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

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

1. **Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104**
2. **Update on Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104**
3. **Personnel Matters – Authority General Provisions Article, §3-305 (b) (1)**

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on June 13, 2018**
2. **New Model Monitoring**
3. **Docket Status – Cases Closed**

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

4. **Docket Status – Cases Open**

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

5. **Final Recommendation for Adjustment to the Differential**
6. **Final Recommendation on Uncompensated Care Policy for FY 2019**
7. **Policy Update Report and Discussion**

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

8. **CRISP Update**
9. **Legal Report**

10. Hearing and Meeting Schedule

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF JULY 3, 2018

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2439A	University of Maryland Medical System	6/11/2018	N/A	N/A	ARM	DNP	OPEN
2440A	University of Maryland Medical System	6/11/2018	N/A	N/A	ARM	DNP	OPEN
2441R	Meritus Health	6/19/2018	7/19/2018	11/23/2018	NEW SERVICE	BG	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

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

Staff Recommendation

July 11, 2018

I. INTRODUCTION

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

II. OVERVIEW OF THE APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating recent historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

Based on the Hospital's favorable performance, staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ transplant, and blood and bone marrow transplant services, for a one year period beginning August 1, 2018. The Hospital will need to file a renewal application to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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

Staff Recommendation

July 11, 2018

I. INTRODUCTION

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

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

this arrangement.

VI. STAFF RECOMMENDATION

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

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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

Staff Recommendation

July 11, 2018

INTRODUCTION:

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

BACKGROUND:

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

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

ASSESSMENT:

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

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

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

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

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

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

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

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

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

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

RECOMMENDATION:

Based on the analysis and findings above, staff recommends:

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

Final Staff Recommendation for Adjustment to the Payer Differential

July 11, 2018

Health Services Cost Review Commission
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PROPOSED COMMISSION ACTION

Staff will be asking the Commission to approve a final recommendation to increase the public-payer differential, effective January 1, 2019.

Final Recommendation for Increasing Public-Payer Differential

The current public-payer differential is 6.0 percent. Given recent trends of increasing bad-debt write-offs in commercial coverage, it is most equitable that the differential be increased 1.7 percentage points (from the current 6.0 percent to 7.7 percent) to ensure that these costs are not shifted to Medicare and Medicaid.

BACKGROUND

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

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

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

This report presents analyses and the staff recommendation to adjust the public-payer differential in order to correct for excess bad-debt write-offs from commercial coverage, which is shifting costs onto Medicare and Medicaid. This adjustment will result in a more equitable distribution of uncompensated care costs. The HSCRC staff is recommending an effective date of January 1, 2019 to allow for implementation by the Medicare intermediary and other payers. This differential change is not intended to supplant the work of providers to generate savings to Medicare under the All-Payer and Total Cost of Care Model Agreements with CMS, but rather to more accurately and fairly adjust for current trends in uncompensated care resulting from plan design changes of private payers.

ASSESSMENT

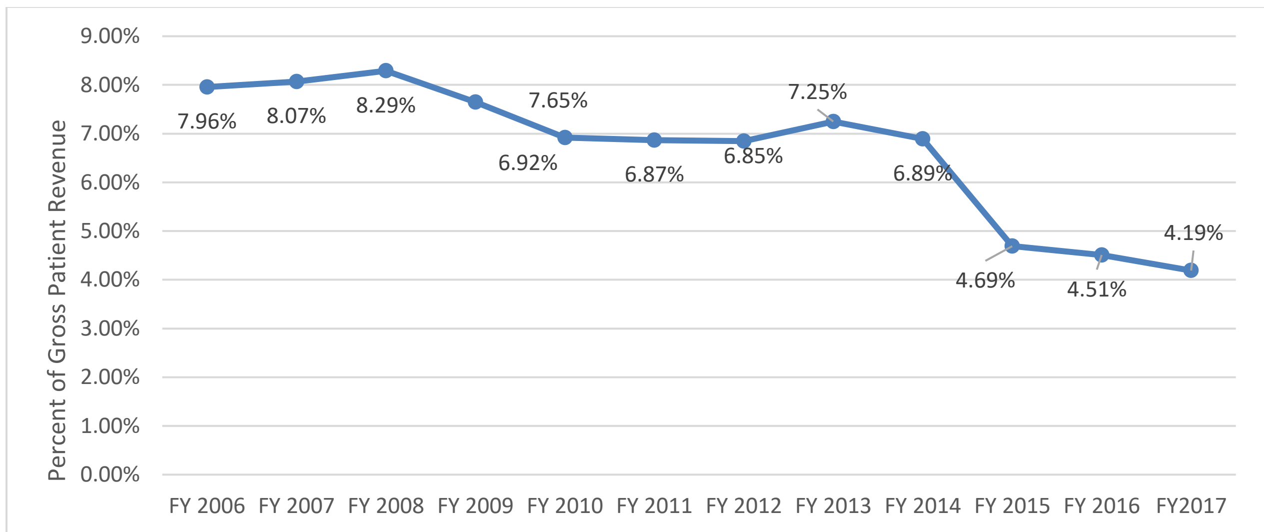
While expansion of coverage under the Affordable Care Act has contributed to a large decline in uncompensated care, rising deductibles and coinsurance have resulted in increased levels of uncompensated care for privately covered beneficiaries. The following section provides information on uncompensated care trends, health care coverage, and more detailed information on plan design trends for private payers in Maryland.

Uncompensated Care Trends

The share of hospital revenues attributed to uncompensated care has been declining in Maryland. This decline aligns with the increase in insurance coverage due to the 2007 Maryland Medicaid expansion and the expansion of Medicaid in 2014 under the Affordable Care Act (ACA). Uncompensated care, as a percentage of total patient revenue, has been reduced from 7.25 percent in 2013 (pre-ACA Medicaid Expansion) to 4.19 percent in 2017, a 3.06 percentage point

reduction or a 42.2 percent decrease in uncompensated care. The HSCRC adjusts hospital rates overall to reflect state-wide levels of uncompensated care, based on state-wide averages derived from hospitals' most recent annual reports filed with the Commission. When the ACA provided a significant expansion of Medicaid in CY 2014, the HSCRC began reducing hospitals' rates on July 1, 2014 and July 1, 2015, before information was available from annual reports. While there was a lag in removing uncompensated care from rates, at the same time, there was an increase in Medicaid utilization resulting from the expansion. As a result, hospitals were overfunded for uncompensated care, but underfunded for utilization resulting from the expansion. This was resolved through a hospital specific adjustment for Medicaid expansion and a return to the use of the annual report source for making the state-wide uncompensated care adjustment beginning July 1, 2016. All payers received the benefit of the 3.06 percentage point reduction in uncompensated care through hospital revenue reductions.

