Report to the Governor

Fiscal Year 2015

Health Services Cost Review Commission
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October 2015

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October 30, 2015

The Honorable Lawrence J. Hogan, Jr.
Governor of Maryland
100 State Circle
Annapolis, Maryland 21401

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-101 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-107 State House
Annapolis, MD 21401-1991

The Honorable Van T. Mitchell
Secretary of DHMH
201 W. Preston Street
Baltimore, MD 21201

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 2015 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 2015.

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. Last year, the HSCRC updated the structure of the annual 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, Director of the Center for Alignment and Engagement, at Steve.Ports@maryland.gov.

Sincerely,

Donna Kinzer

Donna Kinzer
Executive Director

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 (FY) 2015 Report to the Governor from the Health Services Cost Review Commission* (HSCRC or Commission). This report discusses All-Payer Model policy implementation, state and federal reporting requirements, and stakeholder engagement.

This report also includes other HSCRC activities during the reporting period of July 1, 2014 through June 30, 2015, prepared relative to Section 19-207(b)(6) of the Health-General Article of the Annotated Code of Maryland.[1] This report reviews hospital financial performance in FYs 2014 and 2015, discusses hospital quality performance and updated quality initiatives, and provides an overview of HSCRC staffing and budget infrastructure.

The 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. Success of the New All-Payer Model will reduce costs to purchasers of care—businesses, patients, insurers, Medicare, and Medicaid—and improve the quality of the care that patients receive both inside and outside of the hospital. In the past 22 months, the State, in close partnership with providers, payers, and consumers, has made significant progress in this modernization effort.

Goals Established by the All-Payer Model

The All-Payer Model aims to transform Maryland's health care system by enhancing patient care, improving health, and lowering total costs. Under the All-Payer Model, Maryland remains 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 percent per year over the five years of the Model (plus an adjustment for population growth), which is the 10-year compound annual growth rate in per

[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 all reports required by this subtitle on its website for public access and provides a link to those reports in this document.

capita gross state product (GSP). This cap could be adjusted in years four and five based on more recent GSP trending.

- 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 of one percent per year below the national Medicare spending growth rate beginning in year two of the model.

Quality Requirements of the Model

- 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 following:
    - 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 percent in Potentially Preventable Conditions (PPCs) over five years will result in a cumulative 30 percent reduction in PPCs over the life of the model.

Implementing Policies to Achieve Model Goals

The New All-Payer Model continues to build upon decades of innovation and equity in hospital payment and health care delivery in Maryland. The HSCRC works 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 regular 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 the All-Payer Model's goals focused on allowing hospitals to voluntarily participate in global budget strategies, which is an expansion of what had been taking place at various rural hospitals across the State for three years prior to the adoption of the All-Payer Model.

Global Budgets Negotiated will All Hospitals

The Maryland All-Payer Model Agreement allows Maryland to innovate by developing alternative methods of rate determination. During the first six months of the Model, the

HSCRC developed the Global Budget Revenue (GBR) reimbursement model. The HSCRC engaged all hospitals that were not already under a Total Patient Revenue (TPR) agreement in a GBR agreement. Since some revenue is outside of the global budget (such as revenue from some out-of-state referrals), approximately 95 percent of acute hospital revenue is currently under a global budget.

The GBR and TPR methodologies are central to achieving the three part aim set forth in the Maryland All-Payer Model: promoting better care, better health, and lower costs for all Maryland patients. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the New Maryland 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 them 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. Annual revenue is determined from a historical base period that is adjusted to account for inflation updates, infrastructure requirements for GBR hospitals,[2] demographic-driven volume increases, performance relative to 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 shifts, population growth, or shifts of services to unregulated settings.

While the HSCRC may consider augmenting the existing global budget concept with new population-based arrangements in the future, it is important to first evaluate the effectiveness of the existing global budget mechanism. The HSCRC will continue to innovate payment policy and will report any future innovations.

Other Policies Support All-Payer Model Goals

Over the course of FY 2015, 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 established penalties for the new readmission reduction incentive program (RRIP), which started in FY 2014, with positive incentives to hospitals that meet required reductions in readmissions. 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.

