

**State of Maryland
Department of Health**

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Vice-Chairman**

Victoria W. Bayless

John M. Colmers

James N. Elliott, M.D.

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**Chris Peterson, Director
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Health Services Cost Review Commission

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**561st MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
May 8, 2019**

EXECUTIVE SESSION

11:00 a.m.

(The Commission will begin in public session at 11:00 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 Administration of Model - Authority General Provisions Article, §3-103 and §3-104**

PUBLIC SESSION

1:00 p.m.

- 1. Review of the Minutes from the Public and Closed Meetings held on April 10, 2019**
- 2. New Model Monitoring**
- 3. Docket Status – Cases Closed**
2475R - Calvert Health Medical Center 2476A – Johns Hopkins Health System
2477A – Johns Hopkins Health System
- 4. Docket Status – Cases Open**
2478A – University of Maryland Medical Center 2479A – University of Maryland Medical Center
2480A – University of Maryland Medical Center
- 5. Final Recommendation on Nurse Support Program II for FY 2020**
- 6. Draft Recommendation on Market Shift Adjustment Policy**
- 7. Draft Recommendation on the Update Factor for FY 2020**
- 8. Draft Recommendation on Ongoing Support of CRISP in FY 2020**
- 9. Draft Recommendation for the Maryland Patient Safety Center for FY 2020**

10. Draft Recommendation on Changes to the Relative Value Units Scale on Emergency Department Services

11. Policy Update and Discussion

12. Hearing and Meeting Schedule

**Closed Session Minutes
Of the
Health Services Cost Review Commission**

April 10, 2019

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

1. Legal Consultation – Authority General Provisions Article, §3-305(b)(7)

The Closed Session was called to order at 11:40 a.m. and held under authority of §3-305 (b)(7) of the General Provisions Article.

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

In attendance representing Staff were Katie Wunderlich, Jerry Schmith, Allan Pack, Chris Peterson, William Henderson, Alyson Schuster, Will Daniel, Amanda Vaughan, Joe Delenick, Bob Gallion, and Dennis Phelps.

Also attending were Eric Lindemann, Commission Consultant, and Stan Lustman, Commission Counsel.

Item One

Stan Lustman, Commission Counsel, presented and the Commission and staff discussed advice of counsel on potential methodology changes.

Closed Session was adjourned at 1:07 p.m.

AMENDED
MINUTES OF THE
560th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
April 10, 2019

Chairman Nelson Sabatini called the public meeting to order at 11:40 a.m. Commissioners Joseph Antos, Victoria Bayless, John Colmers, James Elliott, M.D., Adam Kane, and Jack Keane were also in attendance. Upon motion made by Commissioner Antos and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Chairman Sabatini reconvened the public meeting at 1:14 p.m.

REPORT OF APRIL 10, 2019 CLOSED SESSION

Mr. Dennis Phelps, Associate Director, Audit & Compliance, summarized the minutes of the April 10, 2019 Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM MARCH 13, 2019 CLOSED SESSION AND
PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the March 13, 2019 Public Meeting and the minutes of the Closed Session.

ITEM II
NEW MODEL MODELING

Ms. Caitlyn Cooksey, Assistant Chief, Hospital Rate Regulation presented CY2018 Medicare FFS data through December 2018 (with claims paid through February 2019). During this period, Maryland Medicare per capita Total Cost of Care (TCOC) spending has been mostly favorable when compared to the nation; however, per capita non-hospital spending has been mostly unfavorable. Ms. Cooksey noted that Maryland is projected to have \$273 million in Medicare TCOC savings for calendar year 2018.

Ms. Amanda Vaughan, Associate Director Clinical and Financial Information, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of February 2019 focuses on the fiscal year (July 1 through June 30) as well as calendar year results.

Ms. Vaughan reported that for the eight months of the fiscal year ending February 28, 2019, All-Payer total gross hospital revenue increased by 1.56% over the same period in FY 2018. All-Payer total gross hospital revenue for Maryland residents increased by 1.60%. All-Payer gross hospital revenue for non-Maryland residents increased by 1.15%.

Ms. Vaughan reported that for the two months of the calendar year ending February 28, 2019, All-Payer total gross hospital revenue increased by 0.37% over the same period in CY 2018. All-Payer total gross hospital revenue for Maryland residents increased by 0.32%. All-Payer gross hospital revenue for non-Maryland residents increased by 1.03%.

Ms. Vaughan reported that for the eight months of fiscal year ending February 28, 2019, Medicare Fee-For-Service gross hospital revenue declined by 0.74% over the same period in FY 2018. Medicare Fee-For-Service gross hospital revenue for Maryland residents declined by 0.65%. Maryland Fee-For-Service gross hospital revenue for non-residents declined by 1.83%.

Ms. Vaughan reported that for the two months of the calendar year ending February 28, 2019, Medicare Fee-For-Service gross hospital revenue declined by 3.74% over the same period in CY 2018. Medicare Fee-For-Service gross hospital revenue for Maryland residents declined by 3.72%. Maryland Fee-For-Service gross hospital revenue for non-residents declined by 4.00%.

Ms. Vaughan reported that for the eight months of the fiscal year ending February 28, 2019 over the same period in FY 2018, All Payer in State per capita hospital revenue growth was 1.30%. Ms. Vaughan noted that the Medicare Fee-For-Service in State per capita hospital revenue for the same period declined by 2.60%.

Ms. Vaughan reported that for the two months of the calendar year ending February 28, 2019 over the same period in FY 2018, the All Payer in State per capita hospital revenue growth was 0.02%. The Medicare Fee for Service per capita hospital revenue growth declined by 5.34% over the same period in CY 2017.

According to Ms. Vaughan, for the eight months fiscal year ending February 28, 2019, unaudited average operating profit for acute hospitals was 2.19%. The median hospital profit was 1.69%, with a distribution of negative 0.40% in the 25th percentile and 5.06% in the 75th percentile. Rate Regulated profits were 5.90%.

ITEM III
DOCKET STATUS CLOSED CASES

2473A- University of Maryland Medical Center

2474A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS – CASES OPEN

2475R- Calvert Health Medical Center

On March 1, 2019, Calvert Health Medical Center (“the Hospital”) submitted a partial rate application to the Commission requesting that its July 1, 2018 Medical Surgical Acute (MSG) and

Definitive Observation (DEF) approved rates be combined effective July 1, 2019.

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

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;
2. That a MSG rate of \$1,054.13 per day be approved effective July 1, 2019; and
3. That no change be made to the Hospital's Global Budget Revenue for MSG service.

The Commission voted unanimously to approve staff's recommendation.

2476A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on March 25, 2019 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals"), requesting approval from the HSCRC for continued participation in a global rate arrangement for solid organ and bone marrow transplants with Preferred Health Care LLC. The Hospitals request that the Commission approve the arrangement for one year beginning May 1, 2019.

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing May 1, 2019. The Hospitals 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 with the Hospitals for the approved contract.

The Commission voted unanimously to approve staff's recommendation. Commissioner Colmers recused himself from the discussion and vote.

2477A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application with the HSCRC on March 28, 2019 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplants services with 6 Degrees Health, Inc. The System requests approval for a period of one year beginning May 1, 2019.

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year

period commencing May 1, 2019. The Hospitals 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 with the Hospitals for the approved contract.

The Commission voted unanimously to approve staff's recommendation. Commissioner Colmers recused himself from the discussion and vote.

ITEM V **FY 2018 COMMUNITY BENEFIT REPORT**

Ms. Laura Spicer, Director of Health Reform Studies, The Hilltop Institute, provided background and summarized the FY 2018 Maryland Hospital Community Benefit Report (CBR) (see "Maryland Hospital Community Benefit Report: FY 2018" on the HSCRC's website).

Each year, the HSCRC collects community benefit information from 51 hospitals to compile into a publicly available statewide CBR. Current year and previous CBRs submitted by hospitals are available on the HSCRC website. According to Ms. Spicer, the FY CBR indicated that hospitals: 1) reported a total of \$1.7 billion in community benefits for FY 2018 (FY 2017 amount was approximately \$1.6 billion); 2) provided an average of 10.80% of total operating expenses in community benefits (compared to 9.90% in FY 2017); and 3) provided net community care of \$1.1 billion or 6.7% of hospitals' net operating expenses (down from \$896 million and 5.7% of hospitals' net operating expenses in FY 2017).

Chairman Sabatini asked if the effectiveness of the community benefit spending was evaluated.

Ms. Spicer replied that some hospitals submitted data on the outcomes of various community benefits activities.

Chairman Sabatini also asked whether there had been a comparison of the value of community benefits provided versus the value of the hospitals' tax-exempt status.

Ms. Spicer indicated that data on the value of hospitals' tax-exempt is not currently collected.

Commissioner Kane suggested that the Report should identify which community benefits are associated with the financial incentives provided by population-based Total Cost of Care All-Payer Model.

Commissioner Bayless noted that there should be a connection between the Community Health Needs Assessment and the Community Benefit Report.

Ms. Spicer stated that this year hospitals were asked how their initiatives targeted the needs

identified in the Community Health Needs Assessment.

Vice Chairman Antos noted that he would scrap the current report and create one that would provide analyses of the effectiveness of the community benefits provided.

Commissioner Elliot asked whether there was a requirement to devote a certain percentage of hospital expenses to community benefits.

Ms. Spicer replied that there is no State of Maryland or federal requirement, and a survey of all 50 states revealed that only a few states have specific community benefit requirements.

Commissioner Keane asked Ms. Spicer whether she thought that because the community benefit data was self-reported and self-audited, this possibly contributed to the enormous range of community benefits provided relative to operating expenses.

Ms. Spicer agreed that it was possible.

Commissioner Keane expressed agreement with Chairman Sabatini and Vice Chairman Antos on assessing the value of hospitals' tax-exempt status, vis-à-vis the value of community benefits provided, and they agreed that the value of hospitals' tax-exempt status should be used in determination of the net value of community benefits provided and that this determination should be included in future reports. The Commissioners accepted the current report with these changes to be incorporated into the Community Benefits Report.

ITEM VI

REPORT ON DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA

Mr. Dennis Phelps, Associate Director, Audit & Compliance, summarized the annual disclosure of financial and statistical data for Maryland hospitals for FY 2018 (See "Disclosure of Hospital Financial and Statistical Data: Fiscal Year 2018" on the HSCRC website). Major highlights of the report were:

- Gross all-payer per capita hospital revenues from services provided to Maryland residents grew by 3.54%, slightly higher than the per capita growth in the Maryland economy, which was 2.90% in CY 2017.
- Over the five-year performance period of the Model, the State was required to achieve cumulative aggregate savings in the Medicare per beneficiary total hospital expenditures for Maryland resident Medicare fee-for-service (FFS) beneficiaries of at least \$330 million. For Performance Year 4 (CY 2017), the State achieved \$330 million in Medicare savings, as compared to the CY 2013 base. The cumulative savings for CY 2014 through CY 2017 are \$916 million.
- Over the Model's performance period, the State was required to have at least 80% of all

regulated hospital revenue for Maryland residents in population-based payment arrangements. The State successfully shifted 100% of hospital revenue into population-based payments through hospital global budgets.

- Over the Model's performance period, the State was required to reduce the aggregate Medicare 30-day readmission rate for Medicare FFS beneficiaries to be less than or equal to the national readmission rate. Using rolling 12-months of data through October 2018, Maryland Medicare readmission rates equal to the national readmission rate of 15.43%. Based on this data, Maryland is anticipated to achieve readmission rates at or below the nation at the end of 2018 as long as Maryland continues to keep up with national improvements over the next two months of data run-out.
- Over the performance period of the Model, the State was required to achieve an aggregate 30% reduction for all payers in a set of potentially preventable complications (PPCs) measures as part of Maryland's Hospital Acquired Conditions program. Based on data through September 2018, the State achieved greater than 50% reduction in PPCs in 2018 compared to 2013.

For FY 2018 versus FY 2017:

- Profits on regulated activities increased slightly from \$1.2 billion (or 8.01% of regulated net operating revenue) in FY2017 to \$1.3 billion (or 8.95% of regulated net operating revenue) in FY 2018.
- Profits on operations (which include profits and losses from regulated and unregulated day-to-day activities) increased from \$458 million in FY 2017 (or 2.86% of total net operating revenue) to \$555 million in FY 2018 (or 3.35% of total net operating revenue).
- Total profits (referred to in the tables that follow by the accounting term "total excess profits," which include profits and losses from regulated and unregulated operating and non-operating activities) decreased from \$1.01 billion in FY 2017 (or 6.08% of the total revenue) to \$897 million in FY 2018 (or 5.30% of the total revenue), primarily due to unrealized losses on investments.
- Total regulated net patient revenue rose from \$14.3 billion in FY 2017 to \$14.6 billion in FY 2018, an increase of 2.1%.
- In FY 2018, Maryland hospitals incurred \$726 million in uncompensated care, a slight increase in amount from FY 2017's \$707 million in uncompensated care. This amounts to approximately four cents of uncompensated care cost for every dollar of gross patient revenue in both years.
- Gross regulated revenue from potentially avoidable utilization (PAU) readmissions increased slightly from \$1.129 billion in FY 2017 to \$1.179 billion in FY 2018. However, the percent of gross regulated revenue associated with all PAUs (readmissions and avoidable admissions) increased from 10.99% percent in FY 2017 to 11.11% in FY 2018. Case-mix adjusted readmissions declined from 11.67% in FY 2017 to 11.47% in FY 2018, a 1.72% reduction. The case-mix adjusted PPC rate declined from 0.57% in FY 2017 to 0.49% in FY 2018, a decrease of 14.04%. These declines reflect improvement in the quality of care delivered in Maryland hospitals, where readmission rates fell below

the national levels for Medicare, and the State achieved the 30% PPC reduction goal.

- Total direct graduate medical education expenditures increased from \$340 million in FY 2017 to \$344 million in FY 2018, an increase of 1.08%.

ITEM VII **NURSE SUPPORT PROGRAM II- DRAFT RECOMMENDATIONS**

Mr. Oscar Ibarra, Chief, Information Management and Program Administration, presented draft recommendations for the Nurse Support Program II (NSP II) FY 2020 Competitive Institutional Grants (See “Nurse Support Program II Competitive Institutional Grants Program Review Panel Recommendations for FY 2019” on the HSCRC website). Mr. Ibarra stated that this report and recommendations are jointly submitted by the staff of the Maryland Higher Education Commission (MHEC) and the HSCRC.

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

The HSCRC implemented the NSP II Program in May 2005. The Commission approved funding of up to 0.1% of regulated gross hospital revenue to increase the number of nurses in the State by increasing the capacity of nursing programs through institutional and nursing faculty interventions. MHEC was selected by the HSCRC to administer the NSP II programs in its capacity as the coordinating board for all Maryland institutions of higher education.

At the conclusion of the first ten years of funding, on January 14, 2015, the HSCRC renewed funding for the Program from FY 2016 through June 30, 2020. In 2016, the Maryland General Assembly revised the NSP II statute to meet Maryland’s changing health care delivery models to recognize all registered nurses (RNs), not only those providing bedside manner are needed to ensure a strong nursing workforce.

In response to the FY 2020 request for applications (RFA), the NSP II Competitive Institutional Grant Review Panel received a total of 26 requests for funding. They include 21 new competitive grant proposals, 3 resource grant requests, and 2 continuation grant recommendations. The proposals were reviewed by a nine-member panel, comprised of former NSP II grant project directors, retired deans of nursing schools, hospital nursing educators, nurse licensing and policy leaders, and MHEC and HSCRC staff. All competitive grant proposals received by the deadline were scored by the panel according to the rubric outlined in the FY 2020 RFA. The review panel convened and reached consensus on the most highly noted proposals. The panel provided feedback to the institutions with more funded proposals to aid in the development of future proposals. The review panel recommends funding for 17 of the 26 total proposals.

The recommended proposals include grants for planning, implementation of programs, continuation of programs, totaling just over \$6 million. The proposals that received the highest ratings focused on graduate nursing progress with partnerships between community colleges, universities, and hospital health systems. See below for the recommended proposals for FY 2020 funding.

Grant #	Institution	Grant Title	Proposed Funding
20-102	Allegany College	LPN- RN Online	\$150,000
20-104	Coppin State University	Cognitive Reflective CARE	\$50,000
20-105	Coppin State University	Planning BSN to DNP	\$148,100
20-106	Coppin State University	ATB with CCBC & Howard	\$143,951
20-108	Johns Hopkins University	PRIME Model for DNP-NP	\$1,001,596
20-109	Johns Hopkins University	Supporting Advance Practice	\$150,000
20-110	Johns Hopkins University	Planning CRNA	\$150,000
20-112	Montgomery College	ASEL Resources	\$50,000
20-116	Morgan State University	Student Resources	\$47,897
20-117	Notre Dame of Maryland University	B-Line Software Resources	\$50,000
20-118	Salisbury University	Planning MA-FAMI	\$149,998
20-120	Towson University	Entry Level MS in Nursing	\$149,556
20-121	University of Maryland	AGPCNP Certification	\$121,972
20-122	University of Maryland	SA and Addictions Program	\$137,408
20-123	University of Maryland	Clinical Faculty Competency	\$264,677
20-125	University of Maryland	Maryland Nursing Workforce Center Continuation	\$1,912,767
20-126	Montgomery College	MCSRC Group Resource Continuation	\$1,475,525
TOTAL			\$6,153,447

HSCRC and MHEC staffs recommend the 17 proposals listed above for funding under the FY 2020 NSP II Competitive Institutional Grants Program. The recommended proposals represent the NSP II's commitment to increasing nursing degree completions and academic practice partnerships across Maryland. The most highly recommended proposals include those for:

- Planning an advanced Faculty Academy and Mentoring Initiative on the Eastern Shore;
- Providing for the continuation of the Maryland Nursing Workforce Center for improved data infrastructure;
- Planning a new Masters entry nursing program at Towson University;
- Implementing the PRIME model for DNP nurse practitioner education at Johns Hopkins University;

- Developing an academic progression partnership for increased diversity with pre-licensure graduates in dual enrollment ATB programs at Community College of Baltimore County and Howard Community College with Coppin State University;
- Continuing the Maryland Clinical Simulation Resource Consortium resources for 26 nursing programs;
- Planning a Certified Registered Nurse Anesthetist (CRNA) program in partnership with Johns Hopkins Healthcare System; and
- Supporting a seamless online educational pathway from LPN to RN in Western Maryland.

Commissioner Elliott asked whether the program funds internships for nurses post-graduation. Kimberly Ford, MHEC, stated that the program funds nurse residency programs.

No Commission action necessary as this is a draft recommendation.

ITEM VIII **LEGAL REPORT**

FINAL ACTION

Rate Application and Approved Procedures- COMAR 10.37.10.26-A

The purpose of this action is to require hospitals to inform patients in the information sheet to be provided before they receive scheduled medical services, of facility fees and their right to receive a written estimate of total charges for non-emergency hospital services, procedures, and supplies that reasonably be expected to be incurred and billed by the hospital.

The Commission voted unanimously to adopt the regulation as proposed.

ITEM IX **POLICY UPDATE AND DISCUSSION**

Capital Funding

Mr. Jerry Schmith, Principle Deputy Director, Revenue and Compliance, updated the Commission on the development of a revised capital funding policy. (see “HSCRC Capital Funding Discussion” on the HSCRC website)

Mr. Schmith presented a historical overview of the Commission’s prior capital funding policies and recent trends in capital spending. Mr. Schmith identified several issues to be considered in revising the capital funding, policy:

- The level of annual funding needed in a fixed revenue system
- The requirements for hospitals to fund a portion of new capital costs
- Desire not to fund capital costs for services that can be provided in a non-hospital setting
- Whether to include comparative hospital performance in determining hospital specific funding.

Mr. Schmith noted that some hospital services have moved to unregulated settings, resulting in excess hospital capacity. He suggested that repurposing existing hospital space and adjusting global budget revenue for services moving to unregulated setting should be considered in developing the revised policy

Mr. Schmith stated that one potential option would be to set aside a portion of the annual update factor to create a funding pool for capital expenses. This option would allow funds for capital to build over time, spreading the cost of capital projects over several years in order to stay within Maryland's per capita Total Cost of Care limits.

Mr. Schmith stated that Commission staff expects to present revised capital funding policy recommendations to the Commission in the summer or fall of 2019.

Commissioner Colmers thanked staff for identifying many important issues for consideration. He also noted that there is a need to make the rules clear and to identify basic principles so that hospitals can know generally what they can expect when undertaking long-term capital projects.

Commissioner Kane identified the need to work with the Maryland Health Care Commission (MHCC) to address the Certificate of Need (CON) process, noting that certain capital spending priorities in the State may not align with existing CON criteria.

Mr. Schmith stated that Staff's plan is to assemble a work group to develop a revised capital funding policy. The workgroup will include hospitals, payers, Commission staff, and MHCC staff.

Legislative Update

Ms. Wunderlich presented a summary of legislation of interest to the HSCRC introduced in the Maryland General Assembly (See "HSCRC Legislative List" on the HSCRC website).

The Bills include 1) House Bill 1423/Senate Bill 1045- Maryland Health Insurance Plan- Use of Remaining Funds, 2) House Bill 1426 - Health Services Cost Review Commission- Duties and Reports, 3) House Bill 1407/Senate Bill 1040- Budget Reconciliation and Financing Act of 2019, 4) House Bill 940- Unregulated Space in Hospital Operating Suites Pilot Project, 5) Senate Bill 803/House Bill 849- Hospitals – Disclosure of Outpatient Facility Fees, 6) House Bill 626/ Senate Bill 649- Health Care Facilities- Change in Bed Capacity, 7) Senate Bill 597/House Bill

646- MHCC- State Health Plan and Certificate of Need for Hospital Capital Expenditures, 8) House Bill 931/ Senate Bill 940- Certificate of Need- Modifications, 9) Senate Bill 1018- Health Facilities- Chestertown Rural Health Care Delivery Innovations Pilot Program, 10) House Bill 768/Senate Bill 759- Prescription Drug Affordability Board, 11) Senate Bill 784/House Bill 1323- Civil Actions- Health Care Malpractice Claims (Life Care Act 2019), 12) Senate Bill 869/ Health Bill 1320- Maryland No-Fault Birth Injury Fund, 13) Senate Bill 773- Health Care Malpractice Qualified Expert- Qualification, 14) Senate Bill 813- Personal Injury or Wrongful Death- Noneconomic Damages, 15) Senate Bill 482/Health Bill 846- Maryland Medical Assistance Program- MCOs- Behavioral Health Services

ITEM X
CRISP UPDATE

Mr. Craig Behm, Executive Director, CRISP, presented CRISP’s plans for funding services in fiscal 2020 and beyond (see “Update on CRISP and ICN” on the HSCRC website)

Mr. Behm said CRISP will rely on a mix of funding sources, including federal matching funds, user fees, and funds generated through the HSCRC’s rate setting system. In fiscal 2020, CRISP plans to request \$7.8 million in funding through the rate setting system. This is an increase when compared to last year’s assessment. The increase replaces some of the \$10.4 million in funding CRISP received last year from MHIP funds that now have been exhausted. Hospital and payer user fees in Maryland and the District of Columbia are also being increased to fill the funding gap.

Mr. Behm stated that actual spending for the Integrated Care Network (ICN) has been significantly lower than initial estimates. ICN provides important resources to facilitate the care transformation envisioned under the TCOC Model. ICN provides tools for activities such as the Prescription Drug Monitoring Program, other point-of-care tools, the Encounter Notification Service, data available through the CRISP Reporting Service, and administration of the Hospital Care Improvement Program.

ITEM XI
HEARING AND MEETING SCHEDULE

May 8, 2019	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
June 12, 2019	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:11 p.m.



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

Data through December 2018 – Claims paid through March 2019

Source: CMMI Monthly Data Set

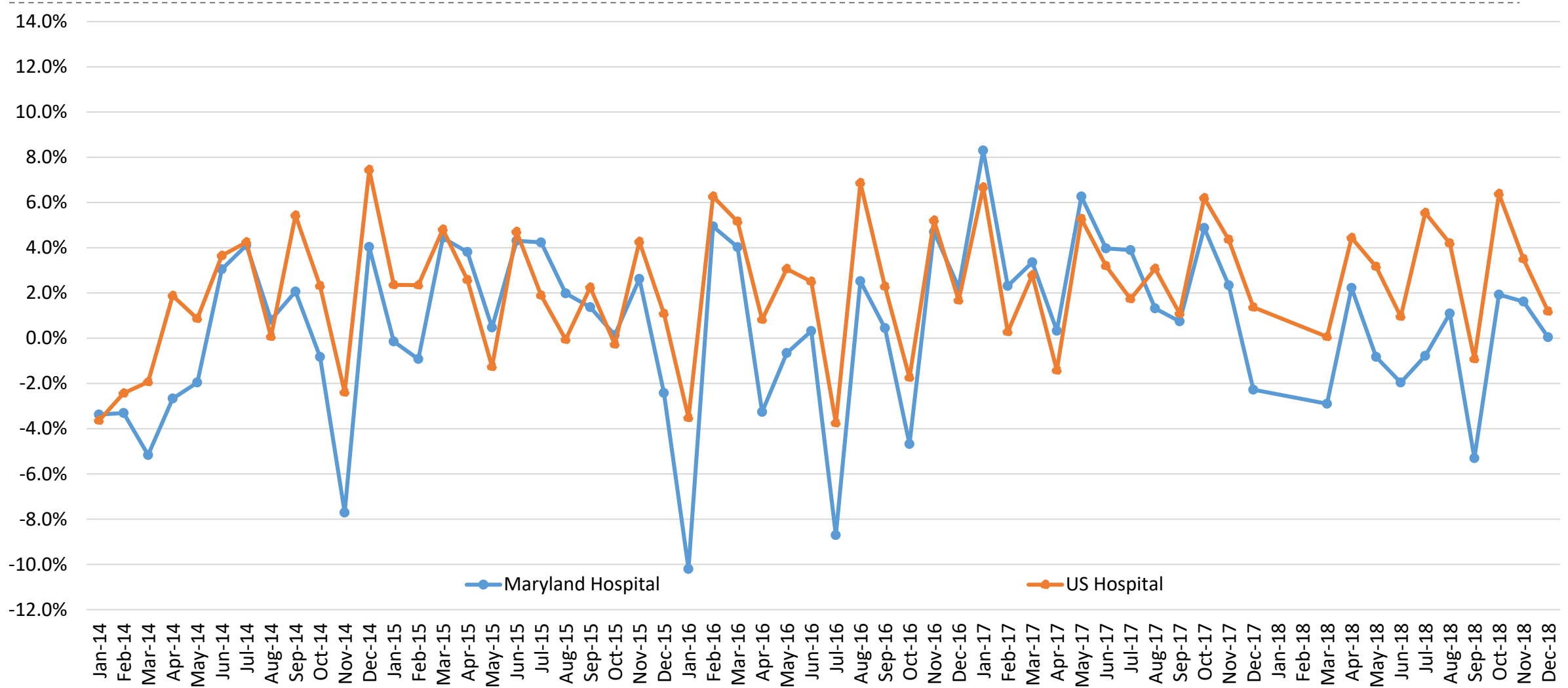


Disclaimer:

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

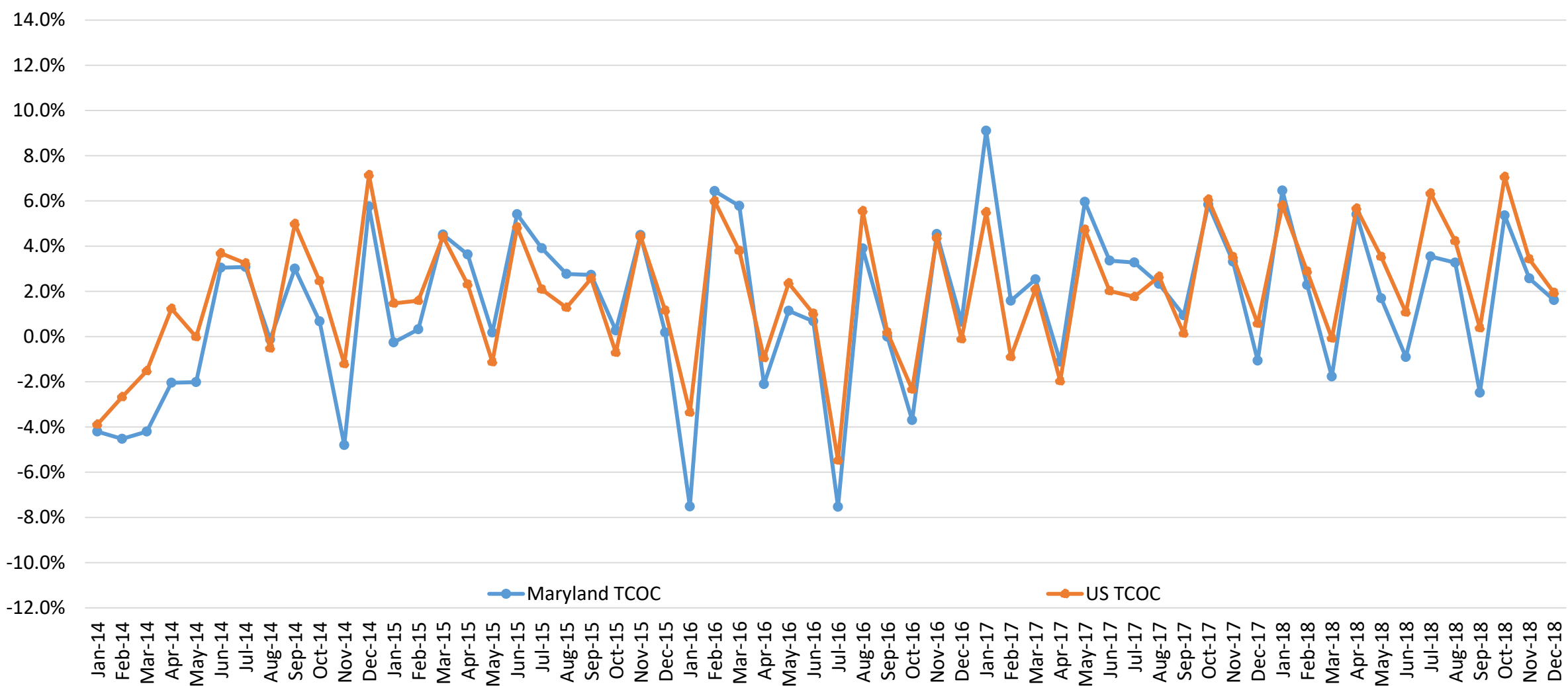
Medicare Hospital Spending per Capita

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



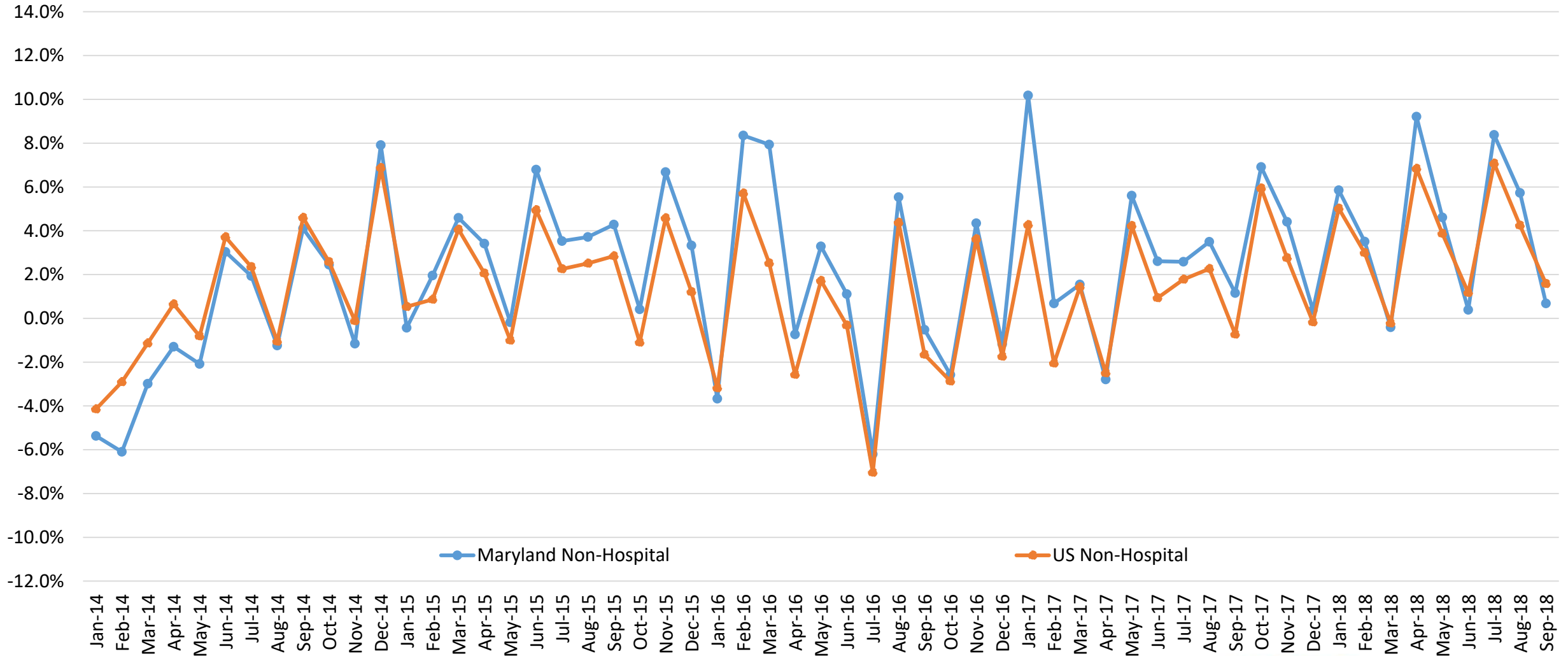
Medicare Total Cost of Care Spending per Capita

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



Medicare Non-Hospital Spending per Capita

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





Monitoring Maryland Performance Financial Data

Fiscal Year to Date through March 2019

Source: Hospital Monthly Volume and Revenue
Run: May 1, 2019

HSCRC

Health Services Cost
Review Commission

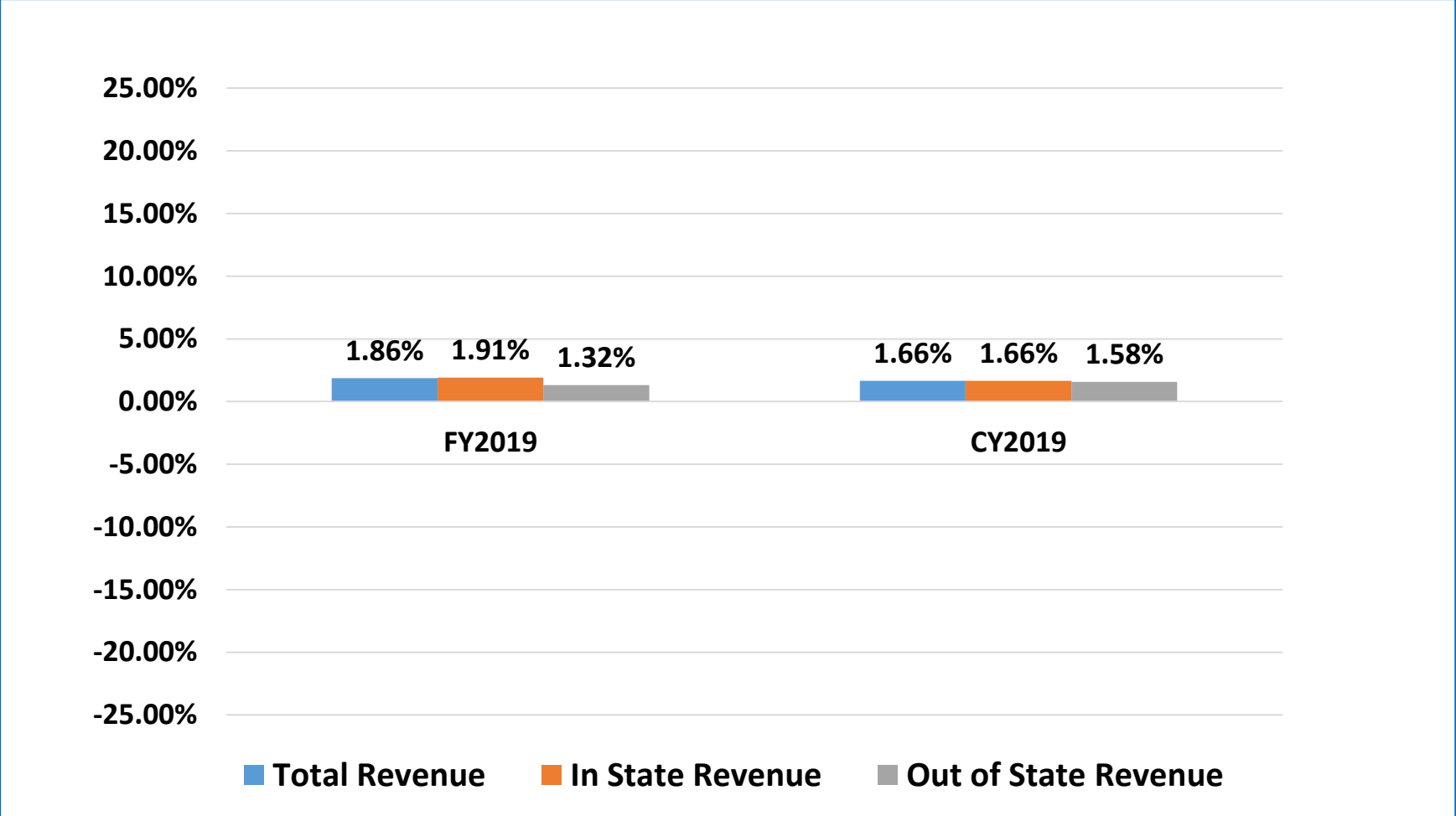


The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2017 have been revised. CMS has changed the enrollment source for the Chronic Condition Data Warehouse (CCW) from the Enrollment Database (EDB) to the Common Medicare Environment (CME) database. Part A changed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

The Population Estimates from the Maryland Department of Planning have been revised in December, 2018. The new FY 18 Population growth number is 0.30%.

Gross All Payer Hospital Revenue Growth

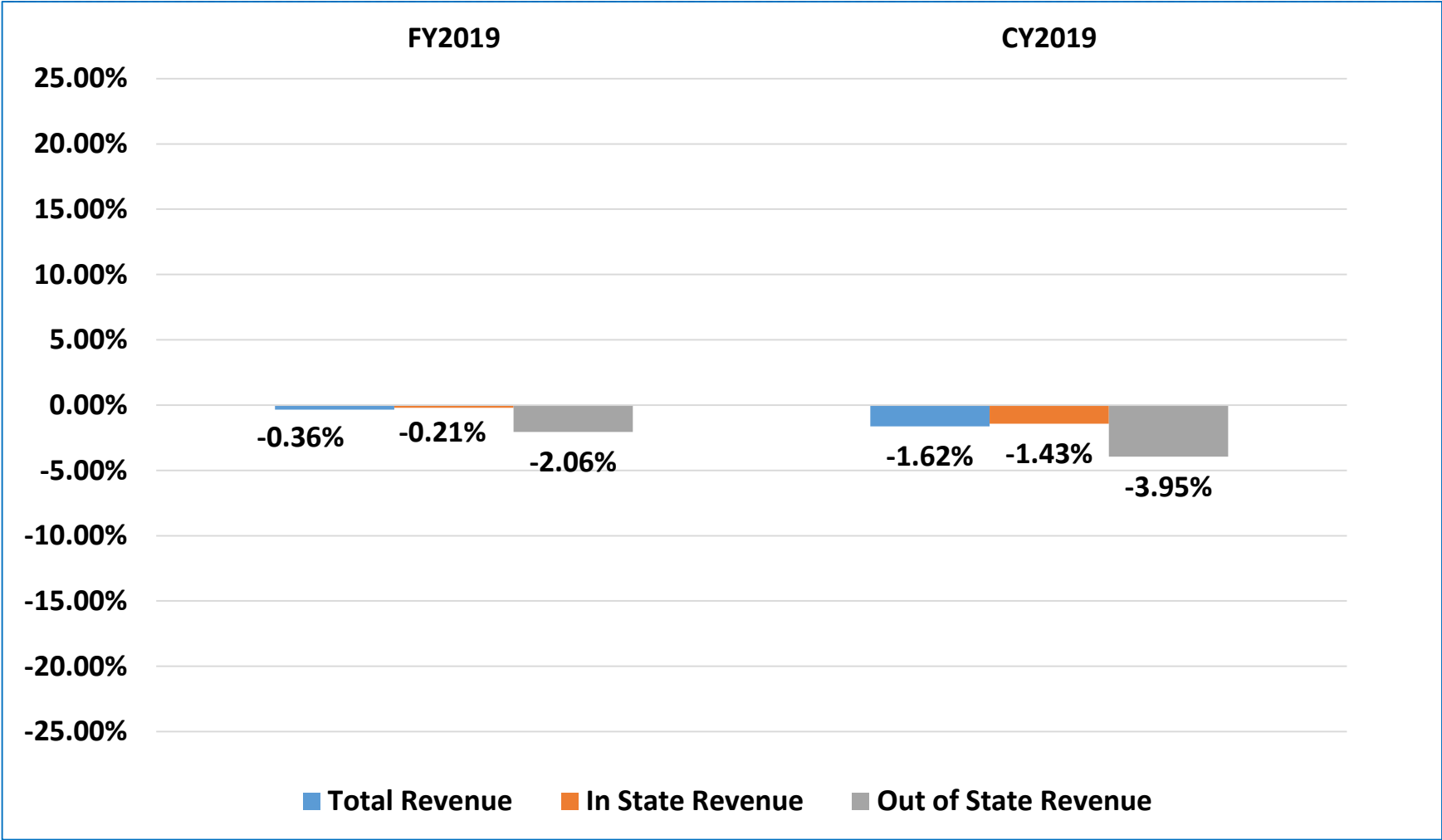
FY 2019 (July 18 – March 19 over July 17 – March 18) CY 2019 (January 19 – March 19 over January 18 – March 18)



The State’s Fiscal Year begins July 1

Gross Medicare Fee for Service Hospital Revenue Growth

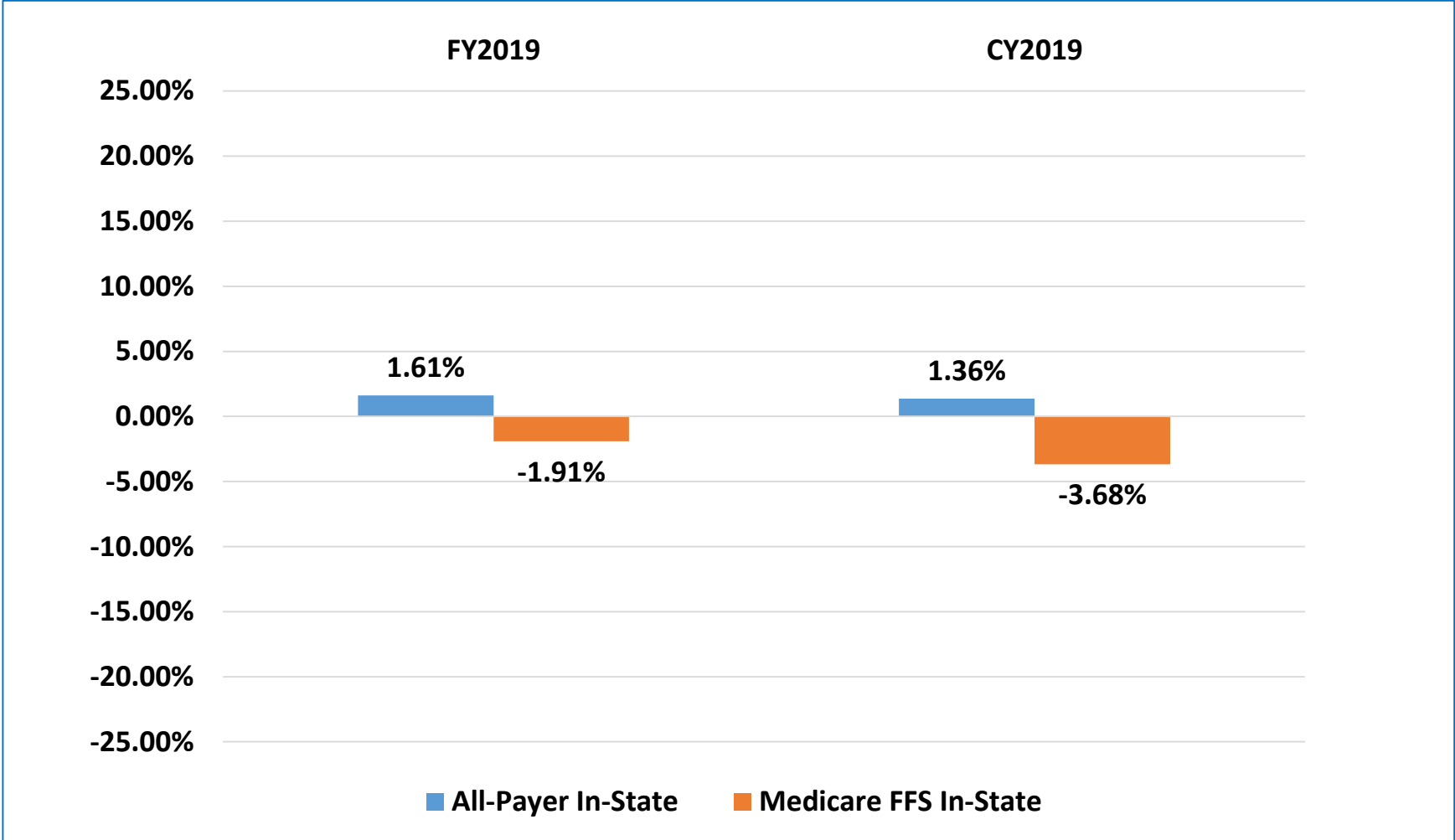
FY 2019 (July 18 – March 19 over July 17 – March 18) CY 2019 (Jan 19 – March 19 over Jan 18 – March 18)



The State’s Fiscal Year begins July 1

Hospital Revenue Per Capita Growth Rates

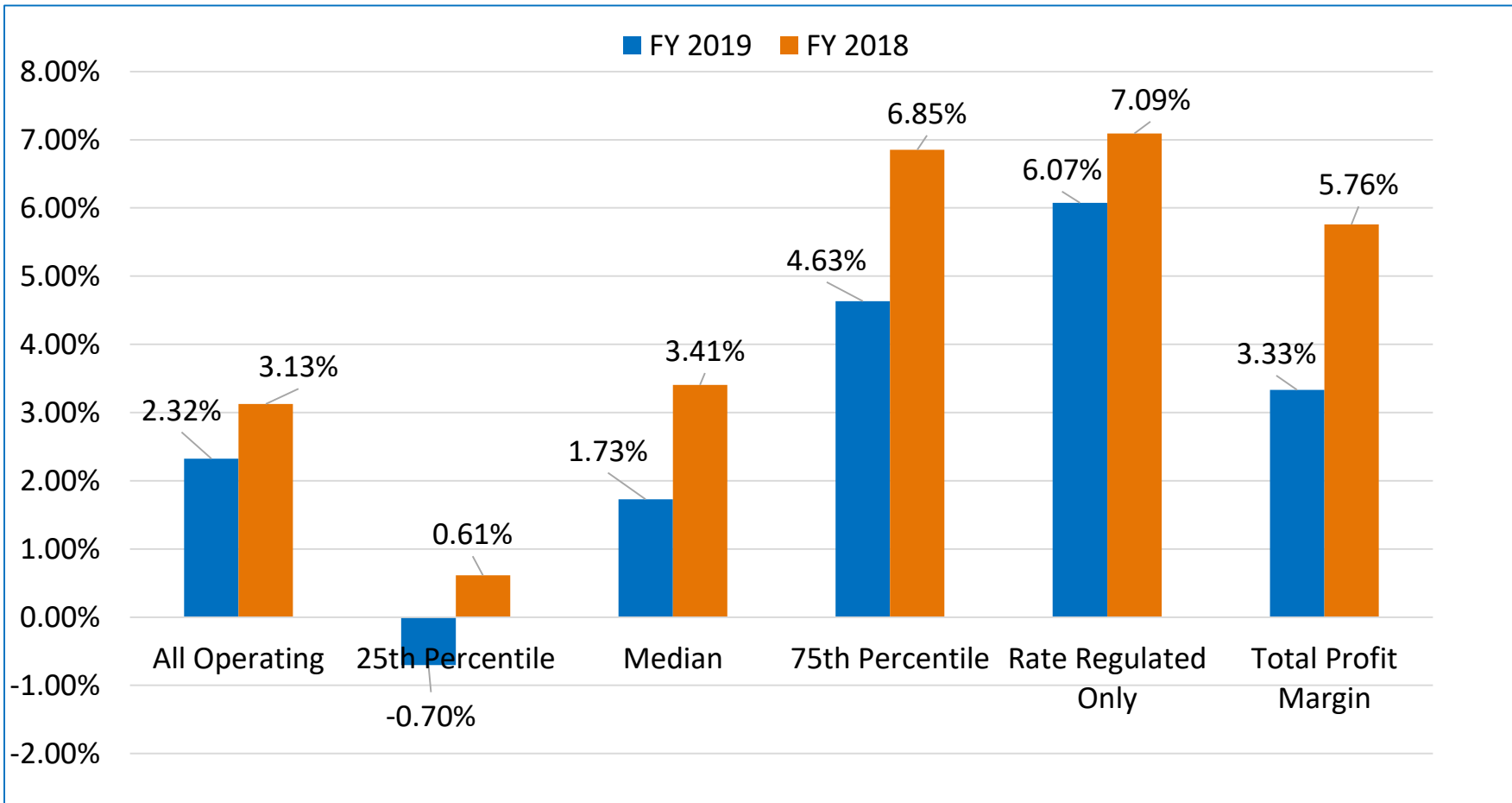
FY 2019 (July 18 – March 19 over July 17 – March 18) CY 2019 (Jan 19 – March 19 over Jan 18 – March 18)



The State's Fiscal Year begins July 1

Hospital Operating, Regulated and Total Profits

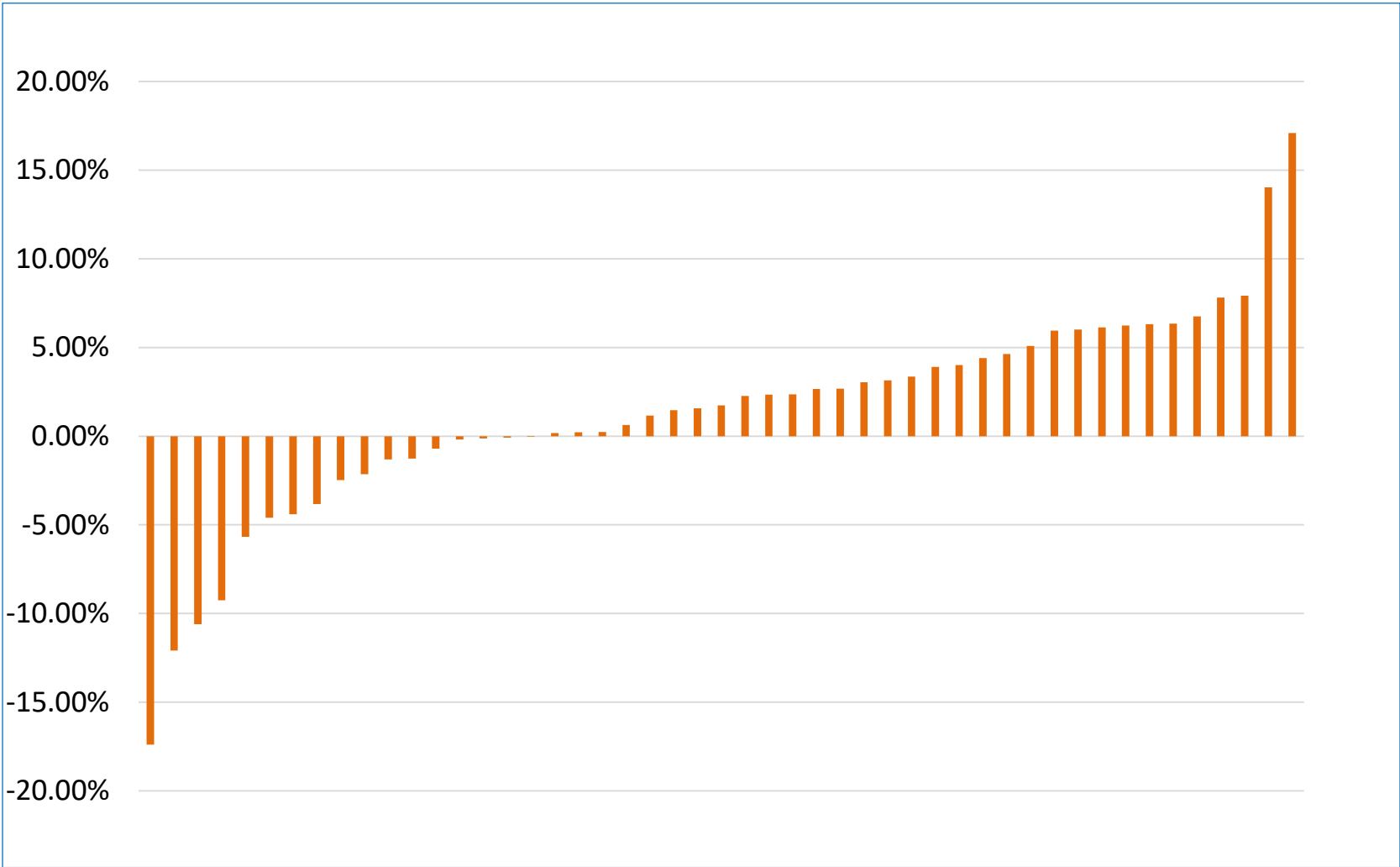
Fiscal Year 2019 (July 2018 – March 2019) Compared to Fiscal Year 2018 (July 2017 – March 2018)



FY 2019 unaudited hospital operating profits show a decline of .81 percentage points in total operating profits compared to FY 2018. Rate regulated profits for FY 2019 have decreased by 1.02 percentage points compared to FY 2018.

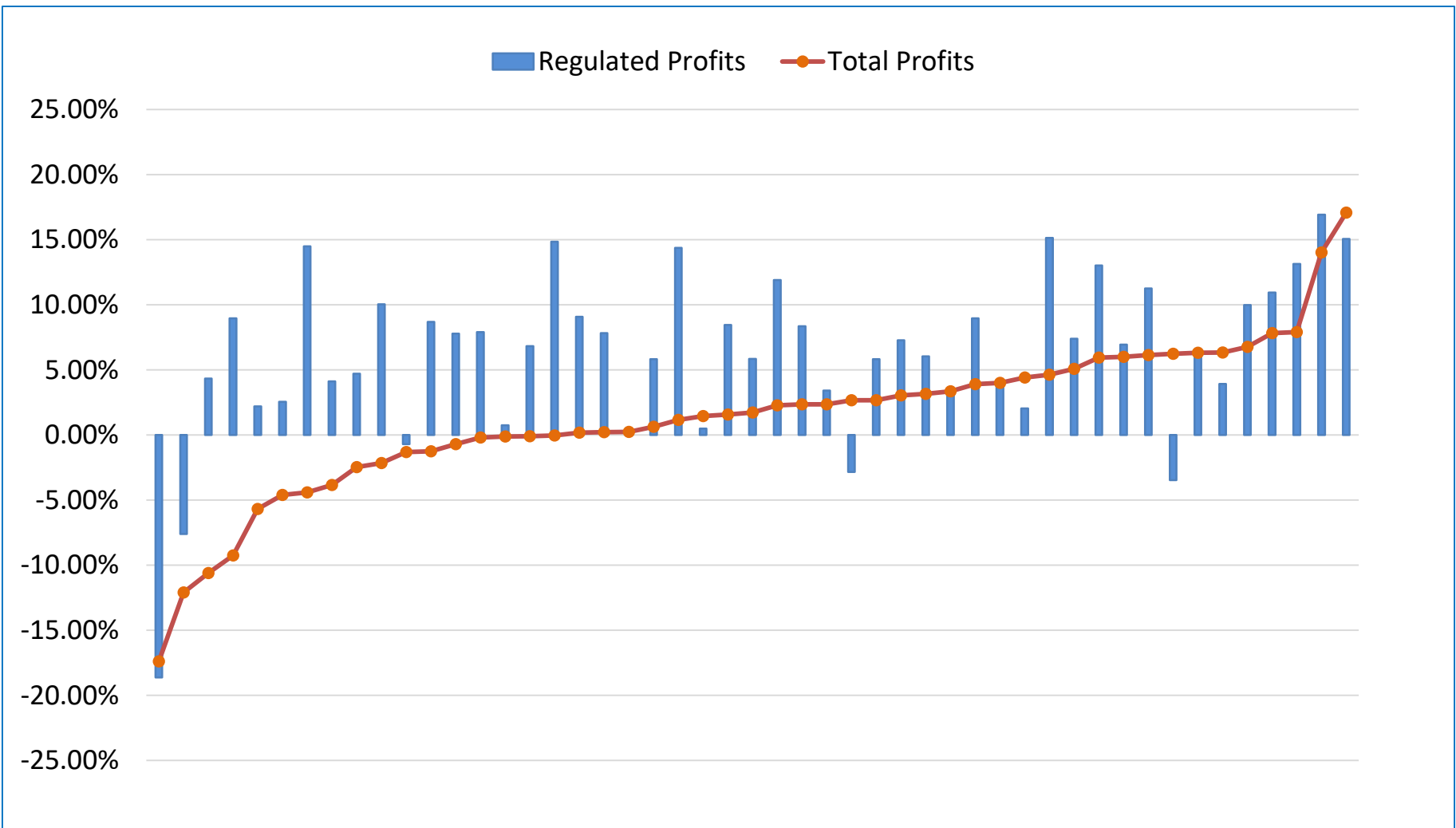
Operating Profits by Hospital

Fiscal Year 2019 (July 2018 – March 2019)



Operating and Regulated Profits by Hospital

Fiscal Year 2019 (July 2018 – March 2019)



Monitoring Maryland Performance Financial/Utilization Data

Calendar Year to Date through March 2019

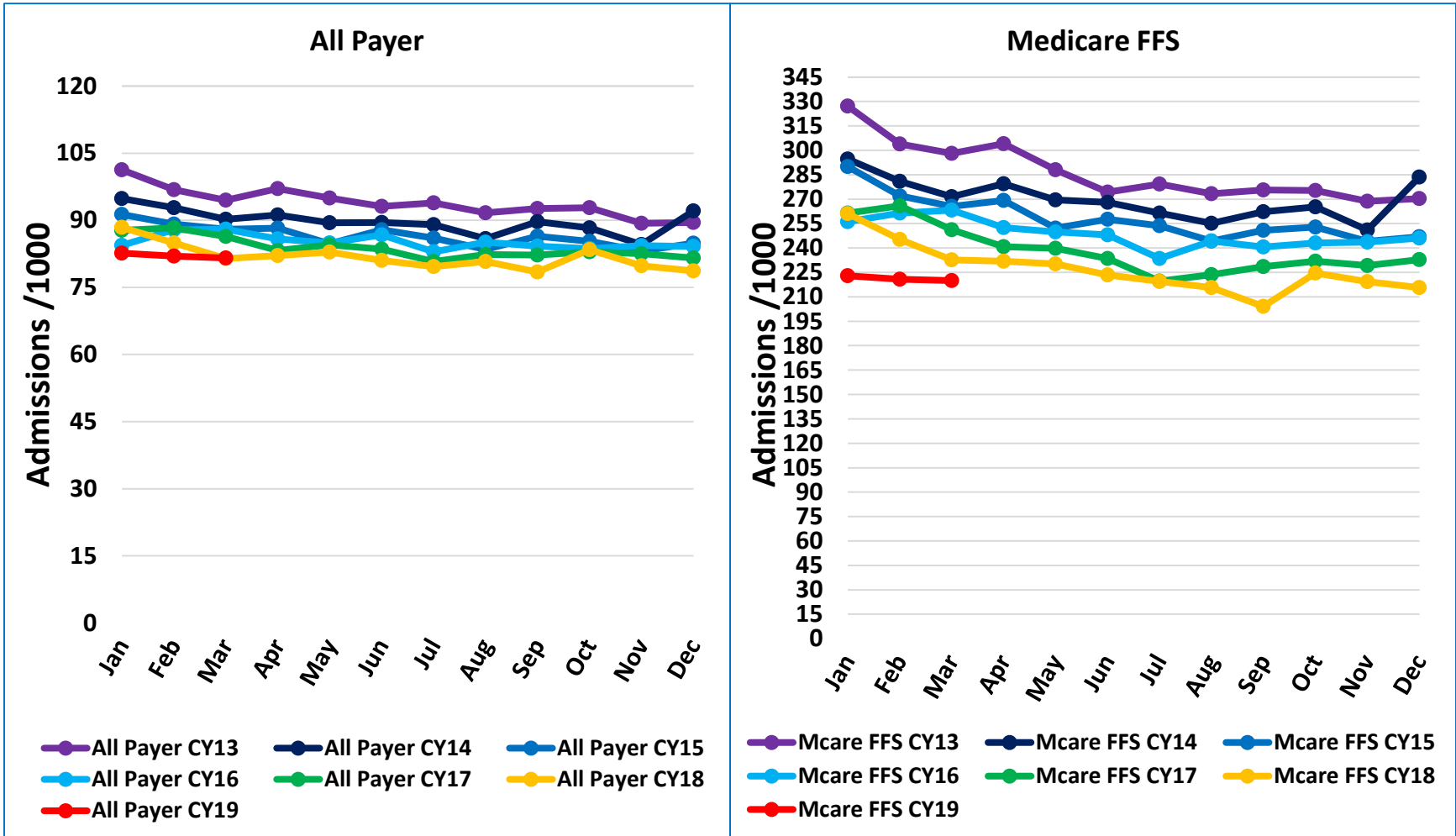
Source: Hospital Monthly Volume and Revenue Data

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

The Maryland Department of Planning released new population estimates in December 2018. The population numbers used to calculate the ADK, BDK and EDK have been revised accordingly.

Annual Trends for ADK Annualized

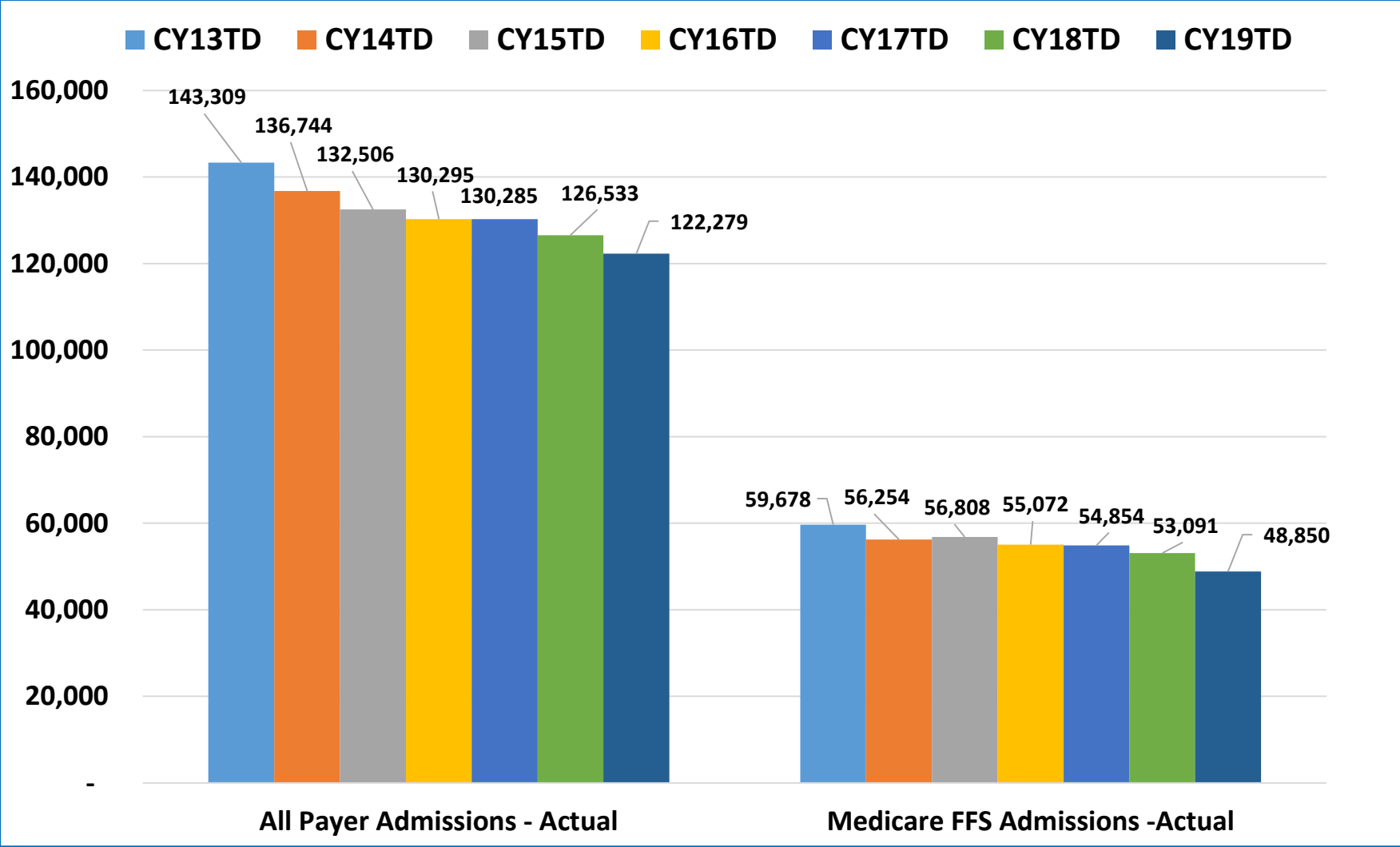
All Payer and Medicare Fee For Service (CY 2013 through CY 2019 March)



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

Actual Admissions by Calendar YTD – March

(CY 2013 through CY 2019)



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



Change in Admissions by Calendar YTD March

(CY 2013 through CY 2019)

Change in All Payer Admissions CYTD13 vs. CYTD14 = -%
Change in All Payer Admissions CYTD14 vs. CYTD15 = -%
Change in All Payer Admissions CYTD15 vs. CYTD16 = -%
Change in All Payer Admissions CYTD16 vs. CYTD17 = %
Change in All Payer Admissions CYTD17 vs. CYTD18 = -%
Change in All Payer Admissions CYTD18 vs. CYTD19 = -%

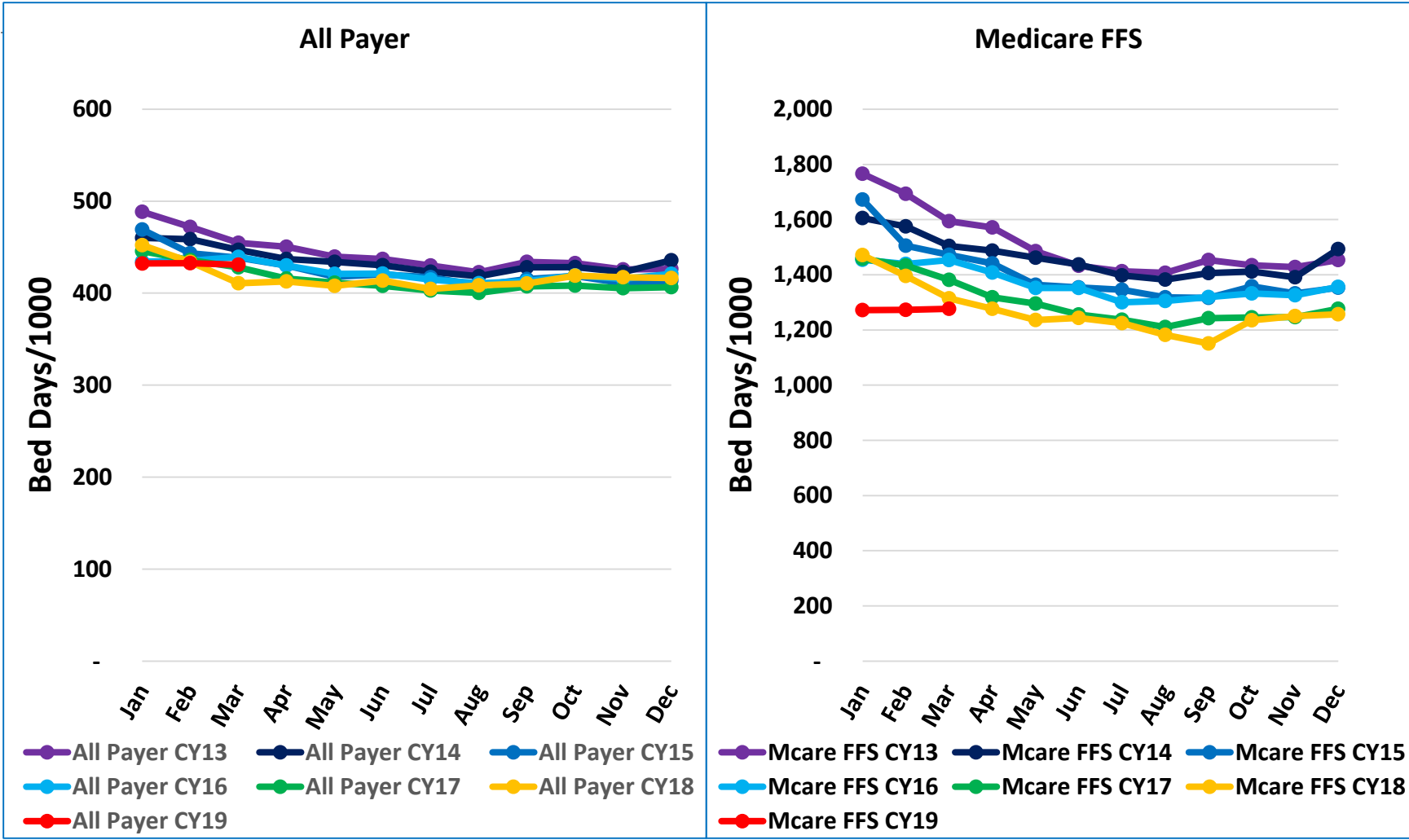
Change in ADK CYTD 13 vs. CYTD 14 = -%
Change in ADK CYTD 14 vs. CYTD 15 = -%
Change in ADK CYTD 15 vs. CYTD 16 = -%
Change in ADK CYTD 16 vs. CYTD 17 = %
Change in ADK CYTD 17 vs. CYTD 18 = -%
Change in ADK CYTD 18 vs. CYTD 19 = -%

Change in Medicare FFS Admissions CYTD13 vs. CYTD14 = -%
Change in Medicare FFS Admissions CYTD14 vs. CYTD15 = %
Change in Medicare FFS Admissions CYTD15 vs. CYTD16 = -%
Change in Medicare FFS Admissions CYTD16 vs. CYTD17 = %
Change in Medicare FFS Admissions CYTD17 vs. CYTD18 = -%
Change in Medicare FFS Admissions CYTD18 vs. CYTD19 = -%

Change in Medicare FFS ADK CYTD 13 vs. CYTD 14 = -%
Change in Medicare FFS ADK CYTD 14 vs. CYTD 15 = -%
Change in Medicare FFS ADK CYTD 15 vs. CYTD 16 = -%
Change in Medicare FFS ADK CYTD 16 vs. CYTD 17 = %
Change in Medicare FFS ADK CYTD 17 vs. CYTD 18 = -%
Change in Medicare FFS ADK CYTD 18 vs. CYTD 19 = -%

Annual Trends for BDK Annualized

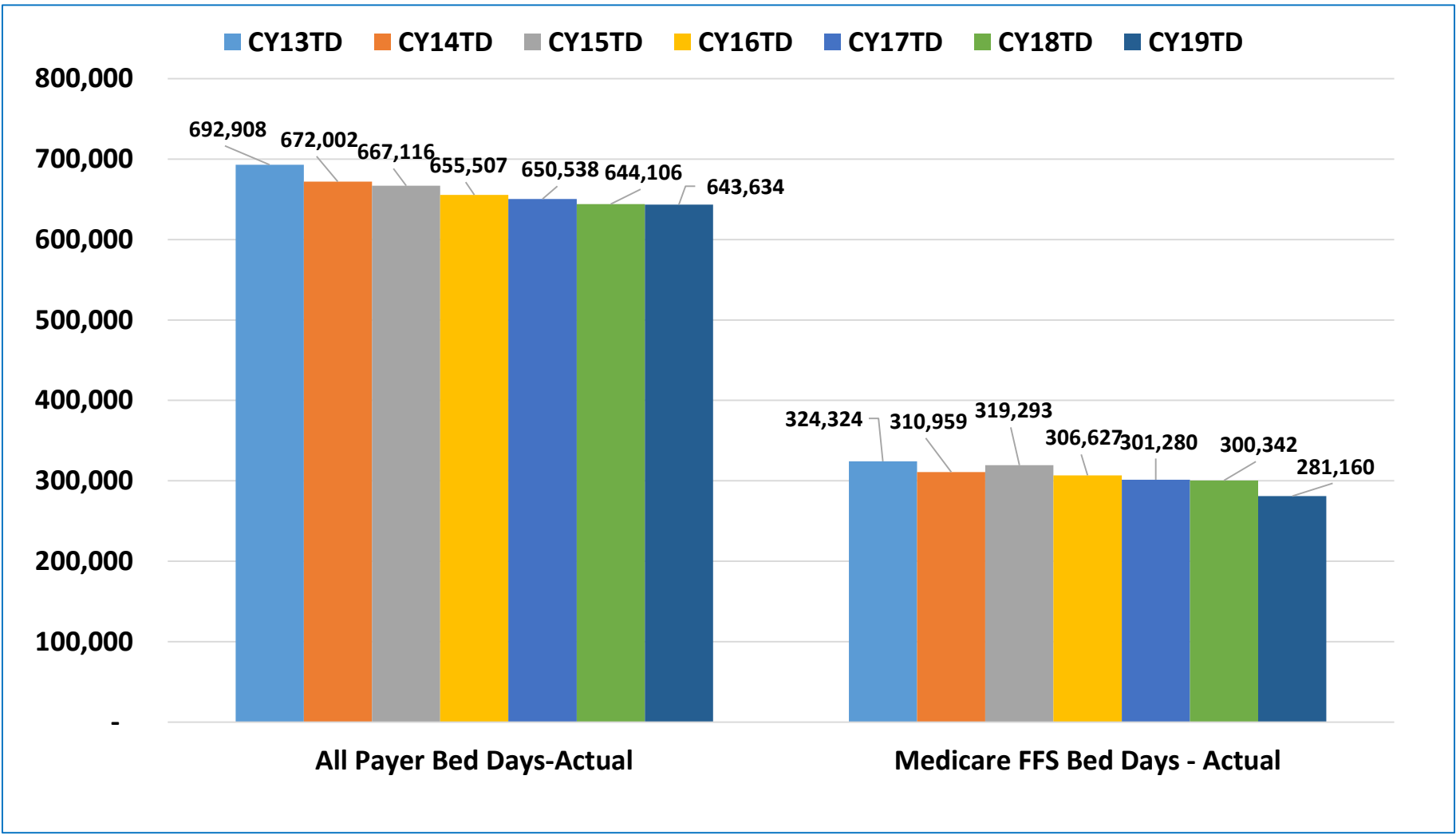
All Payer and Medicare Fee For Service (CY 2013 through CY 2019 March)



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

Actual Bed Days by Calendar YTD March

(CY 2013 through CY 2019)



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

Change in Bed Days by Calendar YTD March

(CY 2013 through CY 2019)

Change in All Payer Bed Days CYTD13 vs. CYTD14 = -3.02%

Change in All Payer Bed Days CYTD14 vs. CYTD15 = -0.73%

Change in All Payer Bed Days CYTD15 vs. CYTD16 = -1.74%

Change in All Payer Bed Days CYTD16 vs. CYTD17 = -0.76%

Change in All Payer Bed Days CYTD17 vs. CYTD18 = -0.99%

Change in All Payer Bed Days CYTD18 vs. CYTD19 = -0.7%

Change in BDK CYTD 13 vs. CYTD 14 = -3.48%

Change in BDK CYTD 14 vs. CYTD 15 = -1.02%

Change in BDK CYTD 15 vs. CYTD 16 = -2.07%

Change in BDK CYTD 16 vs. CYTD 17 = -1.05%

Change in BDK CYTD 17 vs. CYTD 18 = -0.99%

Change in BDK CYTD 18 vs CYTD 19 = -0.07%

Change in Medicare FFS Bed Days CYTD13 vs. CYTD14 = -4.12%

Change in Medicare FFS Bed Days CYTD14 vs. CYTD15 = 2.68%

Change in Medicare FFS Bed Days CYTD15 vs. CYTD16 = -3.97%

Change in Medicare FFS Bed Days CYTD16 vs. CYTD17 = -1.74%

Change in Medicare FFS Bed Days CYTD17 vs. CYTD18 = -0.31%

Change in Medicare FFS Bed Days CYTD18 vs. CYTD19= -6.39%

Change in Medicare FFS BDK CYTD 13 vs. CYTD 14 = -7.32%

Change in Medicare FFS BDK CYTD 14 vs. CYTD 15 = -0.62%

Change in Medicare FFS BDK CYTD 15 vs. CYTD 16 = -5.55%

Change in Medicare FFS BDK CYTD 16 vs. CYTD 17 = -2.80%

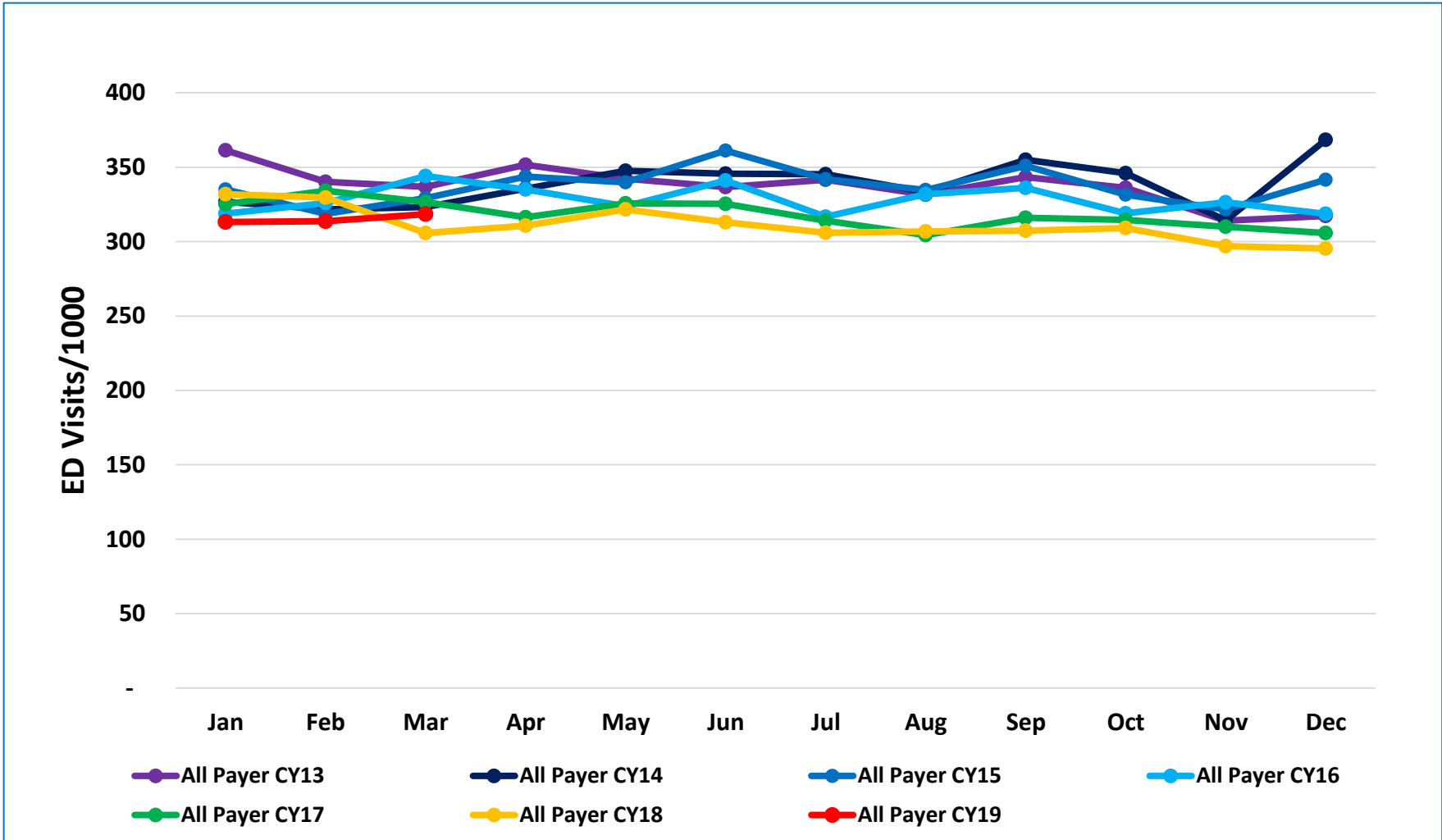
Change in Medicare FFS BDK CYTD 17 vs. CYTD 18 = -2.13%

Change in Medicare FFS BDK CYTD 18 vs. CYTD 19 = -8.62%



Annual Trends for EDK Annualized

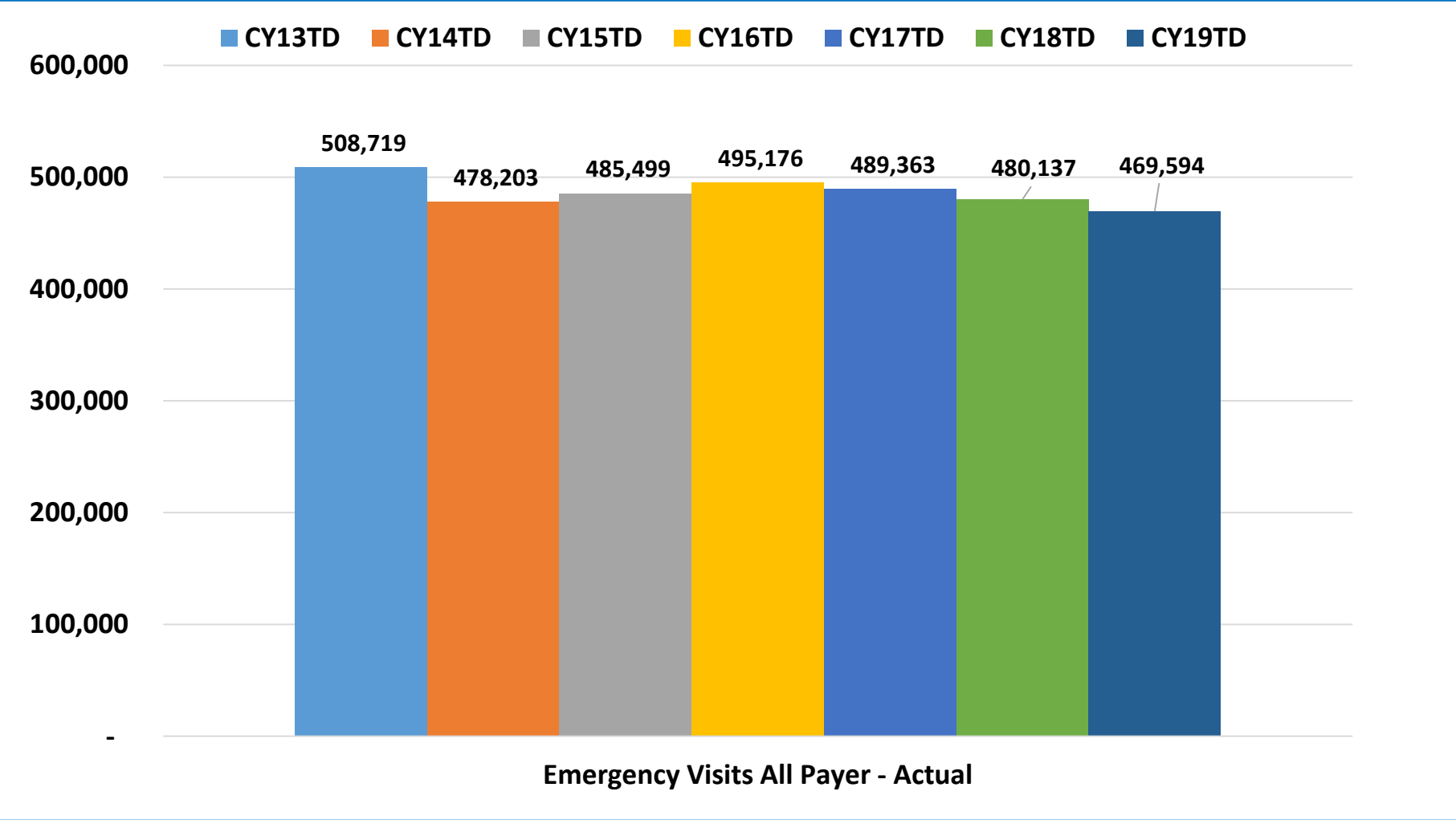
All Payer (CY 2013 through CY2019 March)



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

Actual Emergency Dept. Visits by Calendar YTD - March

(CY 2013 through CY 2019)



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

Change in ED Visits by Calendar YTD February

(CY 2013 through CY 2019)

Change in ED Visits CYTD 13 vs. CYTD 14 = -6.00%

Change in ED Visits CYTD 14 vs. CYTD 15 = 1.53%

Change in ED Visits CYTD 15 vs. CYTD 16 = 1.99%

Change in ED Visits CYTD 16 vs. CYTD 17 = -1.17%

Change in ED Visits CYTD 17 vs. CYTD 18 = -1.89%

Change in ED Visits CYTD 18 vs. CYTD 19 = -2.20%

Change in EDK CYTD 13 vs. CYTD 14 = -6.45%

Change in EDK CYTD 14 vs. CYTD 15 = 1.22%

Change in EDK CYTD 15 vs. CYTD 16 = 1.65%

Change in EDK CYTD 16 vs. CYTD 17 = -1.47%

Change in EDK CYTD 17 vs. CYTD 18 = -1.89%

Change in EDK CYTD 18 vs. CYTD 19 = -2.20%

Purpose of Monitoring Maryland Performance

Evaluate Maryland's performance against Total Cost of Care Model Requirements:

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Maryland's Growth in total expenditures for hospital and non-hospital services for Medicare's fee-for-service beneficiaries must reach a savings level of \$300 million annually relative to the national growth rate by the end of 2023. The Maryland hospital costs represent approximately half of the Medicare total expenditures for Maryland residents.

Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report these patients as Maryland residents. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.



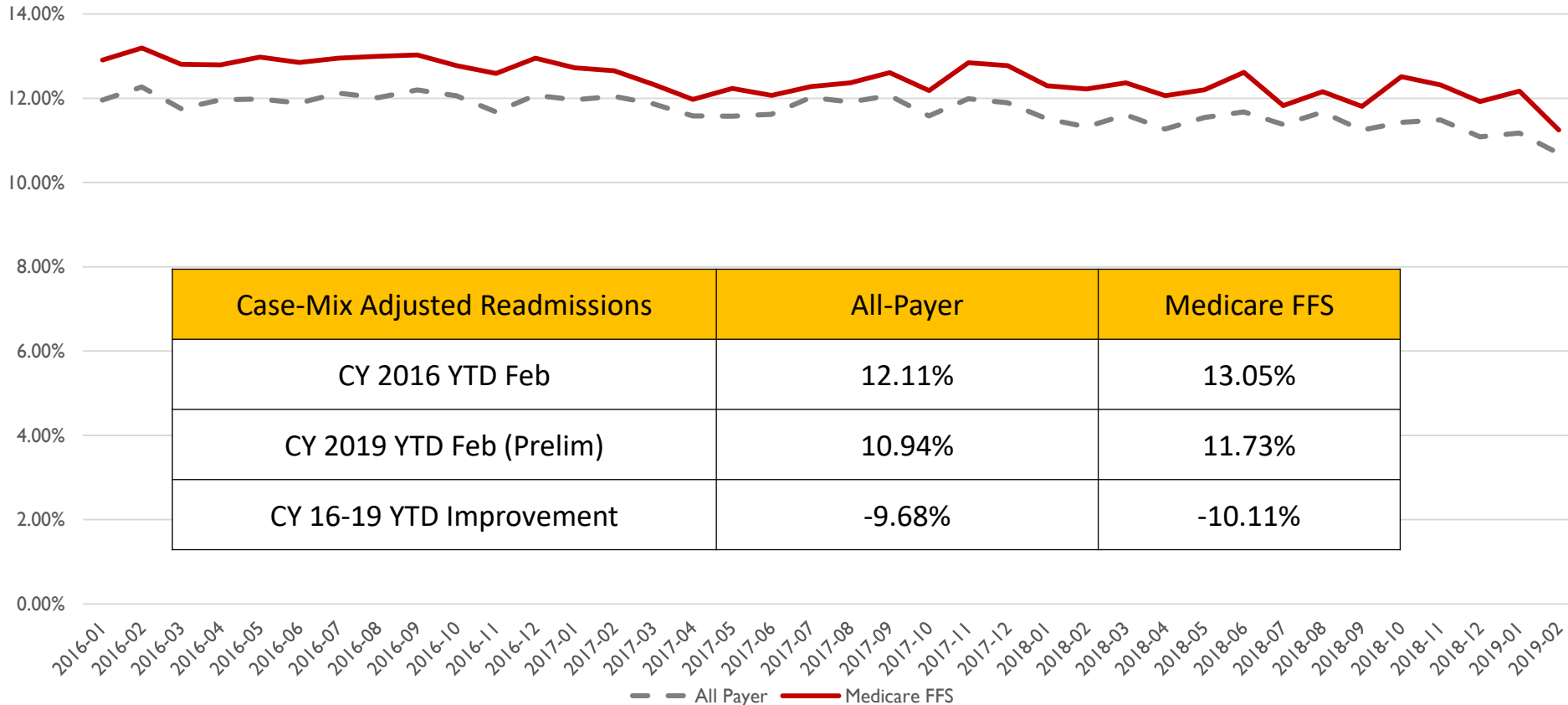
Monitoring Maryland Performance Quality Data

May 8th 2019 Commission Meeting Update



Readmission Reduction Analysis

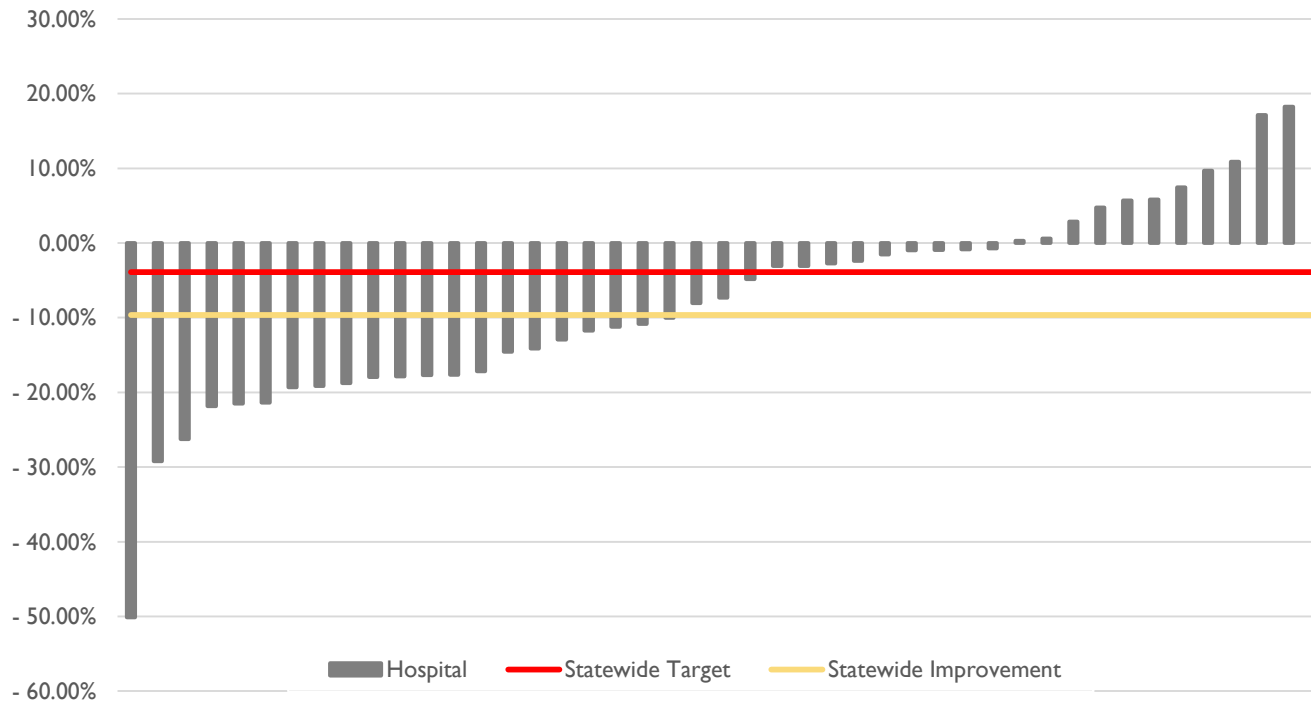
Monthly Case-Mix Adjusted Readmission Rates



Note: Based on final data for Jan 2016 – Dec 2018; Preliminary data through March 2019. Statewide improvement to-date in RY 2021 is compounded with RY 2019 improvement.

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

**Cumulative change CY 2013 – CY 2016 (RY2018) Compounded with
CY 2016 to CY 2018 (Prelim)**



**24 Hospitals
are on Track for
Achieving
Improvement
Goal**

**An Additional 5
Hospitals on
Track for
Achieving
Attainment
Goal**

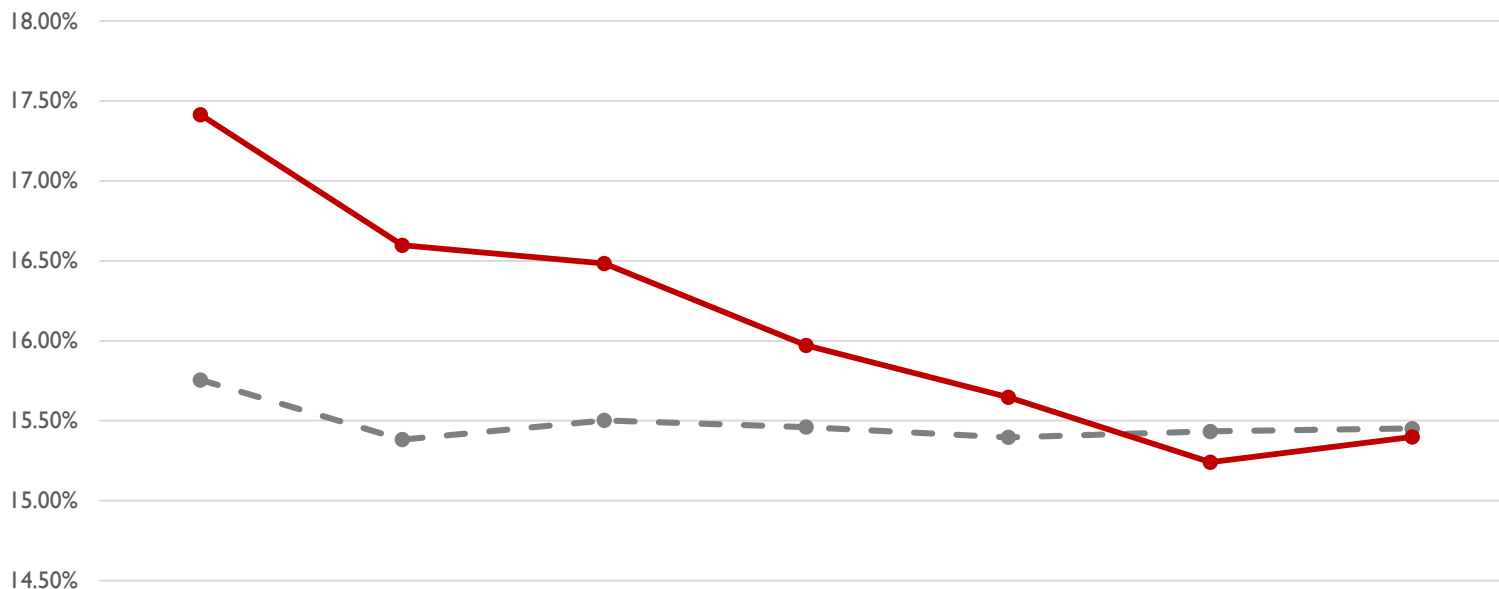
► **Note: Based on Final data through Sep 2018; Prelim through Jan 2019;
McCready hospital data not shown.**

Medicare Readmission Model Test

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

With most recent Medicare Readmissions data, Maryland's Medicare Readmission Rate (15.40%) is on par with the National Medicare Readmission Rate (15.45%). Maryland will need to continue to reduce its readmissions, and match any additional reduction in the national rate.

Readmissions - Rolling 12M through Dec 2018



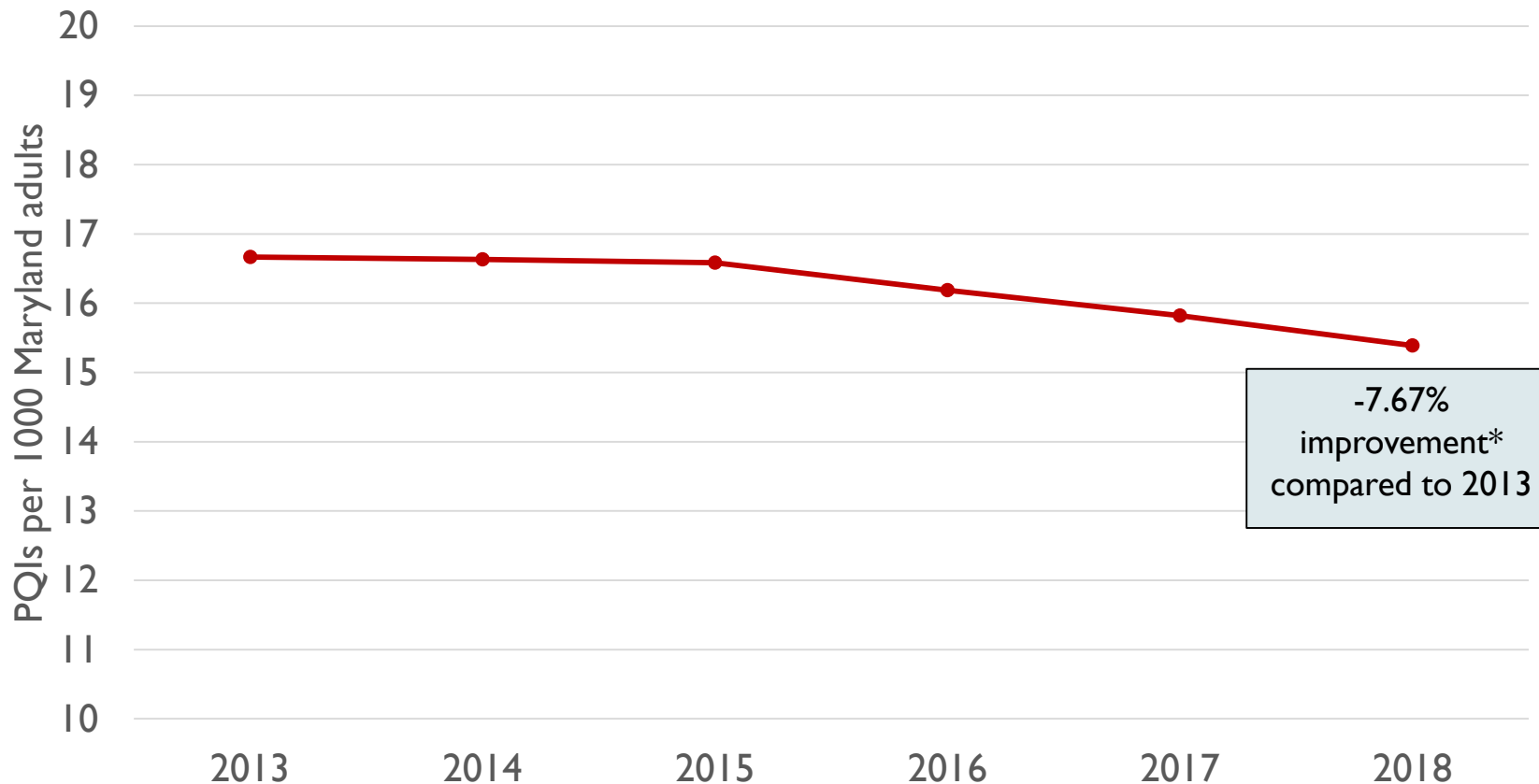
	Rolling 12M 2012	Rolling 12M 2013	Rolling 12M 2014	Rolling 12M 2015	Rolling 12M 2016	Rolling 12M 2017	Rolling 12M 2018
—●— National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%
—●— Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%

Data are currently available through December 2018



Potentially Avoidable Utilization (PAU) Monitoring

PQI Per Capita

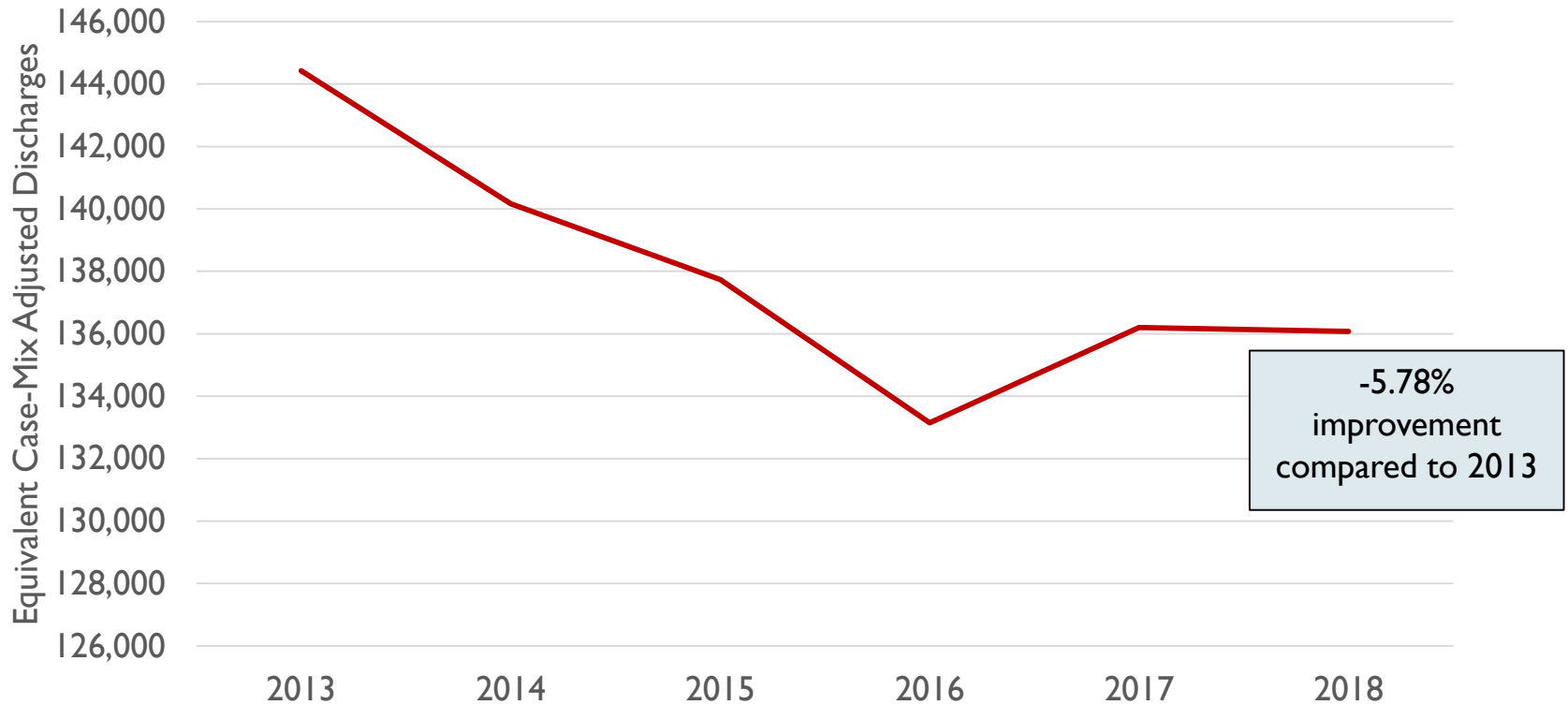


*Analysis shows some hospital data anomalies that may result in actual improvement rate statewide of -6.25%

Note: Based on final data for Jan 2013 – Jan 2019, PQIs with Maryland zipcodes only

PAU ECMADs

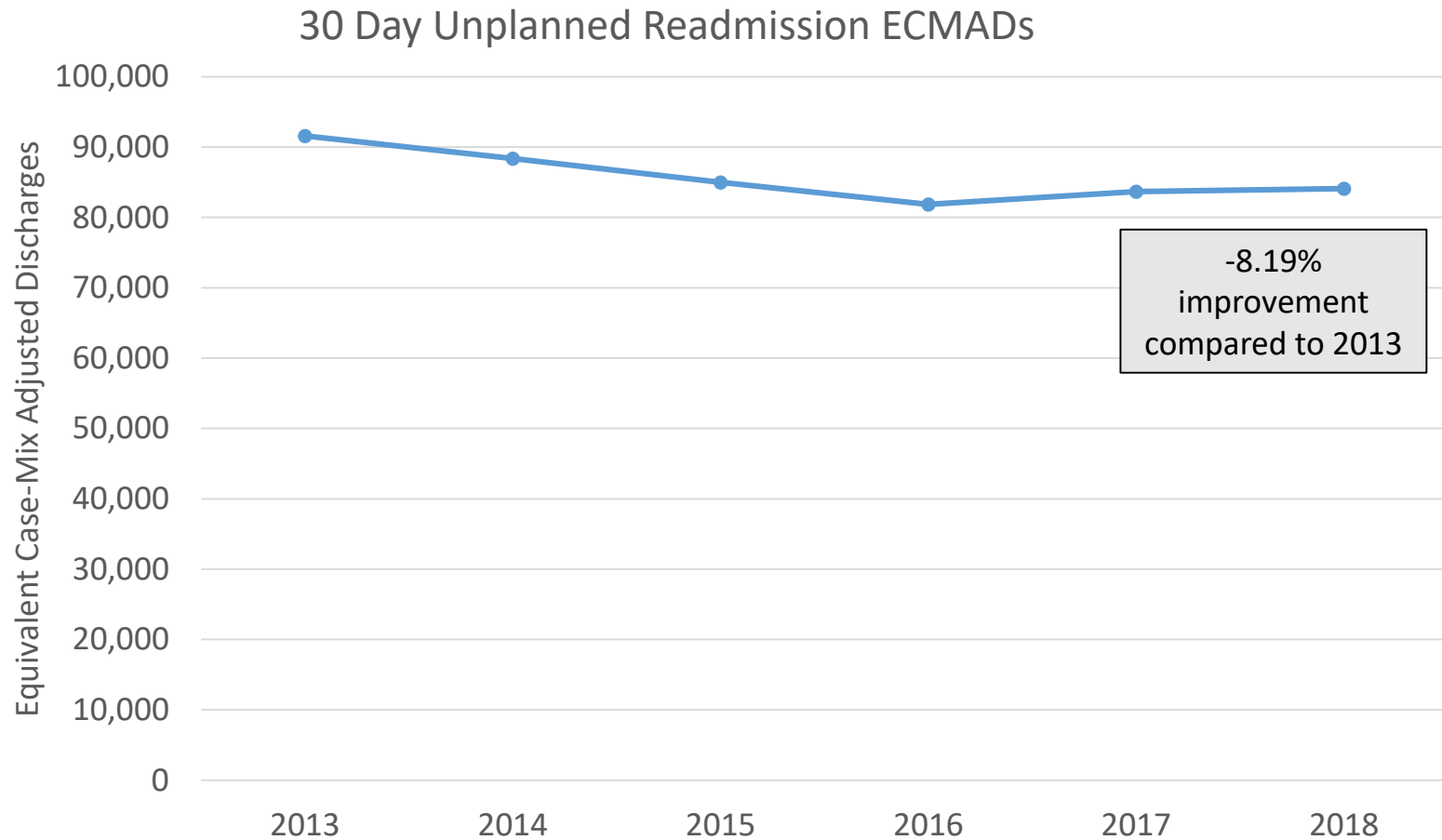
PAU ECMADs for 30 day readmits and PQIs



ECMAD = Equivalent Case-Mix Adjusted Discharges.

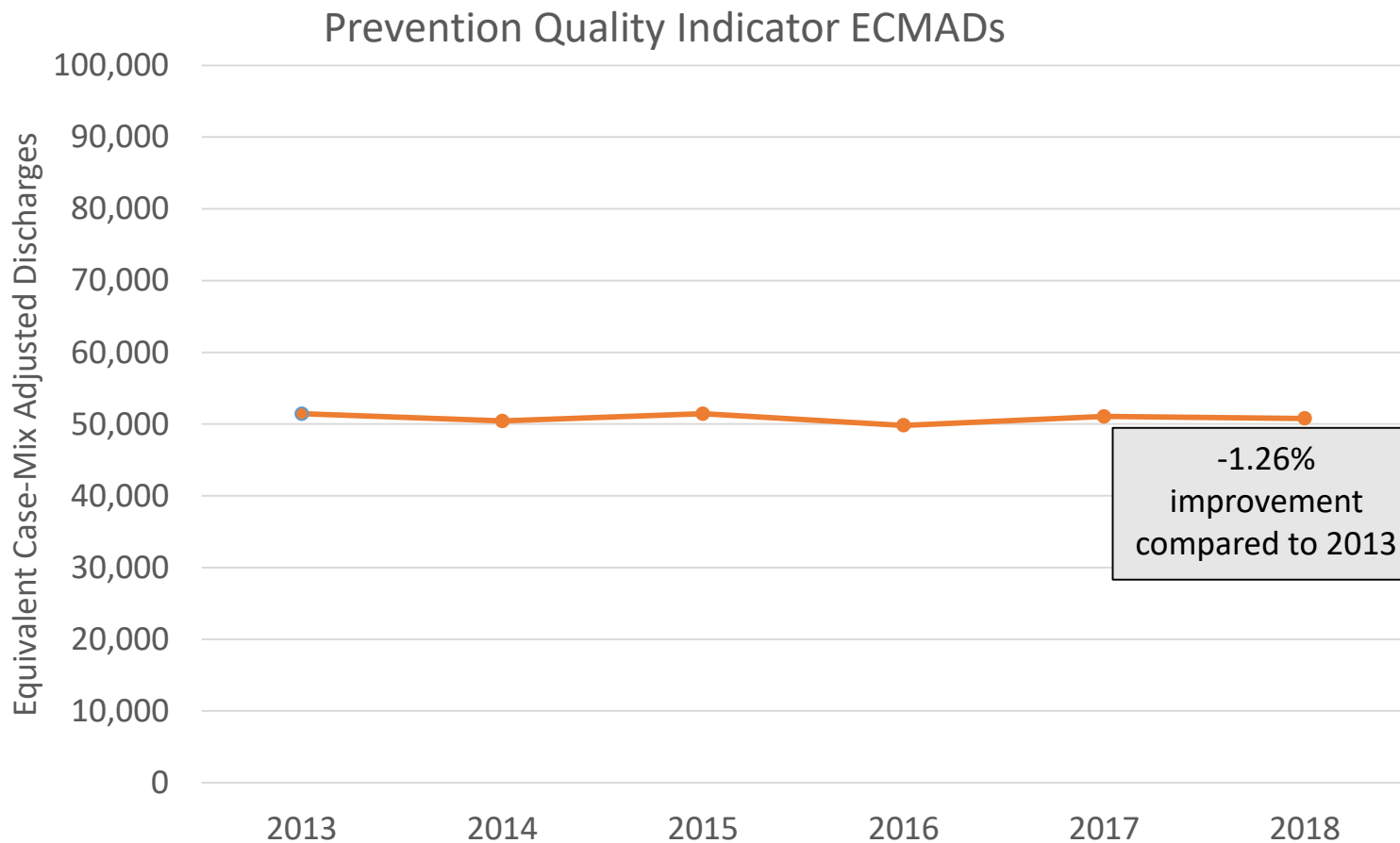


30 day Readmission ECMADs



▶ Discharges flagged as both PQI and readmit are included in the readmit count

PQI ECMADs



Discharges flagged as both PQI and readmit are included in the readmit count

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 APRIL 29, 2019

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
2478A	University of Maryland Medical Center	4/9/2019	N/A	N/A	ARM	DNP	OPEN
2479A	University of Maryland Medical Center	4/9/2019	N/A	N/A	ARM	DNP	OPEN
2480A	University of Maryland Medical Center	4/9/2019	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

**IN RE: THE APPLICATION FOR
ALTERNATIVE METHOD OF RATE
DETERMINATION
UNIVERSITY OF MARYLAND
MEDICAL CENTER
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2019
* FOLIO: 2289
* PROCEEDING: 2479A**

Staff Recommendation

May 8, 2019

I. INTRODUCTION

University of Maryland Medical Center (“Hospital”) filed an application with the HSCRC on April 9, 2019 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, 2019.

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, 2019. 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
ALTERNATIVE METHOD OF RATE
DETERMINATION
UNIVERSITY OF MARYLAND
MEDICAL CENTER
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2019
* FOLIO: 2288
* PROCEEDING: 2478A**

Staff Recommendation

May 8, 2019

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on April 9, 2019 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for heart, liver, kidney, lung, and pancreas transplants, SPK services, blood and bone marrow transplants and VAD services for a period of one year with Cigna Health Corporation beginning June 1, 2019.

II. OVERVIEW OF APPLICATION

The contract will continue 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 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

The staff found that the Hospital's experience under this arrangement for the previous year was favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for heart, liver, kidney, lung, and pancreas transplants, SPK services, blood and bone marrow transplants and VAD services, for a one year period commencing June 1, 2019. 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, 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
ALTERNATIVE METHOD OF RATE
DETERMINATION
UNIVERSITY OF MARYLAND
MEDICAL CENTER
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2019
* FOLIO: 2290
* PROCEEDING: 2480A**

Staff Recommendation

May 8, 2019

I. INTRODUCTION

The University of Maryland Medical Center (“Hospital”) filed an application with the HSCRC on April 9, 2019 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, 2019.

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, 2019. 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.

Nurse Support Program II
Competitive Institutional Grants Program
Review Panel Recommendations for FY 2020

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

Final Recommendation

May 8, 2019

This is a final recommendation for Commission consideration at the May 8, 2019 Public Commission Meeting.

INTRODUCTION

This report presents recommendations of the Review Panel for funding of the Nurse Support Program II (NSP II) Competitive Institutional Grant for Fiscal Year (FY) 2020. This report and recommendations are jointly submitted by the staff of the Maryland Higher Education Commission (MHEC) and the Maryland Health Services Cost Review Commission (HSCRC or Commission).

A summary of NSP II achievements are below:

- The Maryland Council of Deans and Directors of Nursing Programs recommended the new NSP II **Academic Nurse Educator Certification Award as a new faculty focused award**, which provides incentives for current full time faculty to demonstrate expertise in pedagogy, curriculum development, teaching and student learning through achieving and maintaining certification as experts in their field with the National League for Nursing's Certified Nurse Educator (CNE) credential.
- **New Goal:** To increase the number of faculty achieving CNE to 50 percent (from 12 percent). After a year of intense focus, 26 faculty representing 15 nursing programs have achieved the CNE.
- **Goal Progress:** The Maryland Nursing Workforce Center is being recognized by the National Forum of State Workforce Centers to represent Maryland. The Center addresses the need for infrastructure to collect and analyze nursing workforce data.
- **Goal Progress:** MD is increasing the number of nurses with a BSN or higher up to 60 percent.
- **Goals Met:** Through the Nurse Educator Doctoral Grants, doubled the number of nurses with doctoral degrees and increased the number of full time faculty with doctoral degrees to a high of 68 percent.

BACKGROUND

The HSCRC has funded programs to address the cyclical nursing workforce shortages since 1985. In July 2001, the HSCRC implemented the hospital-based Nurse Support Program I (NSP I) to address the nursing shortage impacting Maryland hospitals. Since that time, the NSP I completed three, five-year program evaluation cycles. The most recent renewal was approved on July 12, 2017 to extend the funding until June 30, 2022. The HSCRC implemented the NSP II program in May 2005 to respond to the faculty shortage and other limitations in nursing educational capacity underlying the nursing shortage. The Commission approved an increase of up to 0.1 percent of regulated gross hospital revenue to increase the number of nurses in the state by increasing the capacity of nursing programs through institutional and nursing faculty interventions. MHEC was selected by the HSCRC to administer the NSP II programs, as the coordinating board for all Maryland institutions of higher education. At the conclusion of the first ten years of funding on January 14, 2015, the HSCRC renewed funding for FY 2016 through June 30, 2020. In 2016, the Maryland General Assembly revised the NSP II statute to meet Maryland's changing health care delivery models to recognize all registered nurses (RNs) are needed to ensure a strong nursing workforce. The NSP II program evaluation is in progress

and the final report will be submitted to the Commission in December 2019 for approval for FY 2021-2025 funding cycle.

REVIEW OF NSP II GRANT FUNDING RESULTS

The following sections detail the progress made on key initiatives. NSP II has four key areas of focus to strengthen capacity across the state's nursing programs: increasing pre-licensure graduates while making progress toward the "80 percent BSN by 2020"; doubling the doctoral prepared nurses for more highly qualified nurse faculty; advancing lifelong learning for the pipeline for future nurses; and providing for stronger data infrastructure for the nursing workforce.

CERTIFICATION FOR ACADEMIC NURSE EDUCATORS

One indicator of nursing education excellence is certification. NSP II supports nursing education as a specialty area of practice. As clinical nurses are recognized through certification by the American Nurse Credentialing Center (ANCC), nurse educators have a comparable certification process for academic educators through the National League for Nursing (NLN). The CNE credential communicates to academic and health care communities, students, colleagues, and the public that the highest standard of excellence is being met. Faculty serve as role models and leaders with this mark of distinction.

Since January 8, 2018, four NLN Certified Nurse Educator (CNE) Workshops have been sponsored by NSP II. There were approximately 185 nurse faculty attendees seeking to prepare for the examination and complete the credential of CNE. In 2017, a review of data submitted with proposals and annual reports revealed that approximately 12 percent of faculty in Maryland colleges and universities held the CNE credential. By 2020, the goal across the State's nursing programs is to double the number of full-time faculty with this specialty certification for nurse educators. As of March 29, 2019 an additional 26 nurse faculty across 15 nursing programs have achieved the CNE credential. Of the 26 nurses credentialed, 12 nurse faculty represented 6 community colleges (Anne Arundel Community College, Chesapeake College, Community College of Baltimore County, Harford Community College, Howard Community College and Montgomery College) and the remaining 14 nurse faculty represented 9 universities (Frostburg State University, Johns Hopkins University, Hood College, Notre Dame of Maryland University, Salisbury University, Towson University, University of Maryland, Washington Adventist University, and University of Maryland University College). This is a 21 percent increase and a clear demonstration of excellence in education with nurse faculty committed to the highest standards.

This past February, the Maryland Council of Deans and Directors of Nursing Programs fully endorsed the new NSP II Academic Nurse Educator Certification Award which supports the preparation, CNE examination fees and ongoing professional development each faculty needs to achieve and renew this valued credential every 5 years. This will provide incentives for current

full time faculty to demonstrate expertise in pedagogy, curriculum development, teaching and student learning.

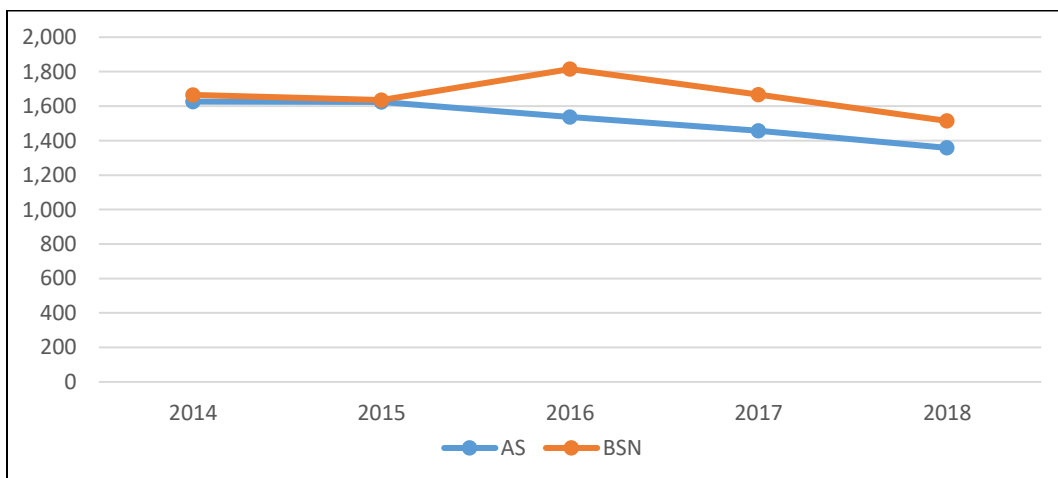
ASSOCIATE TO BACHELORS IN NURSING MODEL

Over the last 5 years, Maryland’s nursing graduate data reflects an increase in the overall education of the nursing workforce. According to leading nursing researchers, the total number of Bachelor of Science in Nursing (BSN) degrees awarded have surpassed the Associate of Science in Nursing (AS) degrees. There are several factors behind this movement in registered nurse (RN) education:

- Hospitals are aware of better patient outcomes associated with BSN-prepared RNs;
- Economic incentives reward hospitals for improved quality;
- Requirements for hospitals to have a higher proportion of BSN-educated RNs for the Magnet Recognition Program® , and
- The Institute of Medicine’s (2010) report recommending that 80 percent of nurses be BSN-prepared by 2020 (Buerhaus, et al., 2017).

Maryland’s nursing programs, both community colleges and universities, have partnered together to promote the BSN with Associate to Bachelors (ATB) agreements for seamless academic progression. We are working with the Maryland Longitudinal Data Center at MHEC to measure ATB completions and determine time and cost savings to the individual nursing student. We expect this seamless transition to result in cost savings to hospitals as fewer courses will need to be completed for the BSN; thereby reducing the amount of tuition reimbursement.

Table 1. Trends in Associate of Science in Nursing (AS) and Bachelor of Science Degrees in Nursing (BSN), 2014 – 2018



Source: Maryland Higher Education Commission Nursing Graduate Data

PROGRESS ON GOALS

The following sections provide an update on the two goals adopted from the IOM *The Future of Nursing* report: 80 percent BSN by 2020 and double the number of doctoral nurses.

80 percent BSN BY 2020

Across the country, progress has been made on the Institute of Medicine's (2010) *The Future of Nursing* report recommendation to increase the number of nurses with a BSN or higher to 80 percent by 2020. The Campaign for Action Maps, funded through the AARP Foundation and Robert Wood Johnson Foundation, used American Community Survey data to display national trends in BSN-prepared nurses. As shown in Table 2, the national average for BSN was 55.9 percent, while Maryland outpaced the national average at 60.2 percent (Courville & Green, 2019). Maryland is making steady progress when compared to other neighboring states in our geographic region, as well as being among the 12 states with over 60 percent BSN prepared nurses.

Table 2. Progress on 80 percent BSN by 2020: A Comparison of Maryland and Neighboring States

	2010	2017	Percent Change
Maryland	55.4%	60.2%	4.8%
Delaware	42.1%	62.8%	20.7%
Pennsylvania	45.9%	57.5%	11.5%
Virginia	51.1%	51.7%	0.6%
West Virginia	37.4%	50.1%	12.7%
US	48.8%	55.9%	7.1%

Source: Campaign for Action Maps Show Nurses' Progress in Earning BSN Degree, 2019

Nursing Workforce Data Infrastructure

Last year, NSP II funded the Maryland Nursing Workforce Center (MNWC) to compile and report on nursing workforce data. The state level data collected from this initiative will be instrumental in future reports on trends in the state's nursing workforce. The MNWC is being recognized by the National Forum of State Nursing Workforce Centers in 2019 to represent Maryland. The Center will serve as a nexus to collect, analyze and manage data, streamline research access and ensure state-level minimum data sets are available at the state and national level. These resources will be available to nursing programs, educators, employers, hospitals, nurses and the public to inform policy development.

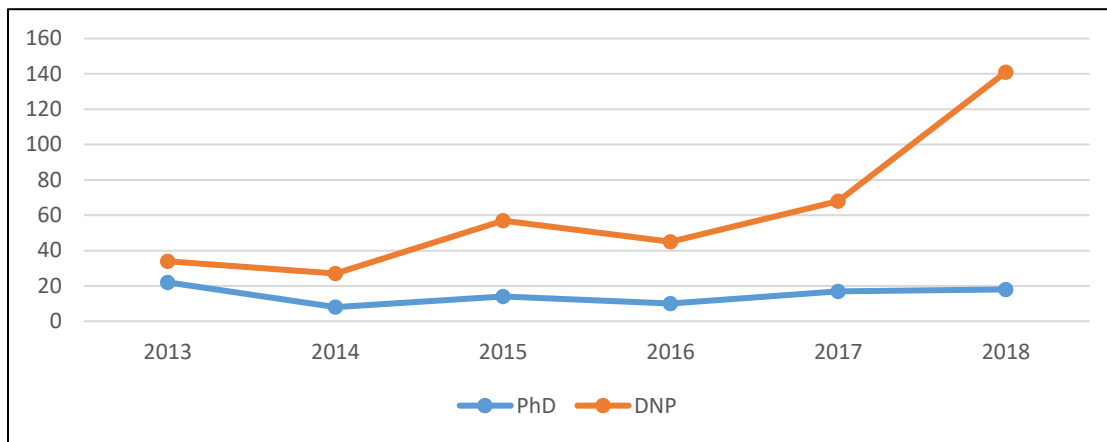
Double the Number of Nurses with Doctoral Degrees

The planning committee for the National Academy of Medicine (formerly IOM) convened a public session on March 22, 2019 for the upcoming study, *The Future of Nursing 2020-2030*. During the meeting, national researchers reported the 2010 goal of doubling the number of nurses with a doctoral degree has been achieved. Maryland data supports this increase in doctoral degrees, for both Doctor of Philosophy in Nursing (PhD) and Doctor of Nursing Practice (DNP). Consistent with national trends, the NSP II Nurse Educator Doctoral Grants for Practice and

Dissertation Research (NEDG) was awarded to 114 faculty as of 2019; 49 faculty for DNP degrees, 42 faculty for PhD in Nursing degrees, 13 faculty for Doctor of Education (EdD) degrees, and the remaining 10 faculty for PhD degrees in other fields.

The DNP education focuses on preparation of nurses for advanced practice roles. A study by Fang and Bednash (2017) found that 56.8 percent of DNP students who planned to work in academia were already full-time or part-time faculty members. Nurse faculty with dual clinical and academic appointments as advanced practice registered nurses (APRNs) maintain clinical credentials; providing primary care while preparing the next generation of new pre-licensure nurses or serving as preceptors for new APRNs at hospitals and clinical sites. Previous NSP II grants have funded APRN preceptor online training modules that are available to all nursing programs.

Table 3. Trends in PhD and DNP Graduates, 2013 – 2018



Source: Maryland Higher Education Commission Nursing Graduate Data

FISCAL YEAR 2020 COMPETITIVE GRANT PROCESS

In response to the FY 2020 request for applications (RFA), the NSP II Competitive Institutional Grant Review Panel received a total of 26 requests for funding, including 21 new competitive grant proposals, 3 resource grant requests and 2 continuation grant recommendations. The nine-member panel, comprised of former NSP II grant project directors, retired nurse deans, hospital educators, licensure and policy leaders, MHEC and HSCRC staff, reviewed the proposals. All competitive grant proposals received by the deadline were scored by the panel according to the rubric outlined in the FY 2020 RFA. The review panel convened and developed consensus around the most highly recommended proposals. For non-funded proposals, the panel provided feedback to the institutions for future proposal development and encouraged them to resubmit next year. As a result, the review panel recommends funding for 17 of the 26 total proposals.

The recommended proposals include grants for planning, full implementation of programs, continuation of programs, as well as, nursing program resource grants; totaling just over \$6 million. The proposals that received the highest ratings for funding focused on nursing graduate

outcomes with partnerships across community colleges, universities and hospital health systems. Table 4 lists the recommended proposals for FY 2020 funding.

Table 4. Final Recommendations for Funding for FY 2020

Grant #	Institution	Grant Title	Proposed Funding
20-102	Allegany College	LPN- RN Online	\$150,000
20-104	Coppin State University	Cognitive Reflective CARE	\$50,000
20-105	Coppin State University	Planning BSN to DNP	\$148,100
20-106	Coppin State University	ATB with CCBC & Howard	\$143,951
20-108	Johns Hopkins University	PRIME Model for DNP-NP	\$1,001,596
20-109	Johns Hopkins University	Supporting Advance Practice	\$150,000
20-110	Johns Hopkins University	Planning CRNA	\$150,000
20-112	Montgomery College	ASEL Resources	\$50,000
20-116	Morgan State University	Student Resources	\$47,897
20-117	Notre Dame of Maryland University	B-Line Software Resources	\$50,000
20-118	Salisbury University	Planning MA-FAMI	\$149,998
20-120	Towson University	Entry Level MS in Nursing	\$149,556
20-121	University of Maryland	AGPCNP Certification	\$121,972
20-122	University of Maryland	SA and Addictions Program	\$137,408
20-123	University of Maryland	Clinical Faculty Competency	\$264,677
20-125	University of Maryland	Maryland Nursing Workforce Center Continuation	\$1,912,767
20-126	Montgomery College	MCSRC Group Resource Continuation	\$1,475,525
TOTAL			\$6,153,447

RECOMMENDATIONS

HSCRC and MHEC staff recommend the 17 proposals presented above in Table 4 for the FY 2020 NSP II Competitive Institutional Grants Program. The most highly recommended proposals include:

- Planning an advanced Faculty Academy and Mentoring Initiative at Salisbury University on the Eastern Shore;
- Providing for the continuation of the Maryland Nursing Workforce Center at the University of Maryland for improved data infrastructure;
- Planning a new Masters entry (second degree) nursing program for adults with a Bachelor’s degree in a different field at Towson University;
- Implementing a more accessible approach for Doctor of Nursing Practice (DNP) nurse practitioner degrees at Johns Hopkins University;
- Developing an academic progression partnership for increased diversity with pre-licensure graduates in dual enrollment programs at Community College of Baltimore County and Howard Community College with Coppin State University;
- Continuing the Maryland Clinical Simulation Resource Consortium at Montgomery College with resources requested by 26 nursing programs at universities and community colleges;

- Planning a Certified Registered Nurse Anesthetist (CRNA) program at Johns Hopkins University in partnership with Johns Hopkins Healthcare System; and
- Supporting a seamless online educational pathway from Licensed Practical Nurse (LPN) to Registered Nurse (RN) at Allegany College in Western Maryland.

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Draft Recommendation to Address Volume
Methodology Concerns
May 8, 2019



Executive overview

- ▶ Provide analysis of funding levels resulting from current Volume Methodologies (CY 2014 – CY 2017)
- ▶ Staff recommends that the Market Shift Adjustment be consolidated along geographies and services lines
 - ▶ Improves statistical stability
 - ▶ Simplifies Market Shift
- ▶ Given concerns over distribution of additional annual funding for population growth, staff recommends creating a workgroup that will seek to modify the Demographic Adjustment while maintaining its status as population based.

Definitions

- ▶ **Unfunded Volume Growth** – The differential between volume funding from various Volume Methodologies and funding of all volume at a 50% variable revenue factor, i.e. a volume variable system.
- ▶ **Retained Decline** – The differential between volume funding from various Volume Methodologies and the defunding of all volume at a 50% variable revenue factor, i.e. a volume variable system.

Scope of Volume Funding Included in Current Volume Methodologies

Included (~70% of revenue)

In-state cases

- ▶ Case-mix adjusted discharges
- ▶ Case mix adjusted outpatient cases (grouped into Enhanced Ambulatory Patient Groups)

Mechanisms

- ▶ Market Shift Adjustment
- ▶ Demographic Adjustment
- ▶ Other Adjustments

Not Included (30% of revenue)

Cases

- ▶ Out-of-state
- ▶ Radiation and Infusion Therapy and Drugs (drugs addressed separately)
- ▶ Defined quaternary cases, (“Categorical” exclusions such as transplants, research, severe burn, Car-T, Spinraza)
- ▶ Readmissions and Prevention Quality Indicators (classified as potentially avoidable utilization, “PAU”)

Mechanisms

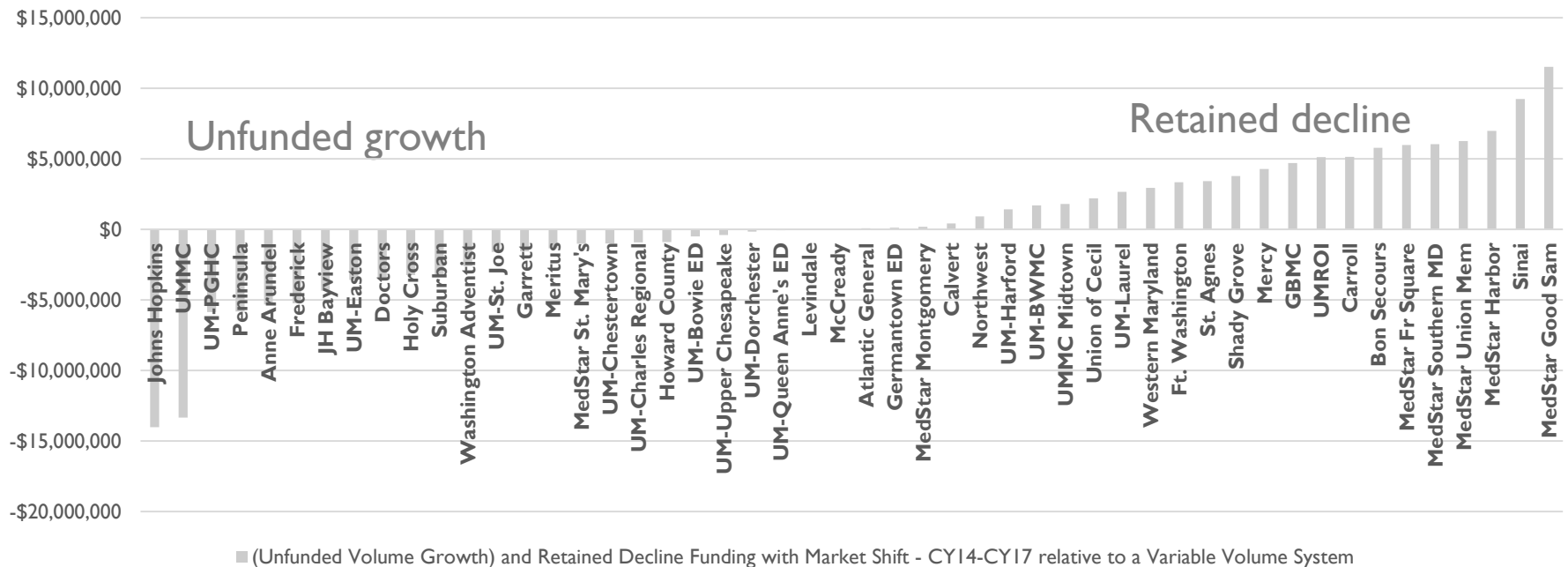
- ▶ Volume Variable for select cases
- ▶ Rate review or special GBR adjustments
- ▶ Intensity Adjustment



Overall Distribution of Unfunded Volume Growth or Retained Decline after Application of Market Shift Adjustment Only

Market Shift moves 50% of the average charge for volume growth that has a corresponding decrease in a given service line and geography. This formulation is not applied to excluded volumes (readmissions, out-of-state, defined quaternary cases, oncology).

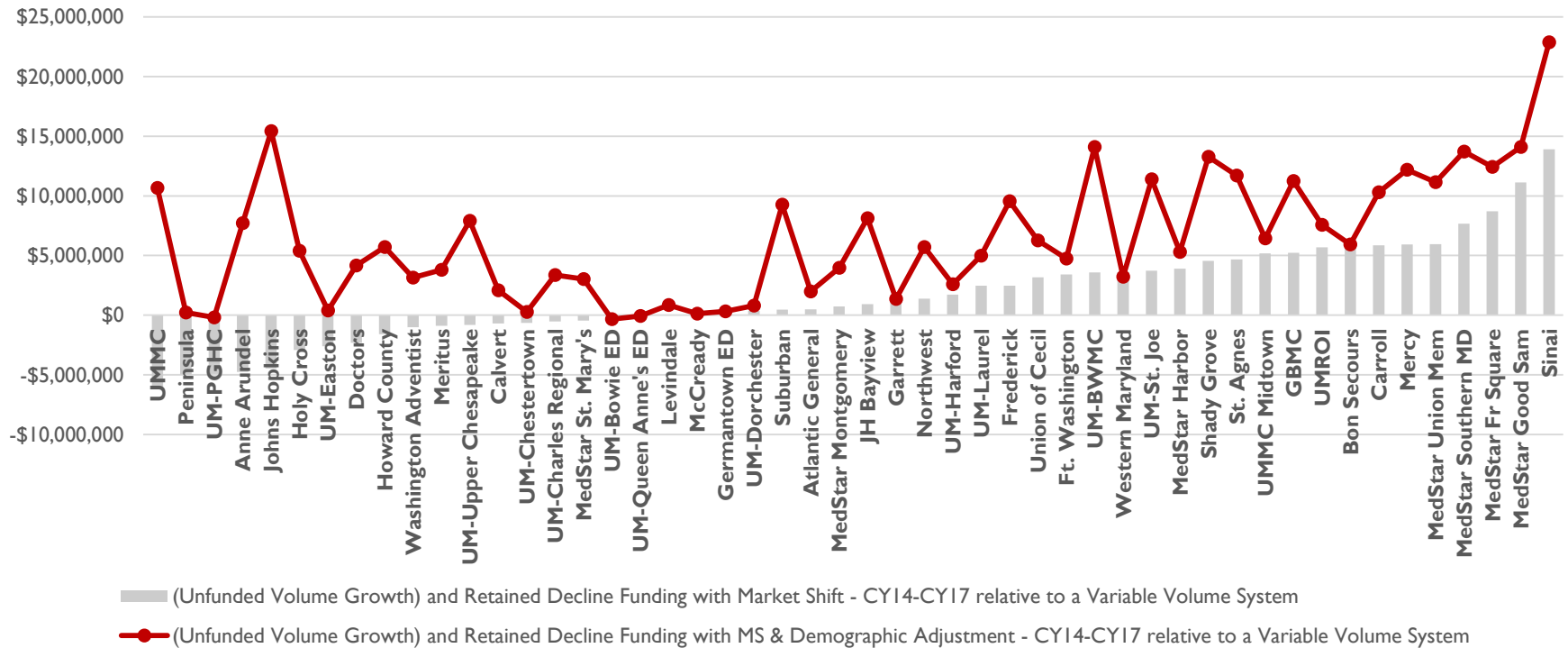
Residual Funding of In-State Volume Growth and Declines at 50% variable revenue factor for CY14-CY17 after applying Market Shift Adjustment only*



The Demographic Adjustment Reduces Unfunded Growth but Increases Retained Revenue for Hospitals with Volume Declines

Demographic Adjustment is a measure of age adjusted population growth that is distributed based on current market share and is capped to the total population growth rate of the State. It does not distribute revenue based on volume growth.

Residual Funding Differences of In-State Volume CY14-CY17 Market Shift and Demographic Adjustment*



Problems with the Market Shift

- The Market Shift methodology has been criticized for being overly complicated due to the number of shifts that are determined across:
 - Geographies (350+ zip codes & 15 counties) and
 - Service lines (46 inpatient, 14 outpatient).
 - 20,000 plus cells/markets
- It has also been suggested that the small cell sizes lead to instability in the market shift.
- While the net change in Market Shift Adjustments statewide and by hospital does not change materially when the Market Shift is consolidated, staff acknowledges that service line variation is more significant, especially for service lines with a low number of discharges per zip code.
- In addition to addressing statistical stability, reducing the number of cells in the Market Shift simplifies the methodology. Thus, staff will develop criteria for reducing service lines and geographies.

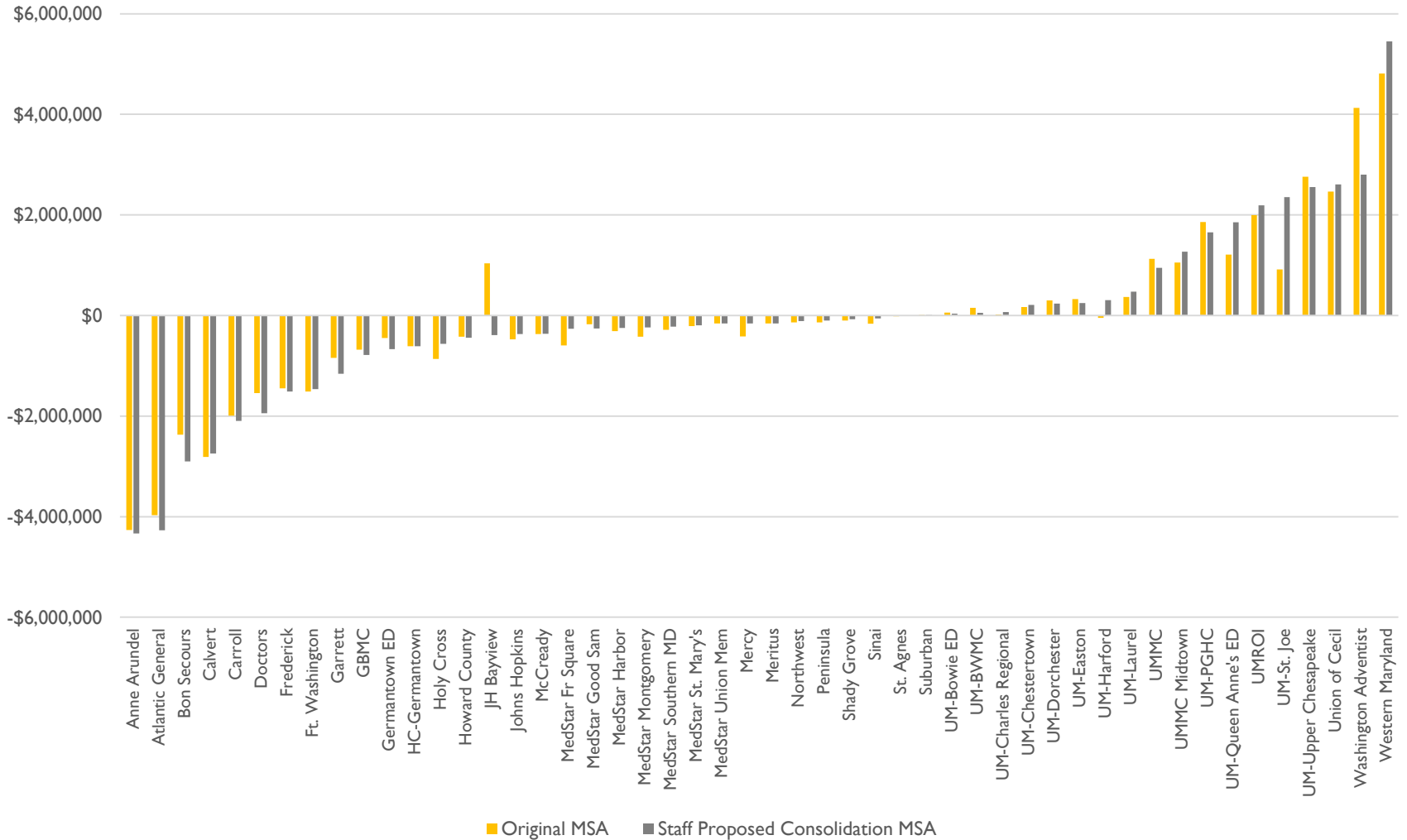
Consolidation of the Market Shift

- ▶ Staff proposes modifications to the Market Shift algorithm to reduce the number of markets (i.e. cells)
- ▶ Medical service lines will be collapsed into similar service lines based on:
 - ▶ Clinical overlap
 - ▶ Similar average charges per equivalent case mix adjusted discharges (ECMADS)
 - ▶ Similar medical designations of APR-DRG's or EAPG's
 - ▶ Similar overrepresentation in emergency room rate center charges
- ▶ Inpatient surgical, major outpatient surgeries, and highly specialized services will be collapsed based on clinical criteria and also consolidated into counties instead of zip codes

Results of the Market Shift consolidation

- ▶ **The proposed consolidation of Market Shift service lines is shown in Appendix 6 of the Draft Recommendation**
 - ▶ The consolidation of services lines based on clinical overlap reduced the total number of service lines from 60 to 44
 - ▶ The 28 inpatient services lines were consolidated from a zip code market to a county market
- ▶ **Reducing the number of markets should increase the stability of the Market Shift Adjustment over time**
 - ▶ The total number of markets has decreased from potentially 20,000 to ~5,000
 - ▶ The number of markets with fewer than 10 beneficiaries has declined from ~7,000 to ~1,000

Consequences of CY 2018 market consolidation (six months)



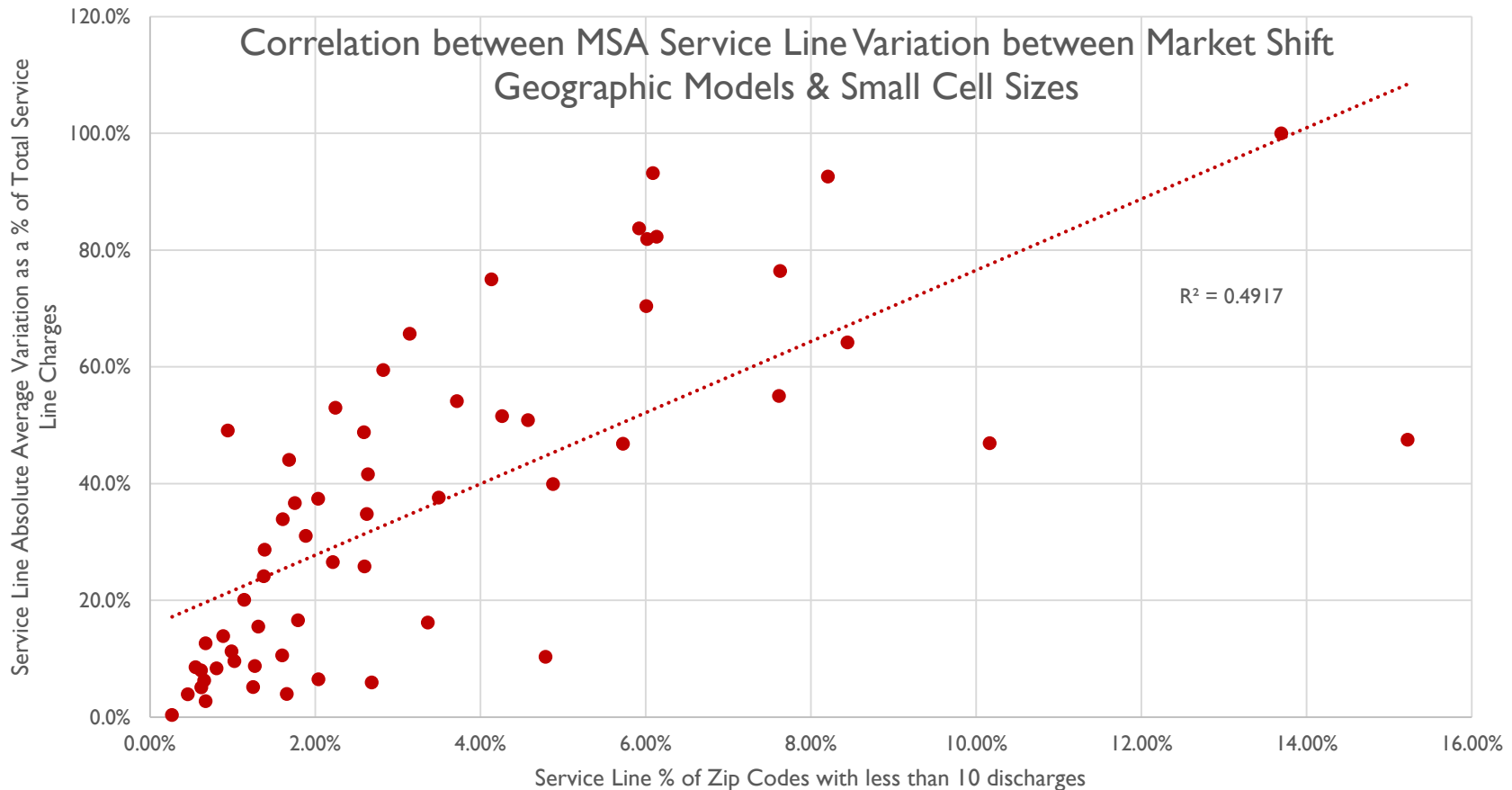
Draft Recommendations

- ▶ 1) Consolidate defined markets in the Market Shift methodology by reducing service lines with clinical overlap and assessing inpatient surgery and other highly specialized services at a county level.
- ▶ 2) Establish a Workgroup to evaluate potential modifications to the Demographic Adjustment that will better anticipate use rate changes while maintaining its status as population based.

Appendices



Appendix 1: Relationship between Small Cell Sizes and Service Line Variation



- If a service line has a higher share of zip codes with less than 10 discharges, then its variation between the two geographic Market Shift models tends to increase, suggesting a relationship between service line variation between the models and small cell sizes.

Appendix 2: Concerns Regarding Geographic Collapsing of Medical Cells

- While consolidating the Market Shift from 350+ zip codes and 15 counties to 23 counties and Baltimore City did not have a substantive impact on individual hospital market shift adjustments, staff does have concerns:
 - Service line variation by Hospital can influenced by small cell sizes
 - But consolidating all zip codes into counties could have unintended consequences, such as treating avoided utilization as a market shift and vice versa.

Hypothetical Emergency Room Market Shift Example

		Base Year - ER ECMADS	Performance Year - ER ECMADS	Growth	Current Market Shift	Unrecognized Growth / (Decline)	Consolidated Geography Market Shift	Unrecognized Growth / (Decline)	
Same Zips	Hospital A West Baltimore	100	90	(10)	(10)	0	(6)	(4)	} Probable market shift being treated as avoided utilization
	Hospital B West Baltimore	200	225	25	10	15	25	-	
Same Zips	Hospital C East Baltimore	250	180	(70)	(20)	(50)	(39)	(31)	} Probable avoided utilization being treated as market shift
	Hospital D East Baltimore	100	120	20	20	0	20	-	
	Total	650	615	-35	0	-35	0	-35	

- In this example, Hospitals A and B are more representative of market area than hospital C and D, and when their shifts are evaluated at the zip code level, Hospital A has 100% of its volume decline shifted to Hospital B. When Hospital C and D have their market growth evaluated at the zip code level Hospital C has 28% of its volume loss shifted to Hospital D.
- However, when all of Baltimore is consolidated Hospital A has only 60% of its volume decline shifted even though its entire decline is more likely due to shifts to Hospital B, which is in its service area. Hospital C, which had a greater volume decline that is more indicative of reduced utilization, gets a larger negative market shift because it is now shouldering a portion of the volume loss Hospital A experienced.

Draft Recommendation for Market Shift Consolidation

May 8, 2019

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This document contains the draft staff recommendations for updating the Market Shift methodology. Please submit comments on this draft to the Commission by Wednesday May 22, 2019, via email to allani.pack@maryland.gov

Key Methodology Concepts and Definitions

1. Variable Cost Factor – The percentage of charges required to reimburse a hospital for the variable costs (supplies, drugs, etc.) associated with increases in volume. The standard by which the industry and the Commission evaluates volume funding adequacy is 50 percent, as 50 percent of all service charges on average covers fixed costs and 50 percent covers variable costs. This value is not uniform by service line.
2. Effective Variable Cost Factor – The percentage of charges that are reimbursed when accounting for revenue adjustments from volume methodologies. This value can be calculated with revenue from one or the sum of multiple volume methodologies
3. Service Lines – Groupings of services into higher level categories that reflect similar clinical delivery. Service lines are utilized to determine market shifts in the Market Shift methodology
4. Equivalent Case Mix Adjusted Discharges (ECMADS) – Often referred to as casemix, ECMADS are a volume statistic that account for acuity, as not all services require the same level of care and resources.

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Recommendations

Staff recommends the following updates to the current Commission Methodologies:

1. Consolidate defined markets in the Market Shift methodology by reducing service lines with clinical overlap and assessing inpatient surgery and other highly specialized services at a county level.
2. Establish a Workgroup to evaluate potential modifications to the Demographic Adjustment that will better anticipate use rate changes while maintaining its status as population based.

Introduction

The State of Maryland has led an effort to transform its health care delivery system to a population-based system that increases the emphasis on patient-centered care, improves population health, and lowers health care costs. To achieve these goals, the State of Maryland worked closely with hospitals, payers, other providers, consumers and the Centers for Medicare & Medicaid Services to develop the Maryland All-Payer Model, which was implemented in 2014. The Model moved away from a volume-based payment system that limited the growth in inpatient charge-per-case to a system that limits the growth in total hospital spending per capita and increasingly focused on outcomes: readmissions, in-hospital complications, potentially avoidable utilization, and patient satisfaction, among others.

At the conclusion of the Model in December of 2018, preliminary results show that the State met and exceeded every contractual target¹ and hospital total profit margins statewide recovered from the unsustainable levels experienced in 2013.² Given that the State has endeavored to continue these transformative efforts and build off of the success of the All-Payer Model with the new Total Cost of Care Model, effective January 1, 2019, and given that various volume methodologies have not been examined since the inception of the All-Payer Model, it is important that the State evaluate its methodologies and modify where necessary.

Fundamental to the All-Payer Model was the Global Budget Revenue (GBR) methodology, which was piloted by ten rural hospitals in 2010 and aimed to provide stability to hospitals by establishing annual prospective budgets and allowing for charges to fluctuate in line with reasonable changes in volume.³ However, while hospital budgets were fixed during a given

¹ Limiting all-payer hospital spending per capita in line with the growth of the economy, saving Medicare a total of at least \$330 million by keeping Maryland's Medicare per beneficiary growth below the national growth rate (currently the State has saved \$1.4 billion), reducing Medicare readmissions to the national average (currently .05% lower than national average), reducing hospital acquired complications by 30 percentage (currently the State has reduced by 51 percent), and moving virtually all hospital payment methodologies to approved population based approaches.

² The statewide average for profit margins for RY 2013 was 1.2 percent; since that time the statewide average for profit margins has been approximately 3 percent. See appendix I for more detail.

³ The HSCRC allows hospitals to adjust charges for individual rate centers (e.g. room and board) to fluctuate within a 5 percent corridor. HSCRC reviews hospital requests adjust prices beyond a 5 percent corridor.

fiscal year, thereby incentivizing hospitals not to grow volumes unnecessarily and providing a high level of predictability, the Commission had to develop strategies to modify budgets in future years based on changes in population, the aging of the population, new health care innovation cost drivers, and changes in market selection.

To achieve the twin goals of funding population related utilization changes and realigning budgets for market shifts, the HSCRC developed two core volume funding methodologies: the Demographic Adjustment and Market Shift Adjustment. The Demographic Adjustment methodology provides funding for age-adjusted growth/decline at the zip code or county level in order to anticipate changes in utilization based on demographic changes.⁴ The Demographic Adjustment is capped by Maryland Department of Planning estimates of statewide population growth to align with the per capita nature of the All-Payer Model tests, i.e. the contractual tests are not age-adjusted.

The HSCRC staff also developed a Market Shift Adjustment methodology that evaluated hospitals' growth/decline for each defined service line and geography to determine the degree to which patients moved from one hospital to another in the most recent calendar year in comparison to the prior year. The Market Shift moved money in the following year at a 50 percent cost factor when volumes moved up at one hospital and down at another in the same service line and geography. Taken together, these policies ensure a competitive hospital market where money follows the patient but only such that statewide volume on net does not grow for anything other than population growth and various forms of healthcare innovation. Both of these methodologies resulted in adequate volume funding statewide while maintaining the Model's status as population-based, but have produced less predictable funding for volume changes at the individual hospital level.

As staff will demonstrate, volume funding statewide has been adequate over the first four years of the Model, but the distribution of funding in any given year has not entirely aligned with medically necessary use rates and to some degree has created hospitals with greater cost inefficiency and poorer total cost of care outcomes. This is because population estimates outlined in the Demographic Adjustment methodology do not necessarily correlate with actual changes in hospital utilization and because the Market Shift methodology is very granular in the development of markets – there are 60 hospital service lines, over 350 geographies and potentially 20,000 markets.

To address these concerns, staff is recommending two key changes in methodology.

- **Market Shift Adjustment:** The first change is to consolidate geographies and service lines to reduce the number of small cells in the Market Shift, improving the reliability of the results.

⁴ The Demographic Adjustment developed for urban areas apportioned age-adjusted population changes among the hospitals serving each zip-code based on their market share in each zip code, in contrast to the rural Demographic Adjustment, which allocated the age-adjusted population change for a county to each rural hospital.

- **Demographic Adjustment:** The second change is to review with a workgroup potential modifications to the Demographic Adjustment that will better anticipate use rate changes while maintaining its status as population-based.

Another concern expressed by the Commissioners is that various hospitals have retained a significant amount of revenue under the current volume methodologies and thus have become cost inefficient. To address this, Commissioners have asked staff to promulgate an efficiency policy that removes revenue from inefficient hospitals. During Rate Year 2018, HSCRC staff developed an Inter-hospital Cost Comparison (ICC) and a geographic Medicare Total Cost of Care Performance Matrix to evaluate hospitals that were high cost outliers. One outlier hospital entered into a spend-down agreement with the Commission. During Rate Year 2018 and 2019, HSCRC staff have also made adjustments of more than \$70 million for services that shifted to unregulated settings, including adjustments for oncology and infusion drugs shifted to unregulated settings. In order to expedite the process of adjusting revenues for high cost outlier hospitals and to make the adjustments more predictable, the HSCRC staff is proposing a more formulaic approach to implementing efficiency adjustments for outliers. This proposed approach will be outlined in a separate Staff Report, along with proposed updates to the Inter-hospital Cost Comparison methodology.

Background

Demographic Adjustment

As aforementioned, the Demographic Adjustment methodology provides funding for age-adjusted growth at the zip code or county level in order to anticipate changes in utilization based on demographic changes, and the Demographic Adjustment is capped by Maryland Department of Planning estimates of statewide population growth to align with the per capita nature of the All-Payer/Total Cost of Care Model tests. In 2011, the HSCRC implemented a demographic adjustment for the 10 rural hospitals on global budgets using age-adjusted county projections. The demographic adjustment was then reduced by a 50 percent variable cost factor and further reduced by a 50 percent productivity adjustment, resulting in a demographic adjustment that was 25 percent of the projected age-adjusted population change. In Rate Year 2015, the HSCRC implemented a full year of the Demographic Adjustment for the remainder of hospitals (beyond the 10 hospitals already under global budgets), and in subsequent years, the Commission included the full value of the statewide population growth in calculating the allowed adjustment. The Demographic Adjustment has averaged approximately 0.40 percent of net hospital revenue or ~\$60 million, with lower values in recent periods resulting from slower population growth.

Market Shift Adjustment

The Market Shift was first implemented in RY 2015 based on CY 2014 calculations. Because a hospital cannot receive additional volume funding unless a different hospital has a reciprocal decline (a shift) in the same service and geography, the net statewide adjustment typically oscillates around \$0.⁵ For CY14 to CY17, the average statewide market shift was \$586,000 and typically realigned \$50 million among all hospitals.

Both methodologies affect permanent revenue and are implemented in conjunction with the annual Update Factor to prospectively cap the upcoming fiscal year budget for all hospitals. As they both impact the amount and distribution of volume funding, they should be considered in tandem when evaluating the adequacy of funding. Since the Market Shift is designed with the intent of moving funding when patients move from one hospital to another and not to adjust for overall increases or decreases in volume, the effective variable cost factor, which is the ratio between GBR adjustments from the Market Shift and total charges for volume change (inclusive of fixed costs and variable costs), is less than 50 percent.⁶ However, when the Demographic Adjustment is considered in tandem with the Market Shift, the effective variable cost factor for hospitals with volume growth typically exceeds 50 percent for all hospitals.

The main difference between the Demographic Adjustment and the Market Shift is that the Demographic Adjustment modifies hospital budgets for volume change expectations based on projected growth or decline in the age-adjusted population while the Market Shift methodology modifies hospitals budgets based on actual movement of volume among hospitals.

Volume Calculation Overviews

In this section staff will explain in detail the calculations for the two core volume methodologies: the Demographic Adjustment and the Market Shift Adjustment. Additional details on these calculations and their input variables may also be found in the Appendices.

Overview of Demographic Adjustment Calculation

The purpose of the Demographic Adjustment is to provide volume funding increases or decreases in anticipation of utilization changes related to changes in age-adjusted population changes for a hospital's service area. This funding, which is based on calendar projections (e.g. RY 2020 will be based on CY 2019 population estimates), is used to prospectively adjust hospital revenues for the upcoming year. There are no retroactive adjustments for changes in

⁵ The impact is not exactly \$0 because realigned volumes are multiplied by hospitals' average charge, which may be different based on their cost structure (e.g. Bon Secours versus Johns Hopkins Hospital), and thus can yield statewide MSA's that deviate from \$0.

⁶ A 50 percent variable cost factor is the industry standard for determining the percent of charges necessary to cover all marginal or variable costs associated with providing one additional service and is the standard by which the Commission will evaluate its volume methodologies.

population estimates. Changes in estimates are addressed in developing the succeeding year's Demographic Adjustment.

The Demographic Adjustment calculation begins by determining a hospital's virtual patient service area (VPSA). A VPSA is determined by aggregating the hospital's service volume in each zip code for eight age groups in the State⁷. The HSCRC uses this service area distribution to attribute population to each hospital based on the proportional amount of casemix adjusted services it provides to patients in each zip code relative to services provided by all hospitals.

The HSCRC then calculates the estimated population change for the attributed population using population projections.⁸ It also applies an age weight to each age/zip code cohort of the hospital's VPSA to adjust for the differences in cost per capita of each age cohort and to allow for changes resulting from aging of the population.

A portion of the existing service volume is a result of potentially avoidable utilization (PAU). The HSCRC removes this portion of the base volume on a hospital specific basis to eliminate any growth allowance for PAU, when projecting each hospital's expected volume growth due to changes in demographics. The remaining statewide age-adjusted population growth is compared to the State's Department of Planning population growth estimates, and each hospital's Demographic Adjustment is multiplied by a pro-rata reduction factor that accounts for the expected per capita efficiencies to accomplish the overall per capita savings targets in the All-Payer and Total Cost of Care Model, i.e. the final statewide Demographic Adjustment equals Department of Planning growth estimates. The result is the population driven volume growth that will be recognized in each hospital's global budget for the upcoming fiscal year.

Summary:

1. Calculate base population estimates for the current calendar year for each hospital based on a hospital's share of volume, as measured by equivalent case-mix adjusted discharges, in a given zip code age cohort.
2. Calculate age adjusted population growth rates by multiplying statewide age cost weights with zip/age population growth rates.
3. Calculate hospital specific age adjusted population growth by multiplying hospital specific base population by age adjusted population growth rates for each zip/age cohort and calculating total projected age adjusted population growth
4. Calculate final demographic adjustment by applying efficiency adjustments
 - a. Reduce age adjusted population growth by hospital specific PAUs as a percent of total all-payer revenue
 - b. Reduce PAU/age adjusted population growth by pro-rata per capita efficiency adjustment reduction

⁷ The eight age cohorts (0 to 4, 5 to 14, 15 to 44, 45 to 54, 65 to 74, 75 to 84, 85+) within each zip code provide more specific cost trends than would otherwise result from an overall distribution since population growth trends and health care use within these cohorts differ significantly.

⁸HSCRC obtains its projections from a private vendor, Claritas, who provides zip code and age specific population estimates for current year and 5-year population projections.

Below is an example calculation with just one zip code for a GBR hospital to arrive at the statewide per capita efficiency adjustment.

Table 1: Demographic Adjustment Example Calculation

Zip Code	Age Cohort	Base Year ECMADs for Hospital	Total ECMADs for All Hospitals	Share of ECMADs	Base Population	Allocated Base Population	State Total Hospital Revenue per Capita	Age Cost Weights	Projected Population Growth Rate of Cohort	Age Adjusted Population Growth Rates	Hospital Age Adjusted Population Growth	Hospital Overall Age Adjusted Population Growth	Hospital PAU %	Hospital Specific Adjusted Growth Rate	Statewide Per capita Efficiency Adjustment
STEP 1a				Step1b		Step2a		Step2b		Step 3		Step 4			
A	B	C	D	E = C/D	F	G=F * E	H	I=H/H(total)	J	K=J*I	L=G*K	M=sum(L)/sum(G)	N	O=M*(1-N)	P=O*50%
00000	0-4	30	60	50%	3,713	1,857	\$1,577	0.68	0.77%	0.52%	10				
00000	05-14	45	100	45%	23,471	10,562	\$119	0.05	-0.07%	0.00%	(0)				
00000	15-44	100	210	48%	8,902	4,239	\$3,798	1.63	-1.16%	-1.89%	(80)				
00000	45-55	20	35	57%	7,533	4,305	\$2,822	1.21	1.18%	1.43%	61				
00000	55-64	25	40	63%	7,450	4,657	\$3,413	1.46	0.16%	0.23%	11				
00000	65-74	25	30	83%	4,517	3,764	\$5,162	2.21	2.73%	6.04%	227				
00000	75-84	55	70	79%	2,282	1,793	\$7,337	3.14	2.42%	7.60%	136				
00000	85+	60	80	75%	1,044	783	\$8,009	3.43	1.32%	4.53%	35				
Total	Total	360	625	58%	58,913	31,959	\$2,335				401	1.3%	14%	1.08%	0.54%

For additional detail, please see Appendix 2.

Overview of Market Shift Calculation

The Market Shift Adjustment (MSA) methodology is an algorithm to calculate MSAs for a specific service line (e.g. orthopedic surgery) and a defined geographic location (e.g. ZIP code) using the case-mix adjusted volume measurement of equivalent case-mix adjusted discharges (ECMADS) for regulated inpatient and outpatient services. In total, there are 60 service lines, 46 inpatient and 14 outpatient, that are determined by 3M's aggregation of inpatient All Patients Refined Diagnostic Related Groupings (APR-DRG's), and HSCRC's aggregation of 3M's outpatient Enhanced Ambulatory Patient Groupings (EAPG's). The outpatient groupings are based on hospital rate center analyses to indicate the general services received at the hospital (e.g. emergency room services), while the inpatient service line aggregation is based on the diagnosis and/or procedure a patient receives (e.g. cardiothoracic surgery). There are also over 350 geographies in the Market Shift, as there are zip code level analyses for dense parts of the State and 15 county level analyses for less dense parts of the State.⁹ After arraying volume in various service lines and geographies, the market shift algorithm compares the growth in volumes at hospitals with utilization increases to the decline in volumes at hospitals with utilization decreases.

It is important to note that not all revenue is included in the MSA. For instance, potentially avoidable utilization (PAU), which consists of 30 day readmissions and Prevention Quality Indicators,¹⁰ is excluded because the Commission does not want to reward hospitals for growth

⁹ For a discussion of Geographic and Service Line Definitions, please see Appendix 3.

¹⁰ Readmissions are admissions to a hospital (defined as inpatient admission or observation stay greater than 23 hours) within a specified time period after a discharge from the same or another hospital. In the PAU measure, readmissions are specified as 30-day, all-payer, all-cause readmissions at the receiving hospital with exclusions for planned admissions. Hospitalizations for ambulatory-care sensitive conditions are measured by the Agency for

in PAU, nor does it want to disincentive hospitals from reducing PAU. The scope of volume evaluated in the MSA is as follows:

Table 2: Scope of Volume Addressed in Market Shift Calculation

Included (~70% of revenue)	Not Included (30% of revenue)
<p><u>In-state cases</u></p> <ul style="list-style-type: none"> ▶ Case-mix adjusted discharges ▶ Case mix adjusted outpatient cases (grouped into Enhanced Ambulatory Patient Groups) <p><u>Mechanisms</u></p> <ul style="list-style-type: none"> ▶ Market Shift Adjustment ▶ Demographic Adjustment ▶ Other Adjustments 	<p><u>Cases</u></p> <ul style="list-style-type: none"> ▶ Out-of-state ▶ Radiation and Infusion Therapy and Drugs (drugs addressed separately) ▶ Defined quaternary cases, ("Categorical" exclusions such as transplants, research, severe burn, Car-T, Spinraza) ▶ Readmissions and Prevention Quality Indicators (classified as potentially avoidable utilization, "PAU") <p><u>Mechanisms</u></p> <ul style="list-style-type: none"> ▶ Volume Variable for select cases ▶ Rate review or special GBR adjustments ▶ Intensity Adjustment

Market Shift Adjustments are capped at the lesser of the growth for volume gains or the decline for volume losses. This approach separates market shifts from collective changes in volume in the service area and removes incentives for driving up volume in the service area. This also means that not all volume growth or declines will be recognized at a 50 percent variable cost factor, only volume changes that are deemed market shifts.

Table 3 provides an illustration of the market shift calculation for ZIP code 21000 and the General Surgery service line. Within this ZIP code, the total volume increase is 654 equivalent case-mix adjusted discharges (ECMADs), and the decline is 129 ECMADs. Applying the "lesser of the two" rule, the allowed market shift is limited to 129 ECMADs, which is allocated to other hospitals with volume increases proportional to this hospital's volume increase in total utilization. In the end, the net impact of market shift volumes in each ZIP code and service line combination equals zero.

Health Care Research and Quality's Prevention Quality Indicators (PQIs). In the PAU measure, PQIs are measured on inpatient admissions and observation stays greater than 23 hours for ambulatory care sensitive conditions

Table 3. Example Calculation of the Market Shift Algorithm

ZIP Code 21000 General Surgery	Volume CY13	Volume CY14	Volume Growth	Hospital's Proportion of Total Increase/Decline	Market Shift
	A	B	C=B-A	D=C/Subtotal C	E=D*Allowed Market Shift
Hospital A	1,000	1,500	500	76%	99
Hospital B	500	600	100	15%	20
Hospital C	50	100	50	8%	10
Hospital D	-	4	4	1%	1
Utilization Increase	1,550	2,204	654	100%	129
Hospital E	500	400	(100)	78%	(100)
Hospital F	50	25	(25)	19%	(25)
Hospital G	4	-	(4)	3%	(4)
Utilization Decline	554	425	(129)	100%	(129)
ZIP Code Total	2,104	2,629	525	-	0
Allowed Market Shift	129				

Summary:

1. Array all APR-DRG's and EAPG's into service lines and geographies for each hospital based on 3M inpatient service line specifications, HSCRC outpatient service line specifications based on rate center analyses, and geographies based on the patient's residency – zip code level for denser parts of the State and county level for the 15 rural jurisdictions in the State.
2. Remove from consideration all excluded market shift revenue, including potentially avoidable utilization, out-of-state volume, categorical exclusions, oncology drugs, and chronic cases from the MSA algorithm
3. Run the Market Shift algorithm to determine growth, both increases and decreases in volume for each service line and geography
4. Calculate final market shift adjustment by multiplying the volumes that have been deemed market shifts by a hospital's unique service line average charge per equivalent case mix adjusted discharge.
 - a. The average charge includes all charges and therefore includes outlier charges built into the base of each hospitals GBR

Volume Assessment

In this section staff will analyze the adequacy of volume funding from both the Market Shift Adjustment and the Demographic Adjustment relative to a 50 percent variable cost factor, which is the standard by which the Commission and various stakeholders evaluate volume funding adequacy. Staff will further comment on the funding predictability from the two core volume methodologies and will analyze the statistical stability of the Market Shift, namely the degree to which small cell sizes in the market shift are contributing to random variation in the revenue adjustments. Finally, staff will outline modifications to the Market Shift that will create greater reliability in the results.

