Executive Director's Update to the Health Services Cost Review Commission October 19, 2016

CMS Annual Meeting

Maryland met with CMS and CMMI staff to discuss performance for the second year and the Progression Plan under development.

Care Redesign Amendment

CMS approved Maryland's Care Redesign Amendment, but we are still awaiting legal documents.

Care Redesign Amendment

At stakeholder request, we asked CMS to approve an amendment to our All-Payer Model (Model) to obtain comprehensive patient level Medicare data to support care coordination, to allow hospitals to share resources with non-hospital providers, and to allow hospitals to share savings with non-hospital providers. CMS has approved that amendment. As we move forward to keep our current model successful in providing care coordination for high needs and rising risk patients and episodes of care, we must work with physicians and nursing home care partners to make this happen. MACRA has provided us with the possibility to tie physicians into the All-Payer Model and participate in an Advance Alternative Payment Model.

The State believes that working with care partners is crucial to the current and future success of the Model. We are asking every hospital and system to participate in the amendment program(s). Hospitals are already working on many of the initiatives that are envisioned in the amendment and the additional tools stakeholders requested will prove to be helpful.
In that regard, we have scheduled a series of webinars with CMMI staff to begin the launch of the program, which will start in 2017 and expand in 2018.

Hospital leaders should plan to attend the joint CMMI-HSCRC-CRISP-MHA Webinar 1 this Friday, October 21st from 1:00-2:00pm EST. You can register here: https://attendee.gotowebinar.com/register/8666939266781516804 and direct questions to hscrc.care-redesign@maryland.gov.

More information on implementation of the Care Redesign Programs is available on HSCRC's website: http://www.hscrc.maryland.gov/care-redesign.cfm

January 1 Rate Update

The revenues deferred from the July 1 rate order to January 1 will soon begin to increase rates for hospitals. These were built into hospital approved revenues, but deferred through the allocation of the GBR from the first half of the year to the second half of the year. HSCRC provided a list of activities that need to be undertaken relative to the additional revenues. Many of those activities tie directly into the amendment programs that stakeholders requested. In particular, the need to focus on providing care management for 20,000 of the highest need

Medicare patients with an estimated 80,000 very high needs patients is a top priority for Maryland. The HSCRC has an expectation that hospitals will fund and undertake this effort. Getting the data as part of the Amendment will allow better targeting, and programs will need to be scaled up. HSCRC tied the current rate adjustment to this effort as well as the focus on Medicare TCOC. Staff also expects to tie future rate adjustments to successful execution of care supports for high needs individuals and a focus on TCOC.

MHA and CRISP will be presenting later today on work to support hospitals in these efforts.

Regulatory Duplication

The Amendment requires submission of implementation protocols and reports relative to care redesign programs. HSCRC also has reports for GBR infrastructure and implementation grants. HSCRC staff is looking to streamline reporting to reduce the GBR and implementation grant report requirements. This is intended to reduce overlap and regulatory burden.

MACRA Update

CMS released its final MACRA regulations. Maryland has the opportunity to create an Advanced Alternative Payment Model (AAPM) to attach physicians who want to participate to the All-Payer Model through the Care Redesign Amendment program, a primary care initiative, and changes to hospital's value-based payment programs. Staff will aim to provide additional information at upcoming meetings.

This website has a link to CMS' final rule, its executive summary, and some fact sheets, including one on AAPM models. Maryland's All-Payer Model is not listed as an AAPM, similar to the proposed rule, but there is discussion regarding a pathway to make it an AAPM.

Progression Plan

HSCRC and DHMH are working to prepare the Progression Plan for submission to CMS/CMMI by December 31.

- The Plan follows the outlines that have already been presented to stakeholders.
- DHMH and HSCRC staff are providing presentations on the plan to the legislature committees.
- A first draft of the plan will be released on October 21 to the Advisory Council for their review and comment. Following an Advisory Council meeting on October 28, we will prepare an updated version for further stakeholder comment. We hope to post a draft for public comment by mid-November, with submission planned to CMS/CMMI by the end of the year.

Pay for Performance Programs Update

As Maryland implemented the initial phase of an all-payer model since January 1, 2014, existing pay-for-performance programs have been modified to ensure the state reached the performance goals of the new model. HSCRC established improvement targets for complications and readmissions and increased the revenue impact of all programs. Performance measurement incorporated both the attainment rates compared to national or state specific benchmarks, and improvement rates. HSCRC also moved towards predictable scoring and payment adjustment

approach where hospitals can monitor progress. Under this revised approach, payment adjustments are determined by a point-system rather than a relative ranking of the performance.

As Maryland is working towards a more coordinated health care system that is person-centered, this provides a valuable opportunity to rethink the pay-for-performance programs and measurement approaches that would align the system and diverse groups of providers to achieve a common set of goals to improve population health, health care quality, and health equity. Through the annual program update process, stakeholders expressed interest in making further modifications to move the programs towards more outcome-based, person-centered measurement approaches and at the same time evaluate opportunities for further simplification.

HSCRC requested white papers on cross-cutting issues that may have relevance to many specific programmatic options/topics that hold potential promise for refining our performance based payment programs to better support and measure the success of Maryland's system transformation. More information on white papers can be found at http://hscrc.maryland.gov/hscrc-workgroup-performance-measurement.cfm.

HSCRC staff is planning to work on developing new methodologies to align measurement across providers and create a person-centered approach to performance based payment adjustments in conjunction with the strategic direction the State is undertaking with the All-Payer Model Progression Plan. Specifically, staff will be focusing on the following concepts in the upcoming year and is not planning to make major changes to the existing pay-for-performance programs.

1. Developing service line/episode value measurement that could potentially combine and streamline different quality measures such readmissions, complication rates, mortality, patient experience and costs, at an episode/service line level such as surgery, medicine, obstetrics, psychiatry, oncology, emergency medicine, outpatient surgery etc.

2. Incorporating population health measures that would align the payment approaches with the top priorities set by the State in reducing avoidable utilization that can be impacted through improved community based care and interventions.

3. Developing performance metrics targeting high-need patients and care coordination.

4. Incorporating new measures for outpatient and ambulatory services that would harmonize measurement across different providers such as Accountable Care Organization (ACO) Measures, CPC+, etc.

5. Creating a road map towards outcomes based performance measurement, focusing on population health, new measures available from EMRs and registries, and patient reported outcomes, as well as administrative data.

Workgroup Updates

Performance Measurement Workgroup

The Performance Measurement Workgroup will continue to have monthly meetings to discuss updated to the pay for performance programs and road map. The work group will need to be expanded to incorporate additional non-hospital providers.

To help achieve the broad improvement goals under Maryland's Model, HSCRC is working to implement three new workgroups.

Consumer Standing Advisory Committee (C-SAC)

Working with other state agency partners, HSCRC and DHMH are coordinating the formation of C-SAC with representation that leverages the consumer engagement and involvement to date across the various work groups, and reflects the broad consumer diversity of the state. The group will bring together a diverse cross-section of consumers, consumer advocates, relevant subject matter experts, and provider, payer and other key stakeholders. An initial meeting is anticipated in the December/January timeframe.

Behavioral Health Subgroup

The Behavioral Health Subgroup will advise the Performance Measurement Work Group and the Commission on measures of performance for care provided to persons with mental health or substance use disorders that should be considered for HSCRC implementation initially and over time. The group will bring together a broad array of key stakeholders. The initial meeting is anticipated in December. MHA has also been focusing on behavioral health needs and will provide input to the subgroup.

Total Cost of Care Workgroup

The Total Cost of Care Workgroup will be formed to provide feedback to HSCRC on the development of the hospital-level TCOC guardrails for the Care Redesign Amendment Programs. The staff will also work with this group to develop measures that can be introduced into performance based payment for FY 2018. An initial meeting is anticipated early November.

QBR

As discussed in the June HSCRC meeting, staff was concerned that there were problems with the QBR scaling for the FY 2017 QBR adjustment. Staff attempted to develop a scale in advance of the year, but the scale was problematic. It provided rewards where performance was not improved. This will be discussed in today's meetings. Staff has revised the scaling to correct it.

January Update

We will update hospitals' July 1 rate order on January 1 for the following:

- Settlement of rate and global revenue compliance from FY 2016
- QBR
- Market shift adjustment for 6 months (January through June 2016)
- Allocation of additional set aside for drug cost growth (approx. $16 million)

Update on Case Mix Data

The case mix data is still defective due to Johns Hopkins EPIC conversion. We have not yet received usable data since the conversion. We are expecting corrected data in the near future. We cannot produce market shift analysis or ECMAD volume analysis without corrected data.

Medicare Total Cost of Care Performance

June figures have been restated due to claims held by Novitas. July figures are not available due to Johns Hopkins EPIC conversion.

Monitoring Maryland Performance
Medicare TCOC Data

Data through June 2016 - Paid Claims through August

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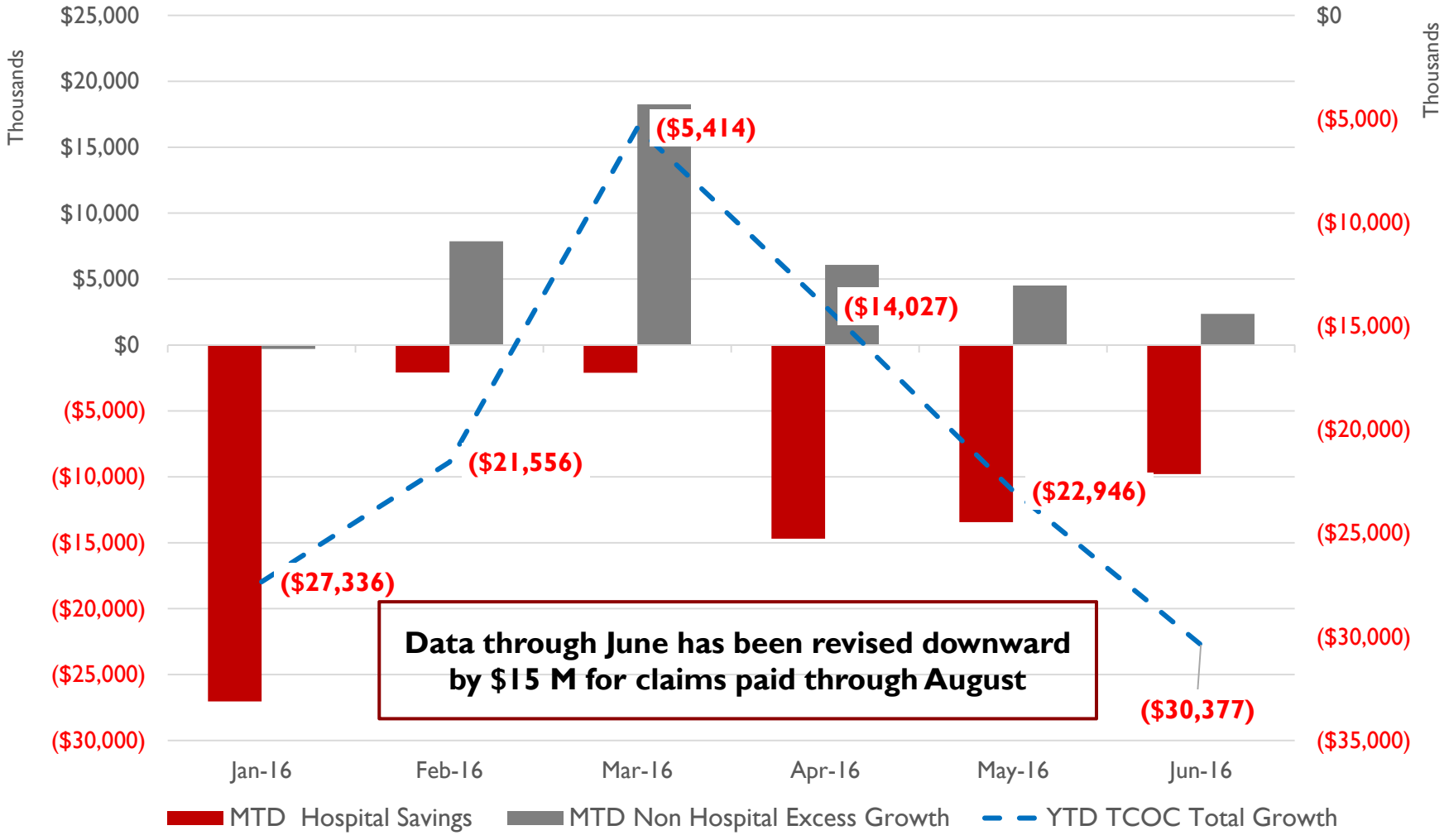
Disclaimer

