HEALTH SERVICES COST REVIEW COMMISSION
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508th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
May 14, 2014

EXECUTIVE SESSION
11:30 a.m.

1. Administrative Issues

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:30 p.m.

1. Review of the Minutes from the Executive Session and Public Meeting on April 9, 2014
2. Executive Director's Report
3. Status of Work Groups for All-Payer Hospital System Modernization
4. Report of Data and Infrastructure Work Group
5. Docket Status – Cases Closed
6. Docket Status – Cases Open
7. Draft Recommendation on Uncompensated Care Methodology and Primary Adult Care Program Impact for FY 2015
8. Draft Recommendation on Readmission Shared Savings for FY 2015
9. Draft Recommendation on a Balance Updates for FY 2015
10. Final Recommendation on Medicaid Current Financing for CY 2014
11. Draft Recommendation for FY 2015 Support for the Maryland Patient Safety Center
12. Report on FY 2015 CRISP Funding Support
13. Hearing and Meeting Schedule

Data and Infrastructure Work Group Report to the Commission:

Recommendations on Data Requirements for Monitoring the All-Payer Model

Health Services Cost Review Commission

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May 14, 2014

This document contains recommendations from the Data and Infrastructure Work Group for addressing the immediate data needs of all-payer model. The recommendations in this report are for discussion purposes and do not require formal action by the Commission.

I. Background

Beginning January 1, 2014, the State of Maryland ("Maryland") entered into a five-year all-payer demonstration with Center of Medicaid and Medicare Innovation (CMMI), in which Maryland agreed to the following specific targets in cost and quality of hospital care:

1. Maintain growth in Maryland acute hospital all-payer charge per capita, for Maryland residents, below 3.58%, the 10 year average of Maryland state GDP growth;

2. Maintain growth in acute hospital Medicare payment per Maryland beneficiary below the national average, resulting in at least $330m of savings by the end of five years;

3. Reduce the Medicare 30-day all-cause hospital readmission rate to below the national Medicare 30-day all-cause hospital readmission rate by the end of five years;

4. Achieve 30% aggregate reduction across all 65 Potentially Preventable Complications in Maryland's Hospital Acquired Conditions program in five years.

In light of these commitments, HSCRC convened four workgroups to make recommendations on implementation issues. One of the workgroups, Data and Infrastructure Workgroup ("Workgroup"), was charged[1] with making recommendations on the data and infrastructure requirements to support oversight and monitoring of the new hospital All-Payer Model. The workgroup considered the needs of the HSCRC, as well as, the needs of the health care industry and other stakeholders to achieve the goals of the model. The first task of the Workgroup was to make recommendations on data needed to:

- Support rate setting activities;
- Conduct evaluation activities using the key performance indicators;
- Monitor and evaluate model performance;
- Monitor shifts in care among hospitals and other providers; and
- Monitor the total cost of care.

This report includes recommendations on the best sources of data to meet the monitoring and compliance requirements of the new model. These initial recommendations are focused on the monitoring requirements included in the contract between Maryland and CMS and do not reflect the full range of data monitoring and infrastructure needs to achieve the goals of the new model. After considering the initial set of measures, the Workgroup in collaboration with other workgroups, will focus on the expanded performance measurement system and related infrastructure needs to support the broader goals of the model. In addition, the HSCRC will work with CMS to address the misalignment of the reporting requirement timelines because monitoring

[1] The Data and Infrastructure Workgroup was charged with making recommendations on: 1. data requirements, 2. Care Coordination Data and Infrastructure, 3. Technical and Staff Infrastructure, and 4. data sharing strategy

measures are due by June 30; however, data for most of the measures will be not be available until the summer or fall of the calendar year.

II. CMS Compliance and Monitoring Commitments

Appendix A contains a list of all measures to monitor the progress of the new All-Payer Model Demonstration. The measures in the list are grouped as follows:

Performance Target Data: This set of measures encompasses specific targets determined under the new model and will require close and timely monitoring of the data. HSCRC will provide the data on the All-Payer per capita test and Potentially Preventable Complications, while CMS will report results on Medicare per beneficiary hospital payments and readmissions.

Guardrails Data: In addition to performance targets, Maryland is committing to certain "guardrails" to ensure the success of the new model. These measures will be monitored and reported by the CMS and will trigger a review process if the conditions are not met.

Compliance Data: HSCRC is committing to collect and monitor these measures in the new model contract at least on an annual basis.

Monitoring Data: To monitor Maryland's progress in achieving the three-part aim (patient experience of care, population health measures, and hospital costs/efficiency measures) the new model contract identifies a set of measures in each domain. These domains and examples of these measures are as follows:

- Patient experience of care, such as patient satisfaction scores on HCAHPS
- Population health measures, such as rate of preventable utilization
- Hospital cost measures such as per capita total health care expenditures for all-payers, and efficiency of diagnostic imaging testing.

For more specific information on individual measures, please see Appendix A: "Monitoring Commitments and Gap Analysis."

III. Recommended Sources of Data and Gap Analysis

HSCRC staff reviewed the compliance documentation for the new All-Payer Model Demonstration and identified current available data sources for the majority of the data reporting and monitoring commitments. The Workgroup reviewed these data sources and provided feedback (please refer to Appendix A for the data sources identified for each compliance, guardrail or monitoring measure).

The evaluation of the measure list within the contract identified five areas with gaps in available data. Potential sources of data and strategies for monitoring required more detailed consideration by the Workgroup and are discussed below.

1. Shared Savings Amounts from Medicare Programs for Maryland Hospitals

The new model contract stipulates that "The State [of Maryland] shall require all Regulated Maryland Hospitals that are participating in Medicare programs, demonstrations, or models involving shared savings to provide information to the State no less than annually on the amount of any and all shared savings payments distributed to the hospital, regardless of the entity receiving the payment from CMS. The State [of Maryland] must transmit all such information to CMS no later than 60 days following receipt." Since the required information is not easily available from public resources or from CMS, the HSCRC's best approach is to develop an instrument to collect this information directly from hospitals and require submission of this data through regulation.

2. Physician Participation in Public Programs and Engagement in Innovative Models of Care

Physician participation and engagement is a critical success factor for the new model. The All-Payer Demonstration model requires the continued participation of providers in public programs and innovative models of care. As part of its reporting requirements on patient experience of care, CMS requires Maryland to report the number of physicians participating in Medicare and Medicaid, as well as, healthcare reform initiatives such as ACOs and bundled payments. This will allow Maryland to monitor access to physician's trends in as it aims to reduce hospital admissions and drive care to lower cost settings.

With input from the Workgroup, HSCRC staff identified several potential sources for physician participation data:

- <u>Provider participation in Patient Centered Medical Home Initiatives:</u>
  Several national organizations recognize or certify providers as Patient Centered Medical Homes (PCMH). The National Committee for Quality Assurance (NCQA) has the largest recognition program and is a potential source to identify the number of providers recognized as Medical Homes. NCQA has a readily available on-line directory of clinicians and sites that have received NCQA recognition as a medical home, including their level of recognition. The Joint Commission and URAC (another national accreditation organization) also recognize PCMH providers; however, their data is not as easily accessible on-line. An advantage of relying on the NCQA, Joint Commission or URAC recognition is that it represents a standardized definition of medical homes that enable cross state comparisons, as well as comparisons over time.

  However, relying solely on national accrediting organizations as a source of data could underestimate the number of providers participating in other medical home initiatives in

Maryland. The Workgroup stressed that the NCQA definition is too restrictive and does not capture the breadth and scope of all PCMH programs in the State. For instance, CareFirst has significant provider participation in its Medical Home initiative that does not require national accreditation. Other payers have similar initiatives and the MHCC leads the multi-payer PCMH, which all have different requirements. The Workgroup was interested in understanding participation in these types of initiatives, but acknowledged that there were challenges to getting consistent data. This information would have to be collected from payers who are engaged in PCMH initiatives and the various PCMH initiatives may have different definitions of medical home as well as, requirements for recognition. The State Innovation Model (SIM) Community Integrated Medical Home (CIMH) advisory board will be addressing this issue and investigating a broader definition of PCMH that reflects the innovation in Maryland and is not restricted to the NCQA definition.

In the meantime, the Workgroup recommended relying on the information available through the national accrediting organizations (primarily NCQA). Although the NCQA will not capture all of the providers participating in PCMH, it will allow HSCRC, in the short-term, to monitor trends that may reflect the broader PCMH environment. In the long term, HSCRC is looking to possibly work with the SIM Community Integrated Medical Home Advisory Board to leverage their work to develop broader definitions of PCMH and with MHCC to amend their annual report submitted by carriers to capture the number of participating physicians in PCMH programs.

- <u>Provider participation in ACOs or Bundled Payment Initiatives:</u>
  The HSCRC should rely on CMS to provide data for the number of providers participating in Medicare ACOs or Bundled Payment Initiatives. It is important to note that, to date, CMS does not permitted Maryland hospitals to participate in Medicare-funded bundled payment demonstrations; however, the agreement with CMS encourages Maryland to come forward with proposals under different CMMI initiatives.

  Through HSCRC rate-setting methodologies, Maryland hospitals have been engaging in bundled payment arrangements since the 1990's. The HSCRC is authorized by law to promote and approve alternative methods of rate determination and payment that are of an experimental nature in order "[t]o promote the most efficient and effective use of health care facility services, if it is in the public interest and consistent with the subtitle."

  The Alternative Rate-setting Methodology (ARM) was developed to encourage innovative and cost-saving payment arrangements without compromising the Commission's long-standing principles of equity and access. There are two types of ARM arrangements:

  - Capitation: This type involves significant risk to the hospital for a broad range of services, including regulated hospital services

- Global or Fixed Price: This type encompasses not only the hospital rates associated with a case but also the professional services provided during the course of treatment, usually negotiated between a hospital and a physician group as a joint venture.

HSCRC will develop a summary report of ARM statistics to address this measure.

- Medicare participating physicians per enrollee:
  Medicare maintains the Medicare.gov Physician Compare directory to provide information on physicians and other providers participating in Medicare. This data source has some challenges, including potential duplication in provider data and a lack of current information on whether providers are actively seeing Medicare beneficiaries or open for new patients. However, this data source is preferable to trying to collect self-reported data on participation in public programs through provider surveys.

- Medicaid participating physicians per enrollee:
  The Medicaid program maintains a directory for all providers participating in the HealthChoice program. Medicaid also issues ID numbers to all participating providers. There are some challenges to relying on the HealthChoice provider directory and Medicaid provider IDs as a resource, including potential duplication of providers, or providers who are not actively seeing Medicaid patients or other inaccuracies. Nonetheless, this is the best data source available. As this data is reported in the future it will be important to distinguish when changes in participating providers may actually be a result of further efforts to clean up the provider data.

3. "Discharges with Primary Care Provider Identified" modified to "Discharges where the 'Principal Provider of Care' was Notified"

The monitoring plan with CMS requires measures to assess patient experience of care. One of these measures is the frequency of the primary care provider (PCP) identified on discharge to support care transitions between providers. The Workgroup's recommendation for monitoring this data will build on a solution already being deployed in Maryland to support hospital efforts to meet meaningful use requirements (Stage 2 Summary of Care/Transitions of Care Measure) and redefine the measure as percent of discharges where the "principal provider of care" was notified. CRISP currently operates an Electronic Notification Service (ENS), that sends information on inpatient admissions and discharges, as well as emergency department visits, on a real-time basis to the Principal Provider of Care (PPC), which includes specialty providers and PCPs. ENS works by gathering patient panels directly from the providers rather than relying on self-reported data from patients during the admission process which is known to be unreliable in Maryland as well as nationally. Recently, CRISP started providing a service to send discharge summaries to the PPCs who subscribe to the ENS.

The Workgroup recommended using data from CRISP for the number of discharges for which there is an associated ENS alert to a provider. This standard is much higher than the CMS

required measure, which only considers whether a PCP was identified on discharge. The CRISP data source will allow us to provide information on the number of discharges where a discharge summary was sent to the provider via the ENS. While this measure is not exactly consistent with CMS requirement, there is a strong case to be made that this measure is a better indicator of supporting transitions in care and more consistent with meaningful use requirements. The Workgroup also suggested that the HSCRC should work with CRISP to create more specific information to capture primary care providers receiving notifications.

4. All-Payer Total Cost of Care Measures

The All-Payer Demonstration Model requires Maryland to monitor the total cost of care for Maryland Medicare beneficiaries, as well as, all Maryland residents. Specifically, Maryland must monitor trends in healthcare costs outside of its regulatory domain and any shifts of cost to unregulated settings. This measure is also of interest to many payers in Maryland.

In its application to CMMI, Maryland indicated it would leverage the existing Maryland Medical Care Data Base (MCDB) to monitor total cost of care trends and to ensure compliance with the monitoring requirement, in the contract, Maryland agreed "to make the best efforts to obtain data from Maryland Payers necessary to evaluate and monitor the model." In addition, the Maryland General Assembly passed legislation in 2013 that stated "each payer shall comply with the applicable terms and conditions of Maryland's All–Payer Model contract approved by the federal Center for Medicare and Medicaid Innovation."

The MCDB, Maryland's All Payer Claims Database (APCD), is managed by the Maryland Health Care Commission (MHCC). The MCDB contains claims-level information on approximately 3.6 million Maryland residents, who are privately insured. There are currently 4 types of claims-related files: professional services, institutional services, pharmacy services, and medical eligibility.

Under new MHCC regulations, the MCDB will include Medicaid data for approximately 900,000 MCO enrollees for calendar year 2012 by June 30, 2014. Discussions are ongoing regarding the timeline for subsequent Medicaid data submissions.

In the private insurance market, the MCDB includes a relatively complete representation of the fully-insured individual, small-group, and large group markets; however, data regarding the self-insured market has had gaps, particularly in the self-insured market as they were not required to report data to the MCDB in the past. To address this gap and to include plans sold on the Maryland Health Benefit Exchange (MHBE), MHCC revised its regulations in 2013 to require pharmacy benefit managers (PBM), behavioral health administrators, third party administrators (TPA), and all MHBE plans to report to the MCDB.2 Furthermore, the threshold for reporting was

[2] In 2014, four qualified health plans (CareFirst, AllSavers (United Health Care), Kaiser Permanente of the Mid-Atlantic, and Evergreen Health Insurance (Coop)) and eight qualified dental plans (Delta Dental (x2), United Concordia, Best Life

changed to be based on the covered lives, with all payors with 1,000 or more covered lives being required to report to the MCDB. The new regulations also added reports for plan benefit design and non-fee-for service claims for non-MHBE plans and for dental services on the MHBE. These new reports will be required starting with the 2014 quarterly data submissions.

For calendar year 2013, the existing entities will submit their annual report in July 31, 2014 and the cleaned database is expected to be available by the end of September 2014. Starting with 2014 claims data, files will be submitted quarterly, with the exception of the first two quarters, which will be submitted together on the new Extraction, Transform, and Load (ETL) system. For bills paid in the first two quarters of 2014, regardless of service date, the cleaned database is expected to be available by November 30, 2014.

Knowing the critical nature of this measure, the HSCRC requested white papers from interested stakeholders to help identify methods for monitoring total cost of care and potential shifts from inpatient and outpatient hospital settings to non-regulated providers. The topic was also discussed in the Workgroup. Based on the white papers and feedback from the Workgroup, the consensus was that the claims-level MCDB was the best long-term source for robust analysis of total cost of care. However, because of current limitations (i.e., timeliness of data and gaps in data for the self-insured market), this was considered a longer-term strategy. In the short-term, the Workgroup pursued a strategy of collecting aggregated data directly from the payers on a voluntary basis. The Workgroup agreed there is an added value of collecting both aggregate and claims-level data, similar to the how HSCRC collects both aggregated financial and patient-level case mix data from the hospitals.

A subgroup was convened to develop a reporting template for payers to report aggregate total care cost and utilization information. The subgroup tried to balance a number of different goals when developing the recommended template. Because the total cost data would be collected from payers on a voluntary basis, the subgroup agreed that the template needed to meet the following criteria:

- Must be simple enough to be feasibly reported on a regular basis;
- Provide clear definitions to ensure consistent reporting across payers and build on definitions that can be validated by other data sources;
- Build upon existing and well-documented reporting models; and
- Sufficiently disaggregate data to allow HSCRC and stakeholders to understand the shifts between regulated and non-regulated settings.

The subgroup reviewed examples of total cost of care reporting templates in order to develop the proposed reporting template (see Appendix C). The subgroup gave focused attention to the Medicaid program's HealthChoice Financial Monitoring Report (HFMR), which is a reporting

and Health, Dental Quest, Dominion Dental Services, Metropolitan Life and Health Insurance, Guardian Life of America) sold on the Maryland Health Benefit Exchange.

template that was developed by the Medicaid program to support their rate setting activities with managed care organizations and has been in place for over fifteen years. The HFMR provided a relatively simple model to collect cost and utilization information from different payers and was used as a starting point for subgroup to develop a proposed reporting template. Payers on the subgroup emphasized the importance of providing clear and detailed instructions for reporting in sufficient time to produce the requested data. Medicaid, Medicare Advantage and commercial payers were engaged in the subgroup discussions. Medicaid, in particular was actively engaged, noting the administrative challenges of reporting the data and the need to recognize the limitations of collecting aggregate data.

The work group recommendations for collecting total cost of care data include:

- **Collect aggregate total cost of care data from payers on a voluntary basis consistent with the initial reporting template developed by the subgroup (Total Cost of Care Report)**: This reporting template is designed to collect data that will help understand shifts in care settings from regulated to unregulated settings in the short-term. The reporting template relies on aggregate data and will not be able to replace a longer-term strategy of using the MCDB for robust analysis of claim level data. The services included in the template are intended to be sufficient to understand shifts. Reporting will need to be disaggregated by market segment so that shifts in care setting or changes total cost of care may be understood in the context of benefit design and changes in coverage. Data should be collected based on the county of residence of plan member and age cohorts that are consistent with other policies implemented by the Commission.

- **Develop detailed template reporting instructions in sufficient time for payers to report data**: The HSCRC should continue to engage the subgroup to review detailed reporting instructions for the Total Cost of Care Report. The goal is to finalize the reporting instructions by July 2014 with at least three months prior to reporting deadlines as requested by the payers. The template resembled the HFMR reporting tool, with additional population segments and service breakouts is already developed based on the discussions with the group (see Appendix C). The workgroup identified areas that would need very specific definitions to ensure consistent collection across payers: place of service, age categories, mapping zip code to counties, and expenses (allowed charges, out of pocket payments etc.).

- **Begin to collect data by October 2014 and establish a routine reporting schedule**: The goal is to collect the first payer Total Cost of Care Report by the fall of 2014 and to engage the subgroup to finalize the subsequent reporting schedule.

5. Outpatient Hospital Cost/Efficiency Measures

The monitoring list for hospital cost includes six outpatient imaging efficiency measures reported by the CMS Hospital Compare. All Maryland regulated hospitals signed permissions to allow CMS

to calculate and report these measures as of January 1, 2014. Based on review of the technical specifications for these measures, three of the efficiency measures should be able to be calculated using only outpatient hospital data. However three of the measures require non-hospital outpatient claims data. The workgroup identified that for measures requiring more than outpatient hospital claims that calculations of similar measures using all-payer claims should be considered within the timelines of all-payer claims data base.

Appendix A: Monitoring Commitments and Data Sources Outlined in the CMS Contract

Measurement	Data Files	Source Agency	Monitoring Timeline	Reporting Timeline	CY Data Availability
Performance Target Data					
All-Payer per Capita Test	HSCRC Financial Database	HSCRC	Monthly, 45 days after the end of the month	May 1st	March 1st
	Population Projections and Estimates	MD Dept. of Planning	Annual, December	May 1st	December 31st
Medicare per Beneficiary Hospital Payments	National and Maryland Medicare Part-A Claims	CMS	Monthly, with 4 month lag	May 1st	May 1st
	Beneficiary Enrollment Data	CMS	Monthly, with 4 month lag	May 1st	May 1st
Readmissions	National and Maryland Medicare Claims	CMS	Monthly, with 4 month lag	June 30th	May 1st
Potentially Preventable Complications	HSCRC Case mix Database	HSCRC	Monthly, with 2 month lag	June 30th	March 1st
Guardrails Data					
Medicare per Beneficiary Total Payments	National and Maryland Medicare Part A and Part B Claims	CMS	Monthly, with 4 month lag	May 1st	May 1st
	Beneficiary Enrollment Data	CMS			
Percent of Revenue from Out of State Patients in Maryland (Medicare and All-Payer)	Medicare Claims Data	CMS	Monthly, with 4 month lag	May 1st	May 1st
	HSCRC Financial Database	HSCRC			
Compliance Data					
Shared Savings Amounts from Medicare Programs for Maryland Hospitals (from ACO's, bundled payments, etc, paid outside of claims)	To be developed	HSCRC	At Least Annually	60 days after receipt	TBD
All-Payer Total Cost and Shifts to unregulated space	See Appendix B "Rec Data Source for Gaps"			TBD	Fall

Appendix A: Monitoring Commitments and Data Sources Outlined in the CMS Contract, cont.

Measurement	Data Files	Source Agency	Monitoring Timeline	Reporting Timeline	CY Data Availability
Monitoring Data					
PATIENT EXPERIENCE OF CARE MEASURES					
HCAHPS: Patient's rating of the hospital HCAHPS: Communication with doctors HCAHPS: Communication with nurses HCAHPS : Three-item care transition measure (CTM-3)	Survey	CMS	Annual	June 30th	October
Home Health CAHPS: Patient's rating of home health agency Home Health CAHPS: Communication with the home health team	Survey	CMS	Annual	June 30th	October
Nursing Home CAHPS (State-administered survey based on) : Family members' perceptions of nursing home care	Survey	CMS	Annual	June 30th	Summer
Clinician and Group CAHPS: Patient's perceptions of care provided by a physician in an office.	Survey	CMS	Annual	June 30th	TBD
Short Stay Nursing Home Resident's discharge needs met Short Stay Nursing Home Resident's Discharge planning and information about medicines and symptoms	Survey	MHCC	Annual	June 30th	Summer
Rate of physician follow up after discharge	Claims - Medicare, Medicaid, MCDB	CMS, DHMH, MHCC	Annual	June 30th	TBD
Discharges with PCP identified (Recommended Modification to the measure)	See Appendix B "Rec Data Source for Gaps"			June 30th	Fall
Medicaid participating physicians per Medicaid enrollee;	See Appendix B "Rec Data Source for Gaps"			June 30th	Fall
Medicare participating physicians per Medicare enrollee	See Appendix B "Rec Data Source for Gaps"			June 30th	Fall

Appendix A: Monitoring Commitments and Data Sources Outlined in the CMS Contract, cont.

