



# Monitoring Maryland Performance Financial Data

Year to Date thru April 2016



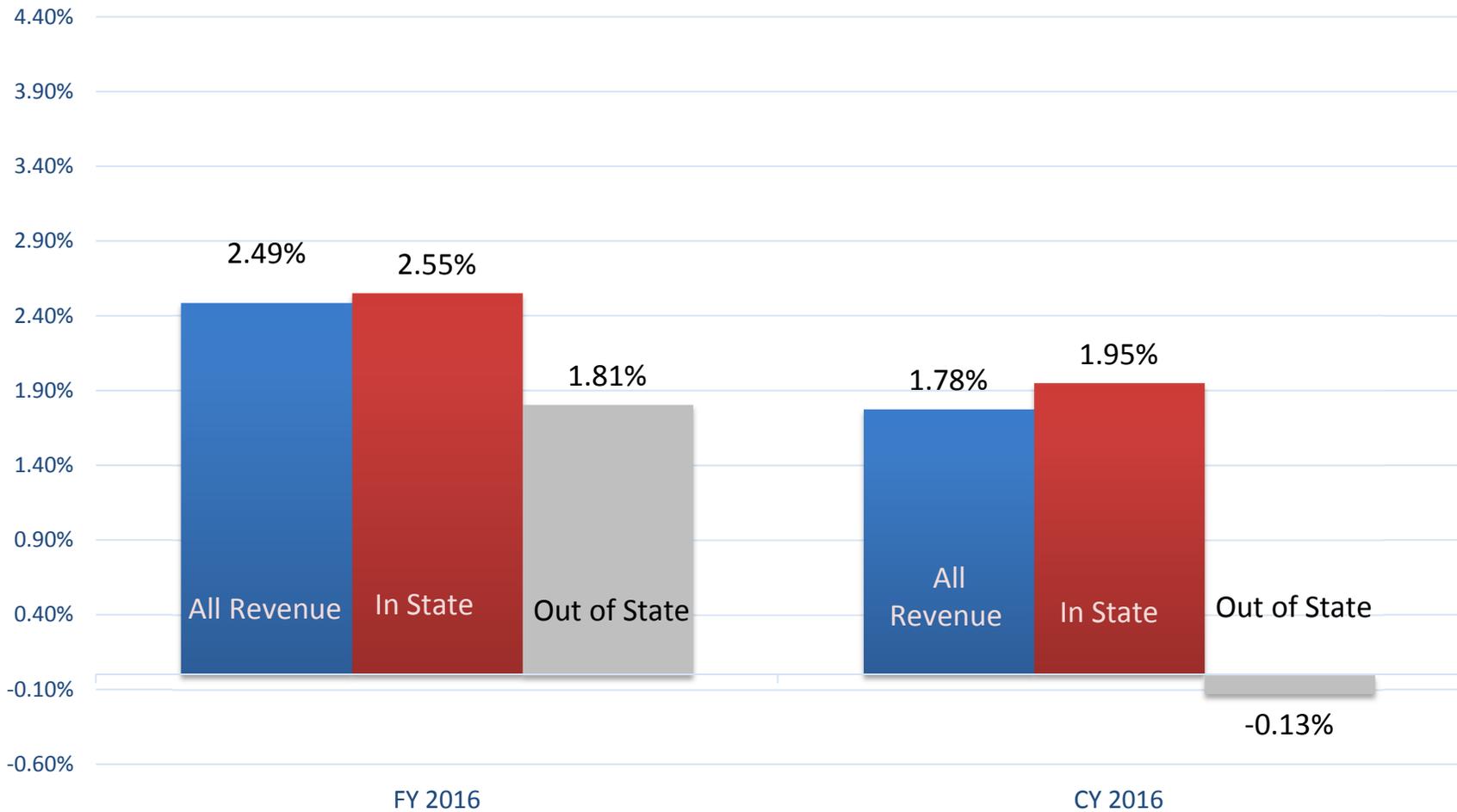
**HSCRC**

Health Services Cost  
Review Commission

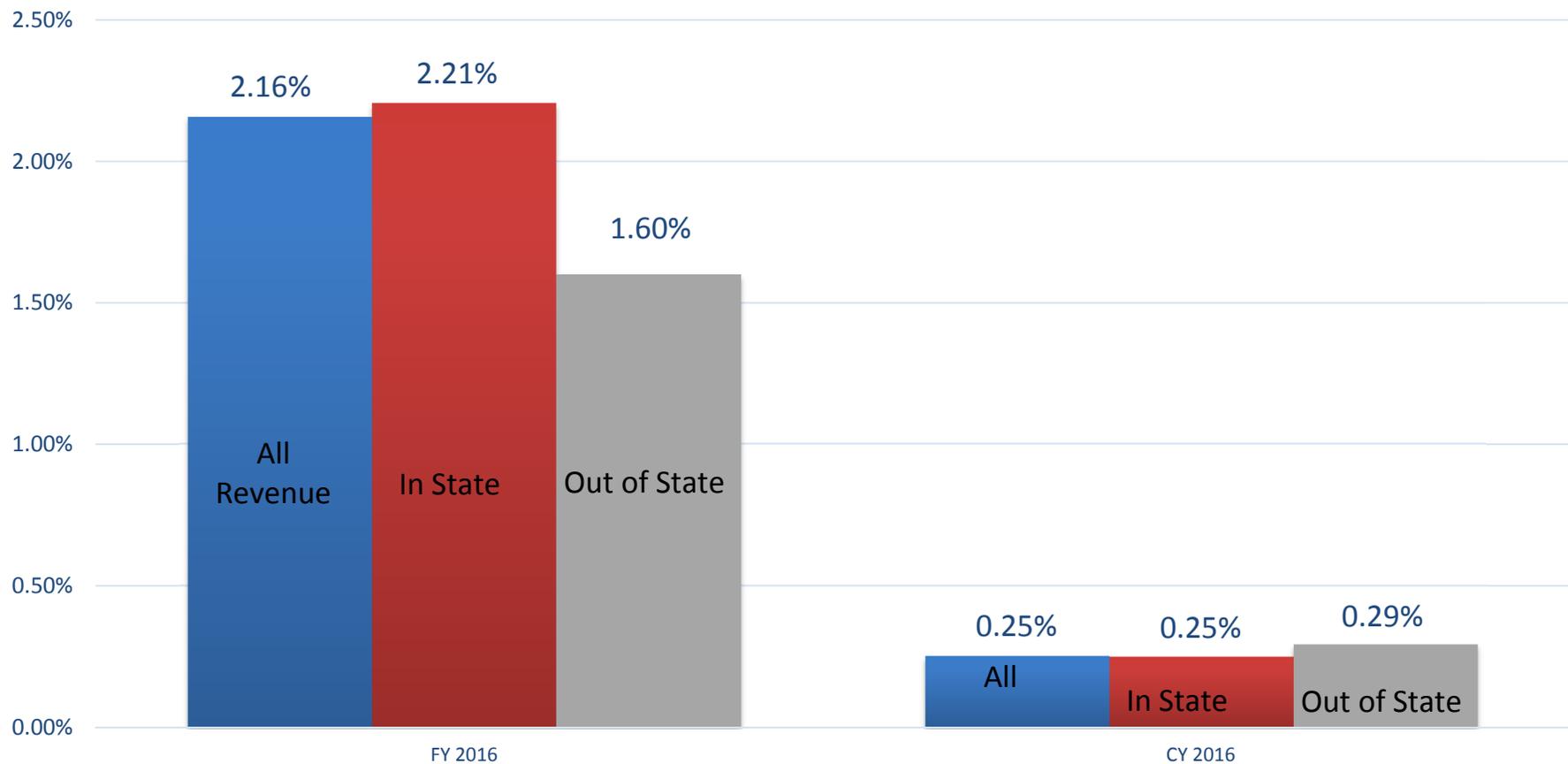
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## Gross All Payer Revenue Growth