Adequacy and Predictability of Volume Funding

Over the first four years of the Model (CY 2014 – CY 2017), the Market Shift Adjustment provided a 50 percent variable cost factor for volume growth and declines that were deemed a market shift in the year following the shift.¹¹ As such, the funding from the Market Shift never reached a 50 percent effective variable cost factor, which was by design as the Market Shift only recognizes volume shifts, not total growth or declines. This is evident in Table 4, which demonstrates that when accounting for Market Shift Adjustments only, hospitals had unfunded growth relative to a 50 percent variable cost factor and retained declines relative to a 50 percent variable cost factor, i.e. if all volume changes were funded at a 50 percent variable cost factor the hospitals in this graph would all equal \$0.

Table 4: Residual Funding of In-State Volume Growth and Declines at 50 percent variable cost factor for CY14-CY17 after applying Market Shift Adjustment only

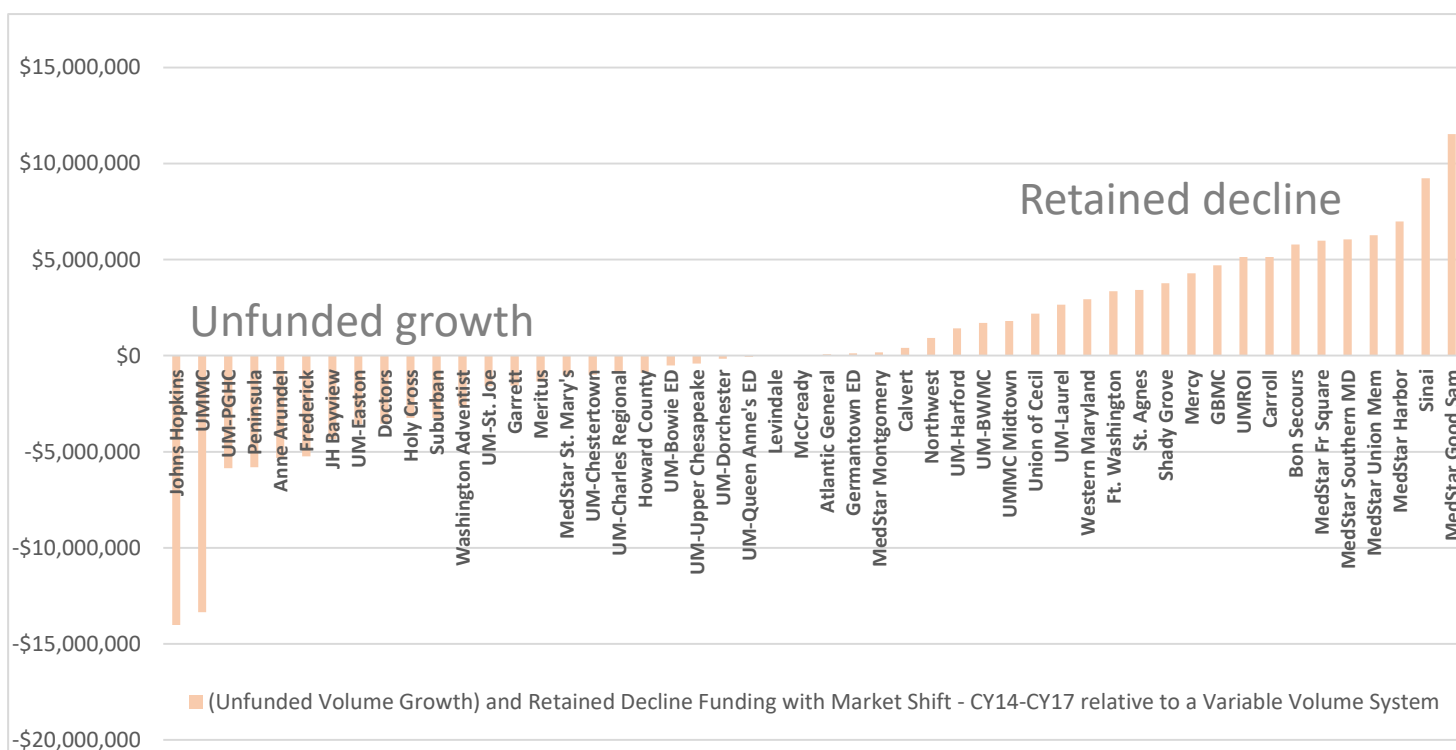


Table 5 builds off of Table 4 and outlines the Market Shift variable cost factor in terms of a percentage, i.e. an effective variable cost factor, both for hospitals with net increases in volume growth and net decreases by year.

¹¹ CY 2018 Market Shift is not included in this analysis because the final issuance of rate orders of CY 2018 Market Shift will not be completed until July 1, 2019.

Table 5: Market Shift Adjustment Effective Cost Factor for All Volume Growth - Net Growing Hospitals and Net Declining Hospitals

	MSA Effective Cost Factor (Net Growers)	Volume Growth \$* (Net Growers)	MSA Effective CostFactor (Net Decliners)	Volume Growth \$* (Net Decliners)
CY14	4.02 percent	\$131.2M	27.7 percent	-\$21.8M
CY15	29.5 percent	\$91.8M	27.8 percent	-\$176.1M
CY16	20.1 percent	\$130.5M	25.7 percent	-\$120.9M
CY17	31.2 percent	\$100.2M	12.1 percent	-\$211.2M

*Calculated by multiplying average charge for each service line by change in volume

As shown, hospitals with volume growth did not ever reach an effective variable cost factor of 50 percent for all volume growth through the Market Shift, which again is by design. The effective variable cost factor was particularly low in CY 2014 (4.02 percent), as hospitals had much larger growth relative to reductions in utilization (\$131.2 million versus declines of -\$21.8 million) and because the various interventions employed in the All-Payer Model were likely not yet implemented to respond to new incentives. Hospital volume growth for net growers slowed in subsequent years with the notable exception of CY 2016, when \$83.5 million of the \$130.5 million of growth for net growers was due to increases in the General Surgery service line. This growth coincided with the implementation of ICD-10, which had an unintended shift of cases into the General Surgery service line from lower weighted APR-DRGs, due to the conversion to ICD-10 in the third quarter of 2015 - in CY16.¹² It is also important to note that as the Model progressed the effective variable cost factor for net growers increased, suggesting that growth was more indicative of market shifts and that hospitals were no longer uniformly responding to the volume driven incentives of the historical fee-for-service methodologies.

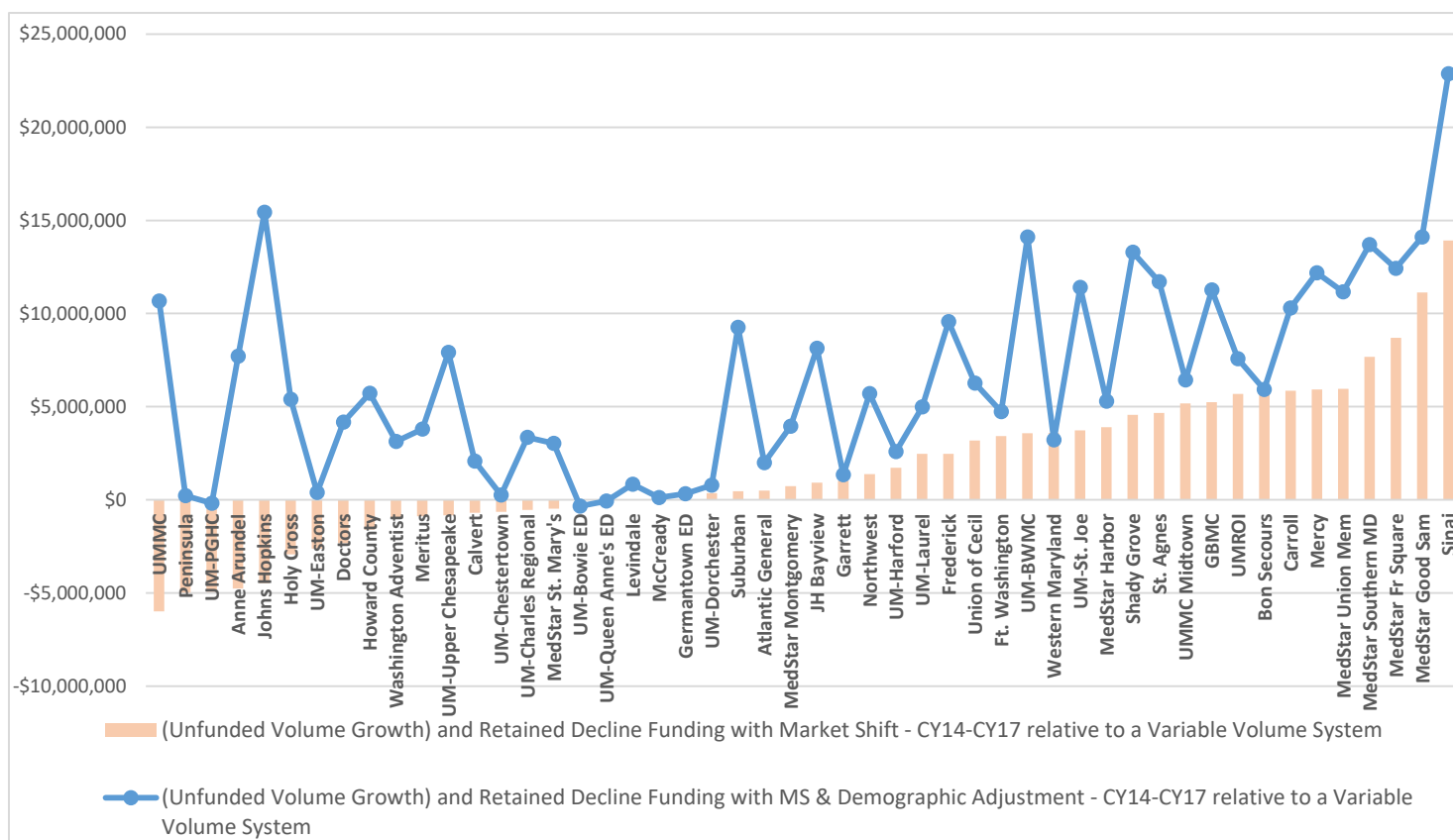
As volume reductions have increased precipitously since CY 2014, net decliners have sustained a fairly consistent effective variable cost factor, approximately 25 percent, which suggests that net declining hospitals have retained 75 percent of the revenue associated with reduced utilization.¹³ In CY 2017, the volume reductions for net decliners reached the highest level totaling \$211.2 million. Of note, \$83.2 million of the CY 2017 decline was related exclusively to reductions in ED utilization.

¹² See Appendix 4 for additional detail on General Surgery volume growth related to ICD-10 conversion.

¹³ In other words, 50 percent of the reductions were deemed market shifts and 50 percent were deemed avoided utilization – 0 percent avoided utilization + (50 percent market shift * 50 percent VCF) = 25 percent effective variable cost factor.

Analyzing the Market Shift in isolation would lead to a concern that hospitals with volume growth over the course of the All-Payer Model had been underfunded, potentially for medically necessary care, such as transcatheter aortic valve replacements (TAVR’s). However, it is important to also consider the funding provided by the Demographic Adjustment, which aims to prospectively fund utilization growth related to demographic changes while maintaining the incentives of the Model to reduce unnecessary utilization. When this funding source is considered all hospitals in aggregate from CY 2014 to CY 2017 have received adequate funding relative to a 50 percent variable cost factor, as can be seen below in the blue line on Table 6:

Table 6: Residual Funding Differences of In-State Volume CY14-CY17 Market Shift and Demographic Adjustment Relative to a 50 percent Variable Cost Factor*



*Excludes Holy Cross Germantown and does not account for special adjustments, e.g. Medicaid Expansion and Deregulation. Note: if all hospitals were funded at a 50 percent variable cost factor for changes in utilization each hospital on the graph would be equal to \$0.

While funding has been adequate for all hospitals over the course of the All-Payer Model, there are concerns that:

- a) The standard of a 50 percent variable cost factor are not met in each individual year for all hospitals with volume growth, thereby leading to potentially unfunded medically necessary care and a degree of unpredictability;

- b) The Market Shift methodology is difficult to interpret, most notably due to the large number of markets defined; and
- c) Hospitals with retained revenue at the far right of Table 6 do not require such a large share of the Demographic Adjustment when they have simultaneously retained 100 percent of revenue for utilization reductions that are not deemed market shifts.

Staff concurs with these concerns and is proposing to evaluate potential modifications to the Demographic Adjustment that will better anticipate use rate changes while maintaining its status as population based. Staff is also proposing to reduce the number of markets/cells the Market Shift evaluates to reduce its complexity. The details of this proposal will be discussed in the *Proposed Modifications to Market Shift* section.

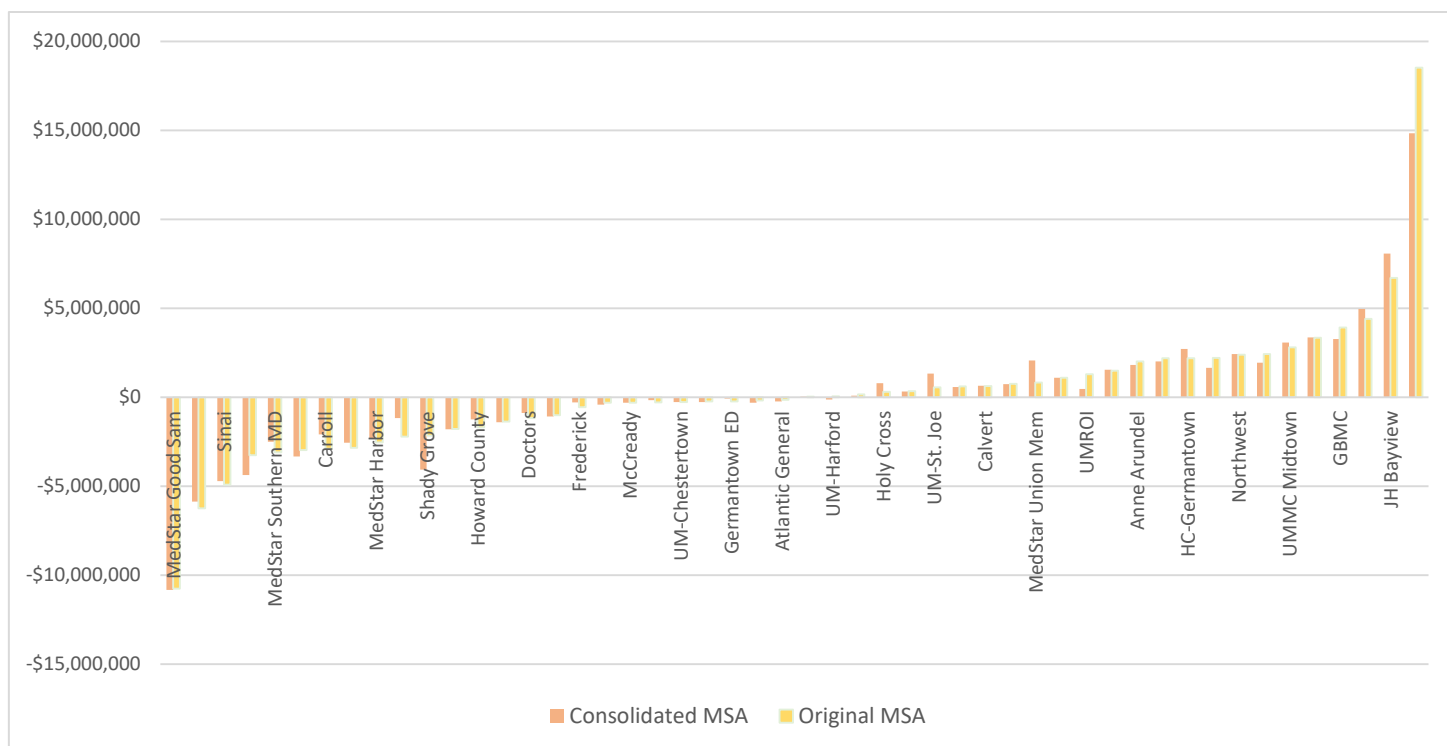
Market Shift Statistical Stability

As aforementioned, the Market Shift does evaluate a significant number of markets statewide - there are 60 hospital service lines¹⁴, over 350 geographies and potentially 20,000 markets. Critics of the Market Shift have noted that the vast amount of markets or cells leads to statistical instability, especially when comparing growth year over year at such a granular level.

To evaluate the statistical stability of the Market Shift, staff consolidated the algorithm such that market shift evaluations only occurred at the county level, i.e. zip code market shifts were eliminated from the calculation. If the market shift revenue adjustments did not materially change under a revised consolidation, staff hypothesized that the Market Shift was not statistically unstable. In Table 7, the results of the consolidated Market Shift versus the regular Market Shift for CY17 indicated that there was not a large degree of change in the revenue adjustments by hospital, especially in comparison to the hospital's overall revenue base.

¹⁴ For a complete list of service lines by APR-DRG or EAPG see Appendix 5.

Table 7: Market Shift Adjustments in Regular CY 2017 Market Shift versus Geographic Consolidated Market Shift



For most hospitals the consolidation of geographic cells did not materially change the market shift adjustment. The average dollar change was \$15,000; the absolute average dollar change was \$421,000. There were, however, various service lines that had a high degree of variation, which led to larger variances at the hospital level. For example, the market shift adjustment for the Ventilator Support service line at University of Maryland Medical Center decreased by \$1.2 million, approximately 1/3 of University's \$3.6 million variation in the two market shift calculations.

While the net hospital variation in market shift adjustments was not extremely large, staff was concerned that the change in dollar adjustments at the hospital level was not sufficient to conclude that the Market Shift is statistically stable. Thus, staff also ran additional analyses to determine the degree to which small cell sizes, e.g. less than 10 discharges per market, were correlated with changes in the consolidated and regular market shift adjustments at the service line level, i.e. random variation. Additionally, staff removed the influence large dollar value service lines can have on this analysis, because if a small dollar service line has random variation due to the statistical instability of the markets defined, it may be masked in a correlation analysis that looks solely at the absolute variation in terms of revenue. Therefore, staff ran the correlation of various small cell size indicators (less than 5, 10, 20 discharges per zip code) relative to service line absolute average dollar variation as a percentage of total service line charges.

Table 8: Correlation between Market Shift Service Line Dollar Variations between Market Shift Geographic Models & Small Cell Sizes

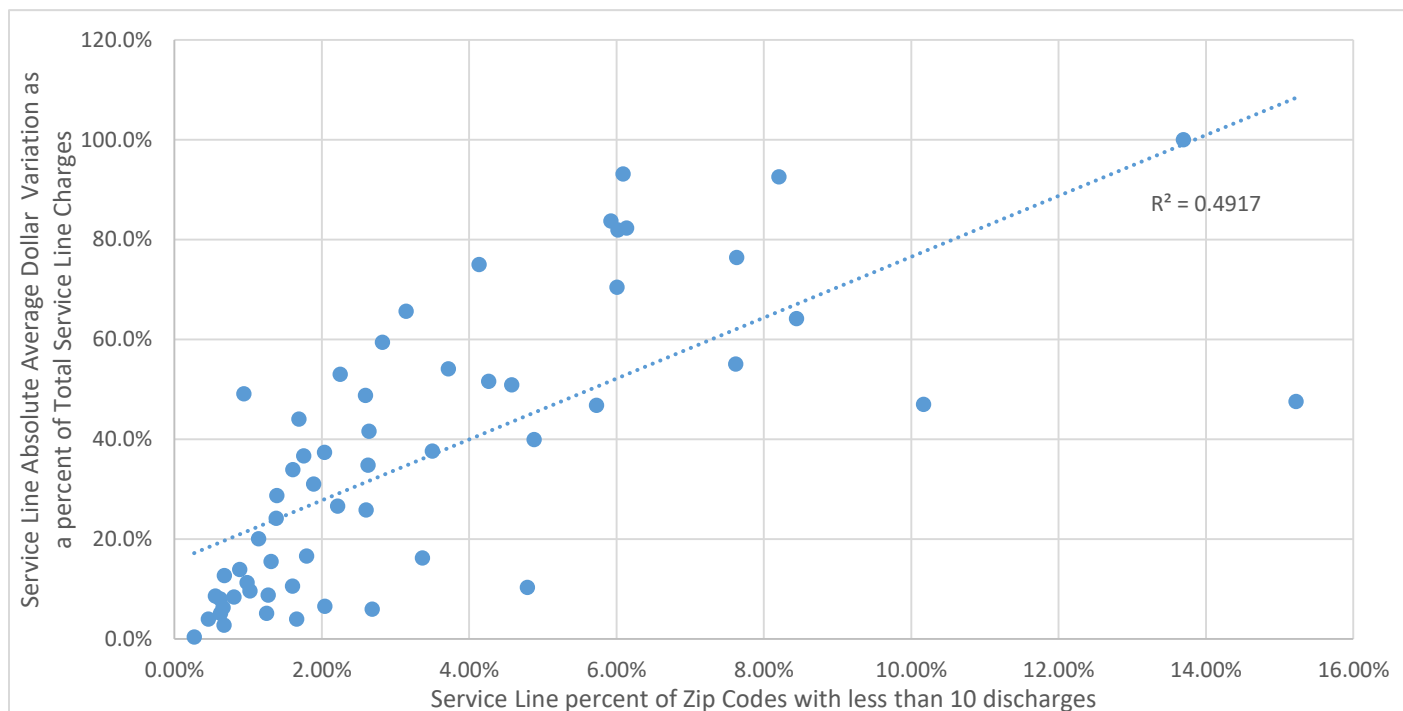


Table 8 indicates that there is indeed a strong relationship between markets with less than 10 discharges and variation between the two market shift calculations, as evidenced by a R^2 of .4917. The relationship becomes even stronger if inpatient and outpatient are evaluated independently of one another.¹⁵ Of note, the correlation to determine the random variation begins to break down beyond 10 discharges, suggesting this is the critical point by which cell size becomes unstable.

Due to these analyses and staff's concurrence that the Market Shift is inherently more difficult to interpret with the sheer size of markets defined, staff is putting forward two strategies to consolidate markets, namely to consolidate medical services in terms of clinical overlap and surgical and highly specialized services in terms of geography, all of which be discussed in the *Proposed Modifications to Market Shift* section.

Proposed Modifications to Market Shift

Staff proposes two core strategies to reduce the number of markets or cells in the market shift algorithm, namely:

- a) Collapsing medical services into similar service lines that have clinical overlap, similar average charges per equivalent casemix adjusted discharges (ECMADS), similar medical

¹⁵ The R2 for an inpatient only analysis is .6194 and for outpatient is .9429.

designations of APR-DRG’s or EAPG’s, and similar overrepresentation in emergency room rate center charges, which signifies less elective forms of care, and

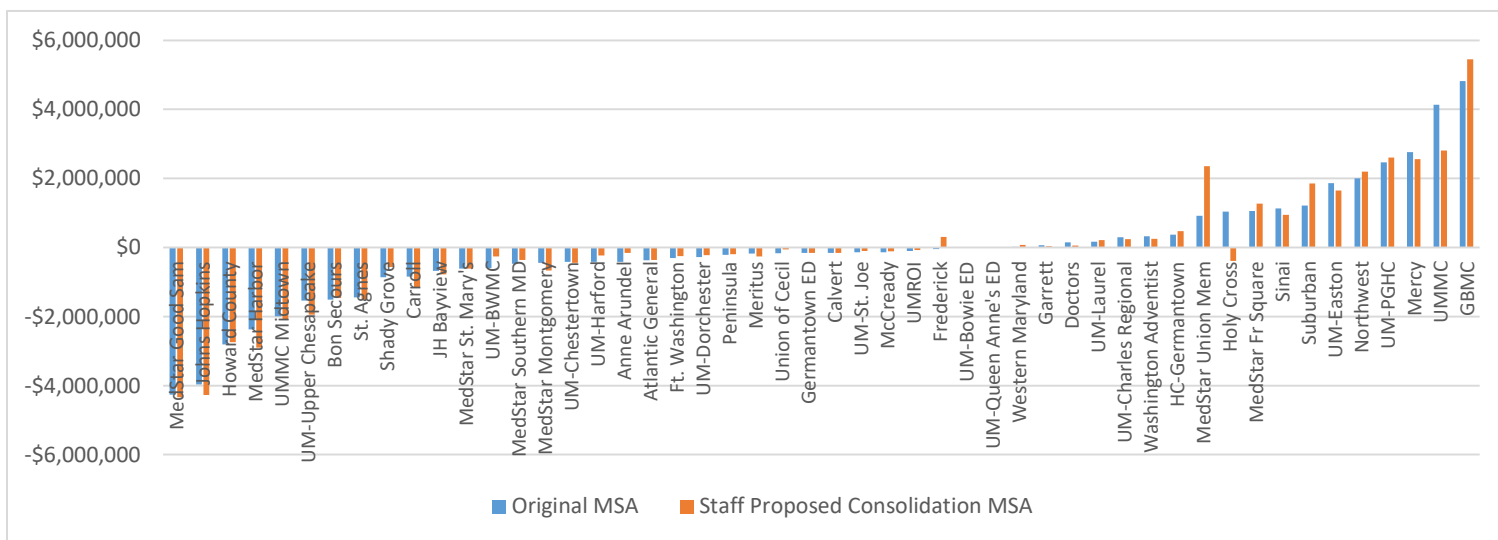
- b) Collapsing inpatient surgeries, outpatient major surgeries, and highly specialized services (e.g. ventilator support, neonatology) into county evaluated markets as opposed to zip code evaluated markets because these services represent more elective forms of care, or care that is referred based on the availability of specialized resources.

Employing the assistance of the Volume Methodology workgroup and a few clinical experts in the field, staff has put forward a plan that takes the number of services lines from 60 to 44 and perhaps more importantly takes 28 service lines from a zip code evaluation to a county evaluation. These changes reduce the Market Shift cells from potentially being in excess of 20,000 to approximately 5,000, and markets with less than 10 discharges (an indicator of a potentially unstable cell size) went from approximately 7,000 to 1,000.¹⁶

Various critics have noted that no markets should be evaluated on a zip code level and that the number of markets should be reduced further; however, staff is reluctant to pursue this course because further geographic consolidation of medical services, which often begin with a visit to the emergency room close to one’s residency regardless of hospital selection, can potentially lead to avoided utilization being treated as a market shift and vice versa.¹⁷

Based on the outline for consolidation in Appendix 6, staff has produced two runs of market shift for the first six months of calendar year 2018 (regular and consolidated) and two runs of unrecognized market shift. For the former, Table 9 outlines revenue adjustment variation in the two market shift models by hospital:

Table 9: Dollar Variation in CY 2018 Market Shift (six months) between Current Market Definitions and Staff Proposed Market Definitions



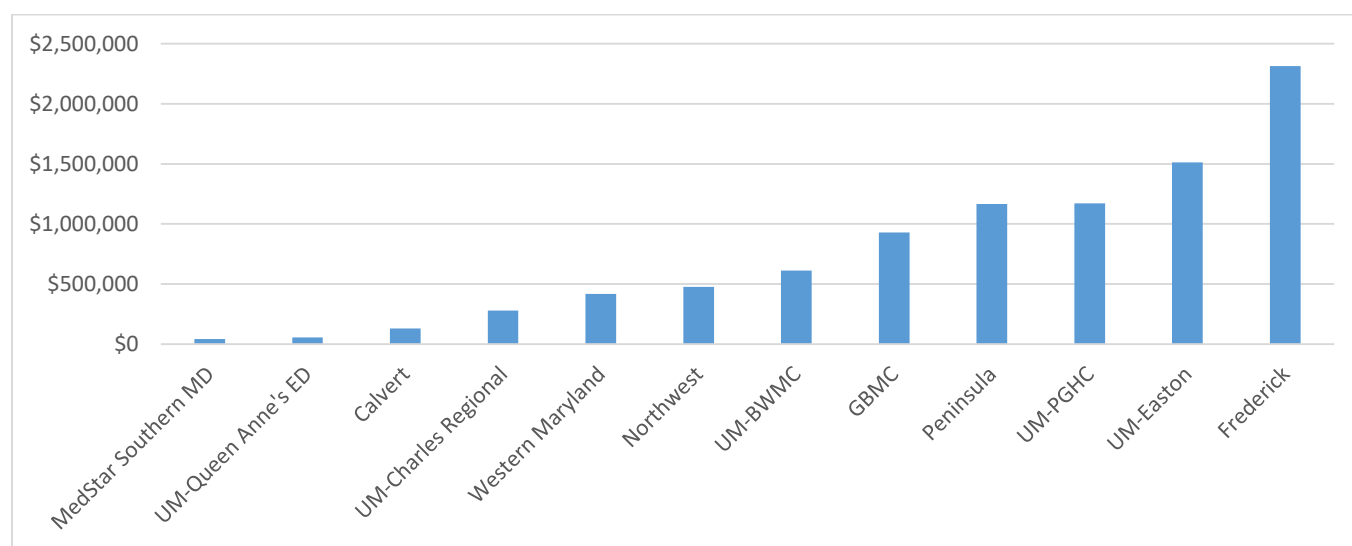
¹⁶ Please see Appendix 7 for the proposed consolidations by service line

¹⁷ Please see Appendix 8 for a hypothetical example of services being misconstrued as a market shift and vice versa.

While the dollar variation as shown in Table 9 is not significant by hospital, it is important to note that the average dollar change of \$7,000 was lower than the prior consolidation analysis and the absolute average dollar of \$225,000 was also lower, suggesting that simplifying Market Shift to have approximately 5,000 cells did not materially affect the outcome. Nevertheless, the changes did simplify the approach and reduce the number of small cells.

For the unrecognized market shift under the newly proposed Market Shift consolidation staff notes that unfunded growth statewide is \$9.1 million. See Table 10 for a break down by Hospital:

Table 10: CY 2018 (six months) Unfunded Growth by Hospital for all Service Lines



Of note, \$5.3 million of the \$9.1 million in unfunded growth is due to the Infectious Disease service line, which is usually indicative of seasonal flu spikes, and the \$9.1 million does not account for any additional funding provided by the Demographic Adjustment.

Additional Considerations for Future Policies

All methodologies, in particular volume methodologies, require revisions to improve their accuracy and effectiveness. Staff's recommendations to the Demographic Adjustment and the Market Shift are incremental steps to make the Commission's core volume policies simpler and more predictable. Going forward staff plans to work to improve these methodologies further by engaging a clinical subgroup to consider additional reductions to the number of defined markets/cells in the Market Shift methodology.

Staff will also consider other approaches to allocation of the Demographic Adjustment. One alternative considered is to incorporate the expectation of declines in medical volumes and avoidable utilization and increases in some surgical utilization by incorporating these expected

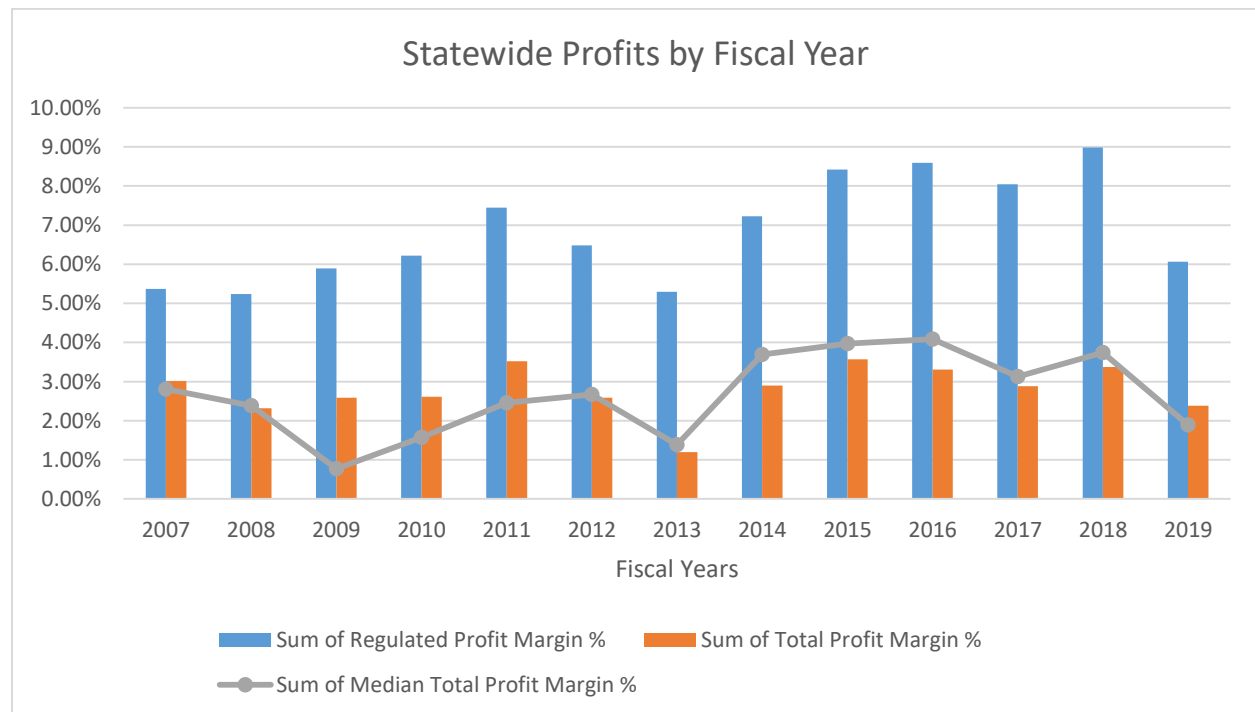
outcomes into the Demographic Adjustment on a service line basis. This would allow for a reallocation of the Demographic Adjustment based on the types of services being offered by each hospital, while not providing payment for actual volume changes. These and other options may be considered. The advantage of this option is that it would not create an incentive for volume growth. The disadvantage is that it does not recognize actual volume changes at each hospital. Staff has not modeled this option at the current time to see if it would address most stakeholder concerns regarding the allocation of the Demographic Adjustment.

Recommendations

Staff recommends the following updates to the current Commission Methodologies:

1. Consolidate defined markets in the Market Shift methodology by reducing service lines with clinical overlap and assessing inpatient surgery and other highly specialized services at a county level.
2. Establish a Workgroup to evaluate potential modifications to the Demographic Adjustment that will better anticipate use rate changes while maintaining its status as population based.

Appendix 1. Statewide Profit Analysis (RY 2007 – RY 2019 YTD)



Appendix 2. Demographic Adjustment Detailed Calculation Steps

This section provides the data sources used and a more detailed explanation of each step of the calculation.

Data Sources:

Volume estimates and total charges by age cohorts are calculated using HSCRC patient level inpatient and outpatient abstract data submitted on a monthly basis. All calculations involving volume and charges include only Maryland residents, determined by the reported billing zip code of the patient.

Zip code and age specific population estimates and projections were provided by Claritas for current year and 5-year population projections, since zip code level data are not available from the Department of State Planning.

Below are the detailed calculation steps:

STEP 1. Calculate base population estimates for each hospital based on its share of volume, as measured by equivalent case-mix adjusted discharges, in a given zip code/age cohort.

Step 1a: Calculate the base year total service volume of the hospital (inpatient and outpatient) for each zip code by each of the eight age cohorts based on Equivalent Case Mix Adjusted Discharges.

- i. Measure the volume of inpatient services as total inpatient case mix adjusted discharges (CMADs) that occurred in the specified fiscal year.
- ii. Measure the volume of outpatient services as follows:
 - a. Calculate the Hospital Unit Charge as the average charge per CMAD for all of the hospital's inpatients that occurred in the specified fiscal year.
 - b. Calculate the outpatient equivalent case mix adjusted discharges (ECMADs) as:

$$\text{Outpatient ECMAD} = \frac{\text{Total Charges} - \text{Inpatient Charges}}{\text{Hospital Unit Charge}}$$

- iii. Sum inpatient CMADs and Outpatient ECMADs to determine total service volume of the hospital ECMADs for each zip code and age cohort.

Step 1b: Allocate the base population for each zip/age cohort.

Use the proportion of each hospital's ECMAD volumes in each zip/age cohort divided by the total ECMADs for all hospitals in that zip/age cohort to allocate a proportion of the population in each zip code to each hospital.

Example:

For Hospital A and Zip/Age Cohort J the base population would be calculated as:

$$\text{Base Population}_{AJ} = \text{Population}_J * (\text{ECMAD}_{AJ} / \text{ECMAD}_J)$$

STEP 2: Calculate age adjusted population growth rates.

Step 2a: Calculate the statewide age cost weight for each age cohort.

Relative age cost weights are applied to a hospital's allocated population and population estimates to arrive at cost weighted populations for the base year and the projection year to account for the age-weighted growth in the population. Age specific hospital cost weights are calculated at the state level as the ratio of average total hospital charges per capita for each statewide age cohort to the statewide average hospital charge per capita in the base year. The total hospital charges include charges for Maryland residents only. This calculation is illustrated below for the statewide [5-14] age cohort.

$$\begin{aligned} & \text{Age Cost Weight for [5 to 14] Age Cohort} \\ &= \frac{\text{Total [5 to 14] Hospitals' Charges/Population in Base Year}}{\text{Total [All cohorts] Hospitals' Charges /Population in Base Year}} \end{aligned}$$

Step 2b: Calculate age adjusted growth rates.

For each zip/age cohort, the estimated population growth rates are multiplied by the age cost weights to determine the cost weighted population growth rates.

For a Zip/Age Cohort J and Age Weight [5 to 14];

$$\text{Age Adjusted Population Growth Rate} = \text{Population Growth Rate}_J * \text{Age-Weight [5 to 14]}$$

STEP 3: Calculate hospital overall age adjusted growth.

The age adjusted projected population related volume growth is calculated by multiplying base population numbers by age adjusted growth rates from Step 2 for each zip/age cohort. The overall hospital specific age adjusted growth rate is the sum of the allocated age adjusted population for the projection period divided by the age adjusted allocated population for the base period. This is converted to a percentage after subtracting 1.

For Hospital A and Zip/Age Cohort J and Age-Weight [5 to 14];

$$\text{Projected Population Growth} = \text{Base Population}_{AJ} * \text{Population Growth Rate}_J * \text{Age-Weight [5 to 14]}$$

Then overall Projected Population for Hospital A for all Zip/Age Cohorts = i....z:

$$\text{Overall Projected Population Growth Rate} = \frac{\text{Sum of (Projected Population Growth } i \dots z)}{\text{Sum of (Base Population } i \dots z)}$$

STEP 4: Calculate the appropriate volume growth by applying efficiency adjustments.

Step 4a: Reduce age adjusted overall projected growth by hospital specific overall PAU percentage of revenue.

The overall growth rate calculated in Step 3 is reduced by the PAU percentage of revenue that is calculated on a hospital specific basis by multiplying the growth rate by the PAU percentage of revenue. The policy result is that the hospital will not receive a demographic adjustment on any of its PAU revenues, which includes revenue from avoidable admissions, 30-day readmissions, observation or emergency department visits, as well as revenue from complications (see below for additional information). PAU percentages of revenue are calculated at the hospital specific level by calculating the ratio of PAU revenue divided by total hospital revenue.

Step 4b: Reduce the PAU adjusted growth percentage for each hospital to achieve an allowance for demographic growth statewide that is lower than the overall growth allowed by the All-Payer Model.

The All-Payer Model provides for per capita growth, without any explicit adjustment for aging of the population. The preliminary result of Step 4a provides a demographic factor for each hospital that includes an age adjustment and that has been reduced by a measure of potentially avoidable utilization. Without further adjustment, the age and PAU adjusted demographic factor statewide would produce an allowance for growth that is above the statewide allowance for growth in population. Therefore, an additional efficiency adjustment reduction percentage is applied to each hospital's age and PAU adjusted growth percentage to bring the allowance statewide to a level within the overall population increase percentage provided by the Model. For example, if the age and PAU adjusted allowance were 1.2percent but the target population allowance was .6percent, then all hospitals would receive an additional efficiency adjustment of 50percent. This adjustment recognizes the ability to provide incremental volumes at a lower marginal cost or to further reduce avoidable volume to achieve the needed efficiency level of the per capita model.

Final Demographic Percentage: At the conclusion of Step 4b, the final demographic adjustment percentage has been calculated for each hospital in the State. After adding 1 to the percentage, this demographic growth rate is multiplied by each hospital's approved revenue from the base year to arrive at the population adjusted revenue for the target year.

[Appendix 3. Geographic and Service Line Definition Discussion](#)

Geographic Area Definitions

Market shift is focused on movement of patients and services between Maryland hospitals. Narrowly defined geographic regions are better for calculating market shift, especially for emergency medical service lines, because the individual hospitals serving the region are not likely to be differentially impacted by population growth or demographically driven changes in utilization rates. However, defining markets too narrowly may result in shifts not being recognized by the MSA. Calculating market shift at the statewide level, in contrast, would result

in the movement of dollars to hospitals in regions experiencing population growth at the expense of other regions.

In densely populated regions of the state where there is significant competition among hospitals, market shift calculations are currently performed at the ZIP code level for all services. However, ZIP code level calculations introduce random variation to the measurement in small geographic areas where the population density is low, and the health care market is concentrated. Such ZIP codes are aggregated to limit the impact of small cell sizes on the calculations. ZIP codes in the following jurisdictions are aggregated at the county level:

Garrett, Allegany, Washington, Cecil, Kent, Queen Anne's, Caroline, Talbot, Dorchester, Wicomico, Somerset, Calvert, Charles, Saint Mary's, Worcester

Random variation has not been entirely addressed by aggregating rural regions into county level markets. Thus, staff will discuss in the Volume Assessment section the concern about small cell sizes and the continuance of random variation in current MSA's. Staff will propose to consolidate geographies further for specialized services that are more elective in nature and to also consolidate service lines with clinical overlap.

In calculating market shifts, all hospitals will still have the same geographic definitions. For example, to calculate volume changes in Garrett County, all ZIP codes in Garrett County will be added together for each hospital with volume in Garrett County. The calculations of volume changes will be based on ZIP code-level analysis for the remaining jurisdictions and service lines that are not aggregated, such as Baltimore City emergency room services.

Service Line Definitions

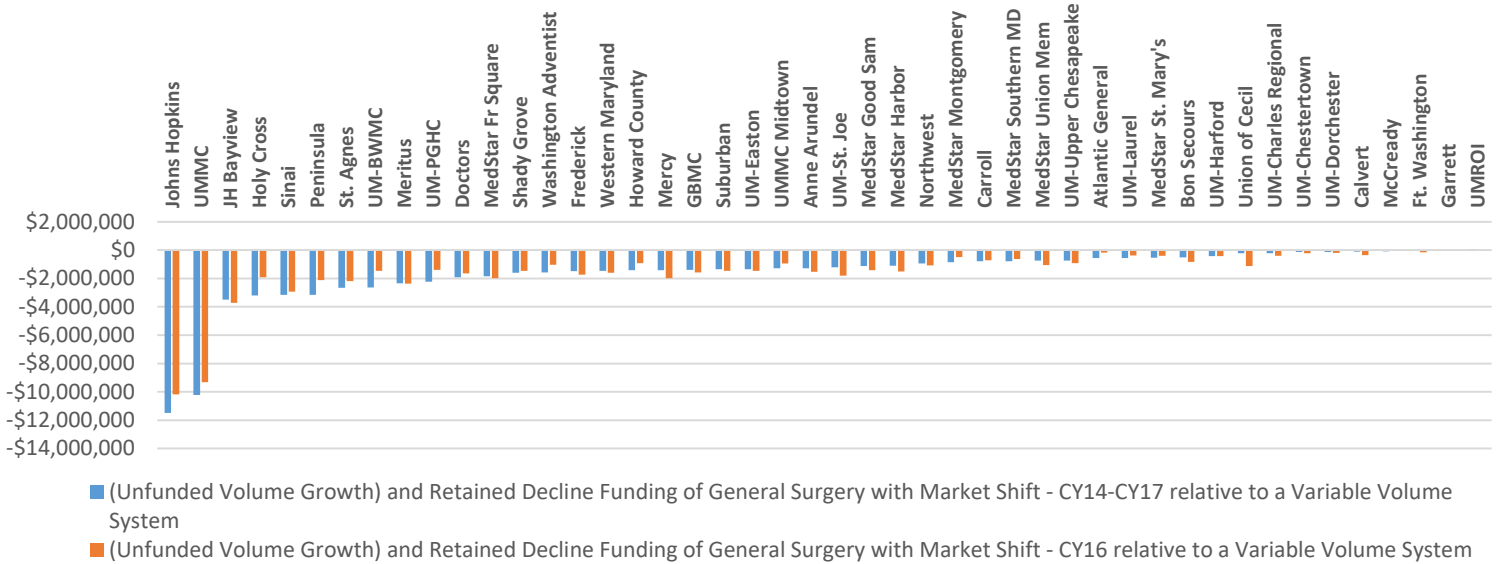
Narrow definitions of service lines were proposed to prevent utilization growth for one component of the service line from masking a shift in patients for another service line. For instance, a service line that captures all surgical procedures might be growing at every hospital in a region due to increasing demand for orthopedic surgery and thereby masking the shift of 50 cardiac surgical procedures from one hospital to another.

Movement of cases from inpatient to outpatient settings and utilization of observation units creates a challenge in differentiating shifts from one hospital to another, or shifts from a hospital's inpatient to outpatient service settings. Staff addressed this issue by counting and weighting all observation room cases of 24 or more hours as inpatient and more recently has started moving outpatient services to inpatient if that service was removed from Medicare's inpatient only list, e.g. total knee arthroplasties.

Inpatient service lines are developed using the existing 3M methodology to group all patient refined-diagnosis related groups (APR-DRGs) to specific service lines with a few modifications. See Appendix 3 in for a cross walk of APR-DRGs to service lines. Staff uses an inpatient-like logic and assigns outpatient visits based on the reasons for acquiring services. For example, all services provided for emergency department (ED) patients are grouped under the ED service line. Appendix 5 provides the hierarchy of outpatient service lines.

Appendix 4 General Surgery ICD-10 Conversion Analyses

Residual Funding of In-State General Surgery Volume Growth and Declines at a 50percent variable revenue factor for CY14-CY17 after applying Market Shift Adjstment only



2015 to 2015 General Surgery Growth by Unique APR-DRG's

APR-DRG Description	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	CMI % Change 2015-2015
	Case Growth (Q1-Q2)	Case Growth (Q2-Q3)	Case Growth (Q3-Q4)	Case Growth (Q4-Q1)	Case Growth (Q1-Q2)	Case Growth (Q2- Q3)	Case Growth (Q3-Q4)	Case Growth (2015-2016)	
Extensive procedure unrelated to principal diagnosis Infectious & parasitic diseases including HIV w O.R. procedure	-5	2	79	34	4	-20	6	350	-14.75%
Laparoscopic cholecystectomy	-38	52	189	31	-54	138	-3	868	-2.61%
Major biliary tract procedures	-35	58	-88	71	-5	52	-32	158	-0.47%
Major stomach, esophageal & duodenal procedures	-2	12	26	-4	26	-10	26	168	-11.65%
Nonextensive procedure unrelated to principal diagnosis	23	13	59	18	-19	31	-107	196	-15.13%
Other digestive system & abdominal procedures	-26	5	60	11	-19	22	1	196	-6.80%
Other hepatobiliary, pancreas & abdominal procedures	-1	1	73	-3	-3	32	-24	239	-4.07%
Other male reproductive system & related procedures	6	10	93	23	-3	13	-4	410	-17.93%
Other skin, subcutaneous tissue & related procedures	-16	8	93	2	24	-35	-5	284	-8.67%
Other small & large bowel procedures	-2	16	103	1	2	31	-22	389	-4.80%
Procedure w diag of rehab, aftercare or oth contact w health service	17	-1	102	13	-10	-43	21	278	-9.36%
Skin graft for skin & subcutaneous tissue diagnoses	-3	1	114	-30	-38	12	21	152	-7.31%
Total	-94	198	970	137	-80	197	-124	3,790	-4.87%

ICD-10 Conversion time period

Appendix 5. APR-DRG and EAPG Service Line Mapping

a. APR-DRG Service Line Map

APR_DRG	DRG_Description	Type	Old_Serviceline	New_Serviceline
0	TOTAL KNEE REPLACEMENT (FROM OUTPATIENT)	S	Major Surgery_TKA	Orthopedic Surgery
1	LIVER TRANSPLANT &/OR INTESTINAL TRANSPLANT	S	Transplant Surgery	Transplant Surgery
2	HEART &/OR LUNG TRANSPLANT	S	Transplant Surgery	Transplant Surgery
4	TRACHEOSTOMY W MV 96+ HOURS W EXTENSIVE PROCEDURE	S	Ventilator Support	Ventilator Support
5	TRACHEOSTOMY W MV 96+ HOURS W/O EXTENSIVE PROCEDURE	S	Ventilator Support	Ventilator Support
6	PANCREAS TRANSPLANT	S	Transplant Surgery	Transplant Surgery
7	ALLOGENEIC BONE MARROW TRANSPLANT	S	Transplant Surgery	Transplant Surgery
8	AUTOLOGOUS BONE MARROW TRANSPLANT	S	Transplant Surgery	Transplant Surgery
9	EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	S	Ventilator Support	Ventilator Support
10	HEAD TRAUMA WITH DEEP COMA	M	Trauma	Trauma
20	CRANIOTOMY FOR TRAUMA	S	Neurological Surgery	Neurological Surgery
21	CRANIOTOMY EXCEPT FOR TRAUMA	S	Neurological Surgery	Neurological Surgery
22	VENTRICULAR SHUNT PROCEDURES	S	Neurological Surgery	Neurological Surgery
23	SPINAL PROCEDURES	S	Spinal Surgery	Spinal Surgery
24	EXTRACRANIAL VASCULAR PROCEDURES	S	Neurological Surgery	Neurological Surgery
26	OTHER NERVOUS SYSTEM & RELATED PROCEDURES	S	Neurological Surgery	Neurological Surgery
40	SPINAL DISORDERS & INJURIES	M	Neurology	Neurology
41	NERVOUS SYSTEM MALIGNANCY	M	Oncology	Oncology
42	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS	M	Neurology	Neurology
43	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES	M	Neurology	Neurology
44	INTRACRANIAL HEMORRHAGE	M	Neurology	Neurology
45	CVA & PRECEREBRAL OCCLUSION W INFARCT	M	Neurology	Neurology
46	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	M	Neurology	Neurology
47	TRANSIENT ISCHEMIA	M	Neurology	Neurology

48	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS	M	Neurology	Neurology
49	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	M	Infectious Disease	Infectious Disease
50	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS	M	Infectious Disease	Infectious Disease
51	VIRAL MENINGITIS	M	Infectious Disease	Infectious Disease
52	ALTERATION IN CONSCIOUSNESS	M	Neurology	Neurology
53	SEIZURE	M	Neurology	Neurology
54	MIGRAINE & OTHER HEADACHES	M	Neurology	Neurology
55	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE	M	Neurology	Neurology
56	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR OR NO COMA	M	Neurology	Neurology
57	CONCUSSION, CLOSED SKULL FX NOS, UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA	M	Neurology	Neurology
58	OTHER DISORDERS OF NERVOUS SYSTEM	M	Neurology	Neurology
59	ANOXIC & OTHER SEVERE BRAIN DAMAGE	M	Neurology	Neurology
73	ORBIT AND EYE PROCEDURES	S	Ophthalmologic Surg	Ophthalmologic Surg
82	EYE INFECTIONS AND OTHER EYE DISORDERS	M	Ophthalmology	Ophthalmology
89	MAJOR CRANIAL/FACIAL BONE PROCEDURES	S	ENT Surgery	ENT Surgery
91	OTHER MAJOR HEAD & NECK PROCEDURES	S	ENT Surgery	ENT Surgery
92	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES	S	ENT Surgery	ENT Surgery
95	CLEFT LIP & PALATE REPAIR	S	ENT Surgery	ENT Surgery
97	TONSIL & ADENOID PROCEDURES	S	ENT Surgery	ENT Surgery
98	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES	S	ENT Surgery	ENT Surgery
110	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES	M	Oncology	Oncology
111	VERTIGO & OTHER LABYRINTH DISORDERS	M	Otolaryngology	General Medicine
113	INFECTIONS OF UPPER RESPIRATORY TRACT	M	Otolaryngology	General Medicine
114	DENTAL DISEASES AND DISORDERS	M	Dental	General Medicine
115	OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES	M	Otolaryngology	General Medicine

120	MAJOR RESPIRATORY & CHEST PROCEDURES	S	Thoracic Surgery	Thoracic Surgery
121	OTHER RESPIRATORY & CHEST PROCEDURES	S	Thoracic Surgery	Thoracic Surgery
130	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	M	Pulmonary	Pulmonary
131	CYSTIC FIBROSIS - PULMONARY DISEASE	M	Pulmonary	Pulmonary
132	BPD & OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATAL PERIOD	M	Neonatology	Neonatology
133	RESPIRATORY FAILURE	M	Pulmonary	Pulmonary
134	PULMONARY EMBOLISM	M	Pulmonary	Pulmonary
135	MAJOR CHEST & RESPIRATORY TRAUMA	M	Trauma	Trauma
136	RESPIRATORY MALIGNANCY	M	Oncology	Oncology
137	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS	M	Pulmonary	Pulmonary
138	BRONCHIOLITIS & RSV PNEUMONIA	M	Pulmonary	Pulmonary
139	OTHER PNEUMONIA	M	Pulmonary	Pulmonary
140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	M	Pulmonary	Pulmonary
141	ASTHMA	M	Pulmonary	Pulmonary
142	INTERSTITIAL & ALVEOLAR LUNG DISEASES	M	Pulmonary	Pulmonary
143	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES	M	Pulmonary	Pulmonary
144	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES	M	Pulmonary	Pulmonary
145	ACUTE BRONCHITIS AND RELATED SYMPTOMS	M	Pulmonary	Pulmonary
160	MAJOR CARDIOTHORACIC REPAIR OF HEART ANOMALY	S	Cardiothoracic Surgery	Cardiothoracic Surgery
161	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT	S	Cardiothoracic Surgery	Cardiothoracic Surgery
162	CARDIAC VALVE PROCEDURES W AMI OR COMPLEX PDX	S	Cardiothoracic Surgery	Cardiothoracic Surgery
163	CARDIAC VALVE PROCEDURES W/O AMI OR COMPLEX PDX	S	Cardiothoracic Surgery	Cardiothoracic Surgery
165	CORONARY BYPASS W AMI OR COMPLEX PDX	S	Cardiothoracic Surgery	Cardiothoracic Surgery
166	CORONARY BYPASS W/O AMI OR COMPLEX PDX	S	Cardiothoracic Surgery	Cardiothoracic Surgery
167	OTHER CARDIOTHORACIC & THORACIC VASCULAR PROCEDURES	S	Cardiothoracic Surgery	Cardiothoracic Surgery
169	MAJOR ABDOMINAL VASCULAR PROCEDURES	S	Vascular Surgery	Vascular Surgery

170	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	S	EP/Chronic Rhythm Mgmt	Invasive Cardiology
171	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK	S	EP/Chronic Rhythm Mgmt	Invasive Cardiology
174	PERCUTANEOUS CORONARY INTERVENTION W AMI	S	Invasive Cardiology	Invasive Cardiology
175	PERCUTANEOUS CORONARY INTERVENTION W/O AMI	S	Invasive Cardiology	Invasive Cardiology
176	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT	S	EP/Chronic Rhythm Mgmt	Invasive Cardiology
177	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT	S	EP/Chronic Rhythm Mgmt	Invasive Cardiology
180	OTHER CIRCULATORY SYSTEM PROCEDURES	S	Cardiothoracic Surgery	Cardiothoracic Surgery
181	LOWER EXTREMITY ARTERIAL PROCEDURES	S	Vascular Surgery	Vascular Surgery
182	OTHER PERIPHERAL VASCULAR PROCEDURES	S	Vascular Surgery	Vascular Surgery
190	ACUTE MYOCARDIAL INFARCTION	M	Myocardial Infarction	Cardiology
191	CARDIAC CATHETERIZATION FOR CORONARY ARTERY DISEASE	M	Invasive Cardiology	Invasive Cardiology
192	CARDIAC CATHETERIZATION FOR OTHER NON-CORONARY CONDITIONS	M	Invasive Cardiology	Invasive Cardiology
193	ACUTE & SUBACUTE ENDOCARDITIS	M	Cardiology	Cardiology
194	HEART FAILURE	M	Cardiology	Cardiology
196	CARDIAC ARREST & SHOCK	M	Cardiology	Cardiology
197	PERIPHERAL & OTHER VASCULAR DISORDERS	M	General Medicine	General Medicine
198	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	M	Cardiology	Cardiology
199	HYPERTENSION	M	Cardiology	Cardiology
200	CARDIAC STRUCTURAL & VALVULAR DISORDERS	M	Cardiology	Cardiology
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	M	Cardiology	Cardiology
203	CHEST PAIN	M	Cardiology	Cardiology
204	SYNCOPE & COLLAPSE	M	Cardiology	Cardiology
205	CARDIOMYOPATHY	M	Cardiology	Cardiology
206	MALFUNCTION,REACTION,COMPLICATION OF CARDIAC/VASC DEVICE OR PROCEDURE	M	Cardiology	Cardiology
207	OTHER CIRCULATORY SYSTEM DIAGNOSES	M	Cardiology	Cardiology
220	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	S	General Surgery	General Surgery

222	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	S	General Surgery	General Surgery
223	OTHER SMALL & LARGE BOWEL PROCEDURES	S	General Surgery	General Surgery
224	PERITONEAL ADHESIOLYSIS	S	General Surgery	General Surgery
226	ANAL PROCEDURES	S	General Surgery	General Surgery
227	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL	S	General Surgery	General Surgery
228	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES	S	General Surgery	General Surgery
229	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES	S	General Surgery	General Surgery
230	MAJOR SMALL BOWEL PROCEDURES	S	General Surgery	General Surgery
231	MAJOR LARGE BOWEL PROCEDURES	S	General Surgery	General Surgery
232	GASTRIC FUNDOPLICATION	S	General Surgery	General Surgery
233	APPENDECTOMY WITH COMPLEX PRINCIPAL DIAGNOSIS	S	General Surgery	General Surgery
234	APPENDECTOMY WITHOUT COMPLEX PRINCIPAL DIAGNOSIS	S	General Surgery	General Surgery
240	DIGESTIVE MALIGNANCY	M	Oncology	Oncology
241	PEPTIC ULCER & GASTRITIS	M	Gastroenterology	Gastroenterology
242	MAJOR ESOPHAGEAL DISORDERS	M	Gastroenterology	Gastroenterology
243	OTHER ESOPHAGEAL DISORDERS	M	Gastroenterology	Gastroenterology
244	DIVERTICULITIS & DIVERTICULOSIS	M	Gastroenterology	Gastroenterology
245	INFLAMMATORY BOWEL DISEASE	M	Gastroenterology	Gastroenterology
246	GASTROINTESTINAL VASCULAR INSUFFICIENCY	M	Gastroenterology	Gastroenterology
247	INTESTINAL OBSTRUCTION	M	Gastroenterology	Gastroenterology
248	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS	M	Gastroenterology	Gastroenterology
249	OTHER GASTROENTERITIS, NAUSEA & VOMITING	M	Gastroenterology	Gastroenterology
251	ABDOMINAL PAIN	M	Gastroenterology	Gastroenterology
252	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE	M	Gastroenterology	Gastroenterology
253	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE	M	Gastroenterology	Gastroenterology

254	OTHER DIGESTIVE SYSTEM DIAGNOSES	M	Gastroenterology	Gastroenterology
260	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	S	General Surgery	General Surgery
261	MAJOR BILIARY TRACT PROCEDURES	S	General Surgery	General Surgery
263	CHOLECYSTECTOMY	S	General Surgery	General Surgery
264	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES	S	General Surgery	General Surgery
279	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS	M	Gastroenterology	Gastroenterology
280	ALCOHOLIC LIVER DISEASE	M	Gastroenterology	Gastroenterology
281	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS	M	Oncology	Oncology
282	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	M	Gastroenterology	Gastroenterology
283	OTHER DISORDERS OF THE LIVER	M	Gastroenterology	Gastroenterology
284	DISORDERS OF GALLBLADDER & BILIARY TRACT	M	Gastroenterology	Gastroenterology
301	HIP JOINT REPLACEMENT	S	Orthopedic Surgery	Orthopedic Surgery
302	KNEE JOINT REPLACEMENT	S	Orthopedic Surgery	Orthopedic Surgery
303	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK	S	Orthopedic Surgery	Orthopedic Surgery
304	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK	S	Orthopedic Surgery	Orthopedic Surgery
305	AMPUTATION OF LOWER LIMB EXCEPT TOES	S	Orthopedic Surgery	Orthopedic Surgery
308	HIP & FEMUR FRACTURE REPAIR	S	Orthopedic Surgery	Orthopedic Surgery
309	OTHER SIGNIFICANT HIP & FEMUR SURGERY	S	Orthopedic Surgery	Orthopedic Surgery
310	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION	S	Orthopedic Surgery	Orthopedic Surgery
312	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES	S	Orthopedic Surgery	Orthopedic Surgery
313	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT	S	Orthopedic Surgery	Orthopedic Surgery
314	FOOT & TOE PROCEDURES	S	Orthopedic Surgery	Orthopedic Surgery
315	SHOULDER, UPPER ARM & FOREARM PROCEDURES EXCEPT JOINT REPLACEMENT	S	Orthopedic Surgery	Orthopedic Surgery

316	HAND & WRIST PROCEDURES	S	Orthopedic Surgery	Orthopedic Surgery
317	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES	S	Orthopedic Surgery	Orthopedic Surgery
320	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES	S	Orthopedic Surgery	Orthopedic Surgery
321	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP	S	Spinal Surgery	Spinal Surgery
322	SHOULDER & ELBOW JOINT REPLACEMENT	S	Orthopedic Surgery	Orthopedic Surgery
340	FRACTURE OF FEMUR	M	Orthopedics	General Medicine
341	FRACTURE OF PELVIS OR DISLOCATION OF HIP	M	Orthopedics	General Medicine
342	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK	M	Orthopedics	General Medicine
343	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG	M	Oncology	Oncology
344	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS	M	Infectious Disease	Infectious Disease
346	CONNECTIVE TISSUE DISORDERS	M	Rheumatology	General Medicine
347	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES	M	Orthopedics	General Medicine
349	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE	M	Orthopedics	General Medicine
351	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	M	Rheumatology	General Medicine
361	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES	S	General Surgery	General Surgery
362	MASTECTOMY PROCEDURES	S	General Surgery	General Surgery
363	BREAST PROCEDURES EXCEPT MASTECTOMY	S	General Surgery	General Surgery
364	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES	S	General Surgery	General Surgery
380	SKIN ULCERS	M	Dermatology	General Medicine
381	MAJOR SKIN DISORDERS	M	Dermatology	General Medicine
382	MALIGNANT BREAST DISORDERS	M	Oncology	Oncology
383	CELLULITIS & OTHER SKIN INFECTIONS	M	Infectious Disease	Infectious Disease
384	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE	M	Dermatology	General Medicine

385	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS	M	Dermatology	General Medicine
401	ADRENAL PROCEDURES	S	Endocrinology Surgery	Endocrinology Surgery
403	PROCEDURES FOR OBESITY	S	Endocrinology Surgery	Endocrinology Surgery
404	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES	S	Endocrinology Surgery	Endocrinology Surgery
405	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS	S	Endocrinology Surgery	Endocrinology Surgery
420	DIABETES	M	Diabetes	General Medicine
421	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS	M	Endocrinology	General Medicine
422	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS	M	Endocrinology	General Medicine
423	INBORN ERRORS OF METABOLISM	M	Endocrinology	General Medicine
424	OTHER ENDOCRINE DISORDERS	M	Endocrinology	General Medicine
425	OTHER NON-HYPOVOLEMIC ELECTROLYTE DISORDERS	M	Endocrinology	General Medicine
426	NON-HYPOVOLEMIC SODIUM DISORDERS	M	Endocrinology	General Medicine
427	THYROID DISORDERS	M	Endocrinology	General Medicine
440	KIDNEY TRANSPLANT	S	Transplant Surgery	Transplant Surgery
441	MAJOR BLADDER PROCEDURES	S	Urological Surgery	Urological Surgery
442	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY	S	Oncology	Oncology
443	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY	S	Urological Surgery	Urological Surgery
444	RENAL DIALYSIS ACCESS DEVICE AND VESSEL REPAIR	S	Urological Surgery	Urological Surgery
445	OTHER BLADDER PROCEDURES	S	Urological Surgery	Urological Surgery
446	URETHRAL & TRANSURETHRAL PROCEDURES	S	Urological Surgery	Urological Surgery
447	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES	S	Urological Surgery	Urological Surgery
461	KIDNEY & URINARY TRACT MALIGNANCY	M	Oncology	Oncology
462	NEPHRITIS & NEPHROSIS	M	Nephrology	General Medicine
463	KIDNEY & URINARY TRACT INFECTIONS	M	Nephrology	General Medicine

465	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION	M	Urology	Urology
466	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC	M	Nephrology	General Medicine
468	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	M	Nephrology	General Medicine
469	ACUTE KIDNEY INJURY	M	Nephrology	General Medicine
470	CHRONIC KIDNEY DISEASE	M	Nephrology	General Medicine
480	MAJOR MALE PELVIC PROCEDURES	S	Urological Surgery	Urological Surgery
482	TRANSURETHRAL PROSTATECTOMY	S	Urological Surgery	Urological Surgery
483	PENIS, TESTES & SCROTAL PROCEDURES	S	Urological Surgery	Urological Surgery
484	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES	S	General Surgery	General Surgery
500	MALIGNANCY, MALE REPRODUCTIVE SYSTEM	M	Oncology	Oncology
501	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY	M	Urology	Urology
510	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS	S	Gynecological Surg	Gynecological Surg
511	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY	S	Oncology	Oncology
512	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG	S	Oncology	Oncology
513	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA	S	Gynecological Surg	Gynecological Surg
514	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	S	Gynecological Surg	Gynecological Surg
517	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES	S	Gynecological Surg	Gynecological Surg
518	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES	S	Gynecological Surg	Gynecological Surg
519	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA	S	Gynecological Surg	Gynecological Surg
530	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY	M	Oncology	Oncology
531	FEMALE REPRODUCTIVE SYSTEM INFECTIONS	M	Gynecology	OB/GYN
532	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	M	Gynecology	OB/GYN
540	CESAREAN DELIVERY	S	Obstetrics/Delivery	OB/GYN

541	VAGINAL DELIVERY W STERILIZATION &/OR D&C	S	Obstetrics/Delivery	OB/GYN
542	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C	S	Obstetrics/Delivery	OB/GYN
544	D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY FOR OBSTETRIC DIAGNOSES	S	Other Obstetrics	OB/GYN
545	ECTOPIC PREGNANCY PROCEDURE	S	Gynecological Surg	Gynecological Surg
546	OTHER O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES	S	Other Obstetrics	OB/GYN
560	VAGINAL DELIVERY	M	Obstetrics/Delivery	OB/GYN
561	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	M	Other Obstetrics	OB/GYN
563	PRETERM LABOR	M	Other Obstetrics	OB/GYN
564	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	M	Other Obstetrics	OB/GYN
565	FALSE LABOR	M	Other Obstetrics	OB/GYN
566	OTHER ANTEPARTUM DIAGNOSES	M	Other Obstetrics	OB/GYN
580	NEONATE, TRANSFERRED <5 DAYS OLD, NOT BORN HERE	M	Neonatology	Neonatology
581	NEONATE, TRANSFERRED < 5 DAYS OLD, BORN HERE	M	Neonatology	Neonatology
583	NEONATE W ECMO	S	Neonatology	Neonatology
588	NEONATE BWT <1500G W MAJOR PROCEDURE	S	Neonatology	Neonatology
589	NEONATE BWT <500G OR GA <24 WEEKS	M	Neonatology	Neonatology
591	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE	M	Neonatology	Neonatology
593	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE	M	Neonatology	Neonatology
602	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	M	Neonatology	Neonatology
603	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION	M	Neonatology	Neonatology
607	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	M	Neonatology	Neonatology
608	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION	M	Neonatology	Neonatology
609	NEONATE BWT 1500-2499G W MAJOR PROCEDURE	S	Neonatology	Neonatology
611	NEONATE BIRTHWT 1500-1999G W MAJOR ANOMALY	M	Neonatology	Neonatology

612	NEONATE BWT 1500-1999G W RESP DIST SYND/OTH MAJ RESP COND	M	Neonatology	Neonatology
613	NEONATE BIRTHWT 1500-1999G W CONGENITAL/PERINATAL INFECTION	M	Neonatology	Neonatology
614	NEONATE BWT 1500-1999G W OR W/O OTHER SIGNIFICANT CONDITION	M	Neonatology	Neonatology
621	NEONATE BWT 2000-2499G W MAJOR ANOMALY	M	Neonatology	Neonatology
622	NEONATE BWT 2000-2499G W RESP DIST SYND/OTH MAJ RESP COND	M	Neonatology	Neonatology
623	NEONATE BWT 2000-2499G W CONGENITAL/PERINATAL INFECTION	M	Neonatology	Neonatology
625	NEONATE BWT 2000-2499G W OTHER SIGNIFICANT CONDITION	M	Neonatology	Neonatology
626	NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	M	Neonatology	Neonatology
630	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE	S	Neonatology	Neonatology
631	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE	S	Neonatology	Neonatology
633	NEONATE BIRTHWT >2499G W MAJOR ANOMALY	M	Neonatology	Neonatology
634	NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND	M	Neonatology	Neonatology
636	NEONATE BIRTHWT >2499G W CONGENITAL/PERINATAL INFECTION	M	Neonatology	Neonatology
639	NEONATE BIRTHWT >2499G W OTHER SIGNIFICANT CONDITION	M	Neonatology	Neonatology
640	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	M	Normal Newborn	Neonatology
650	SPLENECTOMY	S	General Surgery	General Surgery
651	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS	S	General Surgery	General Surgery
660	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL	M	Hematology	Hematology
661	COAGULATION & PLATELET DISORDERS	M	Hematology	Hematology
662	SICKLE CELL ANEMIA CRISIS	M	Hematology	Hematology
663	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS	M	Hematology	Hematology
680	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS	S	General Surgery	General Surgery
681	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS	S	General Surgery	General Surgery

690	ACUTE LEUKEMIA	M	Oncology	Oncology
691	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA	M	Oncology	Oncology
692	RADIOTHERAPY	M	Oncology	Oncology
694	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR	M	Oncology	Oncology
695	CHEMOTHERAPY FOR ACUTE LEUKEMIA	M	Oncology	Oncology
696	OTHER CHEMOTHERAPY	M	Oncology	Oncology
710	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE	S	General Surgery	General Surgery
711	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE	S	General Surgery	General Surgery
720	SEPTICEMIA & DISSEMINATED INFECTIONS	M	Infectious Disease	Infectious Disease
721	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS	M	General Surgery	General Surgery
722	FEVER	M	Infectious Disease	Infectious Disease
723	VIRAL ILLNESS	M	Infectious Disease	Infectious Disease
724	OTHER INFECTIOUS & PARASITIC DISEASES	M	Infectious Disease	Infectious Disease
740	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE	S	General Surgery	General Surgery
750	SCHIZOPHRENIA	M	Psychiatry	Psychiatry
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	M	Psychiatry	Psychiatry
752	DISORDERS OF PERSONALITY & IMPULSE CONTROL	M	Psychiatry	Psychiatry
753	BIPOLAR DISORDERS	M	Psychiatry	Psychiatry
754	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	M	Psychiatry	Psychiatry
755	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	M	Psychiatry	Psychiatry
756	ACUTE ANXIETY & DELIRIUM STATES	M	Psychiatry	Psychiatry
757	ORGANIC MENTAL HEALTH DISTURBANCES	M	Psychiatry	Psychiatry
758	BEHAVIORAL DISORDERS	M	Psychiatry	Psychiatry
759	EATING DISORDERS	M	Psychiatry	Psychiatry
760	OTHER MENTAL HEALTH DISORDERS	M	Psychiatry	Psychiatry
770	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE	M	Substance Abuse	Psychiatry
772	ALCOHOL & DRUG DEPENDENCE W REHAB OR REHAB/DETOX THERAPY	M	Substance Abuse	Psychiatry

773	OPIOID ABUSE & DEPENDENCE	M	Substance Abuse	Psychiatry
774	COCAINE ABUSE & DEPENDENCE	M	Substance Abuse	Psychiatry
775	ALCOHOL ABUSE & DEPENDENCE	M	Substance Abuse	Psychiatry
776	OTHER DRUG ABUSE & DEPENDENCE	M	Substance Abuse	Psychiatry
792	EXTENSIVE OR PROCEDURES FOR OTHER COMPLICATIONS OF TREATMENT	S	Injuries/complic. of prior care	Injuries/complic. of prior care
793	MODERATELY EXTENSIVE OR PROCEDURES FOR OTHER COMPLICATIONS OF TREATMENT	S	Injuries/complic. of prior care	Injuries/complic. of prior care
794	NON-EXTENSIVE OR PROCEDURES FOR OTHER COMPLICATIONS OF TREATMENT	S	Injuries/complic. of prior care	Injuries/complic. of prior care
810	HEMORRHAGE OR HEMATOMA DUE TO COMPLICATION	M	Injuries/complic. of prior care	Injuries/complic. of prior care
811	ALLERGIC REACTIONS	M	General Medicine	General Medicine
812	POISONING OF MEDICINAL AGENTS	M	General Medicine	General Medicine
813	OTHER COMPLICATIONS OF TREATMENT	M	Injuries/complic. of prior care	Injuries/complic. of prior care
815	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES	M	General Medicine	General Medicine
816	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES	M	General Medicine	General Medicine
817	OVERDOSE	M	General Medicine	General Medicine
841	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	S	General Medicine	General Surgery
842	BURNS WITH SKIN GRAFT EXCEPT EXTENSIVE 3RD DEGREE BURNS	S	General Medicine	General Surgery
843	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT	M	General Medicine	General Medicine
844	PARTIAL THICKNESS BURNS W/O SKIN GRAFT	M	General Medicine	General Medicine
850	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE	S	General Surgery	General Surgery
860	REHABILITATION	M	Rehabilitation	Rehabilitation
861	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	M	General Medicine	General Medicine
862	OTHER AFTERCARE & CONVALESCENCE	M	General Medicine	General Medicine
863	NEONATAL AFTERCARE	M	Neonatology	Neonatology
890	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS	M	HIV	Infectious Disease
892	HIV W MAJOR HIV RELATED CONDITION	M	HIV	Infectious Disease

893	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS	M	HIV	Infectious Disease
894	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND	M	HIV	Infectious Disease
910	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	S	Trauma	Trauma
911	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA	S	Trauma	Trauma
912	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	S	Trauma	Trauma
930	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE	M	Trauma	Trauma
950	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	S	General Surgery	General Surgery
951	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	S	General Surgery	General Surgery
952	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	S	General Surgery	General Surgery
955	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS		Invalid	Invalid
956	UNGROUPABLE		Ungroupable	Ungroupable

b. EAPG Service Line Maps

HIGHTYPE	HIGHTYPE_Desc	HIWTAPG	apg_desc	New_Service
1	Significant Procedures	1	PHOTOCHEMOTHERAPY	Other
1	Significant Procedures	2	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION	Other
1	Significant Procedures	3	LEVEL I SKIN INCISION AND DRAINAGE	Minor Surgery
1	Significant Procedures	4	LEVEL II SKIN INCISION AND DRAINAGE	Minor Surgery
1	Significant Procedures	5	NAIL PROCEDURES	Minor Surgery
1	Significant Procedures	6	LEVEL I SKIN DEBRIDEMENT AND DESTRUCTION	Minor Surgery
1	Significant Procedures	7	LEVEL II SKIN DEBRIDEMENT AND DESTRUCTION	Minor Surgery
1	Significant Procedures	8	LEVEL III SKIN DEBRIDEMENT AND DESTRUCTION	Minor Surgery

1	Significant Procedures	9	LEVEL I EXCISION AND BIOPSY OF SKIN AND SOFT TISSUE	Minor Surgery
1	Significant Procedures	10	LEVEL II EXCISION AND BIOPSY OF SKIN AND SOFT TISSUE	Minor Surgery
1	Significant Procedures	11	LEVEL III EXCISION AND BIOPSY OF SKIN AND SOFT TISSUE	Major Surgery
1	Significant Procedures	12	LEVEL I SKIN REPAIR	Minor Surgery
1	Significant Procedures	13	LEVEL II SKIN REPAIR	Minor Surgery
1	Significant Procedures	14	LEVEL III SKIN REPAIR	Major Surgery
1	Significant Procedures	15	LEVEL IV SKIN REPAIR	Major Surgery
1	Significant Procedures	20	LEVEL I BREAST PROCEDURES	Minor Surgery
1	Significant Procedures	21	LEVEL II BREAST PROCEDURES	Major Surgery
1	Significant Procedures	22	LEVEL III BREAST PROCEDURES	Major Surgery
1	Significant Procedures	30	LEVEL I MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Major Surgery
1	Significant Procedures	31	LEVEL II MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Major Surgery
1	Significant Procedures	32	LEVEL III MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Major Surgery
1	Significant Procedures	33	LEVEL I HAND PROCEDURES	Minor Surgery
1	Significant Procedures	34	LEVEL II HAND PROCEDURES	Major Surgery
1	Significant Procedures	35	LEVEL I FOOT PROCEDURES	Major Surgery
1	Significant Procedures	36	LEVEL II FOOT PROCEDURES	Major Surgery
1	Significant Procedures	37	LEVEL I ARTHROSCOPY	Major Surgery
1	Significant Procedures	38	LEVEL II ARTHROSCOPY	Major Surgery
1	Significant Procedures	39	REPLACEMENT OF CAST	Other
1	Significant Procedures	40	SPLINT, STRAPPING AND CAST REMOVAL	Other
1	Significant Procedures	41	CLOSED TREATMENT FX & DISLOCATION OF FINGER, TOE & TRUNK	Minor Surgery
1	Significant Procedures	42	CLOSED TREATMENT FX & DISLOCATION EXC FINGER, TOE & TRUNK	Minor Surgery

1	Significant Procedures	43	OPEN OR PERCUTANEOUS TREATMENT OF FRACTURES	Major Surgery
1	Significant Procedures	44	BONE OR JOINT MANIPULATION UNDER ANESTHESIA	Minor Surgery
1	Significant Procedures	45	BUNION PROCEDURES	Major Surgery
1	Significant Procedures	46	LEVEL I ARTHROPLASTY	Major Surgery
1	Significant Procedures	47	LEVEL II ARTHROPLASTY	Major Surgery
1	Significant Procedures	48	HAND AND FOOT TENOTOMY	Major Surgery
1	Significant Procedures	49	ARTHROCENTESIS AND LIGAMENT OR TENDON INJECTION	Minor Surgery
1	Significant Procedures	60	PULMONARY TESTS	Other
1	Significant Procedures	61	NEEDLE AND CATHETER BIOPSY, ASPIRATION, LAVAGE AND INTUBATION	Minor Surgery
1	Significant Procedures	62	LEVEL I ENDOSCOPY OF THE UPPER AIRWAY	Minor Surgery
1	Significant Procedures	63	LEVEL II ENDOSCOPY OF THE UPPER AIRWAY	Major Surgery
1	Significant Procedures	64	ENDOSCOPY OF THE LOWER AIRWAY	Major Surgery
5	Rehab and Therapy	65	RESPIRATORY THERAPY	Rehab and Therapy
5	Rehab and Therapy	66	PULMONARY REHABILITATION	Rehab and Therapy
1	Significant Procedures	67	VENTILATION ASSISTANCE AND MANAGEMENT	Other
1	Significant Procedures	80	EXERCISE TOLERANCE TESTS	Cardiovascular
1	Significant Procedures	81	ECHOCARDIOGRAPHY	Cardiovascular
1	Significant Procedures	82	CARDIAC ELECTROPHYSIOLOGIC TESTS AND MONITORING	Cardiovascular
1	Significant Procedures	83	PLACEMENT OF TRANSVENOUS CATHETERS	Cardiovascular
1	Significant Procedures	84	DIAGNOSTIC CARDIAC CATHETERIZATION	Cardiovascular
1	Significant Procedures	85	PERIPHERAL TRANSCATHETER AND REVASCULARIZATION PROCEDURES	Cardiovascular
1	Significant Procedures	86	PACEMAKER INSERTION AND REPLACEMENT	Cardiovascular
1	Significant Procedures	87	REMOVAL AND REVISION OF PACEMAKER AND VASCULAR DEVICE	Cardiovascular

1	Significant Procedures	88	LEVEL I CARDIOTHORACIC PROCEDURES	Cardiovascular
1	Significant Procedures	89	LEVEL II CARDIOTHORACIC PROCEDURES	Cardiovascular
1	Significant Procedures	90	SECONDARY VARICOSE VEINS AND VASCULAR INJECTION	Major Surgery
1	Significant Procedures	91	VASCULAR LIGATION AND RECONSTRUCTION	Major Surgery
1	Significant Procedures	92	RESUSCITATION	Minor Surgery
1	Significant Procedures	93	CARDIOVERSION	Cardiovascular
5	Rehab and Therapy	94	CARDIAC REHABILITATION	Rehab and Therapy
1	Significant Procedures	96	ATRIAL AND VENTRICULAR RECORDING AND PACING	Cardiovascular
1	Significant Procedures	97	AICD IMPLANT	Cardiovascular
1	Significant Procedures	99	CORONARY ANGIOPLASTY	Cardiovascular
2	Oncology Related Service	110	PHARMACOTHERAPY BY EXTENDED INFUSION	Oncology Related Services
1	Significant Procedures	110	PHARMACOTHERAPY BY EXTENDED INFUSION	Other
2	Oncology Related Service	111	PHARMACOTHERAPY EXCEPT BY EXTENDED INFUSION	Oncology Related Services
1	Significant Procedures	111	PHARMACOTHERAPY EXCEPT BY EXTENDED INFUSION	Other
1	Significant Procedures	112	PHLEBOTOMY	Other
1	Significant Procedures	113	LEVEL I BLOOD AND BLOOD PRODUCT EXCHANGE	Other
1	Significant Procedures	114	LEVEL II BLOOD AND BLOOD PRODUCT EXCHANGE	Other
1	Significant Procedures	115	DEEP LYMPH STRUCTURE AND THYROID PROCEDURES	Major Surgery
1	Significant Procedures	161	URINARY STUDIES AND PROCEDURES	Other
2	Oncology Related Service	457	VENIPUNCTURE	Clinic
1	Significant Procedures	130	ALIMENTARY TESTS AND SIMPLE TUBE PLACEMENT	Minor Surgery
1	Significant Procedures	131	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY	Minor Surgery

1	Significant Procedures	132	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROCTOSIGMOIDOSCOPY	Minor Surgery
1	Significant Procedures	133	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIOPSY	Minor Surgery
1	Significant Procedures	134	DIAGNOSTIC UPPER GI ENDOSCOPY OR INTUBATION	Minor Surgery
1	Significant Procedures	135	THERAPEUTIC UPPER GI ENDOSCOPY OR INTUBATION	Minor Surgery
1	Significant Procedures	136	DIAGNOSTIC LOWER GASTROINTESTINAL ENDOSCOPY	Minor Surgery
1	Significant Procedures	137	THERAPEUTIC COLONOSCOPY	Minor Surgery
1	Significant Procedures	138	ERCP AND MISCELLANEOUS GI ENDOSCOPY PROCEDURES	Major Surgery
1	Significant Procedures	139	LEVEL I HERNIA REPAIR	Major Surgery
1	Significant Procedures	140	LEVEL II HERNIA REPAIR	Major Surgery
1	Significant Procedures	141	LEVEL I ANAL AND RECTAL PROCEDURES	Minor Surgery
1	Significant Procedures	142	LEVEL II ANAL AND RECTAL PROCEDURES	Major Surgery
1	Significant Procedures	143	LEVEL I GASTROINTESTINAL PROCEDURES	Minor Surgery
1	Significant Procedures	144	LEVEL II GASTROINTESTINAL PROCEDURES	Major Surgery
1	Significant Procedures	145	LEVEL I LAPAROSCOPY	Major Surgery
1	Significant Procedures	146	LEVEL II LAPAROSCOPY	Major Surgery
1	Significant Procedures	147	LEVEL III LAPAROSCOPY	Major Surgery
1	Significant Procedures	148	LEVEL IV LAPAROSCOPY	Major Surgery
1	Significant Procedures	149	SCREENING COLORECTAL SERVICES	Minor Surgery
1	Significant Procedures	160	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY	Major Surgery
1	Significant Procedures	168	HEMODIALYSIS	Other
1	Significant Procedures	162	URINARY DILATATION	Minor Surgery
1	Significant Procedures	163	LEVEL I BLADDER AND KIDNEY PROCEDURES	Minor Surgery
1	Significant Procedures	164	LEVEL II BLADDER AND KIDNEY PROCEDURES	Major Surgery

1	Significant Procedures	165	LEVEL III BLADDER AND KIDNEY PROCEDURES	Major Surgery
1	Significant Procedures	166	LEVEL I URETHRA AND PROSTATE PROCEDURES	Minor Surgery
1	Significant Procedures	167	LEVEL II URETHRA AND PROSTATE PROCEDURES	Major Surgery
1	Significant Procedures	169	PERITONEAL DIALYSIS	Other
1	Significant Procedures	190	ARTIFICIAL FERTILIZATION	Other
1	Significant Procedures	180	TESTICULAR AND EPIDIDYMAL PROCEDURES	Major Surgery
1	Significant Procedures	181	CIRCUMCISION	Minor Surgery
1	Significant Procedures	182	INSERTION OF PENILE PROSTHESIS	Major Surgery
1	Significant Procedures	183	OTHER PENILE PROCEDURES	Major Surgery
1	Significant Procedures	184	DESTRUCTION OR RESECTION OF PROSTATE	Major Surgery
1	Significant Procedures	185	PROSTATE NEEDLE AND PUNCH BIOPSY	Minor Surgery
1	Significant Procedures	210	EXTENDED EEG STUDIES	Other
1	Significant Procedures	191	LEVEL I FETAL PROCEDURES	Minor Surgery
1	Significant Procedures	192	LEVEL II FETAL PROCEDURES	Major Surgery
1	Significant Procedures	193	TREATMENT OF INCOMPLETE ABORTION	Minor Surgery
1	Significant Procedures	194	THERAPEUTIC ABORTION	Minor Surgery
1	Significant Procedures	195	VAGINAL DELIVERY	Major Surgery
1	Significant Procedures	196	LEVEL I FEMALE REPRODUCTIVE PROCEDURES	Minor Surgery
1	Significant Procedures	197	LEVEL II FEMALE REPRODUCTIVE PROCEDURES	Major Surgery
1	Significant Procedures	198	LEVEL III FEMALE REPRODUCTIVE PROCEDURES	Major Surgery
1	Significant Procedures	199	DILATION AND CURETTAGE	Minor Surgery
1	Significant Procedures	200	HYSTEROSCOPY	Major Surgery
1	Significant Procedures	201	COLPOSCOPY	Minor Surgery