Measurement	Data Files	Source Agency	Monitoring Timeline	Reporting Timeline	CY Data Availability
Monitoring Data					
PATIENT EXPERIENCE OF CARE MEASURES, Cont.					
Participation of providers in patient centered medical home models	See Appendix B "Rec Data Source for Gaps"			June 30th	Fall
Participation of providers in ACOs and bundled payments	See Appendix B "Rec Data Source for Gaps"			June 30th	Fall
Quality score using process of care measures in AMI, HF, SCIP, PN, CAC	Hospital Inpatient Quality Reporting Program	CMS	Annual	June 30th	October
Quality score using process of care measures in outpatient setting	Hospital Outpatient Quality Reporting Program	CMS	Annual	June 30th	October
NHSN CLASBI SIR	Hospital Compare	CMS	Annual	June 30th	TBD
Admission Rates from Home Health Agencies to Acute Inpatient Hospital	Home Health Compare	CMS	Annual	June 30th	October
Unplanned, urgent visits to the Emergency Departments for patients receiving Home Health care				June 30th	October
Readmission rates from nursing home to acute care hospital (Readmission rate for Hospital Discharges to Nursing Homes)	Hospital Inpatient Discharge Abstract	HSCRC	Annual	June 30th	March 1st
Readmissions per 1000 residents	HSCRC Case Mix Database Population Estimates	HSCRC MD Dept. of Planning	Annual	June 30th	March 1st
Condition-Specific Hospital Readmissions Rates: • Heart Failure • Pneumonia • Acute Myocardial Infarction • Chronic Obstructive Pulmonary Disease • Hip/Total Knee Arthoplasty	Hospital Inpatient Discharge Abstract	HSCRC	Annual	June 30th	March 1st

Appendix A: Monitoring Commitments and Data Sources Outlined in the CMS Contract, cont.

Measurement	Data Files	Source Agency	Monitoring Timeline	Reporting Timeline	CY Data Availability
Monitoring Data					
POPULATION HEALTH MEASURES				June 30th	
SHIP Objective 1*: Increase life expectancy	Vital Statistics Data	DHMH	Annual	June 30th	July
Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization	HSCRC Case Mix Database	DHMH	Annual	June 30th	July
SHIP Objective 32: Reduce the % of adults who are current smokers	Behavioral Risk Factor Surveillance System (BRFSS)	DHMH	Annual	June 30th	March
SHIP Objective 33: Reduce the % of youth using any kind of tobacco product	Maryland Youth Tobacco Survey	DHMH	Annual	June 30th	June
SHIP Objective 24: Increase the % vaccinated annually for seasonal influenza	CDC National Immunization Survey; BRFSS	DHMH	Annual	June 30th	March
SHIP Objective 23: Increase % of children with recommended vaccinations	CDC National Immunization Survey	DHMH	Annual	June 30th	September
SHIP Objective 20: Reduce new HIV infections among adults and adolescents	MD HIV surveillance system; US Census Bureau; ACS 5 year Census	DHMH	Annual	June 30th	March
SHIP Objective 27: Reduce diabetes-related emergency department visits	HSCRC Case Mix Database	DHMH	Annual	June 30th	July
SHIP Objective 28: Reduce hypertension related emergency department visits	HSCRC Case Mix Database	DHMH	Annual	June 30th	July
SHIP Objective 31: Reduce the % of children who are considered obese	Maryland Youth Tobacco Survey	DHMH	Annual	June 30th	June
SHIP Objective 30: Increase the % of adults who are at a healthy weight	Behavioral Risk Factor Surveillance System (BRFSS)	DHMH	Annual	June 30th	March
SHIP Objective 17: Reduce hospital ED visits from asthma	HSCRC Case Mix Database	DHMH	Annual	June 30th	July
SHIP Objective 34: Reduce hospital ED visits related to behavioral health	HSCRC Case Mix Database	DHMH	Annual	June 30th	July
Fall-related death rate	Mortality database	Maryland Vital Statistics Admin	Annual	June 30th	July

Appendix A: Monitoring Commitments and Data Sources Outlined in the CMS Contract, cont.

Measurement	Data Files	Source Agency	Monitoring Timeline	Reporting Timeline	CY Data Availability
Monitoring Data					
HOSPITAL COST/EFFICIENCY MEASURES					
OP-8 : MRI Lumbar Spine for Low Back Pain OP-9: Mammography Follow-up Rates OP-10: Abdomen CT - Use of Contrast Material OP-11:Thorax CT - Use of Contrast Material OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)	HSCRC Case Mix Database (OP-10, 11, and 14 only) or Medicare Claims (Hospital Compare); See Appendix B "Rec Data Source for Gaps"	CMS, MHCC	Annual	June 30th	July
Per capita hospital expenditure growth (inpatient and outpatient) for: • All-payer • Medicare • Medicaid/CHIP • Private payer • Medicare/Medicaid Enrollees (Dual Eligible)	Hospital Inpatient and Outpatient Discharge Abstract; Insurance Enrollment Files	HSCRC	Annual	June 30th	March 1st
Per capita health expenditure growth (inpatient and outpatient) for: • All-payer • Medicare • Medicaid/CHIP • Private payer • Medicare/Medicaid Enrollees (Dual Eligible)	See Appendix B "Rec Data Source for Gaps"	TBD	June 30th	TBD	

Appendix B: Recommendations for Data Sources to Address Gaps Compliance Data

Measurement	Recommended Data Files	Recommended Data Source Agency	Monitoring Timeline	Limitations & Considerations
Compliance Data				
All-Payer Total Cost and Shifts to unregulated space	Total Cost of Care Template	Medicaid and Commercial Payers	Annually	Considerations include: easy to submit on regular basis; clear definitions to ensure consistent reporting; build upon existing and well-documented models; and sufficiently disaggregated
Monitoring Data				
PATIENT EXPERIENCE OF CARE MEASURES				
Discharges with PCP identified	To be developed	CRISP	Annual	Measure is not exactly consistent with CMS requirement, there is a strong case to be made that this measure is a better indicator of supporting transitions in care and more consistent with meaningful use requirements.
Medicaid participating physicians per Medicaid enrollee;	HealthChoice directory of participating providers	DHMH Medicaid	Annual	Potential duplication of providers, or providers who are not actively seeing Medicaid patients or other inaccuracies
Medicare participating physicians per Medicare enrollee	Medicare.gov Physician Compare directory	CMS	Annual	Potential duplication in provider data and a lack of current information on whether providers are actively seeing Medicare beneficiaries or open for new patients
Participation of providers in patient centered medical home models	On-line directory of clinicians and sites that have received NCQA reorganization as a medical home	National Committee for Quality Assurance (NCQA)	Annual	Does not include providers participating in other medical home initiatives in Maryland (i.e., CareFirst Initiative)

Measurement	Recommended Data Files	Recommended Data Source Agency	Monitoring Timeline	Limitations & Considerations
Monitoring Data				
PATIENT EXPERIENCE OF CARE MEASURES, cot.				
Participation of providers in ACOs and bundled payments	Medicare- Funded: To be developed; Alternative Rate Methodology Statistics	CMS; HSCRC	Annual	CMS has not permitted Maryland hospitals to participate in bundled payment demonstrations; however, the agreement with CMS encourages Maryland to come forward with proposals under different CMMI initiatives.
HOSPITAL COST/EFFICIENCY MEASURES				
OP-8 : MRI Lumbar Spine for Low Back Pain OP-9: Mammography Follow-up Rates OP-10: Abdomen CT - Use of Contrast Material OP-11:Thorax CT - Use of Contrast Material OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)	Claims (Hospital Compare); Other Payers (OP-8, 9, and 13 To Be Developed) (OP-10, 11, and 14 HSCRC Case Mix Database)	CMS; HSCRC; MHCC	Annual	Medicare specific measures are published at Hospital Compare website. All-payer Measures for OP-10, 11, and 14 should be able to be calculated from outpatient hospital data only. The other three efficiency measures need to be developed using all-payer claims data base.
Per capita health expenditure growth (inpatient and outpatient) for: • All-payer • Medicare • Medicaid/CHIP • Private payer • Medicare/Medicaid Enrollees (Dual Eligible)	Total Cost of Care Template for All-Payer, Medicaid & Private Payers; Medicare Data for Medicare and Dual eligible	Medicaid, Commercial Payers and Medicare	Annual	Considerations: See Total Cost of Care template above

Appendix C: Draft Reporting Template for Total Cost of Care

MD Providers																											
Acute Hospital Inpatient						Acute Hospital Outpatient												Specialty Hospitals									
All Inpatient (except Psych& Rehab)		Psych		Rehab		ER		OP/PT		Diagnostic/ Imaging		Surgery		Clinic		All Other		Psych		Rehab		Cancer Hospitals		Children's Hospitals		Chronic/ LTC	
Exp	Adm	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	NA	NA	Exp	Visits	Exp	Visits

Out of State Providers																											
Acute Hospital Inpatient						Acute Hospital Outpatient												Specialty Hospitals									
All Inpatient (except Psych& Rehab)		Psych		Rehab		ER		OP/PT		Diagnostic/ Imaging		Surgery		Clinic		All Other		Psych		Rehab		Cancer Hospitals		Children's Hospitals		Chronic/ LTC	
Exp	Adm	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits

Ambulatory Care																								Enrollment
Non-Hospital Outpatient				Professional/Clinic						Long-TermCare/Post Acute								Other							
ASC		Urgent Care		PCP		Non-PCP		Therapies		SNF		Home Health		Hospice		HCBS		Lab		Pharmacy		Imaging X-Ray		All Other Medical		
Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Member Months

Exp = Expenses; Adm = Admissions

Reporting Levels

Age Groups

Enrollee County of Residents

Market Segment

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117
www.carefirst.com

Paper 5: Monitoring the Total Cost of Care

Submitted by CareFirst 1-10-2014

1. Introduction

1.1 – Under the Demonstration, the HSCRC is required to shift at least 80% of hospital revenue to Global Models by the fifth year. Global Models are arrangements, such as the existing Total Patient Revenue (TPR) model, or the Global Budget Rate (GBR) system, which establish a fixed Target Budget and thereby provide strong financial incentives to reduce unnecessary hospital service use.

1.2 - Under the Global Model structure, hospitals will be expected to attempt to eliminate unnecessary, marginal and duplicative services. These hospitals may engage in efforts that reduce the use of hospital care and increase the use of non-hospital services. For instance, Global Model hospitals will be incentivized to: 1) coordinate with local home health and long-term care providers to actively prevent hospital readmissions; 2) triage or redirect low acuity emergency cases to primary care physician (PCP) offices or urgent care centers; 3) encourage the referral of clinical lab, imaging and other ancillary services to lower cost, non-hospital providers; and 4) restrict physician access to surgical and procedure-based services at the hospital. This last action may result in increased use by surgeons and specialists of non-hospital ambulatory surgery capacity.

1.3 - Other provider organizations operating under the incentives of at-risk or shared savings programs (such as Medicaid MCOs, Medicare Advantage Plans, SSP-ACOs and PCMH programs) will face similar incentives to move care to less expensive non-hospital sites in order to generate cost savings. For instance, the preliminary results of the highly publicized Alternative Quality Contract (AQC) Shared Savings Arrangement organized by Blue Cross of Massachusetts showed that the largest proportion of savings generated under this program in its first year came from shifts in the site of service from high to low cost providers.

1.4 - While shifts in the site of service from hospitals to lower cost non-hospital providers are generally thought to be desirable, because the costs of providing the same services in these settings is less than the cost in the hospital setting, there is a concern that such shifts will not generate overall system savings. This concern issues from the fact that Medicare and the other payers would continue to pay the hospitals for the services that are shifted (if the hospitals on Global Models do not lose revenue when the services are shifted) and they would also pay the non-hospital providers for the services that are re-directed to them.

1.5 – The CMMI has expressed concern that this dynamic could lead to increases in the total cost of care for Medicare Beneficiaries. As a result, CMMI required the contract that will govern the Demonstration to include two limitations on the growth in Medicare per beneficiary costs: one covers hospital expenditures and one encompasses all services (i.e., hospital and non-hospital services). Private payers and the Medicaid program are also concerned about the potential for "double paying" for services that have been shifted from Global Model hospitals to non-hospital providers that are not governed by the HSCRC or included in the Demonstration.

1.6 – The purpose of this Paper is to consider this overall dynamic and to: 1) identify the best available data sources and possible approaches for monitoring trends in the total cost of health care in Maryland and potential shifts of care from regulated hospital to non-hospital settings; 2) suggest a strategy for monitoring trends in the total cost of care in Maryland by payer; and 3) address the feasibility and advisability of making adjustments to hospital Target Budgets in the case of shifts of services from Global Model hospitals to non-hospital providers.

2. Considerations regarding the Shifting of Hospital Services to Non-Hospital Sites of Care

2.1 –As noted above, the CMMI is requiring the Demonstration contract to include two additional payment limitations that are designed to protect CMS against an unintended increase in the total cost of care for Medicare beneficiaries: 1) The annual growth in Medicare per capita total cost of care for Maryland beneficiaries, regardless of the state in which the services are provided, can be no more than 1.5% greater than the national Medicare total cost of care growth rate; and 2) beginning in the second performance year (2015), annual growth in Medicare per beneficiary total cost of care for Maryland residents cannot exceed the national Medicare per beneficiary total cost of care growth rate in any two consecutive years.[1] These tests place a considerable burden and risk on the HSCRC and the Maryland hospitals because excessive increases in non-hospital spending levels, which are not regulated by the HSCRC, could threaten the continuation of the Demonstration.

2.2 – Monitoring the total cost of care trends in Maryland (particularly for Medicare) is thus extremely important in order to ensure that the overall cost containment goals of the Demonstration are met and to avoid the termination of the Demonstration by CMS for non-compliance on either of these two provisions. In particular, the second limitation (i.e., not exceeding the national Medicare trend over any two-year period) imposes an additional and very stringent condition on the Maryland system. Under this provision, if Maryland exceeded the national Medicare trend by, for example, 1% in 2014, it would then have to reduce Medicare costs in the subsequent to a level below nation trend (per 2.1, second term above). The provisions are also problematic for Maryland because the State will not have much notice from Medicare should it exceed either limitation in a given year.

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[1] As noted, the CMMI/CMS limitations discussed here refer to the total cost of care per Medicare beneficiary (for both hospital and non-hospital) care. However, based on conversations with the HSCRC staff, there does not appear to be a consistent understanding regarding the definition of "non-hospital care" (i.e., whether it involves all non-hospital services, including professional services or whether it is restricted to just institutional non-hospital care). This definitional issue should be resolved with the CMMI/CMS.

2.3 - Medicaid and the private payers have expressed concern about Global Model hospitals retaining all of the savings from the shift of services to non-hospital sites. Shifts of this nature that are caused by hospital activities or brought about by insurer-sponsored activities (such as ACOs, MCOs, MA plans and the PCMH) will generally result in some level of overpayment if the hospitals retain their full prior payments and additional payments are made to the non-hospital providers that receive the shifted care. Because of the undesirable total cost implications of this dynamic, and the need to stay in compliance with the two Medicare total cost of care limitations imposed by the CMMI, the HSCRC staff has discussed the potential need for individual hospital rate adjustments to offset the windfall profits that would otherwise accrue to Global Model hospitals due to service shifts from such hospitals to non-hospital providers and to prevent the duplicative payments that would be made by payers for the shifted services.

2.4 – Overall, the situation described above presents a complicated set of circumstances and policy alternatives for the HSCRC. On one hand, there is a desire on the part of HSCRC staff and the major payers for the use of negative adjustments to the rate base of Global Model hospitals in the event that services shift away from these hospitals to less expensive non-hospital providers. On the other hand, there are a number of subtle dynamics that must be considered regarding these service shifts.

2.5 - Organizations operating under at-risk or shared savings arrangements, such as ACOs, face strong financial incentives to shift services to less expensive non-hospital-based settings. These shifts are usually applauded and encouraged if they are payer-sponsored activities and they result in lower total health care costs. Most such organizations pay on a straight fee-for-service (FFS) basis so, when they eliminate volume at a hospital, and purchase it instead from a lower cost provider, as has occurred in the AQC, they eliminate the payments to the hospital and pay only the lower costs at the non-hospital provider. Similarly, under the HSCRC's long-standing DRG-based per case constraint system, Maryland hospitals have been incentivized to reduce LOS and ancillary use per case without adjustment for observed shifts in cases from acute to post-acute settings. Global Model hospitals operating under much stronger incentives to control costs will understandably attempt to reduce the frequency of unnecessary admissions, readmissions, emergency room visits and other hospital services. While there is a legitimate concern about possible overpayment for care as a result of these dynamics, the HSCRC should be careful not to unnecessarily discourage hospitals from engaging in these activities.

2.6 - These considerations raise a fundamental question; namely, under what circumstances should rate adjustments to the Target Budgets of Global Model hospitals take place? In a previous Paper, we argued that upward rate adjustments to Target Budgets are necessary to promote and accommodate the channeling of market demand by "Market Sponsoring Organizations" from low value to high value hospitals, or to respond to other circumstances such as a service closure or a shift of patient volume/demand that is caused by circumstances beyond the particular hospital's control. Unfortunately, in the case of general pressure in the system to migrate services from hospitals to non-hospital providers, it will be difficult to distinguish between deliberate attempts to "shed" hospital-based services and service shifts that occur for other reasons.

2.7 – This problem of how and when to adjust Target Budgets for service shifts into non-hospital settings is extraordinarily complex. Many difficulties will be involved in accurately measuring the

shifts that take place, in attributing causation to these shifts, and in appropriately implementing related reductions to hospital Target Budgets. Nevertheless, given the adverse implications of exceeding the limitations on the growth in Medicare total cost of care that are included in the Maryland Demonstration, and the potential for overpayment by other payers, it will be very important for the HSCRC to monitor trends in hospital and non-hospital care in Maryland at an aggregate level and, as needed, at a disaggregated level. The primary goal of this monitoring exercise should be to measure the total cost of care growth for Medicare on a quarterly basis and to give the HSCRC the information it would need to formulate proactive adjustments to hospital rates to ensure that the Medicare total cost of care limitations that are included in the Demonstration are not exceeded. The secondary goal would be to monitor all payer trends in total cost of care and to develop mechanisms that can curb any excessive increases and help to position the State to submit an effective strategy for a second stage of the Demonstration that would encompass all services, across all payers, rather than just for Medicare.

2.8 - Through this monitoring effort, the HSCRC may learn more about how hospitals (and the Maryland health delivery system overall) are responding to the incentives of the Demonstration and what, if any, policy interventions will be required to meet the State's and CMS's cost containment goals.

3. Sources of Data and Potential Monitoring Effort

3.1 – Successful monitoring of the total cost of care will require access to comprehensive and timely claims data from each major payer. The Maryland Health Care Commission has long maintained a database—i.e., the Medical Care Database (MCDB)—that was meant to collect all health care claims from all payers. However, the MCDB has significant gaps and is not available on a timely basis (The MCDB is only available annually with a lag of 24 months). Efforts that are now underway to enhance the MCDB will likely take many years. Thus, in the short term, these data will need to be generated directly from the major payers (Medicare, Medicaid through UMBC, CareFirst, United Healthcare, and possibly, from other payers including Aetna, Cigna, Coventry and other smaller payers). Comprehensive claims from even the four major payers would constitute about 85% of all health care expenditures for Maryland residents. Trends in per capita payments to hospital, non-hospital providers and for all services that would be computed using the data from the four major payers would be highly reliable indicators of overall trends.

3.2 – More specifically, in its monitoring efforts, the HSCRC might arrange to have direct access to raw claims data (and/or summary reports that it specifies) from the following sources:

- **Medicare**: Per the terms of the Maryland Demonstration, the HSCRC will be receiving total Medicare FFS claims data (including both hospital and non-hospital claims) each quarter three to six months after the quarterly reporting period. The HSCRC staff will be the primary custodian of these data and should have the primary responsibility for analyzing these data and producing the necessary reports to monitor trends in total Medicare costs per Maryland Beneficiary.
- **Medicaid**: Theoretically, Maryland Medicaid should be able to generate comprehensive claims data for all Medicaid beneficiaries. However, based on analyses performed by the HSCRC, Medicaid data suffer from serious gaps: for example, not all MCOs submit complete

encounter data and the HSCRC staff has observed many inconsistencies in the data available through the State's vendor i.e., the Hilltop Institute at the University of Maryland Baltimore Campus (UMBC). Despite these historical limitations, the Medicaid program has indicated that it will participate in any necessary data monitoring activities and has indicated it will be able to prepare periodic reports requested by the HSCRC for this purpose.

- **Private Payers**: Large insurers, such as CareFirst Blue Cross of Maryland and United Healthcare, have the ability to provide raw data (with sufficient patient confidentiality and other non-disclosure protections) and summary quarterly reports of both hospital and non-hospital claims and expenditures in a manner prescribed by the HSCRC staff.[2]
- **Chesapeake Regional Information System for Our Patients (CRISP)**: CRISP is the State-designated regional health information exchange. Although the data collected by CRISP is limited, it could be expanded with appropriate funding through the hospital rate setting system. CRISP may ultimately be the best source for timely data on both hospital and non-hospital expenditures and utilization.

3.3 – Given the availability of data from at least the major payers (i.e., Medicare, Medicaid, CareFirst and United), the HSCRC should consider organizing a coordinated "team-based" data monitoring effort with participation of representatives from the Commission, Medicaid/UMBC, CareFirst and United (The Data-Monitoring Team). The HSCRC could take the lead in this effort by providing specifications to each payer for the type of data and reports that would be needed to match the analyses and reports that the HSCRC staff would perform on the Medicare claims data. The reports specified by the HSCRC would be shared with HSCRC staff on a quarterly basis with the general results reported to the Commissioners.[3]

3.4 – We recommend that the analysis of the Medicare and individual payer data should begin by establishing the baseline historical relationship between hospital and non-hospital expenditures on a county-specific basis over a 5-year period (from CY 2008 – CY 2013). These aggregate level reports would provide the HSCRC with a sense of the historical trends and year-to-year fluctuations in hospital vs. non-hospital expenditures. The Data Monitoring Team could track hospital, non-hospital and total per capita expenditures by county on an ongoing (e.g., quarterly) basis during the Demonstration and could generate "drill down" reports (by type of service, etc.) as needed in any locations that show problematic trends. The historical data (for the State or by county or other designated regions) would be used to establish baseline parameters and triggers for monitoring and comparison purposes during the Demonstration. For instance, if a particular region experienced "significant" decreases in services that are thought to be substitutable hospital services (e.g., simple ambulatory surgery services or CT/MRI or other imaging services), and corresponding increases in non-hospital services of these same types, the HSCRC staff and the individual payers could perform consistent and more detailed analyses of the hospitals and services involved in the identified shifts. The fact that over 50% of hospital outpatient services are

[2] We would need to verify CareFirst's ability and willingness to produce both quarterly reports on hospital and non-hospital expenditures for Maryland residents.

