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Department of Health and Mental Hygiene

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518th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
April 15, 2015

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

1. **Status of Medicare Data Submission and Reconciliation – Authority General Provisions Article, § 3-104**
2. **Contract and Modeling of the All-payer Model and Legal Consultation on Potential Alternate Medicare Payment for Hospital Services vis-a-vis the All-Payer Model Contract – Authority General Provisions Article, § 3-104, and 3-305(b)(7)**
3. **Personnel Resource Matters – Authority General Provisions Article, § 3-305(b)(1)**

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

1. **Review of the Minutes from the Executive Session and Public Meeting on March 11, 2015**

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**
   2288R - MedStar Southern Maryland Hospital Center
   2289R – MedStar Franklin Square Hospital Center
   2290A - University of Maryland Medical Center
   2291A – Johns Hopkins Health System
   2292A – Johns Hopkins Health System
   2293A – Johns Hopkins Health System

5. **Docket Status – Cases Open**
   2294A - Johns Hopkins Health System
   2295A – Johns Hopkins Health System

6. **Draft Recommendation for Ongoing Funding Support of CRISP in FY 2016 for HIE Operations and Reporting Service Activities**

7. **Report of the Care Coordination Work Group**

8. **Final Recommendation on Increasing Rates in FY 2015 to Implement 2014 Budget Reconciliation and Financing Act (BRFA) Provisions**

9. **Draft Recommendation on Uncompensated Care Policy for FY 2016**

10. **Global Budget Update: Medicaid Utilization Adjustment**

11. **Work Group Updates**

12. **Legislative Report**

13. **Hearing and Meeting Schedule**

Minutes to be included after Commissioners' Approval

Executive Director's Report

The Executive Director's Report will be distributed during the Commission Meeting

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Cases Closed

The closed cases from last month are listed in the agenda

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF APRIL 3, 2015

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2294A	Johns Hopkins Health System	3/31/2015	N/A	N/A	N/A	DNP	OPEN
2295A	Johns Hopkins Health System	3/31/2015	N/A	N/A	N/A	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2015**
SYSTEM	*	**FOLIO:**	**2104**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2294A**

Staff Recommendation

April 15, 2015

I. INTRODUCTION

Johns Hopkins Health System (“System’) filed an application with the HSCRC on March 31, 2015 on behalf of its member hospitals (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global arrangement to provide solid organ and bone marrow transplants services with Cigna Health Corporation. The System requests approval of the arrangement for a period of one year beginning May 1, 2015.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for bone marrow and solid organ transplant services, for a one year period commencing May 1, 2015, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2015**
SYSTEM	*****	**FOLIO:**	**2105**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2295A**

Staff Recommendation

April 15, 2015

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on March 31, 2015 on behalf of its member hospitals (the Hospitals), requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. The Hospitals request that the Commission approve the arrangement for one year beginning May 1, 2015.

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II. OVERVIEW OF APPLICATION

The contract will be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

The staff found that the actual experience under this arrangement for the last year has

been favorable.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period beginning May 1, 2015. The Hospitals must file a renewal application annually for continued participation.

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

Draft Recommendation:

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 16 Funding to Support HIE Operations and CRISP Reporting Services

April 8, 2015

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

This is a draft recommendation to be presented at the April 15, 2015 HSCRC public meeting. Any comments may be sent to Steve Ports at Steve.Ports@Maryland.gov on or before May 1, 2015.

CRISP: FY 2016 HIE Operations and CRS Support

Overview

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the All-payer Model and the public interest (Health-General Article, Section 19-219(c)), this recommendation is to provide continued funding support in FY 2016 in the amount of $3.19 million to the Chesapeake Regional Information System for our Patients (CRISP), for the following purposes:

- Health Information Exchange (HIE) Operations; and
- Continuing CRISP reporting services to hospitals in the State.

Background

HIE Operations

Over the past 6 years, the Commission has approved funding to support the general operations of the CRISP HIE through hospital rates as shown in Table 1:

Table 1. CRISP HIE Project HSCRC Funding 2010-2015

CRISP Budget: HSCRC Funds Received	
FY 2010	$4,650,000
FY 2011	No funds received
FY 2012	$2,869,967
FY 2013	$1,313,755
FY 2014	$1,166,278
FY 2015	$1,650,000

In December 2013, the Commission approved continued funding support for CRISP during FYs 2015 through FY 2019 not to exceed $2.5 million in any year. At the May 2014 Commission public meeting, staff reported that $1.65 million in funding support had been granted to CRISP for core operations in FY 2014.

CRISP Reporting Services

In June of 2014, the Commission approved additional funding of $850,000 for specific CRISP functions related to the HSCRC's inter-hospital reporting capabilities. At that point, the Commission had approved a total of $2.5 million for HIE operations and CRISP Reporting Services.

Enhanced Reporting Services and Planning and Evaluation

In September of 2014, the Commission approved an additional $2 million (for a total of $4.5 million in FY 2015) to support expansion of its current monitoring capacity and engagement of resources to assist in further evaluation and planning of possible statewide infrastructure and approaches for care coordination and provider alignment, in conjunction with stakeholders.

FY 2016 Funding Request

For FY 2016, the staff is separating the funding request for HIE operations and standard CRISP reporting services from those relating to HIE connectivity expansion and ambulatory integration, statewide infrastructure needs, and related expanded reporting services while further information can be gathered on potential needs and costs. The FY 2016 request for HIE operations and standard CRISP report services is $3.19 million, which exceeds the $2.5 previously established maximum.

Health Information Exchange Operations Funding

The value of a health information exchange rests in the premise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The General Assembly, in Health-General Article §19-143, charged the MHCC and the HSCRC with the designation of a statewide HIE. In the summer of 2009, MHCC awarded State-Designation to the Chesapeake Regional Information System for our Patients (CRISP), and the HSCRC approved up to $10 million in startup funding over a four-year period through Maryland's unique all-payer hospital rate setting system. HSCRC-funding by year is illustrated in Table 1 above.

The use of HIEs is a key component of health care reform, enabling clinical data sharing among appropriately authorized and authenticated users. The ability to exchange health information electronically in a standardized format is critical to improving health care quality and safety.

Many states along with federal policy makers look to Maryland as a leader in HIE implementation. Further investment in building CRISP's infrastructure is necessary to support existing and future use cases and to assist the HSCRC as it moves to more per-capita and population-based payment structures. A healthy return on the investment will occur from having implemented a robust technical platform that can support innovative use cases to improve care delivery, increase efficiencies in health care, and reduce health care costs. The HSCRC derives significant benefit from the enterprise

master patient index (EMPI) developed by CRISP. This index uses highly sophisticated tools from secure electronic submission to CRISP of registration data from hospitals. The EMPI allows for accumulation of use across hospitals, which HSCRC, in turn, uses to track readmissions across hospitals.

In addition to its role in health information exchange among providers, CRISP is involved in health care reform activities related to the HSCRC, MHCC, DHMH, and other state agencies. In its collaboration with the Medicaid program, uniform and broad-based funding through hospital rates can also be used to leverage federal fiscal participation (90/10 match requirement and 50/50 match requirement) under the Health Information Technology for Economic and Clinical Health (HITECH) Act known as Implementation Advanced Planning Document (IAPD) funding. HITECH enables states to be approved for funding by CMS under the Medicaid EHR Incentive Program and receive a 90 and/or 50 percent federal financial participation match for expanding HIE through 2021. This request will enable CRISP (working with DHMH) to obtain federal funding for both the 90 percent and 50 percent programs. Federal matching for IAPD is expected to draw down approximately $3.4 million in FY16.

For FY 2016, staff is requesting funding of $1.65 million for HIE Operations – the same amount that was requested in FY 2015.

CRISP Reporting Services

CRISP collects admission (or encounter), discharge and transfer information from hospitals in a nearly real time basis. In the fall of 2013, HSCRC expanded the required collection of data by CRISP to include all hospital outpatient encounters. CRISP creates a master patient index using this and other data. The master patient index (a unique identifier number assigned to each person in the data base) can be attached to HSCRC abstract data, enabling the HSCRC to track readmissions across hospitals, transfers among hospitals, movement of patients across local, regional and statewide areas, and to focus on the care and health improvement needs of the population, including the nature and extent of use by high needs patients. This is a complex task that requires constant reconciliation between individual hospital transactional data and the HSCRC abstract data, which are now submitted on a monthly basis. The linking of information using the master patient index enhances the security and confidentiality of patient information, such as name and address, because HSCRC does not collect this information in any data it receives. Through this process, the HSCRC is able to obtain the information it needs in order to broaden its regulatory approaches for focusing on population based measures while eliminating the need for HSCRC to collect or store highly identifiable data such as name and address.

