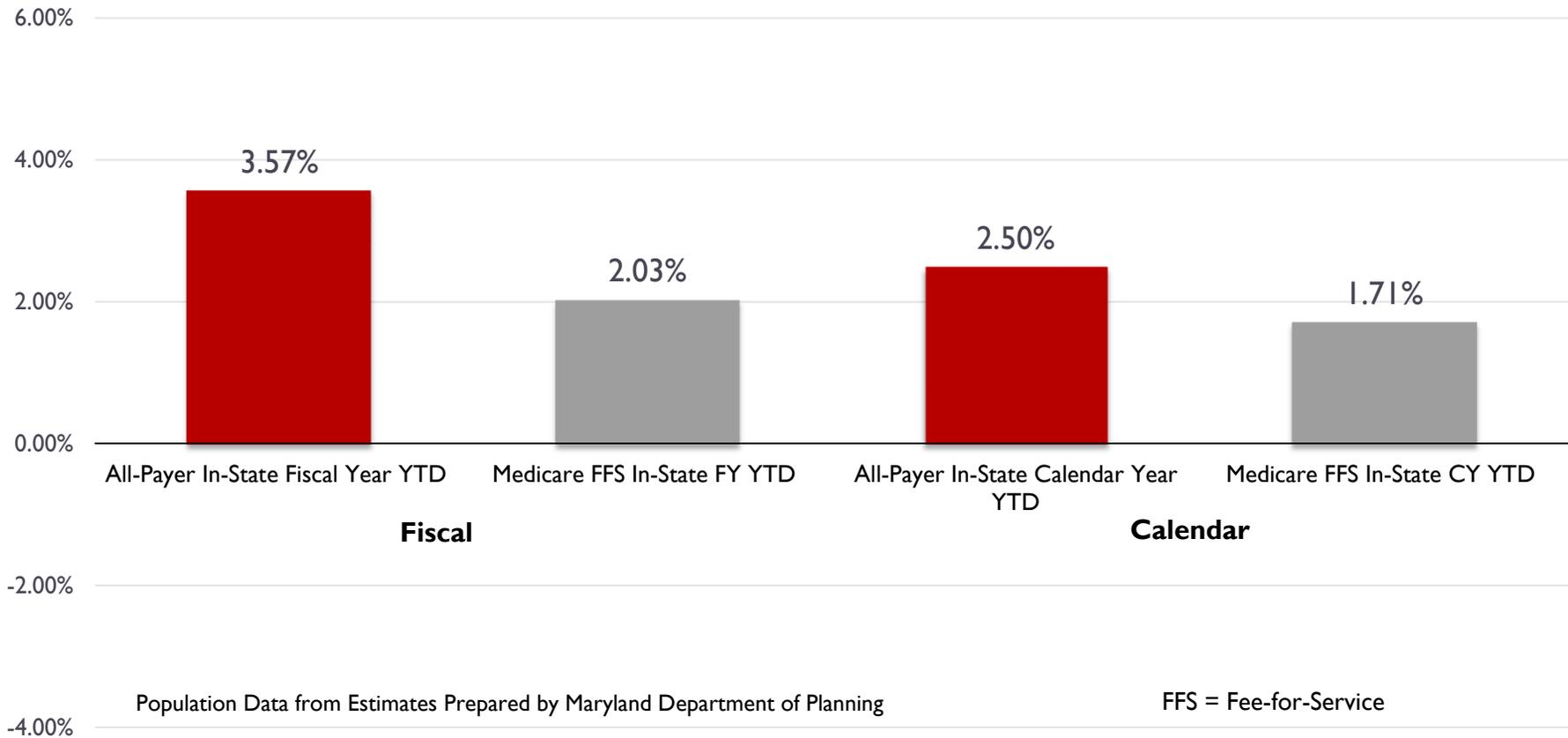


# Gross Medicare Fee-for-Service Revenue Growth

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

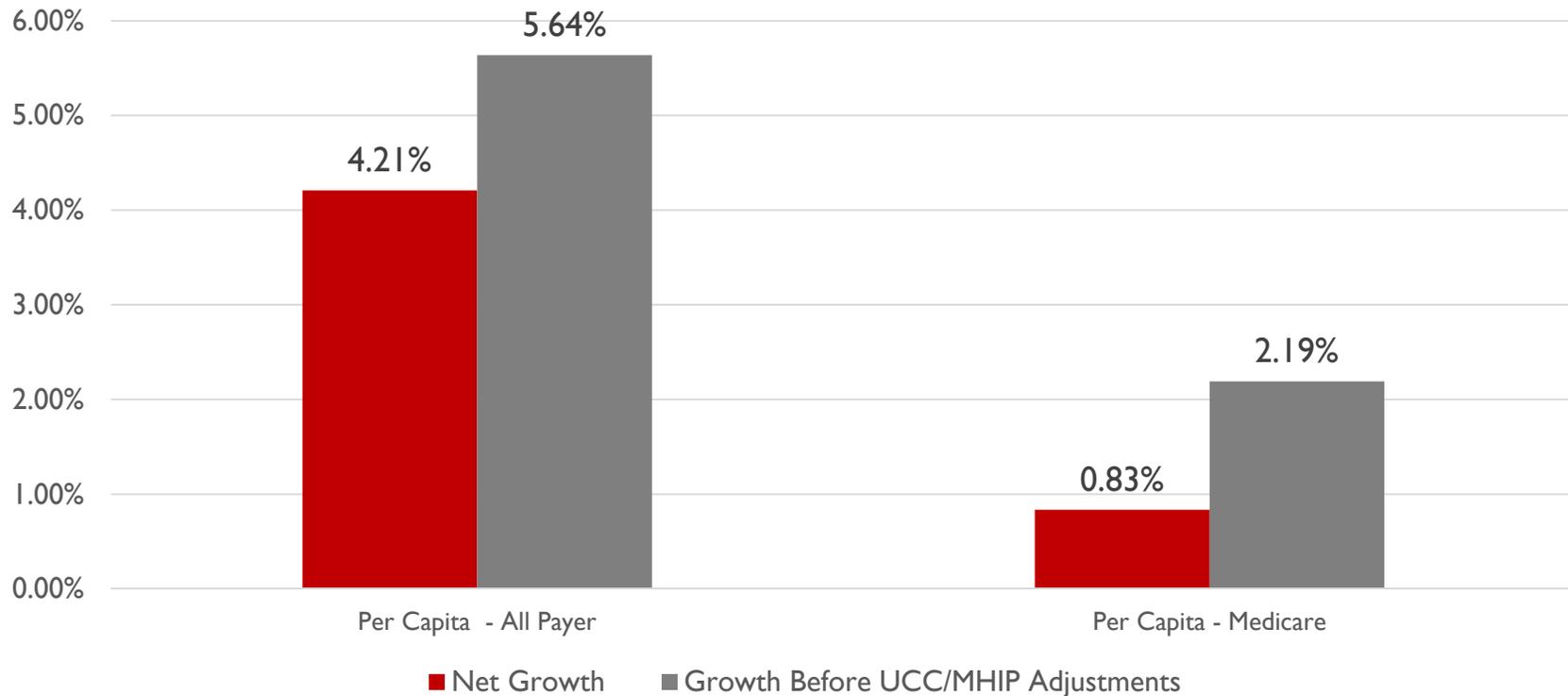