[3] The Private Payers may not wish to have the results of their total cost experience made public.

concentrated in ambulatory surgery and other procedure-based services would make it possible to focus much of the detailed analyses on these services. [4]

3.5 – Simultaneously, for informational purposes, the HSCRC staff might wish to generate hospital-specific monitoring reports focusing on services that the staff identifies that can be provided by non-hospital entities. Unusually large annualized reductions of some pre-determined magnitude (say 10%) could trigger additional analyses, especially where the reductions in hospital services seem to be linked with increases in services at non-hospital providers (e.g., free standing ASCs, labs, imaging centers, etc.) owned by or affiliated with the particular hospitals.[5]

3.6 - The HSCRC staff should require all Global Budget hospitals to file (and regularly update) a comprehensive list of all entities that they own, control, share ownership with or with which they are affiliated to facilitate the HSCRC's efforts to track service utilization shifts that may warrant budget adjustments. This requirement would be similar to the requirement to identify such entities that is currently included in the TPR agreements.

4. Suggested Policy Action with Regard to Hospital Rate Adjustments for Volume Shifts

4.1 – Based on the discussion above, we recommend that the primary focus of the HSCRC's monitoring effort should be on aggregate trends in hospital versus non-hospital services and costs and the growth in total costs relative to historical baseline and expected national trends by payer. Given the importance of meeting the total cost of care limitations imposed by the Demonstration, there should be an extra focus on monitoring the trend in Medicare cost per Maryland beneficiary and on alerting the Commission in a timely way of the need for a proactive policy response if it

[4] For the purposes of any more detailed analyses, it might behoove the HSCRC to identify non-hospital provider types and services that are most readily substitutable for hospital care and focus these enhanced monitoring efforts in these areas. For instance, the outpatient services most at risk for movement to non-hospital providers might include: ambulatory surgery, other procedure-based care, clinical laboratory; imaging services, such as CAT scan and MRI; low acuity emergency room visits, and outpatient primary care clinic services provided by hospital-based physician practices. The services least at risk for migration to non-hospital providers might include: hospital pharmacy, hospital supplies, specialty clinic services, "high-end" outpatient procedures and surgeries.

[5] For the purposes of any more detailed analyses, it might behoove the HSCRC to identify non-hospital provider types and services that are most readily substitutable for hospital care and focus these enhanced monitoring efforts in these areas. For instance, the outpatient services most at risk for movement to non-hospital providers might include: ambulatory surgery, other procedure-based care, clinical laboratory; imaging services, such as CAT scan and MRI; low acuity emergency room visits, and outpatient primary care clinic services provided by hospital-based physician practices. The hospital OP services least at risk for migration to non-hospital providers might include: hospital pharmacy, hospital supplies, specialty clinic services, "high-end" outpatient procedures and surgeries.

appears the Maryland growth rate in total Medicare payments per beneficiary exceeds the projected trend in total per capita Medicare payments per beneficiary on a national basis.

4.2 – In regards to general increases in non-hospital services that are substitutions for hospital care, we suggest that there should be hospital specific adjustments only in limited circumstances. In the suburban and urban areas it will be virtually impossible to tie increases in free-standing surgery, lab, imaging, or urgent care to reductions in the services of particular hospitals (unless the HSCRC sees that the shift is between a hospital and a non-hospital entity that has been identified as either owned by or affiliated with the hospital in the TPR and GBR agreements. Also as demonstrated by the ACQ experience in Massachusetts, relocating the site of service can result in significant system savings.

4.3 - Consistent with the principle of providing hospitals with incentives to shift care to less expensive settings, we recommend that the HSCRC should establish a policy whereby it would apply rate offsets associated with the growth in Medicare's non-hospital care in the form of an across-the-board rate reduction equal to, say, 125% of the increase in Medicare's non-hospital care statewide, measured as a percentage of the hospitals' Medicare charges, in any county in which the rate of increase exceeded a specified limit. Hospital-specific rate offsets, rather than county-wide offsets, would be applied whenever the shifts could be tied to particular hospitals and (especially) any non-hospital entities associated with them.

The key point of this proposal is to recognize that significant cost savings can be achieved if all parties (both hospitals and payer-sponsored entities) are incentivized to shift care to lower cost settings. But total cost levels can be driven upward if service shifts result in duplicative payments. It would be appropriate to give the individual hospitals general incentives to redirect care to non-hospital settings but to offset at least a portion of the costs of the redirected services against the hospitals in general (except where the shifts can be tied to specific hospitals and non-hospital providers (especially here they are associated by ownership, etc.). The HSCRC would then debit the hospital industry in the aggregate (by county or at a more aggregated level) to reduce Medicare and other payer payments in line with the waiver requirements by offsetting a bit more than the incremental costs of the redirected services. In other words, we should encourage the desired activity and then assess the industry for a little more than the incremental costs of the care they shift through their collective enterprise.

4.4 – Certainly, the effectiveness of the monitoring effort and the potential for appropriate rate action will become clearer after the effort is underway and the HSCRC and the Data Monitoring Team members can see how hospitals appear to be responding to the incentives under the Demonstration. However, given the complicated nature of the incentives and dynamics at play, and the relatively tight nature of the Target Budgets being established for hospitals under the HSCRC's Global Models, it may be most appropriate and efficient for the HSCRC to focus on monitoring trends in the cost of hospital and non-hospital care and to make adjustments only in situations where it finds that total Medicare cost growth is in excess of the projected national trends.

May 5, 2014

3601 O'Donnell Street
Baltimore, MD 21224
Telephone 410.864.4404
Facsimile 855.280.0660
Frank.Campbell@Healthspring.com

Donna Kinzer
Executive Director
State of Maryland
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Kinzer,

Cigna-HealthSpring wishes to express its support and commitment to the Maryland's New Waiver Redesign Demonstration.

Our health plan appreciates the opportunity to share a voice with other stakeholders via participation on the Data and Infrastructure Work Group and we look forward to our continued participation. We support the effort to collect aggregate data on the total cost of care from payers on a voluntary basis and will continue to work closely with the HSCRC to share information that can be helpful to understand potential shifts in utilization.

Cigna-HealthSpring is committed to working collaboratively with the HSCRC to implement the New Waiver. This is an important step to improving population health, enhancing patient outcomes and experience, and mitigating per-capita cost of care trends for the benefit of our community.

Sincerely yours,

Frank P. Campbell
Director, Informatics
Mid-Atlantic/Pennsylvania Market

Cc. Brent Sanders, CFO Mid-Atlantic/Pennsylvania Market
Health Services Cost Review Commissioners
Chairman John Colmers
Commissioner George Bone, M.D.
Commissioner Jack Keane
Commissioner Thomas Mullen
Commissioner Herbert Wong, Ph.D.
Commissioner Stephen Jencks, M.P.H.
Commissioner Bernadette Loftus, M.D.

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

May 6, 2014

John M. Colmers
Chairman
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Letter of Support – Total Cost of Care template

Dear Chairman Colmers and Members of the Commission:

The Maryland Department of Health and Mental Hygiene (DHMH) is pleased to offer support to the Health Services Cost Review Commission (HSCRC) in its continuing effort to establish a Total Cost of Care template. With the goals of reducing health care costs and improving population health, the Maryland Medicaid program has been participating in HSCRC's Data and Infrastructure Workgroup. The Workgroup is developing a data infrastructure for the monitoring and evaluation of Maryland's new All-Payer Rate-Setting System in cooperation with providers, including the Maryland Hospital Association (MHA), and other payers and interested stakeholders.

On January 1, 2014, Maryland's new All-Payer Rate-Setting System moved to a per capita total hospital cost test. Starting January 1, 2019, the system will move to a per capita total cost of care test. Not only is Maryland committed to reporting per capita health expenditure growth under the terms and conditions of the waiver with the Centers for Medicare and Medicaid Services (CMS), but the Maryland Medicaid program is particularly interested in monitoring how the slowing of the growth rate of hospital costs impacts other expenditures, such as physician services and long-term care services. For instance, hospital expenditures may decrease. At the same time, long-term care expenditures may increase by a greater amount. This would cause total cost of care to increase for the Medicaid population.

In its current form, the service categories have been defined only in general terms in the Total Cost of Care Template. In order for the Template to generate information that can be reported to CMS, very detailed reporting specifications must be developed. This will ensure consistency across the various payers. As such, Medicaid will continue to work with the Data and Infrastructure

Workgroup to establish a more detailed and clearly defined template between now and the first reporting period in October 2014.

Sincerely,

Charles Lehman
Acting Deputy Secretary
Health Care Financing

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

AS OF MAY 6, 2014

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
2248N	Baltimore Washington Medical Center	5/1/2014	6/2/2014	9/29/2014	ANS/ORC	CK	OPEN
2249A	University of Maryland Medical Center	5/1/2014	N/A	N/A	ARM	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**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2014**
MEDICAL CENTER	*	**FOLIO : 2059**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2249A**

Staff Recommendation

May 14, 2014

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on May 1, 2014 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for liver, kidney, lung, and blood and bone marrow transplants for a period of one year with Cigna Health Corporation beginning July 1, 2014.

II. OVE RVIEW OF APPLICATION

The contract will continue be held and administered by University Physicians, Inc. ("UPI"), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating 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 Hospital will continue submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff found that the Hospital's experience under this arrangement for the previous year was favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for liver, kidney, lung, and blood and bone marrow transplant services, for a one year period commencing July 1, 2014. The Hospital will need to file a renewal application 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 Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, 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: Report on Uncompensated Care Policy Recommendations

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

May 14, 2014

These draft recommendations are for Commission consideration at the May 2014 Public Commission Meeting. No action is required. Public comments should be sent to Dennis Phelps dennis.phelps@maryland.gov. For full consideration, comments must be received by June 2, 2013.

DRAFT: Report on Uncompensated Care Policy Recommendation

INTRODUCTION

Overview

Since 1984, The HSCRC has recognized the cost of uncompensated care (charity care and bad debt) within Maryland's unique hospital rate setting system. Through this provision, patients who cannot pay for care are still able to access hospital services, and hospitals are credited for a reasonable level of charity care or bad debt 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 prospectively calculates the rate of uncompensated care at each regulated Maryland hospital by combining historical uncompensated care rates with predictions from a regression model.

The HSCRC must determine the total amount of uncompensated care that will be placed in hospital rates for FY 2015 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.

Between 2012 and 2013 the rate of uncompensated care in Maryland increased from 6.85 percent to 7.23 percent. A rate increase is necessary to provide adequate funding for this growth. However, the Medicaid expansion under the Affordable Care Act (ACA) will likely contribute to an overall decrease in uncompensated care as approximately 164,000 Maryland Residents have enrolled in Medicaid under the expansion as of March 31, 2014 and it is likely that a significant portion of this population contributed to uncompensated care utilization prior to their Medicaid enrollment.

This expansion of Medicaid has additional bearing as the HSCRC uses Medicaid enrollment as a predictive variable in the current uncompensated care regression model. Historically, HSCRC has used the level of Medicaid coverage to predict the likelihood of uncompensated care. However, as Medicaid coverage expands, it may no longer be a

good predictor of uncompensated care. As a result, the HSCRC must evaluate the regression model to ensure that the explanatory variables used in the model are appropriate for predicting uncompensated care rates at regulated Maryland hospitals given the changing characteristics of the uninsured populations.

This report discusses the factors influencing uncompensated care rates in Maryland and makes recommendations to both adjust the total funds available in the uncompensated care pool and to alter the regression model used to allocate those funds in light of the recent increase in uncompensated care and the Medicaid expansion. These policy changes are necessary to recognize an appropriate level of uncompensated care at hospitals in the State and share the cost of that care equally across all regulated Maryland hospitals.

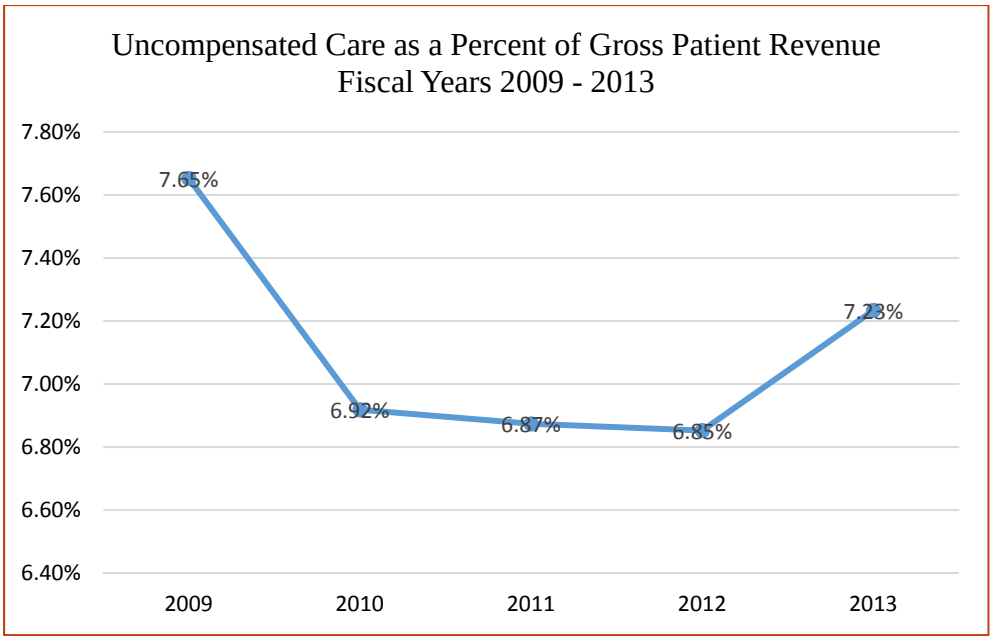
STAKEHOLDER INPUT

The draft staff report has been reviewed with the Payment Models Workgroup and staff has incorporated several Workgroup comments in this staff report. As discussed later in this draft report, staff is continuing to evaluate data submitted by hospitals regarding payments received for PAC patients by hospitals. There may be additional comments on this issue and modifications to the draft report based on the outcome of this 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 2013. Uncompensated care levels dropped between FY 2009 and FY 2010, but remained relatively steady with only a slight decline from FY 2010 to FY 2012. Most recently between FY 2012 and FY 2013 there was a 0.38 percentage point increase in total uncompensated care rate for all regulated Maryland hospitals.



This rise in the level of uncompensated care may be attributed to several factors. The increased prevalence of higher deductibles, coinsurances, and copays among commercial insurance plans may have contributed to increased uncompensated care. Also, the proportion of hospital services that are outpatient has increased, and the patient responsibility portion of outpatient bills is typically higher, resulting in higher levels of uncompensated care. Furthermore, the impact of undocumented immigrant populations on uncompensated care is not well understood and may be contributing to increases for particular hospitals.

Current Uncompensated Care Policy

The current uncompensated care policy was adopted by the Commission in September, 2010. The policy creates a statewide pool built into hospital rates. 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 2013 the actual total cost of uncompensated care were 5 percent, then in 2014 the pool would prospectively be set at 5 percent of the 2014 gross patient revenue.

The prospective uncompensated care percentage for each hospital is computed by taking the average actual percent of uncompensated care experienced by the hospital over the past three 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 is weighted equally between the three-year average and the predicted regression value as shown in the formula below.

$$\frac{Average\ UCC\ Rate\ for\ Past\ 3\ Years + Regression\ Value}{2} = Annual\ UCC\ Percentage$$

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

The regression model used to determine the FY 2014 predicted uncompensated care percentage for each hospital relied upon four explanatory variables:

- The proportion of a hospitals total charges from inpatient non-Medicare admissions through the emergency room
- The proportion of a hospitals total charges from inpatient Medicaid, self-pay, and charity cases
- The proportion of a hospitals total charges from outpatient non-Medicare emergency department charges
- The proportion of a hospitals total charges from outpatient Medicaid, self-pay, and charity visits

This model was applied to data from the three-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 are 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.

Indefinite Suspension of the Charity Care Multiplier

For FY 2014, HSCRC suspended the charity care multiplier it was using as part of the uncompensated care policy because HSCRC staff lacked confidence in the accuracy and consistency in the distinction between charity care and bad debts applied by hospitals.

Enrollment under the Affordable Care Act (ACA)

Expanded coverage under the ACA will reduce uncompensated care. A primary goal of the ACA was to expand coverage to uninsured or underinsured individuals. Counting both individuals who have gained Medicaid coverage and those who have selected a private health plan through Maryland's insurance exchange, 295,077 Marylanders enrolled in coverage as of March 31. This includes coverage of 232,075 Marylanders through Medicaid and 63,002 through private health plans.

HSCRC staff is focusing its efforts on new categories of Medicaid enrollees, comprised of approximately 164,000 individuals. The chart below depicts the newly covered categories of Medicaid enrollees, and their total enrollment as of March 31, 2014:

Summary of New Coverage Enrollment	
Coverage Group	**Total**
Former Primary Adult Care	95,615
Expansion Childless Adults	66,539
Expansion Parents	1,904
Grand Total	**164,058**

The largest category of expansion enrollees is the population formerly under Maryland's Primary Adult Care (PAC) Program. PAC was a health care program for low-income adults aged 19 and older who did not qualify for full Medicaid benefits, but fell below a specified maximum income. 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. When PAC-enrolled individuals received hospital care, hospitals would generally not be reimbursed for the services provided, and the hospitals would treat the cost of these services as uncompensated care. Effective January 1, 2014, this category of enrollees was converted to full benefit coverage under Medicaid. Maryland hospitals will see resulting changes to uncompensated care now that former PAC enrollees have access to full packages of services, including hospital care.

Unlike the PAC enrollees who had limited benefits under Medicaid but were already enrolled, less is known about the other new categories of Medicaid enrollees, and it is likely that some of these individuals had some insurance coverage in the past. As a result, it will take more time to determine the impact of these new Medicaid enrollees on uncompensated care.

Similarly, some of the new private enrollees likely had previous coverage in the past. Additionally, these private enrollees must pay their first premium before obtaining coverage and the deductibles and coinsurances associated with these insurance plans may

be high. It will be some time before the impact of these individuals on uncompensated care can be determined.

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.

The HSCRC staff recommends a prospective yet conservative approach to determining the total funding for uncompensated care at the beginning of FY 2015 by considering two factors: 1) the increase in uncompensated care between FY 2012 and FY 2013; and 2) the expected decrease in uncompensated care based on expansion of Medicaid coverage to the PAC population.

In the future, HSCRC may need to propose further UCC adjustments to account for variations in UCC that are not captured by the PAC population. This may include a variation due to other new Medicaid or exchange enrollees, changes in undocumented immigrant populations, or increased prevalence of high deductible, high copay insurance plans. HSCRC staff will work with Chesapeake Regional Information System for our Patients (CRISP), State Medicaid officials, and hospitals to assess these trends in tandem. If uncompensated care continues to decline beyond the predicted levels and an adjustment is needed prior to the July 1, 2015 update, HSCRC may consider a mid-year reduction to rates to take into account actual and projected changes in uncompensated care.

Increase in Uncompensated Care between FY 2012 and FY 2013

As stated above, uncompensated care increased by 0.38 percentage points between FY 2012 and FY 2013. The HSCRC should take this increase into consideration when determining the final amount of funding to be allocated in hospital rates for uncompensated care.

Enrollment of the Primary Adult Care Population

HSCRC staff has focused initial efforts on quantifying the projected impact of expanded coverage for Maryland's PAC enrollees. Staff focused on this population because it is unlikely that many of these individuals had a form of coverage for hospital bills prior to

Medicaid enrollment and HSCRC has collected data on this population's health care utilization for several years.

The HSCRC staff worked with State officials and CRISP to perform a PAC analysis in which Medicaid enrollment was linked to hospital inpatient and outpatient charges using the CRISP Master Patient Index to obtain the hospital utilization levels of PAC enrollees in the year prior to their enrollment in full Medicaid coverage. A more detailed report on the PAC analysis is available on the HSCRC website:

http://hscrc.maryland.gov/documents/md-maphs/wg-meet/pay/2014-03-20/UCC-and-PAC-analysis-3.16.14-final.docx

The PAC analysis concluded that in FY 2013 the PAC population made up an estimated 15 percent of all uncompensated care in Maryland, approximately 1.08 percent of total gross patient revenue. The table below details PAC enrollee hospital utilization in 2013.

Table: PAC Enrollees Who Received Hospital Care, FY 2013

PAC Enrollees Who Received Hospital Care in FY 2013	
Hospital Inpatient	
Inpatient Stays	14,008
Unique Patients	11,784
Charges for Inpatient Stays	$127.2 million
Hospital Outpatient	
Outpatient Visits	42,839
Unique Patients	19,110
Charges for Outpatient Visits	$37.2 million

Source: CRISP analysis of HSCRC case mix data (7/1/2012-6/30/2013) and Maryland Medicaid MMIS enrollment files (2011-2013) provided by the Hilltop Institute. March 2014.

Note: As PAC reimbursed for emergency department services, the analysis removed emergency department visits from the other outpatient services and totals provided above.

The HSCRC can use the FY 2013 hospital utilization data of the PAC population prior to enrollment to adjust for the total uncompensated care funding for FY 2015 because this population is now fully insured for hospital services.

The HSCRC staff recommends using the actual PAC patient charges, converted to a percent to reduce the provision for UCC in hospitals' rates. HSCRC staff and hospitals verified the initial PAC data to determine accounts where partial or full payment was made, indicating that the amounts were not uncompensated care. Of the initial sample, it appears that an average of 10% of PAC had been paid by some source. HSCRC pulled additional PAC data for 2014, for individuals enrolled at the end of 2013 for charges showing as charity care or self pay in FY 2013 but not already included in the previous analysis. This amount of additional uncompensated care identified more than makes up for the payments received from PAC enrollees in the initial sample of data. As a result, staff recommends using the total amount from the initial data analysis.

The estimate for the reduction in UCC without any offsets for collections is 1.08 percent. It should be noted that Medicaid receives a differential of 6 percent, and 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.

As a result of these two changes, the UCC in hospitals' rates would be set at 6.16 percent:

In rates for FY 2014	6.86%
Increase for change in FY 2013	0.38%
Decrease for PAC	1.08%
Net.	6.16%

The HSCRC staff will need to continue to monitor the reductions in uncompensated care due to expansion of coverage and at the same time monitor the possible rise in uncompensated care due to increasing deductibles and coinsurances among commercial populations as well as other factors affecting collections. As a result, there may be additional reductions in uncompensated care for FY 2016 and if significant, the HSCRC staff may propose applying additional reductions during FY 2015.

Determining the Distribution of Uncompensated Care Funds to Each Regulated Maryland Hospital

The HSCRC staff has evaluated the current regression model together with several new models. The staff recommends replacing the current model based on the conclusion of its analyses that are more fully described below.

As discussed in the background section of this report, the HSCRC has relied on a three-year average of actual uncompensated care rates and a predicted uncompensated care rate calculated using a regression to determine which hospitals withdraw funds from the uncompensated care pool and which hospitals pay into it.

The regression model currently used by the HSCRC must be reevaluated in light of the Medicaid Expansion and may no longer be the best model for predicting uncompensated care rates for regulated Maryland hospitals. HSCRC staff prepared several analyses to evaluate the current regression model and to consider new variables and models that might be applied.