1	Significant Procedures	211	ELECTROENCEPHALOGRAM	Other
1	Significant Procedures	212	ELECTROCONVULSIVE THERAPY	Other
1	Significant Procedures	213	NERVE AND MUSCLE TESTS	Other
1	Significant Procedures	219	SPINAL TAP	Other
1	Significant Procedures	214	LEVEL I NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP	Minor Surgery
1	Significant Procedures	215	LEVEL I REVISION OR REMOVAL OF NEUROLOGICAL DEVICE	Minor Surgery
1	Significant Procedures	216	LEVEL II REVISION OR REMOVAL OF NEUROLOGICAL DEVICE	Major Surgery
1	Significant Procedures	217	LEVEL I NERVE PROCEDURES	Minor Surgery
1	Significant Procedures	218	LEVEL II NERVE PROCEDURES	Major Surgery
1	Significant Procedures	222	SLEEP STUDIES	Other
1	Significant Procedures	220	LEVEL II NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP	Minor Surgery
1	Significant Procedures	221	LAMINOTOMY AND LAMINECTOMY	Major Surgery
1	Significant Procedures	251	OTORHINOLARYNGOLOGIC FUNCTION TESTS	Other
1	Significant Procedures	223	LEVEL III NERVE PROCEDURES	Major Surgery
1	Significant Procedures	224	LEVEL IV NERVE PROCEDURES	Major Surgery
1	Significant Procedures	230	MINOR OPHTHALMOLOGICAL TESTS AND PROCEDURES	Minor Surgery
1	Significant Procedures	232	LASER EYE PROCEDURES	Minor Surgery
1	Significant Procedures	233	CATARACT PROCEDURES	Minor Surgery
1	Significant Procedures	234	LEVEL I ANTERIOR SEGMENT EYE PROCEDURES	Minor Surgery
1	Significant Procedures	235	LEVEL II ANTERIOR SEGMENT EYE PROCEDURES	Major Surgery
1	Significant Procedures	236	LEVEL III ANTERIOR SEGMENT EYE PROCEDURES	Major Surgery
1	Significant Procedures	237	LEVEL I POSTERIOR SEGMENT EYE PROCEDURES	Major Surgery
1	Significant Procedures	238	LEVEL II POSTERIOR SEGMENT EYE PROCEDURES	Major Surgery

1	Significant Procedures	239	STRABISMUS AND MUSCLE EYE PROCEDURES	Major Surgery
1	Significant Procedures	240	LEVEL I REPAIR AND PLASTIC PROCEDURES OF EYE	Minor Surgery
1	Significant Procedures	241	LEVEL II REPAIR AND PLASTIC PROCEDURES OF EYE	Major Surgery
1	Significant Procedures	250	COCHLEAR DEVICE IMPLANTATION	Major Surgery
1	Significant Procedures	257	AUDIOMETRY	Other
1	Significant Procedures	252	LEVEL I FACIAL AND ENT PROCEDURES	Major Surgery
1	Significant Procedures	253	LEVEL II FACIAL AND ENT PROCEDURES	Major Surgery
1	Significant Procedures	254	LEVEL III FACIAL AND ENT PROCEDURES	Major Surgery
1	Significant Procedures	255	LEVEL IV FACIAL AND ENT PROCEDURES	Major Surgery
1	Significant Procedures	256	TONSIL AND ADENOID PROCEDURES	Minor Surgery
1	Significant Procedures	350	LEVEL I ADJUNCTIVE GENERAL DENTAL SERVICES	Other
5	Rehab and Therapy	270	OCCUPATIONAL THERAPY	Rehab and Therapy
5	Rehab and Therapy	271	PHYSICAL THERAPY	Rehab and Therapy
5	Rehab and Therapy	272	SPEECH THERAPY AND EVALUATION	Rehab and Therapy
5	Rehab and Therapy	274	OCCUPATIONAL/PHYSICAL THERAPY, GROUP	Rehab and Therapy
5	Rehab and Therapy	275	SPEECH THERAPY & EVALUATION, GROUP	Rehab and Therapy
1	Significant Procedures	280	VASCULAR RADIOLOGY EXCEPT VENOGRAPHY OF EXTREMITY	Radiology
1	Significant Procedures	281	MAGNETIC RESONANCE ANGIOGRAPHY - HEAD AND/OR NECK	Radiology
1	Significant Procedures	282	MAGNETIC RESONANCE ANGIOGRAPHY - CHEST	Radiology
1	Significant Procedures	283	MAGNETIC RESONANCE ANGIOGRAPHY - OTHER SITES	Radiology
1	Significant Procedures	284	MYELOGRAPHY	Radiology
1	Significant Procedures	285	MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST	Radiology
1	Significant Procedures	286	MAMMOGRAPHY & OTHER RELATED PROCEDURES	Radiology

1	Significant Procedures	287	DIGESTIVE RADIOLOGY	Radiology
1	Significant Procedures	288	DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL AND VASCULAR OF LOWER EXTREMITIES	Radiology
1	Significant Procedures	289	VASCULAR DIAGNOSTIC ULTRASOUND OF LOWER EXTREMITIES	Radiology
1	Significant Procedures	290	PET SCANS	CT/MRI/PET
1	Significant Procedures	291	BONE DENSITOMETRY	Radiology
1	Significant Procedures	292	MRI- ABDOMEN	CT/MRI/PET
1	Significant Procedures	293	MRI- JOINTS	CT/MRI/PET
1	Significant Procedures	294	MRI- BACK	CT/MRI/PET
1	Significant Procedures	295	MRI- CHEST	CT/MRI/PET
1	Significant Procedures	296	MRI- OTHER	CT/MRI/PET
1	Significant Procedures	297	MRI BRAIN AND MAGNETOENCEPHALOGRAPHY	CT/MRI/PET
1	Significant Procedures	298	CAT SCAN BACK	CT/MRI/PET
1	Significant Procedures	299	CAT SCAN - BRAIN	CT/MRI/PET
1	Significant Procedures	300	CAT SCAN - ABDOMEN	CT/MRI/PET
1	Significant Procedures	301	CAT SCAN - OTHER	CT/MRI/PET
1	Significant Procedures	302	ANGIOGRAPHY, OTHER	Radiology
1	Significant Procedures	303	ANGIOGRAPHY, CEREBRAL	Radiology
6	Psychiatric	310	DEVELOPMENTAL & NEUROPSYCHOLOGICAL TESTING	Psychiatric
6	Psychiatric	311	FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE	Psychiatric
6	Psychiatric	312	FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS	Psychiatric
6	Psychiatric	313	HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE	Psychiatric
6	Psychiatric	314	HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS	Psychiatric
6	Psychiatric	315	COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY	Psychiatric

6	Psychiatric	316	INDIVIDUAL COMPREHENSIVE PSYCHOTHERAPY	Psychiatric
6	Psychiatric	317	FAMILY PSYCHOTHERAPY	Psychiatric
6	Psychiatric	318	GROUP PSYCHOTHERAPY	Psychiatric
6	Psychiatric	319	ACTIVITY THERAPY	Psychiatric
6	Psychiatric	320	CASE MANAGEMENT & TREATMENT PLAN DEVELOPMENT - MENTAL HEALTH OR SUBSTANCE ABUSE	Psychiatric
6	Psychiatric	322	MEDICATION ADMINISTRATION & OBSERVATION	Psychiatric
6	Psychiatric	323	MENTAL HYGIENE ASSESSMENT	Psychiatric
6	Psychiatric	327	INTENSIVE OUTPATIENT TREATMENT	Psychiatric
1	Significant Procedures	330	LEVEL I DIAGNOSTIC NUCLEAR MEDICINE	Radiology
1	Significant Procedures	331	LEVEL II DIAGNOSTIC NUCLEAR MEDICINE	Radiology
1	Significant Procedures	332	LEVEL III DIAGNOSTIC NUCLEAR MEDICINE	Radiology
1	Significant Procedures	340	THERAPEUTIC NUCLEAR MEDICINE	Radiology
2	Oncology Related Service	341	RADIATION THERAPY AND HYPERTHERMIA	Oncology Related Services
1	Significant Procedures	342	AFTERLOADING BRACHYTHERAPY	Oncology Related Services
2	Oncology Related Service	342	AFTERLOADING BRACHYTHERAPY	Oncology Related Services
2	Oncology Related Service	343	RADIATION TREATMENT DELIVERY	Oncology Related Services
1	Significant Procedures	343	RADIATION TREATMENT DELIVERY	Radiology
1	Significant Procedures	344	INSTILLATION OF RADIOELEMENT SOLUTIONS	Oncology Related Services
2	Oncology Related Service	344	INSTILLATION OF RADIOELEMENT SOLUTIONS	Oncology Related Services
2	Oncology Related Service	345	HYPERTHERMIC THERAPIES	Oncology Related Services
1	Significant Procedures	346	RADIOSURGERY	Minor Surgery

2	Oncology Related Service	346	RADIOSURGERY	Oncology Related Services
2	Oncology Related Service	349	LEVEL II AFTERLOADING BRACHYTHERAPY	Oncology Related Services
1	Significant Procedures	351	LEVEL II ADJUNCTIVE GENERAL DENTAL SERVICES	Other
1	Significant Procedures	352	LEVEL I PERIODONTICS	Other
1	Significant Procedures	355	LEVEL III PROSTHODONTICS, FIXED	Other
1	Significant Procedures	356	LEVEL I PROSTHODONTICS, REMOVABLE	Other
1	Significant Procedures	357	LEVEL II PROSTHODONTICS, REMOVABLE	Other
1	Significant Procedures	358	LEVEL III PROSTHODONTICS, REMOVABLE	Other
1	Significant Procedures	361	LEVEL I DENTAL RESTORATIONS	Other
1	Significant Procedures	362	LEVEL II DENTAL RESTORATIONS	Other
1	Significant Procedures	363	LEVEL III DENTAL RESTORATION	Other
1	Significant Procedures	364	LEVEL I ENDODONTICS	Other
1	Significant Procedures	371	LEVEL I ORTHODONTICS	Other
1	Significant Procedures	367	LEVEL I ORAL AND MAXILLOFACIAL SURGERY	Minor Surgery
1	Significant Procedures	368	LEVEL II ORAL AND MAXILLOFACIAL SURGERY	Minor Surgery
1	Significant Procedures	372	SEALANT	Other
4	ED Medical Visit	520	SPINAL DIAGNOSES & INJURIES	Other
4	ED Medical Visit	523	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES	Other
4	ED Medical Visit	524	LEVEL I CNS DIAGNOSES	Other
4	ED Medical Visit	526	TRANSIENT ISCHEMIA	Other
4	ED Medical Visit	528	NONTRAUMATIC STUPOR & COMA	Other
7	Ancillary & Other	385	LEVEL I MOLECULAR PATHOLOGY AND GENETIC TESTS	Lab
7	Ancillary & Other	386	LEVEL II MOLECULAR PATHOLOGY AND GENETIC TESTS	Lab
7	Ancillary & Other	387	LEVEL III MOLECULAR PATHOLOGY AND GENETIC TESTS	Lab

7	Ancillary & Other	390	LEVEL I PATHOLOGY	Lab
7	Ancillary & Other	391	LEVEL II PATHOLOGY	Lab
7	Ancillary & Other	392	PAP SMEARS	Lab
7	Ancillary & Other	393	BLOOD AND TISSUE TYPING	Lab
7	Ancillary & Other	394	LEVEL I IMMUNOLOGY TESTS	Lab
7	Ancillary & Other	395	LEVEL II IMMUNOLOGY TESTS	Lab
7	Ancillary & Other	396	LEVEL I MICROBIOLOGY TESTS	Lab
7	Ancillary & Other	397	LEVEL II MICROBIOLOGY TESTS	Lab
7	Ancillary & Other	398	LEVEL I ENDOCRINOLOGY TESTS	Lab
7	Ancillary & Other	399	LEVEL II ENDOCRINOLOGY TESTS	Lab
7	Ancillary & Other	400	LEVEL I CHEMISTRY TESTS	Lab
7	Ancillary & Other	401	LEVEL II CHEMISTRY TESTS	Lab
7	Ancillary & Other	402	BASIC CHEMISTRY TESTS	Lab
7	Ancillary & Other	403	ORGAN OR DISEASE ORIENTED PANELS	Lab
7	Ancillary & Other	404	TOXICOLOGY TESTS	Lab
7	Ancillary & Other	405	THERAPEUTIC DRUG MONITORING	Lab
7	Ancillary & Other	406	LEVEL I CLOTTING TESTS	Lab
7	Ancillary & Other	407	LEVEL II CLOTTING TESTS	Lab
7	Ancillary & Other	408	LEVEL I HEMATOLOGY TESTS	Lab
7	Ancillary & Other	409	LEVEL II HEMATOLOGY TESTS	Lab
7	Ancillary & Other	410	URINALYSIS	Lab
7	Ancillary & Other	411	BLOOD AND URINE DIPSTICK TESTS	Lab
4	ED Medical Visit	529	SEIZURE	Other
4	ED Medical Visit	531	MIGRAINE	Other

4	ED Medical Visit	532	HEAD TRAUMA	Other
4	ED Medical Visit	533	AFTEREFFECTS OF CEREBROVASCULAR ACCIDENT	Other
4	ED Medical Visit	534	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARC	Other
7	Ancillary & Other	417	MINOR REPRODUCTIVE PROCEDURES	Minor Surgery
4	ED Medical Visit	535	CVA & PRECEREBRAL OCCLUSION W INFARCT	Other
4	ED Medical Visit	536	CEREBRAL PALSY	Other
4	ED Medical Visit	550	ACUTE MAJOR EYE INFECTIONS	Other
4	ED Medical Visit	551	CATARACTS	Other
4	ED Medical Visit	552	GLAUCOMA	Other
7	Ancillary & Other	424	DRESSINGS AND OTHER MINOR PROCEDURES	Minor Surgery
4	ED Medical Visit	553	LEVEL I OTHER OPHTHALMIC DIAGNOSES	Other
6	Psychiatric	426	PSYCHOTROPIC MEDICATION MANAGEMENT	Psychiatric
4	ED Medical Visit	554	LEVEL II OTHER OPHTHALMIC DIAGNOSES	Other
4	ED Medical Visit	555	CONJUNCTIVITIS	Other
4	ED Medical Visit	561	VERTIGINOUS DIAGNOSES EXCEPT FOR BENIGN VERTIGO	Other
4	ED Medical Visit	570	CYSTIC FIBROSIS - PULMONARY DISEASE	Other
4	ED Medical Visit	572	BRONCHIOLITIS & RSV PNEUMONIA	Other
8	Oncology Drugs	431	CLASS II CHEMOTHERAPY DRUGS	Onc & Inf Drugs
8	Oncology Drugs	432	CLASS III CHEMOTHERAPY DRUGS	Onc & Inf Drugs
4	ED Medical Visit	573	COMMUNITY ACQUIRED PNEUMONIA	Other
8	Oncology Drugs	433	CLASS IV CHEMOTHERAPY DRUGS	Onc & Inf Drugs
8	Oncology Drugs	434	CLASS V CHEMOTHERAPY DRUGS	Onc & Inf Drugs
4	ED Medical Visit	574	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	Other
4	ED Medical Visit	577	LEVEL II OTHER RESPIRATORY DIAGNOSES	Other
8	Oncology Drugs	436	CLASS II PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	437	CLASS III PHARMACOTHERAPY	Onc & Inf Drugs
4	ED Medical Visit	578	PNEUMONIA EXCEPT FOR COMMUNITY ACQUIRED PNEUMONIA	Other
8	Oncology Drugs	438	CLASS IV PHARMACOTHERAPY	Onc & Inf Drugs
4	ED Medical Visit	579	STATUS ASTHMATICUS	Other

8	Oncology Drugs	439	CLASS V PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	440	CLASS VI PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	441	CLASS VI CHEMOTHERAPY DRUGS	Onc & Inf Drugs
8	Oncology Drugs	443	CLASS VII CHEMOTHERAPY	Onc & Inf Drugs
4	ED Medical Visit	591	ACUTE MYOCARDIAL INFARCTION	Other
8	Oncology Drugs	444	CLASS VII PHARMACOTHERAPY	Onc & Inf Drugs
4	ED Medical Visit	593	LEVEL II CARDIOVASCULAR DIAGNOSES	Other
4	ED Medical Visit	594	HEART FAILURE	Other
4	ED Medical Visit	595	CARDIAC ARREST OR OTHER CAUSES OF MORTALITY	Other
3	Non-ED medical Visit	510	MAJOR SIGNS, SYMPTOMS AND FINDINGS	Clinic
3	Non-ED medical Visit	520	SPINAL DIAGNOSES & INJURIES	Clinic
4	ED Medical Visit	599	HYPERTENSION	Other
4	ED Medical Visit	601	LEVEL I CARDIAC ARRHYTHMIA & CONDUCTION DIAGNOSES	Other
8	Oncology Drugs	460	CLASS VIII - COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	461	CLASS IX COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Onc & Inf Drugs
4	ED Medical Visit	603	LEVEL II CARDIAC ARRHYTHMIA & CONDUCTION DIAGNOSES	Other
4	ED Medical Visit	605	SYNCOPE & COLLAPSE	Other
8	Oncology Drugs	462	CLASS X COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	463	CLASS XI COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	464	CLASS XII COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	465	CLASS XIII COMBINED CHEMOTHERAPY AND PHARMOCOTHERAPY	Onc & Inf Drugs
7	Ancillary & Other	470	OBSTETRICAL ULTRASOUND	Radiology
7	Ancillary & Other	471	PLAIN FILM	Radiology
7	Ancillary & Other	472	ULTRASOUND GUIDANCE	Radiology
7	Ancillary & Other	473	CT GUIDANCE	CT/MRI/PET

7	Ancillary & Other	474	RADIOLOGICAL GUIDANCE FOR THERAPEUTIC OR DIAGNOSTIC PROCEDURES	Radiology
7	Ancillary & Other	475	MRI GUIDANCE	CT/MRI/PET
2	Oncology Related Service	476	LEVEL I THERAPEUTIC RADIATION TREATMENT PREPARATION	Oncology Related Services
2	Oncology Related Service	477	LEVEL II THERAPEUTIC RADIATION TREATMENT PREPARATION	Oncology Related Services
7	Ancillary & Other	477	LEVEL II THERAPEUTIC RADIATION TREATMENT PREPARATION	Oncology Related Services
2	Oncology Related Service	478	MEDICAL RADIATION PHYSICS	Oncology Related Services
2	Oncology Related Service	479	TREATMENT DEVICE DESIGN AND CONSTRUCTION	Oncology Related Services
7	Ancillary & Other	479	TREATMENT DEVICE DESIGN AND CONSTRUCTION	Oncology Related Services
2	Oncology Related Service	480	TELETHERAPY/BRACHYTHERAPY CALCULATION	Oncology Related Services
1	Significant Procedures	481	THERAPEUTIC RADIOLOGY SIMULATION FIELD SETTING	Oncology Related Services
2	Oncology Related Service	481	THERAPEUTIC RADIOLOGY SIMULATION FIELD SETTING	Oncology Related Services
2	Oncology Related Service	482	RADIOELEMENT APPLICATION	Oncology Related Services
2	Oncology Related Service	484	THERAPEUTIC RADIOLOGY TREATMENT PLANNING	Oncology Related Services
7	Ancillary & Other	486	BASIC BLOOD TYPING	Lab
4	ED Medical Visit	623	ESOPHAGITIS	Other
4	ED Medical Visit	626	INFLAMMATORY BOWEL DISEASE	Other
4	ED Medical Visit	627	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	Other
4	ED Medical Visit	629	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE	Other

4	ED Medical Visit	630	CONSTIPATION	Other
4	ED Medical Visit	632	IRRITABLE BOWEL SYNDROME	Other
4	ED Medical Visit	633	ALCOHOLIC LIVER DISEASE	Other
4	ED Medical Visit	635	PANCREAS DIAGNOSES EXCEPT MALIGNANCY	Other
3	Non-ED medical Visit	521	NERVOUS SYSTEM MALIGNANCY	Clinic
3	Non-ED medical Visit	522	DEGENERATIVE NERVOUS SYSTEM DIAGNOSES EXC MULT SCLEROSIS	Clinic
3	Non-ED medical Visit	523	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES	Clinic
4	ED Medical Visit	636	HEPATITIS WITHOUT COMA	Other
3	Non-ED medical Visit	524	LEVEL I CNS DIAGNOSES	Clinic
3	Non-ED medical Visit	525	LEVEL II CNS DIAGNOSES	Clinic
3	Non-ED medical Visit	526	TRANSIENT ISCHEMIA	Clinic
3	Non-ED medical Visit	527	PERIPHERAL NERVE DIAGNOSES	Clinic
3	Non-ED medical Visit	528	NONTRAUMATIC STUPOR & COMA	Clinic
3	Non-ED medical Visit	529	SEIZURE	Clinic
3	Non-ED medical Visit	530	HEADACHES OTHER THAN MIGRAINE	Clinic
3	Non-ED medical Visit	531	MIGRAINE	Clinic
3	Non-ED medical Visit	532	HEAD TRAUMA	Clinic
3	Non-ED medical Visit	533	AFTEREFFECTS OF CEREBROVASCULAR ACCIDENT	Clinic
3	Non-ED medical Visit	534	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	Clinic
3	Non-ED medical Visit	535	CVA & PRECEREBRAL OCCLUSION W INFARCT	Clinic
3	Non-ED medical Visit	536	CEREBRAL PALSY	Clinic
3	Non-ED medical Visit	550	ACUTE MAJOR EYE INFECTIONS	Clinic
3	Non-ED medical Visit	551	CATARACTS	Clinic
3	Non-ED medical Visit	552	GLAUCOMA	Clinic
3	Non-ED medical Visit	553	LEVEL I OTHER OPHTHALMIC DIAGNOSES	Clinic

3	Non-ED medical Visit	554	LEVEL II OTHER OPHTHALMIC DIAGNOSES	Clinic
3	Non-ED medical Visit	555	CONJUNCTIVITIS	Clinic
3	Non-ED medical Visit	560	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES	Clinic
3	Non-ED medical Visit	561	VERTIGINOUS DIAGNOSES EXCEPT FOR BENIGN VERTIGO	Clinic
3	Non-ED medical Visit	562	INFECTIONS OF UPPER RESPIRATORY TRACT & OTITIS MEDIA	Clinic
3	Non-ED medical Visit	563	DENTAL & ORAL DIAGNOSES & INJURIES	Clinic
3	Non-ED medical Visit	564	LEVEL I OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES	Clinic
3	Non-ED medical Visit	565	LEVEL II OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES	Clinic
3	Non-ED medical Visit	570	CYSTIC FIBROSIS - PULMONARY DISEASE	Clinic
3	Non-ED medical Visit	571	RESPIRATORY MALIGNANCY	Clinic
3	Non-ED medical Visit	572	BRONCHIOLITIS & RSV PNEUMONIA	Clinic
3	Non-ED medical Visit	573	COMMUNITY ACQUIRED PNEUMONIA	Clinic
3	Non-ED medical Visit	574	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	Clinic
3	Non-ED medical Visit	575	ASTHMA	Clinic
3	Non-ED medical Visit	576	LEVEL I OTHER RESPIRATORY DIAGNOSES	Clinic
3	Non-ED medical Visit	577	LEVEL II OTHER RESPIRATORY DIAGNOSES	Clinic
3	Non-ED medical Visit	578	PNEUMONIA EXCEPT FOR COMMUNITY ACQUIRED PNEUMONIA	Clinic
3	Non-ED medical Visit	579	STATUS ASTHMATICUS	Clinic
3	Non-ED medical Visit	591	ACUTE MYOCARDIAL INFARCTION	Clinic
3	Non-ED medical Visit	592	LEVEL I CARDIOVASCULAR DIAGNOSES	Clinic
3	Non-ED medical Visit	593	LEVEL II CARDIOVASCULAR DIAGNOSES	Clinic
3	Non-ED medical Visit	594	HEART FAILURE	Clinic
3	Non-ED medical Visit	595	CARDIAC ARREST OR OTHER CAUSES OF MORTALITY	Clinic

3	Non-ED medical Visit	596	PERIPHERAL & OTHER VASCULAR DIAGNOSES	Clinic
3	Non-ED medical Visit	597	PHLEBITIS	Clinic
3	Non-ED medical Visit	598	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	Clinic
3	Non-ED medical Visit	599	HYPERTENSION	Clinic
3	Non-ED medical Visit	600	CARDIAC STRUCTURAL & VALVULAR DIAGNOSES	Clinic
3	Non-ED medical Visit	601	LEVEL I CARDIAC ARRHYTHMIA & CONDUCTION DIAGNOSES	Clinic
3	Non-ED medical Visit	602	ATRIAL FIBRILLATION	Clinic
3	Non-ED medical Visit	603	LEVEL II CARDIAC ARRHYTHMIA & CONDUCTION DIAGNOSES	Clinic
3	Non-ED medical Visit	604	CHEST PAIN	Clinic
3	Non-ED medical Visit	605	SYNCOPE & COLLAPSE	Clinic
3	Non-ED medical Visit	620	DIGESTIVE MALIGNANCY	Clinic
3	Non-ED medical Visit	621	PEPTIC ULCER & GASTRITIS	Clinic
3	Non-ED medical Visit	623	ESOPHAGITIS	Clinic
3	Non-ED medical Visit	624	LEVEL I GASTROINTESTINAL DIAGNOSES	Clinic
3	Non-ED medical Visit	625	LEVEL II GASTROINTESTINAL DIAGNOSES	Clinic
3	Non-ED medical Visit	626	INFLAMMATORY BOWEL DISEASE	Clinic
3	Non-ED medical Visit	627	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	Clinic
3	Non-ED medical Visit	628	ABDOMINAL PAIN	Clinic
3	Non-ED medical Visit	629	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE	Clinic
3	Non-ED medical Visit	630	CONSTIPATION	Clinic
3	Non-ED medical Visit	631	HERNIA	Clinic
3	Non-ED medical Visit	632	IRRITABLE BOWEL SYNDROME	Clinic
3	Non-ED medical Visit	633	ALCOHOLIC LIVER DISEASE	Clinic

3	Non-ED medical Visit	634	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS	Clinic
3	Non-ED medical Visit	635	PANCREAS DIAGNOSES EXCEPT MALIGNANCY	Clinic
3	Non-ED medical Visit	636	HEPATITIS WITHOUT COMA	Clinic
3	Non-ED medical Visit	637	GALLBLADDER & BILIARY TRACT DIAGNOSES	Clinic
3	Non-ED medical Visit	638	CHOLECYSTITIS	Clinic
3	Non-ED medical Visit	639	LEVEL I HEPATOBILIARY DIAGNOSES	Clinic
3	Non-ED medical Visit	640	LEVEL II HEPATOBILIARY DIAGNOSES	Clinic
3	Non-ED medical Visit	650	FRACTURE OF FEMUR	Clinic
3	Non-ED medical Visit	651	FRACTURE OF PELVIS OR DISLOCATION OF HIP	Clinic
3	Non-ED medical Visit	652	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK	Clinic
3	Non-ED medical Visit	653	MUSCULOSKELETAL MALIGNANCY & PATHOLOGICAL FRACTURES	Clinic
3	Non-ED medical Visit	654	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS	Clinic
3	Non-ED medical Visit	655	CONNECTIVE TISSUE DIAGNOSES	Clinic
3	Non-ED medical Visit	656	BACK & NECK DIAGNOSES EXCEPT LUMBAR DISC DIAGNOSES	Clinic
3	Non-ED medical Visit	657	LUMBAR DISC DIAGNOSES	Clinic
3	Non-ED medical Visit	658	LUMBAR DISC DIAGNOSES WITH SCIATICA	Clinic
3	Non-ED medical Visit	659	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE	Clinic
3	Non-ED medical Visit	660	LEVEL I OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	Clinic
3	Non-ED medical Visit	661	LEVEL II OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	Clinic
3	Non-ED medical Visit	662	OSTEOPOROSIS	Clinic
3	Non-ED medical Visit	663	PAIN	Clinic
3	Non-ED medical Visit	670	SKIN ULCERS	Clinic
3	Non-ED medical Visit	671	MAJOR SKIN DIAGNOSES	Clinic

3	Non-ED medical Visit	672	MALIGNANT BREAST DIAGNOSES	Clinic
3	Non-ED medical Visit	673	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	Clinic
3	Non-ED medical Visit	674	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE	Clinic
3	Non-ED medical Visit	675	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DIAGNOSES	Clinic
3	Non-ED medical Visit	676	DECUBITUS ULCER	Clinic
3	Non-ED medical Visit	690	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DIAGNOSES	Clinic
3	Non-ED medical Visit	691	INBORN ERRORS OF METABOLISM	Clinic
3	Non-ED medical Visit	692	LEVEL I ENDOCRINE DIAGNOSES	Clinic
3	Non-ED medical Visit	693	LEVEL II ENDOCRINE DIAGNOSES	Clinic
3	Non-ED medical Visit	694	ELECTROLYTE DISORDERS	Clinic
3	Non-ED medical Visit	695	OBESITY	Clinic
3	Non-ED medical Visit	710	DIABETES WITH OPHTHALMIC MANIFESTATIONS	Clinic
3	Non-ED medical Visit	711	DIABETES WITH OTHER MANIFESTATIONS & COMPLICATIONS	Clinic
3	Non-ED medical Visit	712	DIABETES WITH NEUROLOGIC MANIFESTATIONS	Clinic
3	Non-ED medical Visit	713	DIABETES WITHOUT COMPLICATIONS	Clinic
3	Non-ED medical Visit	714	DIABETES WITH RENAL MANIFESTATIONS	Clinic
3	Non-ED medical Visit	720	RENAL FAILURE	Clinic
3	Non-ED medical Visit	721	KIDNEY & URINARY TRACT MALIGNANCY	Clinic
3	Non-ED medical Visit	722	NEPHRITIS & NEPHROSIS	Clinic
3	Non-ED medical Visit	723	KIDNEY AND CHRONIC URINARY TRACT INFECTIONS	Clinic
3	Non-ED medical Visit	724	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION	Clinic
3	Non-ED medical Visit	725	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC	Clinic
3	Non-ED medical Visit	726	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	Clinic

3	Non-ED medical Visit	727	ACUTE LOWER URINARY TRACT INFECTIONS	Clinic
3	Non-ED medical Visit	740	MALIGNANCY, MALE REPRODUCTIVE SYSTEM	Clinic
3	Non-ED medical Visit	741	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY	Clinic
3	Non-ED medical Visit	742	NEOPLASMS OF THE MALE REPRODUCTIVE SYSTEM	Clinic
3	Non-ED medical Visit	743	PROSTATITIS	Clinic
3	Non-ED medical Visit	744	MALE REPRODUCTIVE INFECTIONS	Clinic
3	Non-ED medical Visit	750	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY	Clinic
3	Non-ED medical Visit	751	FEMALE REPRODUCTIVE SYSTEM INFECTIONS	Clinic
3	Non-ED medical Visit	752	LEVEL I MENSTRUAL AND OTHER FEMALE DIAGNOSES	Clinic
3	Non-ED medical Visit	753	LEVEL II MENSTRUAL AND OTHER FEMALE DIAGNOSES	Clinic
3	Non-ED medical Visit	760	VAGINAL DELIVERY	Clinic
3	Non-ED medical Visit	761	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	Clinic
3	Non-ED medical Visit	762	THREATENED ABORTION	Clinic
3	Non-ED medical Visit	763	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	Clinic
3	Non-ED medical Visit	764	FALSE LABOR	Clinic
3	Non-ED medical Visit	765	OTHER ANTEPARTUM DIAGNOSES	Clinic
3	Non-ED medical Visit	766	ROUTINE PRENATAL CARE	Clinic
3	Non-ED medical Visit	770	NORMAL NEONATE	Clinic
3	Non-ED medical Visit	771	LEVEL I NEONATAL DIAGNOSES	Clinic
3	Non-ED medical Visit	772	LEVEL II NEONATAL DIAGNOSES	Clinic
3	Non-ED medical Visit	780	OTHER HEMATOLOGICAL DIAGNOSES	Clinic
3	Non-ED medical Visit	781	COAGULATION & PLATELET DIAGNOSES	Clinic
3	Non-ED medical Visit	782	CONGENITAL FACTOR DEFICIENCIES	Clinic

3	Non-ED medical Visit	783	SICKLE CELL ANEMIA CRISIS	Clinic
3	Non-ED medical Visit	784	SICKLE CELL ANEMIA	Clinic
3	Non-ED medical Visit	785	ANEMIA EXCEPT FOR IRON DEFICIENCY ANEMIA AND SICKLE CELL ANEMIA	Clinic
3	Non-ED medical Visit	786	IRON DEFICIENCY ANEMIA	Clinic
3	Non-ED medical Visit	805	SEPTICEMIA & DISSEMINATED INFECTIONS	Clinic
3	Non-ED medical Visit	806	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS	Clinic
3	Non-ED medical Visit	807	FEVER	Clinic
3	Non-ED medical Visit	808	VIRAL ILLNESS	Clinic
3	Non-ED medical Visit	809	OTHER INFECTIOUS & PARASITIC DISEASES	Clinic
3	Non-ED medical Visit	810	H. PYLORI INFECTION	Clinic
3	Non-ED medical Visit	840	OPIOID ABUSE & DEPENDENCE	Clinic
3	Non-ED medical Visit	841	COCAINE ABUSE & DEPENDENCE	Clinic
3	Non-ED medical Visit	842	ALCOHOL ABUSE & DEPENDENCE	Clinic
3	Non-ED medical Visit	843	OTHER DRUG ABUSE & DEPENDENCE	Clinic
3	Non-ED medical Visit	850	ALLERGIC REACTIONS	Clinic
3	Non-ED medical Visit	851	POISONING OF MEDICINAL AGENTS	Clinic
3	Non-ED medical Visit	852	OTHER COMPLICATIONS OF TREATMENT	Clinic
3	Non-ED medical Visit	853	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES	Clinic
3	Non-ED medical Visit	854	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES	Clinic
3	Non-ED medical Visit	860	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT	Clinic
3	Non-ED medical Visit	861	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT	Clinic
3	Non-ED medical Visit	870	REHABILITATION	Clinic
3	Non-ED medical Visit	871	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	Clinic

3	Non-ED medical Visit	872	OTHER AFTERCARE & CONVALESCENCE	Clinic
3	Non-ED medical Visit	873	NEONATAL AFTERCARE	Clinic
3	Non-ED medical Visit	874	JOINT REPLACEMENT	Clinic
3	Non-ED medical Visit	875	CONTRACEPTIVE MANAGEMENT	Clinic
3	Non-ED medical Visit	878	GYNECOLOGICAL PREVENTIVE MEDICINE	Clinic
3	Non-ED medical Visit	879	PREVENTIVE OR SCREENING ENCOUNTERS	Clinic
3	Non-ED medical Visit	880	HIV INFECTION	Clinic
3	Non-ED medical Visit	881	AIDS	Clinic
3	Non-ED medical Visit	882	GENETIC COUNSELING	Clinic
3	Non-ED medical Visit	820	SCHIZOPHRENIA	Clinic
3	Non-ED medical Visit	821	MAJOR DEPRESSIVE DIAGNOSES & OTHER/UNSPECIFIED PSYCHOSES	Clinic
3	Non-ED medical Visit	822	PERSONALITY & IMPULSE CONTROL DIAGNOSES	Clinic
4	ED Medical Visit	637	GALLBLADDER & BILIARY TRACT DIAGNOSES	Other
4	ED Medical Visit	638	CHOLECYSTITIS	Other
3	Non-ED medical Visit	823	BIPOLAR DISORDERS	Clinic
4	ED Medical Visit	650	FRACTURE OF FEMUR	Other
3	Non-ED medical Visit	824	DEPRESSION EXCEPT MAJOR DEPRESSIVE DIAGNOSES	Clinic
4	ED Medical Visit	651	FRACTURE OF PELVIS OR DISLOCATION OF HIP	Other
4	ED Medical Visit	652	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK	Other
3	Non-ED medical Visit	825	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	Clinic
4	ED Medical Visit	662	OSTEOPOROSIS	Other
4	ED Medical Visit	695	OBESITY	Other
4	ED Medical Visit	710	DIABETES WITH OPHTHALMIC MANIFESTATIONS	Other
4	ED Medical Visit	713	DIABETES WITHOUT COMPLICATIONS	Other
4	ED Medical Visit	722	NEPHRITIS & NEPHROSIS	Other
4	ED Medical Visit	724	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION	Other

4	ED Medical Visit	725	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC	Other
4	ED Medical Visit	727	ACUTE LOWER URINARY TRACT INFECTIONS	Other
4	ED Medical Visit	743	PROSTATITIS	Other
4	ED Medical Visit	744	MALE REPRODUCTIVE INFECTIONS	Other
4	ED Medical Visit	753	LEVEL II MENSTRUAL AND OTHER FEMALE DIAGNOSES	Other
4	ED Medical Visit	760	VAGINAL DELIVERY	Other
3	Non-ED medical Visit	826	ACUTE ANXIETY & DELIRIUM STATES	Clinic
4	ED Medical Visit	761	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	Other
3	Non-ED medical Visit	827	ORGANIC MENTAL HEALTH DISTURBANCES	Clinic
3	Non-ED medical Visit	828	MENTAL RETARDATION	Clinic
3	Non-ED medical Visit	829	CHILDHOOD BEHAVIORAL DIAGNOSES	Clinic
3	Non-ED medical Visit	830	EATING DISORDERS	Clinic
4	ED Medical Visit	762	THREATENED ABORTION	Other
3	Non-ED medical Visit	831	OTHER MENTAL HEALTH DIAGNOSES	Clinic
4	ED Medical Visit	763	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	Other
4	ED Medical Visit	764	FALSE LABOR	Other
4	ED Medical Visit	765	OTHER ANTEPARTUM DIAGNOSES	Other
4	ED Medical Visit	510	MAJOR SIGNS, SYMPTOMS AND FINDINGS	Other
4	ED Medical Visit	521	NERVOUS SYSTEM MALIGNANCY	Other
4	ED Medical Visit	766	ROUTINE PRENATAL CARE	Other
4	ED Medical Visit	771	LEVEL I NEONATAL DIAGNOSES	Other
4	ED Medical Visit	772	LEVEL II NEONATAL DIAGNOSES	Other
4	ED Medical Visit	780	OTHER HEMATOLOGICAL DIAGNOSES	Other
4	ED Medical Visit	522	DEGENERATIVE NERVOUS SYSTEM DIAGNOSES EXC MULT SCLEROSIS	Other
4	ED Medical Visit	781	COAGULATION & PLATELET DIAGNOSES	Other
4	ED Medical Visit	782	CONGENITAL FACTOR DEFICIENCIES	Other
4	ED Medical Visit	783	SICKLE CELL ANEMIA CRISIS	Other
4	ED Medical Visit	525	LEVEL II CNS DIAGNOSES	Other
4	ED Medical Visit	527	PERIPHERAL NERVE DIAGNOSES	Other
4	ED Medical Visit	530	HEADACHES OTHER THAN MIGRAINE	Other
4	ED Medical Visit	784	SICKLE CELL ANEMIA	Other
4	ED Medical Visit	560	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES	Other

4	ED Medical Visit	785	ANEMIA EXCEPT FOR IRON DEFICIENCY ANEMIA AND SICKLE CELL ANEMIA	Other
4	ED Medical Visit	562	INFECTIONS OF UPPER RESPIRATORY TRACT & OTITIS MEDIA	Other
4	ED Medical Visit	786	IRON DEFICIENCY ANEMIA	Other
4	ED Medical Visit	563	DENTAL & ORAL DIAGNOSES & INJURIES	Other
4	ED Medical Visit	805	SEPTICEMIA & DISSEMINATED INFECTIONS	Other
4	ED Medical Visit	564	LEVEL I OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES	Other
4	ED Medical Visit	565	LEVEL II OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES	Other
4	ED Medical Visit	806	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS	Other
4	ED Medical Visit	571	RESPIRATORY MALIGNANCY	Other
4	ED Medical Visit	575	ASTHMA	Other
4	ED Medical Visit	807	FEVER	Other
4	ED Medical Visit	808	VIRAL ILLNESS	Other
4	ED Medical Visit	576	LEVEL I OTHER RESPIRATORY DIAGNOSES	Other
4	ED Medical Visit	809	OTHER INFECTIOUS & PARASITIC DISEASES	Other
4	ED Medical Visit	810	H. PYLORI INFECTION	Other
4	ED Medical Visit	592	LEVEL I CARDIOVASCULAR DIAGNOSES	Other
4	ED Medical Visit	840	OPIOID ABUSE & DEPENDENCE	Other
4	ED Medical Visit	841	COCAINE ABUSE & DEPENDENCE	Other
4	ED Medical Visit	596	PERIPHERAL & OTHER VASCULAR DIAGNOSES	Other
4	ED Medical Visit	842	ALCOHOL ABUSE & DEPENDENCE	Other
4	ED Medical Visit	843	OTHER DRUG ABUSE & DEPENDENCE	Other
4	ED Medical Visit	850	ALLERGIC REACTIONS	Other
4	ED Medical Visit	851	POISONING OF MEDICINAL AGENTS	Other
4	ED Medical Visit	597	PHLEBITIS	Other
4	ED Medical Visit	598	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	Other
4	ED Medical Visit	852	OTHER COMPLICATIONS OF TREATMENT	Other
4	ED Medical Visit	853	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES	Other
4	ED Medical Visit	854	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES	Other
4	ED Medical Visit	600	CARDIAC STRUCTURAL & VALVULAR DIAGNOSES	Other
4	ED Medical Visit	602	ATRIAL FIBRILLATION	Other
4	ED Medical Visit	604	CHEST PAIN	Other
4	ED Medical Visit	620	DIGESTIVE MALIGNANCY	Other
4	ED Medical Visit	621	PEPTIC ULCER & GASTRITIS	Other

4	ED Medical Visit	624	LEVEL I GASTROINTESTINAL DIAGNOSES	Other
4	ED Medical Visit	625	LEVEL II GASTROINTESTINAL DIAGNOSES	Other
4	ED Medical Visit	628	ABDOMINAL PAIN	Other
4	ED Medical Visit	631	HERNIA	Other
4	ED Medical Visit	860	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT	Other
4	ED Medical Visit	634	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS	Other
4	ED Medical Visit	639	LEVEL I HEPATOBILIARY DIAGNOSES	Other
4	ED Medical Visit	640	LEVEL II HEPATOBILIARY DIAGNOSES	Other
4	ED Medical Visit	653	MUSCULOSKELETAL MALIGNANCY & PATHOLOGICAL FRACTURES	Other
4	ED Medical Visit	654	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS	Other
4	ED Medical Visit	655	CONNECTIVE TISSUE DIAGNOSES	Other
4	ED Medical Visit	656	BACK & NECK DIAGNOSES EXCEPT LUMBAR DISC DIAGNOSES	Other
4	ED Medical Visit	657	LUMBAR DISC DIAGNOSES	Other
4	ED Medical Visit	658	LUMBAR DISC DIAGNOSES WITH SCIATICA	Other
4	ED Medical Visit	659	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE	Other
4	ED Medical Visit	660	LEVEL I OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	Other
4	ED Medical Visit	661	LEVEL II OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	Other
4	ED Medical Visit	663	PAIN	Other
4	ED Medical Visit	861	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT	Other
4	ED Medical Visit	871	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	Other
4	ED Medical Visit	670	SKIN ULCERS	Other
4	ED Medical Visit	671	MAJOR SKIN DIAGNOSES	Other
4	ED Medical Visit	872	OTHER AFTERCARE & CONVALESCENCE	Other
4	ED Medical Visit	672	MALIGNANT BREAST DIAGNOSES	Other
4	ED Medical Visit	673	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	Other
4	ED Medical Visit	674	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE	Other
4	ED Medical Visit	873	NEONATAL AFTERCARE	Other
4	ED Medical Visit	675	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DIAGNOSES	Other
4	ED Medical Visit	874	JOINT REPLACEMENT	Other
4	ED Medical Visit	875	CONTRACEPTIVE MANAGEMENT	Other

2	Oncology Related Service	800	ACUTE LEUKEMIA	Oncology Related Services
4	ED Medical Visit	800	ACUTE LEUKEMIA	Oncology Related Services
2	Oncology Related Service	801	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA	Oncology Related Services
3	Non-ED medical Visit	801	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA	Oncology Related Services
4	ED Medical Visit	801	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA	Oncology Related Services
2	Oncology Related Service	802	RADIOTHERAPY	Oncology Related Services
4	ED Medical Visit	802	RADIOTHERAPY	Oncology Related Services
2	Oncology Related Service	803	CHEMOTHERAPY	Oncology Related Services
3	Non-ED medical Visit	803	CHEMOTHERAPY	Oncology Related Services
4	ED Medical Visit	803	CHEMOTHERAPY	Oncology Related Services
2	Oncology Related Service	804	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR	Oncology Related Services
4	ED Medical Visit	804	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR	Oncology Related Services
4	ED Medical Visit	676	DECUBITUS ULCER	Other
4	ED Medical Visit	878	GYNECOLOGICAL PREVENTIVE MEDICINE	Other
4	ED Medical Visit	690	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DIAGNOSES	Other
4	ED Medical Visit	691	INBORN ERRORS OF METABOLISM	Other
4	ED Medical Visit	879	PREVENTIVE OR SCREENING ENCOUNTERS	Other
4	ED Medical Visit	880	HIV INFECTION	Other
4	ED Medical Visit	692	LEVEL I ENDOCRINE DIAGNOSES	Other
4	ED Medical Visit	693	LEVEL II ENDOCRINE DIAGNOSES	Other
4	ED Medical Visit	694	ELECTROLYTE DISORDERS	Other

4	ED Medical Visit	881	AIDS	Other
7	Ancillary & Other	116	ALLERGY TESTS	Other
7	Ancillary & Other	373	LEVEL I DENTAL FILM	Other
4	ED Medical Visit	711	DIABETES WITH OTHER MANIFESTATIONS & COMPLICATIONS	Other
4	ED Medical Visit	820	SCHIZOPHRENIA	Other
4	ED Medical Visit	712	DIABETES WITH NEUROLOGIC MANIFESTATIONS	Other
4	ED Medical Visit	821	MAJOR DEPRESSIVE DIAGNOSES & OTHER/UNSPECIFIED PSYCHOSES	Other
4	ED Medical Visit	714	DIABETES WITH RENAL MANIFESTATIONS	Other
4	ED Medical Visit	822	PERSONALITY & IMPULSE CONTROL DIAGNOSES	Other
4	ED Medical Visit	720	RENAL FAILURE	Other
4	ED Medical Visit	823	BIPOLAR DISORDERS	Other
4	ED Medical Visit	721	KIDNEY & URINARY TRACT MALIGNANCY	Other
4	ED Medical Visit	824	DEPRESSION EXCEPT MAJOR DEPRESSIVE DIAGNOSES	Other
4	ED Medical Visit	723	KIDNEY AND CHRONIC URINARY TRACT INFECTIONS	Other
4	ED Medical Visit	825	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	Other
4	ED Medical Visit	726	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	Other
4	ED Medical Visit	826	ACUTE ANXIETY & DELIRIUM STATES	Other
4	ED Medical Visit	740	MALIGNANCY, MALE REPRODUCTIVE SYSTEM	Other
4	ED Medical Visit	827	ORGANIC MENTAL HEALTH DISTURBANCES	Other
4	ED Medical Visit	741	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY	Other
4	ED Medical Visit	828	MENTAL RETARDATION	Other
4	ED Medical Visit	750	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY	Other
4	ED Medical Visit	829	CHILDHOOD BEHAVIORAL DIAGNOSES	Other
4	ED Medical Visit	751	FEMALE REPRODUCTIVE SYSTEM INFECTIONS	Other
4	ED Medical Visit	830	EATING DISORDERS	Other
4	ED Medical Visit	752	LEVEL I MENSTRUAL AND OTHER FEMALE DIAGNOSES	Other
4	ED Medical Visit	831	OTHER MENTAL HEALTH DIAGNOSES	Other
7	Ancillary & Other	374	LEVEL II DENTAL FILM	Other

7	Ancillary & Other	376	DIAGNOSTIC DENTAL PROCEDURES	Other
7	Ancillary & Other	377	PREVENTIVE DENTAL PROCEDURES	Other
7	Ancillary & Other	412	SIMPLE PULMONARY FUNCTION TESTS	Other
7	Ancillary & Other	413	CARDIOGRAM	Other
7	Ancillary & Other	414	LEVEL I IMMUNIZATION	Other
7	Ancillary & Other	415	LEVEL II IMMUNIZATION	Other
7	Ancillary & Other	416	LEVEL III IMMUNIZATION	Other
7	Ancillary & Other	418	MINOR CARDIAC AND VASCULAR TESTS	Other
7	Ancillary & Other	419	MINOR OPHTHALMOLOGICAL INJECTION, SCRAPING AND TESTS	Other
7	Ancillary & Other	420	PACEMAKER AND OTHER ELECTRONIC ANALYSIS	Other
7	Ancillary & Other	421	TUBE CHANGE	Other
7	Ancillary & Other	423	INTRODUCTION OF NEEDLE AND CATHETER	Other
7	Ancillary & Other	425	LEVEL I OTHER MISCELLANEOUS ANCILLARY PROCEDURES	Other
7	Ancillary & Other	427	BIOFEEDBACK AND OTHER TRAINING	Other
7	Ancillary & Other	428	PATIENT EDUCATION, INDIVIDUAL	Other
7	Ancillary & Other	429	PATIENT EDUCATION, GROUP	Other
7	Ancillary & Other	430	CLASS I CHEMOTHERAPY DRUGS	Other
7	Ancillary & Other	431	CLASS II CHEMOTHERAPY DRUGS	Other
7	Ancillary & Other	433	CLASS IV CHEMOTHERAPY DRUGS	Other
7	Ancillary & Other	435	CLASS I PHARMACOTHERAPY	Other
7	Ancillary & Other	436	CLASS II PHARMACOTHERAPY	Other
7	Ancillary & Other	438	CLASS IV PHARMACOTHERAPY	Other
4	ED Medical Visit	870	REHABILITATION	Rehab and Therapy

7	Ancillary & Other	439	CLASS V PHARMACOTHERAPY	Other
7	Ancillary & Other	443	CLASS VII CHEMOTHERAPY	Other
7	Ancillary & Other	450	OBSERVATION	Other
7	Ancillary & Other	451	SMOKING CESSATION TREATMENT	Other
7	Ancillary & Other	455	IMPLANTED TISSUE OF ANY TYPE	Other
7	Ancillary & Other	458	ALLERGY THERAPY	Other
7	Ancillary & Other	459	VACCINE ADMINISTRATION	Other
7	Ancillary & Other	461	CLASS IX COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Other
7	Ancillary & Other	462	CLASS X COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Other
7	Ancillary & Other	487	MINOR CARDIAC MONITORING	Other
7	Ancillary & Other	488	MINOR DEVICE EVALUATION & ELECTRONIC ANALYSIS	Other
7	Ancillary & Other	489	LEVEL II OTHER MISCELLANEOUS ANCILLARY PROCEDURES	Other
7	Ancillary & Other	490	INCIDENTAL TO MEDICAL VISIT OR SIGNIFICANT PROCEDURE	Other
7	Ancillary & Other	491	MEDICAL VISIT INDICATOR	Other
7	Ancillary & Other	495	MINOR CHEMOTHERAPY DRUGS	Other
7	Ancillary & Other	496	MINOR PHARMACOTHERAPY	Other
7	Ancillary & Other	497	TELEHEALTH FACILITATION	Other
5	Rehab and Therapy	118	NUTRITION THERAPY	Other
7	Ancillary & Other	457	VENIPUNCTURE	Other
7	Ancillary & Other	993	INPATIENT ONLY PROCEDURES	Unassigned
7	Ancillary & Other	999	UNASSIGNED	Unassigned
7	Ancillary & Other	1001	DURABLE MEDICAL EQUIPMENT AND SUPPLIES - LEVEL 1	Unassigned
7	Ancillary & Other	1002	DURABLE MEDICAL EQUIPMENT AND SUPPLIES - LEVEL 2	Unassigned

7	Ancillary & Other	1003	DURABLE MEDICAL EQUIPMENT AND SUPPLIES - LEVEL 3	Unassigned
7	Ancillary & Other	1004	DURABLE MEDICAL EQUIPMENT - LEVEL 4	Unassigned
7	Ancillary & Other	1005	DURABLE MEDICAL EQUIPMENT - LEVEL 5	Unassigned
7	Ancillary & Other	1006	DURABLE MEDICAL EQUIPMENT - LEVEL 6	Unassigned
7	Ancillary & Other	1009	DURABLE MEDICAL EQUIPMENT - LEVEL 9	Unassigned
7	Ancillary & Other	1010	DURABLE MEDICAL EQUIPMENT - LEVEL 10	Unassigned
7	Ancillary & Other	1011	DURABLE MEDICAL EQUIPMENT - LEVEL 11	Unassigned

Outpatient Service Line Assignment Hierarchy

If <u>New Service</u> is ' Rad/Inf/Chemo ' then <u>Service Line</u> is ' Rad/Inf/Chemo ';
Else If service Line not in ('Rad/Inf/Chemo') and <u>New Service</u> is ' Psychiatric ' then <u>Service Line</u> is ' Psychiatry ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry') and <u>New Service</u> is ' Clinic ' then <u>Service Line</u> is ' Clinic ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry','Clinic') and <u>New Service</u> is ' Rehabilitation ' then <u>Service Line</u> is ' Rehab & Therapy ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry','Clinic','Rehab & Therapy') and (hospid=210333 or hospid=210088 or hospid=210087 or rctcode28 > 0 or rctcode34 > 0 or rctcode90>0) then <u>Service Line</u> is ' ED ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry','Clinic','Rehab & Therapy','ED') and <u>New Service</u> is ' Major Surgery ' then <u>Service Line</u> is ' Major Surgery ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry','Clinic','Rehab & Therapy','ED','Major Surgery') and <u>New Service</u> is ' Minor Surgery ' then <u>Service Line</u> is ' Minor Surgery ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry','Clinic','Rehab & Therapy','ED','Major Surgery','Minor Surgery') and <u>New Service</u> is ' Cardiovascular ' then <u>Service Line</u> is ' Cardiovascular ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry','Clinic','Rehab & Therapy','ED','Major Surgery','Minor Surgery','Cardiovascular') and <u>New Service</u> is ' CT/MRI/PET ' then <u>Service Line</u> is ' CT/MRI/PET ';
Else if <u>ECMAD</u> in (.,0) then <u>Service Line</u> is ' Unassigned ';
Else <u>Service Line</u> is <u>New Service</u> ;

Appendix 6. Proposed Market Shift Service Line Consolidation

<u>Service Line</u>	<u>IP/O P</u>	<u>Consolidation Proposal</u>	<u>Proposed Service Collapse</u>
Cardiology	IP	Service Collapse	Cardiology
Cardiothoracic Surgery	IP	Geography Collapse	Cardiothoracic Surgery
Dental	IP	Service Collapse	General Medicine
Dermatology	IP	Service Collapse	General Medicine
Diabetes	IP	Service Collapse	General Medicine
Endocrinology	IP	Service Collapse	General Medicine
Endocrinology Surgery	IP	Geography Collapse	Endocrinology Surgery
ENT Surgery	IP	Geography Collapse	ENT Surgery
EP/Chronic Rhythm Mgmt	IP	Geography/Service Collapse	Invasive Cardiology
Gastroenterology	IP	NA	Gastroenterology
General Medicine	IP	Service Collapse	General Medicine
General Surgery	IP	Geography Collapse	General Surgery
Gynecological Surg	IP	Geography Collapse	Gynecological Surg
Gynecology	IP	Geography/Service Collapse	Ob/Gyn
Hematology	IP	Geography Collapse	Hematology
HIV	IP	Service Collapse	Infectious Disease
Infectious Disease	IP	Service Collapse	Infectious Disease
Injuries/complic. of prior care	IP	Geography Collapse	Injuries/complic. of prior care
Invasive Cardiology	IP	Geography/Service Collapse	Invasive Cardiology
Myocardial Infarction	IP	Service Collapse	Cardiology
Neonatology	IP	Geography/Service Collapse	Neonatology
Nephrology	IP	NA	General Medicine
Neurological Surgery	IP	Geography Collapse	Neurological Surgery
Neurology	IP	NA	Neurology
Newborn	IP	Geography/Service Collapse	Neonatology
Obstetrics/Delivery	IP	Geography/Service Collapse	Ob/Gyn
Oncology_IP	IP	Geography Collapse	Oncology_IP
Ophthalmologic Surg	IP	Geography Collapse	Ophthalmologic Surg
Ophthalmology	IP	Service Collapse	Ophthamology
Orthopedic Surgery	IP	Geography Collapse	Orthopedic Surgery
Orthopedics	IP	Service Collapse	General Medicine

Other Obstetrics	IP	Geography/Service Collapse	Ob/Gyn
Otolaryngology	IP	Service Collapse	General Medicine
Psychiatry_IP	IP	Service Collapse	Psychiatry_IP
Pulmonary	IP	NA	Pulmonary
Rehabilitation_IP	IP	Geography Collapse	Rehabilitation_IP
Rheumatology	IP	Service Collapse	General Medicine
Spinal Surgery	IP	Geography Collapse	Spinal Surgery
Substance Abuse	IP	Service Collapse	Psychiatry_IP
Thoracic Surgery	IP	Geography Collapse	Thoracic Surgery
Trauma	IP	Geography Collapse	Trauma
Unassigned_IP	IP	NA	Unassigned_IP
Urological Surgery	IP	Geography Collapse	Urological Surgery
Urology	IP	Service Collapse	Urology
Vascular Surgery	IP	Geography Collapse	Vascular Surgery
Ventilator Support	IP	Geography Collapse	Ventilator Support
Cardiovascular	OP	Geography Collapse	Cardiovascular
Clinic	OP	NA	Clinic
CT/MRI/PET	OP	NA	CT/MRI/PET
Drugs	OP	NA	Removed
ED	OP	NA	ED
Lab	OP	Service Collapse	Lab
Major Surgery	OP	Geography Collapse	Major Surgery
Minor Surgery	OP	Geography Collapse	Minor Surgery
Other	OP	NA	Other
Pathology	OP	Service Collapse	Lab
Psychiatry_OP	OP	NA	Psychiatry_OP
Radiology	OP	NA	Radiology
Rehab & Therapy	OP	NA	Rehab & Therapy
Unassigned_OP	OP	NA	Unassigned_OP

Appendix 7. Hypothetical Emergency Room Market Shift Example that Masks Avoided Utilization

		Base Year - ER ECMADS	Performance Year - ER ECMADS	Growth	Current Market Shift	Unrecognized Growth / (Decline)	Consolidated Geography Market Shift	Unrecognized Growth / (Decline)	
Same Zips	Hospital A West Baltimore	100	90	(10)	(10)	0	(6)	(4)	} Probable market shift being treated as avoided utilization
	Hospital B West Baltimore	200	225	25	10	15	25	-	
Same Zips	Hospital C East Baltimore	250	180	(70)	(20)	(50)	(39)	(31)	} Probable avoided utilization being treated as market shift
	Hospital D East Baltimore	100	120	20	20	0	20	-	
	Total	650	615	-35	0	-35	0	-35	



RY 2020 Update Factor Recommendation

May 8th, 2019



Update Factor Considerations

In considering the system-wide update for the hospitals with global revenue budgets under the TCOC Model, HSCRC staff sought to achieve balance among the following conditions:

- ▶ Meeting the requirements of the Total Cost of Care Model agreement;
- ▶ Providing hospitals with the necessary resources to keep pace with changes in inflation and population;
- ▶ Ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model; and
- ▶ Incorporating quality performance programs.

The proposed update factor for hospitals under a global budget is a revenue update that incorporates both price and volume adjustments.

Update Factor Recommendation for Non-Global Budget Revenue

	Global Revenues	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	2.96%	2.96%
Productivity Adjustment		-0.50%
Proposed Update	2.96%	2.46%

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Components of Revenue Change Linked to Hospital Cost Drivers/Performance

		Weighted Allowance
Adjustment for Inflation (this includes 3.10% for compensation)		2.77%
- Rising Cost of Outpatient Oncology Drugs		0.19%
Gross Inflation Allowance	A	2.96%
Care Coordination/Population Health	B	0.00%
Adjustment for Volume		
-Demographic /Population		0.30%
-Transfers		
-High/Low Efficiency Outliers		
-Drug Population/Utilization		
Total Adjustment for Volume	C	0.30%
Other adjustments (positive and negative)		
- Set Aside for Unknown Adjustments	D	0.10%
- Capital Funding -Adventist White Oak Medical Center	E	0.09%
- Categoricals (1%)	F	0.23%
-Reversal of one-time adjustments for drugs	G	-0.03%
Net Other Adjustments	H= Sum of D thru G	0.39%
Quality and PAU Savings		
-PAU Savings	I	-0.30%
-Reversal of prior year quality incentives	J	0.53%
-QBR, MHAC, Readmissions		
-Positive incentives & Negative scaling adjustments	K	0.18%
Net Quality and PAU Savings	L = Sum of I thru K	0.41%
Total Update First Half of Rate Year 20		
Net increase attributable to hospitals	M = Sum of A + B + C + H + L	4.06%
Per Capita First Half of Rate Year (July - December)	N = (1+M)/(1+0.30%)	3.75%
Adjustments in Second Half of Rate Year 20		
-Oncology Drug Adjustment	O	0.00%
-QBR	P	-0.37%
Total Adjustments in Second Half of Rate Year 20	Q = O + P	-0.37%
Total Update Full Fiscal Year 20		
Net increase attributable to hospital for Rate Year	R = M + Q	3.69%
Per Capita Fiscal Year	S = (1+R)/(1+0.30%)	3.38%
<u>Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements</u>		
-Uncompensated care, net of differential	T	0.03%
-Deficit Assessment	U	-0.16%
Net decreases	V = T + U	-0.13%
Total Update First Half of Rate Year 20		
Revenue growth, net of offsets	W = M + V	3.93%
Per Capita Revenue Growth First Half of Rate Year	X = (1+W)/(1+0.30%)	3.62%
Total Update Full Rate Year 20		
Revenue growth, net of offsets	Y = R + V	3.56%
Per Capita Fiscal Year	Z = (1+Y)/(1+0.30%)	3.25%
Private Payer Growth Rate, based on Total Update for Full Rate Year		4.76%
Public Payers Growth Rate		3.06%

Factors Excluded from Medicare Savings

Commitment: The Commission committed that the differential change would not provide for Medicare savings that would lead to higher Rate Updates

Conclusion:

- ▶ Staff analysis uses the all-payer inflation in evaluating the appropriateness of the update factor. Using this test the update factor meets Medicare targets. Therefore the rate update is not relying on differential savings to meet Medicare savings targets.

Estimated CY 2019 All-Payer Revenue Growth

Estimated Position on Medicare Target		
Actual Revenue CY 2018		17,341,823,084
Step 1:		
Estimated Approved GBR RY 2019		17,466,092,860
Actual Revenue 7/1/18-12/31/18		8,596,133,432
Projected Revenue 1/1/19-6/30/19	A	8,869,959,428
Step 2:		
Estimated Approved GBR RY 2020		18,152,802,313
Permanent Update		3.93%
Step 3:		
Estimated Revenue 7/1/19-12/31/19 (after 49.73% & seasonality)		9,027,388,590
Hopkins & Shady Grove*		14,000,000
	B	9,041,388,590
Step 4:		
Estimated Revenue CY 2019	A+B	17,911,348,018
Increase over CY 2018 Revenue		3.28%

*Hopkins Payback & Shady Grove GBR Adj.

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Maximum Increase that can Produce Medicare Savings using CY 2019 Growth

Maximum Increase that Can Produce Medicare Savings			
Medicare			
Medicare TCOC Growth (CY 2018 3.72%)	A	3.72%	
Savings Goal for RY 2020	B	0.00%	
Maximum growth rate that will achieve savings (A+B)	C	3.72%	
Conversion to All-Payer			
Actual statistic between Medicare and All-Payer <i>with conservatism</i>		0.83%	Recommendation:
Excess Growth for Non-Hospital Cost Relative to the Nation <i>with conservatism</i>		-1.18%	Savings:
Net Difference Statistic Related to Total Cost of Care	D	-0.35%	
Conversion to All-Payer growth per resident $(1+C)*(1+D)-1$	E	3.35%	2.98%
Conversion to total All-Payer revenue growth $(1+E)*(1+0.30\%)-1$	F	3.66%	0.38%

Maximum Increase that Can Produce Medicare Savings using RY 2020 Growth

Maximum Increase that Can Produce Medicare Savings			
Medicare			
Medicare TCOC Growth (CY 2018 3.7%)	A	3.72%	
Savings Goal for RY 2020	B	0.00%	
Maximum growth rate that will achieve savings (A+B)	C	3.72%	
Conversion to All-Payer			
Actual statistic between Medicare and All-Payer <i>with conservatism</i>		0.83%	Recommendation:
Excess Growth for Non-Hospital Cost Relative to the Nation <i>with conservatism</i>		-1.18%	Savings:
Net Difference Statistic Related to Total Cost of Care	D	-0.35%	
Conversion to All-Payer growth per resident $(1+C)*(1+D)-1$	E	3.35%	3.25% 0.11%
Conversion to total All-Payer revenue growth $(1+E)*(1+0.30\%)-1$	F	3.66%	3.56% 0.11%

Maximum Increase that Maintains Affordability

Maximum Increase that Maintains Affordability				
State Gross Domestic Product per Capita (3 year CAGR 3.42%)	A	3.42%	Recommendation:	Savings:
Savings Goal for RY 2020	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	3.42%	2.98%	0.44%
Conversion to total All-Payer revenue growth $(1+C)*(1+0.30\%)-1$	D	3.73%	3.28%	0.45%

RY 2020 Update Factor Recommendations

▶ Global Budget Revenues

- ▶ 3.56% for Revenue/3.25% per Capita
 - ▶ Allocate 0.19% of total base inflation allowance to high cost outpatient oncology and infused drugs.
 - ▶ Provide additional allowance to the two major Academic Medical Centers of one percent growth for high cost inpatient procedures.
 - ▶ Reduce Global Budgets by 0.30% statewide for Potentially Avoidable Utilization.

▶ Non-Global Revenues

- ▶ 2.46% (2.96%-0.50% productivity adjustment)

Draft Recommendation for the Update Factors for Rate Year 2020

May 8, 2019

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This document contains the draft staff recommendation for the RY 2020 Update Factors. Please submit comments on this draft to the Commission by May 15, 2019 to hsrc.payment@maryland.gov.

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List of Abbreviations

ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFS	Fee-for-service
FFY	Federal fiscal year, refers to the period of October 1 through September 30
FY	Fiscal year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
MPA	Medicare Performance Adjustment
PAU	Potentially avoidable utilization
QBR	Quality Based Reimbursement
RY	Rate year, which is July 1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care

Summary

The following report includes a draft recommendation for the Update Factor for Rate Year (RY) 2020. This update is designed to meet the Total Cost of Care Requirements while keeping healthcare affordable in the State of Maryland.

At this time, the staff requests that Commissioners consider the following draft recommendations:

- a) Provide an overall increase of 3.56 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.25 percent per capita revenue increase for hospitals under Global Budgets, as shown in Table 2.
 - i) Allocate 0.19 percent of the total inflation allowance to high cost outpatient oncology and infusion drugs, providing a 10 percent increase based on the amount each hospital reported for estimated cost and utilization for the top 80 percent of these drugs for RY 2018.
 - ii) Provide a conditional additional allowance to the two major Academic Medical Centers of one percent for growth in high cost inpatient procedures and intensity for RY 2020.
 - iii) Prospectively reduce Global Budgets by 0.30 percent statewide for Potentially Avoidable Utilization.
- b) Provide an overall increase of 2.46 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

Introduction & Background

The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy related adjustments, other adjustments related to performance, and settlements from the prior year.

Effective January 1, 2013, the State entered into an All-Payer Model Agreement with the Center for Medicare & Medicaid Services ("CMS"), which required the State to limit the growth in total hospital costs per resident in line with the long term growth in the economy, to achieve Medicare savings per beneficiary relative to national Medicare growth rates, to improve quality, and to transform the hospital reimbursement system away from fee for service to population-based payments. Preliminary data from December 2018 shows that the State has met all of the requirements of the All-Payer Model. In July 2018, CMS approved a new 10-year Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. Under the new TCOC Model, the State committed to continue to limit the growth in hospital costs in line with economic growth, reach an annual Medicare total cost of care savings rate of \$300 million by 2023 ("the Medicare TCOC Savings Requirement"), continue quality improvements, and improve the health of the population. The Medicare TCOC Savings Requirement compares the growth in total Medicare FFS expenditures per Maryland Medicare beneficiary to the national growth rate. These expenditures include both hospital and non-hospital costs. Because the State lacks regulatory authority over providers other than hospitals, meeting the Medicare TCOC savings requirement will require a greater emphasis on initiatives that control the total cost of care through transformation and population

health improvement efforts. The HSCRC will increasingly tie hospitals revenue adjustments to Medicare Total Cost of Care performance under the Medicare Performance Adjustment (MPA) Policy.

To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will need to place increased emphasis on ensuring that the Medicare TCOC Savings Requirement is met. The approach to ensuring that the RY 2020 annual update is in line with these Model requirements is outlined in this report.

Update Factors are Revenue Updates

It is important to note that the proposed update factor is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per capita growth rates, rather than unit rate changes.

Hospital Revenue Types Included in this Recommendation

There are two categories of hospital revenue:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority.
2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and, thus, Medicare does not pay on the basis of those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital.

This recommendation proposes Rate Year (RY) 2020 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Draft Update Factors Recommendations

For RY 2020, HSCRC staff is proposing an update of 3.25 percent per capita for global revenues and an update of 2.46 percent for non-global revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted Global Insight's Fourth Quarter 2018 market basket growth estimate with a capital growth estimate. For RY 2020, HSCRC staff combined 91.20 percent of Global Insight's First Quarter 2019 market basket growth of 3.10 percent with 8.80 percent of the capital growth estimate of 1.50 percent, calculating the gross blended amount as a 2.96 percent inflation adjustment.

Update Factor Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC staff proposes applying the FFY 2020 Inpatient Psychiatric Facilities Medicare productivity reduction of

0.50 percent to the inflation adjustment. When subtracting the 0.50 percent productivity adjustment from the gross blended inflation adjustment of 2.96 percent growth, this results in a proposed update of 2.46 percent. Additionally, HSCRC staff note that these hospitals receive a volume adjustment, rather than a population adjustment. HSCRC staff continues to work toward implementing quality measures for these hospitals in future rate years.

Table 1

	Global Revenues	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	2.96%	2.96%
Productivity Adjustment		-0.50%
Proposed Update	2.96%	2.46%

Update Factor Recommendation for Global Budget Revenue Hospitals

In considering the system-wide update for the hospitals with global revenue budgets under the All-Payer Model, HSCRC staff sought to achieve balance among the following conditions:

- Meeting the requirements of the Total Cost of Care Model agreement;
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model; and
- Incorporating quality performance programs.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates net revenue growth (before accounting for changes in uncompensated care and assessments) of 3.69 percent and per capita growth of 3.38 percent for RY 2020. After accounting for changes in uncompensated care and assessments, the HSCRC estimates net revenue growth at 3.56 percent with a corresponding per capita growth of 3.25 percent for RY 2020.

Staff needs to split the annual Rate Year revenue into six month targets to calculate financial tests, which are performed on Calendar Year (CY) results. Consistent with the past several years, the staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2020 estimated revenue used to evaluate the Rate Year year-end target. Of note, there are a few hospitals that do not follow this seasonal pattern, particularly Atlantic General Hospital. Thus, HSCRC staff will adjust the revenue split to accommodate their normal seasonality.

Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC staff’s draft recommendation for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments to global

revenues. Descriptions of each step and the associated policy considerations are explained in the text following the table.

Table 2

Balanced Update Model for Discussion for RY 2020		
<u>Components of Revenue Change Linked to Hospital Cost Drivers/Performance</u>		
		Weighted Allowance
Adjustment for Inflation (this includes 3.10% for compensation)		2.77%
- Rising Cost of Outpatient Oncology Drugs		0.19%
Gross Inflation Allowance	A	2.96%
Care Coordination/Population Health	B	0.00%
Adjustment for Volume		
-Demographic		0.30%
-Transfers		
-High/Low Efficiency Outliers		
-Drug Population/Utilization		
Total Adjustment for Volume	C	0.30%
Other adjustments (positive and negative)		
- Set Aside for Unknown Adjustments	D	0.10%
- Capital Funding -Adventist White Oak Medical Center	E	0.09%
- Categoricals (1%)	F	0.23%
-Reversal of one-time adjustments for drugs	G	-0.03%
Net Other Adjustments	H= Sum of D thru G	0.39%
Quality and PAU Savings		
-PAU Savings	I	-0.30%
-Reversal of prior year quality incentives	J	0.53%
-QBR, MHAC, Readmissions		
-Positive incentives & Negative scaling adjustments	K	0.18%
Net Quality and PAU Savings	L = Sum of I thru K	0.41%
Total Update First Half of Rate Year 20		
Net increase attributable to hospitals	M = Sum of A + B + C + H + L	4.06%
Per Capita First Half of Rate Year (July - December)	N = (1+M)/(1+0.30%)	3.75%
Adjustments in Second Half of Rate Year 20		
-Oncology Drug Adjustment	O	0.00%
-QBR	P	-0.37%
Total Adjustments in Second Half of Rate Year 20	Q = O + P	-0.37%
Total Update Full Fiscal Year 20		
Net increase attributable to hospital for Rate Year	R = M + Q	3.69%
Per Capita Fiscal Year	S = (1+R)/(1+0.30%)	3.38%
<u>Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements</u>		
-Uncompensated care, net of differential	T	0.03%
-Deficit Assessment	U	-0.16%
Net decreases	V = T + U	-0.13%
Total Update First Half of Rate Year 20		
Revenue growth, net of offsets	W = M + V	3.93%
Per Capita Revenue Growth First Half of Rate Year	X = (1+W)/(1+0.30%)	3.62%
Total Update Full Rate Year 20		
Revenue growth, net of offsets	Y = R + V	3.56%
Per Capita Fiscal Year	Z = (1+Y)/(1+0.30%)	3.25%
Private Payer Growth Rate, based on Total Update for Full Rate Year		4.76%
Public Payers Growth Rate		3.06%

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

HSCRC staff accounted for a number of factors that are central provisions to the update process and are linked to hospital costs and performance. These include:

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 2.96 percent. The gross inflation allowance is calculated using Global Insight's First Quarter 2019 market basket growth of 3.10 percent with 8.80 percent of the capital growth 1.50 percent estimate. The adjustment for inflation includes 3.10 percent for compensation. A portion of the 2.96 inflation allowance (0.19 percent) will be allocated to hospitals in order to accurately provide revenues for increases in outpatient oncology drugs. This drug cost adjustment is further discussed below.
- **Rising Cost of New Outpatient Drugs:** The rising cost of drugs, particularly of new physician-administered drugs in the outpatient setting, continues to be a growing concern among hospitals, payers, and consumers. Not all hospitals provide these services and some hospitals have a much larger proportion of costs allocated. To address this situation, staff began allocating a specific part of the inflation adjustment to fund increases in the cost of drugs in Rate Year 16, based on the portion of each hospital's total costs that were comprised of drug costs.

In addition to the drug inflation allowance, in RY 2017, HSCRC initiated a utilization adjustment for changes in use of high cost oncology and infusion drugs. The adjustment for change in use is made utilizing information provided in a supplemental report provided by the hospitals for the top 80 percent of these specified outpatient medications. Half of the estimated cost changes due to usage or volume changes are recognized as a one-time adjustment and half are recognized as a permanent adjustment.

In 2019, staff prepared a drug funding analysis evaluating funding levels by hospital and drug category from RY 2013 through RY 2018. Drug costs were split into three categories: inpatient drugs, outpatient oncology and infusion drugs, and other outpatient drugs. In this evaluation, staff found that oncology and infusion drug costs averaged a 10 percent annual increase, while inpatient and other outpatient drugs rose more in line with general inflation. As a result of these findings, staff is recommending a modification to the approach it used in RY 2019 to focus the additional inflation for drugs to high cost outpatient oncology and infusion drugs. This will result in a higher growth allowance for these high cost drugs, while continuing to provide inflation for other categories of drugs through the overall inflation allowance. For Rate Year 2020, staff proposes to apply a 10 percent growth allowance, based on drug-specific growth trends, to the top 80 percent of the specified outpatient medications, as reported on hospitals' supplemental drug cost for RY 2018. In RY 2019, 0.31 percent was set aside for inflation for drugs. For RY 2020, staff proposes to set aside 0.19 percent of the inflation allowance to apply to high cost oncology and infusion drugs, leaving the remaining drug inflation together with the general inflation allowance.

For Rate Year 2021, staff may explore use of a standard list of drugs, which could be used to calculate the inflation allowance as well as the drug utilization adjustment component of funding

for these high cost drugs. Staff will review this possibility and the standard list of drugs with stakeholders during the upcoming months.

- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for CY 2018 is 0.30 percent. For RY 2020, the staff are proposing recognizing the full value of the 0.30 percent growth for the Demographic Adjustment to hospitals in keeping with prior year norms.
- **Set-Aside for Unforeseen Adjustment:** Staff recommends a 0.10 percent set-aside for unforeseen adjustments during RY 2020.
- **Capital Funding:** Adventist Health Care is opening a new hospital, White Oak Medical Center, in Silver Spring Maryland. This facility is expected to open in August of 2019. This recommendation includes 0.09 percent for capital for the opening of this facility, which is approximately \$15 million as approved by the Commission during the CON process.
- **Categorical Cases:** Existing categorical cases include transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. The HSCRC staff has been working to develop an approach to provide a revenue adjustment for these and other expensive therapies performed primarily at University of Maryland Medical Center and Johns Hopkins Hospital. In Rate Year 2019, the HSCRC provided these two AMC hospitals an additional one percent revenue adjustment to create a fixed pool of funds for these and other quaternary services. For RY 2020, staff is again proposing to provide these two AMCs an additional one percent revenue adjustment for RY 2020. Similar to RY 2019, this adjustment will be contingent upon receipt of data regarding productivity and cost levels relative to national peers and ongoing cost savings efforts submitted by the AMCs, which are essential in assuring that the AMCs are improving productivity levels. HSCRC staff will continue to evaluate the level of funding and funding mechanisms that will be employed for RY 2021 and beyond, and the Commission will need to continue to deliberate how to fund these types of services in the future.
- **QBR Adjustment:** CMS provides data for the Quality Based Reimbursement (QBR) adjustment. Due to the data delivery schedule, HSCRC does not have the final data available to calculate this adjustment at this time. HSCRC expects the adjustment to be approximately -0.37 percent, based on the changes in Commission policy and preliminary modeling. HSCRC staff will include this adjustment in the second half of RY 2020.
- **Quality Scaling Adjustments:** Quality scaling adjustments include Maryland Hospital Acquired Conditions (MHAC) and Readmission Reduction Incentive Program (RRIP). The RY 2019 adjustments have been restored in the base and new adjustments are reflected in staff's recommendation. The amount for these two programs which will be adjusted for in the first half of the rate year is 0.18 percent.
- **PAU Savings Reduction:** The statewide RY 2020 PAU savings adjustment is now calculated based on update factor inflation and demographic adjustment applied to CY 2018 PAU revenue. RY 2020 PAU savings adjustment represents the change between RY 2019 and RY 2020. Previous years of PAU savings adjustments are not reversed out.

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

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2020 will be 0.03 percent. The amount in rates was 4.16 percent in RY 2019, and the proposed amount for RY 2020 is 4.19 percent. This is the first year since 2014 that staff is not reducing UCC in rates since 2014. This outcome is to be expected as Medicaid Expansion and Affordable Care Act Enrollment have plateaued, and thus UCC has remained stable.
- **Deficit Assessment:** The legislature reduced the deficit assessment by \$25 million in RY 2020, and as a result, this line item is -0.16 percent.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. These additional variables include one-time adjustments, revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

PAU Savings Updated Methodology

The PAU Savings Policy prospectively reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY2020, the calculation of the statewide value of the PAU Savings will be included in the Update Factor Recommendation; however, PAU measurement policy will be presented separately. For this year, a brief summary of the PAU performance and measure methodology is available in the appendix, but in subsequent years, staff plans to produce PAU policy reports that will include measure and hospital-specific scaling discussions.

Starting in RY 2020, the incremental amount of statewide PAU Savings reductions will be determined formulaically using inflation and demographic adjustment applied to the amount of PAU revenue (see Table 3). In previous years, staff reversed out the prior year cumulative PAU reduction and recalculated the cumulative PAU reduction with an incremental increase to realize additional savings from continued reductions in PAU. In the current policy, staff recommends keeping prior year reductions in place and only implementing additional incremental reductions in keeping with actual rate setting implementation norms. With this change, staff also proposes discontinuing the additional protection for hospitals with high socioeconomic burden, as the smaller incremental reduction lessens the need for continued protections.

Staff compared the actual PAU savings reductions from RY 2014-RY 2019 to the cumulative formulaic inflation-based approach and found that cumulatively PAU savings reductions were about \$7.2 million more than under the formulaic approach. Therefore, staff and stakeholders suggest reducing the RY2020

reduction amount by \$7.2 million (\$58.1 million to \$50.8 million) to ensure that the cumulative PAU reduction and cumulative PAU inflation net out to zero in RY 2020. This will result in a RY 2020 PAU savings reduction of about -0.3021 percent statewide. For simplicity’s sake, staff recommends rounding this value to -0.30 percent.

Table 3

Statewide Results		Value
RY 2019 Total Estimated Permanent Revenue	A	\$16,842,884,479
Total RY20 PAU %	B	10.77%
Total RY20 PAU \$	C	\$1,922,894,085
Statewide Total Calculations (formulaic)		Value
RY 2020 Inflation Factor (preliminary)	D	3.02%
RY 2020 Revenue Adjustment \$	$E=C*D$	-\$58,071,401
Ry 2020 Revenue Adjustment %	$F=E/A$	-0.345%
Statewide Total Calculations (adjusted)		
Cumulative difference	G	-\$7,188,437
RY 2020 Revenue Adjustment \$	$H=E-G$	-\$50,882,964
Ry 2020 Revenue Adjustment %	$I=H/A$	-0.302%
Recommended RY2020 Revenue Adjustment %		-0.30%

Change in Differential

In December 2018, the Commission voted to approve staff’s recommendation to increase the differential from 6.0 percent to 7.7 percent effective July 1, 2019. The State of Maryland has employed a differential since the 1970s whereby public payers (Medicare and Medicaid) pay less than other payers (primarily commercial payers) due to business practices that avert bad debt in hospitals and keep Maryland’s hospital costs low. Hospital charges are adjusted via a markup to ensure that the differential’s reduction in charges to public payers does not result in a decline in hospitals’ total revenue. 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. This change accounts for the changes in business practices of private Maryland payers that have resulted in higher bad debt costs. To implement the differential, hospital rates will be increased by approximately 1.2 percent. Medicare and Medicaid will receive an additional discount of 1.7 percent off of charges, and the net revenue effect will be revenue neutral to hospitals. As reflected at the bottom of table 2, this change in the differential results in a private payer growth rate of 4.76 percent and a public payer growth rate of 3.06 percent based on the full rate year update.

With the adoption of this increased differential, the Commission specified that any savings to Medicare from this adjustment could not be utilized to result in a higher all-payer rate adjustment. As shown in the

following tables 5a and 5b, staff is using the all-payer revenue increase to evaluate whether Maryland is meeting the all-payer and Medicare growth targets, rather than the lower Medicare increase resulting from the changed public payer differential. Through this approach, staff is ensuring that the savings to Medicare resulting from the differential calculation are not increasing the level of update allowed to hospitals.

Consideration of All-Payer Model Agreement Requirements & National Cost Figures

As described above, the staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Additionally, based on staff calculations, the proposed update falls within the financial parameters of the TCOC Model agreement requirements. The staff's considerations in regards to the TCOC Model agreement requirements are described in detail below.

Medicare Financial Test

Based on the staff's calculations, the proposed update keeps Maryland within the constraints of the TCOC Model's Medicare savings test. This test requires the Model to generate \$300 million in annual Medicare fee-for-service (FFS) savings in total cost of care expenditures (Parts A and B) by 2023. The TCOC Model Medicare Savings Requirement is different from the previous All-Payer Model Medicare savings requirement in several ways. First, as previously discussed, Maryland's Total Cost of Care Model Agreement progresses to setting savings targets based on total costs of care, which includes non-hospital cost increases, as opposed to the hospital only requirements of the All-Payer Model. This shift ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from Model implementation. Additionally, the change to total cost of care focuses hospital efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care. Secondly, the All-Payer Model Savings Requirement was a *cumulative* savings test, where the savings for each year relative to the base period were added up to determine the total *hospital* savings. The TCOC Model requires that the State reach *annual* savings of \$300 million relative to the national growth rate by 2023, relative to a 2013 base year. Thus, there must be sustained improved performance over time to meet the new TCOC Medicare Savings Requirements. The new TCOC Model contains specific annual Medicare Savings Requirements for each year. Based on the CY 2018 performance, staff expects to exceed the TCOC Model's annual Savings Requirement of \$120 million for performance year one (CY 2019). However, similar to the All-Payer Model, there are TCOC growth guardrails. Maryland's Medicare TCOC growth may not exceed the national Medicare TCOC growth rate in any two successive years and Maryland may not exceed the national growth rate by more than one percent in any year. Corrective actions are required if these limits are exceeded.

