



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

March 13, 2014

The Honorable Edward J. Kasemeyer  
Chairman, Budget and Taxation Committee  
3 West Miller Senate Building  
11 Bladen Street  
Annapolis, MD 21401

The Honorable Norman H. Conway  
Chairman, Appropriations Committee  
121 House Office Building  
6 Bladen Street  
Annapolis, MD 21401

RE: 2013 Joint Chairmen's Report (Page 56) Budget Language Requiring a Report on the State's Waiver Modernization Application

Dear Chairmen Kasemeyer and Conway:

In accordance with the language in the Joint Chairmen's Report of the 2013 Session (pg. 56), the Department of Health and Mental Hygiene (Department, or DHMH), in consultation with the Health Services Cost Review Commission (Commission, or HSCRC), is required to submit two reports to the budget committees concerning the modernization of the State's Medicare Waiver:

- Within 30 days after the submission of a final application to the Centers for Medicare & Medicaid Services (CMS), submit a report containing the final application, changes from the March 2013 draft application, a preliminary timeline for implementation of Phase 1 of the modernization plan, and process of stakeholder input prior to any final decision being made by CMS and the State; and
- Within 30 days after CMS approval, a final timeline for the implementation of Phase 1 of the modernization plan, any regulatory or statutory changes required to implement Phase 1 of the plan, the process for stakeholder input prior to the implementation of Phase 1, and a timeline for the implementation of Phase 2 of the modernization plan.

This letter and attachments represent the second of the two reports. The all-payer model design contract was formally signed by the Governor, DHMH Secretary, Chairman of the HSCRC, and the Director of the Center for Medicare and Medicaid Innovation (CMMI) on February 11, 2014. Please be advised that \$100,000 is being withheld from the Office of the Secretary pending submission and review of this report.

## ***Background***

Since the late 1970s, Maryland's independent HSCRC has set hospital rates for all public and private payers.

This structure has provided major benefits to Maryland residents. It has:

- eliminated cost-shifting between payers;
- allowed for creative uses of incentives to improve quality and outcomes;
- substantially limited the growth of hospital per-case costs;
- provided for lower costs on an all-payer basis within our region;
- provided a stable and predictable payment system for hospitals;
- promoted financial stability for efficient and effective hospitals; and
- supported equitable funding of uncompensated care and medical education.

Maryland's rate-setting system, however, at the time had important limitations. Its structure dated back to a time when inpatient services were predominant, and cost per discharge and average length of stay were the primary measures for efficiency. That system focused on per-case costs did not align appropriate incentives for overall population health and comprehensive coordinated care across different settings.

In addition, the former system depended on maintaining per-case costs below a national trend. The "waiver cushion" based on the former waiver is the thinnest that it has been in many years, in part, because the system had begun to focus on reducing patient volumes, resulting in higher per-case costs at the hospital.

## ***Model Design and Changes***

Since January 1, 2014, the State of Maryland has been leading a transformative effort to improve care and lower the growth in health care spending in the State. Maryland is in the process of implementing a new All-Payer Model (the Model) based on its approved agreement with CMMI that seeks to achieve the "Three Part Aim" of improving health care outcomes, enhancing patient experience, and lowering health care costs across the State.

The Model builds upon decades of innovation and equity in health care payment and delivery in Maryland by modernizing the all-payer rate setting system for hospital services. The new Model will shift away from fee-for-service reimbursement towards health care delivery that emphasizes prevention, quality care, and value. The model will work in concert with other care delivery and health care reform initiatives in Maryland.

The key features of the new Model, which are fully described in the application and agreement, are described briefly below:

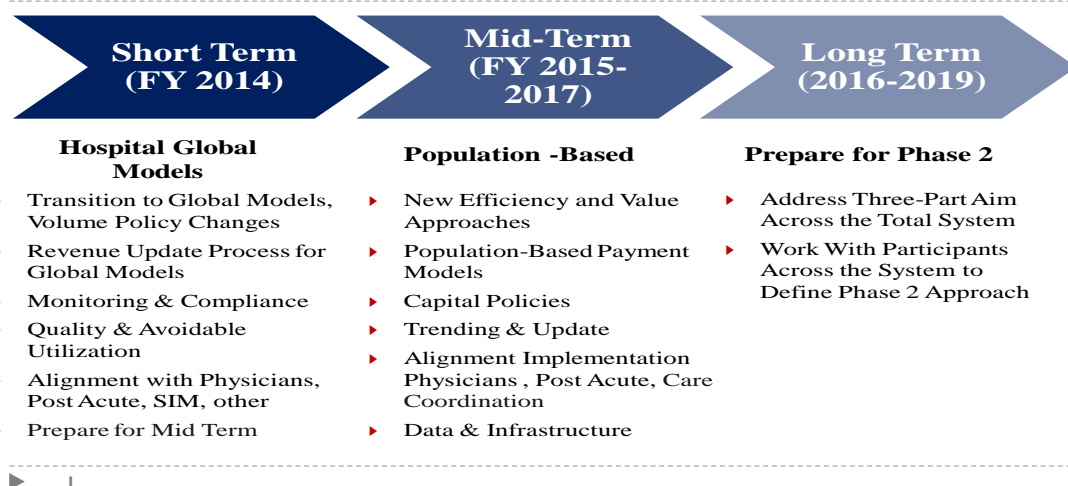
- This model will require Maryland's Medicare per beneficiary total hospital cost growth over five years to be at least \$330 million less than the national Medicare per beneficiary total hospital cost growth over five years.

- This model will require Maryland to limit its annual all-payer per capita total hospital cost growth to 3.58%, the 10-year compound annual growth rate in per capita Gross State Product.
- Maryland will shift virtually 100% of its hospital revenue over the five year model into global payment models.
  - The targets for the end of years two through five will be as follows: Year 2: 50%, Year 3: 60%, Year 4: 70%, Year 5: 80%.
  - Hospital revenues that are not covered under a global model will be subject to a volume adjustment system.
- Maryland will achieve a number of quality targets designed to promote better care, better health and lower costs.
  - Readmissions: Maryland will commit to reducing its aggregate Medicare 30-day unadjusted all-cause, all-site hospital readmission rate in Maryland to the national Medicare 30-day unadjusted all-cause, all-site readmission rate over five years.
  - Hospital Acquired Conditions: Maryland currently operates a Hospital Acquired Condition (HAC) program that measures 3M's 65 Potentially Preventable Conditions (PPC). Under this model, Maryland will achieve an annual aggregate reduction of 6.89% in the 65 PPCs over five years for a cumulative reduction of 30%.
- Before the start of the fourth year of the model, Maryland will develop a proposal to extend the model beyond five years based on a Medicare total per beneficiary cost of care test.

### ***Timeline for Implementation of Phase I and Phase II***

Below is the timeline for HSCRC implementation of the Phase I of the all-payer model.

#### **HSCRC All-Payer Model Implementation Timeline**



Over the course of the first five-year term, the new model proposes to migrate increasing proportions of approved hospital revenue to population-based or “global” approaches, with a goal of shifting virtually all hospital revenue into these models by the end of the 5 year period. Under the new system, a population-based or “global” model is defined as either a model under which a hospital’s allowed revenue is explicitly tied to a defined population and its service needs (i.e., a

“population-based” budget), or a model in which a hospital’s revenue is fixed for a given period of time (e.g., an upcoming rate year), based not on explicit links to a specific population, but on its previously approved budget trended forward.

The movement to global budgets, which is at the center of the new Model, is meant to facilitate the conversion of the hospital economic environment from one that makes revenue and profitability dependent on utilization levels to one that provides hospitals with financial incentives to: (1) improve care and outcomes and to eliminate avoidable volume; (2) provide care in the most appropriate settings; (3) reduce the need for readmissions; (4) increase prevention efforts in combination with physicians and health agencies; and (5) promote overall improvements in population health status.

Finally, the use of global budgets for an increasing number of hospitals will begin to align the incentives of hospitals with the goals and objectives for greater affordability and improved health. These are likewise the goals of emerging physician delivery models such as Primary Care Medical Homes (PCMHs) and Accountable Care Organizations (ACOs), as well as major payers, employers, and many other organizations.

The global budget concept is based upon the HSCRC’s Total Patient Revenue. Over the course of the new model agreement, the Commission expects to evolve the global budget concept into other population-based payment strategies that achieve the triple aim and meet the requirements of the all-payer model contract.

In 2016, the Commission will work with the Department and other stakeholders to begin to prepare a proposal to move to a total per beneficiary cost per care test. This will involve a larger set of stakeholders than the Phase I model.

### ***Statutory or Regulatory Changes Necessary***

The O’Malley Administration (The Administration) has introduced legislation (House Bill 298/Senate Bill 335) to make technical changes to the Commission’s statute to conform to the new all-payer model. Although HSCRC’s enabling legislation is sufficient to implement the new all payer demonstration, this bill would clarify HSCRC’s statutory authority as Maryland transitions from the current statutory waiver to a new demonstration authority granted by CMS. In addition, the bill expands the Commission’s user fee authority to support its special fund budget request to enhance the infrastructure needed to monitor and successfully implement the new waiver authority.

The bill changes references to the section of federal law where the original waiver is codified (Section 1814(b)(3) of the Social Security Act), and instead refers to the contract with the CMMI. The bill supplements HSCRC’s current authority by clarifying that it may set rate levels and rate increases to promote alternative methods of rate determination and payment consistent with the agreement with CMMI.

The bill also would increase HSCRC’s user fee cap from \$7 million to \$12 million since managing under a new all-payer model design will require additional expenditures for data, analysis, staffing, and consulting services.

The Administration and the Commission have proposed an amendment to require payers to comply with the provisions of the all-payer model contract. Statutory language currently

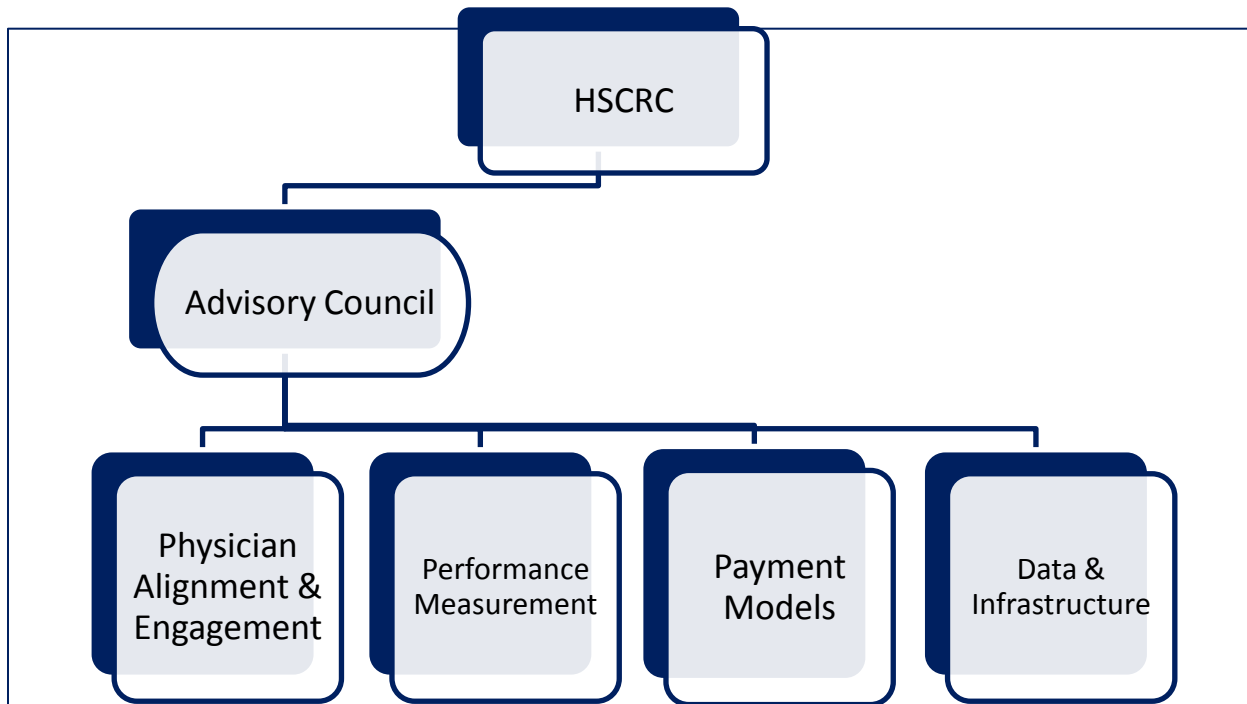
requires payers to pay the rates set by the Commission, but the statute does not include a general statement of conformity with the contract.

The Commission has also adopted regulation to expedite the collection of certain financial and case-mix data to ensure that the Commission has the ability to monitor compliance with the requirements of the contract on a monthly or quarterly basis, and make mid-year changes as necessary. During its March public meeting, the Commission will consider promulgating regulations, consistent with language in the attached contract, to require hospitals to submit to the Commission all data required for evaluation of the all-payer model.

Finally, the Administration has proposed setting aside funds through a reduced assessment for community partnerships. This investment is critical to aligning the health care system to the goals of Maryland's waiver. It is essential to the task of "turning the ship" and establishing a health care system that prevents and manages disease more effectively in lower cost settings.

### ***Stakeholder Input and Public Engagement Strategy***

To assist with implementation of the new model and to receive feedback on, the Commission established an Advisory Council and a series of Work Groups. Below is the structure established by the Commission for public engagement and stakeholder input.



The Advisory Council has issued a report to the Commission with the following suggested principles and guidelines:

- Top priority: meeting the all-payer hospital per capita spending and Medicare savings targets
- Requires clear timetable, interim milestones, key benchmarks, periodic assessments
- Global payment is the tool of preference
- Reducing avoidable utilization through better care is the key to meeting tight targets
- Balance need for near-term cost control with need for infrastructure investments

- Incentives for hospitals to meet and exceed the targets; retain, reinvest savings
- Need secure funding source to finance new investments: new data, Health Information Technology, care coordination
- Provide compilation of best practices
- HSCRC should be effective regulator, catalyst for reforms, and advocate for needed support
- Collect, synthesize, and interpret data
- Allow flexibility for health care sector to devise and implement successful strategies
  - Preference for performance standards
  - Avoid multi-layered design standards
- Strong incentives for discovery & innovation
- HSCRC should actively engage consumers
- Need to guard against under-use as well as over-use of health services
- Incorporate quality improvement, safety goals

Each of the Work Groups has conducted at least one meeting and will continue to meet approximately every two or three weeks. The Work Groups and their functions are summarized below:

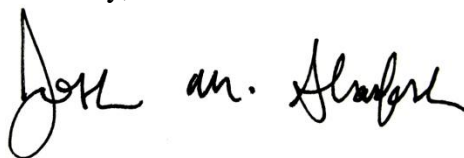
- **Payment Models Work Group**
  - Balanced Update
  - Guardrails for Model Performance
  - Market Share
  - Initial and Future Models
- **Performance Measurement Work Group**
  - Reducing Potentially Avoidable Utilization to achieve Three-Part Aim
  - Statewide Targets & Hospital Performance Measurement
  - Measuring Potentially Avoidable Utilization
  - Value-Based Payments (integration of cost, quality, population health and outcomes)
  - Patient Experience and Patient-Centered Outcomes
- **Physician Alignment and Engagement Work Group**
  - Alignment with Emerging Physician Models
  - Shared Savings
  - Care Improvement
  - Care Coordination Opportunities
  - Post-Acute and Long-Term Care
  - Evidence-Based Care
- **Data and Infrastructure Work Group**
  - Data Requirements
  - Care Coordination Data and Infrastructure
  - Technical and Staff Infrastructure
  - Data Sharing Strategy

The activities of the Advisory Council and Work Groups (as well as those of the Commission) can be followed on the Commission's website. In addition, all Commission, Advisory Council and Work Group meetings are open to the public and provide opportunity for public comment. Consumer/patient representatives have been included on all Work Groups as well.

Membership of the Advisory Council and Work Groups may be found in Appendix II, the Advisory Council report is available under Appendix III, and a more detailed description of the Work Groups may be found in Appendix IV.

Thank you for the opportunity to share with you the status of implementation of the now executed all-payer model contract. Working together, we can build upon our unique strengths to address key challenges of health care cost and outcome and provide a model for the rest of the nation. If you have any questions, please contact Allison Taylor, Director of Governmental Affairs, at (410) 767-6480.