Evaluation of the Current Uncompensated Care Regression

The current regression model relies on four explanatory variables to predict the rate of uncompensated care at each hospital:

1. The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room
2. The proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases
3. The proportion of a hospital's total charges from outpatient non-Medicare emergency department charges
4. The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits

The current regression model was applied to FY 2011, FY 2012, and FY 2013 data in order to calculate the predicted uncompensated care rate for each hospital for FY 2015. Overall, the model had good explanatory results, but the explanatory variable "proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room" was not statistically significant. Appendix II shows the results of the current regression.

The HSCRC staff analyzed more than forty possible variables and identified five statistically significant variables that produced a better model for predicting uncompensated care percentages.

Five Statistically Significant Variables Model

HSCRC staff created a Five Statistically Significant Variables Model using the following explanatory variables:

1. The proportion of a hospital's total charges from inpatient Medicaid admissions through the emergency room

2. The proportion of a hospital's total charges from inpatient commercial insurance cases
3. The proportion of a hospital's total charges from inpatient self-pay and charity cases
4. The proportion of hospital's total charges from outpatient self-pay and charity emergency department charges
5. 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

Appendix III shows the results of the Five Statistically Significant Variable regression.

Similar to the current model that combines the regression with average actual values from the past three years, this regression is combined with actual values from the past two years. This was done so that the model would recognize the recent rise in uncompensated care in the State and to prepare for additional changes that will need to be made next year to adjust actual values for reductions resulting from PAC enrollment and other actions. Again, Levindale Hospital, the University of Maryland Rehabilitation & Orthopedic Institute (formerly Kernan Hospital) and the Shock Trauma Center are excluded from the regression calculation under this new model. And instead the annual uncompensated care percentages for these hospitals at their actual average uncompensated care percentage for the previous two years.

This model fit the observed data more closely than the current model, increasing the adjusted R-square value from 0.6705 under the current model to 0.7783 under the Five Statistically Significant Variables Model. Also the predicted uncompensated care rates from this model for FY 2013 more closely mirrored the actual rates of uncompensated care experienced by hospitals in FY 2013. There is some concern about separating Medicaid and self pay revenue sources as done in this model due to concerns about possible classification differences in Medicaid pending. Consistency in this area should improve with new instructions from HSCRC to facilitate more consistent classification in 2014 and beyond. In spite of this potential issue

The HSCRC included the fifth variable: the proportion of a hospitals total charges from inpatient self-pay and charity admission through the emergency room from the zip codes that represented the 80th percentile of Medicaid undocumented immigrant enrollment zip codes in order to begin to address the concerns regarding the impact of undocumented immigrants on uncompensated care levels. This observation is important because this population of patients will not gain coverage under the ACA. HSCRC staff was able to

construct a variable using zip codes with temporary Medicaid enrollment for undocumented immigrants with pregnancy or emergency room coverage.

The Five Statistically Significant Variables Model should be used in place of the current regression model for predicting the uncompensated care rates for regulated Maryland Hospitals. This model fits the data more closely than the current model and all of the explanatory variables are statistically significant. For FY 2016 and beyond, additional analysis should be conducted on other possible explanatory variables that may improve the model further and capture the continuing drivers of uncompensated care taking into account the impact of the ACA.

Continuing Suspension of Charity Care Multiplier

HSCRC staff recommend 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 is complete.

Evaluation of Continuing Sources of Uncompensated Care

With expanded coverage under ACA, HSCRC will need to carefully evaluate continuing sources of uncompensated care. The Payment Models work group recommended collection of write off data from hospitals that can be combined with hospital encounter data to determine the extent to which increasing deductibles are contributing to increases in uncompensated care and to assess other causes and variables that could be used in future analyses.

Furthermore, as discussed above, HSCRC staff notes that these changes to the uncompensated care policy laid out in this report should only be applied for FY 2015 and that in FY 2016, staff will need to make additional adjustments to the data as a result of the Medicaid expansion and other factors affecting uncompensated care. Staff can begin to prepare additional analysis using case mix data, Medicaid enrollment data, and write off data collected from hospitals to analyze continuing sources of uncompensated care.

RECOMMENDATIONS

The HSCRC staff recommends that:

1. The uncompensated care provision in rates be reduced from 6.86% to 6.16%;

2. Uncompensated care levels continue to be monitored for further potential reductions for FY 2016 or sooner, if warranted;
3. The regression formula be changed from the current model;
    a. To the Five Variable Model described in this report.
    b. The results of the Five Variable Model should be combined with two years of historical data to more closely reflect current trends in uncompensated care. This process will need to be modified next year as a result of the significant changes in bad debt levels.
    c. The regression model results be updated to reflect the more recent experience of hospitals with years ending after June 30, 2013 before finalization in June.
    d. The PAC% of FY 2013 charges should be subtracted 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 IV shows the initial results, but this analysis will need to be updated as indicated in item c above.
4. The Charity Care Adjustment be suspended indefinitely and not be reinstituted in FY 2015 rates;
5. Data be collected on write-offs to guide future development of uncompensated care regression models and uncompensated care policies;
6. Data 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
7. A new uncompensated care policy be developed for FY 2016 that reflects the patterns in uncompensated care experience that are observed in FY 2015 and projected for FY 2016.

Appendix I: Calculation to Achieve a Revenue Neutral Policy

The HSCRC calculates the annual UCC percentage for each hospital by combining the average actual UCC percentage for each hospital for the past three years with a predicted UCC percentage from the regression model. Then the HSCRC adjusts the annual UCC percentage for each hospital so that the total statewide UCC percentage is equal to the actual total statewide UCC percentage for 2013. This is done to achieve a revenue neutral system of pooling across all hospitals. This adjustment is done before any policy adjustments are 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: Results of Current Regression Model for 2015 (Not Revenue Neutral)

Results of the 2015 Uncompensated Care Regression Analysis - Current Methodology (Levindale, Kernan and Shock Trauma not Included)

HOSPID	Hospital Name	Fiscal Year 2013 Actual UCC	Fiscal Year 2013 Regression Predicted UCC	2011-2013 (Three Year Average)	50-50 UCC Blended Percent	Adjusted Blended Percent	Difference between Actual UCC and Adjusted UCC
210002	Univ. of Maryland Medical Center	5.40%	8.86%	6.52%	7.69%	7.60%	2.21%
210045	McCready Foundation, Inc.	8.32%	10.01%	10.45%	10.23%	10.14%	1.82%
210034	Harbor Hospital Center	8.59%	11.41%	8.33%	9.87%	9.78%	1.19%
210010	Univ. of Maryland Shore Medical Center at Dorchester	6.99%	9.94%	6.50%	8.22%	8.13%	1.14%
210060	Fort Washington Medical Center	12.39%	14.28%	12.70%	13.49%	13.40%	1.00%
210035	Univ. of Maryland Charles Regional Medical Center	7.46%	9.63%	7.42%	8.53%	8.44%	0.98%
210015	Franklin Square Hospital	7.06%	8.92%	6.84%	7.88%	7.79%	0.73%
210048	Howard County General Hospital	5.99%	7.56%	6.05%	6.81%	6.72%	0.73%
210057	Shady Grove Adventist Hospital	6.66%	8.51%	6.33%	7.42%	7.33%	0.67%
210012	Sinai Hospital	5.41%	7.22%	5.14%	6.18%	6.09%	0.67%
210009	Johns Hopkins Hospital	4.27%	6.04%	3.94%	4.99%	4.90%	0.64%
210044	Greater Baltimore Medical Center	3.12%	4.51%	3.09%	3.80%	3.71%	0.59%
210033	Carroll County General Hospital	4.70%	5.84%	4.89%	5.36%	5.27%	0.58%
210039	Calvert Memorial Hospital	6.16%	7.72%	5.87%	6.80%	6.71%	0.55%
210001	Meritus Medical Center	7.20%	8.04%	7.50%	7.77%	7.68%	0.49%
210032	Union Hospital of Cecil County	8.69%	9.71%	8.39%	9.05%	8.96%	0.27%
210062	Southern Maryland Hospital	6.84%	7.71%	6.65%	7.18%	7.09%	0.25%
210049	Upper Chesepeake Medical Center	5.94%	6.16%	6.24%	6.20%	6.11%	0.16%
210005	Frederick Memorial Hospital	6.03%	6.18%	6.21%	6.20%	6.11%	0.08%
210037	Univ. of Maryland Shore Medical Center at Easton	5.86%	6.37%	5.54%	5.95%	5.86%	0.01%
210056	Good Samaritan Hospital	6.60%	7.20%	6.06%	6.63%	6.54%	-0.06%
210011	St. Agnes Hospital	7.96%	8.37%	7.18%	7.77%	7.68%	-0.27%
210018	Montgomery General Hospital	6.59%	6.48%	6.32%	6.40%	6.31%	-0.28%
210003	Prince Georges Hospital	15.51%	15.60%	14.98%	15.29%	15.20%	-0.30%
210022	Suburban Hospital Association,Inc	5.07%	4.72%	4.83%	4.78%	4.69%	-0.38%
210019	Peninsula Regional Medical Center	6.87%	6.01%	6.77%	6.39%	6.30%	-0.57%
210004	Holy Cross Hospital of Silver Spring	9.26%	8.41%	9.07%	8.74%	8.65%	-0.61%
210023	Anne Arundel General Hospital	5.21%	4.52%	4.80%	4.66%	4.57%	-0.64%
210061	Atlantic General Hospital	7.68%	7.10%	6.92%	7.01%	6.92%	-0.75%
210040	Northwest Hospital Center, Inc.	8.41%	7.92%	7.56%	7.74%	7.65%	-0.76%
210028	St. Marys Hospital	8.47%	8.79%	6.78%	7.79%	7.70%	-0.78%
210063	Univ. of Maryland St. Josephs Medical Center	5.13%	4.12%	4.64%	4.38%	4.29%	-0.84%
210027	Braddock Hospital	6.89%	6.04%	6.23%	6.14%	6.05%	-0.84%
210029	Johns Hopkins Bayview Med. Center	9.28%	8.31%	8.44%	8.37%	8.28%	-1.00%
210017	Garrett County Memorial Hospital	10.86%	9.35%	10.55%	9.95%	9.86%	-1.00%
210008	Mercy Medical Center, Inc.	8.29%	6.88%	7.69%	7.29%	7.20%	-1.09%
210006	Harford Memorial Hospital	11.64%	9.39%	11.89%	10.64%	10.55%	-1.09%
210051	Doctors Community Hospital	9.29%	7.93%	8.33%	8.13%	8.04%	-1.25%
210024	Union Memorial Hospital	8.13%	6.32%	7.17%	6.74%	6.65%	-1.48%
210043	Univ. of Maryland Baltimore Washington Medical Center	9.78%	7.65%	9.10%	8.37%	8.28%	-1.49%
210030	Univ. of Maryland Shore Medical Center at Chestertown	10.13%	7.22%	9.80%	8.51%	8.42%	-1.71%
210013	Bon Secours Hospital	19.09%	16.76%	16.96%	16.86%	16.77%	-2.32%
210038	Univ. of Maryland Medical Center Midtown Campus	15.22%	12.81%	13.16%	12.98%	12.90%	-2.33%
210016	Washington Adventist Hospital	13.27%	9.33%	12.61%	10.97%	10.88%	-2.38%
210055	Laurel Regional Hospital	14.23%	10.07%	13.62%	11.85%	11.76%	-2.47%

Results of the 2015 Uncompensated Care Regression Analysis - Current Methodology (Levindale, Kernan and Shock Trauma not Included)

Dependent Variable: Actual Uncompensated Care Percent

Number of Observations Read	135
Number of Observations Used	135

Analysis of Variance

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	6	0.0874	0.01457	46.45	<.0001
Error	128	0.04014	0.000314		
Corrected Total	134	0.12754			
Root MSE	0.01771	**R-Square**	**0.6853**		
Dependent Mean	0.07906	**Adj R-Sq**	**0.6705**		
Coeff Var	22.3996				

Parameter Estimates

Variables	DF	Parameter Estimate	Standard Error	t Value	Pr > |t|
Intercept	1	-0.000259	0.00654	-0.04	0.9685
The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room	1	0.06733	0.04091	1.65	0.1022
The proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases	1	0.19333	0.04454	4.34	<.0001
The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits	1	0.24557	0.06884	3.57	0.0005
The proportion of a hospital's total charges from outpatient non-Medicare emergency department charges	1	0.20471	0.04532	4.52	<.0001
DUMMY1	1	-2.68E-05	0.00385	-0.01	0.9944
DUMMY2	1	-0.00378	0.00377	-1	0.3181

Appendix III: Results of Five Statistically Significant Variable Regression Model for 2015 (Not Revenue Neutral)

Results of the 2015 Uncompensated Care Regression Analysis - Five Statistically Significant Variables (using Two Year Average UCC - Kernan and Shock Trauma not Included)						
HOSPID	Hospital Name	Fiscal Year 2013 Actual UCC	2012-2013 (Two Year Average)	Fiscal Year 2013 Regression Predicted UCC	*Adjusted Blended Percent	Difference between Actual UCC and Adjusted UCC
210010	Univ. of Maryland Shore Medical Center at Dorchester	6.99%	6.27%	10.07%	8.21%	1.22%
210045	McCready Foundation, Inc.	8.32%	8.55%	10.35%	9.49%	1.17%
210002	Univ. of Maryland Medical Center	5.40%	5.87%	7.06%	6.50%	1.11%
210056	Good Samaritan Hospital	6.60%	6.25%	8.25%	7.29%	0.68%
210044	Greater Baltimore Medical Center	3.12%	3.09%	4.40%	3.79%	0.67%
210062	Southern Maryland Hospital	6.84%	6.32%	8.58%	7.49%	0.65%
210015	Franklin Square Hospital	7.06%	7.12%	8.21%	7.70%	0.64%
210035	Univ. of Maryland Charles Regional Medical Center	7.46%	7.30%	8.81%	8.09%	0.63%
210057	Shady Grove Adventist Hospital	6.66%	6.66%	7.79%	7.26%	0.60%
210001	Meritus Medical Center	7.20%	7.40%	8.10%	7.79%	0.59%
210033	Carroll County General Hospital	4.70%	4.73%	5.63%	5.22%	0.52%
210037	Univ. of Maryland Shore Medical Center at Easton	5.86%	5.53%	7.15%	6.38%	0.52%
210034	Harbor Hospital Center	8.59%	8.28%	9.73%	9.05%	0.46%
210003	Prince Georges Hospital	15.51%	15.34%	16.46%	15.94%	0.43%
210012	Sinai Hospital	5.41%	5.29%	6.28%	5.82%	0.41%
210018	Montgomery General Hospital	6.59%	6.54%	7.34%	6.98%	0.39%
210039	Calvert Memorial Hospital	6.16%	5.93%	7.04%	6.52%	0.37%
210048	Howard County General Hospital	5.99%	6.15%	6.37%	6.30%	0.31%
210005	Frederick Memorial Hospital	6.03%	6.11%	6.43%	6.31%	0.28%
210022	Suburban Hospital Association,Inc	5.07%	4.79%	5.79%	5.32%	0.25%
210060	Fort Washington Medical Center	12.39%	12.39%	12.80%	12.64%	0.24%
210011	St. Agnes Hospital	7.96%	7.31%	8.77%	8.08%	0.12%
210061	Atlantic General Hospital	7.68%	7.00%	8.52%	7.80%	0.12%
210009	Johns Hopkins Hospital	4.27%	3.98%	4.57%	4.32%	0.05%
210040	Northwest Hospital Center, Inc.	8.41%	7.62%	9.20%	8.45%	0.03%
210019	Peninsula Regional Medical Center	6.87%	6.85%	6.46%	6.69%	-0.17%
210051	Doctors Community Hospital	9.29%	8.61%	9.41%	9.05%	-0.24%
210049	Upper Chesepeake Medical Center	5.94%	5.94%	5.31%	5.67%	-0.28%
210023	Anne Arundel General Hospital	5.21%	4.92%	4.63%	4.81%	-0.40%
210027	Braddock Hospital	6.89%	6.54%	6.35%	6.48%	-0.41%
210016	Washington Adventist Hospital	13.27%	13.27%	12.29%	12.82%	-0.45%
210032	Union Hospital of Cecil County	8.69%	8.29%	8.06%	8.21%	-0.47%
210004	Holy Cross Hospital of Silver Spring	9.26%	9.41%	8.05%	8.77%	-0.49%
210063	Univ. of Maryland St. Josephs Medical Center	5.13%	4.71%	4.46%	4.62%	-0.50%
210029	Johns Hopkins Bayview Med. Center	9.28%	9.17%	8.12%	8.69%	-0.60%
210024	Union Memorial Hospital	8.13%	7.61%	7.23%	7.46%	-0.67%
210017	Garrett County Memorial Hospital	10.86%	11.10%	8.87%	10.02%	-0.83%
210043	Univ. of Maryland Baltimore Washington Medical Center	9.78%	9.20%	8.25%	8.76%	-1.01%
210055	Laurel Regional Hospital	14.23%	14.11%	12.09%	13.13%	-1.10%
210028	St. Marys Hospital	8.47%	7.39%	7.28%	7.37%	-1.10%
210030	Univ. of Maryland Shore Medical Center at Chestertown	10.13%	9.84%	8.03%	8.97%	-1.17%
210006	Harford Memorial Hospital	11.64%	11.64%	9.20%	10.46%	-1.18%
210008	Mercy Medical Center, Inc.	8.29%	7.70%	5.66%	6.72%	-1.57%
210013	Bon Secours Hospital	19.09%	17.79%	17.08%	17.47%	-1.62%
210038	Univ. of Maryland Medical Center Midtown Campus	15.22%	13.76%	11.37%	12.60%	-2.62%
Note: The "Adjusted Blended Percent" will change when Levindale, Kernan and Shock Trauma are included in the overall calculation of the statewide UCC average						

Results of the 2015 Uncompensated Care Regression Analysis - Five Statistically Significant Variables (Levindale, Kernan and Shock Trauma not Included)

Dependent Variable: Actual Uncompensated Care Percent

Number of Observations Read	135
Number of Observations Used	135

Analysis of Variance

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	7	0.10074	0.01439	68.21	<.0001
Error	127	0.0268	0.000211		
Corrected Total	134	0.12754			
Root MSE	0.01453	**R-Square**	**0.7899**		
Dependent Mean	0.07906	**Adj R-Sq**	**0.7783**		
Coeff Var	18.37332				

Parameter Estimates

Variables	DF	Parameter Estimate	Standard Error	t Value	Pr > |t|
Intercept	1	0.04566	0.00565	8.09	<.0001
The proportion of a hospital's total charges from inpatient Medicaid admissions through the emergency room	1	0.2062	0.03632	5.68	<.0001
The proportion of a hospital's total charges from inpatient Commercial Insurance cases	1	-0.12409	0.03072	-4.04	<.0001
The proportion of a hospital's total charges from inpatient Self-pay, and Charity cases	1	0.60815	0.16433	3.7	0.0003
The proportion of a hospital's total charges from outpatient Self-pay and Charity emergency department charges	1	1.49244	0.17785	8.39	<.0001
The proportion of a hospital's total charges from inpatient Self-pay and Charity admissions through the emergency room from the top 80% Medicaid Undocumented Aliens Enrollment Zip Codes	1	0.36559	0.15087	2.42	0.0168
DUMMY1	1	-0.00183	0.00316	-0.58	0.563
DUMMY2	1	-0.00423	0.00308	-1.37	0.1719

Appendix IV: Proposed Uncompensated Care Policy Results from the Five Statistically Significant Variable Model Including the PAC Adjustment

Proposed Policy Results from the Regression, Revenue Neutrality and PAC Adjustment for FY 2015

Hospid	Hospital Name	Actual UCC for FY '13	Predicted UCC	FY '12- FY '13 UCC Average	50/ 50 Blended UCC Average	Revenue Neutrality Adjustment	Policy Results without PAC Adjustemnt	PAC Adjustemnt	Policy Results with PAC Adjustemnt
210001	Meritus Medical Center	7.20%	8.10%	7.40%	7.75%	1.006766	7.80%	1.66%	6.14%
210002	Univ. of Maryland Medical Center	5.40%	7.06%	5.87%	6.47%	1.006766	6.51%	1.85%	4.66%
210003	Prince Georges Hospital	15.51%	16.46%	15.34%	15.90%	1.006766	16.01%	1.09%	14.92%
210004	Holy Cross Hospital of Silver Spring	9.26%	8.05%	9.41%	8.73%	1.006766	8.79%	0.31%	8.48%
210005	Frederick Memorial Hospital	6.03%	6.43%	6.11%	6.27%	1.006766	6.32%	0.90%	5.41%
210006	Harford Memorial Hospital	11.64%	9.20%	11.64%	10.42%	1.006766	10.49%	1.50%	9.00%
210008	Mercy Medical Center, Inc.	8.29%	5.66%	7.70%	6.68%	1.006766	6.73%	1.34%	5.38%
210009	Johns Hopkins Hospital	4.27%	4.57%	3.98%	4.28%	1.006766	4.31%	0.78%	3.53%
210010	Univ. of Maryland Shore Medical Center at Dorchester	6.99%	10.07%	6.27%	8.17%	1.006766	8.23%	2.67%	5.56%
210011	St. Agnes Hospital	7.96%	8.77%	7.31%	8.04%	1.006766	8.09%	1.45%	6.65%
210012	Sinai Hospital	5.41%	6.28%	5.29%	5.78%	1.006766	5.82%	1.10%	4.72%
210013	Bon Secours Hospital	19.09%	17.08%	17.79%	17.44%	1.006766	17.55%	5.80%	11.75%
210015	Franklin Square Hospital	7.06%	8.21%	7.12%	7.67%	1.006766	7.72%	0.95%	6.77%
210016	Washington Adventist Hospital	13.27%	12.29%	13.27%	12.78%	1.006766	12.87%	0.55%	12.31%
210017	Garrett County Memorial Hospital	10.86%	8.87%	11.10%	9.99%	1.006766	10.05%	0.75%	9.31%
210018	Montgomery General Hospital	6.59%	7.34%	6.54%	6.94%	1.006766	6.99%	0.78%	6.21%
210019	Peninsula Regional Medical Center	6.87%	6.46%	6.85%	6.66%	1.006766	6.70%	1.30%	5.40%
210022	Suburban Hospital Association,Inc	5.07%	5.79%	4.79%	5.29%	1.006766	5.32%	0.28%	5.04%
210023	Anne Arundel General Hospital	5.21%	4.63%	4.92%	4.77%	1.006766	4.81%	0.54%	4.27%
210024	Union Memorial Hospital	8.13%	7.23%	7.61%	7.42%	1.006766	7.47%	1.45%	6.02%
210027	Braddock Hospital	6.89%	6.35%	6.54%	6.44%	1.006766	6.49%	1.06%	5.43%
210028	St. Marys Hospital	8.47%	7.28%	7.39%	7.34%	1.006766	7.38%	1.09%	6.30%
210029	Johns Hopkins Bayview Med. Center	9.28%	8.12%	9.17%	8.65%	1.006766	8.71%	1.73%	6.97%
210030	Univ. of Maryland Shore Medical Center at Chestertown	10.13%	8.03%	9.84%	8.93%	1.006766	8.99%	0.77%	8.22%
210032	Union Hospital of Cecil County	8.69%	8.06%	8.29%	8.18%	1.006766	8.23%	1.82%	6.41%
210033	Carroll County General Hospital	4.70%	5.63%	4.73%	5.18%	1.006766	5.22%	0.69%	4.52%
210034	Harbor Hospital Center	8.59%	9.73%	8.28%	9.01%	1.006766	9.07%	1.47%	7.60%
210035	Univ. of Maryland Charles Regional Medical Center	7.46%	8.81%	7.30%	8.05%	1.006766	8.11%	0.80%	7.30%
210037	Univ. of Maryland Shore Medical Center at Easton	5.86%	7.15%	5.53%	6.34%	1.006766	6.38%	0.83%	5.55%
210038	Univ. of Maryland Medical Center Midtown Campus	15.22%	11.37%	13.76%	12.57%	1.006766	12.65%	3.52%	9.13%
210039	Calvert Memorial Hospital	6.16%	7.04%	5.93%	6.48%	1.006766	6.53%	1.05%	5.48%
210040	Northwest Hospital Center, Inc.	8.41%	9.20%	7.62%	8.41%	1.006766	8.46%	0.93%	7.53%
210043	Univ. of Maryland Baltimore Washington Medical Center	9.78%	8.25%	9.20%	8.73%	1.006766	8.79%	1.02%	7.76%
210044	Greater Baltimore Medical Center	3.12%	4.40%	3.09%	3.75%	1.006766	3.77%	0.38%	3.40%
210045	McCready Foundation, Inc.	8.32%	10.35%	8.55%	9.45%	1.006766	9.51%	2.76%	6.75%
210048	Howard County General Hospital	5.99%	6.37%	6.15%	6.26%	1.006766	6.30%	0.61%	5.69%
210049	Upper Chesepeake Medical Center	5.94%	5.31%	5.94%	5.63%	1.006766	5.67%	0.61%	5.06%
210051	Doctors Community Hospital	9.29%	9.41%	8.61%	9.01%	1.006766	9.07%	0.61%	8.46%
210055	Laurel Regional Hospital	14.23%	12.09%	14.11%	13.10%	1.006766	13.18%	0.94%	12.24%
210056	Good Samaritan Hospital	6.60%	8.25%	6.25%	7.25%	1.006766	7.30%	0.90%	6.40%
210057	Shady Grove Adventist Hospital	6.66%	7.79%	6.66%	7.22%	1.006766	7.27%	0.57%	6.70%
210060	Fort Washington Medical Center	12.39%	12.80%	12.39%	12.60%	1.006766	12.68%	0.86%	11.83%
210061	Atlantic General Hospital	7.68%	8.52%	7.00%	7.76%	1.006766	7.81%	1.42%	6.39%
210062	Southern Maryland Hospital	6.84%	8.58%	6.32%	7.45%	1.006766	7.50%	0.94%	6.56%
210063	Univ. of Maryland St. Josephs Medical Center	5.13%	4.46%	4.71%	4.58%	1.006766	4.61%	0.72%	3.89%
210058	Univ. of Maryland Rehabilitation and Orthopaedic Institute	5.20%	5.77%	5.77%	5.77%	1.006766	5.80%	1.13%	4.67%
218992	Univ. of Maryland (MIEMSS)	22.32%	21.22%	21.22%	21.22%	1.006766	21.37%	0.25%	21.11%
212005	Levindale Geriatric Center and Hospital	1.82%	0.00%	1.82%	1.82%	1.006766	1.83%	0.00%	1.83%
	STATEWIDE	7.21%	0.00%	0.00%	7.16%	1.006766	7.21%	1.09%	6.12%