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

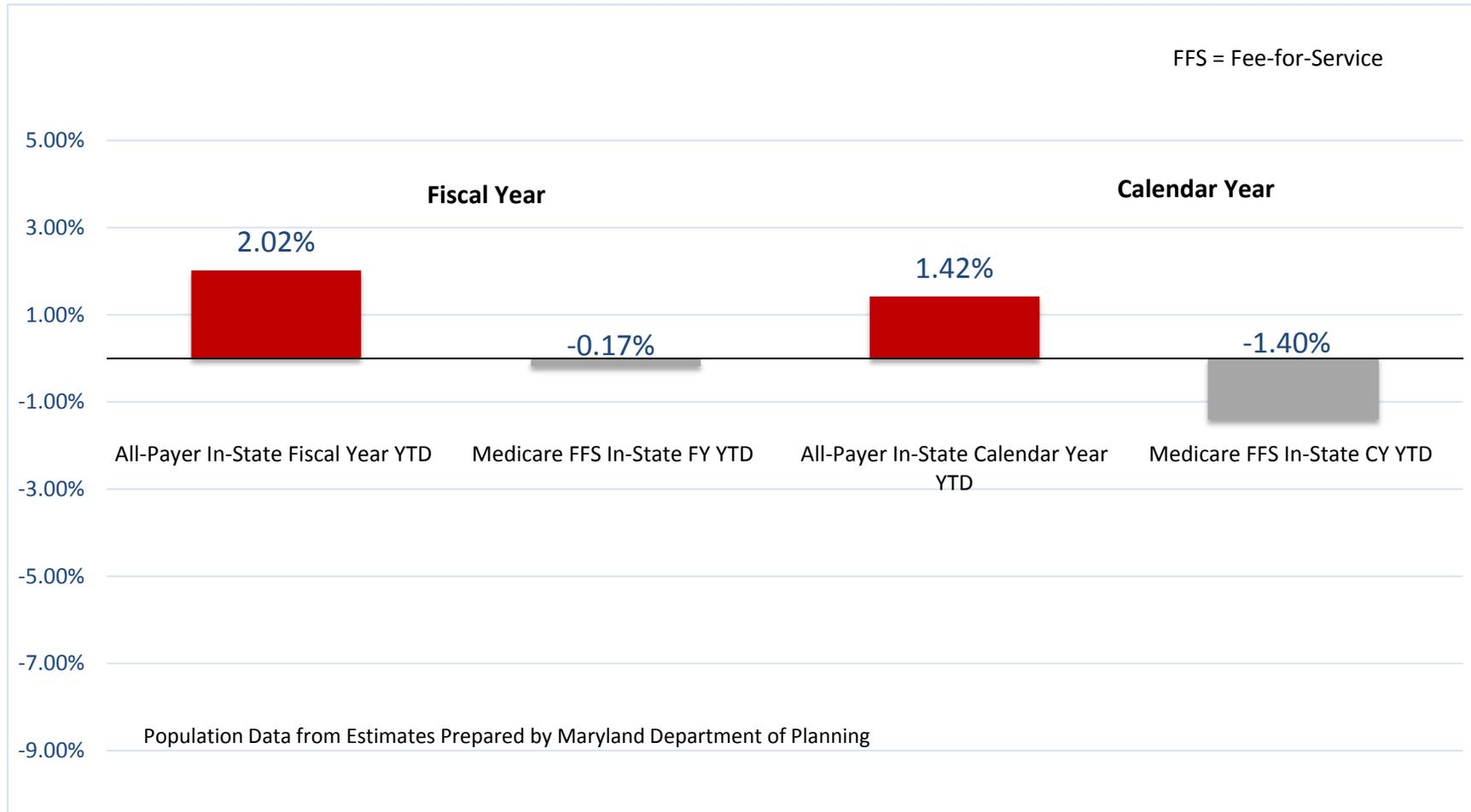


## Gross Medicare Fee-for-Service Revenue Growth Year to Date (thru April 2016) Compared to Same Period in Prior Year



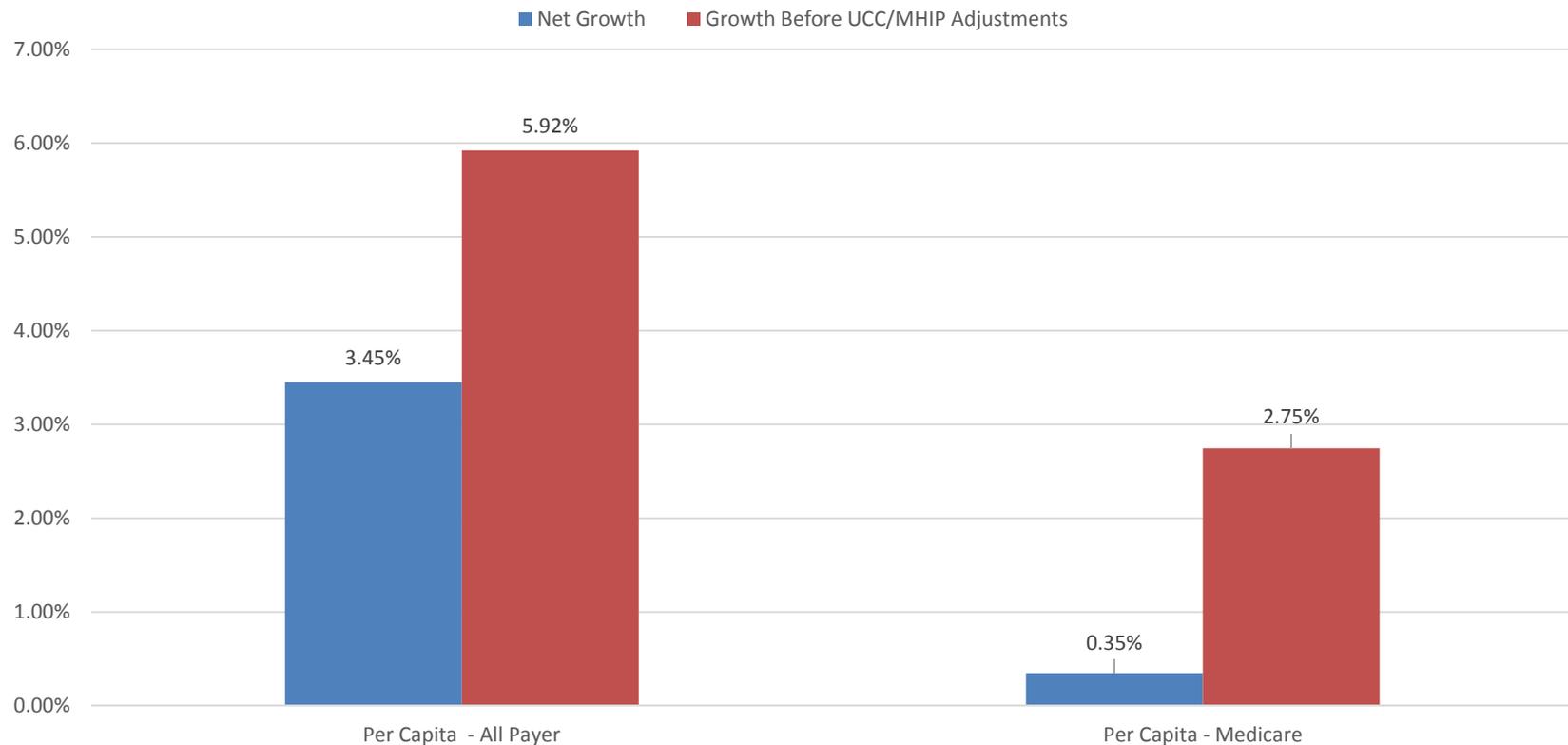
# Per Capita Growth Rates

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



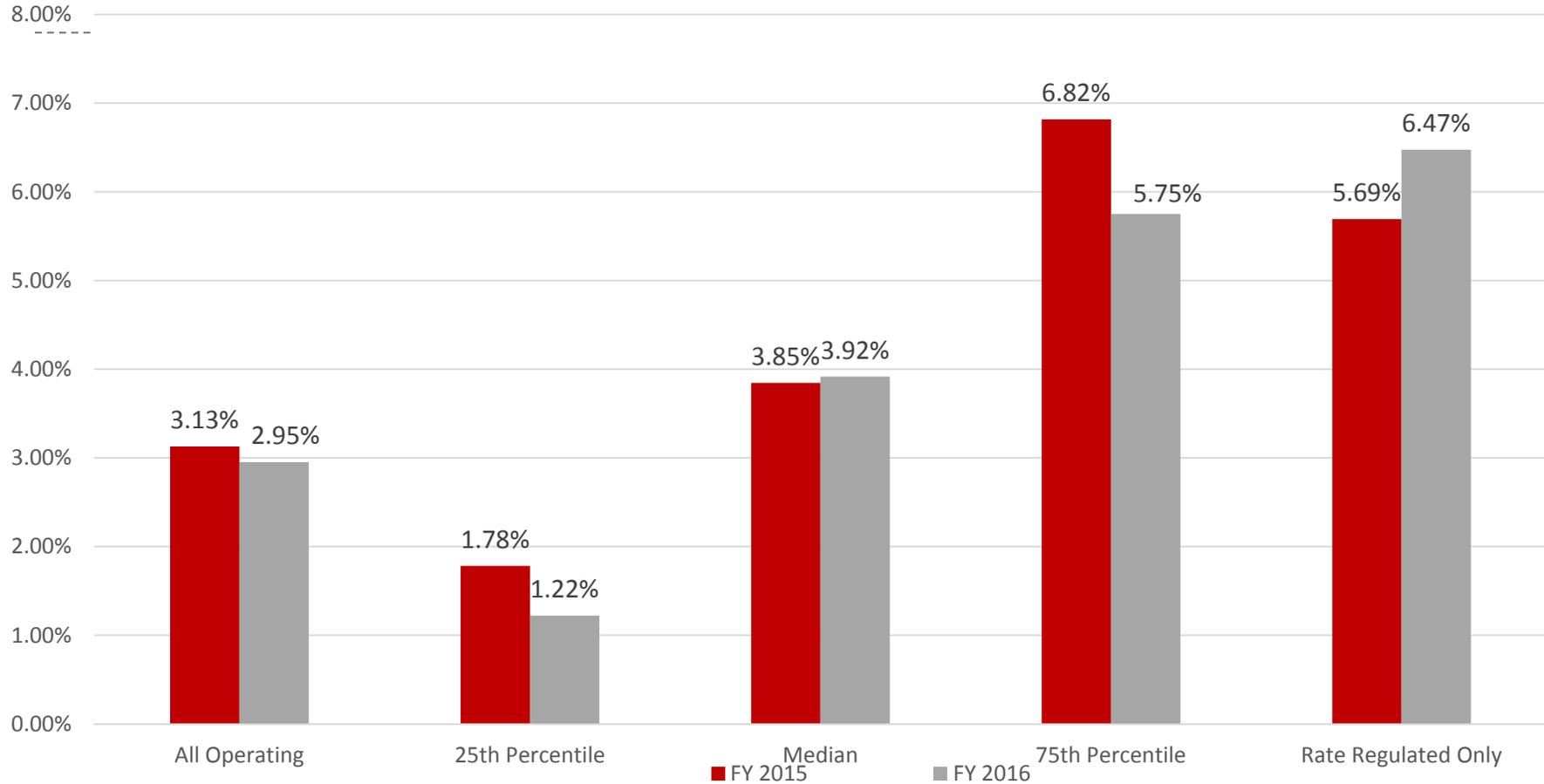
- Calendar and Fiscal Year trends through April are below All-Payer Model Guardrail of 3.58% per year for per capita growth.**

## Per Capita Growth – Actual and Underlying Growth CY 2016 Year to Date Compared to Same Period in Base Year (2013)



- ▶ Three year per capita growth rate is well below maximum allowable growth rate of 11.13% (growth of 3.58% per year)
- ▶ Underlying growth reflects adjustment for FY16 revenue decreases that were budget neutral for hospitals. 2.52% hospital bad debts and elimination of MHIP assessment.

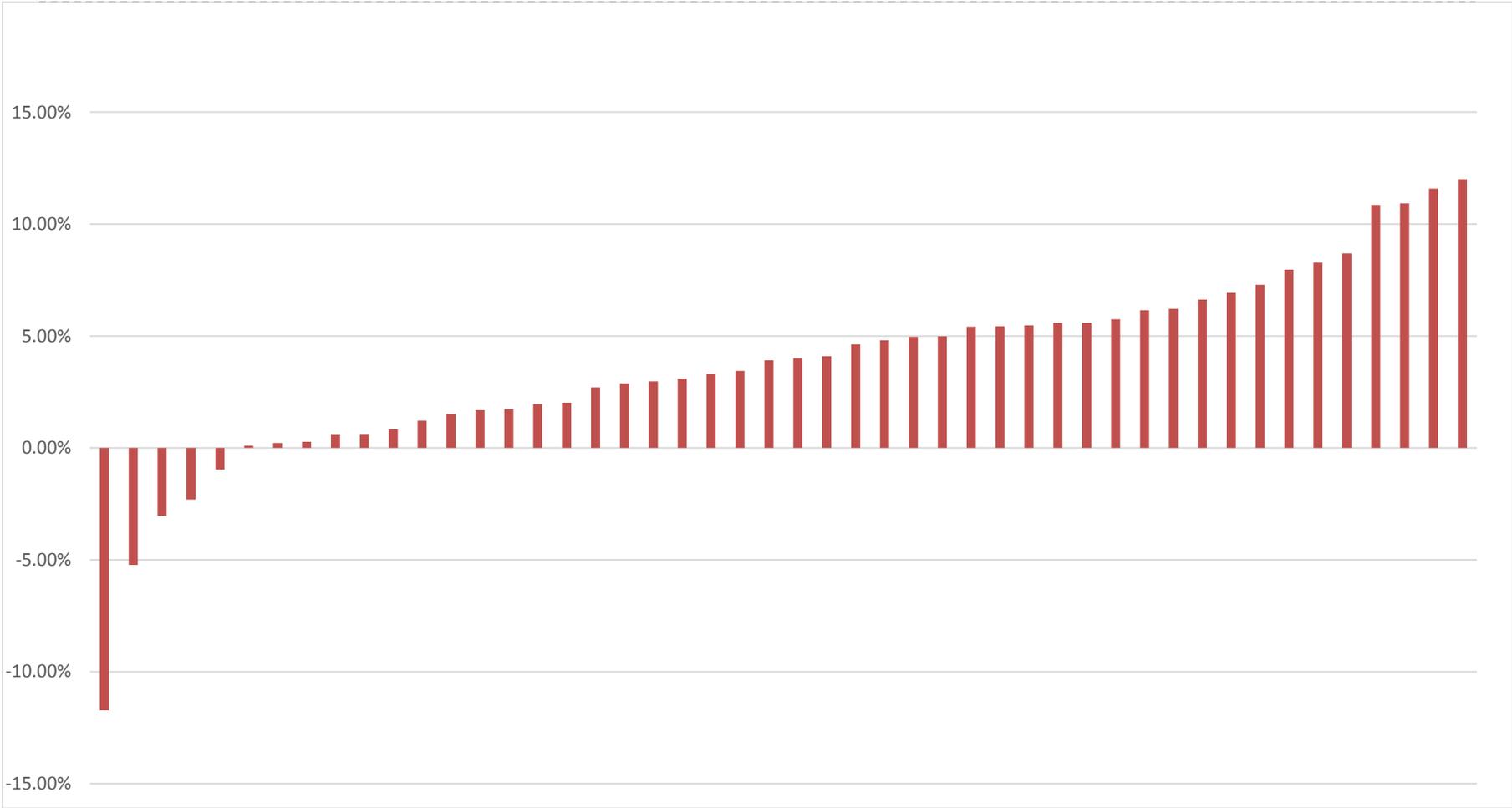
## Operating Profits: Fiscal 2016 Year to Date (July-April) Compared to Same Period in FY 2015