Sincerely,

A handwritten signature in black ink, appearing to read "Josh M. Sharfstein". The signature is fluid and cursive, with the first name "Josh" being more prominent.

Joshua M. Sharfstein, M.D.  
Secretary

## MARYLAND ALL-PAYER MODEL AGREEMENT

This Maryland All-Payer Model Agreement (“Agreement”) is dated 2/11, 2014, and is between the Centers for Medicare & Medicaid Services (“CMS”) and the Governor of Maryland, the Department of Health and Mental Hygiene, and the Health Services Cost Review Commission (“HSCRC”) (collectively, “State” or “Maryland”).

Under Section 1115A of the Social Security Act (the “Act”), the Center for Medicare and Medicaid Innovation (“Innovation Center”) is authorized to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children’s Health Insurance Program (“CHIP”) expenditures while maintaining or improving the quality of care for beneficiaries. Section 1115A(b)(2)(B)(xi) of the Act lists models that the Innovation Center may consider testing, including, “[a]llowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.”

In accordance with Section 1814(b)(3) of the Act, CMS heretofore has exempted certain hospitals in Maryland from reimbursement under the national payment system and has allowed the State to set reimbursement rates payable by Medicare for applicable services that otherwise would be reimbursed under Medicare’s Inpatient Prospective Payment System (“IPPS”) and Outpatient Prospective Payment System (“OPPS”) (collectively, the “1814(b)(3) Medicare Waiver”). Continuation of the 1814(b)(3) Medicare Waiver was subject to the condition that the aggregate rate of increase in the cost per Medicare hospital inpatient admission in Maryland from January 1, 1981 to the most recent date for which annual data are available is equal to or less than the rate of increase in the cost per Medicare inpatient admission nationally over the same time period.

The State hereby elects to no longer be reimbursed in accordance with Section 1814(b)(3) of the Act. The parties also agree that effective with the first day of the Model, Maryland is no longer in continuous operation of a demonstration project reimbursement system since July 1, 1977, as required under Section 1814(b)(3) of the Act. Therefore, Maryland no longer meets the requirements for reimbursement under Section 1814(b)(3) of the Act and all payment waivers under the 1814(b)(3) Medicare Waiver are hereby terminated.

Maryland hospitals will be reimbursed under the terms of the Maryland All-Payer Model, as described in this Agreement, including all appendices (“Model”).

CMS and the State therefore agree as follows:

### 1. Legal authority.

- a. **Medicare authority.** Section 1115A(b) of the Act authorizes CMS, through the Innovation Center, to enter into this Agreement. Medicare reimbursement under

this Model shall continue to operate consistent with all applicable laws, regulations and guidance, as amended or modified, except to the extent these requirements are waived in accordance with Section 1115A(d)(1) of the Act as set forth in this Agreement. As a term and condition of this Model, the State will require that all hospitals in the State of Maryland for which payments are regulated by the State for all payers including Medicare, as listed in Appendix 1 and as updated from time to time (hereafter “Regulated Maryland Hospitals”), will comply in all material respects with Medicare requirements in Title XVIII of the Act and all implementing regulations, insofar as not waived herein, and applicable guidance, as amended from time to time.

- b. **Medicaid authority.** Section 1115A(b) of the Act authorizes CMS, through the Innovation Center, to enter into this Agreement. Medicaid reimbursement under the Model shall continue to operate consistent with all applicable laws, regulations and guidance, including but not limited to all requirements of Maryland’s existing Medicaid state plan and/or Section 1115(a) demonstration waivers, as amended or modified from time to time, except to the extent these requirements are explicitly waived or modified in accordance with Section 1115A(d)(1) of the Act pursuant to this Agreement or in a relevant 1115(a) demonstration waiver or state plan amendment. The State represents and warrants that its Medicaid state plan and/or Section 1115(a) demonstration waivers will be consistent with the terms and conditions of this Agreement with respect to Medicaid by no later than March 31, 2014 and that it shall update timely its Medicaid state plan and/or Section 1115(a) demonstration waivers to accommodate any and all changes in payment methodologies that the State implements pursuant to this Agreement.
- c. **Maryland authority to implement Model.** The State represents and warrants that it has the legal authority under Title 19 of the Health General Article of the Annotated Code of Maryland to require all Regulated Maryland Hospitals to charge rates in accordance with the rules and regulations of the HSCRC, and, under Title 15 of the Insurance Article and Title 15 of the Health General Article of the Annotated Code of Maryland to require all health insurance payers, including Medicaid, (hereafter, “Maryland Payers”), to reimburse Regulated Maryland Hospitals on the basis of rates established by the HSCRC. Failure by any federal health care program, other than Medicare and Maryland Medicaid, to pay for hospital services on the basis of HSCRC-approved rates does not constitute an event of termination as defined herein. The State further represents and warrants that it has the legal authority to enter into this Agreement and has, or will have by no later than July 1, 2014, bound by law or by contract its contractor(s), all Regulated Maryland Hospitals, and all Maryland Payers to

comply with the applicable terms and conditions of this Agreement and all submissions related to the Model required pursuant to this Agreement.

2. **Performance Period of Model.** The performance period shall consist of five performance years, each of 12 months' duration beginning on January 1 ("Performance Year"). The performance period of this Model will begin on January 1, 2014, and will end at midnight on December 31, 2018. CMS or the State may terminate the performance period of this agreement up to and including 11:59 PM EST on December 31, 2018 in accordance with Section 14. Upon the completion or termination of the performance period, the State and Regulated Maryland Hospitals shall have two calendar years from such date to complete a transition to payment under the national Medicare program, whereupon this agreement shall terminate automatically. Prior to the beginning of Performance Year 4, Maryland will submit a proposal for a new model, which shall limit, at a minimum, the Medicare per beneficiary total cost of care growth rate, to take effect no later than 11:59 PM EST on December 31, 2018. Approval of this new model proposal shall be in the sole discretion of CMS and shall require a separate agreement executed by CMS and the State.
3. **Non-election of Section 1814(b)(3) of the Act.** By entering into this Agreement, the State represents and warrants that it is electing to no longer have Medicare reimburse Regulated Maryland Hospitals in accordance with Section 1814(b)(3) of the Act, and represents that, effective with the first day of the Model, Maryland no longer has a demonstration project reimbursement system in continuous operation since July 1, 1977. The parties also agree that effective with the first day of the Model, Maryland is no longer in continuous operation of a demonstration project reimbursement system since July 1, 1977, as required under Section 1814(b)(3) of the Act. Therefore, Maryland no longer meets the requirements for reimbursement under Section 1814(b)(3) of the Act and all payment waivers under the 1814(b)(3) Medicare Waiver are hereby terminated. The State further represents and warrants that it has notified or will notify as soon as possible after execution of this Model Agreement all Regulated Maryland Hospitals and Maryland Payers that it no longer elects reimbursement in accordance with Section 1814(b)(3) of the Act; that it has elected to be reimbursed in accordance with this All-Payer Model Agreement, effective with the first day of the Model and continuing throughout the duration of the Agreement or any extension thereof; and that the provisions of Section 1814(b)(3) will no longer govern Regulated Maryland Hospitals.
4. **Medicare Payment Waivers.** Under the Model, CMS will waive the requirements of the following provisions of the Act as applied solely to Regulated Maryland Hospitals:

- a. **IPPS.** Sections 1886(d), 1886(g), and 1886(b)(1) of the Act and implementing regulations at 42 CFR 412, Subparts A through M, only insofar as necessary solely for the purposes of this Model and only insofar as the State remains in compliance with the terms and conditions of this Agreement.
- b. **OPPS.** Section 1883(t) of the Act and implementing regulations at 42 CFR Part 419, only insofar as the State remains in compliance with the terms and conditions of this Agreement.
- c. **Medicare Readmissions Reduction Program.** Section 1886(q) of the Act and implementing regulations at 42 CFR 412.152 and .154, only insofar as the State remains in compliance with the terms and conditions set forth at Section 8.d.
- d. **Medicare Hospital Acquired Conditions Program.** Section 1886(p) of the Act and implementing regulations at 42 CFR 412.172, only insofar as the State remains in compliance with the terms and conditions set forth at Section 8.e.
- e. **Medicare Hospital Value Based Purchasing.** Section 1886(o) of the Act, and implementing regulations at 42 CFR 412.160 - 412.167, only insofar as the State submits an annual report to the Secretary that provides satisfactory evidence that a similar program in the State for Regulated Maryland Hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under 1886(o) of the Act.
- f. **Electronic Health Record (“EHR”) penalty.** Effective October 1, 2014, Section 1886(b)(3)(B)(ix)(I) of the Act, and implementing regulations at 42 CFR 412.64, only insofar as the State adjusts the payments to each subsection (d) hospital that is not a meaningful EHR user (as defined in Section 1886(n)(3) of the Act and the implementing regulations at 42 CFR 495.4) in a manner that is designed to result in an aggregate reduction in payments to hospitals in the State, including but not limited to Regulated Maryland Hospitals, that is equivalent to the aggregate reduction that would have occurred if payments had been reduced to each subsection (d) hospital in a manner comparable to the reduction under Section 1886(b)(3)(B)(ix)(I) of the Act. The State must submit to the Department of Health and Human Services (“DHHS”) and CMS the methodology it will use to make such payment adjustment at a time and in a manner and format to be specified by CMS.

CMS reserves the right to withdraw any waiver of Medicare payment requirements stated above (“Waiver”) or any waiver that may be issued pursuant to Section 5 below (“Fraud and Abuse Waivers”), or as applicable, to terminate this Agreement, pursuant to the

procedures set forth in Section 14, if Maryland does not comply with the conditions associated with the applicable Waiver as set forth in this Agreement.

5. **Fraud and Abuse Waivers.** Financial arrangements between and among providers must comply with all applicable laws and regulations, except as may be explicitly provided in a waiver issued specifically for the Maryland All-Payer Model pursuant to Section 1115A(d)(1) of the Act. The Secretary may consider issuing waivers of certain fraud and abuse provisions in Sections 1128A, 1128B, and 1877 of the Act, as may be necessary solely for purposes of carrying out this Model. Such waivers, if any, would be set forth in separately issued documentation specific to this Model. Any such waiver would apply solely to this Model and could differ in scope or design from waivers granted for other programs or models.
6. **Continuation of IME/GME Exceptions Provided to Regulated Maryland Hospitals.** CMS shall continue to apply the requirements of the following Medicare provisions with respect to Regulated Maryland Hospitals:
  - a. The Secretary shall continue to establish the rules for the application of Section 1886(d)(11) of the Act to Regulated Maryland Hospitals participating under this Model in the same manner as it would apply to the hospital if it were a hospital paid under Section 1814(b)(3) of the Act.
  - b. The Secretary shall continue to establish the rules for the application of Section 1886(h)(3)(D) of the Act to Regulated Maryland Hospitals participating under this Model in the same manner as it would apply to the hospital if it were a hospital paid under Section 1814(b)(3) of the Act.

Further, to the extent that a provision under the national Medicare program not listed in Section 4 or 6 or otherwise referred to in this Agreement provides for a particular treatment for Section 1814(b)(3) hospitals, the State may request an alternative approach for Regulated Maryland Hospitals under the Model, and, CMS may, at its sole discretion, permit the requested alternative approach. Such alternatives shall be memorialized in an addendum to this Agreement.

7. **Operations of Rate-Setting System**

- a. **All-payer rate-setting system.**
  - i. This Model is predicated on Md. Code Ann. Health-Gen. §19-201 et seq. and the State's maintenance of an all-payer rate-setting system whereby:

1. The total costs of all Regulated Maryland Hospitals services are reasonable;
  2. The aggregate rates are related reasonably to the Regulated Maryland Hospital's aggregate costs; and
  3. Rates are set equitably among all Maryland Payers and Medicare without undue discrimination or preference.
- ii. If Maryland makes changes to Md. Code Ann., Health-Gen. §19-201 *et seq.* that CMS determines, in its sole discretion, are not consistent with the all-payer requirement of this Model, CMS may pursue modification, Corrective Action, or termination under Section 14.
- b. **Differential.**
- i. **Differential definition.** For purposes of this agreement, the Differential is defined as the percentage difference between the rates established by the HSCRC for Regulated Maryland Hospitals for a given charge and the lesser amount paid by public payers (Medicare, Medicaid, and CHIP) for the same charge.
  - ii. **Medicare differential.** The total Differential (including working capital discount) that the State must provide Medicare for its business practices and prompt payment practices shall be at a minimum 6.0%.
  - iii. **Change in payment Differential.** If the per capita total hospital cost growth is less than the all-payer ceiling established in Section 8.a.i during a given Performance Year, but Medicare savings is not sufficient to meet the corresponding target set forth in Section 8.b.i, the State may apply a Differential to assure the required Medicare savings. To assure that the State solely uses the Differential in a manner consistent with this Agreement, CMS must review and approve any change in the Differential prior to its implementation. Any approved Differential must be applied prior to any deductible or coinsurance adjustment being made on any billing.
- c. **Claims processing.** CMS shall continue to pay claims for Medicare services pursuant to established procedures and through the applicable Medicare Administrative Contractor(s) ("MAC").

d. **Design and approval of new payment methods.** The State will notify CMS of any new payment methodology for Regulated Maryland Hospitals, including but not limited to Population-Based Payment reimbursement pursuant to Section 8.c., prior to implementation. Upon notification, if after consultation with the State, CMS believes the change to be substantive, CMS may request within 7 business days of receipt of the State's notification, a detailed proposal and operational plan describing the new payment arrangement for review and approval by CMS. Notwithstanding the above, current payment methodologies used by the State, including routine rate-setting, shall not require prior approval as set forth under this subsection. Certain CMS approvals may be subject to further approval by other departments and/or agencies within the federal executive branch. This operational plan must include the following information:

- i. How the proposed payment change will enhance Maryland's ability to meet the cost and quality targets established under this Model;
- ii. The potential impact of the proposed payment change on the total Medicare cost growth rate;
- iii. Descriptions of any waivers of the requirements of Title XI or Title XVIII of the Act that the State would like the DHHS to consider as part of the new payment method;
- iv. Waivers of the requirements of Title XVIII of the Act that the State believes would be necessary for the successful implementation of a proposed payment model;
- v. The perspective of key stakeholders, including Regulated Maryland Hospitals and governmental and third-party payers that might be included in the proposed payment change;
- vi. The State's plans, as applicable, to encourage Regulated Maryland Hospitals' participation in any proposed payment change that will be voluntary; and
- vii. The State's monitoring and evaluation strategy for the proposed payment change.

CMS shall make reasonable efforts to approve, reject or request amendment or modification of the State's proposal and operational plan within 180 calendar days of receipt. Notwithstanding the above, all normal DHHS approval

processes will apply to proposed new payment methodologies under this Model. Final approval of any proposal and operational plan shall be at the sole discretion of CMS and, as applicable, other departments and/or agencies in the federal executive branch.

8. **Parameters of Model Design.** Maryland must meet, including by imposing these obligations on Regulated Maryland Hospitals through any appropriate statutory or regulatory action, the following requirements as material terms of this Agreement:

a. **All-payer total inpatient and outpatient hospital cost growth per capita.**

- i. **All-payer ceiling.** Over Performance Years 1, 2, and 3, the State must limit the cumulative annual all-payer per capita total hospital revenue growth for Maryland residents, as specified in this Agreement, to less than or equal to the per capita growth ceiling. This calculation will include all Regulated Revenue (as defined in Section 8.c.ii.) for Maryland residents and the per capita calculations will include all Maryland residents. For Performance Years 1 through 3, the growth limit is fixed at 3.58 percent per capita per year, which represents Maryland's per capita gross state product ("GSP") compound annual growth rate between 2002-2012. In the third quarter of Performance Year 3, the State may, subject to prior approval by CMS, update such annual all-payer per capita total hospital revenue growth limit for Performance Years 4 and 5 to Maryland's 10-year per capita GSP growth rate based on the most recently available data.
- ii. **All-payer baseline and Performance Year calculations.** By no later than May 1 in the first Performance Year, the State shall calculate the all-payer per capita total hospital revenue amount for Maryland residents in 2013 in accordance with the methodology set forth in Appendix 3. For any given Performance Year, by no later than May 1 of the subsequent Performance Year, the State will calculate the Performance Year's all-payer per capita total hospital revenue amount for Maryland residents in accordance with the methodology set forth in Appendix 3. At the same time, the State shall also calculate for the entire Model performance period, the compounded annual all-payer revenue limit along with the total hospital revenue amount for Maryland residents. No later than 30 calendar days after performing such calculations, the State will provide to CMS the Performance Year's and the composite Model years' calculated per capita total hospital revenue amount and, in accordance with applicable law, all underlying data, including access to contractors, contract deliverables, and

software systems used to make the calculation, necessary to validate the State's calculation.

