Monitoring Maryland Performance

Financial Data

Year to Date thru March 2016

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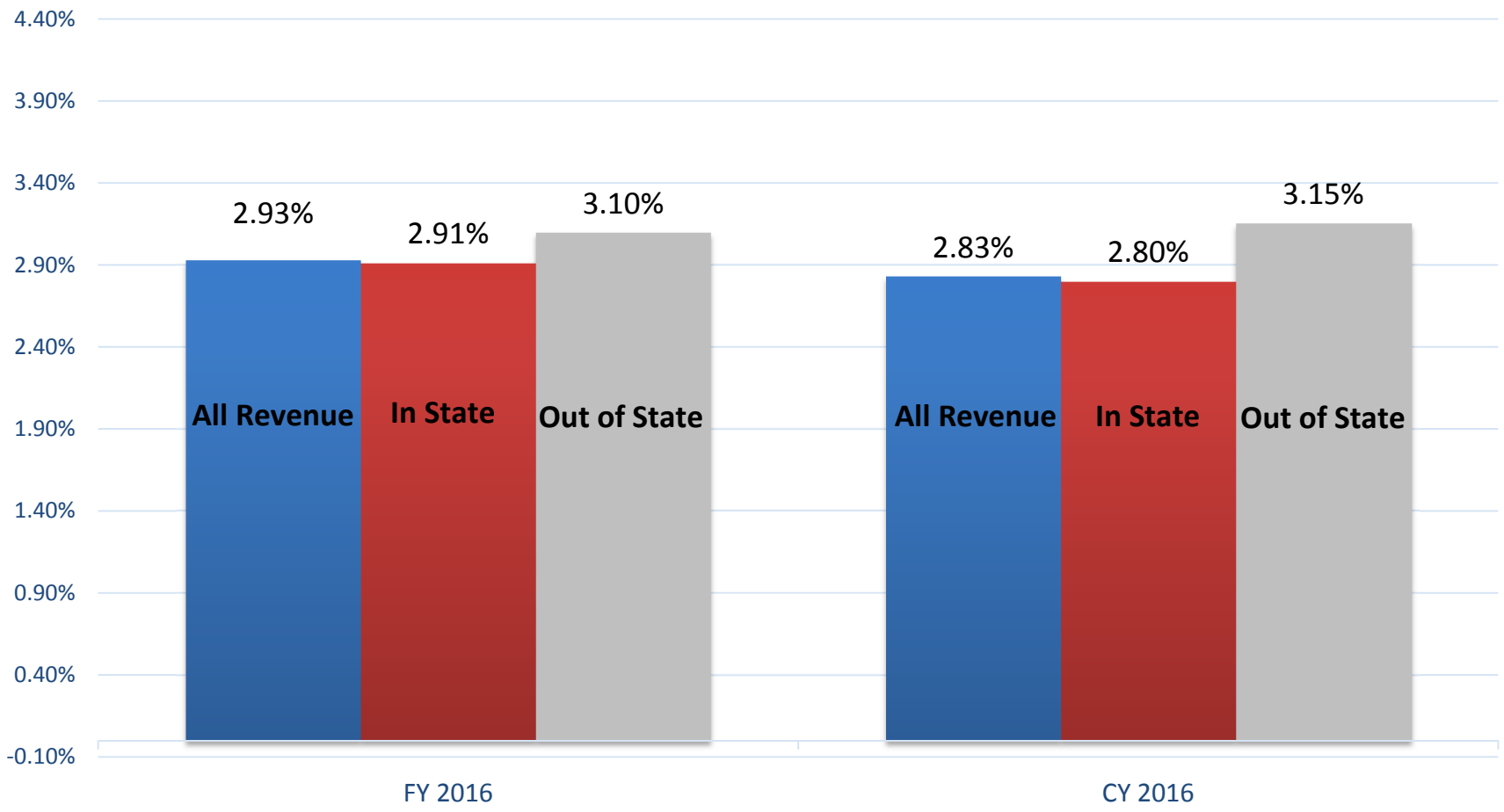
Gross All Payer Revenue Growth

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



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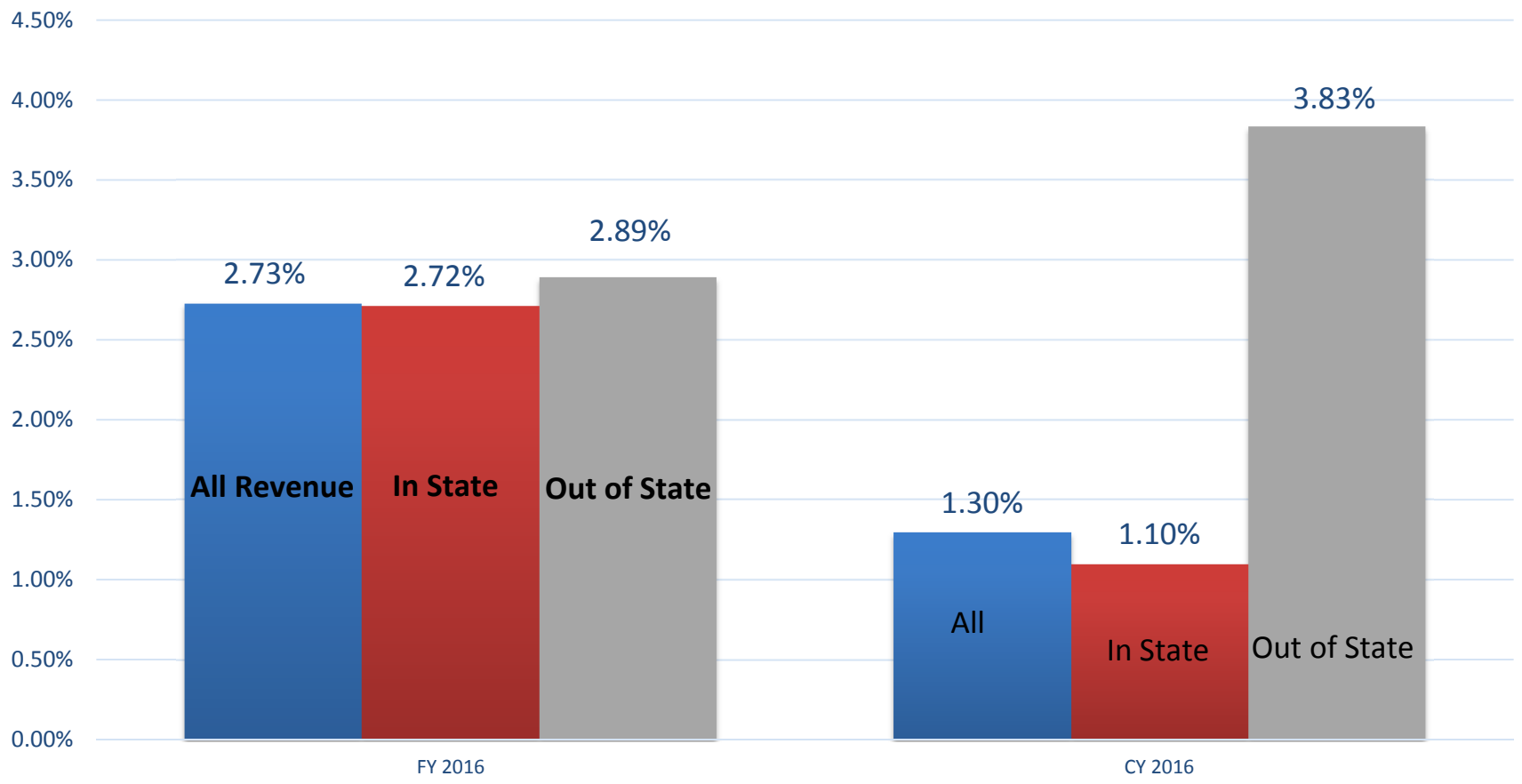
Gross Medicare Fee-for-Service Revenue Growth

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



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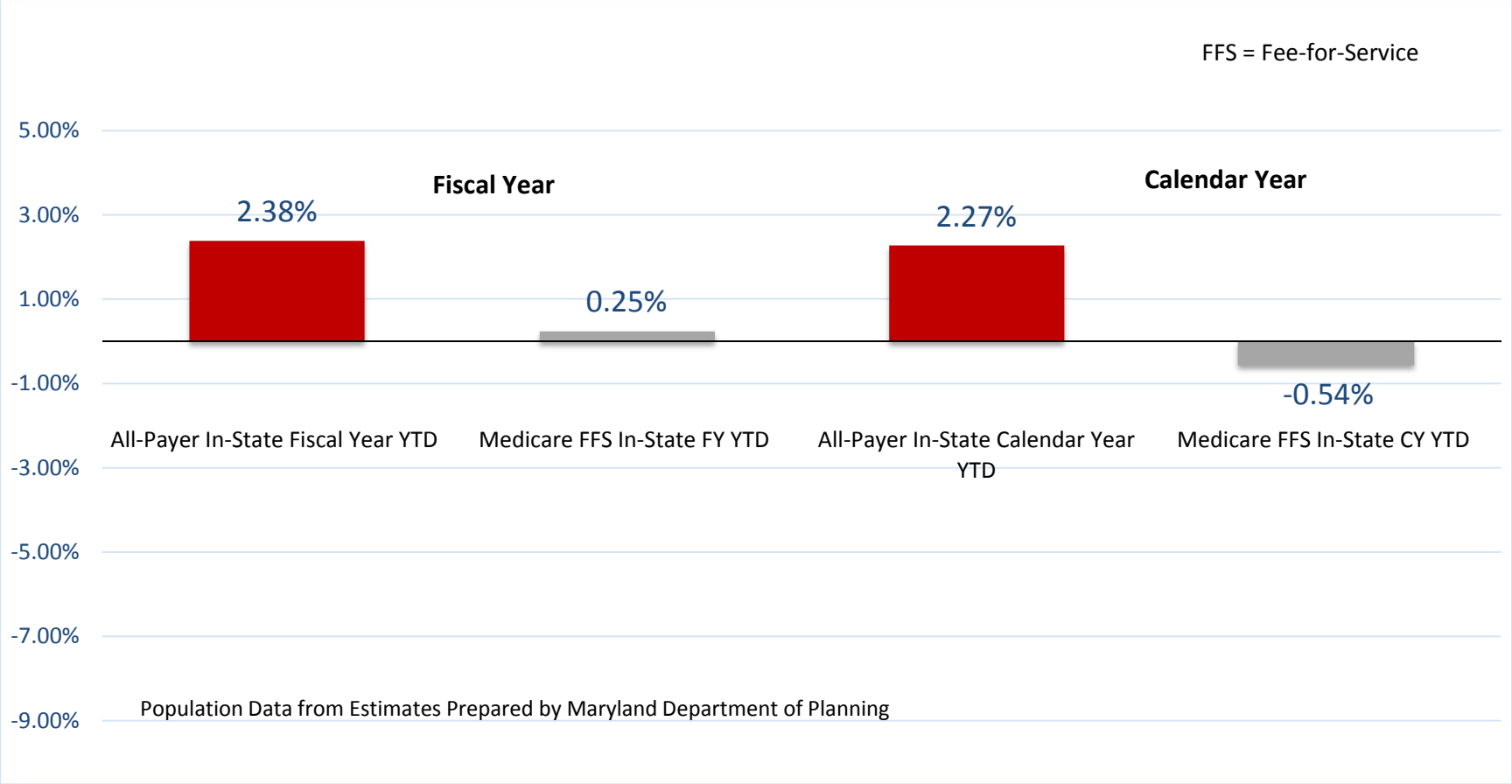
Per Capita Growth Rates

