Executive Director's Report

Health Services Cost Review Commission

April 15, 2015

Staff Focus

Today, staff will present:

- The planned approach to update global budgets for rate year 2016 for estimated utilization increases related to the Medicaid expansion
- Draft recommendations for the uncompensated care update for rate year 2016
- Draft report from the care coordination workgroup (and final recommendations for BRFA funding)
- Draft Recommendation for on-going funding support in FY 2016 for CRISP HIE operations and reporting services
- Overview of balanced update calculations to date (incomplete at this time)

For April and May, staff will be focused on:

- Providing a draft recommendation for the rate year 2016 balanced update
- Continuing work on the market shift adjustment
- Draft recommendation for continued funding support of the Maryland Patient Safety Center
- Review of regional planning grant proposals together with DHMH and review team

Care Coordination

Later today, we will hear the draft report from the care coordination workgroup. We want to emphasize that the results of this process need to be discussed with hospital leadership and stakeholders around the State. HSCRC has an interest in this discussion because it affects the success of the All Payer Model, but it is an activity that needs to be led and implemented by providers and communities, together with patients.

ICD-10

ICD 10 implementation is upon us again for this fall. The HSCRC staff has requested a brief survey from hospitals on this topic. Once we receive the responses, we will focus on the need

to begin further work on this topic. We request that all hospitals complete these brief surveys and return them to us so we can continue with the process.

BRFA Regional Planning Applications

Applications are due today for regional planning grants relative to care coordination efforts. We are appreciative of the efforts of hospitals, community based providers, community organizations, and others in putting forth proposals. We are hopeful that regional planning will help Maryland accelerate effective approaches to care coordination and optimize resources, resulting in more effective patient centered approaches.

Monitoring Maryland Performance

Financial Data

Year to Date thru February 2015

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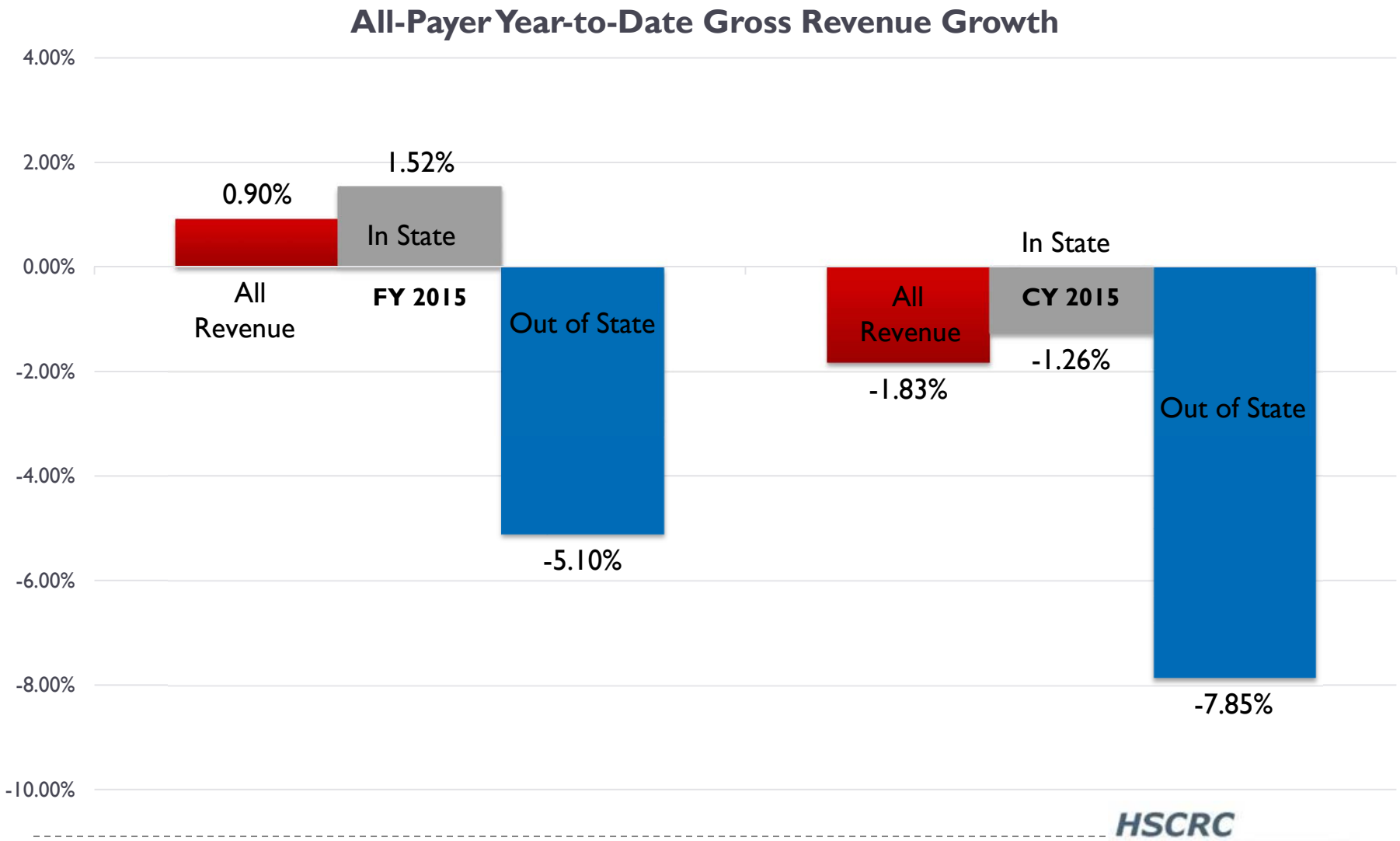
Gross All Payer Revenue Growth

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



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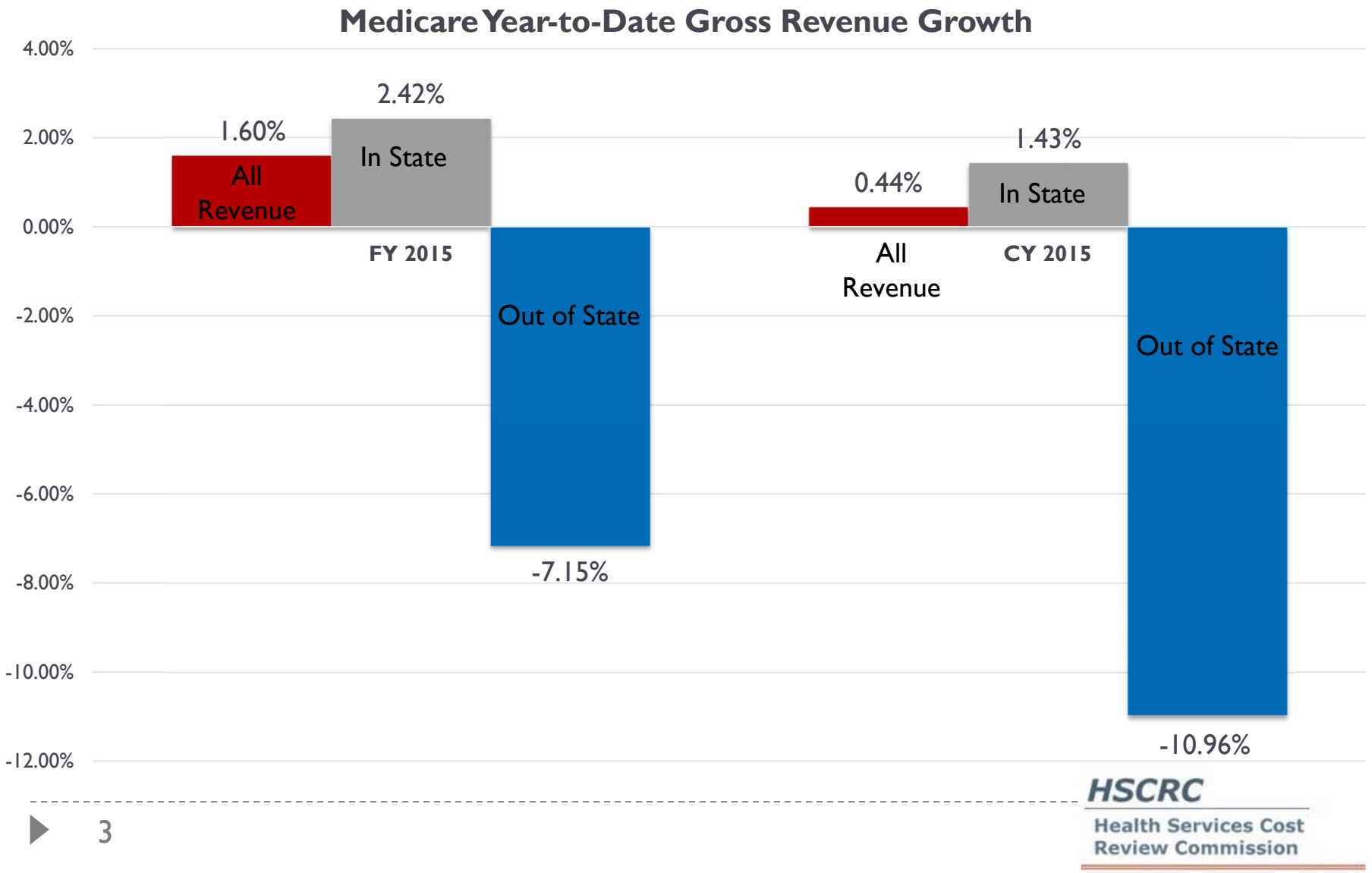
Gross Medicare Fee-for-Service Revenue Growth

