

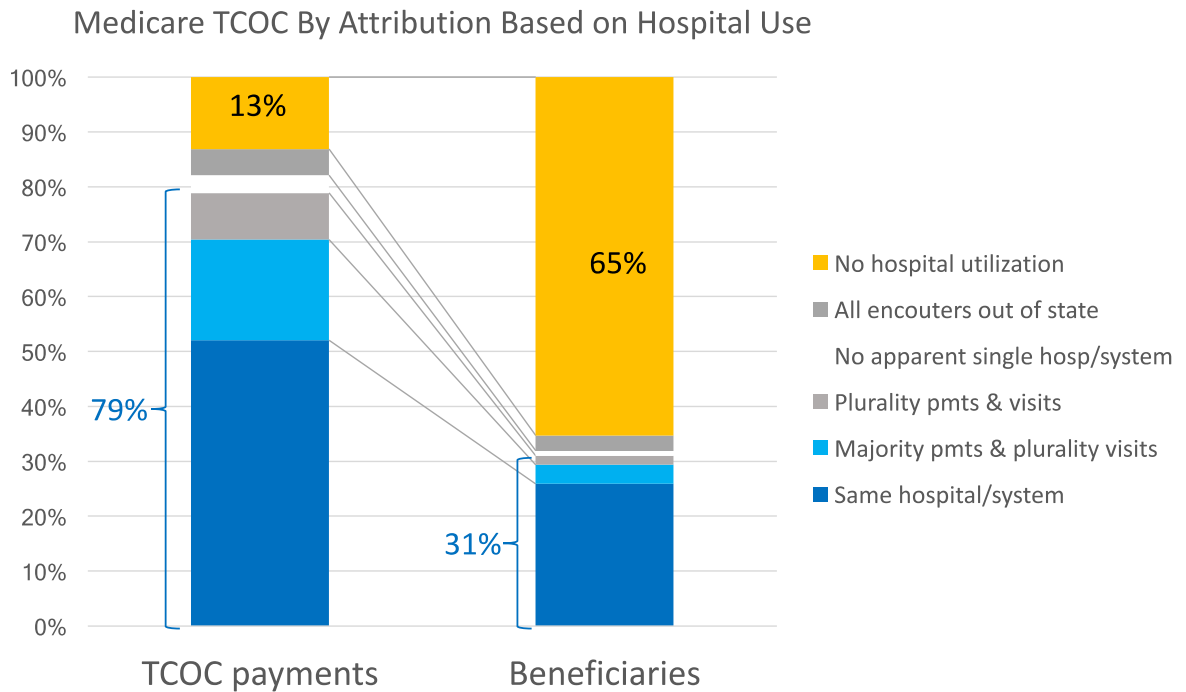
Welcome  
to the  
HSCRC Commission Meeting

# Executive Director's Report

## Emergency department update

Katie Wunderlich will provide an update today on emergency services bypass and performance statistics. HSCRC, DHMH, and MIEMSS are meeting to discuss emergency department overcrowding and diversion issues.

# Majority of TCOC Occurs Among Beneficiaries with Hospital Use



Source: Draft methodology presented by MHA to TCOC Work Group, April 26, 2017



# Emergency Department Performance in Maryland

May 10, 2017

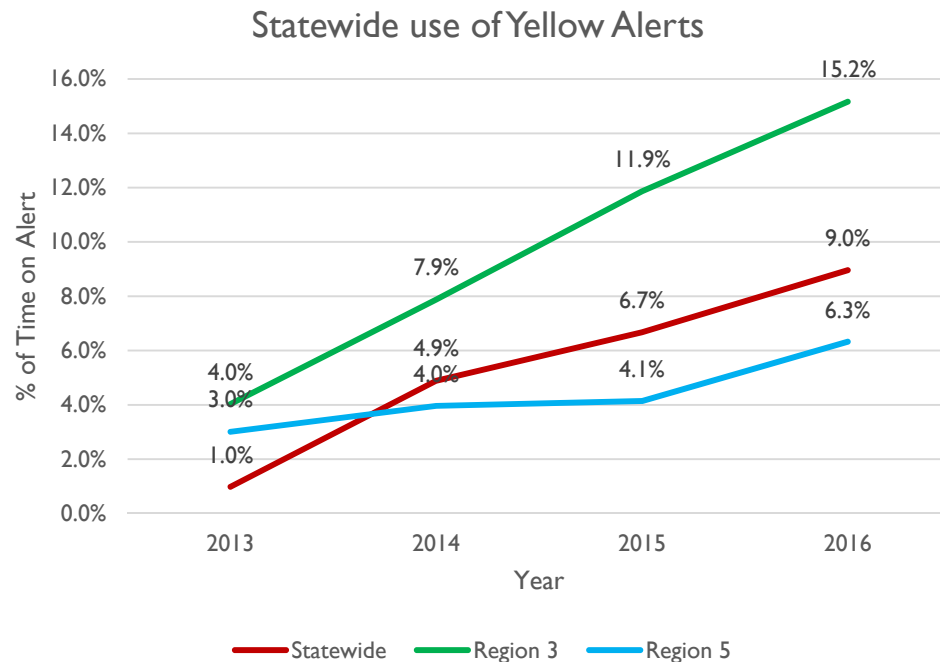
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**HSCRC**

Health Services Cost  
Review Commission

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# Statewide Trends – ED Diversion Over Time



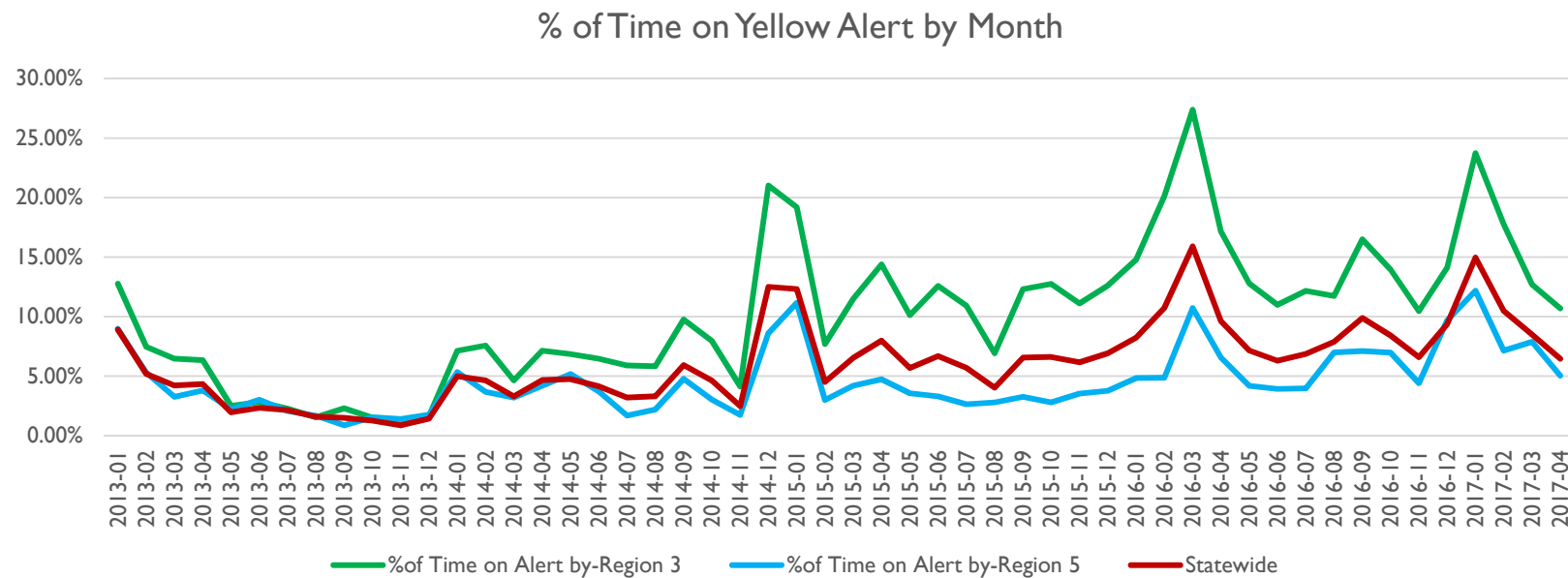
▶ ED Diversion is increasing in Maryland, but particularly in:

- ▶ Region 3 (Baltimore City/County and Central MD)
- ▶ Region 5 (DC suburbs and southern MD)

▶ Diversion remains a critical issue across the country, not just Maryland.

**Yellow Alert:** The ED temporarily requests that it receive absolutely no patients in need of urgent medical care. Yellow Alert is initiated because the ED is experiencing a temporary overwhelming overload such that priority II and III patients may not be managed safely. Prior to diverting pediatric patients, medical consultation is advised for pediatric patient transports when EDs are on yellow alert.

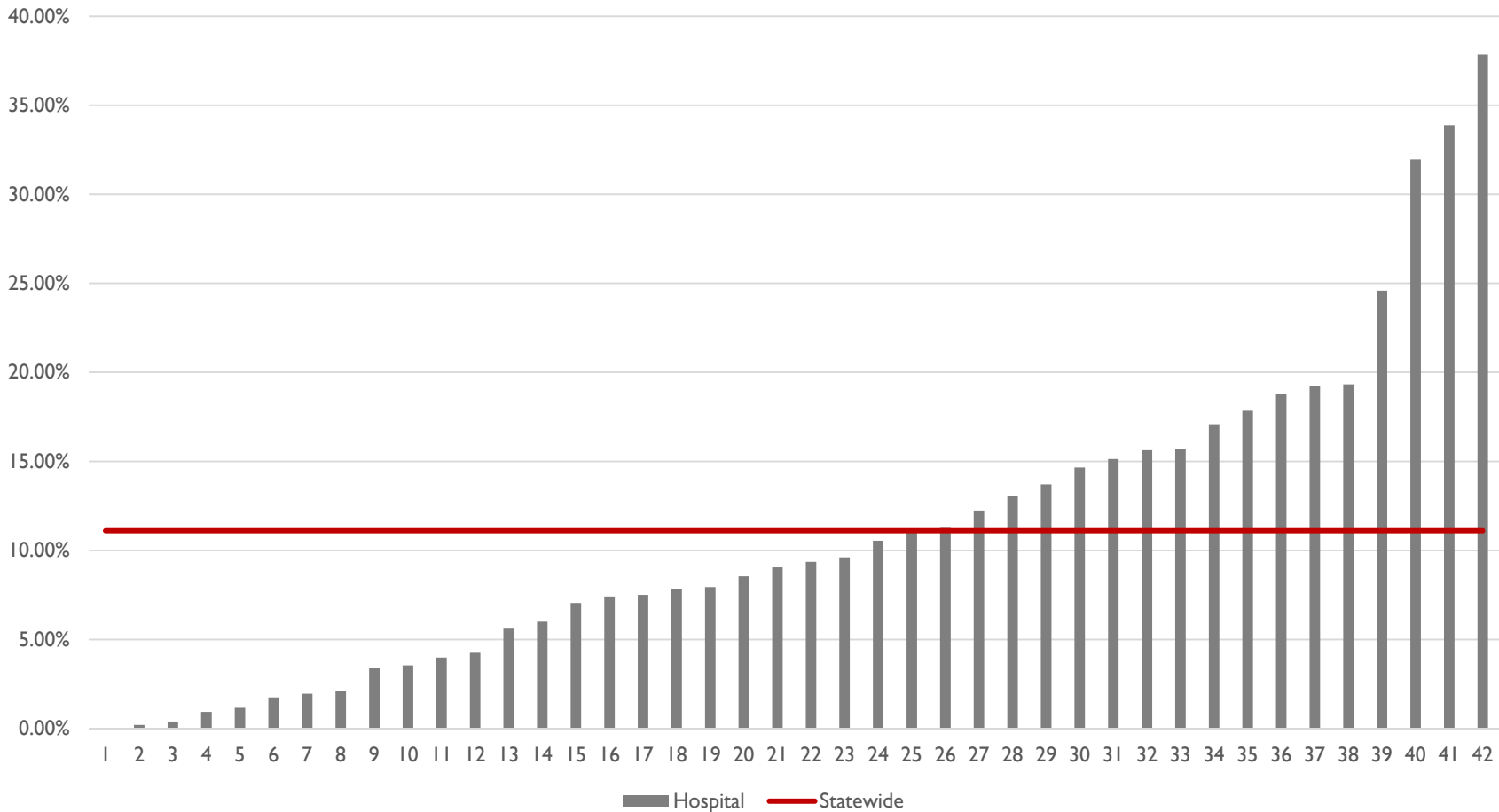
# Statewide Trends – ED Diversion Over Time



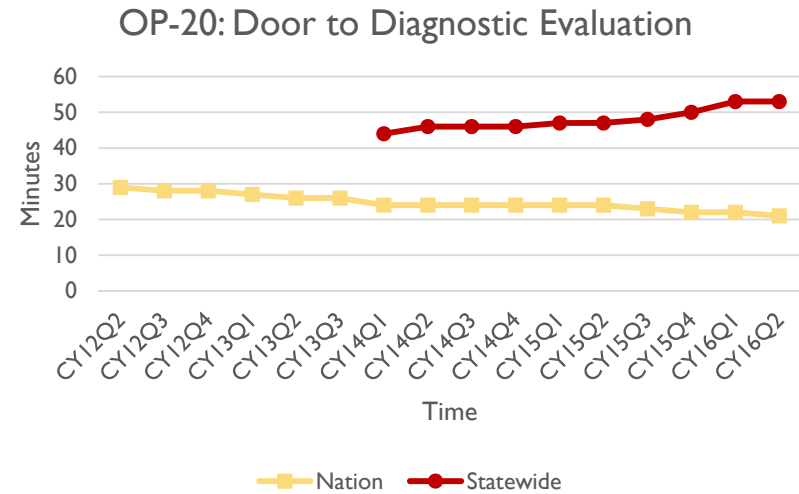
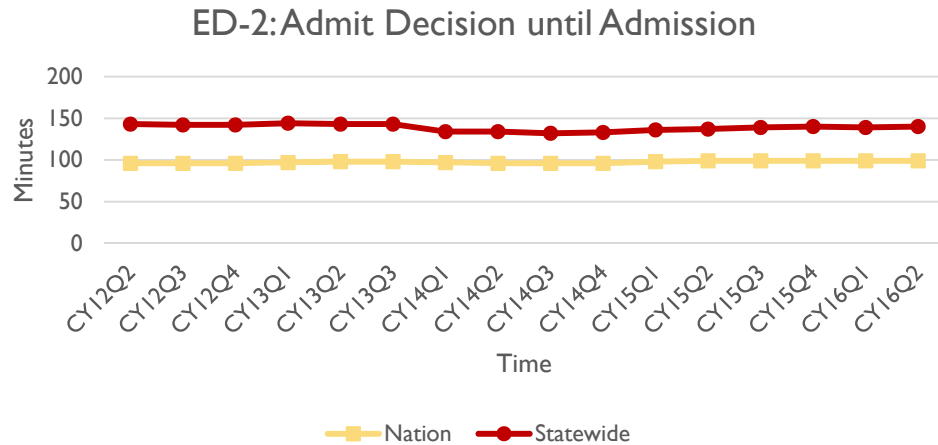
Data Source: Md. Institute for EMS Systems (MIEMSS)

# Statewide Overview – 2016-03 through 2017-02 (Yellow Alert)

% of Time on Alert - 2016-03 to 2017-02



# Statewide Trends – ED Wait Times Over Time

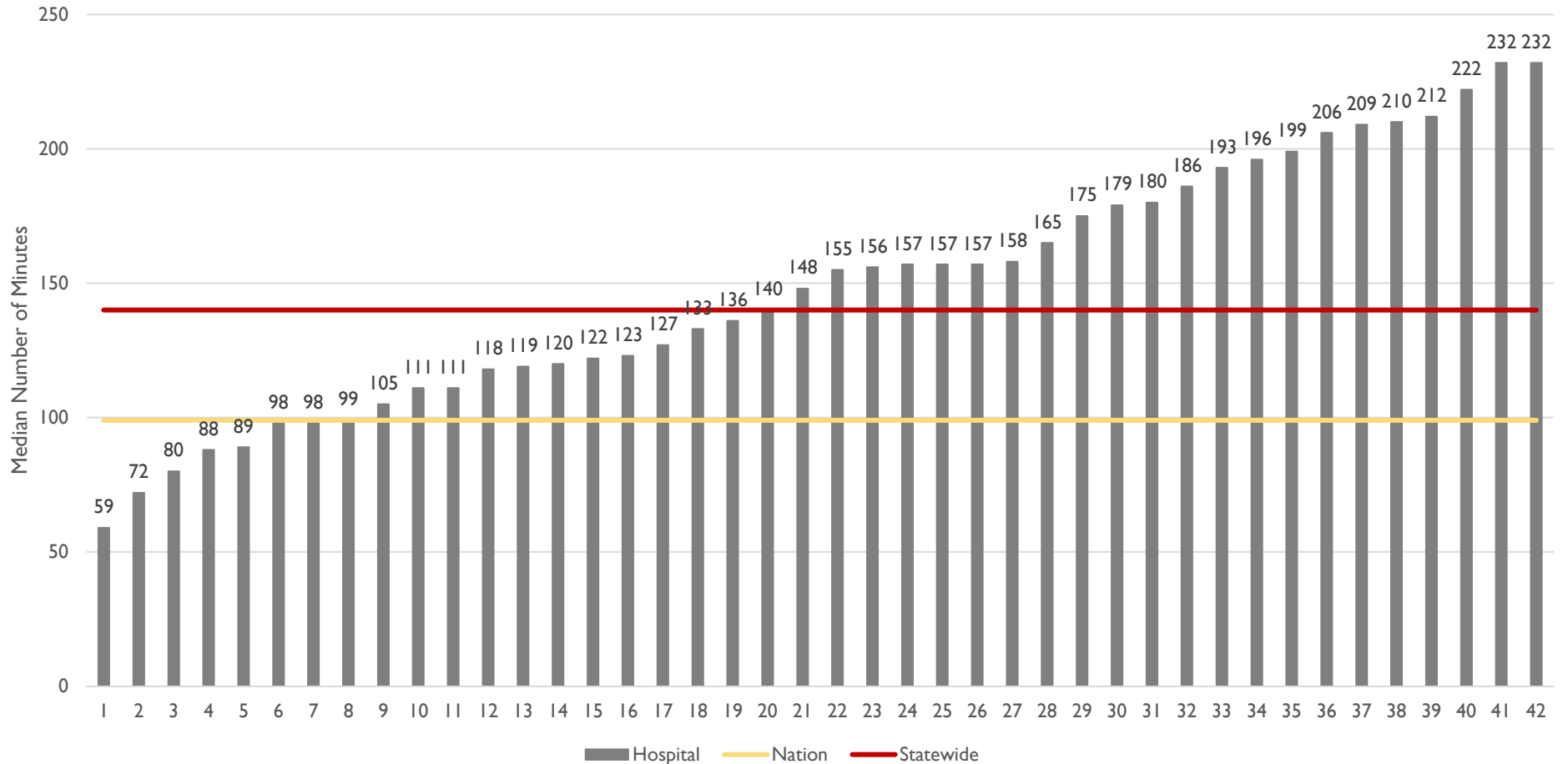


- ▶ ED-2 – Admit Decision until Admission
  - ▶ Some physicians concerned that “boarding” is reducing ED throughput efficiency and increasing wait times.
  - ▶ Boarding is associated with increased mortality rates and length of stay.
- ▶ OP-20 – Door to Diagnostic Evaluation
  - ▶ This measure is most accessible to consumers and was presented in recent local news story.



# Statewide Overview – FY 2016 – ED-2

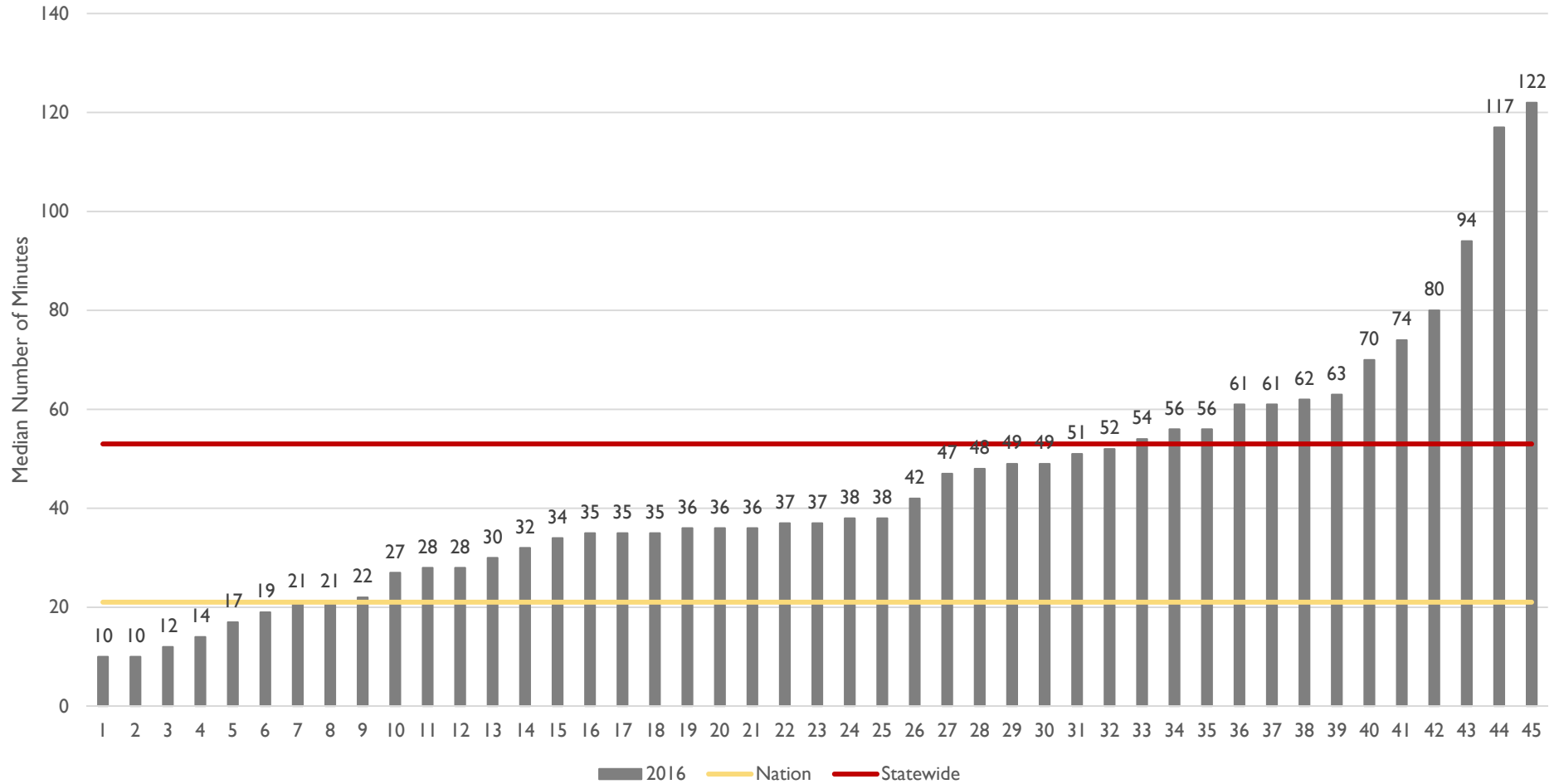
ED-2 - Admit Decision to Admission (Data through Q2 2016)



▶ 6 Data Source: CMS Hospital Compare

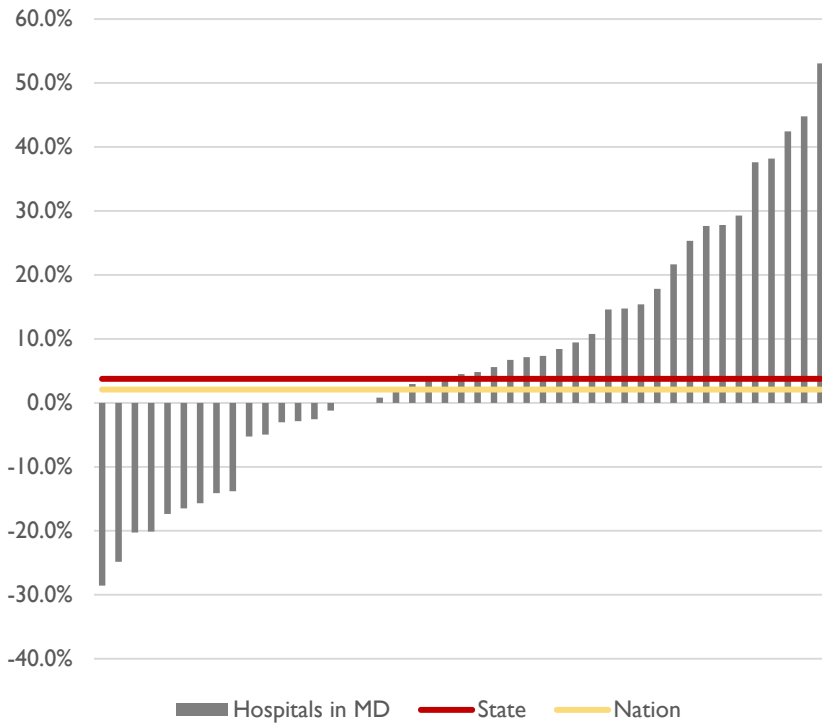
# Statewide Overview – FY 2016 – OP-20

OP-20 - Door to Diagnostic Evaluation (Data through Q2 2016)

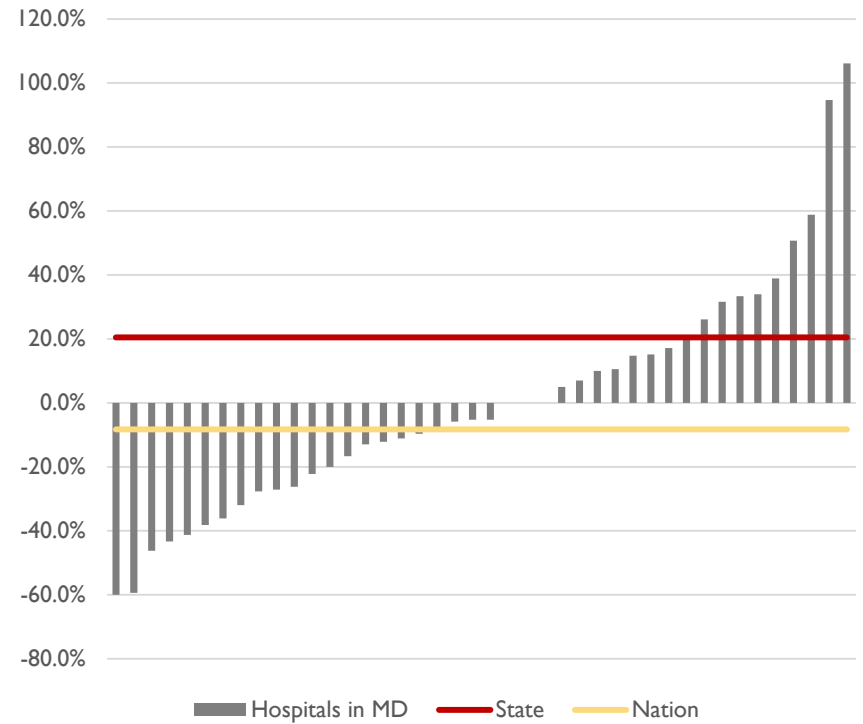


# % Change Wait Times

% Change in ED-2 2016Q1 over 2014Q1



% Change in OP-20 2016Q1 over 2014Q1



## Next Steps

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- ▶ HSCRC is evaluating the feasibility of including select ED wait time measures in RY 2020 QBR program.
- ▶ Hospital Overload and Emergency Department Strategic Workgroup convened in May 2017 to evaluate ED diversion trends in Maryland.
  - ▶ Participants include Maryland Institute for Emergency Medical Services Systems (MIEMSS), HSCRC, DHMH, and Maryland Hospital Association.
  - ▶ Report to the Legislature due in December 2017.
- ▶ Staff is working with MIEMSS to capture additional data on ED diversion to better inform market shift adjustments.