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

Medicare Hospital & Non Hospital Growth (with completion) CYTD through June 2016



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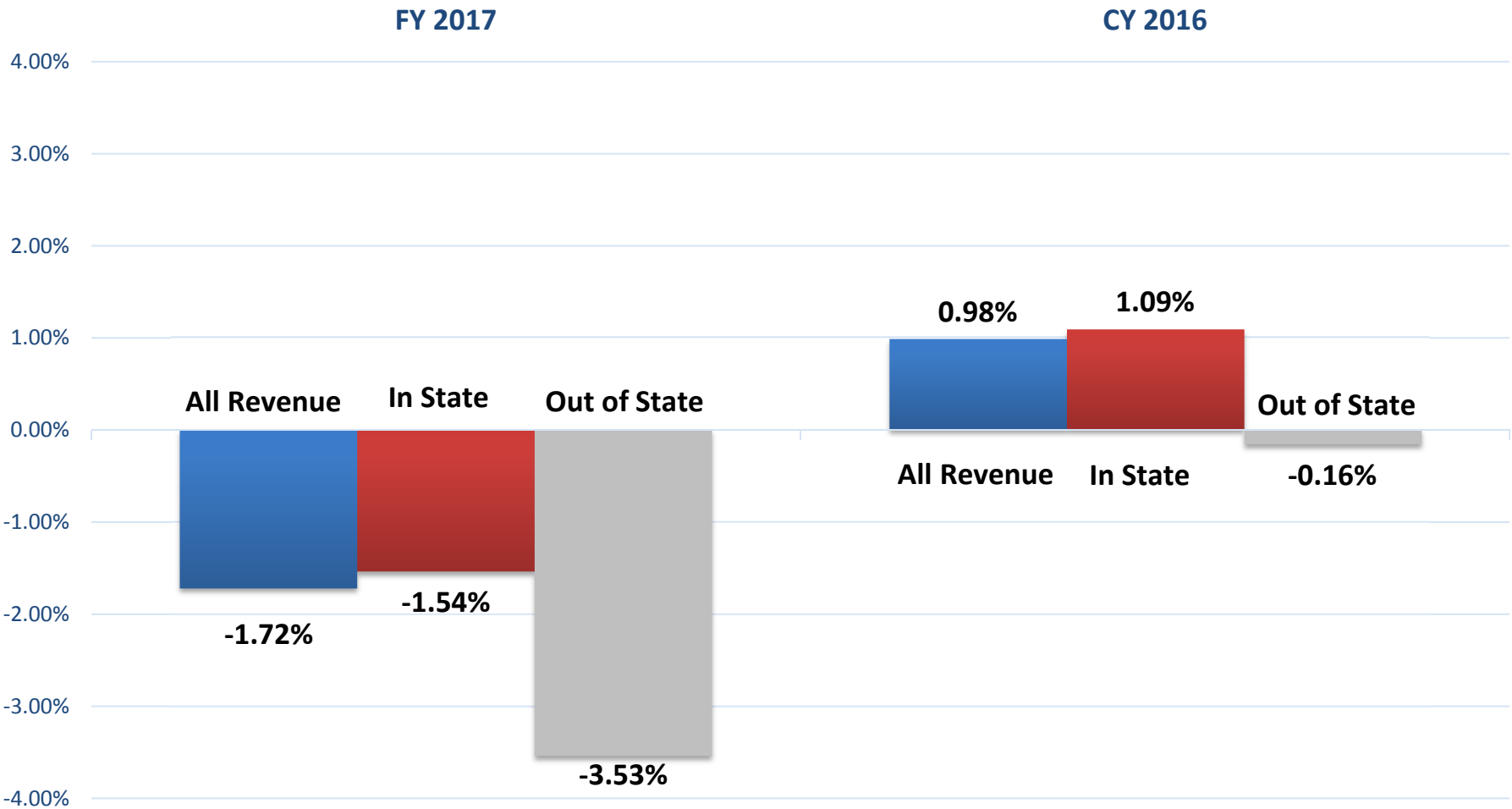
Monitoring Maryland Performance

Financial Data

Year to Date thru August 2016

Gross All Payer Revenue Growth

Year to Date (thru August 2016) Compared to Same Period in Prior Year



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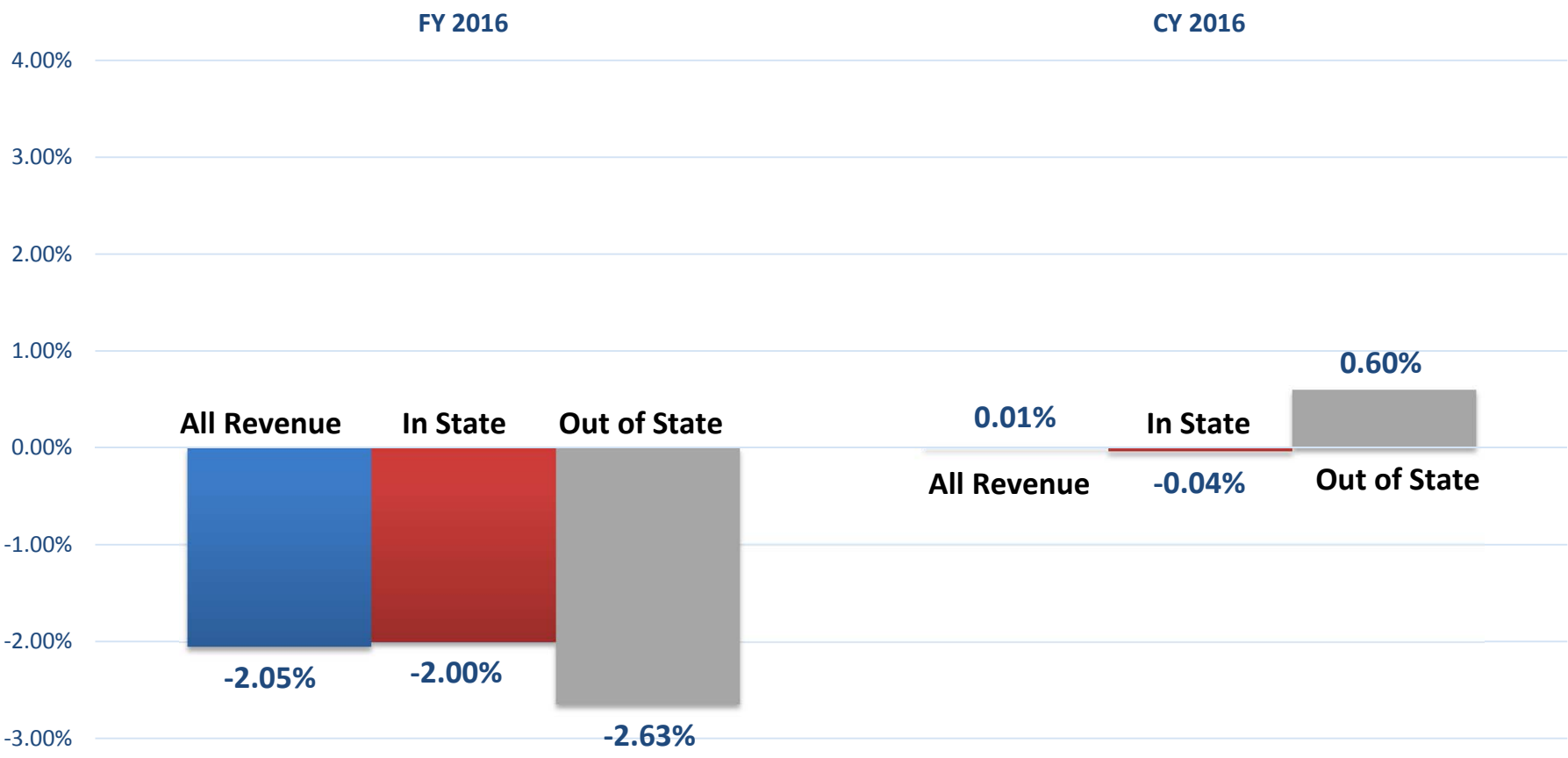
Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru August 2016) Compared to Same Period in Prior Year



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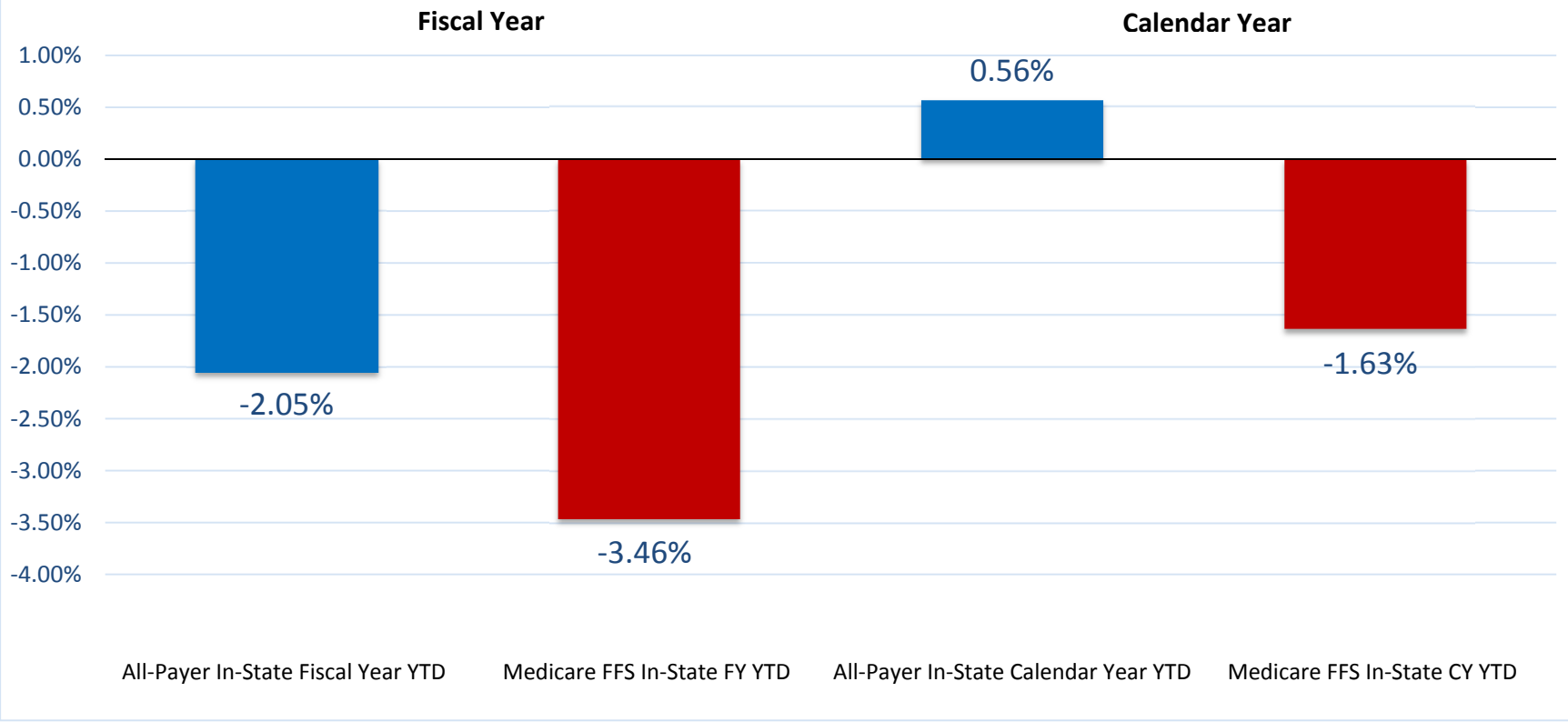
Per Capita Growth Rates