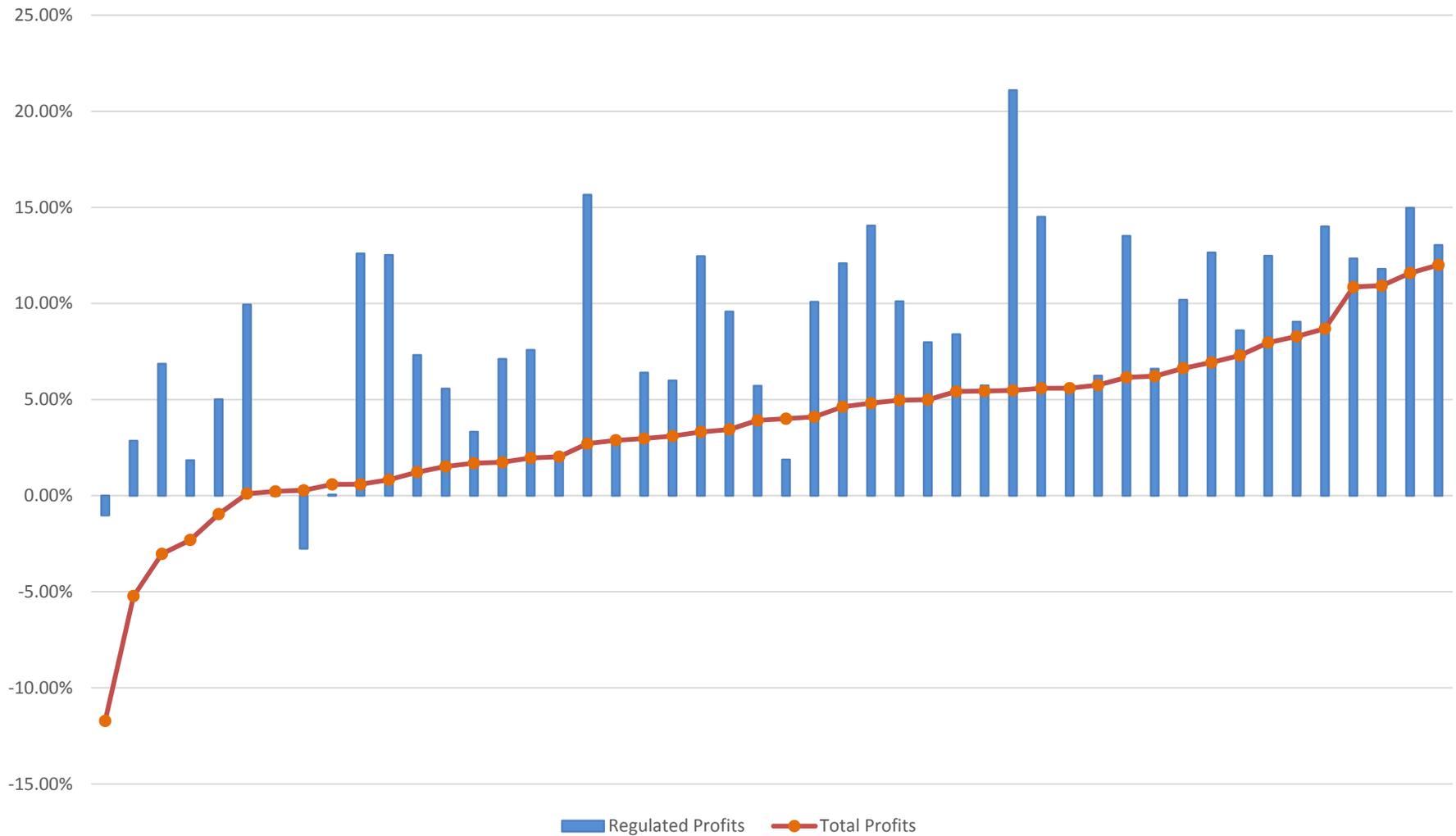
- Year to date FY 2016 unaudited hospital operating profits show a .18% decrease in total profits compared to the same period in FY 2015. Rate regulated profits have increased by .78% compared to the same period in FY 2015.

# Total Operating Profits by Hospital

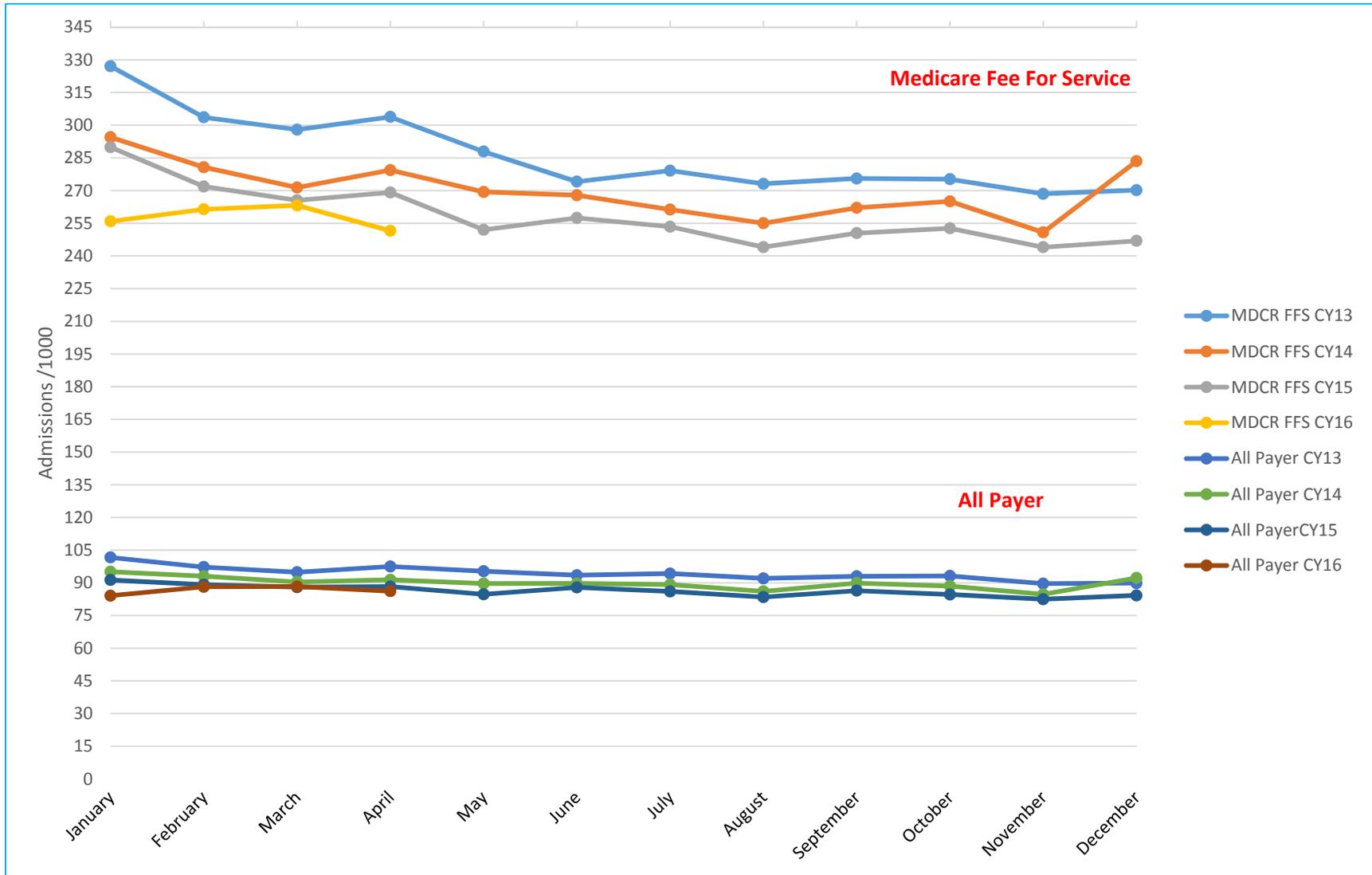
Fiscal Year 2016 to Date (July 2015 – April 2016)



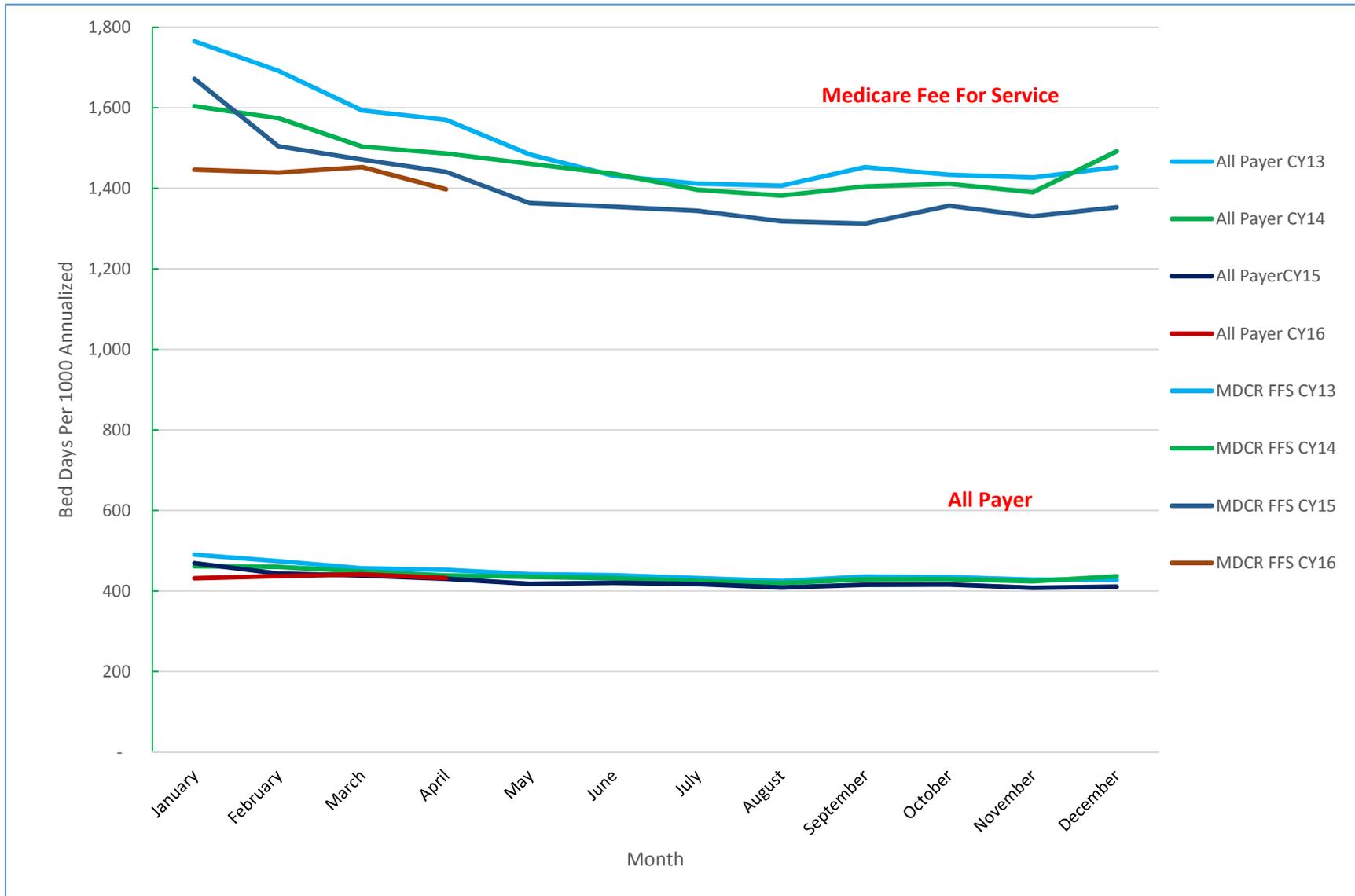
# Regulated and Total Operating Profits by Hospital Fiscal Year to Date (July – April 2016)