Fiscal Year 2016 and Calendar Year 2016 (2016 over 2015)



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

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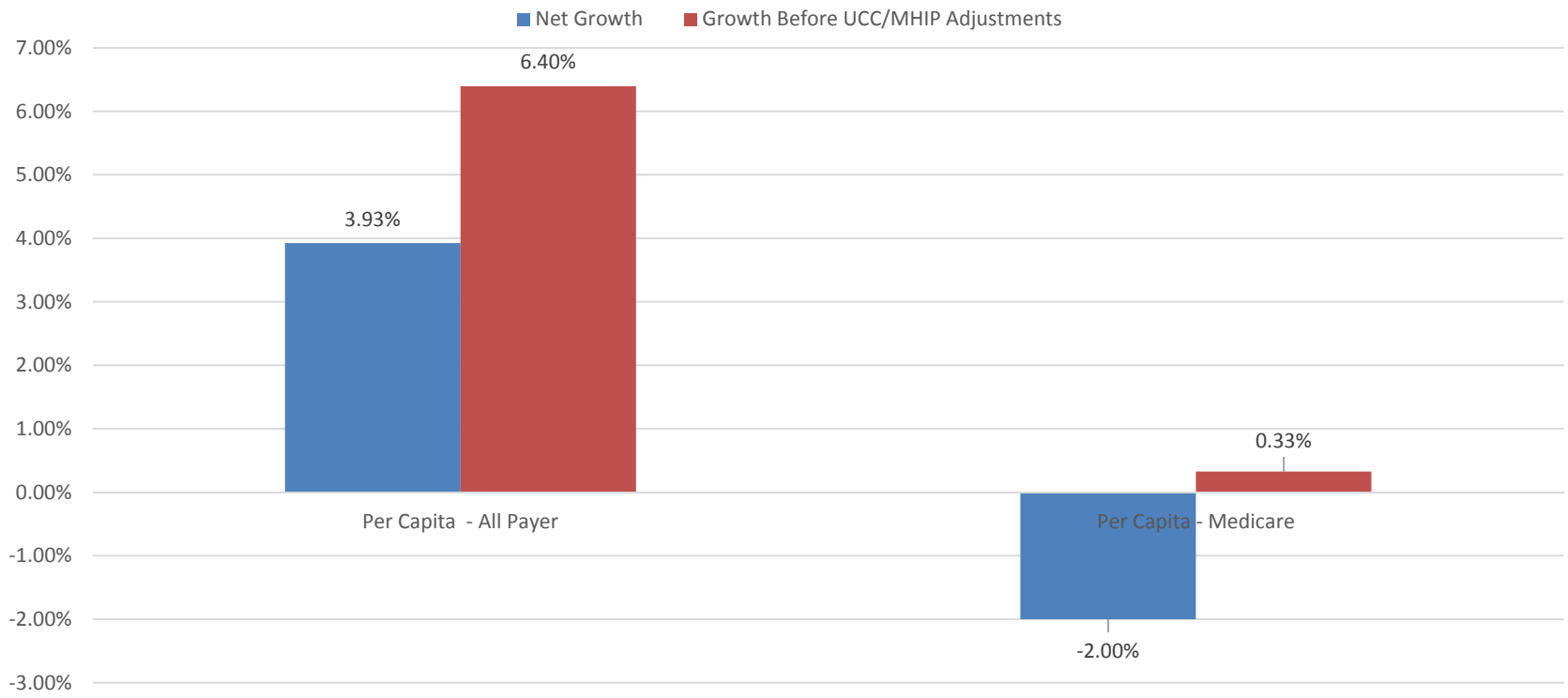
Per Capita Growth – Actual and Underlying Growth

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



- Three year per capita growth rate is well below maximum allowable growth rate of 11.13% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY 16 revenue decreases that were budget neutral for hospitals. 2.52% hospital bad debts and elimination of MHIP assessment.

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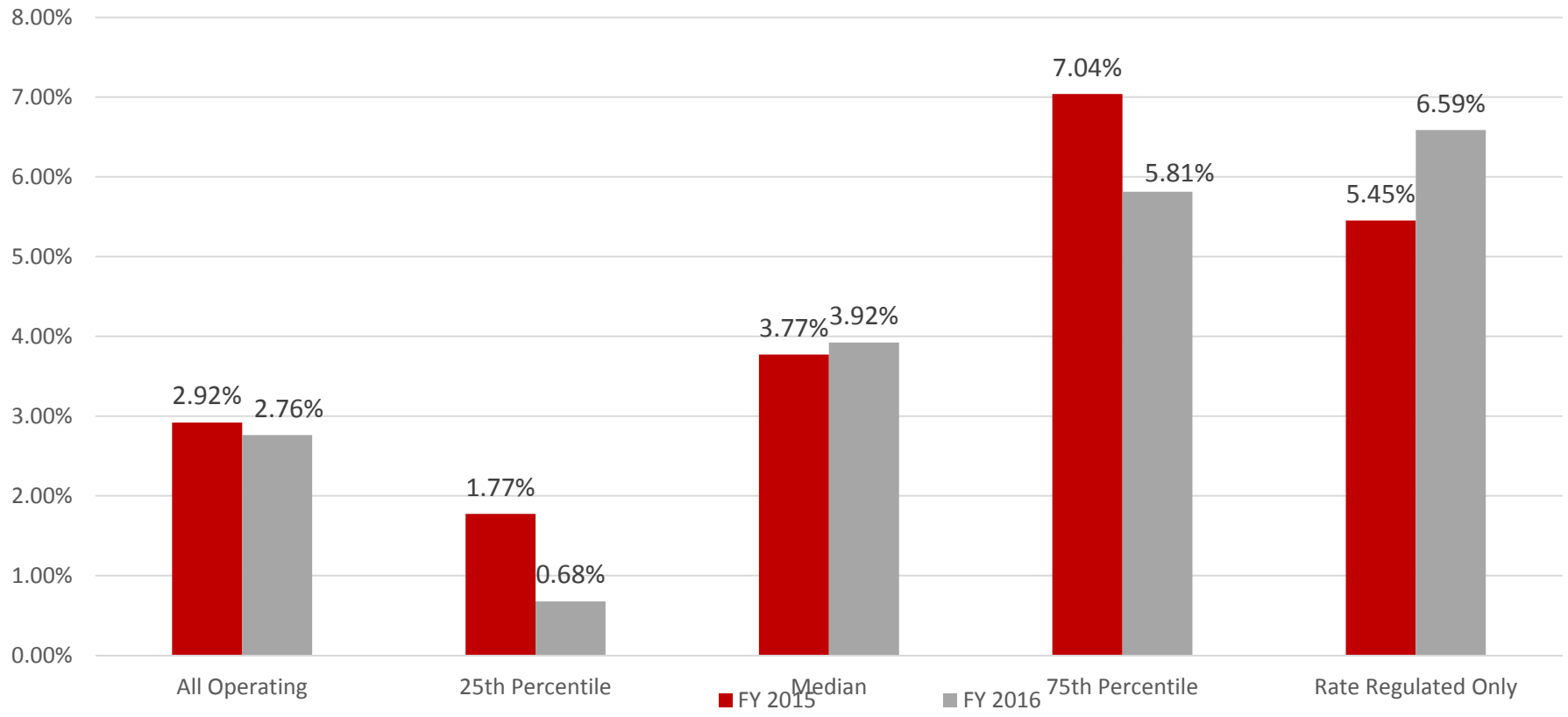
Operating Profits: Fiscal 2016 Year to Date (July-March) Compared to Same Period in FY 2015



- Year to date FY 2016 unaudited hospital operating profits show a 0.16% decrease in total profits compared to the same period in FY 2015. Rate regulated profits have increased by 1.14% compared to the same period in FY 2015.