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



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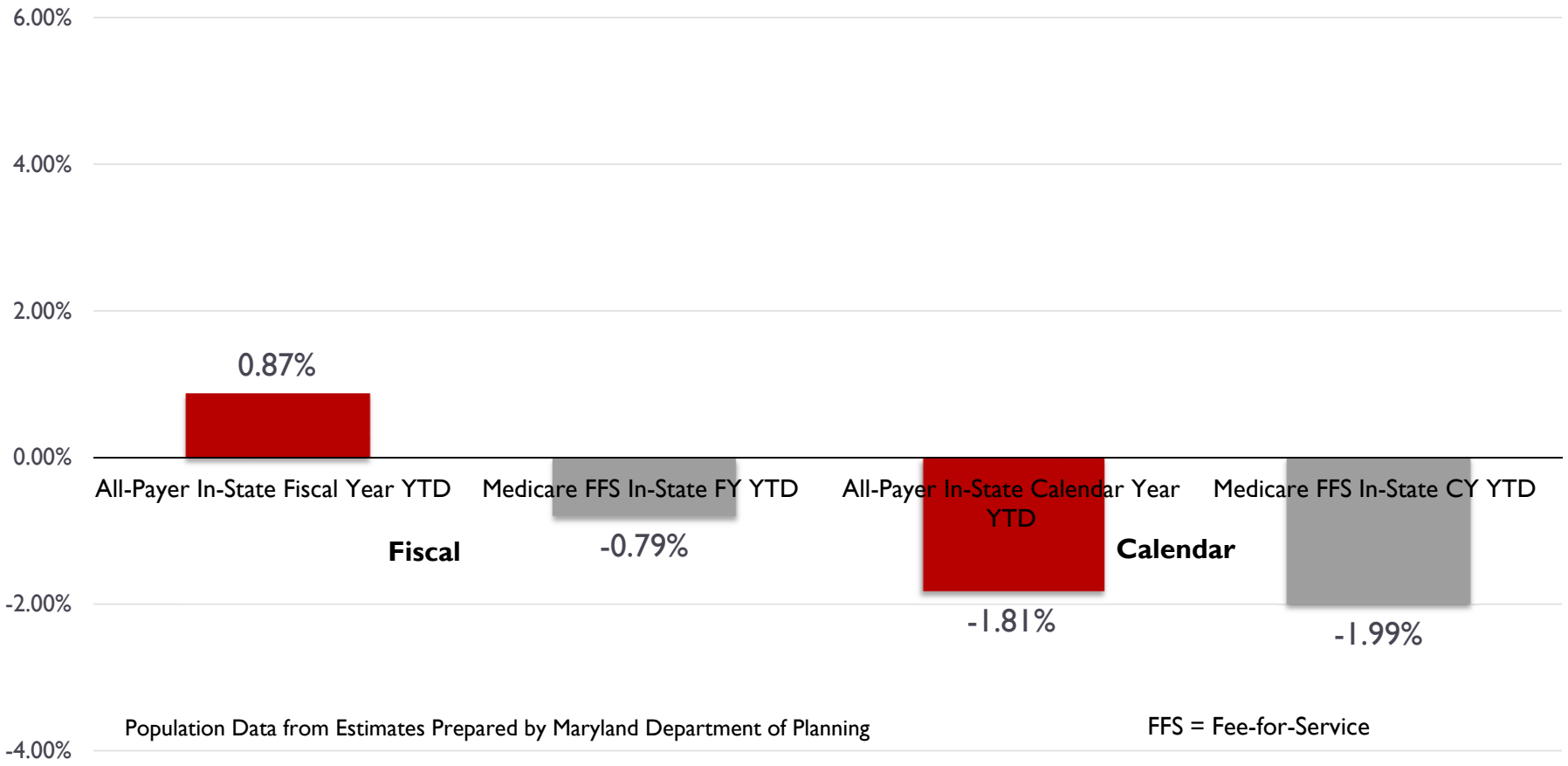
Per Capita Growth Rates
Fiscal Year 2015 and Calendar Year 2015