Figure 1. Actual Uncompensated Care Percentage of Gross Patient Revenue FY2006-FY2017

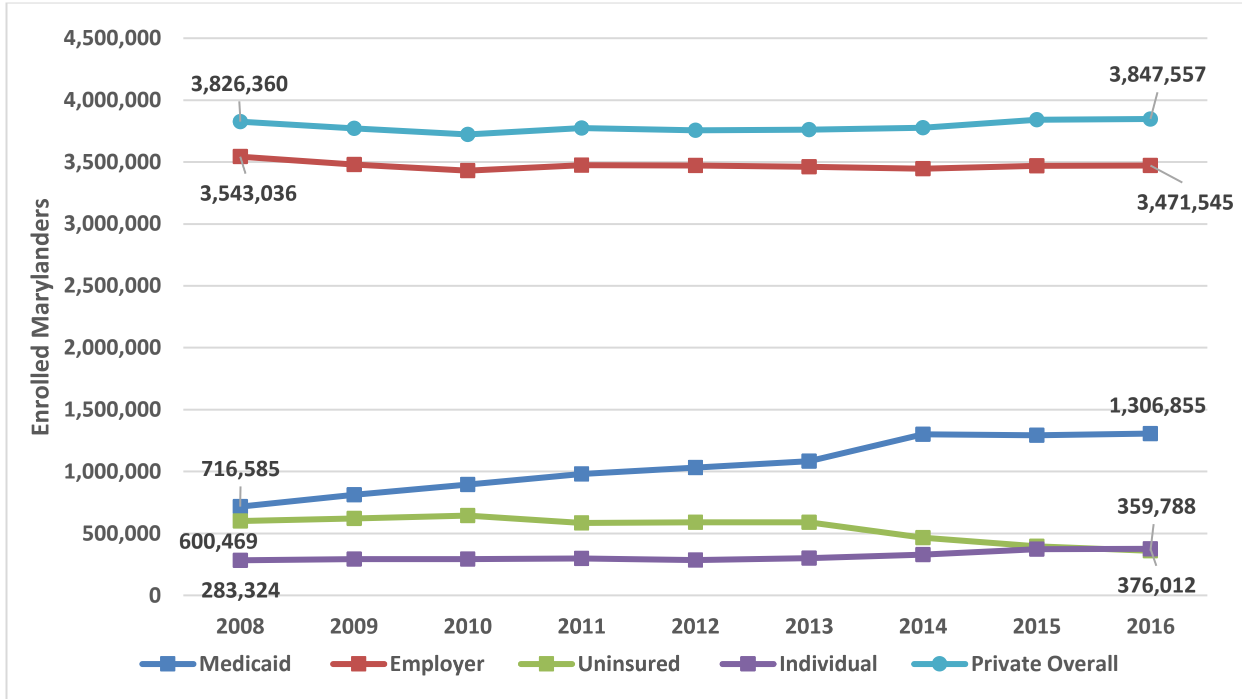


Source: HSCRC Historical Financial Data

<u>Changes in Payer Enrollment</u>

Reduction in uncompensated care resulted from an overall increase in health insurance coverage, mainly from the ACA Medicaid expansion. Figure 2 shows the trend of enrollment for Medicaid, individual insurance, employer-sponsored insurance, and aggregate private insurance (aggregate of individual, small group, and large group enrollees), as well as the trend for uninsured individuals, between 2008 and 2016.

Figure 2. Maryland Health Insurance Coverage by Payer type and Uninsured, CY2008-CY2016.



Source: SHADAC Analysis of the American Community Survey (ACS). http://statehealthcompare.shadac.org/trend/11/health-insurance-coverage-type-by-total#0/1/5/1,2,3,4,5,6,7,8,15/21 and Maryland Department of Health, Office of Healthcare Financing, Accessed June 2018.

While there is little increase overall in privately insured beneficiaries (small and large employers and individual combined), there was an increase of 92,688 people (32.7 percent) enrolled in the individual market. Employer coverage has decreased by 71,491 people, or 2.0 percent. Since 2008, Medicaid enrollment has increased by 589,997 people (82.4 percent overall), with a sharp uptick in Maryland's Medicaid enrollment in 2014 as Maryland Medicaid expanded eligibility under the ACA. As a result of the ACA, the uninsured population has decreased by 240,681 people, or 40.1 percent. Over the same time period, aggregated private health coverage (individual and employer) has only increased by 21,197 people (0.6 percent), significantly less than the population growth rate and the 606,860 people newly enrolled in public coverage from Medicare and Medicaid, a 53.4 percent increase.

Private Insurance through the Maryland Health Benefit Exchange

While the uninsured rate in Maryland dropped precipitously between 2012 and 2015 (during the ACA expansion), it appears that this decrease can be attributed more closely to increases in Medicaid enrollment than a large uptake on the individual exchanges. CY2016 estimates of Maryland's marketplace enrollment among potential enrollees show that only 35 percent of

eligible enrollees have signed up.[1] A Department of Legislative Services report from 2017 notes that the largest drops in the uninsured rate were for Marylanders at 0-138 percent and 139-200 percent brackets of the federal poverty guidelines (FPG); higher income Marylanders (201-400 percent FPG), who could enroll in private insurance on the exchanges, did not have the same magnitude decrease in their uninsured rates.[1]

Although Maryland already had a subsidized high risk product available to individuals prior to the ACA expansion with the Maryland Health Insurance Plan ("MHIP"), many other existing individual policies offered by private carriers were required to expand their benefits under the ACA. CareFirst and Kaiser Permanente provided most of the new individual policies. These policies resulted in losses due to low risk individuals enrolling at a level less than projected, and federal subsidies and premiums not adequately covering costs. During the 2018 legislative session, the State legislature passed legislation to provide relief for insurers providing these products. As a result, a reinsurance program will be established to provide stability in the individual markets and cover some of the losses from the adverse selection noted above.

Private Insurance Offered by Employers

Overall, uptake of employer-sponsored health insurance plans has also dropped in Maryland. Between 2012 and 2015, employee uptake with small group insurance dropped from 72.4 percent to 64.8 percent, and dropped from 78.0 percent to 74.0 percent for large group employers.[1] Medicaid expansion and individual market options may be contributing to this decline.

Commercial Insurance Plan Design Changes

In recent years, private payers have changed plan benefit design to help address growing healthcare costs, as well as address the plan design requirements for individual policies offered under the ACA guidelines. Plans in Maryland, and nationally, are increasingly reliant on beneficiaries to cover larger portions of their care. The share of privately insured Marylanders with a deductible has increased from 49.9 percent in 2006 to 88.7 percent as of 2016. Enrollment in high-deductible health plans has also increased: 44 percent of privately insured Marylanders are now enrolled in a plan with deductibles of at least $1,300 for an individual and $2,600 for a family.[2] Furthermore, average deductibles in Maryland have increased at a rate far outpacing the Consumer Price Index (CPI) for both urban consumers (CPI-U) and medical care (CPI-MC).

