Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

553rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
July 11, 2018

EXECUTIVE SESSION
11:30 a.m.
(The Commission will begin in public session at 11:30 a.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 p.m.)

1. **Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104**

2. **Update on Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104**

3. **Personnel Matters – Authority General Provisions Article, §3-305 (b) (1)**

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on June 13, 2018**

2. **New Model Monitoring**

3. **Docket Status – Cases Closed**

   2429R – Garrett Regional Medical Center
   2432A – University of Maryland Medical System
   2436R - Calvert Health Medical Center
   2437A – University of Maryland Medical System
   2438A – Johns Hopkins Health System

4. **Docket Status – Cases Open**

   2439A – University of Maryland Medical System
   2440A – University of Maryland Medical System
   2441R – Meritus Health

5. **Final Recommendation on Uncompensated Care Policy for FY 2019**

6. **Policy Update Report and Discussion**

   a. **Contract Update**
   b. **Care Redesign Update**
   c. **Update on Deregulation Adjustments and Shifts**
   d. **Drugs Policy**
   e. **Status of Annual Update**

7. **CRISP Update**

8. **Legal Report**

9. **Hearing and Meeting Schedule**

Closed Session Minutes
Of the
Health Services Cost Review Commission

June 13, 2018

Upon motion made in public session, Chairman Sabatini called for adjournment into closed session to discuss the following items:

1. Discussion on Planning for Model Progression– Authority General Provisions Article, §3-103 and §3-104

2. Update on Contract and Modeling of the All-Payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104

3. Personnel Matters – Authority General Provisions Article, §3-305(b) (1)

The Closed Session was called to order at 11:32 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

In attendance in addition to Chairman Sabatini were Commissioners Antos, Bayless, Colmers, Elliott, and Keane.

In attendance representing Staff were Donna Kinzer, Katie Wunderlich, Chris Peterson, Allan Pack, Jerry Schmith, Claudine Williams, Alyson Schuster, Amanda Vaughn, Madeline Fowl, Bob Gallion, and Dennis Phelps.

Also attending were Eric Lindeman, Commission Consultant, and Stan Lustman and Adam Malizio Commission Counsel.

Item One

Mr. Lindeman updated the Commission on Medicare data and analysis vis-a-vis the All-Payer Model Agreement.

Item Two

Ms. Wunderlich and Mr. Pack presented and the Commission and staff discussed Total Cost of Care Model implementation.

Item Three

The Commission discussed various personnel matters.

The Closed Session was adjourned at 1:02 p.m.

MINUTES OF THE
552th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
June 13, 2018

Chairman Nelson Sabatini called the public meeting to order at 11:32 a.m. Commissioners Joseph Antos, Victoria Bayless, John Colmers, James Elliott, M.D., Adam Kane, and Jack C. Keane were also in attendance. Upon motion made by Commissioner Antos and seconded by Commissioner Keane, the meeting was moved to Executive Session. Chairman Sabatini reconvened the public meeting at 1:12 p.m.

REPORT OF JUNE 13, 2018 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director, Audit & Compliance, summarized the minutes of the June 13, 2018 Executive Session.

ITEM I
REVIEW OF THE MINUTES FROM MAY 9, 2018 EXECUTIVE SESSION AND PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the May 9, 2018 Public Meeting and Executive Session.

ITEM II
NEW MODEL MONITORING

Ms. Caitlin Cooksey, Assistant Chief, Hospital Rate Regulation, reported that the Maryland Medicare hospital and nonhospital growth for the three months ending March 2018 was in excess of $17,193,000 over the prior period. Ms. Cooksey noted that Maryland's Medicare Total Cost of Care per Capita spending growth is trending unfavorably to the nation for the same period.

Ms. Amanda Vaughan, Associate Director, Financial Data Administration, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of April 2018 focuses on the fiscal year (July 1 through June 30) as well as calendar year results.

Ms. Vaughan reported that for the ten month period ended April 30, 2018, All-Payer total gross hospital revenue increased by 3.34% over the same period in FY 2017. All-Payer total gross hospital revenue for Maryland residents increased by 3.51%. All-Payer gross hospital revenue for non-Maryland residents increased by 1.43%.

Ms. Vaughan reported that for the four months of the calendar year ended April 30, 2018, All-Payer total gross revenue increased by 2.36% over the same period in CY 2017. All-Payer total gross revenue for Maryland residents increased by 2.69%; this translates to a per capita increase of 2.22%. All-Payer gross revenue for non-Maryland residents decreased by 1.29%.

Ms. Vaughan reported that for the ten month period ended April 30, 2018, Medicare Fee-For-Service gross hospital revenue increased by 3.10% over the same period in FY 2017. Medicare Fee-For-Service gross hospital revenue for Maryland residents increased by 3.16%. Maryland Fee-For-Service gross hospital revenue for non-residents increased by 2.40%.

Ms. Vaughan reported that for the four months of the calendar year ended April 30, 2018, Medicare Fee-For-Service gross revenue increased by 2.76 % over the same period in CY 2017. Medicare Fee-For-Service gross revenue for Maryland residents increased by 3.08%; this translates to a per capita increase of 1.61%. Maryland Fee-For-Service gross revenue for non-residents decreased by 0.91%.

Ms. Vaughan reported that for the ten months of the fiscal year ended April 309, 2018 over the same period in CY 2017:

- All Payer in State capita hospital revenue growth was 3.04%.
- Medicare Fee for Service hospital revenue growth in State was 2.04%.

According to Ms. Vaughan, for the ten months of the fiscal year ended April 30, 2018, unaudited average operating profit for acute hospitals was 2.98%. The median hospital profit was 3.58%, with a distribution of 0.66% in the 25th percentile and 6.74% in the 75th percentile. Rate Regulated profits were 6.97%.

ITEM III
FINAL RECOMMENDATION ON THE UPDATE FACTOR FOR FYE 2019

Mr. Jerry Schmith, Director, Center for Revenue and Regulation Compliance, presented the staff's final recommendation concerning the update factors for FY 2018 (See "Final Recommendations on the Update Factors for FY 2018" on the HSCRC website).

On July 1st 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 prior years.

Mr. Schmith noted that the final recommendation is unchanged from the draft. Schmith stated that the Commission recently received the Medicare total cost of care spending data for the first quarter of calendar year 2018 and noted that Maryland's non-hospital spending grew substantially, causing Maryland's total spending per Medicare beneficiary to be 0.8% above the nation. For the first quarter of calendar year 2018, Maryland's hospital spending per Medicare beneficiary trend did not decline by a large enough margin to offset non-hospital growth. Maryland exceeded the Medicare total cost of care guardrail in calendar year 2017, requiring total spending growth per Maryland Medicare beneficiary to be below national growth in calendar year 2018.

Based on the currently available data and staff's analyses to date, the HSCRC staff is providing the following final recommendations for the FY 2019 update factors.

Based on the currently available data and the staff's analyses to date, the HSCRC staff provides the following final recommendations for the FY 2019 update factors.
For Global Budget Revenue (GBR) hospitals:

- Provide an overall increase of 2.08% for revenue (net of uncompensated care offset) and 1.62% per capita for hospitals under Global Budgets. In addition, staff is proposing to split the approved revenue into two targets, a mid-year target and a year-end target. Staff will apply 49.73% of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
- Allocate 0.31% of the total inflation allowance based on each hospital's proportion of drug cost to total cost to more equitably adjust hospitals' revenue budgets for increases in drug prices and high cost drugs. Continue to adjust for volume changes of high cost oncology drugs at the mid-year data point for RY 2018 over RY 2017. Evaluate the need for an additional adjustment for growth in high cost drugs during RY 2019.
- The Commission should continue to closely monitor performance targets for Medicare, including Medicare's growth in total cost of care and hospital care costs per beneficiary during the performance year. As always, the Commission has the authority to adjust rates as it deems necessary.
- Hospitals should submit, 30 days after the fiscal year, their annual disclosures of their GBR Agreements to disclose any shifts from regulated to unregulated and unregulated to regulated (Appendix F); as well as changes in financial interest, ownership, or control of hospital or non-hospital services within the service area (Appendix G). Failure to submit these disclosures will result in a holdback of 0.50% of a hospital's update for RY 2019. HSCRC should convene a sub-group to outline additional guidance to hospitals in reporting shifts to unregulated settings, as well as outlining the expectations for revenue adjustments.
- Continued refinements should be made to adjust revenues for volume changes in high cost drugs. Hospitals must report shifts to unregulated settings to avoid duplicate billing. Data collection should be expedited and improved and external resources consulted in order to improve the timeliness and ease of adjustments.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- Provide an overall update of 1.77% by using a productivity adjustment of 0.80% from the inflation factor of 2.57%.
- Continue to focus on implementation of quality measures and value based programs for psychiatric facilities.

Mr. Brett McCone, Vice President, Maryland Hospital Association (MHA), stated that they are requesting that an additional 0.5% be added to the staff recommendation for GBR hospitals. Mr.

McCone stated that the calendar year 2018 data are preliminary, and although non-hospital growth is causing Maryland to exceed the total cost of care limit, national hospital spending per beneficiary growth is also higher, which should result in favorable performance by the end of calendar year 2018. McCone also noted that other recently adopted tools, including the care redesign amendment, should improve Maryland's performance.

Ms. Mary Miller, Chief Financial Officer, Mt. Washington Pediatrics Hospital (MWPH), stated that although MWPH's rate structure is linked to the state's psychiatric hospitals, MWPH is different. MWPH has almost no patients that are covered by Medicare. Ms. Miller stated over the past 3 years annual Medicare revenue averaged just $87,000 per year. Because of the low Medicare volume, MWPH is requesting the 0.8% productivity be waived and that the hospital update factor be the full rate increase.

Mr. Robert Murray, CareFirst Inc. Consultant, stated that it is clear that the growth in Maryland's Total Cost of Care (TCOC) per Medicare Fee for Service (FFS) beneficiary in CY 2017 exceeded the US TCOC per FFS beneficiary for the second time in the four years of the All Payer Model (Model). This threatens a key "Guardrail" limitation in the Model agreement that requires Maryland Medicare TCOC growth not to exceed the US TCOC growth in any two consecutive years. If Maryland's TCOC in CY 2018 were to violate this provision, a "Triggering Event" would occur thereby threatening the Model.

Mr. Murray stated that it is imperative for the Commission to approve an Update Factor that is low enough to ensure that the growth in hospital expenditures for Maryland FFS beneficiaries is not underestimated again. He noted that that an Update Factor of no more than 1.32% would be reasonable to ensure that Maryland will not exceed the TCOC trigger.

Chairman Sabatini and Commissioners Antos, Kane, and Keane expressed their concerns that the Staff's recommendation would cause Maryland to exceed the Medicare total cost of care guardrail. However, Chairman Sabatini reminded Commissioners that they approved a higher payment update last year, despite early calendar year total cost of care data reflecting Maryland exceeding the nation.

Commissioner Antos moved that the Staff recommended update for GBR hospitals be reduced by 0.5%. Commissioner Kane suggested that the recommended update for GBR hospitals be reduced to 0.25%. Commissioner Keane stated that the Staff recommendation should be further reduced to mitigate the risk of exceeding the total cost of care guardrail. Commissioner Antos agreed with Commissioner Kane's amendment to reduce the update factor for GBR hospitals by 0.25%. As per the amended motion the amended inflation factor will be 1.83%.

Commissioners voted 4-2 in favor of the amended Staff recommendation. Commissioners Bayless and Keane voted against the amended recommendation.

The Commissioners also approved a 1.77% total revenue increase for Non Global Revenue hospitals.

The Commissioners noted that they were open to restore the 0.25% reduction should the Maryland's Medicare TCOC performance become more favorable.

ITEM 1V
DOCKET STATUS- CASES CLOSED

2425R- University of Maryland Baltimore Washington Medical Center

ITEM V
DOCKET STATUS –OPEN CASES

2429R- Garrett Regional Medical Center

Garrett Regional Medical Center ("GRMC") submitted a full rate application on January 16, 2018, requesting an increase to its permanent Global Budget Revenue (GBR) of $5,977,754 effective February 15, 2018. Following the submission of additional required information not included with its original submission, the HSCRC staff accepted GRMC's full rate application and considered it filed on February 1, 2018. The requested $5,977,754 increase represents an 11.0 percent increase over GRMC's currently approved GBR that was effective for the one-year period from July 1, 2017 through June 30, 2018. GRMC also requested that the budgeted GBR volumes be updated to the actual volumes for the year that ended June 30, 2017. GRMC's request focused on the need to increase its salaries due to competition from other hospitals in Maryland, West Virginia, and Pennsylvania. GRMC's request for salary increases and additional funds for agency nurses totaled $2,152,528 or 4.0 percent of GRMC's current approved revenue. GRMC also requested $3,825,226, or 7.0 percent of the currently approved revenue, to fund a variety of population infrastructure investments, including approximately $1.1 million of losses on physician practices.

GRMC is the first hospital to file a full rate application since the moratorium on these applications was lifted on November 1, 2017.

Based on a thorough consideration of all of the analysis performed and staff's findings, staff makes the following recommendations for Commission consideration:

- 1. A permanent revenue increase of $4,878,975 be provided effective March 3, 2018, inclusive of all settlements through December 31, 2017, with $1,626,010 collected during FY 2018. The total amount recommended includes any additional increases in drug costs related to increased use of high cost outpatient oncology drugs for FY 2018 over 2017. This does not include quality adjustments under the QBR, which have not yet been applied or other quality program adjustments that are due to be applied on July 1, 2018 or thereafter.

- GRMC must accept inflation less 1 percent at its next scheduled update in recognition that part of the salary increases are being funded in advance through this rate application.

- Any incremental savings adjustments and any rate reductions implemented by the Commission will fully apply.

- GRMC believes strongly in managing the total cost of care for all residents in its service area, and it will continue to invest in the necessary infrastructure to truly manage the health of the people it serves. GRMC must agree to reduce the potentially avoidable hospitalizations for COPD patients in its service area by 25 percent over five years, provide care and medication management, and pulmonary rehabilitation. Because this commitment has not been thoroughly evaluated, GRMC and HSCRC staff may revise the target with further analysis. HSCRC and GRMC will develop similarly aggressive targets for diabetes prevention and reduction in avoidable use.

- GRMC and HSCRC will develop and evaluate total cost of care and utilization benchmarks for GRMC's service area using national Medicare benchmark data. HSCRC recognizes that GRMC has one of the lowest cost-per-case rankings in the State. However, because a revenue increase is being provided in spite of excess total cost of care growth, GRMC must work with HSCRC to establish an appropriate Medicare total cost of care benchmark for its service area. Over a five-year period, GRMC must reach its benchmark attainment goal, consistent with the requirements of the Total Cost of Care Model Agreement with CMS.

- GRMC, HSCRC, and Medicaid will work to develop total cost of care benchmarks for Medicaid. GRMC will develop goals for the Medicaid upon completion of these efforts.

Commissioners approved Staff recommendation with a vote of 5-1. Commissioner Keane voted against the recommendation.

2432R- University of Maryland Medical System

On March 19, 2018, the University of Maryland Medical System (the "System") on behalf of the University of Maryland St. Joseph Medical Center (St. Joseph), University of Maryland Upper Chesapeake Medical Center (UCMC), and University of Maryland Medical Center (UMMC) submitted a partial rate application to the Commission requesting that the rates of St. Joseph, UCMC, and UMMC be revised to reflect that the outpatient infusion clinics at St. Joseph and UCMC will operate as an off-site provider-based child-sites of UMMC for purposes of the federal 340B program. The System requests that:

- A total of $41,944,401 be transferred from St. Joseph's Global Budget Revenue (GBR) cap to UMMC's GBR cap, $ 6,990,742 to be transferred effective May 1, 2018 and $ 34,953,662 to be transferred effective July 1, 2018;
- A total of $39,762,023 be transferred from UCMC's GBR cap to UMMC's GBR cap, $6,626,991 to be transferred effective May 1, 2018 and $ 33,135,033 to be transferred effective July 1, 2018;

- The Commission approve new unit rates for St. Joseph's and UCMC's infusion clinics on UMMC's rate order effective May 1, 2018;
- The Commission exclude the revenue for the new unit rates from rate realignment; and
- The Commission adjust rate order volumes in St. Joseph's, UCMC's, and UMMC's rate orders to maintain a revenue neutral impact to rate capacity as a result of the request

Maryland 2015 legislation (Senate Bill 513) altered the definition of "hospital services" to include hospital outpatient services of a hospital that is designated as part of another hospital under the same merged asset system to make it possible for the hospital to participate in the federal 340B Prescription Drug Discount program.

After review of the application, staff recommends that the System's request be approved because:

- it will enable UMMC to provide lower cost services to current oncology patients, and
- it will generate future saving to the Maryland healthcare system and to oncology patients through lower drug costs at the St. Joseph and UCMC locations.

Staff recommends that the approval be contingent upon UMMC applying for and receiving provider-based status from the Centers for Medicare and Medicaid Services for the infusion clinics at the St. Joseph and UCMC sites.

Staff also recommends that the following rates and two months of the annual revenue for the infusion clinic services provided at the St. Joseph and UCMC locations be approved and added to UMMC's approved rated order and GBR effective May 1, 2018:

- Clinic rates of $ 48.78736 and $ 40.8059 per RVU respectively for the St. Joseph and UCMC locations and revenue of $ 1,535,415 and $ 1,568,293 respectively;
- Laboratory rates of $ 2.0467 and $ 2.6123 per RVU respectively for the St. Joseph and UCMC locations and revenue of $ 172,332 and $ 174,624 respectively; and
- Drug revenue of $ 5,282,995 and $ 4,884,073 respectively for St. Joseph and UCMC locations.

In addition, the staff recommends that effective July 1, 2018, the remaining 10 months of the annual revenue for the services provided at the St. Joseph and UCMC locations be added to UMMC's approved RY 2019 rate order and GBR:

- Clinic revenue of $ 7,677,026 and $ 7,841,547 respectively for the St. Joseph and UCMC locations;
- Laboratory revenue of $ 861,661 and $ 872,122 respectively the St. Joseph and UCMC locations;
- Drug revenue of $ 26,414,975 and $ 24,420,364 respectively for St. Joseph and UCMC locations; and
- The rates for the infusion clinic services provided at the St. Joseph and UCMC locations

be excluded from rate realignment.

Commissioners voted in favor of Staff's recommendation with a 4-2 vote. Commissioners Antos and Keene voted against the recommendation.

2436R- Calvert Health Medical Center

On April 27, 2018, Calvert Health Medical Center (the "Hospital") submitted a partial rate application to the Commission pursuant to COMAR 10.37.10.03-1. The Hospital requests that its Medical Surgical Acute Unit (MSG) and Pediatric Unit (PED) rates be combined effective July 1, 2018 utilizing FY 2019 approved volumes and revenues.

After reviewing the Hospital's application, the staff recommends as follows:

- That the Hospital be allowed to consolidate its PED rate into its MSG rate effective July 1, 2018;
- That FY 2019 approved volume and revenue will be utilized to calculate the combined rate; and
- That no change be made to the Hospital's Global Budget

Commissioners voted unanimously in favor of Staff's recommendation

2437A- University of Maryland Medical System

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on May 24, 2018 for an alternative method of rate determination under COMAR 10.37.10.06. The Hospital requests approval to continue to participate in a global rate arrangement with the Kaiser Foundation Hospitals and the Permanente Federation, LLC ("Kaiser") for Heart Transplant and Mechanical Circulatory Support services for a period of one year beginning July 1, 2018.

The staff recommends that the Commission approve the Hospital's application to continue an alternative method of rate determination for Heart Transplant and Mechanical Circulatory Support services, for a one year period commencing July 1, 2018. Staff also recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding.