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

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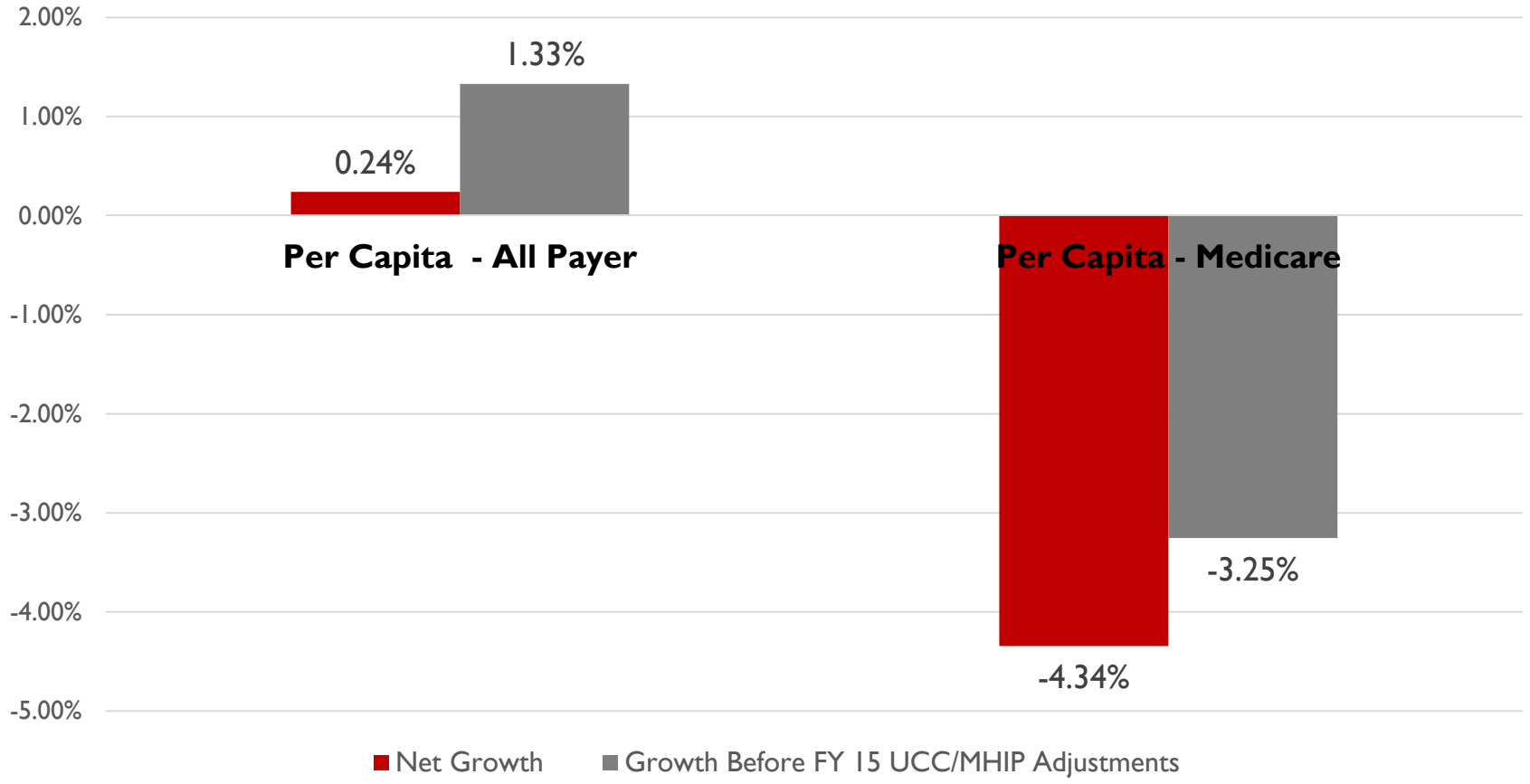
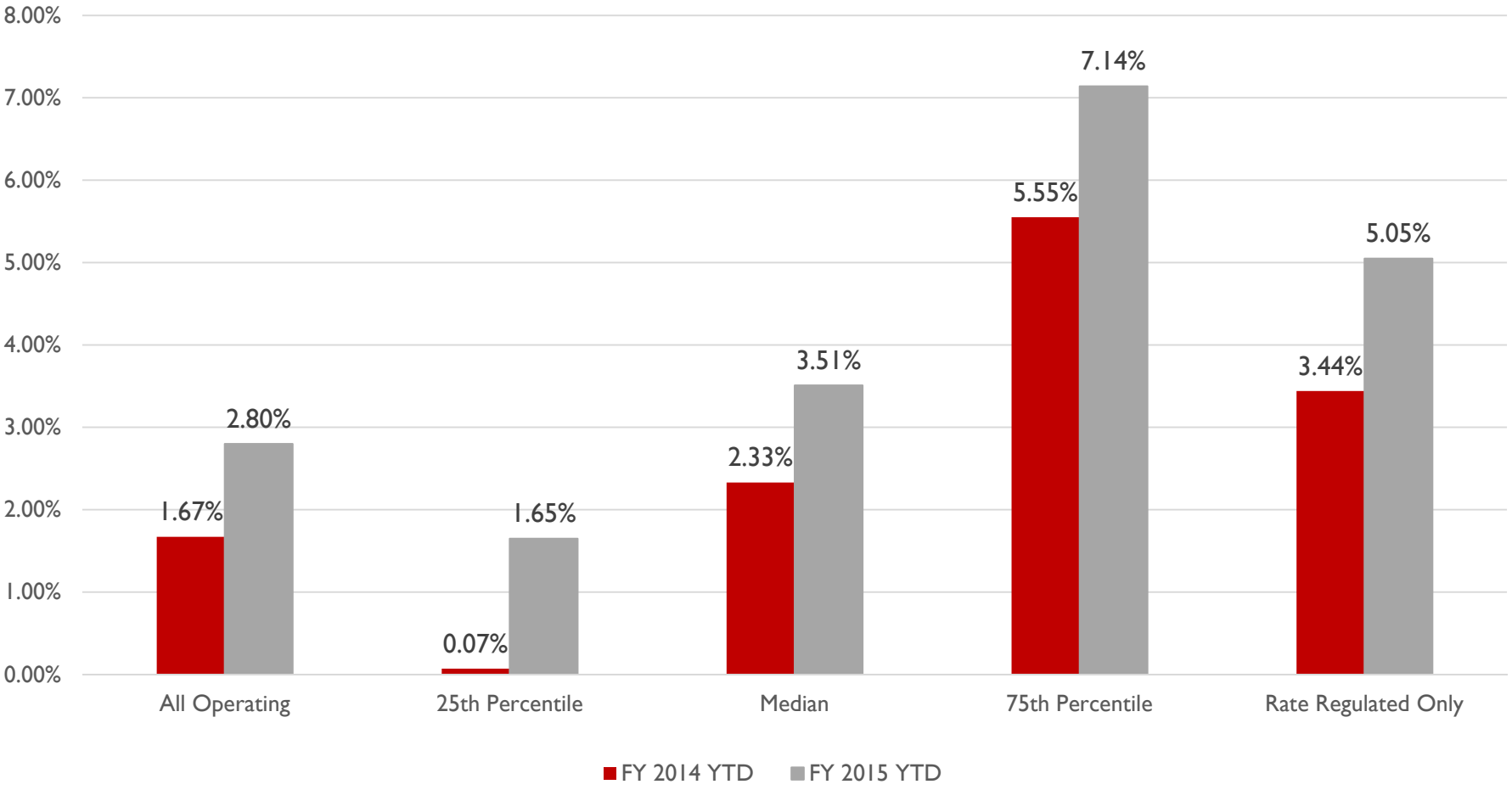
Per Capita Growth – Actual and Underlying Growth

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



- Per capita growth rates distorted by the availability of only two months of CY 2015 data.
- Underlying growth reflects adjustment for FY 15 revenue decreases that were budget neutral for hospitals. 1.09% revenue decrease offset by reduction in MHIP assessment and hospital bad debts.

Operating Profits: Fiscal 2015 Year to Date (July-Feb.) Compared to Same Period in FY 2014



- Year-to-Date FY 2015 hospital operating profits improved compared to the same period in FY 2014.

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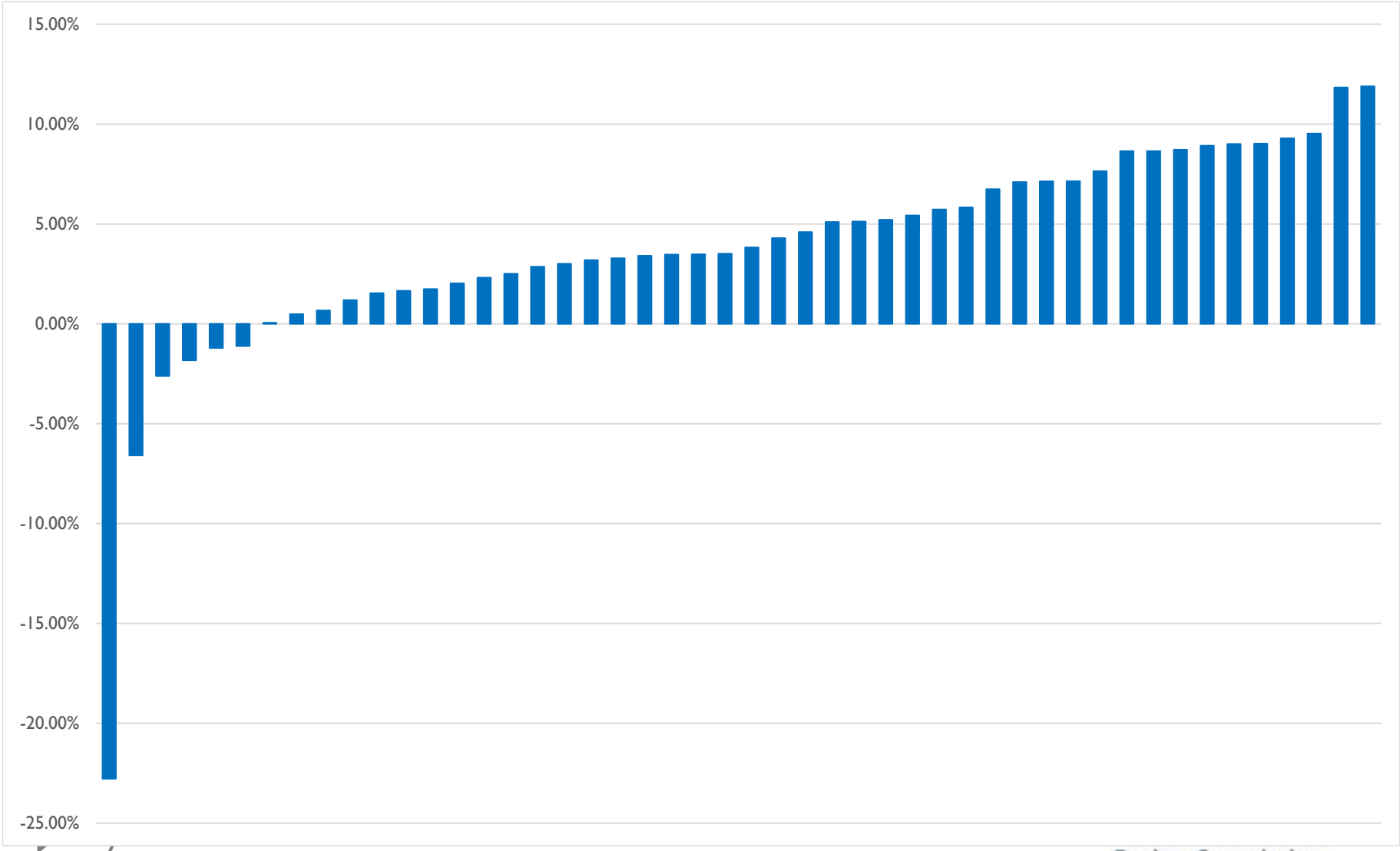
Operating Profits by Hospital

Fiscal Year to Date (July – February)