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

Data through February 2017– Claims paid through March  
Source: CMMI Monthly Data Set



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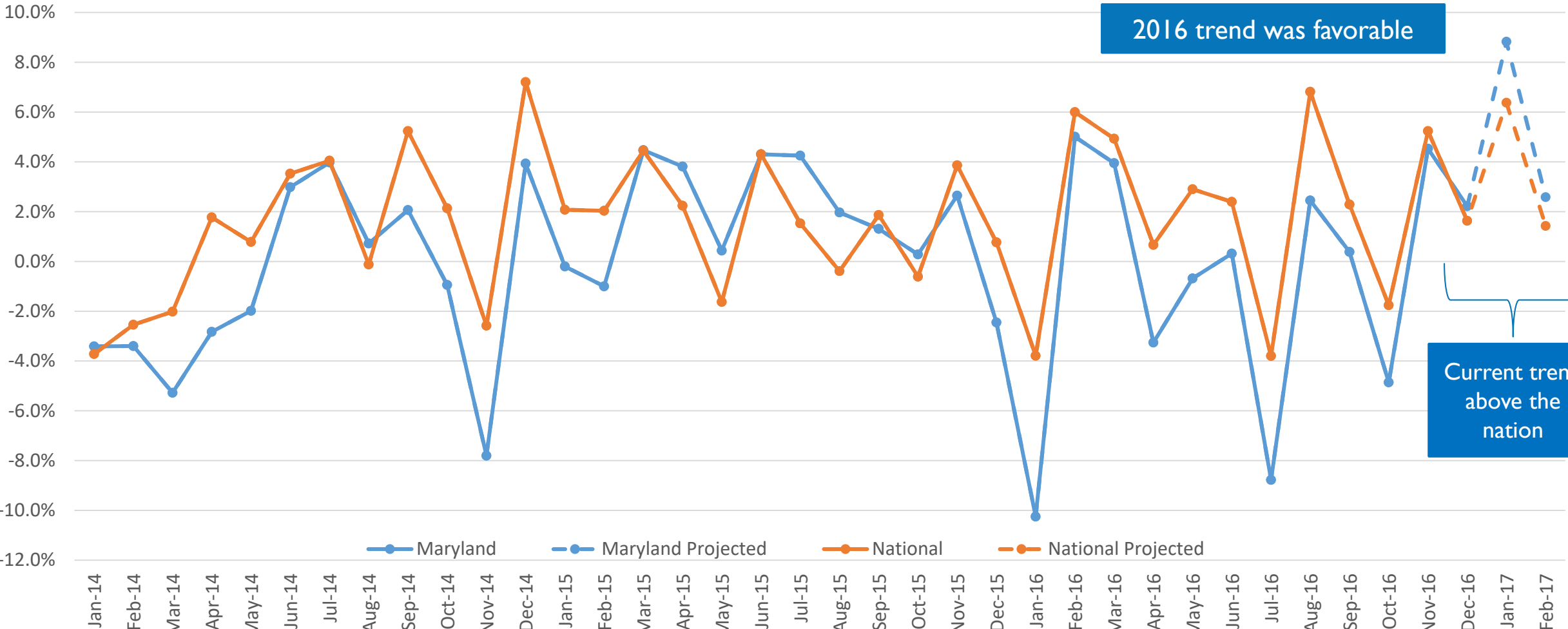
## Disclaimer:

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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.

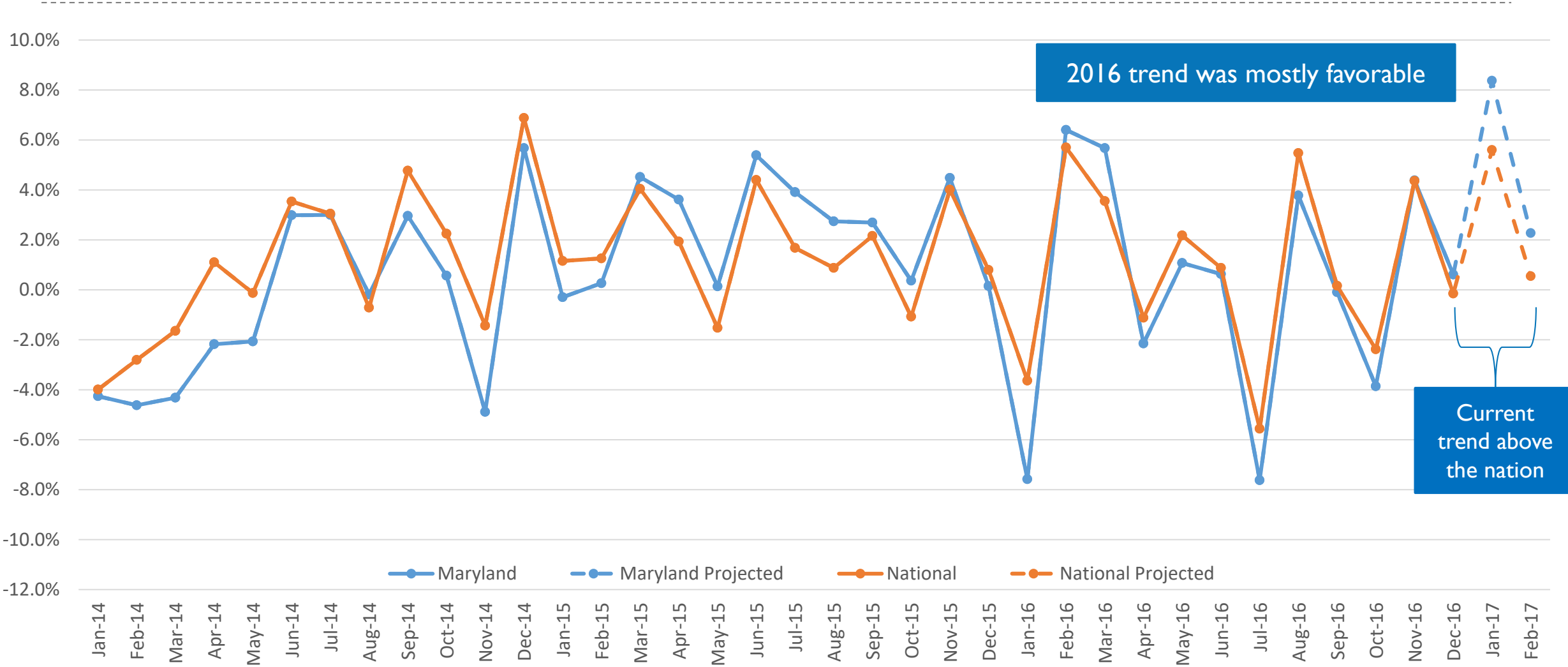
# Medicare Hospital Spending per Capita

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



# Medicare Total Cost of Care per Capita

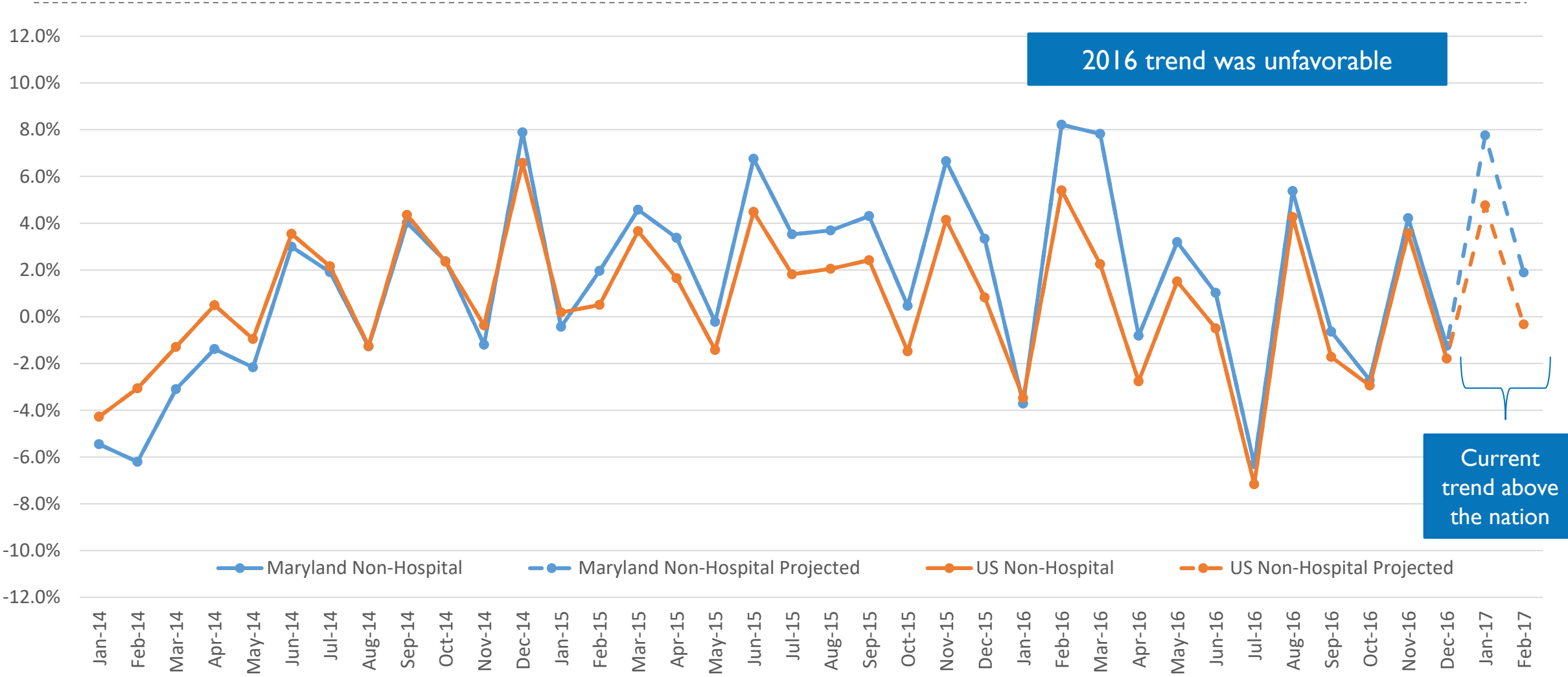
Actual Growth Trend (CY month vs. prior CY month)





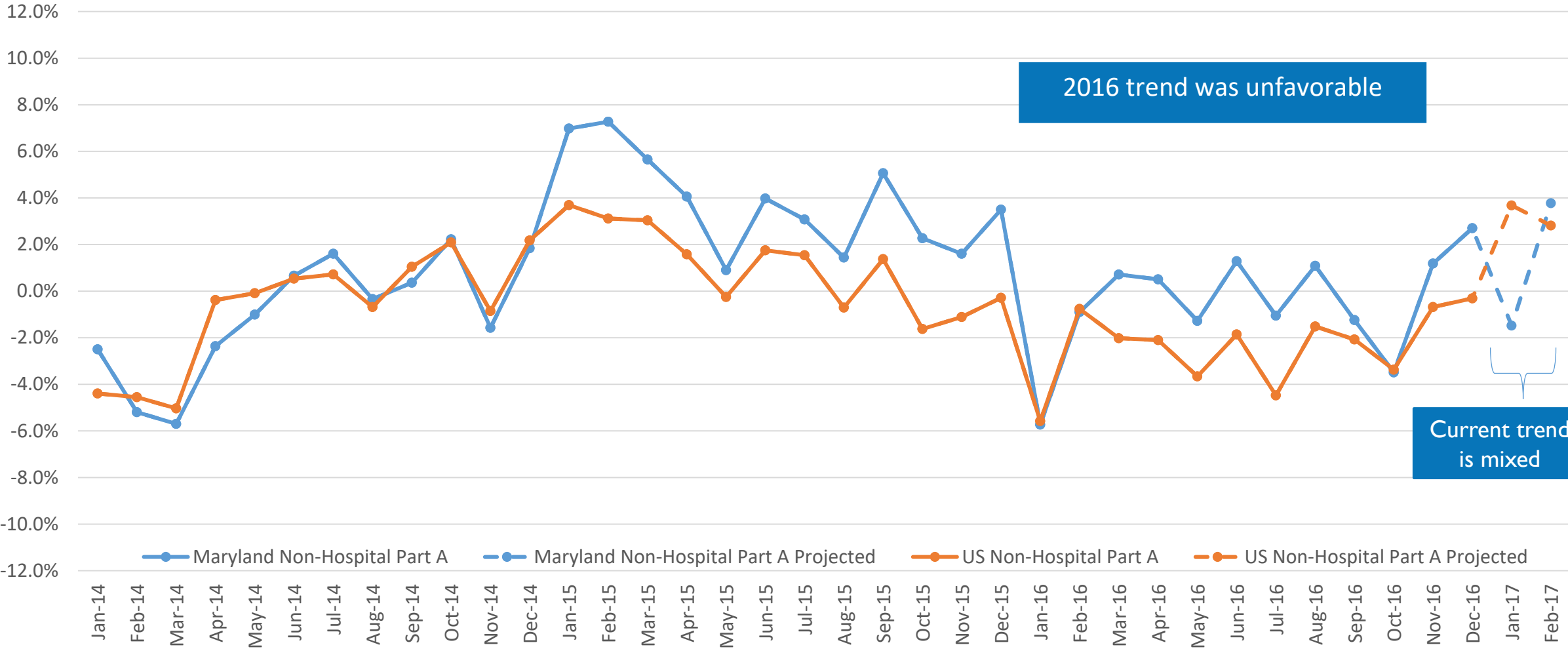
# Medicare Non-Hospital Spending per Capita

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



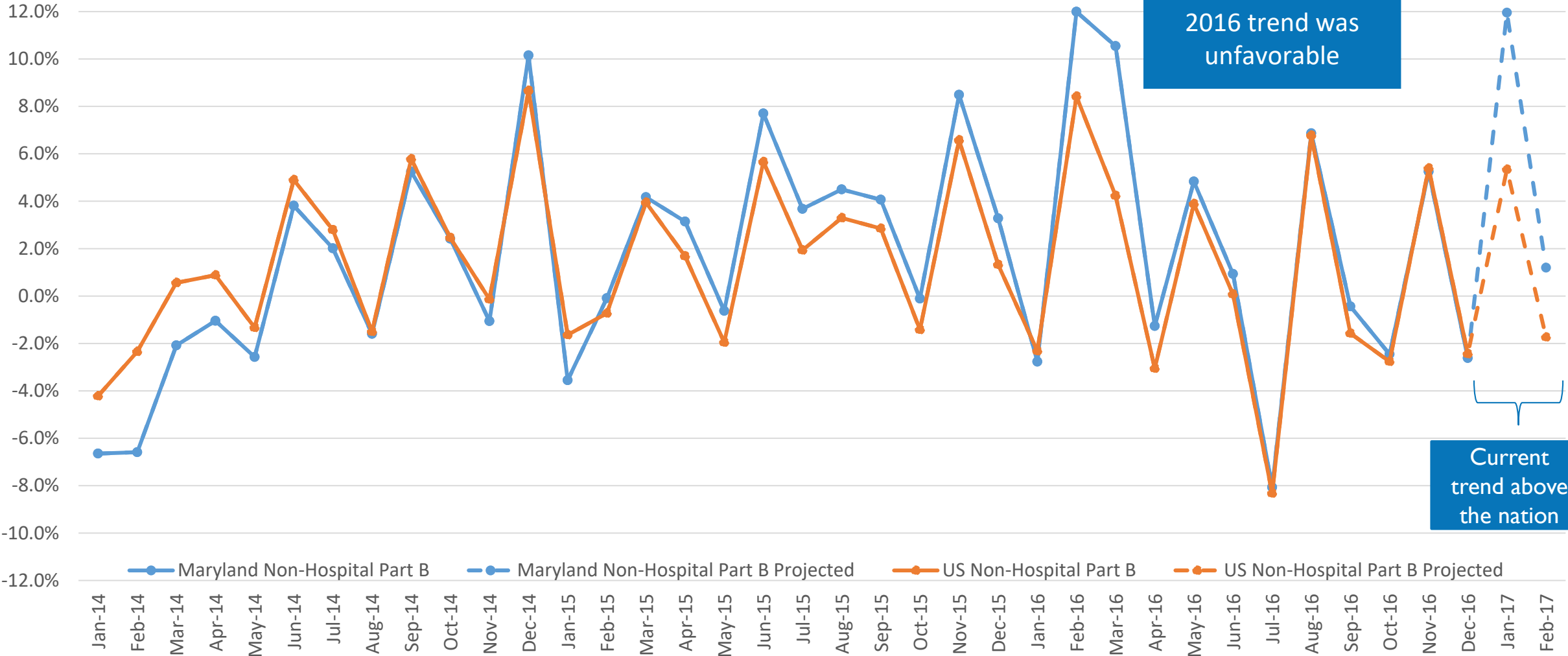
# Medicare Non-Hospital Part A Spending per Capita

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



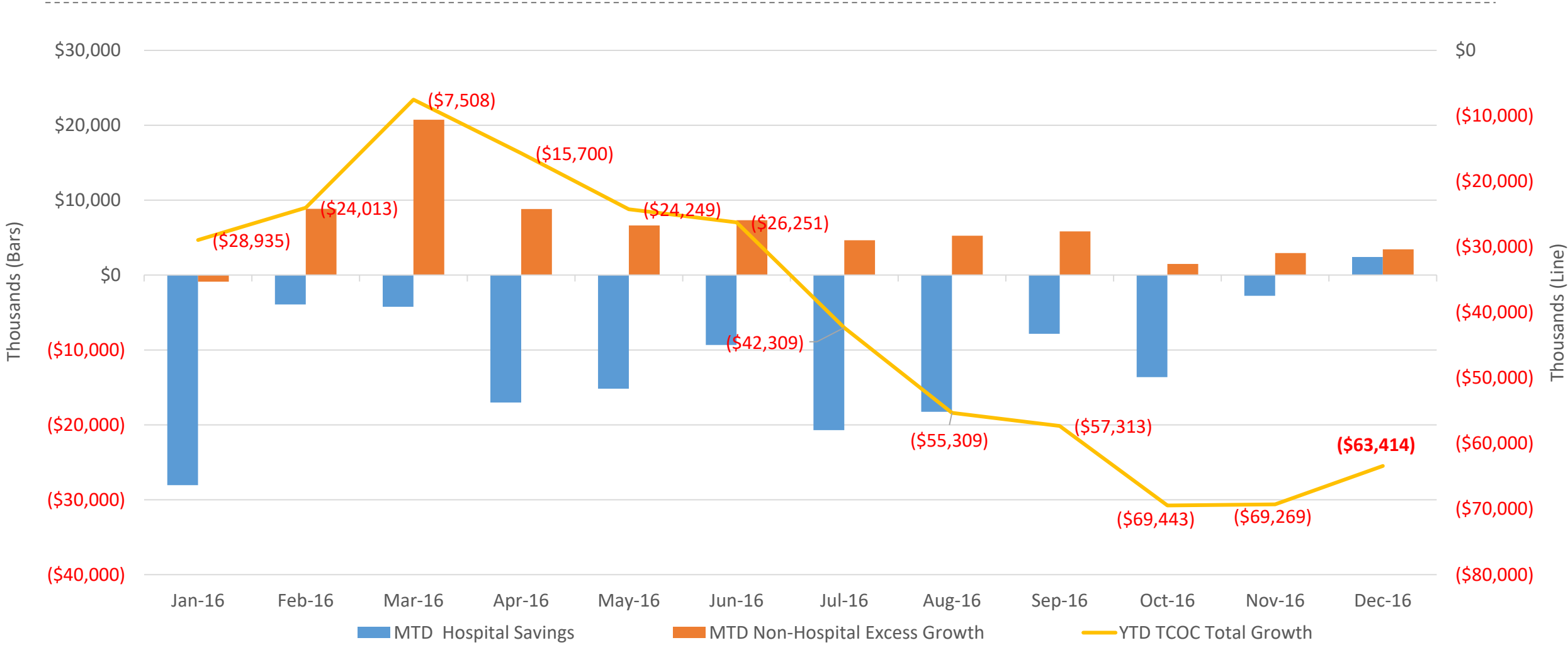
# Medicare Non-Hospital Part B Spending per Capita

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



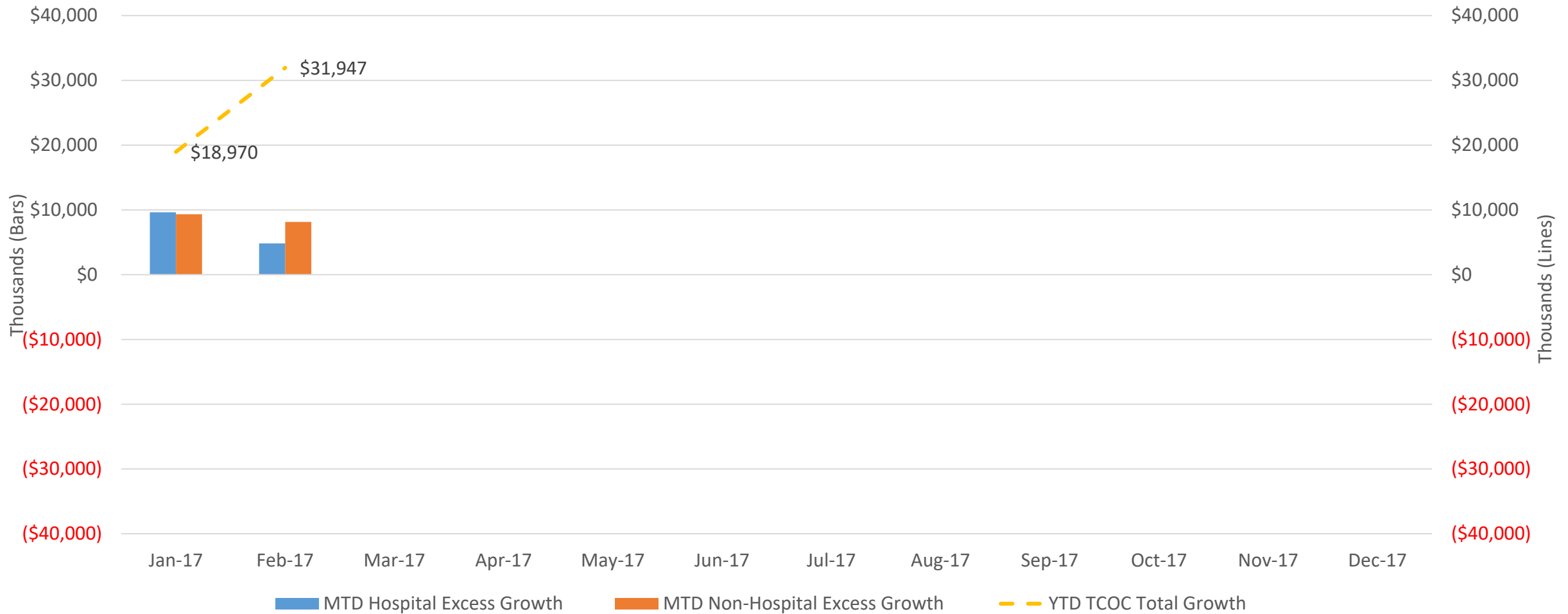
# Medicare Hospital & Non-Hospital Growth