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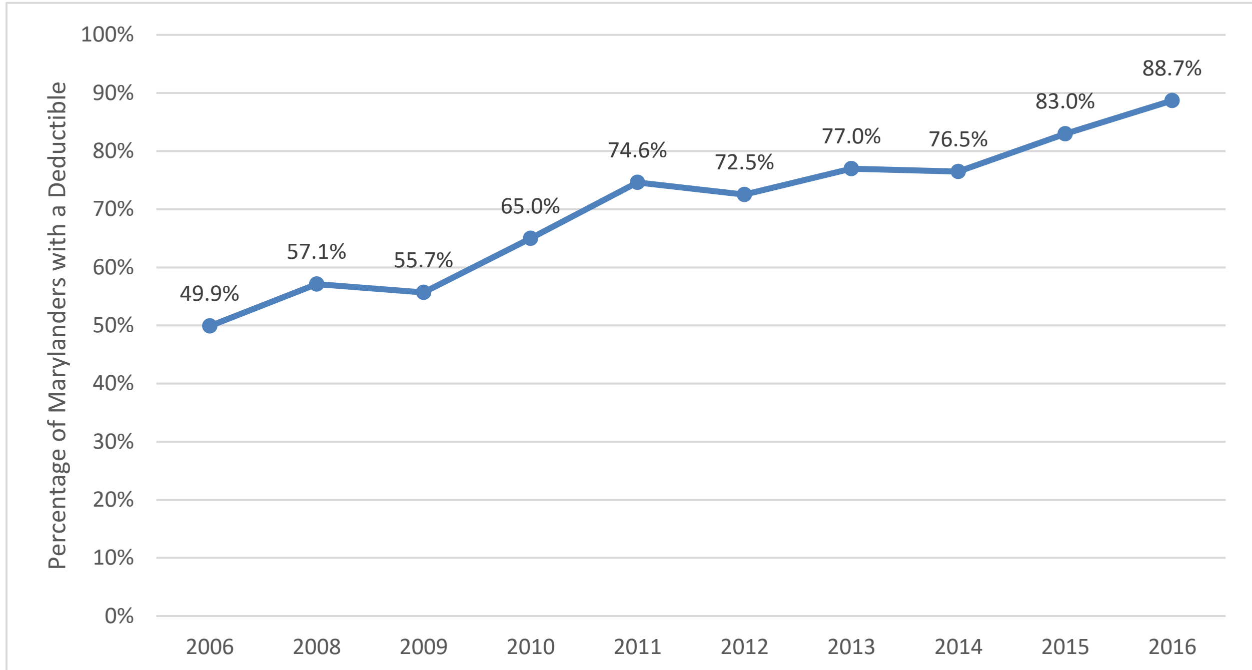
[1]Maryland Department of Legislative Services. Assessing the Impact of Health Care Reform In Maryland. January 2017. http://mgaleg.maryland.gov/pubs/legislegal/2017-impact-health-care-reform.pdf

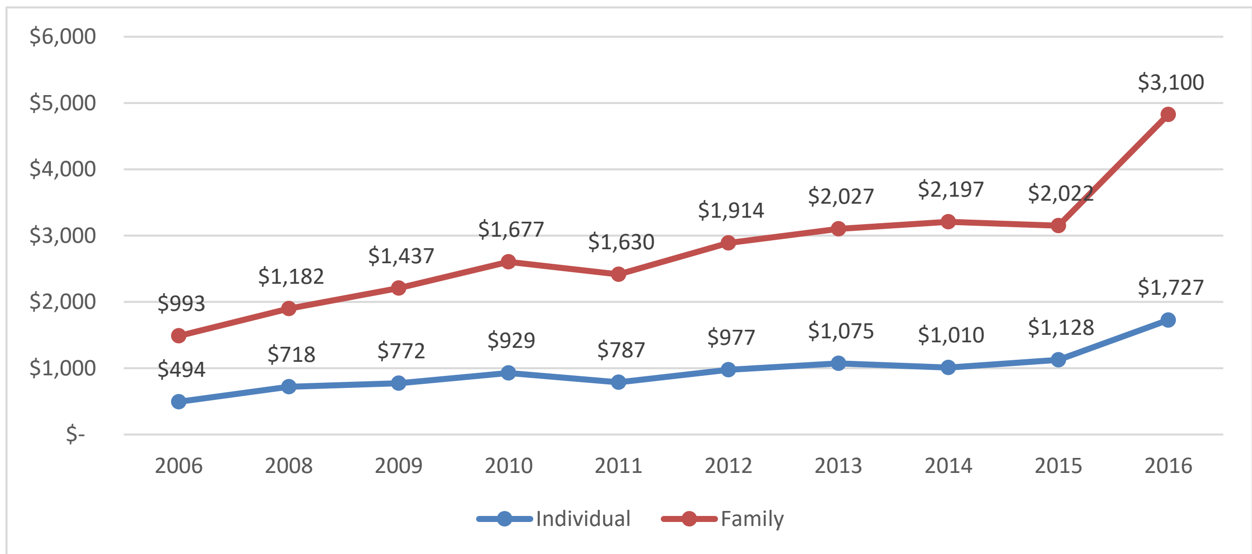
[2] Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017 https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp

Figure 3. Percent of Maryland private-sector employees enrolled in a health insurance plan with deductible (CY2002-CY2016)



Source: Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017.
https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp

Figure 4. Maryland Average Deductibles for Private Insurance, Unadjusted (CY2002-CY2016)



Source: Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017.
https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp

While the plan design changes are aimed at encouraging individual attention to cost levels, the HSCRC staff does not believe it is equitable to have the related uncompensated care allocated to

all payers. Deductibles have increased three-fold since 2006, and twice as many Marylanders are exposed to the rapidly increasing cost burden imposed by deductibles, thereby increasing the level of private payer uncompensated care at hospitals.

Hospital Bad Debt Share by Payer

As a results of the trends noted above, HSCRC staff is concerned that public payers are unduly burdened with the bad debts of private payers. Until recently, HSCRC did not have reliable data to evaluate the impact of increased bad debts for these changing plan designs. The HSCRC used a regression adjustment to estimate predicted bad debt levels for hospitals. Medicaid payer percentages were used to estimate expected charity levels, but with the expansion of Medicaid under the ACA, the relationships used in the regression were no longer valid. Since 2015, HSCRC collected actual write-offs at the account level and matched the write-offs to the case mix data. Upon collection of this data, HSCRC was able to create new and more accurate estimates of predicted uncompensated care. Staff also evaluated differences in write-offs of patient balances for insured patients. The HSCRC has now collected and analyzed several years of actual write-off data. The data below show a consistent pattern: commercial payer write-off rates are significantly higher than Medicare and Medicaid write-off rates.

	Medicare and Medicaid	Commercial	Difference
FY 2015	2.2%	3.6%	1.4%
FY 2016	2.1%	3.8%	1.7%
FY 2017	1.8%	3.6%	1.9%
Change	**-0.5%**	**0.0%**	

According to FY 2017 write-off data, commercial payers' bad-debt write-off rate (3.6 percent) is much higher than the combined rate for Medicare and Medicaid (1.8 percent). If these percentages were applied to FY 2019 revenues, they would translate to approximately $100 million more in write-offs for commercial payers than for Medicare and Medicaid. Of this $100 million, approximately $67 million would be allocated to Medicare and Medicaid through uncompensated care payments funded through hospital rates.

Proposed Change in the Differential

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

- A lower cost to Medicare of approximately $40 million;
- A lower cost to Medicaid of approximately $27 million; and
- An increase in overall commercial payer costs of $67 million, or 0.4 percent, assuming commercial costs reflect approximately one-third of total hospital costs.

The adjustment in the differential is being made to change the allocation of uncompensated care to Medicaid and Medicare. When it is implemented, it will have a revenue neutral effect on

hospitals, providing neither more nor less net revenue for each hospital through the formulaic adjustment that is made each year to the mark up for uncompensated care and payer differential. Private payers will see an increase in hospital payments of approximately 1.2 percent (which represents an overall increase of approximately 0.4 percent), while Medicare and Medicaid will see a corresponding decrease in their net payments of 0.7 percent as a result of the higher differential afforded.