Purpose of Monitoring Maryland Performance

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

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

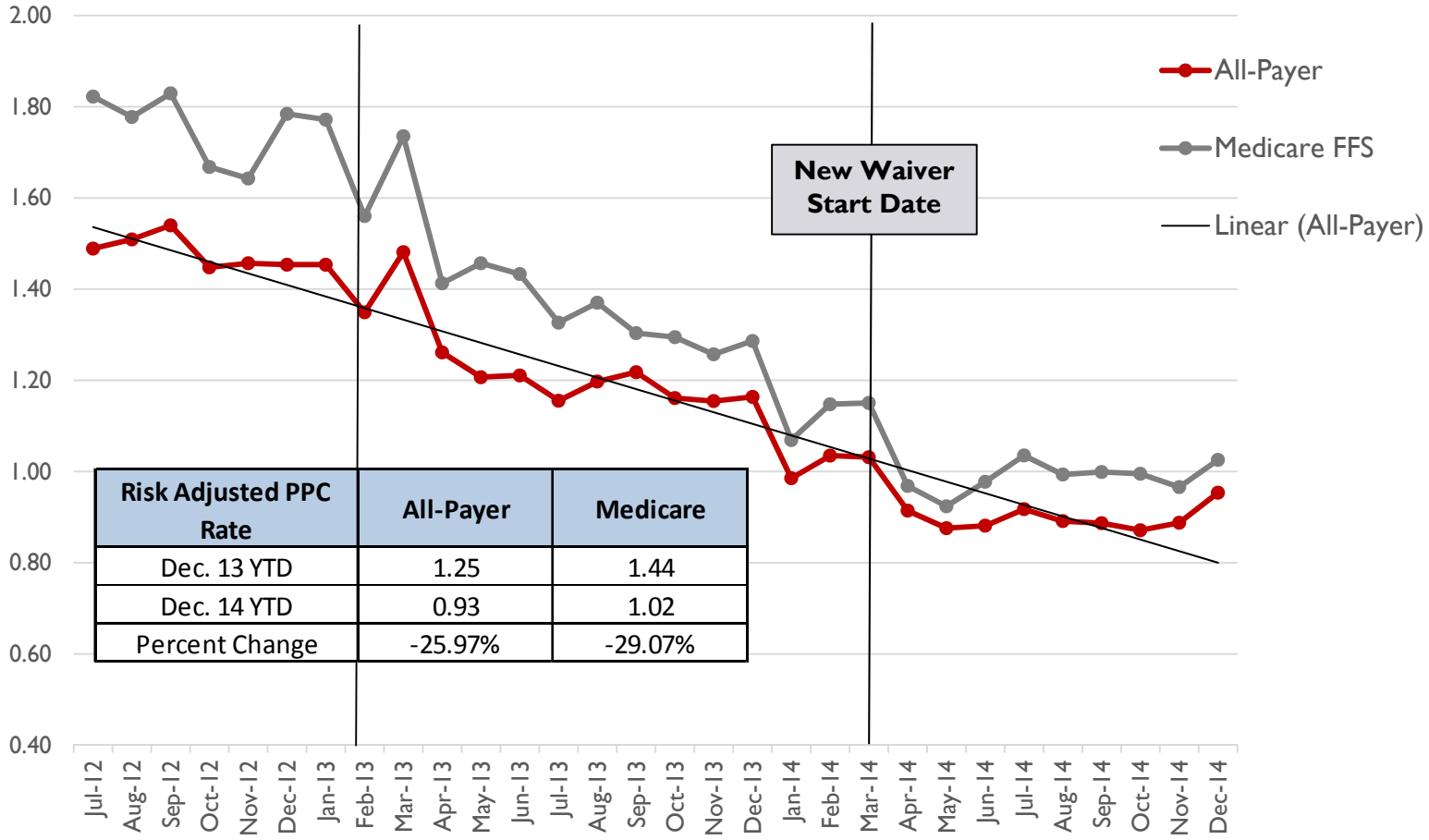
Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 and Fiscal 2015 rely on Maryland Department of Planning projections of population growth of .64% for FY 15 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

April 2015 Commission Meeting Update

Monthly Risk-Adjusted PPC Rates



Risk Adjusted PPC Rate	All-Payer	Medicare
Dec. 13 YTD	1.25	1.44
Dec. 14 YTD	0.93	1.02
Percent Change	-25.97%	-29.07%

Note: Based on final data for January 2013 - December 2014.

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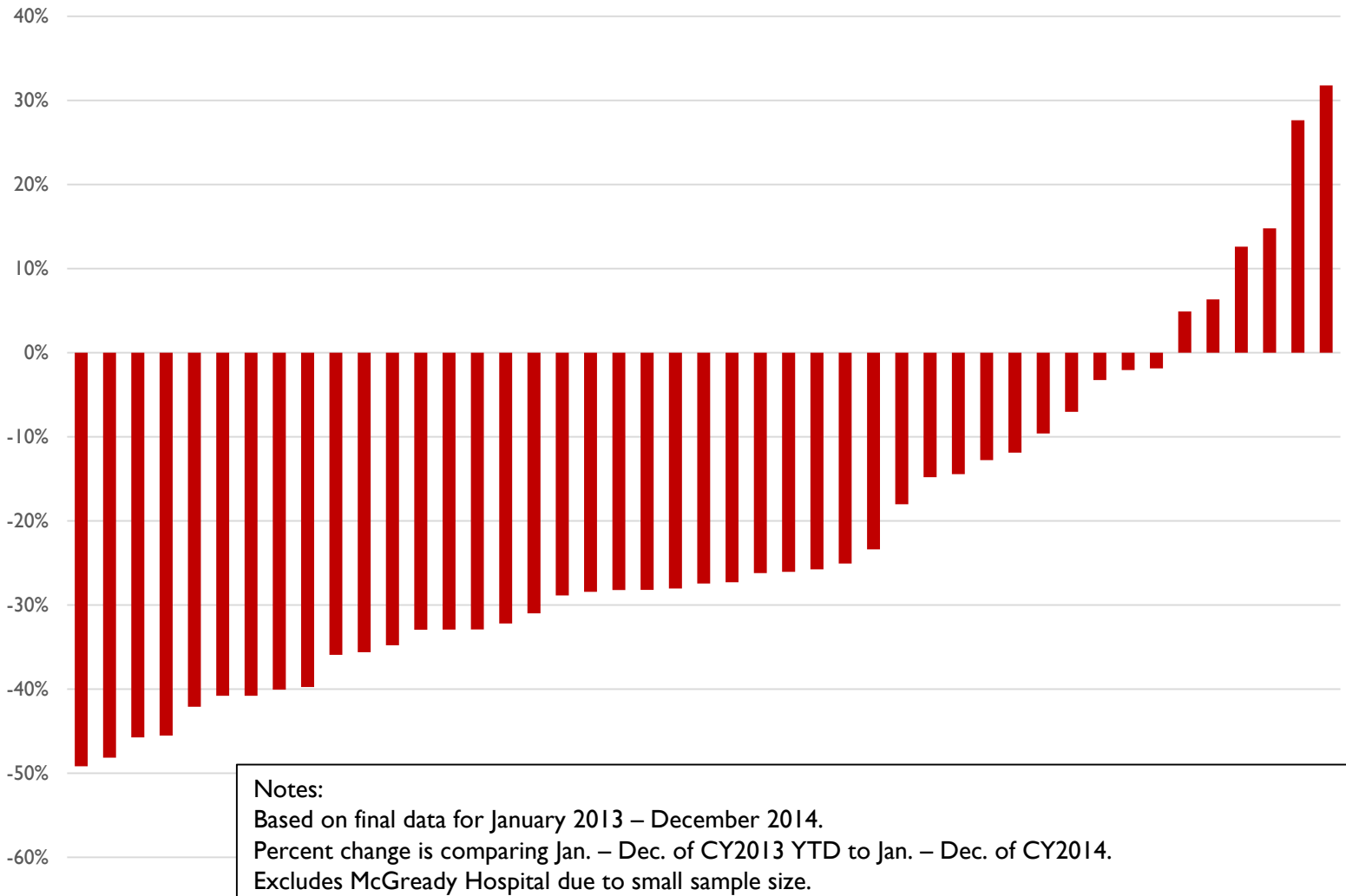
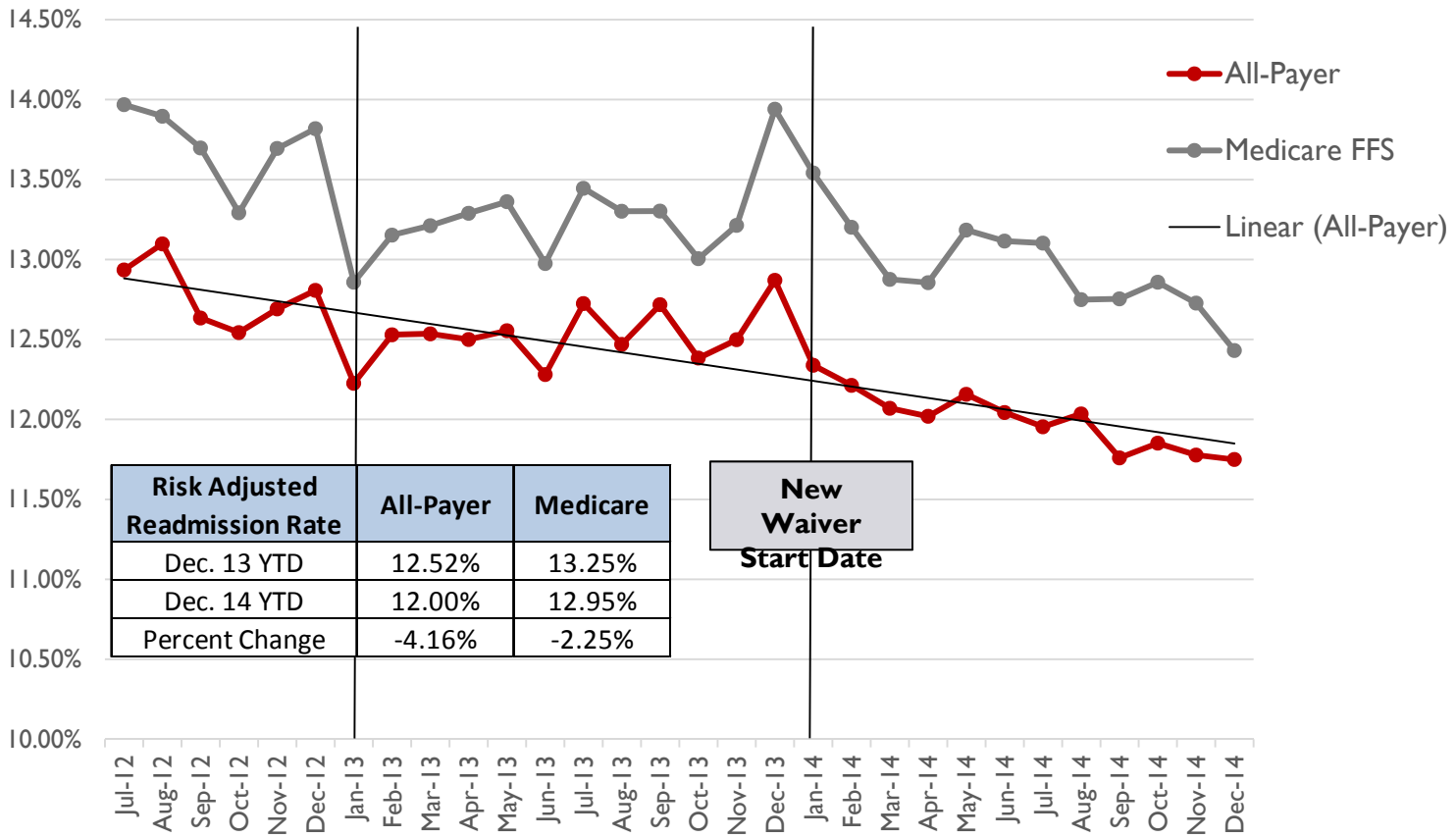
Change in All-Payer Risk-Adjusted PPC Rates YTD by Hospital



