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November 19, 2014

The Honorable Martin O'Malley
Governor of Maryland
100 State Circle
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The Honorable Joshua M. Sharfstein, M.D.
Secretary of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

RE: Health - General Article Section 19-207(b)(6) Annual Report on Activities of the Health Services Cost Review Commission

I am pleased to provide you with the FY 2014 Report to Governor from the Health Services Cost Review Commission (HSCRC), prepared relative to Section 19-207(b)(6) of the Health-General Article. This report provides a review of HSCRC activities during FY 2014.

Effective January 1, 2014, the State of Maryland and the Center for Medicare and Medicaid Innovation (CMMI) entered into a new initiative to modernize Maryland's unique all-payer rate-setting system for hospital services. This initiative, replacing Maryland's 36-year-old Medicare waiver, allows Maryland to adopt new and innovative policies aimed at reducing per capita hospital expenditures and improving patient health outcomes. The HSCRC has updated the structure of this year's Governor's Report to reflect activities supporting the modernized All Payer Model. More information on HSCRC and Maryland hospital activities can be found on the HSCRC's website: http://www.hscrc.state.md.us/

Please contact me if you any questions about this report, or you may contact Steve Ports, Deputy Director, Policy and Operations, at Steve.Ports@maryland.gov.

Sincerely,

Donna Kinzer
Executive Director

Report to the Governor

Fiscal Year 2014

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

November 19, 2014

Introduction

The State of Maryland is leading a transformative effort to improve care and lower the growth in healthcare spending through Maryland's new All-Payer Model. The All-Payer Model serves as the central focus in this Fiscal Year 2014 Report to the Governor from the Health Services Cost Review Commission ("HSCRC," or "Commission"). We discuss All-Payer Model policy implementation, state and federal reporting requirements, and stakeholder engagement.

This report also discusses other HSCRC activities during the reporting period July 1, 2013 through June 30, 2014, prepared relative to Section 19-207(b)(6) of the Health-General Article of the Annotated Code of Maryland.[1] We review hospital financial performance in state fiscal years 2013 and 2014, discuss hospital quality performance and updated quality initiatives, as well as review HSCRC staffing and budget infrastructure.

New All-Payer Model with CMMI

Effective January 1, 2014, the State of Maryland and the Center for Medicare & Medicaid Innovation (CMMI) entered into a new initiative to modernize Maryland's unique all-payer rate-setting system for hospital services. This initiative, replacing Maryland's 36-year-old Medicare waiver, allows Maryland to adopt new and innovative policies aimed at reducing per capita hospital expenditures and improving patient health outcomes.

Developing the modernized All-Payer Model required an intense and highly collaborative effort between the State, the Maryland Hospital Association, and the State's payers. Representatives met frequently with CMMI for nearly one year prior to Governor O'Malley's submission of the State's updated application to CMMI on October 11, 2013. CMMI approved Maryland's All-Payer Model effective January 1, 2014.

Goals Established by the All-Payer Model

The All-Payer Model aims to transform Maryland's health care system to enhance patient care, improve health, and lower total costs. Under the All-Payer Model, 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 five years (plus an adjustment for population growth), which is the 10-year compound annual growth rate in per capita gross state product ("GSP"). This cap could be adjusted in years four and five based on more recent GSP trending.

[1] Section 19-207(b)(6)(i) requires this Report to the Governor to include a copy of each report required by this subtitle. HSCRC posts on its website for public access all reports required by this subtitle, and we provide a link to those reports in this document.

- 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. This is estimated to represent a savings level of about one-half 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.

Implementing Policies to Achieve Model Goals

The All-Payer Model builds upon decades of innovation and equity in hospital payment and health care delivery in Maryland. HSCRC worked closely with stakeholders and CMMI to develop and deploy policies to enable the State to meet the goals established by the All-Payer Model. An Advisory Council, several stakeholder work groups (discussed in the Stakeholder Engagement section below), and bi-weekly meetings with HSCRC and CMMI staff facilitated policy implementation.

The All-Payer Model is designed in conjunction with a number of other endeavors currently underway in Maryland, including efforts to strengthen primary care and coordinate hospital care with community care; map and track preventable disease and health costs; develop public-private coalitions for improved health outcomes; establish health enterprise zones; and enroll individuals in health coverage.

Initial policies toward All-Payer Model goals focused on allowing hospitals to voluntarily choose to participate in hospital global budget strategies, which is an expansion of what had been taking place at various hospitals across the State for at least three years.