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

STAKEHOLDER INPUT

Staff has received and reviewed comments from Consumer Health First, CareFirst BlueCross BlueShield (CareFirst), the Maryland Hospital Association, the Maryland Medicaid program, LifeBridge Health, the League of Life and Health Insurers of Maryland, UnitedHealthcare, and Union Hospital of Cecil County. Staff expanded the analysis provided above in response to several of the comments and has provided further commentary below.

Payer Comments

CareFirst BlueCross BlueShield, UnitedHealthcare, and the League of Life and Health Insurers of Maryland wrote opposing the proposed change in the differential. Maryland Medicaid wrote in favor of the change in the differential.

Comment: CareFirst noted that, "due to the lag in recognizing declines in uncompensated care, we believe the hospitals have been substantially overpaid in recent years..." **Response:** Whether uncompensated care was recognized correctly in hospital rates is not relevant to the differential change. The differential change does not impact the amount of bad debt in rates, rather it allocates the appropriate share of bad debts back to commercial payers. While there was a lag in recognizing uncompensated care declines, there was also a lag in recognizing the increasing utilization of hospital services due to the Medicaid expansion. HSCRC acted in advance of Medicare by making these adjustments with the best data it had available, initiating these adjustments in 2014, while Medicare did not initiate adjustments until October 2015. The HSCRC staff prioritized an early claims analysis of partially covered adults to calculate the first post-ACA uncompensated care reduction estimates, which was used to reduce hospitals' rates in 2014. Since this initial reduction was applied, HSCRC staff has made successive annual reductions. As annual report data has become available, staff has adjusted appropriately for these factors on an ongoing basis.

Comment: CareFirst stated that this differential change would adversely impact those who helped to maintain a viable Health Benefits Exchange, and the State has relied upon the private insurers to maintain coverage for the individually insured population. **Response:** HSCRC is especially appreciative of CareFirst and Kaiser Permanente as the insurers who have stepped up to provide coverage to individuals under the ACA. CareFirst has been an important source of coverage to individuals for decades. Less than one-third of privately covered individuals are

covered under actual insurance. Most privately insured individuals are covered under plans where the costs are passed through to the employers (self-insured plans). The HSCRC has supported more direct and appropriate approaches to address individual insurance market losses and risk. The federal government provides direct premium support for individuals who do not qualify for Medicaid, but have more limited income levels. In spite of this support, private premiums have risen due to adverse risk selection and other factors. During the 2018 legislative session, the legislature passed Maryland House Bill 1795 – Maryland Health Benefit Exchange – Establishment of a Reinsurance Program, an emergency bill that directed the Maryland Health Benefit Exchange to establish a State Reinsurance program to mitigate the impact of high-risk individuals on rates in the individual insurance market, inside and outside of the Exchange. The HSCRC supported this bill, which provides a more direct approach to easing the burden of adverse risk selection. This bill will help stabilize the individual market and decrease private sector losses.

Comment: CareFirst indicated that it sees the proposal to increase the differential as a "worrisome admission of failure" on the part of the HSCRC to control the total cost of care increases for Medicare, and raises a concern regarding whether this should count as contributing to Medicare total cost of care savings. **Response:** Staff does not agree with the statement regarding failure to control the growth in total cost of care. Under the All-Payer Model, cumulative Medicare total cost of care growth since the initiation of the All-Payer Model in Maryland in 2014 is 1.36 percent lower than the national growth rate over the first four Model performance years.[3] Over the first three Model years, the independent evaluation of the Model prepared for CMS by RTI International found that Maryland's Total Cost of Care had fallen relative to the matched comparison group. Inpatient utilization rates also remain below the matched comparison group according to the independent evaluation. While there can be fluctuations year over year due to the use of estimates in rate setting, changes in site of service initiated under the Model, or normal fluctuations in cost and use, the HSCRC staff and Commissioners have consistently demonstrated concern regarding Model performance. The overall trend and momentum of the trend is most important. Therefore, staff believes that in keeping with this concern, it is most appropriate to remove the effect of the change in the differential when evaluating performance under the Model. The Commission should take action and make update decisions without considering the impact of this change on Medicare costs. This change will not affect calendar year 2018 performance, as it would not take effect before 2019. This change will not have any effect on a need for corrective action resulting from calendar year 2018 performance, should the total cost of care growth exceed the national growth rate in 2018.

Comment: CareFirst objected to the manner in which the proposal came about. It commented that it was not distributed until two days before the last public meeting. The League of Life and Health Insurers of Maryland also commented about the timeliness and the lack of information about changes in private payer uncompensated care. **Response:** Staff apologizes for the delay

[3]Figures are derived from the calculations used for the Year 4 Report on the All-Payer Model results.

in providing its recommendation. Staff intended to raise the issue in the implementation workplan that was presented in the June Commission meeting and to make a proposed recommendation in the July Commission meeting. Staff has outlined a number of work activities to undertake in connection with the implementation of the Total Cost of Care Model. After contacting the Maryland Insurance Administration to understand the timeline for rate filings for calendar year 2019 premiums, staff took steps to introduce the proposed change in June to ensure public awareness of the proposed adjustment. While the estimated premium impact is modest (0.40 percent), we nevertheless wanted to ensure this information was available. Staff also made additional information available on the history of private payer deductibles in the Assessment section of this report.

Comment: CareFirst indicates that it understands the Commission's concern regarding the increase in cost sharing and its impact on uncompensated care. **Response:** Staff is not concerned about the increase in uncompensated care due to commercial payer changes in plan design. Some changes in plan design can be very beneficial, as, for example, when they drive consumer awareness and responsiveness to cost of care. Commercial payers and employers have received the full benefit of these changes through lower costs and lower utilization. However, staff does not believe it is equitable to allocate these uncompensated care dollars to public payers who have recently expanded coverage with resulting large reductions in uncompensated care. While staff understands the concerns raised regarding the change in the differential, staff believe this is the right time to make a correction for this resulting uncompensated care

Comment: UnitedHealthcare indicates that the discounts were negotiated over 40 years ago and that UnitedHealthcare relies on the Commission to control costs within the State, rather than shifting them from one bucket to another and burdening private payers. United Healthcare indicates that while uninsured populations are at their all-time low within the State of Maryland, the Staff is using uncompensated care as the basis for changing the differential. United does not believe this burden should be put on private payers. The League of Life and Health Insurers of Maryland commented that the recommendation appears to shift the burden of about $60 million of uncompensated care onto employers and individuals, who are struggling with affordability. **Response:** Medicaid has taken on an unprecedented expansion to provide coverage to uninsured populations. The HSCRC has not placed the burden of uncompensated care on private payers. In fact, unlike the remainder of the U.S., where the reduction in uncompensated care was only credited to the benefit of Medicare and Medicaid through reductions in disproportionate share payments to hospitals, the 3.06 percentage point reduction in uncompensated care in Maryland was spread across all payers. While most of the increase in access comes from the Medicaid expansion, private payers nevertheless received the benefit of the reduction in uncompensated care. The change in differential does not relate to individuals who are uninsured. Rather, the change is driven by the business practices of private payers to increase deductibles and coinsurance, resulting in increased uncompensated care.