# Per Capita Growth Rates Fiscal Year 2016 and Calendar Year 2015



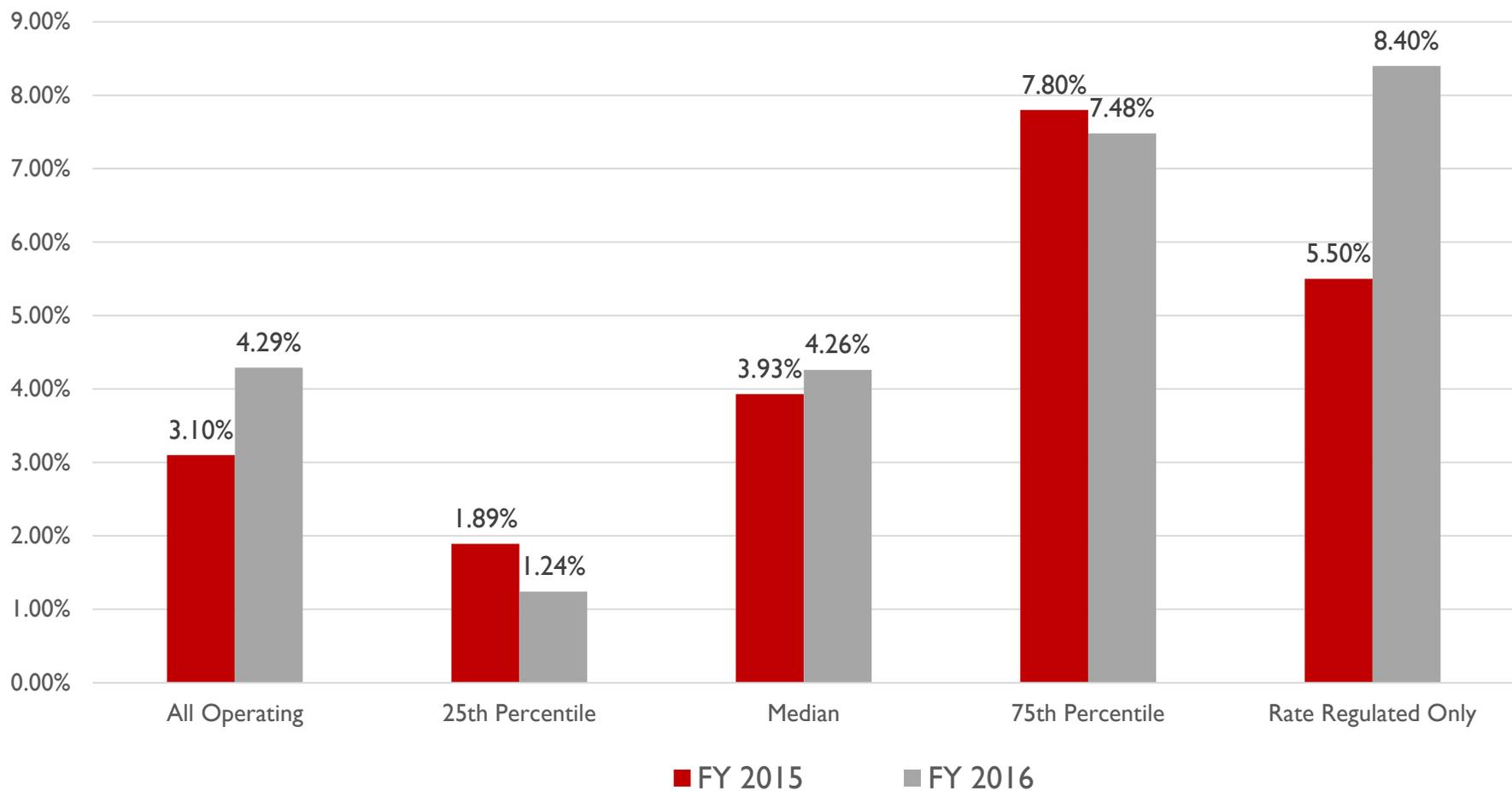
- Calendar and Fiscal Year trends to date are below All-Payer Model Guardrail for per capita growth.

## 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% decrease from 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.