Notes:
Based on final data for January 2013 – December 2014.
Percent change is comparing Jan. – Dec. of CY2013 YTD to Jan. – Dec. of CY2014.
Excludes McGready Hospital due to small sample size.

Monthly Risk-Adjusted Readmission Rates



Risk Adjusted Readmission Rate	All-Payer	Medicare
Dec. 13 YTD	12.52%	13.25%
Dec. 14 YTD	12.00%	12.95%
Percent Change	-4.16%	-2.25%

Note: Based on final data for January 2013 - December 2014, and preliminary data through January 2015.

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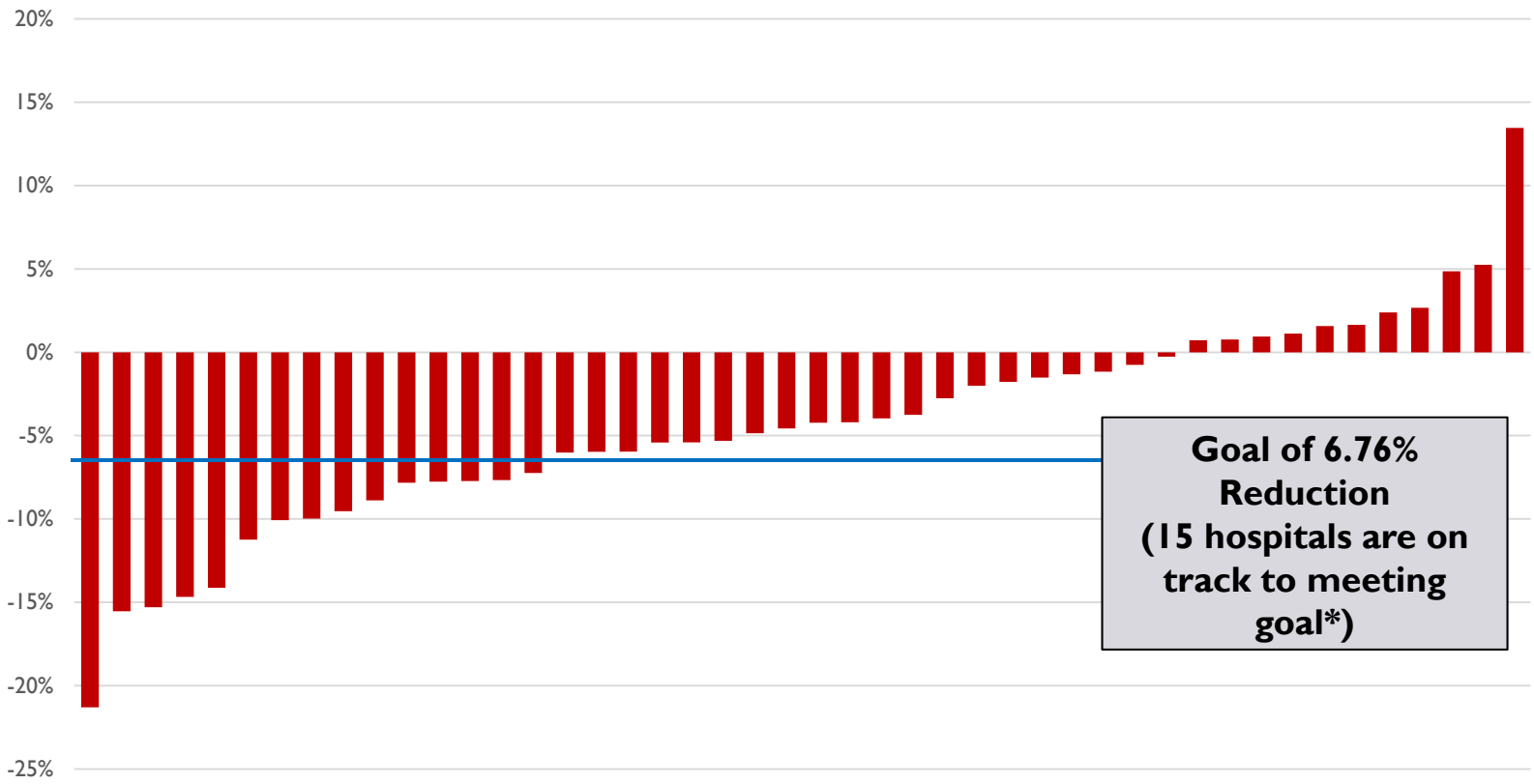
Change in All-Payer Risk-Adjusted Readmission Rates YTD by Hospital



Notes:
Based on final data for January 2013 – December 2014 and preliminary data for January 2015.
Percent change is comparing Jan. – Dec. of CY2013 YTD to Jan. – Dec. of CY2014.
*Final numbers will be re-run with more recent January 2015 data for RY2016 rewards.