Fiscal Year 2017 (YTD Aug 2016 over YTD Aug 2015) and Calendar Year 2016 (Jan-Aug 2016 over Jan- Aug 2015)



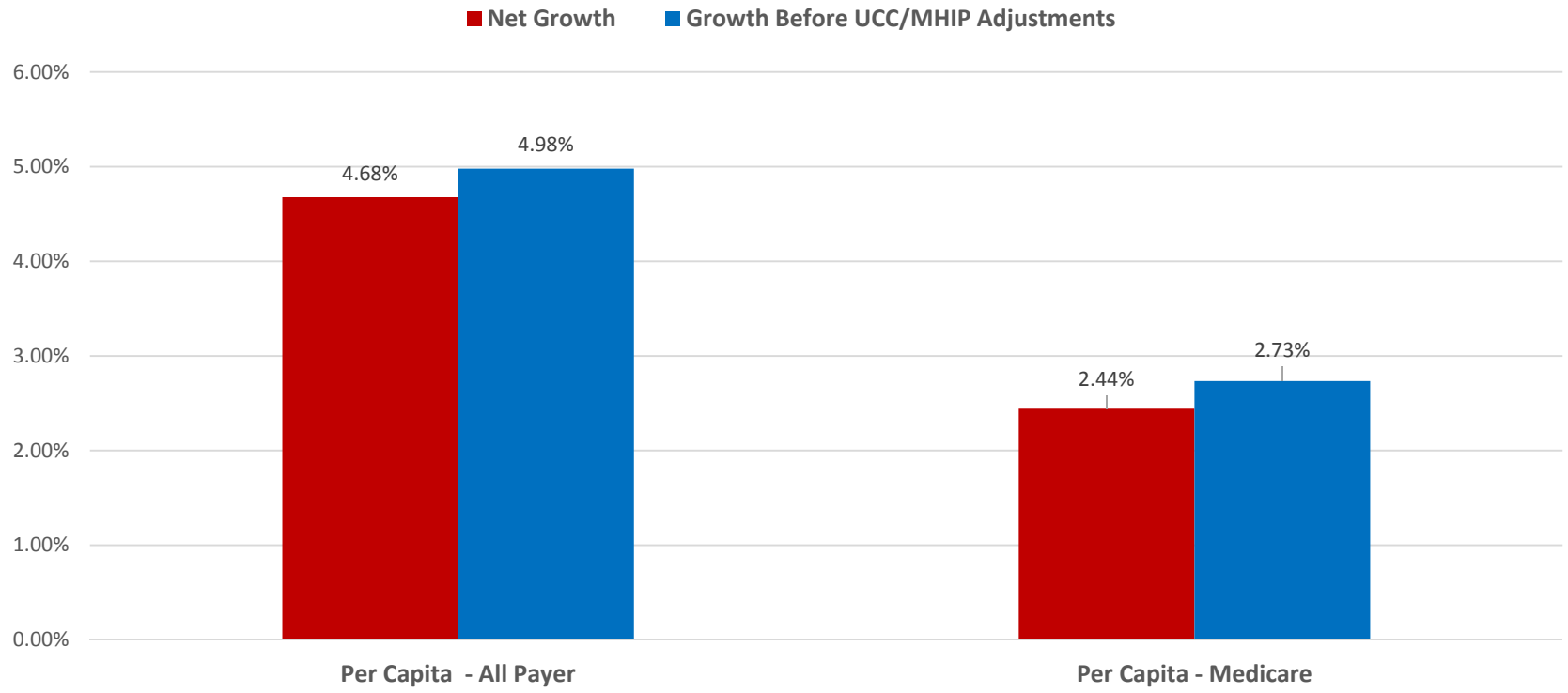
- **Calendar and Fiscal Year trends through August are below All-Payer Model Guardrail of 3.58% per year for per capita growth.**

FFS = Fee-for-Service

Population Data from Estimates Prepared by Maryland Department of Planning

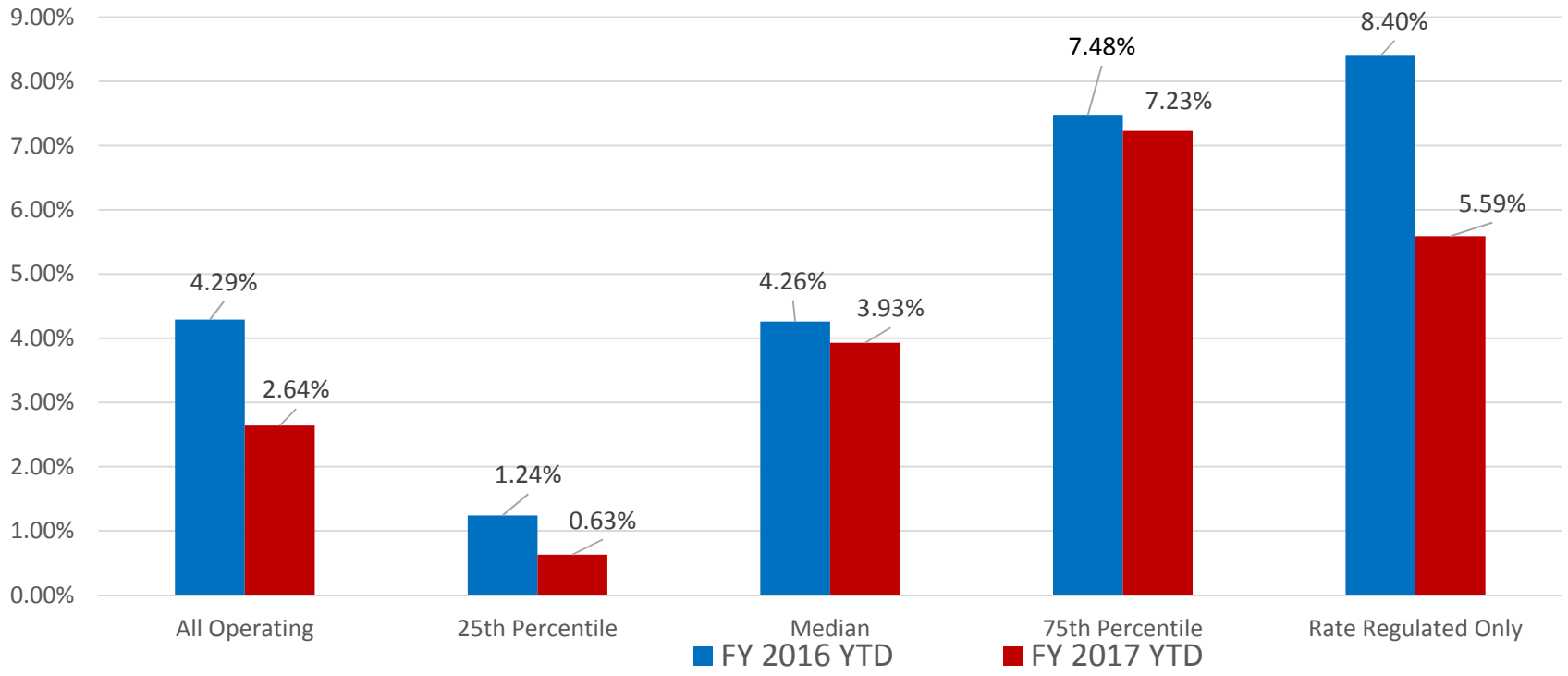
Per Capita Growth – Actual and Underlying Growth

CY 2016 Year to Date (Jan-Aug) Compared to Same Period in Base Year (2013)



- Three year per capita growth rate is well below maximum allowable growth rate of 11.13% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY16 revenue decreases that were budget neutral for hospitals. 2.52% hospital bad debts and elimination of MHIP assessment.

Total Operating Profits FYTD 2016 vs FYTD 2017
(July-August)



- FY 2017 unaudited hospital operating profits show a decline of 1.64 percentage points in total profits compared to the same period in FY 2016. Rate regulated profits have declined by 2.81 percentage points compared to the same period in FY 2016.

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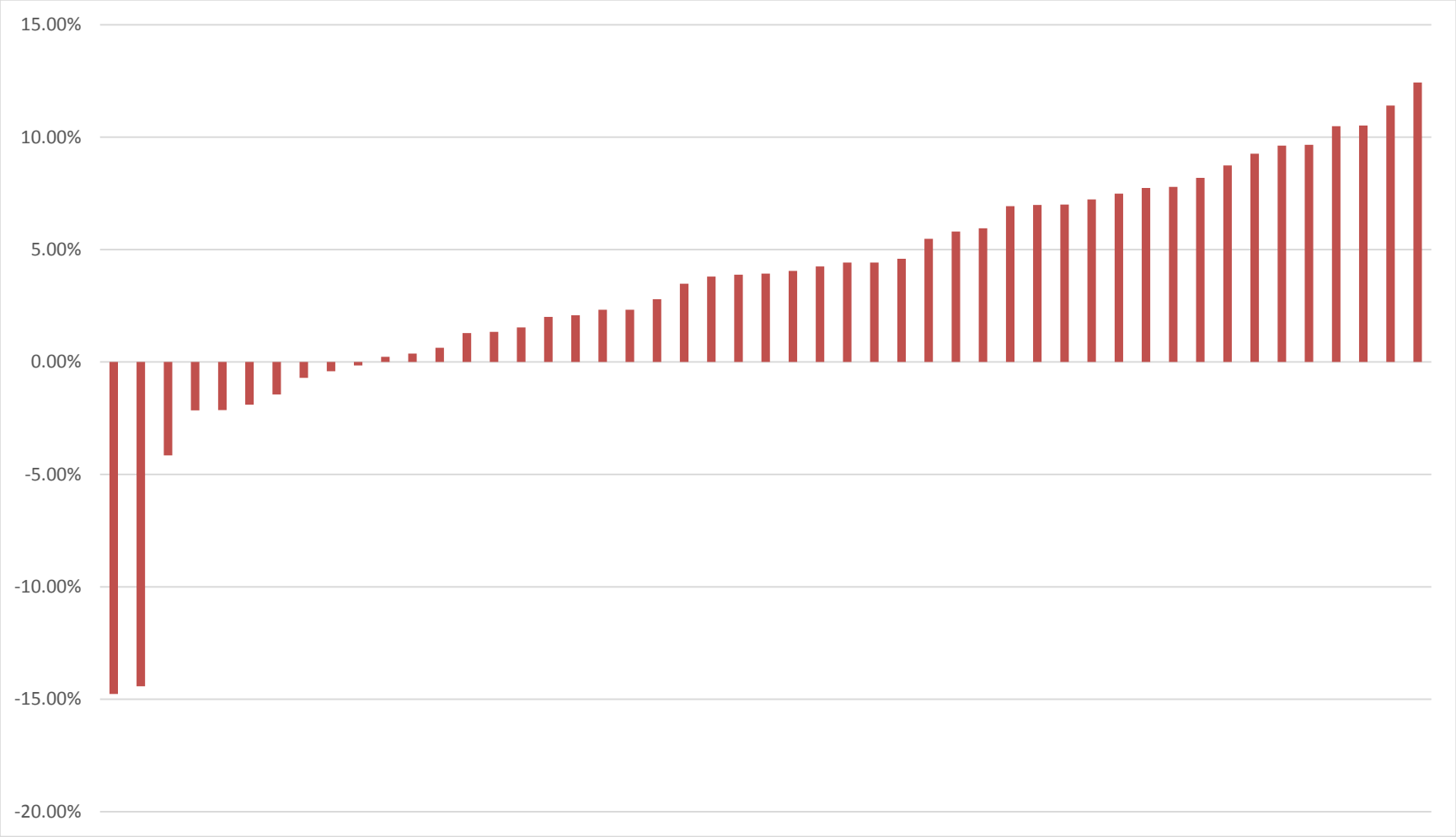
Total Operating Profits by Hospital