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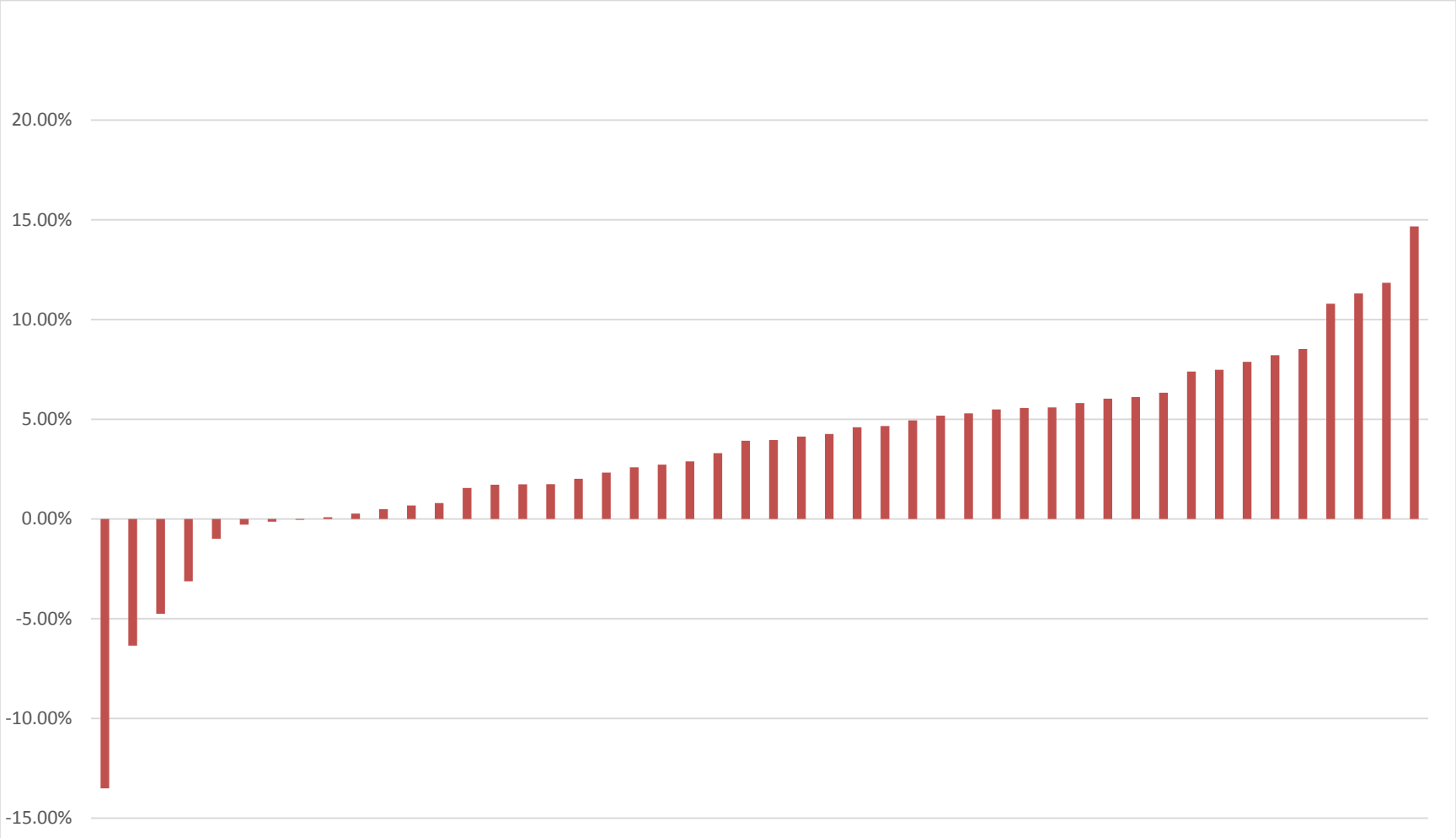
Operating Profits by Hospital

Fiscal Year to Date (July – March)



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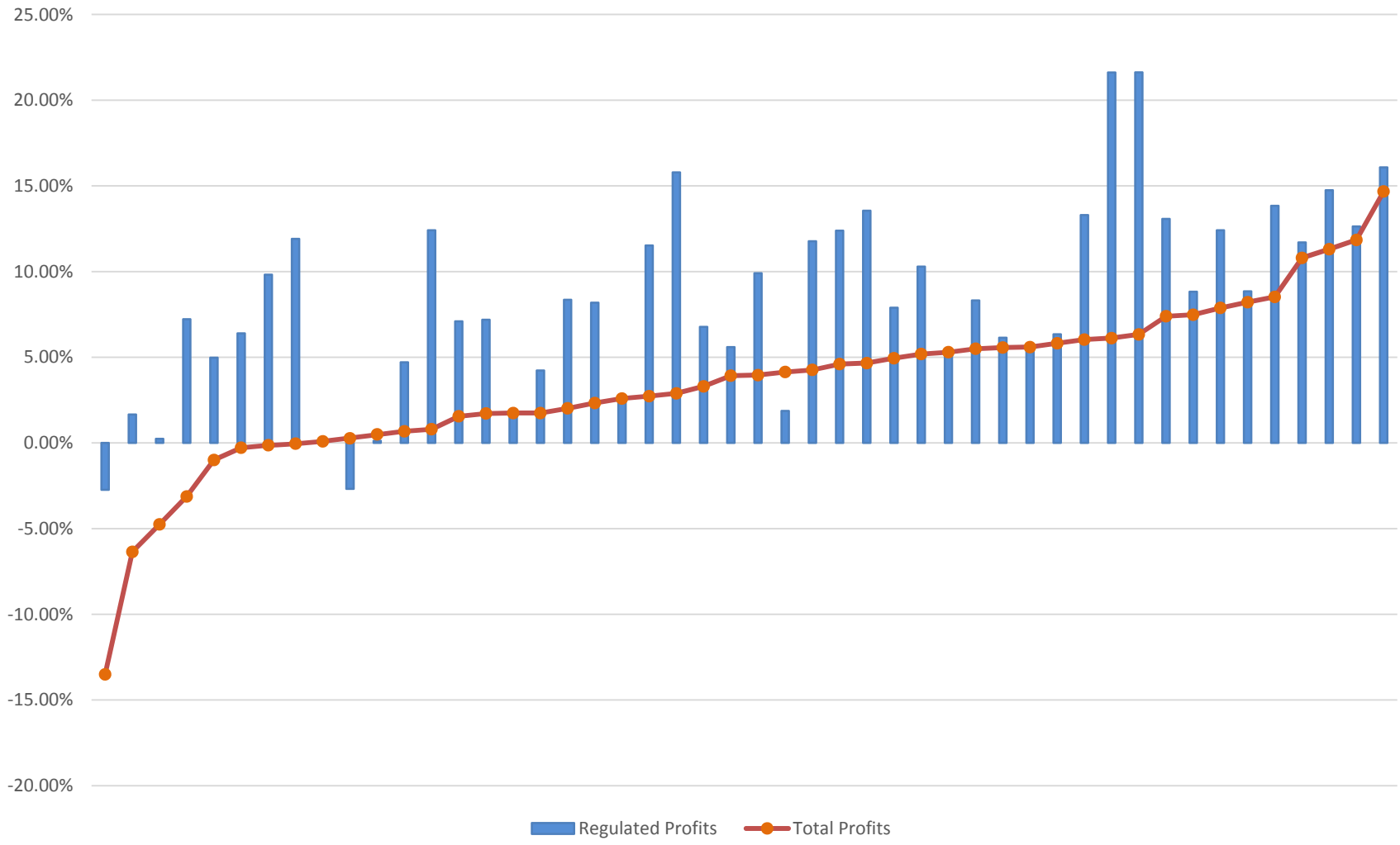
Regulated and Total Operating Profits by Hospital

Fiscal Year to Date (July – March)



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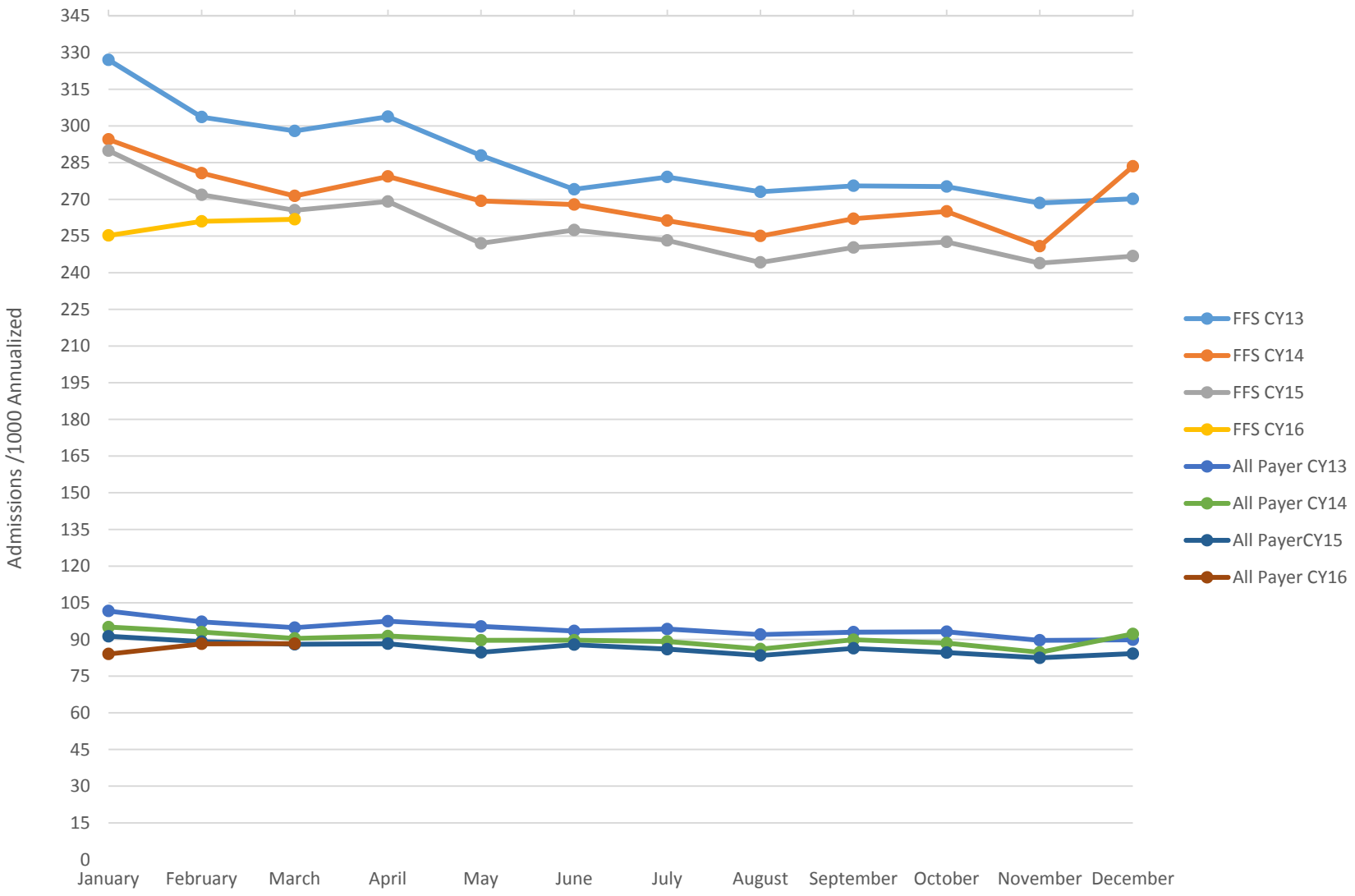
Admissions/1000 Annualized
Medicare FFS and All Payer