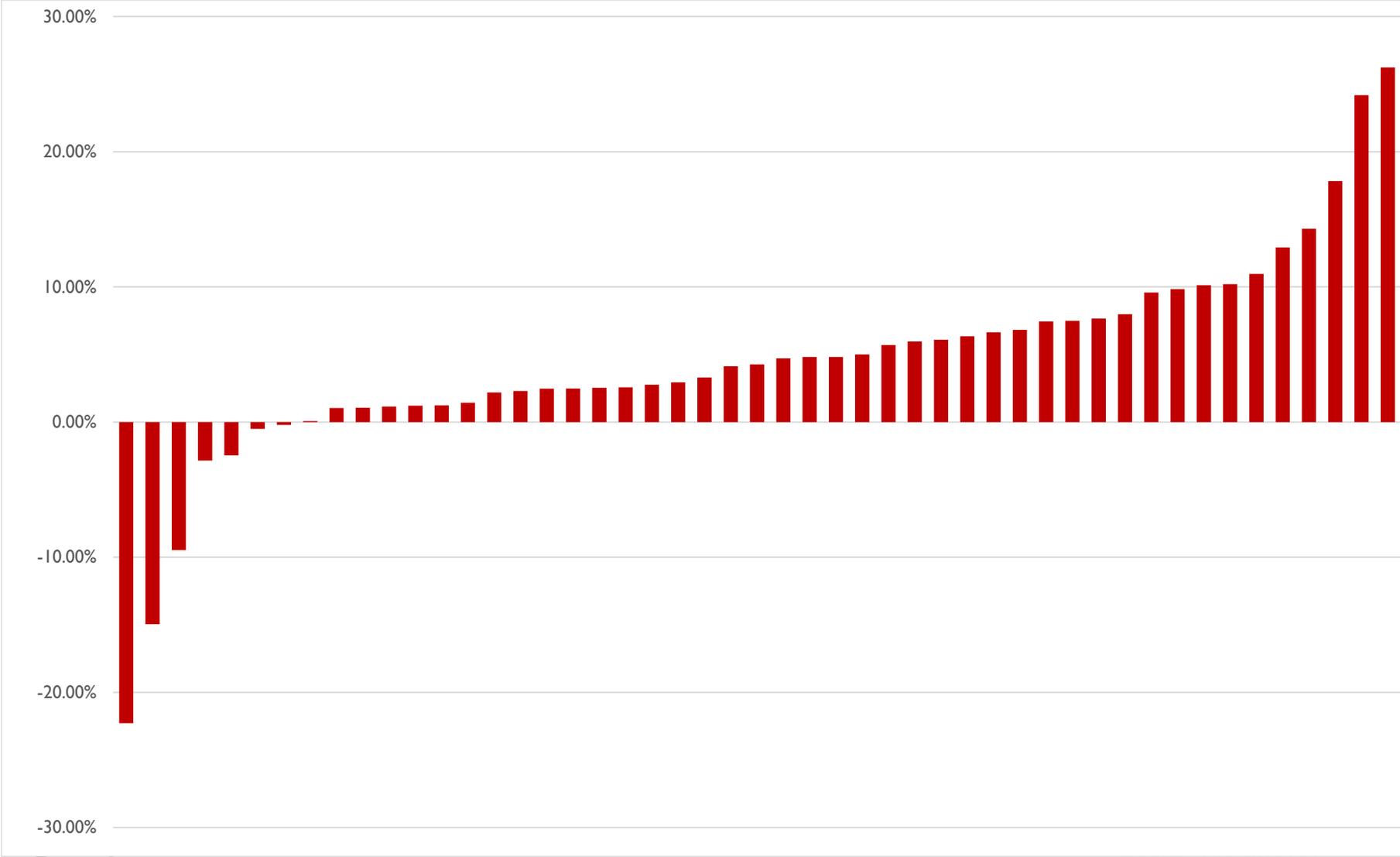
# Operating Profits: Fiscal 2016 Year to Date (July-August) Compared to Same Period in FY 2015



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

# Operating Profits by Hospital

Fiscal Year to Date (July – August)



## Purpose of Monitoring Maryland Performance

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**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

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- 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.