Fiscal Year 2017 to Date (Jul-Aug 2016)



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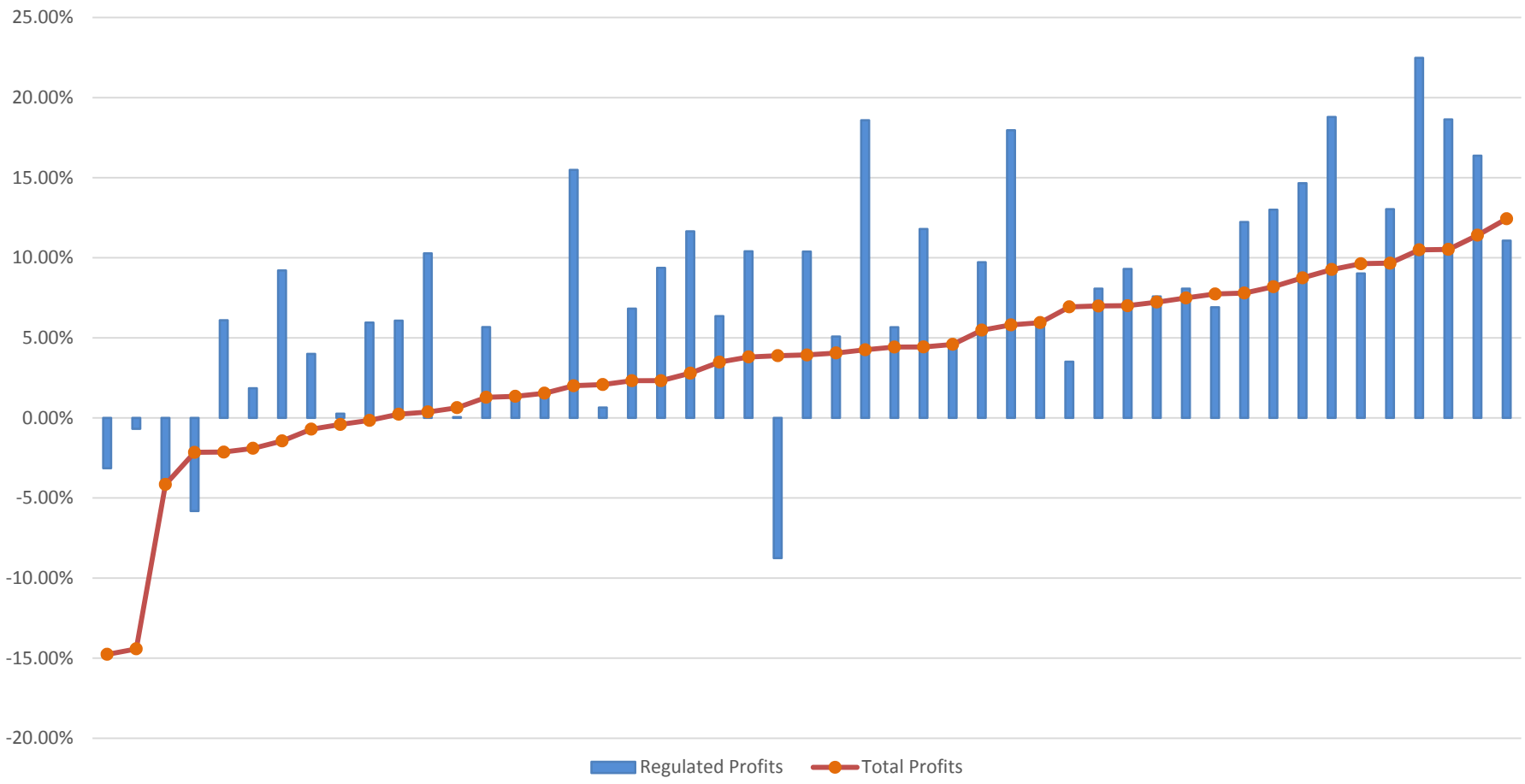
Regulated and Total Operating Profits by Hospital

Fiscal Year 2017 to Date (Jul-Aug 2016)



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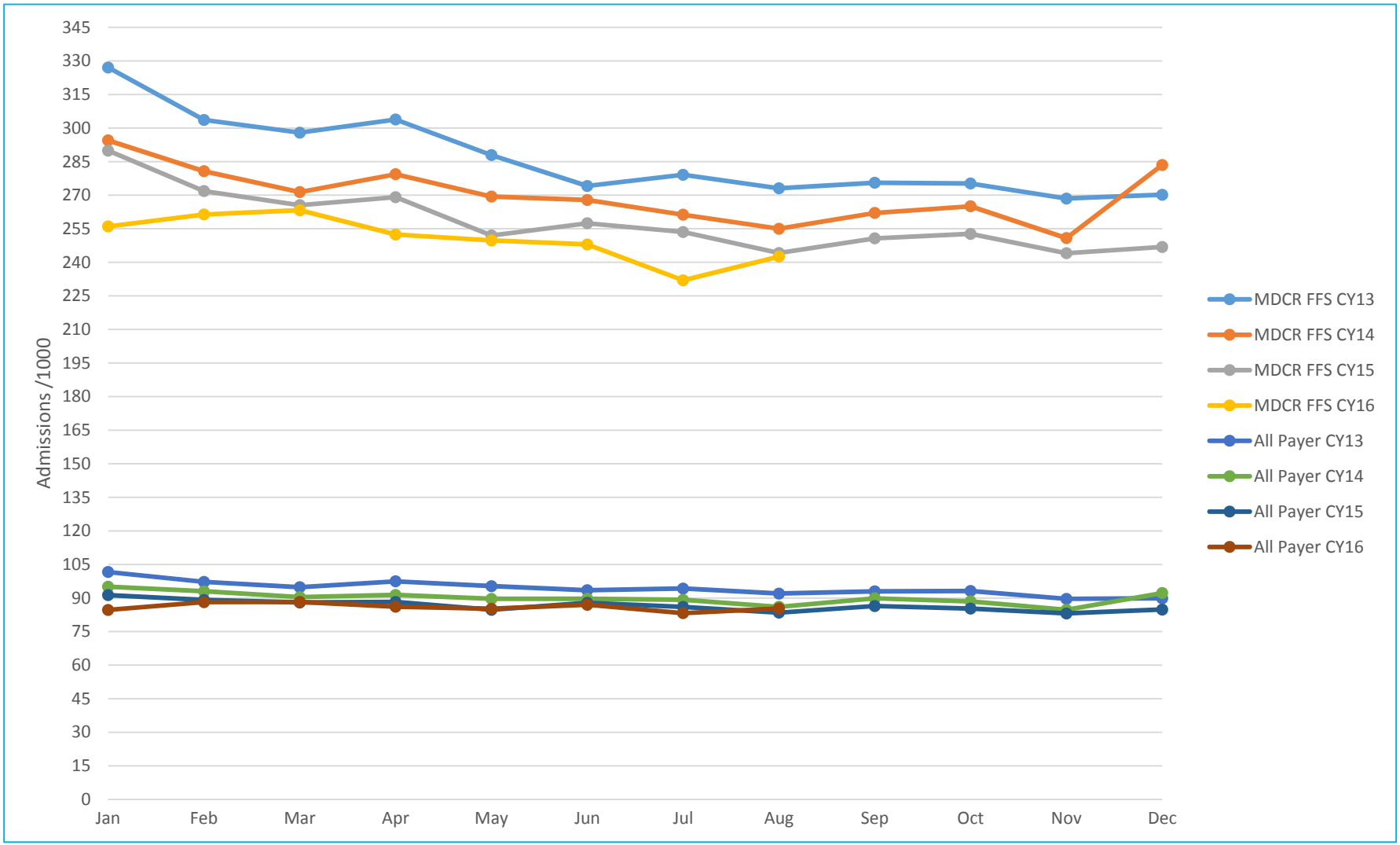
Annual Trends for Admissions/1000 (ADK) Annualized Medicare FFS and All Payer (CY 2013 through CY 2016 YTD)



*Note – The admissions do not include out of state migration or specialty psych and rehab hospitals

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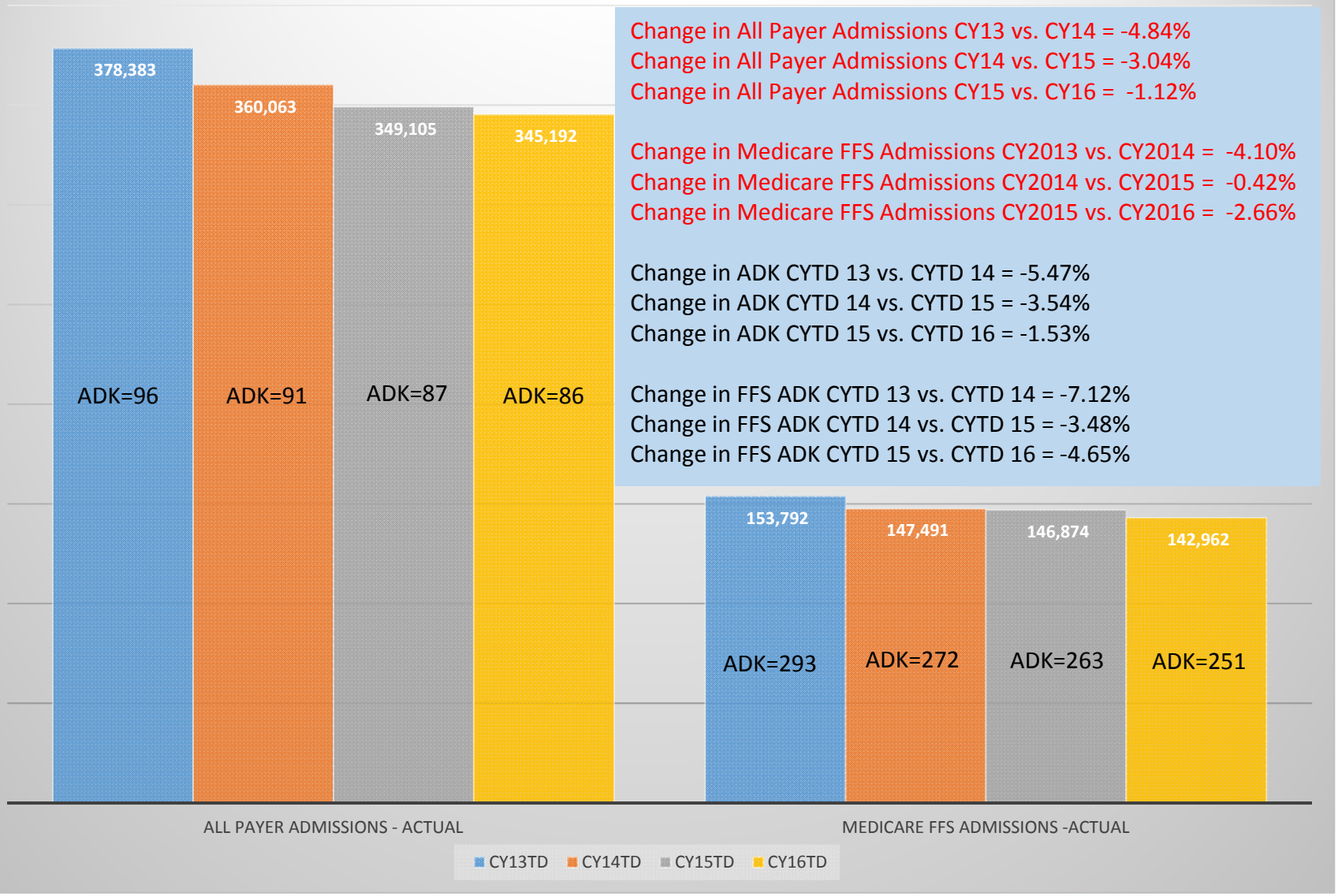
Actual Admissions by Calendar Year to Date through August



