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509th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
June 11, 2014

EXECUTIVE SESSION
11:30 a.m.

1. **Administrative Issues**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Minutes from the Executive Session and Public Meeting on May 14, 2014**

2. **Executive Director's Report**

3. **Report of the Physician Alignment and Engagement Work Group**

4. **Docket Status – Cases Closed**
   2249A – University of Maryland Medical Center

5. **Docket Status – Cases Open**
   2248N – Baltimore-Washington Medical Center

6. **Final Recommendation on Uncompensated Care Policy**

7. **Final Recommendation on Readmission Shared Savings for FY 2015**

8. **Final Recommendation on a Balanced Updates for FY 2015**

9. **Final Recommendation for FY 2015 Support for the Maryland Patient Safety Center**

10. **Final Recommendation on Nurse Support Program II Competitive Institutional Grants**

11. **Report on FY 2015 CRISP Funding Support**

12. **Draft Recommendation for Revision to the Relative Value Units Scale for Laboratory Services**

13. **Legal Report**

14. Hearing and Meeting Schedule

DRAFT: Report on Current Physician Payment Models and Recommendations for Shared Strategies under the All-Payer Model

Executive Summary

Purpose

The purpose of this draft report is to provide the HSCRC with the Workgroup's suggestions on how to prioritize the development and implementation of a full range of strategies to better align hospitals, physicians and other health care providers to achieve the goals of the new All-Payer Model. While alignment will involve strategies to be employed by providers, payers, and other stakeholders, this report focuses on what the State and Commission could do as a regulator, facilitator and catalyst to promote alignment of strategies between hospitals and other health care providers.

Recommendations are intended to provide direction, recognizing that the HSCRC's role in implementation will vary, resources will be required for planning and implementation, and additional details will need to be fleshed out. The new All-Payer Model and hospitals' global budgets have changed the incentives in the Maryland system to encourage meeting the goals of the Three-Part Aim--better care, better health, and lower cost. The report is prescriptive in recommending that the HSCRC and State should work to obtain federal waivers and address State legal barriers that enable alignment under the new model. In other recommendations, the role of the HSCRC will be to encourage and work with the hospitals, physicians, and other providers to create and utilize alignment models and care management activities to improve the delivery of care..

The Issue

Under the new All-Payer approach, hospitals are moving to global budget arrangements to facilitate achieving the goals of the new Model. Changes will need to be made to improve alignment with physicians and other providers. In most instances, physicians and other health care providers are paid on a fee-for-service basis. Moreover, a substantial percentage of physicians are employed by or contracted with hospitals using approaches that will need to be adjusted. In order to reach the goals of the new All-Payer Model, there needs to be some harmonization of incentives and increased integration of care.. There are various aspects of this harmonization where the HSCRC may play a role. The potential strategies are both compensatory and non-compensatory. Below is a list of some of some of the potential alignment strategies:

- Non-Compensatory
    - Shared infrastructure, analytics and other resources;
    - Better health care quality and cost reporting;
    - Investment to improve ease of practice, such as care management support.
- Compensatory
    - Pay for Performance
    - Gain Sharing
    - Shared Savings

Some of these strategies face legal barriers that would first need to be addressed including State and federal Stark laws, the Anti-Kickback Statute, the False Claims Act, the Civil Monetary Penalty Act, antitrust limitations, IRS limitations on charitable hospitals, and State insurance law restrictions.

Opportunities

Medical care for Medicare enrollees is largely unmanaged even though they require more acute and chronic care services and are often less able than younger persons to access and manage their own health and care needs. Medicare offers the greatest opportunity for improvement in the quality and cost goals of the All-Payer model. Therefore, ACO's, Integrated Shared Savings Organizations (ISSOs), PCMH's, and other similar models could be most effective for this population. As these models are developed, it would be most useful to establish a baseline of agreed upon principles, standards, and language to facilitate compatible efforts with measureable outcomes. Ideally, the models would create financial incentives and incorporate evidence-based strategies that would gain support among payers, hospitals, physicians and other providers and would promote efficient, high quality, patient centric, medical services.

Goals and Desirable Features

The Workgroup created a list of goals and desirable features it hopes to achieve through the physician alignment and engagement strategies that are recommended under the All-Payer Model. While some of these goals and desired features are aspirational, they can serve as a guide in prioritizing efforts and as a roadmap for developing future policies. The identified goals are as follows:

Goals

- Engage health care providers and align their incentives based on quality improvement goals, consistent with the goals, requirements and policies of the All-Payer Model
- Promote aligned incentives to improve the overall health of the entire population, including hospital and non-hospital-based health care services
- Encourage the development of programs and services that keep stride with the national trend of movement from a volume based provider centric system to a value based consumer centric system
- Strive to engage all payers in the incentive and alignment programs

Desirable Features

- Alignment
    - Attention of different providers is focused on strategies that are most likely to help is to meet the All-Payer and Medicare savings requirements of the new model.
    - The models are tailored to specific health care provider roles, and recognize that significant differences exist among primary care physicians and specialists, independent and hospital-owned practices, and physicians and other health care providers in terms of their goals, capabilities, resources and other characteristics.
    - The models reward value, and take into consideration in the development of rewards both higher existing levels of value, as well as, value improvement.

    - In order to have the greatest impact, staging of models is based on opportunities that are possible today under the current regulatory environment, while working to remove barriers to enable broader population-based approaches.
    - To the extent practicable, savings are targeted to those who have produced the savings.

- Engagement
    - Physicians are provided an active role in developing and refining alignment strategies related to the All-Payer Model.
    - Health care consumers are engaged in the alignment process across all segments of the health care industry.
    - Hospitals and physicians are invited to participate on a voluntary basis.
    - Physicians are sufficiently incentivized to commit time and effort to improving quality and lowering cost.
- Awareness
    - Education is available to ensure all stakeholders understand the existence and incentives of the new Triple Aim-focused model.
- Transparency
    - Data are presented in a timely and actionable form.
    - Metrics are clear in purpose and meaning and, to the extent practicable, understood in advance by the providers to which they apply.
    - Accountability is required from providers and payers.
- Scalability
    - Strategies are simple in design and replicable.
    - Hospitals and physicians have sufficient support for the infrastructure investments needed to succeed under new alignment strategies.
    - All payers and hospitals/system are permitted and encouraged to construct arrangements to meet specific organizational and community goals with common elements that have the power to focus attention on shared goals and encourage collaboration.
- Sustainability
    - Existing health care infrastructure is repurposed and current assets are fully leveraged so that unnecessary duplication and fragmentation are reduced.
    - The regulatory, legal and administrative environments prudently encourage innovation under the All-Payer Model.
    - Hospital payment models and alignment models should aim for consistency and predictability, to encourage participation, investment, and sustainability.
    - Sustainability ultimately rests on the ability to improve the overall health of the citizens of Maryland. All programs should be evaluated through the effectiveness of this overarching goal.

Potential Options

Below are some initial potential options for consideration related to the strategies discussed above.

- The HSCRC could serve as a catalyst to encourage the hospital industry, providers, and providers to consider ways to:
    - share infrastructure, analytics, and other resources;
    - improve reporting between and for hospitals and providers;
    - make the practice of medicine more efficient for providers; and
    - promote broad awareness of the objectives of the new model financial incentives promoting it and the various types of programs designed to support it.

- HSCRC serve as catalyst for hospitals, physicians, and other providers to work collaboratively toward models that are consistent with the goals of the Three-Part Aim and the new All-Payer Model.

- HSCRC should work with the field to pursue confirming with CMS/OIG (and/or other appropriate regulatory bodies) the ability of Maryland hospitals to pursue pay-for-performance models, without additional regulatory approval.

- The Maryland Hospital Association and MedChi work collaboratively to pursue a New Jersey type physician incentive model that is modified to be consistent with the goals of the new All-Payer Model (with input and advocacy from the HSCRC).

- The HSCRC should work with the State and key stakeholders to pursue a Maryland-specific ACO-like or Integrated Share Savings Organization (ISSO) option, which would require infrastructure development and regulatory approval, and provide Maryland with increased flexibility in the development of a default model for beneficiaries not in ACOs, Medicare Advantage, or other CMS demonstration projects.

- HSCRC should serve as catalyst for encouraging and expanding alignment models across all payers, and consistency regarding incentives, including working with stakeholders to determine if legislative or regulatory changes are necessary to achieve the options above and to sponsor or promote those changes, as appropriate.

- HSCRC should serve as catalyst for encouraging models that are possible today (e.g., Primary Care Medical Homes and pay for performance enhancements to fee-for-service and salary models)), while pursuing broader population-based models (e.g., ISSO) that require regulatory approvals and additional infrastructure development.

Maryland could use a staged combination of strategies, including a gain sharing strategy (New Jersey-type model) that could be implemented relatively quickly and target inpatient hospital costs per case (and may be expanded to include episode costs), while the State works in collaboration with the field to further develop details of an ISSO methodology and to receive regulatory approvals for broader population-based shared savings strategies.

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

AS OF JUNE 3, 2014

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2248N	Baltimore Washington Medical Center	5/1/2014	7/9/2014	9/29/2014	ANS/ORC	CK	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

Report on Uncompensated Care Policy Recommendations

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

June 11, 2014

These final recommendations are for Commission action at the June 2014 Public Commission Meeting.

Final Report on Uncompensated Care Policy Recommendation

INTRODUCTION

Overview

Since it first began setting rates, the HSCRC has recognized the cost of uncompensated care (charity care and bad debt) 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 uncompensated care provided to those patients.

Under the current HSCRC policy, uncompensated care is funded by a statewide pooling system in which regulated Maryland hospitals draw funds from the pool if they experience a greater-than-average level of uncompensated care and pay into the pool if they experience a less-than-average level of uncompensated care. This ensures that the cost of uncompensated care is shared equally across all of the hospitals within the system.

The HSCRC prospectively calculates the rate of uncompensated care at each regulated Maryland hospital by combining historical uncompensated care rates with predictions from a regression model.

The HSCRC must determine the total amount of uncompensated care that will be placed in hospital rates for FY 2015 and the amount of funding that will be made available for the uncompensated care pool. Additionally, HSCRC must review the methodology for distributing these funds among hospitals.