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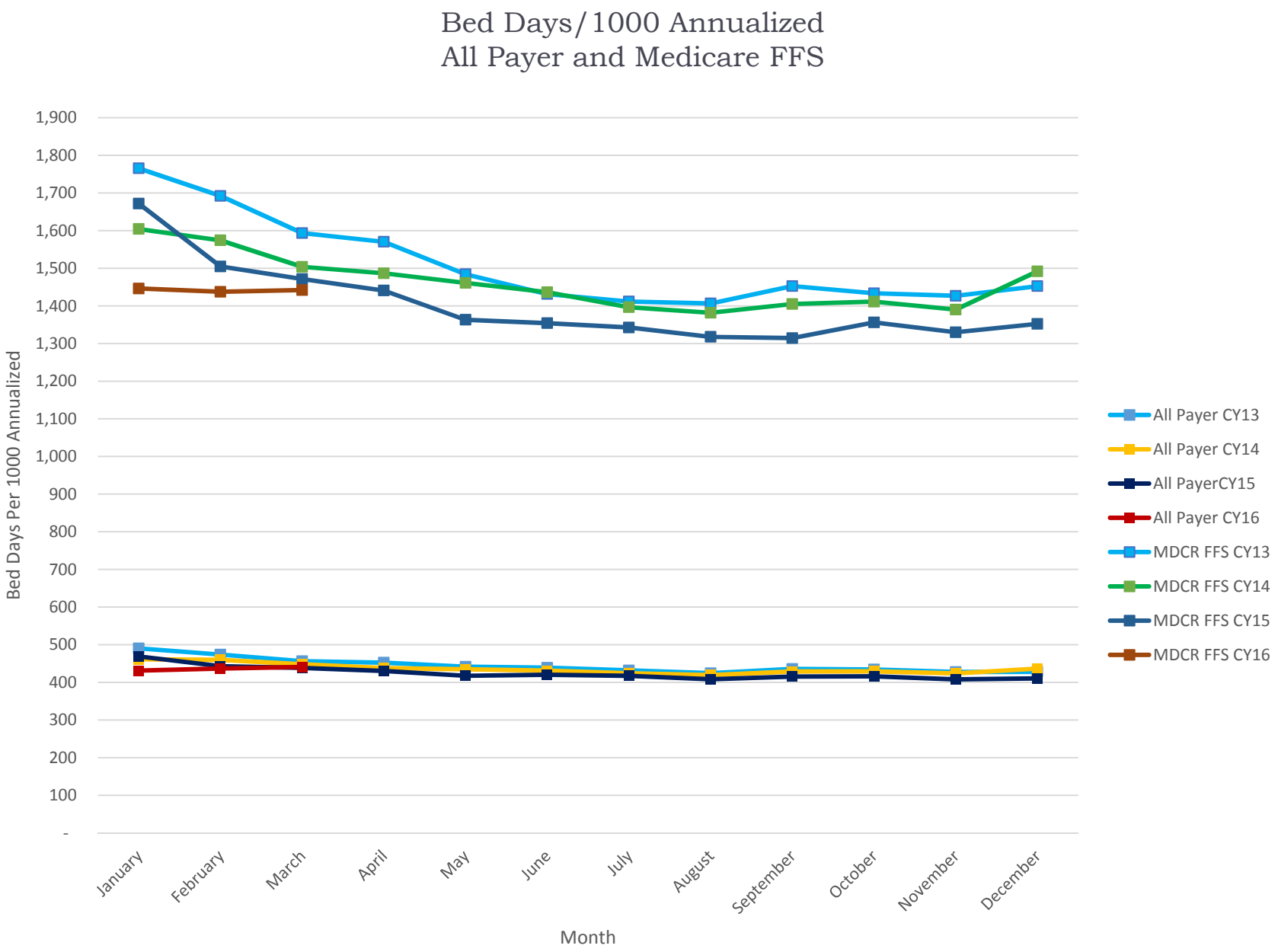

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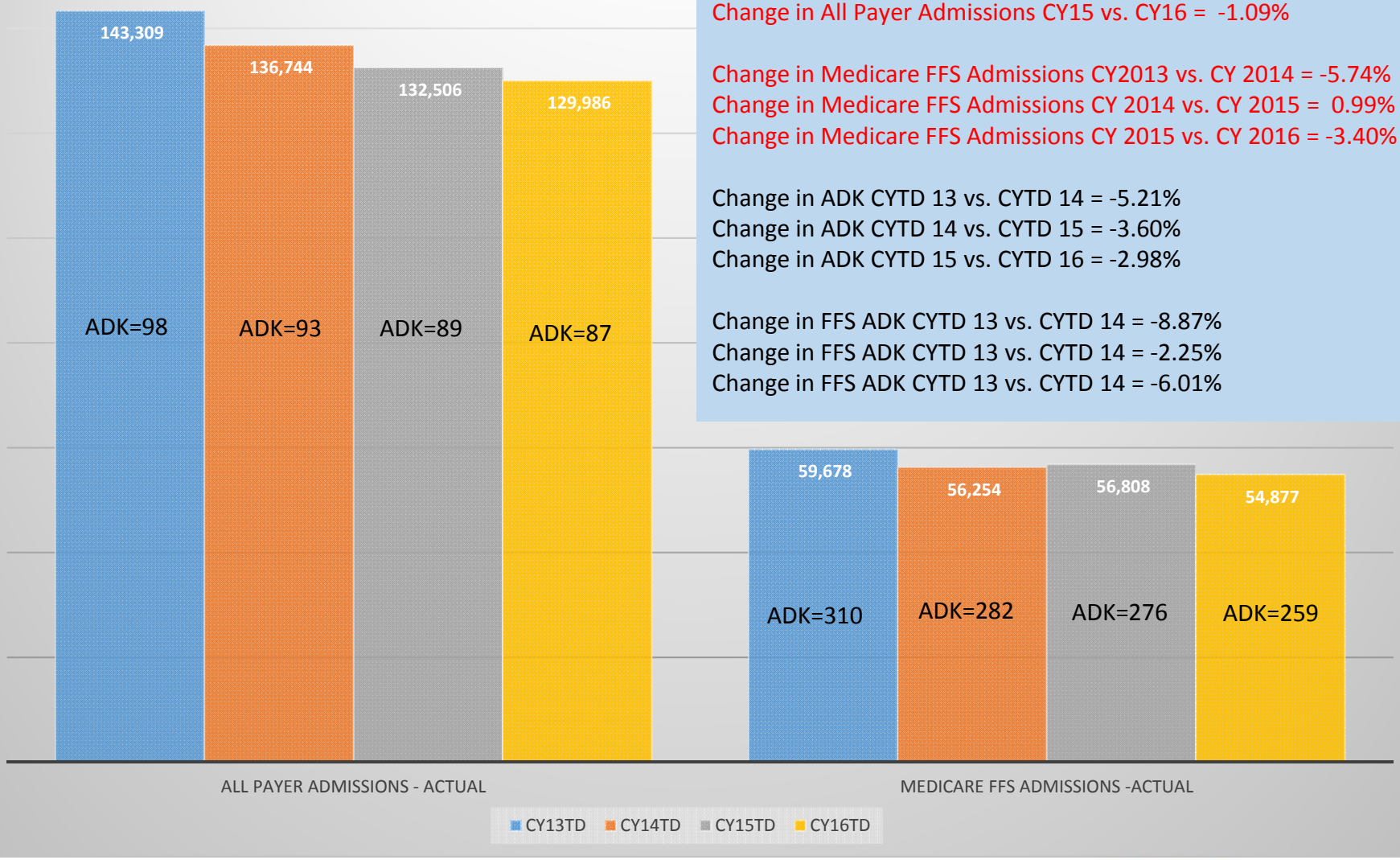
Actual Admissions by Calendar Year to Date through March 2016



Change in All Payer Admissions CY13 vs. CY14 = -4.58%
Change in All Payer Admissions CY14 vs. CY15 = -3.10%
Change in All Payer Admissions CY15 vs. CY16 = -1.09%