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

- Inflation Update: The balanced update policy, which was implemented effective July 1, 2015, provides a full inflation update. The Commission adopted the following policies as a part of the FY 2016 update factor:
    - Provide updates for the following three categories of hospitals and revenues:
        - Revenues under global budgets- 2.4 percent with an additional 0.4 percent provided for care coordination and population health infrastructure investments
        - Revenues not under global budgets but subject to the Medicare rate-setting waiver-1.6 percent
        - Revenues for psychiatric hospitals and Mt. Washington Pediatric Hospital- 1.9 percent with an additional 0.25 percent provided for infrastructure investments to support reductions in readmissions and other avoidable utilization
    - Require all acute hospitals to submit multi-year plans for improving care coordination, chronic care, and provider alignment by December 1, 2015.
    - Require psychiatric hospitals and Mt. Washington Pediatric Hospital to submit a report outlining plans to reduce readmissions and other avoidable utilization by December 1, 2015, and to begin submitting admission and discharge data to the Chesapeake Regional Information System for Our Patients (CRISP) by July 1, 2016.
    - Provide an additional 0.25 percent for competitive awards to hospitals to implement or expand innovative care coordination, provider alignment, and population health strategies.
- Uncompensated Care Reduction: The HSCRC implemented an uncompensated care reduction based on analysis of available data that reflected reductions in uncompensated care due to the Affordable Care Act (ACA) coverage expansion and the corresponding changes in utilization. As a result, the Commission approved a reduction in the amount of uncompensated care included in rates from 6.14 percent in FY 2015 to 5.25 percent in FY 2016.
- GBR Infrastructure Reporting: A vital step in evaluating charge corridor expansion requests is evaluating a hospital's efforts to improve care delivery, population health, and care management, as those efforts will reduce Potentially Avoidable Utilization (PAU). HSCRC staff finalized a template that each hospital must submit annually to report on investments to improve care delivery, population health, and care management. The template includes program descriptions, expenditures, and results. The first round of these reports was due at the end of September 2015. The HSCRC and Maryland Department of Health and Mental Hygiene (DHMH) staff are currently reviewing these reports and assessing whether the investments reported meet the criteria.

- Transfer Case Payment Adjustment: An early concern with the expansion of global budgets was the possibility that transfer rates to academic medical centers (AMCs) would increase as high cost care would leave community hospitals with the associated revenue for cases that had been transferred. Global budget hospitals are encouraged to reduce PAU and promote care management and quality improvement. This could result in hospitals transferring a greater number of complex cases to AMCs in order to both provide patients with the advanced care they need and reduce the high costs associated with such cases. The Transfer Case Adjustment addresses these concerns by ensuring that receiving hospitals have the capacity to take on a possible influx of complex cases without facing financial penalties under a global budget. The HSCRC accomplished this objective by establishing a process to monitor and adjust for changes in transfer rates to AMCs and from sending hospitals on a periodic basis. The Transfer Case Adjustment Policy is being implemented for FY 2016.
- Market Shift Adjustment: HSCRC staff and the Payment Models Work Group continued to make considerable progress on the Market Shift Adjustment (MSA). The purpose of the MSA is to provide a mechanism to appropriately shift revenue between hospitals when utilization shifts from one hospital to another/others. Hospital GBRs are adjusted at 50 percent of the variable cost (i.e., hospitals that receive additional volume due to market shifts receive GBR incentives at 50 percent of the associated costs of the additional volume, while hospitals that lose volume due to market shift lose 50 percent of the revenue associated with this lost volume). HSCRC staff finalized the calculations for MSAs related to shifts occurring during the six months ending on December 31, 2014, as compared with the same six month period in the preceding year. These calculations were finalized after staff received corrections of outpatient encounter data from hospitals and made some modifications to the outpatient weights based on input received through the process. Staff will continue to work on revising the methodology for future years.

Statutory and Regulatory Updates

The Governor signed two bills during the 2015 legislative session that directly affected Commission policy. House Bill 72 (Chapter 489) is the Budget Reconciliation and Financing Act (BRFA) of 2015. Among many other provisions in the legislation, the following affect the HSCRC:

- Removes the provision added in the 2014 BRFA that requires the Commission and DHMH to calculate the savings to Medicaid resulting from the All-Payer Model and reduce that savings from the Medicaid deficit assessment each year.
- Beginning in FY 2017, requires a reduction in the Medicaid deficit assessment of $25 million per year over each prior year's assessment.
- Requires the Commission to adopt policies that reduce uncompensated care that will in turn achieve $16.7 million in Medicaid savings in FY 2016. If the

uncompensated care policy does not achieve this amount of savings, then the Commission is required to submit an alternative plan for review to the Maryland Department of Budget and Management (DBM) and DHMH by Sept. 1, 2015.