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

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

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

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

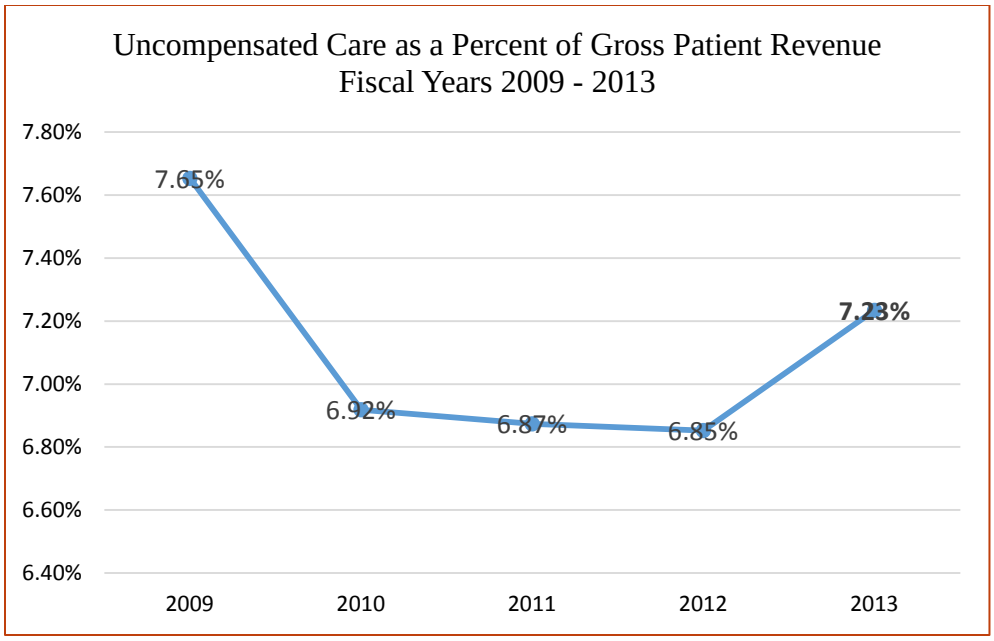
STAKEHOLDER INPUT

The draft staff report was reviewed with the Payment Models Workgroup, and staff incorporated several Workgroup comments in this staff report. As discussed below, staff also evaluated data submitted by hospitals regarding payments received for PAC patients by hospitals.

BACKGROUND

Recent Trends in Uncompensated Care

The chart below shows the actual total uncompensated care rate for all regulated Maryland hospitals between FY 2009 and FY 2013. Uncompensated care levels dropped between FY 2009 and FY 2010, but remained relatively steady with only a slight decline from FY 2010 to FY 2012. Most recently between FY 2012 and FY 2013 there was a 0.38 percentage point increase in the total uncompensated care rate for all regulated Maryland hospitals.



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

Current Uncompensated Care Policy

The current uncompensated care policies were adopted by the Commission between 2007 and 2013 . The policies create a statewide pool built into the rate structure of Maryland hospitals. Hospitals either pay into or withdraw from the pool depending on each hospital's prospectively calculated rate of uncompensated care. Each year, the total amount of funds available in the pool is determined by the total percent of gross patient revenue due to uncompensated care experienced in regulated Maryland hospitals during the previous year. For example, if in 2013 the actual total cost of uncompensated care were 5 percent, then in 2014 the pool would prospectively be set at 5 percent of the 2014 gross patient revenue.

The prospective uncompensated care percentage for each hospital is computed by taking the average actual percent of uncompensated care experienced by the hospital over the

past three years and combining that "actual" value with a predicted value of uncompensated care determined by a regression model. The annual uncompensated care percentage for each hospital is weighted equally between the three-year average and the predicted regression value as shown in the formula below.

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

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

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

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

This model was applied to data from the three-year historical period used to generate the average actual uncompensated care percentage described above. Three hospitals, Levindale Hospital, the University of Maryland Rehabilitation & Orthopedic Institute (formerly Kernan Hospital), and the Shock Trauma Center are excluded from the regression calculation. Under the current model, the HSCRC set the annual uncompensated care percentages for these hospitals at their actual average uncompensated care percentage for the previous three years.

Indefinite Suspension of the Charity Care Multiplier

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

Enrollment under the Affordable Care Act (ACA)

Expanded coverage under the ACA will reduce uncompensated care. A primary goal of the ACA was to expand coverage to uninsured or underinsured individuals. Counting both individuals who have obtained Medicaid coverage and those who have selected a private health plan through Maryland's insurance exchange, 295,077 Marylanders enrolled in coverage as of March 31, 2014. This includes coverage of 232,075 Marylanders through Medicaid and 63,002 through private health plans.

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

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

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

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

Similarly, some of the new private enrollees likely had coverage in the past. Additionally, these private enrollees must pay their first premium before obtaining coverage, and the deductibles and coinsurances associated with these insurance plans may be high. It will be some time before the impact of these individuals on uncompensated care can be determined.

ANALYSIS

Determining Appropriate Level of Uncompensated Care Funding in Rates

The HSCRC must determine the percentage of uncompensated care to recognize in hospitals' rates to enable funding of the uncompensated care pool.

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

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

Increase in Uncompensated Care between FY 2012 and FY 2013

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

Enrollment of the Primary Adult Care Population

HSCRC staff has focused initial efforts on quantifying the projected impact of expanded coverage for Maryland's PAC enrollees. Staff focused on this population because it is unlikely that many of these individuals had a form of coverage for their hospital bills prior to Medicaid enrollment. The HSCRC has collected data on this population's health care utilization for several years.

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

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

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

Table: PAC Enrollees Who Received Hospital Care, FY 2013

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

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

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

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

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

The estimate for the reduction in UCC without any offsets for collections is 1.09 percent. It should be noted that Medicaid receives a differential of 6 percent; therefore, approximately 94 percent of the reduction of the uncompensated care will be recognized in hospital rates due to a corresponding increase that will occur in the mark up relative to the increase in the differential that will result from the higher proportion of Medicaid revenues. This mark up change is a separate provision in the rate update process.

As a result of these two changes, the UCC in hospitals' rates would be set at 6.15 percent:

In rates for FY 2014	6.86%
Increase for change in FY 2013	0.38%
Decrease for PAC	1.09%
Net.	6.15%

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

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

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

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

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

Evaluation of the Current Uncompensated Care Regression

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

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

The current regression model was applied to FY 2011, FY 2012, and FY 2013 data in order to calculate the predicted uncompensated care rate for each hospital for FY 2015. Overall, the model had good explanatory results, but the first explanatory variable above was not statistically significant. Appendix II shows the results of the current regression.

The HSCRC staff analyzed more than forty possible variables and identified five statistically significant variables that produced a better model for predicting uncompensated care percentages. These models have been updated from the draft

recommendation to include the reported FY 2013 uncompensated care amounts for hospitals with years ending after June 30.

Five Statistically Significant Variables Model

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

1. The proportion of a hospital's total charges from inpatient Medicaid admissions through the emergency room
2. The proportion of a hospital's total charges from inpatient commercial insurance cases
3. The proportion of a hospital's total charges from inpatient self-pay and charity cases
4. The proportion of hospital's total charges from outpatient self-pay and charity emergency department charges
5. The proportion of a hospital's total charges from inpatient self-pay and charity admission through the emergency room from the 80th percentile of Medicaid undocumented immigrant enrollment zip codes

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

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

This model fit the observed data more closely than the current model, increasing the adjusted R-square value from 0.6777 under the current model to 0.7792 under the Five Statistically Significant Variables Model. Also, the predicted uncompensated care rates from this model for FY 2013 more closely mirrored the actual rates of uncompensated care experienced by hospitals in FY 2013. There is some concern about separating Medicaid and self-pay revenue sources as done in this model due to possible classification differences in charges associated with Medicaid pending status, but the benefit in terms of the improved results and model fit outweighed the concern. Consistency in this area should improve with new instructions from HSCRC to facilitate more consistent classification in 2014 and beyond.

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

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

Continuing Suspension of Charity Care Multiplier

HSCRC staff recommends continuing the suspension of the charity care multiplier indefinitely. The data have not improved and, furthermore, the expansion of coverage under the ACA will likely reduce charity care. This policy can be reevaluated in two to three years after the expansion and implementation of ACA have been completed.

Evaluation of Continuing Sources of Uncompensated Care

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

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

RECOMMENDATIONS

Based on the foregoing, the HSCRC staff recommends that:

1. The uncompensated care provision in rates be reduced from 6.86% to 6.15%, effective July 1, 2014;
2. Uncompensated care levels continue to be monitored for further potential reductions for FY 2016 or sooner, if warranted;
3. The regression formula be changed from the current model:
    a. Use Five Variable Model described in this report;
    b. Combine results of the Five Variable Model with two years of historical data to more closely reflect current trends in uncompensated care. This process will need to be modified next year as a result of the significant changes in bad debt levels;
    c. Subtract the PAC% of FY 2013 charges from the modeled uncompensated care result for each hospital to derive its final percentage for determining its contribution or withdrawal from the uncompensated care pool. Appendix IV shows the result of this calculation.
4. The Charity Care Adjustment be suspended indefinitely and not be reinstituted in FY 2015 rates;
5. Data be collected on write-offs to guide future development of uncompensated care regression models and uncompensated care policies;
6. Data be collected on outpatient denials, in addition to data already collected on inpatient denials, to understand the continuing trends in denials under the new All-Payer model; and
7. A new uncompensated care policy be developed for FY 2016 that reflects the patterns in uncompensated care experience, which are observed in FY 2015 and projected for FY 2016.

Appendix I: Calculation to Achieve a Revenue Neutral Policy

The HSCRC calculates the annual UCC percentage for each hospital by combining the average actual UCC percentage for each hospital for the past three years with a predicted UCC percentage from the regression model. The HSCRC then adjusts the annual UCC percentage for each hospital so that the total statewide UCC percentage is equal to the actual total statewide UCC percentage for 2013. This is done to achieve a revenue neutral system of pooling across all hospitals. This adjustment is done before any policy adjustments are made, such as the PAC reduction.

Revenue neutral adjustment factor:

$$= \frac{Total\ actual\ 2013\ UCC\ \% - Total\ calculated\ UCC\%\ for\ 2015}{Total\ actual\ \ 2013\ UCC\%} + 1$$

Adjusted UCC percentage for each hospital:

$$= revenue\ neutral\ adjustment\ factor * 2015\ UCC\%\ calculated\ for\ hospital\ 1$$

Appendix II: Results of Current Regression Model for 2015 (Not Revenue Neutral)