Draft Recommendation for Shared Savings Program for FY 2015

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

May 14, 2014

This document contains the draft staff recommendations for implementing a Shared Savings Program for FY 2015. Comments on the draft recommendation are due in writing to the Commission by COB Thursday, June 2nd, 2014, attention: Dr. Sule Calikoglu at the Commission address or to Sule.Calikoglu@maryland.gov

A. Introduction

The Commission approved a shared savings policy on May 1, 2013, which reduced hospital revenues based on risk-adjusted readmission rates using specifications set forth in the Admission-Readmission Revenue Constraint Program (ARR). The program was developed to maintain Maryland's exemption from the CMS readmission program and required a reduction of 0.3 percent of inpatient revenues in the state during FY2015. This draft recommendation proposes the continuation of the shared savings policy with no methodology changes.

B. Background

Exemption Criteria from CMS Quality-Based Payment Programs

As of federal fiscal year 2013, Section 3025 of the Patient Protection and Affordable Care Act (H.R. 3590) requires the Secretary of Health and Human Services to reduce payments to hospitals relative to excess readmissions as a means of reducing Medicare readmissions nationally. Medicare requires Inpatient Prospective Payment System (IPPS) hospitals outside of Maryland to engage in Medicare's Hospital Readmissions Reduction program. According to this IPPS rule published for FFY 2015, the Secretary is authorized to exempt Maryland hospitals from the Medicare Readmissions Reduction Program if Maryland submits an annual report describing how a similar program in the State achieves or surpasses the nationally measured results for patient health outcomes and cost savings under the Medicare program. As mentioned in other quality-based payment recommendations, the new All-Payer model changed the criteria for maintaining exemptions from the CMS programs. As part of the CMMI contract, the aggregate maximum revenue at risk in Maryland quality/performance based payment programs must be equal to or greater than the aggregate maximum revenue at risk in the CMS Medicare quality programs.

Staff is currently working with CMMI to determine the exact calculation of aggregate amount at of revenue risk for CY 2014, the first year of performance period. Table 1 provides the most current estimates based on existing and proposed adjustments.

Table 1: Maximum Percent At Risk Amounts for Medicare and Maryland Quality Programs

Program	Medicare	Maryland
	FFY 2014	SFY 2014
VBP/QBR	1.25%	0.50%
HAC/MHAC		2.00%
HRRP/Readmission Shared Savings	2.00%	0.41%
GBR Adjustments		TBD
TOTAL	**3.25%**	**2.91%**
	FFY 2015	SFY 2015
VBP/QBR	1.50%	0.50%
HAC/MHAC	1.00%	3.00%
HRRP/Readmission Shared Savings	3.00%	0.86%
GBR Adjustments		TBD
TOTAL	**5.50%**	**4.36%**

	Medicare	Maryland	MD - Medicare
CY 2014	3.81%	3.64%	-0.18%

Approved Methodology to Implement Shared Savings Program

The approved shared savings methodology the HSCRC calculates a case mix adjusted readmission rate based on ARR specifications (intra-hospital readmissions excluding 0-1 day stays with planned admission exclusions) for each hospital for the base period and determines a statewide required percent reduction in readmission rates to achieve the revenue for shared savings. The case mix adjustment is based on observed vs. expected readmissions, calculated using the statewide average readmission rate for each DRG SOI cell and aggregated for each hospital. HSCRC staff then applies a shared savings benchmark to the risk-adjusted readmission rate to calculate the contribution from each hospital. The shared savings benchmark is the required percent reduction in readmissions necessary to achieve the predetermined revenue for shared shavings,

C. Assessment

HSCRC staff calculated risk-adjusted readmission rates of each hospital for calendar year 2012 APR-DRG v29 to be used as the basis of shared savings reductions (Appendix 1). The readmission rates are based on current ARR methodology, which includes only intra-hospital readmissions based on a fixed 30-day period excluding 0-1 day stays and excludes planned readmissions using CMS planned admission algorithm v2. Once the statewide number of readmissions is determined, the statewide required reductions are calculated as described in Table 2.

Table 2: Calculation of Statewide Reduction based on 0.4% of total revenue shared savings

Total Approved Revenue FY 2014	A	$15,208,056,320
Percent Inpatient	B	59.3%
Approved Inpatient Revenue	C = (A/B)	$9,014,965,119
Proposed Required Revenue Reduction %	F	0.40%
Proposed Required Revenue Reduction ($)	G=A*F	$60,832,225
Total Discharges Included	D	551,514
Average Approved Charge Per Case	E=C/D	$16,346
Readmission as a percent of Total Discharges	H	7.36%
Total Number of Readmissions	I = D*H	40,592
Required Reduction in Readmissions to achieve savings	J=G/E	(3,722)
Required New Readmission Rate	K=(I+J)/D	6.69%
Required Percent Reduction in Readmission Rate	L=K/H-1	**-9.17%**

Once the overall required reduction in readmission rates is determined, the hospital specific reduction as a percent of total revenue would be based on the following formula:

*Inpatient revenue percent reduction= Hospital Risk-Adjusted Readmission Rate*Statewide required reduction in readmission rate*

The conversion to reduction as a percent of total revenue then would be:

*Total revenue percent reduction= Inpatient percent revenue reduction*proportion of total revenue from inpatient.*

Appendix 2 provides the results of shared savings policy based on proposed 0.4% reduction in total patient revenues.

The existing shared savings reductions policy has a number of advantages:

- Every hospital contributes to the shared savings; however, the shared savings are distributed in proportion to each hospital's case mix adjusted readmission rates in the base year.
- The shared savings amount is not related to actual reduction in readmissions during the rate year, hence providing equitable incentive across all hospitals. Hospitals that reduce their readmission rates beyond the shared savings benchmark during the rate year will retain 100 percent of the difference between their actual reduction and the shared savings benchmark.
- When applied prospectively, the HSCRC sets and may adjust the targeted dollar amount for shared savings, thus guaranteeing a fixed amount of shared savings.
- As the shared savings contributions are calculated as a reduction in readmissions in the current ARR program, the methodology does not rank hospitals based on readmission rates, which require adjustment for inter-hospital and out-of-state readmissions.

The measurement for future years will need to be expanded as majority of hospitals will be under global budgets and will have incentives to reduce overall avoidable utilization not only readmissions,.

D. Recommendations

HSCRC staff recommends that the Commission to set the value of the shared savings amount to at 0.4 % of total permanent revenue in the state.

Appendix I: Risk Adjusted ARR Readmission Rates, CY 2013

Hospital ID	Hospital Name	CY2013					
		Total Admissions	Expected Readmissions*	Observed Readmissions	Observed Rate	Readmission Ratio	Risk Adjusted Rate
		A	B	C	D = C/A	E=C/B	F = E*Total D
210027	WESTERN MARYLAND HEALTH SYS	11,529	856.78	1,088	9.44%	1.2699	9.35%
210040	NORTHWEST	11,224	1111.8	1,377	12.27%	1.2385	9.12%
210030	CHESTERTOWN	1,674	172.56	204	12.19%	1.1822	8.70%
210009	JOHNS HOPKINS	37,234	3227.1	3,641	9.78%	1.1283	8.30%
210001	MERITUS	15,780	1121.6	1,252	7.93%	1.1163	8.22%
210029	HOPKINS BAYVIEW MED CTR	17,627	1355.5	1,521	8.63%	1.1221	8.26%
210043	BALTIMORE WASHINGTON MEDICAL	15,782	1400	1,570	9.95%	1.1214	8.25%
210028	ST. MARY	6,614	430.07	476	7.20%	1.1068	8.15%
210023	ANNE ARUNDEL	26,652	1462.1	1,578	5.92%	1.0793	7.94%
210012	SINAI	22,764	1787.6	1,919	8.43%	1.0735	7.90%
210015	FRANKLIN SQUARE	20,473	1497.9	1,601	7.82%	1.0688	7.87%
210019	PENINSULA REGIONAL	17,152	1319	1,408	8.21%	1.0675	7.86%
210056	GOOD SAMARITAN	10,307	1015.9	1,084	10.52%	1.0670	7.85%
210032	UNION HOSPITAL OF CECIL COUNT	4,959	387.67	412	8.31%	1.0628	7.82%
210033	CARROLL COUNTY	9,842	736.28	779	7.92%	1.0580	7.79%
210005	FREDERICK MEMORIAL	16,815	1213.2	1,255	7.46%	1.0345	7.61%
210048	HOWARD COUNTY	16,855	1021.4	1,051	6.24%	1.0290	7.57%
210011	ST. AGNES	16,388	1249.4	1,233	7.52%	0.9869	7.26%
210018	MONTGOMERY GENERAL	7,547	580.03	572	7.58%	0.9862	7.26%
210035	CHARLES REGIONAL	7,087	562.52	550	7.76%	0.9777	7.20%
210013	BON SECOURS	4,847	499.67	484	9.99%	0.9686	7.13%
210049	UPPER CHESAPEAKE HEALTH	11,585	862.52	831	7.17%	0.9635	7.09%
210051	DOCTORS COMMUNITY	8,933	906.23	871	9.75%	0.9611	7.07%
210055	LAUREL REGIONAL	5,853	388.33	368	6.29%	0.9476	6.97%
210004	HOLY CROSS	31,613	1544.1	1,448	4.58%	0.9378	6.90%
210034	HARBOR	8,327	549.41	515	6.18%	0.9374	6.90%
210022	SUBURBAN	10,806	924.61	856	7.92%	0.9258	6.81%
210057	SHADY GROVE	21,970	1213.1	1,131	5.15%	0.9323	6.86%
210062	SOUTHERN MARYLAND	12,802	1007.4	932	7.28%	0.9252	6.81%
210002	UNIVERSITY OF MARYLAND	22,419	1886.6	1,722	7.68%	0.9128	6.72%
210024	UNION MEMORIAL	10,899	942.98	858	7.87%	0.9099	6.70%
210008	MERCY	16,357	896.41	798	4.88%	0.8902	6.55%
210010	DORCHESTER	2,047	196.97	173	8.45%	0.8783	6.46%
210060	FT. WASHINGTON	1,881	161.23	142	7.55%	0.8807	6.48%
210016	WASHINGTON ADVENTIST	11,718	846.31	734	6.26%	0.8673	6.38%
210006	HARFORD	3,929	371.46	315	8.02%	0.8480	6.24%
210037	EASTON	7,890	551.47	468	5.93%	0.8486	6.25%
210039	CALVERT	6,059	428.03	362	5.97%	0.8457	6.22%
210061	ATLANTIC GENERAL	2,708	263.24	225	8.31%	0.8547	6.29%
210063	UM ST. JOSEPH	14,301	959.5	814	5.69%	0.8484	6.24%
210044	G.B.M.C.	18,130	1059	876	4.83%	0.8272	6.09%
210038	UMMC MIDTOWN	5,840	557.17	426	7.29%	0.7646	5.63%
210003	PRINCE GEORGE	11,422	750.67	561	4.91%	0.7473	5.50%
210045	MCCREADY	264	29.62	20	7.58%	0.6752	4.97%
210017	GARRETT COUNTY	1,858	114.69	71	3.82%	0.6191	4.56%
210058	REHAB & ORTHO	2,751	172.79	20	0.73%	0.1157	0.85%
TOTAL		**551,514**	**40,592**	**40,592**	**7.36%**	**1.0000**	**7.36%**

* Based on Statewide readmissions by Initial Admission APR-DRG SOI

UPDATED 3/18/13

Appendix 2: Proposed Shared Savings Policy Reductions for FY 2015

Hospital ID	Hospital Name	CY13 Risk Adjusted Rate	Inpatient Revenue Reduction	Proportion of Total Revenue from Inpatient CY 2013	Percent Reduction in Total Revenue For RY 2015
A	B	C	D=C*9.17%	E	F=E*D
210027	WESTERN MARYLAND HEALTH	9.35%	-0.86%	57.40%	**-0.49%**
210040	NORTHWEST	9.12%	-0.84%	57.32%	**-0.48%**
210030	CHESTERTOWN	8.70%	-0.80%	46.74%	**-0.37%**
210009	JOHNS HOPKINS	8.30%	-0.76%	62.62%	**-0.48%**
210029	HOPKINS BAYVIEW MED CTR	8.26%	-0.76%	59.24%	**-0.45%**
210043	BALTIMORE WASHINGTON MED	8.25%	-0.76%	57.27%	**-0.43%**
210001	MERITUS	8.22%	-0.75%	62.34%	**-0.47%**
210028	ST. MARY	8.15%	-0.75%	43.92%	**-0.33%**
210023	ANNE ARUNDEL	7.94%	-0.73%	56.33%	**-0.41%**
210012	SINAI	7.90%	-0.72%	61.90%	**-0.45%**
210015	FRANKLIN SQUARE	7.87%	-0.72%	59.69%	**-0.43%**
210019	PENINSULA REGIONAL	7.86%	-0.72%	57.28%	**-0.41%**
210056	GOOD SAMARITAN	7.85%	-0.72%	60.06%	**-0.43%**
210032	UNION HOSPITAL OF CECIL COU	7.82%	-0.72%	44.30%	**-0.32%**
210033	CARROLL COUNTY	7.79%	-0.71%	56.43%	**-0.40%**
210005	FREDERICK MEMORIAL	7.61%	-0.70%	56.85%	**-0.40%**
210048	HOWARD COUNTY	7.57%	-0.69%	61.57%	**-0.43%**
210011	ST. AGNES	7.26%	-0.67%	58.27%	**-0.39%**
210018	MONTGOMERY GENERAL	7.26%	-0.67%	52.51%	**-0.35%**
210035	CHARLES REGIONAL	7.20%	-0.66%	51.49%	**-0.34%**
210013	BON SECOURS	7.13%	-0.65%	60.81%	**-0.40%**
210049	UPPER CHESAPEAKE HEALTH	7.09%	-0.65%	48.21%	**-0.31%**
210051	DOCTORS COMMUNITY	7.07%	-0.65%	60.72%	**-0.39%**
210055	LAUREL REGIONAL	6.97%	-0.64%	63.36%	**-0.41%**
210004	HOLY CROSS	6.90%	-0.63%	69.00%	**-0.44%**
210034	HARBOR	6.90%	-0.63%	62.23%	**-0.39%**
210057	SHADY GROVE	6.86%	-0.63%	62.33%	**-0.39%**
210022	SUBURBAN	6.81%	-0.62%	64.13%	**-0.40%**
210062	SOUTHERN MARYLAND	6.81%	-0.62%	62.20%	**-0.39%**
210002	UNIVERSITY OF MARYLAND	6.72%	-0.62%	68.90%	**-0.42%**
210024	UNION MEMORIAL	6.70%	-0.61%	59.21%	**-0.36%**
210008	MERCY	6.55%	-0.60%	48.87%	**-0.29%**
210060	FT. WASHINGTON	6.48%	-0.59%	41.58%	**-0.25%**
210010	DORCHESTER	6.46%	-0.59%	49.18%	**-0.29%**
210016	WASHINGTON ADVENTIST	6.38%	-0.59%	63.33%	**-0.37%**
210061	ATLANTIC GENERAL	6.29%	-0.58%	40.11%	**-0.23%**
210037	EASTON	6.25%	-0.57%	53.41%	**-0.31%**
210063	UM ST. JOSEPH	6.24%	-0.57%	60.02%	**-0.34%**
210006	HARFORD	6.24%	-0.57%	44.99%	**-0.26%**
210039	CALVERT	6.22%	-0.57%	47.51%	**-0.27%**
210044	G.B.M.C.	6.09%	-0.56%	48.05%	**-0.27%**
210038	UMMC MIDTOWN	5.63%	-0.52%	60.59%	**-0.31%**
210003	PRINCE GEORGE	5.50%	-0.50%	69.60%	**-0.35%**
210045	MCCREADY	4.97%	-0.46%	23.06%	**-0.11%**
210017	GARRETT COUNTY	4.56%	-0.42%	41.63%	**-0.17%**
210058	REHAB & ORTHO	0.85%	-0.08%	60.17%	**-0.05%**
Total		**7.36%**	**-0.67%**	**60.00%**	**-0.40%**

DRAFT: Update Factors Recommendations for FY 2015

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

May 14, 2014

These draft recommendations are for Commission consideration at the May 2014 Public Commission Meeting. No action is required. Public comments should be sent to Dennis Phelps dennis.phelps@maryland.gov. For full consideration, comments must be received by June 2, 2014.

DRAFT: Recommendations on Update Factors

INTRODUCTION

Overview

On July 1 of each year, the HSCRC updates hospitals' rates and approved revenues to account for inflation, policy adjustments, and other adjustments related to performance and settlements from the prior year.

On January 10, 2014, the Center for Medicare & Medicaid Innovation (CMMI) approved the implementation of a new All-Payer Model for Maryland. The All-Payer Model has a three part aim of promoting better care, better health, and lower cost for all Maryland patients. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model focuses on controlling increases in total hospital revenue per capita. The Model establishes both an All-Payer limit of 3.58% annual per capita growth for Maryland residents for the first three years of the Model and a Medicare savings target of $330 million over the initial five-year period of the Model.

The update process needs to take into account all sources of hospital revenue that will contribute to the growth of total Maryland hospital revenues for Maryland residents in order to meet the requirements of the All-Payer Model and assure that the annual update approved by the HSCRC will not result in a revenue increase beyond the limit. In addition, HSCRC needs to consider the effect of the update on the Model's Medicare savings requirement and the total hospital revenue at risk for quality, care delivery, and value enhancement. While rates and global budgets are approved on a fiscal year basis, the All-Payer Model revenue limits and the Medicare savings are determined on a calendar year basis. Therefore, it is necessary to account for both calendar year and fiscal year revenues in establishing updates for the fiscal year.

There are three categories of hospital revenue under the All-Payer Model. The first two categories are under full rate setting authority of HSCRC. The third category of hospital revenue includes hospitals where HSCRC sets rates, but Medicare does not pay on the basis of those rates. The three categories are:

1. Hospitals/revenues under global budgets, including the Global Budget Revenue (GBR) agreements initiated in conjunction with transition policies and Total Patient Revenue (TPR) agreements for 10 hospitals that were renewed July 1, 2013 for their second three-year term.

2. Hospital revenues that are not included under global budgets but are subject to rate regulation on an All-Payer basis by HSCRC, including hospitals that remain on a Charge-Per-Episode (CPE)/Charge-Per-Case (CPC) agreement and hospital revenues excluded from a global budget, such as revenues for non-residents.
3. Hospital revenues for which HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMMI has not waived Medicare's rate setting authority to Maryland. This includes psychiatric hospitals and Mount Washington Pediatric Hospital.

This report includes draft recommendations for fiscal year (FY) 2015 updates.

STAKEHOLDER INPUT

HSCRC staff has worked with the Payment Models work group to provide input and review of its draft recommendations regarding updates and short-term adjustments. A draft work group report entitled "Report on Balanced Update and Short-Term Adjustments" was presented to the Commission at the April public meeting. A copy of the draft report is included as an attachment to this recommendation to facilitate reference and review.

ANALYSIS

Calculation of Update Factors for Revenue Categories 1-3

In this draft staff recommendation, we are focused on recommending the update factor that will be provided for inflation/trend for hospitals or revenues in each of the three categories. There are separate staff reports that provide recommendations on uncompensated care and shared savings relative to readmissions.