CYTD through December 2016



# Medicare Hospital & Non-Hospital Growth

(with completion) CYTD through February 2017





# Monitoring Maryland Performance Financial Data

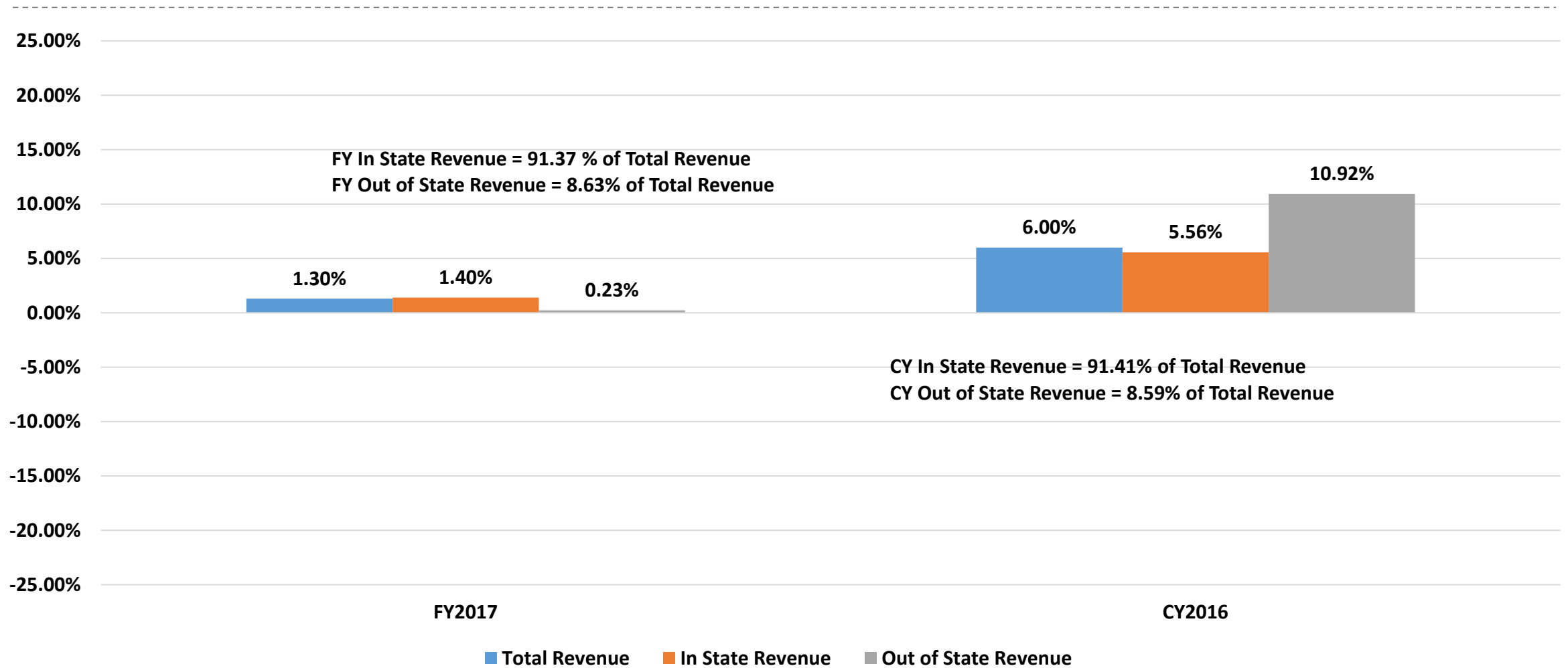
Year to Date through March 2017

Source: Hospital Monthly Volume and Revenue and Financial Statement Data  
Run: May 2017



# Gross All Payer Revenue Growth

FY 2017 (Jul 2016-March 2017 over Jul 2015-March 2016) and CY 2017 (Jan-March 2017 over Jan-March 2016)

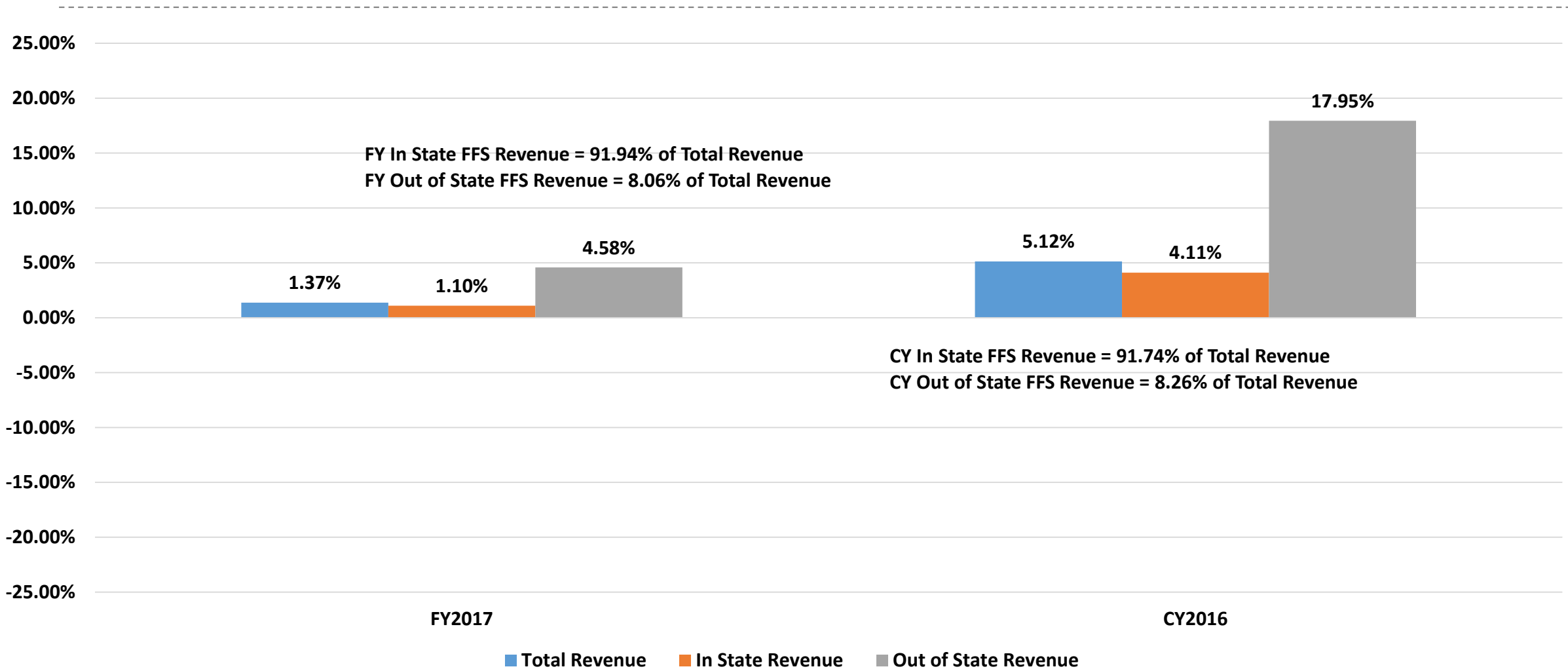


The State's Fiscal Year begins July 1



# Gross Medicare Fee for Service Revenue Growth

FY 2017 (Jul 2016 - March 2017 over Jul-March 2015) and CY 2016 (Jan-March 2017 over Jan-March 2016)



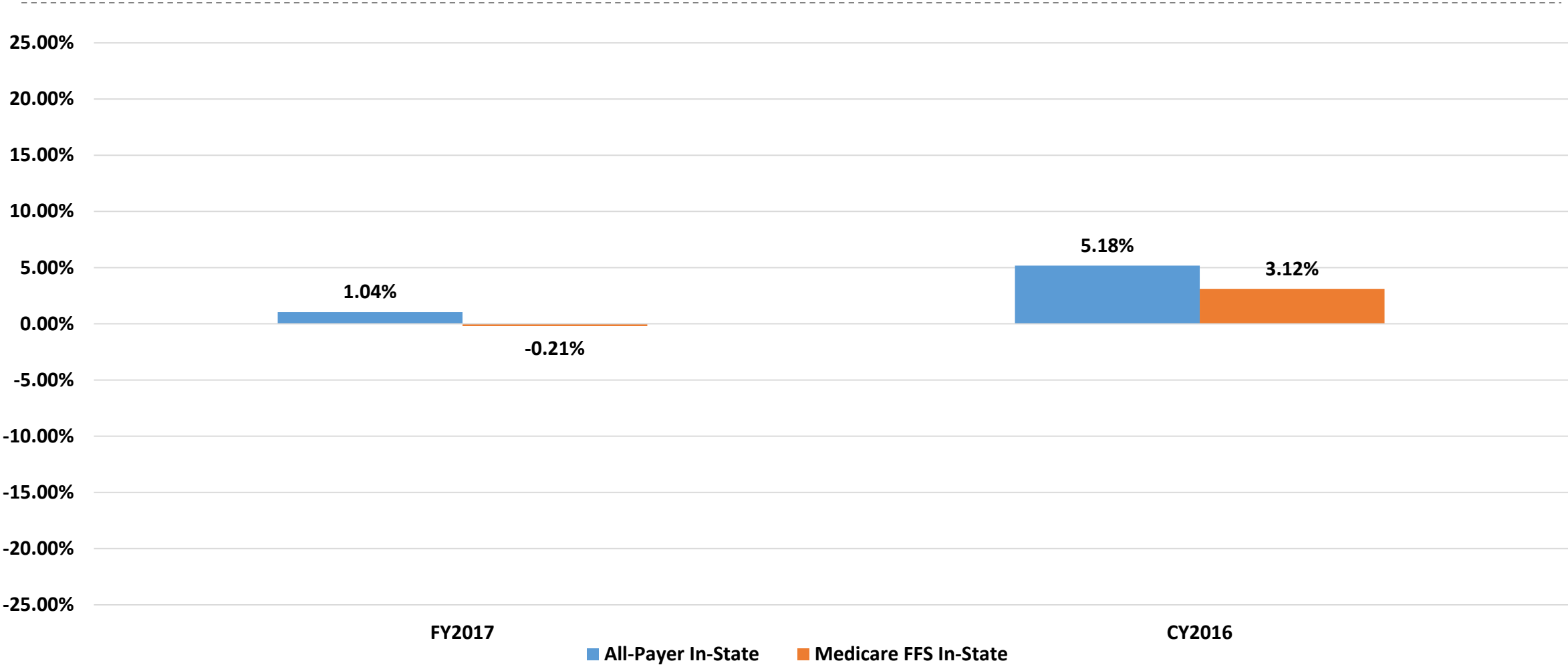
The State's Fiscal Year begins July 1





# Hospital Revenue Per Capita Growth Rates

FY 2017 (Jul 2016 – March 2017 over Jul 2015 – March 2016) and CY 2017 (Jan-March 2017 over Jan-March 2016)

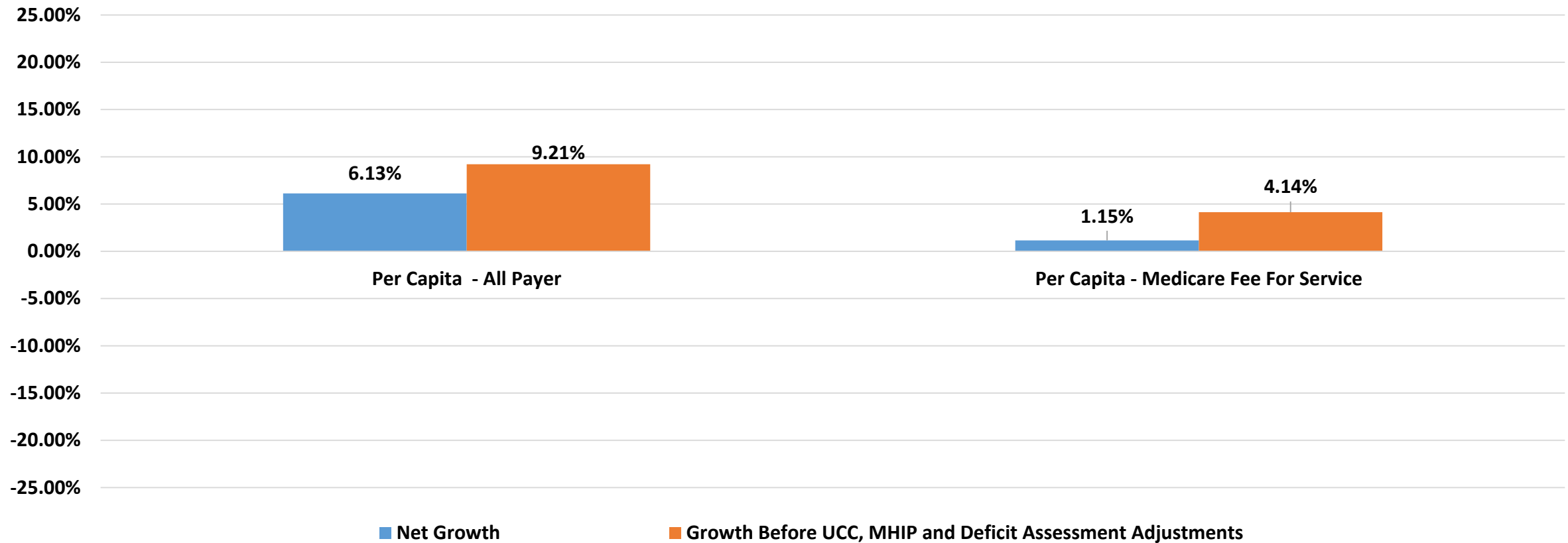


The State's Fiscal Year begins July 1



# Hospital Revenue Per Capita: Actual and Underlying Growth

CY 2017 (Jan-March) over Base Year CY 2013 (Jan-March)

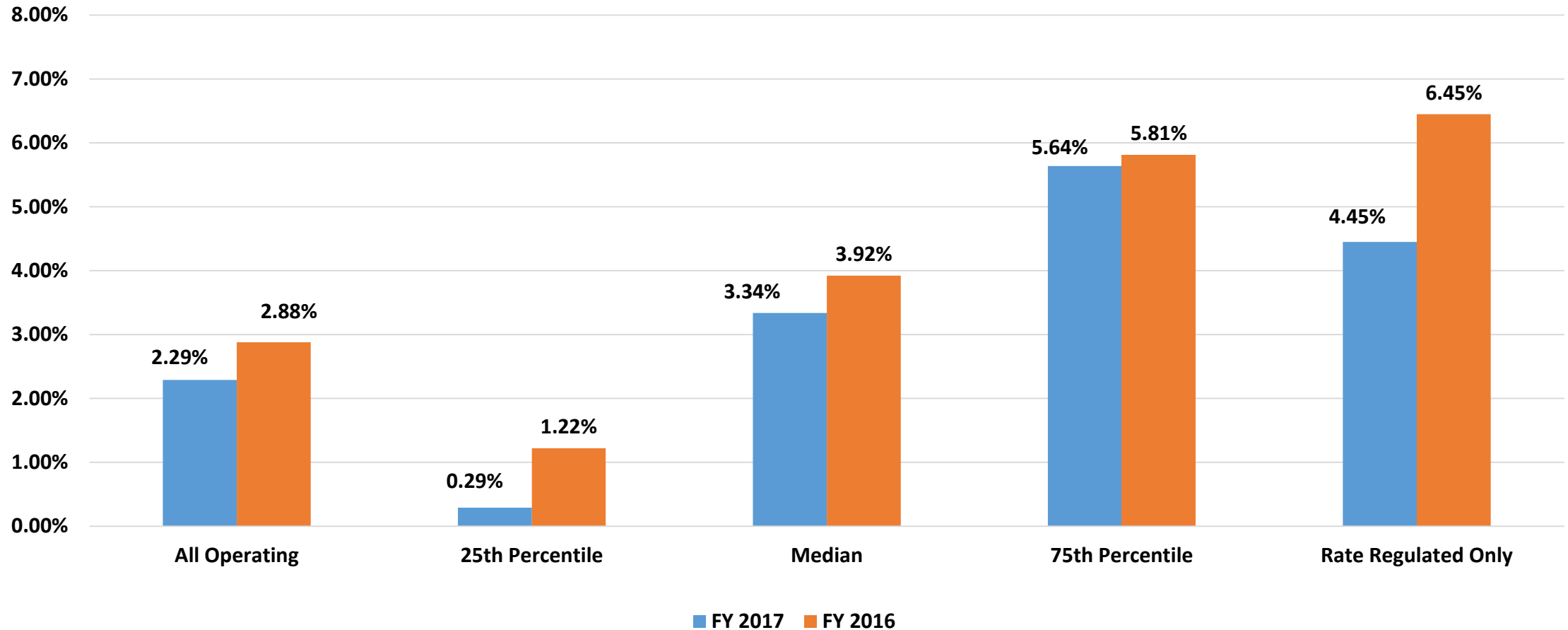


- Four year All Payer per capita growth rate is well below maximum allowable growth rate of 15.11% (growth of 3.58% per year)
- Underlying growth reflects adjustments for FY16 revenue decreases that were budget neutral for hospitals. 2.52% hospital bad debts, and elimination of MHIP assessment and FY17 revenue decreases of .49% UCC and 0.15% deficit assessment.



# Operating Profits

Fiscal Year 2017 (Jul 2016-March 2017) Compared to Same Period in Fiscal Year 2016 (Jul 2015 - March 2016)

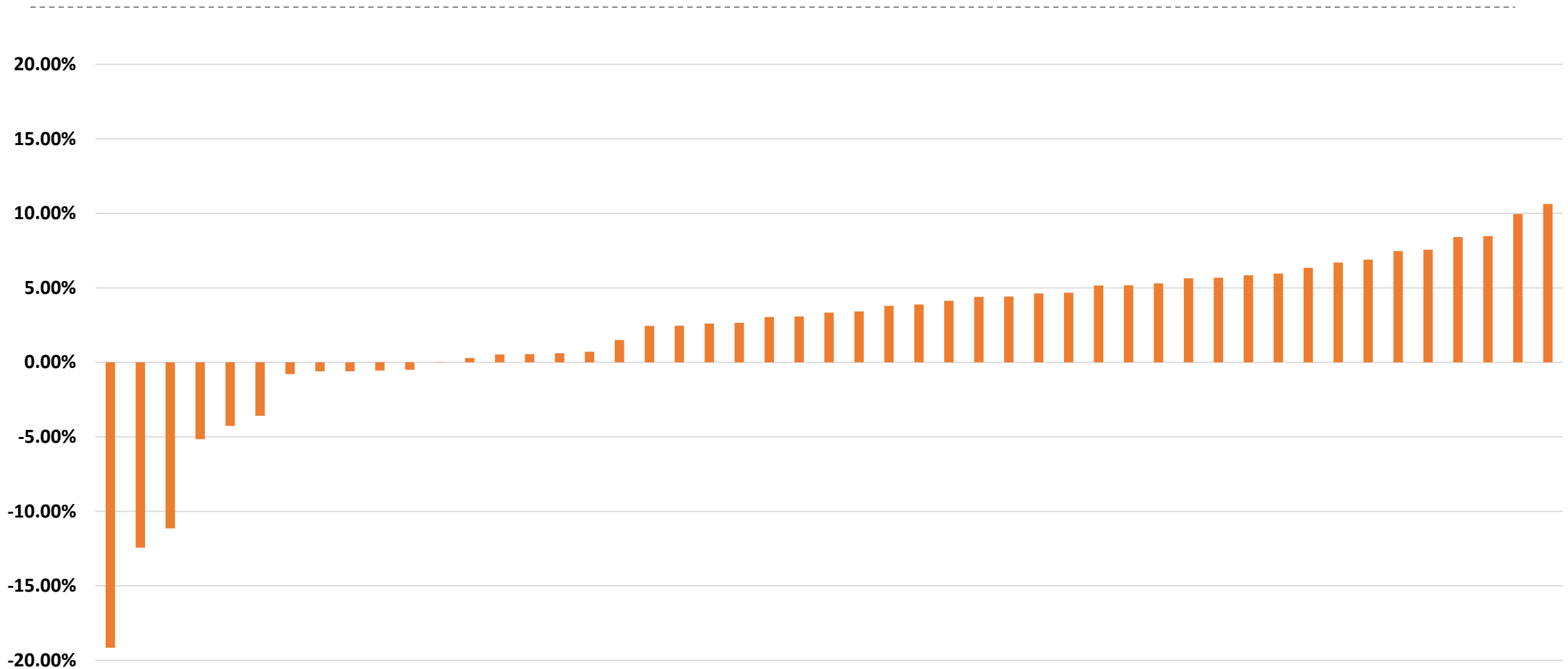


FY 2017 unaudited hospital operating profits to date show a .59 percentage point decrease in total profits compared to the same period in FY 2016. Rate regulated profits have decreased by 2 percentage points compared to the same period in FY 2016.



# Total Operating Profits by Hospital

Fiscal Year 2017 (Jul 2016-March 2017)



# Regulated and Total Operating Profits

Fiscal Year 2017 (Jul 2016 – March 2017)



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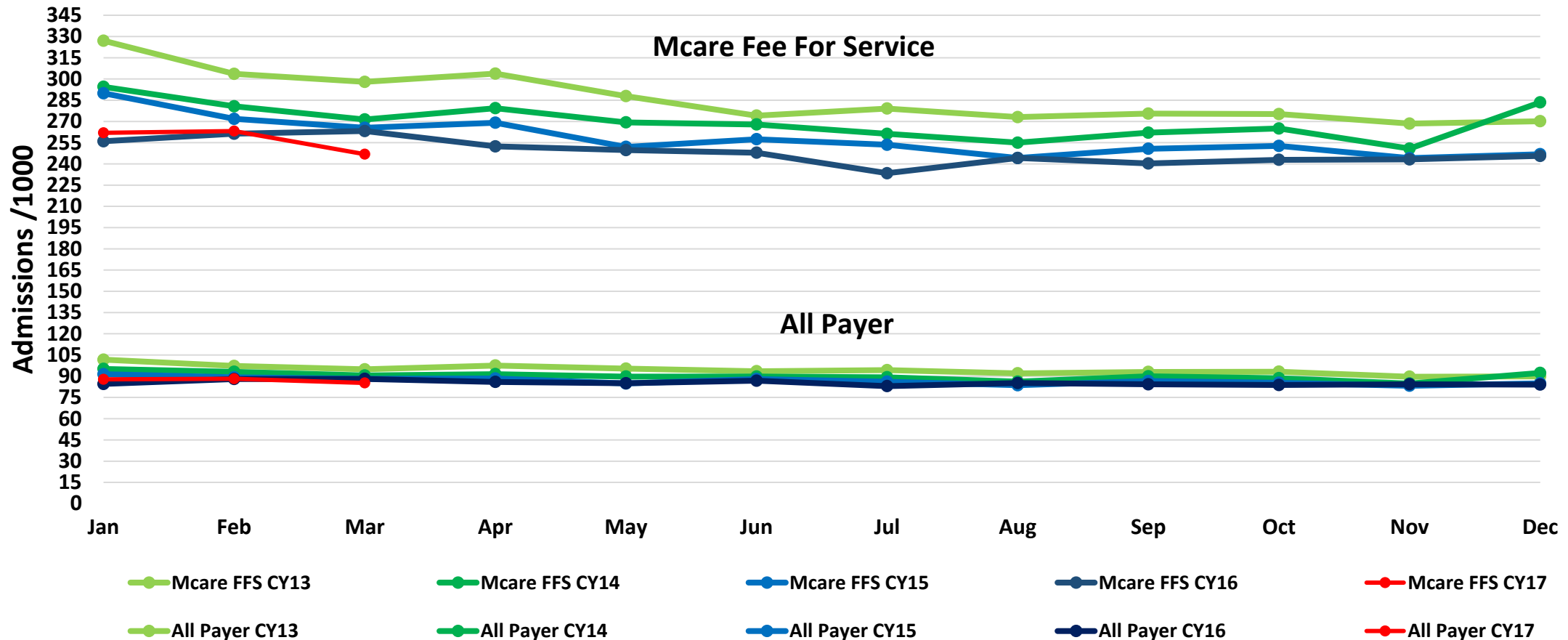
# Monitoring Maryland Performance Financial/Utilization Data

Year to Date through March 2017

Source: Hospital Monthly Volume and Revenue Data

# Annual Trends for ADK Annualized Medicare Fee For Service and All Payer

(CY 2013 through CY 2017 March)

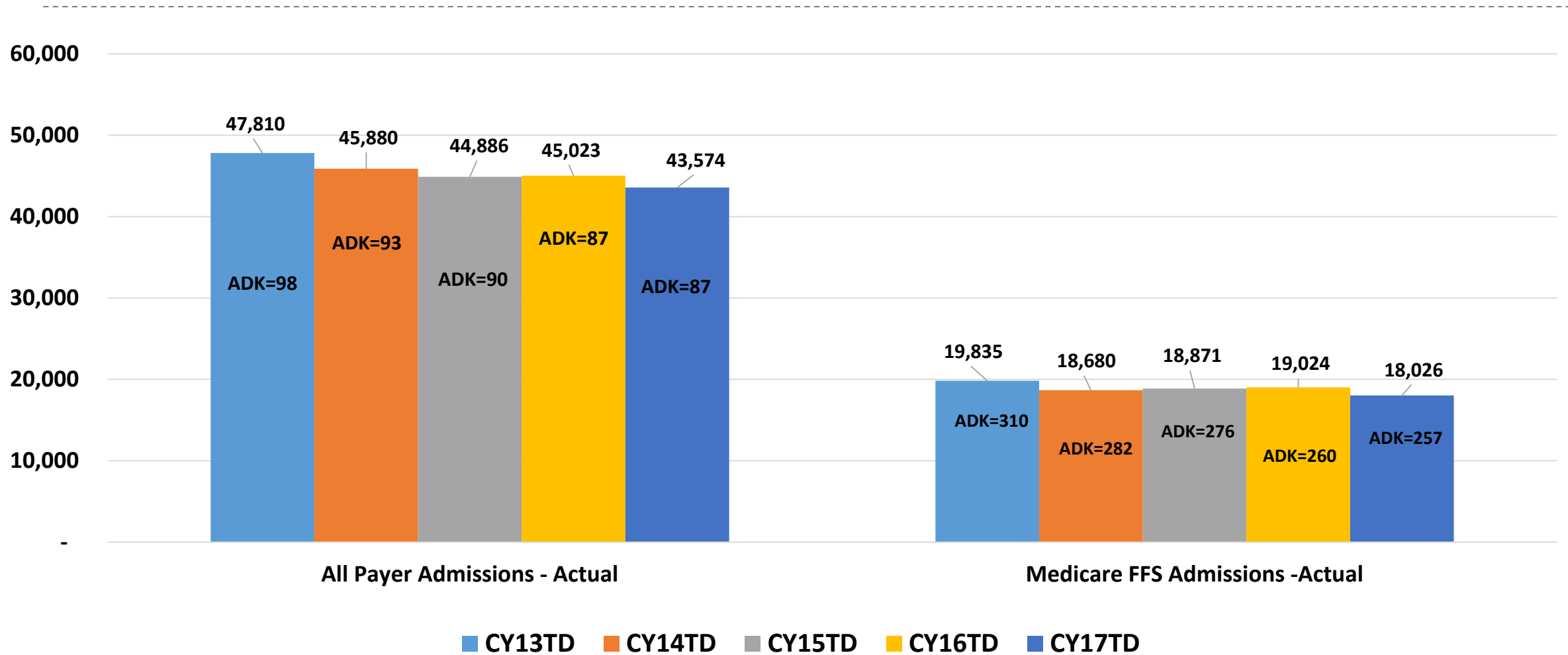


\*Note - The admissions do not include out of state migration or specialty psych and rehab hospitals.



