Preliminary Evaluation of the Health Services Cost Review Commission

Recommendations:	**Waive from full evaluation** **Require the Department of Legislative Services to conduct a separate review of the missions and responsibilities of all three health regulatory commissions by December 1, 2016** **Defer decision on extension of the commission's evaluation date pending receipt of the review**
Date Established:	1971
Most Recent Prior Evaluation:	Full evaluation, 2006 Extended evaluation date by 10 years to July 1, 2017 (enacted by Chapter 628 of 2007)
Composition:	Seven members (four who may not have any connection with the management or policy of any hospital or related institution)
Staff:	35 full-time positions
Regulatory Activities:	Sets hospital rates for all payers, including Medicare and Medicaid, at 55 hospitals
Authorizing Statute:	Title 19, Subtitle 2, Health-General Article
Evaluation Completed by:	Nathan McCurdy, Department of Legislative Services, 2015

Overview of Regulatory Activity

The Health Services Cost Review Commission (HSCRC) was established in 1971 to address escalating health care costs and increase the quality of health care through hospital rate regulation. HSCRC is an independent commission within the Department of Health and Mental Hygiene. HSCRC has set rates for all payers, including Medicare and Medicaid, since 1977 and has largely achieved the key policy objectives established by the legislature. In recent years, HSCRC has devoted considerable resources toward the development and implementation of payment-related initiatives designed to improve the overall quality of care in Maryland hospitals.

Legislative and Regulatory Changes Since the 2006 Sunset Evaluation

There have been a number of legislative and regulatory changes since the last sunset evaluation in 2006 (See **Appendices 1** and **2**). It should be noted, however, that the majority of regulatory changes were the direct result of implementing legislation. Due to significant changes in the landscape of health care over the last several years, primarily as a result of the passage of the federal Patient Protection and Affordable Care Act, many of the recommendations made as part of the 2006 review are either obsolete or were abrogated by subsequent changes to statute or regulations intended to implement federal health care reform in Maryland. The most significant legislative changes involved altering rates to reflect reductions in uncompensated care and the Medicaid deficit assessment and implementing the new Maryland All-payer Model Contract.

Maryland All-payer Model Contract

Effective January 1, 2014, Maryland and the federal Centers for Medicare & Medicaid Services (CMS) entered into a new initiative (the Maryland All-payer Model Contract) to modernize Maryland's all-payer, rate-setting system for hospital services. This initiative, which replaced Maryland's 36-year-old Medicare waiver, allows Maryland to adopt new policies aimed at reducing per capita hospital expenditures and improving patient health outcomes. Under the waiver, Maryland's success was based solely on the cumulative rate of growth in Medicare inpatient per admission costs. Under the model contract, however, the State will not only limit inpatient, outpatient, and Medicare per beneficiary hospital growth but also shift hospital revenues to a population-based system and reduce both hospital readmissions and potentially preventable complications.

Success of the new model contract will be determined by (1) limiting the annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58%; (2) achieving aggregate Medicare savings of at least $330 million over five years; (3) shifting at least 80% of hospital revenue to a population-based payment structure; (4) reducing the hospital readmission rate for Medicare beneficiaries to below the national rate over a five-year period; and (5) producing a cumulative 30% reduction in hospital-acquired conditions over five years. To date, Maryland continues to perform well and is on pace to meet or exceed these goals. (See **Appendix 3**).

Few Consumer Complaints Regarding Hospitals

While not one of its primary functions, HSCRC occasionally fields consumer complaints regarding hospitals, averaging 21 complaints per year over the last five fiscal years. (See **Appendix 4**). The volume of complaints received remains low. Few ultimately require action by HSCRC, and any such action is handled in a timely manner. When a complaint is received, HSCRC follows a protocol that includes (1) contacting the complainant; (2) analyzing the complaint to see if staff can resolve the problem without contacting the hospital for medical records or other data; (3) if necessary, contacting the hospital for relevant data; (4) determining whether the complaint is valid; and (5) if the complaint is valid, contacting the hospital for a correction. If the complaint is not valid, HSCRC contacts the complainant with the result of the commission's analysis and closes the complaint. HSCRC reports that hospitals' responses to inquiries (such as making appropriate adjustments) have been sufficient to address complaints.