Change in All Payer Admissions CY13 vs. CY14 = -4.84%
Change in All Payer Admissions CY14 vs. CY15 = -3.04%
Change in All Payer Admissions CY15 vs. CY16 = -1.12%

Change in Medicare FFS Admissions CY2013 vs. CY2014 = -4.10%
Change in Medicare FFS Admissions CY2014 vs. CY2015 = -0.42%
Change in Medicare FFS Admissions CY2015 vs. CY2016 = -2.66%

Change in ADK CYTD 13 vs. CYTD 14 = -5.47%
Change in ADK CYTD 14 vs. CYTD 15 = -3.54%
Change in ADK CYTD 15 vs. CYTD 16 = -1.53%

Change in FFS ADK CYTD 13 vs. CYTD 14 = -7.12%
Change in FFS ADK CYTD 14 vs. CYTD 15 = -3.48%
Change in FFS ADK CYTD 15 vs. CYTD 16 = -4.65%

*Note – The admissions do not include out of state migration or specialty psych and rehab hospitals

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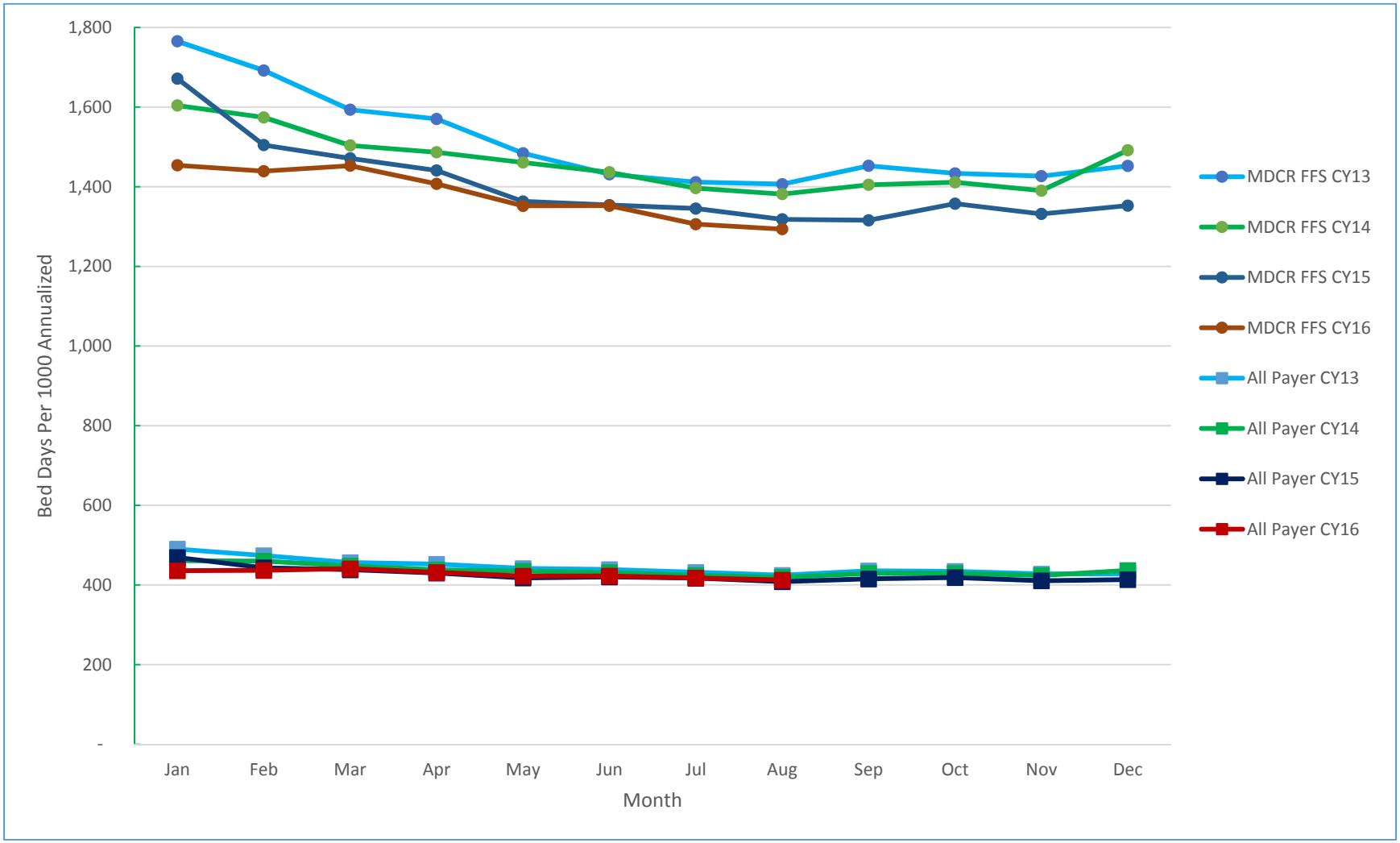
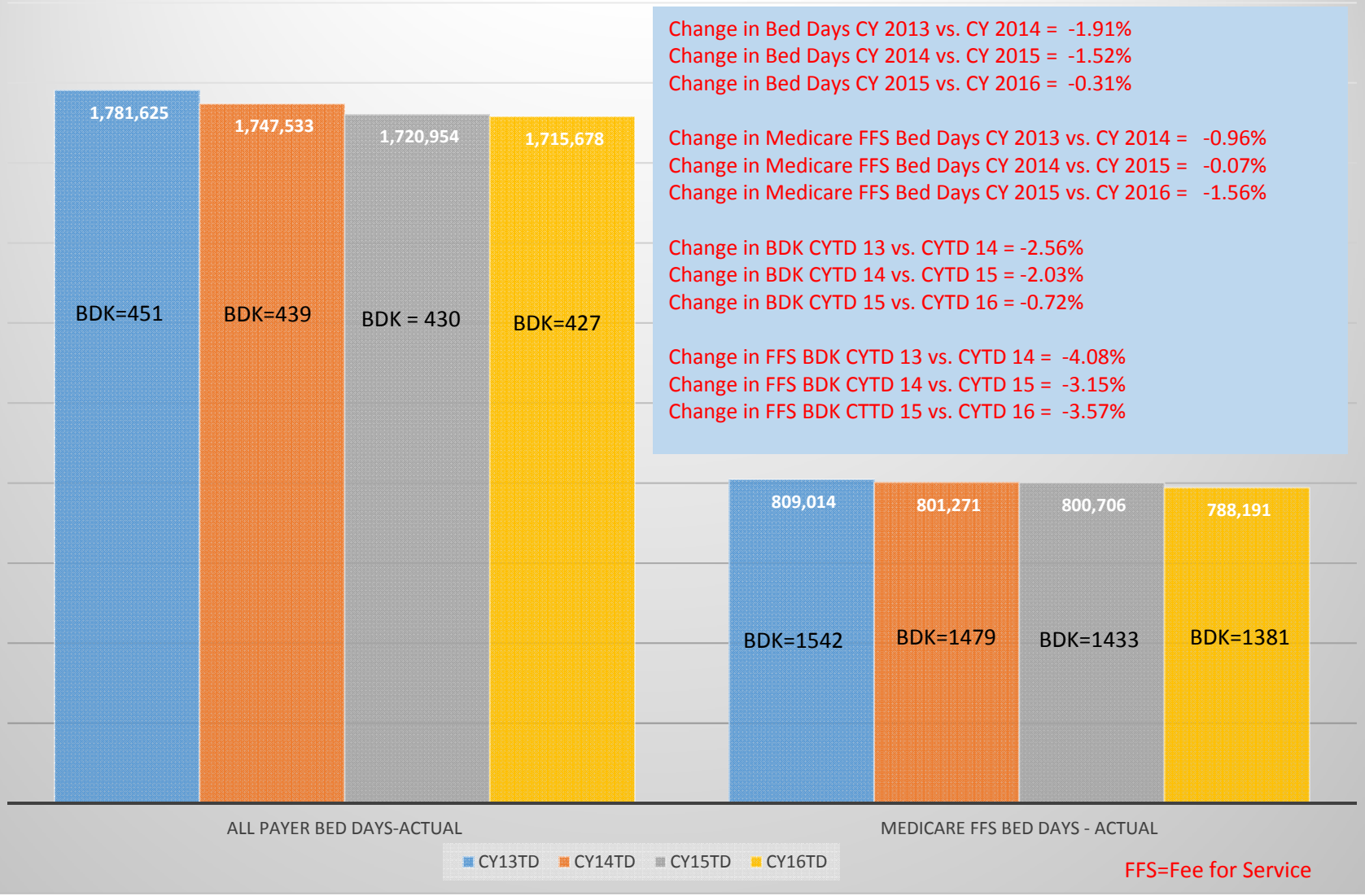
Annual Trends for Bed Days/1000 (BDK) Annualized Medicare FFS and All Payer (CY 2013 through CY 2016 YTD)



*Note – The bed days do not include out of state migration or specialty psych and rehab hospitals.

Actual Bed Days by Calendar Year to Date through August 2016



Change in Bed Days CY 2013 vs. CY 2014 = -1.91%
Change in Bed Days CY 2014 vs. CY 2015 = -1.52%
Change in Bed Days CY 2015 vs. CY 2016 = -0.31%

Change in Medicare FFS Bed Days CY 2013 vs. CY 2014 = -0.96%
Change in Medicare FFS Bed Days CY 2014 vs. CY 2015 = -0.07%
Change in Medicare FFS Bed Days CY 2015 vs. CY 2016 = -1.56%