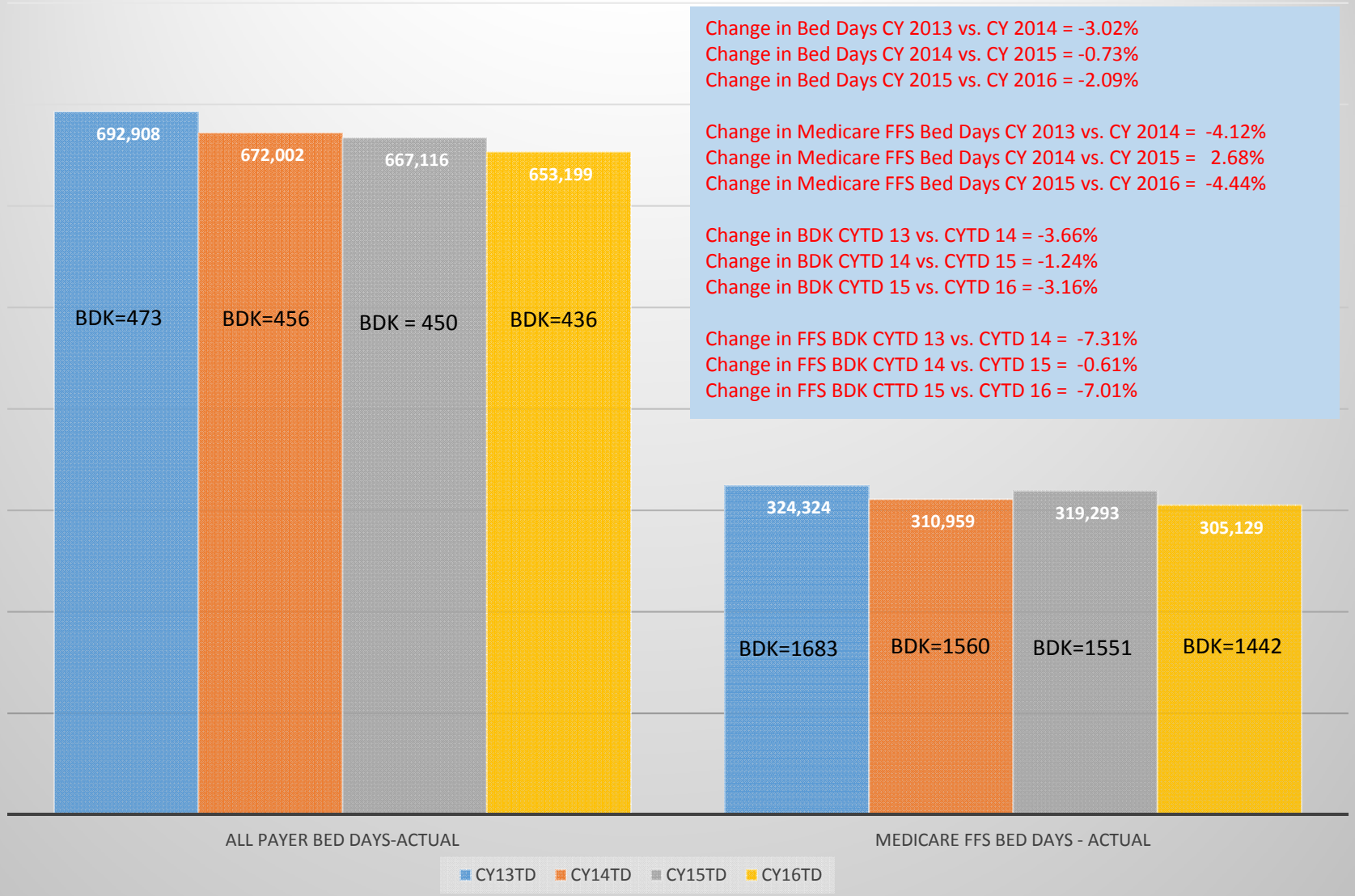
Change in Medicare FFS Admissions CY2013 vs. CY 2014 = -5.74%
Change in Medicare FFS Admissions CY 2014 vs. CY 2015 = 0.99%
Change in Medicare FFS Admissions CY 2015 vs. CY 2016 = -3.40%

Change in ADK CYTD 13 vs. CYTD 14 = -5.21%
Change in ADK CYTD 14 vs. CYTD 15 = -3.60%
Change in ADK CYTD 15 vs. CYTD 16 = -2.98%

Change in FFS ADK CYTD 13 vs. CYTD 14 = -8.87%
Change in FFS ADK CYTD 13 vs. CYTD 14 = -2.25%
Change in FFS ADK CYTD 13 vs. CYTD 14 = -6.01%

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

Actual Bed Days by Calendar Year to Date through March 2016



Change in Bed Days CY 2013 vs. CY 2014 = -3.02%
Change in Bed Days CY 2014 vs. CY 2015 = -0.73%
Change in Bed Days CY 2015 vs. CY 2016 = -2.09%

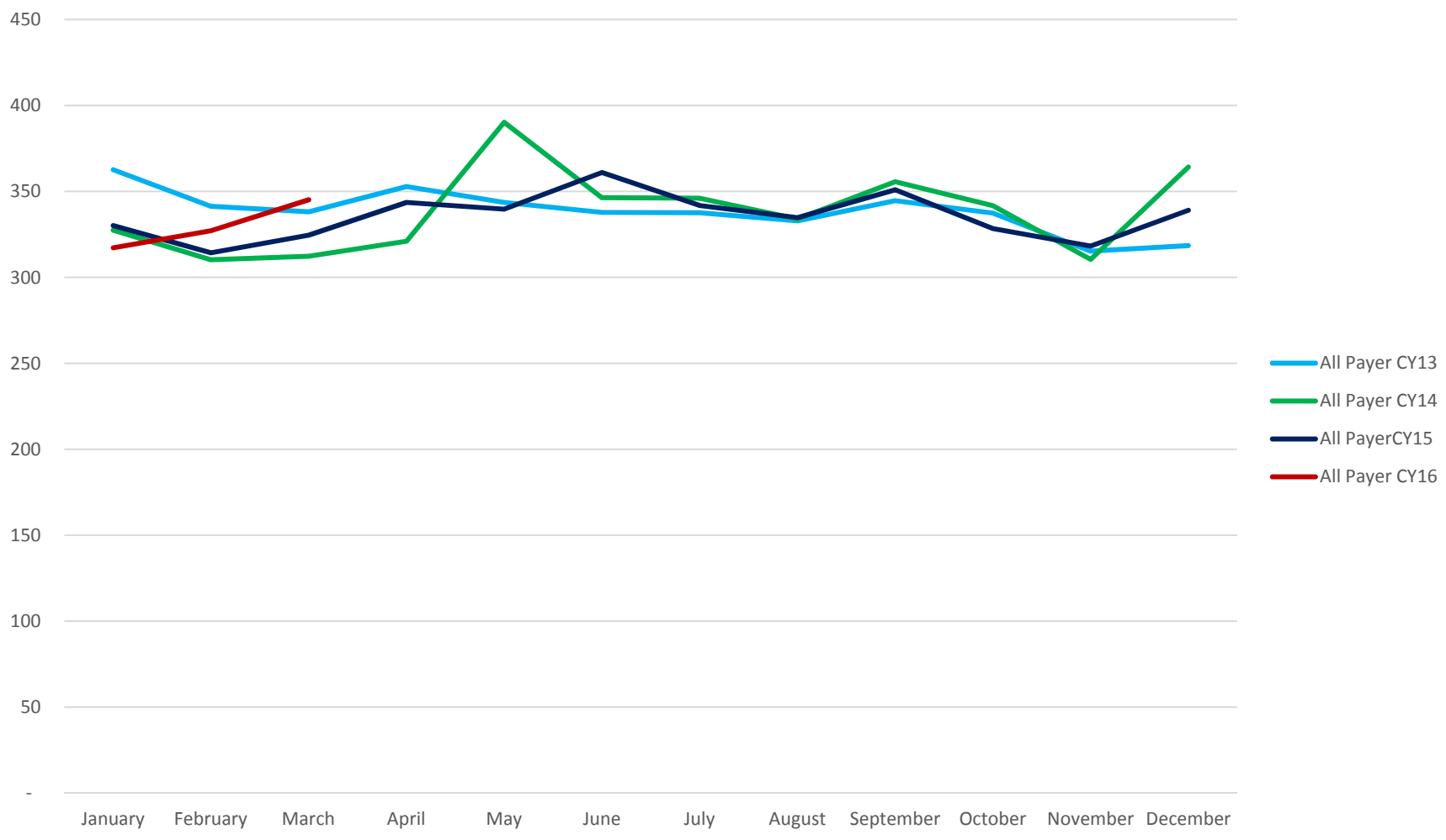
Change in Medicare FFS Bed Days CY 2013 vs. CY 2014 = -4.12%
Change in Medicare FFS Bed Days CY 2014 vs. CY 2015 = 2.68%
Change in Medicare FFS Bed Days CY 2015 vs. CY 2016 = -4.44%

Change in BDK CYTD 13 vs. CYTD 14 = -3.66%
Change in BDK CYTD 14 vs. CYTD 15 = -1.24%
Change in BDK CYTD 15 vs. CYTD 16 = -3.16%

Change in FFS BDK CYTD 13 vs. CYTD 14 = -7.31%
Change in FFS BDK CYTD 14 vs. CYTD 15 = -0.61%
Change in FFS BDK CTTD 15 vs. CYTD 16 = -7.01%

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

In State All Payer ED Visits Per 1000 Annualized



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

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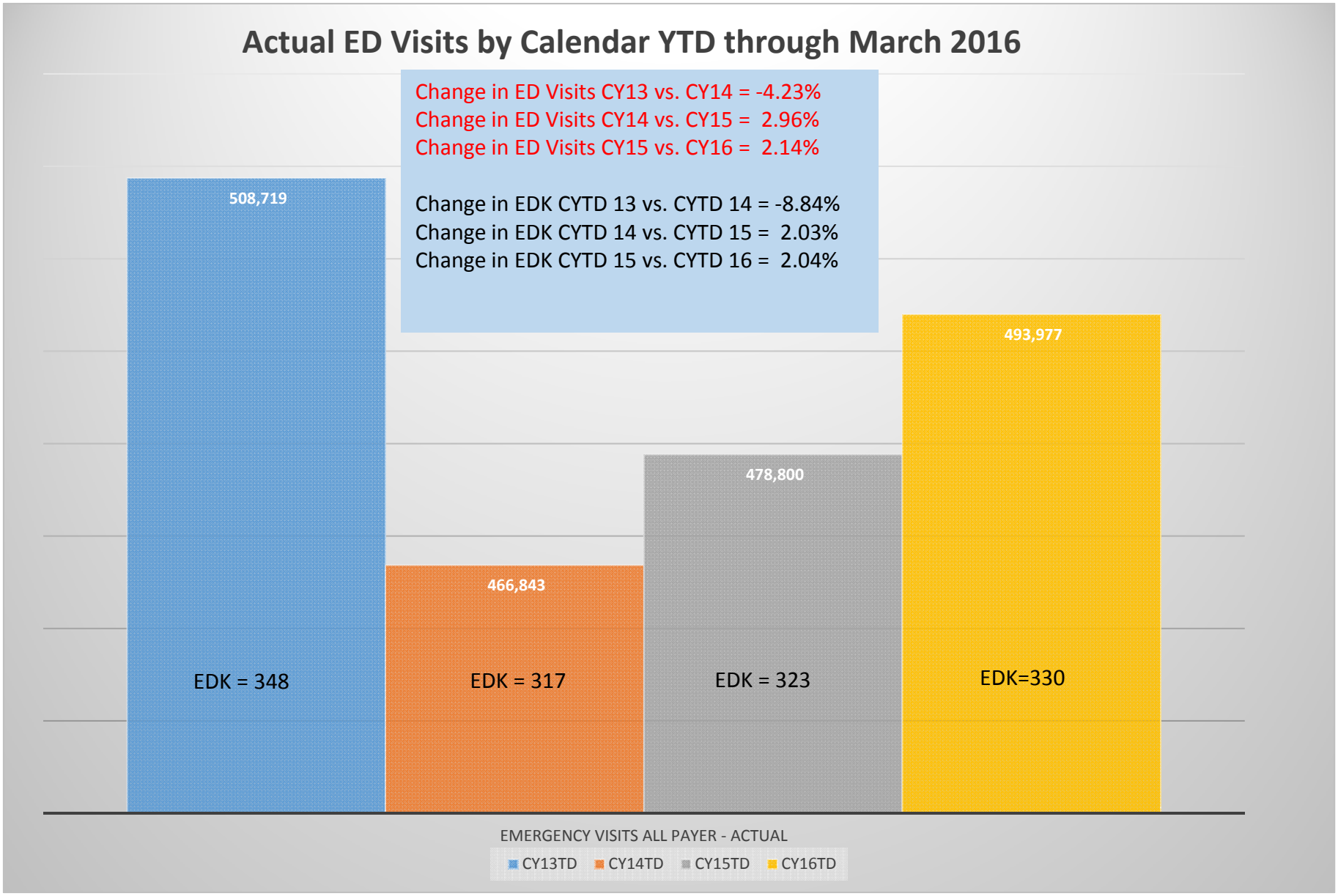
Actual ED Visits by Calendar YTD through March 2016



