Executive Director's Report

March 8, 2017

All Payer Model Update

DHMH and HSCRC are discussing the Progression Plan and the Maryland Comprehensive Primary Care Model with CMMI. This effort is consuming a significant amount of staff time and resources.

We have received an initial draft of the Care Redesign Amendment and Participation Agreement. We expect a second version of these documents to share with stakeholders shortly.

Rate Update for Second Half of FY 2017

As a reminder, the Commission provided for a deferral of .56% of the RY 2017 update to the second half of Rate Year 2017 (January through June 2017). Other components of revenue change that will occur in the second half of the year include the recovery of an undercharge from the first half of the year (~1%), and settlements. These figures bring the increase expected in the second half of the year to approximately 4.3%.

Readmissions Recommendation and 2016 settlement calculations

HSCRC has been working with CMS to reconcile readmissions post ICD-10 conversion. CMS has provided the program documentation to aid in that effort. Ideally, we need to complete the reconciliation to assure that targets are being set accurately. This has been a difficult process because the State does not currently receive identifiable data from CMS, and CMS excludes substance abuse data from the research identifiable files.

Staff will be focused on MHAC and readmissions data for the year ended 12-31-16, which is used in the reward/penalty calculations for FY 18 rates. We will work to understand the possible impact of the ICD-10 conversion on the settlements. The DRG assignment has changed under ICD-10.

Work group updates

Total cost of care workgroup--This workgroup is focused on implementation requirements for the Care Redesign amendment, as well as the development of a value based payment that links hospital payments with total cost of care, similar to other quality based programs. This group is continuing to meet. Staff will create a timeline of

activities that will be needed to bring this effort to implementation of an initial performance year of CY 2018.

Population health measures-- DHMH Office of Population Health has been working on a plan with performance goals for the State. It is expected that goals from this plan will play a role in future value based payments, beginning with Rate Year 2020. DHMH has made several presentations to stakeholders, including to the performance measurement workgroup. We will invite DHMH to make a presentation to the Commission in April.

Payment models workgroup--This workgroup began its annual deliberations and will be meeting regularly through the completion of the update. The office of the actuary (OACT) has not yet released figures for estimated growth in hospital costs and total cost of care (TCOC) that we use in our evaluation process.

Performance measurement workgroup--This work group is meeting to update policies. The draft recommendation for the Readmission Reduction Incentive Program is being finalized with the workgroup. The workgroup will also be reviewing Mathematica's analysis on the impact of the ICD-10 transition for RY 2018 and revised in-hospital mortality model that includes palliative care for RY 2019. A behavioral health subgroup is focusing on performance measures to use for the psychiatric hospitals—e.g. readmissions or other measures.

Consumer Advisory Council--This joint workgroup of DHMH and HSCRC had its second meeting on March 1st and continued its work to engage consumer groups on health care transformation efforts in the State. The Council received an update on the work of the All-Payer Model 2.0 development and negotiations, as well as the continued development of the Maryland Comprehensive Primary Care Model. Additionally, the Council heard a presentation from the Maryland Faith Health Network on the support that faith communities provide to patients that have signed up through the network, including transportation for follow up appointments, meal preparation, caregiver support, and other social supports to aide in patient recovery.

Emergency department wait times

We will have an update on this item at the April Commission meeting. The Staff talked with one of the rating agencies in the last several weeks, and they indicated that there are nursing shortages arising in some areas of the country, as the economy improves and deferred retirements take place.

Staff priorities

These include discussions of the Progression Plan with CMMI, annual updates to the quality based programs, settlement calculations of quality programs and market shift for CY 2016, and preparing for the annual update.

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

Data thru November 2016 – Claims paid through January

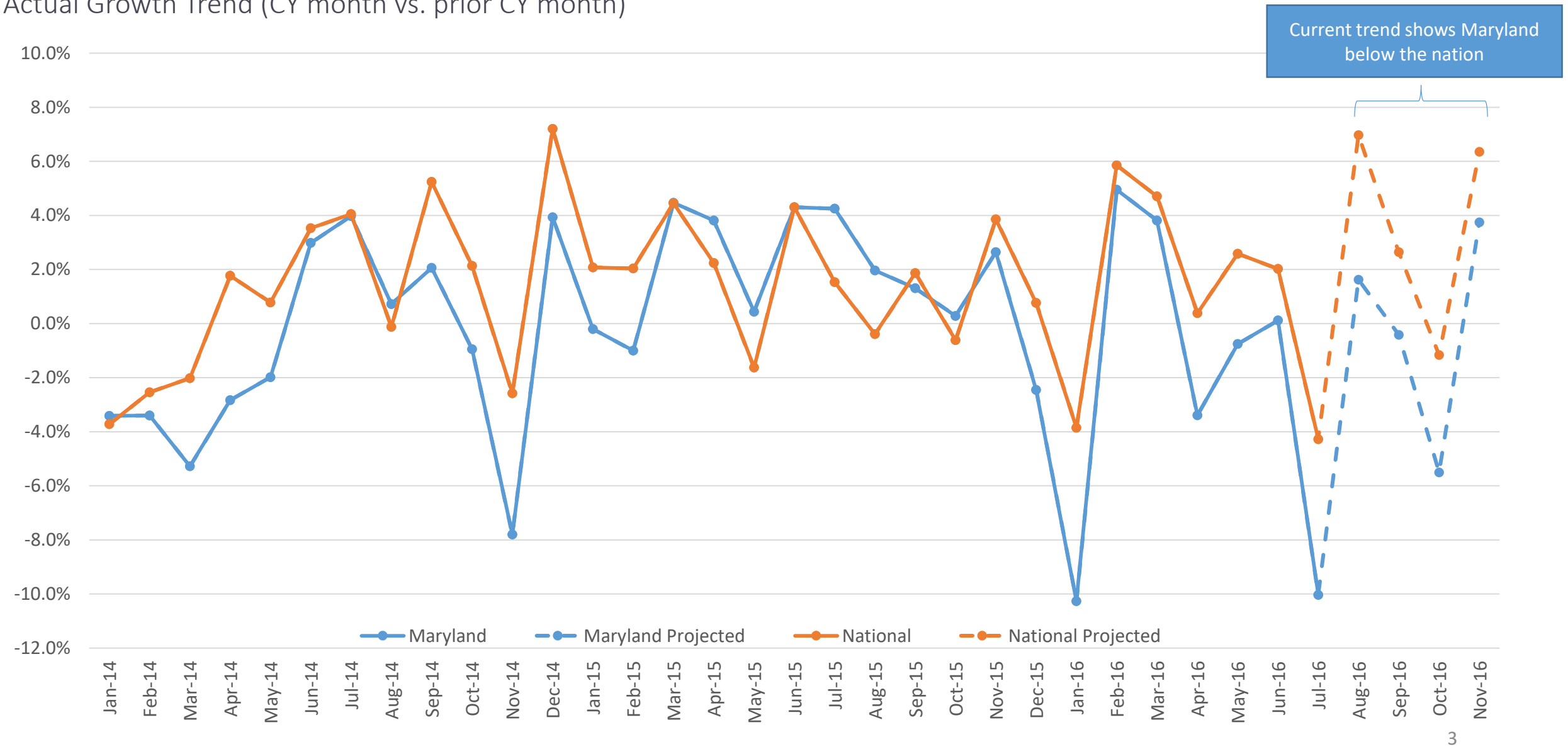
Source: CMMI Monthly Data Set

Disclaimer:

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

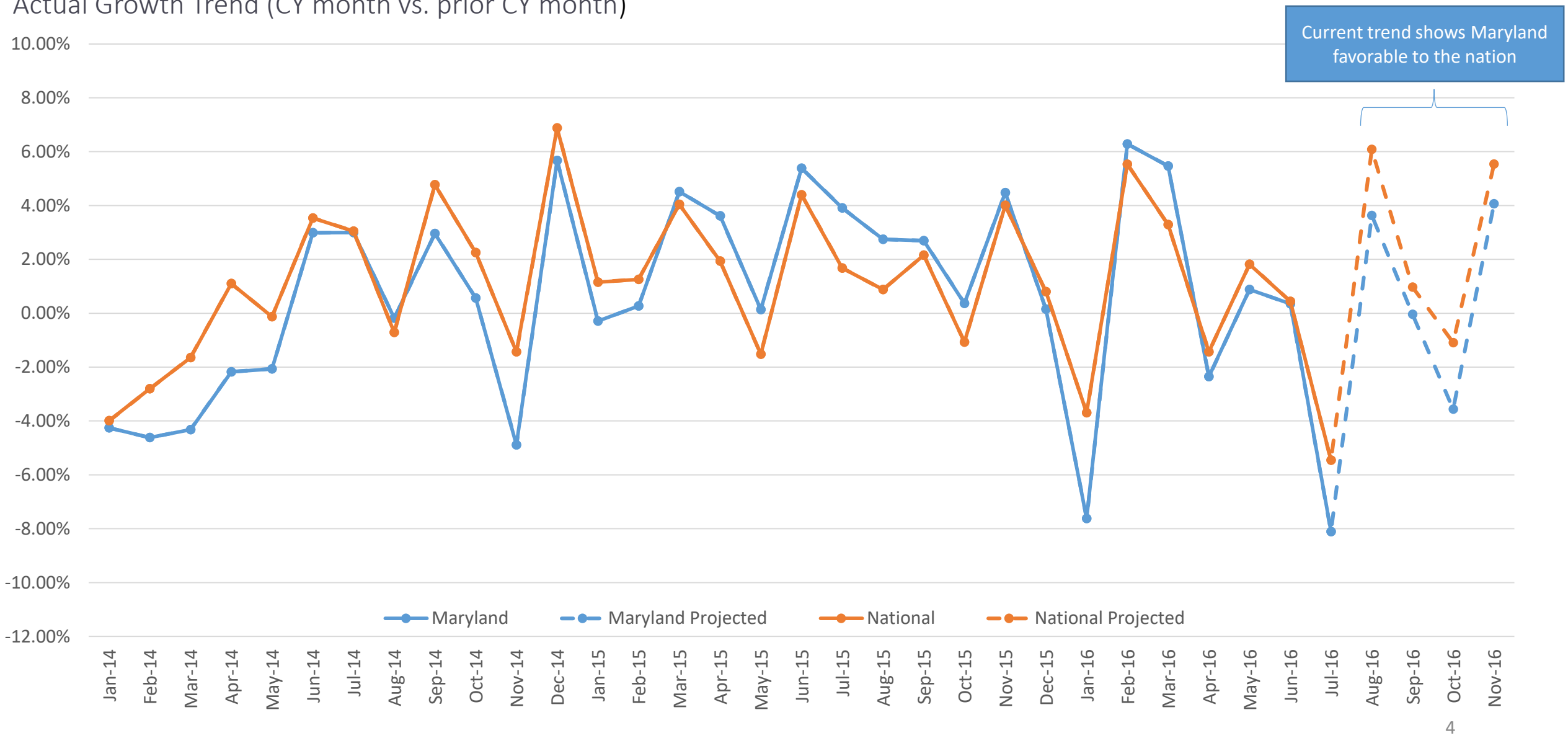
Medicare Hospital Spending per Capita

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



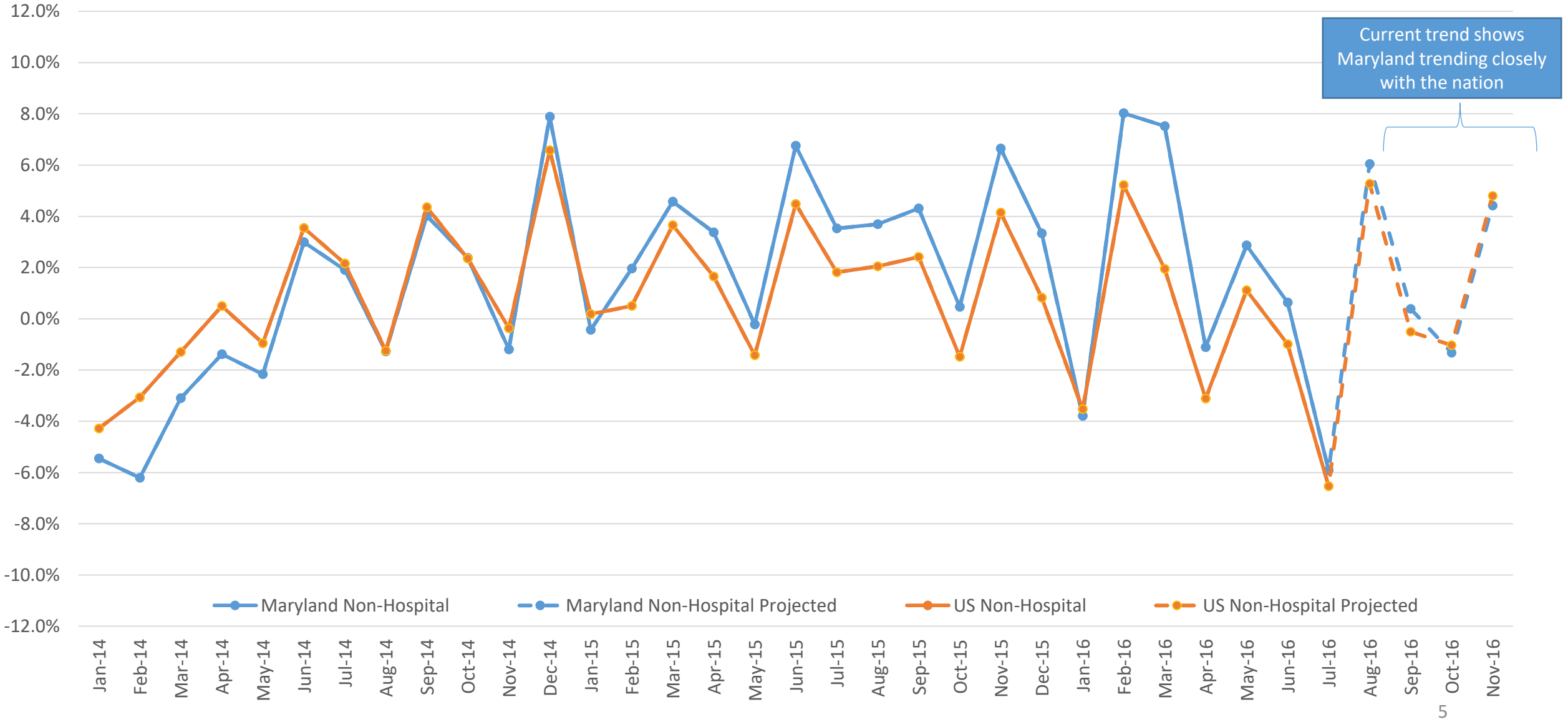
Medicare Total Cost of Care per Capita

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



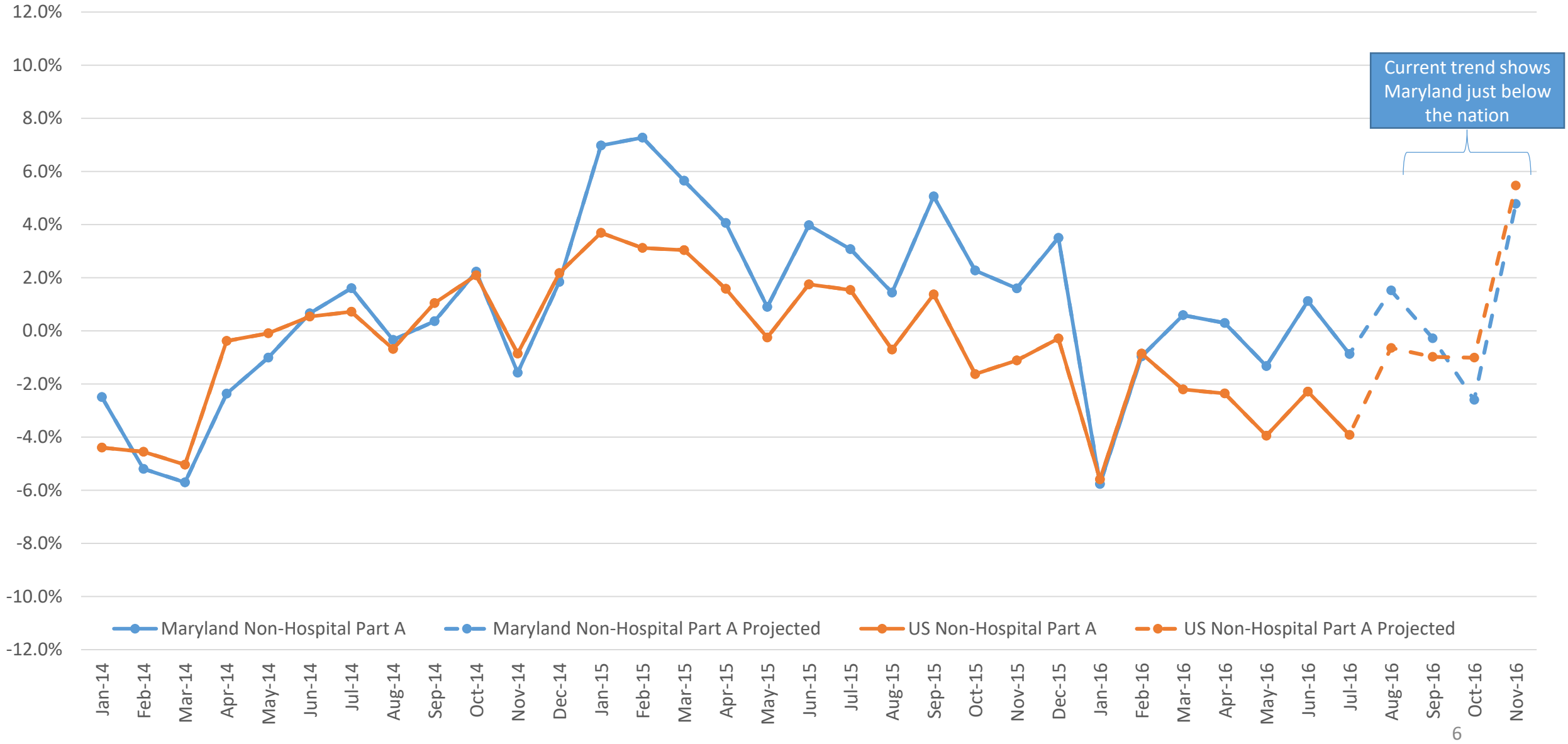
Medicare Non-Hospital Spending per Capita

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



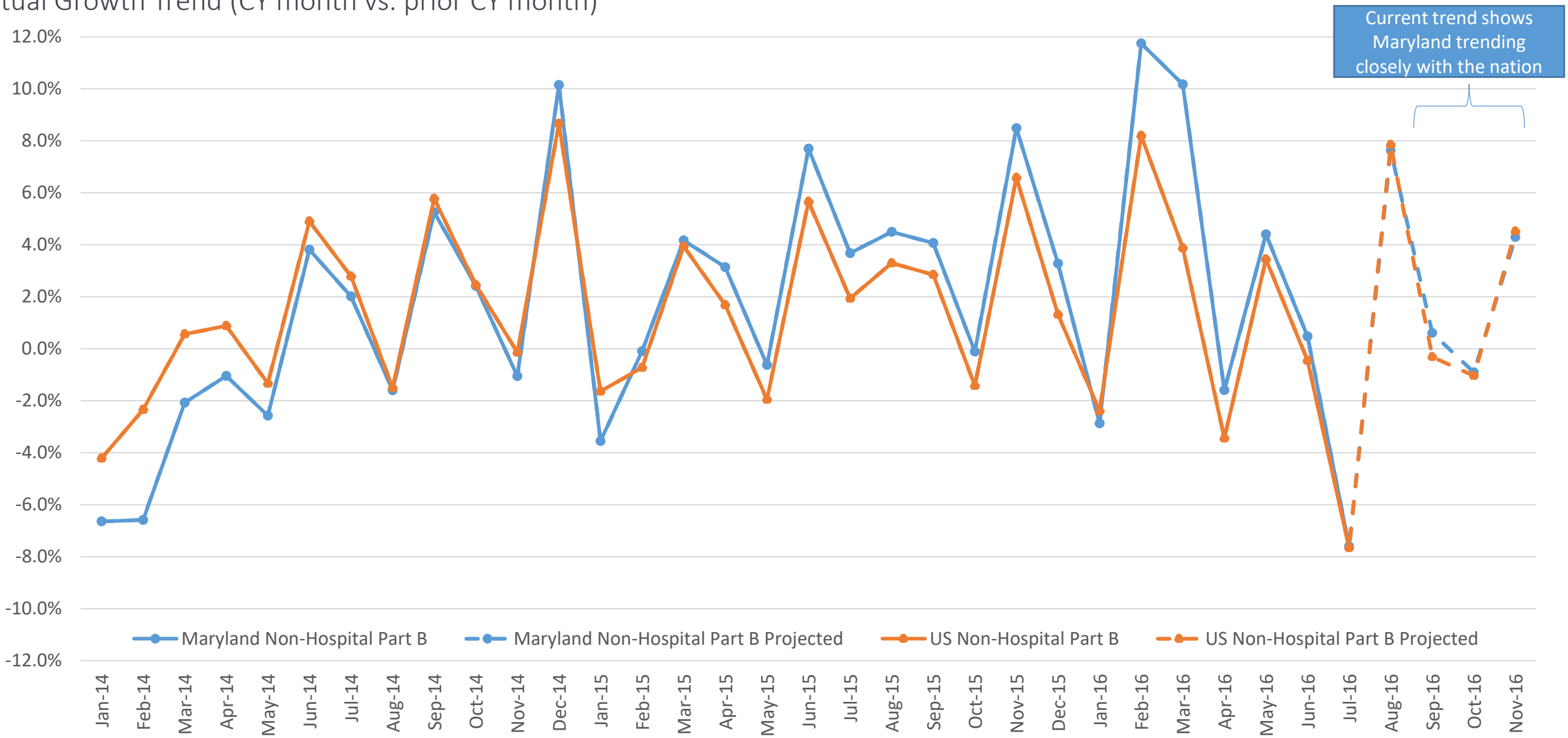
Medicare Non-Hospital Part A Spending per Capita