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

HOSPID	Hospital Name	Fiscal Year 2013 Actual UCC	Fiscal Year 2013 Regression Predicted UCC	2011-2013 (Three Year Average)	50-50 UCC Blended Percent	Adjusted Blended Percent	Difference between Actual UCC and Adjusted UCC
210002	Univ. of Maryland Medical Center	5.40%	8.87%	6.52%	7.70%	7.61%	2.22%
210045	McCready Foundation, Inc.	8.32%	10.12%	10.45%	10.28%	10.20%	1.88%
210034	Harbor Hospital Center	8.59%	11.49%	8.33%	9.91%	9.83%	1.24%
210010	Univ. of Maryland Shore Medical Center at Dorchester	6.99%	10.03%	6.50%	8.26%	8.18%	1.19%
210035	Univ. of Maryland Charles Regional Medical Center	7.46%	9.80%	7.42%	8.61%	8.53%	1.07%
210048	Howard County General Hospital	5.99%	7.67%	6.05%	6.86%	6.78%	0.79%
210015	Franklin Square Hospital	7.06%	8.99%	6.84%	7.92%	7.83%	0.77%
210012	Sinai Hospital	5.41%	7.22%	5.14%	6.18%	6.09%	0.68%
210009	Johns Hopkins Hospital	4.27%	6.01%	3.94%	4.97%	4.89%	0.62%
210044	Greater Baltimore Medical Center	3.12%	4.55%	3.09%	3.82%	3.74%	0.62%
210033	Carroll County General Hospital	4.70%	5.90%	4.89%	5.39%	5.31%	0.61%
210039	Calvert Memorial Hospital	6.16%	7.82%	5.87%	6.85%	6.77%	0.61%
210001	Meritus Medical Center	7.20%	8.11%	7.50%	7.81%	7.72%	0.53%
210057	Shady Grove Adventist Hospital	6.76%	7.98%	6.38%	7.18%	7.10%	0.34%
210032	Union Hospital of Cecil County	8.69%	9.77%	8.39%	9.08%	9.00%	0.31%
210062	Southern Maryland Hospital	6.84%	7.79%	6.65%	7.22%	7.14%	0.29%
210060	Fort Washington Medical Center	13.63%	14.61%	13.10%	13.85%	13.77%	0.15%
210005	Frederick Memorial Hospital	6.03%	6.23%	6.21%	6.22%	6.14%	0.11%
210049	Upper Chesepeake Medical Center	6.08%	6.11%	6.28%	6.20%	6.11%	0.03%
210037	Univ. of Maryland Shore Medical Center at Easton	5.86%	6.39%	5.54%	5.97%	5.88%	0.02%
210056	Good Samaritan Hospital	6.60%	7.24%	6.06%	6.65%	6.56%	-0.04%
210003	Prince Georges Hospital	15.51%	15.78%	14.98%	15.38%	15.30%	-0.21%
210018	Montgomery General Hospital	6.59%	6.56%	6.32%	6.44%	6.35%	-0.24%
210011	St. Agnes Hospital	7.96%	8.42%	7.18%	7.80%	7.72%	-0.24%
210022	Suburban Hospital Association,Inc	5.07%	4.78%	4.83%	4.80%	4.72%	-0.35%
210019	Peninsula Regional Medical Center	6.87%	6.03%	6.77%	6.40%	6.31%	-0.55%
210004	Holy Cross Hospital of Silver Spring	9.26%	8.44%	9.07%	8.75%	8.67%	-0.59%
210023	Anne Arundel General Hospital	5.21%	4.53%	4.80%	4.66%	4.58%	-0.63%
210061	Atlantic General Hospital	7.68%	7.20%	6.92%	7.06%	6.98%	-0.70%
210028	St. Marys Hospital	8.47%	8.92%	6.78%	7.85%	7.77%	-0.71%
210040	Northwest Hospital Center, Inc.	8.41%	7.98%	7.56%	7.77%	7.69%	-0.73%
210063	Univ. of Maryland St. Josephs Medical Center	5.13%	4.12%	4.64%	4.38%	4.30%	-0.83%
210027	Braddock Hospital	6.89%	6.04%	6.23%	6.14%	6.05%	-0.83%
210017	Garrett County Memorial Hospital	10.86%	9.43%	10.55%	9.99%	9.90%	-0.95%
210029	Johns Hopkins Bayview Med. Center	9.28%	8.31%	8.44%	8.37%	8.29%	-1.00%
210008	Mercy Medical Center, Inc.	8.29%	6.87%	7.69%	7.28%	7.20%	-1.09%
210051	Doctors Community Hospital	9.29%	8.02%	8.33%	8.18%	8.09%	-1.19%
210043	Univ. of Maryland Baltimore Washington Medical Center	9.78%	7.73%	9.10%	8.42%	8.33%	-1.45%
210024	Union Memorial Hospital	8.13%	6.31%	7.17%	6.74%	6.66%	-1.48%
210006	Harford Memorial Hospital	12.44%	9.64%	12.16%	10.90%	10.82%	-1.62%
210030	Univ. of Maryland Shore Medical Center at Chestertown	10.13%	7.27%	9.80%	8.53%	8.45%	-1.69%
210013	Bon Secours Hospital	19.09%	16.90%	16.96%	16.93%	16.85%	-2.25%
210038	Univ. of Maryland Medical Center Midtown Campus	15.22%	12.86%	13.16%	13.01%	12.92%	-2.30%
210055	Laurel Regional Hospital	14.23%	10.19%	13.62%	11.91%	11.82%	-2.41%
210016	Washington Adventist Hospital	14.08%	9.96%	12.86%	11.41%	11.32%	-2.76%

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

Dependent Variable: Actual Uncompensated Care Percent

Number of Observations Read	135
Number of Observations Used	135

Analysis of Variance

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	6	0.09019	0.01503	47.96	<.0001
Error	128	0.04012	0.0003135		
Corrected Total	134	0.13031			
Root MSE	0.0177	**R-Square**	**0.6921**		
Dependent Mean	0.07929	**Adj R-Sq**	**0.6777**		
Coeff Var	22.32978				

Parameter Estimates

Variables	DF	Parameter Estimate	Standard Error	t Value	Pr > |t|	Variance Inflation
Intercept	1	-0.00114	0.00653	-0.17	0.8614	0
The proportion of a hospital's total charges from inpatient non-Medicare admissions through the emergency room	1	0.07025	0.04088	1.72	0.0881	2.46728
The proportion of a hospital's total charges from inpatient Medicaid, self-pay, and charity cases	1	0.1922	0.04452	4.32	<.0001	3.53493
The proportion of a hospital's total charges from outpatient Medicaid, self-pay, and charity visits	1	0.24438	0.0688	3.55	0.0005	3.34674
The proportion of a hospital's total charges from outpatient non-Medicare emergency department charges	1	0.21567	0.04532	4.76	<.0001	2.39447
DUMMY1	1	-0.0005034	0.00385	-0.13	0.8961	1.41696
DUMMY2	1	-0.00439	0.00377	-1.17	0.2461	1.35687

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

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

HOSPID	Hospital Name	Fiscal Year 2013 Actual UCC	Fiscal Year 2013 Regression Predicted UCC	2012-2013 (Two Year Average)	50-50 UCC Blended Percent	Adjusted Blended Percent	Difference between Actual UCC and Adjusted UCC
210010	Univ. of Maryland Shore Medical Center at Dorchester	6.99%	10.12%	6.27%	8.20%	8.23%	1.24%
210045	McCready Foundation, Inc.	8.32%	10.47%	8.55%	9.51%	9.55%	1.23%
210002	Univ. of Maryland Medical Center	5.40%	7.04%	5.87%	6.45%	6.49%	1.09%
210056	Good Samaritan Hospital	6.60%	8.31%	6.25%	7.28%	7.32%	0.71%
210044	Greater Baltimore Medical Center	3.12%	4.44%	3.09%	3.77%	3.80%	0.69%
210062	Southern Maryland Hospital	6.84%	8.66%	6.32%	7.49%	7.53%	0.68%
210035	Univ. of Maryland Charles Regional Medical Center	7.46%	8.91%	7.30%	8.10%	8.14%	0.68%
210015	Franklin Square Hospital	7.06%	8.27%	7.12%	7.69%	7.73%	0.67%
210001	Meritus Medical Center	7.20%	8.17%	7.40%	7.78%	7.82%	0.63%
210033	Carroll County General Hospital	4.70%	5.66%	4.73%	5.19%	5.23%	0.53%
210037	Univ. of Maryland Shore Medical Center at Easton	5.86%	7.18%	5.53%	6.35%	6.39%	0.53%
210034	Harbor Hospital Center	8.59%	9.84%	8.28%	9.06%	9.10%	0.51%
210003	Prince Georges Hospital	15.51%	16.60%	15.34%	15.97%	16.01%	0.50%
210057	Shady Grove Adventist Hospital	6.76%	7.67%	6.71%	7.19%	7.22%	0.46%
210018	Montgomery General Hospital	6.59%	7.42%	6.54%	6.98%	7.02%	0.42%
210012	Sinai Hospital	5.41%	6.30%	5.29%	5.79%	5.83%	0.42%
210039	Calvert Memorial Hospital	6.16%	7.09%	5.93%	6.51%	6.55%	0.39%
210048	Howard County General Hospital	5.99%	6.43%	6.15%	6.29%	6.33%	0.34%
210005	Frederick Memorial Hospital	6.03%	6.47%	6.11%	6.29%	6.33%	0.30%
210022	Suburban Hospital Association,Inc	5.07%	5.81%	4.79%	5.30%	5.34%	0.27%
210061	Atlantic General Hospital	7.68%	8.62%	7.00%	7.81%	7.84%	0.17%
210011	St. Agnes Hospital	7.96%	8.85%	7.31%	8.08%	8.12%	0.16%
210009	Johns Hopkins Hospital	4.27%	4.58%	3.98%	4.28%	4.31%	0.05%
210040	Northwest Hospital Center, Inc.	8.41%	9.22%	7.62%	8.42%	8.46%	0.04%
210019	Peninsula Regional Medical Center	6.87%	6.48%	6.85%	6.67%	6.70%	-0.16%
210051	Doctors Community Hospital	9.29%	9.47%	8.61%	9.04%	9.08%	-0.21%
210049	Upper Chesepeake Medical Center	6.08%	5.34%	6.01%	5.67%	5.71%	-0.37%
210023	Anne Arundel General Hospital	5.21%	4.67%	4.92%	4.79%	4.83%	-0.38%
210027	Braddock Hospital	6.89%	6.35%	6.54%	6.45%	6.48%	-0.40%
210004	Holy Cross Hospital of Silver Spring	9.26%	8.17%	9.41%	8.79%	8.82%	-0.44%
210032	Union Hospital of Cecil County	8.69%	8.11%	8.29%	8.20%	8.23%	-0.45%
210063	Univ. of Maryland St. Josephs Medical Center	5.13%	4.49%	4.71%	4.60%	4.64%	-0.49%
210060	Fort Washington Medical Center	13.63%	13.00%	13.01%	13.01%	13.04%	-0.58%
210029	Johns Hopkins Bayview Med. Center	9.28%	8.13%	9.17%	8.65%	8.69%	-0.60%
210024	Union Memorial Hospital	8.13%	7.27%	7.61%	7.44%	7.47%	-0.66%
210016	Washington Adventist Hospital	14.08%	12.89%	13.66%	13.28%	13.31%	-0.77%
210017	Garrett County Memorial Hospital	10.86%	8.98%	11.10%	10.04%	10.07%	-0.78%
210043	Univ. of Maryland Baltimore Washington Medical Center	9.78%	8.33%	9.20%	8.77%	8.80%	-0.97%
210055	Laurel Regional Hospital	14.23%	12.21%	14.11%	13.16%	13.20%	-1.04%
210028	St. Marys Hospital	8.47%	7.33%	7.39%	7.36%	7.40%	-1.08%
210030	Univ. of Maryland Shore Medical Center at Chestertown	10.13%	8.08%	9.84%	8.96%	8.99%	-1.14%
210008	Mercy Medical Center, Inc.	8.29%	5.69%	7.70%	6.70%	6.73%	-1.55%
210013	Bon Secours Hospital	19.09%	17.17%	17.79%	17.48%	17.51%	-1.58%
210006	Harford Memorial Hospital	12.44%	9.32%	12.04%	10.68%	10.72%	-1.72%
210038	Univ. of Maryland Medical Center Midtown Campus	15.22%	11.38%	13.76%	12.57%	12.61%	-2.61%