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

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Purpose of Monitoring Maryland Performance

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

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

Data Caveats

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

Data Caveats cont.

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

Nurse Support Program II

Recommendations for the FY 2017 NSP II Competitive Institutional Grants

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FY 2016 - FY 2020: Updates

- NSP II Statute in Education Article, Section 11-405, revised to remove "bedside" as a descriptor.
- SB 208 voted favorable in both the House and Senate.
- Improved metrics and program evaluation process
- Developing enhancements to nursesupport.org website to provide automated data collection, management, analysis and reporting.

FY 2017 Grant Recommendations

- Total Funding Recommended- $17.5 mil
  - 4 Planning Grants
  - 12 Implementation Grants
  - 3 Continuation Grants
- Broad geographic representation
- Funding recommended for proposals at 11 higher education institutions
  - 4 community colleges
  - 4 private
  - 2 public Universities
  - 1 HBCU

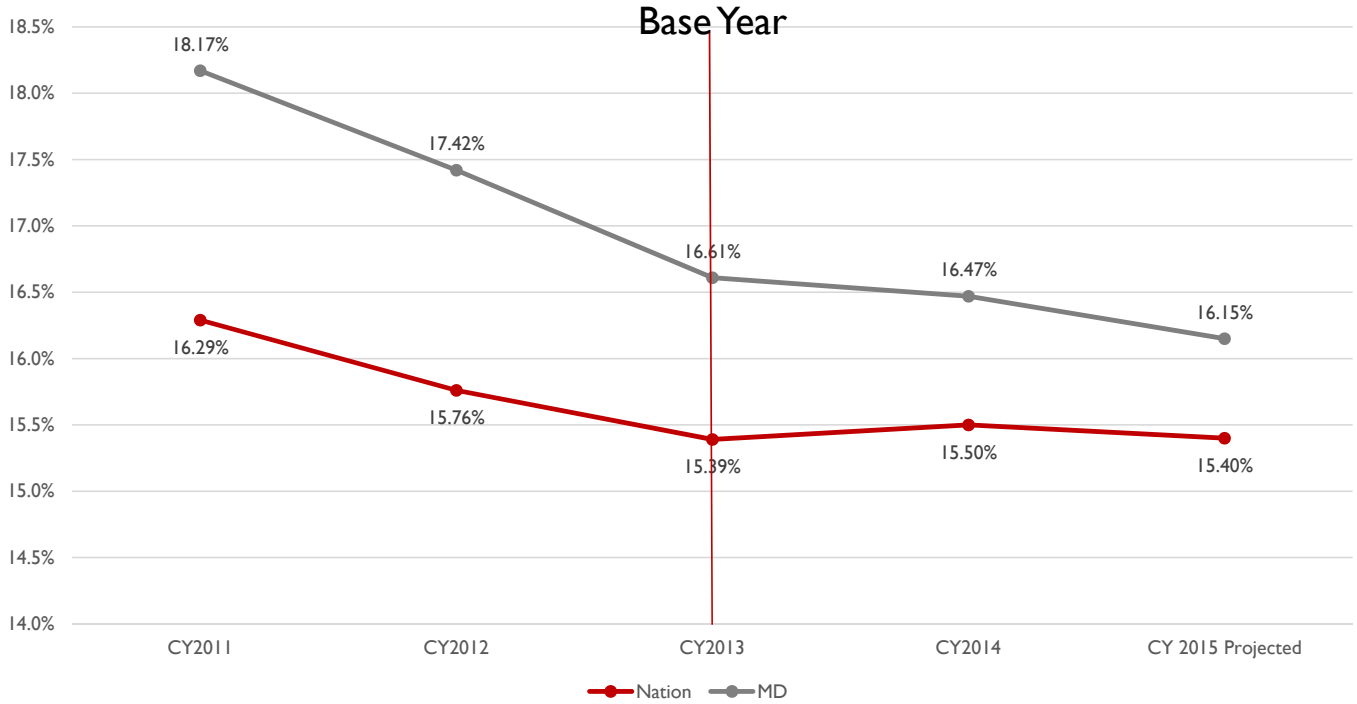
Readmission Reduction Incentive Program Draft FY 2018 Policy

RRIP Background

- Started in CY 2014 performance year with 0.5% inpatient revenue bonus if a hospital reduced its case-mix adjusted readmission rate by 6.76% in one year.
- Last year
  - Improvement target was set at 9.3% over two years (CY 2015 compared to CY 2013 rates)
  - Rewards scaled up to 1% commensurate with improvement rates
  - Penalties scaled up to -2% were introduced for hospitals that were below the improvement target commensurate with improvement rates
  - Continue to evaluate factors that may impact performance and meeting Medicare readmission benchmarks

Medicare Benchmark: At or below National Medicare Readmission Rate by CY 2018

Maryland is reducing readmission rate faster than the nation. Maryland is projected to reduce the gap from 7.93% in the base year to 4.87 % in CY 2015*



*HSCRC and CMMI staff identified an ICD-10 issue impacting readmission rates and are working on resolutions.

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Analyses of Issues Discussed in FY 2017 Policy

- Medicare vs All-Payer Targets
- Relationship between overall admissions (denominator) and readmission rate
- Impact of Socio-economic and Demographic Factors
- Impact of Observation stays
- Diminishing impact to reduce readmissions as readmission rates are lower

RRIP proposals for FY 2018

- Payment adjustments based on readmission rates (attainment) needs further considerations for;
  - Readmissions at out of state hospitals
  - Impact of patient's socio-economic factors
- MHA proposal combines improvement and attainment into a single payment adjustment
- Carefirst proposal blends 50/50 actual readmission rate with indigenous adjusted readmission rates

Draft Recommendations for the RRIP Policy

- For RY 2018
  - The RRIP policy should continue to be set for all-payers.
  - Hospital performance should be measured better of attainment of improvement
  - Set attainment benchmark at the state top-quartile readmission rate in the most recent performance period.
  - Set the reduction target at 9.5 percent from CY2013 readmission rates
- For RY 2017 apply the same methodology outlined above based on 9.3 reduction target as approved by the Commission last year.
- Staff will evaluate the appropriate risk adjustment in May to finalize the recommendation.

DRAFT Recommendation for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018

Background

- Maryland quality based programs are exempt from Medicare Programs.
  - Exemption from the Medicare Value-Based Purchasing (VBP) program is evaluated annually
  - Exceptions from the Medicare Hospital Readmissions Reduction Program and the Medicare Hospital-Acquired Condition Reduction Program are granted based on achieving performance targets
  - Maryland aggregate at-risk amounts are compared against Medicare programs

Maryland surpasses National Medicare Aggregate Revenue at Risk in Quality Payments

Figure 1. Potential Revenue at Risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2017

% of MD All-Payer Inpatient Revenue	FY 2014	FY 2015	FY 2016	FY 2017
MHAC - Complications	2.00%	3.00%	4.00%	3.00%
RRIP - Readmissions			0.50%	2.00%
QBR – Patient Experience, Mortality, Safety	0.50%	0.50%	1.00%	2.00%
Shared Savings	0.41%	0.86%	1.35%	4.36%*
GBR Potentially Avoidable Utilization (PAU)	0.50%	0.86%	1.10%	TBD
MD Aggregate Maximum At Risk	3.41%	5.22%	7.95%	11.36%

*Italics are based on RY 2016 results, and subject to change
based on RY 2017 policy, which is to be finalized at June 2016 Commission meeting.