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



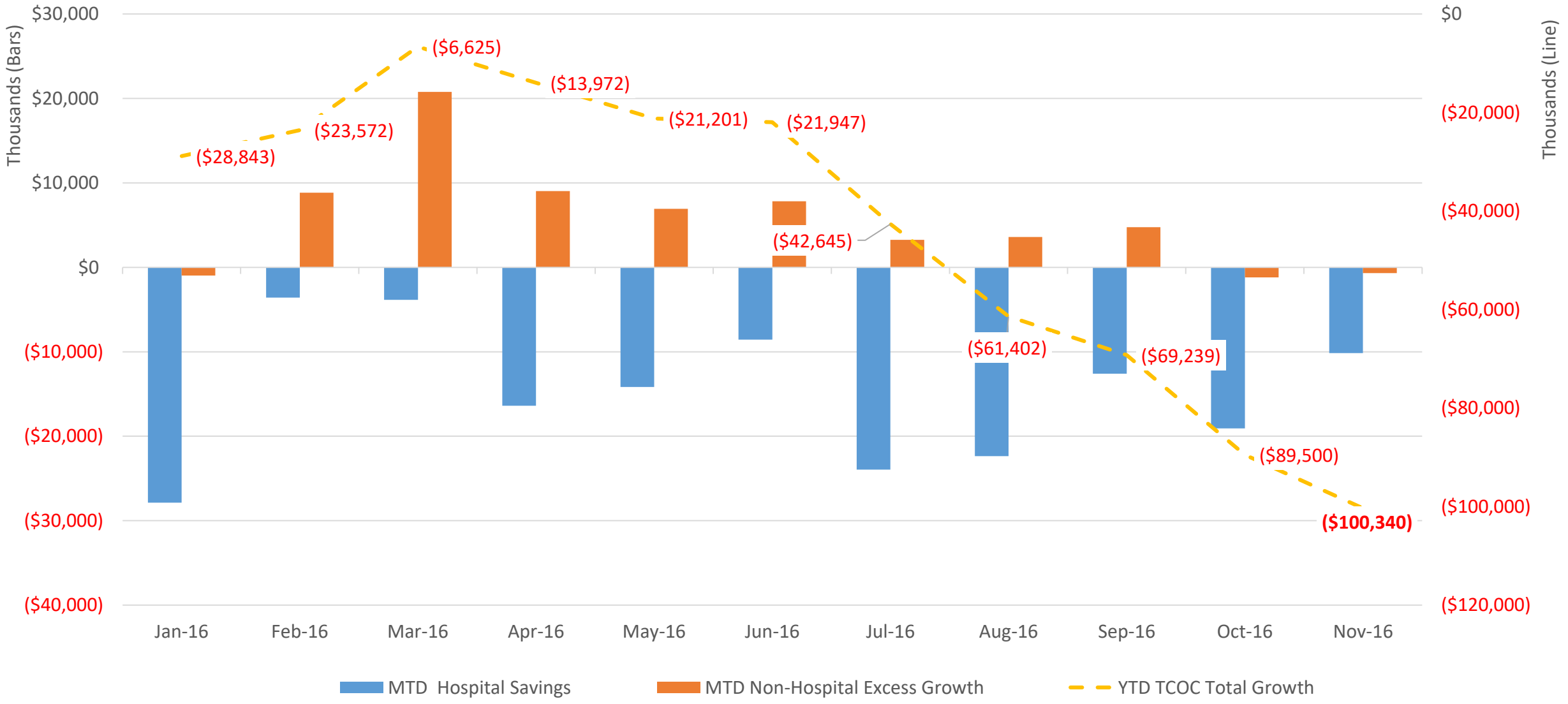
Medicare Non-Hospital Part B Spending per Capita

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



Medicare Hospital & Non-Hospital Growth

(with completion) CYTD through November 2016



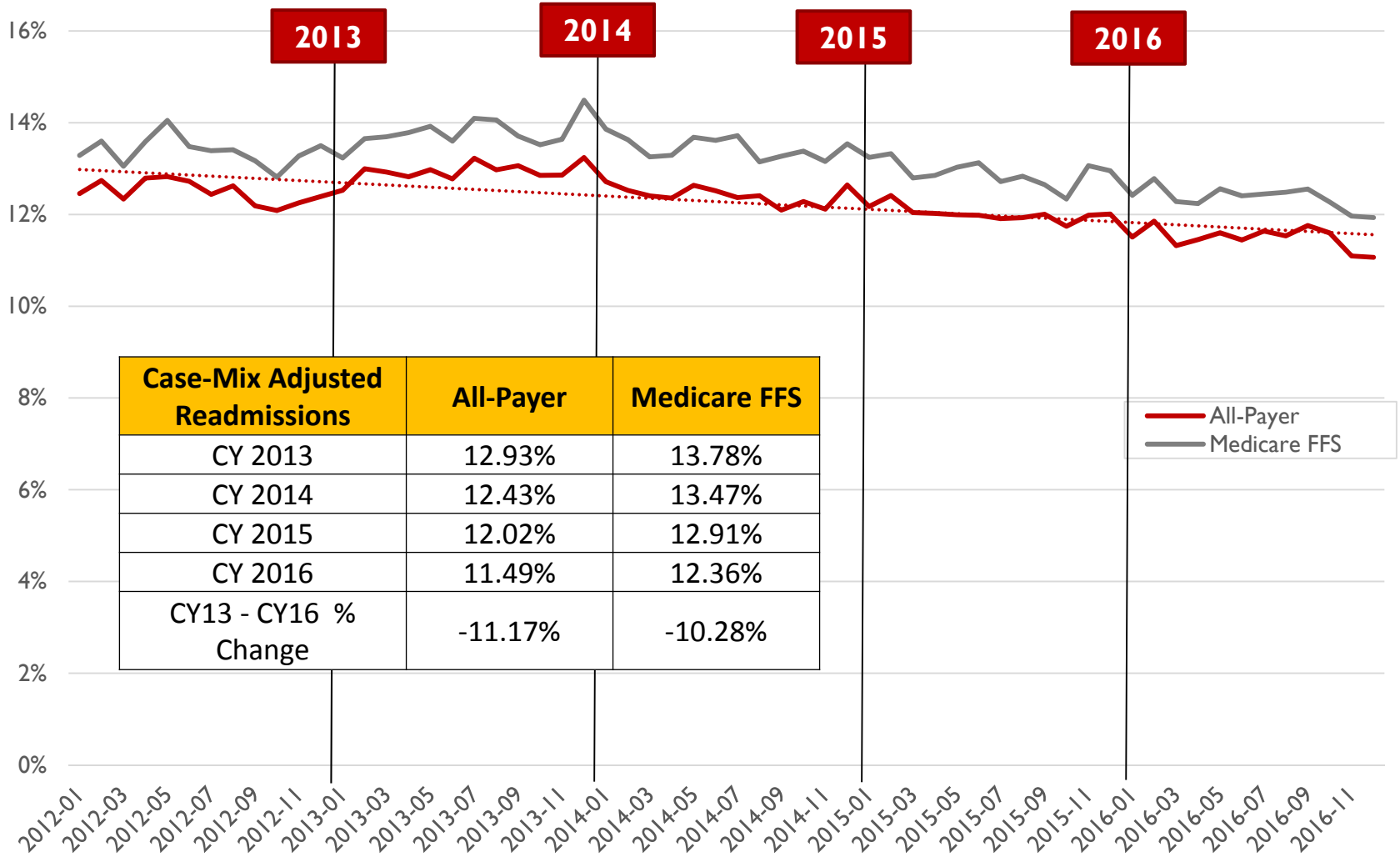
Monitoring Maryland Performance
Quality Data

February 2017 Commission Meeting Update

HSCRC
Health Services Cost Review Commission

Readmission Reduction Analysis

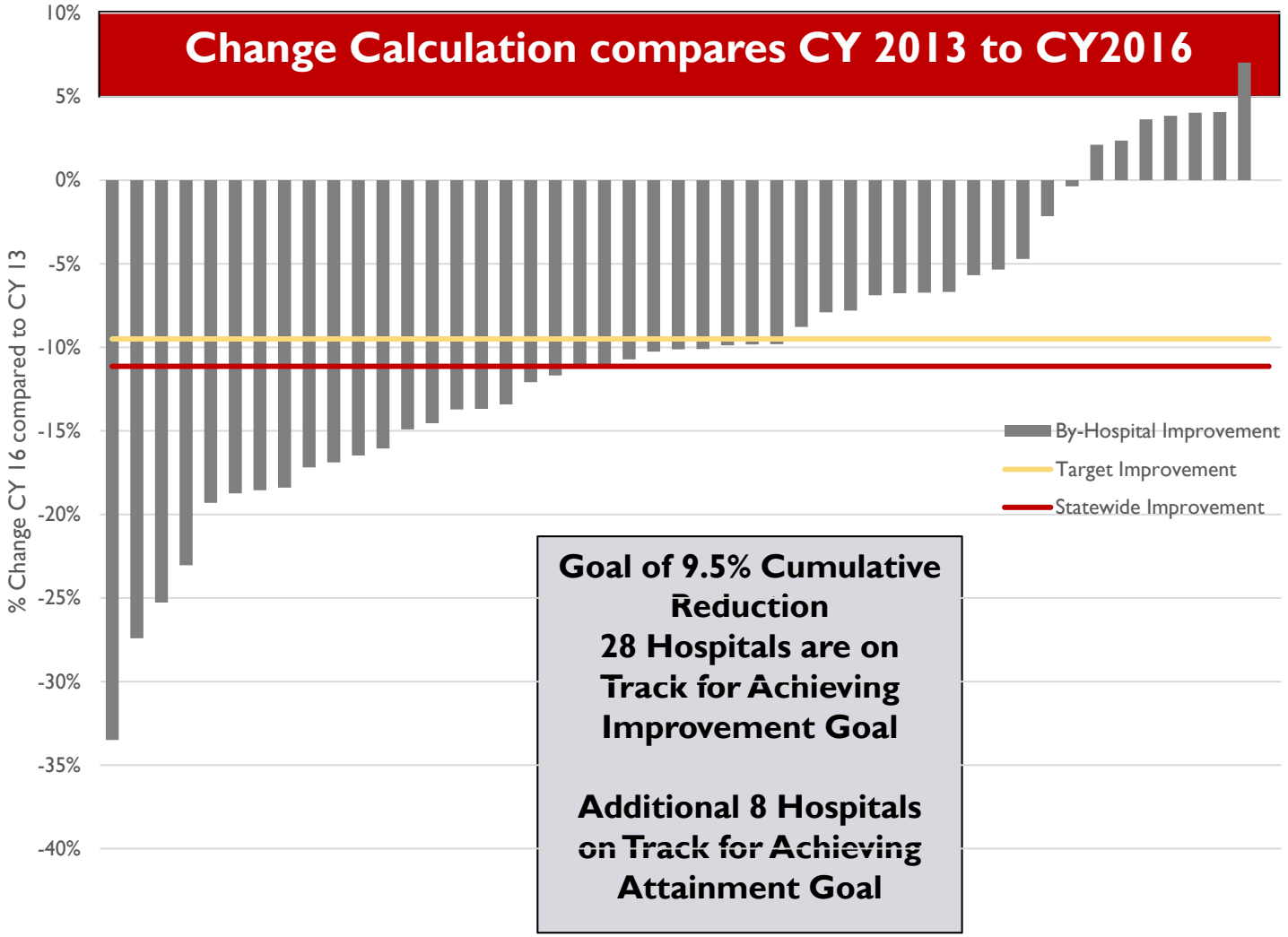
Monthly Case-Mix Adjusted Readmission Rates



Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
CY 2013	12.93%	13.78%
CY 2014	12.43%	13.47%
CY 2015	12.02%	12.91%
CY 2016	11.49%	12.36%
CY13 - CY16 % Change	-11.17%	-10.28%

Note: Based on final data for January 2012 – Sept. 2016, and preliminary data through December 2016.