- iii. **Adjustments to the All-Payer limit calculation for exogenous factors.** Per capita cost increases may occur due to factors unrelated to the Model (e.g., a localized disease outbreak, expansion of health insurance coverage under the Affordable Care Act, the construction of the new hospital facility in Prince George's County). The State may submit in writing to CMS feedback on the impact of any such factors on the Model, including a suggestion on how to adjust the Model on the basis of such factors. Any such adjustment will be at the sole discretion of CMS.

**b. Medicare per beneficiary total hospital cost growth.**

- i. **Performance Year savings.** Over the performance period of this Model, the State must produce aggregate savings in the Medicare per beneficiary total hospital expenditure for Maryland resident fee-for-service ("FFS") Medicare beneficiaries, regardless of the state in which the service was provided, equal to or greater than \$330,000,000.00, to be calculated in the manner specified in Appendix 4. The State shall achieve the following minimum savings amount during the performance period of the Model:

Performance Year 1: \$0.00 (\$0.00 cumulative savings)  
Performance Year 2: \$49,500,000.00 (\$49.5M cumulative savings)  
Performance Year 3: \$82,500,000.00 (\$132M cumulative savings)  
Performance Year 4: \$115,500,000.00 (\$247.5M cumulative savings)  
Performance Year 5: \$82,500,000.00 (\$330M cumulative savings)

- ii. **Medicare baseline and Performance Year calculations.** CMS shall calculate Medicare baseline and Performance Year expenditures in accordance with the methodology set forth in Appendix 4. Specifically, by no later than May 1 in the first Performance Year, CMS shall calculate a Medicare baseline consisting of the actual Medicare per beneficiary total hospital expenditure for Maryland resident FFS beneficiaries in 2013, regardless of the state in which the service was provided, and a baseline for the national Medicare per beneficiary total hospital expenditure for non-Maryland resident FFS beneficiaries. For any given Performance Year, by no later than May 1 of the subsequent Performance Year, CMS shall calculate the Performance Year's Medicare per beneficiary total

hospital expenditure amount for Maryland resident FFS beneficiaries, regardless of the state in which the service was provided.

- iii. **Medicare savings calculation.** Using the methodology set forth in Appendix 4, CMS shall determine Medicare savings for each Performance Year by comparing the growth rate from the 2013 baseline in Medicare per beneficiary total hospital expenditures for Maryland resident FFS beneficiaries, regardless of the state in which the service was provided, to the national growth rate in Medicare per beneficiary total hospital expenditures for FFS beneficiaries. No later than 30 calendar days after performing such calculation, CMS will provide the State with the Performance Year's Medicare savings calculation and, in accordance with applicable law, all underlying data necessary to validate the calculation.
- iv. **Adjustments to the Medicare savings calculation for payments made under the Medicare program and/or Medicare demonstrations or models.** CMS may make adjustments to the Medicare savings calculation as necessary and as specified in this sub-section to avoid duplicative accounting for, and payment of, amounts made to or received by hospitals in the State of Maryland that are participating in any existing or future Medicare program, demonstration or model, including but not limited to those that involve shared savings or incentive payments. In order to assure a fair comparison, CMS will adjust national Medicare fee-for-service expenditures in a manner similar to any adjustments made for Maryland Medicare fee-for-service expenditures, e.g., to reflect cash payments for hospitals outside of the fee for service model or under any shared savings or incentive payments. By no later than December 31 of Performance Year 1, CMS, in consultation with the State, will finalize an adjustment methodology to apply to each Performance Year of the Model, including Performance Year 1.
  - 1. **Shared savings.** The State shall require all Regulated Maryland Hospitals that are participating in Medicare programs, demonstrations, or models involving shared savings to provide information to the State no less than annually on the amount of any and all shared savings payments distributed to the hospital, regardless of the entity receiving the payment from CMS. The State must transmit all such information to CMS no later than 60 calendar days following receipt. CMS shall adjust Maryland's annual Medicare savings amount as appropriate in accordance with the preceding paragraph.

2. **Program penalties.** Any Medicare penalties (e.g., EHR penalty) applied to hospitals in the State of Maryland shall be excluded from the calculation of the annual Medicare savings amount specified in this sub-section. CMS will exclude penalties from national data in a similar manner to achieve comparability.
- v. **Adjustments to the Medicare savings calculation for exogenous factors.** CMS recognizes that Medicare per beneficiary cost increases may occur due to factors unrelated to the Model (e.g., a localized disease outbreak solely in Maryland, expansion of health insurance coverage under the Affordable Care Act, the construction of the new hospital facility in Prince George's County). The State may submit in writing to CMS feedback on the impact of any such factors on the Model, including a suggestion on how to adjust the Model on the basis of such factors. Any such adjustment will be at the sole discretion of CMS.
- c. **Population-based revenue.**
- i. **Population-Based Payment definition.** Population-Based Payment is defined as hospital payment that either (1) is directly population-based, such as tying hospitals' reimbursement to the projected services of a specific population or specific residents, or (2) establishes a fixed global budget for hospitals for services unconnected to assignment of a specific population but is related to historical trends, the hospital service area, and residents served through the implementation of innovative care models.
  - ii. **Regulated Revenue.** Regulated Revenue is defined as the full subset of revenue earned by Regulated Maryland Hospitals for which the State has the legal authority to set payment rates and for which CMS has agreed to reimburse on the basis of the set rates under this Model.
  - iii. **Hospital revenue requirements.** Over the performance period of this Model, the State must facilitate the movement of all Regulated Revenue for Maryland residents into Population-Based Payment reimbursement. The State must request prior approval from CMS to determine whether certain revenue qualifies as Population-Based Payment reimbursement. Beginning with the second Performance Year, by no later than May 1 following a Performance Year, the State must report the percentage of all Regulated Revenue for Maryland residents under Population-Based Payment reimbursement for the previous Performance Year. This percentage will be calculated by including in the numerator all Regulated

Revenue for Maryland residents approved by CMS as Population-Based Payment reimbursement and the denominator will include all Regulated Revenue for Maryland residents. The following minimum percentages of all Regulated Revenue under Population-Based Payment reimbursement must be met:

Performance Year 2: 50.0%

Performance Year 3: 60.0%

Performance Year 4: 70.0%

Performance Year 5: 80.0%

- iv. **Non-population based revenue and variable cost factors.** The State will subject hospital Regulated Revenue that is not covered under a Population-Based Payment approach to a volume adjustment system with use of variable cost factors, update factors, and a volume governor, as necessary, so that these hospitals operate within the all-payer and Medicare revenue limitations prescribed by the Model as enumerated in this Agreement. The HSCRC will be able to adjust these factors on a more specific regional or hospital basis to assure accountability and compliance with the terms of this Agreement at the operational level for key population health and revenue goals.

**d. Maryland hospital readmissions program.**

- i. **Model requirements.** As a condition of the Waiver set forth in Section 4.c., over the performance period of this Model, the State must reduce the aggregate Medicare 30-day unadjusted all-cause, all-site hospital readmission rate (“Readmission Rate”) for Medicare FFS beneficiaries such that, by the end of Performance Year 5, Regulated Maryland Hospitals have achieved equal to or less than the national Readmission Rate for Medicare FFS beneficiaries at the end of Performance Year 5. If in a given Performance Year Regulated Maryland Hospitals, in aggregate, fail to outperform the national Readmissions Rate change by an amount equal to or greater than the cumulative difference between the Regulated Maryland Hospital and national Readmission Rates in the base period divided by five, CMS shall follow the corrective action and/or termination provisions of the Waiver of Section 1886(q) as set forth in Section 4.c and in Section 14. CMS shall consider whether the State can demonstrate that it is implementing a program for Regulated Maryland Hospitals and, as applicable, other hospitals in Maryland that achieves or surpasses the

measured results in terms of patient outcomes and cost savings established under Section 1886(q) of the Act.

**ii. Readmission rate calculation.**

- 1. Base period calculation.** By no later than May 1 of the first Performance Year (2014), CMS will calculate the Regulated Maryland Hospital Readmission Rate and the national Readmission Rate for the base year (2013) in accordance with the methodology set forth in Appendix 5. CMS will provide the State with the calculation and, in accordance with the procedures set forth in Section 9 and applicable law, all underlying data necessary to validate the calculation.
- 2. Performance period calculation.** For a given Performance Year, by no later than May 1 of the subsequent Performance Year, CMS shall calculate the Regulated Maryland Hospital Readmission Rate and the national Readmission Rate in accordance with the methodology set forth in Appendix 5. CMS will provide the State with the calculation and, in accordance with the procedures set forth in Section 9 and applicable law, all underlying data necessary to validate the calculation.

**e. Maryland hospital acquired conditions program.**

- i. Model requirements.** As a condition of the Waiver set forth in Section 4.d, over the performance period of this Agreement, the State must achieve an aggregate 30.0% reduction across all 65 Potentially Preventable Conditions (PPC) that comprise Maryland's Hospital Acquired Condition program. The State shall calculate percentage achievement in accordance with the methodology set forth in Appendix 6. The State will provide CMS with the calculation and, in accordance with applicable law, all underlying data necessary to validate the calculation. Prior to Performance Year 2, CMS and Maryland will establish annual reduction targets for PPCs that overlap with conditions indicated in Appendix 6. If the State fails to achieve an aggregate 6.89% reduction across all 65 PPCs that comprise Maryland's Hospital Acquired Condition program in a given Performance Year, CMS shall follow the corrective action and/or termination provisions of the Waiver of Section 1886(p) as set forth in Section 14. CMS shall consider whether the State can

demonstrate that it is implementing a program for Regulated Maryland Hospitals and, as applicable, other hospitals in Maryland that achieves or surpasses the measured results in terms of patient outcomes and cost savings established under Section 1886(q) of the Act.

- f. **Medical education innovation.** The State must convene medical schools and schools of health professionals in Maryland to develop a five-year plan that will serve as a blueprint for improvement elements necessary to sustain health transformation initiatives in Maryland and which will be generalizable to other schools across the United States. The State shall submit this plan to CMS no later than January 1, 2016. CMS will not provide funds to develop or implement such plan. Further, the State will not fund the development of such plan through an increase in hospital rates reimbursed by Maryland Payers and Medicare.
  - g. **Regulated Revenue at risk.** The State must ensure that the aggregate percentage of Regulated Revenue at risk for quality programs administered by the State is equal to or greater than the aggregate percentage of revenue at risk under national Medicare quality programs. Quality programs include, but are not limited to, readmissions, hospital acquired conditions, and value-based purchasing programs. CMS shall provide the State with the aggregate percentage of revenue at risk under national Medicare quality programs annually. Each Performance Year, at a time and in a manner and format to be specified by CMS, the State must provide CMS with Maryland's aggregate percentage of Regulated Revenue at risk for quality programs and shall make available, at CMS's request, all underlying data, including access to contractors, contract deliverables, and software systems used to make the calculation, necessary to validate the State's calculation.
9. **Data Sharing.** Over the performance period of the Model, CMS is willing to accept data requests from the State or its agents for data necessary to achieve the purposes of the Model. Such data could include de-identified (by patient or by provider) data or individually identifiable health information such as claims level data. All such requests for individually-identifiable health information must clearly state the HIPAA basis for requested disclosure. CMS will make best efforts to approve, deny or request additional information within 30 calendar days of receipt. Appropriate privacy and security protections will be required for any data disclosed under this Model.
10. **Confidentiality.** The State must develop procedures to protect the confidentiality of all information that identifies individual Medicare beneficiaries in accordance with all applicable laws.

## 11. Evaluation of Model.

- a. **CMS evaluation.** CMS shall evaluate the Model in accordance with Section 1115A(b)(4) of the Act, and in comparison with the national Medicare program in other states. CMS and/or its contractor(s) shall measure, monitor, and evaluate the overall impact of the Model including but not limited to the impacts on program expenditures and service utilization changes, including any shifting of services between medical and non-medical services and any growth in Maryland hospital spending by non-resident Medicare beneficiaries receiving hospital care in Maryland. The evaluation shall include elements selected by CMS for assessing the Model including, changes in person-level health outcomes, experience of care, and costs by sub-population(s); changes in patterns of primary, acute, and long-term care and support services use and expenditures; and changes in the dynamics of the healthcare market, using principles of rapid-cycle evaluation and feedback. The evaluation shall consider potential interactions with other demonstrations and initiatives, and seek to isolate the effect of this Model as appropriate. CMS and the State agree that the State or its agents will provide CMS and/or its contractor(s) with all data needed to operate the Model in accordance with applicable law. Such data, may include, but would not be limited to, individually identifiable health information that is needed to carry out CMS' evaluation and monitoring of this Model. The State will ensure the production of such data for evaluation purposes through statutory or regulatory mandates on those holding the required data, or through arrangements under alternative legal bases. Furthermore, the State and its agents shall cooperate, and shall also ensure the cooperation of the State's contractor(s) and, to the extent permitted by law, Regulated Maryland Hospitals and Maryland Payers, in any CMS health oversight activities under its health oversight authority. The State, its contractor(s) and Regulated Maryland Hospitals must submit timely all data required for the monitoring and evaluation of this Model, which may include the terms of any arrangements related to rate-setting or payment entered into between the State and Regulated Maryland Hospitals prior to or during the Model. Where available, and to the extent permitted by law, the State will make best efforts to obtain data from Maryland Payers necessary to evaluate and monitor the Model. As permitted by applicable law, the State and Regulated Maryland Hospitals must submit both historical data relevant to the evaluation from the years immediately preceding the Model, and data generated during the Model period.
- b. **Maryland evaluation.** For any given Performance Year, by no later than June 30 of the subsequent Performance Year, the State must submit to CMS a report cataloging its performance with respect to the financial and quality requirements

described in this Agreement, including the data and measures listed in Appendix 7. The State must make available to CMS and CMS' contractors for validation and oversight purposes the Maryland datasets and methodologies used for this evaluation, including, as applicable, access to contractors, contract deliverables, and software systems used to make calculations required under this Agreement. Any information provided to CMS will be used by CMS solely for the purposes described in this Agreement. Additionally, the State will make best efforts to require by law or regulation non-federal hospitals licensed in the State of Maryland, including but not limited to Regulated Maryland Hospitals, to meet the reporting requirements under the Hospital Inpatient Quality Reporting ("IQR") and Hospital Outpatient Quality Reporting ("OQR") programs. In its annual report, Maryland must include a summary of data it has received on all such hospitals' performance with respect to the IQR and OQR measures.

## **12. Monitoring of Model.**

- a. **CMS monitoring.** CMS shall monitor the State's compliance with the terms of this Agreement and reserves the right to conduct monitoring activities.
- b. **Maryland monitoring.** The State must establish procedures to monitor Regulated Maryland Hospitals. The State's monitoring plan, as updated from time to time, is attached to this Agreement as Appendix 8. Further, for any given Performance Year, by no later than May 1 of the subsequent Performance Year, the State and CMS will calculate the percentage of Medicare hospital revenue attributable to non-resident Medicare beneficiaries. If the percentage of Medicare hospital revenue attributable to non-resident Medicare beneficiaries is 1.5 percentage points above the percentage level of calendar year 2013, the State must also provide a review of the causes of such increase. Further, the State must monitor for deviations from standard business practices related to the Model by Regulated Maryland Hospitals and will report any such deviations to CMS no later than 30 calendar days after identification. The State must timely provide CMS with records relating to its monitoring efforts and findings at CMS's request.
- c. **Maintenance of records.** In accordance with applicable law, the State must maintain and give CMS, DHHS, the Department of Justice, the Government Accountability Office, and other federal agencies or their designees access to all books, contracts, records, documents, software systems, and other information (including data related to calculations required under this Agreement, Medicare utilization and costs, quality performance measures, shared savings distributions, and other financial arrangements) sufficient to enable the audit, evaluation,

inspection, or investigation of the State's and/or Regulated Maryland Hospitals' compliance with the requirements of this Model. The State must maintain such books, contracts, records, documents, and other information for a period of 10 years after the final date of the performance period or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later.