Varying business practices represent a major part of the rationale behind the establishment of a differential in the first place. For example, in 1974, the HSCRC observed that some practices of major third parties either reduced hospital costs or averted bad debts. At that time, Maryland Blue Cross/Blue Shield, CareFirst's predecessor, offered an "open enrollment" health care policy

for individuals, which enabled an applicant to obtain health insurance without regard to his or her health condition. The HSCRC concluded that the availability of such insurance coverage for high risk individuals resulted in a reduction in the amount of uncompensated care or "bad debt" care that hospitals would otherwise have been required to provide if those high risk individuals had not been able to obtain insurance. In order to encourage other insurers to offer such open enrollment, the HSCRC developed the 4% Substantial, Available, and Affordable Coverage ("SAAC") differential designed to reflect the cost savings to hospitals by carriers such as Blue Cross/Blue Shield offering SAAC. This program was discontinued and replaced by the Maryland Health Insurance Plan, as previously noted. SAAC was made obsolete by the expansion and coverage provided under the ACA and subsidized by the federal government.

Staff does not believe that it is equitable to allocate these private payer driven costs to public payers who have borne the burden of the expansion. While affordability is of great concern in Maryland, hospital costs borne by private payers in Maryland are among the lowest in the nation. Private payers and purchasers have consistently benefitted from this effort. Hospital costs to private payers are the lowest of any Mid-Atlantic state.

Comment: Medicaid comments that the differential should be changed to foster a more equitable and accurate allocation of uncompensated care among payers, particularly as Medicaid has shouldered the burden of $2.74 billion in medical costs (including $1.23 billion in hospital costs) for 311,423 beneficiaries provided coverage under the recent Medicaid expansion. The information that was recently collected by HSCRC to address the payment of uncompensated care after the expansion of Medicaid has demonstrated that private payers are disproportionately contributing to increased levels of uncompensated care.

Hospital Comments

The Maryland Hospital Association, LifeBridge Health, and Union Hospital of Cecil County wrote in favor of the differential change. Hospitals and the Association noted recent significant increases in private payer uncompensated care resulting from the proliferation of high deductible and other large cost sharing plans. They also noted the inequitable distribution of this cost to Medicare and Medicaid. Overall, the hospital sector agrees that a change to the differential should be made to correct inequitable cost allocations of bad debt.

Consumer Health First

Comment: Consumer Health First expressed concerns that changing the differential may negatively impact individual market premiums and consumer affordability. Increase in hospital rates will disproportionately impact the individual insurance market, as opposed to group insurance. Further conversations indicated that Consumer Health First would like to begin a dialogue with HSCRC staff and other State agencies on ways to further stabilize the individual insurance market. **Response:** During the 2018 legislative session, the legislature passed Maryland House Bill 1795 – Maryland Health Benefit Exchange – Establishment of a Reinsurance Program, an emergency bill that directed the Maryland Health Benefit Exchange to establish a State reinsurance program to mitigate the impact of high-risk individuals on rates in

the individual insurance market, inside and outside of the Exchange. The HSCRC supported this bill, which provides a more direct approach to easing the burden of adverse risk selection, stabilizes the individual market, and decreases private sector losses. Staff supports a robust insurance market that offers affordable, quality plans to Marylanders and will continue to advocate for policies towards this end. While further conversations are needed to address insurance plan design changes and affordability in the Maryland market, the staff recommendation to increase the differential would not substantially affect individual plan premiums.

RECOMMENDATION

Based on the assessment above, staff recommends the following, effective January 1, 2019:

1) Increase the differential by 1.7 percentage points (from the current 6.0 percent to 7.7 percent) to more equitably allocate higher uncompensated care costs incurred by commercially insured patients. This adjustment will be made through the hospital mark-up adjustment, which will provide a net revenue neutral approach for hospitals.
2) To assure that the savings from the differential adjustment is not used to justify an increase to rates in a future rate year, the staff recommends that the cost reduction to Medicare as a result of the change in the differential be removed from the Total Cost of Care performance evaluation when establishing future annual updates, including any reconsideration of the rate year 2019 update.
3) Similarly, the savings to Medicare resulting from the differential adjustment should not be included in the trend factor used to calculate a hospital's performance under the Medicare Total Cost of Care algorithm.
4) The Commission should develop and adopt policies regarding the appropriate use of various rate-setting tools to meet Medicare total cost of care performance requirements. All-payer rate reductions and the Medicare Performance Adjustment should be evaluated and considered before resorting to changing the payer differential. The success of the TCOC Model is dependent on improving care and health, reducing avoidable utilization, and providing efficient, valuable services.

Maryland
Hospital Association

June 20, 2018

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

On behalf of the Maryland Hospital Association's (MHA) 64 member hospitals and health systems, we are submitting comments in response to the draft policy recommendation for a small adjustment to the public payer differential, from 6 percent to 7.7 percent. We strongly support the proposed recommendation and we look forward to working with the commission to seek federal approval of this modest but important change. We also hope to work with staff on how this proposal will impact individual hospitals for whom Medicare and Medicaid represent varying shares of total patient population.

We agree with the staff analysis that reveals a significant increase in hospital bad debts over the last few years due to the proliferation of high deductible and other large cost-sharing plans. This added burden on commercially insured consumers has inequitably distributed uncompensated care costs to Medicare and Medicaid. This cost shift occurred at the same time that commercial payers benefitted from the expansion of Medicaid coverage under the Affordable Care Act. That prompted a reduction of uncompensated care in hospitals' rates – from over 7 percent to just 4.16 percent – in the latest global budget update approved by the commission.

As we noted at the June commission meeting, the success of the Total Cost of Care Model that begins January 1 will require the contribution of all stakeholders – providers, payers, and state government. The proposed small increase in the differential from 6 percent to 7.7 percent should be seen as part of that effort, and, as staff notes, is likely to increase private payer premiums negligibly, by no more than 0.4 percent. We look forward to discussing this proposed recommendation at the July meeting.

Sincerely,

Michael B. Robbins

Michael B. Robbins, Senior Vice President

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James N. Elliott, M.D
Adam Kane
Jack Keane
Donna Kinzer, Executive Director

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Exhibit A

Chet Burrell
President and Chief Executive Officer

CareFirst BlueCross BlueShield
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-605-2558
Fax: 410-781-7606
chet.burrell@carefirst.com

June 26, 2018

Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Sabatini,

I am writing on behalf of CareFirst BCBS to express our profound concern with the proposed increase effective 1/1/19 in the Medicare differential that was proposed by the HSCRC staff at the June 13 public meeting. The stated purpose of this increase is to respond to adverse changes in uncompensated care (UCC) patterns that allegedly are attributable to private sector carriers.

This strikes us as highly unlikely at a time when enrollments under the ACA and improvements in the economy have caused uncompensated care to drop to historic lows – nearly cutting in half the amount of UCC charges built into hospital rates over the last 5 years. Due to the lag in recognizing declines in uncompensated care, we believe the hospitals have been substantially overpaid in recent years for UCC since the actual levels have turned out to be consistently below the levels built into hospital rates.