The growth in Medicare expenditures in Maryland outside of hospitals continues to exceed the national growth rate. Under the All-Payer Model, the HSCRC built a conservative approach to estimating variations in hospital cost growth. For the Total Cost of Care Model, HSCRC staff proposes to extend

this approach to evaluating variations in Total Cost of Care performance. This revised approach will be discussed in the following section.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In order to ensure Model savings and guardrails are being met, staff compared Medicare growth estimates to the all-payer spending limits. Because the actual revenue resulting from updates in RY 2019 affect the CY 2019 results, staff must convert the recommended RY 2020 update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2019 to assist in estimating the impact of the recommended update factor together with the projected RY 2019 results. The overall increase from the bottom of this table is used in Table 5a.

Table 4

Estimated Position on Medicare Target		
Actual Revenue CY 2018		17,341,823,084
Step 1:		
Estimated Approved GBR RY 2019		17,466,092,860
Actual Revenue 7/1/18-12/31/18		8,596,133,432
Projected Revenue 1/1/19-6/30/19	A	8,869,959,428
Step 2:		
Estimated Approved GBR RY 2020		18,152,802,313
Permanent Update		3.93%
Step 3:		
Estimated Revenue 7/1/19-12/31/19 (after 49.73% & seasonality)		9,027,388,590
Hopkins & Shady Grove*		14,000,000
	B	9,041,388,590
Step 4:		
Estimated Revenue CY 2019	A+B	17,911,348,018
Increase over CY 2018 Revenue		3.28%

*Hopkins Payback & Shady Grove GBR Adj.

Steps to explain Table 4 are described as below:

- Step 1: The table begins with the estimated global revenue for RY 2019 and actual revenue for the last six months for CY 2018 to calculate the projected revenue for the first six months of CY 2019 (i.e. the last six months of RY 2019).
- Step 2: This step shows the estimated RY 2020 global budget revenue based on the information that staff have available to date. The permanent update over RY 2018 of 3.93 percent represents the portion of the RY 2020 update provided during the calendar year 2019, as shown in Table 2.
- Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2020 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2020 and hospital specific seasonality adjustments. An adjustment for

the temporary rate adjustment for Johns Hopkins Hospital and Adventist Behavioral Health is also added to revenues.

· Step 4: This step shows the resulting estimated revenue for CY 2019 and then calculates the increase over actual CY 2018 Revenue.

For the past five updates, Maryland obtained calendar year Medicare fee-for-service growth estimates from the CMS Office of the Actuary. The projected per capita amount for Medicare Parts A and B for CY 2019 is 4.03 percent. Due to the variability in the estimates from actual performance, particularly with estimates beyond the current year, staff is proposing using actual national Medicare FFS total cost of care growth from the previous calendar year moving forward in our guardrail and savings test, absent large policy changes that would suggest significantly different growth estimates. National Medicare FFS total cost of care growth for CY 2018 was 3.72 percent, shown in line A of Table 5a and 5b.

During CY 2014-CY 2018, all-payer growth outpaced Medicare growth on a per capita basis and in the updates staff adjusted the all-payer growth limit using the difference in Medicare and all-payer per capita growth to estimate the implied limit for Medicare.

For the purposes of evaluating the maximum all-payer spending growth that will allow Maryland to meet the per capita Medicare FFS target, the Medicare target must be translated to an all-payer growth limit. There are several ways to calculate the difference between Medicare FFS and all-payer growth rates using recent data trends. A consultant to CareFirst developed a “conservative difference statistic” that reflected the historical increase in Medicare per capita spending in Maryland relative to all-payer per capita spending growth. This conservative statistic has been updated each year using data provided by HSCRC. For the RY 2020 update, CareFirst and HSCRC staff calculated a difference of 0.83 percent, which used a five-year average difference between Maryland Medicare and all-payer claims reduced by the average annual absolute variance.

Maryland Medicare total cost of care cannot exceed national Medicare total cost of care growth by one percent in any single year and cannot exceed the national growth by any amount in two consecutive years; these are known as ‘total cost of care guardrails.’ In an effort to ensure that Maryland does not exceed the national Medicare growth rate in CY 2019, staff modeled the impact of excess non-hospital growth on the maximum hospital update that could be provided. This calculation assesses Medicare growth in unregulated settings and factors this excess growth into allowable hospital rate increases for RY 2020. Staff modeled non-hospital excess growth, inclusive of a conservative factor of -1.18 percent, which was calculated by taking a five year average of non-hospital excess growth and additionally accounting for the absolute average variance to provide conservatism.

In prior years the staff has included a 0.50 percent reduction in the Medicare Growth target to ensure the State achieves savings under the All-Payer Model. This year we omitted that adjustment in both tables 5a and 5b, as results for CY 2018 show the State well ahead of savings targets. In future years this target adjustment will not be necessary, assuming the Commission subsequently approves the MPA Efficiency Component draft recommendation reviewed in April 2019 which provides a vehicle for achieving savings on a Medicare-only basis. If that policy is not approved the all-payer approach to achieving Medicare savings will be restored to the update factor.

The first scenario, shown in Table 5a calculates savings using the calendar year growth calculated in Table 4. The second scenario, shown in Table 5b calculates savings using the full rate year growth projection from lines Y & Z on Table 2. Both scenarios project a favorable outcome based on staff’s projections.

Table 5a – Using Calendar Year Growth Estimate

Maximum Increase that Can Produce Medicare Savings			
Medicare			
Medicare TCOC Growth (CY 2018 3.72%)	A	3.72%	
Savings Goal for RY 2020	B	0.00%	
Maximum growth rate that will achieve savings (A+B)	C	3.72%	
Conversion to All-Payer			
Actual statistic between Medicare and All-Payer <i>with conservatism</i>		0.83%	Recommendation: Savings:
Excess Growth for Non-Hospital Cost Relative to the Nation <i>with conservatism</i>		-1.18%	
Net Difference Statistic Related to Total Cost of Care	D	-0.35%	
Conversion to All-Payer growth per resident $(1+C)*(1+D)-1$	E	3.35%	2.98% 0.38%
Conversion to total All-Payer revenue growth $(1+E)*(1+0.30\%)-1$	F	3.66%	3.28% 0.38%

Table 5b – Using Rate Year Growth Estimate

Maximum Increase that Can Produce Medicare Savings			
Medicare			
Medicare TCOC Growth (CY 2018 3.72%)	A	3.72%	
Savings Goal for FY 2020	B	0.00%	
Maximum growth rate that will achieve savings (A+B)	C	3.72%	
Conversion to All-Payer			
Actual statistic between Medicare and All-Payer <i>with conservatism</i>		0.83%	Recommendation: Savings:
Excess Growth for Non-Hospital Cost Relative to the Nation <i>with conservatism</i>		-1.18%	
Net Difference Statistic Related to Total Cost of Care	D	-0.35%	
Conversion to All-Payer growth per resident $(1+C)*(1+D)-1$	E	3.36%	3.25% 0.11%
Conversion to total All-Payer revenue growth $(1+E)*(1+0.30\%)-1$	F	3.67%	3.56% 0.11%

Staff also modeled the growth and compared it to economic growth in Maryland as measured by the State Gross Domestic Product (State GDP, which was previously called the Gross State Product (GSP)). The purpose of this modeling is to ensure that healthcare remains affordable in the state. Staff calculated the compounded annual growth rate (CAGR) for three years using the most updated State GDP numbers available. (CY14-CY17). The 3-year CAGR calculation shows a per capita amount of 3.42 percent. Staff compared that number to the calendar year increase shown in Table 6 to ensure that the update provided in this draft recommendation would maintain growth in line with economic growth. The chart below shows this comparison.

Table 6 – Using Calendar Year Growth Estimate

Maximum Increase that Maintains Affordability				
State Gross Domestic Product per Capita (3 year CAGR 3.42%)	A	3.42%	Recommendation:	Savings:
Savings Goal for RY 2020	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	3.42%	2.98%	0.44%
Conversion to total All-Payer revenue growth $(1+C)*(1+0.30\%)-1$	D	3.73%	3.28%	0.45%

Medicare’s Proposed National Rate Update for FFY 2020

CMS published proposed updates to the federal Medicare inpatient rates for FFY 2020 in the Federal Register in mid-April 2019. These updates are summarized in Table 7 below. These updates will not be finalized for several months and are subject to change. In the proposed rule, CMS would increase rates by approximately 3.20 percent in FFY 2020 compared to FFY 2019, after accounting for inflation, a disproportionate share increase, and other adjustments required by law. The proposed rule includes an initial market basket update of 3.20 percent for those hospitals that were meaningful users of electronic health records and for those hospitals that submitted data on quality measures, less a productivity cut of 0.50 percent. This proposed update also reflects a proposed 0.50 percentage point increase for documentation and coding required by the American Taxpayer Relief Act of 2012. Disproportionate share payment changes resulted in an increase of approximately 0.18 percent from FFY 2019.

Table 7

	Inpatient	Outpatient
Base Update		
Market Basket	3.20%	3.20%
Productivity	-0.50%	-0.50%
ACA	0.00%	0.00%
Coding	0.50%	
	<hr/>	<hr/>
	3.20%	2.70%
Other Changes		
DSH	0.18%	0.00%
Other Changes	0.00%	0.00%
	<hr/>	<hr/>
	0.18%	0.00%
	<hr/>	<hr/>
	3.38%	2.70%

Applying the inpatient assumptions about market basket, and productivity, staff estimates a 2.70 percent Medicare outpatient update effective January 2020. This estimate is pending any adjustments that may be made when the final update to the federal Medicare outpatient rates is published.

Stakeholder Comments

HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2020 update. HSCRC staff will update this section when the official stakeholder comment period has closed.

Recommendations

Based on the currently available data and the staff's analyses to date, the HSCRC staff provides the following draft recommendations for the RY 2020 update factors.

- a) Provide an overall increase of 3.56 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.25 percent per capita revenue increase for hospitals under Global Budgets, as shown in Table 2.
 - i) Allocate 0.19 percent of the total inflation allowance to high cost outpatient oncology and infusion drugs, providing a 10 percent increase based on the amount each hospital reported for estimated cost and utilization for the top 80 percent of these drugs for RY 2018.
 - ii) Provide a conditional additional allowance to the two major Academic Medical Centers of one percent for growth in high cost inpatient procedures and intensity for RY 2020.
 - iii) Prospectively reduce Global Budgets by 0.30 percent statewide for Potentially Avoidable Utilization.
- b) Provide an overall increase of 2.46 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

Appendix A. Potentially Avoidable Utilization (PAU) Savings Methodology

This year the PAU Savings reduction has been incorporated into the Update Factor recommendation since the statewide reduction is now being linked to the update factor inflation and demographic adjustment. This appendix provides additional details on the RY 2020 PAU measurement methodology, as well as the future direction of PAU measurement.

RY2020 PAU Hospital-Specific Measurement

The PAU Savings Policy applies the statewide reduction (as specified in the body of Update Factor Recommendation) to each hospital's total permanent revenue. The statewide reduction is scaled for each hospital based on the amount of PAU revenue assigned to that hospital (e.g., hospitals with PAU revenue greater than the statewide average receive a higher revenue adjustment than the statewide reduction). For RY 2020, PAU revenue is defined as revenue associated with 30-day, all-cause readmissions¹ and ambulatory-care sensitive condition admissions (measured by AHRQ Prevention Quality Indicators (PQIs)).

Readmissions: In prior years, readmissions were assigned to the hospital that received the readmission (i.e., the hospital where the readmission occurred). In response to Commissioner and stakeholder feedback, staff has changed the methodology to assign readmissions to the sending or index hospital for the RY 2020 adjustment. To calculate the readmission revenue associated with the sending hospital, staff vetted with Performance Measurement Workgroup applying the average cost of an intra-hospital readmission (i.e., cost of readmissions that occurred to and from the same hospital) to the total number of sending readmissions assigned to each hospital. Applying this average cost avoids holding sending hospitals accountable for the cost structure at a receiving hospital.

PQIs: HSCRC will use AHRQ PQI version 2018 for Calendar Year 2018 performance.² As with previous PAU Savings policy, PQI revenue will exclude revenue flagged as both a PQI and a readmission. Revenue flagged as both PQI and readmission will be included in the readmissions revenue.

Protection: As detailed in the Draft RY 2020 Update Factor Recommendation, staff recommends discontinuing the additional protection for hospitals with high socioeconomic burden. In prior years, the PAU savings reductions were capped at the state average if a hospital served a high proportion of disadvantaged populations.³ This policy was initially adopted because hospitals serving areas with higher socioeconomic burden may face additional challenges in reducing PAU, such as issues with transportation, family and community resources, or health literacy barriers. On the other hand, the Commission does not want to excuse poor quality of care or inadequate care coordination for patients in disadvantaged communities. Due to these issues, staff indicated a potential future phasing out of the protection in the RY 2019 PAU Savings Policy.

Staff believes ending the additional protection for incremental PAU adjustments ensures that these hospitals have the needed resources to serve their communities, while still incentivizing them to reduce

¹ 30-day, all-cause, all-payer, all-hospital readmissions for inpatient stays and observation stays greater than 23 hours, excluding planned admissions, same and next day transfers, oncology cases, and newborns.

² Starting in 2018, staff will begin to phase out the use of PQI02 perforated appendix. PQI02 data after October 2018 will NOT be included in determining performance and revenue adjustments due to AHRQ logic issues.

³ In the RY2019 Policy, this criterion was defined as hospitals in the top quartile in Maryland in terms of the percentage of their total inpatient equivalent case-mix adjusted discharges that are Medicaid/Self-Pay/Charity.

their PAU percentage below the statewide level to receive a lower reduction. Because PAU savings adjustments are built into permanent revenue, hospitals that received the protection continue to benefit from prior years of protection. With the policy shift to calculating only incremental PAU savings adjustments, this historically protected revenue will remain in permanent revenue. Only new PAU Savings adjustments will not have the protection.

RY2020 Hospital-specific results: Draft and final PAU revenue adjustments by hospital will be posted on the HSCRC website (<https://hscrc.maryland.gov/Pages/PAU-Savings.aspx>) as they are available.

PAU refinement and expansion

Based on Commissioner and stakeholder feedback, staff and stakeholders explored approaches to modernize the PAU measurement in order to increase measure comprehensiveness, resolve methodological concerns with PQI measures, and align with the Total Cost of Care Model. Staff discussed potential expansion and refinement of PAU with a PAU subgroup in the summer and fall of 2018, as well as with the Performance Measurement Workgroup throughout 2018.

Low Value Care. The subgroup proposed and considered a total of thirty-six potential low value care measures, and based on stakeholder input and data availability, the HSCRC calculated three measures for consideration. Ultimately, subgroup members felt the tested measures were too narrow and represented too small dollar values to be worth implementation. Many subgroup members felt that broader measures of utilization represented greater opportunities for making meaningful change and impact on total cost of care. However, they also felt that the PAU Savings policy may not be the most appropriate incentive mechanism, given that many of these measures are not clearly specified, or may occur outside the hospital. Given this feedback, HSCRC is planning on monitoring broad utilization through Medicare data to identify outliers and consider taking action on a case-by-case basis.

New measures. In response to strong consumer and Medicaid support, staff plans on recommending the addition of avoidable pediatric admissions to the PAU measurement for RY 2021.⁴

Per Capita. For RY2021, HSCRC staff intends to recommend a shift to a per capita PAU performance evaluation for PQIs. This approach better aligns with the original population-based intention of PQIs, better recognizes hospital accountability in communities, and enables inclusion of avoidable pediatric admissions. Working with the PAU subgroup and Performance Measurement Work Group, HSCRC plans to propose a methodology for attributing avoidable admissions to hospitals that incorporates the Medicare Performance Adjustment (MPA) attribution process for applicable Medicare beneficiaries, followed by a geographic attribution approach for other patients. Currently, the staff and stakeholders have not made a decision on whether or how to measure readmissions under a per capita model, but starting in 2019 PQI admissions will be flagged prior to readmissions (i.e., if both a PQI and a readmission, then will count as PQI). HSCRC is working with CRISP to produce per-capita performance reports for CY 2019 on PQIs and PDIs as data becomes available. With the incorporation of the MPA attribution in per-capita PQI calculation⁵, HSCRC anticipates that CRISP reports for per-capita PQI performance results will be available approximately three to four months following the encounter. A detailed memo on the overall

⁴ AHRQ pediatric quality indicators (PDIs) and PQI 09 Low Birthweight Newborns

⁵ MPA relies on Medicare billing data that has longer data lags compared to hospital case-mix data. In addition, the first reports of the year may have an additional delay due to loading of new algorithm information.

PQI per capita attribution and readmission measurement will be available as details are vetted by stakeholders and moved into production for CY 2019 performance measurement.



CRISP

Final HIE Funding Request

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HIE Funding Request for FY2020

	HSCRC Assessment	MMIS Development	MMIS Maintenance
ICN Activities			
Core HIE Services	\$670,000	\$0	\$0
Population Health	\$480,000	\$790,000	\$1,440,000
Program Administration	\$840,000	\$440,000	\$170,000
ICN Total by Funding Source	\$1,990,000	\$1,230,000	\$1,610,000
ICN Total	\$4,830,000		
HIE and Regulatory Activities			
Regulatory Casemix Reporting	\$210,000	\$0	\$640,000
HIE Operations and IAPD Match	\$2,500,000	\$0	\$0
HIE and Regulatory Total by Source	\$2,710,000	\$0	\$640,000
HIE and Regulatory Total	\$3,350,000		

Full ICN and HIE Budget*	\$8,180,000
Medicaid MMIS Funding Request	(\$3,480,000)
MMIS Matching Requirement	\$690,000
Final ICN and HIE Assessment Request	\$5,390,000

*Note: MDPCP Program Management funds are not included

Core HIE: Point of Care and Care Coordination

- Projects to enhance data and make it more accessible in providers' workflows; part of CRISP's core HIE services and will be absorbed into operations covered by user fees by FY22

Population Health

- Casemix and Medicare claims reports that increase transparency between policymakers and hospital finance departments, and are used for supporting population health initiatives; paid for by hospital assessments

Program Administration

- Support for Care Redesign Programs by being a central source for document submission, facilitating reports for participants, and helping in the protocol design for new programs as requested by stakeholders; CRISP's focus is on efficiency in providing these services
- Primarily includes operations for ECIP and potential new program development

Regulatory Casemix Reporting

- CRISP provides reports to hospitals and policymakers that support transparency and consistency in reimbursement methodology and payment policy

HIE Operations and IAPD Match

- Funding certain HIE operations such as the support team and the source for the required 10% match for IAPD projects

**Draft Recommendation:
Maryland's Statewide Health Information Exchange,
the Chesapeake Regional Information System for our
Patients: FY 2020 Funding to Support HIE Operations,
CRISP Reporting Services and the ICN Project**

May 8, 2019

Health Services Cost Review Commission
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LIST OF ABBREVIATIONS

BRFA	Budget Reconciliation and Financing Act
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
CRP	Care Redesign Program
CRS	CRISP Reporting Services
FY	Fiscal year
HIE	Health information exchange
HITECH	Health Information Technology for Economic and Clinical Health Act
HSCRC	Health Services Cost Review Commission
IAPD	Implementation Advanced Planning Document
ICN	Integrated care network
MDH	Maryland Department of Health
MHCC	Maryland Health Care Commission
MHIP	Maryland Health Insurance Plan
MMIS	Medicaid Management Information Systems

OVERVIEW AND RECOMMENDATION

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the Total Cost of Care Model and the public interest,¹ this recommendation identifies the amount of funding support required in fiscal year (FY) 2020 to the Chesapeake Regional Information System for our Patients (CRISP), for the following purposes:

- Health Information Exchange (HIE) operations (\$1,500,000); and
- Implementation Advanced Planning Document (IAPD) matching funds (\$1,000,000)
- ICN Program Support (\$2,200,000)
- Medicaid Management Information System (MMIS) matching funds (\$690,000)

Therefore the recommendation is that the HSCRC provide total funding of \$5,390,000 to CRISP. This reflects a \$2,890,000 increase from FY 2019 funding of \$2,500,000.

The increase in this assessment entirely relates to a transition in funding sources for Integrated Care Network (ICN) projects. Through FY 2019, under the Budget Reconciliation and Financing Act (BRFA) of 2015, the ICN projects were funded by the Maryland Health Insurance Plan (MHIP) funds, however, beginning in FY 2020 these funds are no longer available.

ICN projects include (1) CRISP Reporting Services (CRS), which provide reporting to the Maryland Health Services Cost Review Commission (HSCRC or Commission) and hospitals and other stakeholders in the State, (2) point of care resources to aid providers and care managers with effective care management and (3) the development and administration of the Care Redesign Program (CRP) which addresses specific opportunities to align healthcare providers and improve the efficiency of care delivery in Maryland.

The original sustainability plan for ICN projects was to shift operating costs to participant fees. The HSCRC and CRISP will continue to transition costs associated with ongoing CRP administration and point of care services to participants through user fees. New program development and reporting will continue to be funded by the CRISP-related assessment and Federal matching funds. This recommendation reflects this new blend of funding sources for ICN projects.

¹ MD. CODE ANN., Health-Gen §19-219(c).

BACKGROUND – PAST FUNDING

Over the past nine years, the Commission has approved funding to support the general operations of the CRISP HIE and reporting services through hospital rates as shown in Table 1.

Table 1. HSCRC Funding for CRISP HIE and Reporting Services, FYs 2010-2019

CRISP Budget: HSCRC Funds Received	
FY 2010	\$4,650,000
FY 2011	No funds received
FY 2012	\$2,869,967
FY 2013	\$1,313,755
FY 2014	\$1,166,278
FY 2015	\$1,650,000
FY 2016	\$3,250,000
FY 2017	\$2,360,000
FY 2018	\$2,360,000
FY 2019	\$2,500,000

In December 2013, the Commission authorized staff to provide continued funding support for CRISP for FYs 2015 through 2019 without further Commission approval as long as the amount does not exceed \$2.5 million in any year. Requested funding for FY 2020 will exceed that level and the Commission is required to approve this recommendation.

FY 2020 FUNDING THROUGH HOSPITAL RATES

Beginning in FY 2015, CRISP-related hospital rate assessments are paid into an MHCC fund, and MHCC and the HSCRC review the invoices for approval of appropriate payments to CRISP. This process, along with the auditing of the expenditures, has created an extra layer of accountability. The remaining section details the infrastructure and support that will be funded in FY 2020 through the hospital rate setting system.

HIE Operations Funding

The value of an HIE rests in the premise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The

General Assembly charged the MHCC and HSCRC with the designation of a statewide HIE.² In the summer of 2009, MHCC awarded state designation to CRISP, and HSCRC approved up to \$10 million in startup funding over a four-year period through Maryland's unique all-payer hospital rate setting system. HSCRC's annual funding for CRISP is illustrated in Table 1 above.

The use of HIEs is a key component of health care reform, enabling clinical data sharing among appropriately authorized and authenticated users. The ability to exchange health information electronically in a standardized format is critical to improving health care quality and safety.

Many states, along with federal policy makers, look to Maryland as a leader in HIE implementation. Further investment in building CRISP's infrastructure is necessary to support existing and future use cases and to assist HSCRC as it moves to per-capita and population-based payment structures under the Total Cost of Care Model. A return on the investment will occur from having implemented a robust technical platform that can support innovative use cases to improve care delivery, increase efficiencies in health care, and reduce health care costs.

The total amount of funding recommended by staff for FY 2020 for the HIE function is \$1,500,000.

Implementation Advanced Planning Document (IAPD) Matching Funds

In addition to its role in HIE among providers, CRISP is also involved in health care reform activities related to HSCRC, MHCC, and the Maryland Department of Health (MDH). In its collaboration with the Medicaid program, uniform and broad-based funding through hospital rates can also be used to leverage federal financial participation under the Health Information Technology for Economic and Clinical Health (HITECH) Act, known as IAPD funding. Under the HITECH Act, the Centers for Medicare & Medicaid Services (CMS) may approve states for Medicaid Electronic Health Record Incentive Program funding, and states receive a 90 percent federal financial participation match for expanding HIE through 2021. This request will enable CRISP (working with MDH) to obtain federal funding. IAPD funding allows CRISP (working with MDH) to qualify for funding to implement use cases that compliment ICN activities.

In FY 2020, the State's match of \$1.0 million will leverage \$9.0 million in federal funds for a variety of initiatives. Activities enabled through IAPD that enhance the point of care delivery include: encounter notification services, practice-level advanced-implementation support, ambulatory integration, hospital integration, and image exchange. Common infrastructure activities include: data routing and consent management, technical infrastructure and operations expense, and data architecture. Finally, there are a number of public health reporting initiatives as well, including: public health use case management, electronic lab reporting, MDH interface development and validation, and CMS Clinical Quality Measures reporting.

² MD. CODE ANN., Health-Gen §19-143(a).

The total amount of funding recommended by staff to obtain IAPD matching funds for FY 2020 is \$1,000,000.

ICN Project Support

The ICN initiatives were 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. The ICN initiative encourages collaboration between and among providers, provides a platform for provider and patient engagement, and allows for confidential sharing of information among providers. To succeed under the new Total Cost of Care Model, providers will need a variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

The intent is to transition funding for the administration of ICN projects to user fees. This transition began in FY 2019 and continues through FY 2022. This recommendation covers three components that are not currently funded by user fees, (1) funding of existing program administration during the transition to user fee funding (2) funding for enhancements to current administrative processes and (3) transitional funding for ICN related reporting. The existing programs recommended for funding are:

- Point of care tools provided to providers and care managers. Funding for these tools is scheduled to transfer to 100 percent CRISP user fee funding by FY 2022.
- Administration of existing Care Redesign Program tracks. These tracks will be 100 percent user fee funded beginning January 1, 2020.

The enhancements recommended for funding include developing and implementing streamlined administrative procedures and support for enhanced knowledge sharing tools in support of existing and future CRP programs.

The transitional funding represents funding for CRS reporting for the period prior to anticipated MMIS matching funds on October 1, 2019 at which point this reporting will be funded under the MMIS section of this recommendation

The total amount of funding recommended by staff for FY 2020 for ICN Project Support is \$2,200,000. Approximately \$800,000 of the funding is for activities already scheduled to transition to user fee funding in future fiscal years. Another \$750,000 represents CRS funding for the period prior to the transition to MMIS funding.

Medicaid Management Information Systems Matching Funds

A major component of the ICN project is the reporting provided by CRISP to hospitals, the HSCRC and other system stakeholders from both Medicare and All-Payer sources. CRISP expects to be able to transition funding for this reporting, previously funded by MHIP dollars, to matching grants under the Federal MMIS program beginning October 1, 2019. MMIS is a Federal program designed to promote effective care for Medicaid beneficiaries through

investments in information technology infrastructure. Medicaid benefits from CRISP's reporting initiatives through the care management and cost control initiatives facilitated for all Medicaid patients under CRISP all-payer reporting and for dual-eligible patients under CRISP's Medicare reporting.

Under MMIS, state funds are eligible for either a 90 percent match for new reporting initiatives or a 75 percent match for ongoing reporting. The assessment funding will provide the State's portion of this match. Approximately \$560,000 relates to maintaining existing reporting infrastructure and is therefore eligible for a 75 percent match. The remainder of funds relates to new reporting initiatives which are eligible for a 90 percent match.

Reporting funded under this element of the assessment includes CRISP reporting tools utilizing the Medicare claims and the HSCRC's hospital Casemix data set. CRISP reporting from these datasets are used by hospitals, the HSCRC and other stakeholders to manage and track progress under a number of HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

The total amount of funding recommended by staff for FY 2020 for to obtain Federal MMIS matching funds is \$690,000

SUMMARY

Staff is recommending the Commission approve a total of \$5,390,000 in funding through hospital rates in FY 2020 to support the HIE and IAPD initiative activities and continue the investments made in the ICN initiatives (previously funded through MHIP) through both direct funding and obtaining Federal MMIS matching funds.

Table 2 shows the recommended funding through hospital rates and the federal match that will be generated from the IAPD and MMIS funding as well as the user fee funding.

Table 2. FY 2020 Recommended Rate Support for CRISP as a share of total Funding

FY 2020 Project Name	Hospital Rates (State)	Budgeted Funding (Federal)	User Fees (primarily Hospitals)	Total
HIE Operations	\$1,500,000	--	\$3,772,000	\$5,272,000
IAPD Match	\$1,000,000	\$9,000,000	--	\$10,000,000
ICN Project Support	\$2,200,000	--	\$2,504,000	\$4,704,000
MMIS Match	\$690,000	\$2,790,000	--	\$3,480,000
Total funded	\$5,390,000	\$11,790,000	\$6,276,000	\$23,456,000
% of Total	23%	50%	27%	100%

Maryland Patient Safety Center



FY 20 Initiatives (collaboratives)

- **Safe Infant Sleep**
 - Reduce rate of infant deaths through Safe Infant Sleep program (infant mortality)
- **Opioid Use Disorder in Pregnancy**
 - Increase in number of Opioid Use Disorder (OUD) pregnant women in treatment; reduce maternal deaths due to accidental overdose (maternal mortality, LOS)
- **OB Hemorrhage**
 - Simulation training that will focus on helping participants run *in situ simulations* (simulations on actual L&D and postpartum units) to prepare their teams for obstetrical hemorrhage emergencies. (readmissions, LOS, maternal mortality)
- **Errors in Diagnosis**
 - A three phase, multi-year initiative that will first determine the scope of the problem, develop actions and implement those procedures and protocols (LOS, readmissions, utilization)
- **Opioid Education**
 - State-wide public awareness initiative in partnership with MedChi and MHA aimed at educating the public about several components related to opioid misuse (utilization, LOS)
- **Adverse Event Reporting**
 - Data submissions from hospitals in order to determine trending patient safety issues

FY 20 Initiatives (education)

- Annual Patient Safety Conference (spring)
- Medication Safety Conference (fall)
- Root Cause Analysis
- Six Sigma
- Lean
- TeamSTEPPS
- Failure Mode Effect Analysis
- Human Factors
- Patient Safety Foundations
- Appreciative Inquiry

FY 20 Initiatives (revenue generating)

- Caring for the Caregiver
- TeamSTEPPS
- Lean Daily Management
- Patient Safety Certification

FY 19 Outcomes

- Decreased transfers of NAS infants from out of birth hospital by 57%; decreased LOS for infants treated pharmacologically for NAS by 3 days resulting in a cost savings of \$1.8 million.
- Decrease in rate of NTSV c-sections (2015-2018) by 65% of participating hospitals decreased NTSV rate (20/31); 36% decreased rate by more than 10%; 10% decreased rate by more than 20%; Aggregate decrease: 5.1% NTSV; 6.8% NTSV after induction resulting in 473 less C-section births for a cost avoidance of \$898,701.
- 35% improvement in cleanliness in participating acute care hospitals as measured by RLUs and a 54% increase in cleanliness in participating ambulatory surgery centers as measured by RLUs. (preliminary data as of 1/19)
- Presented the opioid education program to over 800 individuals in 12 jurisdictions.
- Implemented *Caring for the Caregiver* in 11 states with \$237,000 in gross sales (an additional \$130,000 expected to close by June 30)
- Implemented MPSC Certification in 2 hospitals and 1 post acute facility with \$84,500 in gross sales

Draft Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2020

May 8, 2019

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This is a draft recommendation. Written comments should be submitted to erin.schurmann@maryland.gov no later than May 15, 2019.

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LIST OF ABBREVIATIONS

Delmarva	Delmarva Foundation for Medical Care
FY	Fiscal Year
HQI	Hospital Quality Initiative
HSCRC	Health Services Cost Review Commission
MAPSO	Mid-Atlantic Patient Safety Organization
MDH	Maryland Department of Health
MHA	Maryland Hospital Association
MHCC	Maryland Health Care Commission
MPSC	Maryland Patient Safety Center
NAS	Neonatal Abstinence Syndrome
RFP	Request for Proposals
TCOC	Total Cost of Care

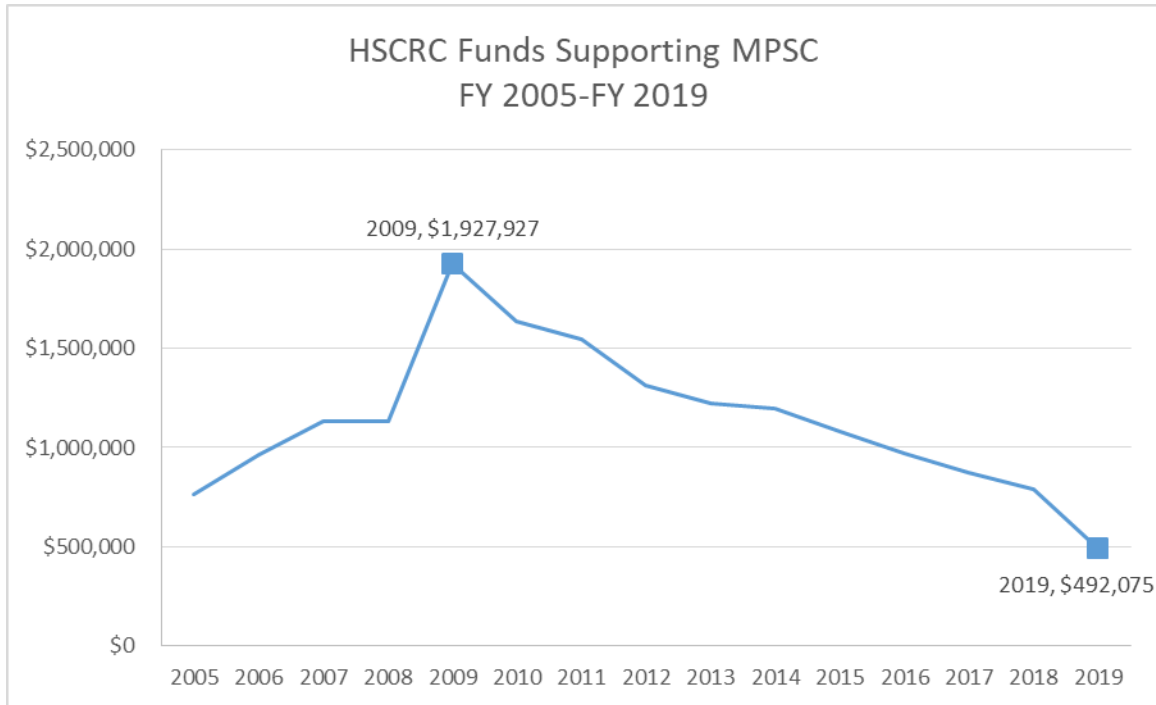
INTRODUCTION

In 2004, the Maryland Health Services Cost Review Commission (HSCRC or Commission) adopted recommendations to provide seed funding for the Maryland Patient Safety Center (MPSC) through hospital rates. The initial recommendations funded 50 percent of the reasonable budgeted costs of the MPSC. In FY 2019, HSCRC-dedicated funds accounted for 29 percent of its total budget. The proposed support for MPSC in FY 2020 represents 20 percent of the total budget. The HSCRC collaborates with MPSC on projects as appropriate, receives an annual briefing and documentation on the progress of the MPSC in meeting its goals, as well as an estimate of expected expenditures and revenues for the upcoming fiscal year. Based on the annual budget item information provided by the MPSC and staff experience, staff makes recommendations to the Commission regarding the continued financial support of the MPSC.

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

Over the past 15 years, the HSCRC included an adjustment to the rates of eight Maryland hospitals to provide funding to cover the costs of the MPSC. Funds are transferred biannually, by October 31 and March 31 of each year. Although funding increased between FY 2005 and FY 2009, the level of HSCRC support has declined each year since FY 2009, consistent with the original intent to scale back State-funded support. **Figure 1** below shows the funding level the HSCRC's in support of the MPSC.

Figure 1. HSCRC funds supporting MPSC FY2005-FY2019



In March 2019, the HSCRC received the MPSC program plan update for FYs 2019 and 2020. The MPSC is requesting a total of \$369,056 in funding support from the HSCRC for FY 2020, a 25 percent decrease over the previous year that is consistent with the Commission’s intent to reduce State funds over time and encourage a sustainable business model for the MPSC.

BACKGROUND

The 2001 General Assembly passed the Patients’ Safety Act of 2001,¹ charging the Maryland Health Care Commission (MHCC)—in consultation with the Maryland Department of Health (MDH)—with studying the feasibility of developing a system for reducing the number of preventable adverse medical events in Maryland, including a system of reporting such incidences. The MHCC subsequently recommended the establishment of the MPSC to improve patient safety in Maryland.

¹ Chapter 318, 2001 Md. Laws.

In 2003, the General Assembly endorsed this concept by including a provision in legislation to allow the MPSC to have medical review committee status, thereby making the proceedings, records, and files of the MPSC confidential and not discoverable or admissible as evidence in any civil action.²

The MHCC selected the Maryland Hospital Association (MHA) and the Delmarva Foundation for Medical Care (Delmarva) through the State's Request for Proposals (RFP) procurement process to establish and operate the MPSC in 2004, with an agreement that the two organizations would collaborate in their efforts. MHA and Delmarva jointly operated the MPSC from 2004 to 2009. The MPSC was then reorganized as an independent entity and was re-designated by the MHCC as the State's patient safety center starting in 2010 for two additional five-year periods. The MPSC has started the process to renew their designation as the State's patient safety center, which expires December 2019.

ASSESSMENT

Strategic Priorities and Partnerships

The MPSC's vision is to be a center of patient safety innovation, convening health care providers to accelerate understanding of, and implement evidence-based solutions for preventing avoidable harm. Its mission is to make healthcare in Maryland the safest in the nation.

The MPSC's goals are to:

- Eliminate preventable harm for every patient, with every touch, every time;
- Develop a shared culture of safety among patient care providers; and,
- Be a model for safety innovation in other states.

To accomplish its vision, mission, and goals, the MPSC established and continues to build new strategic partnerships with an array of key private and public organizations. The organizations represent a broad array of interests and expertise, including policymakers and providers across the continuum of healthcare quality, safety, and learning and education.

MPSC Members and Partnerships

- The MPSC has membership agreements with 42 member hospitals, representing \$400,000 in annual dues.

² MD. CODE. ANN., Health-Gen. § 1-401(b)(14);(d)(1).

- The Mid-Atlantic Patient Safety Organization (MAPSO), a component of the MPSC, includes 42 members representing hospitals, long-term care facilities, and ambulatory care facilities. The primary activities of the MAPSO are to improve patient safety and healthcare quality by collecting adverse event reports, and holding educational events for members.
- The MPSC includes 12 strategic partners:
 - Alliance for Innovation in Maternal Health
 - Health Facilities Association of Maryland
 - HQI
 - Johns Hopkins School of Medicine/The Armstrong Institute for Patient Safety and Quality
 - Lifespan
 - Maryland Ambulatory Surgical Association
 - Maryland Department of Health
 - Maryland Department of Human Services
 - MedChi
 - Maryland Hospital Association
 - NextPlane
 - PRONTO

Educational Programs and Conferences

- Customized educational programs for MPSC members driven by changing needs of members and the healthcare industry. Examples include root cause analysis, failure mode effects analysis, positive accountability, and appreciative inquiry.
- Expanded the reach of the MPSC and increased participation levels of member hospitals through educational opportunities.
- Convened the Annual Maryland Patient Safety Center Conference, which is the MPSC's signature event providing awareness, education, and information regarding best practice solutions.

Maryland Patient Safety Center Activities, Accomplishments, and Outcomes

Ongoing MPSC initiatives have engaged providers in hospitals, long-term care facilities, and ambulatory care facilities, as well as patients and consumers. MPSC uses a collaborative model to bring together providers from across the care spectrum to learn best practices to improve care and outcomes. MPSC is now using the Berkley Research Group to verify and analyze data collected from hospitals and other providers participating in MPSC initiatives.

Highlights from the data analyzed by MPSC include:

- Neonatal Abstinence Syndrome – The number of newborns with NAS that need to be transferred to a higher level nursery and specialty hospital decreased by 57 percent from 2016 to 2018. Length of stay for newborns decreased by 3 days, resulting in a cost avoidance of \$1.8 million from January to September 2018.
- Reducing First Time Cesarean Sections – From 2015-2018, 65 percent of hospitals participating in the collaborative experienced reductions in NTSV cesarean sections, resulting in a 5.1 percent aggregate decrease.
- Clean Collaborative – As measured in relative light units (RLUs), participating hospitals showed a 35 percent improvement in cleanliness and participating ambulatory surgery centers showed a 54 percent increase in cleanliness.

FY 2020 Quality and Safety Initiatives

The MPSC has a number of ongoing multi-year quality and safety initiatives, as well as new initiatives that will commence in FY 2020. At the suggestion of the Commission, the initiatives more closely track the quality goals of the TCOC Model.

New programming that addresses quality and safety issues in FY 2020 include:

- **Safe Infant Sleep** - The Maryland Patient Safety Center Neonatal Quality Collaborative is facilitating a collaborative to improve statewide infant safe sleep practices to reduce preventable sleep-related infant deaths in our state. All delivery hospitals in Maryland were invited to participate in the Maryland Patient Safety Center Safe Infant Sleep Project. The collaborative will run from March 2019 until February of 2021.
- **Obstetric Hemorrhage** - The Maryland Patient Safety Center will be offering a simulation workshop on conducting effective simulations and drills. The workshop will focus on helping participants run in situ simulations (i.e. simulations on actual L&D and postpartum units) to prepare their teams for obstetrical hemorrhage emergencies.
- **Obstetric Care for Women with Opioid Use Disorder** – The MPSC is joining a multi-state collaborative in collaboration with the Alliance for Innovation in maternal Health (AIM). MPSC will coordinate the activities in Maryland utilizing the AIM bundle of best practices. The collaborative will run for two years - from February 2019 to January 2021.

Ongoing initiatives that will continue in FY 2019 include:

- **Opioid Education for Consumers** – In response to the statewide opioid addiction epidemic, the MPSC has partnered with MHA and MedChi to conduct a patient-centered statewide public awareness campaign aimed at educating

consumers on opioid use. Topics include reasonable pain management expectations, the pros and cons of opioid use, opioid prescription storage and disposal, and important questions to ask when being prescribed an opioid medication. MPSC has presented the opioid education program to over 800 individuals in 12 jurisdictions.

- **Adverse Event Reporting:** Initiated in July 2016, the Adverse Event Reporting initiative identifies trending patient safety issues, such as medication errors, at select Maryland hospitals. Data collected on adverse events help to determine future programming and educational needs for Maryland hospitals.
- **Diagnostic Errors:** A study group will explore the role that the MPSC could take in the emerging work on diagnostic errors

FY 2020 Projected Budget

The MPSC continued to work with its partners to secure program-specific funding for FY 2020 and estimated the amounts it will secure for FY 2020 in the proposed budget outlined in Figure 2 below, including potential funds from the HSCRC. Consistent with FY 2019, the majority of the revenue anticipated in FY 2020 are derived from membership dues and conference revenue. In FY 2019, HSCRC funding accounted for 29 percent of its operating expenses. If approved, the FY 2020 HSCRC funding will account for approximately 20 percent of the total MPSC expenses.

During FY 2019, the MPSC made progress bolstering its other revenue streams, of which key ones are listed below. Diversifying the revenue stream for MPSC is crucial to the long-term sustainability of the Center in order to create stability in fiscal planning and to move away from the reliance on rate setting funds.

- **Caring for the Caregiver** – MPSC implemented Caring for the Caregiver program in 11 states and expects to close FY 2019 with \$254,500 in gross sales.
- **Patient Safety Certification** – MPSC implemented the Patient Safety Certification in two hospitals and one post-acute facility with \$84,500 in gross sales in YTD in FY 2019.
- **Lean Daily Management** – This is a new initiative in FY 2020 that MPSC expects to generate an additional \$34,000 in additional revenue. Lean Daily Management, which is based on the widely-used Toyota Production System, provides tools to encourage hospitals to optimize both quality and cost through streamlining activities and eliminating waste in healthcare delivery.
- **TeamSTEPPs** – This is a new initiative in FY 2020 that the MPSC expects to generate \$130,000 in additional revenue. TeamSTEPPs aims to improve patient outcomes through improving communication and teamwork between healthcare providers.

Figure 2. Proposed MPSC Revenue and Expenses

Maryland Patient Safety Center, Inc. Statement of Income and Expenses Budget FY19 and Proposed FY20	FY 2019 Total Budget	FY 2020 Proposed Total Budget
Restricted Fund Beginning Balance as of 7/1/2018	0	0
Restricted/Temp Restricted Grant Revenue	200,000	359,500
Net Assets Released from Restriction	(200,000)	(356,167)
Change in Restricted/Temp Restricted Net Assets	0	3,333
Ending Restricted/Temp Restricted Fund Balance	0	3,333
Unrestricted Fund Beginning Balance as of 7/1/2018		
Board Designated Operating Reserve	174,344	174,344
Unrestricted Net Assets	1,675,306	1,699,262
Total	1,849,650	1,873,606
<u>Unrestricted Revenue</u>		
HSCRC Hospital Contributions	492,075	369,056
Membership Dues	375,000	400,000
Education Session Revenue	22,000	19,750
Annual Patient Safety Conference Revenue	210,000	200,000
Medsafe Revenue	4,000	10,000
Program Sales - Caring for HC	137,750	175,000
Program Sales - Patient Safety	125,000	100,000
Program Sales - Team STEPPS	25,000	125,000
Program Sales - Lean Daily Management	0	25,000
Care Alerts Collaborative Revenue	27,600	8,494
Other Grants & Contributions	50,000	0
Net Assets Released from Restriction	200,000	356,167
Total Unrestricted Revenue	1,668,425	1,788,467
<u>Unrestricted Expenses</u>		
Administration	387,800	409,646
Education Sessions	35,250	32,750
Annual Patient Safety Conference	315,500	287,500
Medsafe Medication Safety Initiative	22,750	21,500
Caring for HC	110,888	158,457
Safe Sleep	0	156,167
Patient Safety Training & Certification	81,500	90,733
Team STEPPS	0	130,191
Lean Daily Management	0	33,908
Adverse Event Reporting System	34,500	34,500
Perinatal/Neonatal Patient Safety Collaboratives	205,082	200,000
OB Hemorrhage	0	58,000
Clean Environment	80,000	0
Medication Reconciliation	24,500	0
Diagnosis Errors	48,500	66,900
Opioid Misuse	131,400	60,100
Joy & Meaning	50,700	15,000
Emergency Department	88,500	0
Care Alerts Collaborative	27,600	8,494
Total Unrestricted Expenses	1,644,470	1,763,845
Change in Unrestricted Net Assets	23,956	24,622

MPSC Return on Investment

As noted in the last several Commission recommendations, the HSCRC provides funding for the MPSC with the expectation that there will be both short- and long-term reductions in Maryland healthcare costs, particularly related to such outcomes as reduced mortality rates, lengths of stay, patient acuity, and malpractice insurance costs. The MPSC must continue to collect data on its programs in order to show quantifiable improvements in patient safety and outcomes and share best practices.

Additional data on all of the MPSC's programs is needed to ensure that the limited dollars available for MPSC funding creates meaningful improvements in quality and outcomes at facilities in Maryland to achieve the goals of the Total Cost of Care Model. Beginning in FY 2018, MPSC engaged the work of the Berkley Research Group to collect and analyze data from hospitals participating in MPSC programs or initiatives. The MPSC should continue to report results from its initiatives to HSCRC staff.

RECOMMENDATIONS

Quality and safety improvements are the primary drivers to achieve the goals of reduced potentially avoidable utilization and reduced complications in acute care settings under the TCOC Model. For these reasons, it is important to continue to support hospitals in identifying and sharing best practices to improve patient quality and outcomes. While individual hospitals across the State are experimenting with strategies to improve care coordination, enhance processes for better care, and advance systems and data sharing to maximize the efficiency and effectiveness of care, the MPSC is in a unique position to convene healthcare providers and share best practices that have been identified through multi-provider collaborative testing and change. The key stakeholders that are involved with the MPSC include hospitals, patients, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the Total Cost of Care Model. The MPSC is in a favorable position in the State to develop and share best practices among this group of key stakeholders. To support the overall mission of the State, the MPSC should align initiatives with the broader statewide plan and activities for patient safety.

In light of the information presented above, HSCRC staff provides the following recommendations for the MPSC funding support policy for FY 2020:

1. Consistent with the prior Commission recommendations, the HSCRC should reduce the amount of funding support for the MPSC in FY 2020 by 25 percent. The result is an adjustment to hospital rates in the amount of \$369,056 in FY 2020, a 25 percent reduction from FY 2019.
2. In order to receive future funding from the hospital rate setting system, the MPSC should continue to report on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.

3. Going forward, the HSCRC should decrease the amount of support by 25 percent per year in order to achieve the goal of independent sustainability for MPSC.
4. The MPSC should continue to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs.

Draft Recommendation
Changes to Relative Value Units for Emergency Services
Effective July 1, 2019

May 8, 2019

Health Services Cost Review Commission

4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX (410) 358-6217

This is a draft recommendation for Commission consideration at the May 8, 2019 Public Commission Meeting. Please submit comments on this draft to the Commission by Friday, May 31, 2019, via hard copy mail or email to William Hoff, William.Hoff@maryland.gov.

Draft Staff Recommendation

May 8, 2019

Recommendation

The Commission staff recommends for review and public comment revisions to the Relative Value Unit (RVU) Scale for Emergency Services. The revisions are specific to the Chart of Accounts and Appendix D of the Accounting and Budget Manual. These revised RVUs were developed by a workgroup established by the Health Services Cost Review Commission, and membership included representatives of Maryland Hospital Association, Maryland Hospitals, Maryland Insurance Industry and Consultants. The RVU scale was updated to reflect the revisions to the Current Procedural Terminology (CPT) codes mandated by the American Medical Association. At your direction, the staff will send the revisions to all Maryland Hospitals for their Review and Comments.

**SECTION 200
CHART OF ACCOUNTS**

6710 EMERGENCY SERVICES

6711 Emergency Room

6719 Other Emergency Services

Function:

Emergency Services provide emergency services to the ill and injured who require immediate medical or surgical care on an unscheduled basis. (See Appendix D for definition of services)

Description

This cost center contains the direct expenses incurred in providing services in the Emergency Department. Direct expenses included are: salaries and wages, employee benefits, professional fees (non-physician), non-medical supplies, purchased services, other direct expenses.

Standard Unit of Measure: Number of Relative Value Units

Relative Value Units as determined by the HSCRC. (See Appendix D of this manual)

Data Source

The number of Relative Value Units shall be the actual count maintained by Emergency Services.

Reporting Schedule

Schedule D – Line D19

REVISED APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
EMERGENCY SERVICES

Account Number
6710

Cost Center Title
Emergency Services

Cost Center Code
EMG

EMG

HSCRC abbreviation for Emergency Department

Relative Value Units (RVUs)

A standard unit of measure. A unique value or weight assigned to a specific service, e.g., number of visits for a particular hospital unit.

The RVUs for this cost center are based on resource consumption. Each facility is expected to develop, retain, and maintain Internal Guidelines, which identify the resources consumed. These resources may include but are not limited to time, staff intervention, complexity, patient severity, etc. The facility's Internal Guidelines are to be used for the purpose of maintaining Service Level reporting consistency among patients receiving comparable or similar treatment/care/resource consumption; and that patients receiving greater (or lesser) treatment/care/resource consumption would be assigned an appropriately higher (or lesser) Service Level.

General Guidelines

1. There is a direct relationship between the amounts of EMG resources consumed by a patient and the Service Level assigned to the patient.
2. The facility will prepare, record, and maintain appropriate documentation to support and justify the EMG Service Level assigned. If a service or task is not documented, then that service or task cannot be included in the determination of the Service Level assignment. Patients are not to be charged, nor RVUs reported for a service or task that is not documented.
3. The facility's Internal Guidelines may not be totally inclusive or explanatory. It is recognized that the circumstance of the visit and the EMG Service Level selected will involve a degree of clinical judgment and patient acuity. It is recommended that each facility's Internal Guidelines include an analysis of resource use and the services provided by EMG staff. The format and content are at the facility's discretion.
4. Charges for EMG services are a by-product of all expenses and RVUs assigned to the EMG department. Ancillary services can be provided within the EMG area (e.g., laboratory, radiology, respiratory, etc.). If the cost of providing an ancillary service in the EMG is assigned to the ancillary center, regulated charges for that ancillary service must be included in the patient bill. However, if the cost associated with an ancillary service is assigned to the EMG department (e.g., an EMG registered nurse or other EMG personnel providing respiratory care or specimen collection), then the cost associated with the service is part of the EMG determination of Service Level. It is recommended that this distinction be part of the facility's Internal Guidelines.
5. EMG patients will be assigned a Service Level based on total resources consumed, from the EMTALA Medical Screening Examination to final patient disposition.
6. In addition to EMG Service Level charge, the hospital will charge separately for drugs, supplies, and ancillary services (as noted in 4 above). Professional fees are not regulated by the HSCRC and therefore are not included in the hospital's charges. Professional fees would be a separate charge.

**REVISED APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
EMERGENCY SERVICES**

<u>CPT Services Levels</u>		<u>RVU</u>
99281	Level I/ EMTALA (Medical Screening Examination)	1
99282	Level II	1
99283	Level III	2
99284	Level IV	4
99285	Level V	7
99291	Level V	7

ECS (Extended Care Services) - The RVUs assigned are based on clock time.
1 RVU per 2 hours period up to 48 hours.

Extended Care Service

- This service is associated with outpatients who have received EMG services and are awaiting transfer/discharge to another facility some examples includes; tertiary care facility, nursing home, inpatient psychiatric facility, and etc.. The services being provided to the patient during ECS may or may not be minor.
- This is an add-on RVU to Level V only (e.g., ECS RVUs may be added to the Treatment Level V RVUs) and is for services provided AFTER EMG Treatment.
- If the services provided during ECS are major, the Service Level may be increased.
- Extended Care Services are based on "clock time". For each full two hour period of clock time, one (1) RVU is assigned. Any partial hours are rounded down to the nearest full two hour period. For example, two hours and five minutes is reported as two hours = one RVU. Two hour and fifty-five minutes is reported as one two hours period = one RVU.
- To qualify for ECS reporting, the patient must be an outpatient and must be transferred to another facility. The transfer must be fully documented in the medical record.

REVISED APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
EMERGENCY SERVICES

- Below are four examples of the proper reporting of Extended Care Service:
 1. A trauma patient begins his EMG visit at noon. The resources utilized resulted in a Level V service being assigned. The patient is stabilized and is to be transferred to a trauma facility. The time is now 12:55 pm. Because of inclement weather conditions, the transfer is delayed for four and one half (4.5) hours. The reporting of RVUs would be as follows: EMTALA one RVU plus service Level V seven RVUs , plus ECS for 4 hours = 2.0 RVUs (rounded down to four hours from the actual of four and one half hours (4.5), the total RVUs reported would be 10).
 2. A trauma patient begins his EMG visit at noon. The resources utilized resulted in a service Level III being assigned. The patient is stabilized and is to be transferred to a trauma facility. The time is now 12:45 pm. The patient is immediately transferred to another facility. The reporting of RVUs would be as follows: EMTALA one RVU plus service Level III two RVUs. There are no ECS RVUs reported, since the reported Level was something other than Level V.
 3. A trauma patient begins his EMG visit at noon. The patient is stabilized and is to be transferred to a trauma facility. The resources utilized resulted in a service Level IV being assigned. The time is now 1:00 pm. Because of inclement weather conditions, the transfer is delayed for four and one half (4.5) hours. The reporting of RVUs would be as follows: EMTALA one RVU plus service Level IV four RVUs. There is no ECS RVUs reported, since the reported Level was something other than Level V.
 4. A trauma patient begins his EMG visit at noon. The patient is stabilized and is to be transferred to a trauma facility. The resources utilized resulted in a service Level III being assigned. Because of inclement weather conditions, the transfer is delayed for nine (9.0) hours and is transferred at 9:00 P.M. Major resources were utilized the first three hours of the delay and the service level was increased to Level V. The remaining six (6) hours of the delay is now considered ECS. The reporting of RVUs would be a follows, EMTALA one RVU plus services Level V 7 RVUs., plus ECS for 6 hours 3 RVUs, the total RVUs would be 11 RVUs.



Interim Follow-Ups

May 2019



Interim Policy Work with other State Partners

- ▶ Certificate of Need – Coordination and engagement with MHCC
- ▶ Alternate use of excess regulated space
- ▶ Facility Fee notification and consumer awareness
- ▶ MDPCP reporting
- ▶ Coordination with EMS providers and evaluation of ED overcrowding
- ▶ Update Financial Disclosures
- ▶ Rural Health Delivery and Financing
- ▶ Medicaid Total Cost of Care
- ▶ Maryland Maternal and Child Health

State of Maryland
Department of Health

Nelson J. Sabatini
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

John M. Colmers

James N. Elliott, M.D.

Adam Kane

Jack C. Keane



Katie Wunderlich
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Allan Pack, Director
Population Based
Methodologies

Chris Peterson, Director
Payment Reform &
Provider Alignment

Gerard J. Schmith, Director
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Compliance

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Health Services Cost Review Commission

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**561st MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
May 8, 2019**

EXECUTIVE SESSION

11:00 a.m.

(The Commission will begin in public session at 11:00 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**
 - Staff will discuss updates on the TCOC Model and implementation activities for the TCOC Model.
- 2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104**
 - Staff will discuss updates related to TCOC and Medicare performance.

PUBLIC SESSION

1:00 p.m.

- 1. Review of the Minutes from the Public and Closed Meetings held on April 10, 2019.**
- 2. New Model Monitoring**
 - Staff will present an abbreviated report on hospital financials and per capita numbers.
- 3. Docket Status – Cases Closed**

2475R - Calvert Health Medical Center 2476A – Johns Hopkins Health System
2477A – Johns Hopkins Health System
- 4. Docket Status – Cases Open**

2478A – University of Maryland Medical Center 2479A – University of Maryland Medical Center
2480A – University of Maryland Medical Center

 - Commissioners will vote on 2478A, 2479A, and 2480A.
- 5. Final Recommendation on Nurse Support Program II for FY 2020**
 - Commissioners will vote on final NSP II funding proposals for FY 2020.
- 6. Draft Recommendation on Market Shift Adjustment Policy**
 - This is a draft recommendation. Commissioners will vote on the final policy in June.

- 7. Draft Recommendation on the Update Factor for FY 2020**
 - This is a draft recommendation. Commissioners will vote on the final policy in June.
- 8. Draft Recommendation on Ongoing Support of CRISP in FY 2020**
 - This is a draft recommendation. Commissioners will vote on the final policy in June.
- 9. Draft Recommendation for the Maryland Patient Safety Center for FY 2020**
 - This is a draft recommendation. Commissioners will vote on the final policy in June.
- 10. Draft Recommendation on Changes to the Relative Value Units Scale on Emergency Department Services**
 - This is a draft recommendation. Commissioners will vote on the final policy in June.
- 11. Policy Update and Discussion**
 - Staff will provide an update on staff activities and other relevant subjects to the Commission.
- 12. Hearing and Meeting Schedule**

**Closed Session Minutes
Of the
Health Services Cost Review Commission**

April 10, 2019

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

1. Legal Consultation – Authority General Provisions Article, §3-305(b)(7)

The Closed Session was called to order at 11:40 a.m. and held under authority of §3-305 (b)(7) of the General Provisions Article.

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

In attendance representing Staff were Katie Wunderlich, Jerry Schmith, Allan Pack, Chris Peterson, William Henderson, Alyson Schuster, Will Daniel, Amanda Vaughan, Joe Delenick, Bob Gallion, and Dennis Phelps.

Also attending were Eric Lindemann, Commission Consultant, and Stan Lustman, Commission Counsel.

Item One

Stan Lustman, Commission Counsel, presented and the Commission and staff discussed advice of counsel on potential methodology changes.

Closed Session was adjourned at 1:07 p.m.

MINUTES OF THE
560th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
April 10, 2019

Chairman Nelson Sabatini called the public meeting to order at 11:40 a.m. Commissioners Joseph Antos, Victoria Bayless, John Colmers, James Elliott, M.D., Adam Kane, and Jack Keane were also in attendance. Upon motion made by Commissioner Antos and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Chairman Sabatini reconvened the public meeting at 1:14 p.m.

REPORT OF APRIL 10, 2019 CLOSED SESSION

Mr. Dennis Phelps, Associate Director, Audit & Compliance, summarized the minutes of the April 10, 2019 Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM MARCH 13, 2019 CLOSED SESSION AND
PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the March 13, 2019 Public Meeting and the minutes of the Closed Session.

ITEM II
NEW MODEL MODELING

Ms. Caitlyn Cooksey, Assistant Chief, Hospital Rate Regulation presented CY2018 Medicare FFS data through December 2018 (with claims paid through February 2019). During this period, Maryland Medicare per capita Total Cost of Care (TCOC) spending has been mostly favorable when compared to the nation; however, per capita non-hospital spending has been mostly unfavorable. Ms. Cooksey noted that Maryland is projected to have \$273 million in Medicare TCOC savings for calendar year 2018.

Ms. Amanda Vaughan, Associate Director Clinical and Financial Information, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of February 2019 focuses on the fiscal year (July 1 through June 30) as well as calendar year results.

Ms. Vaughan reported that for the eight months of the fiscal year ending February 28, 2019, All-Payer total gross hospital revenue increased by 1.56% over the same period in FY 2018. All-Payer total gross hospital revenue for Maryland residents increased by 1.60%. All-Payer gross hospital revenue for non-Maryland residents increased by 1.15%.

Ms. Vaughan reported that for the two months of the calendar year ending February 28, 2019, All-Payer total gross hospital revenue increased by 0.37% over the same period in CY 2018. All-Payer total gross hospital revenue for Maryland residents increased by 0.32%. All-Payer gross hospital revenue for non-Maryland residents increased by 1.03%.

Ms. Vaughan reported that for the eight months of fiscal year ending February 28, 2019, Medicare Fee-For-Service gross hospital revenue declined by 0.74% over the same period in FY 2018. Medicare Fee-For-Service gross hospital revenue for Maryland residents declined by 0.65%. Maryland Fee-For-Service gross hospital revenue for non-residents declined by 1.83%.

Ms. Vaughan reported that for the two months of the calendar year ending February 28, 2019, Medicare Fee-For-Service gross hospital revenue declined by 3.74% over the same period in CY 2018. Medicare Fee-For-Service gross hospital revenue for Maryland residents declined by 3.72%. Maryland Fee-For-Service gross hospital revenue for non-residents declined by 4.00%.

Ms. Vaughan reported that for the eight months of the fiscal year ending February 28, 2019 over the same period in FY 2018, All Payer in State per capita hospital revenue growth was 1.30%. Ms. Vaughan noted that the Medicare Fee-For-Service in State per capita hospital revenue for the same period declined by 2.60%.

Ms. Vaughan reported that for the two months of the calendar year ending February 28, 2019 over the same period in FY 2018, the All Payer in State per capita hospital revenue growth was 0.02%. The Medicare Fee for Service per capita hospital revenue growth declined by 5.34% over the same period in CY 2017.

According to Ms. Vaughan, for the eight months fiscal year ending February 28, 2019, unaudited average operating profit for acute hospitals was 2.19%. The median hospital profit was 1.69%, with a distribution of negative 0.40% in the 25th percentile and 5.06% in the 75th percentile. Rate Regulated profits were 5.90%.

ITEM III
DOCKET STATUS CLOSED CASES

2473A- University of Maryland Medical Center

2474A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS – CASES OPEN

2475R- Calvert Health Medical Center

On March 1, 2019, Calvert Health Medical Center (“the Hospital”) submitted a partial rate application to the Commission requesting that its July 1, 2018 Medical Surgical Acute (MSG) and

Definitive Observation (DEF) approved rates be combined effective July 1, 2019.

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

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;
2. That a MSG rate of \$1,054.13 per day be approved effective July 1, 2019; and
3. That no change be made to the Hospital's Global Budget Revenue for MSG service.

The Commission voted unanimously to approve staff's recommendation.

2476A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on March 25, 2019 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals"), requesting approval from the HSCRC for continued participation in a global rate arrangement for solid organ and bone marrow transplants with Preferred Health Care LLC. The Hospitals request that the Commission approve the arrangement for one year beginning May 1, 2019.

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing May 1, 2019. The Hospitals 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 with the Hospitals for the approved contract.

The Commission voted unanimously to approve staff's recommendation. Commissioner Colmers recused himself from the discussion and vote.

2477A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application with the HSCRC on March 28, 2019 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplants services with 6 Degrees Health, Inc. The System requests approval for a period of one year beginning May 1, 2019.

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year

period commencing May 1, 2019. The Hospitals 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 with the Hospitals for the approved contract.

The Commission voted unanimously to approve staff's recommendation. Commissioner Colmers recused himself from the discussion and vote.

ITEM V **FY 2018 COMMUNITY BENEFIT REPORT**

Ms. Laura Spicer, Director of Health Reform Studies, The Hilltop Institute, provided background and summarized the FY 2018 Maryland Hospital Community Benefit Report (CBR) (see "Maryland Hospital Community Benefit Report: FY 2018" on the HSCRC's website).

Each year, the HSCRC collects community benefit information from 51 hospitals to compile into a publicly available statewide CBR. Current year and previous CBRs submitted by hospitals are available on the HSCRC website. According to Ms. Spicer, the FY CBR indicated that hospitals: 1) reported a total of \$1.7 billion in community benefits for FY 2018 (FY 2017 amount was approximately \$1.6 billion); 2) provided an average of 10.80% of total operating expenses in community benefits (compared to 9.90% in FY 2017); and 3) provided net community care of \$1.1 billion or 6.7% of hospitals' net operating expenses (down from \$896 million and 5.7% of hospitals' net operating expenses in FY 2017).

Chairman Sabatini asked if the effectiveness of the community benefit spending was evaluated.

Ms. Spicer replied that some hospitals submitted data on the outcomes of various community benefits activities.

Chairman Sabatini also asked whether there had been a comparison of the value of community benefits provided versus the value of the hospitals' tax-exempt status.

Ms. Spicer indicated that data on the value of hospitals' tax-exempt is not currently collected.

Commissioner Kane suggested that the Report should identify which community benefits are associated with the financial incentives provided by population-based Total Cost of Care All-Payer Model.

Commissioner Bayless noted that there should be a connection between the Community Health Needs Assessment and the Community Benefit Report.

Ms. Spicer stated that this year hospitals were asked how their initiatives targeted the needs

identified in the Community Health Needs Assessment.

Vice Chairman Antos noted that he would scrap the current report and create one that would provide analyses of the effectiveness of the community benefits provided.

Commissioner Elliot asked whether there was a requirement to devote a certain percentage of hospital expenses to community benefits.

Ms. Spicer replied that there is no State of Maryland or federal requirement, and a survey of all 50 states revealed that only a few states have specific community benefit requirements.

Commissioner Keane asked Ms. Spicer whether she thought that because the community benefit data was self-reported and self-audited, this possibly contributed to the enormous range of community benefits provided relative to operating expenses.

Ms. Spicer agreed that it was possible.

Commissioner Keane expressed agreement with Chairman Sabatini on assessing the value of hospitals' tax-exempt status, vis-à-vis the value of community benefits provided, and with Vice Chairman Antos that analyses of the impact of community benefits provided should be included in future reports.

ITEM VI

REPORT ON DISCLOSURE OF HOSPITAL FINANCIAL AND STATISTICAL DATA

Mr. Dennis Phelps, Associate Director, Audit & Compliance, summarized the annual disclosure of financial and statistical data for Maryland hospitals for FY 2018 (See "Disclosure of Hospital Financial and Statistical Data: Fiscal Year 2018" on the HSCRC website). Major highlights of the report were:

- Gross all-payer per capita hospital revenues from services provided to Maryland residents grew by 3.54%, slightly higher than the per capita growth in the Maryland economy, which was 2.90% in CY 2017.
- Over the five-year performance period of the Model, the State was required to achieve cumulative aggregate savings in the Medicare per beneficiary total hospital expenditures for Maryland resident Medicare fee-for-service (FFS) beneficiaries of at least \$330 million. For Performance Year 4 (CY 2017), the State achieved \$330 million in Medicare savings, as compared to the CY 2013 base. The cumulative savings for CY 2014 through CY 2017 are \$916 million.
- Over the Model's performance period, the State was required to have at least 80% of all regulated hospital revenue for Maryland residents in population-based payment arrangements. The State successfully shifted 100% of hospital revenue into population-based payments through hospital global budgets.

- Over the Model’s performance period, the State was required to reduce the aggregate Medicare 30-day readmission rate for Medicare FFS beneficiaries to be less than or equal to the national readmission rate. Using rolling 12-months of data through October 2018, Maryland Medicare readmission rates equal to the national readmission rate of 15.43%. Based on this data, Maryland is anticipated to achieve readmission rates at or below the nation at the end of 2018 as long as Maryland continues to keep up with national improvements over the next two months of data run-out.
- Over the performance period of the Model, the State was required to achieve an aggregate 30% reduction for all payers in a set of potentially preventable complications (PPCs) measures as part of Maryland’s Hospital Acquired Conditions program. Based on data through September 2018, the State achieved greater than 50% reduction in PPCs in 2018 compared to 2013.

For FY 2018 versus FY 2017:

- Profits on regulated activities increased slightly from \$1.2 billion (or 8.01% of regulated net operating revenue) in FY2017 to \$1.3 billion (or 8.95% of regulated net operating revenue) in FY 2018.
- Profits on operations (which include profits and losses from regulated and unregulated day-to-day activities) increased from \$458 million in FY 2017 (or 2.86% of total net operating revenue) to \$555 million in FY 2018 (or 3.35% of total net operating revenue).
- Total profits (referred to in the tables that follow by the accounting term “total excess profits,” which include profits and losses from regulated and unregulated operating and non-operating activities) decreased from \$1.01 billion in FY 2017 (or 6.08% of the total revenue) to \$897 million in FY 2018 (or 5.30% of the total revenue), primarily due to unrealized losses on investments.
- Total regulated net patient revenue rose from \$14.3 billion in FY 2017 to \$14.6 billion in FY 2018, an increase of 2.1%.
- In FY 2018, Maryland hospitals incurred \$726 million in uncompensated care, a slight increase in amount from FY 2017’s \$707 million in uncompensated care. This amounts to approximately four cents of uncompensated care cost for every dollar of gross patient revenue in both years.
- Gross regulated revenue from potentially avoidable utilization (PAU) readmissions increased slightly from \$1.129 billion in FY 2017 to \$1.179 billion in FY 2018. However, the percent of gross regulated revenue associated with all PAUs (readmissions and avoidable admissions) increased from 10.99% percent in FY 2017 to 11.11% in FY 2018. Case-mix adjusted readmissions declined from 11.67% in FY 2017 to 11.47% in FY 2018, a 1.72% reduction. The case-mix adjusted PPC rate declined from 0.57% in FY 2017 to 0.49% in FY 2018, a decrease of 14.04%. These declines reflect improvement in the quality of care delivered in Maryland hospitals, where readmission rates fell below the national levels for Medicare, and the State achieved the 30% PPC reduction goal.
- Total direct graduate medical education expenditures increased from \$340 million in FY 2017 to \$344 million in FY 2018, an increase of 1.08%.

ITEM VII
NURSE SUPPORT PROGRAM II- DRAFT RECOMMENDATIONS

Mr. Oscar Ibarra, Chief, Information Management and Program Administration, presented draft recommendations for the Nurse Support Program II (NSP II) FY 2020 Competitive Institutional Grants (See “Nurse Support Program II Competitive Institutional Grants Program Review Panel Recommendations for FY 2019” on the HSCRC website). Mr. Ibarra stated that this report and recommendations are jointly submitted by the staff of the Maryland Higher Education Commission (MHEC) and the HSCRC.

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

The HSCRC implemented the NSP II Program in May 2005. The Commission approved funding of up to 0.1% of regulated gross hospital revenue to increase the number of nurses in the State by increasing the capacity of nursing programs through institutional and nursing faculty interventions. MHEC was selected by the HSCRC to administer the NSP II programs in its capacity as the coordinating board for all Maryland institutions of higher education.

At the conclusion of the first ten years of funding, on January 14, 2015, the HSCRC renewed funding for the Program from FY 2016 through June 30, 2020. In 2016, the Maryland General Assembly revised the NSP II statute to meet Maryland’s changing health care delivery models to recognize all registered nurses (RNs), not only those providing bedside manner are needed to ensure a strong nursing workforce.

In response to the FY 2020 request for applications (RFA), the NSP II Competitive Institutional Grant Review Panel received a total of 26 requests for funding. They include 21 new competitive grant proposals, 3 resource grant requests, and 2 continuation grant recommendations. The proposals were reviewed by a nine- member panel, comprised of former NSP II grant project directors, retired deans of nursing schools, hospital nursing educators, nurse licensing and policy leaders, and MHEC and HSCRC staff. All competitive grant proposals received by the deadline were scored by the panel according to the rubric outlined in the FY 2020 RFA. The review panel convened and reached consensus on the most highly noted proposals. The panel provided feedback to the institutions with more funded proposals to aid in the development of future proposals. The review panel recommends funding for 17 of the 26 total proposals.

The recommended proposals include grants for planning, implementation of programs, continuation of programs, totaling just over \$6 million. The proposals that received the highest

ratings focused on graduate nursing progress with partnerships between community colleges, universities, and hospital health systems. See below for the recommended proposals for FY 2020 funding.

Grant #	Institution	Grant Title	Proposed Funding
20-102	Allegany College	LPN- RN Online	\$150,000
20-104	Coppin State University	Cognitive Reflective CARE	\$50,000
20-105	Coppin State University	Planning BSN to DNP	\$148,100
20-106	Coppin State University	ATB with CCBC & Howard	\$143,951
20-108	Johns Hopkins University	PRIME Model for DNP-NP	\$1,001,596
20-109	Johns Hopkins University	Supporting Advance Practice	\$150,000
20-110	Johns Hopkins University	Planning CRNA	\$150,000
20-112	Montgomery College	ASEL Resources	\$50,000
20-116	Morgan State University	Student Resources	\$47,897
20-117	Notre Dame of Maryland University	B-Line Software Resources	\$50,000
20-118	Salisbury University	Planning MA-FAMI	\$149,998
20-120	Towson University	Entry Level MS in Nursing	\$149,556
20-121	University of Maryland	AGPCNP Certification	\$121,972
20-122	University of Maryland	SA and Addictions Program	\$137,408
20-123	University of Maryland	Clinical Faculty Competency	\$264,677
20-125	University of Maryland	Maryland Nursing Workforce Center Continuation	\$1,912,767
20-126	Montgomery College	MCSRC Group Resource Continuation	\$1,475,525
TOTAL			\$6,153,447

HSCRC and MHEC staffs recommend the 17 proposals listed above for funding under the FY 2020 NSP II Competitive Institutional Grants Program. The recommended proposals represent the NSP II's commitment to increasing nursing degree completions and academic practice partnerships across Maryland. The most highly recommended proposals include those for:

- Planning an advanced Faculty Academy and Mentoring Initiative on the Eastern Shore;
- Providing for the continuation of the Maryland Nursing Workforce Center for improved data infrastructure;
- Planning a new Masters entry nursing program at Towson University;
- Implementing the PRIME model for DNP nurse practitioner education at Johns Hopkins University;

- Developing an academic progression partnership for increased diversity with pre-licensure graduates in dual enrollment ATB programs at Community College of Baltimore County and Howard Community College with Coppin State University;
- Continuing the Maryland Clinical Simulation Resource Consortium resources for 26 nursing programs;
- Planning a Certified Registered Nurse Anesthetist (CRNA) program in partnership with Johns Hopkins Healthcare System; and
- Supporting a seamless online educational pathway from LPN to RN in Western Maryland.

Commissioner Elliott asked whether the program funds internships for nurses post-graduation. Kimberly Ford, MHEC, stated that the program funds nurse residency programs.

No Commission action necessary as this is a draft recommendation.

ITEM VIII **LEGAL REPORT**

FINAL ACTION

Rate Application and Approved Procedures- COMAR 10.37.10.26-A

The purpose of this action is to require hospitals to inform patients in the information sheet to be provided before they receive scheduled medical services, of facility fees and their right to receive a written estimate of total charges for non-emergency hospital services, procedures, and supplies that reasonably be expected to be incurred and billed by the hospital.

The Commission voted unanimously to adopt the regulation as proposed.

ITEM IX **POLICY UPDATE AND DISCUSSION**

Capital Funding

Mr. Jerry Schmith, Principle Deputy Director, Revenue and Compliance, updated the Commission on the development of a revised capital funding policy. (see “HSCRC Capital Funding Discussion” on the HSCRC website)

Mr. Schmith presented a historical overview of the Commission’s prior capital funding policies and recent trends in capital spending. Mr. Schmith identified several issues to be considered in revising the capital funding, policy:

- The level of annual funding needed in a fixed revenue system
- The requirements for hospitals to fund a portion of new capital costs
- Desire not to fund capital costs for services that can be provided in a non-hospital setting
- Whether to include comparative hospital performance in determining hospital specific funding.

Mr. Schmith noted that some hospital services have moved to unregulated settings, resulting in excess hospital capacity. He suggested that repurposing existing hospital space and adjusting global budget revenue for services moving to unregulated setting should be considered in developing the revised policy

Mr. Schmith stated that one potential option would be to set aside a portion of the annual update factor to create a funding pool for capital expenses. This option would allow funds for capital to build over time, spreading the cost of capital projects over several years in order to stay within Maryland's per capita Total Cost of Care limits.

Mr. Schmith stated that Commission staff expects to present revised capital funding policy recommendations to the Commission in the summer or fall of 2019.

Commissioner Colmers thanked staff for identifying many important issues for consideration. He also noted that there is a need to make the rules clear and to identify basic principles so that hospitals can know generally what they can expect when undertaking long-term capital projects.

Commissioner Kane identified the need to work with the Maryland Health Care Commission (MHCC) to address the Certificate of Need (CON) process, noting that certain capital spending priorities in the State may not align with existing CON criteria.

Mr. Schmith stated that Staff's plan is to assemble a work group to develop a revised capital funding policy. The workgroup will include hospitals, payers, Commission staff, and MHCC staff.

Legislative Update

Ms. Wunderlich presented a summary of legislation of interest to the HSCRC introduced in the Maryland General Assembly (See "HSCRC Legislative List" on the HSCRC website).

The Bills include 1) House Bill 1423/Senate Bill 1045- Maryland Health Insurance Plan- Use of Remaining Funds, 2) House Bill 1426 - Health Services Cost Review Commission- Duties and Reports, 3) House Bill 1407/Senate Bill 1040- Budget Reconciliation and Financing Act of 2019, 4) House Bill 940- Unregulated Space in Hospital Operating Suites Pilot Project, 5) Senate Bill 803/House Bill 849- Hospitals – Disclosure of Outpatient Facility Fees, 6) House Bill 626/ Senate Bill 649- Health Care Facilities- Change in Bed Capacity, 7) Senate Bill 597/House Bill

646- MHCC- State Health Plan and Certificate of Need for Hospital Capital Expenditures, 8) House Bill 931/ Senate Bill 940- Certificate of Need- Modifications, 9) Senate Bill 1018- Health Facilities- Chestertown Rural Health Care Delivery Innovations Pilot Program, 10) House Bill 768/Senate Bill 759- Prescription Drug Affordability Board, 11) Senate Bill 784/House Bill 1323- Civil Actions- Health Care Malpractice Claims (Life Care Act 2019), 12) Senate Bill 869/ Health Bill 1320- Maryland No-Fault Birth Injury Fund, 13) Senate Bill 773- Health Care Malpractice Qualified Expert- Qualification, 14) Senate Bill 813- Personal Injury or Wrongful Death- Noneconomic Damages, 15) Senate Bill 482/Health Bill 846- Maryland Medical Assistance Program- MCOs- Behavioral Health Services

ITEM X
CRISP UPDATE

Mr. Craig Behm, Executive Director, CRISP, presented CRISP’s plans for funding services in fiscal 2020 and beyond (see “Update on CRISP and ICN” on the HSCRC website)

Mr. Behm said CRISP will rely on a mix of funding sources, including federal matching funds, user fees, and funds generated through the HSCRC’s rate setting system. In fiscal 2020, CRISP plans to request \$7.8 million in funding through the rate setting system. This is an increase when compared to last year’s assessment. The increase replaces some of the \$10.4 million in funding CRISP received last year from MHIP funds that now have been exhausted. Hospital and payer user fees in Maryland and the District of Columbia are also being increased to fill the funding gap.

Mr. Behm stated that actual spending for the Integrated Care Network (ICN) has been significantly lower than initial estimates. ICN provides important resources to facilitate the care transformation envisioned under the TCOC Model. ICN provides tools for activities such as the Prescription Drug Monitoring Program, other point-of-care tools, the Encounter Notification Service, data available through the CRISP Reporting Service, and administration of the Hospital Care Improvement Program.

ITEM XI
HEARING AND MEETING SCHEDULE

May 8, 2019	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
June 12, 2019	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:11 p.m.

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 APRIL 29, 2019

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
2478A	University of Maryland Medical Center	4/9/2019	N/A	N/A	ARM	DNP	OPEN
2479A	University of Maryland Medical Center	4/9/2019	N/A	N/A	ARM	DNP	OPEN
2480A	University of Maryland Medical Center	4/9/2019	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

**IN RE: THE APPLICATION FOR
ALTERNATIVE METHOD OF RATE
DETERMINATION
UNIVERSITY OF MARYLAND
MEDICAL CENTER
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2019
* FOLIO: 2288
* PROCEEDING: 2478A**

Staff Recommendation

May 8, 2019

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on April 9, 2019 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for heart, liver, kidney, lung, and pancreas transplants, SPK services, blood and bone marrow transplants and VAD services for a period of one year with Cigna Health Corporation beginning June 1, 2019.

II. OVERVIEW OF APPLICATION

The contract will continue 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 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

The staff found that the Hospital's experience under this arrangement for the previous year was favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for heart, liver, kidney, lung, and pancreas transplants, SPK services, blood and bone marrow transplants and VAD services, for a one year period commencing June 1, 2019. 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, 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
ALTERNATIVE METHOD OF RATE
DETERMINATION
UNIVERSITY OF MARYLAND
MEDICAL CENTER
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2019
* FOLIO: 2289
* PROCEEDING: 2479A**

Staff Recommendation

May 8, 2019

I. INTRODUCTION

University of Maryland Medical Center (“Hospital”) filed an application with the HSCRC on April 9, 2019 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, 2019.

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, 2019. 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
ALTERNATIVE METHOD OF RATE
DETERMINATION
UNIVERSITY OF MARYLAND
MEDICAL CENTER
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2019
* FOLIO: 2290
* PROCEEDING: 2480A**

Staff Recommendation

May 8, 2019

I. INTRODUCTION

The University of Maryland Medical Center (“Hospital”) filed an application with the HSCRC on April 9, 2019 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, 2019.

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, 2019. 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.

Nurse Support Program II
Competitive Institutional Grants Program
Review Panel Recommendations for FY 2020

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

Final Recommendation

May 8, 2019

This is a final recommendation for Commission consideration at the May 8, 2019 Public Commission Meeting.

INTRODUCTION

This report presents recommendations of the Review Panel for funding of the Nurse Support Program II (NSP II) Competitive Institutional Grant for Fiscal Year (FY) 2020. This report and recommendations are jointly submitted by the staff of the Maryland Higher Education Commission (MHEC) and the Maryland Health Services Cost Review Commission (HSCRC or Commission).

A summary of NSP II achievements are below:

- The Maryland Council of Deans and Directors of Nursing Programs recommended the new NSP II **Academic Nurse Educator Certification Award as a new faculty focused award**, which provides incentives for current full time faculty to demonstrate expertise in pedagogy, curriculum development, teaching and student learning through achieving and maintaining certification as experts in their field with the National League for Nursing's Certified Nurse Educator (CNE) credential.
- **New Goal:** To increase the number of faculty achieving CNE to 50 percent (from 12 percent). After a year of intense focus, 26 faculty representing 15 nursing programs have achieved the CNE.
- **Goal Progress:** The Maryland Nursing Workforce Center is being recognized by the National Forum of State Workforce Centers to represent Maryland. The Center addresses the need for infrastructure to collect and analyze nursing workforce data.
- **Goal Progress:** MD is increasing the number of nurses with a BSN or higher up to 60 percent.
- **Goals Met:** Through the Nurse Educator Doctoral Grants, doubled the number of nurses with doctoral degrees and increased the number of full time faculty with doctoral degrees to a high of 68 percent.

BACKGROUND

The HSCRC has funded programs to address the cyclical nursing workforce shortages since 1985. In July 2001, the HSCRC implemented the hospital-based Nurse Support Program I (NSP I) to address the nursing shortage impacting Maryland hospitals. Since that time, the NSP I completed three, five-year program evaluation cycles. The most recent renewal was approved on July 12, 2017 to extend the funding until June 30, 2022. The HSCRC implemented the NSP II program in May 2005 to respond to the faculty shortage and other limitations in nursing educational capacity underlying the nursing shortage. The Commission approved an increase of up to 0.1 percent of regulated gross hospital revenue to increase the number of nurses in the state by increasing the capacity of nursing programs through institutional and nursing faculty interventions. MHEC was selected by the HSCRC to administer the NSP II programs, as the coordinating board for all Maryland institutions of higher education. At the conclusion of the first ten years of funding on January 14, 2015, the HSCRC renewed funding for FY 2016 through June 30, 2020. In 2016, the Maryland General Assembly revised the NSP II statute to meet Maryland's changing health care delivery models to recognize all registered nurses (RNs) are needed to ensure a strong nursing workforce. The NSP II program evaluation is in progress

and the final report will be submitted to the Commission in December 2019 for approval for FY 2021-2025 funding cycle.

REVIEW OF NSP II GRANT FUNDING RESULTS

The following sections detail the progress made on key initiatives. NSP II has four key areas of focus to strengthen capacity across the state's nursing programs: increasing pre-licensure graduates while making progress toward the "80 percent BSN by 2020"; doubling the doctoral prepared nurses for more highly qualified nurse faculty; advancing lifelong learning for the pipeline for future nurses; and providing for stronger data infrastructure for the nursing workforce.