Commissioners voted unanimously in favor of Staff's recommendation

2438A- Johns Hopkins Health System

Johns Hopkins Health System ("System') filed an application with the HSCRC on May 25, 2018 on behalf of its member hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global arrangement to provide solid organ and bone

marrow transplants services with Cigna Health Corporation. The System requests approval of the arrangement for a period of one year beginning July 1, 2018.

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for bone marrow and solid organ transplant services, for a one year period commencing July 1, 2018, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU").

Commissioners voted unanimously in favor of Staff's recommendation. Commissioner Colmers recused himself from the discussion and the vote.

ITEM VI
POLICY UPDATE REPORT AND DISCUSSION

UPDATE ON TOTAL COST OF CARE CONTRACT

Ms. Donna Kinzer, Executive Director, thanked all of the parties who had a hand in securing the Centers for Medicare and Medicaid Services (CMS) approval of the 10 year All- Payer Model contract effective January 1, 2019. She stated that it was an honor to serve the State under this great time of change.

Mr. Chris Peterson, Director, Clinical & Financial Information, reported that an amendment to the new All-Payer Model agreement to add the Medicare Performance Adjustment and provide a pathway for certain providers to receive MACRA bonuses through a Care Redesign Program has been crafted to the satisfaction of both the state and the federal government. Mr. Peterson expects that the agreement will be signed by mid-July. Mr. Peterson noted that the new Care Redesign Program Participation Agreement will be sent out to participating hospitals to sign. Hospital have 10 days to sign and return back to HSCRC.

STAFF UPDATE

Ms Kinzer introduced four new staff members: Ms LaTonya Hamilton, Executive Associate, Alphius Sesay, Kameron Knab, and Quanshay Henderson, Fellows who are working in our new fellowship program. This program will help in the develop and implementation of new policies.

TOTAL COST OF CARE MODEL IMPLEMENTATION 2018-2019

Katie Wunderlich, Director, Engagement and Alignment, presented HSCRC staff's priorities for 2018-2019 (see "Total Cost of Care Model Implementation 2018-2019" see HSCRC website).

Ms. Wunderlich stated that the Commission must identify bold improvement goals for hospitals, providers, and public health agencies, such as population health and health disparities. Most importantly, if the Model reduces cost but makes no improvement in health outcomes, it will not be considered successful. The five priorities:

- Executing and implementing the Total Cost of Care Model contract
- Developing and refining policies and incentives

- Launching and operating the Maryland Primary Care Program and Care Redesign Programs
- Enhancing data systems and access to all-payer TCOC data for performance improvement
- Addressing administrative challenges such as adequate resources and leadership bench strength.

Ms. Kinzer emphasized the need to analyze and improve our cost accounting system, and that changes in the cost accounting system may result in Staff recommending a change in the differential. However, the change in the differential for uncompensated care is a different issue. Staff believes that the growth in commercial payers' uncompensated care is being shifted inequitably to Medicare and Medicaid.

Mr Keane stated that the TCOC implementation document should be changed to indicate that the differential might be changed to improve cost and rate realignment. Mr Keane also indicated that he thought that changing the differential may be illegal.

Commissioner Elliott asked whether it would be possible to speed up the timing of the development of total cost of care and utilization benchmarks. Ms. Kinzer responded that Commission staff is in the process of securing data and contractors to develop those benchmarks, and that data availability and resources limit the ability to complete this process sooner.

ITEM VII
CONFIDENTIAL DATA REQUEST

Ms. Claudine Williams, Associate Director Policy Analysis, presented Staff's final recommendation on The University of Maryland, Baltimore School of Medicine confidential data request (See "Final Staff Recommendation on The University of Maryland, Baltimore School of Medicine Request to Access HSCRC Confidential Patient Level Data" on the HSCRC website).

The University of Maryland, Baltimore (UMB) School of Medicine is requesting to use a limited confidential dataset to examine the spatiotemporal relationship between asthma- related emergency department (ED) visits and hospitalizations with ground- level air pollution for Marylanders in relation to surrounding municipal waste incinerators.

The primary objective of this study is to construct models to assess the relationship between asthma hospital patients (emergency and inpatient) and Air Quality Index, with subsequent proximity analysis around the State's municipal waste incinerator sites and the ones that have recently closed. The limited dataset will include confidential variables such as dates of service and age. Investigators received approval from UMB Institutional Review Board (IRB) on April 27, 2017. These data will not be used to identify individual hospitals or patients. The data will be retained by UMB until January 31, 2020; at that time, the files will be destroyed and a Certification of Destruction will be submitted to the HSCRC.

Staff's final recommendation is as follows:

- HSCRC staff recommends that the request for the limited inpatient and outpatient confidential data files for Calendar Year 2013 through Calendar Year 2017 be approved.

- This access will be limited to identifiable data for subjects enrolled in the research study.

The Commissioners unanimously approved Staff's recommendation.

ITEM VIII
FINAL RECOMMENDATION ON POTENTIALLY AVOIDABLE UTILIZATION SAVINGS FOR RY 2019

Ms. Laura Mandel, Analyst, Quality and Population Health, presented Staff's final recommendation on the Potentially Avoidable Utilization savings for FY 2019 (see "Final Recommendation for the Potentially Avoidable Utilization Savings Policy for Rate Year 2019" on the HSCRC website).

HSCRC operates a Potentially Avoidable Utilization (PAU) savings policy as part of its portfolio of value-based payment policies. The PAU Savings policy is an important tool to maintain hospitals' focus on improving patient care and health through reducing potentially avoidable utilization and its associated costs. While hospitals have achieved significant progress to date in transforming the delivery system, the State must maintain continued emphasis on care management, quality of care, and care coordination, especially for complex and high-needs patients. The PAU Savings policy is also important for maintaining Maryland's exemption from the Centers for Medicare & Medicaid Services quality-based payment programs, which is pivotal, as this autonomy allows the State to operate its own programs on an all-payer basis.

Staff recommends the following for the PAU Savings policy for RY 2019:

- Increase the net PAU reduction by 0.30%, which would be a cumulative PAU reduction of 1.75% compared to the 1.45% reduction in RY 2018.

- Cap the PAU Savings reduction for hospitals with higher socioeconomic burden at the statewide average reduction for hospitals; however, solicit input on phasing out or adjusting for subsequent years.

- Evaluate expansion and refinement of the PAU measure to incorporate additional categories of potentially avoidable admissions and potentially low-value care.

The Commissioners approve Staff's recommendation with a vote of 4-1. Commissioner Keane voted against the recommendation.

ITEM IX
FINAL RECOMMENDATION ON CONTINUED SUPPORT OF THE MARYLAND PATIENT SAFETY CENTER FOR FY 2019

Ms. Wunderlich presented Staff's draft recommendation on the funding of the Maryland Patient Safety Center for FY 2019 (see "Final Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2019" see HSCRC website).

In 2004, the HSCRC adopted recommendations to provide seed funding for the Maryland Patient Safety Center (MPSC) through hospital rates. The initial recommendations funded 50% of the reasonable budgeted costs of the MPSC. In FY 2018, HSCRC-dedicated funds accounted for 37% of its total budget. The proposed support for MPSC in FY 2019 represents 28% of the total budget. The HSCRC collaborates with MPSC on projects as appropriate, receives an annual briefing and documentation 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 the annual budget item information provided by the MPSC and staff experience, staff makes recommendations to the Commission regarding the continued financial support of the MPSC.

As the State moves toward a Total Cost of Care All-Payer Model (TCOC Model), it is increasingly important that safety and quality are improved across all care settings. The key stakeholders that are involved with the MPSC include hospitals, patients, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the All-Payer Model and the future TCOC Model. The MPSC is in a unique position in the State to develop and share best practices among these key stakeholders. It is also favorably positioned to act as a convener for hospital and non-hospital providers in Maryland to disseminate data that will help them succeed under the TCOC Model.

Over the past 14 years, the HSCRC included an adjustment to the rates of eight Maryland hospitals to provide funding to cover the costs of the MPSC. Funds are transferred biannually, by October 31 and March 31 of each year. Although funding increased between FY 2005 and FY 2009, the level of HSCRC support has declined each year since FY 2009.

In April 2018, the HSCRC received the MPSC program plan update for FYs 2018 and 2019. The MPSC is requesting a total of $492,075 in funding support from the HSCRC for FY 2019, a 25% decrease over the previous year that is consistent with the Commission's intent to reduce State funds over time and encourage a sustainable business model for the MPSC.

Quality and safety improvements are the primary drivers to achieve the goals of reduced potentially avoidable utilization and reduced complications in acute care settings as required by the State's All-Payer Model and future TCOC Model. For these reasons, it is important to continue to support hospitals in identifying and sharing best practices to improve patient quality and outcomes. While individual hospitals across the State are experimenting with strategies to improve care coordination, enhance processes for better care, and advance systems and data sharing to maximize the efficiency and effectiveness of care, the MPSC is well situated to convene healthcare providers and share best practices that have been identified through multi-provider collaborative testing and change. The key stakeholders that are involved with the MPSC

include hospitals, patients, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the All-Payer Model. The MPSC is in a favorable position in the State to develop and share best practices among this group of key stakeholders.

In light of the information presented above, HSCRC staff provides the following final recommendations for the MPSC funding support policy for FY 2019:

- Consistent with the approval of the Commission last year, the HSCRC should reduce the amount of funding support for the MPSC in FY 2019 by 25%. The result is an adjustment to hospital rates in the amount of $492,075 in FY 2019, a 25% reduction from FY 2018.
- In order to receive future funding from the hospital rate setting system, the MPSC should continue to report quarterly on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.
- Going forward, the HSCRC should decrease the amount of support by 25% per year, contingent upon:
- MPSC's continuing to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs.

Commissioners voted unanimously in favor of Staff's recommendation.

ITEM X
STATUS UPDATE ON ED WAIT TIMES IN RY 2020 QBR POLICY

Dr. Alyson Schuster, Associate Director, Performance Measurement, presented on Emergency Department wait time measures in the Quality Based Reimbursement policy for FY2020 (see "Status Update on ED Wait Times in RY 2020 QBR Policy,"see HSCRC website).

Dr. Schuster reported that after significant evaluation of causal factors, Staff does not recommend an additional adjustment of performance on Emergency Department (ED) wait time measures in the Quality Based Reimbursement (QBR) policy for fiscal 2020. Instead, staff will re-examine performance for the impact of the 2017-2018 flu season once data are available. If the substantial increase in hospital volume due to the flu season appears to have constrained hospitals' ability to reduce ED wait times, they would consider a retroactive adjustment to mitigate penalties.

Commissioners voted in December to add ED wait time measures to the QBR policy, in a way that the addition of the measures would not hurt a hospital's score if the hospital improved on ED measures.

ITEM XI
DRAFT RECOMMENDATION ON CHANGES TO THE RELATIVE VALUE UNITS SCALE FOR RESPIRATORY THERAPY

Mr. Chris Konsowski, Chief- Audit & Compliance, presented a recommendation for final adoption of revisions to the Relative Value Unit (RVU) scale for Respiratory Therapy services to be effective July 1, 2018.
The Commission voted unanimously to approve staff's recommendation.

ITEM XII
FINAL RECOMMENDATION FOR NURSE SUPPORT PROGRAM II

Ms. Claudine Williams, Associate Director Policy Analysis, presented staff's final recommendations for the Nurse Support Program II (NSP II) FY 2019 Competitive Institutional Grants (See "Nurse Support Program II Competitive Institutional Grants Program Review Panel Recommendations for FY 2019" on the HSCRC website).

Ms. Williams stated that this final recommendation presents Staff's recommendations for the Nurse Support Program II (NSP II) Competitive Institutional Grant Review Panel for Fiscal Year (FY) 2019. The FY 2019 Recommendations align with both NSP II and national nursing initiatives. This report and recommendations are jointly submitted by the staff of the Maryland Higher Education Commission (MHEC) and HSCRC.

The HSCRC has funded programs to address the cyclical nursing workforce shortages since 1985. In July 2001, the HSCRC implemented the hospital-based Nurse Support Program I (NSP I) to address the nursing shortage impacting Maryland hospitals. Since that time, NSP I completed three program evaluation cycles at five year intervals. The most recent renewal was approved on July 12, 2017 to extend the funding until June 30, 2022.

The HSCRC implemented the NSP II program in May 2005 to respond to the faculty shortage and other limitations in nursing educational capacity underlying the nursing shortage. The Commission approved an increase of up to 0.1% of regulated gross hospital revenue to increase the number of nurses in the State by increasing the capacity of nursing programs through institutional and nursing faculty interventions. MHEC was selected by the HSCRC to administer the NSP II programs, as the coordinating board for all Maryland institutions of higher education. On March 7, 2012, the HSCRC approved modifications to NSP II to include increased doctoral education support for greater development of new and existing nursing faculty.

At the conclusion of the first ten years of funding on January 14, 2015, the HSCRC renewed funding for FY 2016 through June 30, 2020. In 2016, the Maryland General Assembly revised the NSP II statute to meet Maryland's changing health care delivery models and to recognize that all registered nurses (RNs) are needed to ensure a strong nursing workforce.

In response to the FY 2019 request for applications, the NSP II Competitive Institutional Grant Review Panel received a total of 29 requests for funding, including 25 new competitive grants proposals, 3 resource grant requests, and 1 continuation grant recommendation. The nine-member review panel, comprised of former NSP II grant project directors, retired nurse faculty, hospital educators, licensure and policy leaders, MHEC and HSCRC staff, reviewed the proposals. All new proposals received by the deadline were scored by the panel according to the rubric outlined in the FY 2019 RFA. The review panel convened and developed consensus around the most highly recommended proposals. As a result, the review panel recommends funding for 16 of the 29 total proposals. There were many deserving proposals, and the Panel encouraged those not funded this year to resubmit next year.

The recommended proposals include one-year planning grants, three-year full implementation grants, continuation grants, and nursing program resource grants for a total just under $9.6 million. The proposals that received the highest ratings for funding focused on nursing graduate outcomes with partnerships across community colleges, universities and hospital health systems. See below for the recommended proposals for FY 2019 funding.

Grant #	Institution	Grant Title	Proposed Funding
19-106	Harford Community College	Harford Community College/Towson University Collaborative	$850,631
19-107	Hood College	Increasing Capacity for Pre-licensure Graduates	$689,235
19-109	Johns Hopkins University	Preceptor Education for Vulnerable Populations	$569,344
19-113	Montgomery College	Montgomery College Resources for Educators	$45,850
19-114	Morgan State University	Nursing Dual Enrollment: Pipeline for HS Students	$139,686
19-116	Notre Dame of Maryland University	Accelerated Second Degree BSN	$965,927
19-117	Notre Dame of Maryland University	PARSystem Testing Resources	$34,010
19-118	Stevenson University	Increasing Numbers of BS prepared Nurses	$976,452
19-119	Towson University	Increasing the Supply of Qualified Nurse Faculty	$902,000
19-120	Towson University	Online Option for Degree Completion	$1,050,062
19-121	Towson University	Graduate Program Planning and Revision	$146,570
19-123	University of Maryland	PTECH at Dunbar HS for Health Professions with Baltimore City Community College	$629,919
19-124	University of Maryland	Establishing the Maryland Nursing Workforce Center	$265,467
19-125	University of Maryland	Advancing Implementation Science Education (ADvISE) Project	$698,995

Grant #	Institution	Grant Title	Proposed Funding
19-128	University of Maryland	Continuation of Preceptor Modules for APRNs	$359,211
19-129	Montgomery College	MCSRC Simulation Resources	$1,266,050
Total			**$9,589,409**

HSCRC and MHEC staff recommend the 16 proposals presented above for the FY 2019 NSP II Competitive Institutional Grants Program. The recommended proposals represent the NSP II's commitment to increasing nursing degree completions and academic practice partnerships across Maryland. The most highly recommended proposals include:

- Supporting additional nursing undergraduate degree completions at Hood College,

- Stevenson University and Towson University with the following hospital partners:
  - Frederick Memorial,
  - Lifebridge Health Centers (Northwest Hospital, Levindale and Sinai Hospital Center),
  - Medstar Union Memorial and Good Samaritan,
  - Howard County Hospital and Johns Hopkins Hospital,
  - UMMS St. Joseph's Medical Center and University of Maryland Medical Center

- Implementing an accelerated second-degree BSN program at Notre Dame of Maryland University;

- Awarding a planning grant for dual enrollment with Morgan State University to work with the Vivien T. Thomas Medical Arts Academy, a public high school in Baltimore;

- Establishing a Maryland Nursing Workforce Center for improved data infrastructure;

- Implementing a new preceptor education program for vulnerable populations at Johns Hopkins University;

- Developing an academic progression partnership with increased pre-licensure graduates in dual enrollment ATB programs at Harford Community College and Towson University;

- Continuing the Advanced Practice Nurse Preceptor online modules with an in-person simulation component developed through an earlier grant at the University of Maryland with participants from University of Maryland Medical Center, Johns Hopkins Hospital, Upper Chesapeake Health, MedStar Franklin Square and St. Agnes Hospital, scheduled for expansion of access to all APRN programs across the State; and

- Strengthening all Maryland nursing programs through the MCSRC's benchmarking assessments with targeted awards to ensure all schools have adequate and equitable clinical simulation opportunities with additional resources for Washington Adventist University, Johns Hopkins University, Anne Arundel Community College, Carroll Community College, Hood College, Salisbury University, Morgan State University, Towson University, Community College of Baltimore County at Catonsville and Essex.

Commissioners voted 4-0 in favor of Staff's recommendation for all grants except for The Johns Hopkins University grant. The grant to The Johns Hopkins University grant was approved 4-0. Commissioner Colmers recused himself from the vote and discussion. Chairman Sabatini cast the fourth vote.

ITEM XIII
DRAFT RECOMMENDATION ON UNCOMPENSATED CARE POLICY FOR FY 2019

Mr. Allan Pack, Director Population Based Methodologies, presented Staff's draft recommendation on the Uncompensated Care Policy for FY 2019 (See "Draft Recommendation for the Uncompensated Care Policy for Rate Year 2019" on the HSCRC website).

Uncompensated care (UCC) refers to care provided for which compensation is not received. This may include a combination of bad debt and charity care. Since it first began setting rates, the HSCRC has recognized the cost of UCC within Maryland's unique hospital rate-setting system. As a result, patients who cannot pay for care are still able to access hospital services, and hospitals are credited for a reasonable level of UCC provided to those patients. Under the current HSCRC policy, UCC 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 UCC and pay into the pool if they experience a less-than-average level of UCC. This ensures that the cost of UCC is shared equally across all of the hospitals within the system.

The HSCRC determines the total amount of UCC that will be placed in hospital rates for each year and the amount of funding that will be made available for the UCC pool. Additionally, the Commission approves the methodology for distributing these funds among hospitals.

HSCRC staff recommends the following for RY 2019:

- Reduce statewide UCC provision in rates from 4.51 % to 4.16 % effective July 1, 2018;
- Continue to use the regression modeling approach approved by the Commission at the June 2016 meeting;
- Continue to do 50/50 blend of FY16 audited UCC and predicted UCC.

As this is a draft recommendation, no Commission action is necessary.

ITEM XIV
DRAFT RECOMMENDATION FOR ADJUSTMENT TO THE DIFFERENTIAL

Ms. Kinzer presented Staff's draft recommendation to increase public-payer differential (see "Draft recommendation for Adjustment to the Differential" on the HSCRC website).