Care Coordination Workgroup

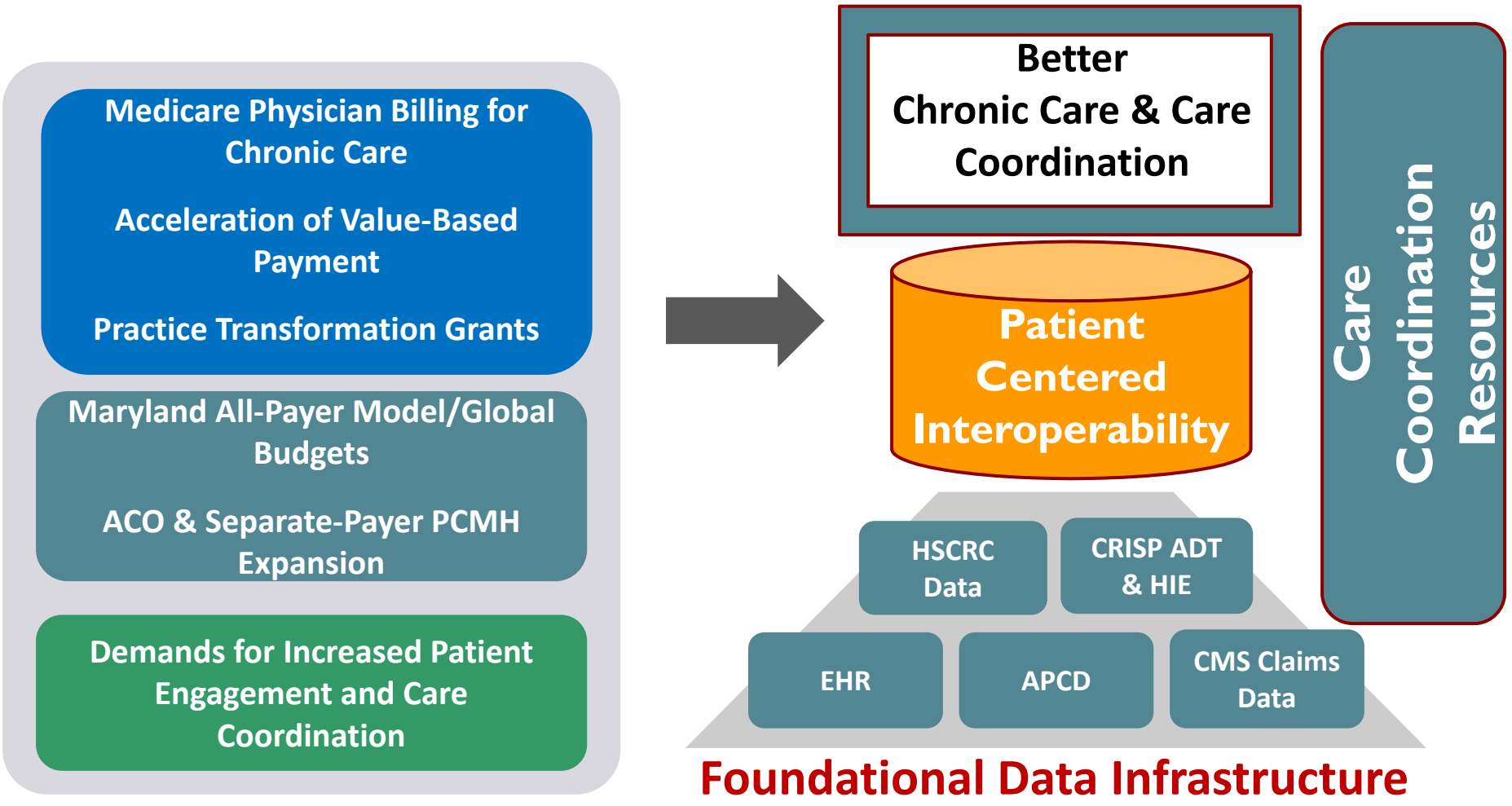
Care Coordination to Support
Integrated Value-Based Patient-Centered Care

April 2015

Care Coordination Workgroup

- Established to offer advice on how stakeholders can work together on effective care coordination to accelerate efforts underway that support the Triple Aim under the Maryland All-Payer model
- Workgroup focus:
  - Promote acceleration of care coordination models and efforts already underway, focusing on opportunities to align providers, patients, and communities
  - Recommend strategies and priorities for statewide approaches and investments, building on investments already made, to accelerate timely, scalable, effective implementation
- The Workgroup
  - met six times November 2014 - March 2015.
  - Completed assignment on the identification of key work to be done at the state-level

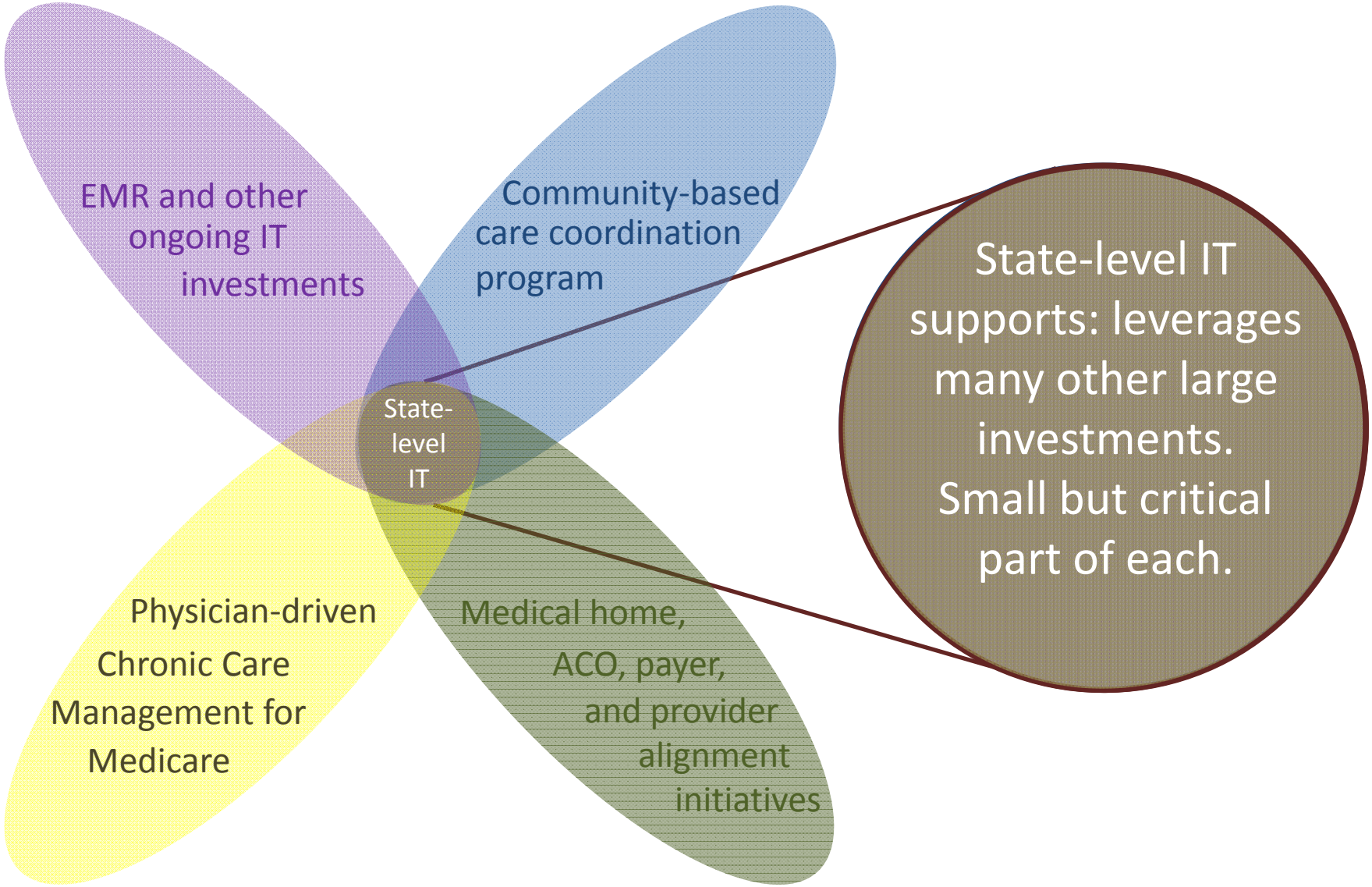
Workgroup Focus:
How to Accelerate Care Coordination



Major Findings

- Numerous care coordination initiatives underway in Maryland
- Smart public investments can support promising initiatives and bring them to scale
- Shared tools are needed to accomplish a three-step sequence to care coordination:
  - effective risk stratification to identify people with complex medical and social needs
  - health risk assessments to ascertain patients' needs
  - patient-driven care profiles and plans addressing the medical and social needs of patients
- Care coordination will focus on accelerating initiatives for high-needs patients in the Medicare fee-for-service system – the highest cost/ highest utilizers in Maryland
  - 2/3 of high utilizers and dollars are Medicare or Dual eligible
    - 40k high needs patients
    - 280k chronically ill Medicare patients with 4+ chronic conditions
- Partnerships are critical to effective care coordination. The challenge is to create opportunities to cooperate even while healthcare organizations compete in other ways
- Ultimately, goal is all-payer, all population care coordination with flexible approaches to operate within different payer and provider organizations while leveraging common IT to share structured care profiles and other information

Enhanced State-Level IT Infrastructure Supports Current Investments



Build/secure a data infrastructure to facilitate identification of individuals who would benefit from care coordination

High-level goal: To secure, organize, synthesize, and share data that will support care coordination.