13. **Modification.** The Parties may amend this Agreement, including any appendix hereto, at any time by mutual written consent. CMS may, in its sole discretion, amend this Agreement for good cause shown or as necessary to comply with applicable federal or State law, regulatory requirements, accreditation standards or licensing guidelines or rules. CMS shall include with any proposed amendment an explanation of the reasons for the proposed amendment. To the extent practicable, CMS shall provide the State with 30 calendar days advance written notice of any such amendment, which notice shall specify the amendment's effective date. If State law precludes application of the amendment to the Agreement, the parties will promptly seek modification of the amendment. If modification of the amendment is impracticable and consensus cannot be reached, CMS may terminate the Model and/or Waivers under the terms of Section 14.

14. **Corrective Action and Termination of Model and/or Waivers.**

- a. **Warning notice and corrective action plan ("CAP").** If CMS determines that a Triggering Event (as defined in this section) has occurred, CMS shall provide written notice to the State that it is not meeting a requirement of this Agreement ("Warning Notice") with an explanation and, as permitted by applicable law, data supporting its determination. CMS shall provide the State with the Warning Notice no later than six months following the end of the applicable Performance Year for any Triggering Event specified in Section 14.c.ii-vii; CMS may provide the Warning Notice at any time for all other Triggering Events in Section 14.c. Within 90 calendar days of receipt of the Warning Notice, the State must submit a written response to CMS. CMS will review the State's response within 90 calendar days and will either accept the response as sufficient or require the State to submit a CAP within 30 calendar days addressing all actions the State and/or participants in the Model will take to correct any deficiencies and remain in compliance with this Agreement. Options for the CAP may include, but are not limited to, new safeguards or programmatic features, modification to the Model, and/or prospective adjustments to hospital payment levels. In developing its CAP, the State shall consult with CMS as to whether the CAP fully corrects any deficiencies. Approval of the CAP shall be at the sole discretion of CMS.

- i. **Review factors considered by CMS.** A Triggering Event may or may not require corrective action, depending on the totality of the circumstances. CMS will consider whether the State can demonstrate a factor unrelated to the Model caused the Triggering Event (e.g., a localized disease outbreak solely in Maryland, expansion of health insurance coverage under the Affordable Care Act, the construction of the new hospital facility in Prince George's County). Notwithstanding the above, CMS, in its sole discretion, will determine the sufficiency of the State's response to any Warning Notice issued pursuant to this section.
- b. **Implementation of CAP.** The State shall successfully implement any required CAP as approved by CMS, by no later than 365 calendar days from the date of postmark of the Warning Notice. If the Triggering Event is related to an aspect of the Model involving a Waiver from the Act, as specified in Section 4.c., d., e., and f., CMS, in its sole discretion, shall decide whether to allow the State to maintain such Waiver during the time period that the State is under the CAP. In making this determination, CMS shall consider whether the State can demonstrate that it is implementing a program for Regulated Maryland Hospitals and, as applicable, other hospitals in Maryland that achieves or surpasses the measured results in terms of patient outcomes and cost savings established under the applicable section of the Act from which it was waived.
- c. **Triggering Event.** A Triggering Event may include, but is not limited to, any of the following:
  - i. A material breach of any provision set forth in this Agreement.
  - ii. A determination by CMS that the State has not produced aggregate savings in the Medicare per beneficiary total hospital expenditure for Maryland resident FFS beneficiaries, regardless of the state in which the service was provided, for two consecutive Performance Years, as calculated in accordance with Section 8.b.
  - iii. A determination by CMS that the State has failed to meet the cumulative target set forth for the applicable Performance Year under Section 8.b. by a total of \$100,000,000.00 or more.
  - iv. A determination by CMS that the annual growth rate in Medicare per beneficiary total cost of care for Maryland residents, regardless of the state in which such residents receive service, is greater than 1.0 percentage point above the annual national Medicare per beneficiary total cost of care

growth rate during a single Performance Year. In accordance with Section 9, and as permitted by applicable law, CMS will provide the State with national and Maryland-specific data necessary to validate CMS's calculation of the annual growth rate in Medicare per beneficiary total cost of care trends by service line.

- v. Effective beginning Performance Year 2, a determination by CMS that the annual growth rate in Medicare per beneficiary total cost of care for Maryland residents, regardless of the state in which such residents receive service, is greater than the annual national Medicare per beneficiary total cost of care growth rate for any two consecutive Performance Years.
  - vi. A determination by CMS that the percentage of Medicare hospital revenue attributable to non-resident Medicare beneficiaries is 1.5 percentage points above the percentage level of calendar year 2013.
  - vii. A determination by CMS that the quality of care provided to Medicare, Medicaid or CHIP beneficiaries has deteriorated.
  - viii. A determination by CMS that the State and/or Regulated Maryland Hospital(s) have taken actions that compromise the integrity of the Model and/or the Medicare trust funds.
- d. **Rescission or modification of aspects of Model and/or Waivers.** If CMS determines, in its sole discretion, that the State has not successfully implemented a required CAP in the time period specified under a Warning Notice, CMS may amend or rescind the relevant aspect of the Model and/or relevant accompanying Waiver. If CMS rescinds a Waiver provided for under Section 4, except for the Waivers specified in Sections 4.a. and 4.b., the State must comply with applicable national Medicare requirements by a date certain to be specified by CMS.
- e. **Termination of the Performance Period.**
- i. **Termination by CMS.** If CMS determines, in its sole discretion, that the State has not successfully implemented a required CAP or complied with an alternative CMS-provided corrective action in the time period specified under a Warning Notice, CMS may immediately terminate the performance period of this Agreement. Notwithstanding the above, CMS will not terminate this Agreement based on Triggering Events under Sections 14.c.vi., but may require additional corrective action to be specified in the sole discretion of CMS.

- ii. **Termination by the State.** The State may terminate the performance period of this Agreement at any time for any reason upon 180 calendar days written advance notice to CMS.
  - iii. **Transition to IPPS/OPPS.** If either CMS or the State terminates the performance period of this Agreement, the State shall have two calendar years from the date of termination for Regulated Maryland Hospitals to transition to payment under the national Medicare program, whereupon this Agreement shall terminate immediately.
  - iv. **Survival.** Termination of this Agreement by either Party shall not affect the rights and obligations of the Parties accrued prior to the effective date of the termination or expiration of this Agreement.
- f. **Termination under Section 1115A(b)(3)(B).** CMS may terminate this Agreement immediately if the Secretary makes findings under Section 1115A(b)(3)(B) of the Act requiring the termination of the Model.
- g. **Federal government enforcement.** Nothing contained in this Agreement is intended or shall be construed as a waiver by the United States Department of Justice, the Internal Revenue Service, the Federal Trade Commission, HHS Office of the Inspector General (OIG), or CMS of any right to institute any proceeding or action against defendants for violations of any statutes, rules or regulations administered by the federal government, or to prevent or limit the rights of the federal government to obtain relief under any other federal statutes or regulations, or on account of any violation of this Agreement or any other provision of law. This Agreement shall not be construed to bind any federal government agency except CMS, and this Agreement binds CMS only to the extent provided herein. The failure by CMS to require performance of any provision shall not affect CMS's right to require performance at any time thereafter, nor shall a waiver of any breach or default of this Agreement constitute a waiver of any subsequent breach or default or a waiver of the provision itself. None of the provisions of this Agreement limit or restrict the OIG's authority to audit, evaluate, investigate, or inspect the State, hospitals or providers in the state of Maryland, or individuals or entities performing functions or services related to activities under this Agreement.

## 15. Preclusion.

- a. **Matters precluded from administrative and judicial review.** The State acknowledges and understands that Section 1115A(d)(2) of the Act precludes

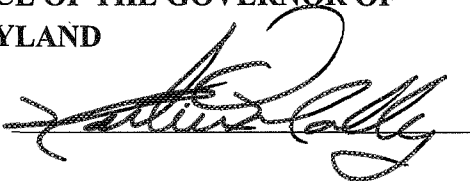
from administrative and judicial review the elements, parameters, scope and duration of this Model, and that the elements and parameters of this Model include, but are not limited to, the following: (1) the methodology used to determine the annual all-payer per capita total hospital cost growth for Maryland residents; (2) the methodology used to determine the aggregate savings in the Medicare per beneficiary total hospital expenditure for Maryland resident FFS beneficiaries; (3) the methodology used to determine the percentage of Regulated Revenue that is under Population-Based Payment reimbursement; (4) the methodology used to make adjustments to the Medicare savings calculation as necessary to avoid duplicative accounting for, and payment of, Medicare amounts made to or received by hospitals, including but not limited to those that involve shared savings or incentive payments; (5) claims that dispute financial or quality results based on the State's inability to use or apply CMS data provided during the Performance Year; and (6) the transition to payment under the national Medicare program if invoked under this Agreement.

**16. Entire Agreement.** This Agreement, including all appendices hereto, each of which is incorporated by reference, constitutes the entire agreement between the Parties.

**The Parties are signing this Agreement on the date stated in the introductory clause.**

**OFFICE OF THE GOVERNOR OF  
MARYLAND**

By



Martin O'Malley  
Governor

**CENTERS FOR MEDICARE  
& MEDICAID SERVICES**

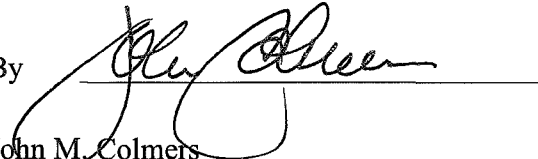
By



Patrick Conway  
Director, CMMI

**HEALTH SERVICES COST  
REVIEW COMMISSION**

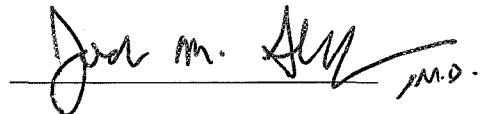
By



John M. Colmers  
Chairman

**DEPARTMENT OF HEALTH  
AND MENTAL HYGIENE**

By



Joshua M. Sharfstein  
Secretary

**Attachments:**

- Appendix 1: Maryland Hospital Facilities and Revenue Regulation Status
- Appendix 2: Maryland Statement of Non-Election of Section 1814(b)(3)
- Appendix 3: Specifications for Calculating All-Payer Ceiling
- Appendix 4: Specifications for Calculating Medicare Savings
- Appendix 5: Specifications for Maryland's Hospital Readmissions Program
- Appendix 6: Specifications for Maryland's Hospital Acquired Conditions Program
- Appendix 7: Maryland Reporting
- Appendix 8: Maryland Monitoring Plan

## Appendix 1: Maryland Hospital Facilities and Revenue Regulation Status

Maryland regulates rates and Medicare pays on the basis of regulated rates for those entities indicated below. The State will update timely this list, such that at all times during the term of this Agreement it accurately reflects all hospitals in the State of Maryland for which payments are regulated by the State for all payers including Medicare.

Regulated (Medicare)	Medicare Provider Number	Hospital Name	Type
Yes	21 0001	Meritus Medical Center	Acute
Yes	21 0002	University of Maryland Medical Center	Acute
Yes	21 0003	Dimensions - Prince Georges	Acute
Yes	21 0004	Holy Cross	Acute
Yes	21 0005	Frederick Memorial	Acute
Yes	21 0006	UCH-Harford	Acute
Yes	21 0008	Mercy	Acute
Yes	21 0009	Johns Hopkins	Acute
Yes	21 0010	UM Shore Medical Easton/Dorchester	Acute
Yes	21 0011	St. Agnes	Acute
Yes	21 0012	Sinai	Acute
Yes	21 0013	Bon Secours	Acute
Yes	21 0015	MedStar Franklin Square	Acute
Yes	21 0016	Washington Adventist	Acute
Yes	21 0017	Garrett County	Acute
Yes	21 0018	MedStar Montgomery General	Acute
Yes	21 0019	Peninsula Regional	Acute
Yes	21 0022	Suburban	Acute
Yes	21 0023	Anne Arundel	Acute
Yes	21 0024	MedStar Union Memorial	Acute
Yes	21 0027	Western Maryland Health System	Acute
Yes	21 0028	MedStar St. Mary's	Acute
Yes	21 0029	Johns Hopkins -Bayview	Acute
Yes	21 0030	UM Shore Medical Center Chestertown	Acute
Yes	21 0032	Union Hospital Cecil County	Acute
Yes	21 0033	Carroll County Medical Center	Acute
Yes	21 0034	MedStar Harbor Hospital	Acute
Yes	21 0035	UM Charles Regional Medical Center	Acute
Yes	21 0037	UM Shore Medical Easton	Acute
Yes	21 0038	UMMC Midtown	Acute

Yes	21	0039	Calvert Memorial	Acute
Yes	21	0040	Northwest	Acute
Yes	21	0043	UM Baltimore Washington	Acute
Yes	21	0044	G.B.M.C.	Acute
Yes	21	0045	McCreedy	Acute
Yes	21	0048	Howard County General Hospital	Acute
Yes	21	0049	Upper Chesapeake Health	Acute
Yes	21	0051	Doctors Community	Acute
Yes	21	0055	Dimensions - Laurel Regional	Acute
Yes	21	0060	Ft. Washington	Acute
Yes	21	0061	Atlantic General	Acute
Yes	21	0062	MedStar Southern Maryland	Acute
Yes	21	0063	UM St. Joseph	Acute
Yes	21	0904	Johns Hopkins - Oncology	Acute
Yes	21	0058	UM Rehabilitation & Orthopedic Institute	Acute
Yes	21	0056	MedStar Good Samaritan	Acute
Yes	21	0057	Adventist HealthCare - Shady Grove	Acute
Yes	21	8992	Univ. of MD MEIMS	Acute
Yes	21	0087	Germantown Emergency Center	FSE
Yes	21	0088	Queen Anne's Emergency Center	FSE
Yes	21	0333	Bowie Emergency Center	FSE
Yes	21	5033	Levindale	Specialty
No	21	02V0	VA –Maryland Healthcare System - Baltimore	Acute-Veterans
No	21	3478	Adventist Behavioral Health at Eastern Shore	Psychiatric
No (Note)	21	4000	Sheppard Pratt	Psychiatric
No (Note)	21	4003	Brook Lane	Psychiatric
No (Note)	21	4013	Adventist Behavioral Health Rockville	Psychiatric
No	21	3028	Health South - Chesapeake Rehab	Rehabilitation
No	21	3029	Adventist Rehab of Maryland	Rehabilitation
No (Note)	21	5034	Mt. Washington Pediatrics	Specialty
No	21	4012	Thomas B Finan Center	Psychiatric
No	21	3301	Kennedy Krieger Institute	Specialty

Note: The State regulates rates for these facilities for non-governmental payers, but Medicare does not pay on the basis of these regulated rates.

**STATE OF MARYLAND**  
**OFFICE OF THE GOVERNOR**

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**MARTIN O'MALLEY**  
GOVERNOR

STATE HOUSE  
100 STATE CIRCLE  
ANNAPOLIS, MARYLAND 21401-1925  
(410) 974-3901  
(TOLL FREE) 1-800-811-8336  
TTY USERS CALL VIA MD RELAY

February 6, 2014

Secretary Kathleen Sebelius  
U.S. Department of Health and Human Services  
200 Independence Ave., S.W.  
Washington, DC 20201

Dear Secretary Sebelius:

In April of 1985, Maryland's Governor Harry Hughes notified the Health Care Financing Administration that the State of Maryland was choosing to continue its Medicare waiver, granted as of July 1, 1977, in accordance with the provisions of Section 1814(b)(3) of the Social Security Act. During these intervening years, Maryland has consistently held the rate of increase in hospital costs per admission below the national rate of increase, with cumulative savings to all payers of more than \$52.8 billion. Maryland's unique system has also fairly distributed the costs of caring for the uninsured, and it has eliminated cost shifting among payers.

In recent years, changes in the national healthcare delivery system have created an imperative to control costs, improve outcomes, and improve patient experience at the same time. To accomplish these goals, Maryland's all-payer system needs to be modernized. It was designed to provide incentives for treating people when they got sick – but it provides insufficient incentive for keeping people healthy.

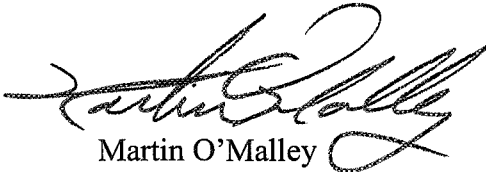
Our All-Payer System allows the federal government and Maryland to work together to test innovations and payment reforms. I am proud, therefore, that the partnership between the State of Maryland and the federal government is becoming even stronger with the implementation of a groundbreaking new model of health care delivery. The new model will allow us to create consistent and aligned incentives for all providers. Our hospitals have committed to achieving significant quality improvements, including reductions in the rate of readmissions and the number of patients with hospital-acquired-conditions. Through this continuing partnership, we are committed to serving as a guide for the rest of the nation in the launching of an innovative and transformative healthcare delivery system that prioritizes the prevention of sickness, the promotion of wellness, and the reduction of overall costs.