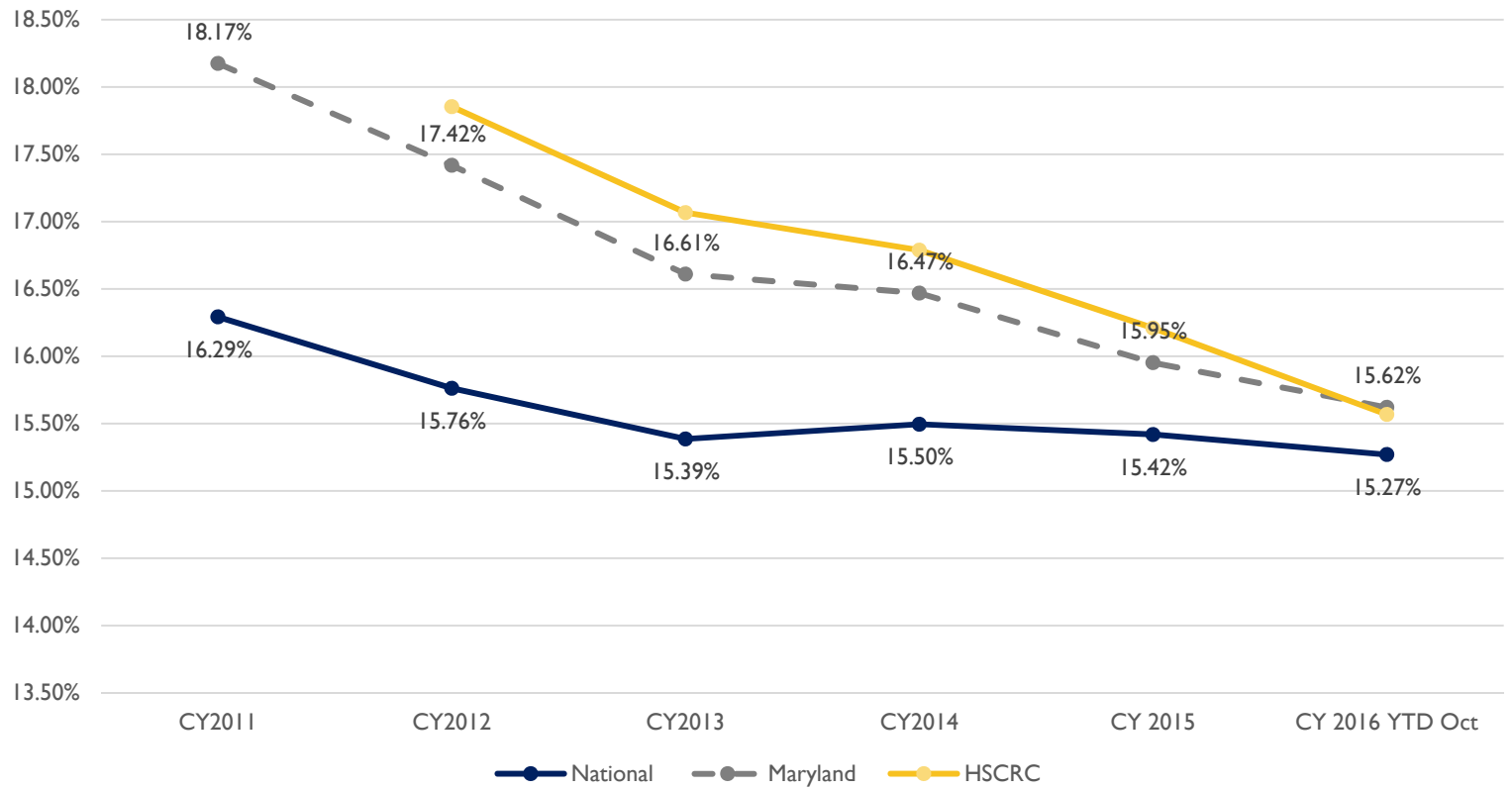
Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital



Note: Based on final data for January 2012 – Sept. 2016, and preliminary data through December 2016.

Medicare Readmission All-Payer Model Test

Maryland is reducing readmission rate but only slightly faster than the nation



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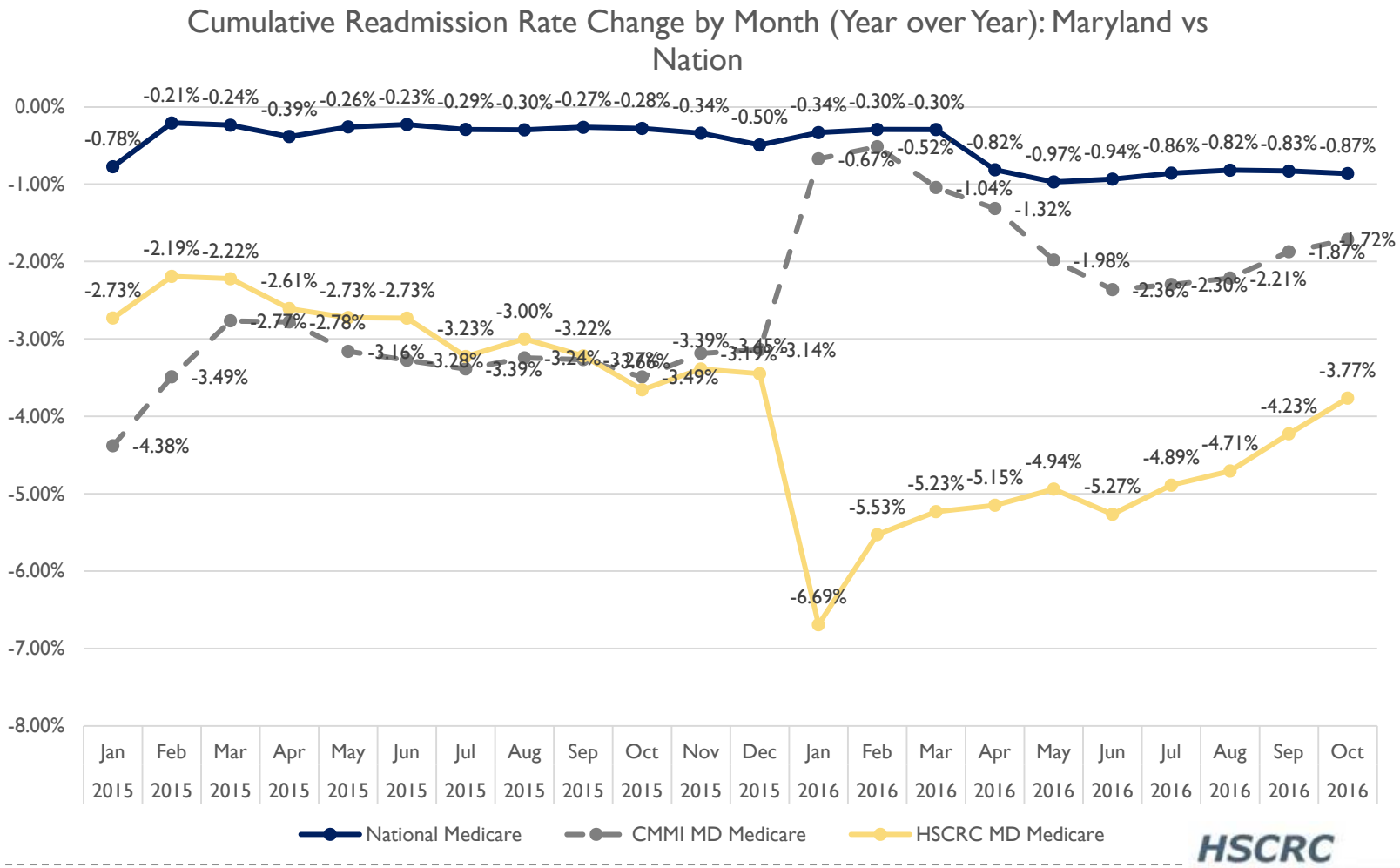
Cumulative Readmission Rate Change by Month (year over year): Maryland vs Nation

Reduction in the National Readmission Rate has increased in CY 2016



HSCRC
Health Services Cost Review Commission

UNIVERSITY of MARYLAND
ST. JOSEPH MEDICAL CENTER

Health Services Cost Review Commission

Public Meeting

March 8, 2017

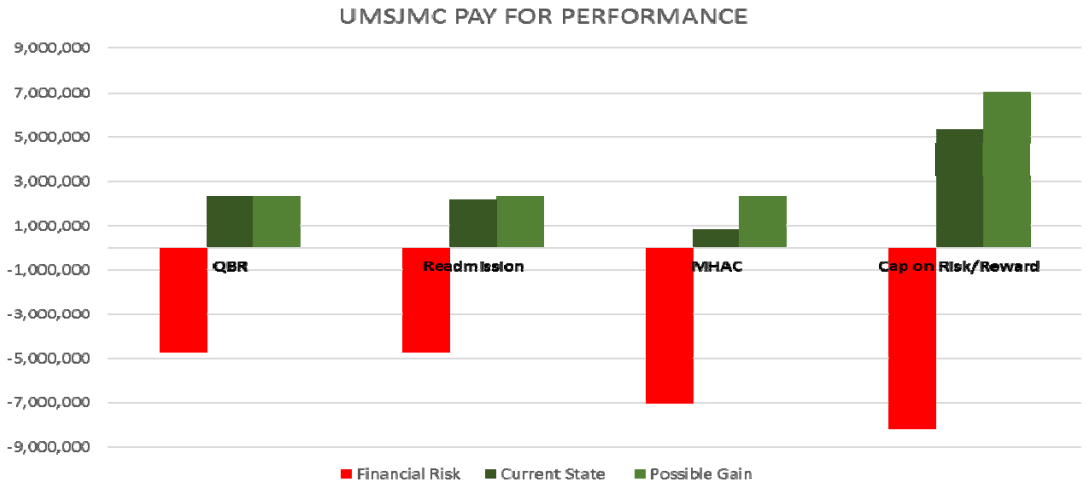
Agenda

- UM SJMC QBR Performance
- MAXIM Transitions Assist
- Transitional Care Center
- Behavioral Health Center
- Transitional Care Rounds and LOS
- ED High Utilizer Care Plan and Care Alert
- Transitional Nurse Navigators (TNNs)
- Medicare Utilization
- Population Health Infrastructure Investments
- True North

UM SJMC Pay for Performance

opportunity as of Nov 2016

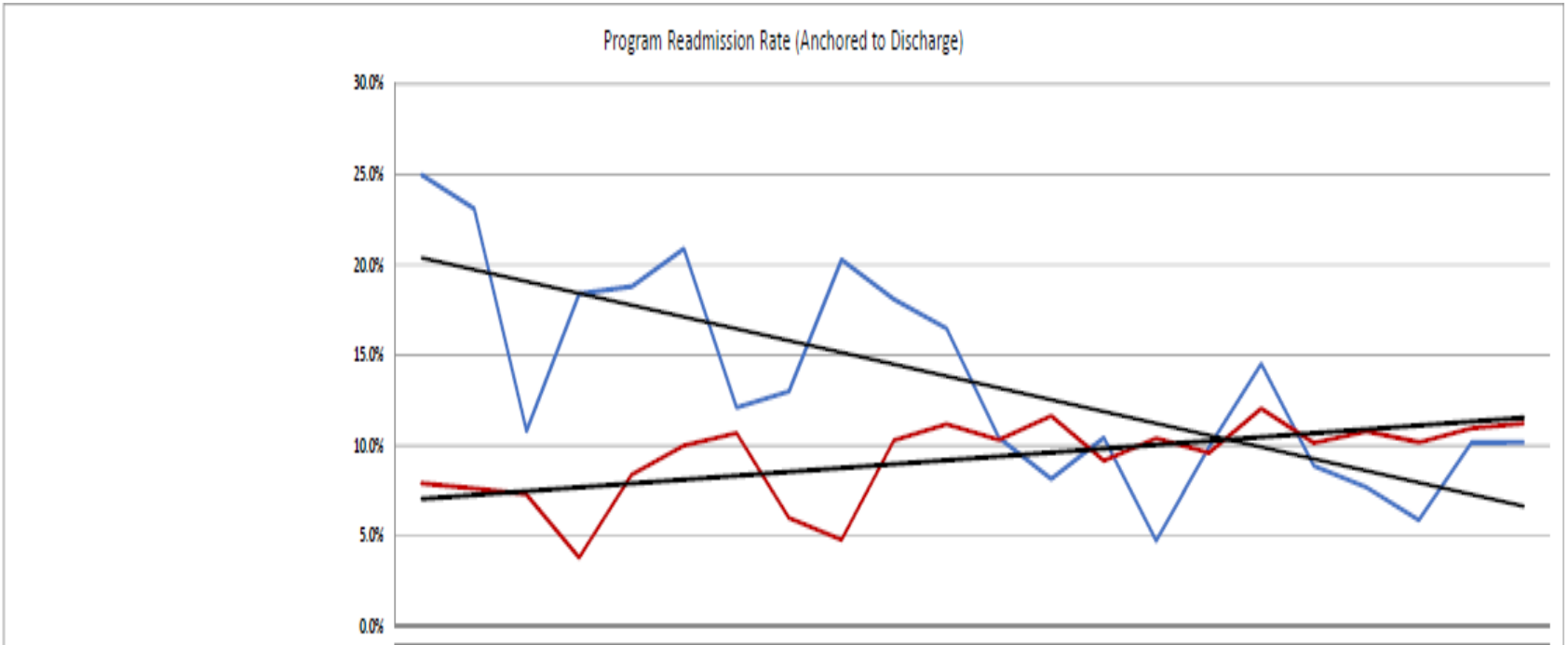
	Financial Risk	Current State	Possible Gain
QBR	$ (4,684,466)	$ 2,342,233	$ 2,342,223
Readmission	(4,684,466)	2,143,879	2,342,223
MHAC	(7,026,698)	850,458	2,342,223
Cap on Risk/Reward	$ (8,197,815)	$ 5,336,570	$ 7,026,669