- **Develop procedures and policies to secure patient consent** for the sharing of data for purposes of care coordination, building on existing resources and processes
- **Combine existing data sources** for the purpose of identifying individuals who would benefit from care coordination.
- **Secure new data sources**. Specifically, request the use of Medicare patient-level data for the purpose of identifying individuals who would benefit from care coordination and chronic care management.
- **Engage CRISP to contract with a qualified vendor(s)** to store, clean, and normalize the Medicare data and other Medicare-related data sets Maryland may be able to obtain for this purpose.
- Use data to **identify individuals who would benefit from care coordination** and chronic care management; use alert mechanisms to connect these patients to the physicians and hospitals who care for them (e.g. alerts to PCPs when their patients are in the ED or admitted to the hospital. The alerts are set in motion by enrolling providers in the CRISP ENS system)

Encourage Patient-Centered Care

High-level goal: Identify standard elements of care profiles that can be shared; propose future standards for the creation of Individualized Care Profiles.

- Provide resources to design basic patient care profiles that are standardized and interoperable; make these profiles readily viewable across the continuum of care: Restated, care profiles should be “doable and viewable” after establishment, to facilitate implementation and ongoing use.
- Standardize health risk assessment elements.
- Standardize elements in discharge summaries to aid transitions to long-term and post-acute care (LTPAC) providers as well as home-based settings.
- Develop approach to identify patients with care plans through CRISP, together with identification of care managers and providers. Set up process for learning, monitoring, and managing the system to determine the effectiveness of this effort over time, and make needed adjustments.
- Lead a state-level campaign to encourage individuals to participate in care plans.
- Educate patients about care coordination resources and opportunities.

Encourage Collaboration

High-level goal: Regional and local care coordination should be based on local needs and environment, with focus on some common requirements and best practices.

- Facilitate somatic and behavioral health integration.
- Facilitate care integration between hospitals and long-term care/ post-acute services.
- Facilitate collaborative relationships among providers, patient advocates, public health agencies, faith-based initiatives and others with a particular focus on resource planning, resource coordination, and training.
- Develop processes to avoid duplication of resources across provider (and payer) systems.
- Support practice transformation through technical assistance and dissemination of information on best practices.
- Create gain sharing and pay for performance programs.
- Encourage providers to take advantage of new Medicare Chronic Care Management payments.

Connect Providers

- Accelerate efforts to connect community-based providers to CRISP.
- Expand efforts to connect long-term and post-acute providers (LTPAC) using HIE and telehealth. Develop approaches to meet needs of LTPAC.
- Purchase/develop applications to facilitate interoperability among providers' EMRs to make clinically relevant information available to providers.
- Coordinate the effort to use Medicare data with initiatives to use EMR data, information on high-needs patients in Medicaid and private plans for population health and outcomes measurement.

Care Coordination Cost Summary:

Common State Level Support + Regional Planning

Start-up Cost: $51m ($41m is IT/data)	Annual Operating Cost: $8m (low) to $28m
• $8.5m Build/secure data infrastructure (includes analytics) • $4.2m Data sharing (patient-centered care/engagement) • $7m, Collaboration (training, support, TA) ($4m regional planning & support) • $31m Provider Connectivity (ambulatory and LTCF EMR interfaces)	• $3.7m Data analytics/infrastructure • $0.6m Data Sharing • $1m QA/QI staff (including training/support/TA) • $1.5m Provider Connectivity • $1m Profile of common care plan elements

A sophisticated method is needed to assess, scope and decide on the best approach to IT, analytics and connectivity. An expert committee of CRISP should work expeditiously to address these technical implications and select vendors.

Immediate Next Steps

1. **Engage Maryland Healthcare Leadership**
2. **Develop Specific Budget Estimates and Implementation Plans**
3. **Initiate data process**
4. **Tap CRISP to organize data**
5. **Build data infrastructure and identify target populations**
6. **Designate CRISP to identify consistent information that can be shared among provider and support different care management platforms**
7. **Design standardized care profiles**
8. **Establish consumer outreach strategy**
9. **Develop Care coordination programmatic efforts**
10. **Develop plan for sustainability of care coordination infrastructure**

Uncompensated Care

Analytical Approach for FY 2016

- Traditionally staff prospectively calculates the rate of uncompensated care at each regulated hospital by combining historical uncompensated care rates with predictions from a regression model.

- For fiscal 2015, the Commission adjusted this methodology to incorporate a prospective yet conservative adjustment for the expected impact of the ACA's Medicaid expansion on uncompensated care.
  - Results of the historic trend and regression model were adjusted down from 7.23% to 6.14% to capture the expected impact of the State extending full Medicaid benefits to people previously enrolled in the PAC program.

- Inadequate post-Medicaid expansion data is available to update the regression analysis to appropriately capture the impact of the expansion on uncompensated care.

- Rather than changing the regression variables and updating the UCC calculation to include actual FY 2014 data, staff recommends:
  - Carrying forward the variables and results (7.23% before Medicaid expansion adjustment) from the FY 2015 analysis.
  - Updating the Medicaid expansion adjustment to capture the impact of the entire expansion population.

Analysis of Impact of Medicaid Expansion on Uncompensated Care

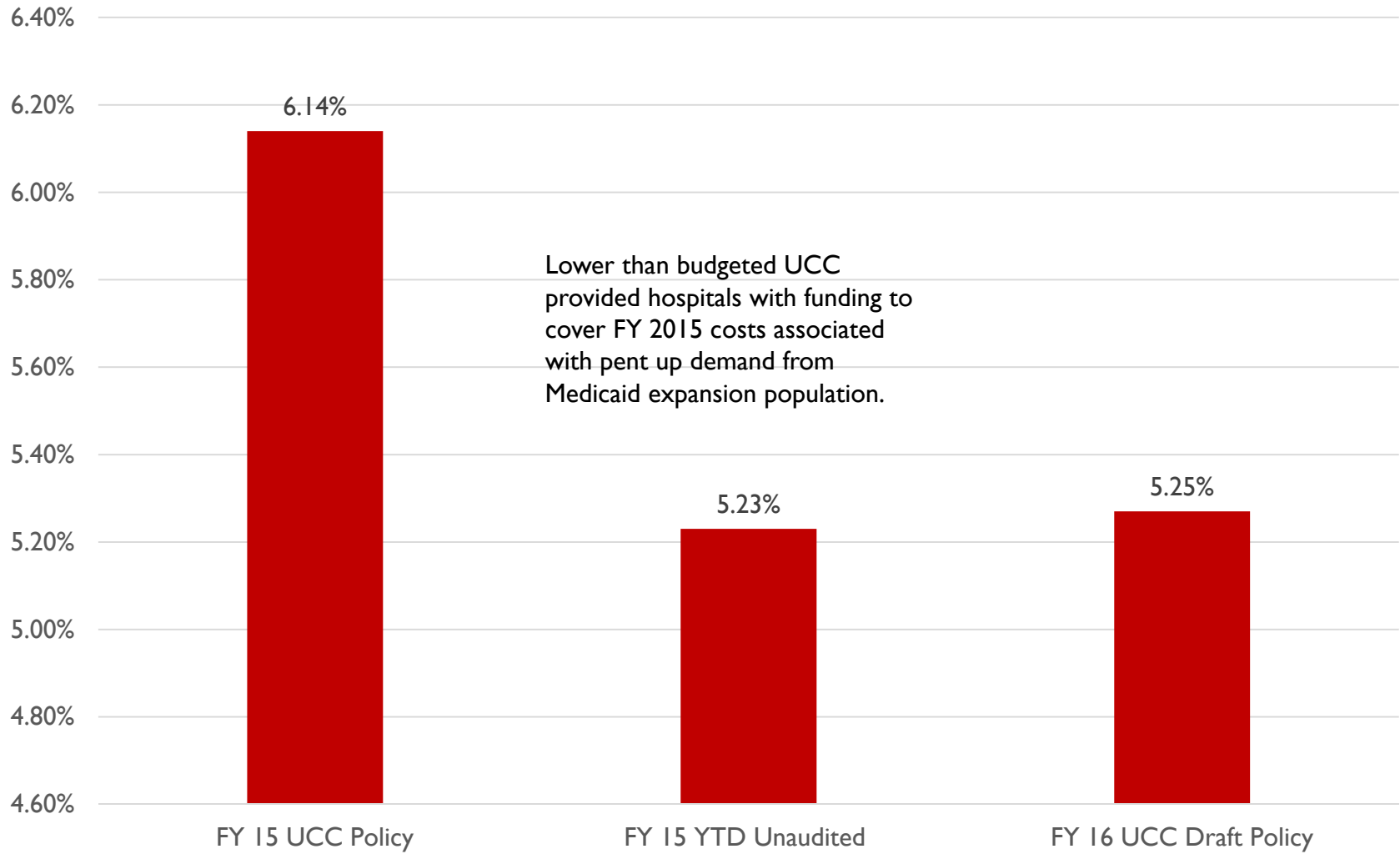
- Compare CY 2013 (pre-expansion) to CY 2014 (post-expansion) data
  - Use decline in self-pay/charity charges as proxy for ACA impact on uncompensated care.
  - Analysis covered January to June of 2013 and January to June 2014.
  - Data scrubbing was required to adjust for consistency in classification of Medicaid and self pay