# Actual Admissions by Calendar YTD March

(CY 2013 through CY 2017)





# Change in Admissions by Calendar YTD March

(CY 2013 through CY 2017)

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**Change in All Payer Admissions CYTD13 vs. CYTD14 = -4.04%**

**Change in All Payer Admissions CYTD14 vs. CYTD15 = -2.17%**

**Change in All Payer Admissions CYTD15 vs. CYTD16 = 0.30%**

**Change in All Payer Admissions CYTD16 vs. CYTD17 = -3.22%**

**Change in ADK CYTD 13 vs. CYTD 14 = -5.16%**

**Change in ADK CYTD 14 vs. CYTD 15 = -3.55%**

**Change in ADK CYTD 15 vs. CYTD 16 = -3.10%**

**Change in ADK CYTD 16 vs. CYTD 17 = 0.22%**

**Change in Medicare FFS Admissions CYTD13 vs. CYTD14 = -5.82%**

**Change in Medicare FFS Admissions CYTD14 vs. CYTD15 = 1.02%**

**Change in Medicare FFS Admissions CYTD15 vs. CYTD16 = 0.81%**

**Change in Medicare FFS Admissions CYTD16 vs. CYTD17 = -5.24%**

**Change in Medicare FFS ADK CYTD 13 vs. CYTD 14 = -8.87%**

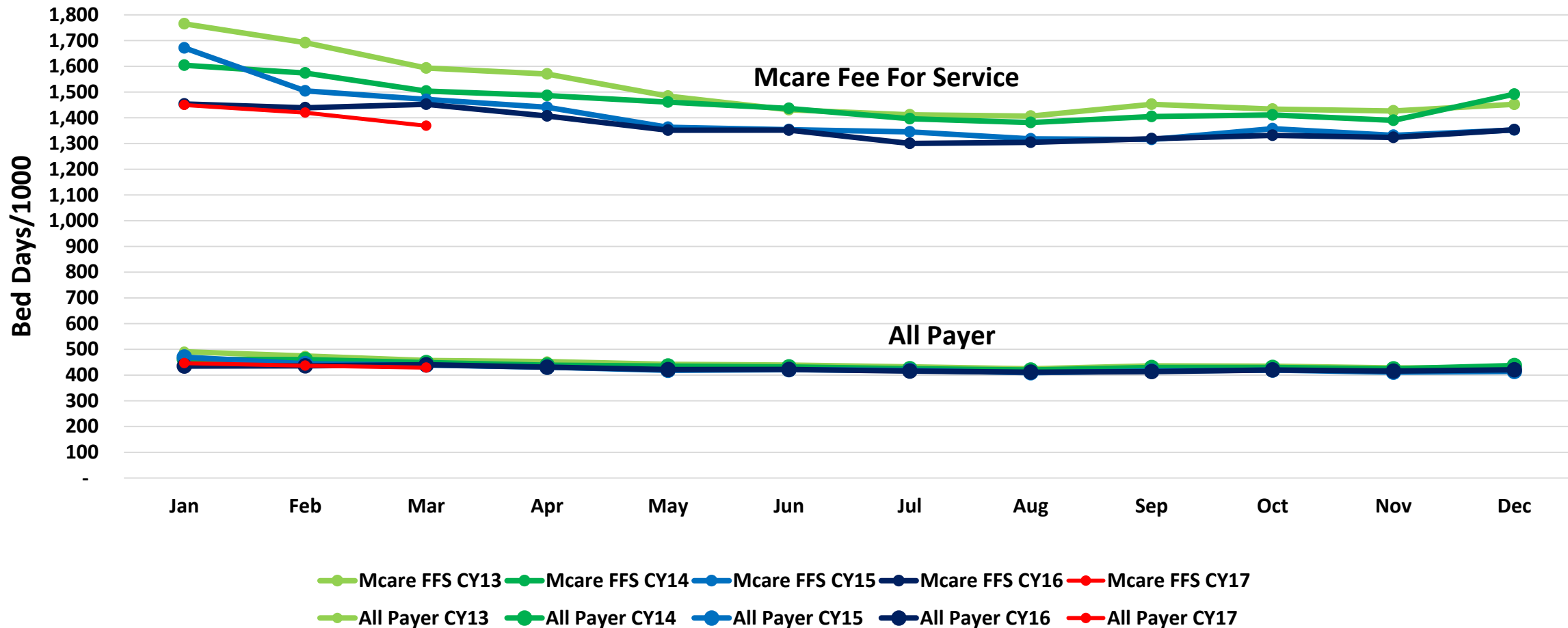
**Change in Medicare FFS ADK CYTD 14 vs. CYTD 15 = -2.25%**

**Change in Medicare FFS ADK CYTD 15 vs. CYTD 16 = -5.69%**

**Change in Medicare FFS ADK CYTD 16 vs. CYTD 17 = -1.38%**

# Annual Trends for BDK Annualized

Medicare Fee For Service and All Payer (CY 2013 through CY 2017 March)

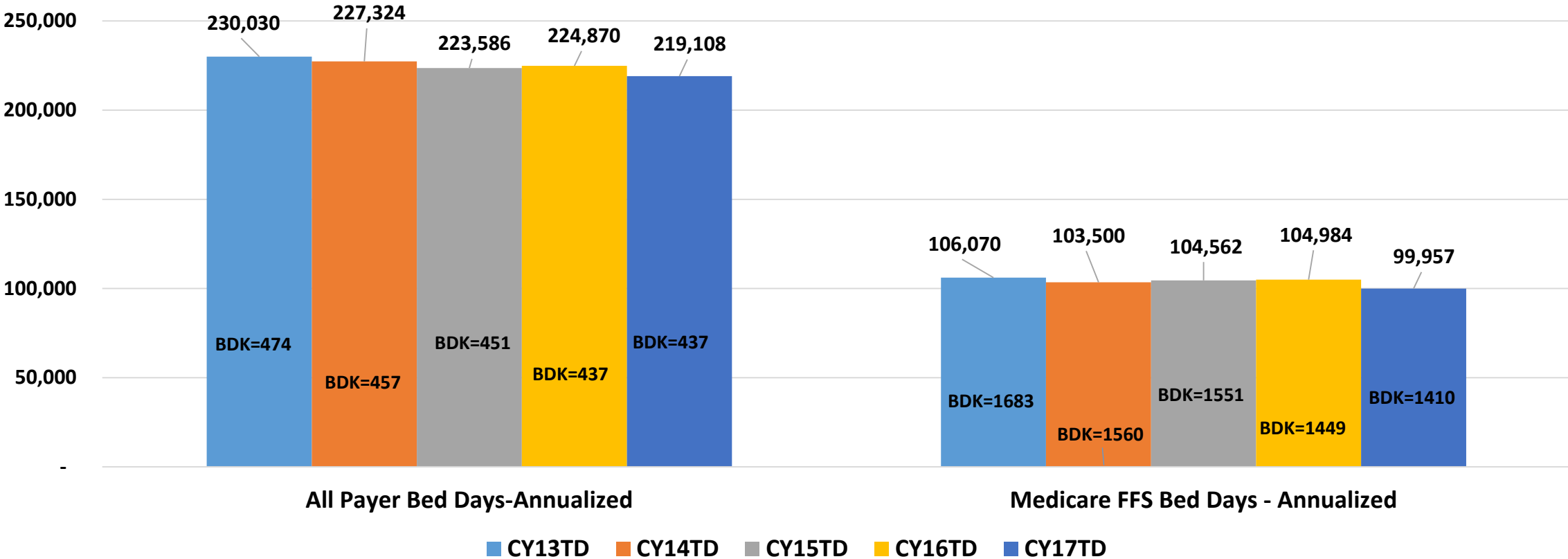


\*Note - The bed days do not include out of state migration or specialty psych and rehab hospitals.



# Actual Bed Days by Calendar YTD March

(CY 2013 through CY 2017)



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

# Change in Bed Days by Calendar YTD March

(CY 2013 through CY 2017)

---

**Change in All Payer Bed Days CYTD13 vs. CYTD14 = -1.18%**

**Change in All Payer Bed Days CYTD14 vs. CYTD15 = -1.64%**

**Change in All Payer Bed Days CYTD15 vs. CYTD16 = 0.57%**

**Change in All Payer Bed Days CYTD16 vs. CYTD17 = -2.56%**

**Change in BDK CYTD 13 vs. CYTD 14 = -3.60%**

**Change in BDK CYTD 14 vs. CYTD 15 = -1.19%**

**Change in BDK CYTD 15 vs. CYTD 16 = -3.17%**

**Change in BDK CYTD 16 vs. CYTD 17 = 0.06%**

**Change in Medicare FFS Bed Days CYTD13 vs. CYTD14 = -2.42%**

**Change in Medicare FFS Bed Days CYTD14 vs. CYTD15 = 1.03%**

**Change in Medicare FFS Bed Days CYTD15 vs. CYTD16 = 0.40%**

**Change in Medicare FFS Bed Days CYTD16 vs. CYTD17 = -4.79%**

**Change in Medicare FFS BDK CYTD 13 vs. CYTD 14 = -7.31%**

**Change in Medicare FFS BDK CYTD 14 vs. CYTD 15 = -0.61%**

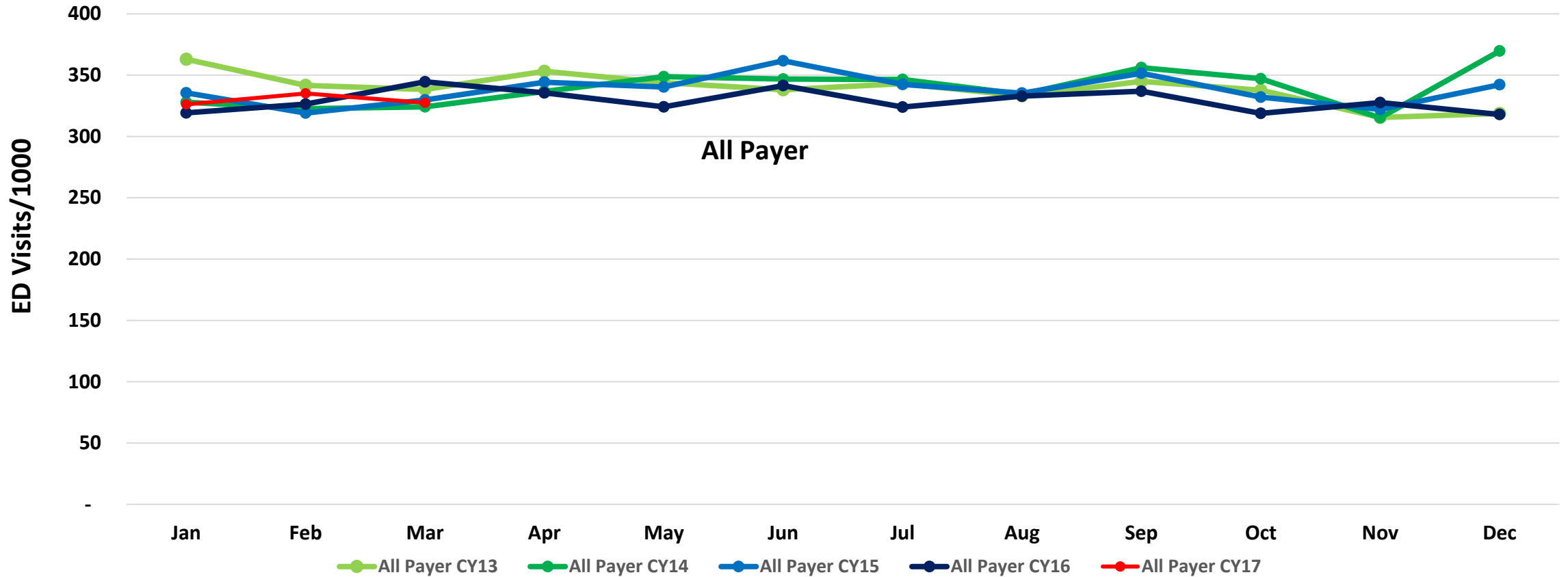
**Change in Medicare FFS BDK CYTD 15 vs. CYTD 16 = -6.58%**

**Change in Medicare FFS BDK CYTD 16 vs. CYTD 17 = -2.69%**



# Annual Trends for EDK Annualized All Payer

(CY 2013 through CY2017 March)

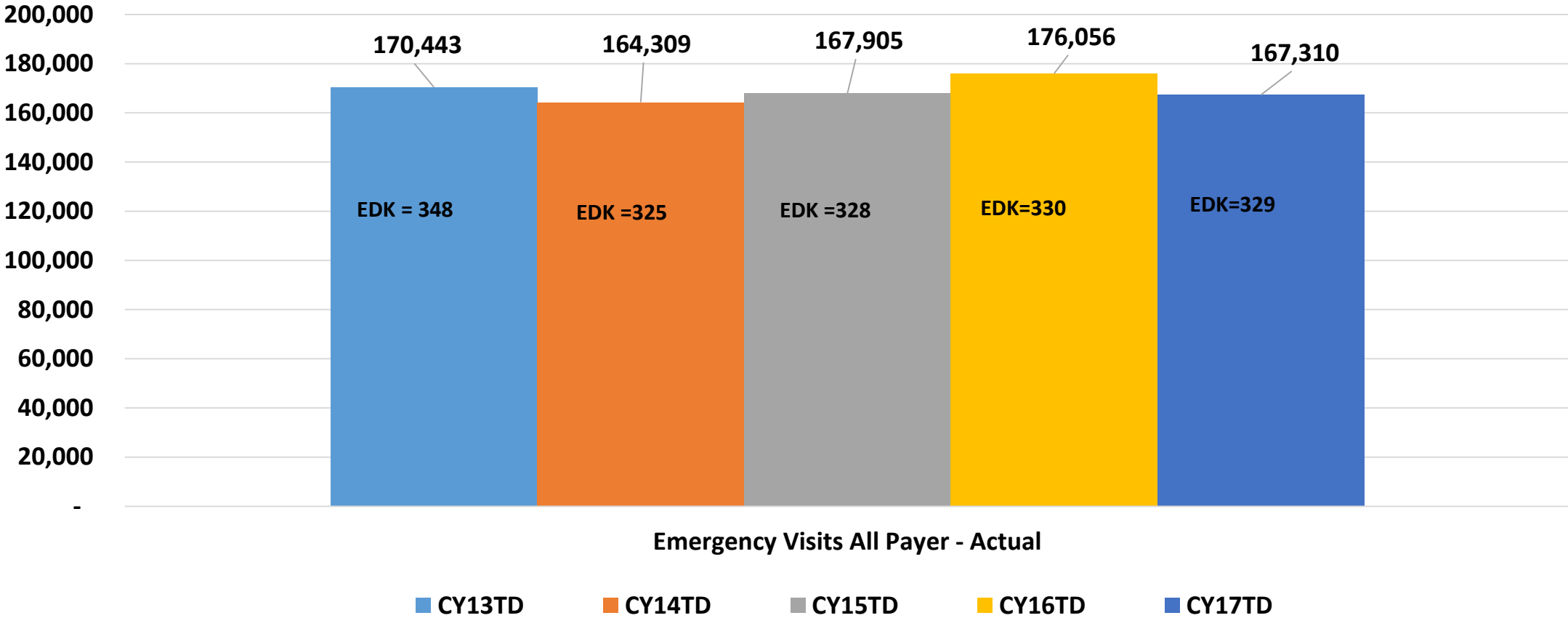


\*Note - The ED Visits do not include out of state migration or specialty psych and rehab hospitals.



# Actual Emergency Department Visits by Calendar YTD March

(CY 2013 through CY 2017)



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

# Change in ED Visits by Calendar YTD March

(CY 2013 through CY 2017)

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**Change in ED Visits CYTD 13 vs. CYTD 14 = -3.60%**

**Change in ED Visits CYTD 14 vs. CYTD 15 = 2.19%**

**Change in ED Visits CYTD 15 vs. CYTD 16 = 4.85%**

**Change in ED Visits CYTD 16 vs. CYTD 17 = -4.97%**

**Change in EDK CYTD 13 vs. CYTD 14 = -6.57%**

**Change in EDK CYTD 14 vs. CYTD 15 = 1.06%**

**Change in EDK CYTD 15 vs. CYTD 16 = 0.51%**

**Change in EDK CYTD 16 vs. CYTD 17 = -0.22%**



# Purpose of Monitoring Maryland Performance

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

**All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita

- 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of \$330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets



# Data Caveats

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- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 and Fiscal 2016 rely on Maryland Department of Planning projections of population growth of .52% for FY 16 and .52% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

# Data Caveats cont.

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



# Monitoring Maryland Performance Preliminary Utilization Trends

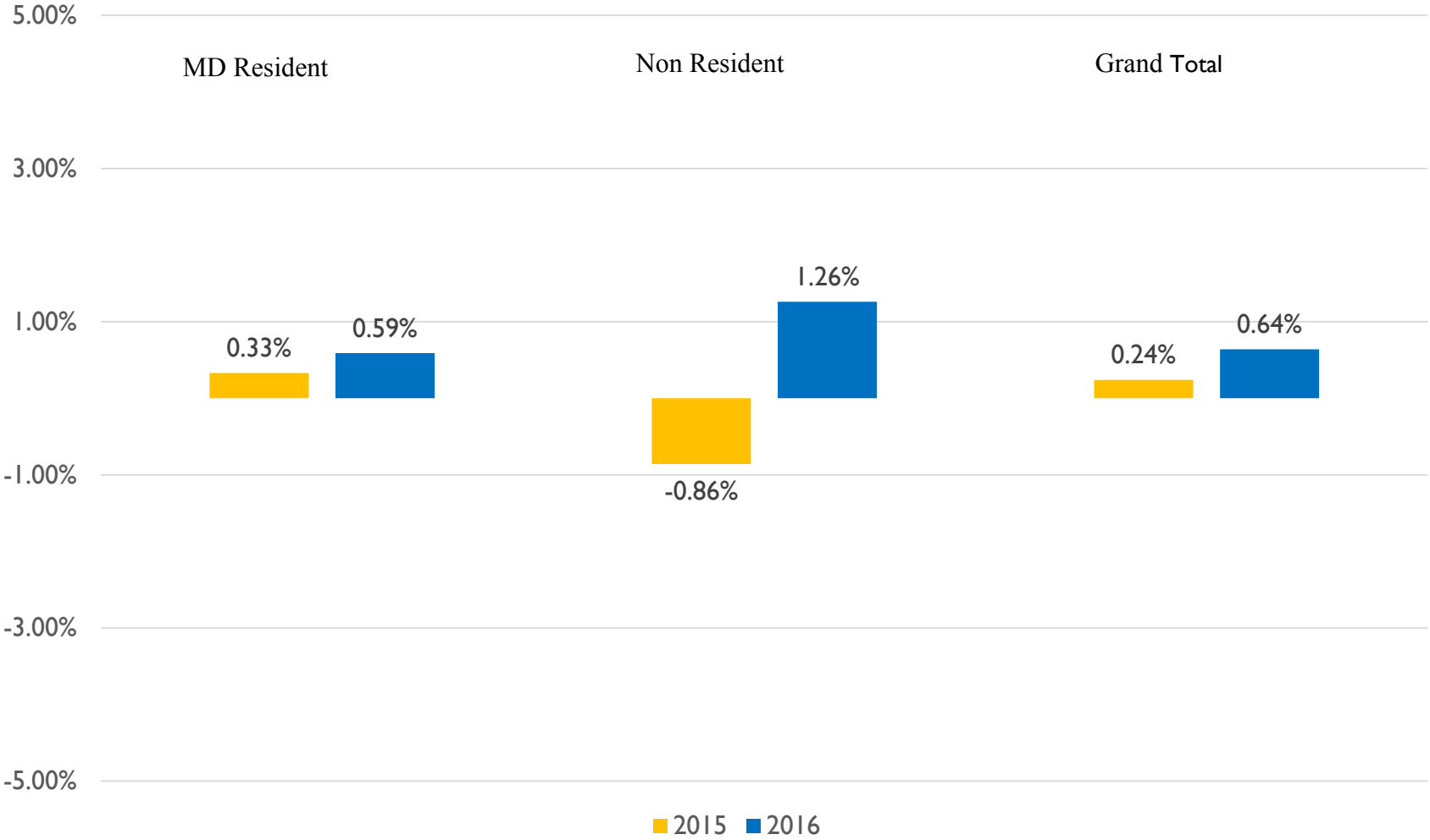
2016 vs 2015  
(January to December)