CRISP: FY 2016 HIE Operations and CRS Support

In FY 2015, the Commission approved a total amount of funding for CRISP reporting services of $1.85 million ($850,000 for core reporting and $1 million for enhanced reporting). HSCRC and MHCC staff are requesting the authority to increase hospital rates to continue support of CRISP reporting in services in FY 2016 in the amount of $1.54 million.

The $1.54 million request may be disaggregated into two categories: core reporting services and expanded reporting services, as they were in FY 2015. Last year, CRISP requested $850,000 to provide core reporting services to hospitals and the HSCRC. The work requires technology hardware and software licensing along with a small team to create and process the reports. CRISP is beginning to transition the core reporting services from the consultants who originally installed the infrastructure and created the reports, to permanent staff who can operate the service more efficiently. CRISP's request this year is $539,000 for the following work:

Unique ID Creation and Assignment

- CRISP links the unique master patient index ID to the HSCRC abstract data on a monthly basis and provides the unique ID linkage to HSCRC staff for inter-hospital and other analysis. HSCRC staff uses the unique ID to track inter-hospital readmissions for the new All-Payer waiver, to track transfers among hospitals on a monthly basis, and to support the analysis of use of hospital services aggregated around populations, episodes, and patients.

Basic Cross-Entity Report Production for HSCRC

- CRISP obtains HSCRC abstract data in order to generate reports requested by HSCRC, such as inter-hospital readmission rates.

Standard Report Creation for Hospitals

- CRISP provides hospitals with a core set of standard reports that require use of the unique patient identifier index on a monthly basis, such as inter-hospital readmissions, potentially avoidable utilization, and high needs patients.

Beginning in October 2014, CRISP began working with HSCRC and with hospitals to expand the reporting services available. Changes to the All-Payer model, which are generating an increased focus on population health, are also creating a need for additional information and new reports. CRISP is requesting $1 million to pursue this work, which will be prioritized by the HSCRC and by the CRISP Reporting & Analytics Committee that is comprised of experts from hospitals and other provider organizations who use the information, in collaboration with MHCC.

One way CRISP has been supporting ad hoc analysis for HSCRC staff is by linking the abstract data to other sources of information, such as Medicaid enrollment files and the MHCC's APCD. CRISP is able to support such analysis by linking through its master patient index.

The expanded services include:

- Ad hoc analyses of cost and utilization, such as: measuring Medicaid savings under State statute; uncompensated care analytics related to the ACA expansion, other Medicaid enrollment expansions, and other analyses as needed;
- Reporting on Potential Avoidable Utilization (PAU) at the case level including regular detail and summary reports;
- Other population based reports;
- Tableau programming to support real-time report production and analysis.

A focus of the additional Reporting funding will be creation of tools (primarily through Tableau) to enable hospitals and other provider organizations to perform analysis without requiring custom reports. Such functionality will support provider organizations in their improvement efforts.

Finally, CRISP anticipates that as reporting capabilities and services are developed, the operation of such services will gradually shift to a less expensive staffing model. This transition, which has started for Unique ID creation, will continue for the standard monthly reports.

Additional Funding for Support of Care Coordination and Integrated Care Network Activities, and Evaluation and Planning Resources

The Care Coordination Work Group is a multi-stakeholder group charged with looking at statewide, regional and provider-based approaches to support care coordination activities that assist in meeting the goals of the All-Payer Model. The Work Group is making a series of recommendations to the HSCRC. At their highest level, these intend to:

- Build/secure a data infrastructure to facilitate identification of individuals who would benefit from care coordination – The Goal is to secure, organize, synthesize, and share data that will support care coordination

- Encourage Patient-Centered Care - Identify standard elements of care profiles that can be shared, and propose future standards for the creation of Individualized Care Profiles.
- Encourage Patient Engagement – This involves educating patients about care coordination, and encouraging individuals to participate in care plans and complete and share medical orders for life-sustaining treatment.
- Encourage Collaboration – Priorities include facilitating somatic and behavioral health collaboration, integration between hospitals and long-term care/post acute care services, and creating standard gain sharing and pay for performance programs.
- Connect Providers – Call on CRISP to connect community-based and long-term and post acute providers to CRISP, and to coordinate efforts to use Medicare data on high needs patients to support population health and outcomes initiatives.

In light of these recommendations, staff intends to evaluate the role that CRISP can play in further supporting care coordination and integrated care network development and implementation in the State, and report back to the Commission on the potential for additional CRISP funding to meet these critical needs. Further development of budgets and timelines will be required to determine these needs.

In FY 2015, the Commission approved $1 million in funding for consulting and expert resource needs to support more detailed planning, evaluation, and stakeholder input relative to provider alignment and care coordination initiatives and infrastructure needs. These activities fall outside of the ongoing recurring work of the HSCRC staff and require flexible and agile approaches to convening stakeholders and planning resource requirements. Staff is currently discussing future needs and will likely submit recommendations in the coming months on continuing funding for planning and evaluation resources in FY 2016 that are designed to bring success to Maryland's providers in meeting the Three-Part Aim in a patient-centered way.

Recommendation

HSCRC and MHCC staff recommend that hospital rates be increased in FY 2016 by $3.19 million to continue to support the ongoing costs of CRISP HIE operations and reporting services. The FY 2016 budget for each of these functions is as follows:

- CRISP HIE Operations - $1,650,000 (consistent with funding in FY 2015);
- CRISP Reporting Services - $1,539,000 (compared to $1,850,000 in FY 2015).

Additionally, HSCRC and MHCC staff will to continue to work with CRISP in the development of a budget and timeline for further support of the All-Payer Model consistent with the recommendations of the Care Coordination Work Group. As necessary, it is likely that a recommendation for additional FY 2016 funding through CRISP to support the care coordination needs identified in the Care Coordination Work Group recommendations will be forthcoming.

Care Coordination Work Group Report

The Report will be e-mailed to Commissioners over the next few days, and slides will be presented at the Commission meeting

Final Recommendation:

FY 2015 Rate Adjustment to Implement the 2014 Budget Reconciliation and Financing Act (BRFA) Provisions

April 8, 2015

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

This is a final recommendation to be presented at the April 15, 2015 HSCRC public meeting and is ready for final action.

Overview

In accordance with the provisions of the Budget Reconciliation and Financing Act of 2014 (BRFA), this recommendation is to authorize Commission staff to increase rates (in FY 2015) effective May 1, 2015 to provide up to $15 million for the purpose of funding the planning of regional partnerships for health system transformation throughout the State, along with statewide infrastructure to support care management, transitions, coordination, and planning.

Background

During the 2014 Legislative Session, the General Assembly adopted the BRFA of 2014. This legislation provides that the Health Services Cost Review Commission ("HSCRC" or "Commission") may include an additional $15,000,000 in hospital revenue when determining hospital rates that are effective in fiscal year 2015 for the purpose of:

> (1) Assisting hospitals in covering costs associated with the implementation of Maryland's all–payer model contract; or
>
> (2) Funding of statewide or regional proposals that support the implementation of Maryland's all–payer model contract.

Statewide or regional proposals for funding are to be submitted to the Commission and the Department of Health and Mental Hygiene ("the Department" or "DHMH") for approval. The Department and the Commission are required to establish a committee to review regional proposals and make recommendations to the Department and the Commission for funding. The review committee is required to include representatives from the Department and the Commission as well as subject matter experts, including individuals with expertise in areas such as public health, community–based health care services and support, primary care, long–term care, end–of–life care, behavioral health, and health information technology.

The Commission may take action on a statewide or regional proposal that has been reviewed by the committee and approved by the Commission and the Department (staff).

Rate Adjustment Request

Beginning in late 2013, the HSCRC convened an Advisory Council to develop Guiding Principles for implementation of the new All Payer Model. The Advisory Council put forth its Final Report on January 31, 2014.