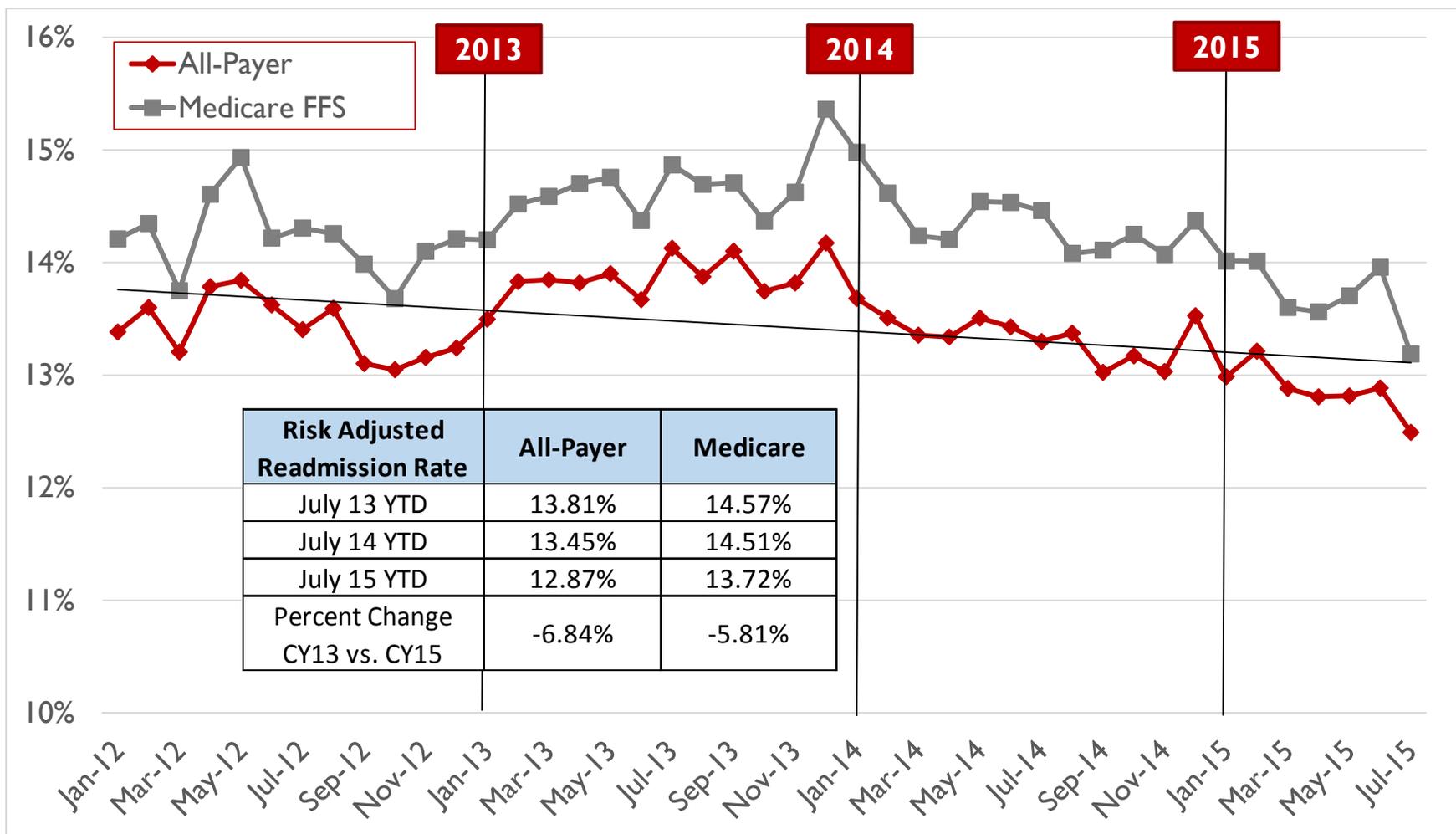


# Monitoring Maryland Performance Quality Data

October 2015 Commission Meeting Update

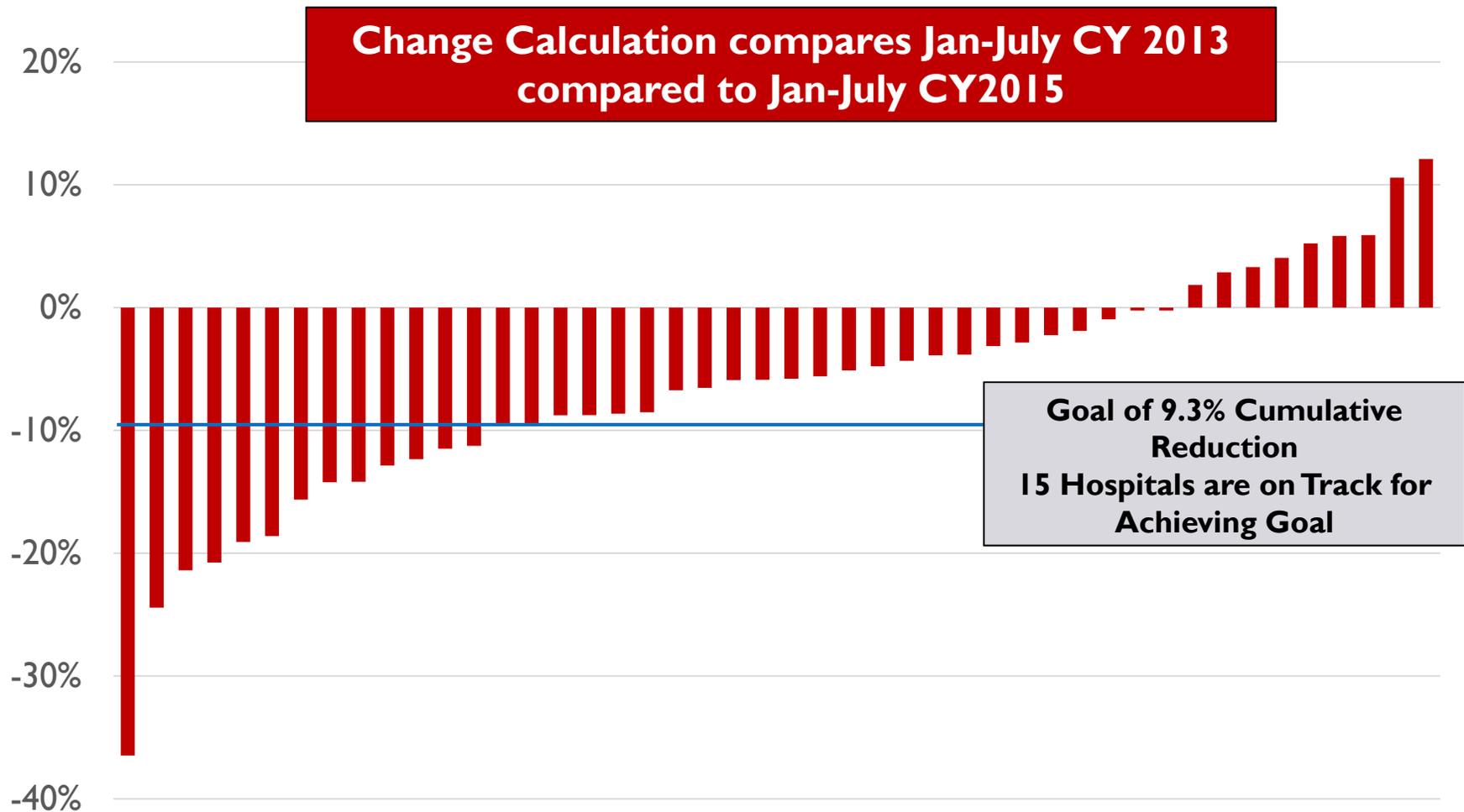


# Monthly Risk-Adjusted Readmission Rates



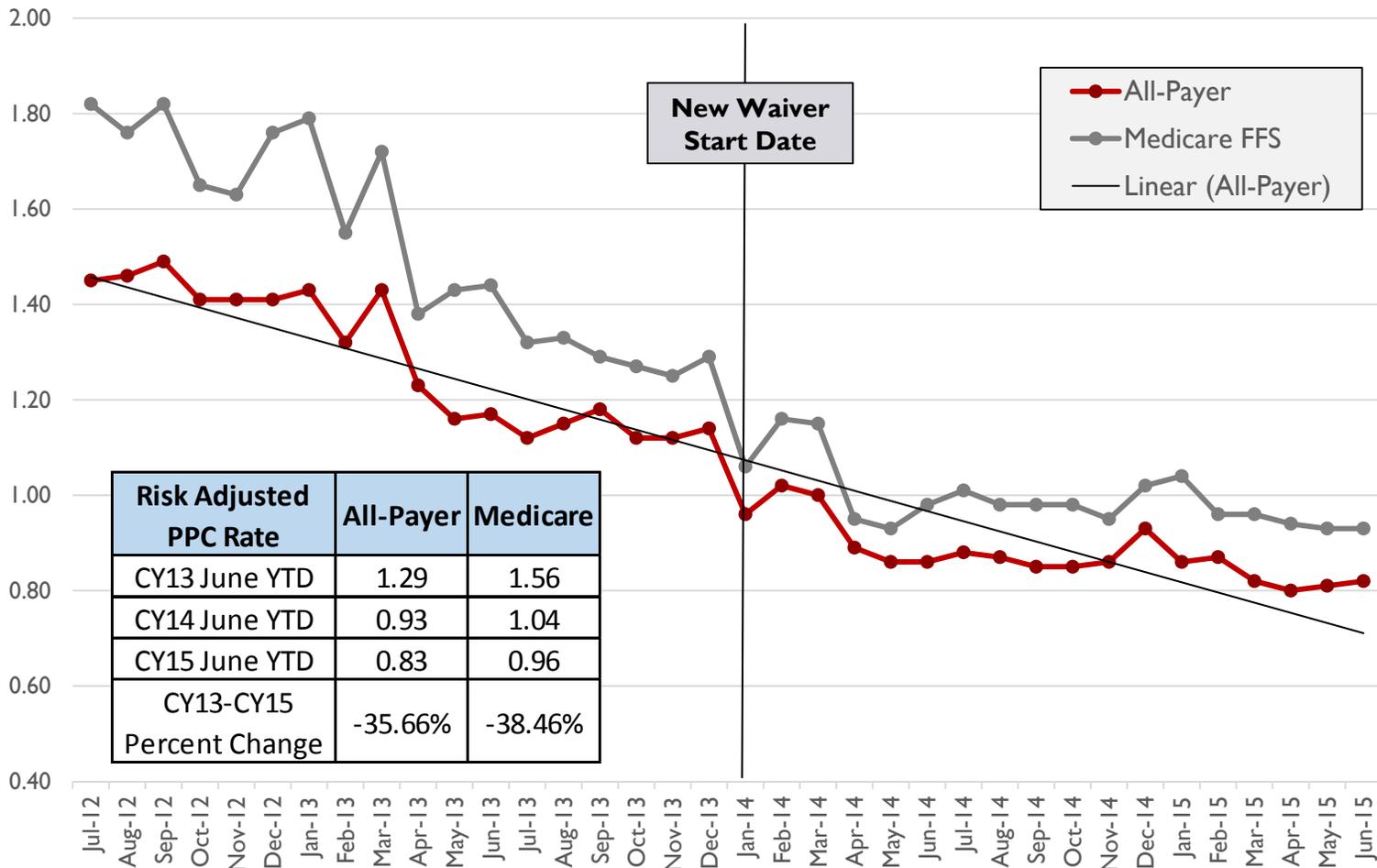
Note: Based on final data for January 2012 – June 2015, and preliminary data through August 2015.

# Change in All-Payer Risk-Adjusted Readmission Rates by Hospital



12 Note: Based on final data for January 2012 – June 2015, and preliminary data through August 2015.

# Monthly Risk-Adjusted PPC Rates



Note: Reported as of 9/30/2015, based on final data through June 2015. Includes PPC24.

# Change in All-Payer Risk-Adjusted PPC Rates YTD by Hospital

Notes:  
Based on final data for January 2014 – June 2015.  
Percent change is comparing Jan. – June. of CY2014 YTD to Jan. – June. of CY2015.  
Excludes McGready Hospital due to small sample size and includes PPC 24.