Medicare National				
% of National Medicare Inpatient Revenue	FFY 2014	FFY 2015	FFY 2016	FFY 2017
Hospital Acquired Complications (HAC)		1.00%	1.00%	1.00%
Readmissions	2.00%	3.00%	3.00%	3.00%
VBP	1.25%	1.50%	1.75%	2.00%
Medicare Aggregate Maximum At Risk	3.25%	5.50%	5.75%	6.00%
Cumulative MD-Medicare National Difference	0.16%	-0.12%	2.08%	7.44%

RY 2017 Year to Date Results

	MHAC*	RRIP**	QBR***	Shared Savings***	Net Shared Savings***	PAU*	State Aggregate	Hospital Net
	A	B	C	D	E	F	G=Sum(A-D)	
Potential At Risk (Absolute Value)	3.00%	2.00%	2.00%	4.36%	3.52%		11.36%	
Maximum Hospital Penalty (% Inpatient Revenue)	-0.25%	-2.00%	-1.78%	-4.36%	-3.52%		-8.38%	-3.10%
Maximum Hospital Reward (% Inpatient Revenue)	1.00%	1.00%	1.00%	NA	0.44%	NA	3.00%	1.41%
Average Absolute Level Adjustment (% Inpatient Revenue)	**0.42%**	**0.65%**	**0.51%**	**2.56%**	**1.60%**		**4.13%**	**1.35%**
Total Penalty	-$502,722	-$36,224,835	-$4,980,623	-$190,634,642	-$99,309,267		-$141,017,447	
Total Reward	$29,403,229	$8,358,316	$33,335,873	$0	$278,971	NA	$71,097,418	
Total Net Adjustments	**$28,900,507**	**-$27,866,519**	**$28,355,250**	**-$190,634,642**	**-$99,309,267**		**-$69,920,029**	
% Total GBR Revenue	**0.19%**	**-0.18%**	**0.19%**	**-1.25%**	**-0.65%**		**-0.46%**	

**All calculations are preliminary subject to the assessment of ICD-10 impact.*
***RRIP results are preliminary results as of December 2015 and do not reflect any potential protections that may be developed based on the approved RY 2017 recommendation.*
****QBR YTD results are preliminary estimates based on two quarters of new data due to data lag for measures from CMS. Staff will provide updated calculations for the final recommendation.*
*****Shared Savings are based on 0.65 % net statewide reduction based on draft FY2017 recommendation.*

DRAFT Recommendations

- No change is recommended to FY 2017 levels

	Max Penalty	Max Reward
MHAC Below target	-3.0%	0.0%
MHAC Above Target	-1.0%	1.0%
RRIP	-2.0%	1.0%
QBR	-2.0%	1.0%

- Continue to set the maximum penalty guardrail at 3.5 percent of total hospital revenue
- The quality adjustments should be applied to inpatient revenue centers, similar to the approach used by CMS. The HSCRC staff can apply the adjustments to hospitals' medical surgical rates to concentrate the impact of this adjustment to inpatient revenues, consistent with federal policies.

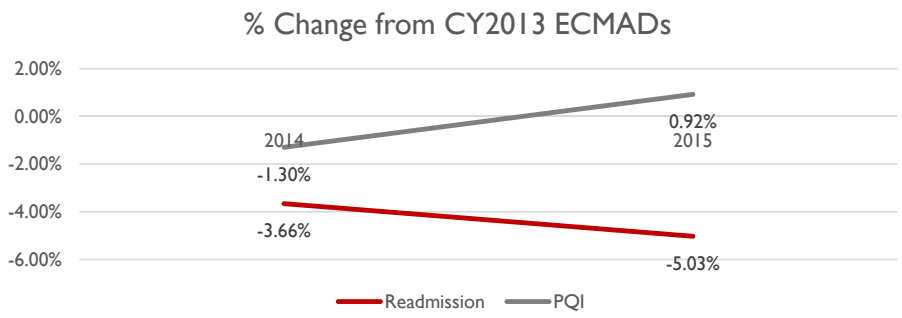
Rate Year (RY) 2017 Potentially Avoidable Utilization Savings Policy Draft Recommendation

Background

- 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
- All-Payer Model moved the payments to global budgets
  - RY2016 Policy remained the focus on readmissions because of concerns over progress in readmissions reductions
  - Aligned the readmission measure from same hospital readmissions to any hospital within the state
  - Capped the reductions to statewide average for hospitals that are above the 75th percentile on the percentage of Medicaid discharges for those over age 18

Proposed Changes to the Savings Policy

- Align the shared savings with Potentially Avoidable Utilization
  - Add Prevention Quality Indicators (PQI)*
  - Readmissions are counted at the receiving hospital
  - Add observation stays lasting 23 hour or longer to inpatient discharges



*Developed Agency For Health Care Quality and Research 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.

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RY 2017 PAU Savings Draft Recommendations

- Align the measure with the PAU definitions used in the market shift adjustment, which is comprised of readmissions and PQIs (inclusive of observation cases that are greater than 23 hours).
- Set the value of the PAU savings amount to 1.25 percent of total permanent revenue in the state, which is a 0.65 percent net reduction in RY 2017.
- 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 2018 to incorporate additional categories of unplanned admissions.
- Evaluate progress on sepsis coding and the apparent discrepancies in levels of sepsis cases across hospitals, including the need for possible independent coding audits.

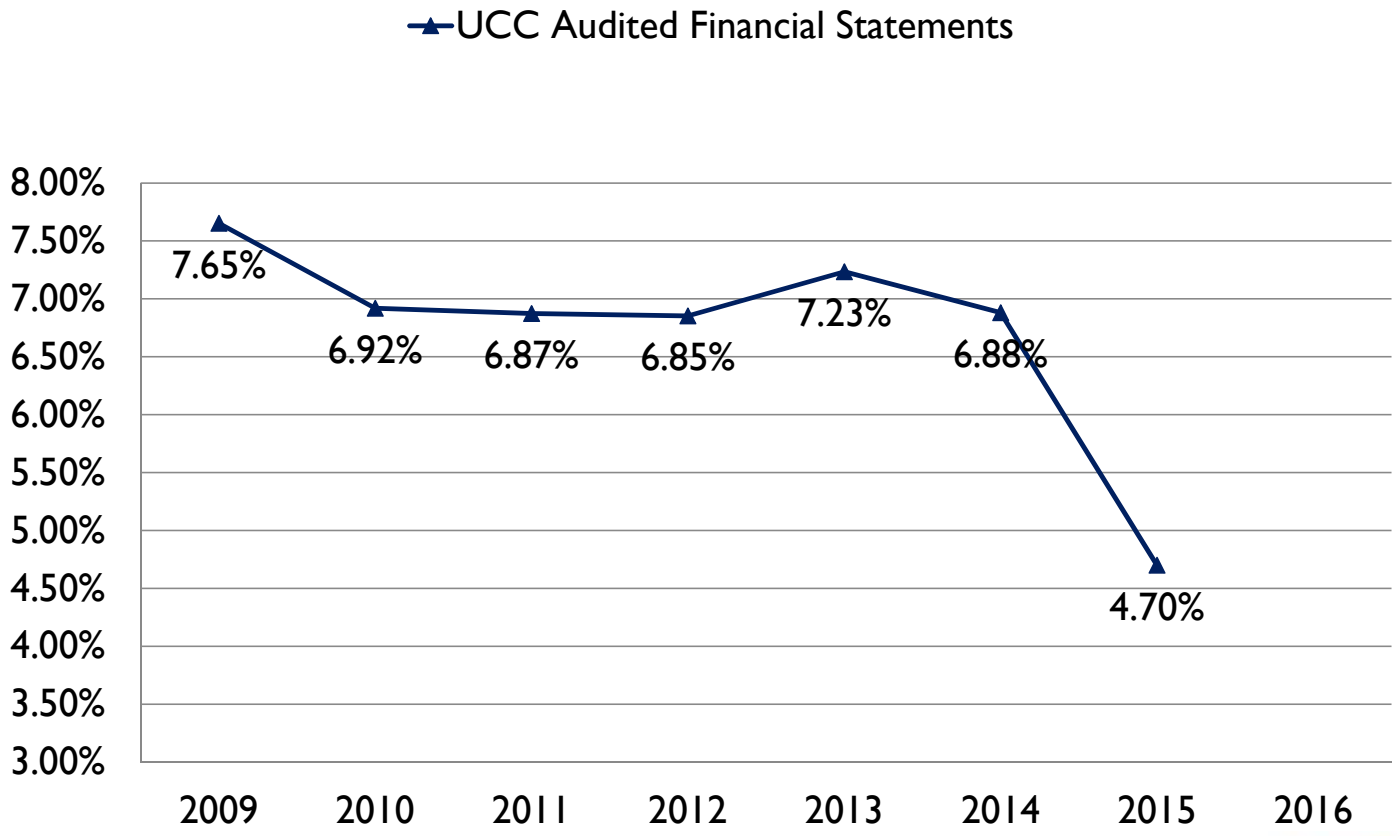
"Shared Savings" Reductions are Simply Revenue Reductions

- The proposed shared savings adjustment of 1.25 percent would remove $190.6 million from hospital budgets
- It's been characterized as a savings mechanism that allows hospitals to retain 100 percent of the reduction beyond the savings benchmark. However, since costs are both fixed and variable, savings are generated and accrued at less than 100 percent.
- Assuming hospital costs are 50% variable, for the hospital field to break even on a $190.6 million reduction, the field must reduce volume equivalent to $381.2 million ($190.6 x 2)
- A hospital would not begin to keep any cost savings until PQIs were reduced by 46 percent or readmissions by 30 percent

	CY 2015 Average Charge	Number cases to reduce to achieve $381.2 million savings	CY 2015 number of cases (including Observation)	**Percent reduction required for hospital to break even**
		(Savings target of $381.2 M / PQI avg chg $10,651)		(Cases to reduce / CY 15 number of cases)
PQI	$10,651	35,789	77,654	**-46.1%**
Readmissions	$15,277	24,953	83,412	**-29.9%**

Uncompensated Care Policy
Year 2017

Uncompensated Care as a Percent of Gross Patient Revenue Fiscal Years 2009- 2015



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HSCRC UCC Adjustments for ACA

- Traditionally staff prospectively calculates the rate of uncompensated care at each regulated hospital by combining historical uncompensated care rates with predictions from a regression model over three years.
- The Commission adjusted this methodology to incorporate a prospective yet conservative adjustment for the expected impact of the ACA's Medicaid expansion on uncompensated care.
  - For FY 2015, results of the historic trend and regression model were adjusted down from 7.23% to 6.14% to capture the expected impact of the State extending full Medicaid benefits to people previously enrolled in the PAC program.
  - For FY 2016, results were adjusted further down to 5.25 % based on estimated impact for higher enrollment rates in Medicaid due to woodwork effect and expansion.