The Advisory Council indicated that HSCRC should work with providers, payers, and consumers to analyze data for identifying opportunities that would improve patient care and health outcomes. In particular, patients with complex medical needs and chronic conditions, who are frequent users of the health care system, can be appropriately identified without infringing on their confidentiality rights, and they can be targeted for better care coordination and health improvement.

The recommendations of the Advisory Council are summarized below:

- Focus on meeting early Model requirements (through hospitals being on global budgets supported by multi-disciplinary care coordination, especially for high-risk Medicare fee-for-service patients, to enable meeting the state-wide ceilings and Medicare savings requirements);
- Meet budget targets while making important investments in infrastructure and providing flexibility for private sector innovation;
- HSCRC should play the roles of regulator, catalyst and advocate;
- Consumers should be involved in planning and implementation;
- Physician and other provider alignment is essential; and
- An ongoing, transparent public engagement process is needed.

In the Advisory Council meetings, members advised that the Commission should focus attention on care coordination models that have demonstrated success rather than on untested strategies. The Data and Infrastructure Work Group and Physician Alignment and Engagement Work Group recommended considering shared infrastructure and common approaches to care coordination. Based on this advice, the HSCRC's goal is to facilitate consideration of shared infrastructure and common approaches that might limit confusion and improve effectiveness for providers and patients.

Subsequently, the Care Coordination Work Group has discussed opportunities that can best provide success in meeting the all-payer model requirements. This Work Group emphasized that success is predicated on effective sharing of data and analytics across

providers that are used in the care coordination process. This will require hospitals, patients, community-based providers, long-term care, and post-acute care providers to work together to effectively coordinate patient care, reducing the need for hospitalizations and re-hospitalizations.

Below are three proposed uses of BRFA funds that are designed to reach the goals of improving regional collaboration for care coordination, improving statewide infrastructure to enable proven care coordination strategies to be successful, and providing evaluation and planning resources.

Planning Grants for Regional Partnerships for Health System Transformation

In order to improve population health, it is essential that regional collaborations develop across the State. Enabling Maryland's health care system to be highly reliable, highly efficient, and a point of pride in our communities will require increased collaboration between health systems, payers, community hospitals, ambulatory physician practices, long-term care providers, and many other community-based organizations. It will also require effectively engaging patients and consumers.

In order to achieve these goals and to pave a way for success of the All-Payer Model, the Department, in collaboration with the HSCRC, released a Request for Proposals ("RFP") on February 9, 2015 for funding to support planning, development initiatives, and operational plans for regional partnerships for health system transformation. Applications are due by April 15, 2015.

The RFP invites proposals to develop partnerships capable of identifying and addressing their regional needs and priorities and, in turn, shaping the future of health care in Maryland. The proposals should include developing care coordination and population health priorities, determining what resources are needed and available, and how resources and strategies should be deployed. While the model concept itself should focus on particular patient populations (e.g., patients with multiple chronic conditions and high resource use, frail elders with support requirements, dual-eligibles with high resource needs), the proposals may include a strategy for improving overall population health in the region over the long-term, with particular attention paid to reducing risk factors. This population health strategy should incorporate and build upon those existing population health action plans developed by Local Health Improvement Coalitions together with Community Health Needs Assessments, and expand to address chronic conditions and frail elders, and other specific resource needs

relevant to aging populations that are proven or expected to move Maryland toward meeting the goals and requirements of the All-Payer Model.

Under the RFP, DHMH and HSCRC will provide a maximum of $400,000 for each approved application. The application process will be competitive, with five or more awards being made in the State. It is anticipated that up to a total of $2.5 million will be used to fund selected proposals. Some areas of the State may require more time to prepare for this undertaking or may benefit from joining forces with other applicants. Funding will be allocated via HSCRC-approved rate increases for hospitals participating in partnerships that receive awards. For this reason, applications are to be submitted by a hospital in consultation with partner organizations. Individual applicant partners may be included in more than one application due to the nature of the process.

The evaluation committee will provide preference to those models that include the following characteristics/features:

- A comprehensive, diverse set of partners with standing in the region
- Multiple target high-cost conditions/populations, with initial focus on Medicare
- Integrating primary care, prevention, and addressing multiple determinants of health
- Sustainability concept that builds on the All Payer Model and other delivery/financing models

Successful bidders are required to submit an interim report to the Department and HSCRC by September 1, 2015, and a final report is due on December 1, 2015.

Funding of Common Care Coordination Infrastructure to Provide Support on a Statewide Basis

The Care Coordination Work Group has considered statewide, regional and provider-based strategies to improve care coordination, transitions, management, and planning. The Work Group has identified a two-track approach for using data to inform and support care coordination:

> Track 1 – Use Existing Data Sources: First, it is important to use information from existing data sources that could be used to identify patients with the most complex medical needs. These data would include data currently available through CRISP such as real time Hospital Admit,

Discharge, and Transfer (ADT), hospital inpatient and outpatient data available on a monthly basis through the HSCRC abstract, and potentially other clinical data available through CRISP. Additionally, other sources of data should be evaluated for possible use in these efforts, including: pharmacy data obtained from pharmacy benefit managers (PBMs), Outcome and Assessment Information Set (OASIS) data on home care, Minimum Data Set (MDS) records on nursing home care, and other information sources.

Track 2 – Acquire Medicare data: On a parallel track, Maryland should take steps as soon as possible to acquire Medicare claims data under its existing CMMI grant. Medicare data that include physician encounters as well as skilled nursing facility and other post-acute providers linked with hospital data, clinical data, ADT, and HSCRC abstract data will create powerful tools for care coordination.

The Work Group also considered opportunities for investment in care coordination. One of the sources of such investment is utilization of the funds identified in BRFA. Some of the potential priorities for such funding include:

- Building/securing a data infrastructure to facilitate identification of individuals who would benefit from care coordination
- Encourage patient-centered care and patient engagement including sharing common information regarding patient care among providers and care coordinators
- Encouraging collaboration among providers (including social services, behavioral health, long-term care, post-acute care providers), patient advocates, public health, faith-based initiatives
- Connect providers to CRISP

The full report may be found on the Commission's website.

Evaluation and Planning Resources

On October 15, 2014, the Commission approved a staff recommendation to increase rates of approximately $1 million to fund consulting and expert resource needs to support more detailed planning, evaluation, and stakeholder input relative to provider alignment and care coordination initiatives and infrastructure needs through CRISP. Under a Memorandum of Understanding with CRISP, the vendors obtained under this

recommendation have been critical in bringing the Care Coordination Work Group activities to their current level of progression, as well as in considering options, challenges, and barriers for establishing regional integrated care networks in Maryland. The October recommendation specifically stated that BRFA funds should be used to support this activity, since it is directly related to supporting statewide and regional planning and infrastructure. The recommendation also provided that the planning and implementation funding shall reduce the amount of BRFA funding available for implementation of the All-Payer Model from $15 million to $14 million. This is because the HSCRC will have allocated revenue capacity to implement a planning and implementation process that is needed to ensure stakeholder and public input into the approach that will be recommended to the Commission.

The Maryland Hospital Association supported this funding approach but has advocated for caution to ensure that funded activities benefit hospitals in the implementation of the new All-Payer Model. HSCRC staff agrees with this cautious approach, and we have focused our recommendations to limit resource allocation to those activities that result from the recommendations of the Advisory Council, the Work Groups, and public input received during the planning process.

Recommendation

HSCRC staff recommends that hospital rates be increased in FY 2015 beginning May 1, 2015 to provide up to $15 million to support:

- Planning grants for regional partnerships for health system transformation (up to $2.5 million) - Rates will be increased only for those hospitals that are part of a collaborative RFP chosen by the review committee and approved by the Department and the Commission pursuant to the process outlined in the RFP.

- Common care coordination infrastructure to provide support on a statewide basis for specific opportunities to improve care coordination and chronic condition management (up to $12 million) – Rates will be increased for all or a subset of hospitals to support this activity.

- The existing engagement of resources to assist (in conjunction with stakeholders) in further evaluation and planning of possible statewide infrastructure and approaches for care coordination and provider alignment ($1 million) - Rates will be increased for all or a subset of hospitals to support this activity.