University of Maryland St. Joseph Medical Center

MAXIM Transitions Assist

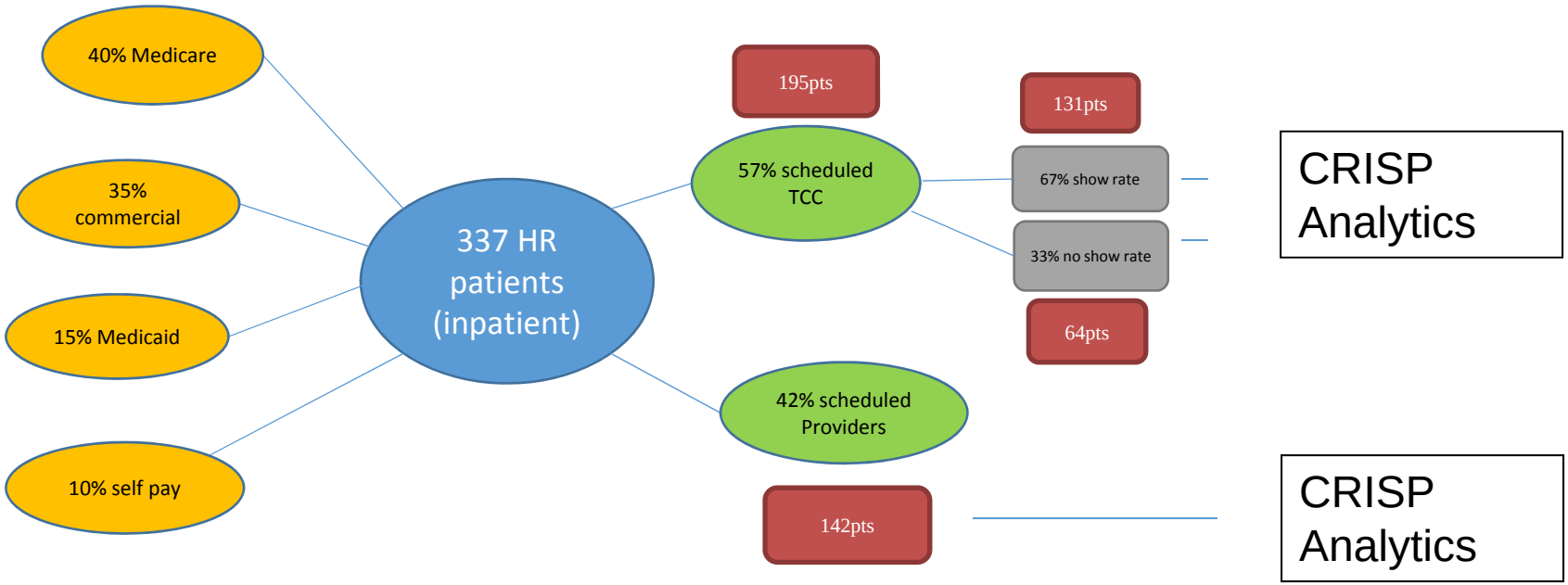
community health worker program



	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
Program Readmission Rate	25.0%	23.1%	10.8%	18.4%	18.8%	20.9%	12.1%	13.0%	20.3%	18.1%	16.5%	10.4%	8.2%	10.4%	4.7%	9.9%	14.5%	8.9%	7.7%	5.9%	10.2%	10.2%
Not Admitted to MTA program (LWBS, SNF, SAR, Ref Consent, Other)	7.9%	7.6%	7.3%	3.8%	8.4%	10.0%	10.7%	6.0%	4.8%	10.3%	11.2%	10.3%	11.6%	9.2%	10.4%	9.6%	12.1%	10.2%	10.8%	10.2%	11.0%	11.2%

Transitional Care Center (TCC)

process flow and results June 15th – Feb 17th



Transitional Care Center

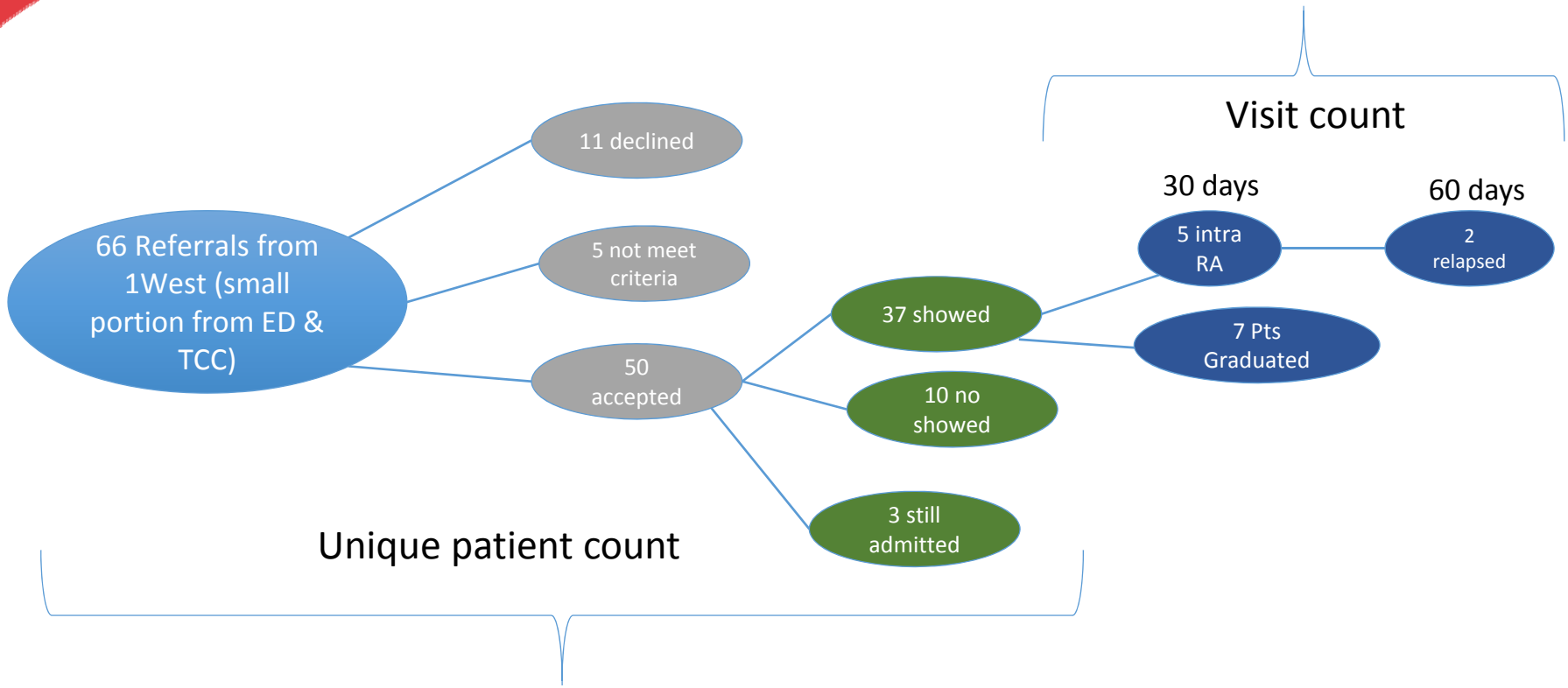
CRISP analysis

Total Utilization % Change Pre- to Post-	ED	IP	OBV	Total
Back To Community in 7 days (n=105)	-30%	-50%	-22%	-46%
TCC Arrived (n=68)	-26%	-67%	-58%	-59%
TCC No Show (n=23)	114%	0%	-33%	31%

The data is run out of CRISP PaTH report for a 12 months analysis, reflected on **ALL hospital** utilization, case mix adjusted. Not all patients in the groupings contain a consecutive 12 months data and is eliminated accordingly to provide equally weighted pre-post- analysis.

Behavioral Health Center

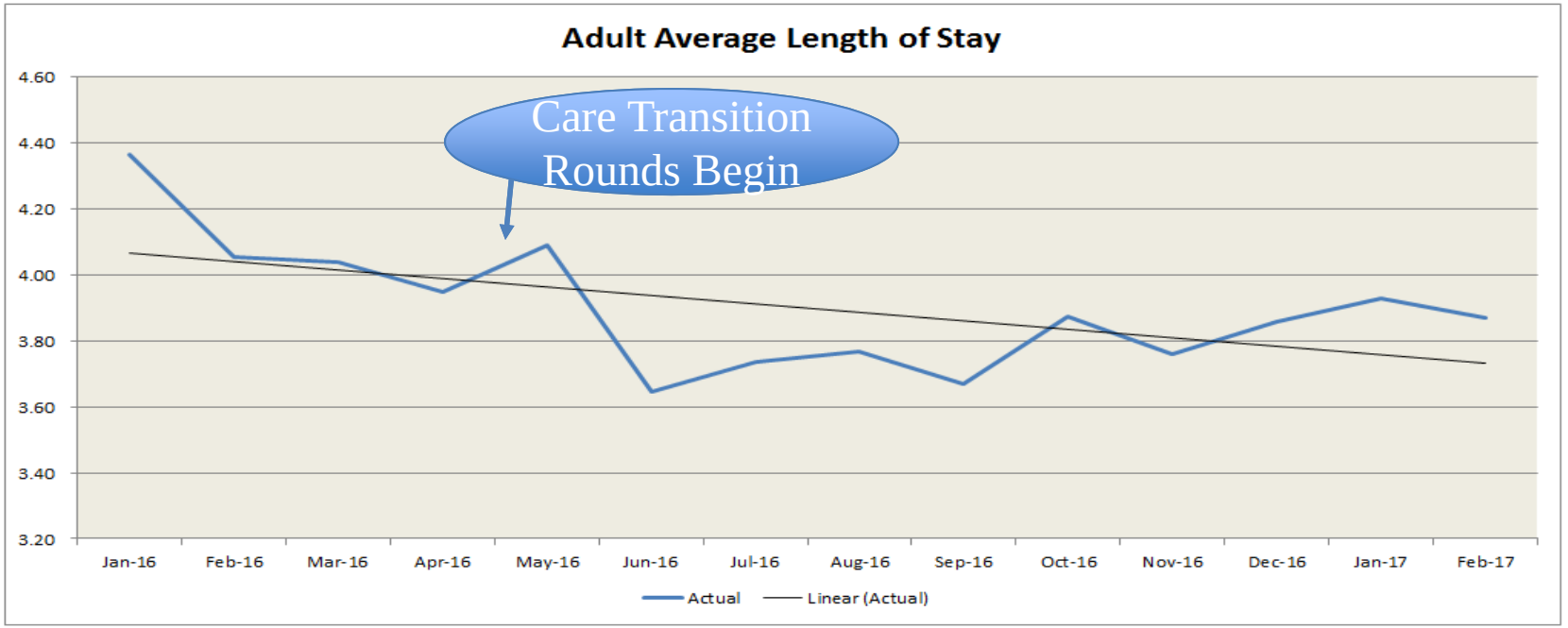
process flow and results fall 2016



- Patient contact hours are : Tues / Thursday 9-4pm.
  - Providers can see acute patients on M,W,F non-TCC hours (workflow and referral process is under development)
  - Current 1.0 FTE LCSWC is dedicated to working on Psych inpatient, TCC and ED referral
- Ramp up will continue
- Limiting factor is LCSWC recruitment