Page Two  
February 6, 2014  
Secretary Kathleen Sebelius

Therefore, the State of Maryland elects to no longer have Medicare reimburse our hospitals in accordance with Section 1814(b)(3), and represents that, effective with the first day of the new Model, i.e., January 1, 2014, Maryland is no longer in continuous operation of a demonstration project reimbursement system since July 1, 1977, as required under Section 1814(b)(3) of the Act. Therefore, because Maryland and CMS have entered into the Maryland All-Payer Model Agreement, Maryland acknowledges that it no longer meets the requirements for reimbursement under Section 1814(b)(3) of the Act, and understands that all payment waivers under the 1814(b)(3) Medicare Waiver are thus terminated.

On behalf of the State of Maryland, thank you for your longstanding support of Maryland's unique approach to hospital payment, for your commitment to innovation, and for your efforts in bringing to fruition this bold new system of providing and paying for the care of all of Maryland's residents.

Sincerely,



Martin O'Malley  
Governor

cc: Secretary Joshua M. Sharfstein, Maryland Department of Health & Mental Hygiene  
John Colmers, Chairman, Health Services Cost Review Commission

## **Appendix 3: Specifications for Calculating All-Payer Ceiling**

### **I. The revenue increase limit calculation**

- 1) Base period: Regulated gross patient service revenue for Maryland residents in Maryland hospitals, where Maryland regulates rates paid by all-payers<sup>1</sup>. The base period is calendar year 2013.
- 2) Application of growth limit: Each year, this amount is increased by the annual growth ceiling (Base period revenue multiplied by  $1 + \text{All-Payer Revenue Limit of } 3.58\%$  for the first three years of the Model)
- 3) Population adjustment: Each year, the revenue limit will be adjusted for population growth, based on population projections from the Department of State Planning (Results of Line 2 above  $\times 1 + \text{Population Growth Percentage}$ )
- 4) Adjusted base: The results of this calculation will result in an adjusted base period that can be used in the calculation for the following year
- 5) Adjustments to cumulative revenue limit calculation: Maryland may request adjustments to the methodology used to calculate the limit. Adjustments will be reported and be subject to approval by CMMI/CMS. Requests for adjustment may include but are not limited to the following:
  - a) Changes in Regulated Revenues: If Maryland's regulation of hospital revenues were changed through statute and/or additional applications with CMS.
  - b) In and Out-Migration of Maryland residents: Changes in the in and out-migration of Maryland residents.
  - c) Exogenous Factors: Any exogenous factors that impacted hospital revenues

### **II. Reporting of actual revenue for comparison to the ceiling**

- 1) Actual revenue will be reported in a consistent manner with the calculation of the revenue limit calculation, beginning with Performance Year 2014.
  - a) Actual revenue will include gross revenue for Maryland residents served in Maryland hospitals for those hospitals where HSCRC sets the rates paid by all-payers.
  - b) By May 1 of each year following the end of the Performance Year, the State will compare the actual revenues to the maximum allowed revenue under the Model.
  - c) Actual revenues will be adjusted for changes in differential to achieve the required Medicare savings of the Model as follows: If HSCRC adjusts gross revenue to reflect the use of an increased differential to achieve cost savings to Medicare that are permitted under the Maryland All-Payer Model, the resulting changes to gross revenue when calculating a new differential will be netted against the gross revenue in reporting the actual revenue.

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<sup>1</sup> This excludes several facilities where Maryland sets hospital rates but these facilities are not

### **III. The Population Growth Factor**

The population growth estimates used in the calculations will be based on the population estimates of Maryland residents, based on Department of State Planning projections.

### **IV. All-Payer Per Capita Total Hospital Calculation**

For each Performance Year, beginning with Performance Year 2014, by May 1 of the following year, Maryland will provide CMS with a calculation of the All-Payer Per Capita Total Hospital Amount by dividing the actual revenues as described in this Appendix by the most recently available population estimates at the time of the calculation.

## **Appendix 4: Specifications for Calculating Medicare Savings**

1. CMS will calculate two fractions –1) Medicare per beneficiary inpatient hospital expenditures and 2) Medicare per beneficiary outpatient hospital expenditures, both for the State of Maryland and the nation. These two fractions will be added to determine the Medicare per beneficiary total hospital expenditures.

- This calculation will be done for both national Medicare fee-for-service beneficiaries and Maryland resident Medicare fee-for-service beneficiaries.
- The per beneficiary total hospital expenditure calculation for Maryland resident Medicare fee-for-service beneficiaries will include all inpatient and outpatient hospital expenditures for Maryland Medicare fee-for-service beneficiaries per these specifications, regardless of the state of service.

2. Medicare savings will be calculated in the following manner:

- Using the calculated Medicare per beneficiary total hospital expenditure described above, a baseline that is the actual Medicare per beneficiary total hospital expenditures for Maryland Medicare fee-for-service beneficiaries in 2013 will be established.
- For any given performance year, the baseline will be trended forward by the actual growth rate in national Medicare per beneficiary hospital expenditures to establish a benchmark. The national Medicare per beneficiary hospital expenditure amount will be calculated in the same manner as the Maryland Medicare per beneficiary expenditure amount.
- For the same performance year, the savings amount will be determined by comparing actual Maryland Medicare per beneficiary total hospital expenditures to the benchmark.
- CMS shall total all performance years to determine the cumulative savings/excess expenditure.

CMS will share the details of the methodology to be used for this calculation with Maryland. CMS may make adjustments to the Medicare savings calculation as necessary and as specified in this Agreement.

3. Medicare per beneficiary inpatient expenditures will be calculated by including in the numerator all fee-for service claims with a claim code “60” (indicating an inpatient service) billed from any facility listed in the table below. Facility serial numbers indicate the facility type. Serial numbers preceded with “21” indicate the facility is located in Maryland.

4. Medicare per beneficiary outpatient expenditures will be calculated by including in the numerator all fee-for service claims with a claim code “40” (indicating an outpatient service) billed from any of the highlighted facilities listed in the table below with the following exception: any 72x bill type (CLM\_BILL\_FAC\_TYPE\_CD = ‘7’ and CLM\_BILL\_CLSFCTN\_CD = ‘2’) will be excluded as these represent bills from ESRD clinics.

5. CMS and Maryland understand that Medicare billing rules and requirements may change over the course of the Model. As stated in Section of 13 of this Agreement, CMS and Maryland may modify the savings calculation methodology described in this Appendix.

6. CMS will make available data used for this calculation as specified in Section 9 of this Agreement.

#### Medicare Facility Types

Serial Number	Facility Description
0001-0879	Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X
0880-0899	Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X
0900-0999	Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1000-1199	Reserved for future use
1200-1224	Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1225-1299	Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X
1300-1399	Rural Primary Care Hospital (RCPH) - eff. 10/97 changed to Critical Access Hospitals (CAH)
1400-1499	Continuation of 4900-4999 series (CMHC)
1500-1799	Hospices
1800-1989	Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB) where TOB = 22X; HHA where TOB = 32X, 33X, 34X
1990-1999	Christian Science Sanatoria (hospital services) - eff. 7/00 changed to Religious Nonmedical Health Care Institutions (RNHCI)
2000-2299	Long-term hospitals
2300-2499	Chronic renal disease facilities (hospital based)
2500-2899	Non-hospital renal disease treatment centers
2900-2999	Independent special purpose renal dialysis facility (1)
3000-3024	Formerly tuberculosis hospitals (numbers retired)
3025-3099	Rehabilitation hospitals
3100-3199	Continuation of Subunits of Nonprofit and Proprietary Home Health Agencies (7300-7399) Series (3) (eff. 4/96)
3200-3299	Continuation of 4800-4899 series (CORF)
3300-3399	Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X
3400-3499	Continuation of rural health clinics (provider-based) (3975-3999)
3500-3699	Renal disease treatment centers (hospital satellites)
3700-3799	Hospital based special purpose renal dialysis facility (1)
3800-3974	Rural health clinics (free-standing)
3975-3999	Rural health clinics (provider-based)
4000-4499	Psychiatric hospitals
4500-4599	Comprehensive Outpatient Rehabilitation Facilities (CORF)
4600-4799	Community Mental Health Centers (CMHC); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X

4800-4899	Continuation of 4500-4599 series (CORF) (eff. 10/95)
4900-4999	Continuation of 4600-4799 series (CMHC) (eff. 10/95); 9/30/91 - 3/31/97 used for clinic OPT where TOB = 74X
5000-6499	Skilled Nursing Facilities
6500-6989	CMHC / Outpatient physical therapy services where TOB = 74X; CORF where TOB = 75X
6990-6999	Christian Science Sanatoria (skilled nursing services) - eff. 7/00 Numbers Reserved (formerly CS)
7000-7299	Home Health Agencies (HHA) (2)
7300-7399	Subunits of 'nonprofit' and 'proprietary' Home Health Agencies (3)
7400-7799	Continuation of 7000-7299 series
7800-7999	Subunits of state and local governmental Home Health Agencies (3)
8000-8499	Continuation of 7400-7799 series (HHA)
8500-8899	Continuation of rural health center (provider based) (3400-3499)
8900-8999	Continuation of rural health center (free-standing) (3800-3974)
9000-9799	Continuation of 8000-8499 series (HHA) (eff. 10/95)
9800-9899	Transplant Centers (eff. 10/1/07)
9900-9999	Reserved for future use

## **Appendix 5: Specifications for Maryland's Hospital Readmissions Program**

1. Use Part A claims for all Medicare beneficiaries that were enrolled in fee-for-service during the reference period and within 30 calendar days of the end of that period.
2. Limit analysis to inpatient claims from acute care hospitals.
3. Combine multiple stays (including transfers) into a single stay if the last day of one stay is the same as the first day of the next stay.
  - Multiple claims are combined into a single stay if the claims are on consecutive calendar days (i.e., March 2<sup>nd</sup> and March 3<sup>rd</sup>) and the first claim has a discharge code of 30 (still a patient).
4. Classify each inpatient stay as an index admission, a readmission, or both, as follows:
  - An inpatient stay counts as an index admission if:
    - The last service date for a stay falls within the month being analyzed and,
    - The stay does not have a patient discharge status code of 20 (patient died during stay).
    - Instances where a patient was discharged “against medical advice” are included as index stays.
  - An inpatient stay counts as a readmission if the first day of the stay occurred within 30 calendar days of the last service date of an index admission stay.
    - For example, when identifying readmissions for March index stays, the first day of the stay for a readmission could be as early as March 2 or as late as April 30.
    - For transfers, the 30-day period starts at the end of the combined stay.
    - Inpatient stays can count as readmissions even if the patient died during the stay.
5. The monthly readmission rate is equal to the total number of readmissions that occurred during the 30-day period divided by the total number of index admissions that occurred during the month.
  - Index stays are counted under the month of the last service date from that stay.
  - Readmission stays are counted under the month of the last service date from the corresponding index stay.
  - An inpatient stay can be both an index admission and a readmission, but an index admission cannot have more than one readmission.

## Appendix 6: Specifications for Maryland's Hospital Acquired Conditions Program

The Maryland Hospital Acquired Conditions Program utilizes a measurement methodology developed by 3M Health Information Systems, which identifies Potentially Preventable Complication (PPCs) for inpatients based on the hospital discharge abstract data set submitted to the HSCRC along with the present on admission (POA) indicator. PPCs are defined as harmful events (e.g. accidental laceration during a procedure) or negative outcomes (e.g. hospital acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease. Below are the specifications in the Model to calculate Maryland Hospital Acquired Conditions hospital achievements.

### TOTAL PPC COUNT CALCULATION

1. Run the HSCRC patient level data for the base year and Performance Year with the same PPC grouper version, which provides the following classifications for each PPC:
  - a. PPC at risk
  - b. PPC assigned
2. Limit the analysis to acute care hospitals
3. Identify PPC cases for all PPCs in the data sets (i.e. PPC Assigned), currently 65.
4. Exclude cases with any of the following conditions since the State excludes these patients from the MHAC program:
  - a. Hospice Palliative Care Patients (defined as cases with ICD-9 code = V66.7)
  - b. Patients with more than 6 PPCs
5. Total the count of all PPC cases for each year

### RATE CALCULATION

6. Identify patients at risk for each PPC
7. Total the count of at risk cases for all PPCs for each year
8. Rate is equal to total PPC cases divided by total at risk for each year

### CASEMIX ADJUSTED RATES

9. Calculate base-year observed rates by dividing total PPC cases by total at risk cases for each admission APRDRG SOI category using base year data.
10. Calculate base-year observed PPC rate by dividing statewide total count of PPC cases by total count of at risk cases using base year data.
11. Calculate expected PPC cases in the performance year by multiplying count of at risk cases by base-year observed rate for each admission APRDRG SOI from step 9 and summing for each PPC.
12. Calculate the risk adjustment ratio by dividing total observed PPC counts in the performance year by expected number of PPCs from step 11.
13. Calculate the risk adjusted rate of PPCs in the performance year by multiplying risk adjustment ratio from step 11 by base-year observed PPC rate from step 10.

The following table includes the list of PPCs included based on PPC grouper version 30. If the list and definitions of PPCs change during the Model period, the State will update the list and assess modifications to the measurements and targets needed. Updates to the base year may be

required due to the introduction of ICD-10, or other factors. Updates will be submitted to CMS for review and approval.

PPC #	PPC Description
1	Stroke & Intracranial Hemorrhage
2	Extreme CNS Complications
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation
5	Pneumonia & Other Lung Infections
6	Aspiration Pneumonia
7	Pulmonary Embolism
8	Other Pulmonary Complications
9	Shock
10	Congestive Heart Failure
11	Acute Myocardial Infarction
12	Cardiac Arrhythmias & Conduction Disturbances
13	Other Cardiac Complications
14	Ventricular Fibrillation/Cardiac Arrest
15	Peripheral Vascular Complications Except Venous Thrombosis
16	Venous Thrombosis
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding
19	Major Liver Complications
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding
23	GU Complications Except UTI
24	Renal Failure without Dialysis
25	Renal Failure with Dialysis
26	Diabetic Ketoacidosis & Coma
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion
28	In-Hospital Trauma and Fractures
29	Poisonings Except from Anesthesia
31	Decubitus Ulcer
33	Cellulitis
34	Moderate Infectious
35	Septicemia & Severe Infections
36	Acute Mental Health Changes
37	Post-Operative Infection & Deep Wound Disruption Without Procedure
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure
39	Reopening Surgical Site
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc
42	Accidental Puncture/Laceration During Invasive Procedure
44	Other Surgical Complication - Mod

45	Post-procedure Foreign Bodies
47	Encephalopathy
48	Other Complications of Medical Care
49	Iatrogenic Pneumothorax
50	Mechanical Complication of Device, Implant & Graft
51	Gastrointestinal Ostomy Complications
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusions
54	Infections due to Central Venous Catheters
56	Obstetrical Hemorrhage with Transfusion
59	Medical & Anesthesia Obstetric Complications
65	Urinary Tract Infection without Catheter
66	Catheter-Related Urinary Tract Infection

#### Timing

By June 30, 2014, HSCRC will submit the final base year results to CMS for its review. For each Performance Year, HSCRC will submit the final MHAC and PPC reports for the Performance Year no later than June 30 of the following year.

## Appendix 7: Maryland Reporting

Maryland will submit to CMS an annual report on June 30 following the end of each Performance Year cataloging its performance with respect to the quality measures described below. Maryland will make available to CMS the Maryland datasets and methodologies used for this evaluation. Additionally, Maryland hospitals will meet the reporting requirements under the Hospital Inpatient Quality Reporting (IQR) and Hospital Outpatient Quality Reporting (OQR) programs. In its annual report, Maryland will include its performance with respect to the IQR and OQR measures.

### *Maryland Regulated Rates for non-Medicare Payers*

Maryland will report on the performance of facilities list in Appendix 1, for which Maryland regulates non-governmental payer rates. Specifically, Maryland will provide the following information:

- Total revenue for these facilities and revenue growth rates
- Volume of services provided at these facilities
- Case mix and level of acuity of service provided at these facilities
- Medicaid spending growth for these facilities

### *Patient Experience of Care*

Maryland will develop a plan to assess improvements in patient experience by monitoring the following:

- Care transition interventions that are designed to improve communication and coordination between providers;
- The number of Medicaid participating physicians per Medicaid enrollee, Medicare participating physicians per Medicare enrollee, and participation of providers in patient centered medical home models, Accountable Care Organizations, and bundled payment models;
- Patient satisfaction and experience for hospitals through Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys for all sites of care for which they are available.