Draft Report on Uncompensated Care Policy Recommendations

Health Services Cost Review Commission
4160 Patterson Avenue Baltimore, MD 21215
(410) 764-2605

April 15, 2015

Draft Report on Uncompensated Care Policy Recommendation

INTRODUCTION

Overview

Since it first began setting rates, the HSCRC has recognized the cost of uncompensated care (charity care and bad debt) within Maryland's unique hospital rate setting system. As a result, patients who cannot pay for care are still able to access hospital services, and hospitals are credited for a reasonable level of uncompensated care provided to those patients.

Under the current HSCRC policy, uncompensated care is funded by a statewide pooling system in which regulated Maryland hospitals draw funds from the pool if they experience a greater-than-average level of uncompensated care and pay into the pool if they experience a less-than-average level of uncompensated care. This ensures that the cost of uncompensated care is shared equally across all of the hospitals within the system.

The HSCRC must determine the total amount of uncompensated care that will be placed in hospital rates for FY 2016 and the amount of funding that will be made available for the uncompensated care pool. Additionally, HSCRC must review the methodology for distributing these funds among hospitals.

Traditionally the HSCRC prospectively calculates the rate of uncompensated care at each regulated Maryland hospital by combining historical uncompensated care rates with predictions from a regression model. For fiscal 2015, the HSCRC adjusted this methodology to incorporate a prospective yet conservative adjustment for the expected impact of the Affordable Care Act's (ACA) Medicaid expansion on uncompensated care. The 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 the full Medicaid benefits to people previously enrolled in the Primary Adult Care (PAC) program. PAC offered limited health care coverage including the cost of primary care, family planning, prescriptions, mental health care and addiction services, and outpatient hospital emergency room services. However, PAC did not reimburse hospitals for inpatient or outpatient care beyond the emergency room.

ACA implementation will influence the FY 2016 update as the variables underlying regression model include Medicaid coverage and the actual Medicaid expansion enrollment far exceeded the participants in the PAC program.

This report discusses the factors influencing uncompensated care rates in Maryland and makes recommendations to adjust the total funds available in the uncompensated care pool, to again use the results of last year's regression model for allocation of those funds in lieu of updating the regression analysis, and to update last's year prospective ACA adjustment to capture the full impact of the Medicaid expansion on uncompensated care.

The changes recommended are necessary to recognize an appropriate level of uncompensated care at hospitals in the State and to share the cost of that care equally across all regulated Maryland hospitals.

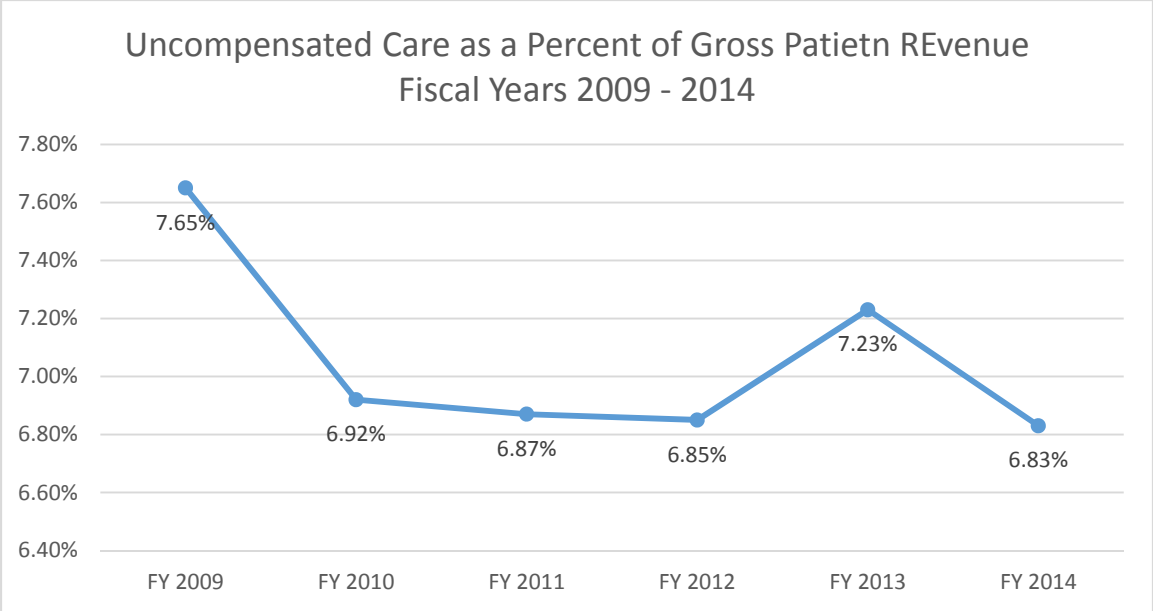
STAKEHOLDER INPUT

The conclusions in this report were reviewed with the Payment Models Workgroup and the Maryland Hospital Association's Financial Technical Issues workgroup. Several comments from the workgroups are incorporated in this staff report. Multiple iterations of hospital specific trends in self-pay and charity care were shared with each Maryland hospital. The overall analytic approach and figures for some hospitals were adjusted based on hospital feedback and additional analysis.

BACKGROUND

Recent Trends in Uncompensated Care

The chart below shows the actual total uncompensated care rate for all regulated Maryland hospitals between FY 2009 and FY 2014. Uncompensated care levels dropped between FY 2009 and FY 2012, before climbing slightly in FY 2013. Implementation of the ACA in mid-FY 2014 resulted in a decline in an overall uncompensated care for the year.



Current Uncompensated Care Policy

The Commission adopted the current uncompensated care policies between 2007 and 2014. The policies create a statewide pool built into the rate structure of Maryland hospitals. Hospitals either pay into or withdraw from the pool depending on each hospital's prospectively calculated rate of uncompensated care. Each year, the total amount of funds available in the pool is determined by the total percent of gross patient revenue due to uncompensated care experienced in regulated Maryland hospitals during the previous year. For example, if in 2014 the actual total cost of uncompensated care were 6 percent, then in 2014 the pool would prospectively be set at 6 percent of the 2014 gross patient revenue.

For FY 2015, the prospective uncompensated care percentage for each hospital was computed by taking the average actual percent of uncompensated care experienced by the hospital over the past two years and combining that "actual" value with a predicted value of uncompensated care determined by a regression model. The annual uncompensated care percentage for each hospital was weighted equally between the two-year average and the predicted regression value as shown in the formula below.

$$\frac{Average\ UCC\ Rate\ for\ Past\ 2\ Years + Regression\ Value}{2} = Annual\ UCC\ Percentage$$

Once the annual uncompensated care percentages were calculated for each hospital, they were adjusted so that the pooling system will remain revenue neutral. Appendix I illustrates this calculation.

The regression model used to determine the FY 2015 predicted uncompensated care percentage for each hospital relied upon five explanatory variables:

- The proportion of a hospital's total charges from inpatient Medicaid admissions through the emergency room
- The proportion of a hospital's total charges from inpatient commercial insurance cases
- The proportion of a hospital's total charges from inpatient self-pay and charity cases
- The proportion of hospital's total charges from outpatient self-pay and charity emergency department charges
- The proportion of a hospital's total charges from inpatient self-pay and charity admission through the emergency room from the 80th percentile of Medicaid undocumented immigrant enrollment zip codes

This model was applied to data from the two-year historical period used to generate the average actual uncompensated care percentage described above. Three hospitals, Levindale Hospital, the University of Maryland Rehabilitation & Orthopedic Institute (formerly Kernan Hospital), and the Shock Trauma Center were excluded from the regression calculation. Under the current model, the HSCRC set the annual uncompensated care percentages for these hospitals at their actual average uncompensated care percentage for the previous three years.

Enrollment under the Affordable Care Act (ACA)

A primary goal of the ACA was to expand coverage to uninsured or underinsured individuals. Counting both individuals who have obtained Medicaid coverage and those who have selected a private health plan through Maryland's insurance exchange, more than 370,000 Marylanders enrolled in coverage through February 2015. This includes coverage of about 254,000 Marylanders through new Medicaid eligibility categories (including people previously covered under PAC) and about 120,000 through private health plans.

HSCRC staff is focusing its efforts on the new categories of Medicaid enrollees who account for about 70% of people covered through ACA related expansions. A wealth of information on this populations' utilization of hospital services before and after ACA

implementation is available due to the collaborative efforts of Medicaid and the Chesapeake Regional Information System for our Patients (CRISP).