Updates for both categories 1 and 2 start by using the actual blended statistic of 2.41% growth, derived from combining 91.2% of the 2014 estimates of 2.5% from Global Insights for market basket increase with 8.8% of the capital growth estimate of 1.5%. For those revenues that are not subject to global budgets, additional subtractions are made to reflect productivity and an additional reduction provided under the Affordable Care Act for Medicare. The 0.5% reduction for productivity is 0.1% above the amount used in the Medicare adjustment, but Medicare makes other adjustments that have not been applied. As a result, the proposed rate adjustment would be as follows:

	Global Revenues	Non-Global Revenues
Proposed base update	2.41%	2.41%
Productivity adjustment		-0.50%
ACA adjustment		-0.20%
Proposed update	2.41%	1.71%

For psychiatric hospitals and Mt. Washington Pediatric Hospital, we turn to the proposed psychiatric facility update for Medicare. Medicare applies a 0.7% reduction for productivity and ACA savings mandates to a market basket update of 2.7% to derive a net amount of 2.0%. HSCRC staff proposes to use that same factor for the Maryland psychiatric hospitals and Mt. Washington Pediatric Hospital.

Medicare Growth

Under the previous waiver, HSCRC focused on cost per case. Under the new All-Payer model, the Medicare savings requirement is driven by changes in Medicare payments per beneficiary in Maryland relative to changes in per beneficiary payment nationally.

HSCRC staff obtained per beneficiary projections from the Office of the Actuary, reviewed proposed and actual updates for PPS, and reviewed the 2014 MedPac repot for use in its evaluation. The table below presents the estimates received from the Office of the Actuary. These tables were provided based on projections used for the federal budget as of February 2014. The most significant factor driving per beneficiary increases is outpatient volumes. As discussed in the following paragraphs, the impact of Medicare's Disproportionate Share adjustment (DSH) is significant while also being difficult to ascertain. Medicaid enrollment increases may cause the allowance to go up while the law mandates a reduction in the levels paid, decreasing the allowance[1]. Actual Medicare cost increases could vary significantly from the estimates.

[1] MedPac estimates a 0.7% increase in DSH payments in 2014 followed by more than a 2% decrease in DSH payments in 2015. The CMS website indicates, "As part of the PPACA, Medicare DSH payments will be reduced 75 percent by 2019, or $49.9 billion. The 2015 proposed rule would cut overall Medicare DSH payments by 1.1 percent in FY 2015, compared with FY 2014. Medicare DSH payments would continue to be distributed under the new policy, which is based on hospitals' uncompensated care amounts."

HSCRC staff will be working with CMS staff to monitor the actual results and will be acquiring actuarial and other assistance from outside vendors to help monitor these factors on an ongoing basis. HSCRC staff will confer with MedPac and CMS staff gain additional insights where possible.

Per Capita Hospital Spending Projections

[Based on the President's FY 2015 Budget]

	Annual Per Capita Expenditures			Per Capita Trend		
CY	Inpatient	Outpatient	Total Hospital	Inpatient	Outpatient	Total Hospital
2013	3,704	1,085	4,789			
2014	3,724	1,144	4,868	0.5%	5.5%	1.7%
2015	3,730	1,221	4,952	0.2%	6.8%	1.7%
2016	3,759	1,306	5,065	0.8%	6.9%	2.3%
2017	3,843	1,389	5,233	2.2%	6.4%	3.3%
2018	4,022	1,481	5,503	4.6%	6.6%	5.2%

Proposed updates to federal Medicare inpatient rates for 2015 have just been published in the Federal Register. These will not be finalized for several months and could change. A summary description of proposed changes is attached. Additional subtracting from the CMS updates include value based purchasing, HAC, and readmission adjustments, as well as the DSH adjustment. The Medicare figures below do not include a provision for volume increases. The inpatient adjustment becomes negative when considering the other adjustments to the base.

Federal FY 2015	Proposed IP	Estimated OP based on IP
Base Update		
Market Basket	2.70%	
Productivity	-0.40%	
ACA	-0.20%	
Coding	-0.80%	N/A
	1.30%	2.10%

In its December 2013 report, Staff estimated updates of 0.2% for inpatient (effective 10.1.2013) and 1.7% for outpatient (effective 1.1.2014).

Evaluation of the Balanced Update

Staff has inserted the figures above into the balanced update model that was presented in the Draft Payment Models Workgroup Report on Balanced Updates and Short-Term Adjustments. The table has been reordered to facilitate the understanding of the impact of uncompensated care and assessments on the results. A section has been added to the table to compare the update results to the CareFirst model that projects the impact of the update on the Medicare savings estimates.

RECOMMENDATIONS

The preliminary recommendations of the HSCRC Staff are as follows:

1) Provide update for the three categories of hospitals and revenues as follows:
   a) Revenues under global budgets--2.4%.
   b) Revenues not under global budgets but subject to Medicare rate setting waiver--1.7%.
   c) Revenues for psychiatric hospitals and Mr. Washington Pediatric Hospital--2.0%.

2) Since the new All-Payer model operates on a Calendar Year, review the results from contracting to determine any impact on the recommendations that would result from the global budget agreements and report at June Commission meeting.

3) Establish update factor for 6 month period, to allow for consideration of calendar year performance and unanticipated changes under the new model. Monitor and review results on an ongoing basis and make changes as needed on January 1.
   a) Complete guardrail policy recommendations from workgroup relative to approaches to make adjustments when targets are not being met.

4) Ensure that other policy recommendations are implemented that assure the overall targets, including the readmissions savings policy and the uncompensated care adjustment that are under review in providing a final recommendation.

The HSCRC Staff expects to present final recommendations at the June 2014 HSCRC meeting, with expected implementation effective July 1, 2014. Comments can be sent to Dennis Phelps at dennis.phelps@maryland.gov. For full consideration, comments must be received by June 2, 2014

Balanced Update Model

Maximum allowed revenue growth limit percentage

Maximum revenue growth per capita	A	3.58% per capita
Population growth	B	0.71%
Maximum revenue growth total ((1+A)*(1+B) -1	C	4.32% total

Components of revenue change-increases

	Proportion of Revenues	Allowance	Weighted Allowance
Adjustment for inflation/policy adjustments			
-Global budget revenues	90%	2.41%	2.17%
-Non global revenues	10%	1.71%	0.17%
			2.34%
Adjustment for volume			
-Global budget revenues	90%	0.80%	0.72%
-Non global revenues	10%	1.20%	0.12%
-Market share adjustments			
			0.84%
Infrastructure allowance provided			
-Global budget revenues except TPR	80%	0.33%	0.26%
CON adjustments-			
-Opening of Holy Cross Germantown Hospital			0.40%
Net increase before adjustments			3.84%
Other adjustments (positive and negative)			
-Set aside for unforeseen adjustments and cushion			0.50%
-Reverse prior year's shared savings reduction			0.20%
-Positive incentives			0.00%
-Shared savings/negative scaling adjustments			-0.40%
Net increaes attributable to hospitals			4.14%
Per Capita			3.41%

Components of revenue changes-net decreases from UCC and assessments

-Uncompensated care increase	0.38%
-Uncompensated care reduction	-1.00%
-MHIP adjustment	-0.45%
- Other Assessment Adjustment	0.00%
Net decreases	-1.07%
Net result	3.07%
Per Capita	2.34%

Balanced Update Model

Comparison to Maximum Increase that Can Produce Medicare Savings (CareFirst Formula)

Medicare		
Two year average of Medicare growth (CY 2014 + CY 2015)/2	D	1.70%
Savings Requirement for Year 2/2 years	E	-0.50%
Maximum growth rate that will achieve savings (D+E)	F	1.20%
Conversion to All-Payer		
Difference statistic between Medicare and All-Payer	G	2.00%
Conversion to All-Payer growth per resident (1+F)*(1+G)-1	H	3.22%
Converstion to total All-Payer revenue growth (1+H)*(1+B)-1	I	3.96%

When using the estimates provided above, the model projects that an update within the parameters of the allowed 3.58% per capita can be derived on an All-Payer basis for the fiscal year and that the Medicare savings can be achieved if the differential statistic of 2% is maintained and if the actuarial projections are reasonable. The Chart below compares the expected maximum All-Payer Growth that could occur to achieve Medicare savings based on the 2% difference statistic model. As stated before, the actual results for Medicare will be different than the projections and those differences may be material.

	All-Payer Maximum to achieve Medicare Savings	Projected All-Payer Growth
Revenue Growth	3.96%	3.07%
Per Capita Growth	3.22%	2.34%

Staff Recommendation

Request by the Medical Assistance Program to Modify the Calculation of Current Financing Deposits for CY 2014

May 14, 2014

Introduction

The Medical Assistance Program (MAP) has been providing working capital advance monies (current financing) to hospitals for many years. As a result, MAP receives the prompt pay discount as per COMAR 10.37.10.26(B). MAP is unique among third-party payers in that it is a governmentally funded program that covers qualified poor residents of Maryland. As such, it deals, to a large extent, with retroactive coverage. Recognizing the uniqueness of MAP, the Commission allowed MAP to negotiate a special formula with the hospital industry to calculate its fair share of current financing monies. The Commission approved this alternative method of calculating current financing at its February 1, 1995 public meeting. Currently MAP has approximately $94 million in current financing on deposit with Maryland hospitals.

As a result of the state budget crisis, MAP requested, and the Commission approved, an exception to the requirement that the amount of current financing on deposit with hospitals be re-calculated annually based on the alternative methodology approved by the Commission for CYs 2009 through 2013. MAP also proposed that there be changes in its current financing formula when its new claims system, which is projected to achieve a dramatic reduction in hospital receivables, is implemented.

MAP's Current Request

As a result of continuing budget shortfalls, on February 24, 2014, MAP requested an exception to the approved current financing calculation for FY 2014. MAP requested that it be permitted to increase the current financing amounts on deposit with each hospital by the HSCRC's update factor for FY 2014. MAP also reported that it anticipated deploying the new claims system in the 2nd quarter of FY 2015.

Staff Recommendation

Based on the current condition of MAP's budget, staff recommends that the Commission approve MAP's request. Staff also recommends that the approval be subject to the requirement that MAP continue to report annually on the status of the implementation of its new claims system.

Draft Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2015

May 14, 2014

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

This is a Draft to be considered at the May 14, 2014 HSCRC public meeting. Any comments on this draft must be emailed to Dianne Feeney at dianne.feeney@maryland.gov by COB on May 27, 2014.

Draft Recommendations on HSCRC Financial Support of the Maryland Patient Safety Center for FY 2015

Introduction

In 2004, the HSCRC adopted recommendations that made it a partner in the initiation of the MPSC by providing seed funding through hospital rates. The initial recommendations provided funding to cover 50% of the reasonable budgeted costs of the Center. The Commission receives a briefing and documentation annually on the progress of the MPSC in meeting its goals as well as an estimate of expected expenditures and revenues for the upcoming fiscal year. Based on these presentations, staff has evaluated the reasonableness of the budget items presented and made recommendations to the Commission.

Over the past 10 years, the rates of eight Maryland hospitals were increased by the following amounts in total, and funds have been transferred on a biannual basis (by October 31 and March 31 of each year):

- FY 2005 - $ 762,500
- FY 2006 - $ 963,100
- FY 2007 - $1,134,980
- FY 2008 - $1,134,110
- FY 2009 - $1,927,927
- FY 2010 - $1,636,325
- FY 2011 - $1,544,594
- FY 2012 - $1,314,433
- FY 2013 - $1,225,637
- FY 2014 - $1,200,000

On March 10, 2014, the HSCRC received the attached request for continued financial support of the MPSC through rates in FY 2015 (Appendix I). The MPSC is requesting a total of $1,080,000 in funding support from HSCRC.

Background

The 2001 General Assembly passed the "Patients' Safety Act of 2001," charging the Maryland Health Care Commission (MHCC), in consultation with the Department of Health and Mental Hygiene (DHMH), with studying the feasibility of developing a system for reducing the number of preventable adverse medical events in Maryland including, a system of reporting such incidences. The MHCC subsequently recommended the establishment of a Maryland Patient Safety Center (MPSC or Center) as one approach to improving patient safety in Maryland.

In 2003, the General Assembly endorsed this concept by including a provision in legislation to allow the MPSC to have medical review committee status, thereby making the proceedings, records, and files of the MPSC confidential and not discoverable or admissible as evidence in any civil action.

The operators of the MPSC were initially chosen through the State of Maryland's Request for Proposals (RFP) procurement process. At the request of MHCC, the two respondents to the RFP to operate the MPSC, the Maryland Hospital Association (MHA) and the Delmarva Foundation for Medical Care (Delmarva), agreed to collaborate in their efforts. The RFP was subsequently awarded jointly to the two organizations for a three-year period (January 2004 through December 2006). The RFP authorized two one-year extensions beyond the first three years of the pilot project. MHCC extended the contract for two years ending December 31, 2009. The Center was reorganized and subsequently re-designated as an entity independent from MHA and the Delmarva Foundation by MHCC as the state's patient safety center for an additional five years – through 2014. The Center is currently in discussions with MHCC regarding the re-designation of the Center for an additional five years, with an MHCC vote anticipated on this in June 2014.

Assessment

Strategic Partnerships

The MPSC has established and continues to build new strategic partnerships with key organizations to achieve its mission and goals. The organizations with which they indicate they are working closely and anticipate continuing to do so for FY 2015 and beyond include private and public agencies and organizations working across the continuum of care to improve patient safety (Appendix I). Notably, the MPSC continues to expand their partnerships with nursing home, home health and other provider stakeholders. For home health, the newest setting of focus for MPSC, the number of agencies and patients served are illustrated in Table 1 below.

Table 1. Home Health Facilities Reporting to MPSC

Home Health		
Month-Year	**# of Facilities Reporting**	**Patients Served**
Jan '13	8	2867
Feb '13	8	2916
Mar '13	8	3073
Apr '13	8	3045
May '13	9	3989
Jun '13	8	3488
Jul '13	8	3215
Aug '13	8	3318
Sep '13	6	2577
Oct '13	9	3631
Nov '13	9	3282
Dec '13	10	3415
TOTAL		**38816**
AVERAGE		**3235**

Draft Recommendations on HSCRC Financial Support of the Maryland Patient Safety Center for FY 2015

Maryland Patient Safety Center 2013 Activities, Accomplishments, and Outcomes

The Center's key activities and accomplishments are outlined in Appendix 1. Some highlights are as follows:

- For Falls Prevention and Reduction of Harm, for rate of falls with injury, transition from acute care to long-term care.
    - Falls rate in general has remained steady in acute care settings but have increased in long term and home health care settings, likely due to increased focus on measurement in the latter settings; falls with injury have decreased in all three settings, significantly in acute care and slightly in long term and home health care.
- For Hand Hygiene Initiative, transferring acute care model to emergency department and long-term care in order to reduce preventable infections through better hand hygiene compliance.
    - Compliance in acute care reached the 90% goal in January 2014.
- For the perinatal/Neonatal Learning Network:
    - Advancing proven developed toolkits and education aimed at improved management of OB hemorrhage with an ultimate goal of reducing mortality.
    - Prevention of necrotizing enterocolitis utilizing best practice and evidenced-based research to reduce infant mortality.
        - Inductions before 39 weeks without medical indication has decreased from 0.8% in March 2011 to 0.22% in December 2013.
        - Cesarean sections before 39 weeks without medical indication has decreased from 2.6% in March 2011 to 0.75% in December 2013.
- For Sepsis Prevention, beginning July 1, 2014 reduce mortality due to sepsis through early identification and treatment in acute care settings.

MPSC Cash Reserves and FY 2015 Projected Budget

MPSC reported to the HSCRC that as of 2/28/14 they have cash reserves of $743,038 which is approximately 132 days cash on hand.

In, FY 14, MPSC continued its efforts to work with its partners to secure program-specific funding, and estimates the amounts they will secure for FY 2015 as illustrated in Table 2 below. Staffing and fringe expenses proposed for 5 FTEs, which are allocated to the program areas in the expenses, total $711,194.

Draft Recommendations on HSCRC Financial Support of the Maryland Patient Safety Center for FY 2015

Table 2. Proposed Revenue and Expenses

REVENUE	FY 2014 Budget	FY 2015 Budget
Cash Contributions from MHA/Delmarva	200,000	200,000
Cash Contributions from Hospitals	300,000	151,350
Cash Contributions for Long-term Care	50,000	25,000
HSCRC Funding	1,200,000	1,080,000
Membership Dues	-	247,500
Education Session Revenue	150,000	35,000
Conference Registrations-Annual MedSafe Conference	10,000	7,000
Conference Registrations-Annual Patient Safety Conference	230,000	157,500
Sponsorships	125,000	128,000
Program Sales	-	50,000
DHMH Grant	-	250,000
Other Grants/Contributions	100,000	135,000
Total Revenue	**2,365,000**	**2,466,350**

EXPENSES	FY 2014 MPSC	FY 2014 Consultants	FY 2014 Total	FY 2015 MPSC	FY 2015 Consultants	FY 2015 Total
Administration	562,450		562,450	538,000		538,000
Outpatient Dialysis (previously committed)	75,000		75,000	-		-
Programs			-			-
Education Sessions		189,000	189,000		98,000	98,000
Annual Patient Safety Conference		417,650	417,650		400,000	400,000
MEDSAFE Conference		52,850	52,850		55,000	55,000
Caring for HC	65,300	88,550	153,850	67,500	130,000	197,500
Patient/Family Centered Care	59,400	16,150	75,550	-	-	-
Safety Initiatives-Perinatal/Neonatal	81,850	55,000	136,850	250,000	-	250,000
Safety Initiatives-Hand Hygiene	66,850	55,000	121,850	87,500	7,500	95,000
Safety Initiatives-Safe from Falls	66,850	55,000	121,850	52,250	250	52,500
Safety Initiatives-Adverse Event Reporting	-	-	-	21,000	84,000	105,000
Patient Safety Certification	129,600	327,200	456,800	115,500	285,000	400,500
Sepsis	-	-	-	169,000	17,500	186,500
Total Expenses	**1,107,299**	**1,256,400**	**2,363,700**	**1,300,750**	**1,077,250**	**2,378,000**

MPSC Return on Investment

As was noted in the last several Commission recommendations, the All-Payer System has provided funding support for the Maryland Patient Safety Center with the expectation that there would be both short-term and long-term reductions in hospital costs – particularly as a result of reduced mortality rates, lengths of stays, patient acuity, and malpractice insurance costs. However, these results are difficult to quantify and the Center has been able to provide limited evidence that the programs have resulted in cost savings, and only to the extent that these savings relate to individual programs and for limited periods of time. The Commission continues to desire that the Center provide more information that would:

1. Show program outcomes on a longer term basis along with concomitant savings; and,
2. Demonstrate the magnitude of the public's return on investment of funding support.

The MPSC has begun to analyze the data on HSCRC Maryland Hospital Acquired Conditions related to infection in order to monitor changes in rates that may correlate

with the MPSC Hand Hygiene and Sepsis Prevention work. Results will be reported as they become available.

Based on the reports MPSC has provided, staff continues to believe that the programs of the MPSC are well conceived. The new sepsis prevention program aligns with the Commission's goals as it aspires to reduce infection complications and mortality. MPSC has worked particularly hard at establishing relationships with providers across the continuum of care in the past year, and to raise alternate sources of revenue, particularly in conference registration fees and in membership dues, demonstrating perceived value of the Center's provider customer base.

Recommendations

In light of the information presented above, staff provides for the Commission's consideration the draft recommendations below on the MPSC funding support policy.

1. HSCRC provide funding support for the MPSC in FY 2015 through an increase in hospital rates in the amount of $1,080,000, a $120,000 (10%) reduction from FY 2014;
2. The MPSC establish and maintain reasonable cash reserves;
3. The MPSC continue to aggressively pursue other sources of revenue, including from other provider groups that benefit from the programs of the Center, to help support the Center into the future;
4. MPSC staff continue to develop and conduct its activities to ensure standardization of self-reported data collection;
5. As has been articulated in the last several FY's funding recommendations, funding support in the future should consider: (1) how well the MPSC initiatives fit into a broader statewide plan for patient safety; (2) whether new MPSC revenues should offset HSCRC funding support; (3) how much MPSC has in budgetary reserve; (4) information on patient safety outcomes and the public's return on investment (from HSCRC funding); and (5) how MPSC initiatives dovetail with the HSCRC's payment-related initiatives and priorities, and other relevant patient safety activities, e.g., the HSCRC MHAC work; MHCC and MHA work to decrease surgical site infections, catheter associated urinary tract infection, central line associated blood stream infection; statewide steering committee work to improve care transitions and reduce harm across the continuum of care, etc.; and,
6. Going forward, HSCRC decrease the dollar amount of support by a minimum of 10% per year. Staff notes the criteria outlined in recommendation 5 are intended to provide rationale for funding decreases greater than 10%, but not less, in subsequent years.

Maryland Patient Safety Center FY 2015 Program Plan & Budget

Presented to the Health Services Cost Review Commission

March 2014

Creation of the Maryland Patient Safety Center

- In 2001, the Maryland General Assembly passed the "Patients' Safety Act of 2001" charging the Maryland Health Care Commission (MHCC) with studying the feasibility of developing a system for reducing the incidence of preventable adverse medical events in Maryland
- In 2003, legislation was passed establishing the Maryland Patient Safety Center
- In 2004, the MHCC solicited proposals from organizations to create the Maryland Patient Safety Center. They approved a joint proposal from the Maryland Hospital Association and the Delmarva Foundation
- In 2004, designated by the MHCC as the state's Patient Safety Organization through 2009. Re-designated in 2009 through 2014
- In 2007, the Maryland Patient Safety Center was incorporated as a 501(c)(3) organization
- In 2008, listed as a federal Patient Safety organization and relisted through 2014

MPSC Awards & Distinctions

- Recognized at the 2009 National Patient Safety Foundation Annual Conference and Institute for Healthcare Improvement Conference
- Honored in 2005 with the Agency for Healthcare Research and Quality's John M. Eisenberg Patient & Safety Quality Award
- Considered a model by other states. The Maryland Patient Safety Center has acted as host and resource for other states interested in creating something similar
- Selected by the Maryland Health Quality & Cost Council to lead the statewide Maryland Hospital Hand Hygiene Collaborative
- First state organization to submit harm prevention data to the Centers for Medicare and Medicaid Services as part of the Partnership for Patients initiative
- 75 % of Maryland hospitals made annual voluntary contributions to the Center in FY2014 representing $ 246,650

Maryland Patient Safety Center Board of Directors

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  Shady Grove Adventist Hospital
- **Fredia S. Wadley**, MD, President & CEO
  Quality Health Strategies
- **Kathleen White**, PhD, RN, NEA-BC, FAAN,
  Associate Professor,
  Department of Acute and Chronic Care
  The Johns Hopkins University School of Nursing

Strategic Priorities

Vision - *Who we are*

A center of patient safety innovation, convening providers of care to accelerate our understanding of, and implement evidence–based solutions for, preventing avoidable harm

Mission – *Why we exist*

Making healthcare in Maryland the safest in the nation

Goals - *What will we accomplish*

- Eliminate preventable harm for every patient, with every touch, every time
- Develop a shared culture of safety among patient care providers
- Be a model for safety innovation in other states

Strategic Areas of Focus - *What we will do*

- Prevent Harm and Demonstrate the Value of Safety
- Spread Excellence
- Lead Innovation in New Areas of Safety Improvement

Strategic Partners

- **Courtemanche & Associates -** An interdisciplinary healthcare firm that serves healthcare organizations to improve care through compliance with regulatory and accreditation requirements.
- **Quantros -** National vendor of adverse event reporting services.
- **Delmarva Foundation** – Maryland state QIO
- **Health Facilities Association of Maryland -** A leader and advocate for Maryland's long-term care provider community.
- **Institute for Safe Medication Practices** – The leading national organization educating others about safe medication practices.
- **Maryland Healthcare Education Institute** – The educational affiliate of the Maryland Hospital Association.
- **Maryland Hospital Association** - The advocate for Maryland's hospitals, health systems, communities, and patients before legislative and regulatory bodies.
- **LifeSpan Network -** The largest senior care provider association in the Mid-Atlantic, representing more than 300 senior care provider organizations in Maryland and the District of Columbia.
- **Maryland Ambulatory Surgical Association -** The state membership association that represents ambulatory surgery centers (ASCs) and provides advocacy and resources to assist ASCs in delivering high quality, cost-effective ambulatory surgery to the patients they serve.
- **Johns Hopkins School of Medicine / The Armstrong Institute for Patient Safety and Quality** – The patient safety center within Johns Hopkins Medicine.