Revenues and Expenditures

HSCRC is funded through the collection of user fees assessed on all hospitals (including private, psychiatric, and rehabilitation hospitals), with rates approved by the commission. Individual hospital and related institution assessments in fiscal 2015 ranged from $8,182 (McCready Memorial Hospital) to $1,077,343 (Johns Hopkins Hospital). (See **Appendix 5**). The total user fees assessed by the commission are capped by statute. This cap was last increased from $7.0 million to $12.0 million by Chapter 263 of 2014. Commission expenditures have doubled since fiscal 2011. The significant increase in direct costs incurred by HSCRC over the last two fiscal years is a direct result of contracts related to the implementation of the new model contract. HSCRC currently has 17 contracts in place or planned for fiscal 2016, totaling approximately $5.0 million.

Use of Statewide Infrastructure

The statewide health information exchange, the Chesapeake Regional Information System for our Patients (CRISP), serves as a significant partner providing planning and start-up support for expanded information technology and analytic infrastructure, as well as support for implementation of care coordination and alignment activities.

Conclusion and Recommendations

Throughout this preliminary evaluation, the Department of Legislative Services (DLS) found that HSCRC functions well to fulfill its statutory requirements. The commission consistently implements legislative directives, promulgates regulations in a timely manner, and maintains positive relationships with regulated entities and other stakeholders. HSCRC has been, and continues to be, instrumental in controlling health care costs in the State. In the past two years, HSCRC has worked with stakeholders and federal partners to implement the new model contract, which represents a significant shift in the way that the health care system relates to public health and health care outcomes and builds on the roughly $45 billion that the old waiver saved the State

over its 36-year history. In conducting this evaluation, DLS found that HSCRC remains focused on its legislative mandate.

However, the landscape of health policy in Maryland has changed significantly; under the All-payer Model Contract, Maryland is moving to a population-based approach that now impacts both hospitals and community providers. The activities of *all three* health care regulatory commissions (HSCRC, the Maryland Health Care Commission, and the Maryland Community Health Resources Commission), which each have varying policy and funding roles, may have overlapping responsibilities in light of these changes. As such, **DLS recommends that the Legislative Policy Committee (LPC) waive HSCRC from full evaluation at this time. DLS further recommends that LPC require DLS, by December 1, 2016, to conduct a review of the missions and responsibilities of all three health care regulatory commissions and make recommendations regarding how the responsibilities and roles of the commissions could be better aligned. This review should include recommendations regarding the relationship between State agencies and major health information technology efforts, such as CRISP. The decision on the length of time for which HSCRC's evaluation date should be extended should be deferred pending receipt of the review.**

Policy Issues for Consideration

Assessment Cap

Last raised in 2014, HSCRC's user fee cap is currently $12.0 million. This amount is likely sufficient to cover expenditures within HSCRC's current scope of activity. **However, should HSCRC, in conjunction with CMS, attempt to expand the scope of the model contract, the user fee cap may need to be raised.**

Staffing

Throughout discussions with HSCRC staff, board members, and external stakeholders, staff succession was raised as an area of particular concern. Several staff members are near, at, or have exceeded retirement age, and efforts to secure qualified replacements have been unsuccessful. In particular, one associate director position has remained vacant for over a year, due to an inability to find a qualified applicant. The main issue cited for the difficulty finding qualified applicants was the pay scale. While HSCRC does have independent salary setting authority, the levels of compensation offered are significantly lower than what is available in the private sector. HSCRC is currently exploring other ways of filling these positions, including training an otherwise underqualified individual or dividing the position's responsibilities in such a way that suitable applicants can be found. **HSCRC should continue to explore innovative ways to meet its staffing needs, including reevaluating its current salary schedule.**