Care Transition Rounds

impact on adult LOS



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Actual	4.36	4.05	4.04	3.95	4.09	3.64	3.74	3.77	3.67	3.87	3.76	3.86	3.93	3.87
Budget	3.68	3.94	3.83	3.80	3.81	3.89	3.98	4.00	3.91	3.94	3.94	3.98	3.95	3.97

ED High Utilizer Care Plan and Care Alert

CY 2016 - first year results

CARE PLAN PATIENTS

ED VISITS BY DISPOSITION

Through Dec 31, 2016

		Total ED Visits			Discharged from ED			Placed in Obs			Admitted to Hospital		
Time Period	# pts	Pre	Post	% change	Pre	Post	% change	Pre	Post	% change	Pre	Post	% change
0-3 months	252	708	259	-63.4%	518	185	-64.3%	84	28	-66.7%	106	46	-56.6%
4-6 months	130	158	96	-39.2%	106	75	-29.2%	23	12	-47.8%	29	9	-69.0%
7-9 months	59	97	45	-53.6%	70	35	-50.0%	12	5	-58.3%	15	5	-66.7%
9-12 months	37	63	27	-57.1%	48	18	-62.5%	4	5	25.0%	11	4	-63.6%
Overall		1026	427	-58.4%	742	313	-57.8%	123	50	-59.3%	161	64	-60.2%

Pre/Post "TNN Impact" on CHF Readmit %

St. Joseph Hospital – All Payor

Transition Nurse Navigator Program: Focus is to reduce readmissions by targeting the highest risk patients with an emphasis on CHF

30d Intra-hospital Readmit % (DRG = Heart Failure)				
Severity of Illness	**Pre TNN (Jan '15 – Feb '16)**	**Transition (Mar '16 – Apr '16)**	**Post TNN (May '16 – Oct '16)**	**Pre/Post % Change**
1	6.7% N=15	0% N=3	0% N=11	100%
2	7.7% N=142	8.7% N=23	13.1% N=61	-69.3%
3	12.1% N=281	14.9% N=47	10.8% N=111	10.7%
4	14.9% N=67	0% N=4	4.8% N=21	68.1%
Total[2]	**10.8% N=481**	**11.7% N=77**	**10.3% N=204**	**4.8%**

High Risk Population

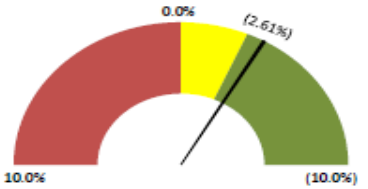
[1]Data Source: UMMS Revenue and Reimbursement Team (Oct YTD). Includes IP and Obs > 23 hr cases.
[2]Includes cases that does not have a Severity of Illness assigned to the admission so N does not sum to total.

CY16 Medicare Utilization Performance

St Joseph Medical Center

Medicare Utilization Performance Dashboard
CYTD December 31, 2016 vs CYTD December 31, 2015

Medicare Utilization Reduction Status

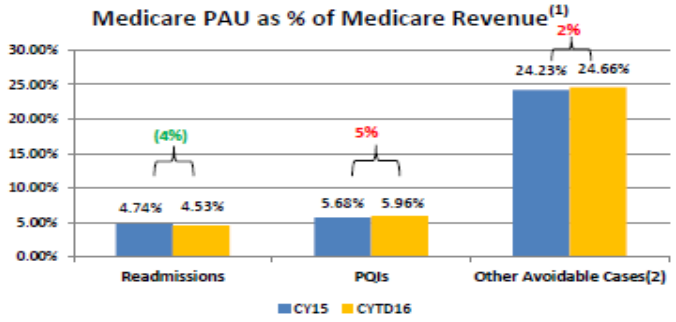


CYTD Actual	($4,533,497)	(3.26%)
CYTD Target	($3,624,936)	(2.61%)
(Better) Worse	($908,562)	(0.65%)
CYE Target	($3,624,936)	(2.61%)

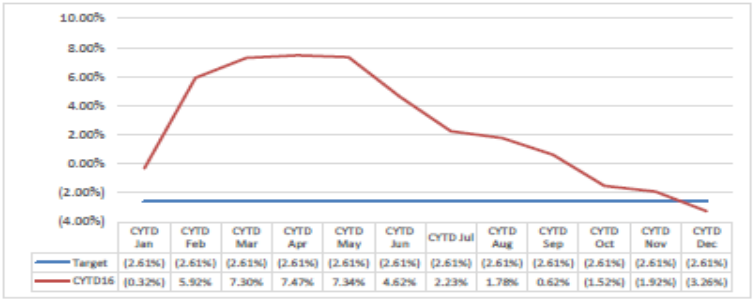
Components of Medicare Utilization Reduction

	Medical	Surgical	Total
Cases	$949,456	$2,687,632	$3,637,088
% Increase (Decrease)	0.68%	1.94%	2.62%
LOS	(2,132,257)	(3,645,792)	(5,778,048)
% Increase (Decrease)	(1.54%)	(2.63%)	(4.16%)
Utilization per Case	(4,756,406)	(2,588,259)	(7,344,665)
% Increase (Decrease)	(3.42%)	(1.86%)	(5.29%)
Outpatient			4,952,128
% Increase (Decrease)			3.57%
Total Utilization	($5,939,207)	($3,546,419)	($4,533,497)
% Increase (Decrease)	(4.28%)	(2.55%)	(3.26%)
Case Mix	(562,794)	(26,096)	(588,889)
% Increase (Decrease)	(0.41%)	(0.02%)	(0.42%)

Medicare PAU as % of Medicare Revenue[(1)]



Medicare Utilization Reduction Trend



Note (1): Individual case may be listed under multiple categories.

Note (2): Defined as 103 medical DRGs

University of Maryland St. Joseph Medical Center

Population Health Infrastructure Investments

- Transitional Nurse Navigator
- ED Access Case Managers
- Population Health Physician Advisor
- ED High Risk Coordinator
- Access Case Manager
- Maxim Transition Assist
- Homecare Services Coordination
- Transitional Care Center
- Behavioral Health Center
- Referral Coordination
- Physician Liaisons
- Evidence based self management
- Diabetes Management IP
- Diabetes and Nutrition OP
- Urgent Care
- Palliative Care
- Medication History Verification
- Medication Discharge Instructions
- Wound Care Management
- Wound Care Clinic
- Facility Clinical Performance improvement

$4.3 million

UM SJMC True North

Our Patients

Our Colleagues

Our Community

Maryland Hospital Acquired Conditions (MHAC) RY 2019 Policy Final Staff Recommendations

March 8, 2017

HSCRC
Health Services Cost Review Commission

RY 2019 MHAC Policy Development

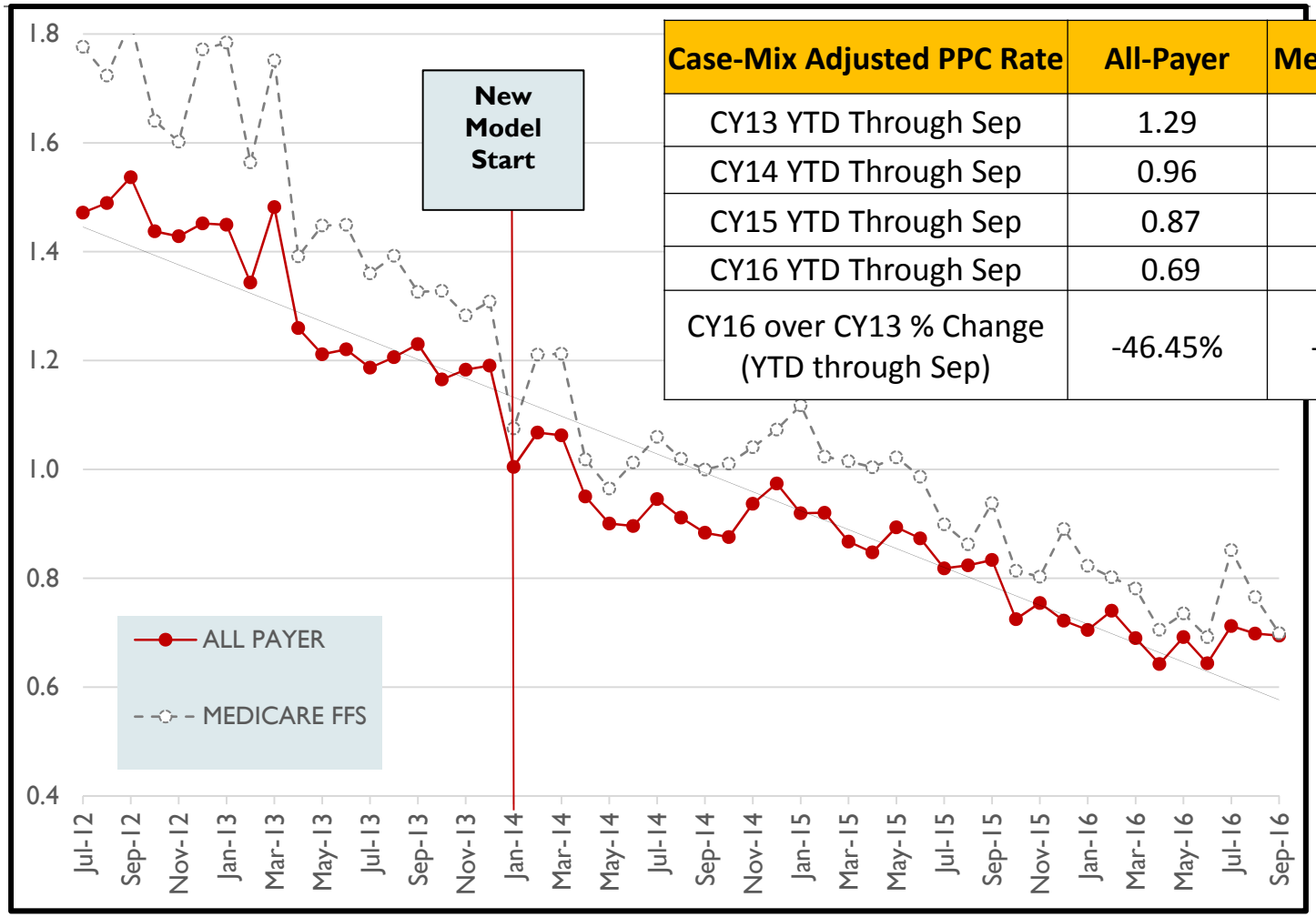
- RY 2018 MHAC recommendation developed in consultation with performance measurement workgroup and other stakeholder input.
- Assessment areas:
  - Statewide Potentially Preventable Complication (PPC) trends
  - Grouper Version and PPC List/Tiers
  - Palliative Care Exclusion
  - Payment adjustment methodology

PPC Trends Over Time

There is a Cumulative Case-Mix Adjusted Improvement Rate of 48% Percent Between FY13-16