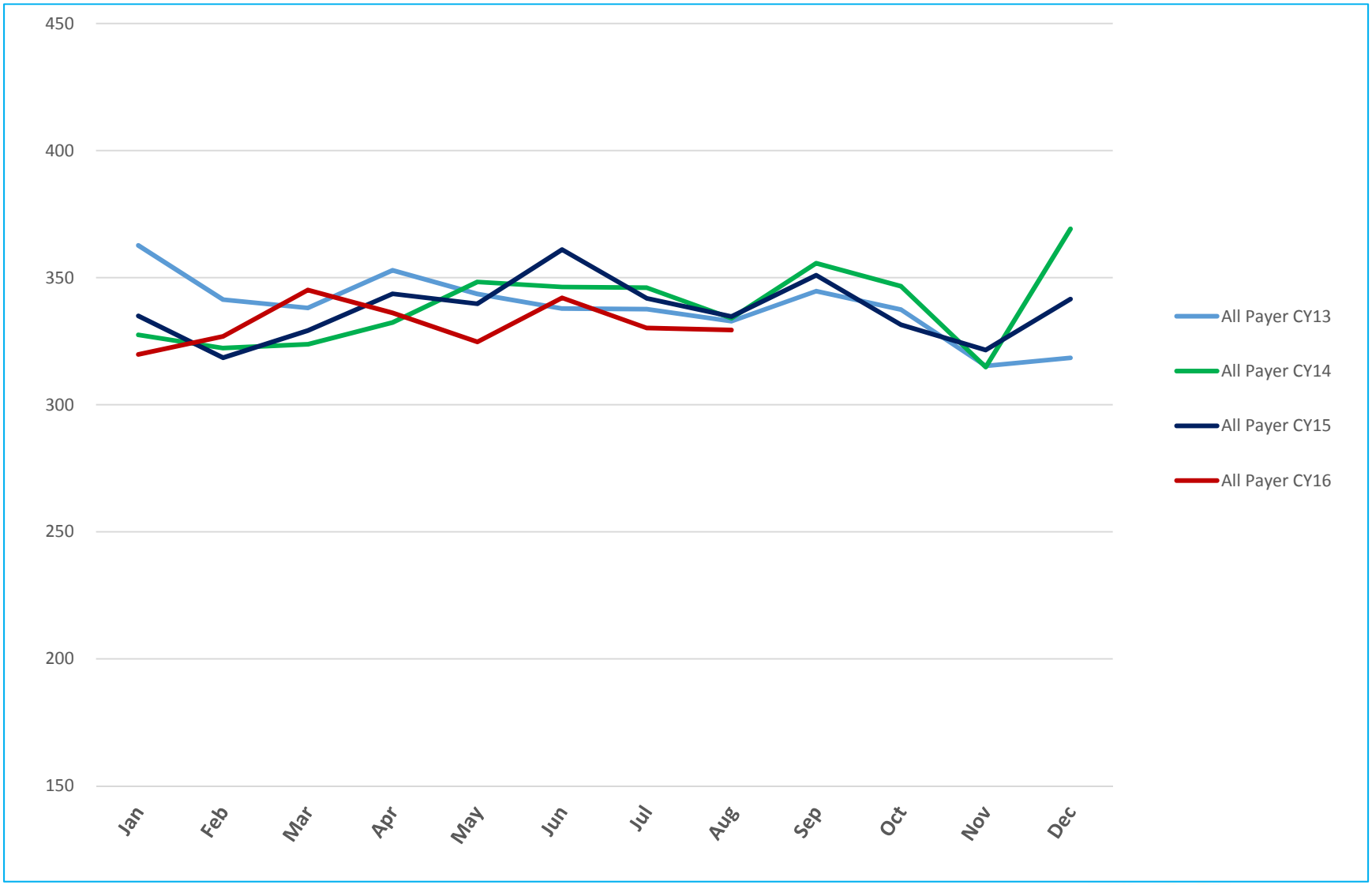
Change in BDK CYTD 13 vs. CYTD 14 = -2.56%
Change in BDK CYTD 14 vs. CYTD 15 = -2.03%
Change in BDK CYTD 15 vs. CYTD 16 = -0.72%

Change in FFS BDK CYTD 13 vs. CYTD 14 = -4.08%
Change in FFS BDK CYTD 14 vs. CYTD 15 = -3.15%
Change in FFS BDK CTTD 15 vs. CYTD 16 = -3.57%

FFS=Fee for Service

*Note – The bed days do not include out of state migration or specialty psych and rehab hospitals.

Annual Trends for ED Visits /1000 (EDK) Annualized All Payer
(CY2013 through CY2016 YTD)



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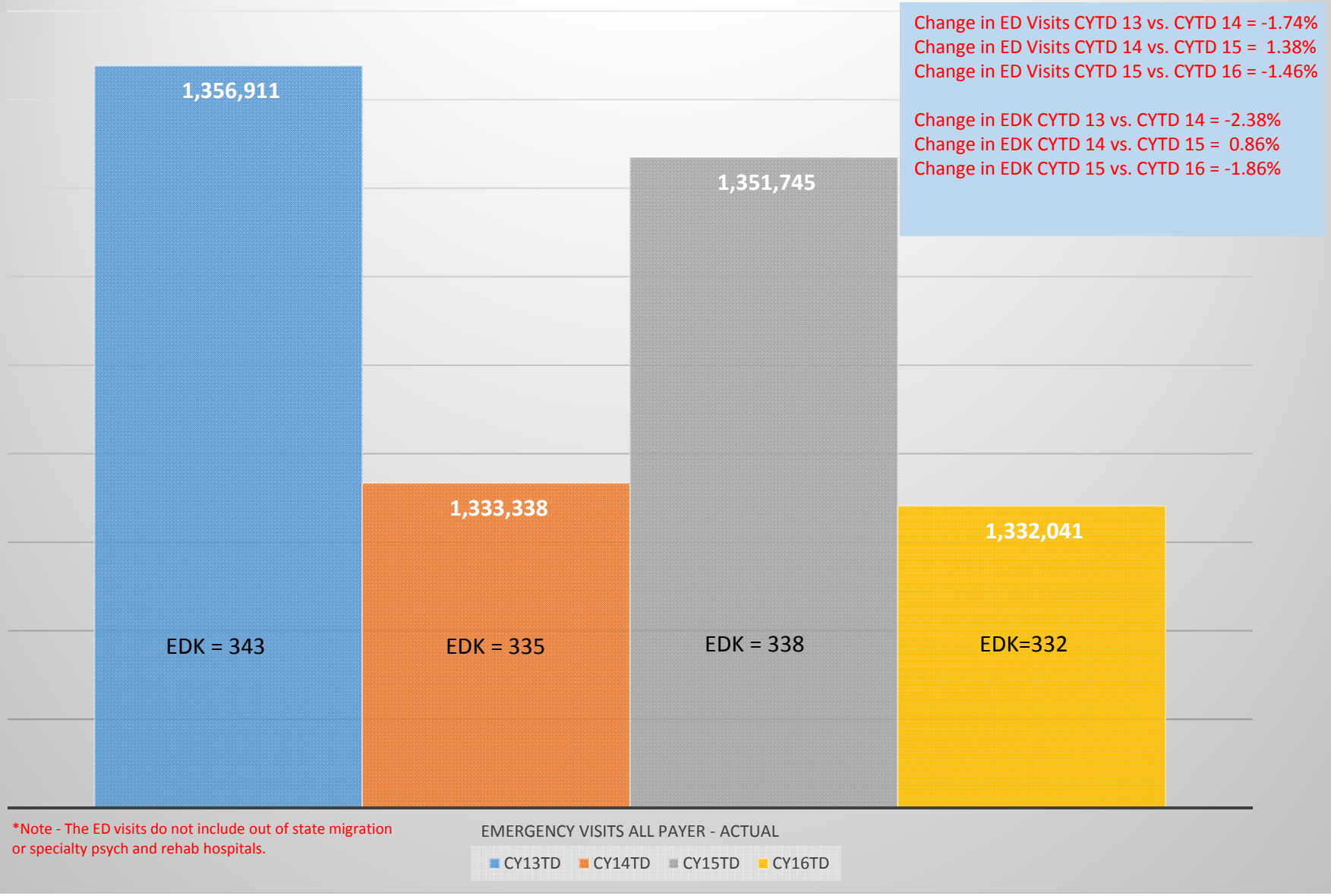
Actual ED Visits by Calendar YTD through August 2016



*Note - The ED visits do not include out of state migration or specialty psych and rehab hospitals.

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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 2016 rely on Maryland Department of Planning projections of population growth of .52% for FY 16 and .52% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

Data Caveats cont.

- The source data is the monthly volume and revenue statistics.
- ADK – Calculated using the admissions multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- BDK – Calculated using the bed days multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- EDK – Calculated using the ED visits multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- All admission and bed days calculations exclude births and nursery center.
- Admissions, bed days, and ED visits do not include out of state migration or specialty psych and rehab hospitals.

Final Recommendation for Population Health Workforce Support for Disadvantaged Areas Program Awards

Baltimore Population Health Workforce Collaborative

10/19/2016

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Background

- In December 2015, the Commission authorized up $10 million in hospital rates for hospitals that commit to train and hire workers from geographic areas of high economic disparities and unemployment.
- These workers will fill new care coordination, population health, health information exchange, health information technology, consumer engagement, and related positions.
- The program will continue through June 30, 2018, on a hospital-specific basis assuming the hospital's ongoing compliance with the grant requirements. The grants could continue July 1, 2018, if, after evaluation, the Commission finds that the program is effective.

Review Process

- Commission hired a contractor to facilitate the review process, as well as the evaluation process.
- Review Committee comprised of DHMH, HSCRC, and Subject-Matter Experts
- The review committee received three applications by the submission date of June 30, 2016
- Commission required a 50% match of the amount requested to be included in rates.

Preference

- The Review Committee gave preference to those proposals that included the following features:
  - The likelihood that the proposed programs would be successful in reducing avoidable utilization and improving population health
  - The operational readiness and sustainable staffing detail of the proposal
  - The overall feasibility of the proposal to be successful
- The Commission approved the Garrett Regional Hospital proposal during the September Commission Meeting
- The Baltimore Collaborative revised their original proposal to:
  - increase the number of jobs hired
  - reduce the ratio of trained to hired
  - Requesting approval of this as Phase I with opportunity to propose Phase II

Revised Baltimore Population Health Workforce Collaborative

- A consortium of four major health systems that includes nine hospitals proposes to train and hire individuals from high poverty communities in the Baltimore Metropolitan area to be community healthcare workers (CHWs), peer outreach specialists (PRSs), and certified nursing /geriatric nursing assistants (CNAs/GNAs).
- They propose to partner with the Baltimore Alliance for Careers in Healthcare (BACH), which will coordinate the recruitment and training of individuals from the community.
- They will also target hospital employees from "high poverty communities" to train and promote them to positions with a "career ladder."
- In the revised proposal they will screen, select, and train 444 individuals in essential skills over three years. Of these individuals, 263 will be trained as CHWs, PRSs, or CNAs/GNAs.
- The applicant projected that of those technically trained 208 will be hired by the hospitals.

Recommendations

Applicant	Revised Award Request	Rate Award Amount	Hospital(s) in Proposal
BPHWC Phase I	$6,675,666	$6,675,666	Johns Hopkins Hospital Johns Hopkins – Bayview LifeBridge Health Sinai Hospital MedStar Franklin Square Medical Center MedStar Harbor Hospital MedStar Good Samaritan Hospital MedStar Union Memorial Hospital University of Maryland Medical Center University of Maryland – Midtown Campus
Sinai Hospital (Safe Streets)	N/A	$200,000	LifeBridge Health Sinai Hospital
Total		$6,875,666	

Conditions

- In Phase I, provide $6,675,666 to be awarded and phased in over three years
- Require a match of at least $3,337,833
- With the resurgence of violence in Baltimore City, HSCRC staff recommends that $300,000 be added to the Sinai portion of the proposal to expand the Safe Streets Program by one additional "pod." Sinai Hospital shall contribute $100,000 of the $300,000. Individuals hired to support this program shall be from disadvantaged areas as defined in the RFP
- Authorize Commission staff to review and approve a second phase of funding provided that BPHWC:
  - Meets the letter and spirit of the RFP
  - The total amount provided in rates to all hospitals (including the amount approved for Garrett Regional Hospital) does not exceed $10 million when fully phased in by FY 2019

Reporting and Evaluation

- Hospitals receiving funding under this program shall report to the Commission periodically, including annual reports beginning in the spring of 2017.
- The contractor shall evaluate the effectiveness of the program prior to July 1, 2018, and Staff shall make a recommendation to the Commission on whether the program should be continued in general, or for individual hospitals.