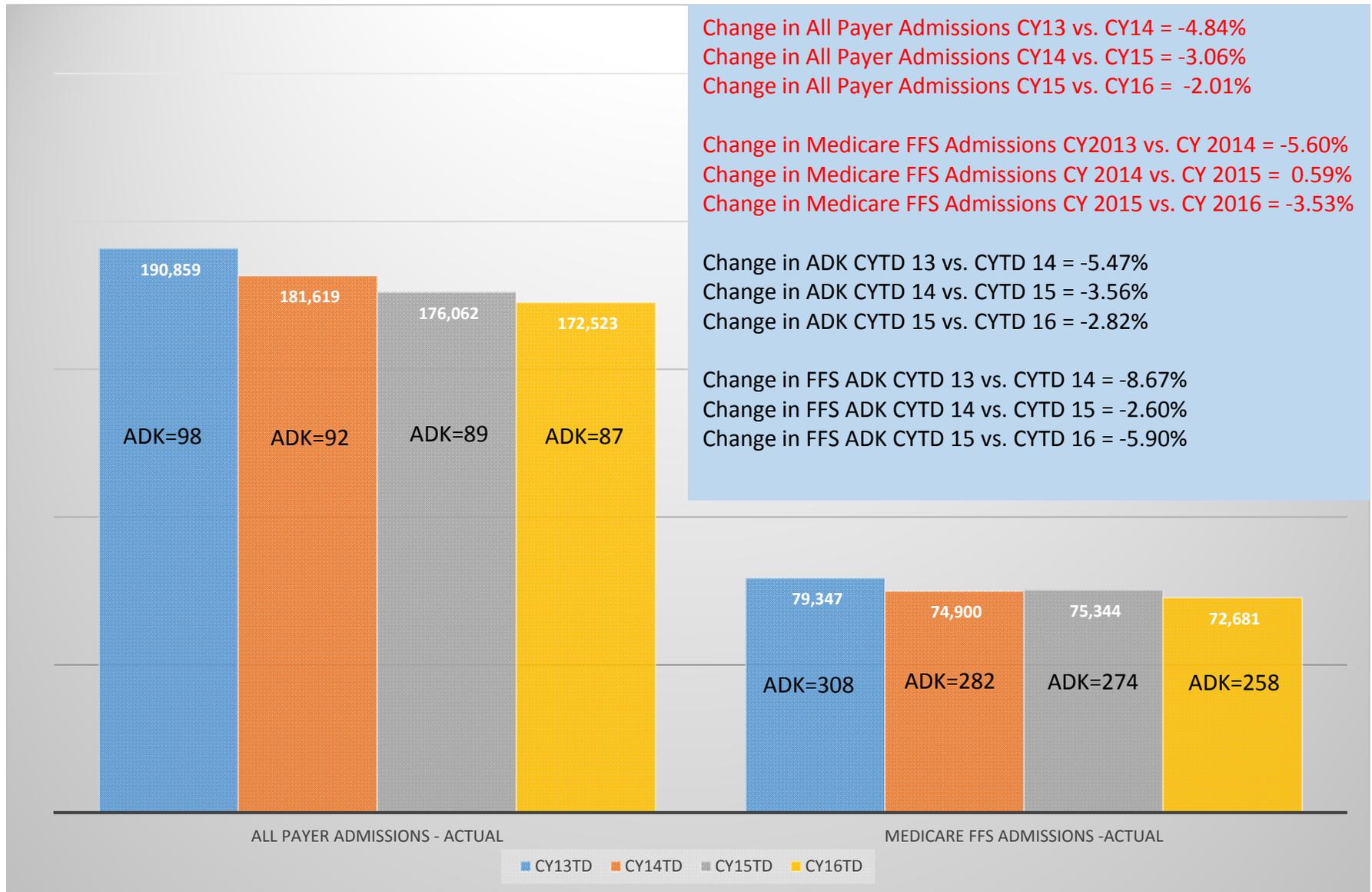
## Admissions/1000 Annualized Medicare FFS and All Payer



## Bed Days/1000 Annualized All Payer and Medicare FFS



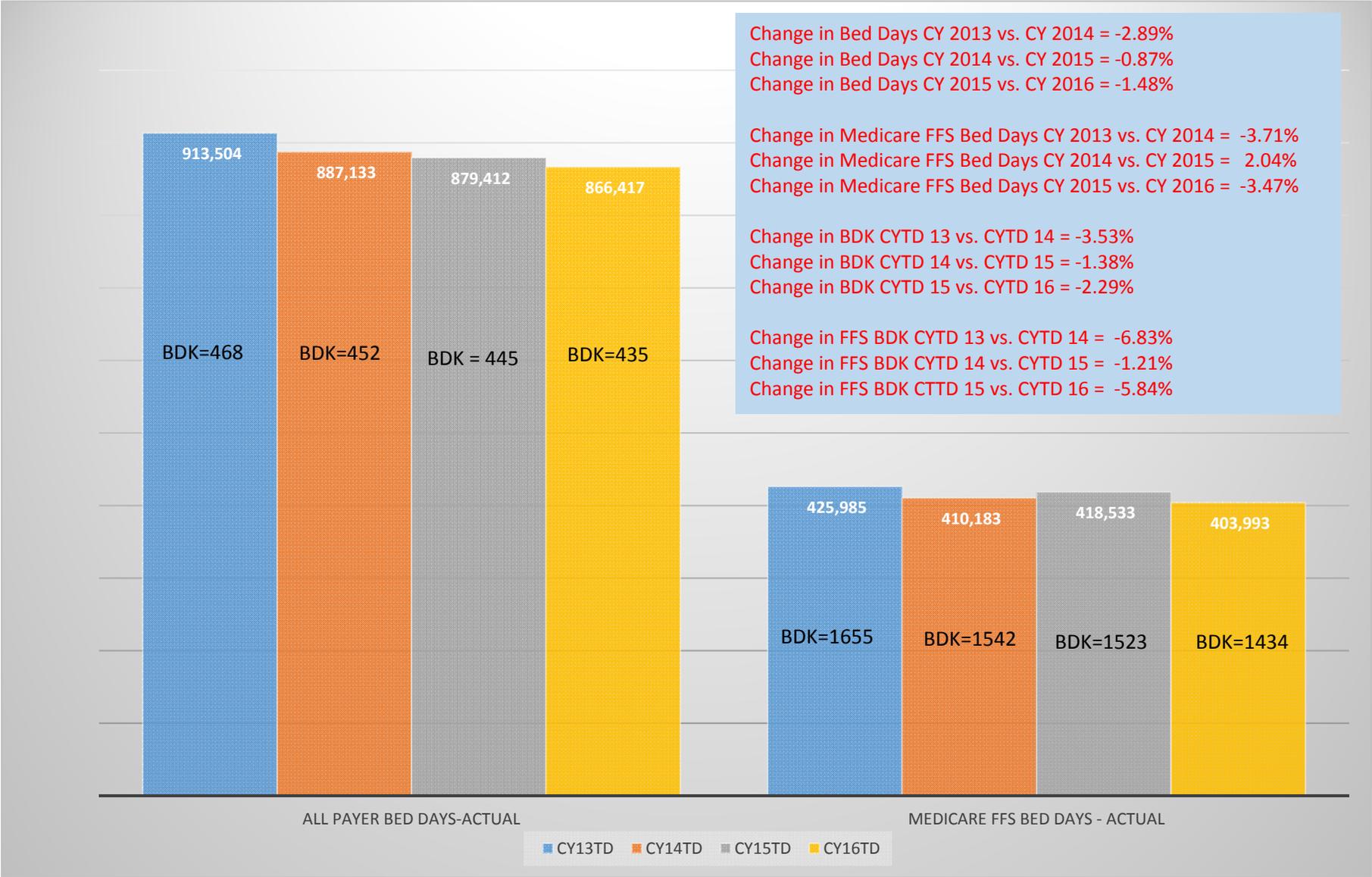
## In State Admissions by CYTD through April 2016