The Maryland Health Services Cost Review Commission (HSCRC) is a state agency with unique regulatory authority. The HSCRC is legally authorized to set the rates to be charged by all Maryland hospitals. These rates form the basis of payment by all payers for the provision of hospital services in Maryland. The federal government has granted Maryland the authority for HSCRC to set hospital payment rates for Medicare as part of its all-payer hospital rate-setting system. This all-payer rate-setting approach, which has been in place since 1977, eliminates cost shifting among payers, while also appropriately accounting for certain differences among payers.

Since the 1970s, the State of Maryland has employed a differential, whereby public payers (Medicare and Medicaid) pay 6 percent less than other payers (primarily commercial payers). Hospital charges are adjusted to ensure that the differential's reduction in charges to public payers does not result in a decline in hospitals' total revenue.

The State of Maryland's current All-Payer Model contract requires that the differential "be at a minimum 6.0%." This is to account for Medicare's "business practices and prompt payment practices."

The purpose of this recommendation is to present analyses and make a recommendation to increase the public-payer differential in order to correct for excess bad-debt write-offs for commercial coverage that shift costs onto Medicare and Medicaid. The staff is recommending an effective date of January 1, 2019 to allow for implementation by the Medicare intermediary as well as other payers. This proposed change is not meant as a mechanism to create additional room for all-payer rate updates in future years.

In the future, staff may also offer a draft recommendation to increase the differential to ensure that the realignment of hospital cost allocations does not increase combined payments to hospitals by Medicare and Medicaid. However, more analyses are required to quantify the effects of such cost realignment.

The HSCRC staff believes that this allocation should be corrected through an increase in the differential by 1.7 percentage points in CY 2019. This would result in:

- A lower cost to Medicare of approximately $40 million;
- A lower cost to Medicaid of approximately $27 million; and
- An increase in overall commercial payer costs of $67 million. Assuming hospital costs are approximately one-third of total commercial costs, this would increase overall commercial payer costs by an estimated 0.4%.

This adjustment will ensure more equitable cost allocation going forward, consistent with the HSCRC's statutory mandate.

Staff's draft recommendation is as following:

Effective January 1, 2019, increase the public-payer differential by 1.7 percentage points (from the current 6.0 percent to 7.7 percent) to more equitably allocate higher uncompensated care costs incurred by commercially insured patients.

As this is a draft recommendation, no Commission action is necessary.

ITEM XV
REPORT ON ONGOING SUPPORT OF CRISP IN 2019 FOR HIE OPERATIONS AND REPORTING SERVICES

Ms. Wunderlich presented staff's draft recommendations for FY 2019 funding to support Health Information Exchange (HIE) Operations and the Chesapeake Regional Information System for our Patients (CRISP) (See "Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2019 Funding to Support HIE Operations and CRISP Reporting Services" on the HSCRC website).

Under the authority granted by the Commission, HSCRC staff approved a total of $2.5 million in funding through hospital rates in FY 2019 to support the HIE and Implementation Advanced Planning Document (IAPD) initiative activities for the Commission. No additional funds are requested through hospital rates in FY 2019 to support ICN-related activities. Funding for FY 2019 ICN activities is through the appropriation and authority provided under the BRFA of 2015.

The approved rate funding for HIE and standard reporting functions in FY 2019 including the federal match that will be generated from the IAPD funding are as follows:

Health Information Exchange Assessment	$1,500,000
Implementation Advanced Planning Document	1,000,000

No Commission action is required.

ITEM XVI
HEARING AND MEETING SCHEDULE

July 13, 2018	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
August 8, 2018	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:30 p.m.

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

Data through April 2018 – Claims paid through May

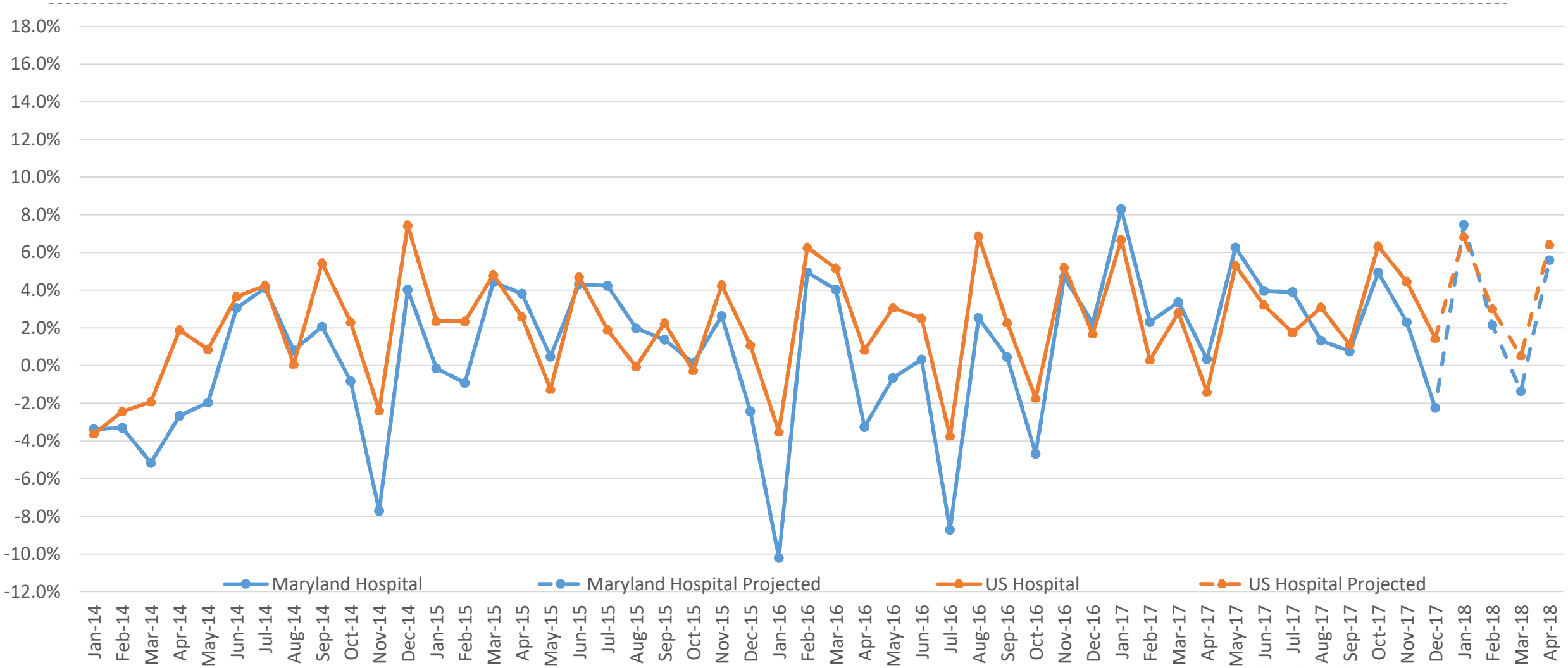
Source: CMMI Monthly Data Set

Disclaimer:

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

Medicare Hospital Spending per Capita

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



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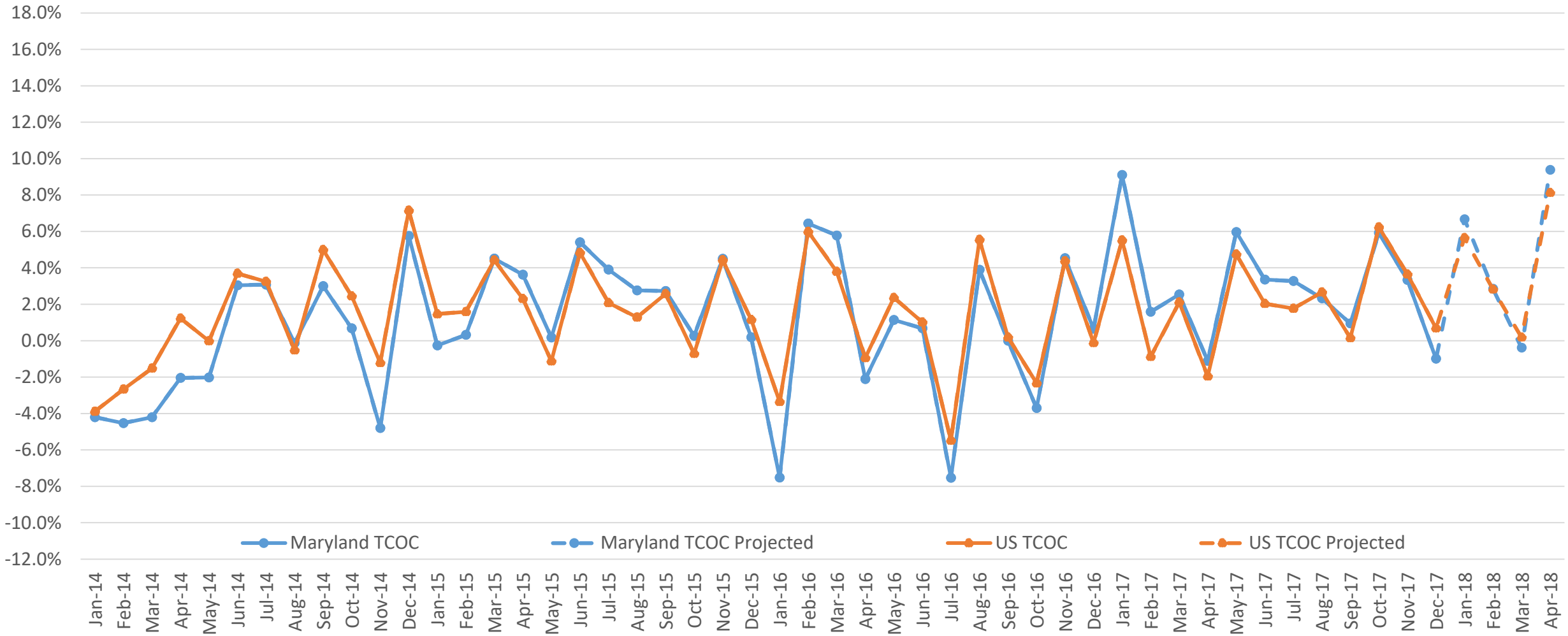
HSCRC
Health Services Cost Review Commission

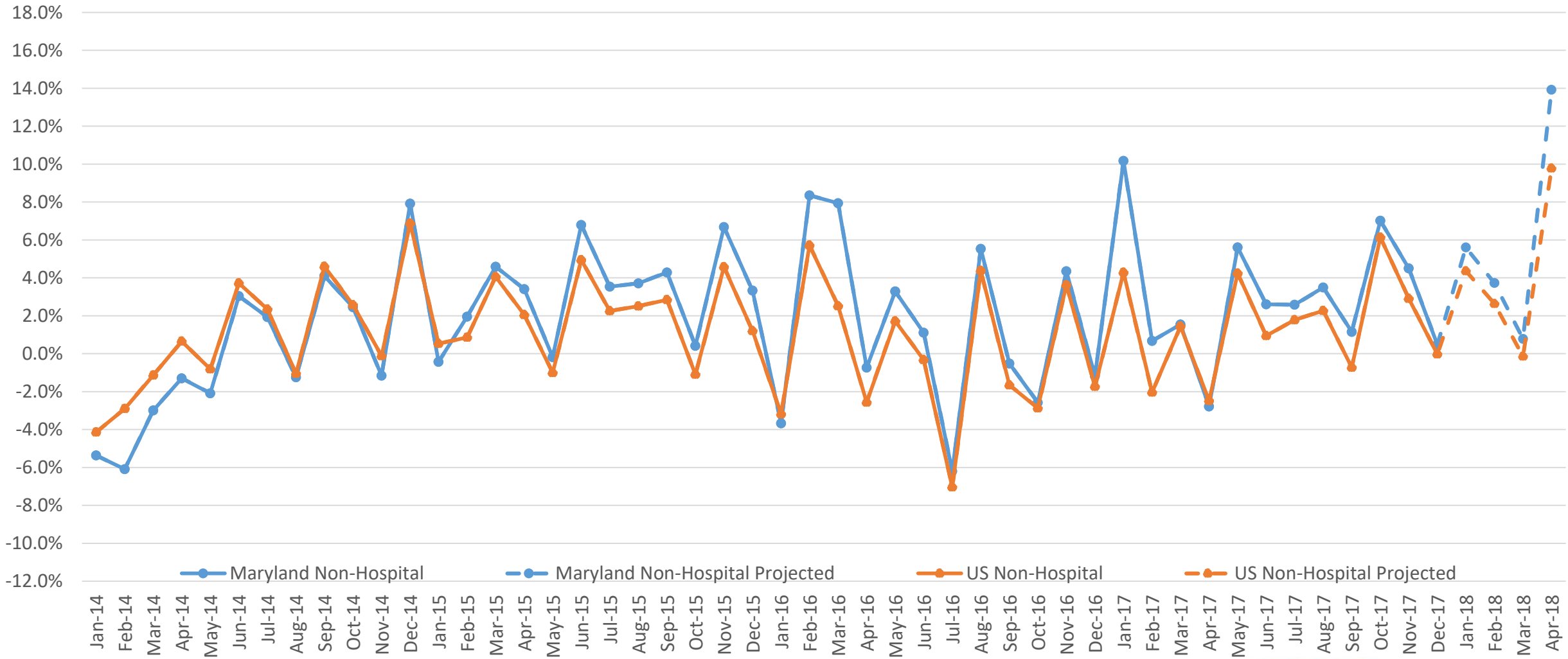
Medicare Total Cost of Care Spending per Capita

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

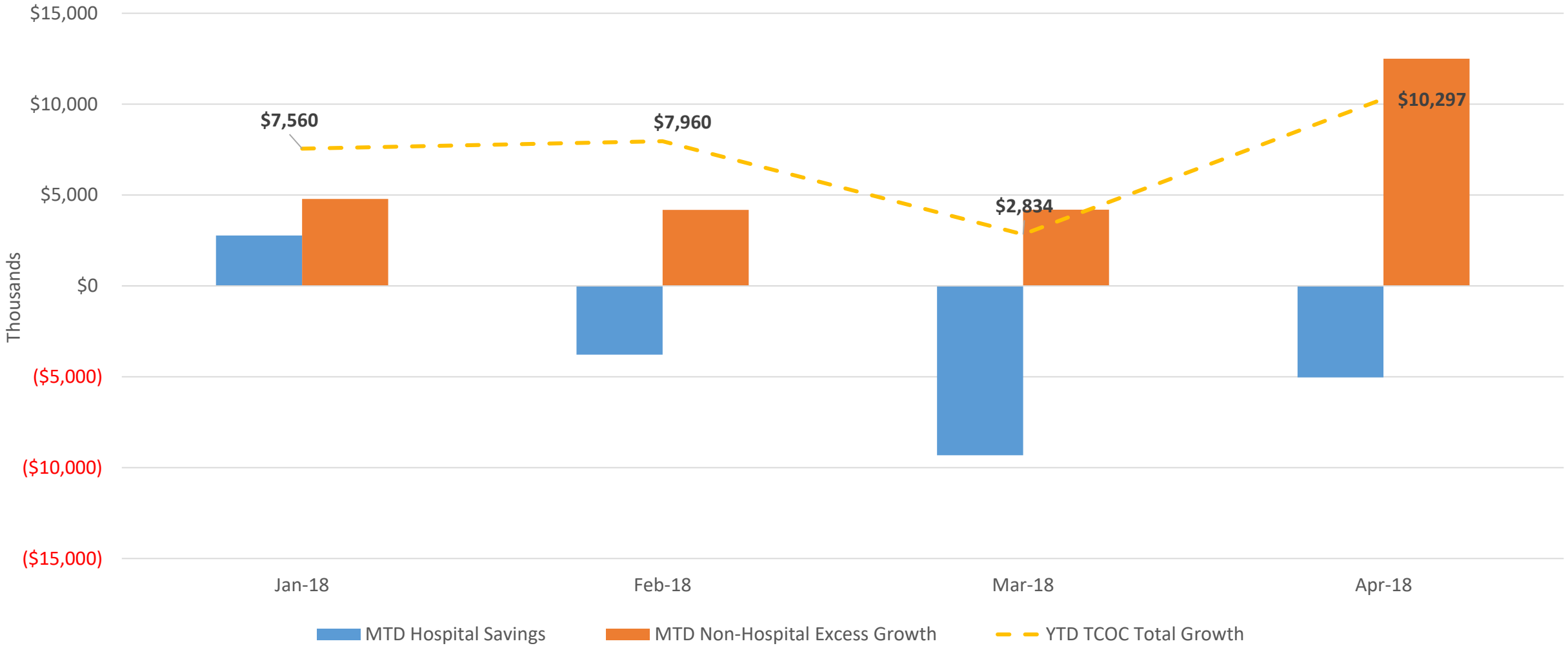


Medicare Non-Hospital Spending per Capita

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



Medicare Hospital & Non-Hospital Growth
(with completion) CYTD through 2018



Monitoring Maryland Performance
Financial Data

Year to Date through May 2018*

Source: Hospital Monthly Volume and Revenue and Financial Statement Data
Run: July 2018

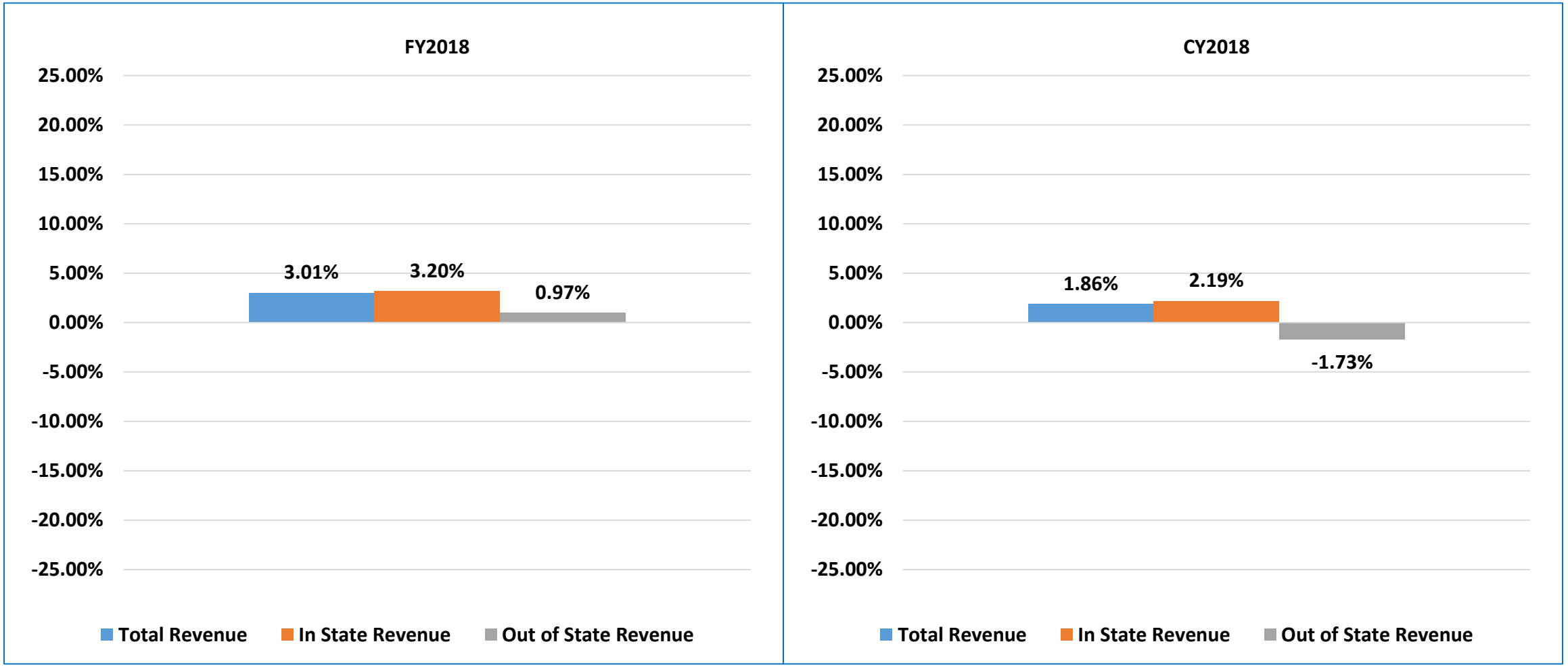
*Revenues used in the fiscal year growth calculations are not adjusted for the undercharge that occurred in Jul-Dec 2016.