Results of the 2015 Uncompensated Care Regression Analysis - Five Statistically Significant Variables (Levindale, Kernan and Shock Trauma not Included)						
Dependent Variable: Actual Uncompensated Care Percent						
Number of Observations Read	135					
Number of Observations Used	135					
Analysis of Variance						
Source	**DF**	**Sum of Squares**	**Mean Square**	**F Value**	**Pr > F**	
Model	7	0.10304	0.01472	68.55	<.0001	
Error	127	0.02727	0.0002147			
Corrected Total	134	0.13031				
Root MSE	0.01465	**R-Square**	**0.7907**			
Dependent Mean	0.07929	**Adj R-Sq**	**0.7792**			
Coeff Var	18.48201					
Parameter Estimates						
Variables	**DF**	**Parameter Estimate**	**Standard Error**	**t Value**	**Pr > |t|**	**Variance Inflation**
Intercept	1	0.04552	0.0057	7.98	<.0001	0
The proportion of a hospital's total charges from inpatient Medicaid admissions through the emergency room	1	0.20024	0.03665	5.46	<.0001	1.24164
The proportion of a hospital's total charges from inpatient Commercial Insurance cases	1	-0.1224	0.03111	-3.93	0.0001	1.69037
The proportion of a hospital's total charges from inpatient Self-pay, and Charity cases	1	0.58103	0.16588	3.5	0.0006	1.33873
The proportion of a hospital's total charges from outpatient Self-pay and Charity emergency department charges	1	1.538	0.17967	8.56	<.0001	2.37424
The proportion of a hospital's total charges from inpatient Self-pay and Charity admissions through the emergency room from the top 80% Medicaid Undocumented Aliens Enrollment Zip Codes	1	0.37907	0.15165	2.5	0.0137	1.24958
DUMMY1	1	-0.00227	0.00319	-0.71	0.4771	1.419
DUMMY2	1	-0.00478	0.00311	-1.54	0.1265	1.34804

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

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

Hospid	Hospital Name	Actual UCC for FY '13	Predicted UCC	FY '12- FY '13 UCC Average	50/ 50 Blended UCC Average	Revenue Neutrality Adjustment	Policy Results without PAC Adjustemnt	PAC Adjustemnt	Policy Results with PAC Adjustemnt
210001	Meritus Medical Center	7.20%	8.17%	7.40%	7.78%	1.006449	7.83%	1.66%	6.17%
210002	Univ. of Maryland Medical Center	5.40%	7.04%	5.87%	6.45%	1.006449	6.50%	1.85%	4.65%
210003	Prince Georges Hospital	15.51%	16.60%	15.34%	15.97%	1.006449	16.07%	1.09%	14.98%
210004	Holy Cross Hospital of Silver Spring	9.26%	8.17%	9.41%	8.79%	1.006449	8.84%	0.31%	8.53%
210005	Frederick Memorial Hospital	6.03%	6.47%	6.11%	6.29%	1.006449	6.33%	0.90%	5.43%
210006	Harford Memorial Hospital	12.44%	9.32%	12.04%	10.68%	1.006449	10.75%	1.51%	9.24%
210008	Mercy Medical Center, Inc.	8.29%	5.69%	7.70%	6.70%	1.006449	6.74%	1.34%	5.40%
210009	Johns Hopkins Hospital	4.27%	4.58%	3.98%	4.28%	1.006449	4.31%	0.78%	3.53%
210010	Univ. of Maryland Shore Medical Center at Dorchester	6.99%	10.12%	6.27%	8.20%	1.006449	8.25%	2.67%	5.58%
210011	St. Agnes Hospital	7.96%	8.85%	7.31%	8.08%	1.006449	8.13%	1.45%	6.69%
210012	Sinai Hospital	5.41%	6.30%	5.29%	5.79%	1.006449	5.83%	1.10%	4.73%
210013	Bon Secours Hospital	19.09%	17.17%	17.79%	17.48%	1.006449	17.59%	5.80%	11.79%
210015	Franklin Square Hospital	7.06%	8.27%	7.12%	7.69%	1.006449	7.74%	0.95%	6.80%
210016	Washington Adventist Hospital	14.08%	12.89%	13.66%	13.28%	1.006449	13.36%	0.59%	12.78%
210017	Garrett County Memorial Hospital	10.86%	8.98%	11.10%	10.04%	1.006449	10.10%	0.75%	9.36%
210018	Montgomery General Hospital	6.59%	7.42%	6.54%	6.98%	1.006449	7.02%	0.78%	6.25%
210019	Peninsula Regional Medical Center	6.87%	6.48%	6.85%	6.67%	1.006449	6.71%	1.30%	5.41%
210022	Suburban Hospital Association,Inc	5.07%	5.81%	4.79%	5.30%	1.006449	5.33%	0.28%	5.05%
210023	Anne Arundel General Hospital	5.21%	4.67%	4.92%	4.79%	1.006449	4.82%	0.54%	4.29%
210024	Union Memorial Hospital	8.13%	7.27%	7.61%	7.44%	1.006449	7.49%	1.45%	6.03%
210027	Braddock Hospital	6.89%	6.35%	6.54%	6.45%	1.006449	6.49%	1.06%	5.43%
210028	St. Marys Hospital	8.47%	7.33%	7.39%	7.36%	1.006449	7.41%	1.09%	6.32%
210029	Johns Hopkins Bayview Med. Center	9.28%	8.13%	9.17%	8.65%	1.006449	8.71%	1.73%	6.98%
210030	Univ. of Maryland Shore Medical Center at Chestertown	10.13%	8.08%	9.84%	8.96%	1.006449	9.01%	0.77%	8.24%
210032	Union Hospital of Cecil County	8.69%	8.11%	8.29%	8.20%	1.006449	8.25%	1.82%	6.43%
210033	Carroll County General Hospital	4.70%	5.66%	4.73%	5.19%	1.006449	5.23%	0.69%	4.53%
210034	Harbor Hospital Center	8.59%	9.84%	8.28%	9.06%	1.006449	9.12%	1.47%	7.65%
210035	Univ. of Maryland Charles Regional Medical Center	7.46%	8.91%	7.30%	8.10%	1.006449	8.15%	0.80%	7.35%
210037	Univ. of Maryland Shore Medical Center at Easton	5.86%	7.18%	5.53%	6.35%	1.006449	6.40%	0.83%	5.56%
210038	Univ. of Maryland Medical Center Midtown Campus	15.22%	11.38%	13.76%	12.57%	1.006449	12.65%	3.52%	9.14%
210039	Calvert Memorial Hospital	6.16%	7.09%	5.93%	6.51%	1.006449	6.55%	1.05%	5.51%
210040	Northwest Hospital Center, Inc.	8.41%	9.22%	7.62%	8.42%	1.006449	8.47%	0.93%	7.54%
210043	Univ. of Maryland Baltimore Washington Medical Center	9.78%	8.33%	9.20%	8.77%	1.006449	8.82%	1.02%	7.80%
210044	Greater Baltimore Medical Center	3.12%	4.44%	3.09%	3.77%	1.006449	3.79%	0.38%	3.42%
210045	McCready Foundation, Inc.	8.32%	10.47%	8.55%	9.51%	1.006449	9.57%	2.76%	6.81%
210048	Howard County General Hospital	5.99%	6.43%	6.15%	6.29%	1.006449	6.33%	0.61%	5.72%
210049	Upper Chesepeake Medical Center	6.08%	5.34%	6.01%	5.67%	1.006449	5.71%	0.59%	5.12%
210051	Doctors Community Hospital	9.29%	9.47%	8.61%	9.04%	1.006449	9.10%	0.61%	8.49%
210055	Laurel Regional Hospital	14.23%	12.21%	14.11%	13.16%	1.006449	13.24%	0.94%	12.30%
210056	Good Samaritan Hospital	6.60%	8.31%	6.25%	7.28%	1.006449	7.33%	0.90%	6.43%
210057	Shady Grove Adventist Hospital	6.76%	7.67%	6.71%	7.19%	1.006449	7.24%	0.53%	6.71%
210060	Fort Washington Medical Center	13.63%	13.00%	13.01%	13.01%	1.006449	13.09%	0.86%	12.23%
210061	Atlantic General Hospital	7.68%	8.62%	7.00%	7.81%	1.006449	7.86%	1.42%	6.43%
210062	Southern Maryland Hospital	6.84%	8.66%	6.32%	7.49%	1.006449	7.54%	0.94%	6.60%
210063	Univ. of Maryland St. Josephs Medical Center	5.13%	4.49%	4.71%	4.60%	1.006449	4.63%	0.72%	3.90%
210058	Univ. of Maryland Rehabilitation and Orthopaedic Institute	5.20%	5.77%	5.77%	5.77%	1.006449	5.80%	1.13%	4.67%
218992	Univ. of Maryland (MIEMSS)	22.32%	21.22%	21.22%	21.22%	1.006449	21.36%	0.25%	21.11%
212005	Levindale Geriatric Center and Hospital	1.82%	0.00%	1.82%	1.82%	1.006449	1.83%	0.00%	1.83%
	STATEWIDE	7.23%	0.00%	0.00%	7.19%	1.006449	7.23%	1.09%	6.14%

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Johns Hopkins at Keswick
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JOHNS HOPKINS
MEDICINE
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HEALTH SYSTEM

June 2, 2014

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

Dear Ms. Kinzer:

We are submitting this letter on behalf of the Johns Hopkins Health System member hospitals. The purpose of this letter is to discuss our concerns regarding the recently proposed changes to the Commission's uncompensated care policy. In reviewing the policy recommendation that the staff submitted to the Commissioners at the May meeting, we have a number of issues with the policy that we would like to address, particularly with the regression component of the policy.

Inconsistent Classification of Medicaid Pending Cases

First, we are concerned that the effects of classifying cases differently by primary payer may distort the predicted value for uncompensated care across hospitals. Classification as Medicaid, self-pay, or charity has never been consistent across hospitals in the State, with different hospitals inconsistently classifying Medicaid pending cases. The consequence of the staff's new regression formulation is that two hospitals with the same level of uncompensated care could have different levels of predicted uncompensated care simply because they classified their Medicaid pending cases differently. This problem with the UCC policy is not new and was the primary reason that the policy Medicaid, self-pay, and charity were folded together in the UCC model measures in the past.

Limited Impact of Medicaid Zip Code Variable for Undocumented Residents

Second, while the undocumented resident variable created from Medicaid data was designed to improve the UCC regression's predictive power for hospitals like Washington Adventist and Johns Hopkins Bayview Medical Center, Bayview receives little relief from this measure. Our analysis indicates that Bayview receives a small negative impact (-0.08 percentage points) from the application of this variable, all else equal. This result suggests that the variable is only partially successful in capturing the impact of undocumented residents on hospital uncompensated care in the State.

Incentives for Collection and Medicaid Sign Up

Finally, the policy change penalizes hospitals that have worked hard to improve collection activities and patient qualification for Medicaid. When the current structure of the policy was developed, blending three years of actual average experience with a predicted value was designed to reward hospitals with some temporary overfunding for UCC while providing an external standard of efficiency. Both of our systems have spent considerable resources in getting patients signed up for Medicaid to reduce bad debt to the hospital, but the changes proposed by the staff do not recognize – and even penalize – those efforts.

Concerns in Spite of Model Fit

While the proposed regression configuration achieves a higher adjusted R^2, it appears to do so by peeling off selected high UCC categories to explain the variation in UCC – high UCC categories are used to explain high UCC. The reference is self-fulfilling and appears to be a consequence of mining the data rather than of a clear policy relationship. Further, the staff has noted that the relationship between UCC and Medicaid is changing with the Medicaid expansion to historically self-pay patients. While true, Medicaid as a payer has never been considered an indicator of bad debt from Medicaid patients – the variable has indicated that the population treated at the hospital is predominantly poor and therefore likely to have relatively larger amounts of uncompensated care. Even with the Medicaid expansion, that is likely to continue. To the degree that the association between Medicaid and uncompensated care changes with the Medicaid and the Insurance Exchanges, estimating the regression model with updated data picks up that effective change in the relationship in the model's coefficients.