Global Budgets Negotiated will All Hospitals

The All-Payer Model agreement affords Maryland the ability to creatively develop alternative methods of rate determination. During the first six months of the All-Payer Model, the HSCRC developed the Global Budget Revenue (GBR) reimbursement model and engaged all hospitals not already under a Total Patient Revenue (TPR) agreement to consider transitioning to GBR. Since some revenue can be excluded from the global budget (such as revenue from some out-of-state referrals), approximately 95% of acute hospital revenue is now under a global budget.

The GBR and TPR methodologies are central to achieving the Three-Part Aim set forth in the All-Payer Model: promoting better care, better health, and lower cost for all Maryland patients. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model focuses on controlling increases in total hospital revenue per capita. GBR and TPR agreements prospectively establish a fixed annual revenue cap for each hospital to encourage hospitals to focus on care improvement and population-based health management.

Under GBR and TPR contracts, each hospital's total annual revenue is known at the beginning of each fiscal year. HSCRC determines annual revenue from a historical base period that HSCRC adjusts to account for inflation updates, infrastructure requirements for GBR hospitals,[2] demographically driven volume increases, performance in quality-based or efficiency-based programs, changes in payer mix and changes in levels of approved uncompensated care. Annual revenue may also be modified for changes in service levels, market share, or shifts of services to unregulated settings.

HSCRC is establishing a tool to understand how hospitals are utilizing their resources to meet care coordination goals and to evaluate the success of certain care strategies to reduce potentially avoidable utilization at the hospital. Understanding these investments and their impact is important for maximizing the potential for success under global budgets and improving care coordination and population health.

Other Policies Support All-Payer Model Goals

In addition to GBR, the Commission approved additional policies to support the All-Payer Model goals.

- Quality: The HSCRC amended the existing Maryland Hospital Acquired Conditions (MHAC) and Readmissions Programs to tie them to the new All-Payer Model requirements. The Commission also established a new readmission reduction incentive program that would provide positive incentives to hospitals if hospitals in aggregate meet or exceed a specific target designed to make progress toward the goal of bringing readmissions down to below the nation. As quality is a central component of the All-Payer Model, we discuss these and other quality programs in greater detail in the Quality Performance section of this report.
- Inflation Update: Balanced update policy implemented effective July 1, 2014 provides a full inflation update. ACA related reductions allowed for a larger update compared to FY 2014 while providing reasonable assurance of ability to meet overall revenue growth targets.
- Uncompensated Care Reduction: The HSCRC implemented an uncompensated care (UCC) reduction based on data driven assessments of UCC reductions that would be expected with the shift of Medicaid PAC enrollees from a limited benefit package to a

[2] TPR hospitals were previously provided allowances at the initiation of their agreements.

full Medicaid benefit. Additional future reductions may be possible; however, the HSCRC will evaluate experience across time when incorporating UCC modifications.

Statutory and Regulatory Updates

During its 2014 Session, the Governor signed two bills that have direct effect on Commission policy. House Bill 298 (Chapter 263) conformed the HSCRC statute to the provisions of the new All-Payer Model. More specifically the legislation:

- Permits the HSCRC to set rate levels and rate increases and to promote alternative methods of rate determination and payment consistent with the All-Payer Model Agreement;
- Increases the HSCRC's user fee from $7 million to $12 million; and
- Requires biannual reporting to the Governor and the General Assembly regarding progress on achieving the goals of the new model.

The second bill is the Budget Reconciliation and Financing Act (Senate Bill 172/Chapter 464) which:

- Reduces the MHIP assessment from 1% of net patient revenue to 0.3%;
- Permits, but does not require, up to $15 million in hospital revenue to be used to support planning and implementation of the All-Payer Model and establishes the processes for how such funding would be provided; and
- Requires the Commission and the Department of Health and Mental Hygiene to calculate the savings that accrue to Medicaid as a result of implementation of the All-Payer Model, and to reduce those savings from the Medicaid deficit assessment each year.