Appendix 1.
Major Legislative Changes Since the 2006 Sunset Evaluation

Year	Chapter	Change
2007	628	Extends the evaluation date for the Health Services Cost Review Commission (HSCRC) by 10 years to July 1, 2017.
		Increases HSCRC's user fee cap from $4.0 million to $5.5 million.
2008	245	Requires HSCRC to assess an amount in hospital rates to (1) reflect the aggregate reduction in hospital uncompensated care resulting from the expansion of Medicaid coverage under Chapter 7 of the 2007 special session and (2) operate and administer the Maryland Health Insurance Plan (MHIP).
2009	310	Requires HSCRC to require specified hospitals to develop a financial assistance policy for providing free and reduced-cost care to specified patients.
	689	Requires the Maryland Health Care Commission and HSCRC to designate a statewide health information exchange.
2010	505	Requires HSCRC to set rates for hospital services provided at freestanding medical facilities and payers to pay HSCRC rates for services provided at such facilities.
2011	397	Requires HSCRC to approve a combination of additional hospital assessments and remittances in the amount of $389.8 million to support the general operations of the Medicaid program in fiscal 2012.
		Requires HSCRC, for fiscal 2013 and thereafter, to adopt policies that continue to generate at least $389.8 million annually in special fund revenues and/or general fund savings from reduced Medicaid hospital or other payments.
		Sets the assessment on hospitals used to capture averted uncompensated care to 1.25% of projected regulated net patient revenue.
		Requires HSCRC to report on the reduction in uncompensated care resulting from federal health care reform legislation.
	582	Increases HSCRC's user fee cap from $5.5 million to $7.0 million.

Year	Chapter	Change
2014	263	Alters State law governing HSCRC to comply with provisions of the Maryland All-payer Model Contract. Increases HSCRC's user fee cap from $7.0 million to $12.0 million.
	464	Requires the Governor to reduce the Medicaid deficit assessment by the full amount of the hospital savings that accrue to Medicaid as a result of the implementation of the All-payer Model Contract (and requires HSCRC to calculate the extent of such savings). Reduces the MHIP assessment from 1% of net patient revenue to 0.3%. For fiscal 2015 only, authorizes HSCRC to include an additional $15.0 million in hospital revenue to support planning and implementation of the All-payer Model Contract.
2015	489	Requires HSCRC, from the recognition of additional hospital savings due to a decrease in uncompensated care, to adopt policies that generate general fund Medicaid savings of at least $16.7 million in fiscal 2016. Authorizes MHIP surplus funds to be used in fiscal 2016 through 2019 to support integrated care networks for Medicare patients and dual-eligible patients, consistent with the goals of the all-payer model. Prohibits imposition of the MHIP assessment for fiscal 2016 only.

Source: Laws of Maryland

Appendix 2.
Major Regulatory Changes Since the 2006 Sunset Evaluation

Year	COMAR Citation	Major Changes
2008	10.37.06..2-3	Expands the inpatient case mix discharge data set to include an additional 15 diagnosis codes and an additional 15 diagnosis-present-on-admission codes.
2010	10.37.10.26B(5)	Raises the income threshold for receiving free hospital care to patients with family incomes at or below 200% of the federal poverty level (FPL) and establishes a standard reduced cost care threshold between 200% and 300% FPL, unless the increase would yield undue financial hardship to a given hospital.
2011	10.37.07.01-.07	Enables the Health Services Cost Review Commission (HSCRC) to fully measure and compare hospital-specific performance on readmissions and to use the data to further enhance and strengthen the financial incentives linked with performance.
2012	10.37.10.07-1	Requires hospitals to file a request for a determination on the regulated or unregulated status of outpatient services at least 60 days before certain contemplated action.
2014	10.37.01.03	Requires hospitals to include revenue and utilization breakouts for out-of-state and Medicare patients in monthly reporting, effective January 1, 2014.
	10.37.04.01	Requires hospitals to submit monthly, patient-level outpatient visit data and enables HSCRC to fully monitor population-based metrics and approved revenue under population-based payment models.
	10.37.06.01	Requires hospitals to submit monthly patient-level inpatient discharge data and enables HSCRC to fully monitor population-based metrics and approved revenue under population-based payment models.
2015	10.37.01.13	Requires hospitals to submit to HSCRC all data required for evaluation purposes in compliance with the January 1, 2014 All-payer Model Contract.