ANALYSIS

Determining Appropriate Level of Uncompensated Care Funding in Rates

The HSCRC must determine the percentage of uncompensated care to recognize in hospitals' rates to enable funding of the uncompensated care pool.

Normally staff would begin by updating the regression model and examining the actual UCC rate for the last two or three years. Updating the regression model or the historical uncompensated care experience to include FY 2014 data is not recommended. Only six months of experience with the ACA expansion is captured in the FY 2014 data. This short a period is inadequate for assessing the impact of the Medicaid expansion on uncompensated care. Staff, instead, recommend continuing to use the historical experience from FY 12 and FY 13 and the results of last year's regression model.

The only recommended change to the FY 2015 uncompensated care analysis is to update the prospective adjustment for the impact of Medicaid expansion for an analysis of the actual calendar 2014 impact of the Medicaid coverage expansion. The prospective adjustment made for FY 2015 was limited to an estimate of the impact of the PAC population gaining full Medicaid coverage. The adjustment for FY 2016 captures the actual calendar 2014 impact on uncompensated care from extending Medicaid coverage to the entire expansion population covered by Medicaid (PAC and non-PAC).

Changes in Self-Pay and Charity Charges

HSCRC staff has focused on quantifying the impact of the ACA's Medicaid expansion on uncompensated care. To evaluate the impact, staff initially compared the charges identified in the Commission's case mix data with a primary expected payer of self-pay or charity before and after the ACA expansion. Self-pay and charity were the focus of the analysis as they are the best indicators of charges incurred by the uninsured population. This assumption is supported by an analysis of write-off data that shows about 80% of self-pay/charity charges are written off at most hospitals.

The staff analysis compared total charges with a primary expected payer of self-pay/charity for the first six months of calendar 2013 (pre-Medicaid expansion) and calendar 2014 (post- Medicaid expansion). Only six months of data for each year were used as Medicaid enrollment files were required to verify the accuracy of some of the

data (see discussion below). Because Medicaid allows retroactive eligibility, incomplete enrollment data was available at the time of the analysis for the 2nd half of calendar 2014.

Hospitals advised that the trends from 2013 to 2014 were distorted by a lack of uniformity in the classification of charges identified as Medicaid pending (charges associated with cases where the patient was not already enrolled in Medicaid but may qualify for coverage). Until July 2014 when the Commission staff established a uniform policy, some hospitals reported Medicaid pending cases as self-pay while others reported these cases as Medicaid. To resolve this data issue, staff collaborated with Medicaid and CRISP. CRISP's master patient index was used to identify all the hospital charges associated with people with Medicaid coverage for the time of service. Commission staff used the results of the CRISP analysis to reassign charges between Medicaid and self-pay/charity:

- Charges identified in the case mix data as self-pay or charity but associated with a patient enrolled in Medicaid were re-assigned to the Medicaid category.

- Charges identified in the case mix data as Medicaid but associated with a patient who was not identified as CRISP as enrolled in Medicaid were re-assigned to the self-pay category.

The results of the revised analysis are provided in the table below. Combined self-pay/charity charges dropped by $150 million from the first half of calendar 2013 to the first half of calendar 2014. Annualizing the six-month trend produces a $299 million decline in self-pay/charity charges. This amount is $133 million more than the prospective adjustment of the Medicaid expansion to the PAC population incorporated into the HSCRC's FY 2015 uncompensated care policy.

Analysis of Self-Pay/Charity Charges First Half of 2013 to First Half of 2014
($ in Millons)

	CY 2013	CY 2014	$ Change	% Change
Self-Pay/Charity Charges in Case Mix Data	$357	$183		
Remove Self-pay/Charity in CRISP Medicaid	-75	-27		
Add MA as Payer Not in CRISP	165	140		
	$446	**$296**	**-$150**	-34%
Annualized Change			**-$299**	

The annualized $299 million change was then adjusted for:

- Increases in Out-of-State Medicaid charges that were reported with in-State Medicaid charges at certain hospitals. The analysis treated out-of-State Medicaid as self-pay/charity. As a result, calendar 2014 self-pay/charity charges at border hospitals with significant growth in out-of-State Medicaid charges were overstated.

- An overstatement of calendar 2014 self-pay/charity charges at one hospital that appears to have incorrectly classified expected payers in the case mix data.

- Price changes at five hospitals that experienced significant swings in prices from calendar 2013 to calendar 2014. .

The net impact of the adjustments is to reduce self-pay/charity charges by $10 million in calendar 2014. As shown in the table below, the revised annualized change in self-pay charity charges from calendar 2013 to calendar 2014 is $310 million. Staff recommends using the CY 2014 decline in self-pay/charity charges, converted to a percentage to reduce the provision for UCC in hospitals' rates for FY 2016.

Adjustments to Analysis of Self-Pay /Charity Charges

$ in Millions

	CY 2013 1st 6 Months	CY 2014 1st 6 Months	$ Change
Self-Pay Charity Charges for First Half of Year	$446	$296	-$150
Out-of-State Medicaid	-14	-16	-2
Correct Data issue at one hospital		-4	-4
Price Leveling		1	1
Revised Totals	$432	$278	-$155
Annualized Change			-$310

The estimate for the reduction in UCC without any offsets for collections is 1.98 percent. It should be noted that Medicaid receives a differential of 6 percent; therefore, approximately 94 percent of the reduction of the uncompensated care will be recognized in hospital rates due to a corresponding increase that will occur in the mark up relative to the increase in the differential that will result from the higher proportion of Medicaid revenues. This mark-up change is a separate provision in the rate update process.

Based on these recommendations, the UCC in hospitals' rates would be set at 5.25 percent as shown below. This percent is nearly identical to the FY 2015 year-to-date figure of 5.23% reported by hospitals through February 2015.

	FY 15 UCC	FY 16 UCC
FY 15 Policy Before ACA Adjustment	7.23%	7.23%
ACA Impact*	-1.09%	-1.98%
Net	**6.14%**	**5.25%**

*FY 2015 Adjustment limited to PAC population.

Continuing Suspension of Charity Care Multiplier

HSCRC staff recommends continuing the suspension of the charity care multiplier indefinitely. The data have not improved and, furthermore, the expansion of coverage under the ACA will likely reduce charity care. This policy can be reevaluated in two to three years after the expansion and implementation of ACA have been completed.

Evaluation of Continuing Sources of Uncompensated Care

Last year the Commission directed staff to begin collecting data on write-offs to guide future development of uncompensated care regression models and uncompensated care policies. Hospitals have submitted information on write-offs and recoveries that occurred during calendar 2014. The data submitted cover claims for services incurred in calendar 2014 and prior years. The data, which are still being scrubbed, are summarized in the table below.

Write-off and Recovery Data Submitted During CY 2014

$ in Millions

	Write-Off Amount	Payer Share of Write-offs	Total Billed Amount	Write-off as % of Bill
Self-Pay/Charity/Medicaid	$586	58%	$1,229	48%*
Commercial	265	26%	1,630	16%
Medicare	116	11%	1,264	9%
Workers' Comp	14	1%	53	26%
Other	31	3%	84	37%
Total	**$1,012**		**$4,260**	

	Recovery	Recovery as % of Writeoff
Self-Pay/Charity/Medicaid	$104	18%
Commercial	128	48%
Medicare	44	38%
Workers' Comp	7	50%
Other	11	35%
Total	**$294**	29%

	Write-off Net of Recovery	Payer Share of Net	Total Billed Amount	Write-off as % of Bill
Self-Pay/Charity/Medicaid	$482	67%	$1,229	39%*
Commercial	$137	19%	1,630	8%
Medicare	$72	10%	1,264	6%
Workers' Comp	$7	1%	53	13%
Other	$20	3%	84	24%
Total	**$718**		**$4,260**	

*Most hospitals report write-offs as share of Medicaid, self-pay, charity bills at 75% to 80%. The state average is pulled down by a couple of outliers who report a substantial volume of charges and write-offs of about 20%. Staff are working with those hospitals to determine if there is a data reporting issue.

The majority (58%) of the write-offs were for charges with a primary expected payer of self-pay, charity, or Medicaid. Since Medicaid does not require enrollee cost sharing,

Medicaid write-offs are most likely cases where the person ultimately failed to qualify for Medicaid and lacked insurance.