State and Federal All-Payer Model Status Reporting Requirements

State All-Payer Model Reporting Requirements

On October 1, 2014, the HSCRC submitted a report summarizing implementation, monitoring, and other activities to inform the Maryland legislature regarding the status of the new All-Payer Model. The inaugural Monitoring of Maryland's All-Payer Model Biannual Report, prepared relative to Section 19-207(b)(9) of the Health-General Article of the Annotated Code of Maryland, discussed the State's progress during the period from January 1, 2014 through June 30, 2014, the first six months of Maryland's new agreement. Figure 1 provides an overview of the reporting required relative to Health-General Section 19-207(b)(9) for Maryland's first six months under the new All-Payer Model. The HSCRC will produce an updated Biannual Report every six months and also report the key findings here in the annual Report to the Governor. The complete report is available at: http://hscrc.maryland.gov/documents/Legal-Legislative/Reports/HSCRC-Biannual-Report-on-All-Payer-Model-Monitoring-October-2014.pdf

Figure 1: State Biannual Reporting of Maryland's All-Payer Model

Code Section	Achievement Requirement	Metric Finding	Status
I.1.	Limit the annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58% growth rate	Per capita revenue for Maryland residents grew 0.96%	• Ongoing monthly measurement • Expecting continued favorable performance for Calendar Year 2014
I.2.	Achieve aggregate savings in Medicare spending equal to or greater than $330 million over 5 years	*Data not yet available from CMS*	• HSCRC and CMS met on methodology • Testing data from Centers for Medicare & Medicaid Services (CMS), expect preliminary tests to conclude in November
I.3.	Shift at least 80% of hospital revenue to a population-based payment structure (such as global budgets)	95% of hospital revenue shifted to global budgets	• All hospitals engaged in global budgets under Global Budget Revenue agreements and Total Patient Revenue agreements
I.4.	Reduce the hospital readmission rate for Medicare beneficiaries to below the national rate over the 5 year period of the agreement	*Data not yet available from CMS*	• HSCRC and CMMI are refining methodology • HSCRC does not yet have Medicare data needed to measure progress • Monitoring progress within Maryland using data collected from hospitals by HSCRC
I.5.	Cumulative reduction in hospital acquired conditions by 30% over 5 years	Reduction of 24.27% in hospital acquired conditions 2014 year to date compared to 2013 year to date	• HSCRC staff reviewing and auditing these findings
Code Section	**Description**	**Report**	**Status**
II.	Work group actions	All work groups have reported to the HSCRC	• Work groups meeting on a regular basis. Two new work groups established for fall 2014.
III.	New alternative methods of rate determination	95% of hospital revenue now under global budgets arrangements, implemented in accordance with policies approved by the Commission	• New global budget agreements published on HSCRC website • Ongoing modifications underway to refine approaches
IV.	Ongoing reporting to CMMI of relevant policy development	See Appendices for reports provided to CMMI	• Provided reports to CMMI on an ongoing basis

Code Section	Achievement Requirement	Metric Finding	Status
	and implementation		

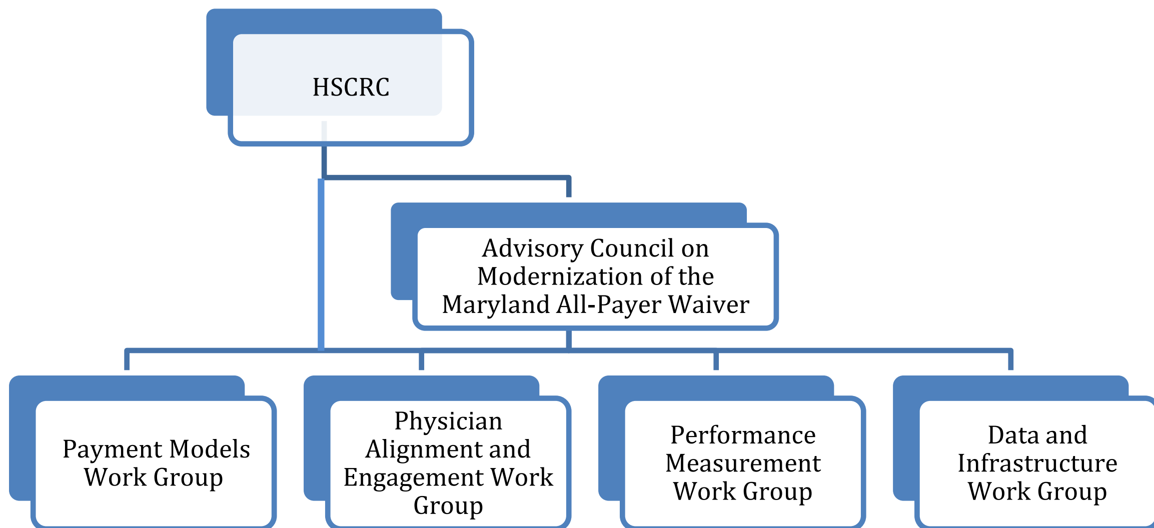
Federal All-Payer Model Reporting Requirements