### Patient Experience Goals and Measures

Goal	Description of Measure	Data Source	Considerations/Comments
Increase patient satisfaction- Hospital	HCAHPS: Patient's rating of the hospital HCAHPS: Communication with doctors HCAHPS: Communication with nurses	Survey	(NOTE: Most recent HCAHPS average improvement rate is 3.06%)

Goal	Description of Measure	Data Source	Considerations/ Comments
Increase patient satisfaction- Home Health	Home Health CAHPS: Patient's rating of home health agency Home Health CAHPS: Communication with the home health team	Survey	Home Health Based- This measure will be monitored with the intent to add targets after year 5.
Increase patient satisfaction- Nursing Homes	State-administered survey based on Nursing Home CAHPS: Family members' perceptions of nursing home care	Survey	Nursing Home Based- This measure will be monitored with the intent to add targets after year 5. Maryland will consider transitioning to Nursing Home CAHPS survey instrument during the initial 3 year period of the model.
Increase patient satisfaction- Ambulatory Care	Clinician and Group CAHPS: Patient's perceptions of care provided by a physician in an office.	Survey	Physician Office Based- This measure will be monitored with the intent to add targets after year 5.
Enhance care transitions – patient experience- Hospital	HCAHPS : Three-item care transition measure (CTM-3)	Survey	New HCAHPS measures for 2013; as a new measure, historic data not available
Enhance care transitions – patient experience- Short Stay Nursing Homes	Short Stay Nursing Home Resident's discharge needs met Short Stay Nursing Home Resident's Discharge planning and information about medicines and symptoms	Survey	Short Stay Recently Discharged Nursing Home Resident- This measure will be monitored with the intent to add targets after year 5.
Enhance care transitions – coordination with primary care	Rate of physician follow up after discharge	Claims	Medicare and Medicaid; later state all payer database
Enhance care transitions – coordination with primary care	Discharges with PCP identified	To be developed	
Sustain high physician participation in public programs	Medicaid participating physicians per Medicaid enrollee; Medicare participating physicians per Medicare enrollee	Medicaid/Medicare provider enrollment; Survey	Concerns regarding participating physicians not accepting new patients
Broaden engagement in innovative models of care	Participation of providers in patient centered medical home models, ACOs, bundled payments	Administrative	
Improve process of care – Inpatient	Quality score using process of care measures in AMI, HF, SCIP, PN, CAC	Hospital Inpatient Quality Reporting Program	NOTE: QBR clinical score improvement: +0.82% (2009- 2011 average), +2.4 % in 2011

Goal	Description of Measure	Data Source	Considerations/ Comments
Improve process of care – Outpatient	Quality score using process of care measures in outpatient setting	Hospital Outpatient Quality Reporting Program	Maryland hospitals currently developing processes to collect outpatient process measures with the intent to add targets after year 5.
Reduce high priority hospital complications as these may change from time to time	Potentially Preventable Complications (PPC): PPC24/25: Renal Failure with/without Dialysis PPC5: Pneumonia & Other Lung Infections PPC35: Septicemia & Severe Infections PPC6: Aspiration Pneumonia PPC16: Venous Thrombosis PPC37: Post-Operative Infection & Deep Wound Disruption Without Procedure PPC 7: Pulmonary Embolism PPC31: Decubitus Ulcer PPC54: Infections due to Central Venous Catheters PPC25: Renal Failure with Dialysis PPC38: Post-Operative Wound Infection & Deep Wound Disruption with Procedure PPC 66: Catheter-Related Urinary Tract Infection PPC28: In-Hospital Trauma and Fractures NHSN CLASBI SIR	HSCRC Hospital Inpatient Discharge Abstract	NOTE: Inpatient only  NHSN CLABSI SIR represents central line-associated bloodstream infection (CLABSI), measured by the Standardized Infection Ratio (SIR) calculated by dividing the number of observed infections by the projected expected number of infections calculated using CLABSI rates from a standard population during a baseline period.
Reduce readmissions- Home Health	Admission Rates from Home Health Agencies to Acute Inpatient Hospital Unplanned, urgent visits to the Emergency Departments for patients receiving Home Health care	Home Health Compare	This measure will be monitored during the model with the intent to add targets to the second total cost care model to begin after year 5.
Reduce readmissions- Nursing Homes	Readmission rates from nursing home to acute care hospital	HSCRC Hospital Inpatient Discharge Abstract	As several hospitals have nursing home interventions as part of their ARR intervention plans, there should be a reduction in readmissions.
Reduce readmissions- Hospital	Hospital wide all cause 30-day readmissions Readmissions per 1000 residents National Readmissions Reduction Program Measures: Heart Failure Pneumonia Acute Myocardial Infarction Chronic Obstructive Pulmonary Disease Hip/Total Knee Arthroplasty	HSCRC Hospital Inpatient Discharge Abstract; Medicare Claims	HSCRC data is limited to discharges from Maryland hospitals, Medicare data provides access to discharges outside of state NOTE: Inter-hospital Medicare Readmissions: 0.3 percentage points decline in FY2012

### Population Health

Maryland has established a State Health Improvement Process<sup>2</sup> with 39 health benchmark measures. Through this process, 17 regional planning councils have developed action plans for improvement.

As key indicators of population health are expected to improve as the Model evolves, Maryland will continually measure population health metrics, including but not limited to hospital admission rates (as well as readmission rates), ED visits, and admissions and ED visits for ambulatory sensitive conditions. Maryland will also measure life expectancy, hospitalizations for ambulatory care sensitive conditions, primary and secondary prevention for cardiovascular disease, and behavioral health emergencies, including racial and ethnic disparities in these measures.

Maryland will consider a range of population health measures developed by quality measurement groups such as the National Committee for Quality Assurance (NCQA) and National Quality Forum (NQF) some of which are being used in numerous initiatives including the CMS Medicare Shared Savings Program and Meaningful Use incentive program. These include:

- Screening Mammography
- Colorectal Cancer Screening
- Persistence of beta-blocker treatment after a heart attack
- Optimal Diabetes Care
- Screening for future fall risk
- Blood Pressure Control
- Million Hearts ABCs (a composite of NQF measures)
- Screening for Clinical Depression and Follow-Up Plan
- Medication reconciliation post-discharge
- Adult influenza immunization: Influenza immunization received
- Pneumonia Vaccination for Patients 65 Years and Older
- Smoking Cessation, Medical assistance: a. Advising Smokers to Quit, b. Discussing Smoking Cessation Medications, c. Discussing Smoking Cessation Strategies
- Annual monitoring for patients on persistent medications

Beginning in June of 2012, HSCRC staff convened the *Hospital Race and Ethnicity Disparities Work Group*, a multi-stakeholder group of individuals working to reduce or eliminate disparities in Maryland healthcare, to guide HSCRC staff efforts and work to analyze the status of hospital patient race and ethnicity data collection and consider how this data may be used in payment incentive programs. Maryland will continue to analyze race and ethnicity data using hospital discharge and quality datasets and will use race and ethnicity data in its quality incentive programs as appropriate.

Finally, advances in computing and connectivity have the potential to improve population health by expanding the reach of knowledge, increasing access to clinical information when and where needed, and assisting patients and providers in managing chronic diseases.

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<sup>2</sup> The SHIP website is <http://dhmh.maryland.gov/ship/SitePages/Home.aspx>

Maryland will monitor encounter data flow through its HIE, CRISP (Maryland's state information exchange).

### Population Health Measures

Goal	Description of Measure	Data Source	Measure Specification
<b>Improve life expectancy</b>	SHIP Objective 1*: Increase life expectancy	Vital Statistics Administration, Department of Health and Mental Hygiene	Standard calculations based on birth and death records.
<b>Reduce the rate of hospitalizations for ambulatory care sensitive conditions</b>	Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization	HSCRC	Preventable hospitalizations per 100,000 population. Will be calculated using AHRQ methodology**. The PQI tracks the number of hospitalizations that occurred for ambulatory care sensitive conditions, conditions for which effective outpatient care can prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The HSCRC data source includes data for Maryland hospitals only.
<b>Improve cancer control</b>	SHIP Objective 32: Reduce the % of adults who are current smokers	Behavioral Risk Factor Surveillance System (BRFSS)	Numerator is number of persons who reported currently smoking cigarettes some days or every day. Denominator is number of persons.
	SHIP Objective 33: Reduce the % of youth using any kind of tobacco product	Maryland Youth Tobacco Survey	Numerator is number of surveyed adolescents ages 12 through 19 in public schools who report using any kind of tobacco product in the past 12 months. Denominator is number surveyed.
<b>Improve primary prevention of infectious disease</b>	SHIP Objective 24: Increase the % vaccinated annually for seasonal influenza	CDC National Immunization Survey; BRFSS	Coverage estimates are for all persons over 6 months of age.
	SHIP Objective 23: Increase % of children with recommended vaccinations	CDC National Immunization Survey	Numerator is number of children aged 19-35 months old vaccinated under NIS vaccine coverage definitions. Denominator is number of children in this age group surveyed.
	SHIP Objective 20: Reduce new HIV infections among adults and adolescents	MD HIV surveillance system; US Census Bureau; ACS 5 year Census	Rate of new adult and adolescent HIV cases during a calendar year (age 13 or greater) reported to the State of Maryland per 100,000 population.

Goal	Description of Measure	Data Source	Measure Specification
<b>Improve prevention for diabetes and cardiovascular disease</b>	SHIP Objective 27: Reduce diabetes-related emergency department visits	HSCRC	Numerator is number of inpatient and outpatient emergency department visits for which the primary diagnosis was coded as 250.xx. Denominator is the number of persons. HSCRC data is limited to data from Maryland hospitals.
	SHIP Objective 28: Reduce hypertension related emergency department visits	HSCRC	Numerator is number of inpatient and outpatient emergency department visits for which the primary diagnosis was coded as 401.x. Denominator is the number of persons. HSCRC data is limited to data from Maryland hospitals.
	SHIP Objective 31: Reduce the % of children who are considered obese	Maryland Youth Tobacco Survey	Numerator is number of adolescents ages 12 to 19 attending public school who have a Body Mass Index (determined through self-reported height and weight) equal to or above the 95 <sup>th</sup> percentile for age and gender. Denominator is total population surveyed.
	SHIP Objective 30: Increase the % of adults who are at a healthy weight	Behavioral Risk Factor Surveillance System	Number of people with BMI of less than 25kg/m <sup>2</sup> . Denominator is population surveyed.
<b>Improve prevention for asthma</b>	SHIP Objective 17: Reduce hospital ED visits from asthma	HSCRC	Numerator is number of inpatient and outpatient emergency department visits for which the primary diagnosis was coded as 493.xx. Denominator is the number of persons. HSCRC data is limited to data from Maryland hospitals.
<b>Promote behavioral health integration in primary care</b>	SHIP Objective 34: Reduce hospital ED visits related to behavioral health	HSCRC	Number of inpatient and outpatient emergency department visits for which the primary or secondary diagnosis was defined as related to behavioral health by the Healthcare Cost and Utilization Project of the Agency for Healthcare Research and Quality. These diagnoses include adjustment disorders, anxiety disorders, attention deficit, conduct or disruptive behavior disorders, disorders usually diagnosed in infancy, childhood, or adolescence, impulse control disorders (not classified elsewhere), mood disorders, personality disorders, schizophrenia and other psychotic disorders, alcohol-related disorders, substance-related disorders, suicide and intentional self-inflicted injury, and miscellaneous mental disorders. HSCRC data is limited to data from Maryland hospitals.
<b>Promote health through safe physical environments</b>	Fall-related death rate	Maryland Vital Statistics Administration	Numerator is deaths with an ICD-10 code of W00-W19, denominator is total population.
<p><i>*Most measures have all been adopted as core measures in Maryland's State Health Improvement Process. Technical specifications for these measures are located at: <a href="http://dhmh.maryland.gov/ship/SitePages/measures.aspx">http://dhmh.maryland.gov/ship/SitePages/measures.aspx</a>. Each measure is tracked, where possible, by race/ethnicity and gender and by county. Local public-private public health coalitions, which include local hospitals, develop plans to achieve improvements in these measures.</i></p> <p><i>**The AHRQ PQI technical specifications are located at</i></p>			

Goal	Description of Measure	Data Source	Measure Specification
			<a href="http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx">http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx</a>

AHRQ = Agency for Healthcare Research and Quality

PQI = prevention quality indicators

SHIP = State Health Improvement Process

PQRS = Physician Quality Reporting System

NQF = National Quality Forum

Maryland will report annually the quality and cost measure results for the Quality Based Reimbursement, MHAC and readmissions reduction programs. Maryland will establish the data collection and analysis infrastructure for reporting future quality measures.

## Appendix 8: Maryland Monitoring Plan

Maryland will monitor its methods currently used to continuously improve quality and outcomes and will measure and monitor its financial outcomes. Monitoring will be conducted throughout the year. Maryland will provide a summary of its monitoring activities to CMS on June 30 following end of each Performance Year. Maryland will make available to CMS the Maryland datasets, methodologies, and audits used for this evaluation.

- **Patient experience of care:** Maryland will measure patient satisfaction, the effectiveness of care transitions, physician participation in public programs, and complication rates and hospital acquired condition rates. (See Appendix 8 for reporting to CMS).
- **Population Health:** Maryland will measure life expectancy; hospitalizations for ambulatory care sensitive conditions, primary and secondary prevention for cardiovascular disease, and behavioral health emergencies, including racial and ethnic disparities in these measures. (See Appendix 8 for reporting to CMS).
- **Health care expenditures:** Maryland will measure overuse of diagnostic imaging, inpatient and outpatient costs trends, readmission rates and total cost of care for all residents. The state will track expenditures for specific payers, including Medicare, Medicaid, CHIP, and CMS subsidies through the Maryland Health Benefit Exchange.

### *Health Care Costs*

Maryland will integrate frequent and regular monitoring into the Model relying on a number of datasets, data collection processes already established by the HSCRC, Medicare claims and clinical data. To calculate all payer financial success under the Model, Maryland will rely on HSCRC datasets with population numbers provided by Maryland's Department of Planning.<sup>3</sup> Maryland will also complete implementation of a state all-payer database in order to monitor per capita health expenditure growth for inpatient and outpatient services across all payers.

#### **HSCRC Data to Monitor All-Payer Financial Success**

<b>Dataset</b>	<b>Financial Monitoring Use</b>	<b>Collection Schedule</b>	<b>Data Lag</b>
Unaudited financial	Rapid revenue trend monitoring,	Monthly	One month from

<sup>3</sup> Financial reports have recently been modified to distinguish between resident and non-resident revenue. The HSCRC will employ patient-level case mix datasets to test reported regulated charge ratios of resident and non-residents and will perform periodic audits the reported data. Maryland cannot capture revenue for care provided to Maryland residents outside the state. Therefore, the all payer numerator differs from the numerator used for the Medicare calculation. Maryland will rely on monthly financial data without adjustments for out-of-state revenue as a proxy. This will provide Maryland the ability to manage the system in something close to real time. These data are a good proxy for monitoring the Medicare growth over time.

data, monthly submissions	trends for out of state patients		end of reporting period
Audited financial data, annual filing	Revenue trend monitoring	Annually	Four months from end of reporting period
Inpatient and outpatient case mix data	Innovation Center monitoring, trends for out of state patients	Quarterly	Two months from end of reporting period
Maryland population (Provided by the Maryland Department of Planning)	Establish Maryland's population; potential for use in population attribution methods	Annually	Projections based on US Census

Maryland will also monitor utilization of certain diagnostic tests and procedures to assess and decrease unnecessary and wasteful practices (i.e., duplicate imaging).