Request

Under the new demonstration model, payment policies have been reformed quickly to meet its requirements. The uncompensated care policy is no exception. While we recognize the necessity of the PAC adjustment to the uncompensated care policy with the Medicaid expansion and view that discussion as a separate issue for consideration, the traditional uncompensated care policy is a part of a distributional model for uncompensated care. Changes to the regression model and its ancillary logic have generally been carefully vetted over months, exploring a wide variety of options with both staff and hospital representatives considering proposed changes.

We believe that the treatment of payer classification creates inequities among hospitals when there has been little guidance for the classification of these cases. There may be straightforward methods for addressing that issue. For example, our preliminary modeling results suggest that including Medicaid along with self-pay and charity in the staff model produces a fit that is close to the staff's proposed model but avoids the issue of inconsistent primary payer classification. Further work should be conducted for the uncompensated care policy going forward to examine those inequities and to review potential alternative models. Alternatively, clear rules for the classification of Medicaid pending cases would produce more consistency across hospitals going forward. While the staff has issued new guidelines for classification in FY2014, compliance with the guidelines needs to be monitored to insure equity across hospitals if classification continues to determine the predicted amount from the

regression model. We request that these issues receive full consideration in discussions for changes to the uncompensated care policy for FY2016.

We appreciate your consideration of these issues.

Sincerely,

Ed Beranek
Sr. Director of Finance
Johns Hopkins Health System

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

Financial Shared Services

250 W. Pratt Street, 14th Floor
Baltimore, Maryland 21201
410-328-3645 | 410-328-3501 FAX
umm.edu

June 2, 2014

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

Dear Donna:

We are submitting this letter on behalf of the University of Maryland Medical System. The purpose of this letter is to discuss our concerns regarding the recently proposed changes to the Commission's uncompensated care policy. In reviewing the policy recommendation that the staff submitted to the Commissioners at the May meeting, we have a number of issues with the policy that we would like to address, particularly with the regression component of the policy.

Inconsistent Classification of Medicaid Pending Cases

First, we are concerned that the effects of classifying cases differently by primary payer may distort the predicted value for uncompensated care across hospitals. Classification as Medicaid, self-pay, or charity has never been consistent across hospitals in the State, with different hospitals inconsistently classifying Medicaid pending cases. The consequence of the staff's new regression formulation is that two hospitals with the same level of uncompensated care could have different levels of predicted uncompensated care simply because they classified their Medicaid pending cases differently. This problem with the UCC policy is not new and was the primary reason that Medicaid, self-pay, and charity were folded together in the UCC model measures in the past.

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While the proposed regression configuration achieves a higher adjusted R^2, it appears to do so by peeling off selected high UCC categories to explain the variation in UCC – high UCC categories are used to explain high UCC. The reference is self-fulfilling and appears to be a consequence of mining the data rather than of a clear policy relationship. Further, the staff has noted that the relationship between UCC and Medicaid is changing with the Medicaid expansion to historically self-pay patients. While true, Medicaid as a payer has never been considered an indicator of bad debt from Medicaid patients – the variable has indicated that the population treated at the hospital is predominantly poor and therefore likely to have relatively larger amounts of uncompensated care. Even with the Medicaid expansion, that is likely to continue. To the degree that the association between Medicaid and uncompensated care changes with the Medicaid and the Insurance Exchanges, estimating the regression model with updated data picks up that effective change in the relationship in the model's coefficients.

Request

Under the new demonstration model, payment policies have been reformed quickly to meet its requirements. The uncompensated care policy is no exception. While we recognize the HSCRC's position on making the PAC adjustment to the uncompensated care policy with the Medicaid expansion and view that discussion as a separate issue for consideration, the traditional uncompensated care policy is a part of a distributional model for uncompensated care. Changes to the regression model and its ancillary logic have generally been carefully vetted over months, exploring a wide variety of options with both staff and hospital representatives considering proposed changes.

We believe that the treatment of payer classification creates inequities among hospitals when there has been little guidance for the classification of these cases. There may be straightforward methods for addressing that issue. For example, our preliminary modeling results suggest that including Medicaid along with self-pay and charity in the staff model produces a fit that is close to the staff's proposed model but avoids the issue of inconsistent primary payer classification. Further work should be conducted for the uncompensated care policy going forward to examine those inequities and to review potential alternative models. Alternatively, clear rules for the

classification of Medicaid pending cases would produce more consistency across hospitals going forward. While the staff has issued new guidelines for classification in FY2014, compliance with the guidelines needs to be monitored to insure equity across hospitals if classification continues to determine the predicted amount from the regression model. We request that these issues receive full consideration in discussions for changes to the uncompensated care policy for FY2016.

We appreciate your consideration of these issues.

Sincerely,

Alicia Cunningham

Alicia Cunningham
Reimbursement & Revenue Advisory Services

cc: Henry Franey, SVP and Chief Financial Officer - UMMS

Final Recommendation for Readmission Shared Savings Program for

FY 2015

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

June 11, 2014

These final recommendations are for Commission action at the June 2014 Public Commission Meeting.

Introduction

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

A. Background

Exemption Criteria from CMS Quality-Based Payment Programs

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

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

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

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

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

Approved Methodology to Implement Shared Savings Program

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

B. Assessment

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

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

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

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

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

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

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

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

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

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

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

C. Recommendations

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

Appendix I: Risk Adjusted ARR Readmission Rates, CY 2013

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

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

UPDATED 3/18/13

Appendix 2: Proposed Shared Savings Policy Reductions for FY 2015

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

Update Factors Recommendations for FY 2015

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

June 11, 2014

These recommendations are for Commission action at the June 2014 Public Commission Meeting.

Final Recommendations on Update Factors

INTRODUCTION

Overview

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

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

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

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

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

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

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

STAKEHOLDER INPUT

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

Comments were received from CareFirst and United supporting the draft recommendation. The Maryland Hospital Association(MHA) provided comments in support of the recommendation with three proposed areas for additional consideration: 1)Consideration be given to providing additional infrastructure support in hospitals' rates; 2)HSCRC staff should pursue Medicaid deficit assessment reductions based on the update level; and 3)HSCRC should increase the update for non-waiver hospitals to eliminate the ACA impact adjustment. Each of these items will be discussed below in the analysis.

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ANALYSIS

Calculation of Update Factors for Revenue Categories 1-3

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

Updates for both categories 1 and 2 start by using the actual blended statistic of 2.41% growth, derived from combining 91.2% of the 2014 estimates of 2.5% from Global Insights for market basket increase with 8.8% of the capital growth estimate of 1.5%. For those revenues that are

not subject to global budgets, additional subtractions are made to reflect productivity and an additional reduction provided under the Affordable Care Act for Medicare. The 0.5% reduction for productivity is 0.1% above the amount used in the Medicare adjustment, but Medicare makes other adjustments that have not been applied. As a result, the proposed rate adjustment would be as follows:

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

MHA commented that the allowance should be increased to provide for additional infrastructure investment. While staff recognizes the need for additional infrastructure, hospitals have already been provided some funding. As shown in the balanced update table and discussed in the April 2014 HSCRC meeting, the legislature reduced the MHIP assessment by .7% but provided that up to $15 million of this amount could be placed back in hospital rates to fund programs and infrastructure that would support three part aim of the new All-Payer Model. Staff recommends evaluating whether those funds could be used to support infrastructure development that could benefit hospitals statewide, particularly in the development of care management infrastructure and analytics. While staff is not prepared at this time to recommend additional funding, this $15 million level of funding is already accounted for in the analysis and could be deployed toward development of infrastructure.

For psychiatric hospitals and Mt. Washington Pediatric Hospital, we turn to the proposed psychiatric facility update for Medicare. Medicare applies a 0.7% reduction for productivity and ACA savings mandates to a market basket update of 2.7% to derive a net amount of 2.0%. HSCRC staff initially proposed to use the same factor and net adjustments for the Maryland psychiatric hospitals and Mt. Washington Pediatric Hospital. MHA argued that the ACA adjustment should be eliminated. While Medicare will apply this adjustment in determining payment to the psychiatric hospitals, there are changes underway in the Medicaid program to reorganize psychiatric and substance abuse services. Additionally, the recognition of the importance of the integration of somatic and behavioral health makes it critical that these hospitals effectively coordinate care and integrate services with both community based providers, families, and other hospitals. Similarly, Mt. Washington Pediatric Hospital plays an important role in providing care for children with complex health problems that must be carefully coordinated and integrated with other providers. Staff agrees with the need for increased care coordination for these hospitals. In that light, Staff has changed its recommendation to provide .3% for care coordination and population health resources, offsetting

the ACA adjustment. In order to receive the additional monies, the hospitals will be required to use the funds solely for care coordination and population health infrastructure and to file a plan and report results using the same format that is being developed for reporting population health infrastructure investments for global budget hospitals.

Medicare Growth

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

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

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

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

Per Capita Hospital Spending Projections

[Based on the President's FY 2015 Budget]

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

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

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

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

Medicaid Deficit Assessment

The Medicaid deficit assessment for FY 2015 is unchanged from FY 2014, and the hospital funded portion and rate funded portion will remain at the same level and be apportioned to hospitals in a similar manner as FY 2014.

MHA recommended that HSCRC staff pursue a reduction in the Medicaid assessment based on the 2014 BRFA legislation that would allow a reduction in the event of Medicaid savings under the new All-Payer model. HSCRC staff notes that any assessment reduction based on savings may not be applicable prior to FY 2016 under the 2014 legislation. However, staff agrees that the process of calculating savings must begin in order to support this possible outcome in 2016 or sooner.

Calendar Year Impact

Staff has completed global models for more than 90 percent of revenues falling under the All-Payer Model. The global models determine the amount of revenue that will be generated for the first half of the Calendar Year 2014, while the update factors will guide the revenue allowed in the second half of Calendar Year 2014. By subtracting December year to date revenues from the FY 2014 allowed amounts, staff was able to determine the estimated revenues for January through June 2013 and compare those revenues to the first six months of Calendar Year 2013, which is the base period for the new All-Payer Model. In making the comparisons, staff concluded that the revenues would fall within the limits of the All-Payer Model for the first six months of the year, with the result that there would be no expected need to adjust the update factor for any overage from this period.

Evaluation of the Balanced Update

Staff has inserted the figures above into the balanced update model (see Attachment) that was presented in the Draft Payment Models Workgroup Report on Balanced Updates and Short-Term Adjustments from the April 2014 meeting of the Commission. The table has been reordered to facilitate the understanding of the impact of uncompensated care and assessments on the results. A section has been added to the table to compare the update results to the CareFirst model that projects the impact of the update on the Medicare savings estimates. When using the recommended update allowances provided above, the model projects that an update within the parameters of the allowed 3.58% per capita can be derived on an All-Payer basis for the fiscal year and that the Medicare savings can be achieved if the differential statistic of 2% is maintained and if the national actuarial projections are reasonable.