Maryland's All-Payer Model agreement with CMMI establishes a number of requirements that Maryland must fulfill. CMMI must evaluate Maryland's performance under the model and provide reports on an annual basis. The evaluations will be made based on calendar year performance, with the first evaluation due in July 2015.[3] In addition to the annual report, the HSCRC provides ongoing reporting to CMMI of relevant policy development and implementation. If Maryland fails to meet selected requirements, CMMI must provide notification and Maryland will have the opportunity to provide information for evaluation and to provide a corrective action plan, if warranted. At this time, CMMI has not provided any such notices.

Stakeholder Engagement

The HSCRC has implemented a broad stakeholder engagement approach, see Figure 2. More than 100 stakeholders representing consumers, payers, providers, physicians, nurses, other health care professionals, and experts have participated in an Advisory Council, four work groups, and 6 sub-groups. All work group meetings have been conducted in public sessions, and comments from the public have been solicited at each meeting.

Figure 2: The Advisory Council and Work Groups



The work groups also solicited and evaluated technical white papers submitted by members of the research community and general public. Work group reports are

[3] Initial Model metrics are due to CMMI May 1, 2015 with the complete annual report due June 30, 2015.

available at the HSCRC's website http://hscrc.maryland.gov/hscrc-advisory-council.cfm. Each work group includes members representing consumers and encouraged input and white papers from those representatives to ensure that the Commission addresses consumers' needs as policies are made, and to inform how the HSCRC and providers can best educate consumers on the changes being made to the health care delivery system.

Beginning in December, the Commission will engage in Phase II of the work group process. The Payment Models, Alignment, and Performance Measurement work groups will continue to pursue the work identified above. The Commission will be working with two new work groups that will include multi-stakeholder and multi-State representation. The industry and key consumer representatives will lead these groups, and the Commission will help support and participate in these work groups. The two new work groups are the Care Coordination Initiatives and Infrastructure Work Group and the Work Group on Consumer Engagement, Outreach, and Education.

Hospital Financial Performance

Hospital Profitability

The HSCRC utilizes hospitals' financial data submissions to monitor hospital financial performance on a monthly basis using unaudited data and on an annual basis using annual audited data. The financial data provide a metric to monitor the efficiency and effectiveness of hospitals pursuant to the HSCRC's statutory charge. While each hospital may adjust and correct its unaudited data throughout the year, the unaudited data provide a good indicator of the direction of trends in statewide hospital revenue, expenditures, utilization, and profitability. Below is a summary of key data regarding the profitability of hospitals on an audited basis in FY 2013 and on an unaudited basis for FY 2014.

The HSCRC monitors financial performance of regulated hospitals. Under its authority, the HSCRC regulates inpatient and outpatient hospital services located at the hospital. The HSCRC does not regulate the rates of physicians, nor does it regulate those continuing revenue producing activities which, while not related directly to the care of patients, are business-like activities commonly found in hospitals for the convenience of employees, physicians, patients and/or visitors.

Audited Financial Data—FY 2013

Data for FY 2013 show a decrease in profitability on operations and an increase in total profitability, i.e., both operating and non-operating activities, compared to recent years. The decrease in operating profitability may be attributed, in no small part, to the low update factor for FY 2013 approved by the Commission, in an effort to meet the requirements of the former All-Payer Waiver. It may also be attributable to the effect of federal sequestration, which reduced Medicare payments to hospitals nationally, including Maryland hospitals, in the last quarter of FY 2013. The increase in total hospital profitability is attributable to unrealized profits on investments.

Below shows profitability in FY 2013 based on audited data for total operations, hospital operations regulated by the HSCRC, and for total hospital activities:

- Total combined audited regulated and unregulated profit margins for FY 2013:
  - Operating Margin: 1.17%
  - Total Margin: 3.83%
- Audited profit margin for FY 2013 for services regulated by the HSCRC:
  - Operating Margin: 5.32%

Unaudited Financial Data—FY 2014

Based on unaudited financial data for FY 2014, total profit margins increased in FY 2014. Contributing factors include a larger July 1, 2013 update and a heightened focus on reducing costs. In FY 2013, the update factor was 0.3%, the lowest update factor in many years. Based on Commission policies and strategy to improve on the former Waiver test, the Commission was able to increase the update factor to 1.65%. While it was increased over FY 2013, the 1.65% increase was more in line with, although lower than, update factors applied over the past four or five years. Nonetheless, regulated operating margins have continued to decline since 2011 due to lower than average update factors and the impact of the federal sequester which was fully realized in FY 2014.