The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2017 have been revised. CMS has changed the enrollment source for the Chronic Condition Data Warehouse (CCW) from the Enrollment Database (EDB) to the Common Medicare Environment (CME) database. Part A changed very slightly and Part B is more noticeably changed.

The Population Estimates from the Maryland Department of Planning have been revised in December, 2017. The new FY 18 Population growth number is 0.46%.

Gross All Payer Hospital Revenue Growth

FY 2018 (July 17 – May 18 over July 16 – May 17) and CY 2018 (Jan-May 18 over Jan-May 17)

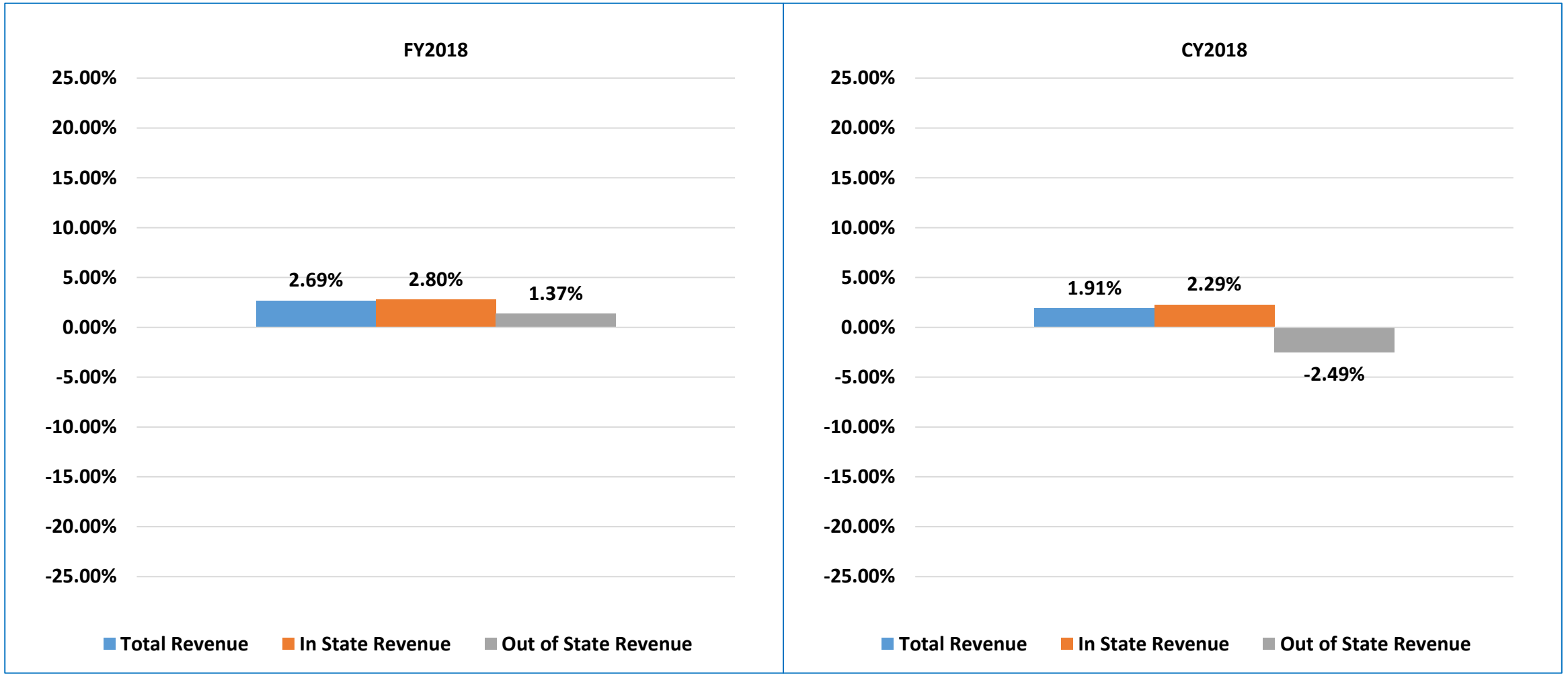


These Fiscal Year figures are not adjusted for the undercharge that occurred Jul-Dec 2016.

The State's Fiscal Year begins July 1

Gross Medicare Fee for Service Hospital Revenue Growth

FY 2018 (July 17 – May 18 over July 16 – May 17) and CY 2018 (Jan - May 18 over Jan – May 17)

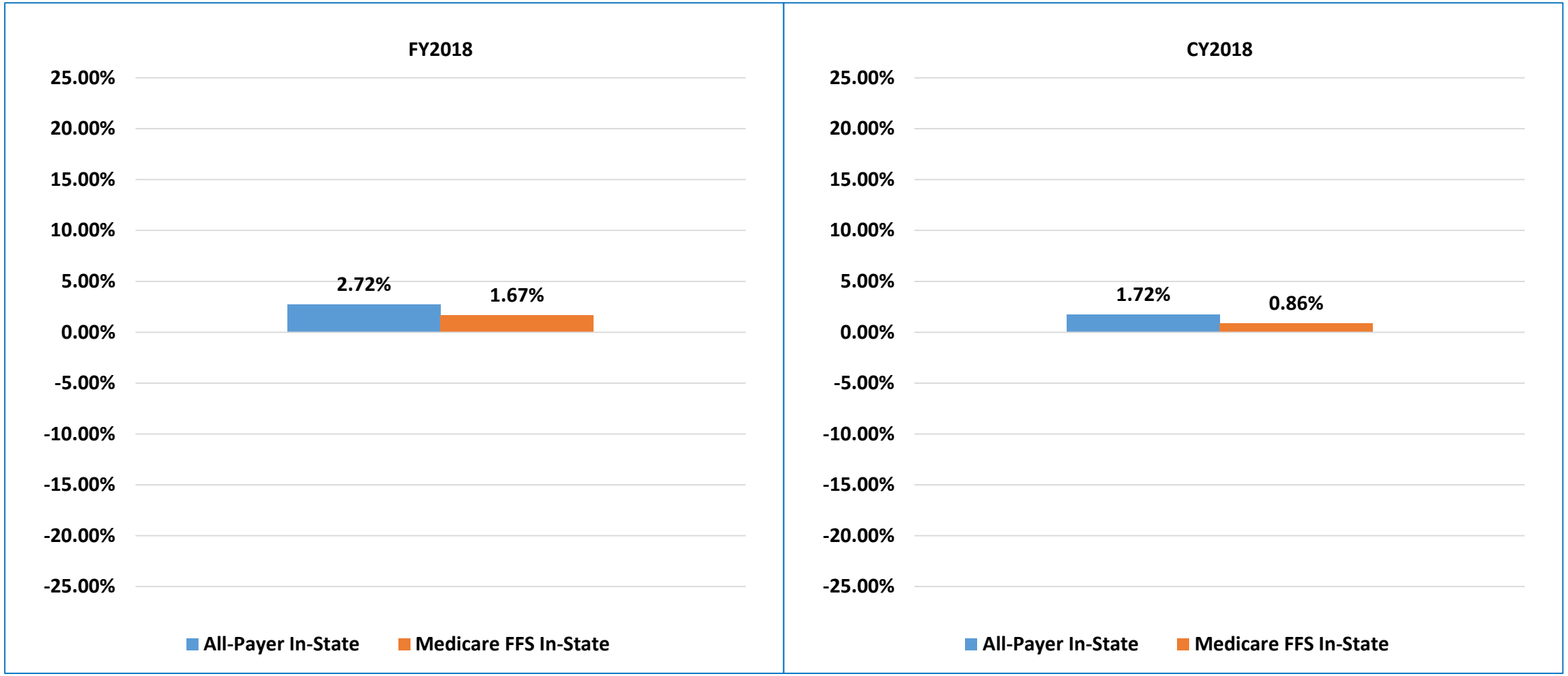


The State's Fiscal Year begins July 1

HSCRC
Health Services Cost Review Commission

Hospital Revenue Per Capita Growth Rates

FY 2018 (Jul 17–May 18 over July 16–May 17) and CY 2018 (Jan-May 17 over Jan-May 18)



The State's Fiscal Year begins July 1

HSCRC
Health Services Cost Review Commission

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

AS OF JULY 3, 2018

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
2439A	University of Maryland Medical System	6/11/2018	N/A	N/A	ARM	DNP	OPEN
2440A	University of Maryland Medical System	6/11/2018	N/A	N/A	ARM	DNP	OPEN
2441R	Meritus Health	6/19/2018	7/19/2018	11/23/2018	NEW SERVICE	BG	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

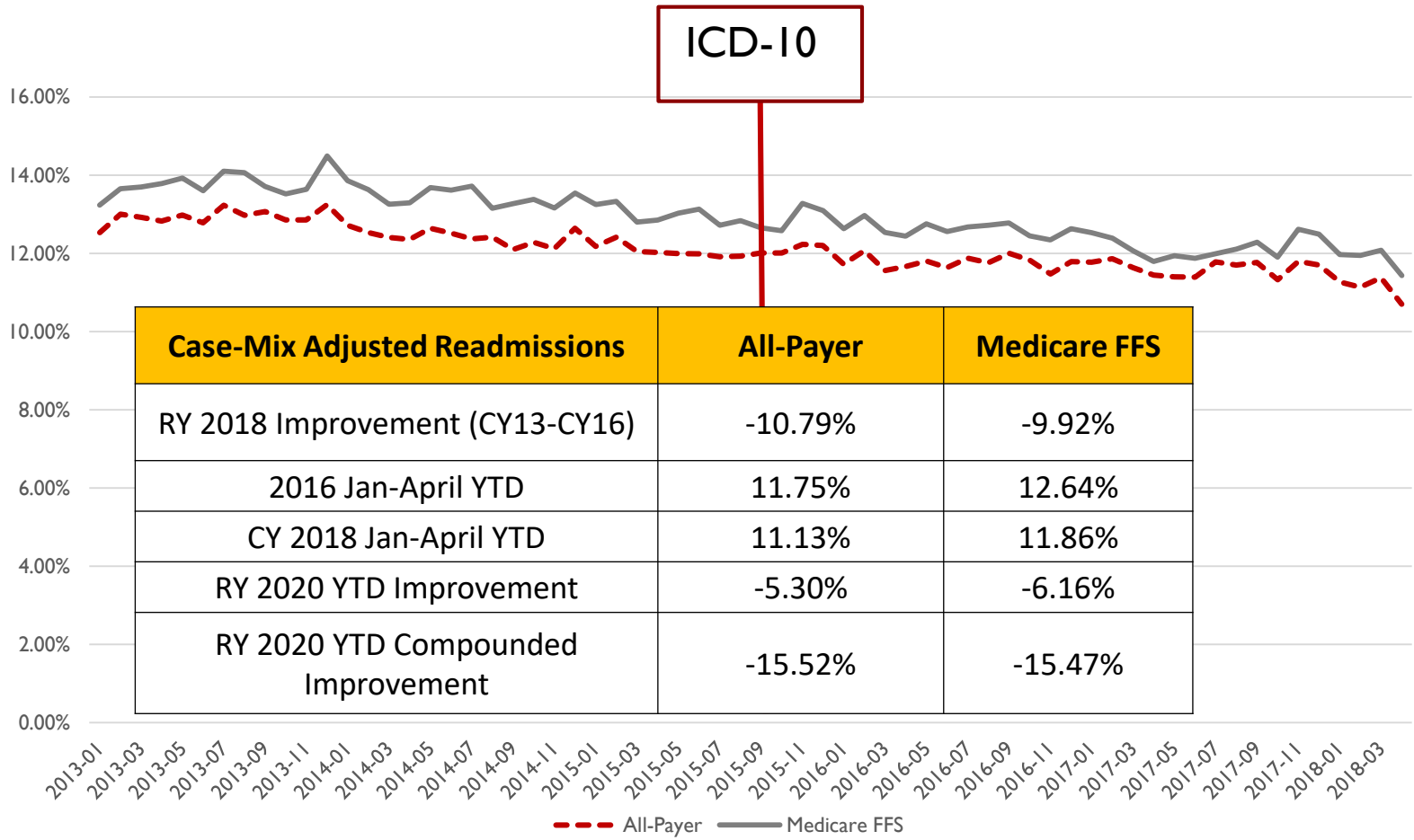
NONE

Monitoring Maryland Performance
Quality Data

July 2018 Commission Meeting Update

Readmission Reduction Analysis

Monthly Case-Mix Adjusted Readmission Rates

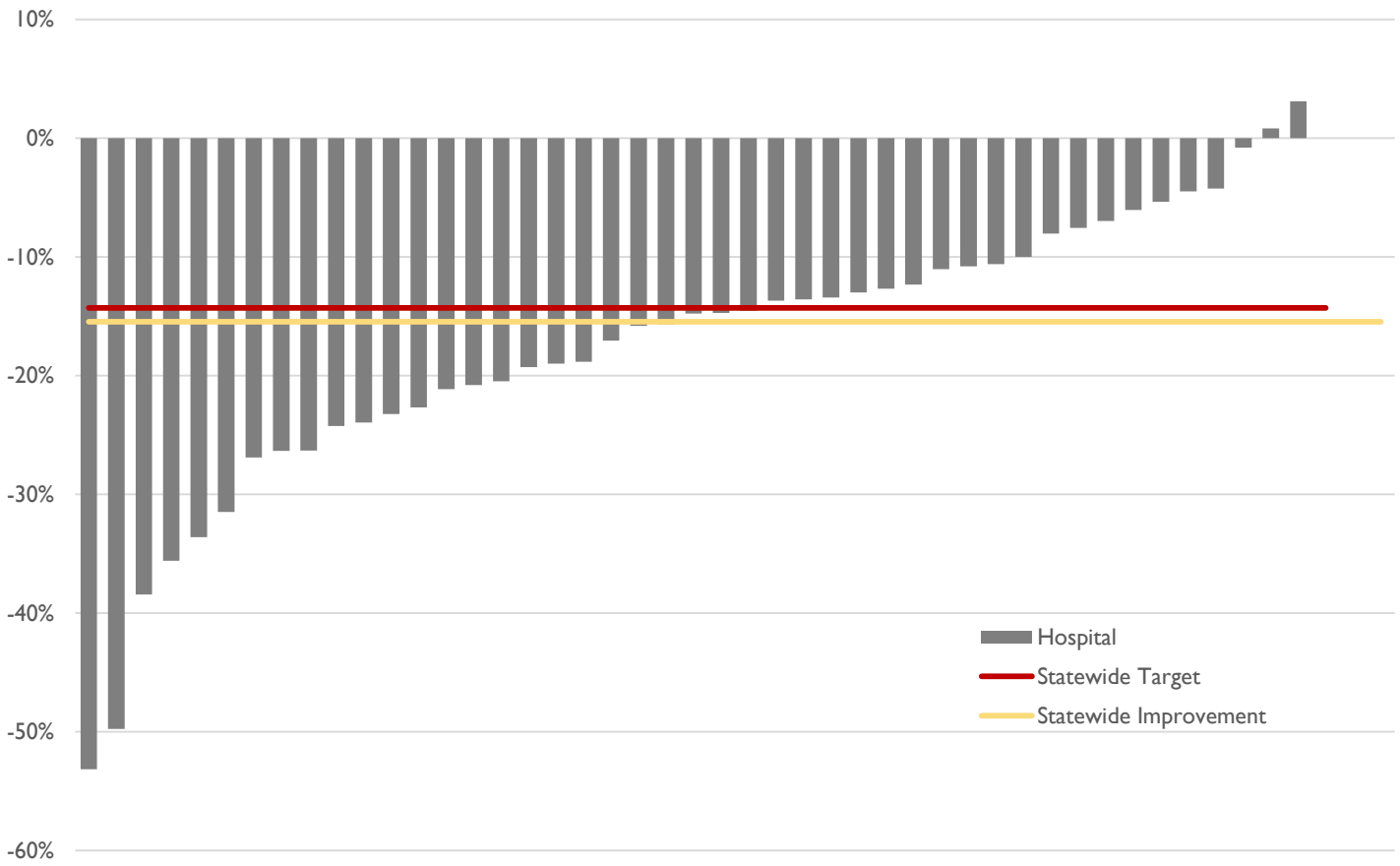


Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
RY 2018 Improvement (CY13-CY16)	-10.79%	-9.92%
2016 Jan-April YTD	11.75%	12.64%
CY 2018 Jan-April YTD	11.13%	11.86%
RY 2020 YTD Improvement	-5.30%	-6.16%
RY 2020 YTD Compounded Improvement	-15.52%	-15.47%

Note: Based on final data for Jan 2013 – Mar 2018; Preliminary data May 2018. Statewide improvement to-date in RY 2020 is compounded with RY 2018 improvement.

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

Cumulative change CY 2013 – CY 2016 (RY2018)
Compounded with CY 2016 to CY 2017



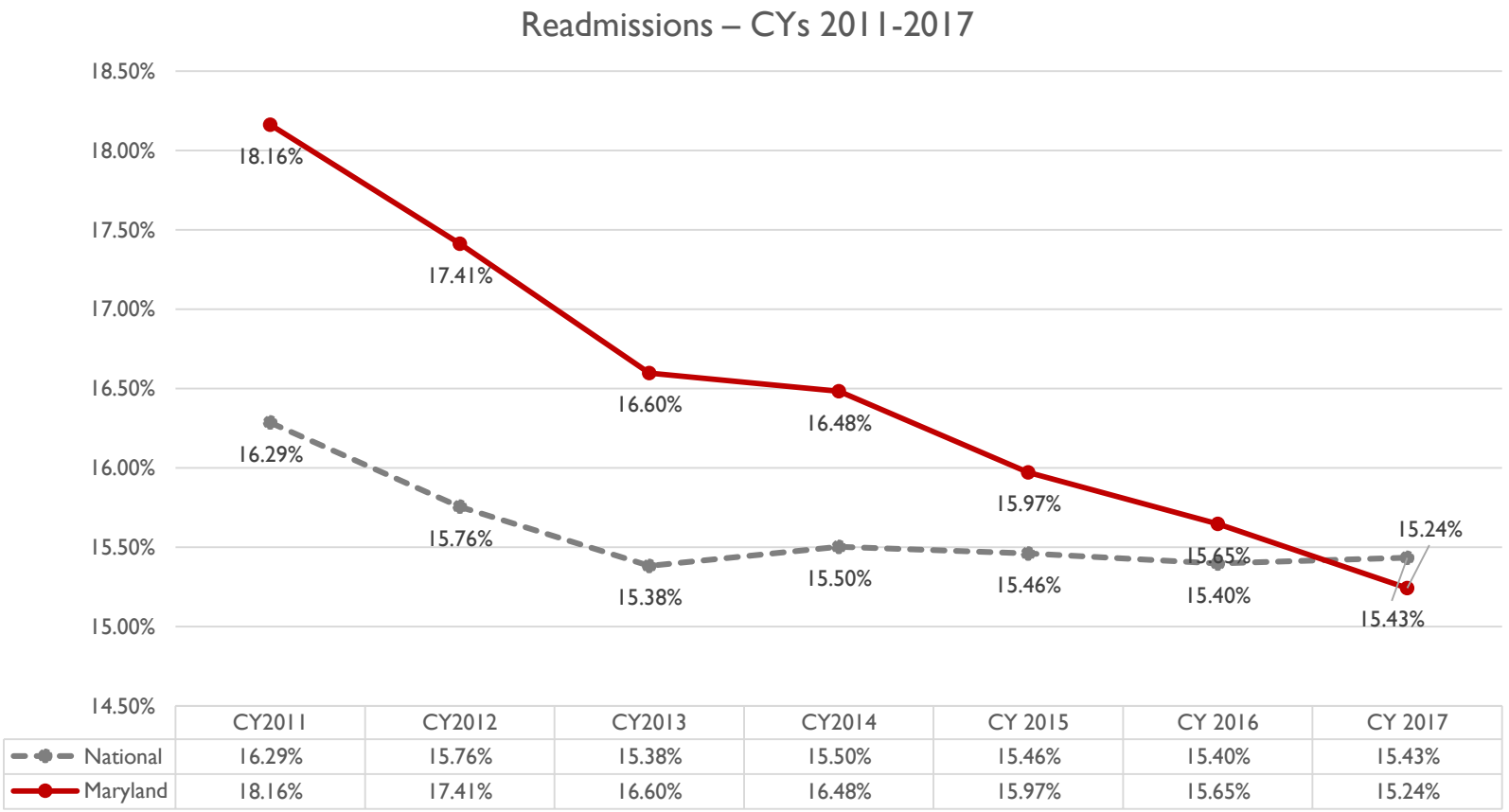
25 Hospitals are on Track for Achieving Improvement Goal

Additional 4 Hospitals on Track for Achieving Attainment Goal

Note: Based on Final data for Oct 2015 - Mar 2018; Prelim through Apr 2018.