Source: Code of Maryland Regulations, *Maryland Register*

Appendix 3.
Maryland's Initial Performance on the Requirements of the All-payer Model Contract as of October 2015

Requirement	Initial Performance/Status
Total Hospital Cost Growth: Limit annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58% growth.	Per capita revenue for Maryland residents grew by 1.47% from calendar 2013 to 2014. Calendar 2015 growth through June 30 was up 2.28% over the same period in calendar 2014.
Medicare Total Hospital Cost Growth: Limit Medicare per beneficiary hospital cost growth to produce $330.0 million in cumulative Medicare savings over five years beginning with an estimated $49.5 million in savings in 2015.	HSCRC and CMS report that, in calendar 2014, Medicare's per capita hospital costs grew by 1.07% nationally, and decreased by 1.08% in Maryland, equivalent to a savings of $116 million.
Population-based Revenue: Shift hospital reimbursement from a per case to a population-based system, with at least 80.0% of hospital revenues shifted to global budgeting over five years.	All hospitals are under either GBR or TPR agreements. Ninety-five percent of hospital revenue has been shifted to global budgets; the remaining 5.0% is excluded out-of-state revenue for five hospitals.
Reduction of Hospital Readmissions: Reduce the Medicare readmission rate to below the national average over five years.	Between calendar 2013 and 2014, the gap between the Maryland and the national all-cause readmission rate among Medicare patients decreased from 1.2% to 1.0%.
Reduction of Hospital-acquired Conditions: Achieve a cumulative reduction of potentially preventable complications of 30.0% over five years.	In June 2015, the all-payer risk-adjusted PPC rate was 0.83 per 1,000 compared with 1.29 per 1,000 in June 2013, a 35.66% reduction. HSCRC will continue to set annual improvement targets for hospitals to further reduce PPC.

CMS: Centers for Medicare & Medicaid Services
GBR: global budget revenue
HSCRC: Health Services Cost Review Commission
PPC: potentially preventable complications
TPR: Total Patient Revenue

Source: Health Services Cost Review Commission; Department of Legislative Services

Appendix 4.
Number and Disposition of Complaints Received by the Health Services Cost Review Commission
Fiscal 2011-2015

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Complaints Received	17	12	40	20	17
Nature of Complaints					
Hospital Charges[1]	17	12	38	20	15
Discounts	0	0	1	0	0
Coding	0	0	0	0	1
Coverage	0	0	0	0	1
Billing	0	0	1	0	0
Disposition of Complaints					
Hospital Bills Adjusted	1	2	6	6	1
No Further Action Taken	16	10	34	14	16

[1]The commission notes that the majority of complaints regarding hospital charges concerned the magnitude of the charges, while the remainder questioned whether the services billed were actually received by the patient.