Below shows the profitability in FY 2014 based on unaudited data. Please note that final audited data, when available, may adjust these margins:

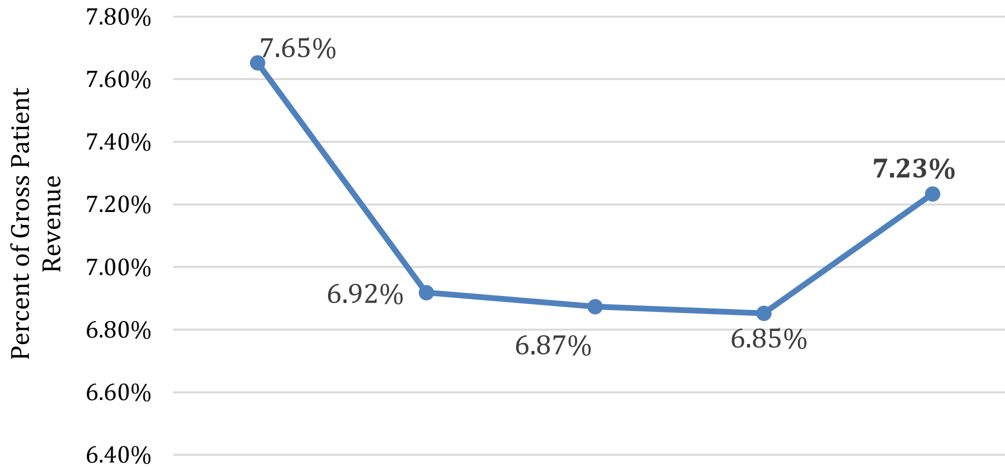
- Total combined unaudited regulated and unregulated profit margins for FY 2014:
  - Operating Margin: 2.52%
  - Total Margin: 5.08%
- Unaudited profit margin for FY 2014 for services regulated by the HSCRC:
  - Operating Margin: 4.37%

Uncompensated Care

The HSCRC provides as a component of hospital rates an amount for uncompensated care (UCC). This is one of the unique features of rate regulation in Maryland. Recognizing reasonable levels of bad debt and charity care in hospital rates enhances access to hospital care for those who cannot pay for care. The HSCRC provides for UCC statewide based on the prior year's actual statewide experience, as well as hospital's expected performance based on a regression analysis.

Figure 3, below, shows the actual total uncompensated care rate for all regulated Maryland hospitals between FY 2009 and FY 2013. Uncompensated care levels dropped between FY 2009 and FY 2010, but remained relatively steady with only a slight decline from FY 2010 to FY 2012. Most recently, between FY 2012 and FY 2013, there was a 0.38 percentage point increase in the total uncompensated care rate for all regulated Maryland hospitals.

Figure 3: Uncompensated Care as a Percentage of Gross Patient Revenue, FY 2009-2013



This rise in the level of UCC may be attributed to several factors. The increased prevalence of higher deductibles, coinsurances, and copays among commercial insurance plans may have contributed to increased UCC. Also, the proportion of hospital services that are outpatient has increased, and the patient responsibility portion of outpatient bills is typically higher, resulting in higher levels of UCC.

The total prospective amount built into rates across the industry is the percentage actually experienced in the previous year of available data. If, for example, UCC were $1 billion in FY 2012, this model would establish rates that would deliver $1 billion in fiscal year 2014, provided volumes and rates remain the same. HSCRC policies then determine how the $1 billion in this example is distributed among the hospitals through payments to or distributions from an UCC pool. Distribution policies reflect both hospitals' actual UCC levels and expected UCC based on the each hospital's patient mix. For FY 2014, the total amount of UCC included in rates after applying the Commission's UCC policy was 6.68%.

The Commission adopted changes to its UCC policy for FY 2015 to reflect the impact of expanded health insurance and Medicaid coverage resulting from the ACA. That policy reflected the expected reduction in uncompensated care from the expansion of Medicaid coverage to Medicaid's Primary Adult Care (PAC) program, and altered the methodology going forward recognizing that the demographics of the uninsured are different after the implementation of the ACA.