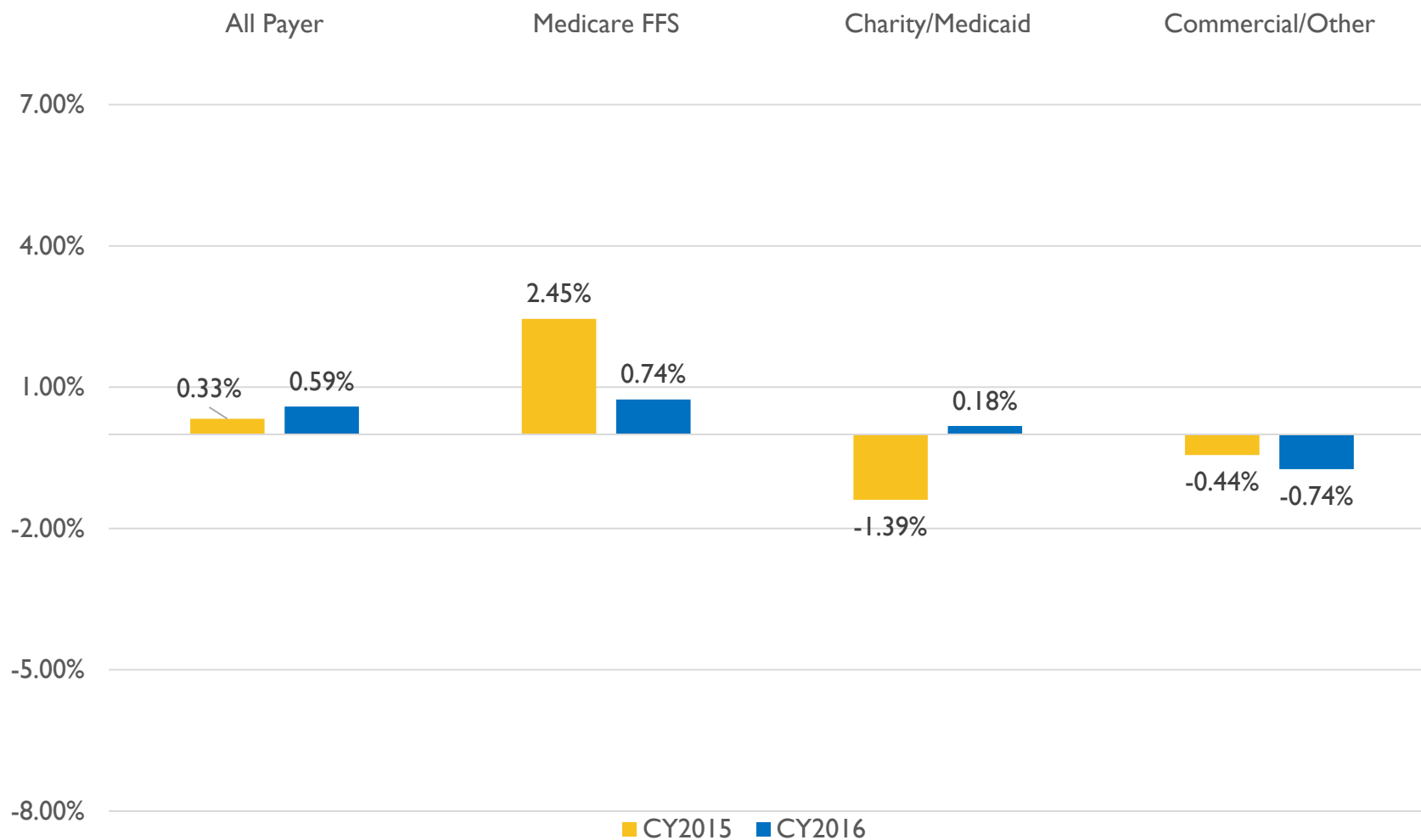
**HSCRC**

Health Services Cost  
Review Commission

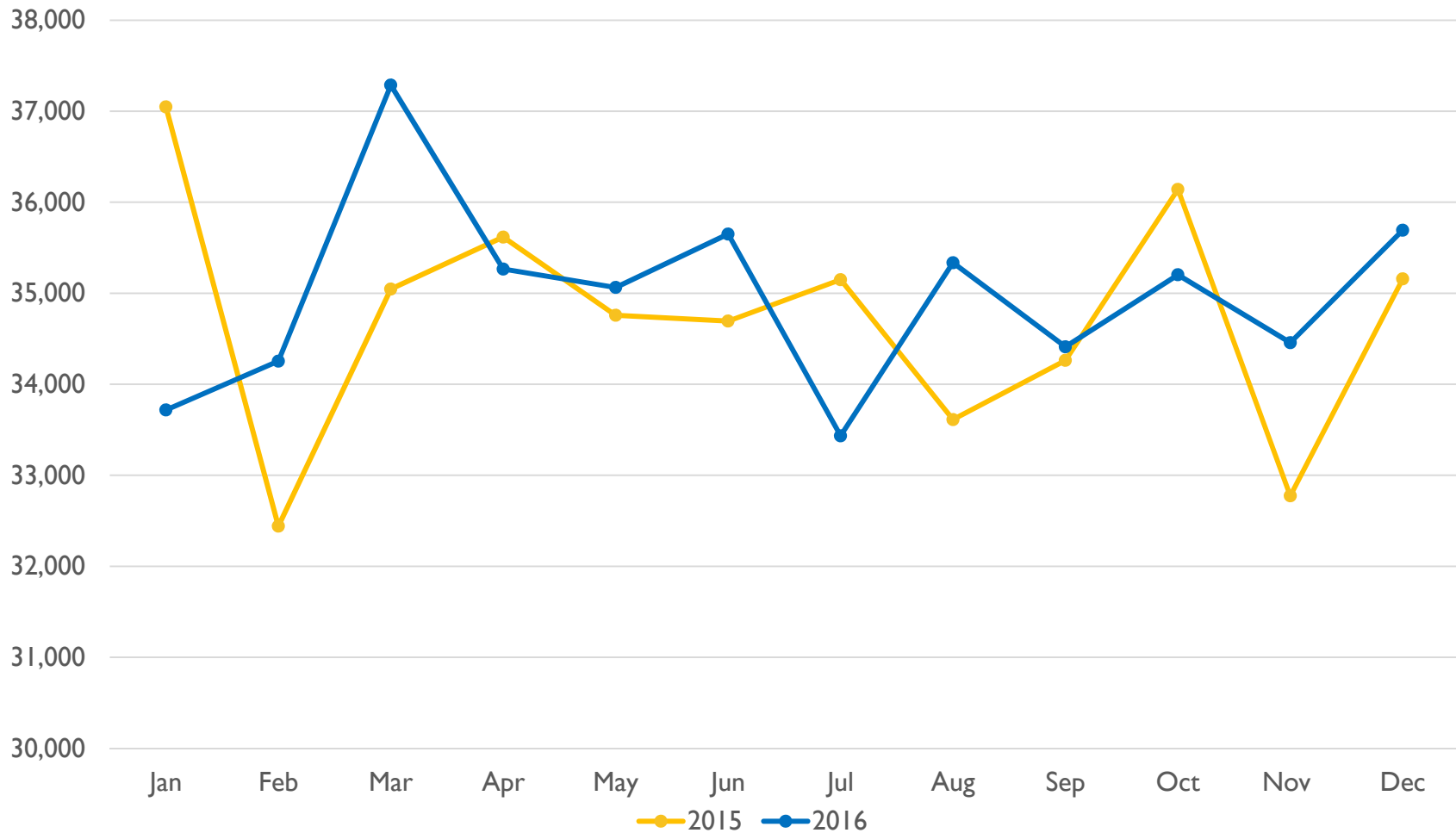
# All Payer ECMAD CYTD Annual Growth



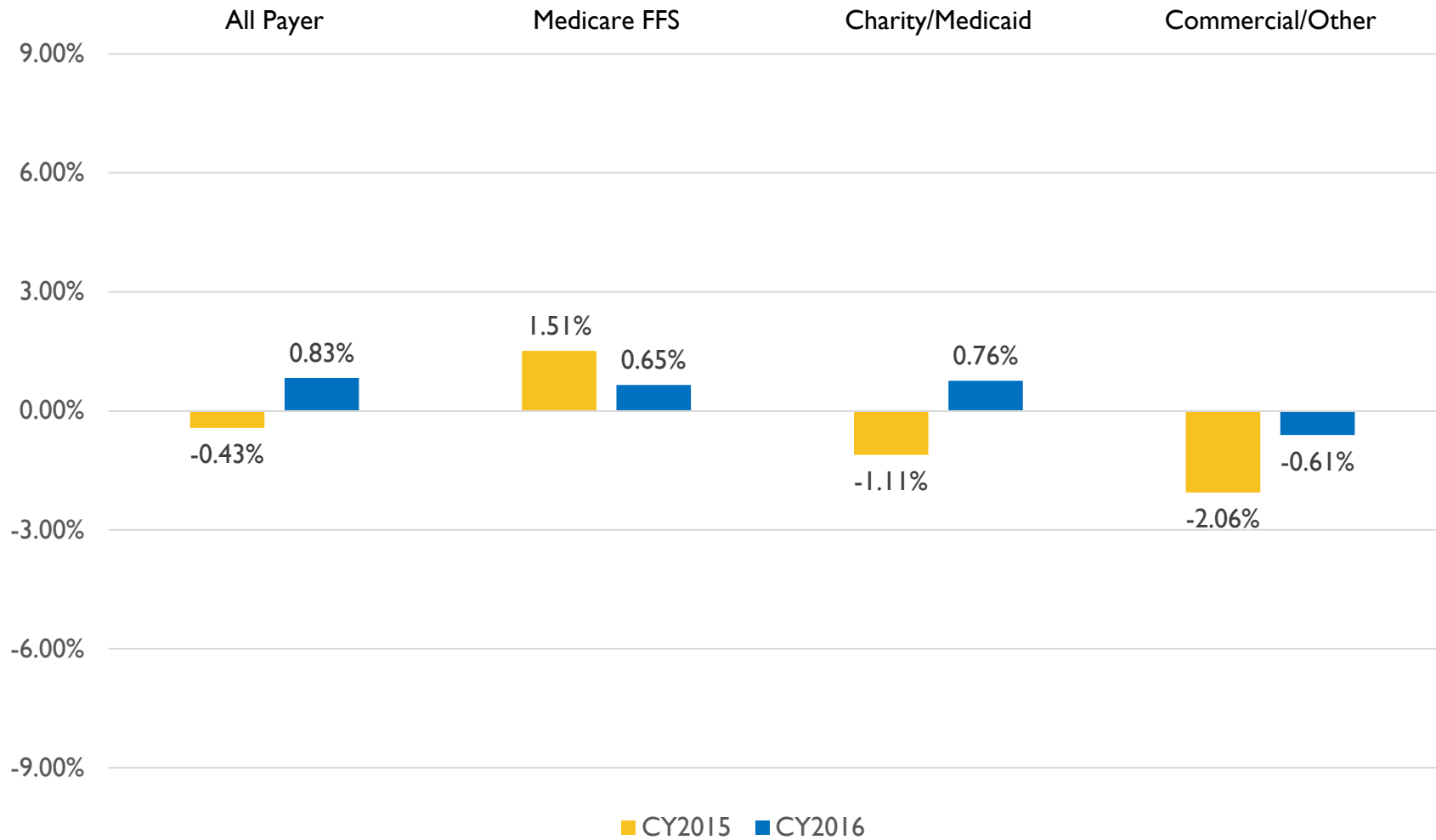
## MD Resident ECMAD CYTD Annual Growth



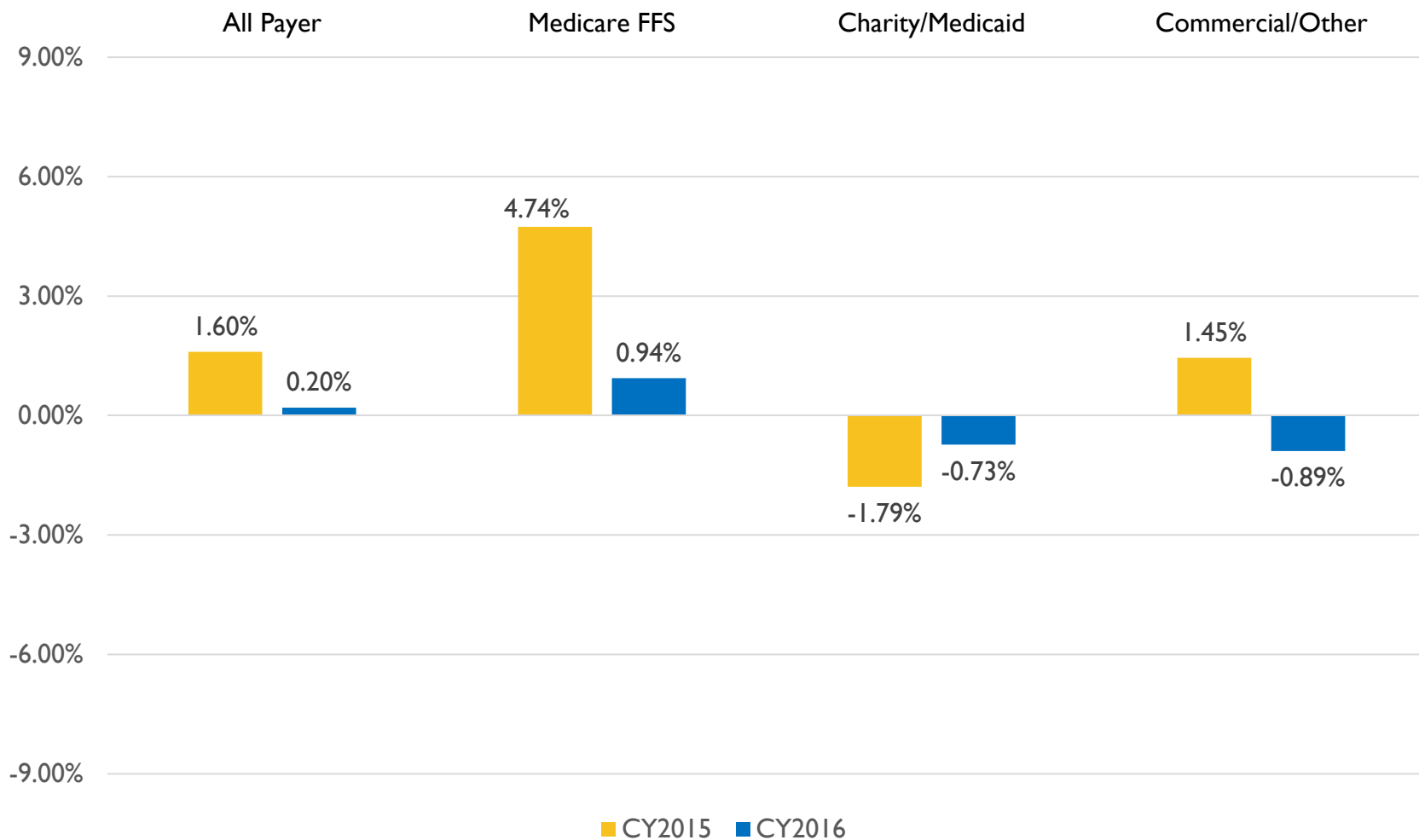
## Medicare MD Resident ECMAD Annual Growth by Month



# MD Resident Inpatient ECMAD CYTD Annual Growth



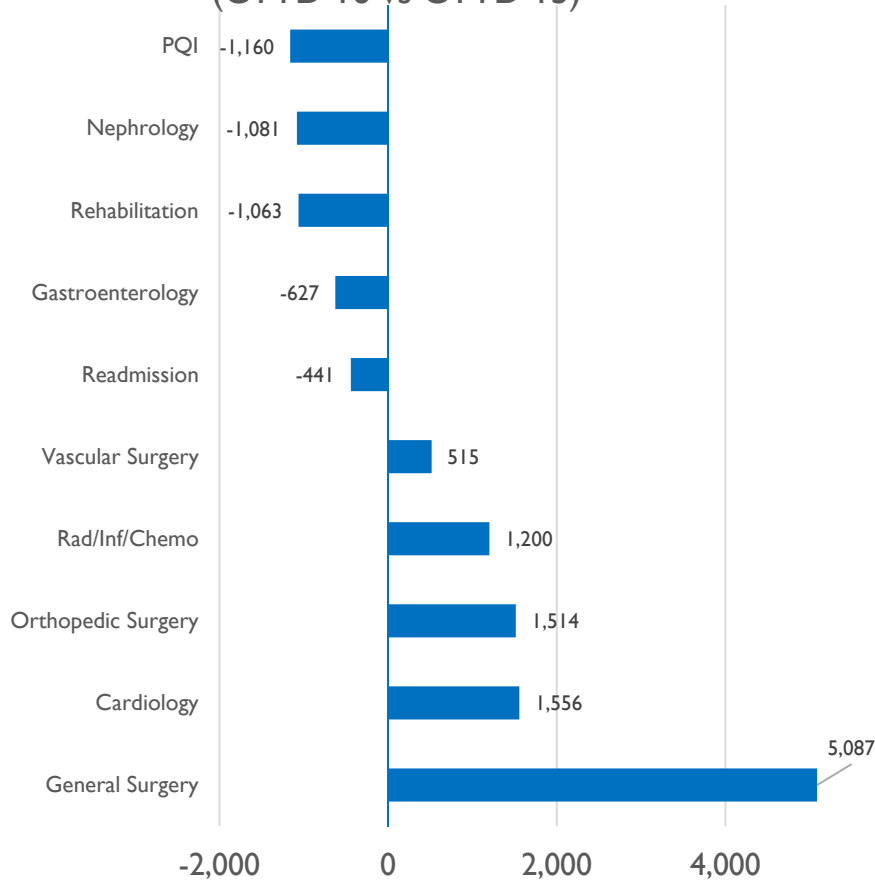
## MD Resident Outpatient ECMAD CYTD Annual Growth



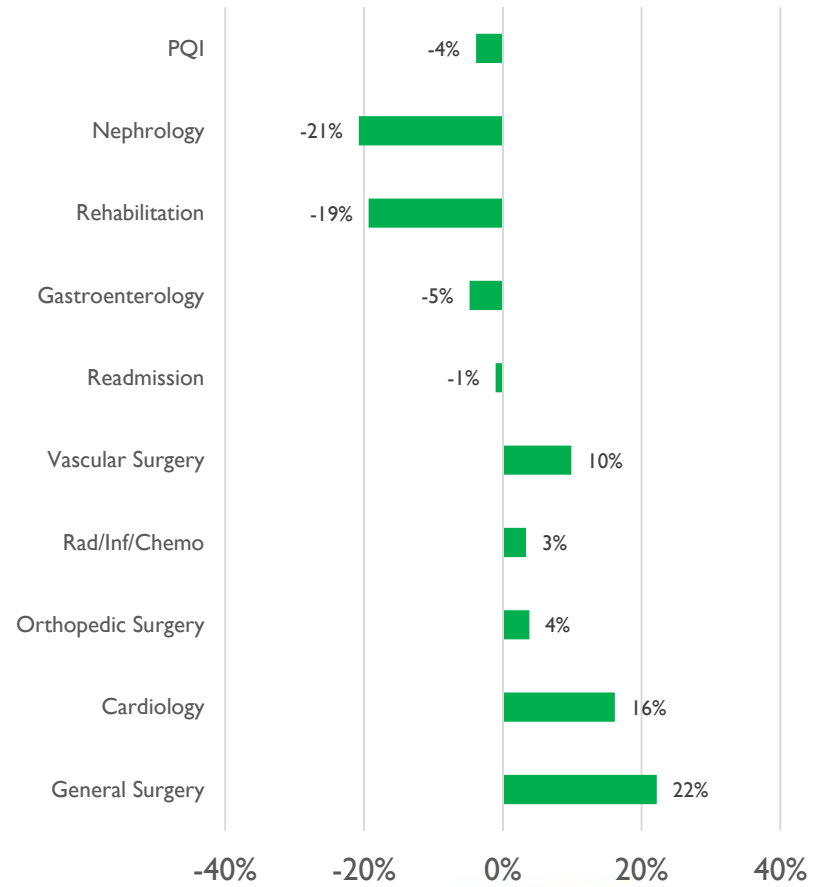


# Medicare MD Resident Top 5 Service Line Changes (Total ECMAD Increase = 3,071)

Medicare Resident Top 5 Service Lines  
Changes  
(CYTD 16 vs CYTD 15)



Medicare Resident Top 5 Service Lines  
% Changes (CYTD 16 vs CYTD 15)



Note: General Surgery surge due to transition from ICD 9 to ICD 10 Coding

# Utilization Analytics – Data Notes

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- Utilization as measured by Equivalent Case-mix Adjusted Discharges (ECMAD)
  - 1 ECMAD Inpatient discharge=1 ECMAD Outpatient Visit
- Observation stays with more than 23 hour are included in the inpatient counts
  - $IP = IP + \text{Observation cases } >23 \text{ hrs.}$
  - $OP = OP - \text{Observation cases } >23 \text{ hrs.}$
- Preliminary data, not yet reconciled with financial data
- Careful review of outpatient service line trends is needed

# Service Line Definitions

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- ▶ **Inpatient service lines:**

- ▶ APR DRG (All Patient Refined Diagnostic Related Groups) to service line mapping
- ▶ Readmissions and PQIs (Prevention Quality Indicators) are top level service lines (include different service lines)

- ▶ **Outpatient service lines:**

- ▶ Highest EAPG (Enhanced Ambulatory Patient Grouping System) to service line mapping
- ▶ Hierarchical classifications (Emergency Department, major surgery etc)

- ▶ **Market Shift technical documentation**

# GBMC HealthCare System

Greater Baltimore Medical Center  
HSGRC Discussion #2  
DRAFT #3

## Population Health Update to the Health Services Cost Review Commission

May 10, 2017

GBMC

*“To every patient, every time, we will provide the care that we would want for our own loved ones”*

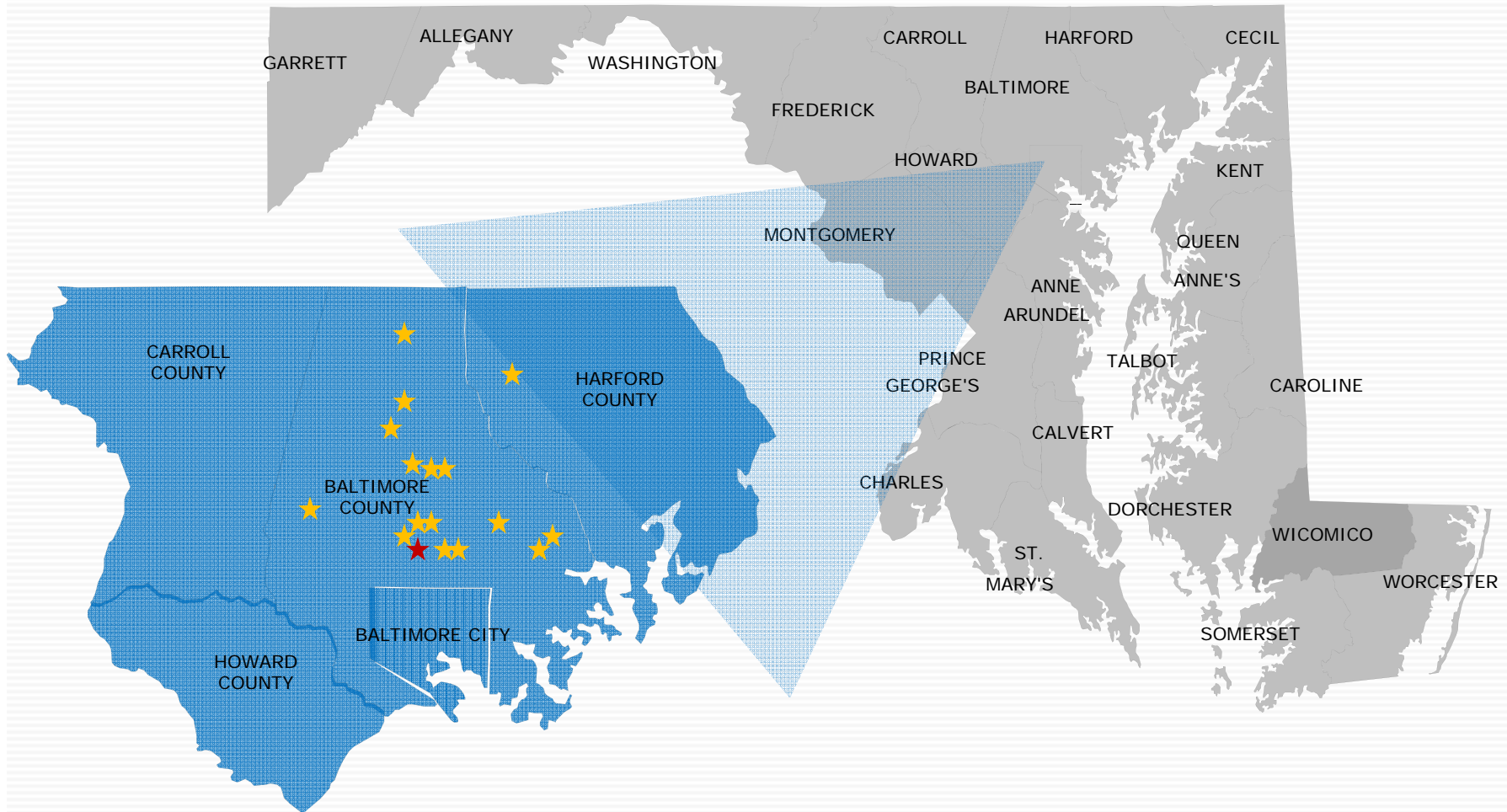
# The GBMC HealthCare System

- **Greater Baltimore Health Alliance (GBHA)**
  - Private practicing physicians
  - Greater Baltimore Medical Associates (GBMA)
- **GBMC Medical Center**
- **Gilchrist**
  - Hospice: 800 patients/day
  - Eldercare: including palliative care

*“To every patient, every time, we will provide the care that we would want for our own loved ones.”*

**GBMC**

# GBMC HealthCare System



*"To every patient, every time, we will provide the care that we would want for our own loved ones."*

**GBMC**

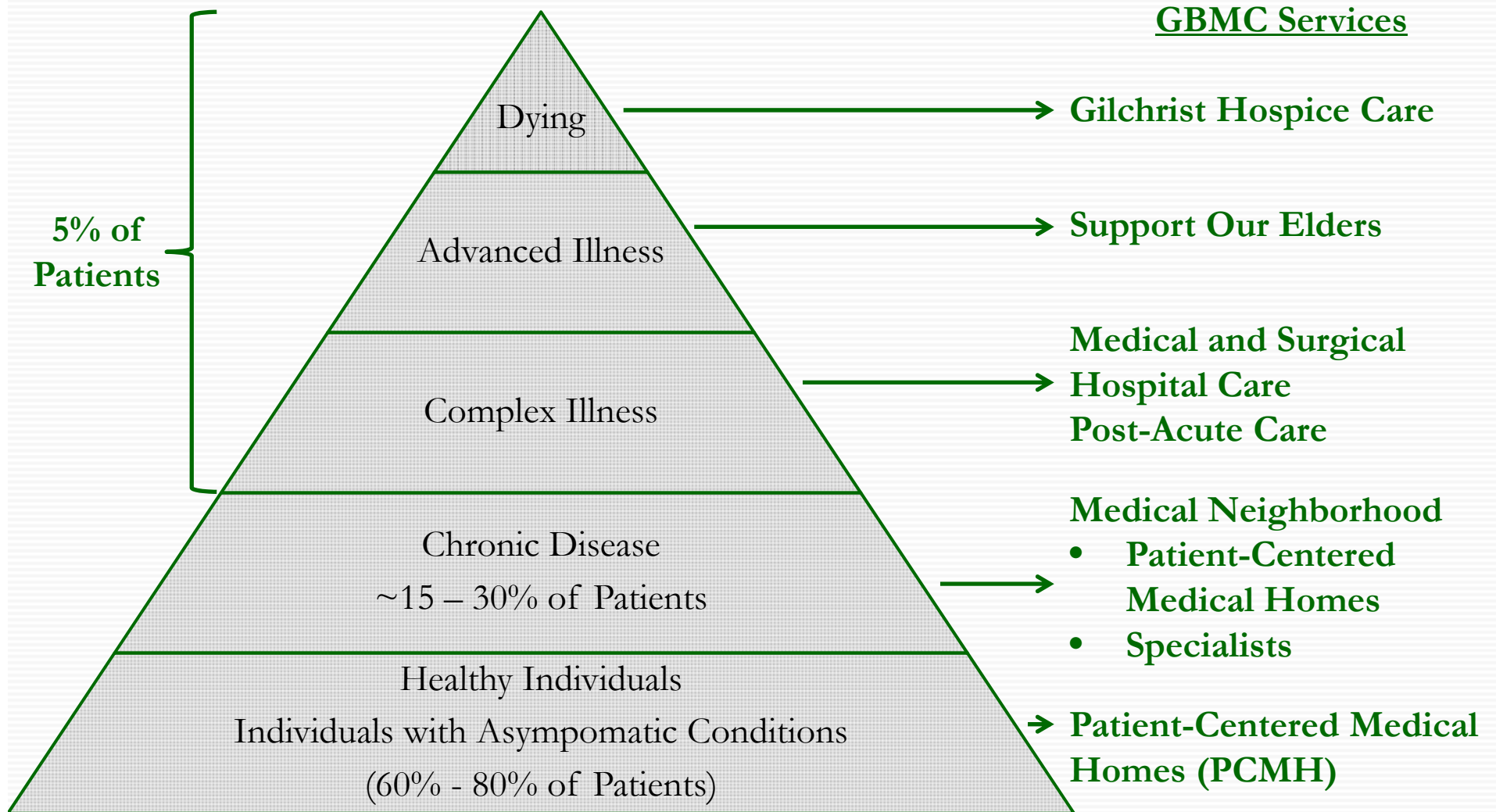
# GBMC and Population Health

- Board Visioning Retreat 2010
  - Create a true system to drive the three-part aim (**better health and better care at lower cost**)
- Since FY2012 we have invested more than \$70.5 million in population health
  - Primary Care centered
    - Patient-Centered Medical Homes (12)
    - Accountable Care Organization (ACO) in FY2012
  - Hospital centered
    - Expansion of networks for home health and post acute services