QBR Program FY 2019
Draft Recommendation

10/19/16 Commission Meeting

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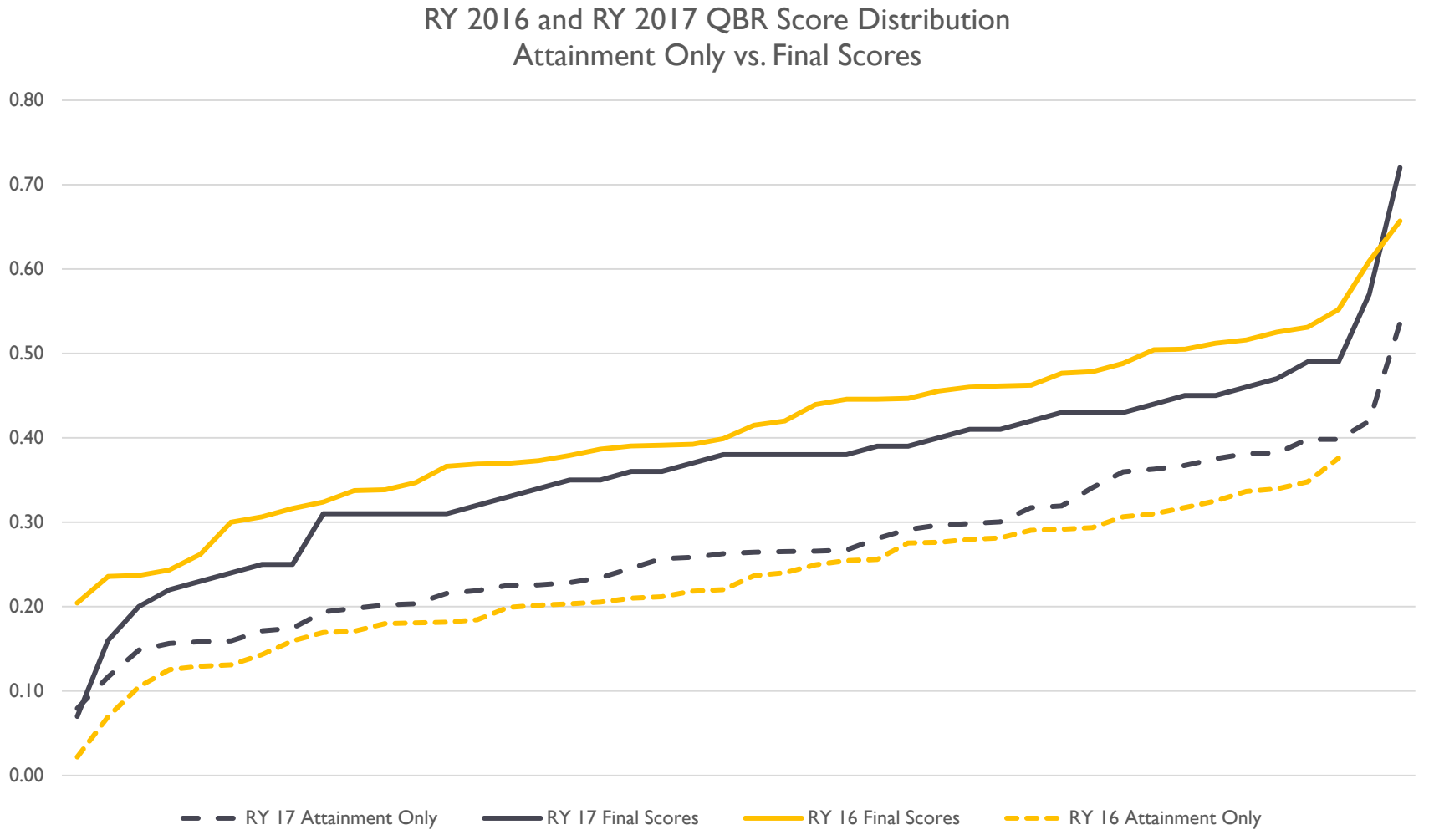
RY 2017 QBR Program: Statewide Performance

- **HCAHPS (weighted 45%)-**
  - Scores lowest for this domain
  - Statewide performance lags behind the nation for both base and performance periods, and gap widened slightly (now at 6.5%)
- **Safety (weighted 35%)-**
  - Scores second lowest for this domain
  - Statewide performance better relative to the national average of 1 for 4 of 5 CDC infection measures
- **Mortality (weighted 5%)-**
  - Statewide performance on all-cause inpatient QBR measure improved
  - Statewide performance on three condition-specific 30-day VBP measures slightly better than the nation and improved from the base year
- **Clinical Care Process (weighted 15%)-**
  - For VBP, weighting for these measures=5% of total score, domain retired for RY 2018
  - Performance on PC 01 measure (moved to Safety domain for RY 2018) declined and worse than the nation, (NOTE: need to validate measure results)
  - Statewide scores highest for this domain

QBR RY 2016 and Ry 2017 Score Comparison



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QBR Draft Recommendations

- Adjust retrospectively the RY 2017 and RY 2018 QBR preset scale for determining rewards and penalties such that the scale takes into account attainment and improvement trends.
- For RY 2019, use the preset scale based on RY 2017 final scores.
- Continue to use the domain weights set for RY 2018

	Clinical Care	Patient Community Engagement	Safety	Efficiency
CMS VBP (proposed)	25% -3 measures: condition-specific mortality	25% -HCAHPS + CTM	25% -CDC infection, PSI, PC01	25% spending per bene
QBR (Draft)	15% - all cause inpatient mortality	50% HCAHPS + CTM	35% - CDC infection, PSI (Suspended?), PC01	N/A

- Continue to set the maximum penalty at two percent and the maximum reward at one percent of approved hospital inpatient revenue.

Draft Recommendation for Final Round of Transformation Implementation Grants

October 19, 2016

HSCRC
Health Services Cost Review Commission

Background

- In June 2015, the Commission authorized up to 0.25% of total hospital rates to be allocated to deserving applicants under a competitive Healthcare Transformation Implementation Grant Program.
  - "Shovel-ready" projects that generate short-term ROI and reduced Medicare PAU
  - Involve community-based care coordination and provider alignment and not duplicate care transitions and prior infrastructure funding
- The RFP was released on August 28, and applications were submitted by COB December 21, 2015
- HSCRC received 22 proposals from single- or multiple-hospital applicants, addressing needs of particular regions

Review Process

- Review Committee comprised of DHMH, HSCRC, and Subject-Matter Experts
- Extensive review process evaluating several different criteria (detailed in report on page 2-3) including having the best opportunity to help Maryland on achieving the goals of the All-Payer Model
- In June, the Commission approved $30.6 million for round 1 of Implementation grants leaving $6.4 million

Re-convening of Review Committee

- Commission agreed to conduct a second review to provide partial funding based on:
  - Individual projects that are efficacious
  - Support promising regional partnerships
- Review Committee reconvened to consider:
  - Specific promising programs within remaining proposals
  - Compelling community-based regional partnerships
  - Programs to address underserved geographic areas
  - Reduction of TCOC

Recommendations

Partnership Group Name	Award Request	Award Recommendation	Hospital(s) in Proposal - Purpose of Award
Calvert Memorial	$ 361,927.00	$ 360,424.00	Calvert Memorial Hospital
Lifebridge Health System	$ 6,751,982.00	$ 1,350,396.00	Carroll Hospital Northwest Hospital Sinai Hospital - 24-hour call center/care coordination hub - Efforts to enable seniors to age in place - Tele-psychiatry capability expansion
Peninsula Regional	$ 3,926,412.00	$ 1,570,565.00	Atlantic General Hospital McCready Memorial Hospital Peninsula Regional Medical Center - Inter-Hospital Care Coordination Efforts - Patient Engagement and Activation Efforts - Crisfield Clinic - Wagner Van
Totally Linking Care – Southern MD	$ 6,211,906.00	$ 1,200,000.00	Calvert Memorial Hospital Doctor's Community Hospital Fort Washington Medical Center Laurel Regional Hospital MedStar Southern Maryland Hospital MedStar St. Mary's Hospital Prince George's Hospital Center - Support the continuation of the regional partnership - Reinforce care coordination with special focus on medication management - Support physician practices providing care to high-needs patients
West Baltimore Collaborative	$ 9,902,774.00	$ 1,980,555.00	Bon Secours Hospital St. Agnes Hospital University of Maryland Medical Center UMMC – Midtown Campus - Patient-related expenditures - Care Management Teams, particularly focused on primary care - Collaboration and sharing resources with community providers
	$27,154,371.00	$ 6,461,940.00	

Next Steps

- The Review Committee has recommended the five additional proposals based on the review criteria totally $6.46 million.
- HSCRC will monitor the implementation of the awarded grants through additional reporting requirements.
- HSCRC is also recommending that a schedule of savings be remitted to payers through the global budget on the following schedule.
  - (Savings represent the below percentage of the award amount)

FY2018	FY2019	FY2020
10%	20%	30%

- The revised RFPs and summaries of the awardees will be posted on the HSCRC website.

HSCRC
FY 2015 Community Benefit Report Findings

Steve Ports, Principal Deputy Director

October 19, 2016

Findings from FY 2015 Summary Report

- FY15 – total of 53 hospitals: 48 acute and 5 specialty hospitals
  - (Holy Cross Germantown new hospital and Levindale categorized as an acute hospital rather than a specialty hospital)
- FY14 – total of 52 hospitals: 46 acute and 6 specialty hospitals
- Reported Total Community Benefits
  - FY 15 – $1.5 billion
  - FY 14 – $1.5 billion
- CBR Dollars as a Percentage of Hospital Operating Expenses
  - FY 15 – Ranging from 3.03% to 45.06% - total of 10.8%
  - FY 14 – Ranging from 2.61% to 27.46% - total of 10.6%
- Staff Hours Dedicated to CB
  - FY15 – Average 1,803 hours
  - FY 14– Average 1,514 hours

Offsetting Charity Care, DME, and NSPI

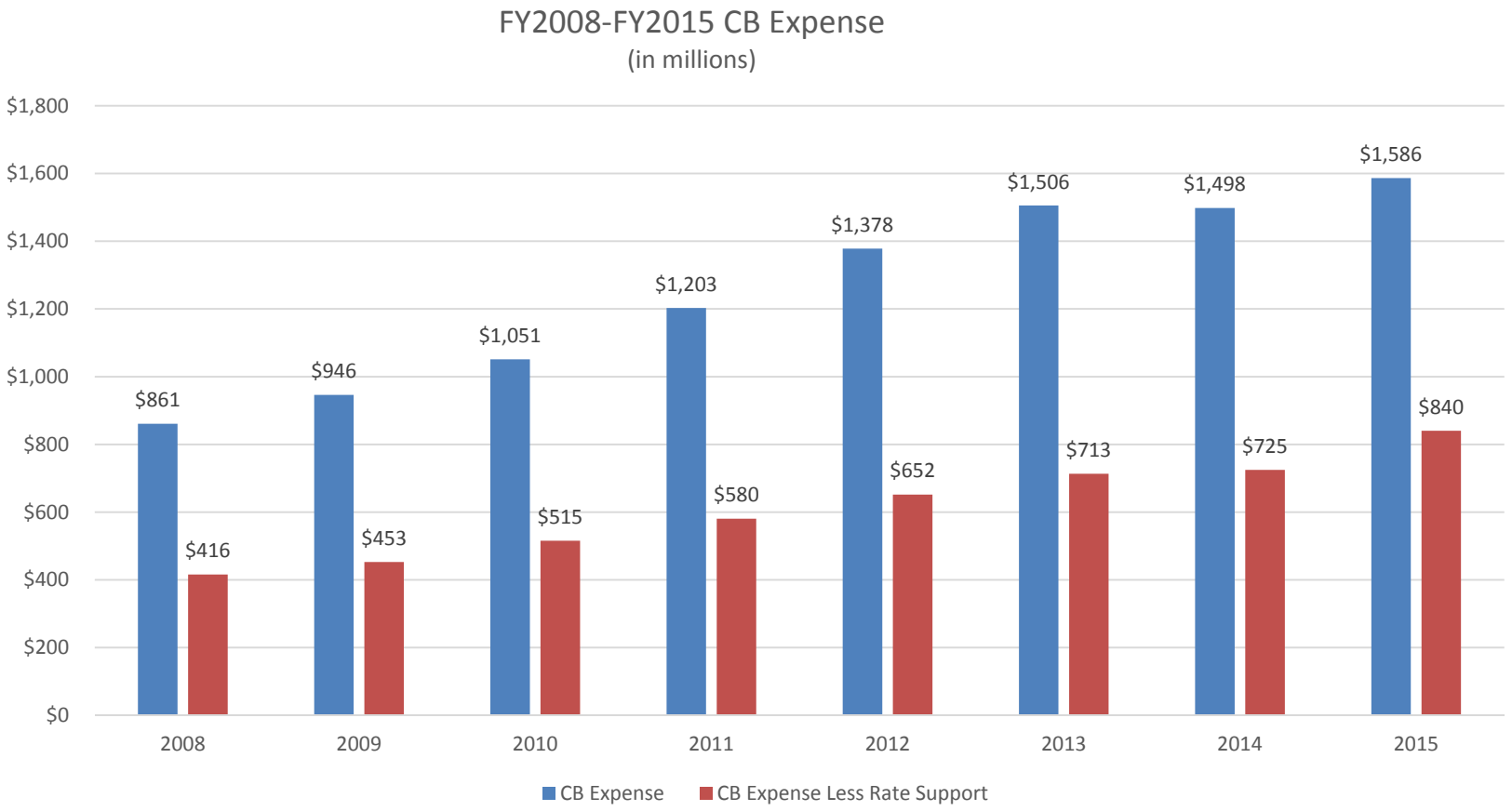
- 2015 Charity Care DME and NSPI Rate Funding:
  - Charity Care - $428.1 million
  - DME - $302.6 million
  - NSPI - $15.3 million