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

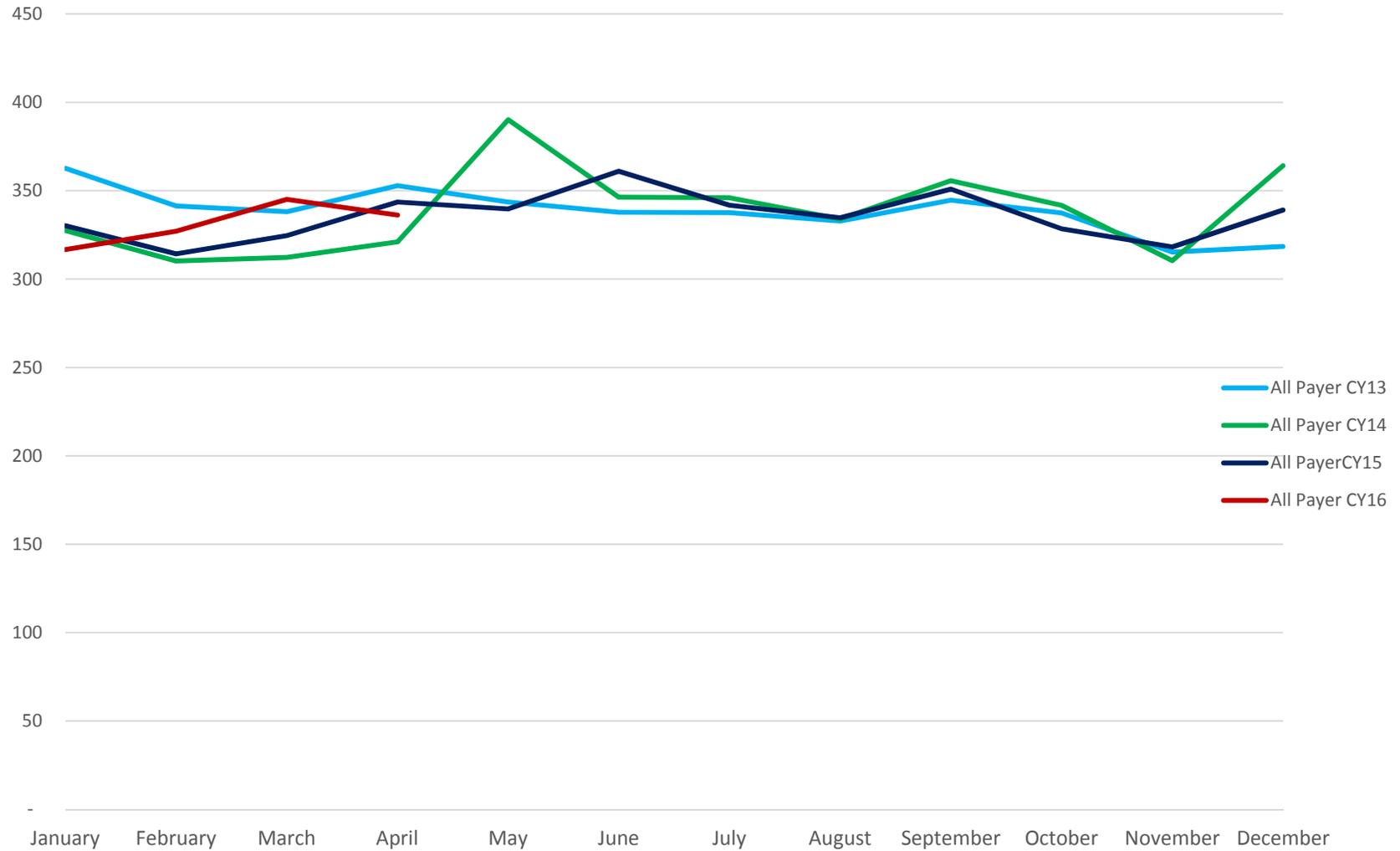


# In State Bed Days by CYTD through April 2016



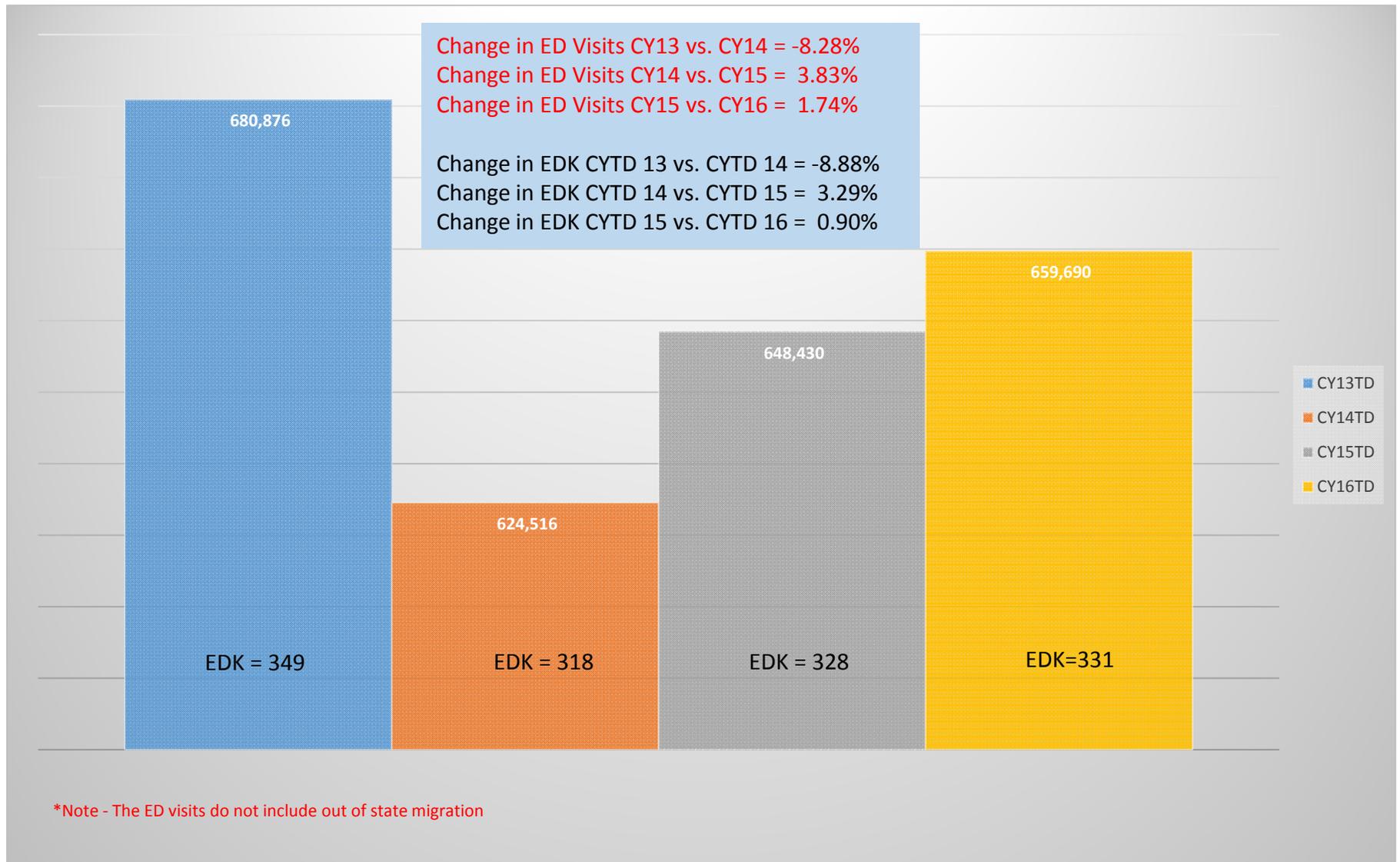
\*Note – The bed days do not include out of state migration or specialty psych and rehab hospitals.

### In State All Payer ED Visits Per 1000 Annualized



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

# Actual All Payer ED Visits by Calendar YTD through April 2016



## Purpose of Monitoring Maryland Performance

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

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

# Data Caveats

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

## Data Caveats cont.

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



# Monitoring Maryland Performance Utilization Trends

2016 vs 2015  
(January to March Preliminary Data)

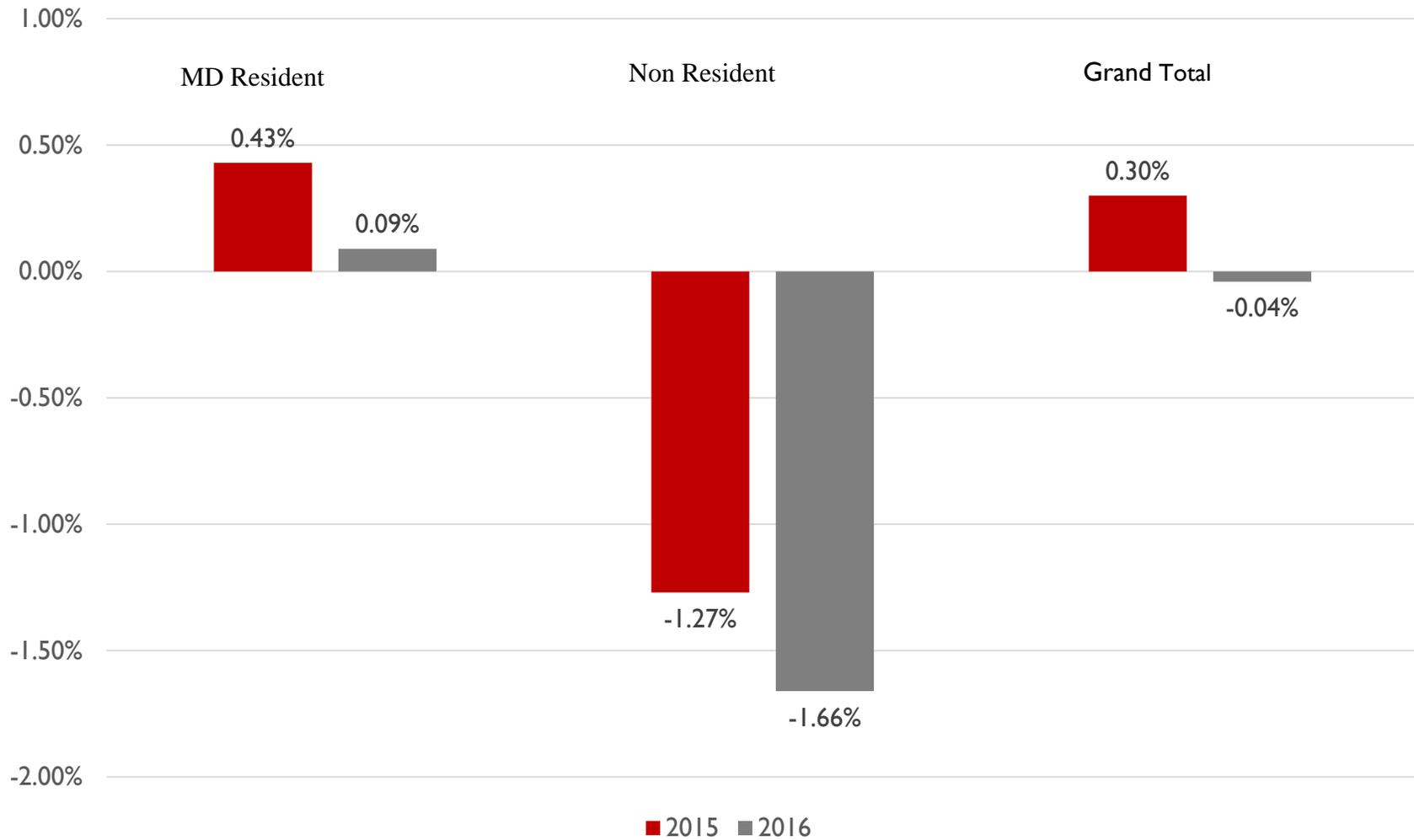


**HSCRC**

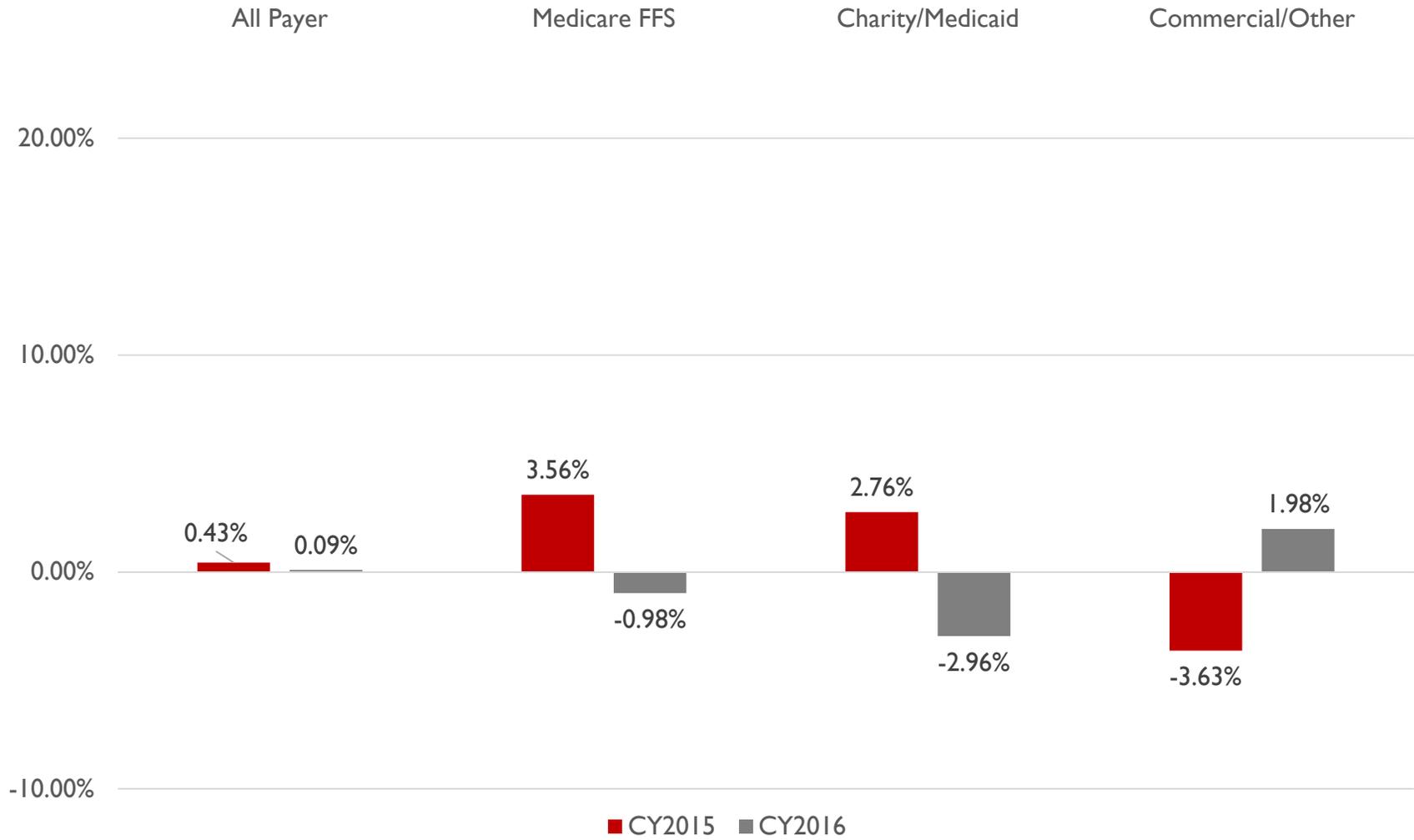
Health Services Cost  
Review Commission

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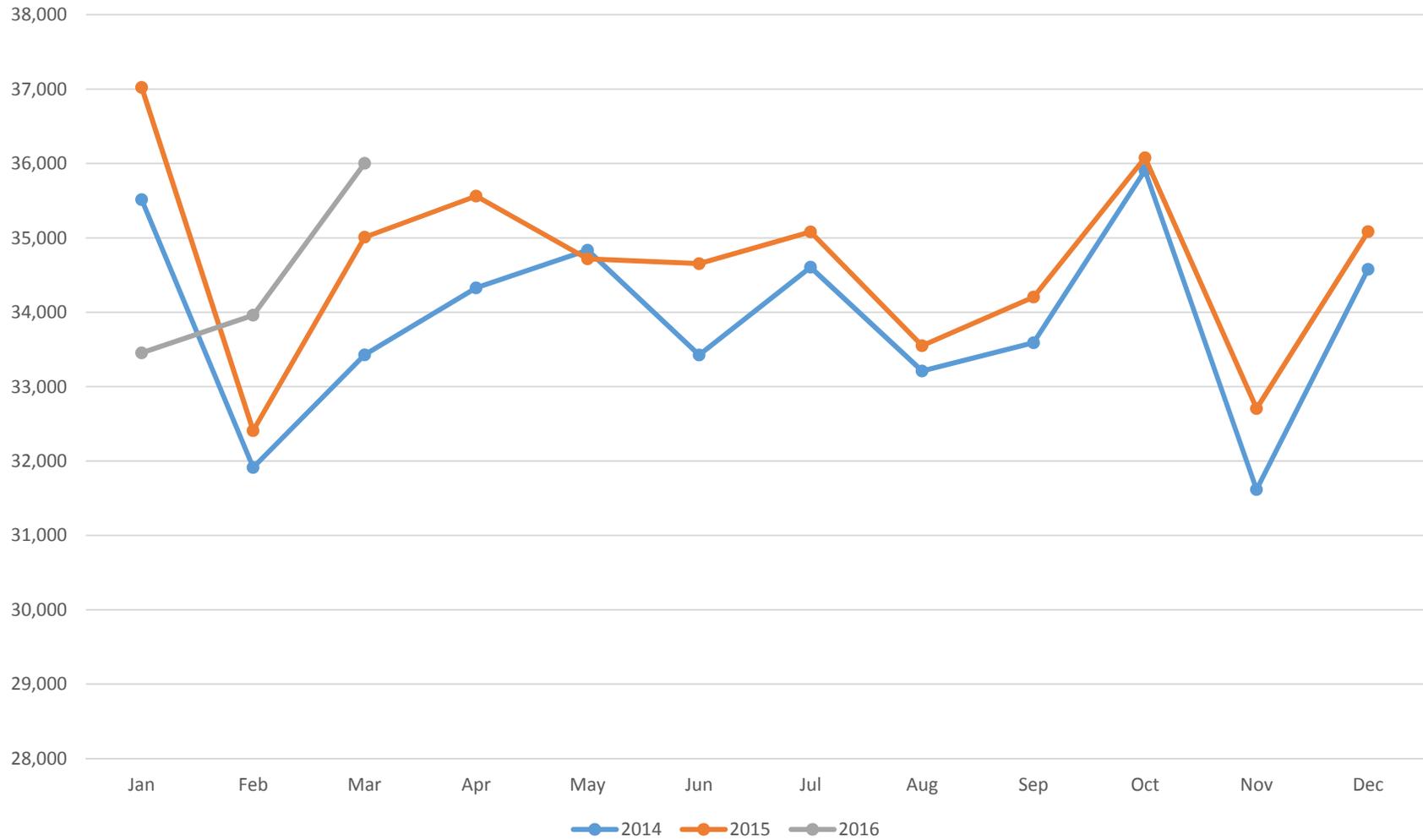
## All Payer ECMAD Annual Growth- CYTD