PPC and APR-DRG Grouper Version 32 (ICD-9) and Version 33 (ICD-10)	PPC RATES				Annual Change			Cumulative Improvement
	FY13	FY14	FY15	FY16	FY13-FY14	FY14-FY15	FY15-FY16	FY13-FY16
TOTAL NUMBER OF COMPLICATIONS	27,934	21,056	17,341	14,508	-24.6%	-17.6%	-16.3%	-48.1%
UNADJUSTED PPC RATE PER 1,000 AT-RISK	1.18	0.94	0.80	0.69	-20.5%	-14.6%	-13.5%	-41.3%
CASE-MIX ADJUSTED COMPLICATION RATE PER 1,000 AT-RISK	1.40	1.09	0.90	0.73	-22.4%	-16.8%	-19.2%	-47.8%

Monthly Case-Mix Adjusted PPC Rates



Case-Mix Adjusted PPC Rate	All-Payer	Medicare FFS
CY13 YTD Through Sep	1.29	1.50
CY14 YTD Through Sep	0.96	1.06
CY15 YTD Through Sep	0.87	0.99
CY16 YTD Through Sep	0.69	0.76
CY16 over CY13 % Change (YTD through Sep)	-46.45%	-49.31%

Note: Based on final MHAC Program data for January 2012 – Sept. 2016

PPC Grouper Version and PPC List/Tiers

PPC Grouper Version

- Moved base time period to be under ICD-10
  - Base Year = October 2015 – September 2016
  - Performance Year = CY 2017
- Switched to Version 34 PPC and APR-DRG grouper
  - Version 34 takes into account increased specificity of ICD-10
  - Historical data under ICD-9 cannot be grouped under v34

PPC List and Tiers

- Continued from RY 2018 policy:
  - Group PPCs into two tiers (Tier 1 weighted 100%, Tier 2 weighted at 50%).
  - Combine some PPCs with low volume
  - Keep small subset of PPCs in a "monitoring" status
  - Maintain five PPCs as serious reportable events
- New in RY 2019:
  - 3M has discontinued four PPCs
  - No hospitals meet minimum inclusion for two PPCs
  - PPC 21 (c. Diff) moved to tier 2
- For RY 2019 there are 53 PPCs (48 with combinations) included in payment program

Palliative Care Exclusion

Palliative Care Considerations

- Staff reconsidered the inclusion of palliative care cases, balancing the following issues:
  - Clinical concerns for palliative care patients
  - Serious complications could lead to palliative care
  - Coding changes and variation
- 3M recommended including discharges where palliative care is not present on admission
  - Starting Federal FY17 (Oct. 2016) PC dx requires POA

Staff Recommend Maintaining Palliative Care Exclusion for RY 2019

- Workgroup members and other stakeholders raised clinical concerns with including palliative care cases
- Additional data analysis suggests that hospital specific audits may better address coding concerns
  - Continue special audit of palliative care coding
- Consider including palliative care cases in RY 2020 when POA is available

Payment Adjustment Methodology

RY2019 MHAC Scaling Recommendation

- No statewide improvement goal
  - Single revenue adjustment scale with max penalty 2% and max reward 1%
- Move to a full range scale (0-100%)
  - Modeled options with and without revenue neutral zone
  - Staff recommends maintaining a revenue neutral zone (45-55%)

RY 2019 MHAC Scaling Options

RY 2018 Scale

Final MHAC Score		Below State Quality Target	Exceed State Quality Target
Scores less than or equal to	0.20	-3.00%	-1.00%
	0.25	-2.52%	-0.69%
	0.30	-2.03%	-0.38%
	0.35	-1.55%	-0.06%
	0.40	-1.06%	0.00%
	0.45	-0.58%	0.00%
	0.50	-0.10%	0.12%
	0.55	0.00%	0.26%
	0.60	0.00%	0.41%
	0.65	0.00%	0.56%
	0.70	0.00%	0.71%
	0.75	0.00%	0.85%
Scores greater than or equal to	0.80	0.00%	1.00%
Penalty threshold:		0.51	0.36
Reward Threshold		No rewards	0.46

Option 1: Full Scale without Neutral Zone

Final MHAC Score	Revenue Adjustment
0.00	-2.00%
0.05	-1.80%
0.10	-1.60%
0.15	-1.40%
0.20	-1.20%
0.25	-1.00%
0.30	-0.80%
0.35	-0.60%
0.40	-0.40%
0.45	-0.20%
0.50	0.00%
0.55	0.10%
0.60	0.20%
0.65	0.30%
0.70	0.40%
0.75	0.50%
0.80	0.60%
0.85	0.70%
0.90	0.80%
0.95	0.90%
1.00	1.00%
Penalty/Reward threshold:	0.50

Option 2: Full Scale with Neutral Zone

Final MHAC Score	Revenue Adjustment
0.00	-2.00%
0.05	-1.78%
0.10	-1.56%
0.15	-1.33%
0.20	-1.11%
0.25	-0.89%
0.30	-0.67%
0.35	-0.44%
0.40	-0.22%
0.45	0.00%
0.50	0.00%
0.55	0.00%
0.60	0.11%
0.65	0.22%
0.70	0.33%
0.75	0.44%
0.80	0.56%
0.85	0.67%
0.90	0.78%
0.95	0.89%
1.00	1.00%
Penalty threshold:	0.45
Reward Threshold	0.55

MHAC Revenue Adjustment Modeling

RY 17 Modeled Results	Min	Penalty/Reward Cut Point	Max	Statewide Penalties	Statewide Rewards
RY 2017 Actual Results	17%	33%/43%	80%	<$1M	+30M
RY 2017 scores w/RY18 Scale	20%	36%/46%	80%	-$1.3M	+27M
Full Range Scale without Neutral Zone	0%	50%	100%	-$10M	+$13M
Full Range Scale with Neutral Zone	**0%**	**45%/55%**	**100%**	**-$6M**	**+$9M**

Staff Recommendations

HSCRC Staff Recommends the Following for RY 2019

- Continue to exclude palliative care discharges in program for RY 2019, and perform a special hospital audit on palliative care coding.
- Modify scaling methodology to be a single payment scale, ranging from 0% to 100%, with a revenue neutral zone between 45% and 55%.
- Set the maximum penalty at 2% and the maximum reward at 1%.

Legislative Report – March 8, 2017

Maryland Patient Referral Law – Compensation Arrangements Under Federally Approved Programs and Models (HB 403/SB 369)

HB 403/SB 369 creates another exemption to the Maryland Patient Referral Law for a health care practitioner who has a compensation arrangement with a health care entity, if that compensation arrangement is funded or paid under a program approved by the Federal Centers for Medicare and Medicaid Services. Eligible programs include Medicare ACO, Advanced Payment ACO, Pioneer ACO, Next Generation ACO, an alternative payment model approved by CMS, or another model approved by CMS that may be applied to health care services provided to both Medicare and non-Medicare patients.

Review and approval by the Maryland Insurance Administration (MIA) is required for models that include both Medicare and non-Medicare patients and involve any cash compensation. The bill creates a process by which MIA reviews the participation agreements to determine whether the agreements constitute insurance and comply with State law.

This bill is needed to allow hospitals to implement the Care Redesign Amendment programs.

Status: SB 369 passed the Senate with amendments on a vote of 47-0 on February 28. HB 403 passed the House Health and Government Operations Committee on March 3 with the same amendments as the Senate.

Commission position: Submitted written and oral testimony to the House and Senate Committees to support the bill.

Hospitals – Changes in Status – Hospital Employee Retraining and Economic Impact Statements (SB 379/HB 921)

SB 379 requires a hospital that voluntarily converts to a freestanding medical facility or is acquired by another hospital or health system to pay a fee directly to the State Department of Labor, Licensing, and Regulation if workers are displaced not to exceed 0.01 percent of total revenue approved by the Commission for the preceding fiscal year. The funds will be deposited into the Hospital Employees Training Fund. The bill also requires a hospital that closes or converts to a freestanding medical facility to produce an economic impact study related to the dislocation of the hospital's employees including the number of potential layoffs and the categories of employment affected by the potential layoffs.

Status: Hearing 2/9 in Senate Finance; Hearing 3/02 in House Health and Government Operations Committee.

Commission Position: Submitted a letter of information on previous assessments for the closure of hospitals, including payments into the Hospital Employees Training Fund.

Hospitals – Community Benefit Report – Disclosure of Tax Exemptions (SB 623/HB 932)

SB 623/HB 932 adds a reporting requirement for hospital community benefit reports to include an itemization of all tax exemptions received by the hospital. This will require the HSCRC to contract with a tax professional to update the reporting instructions and to verify tax exemptions reported.

Status: Hearing 3/2 in Senate Finance Committee; Hearing 3/2 in House Health and Government Operations Committee.

Commission Position: Submitted a letter of information on current community benefit reporting requirements and potential need for assistance by tax professional to develop reporting requirements and instructions to comply with proposed legislation.

Hospitals – Substance Use Treatment Demonstration Program – Requirements (HB 189)

HB 189 creates a substance abuse treatment demonstration program for up to 5 hospitals to identify best practices to identify and screen patients who may be in need of substance abuse treatment and provide inpatient and outpatient substance abuse services. Inpatient and outpatient services provided through the demonstration program shall include 24/7 counseling either on-site or on-call, screening, intervention, and treatment in the hospital's facility, and referral to the next appropriate level of care. The legislation directs the HSCRC to select the participants and develop a methodology to evaluate the effectiveness of the program. While Commission staff can select the participants, a contractor would be needed to evaluate the effectiveness of the program as that is not within the staff's purview.

HB 189 is similar to a bill submitted last year, for which the Commission ultimately submitted a letter of support with a caveat that funding be provided to procure a contract to vet and select demonstration participants, and evaluate the effectiveness of the program.

Status: Hearing 2/28 House Health and Government Operations Committee

Commission Position: No Position; Submitted letter of information detailing current activities at hospitals aimed at behavioral health care services.

Hospitals - Establishment of Substance Use Treatment Program - Requirements

HB 515 requires all hospitals to have a substance use treatment program to identify patients that need services and to admit the patients to the appropriate level of care. It also requires the Commission to provide an update in rates to cover capital and operating costs of the program.

Status: Hearing 2/28 House Health and Government Operations

Commission Position: No Position; Submitted a letter of information cautioning against the mandated creation of substance use treatment programs in every single hospital and funding those programs through hospital rates.

Civil Actions – Noneconomic Damages (SB 682/ HB 1459)

SB 682/HB 1459 increases the cap on non-economic damages for a wrongful death action arising on or after October 1, 2017.

Status: Hearing 2/23 Senate Judicial Proceedings Committee; Hearing 3/8 House Judiciary Committee.

Commission Position: No Position; Letter of information including the cost of medical malpractice and the practice of defensive medicine and incentives in place under global budgets to reduce adverse events.

Maryland No-Fault Birth Injury Fund (SB 877/ HB 1347)

SB 877/HB 1347 establishes a fund as well as an adjudication system for birth-related neurological injuries. The Maryland birth injury fund provides an exclusive "no-fault" remedy to claimants with an injury that falls within the statutory eligibility criteria for the birth injury program. Moneys in the fund would derive from hospital assessments established by the HSCRC.

Status: Hearing 2/23 Senate Judicial Proceedings Committee; Hearing 3/6 House Health and Government Operations Committee.

Commission Position: No Position; Letter of information including the cost of medical malpractice and the practice of defensive medicine and incentives in place under global budgets to reduce adverse events.

Budget Bill (Fiscal Year 2018) (HB 150/SB 170)

Fiscal 2017 Deficiency Appropriation

The annual budget bill usually includes deficiency appropriations and adjustments for the current fiscal year (Fiscal 2017), while also proposing an operating budget for the coming fiscal year (Fiscal 2018). The Fiscal 2017 deficiency appropriation includes a $10 million transfer from the Uncompensated Care Fund to Medicaid, which we oppose.