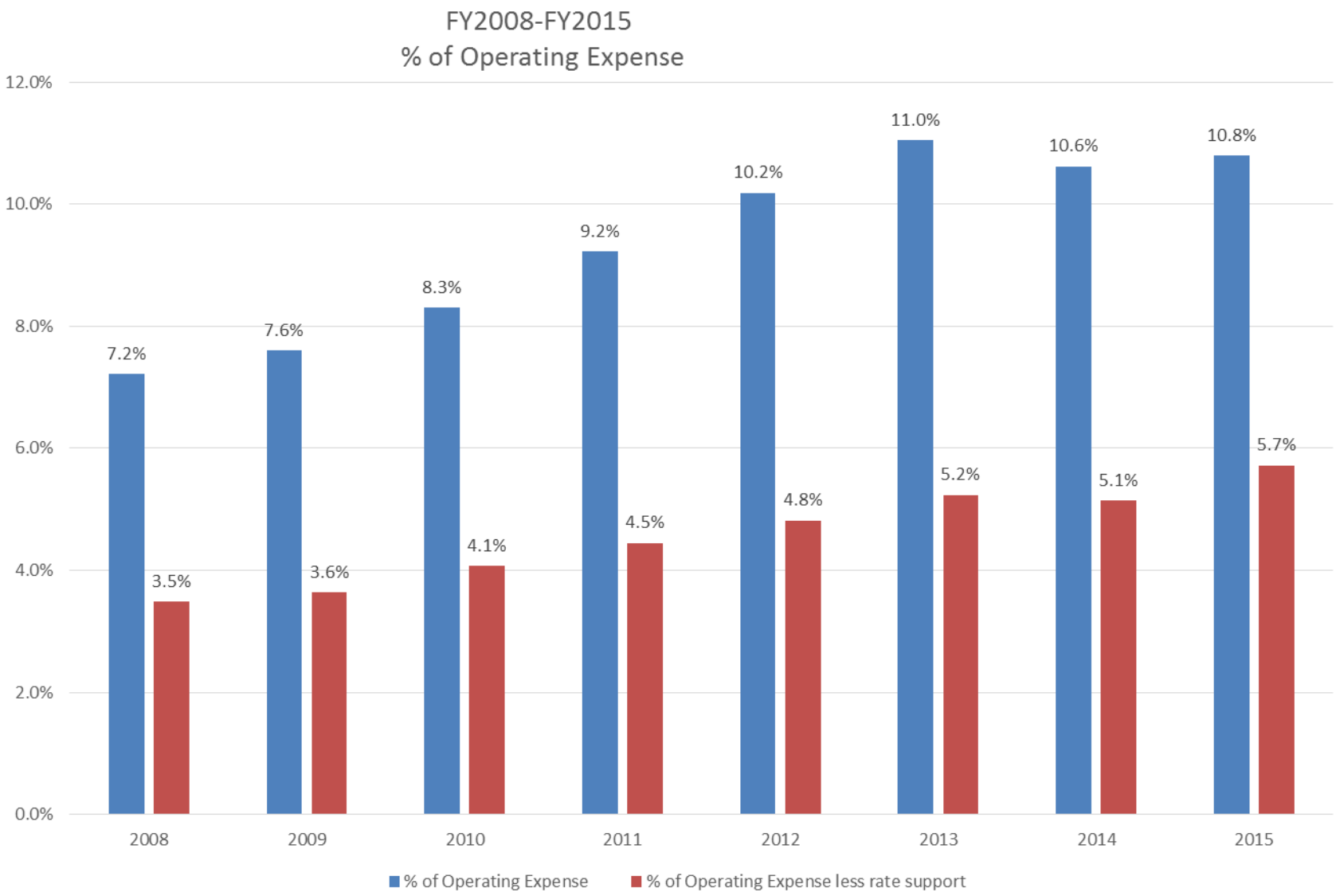
- Total Net Community Benefit Expenditures
  - 2015 - $840.3 million (5.72% of expenses)
  - 2014 - $724.7 million (5.14% of expenses)

- In FY 15 Hospitals provided $43.6 million more in Charity Care and Medicaid expansion services than was provided in rates.
  - Charity Care - $362.6 million
  - ACA Medicaid expansion services - $109.1 million in expanded utilization by formerly uninsured and underinsured population, not included in hospitals' Global Budgets

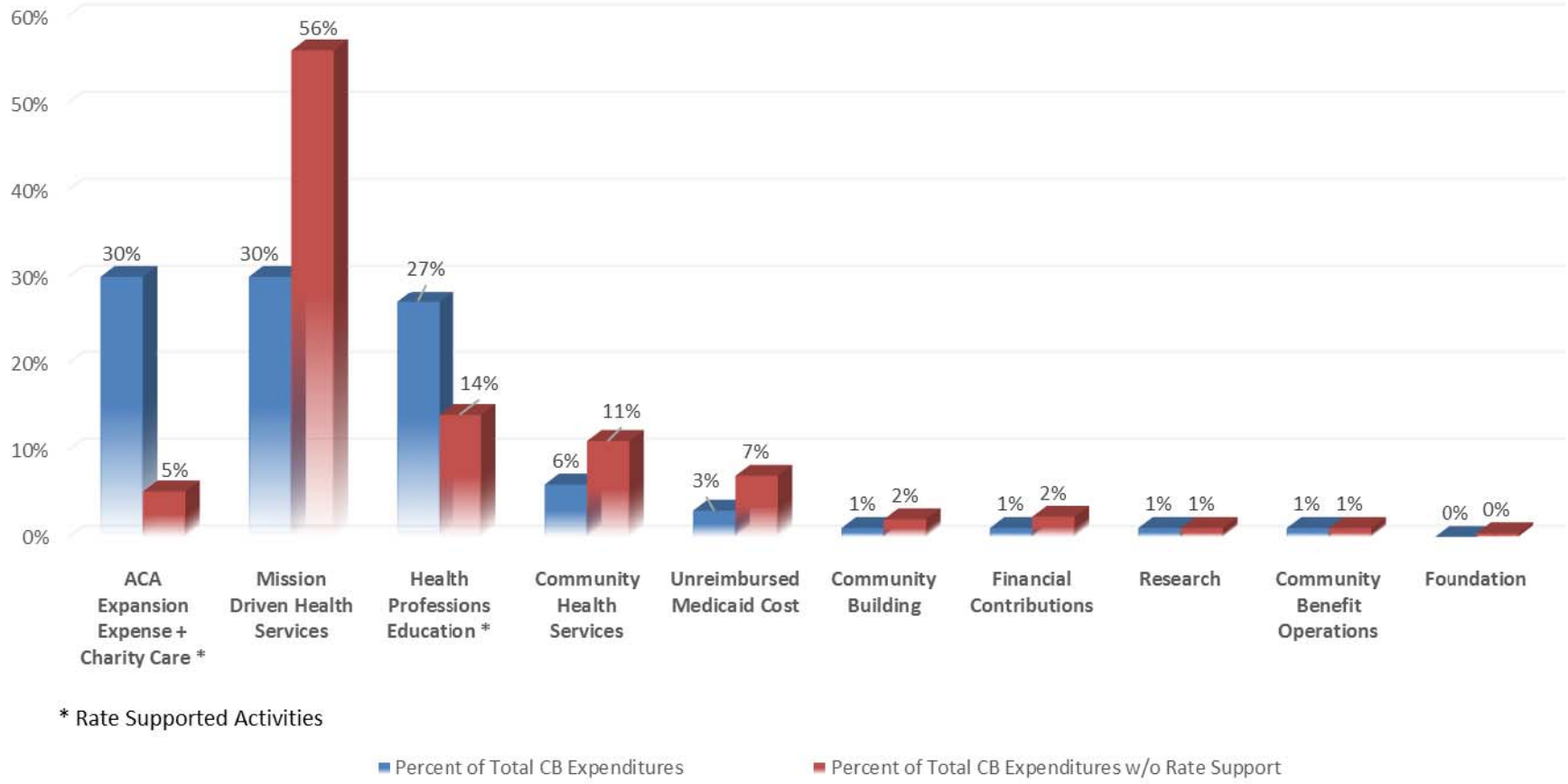
FY2008-FY2015 Community Benefit Expenditures

- Increase from $861 million to $1.5 billion




FY2008-FY2015
% of Operating Expense
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
7.2%
3.5%
7.6%
3.6%
8.3%
4.1%
9.2%
4.5%
10.2%
4.8%
11.0%
5.2%
10.6%
5.1%
10.8%
5.7%
2008
2009
2010
2011
2012
2013
2014
2015
% of Operating Expense
% of Operating Expense less rate support

FY15 PERCENT OF CB EXPENDITURES WITH AND WITHOUT RATE SUPPORT



Narrative Highlights

- Hospital defined ‘Community Benefit Service Area’ driven by following need related factors:
    - Prevalence of poverty
    - Infants with low birth weight
    - Specific diseases or conditions
    - Predominant areas of residence for charity care patients
    - Designation as a medically underserved area
- Primary Health Needs to be addressed by Community Benefit Initiatives:
    - Access to care
    - Behavioral health
    - Substance abuse/addiction
    - Obesity
    - Diabetes
    - Cancer
    - Heart disease/hypertension/stroke
    - Healthy lifestyle
- Primary Needs to be addressed that are associated with social determinants of health:
    - Housing
    - Economic factors
    - Access to healthy food
    - Employment
    - Advocacy
    - Education

Observations

- Dollars and effort toward CB has continued to grow in FY 2015
- Reductions in the percentage of charity care may impact the total amount invested in CB going forward
- The quality of the narrative reporting is getting better but still room for improvement
  - Describing information gaps impacting ability to assess needs of community
  - Describing process and methods to conduct CHNA's
  - Prioritizing community needs with criteria
  - Explanation of unmet needs
- HSCRC has contracted with the Hilltop Institute for three years:
  - Automate the collection and aggregation of the community benefit data
  - Align the reporting process with the federal standards wherever possible
  - Align the reporting with the "all payer model measures" wherever possible
  - Create community benefit report dashboards for public use