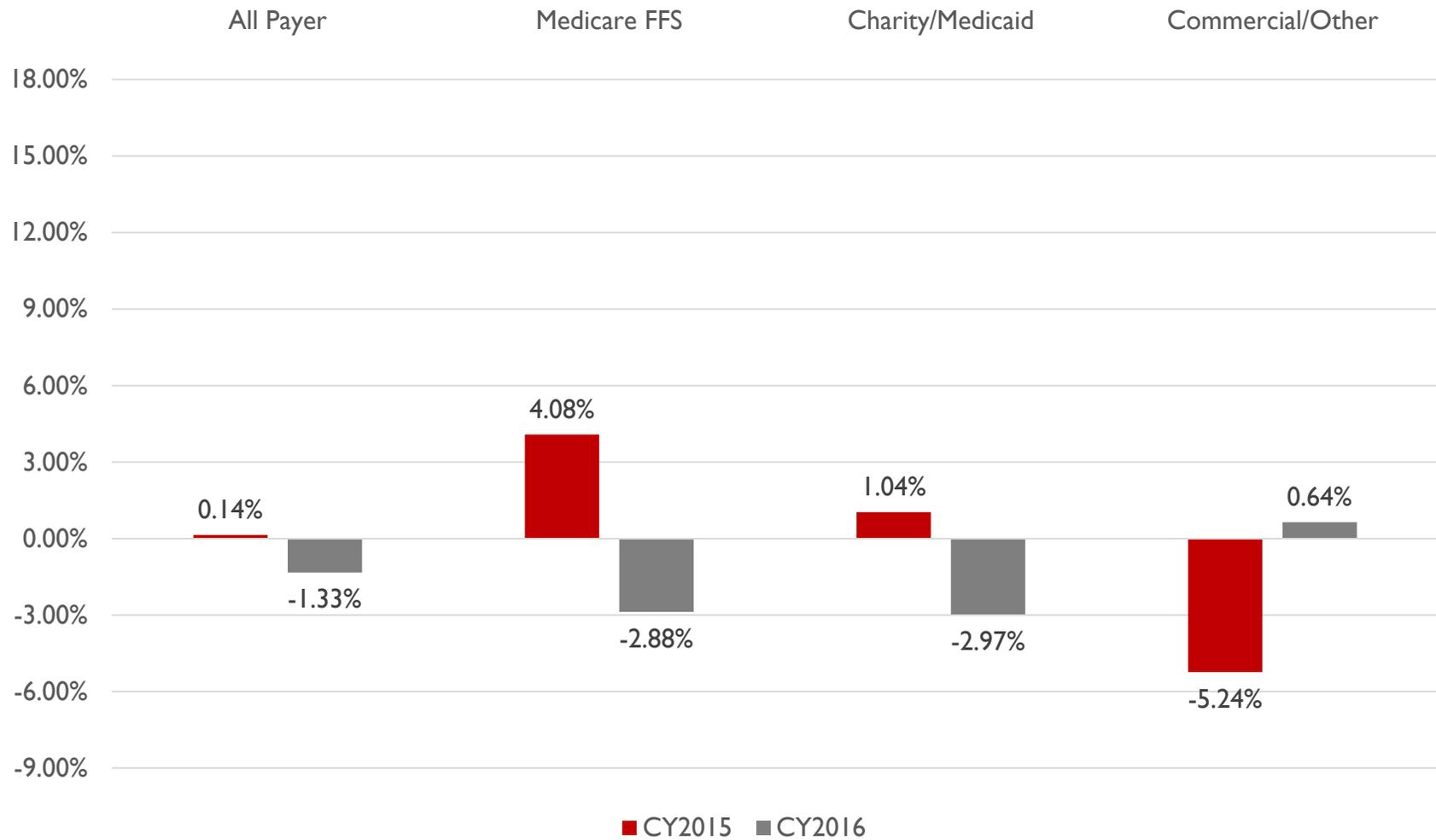
# MD Resident ECMAD Annual Growth by Payer– CYTD



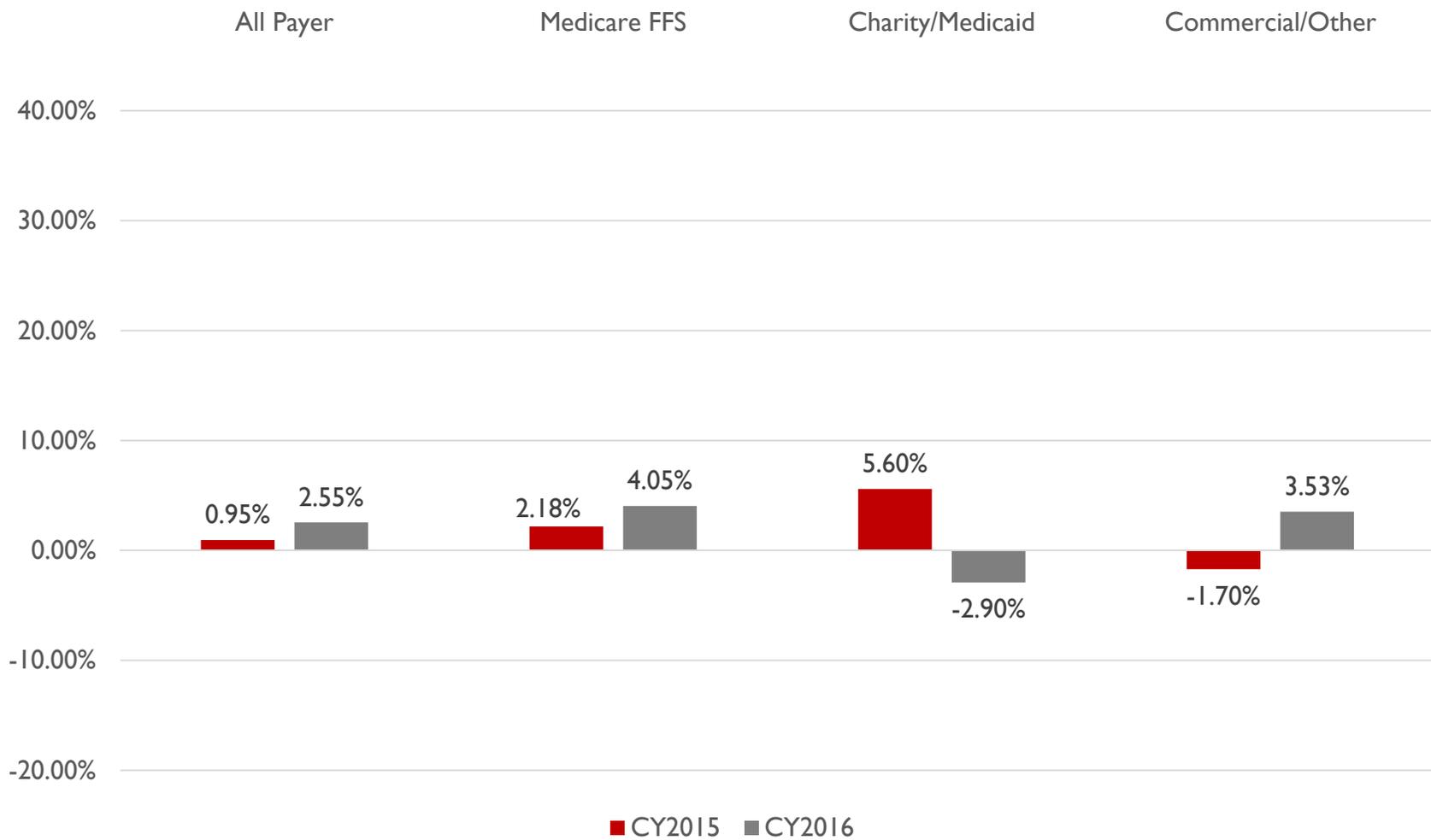
## Medicare MD Resident ECMAD Growth by Month



# MD Resident Inpatient ECMAD Annual Growth by Payer – CYTD



## MD Resident Outpatient ECMAD Annual Growth by Payer– CYTD



# Utilization Analytics – Data Notes

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

# Service Line Definitions

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- ▶ **Inpatient service lines:**

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

- ▶ **Outpatient service lines:**

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

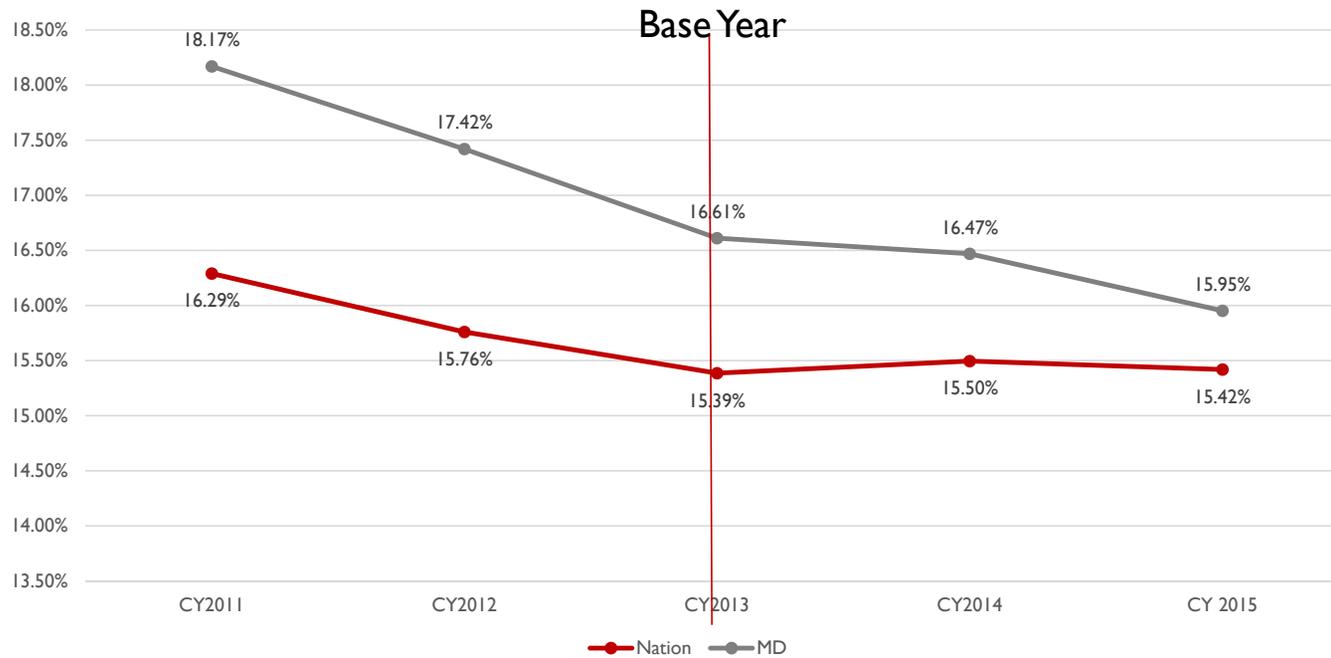
- ▶ **Market Shift technical documentation**

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Readmission Reduction Incentive Program Draft  
FY 2018 Policy

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

Maryland is reducing readmission rate faster than the nation. Maryland reduced reduce the gap from 7.93% in the base year to 3.46 % in CY 2015. Our target for the gap is 4.77% difference.\*



\*In percentage point terms, the base year gap of 1.23 percentage points is reduced to 0.53 percentage points. The target was 0.74 percentage points.