CERTIFICATION FOR ACADEMIC NURSE EDUCATORS

One indicator of nursing education excellence is certification. NSP II supports nursing education as a specialty area of practice. As clinical nurses are recognized through certification by the American Nurse Credentialing Center (ANCC), nurse educators have a comparable certification process for academic educators through the National League for Nursing (NLN). The CNE credential communicates to academic and health care communities, students, colleagues, and the public that the highest standard of excellence is being met. Faculty serve as role models and leaders with this mark of distinction.

Since January 8, 2018, four NLN Certified Nurse Educator (CNE) Workshops have been sponsored by NSP II. There were approximately 185 nurse faculty attendees seeking to prepare for the examination and complete the credential of CNE. In 2017, a review of data submitted with proposals and annual reports revealed that approximately 12 percent of faculty in Maryland colleges and universities held the CNE credential. By 2020, the goal across the State's nursing programs is to double the number of full-time faculty with this specialty certification for nurse educators. As of March 29, 2019 an additional 26 nurse faculty across 15 nursing programs have achieved the CNE credential. Of the 26 nurses credentialed, 12 nurse faculty represented 6 community colleges (Anne Arundel Community College, Chesapeake College, Community College of Baltimore County, Harford Community College, Howard Community College and Montgomery College) and the remaining 14 nurse faculty represented 9 universities (Frostburg State University, Johns Hopkins University, Hood College, Notre Dame of Maryland University, Salisbury University, Towson University, University of Maryland, Washington Adventist University, and University of Maryland University College). This is a 21 percent increase and a clear demonstration of excellence in education with nurse faculty committed to the highest standards.

This past February, the Maryland Council of Deans and Directors of Nursing Programs fully endorsed the new NSP II Academic Nurse Educator Certification Award which supports the preparation, CNE examination fees and ongoing professional development each faculty needs to achieve and renew this valued credential every 5 years. This will provide incentives for current

full time faculty to demonstrate expertise in pedagogy, curriculum development, teaching and student learning.

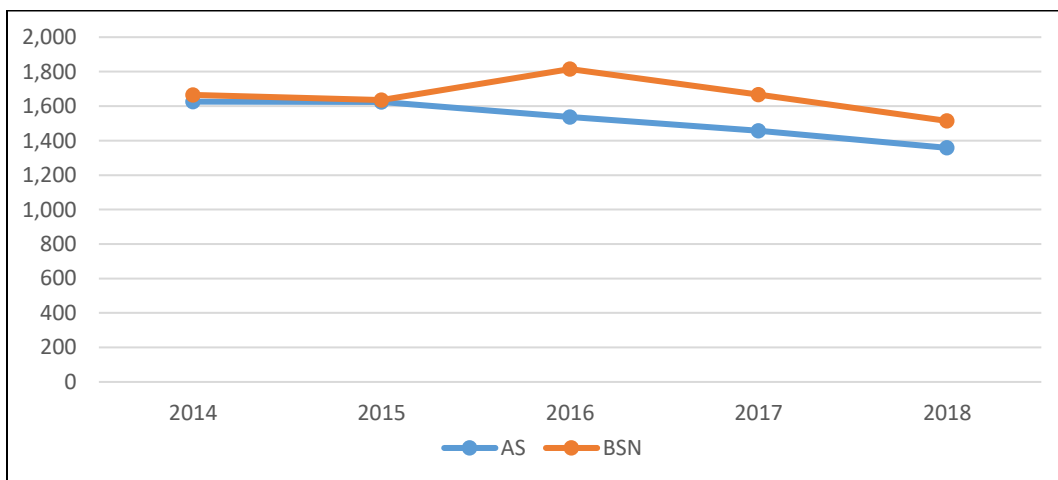
ASSOCIATE TO BACHELORS IN NURSING MODEL

Over the last 5 years, Maryland’s nursing graduate data reflects an increase in the overall education of the nursing workforce. According to leading nursing researchers, the total number of Bachelor of Science in Nursing (BSN) degrees awarded have surpassed the Associate of Science in Nursing (AS) degrees. There are several factors behind this movement in registered nurse (RN) education:

- Hospitals are aware of better patient outcomes associated with BSN-prepared RNs;
- Economic incentives reward hospitals for improved quality;
- Requirements for hospitals to have a higher proportion of BSN-educated RNs for the Magnet Recognition Program® , and
- The Institute of Medicine’s (2010) report recommending that 80 percent of nurses be BSN-prepared by 2020 (Buerhaus, et al., 2017).

Maryland’s nursing programs, both community colleges and universities, have partnered together to promote the BSN with Associate to Bachelors (ATB) agreements for seamless academic progression. We are working with the Maryland Longitudinal Data Center at MHEC to measure ATB completions and determine time and cost savings to the individual nursing student. We expect this seamless transition to result in cost savings to hospitals as fewer courses will need to be completed for the BSN; thereby reducing the amount of tuition reimbursement.

Table 1. Trends in Associate of Science in Nursing (AS) and Bachelor of Science Degrees in Nursing (BSN), 2014 – 2018



Source: Maryland Higher Education Commission Nursing Graduate Data

PROGRESS ON GOALS

The following sections provide an update on the two goals adopted from the IOM *The Future of Nursing* report: 80 percent BSN by 2020 and double the number of doctoral nurses.

80 percent BSN BY 2020

Across the country, progress has been made on the Institute of Medicine's (2010) *The Future of Nursing* report recommendation to increase the number of nurses with a BSN or higher to 80 percent by 2020. The Campaign for Action Maps, funded through the AARP Foundation and Robert Wood Johnson Foundation, used American Community Survey data to display national trends in BSN-prepared nurses. As shown in Table 2, the national average for BSN was 55.9 percent, while Maryland outpaced the national average at 60.2 percent (Courville & Green, 2019). Maryland is making steady progress when compared to other neighboring states in our geographic region, as well as being among the 12 states with over 60 percent BSN prepared nurses.

Table 2. Progress on 80 percent BSN by 2020: A Comparison of Maryland and Neighboring States

	2010	2017	Percent Change
Maryland	55.4%	60.2%	4.8%
Delaware	42.1%	62.8%	20.7%
Pennsylvania	45.9%	57.5%	11.5%
Virginia	51.1%	51.7%	0.6%
West Virginia	37.4%	50.1%	12.7%
US	48.8%	55.9%	7.1%

Source: Campaign for Action Maps Show Nurses' Progress in Earning BSN Degree, 2019

Nursing Workforce Data Infrastructure

Last year, NSP II funded the Maryland Nursing Workforce Center (MNWC) to compile and report on nursing workforce data. The state level data collected from this initiative will be instrumental in future reports on trends in the state's nursing workforce. The MNWC is being recognized by the National Forum of State Nursing Workforce Centers in 2019 to represent Maryland. The Center will serve as a nexus to collect, analyze and manage data, streamline research access and ensure state-level minimum data sets are available at the state and national level. These resources will be available to nursing programs, educators, employers, hospitals, nurses and the public to inform policy development.

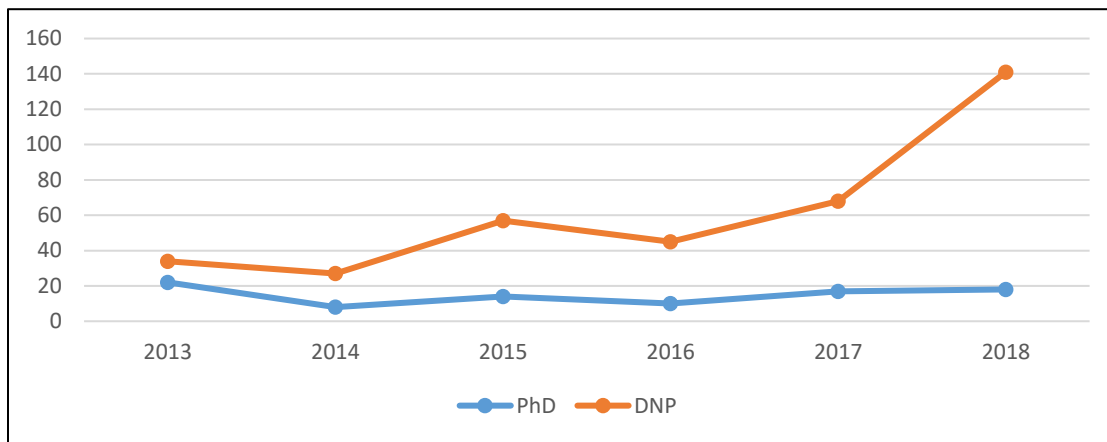
Double the Number of Nurses with Doctoral Degrees

The planning committee for the National Academy of Medicine (formerly IOM) convened a public session on March 22, 2019 for the upcoming study, *The Future of Nursing 2020-2030*. During the meeting, national researchers reported the 2010 goal of doubling the number of nurses with a doctoral degree has been achieved. Maryland data supports this increase in doctoral degrees, for both Doctor of Philosophy in Nursing (PhD) and Doctor of Nursing Practice (DNP). Consistent with national trends, the NSP II Nurse Educator Doctoral Grants for Practice and

Dissertation Research (NEDG) was awarded to 114 faculty as of 2019; 49 faculty for DNP degrees, 42 faculty for PhD in Nursing degrees, 13 faculty for Doctor of Education (EdD) degrees, and the remaining 10 faculty for PhD degrees in other fields.

The DNP education focuses on preparation of nurses for advanced practice roles. A study by Fang and Bednash (2017) found that 56.8 percent of DNP students who planned to work in academia were already full-time or part-time faculty members. Nurse faculty with dual clinical and academic appointments as advanced practice registered nurses (APRNs) maintain clinical credentials; providing primary care while preparing the next generation of new pre-licensure nurses or serving as preceptors for new APRNs at hospitals and clinical sites. Previous NSP II grants have funded APRN preceptor online training modules that are available to all nursing programs.

Table 3. Trends in PhD and DNP Graduates, 2013 – 2018



Source: Maryland Higher Education Commission Nursing Graduate Data

FISCAL YEAR 2020 COMPETITIVE GRANT PROCESS

In response to the FY 2020 request for applications (RFA), the NSP II Competitive Institutional Grant Review Panel received a total of 26 requests for funding, including 21 new competitive grant proposals, 3 resource grant requests and 2 continuation grant recommendations. The nine-member panel, comprised of former NSP II grant project directors, retired nurse deans, hospital educators, licensure and policy leaders, MHEC and HSCRC staff, reviewed the proposals. All competitive grant proposals received by the deadline were scored by the panel according to the rubric outlined in the FY 2020 RFA. The review panel convened and developed consensus around the most highly recommended proposals. For non-funded proposals, the panel provided feedback to the institutions for future proposal development and encouraged them to resubmit next year. As a result, the review panel recommends funding for 17 of the 26 total proposals.

The recommended proposals include grants for planning, full implementation of programs, continuation of programs, as well as, nursing program resource grants; totaling just over \$6 million. The proposals that received the highest ratings for funding focused on nursing graduate

outcomes with partnerships across community colleges, universities and hospital health systems. Table 4 lists the recommended proposals for FY 2020 funding.

Table 4. Final Recommendations for Funding for FY 2020

Grant #	Institution	Grant Title	Proposed Funding
20-102	Allegany College	LPN- RN Online	\$150,000
20-104	Coppin State University	Cognitive Reflective CARE	\$50,000
20-105	Coppin State University	Planning BSN to DNP	\$148,100
20-106	Coppin State University	ATB with CCBC & Howard	\$143,951
20-108	Johns Hopkins University	PRIME Model for DNP-NP	\$1,001,596
20-109	Johns Hopkins University	Supporting Advance Practice	\$150,000
20-110	Johns Hopkins University	Planning CRNA	\$150,000
20-112	Montgomery College	ASEL Resources	\$50,000
20-116	Morgan State University	Student Resources	\$47,897
20-117	Notre Dame of Maryland University	B-Line Software Resources	\$50,000
20-118	Salisbury University	Planning MA-FAMI	\$149,998
20-120	Towson University	Entry Level MS in Nursing	\$149,556
20-121	University of Maryland	AGPCNP Certification	\$121,972
20-122	University of Maryland	SA and Addictions Program	\$137,408
20-123	University of Maryland	Clinical Faculty Competency	\$264,677
20-125	University of Maryland	Maryland Nursing Workforce Center Continuation	\$1,912,767
20-126	Montgomery College	MCSRC Group Resource Continuation	\$1,475,525
TOTAL			\$6,153,447

RECOMMENDATIONS

HSCRC and MHEC staff recommend the 17 proposals presented above in Table 4 for the FY 2020 NSP II Competitive Institutional Grants Program. The most highly recommended proposals include:

- Planning an advanced Faculty Academy and Mentoring Initiative at Salisbury University on the Eastern Shore;
- Providing for the continuation of the Maryland Nursing Workforce Center at the University of Maryland for improved data infrastructure;
- Planning a new Masters entry (second degree) nursing program for adults with a Bachelor’s degree in a different field at Towson University;
- Implementing a more accessible approach for Doctor of Nursing Practice (DNP) nurse practitioner degrees at Johns Hopkins University;
- Developing an academic progression partnership for increased diversity with pre-licensure graduates in dual enrollment programs at Community College of Baltimore County and Howard Community College with Coppin State University;
- Continuing the Maryland Clinical Simulation Resource Consortium at Montgomery College with resources requested by 26 nursing programs at universities and community colleges;

- Planning a Certified Registered Nurse Anesthetist (CRNA) program at Johns Hopkins University in partnership with Johns Hopkins Healthcare System; and
- Supporting a seamless online educational pathway from Licensed Practical Nurse (LPN) to Registered Nurse (RN) at Allegany College in Western Maryland.

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Draft Recommendation for Market Shift Consolidation

May 8, 2019

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This document contains the draft staff recommendations for updating the Market Shift methodology. Please submit comments on this draft to the Commission by Wednesday May 22, 2019, via email to allani.pack@maryland.gov

Key Methodology Concepts and Definitions

1. Variable Cost Factor – The percentage of charges required to reimburse a hospital for the variable costs (supplies, drugs, etc.) associated with increases in volume. The standard by which the industry and the Commission evaluates volume funding adequacy is 50 percent, as 50 percent of all service charges on average covers fixed costs and 50 percent covers variable costs. This value is not uniform by service line.
2. Effective Variable Cost Factor – The percentage of charges that are reimbursed when accounting for revenue adjustments from volume methodologies. This value can be calculated with revenue from one or the sum of multiple volume methodologies
3. Service Lines – Groupings of services into higher level categories that reflect similar clinical delivery. Service lines are utilized to determine market shifts in the Market Shift methodology
4. Equivalent Case Mix Adjusted Discharges (ECMADS) – Often referred to as casemix, ECMADS are a volume statistic that account for acuity, as not all services require the same level of care and resources.

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Recommendations

Staff recommends the following updates to the current Commission Methodologies:

1. Consolidate defined markets in the Market Shift methodology by reducing service lines with clinical overlap and assessing inpatient surgery and other highly specialized services at a county level.
2. Establish a Workgroup to evaluate potential modifications to the Demographic Adjustment that will better anticipate use rate changes while maintaining its status as population based.

Introduction

The State of Maryland has led an effort to transform its health care delivery system to a population-based system that increases the emphasis on patient-centered care, improves population health, and lowers health care costs. To achieve these goals, the State of Maryland worked closely with hospitals, payers, other providers, consumers and the Centers for Medicare & Medicaid Services to develop the Maryland All-Payer Model, which was implemented in 2014. The Model moved away from a volume-based payment system that limited the growth in inpatient charge-per-case to a system that limits the growth in total hospital spending per capita and increasingly focused on outcomes: readmissions, in-hospital complications, potentially avoidable utilization, and patient satisfaction, among others.

At the conclusion of the Model in December of 2018, preliminary results show that the State met and exceeded every contractual target¹ and hospital total profit margins statewide recovered from the unsustainable levels experienced in 2013.² Given that the State has endeavored to continue these transformative efforts and build off of the success of the All-Payer Model with the new Total Cost of Care Model, effective January 1, 2019, and given that various volume methodologies have not been examined since the inception of the All-Payer Model, it is important that the State evaluate its methodologies and modify where necessary.

Fundamental to the All-Payer Model was the Global Budget Revenue (GBR) methodology, which was piloted by ten rural hospitals in 2010 and aimed to provide stability to hospitals by establishing annual prospective budgets and allowing for charges to fluctuate in line with reasonable changes in volume.³ However, while hospital budgets were fixed during a given

¹ Limiting all-payer hospital spending per capita in line with the growth of the economy, saving Medicare a total of at least \$330 million by keeping Maryland's Medicare per beneficiary growth below the national growth rate (currently the State has saved \$1.4 billion), reducing Medicare readmissions to the national average (currently .05% lower than national average), reducing hospital acquired complications by 30 percentage (currently the State has reduced by 51 percent), and moving virtually all hospital payment methodologies to approved population based approaches.

² The statewide average for profit margins for RY 2013 was 1.2 percent; since that time the statewide average for profit margins has been approximately 3 percent. See appendix I for more detail.

³ The HSCRC allows hospitals to adjust charges for individual rate centers (e.g. room and board) to fluctuate within a 5 percent corridor. HSCRC reviews hospital requests adjust prices beyond a 5 percent corridor.

fiscal year, thereby incentivizing hospitals not to grow volumes unnecessarily and providing a high level of predictability, the Commission had to develop strategies to modify budgets in future years based on changes in population, the aging of the population, new health care innovation cost drivers, and changes in market selection.

To achieve the twin goals of funding population related utilization changes and realigning budgets for market shifts, the HSCRC developed two core volume funding methodologies: the Demographic Adjustment and Market Shift Adjustment. The Demographic Adjustment methodology provides funding for age-adjusted growth/decline at the zip code or county level in order to anticipate changes in utilization based on demographic changes.⁴ The Demographic Adjustment is capped by Maryland Department of Planning estimates of statewide population growth to align with the per capita nature of the All-Payer Model tests, i.e. the contractual tests are not age-adjusted.

The HSCRC staff also developed a Market Shift Adjustment methodology that evaluated hospitals' growth/decline for each defined service line and geography to determine the degree to which patients moved from one hospital to another in the most recent calendar year in comparison to the prior year. The Market Shift moved money in the following year at a 50 percent cost factor when volumes moved up at one hospital and down at another in the same service line and geography. Taken together, these policies ensure a competitive hospital market where money follows the patient but only such that statewide volume on net does not grow for anything other than population growth and various forms of healthcare innovation. Both of these methodologies resulted in adequate volume funding statewide while maintaining the Model's status as population-based, but have produced less predictable funding for volume changes at the individual hospital level.

As staff will demonstrate, volume funding statewide has been adequate over the first four years of the Model, but the distribution of funding in any given year has not entirely aligned with medically necessary use rates and to some degree has created hospitals with greater cost inefficiency and poorer total cost of care outcomes. This is because population estimates outlined in the Demographic Adjustment methodology do not necessarily correlate with actual changes in hospital utilization and because the Market Shift methodology is very granular in the development of markets – there are 60 hospital service lines, over 350 geographies and potentially 20,000 markets.

To address these concerns, staff is recommending two key changes in methodology.

- **Market Shift Adjustment:** The first change is to consolidate geographies and service lines to reduce the number of small cells in the Market Shift, improving the reliability of the results.

⁴ The Demographic Adjustment developed for urban areas apportioned age-adjusted population changes among the hospitals serving each zip-code based on their market share in each zip code, in contrast to the rural Demographic Adjustment, which allocated the age-adjusted population change for a county to each rural hospital.

- **Demographic Adjustment:** The second change is to review with a workgroup potential modifications to the Demographic Adjustment that will better anticipate use rate changes while maintaining its status as population-based.

Another concern expressed by the Commissioners is that various hospitals have retained a significant amount of revenue under the current volume methodologies and thus have become cost inefficient. To address this, Commissioners have asked staff to promulgate an efficiency policy that removes revenue from inefficient hospitals. During Rate Year 2018, HSCRC staff developed an Inter-hospital Cost Comparison (ICC) and a geographic Medicare Total Cost of Care Performance Matrix to evaluate hospitals that were high cost outliers. One outlier hospital entered into a spend-down agreement with the Commission. During Rate Year 2018 and 2019, HSCRC staff have also made adjustments of more than \$70 million for services that shifted to unregulated settings, including adjustments for oncology and infusion drugs shifted to unregulated settings. In order to expedite the process of adjusting revenues for high cost outlier hospitals and to make the adjustments more predictable, the HSCRC staff is proposing a more formulaic approach to implementing efficiency adjustments for outliers. This proposed approach will be outlined in a separate Staff Report, along with proposed updates to the Inter-hospital Cost Comparison methodology.

Background

Demographic Adjustment

As aforementioned, the Demographic Adjustment methodology provides funding for age-adjusted growth at the zip code or county level in order to anticipate changes in utilization based on demographic changes, and the Demographic Adjustment is capped by Maryland Department of Planning estimates of statewide population growth to align with the per capita nature of the All-Payer/Total Cost of Care Model tests. In 2011, the HSCRC implemented a demographic adjustment for the 10 rural hospitals on global budgets using age-adjusted county projections. The demographic adjustment was then reduced by a 50 percent variable cost factor and further reduced by a 50 percent productivity adjustment, resulting in a demographic adjustment that was 25 percent of the projected age-adjusted population change. In Rate Year 2015, the HSCRC implemented a full year of the Demographic Adjustment for the remainder of hospitals (beyond the 10 hospitals already under global budgets), and in subsequent years, the Commission included the full value of the statewide population growth in calculating the allowed adjustment. The Demographic Adjustment has averaged approximately 0.40 percent of net hospital revenue or ~\$60 million, with lower values in recent periods resulting from slower population growth.

Market Shift Adjustment

The Market Shift was first implemented in RY 2015 based on CY 2014 calculations. Because a hospital cannot receive additional volume funding unless a different hospital has a reciprocal decline (a shift) in the same service and geography, the net statewide adjustment typically oscillates around \$0.⁵ For CY14 to CY17, the average statewide market shift was \$586,000 and typically realigned \$50 million among all hospitals.

Both methodologies affect permanent revenue and are implemented in conjunction with the annual Update Factor to prospectively cap the upcoming fiscal year budget for all hospitals. As they both impact the amount and distribution of volume funding, they should be considered in tandem when evaluating the adequacy of funding. Since the Market Shift is designed with the intent of moving funding when patients move from one hospital to another and not to adjust for overall increases or decreases in volume, the effective variable cost factor, which is the ratio between GBR adjustments from the Market Shift and total charges for volume change (inclusive of fixed costs and variable costs), is less than 50 percent.⁶ However, when the Demographic Adjustment is considered in tandem with the Market Shift, the effective variable cost factor for hospitals with volume growth typically exceeds 50 percent for all hospitals.

The main difference between the Demographic Adjustment and the Market Shift is that the Demographic Adjustment modifies hospital budgets for volume change expectations based on projected growth or decline in the age-adjusted population while the Market Shift methodology modifies hospitals budgets based on actual movement of volume among hospitals.

Volume Calculation Overviews

In this section staff will explain in detail the calculations for the two core volume methodologies: the Demographic Adjustment and the Market Shift Adjustment. Additional details on these calculations and their input variables may also be found in the Appendices.

Overview of Demographic Adjustment Calculation

The purpose of the Demographic Adjustment is to provide volume funding increases or decreases in anticipation of utilization changes related to changes in age-adjusted population changes for a hospital's service area. This funding, which is based on calendar projections (e.g. RY 2020 will be based on CY 2019 population estimates), is used to prospectively adjust hospital revenues for the upcoming year. There are no retroactive adjustments for changes in

⁵ The impact is not exactly \$0 because realigned volumes are multiplied by hospitals' average charge, which may be different based on their cost structure (e.g. Bon Secours versus Johns Hopkins Hospital), and thus can yield statewide MSA's that deviate from \$0.

⁶ A 50 percent variable cost factor is the industry standard for determining the percent of charges necessary to cover all marginal or variable costs associated with providing one additional service and is the standard by which the Commission will evaluate its volume methodologies.

population estimates. Changes in estimates are addressed in developing the succeeding year's Demographic Adjustment.

The Demographic Adjustment calculation begins by determining a hospital's virtual patient service area (VPSA). A VPSA is determined by aggregating the hospital's service volume in each zip code for eight age groups in the State⁷. The HSCRC uses this service area distribution to attribute population to each hospital based on the proportional amount of casemix adjusted services it provides to patients in each zip code relative to services provided by all hospitals.

The HSCRC then calculates the estimated population change for the attributed population using population projections.⁸ It also applies an age weight to each age/zip code cohort of the hospital's VPSA to adjust for the differences in cost per capita of each age cohort and to allow for changes resulting from aging of the population.

A portion of the existing service volume is a result of potentially avoidable utilization (PAU). The HSCRC removes this portion of the base volume on a hospital specific basis to eliminate any growth allowance for PAU, when projecting each hospital's expected volume growth due to changes in demographics. The remaining statewide age-adjusted population growth is compared to the State's Department of Planning population growth estimates, and each hospital's Demographic Adjustment is multiplied by a pro-rata reduction factor that accounts for the expected per capita efficiencies to accomplish the overall per capita savings targets in the All-Payer and Total Cost of Care Model, i.e. the final statewide Demographic Adjustment equals Department of Planning growth estimates. The result is the population driven volume growth that will be recognized in each hospital's global budget for the upcoming fiscal year.

Summary:

1. Calculate base population estimates for the current calendar year for each hospital based on a hospital's share of volume, as measured by equivalent case-mix adjusted discharges, in a given zip code age cohort.
2. Calculate age adjusted population growth rates by multiplying statewide age cost weights with zip/age population growth rates.
3. Calculate hospital specific age adjusted population growth by multiplying hospital specific base population by age adjusted population growth rates for each zip/age cohort and calculating total projected age adjusted population growth
4. Calculate final demographic adjustment by applying efficiency adjustments
 - a. Reduce age adjusted population growth by hospital specific PAUs as a percent of total all-payer revenue
 - b. Reduce PAU/age adjusted population growth by pro-rata per capita efficiency adjustment reduction

⁷ The eight age cohorts (0 to 4, 5 to 14, 15 to 44, 45 to 54, 65 to 74, 75 to 84, 85+) within each zip code provide more specific cost trends than would otherwise result from an overall distribution since population growth trends and health care use within these cohorts differ significantly.

⁸HSCRC obtains its projections from a private vendor, Claritas, who provides zip code and age specific population estimates for current year and 5-year population projections.

Below is an example calculation with just one zip code for a GBR hospital to arrive at the statewide per capita efficiency adjustment.

Table 1: Demographic Adjustment Example Calculation

Zip Code	Age Cohort	Base Year ECMADs for Hospital	Total ECMADs for All Hospitals	Share of ECMADs	Base Population	Allocated Base Population	State Total Hospital Revenue per Capita	Age Cost Weights	Projected Population Growth Rate of Cohort	Age Adjusted Population Growth Rates	Hospital Age Adjusted Population Growth	Hospital Overall Age Adjusted Population Growth	Hospital PAU %	Hospital Specific Adjusted Growth Rate	Statewide Per capita Efficiency Adjustment
STEP 1a				Step1b		Step2a		Step2b		Step 3		Step 4			
A	B	C	D	E = C/D	F	G=F * E	H	I=H/H(total)	J	K=J*I	L=G*K	M=sum(L)/sum(G)	N	O=M*(1-N)	P=O*50%
00000	0-4	30	60	50%	3,713	1,857	\$1,577	0.68	0.77%	0.52%	10				
00000	05-14	45	100	45%	23,471	10,562	\$119	0.05	-0.07%	0.00%	(0)				
00000	15-44	100	210	48%	8,902	4,239	\$3,798	1.63	-1.16%	-1.89%	(80)				
00000	45-55	20	35	57%	7,533	4,305	\$2,822	1.21	1.18%	1.43%	61				
00000	55-64	25	40	63%	7,450	4,657	\$3,413	1.46	0.16%	0.23%	11				
00000	65-74	25	30	83%	4,517	3,764	\$5,162	2.21	2.73%	6.04%	227				
00000	75-84	55	70	79%	2,282	1,793	\$7,337	3.14	2.42%	7.60%	136				
00000	85+	60	80	75%	1,044	783	\$8,009	3.43	1.32%	4.53%	35				
Total	Total	360	625	58%	58,913	31,959	\$2,335				401	1.3%	14%	1.08%	0.54%

For additional detail, please see Appendix 2.

Overview of Market Shift Calculation

The Market Shift Adjustment (MSA) methodology is an algorithm to calculate MSAs for a specific service line (e.g. orthopedic surgery) and a defined geographic location (e.g. ZIP code) using the case-mix adjusted volume measurement of equivalent case-mix adjusted discharges (ECMADS) for regulated inpatient and outpatient services. In total, there are 60 service lines, 46 inpatient and 14 outpatient, that are determined by 3M's aggregation of inpatient All Patients Refined Diagnostic Related Groupings (APR-DRG's), and HSCRC's aggregation of 3M's outpatient Enhanced Ambulatory Patient Groupings (EAPG's). The outpatient groupings are based on hospital rate center analyses to indicate the general services received at the hospital (e.g. emergency room services), while the inpatient service line aggregation is based on the diagnosis and/or procedure a patient receives (e.g. cardiothoracic surgery). There are also over 350 geographies in the Market Shift, as there are zip code level analyses for dense parts of the State and 15 county level analyses for less dense parts of the State.⁹ After arraying volume in various service lines and geographies, the market shift algorithm compares the growth in volumes at hospitals with utilization increases to the decline in volumes at hospitals with utilization decreases.

It is important to note that not all revenue is included in the MSA. For instance, potentially avoidable utilization (PAU), which consists of 30 day readmissions and Prevention Quality Indicators,¹⁰ is excluded because the Commission does not want to reward hospitals for growth

⁹ For a discussion of Geographic and Service Line Definitions, please see Appendix 3.

¹⁰ Readmissions are admissions to a hospital (defined as inpatient admission or observation stay greater than 23 hours) within a specified time period after a discharge from the same or another hospital. In the PAU measure, readmissions are specified as 30-day, all-payer, all-cause readmissions at the receiving hospital with exclusions for planned admissions. Hospitalizations for ambulatory-care sensitive conditions are measured by the Agency for

in PAU, nor does it want to disincentive hospitals from reducing PAU. The scope of volume evaluated in the MSA is as follows:

Table 2: Scope of Volume Addressed in Market Shift Calculation

Included (~70% of revenue)	Not Included (30% of revenue)
<p><u>In-state cases</u></p> <ul style="list-style-type: none"> ▶ Case-mix adjusted discharges ▶ Case mix adjusted outpatient cases (grouped into Enhanced Ambulatory Patient Groups) <p><u>Mechanisms</u></p> <ul style="list-style-type: none"> ▶ Market Shift Adjustment ▶ Demographic Adjustment ▶ Other Adjustments 	<p><u>Cases</u></p> <ul style="list-style-type: none"> ▶ Out-of-state ▶ Radiation and Infusion Therapy and Drugs (drugs addressed separately) ▶ Defined quaternary cases, ("Categorical" exclusions such as transplants, research, severe burn, Car-T, Spinraza) ▶ Readmissions and Prevention Quality Indicators (classified as potentially avoidable utilization, "PAU") <p><u>Mechanisms</u></p> <ul style="list-style-type: none"> ▶ Volume Variable for select cases ▶ Rate review or special GBR adjustments ▶ Intensity Adjustment

Market Shift Adjustments are capped at the lesser of the growth for volume gains or the decline for volume losses. This approach separates market shifts from collective changes in volume in the service area and removes incentives for driving up volume in the service area. This also means that not all volume growth or declines will be recognized at a 50 percent variable cost factor, only volume changes that are deemed market shifts.

Table 3 provides an illustration of the market shift calculation for ZIP code 21000 and the General Surgery service line. Within this ZIP code, the total volume increase is 654 equivalent case-mix adjusted discharges (ECMADs), and the decline is 129 ECMADs. Applying the "lesser of the two" rule, the allowed market shift is limited to 129 ECMADs, which is allocated to other hospitals with volume increases proportional to this hospital's volume increase in total utilization. In the end, the net impact of market shift volumes in each ZIP code and service line combination equals zero.

Health Care Research and Quality's Prevention Quality Indicators (PQIs). In the PAU measure, PQIs are measured on inpatient admissions and observation stays greater than 23 hours for ambulatory care sensitive conditions

Table 3. Example Calculation of the Market Shift Algorithm

ZIP Code 21000 General Surgery	Volume CY13	Volume CY14	Volume Growth	Hospital's Proportion of Total Increase/Decline	Market Shift
	A	B	C=B-A	D=C/Subtotal C	E=D*Allowed Market Shift
Hospital A	1,000	1,500	500	76%	99
Hospital B	500	600	100	15%	20
Hospital C	50	100	50	8%	10
Hospital D	-	4	4	1%	1
Utilization Increase	1,550	2,204	654	100%	129
Hospital E	500	400	(100)	78%	(100)
Hospital F	50	25	(25)	19%	(25)
Hospital G	4	-	(4)	3%	(4)
Utilization Decline	554	425	(129)	100%	(129)
ZIP Code Total	2,104	2,629	525	-	0
Allowed Market Shift	129				

Summary:

1. Array all APR-DRG's and EAPG's into service lines and geographies for each hospital based on 3M inpatient service line specifications, HSCRC outpatient service line specifications based on rate center analyses, and geographies based on the patient's residency – zip code level for denser parts of the State and county level for the 15 rural jurisdictions in the State.
2. Remove from consideration all excluded market shift revenue, including potentially avoidable utilization, out-of-state volume, categorical exclusions, oncology drugs, and chronic cases from the MSA algorithm
3. Run the Market Shift algorithm to determine growth, both increases and decreases in volume for each service line and geography
4. Calculate final market shift adjustment by multiplying the volumes that have been deemed market shifts by a hospital's unique service line average charge per equivalent case mix adjusted discharge.
 - a. The average charge includes all charges and therefore includes outlier charges built into the base of each hospitals GBR

Volume Assessment

In this section staff will analyze the adequacy of volume funding from both the Market Shift Adjustment and the Demographic Adjustment relative to a 50 percent variable cost factor, which is the standard by which the Commission and various stakeholders evaluate volume funding adequacy. Staff will further comment on the funding predictability from the two core volume methodologies and will analyze the statistical stability of the Market Shift, namely the degree to which small cell sizes in the market shift are contributing to random variation in the revenue adjustments. Finally, staff will outline modifications to the Market Shift that will create greater reliability in the results.

Adequacy and Predictability of Volume Funding

Over the first four years of the Model (CY 2014 – CY 2017), the Market Shift Adjustment provided a 50 percent variable cost factor for volume growth and declines that were deemed a market shift in the year following the shift.¹¹ As such, the funding from the Market Shift never reached a 50 percent effective variable cost factor, which was by design as the Market Shift only recognizes volume shifts, not total growth or declines. This is evident in Table 4, which demonstrates that when accounting for Market Shift Adjustments only, hospitals had unfunded growth relative to a 50 percent variable cost factor and retained declines relative to a 50 percent variable cost factor, i.e. if all volume changes were funded at a 50 percent variable cost factor the hospitals in this graph would all equal \$0.

Table 4: Residual Funding of In-State Volume Growth and Declines at 50 percent variable cost factor for CY14-CY17 after applying Market Shift Adjustment only

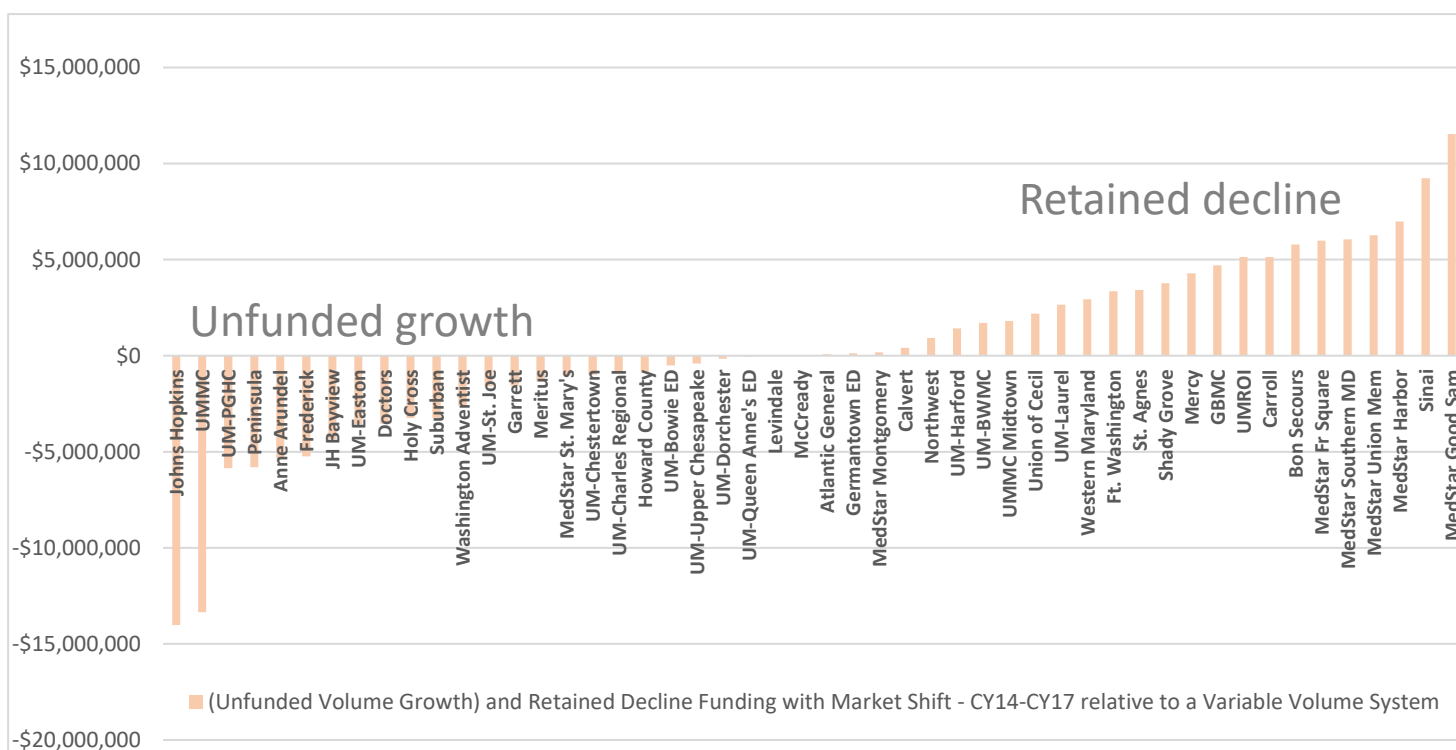


Table 5 builds off of Table 4 and outlines the Market Shift variable cost factor in terms of a percentage, i.e. an effective variable cost factor, both for hospitals with net increases in volume growth and net decreases by year.

¹¹ CY 2018 Market Shift is not included in this analysis because the final issuance of rate orders of CY 2018 Market Shift will not be completed until July 1, 2019.

Table 5: Market Shift Adjustment Effective Cost Factor for All Volume Growth - Net Growing Hospitals and Net Declining Hospitals

	MSA Effective Cost Factor (Net Growers)	Volume Growth \$* (Net Growers)	MSA Effective CostFactor (Net Decliners)	Volume Growth \$* (Net Decliners)
CY14	4.02 percent	\$131.2M	27.7 percent	-\$21.8M
CY15	29.5 percent	\$91.8M	27.8 percent	-\$176.1M
CY16	20.1 percent	\$130.5M	25.7 percent	-\$120.9M
CY17	31.2 percent	\$100.2M	12.1 percent	-\$211.2M

*Calculated by multiplying average charge for each service line by change in volume

As shown, hospitals with volume growth did not ever reach an effective variable cost factor of 50 percent for all volume growth through the Market Shift, which again is by design. The effective variable cost factor was particularly low in CY 2014 (4.02 percent), as hospitals had much larger growth relative to reductions in utilization (\$131.2 million versus declines of -\$21.8 million) and because the various interventions employed in the All-Payer Model were likely not yet implemented to respond to new incentives. Hospital volume growth for net growers slowed in subsequent years with the notable exception of CY 2016, when \$83.5 million of the \$130.5 million of growth for net growers was due to increases in the General Surgery service line. This growth coincided with the implementation of ICD-10, which had an unintended shift of cases into the General Surgery service line from lower weighted APR-DRGs, due to the conversion to ICD-10 in the third quarter of 2015 - in CY16.¹² It is also important to note that as the Model progressed the effective variable cost factor for net growers increased, suggesting that growth was more indicative of market shifts and that hospitals were no longer uniformly responding to the volume driven incentives of the historical fee-for-service methodologies.

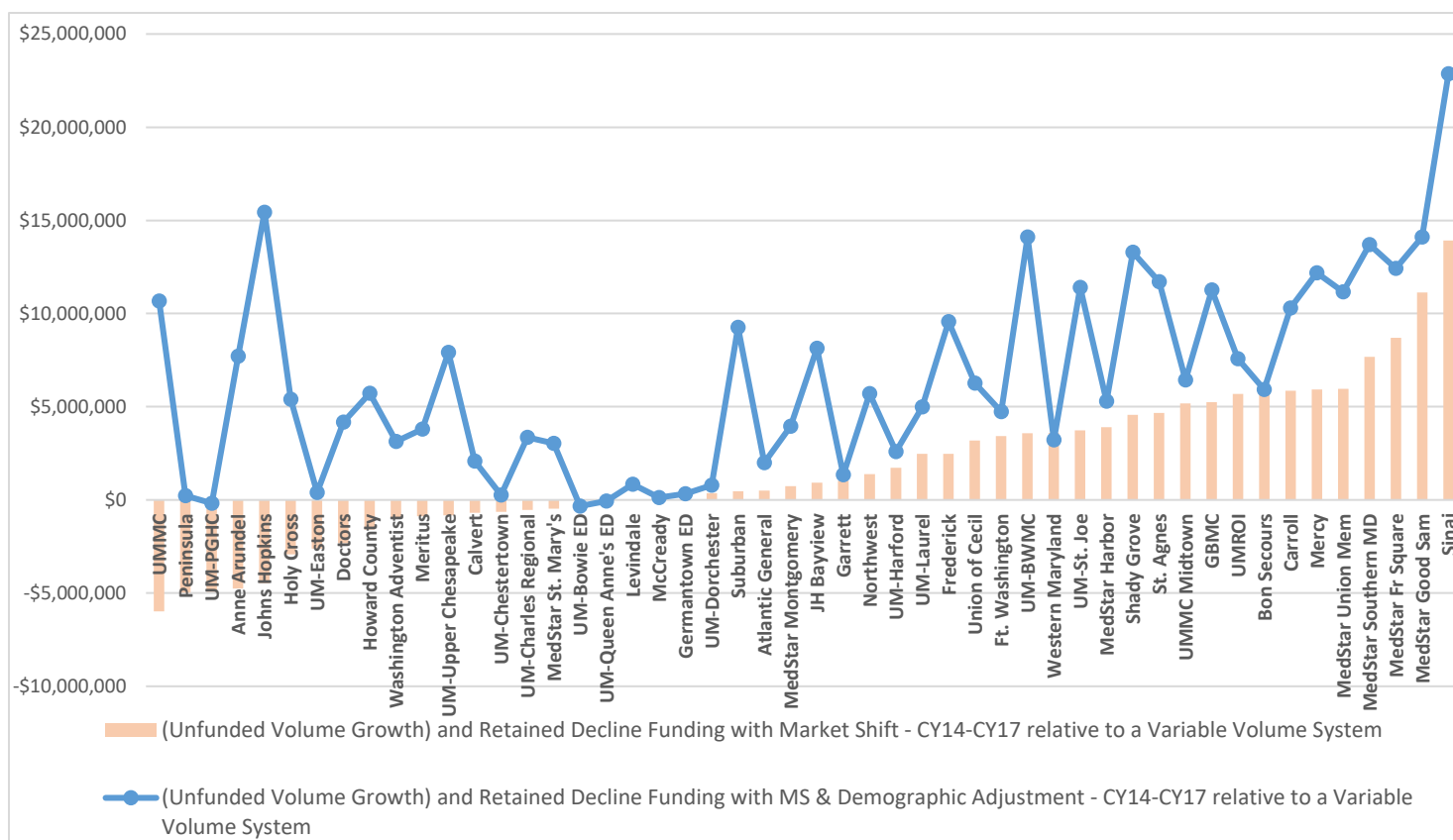
As volume reductions have increased precipitously since CY 2014, net decliners have sustained a fairly consistent effective variable cost factor, approximately 25 percent, which suggests that net declining hospitals have retained 75 percent of the revenue associated with reduced utilization.¹³ In CY 2017, the volume reductions for net decliners reached the highest level totaling \$211.2 million. Of note, \$83.2 million of the CY 2017 decline was related exclusively to reductions in ED utilization.

¹² See Appendix 4 for additional detail on General Surgery volume growth related to ICD-10 conversion.

¹³ In other words, 50 percent of the reductions were deemed market shifts and 50 percent were deemed avoided utilization – 0 percent avoided utilization + (50 percent market shift * 50 percent VCF) = 25 percent effective variable cost factor.

Analyzing the Market Shift in isolation would lead to a concern that hospitals with volume growth over the course of the All-Payer Model had been underfunded, potentially for medically necessary care, such as transcatheter aortic valve replacements (TAVR’s). However, it is important to also consider the funding provided by the Demographic Adjustment, which aims to prospectively fund utilization growth related to demographic changes while maintaining the incentives of the Model to reduce unnecessary utilization. When this funding source is considered all hospitals in aggregate from CY 2014 to CY 2017 have received adequate funding relative to a 50 percent variable cost factor, as can be seen below in the blue line on Table 6:

Table 6: Residual Funding Differences of In-State Volume CY14-CY17 Market Shift and Demographic Adjustment Relative to a 50 percent Variable Cost Factor*



*Excludes Holy Cross Germantown and does not account for special adjustments, e.g. Medicaid Expansion and Deregulation. Note: if all hospitals were funded at a 50 percent variable cost factor for changes in utilization each hospital on the graph would be equal to \$0.

While funding has been adequate for all hospitals over the course of the All-Payer Model, there are concerns that:

- a) The standard of a 50 percent variable cost factor are not met in each individual year for all hospitals with volume growth, thereby leading to potentially unfunded medically necessary care and a degree of unpredictability;

- b) The Market Shift methodology is difficult to interpret, most notably due to the large number of markets defined; and
- c) Hospitals with retained revenue at the far right of Table 6 do not require such a large share of the Demographic Adjustment when they have simultaneously retained 100 percent of revenue for utilization reductions that are not deemed market shifts.

Staff concurs with these concerns and is proposing to evaluate potential modifications to the Demographic Adjustment that will better anticipate use rate changes while maintaining its status as population based. Staff is also proposing to reduce the number of markets/cells the Market Shift evaluates to reduce its complexity. The details of this proposal will be discussed in the *Proposed Modifications to Market Shift* section.

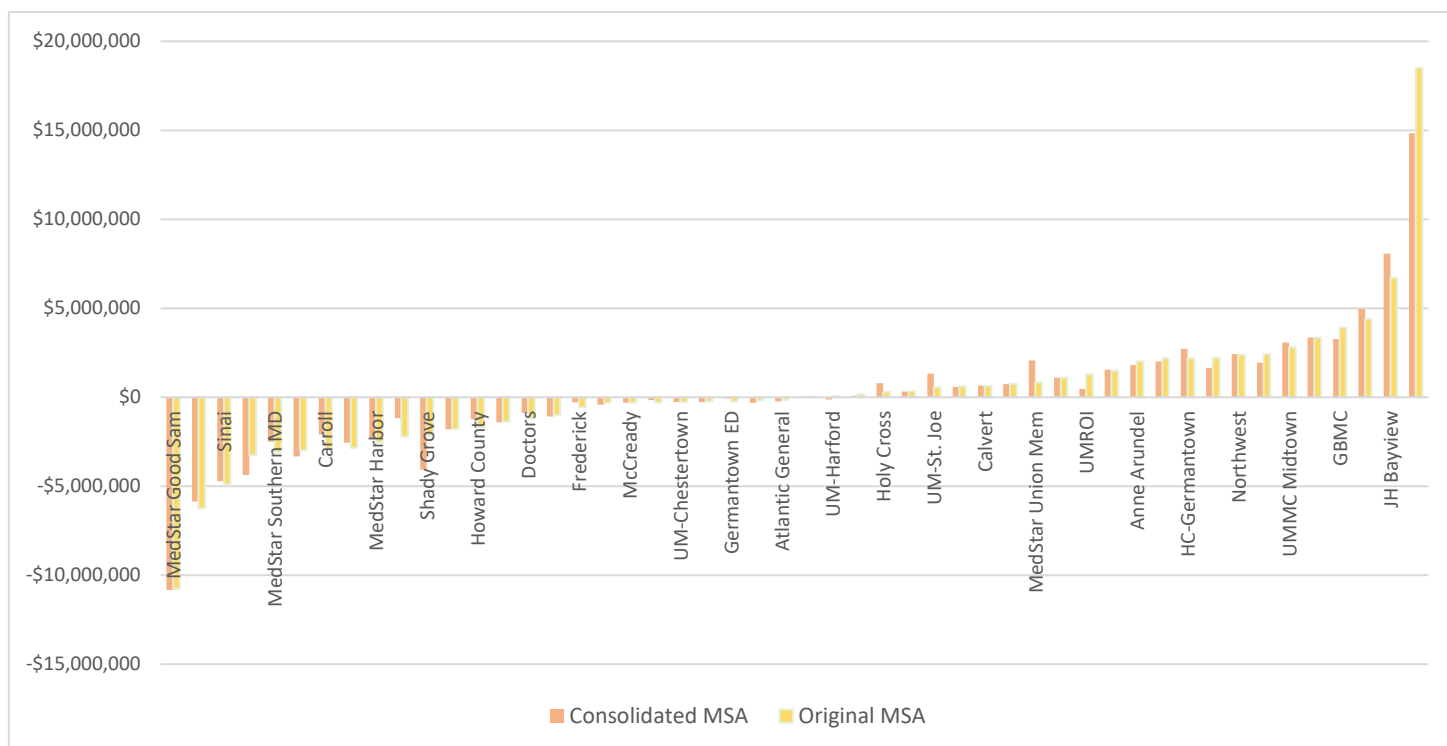
Market Shift Statistical Stability

As aforementioned, the Market Shift does evaluate a significant number of markets statewide - there are 60 hospital service lines¹⁴, over 350 geographies and potentially 20,000 markets. Critics of the Market Shift have noted that the vast amount of markets or cells leads to statistical instability, especially when comparing growth year over year at such a granular level.

To evaluate the statistical stability of the Market Shift, staff consolidated the algorithm such that market shift evaluations only occurred at the county level, i.e. zip code market shifts were eliminated from the calculation. If the market shift revenue adjustments did not materially change under a revised consolidation, staff hypothesized that the Market Shift was not statistically unstable. In Table 7, the results of the consolidated Market Shift versus the regular Market Shift for CY17 indicated that there was not a large degree of change in the revenue adjustments by hospital, especially in comparison to the hospital's overall revenue base.

¹⁴ For a complete list of service lines by APR-DRG or EAPG see Appendix 5.

Table 7: Market Shift Adjustments in Regular CY 2017 Market Shift versus Geographic Consolidated Market Shift



For most hospitals the consolidation of geographic cells did not materially change the market shift adjustment. The average dollar change was \$15,000; the absolute average dollar change was \$421,000. There were, however, various service lines that had a high degree of variation, which led to larger variances at the hospital level. For example, the market shift adjustment for the Ventilator Support service line at University of Maryland Medical Center decreased by \$1.2 million, approximately 1/3 of University's \$3.6 million variation in the two market shift calculations.

While the net hospital variation in market shift adjustments was not extremely large, staff was concerned that the change in dollar adjustments at the hospital level was not sufficient to conclude that the Market Shift is statistically stable. Thus, staff also ran additional analyses to determine the degree to which small cell sizes, e.g. less than 10 discharges per market, were correlated with changes in the consolidated and regular market shift adjustments at the service line level, i.e. random variation. Additionally, staff removed the influence large dollar value service lines can have on this analysis, because if a small dollar service line has random variation due to the statistical instability of the markets defined, it may be masked in a correlation analysis that looks solely at the absolute variation in terms of revenue. Therefore, staff ran the correlation of various small cell size indicators (less than 5, 10, 20 discharges per zip code) relative to service line absolute average dollar variation as a percentage of total service line charges.

Table 8: Correlation between Market Shift Service Line Dollar Variations between Market Shift Geographic Models & Small Cell Sizes

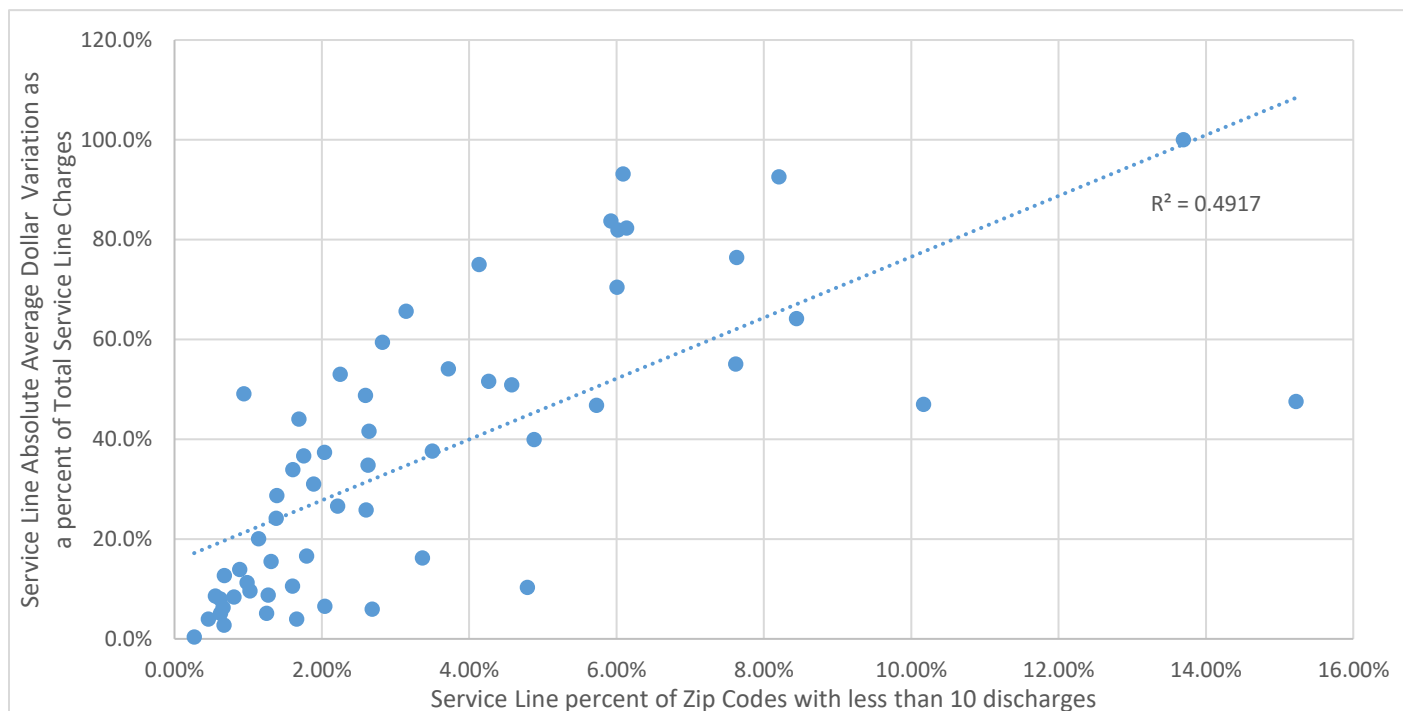


Table 8 indicates that there is indeed a strong relationship between markets with less than 10 discharges and variation between the two market shift calculations, as evidenced by a R^2 of .4917. The relationship becomes even stronger if inpatient and outpatient are evaluated independently of one another.¹⁵ Of note, the correlation to determine the random variation begins to break down beyond 10 discharges, suggesting this is the critical point by which cell size becomes unstable.

Due to these analyses and staff's concurrence that the Market Shift is inherently more difficult to interpret with the sheer size of markets defined, staff is putting forward two strategies to consolidate markets, namely to consolidate medical services in terms of clinical overlap and surgical and highly specialized services in terms of geography, all of which be discussed in the *Proposed Modifications to Market Shift* section.

Proposed Modifications to Market Shift

Staff proposes two core strategies to reduce the number of markets or cells in the market shift algorithm, namely:

- a) Collapsing medical services into similar service lines that have clinical overlap, similar average charges per equivalent casemix adjusted discharges (ECMADS), similar medical

¹⁵ The R2 for an inpatient only analysis is .6194 and for outpatient is .9429.

designations of APR-DRG's or EAPG's, and similar overrepresentation in emergency room rate center charges, which signifies less elective forms of care, and

- b) Collapsing inpatient surgeries, outpatient major surgeries, and highly specialized services (e.g. ventilator support, neonatology) into county evaluated markets as opposed to zip code evaluated markets because these services represent more elective forms of care, or care that is referred based on the availability of specialized resources.

Employing the assistance of the Volume Methodology workgroup and a few clinical experts in the field, staff has put forward a plan that takes the number of services lines from 60 to 44 and perhaps more importantly takes 28 service lines from a zip code evaluation to a county evaluation. These changes reduce the Market Shift cells from potentially being in excess of 20,000 to approximately 5,000, and markets with less than 10 discharges (an indicator of a potentially unstable cell size) went from approximately 7,000 to 1,000.¹⁶

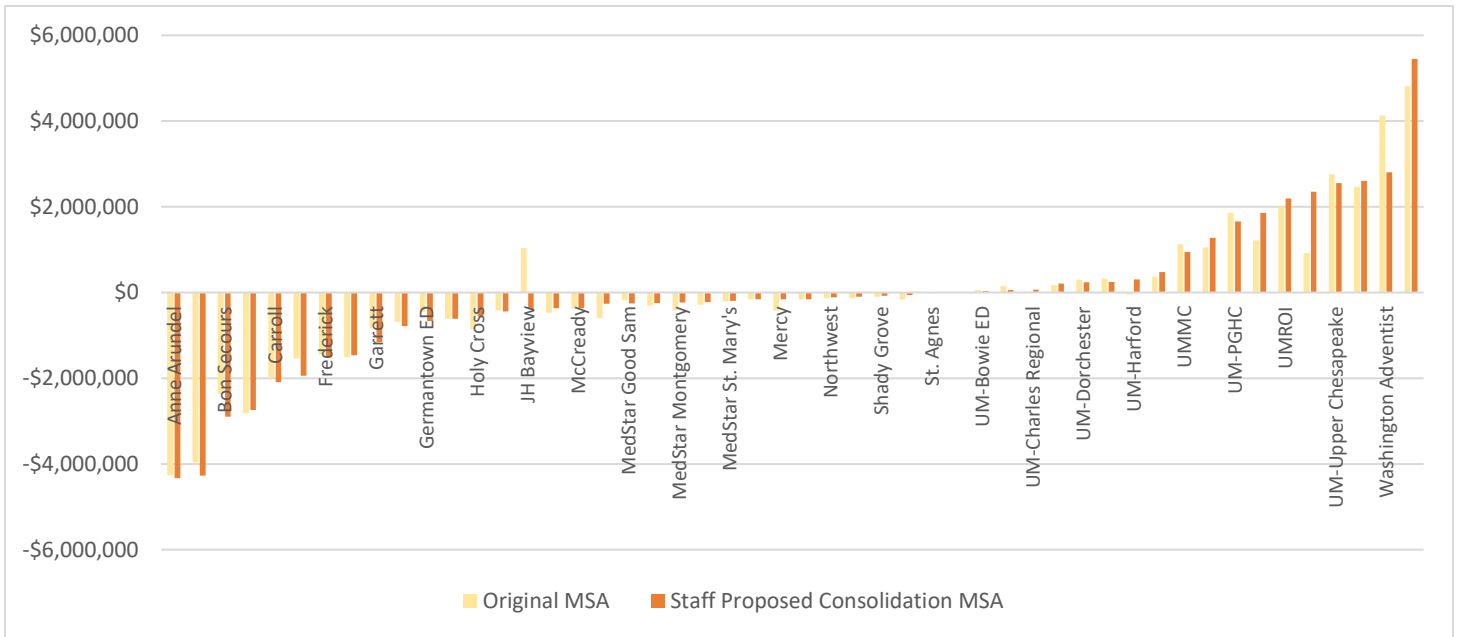
Various critics have noted that no markets should be evaluated on a zip code level and that the number of markets should be reduced further; however, staff is reluctant to pursue this course because further geographic consolidation of medical services, which often begin with a visit to the emergency room close to one's residency regardless of hospital selection, can potentially lead to avoided utilization being treated as a market shift and vice versa.¹⁷

Based on the outline for consolidation in Appendix 6, staff has produced two runs of market shift for the first six months of calendar year 2018 (regular and consolidated) and two runs of unrecognized market shift. For the former, Table 9 outlines revenue adjustment variation in the two market shift models by hospital:

¹⁶ Please see Appendix 7 for the proposed consolidations by service line

¹⁷ Please see Appendix 8 for a hypothetical example of services being misconstrued as a market shift and vice versa.

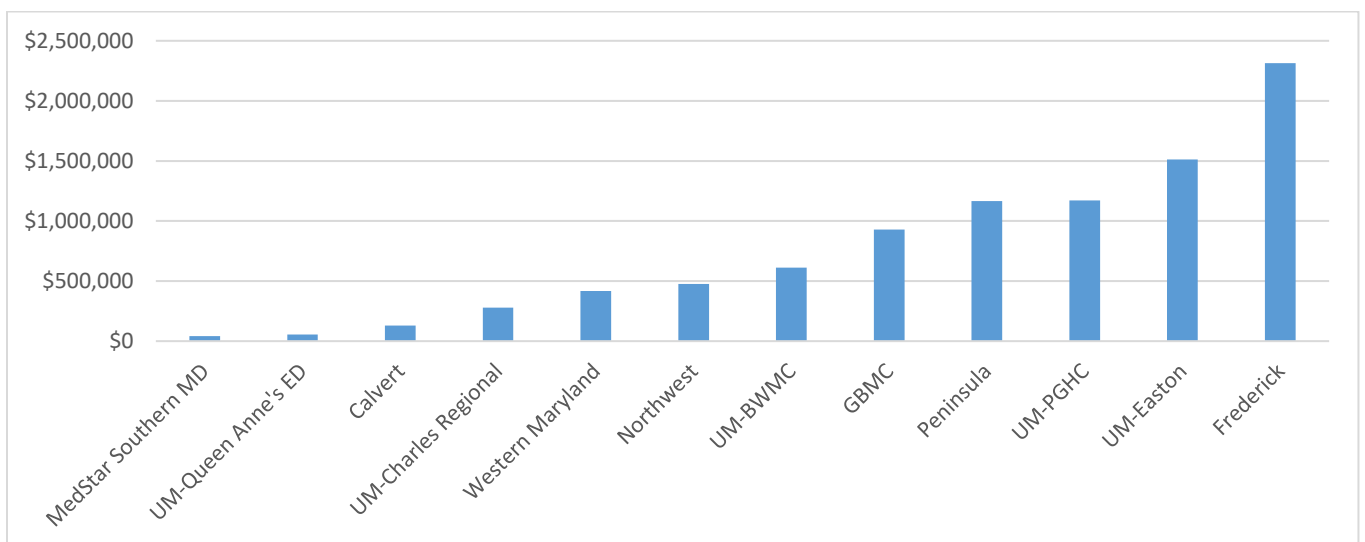
Table 9: Dollar Variation in CY 2018 Market Shift (six months) between Current Market Definitions and Staff Proposed Market Definitions



While the dollar variation as shown in Table 9 is not significant by hospital, it is important to note that the average dollar change of \$7,000 was lower than the prior consolidation analysis and the absolute average dollar of \$225,000 was also lower, suggesting that simplifying Market Shift to have approximately 5,000 cells did not materially affect the outcome. Nevertheless, the changes did simplify the approach and reduce the number of small cells.

For the unrecognized market shift under the newly proposed Market Shift consolidation staff notes that unfunded growth statewide is \$9.1 million. See Table 10 for a break down by Hospital:

Table 10: CY 2018 (six months) Unfunded Growth by Hospital for all Service Lines



Of note, \$5.3 million of the \$9.1 million in unfunded growth is due to the Infectious Disease service line, which is usually indicative of seasonal flu spikes, and the \$9.1 million does not account for any additional funding provided by the Demographic Adjustment.

Additional Considerations for Future Policies

All methodologies, in particular volume methodologies, require revisions to improve their accuracy and effectiveness. Staff's recommendations to the Demographic Adjustment and the Market Shift are incremental steps to make the Commission's core volume policies simpler and more predictable. Going forward staff plans to work to improve these methodologies further by engaging a clinical subgroup to consider additional reductions to the number of defined markets/cells in the Market Shift methodology.

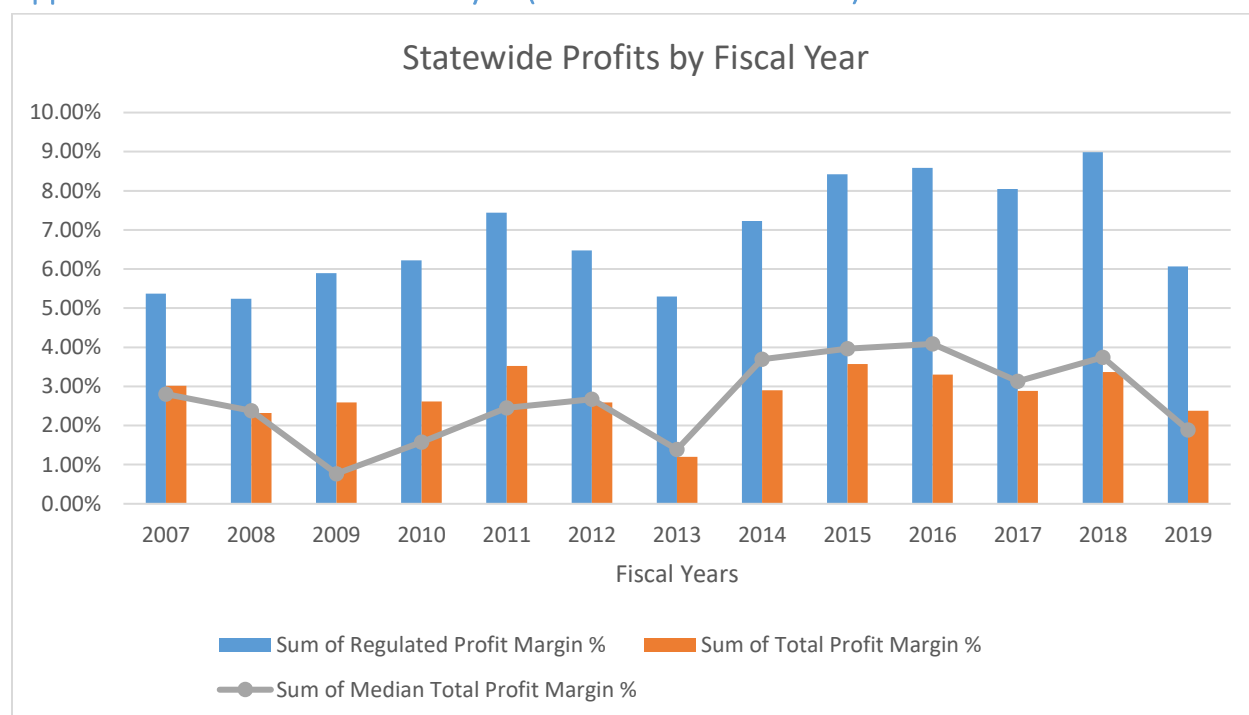
Staff will also consider other approaches to allocation of the Demographic Adjustment. One alternative considered is to incorporate the expectation of declines in medical volumes and avoidable utilization and increases in some surgical utilization by incorporating these expected outcomes into the Demographic Adjustment on a service line basis. This would allow for a reallocation of the Demographic Adjustment based on the types of services being offered by each hospital, while not providing payment for actual volume changes. These and other options may be considered. The advantage of this option is that it would not create an incentive for volume growth. The disadvantage is that it does not recognize actual volume changes at each hospital. Staff has not modeled this option at the current time to see if it would address most stakeholder concerns regarding the allocation of the Demographic Adjustment.

Recommendations

Staff recommends the following updates to the current Commission Methodologies:

1. Consolidate defined markets in the Market Shift methodology by reducing service lines with clinical overlap and assessing inpatient surgery and other highly specialized services at a county level.
2. Establish a Workgroup to evaluate potential modifications to the Demographic Adjustment that will better anticipate use rate changes while maintaining its status as population based.

Appendix 1. Statewide Profit Analysis (RY 2007 – RY 2019 YTD)



Appendix 2. Demographic Adjustment Detailed Calculation Steps

This section provides the data sources used and a more detailed explanation of each step of the calculation.

Data Sources:

Volume estimates and total charges by age cohorts are calculated using HSCRC patient level inpatient and outpatient abstract data submitted on a monthly basis. All calculations involving volume and charges include only Maryland residents, determined by the reported billing zip code of the patient.

Zip code and age specific population estimates and projections were provided by Claritas for current year and 5-year population projections, since zip code level data are not available from the Department of State Planning.

Below are the detailed calculation steps:

STEP 1. Calculate base population estimates for each hospital based on its share of volume, as measured by equivalent case-mix adjusted discharges, in a given zip code/age cohort.

Step 1a: Calculate the base year total service volume of the hospital (inpatient and outpatient) for each zip code by each of the eight age cohorts based on Equivalent Case Mix Adjusted Discharges.

- i. Measure the volume of inpatient services as total inpatient case mix adjusted discharges (CMADs) that occurred in the specified fiscal year.
- ii. Measure the volume of outpatient services as follows:
 - a. Calculate the Hospital Unit Charge as the average charge per CMAD for all of the hospital's inpatients that occurred in the specified fiscal year.
 - b. Calculate the outpatient equivalent case mix adjusted discharges (ECMADs) as:

$$\text{Outpatient ECMAD} = \frac{\text{Total Charges} - \text{Inpatient Charges}}{\text{Hospital Unit Charge}}$$

- iii. Sum inpatient CMADs and Outpatient ECMADs to determine total service volume of the hospital ECMADs for each zip code and age cohort.

Step 1b: Allocate the base population for each zip/age cohort.

Use the proportion of each hospital's ECMAD volumes in each zip/age cohort divided by the total ECMADs for all hospitals in that zip/age cohort to allocate a proportion of the population in each zip code to each hospital.

Example:

For Hospital A and Zip/Age Cohort J the base population would be calculated as:

$$\text{Base Population}_{AJ} = \text{Population}_J * (\text{ECMAD}_{AJ} / \text{ECMAD}_J)$$

STEP 2: Calculate age adjusted population growth rates.

Step 2a: Calculate the statewide age cost weight for each age cohort.

Relative age cost weights are applied to a hospital's allocated population and population estimates to arrive at cost weighted populations for the base year and the projection year to account for the age-weighted growth in the population. Age specific hospital cost weights are calculated at the state level as the ratio of average total hospital charges per capita for each statewide age cohort to the statewide average hospital charge per capita in the base year. The total hospital charges include charges for Maryland residents only. This calculation is illustrated below for the statewide [5-14] age cohort.

$$\begin{aligned} &\text{Age Cost Weight for [5 to 14] Age Cohort} \\ &= \frac{\text{Total [5 to 14] Hospitals' Charges / Population in Base Year}}{\text{Total [All cohorts] Hospitals' Charges / Population in Base Year}} \end{aligned}$$

Step 2b: Calculate age adjusted growth rates.

For each zip/age cohort, the estimated population growth rates are multiplied by the age cost weights to determine the cost weighted population growth rates.

For a Zip/Age Cohort J and Age Weight [5 to 14];

$$\text{Age Adjusted Population Growth Rate} = \text{Population Growth Rate}_J * \text{Age-Weight [5 to 14]}$$

STEP 3: Calculate hospital overall age adjusted growth.

The age adjusted projected population related volume growth is calculated by multiplying base population numbers by age adjusted growth rates from Step 2 for each zip/age cohort. The overall hospital specific age adjusted growth rate is the sum of the allocated age adjusted population for the projection period divided by the age adjusted allocated population for the base period. This is converted to a percentage after subtracting 1.

For Hospital A and Zip/Age Cohort J and Age-Weight [5 to 14];

$$\text{Projected Population Growth} = \text{Base Population}_{AJ} * \text{Population Growth Rate}_J * \text{Age-Weight [5 to 14]}$$

Then overall Projected Population for Hospital A for all Zip/Age Cohorts = i....z:

$$\text{Overall Projected Population Growth Rate} = \frac{\text{Sum of (Projected Population Growth } i \dots z)}{\text{Sum of (Base Population } i \dots z)}$$

STEP 4: Calculate the appropriate volume growth by applying efficiency adjustments.

Step 4a: Reduce age adjusted overall projected growth by hospital specific overall PAU percentage of revenue.

The overall growth rate calculated in Step 3 is reduced by the PAU percentage of revenue that is calculated on a hospital specific basis by multiplying the growth rate by the PAU percentage of revenue. The policy result is that the hospital will not receive a demographic adjustment on any of its PAU revenues, which includes revenue from avoidable admissions, 30-day readmissions, observation or emergency department visits, as well as revenue from complications (see below for additional information). PAU percentages of revenue are calculated at the hospital specific level by calculating the ratio of PAU revenue divided by total hospital revenue.

Step 4b: Reduce the PAU adjusted growth percentage for each hospital to achieve an allowance for demographic growth statewide that is lower than the overall growth allowed by the All-Payer Model.

The All-Payer Model provides for per capita growth, without any explicit adjustment for aging of the population. The preliminary result of Step 4a provides a demographic factor for each hospital that includes an age adjustment and that has been reduced by a measure of potentially avoidable utilization. Without further adjustment, the age and PAU adjusted demographic factor statewide would produce an allowance for growth that is above the statewide allowance for growth in population. Therefore, an additional efficiency adjustment reduction percentage is applied to each hospital's age and PAU adjusted growth percentage to bring the allowance

statewide to a level within the overall population increase percentage provided by the Model. For example, if the age and PAU adjusted allowance were 1.2percent but the target population allowance was .6percent, then all hospitals would receive an additional efficiency adjustment of 50percent. This adjustment recognizes the ability to provide incremental volumes at a lower marginal cost or to further reduce avoidable volume to achieve the needed efficiency level of the per capita model.

Final Demographic Percentage: At the conclusion of Step 4b, the final demographic adjustment percentage has been calculated for each hospital in the State. After adding 1 to the percentage, this demographic growth rate is multiplied by each hospital's approved revenue from the base year to arrive at the population adjusted revenue for the target year.

Appendix 3. Geographic and Service Line Definition Discussion

Geographic Area Definitions

Market shift is focused on movement of patients and services between Maryland hospitals. Narrowly defined geographic regions are better for calculating market shift, especially for emergency medical service lines, because the individual hospitals serving the region are not likely to be differentially impacted by population growth or demographically driven changes in utilization rates. However, defining markets too narrowly may result in shifts not being recognized by the MSA. Calculating market shift at the statewide level, in contrast, would result in the movement of dollars to hospitals in regions experiencing population growth at the expense of other regions.

In densely populated regions of the state where there is significant competition among hospitals, market shift calculations are currently performed at the ZIP code level for all services. However, ZIP code level calculations introduce random variation to the measurement in small geographic areas where the population density is low, and the health care market is concentrated. Such ZIP codes are aggregated to limit the impact of small cell sizes on the calculations. ZIP codes in the following jurisdictions are aggregated at the county level:

Garrett, Allegany, Washington, Cecil, Kent, Queen Anne's, Caroline, Talbot, Dorchester, Wicomico, Somerset, Calvert, Charles, Saint Mary's, Worcester

Random variation has not been entirely addressed by aggregating rural regions into county level markets. Thus, staff will discuss in the Volume Assessment section the concern about small cell sizes and the continuance of random variation in current MSA's. Staff will propose to consolidate geographies further for specialized services that are more elective in nature and to also consolidate service lines with clinical overlap.

In calculating market shifts, all hospitals will still have the same geographic definitions. For example, to calculate volume changes in Garrett County, all ZIP codes in Garrett County will be added together for each hospital with volume in Garrett County. The calculations of volume changes will be based on ZIP code-level analysis for the remaining jurisdictions and service lines that are not aggregated, such as Baltimore City emergency room services.

Service Line Definitions

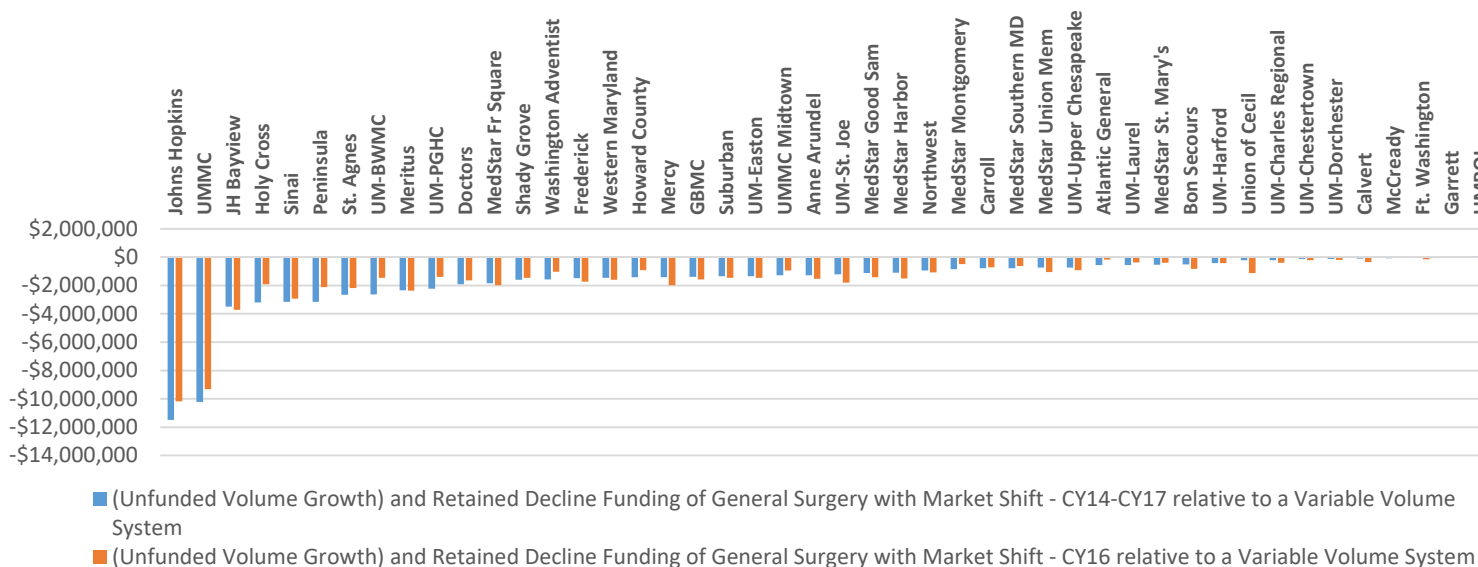
Narrow definitions of service lines were proposed to prevent utilization growth for one component of the service line from masking a shift in patients for another service line. For instance, a service line that captures all surgical procedures might be growing at every hospital in a region due to increasing demand for orthopedic surgery and thereby masking the shift of 50 cardiac surgical procedures from one hospital to another.

Movement of cases from inpatient to outpatient settings and utilization of observation units creates a challenge in differentiating shifts from one hospital to another, or shifts from a hospital's inpatient to outpatient service settings. Staff addressed this issue by counting and weighting all observation room cases of 24 or more hours as inpatient and more recently has started moving outpatient services to inpatient if that service was removed from Medicare's inpatient only list, e.g. total knee arthroplasties.

Inpatient service lines are developed using the existing 3M methodology to group all patient refined-diagnosis related groups (APR-DRGs) to specific service lines with a few modifications. See Appendix 3 in for a cross walk of APR-DRGs to service lines. Staff uses an inpatient-like logic and assigns outpatient visits based on the reasons for acquiring services. For example, all services provided for emergency department (ED) patients are grouped under the ED service line. Appendix 5 provides the hierarchy of outpatient service lines.