Medicare Readmission Model Test

Medicare Readmissions – Rolling 12 Months Trend

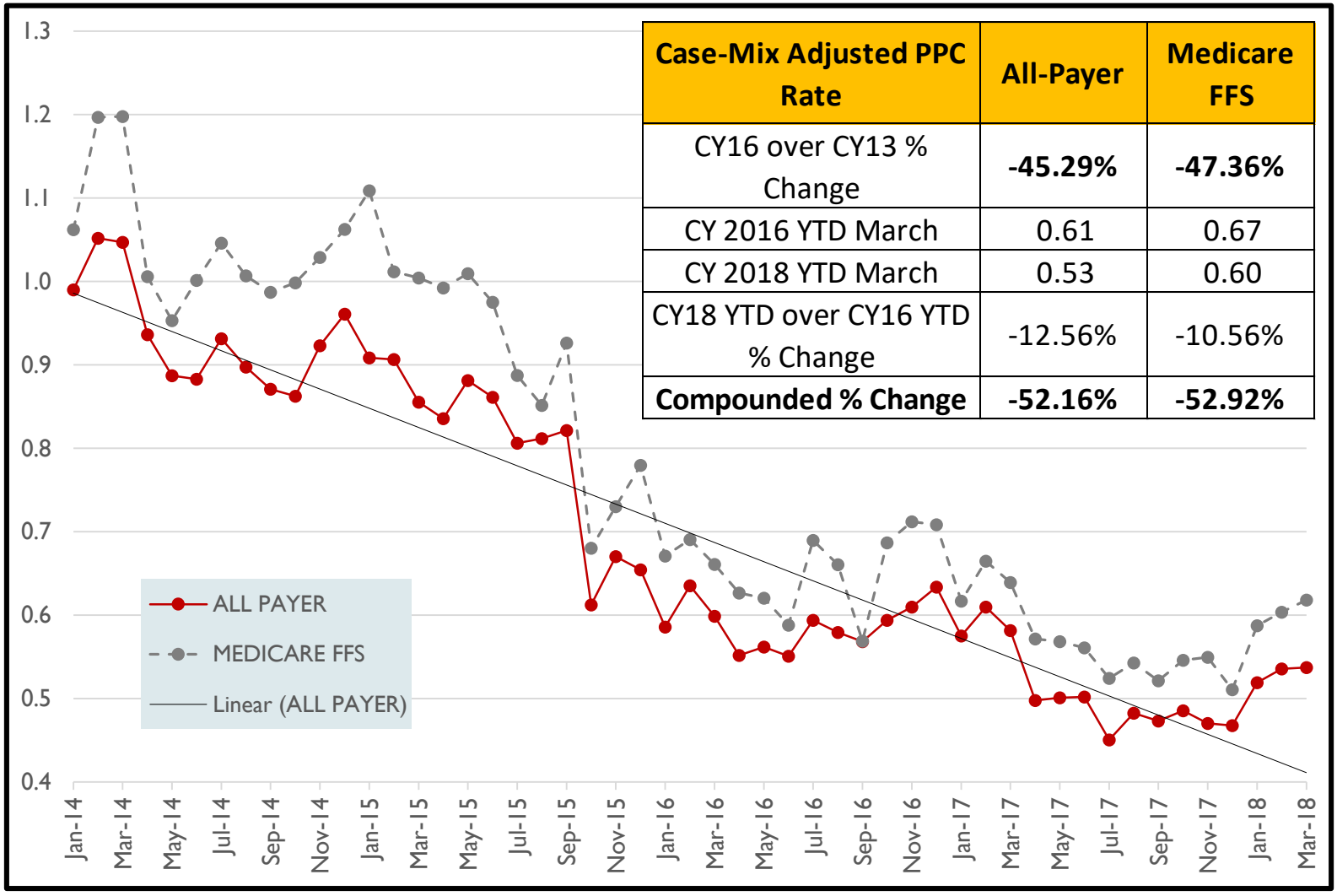


	CY2011	CY2012	CY2013	CY2014	CY 2015	CY 2016	CY 2017
National	16.29%	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%
Maryland	18.16%	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%

NOTE: These data represent the final re-stated data from CMS for CY 2017. Based on these numbers, Maryland has achieved the required 2017 reduction in readmissions. Numbers for 2018 not yet available.

MHAC PPC Reduction Update

Monthly Case-Mix Adjusted PPC Rates



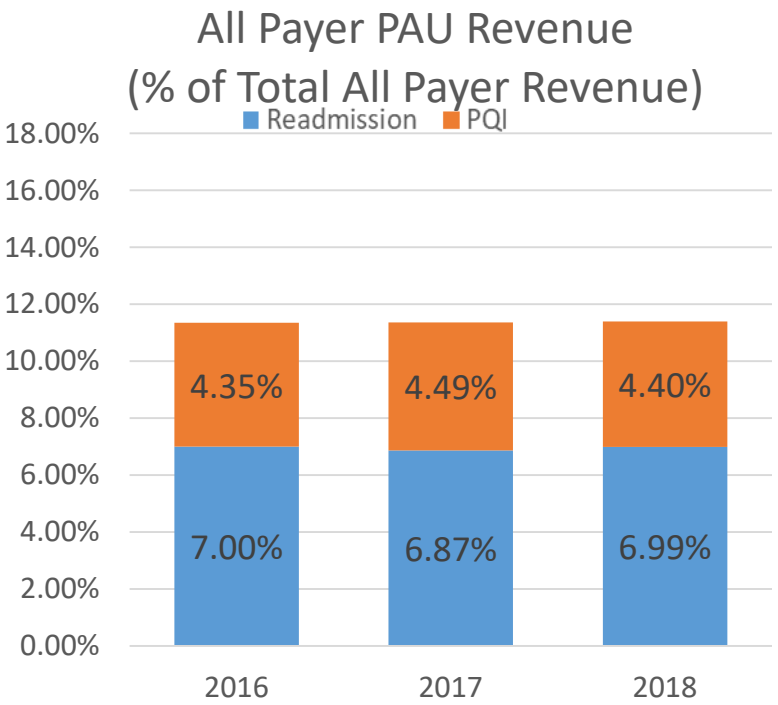
Case-Mix Adjusted PPC Rate	All-Payer	Medicare FFS
CY16 over CY13 % Change	**-45.29%**	**-47.36%**
CY 2016 YTD March	0.61	0.67
CY 2018 YTD March	0.53	0.60
CY18 YTD over CY16 YTD % Change	-12.56%	-10.56%
Compounded % Change	**-52.16%**	**-52.92%**

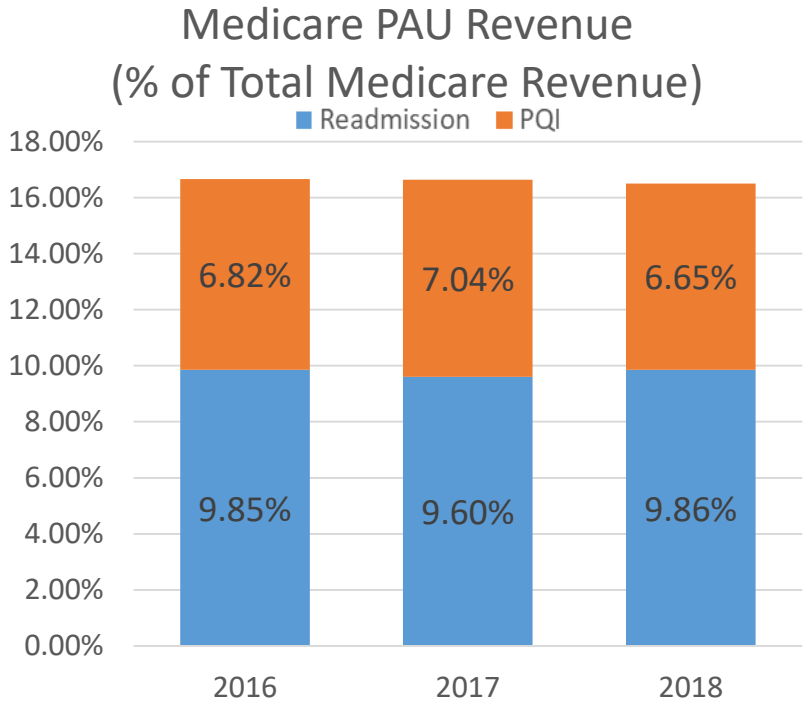
Note: Line graph based on v32 prior to October 2015; and v35 October 2015 to March 2018; all data are final, but are subject to validation.

Potentially Avoidable Utilization (PAU) Monitoring

The PAU Monitoring analysis is included in the RY 2019 PAU Savings Draft Policy.

Potentially Avoidable Utilization (PAU) Statewide CYTD (Jan-May)





- Using All Payer data, CYTD 2018 shows that the percent of total revenue attributable to PAU has increased slightly over the past three years, from 11.35% of All Payer revenue in CYTD 2016 to 11.39% of All Payer revenue in CYTD 2018.
- Using Medicare FFS only data, CYTD 2018 shows that the percent of total revenue attributable to PAU has declined over time, from 16.67% of Medicare revenue in CYTD 2016 to 16.51% of revenue in CYTD 2018.

Cases Closed

The closed cases from last month are listed in the agenda

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2018**
MEDICAL CENTER	*****	**FOLIO:**	**2249**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2439A**

Staff Recommendation

July 11, 2018

I. INTRODUCTION

University of Maryland Medical Center (“Hospital”) filed an application with the HSCRC on June 11, 2018 for an alternative method of rate determination under COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for solid organ transplant and blood and bone marrow transplants for one year with Aetna Health Inc. and Coventry Health Plan, Inc. beginning August 1, 2018.

II. OVERVIEW OF THE APPLICATION

The contract will be continue to 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 recent 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 to 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

Staff reviewed the experience under this arrangement for the last year and found it to be favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

Based on the Hospital's favorable performance, staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ transplant, and blood and bone marrow transplant services, for a one year period beginning August 1, 2018. 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, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2018**
MEDICAL CENTER	*****	**FOLIO:**	**2250**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2440A**

Staff Recommendation

July 11, 2018

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on June 11, 2018 for an alternative method of rate determination under COMAR 10.37.10.06. The Hospital requests approval to continue its participation in a global rate arrangement with Maryland Physicians Care ("MPC") for solid organ and blood and bone marrow transplant services for a period of one year beginning August 23, 2018.

II. OVERVIEW OF APPLICATION

The contract will continue to 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.

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V. STAFF EVALUATION

Staff found that the actual experience under the arrangement for the last year has been favorable. Staff believes that the Hospital can continue to achieve favorable performance under

this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing August 23, 2018. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the 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.

IN RE: PARTIAL RATE APPLICATION OF	*	**BEFORE THE MARYLAND HEALTH SERVICES**
MERITUS MEDICAL CENTER, INC.	*	**COST REVIEW COMMISSION**
	*	
	*	**DOCKET: 2018**
	*	**FOLIO: 2251**
HAGERSTOWN, MARYLAND	*	**PROCEEDING: 2441R**

Staff Recommendation

July 11, 2018

INTRODUCTION:

On June 19, 2018, Meritus Medical Center, Inc. ("Meritus", or the "Hospital") submitted an application requesting that its outpatient cancer center be permitted to become part of its regulated hospital, and that the Hospital's Global Budget Revenue ("GBR") be increased accordingly, effective July 1, 2018.

BACKGROUND:

Meritus is licensed for 236 beds and is located in Hagerstown, Maryland. The John R. Marsh Cancer Center ("Cancer Center") is located within the Robinwood Professional Center, which is positioned adjacent to the Hospital on the campus of Meritus.

Meritus has operated the Cancer Center as an unregulated entity since 2004. Based on a June 18, 2004 letter from the Centers for Medicare & Medicaid Services' fiscal Intermediary for Maryland, Office of Medicare Audit & Reimbursement, the Cancer Center billed Medicare as a provider-based service under the Hospital Outpatient Prospective Payment System ("OPPS") using a sub-provider number of the Hospital. Other payers paid according to negotiated "facility" contracts. In 2018, the Medicare Audit & Reimbursement representative informed Meritus that it would not be permitted to continue to bill under the Hospital's provider number and be paid under OPPS as an outpatient prospective payment entity. The Cancer Center would either have to be subject to HSCRC regulatory and rate setting authority or bill as an unregulated physician-based entity.

ASSESSMENT:

On April 30, 2018, Meritus requested a determination of rate regulated status from HSCRC staff for the Cancer Center pursuant to COMAR 10.37.10.07-1. Upon staff review, it was noted that certain physical changes to the patient entrance and related signage would be required to achieve regulated status. Additionally, the services to be rendered within the Cancer Center are to be limited to regulated oncology and infusion services. Conditioned upon completion of the required changes and conformance with COMAR 10.37.10.07-1, the HSCRC staff determined that the Cancer Center met the requirements for rate regulated status effective July 1, 2018.

In recognition of the All-Payer Model, the HSCRC staff undertook a review process to ensure that there would not be an increase in the cost to Medicare and all payers as a result of moving the service from unregulated status to a regulated billing status. Staff also undertook a review to ensure that the resulting rates were reasonable relative to the cost of the services and in relation to other hospitals offering the services. Additionally, since HSCRC staff is working to amend its regulatory process for high cost outpatient drugs, staff evaluated the opportunity to test a new approach for setting rates for the high cost outpatient drugs.

In an effort to determine the value to be added to the approved global budget revenue of Meritus, staff reviewed Meritus' annual filings with HSCRC ("HSCRC cost reports") and the annual cost reports filed with Medicare for fiscal 2017, 2016 and 2015 with particular focus on the costs and revenues reported for the Cancer Center. Staff also reviewed drug cost estimates for fiscal 2018 derived from 11 months of actual fiscal 2018 data extrapolated to 12 months. In addition, staff reviewed in detail the total gross charges and reimbursements by payer for the Cancer Center for the first 11 months of fiscal 2018 and extrapolated the likely collections by payer for the full period. Staff determined that the value of Medicare payments for fiscal 2018 was approximately $15,966,000, and that such value when inflated to 2019 would approximate $16,541,000. Staff then determined that the all-payer revenue amount (assuming the same payer mix as existed in 2018), which would ensure that Medicare payments did not increase by moving the service from unregulated to a regulated status, would be approximately $32,050,468. Staff also reviewed all-payer payments and determined that this revenue amount

was not higher than the all-payer expenditures in the unregulated setting. As such, $32,050,000 was set as the upper level ceiling for global budget revenue for fiscal 2019 for the Cancer Center.

Staff reviewed the financial data for the Cancer Center for fiscal years 2017, 2016 and 2015 and reconciled such data to the annual filings with the HSCRC and the audited financial statements for Meritus. The review disclosed that the volume of business in 2017 and 2016 (as measured in net patient revenues, and operating costs) was relatively consistent and presented a fair representation of the likely volume expected in the near future, after adjusting for 2018 drug cost. The 2017 actual operating costs for the Cancer Center were then inflated to fiscal 2019 (using an annual inflation assumption of 2%), and the 2018 estimated drug costs were inflated using an annual inflation assumption of 5.3% and reduced for anticipated discounts from participation in the 340B program. Such costs were then extended by the payer differential mark-up (approximately 1.1000) and then further extended by the various HSCRC assessments (approximately 3.7%).

Given that staff has utilized estimates, extrapolations, and assumptions derived from partial 2018 data in researching the GBR increment recommendation, the approved amount will be subject to reconciliation and audit of final 2018 payer collection, drug costs, and other operating costs.

Using revenues of $32,050,000, HSCRC staff allocated the revenues to Drugs, Radiation Therapy, Clinic, Laboratory, and Supplies. Meritus submitted 2018 RVUs for Radiation Therapy and Clinic services. The allocation to Drugs was based on estimated costs (plus markup and assessments) with the remainder of revenues apportioned to the other rate centers. Staff reviewed the resulting rates for the Clinic and Radiation Therapy centers and found them to be below the median for Meritus' Inter-hospital Cost Comparison peer group and below the statewide median rates for these services. Laboratory and Supplies reflected minor revenue amounts, and staff assumed that these amounts were reasonable. As such, staff determined that a revenue budget of $32,050,000 would result in rates that were not higher than peer hospitals and were reasonable in relation to estimated costs.

With the exception of the drugs, staff proposes to blend the resulting revenues for each center with existing approved hospital revenues for each center.

For the cancer drugs, staff proposes to establish a new revenue center, Outpatient Cancer and Infusion Drugs. Staff proposes that the Hospital be permitted to bill 340B or Average Selling Price ("ASP") based prices, plus markup for payer differential and the various HSCRC assessments. There will be no additional overhead added to this rate center. This will assure that rates are reasonable in relationship to cost, and provide an opportunity to test a new approach to setting rates for high cost outpatient drugs. Unlike other revenue centers, this rate center will not use corridors. This billing approach is not intended to result in changes in the global budget, but it will provide a mechanism to more closely evaluate changes in cost and usage of high cost cancer and infusion drugs and to refine regulatory policies. It will also create a more site neutral approach (meaning payment levels that are on par with other providers offering the same drugs) for these expensive drugs.

Commission regulations (COMAR 10.37.10.07) require a hospital to file a rate application at least 60 days before the operational opening of a new service within a hospital whose projected annual operating costs exceed $100,000. Meritus filed an application on June 19, 2018 for a new oncology service with a requested effective date of July 1, 2018. The Commission staff recommends that the request be approved, and that the Commission waive the 60-day rate application requirement given that Meritus had previously filed a request for staff determination of regulated status for this service on April 30, 2018. Because of the April filing, staff has had sufficient time to evaluate, and now recommends approval for this service.