RECOMMENDATIONS

The final recommendations of the HSCRC Staff are as follows and are offered on the assumption that the other policy recommendations that affect the overall targets are approved (including the shared savings adjustment for readmissions and the uncompensated care and MHIP reductions):

1) Provide update for the three categories of hospitals and revenues as follows:
   a) Revenues under global budgets--2.4%;

b) Revenues not under global budgets but subject to Medicare rate setting waiver--1.7%;
c) Revenues for psychiatric hospitals and Mt. Washington Pediatric Hospital--2.0% with an additional .3% provided for care coordination and population health infrastructure investments.

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

3) Calculate the Medicaid deficit assessment for FY 2015 at the same total amount as FY 2014 and apportion it between hospital funded and rate funded in the same total amounts as FY 2014.

4) Begin the process of working with Medicaid to develop the calculations to determine whether savings are accruing under the new All-Payer model that would allow for a reduction in the Medicaid deficit assessment.

ATTACHMENT--Balanced Update Model as of 6/11/14

Maximum allowed growth

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

Components of revenue change-increases

	Proportion of Revenues	Allowance	Weighted Allowance
Adjustment for inflation/policy adjustments			
-Global budget revenues	95%	2.41%	2.29%
-Non global revenues	5%	1.71%	0.09%
			2.38%
Adjustment for volume			
-Global budget revenues	95%	0.80%	0.76%
-Non global revenues	5%	1.20%	0.06%
-Market share adjustments			
			0.82%
Infrastructure allowance provided			
-Global budget revenues except TPR	85%	0.33%	0.28%
CON adjustments-			
-Opening of Holy Cross Germantown Hospital			0.40%
Net increase before adjustments			3.87%
Other adjustments (positive and negative)			
-Set aside for unforeseen adjustments			0.50%
-Reverse prior year's shared savings reduction			0.20%
-Positive incentives			0.00%
-Shared savings/negative scaling adjustments			-0.40%
Net increases attributable to hospitals			4.17%
Per Capita			3.44%

Components of revenue changes-net decreases not hospital generated

-Uncompensated care increase	0.38%
-Uncompensated care reduction, net of 6% differential	-1.02%
-MHIP adjustment	-0.45%
-Other assessment changes	
Net decreases	-1.09%
Net revenue growth	3.08%
Per capita revenue growth	2.35%

The first chart below compares the expected maximum All-Payer Growth that could occur to achieve Medicare savings based on the 2% difference statistic model. As stated before, the actual results for Medicare will be different than the projections and those differences may be material.

The second chart shows that when using the recommended update allowances provided, the model projects that an update within the parameters of the allowed 3.58% per capita can be derived on an All-Payer basis for the fiscal year and that the Medicare savings can be achieved if the differential statistic of 2% is maintained and if the national actuarial projections are reasonable.

Balanced Update Model-Medicare Savings Requirement

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

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	3.96%	3.08%	-0.88%
Per Capita Growth	3.22%	2.35%	-0.87%

Maryland
Hospital Association

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May 12, 2014

John M. Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, Maryland 21211

Dear Chairman Colmers:

On behalf of the 66 members of the Maryland Hospital Association (MHA), we would like to take this opportunity to comment on the draft *Update Factors Recommendations for FY 2015* scheduled to be presented to the commission at its May 14 meeting. The hospital field has been actively engaged in the discussions held by the commission's Payment Models Workgroup, which has provided guidance to the staff as it prepared the recommendations to be considered. We would like to compliment commission staff on the constructive dialogue that has taken place throughout these deliberations. The commission should be proud of the efforts to date in moving forward expeditiously with the implementation of Maryland's new all-payer model. Much work will remain after the commission takes action on this fiscal year 2015 balanced update recommendation, and hospitals will continue our commitment to the workgroup process.

In its final report, the HSCRC's Advisory Council provided important advice to the Commission: "…***to strike a balance between near-term cost control***, ***which is paramount***, ***and making the required investments in physical and human infrastructure necessary for success***. ***If we do not meet the near-term targets***, ***there will be no long-term program***. ***But if we fail to make the needed infrastructure investments***, ***we will not have the toolkit of reforms necessary to achieve lasting success***." Based on that advice, we ask for three changes to the draft recommendation on the update before you: (1) the level of infrastructure allowance provided for global budget hospitals; (2) adjustments for other assessments; and (3) the proposed update for non-waiver hospitals.

Infrastructure Allowance

During the Payment Models Workgroup deliberations, there was general concern expressed that the level of infrastructure funding being provided in the proposed update (0.33 percent for global budget hospitals, for an overall system impact of 0.26 percent) was insufficient for hospitals to make the necessary adjustments to achieve sustainable success under the waiver. In their initial Total Patient Revenue (TPR) agreements three years ago, TPR hospitals were provided incentive funding well in excess of the amounts proposed here to allow them to undertake the risks inherent in the global budget model. We urge the commission to increase (from 0.33 percent as proposed, to 0.66 percent of the new global budget hospital revenues, or 0.50 percent overall system impact) this critical infrastructure funding for fiscal year 2015. The additional funding should come from the "set aside for unforeseen adjustments and cushion" indicated in staff's draft balanced update model. Staff has charged a sub-group with designing a formal reporting template for all global budget hospitals to provide an accounting of their use of these infrastructure funds, so that commissioners will be able to link the investment of these funds with measurable outcomes of the programs hospitals will be implementing/enhancing to ensure long-term success under the new all-payer model.

-more-

Other Assessments

At the request of MHA, the staff model includes a line for "other assessment adjustments," to specifically account for reductions in the Medicaid deficit assessment that should be anticipated in this balanced update model for fiscal year 2015. The net reduction in uncompensated care and the Maryland Health Insurance Plan assessment will save Medicaid money in fiscal year 2015, potentially as much as $15 million in general funds, as a result of these two rate reductions alone. Just as the commission has prospectively anticipated reductions in uncompensated care from the full benefits now provided to the Medicaid Primary Adult Care population and lowered rates accordingly, the Commission should prospectively reduce rates, accounting for the lower Medicaid assessment. That way, the Medicaid assessment reduction in rates is available to reduce costs to all payers, including the Medicare program.

Non-waiver Hospital Update

Staff has recommended an update of 2.0 percent for the psychiatric hospitals and Mt. Washington Pediatric Hospital for next year. They derive this recommendation by using the offsets in the Medicare proposed rule for Inpatient Psychiatric Facilities (0.4 percent for productivity, and 0.3 percent as required for those facilities under the Affordable Care Act). We oppose applying the Medicare budget-mandated offset of 0.3 percent to non-Medicare payers in Maryland, and propose instead an update for these facilities of 2.3 percent. For Medicare, the psychiatric hospitals in Maryland would receive the same 2.0 percent update as hospitals nationally, so there would be no impact on the Medicare waiver savings calculation by accepting the MHA recommendation. Furthermore, these hospitals are excluded from the all-payer test calculation, so allowing the additional request of 0.3 percent in all-payer rates will have no impact on the all-payer test calculation. Just like their waiver hospital counterparts, these non-waiver hospitals will be critical to the long-term success of managing the health of entire populations under our all-payer model, especially for the unique populations that they serve. We believe that the update request of 2.3 percent for fiscal year 2015 will provide these hospitals with the critical resources they need

We appreciate the opportunity you have provided us to address the *Update Factor Recommendations for FY 2015*, and look forward to further discussion of the concerns that we have raised at the commission meeting on May 14. In the meantime, if you have any questions, please contact me at MHA.

Sincerely,

Michael B. Robbins

Michael B. Robbins, Senior Vice President Financial Policy & Advocacy

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
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May 9, 2014

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

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

Re: HSCRC DRAFT Recommendation: Update Factors for FY2015

Dear Mr. Colmers and Ms. Kinzer,

I would like to take this opportunity to say that staff did an excellent job engaging all stakeholders, assessing all industry issues and comments and developing an Update Factor recommendation that we believe will favorably position the State of Maryland to meet all the conditions of the Medicare Waiver agreement, especially the All-Payer and the Medicare financial targets.

As CareFirst noted at the April Public meeting, Maryland's Demonstration model is predicated on successfully achieving both the All-Payer target of 3.58% and the Medicare savings target of $330M over five years. As you well know, meeting these dual targets will be challenging given the difference in the historical growth rates of Medicare and All-Payer Maryland hospital expenditures. The Medicare actuaries are forecasting the Medicare cost trend to be 1.7% for fiscal years 2014 and 2015.

In order to achieve the Medicare annual savings, we must curb the Medicare trend in Maryland to approximately 1.2% in each of these years. We believe there is evidence to support an approximate 2.0% differential rate of growth between the All-Payer and Medicare trends, in part due to different service use patterns of Medicare beneficiaries. As a result, we need to be conservative on the All-Payer allowance and at the same time focus utilization control measures most specifically on the Medicare population. This conclusion is included in the recommendation in the draft report. CareFirst strongly supports this overall strategy and believes it will position Maryland to successfully achieve both targets over the course of the Demonstration.

Overall, CareFirst supports the Update Factor recommendation which has been structured to provide hospitals reasonable allowances for inflation, volume, and infrastructure while providing a slight cushion which we believe is necessary given current forecasting uncertainties and the yet unproven ability to manage the utilization specific to the Medicare population. This recommendation will allow time to demonstrate that our new policies, incentives, and reimbursement models are producing the expected results.

Thank you for this opportunity to provide comments on this recommendation.

Sincerely,

Chet Burrell
President and Chief Executive Officer

UnitedHealthcare
800 King Farm Blvd., Suite 600
Rockville, MD 20850

May 14, 2014

Mr. John Colmers
Chairman
Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, Maryland

Re: HSCRC Draft Recommendation: Update Factors for FY2015

Dear Mr. Colmers:

United Healthcare would like to extend our appreciation for the leadership of Ms. Donna Kinzer, Executive Direction and her staff in preparation of the Update Factor Recommendation for FY2015. We have reviewed the Staff recommendation and believe this will enable the State of Maryland to be in compliance with the new Medicare Waiver agreement or specifically for the All-Payer and Medicare financial targets.

As Carefirst presented in the April Public meeting, both the All-Payer 3.5% target and the Medicare savings target of $330 million over five years must be met, respectively. United agrees both targets are essential to the success of the Maryland Demonstration. We realize meeting both targets will be a challenge based upon the Maryland historical growth rates occurring in the hospital payments.

United recommends to be conservative on the All-Payer allowance while focusing efforts on reducing utilization and/or redirecting to the proper location of service in behalf of Medicare beneficiaries. We note this position is included in the recommendation in the draft report.

In summary, United supports the Update Factor recommendation. We believe this recommendation provides a reasonable adjustment for inflation, volume, and adequately funds infrastructure in this early adoption of the new Medicare Waiver agreement. We further encourage the HSCRC to be conservative while new policies, hospital incentives are implemented as well as new reimbursement models to ensure expected results are obtained.

Respectfully

Gary B. Simmons
Regional Vice President, Networks

Cc: Ms. Donna Kinzer, Executive Director

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

June 11, 2014

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

This is a final recommendation to be considered at the June 11, 2014 HSCRC public meeting.