## RRIP proposal for FY 2018

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- ▶ Updating the policy to include an “attainment” as well as an improvement evaluation
  - ▶ Readmissions at out-of-state hospitals- use Medicare ratios
  - ▶ Impact of patient’s socio-economic factors –no adjustment is necessary as long as improvement rates are recognized
  - ▶ Benchmarks: Staff recommends the highest benchmark rather than the state average readmission rate

# Final Recommendations for the RRIP Policy

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## ▶ For RY 2018

- ▶ The RRIP policy should continue to be set for all-payers
- ▶ Hospital performance should be measured better of attainment of improvement
- ▶ Set attainment benchmark at 11.85 percent, which is 2 percent lower than the state top-quartile readmission rate in CY 2015
- ▶ Set the reduction target at 9.50 percent from CY 2013 readmission rates

## ▶ For RY 2017

- ▶ Apply the same methodology outlined above based on 9.30 reduction target as approved by the Commission last year and the state top-quartile readmission rate in CY 2015, which is 12.09 percent

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

# Background

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

	<b>FY 2014</b>	<b>FY 2015</b>	<b>FY 2016</b>	<b>FY 2017*</b>
<b>MD Potential At Risk</b>	3.41%	5.22%	7.95%	12.41%
<b>Medicare Potential At Risk</b>	3.25%	5.50%	5.75%	6.00%
<b>MD Average Adjustment (realized)</b>	0.90%	1.22%	1.95%	4.31%
<b>Medicare Average Adjustment (realized)</b>	0.47%	0.97%	1.14%	1.14%

# Final Recommendations

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- ▶ No change is recommended to FY 2017 levels

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

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

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

# Background

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- ▶ Builds on the Readmission Shared Savings Policy implemented for the Admission-Readmission Revenue (ARR) program to maintain exemption from CMS Readmission Reduction Program by ensuring savings to the purchasers
- ▶ Last year, the Commission continued to focus the policy on readmissions due to concerns over slower reductions in readmission rates
- ▶ Population health infrastructure investments were provided without specific benchmarks in the past three years as it would take time to operationalize the strategies

# Measurement Updates

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- ▶ Staff is proposing to include Prevention Quality Indicators (PQIs) in FY 2017
  - ▶ Progress in reducing PQIs is limited compared to CY 2013 levels
  - ▶ PQIs will also be used for physician payment adjustments by the CMS
- ▶ Align the PAU definitions with market shift adjustments, which include observation cases lasting 23 hour longer and measure readmissions at the receiving hospital

## RX 2017 PAU Savings Final Recommendations

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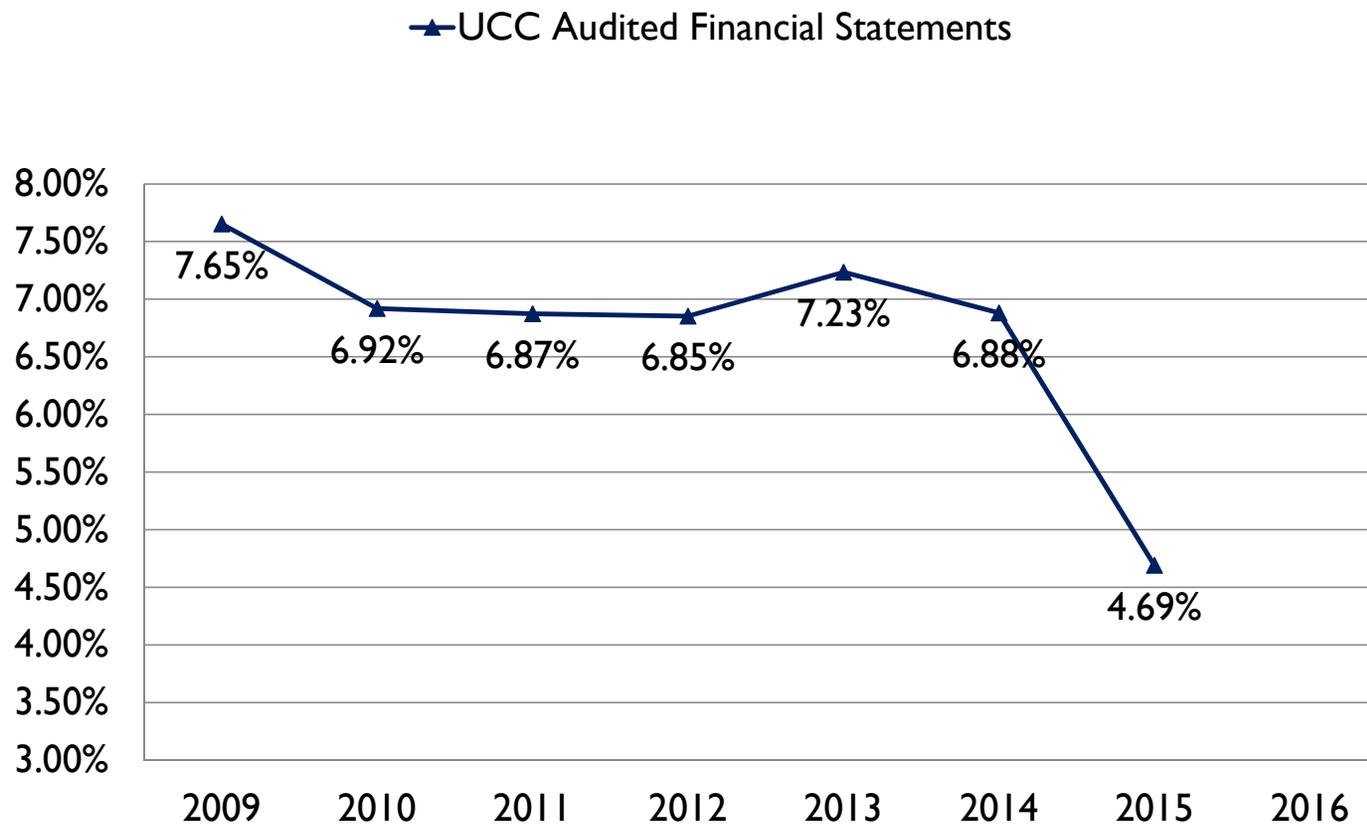
- ▶ Align the measure with the PAU definitions used in the market shift adjustment
- ▶ Increase the annual value of the PAU savings amount from 0.20 percent to 0.45 percent. This will result in 1.25 percent of reduction in total revenue, which is a 0.65 percent net reduction in RX 2017.
- ▶ Cap the PAU savings reduction at the statewide average reduction for hospitals with higher socio-economic burden.
- ▶ Evaluate further expansion of PAU definitions for RX 2018 to incorporate additional categories of unplanned admissions.
- ▶ Evaluate progress on sepsis coding and the apparent discrepancies in levels of sepsis cases across hospitals, including the need for possible independent coding audits.

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Uncompensated Care Policy  
Fiscal Year 2017

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



\*Updated from the Draft recommendation.

# HSCRC UCC Adjustments for ACA

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

# Hospital Level UCC levels

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- ▶ Used account level information collected for the first time
- ▶ MHA led the analysis and discussion to update the hospital level modeling
  - ▶ Two main approaches were evaluated
    - ▶ Accounting model: using state average % UCC by Payer source, type of service.
    - ▶ Predictive regression analysis: Logistic regression to predict the chances of write-off
      - Area Deprivation Index (ADI), a socioeconomic deprivation metric of a given area
      - Primary payer: Medicare, Medicaid, self-pay, Blue Cross/commercial/HMO, and other
      - Patient type: Inpatient, outpatient or emergency room
    - ▶ The impact of undocumented immigrants on UCC levels needs further study. Logistic regression using patient level data would predict higher levels of UCC for these patients as they have self-pay/charity primary expected payer.

## UCC Policy 2017 Recommendations

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- ▶ Reduce statewide UCC provision in rates from 5.25 % to 4.69 % effective July 1, 2016
- ▶ Continue to do 50/50 blend of FY15 audited UCC and predicted UCC
- ▶ Staff supports the regression modeling approach proposed by MHA



# FY 2017 Update Factor

June 8, 2016



**HSCRC**

Health Services Cost  
Review Commission

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## Balanced Update Model for Discussion

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

		Weighted Allowance
<b>Adjustment for Inflation</b>		<b>1.72%</b>
- Total Drug Cost Inflation for All Hospitals*		<b>0.20%</b>
<b>Gross Inflation Allowance</b>	<b>A</b>	<b>1.92%</b>
<b>Implementation for Partnership Grants</b>	<b>B</b>	<b>0.25%</b>
<b>Care Coordination</b>		
-Rising Risk With Community Based Providers		
-Complex Patients With Regional Partnerships & Community Partners		
-Long Term Care & Post Acute		
	<b>C</b>	
<b>Adjustment for volume</b>	<b>D</b>	<b>0.52%</b>
-Demographic Adjustment		
-Transfers		
-Categoricals		
<b>Other adjustments (positive and negative)</b>		
- Set Aside for Unknown Adjustments (Includes .10 Earmark**)	<b>E</b>	<b>0.50%</b>
- Workforce Support Program	<b>F</b>	<b>0.06%</b>
- Holy Cross Germantown	<b>G</b>	<b>0.07%</b>
- Non Hospital Cost Growth	<b>H</b>	<b>0.00%</b>
<b>Net Other Adjustments</b>	<b>I = Sum of E thru H</b>	<b>0.63%</b>
-Reverse prior year's PAU savings reduction	<b>J</b>	<b>0.60%</b>
-PAU Savings	<b>K</b>	<b>-1.25%</b>
-Reversal of prior year quality incentives	<b>L</b>	<b>-0.15%</b>
-Positive incentives & Negative scaling adjustments	<b>M</b>	<b>0.27%</b>
<b>Net Quality and PAU Savings</b>	<b>N = Sum of J thru M</b>	<b>-0.53%</b>
<b>Net increase attributable to hospitals</b>	<b>O = Sum of A + B + C + D + I + N</b>	<b>2.80%</b>
<b>Per Capita</b>	<b>P = (1+O)/(1+0.52%)</b>	<b>2.27%</b>
<b><u>Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements</u></b>		
-Uncompensated care reduction, net of differential	<b>Q</b>	<b>-0.49%</b>
-Deficit Assessment	<b>R</b>	<b>-0.15%</b>
<b>Net decreases</b>	<b>S = Q + R</b>	<b>-0.64%</b>
<b>Revenue growth, net of offsets</b>	<b>T = O + S</b>	<b>2.16%</b>
<b>Per capita revenue growth</b>	<b>U = (1+V)/(1+0.52%)</b>	<b>1.63%</b>

\* Provided Based on proportion of drug cost to total cost

\*\*Earmark 0.10 percent for new outpatient infusion and chemotherapy drugs

# Medicare Savings Requirements: Scenario 1

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

<b>Comparison of Medicare Savings Requirements to Model Results</b>			
	<b>All-Payer Maximum to Achieve Medicare Savings</b>	<b>Modeled All-Payer Growth</b>	<b>Difference</b>
<b>Comparison to Modeled Requirements</b>			
Revenue Growth	2.12%	2.16%	0.03%
Per Capita Growth	1.60%	1.63%	0.03%

## Balanced Update Model for Discussion

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

		Weighted Allowance
Adjustment for Inflation		2.29%
- Total Drug Cost Inflation for All Hospitals*		0.20%
Gross Inflation Allowance	A	2.49%
Implementation for Partnership Grants	B	0.25%
Care Coordination		
-Rising Risk With Community Based Providers		
-Complex Patients With Regional Partnerships & Community Partners		
-Long Term Care & Post Acute		
	C	
Adjustment for volume	D	0.52%
-Demographic Adjustment		
-Transfers		
-Categoricals		
Other adjustments (positive and negative)		
- Set Aside for Unknown Adjustments (Includes .10 Earmark**)	E	0.50%
- Workforce Support Program	F	0.06%
- Holy Cross Germantown	G	0.07%
- Non Hospital Cost Growth	H	0.00%
Net Other Adjustments	I = Sum of E thru H	0.63%
-Reverse prior year's PAU savings reduction	J	0.60%
-PAU Savings	K	-1.25%
-Reversal of prior year quality incentives	L	-0.15%
-Positive incentives & Negative scaling adjustments	M	0.27%
Net Quality and PAU Savings	N = Sum of J thru M	-0.53%
Net increase attributable to hospitals	O = Sum of A + B + C + D + I + N	3.36%
Per Capita	P = $(1+O)/(1+0.52\%)$	2.82%