FY15 Initiatives: Education Programs

- Educational programming according to needs of members & marketplace.
- Objectives:
  - Educate providers regarding pertinent patient safety/medication related issues
  - Expand geographic and participant reach of the Center
  - Increase participation levels
  - Increase revenue generation
  - Establish Center as recognized educational resource
- Vendor – Maryland Healthcare Education Institute

FY15 Initiatives: Conferences

- The Annual Maryland Patient Safety Center Conference is the Center's signature event; providing awareness, education and the exchange of best practice solutions to a broad-based audience that goes well beyond the Center's usual participants. The annual Medication Safety Conference has become a premier event for the Center concentrating on the prevention of medication errors with an emphasis on processes and technology.
- Objectives:
  - Educate providers regarding pertinent patient safety / medication related issues
  - Expand geographic and participant reach of the Center
  - Increase participation levels
  - Increase revenue generation
  - Establish Center as recognized educational resource
- Vendor: Maryland Healthcare Education Institute

FY15 Initiatives: Patient Safety Certification

- The certification will utilize both traditional classroom instruction and practical application methodology incorporating positive psychology ; using the Patient Safety Officer (PSO) as the focal point. This is an institutional certification.
- Objectives:
  - Ensure competency level of PSO
  - Identify and solve actual patient safety issues
  - Engrain “culture of patient safety”
  - Establish patient safety as an institutional focus
  - Develop teamwork approach to solving patient safety issues
  - Empower participating staff to be patient safety leaders
  - Provide real and measurable impact
- Year two funding focuses on evaluation of pilot sites, implementation of positive psychology module and post-pilot curriculum refinements
- Vendor: Courtemanche & Associates

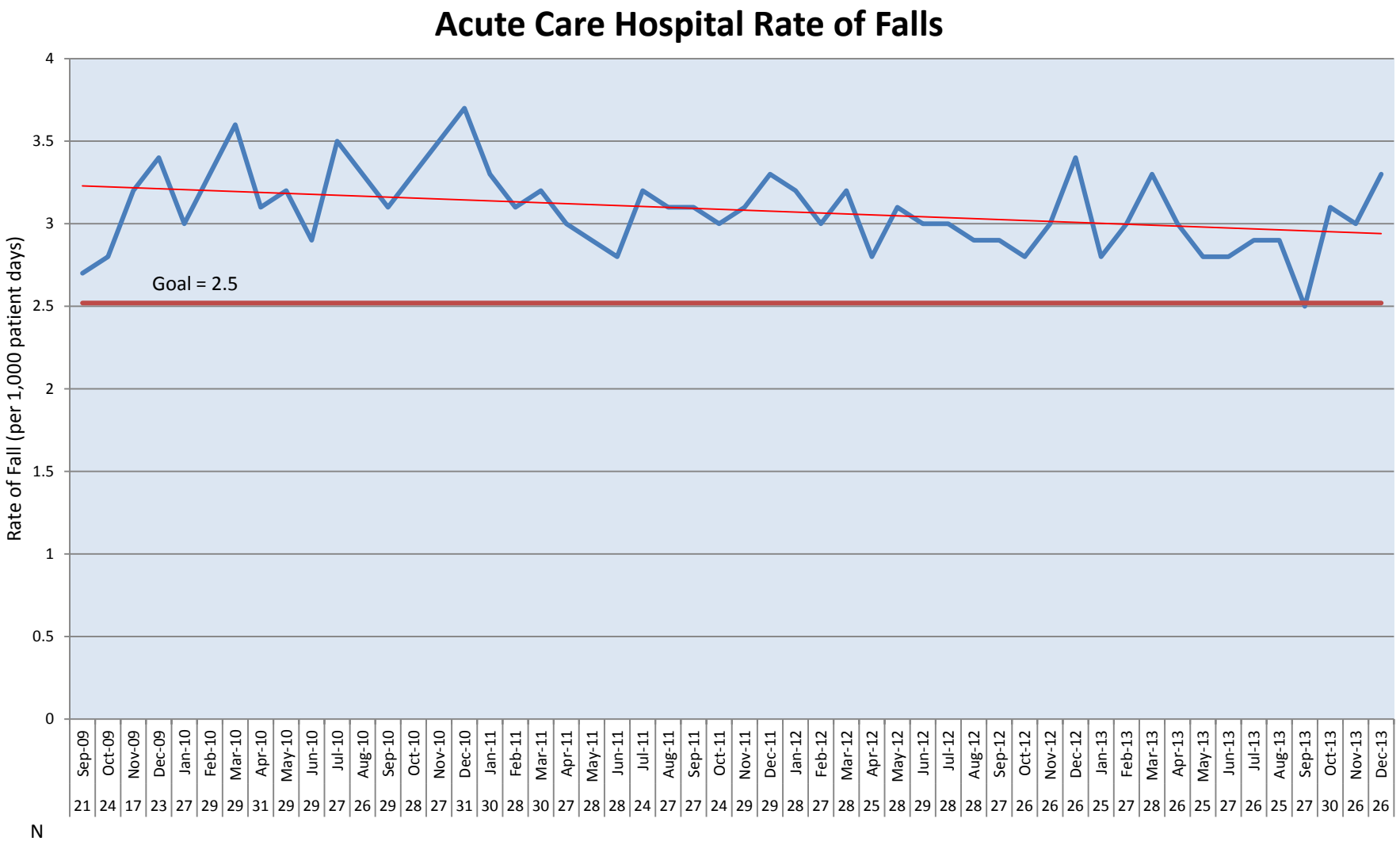
FY15 Initiatives: Caring for the Caregiver

- Provides timely support to healthcare employees who encounter stressful, patient-related events related to the "second victim" situation.
- Objectives:
  - Reduce the number of harmful patient safety incidents
  - Increase patient satisfaction scores
  - Improve worker satisfaction
  - Increase worker retention rates
- Year two funding focuses on evaluation and development of the "peer to peer" training module
- Vendor: Johns Hopkins University School of Medicine / Armstrong Institute for Patient Safety and Quality

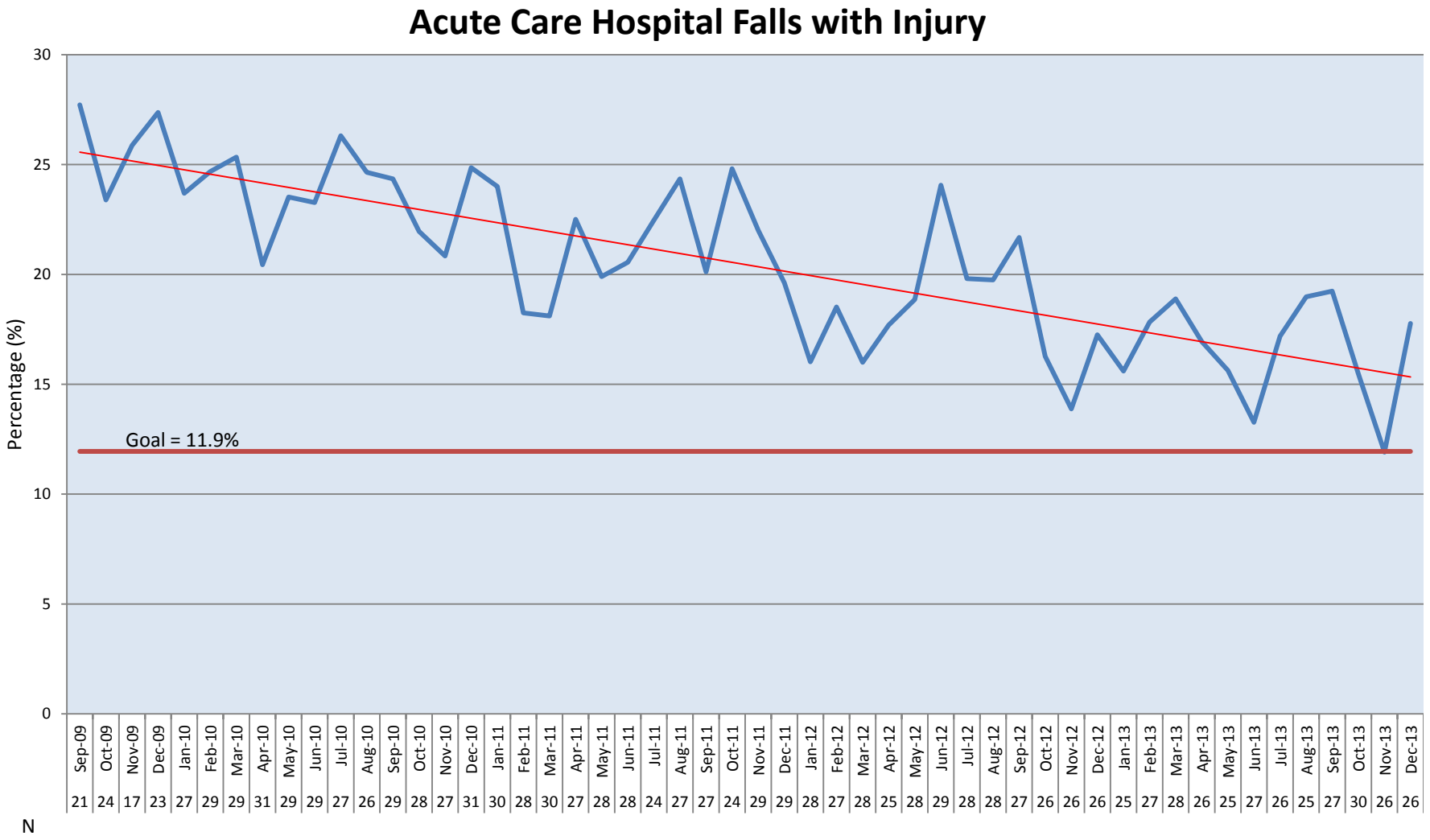
FY15 Initiatives: Safety Initiatives

- Falls Reduction & Prevention of Harm
  - Transition from acute care to long-term care with a focus on rate of falls with injury
- Hand Hygiene Initiative
  - Transferring acute care model to ED specific and long-term care in order to reduce preventable infections through better hand hygiene compliance
- Perinatal/Neonatal Learning Network
  - Advancing proven developed toolkits and education aimed at improved management of OB hemorrhage with an ultimate goal of reducing mortality
  - Prevention of NEC utilizing best practice and evidenced based research to reduce infant mortality
- Sepsis Prevention
  - Reduce mortality due to sepsis through early identification and treatment