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

Introduction

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

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

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

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

Background

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

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

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

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

Assessment

Strategic Partnerships

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

Table 1. Home Health Facilities Reporting to MPSC

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

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

Maryland Patient Safety Center 2013 Activities, Accomplishments, and Outcomes

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

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

MPSC Cash Reserves and FY 2015 Projected Budget

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

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

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

Table 2. Proposed Revenue and Expenses

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

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

MPSC Return on Investment

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

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

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

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

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

Recommendations

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

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

Nurse Support Program II

Competitive Grant Review Panel Recommendations

For FY 2015

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

June 11, 2014

These recommendations are for Commission action at the June 2014 Public Commission Meeting.

INTRODUCTION

This recommendation summarizes the funding recommendations of the Nurse Support Program II Competitive Grant Review Panel for FY 2015 and provides an update of the activities of Nurse Support Program II (NSP II).

BACKGROUND

In July, 2001, the Health Services Cost Review Commission (HSCRC) implemented the first phase of the Nurse Support Program (NSP I) to address the issues of recruiting and retaining nurses. *Maryland's Nursing Shortage: a Workforce Crisis*, published in 2003 (Heller & Sweeney) of the Maryland Center for Health Workforce Development cited a root cause of the nursing shortage as a faculty shortage.

The Maryland Statewide Commission on the Crisis in Nursing completed multiple white papers and reports between 2001 and 2005 under the leadership of the Maryland Board of Nursing (MBON), including the *Nursing Faculty Shortage: Causes, Effects and Suggestions for Resolution*. Causes of the faculty shortage included an aging nurse faculty workforce with imminent faculty retirements and a limited pool of potential nurse educators. Barriers to recruiting qualified new faculty included limited availability of master's and doctoral programs with a focus on nursing education.

On May 4, 2005, the HSCRC responded to the faculty shortage and limited nursing educational capacity underlying the nursing shortage with the NSP II. They approved an increase of 0.1% of regulated gross hospital revenue for use in expanding the pool of nurses in the state by increasing the capacity of nursing programs in Maryland through institutional and nursing faculty- based workforce interventions.

The Maryland Higher Education Commission (MHEC), the coordinating board for all Maryland institutions of higher education was selected by the HSCRC to administer the NSP II programs. MHEC supports the (1) development of applications and guidelines, (2) management of the review process and selection of applicants, (3) ongoing monitoring and evaluation of NSP II funded programs, and (4) the receipt and distribution of NSP II funds submitted by Maryland hospitals in accordance with the HSCRC's schedule of payments.

MHEC conducted the *Maryland Nursing Program Capacity Study*, in collaboration with the Maryland Board of Nursing (MBON), in accordance with Senate Bill 511 (Chapter 487, Acts of 2005). As required, the study addressed: (1) the demand for and capacity of nursing programs offered by Maryland higher education, and (2) the availability of financial aid and other incentives to encourage individuals to pursue nursing education.

The Nurse Support Program I began in 2001, at the height of the last nursing shortage. The NSP II began in 2005 when it was determined that a shortage of nursing faculty limited the production of degreed nurses in Maryland. Both programs have benefited the state by creating an adequate supply of RNs, evidenced by the reductions in hospital vacancy rates, and a $98 million cost savings on agency nurse use reported in the evaluation of the NSP I on June 6, 2012.

NURSING WORKFORCE INVESTMENT

A prominent team of health economist and nurse researchers, Drs. Buerhaus, Auerbach, and Staiger forecasted a greater shortage of RNs that has been mitigated by the recession. However, they caution employers and policy makers to avoid complacency based on the current supply of nurses. The current positive effect is likely to evaporate as the economy improves since many nurses will leave the job market again with a possible post-recession nursing shortage. In the face of projected shortages of primary care professionals, slower growth in the RN workforce could not come at a worse time. The demand for RNs will outstrip projected growth through 2020 (Staiger, et al., 2012, NEJM). The responsiveness of the supply or supply elasticity of RNs is an important factor as access to medical services by newly ACA insured consumers increases the demand. Demand for medical services will continue to rise as the population ages, incomes increase, people live longer and medical advancements through new technology and benefits of treatment expand more rapidly than inflation (Feldstein, 2011).

Health economists note that few approaches to control rising medical costs were included in the Affordable Care Act (ACA). The Medical Care Sector is composed of three interdependent submarkets. They are hospitals, the health care workforce and educational programs for nurses and physicians. The NSP II funding has impacted two of the submarkets: 1.) RNs for the workforce as both bedside nurses and nursing faculty, and 2.) The capacity of nursing educational programs in the state. These entities function independently, yet share a joint mission to control medical costs, and produce and distribute quality services. There are multiple methods of measuring costs, i.e.: cost benefit analysis considering the monetary outcomes, cost effectiveness analysis considering specific health outcomes or cost utility analysis considering quality adjusted life years.

NURSING WORKFORCE TRENDS

The 2013 *US Nursing Workforce Trends in Supply and Education* report released by the US Department of Health and Human Services, Health Resources and Services Administration (HSRA) provides information on both the nursing workforce and nursing education markets. These key indicators should be followed closely in the coming years as health reform, changing demographics, advancing medical technology, and the economic recovery all converge to shape the nursing workforce supply and demand. The RN workforce in Maryland is consistent with national changes, including increasing workforce diversity from 20-25% and increasing the proportion of men from 8-9%. Many of the NSP II grants have focused on increasing

underrepresented groups in nursing. Some of the most highly recommended grants from the last three years have funded military to Associate Nursing seamless transitions, with the latest including a BSN partner. The majority of RNs (63.2%) continue to be employed nationally at hospitals providing inpatient and outpatient care. This has held steady over the last decade and is consistent in Maryland despite changing delivery models.

The most recently available *MHA Hospital Personnel Survey* revealed a 5.6% nurse vacancy rate. The National League for Nursing's research in a 2011 survey completed by 60,000 nurse educators found 55% of nurses plan to leave in the next 10 years, and 60% were aged 45-60. Over the next 10 to 15 years, HRSA reports the nearly 1 million RNs older than 50—about one-third of the current workforce—will reach retirement age. For example in 2013, Salisbury University Nursing reported 25% of the nursing faculty retired in one year. The NSP II faculty scholarships, fellowships and doctoral grants were cited for supporting the recruitment and retention of replacement faculty.

NSP II NURSING WORKFORCE INTERVENTIONS

Academic Program Capacity Building

All 26 Maryland Schools of Nursing have participated in at least one of the NSP II grant cycles for broad regional impact, inclusivity, and diversity. NSP II grants have supported new nursing programs at both the undergraduate and graduate level, along with post-graduate teaching certificates and professional development for faculty. Across the state, at public and private universities, historically black colleges and universities and community colleges, NSP II funding has positively impacted nursing professionals. These funds have supported academic capacity by implementing new four-year BSN programs, building collaborative educational partnerships to allow for dual enrollment, additional RN-to-BSN programs , simulation and distance learning options and academic-service partnerships. Nursing programs have grown and evolved to reach a broader, younger, and more diverse student population.

Graduate Education Support

There are currently 165 *Hal and Jo Cohen Graduate Nurse Faculty Scholars* who completed their educational coursework, and embarked on a nursing faculty career within the last five years. MHEC service obligation records indicate they are teaching across the state at the following institutions: Allegany Community College, Anne Arundel Community College, Baltimore City Community College, Bowie State University, Carroll Community College, Chesapeake College, College of Southern Maryland, Community College of Baltimore County (Essex, Dundalk and Catonsville) , Coppin State University, Frederick Community College, Hagerstown Community College, Harford Community College, Howard Community College, Johns Hopkins University, Montgomery College, Notre Dame of Maryland University, Sojourner Douglass College, Morgan State University, Prince George Community College, Salisbury University, Stevenson University, Towson University, University of Maryland (Baltimore and Shady Grove),

Washington Adventist and Wor-Wic Community College. This represents 25 of the 26 nursing programs impacting both the diversity of nursing faculty and coverage of geographical regions.

To date, there are 211 *New Nurse Faculty Fellowship Scholars* and 30 *Nurse Educator Doctoral Grant for Practice and Dissertation Research* recipients working across the state. Earlier research indicates a strong tendency for nurses to remain in the geographical location where they complete their education. Two nursing programs, one in western Maryland, and one on the Eastern Shore will have a fully doctorally prepared nursing faculty once current faculty complete their programs. This allows faculty to hold long-term tenure track positions and strengthens the school of nursing infrastructure at their respective institutions.

The combination of these programs has led to the recruitment, retention and advancement of greater numbers of doctorally prepared nursing professoriate. The NSP II faculty focused initiatives are expected to pay long-term dividends as nurse educators enhance their professional development and extend their career trajectory.

NURSING EXCELLENCE IN EDUCATION

NSP II project directors are being recognized for nursing excellence and innovative work in nursing education. They are publishing their experiences and sharing resources supported by NSP II grants.

- Dr. Louise Jenkins, Co-Director of the Institute for Educators at the University of Maryland, and co-PI for NSP II 12-117 (*Implementing Statewide Initiatives for Nursing Faculty*) and NSP II-14-113 (*Preparing Clinical Faculty for Maryland Nursing Schools*) will be inducted as a Fellow of the Academy of Nursing Education at the 2014 National League for Nursing Education Summit in September. She is being recognized for a commitment to excellence and her sustained and enduring contributions to nursing education, particularly in preparing and developing nursing faculty.
- Two recent articles authored by NSP II project director teams referencing awarded projects were published in peer-reviewed nursing journals. Authors acknowledged the HSCRC funding through the NSP II competitive institutional grants program. *Expert Clinician to Clinical Teacher: Developing a Faculty Academy and Mentoring Initiative* (2013) was published in *Nurse Education in Practice* by Dr. Tina Reid, Dr. Katharine Hinderer, Dr. Judith Jarosinski, Dr. Brenda Mister and Dr. Lisa Seldomridge from Salisbury University and Wor-Wic Community College. *Developing Dual Role Nursing Staff- Clinical Instructor: A Partnership Model* (2014) was published in the *Journal of Nursing Administration* by Dr. Mary Etta Mills, Dr. Linda Hickman and Dr. Joan Warren from the University of Maryland and MedStar Franklin Square Medical Center.
- Two nursing programs supported initiatives for Maryland faculty to complete the certification process comparable to the American Nurses Credentialing Center (ANCC)

Certifications for clinical RNs encouraged by hospitals seeking Magnet status. NSP II has increased the number of Certified Nurse Educators (CNEs) credentialed in Maryland through the National League for Nursing program. Stevenson University hosted a statewide CNE workshop with over 100 participants last May. Maryland's CNE certified educators baseline is approximately 50; with a goal is to triple that number by 2015. As of January 28, 2014, Dr. Karen Russell at College of Southern Maryland reported a 28% increase in CNE credentialed educators.

- Nurse faculty and researchers at several Maryland hospitals are participating in the ANCC READI –Readiness Evaluation and Discharge Interventions study, and the National Council of State Boards of Nursing national multi-site, longitudinal study of simulation use in pre-licensure nursing programs across the country.