### Health Care Costs

Goal	Description of Measure	Data Source	Considerations/Comments
Reduce overuse of diagnostic testing – imaging	OP-8 : MRI Lumbar Spine for Low Back Pain OP-9: Mammography Follow-up Rates OP-10: Abdomen CT - Use of Contrast Material OP-11: Thorax CT - Use of Contrast Material OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)	Claims	Medicare (Hospital Compare) and Medicaid; later state all payer database
Control expenditure growth – hospital	Per capita hospital expenditure growth (inpatient and outpatient) for: <ul style="list-style-type: none"> <li>• All-payer</li> <li>• Medicare</li> <li>• Medicaid/CHIP</li> <li>• Private payer</li> <li>• Medicare/Medicaid Enrollees (Dual Eligible)</li> </ul>	HSCRC Hospital Inpatient and Outpatient Discharge Abstract; Medicare and Medicaid enrollment files	For all expenditures, risk adjustment for in and out of state services
Control expenditure growth – all services	Per capita health expenditure growth (inpatient and outpatient) for: <ul style="list-style-type: none"> <li>• All-payer</li> <li>• Medicare</li> <li>• Medicaid/CHIP</li> <li>• Private payer</li> <li>• Medicare/Medicaid Enrollees (Dual Eligible)</li> </ul>	Claims	Medicare and Medicaid; later state all payer database

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**Guiding Principles for Implementation of  
Population-Based and Patient Centered  
Payment Systems:**

**A Report from the Advisory Council to the  
Maryland Health Services Cost Review  
Commission**

**January 31, 2014**

## Introduction and Statement of Purpose

The State of Maryland is leading a transformative effort to improve care and lower the growth in health care spending in the State. Stated in terms of the “Three Part Aim,” the goal is a health care system that enhances patient care, improves health, and lowers total costs.

To achieve this goal, the State of Maryland worked closely with the Centers for Medicare and Medicaid Services (CMS) throughout 2013 to craft an innovative plan that would make Maryland a national leader achieving the Three Part Aim and permit the federal government to continue to participate in the four-decade long all-payer hospital payment system that has proven to be both successful and enduring. The federal government approved Maryland’s new Model Design application and implementation began in January 2014.

## The Advisory Council

As the State’s rate setting authority, the Health Services Cost Review Commission (HSCRC) will play a vital role in the implementation of this innovative approach to health reform. In order to implement and develop such an ambitious effort, HSCRC created an Advisory Council to enlist the guidance of stakeholders and health care leaders from across the State and with a national perspective. A list of Advisory Council members appears at the end of this report.

The Advisory Council is charged with advising the Commission on implementing the Model as approved by the federal government. The Council is offering real-world advice and practical guidance to support the successful implementation of this comprehensive and complex initiative. Council membership represents a variety of sectors in health care including hospitals, payers, and physicians, as well as outside experts. Following an initial meeting with the Commission on November 13, 2013, the Council held four public meetings from December 2013 through January 2014, and taken suggestions from members of the public, including patient advocacy groups. The public was invited to share their thoughts during the public meetings of the Advisory Council and to email their comments to the Council through the HSCRC website.

The Council stands ready to make more specific recommendations upon the request of the HSCRC.

## The Model Requirements

Building on the Commission’s existing authority to regulate and set hospital rates across all payers, including Medicare, the State is preparing to expand its efforts to control growth in total hospital cost per capita. New health care delivery and payment models will be aligned with other initiatives underway to help meet the goals.

Maryland has committed to meeting the following key requirements:

## *Cost Requirements of the Model*

- The all-payer per capita total hospital revenue growth will be limited to 3.58% per year over the first three years (plus an adjustment for population growth), which is the 10-year compound annual growth rate in per capita gross state product.
- Medicare per beneficiary total hospital cost growth over five years shall be at least \$330 million less than the national Medicare per capita total hospital cost growth over five years.<sup>1</sup> This represents a savings level of about one-half of one percent per year under the national Medicare spending growth rate beginning in year two of the model.

## *Quality Requirements*

Maryland will achieve a number of quality targets designed to promote better care, better health and lower costs. Under the model, the quality of care for Maryland residents, including Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries, will improve as measured by hospital quality and population health measures.

Specific requirements of the model to improve quality include:

- The aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate will be reduced to the corresponding national rate over five years.
- An annual aggregate reduction of 6.89% in Potentially Preventable Conditions (PPCs) over five years will result in a cumulative reduction of 30% in PPCs over the life of the model.

This report provides the Advisory Council's recommendations to the HSCRC on how best to meet these goals through the implementation of the new Model.<sup>2</sup>

## **Advisory Council Recommendations**

### **1. Focus on meeting the early Model requirements**

**1.1 The Advisory Council recommends that the HSCRC prioritize implementation initiatives that contribute to meeting the All Payer Target hospital per capita spending growth rate and the Medicare savings target in the first two years of the proposed model.**

**1.2 To ensure that the state is on track in meeting the tight goals, it will be necessary to develop a clear timetable, interim milestones, key benchmarks, and periodic assessments of progress.**

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<sup>1</sup> The target includes inpatient services and outpatient services under Medicare definitions. HSCRC regulates outpatient hospital services located at the hospital. The Medicare definition is broader and will include some freestanding outpatient facilities owned and operated by hospitals.

<sup>2</sup> This report reflects a general consensus of Advisory Council members; agreement on the various recommendations reflects the consensus of opinions, but that should not be taken to mean unanimous agreement on each point.

**1.3 Global payment methods for Maryland hospitals should be the tool of preference to assure revenue controls.**

**1.4 Success under global payment methods will feature the ability to reduce avoidable utilization through better care.**

**1.5 It will also be important to monitor access and quality challenges regarding health services that will likely shift from hospitals to other settings, such as skilled nursing facilities, ambulatory surgery centers, and others that are not under the HSCRC authority to regulate.**

## **Discussion**

Meeting the targets will require a strong work plan and continuous vigilance to ensure that interim milestones are being met. The HSCRC should track and report on progress in meeting the benchmarks. Particularly in the first two years, it will be important to measure progress toward the endpoint—is the State as far along, for example, after six months, as it should be to meet targets for the first year and the second year? All this translates simply into having a good business plan and a series of specific milestones toward fulfilling it.

The Advisory Council believes that the new model design presents near-term tight revenue constraints that can only be met with quick and strong reforms in both the health care delivery system and the payment systems. While long-term reforms are needed to improve population health, there is a risk that Maryland will miss the opportunity to achieve these ultimate goals if spending exceeds the limits in the model design or if the promised savings to Medicare do not materialize.

The following steps are necessary to achieve the targets:

### ***Identifying opportunities for controlling avoidable utilization***

HSCRC should work with providers and consumers to analyze data to identify the types of utilization of health services that could be reduced with better access to primary care and care coordination, such as inpatient admissions for ambulatory-sensitive conditions, readmissions, and emergency department visits presenting needs that could be served in lower-cost settings. Reducing this type of volume may yield significant savings and also likely improve patient care and health outcomes. It also will be important to reduce avoidable complications in areas such as infections, respiratory and renal failure, and medical errors.

### ***Identifying high-need patients***

Improving the health care delivery system requires the careful identification of high-need patients. The HSCRC should work with other State agencies with expertise and data resources, as well as with stakeholders *to identify and secure data* that can be helpful in targeting care coordination to high-need patients. Health care leaders can use predictive modeling, claims analysis, health status questionnaires, and other techniques to identify patients (using secure and confidential approaches to data access and management) with complex medical needs who are frequent users of the health care system, particularly in high-cost settings. In order for care coordination interventions to be cost-effective, they need to be targeted carefully to patients who could really benefit.

### *Implementing care coordination reforms*

Another important step is to inform the development of care coordination programs targeted to these patients with complex medical conditions. Both public and private payers as well as providers would benefit from obtaining objective and evidence-based information on promising care coordination initiatives.

Multi-disciplinary teams including physicians, nurses, nurse practitioners, and individuals outside the medical model such as nutritionists, social workers, and community health workers can work with high-need/high-resource patients and their families to manage chronic conditions. Effective care coordination can help avoid ambulatory-sensitive use of emergency departments, inpatient admissions, and hospital outpatient care.

The State and private sector leaders should coordinate the new model design with efforts already underway involving Patient Centered Medical Homes (PCMH), Accountable Care Organizations (ACOs), SIM projects, and team-based care. Both public and private payers in Maryland are already engaged in some of these activities. What is needed is to bring the scattered initiatives to scale and share evidence related to program impact. HSCRC could play a useful role in helping to gather leaders and data to facilitate discussions about promising strategies and practices.

### *Focusing on the opportunity to improve care for the Medicare fee-for-service population*

An important challenge involves the Medicare population. Nearly three of four Medicare enrollees in the standard fee-for-service setting receive largely uncoordinated, highly fragmented care. It is vitally important to bring the tools of improved care management to this population. This includes identifying Medicare patients whose care is not well managed and coordinating their care.

The Advisory Council believes that it would be helpful to have a concise and user-friendly compilation of the evidence base and best practices in both the identification of high-need patients and effective care management for this population.

### *Developing payment reforms*

Payment system reform will require moving away from fee-for-service payments, toward payment models that reward better patient outcomes, quality of care improvements, and overall cost containment.

The HSCRC anticipates that nearly all Maryland hospitals will be operating under global payment models in the near future. The Council believes that these models hold the most promise for meeting the revenue targets in the early years because they move away from incentives in fee-for-service payment that foster a greater volume of services, and offer strong budget discipline. In addition, global payments provide clear and simple revenue targets with flexibility for hospitals to manage within these macro goals.

## 2. Meet budget targets while making important investments in infrastructure and providing flexibility for private sector innovation

- 2.1** The Advisory Council urges the HSCRC to strike a balance between near-term cost control, which is paramount, and making the required investments in physical and human infrastructure necessary for success. If we do not meet the near-term targets, there will be no long-term program. But if we fail to make the needed infrastructure investments, we will not have the toolkit of reforms necessary to achieve lasting success.
- 2.2** Given the challenging targets in this initiative, goals should be set in the aggregate as close to the targets as practicable based on the degree of comfort that individual institutional targets will be met.
- 2.3** There should be incentives for hospitals to meet and exceed the challenging targets of the new model; hospitals should be able to retain and reinvest a high percentage of their savings.
- 2.4** A portion of the savings that hospitals achieve could be reinvested into “common good” investments. But given the tightness of the revenue caps under the new model, a new and secure funding source for this type of infrastructure is also essential.
- 2.5** HSCRC, other State agencies, and private sector leaders should build the data infrastructure needed to ensure waiver success. Specific tasks include:
- Lead data collection efforts
  - Ensure open access to data by all stakeholders
  - Lead data analytics to monitor waiver metrics;
  - Assess policy impacts;
  - Guide clinical decision making

### Discussion

Meeting the model performance targets will require the readiness of the hospital industry. This, in turn, will require investments in infrastructure across the state. The infrastructure could include care coordination resources, data analytics, disease-focused providers and resources, and IT resources, among others.

*These investments will cost money. This funding should not all come from hospital rates. The State should consider developing some type of statewide infrastructure fund devoted to making the up-front investments needed to produce that infrastructure. Maryland needs a secure funding stream to make these investments.*

The HSCRC should consider the variability in readiness among hospital systems as it plans for the phased implementation of model components. One factor is that hospitals serving complex patients will face additional challenges and expenses associated managing the care of vulnerable patients. Investments in infrastructure should also take into account the higher costs incurred by patients who experience barriers to care due to socioeconomic status, language, and other factors.

The Council notes that some of the required investments represent “public goods.” These are benefits for the whole public that would likely not emerge from each individual hospital, clinic, and medical practice following its own best interest.

### *Data Infrastructure*

The required infrastructure includes such key areas as accelerated progress toward the Health Information Exchange (HIE), with interoperable and secure data that can be used by physicians and hospitals in real time as they are treating patients. The Council believes that there should be “open access” to the data collected. In some cases, HSCRC is an “aggregator” of the data but it should be readily and publicly accessible to health care providers and others as needed within the bounds of federal and state confidentiality protections.

The progress of the Health Information Exchange to share clinically actionable information among treating providers should be accelerated. Infrastructure will also be needed to foster continued progress to reduce potentially preventable conditions and to reduce hospital readmissions. These investments should be funded primarily from a new infrastructure fund, as noted above, rather than solely by hospitals.

### *Supporting primary care providers*

Primary care providers are at the heart of the new model of care as efforts are made to move care “upstream” to reduce avoidable use of services in high-cost settings. Primary care providers will be called upon to help avoid ambulatory-sensitive utilization of care in ER, inpatient, and hospital outpatient settings. They should be supported as they struggle to adhere to the many requirements placed on them including achieving advanced stages of meaningful use of HIT; adapting to the forthcoming ICD-10 requirements (a challenge for all providers); the demands of continuing medical education, and participating in new care delivery models such as ACOs and patient-centered medical homes.

### *Regulatory flexibility will help meet the goals of the model*

**2.6 Within the context of per capita growth ceilings on hospital spending, HSCRC should allow considerable flexibility for the health care sector to implement its own strategies for achieving the desired results while recognizing the importance of following evidence-based best practices and the potential value of some standardization.**

### *Discussion*

The Advisory Council believes that the private healthcare sector is well positioned to test and deploy innovative approaches to improve care and meet revenue and spending targets. HSCRC should *encourage, facilitate, and promote promising private sector initiatives to help meet the goals.*

*Within the context of global budgets, the Council favors the use of performance standards over detailed design standards.* Performance standards allow the flexibility for hospitals and other health care providers to make key decisions about how they will design specific changes in practice patterns and manage the supply chain in order to improve performance.

Thus, effective regulatory policy involves resisting the temptation to layer additional levels of detailed design standards under the overall performance standards.

Regulatory policies should also avoid protecting inefficient service providers from competitive pressures and encourage the introduction of cost-saving innovations. Tight revenue targets are important to meeting the promised targets, but it is important to let hospitals retain and reinvest their savings.

It is also important to balance the need to meet tight cost control targets with goals related to health care research and discovery, innovation, and the modernization of treatment techniques and facilities.

The regulatory environment should encourage market shifts that involve patients moving toward high-value providers. In addition, it should reward those providers who recognize and remove excess capacity from the system. The HSCRC should seek to balance the general principle for funding to “follow the people” with the equally important desire to encourage providers to eliminate excess capacity. Finally, mechanisms for implementing this principle should not undermine the incentive for each hospital to strive for savings via reduced inpatient and outpatient volume where appropriate.

## **2.7 The consensus of the hospital industry should have a significant weight in policy development**

### **Discussion**

When hospitals adopt global or population-based payments, they will be taking on significant responsibility for the total cost of care under the new Model design. The performance of any one hospital will affect all hospitals and the State’s ability to meet the Model requirements. The new Model will require collaboration between organizations to meet the performance goals. In order to foster collaboration, the Council recommends that the HSCRC give significant consideration and preference to policy recommendations that reflect a consensus among hospitals.

As the model implementation unfolds over time, some hospitals will hit their targets and some will not. For example, some hospitals will reduce volume, while some will see volume increase. In some sub-regions of the State, population will increase while in others it will decrease. Many factors will be in play in determining how successful hospitals are in meeting their targets, *some within their control and some outside of their control*.

As HSCRC adjusts targets over time in response to these shifts, some hospitals are rewarded and others penalized. The Council recommends that this process be transparent. While, HSCRC will exercise its regulatory authority to make these adjustments during implementation, the hospital industry can provide valuable input and advice to this process.

## **3. HSCRC Should Play the Roles of Regulator, Catalyst, and Advocate**

### **3.1 HSCRC should play three key roles as it strives to make the new model work: *effective regulator, a catalyst for needed reforms, and an advocate* within the state and to the federal government for the support needed to ensure success.**

## Discussion

In its regulatory role, within the boundaries of its mandate, the HSCRC plays a key role in payment reforms. The main challenge is to complete a significant conversion of hospitals to global budgets and then monitor and enforce the revenue caps to ensure compliance with the new model design caps on hospital spending per capita.

In its role as a catalyst for change, HSCRC should inform needed delivery system innovations, and increased data exchange. HSCRC should work with both other State agencies and the private sector to collect, synthesize, and interpret data on performance including revenues, costs, quality metrics, and patient safety.

In advocacy, HSCRC should work with CMS and collaborate with other State stakeholders to promote integrated care models and new approaches to payment under Medicare and other government programs. HSCRC, as the keeper of the system, should be a strong advocate for state budget and other actions that would support success, and against state actions that undermine it.

While data on individual hospital performance is necessary, an important goal is to move toward population-based performance metrics wherever feasible. This can facilitate both reductions in the incidence of chronic diseases such as diabetes, hypertension, and asthma, as well as improvements in the health status of people who have these diseases.

## 4. Consumers should be involved in planning and implementation

### 4.1 The HSCRC should actively engage consumers and their representatives to participate in implementation activities.