Averted Bad Debt

Section 19-214(e) of the Health General Article requires the HSCRC to report to the Governor and the General Assembly reductions in UCC and number of individuals enrolled in Medicaid as a result of eligibility changes. See Figure 4. HSCRC submitted this report in January 2014. The report is available at http://hscrc.maryland.gov/documents/Legal-Legislative/Reports/hscrc-report-to-gov-and-ga-on-avbd-jan-2014.pdf

Figure 4: Averted Bad Debt Reporting

Reporting Requirement	Reference	Finding
Aggregate reduction in hospital UCC realized from the expansion of health care coverage	Chapter 7, Acts of the General Assembly, 2007 Special Session	HSCRC estimate: $158.6 million
Number of individuals who enrolled in Medicaid as a result of the change in eligibility standards	Health-General Section 15-103(A)(2)(ix) and (x) of the Health General Article	Maryland Medicaid projection: 107,743 individuals

Community Benefits

The Internal Revenue Service Code requires non-profit organizations to report with their taxes the amount of community benefits that those organizations provide in exchange for not having to pay federal, state, or local taxes. Under Maryland law, hospitals are also required to report to the HSCRC similar data and qualitative information regarding community benefit expenditures and their community benefit operations. Community benefits are defined as activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including:

- Health services provided to vulnerable or underserved populations;
- Financial or in-kind support of public health programs;
- Donations of funds, property, or other resources that contribute to a community priority;
- Health care cost containment activities; and
- Health education screening and prevention services.

The most recent available report from hospitals reflects community benefits for FY 2013. In that year, Maryland hospitals expended a total of $1.2 billion in community benefits or 11% of total hospital operating expenses. After offsetting expenditures related to amounts that are included in rates and not generated through hospital resources, the amount of community benefits spending is $712 million or 5.2% of operating expenses.

FY 2013 is the first year that all hospitals are required to have conducted a community health needs assessment. The Commission annually obtains information on each hospital's community needs assessments, related collaborations, how their community benefits functions are organized, and a summary of each of the primary community benefits initiatives. Those reports may be found on the Commission's website at http://www.hscrc.maryland.gov/init_cb.cfm.

Quality Performance

Maryland continues to be a leader in the U.S. in implementing innovative hospital payment systems to achieve our goals of cost containment, access to care, equity in

payment, financial stability, and quality improvement. Maryland's achievements in recent years have resulted in hospital pay-for-performance programs that are broader than any other in design and scope, and encompass a robust set of performance measures with strong and increasing emphasis on patient outcomes. Maryland has steadily expanded the magnitude and scope of its quality payment reform initiatives since 2008. Maryland's hospital quality initiatives are part of an overall, comprehensive set of emerging healthcare delivery reform efforts and activities in the State to achieve the three-part aim of better care for individuals, better health for populations, and reduced expenditures for all patients.

QBR

The Quality Based Reimbursement (QBR) initiative used CY 2011 as the base year and CY 2012 as the performance measurement year for FY 2014 (July 1, 2013 to June 30, 2014) payment adjustments using CMS/Joint Commission core process measures and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience survey measure. The core process measures accounted for 70%, and HCAHPS 30%, of each hospital's total performance score. The maximum amount of penalties/rewards is 0.5% of the total revenue of the hospitals. This translates into a total penalty amount of $4.2 million for FY2014.