Data Supports Removing $140 M+ from FY 2016 Rates

Six Month Self-Pay Charity Decline	$150 M
Adjust figure for price leveling/out-of-state Medicaid	$ 5 M
Revised Six Month Decline	$155 M
Annualized Self-Pay/Charity Decline ($155 M x 2)	$310 M
UCC Policy Adjustment for PAC In FY 2015 Rates	-$166 M
UCC/Charity Decline Exceeds PAC Adjustment	$143 M

- Staff recommends updating the ACA expansion adjustment to remove $310 M in FY 2016 (replacing the $166 M FY 2015 adjustment)
- Recommendation results in a statewide UCC rate of 5.25%

FY 2015 UCC Policy Compared to Year to Date Experience (Unaudited Data from Financials thru February)



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Summary of Recommendations

- Reduce uncompensated care provision in rates from 6.14% to 5.25% effective July 1, 2015.
- Re-use combined results of regression model and two years of historical data underpinning the FY 2015 UCC policy.
- Continue to collect data on write-offs and recoveries to better understand factors impacting UCC.
- Continue to collect data on outpatient denials to facilitate understanding of trends.
- Continue suspension of charity care adjustment indefinitely.
- Develop new UCC policy for FY 2017 that reflects patterns of uncompensated care observed in FY 2015 and projected for FY 2016.

Impact of ACA's Medicaid Expansion on Hospital Utilization

Purpose of Analysis

- Determine impact of Affordable Care Act's Medicaid expansion on hospital utilization.

- Identify ongoing impact of utilization growth and adjust Global Contracts for FY 2016 to reflect

Methodology

- Identify people who enrolled in a Medicaid expansion category at any point in the first quarter of 2014.
  - Included both 98,000 people who transferred from PAC on January 1, 2014; and
  - 114,000 new enrollees who qualified due to the expansion.

- Use CRISP's Master Patient Index to identify all hospital admissions/visits by expansion cohort in calendar 2013 and calendar 2014.

- All hospital utilization by the cohort is captured – no matter who the expected payer was.

Utilization by Expansion Population

- $542 Million of charges in CY 2013 for people enrolled in ACA Expansion in 1st Quarter of CY 2014.
- $762 Million of charges in CY 2014 for people enrolled in ACA Expansion in 1st Quarter of CY 2014.
- Enrollees in first quarter explain almost all of the net charge growth for patients with an expected payer of Medicaid/Self-Pay/Charity
  - $220 M increase in CY 2014 charges associated with people enrolling in expansion in Quarter 1
  - $244 M increase in net charge growth for all CY 2014 patients with expected payer of Medicaid/self-pay/charity
  - $267 M increase in all hospital charges from CY 2013 to CY 2014

Hospital Charges for Medicaid Expansion Population

People who Enrolled During First Quarter of 2014

($ Millions)

	Q1	Q2	Q3	Q4	Total
CY 2013	$121	$129	$143	$150	$542
CY 2014	198	194	193	177	762
Change	77	65	50	27	220
% Change	64%	51%	35%	18%	40%
All Payer Charge Growth	2%	1%	4%	0%	2%

Approach: Include Funds in 2016 Rates to Cover Ongoing Impact of Uptick in Utilization by Expansion Population

- Approach
  - Calculate ongoing growth by applying growth rate for Quarter 4 of 2014 of 21% to CY 2013 base
    - Actual Growth was 18% but overall charges did not increase statewide for Quarter 4
    - Actual adjusted upward for statewide charge growth during CY 2014 of 2% and price leveling at facilities with temporary rate reductions.
  - Apply 50% Variable Cost Factor
  - $57 M Rate Adjustment
    - $542 M (CY 2013 base) x .21 x .50 = $57 M
  - Allocate increased funding across hospitals based on hospital growth from 2013 to 2014
    - Each hospital receives 26% of its growth ($57 M/statewide growth in expansion charges)
    - Price leveling applied for hospitals with significant rate adjustments in 2014

Out-of-State Medicaid Utilization Growth

- Growth in Out-of-State Medicaid utilization observed at some border hospitals
- Staff proposes funding 26% growth in FY 2016 (same share of in-State Medicaid growth funded).
- $2.7 Million added to hospital rates in FY 2016.

Update on Work Groups

Payment Models

Performance Measurement

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Balanced Update Model

Components of Revenue Change Linked to Hospital Cost Drivers/Performance

		Weighted Allowance
Adjustment for inflation/policy adjustments		2.40%
Adjustment for volume (population net of PAU)		
-Global budget revenues		
-Transfers ($1 M -$5 M impact)	0.1%	
-Categoricals		
-Market share adjustments ($4 M est. impact)		
		0.57%
Utilization Impact of Medicaid Expansion ($60 M)		0.38%
Infrastructure allowance provided		TBD
CON adjustments-		
-Opening of Holy Cross Germantown Hospital		0.21%
Net increase before adjustments		3.56%
Other adjustments (positive and negative)		
-Set aside for unknown adjustments		0.50%
-Reverse prior year's shared savings reduction		0.40%
-Positive incentives (Readmissions and Other Quality)		0.15%
-Shared savings/negative scaling adjustments		-0.60%
Net increase attributable to hospitals		4.01%
Per Capita excluding Medicaid Adjustment		3.04%
Per Capita including Medicaid Adjustment		3.42%

Components of Revenue Change - Not Hospital Generated

-Uncompensated care reduction, net of differential	-0.84%
-MHIP (Assumes $0 MHIP in 2016)/2015 BRFA adjustment	-0.57%
Net decreases	-1.41%
Net revenue growth	2.60%
Per capita revenue growth	2.02%

Market Shift Adjustments (MSAs): Draft Principles--Application

- Applied as part of global budget mechanism.
- Only one of many mechanisms.
- Examples of other situations where global budgets might be adjusted for changes in volumes include;
  - Opening of a new hospital,
  - Increases in transfers of patients,
  - Discontinuation of services, changes in levels of services,
  - Shifts to unregulated settings,
  - Shifts from/to out of state hospitals or
  - Actions that undermine the Triple Aim.

Market Shift: Work in Progress

- A work in progress
  FY2015 Q1 and preliminary Q2 data released on Feb 27th
  - Data cleanup (resubmissions)
  - Understanding the service line trends
- Aggregating zip codes in low population density, high market concentration areas (rural counties).
- Outpatient weights
  - Weight and service line methodology
  - Oncology, drugs and radiation therapy methodology
- Turning to define the calculation of the revenue transfer
  - Intend to utilize 50% variable cost in routine calculations
- Approach to payer/MSO driven market shifts

Market Shift: Measurement Periods

- Measurement Period for FY2016 GBRs (July 2015)
  - July-Dec 2014 Discharges -
  - July-Dec 2013 Discharges
- Measurement Period for FY2017 GBRs (July 2016)
  - Jan-Dec 2015 Discharges -
  - Jan-Dec 2014 Discharges

Market Shift:
Work Group and Commission Meeting Timelines

- April
  - 6th – Payment Models Workgroup Update
  - 15th – Commissioner Update
  - 22nd – Market Share Subgroup
- May
  - 4th – Payment Models Workgroup Update
  - 13th – Commission Update
  - TBD – Market Share Subgroup
- June
  - 1th – Payment Models Workgroup Draft Final Report
  - 10th - Present Final Staff Report to the Commission
  - Finalize calculations

Performance Work Group

- Staff is working on work plan to receive strategic high level input from stakeholders on the value-based purchasing in Maryland.
- Preparing the work plans and reviewing the roster for summer/fall
- Readmission socio-economic adjustment subgroup is scheduled to meet in May.