## Discussion

Achieving the goals of the Three Part Aim will require the active engagement and support from consumers and their families. Patients and patient representatives should have a seat at the table in planning and developing implementation activities and provide meaningful input to the HSCRC, hospitals and others about how the implementation goals will be met. In order for individuals to make the best decisions for themselves and their families, a true working partnership should be developed between individuals and their providers. Consumers will need timely and user-friendly information and tools to increase health and illness self-management.

While tight budget caps are important, the HSCRC should also recognize the need for vulnerable populations to obtain the full complement of services and supports they need to achieve the best possible state of health and functional status. Avenues for grievances and appeals should be available to patients.

### 4.2 Guard against under-use of health services.

As providers begin to operate under a set of tight caps, they face incentives to reduce utilization. To the extent that this is *avoidable use, and represents unnecessary, duplicative care*, savings will be achieved without blocking access to needed services. But now concerns about over-use should be accompanied by careful monitoring and avenues for redress when there may be under-use as well. As noted earlier,

some care may shift from hospitals to lower-cost settings that are not within the model design cap. Monitoring the quality of these services is important but likely beyond the scope of HSCRC so that cooperation with other State agencies may be needed.

#### **4.3 Incorporate quality improvement and patient safety goals into the overall plan.**

Another important challenge in the new model design is that regulatory standards continue to incorporate quality and patient safety into payment formulas and focus on monitoring and reporting on the quality of care. The goal is now better care and better health along with effective cost control. HSCRC has already been engaged in patient safety and quality improvement initiatives. But now these ancillary goals have become embedded into the central objectives of the Three Part aim that are at the heart of the new all-payer model.

### **5. Physician and Other Provider Alignment is Essential**

**5.1 Physician engagement and alignment must be strong enough and occur early to support the goals of population-based and patient centered models.**

**5.2 The HSCRC should charge a workgroup to develop specific recommendations on strategies that align incentives among hospitals, physicians and other providers.**

**5.3 HSCRC should advocate for arrangements in which physicians can share in the savings achieved by hospitals under the new Model. This could involve pay-for-performance arrangements as well as formal shared-savings arrangements. The State should apply to OIG at HHS to permit gain-sharing arrangements between hospitals and physicians.**

### **Discussion**

The new All-Payer Model creates strong incentives for hospitals to reduce unnecessary and inappropriate care and increase efficiency. Starting in January 2014, hospitals will be benefit not only by reducing costs *during an admission*, but also by improving care in a way that results in *fewer ER visits, inpatient admissions, readmissions, and reduced hospital outpatient care*. Hospitals can be more successful in meeting these goals if their new models are complemented by aligned incentives for physicians as well. Physicians' decisions about treatment, the need for care and the venue in which it is delivered determine a large proportion of the utilization. The desired reductions in ambulatory-sensitive care will only occur if physicians are both trained and rewarded to provide the types of prevention and evidence-based care that mitigate avoidable hospital care.

Further, physicians must be made fully aware of the basis for their rewards under gain-sharing arrangements. They need full transparency about the basis for and the metrics of their payments, as well as assurances that proper adjustments are made to account for the wide variation in the complexity of their patient mix and that rewards account for both cost and quality of care.

Long-term care facilities must also be in synch with the redesign of health care delivery and payment. Eventually, other providers should be brought on board as well. Alignment of incentives could also cover changes in the 3-day rule and other payment modifications related to long-term care facilities.

The Physician Alignment and Engagement workgroup should consider current initiatives underway in Maryland or in development that provide opportunity for alignment among providers, including ACOs, PCMH, and other emerging models.

### *The Importance of Medical Malpractice Reform*

The incentives in the current medical malpractice system can run counter to the key cost containment goals in the model design. The current malpractice system encourages health care providers to increase utilization (e.g. order more tests, conduct more procedures) at the same time as the model design encourages them to reduce unneeded utilization.

Physician and hospital alignment with the goals of the new model could be supported by reforms in the medical malpractice system. These reforms should go beyond the caps on awards for pain and suffering that many states have enacted, to address more fundamental restructuring of the medical malpractice system.

The Council recognizes that medical malpractice is not within the purview of HSCRC. We recommend that the Commission be aware of the dissonance between its cost containment goals and the current medical malpractice system, and lend its voice to the need for reforming it. While the Council did not reach unanimous agreement on the specific types of reforms that are needed, or the likely impact of those reforms, most of the Council believes that addressing issues around medical malpractice is important in supporting the goal of reducing avoidable utilization and should be pursued in concert with the three-part aim.

## **6. An ongoing, transparent public engagement process is needed**

### **6.1 The Advisory Council supports the establishment of Work Groups to address technical and operational issues.**

#### **Discussion**

The new Model represents a significant transformation of the health system in Maryland, and as such, will require ongoing engagement of hospitals, physicians, other providers, patients, and experts to build the consensus necessary for successful implementation. The technical challenges of implementing the new model require careful and thoughtful consideration. The Council supports immediately convening technical Work Groups to address the implementation issues.

#### **Conclusion**

Maryland's new all-payer model is a very advanced, cutting-edge approach to long-term cost control and health system reform. The new approach broadens and corrects limitations in the long-standing Maryland all-payer system. It commits the State of Maryland to some very tight budget controls, with near-term and long-term limits on spending. Meeting these targets will require a large-scale transformation of the Maryland health care system. The starting point is the quick adoption of global payments for Maryland hospitals. This should be accompanied by an all-out effort to reduce avoidable care in high-cost settings by identifying high-risk, high-need patients and developing effective care coordination and initiatives to manage chronic illnesses.

HSCRC can play three key roles in facilitating the success of the new model—as a regulator, a catalyst for reform, and an advocate. The Council looks forward to working with HSCRC to help make this exciting new model successful.

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# **HSCRC Implementation of Population-Based and Patient-Centered Payment Systems Workgroup Descriptions**

**January 13, 2014**

The Health Services Cost Review Commission (HSCRC) is establishing workgroups to support the implementation of the new Population-Based and Patient-Centered Payment Systems. The workgroups are designed to provide structured input to the HSCRC on key implementation activities, lending expertise on the state of the art and the feasibility of possible solutions. The workgroups will build on the work of the Advisory Council, which the HSCRC convened in November, 2013 to provide recommendations on the guiding principles for implementation, the priorities for implementation phasing, and issues that should be addressed by workgroups. The Advisory Council is still finalizing its work; however, clear consensus seems to be emerging that the HSCRC should focus on the most immediate tasks for implementation of the new model, meeting the significant requirements for containing increases in Medicare and All-Payer costs, and meeting requirements for improved care delivery and quality.

The HSCRC staff has developed a focused set of tasks, described below, for each of the workgroups. The majority of these tasks are the work that the HSCRC needs to address by July, 2014. There will be a need for continued input on implementation activities and the HSCRC will ask each workgroup to make recommendations on the issues that should be taken up by workgroups during the next phase of implementation activities. The HSCRC is requesting a report from each workgroup by July, 2014. The workgroups should make recommendations to the extent that they can in their July report and may also identify topics that are still works in progress. There are interim deliverables that will be needed before July to support the HSCRC's decisions for July rate orders. The HSCRC staff will work with each workgroup to establish a work plan that provides the HSCRC with input and guidance at different decision points for the HSCRC in the next six months and develops a work plan for the following six months. Many of these interim deadlines identified in this document include aggressive timelines, and the HSCRC staff and the Commission recognize that some dates may change as the workgroups get underway and the work plans for the Commission and the workgroups evolve. There is some overlap in the topics that the workgroups will address necessitating coordination, which may occur through strategies such as joint meetings, small subgroup meetings or coordination at the staff level.

The deliverables below are generally listed in order of priority, subject to input from the work groups.

**Payment Models.** In general, this workgroup will develop recommendations for the HSCRC on the structure of payment models and how to balance its approach to updates.

1. Balanced Updates: Recommendations for how the HSCRC should change its historic approach to annual updates, including what factors should be considered (weighting inflation, different types of volume and trends including demographic trends), innovation, capital and new services, efficiency, variable cost concepts, the "spread" between update factors for global budgets and fee-for-service budgets, the methodology used for Uncompensated Care given the significant changes in insurance coverage expected with health reform implementation, the timing of updates and the magnitude of revenue that is put at risk for meeting value-based performance goals, the use of positive incentives for quality and care improvement, and other adjustments to transitional policies adopted by HSCRC. **Recommendations on this topic are due to the HSCRC by April, 2014.**
2. Guardrails for Model Performance: Recommendations on whether there are certain performance targets the HSCRC should establish that, if not met, would trigger a policy change, mid-year course correction or other corrective action, including whether guardrails should be developed at the hospital, region, and/or state level. **Recommendations on this topic are due to the HSCRC by July, 2014.**
3. Market share: Recommendations on how the HSCRC should incorporate market share adjustments into payment and the timing of adjustments. **Initial recommendations on this topic are due by July, 2014.**
4. Initial and Future Models: Recommendations on how and when the HSCRC should evolve beyond the Global Payment Models that are expected to be in place for many hospitals, effective as of January, 2014. Considerations should begin to account for the Phase 2 application requirement in 2016 focused on the total cost of care, the role of episodes of care, physician alignment, post- acute care, and population health concepts. Advice should also be given on the use of population-based concepts with regard to assignment of accountability and accounting for market share in model development, and incorporating patient-centered concepts through payment incentives. **Initial strategic recommendations on this topic are due after July, 2014, with detail design work to follow.**

**Physician Alignment & Engagement.** In general, this workgroup will make recommendations on how the new hospital payment models should align and engage with physicians and other health care providers in partnership with patients to achieve the goals of the new model.

1. Alignment with Emerging Physician Models: identification of current physician payment models as background and a foundation for recommendations on shared savings, and informing the Payment Models workgroup. The report should include a discussion of payment models and hospital/physician payment arrangements for different types of physicians (employed, community, primary care, specialty), and under different physician engagement scenarios, such as Accountable Care Organizations (ACO), Patient-Centered Medical Home (PCMH), and any other existing alignment programs. The report should discuss new Medicare Value Based

Payments for physicians and role (if any) in model development. **The report on this topic is due by May, 2014.**

2. Shared Savings: Recommendations on how hospitals and physicians can create aligned incentive models on an All-Payer basis to share savings, such as through creating gain sharing or pay-for-performance structures, bundled payments, including relationship to ACO, PCMH, and Medicare fee-for-service models. Recommendations on developing standard approaches, accounting for unduplicated savings, and pursuing federal waivers and exemptions relative to operation of these models where necessary. **Initial recommendations are due by May, 2014.**
3. Care Improvement: Recommendations on the need for a multi-stakeholder campaign to support care improvement and the extent to which existing efforts could be leveraged to support the goals of the new All-Payer Model and enhance overall efficiency. The recommendations should address the role for the HSCRC in convening stakeholders, encouraging standardization and facilitating the acquisition and use of data, and how the HSCRC role should be coordinated among State agencies and other stakeholders. Recommendations on care improvement should address the following topics:
  - a. Care Coordination Opportunities: Opportunities to improve quality and reduce costs by planning and coordinating for the needs of high risk patients. Consider the relationship to initiatives supported by the Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) funding. **Initial recommendations are due by July, 2014.**
  - b. Post-Acute and Long-Term Care: Opportunities to facilitate the creation of aligned incentives for hospitals, physicians, and other providers to provide well-coordinated post-acute and long-term care, improve care transitions and reduce readmissions in Skilled Nursing Facilities and other long term care settings, including the need for models and incentives that require federal approval. **Initial recommendations are due by July, 2014.**
  - c. Evidence-Based Care: How to identify opportunities, accelerate the introduction, and align incentives to improve care and lower costs using evidence based practices. **Recommendations on this topic will be due to the HSCRC after July, 2014.**

**Performance Measurement**. In general, this workgroup will develop recommendations for the HSCRC on measures that are reliable, informative, and practical for assessing a number of important issues. The Payment Models workgroup will design the overall structure through which the results of these measures are applied to payment updates and rate orders. The topics are listed in priority order that reflect a combination of program impact and how fast work can be completed, given the state of the art.

1. Reducing potentially avoidable utilization to achieve the Three-Part Aim: Recommendations on measuring volume of services that could be avoided and establishing incentives to improve patient care and reduce health care costs. **Initial recommendations are due by the end of February, 2014 to facilitate the efforts of the Payment Models workgroup.** The recommendations should address the following topics:
  - a. Development of Statewide Targets and Hospital Performance Measurement: Recommendations on establishing statewide targets for readmissions and potentially preventable conditions and how to achieve these targets through hospital performance measurement. The new All-Payer Model requires reductions in Medicare readmissions to national levels within five (5) years and a thirty percent (30%) reduction in Maryland Hospital Acquired Conditions (MHACs). It also requires that the combination of value-based purchasing programs for Maryland put comparable revenues at risk to the national Medicare programs. The workgroup should initially focus on Calendar Year 2014 targets and their relationship to the MHAC, Quality Based reimbursement (QBR), and readmissions revenue at risk and incentive programs for FY 2015.
  - b. Measuring potentially avoidable utilization: Recommendations on developing a comprehensive set of measures for volume of services that could be avoided with benefit to patients and health care costs. The initial set of measures under consideration includes hospital acquired conditions (safety issues), readmissions and re-hospitalizations (care planning and coordination), ambulatory sensitive conditions (effective primary care), and care coordination for high needs patients (identification and planning of care). Beyond the July timeframe, the workgroup should make recommendations for evaluation of other opportunities for focus, such as use of emergency room, practice variation, studies and tests that are needlessly duplicated (information systems) or not evidence based, and other identifiable opportunities.
2. Value-based payment (integration of cost, quality, population health and outcomes): Recommendations on what specific measures of cost, care and health should be considered for adoption, retention or development in order to evaluate and incentivize the population-based All-Payer Model. This measurement and payment approach relates to the policy objectives of establishing payment levels that are reasonably related to the cost of providing services on an efficient basis and in accordance with the value concepts embodied in the new All-Payer Model. Recommendations should consider both the evidence supporting the approach and the improvement in health likely to result. Recommendations on whether or not access to hospital-based care should be measured and monitored. The aim should focus on ensuring that Maryland's approaches exceed those being developed by CMS while focusing on the opportunities of the All-Payer Model and recognizing its fundamental differences from the national

Medicare fee-for-service program. **Initial strategy recommendations are due by July, 2014 with detail design work to follow.**

3. Patient Experience and Patient-Centered Outcomes: Recommendations on integrating patient-centered concepts in the performance measurement work as well as the measures used, including, but not limited to, patient perspective measures, whether gathered through CAHPS-type instruments or in other ways, and outcome measures that are valued by patients to improve efficiency, effectiveness, and outcomes of care. **Initial recommendations are due by July, 2014.**

**Data and Infrastructure**. In general, this workgroup will develop recommendations to the HSCRC on the data and infrastructure requirements needed to support oversight and monitoring of the new hospital All-Payer Model and successful performance. Recommendations should take into consideration the needs of the HSCRC, as well as the needs for the health care industry and other stakeholders to achieve the goals of the model. This workgroup should work in careful collaboration with other state agencies and other stakeholders to build upon the available resources and existing models for data governance.

1. Data Requirements: Recommendations on the data needed to: support rate setting activities; conduct evaluation activities using the key performance indicators; monitor and evaluate model performance; monitor shifts in care among hospitals and other providers; and, monitor the total cost of care. The recommendations should also consider the need for patient-centered, timely and hospital-specific data needs as well as identification of reliable sources outside of the HSCRC, including the All-Payer Claims Database, data available through the Chesapeake Regional Information Systems for Patients (CRISP) or other sources that could support the new payment model. **Initial recommendations are due by April, 2014.**
2. Care Coordination Data and Infrastructure: Recommendations on the potential opportunities to use Medicare data to support care coordination initiatives, including: identifying the gaps in Medicare data; the best practices in predictive modeling and targeting care coordination resources; the most efficient infrastructure to support the needs of the state, hospitals, and other health care providers to meet the goals of the new model; and the relationship to initiatives supported by CMMI SIM funding. **Initial recommendations are due by May, 2014.**
3. Technical and Staff Infrastructure: Recommendations on the technical infrastructure, staff resources and external resources needed to build, maintain and optimize the use of the data. **Initial recommendations are due by July, 2014.**
4. Data Sharing Strategy: Recommendations on the data that should be shared among the HSCRC, MHCC, SIM, DHMH, hospitals and others to manage and implement the new payment models, including the data sharing strategy to ensure protection of patient confidentiality and compliance with federal and state requirements and best practices. **Recommendations are due by July, 2014.**