Fiscal 2018 Operating Budget

The proposed budget for Fiscal 2018 for the Commission totals $140 million, which includes $14 million for the operation of the Commission funded through user fees, $120 million for the Uncompensated Care Fund, and $6 million for the Integrated Care Network project to target high-needs Medicare and dually eligible individuals. This proposed appropriation is slightly higher than the request submitted by the Commission in the fall due to a higher indirect cost rate

for overhead expenses provided by the Department, which increases special fund appropriation by $469,000 to be remitted to DHMH from HSCRC.

Status: Subcommittee budget decisions reported out on March 6. Full Committee report out expected on March 10.

Recommended Position: No Position/Monitor

Budget Reconciliation and Financing Act of 2017 (HB 152/SB 172)

In order to balance the Fiscal 2017 and 2018 budget, a Budget Reconciliation and Financing Act (BRFA) is proposed that alters distribution of certain revenue and makes changes to appropriations that are ordered in statute. One item affecting the hospital industry is the Medicaid Deficit Assessment, which was included in law in 2011 and amended in 2013, 2014, and 2015 and totaled $389,825,000 in fiscal year 2016. Beginning in fiscal year 2017, the deficit assessment was scheduled to be reduced by $25 million per year. While that reduction is reflected for fiscal year 2017, HB 152 amends that law to delay the annual reduction to fiscal year 2019. For fiscal year 2018, the previously scheduled $25 million reduction is not included in the budget and the deficit assessment remains at $364,825,000.

Status: Hearing in House on 2/28; hearing in Senate on 3/1

Recommended Position: No Position/Monitor

Budget Update

The Appropriations Subcommittee on Health and Human Resources made budget decisions on March 6th that included changes to both the annual budget bill and the Budget Reconciliation and Financing Act. Among those that affect the Commission include:

- Adopted recommendation to cut $10 million special fund appropriation for the Medicaid program from the Uncompensated Care Fund.
- Adopted the Administration amendment to the BRFA to allow DHMH to charge the Commission a higher indirect cost rate for fiscal 2018 only.
- Modified BRFA language that freezes the reduction to the Medicaid deficit assessment for Fiscal 2018 to reduce the deficit assessment by $5 million in Fiscal 2018. This would result in an assessment of $359,825,000 in Fiscal 2018.
- Restores funding for the Prince George's Regional Medical Center by striking the $7.5 million negative deficiency in Fiscal 2017.
- Adopted recommendation to require a report evaluating the impact of emergency department overcrowding. Report will be co-authored by Maryland Institute for Emergency Medical Services Systems and HSCRC.

New Bills for Consideration

Workgroup to Recommend Possible Reforms to Maryland's Health Care System (HB 736)

HB 736 directs the Secretary of DHMH to convene a workgroup to recommend possible reforms to the State's health care system if the federal Affordable Care Act is repealed or significantly reformed, if there is significant Medicaid reform, if there are changes to the operation of the Maryland Health Benefit Exchange, or if the All-Payer Model contract is terminated or not renewed. The workgroup would consist of members of the Maryland General Assembly, the Attorney General, Secretary of Budget and Management, Maryland Insurance Commissioner, the Executive Director of the Maryland Health Care Commission and the Health Services Cost Review Commission, and representatives from the health care industry. If convened, the workgroup shall report back to the General Assembly on the findings and recommendations.

Status: Hearing 3/10 House Health and Government Operations Committee.

Commission Position: No Position; Letter of information.

Integrated Community Oncology Reporting Program (HB 1053)

HB 1053 creates an Integrated Community Oncology Reporting Program and allows an exemption to the Maryland Patient Referral Law for a health care practitioner who has a beneficial interest in and practices medicine at an integrated community oncology center that participates in the reporting program between January 1, 2019 and May 31, 2025.

The purpose of the Integrated Community Oncology Reporting Program is to determine if integrated community oncology centers have the ability to safely and appropriately deliver radiation therapy to patients, reduce the per capita case mix-adjusted total cost of care for cancer patients, reduce the average patient cost-sharing responsibilities; and achieve the goals and milestones of Maryland's All-Payer Model contract.

The reporting program shall be administered by the Maryland Health Care Commission with the assistance of a clinical advisory workgroup to advise on the development of regulations and ongoing monitoring of the performance of the integrated community oncology centers. A total of four programs will be selected to participate in the reporting program, including two that are wholly owned by an oncology group practice and two that are jointly owned by an oncology group practice and a hospital or hospital system. Programs must serve patients in markets with limited consumer choices in radiation therapy, medically underserved areas, and areas of the state with a shortage of primary care providers.

MHCC shall consult with the Health Services Cost Review Commission, the Attorney General's Office, and DHMH to review data reported by the program to determine if an integrated community oncology center should remain in the program, need a corrective action plan, or be disqualified from the program.

Finally, the bill requires MHCC to report to the Legislature by December 1, 2024 on the performance of each integrated community oncology center and the impact the program has on Maryland's All-Payer Model (including total cost of care).

Status: Hearing 3/8 House Health and Government Operations Committee.

Commission Position: Monitor

Maryland Health Care Regulatory Reform Act of 2017 (SB 1020)

SB 1020 would reorganize the Health Services Cost Review Commission and the Maryland Health Care Commission to create a new commission that regulates health services in Maryland – the Maryland Health Care and Cost Review Commission.

The current Commissioners of the MHCC and HSCRC would be terminated on September 30, 2017 and be replaced with 5 new Commissioners with recognized knowledge and experience in the following areas: health care regulation; hospital, health care facility, or health plan administration; medical professions; business or legal professions; or consumer protection. Commissioners would be paid full-time members appointed by the Governor with approval by the Senate for 5-year terms, and would be paid at least $35,000 per year ($40,000 for the chairman). The Executive Director of the new Commission would be appointed by the Governor with the consent of the Senate to a term of only 3 years.

SB 1020 does NOT include a cap increase.

Finally, the Commission must propose to the General Assembly a streamlined certificate of need (CON) process and a list of health care facilities and services that currently require a CON but that would be suitable to remove from the CON requirement.

Status: Hearing 3/21 Senate Finance Committee

Commission Position: Monitor; Letter of concern, supported by meetings with the Sponsor and President of the Senate to explain the Commission position.

FY17: Focus on Care Coordination

CRISP will support Maryland hospitals this year, with an aim of helping them all do these four things, to collectively improve care coordination:

1. **Flag Patient Care Management Relationships:** Notify CRISP for each patient who is enrolled/dis-enrolled in a care management program, including contact information for the patient, care coordinator, and primary care provider.

2. **Share Care Planning Data**: Whenever care management information appropriate for sharing is created or updated for a participating patient, send a copy of the information to CRISP.

3. **Use In-Context Alerts:** Create an “alert mechanism” in your hospital EHR so your clinicians know when a person who is in care management has shown up, with easy access to the full data.

4. **Use CRISP Reports:** Incorporate CRISP reports and compiled data into the work of the population health team. (For patient identification and performance measurement.)

This approach should align with broader interventions and programs in place to support the high need / complex patients

Focus Aligns with State Priority on High and Rising Need Patients

Bringing high need and rising need Medicare patients into care management is key to reducing potentially avoidable utilization (PAU):

- **High Need:** patients with at least 3 inpatient visits* in past 12 months
- **Rising Need:** patients with at least 2 hospital visits in the past 12 months, where a hospital visit is defined as an inpatient OR ED visit
- Use in statewide monitoring, assessment of care coordination activities, and CRISP reports

Medicare Fee For Service	High Need	Rising Need
# of Beneficiaries	20,000	95,000
Total Hospital Charges	$1.4 billion	$2 billion
Total Potentially Avoidable Utilization	$550 million	$330 million
% PAU	40%	17%

Numbers will change with each monthly data submission and QA

* inpatient visits = inpatient discharges or observation visits > 23 hours

Positive Trends through FY17

Care Coordination Measures – High-needs Medicare FFS Beneficiaries

Measure 1: Known primary care provider or care manager

Beneficiaries	Total	w/PCP		w/CM		w/both	
3/7/2017	18,837	11,467	60.87%	2,801	14.87%	2,440	12.95%
2/10/2017	18,856	10,967	58.16%	2,594	13.76%	2,258	11.97%
1/6/2017	18,681	10,099	54.06%	1,804	9.66%	1,624	8.69%
12/13/2016	18,729	9,799	52.32%	798	4.26%	653	3.49%
12/7/2016	18,752	9,139	48.74%	463	2.47%	241	1.29%
11/29/2016	21,509	10,427	48.48%	499	2.32%	254	1.18%
11/4/2016	21,849	10,379	47.50%	468	2.14%	239	1.09%
9/27/2016	21,644	9,453	43.67%	172	0.79%		

Measure 2: Shared care alert or care plan

Beneficiaries	Total	w/CareAlert		w/CarePlan		w/either	
3/7/2017	18,837	937	4.97%	420	2.23%	1,354	7.19%
2/10/2017	18,856	652	3.46%	360	1.91%	1,011	5.36%
1/6/2017	18,681	536	2.87%	319	1.71%	854	4.57%
12/13/2016	18,729	506	2.70%	276	1.47%	781	4.17%
12/7/2016	18,752	508	2.71%	277	1.48%	784	4.18%
11/29/2016	21,509	410	1.91%	248	1.15%	658	3.06%
11/4/2016	21,849	394	1.80%	231	1.06%	625	2.86%
9/27/2016	21,644	244	1.13%	157	0.73%	401	1.85%

Data Exchange Support Program

Purpose: To support CRISP's mission, improving care coordination in Maryland communities and the region

Details:

- Federal funding (IAPD) coupled with state funding (ICN) will accelerate current health information exchange adoption and connectivity work by providing financial support directly to the practices for providing data to CRISP
- Designed to align with Care Redesign/CCIP program and Maryland Comprehensive Primary Care model
- Aligns with national Medicare priorities such as CCM and MIPS

Goal: Establish 200 ambulatory practice connections, 25 behavioral health facility connections and 65 skilled nursing facility connections in a 12 month period.

Who is eligible for the financial support?

- Medicaid Eligible Providers (EPs), OR
- Non Eligible Medicaid practices with at least one patient overlap with an EP (NEMPs), OR
- Medicare providers

Note: the practice's certified EHR must be capable of providing required data elements in order for the practice to take advantage of the full financial opportunity. This requirement aligns with MACRA.

Data Exchange Support Program Summary
Ambulatory Practice & Behavioral Health

Requirement/Opportunity	Payment Schedule
Milestone 1: Initiation * Complete CRISP Participation documentation * Sign interface agreement with EHR vendor to integrate with CRISP	$3,000
Milestone 2: Go-Live with 1 AND (2b OR 2b): A. Encounter data interface (ADT, SIU, etc.): $2,000 B. C-CDA interface that meets one of the two options below (1) Interface meets Meaningful Use Summary of Care C-CDA core elements: $5,000 (2) Interface meets at least 12 Meaningful Use clinical quality measures: $8,000	$7,000 - A & B(1) OR $10,000 - A & B(2)
Additionally, receive $500 for each provider per practice upon completion of the C-CDA interface. This will be paid out with Milestone 2. The payment will be specific to the interface setup. Therefore, if a multi-practice site sets up a single interface that includes 10 practices, a single milestone payment will be made, but the per-provider payment will still take effect. This amount will also be capped at payment for a maximum of 40 providers.	$500/Provider

Data Exchange Support Program Summary
Post Acute Care Facilities

Requirement/Opportunity	Payment Schedule
Milestone 1: Initiation * Complete CRISP Participation documentation * Sign interface agreement with EHR vendor to integrate with CRISP	$3,000
Milestone 2: Go-Live with: * Encounter data interface (ADT, SIU, etc.): $4,000 * C-CDA interface: $5,500 o Must contain: demographics, encounters, labs, allergies, medications, procedure, and diagnoses	$9,500
Total Potential Payment per Facility	$12,500