RECOMMENDATION:

Based on the analysis and findings above, staff recommends:

1. That the global budget revenue for Meritus for fiscal 2019 be increased by $32,050,000 effective July 1, 2018, to incorporate the Cancer Center into the GBR.
2. That a new Outpatient Cancer and Infusion Drugs rate center be established for specific high cost drugs, and that the billing for these services be based on 340B or ASP based prices, plus markup for payer differential and the various HSCRC assessments.
3. That the revenues for other related services be blended with existing hospital rates.

Final Recommendations for the Uncompensated Care Policy for Rate Year 2019

07/11/2018

HSCRC
Health Services Cost Review Commission

Stakeholder Feedback & Results of the Model

- There were no letters received regarding the RY 2019 UCC Draft Recommendation
- The RY 2019 Statewide UCC amount is recommended to be 4.16%
- Hospital-specific UCC adjustments range from 2.45% to 9.55%.
  - The results of this model are contained in Appendix I of the final recommendation.

Final Recommendations

Staff recommends the following for RY 2019:

- Reduce statewide UCC provision in rates from 4.51%, which was the UCC rate effective for RY 2018 to 4.16% for RY 2019.

- Continue to use the logistic regression model approved by the Commission at the June 2016 meeting.

- Continue to do 50/50 blend of the most recent actual hospital audited UCC levels and the hospitals estimated UCC levels using the logistic regression model.

Final Recommendations for the Uncompensated Care Policy for Rate Year 2019

July 11, 2018

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

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CHANGES FROM DRAFT TO FINAL RECOMMENDATION

Staff did not receive any stakeholder feedback on the proposed draft recommendation. There are no changes between the draft and final policies.

INTRODUCTION

Uncompensated care (UCC) refers to care provided for which compensation is not received. This may include a combination of bad debt and charity care.[1] Since it first began setting rates, the Maryland Health Services Cost Review Commission (HSCRC or Commission) has recognized the cost of UCC within Maryland's unique hospital rate-setting system. As a result, patients who cannot pay for care are still able to access hospital services, and hospitals are credited for a reasonable level of UCC provided to those patients. Under the current HSCRC policy, UCC 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 UCC and pay into the pool if they experience a less-than-average level of UCC. This ensures that the cost of UCC is shared equally across all of the hospitals within the system.

The HSCRC determines the total amount of UCC that will be placed in hospital rates for each year and the amount of funding that will be made available for the UCC pool. Additionally, the Commission approves the methodology for distributing these funds among hospitals. The purpose of this report is to provide background information on the UCC policy and to make recommendations for the UCC pool and methodology for rate year (RY) 2019. The UCC amount to be built into rates for Maryland hospitals is 4.16 percent for RY 2019.

BACKGROUND

Overview of Maryland's Uncompensated Care Policy

Methodology

The HSCRC prospectively calculates the rate of UCC at each regulated Maryland hospital by combining historical UCC rates with predictions from a regression model,[2] the latter of which is incorporated because HSCRC policy aims to continue incentivizing hospitals to reduce bad debts. Using these calculated UCC rates, the HSCRC builds a statewide pool into the rate structure for Maryland hospitals, and hospitals either pay into or withdraw from the pool, depending on each hospital's prospectively calculated UCC rate relative to the most recent statewide average.

The UCC Methodology for RY 2019 uses RY 2017 actual UCC rates from hospitals' audited financial statements and a logistic regression model that predicts a patient's chances of having UCC based on payer type, location of service (inpatient, ED, and other outpatient) and the Area Deprivation Index. The results of the logistic regression model are then multiplied by the total charges of the hospital as well as the percentage of services that are delivered to commercial patients in the emergency room, which is the greatest indication of likely uncompensated care. This calculation creates a predicted UCC rate for each hospital. A 50/50 blend of audited

[1] COMAR 10.37.10.01K

[2] A regression is a general statistical technique for determining how much of a change in an output amount is likely to result from changes in measures of multiple inputs.

financial statements and the predicted UCC rate for each hospital is used to determine hospital-specific adjustments. The RY 2019 UCC amount is set at 4.16 percent.

ASSESSMENT

Determining the Appropriate Level of Uncompensated Care Funding in Rates

The HSCRC must determine the percentage of UCC to incorporate in hospitals' rates in order to fund the UCC pool. Based on the most recent audited reports, the statewide UCC rate was 4.16 percent in RY 2017, which represents a 42.5% decrease in uncompensated care since the start of GBR (RY 2013 UCC – 7.23%).

The rate of Marylanders without health insurance decreased from 10.2 percent in 2013 to 7.9 percent in 2014, according to the statistics published by the U.S. Census Bureau on September 16, 2015.[3] Maryland's uninsured rate continued to decrease to 6 percent as of March 2015, according to a report issued by the Census Bureau and Kaiser Family Foundation.[4] . This downward trajectory in uninsured rates is reflected in the reductions in hospital uncompensated care. Given the continued reduction in UCC, HSCRC staff recommends funding a UCC rate of 4.16 percent, which is slightly less than the RY2018 UCC rate of 4.51%.

RECOMMENDATIONS

Based on the preceding analysis, HSCRC staff recommends the following for RY 2019:

1. Reduce statewide UCC provision in rates from 4.51 % to 4.16 % effective July 1, 2018.
2. Continue to use the regression modeling approach approved by the Commission at the June 2016 meeting.
3. Continue to do 50/50 blend of FY17 audited UCC and predicted UCC.

[3] http://www.marylandhbe.com/fewer-marylanders-without-health-coverage-census-bureau-reports/

APPENDIX I. HOSPITAL UNCOMPENSATED CARE PROVISION FOR RY 2019

HOSPID	Hospital Name	RY 2019 Projected Regulated Revenue	RY 2019 UCC Based on RY 2019 Projected Regulated Revenue	RY 2017 Percent UCC from the RE Schedule	Percent Predicted UCC (Adjusted)	50/50 Blend Percent	Percent UCC
210001	Meritus Medical Center	314,827,422	13,487,120	4.28%	4.73%	4.51%	4.60%
210002	Univ. of Maryland Medical Center	1,332,408,795	54,239,175	4.07%	2.90%	3.48%	3.56%
210003	Prince Georges Hospital	286,573,599	24,930,563	8.70%	7.82%	8.26%	8.44%
210004	Holy Cross	479,654,944	34,507,803	7.19%	6.81%	7.00%	7.15%
210005	Frederick Memorial Hospital	329,156,555	14,538,410	4.42%	4.58%	4.50%	4.59%
210006	Univ. of Maryland Harford Memorial Hospital	99,998,182	6,773,854	6.77%	4.08%	5.43%	5.54%
210008	Mercy Medical Center, Inc.	502,208,027	21,443,376	4.27%	3.53%	3.90%	3.98%
210009	Johns Hopkins	2,240,813,393	58,878,632	2.63%	2.68%	2.66%	2.71%
210010	Univ. of Maryland Shore Medical Center at Dorchester	48,094,357	2,464,379	5.12%	4.98%	5.05%	5.16%
210011	St. Agnes Hospital	416,466,586	16,673,168	4.00%	4.36%	4.18%	4.27%
210012	Sinai Hospital	736,861,799	24,229,357	3.29%	3.51%	3.40%	3.47%
210013	Bon Secours Hospital	102,000,000	2,514,493	2.47%	3.57%	3.02%	3.08%
210015	MedStar Franklin Square Hospital	492,402,641	17,442,807	3.54%	3.73%	3.64%	3.72%
210016*	Washington Adventist Hospital	258,319,310	16,701,589	6.47%	6.48%	6.47%	6.61%
210017	Garrett County Memorial Hospital	52,939,702	4,137,179	7.81%	5.38%	6.60%	6.74%
210018	MedStar Montgomery General Hospital	169,927,186	5,127,319	3.02%	3.52%	3.27%	3.34%
210019	Peninsula Regional Medical Center	419,622,018	17,497,864	4.17%	4.48%	4.32%	4.42%
210022	Suburban Hospital Association,Inc	298,564,642	8,811,872	2.95%	3.89%	3.42%	3.50%
210023	Anne Arundel General Hospital	575,908,246	16,982,546	2.95%	3.23%	3.09%	3.16%
210024	MedStar Union Memorial Hospital	414,710,552	12,905,658	3.11%	3.47%	3.29%	3.36%
210027	Western Maryland Hospital	316,661,093	15,341,700	4.84%	4.26%	4.55%	4.65%
210028	MedStar St. Marys Hospital	172,574,583	6,810,649	3.95%	3.87%	3.91%	3.99%
210029	Johns Hopkins Bayview Med. Center	621,515,865	25,528,388	4.11%	4.71%	4.41%	4.50%
210030	Univ. of Maryland Shore Medical Center at Chestertown	54,289,889	2,711,118	4.99%	3.54%	4.27%	4.36%
210032	Union Hospital of Cecil County	156,358,285	6,465,055	4.13%	4.44%	4.29%	4.38%

210033	Carroll County General Hospital	223,662,684	3,401,434	1.52%	3.28%	2.40%	2.45%
210034	MedStar Harbor Hospital Center	190,469,979	8,979,022	4.71%	4.28%	4.50%	4.59%
210035	Univ. of Maryland Charles Regional Medical Center	143,723,289	7,606,141	5.29%	4.67%	4.98%	5.09%
210037	Univ. of Maryland Shore Medical Center at Easton	195,481,707	6,154,856	3.15%	3.29%	3.22%	3.29%
210038	Univ. of Maryland Medical Center Midtown Campus	228,124,869	16,628,297	7.29%	3.92%	5.60%	5.72%
210039	Calvert Memorial Hospital	141,821,983	5,884,502	4.15%	3.59%	3.87%	3.95%
210040	Northwest Hospital Center, Inc.	248,058,564	11,929,061	4.81%	4.54%	4.67%	4.77%
210043	Univ. of Maryland Baltimore Washington Medical Center	398,733,080	25,346,441	6.36%	3.94%	5.15%	5.26%
210044	Greater Baltimore Medical Center	435,420,575	14,353,223	3.30%	3.29%	3.29%	3.36%
210045	McCready Foundation, Inc.	15,530,984	711,473	4.58%	6.25%	5.42%	5.53%
210048	Howard County General Hospital	291,104,867	8,402,599	2.89%	3.69%	3.29%	3.36%
210049	Univ. of Maryland Upper Chesepeake Medical Center	325,619,300	12,279,249	3.77%	3.14%	3.45%	3.53%
210051	Doctors Community Hospital	226,126,371	10,619,569	4.70%	4.72%	4.71%	4.81%
210055	Laurel Regional Hospital	98,343,286	10,313,930	10.49%	8.20%	9.35%	9.55%
210056	MedStar Good Samaritan Hospital	284,642,445	11,289,438	3.97%	3.97%	3.97%	4.06%
210057*	Shady Grove Adventist Hospital	376,694,222	12,990,236	3.45%	4.52%	3.98%	4.07%
210060*	Fort Washington Medical Center	47,023,363	4,025,441	8.56%	8.45%	8.50%	8.69%
210061	Atlantic General Hospital	102,841,659	5,769,252	5.61%	4.92%	5.27%	5.38%
210062	MedStar Southern Maryland Hospital	269,769,528	11,754,873	4.36%	4.27%	4.31%	4.41%
210063	Univ. of Maryland St. Josephs Medical Center	388,253,807	15,995,075	4.12%	3.74%	3.93%	4.01%
210065	Holy Cross German Town	100,218,434	9,178,902	9.16%	8.37%	8.76%	8.95%
Total		15,624,522,668	644,757,088	4.13%	3.95%	4.04%	4.13%

Note: Levindale, UMROI, and UM-Shock Trauma are not included in this analysis.

APPENDIX II. WRITE-OFF DATA SUMMARY STATISTICS

The table below presents the actual UCC reduction rate by hospital between FY 2016 and FY 2017 – it does not reflect predicted UCC rates. Reduction rates vary by hospital.

Appendix II. Table 1. UCC Reductions by Hospital, FY 2016-2017

HOSPID	Hospital Name	RY 2016 % UCC	RY 2017 % UCC	Variance over/under
210001	Meritus Medical Center	4.71%	4.28%	-0.43%
210002	UM Medical Center	4.03%	4.07%	0.04%
210003	Prince Georges Hospital	9.47%	8.70%	-0.77%
210004	Holy Cross	8.99%	7.19%	-1.79%
210005	Frederick Memorial Hospital	4.08%	4.42%	0.34%
210006	UM Harford Memorial Hospital	6.17%	6.77%	0.60%
210008	Mercy Medical Center, Inc.	5.31%	4.27%	-1.04%
210009	Johns Hopkins	2.09%	2.63%	0.53%
210010	UM Shore Medical Center at Dorchester	4.86%	5.12%	0.26%
210011	St. Agnes Hospital	5.76%	4.00%	-1.76%
210012	Sinai Hospital	3.90%	3.29%	-0.61%
210013	Bon Secours Hospital	3.72%	2.47%	-1.25%
210015	MedStar Franklin Square Hospital	4.43%	3.54%	-0.89%
210016*	Washington Adventist Hospital	7.42%	6.47%	-0.95%
210017	Garrett County Memorial Hospital	6.90%	7.81%	0.91%
210018	MedStar Montgomery General Hospital	4.04%	3.02%	-1.02%
210019	Peninsula Regional Medical Center	4.12%	4.17%	0.05%
210022	Suburban Hospital Association,Inc	2.06%	2.95%	0.89%
210023	Anne Arundel General Hospital	2.54%	2.95%	0.41%
210024	MedStar Union Memorial Hospital	4.24%	3.11%	-1.13%
210027	Western Maryland Hospital	4.88%	4.84%	-0.04%
210028	MedStar St. Marys Hospital	5.22%	3.95%	-1.27%
210029	Johns Hopkins Bayview Med. Center	5.10%	4.11%	-1.00%
210030	UM Shore Medical Center at Chestertown	4.98%	4.99%	0.02%
210032	Union Hospital of Cecil County	4.80%	4.13%	-0.67%
210033	Carroll County General Hospital	2.88%	1.52%	-1.36%
210034	MedStar Harbor Hospital Center	5.76%	4.71%	-1.05%
210035	UM Charles Regional Medical Center	5.83%	5.29%	-0.54%
210037	UM Shore Medical Center at Easton	3.49%	3.15%	-0.34%
210038	UM Medical Center Midtown Campus	8.17%	7.29%	-0.88%
210039	Calvert Memorial Hospital	2.91%	4.15%	1.24%
210040	Northwest Hospital Center, Inc.	5.65%	4.81%	-0.84%
210043	UM BWMC	5.63%	6.36%	0.73%
210044	Greater Baltimore Medical Center	2.61%	3.30%	0.68%
210045	McCready Foundation, Inc.	2.86%	4.58%	1.72%
210048	Howard County General Hospital	3.29%	2.89%	-0.41%
210049	UM Upper Chesepeake Medical Center	3.60%	3.77%	0.18%
210051	Doctors Community Hospital	7.35%	4.70%	-2.65%
210055	Laurel Regional Hospital	11.60%	10.49%	-1.12%

210056	MedStar Good Samaritan Hospital	5.04%	3.97%	-1.07%
210057*	Shady Grove Adventist Hospital	4.18%	3.45%	-0.73%
210060*	Fort Washington Medical Center	9.49%	8.56%	-0.93%
210061	Atlantic General Hospital	5.57%	5.61%	0.04%
210062	MedStar Southern Maryland Hospital	5.95%	4.36%	-1.59%
210063	UM St. Josephs Medical Center	4.09%	4.12%	0.03%
210065	Holy Cross Germantown	9.97%	9.16%	-0.81%
Total		4.48%	4.12%	-0.32%

Note: Levindale, UMROI, and UM-Shock Trauma are not included in this analysis. If they were included, the statewide rate for RY 2016 would be 4.51% and for RY17 it would be 4.16%.
Source: HSCRC Financial Audited Data

The table below presents the UCC write off distribution by payer for services provided in RY 2017 based on the account-level information provided to the Commission. 35.31 percent of UCC Write Off has a primary payer of charity care/self-pay. Commercial payers and Medicaid (including out-of-state Medicaid) accounted for 30.51 and 11.10 percent of UCC, respectively.

Appendix II. Table 2. UCC Write Off Distribution by Payer, RY 2017

Payer	Total Write Off	% of Total Write Off
Charity/Self Pay	$234,539,069	35.31%
Commercial	$202,671,077	30.51%
Medicaid	$73,738,627	11.10%
Medicare	$110,604,587	16.65%
Other	$42,634,620	6.42%
Grand Total	$664,187,981	100.00%

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 7/5/18

By: _____

Adam Boehler, Director, Center for Medicare and Medicaid Innovation

GOVERNOR OF MARYLAND

Date: 7/9/18

By: _____

Lawrence Joseph Hogan, Jr., Governor

MARYLAND DEPARTMENT OF HEALTH

Date: 7/9/2018

By: _____

Robert R. Neall, Secretary of Health

HEALTH SERVICES COST REVIEW COMMISSION

Date: 7/9/2018

By: _____

Nelson Sabatini, Chairman

TCOC Contract Status

Signed July 9, 2018!

Care Redesign Program (CRP) Update

Current CRP Tracks: HCIP and CCIP

- 42 hospitals submitted Participation Agreements (PAs) to participate

Hospital Care Improvement Program (HCIP)
• Designed for hospitals and Care Partners practicing at hospitals • Hospitals improve care and save money through more efficient episodes of care • Physicians may share in those gains • **Goal**: Facilitate improvements in hospital care that result in care improvements and efficiency

Complex and Chronic Care Improvement Program (CCIP)
• Designed for hospitals and community-based Care Partners • Hospitals and Care Partners collaborate on care of complex and chronic patients • Hospitals provide resources to practices that should improve quality and reduce costs • **Goal**: Enhance care management and care coordination

Hospital submitting Care Redesign PAs
Performance Period 3: July 1 – December 31, 2018

- Adventist - Shady Grove
- Adventist - Washington Adventist
- Anne Arundel
- Atlantic General
- Calvert
- Doctors
- Frederick Memorial
- Garrett Regional
- GBMC
- Holy Cross
- Holy Cross - Germantown
- JHHS - Bayview
- JHHS - Howard County
- JHHS - JHH
- JHHS - Suburban
- Lifebridge - Carroll
- Lifebridge - Northwest
- Lifebridge - Sinai
- Medstar - Frankin Sq
- Medstar - Good Sam
- Medstar - Harbor
- Medstar - Montgomery
- Medstar - Southern MD
- Medstar - St. Mary's
- Medstar - Union Mem
- Mercy
- Meritus
- Peninsula Regional
- St. Agnes
- UMMS - Baltimore Washington
- UMMS - Charles Regional
- UMMS - Chestertown
- UMMS - Easton/Dorchester
- UMMS - Harford Memorial
- UMMS - Laurel Regional
- UMMS - Midtown
- UMMS - Prince George's
- UMMS - Rehab
- UMMS - St. Joseph's
- UMMS - UMMC
- UMMS - Upper Chesapeake
- Western Maryland

Bundled Payments for Care Improvement in Maryland (BPCIM)

Status Update of BPCIM

- April 2018: Stakeholder Innovation Group (SIG) recommended that State should seek federal approval of voluntary bundled payment programs through:
  - Hospital-led effort to create new Care Redesign track for January 2019 and
  - Multi-stakeholder effort to develop a New Model Program for non-hospital conveners
- June 2018: Secretary's Vision Group agreed to pursue new Care Redesign track for January 2019
- June 2018: State submitted to CMS a draft Implementation Protocol for BPCIM
- **July 6, 2018: CMS approved BPCIM Implementation Protocol**

Overview of Federal Bundled Programs

Bundled Payments for Care Initiative (BPCI)

- 4 tracks, ends in September 2018
- Saved ~$300 million since 2014

Bundled Payments for Care Initiative Advanced (BPCI-A)

- Announced in January 2018
- Features include:
  - Voluntary model, single retrospective payment with 90 day Clinical Episode duration, 29 Inpatient Clinical Episodes, 3 Outpatient Clinical Episodes, qualifies as an Advanced Alternative Payment Model (AAPM), payment is tied to performance on quality measures.