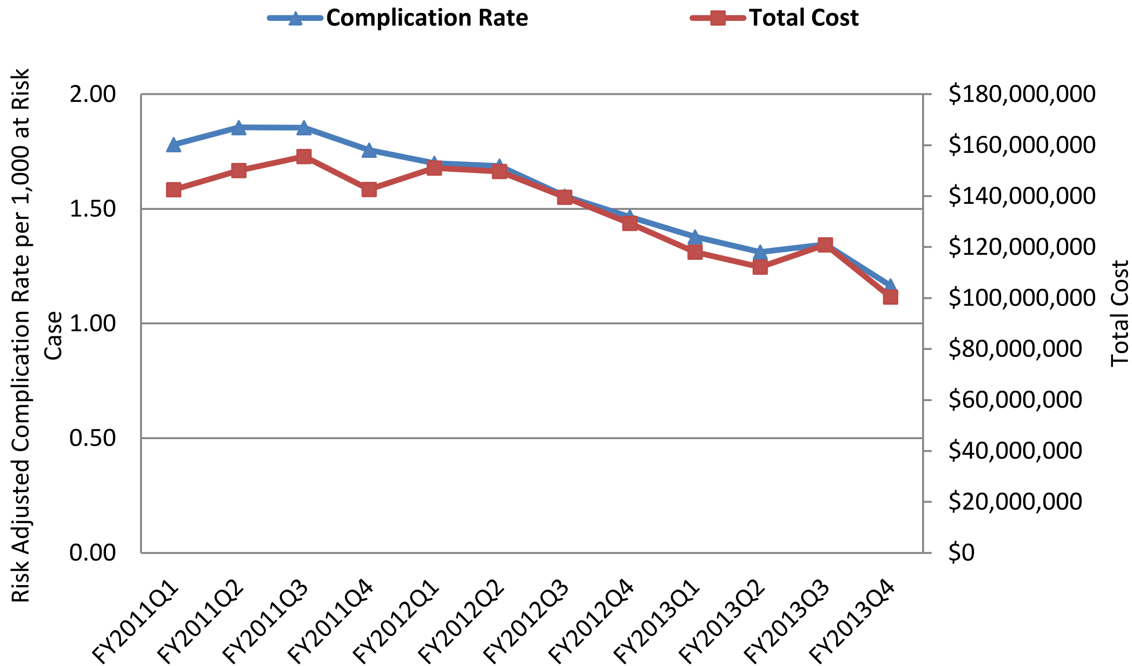
Data from Hospital Compare (https://data.medicare.gov/data/hospital-compare) and WhyNotTheBest (http://whynotthebest.org/) reveal that Maryland has improved faster than the nation in aggregate for the clinical process measures and has improved at the same rate as the nation for HCAHPS.

MHAC

For the Maryland Hospital Acquired Conditions (MHAC) program, actual versus expected rates of complications for each of the 51 Potentially Preventable Complications (PPCs) developed by 3M Health Information Systems are calculated and risk adjusted using the mix of patients served in each hospital. Like the QBR program, HSCRC has continued to update and refine the MHAC initiative. The maximum amount of penalties and or rewards under this program stands at 2% of the total revenue of the hospital, and this translates into a total penalty amount of $9.3 million for FY 2014.

For FY 2015, approved changes to the MHAC program include increasing the amount at risk for the program to a total of 3%, with 2% allocated for attainment and 1% allocated for improvement on a subset of five PPCs that constitute higher volume and high cost events. As shown in Figure 5, the overall risk adjusted hospital-acquired potentially preventable complication (PPC) rates declined by 34.6% since the first quarter of FY 2011.

Figure 5: Trends in Hospital-Acquired Potentially Preventable Complication Rates and Costs in Maryland, July 2011 to June 2013



Note: Includes all 65 Potentially Preventable Complication Rates. Total cost is not adjusted for patient-mix.

Other Measures

Maryland hospitals performed better than the national average on mortality and Central Line Associated Blood Stream Infection (CLABSI) measures, two other CMS measures. As shown in Figure 6, under the most current data available on Hospital Compare, Maryland has performed substantially better than the nation for 30-day mortality rates for heart attack, heart failure and pneumonia. Maryland hospitals are currently performing better and have been improving at a faster rate than the national average on the CDC CLABSI measure.

Figure 6: Maryland Hospitals Compared to All US Hospitals for Medicare 30-Day AMI, CHF, and Pneumonia Patients

Maryland 30-Day Mortality	Hospitals Better Than US	Hospital Same as US	Hospitals Worse Than US	Small Case Numbers
Heart Attack	1 (2%)	40 (85%)	0	6
Heart Failure	9 (19%)	35 (75%)	2 (4%)	1
Pneumonia	8 (17%)	37 (79%)	0	1

Source: Hospital Compare Data, Measurement Period 7/1/09 to 6/30/12

Infrastructure

HSCRC Staff Structure and Budget

The HSCRC is the only agency in the country with the mission of setting all payer rates for hospital services within a state. The HSCRC functions as an independent Commission within the Maryland Department of Health and Mental Hygiene (“DHMH”). Seven Commissioners, appointed by the Governor, govern the HSCRC. Figure 7 provides a list of current Commissioners.