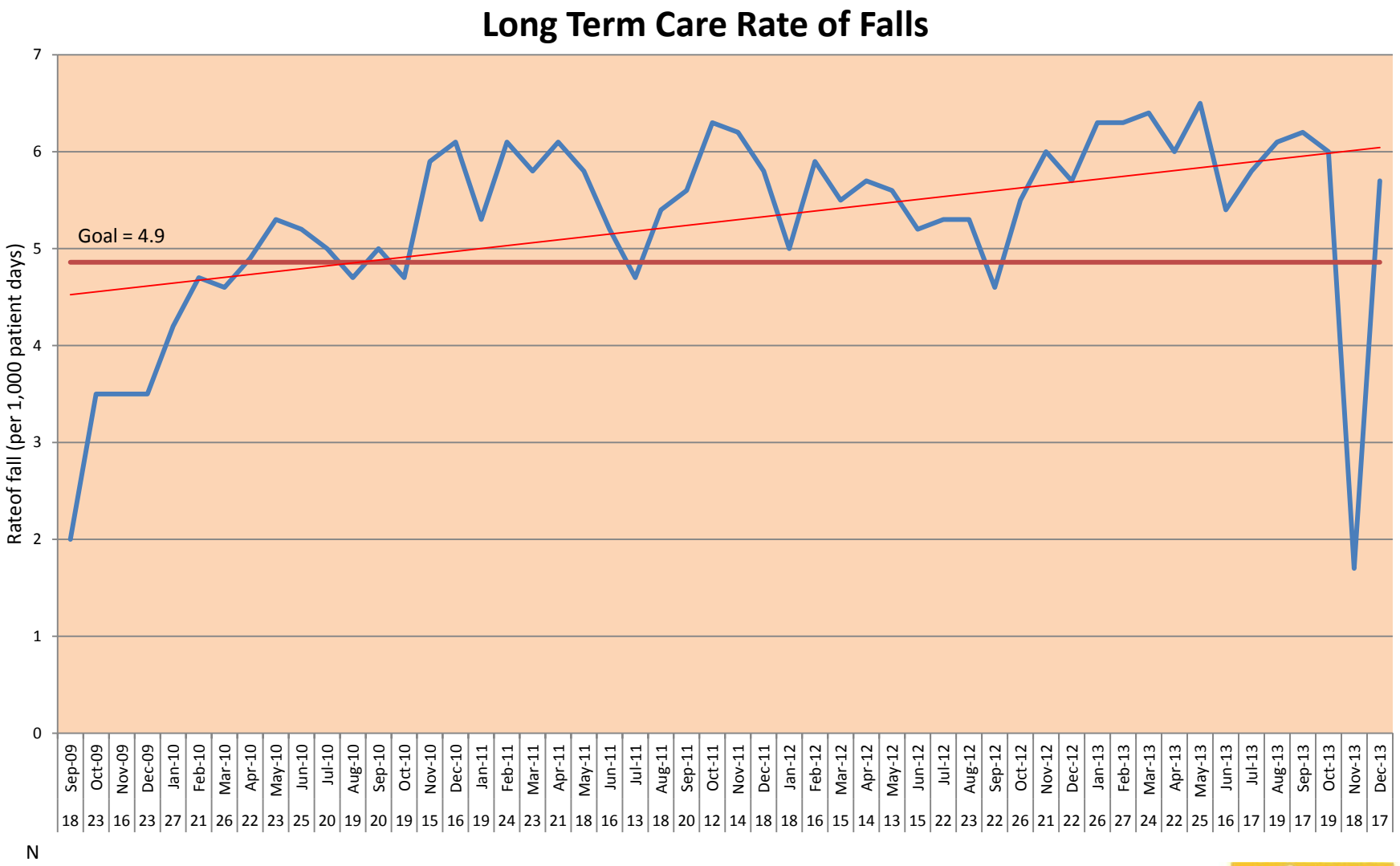
SAFE from FALLS – Acute Care



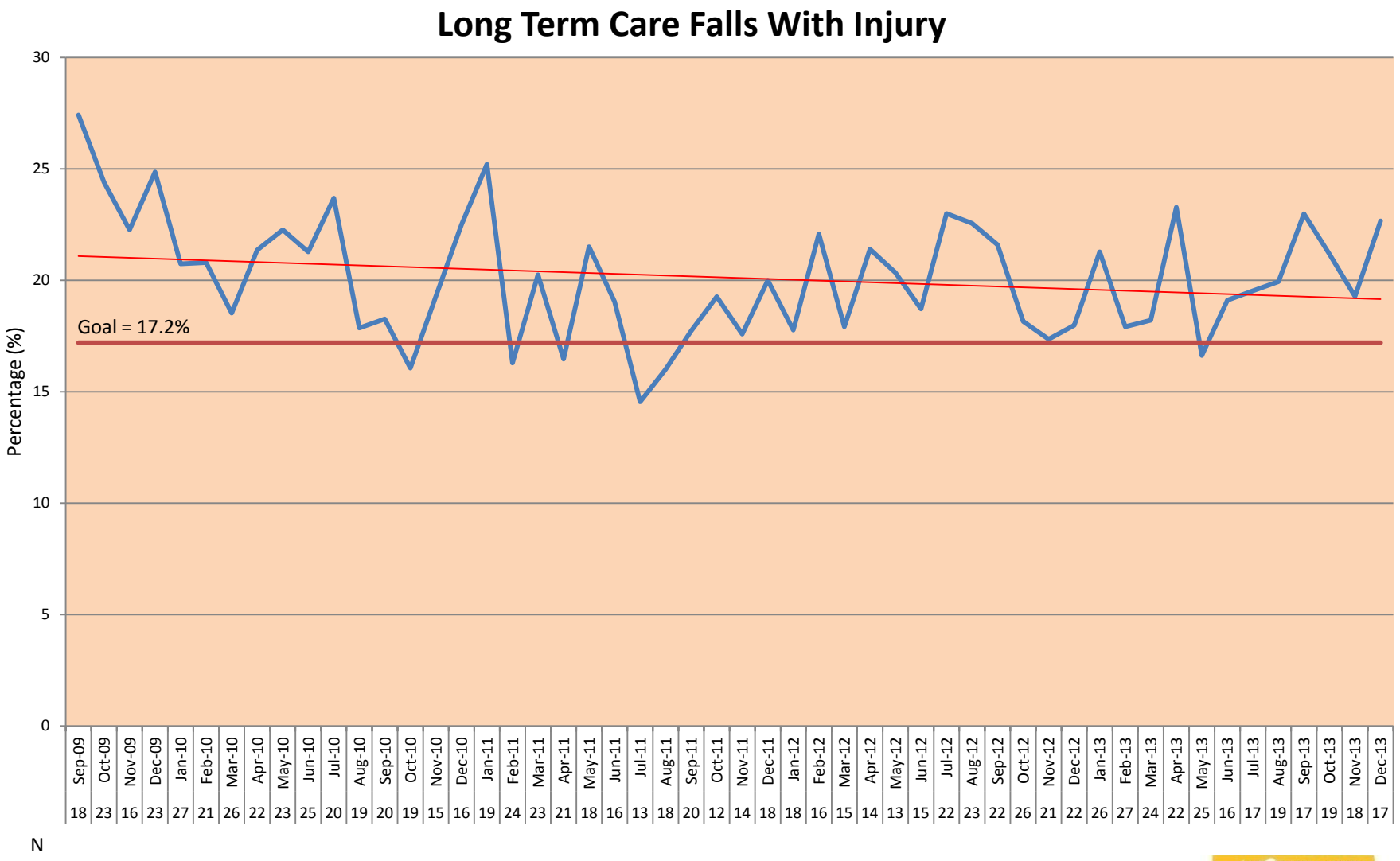
SAFE from FALLS – Acute Care



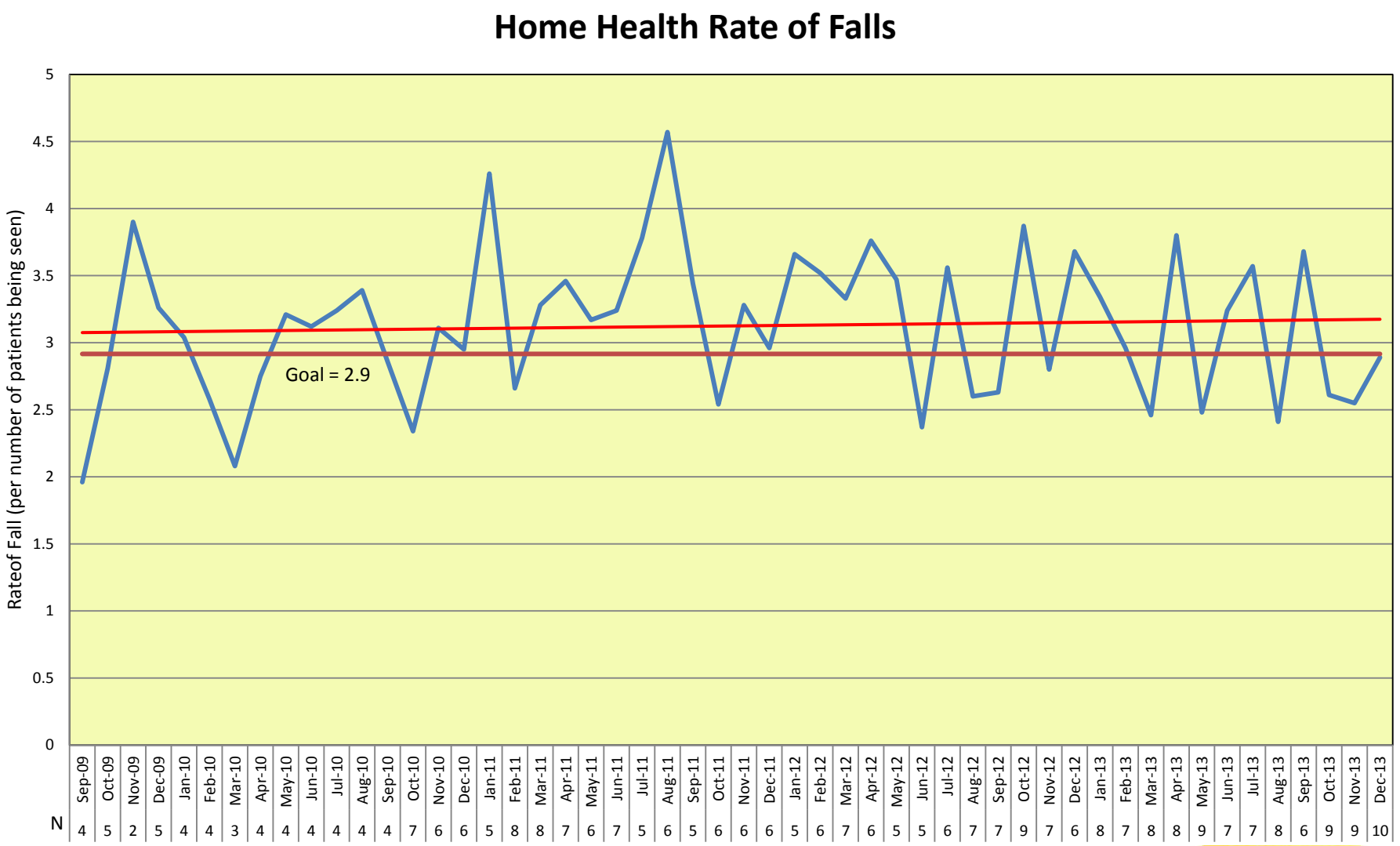
SAFE from FALLS – Long Term Care



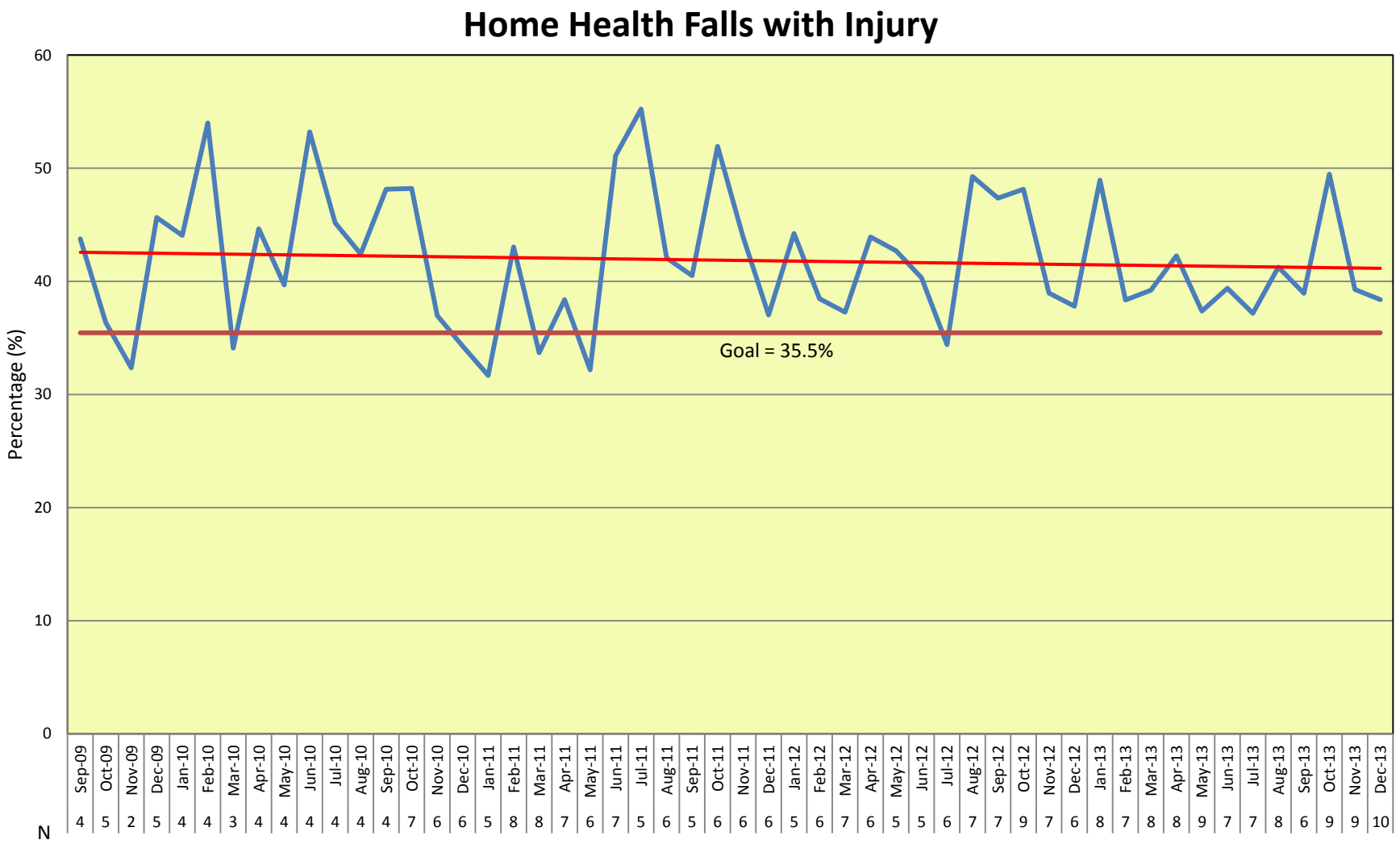
SAFE from FALLS – Long Term Care



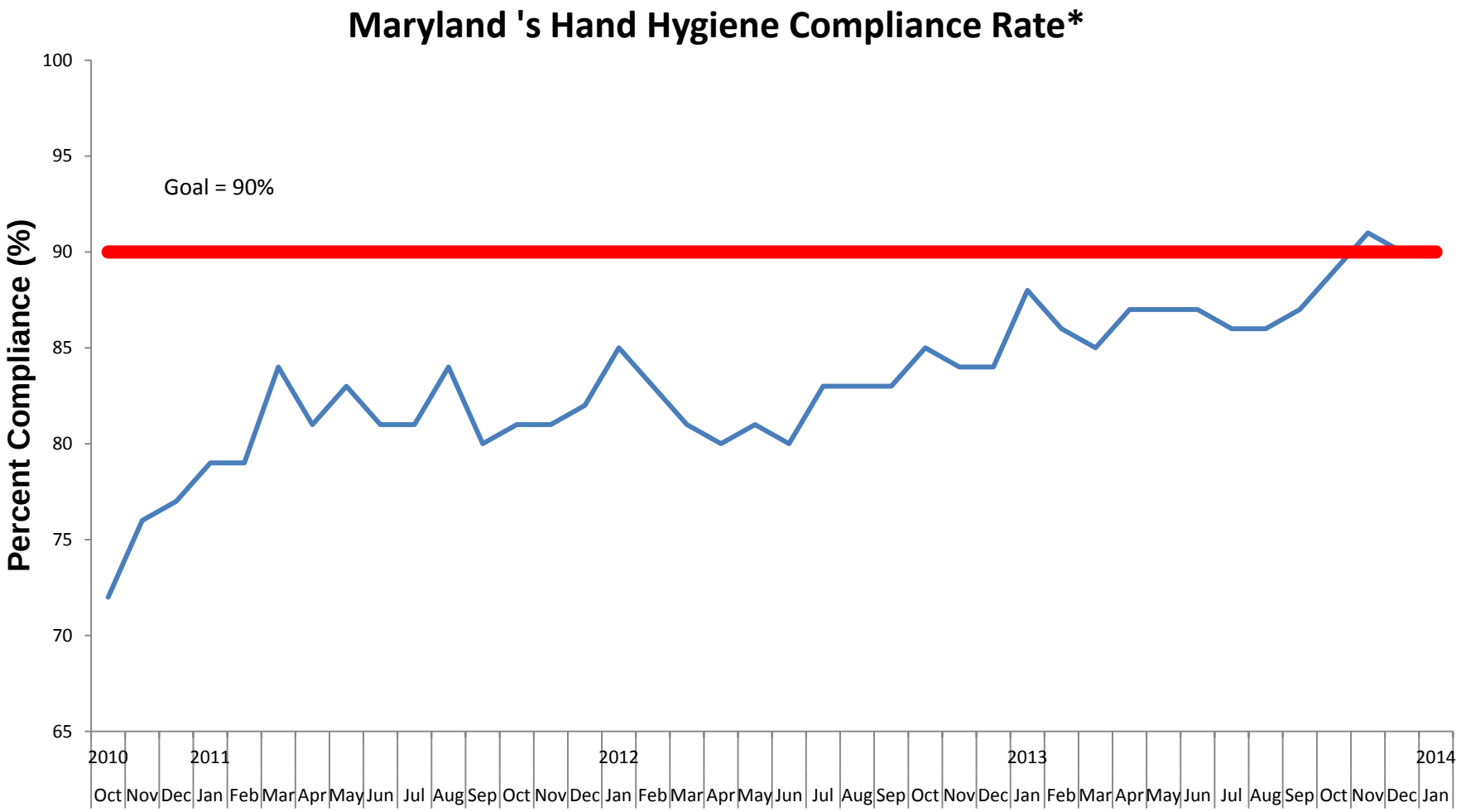
SAFE from FALLS – Home Health



SAFE from FALLS – Home Health

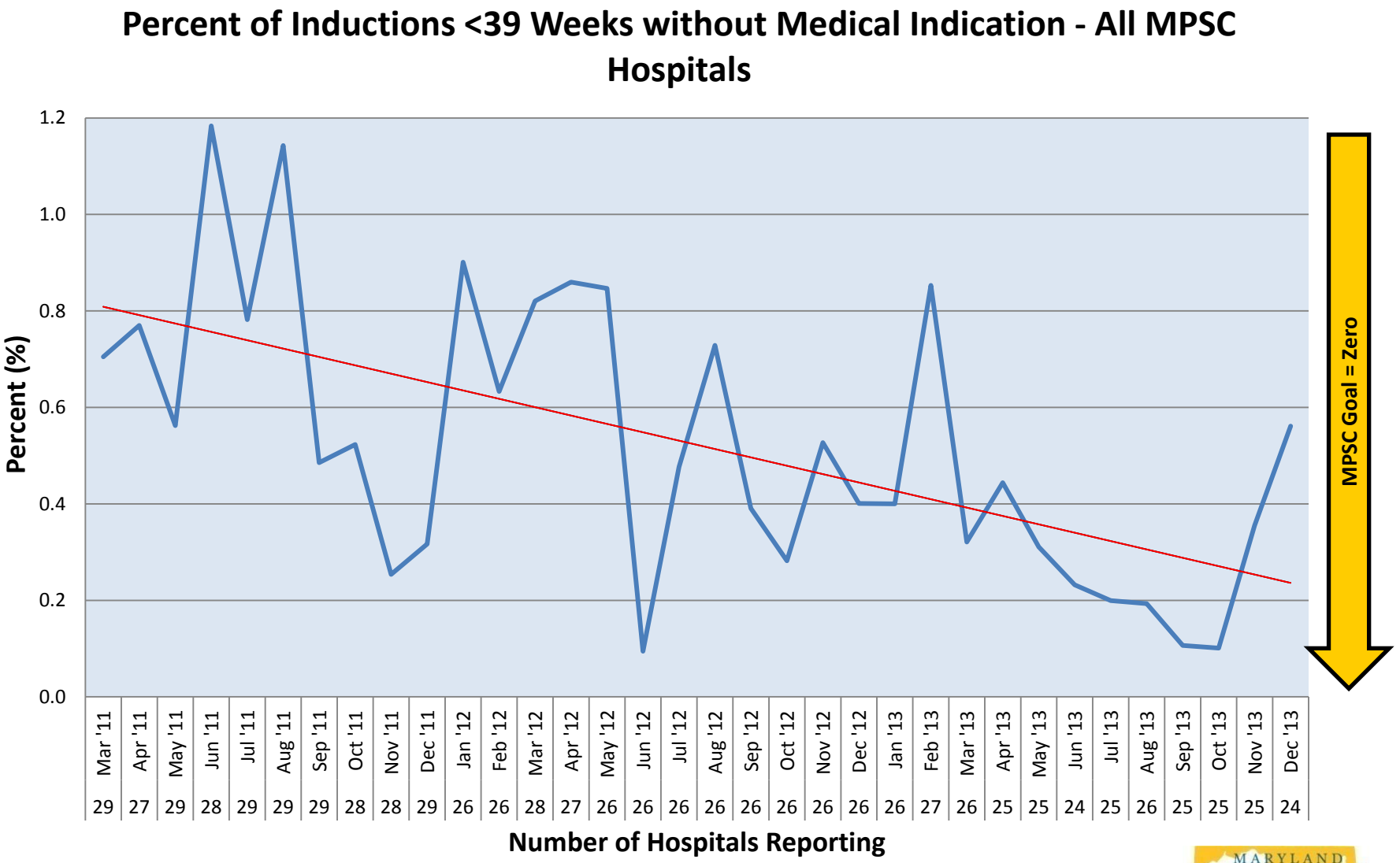


Hand Hygiene

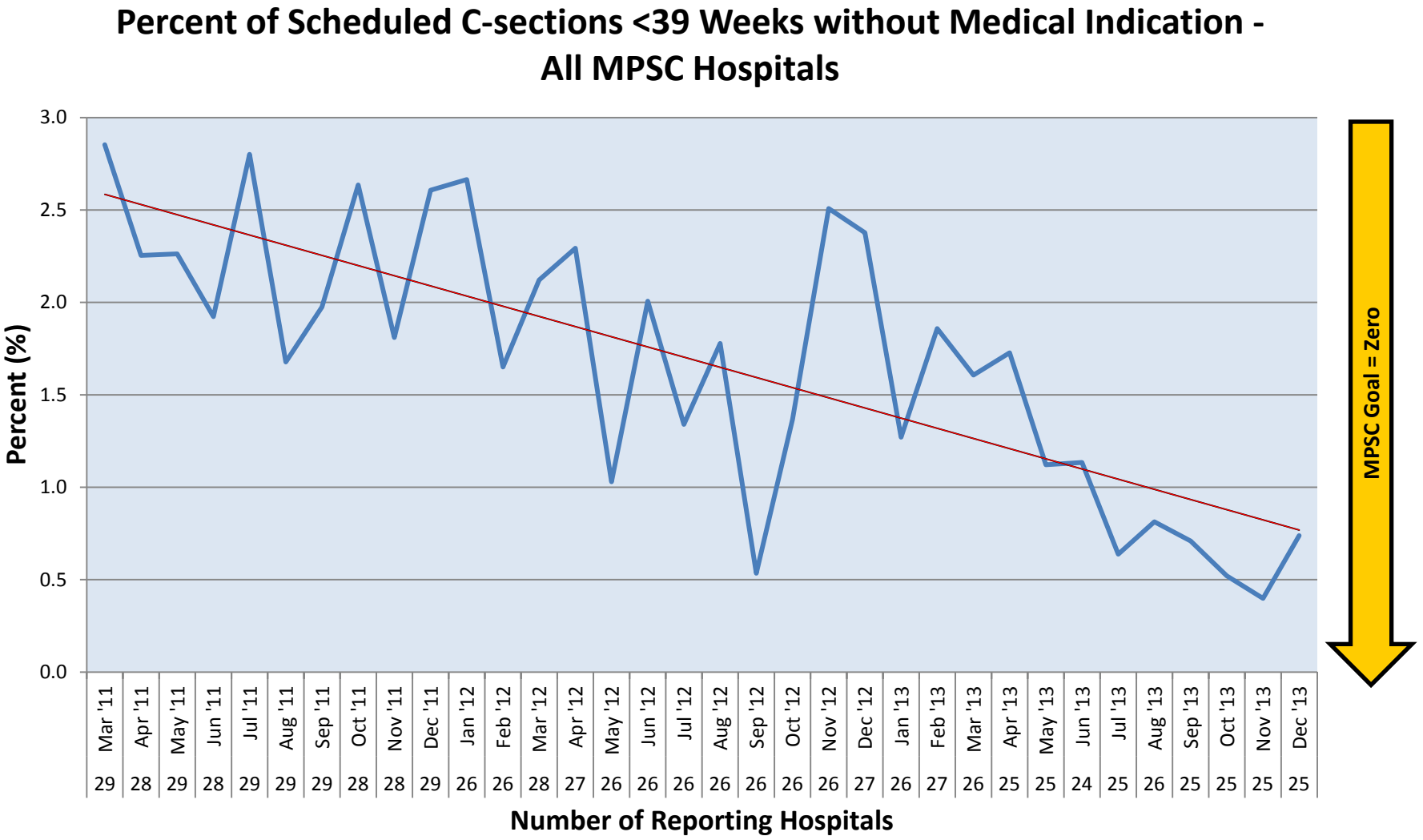


*As of January 1, 2013 Exit and/or Entry HH compliance rate was calculated.

Perinatal/Neonatal Learning Network



Perinatal/Neonatal Learning Network



Strategic Direction

- Development
- Expansion
- Supporting provider efforts with regard to Waiver requirements and initiatives
- Having greater overall impact on patient safety
- Coordination with statewide healthcare priorities:
  - HSCRC
  - OHCQ
  - Governor's Health Quality & Cost Council

FY 2015 Budget

REVENUE	FY 2014 Budget	FY 2015 Budget
Cash Contributions from MHA/Delmarva	200,000	200,000
Cash Contributions from Hospitals	300,000	151,350
Cash Contributions for Long-term Care	50,000	25,000
HSCRC Funding	1,200,000	1,080,000
Membership Dues	-	247,500
Education Session Revenue	150,000	35,000
Conference Registrations-Annual MedSafe Conference	10,000	7,000
Conference Registrations-Annual Patient Safety Conference	230,000	157,500
Sponsorships	125,000	128,000
Program Sales	-	50,000
DHMH Grant	-	250,000
Other Grants/Contributions	100,000	135,000
Total Revenue	**2,365,000**	**2,466,350**

EXPENSES	FY 2014 MPSC	FY 2014 Consultants	FY 2014 Total	FY 2015 MPSC	FY 2015 Consultants	FY 2015 Total
Administration	562,450		562,450	538,000		538,000
Outpatient Dialysis (previously committed)	75,000		75,000	-		-
Programs			-			-
Education Sessions		189,000	189,000		98,000	98,000
Annual Patient Safety Conference		417,650	417,650		400,000	400,000
MEDSAFE Conference		52,850	52,850		55,000	55,000
Caring for HC	65,300	88,550	153,850	67,500	130,000	197,500
Patient/Family Centered Care	59,400	16,150	75,550	-	-	-
Safety Initiatives-Perinatal/Neonatal	81,850	55,000	136,850	250,000	-	250,000
Safety Initiatives-Hand Hygiene	66,850	55,000	121,850	87,500	7,500	95,000
Safety Initiatives-Safe from Falls	66,850	55,000	121,850	52,250	250	52,500
Safety Initiatives-Adverse Event Reporting	-	-	-	21,000	84,000	105,000
Patient Safety Certification	129,600	327,200	456,800	115,500	285,000	400,500
Sepsis	-	-	-	169,000	17,500	186,500
Total Expenses	**1,107,299**	**1,256,400**	**2,363,700**	**1,300,750**	**1,077,250**	**2,378,000**

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: HSCRC Funding and Status Report

May 14, 2014

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

This is a report presented at the May 14, 2014 HSCRC public meeting.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: HSCRC Funding and Status Report

Overview

This report is to update the Commission on FY 2013 activities and accomplishments and on FY 2015 HSCRC funding support of the Chesapeake Regional Information System for our Patients (CRISP).

Background

In July of 2009 upon CRISP's designation as Maryland's Health Information Exchange (HIE) by the Maryland Health Care Commission (MHCC), it was with the conception that the HIE would create an interconnected, consumer-driven electronic health care system that would enhance our ability to improve health care quality, safety, and effectiveness, and reduce health care costs.

Based on CRISP's statewide HIE proposed technical approach that was flexible and protective yet not prohibitively restrictive, and financial approach that was sustainable, in August of 2009 the HSCRC approved funding for CRISP to initiate the development of the statewide HIE through an adjustment to the rates of participating hospitals of up to $10 million over the subsequent 2-5 years. In December 2013, the Commission adopted a subsequent recommendation to permit continued funding support during FYs 2015 through FY 2019 not to exceed $2.5 million in any year. That recommendation recognized that, in order to leverage federal fiscal participation or matching funds under the Health Information Technology for Economic and Clinical Health (HITECH)Act for certain functionality, the method to assess hospitals will need to change. Instead of applying the assessment to a limited number of hospitals it will be required to apply to all regulated hospitals in order to be broad-based and uniform.

In accordance with the August 2009 and 2013 approved recommendations, MHCC and HSCRC staff have reviewed annually CRISP deliverables and funding needs in order to determine whether adjustments should be made to the approved funding, with HSCRC having reserved the right to withhold or discontinue funding in the event that expectations were not met. Staff has considered performance on selected activities requested by MHCC and HSCRC as well as sustainability of CRISP under multiple sources of funding from HSCRC fees, grants, user fees, and other revenue sources.

Over the past 5 years, the Commission has approved funding through hospital rates as shown in Table 1:

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: HSCRC Funding and Status Report

Table 1. CRISP HIE Project HSCRC Funding 2010-2013

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

Current CRISP HIE Activities, Other Projects, and HSCRC Funding

Leveraging CRISP's HIE infrastructure, explicitly established and mandated to electronically connect all healthcare providers in the State, offered a "win-win" solution for creating a unique patient identifier that would benefit the Commission, providers, payers and most importantly, consumers.

In April of 2011, the Commission required all hospitals to connect with CRISP and send "admission discharge transfer" ("ADT")/patient demographic data beginning in December of 2011, making it the first HIE in the nation to connect all acute care hospitals in a state. CRISP has also worked to connect many other providers to the HIE. In addition to producing the unique patient identifier using Master Patient Index technology, CRISP has implemented a number of additional value added services, for example, its Encounter Notification System which provides patient encounter alerts to over 86 organizations.

With a total annual operating budget projected to be approximately $9.1 million for FY 2015, CRISP's breadth of work has grown significantly since 2009 with the addition of multiple funded projects and marked progress on implementation for these projects, demonstrating its sustainability and increasing value to multiple public and private entities. Table 1 below lists CRISP's projects in addition to the HIE work funded by the HSCRC and Federal HIE grants, and total estimated dollar amounts for each of these projects estimated for FY 2015. In addition to these other grant-funded projects, in FY 2012 CRISP began generating revenue through user fees, and projects it will generate approximately $1.7 M in user fees for FY 2015.

Table 2. Key CRISP Initiatives and FY 2015 Budget

HIE Operations	$3.3 million
Prescription Drug Monitoring Program – implementation of a provider access portal	$630,000
Medicaid IAPD – Deploying new HIE functionality	$3.5 million
Regional Extension Center – Consulting assistance to PCPs deploying EMR, through sub-grants	$591,000
Health Benefit Exchange – Assist HBE including linking with APCD data	$510,000
CRISP Reporting Services – Reporting Analytical information to hospitals, such as Readmissions	$469,000

Recommendation

MHCC and HSCRC staff have reviewed CRISP's FY 2015 proposed budget, and evaluated the need and efficacy of continued funding support. Pursuant to the authority provided to Commission staff to review and approve reasonable funding support in an amount not to exceed $2.5 million per year, staff deems it appropriate to apply an assessment in hospitals rates in FY 2015 in the amount of $1.65 million. This would include $1.5 million for HIE operations and $150,000 for the state portion of matching funds to achieve 90% federal IAPD Medicaid matching funds to improve HIE functionality. This amount would represent less than 50% of CRISP's HIE operations revenue in FY 2015.

Staff will continue to consider whether specific projects that are being conducted in conjunction with the HSCRC will warrant additional funding support through the Commission during the course of FY 2015. After reviewing and assessing options, whether through CRISP or other vendors, staff will report back to the Commission as more information is available.

Moving forward beyond FY 2015, HSCRC and MHCC staff will continue to work with CRISP to develop key deliverables and milestones as the basis to evaluate any future HIE funding requests.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Hospital Rate Setting

Sule Calikoglu, Ph.D.
Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: May 7, 2014

RE: Hearing and Meeting Schedule

Public Session:

June 11, 2014 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room
July 9, 2014 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner's packets will be available in the Commission's office at 11:45 p.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.
http://www.hscrc.maryland.gov/commission-meetings-2014.cfm

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