Reduced

Comprehensive Care for Joint Replacement (CCJR) Program

- *Voluntary in 33 MSAs*
- *Projected to save CMS $189 million over 5 years*

Canceled

Episode Payment Models and Cardiac Rehabilitation (CR) Incentive Payment Models

- *Canceled in favor of other programs*
- *Projected to save Medicare $170 million over 5 years*

Introducing Bundled Payments for Care Initiative in Maryland (BPCIM)

- BPCIM is based on the BPCI Advanced Model but tailored for Maryland and simplified for implementation ease.

What's the same?

Features	BPCI-Advanced	BPCI-Maryland
Participation	Voluntary	Voluntary
Episodes	90-day episode -- from triggering inpatient stay	90-day episode -- from discharge from triggering inpatient stay
CMS Savings Discount	Episode targets are set 3% below average total cost of care	Episode targets are set 3% below average total cost of care

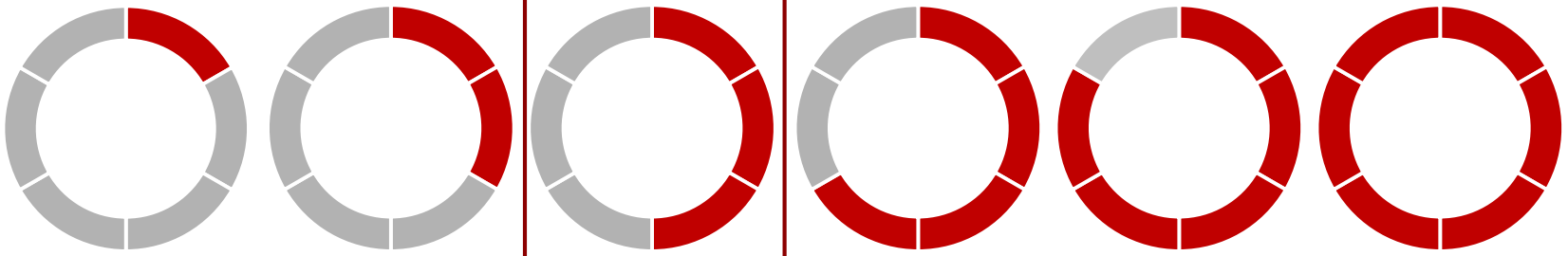
Introducing Bundled Payments for Care Initiative in Maryland (BPCIM) for Medicare patients

- BPCIM is based on the BPCI Advanced Model but tailored for Maryland and simplified for implementation ease.

What's NOT the same?

Features	BPCI- Advanced	BPCI-Maryland
Conveners	Hospitals and physician group practices (PGPs) can be conveners	Only hospitals can be conveners under Care Redesign Programs
Clinical Episodes	29 Inpatient Clinical Episodes 3 Outpatient Clinical Episodes	Only Inpatient Clinical Episodes
Risk	Upside and downside required for MACRAtization	Upside only because hospitals already bear risk under global budgets and MPA (but poor performing episodes can reduce upside BPCIM payment)
Charge Inclusion	Includes Medicare hospital, physician, post-acute, and readmission spending	Like BPCI-A but excludes hospital spending

Timeline and Application Process



May	June/July	Summer	Sept./Oct.	Oct. 31	Jan. 1, '19
• Developed BPCIM Template Protocol	• State submitted draft Protocol to CMMI for approval • Approved by CMS on July 6, 2018	• Hospital-specific episode prices developed • Design details finalized	• Informational meetings and webinars for hospitals and potential care partners	• Participating hospitals submit Protocol to HSCRC for approval	• BPCIM launch

Current Status

CMS List of Inpatient Clinical Episodes

Please note that not all Clinical Episodes will be offered to every hospital.

1. **APR-DRG Conversion:** Certain Clinical Episodes may be collapsed in the MS-DRG to APR-DRG conversion.
2. **Low Volume Limits:** Hospitals with fewer than 30 episodes for a particular category during the baseline period of the most recent three years are ineligible to participate in that bundle and will not receive target prices for those episode categories.

CMS BPCI-Advanced Inpatient Clinical Episodes

- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis
- Acute myocardial infarction
- Back & neck except spinal fusion
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- COPD, bronchitis, asthma
- Combined anterior posterior spinal fusion
- Congestive heart failure
- Coronary artery bypass graft
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Hip & femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Major bowel procedure
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Pacemaker
- Percutaneous coronary intervention
- Renal failure
- Sepsis
- Simple pneumonia and respiratory infections
- Spinal fusion (non-cervical)
- Stroke
- Urinary tract infection

Care Partners in BPCIM

Care partners provide care under the BPCIM initiative, participate in BPCIM interventions, and are paid separately by Medicare for their services. Hospitals may choose care partners from the following provider types:

- General or specialist physician
- Clinical nurse specialist or nurse practitioner
- Physician assistant
- Physical therapist
- Skilled nursing facility (SNF)
- Home health agencies
- Long term care hospitals
- Inpatient rehabilitation facilities

Care Partner Qualifications

- Each potential care partner must meet, at a minimum, the following care partner qualifications specific to BCPIM in addition to the care partner requirements described in the Participation Agreement:
  - A clinician must have a National Provider Identifier (NPI) and a facility must have a Taxpayer Identification Number (TIN);
  - The provider must participate in the Medicare program;
  - The provider must be licensed;
  - The provider must use CEHRT and CRISP, Maryland's Health Information Exchange; and
  - The provider must pass the federal program integrity screening process.
- Care partners must sign a care partner arrangement with the hospital and comply with all applicable requirements under the Participation Agreement.
- A care partner may participate in multiple hospitals' BPCIM programs.

Looking Ahead:
New Model Programs

TCOC Contract Provides Opportunity for New Model Programs

Care Redesign Program

- ✓ Hospitals serve as conveners
  - ✓ Provide enrolled clinicians pathway to MACRA
  - ✓ Determine how to share savings with care partners (physicians, nursing facilities)
- ✓ Upside only
- ✓ Available July 2017

New Model Program

- ✓ Non-hospital providers serve as conveners
- ✓ Non-hospital conveners must take downside risk
  - ✓ Only pathway to MACRA
- X Longer time to develop

- Most aggressive timeline: Start now toward (1) Amendment to TCOC Contract, and (2) Participation Agreement for New Model Program to begin in 2020.
- Will want feedback from SIG and SVG on initial New Model Program

Staff Report:
Integrated Care Network Update

July 11, 2018

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

Table of Contents

LIST OF ABREVIATIONS

BRFA	Budget Reconciliation and Financing Act of 2015
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
FY	Fiscal year
HSCRC	Health Services Cost Review Commission
ICN	Integrated care network
MHCC	Maryland Health Care Commission
MHIP	Maryland Health Insurance Plan

OVERVIEW

Since Fiscal Year 2016, the State has leveraged surplus special funds to advance health information technology connection and use. At the core of Maryland's All-Payer Model and the future Total Cost of Care Model is a recognition that coordinated care across the provider spectrum will enhance the delivery of care, improve quality and outcomes, and drive down costs, especially for those with chronic and complex conditions. In order to advance coordination for high needs Medicare and dual eligible Medicaid beneficiaries, the Budget Reconciliation and Financing Act of 2015 (BRFA of 2015) gave the Commission authorization to use the portion of the Maryland Health Insurance Plan (MHIP) balance that was derived from the federal Medicare and Medicaid programs to support Integrated Care Network (ICN) activities in FYs 2016 through 2019. ICN activities eligible for such funding are required to be designed to reduce health care expenditures and improve outcomes for unmanaged high-needs Medicare patients and patients dually eligible for Medicaid and Medicare, consistent with the goals of Maryland's All-Payer Model.

At the outset of the ICN initiative, CRISP was tasked with identifying and standing up the infrastructure necessary to support care coordination, program development, and information technology connection shared by hospitals, ambulatory care providers, long-term care providers, and others in the system.

BACKGROUND

Past Funding

The surplus identified in the BRFA of 2015 to be used to fund projects that reduce health care expenditures totaled just under $53 million. While the bulk of the ICN funds support CRISP projects, they also provide for other State projects run by MDH and Medicaid that support ICN goals including Medicare data analytics, planning and development of the Maryland Primary Care Program, and planning for dual-eligible coordination. Table 1 below shows the major funding divided between CRISP and State activities.

Table 1. Integrated Care Network, FYs 2016-2020

FY 16 CLOSE-OUT TOTAL		**$52,978,322**
FY 17 – ACTUALS	**CRISP- ICN**	**-16,424,372**
	HSCRC – ICN Special Projects	**-1,732,672**
FY 17 CLOSE-OUT TOTAL		**$34,821,278**

FY 18 – PROJECTION	**CRISP-ICN**	**-7,446,253**
	HSCRC – ICN Special Projects	**-1,738,764**
	MD Primary Care Program	**-68,432**
	EVA Assessment	**-29,200**
	Duals Planning	**-20,591**
FY 18 Projected CLOSE-OUT through May 2018 TOTAL		**$25,538,629**
FY 19 – PROJECTION	**CRISP-ICN**	**-7,038,900**
	HSCRC – ICN Special Projects	**-3,000,000**
	MD Primary Care Program	**-3,000,000**
FY 19 Projected CLOSE-OUT TOTAL		**$12,499,729**
FY 20 – PROJECTION	**CRISP-ICN**	**-5,214,000**
	HSCRC – ICN Special Projects	**-3,000,000**
	MD Primary Care Program	**-3,000,000**
FY 20 Projected CLOSE-OUT TOTAL		**$1,285,729**

FY 2019 ACTIVITIES

CRISP ICN Projects

As discussed above, the BRFA of 2015 permits the Commission to use the portion of the MHIP balance that was derived from the federal Medicare and Medicaid programs to support integrated care networks (ICNs). These are designed to reduce health care expenditures and improve outcomes for unmanaged high-needs Medicare patients and patients dually eligible for Medicaid and Medicare, consistent with the goals of Maryland's All–Payer Model. Care management for this population is critical to the success of the current All-Payer Model and the enhanced Total Cost of Care All-Payer Model, expected to begin in January 2019. The ICN initiative is designed to encourage collaboration between and among providers, provide a platform for provider and patient engagement, and allow for confidential sharing of information among providers. To succeed under the current and future All-Payer Models, providers will need a

variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

As the project progressed, CRISP reorganized the goals and funding of the ICN initiative around the venues where information is provided and used: (1) at the point of care, (2) by care managers and coordinators, (3) by population health teams, (4) for patients, and (5) by program administrators, provider executives, and policy makers.

During FY 2017 and FY 2018, CRISP focused its efforts to improve care coordination for high need/complex patients around efforts such as assembling information for the patient care overview, implementing a "care alerts" intervention, delivering key information automatically at the point-of-care, significantly expanding ENS notifications for care coordination, publishing Medicare reports, and publishing enhanced case-mix reports including Patient Total Hospitalization dashboard.

Moving forward in FY 2019 and beyond, CRISP plans to operationalize the successful programs launched in the previous years, expand ambulatory connectivity for encounter data and operationalize panel management at scale, publish additional Medicare reports, improve working technology, support learning collaboratives and ways to improve the use of existing tools by providers, and continue to administer the Care Redesign Programs.

Care Redesign Programs

One of the fastest growing parts of the CRISP ICN budget is the administration of the Care Redesign Programs, budgeted for $2.9 million in FY 2019. The Care Redesign Amendment was created in 2017 to provide additional tools to help with provider alignment and transformation efforts under the All-Payer Model. Programs under the Amendment are voluntary and aim to align hospitals with other providers through common goals and incentives. The programs started in July 2017 with sixteen participants. Forty-two hospitals submitted Participation Agreements to participate in one or both care redesign programs in the third Performance Period, which began in July 2018. Staff is currently reviewing hospital implementation protocols for approval to participate. This large increase in participation will dramatically increase the expenses related to administration of the Care Redesign Programs, potentially doubling the budget for CRP administration. In the future, the Commission will need to make policy decisions regarding funding for these programs as they grow in quantity and participating hospitals.

As a reminder, the Care Redesign Program amendment is designed to support:

- Effective care management and population health activities
- Improvement in care for high and rising risk populations
- Efforts to provide high quality, efficient, well-coordinated episodes of care
- Monitoring and Controlling Total Cost of Care (TCOC) growth

Currently, there are two voluntary programs: the Hospital Care Improvement Program (HCIP) and the Complex and Chronic Care Improvement Program (CCIP). HSCRC staff is currently

developing a third track, the Bundled Payments for Care Improvement in Maryland (BPCIM), which is being reviewed by CMS for approval.

The Hospital Care Improvement Program was designed to allow hospitals to collaborate with hospital-based providers such as surgeons and hospitalists. The program aims to improve hospital care delivery, care transitions, and improve efficiency and management of resources. Types of activities would include care coordination and discharge planning, as well as cost reduction.

The Complex and Chronic Care Improvement Program was designed for hospitals to work with community-based providers (i.e. primary care providers) to improve care for complex and chronic patients and reduce avoidable hospital utilization. The program focuses on supporting care management activities and facilitating high-quality, person-centered care.

The Bundled Payments for Care Improvement in Maryland will be a third track under the Care Redesign Amendment that will allow hospitals to link payments across providers for certain clinical episodes of care. This is modeled after the CMS Bundled Payments for Care Improvement, Advanced program. The bundled payment approach aligns incentives across hospitals, physicians, and post-acute care facilities to generate savings and improve quality through better care management throughout episodes, eliminating unnecessary care, and reducing post-discharge Emergency Department (ED) visits and hospital readmissions. If BPCIM is approved by CMS, hospitals may begin participating in January 2019.

Other State Projects

As shown in Table 1, there are other projects that are funded with ICN special funds that advance State planning for unmanaged Medicare and dually-eligible beneficiaries. HSCRC special projects include data analytics for the Medicare population, and planning and preparation for the Total Cost of Care Model. Support for the development of the Maryland Primary Care Program, including outreach, analytics, and administrative support, is also included in the ICN budget. Finally, there were some expenses in FY 2018 related to the planning for coordination of the dually-eligible population.

FUTURE GOVERNANCE ISSUES

As ICN funds wind down over the next few years, the Commission will have to make policy decisions about how to incorporate existing programs and supports into the long-term HIE budget. These decisions include:

- **Legislation to extend authorization of ICN funds beyond FY 2019** – Current chapter law only gives the HSCRC the authority to spend surplus MHIP special funds through FY 2019. As this report summarizes, there will be a sufficient fund balance remaining that could be used in future fiscal years with the appropriate legislative approval. As the State enters into the Total Cost of Care Model, significant work will be required to engage providers and support care coordination for high needs Medicare beneficiaries.

Legislation will be required in the 2019 General Assembly session to enable continued use of ICN special funds.

- **Cost sharing for providers in the Care Redesign Program –** Currently, ICN funds pay for the totality of costs associated with administration of the Care Redesign Program, including data analytics required by each track. As additional hospitals participate in the program and new tracks are developed, the cost of administration could increase significantly. In the future, cost sharing for providers using the Care Redesign Program may be necessary. The Commission will need to explore how long a new track should be supported with State funds and when providers should be expected to contribute.
- **Long-term sustainability of ICN projects –** As the ICN funds wind down, the Commission will need to weigh in on which projects should be folded into the overall budget for CRISP and funded through State rate-setting dollars.

A small steering committee consisting of Commissioners, staff, and provider representatives could be convened to discuss these and other important issues regarding use of CRISP supports in the transformation of health delivery and payment in Maryland.

CRISP

CRISP Update: HSCRC Commission Meeting

July 2018

7160 Columbia Gateway Drive, Suite. 230
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

CRISP

3-Year ICN Infrastructure Investment

ICN and the Care Coordination Workgroup

In 2014, HSCRC established a Care Coordination Work Group to offer advice on how hospitals, physicians, and other key stakeholders can work together with government leaders on effective care coordination to support the Maryland All-Payer model.

The workgroup led to the creation of the Integrated Care Network Infrastructure or “ICN” project, through which CRISP was charged to establish processes and leverage services for three components critical to modernization effort:

- Identification of at-risk patients who could benefit from care coordination or a targeted intervention
- Communication—especially at the point of care—of existing patient relationships and connected services
- Monitoring the effectiveness of programs and initiatives, especially by measuring their impacts on the bigger total-cost-of-care

User Stories

To help refine and prioritize the tasks required to fulfill the spirit of each goal, CRISP works with stakeholders and clinicians to develop user stories. The user stories which served as a foundation for much of the ICN work are provided in the handouts, and a sample is below.

Goal for The Point of Care

Our aim is that in every hospital in Maryland, when a patient presents for treatment, the clinician knows if her patient is in a care management program and without having to log into a separate system. She has contact information for the coordinator of this patient's care team and other engaged clinicians, regardless of whether those individuals are employed by her hospital. And she has efficient means to contact other care team members, including by secure text message. She is able to see who the PCP is and when the patient last visited. She is able to review the most current care plan if one exists and is aware of special resources available for her patient. And if a peer clinician or care coordinator has made important notes about this patient – a "care alert" – she has those at her fingertips.

Initial Workgroup Cost Projection, April 2015

The original budget estimate emerging from the Care Coordination Workgroup was that shared infrastructures would cost $51M to build, over a two to three year period. The estimates was especially sensitive to the uncertain cost of achieving broad ambulatory connectivity.

Ongoing operations was expected to cost between $8M and $28M annually, with the cost of shared care management software the biggest unknown.

Original Implementation Estimate, April 2015	
Build/secure data infrastructure	$8,500,000
Data sharing	$4,200,000
Collaboration (training, support, TA)	$7,000,000
Provider Connectivity	$31,000,000
TOTAL	**$50,700,000**

Original Annual Ops Estimate, April 2015	
Low Range	High Range
$8,000,000	$28,000,000

A subsequent more detailed “Planning Budget” included $24M for new Reporting & Analytics capabilities, pushing the expected three year total to $75M. (Shown on next page)

First Detailed Budget, November 2015

The first detailed “Planning Budget” broke the project into “workstreams” as shown below. $24M was reserved for new Reporting & Analytics capabilities, which was expected to include distribution of standard Medicare data based reports to hospitals and ambulatory providers.

First Detailed Budget, November 2015	
Ambulatory Connectivity	$31,400,000
Data Router	$2,200,000
Clinical Portal Enhancements	$2,400,000
Alerts & Notifications	$3,700,000
Reporting & Analytics	$23,700,000
Basic Care Management Software	$3,900,000
Practice Transformation	$8,000,000
TOTAL	**$75,300,000**

Annual operations costs were not projected in the first detailed budget. However, the growing expectation was that we would not be running a single mammoth care management software for all Medicare beneficiaries. Without the corresponding high PMPM, the annual operating costs were expected to be lower than originally predicted by the Care Coordination Workgroup.