We see this proposal by staff as a worrisome admission of failure on the part of the State (more specifically, the HSCRC) to convincingly control per capita Medicare costs over the past four years as evidenced by the State record of exceeding TCOC limits under the All Payer Waiver in two of the last four years and a strong likelihood of exceeding it again in 2018. Despite this, our recent recommendation to keep the Update Factor low in light of concerns with TCOC trends went unheeded.

Now, because the State seeks to avoid a corrective action plan just as implementation of Phase II begins, the staff seeks to increase the differential and shift cost to the private sector ($67 million a year) at a time when employers and individuals are struggling to pay for the high cost of health care as it is.

We would point out that in all the decades of the Maryland waiver, the differential has never been changed except to recognize prompt payment and the special SAAC discount prior to the advent of MHIP. We now find ourselves in the position of having subsidized individual premium rates for tens of thousands of Marylanders over the past five years in order to maintain coverage for them (incurring $500m in losses from inadequate premium rates in the process) only to face this faulty staff proposal that requires the private sector – of which we are the greatest part – to pay even more since this proposal shifts cost to the very party(ies) the State depended on most to operate a viable Health Benefits Exchange.

We would point out that the combined impact of ACA's expansion of private sector coverage together with Medicaid expansion has resulted in over 800,000 Marylanders receiving coverage who would otherwise have gone uncovered. This caused a drop in the uninsured population to historic lows thanks also to an improving economy. Exactly what justification shows the compelling need now to adjust the differential to "better relate to costs"?

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We draw even greater concern from our perception that this shift in policy may be the beginning of a willingness on the part of the State to enact further differential increases in the future when Medicare TCOC is threatened – making this policy shift even more concerning. We – and the employers and individuals of Maryland - rely on the HSCRC to control costs, not shift them. If this cannot be done, then the Commission should admit as much and let the State move to the federal system that the rest of the country operates under - which has lower overall Medicare TCOC trends and hospital use levels than Maryland.

We further object to the manner in which this proposed policy came about. The fact is that this objectionable proposal was not distributed by staff for review until two working days before the public meeting and we and other payers were given only ten working days after the public meeting to submit written comments. We have been provided with no sound justification for this significant change in long standing policy. From the perspective of proper process alone, this is no way for a responsible regulatory process to work. HSCRC work groups consume months of discussion on far less consequential methodological matters.

We are interested in knowing whether the HSCRC would intend to count any Medicare payment reductions that would result from differential increases as contributing to TCOC savings that must be achieved in Phase II. We presume this to be the case. If so, we would regard such savings as artificial reductions achieved by cost shifting rather than by real cost control.

Finally, we understand there has been concern that increased member cost sharing in commercial coverage plans has led to increased hospital bad debts. But, we would point out that the member share of costs for CareFirst's book of business has increased only a few percentage points in the last five years – hardly enough to create a significant enough problem to justify such a dramatic shift in policy. Further, the cost share of most of the ACA enrollment is subsidized by the federal government – thereby reducing its impact on providers as was one of its major purposes.

We want to make certain that you understand that both the substance and the process involved in this policy shift proposed by staff is highly objectionable to us and detrimental to the "all payer" partnership so essential to the success of the Maryland experiment. It is certainly detrimental to the parties who ultimately pay the bill: individuals and employer groups.

Let me be clear: on this matter you do not have the support of the State's most significant private payer and we believe the staff have not made this unwarranted proposal in a manner that engenders trust among the key parties. This is unfortunate on multiple levels and is not an auspicious way to begin Phase II.

We urge you and the Commission members in the strongest possible terms to vote against this staff proposal.

Sincerely,

Chet Burrell
President & CEO

Cc: Joseph Antos, Ph.D., Vice Chairman
Victoria Bayless
John Colmers
James N. Elliott, M.D.
Adam Kane
Jack Keane
Donna Kinzer, Executive Director

CareFirst BlueCross BlueShield is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

June 27, 2018

Nelson Sabatini
Chair
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Sabatini,

On behalf of the Maryland Medicaid program, I would like to thank you for the opportunity to provide comments on the draft recommendation for increasing the public payer differential from 6.0 percent to 7.7 percent. The intent of the increased differential is to eliminate the allocation of higher bad-debt write-offs occurring in commercial coverage to Medicare and Medicaid. The Maryland Medicaid program is in support of the recommendation, as it fosters a more equitable and accurate distribution of uncompensated care among payers.

Historically, Medicaid payer percentages were used to estimate expected charity levels; this methodology was altered after Maryland expanded Medicaid under the Patient Protection and Affordable Care Act (ACA) in 2014. During the first year, 283,716 Marylanders gained coverage as part of the expansion; this number has grown to 311,423 as of May 2018. In 2017, this population accounted for over $2.74 billion in health care costs, including nearly $1.23 billion in hospital expenditures. Since the enactment of the Medicaid expansion in 2014, expenditures for this population have totaled over $8.79 billion. As a result, the HSCRC has decreased the uncompensated care pool; however, more recent analysis has demonstrated that write-offs for commercial coverage are much higher than for public payers, with the difference equating to approximately $100 million. The proposed differential increase will reallocate a portion of that difference to Medicare ($40 million) and Medicaid ($27 million). This will become increasingly important as the State assumes a greater share of Medicaid expansion expenditures in the coming years.

If you have any questions, please do not hesitate to contact me via phone at 410-767-5809 or via email at tricia.roddy@maryland.gov.

Sincerely,

Tricia Roddy

Tricia Roddy
Director, Planning Administration
Office of Health Care Financing

The
League
of
Life and
Health
Insurers
of
Maryland

200 Duke of Gloucester Street
Annapolis, Maryland 21401
410-269-1554

June 27, 2018

Nelson J. Sabatini
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Via e-mail to hscrc.payment@maryland.gov

RE: Draft Recommendation for Adjustment to the Differential

Dear Chairman Sabatini,

I am writing on behalf of the League of Life and Health Insurers of Maryland, Inc., "League", the State trade association for life and health insurers that operate in the State whose member companies include all of the major medical carriers in the State. The League is concerned about the above referenced *Recommendation for Adjustment to the Differential* that was proposed by the Health Services Cost Review Commission (HSCRC) staff at the June 13 public meeting. The purpose of increasing the differential by 1.7 percentage points is "to eliminate the allocation of the higher bad-debt write-offs in Commercial coverage to Medicare and Medicaid."

The League is concerned about what appears to be a shift in cost and the manner in which the shift is being decided, giving little opportunity to respond by payers. The analysis in the draft recommendation cites an increase in bad debt attributable to commercial payers in recent years but does not offer prior years of analysis for comparison. The analysis also does not appear to take into account the increased coverage achieved by the ACA which has cut uncompensated care almost in half.

The proposal seeks to shift approximately $60 million a year to the private sector thereby increasing health insurance rates for employers and individuals at a time when they are already struggling to pay for the high cost of healthcare. Specifically the Small Group rates that carriers have already filed with the Maryland Insurance Administration for 2019 will need to be re-filed to reflect the new cost structure in the proposal. The rating impacts will also be felt in all other segments resulting in higher insurance costs for consumers.

The League believes that the proposal sets a dangerous precedent with respect to the manner in which the proposal was presented to carriers who are the ultimate payers for the increase. The proposal was only made available two days prior to the June 13 meeting with a comment period of ten working days. It is our understanding the HSCRC work groups can take months to discuss and decide matters of

far less consequence. We think that this process leads to less stability and predictability for payers, which could have negative implications on the health insurance market in the State as a whole.