About 26% of the write-offs are associated with a commercial payer with the average write-off representing 16% of total charges. With only one year of data available, it is too soon to determine the extent to which increasing deductibles are contributing to increases in uncompensated care. Continued collection of the data is recommended to enable analysis of multi-year trends and guide future development of uncompensated care regression models and policies.

Impact of Denials on All-Payer Model

In response to direction from the Commission during development of the FY 2015 uncompensated care policy, hospitals have begun submitting data on outpatient denials. Due to the uneven quality of initial submissions, insufficient data are available at this point to perform a meaningful analysis. Staff are working with hospitals to improve the uniformity of the data submissions and expect to release an initial analysis in September.

HSCRC staff recommend continued collection of this data to support development of trends analysis and a better understanding of the impact denials have on individual hospital revenues.

Future Uncompensated Care Policy

HSCRC staff notes that the changes to the uncompensated care policy laid out in this report should only be applied for FY 2016. Development of the FY 2017 uncompensated policy will occur in a less dynamic insurance market place and a more data rich environment. Almost two years of post-ACA implementation data including audited financial statements for FY 2015 will be available to update the regression model. With two years of data on write-offs also available, staff may be able to incorporate new variables into the regression model that better capture the continuing sources of uncompensated care.

RECOMMENDATIONS

Based on the preceding analysis, the HSCRC staff recommends that:

1. The uncompensated care provision in rates be reduced from 6.14% to 5.25%, effective July 1, 2015;

2. The combined results of the regression model and two years of historical data underpinning the FY 2015 uncompensated care policy be re-used for FY 2016:
    a. No update to the regression results.
    b. Combine the regression results with the same two years of actual data (FY 2012 and FY 2013) incorporated into the FY 2015 policy.
    c. Subtract the ACA driven decline in self-pay/charity charges from CY 2013 to CY 2014 from the modeled uncompensated care result for each hospital to derive its final percentage for determining its contribution or withdrawal from the uncompensated care pool. Appendix II shows the result of this calculation.
3. The Charity Care Adjustment be suspended indefinitely and not be reinstituted in FY 2016 rates;
4. Data continued to be collected on write-offs to guide future development of uncompensated care regression models and uncompensated care policies;
5. Data continued to be collected on outpatient denials, in addition to data already collected on inpatient denials, to understand the continuing trends in denials under the new All-Payer model; and
6. A new uncompensated care policy be developed for FY 2017 that reflects the patterns in uncompensated care experience, which are observed in FY 2015 and projected for FY 2016.

Appendix I: Calculation to Achieve a Revenue Neutral Policy

The HSCRC calculated the annual UCC percentage for each hospital by combining the average actual UCC percentage for each hospital for the past two years with a predicted UCC percentage from the regression model. The HSCRC then adjusted the annual UCC percentage for each hospital so that the total statewide UCC percentage was equal to the actual total statewide UCC percentage for 2013. This was done to achieve a revenue neutral system of pooling across all hospitals. This adjustment was done before any policy adjustments were made, such as the PAC reduction.

Revenue neutral adjustment factor:

$$= \frac{Total\ actual\ 2013\ UCC\ \% - Total\ calculated\ UCC\%\ for\ 2015}{Total\ actual\ \ 2013\ UCC\%} + 1$$

Adjusted UCC percentage for each hospital:

$$= revenue\ neutral\ adjustment\ factor * 2015\ UCC\%\ calculated\ for\ hospital\ 1$$

Appendix II: Proposed Uncompensated Care Levels by Hospital for FY 2016

	A	B	C		D	E
			C = A - B			E = A -D
	FY 2015 Policy Results Without PAC	FY 15 PAC Adjustment	FY 2015 Policy		FY 2016 ACA Expansion Adjustment	FY 2016 Policy
Meritus Medical Center	7.83%	1.66%	6.17%		3.08%	4.76%
Univ. of Maryland Medical Center	6.50%	1.85%	4.65%		3.69%	2.81%
Prince Georges Hospital	16.07%	1.09%	14.98%		1.09%	14.98%
Holy Cross Hospital of Silver Spring	8.84%	0.31%	8.53%		1.46%	7.39%
Frederick Memorial Hospital	6.33%	0.90%	5.43%		2.32%	4.02%
Harford Memorial Hospital	10.75%	1.51%	9.24%		2.00%	8.75%
Mercy Medical Center, Inc.	6.74%	1.34%	5.40%		1.02%	5.72%
Johns Hopkins Hospital	4.31%	0.78%	3.53%		1.21%	3.10%
UM Dorchester	8.25%	2.67%	5.58%		4.16%	4.09%
St. Agnes Hospital	8.13%	1.45%	6.69%		2.81%	5.33%
Sinai Hospital	5.83%	1.10%	4.73%		1.33%	4.50%
Bon Secours Hospital	17.59%	5.80%	11.79%		7.12%	10.47%
Franklin Square Hospital	7.74%	0.95%	6.80%		2.82%	4.92%
Washington Adventist Hospital	13.36%	0.59%	12.78%		1.16%	12.20%
Garrett County Memorial Hospital	10.10%	0.75%	9.36%		3.24%	6.86%
Montgomery General Hospital	7.02%	0.78%	6.25%		1.55%	5.47%
Peninsula Regional Medical Center	6.71%	1.30%	5.41%		1.84%	4.87%
Suburban Hospital Association,Inc	5.33%	0.28%	5.05%		1.25%	4.08%
Anne Arundel General Hospital	4.82%	0.54%	4.29%		1.45%	3.38%
Union Memorial Hospital	7.49%	1.45%	6.03%		2.39%	5.10%
Western Maryland	6.49%	1.06%	5.43%		2.88%	3.61%
St. Marys Hospital	7.41%	1.09%	6.32%		3.09%	4.32%
Johns Hopkins Bayview Med. Center	8.71%	1.73%	6.98%		3.22%	5.49%
UM Chestertown	9.01%	0.77%	8.24%		2.50%	6.51%
Union Hospital of Cecil County	8.25%	1.82%	6.43%		2.61%	5.64%
Carroll County General Hospital	5.23%	0.69%	4.53%		1.23%	3.99%
Harbor Hospital Center	9.12%	1.47%	7.65%		2.55%	6.57%
UM Charles Regional	8.15%	0.80%	7.35%		2.36%	5.79%
UM Easton	6.40%	0.83%	5.56%		1.58%	4.82%
UM Midtown	12.65%	3.52%	9.14%		4.14%	8.51%
Calvert Memorial Hospital	6.55%	1.05%	5.51%		2.17%	4.39%
Northwest Hospital Center, Inc.	8.47%	0.93%	7.54%		2.75%	5.73%
UM Baltimore Washington	8.82%	1.02%	7.80%		2.01%	6.81%
Greater Baltimore Medical Center	3.79%	0.38%	3.42%		0.41%	3.39%
McCready Foundation, Inc.	9.57%	2.76%	6.81%		3.54%	6.04%
Howard County General Hospital	6.33%	0.61%	5.72%		2.18%	4.15%
Upper Chesepeake Medical Center	5.71%	0.59%	5.12%		0.61%	5.10%
Doctors Community Hospital	9.10%	0.61%	8.49%		2.09%	7.01%
Laurel Regional Hospital	13.24%	0.94%	12.30%		1.74%	11.51%
Good Samaritan Hospital	7.33%	0.90%	6.43%		1.93%	5.40%
Shady Grove Adventist Hospital	7.24%	0.53%	6.71%		1.06%	6.17%
Fort Washington Medical Center	13.09%	0.86%	12.23%		1.34%	11.76%
Atlantic General Hospital	7.86%	1.42%	6.43%		1.26%	6.60%
Southern Maryland Hospital	7.54%	0.94%	6.60%		2.65%	4.89%
UM St. Joseph's	4.63%	0.72%	3.90%		0.68%	3.95%
UM Rehab and Ortho	5.80%	1.13%	4.67%		1.61%	4.19%
Univ. of Maryland (MIEMSS)	21.36%	0.25%	21.11%		-0.73%	22.09%
Levindale	1.83%	0.00%	1.83%		0.00%	1.83%
Statewide	**7.23%**	**1.09%**	**6.14%**		**1.98%**	**5.25%**
*University of Maryland and MIEMSS will have a combined rate of 5.35%						

Impact of ACA's Medicaid Expansion on Hospital Utilization

Planned Adjustments per Global Contract Provisions

Health Services Cost Review Commission
4160 Patterson Avenue Baltimore, MD 21215
(410) 764-2605

April 15, 2015

INTRODUCTION

Overview

On January 1, 2014, the Maryland Medicaid Program extended full coverage to adults with incomes up to 138% of the federal poverty level who previously were ineligible for Medicaid or qualified for a limited benefit package through the Primary Adult Care (PAC) Program. The coverage expansion authorized by the federal Patient Protection and Affordable Care Act of 2010 (ACA) enrolled more than 200,000 people during CY 2014.