Source: Health Services Cost Review Commission

Appendix 5.
Financial History of the Health Services Cost Review Commission
Fiscal 2011-2016

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Beginning Balance	$838,561	$572,763	$1,592,699	$957,930	$1,449,879	$2,627,736
Revenues	4,743,823	6,331,979	5,351,676	7,016,529	9,685,460	8,550,000
Transfers to General Fund	(83,435)	0	0	0	0	0
Total Revenues Available	**$5,498,949**	**$6,904,742**	**$6,944,375**	**$7,974,459**	**$11,135,339**	**$11,177,736**
Direct Costs	$4,500,706	$4,839,239	$5,476,900	$5,978,174	$7,888,386	$9,667,766
Indirect Costs	425,480	472,804	509,545	546,406	619,217	637,351
Total Expenditures	**$4,926,186**	**$5,312,043**	**$5,986,445**	**$6,524,580**	**$8,507,603**	**$10,305,117**
Ending Balance	**$572,763**	**$1,592,699**	**$957,930**	**$1,449,879**	**$2,627,736**	**$872,619**
% of Total Expenditures	11.6%	30.0%	16.0%	22.2%	30.9%	8.5%

Note: Numbers may not sum to total due to rounding. Fiscal 2016 revenue estimates are based on fiscal 2011 through 2014 experience. Fiscal 2016 expenditures reflect current obligations and are subject to change.

Source: Health Services Cost Review Commission

Appendix 6.
Written Comments of the Health Services Cost Review Commission

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Memorandum

To: Jennifer Chasse and Nathan McCurdy

From: Donna Kinzer DK

RE: Comments on Draft Preliminary Sunset Evaluation of the HSCRC

Date: December 1, 2015

Thank you for the opportunity to comment on the Exposure Draft of the Preliminary Sunset Evaluation of the Health Services Cost Review Commission (HSCRC). Department of Legislative Services staff has conducted a thorough preliminary review and has done an excellent job in conveying the responsibilities and duties of the HSCRC as well as in summarizing the new All-Payer Model.

The HSCRC supports the DLS recommendation to waive the HSCRC from full evaluation. The All-Payer Model is a huge asset to the State in that it keeps per capita cost growth below the nation and below historical rates, improves quality for patients, restricts cost shifting among payers, involves stakeholders in the process including patients and family representatives, and provides that Medicare will pay its fair share of uncompensated care and underlying costs (which results in approximately $1.8 billion of additional health care dollars coming into Maryland each year). As the All-Payer Model begins to extend its reaches beyond hospital services, the model becomes even more relevant in improving quality and reducing costs for all purchasers of health care. The success of the model will also depend on alignment among providers that the Commission do not regulate. Therefore, it is very important that the Department of Health and Mental Hygiene, the Maryland Health Care Commission (MHCC), Maryland Community Health Resources Commission (MCHRC), the HSCRC, various providers, patients, and other stakeholders work in concert with each other.

The Draft Preliminary Sunset recommends that the LPC "require DLS, by December 1, 2106, to conduct a review of the mission and responsibilities of all three health care regulatory commissions and make recommendations regarding how the roles and commissions could be better aligned." Under the All-Payer Model, there is a requirement that the State submit to the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of the fourth year of the existing model (by December 31, 2016) a proposal for a new model, which shall limit, at a minimum, the Medicare per beneficiary total cost of care growth rate. A new total cost of care model, if approved, would take effect no later than December 31, 2018.

Given the timing of the total cost of care model submission, HSCRC suggests that it would be best to conduct a review of the roles and responsibilities of the various commissions when it is clear what those new roles and responsibilities will be under a total cost of care model. While the HSCRC currently works closely with the MHCC and the MCHRC on many matters that intersect with our respective missions, there will likely be an even greater need for collaboration at this next stage of implementation. Therefore, the Commission recommends that such a review take place after a total cost of care model has been approved by CMS. The hope is that such an approval would take place by the end of 2017, but that date is unknown at this time.

The recommendation also focuses on a review of the various commissions' roles relating to health information technology, including CRISP. HSCRC and MHCC have been collaborating closely and functionally on matters pertaining to both the Health Information Exchange functions of CRISP and its role in care coordination, care transitions, and integrated care networks. This collaboration should and will continue.

Again, thank you for a well thought out and comprehensive preliminary review of the HSCRC. We look forward to working with you on any further reviews that might take place in the future.