Various stakeholders have made significant progress in the previous decade at ensuring that hundreds of thousands of Marylanders have access to health care coverage to which they had once struggled to obtain. While these cost shifts may seem to be a trivial budgetary decision at ensuring performance measures are met for the State waiver benchmarks, it may become a catalyst to the creation of significant barriers to ensuring timely and much-needed access to health care services.

For these reasons, we urge the Commission members to vote against this staff proposal.

Respectfully submitted,

Tinna Quigley
Executive Director

Cc: Donna Kinzer, Executive Director
Katie Wunderlich, Director, Engagement and Alignment
Bobby Neall, Secretary, Maryland Department of Health
Al Redmer, Commissioner, Maryland Insurance Administration

UnitedHealthcare®

800 King Farm Boulevard
Suite 600
Rockville, MD 20850

Mr. Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Sabatini:

We are writing to express our concern over Staff's recommendation to increase the Medicare differential effective January 1, 2019. UnitedHealthcare opposes this action and urges the Health Services Cost Review Commission (HSCRC or Commission) to reject the current recommendation for the following reasons:

- Movement such as this comes at a time when we are faced with exceeding national Medicare Total Cost of Care (TCOC) trends under the All Payer Waiver. We have been above this guardrail in 2 of the last 4 years, and all eyes are on 2019.
- Our State is an all Payer jurisdiction, and the "discounts" were negotiated over 40 years ago. We rely on the Commission to control costs within the State of Maryland and to move from one bucket to another is not controlling cost but shifting more of the burden to commercial payers and members.
- As a payer, we were not part of any pervious discussions to express our concerns with this type of cost shifting. We think that the Commission will find our perspective helpful given our unique position of servicing commercial, Medicare and Medicaid customers.

Uninsured populations are at their all-time low within the State of Maryland, yet the Staff is using uncompensated care as their basis for flexing the differential. We believe the HSCRC should be holding the entire process accountable and not placing this burden on private payers and the members they serve.

As captured on its website, the HSCRC has the laudable goal of reducing costs – "Success of the All-Payer Model will reduce costs to purchasers of care—businesses, patients, insurers, Medicare, and Medicaid—and improve the quality of the care that patients receive both inside and outside of the hospital. Since 2014, the State, in close partnership with providers, payers, and consumers, has made significant progress toward this modernization effort" (emphasis added).

As this statement reflects, the intent of the Commission is clearly to reduce costs to all purchasers of care, not only those involving the Medicare and Medicaid programs. The move

currently being contemplated by the HSCRC not only affects commercial payers, but businesses will see an increase in premium dollars, and more importantly, it affects members who are responsible for paying their coinsurances and deductibles. We see this as not only a move to shift the costs from government programs onto the Payers, but a change that will lead to significant increase to the community business partners and to patients.

We appreciate the opportunity to provide perspective on the recommendation being considered. We support the goal of the Commission to help control costs in a comprehensive way within the State of Maryland. However, the present recommendation will not promote this goal.

We respectfully ask the Commission to reject this recommendation.

Sincerely,

Christopher J. Mullins

UnitedHealthcare CEO-Mid Atlantic

Consumer Health First

Access ▪ Quality ▪ Equity

June 26, 2018

Health Services Cost Review Commission
c/o hscrc.payment@maryland.gov

To Whom It May Concern:

Consumer Health First (CHF), a statewide advocacy organization dedicated to promoting health equity through access to high-quality, comprehensive and affordable health care for all Marylanders, offers the following comments regarding the proposed adjustment to the differential.

The Health Services Cost Review Commission staff recommends increasing the differential by 1.7 percentage points (from the current 6.0 percent to 7.7 percent) to eliminate the allocation of the higher bad debt write-offs occurring in Commercial coverage to Medicare and Medicaid. We accept the staff analysis. However, we respectfully request you consider the impact of this proposed change on Maryland's individual health insurance market.

About 7 percent of Marylanders under the age of 65 purchase individual health insurance coverage through the Maryland Health Benefit Exchange, brokers or directly from CareFirst and Kaiser Permanente. For those with incomes over 400 percent of the Federal Poverty Level, purchasing individual health insurance coverage has become increasingly unaffordable. Beginning next year, consumers are no longer required by Federal law to purchase coverage. We believe many consumers will gamble that they will not need health care services in 2019 and forego purchasing health insurance thus increasing the number of uninsured Marylanders and the amount of uncompensated care.

Only CareFirst and Kaiser Permanente offer individual health insurance coverage in Maryland. We believe everything needs to be done to incentivize these carriers to continue to offer coverage at an affordable rate in this market. One way to do this is to replicate what was historically done through the Commission's SAAC program, offering a different differential to carriers offering coverage to individuals on a guaranteed issued basis. We invite the Commission staff to consider a bi-furcated differential for carriers in the individual market.

In closing, we very much appreciate the opportunity to provide our perspective and ideas on your important deliberations and look forward to working with you.

Sincerely,

Beth Sammis
President, Consumer Health First
bethsammis@gmail.com

Sinai Hospital
Northwest Hospital
Carroll Hospital
Levindale Hebrew Geriatric Center and Hospital

Neil M. Meltzer
President and Chief Executive Officer

June 22, 2018

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Nelson,

On behalf of the LifeBridge Health System and its four member hospitals (Sinai, Northwest, Carroll and Levindale), please accept this letter as support for the Staff recommendation offered at the June 13th public meeting to increase the payer differential to Medicare and Medicaid from 6.0% to 7.7%.

While LifeBridge has long maintained a position that any changes to the payer differential should be carefully considered and proposed only when necessary to the successful continuation of Maryland's unique Medicare/Medicaid waiver demonstration, we believe this constitutes the recommended payer differential increase. Medicare and Medicaid should not be disproportionately disadvantaged by the significant changes in commercial insurance benefit plan design which has shifted considerable responsibility to individual consumers, particularly at the juncture when we are collectively challenged to meet the requirements of the recently approved new Total Cost of Care Model.

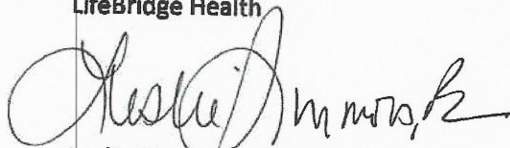
We look forward to working collectively with the HSCRC to continue advancing Maryland's unique demonstration model. As always, should you wish to discuss this issue in greater detail, please do not hesitate to reach-out to us directly.

Sincerely,

Neil Meltzer
President and Chief Executive Officer
LifeBridge Health

David Krajewski
Executive Vice President and Chief Financial Officer, LifeBridge Health
President, LifeBridge Health Partners

Brian White
Executive Vice President
LifeBridge Health



Leslie Simmons
Executive Vice President
LifeBridge Health

Michael D. Myers
Vice President Regulatory Reporting and Reimbursement
LifeBridge Health

CC: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James N. Elliott, M.D.
Adam Kane
Jack Keane
Donna Kinzer, Executive Director

June 28, 2019

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Nelson,

On behalf of Union Hospital of Cecil County, please accept this letter as support for the Staff recommendation offered at the June 13th public meeting to increase the payer differential to Medicare and Medicaid from 6.0% to 7.7%.