Global budgets for FY 2015 were prospectively adjusted to capture a portion of the expected decline in uncompensated care resulting from the Medicaid expansion. No adjustments were made to capture the potential impact on volume of uninsured and underinsured individuals increasing their utilization of hospital services after enrolling in Medicaid. Global budget contracts did, however, include a provision indicating the Commission would review the impact of the Medicaid expansion on volumes and adjust funding as appropriate.

To assess the impact of the Medicaid expansion on hospital utilization, HSCRC staff worked with Maryland Medicaid and CRISP. CRISP's Master Patient Index was used to identify hospital admissions/visits in calendar 2013 and calendar 2014 for anyone who enrolled in the Maryland Medicaid expansion during the first quarter of 2014.

This report includes the results of the analysis and planned FY 2016 adjustments to rates to capture the ongoing impact of the Medicaid expansion on hospital utilization.

ANALYSIS

About 214,000 people enrolled in a Medicaid expansion group in the first quarter of 2014. Enrollees included almost 98,000 people who transferred from the PAC Program in January 2014 and 116,000 new (non-PAC) enrollees. The CY 2013 and CY 2014 hospital charges associated with people who enrolled in the Medicaid expansion during the first quarter of CY 2014 are presented in the table below. Charges in CY 2014 exceeded charges for the same population in 2013 by $219.5 million or 40%. The growth rate declined over the course of the year falling from 64% in Quarter 1 of 2014 (compared to the same quarter in 2013) to 18% in Quarter 4. The trend is consistent with the expectation that pent up demand would drive an initial surge in care.

Table 1
Hospital Charges for Medicaid Expansion Population
People who Enrolled During the First Quarter of 2014
($ in Millions)

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
CY 2013	$120,569,479	$128,794,628	$142,995,696	$150,138,688	$542,498,491
CY 2014	197,668,011	194,149,949	192,896,309	177,294,476	762,008,745
Change	**$77,098,532**	**$65,355,321**	**$49,900,613**	**$27,155,788**	**$219,510,254**
% Change	64%	51%	35%	18%	40%

Table 2 breaks the charge growth down by the PAC program and other (non-PAC). Charges for the PAC population in CY 2014 exceeded 2013 levels at relatively constant rates each quarter of the year with a modest decline in the last two quarters. Non-PAC charges more than doubled in the first quarter of 2014 and slowly dropped off during the year. The variation between the two groups may reflect differences in access to care in 2013. PAC participants were enrolled with a Medicaid Managed Care Organization and receiving primary care and prescription drug benefits for some or all of CY 2013. The prior insurance of the non-PAC population is less certain and some patients may have been waiting for coverage to receive diagnosis/treatment for ongoing health issues.

Table 2
Charge Trends by Expansion Population
($ in Millions)

PAC Enrollees Converted to Full Medicaid

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
CY 2013	$77,084,367	$81,234,105	$88,727,908	$86,522,863	$333,569,243
CY 2014	99,364,118	108,568,202	112,087,636	103,208,279	423,228,235
Change	$22,279,751	$27,334,097	$23,359,728	$16,685,416	$89,658,992
% Change	29%	34%	26%	19%	27%

Non-PAC (A02)

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
CY 2013	43,258,287	47,375,386	54,426,673	64,093,352	209,153,698
CY 2014	99,021,701	85,905,023	81,177,667	74,229,339	340,333,730
Change	$55,763,414	$38,529,637	$26,750,994	$10,135,987	$131,180,032
% Change	129%	81%	49%	16%	63%

Consistent with the charge trends, both the PAC and non-PAC enrollees utilized more services in CY 2014 than in CY 2013:

- 16% of expansion enrollees utilized outpatient hospital care in a quarter in CY 2013 compared to 18% in CY 2014.

- 2.6% of expansion enrollees were admitted to the hospital in a quarter in CY 2013 compared to 2.8% in 2014.

- The utilization uptick was concentrated in the first three quarters of the years as shown in Table 3 below.

Table 3

Hospital Utilization - Share of Expansion Enrollees with Hospital Visit Per Quarter

Inpatient Admissions	CY 2013	CY 2014	Difference
Quarters 1 thru 3	2.6%	2.9%	0.3%
Quarter 4	2.7%	2.8%	0.1%
Outpatient Visits			
Quarters 1 thru 3	16.0%	18.7%	2.8%
Quarter 4	15.9%	17.1%	1.2%

Charge and volume growth were concentrated in surgical product lines (orthopedic, general, major, and minor surgery), cancer treatment (radiation, infusion, chemotherapy), cardiovascular care, and clinic services.

Does Analysis of Quarter 1 Adequately Capture Impact of Expansion?

Limiting the analysis of utilization by expansion enrollees to those individuals who enrolled in the 1st quarter of CY 2014 adequately captures the growth in hospital volumes associated with the expansion. While additional people enrolled in the expansion beyond the 1st quarter, the charges associated with the population that enrolled in the 1st quarter explain almost all of the net Medicaid, charity, and self-pay growth in CY 2014.

The net growth in Medicaid, self-pay, and charity charges from CY 2013 to CY 2014 was $244 million. The expansion analysis encompasses $220 million of new charges more than explaining the overall charge growth after adjusting the impact of rate updates ($56 million). Staff does not believe the impact of the expansion is significantly overstated as hospitals reducing charges to remain within global budgets while managing a larger Medicaid volume may have constrained the growth in charges associated with the expansion population.

Out-of-State Medicaid Expansions

CY 2014 Medicaid expansions in many of Maryland's neighboring states also appear to have impacted Maryland hospitals. To determine the impact of Medicaid expansions in other states

on Maryland hospitals, staff reviewed charges reported in case mix data for out-of-state residents with an expected payer of Medicaid or Other Government Payer. The Other Government Payer category was included in the analysis as HSCRC guidance instructs hospitals to report out-of-state Medicaid and miscellaneous government payers in this bucket. The analysis was limited to hospitals that are located in close proximity to the Maryland line (within 10-15 miles).

The staff analysis identified 12 hospitals which experienced a collective $10.4 million increase in CY 2014 out-of-state charges that appear to be associated with Medicaid patients.

Table 4
Estimated Change in Out-of-State Medicaid Charges at Maryland Border Hospitals

	CY 2013 to CY 2014 Change
Garrett	$780,454
Holy Cross	281,068
Meritus	674,509
Prince George's	2,025,133
Shady Grove	103,736
Suburban	220,095
Easton	135,976
Washington Adventist	1,730,707
Western Maryland	3,904,881
Ft. Washington	109,947
Charles Regional	246,783
Peninsula Regional	178,376
Total	**$10,391,665**

Discussion

The Medicaid expansion has generated volume growth at Maryland hospitals with newly insured and fully insured patients increasing their utilization of care. Much of the increase reflects an initial surge following the receipt of insurance. The ongoing portion of the uptick in utilization appears to be best captured by the experience in the 4th quarter of 2014 when charges for Maryland residents who enrolled in the 1st quarter of the year exceeded charges for the same period in the prior year by 18%. The experience with PAC patients, who had access to limited benefits prior to the expansion, also supports this view. The 18% growth factor, however, understates the ongoing growth as charges in the fourth quarter of 2014 were depressed by hospital efforts to comply with mid-year charge targets (charges grew 0% in the 4th quarter compared to 2% for all of CY 14) and temporary charge penalties related to overcharging in prior years (1% impact on growth rates). Adjusting for these issues brings the growth rate to 21%.

Applying 21% growth to the full $542 million of CY 2013 charges for the expansion population results in an estimated ongoing annual increase of $114 million. Staff has applied a 50% variable cost factor to this figure, to provide for the incremental cost associated with this volume allowance, bringing the proposed adjustment for FY 2016 to $57 million.