Figure 7: HSCRC Commissioners

Commissioner	Term Start Date
John M. Colmers, Chairman	July 1, 2013
Herbert S. Wong, Ph.D., Vice Chairman	July 1, 2013
George H. Bone, M.D.	July 1, 2010
Stephen F. Jencks, M.D., M.P.H.	July 1, 2012
Jack C. Keane	July 1, 2011
Bernadette C. Loftus, M.D.	July 1, 2010
Thomas R. Mullen	July 11, 2011

The State charges the HSCRC with regulating the rates and revenues of Maryland’s 46 acute care and five specialty hospitals, an industry with revenues in excess of $16 billion per annum. This responsibility is accomplished by a relatively small and highly skilled staff of 34 full time equivalents (FTEs). Staff has traditionally been organized in three divisions: Rate Setting and Compliance, Research and Methodology, and Quality Performance. The Commission will be altering this structure to be consistent with the demands of the new All-Payer Model.

A small user fee assessed on hospital rates in Maryland supports the Commission staff salaries and Commission operations. Due to the technical nature of the work of the Commission, expenses are driven primarily by personnel costs and contracts. The total user fee assessment in FY 2014 was $7,016,529. Due to prudent spending and vacancies that occurred during the first and second quarters of the fiscal year, the fund balance at the end of fiscal year 2014 was $1,449,879 (or 22.2% percent of expenditures). FY 2015 user fee assessments were reduced to bring the fund balance back to the targeted 10% level. User fees will continue to be adjusted throughout the year as necessary to achieve a reasonable reserve threshold.

Future Outlook

Data Acquisition and Integrity

In order for the Commission and Medicare to monitor success on the metrics of the new All-Payer Model it is critical that HSCRC alter existing policies regarding reporting requirements, deadlines, and analysis. The Commission, in consultation with the work groups, identified areas of priority to improve the monitoring system in the coming year. As a result the Commission has begun to obtain data in a manner that will:

- More accurately reflect the split of in-state and out-of-state patients
- Provide for reconciliation between case mix (discharges/visit-level administrative data) and hospital financial data
- Mitigate changes between preliminary monthly and quarterly final quality data

Several of the All-Payer Model goals require Maryland to measure against national Medicare trends. Therefore, it is critical that the HSCRC obtain timely Medicare data and that metric standards be documented and understood by all parties. HSCRC staff continues to work with CMMI to attempt to finalize the terms of the metrics and obtain the Medicare data. HSCRC will report on the Medicare metrics in future years.

Population-Based Policies

In addition, the Commission will continue to develop per-capita based incentives that are intended to improve population health. This includes revising existing quality incentive programs to reflect per-capita performance rather than per-case performance. In a broader sense, the Commission will look at how to reflect per-capita efficiency of hospitals under the new system. With the movement to global budgets, the HSCRC will focus on adjustments for shifts in patients between hospitals and from hospitals to unregulated sites. This will include:

- Evaluating reasonableness of rates when volumes fall
- Gaining more consumer input and engagement
- Strengthening use of quality, outcomes, and consumer input in rate setting and payment
- Improving performance on patient experience at Maryland hospitals

Building and Strengthening Partnerships

The HSCRC will continue to facilitate education and collaboration among hospitals and community providers to improve transitions of care and to promote the alignment of incentives among hospitals and other providers. While many of these activities will occur outside the HSCRC, our agency will continue the public engagement process by bringing providers together to encourage collaborative activity, especially through the HSCRC's robust and inclusive work groups:

- The Care Coordination Work Group, involving a broad set of stakeholders, will be working with the various providers to share best practices, develop common successful tools and strategies, and implement effective approaches to address the needs of high utilizers of care.
- The Physician Alignment Work Group will continue to develop concepts that ensure that hospitals, physicians, and other providers are moving toward the same goals of the Three-Part Aim. They will consider gain-sharing models, pay-for-performance models which reward physicians who meet certain quality performance benchmarks, and an integrated care network model that is designed to appropriately coordinate the care for high utilizers whose care is largely unmanaged. Most of these strategies will be employed outside the Commission but will be consistent with the goals of the All-Payer Model.
- Cutting across all of the Commission's activities, the HSCRC is forming a Consumer Engagement, Education and Outreach Work Group. This work group will be led by key consumer leaders and will help to inform hospitals, the State, and other providers on how to improve patient experience and education so that individuals understand why the delivery system is changing and how it affects them.

As the Commission continues to transition to the new All-Payer Model, it is important to note that success is dependent on a robust partnership with hospitals, payers, DHMH, physicians, other providers of care, and consumers. The financial incentives put into place by the HSCRC are but one of the drivers of change and improvement. It is the many initiatives implemented by the State, the partners and providers that will determine ultimate success. The HSCRC's financial incentives are consistent with other State initiatives and tools, which are working in concert to improve population health and reduce costs.