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

-Uncompensated care reduction, net of differential	Q	-0.49%
-Deficit Assessment	R	-0.15%
Net decreases	S = Q + R	-0.64%
Revenue growth, net of offsets	T = O + S	2.72%
Per capita revenue growth	U = $(1+V)/(1+0.52\%)$	2.19%

\* Provided Based on proportion of drug cost to total cost

\*\*Earmark 0.10 percent for new outpatient infusion and chemotherapy drugs

# Medicare Savings Requirements: Scenario 2

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

<b>Comparison of Medicare Savings Requirements to Model Results</b>			
	<b>All-Payer Maximum to Achieve Medicare Savings</b>	<b>Modeled All-Payer Growth</b>	<b>Difference</b>
<b>Comparison to Modeled Requirements</b>			
Revenue Growth	2.68%	2.72%	0.04%
Per Capita Growth	2.15%	2.19%	0.04%

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

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	A Actual Jan- June 2014	B Actual FY 2015	C Staff Est. FY 2016	D Proposed FY 2017	E = (1+A)*(1+B)*(1+C)*(1+D) Cumulative Through FY 2017
<b>Maximum Gross Revenue Growth Allowance</b>	<b>2.13%</b>	<b>4.26%</b>	<b>4.12%</b>	<b>4.12%</b>	<b>15.44%</b>
Revenue Growth for Period	0.90%	2.51%	2.94%	2.72%	9.37%
Savings from UCC & Assessment Declines that do not Adversely Impact Hospital Bottom Line		1.09%	1.41%	0.64%	3.17%
Revenue Growth with UCC & Assessment Savings Removed	0.90%	3.60%	4.35%	3.36%	<b>12.74%</b>
Revenue Difference between Cap & Projection					<b>2.70%</b>

# Total Approved Inflation Allocation

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<b>Example:</b> <b>YE June 30, 2016</b>	<b>Current Approved Revenue</b> <b>\$ 100,000,000.00</b>	<b>Update Approved</b> <b>2.72%</b>	<b>Total Approved Revenue</b> <b>\$ 102,720,000.00</b>	<b>Percent of Total</b>
Allocated as Follows:				
July 1 2016 though Decenber 31, 2016	\$ 50,000,000.00	2.16%	\$ 51,080,000.00	49.73%
January 1, 2017 through June 30, 2017	Remainder		\$ 51,640,000.00	50.27%
<b>Total Approved Revenue FY June 30 2017</b>			<b>\$ 102,720,000.00</b>	

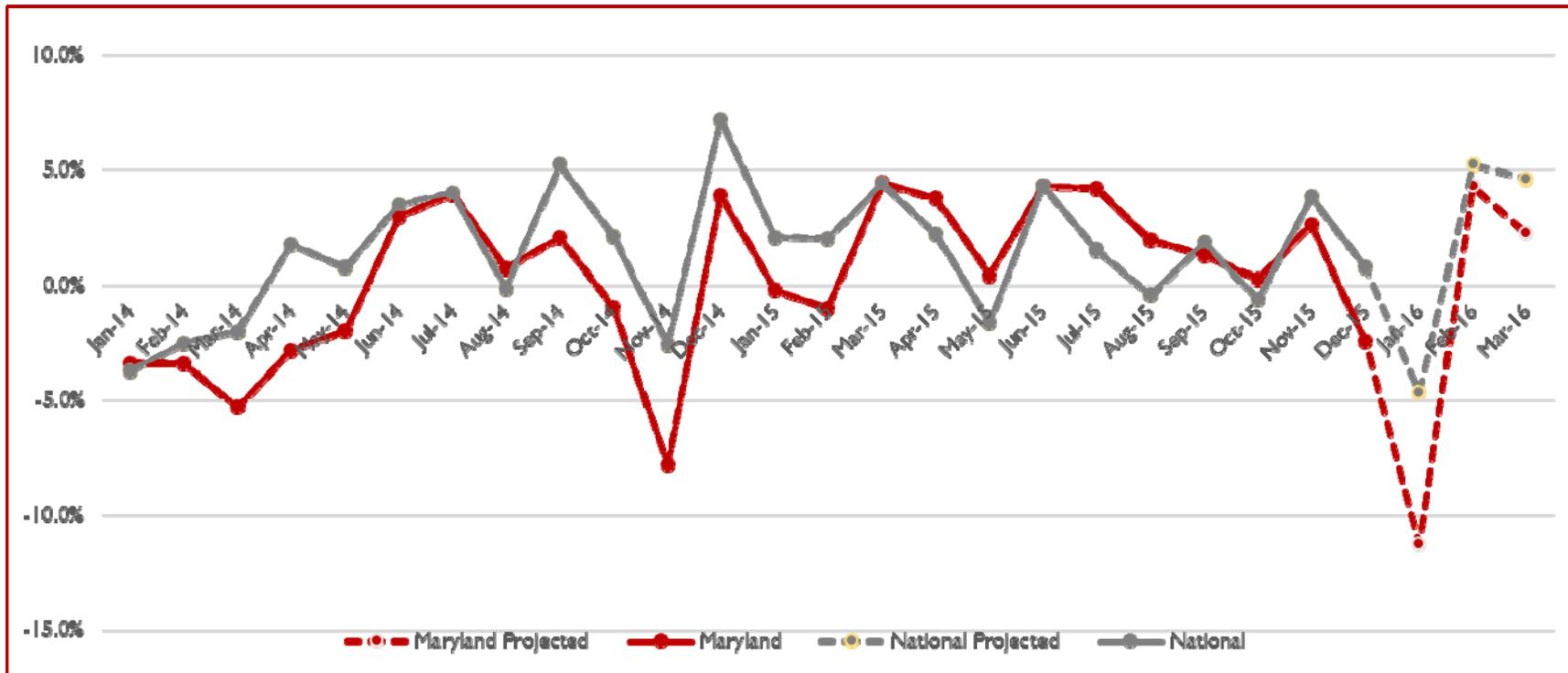
# Summary of Recommendations

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- ▶ Update the three categories of hospitals & revenues:
  - ▶ 2.72% for revenues under global budgets
    - ▶ 2.16% for the first 6 months of the FY
    - ▶ The remainder over the final 6 months of the FY
  - ▶ 1.24% for revenues subject to waiver but excluded from global budgets
  - ▶ 1.55% for psychiatric hospitals and Mt. Washington Pediatric Hospital
  
- ▶ Allocate 0.20% of the inflation allowance based on each hospital's proportion of drug cost to total cost .
  
- ▶ Earmark 0.10% of the allowance for unforeseen adjustments for increases in cost related to new outpatient physician-administered drugs.

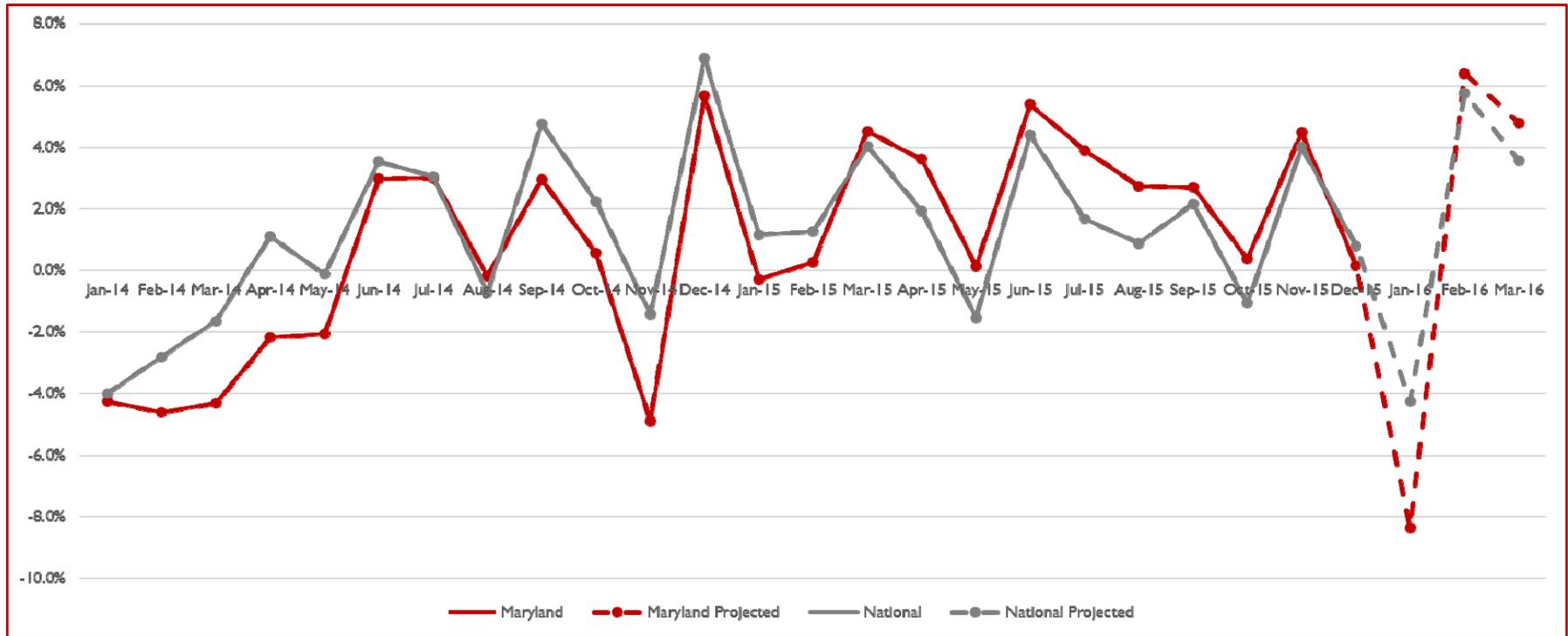
# Medicare Hospital Payments Per Capita Month to Month Growth Compared to Same Month in Prior Year Maryland vs. Nation

Data prepared by HSCRC Staff from federal extracts, subject to change



# Maryland Total Cost of Care Payment Per Capita Month to Month Growth Compared to Same Month in Prior Year Maryland vs. Nation

**Most recent projections show Maryland trending higher than national**



# Additional Update Recommendation

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- ▶ To receive additional inflation factor,
  - ▶ Each hospital must agree to adhere to its mid-year target
  - ▶ Monitor growth in Medicare TCOC and hospital cost for its service area, monitor PAU and utilization for Medicare and All Payers
  - ▶ Obtain and use available information for care redesign, including detailed Medicare data
  - ▶ Implement programs focused on complex and high needs patients
  - ▶ Partner with physicians and post-acute/long-term care facilities in these efforts. Work with physicians relative to MACRA
  - ▶ Participate in All Payer Model progression

# Additional Update Recommendation

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- ▶ The Commission should closely monitor performance targets for Medicare. As deemed necessary, the Commission should adjust rates in accordance with the requirements of the All Payer Model
- ▶ Performance may affect the RY 2018 update. Hospitals will need to reduce PAUs and increases in non-hospital costs that are not offset by reductions in hospital costs will need to be addressed.

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# Final Recommendation for Transformation Implementation Grants

6/8/2016

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**HSCRC**

Health Services Cost  
Review Commission

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# Recommendations

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

# Next Steps

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- ▶ HSCRC will monitor the implementation of the awarded grants through additional reporting requirements.
- ▶ HSCRC is also recommending that a schedule of savings be remitted to payers through the global budget on the following schedule.
  - ▶ (Savings represent the below percentage of the award amount)

FY2018	FY2019	FY2020
10%	20%	30%

- ▶ Staff is recommending allocating the remaining \$6,461,940 of the FY2016 0.25% to deserving projects and promising collaborations within the unfunded proposals. Recommendations will be made in September 2016.
- ▶ HSCRC staff has offered to consult with those who have not obtain grants thus far on strengths and weakness.
- ▶ Staff provided several weeks of extensions for hospitals to confirm their participation in the program and staff has responded to questions by applicants.