CRISP

Current Status

Three Year ICN Investment

ICN BUDGET SUMMARY						
Workstream	2016	2017		2018		3-YEAR TOTAL
	FY2016 State & Federal Actual	FY2017 HSCRC State Actual	FY2017 State & Federal Actual	FY2018 HSCRC State Actual and Forecast	FY2018 State & Federal Actual	3-Year Forecasted State & Federal Total
Point of Care	$1,582,606	$3,487,162	$4,847,081	$1,051,651	$5,299,164	
Care Managers & Coordinators	$361,068	$1,109,863	$2,494,597	$1,655,213	$4,694,336	
Population Health Teams	$1,506,624	$1,985,479	$3,481,993	$2,620,210	$4,834,565	
Patients	$0	$0	$0	$99,162	$99,162	
Common Infrastructure	$1,478,700	$2,755,134	$3,979,319	$1,126,805	$3,239,904	
Administrators & Policymakers	$4,756,234.33	$7,693,996	$7,693,996	$2,860,597	$2,860,597	
TOTAL	**$9,685,233**	**$17,031,634**	**$22,496,986**	**$9,413,638**	**$21,027,728**	**$53,209,947**

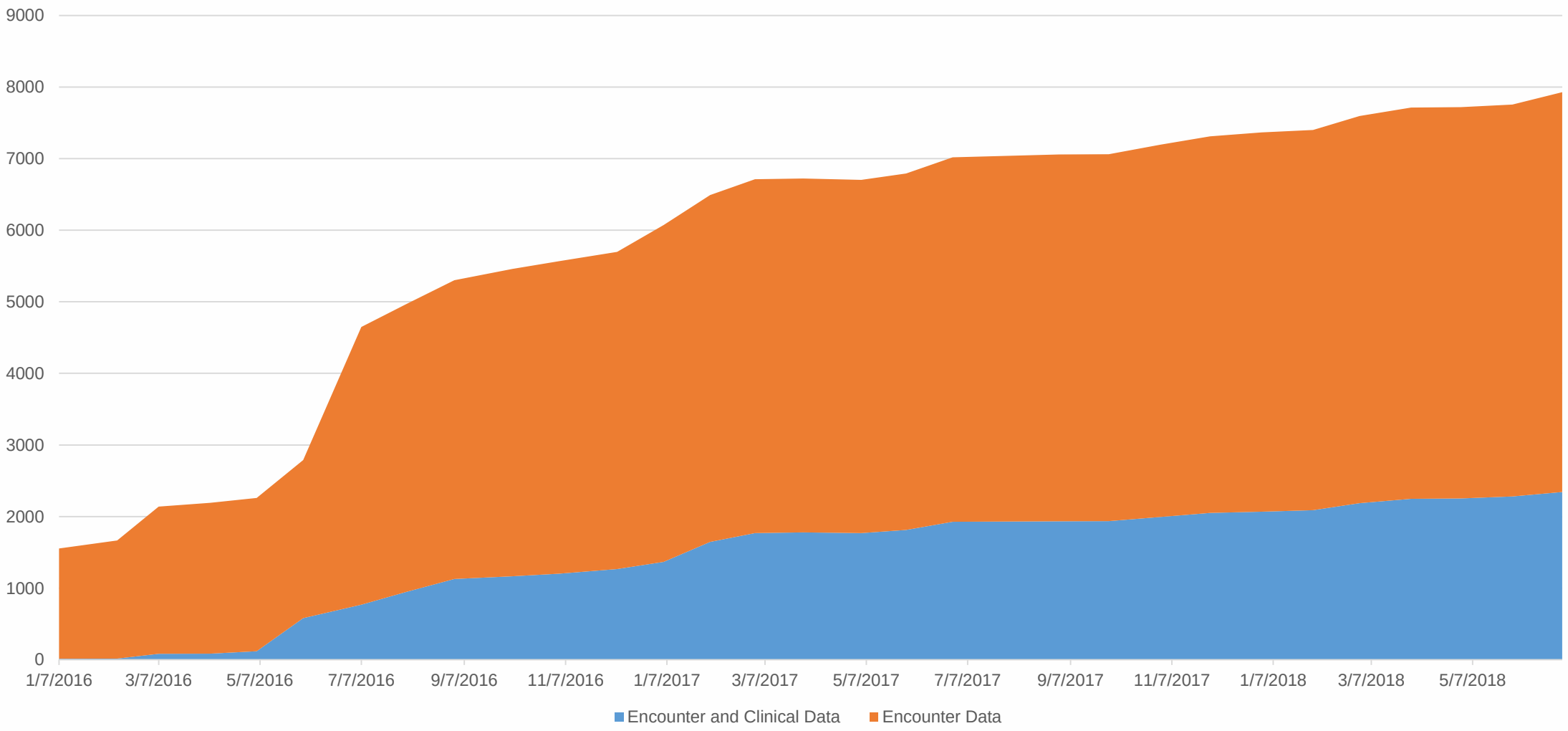
Approximately $33 million in MHIP/BRFA funds have been expended over three years. The BRFA was used to leverage another $20+ million in federal dollars.

A balance of around $18 million remains in the MHIP account at the end of FY2018.

Utilization Statistics

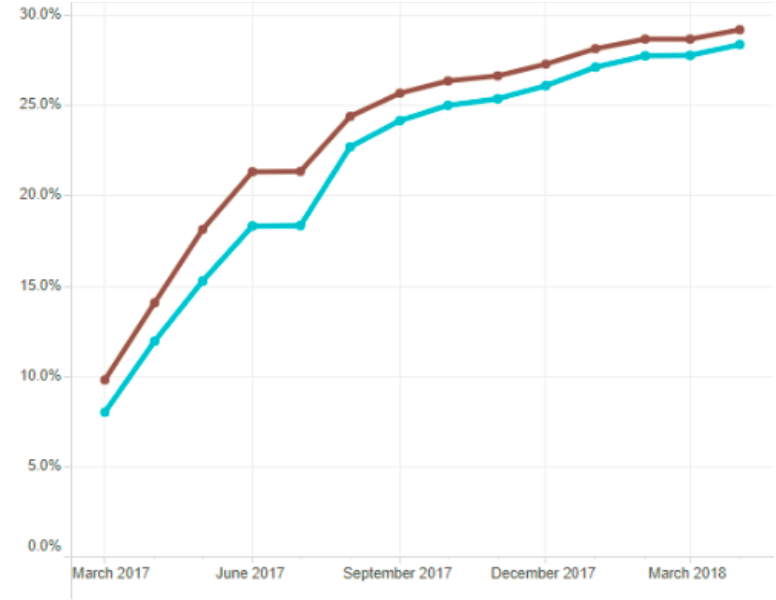
Service	Typical Week
Admit, Discharges from Hospitals and Ambulatory	4,159,212
Laboratory Reports Received	964,712
Received Transcriptions/Reports	236,335
Received Radiology Reports	163,407
Encounter Notifications Sent	852,411
InContext Requests for HIE Registry data	470,060
Delivery of Registry into EMRs	311,040
InContext Requests for PDMP Data	369,580
Delivery of PDMP Data into EMRs	95,540
Patients Searched	61,489
Patients searched in ULP Portal	41,403
Patients searched from an EMR	13,606
Images Viewed	176
New data sent to MPI	1,833,000

Ambulatory Connectivity



Care Alert/Care Plan Adoption

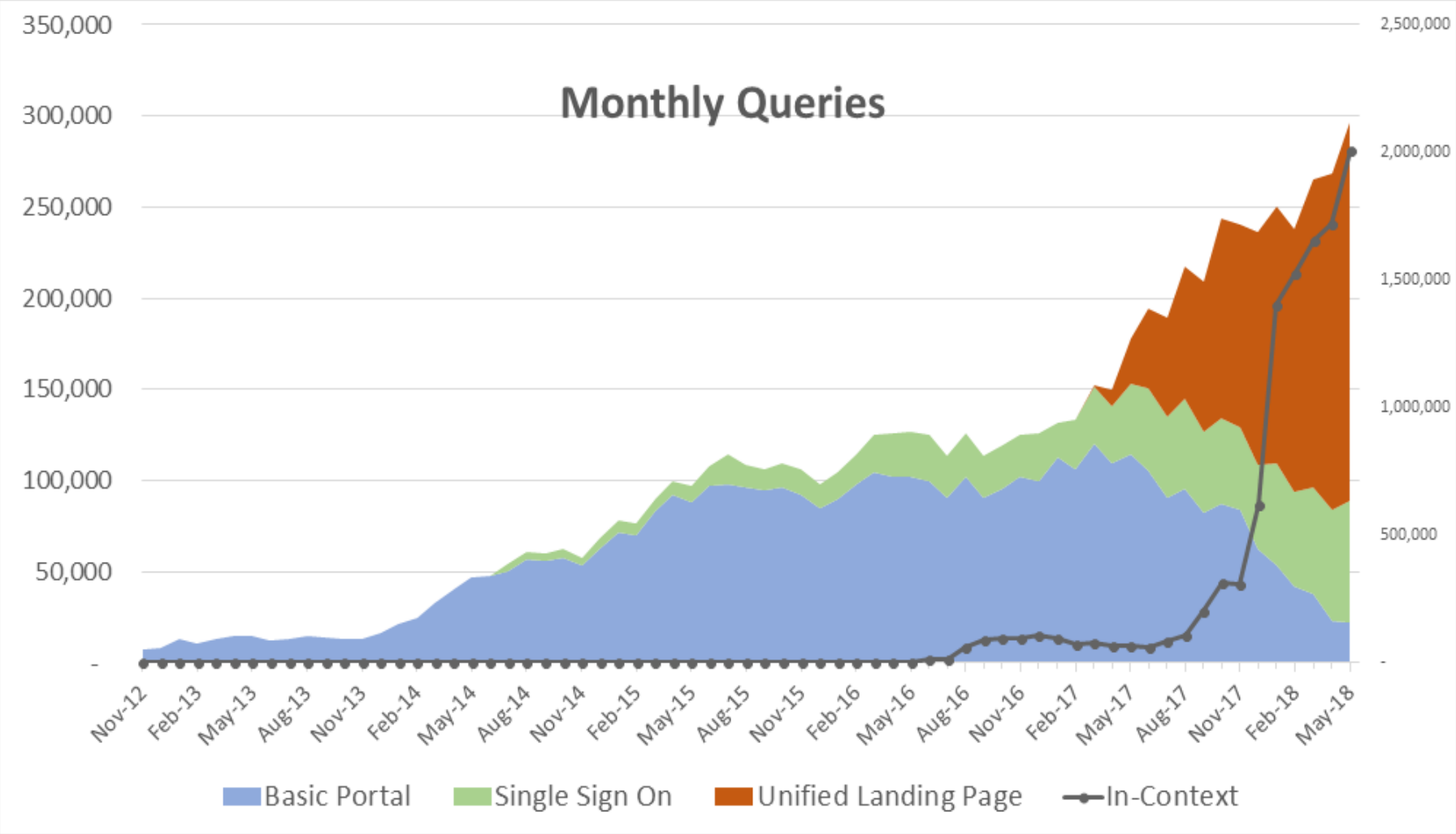
% of Care Alerts/Plans Available for Patients with 3+ Bedded Stays



Care Coordination Data Accessed at the Point of Care

	Care Alerts	Care Plans	Care Managers	PCPs	Care Managers & PCP	Patients
Jan 2018	1,382	4	221	843	125	1,290
Feb 2018	1,272	0	237	889	129	1,099
Mar 2018	1,470	2	919	3,847	486	2,248
Apr 2018	1,437	4	942	3,647	540	2,176

Overall Growth in Utilization



CRISP “In-Context” Roll-Out

Epic

MEDITECH

Cerner

NEXTGEN

Allscripts

athenahealth

DrFirst

Statewide Medicare Data Milestones

- Statewide reporting/analytics vendor procured
- New platform rolled out in ICN year 2
- Medicare data analytics accessed by 35 hospitals and health systems to date
- CRISP casemix analytics function refactored to use same platform
- Predictive risk model developed initially to support CCIP (hAM)
- Positioned to support other state priorities (MPA, MDPCP, BPCIA, etc.)

Care Redesign Administration

- Hospital participation grew each performance period, with a large jump in participation for July 1 starts
  - PP1: July 2017-December 2017 – 10 hospitals in HCIP, 6 in CCIP
  - PP2: January 2018-June 2018 – All hospitals stayed, plus 2 new joined and 5 added a second track
  - **PP3: July 2018-December 2018 – 42 total participants, with 34 in HCIP, 3 in CCIP, and 5 in both**
- Participation has been greater in HCIP than CCIP
  - HCIP was an already established program and CCIP was a new ”home-grown” program
  - CCIP hospitals have identified the challenge of trying to engage PCPs with MDPCP on the horizon
  - The recent CMS announcement that clinicians participating in CRP could be eligible for MACRA incentives is likely to promote greater physician engagement
- Since the CRP launch, CRISP contracted with AMS to administer HCIP
- CRISP has provided a range of tools to CCIP hospitals to support patient enrollment

CRISP

FY19 Priorities & Proposed Scope

Funding Details

Workstream	Original Full Project "Planning Budget"	FY 2019 Budget Request	FY2019 Estimated Federal Funding Source*	FY2019 HSCRC Funding Source**
Point of Care	$26,309,796	$2,499,000	$1,619,000	$880,000
Care Managers & Coordinators	$2,731,936	$3,431,000	$3,310,000	$121,000
Population Health Teams	$7,049,757	$2,308,900	$0	$2,308,900
Patients	$0	$643,000	$643,000	$0
Common Infrastructure	$15,467,781	$1,420,000	$826,000	$594,000
Sub-Total	$51,559,270	$10,301,900	$6,398,000	$3,903,900
Administrators & Policymakers	$23,737,353	$5,005,000	$0	$5,005,000
TOTAL	**$75,296,623**	**$15,306,900**	**$6,398,000**	**$8,908,900**

Three-year actual spend of $53M ($33M State / $20M Federal) plus $15M planned for FY19 ($9M State / $6M Federal) demonstrates better-than-expected use of funds as CRISP and the health care industry built a foundation for the new Total Cost of Care Model.

What Still Needs Work?

- The quality of care coordination data, and care alerts in particular, is highly variable.
- CRISP in-context data may not sufficiently “pop” for some hospital users.
- Fostering integration between providers of somatic and behavioral health was an original priority.
- It’s an ongoing process to socialize and educate on the Medicare data tools and how to use them.
- Care Redesign Program Administration may benefit from more formal stakeholder input.

(This is not an exhaustive list…)

ICN Priorities Aligned with TCOC Model

1. Continued investment to refactor and drive adoption of ICN infrastructure
   - Improving breadth and depth of Care Alerts and CRISP In-Context
   - EHR-specific strategies to better incorporate data at the point of care
2. Ongoing rollout and enhancement of the Medicare CCLF data and reporting
   - Support for TCOC Model
   - Additional training and user feedback
3. Administrative support for the Care Redesign Amendment
   - Including development and support for new programs
   - Alignment and reporting for MDPCP

CRISP

Connecting Providers with Technology to Improve Patient Care

ICN User Stories

Drafted: 07/18/2016

Proposed revisions: 8/28/2017

Goal for The Point of Care

Our aim is that in every hospital in Maryland, when a patient presents for treatment, the clinician knows if her patient is in a care management program and without having to log into a separate system. She has contact information for the coordinator of this patient's care team and other engaged clinicians, regardless of whether those individuals are employed by her hospital. And she has efficient means to contact other care team members, including by secure text message. She is able to see who the PCP is and when the patient last visited. She is able to review the most current care plan if one exists and is aware of special resources available for her patient. And if a peer clinician or care coordinator has made important notes about this patient – a "care alert" – she has those at her fingertips.

Goal for Care Managers / Coordinators

CRISP aims to offer care managers access to rich, real-time data for patients who have been enrolled into care management, whether the care manager is part of a hospital-based intervention, and ambulatory ACO, a payer, or otherwise. Whether a care manager uses our lightweight care management software or a system maintained locally, CRISP will feed the system records to help him track and coordinate a patient's care at other hospitals, the primary care practice, specialists, and long-term care. He is notified when a patient under his care has an encounter elsewhere, including at ambulatory practices. He can identify gaps and redundancies in care. He is able to coordinate with community resources. And, he knows that his own contact information, critical notes and care planning instructions are shared with others when appropriate, and is even available to others via secure text message. His care management documents and health risk assessments follow statewide best-practice, making his documentation easy for others to understand.

Goal for the Population Health Team

CRISP aggregates data, combining the hospital's own records with those of peer hospitals and Medicare claims. For the population health team, CRISP tools make identification of at-risk patients more comprehensive and allow coordination between hospitals as to which is taking point for a particular patient. The population health team knows who among its patient population is a shared patient, who is considered at risk according to ~~common~~ criteria developed by the hospitals, and what portion of those patients are enrolled in care management.

Total-cost-of-care and episode-of-care reports show the team the progress by region and by hospital service area. Using a Maryland-specific Medicare Limited Data Set, CRISP provides reports to the population health team so they can understand line-of-service performance in comparison with peers, analyze non-hospital costs incurred at partner organizations, and examine total incurred costs at the physician level. Using aggregated casemix files, the population health team tracks performance on quality metrics (such as PAUs and MHACs) each month. CRISP's weekly "early indicator" reports show readmissions and census information for the prior week.

If the hospital's team possesses sophisticated tools to conduct such analysis, CRISP's main role is to facilitate the hospital receiving the raw Medicare data and the complete casemix data for any patient of the hospital. The CRISP infrastructure for managing patient consent is an asset in obtaining the data in this manner, giving the stakeholders who release the data confidence that patient privacy is being protected.

Goal for Patients

Most of the patient engagement required is by the provider community and not CRISP. However, we will engage patients around consent. When a patient visits his ambulatory provider, he will be informed at least once a year that the practice participates in a health information exchange. He will always be able to learn more information from a notice of privacy practices, or from an easy to navigate CRISP web site. If he chooses not to participate, the process to opt-out will be easy, and he will have the option to exclude only records from certain providers or certain types of providers. He will also have the option to restrict access to his records by certain organizations.

When a patient is enrolled in a care management program, he will understand that his records will be shared among his care team, and he will approve of the activity before it happens. If he so chooses, he will be notified when a clinician references his medical records from the HIE. He can request that his healthcare proxy, such as his daughter, be notified when he has a hospital encounter. He can upload his advance directive online, and CRISP will make it available at the point of care.

Goal for Administrators/Policy Makers

CRISP will supply Maryland hospital executives and a hospital's administrative and financial teams with thoughtful, actionable analytics, including total-cost-of-care and episode-of-care reports. Hospital executives can use CRISP reports to gain insight into the hospital or system's performance regionally and by hospital service area. Using a Maryland-specific Medicare Limited Data Set and the patient-identified CCLF data set, CRISP reports can help highlight line-of-service performance in comparison with peers, analyze non-hospital costs incurred with partner organizations, and understand total incurred costs at the physician level. The data help the executive team design and manage hospital initiatives under state programs such as the Care Redesign Amendment.

For hospitals participating in a Care Redesign program, CRISP will provide patient-level reports using a Maryland-specific CCLF data set that will allow the population health team to track line-of-service performance, episodic costs, and care coordination measures at the patient level, with patient identifiers included. Using the same data set, CRISP will provide total-cost-or-care and episode-of-care reports to those hospitals not participating in a Care Redesign program that will be more timely than those produced using the Limited Data Set.

CRISP will support Maryland health policymakers charged with ensuring Maryland's healthcare system delivers high-quality, reasonably priced care, particularly for patients with the greatest and/or most complex needs. We will do this by serving as a convener of industry stakeholders on issues that align with CRISP's mission and in accordance with the recommendations of the HSCRC's Care Coordination Workgroup. Within the mandate approved by CRISP's board, CRISP will serve the state as the administrator of programs under the Care Redesign Amendment.

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **July 11, 2018**

RE: **Hearing and Meeting Schedule**

August 8, 2018	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
September 12, 2018	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:15 a.m.

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

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