*“To every patient, every time, we will provide the care that we would want for our own loved ones.”*

GBMC

# GBMC's Systematic Approach to Caring for a Population of Patients



*“To every patient, every time, we will provide the care that we would want for our own loved ones.”*

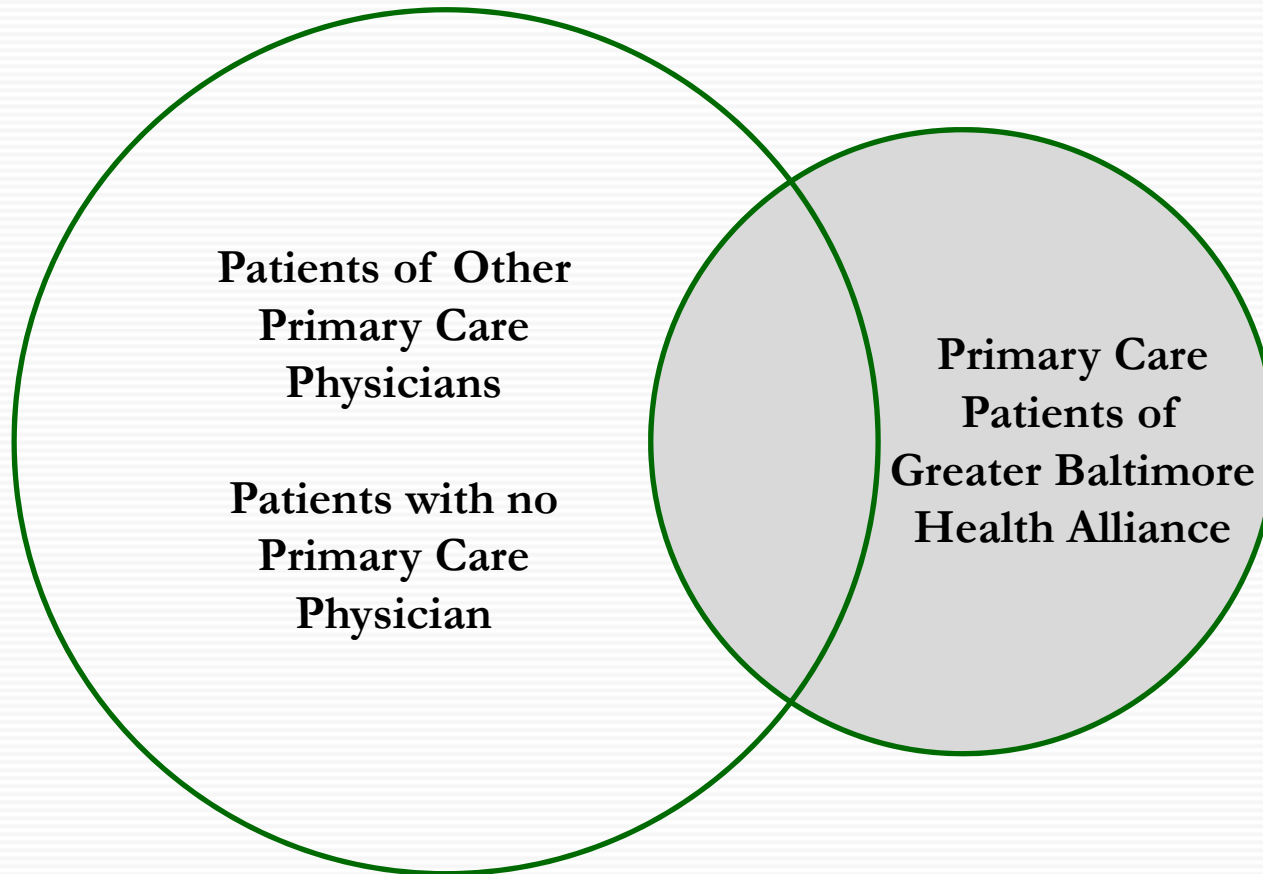
**GBMC**



# GBMC's Two Foci of Care Management

## 1. Hospital Based

## 2. Primary Care Based



*“To every patient, every time, we will provide the care that we would want for our own loved ones.”*

**GBMC**

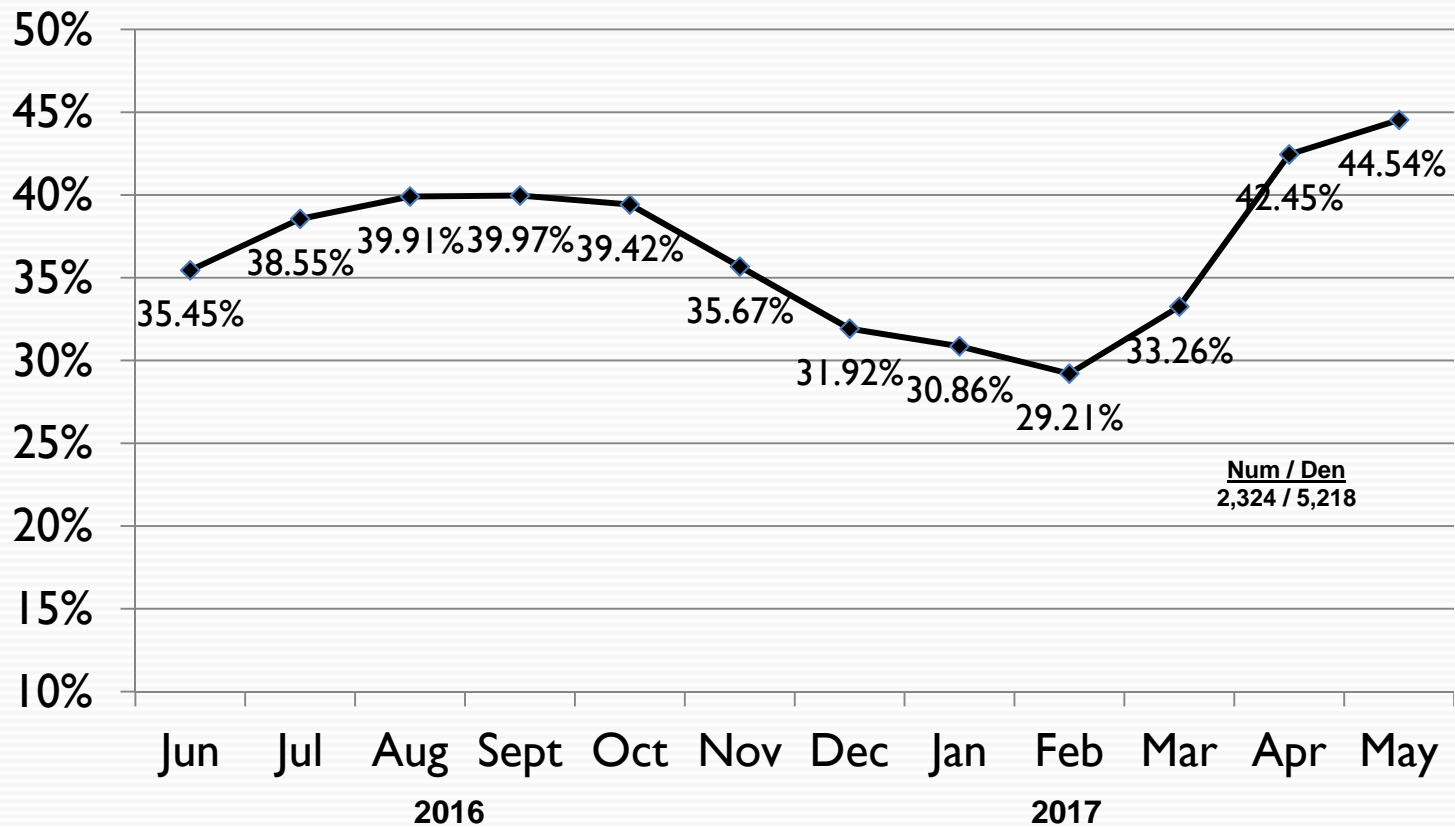
# Advanced Primary Care: The Patient Centered Medical Home

- It is not about visits...it is about accountability for better health and better care at lower cost
- Expanded hours of operation: 7AM to 7PM or 9 PM; Saturdays, Sundays and Holidays
  - We don't believe in urgent care – we do it in primary care
- Embedded nurse care managers and care coordinators who work with the physicians and use disease-state registries
- *Embedded psychiatrists, behavioral specialists, and substance abuse providers....thank you!*
- Daily downloads from CRISP
- Connecting to non-employed specialists through CRISP

*“To every patient, every time, we will provide the care that we would want for our own loved ones.”*

GBMC

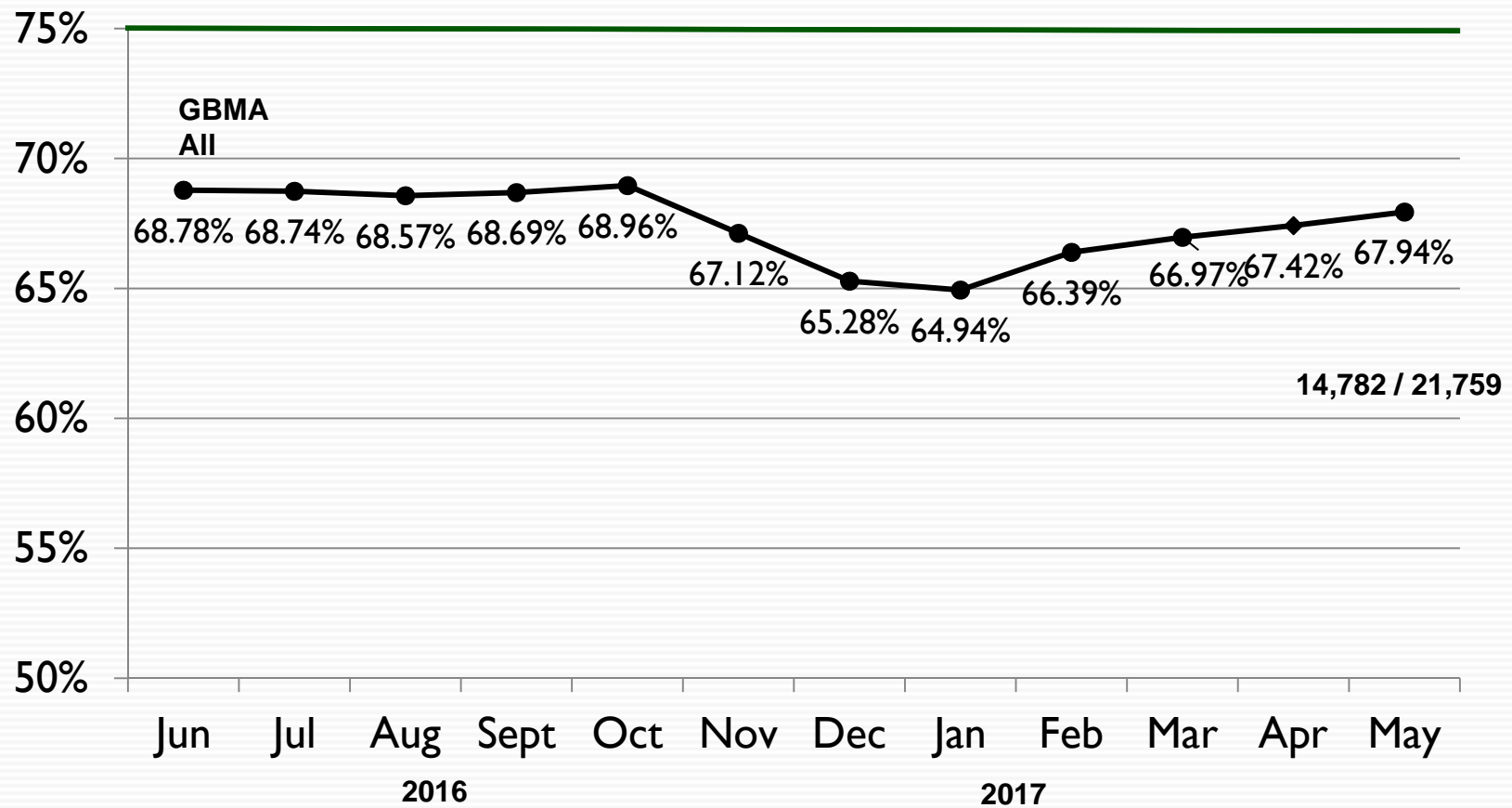
# Evidence-Based Diabetic Eye Exam



*“To every patient, every time, we will provide the care that we would want for our own loved ones.”*

GBMC

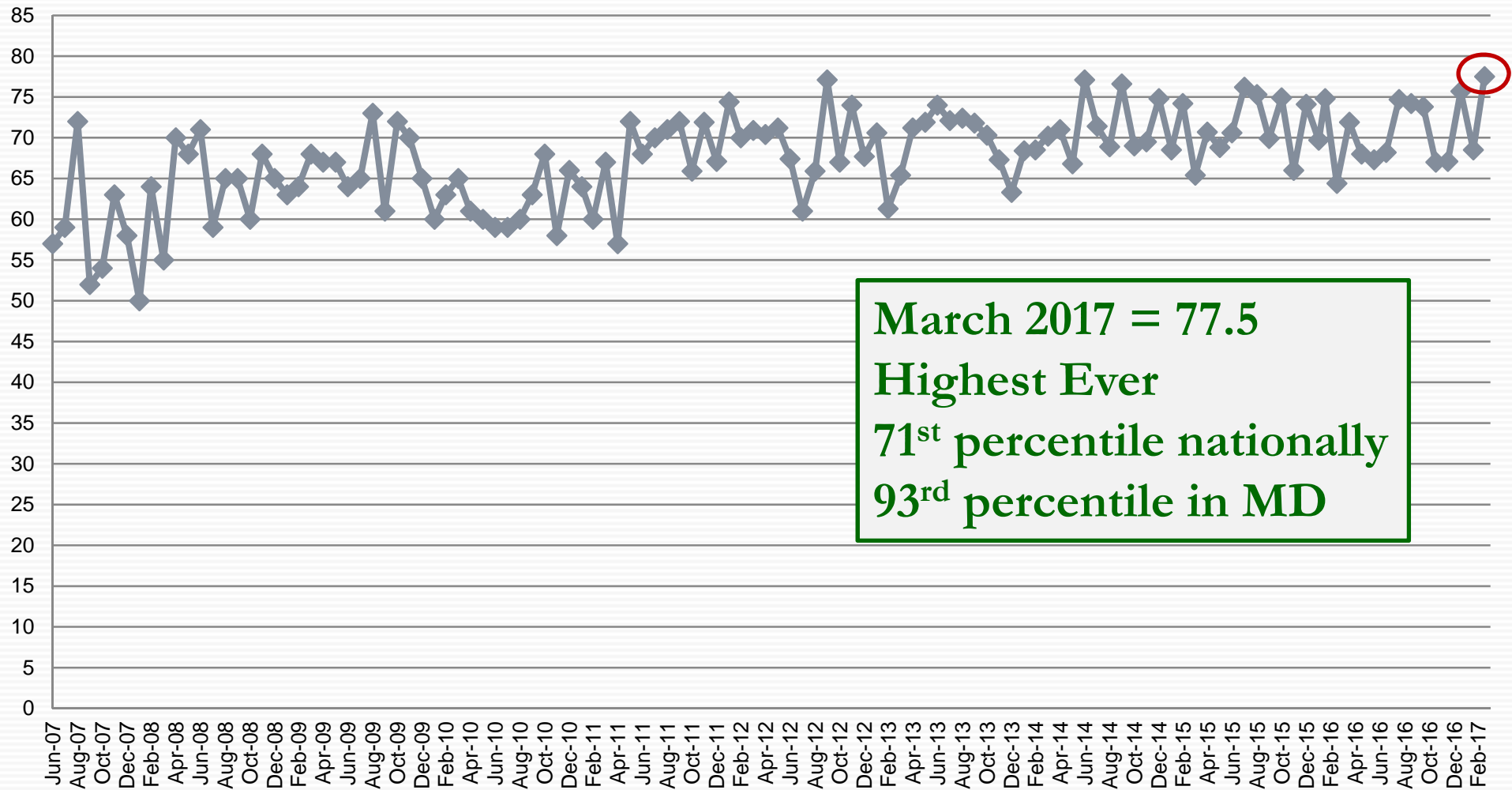
# Evidence-Based Colon Cancer Screening



*“To every patient, every time, we will provide the care that we would want for our own loved ones.”*

GBMC

# Monthly Overall Inpatient HCAHPs



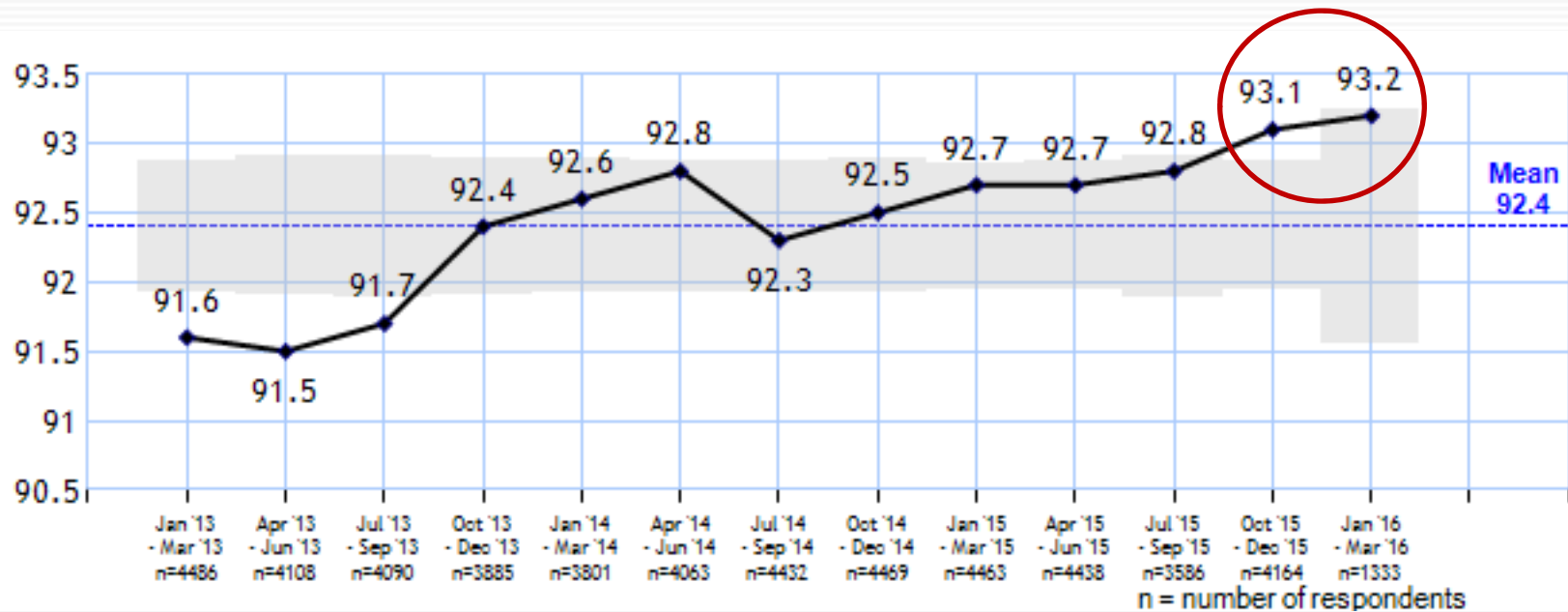
**March 2017 = 77.5**  
**Highest Ever**  
**71<sup>st</sup> percentile nationally**  
**93<sup>rd</sup> percentile in MD**

*“To every patient, every time, we will provide the care that we would want for our own loved ones.”*