Appendix 1 shows that the impact of the Medicaid utilization uptick varies greatly by hospital with some facilities experiencing growth in excess of 70%. To fairly allocate the additional funding across hospitals, staff proposes providing each hospital with 26% of its gross revenue growth (after price leveling hospitals with substantial changes in rates in CY 2014). This allocation methodology ensures that the dollars follow the patients.

Table 4
Methodology for Allocating Additional Dollars to Hospitals

Amount Available for Allocation to Hospitals	A	$57 M
Growth in Charges Associated with Expansion Population*	B	$219 M
Share of Hospital Specific 2014 Expansion Charge Growth to be Added to FY 2016 Rates	C = B/A	26%

*After price leveling for hospitals with significant swings in prices from CY 2013 to CY 2014.

Staff plans to apply the same 26% of growth methodology to the increase in Medicaid charges associated with out-of-State residents. The combined adjustments for in-State and out-of-State Medicaid expansion impacts by hospital are presented in Appendix 2.

Summary of Staff Planned Adjustments for FY 2016 under GBR and TPR Agreements

- Increase rates for FY 2016 by $57 million (0.36%) to capture the ongoing uptick in volumes associated with the calendar 2014 Medicaid expansion.

- Allocate the additional funding across hospitals based on the actual growth in charges associated with the expansion population in CY 2014. Each hospital will receive about 26% of the growth in adjusted charges associated with people who enrolled in the expansion in the 1st quarter of 2014.

- Continue to monitor the utilization rate of expansion enrollees and report back to the Commission in six months regarding the ongoing trends.

Appendix 1

Adjustments to FY 2016 Hospital Funding to Reflect Impact of ACA's Medicaid Expansion				
	CY 2013	CY 2014	$ Change	% Chg
AAMC	$10,284,104	$14,396,144	$4,112,040	40%
Atlantic	3,367,342	5,009,993	1,642,651	49%
Bayview	29,203,441	35,597,972	6,394,531	22%
Bon Secours	17,057,315	15,408,512	(1,648,803)	-10%
Bowie	521,282	731,096	209,814	40%
Calvert	5,692,155	7,553,489	1,861,334	33%
Carroll	7,288,631	11,213,737	3,925,106	54%
Doctor's	6,938,973	11,622,013	4,683,040	67%
Frederick	9,705,004	14,346,701	4,641,697	48%
Ft. Washington	1,742,094	2,046,065	303,971	17%
Garrett County	1,295,193	1,671,169	375,976	29%
GBMC	7,715,503	9,756,827	2,041,324	26%
Germantown Emergency	644,556	814,352	169,796	26%
Greater Laurel	5,103,596	6,337,222	1,233,626	24%
Harford Memorial	5,950,816	7,108,187	1,157,371	19%
Holy Cross	9,223,701	10,508,102	1,284,401	14%
Holy Cross Germantown		381,928	381,928	
Howard	7,113,591	8,778,671	1,665,080	23%
Johns Hopkins	54,987,445	77,074,324	22,086,879	40%
McCready	1,106,900	1,400,491	293,591	27%
Medstar Good Samaritan	8,895,764	13,419,091	4,523,327	51%
Medstar Franklin Square	18,606,673	29,025,479	10,418,806	56%
Medstar Harbor	10,225,037	14,343,315	4,118,278	40%
Medstar Montgomery	4,363,513	6,504,709	2,141,196	49%
Medstar Southern MD	7,578,906	13,827,876	6,248,970	82%
Medstar St. Mary's	5,812,615	7,956,154	2,143,539	37%
Medstar Union Memorial	16,705,134	24,456,967	7,751,833	46%
Mercy	17,776,487	24,054,080	6,277,593	35%
Meritus	11,251,028	13,005,321	1,754,293	16%
Northwest	8,809,263	11,833,832	3,024,569	34%
Peninsula	14,569,984	20,282,520	5,712,536	39%
Prince George's	11,496,709	15,089,576	3,592,867	31%
Shady Grove Adventist	8,411,001	11,409,177	2,998,176	36%
Sinai	23,507,285	41,451,270	17,943,985	76%
St. Agnes	15,954,475	20,723,745	4,769,270	30%
Suburban	4,224,423	6,911,817	2,687,394	64%
Union of Cecil	8,598,256	12,384,586	3,786,330	44%
University	76,082,680	108,390,813	32,308,133	42%
University - Charles	6,024,743	7,461,897	1,437,154	24%
University - Chestertown	2,628,533	3,971,162	1,342,629	51%
University - Dorchester	3,618,301	5,605,277	1,986,976	55%
University - Easton	5,546,661	9,250,469	3,703,808	67%
University - Queen Anne's	284,920	285,721	801	0%
University - Rehab & Ortho	3,308,918	6,396,453	3,087,535	93%
University - Shock Trauma	1,253,826	2,217,487	963,661	77%
University Balt - Wash	15,271,621	22,470,402	7,198,781	47%
University Midtown	16,496,810	25,477,161	8,980,351	54%
University St. Joe's*	6,805,865	6,874,192	68,327	1%
Upper Cheasapeake	7,337,826	9,177,861	1,840,035	25%
Washington Adventist	7,701,237	13,851,047	6,149,810	80%
Western Maryland	8,199,096	11,077,460	2,878,364	35%
	542,289,232	760,943,912	218,654,680	40%

*Due to a data issue, CY 14 charges are understated. Staff are working with CRISP to update the analysis.

Appendix 4

Planned Adiustments to FY 2016 Rates

	Proposed Adjustment - 26% of Growth		
	In-State	Out-of-State	Total
AAMC	$1,071,239		$1,071,239
Atlantic	427,932		427,932
Bayview	1,665,857		1,665,857
Bon Secours	-		-
Bowie	54,659		54,659
Calvert	484,901		484,901
Carroll	1,022,540		1,022,540
Doctor's	1,219,992		1,219,992
Frederick	1,209,221		1,209,221
Ft. Washington	79,188	28,586	107,774
Garrett County	97,947	202,918	300,865
GBMC	531,791		531,791
Germantown Emergency	44,234		44,234
Greater Laurel	321,375		321,375
Harford Memorial	301,510		301,510
Holy Cross	334,603	73,078	407,681
Holy Cross Germantown	99,497		99,497
Howard	433,775		433,775
Johns Hopkins	5,753,914		5,753,914
McCready	76,484		76,484
Medstar Good Samaritan	1,178,385		1,178,385
Medstar Franklin Square	2,714,232		2,714,232
Medstar Harbor	1,072,864		1,072,864
Medstar Montgomery	557,809		557,809
Medstar Southern MD	1,627,937		1,627,937
Medstar St. Mary's	558,419		558,419
Medstar Union Memorial	2,019,452		2,019,452
Mercy	1,635,393		1,635,393
Meritus	457,016	175,372	632,388
Northwest	787,939		787,939
Peninsula	1,488,189	46,378	1,534,567
Prince George's	935,988	526,535	1,462,523
Shady Grove Adventist	781,063	26,971	808,034
Sinai	4,674,638		4,674,638
St. Agnes	1,242,456		1,242,456
Suburban	700,101	57,225	757,326
Union of Cecil	986,387		986,387
University	8,416,682		8,416,682
University - Charles	374,397	64,164	438,561
University - Chestertown	349,772		349,772
University - Dorchester	517,633		517,633
University - Easton	964,889	35,354	1,000,243
University - Queen Anne's	209		209
University - Rehab & Ortho	804,342		804,342
University - Shock Trauma	251,046		251,046
University Balt - Wash	1,875,375		1,875,375
University Midtown	2,339,496		2,339,496
University St. Joe's	17,800		17,800
Upper Cheasapeake	479,353		479,353
Washington Adventist	1,602,104	449,984	2,052,088
Western Maryland	749,851	1,015,269	1,765,120
	57,391,875	2,701,834	60,093,709

Work Group Updates

Slides will be presented at the Commission Meeting

Legislative Update

The Legislative Update will be presented at the Commission Meeting

State of Maryland
Department of Health and Mental Hygiene

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Deputy Director
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TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **April 8, 2015**

RE: **Hearing and Meeting Schedule**

May 13, 2015	Time to be determined, 4160 Patterson Avenue HSCRC/MHCC Conference Room
June 10 , 2015	Time to be determined, 4160 Patterson Avenue HSCRC/MHCC Conference Room

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

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

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