PROGRAM EVALUATION

FY 2015 is the final year of the NSPII program under current Commission recommendations. Therefore, MHEC and HSCRC staff are actively engaged in planning and delivering an NSP II program evaluation. These agencies are working collaboratively to deliver a comprehensive program evaluation to the HSCRC for the NSP II program with clear and relevant recommendations regarding proposed program revisions and funding continuation. The evaluation will focus on the NSP II program impact, nursing outcomes, any replicable models, gaps or unaddressed needs, and the state of the nursing workforce, nursing faculty and nursing education programs in Maryland. It is anticipated that the results will be presented at the December 11, 2014 meeting.

FINDINGS AND RECOMMENDATION: NSP II COMPETITIVE INSTITUTIONAL GRANTS FOR FY 2015

For FY 2015, MHEC received 23 proposals. The seven-member Evaluation Review Panel comprised of hospital nursing administrators, former NSP II grant project directors, retired nursing educators, current NSP I project directors, licensure and policy leaders along with MHEC and HSCRC staff reviewed all proposals. All proposals were received by the deadline and followed the guidelines for submission, so the panel scored each proposal following the rubric in the FY 2015 RFA. After the panel convened for full discussions, a consensus developed around the most highly recommended proposals. Therefore, the committee agreed to recommend funding for 15 of the 23 requests for one to three year programs totaling $3.7 million. See Table 1 for a listing of the recommended grant awardees for FY 2015.

The most highly recommended proposals were representative of the commitment of NSP II to interventions directed at the faculty shortage. A new MSN degree program at Frostburg State University was supported by an NSP II planning grant in FY 2014 and approved by MHEC this Spring. The program provides an on-line, highly accessible format as the only graduate nursing

program in the region. The successful RN-BSN and MSN programs at Notre Dame of Maryland University included a strong proposal to increase the number of students accepted to the growing undergraduate BSN program with a strong institutional commitment for sustainability and sizeable funding match. Seamless transition programs for the military to nursing careers in the southern and central region were balanced by a planning grant for partnerships between community colleges and universities for seamless transition to higher degrees and non-duplication of programs in the western region. A new Masters entry-level degree program, extensions of successful clinical academic partnerships to additional hospitals, innovative clinical practice sites and alternatives within simulation for clinical learning were supported by the review panel. The funded proposals covered all regions of the state and addressed underrepresented groups in nursing.

Table 1: Final Recommendations for funding for FY 2015 Competitive Institutional Grants

NSP II FY 2015 Final Recommendations for Competitive Institutional Grants Program						
Proposal	**Name**	**School of Nursing**	**Total Request**	**Year 1**	**Year 2**	**Year 3**
I5-101	Nurse Managed Wellness Center	Allegany College	$269,324.00	$160,351.00	$108,973.00	$0.00
15-102	Simulation & Clinical Education Model	Anne Arundel CC	$139,399.00	$95,847.00	$21,938.00	$21,614.00
15-103	Faculty Pipeline RN-BSN, RN-MSN	Bowie State	$299,104.00	$150,860.00	$148,244.00	$0.00
15-104	Pre-Admission Testing	Carroll CC	$81,972.00	$27,324.00	$27,324.00	$27,324.00
15-105	CSM Medic/Corpsman Transition	College of Southern MD	$278,753.00	$145,004.00	$133,749.00	$0.00
15-109	Implementing the MSN	Frostburg State	$298,758.00	$143,316.00	$155,442.00	$0.00
15-110	Collaborative BSN Model	Frostburg State	$67,122.00	$67,122.00	$0.00	$0.00
15-112	Military to Associate RN Pathway	Howard CC	$299,999.00	$45,615.00	$126,952.00	$127,432.00
15-113	MSN Faculty Development	Johns Hopkins	$299,703.00	$128,373.00	$133,900.00	$37,430.00
15-114	Masters Entry Program Development	Johns Hopkins	$299,570.00	$43,460.00	$126,195.00	$129,915.00
15-115	Academic Enhancement	Morgan State	$300,000.00	$150,000.00	$150,000.00	$0.00
15-116	BSN for Better Outcomes	Notre Dame	$299,920.00	$207,312.00	$92,608.00	$0.00
15-118	Faculty Toolkits for Psych MH	Salisbury	$299,983.00	$140,864.00	$159,119.00	$0.00
15-120	Graduate Ambassadors	University of MD	$147,362.00	$62,658.00	$84,704.00	$0.00
15-121	Expanding Clinical Instructors	University of MD	$297,282.00	$137,315.00	$159,967.00	$0.00
Total	**15 Recommended Proposals**		**$3,678,251.00**	**$1,705,421.00**	**$1,629,115.00**	**$343,715.00**

RECOMMENDATION

The HSCRC and MHEC staff recommend that the NSP II Competitive Grant Review Panel recommendations are approved for funding as presented.

Due to the timing of this review, staff of the HSCRC and MHEC request that this recommendation be waived from the comment rule so that it may become effective on July 1, 2014.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: Additional HSCRC Funding for CRISP Reporting Services

June 11, 2014

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

This is a report to be presented at the June 11, 2014 HSCRC public meeting.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients:

Additional HSCRC Funding for CRISP Reporting Services

Overview

This report is to update the Commission regarding additional funding for Chesapeake Regional Information System for our Patients (CRISP) to continue to conduct and expand reporting services in FY2015.

Background

During the May 2014 public meeting of the Commission, staff reported on funding support of CRISP operations in FY 2015 in the amount of $1.65 million. This amount is designed to provide funding support of CRISP's core operations and core service offerings, such as the Query portal and the associated support center that enables providers to search for patient information in real-time.

Over the past 6 years, the Commission has approved funding to support the general operations of the CRISP HIE through hospital rates as shown in Table 1:

Table 1. CRISP HIE Project HSCRC Funding 2010-2015

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

In December 2013, the Commission adopted a recommendation to permit continued funding support during FYs 2015 through FY 2019 not to exceed $2.5 million in any year.

During the May 2015 meeting, staff indicated that they were reviewing an additional funding request to support CRISP reporting services (CRS). This report is to provide background and details for providing CRISP additional funding up to the existing assessment cap of $2.5 million. This amount, an additional $850,000 above the amount the staff update provided at the May meeting, is to finance a specific set of CRISP reporting services important to HSCRC's inter-hospital reporting capabilities.

CRISP Reporting Services to be Funded

CRISP has defined a range of service offerings that can be supported or pursued through the CRS infrastructure. These service levels range from basic support of the CRISP ID creation process to more sophisticated analytic capabilities that are more broadly applicable to the healthcare community.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients:

Additional HSCRC Funding for CRISP Reporting Services

CRISP has developed a tiered series of service levels defining the activities and the necessary resources to support those activities. All three of the categories below represent on-going monthly activities.

Unique ID Creation and Assignment – Approximately $310,000

- Establishing and maintaining link between HSCRC hospital data and CRISP ID by processing monthly Inpatient and Outpatient hospital files for CRISP ID assignment.
- CRISP will receive monthly hospital files from St. Paul group to create the Unique ID assignment which HSCRC will use for various analyses, such as inter-hospital readmission analysis.
- **Deliverable** - CRISP will link the unique ID to the HSCRC abstract data and provide the unique ID linkage to HSCRC staff for further inter-hospital and other analysis.

Basic Cross-Entity Report Production for HSCRC – Approximately $430,000

- CRISP will host HSCRC abstract data in order to generate reports requested by HSCRC, such as inter-hospital readmission rates.
- CRISP will work closely with HSCRC to implement the most current methodologies for readmissions and other methodologies HSCRC deems important.
- CRISP will provide the HSCRC and other stakeholders with the ability to use the MPI to link with other data sets.
- **Deliverable** - CRISP will support ad hoc reporting request from HSCRC for day-to-day operational needs under the modernized waiver.
- **Deliverable -** Linking of additional data sets, such as Medicaid data.

Static Report Creation for Hospitals – Approximately $260,000

- CRISP will provide hospitals with a core set of static reports on a monthly basis focused on inter-hospital readmissions and primary service area / clinical service line analysis, and super-utilization analysis.
- CRISP will work with the hospital stakeholder community to identify and develop additional static reports.
- **Deliverable** - Monthly distribution and development of static reports to hospitals.

Costs and Staffing

CRISP's budget consists of both software and services costs. The majority of the budgeted expenses are services related costs. In FY 2014, CRISP utilized funding through (State Innovation Models) SIM to cover these costs. Such funding is not available in FY 2015 and CRISP would need an additional approximately $1 million to continue and expand the

reporting services they have provided in FY 2014. CRISP will maintain the same contractual relationships with the current partners supporting the reporting services. These partners include technical architecture, development, quality assurance, and subject matter experts.

CRISP intends to finance the $150,000 gap (between $850,000 funding support and the $1 million in costs) from their core HIE budget.

Recommendation

MHCC and HSCRC staff have reviewed CRISP's request for additional funding to provide support beyond core operations. Based on a recent meeting with CRISP where they detailed additional activities and costs, staffs of the two Commissions believe supporting the additional funding is necessary to meet the goal of the all-payer model. Therefore, staff deems it appropriate to apply a total uniform and broad based assessment in hospitals rates in FY 2015 in the amount of $2.5 million which will include the $1.65 million approved at the May 2014 Commission meeting for core operational support, and $850,000 to support the costs of CRISP reporting services.

However, staff reserves the right, subsequent to reporting its intention to the Commission, to discontinue CRISP reporting services funding during the course of FY 2015 under the following circumstances:

- Staff finds that either the reporting services are not as efficacious, accurate, or timely as anticipated in order to meet the goals of the all-payer model;
- The State determines that a different vendor would be more appropriate to provide these services; or
- If funding from other grants or sources becomes available for these purposes.

CRISP has outlined additional services beyond those outlined in this update. These additional services include expanded dynamic reporting for hospitals and other providers, hosting of Medicare data, and application of predictive modeling tools. HSCRC staff will continue to work with CRISP to evaluate if and how the HSCRC should be engaged in pursuing and financing those activities in partnership with CRISP or with other vendors.

Draft Recommendation

Revision to the Relative Value Units Scale for Laboratory Services

June 11, 2014

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

This draft recommendation is being presented at the June 11, 2014 HSCRC public meeting.

The Commission staff recommends for review and public comment revisions to the Relative Value Unit (RVU) Scale for Laboratory services. The revisions are specific to Appendix D of the Accounting and Budget Manual. These revised RVUs were developed by a sub-group of the Maryland Hospital Association's HSCRC Technical Issues Task Force. The sub-group's membership included representatives of the Laboratory departments of many of the Maryland hospitals.

The RVU scale was updated to reflect the addition of new codes added to the Current Procedural Terminology (CPT) codes in 2013 to reflect new technology and to reflect the move of Apheresis and the costs of Bone, Organ and Tissue to the Clinic and Medical Surgical Supplies cost centers respectively for a more appropriate classification of these services. At your direction, the staff will send the revision to all Maryland hospitals for their review and comment.

HEALTH SERVICES COST REVIEW COMMISSION
4160 Patterson Avenue, Baltimore, Maryland 21215
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Toll Free: 1-888-287-3229
hscrc.maryland.gov

TO: Commissioners

FROM: Legal Department

DATE: June 11, 2014

RE: Hearing and Meeting Schedule

Public Session:

July 9, 2014 at 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room
August 13, 2014 at 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

Please note that the Commissioner's packets will be available in the Commission's office at 11:45 p.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website.
http://hscrc.maryland.gov/commissionMeetingSchedule2014.cfm

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