**GBMC**

# GBMA – Overall Satisfaction Score

## 85<sup>th</sup> National Percentile



All My Sites



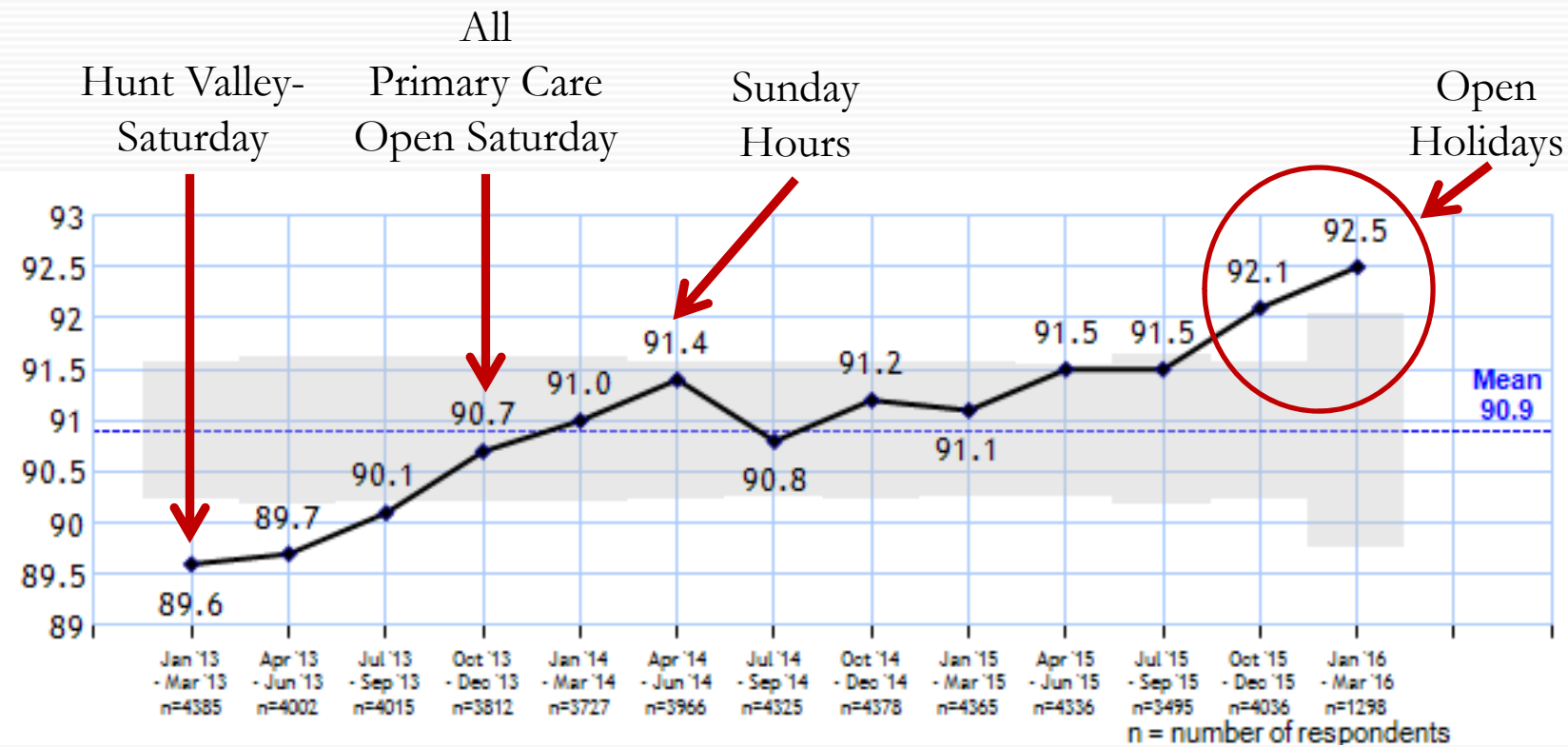
Higher is Better



GBMC

# GBMA – Convenience of our Office Hours

## 92<sup>nd</sup> National Percentile

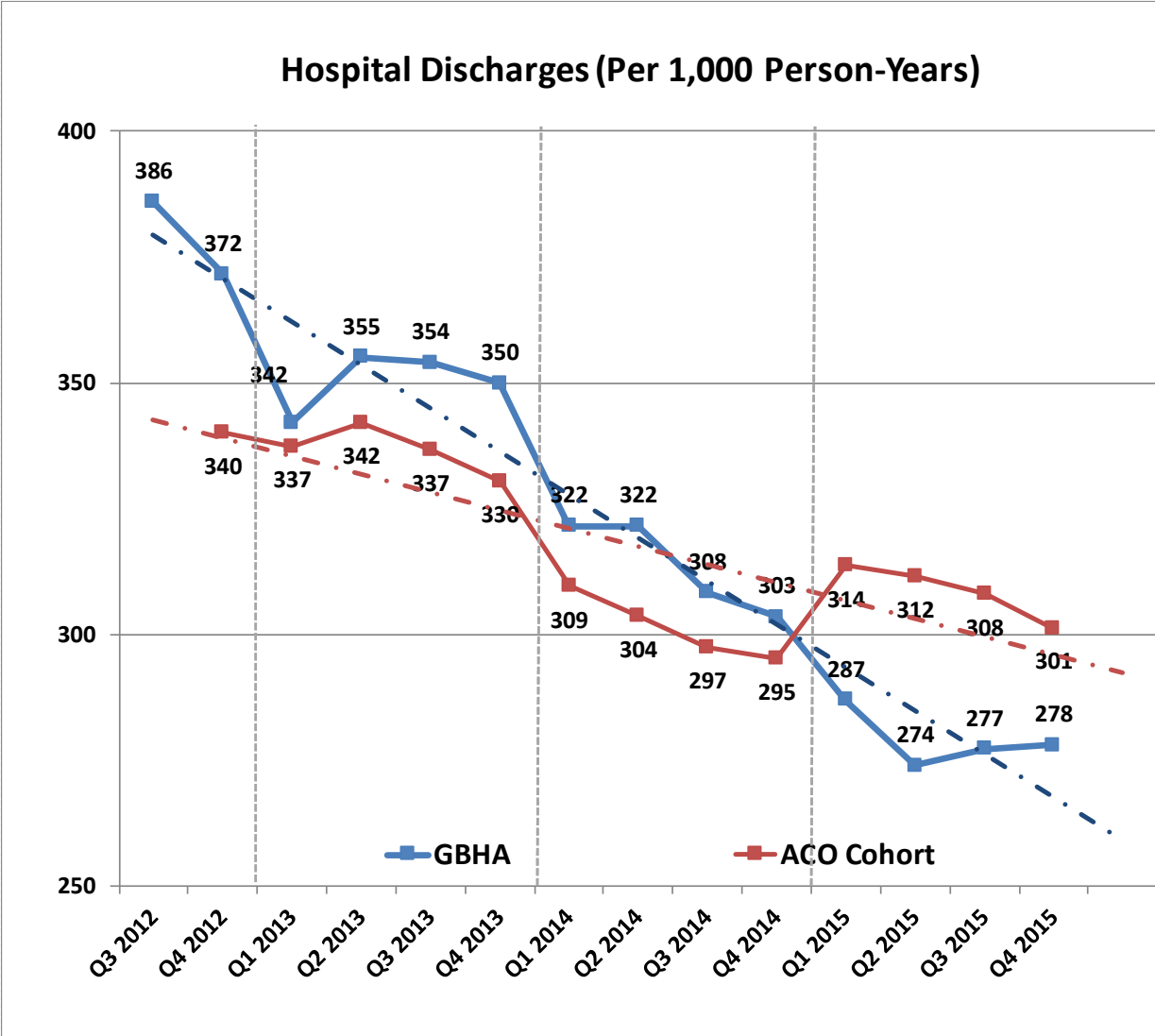


Higher is Better

GBMC

# MSSP Expenditures/Utilization – Trends

**Hospital Discharges**  
 GBHA – 27.98% Decrease ( $\Delta$  108)  
 ACO Cohort – 11.39% Decrease ( $\Delta$  39)



GREATER BALTIMORE  
 HEALTH ALLIANCE

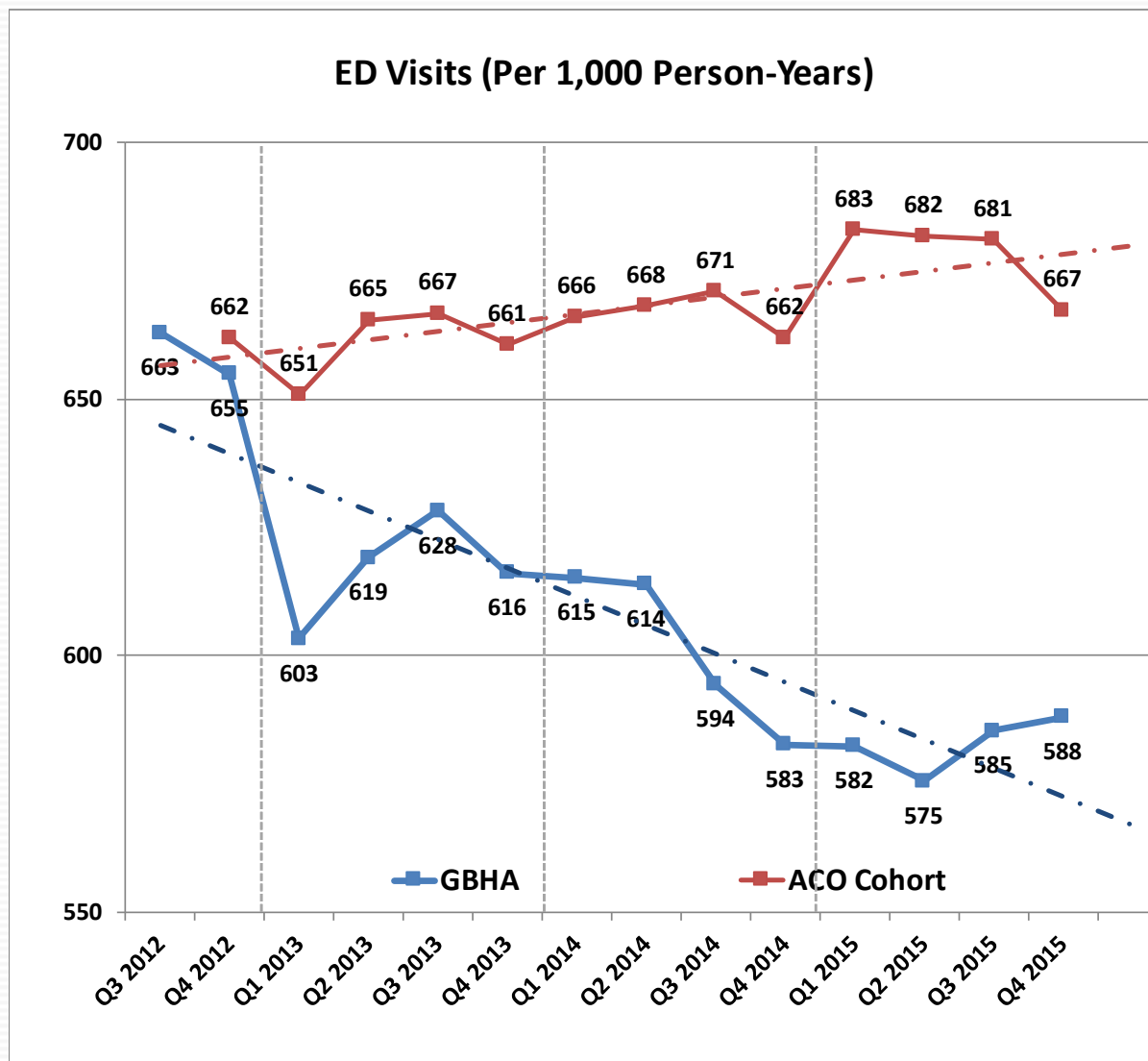
*“To every patient, every time, we will provide the care that we would want for our own loved ones.”*

GBMC



# MSSP Expenditures/Utilization – Trends

**ED Visits**  
 GBHA –11.30% Decrease ( $\Delta$  75)  
 ACO Cohort – 0.83% Increase ( $\Delta$  6)



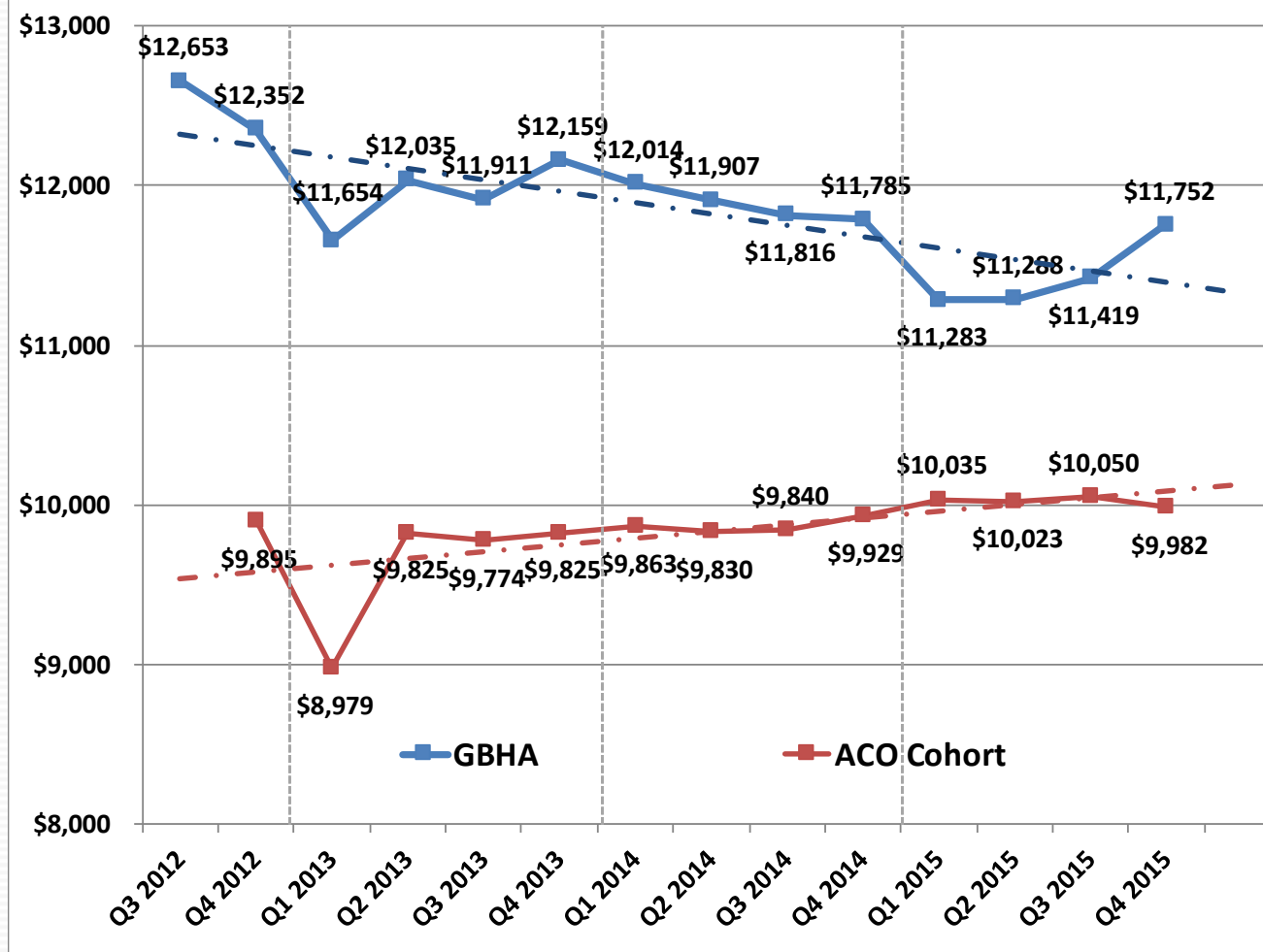
GREATER BALTIMORE  
 HEALTH ALLIANCE

*“To every patient, every time, we will provide the care that we would want for our own loved ones.”*

GBMC

# MSSP Expenditures/Utilization – Trends

Total Expenditures Per Assigned Beneficiary (Annual)



**Total Expenditures**  
 GBHA – 7.12% Decrease (Δ \$901)  
 ACO Cohort – 0.88% Increase (Δ \$87)

GREATER BALTIMORE  
 HEALTH ALLIANCE

*“To every patient, every time, we will provide the care that we would want for our own loved ones.”*



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# Readmission Reduction Analysis

May 2017

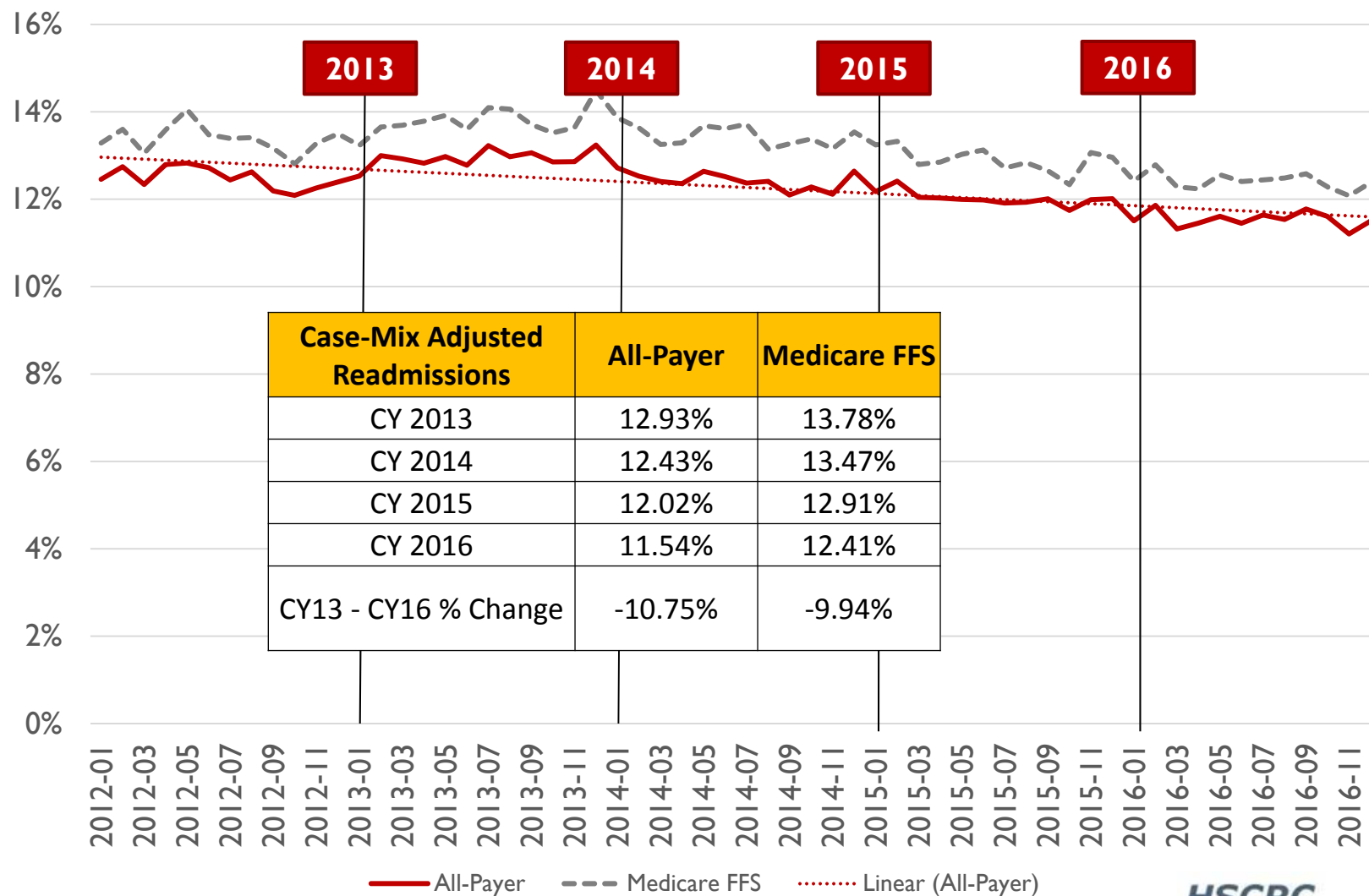
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**HSCRC**

Health Services Cost  
Review Commission

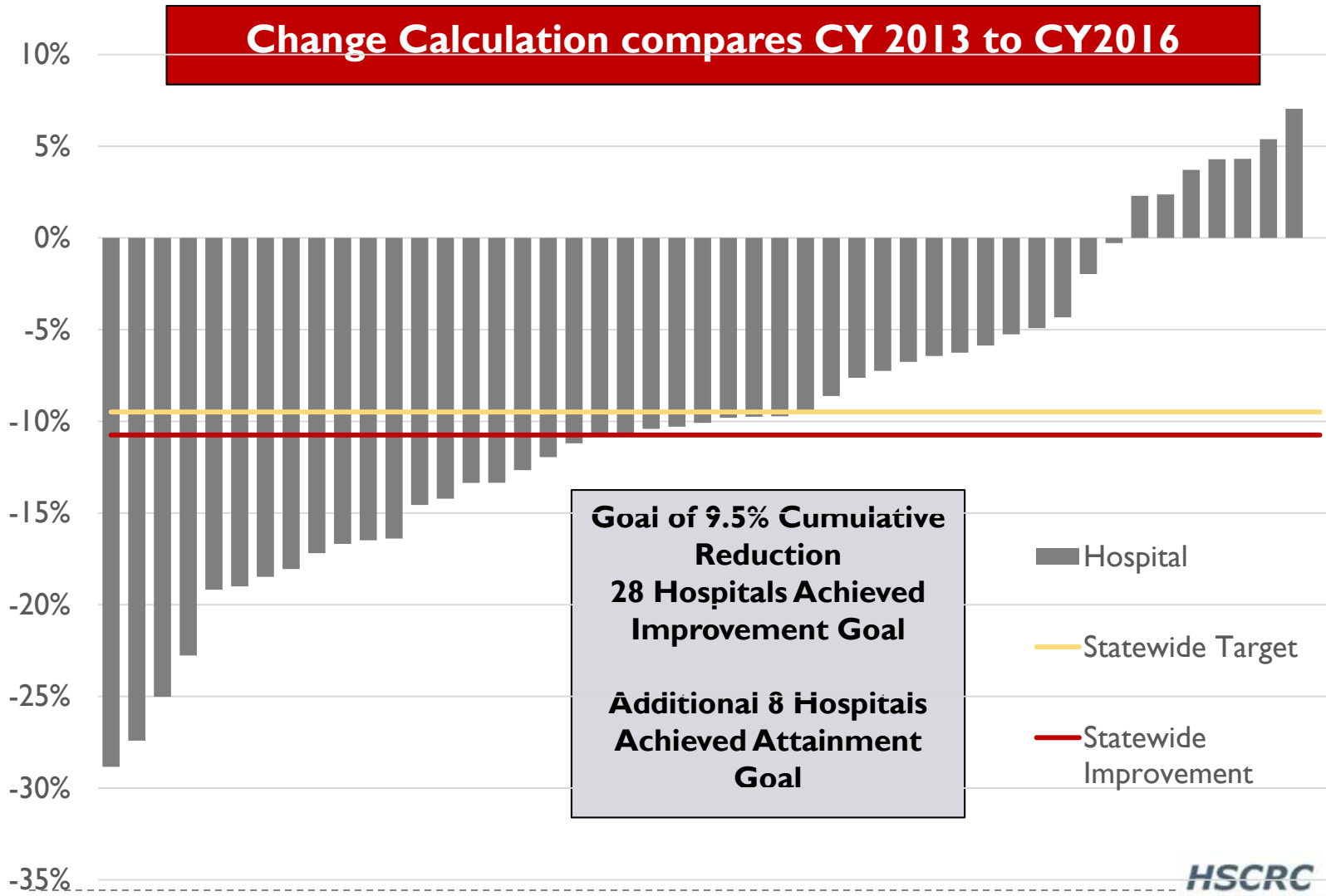
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# Monthly Case-Mix Adjusted Readmission Rates



2 Note: Based on final data for January 2012 – December 2016

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



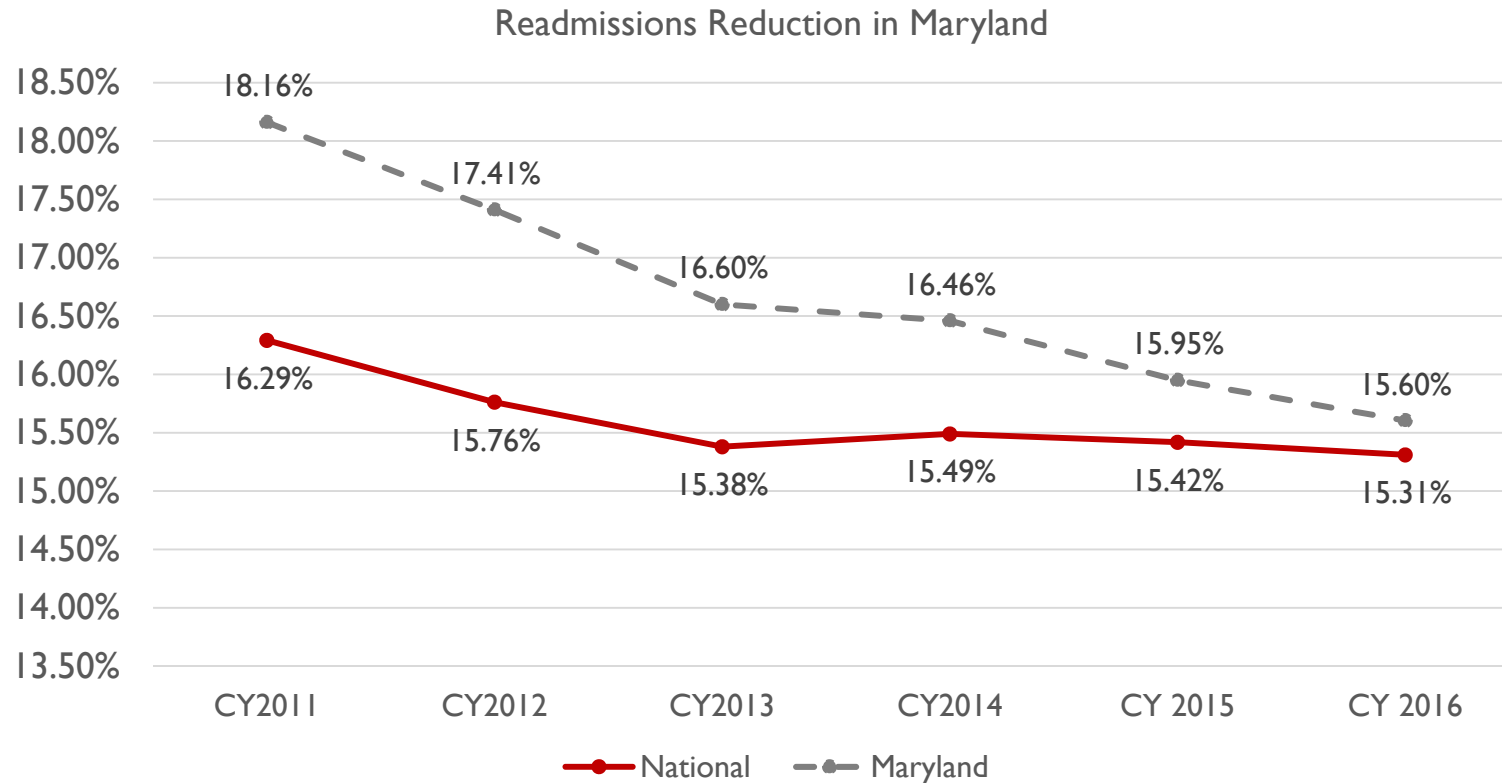
▶ 3 Note: Based on final data for January 2012 – December 2016.

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# Final RY 2019 RRIP Policy

# Medicare Test: At or below National Medicare Readmission Rate by CY 2018

Maryland is reducing readmission rate faster than the nation. Maryland reduced the gap from 1.22 percentage points in the base year to 0.29 percentage points in CY 2016. Our target for the gap for CY 2016 was a 0.49 percentage point difference.



# RRIP proposal for RY 2019

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- ▶ Continue to measure hospitals on the better of improvement or attainment
  - ▶ Use RY 2018 methodology to calculate updated Attainment Target
  - ▶ Continue to adjust readmission rate using Out-of-State readmission ratios calculated from Medicare data
- ▶ Update the policy to calculate improvement CY 2016 to CY 2017
  - ▶ Annual target ensures base and performance run under ICD-10
  - ▶ Add this improvement to CY 2013 to CY 2016 improvement (i.e., RY 2018 improvement) to calculate a **modified cumulative improvement rate**



# Steps for Calculating Improvement Target

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- ▶ Estimate National Medicare FFS Improvement for CY 2017 and CY 2018
  - ▶ Modeled 0.71% (actual CY 2015 to CY 2016 improvement), 1%, and 1.5%
- ▶ Calculate necessary Maryland Medicare FFS readmission rate to correspond with projected National Medicare readmission rate
  - ▶ CY 2017 target gap between MD and Nation is 0.15 percentage points
- ▶ Convert Maryland unadjusted Medicare FFS improvement to a case-mix adjusted All-Payer improvement
  - ▶ Multiple methods for this conversion were tested; with 1% national improvement trend these methods resulted in case-mix adjusted all-payer improvement targets ranging from 3.15% to 6.65%.