While Union Hospital believes that any changes to the payer differential should be carefully considered and proposed only when necessary to the successful continuation of Maryland's unique Medicare/Medicaid waiver demonstration, we consider this recommended payer differential increase an essential change to the Maryland model. Medicare and Medicaid should not be disproportionately disadvantaged by the changes in commercial insurance benefit plan design which has shifted considerable responsibility to individual consumers, particularly at the juncture when we are collectively challenged to meet the requirements of the recently approved new Total Cost Care Model.

We look forward to working with the HSCRC staff to continue advancing Maryland's unique demonstration model. As always, should you wish to discuss this issue in greater detail, please do not hesitate to reach out to us.

Sincerely,

Richard C. Szumel, M.D.
President and Chief Executive Officer
Union Hospital of Cecil County

James G. Raab
Senior Vice President and Chief Financial Officer
Union Hospital of Cecil County

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James N. Elliott, M.D.
Adam Kane
Jack Keane
Donna Kinzer, Executive Director

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www.uhcc.com

Final Recommendations for the Uncompensated Care Policy for Rate Year 2019

July 11, 2018

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

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CHANGES FROM DRAFT TO FINAL RECOMMENDATION

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

INTRODUCTION

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

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

BACKGROUND

Overview of Maryland's Uncompensated Care Policy

Methodology

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

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

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[1] COMAR 10.37.10.01K

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

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

ASSESSMENT

Determining the Appropriate Level of Uncompensated Care Funding in Rates

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

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

RECOMMENDATIONS

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

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

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

APPENDIX I. HOSPITAL UNCOMPENSATED CARE PROVISION FOR RY 2019

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

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

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

APPENDIX II. WRITE-OFF DATA SUMMARY STATISTICS

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

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

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

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

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

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

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

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

Kevin W. Sowers, MSN, RN, FAAN

President
Johns Hopkins Health System

Executive Vice President
Johns Hopkins Medicine

June 12, 2018

Dianne S. Feeney
Associate Director, Quality Initiative
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Feeney,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the proposed Emergency Department(ED) Wait Time risk adjustment policies under consideration by the Health Services Cost Review Commission (HSCRC). In December of 2017, the Commission approved the inclusion of two ED Wait Time measures in the RY 2019 QBR Program under the condition that HSCRC staff explore additional risk adjustment beyond ED volume.

JHHS appreciates the time and effort HSCRC staff have dedicated to evaluating the various risk adjustment factors, including staff's recognition of the impact of the flu season. However, we continue to have concerns that a metric that adjusts for volume only will impede the ability of Maryland hospitals to safely and appropriately reduce ED wait times.

While we recognize that the proposed methodology focuses on improvement, without the appropriate metrics and risk adjustment, many hospitals will not be afforded the opportunity to improve over time. If the ED Wait Time policy is to succeed in helping hospitals improve efficiency while maintaining quality patient care, it is critical that the policy include appropriate protections and considerations. We recommend that the risk adjustment account for:

- The volume of transfers a hospital receives from other ED's: We have seen a significant increase in the number of patient transfer requests from other hospitals. The total number of patients transferred from other hospitals to Johns Hopkins has increased significantly since FY 2014. That volume increase has impacted our inpatient occupancy. Most significantly however, is the fact that the percentage of patient transfers from other emergency departments has grown from 55% of all transfers to 61% of all transfers. Under

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EMTALA regulations, we are required to accept these patients as if they were already physically in our ED. There is simply little opportunity for JHH to mitigate the impact of these patients to our ED and the transferred patient demand continues to grow each year.

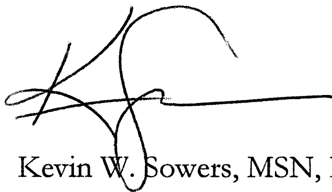
- Inpatient occupancy: Boarding time and admitted patient throughput is difficult to improve when inpatient occupancy remains high. At JHH, occupancy in the Department of Medicine, where most patients from the ED are admitted, is consistently at 96-98%. The lack of available beds results in extended ED wait times. The attached graph demonstrates that at occupancy rates below 93%, boarding time is more reasonable for patients going to the Department of Medicine. However, once beyond 93% occupancy, boarding time rises rapidly; the graph illustrates that JHH typically operates at occupancy rates exceeding 94%.
- Volume of psychiatric patients in the ED: All hospitals within JHHS have experienced increases in the number and length of stay of psychiatric patients in the ED. While the proposed wait measure excludes psychiatric patients, these patients have a significant impact on the overall function of the ED. The volume of patients with behavioral health emergencies exceeds the capacity of our behavioral health portion of the ED 98% of the time. When this happens, behavioral health patients "overflow" into the main ED and patients remain there for extended periods of time. This overflow consumes resources and prevents timely evaluation and treatment of other patients, which ultimately increases the total admitted patient throughput times. We have recently discovered that the ED at Johns Hopkins receives a disproportionate share of patients under "emergency petition" with the Baltimore City Police. Approximately 33% of all emergency petition patients are brought to Johns Hopkins for assessment. This patient population puts an enormous burden on the ED and uses bed space and resources that could be used for the care of other patients.
- Exclusion of patient under observation status: At JHH we have an observation unit within the ED. This unit is dedicated and designed to avoid inpatient admission when appropriate. An ED should not be penalized for the increased time spent in evaluating the medical necessity of an admission. Patients in ED Observation status who convert to inpatient status should be eliminated from the admission throughput metric.

As noted in previous communications with the HSCRC, JHHS hospitals have been actively engaged in improving the patient experience and maximizing capacity and efficiency at each of our EDs. This is difficult, but important work. Despite the value in improving ED wait times; current ED wait time measures have a high degree of variability and unreliability. As we have discussed, there is no standard time in the industry that defines when boarding time should start. Specifically because of this uncertainty and lack of definition, CMS has not associated ED wait times with any financial penalties or rewards. Considering the recently proposed rule from CMS regarding ED wait times, delay of the Maryland specific ED Wait Time measure may be more appropriate. JHHS has concerns with the use of Maryland specific measures and targets that are not aligned with national measures and targets; doing so creates additional disparities between Maryland and national measures as well as increased complexity.

Should the ED Wait Time measure move forward within the QBR program, we recommend consideration be given to the above factors. Unintended consequences could result without thoughtful consideration of all the factors contributing to ED Wait Times.

Thank you again to the efforts of the HSCRC staff who have been thoughtful, accessible, and diligent in their efforts around this issue. We look forward to continued collaboration in our mutual efforts to reduce ED wait times.

Sincerely,



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Staff Report:
Integrated Care Network Update

July 11, 2018

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LIST OF ABREVIATIONS

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

OVERVIEW

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

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

BACKGROUND

Past Funding

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

Table 1. Integrated Care Network, FYs 2016-2020

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

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

FY 2019 ACTIVITIES

CRISP ICN Projects

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

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

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

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

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

Care Redesign Programs

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

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

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

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

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

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

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

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

Other State Projects

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

FUTURE GOVERNANCE ISSUES

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

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

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

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

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

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TO: Commissioners

FROM: HSCRC Staff

DATE: July 11, 2018

RE: Hearing and Meeting Schedule

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

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

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

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