Appendix 4 General Surgery ICD-10 Conversion Analyses

Residual Funding of In-State General Surgery Volume Growth and Declines at a 50percent variable revenue factor for CY14-CY17 after applying Market Shift Adjstment only



2015 to 2015 General Surgery Growth by Unique APR-DRG's

APR-DRG Description	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide	CMI % Change 2015-2015
	Case Growth (Q1-Q2)	Case Growth (Q2-Q3)	Case Growth (Q3-Q4)	Case Growth (Q4-Q1)	Case Growth (Q1-Q2)	Case Growth (Q2- Q3)	Case Growth (Q3-Q4)	Case Growth (2015-2016)	
Extensive procedure unrelated to principal diagnosis Infectious & parasitic diseases including HIV w O.R. procedure	-5	2	79	34	4	-20	6	350	-14.75%
Laparoscopic cholecystectomy	-38	52	189	31	-54	138	-3	868	-2.61%
Major biliary tract procedures	-35	58	-88	71	-5	52	-32	158	-0.47%
Major stomach, esophageal & duodenal procedures	-2	12	26	-4	26	-10	26	168	-11.65%
Nonextensive procedure unrelated to principal diagnosis	23	13	59	18	-19	31	-107	196	-15.13%
Other digestive system & abdominal procedures	-26	5	60	11	-19	22	1	196	-6.80%
Other hepatobiliary, pancreas & abdominal procedures	-1	1	73	-3	-3	32	-24	239	-4.07%
Other male reproductive system & related procedures	6	10	93	23	-3	13	-4	410	-17.93%
Other skin, subcutaneous tissue & related procedures	-16	8	93	2	24	-35	-5	284	-8.67%
Other small & large bowel procedures	-2	16	103	1	2	31	-22	389	-4.80%
Procedure w diag of rehab, aftercare or oth contact w health service	17	-1	102	13	-10	-43	21	278	-9.36%
Skin graft for skin & subcutaneous tissue diagnoses	-3	1	114	-30	-38	12	21	152	-7.31%
Total	-94	198	970	137	-80	197	-124	3,790	

ICD-10 Conversion time period

Appendix 5. APR-DRG and EAPG Service Line Mapping

a. APR-DRG Service Line Map

APR_DRG	DRG_Description	Type	Old_Serviceline	New_Serviceline
0	TOTAL KNEE REPLACEMENT (FROM OUTPATIENT)	S	Major Surgery_TKA	Orthopedic Surgery
1	LIVER TRANSPLANT &/OR INTESTINAL TRANSPLANT	S	Transplant Surgery	Transplant Surgery
2	HEART &/OR LUNG TRANSPLANT	S	Transplant Surgery	Transplant Surgery
4	TRACHEOSTOMY W MV 96+ HOURS W EXTENSIVE PROCEDURE	S	Ventilator Support	Ventilator Support
5	TRACHEOSTOMY W MV 96+ HOURS W/O EXTENSIVE PROCEDURE	S	Ventilator Support	Ventilator Support
6	PANCREAS TRANSPLANT	S	Transplant Surgery	Transplant Surgery
7	ALLOGENEIC BONE MARROW TRANSPLANT	S	Transplant Surgery	Transplant Surgery
8	AUTOLOGOUS BONE MARROW TRANSPLANT	S	Transplant Surgery	Transplant Surgery
9	EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	S	Ventilator Support	Ventilator Support
10	HEAD TRAUMA WITH DEEP COMA	M	Trauma	Trauma
20	CRANIOTOMY FOR TRAUMA	S	Neurological Surgery	Neurological Surgery
21	CRANIOTOMY EXCEPT FOR TRAUMA	S	Neurological Surgery	Neurological Surgery
22	VENTRICULAR SHUNT PROCEDURES	S	Neurological Surgery	Neurological Surgery
23	SPINAL PROCEDURES	S	Spinal Surgery	Spinal Surgery
24	EXTRACRANIAL VASCULAR PROCEDURES	S	Neurological Surgery	Neurological Surgery
26	OTHER NERVOUS SYSTEM & RELATED PROCEDURES	S	Neurological Surgery	Neurological Surgery
40	SPINAL DISORDERS & INJURIES	M	Neurology	Neurology
41	NERVOUS SYSTEM MALIGNANCY	M	Oncology	Oncology
42	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS	M	Neurology	Neurology
43	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES	M	Neurology	Neurology
44	INTRACRANIAL HEMORRHAGE	M	Neurology	Neurology
45	CVA & PRECEREBRAL OCCLUSION W INFARCT	M	Neurology	Neurology
46	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	M	Neurology	Neurology
47	TRANSIENT ISCHEMIA	M	Neurology	Neurology

48	PERIPHERAL, CRANIAL & AUTONOMIC NERVE DISORDERS	M	Neurology	Neurology
49	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM	M	Infectious Disease	Infectious Disease
50	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXC VIRAL MENINGITIS	M	Infectious Disease	Infectious Disease
51	VIRAL MENINGITIS	M	Infectious Disease	Infectious Disease
52	ALTERATION IN CONSCIOUSNESS	M	Neurology	Neurology
53	SEIZURE	M	Neurology	Neurology
54	MIGRAINE & OTHER HEADACHES	M	Neurology	Neurology
55	HEAD TRAUMA W COMA >1 HR OR HEMORRHAGE	M	Neurology	Neurology
56	BRAIN CONTUSION/LACERATION & COMPLICATED SKULL FX, COMA < 1 HR OR NO COMA	M	Neurology	Neurology
57	CONCUSSION, CLOSED SKULL FX NOS, UNCOMPLICATED INTRACRANIAL INJURY, COMA < 1 HR OR NO COMA	M	Neurology	Neurology
58	OTHER DISORDERS OF NERVOUS SYSTEM	M	Neurology	Neurology
59	ANOXIC & OTHER SEVERE BRAIN DAMAGE	M	Neurology	Neurology
73	ORBIT AND EYE PROCEDURES	S	Ophthalmologic Surg	Ophthalmologic Surg
82	EYE INFECTIONS AND OTHER EYE DISORDERS	M	Ophthalmology	Ophthalmology
89	MAJOR CRANIAL/FACIAL BONE PROCEDURES	S	ENT Surgery	ENT Surgery
91	OTHER MAJOR HEAD & NECK PROCEDURES	S	ENT Surgery	ENT Surgery
92	FACIAL BONE PROCEDURES EXCEPT MAJOR CRANIAL/FACIAL BONE PROCEDURES	S	ENT Surgery	ENT Surgery
95	CLEFT LIP & PALATE REPAIR	S	ENT Surgery	ENT Surgery
97	TONSIL & ADENOID PROCEDURES	S	ENT Surgery	ENT Surgery
98	OTHER EAR, NOSE, MOUTH & THROAT PROCEDURES	S	ENT Surgery	ENT Surgery
110	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES	M	Oncology	Oncology
111	VERTIGO & OTHER LABYRINTH DISORDERS	M	Otolaryngology	General Medicine
113	INFECTIONS OF UPPER RESPIRATORY TRACT	M	Otolaryngology	General Medicine
114	DENTAL DISEASES AND DISORDERS	M	Dental	General Medicine
115	OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES	M	Otolaryngology	General Medicine

120	MAJOR RESPIRATORY & CHEST PROCEDURES	S	Thoracic Surgery	Thoracic Surgery
121	OTHER RESPIRATORY & CHEST PROCEDURES	S	Thoracic Surgery	Thoracic Surgery
130	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	M	Pulmonary	Pulmonary
131	CYSTIC FIBROSIS - PULMONARY DISEASE	M	Pulmonary	Pulmonary
132	BPD & OTH CHRONIC RESPIRATORY DISEASES ARISING IN PERINATAL PERIOD	M	Neonatology	Neonatology
133	RESPIRATORY FAILURE	M	Pulmonary	Pulmonary
134	PULMONARY EMBOLISM	M	Pulmonary	Pulmonary
135	MAJOR CHEST & RESPIRATORY TRAUMA	M	Trauma	Trauma
136	RESPIRATORY MALIGNANCY	M	Oncology	Oncology
137	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS	M	Pulmonary	Pulmonary
138	BRONCHIOLITIS & RSV PNEUMONIA	M	Pulmonary	Pulmonary
139	OTHER PNEUMONIA	M	Pulmonary	Pulmonary
140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	M	Pulmonary	Pulmonary
141	ASTHMA	M	Pulmonary	Pulmonary
142	INTERSTITIAL & ALVEOLAR LUNG DISEASES	M	Pulmonary	Pulmonary
143	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES	M	Pulmonary	Pulmonary
144	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES	M	Pulmonary	Pulmonary
145	ACUTE BRONCHITIS AND RELATED SYMPTOMS	M	Pulmonary	Pulmonary
160	MAJOR CARDIOTHORACIC REPAIR OF HEART ANOMALY	S	Cardiothoracic Surgery	Cardiothoracic Surgery
161	CARDIAC DEFIBRILLATOR & HEART ASSIST IMPLANT	S	Cardiothoracic Surgery	Cardiothoracic Surgery
162	CARDIAC VALVE PROCEDURES W AMI OR COMPLEX PDX	S	Cardiothoracic Surgery	Cardiothoracic Surgery
163	CARDIAC VALVE PROCEDURES W/O AMI OR COMPLEX PDX	S	Cardiothoracic Surgery	Cardiothoracic Surgery
165	CORONARY BYPASS W AMI OR COMPLEX PDX	S	Cardiothoracic Surgery	Cardiothoracic Surgery
166	CORONARY BYPASS W/O AMI OR COMPLEX PDX	S	Cardiothoracic Surgery	Cardiothoracic Surgery
167	OTHER CARDIOTHORACIC & THORACIC VASCULAR PROCEDURES	S	Cardiothoracic Surgery	Cardiothoracic Surgery
169	MAJOR ABDOMINAL VASCULAR PROCEDURES	S	Vascular Surgery	Vascular Surgery

170	PERMANENT CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	S	EP/Chronic Rhythm Mgmt	Invasive Cardiology
171	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK	S	EP/Chronic Rhythm Mgmt	Invasive Cardiology
174	PERCUTANEOUS CORONARY INTERVENTION W AMI	S	Invasive Cardiology	Invasive Cardiology
175	PERCUTANEOUS CORONARY INTERVENTION W/O AMI	S	Invasive Cardiology	Invasive Cardiology
176	CARDIAC PACEMAKER & DEFIBRILLATOR DEVICE REPLACEMENT	S	EP/Chronic Rhythm Mgmt	Invasive Cardiology
177	CARDIAC PACEMAKER & DEFIBRILLATOR REVISION EXCEPT DEVICE REPLACEMENT	S	EP/Chronic Rhythm Mgmt	Invasive Cardiology
180	OTHER CIRCULATORY SYSTEM PROCEDURES	S	Cardiothoracic Surgery	Cardiothoracic Surgery
181	LOWER EXTREMITY ARTERIAL PROCEDURES	S	Vascular Surgery	Vascular Surgery
182	OTHER PERIPHERAL VASCULAR PROCEDURES	S	Vascular Surgery	Vascular Surgery
190	ACUTE MYOCARDIAL INFARCTION	M	Myocardial Infarction	Cardiology
191	CARDIAC CATHETERIZATION FOR CORONARY ARTERY DISEASE	M	Invasive Cardiology	Invasive Cardiology
192	CARDIAC CATHETERIZATION FOR OTHER NON-CORONARY CONDITIONS	M	Invasive Cardiology	Invasive Cardiology
193	ACUTE & SUBACUTE ENDOCARDITIS	M	Cardiology	Cardiology
194	HEART FAILURE	M	Cardiology	Cardiology
196	CARDIAC ARREST & SHOCK	M	Cardiology	Cardiology
197	PERIPHERAL & OTHER VASCULAR DISORDERS	M	General Medicine	General Medicine
198	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	M	Cardiology	Cardiology
199	HYPERTENSION	M	Cardiology	Cardiology
200	CARDIAC STRUCTURAL & VALVULAR DISORDERS	M	Cardiology	Cardiology
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	M	Cardiology	Cardiology
203	CHEST PAIN	M	Cardiology	Cardiology
204	SYNCOPE & COLLAPSE	M	Cardiology	Cardiology
205	CARDIOMYOPATHY	M	Cardiology	Cardiology
206	MALFUNCTION,REACTION,COMPLICATION OF CARDIAC/VASC DEVICE OR PROCEDURE	M	Cardiology	Cardiology
207	OTHER CIRCULATORY SYSTEM DIAGNOSES	M	Cardiology	Cardiology
220	MAJOR STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	S	General Surgery	General Surgery

222	OTHER STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	S	General Surgery	General Surgery
223	OTHER SMALL & LARGE BOWEL PROCEDURES	S	General Surgery	General Surgery
224	PERITONEAL ADHESIOLYSIS	S	General Surgery	General Surgery
226	ANAL PROCEDURES	S	General Surgery	General Surgery
227	HERNIA PROCEDURES EXCEPT INGUINAL, FEMORAL & UMBILICAL	S	General Surgery	General Surgery
228	INGUINAL, FEMORAL & UMBILICAL HERNIA PROCEDURES	S	General Surgery	General Surgery
229	OTHER DIGESTIVE SYSTEM & ABDOMINAL PROCEDURES	S	General Surgery	General Surgery
230	MAJOR SMALL BOWEL PROCEDURES	S	General Surgery	General Surgery
231	MAJOR LARGE BOWEL PROCEDURES	S	General Surgery	General Surgery
232	GASTRIC FUNDOPLICATION	S	General Surgery	General Surgery
233	APPENDECTOMY WITH COMPLEX PRINCIPAL DIAGNOSIS	S	General Surgery	General Surgery
234	APPENDECTOMY WITHOUT COMPLEX PRINCIPAL DIAGNOSIS	S	General Surgery	General Surgery
240	DIGESTIVE MALIGNANCY	M	Oncology	Oncology
241	PEPTIC ULCER & GASTRITIS	M	Gastroenterology	Gastroenterology
242	MAJOR ESOPHAGEAL DISORDERS	M	Gastroenterology	Gastroenterology
243	OTHER ESOPHAGEAL DISORDERS	M	Gastroenterology	Gastroenterology
244	DIVERTICULITIS & DIVERTICULOSIS	M	Gastroenterology	Gastroenterology
245	INFLAMMATORY BOWEL DISEASE	M	Gastroenterology	Gastroenterology
246	GASTROINTESTINAL VASCULAR INSUFFICIENCY	M	Gastroenterology	Gastroenterology
247	INTESTINAL OBSTRUCTION	M	Gastroenterology	Gastroenterology
248	MAJOR GASTROINTESTINAL & PERITONEAL INFECTIONS	M	Gastroenterology	Gastroenterology
249	OTHER GASTROENTERITIS, NAUSEA & VOMITING	M	Gastroenterology	Gastroenterology
251	ABDOMINAL PAIN	M	Gastroenterology	Gastroenterology
252	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE	M	Gastroenterology	Gastroenterology
253	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE	M	Gastroenterology	Gastroenterology

254	OTHER DIGESTIVE SYSTEM DIAGNOSES	M	Gastroenterology	Gastroenterology
260	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	S	General Surgery	General Surgery
261	MAJOR BILIARY TRACT PROCEDURES	S	General Surgery	General Surgery
263	CHOLECYSTECTOMY	S	General Surgery	General Surgery
264	OTHER HEPATOBILIARY, PANCREAS & ABDOMINAL PROCEDURES	S	General Surgery	General Surgery
279	HEPATIC COMA & OTHER MAJOR ACUTE LIVER DISORDERS	M	Gastroenterology	Gastroenterology
280	ALCOHOLIC LIVER DISEASE	M	Gastroenterology	Gastroenterology
281	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS	M	Oncology	Oncology
282	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	M	Gastroenterology	Gastroenterology
283	OTHER DISORDERS OF THE LIVER	M	Gastroenterology	Gastroenterology
284	DISORDERS OF GALLBLADDER & BILIARY TRACT	M	Gastroenterology	Gastroenterology
301	HIP JOINT REPLACEMENT	S	Orthopedic Surgery	Orthopedic Surgery
302	KNEE JOINT REPLACEMENT	S	Orthopedic Surgery	Orthopedic Surgery
303	DORSAL & LUMBAR FUSION PROC FOR CURVATURE OF BACK	S	Orthopedic Surgery	Orthopedic Surgery
304	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK	S	Orthopedic Surgery	Orthopedic Surgery
305	AMPUTATION OF LOWER LIMB EXCEPT TOES	S	Orthopedic Surgery	Orthopedic Surgery
308	HIP & FEMUR FRACTURE REPAIR	S	Orthopedic Surgery	Orthopedic Surgery
309	OTHER SIGNIFICANT HIP & FEMUR SURGERY	S	Orthopedic Surgery	Orthopedic Surgery
310	INTERVERTEBRAL DISC EXCISION & DECOMPRESSION	S	Orthopedic Surgery	Orthopedic Surgery
312	SKIN GRAFT, EXCEPT HAND, FOR MUSCULOSKELETAL & CONNECTIVE TISSUE DIAGNOSES	S	Orthopedic Surgery	Orthopedic Surgery
313	KNEE & LOWER LEG PROCEDURES EXCEPT FOOT	S	Orthopedic Surgery	Orthopedic Surgery
314	FOOT & TOE PROCEDURES	S	Orthopedic Surgery	Orthopedic Surgery
315	SHOULDER, UPPER ARM & FOREARM PROCEDURES EXCEPT JOINT REPLACEMENT	S	Orthopedic Surgery	Orthopedic Surgery

316	HAND & WRIST PROCEDURES	S	Orthopedic Surgery	Orthopedic Surgery
317	TENDON, MUSCLE & OTHER SOFT TISSUE PROCEDURES	S	Orthopedic Surgery	Orthopedic Surgery
320	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES	S	Orthopedic Surgery	Orthopedic Surgery
321	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP	S	Spinal Surgery	Spinal Surgery
322	SHOULDER & ELBOW JOINT REPLACEMENT	S	Orthopedic Surgery	Orthopedic Surgery
340	FRACTURE OF FEMUR	M	Orthopedics	General Medicine
341	FRACTURE OF PELVIS OR DISLOCATION OF HIP	M	Orthopedics	General Medicine
342	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK	M	Orthopedics	General Medicine
343	MUSCULOSKELETAL MALIGNANCY & PATHOL FRACTURE D/T MUSCSKEL MALIG	M	Oncology	Oncology
344	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS	M	Infectious Disease	Infectious Disease
346	CONNECTIVE TISSUE DISORDERS	M	Rheumatology	General Medicine
347	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES	M	Orthopedics	General Medicine
349	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE	M	Orthopedics	General Medicine
351	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	M	Rheumatology	General Medicine
361	SKIN GRAFT FOR SKIN & SUBCUTANEOUS TISSUE DIAGNOSES	S	General Surgery	General Surgery
362	MASTECTOMY PROCEDURES	S	General Surgery	General Surgery
363	BREAST PROCEDURES EXCEPT MASTECTOMY	S	General Surgery	General Surgery
364	OTHER SKIN, SUBCUTANEOUS TISSUE & RELATED PROCEDURES	S	General Surgery	General Surgery
380	SKIN ULCERS	M	Dermatology	General Medicine
381	MAJOR SKIN DISORDERS	M	Dermatology	General Medicine
382	MALIGNANT BREAST DISORDERS	M	Oncology	Oncology
383	CELLULITIS & OTHER SKIN INFECTIONS	M	Infectious Disease	Infectious Disease
384	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE	M	Dermatology	General Medicine

385	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DISORDERS	M	Dermatology	General Medicine
401	ADRENAL PROCEDURES	S	Endocrinology Surgery	Endocrinology Surgery
403	PROCEDURES FOR OBESITY	S	Endocrinology Surgery	Endocrinology Surgery
404	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES	S	Endocrinology Surgery	Endocrinology Surgery
405	OTHER PROCEDURES FOR ENDOCRINE, NUTRITIONAL & METABOLIC DISORDERS	S	Endocrinology Surgery	Endocrinology Surgery
420	DIABETES	M	Diabetes	General Medicine
421	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DISORDERS	M	Endocrinology	General Medicine
422	HYPOVOLEMIA & RELATED ELECTROLYTE DISORDERS	M	Endocrinology	General Medicine
423	INBORN ERRORS OF METABOLISM	M	Endocrinology	General Medicine
424	OTHER ENDOCRINE DISORDERS	M	Endocrinology	General Medicine
425	OTHER NON-HYPOVOLEMIC ELECTROLYTE DISORDERS	M	Endocrinology	General Medicine
426	NON-HYPOVOLEMIC SODIUM DISORDERS	M	Endocrinology	General Medicine
427	THYROID DISORDERS	M	Endocrinology	General Medicine
440	KIDNEY TRANSPLANT	S	Transplant Surgery	Transplant Surgery
441	MAJOR BLADDER PROCEDURES	S	Urological Surgery	Urological Surgery
442	KIDNEY & URINARY TRACT PROCEDURES FOR MALIGNANCY	S	Oncology	Oncology
443	KIDNEY & URINARY TRACT PROCEDURES FOR NONMALIGNANCY	S	Urological Surgery	Urological Surgery
444	RENAL DIALYSIS ACCESS DEVICE AND VESSEL REPAIR	S	Urological Surgery	Urological Surgery
445	OTHER BLADDER PROCEDURES	S	Urological Surgery	Urological Surgery
446	URETHRAL & TRANSURETHRAL PROCEDURES	S	Urological Surgery	Urological Surgery
447	OTHER KIDNEY, URINARY TRACT & RELATED PROCEDURES	S	Urological Surgery	Urological Surgery
461	KIDNEY & URINARY TRACT MALIGNANCY	M	Oncology	Oncology
462	NEPHRITIS & NEPHROSIS	M	Nephrology	General Medicine
463	KIDNEY & URINARY TRACT INFECTIONS	M	Nephrology	General Medicine

465	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION	M	Urology	Urology
466	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC	M	Nephrology	General Medicine
468	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	M	Nephrology	General Medicine
469	ACUTE KIDNEY INJURY	M	Nephrology	General Medicine
470	CHRONIC KIDNEY DISEASE	M	Nephrology	General Medicine
480	MAJOR MALE PELVIC PROCEDURES	S	Urological Surgery	Urological Surgery
482	TRANSURETHRAL PROSTATECTOMY	S	Urological Surgery	Urological Surgery
483	PENIS, TESTES & SCROTAL PROCEDURES	S	Urological Surgery	Urological Surgery
484	OTHER MALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES	S	General Surgery	General Surgery
500	MALIGNANCY, MALE REPRODUCTIVE SYSTEM	M	Oncology	Oncology
501	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY	M	Urology	Urology
510	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & OTHER RADICAL GYN PROCS	S	Gynecological Surg	Gynecological Surg
511	UTERINE & ADNEXA PROCEDURES FOR OVARIAN & ADNEXAL MALIGNANCY	S	Oncology	Oncology
512	UTERINE & ADNEXA PROCEDURES FOR NON-OVARIAN & NON-ADNEXAL MALIG	S	Oncology	Oncology
513	UTERINE & ADNEXA PROCEDURES FOR NON-MALIGNANCY EXCEPT LEIOMYOMA	S	Gynecological Surg	Gynecological Surg
514	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	S	Gynecological Surg	Gynecological Surg
517	DILATION & CURETTAGE FOR NON-OBSTETRIC DIAGNOSES	S	Gynecological Surg	Gynecological Surg
518	OTHER FEMALE REPRODUCTIVE SYSTEM & RELATED PROCEDURES	S	Gynecological Surg	Gynecological Surg
519	UTERINE & ADNEXA PROCEDURES FOR LEIOMYOMA	S	Gynecological Surg	Gynecological Surg
530	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY	M	Oncology	Oncology
531	FEMALE REPRODUCTIVE SYSTEM INFECTIONS	M	Gynecology	OB/GYN
532	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	M	Gynecology	OB/GYN
540	CESAREAN DELIVERY	S	Obstetrics/Delivery	OB/GYN

541	VAGINAL DELIVERY W STERILIZATION &/OR D&C	S	Obstetrics/Delivery	OB/GYN
542	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C	S	Obstetrics/Delivery	OB/GYN
544	D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY FOR OBSTETRIC DIAGNOSES	S	Other Obstetrics	OB/GYN
545	ECTOPIC PREGNANCY PROCEDURE	S	Gynecological Surg	Gynecological Surg
546	OTHER O.R. PROC FOR OBSTETRIC DIAGNOSES EXCEPT DELIVERY DIAGNOSES	S	Other Obstetrics	OB/GYN
560	VAGINAL DELIVERY	M	Obstetrics/Delivery	OB/GYN
561	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	M	Other Obstetrics	OB/GYN
563	PRETERM LABOR	M	Other Obstetrics	OB/GYN
564	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	M	Other Obstetrics	OB/GYN
565	FALSE LABOR	M	Other Obstetrics	OB/GYN
566	OTHER ANTEPARTUM DIAGNOSES	M	Other Obstetrics	OB/GYN
580	NEONATE, TRANSFERRED <5 DAYS OLD, NOT BORN HERE	M	Neonatology	Neonatology
581	NEONATE, TRANSFERRED < 5 DAYS OLD, BORN HERE	M	Neonatology	Neonatology
583	NEONATE W ECMO	S	Neonatology	Neonatology
588	NEONATE BWT <1500G W MAJOR PROCEDURE	S	Neonatology	Neonatology
589	NEONATE BWT <500G OR GA <24 WEEKS	M	Neonatology	Neonatology
591	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE	M	Neonatology	Neonatology
593	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE	M	Neonatology	Neonatology
602	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	M	Neonatology	Neonatology
603	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION	M	Neonatology	Neonatology
607	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM	M	Neonatology	Neonatology
608	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION	M	Neonatology	Neonatology
609	NEONATE BWT 1500-2499G W MAJOR PROCEDURE	S	Neonatology	Neonatology
611	NEONATE BIRTHWT 1500-1999G W MAJOR ANOMALY	M	Neonatology	Neonatology

612	NEONATE BWT 1500-1999G W RESP DIST SYND/OTH MAJ RESP COND	M	Neonatology	Neonatology
613	NEONATE BIRTHWT 1500-1999G W CONGENITAL/PERINATAL INFECTION	M	Neonatology	Neonatology
614	NEONATE BWT 1500-1999G W OR W/O OTHER SIGNIFICANT CONDITION	M	Neonatology	Neonatology
621	NEONATE BWT 2000-2499G W MAJOR ANOMALY	M	Neonatology	Neonatology
622	NEONATE BWT 2000-2499G W RESP DIST SYND/OTH MAJ RESP COND	M	Neonatology	Neonatology
623	NEONATE BWT 2000-2499G W CONGENITAL/PERINATAL INFECTION	M	Neonatology	Neonatology
625	NEONATE BWT 2000-2499G W OTHER SIGNIFICANT CONDITION	M	Neonatology	Neonatology
626	NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	M	Neonatology	Neonatology
630	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE	S	Neonatology	Neonatology
631	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE	S	Neonatology	Neonatology
633	NEONATE BIRTHWT >2499G W MAJOR ANOMALY	M	Neonatology	Neonatology
634	NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND	M	Neonatology	Neonatology
636	NEONATE BIRTHWT >2499G W CONGENITAL/PERINATAL INFECTION	M	Neonatology	Neonatology
639	NEONATE BIRTHWT >2499G W OTHER SIGNIFICANT CONDITION	M	Neonatology	Neonatology
640	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM	M	Normal Newborn	Neonatology
650	SPLENECTOMY	S	General Surgery	General Surgery
651	OTHER PROCEDURES OF BLOOD & BLOOD-FORMING ORGANS	S	General Surgery	General Surgery
660	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL	M	Hematology	Hematology
661	COAGULATION & PLATELET DISORDERS	M	Hematology	Hematology
662	SICKLE CELL ANEMIA CRISIS	M	Hematology	Hematology
663	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS	M	Hematology	Hematology
680	MAJOR O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS	S	General Surgery	General Surgery
681	OTHER O.R. PROCEDURES FOR LYMPHATIC/HEMATOPOIETIC/OTHER NEOPLASMS	S	General Surgery	General Surgery

690	ACUTE LEUKEMIA	M	Oncology	Oncology
691	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA	M	Oncology	Oncology
692	RADIOTHERAPY	M	Oncology	Oncology
694	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR	M	Oncology	Oncology
695	CHEMOTHERAPY FOR ACUTE LEUKEMIA	M	Oncology	Oncology
696	OTHER CHEMOTHERAPY	M	Oncology	Oncology
710	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE	S	General Surgery	General Surgery
711	POST-OP, POST-TRAUMA, OTHER DEVICE INFECTIONS W O.R. PROCEDURE	S	General Surgery	General Surgery
720	SEPTICEMIA & DISSEMINATED INFECTIONS	M	Infectious Disease	Infectious Disease
721	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS	M	General Surgery	General Surgery
722	FEVER	M	Infectious Disease	Infectious Disease
723	VIRAL ILLNESS	M	Infectious Disease	Infectious Disease
724	OTHER INFECTIOUS & PARASITIC DISEASES	M	Infectious Disease	Infectious Disease
740	MENTAL ILLNESS DIAGNOSIS W O.R. PROCEDURE	S	General Surgery	General Surgery
750	SCHIZOPHRENIA	M	Psychiatry	Psychiatry
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	M	Psychiatry	Psychiatry
752	DISORDERS OF PERSONALITY & IMPULSE CONTROL	M	Psychiatry	Psychiatry
753	BIPOLAR DISORDERS	M	Psychiatry	Psychiatry
754	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	M	Psychiatry	Psychiatry
755	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	M	Psychiatry	Psychiatry
756	ACUTE ANXIETY & DELIRIUM STATES	M	Psychiatry	Psychiatry
757	ORGANIC MENTAL HEALTH DISTURBANCES	M	Psychiatry	Psychiatry
758	BEHAVIORAL DISORDERS	M	Psychiatry	Psychiatry
759	EATING DISORDERS	M	Psychiatry	Psychiatry
760	OTHER MENTAL HEALTH DISORDERS	M	Psychiatry	Psychiatry
770	DRUG & ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE	M	Substance Abuse	Psychiatry
772	ALCOHOL & DRUG DEPENDENCE W REHAB OR REHAB/DETOX THERAPY	M	Substance Abuse	Psychiatry

773	OPIOID ABUSE & DEPENDENCE	M	Substance Abuse	Psychiatry
774	COCAINE ABUSE & DEPENDENCE	M	Substance Abuse	Psychiatry
775	ALCOHOL ABUSE & DEPENDENCE	M	Substance Abuse	Psychiatry
776	OTHER DRUG ABUSE & DEPENDENCE	M	Substance Abuse	Psychiatry
792	EXTENSIVE OR PROCEDURES FOR OTHER COMPLICATIONS OF TREATMENT	S	Injuries/complic. of prior care	Injuries/complic. of prior care
793	MODERATELY EXTENSIVE OR PROCEDURES FOR OTHER COMPLICATIONS OF TREATMENT	S	Injuries/complic. of prior care	Injuries/complic. of prior care
794	NON-EXTENSIVE OR PROCEDURES FOR OTHER COMPLICATIONS OF TREATMENT	S	Injuries/complic. of prior care	Injuries/complic. of prior care
810	HEMORRHAGE OR HEMATOMA DUE TO COMPLICATION	M	Injuries/complic. of prior care	Injuries/complic. of prior care
811	ALLERGIC REACTIONS	M	General Medicine	General Medicine
812	POISONING OF MEDICINAL AGENTS	M	General Medicine	General Medicine
813	OTHER COMPLICATIONS OF TREATMENT	M	Injuries/complic. of prior care	Injuries/complic. of prior care
815	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES	M	General Medicine	General Medicine
816	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES	M	General Medicine	General Medicine
817	OVERDOSE	M	General Medicine	General Medicine
841	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	S	General Medicine	General Surgery
842	BURNS WITH SKIN GRAFT EXCEPT EXTENSIVE 3RD DEGREE BURNS	S	General Medicine	General Surgery
843	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT	M	General Medicine	General Medicine
844	PARTIAL THICKNESS BURNS W/O SKIN GRAFT	M	General Medicine	General Medicine
850	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH SERVICE	S	General Surgery	General Surgery
860	REHABILITATION	M	Rehabilitation	Rehabilitation
861	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	M	General Medicine	General Medicine
862	OTHER AFTERCARE & CONVALESCENCE	M	General Medicine	General Medicine
863	NEONATAL AFTERCARE	M	Neonatology	Neonatology
890	HIV W MULTIPLE MAJOR HIV RELATED CONDITIONS	M	HIV	Infectious Disease
892	HIV W MAJOR HIV RELATED CONDITION	M	HIV	Infectious Disease

893	HIV W MULTIPLE SIGNIFICANT HIV RELATED CONDITIONS	M	HIV	Infectious Disease
894	HIV W ONE SIGNIF HIV COND OR W/O SIGNIF RELATED COND	M	HIV	Infectious Disease
910	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	S	Trauma	Trauma
911	EXTENSIVE ABDOMINAL/THORACIC PROCEDURES FOR MULT SIGNIFICANT TRAUMA	S	Trauma	Trauma
912	MUSCULOSKELETAL & OTHER PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	S	Trauma	Trauma
930	MULTIPLE SIGNIFICANT TRAUMA W/O O.R. PROCEDURE	M	Trauma	Trauma
950	EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	S	General Surgery	General Surgery
951	MODERATELY EXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	S	General Surgery	General Surgery
952	NONEXTENSIVE PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	S	General Surgery	General Surgery
955	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS		Invalid	Invalid
956	UNGROUPABLE		Ungroupable	Ungroupable

b. EAPG Service Line Maps

HIGHTYPE	HIGHTYPE_Desc	HIWTAPG	apg_desc	New_Service
1	Significant Procedures	1	PHOTOCHEMOTHERAPY	Other
1	Significant Procedures	2	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION	Other
1	Significant Procedures	3	LEVEL I SKIN INCISION AND DRAINAGE	Minor Surgery
1	Significant Procedures	4	LEVEL II SKIN INCISION AND DRAINAGE	Minor Surgery
1	Significant Procedures	5	NAIL PROCEDURES	Minor Surgery
1	Significant Procedures	6	LEVEL I SKIN DEBRIDEMENT AND DESTRUCTION	Minor Surgery
1	Significant Procedures	7	LEVEL II SKIN DEBRIDEMENT AND DESTRUCTION	Minor Surgery
1	Significant Procedures	8	LEVEL III SKIN DEBRIDEMENT AND DESTRUCTION	Minor Surgery

1	Significant Procedures	9	LEVEL I EXCISION AND BIOPSY OF SKIN AND SOFT TISSUE	Minor Surgery
1	Significant Procedures	10	LEVEL II EXCISION AND BIOPSY OF SKIN AND SOFT TISSUE	Minor Surgery
1	Significant Procedures	11	LEVEL III EXCISION AND BIOPSY OF SKIN AND SOFT TISSUE	Major Surgery
1	Significant Procedures	12	LEVEL I SKIN REPAIR	Minor Surgery
1	Significant Procedures	13	LEVEL II SKIN REPAIR	Minor Surgery
1	Significant Procedures	14	LEVEL III SKIN REPAIR	Major Surgery
1	Significant Procedures	15	LEVEL IV SKIN REPAIR	Major Surgery
1	Significant Procedures	20	LEVEL I BREAST PROCEDURES	Minor Surgery
1	Significant Procedures	21	LEVEL II BREAST PROCEDURES	Major Surgery
1	Significant Procedures	22	LEVEL III BREAST PROCEDURES	Major Surgery
1	Significant Procedures	30	LEVEL I MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Major Surgery
1	Significant Procedures	31	LEVEL II MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Major Surgery
1	Significant Procedures	32	LEVEL III MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT	Major Surgery
1	Significant Procedures	33	LEVEL I HAND PROCEDURES	Minor Surgery
1	Significant Procedures	34	LEVEL II HAND PROCEDURES	Major Surgery
1	Significant Procedures	35	LEVEL I FOOT PROCEDURES	Major Surgery
1	Significant Procedures	36	LEVEL II FOOT PROCEDURES	Major Surgery
1	Significant Procedures	37	LEVEL I ARTHROSCOPY	Major Surgery
1	Significant Procedures	38	LEVEL II ARTHROSCOPY	Major Surgery
1	Significant Procedures	39	REPLACEMENT OF CAST	Other
1	Significant Procedures	40	SPLINT, STRAPPING AND CAST REMOVAL	Other
1	Significant Procedures	41	CLOSED TREATMENT FX & DISLOCATION OF FINGER, TOE & TRUNK	Minor Surgery
1	Significant Procedures	42	CLOSED TREATMENT FX & DISLOCATION EXC FINGER, TOE & TRUNK	Minor Surgery

1	Significant Procedures	43	OPEN OR PERCUTANEOUS TREATMENT OF FRACTURES	Major Surgery
1	Significant Procedures	44	BONE OR JOINT MANIPULATION UNDER ANESTHESIA	Minor Surgery
1	Significant Procedures	45	BUNION PROCEDURES	Major Surgery
1	Significant Procedures	46	LEVEL I ARTHROPLASTY	Major Surgery
1	Significant Procedures	47	LEVEL II ARTHROPLASTY	Major Surgery
1	Significant Procedures	48	HAND AND FOOT TENOTOMY	Major Surgery
1	Significant Procedures	49	ARTHROCENTESIS AND LIGAMENT OR TENDON INJECTION	Minor Surgery
1	Significant Procedures	60	PULMONARY TESTS	Other
1	Significant Procedures	61	NEEDLE AND CATHETER BIOPSY, ASPIRATION, LAVAGE AND INTUBATION	Minor Surgery
1	Significant Procedures	62	LEVEL I ENDOSCOPY OF THE UPPER AIRWAY	Minor Surgery
1	Significant Procedures	63	LEVEL II ENDOSCOPY OF THE UPPER AIRWAY	Major Surgery
1	Significant Procedures	64	ENDOSCOPY OF THE LOWER AIRWAY	Major Surgery
5	Rehab and Therapy	65	RESPIRATORY THERAPY	Rehab and Therapy
5	Rehab and Therapy	66	PULMONARY REHABILITATION	Rehab and Therapy
1	Significant Procedures	67	VENTILATION ASSISTANCE AND MANAGEMENT	Other
1	Significant Procedures	80	EXERCISE TOLERANCE TESTS	Cardiovascular
1	Significant Procedures	81	ECHOCARDIOGRAPHY	Cardiovascular
1	Significant Procedures	82	CARDIAC ELECTROPHYSIOLOGIC TESTS AND MONITORING	Cardiovascular
1	Significant Procedures	83	PLACEMENT OF TRANSVENOUS CATHETERS	Cardiovascular
1	Significant Procedures	84	DIAGNOSTIC CARDIAC CATHETERIZATION	Cardiovascular
1	Significant Procedures	85	PERIPHERAL TRANSCATHETER AND REVASCULARIZATION PROCEDURES	Cardiovascular
1	Significant Procedures	86	PACEMAKER INSERTION AND REPLACEMENT	Cardiovascular
1	Significant Procedures	87	REMOVAL AND REVISION OF PACEMAKER AND VASCULAR DEVICE	Cardiovascular

1	Significant Procedures	88	LEVEL I CARDIOTHORACIC PROCEDURES	Cardiovascular
1	Significant Procedures	89	LEVEL II CARDIOTHORACIC PROCEDURES	Cardiovascular
1	Significant Procedures	90	SECONDARY VARICOSE VEINS AND VASCULAR INJECTION	Major Surgery
1	Significant Procedures	91	VASCULAR LIGATION AND RECONSTRUCTION	Major Surgery
1	Significant Procedures	92	RESUSCITATION	Minor Surgery
1	Significant Procedures	93	CARDIOVERSION	Cardiovascular
5	Rehab and Therapy	94	CARDIAC REHABILITATION	Rehab and Therapy
1	Significant Procedures	96	ATRIAL AND VENTRICULAR RECORDING AND PACING	Cardiovascular
1	Significant Procedures	97	AICD IMPLANT	Cardiovascular
1	Significant Procedures	99	CORONARY ANGIOPLASTY	Cardiovascular
2	Oncology Related Service	110	PHARMACOTHERAPY BY EXTENDED INFUSION	Oncology Related Services
1	Significant Procedures	110	PHARMACOTHERAPY BY EXTENDED INFUSION	Other
2	Oncology Related Service	111	PHARMACOTHERAPY EXCEPT BY EXTENDED INFUSION	Oncology Related Services
1	Significant Procedures	111	PHARMACOTHERAPY EXCEPT BY EXTENDED INFUSION	Other
1	Significant Procedures	112	PHLEBOTOMY	Other
1	Significant Procedures	113	LEVEL I BLOOD AND BLOOD PRODUCT EXCHANGE	Other
1	Significant Procedures	114	LEVEL II BLOOD AND BLOOD PRODUCT EXCHANGE	Other
1	Significant Procedures	115	DEEP LYMPH STRUCTURE AND THYROID PROCEDURES	Major Surgery
1	Significant Procedures	161	URINARY STUDIES AND PROCEDURES	Other
2	Oncology Related Service	457	VENIPUNCTURE	Clinic
1	Significant Procedures	130	ALIMENTARY TESTS AND SIMPLE TUBE PLACEMENT	Minor Surgery
1	Significant Procedures	131	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY	Minor Surgery

1	Significant Procedures	132	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROCTOSIGMOIDOSCOPY	Minor Surgery
1	Significant Procedures	133	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIOPSY	Minor Surgery
1	Significant Procedures	134	DIAGNOSTIC UPPER GI ENDOSCOPY OR INTUBATION	Minor Surgery
1	Significant Procedures	135	THERAPEUTIC UPPER GI ENDOSCOPY OR INTUBATION	Minor Surgery
1	Significant Procedures	136	DIAGNOSTIC LOWER GASTROINTESTINAL ENDOSCOPY	Minor Surgery
1	Significant Procedures	137	THERAPEUTIC COLONOSCOPY	Minor Surgery
1	Significant Procedures	138	ERCP AND MISCELLANEOUS GI ENDOSCOPY PROCEDURES	Major Surgery
1	Significant Procedures	139	LEVEL I HERNIA REPAIR	Major Surgery
1	Significant Procedures	140	LEVEL II HERNIA REPAIR	Major Surgery
1	Significant Procedures	141	LEVEL I ANAL AND RECTAL PROCEDURES	Minor Surgery
1	Significant Procedures	142	LEVEL II ANAL AND RECTAL PROCEDURES	Major Surgery
1	Significant Procedures	143	LEVEL I GASTROINTESTINAL PROCEDURES	Minor Surgery
1	Significant Procedures	144	LEVEL II GASTROINTESTINAL PROCEDURES	Major Surgery
1	Significant Procedures	145	LEVEL I LAPAROSCOPY	Major Surgery
1	Significant Procedures	146	LEVEL II LAPAROSCOPY	Major Surgery
1	Significant Procedures	147	LEVEL III LAPAROSCOPY	Major Surgery
1	Significant Procedures	148	LEVEL IV LAPAROSCOPY	Major Surgery
1	Significant Procedures	149	SCREENING COLORECTAL SERVICES	Minor Surgery
1	Significant Procedures	160	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY	Major Surgery
1	Significant Procedures	168	HEMODIALYSIS	Other
1	Significant Procedures	162	URINARY DILATATION	Minor Surgery
1	Significant Procedures	163	LEVEL I BLADDER AND KIDNEY PROCEDURES	Minor Surgery
1	Significant Procedures	164	LEVEL II BLADDER AND KIDNEY PROCEDURES	Major Surgery

1	Significant Procedures	165	LEVEL III BLADDER AND KIDNEY PROCEDURES	Major Surgery
1	Significant Procedures	166	LEVEL I URETHRA AND PROSTATE PROCEDURES	Minor Surgery
1	Significant Procedures	167	LEVEL II URETHRA AND PROSTATE PROCEDURES	Major Surgery
1	Significant Procedures	169	PERITONEAL DIALYSIS	Other
1	Significant Procedures	190	ARTIFICIAL FERTILIZATION	Other
1	Significant Procedures	180	TESTICULAR AND EPIDIDYMAL PROCEDURES	Major Surgery
1	Significant Procedures	181	CIRCUMCISION	Minor Surgery
1	Significant Procedures	182	INSERTION OF PENILE PROSTHESIS	Major Surgery
1	Significant Procedures	183	OTHER PENILE PROCEDURES	Major Surgery
1	Significant Procedures	184	DESTRUCTION OR RESECTION OF PROSTATE	Major Surgery
1	Significant Procedures	185	PROSTATE NEEDLE AND PUNCH BIOPSY	Minor Surgery
1	Significant Procedures	210	EXTENDED EEG STUDIES	Other
1	Significant Procedures	191	LEVEL I FETAL PROCEDURES	Minor Surgery
1	Significant Procedures	192	LEVEL II FETAL PROCEDURES	Major Surgery
1	Significant Procedures	193	TREATMENT OF INCOMPLETE ABORTION	Minor Surgery
1	Significant Procedures	194	THERAPEUTIC ABORTION	Minor Surgery
1	Significant Procedures	195	VAGINAL DELIVERY	Major Surgery
1	Significant Procedures	196	LEVEL I FEMALE REPRODUCTIVE PROCEDURES	Minor Surgery
1	Significant Procedures	197	LEVEL II FEMALE REPRODUCTIVE PROCEDURES	Major Surgery
1	Significant Procedures	198	LEVEL III FEMALE REPRODUCTIVE PROCEDURES	Major Surgery
1	Significant Procedures	199	DILATION AND CURETTAGE	Minor Surgery
1	Significant Procedures	200	HYSTEROSCOPY	Major Surgery
1	Significant Procedures	201	COLPOSCOPY	Minor Surgery

1	Significant Procedures	211	ELECTROENCEPHALOGRAM	Other
1	Significant Procedures	212	ELECTROCONVULSIVE THERAPY	Other
1	Significant Procedures	213	NERVE AND MUSCLE TESTS	Other
1	Significant Procedures	219	SPINAL TAP	Other
1	Significant Procedures	214	LEVEL I NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP	Minor Surgery
1	Significant Procedures	215	LEVEL I REVISION OR REMOVAL OF NEUROLOGICAL DEVICE	Minor Surgery
1	Significant Procedures	216	LEVEL II REVISION OR REMOVAL OF NEUROLOGICAL DEVICE	Major Surgery
1	Significant Procedures	217	LEVEL I NERVE PROCEDURES	Minor Surgery
1	Significant Procedures	218	LEVEL II NERVE PROCEDURES	Major Surgery
1	Significant Procedures	222	SLEEP STUDIES	Other
1	Significant Procedures	220	LEVEL II NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP	Minor Surgery
1	Significant Procedures	221	LAMINOTOMY AND LAMINECTOMY	Major Surgery
1	Significant Procedures	251	OTORHINOLARYNGOLOGIC FUNCTION TESTS	Other
1	Significant Procedures	223	LEVEL III NERVE PROCEDURES	Major Surgery
1	Significant Procedures	224	LEVEL IV NERVE PROCEDURES	Major Surgery
1	Significant Procedures	230	MINOR OPHTHALMOLOGICAL TESTS AND PROCEDURES	Minor Surgery
1	Significant Procedures	232	LASER EYE PROCEDURES	Minor Surgery
1	Significant Procedures	233	CATARACT PROCEDURES	Minor Surgery
1	Significant Procedures	234	LEVEL I ANTERIOR SEGMENT EYE PROCEDURES	Minor Surgery
1	Significant Procedures	235	LEVEL II ANTERIOR SEGMENT EYE PROCEDURES	Major Surgery
1	Significant Procedures	236	LEVEL III ANTERIOR SEGMENT EYE PROCEDURES	Major Surgery
1	Significant Procedures	237	LEVEL I POSTERIOR SEGMENT EYE PROCEDURES	Major Surgery
1	Significant Procedures	238	LEVEL II POSTERIOR SEGMENT EYE PROCEDURES	Major Surgery

1	Significant Procedures	239	STRABISMUS AND MUSCLE EYE PROCEDURES	Major Surgery
1	Significant Procedures	240	LEVEL I REPAIR AND PLASTIC PROCEDURES OF EYE	Minor Surgery
1	Significant Procedures	241	LEVEL II REPAIR AND PLASTIC PROCEDURES OF EYE	Major Surgery
1	Significant Procedures	250	COCHLEAR DEVICE IMPLANTATION	Major Surgery
1	Significant Procedures	257	AUDIOMETRY	Other
1	Significant Procedures	252	LEVEL I FACIAL AND ENT PROCEDURES	Major Surgery
1	Significant Procedures	253	LEVEL II FACIAL AND ENT PROCEDURES	Major Surgery
1	Significant Procedures	254	LEVEL III FACIAL AND ENT PROCEDURES	Major Surgery
1	Significant Procedures	255	LEVEL IV FACIAL AND ENT PROCEDURES	Major Surgery
1	Significant Procedures	256	TONSIL AND ADENOID PROCEDURES	Minor Surgery
1	Significant Procedures	350	LEVEL I ADJUNCTIVE GENERAL DENTAL SERVICES	Other
5	Rehab and Therapy	270	OCCUPATIONAL THERAPY	Rehab and Therapy
5	Rehab and Therapy	271	PHYSICAL THERAPY	Rehab and Therapy
5	Rehab and Therapy	272	SPEECH THERAPY AND EVALUATION	Rehab and Therapy
5	Rehab and Therapy	274	OCCUPATIONAL/PHYSICAL THERAPY, GROUP	Rehab and Therapy
5	Rehab and Therapy	275	SPEECH THERAPY & EVALUATION, GROUP	Rehab and Therapy
1	Significant Procedures	280	VASCULAR RADIOLOGY EXCEPT VENOGRAPHY OF EXTREMITY	Radiology
1	Significant Procedures	281	MAGNETIC RESONANCE ANGIOGRAPHY - HEAD AND/OR NECK	Radiology
1	Significant Procedures	282	MAGNETIC RESONANCE ANGIOGRAPHY - CHEST	Radiology
1	Significant Procedures	283	MAGNETIC RESONANCE ANGIOGRAPHY - OTHER SITES	Radiology
1	Significant Procedures	284	MYELOGRAPHY	Radiology
1	Significant Procedures	285	MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST	Radiology
1	Significant Procedures	286	MAMMOGRAPHY & OTHER RELATED PROCEDURES	Radiology

1	Significant Procedures	287	DIGESTIVE RADIOLOGY	Radiology
1	Significant Procedures	288	DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL AND VASCULAR OF LOWER EXTREMITIES	Radiology
1	Significant Procedures	289	VASCULAR DIAGNOSTIC ULTRASOUND OF LOWER EXTREMITIES	Radiology
1	Significant Procedures	290	PET SCANS	CT/MRI/PET
1	Significant Procedures	291	BONE DENSITOMETRY	Radiology
1	Significant Procedures	292	MRI- ABDOMEN	CT/MRI/PET
1	Significant Procedures	293	MRI- JOINTS	CT/MRI/PET
1	Significant Procedures	294	MRI- BACK	CT/MRI/PET
1	Significant Procedures	295	MRI- CHEST	CT/MRI/PET
1	Significant Procedures	296	MRI- OTHER	CT/MRI/PET
1	Significant Procedures	297	MRI BRAIN AND MAGNETOENCEPHALOGRAPHY	CT/MRI/PET
1	Significant Procedures	298	CAT SCAN BACK	CT/MRI/PET
1	Significant Procedures	299	CAT SCAN - BRAIN	CT/MRI/PET
1	Significant Procedures	300	CAT SCAN - ABDOMEN	CT/MRI/PET
1	Significant Procedures	301	CAT SCAN - OTHER	CT/MRI/PET
1	Significant Procedures	302	ANGIOGRAPHY, OTHER	Radiology
1	Significant Procedures	303	ANGIOGRAPHY, CEREBRAL	Radiology
6	Psychiatric	310	DEVELOPMENTAL & NEUROPSYCHOLOGICAL TESTING	Psychiatric
6	Psychiatric	311	FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE	Psychiatric
6	Psychiatric	312	FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS	Psychiatric
6	Psychiatric	313	HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE	Psychiatric
6	Psychiatric	314	HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS	Psychiatric
6	Psychiatric	315	COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY	Psychiatric

6	Psychiatric	316	INDIVIDUAL COMPREHENSIVE PSYCHOTHERAPY	Psychiatric
6	Psychiatric	317	FAMILY PSYCHOTHERAPY	Psychiatric
6	Psychiatric	318	GROUP PSYCHOTHERAPY	Psychiatric
6	Psychiatric	319	ACTIVITY THERAPY	Psychiatric
6	Psychiatric	320	CASE MANAGEMENT & TREATMENT PLAN DEVELOPMENT - MENTAL HEALTH OR SUBSTANCE ABUSE	Psychiatric
6	Psychiatric	322	MEDICATION ADMINISTRATION & OBSERVATION	Psychiatric
6	Psychiatric	323	MENTAL HYGIENE ASSESSMENT	Psychiatric
6	Psychiatric	327	INTENSIVE OUTPATIENT TREATMENT	Psychiatric
1	Significant Procedures	330	LEVEL I DIAGNOSTIC NUCLEAR MEDICINE	Radiology
1	Significant Procedures	331	LEVEL II DIAGNOSTIC NUCLEAR MEDICINE	Radiology
1	Significant Procedures	332	LEVEL III DIAGNOSTIC NUCLEAR MEDICINE	Radiology
1	Significant Procedures	340	THERAPEUTIC NUCLEAR MEDICINE	Radiology
2	Oncology Related Service	341	RADIATION THERAPY AND HYPERTHERMIA	Oncology Related Services
1	Significant Procedures	342	AFTERLOADING BRACHYTHERAPY	Oncology Related Services
2	Oncology Related Service	342	AFTERLOADING BRACHYTHERAPY	Oncology Related Services
2	Oncology Related Service	343	RADIATION TREATMENT DELIVERY	Oncology Related Services
1	Significant Procedures	343	RADIATION TREATMENT DELIVERY	Radiology
1	Significant Procedures	344	INSTILLATION OF RADIOELEMENT SOLUTIONS	Oncology Related Services
2	Oncology Related Service	344	INSTILLATION OF RADIOELEMENT SOLUTIONS	Oncology Related Services
2	Oncology Related Service	345	HYPERTHERMIC THERAPIES	Oncology Related Services
1	Significant Procedures	346	RADIOSURGERY	Minor Surgery

2	Oncology Related Service	346	RADIOSURGERY	Oncology Related Services
2	Oncology Related Service	349	LEVEL II AFTERLOADING BRACHYTHERAPY	Oncology Related Services
1	Significant Procedures	351	LEVEL II ADJUNCTIVE GENERAL DENTAL SERVICES	Other
1	Significant Procedures	352	LEVEL I PERIODONTICS	Other
1	Significant Procedures	355	LEVEL III PROSTHODONTICS, FIXED	Other
1	Significant Procedures	356	LEVEL I PROSTHODONTICS, REMOVABLE	Other
1	Significant Procedures	357	LEVEL II PROSTHODONTICS, REMOVABLE	Other
1	Significant Procedures	358	LEVEL III PROSTHODONTICS, REMOVABLE	Other
1	Significant Procedures	361	LEVEL I DENTAL RESTORATIONS	Other
1	Significant Procedures	362	LEVEL II DENTAL RESTORATIONS	Other
1	Significant Procedures	363	LEVEL III DENTAL RESTORATION	Other
1	Significant Procedures	364	LEVEL I ENDODONTICS	Other
1	Significant Procedures	371	LEVEL I ORTHODONTICS	Other
1	Significant Procedures	367	LEVEL I ORAL AND MAXILLOFACIAL SURGERY	Minor Surgery
1	Significant Procedures	368	LEVEL II ORAL AND MAXILLOFACIAL SURGERY	Minor Surgery
1	Significant Procedures	372	SEALANT	Other
4	ED Medical Visit	520	SPINAL DIAGNOSES & INJURIES	Other
4	ED Medical Visit	523	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES	Other
4	ED Medical Visit	524	LEVEL I CNS DIAGNOSES	Other
4	ED Medical Visit	526	TRANSIENT ISCHEMIA	Other
4	ED Medical Visit	528	NONTRAUMATIC STUPOR & COMA	Other
7	Ancillary & Other	385	LEVEL I MOLECULAR PATHOLOGY AND GENETIC TESTS	Lab
7	Ancillary & Other	386	LEVEL II MOLECULAR PATHOLOGY AND GENETIC TESTS	Lab
7	Ancillary & Other	387	LEVEL III MOLECULAR PATHOLOGY AND GENETIC TESTS	Lab

7	Ancillary & Other	390	LEVEL I PATHOLOGY	Lab
7	Ancillary & Other	391	LEVEL II PATHOLOGY	Lab
7	Ancillary & Other	392	PAP SMEARS	Lab
7	Ancillary & Other	393	BLOOD AND TISSUE TYPING	Lab
7	Ancillary & Other	394	LEVEL I IMMUNOLOGY TESTS	Lab
7	Ancillary & Other	395	LEVEL II IMMUNOLOGY TESTS	Lab
7	Ancillary & Other	396	LEVEL I MICROBIOLOGY TESTS	Lab
7	Ancillary & Other	397	LEVEL II MICROBIOLOGY TESTS	Lab
7	Ancillary & Other	398	LEVEL I ENDOCRINOLOGY TESTS	Lab
7	Ancillary & Other	399	LEVEL II ENDOCRINOLOGY TESTS	Lab
7	Ancillary & Other	400	LEVEL I CHEMISTRY TESTS	Lab
7	Ancillary & Other	401	LEVEL II CHEMISTRY TESTS	Lab
7	Ancillary & Other	402	BASIC CHEMISTRY TESTS	Lab
7	Ancillary & Other	403	ORGAN OR DISEASE ORIENTED PANELS	Lab
7	Ancillary & Other	404	TOXICOLOGY TESTS	Lab
7	Ancillary & Other	405	THERAPEUTIC DRUG MONITORING	Lab
7	Ancillary & Other	406	LEVEL I CLOTTING TESTS	Lab
7	Ancillary & Other	407	LEVEL II CLOTTING TESTS	Lab
7	Ancillary & Other	408	LEVEL I HEMATOLOGY TESTS	Lab
7	Ancillary & Other	409	LEVEL II HEMATOLOGY TESTS	Lab
7	Ancillary & Other	410	URINALYSIS	Lab
7	Ancillary & Other	411	BLOOD AND URINE DIPSTICK TESTS	Lab
4	ED Medical Visit	529	SEIZURE	Other
4	ED Medical Visit	531	MIGRAINE	Other

4	ED Medical Visit	532	HEAD TRAUMA	Other
4	ED Medical Visit	533	AFTEREFFECTS OF CEREBROVASCULAR ACCIDENT	Other
4	ED Medical Visit	534	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARC	Other
7	Ancillary & Other	417	MINOR REPRODUCTIVE PROCEDURES	Minor Surgery
4	ED Medical Visit	535	CVA & PRECEREBRAL OCCLUSION W INFARCT	Other
4	ED Medical Visit	536	CEREBRAL PALSY	Other
4	ED Medical Visit	550	ACUTE MAJOR EYE INFECTIONS	Other
4	ED Medical Visit	551	CATARACTS	Other
4	ED Medical Visit	552	GLAUCOMA	Other
7	Ancillary & Other	424	DRESSINGS AND OTHER MINOR PROCEDURES	Minor Surgery
4	ED Medical Visit	553	LEVEL I OTHER OPHTHALMIC DIAGNOSES	Other
6	Psychiatric	426	PSYCHOTROPIC MEDICATION MANAGEMENT	Psychiatric
4	ED Medical Visit	554	LEVEL II OTHER OPHTHALMIC DIAGNOSES	Other
4	ED Medical Visit	555	CONJUNCTIVITIS	Other
4	ED Medical Visit	561	VERTIGINOUS DIAGNOSES EXCEPT FOR BENIGN VERTIGO	Other
4	ED Medical Visit	570	CYSTIC FIBROSIS - PULMONARY DISEASE	Other
4	ED Medical Visit	572	BRONCHIOLITIS & RSV PNEUMONIA	Other
8	Oncology Drugs	431	CLASS II CHEMOTHERAPY DRUGS	Onc & Inf Drugs
8	Oncology Drugs	432	CLASS III CHEMOTHERAPY DRUGS	Onc & Inf Drugs
4	ED Medical Visit	573	COMMUNITY ACQUIRED PNEUMONIA	Other
8	Oncology Drugs	433	CLASS IV CHEMOTHERAPY DRUGS	Onc & Inf Drugs
8	Oncology Drugs	434	CLASS V CHEMOTHERAPY DRUGS	Onc & Inf Drugs
4	ED Medical Visit	574	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	Other
4	ED Medical Visit	577	LEVEL II OTHER RESPIRATORY DIAGNOSES	Other
8	Oncology Drugs	436	CLASS II PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	437	CLASS III PHARMACOTHERAPY	Onc & Inf Drugs
4	ED Medical Visit	578	PNEUMONIA EXCEPT FOR COMMUNITY ACQUIRED PNEUMONIA	Other
8	Oncology Drugs	438	CLASS IV PHARMACOTHERAPY	Onc & Inf Drugs
4	ED Medical Visit	579	STATUS ASTHMATICUS	Other

8	Oncology Drugs	439	CLASS V PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	440	CLASS VI PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	441	CLASS VI CHEMOTHERAPY DRUGS	Onc & Inf Drugs
8	Oncology Drugs	443	CLASS VII CHEMOTHERAPY	Onc & Inf Drugs
4	ED Medical Visit	591	ACUTE MYOCARDIAL INFARCTION	Other
8	Oncology Drugs	444	CLASS VII PHARMACOTHERAPY	Onc & Inf Drugs
4	ED Medical Visit	593	LEVEL II CARDIOVASCULAR DIAGNOSES	Other
4	ED Medical Visit	594	HEART FAILURE	Other
4	ED Medical Visit	595	CARDIAC ARREST OR OTHER CAUSES OF MORTALITY	Other
3	Non-ED medical Visit	510	MAJOR SIGNS, SYMPTOMS AND FINDINGS	Clinic
3	Non-ED medical Visit	520	SPINAL DIAGNOSES & INJURIES	Clinic
4	ED Medical Visit	599	HYPERTENSION	Other
4	ED Medical Visit	601	LEVEL I CARDIAC ARRHYTHMIA & CONDUCTION DIAGNOSES	Other
8	Oncology Drugs	460	CLASS VIII - COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	461	CLASS IX COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Onc & Inf Drugs
4	ED Medical Visit	603	LEVEL II CARDIAC ARRHYTHMIA & CONDUCTION DIAGNOSES	Other
4	ED Medical Visit	605	SYNCOPE & COLLAPSE	Other
8	Oncology Drugs	462	CLASS X COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	463	CLASS XI COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	464	CLASS XII COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Onc & Inf Drugs
8	Oncology Drugs	465	CLASS XIII COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Onc & Inf Drugs
7	Ancillary & Other	470	OBSTETRICAL ULTRASOUND	Radiology
7	Ancillary & Other	471	PLAIN FILM	Radiology
7	Ancillary & Other	472	ULTRASOUND GUIDANCE	Radiology
7	Ancillary & Other	473	CT GUIDANCE	CT/MRI/PET

7	Ancillary & Other	474	RADIOLOGICAL GUIDANCE FOR THERAPEUTIC OR DIAGNOSTIC PROCEDURES	Radiology
7	Ancillary & Other	475	MRI GUIDANCE	CT/MRI/PET
2	Oncology Related Service	476	LEVEL I THERAPEUTIC RADIATION TREATMENT PREPARATION	Oncology Related Services
2	Oncology Related Service	477	LEVEL II THERAPEUTIC RADIATION TREATMENT PREPARATION	Oncology Related Services
7	Ancillary & Other	477	LEVEL II THERAPEUTIC RADIATION TREATMENT PREPARATION	Oncology Related Services
2	Oncology Related Service	478	MEDICAL RADIATION PHYSICS	Oncology Related Services
2	Oncology Related Service	479	TREATMENT DEVICE DESIGN AND CONSTRUCTION	Oncology Related Services
7	Ancillary & Other	479	TREATMENT DEVICE DESIGN AND CONSTRUCTION	Oncology Related Services
2	Oncology Related Service	480	TELETHERAPY/BRACHYTHERAPY CALCULATION	Oncology Related Services
1	Significant Procedures	481	THERAPEUTIC RADIOLOGY SIMULATION FIELD SETTING	Oncology Related Services
2	Oncology Related Service	481	THERAPEUTIC RADIOLOGY SIMULATION FIELD SETTING	Oncology Related Services
2	Oncology Related Service	482	RADIOELEMENT APPLICATION	Oncology Related Services
2	Oncology Related Service	484	THERAPEUTIC RADIOLOGY TREATMENT PLANNING	Oncology Related Services
7	Ancillary & Other	486	BASIC BLOOD TYPING	Lab
4	ED Medical Visit	623	ESOPHAGITIS	Other
4	ED Medical Visit	626	INFLAMMATORY BOWEL DISEASE	Other
4	ED Medical Visit	627	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	Other
4	ED Medical Visit	629	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE	Other

4	ED Medical Visit	630	CONSTIPATION	Other
4	ED Medical Visit	632	IRRITABLE BOWEL SYNDROME	Other
4	ED Medical Visit	633	ALCOHOLIC LIVER DISEASE	Other
4	ED Medical Visit	635	PANCREAS DIAGNOSES EXCEPT MALIGNANCY	Other
3	Non-ED medical Visit	521	NERVOUS SYSTEM MALIGNANCY	Clinic
3	Non-ED medical Visit	522	DEGENERATIVE NERVOUS SYSTEM DIAGNOSES EXC MULT SCLEROSIS	Clinic
3	Non-ED medical Visit	523	MULTIPLE SCLEROSIS & OTHER DEMYELINATING DISEASES	Clinic
4	ED Medical Visit	636	HEPATITIS WITHOUT COMA	Other
3	Non-ED medical Visit	524	LEVEL I CNS DIAGNOSES	Clinic
3	Non-ED medical Visit	525	LEVEL II CNS DIAGNOSES	Clinic
3	Non-ED medical Visit	526	TRANSIENT ISCHEMIA	Clinic
3	Non-ED medical Visit	527	PERIPHERAL NERVE DIAGNOSES	Clinic
3	Non-ED medical Visit	528	NONTRAUMATIC STUPOR & COMA	Clinic
3	Non-ED medical Visit	529	SEIZURE	Clinic
3	Non-ED medical Visit	530	HEADACHES OTHER THAN MIGRAINE	Clinic
3	Non-ED medical Visit	531	MIGRAINE	Clinic
3	Non-ED medical Visit	532	HEAD TRAUMA	Clinic
3	Non-ED medical Visit	533	AFTEREFFECTS OF CEREBROVASCULAR ACCIDENT	Clinic
3	Non-ED medical Visit	534	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	Clinic
3	Non-ED medical Visit	535	CVA & PRECEREBRAL OCCLUSION W INFARCT	Clinic
3	Non-ED medical Visit	536	CEREBRAL PALSY	Clinic
3	Non-ED medical Visit	550	ACUTE MAJOR EYE INFECTIONS	Clinic
3	Non-ED medical Visit	551	CATARACTS	Clinic
3	Non-ED medical Visit	552	GLAUCOMA	Clinic
3	Non-ED medical Visit	553	LEVEL I OTHER OPHTHALMIC DIAGNOSES	Clinic

3	Non-ED medical Visit	554	LEVEL II OTHER OPHTHALMIC DIAGNOSES	Clinic
3	Non-ED medical Visit	555	CONJUNCTIVITIS	Clinic
3	Non-ED medical Visit	560	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES	Clinic
3	Non-ED medical Visit	561	VERTIGINOUS DIAGNOSES EXCEPT FOR BENIGN VERTIGO	Clinic
3	Non-ED medical Visit	562	INFECTIONS OF UPPER RESPIRATORY TRACT & OTITIS MEDIA	Clinic
3	Non-ED medical Visit	563	DENTAL & ORAL DIAGNOSES & INJURIES	Clinic
3	Non-ED medical Visit	564	LEVEL I OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES	Clinic
3	Non-ED medical Visit	565	LEVEL II OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES	Clinic
3	Non-ED medical Visit	570	CYSTIC FIBROSIS - PULMONARY DISEASE	Clinic
3	Non-ED medical Visit	571	RESPIRATORY MALIGNANCY	Clinic
3	Non-ED medical Visit	572	BRONCHIOLITIS & RSV PNEUMONIA	Clinic
3	Non-ED medical Visit	573	COMMUNITY ACQUIRED PNEUMONIA	Clinic
3	Non-ED medical Visit	574	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	Clinic
3	Non-ED medical Visit	575	ASTHMA	Clinic
3	Non-ED medical Visit	576	LEVEL I OTHER RESPIRATORY DIAGNOSES	Clinic
3	Non-ED medical Visit	577	LEVEL II OTHER RESPIRATORY DIAGNOSES	Clinic
3	Non-ED medical Visit	578	PNEUMONIA EXCEPT FOR COMMUNITY ACQUIRED PNEUMONIA	Clinic
3	Non-ED medical Visit	579	STATUS ASTHMATICUS	Clinic
3	Non-ED medical Visit	591	ACUTE MYOCARDIAL INFARCTION	Clinic
3	Non-ED medical Visit	592	LEVEL I CARDIOVASCULAR DIAGNOSES	Clinic
3	Non-ED medical Visit	593	LEVEL II CARDIOVASCULAR DIAGNOSES	Clinic
3	Non-ED medical Visit	594	HEART FAILURE	Clinic
3	Non-ED medical Visit	595	CARDIAC ARREST OR OTHER CAUSES OF MORTALITY	Clinic

3	Non-ED medical Visit	596	PERIPHERAL & OTHER VASCULAR DIAGNOSES	Clinic
3	Non-ED medical Visit	597	PHLEBITIS	Clinic
3	Non-ED medical Visit	598	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	Clinic
3	Non-ED medical Visit	599	HYPERTENSION	Clinic
3	Non-ED medical Visit	600	CARDIAC STRUCTURAL & VALVULAR DIAGNOSES	Clinic
3	Non-ED medical Visit	601	LEVEL I CARDIAC ARRHYTHMIA & CONDUCTION DIAGNOSES	Clinic
3	Non-ED medical Visit	602	ATRIAL FIBRILLATION	Clinic
3	Non-ED medical Visit	603	LEVEL II CARDIAC ARRHYTHMIA & CONDUCTION DIAGNOSES	Clinic
3	Non-ED medical Visit	604	CHEST PAIN	Clinic
3	Non-ED medical Visit	605	SYNCOPE & COLLAPSE	Clinic
3	Non-ED medical Visit	620	DIGESTIVE MALIGNANCY	Clinic
3	Non-ED medical Visit	621	PEPTIC ULCER & GASTRITIS	Clinic
3	Non-ED medical Visit	623	ESOPHAGITIS	Clinic
3	Non-ED medical Visit	624	LEVEL I GASTROINTESTINAL DIAGNOSES	Clinic
3	Non-ED medical Visit	625	LEVEL II GASTROINTESTINAL DIAGNOSES	Clinic
3	Non-ED medical Visit	626	INFLAMMATORY BOWEL DISEASE	Clinic
3	Non-ED medical Visit	627	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	Clinic
3	Non-ED medical Visit	628	ABDOMINAL PAIN	Clinic
3	Non-ED medical Visit	629	MALFUNCTION, REACTION & COMPLICATION OF GI DEVICE OR PROCEDURE	Clinic
3	Non-ED medical Visit	630	CONSTIPATION	Clinic
3	Non-ED medical Visit	631	HERNIA	Clinic
3	Non-ED medical Visit	632	IRRITABLE BOWEL SYNDROME	Clinic
3	Non-ED medical Visit	633	ALCOHOLIC LIVER DISEASE	Clinic

3	Non-ED medical Visit	634	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS	Clinic
3	Non-ED medical Visit	635	PANCREAS DIAGNOSES EXCEPT MALIGNANCY	Clinic
3	Non-ED medical Visit	636	HEPATITIS WITHOUT COMA	Clinic
3	Non-ED medical Visit	637	GALLBLADDER & BILIARY TRACT DIAGNOSES	Clinic
3	Non-ED medical Visit	638	CHOLECYSTITIS	Clinic
3	Non-ED medical Visit	639	LEVEL I HEPATOBILIARY DIAGNOSES	Clinic
3	Non-ED medical Visit	640	LEVEL II HEPATOBILIARY DIAGNOSES	Clinic
3	Non-ED medical Visit	650	FRACTURE OF FEMUR	Clinic
3	Non-ED medical Visit	651	FRACTURE OF PELVIS OR DISLOCATION OF HIP	Clinic
3	Non-ED medical Visit	652	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK	Clinic
3	Non-ED medical Visit	653	MUSCULOSKELETAL MALIGNANCY & PATHOLOGICAL FRACTURES	Clinic
3	Non-ED medical Visit	654	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS	Clinic
3	Non-ED medical Visit	655	CONNECTIVE TISSUE DIAGNOSES	Clinic
3	Non-ED medical Visit	656	BACK & NECK DIAGNOSES EXCEPT LUMBAR DISC DIAGNOSES	Clinic
3	Non-ED medical Visit	657	LUMBAR DISC DIAGNOSES	Clinic
3	Non-ED medical Visit	658	LUMBAR DISC DIAGNOSES WITH SCIATICA	Clinic
3	Non-ED medical Visit	659	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE	Clinic
3	Non-ED medical Visit	660	LEVEL I OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	Clinic
3	Non-ED medical Visit	661	LEVEL II OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	Clinic
3	Non-ED medical Visit	662	OSTEOPOROSIS	Clinic
3	Non-ED medical Visit	663	PAIN	Clinic
3	Non-ED medical Visit	670	SKIN ULCERS	Clinic
3	Non-ED medical Visit	671	MAJOR SKIN DIAGNOSES	Clinic

3	Non-ED medical Visit	672	MALIGNANT BREAST DIAGNOSES	Clinic
3	Non-ED medical Visit	673	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	Clinic
3	Non-ED medical Visit	674	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE	Clinic
3	Non-ED medical Visit	675	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DIAGNOSES	Clinic
3	Non-ED medical Visit	676	DECUBITUS ULCER	Clinic
3	Non-ED medical Visit	690	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DIAGNOSES	Clinic
3	Non-ED medical Visit	691	INBORN ERRORS OF METABOLISM	Clinic
3	Non-ED medical Visit	692	LEVEL I ENDOCRINE DIAGNOSES	Clinic
3	Non-ED medical Visit	693	LEVEL II ENDOCRINE DIAGNOSES	Clinic
3	Non-ED medical Visit	694	ELECTROLYTE DISORDERS	Clinic
3	Non-ED medical Visit	695	OBESITY	Clinic
3	Non-ED medical Visit	710	DIABETES WITH OPHTHALMIC MANIFESTATIONS	Clinic
3	Non-ED medical Visit	711	DIABETES WITH OTHER MANIFESTATIONS & COMPLICATIONS	Clinic
3	Non-ED medical Visit	712	DIABETES WITH NEUROLOGIC MANIFESTATIONS	Clinic
3	Non-ED medical Visit	713	DIABETES WITHOUT COMPLICATIONS	Clinic
3	Non-ED medical Visit	714	DIABETES WITH RENAL MANIFESTATIONS	Clinic
3	Non-ED medical Visit	720	RENAL FAILURE	Clinic
3	Non-ED medical Visit	721	KIDNEY & URINARY TRACT MALIGNANCY	Clinic
3	Non-ED medical Visit	722	NEPHRITIS & NEPHROSIS	Clinic
3	Non-ED medical Visit	723	KIDNEY AND CHRONIC URINARY TRACT INFECTIONS	Clinic
3	Non-ED medical Visit	724	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION	Clinic
3	Non-ED medical Visit	725	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC	Clinic
3	Non-ED medical Visit	726	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	Clinic

3	Non-ED medical Visit	727	ACUTE LOWER URINARY TRACT INFECTIONS	Clinic
3	Non-ED medical Visit	740	MALIGNANCY, MALE REPRODUCTIVE SYSTEM	Clinic
3	Non-ED medical Visit	741	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY	Clinic
3	Non-ED medical Visit	742	NEOPLASMS OF THE MALE REPRODUCTIVE SYSTEM	Clinic
3	Non-ED medical Visit	743	PROSTATITIS	Clinic
3	Non-ED medical Visit	744	MALE REPRODUCTIVE INFECTIONS	Clinic
3	Non-ED medical Visit	750	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY	Clinic
3	Non-ED medical Visit	751	FEMALE REPRODUCTIVE SYSTEM INFECTIONS	Clinic
3	Non-ED medical Visit	752	LEVEL I MENSTRUAL AND OTHER FEMALE DIAGNOSES	Clinic
3	Non-ED medical Visit	753	LEVEL II MENSTRUAL AND OTHER FEMALE DIAGNOSES	Clinic
3	Non-ED medical Visit	760	VAGINAL DELIVERY	Clinic
3	Non-ED medical Visit	761	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	Clinic
3	Non-ED medical Visit	762	THREATENED ABORTION	Clinic
3	Non-ED medical Visit	763	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	Clinic
3	Non-ED medical Visit	764	FALSE LABOR	Clinic
3	Non-ED medical Visit	765	OTHER ANTEPARTUM DIAGNOSES	Clinic
3	Non-ED medical Visit	766	ROUTINE PRENATAL CARE	Clinic
3	Non-ED medical Visit	770	NORMAL NEONATE	Clinic
3	Non-ED medical Visit	771	LEVEL I NEONATAL DIAGNOSES	Clinic
3	Non-ED medical Visit	772	LEVEL II NEONATAL DIAGNOSES	Clinic
3	Non-ED medical Visit	780	OTHER HEMATOLOGICAL DIAGNOSES	Clinic
3	Non-ED medical Visit	781	COAGULATION & PLATELET DIAGNOSES	Clinic
3	Non-ED medical Visit	782	CONGENITAL FACTOR DEFICIENCIES	Clinic

3	Non-ED medical Visit	783	SICKLE CELL ANEMIA CRISIS	Clinic
3	Non-ED medical Visit	784	SICKLE CELL ANEMIA	Clinic
3	Non-ED medical Visit	785	ANEMIA EXCEPT FOR IRON DEFICIENCY ANEMIA AND SICKLE CELL ANEMIA	Clinic
3	Non-ED medical Visit	786	IRON DEFICIENCY ANEMIA	Clinic
3	Non-ED medical Visit	805	SEPTICEMIA & DISSEMINATED INFECTIONS	Clinic
3	Non-ED medical Visit	806	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS	Clinic
3	Non-ED medical Visit	807	FEVER	Clinic
3	Non-ED medical Visit	808	VIRAL ILLNESS	Clinic
3	Non-ED medical Visit	809	OTHER INFECTIOUS & PARASITIC DISEASES	Clinic
3	Non-ED medical Visit	810	H. PYLORI INFECTION	Clinic
3	Non-ED medical Visit	840	OPIOID ABUSE & DEPENDENCE	Clinic
3	Non-ED medical Visit	841	COCAINE ABUSE & DEPENDENCE	Clinic
3	Non-ED medical Visit	842	ALCOHOL ABUSE & DEPENDENCE	Clinic
3	Non-ED medical Visit	843	OTHER DRUG ABUSE & DEPENDENCE	Clinic
3	Non-ED medical Visit	850	ALLERGIC REACTIONS	Clinic
3	Non-ED medical Visit	851	POISONING OF MEDICINAL AGENTS	Clinic
3	Non-ED medical Visit	852	OTHER COMPLICATIONS OF TREATMENT	Clinic
3	Non-ED medical Visit	853	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES	Clinic
3	Non-ED medical Visit	854	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES	Clinic
3	Non-ED medical Visit	860	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT	Clinic
3	Non-ED medical Visit	861	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT	Clinic
3	Non-ED medical Visit	870	REHABILITATION	Clinic
3	Non-ED medical Visit	871	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	Clinic

3	Non-ED medical Visit	872	OTHER AFTERCARE & CONVALESCENCE	Clinic
3	Non-ED medical Visit	873	NEONATAL AFTERCARE	Clinic
3	Non-ED medical Visit	874	JOINT REPLACEMENT	Clinic
3	Non-ED medical Visit	875	CONTRACEPTIVE MANAGEMENT	Clinic
3	Non-ED medical Visit	878	GYNECOLOGICAL PREVENTIVE MEDICINE	Clinic
3	Non-ED medical Visit	879	PREVENTIVE OR SCREENING ENCOUNTERS	Clinic
3	Non-ED medical Visit	880	HIV INFECTION	Clinic
3	Non-ED medical Visit	881	AIDS	Clinic
3	Non-ED medical Visit	882	GENETIC COUNSELING	Clinic
3	Non-ED medical Visit	820	SCHIZOPHRENIA	Clinic
3	Non-ED medical Visit	821	MAJOR DEPRESSIVE DIAGNOSES & OTHER/UNSPECIFIED PSYCHOSES	Clinic
3	Non-ED medical Visit	822	PERSONALITY & IMPULSE CONTROL DIAGNOSES	Clinic
4	ED Medical Visit	637	GALLBLADDER & BILIARY TRACT DIAGNOSES	Other
4	ED Medical Visit	638	CHOLECYSTITIS	Other
3	Non-ED medical Visit	823	BIPOLAR DISORDERS	Clinic
4	ED Medical Visit	650	FRACTURE OF FEMUR	Other
3	Non-ED medical Visit	824	DEPRESSION EXCEPT MAJOR DEPRESSIVE DIAGNOSES	Clinic
4	ED Medical Visit	651	FRACTURE OF PELVIS OR DISLOCATION OF HIP	Other
4	ED Medical Visit	652	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK	Other
3	Non-ED medical Visit	825	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	Clinic
4	ED Medical Visit	662	OSTEOPOROSIS	Other
4	ED Medical Visit	695	OBESITY	Other
4	ED Medical Visit	710	DIABETES WITH OPHTHALMIC MANIFESTATIONS	Other
4	ED Medical Visit	713	DIABETES WITHOUT COMPLICATIONS	Other
4	ED Medical Visit	722	NEPHRITIS & NEPHROSIS	Other
4	ED Medical Visit	724	URINARY STONES & ACQUIRED UPPER URINARY TRACT OBSTRUCTION	Other

4	ED Medical Visit	725	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC	Other
4	ED Medical Visit	727	ACUTE LOWER URINARY TRACT INFECTIONS	Other
4	ED Medical Visit	743	PROSTATITIS	Other
4	ED Medical Visit	744	MALE REPRODUCTIVE INFECTIONS	Other
4	ED Medical Visit	753	LEVEL II MENSTRUAL AND OTHER FEMALE DIAGNOSES	Other
4	ED Medical Visit	760	VAGINAL DELIVERY	Other
3	Non-ED medical Visit	826	ACUTE ANXIETY & DELIRIUM STATES	Clinic
4	ED Medical Visit	761	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	Other
3	Non-ED medical Visit	827	ORGANIC MENTAL HEALTH DISTURBANCES	Clinic
3	Non-ED medical Visit	828	MENTAL RETARDATION	Clinic
3	Non-ED medical Visit	829	CHILDHOOD BEHAVIORAL DIAGNOSES	Clinic
3	Non-ED medical Visit	830	EATING DISORDERS	Clinic
4	ED Medical Visit	762	THREATENED ABORTION	Other
3	Non-ED medical Visit	831	OTHER MENTAL HEALTH DIAGNOSES	Clinic
4	ED Medical Visit	763	ABORTION W/O D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	Other
4	ED Medical Visit	764	FALSE LABOR	Other
4	ED Medical Visit	765	OTHER ANTEPARTUM DIAGNOSES	Other
4	ED Medical Visit	510	MAJOR SIGNS, SYMPTOMS AND FINDINGS	Other
4	ED Medical Visit	521	NERVOUS SYSTEM MALIGNANCY	Other
4	ED Medical Visit	766	ROUTINE PRENATAL CARE	Other
4	ED Medical Visit	771	LEVEL I NEONATAL DIAGNOSES	Other
4	ED Medical Visit	772	LEVEL II NEONATAL DIAGNOSES	Other
4	ED Medical Visit	780	OTHER HEMATOLOGICAL DIAGNOSES	Other
4	ED Medical Visit	522	DEGENERATIVE NERVOUS SYSTEM DIAGNOSES EXC MULT SCLEROSIS	Other
4	ED Medical Visit	781	COAGULATION & PLATELET DIAGNOSES	Other
4	ED Medical Visit	782	CONGENITAL FACTOR DEFICIENCIES	Other
4	ED Medical Visit	783	SICKLE CELL ANEMIA CRISIS	Other
4	ED Medical Visit	525	LEVEL II CNS DIAGNOSES	Other
4	ED Medical Visit	527	PERIPHERAL NERVE DIAGNOSES	Other
4	ED Medical Visit	530	HEADACHES OTHER THAN MIGRAINE	Other
4	ED Medical Visit	784	SICKLE CELL ANEMIA	Other
4	ED Medical Visit	560	EAR, NOSE, MOUTH, THROAT, CRANIAL/FACIAL MALIGNANCIES	Other

4	ED Medical Visit	785	ANEMIA EXCEPT FOR IRON DEFICIENCY ANEMIA AND SICKLE CELL ANEMIA	Other
4	ED Medical Visit	562	INFECTIONS OF UPPER RESPIRATORY TRACT & OTITIS MEDIA	Other
4	ED Medical Visit	786	IRON DEFICIENCY ANEMIA	Other
4	ED Medical Visit	563	DENTAL & ORAL DIAGNOSES & INJURIES	Other
4	ED Medical Visit	805	SEPTICEMIA & DISSEMINATED INFECTIONS	Other
4	ED Medical Visit	564	LEVEL I OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES	Other
4	ED Medical Visit	565	LEVEL II OTHER EAR, NOSE, MOUTH, THROAT & CRANIAL/FACIAL DIAGNOSES	Other
4	ED Medical Visit	806	POST-OPERATIVE, POST-TRAUMATIC, OTHER DEVICE INFECTIONS	Other
4	ED Medical Visit	571	RESPIRATORY MALIGNANCY	Other
4	ED Medical Visit	575	ASTHMA	Other
4	ED Medical Visit	807	FEVER	Other
4	ED Medical Visit	808	VIRAL ILLNESS	Other
4	ED Medical Visit	576	LEVEL I OTHER RESPIRATORY DIAGNOSES	Other
4	ED Medical Visit	809	OTHER INFECTIOUS & PARASITIC DISEASES	Other
4	ED Medical Visit	810	H. PYLORI INFECTION	Other
4	ED Medical Visit	592	LEVEL I CARDIOVASCULAR DIAGNOSES	Other
4	ED Medical Visit	840	OPIOID ABUSE & DEPENDENCE	Other
4	ED Medical Visit	841	COCAINE ABUSE & DEPENDENCE	Other
4	ED Medical Visit	596	PERIPHERAL & OTHER VASCULAR DIAGNOSES	Other
4	ED Medical Visit	842	ALCOHOL ABUSE & DEPENDENCE	Other
4	ED Medical Visit	843	OTHER DRUG ABUSE & DEPENDENCE	Other
4	ED Medical Visit	850	ALLERGIC REACTIONS	Other
4	ED Medical Visit	851	POISONING OF MEDICINAL AGENTS	Other
4	ED Medical Visit	597	PHLEBITIS	Other
4	ED Medical Visit	598	ANGINA PECTORIS & CORONARY ATHEROSCLEROSIS	Other
4	ED Medical Visit	852	OTHER COMPLICATIONS OF TREATMENT	Other
4	ED Medical Visit	853	OTHER INJURY, POISONING & TOXIC EFFECT DIAGNOSES	Other
4	ED Medical Visit	854	TOXIC EFFECTS OF NON-MEDICINAL SUBSTANCES	Other
4	ED Medical Visit	600	CARDIAC STRUCTURAL & VALVULAR DIAGNOSES	Other
4	ED Medical Visit	602	ATRIAL FIBRILLATION	Other
4	ED Medical Visit	604	CHEST PAIN	Other
4	ED Medical Visit	620	DIGESTIVE MALIGNANCY	Other
4	ED Medical Visit	621	PEPTIC ULCER & GASTRITIS	Other

4	ED Medical Visit	624	LEVEL I GASTROINTESTINAL DIAGNOSES	Other
4	ED Medical Visit	625	LEVEL II GASTROINTESTINAL DIAGNOSES	Other
4	ED Medical Visit	628	ABDOMINAL PAIN	Other
4	ED Medical Visit	631	HERNIA	Other
4	ED Medical Visit	860	EXTENSIVE 3RD DEGREE OR FULL THICKNESS BURNS W/O SKIN GRAFT	Other
4	ED Medical Visit	634	MALIGNANCY OF HEPATOBILIARY SYSTEM & PANCREAS	Other
4	ED Medical Visit	639	LEVEL I HEPATOBILIARY DIAGNOSES	Other
4	ED Medical Visit	640	LEVEL II HEPATOBILIARY DIAGNOSES	Other
4	ED Medical Visit	653	MUSCULOSKELETAL MALIGNANCY & PATHOLOGICAL FRACTURES	Other
4	ED Medical Visit	654	OSTEOMYELITIS, SEPTIC ARTHRITIS & OTHER MUSCULOSKELETAL INFECTIONS	Other
4	ED Medical Visit	655	CONNECTIVE TISSUE DIAGNOSES	Other
4	ED Medical Visit	656	BACK & NECK DIAGNOSES EXCEPT LUMBAR DISC DIAGNOSES	Other
4	ED Medical Visit	657	LUMBAR DISC DIAGNOSES	Other
4	ED Medical Visit	658	LUMBAR DISC DIAGNOSES WITH SCIATICA	Other
4	ED Medical Visit	659	MALFUNCTION, REACTION, COMPLIC OF ORTHOPEDIC DEVICE OR PROCEDURE	Other
4	ED Medical Visit	660	LEVEL I OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	Other
4	ED Medical Visit	661	LEVEL II OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	Other
4	ED Medical Visit	663	PAIN	Other
4	ED Medical Visit	861	PARTIAL THICKNESS BURNS W OR W/O SKIN GRAFT	Other
4	ED Medical Visit	871	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	Other
4	ED Medical Visit	670	SKIN ULCERS	Other
4	ED Medical Visit	671	MAJOR SKIN DIAGNOSES	Other
4	ED Medical Visit	872	OTHER AFTERCARE & CONVALESCENCE	Other
4	ED Medical Visit	672	MALIGNANT BREAST DIAGNOSES	Other
4	ED Medical Visit	673	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	Other
4	ED Medical Visit	674	CONTUSION, OPEN WOUND & OTHER TRAUMA TO SKIN & SUBCUTANEOUS TISSUE	Other
4	ED Medical Visit	873	NEONATAL AFTERCARE	Other
4	ED Medical Visit	675	OTHER SKIN, SUBCUTANEOUS TISSUE & BREAST DIAGNOSES	Other
4	ED Medical Visit	874	JOINT REPLACEMENT	Other
4	ED Medical Visit	875	CONTRACEPTIVE MANAGEMENT	Other

2	Oncology Related Service	800	ACUTE LEUKEMIA	Oncology Related Services
4	ED Medical Visit	800	ACUTE LEUKEMIA	Oncology Related Services
2	Oncology Related Service	801	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA	Oncology Related Services
3	Non-ED medical Visit	801	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA	Oncology Related Services
4	ED Medical Visit	801	LYMPHOMA, MYELOMA & NON-ACUTE LEUKEMIA	Oncology Related Services
2	Oncology Related Service	802	RADIOTHERAPY	Oncology Related Services
4	ED Medical Visit	802	RADIOTHERAPY	Oncology Related Services
2	Oncology Related Service	803	CHEMOTHERAPY	Oncology Related Services
3	Non-ED medical Visit	803	CHEMOTHERAPY	Oncology Related Services
4	ED Medical Visit	803	CHEMOTHERAPY	Oncology Related Services
2	Oncology Related Service	804	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR	Oncology Related Services
4	ED Medical Visit	804	LYMPHATIC & OTHER MALIGNANCIES & NEOPLASMS OF UNCERTAIN BEHAVIOR	Oncology Related Services
4	ED Medical Visit	676	DECUBITUS ULCER	Other
4	ED Medical Visit	878	GYNECOLOGICAL PREVENTIVE MEDICINE	Other
4	ED Medical Visit	690	MALNUTRITION, FAILURE TO THRIVE & OTHER NUTRITIONAL DIAGNOSES	Other
4	ED Medical Visit	691	INBORN ERRORS OF METABOLISM	Other
4	ED Medical Visit	879	PREVENTIVE OR SCREENING ENCOUNTERS	Other
4	ED Medical Visit	880	HIV INFECTION	Other
4	ED Medical Visit	692	LEVEL I ENDOCRINE DIAGNOSES	Other
4	ED Medical Visit	693	LEVEL II ENDOCRINE DIAGNOSES	Other
4	ED Medical Visit	694	ELECTROLYTE DISORDERS	Other