**In this final recommendation, staff is proposing a 3.75% annual improvement target. This annual target is added to the actual statewide CY 2013 to CY 2016 improvement (10.75%) to get a 14.5% modified cumulative improvement target.**

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# RY 2019 Proposed Revenue Adjustment Scales

## ▶ Improvement Scale

All Payer Readmission Rate Change CY13-CY17	Over/Under Target	RRIP % Inpatient Revenue Payment Adjustment
A	B	C
LOWER		1.0%
-25.0%	-10.5%	1.0%
-19.8%	-5.3%	0.5%
<b>-14.5%</b>	<b>0.0%</b>	<b>0.0%</b>
-9.2%	5.3%	-0.5%
-4.0%	10.5%	-1.0%
1.3%	15.8%	-1.5%
6.5%	21.0%	-2.0%
Higher		-2.0%

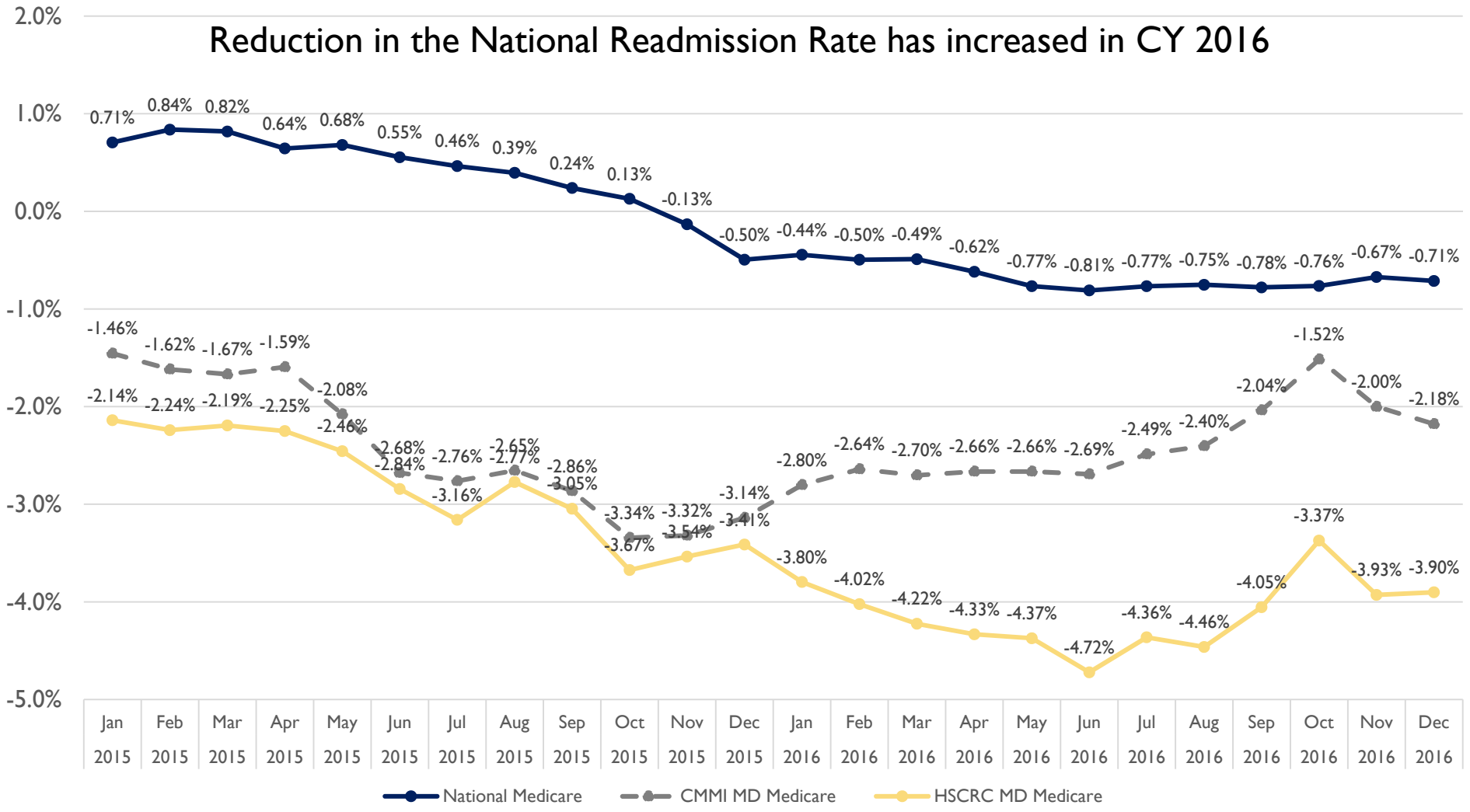
- ▶ The improvement scale uses the slope of the RY 2018 scaling, adjusted for the RY 2019 reward/penalty cut point.

## ▶ Attainment Scale

All Payer Readmission Rate CY17	Over/Above Target From Target	RRIP % Inpatient Revenue Payment Adjustment
A	B	C
LOWER		1.0%
9.83%	-1.0%	1.0%
10.33%	-0.5%	0.5%
<b>10.83%</b>	<b>0.0%</b>	<b>0.0%</b>
11.33%	0.5%	-0.5%
11.83%	1.0%	-1.0%
12.33%	1.5%	-1.5%
12.83%	2.0%	-2.0%
Higher		-2.0%

- ▶ The attainment scale calculates maximum rewards at the 10<sup>th</sup> percentile of performance for RY 2018, and maximum penalties are linearly scaled based on max reward and reward/penalty cut point.

# Cumulative Readmission Rate Change by Rolling 12 Months (year over year): Maryland vs Nation



# Final Recommendations for RY 2019

## RRIP Policy

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- ▶ The RRIP policy should continue to be set for **all-payers**.
- ▶ Hospital performance should continue to be measured as the **better of attainment or improvement**.
- ▶ Due to ICD-10, RRIP should have a **one-year improvement target (CY 2017 over CY 2016)**, and will add this one-year improvement to the achieved improvement CY 2016 over CY 2013, to create a **modified cumulative improvement target**.
- ▶ The attainment benchmark should be set at **10.83 percent**.
- ▶ The reduction benchmark for CY 2017 readmissions should be **-3.75 percent** from CY 2016 readmission rates.
- ▶ Hospitals should be eligible for a **maximum reward of 1 percent**, or a **maximum penalty of 2 percent**, based on the better of their attainment or improvement scores.
- ▶ Staff will continue to work with CMS to **review readmission logic and data discrepancies**, and an update will be provided to the Commission if any substantive issues are found that warrant revisiting RY 2019 targets.

# Maryland Patient Safety Center Final Recommendation

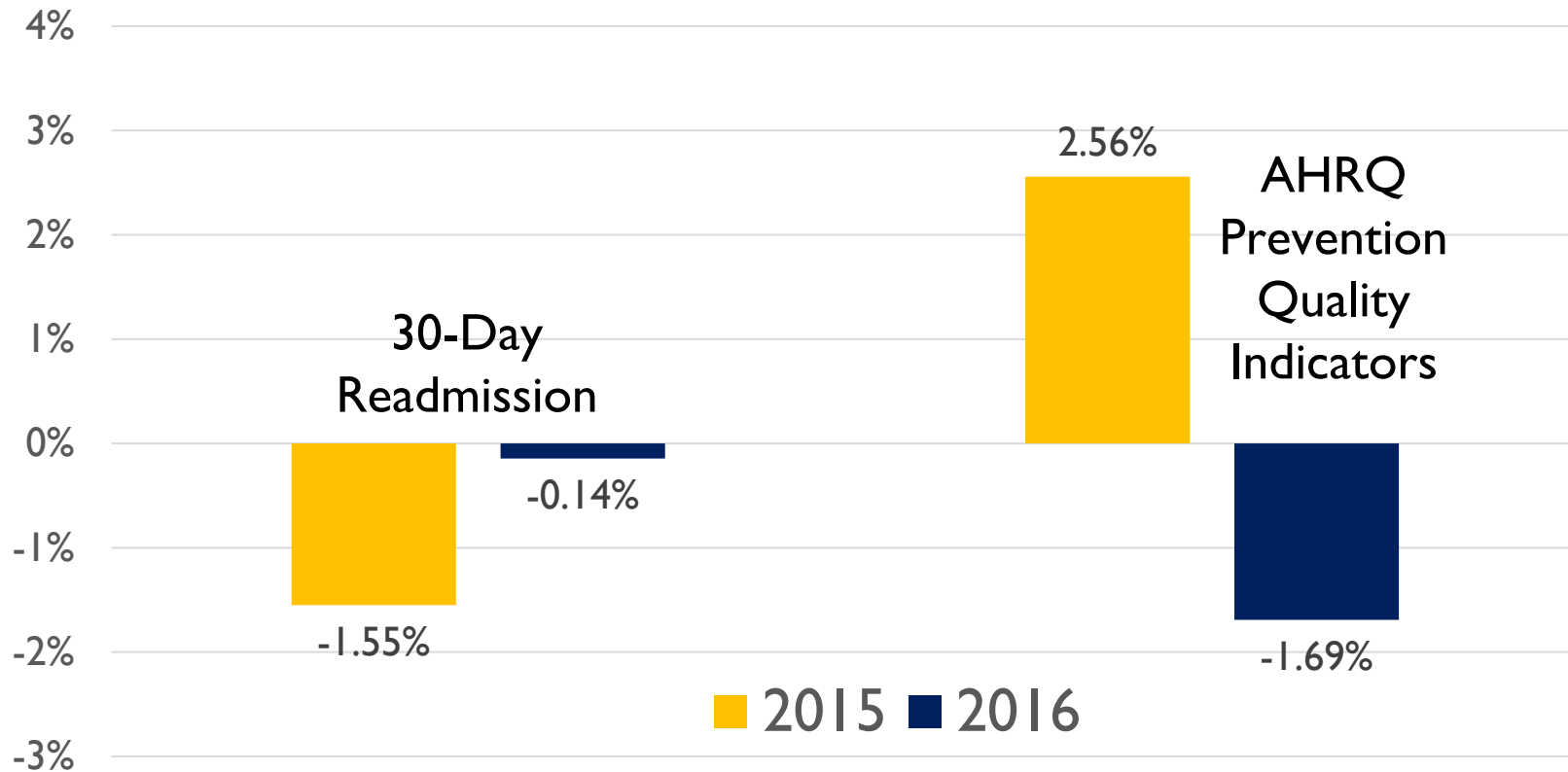
# Medicaid Current Financing Final Recommendation

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# Potentially Avoidable Utilization (PAU) Analysis

# All Payer Readmission and Prevention Quality Indicator ECMAD Annual Growth – CYTD Dec.

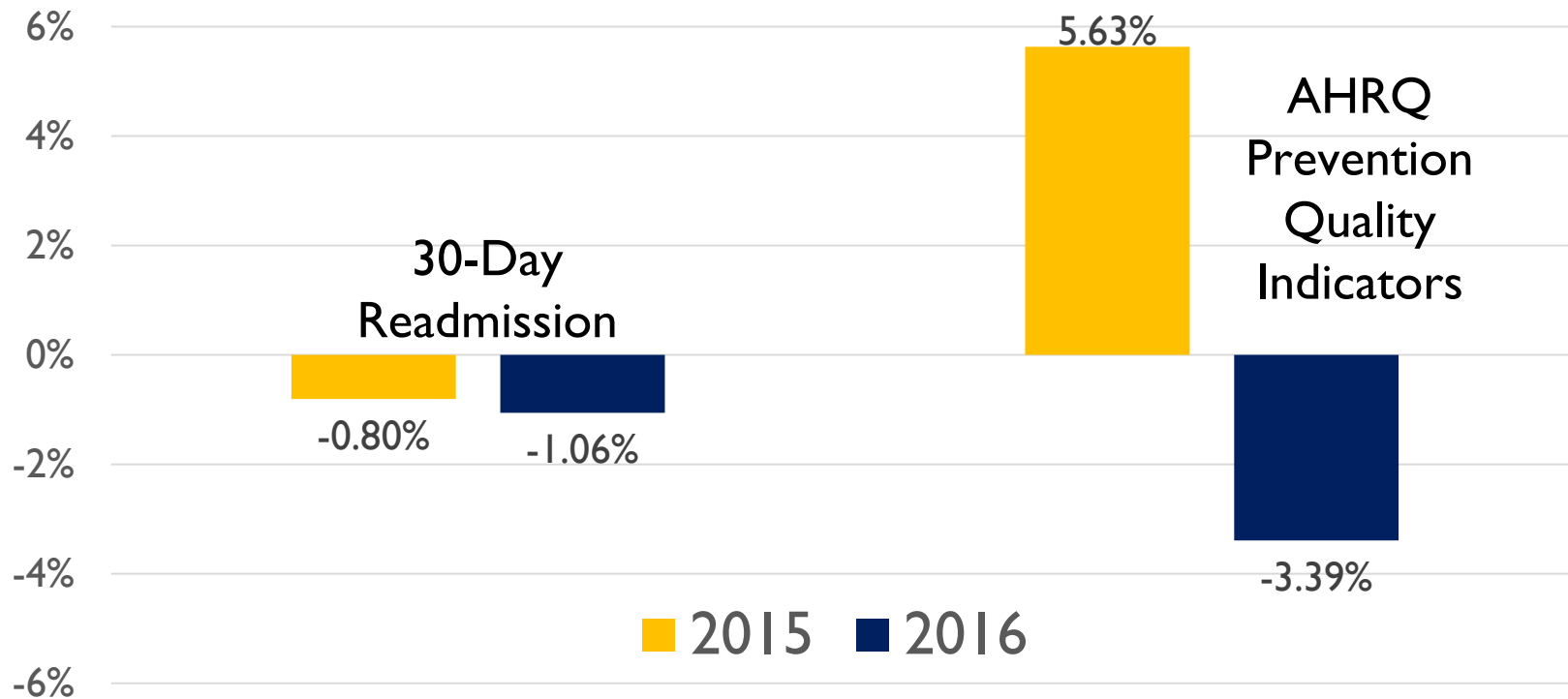
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# Medicare FFS Readmission and Prevention Quality Indicator ECMAD Annual Growth – CYTD Dec.

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Rate Year (RY) 2018 Potentially Avoidable  
Utilization Savings Policy Draft  
Recommendation

# Background

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- ▶ Ensure savings to the purchasers from incentive programs and satisfy exemption requirements from Medicare programs
- ▶ Started in RY 2014 in conjunction with the Admission Readmission Revenue (ARR) Program
- ▶ RY 2017 PAU Savings policy was updated to align the measure with the PAU definitions used in the market shift adjustment
  - ▶ Added Prevention Quality Indicators (PQI)\*
  - ▶ Readmissions counted at the receiving hospital
  - ▶ Added observation stays lasting 23 hour or longer to inpatient discharges

\*Developed by Agency For Health Care Quality and Research

[http://www.qualityindicators.ahrq.gov/modules/pqi\\_overview.aspx](http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx)

Also known as Ambulatory Care Sensitive Conditions, that is conditions for which good outpatient care can potentially prevent the hospitalization.

# RY 2018 PAU Savings Draft Recommendations

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- ▶ Set the value of the PAU savings amount to 1.45 percent of total permanent revenue in the state, which is a 0.20 percent net reduction in RY 2018.
  - ▶ All hospitals contribute to the statewide PAU savings, however, each hospital's reduction is proportional to their percent PAU revenue.
- ▶ Cap the PAU savings reduction at the statewide average reduction for hospitals with higher socio-economic burden.
- ▶ Evaluate further expansion of PAU definitions for RY 2019 to incorporate additional categories of unplanned admissions.

# RY 2018 PAU Savings State-Wide Calculation

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Statewide Results		Value		
RY 2017 Total Approved Permanent Revenue	A	\$15.8 billion		
Total RY18 PAU %	B	10.86%		
Total RY18 PAU \$	C	\$1.7 billion		
Statewide Total Calculations		Total	Last year	Net
Proposed RY 2018 Revenue Adjustment %	D	-1.45%	-1.25%	-0.20%
Proposed RY 2018 Revenue Adjustment \$	E=A*D	-\$228.4 million	-\$194.4 million	-\$34.0 million
Percent Revenue Adjustment of Total RY18 PAU \$	F=C/E	-13.35% <sup>a</sup>		
<sup>a</sup> -13.90% with Medicaid Protections				

Draft Recommendation for the  
Maximum Revenue  
Guardrail for Maryland Hospital  
Quality Programs for Rate  
Year 2019

# DRAFT NSP II FY18 Grants



# Draft Recommendation on the Update Factor for FY 2018

May 10, 2017



## Balanced Update Model for Discussion

### Components of Revenue Change Linked to Hospital Cost Drivers/Performance

		Weighted Allowance
Adjustment for Inflation		2.40%
- Total Drug Cost Inflation for All Hospitals*		0.28%
Gross Inflation Allowance	A	2.68%
Care Coordination		
-Rising Risk With Community Based Providers		
-Complex Patients With Regional Partnerships & Community Partners		
-Long Term Care & Post Acute		
	B	
Adjustment for volume	C	0.56%
-Demographic Adjustment (0.36%)		
-Transfers		
-Categoricals		
- Drug Population/Utilization (.2%**)		
Other adjustments (positive and negative)		
- Set Aside for Unknown Adjustments	D	0.40%
- Medicare Performance Adjustment (Future Use)	E	0.00%
Net Other Adjustments	F = Sum of D thru E	0.40%
- Reversal of one-time adjustments for drugs	G	-0.10%
-Reverse prior year's PAU savings reduction	H	1.25%
-PAU Savings	I	-1.45%
-Reversal of prior year quality incentives	J	-0.12%
-QBR, MHAC, Readmissions		
-Positive incentives & Negative scaling adjustments	K	0.30%
Net Quality and PAU Savings	L = Sum of G thru K	-0.12%
Net increase attributable to hospitals	M = Sum of A + B + C + F + L	3.52%
Per Capita	N = (1+M)/(1+0.36%)	3.15%

### Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements

-Uncompensated care reduction, net of differential	O	-0.13%
-Deficit Assessment	P	0.00%
Net decreases	Q = O + P	-0.13%
Revenue growth, net of offsets	R = M + Q	3.39%
Per capita revenue growth	S = (1+R)/(1+0.36%)	3.02%

\* Provided Based on proportion of drug cost to total cost (drug index 5.2% X 5.4% national weight)

\*\*Prospective adjustment 0.10 percent for new outpatient infusion and chemotherapy drugs (50% of estimated input in rates the beginning of FY)

The second 0.10 percent will be earmarked for new outpatient infusion and chemotherapy drugs (50% of actual input in rates mid-year)

# Proposed Update & Compliance with the All-Payer Per Capita & Gross Revenue Test

	A	B	C	D	E	F = (1+A)*(1+B)*(1+C)*(1+D)*(1+E)
	Actual Jan- June 2014	Actual FY 2015	Actual FY 2016	Staff Est. FY 2017	Proposed FY 2018	Cumulative Through FY 2018
<b>Maximum Gross Revenue Growth Allowance</b>	<b>2.13%</b>	<b>4.21%</b>	<b>4.06%</b>	<b>3.95%</b>	<b>3.95%</b>	<b>19.68%</b>
Revenue Growth for Period	0.90%	2.51%	2.47%	2.14%	3.39%	11.93%
Savings from UCC & Assessment Declines that do not Adversely Impact Hospital Bottom Line Revenue Growth with UCC & Assessment Savings Removed	0.90%	1.09%	1.40%	0.69%	0.13%	3.35%
		3.60%	3.87%	2.83%	3.52%	<b>15.59%</b>
Revenue Difference from Growth Limit						<b>4.09%</b>

# Summary of Recommendations

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- ▶ **Update the two categories of hospitals & revenues:**
  - ▶ 3.39% for revenues under global budgets (3.02% per capita)
    - ▶ Proposing to split the approved revenue into a mid-year and year-end target
  - ▶ 2.18% for psychiatric hospitals and Mt. Washington Pediatric Hospital
- ▶ **Allocate 0.28% of the inflation allowance based on each hospitals proportion of drug cost to total cost**
- ▶ **Allocate 0.20% for drug population/utilization to fund rising cost of new outpatient physician-administered drugs**



**The Hilltop Institute**

*analysis to advance the health of vulnerable populations*

# FY 2016 Maryland Hospital Community Benefit Reporting

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May 10, 2017

Laura Spicer

HSCRC May Meeting

# Presentation Outline

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- Highlights from the FY 2016 reports
- Proposed changes for reporting instructions

# Maryland Community Benefit Reporting Requirements

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- The HSCRC is required to collect hospital community benefit information and compile into a statewide, publicly available report.
- The HSCRC's community benefit reporting system has two components:
  - Community Benefit Collection Tool – a spreadsheet that inventories hospital community benefit expenses in various categories.
  - Narrative Report – intended to strengthen and supplement the quantitative community benefit data that hospitals report in their inventory spreadsheets.

# FY 2016 Financial Report Summary

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- 52 hospitals submitted financial reports
- \$1.5 billion in community benefit expenditures, representing:
  - 9.3% of statewide hospital operating expenses
    - Ranging from 1.5% - 24.8% within hospitals
  - 9.2 million staff hours and 5.9 million encounters

# FY 2016 Hospital Community Benefit Expenditures by Category

Community Benefit Category	Net Community Benefit Expense	% of Total Community Benefit Expenditures	Net Community Benefit Expense Less: Rate Support	% of Total Community Benefit Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	\$56,475,883	3.71%	\$56,475,883	6.82%
Community Health Services	\$107,226,253	7.04%	\$107,226,253	12.96%
Health Professions Education	\$469,283,494	30.80%	\$117,157,540	14.16%
Mission Driven Health Services	\$492,748,329	32.34%	\$492,748,329	59.53%
Research	\$9,649,972	0.63%	\$9,649,972	1.17%
Financial Contributions	\$20,827,391	1.37%	\$20,827,391	2.52%
Community Building	\$24,739,540	1.62%	\$24,739,540	2.99%
Community Benefit Operations	\$13,417,597	0.88%	\$13,417,597	1.62%
Foundation	\$1,742,933	0.11%	\$1,742,933	0.21%
Charity Care	\$320,932,030	21.06%	(\$22,947,729)	-2.77%
ACA Medicaid Expansion Expense	\$6,629,446	0.44%	\$6,629,446	0.80%
<b>Total</b>	<b>\$1,523,672,867</b>	<b>100%</b>	<b>\$827,667,153</b>	<b>100%</b>

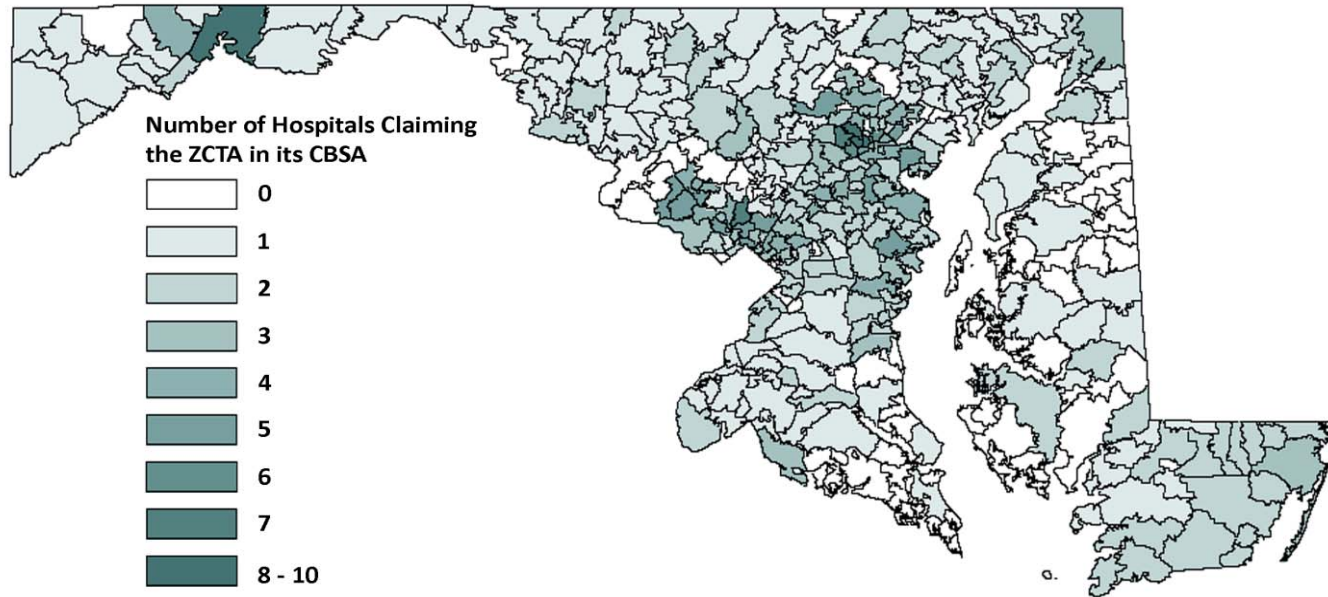


# FY 2016 Narrative Report Demographics

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- 52 hospitals submitted narrative reports; 40 were complete
- Hospitals reported 11,803 beds and over 600,000 inpatient admissions
- Percentage of uninsured patients ranged from 0 - 27%
- Percentage of patients enrolled in Medicaid ranged from 3 - 79%
- Percentage of patients enrolled in Medicare ranged from 11 - 79%

# Community Benefit Service Areas (CBSAs)



- 186 ZIP codes are not part of any hospital's CBSA
- 3 zip codes are covered by 8 or more hospitals

# Financial Assistance Policies

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- Patients at or below 200% of the federal poverty level (FPL) qualify for free medically necessary care
  - 7 hospitals reported a higher/more generous threshold
- Patients 200-300% of the FPL qualify for reduced-cost, medically necessary care
  - 22 hospitals reported a more generous
- Patients below 500% of the FPL who have a financial hardship qualify for reduced-cost, medically-necessary care
  - 2 hospitals reported a more generous policy

# Community Benefit External Collaboration

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- Hospitals are required to report on partnerships with community stakeholders
- Local health departments and faith-based organizations were the most common type of external collaborators
  - Behavioral health organizations were the least frequent
- 90% participate in their Local Health Improvement Collaborative

# Proposed Changes for FY 2018

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- Developing an electronic reporting tool
- Pre-populating the report with data available from other sources where applicable, e.g., admission counts
- Simplifying the format by replacing some of the free text questions with response options
- Reviewing the measures and reporting requirements for other HSCRC reports, and editing questions and definitions accordingly
- Removing the requirement for hospitals to attach their mission, vision, and values statements, as this information is typically available online

# Proposed Changes for FY 2018

continued

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- Collecting additional information about the community health needs assessment
- Adding questions about community benefit decision-making authority within the hospital
- Adding questions about community benefit and population health staffing within the hospital
- Next Steps:
  - Refine the reporting instructions and tools in collaboration with the Community Benefit Workgroup
  - Review the ZIP codes that are not covered by any hospital's CBSA in more depth

# Contact Information

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# Motion to Adjourn