UCC Policy 2017 Considerations

- Reduce statewide UCC provision in rates from 5.25 % to 4.70 % effective July 1, 2016
- Continue to do 50/50 blend of FY15 audited UCC and predicted UCC
- For hospital predicted rates
  - Focus on post ACA period (FY 15 experience)
  - Two alternatives are considered
    - Statewide hospital level model using average UCC % by Payer source, type of service.
    - Predictive regression analysis

FY 2017 Update Factor

May 11, 2016

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Balanced Update Model for Discussion

Components of Revenue Change Linked to Hospital Cost Drivers/Performance

			Weighted Allowance
Adjustment for Inflation			1.72%
- Allowance for High Cost New Drugs			0.20%
Gross Inflation Allowance	A		1.92%
Implementation for Partnership Grants	B		0.25%
Care Coordination			
-Rising Risk With Community Based Providers			
-Complex Patients With Regional Partnerships & Community Partners			
-Long Term Care & Post Acute			
	C		
Adjustment for volume	D		0.52%
-Demographic Adjustment			
-Transfers			
-Categoricals			
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	E		0.50%
- Workforce Support Program	F		0.06%
- Holy Cross Germantown	G		0.07%
- Non Hospital Cost Growth	H		0.00%
Net Other Adjustments	I =	Sum of E thru H	0.63%
-Reverse prior year's PAU savings reduction	J		0.60%
-PAU Savings	K		-1.25%
-Reversal of prior year quality incentives	L		-0.15%
-Positive incentives (Readmissions and Other Quality	M		0.47%
-Negative scaling adjustments	N		-0.28%
Net Quality and PAU Savings	O =	Sum of J thru N	-0.61%
Net increase attributable to hospitals	P =	Sum of A + B + C + D + I + O	2.72%
Per Capita	Q =	(1+P)/(1+0.52%)	2.19%

Components of Revenue Change with Neutral Impact on Hosptial Finanical Statements

-Uncompensated care reduction, net of differential	R		-0.55%
-Deficit Assessment	S		-0.15%
Net decreases	T =	R + S	-0.70%
Net revenue growth	U =	P + T	2.02%
Per capita revenue growth	V =	(1+U)/(1+0.52%)	1.49%

Medicare Savings Requirements: Scenario 1

Maximum Increase that Can Produce Medicare Savings		
Medicare		
Medicare Growth CY 2016	A	1.20%
Savings Goal for FY 2017	B	-0.50%
Maximum growth rate that will achieve savings (A+B)	C	0.70%
Conversion to All-Payer		
Actual statistic between Medicare and All-Payer	D	0.89%
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**1.60%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.52%)-1	F	**2.12%**

Comparison of Medicare Savings Requirements to Model Results			
Comparison to Modeled Requirements	**All-Payer Maximum to Achieve Medicare Savings**	**Modeled All-Payer Growth**	**Difference**
Revenue Growth	2.12%	2.02%	-0.11%
Per Capita Growth	1.60%	1.49%	-0.11%

Medicare Savings Requirements: Scenario 2

Maximum Increase that Can Produce Medicare Savings		
Medicare		
Medicare Growth (CY 2016 + CY 2017)/2	A	1.75%
Savings Goal for FY 2017	B	-0.50%
Maximum Growth Rate that will Achieve Savings (A+B)	C	1.25%
Conversion to All-Payer		
Actual Statistic between Medicare and All-Payer	D	0.89%
Conversion to All-Payer Growth per Resident (1+C)*(1+D)-1	E	**2.15%**
Conversion to Total All-Payer Revenue Growth (1+E)*(1+0.52%)-1	F	**2.68%**

Comparison of Medicare Savings Requirements to Model Results			
Comparison to Modeled Requirements	**All-Payer Maximum to Achieve Medicare Savings**	**Modeled All-Payer Growth**	**Difference**
Revenue Growth	2.68%	2.02%	-0.67%
Per Capita Growth	2.15%	1.49%	-0.66%

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

Table 5B

	A Actual Jan- June 2014	B Actual FY 2015	C Staff Est. FY 2016	D Proposed FY 2017	Cumulative Through FY 2017
Maximum Gross Revenue Growth Allowance	**2.13%**	**4.26%**	**4.12%**	**4.12%**	**15.44%**
Revenue Growth for Period	**0.90%**	**2.51%**	**2.94%**	**2.02%**	**8.62%**
Savings from UCC & Assessment Declines that do not Adversely Impact Hospital Bottom Line		1.09%	1.41%	0.70%	3.23%
Revenue Growth less UCC & Assessment Savings	**0.90%**	**3.60%**	**4.35%**	**2.72%**	**12.04%**
Revenue Difference between Cap & Projection					**3.40%**

Summary of Recommendations

- Update the three categories of hospitals & revenues:
  - 2.02% for revenues under global budgets
  - 1.24% for revenues subject to waiver but excluded from global budgets
  - 1.55% for psychiatric hospitals and Mt. Washington Pediatric Hospital
- Increase in PAU Savings (Shared Savings)
- 0.20% set aside for allowance of Physician Administered High Cost Drugs

DRAFT Recommendation for Transformation Implementation Grants

5/11/2016

Background

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

Review Process

- Review Committee comprised of DHMH, HSCRC, and Subject-Matter Experts
- Extensive review process evaluating several different criteria (detailed in report on page 2-3) including having the best opportunity to help Maryland on achieving the goals of the All-Payer Model
- Nine top-tier applicants were invited, with their community partners, to present their proposal; these applicants are recommended for either full or partial funding as detailed in the Recommendations table.

Recommendations

Partnership Group Name	Award Request	Award Recommendation	Hospital(s) in Proposal
Bay Area Transformation Partnership	$4,246,698.00	$3,831,143.00	Anne Arundel Medical Center; UM Baltimore Washington Medical Center
Community Health Partnership	$15,500,000.00	$6,674,286.00	Johns Hopkins Hospital; Johns Hopkins – Bayview; MedStar Franklin Square; MedStar Harbor Hospital; Mercy Medical Center; Sinai Hospital
GBMC	$2,942,000.00	$2,115,131.00	Greater Baltimore Medical Center
Howard County Regional Partnership	$1,533,945.00	$1,468,258.00	Howard County General Hospital
Nexus Montgomery	$7,950,216.00	$7,663,683.00	Holy Cross Hospital; Holy Cross – Germantown; MedStar Montgomery General; Shady Grove Medical Center; Suburban Hospital; Washington Adventist Hospital
Total Eldercare Collaborative	$1,882,870.00	$1,882,870.00	MedStar Good Samaritan; MedStar Union Memorial
Trivergent Health Alliance	$4,900,000.00	$3,100,000.00	Frederick Memorial Hospital; Meritus Medical Center; Western Maryland Hospital Center
UM-St. Joseph	$1,147,000.00	$1,147,000.00	UM St. Joseph Medical Center
Upper Chesapeake Health	$2,717,963.00	$2,692,475.00	UM Harford Memorial Hospital; UM Upper Chesapeake Medical Center; Union Hospital of Cecil County
Total	$42,820,692.00	$ 30,574,846.00	

Next Steps

- The Review Committee has recommended the nine proposals for funding at the levels indicated above.
- HSCRC will monitor the implementation of the awarded grants through additional reporting requirements.
- HSCRC is also recommending that a schedule of savings be remitted to payers through the global budget on the following schedule.
  - (Savings represent the below percentage of the award amount)

FY2018	FY2019	FY2020
10%	20%	30%

- Finally, Staff is recommending allocating the remaining $6,461,940 of the FY2016 0.25% to deserving projects and promising collaborations within the unfunded proposals. Recommendations will be made in September 2016.
- All Submitted RFPs will be posted on the HSCRC website.

Staff Report: CRISP FY 2017 Approved Budget for HIE Operations and CRISP Reporting Services

May 11, 2016

HSCRC Funding Support for HIE and CRS

- Over the past 7 years, the Commission has approved funding to support the general operations of the CRISP HIE and reporting services through hospital rates

CRISP Budget: HSCRC Funds Received	
FY 2010	$4,650,000
FY 2011	No funds received
FY 2012	$2,869,967
FY 2013	$1,313,755
FY 2014	$1,166,278
FY 2015	$1,650,000
FY 2016	$3,250,000

Staff Authority to Provide Funding through Rates

- Staff is authorized, without further Commission approval, to provide up to $2.5 million in hospital rates to support CRISP
- Budget consists of:
  - Health Insurance Exchange Operations (FY16 - $1.7M)
  - Standard CRISP report services (FY16 1.5M)
- Non-rate Support - Beginning in FY16, BRFA 2015 permits the use of MHIP surplus funds derived from federal Medicare and Medicaid to be used for integrated care network activities in FY16-19
  - ICN are activities designed to reduce health care expenditures and improve outcomes for unmanaged Medicare and Duals consistent with the All-Payer Model.

FY17 HIE and CRISP Reporting Services in Rates

- Under the authority granted by the Commission, HSCRC staff approved a total of $2.36 million in funding through hospital rates in FY 2017 to support the HIE and standard CRISP reporting services for the Commission.

FY17 Project Name	Budgeted Funding (State)	Budgeted Funding (Federal)	Total
HIE Ops Assessment	1,060,000	-	1,060,000
IAPD Ops Match (50%)	350,000	350,000	700,000
IAPD Project Match (10%)	300,000	2,700,000	3,000,000
CRS Operations	650,000	-	650,000
Amount Funded by Hospital Rates	**2,360,000**	**3,050,000**	**5,410,000**

ICN Budget for FY 2017

FY17 Project Name	Budgeted Funding (State)	Budgeted Funding (Federal)	Total
ICN Infrastructure: Ambulatory Connectivity	3,187,049	6,210,000	9,397,049
ICN Infrastructure: Data Router	939,134	-	939,134
ICN Infrastructure: Clinical Portal Enhancements	1,265,348	-	1,265,348
ICN Infrastructure: Alerts & Notifications	1,019,838	-	1,019,838
ICN Infrastructure: Reporting and Analytics	8,996,529	-	8,996,529
ICN Infrastructure: Basic Care Management Software	2,660,586	-	2,660,586
ICN Infrastructure: Practice Transformation	1,214,240	3,465,000	4,679,240
Amount Funded through BRFA / ICN	**12,871,355**	**3,465,000**	**16,336,355**