4	ED Medical Visit	881	AIDS	Other
7	Ancillary & Other	116	ALLERGY TESTS	Other
7	Ancillary & Other	373	LEVEL I DENTAL FILM	Other
4	ED Medical Visit	711	DIABETES WITH OTHER MANIFESTATIONS & COMPLICATIONS	Other
4	ED Medical Visit	820	SCHIZOPHRENIA	Other
4	ED Medical Visit	712	DIABETES WITH NEUROLOGIC MANIFESTATIONS	Other
4	ED Medical Visit	821	MAJOR DEPRESSIVE DIAGNOSES & OTHER/UNSPECIFIED PSYCHOSES	Other
4	ED Medical Visit	714	DIABETES WITH RENAL MANIFESTATIONS	Other
4	ED Medical Visit	822	PERSONALITY & IMPULSE CONTROL DIAGNOSES	Other
4	ED Medical Visit	720	RENAL FAILURE	Other
4	ED Medical Visit	823	BIPOLAR DISORDERS	Other
4	ED Medical Visit	721	KIDNEY & URINARY TRACT MALIGNANCY	Other
4	ED Medical Visit	824	DEPRESSION EXCEPT MAJOR DEPRESSIVE DIAGNOSES	Other
4	ED Medical Visit	723	KIDNEY AND CHRONIC URINARY TRACT INFECTIONS	Other
4	ED Medical Visit	825	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	Other
4	ED Medical Visit	726	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	Other
4	ED Medical Visit	826	ACUTE ANXIETY & DELIRIUM STATES	Other
4	ED Medical Visit	740	MALIGNANCY, MALE REPRODUCTIVE SYSTEM	Other
4	ED Medical Visit	827	ORGANIC MENTAL HEALTH DISTURBANCES	Other
4	ED Medical Visit	741	MALE REPRODUCTIVE SYSTEM DIAGNOSES EXCEPT MALIGNANCY	Other
4	ED Medical Visit	828	MENTAL RETARDATION	Other
4	ED Medical Visit	750	FEMALE REPRODUCTIVE SYSTEM MALIGNANCY	Other
4	ED Medical Visit	829	CHILDHOOD BEHAVIORAL DIAGNOSES	Other
4	ED Medical Visit	751	FEMALE REPRODUCTIVE SYSTEM INFECTIONS	Other
4	ED Medical Visit	830	EATING DISORDERS	Other
4	ED Medical Visit	752	LEVEL I MENSTRUAL AND OTHER FEMALE DIAGNOSES	Other
4	ED Medical Visit	831	OTHER MENTAL HEALTH DIAGNOSES	Other
7	Ancillary & Other	374	LEVEL II DENTAL FILM	Other

7	Ancillary & Other	376	DIAGNOSTIC DENTAL PROCEDURES	Other
7	Ancillary & Other	377	PREVENTIVE DENTAL PROCEDURES	Other
7	Ancillary & Other	412	SIMPLE PULMONARY FUNCTION TESTS	Other
7	Ancillary & Other	413	CARDIOGRAM	Other
7	Ancillary & Other	414	LEVEL I IMMUNIZATION	Other
7	Ancillary & Other	415	LEVEL II IMMUNIZATION	Other
7	Ancillary & Other	416	LEVEL III IMMUNIZATION	Other
7	Ancillary & Other	418	MINOR CARDIAC AND VASCULAR TESTS	Other
7	Ancillary & Other	419	MINOR OPHTHALMOLOGICAL INJECTION, SCRAPING AND TESTS	Other
7	Ancillary & Other	420	PACEMAKER AND OTHER ELECTRONIC ANALYSIS	Other
7	Ancillary & Other	421	TUBE CHANGE	Other
7	Ancillary & Other	423	INTRODUCTION OF NEEDLE AND CATHETER	Other
7	Ancillary & Other	425	LEVEL I OTHER MISCELLANEOUS ANCILLARY PROCEDURES	Other
7	Ancillary & Other	427	BIOFEEDBACK AND OTHER TRAINING	Other
7	Ancillary & Other	428	PATIENT EDUCATION, INDIVIDUAL	Other
7	Ancillary & Other	429	PATIENT EDUCATION, GROUP	Other
7	Ancillary & Other	430	CLASS I CHEMOTHERAPY DRUGS	Other
7	Ancillary & Other	431	CLASS II CHEMOTHERAPY DRUGS	Other
7	Ancillary & Other	433	CLASS IV CHEMOTHERAPY DRUGS	Other
7	Ancillary & Other	435	CLASS I PHARMACOTHERAPY	Other
7	Ancillary & Other	436	CLASS II PHARMACOTHERAPY	Other
7	Ancillary & Other	438	CLASS IV PHARMACOTHERAPY	Other
4	ED Medical Visit	870	REHABILITATION	Rehab and Therapy

7	Ancillary & Other	439	CLASS V PHARMACOTHERAPY	Other
7	Ancillary & Other	443	CLASS VII CHEMOTHERAPY	Other
7	Ancillary & Other	450	OBSERVATION	Other
7	Ancillary & Other	451	SMOKING CESSATION TREATMENT	Other
7	Ancillary & Other	455	IMPLANTED TISSUE OF ANY TYPE	Other
7	Ancillary & Other	458	ALLERGY THERAPY	Other
7	Ancillary & Other	459	VACCINE ADMINISTRATION	Other
7	Ancillary & Other	461	CLASS IX COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Other
7	Ancillary & Other	462	CLASS X COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Other
7	Ancillary & Other	487	MINOR CARDIAC MONITORING	Other
7	Ancillary & Other	488	MINOR DEVICE EVALUATION & ELECTRONIC ANALYSIS	Other
7	Ancillary & Other	489	LEVEL II OTHER MISCELLANEOUS ANCILLARY PROCEDURES	Other
7	Ancillary & Other	490	INCIDENTAL TO MEDICAL VISIT OR SIGNIFICANT PROCEDURE	Other
7	Ancillary & Other	491	MEDICAL VISIT INDICATOR	Other
7	Ancillary & Other	495	MINOR CHEMOTHERAPY DRUGS	Other
7	Ancillary & Other	496	MINOR PHARMACOTHERAPY	Other
7	Ancillary & Other	497	TELEHEALTH FACILITATION	Other
5	Rehab and Therapy	118	NUTRITION THERAPY	Other
7	Ancillary & Other	457	VENIPUNCTURE	Other
7	Ancillary & Other	993	INPATIENT ONLY PROCEDURES	Unassigned
7	Ancillary & Other	999	UNASSIGNED	Unassigned
7	Ancillary & Other	1001	DURABLE MEDICAL EQUIPMENT AND SUPPLIES - LEVEL 1	Unassigned
7	Ancillary & Other	1002	DURABLE MEDICAL EQUIPMENT AND SUPPLIES - LEVEL 2	Unassigned

7	Ancillary & Other	1003	DURABLE MEDICAL EQUIPMENT AND SUPPLIES - LEVEL 3	Unassigned
7	Ancillary & Other	1004	DURABLE MEDICAL EQUIPMENT - LEVEL 4	Unassigned
7	Ancillary & Other	1005	DURABLE MEDICAL EQUIPMENT - LEVEL 5	Unassigned
7	Ancillary & Other	1006	DURABLE MEDICAL EQUIPMENT - LEVEL 6	Unassigned
7	Ancillary & Other	1009	DURABLE MEDICAL EQUIPMENT - LEVEL 9	Unassigned
7	Ancillary & Other	1010	DURABLE MEDICAL EQUIPMENT - LEVEL 10	Unassigned
7	Ancillary & Other	1011	DURABLE MEDICAL EQUIPMENT - LEVEL 11	Unassigned

Outpatient Service Line Assignment Hierarchy

If <u>New Service</u> is ' Rad/Inf/Chemo ' then <u>Service Line</u> is ' Rad/Inf/Chemo ';
Else If service Line not in ('Rad/Inf/Chemo') and <u>New Service</u> is ' Psychiatric ' then <u>Service Line</u> is ' Psychiatry ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry') and <u>New Service</u> is ' Clinic ' then <u>Service Line</u> is ' Clinic ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry','Clinic') and <u>New Service</u> is ' Rehabilitation ' then <u>Service Line</u> is ' Rehab & Therapy ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry','Clinic','Rehab & Therapy') and (hospid=210333 or hospid=210088 or hospid=210087 or rctcode28 > 0 or rctcode34 > 0 or rctcode90>0) then <u>Service Line</u> is ' ED ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry','Clinic','Rehab & Therapy','ED') and <u>New Service</u> is ' Major Surgery ' then <u>Service Line</u> is ' Major Surgery ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry','Clinic','Rehab & Therapy','ED','Major Surgery') and <u>New Service</u> is ' Minor Surgery ' then <u>Service Line</u> is ' Minor Surgery ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry','Clinic','Rehab & Therapy','ED','Major Surgery','Minor Surgery') and <u>New Service</u> is ' Cardiovascular ' then <u>Service Line</u> is ' Cardiovascular ';
Else If Service Line is not in ('Rad/Inf/Chemo','Psychiatry','Clinic','Rehab & Therapy','ED','Major Surgery','Minor Surgery','Cardiovascular') and <u>New Service</u> is ' CT/MRI/PET ' then <u>Service Line</u> is ' CT/MRI/PET ';
Else if <u>ECMAD</u> in (.,0) then <u>Service Line</u> is ' Unassigned ';
Else <u>Service Line</u> is <u>New Service</u> ;

Appendix 6. Proposed Market Shift Service Line Consolidation

<u>Service Line</u>	<u>IP/O P</u>	<u>Consolidation Proposal</u>	<u>Proposed Service Collapse</u>
Cardiology	IP	Service Collapse	Cardiology
Cardiothoracic Surgery	IP	Geography Collapse	Cardiothoracic Surgery
Dental	IP	Service Collapse	General Medicine
Dermatology	IP	Service Collapse	General Medicine
Diabetes	IP	Service Collapse	General Medicine
Endocrinology	IP	Service Collapse	General Medicine
Endocrinology Surgery	IP	Geography Collapse	Endocrinology Surgery
ENT Surgery	IP	Geography Collapse	ENT Surgery
EP/Chronic Rhythm Mgmt	IP	Geography/Service Collapse	Invasive Cardiology
Gastroenterology	IP	NA	Gastroenterology
General Medicine	IP	Service Collapse	General Medicine
General Surgery	IP	Geography Collapse	General Surgery
Gynecological Surg	IP	Geography Collapse	Gynecological Surg
Gynecology	IP	Geography/Service Collapse	Ob/Gyn
Hematology	IP	Geography Collapse	Hematology
HIV	IP	Service Collapse	Infectious Disease
Infectious Disease	IP	Service Collapse	Infectious Disease
Injuries/complic. of prior care	IP	Geography Collapse	Injuries/complic. of prior care
Invasive Cardiology	IP	Geography/Service Collapse	Invasive Cardiology
Myocardial Infarction	IP	Service Collapse	Cardiology
Neonatology	IP	Geography/Service Collapse	Neonatology
Nephrology	IP	NA	General Medicine
Neurological Surgery	IP	Geography Collapse	Neurological Surgery
Neurology	IP	NA	Neurology
Newborn	IP	Geography/Service Collapse	Neonatology
Obstetrics/Delivery	IP	Geography/Service Collapse	Ob/Gyn
Oncology_IP	IP	Geography Collapse	Oncology_IP
Ophthalmologic Surg	IP	Geography Collapse	Ophthalmologic Surg
Ophthalmology	IP	Service Collapse	Ophthamology
Orthopedic Surgery	IP	Geography Collapse	Orthopedic Surgery
Orthopedics	IP	Service Collapse	General Medicine

Other Obstetrics	IP	Geography/Service Collapse	Ob/Gyn
Otolaryngology	IP	Service Collapse	General Medicine
Psychiatry_IP	IP	Service Collapse	Psychiatry_IP
Pulmonary	IP	NA	Pulmonary
Rehabilitation_IP	IP	Geography Collapse	Rehabilitation_IP
Rheumatology	IP	Service Collapse	General Medicine
Spinal Surgery	IP	Geography Collapse	Spinal Surgery
Substance Abuse	IP	Service Collapse	Psychiatry_IP
Thoracic Surgery	IP	Geography Collapse	Thoracic Surgery
Trauma	IP	Geography Collapse	Trauma
Unassigned_IP	IP	NA	Unassigned_IP
Urological Surgery	IP	Geography Collapse	Urological Surgery
Urology	IP	Service Collapse	Urology
Vascular Surgery	IP	Geography Collapse	Vascular Surgery
Ventilator Support	IP	Geography Collapse	Ventilator Support
Cardiovascular	OP	Geography Collapse	Cardiovascular
Clinic	OP	NA	Clinic
CT/MRI/PET	OP	NA	CT/MRI/PET
Drugs	OP	NA	Removed
ED	OP	NA	ED
Lab	OP	Service Collapse	Lab
Major Surgery	OP	Geography Collapse	Major Surgery
Minor Surgery	OP	Geography Collapse	Minor Surgery
Other	OP	NA	Other
Pathology	OP	Service Collapse	Lab
Psychiatry_OP	OP	NA	Psychiatry_OP
Radiology	OP	NA	Radiology
Rehab & Therapy	OP	NA	Rehab & Therapy
Unassigned_OP	OP	NA	Unassigned_OP

Appendix 7. Hypothetical Emergency Room Market Shift Example that Masks Avoided Utilization

		Base Year - ER ECMADS	Performance Year - ER ECMADS	Growth	Current Market Shift	Unrecognized Growth / (Decline)	Consolidated Geography Market Shift	Unrecognized Growth / (Decline)	
Same Zips	Hospital A West Baltimore	100	90	(10)	(10)	0	(6)	(4)	} Probable market shift being treated as avoided utilization
	Hospital B West Baltimore	200	225	25	10	15	25	-	
Same Zips	Hospital C East Baltimore	250	180	(70)	(20)	(50)	(39)	(31)	} Probable avoided utilization being treated as market shift
	Hospital D East Baltimore	100	120	20	20	0	20	-	
	Total	650	615	-35	0	-35	0	-35	

Draft Recommendation for the Update Factors for Rate Year 2020

May 8, 2019

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This document contains the draft staff recommendation for the RY 2020 Update Factors. Please submit comments on this draft to the Commission by May 15, 2019 to hsrc.payment@maryland.gov.

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List of Abbreviations

ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFS	Fee-for-service
FFY	Federal fiscal year, refers to the period of October 1 through September 30
FY	Fiscal year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
MPA	Medicare Performance Adjustment
PAU	Potentially avoidable utilization
QBR	Quality Based Reimbursement
RY	Rate year, which is July 1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care

Summary

The following report includes a draft recommendation for the Update Factor for Rate Year (RY) 2020. This update is designed to meet the Total Cost of Care Requirements while keeping healthcare affordable in the State of Maryland.

At this time, the staff requests that Commissioners consider the following draft recommendations:

- a) Provide an overall increase of 3.56 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.25 percent per capita revenue increase for hospitals under Global Budgets, as shown in Table 2.
 - i) Allocate 0.19 percent of the total inflation allowance to high cost outpatient oncology and infusion drugs, providing a 10 percent increase based on the amount each hospital reported for estimated cost and utilization for the top 80 percent of these drugs for RY 2018.
 - ii) Provide a conditional additional allowance to the two major Academic Medical Centers of one percent for growth in high cost inpatient procedures and intensity for RY 2020.
 - iii) Prospectively reduce Global Budgets by 0.30 percent statewide for Potentially Avoidable Utilization.
- b) Provide an overall increase of 2.46 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

Introduction & Background

The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy related adjustments, other adjustments related to performance, and settlements from the prior year.

Effective January 1, 2013, the State entered into an All-Payer Model Agreement with the Center for Medicare & Medicaid Services ("CMS"), which required the State to limit the growth in total hospital costs per resident in line with the long term growth in the economy, to achieve Medicare savings per beneficiary relative to national Medicare growth rates, to improve quality, and to transform the hospital reimbursement system away from fee for service to population-based payments. Preliminary data from December 2018 shows that the State has met all of the requirements of the All-Payer Model. In July 2018, CMS approved a new 10-year Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. Under the new TCOC Model, the State committed to continue to limit the growth in hospital costs in line with economic growth, reach an annual Medicare total cost of care savings rate of \$300 million by 2023 ("the Medicare TCOC Savings Requirement"), continue quality improvements, and improve the health of the population. The Medicare TCOC Savings Requirement compares the growth in total Medicare FFS expenditures per Maryland Medicare beneficiary to the national growth rate. These expenditures include both hospital and non-hospital costs. Because the State lacks regulatory authority over providers other than hospitals, meeting the Medicare TCOC savings requirement will require a greater emphasis on initiatives that control the total cost of care through transformation and population

health improvement efforts. The HSCRC will increasingly tie hospitals revenue adjustments to Medicare Total Cost of Care performance under the Medicare Performance Adjustment (MPA) Policy.

To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will need to place increased emphasis on ensuring that the Medicare TCOC Savings Requirement is met. The approach to ensuring that the RY 2020 annual update is in line with these Model requirements is outlined in this report.

Update Factors are Revenue Updates

It is important to note that the proposed update factor is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per capita growth rates, rather than unit rate changes.

Hospital Revenue Types Included in this Recommendation

There are two categories of hospital revenue:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority.
2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and, thus, Medicare does not pay on the basis of those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital.

This recommendation proposes Rate Year (RY) 2020 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Draft Update Factors Recommendations

For RY 2020, HSCRC staff is proposing an update of 3.25 percent per capita for global revenues and an update of 2.46 percent for non-global revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted Global Insight's Fourth Quarter 2018 market basket growth estimate with a capital growth estimate. For RY 2020, HSCRC staff combined 91.20 percent of Global Insight's First Quarter 2019 market basket growth of 3.10 percent with 8.80 percent of the capital growth estimate of 1.50 percent, calculating the gross blended amount as a 2.96 percent inflation adjustment.

Update Factor Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC staff proposes applying the FFY 2020 Inpatient Psychiatric Facilities Medicare productivity reduction of

0.50 percent to the inflation adjustment. When subtracting the 0.50 percent productivity adjustment from the gross blended inflation adjustment of 2.96 percent growth, this results in a proposed update of 2.46 percent. Additionally, HSCRC staff note that these hospitals receive a volume adjustment, rather than a population adjustment. HSCRC staff continues to work toward implementing quality measures for these hospitals in future rate years.

Table 1

	Global Revenues	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	2.96%	2.96%
Productivity Adjustment		-0.50%
Proposed Update	2.96%	2.46%

Update Factor Recommendation for Global Budget Revenue Hospitals

In considering the system-wide update for the hospitals with global revenue budgets under the All-Payer Model, HSCRC staff sought to achieve balance among the following conditions:

- Meeting the requirements of the Total Cost of Care Model agreement;
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model; and
- Incorporating quality performance programs.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates net revenue growth (before accounting for changes in uncompensated care and assessments) of 3.69 percent and per capita growth of 3.38 percent for RY 2020. After accounting for changes in uncompensated care and assessments, the HSCRC estimates net revenue growth at 3.56 percent with a corresponding per capita growth of 3.25 percent for RY 2020.

Staff needs to split the annual Rate Year revenue into six month targets to calculate financial tests, which are performed on Calendar Year (CY) results. Consistent with the past several years, the staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2020 estimated revenue used to evaluate the Rate Year year-end target. Of note, there are a few hospitals that do not follow this seasonal pattern, particularly Atlantic General Hospital. Thus, HSCRC staff will adjust the revenue split to accommodate their normal seasonality.

Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC staff’s draft recommendation for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments to global

revenues. Descriptions of each step and the associated policy considerations are explained in the text following the table.

Table 2

Balanced Update Model for Discussion for RY 2020		
<u>Components of Revenue Change Linked to Hospital Cost Drivers/Performance</u>		
		Weighted Allowance
Adjustment for Inflation (this includes 3.10% for compensation)		2.77%
- Rising Cost of Outpatient Oncology Drugs		0.19%
Gross Inflation Allowance	A	2.96%
Care Coordination/Population Health	B	0.00%
Adjustment for Volume		
-Demographic		0.30%
-Transfers		
-High/Low Efficiency Outliers		
-Drug Population/Utilization		
Total Adjustment for Volume	C	0.30%
Other adjustments (positive and negative)		
- Set Aside for Unknown Adjustments	D	0.10%
- Capital Funding -Adventist White Oak Medical Center	E	0.09%
- Categoricals (1%)	F	0.23%
-Reversal of one-time adjustments for drugs	G	-0.03%
Net Other Adjustments	H= Sum of D thru G	0.39%
Quality and PAU Savings		
-PAU Savings	I	-0.30%
-Reversal of prior year quality incentives	J	0.53%
-QBR, MHAC, Readmissions		
-Positive incentives & Negative scaling adjustments	K	0.18%
Net Quality and PAU Savings	L = Sum of I thru K	0.41%
Total Update First Half of Rate Year 20		
Net increase attributable to hospitals	M = Sum of A + B + C + H + L	4.06%
Per Capita First Half of Rate Year (July - December)	N = (1+M)/(1+0.30%)	3.75%
Adjustments in Second Half of Rate Year 20		
-Oncology Drug Adjustment	O	0.00%
-QBR	P	-0.37%
Total Adjustments in Second Half of Rate Year 20	Q = O + P	-0.37%
Total Update Full Fiscal Year 20		
Net increase attributable to hospital for Rate Year	R = M + Q	3.69%
Per Capita Fiscal Year	S = (1+R)/(1+0.30%)	3.38%
<u>Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements</u>		
-Uncompensated care, net of differential	T	0.03%
-Deficit Assessment	U	-0.16%
Net decreases	V = T + U	-0.13%
Total Update First Half of Rate Year 20		
Revenue growth, net of offsets	W = M + V	3.93%
Per Capita Revenue Growth First Half of Rate Year	X = (1+W)/(1+0.30%)	3.62%
Total Update Full Rate Year 20		
Revenue growth, net of offsets	Y = R + V	3.56%
Per Capita Fiscal Year	Z = (1+Y)/(1+0.30%)	3.25%
Private Payer Growth Rate, based on Total Update for Full Rate Year		4.76%
Public Payers Growth Rate		3.06%

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

HSCRC staff accounted for a number of factors that are central provisions to the update process and are linked to hospital costs and performance. These include:

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 2.96 percent. The gross inflation allowance is calculated using Global Insight's First Quarter 2019 market basket growth of 3.10 percent with 8.80 percent of the capital growth 1.50 percent estimate. The adjustment for inflation includes 3.10 percent for compensation. A portion of the 2.96 inflation allowance (0.19 percent) will be allocated to hospitals in order to accurately provide revenues for increases in outpatient oncology drugs. This drug cost adjustment is further discussed below.
- **Rising Cost of New Outpatient Drugs:** The rising cost of drugs, particularly of new physician-administered drugs in the outpatient setting, continues to be a growing concern among hospitals, payers, and consumers. Not all hospitals provide these services and some hospitals have a much larger proportion of costs allocated. To address this situation, staff began allocating a specific part of the inflation adjustment to fund increases in the cost of drugs in Rate Year 16, based on the portion of each hospital's total costs that were comprised of drug costs.

In addition to the drug inflation allowance, in RY 2017, HSCRC initiated a utilization adjustment for changes in use of high cost oncology and infusion drugs. The adjustment for change in use is made utilizing information provided in a supplemental report provided by the hospitals for the top 80 percent of these specified outpatient medications. Half of the estimated cost changes due to usage or volume changes are recognized as a one-time adjustment and half are recognized as a permanent adjustment.

In 2019, staff prepared a drug funding analysis evaluating funding levels by hospital and drug category from RY 2013 through RY 2018. Drug costs were split into three categories: inpatient drugs, outpatient oncology and infusion drugs, and other outpatient drugs. In this evaluation, staff found that oncology and infusion drug costs averaged a 10 percent annual increase, while inpatient and other outpatient drugs rose more in line with general inflation. As a result of these findings, staff is recommending a modification to the approach it used in RY 2019 to focus the additional inflation for drugs to high cost outpatient oncology and infusion drugs. This will result in a higher growth allowance for these high cost drugs, while continuing to provide inflation for other categories of drugs through the overall inflation allowance. For Rate Year 2020, staff proposes to apply a 10 percent growth allowance, based on drug-specific growth trends, to the top 80 percent of the specified outpatient medications, as reported on hospitals' supplemental drug cost for RY 2018. In RY 2019, 0.31 percent was set aside for inflation for drugs. For RY 2020, staff proposes to set aside 0.19 percent of the inflation allowance to apply to high cost oncology and infusion drugs, leaving the remaining drug inflation together with the general inflation allowance.

For Rate Year 2021, staff may explore use of a standard list of drugs, which could be used to calculate the inflation allowance as well as the drug utilization adjustment component of funding

for these high cost drugs. Staff will review this possibility and the standard list of drugs with stakeholders during the upcoming months.

- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for CY 2018 is 0.30 percent. For RY 2020, the staff are proposing recognizing the full value of the 0.30 percent growth for the Demographic Adjustment to hospitals in keeping with prior year norms.
- **Set-Aside for Unforeseen Adjustment:** Staff recommends a 0.10 percent set-aside for unforeseen adjustments during RY 2020.
- **Capital Funding:** Adventist Health Care is opening a new hospital, White Oak Medical Center, in Silver Spring Maryland. This facility is expected to open in August of 2019. This recommendation includes 0.09 percent for capital for the opening of this facility, which is approximately \$15 million as approved by the Commission during the CON process.
- **Categorical Cases:** Existing categorical cases include transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. The HSCRC staff has been working to develop an approach to provide a revenue adjustment for these and other expensive therapies performed primarily at University of Maryland Medical Center and Johns Hopkins Hospital. In Rate Year 2019, the HSCRC provided these two AMC hospitals an additional one percent revenue adjustment to create a fixed pool of funds for these and other quaternary services. For RY 2020, staff is again proposing to provide these two AMCs an additional one percent revenue adjustment for RY 2020. Similar to RY 2019, this adjustment will be contingent upon receipt of data regarding productivity and cost levels relative to national peers and ongoing cost savings efforts submitted by the AMCs, which are essential in assuring that the AMCs are improving productivity levels. HSCRC staff will continue to evaluate the level of funding and funding mechanisms that will be employed for RY 2021 and beyond, and the Commission will need to continue to deliberate how to fund these types of services in the future.
- **QBR Adjustment:** CMS provides data for the Quality Based Reimbursement (QBR) adjustment. Due to the data delivery schedule, HSCRC does not have the final data available to calculate this adjustment at this time. HSCRC expects the adjustment to be approximately -0.37 percent, based on the changes in Commission policy and preliminary modeling. HSCRC staff will include this adjustment in the second half of RY 2020.
- **Quality Scaling Adjustments:** Quality scaling adjustments include Maryland Hospital Acquired Conditions (MHAC) and Readmission Reduction Incentive Program (RRIP). The RY 2019 adjustments have been restored in the base and new adjustments are reflected in staff's recommendation. The amount for these two programs which will be adjusted for in the first half of the rate year is 0.18 percent.
- **PAU Savings Reduction:** The statewide RY 2020 PAU savings adjustment is now calculated based on update factor inflation and demographic adjustment applied to CY 2018 PAU revenue. RY 2020 PAU savings adjustment represents the change between RY 2019 and RY 2020. Previous years of PAU savings adjustments are not reversed out.

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

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2020 will be 0.03 percent. The amount in rates was 4.16 percent in RY 2019, and the proposed amount for RY 2020 is 4.19 percent. This is the first year since 2014 that staff is not reducing UCC in rates since 2014. This outcome is to be expected as Medicaid Expansion and Affordable Care Act Enrollment have plateaued, and thus UCC has remained stable.
- **Deficit Assessment:** The legislature reduced the deficit assessment by \$25 million in RY 2020, and as a result, this line item is -0.16 percent.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. These additional variables include one-time adjustments, revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

PAU Savings Updated Methodology

The PAU Savings Policy prospectively reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY2020, the calculation of the statewide value of the PAU Savings will be included in the Update Factor Recommendation; however, PAU measurement policy will be presented separately. For this year, a brief summary of the PAU performance and measure methodology is available in the appendix, but in subsequent years, staff plans to produce PAU policy reports that will include measure and hospital-specific scaling discussions.

Starting in RY 2020, the incremental amount of statewide PAU Savings reductions will be determined formulaically using inflation and demographic adjustment applied to the amount of PAU revenue (see Table 3). In previous years, staff reversed out the prior year cumulative PAU reduction and recalculated the cumulative PAU reduction with an incremental increase to realize additional savings from continued reductions in PAU. In the current policy, staff recommends keeping prior year reductions in place and only implementing additional incremental reductions in keeping with actual rate setting implementation norms. With this change, staff also proposes discontinuing the additional protection for hospitals with high socioeconomic burden, as the smaller incremental reduction lessens the need for continued protections.

Staff compared the actual PAU savings reductions from RY 2014-RY 2019 to the cumulative formulaic inflation-based approach and found that cumulatively PAU savings reductions were about \$7.2 million more than under the formulaic approach. Therefore, staff and stakeholders suggest reducing the RY2020

reduction amount by \$7.2 million (\$58.1 million to \$50.8 million) to ensure that the cumulative PAU reduction and cumulative PAU inflation net out to zero in RY 2020. This will result in a RY 2020 PAU savings reduction of about -0.3021 percent statewide. For simplicity's sake, staff recommends rounding this value to -0.30 percent.

Table 3

Statewide Results		Value
RY 2019 Total Estimated Permanent Revenue	A	\$16,842,884,479
Total RY20 PAU %	B	10.77%
Total RY20 PAU \$	C	\$1,922,894,085
Statewide Total Calculations (formulaic)		Value
RY 2020 Inflation Factor (preliminary)	D	3.02%
RY 2020 Revenue Adjustment \$	$E=C*D$	-\$58,071,401
Ry 2020 Revenue Adjustment %	$F=E/A$	-0.345%
Statewide Total Calculations (adjusted)		
Cumulative difference	G	-\$7,188,437
RY 2020 Revenue Adjustment \$	$H=E-G$	-\$50,882,964
Ry 2020 Revenue Adjustment %	$I=H/A$	-0.302%
Recommended RY2020 Revenue Adjustment %		-0.30%

Change in Differential

In December 2018, the Commission voted to approve staff's recommendation to increase the differential from 6.0 percent to 7.7 percent effective July 1, 2019. The State of Maryland has employed a differential since the 1970s whereby public payers (Medicare and Medicaid) pay less than other payers (primarily commercial payers) due to business practices that avert bad debt in hospitals and keep Maryland's hospital costs low. Hospital charges are adjusted via a markup to ensure that the differential's reduction in charges to public payers does not result in a decline in hospitals' total revenue. 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. This change accounts for the changes in business practices of private Maryland payers that have resulted in higher bad debt costs. To implement the differential, hospital rates will be increased by approximately 1.2 percent. Medicare and Medicaid will receive an additional discount of 1.7 percent off of charges, and the net revenue effect will be revenue neutral to hospitals. As reflected at the bottom of table 2, this change in the differential results in a private payer growth rate of 4.76 percent and a public payer growth rate of 3.06 percent based on the full rate year update.

With the adoption of this increased differential, the Commission specified that any savings to Medicare from this adjustment could not be utilized to result in a higher all-payer rate adjustment. As shown in the

following tables 5a and 5b, staff is using the all-payer revenue increase to evaluate whether Maryland is meeting the all-payer and Medicare growth targets, rather than the lower Medicare increase resulting from the changed public payer differential. Through this approach, staff is ensuring that the savings to Medicare resulting from the differential calculation are not increasing the level of update allowed to hospitals.

Consideration of All-Payer Model Agreement Requirements & National Cost Figures

As described above, the staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Additionally, based on staff calculations, the proposed update falls within the financial parameters of the TCOC Model agreement requirements. The staff's considerations in regards to the TCOC Model agreement requirements are described in detail below.

Medicare Financial Test

Based on the staff's calculations, the proposed update keeps Maryland within the constraints of the TCOC Model's Medicare savings test. This test requires the Model to generate \$300 million in annual Medicare fee-for-service (FFS) savings in total cost of care expenditures (Parts A and B) by 2023. The TCOC Model Medicare Savings Requirement is different from the previous All-Payer Model Medicare savings requirement in several ways. First, as previously discussed, Maryland's Total Cost of Care Model Agreement progresses to setting savings targets based on total costs of care, which includes non-hospital cost increases, as opposed to the hospital only requirements of the All-Payer Model. This shift ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from Model implementation. Additionally, the change to total cost of care focuses hospital efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care. Secondly, the All-Payer Model Savings Requirement was a *cumulative* savings test, where the savings for each year relative to the base period were added up to determine the total *hospital* savings. The TCOC Model requires that the State reach *annual* savings of \$300 million relative to the national growth rate by 2023, relative to a 2013 base year. Thus, there must be sustained improved performance over time to meet the new TCOC Medicare Savings Requirements. The new TCOC Model contains specific annual Medicare Savings Requirements for each year. Based on the CY 2018 performance, staff expects to exceed the TCOC Model's annual Savings Requirement of \$120 million for performance year one (CY 2019). However, similar to the All-Payer Model, there are TCOC growth guardrails. Maryland's Medicare TCOC growth may not exceed the national Medicare TCOC growth rate in any two successive years and Maryland may not exceed the national growth rate by more than one percent in any year. Corrective actions are required if these limits are exceeded.

The growth in Medicare expenditures in Maryland outside of hospitals continues to exceed the national growth rate. Under the All-Payer Model, the HSCRC built a conservative approach to estimating variations in hospital cost growth. For the Total Cost of Care Model, HSCRC staff proposes to extend

this approach to evaluating variations in Total Cost of Care performance. This revised approach will be discussed in the following section.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In order to ensure Model savings and guardrails are being met, staff compared Medicare growth estimates to the all-payer spending limits. Because the actual revenue resulting from updates in RY 2019 affect the CY 2019 results, staff must convert the recommended RY 2020 update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2019 to assist in estimating the impact of the recommended update factor together with the projected RY 2019 results. The overall increase from the bottom of this table is used in Table 5a.

Table 4

Estimated Position on Medicare Target		
Actual Revenue CY 2018		17,341,823,084
Step 1:		
Estimated Approved GBR RY 2019		17,466,092,860
Actual Revenue 7/1/18-12/31/18		8,596,133,432
Projected Revenue 1/1/19-6/30/19	A	8,869,959,428
Step 2:		
Estimated Approved GBR RY 2020		18,152,802,313
Permanent Update		3.93%
Step 3:		
Estimated Revenue 7/1/19-12/31/19 (after 49.73% & seasonality)		9,027,388,590
Hopkins & Shady Grove*		14,000,000
	B	9,041,388,590
Step 4:		
Estimated Revenue CY 2019	A+B	17,911,348,018
Increase over CY 2018 Revenue		3.28%

*Hopkins Payback & Shady Grove GBR Adj.

Steps to explain Table 4 are described as below:

- Step 1: The table begins with the estimated global revenue for RY 2019 and actual revenue for the last six months for CY 2018 to calculate the projected revenue for the first six months of CY 2019 (i.e. the last six months of RY 2019).
- Step 2: This step shows the estimated RY 2020 global budget revenue based on the information that staff have available to date. The permanent update over RY 2018 of 3.93 percent represents the portion of the RY 2020 update provided during the calendar year 2019, as shown in Table 2.
- Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2020 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2020 and hospital specific seasonality adjustments. An adjustment for

the temporary rate adjustment for Johns Hopkins Hospital and Adventist Behavioral Health is also added to revenues.

· Step 4: This step shows the resulting estimated revenue for CY 2019 and then calculates the increase over actual CY 2018 Revenue.

For the past five updates, Maryland obtained calendar year Medicare fee-for-service growth estimates from the CMS Office of the Actuary. The projected per capita amount for Medicare Parts A and B for CY 2019 is 4.03 percent. Due to the variability in the estimates from actual performance, particularly with estimates beyond the current year, staff is proposing using actual national Medicare FFS total cost of care growth from the previous calendar year moving forward in our guardrail and savings test, absent large policy changes that would suggest significantly different growth estimates. National Medicare FFS total cost of care growth for CY 2018 was 3.72 percent, shown in line A of Table 5a and 5b.

During CY 2014-CY 2018, all-payer growth outpaced Medicare growth on a per capita basis and in the updates staff adjusted the all-payer growth limit using the difference in Medicare and all-payer per capita growth to estimate the implied limit for Medicare.

For the purposes of evaluating the maximum all-payer spending growth that will allow Maryland to meet the per capita Medicare FFS target, the Medicare target must be translated to an all-payer growth limit. There are several ways to calculate the difference between Medicare FFS and all-payer growth rates using recent data trends. A consultant to CareFirst developed a “conservative difference statistic” that reflected the historical increase in Medicare per capita spending in Maryland relative to all-payer per capita spending growth. This conservative statistic has been updated each year using data provided by HSCRC. For the RY 2020 update, CareFirst and HSCRC staff calculated a difference of 0.83 percent, which used a five-year average difference between Maryland Medicare and all-payer claims reduced by the average annual absolute variance.

Maryland Medicare total cost of care cannot exceed national Medicare total cost of care growth by one percent in any single year and cannot exceed the national growth by any amount in two consecutive years; these are known as ‘total cost of care guardrails.’ In an effort to ensure that Maryland does not exceed the national Medicare growth rate in CY 2019, staff modeled the impact of excess non-hospital growth on the maximum hospital update that could be provided. This calculation assesses Medicare growth in unregulated settings and factors this excess growth into allowable hospital rate increases for RY 2020. Staff modeled non-hospital excess growth, inclusive of a conservative factor of -1.18 percent, which was calculated by taking a five year average of non-hospital excess growth and additionally accounting for the absolute average variance to provide conservatism.

In prior years the staff has included a 0.50 percent reduction in the Medicare Growth target to ensure the State achieves savings under the All-Payer Model. This year we omitted that adjustment in both tables 5a and 5b, as results for CY 2018 show the State well ahead of savings targets. In future years this target adjustment will not be necessary, assuming the Commission subsequently approves the MPA Efficiency Component draft recommendation reviewed in April 2019 which provides a vehicle for achieving savings on a Medicare-only basis. If that policy is not approved the all-payer approach to achieving Medicare savings will be restored to the update factor.

The first scenario, shown in Table 5a calculates savings using the calendar year growth calculated in Table 4. The second scenario, shown in Table 5b calculates savings using the full rate year growth projection from lines Y & Z on Table 2. Both scenarios project a favorable outcome based on staff's projections.

Table 5a – Using Rate Year Growth Estimate

Maximum Increase that Can Produce Medicare Savings			
Medicare			
Medicare TCOC Growth (CY 2018 3.72%)	A	3.72%	
Savings Goal for RY 2020	B	0.00%	
Maximum growth rate that will achieve savings (A+B)	C	3.72%	
Conversion to All-Payer			
Actual statistic between Medicare and All-Payer <i>with conservatism</i>		0.83%	Recommendation: Savings:
Excess Growth for Non-Hospital Cost Relative to the Nation <i>with conservatism</i>		-1.18%	
Net Difference Statistic Related to Total Cost of Care	D	-0.35%	
Conversion to All-Payer growth per resident $(1+C)*(1+D)-1$	E	3.35%	2.98% 0.38%
Conversion to total All-Payer revenue growth $(1+E)*(1+0.30\%)-1$	F	3.66%	3.28% 0.38%

Table 5b – Using Calendar Year Growth Estimate

Maximum Increase that Can Produce Medicare Savings			
Medicare			
Medicare TCOC Growth (CY 2018 3.72%)	A	3.72%	
Savings Goal for FY 2020	B	0.00%	
Maximum growth rate that will achieve savings (A+B)	C	3.72%	
Conversion to All-Payer			
Actual statistic between Medicare and All-Payer <i>with conservatism</i>		0.83%	Recommendation: Savings:
Excess Growth for Non-Hospital Cost Relative to the Nation <i>with conservatism</i>		-1.18%	
Net Difference Statistic Related to Total Cost of Care	D	-0.35%	
Conversion to All-Payer growth per resident $(1+C)*(1+D)-1$	E	3.36%	3.25% 0.11%
Conversion to total All-Payer revenue growth $(1+E)*(1+0.30\%)-1$	F	3.67%	3.56% 0.11%

Staff also modeled the growth and compared it to economic growth in Maryland as measured by the State Gross Domestic Product (State GDP, which was previously called the Gross State Product (GSP)). The purpose of this modeling is to ensure that healthcare remains affordable in the state. Staff calculated the compounded annual growth rate (CAGR) for three years using the most updated State GDP numbers available. (CY14-CY17). The 3-year CAGR calculation shows a per capita amount of 3.42 percent. Staff compared that number to the calendar year increase shown in Table 6 to ensure that the update provided in this draft recommendation would maintain growth in line with economic growth. The chart below shows this comparison.

Table 6 – Using Calendar Year Growth Estimate

Maximum Increase that Maintains Affordability				
State Gross Domestic Product per Capita (3 year CAGR 3.42%)	A	3.42%	Recommendation:	Savings:
Savings Goal for RY 2020	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	3.42%	2.98%	0.44%
Conversion to total All-Payer revenue growth $(1+C)*(1+0.30\%)-1$	D	3.73%	3.28%	0.45%

Medicare’s Proposed National Rate Update for FFY 2020

CMS published proposed updates to the federal Medicare inpatient rates for FFY 2020 in the Federal Register in mid-April 2019. These updates are summarized in Table 7 below. These updates will not be finalized for several months and are subject to change. In the proposed rule, CMS would increase rates by approximately 3.20 percent in FFY 2020 compared to FFY 2019, after accounting for inflation, a disproportionate share increase, and other adjustments required by law. The proposed rule includes an initial market basket update of 3.20 percent for those hospitals that were meaningful users of electronic health records and for those hospitals that submitted data on quality measures, less a productivity cut of 0.50 percent. This proposed update also reflects a proposed 0.50 percentage point increase for documentation and coding required by the American Taxpayer Relief Act of 2012. Disproportionate share payment changes resulted in an increase of approximately 0.18 percent from FFY 2019.

Table 7

	Inpatient	Outpatient
Base Update		
Market Basket	3.20%	3.20%
Productivity	-0.50%	-0.50%
ACA	0.00%	0.00%
Coding	0.50%	
	<hr/>	<hr/>
	3.20%	2.70%
Other Changes		
DSH	0.18%	0.00%
Other Changes	0.00%	0.00%
	<hr/>	<hr/>
	0.18%	0.00%
	<hr/>	<hr/>
	3.38%	2.70%

Applying the inpatient assumptions about market basket, and productivity, staff estimates a 2.70 percent Medicare outpatient update effective January 2020. This estimate is pending any adjustments that may be made when the final update to the federal Medicare outpatient rates is published.

Stakeholder Comments

HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2020 update. HSCRC staff will update this section when the official stakeholder comment period has closed.

Recommendations

Based on the currently available data and the staff's analyses to date, the HSCRC staff provides the following draft recommendations for the RY 2020 update factors.

- a) Provide an overall increase of 3.56 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.25 percent per capita revenue increase for hospitals under Global Budgets, as shown in Table 2.
 - i) Allocate 0.19 percent of the total inflation allowance to high cost outpatient oncology and infusion drugs, providing a 10 percent increase based on the amount each hospital reported for estimated cost and utilization for the top 80 percent of these drugs for RY 2018.
 - ii) Provide a conditional additional allowance to the two major Academic Medical Centers of one percent for growth in high cost inpatient procedures and intensity for RY 2020.
 - iii) Prospectively reduce Global Budgets by 0.30 percent statewide for Potentially Avoidable Utilization.
- b) Provide an overall increase of 2.46 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

Appendix A. Potentially Avoidable Utilization (PAU) Savings Methodology

This year the PAU Savings reduction has been incorporated into the Update Factor recommendation since the statewide reduction is now being linked to the update factor inflation and demographic adjustment. This appendix provides additional details on the RY 2020 PAU measurement methodology, as well as the future direction of PAU measurement.

RY2020 PAU Hospital-Specific Measurement

The PAU Savings Policy applies the statewide reduction (as specified in the body of Update Factor Recommendation) to each hospital's total permanent revenue. The statewide reduction is scaled for each hospital based on the amount of PAU revenue assigned to that hospital (e.g., hospitals with PAU revenue greater than the statewide average receive a higher revenue adjustment than the statewide reduction). For RY 2020, PAU revenue is defined as revenue associated with 30-day, all-cause readmissions¹ and ambulatory-care sensitive condition admissions (measured by AHRQ Prevention Quality Indicators (PQIs)).

Readmissions: In prior years, readmissions were assigned to the hospital that received the readmission (i.e., the hospital where the readmission occurred). In response to Commissioner and stakeholder feedback, staff has changed the methodology to assign readmissions to the sending or index hospital for the RY 2020 adjustment. To calculate the readmission revenue associated with the sending hospital, staff vetted with Performance Measurement Workgroup applying the average cost of an intra-hospital readmission (i.e., cost of readmissions that occurred to and from the same hospital) to the total number of sending readmissions assigned to each hospital. Applying this average cost avoids holding sending hospitals accountable for the cost structure at a receiving hospital.

PQIs: HSCRC will use AHRQ PQI version 2018 for Calendar Year 2018 performance.² As with previous PAU Savings policy, PQI revenue will exclude revenue flagged as both a PQI and a readmission. Revenue flagged as both PQI and readmission will be included in the readmissions revenue.

Protection: As detailed in the Draft RY 2020 Update Factor Recommendation, staff recommends discontinuing the additional protection for hospitals with high socioeconomic burden. In prior years, the PAU savings reductions were capped at the state average if a hospital served a high proportion of disadvantaged populations.³ This policy was initially adopted because hospitals serving areas with higher socioeconomic burden may face additional challenges in reducing PAU, such as issues with transportation, family and community resources, or health literacy barriers. On the other hand, the Commission does not want to excuse poor quality of care or inadequate care coordination for patients in disadvantaged communities. Due to these issues, staff indicated a potential future phasing out of the protection in the RY 2019 PAU Savings Policy.

Staff believes ending the additional protection for incremental PAU adjustments ensures that these hospitals have the needed resources to serve their communities, while still incentivizing them to reduce

¹ 30-day, all-cause, all-payer, all-hospital readmissions for inpatient stays and observation stays greater than 23 hours, excluding planned admissions, same and next day transfers, oncology cases, and newborns.

² Starting in 2018, staff will begin to phase out the use of PQI02 perforated appendix. PQI02 data after October 2018 will NOT be included in determining performance and revenue adjustments due to AHRQ logic issues.

³ In the RY2019 Policy, this criterion was defined as hospitals in the top quartile in Maryland in terms of the percentage of their total inpatient equivalent case-mix adjusted discharges that are Medicaid/Self-Pay/Charity.

their PAU percentage below the statewide level to receive a lower reduction. Because PAU savings adjustments are built into permanent revenue, hospitals that received the protection continue to benefit from prior years of protection. With the policy shift to calculating only incremental PAU savings adjustments, this historically protected revenue will remain in permanent revenue. Only new PAU Savings adjustments will not have the protection.

RY2020 Hospital-specific results: Draft and final PAU revenue adjustments by hospital will be posted on the HSCRC website (<https://hscrc.maryland.gov/Pages/PAU-Savings.aspx>) as they are available.

PAU refinement and expansion

Based on Commissioner and stakeholder feedback, staff and stakeholders explored approaches to modernize the PAU measurement in order to increase measure comprehensiveness, resolve methodological concerns with PQI measures, and align with the Total Cost of Care Model. Staff discussed potential expansion and refinement of PAU with a PAU subgroup in the summer and fall of 2018, as well as with the Performance Measurement Workgroup throughout 2018.

Low Value Care. The subgroup proposed and considered a total of thirty-six potential low value care measures, and based on stakeholder input and data availability, the HSCRC calculated three measures for consideration. Ultimately, subgroup members felt the tested measures were too narrow and represented too small dollar values to be worth implementation. Many subgroup members felt that broader measures of utilization represented greater opportunities for making meaningful change and impact on total cost of care. However, they also felt that the PAU Savings policy may not be the most appropriate incentive mechanism, given that many of these measures are not clearly specified, or may occur outside the hospital. Given this feedback, HSCRC is planning on monitoring broad utilization through Medicare data to identify outliers and consider taking action on a case-by-case basis.

New measures. In response to strong consumer and Medicaid support, staff plans on recommending the addition of avoidable pediatric admissions to the PAU measurement for RY 2021.⁴

Per Capita. For RY2021, HSCRC staff intends to recommend a shift to a per capita PAU performance evaluation for PQIs. This approach better aligns with the original population-based intention of PQIs, better recognizes hospital accountability in communities, and enables inclusion of avoidable pediatric admissions. Working with the PAU subgroup and Performance Measurement Work Group, HSCRC plans to propose a methodology for attributing avoidable admissions to hospitals that incorporates the Medicare Performance Adjustment (MPA) attribution process for applicable Medicare beneficiaries, followed by a geographic attribution approach for other patients. Currently, the staff and stakeholders have not made a decision on whether or how to measure readmissions under a per capita model, but starting in 2019 PQI admissions will be flagged prior to readmissions (i.e., if both a PQI and a readmission, then will count as PQI). HSCRC is working with CRISP to produce per-capita performance reports for CY 2019 on PQIs and PDIs as data becomes available. With the incorporation of the MPA attribution in per-capita PQI calculation⁵, HSCRC anticipates that CRISP reports for per-capita PQI performance results will be available approximately three to four months following the encounter. A detailed memo on the overall

⁴ AHRQ pediatric quality indicators (PDIs) and PQI 09 Low Birthweight Newborns

⁵ MPA relies on Medicare billing data that has longer data lags compared to hospital case-mix data. In addition, the first reports of the year may have an additional delay due to loading of new algorithm information.

PQI per capita attribution and readmission measurement will be available as details are vetted by stakeholders and moved into production for CY 2019 performance measurement.

**Draft Recommendation:
Maryland's Statewide Health Information Exchange,
the Chesapeake Regional Information System for our
Patients: FY 2020 Funding to Support HIE Operations,
CRISP Reporting Services and the ICN Project**

May 8, 2019

Health Services Cost Review Commission
4160 Patterson Avenue
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LIST OF ABBREVIATIONS

BRFA	Budget Reconciliation and Financing Act
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
CRP	Care Redesign Program
CRS	CRISP Reporting Services
FY	Fiscal year
HIE	Health information exchange
HITECH	Health Information Technology for Economic and Clinical Health Act
HSCRC	Health Services Cost Review Commission
IAPD	Implementation Advanced Planning Document
ICN	Integrated care network
MDH	Maryland Department of Health
MHCC	Maryland Health Care Commission
MHIP	Maryland Health Insurance Plan
MMIS	Medicaid Management Information Systems

OVERVIEW AND RECOMMENDATION

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the Total Cost of Care Model and the public interest,¹ this recommendation identifies the amount of funding support required in fiscal year (FY) 2020 to the Chesapeake Regional Information System for our Patients (CRISP), for the following purposes:

- Health Information Exchange (HIE) operations (\$1,500,000); and
- Implementation Advanced Planning Document (IAPD) matching funds (\$1,000,000)
- ICN Program Support (\$2,200,000)
- Medicaid Management Information System (MMIS) matching funds (\$690,000)

Therefore the recommendation is that the HSCRC provide total funding of \$5,390,000 to CRISP. This reflects a \$2,890,000 increase from FY 2019 funding of \$2,500,000.

The increase in this assessment entirely relates to a transition in funding sources for Integrated Care Network (ICN) projects. Through FY 2019, under the Budget Reconciliation and Financing Act (BRFA) of 2015, the ICN projects were funded by the Maryland Health Insurance Plan (MHIP) funds, however, beginning in FY 2020 these funds are no longer available.

ICN projects include (1) CRISP Reporting Services (CRS), which provide reporting to the Maryland Health Services Cost Review Commission (HSCRC or Commission) and hospitals and other stakeholders in the State, (2) point of care resources to aid providers and care managers with effective care management and (3) the development and administration of the Care Redesign Program (CRP) which addresses specific opportunities to align healthcare providers and improve the efficiency of care delivery in Maryland.

The original sustainability plan for ICN projects was to shift operating costs to participant fees. The HSCRC and CRISP will continue to transition costs associated with ongoing CRP administration and point of care services to participants through user fees. New program development and reporting will continue to be funded by the CRISP-related assessment and Federal matching funds. This recommendation reflects this new blend of funding sources for ICN projects.

¹ MD. CODE ANN., Health-Gen §19-219(c).

BACKGROUND – PAST FUNDING

Over the past nine years, the Commission has approved funding to support the general operations of the CRISP HIE and reporting services through hospital rates as shown in Table 1.

Table 1. HSCRC Funding for CRISP HIE and Reporting Services, FYs 2010-2019

CRISP Budget: HSCRC Funds Received	
FY 2010	\$4,650,000
FY 2011	No funds received
FY 2012	\$2,869,967
FY 2013	\$1,313,755
FY 2014	\$1,166,278
FY 2015	\$1,650,000
FY 2016	\$3,250,000
FY 2017	\$2,360,000
FY 2018	\$2,360,000
FY 2019	\$2,500,000

In December 2013, the Commission authorized staff to provide continued funding support for CRISP for FYs 2015 through 2019 without further Commission approval as long as the amount does not exceed \$2.5 million in any year. Requested funding for FY 2020 will exceed that level and the Commission is required to approve this recommendation.

FY 2020 FUNDING THROUGH HOSPITAL RATES

Beginning in FY 2015, CRISP-related hospital rate assessments are paid into an MHCC fund, and MHCC and the HSCRC review the invoices for approval of appropriate payments to CRISP. This process, along with the auditing of the expenditures, has created an extra layer of accountability. The remaining section details the infrastructure and support that will be funded in FY 2020 through the hospital rate setting system.

HIE Operations Funding

The value of an HIE rests in the premise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The

General Assembly charged the MHCC and HSCRC with the designation of a statewide HIE.² In the summer of 2009, MHCC awarded state designation to CRISP, and HSCRC approved up to \$10 million in startup funding over a four-year period through Maryland's unique all-payer hospital rate setting system. HSCRC's annual funding for CRISP is illustrated in Table 1 above.

The use of HIEs is a key component of health care reform, enabling clinical data sharing among appropriately authorized and authenticated users. The ability to exchange health information electronically in a standardized format is critical to improving health care quality and safety.

Many states, along with federal policy makers, look to Maryland as a leader in HIE implementation. Further investment in building CRISP's infrastructure is necessary to support existing and future use cases and to assist HSCRC as it moves to per-capita and population-based payment structures under the Total Cost of Care Model. A return on the investment will occur from having implemented a robust technical platform that can support innovative use cases to improve care delivery, increase efficiencies in health care, and reduce health care costs.

The total amount of funding recommended by staff for FY 2020 for the HIE function is \$1,500,000.

Implementation Advanced Planning Document (IAPD) Matching Funds

In addition to its role in HIE among providers, CRISP is also involved in health care reform activities related to HSCRC, MHCC, and the Maryland Department of Health (MDH). In its collaboration with the Medicaid program, uniform and broad-based funding through hospital rates can also be used to leverage federal financial participation under the Health Information Technology for Economic and Clinical Health (HITECH) Act, known as IAPD funding. Under the HITECH Act, the Centers for Medicare & Medicaid Services (CMS) may approve states for Medicaid Electronic Health Record Incentive Program funding, and states receive a 90 percent federal financial participation match for expanding HIE through 2021. This request will enable CRISP (working with MDH) to obtain federal funding. IAPD funding allows CRISP (working with MDH) to qualify for funding to implement use cases that compliment ICN activities.

In FY 2020, the State's match of \$1.0 million will leverage \$9.0 million in federal funds for a variety of initiatives. Activities enabled through IAPD that enhance the point of care delivery include: encounter notification services, practice-level advanced-implementation support, ambulatory integration, hospital integration, and image exchange. Common infrastructure activities include: data routing and consent management, technical infrastructure and operations expense, and data architecture. Finally, there are a number of public health reporting initiatives as well, including: public health use case management, electronic lab reporting, MDH interface development and validation, and CMS Clinical Quality Measures reporting.

² MD. CODE ANN., Health-Gen §19-143(a).

The total amount of funding recommended by staff to obtain IAPD matching funds for FY 2020 is \$1,000,000.

ICN Project Support

The ICN initiatives were 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. The ICN initiative encourages collaboration between and among providers, provides a platform for provider and patient engagement, and allows for confidential sharing of information among providers. To succeed under the new Total Cost of Care Model, providers will need a variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

The intent is to transition funding for the administration of ICN projects to user fees. This transition began in FY 2019 and continues through FY 2022. This recommendation covers three components that are not currently funded by user fees, (1) funding of existing program administration during the transition to user fee funding (2) funding for enhancements to current administrative processes and (3) transitional funding for ICN related reporting. The existing programs recommended for funding are:

- Point of care tools provided to providers and care managers. Funding for these tools is scheduled to transfer to 100 percent CRISP user fee funding by FY 2022.
- Administration of existing Care Redesign Program tracks. These tracks will be 100 percent user fee funded beginning January 1, 2020.

The enhancements recommended for funding include developing and implementing streamlined administrative procedures and support for enhanced knowledge sharing tools in support of existing and future CRP programs.

The transitional funding represents funding for CRS reporting for the period prior to anticipated MMIS matching funds on October 1, 2019 at which point this reporting will be funded under the MMIS section of this recommendation

The total amount of funding recommended by staff for FY 2020 for ICN Project Support is \$2,200,000. Approximately \$800,000 of the funding is for activities already scheduled to transition to user fee funding in future fiscal years. Another \$750,000 represents CRS funding for the period prior to the transition to MMIS funding.

Medicaid Management Information Systems Matching Funds

A major component of the ICN project is the reporting provided by CRISP to hospitals, the HSCRC and other system stakeholders from both Medicare and All-Payer sources. CRISP expects to be able to transition funding for this reporting, previously funded by MHIP dollars, to matching grants under the Federal MMIS program beginning October 1, 2019. MMIS is a Federal program designed to promote effective care for Medicaid beneficiaries through

investments in information technology infrastructure. Medicaid benefits from CRISP’s reporting initiatives through the care management and cost control initiatives facilitated for all Medicaid patients under CRISP all-payer reporting and for dual-eligible patients under CRISP’s Medicare reporting.

Under MMIS, state funds are eligible for either a 90 percent match for new reporting initiatives or a 75 percent match for ongoing reporting. The assessment funding will provide the State’s portion of this match. Approximately \$560,000 relates to maintaining existing reporting infrastructure and is therefore eligible for a 75 percent match. The remainder of funds relates to new reporting initiatives which are eligible for a 90 percent match.

Reporting funded under this element of the assessment includes CRISP reporting tools utilizing the Medicare claims and the HSCRC’s hospital Casemix data set. CRISP reporting from these datasets are used by hospitals, the HSCRC and other stakeholders to manage and track progress under a number of HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

The total amount of funding recommended by staff for FY 2020 for to obtain Federal MMIS matching funds is \$690,000

SUMMARY

Staff is recommending the Commission approve a total of \$5,390,000 in funding through hospital rates in FY 2020 to support the HIE and IAPD initiative activities and continue the investments made in the ICN initiatives (previously funded through MHIP) through both direct funding and obtaining Federal MMIS matching funds.

Table 2 shows the recommended funding through hospital rates and the federal match that will be generated from the IAPD and MMIS funding as well as the user fee funding.

Table 2. FY 2020 Recommended Rate Support for CRISP as a share of total Funding

FY 2020 Project Name	Hospital Rates (State)	Budgeted Funding (Federal)	User Fees (primarily Hospitals)	Total
HIE Operations	\$1,500,000	--	\$3,772,000	\$5,272,000
IAPD Match	\$1,000,000	\$9,000,000	--	\$10,000,000
ICN Project Support	\$2,200,000	--	\$2,504,000	\$4,704,000
MMIS Match	\$690,000	\$2,790,000	--	\$3,480,000
Total funded	\$5,390,000	\$11,790,000	\$6,276,000	\$23,456,000
% of Total	23%	50%	27%	100%

Draft Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2020

May 8, 2019

Health Services Cost Review Commission
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This is a draft recommendation. Written comments should be submitted to erin.schurmann@maryland.gov no later than May 15, 2019.

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LIST OF ABBREVIATIONS

Delmarva	Delmarva Foundation for Medical Care
FY	Fiscal Year
HQI	Hospital Quality Initiative
HSCRC	Health Services Cost Review Commission
MAPSO	Mid-Atlantic Patient Safety Organization
MDH	Maryland Department of Health
MHA	Maryland Hospital Association
MHCC	Maryland Health Care Commission
MPSC	Maryland Patient Safety Center
NAS	Neonatal Abstinence Syndrome
RFP	Request for Proposals
TCOC	Total Cost of Care

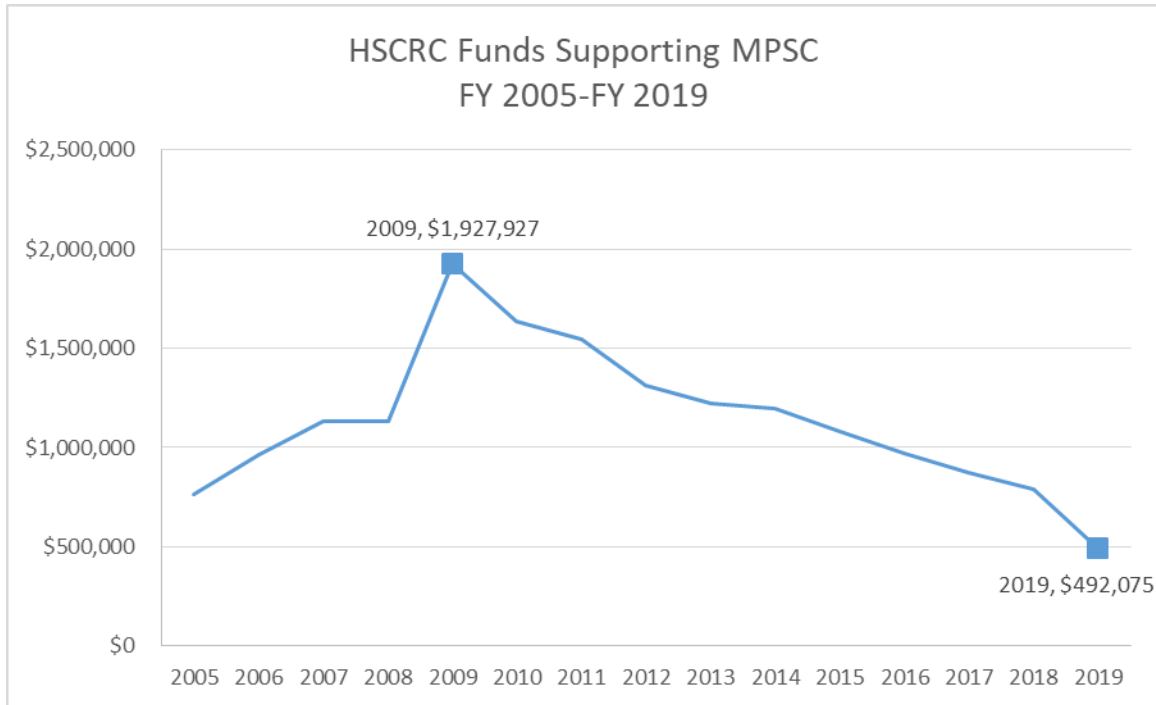
INTRODUCTION

In 2004, the Maryland Health Services Cost Review Commission (HSCRC or Commission) adopted recommendations to provide seed funding for the Maryland Patient Safety Center (MPSC) through hospital rates. The initial recommendations funded 50 percent of the reasonable budgeted costs of the MPSC. In FY 2019, HSCRC-dedicated funds accounted for 29 percent of its total budget. The proposed support for MPSC in FY 2020 represents 20 percent of the total budget. The HSCRC collaborates with MPSC on projects as appropriate, receives an annual briefing and documentation on the progress of the MPSC in meeting its goals, as well as an estimate of expected expenditures and revenues for the upcoming fiscal year. Based on the annual budget item information provided by the MPSC and staff experience, staff makes recommendations to the Commission regarding the continued financial support of the MPSC.

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

Over the past 15 years, the HSCRC included an adjustment to the rates of eight Maryland hospitals to provide funding to cover the costs of the MPSC. Funds are transferred biannually, by October 31 and March 31 of each year. Although funding increased between FY 2005 and FY 2009, the level of HSCRC support has declined each year since FY 2009, consistent with the original intent to scale back State-funded support. **Figure 1** below shows the funding level the HSCRC's in support of the MPSC.

Figure 1. HSCRC funds supporting MPSC FY2005-FY2019



In March 2019, the HSCRC received the MPSC program plan update for FYs 2019 and 2020. The MPSC is requesting a total of \$369,056 in funding support from the HSCRC for FY 2020, a 25 percent decrease over the previous year that is consistent with the Commission’s intent to reduce State funds over time and encourage a sustainable business model for the MPSC.

BACKGROUND

The 2001 General Assembly passed the Patients’ Safety Act of 2001,¹ charging the Maryland Health Care Commission (MHCC)—in consultation with the Maryland Department of Health (MDH)—with studying the feasibility of developing a system for reducing the number of preventable adverse medical events in Maryland, including a system of reporting such incidences. The MHCC subsequently recommended the establishment of the MPSC to improve patient safety in Maryland.

¹ Chapter 318, 2001 Md. Laws.

In 2003, the General Assembly endorsed this concept by including a provision in legislation to allow the MPSC to have medical review committee status, thereby making the proceedings, records, and files of the MPSC confidential and not discoverable or admissible as evidence in any civil action.²

The MHCC selected the Maryland Hospital Association (MHA) and the Delmarva Foundation for Medical Care (Delmarva) through the State's Request for Proposals (RFP) procurement process to establish and operate the MPSC in 2004, with an agreement that the two organizations would collaborate in their efforts. MHA and Delmarva jointly operated the MPSC from 2004 to 2009. The MPSC was then reorganized as an independent entity and was re-designated by the MHCC as the State's patient safety center starting in 2010 for two additional five-year periods. The MPSC has started the process to renew their designation as the State's patient safety center, which expires December 2019.

ASSESSMENT

Strategic Priorities and Partnerships

The MPSC's vision is to be a center of patient safety innovation, convening health care providers to accelerate understanding of, and implement evidence-based solutions for preventing avoidable harm. Its mission is to make healthcare in Maryland the safest in the nation.

The MPSC's goals are to:

- Eliminate preventable harm for every patient, with every touch, every time;
- Develop a shared culture of safety among patient care providers; and,
- Be a model for safety innovation in other states.

To accomplish its vision, mission, and goals, the MPSC established and continues to build new strategic partnerships with an array of key private and public organizations. The organizations represent a broad array of interests and expertise, including policymakers and providers across the continuum of healthcare quality, safety, and learning and education.

MPSC Members and Partnerships

- The MPSC has membership agreements with 42 member hospitals, representing \$400,000 in annual dues.

² MD. CODE. ANN., Health-Gen. § 1-401(b)(14);(d)(1).

- The Mid-Atlantic Patient Safety Organization (MAPSO), a component of the MPSC, includes 42 members representing hospitals, long-term care facilities, and ambulatory care facilities. The primary activities of the MAPSO are to improve patient safety and healthcare quality by collecting adverse event reports, and holding educational events for members.
- The MPSC includes 12 strategic partners:
 - Alliance for Innovation in Maternal Health
 - Health Facilities Association of Maryland
 - HQI
 - Johns Hopkins School of Medicine/The Armstrong Institute for Patient Safety and Quality
 - Lifespan
 - Maryland Ambulatory Surgical Association
 - Maryland Department of Health
 - Maryland Department of Human Services
 - MedChi
 - Maryland Hospital Association
 - NextPlane
 - PRONTO

Educational Programs and Conferences

- Customized educational programs for MPSC members driven by changing needs of members and the healthcare industry. Examples include root cause analysis, failure mode effects analysis, positive accountability, and appreciative inquiry.
- Expanded the reach of the MPSC and increased participation levels of member hospitals through educational opportunities.
- Convened the Annual Maryland Patient Safety Center Conference, which is the MPSC's signature event providing awareness, education, and information regarding best practice solutions.

Maryland Patient Safety Center Activities, Accomplishments, and Outcomes

Ongoing MPSC initiatives have engaged providers in hospitals, long-term care facilities, and ambulatory care facilities, as well as patients and consumers. MPSC uses a collaborative model to bring together providers from across the care spectrum to learn best practices to improve care and outcomes. MPSC is now using the Berkley Research Group to verify and analyze data collected from hospitals and other providers participating in MPSC initiatives.

Highlights from the data analyzed by MPSC include:

- Neonatal Abstinence Syndrome – The number of newborns with NAS that need to be transferred to a higher level nursery and specialty hospital decreased by 57 percent from 2016 to 2018. Length of stay for newborns decreased by 3 days, resulting in a cost avoidance of \$1.8 million from January to September 2018.
- Reducing First Time Cesarean Sections – From 2015-2018, 65 percent of hospitals participating in the collaborative experienced reductions in NTSV cesarean sections, resulting in a 5.1 percent aggregate decrease.
- Clean Collaborative – As measured in relative light units (RLUs), participating hospitals showed a 35 percent improvement in cleanliness and participating ambulatory surgery centers showed a 54 percent increase in cleanliness.

FY 2020 Quality and Safety Initiatives

The MPSC has a number of ongoing multi-year quality and safety initiatives, as well as new initiatives that will commence in FY 2020. At the suggestion of the Commission, the initiatives more closely track the quality goals of the TCOC Model.

New programming that addresses quality and safety issues in FY 2020 include:

- **Safe Infant Sleep** - The Maryland Patient Safety Center Neonatal Quality Collaborative is facilitating a collaborative to improve statewide infant safe sleep practices to reduce preventable sleep-related infant deaths in our state. All delivery hospitals in Maryland were invited to participate in the Maryland Patient Safety Center Safe Infant Sleep Project. The collaborative will run from March 2019 until February of 2021.
- **Obstetric Hemorrhage** - The Maryland Patient Safety Center will be offering a simulation workshop on conducting effective simulations and drills. The workshop will focus on helping participants run in situ simulations (i.e. simulations on actual L&D and postpartum units) to prepare their teams for obstetrical hemorrhage emergencies.
- **Obstetric Care for Women with Opioid Use Disorder** – The MPSC is joining a multi-state collaborative in collaboration with the Alliance for Innovation in maternal Health (AIM). MPSC will coordinate the activities in Maryland utilizing the AIM bundle of best practices. The collaborative will run for two years - from February 2019 to January 2021.

Ongoing initiatives that will continue in FY 2019 include:

- **Opioid Education for Consumers** – In response to the statewide opioid addiction epidemic, the MPSC has partnered with MHA and MedChi to conduct a patient-centered statewide public awareness campaign aimed at educating

consumers on opioid use. Topics include reasonable pain management expectations, the pros and cons of opioid use, opioid prescription storage and disposal, and important questions to ask when being prescribed an opioid medication. MPSC has presented the opioid education program to over 800 individuals in 12 jurisdictions.

- **Adverse Event Reporting:** Initiated in July 2016, the Adverse Event Reporting initiative identifies trending patient safety issues, such as medication errors, at select Maryland hospitals. Data collected on adverse events help to determine future programming and educational needs for Maryland hospitals.
- **Diagnostic Errors:** A study group will explore the role that the MPSC could take in the emerging work on diagnostic errors

FY 2020 Projected Budget

The MPSC continued to work with its partners to secure program-specific funding for FY 2020 and estimated the amounts it will secure for FY 2020 in the proposed budget outlined in Figure 2 below, including potential funds from the HSCRC. Consistent with FY 2019, the majority of the revenue anticipated in FY 2020 are derived from membership dues and conference revenue. In FY 2019, HSCRC funding accounted for 29 percent of its operating expenses. If approved, the FY 2020 HSCRC funding will account for approximately 20 percent of the total MPSC expenses.

During FY 2019, the MPSC made progress bolstering its other revenue streams, of which key ones are listed below. Diversifying the revenue stream for MPSC is crucial to the long-term sustainability of the Center in order to create stability in fiscal planning and to move away from the reliance on rate setting funds.

- **Caring for the Caregiver** – MPSC implemented Caring for the Caregiver program in 11 states and expects to close FY 2019 with \$254,500 in gross sales.
- **Patient Safety Certification** – MPSC implemented the Patient Safety Certification in two hospitals and one post-acute facility with \$84,500 in gross sales in YTD in FY 2019.
- **Lean Daily Management** – This is a new initiative in FY 2020 that MPSC expects to generate an additional \$34,000 in additional revenue. Lean Daily Management, which is based on the widely-used Toyota Production System, provides tools to encourage hospitals to optimize both quality and cost through streamlining activities and eliminating waste in healthcare delivery.
- **TeamSTEPPs** – This is a new initiative in FY 2020 that the MPSC expects to generate \$130,000 in additional revenue. TeamSTEPPs aims to improve patient outcomes through improving communication and teamwork between healthcare providers.

Figure 2. Proposed MPSC Revenue and Expenses

Maryland Patient Safety Center, Inc. Statement of Income and Expenses Budget FY19 and Proposed FY20	FY 2019 Total Budget	FY 2020 Proposed Total Budget
Restricted Fund Beginning Balance as of 7/1/2018	0	0
Restricted/Temp Restricted Grant Revenue	200,000	359,500
Net Assets Released from Restriction	(200,000)	(356,167)
Change in Restricted/Temp Restricted Net Assets	0	3,333
Ending Restricted/Temp Restricted Fund Balance	0	3,333
Unrestricted Fund Beginning Balance as of 7/1/2018		
Board Designated Operating Reserve	174,344	174,344
Unrestricted Net Assets	1,675,306	1,699,262
Total	1,849,650	1,873,606
<u>Unrestricted Revenue</u>		
HSCRC Hospital Contributions	492,075	369,056
Membership Dues	375,000	400,000
Education Session Revenue	22,000	19,750
Annual Patient Safety Conference Revenue	210,000	200,000
Medsafe Revenue	4,000	10,000
Program Sales - Caring for HC	137,750	175,000
Program Sales - Patient Safety	125,000	100,000
Program Sales - Team STEPPS	25,000	125,000
Program Sales - Lean Daily Management	0	25,000
Care Alerts Collaborative Revenue	27,600	8,494
Other Grants & Contributions	50,000	0
Net Assets Released from Restriction	200,000	356,167
Total Unrestricted Revenue	1,668,425	1,788,467
<u>Unrestricted Expenses</u>		
Administration	387,800	409,646
Education Sessions	35,250	32,750
Annual Patient Safety Conference	315,500	287,500
Medsafe Medication Safety Initiative	22,750	21,500
Caring for HC	110,888	158,457
Safe Sleep	0	156,167
Patient Safety Training & Certification	81,500	90,733
Team STEPPS	0	130,191
Lean Daily Management	0	33,908
Adverse Event Reporting System	34,500	34,500
Perinatal/Neonatal Patient Safety Collaboratives	205,082	200,000
OB Hemorrhage	0	58,000
Clean Environment	80,000	0
Medication Reconciliation	24,500	0
Diagnosis Errors	48,500	66,900
Opioid Misuse	131,400	60,100
Joy & Meaning	50,700	15,000
Emergency Department	88,500	0
Care Alerts Collaborative	27,600	8,494
Total Unrestricted Expenses	1,644,470	1,763,845
Change in Unrestricted Net Assets	23,956	24,622

MPSC Return on Investment

As noted in the last several Commission recommendations, the HSCRC provides funding for the MPSC with the expectation that there will be both short- and long-term reductions in Maryland healthcare costs, particularly related to such outcomes as reduced mortality rates, lengths of stay, patient acuity, and malpractice insurance costs. The MPSC must continue to collect data on its programs in order to show quantifiable improvements in patient safety and outcomes and share best practices.

Additional data on all of the MPSC's programs is needed to ensure that the limited dollars available for MPSC funding creates meaningful improvements in quality and outcomes at facilities in Maryland to achieve the goals of the Total Cost of Care Model. Beginning in FY 2018, MPSC engaged the work of the Berkley Research Group to collect and analyze data from hospitals participating in MPSC programs or initiatives. The MPSC should continue to report results from its initiatives to HSCRC staff.

RECOMMENDATIONS

Quality and safety improvements are the primary drivers to achieve the goals of reduced potentially avoidable utilization and reduced complications in acute care settings under the TCOC Model. For these reasons, it is important to continue to support hospitals in identifying and sharing best practices to improve patient quality and outcomes. While individual hospitals across the State are experimenting with strategies to improve care coordination, enhance processes for better care, and advance systems and data sharing to maximize the efficiency and effectiveness of care, the MPSC is in a unique position to convene healthcare providers and share best practices that have been identified through multi-provider collaborative testing and change. The key stakeholders that are involved with the MPSC include hospitals, patients, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the Total Cost of Care Model. The MPSC is in a favorable position in the State to develop and share best practices among this group of key stakeholders. To support the overall mission of the State, the MPSC should align initiatives with the broader statewide plan and activities for patient safety.

In light of the information presented above, HSCRC staff provides the following recommendations for the MPSC funding support policy for FY 2020:

1. Consistent with the prior Commission recommendations, the HSCRC should reduce the amount of funding support for the MPSC in FY 2020 by 25 percent. The result is an adjustment to hospital rates in the amount of \$369,056 in FY 2020, a 25 percent reduction from FY 2019.
2. In order to receive future funding from the hospital rate setting system, the MPSC should continue to report on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.

3. Going forward, the HSCRC should decrease the amount of support by 25 percent per year in order to achieve the goal of independent sustainability for MPSC.
4. The MPSC should continue to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs.

Draft Recommendation
Changes to Relative Value Units for Emergency Services
Effective July 1, 2019

May 8, 2019

Health Services Cost Review Commission

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This is a draft recommendation for Commission consideration at the May 8, 2019 Public Commission Meeting. Please submit comments on this draft to the Commission by Friday, May 31, 2019, via hard copy mail or email to William Hoff, William.Hoff@maryland.gov.

Draft Staff Recommendation

May 8, 2019

Recommendation

The Commission staff recommends for review and public comment revisions to the Relative Value Unit (RVU) Scale for Emergency Services. The revisions are specific to the Chart of Accounts and Appendix D of the Accounting and Budget Manual. These revised RVUs were developed by a workgroup established by the Health Services Cost Review Commission, and membership included representatives of Maryland Hospital Association, Maryland Hospitals, Maryland Insurance Industry and Consultants. The RVU scale was updated to reflect the revisions to the Current Procedural Terminology (CPT) codes mandated by the American Medical Association. At your direction, the staff will send the revisions to all Maryland Hospitals for their Review and Comments.

**SECTION 200
CHART OF ACCOUNTS**

6710 EMERGENCY SERVICES

6711 Emergency Room

6719 Other Emergency Services

Function:

Emergency Services provide emergency services to the ill and injured who require immediate medical or surgical care on an unscheduled basis. (See Appendix D for definition of services)

Description

This cost center contains the direct expenses incurred in providing services in the Emergency Department. Direct expenses included are: salaries and wages, employee benefits, professional fees (non-physician), non-medical supplies, purchased services, other direct expenses.

Standard Unit of Measure: Number of Relative Value Units

Relative Value Units as determined by the HSCRC. (See Appendix D of this manual)

Data Source

The number of Relative Value Units shall be the actual count maintained by Emergency Services.

Reporting Schedule

Schedule D – Line D19

**REVISED APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
EMERGENCY SERVICES**

Account Number
6710

Cost Center Title
Emergency Services

Cost Center Code
EMG

EMG

HSCRC abbreviation for Emergency Department

Relative Value Units (RVUs)

A standard unit of measure. A unique value or weight assigned to a specific service, e.g., number of visits for a particular hospital unit.

The RVUs for this cost center are based on resource consumption. Each facility is expected to develop, retain, and maintain Internal Guidelines, which identify the resources consumed. These resources may include but are not limited to time, staff intervention, complexity, patient severity, etc. The facility's Internal Guidelines are to be used for the purpose of maintaining Service Level reporting consistency among patients receiving comparable or similar treatment/care/resource consumption; and that patients receiving greater (or lesser) treatment/care/resource consumption would be assigned an appropriately higher (or lesser) Service Level.

General Guidelines

1. There is a direct relationship between the amounts of EMG resources consumed by a patient and the Service Level assigned to the patient.
2. The facility will prepare, record, and maintain appropriate documentation to support and justify the EMG Service Level assigned. If a service or task is not documented, then that service or task cannot be included in the determination of the Service Level assignment. Patients are not to be charged, nor RVUs reported for a service or task that is not documented.
3. The facility's Internal Guidelines may not be totally inclusive or explanatory. It is recognized that the circumstance of the visit and the EMG Service Level selected will involve a degree of clinical judgment and patient acuity. It is recommended that each facility's Internal Guidelines include an analysis of resource use and the services provided by EMG staff. The format and content are at the facility's discretion.
4. Charges for EMG services are a by-product of all expenses and RVUs assigned to the EMG department. Ancillary services can be provided within the EMG area (e.g., laboratory, radiology, respiratory, etc.). If the cost of providing an ancillary service in the EMG is assigned to the ancillary center, regulated charges for that ancillary service must be included in the patient bill. However, if the cost associated with an ancillary service is assigned to the EMG department (e.g., an EMG registered nurse or other EMG personnel providing respiratory care or specimen collection), then the cost associated with the service is part of the EMG determination of Service Level. It is recommended that this distinction be part of the facility's Internal Guidelines.
5. EMG patients will be assigned a Service Level based on total resources consumed, from the EMTALA Medical Screening Examination to final patient disposition.
6. In addition to EMG Service Level charge, the hospital will charge separately for drugs, supplies, and ancillary services (as noted in 4 above). Professional fees are not regulated by the HSCRC and therefore are not included in the hospital's charges. Professional fees would be a separate charge.

**REVISED APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
EMERGENCY SERVICES**

<u>CPT Services Levels</u>	<u>RVU</u>
99281 Level I/ EMTALA (Medical Screening Examination)	1
99282 Level II	1
99283 Level III	2
99284 Level IV	4
99285 Level V	7
99291 Level V	7

ECS (Extended Care Services) - The RVUs assigned are based on clock time.
1 RVU per 2 hours period up to 48 hours.

Extended Care Service

- This service is associated with outpatients who have received EMG services and are awaiting transfer/discharge to another facility some examples includes; tertiary care facility, nursing home, inpatient psychiatric facility, and etc.. The services being provided to the patient during ECS may or may not be minor.
- This is an add-on RVU to Level V only (e.g., ECS RVUs may be added to the Treatment Level V RVUs) and is for services provided AFTER EMG Treatment.
- If the services provided during ECS are major, the Service Level may be increased.
- Extended Care Services are based on "clock time". For each full two hour period of clock time, one (1) RVU is assigned. Any partial hours are rounded down to the nearest full two hour period. For example, two hours and five minutes is reported as two hours = one RVU. Two hour and fifty-five minutes is reported as one two hours period = one RVU.
- To qualify for ECS reporting, the patient must be an outpatient and must be transferred to another facility. The transfer must be fully documented in the medical record.

REVISED APPENDIX D
STANDARD UNIT OF MEASURE REFERENCES
EMERGENCY SERVICES

- Below are four examples of the proper reporting of Extended Care Service:
 1. A trauma patient begins his EMG visit at noon. The resources utilized resulted in a Level V service being assigned. The patient is stabilized and is to be transferred to a trauma facility. The time is now 12:55 pm. Because of inclement weather conditions, the transfer is delayed for four and one half (4.5) hours. The reporting of RVUs would be as follows: EMTALA one RVU plus service Level V seven RVUs , plus ECS for 4 hours = 2.0 RVUs (rounded down to four hours from the actual of four and one half hours (4.5), the total RVUs reported would be 10).
 2. A trauma patient begins his EMG visit at noon. The resources utilized resulted in a service Level III being assigned. The patient is stabilized and is to be transferred to a trauma facility. The time is now 12:45 pm. The patient is immediately transferred to another facility. The reporting of RVUs would be as follows: EMTALA one RVU plus service Level III two RVUs. There are no ECS RVUs reported, since the reported Level was something other than Level V.
 3. A trauma patient begins his EMG visit at noon. The patient is stabilized and is to be transferred to a trauma facility. The resources utilized resulted in a service Level IV being assigned. The time is now 1:00 pm. Because of inclement weather conditions, the transfer is delayed for four and one half (4.5) hours. The reporting of RVUs would be as follows: EMTALA one RVU plus service Level IV four RVUs. There is no ECS RVUs reported, since the reported Level was something other than Level V.
 4. A trauma patient begins his EMG visit at noon. The patient is stabilized and is to be transferred to a trauma facility. The resources utilized resulted in a service Level III being assigned. Because of inclement weather conditions, the transfer is delayed for nine (9.0) hours and is transferred at 9:00 P.M. Major resources were utilized the first three hours of the delay and the service level was increased to Level V. The remaining six (6) hours of the delay is now considered ECS. The reporting of RVUs would be a follows, EMTALA one RVU plus services Level V 7 RVUs., plus ECS for 6 hours 3 RVUs, the total RVUs would be 11 RVUs.

Policy Update Report and Discussion

Staff will present materials at the Commission Meeting.

State of Maryland
Department of Health



Nelson J. Sabatini
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

John M. Colmers

James N. Elliott, M.D.

Adam Kane

Jack C. Keane

Katie Wunderlich
Executive Director

Allan Pack, Director
Population Based
Methodologies

Chris Peterson, Director
Payment Reform &
Provider Alignment

Gerard J. Schmith, Director
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Compliance

William Henderson, Director
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Health Services Cost Review Commission

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TO: Commissioners

FROM: HSCRC Staff

DATE: May 8, 2019

RE: Hearing and Meeting Schedule

June 12, 2019 To be determined - 4160 Patterson Avenue
HSCRC/MHCC Conference Room

July 10, 2019 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://hsrc.maryland.gov/Pages/commission-meetings.aspx>.

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