- Eliminates the Maryland Health Insurance Plan (MHIP) assessment in FY 2016 only.
- Allows for the transfer of the following funds to Medicaid in FY 2016: the greater of $55 million or the MHIP surplus funds that are not derived from Medicare or Medicaid (state and federal).
- The remaining MHIP surplus funds that are derived from Medicare and Medicaid may be used from FY 2016 through FY 2019 to support integrated care networks for Medicare and dual eligible patients, consistent with the goals of the All-Payer Model.

The second bill, House Bill 613 (Chapter 263), alters the definition of hospital services in HSCRC statute to clarify that merged asset hospitals in Maryland may operate a 340B program "child site" or satellite department at another system hospital, provided that it meets the requirements that apply to hospitals nationally under the 340B program and provider-based status regulations under the federal law.

State and Federal All-Payer Model Status Reporting Requirements

State All-Payer Model Reporting Requirements

On April 1, 2015, and October 16, 2015, the HSCRC submitted reports summarizing implementation, monitoring, and other activities to inform the Maryland General Assembly regarding the status of the New All-Payer Model. The 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 September 30, 2015, based on the information available at the time. Figure 1 provides an overview of the reporting required relative to Health-General Section 19-207(b)(9) for Maryland's New All-Payer Model. The HSCRC will continue to produce an updated Biannual Report every six months and will also report the key findings here in the annual Report to the Governor. The complete reports are available at: http://www.hscrc.maryland.gov/legal_reports.cfm.

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

Achievement Requirement	Metric Finding to Date	Ongoing Activities
Limit the annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58%	Per capita revenue for Maryland residents grew 1.47% between calendar year (CY) 2013 and CY 2014. CY 2015 per capita revenue growth through July is up 2.28% over the same period in CY 2014.	• Ongoing monthly measurement • Expecting continued favorable performance for CY 2015

Achievement Requirement	Metric Finding to Date	Ongoing Activities
Achieve aggregate savings in Medicare spending equal to or greater than $330 million over 5 years	*Finalized data not yet available from CMMI*	• HSCRC gained access to preliminary CMMI data and began work with an analytics contractor to examine the calculation of the per beneficiary amounts and growth rates
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 are engaged in global budgets under Global Budget Revenue (GBR) and Total Patient Revenue (TPR) agreements • HSCRC is continuing to refine the TPR and GBR methodologies
Reduce the hospital readmission rate for Medicare beneficiaries to below the national rate over the 5-year period of the agreement	*Finalized data not yet available from CMMI*	• HSCRC and CMMI are refining the calculation methodology for the final readmission measure • HSCRC gained access to some CMMI readmission data, and the analytics contractor has replicated the calculation of the interim Medicare readmission rate • Monitoring progress within Maryland using data collected from hospitals by HSCRC; however national data for 2015 will not be available to the contractor until the end of the year • The HSCRC RRIP was updated for state fiscal year (SFY) 2017 to increase hospital focus on reducing readmissions, and readmissions decreased in CY 2015
Cumulative reduction in hospital acquired conditions by 30% over 5 years	Reduction of greater than 30% has been achieved	• HSCRC staff continue to review and audit these findings and prepare for ICD-10 conversion • HSCRC staff set a statewide reduction target of 7%, comparing SFY 2014 with CY 2015 • Expecting continued favorable performance for CY 2015
Description	**Report**	**Status**
Work Group actions	• All original Work Groups have reported to the HSCRC • HSCRC is convening an additional Work Group: Innovations in Graduate Medical Education	• Active Work Groups have continued to meet on a regular basis • Care Coordination Work Group reported to the Commission in April 2015 • Consumer Engagement & Outreach and Care Coordination Work Groups reported to the Commission in September 2015 • Staff are implementing the Model based on recommendations from the Work Groups
New alternative methods of rate determination	95% of hospital revenue is now under global budget arrangements,	• Global budget agreements are published on HSCRC's website

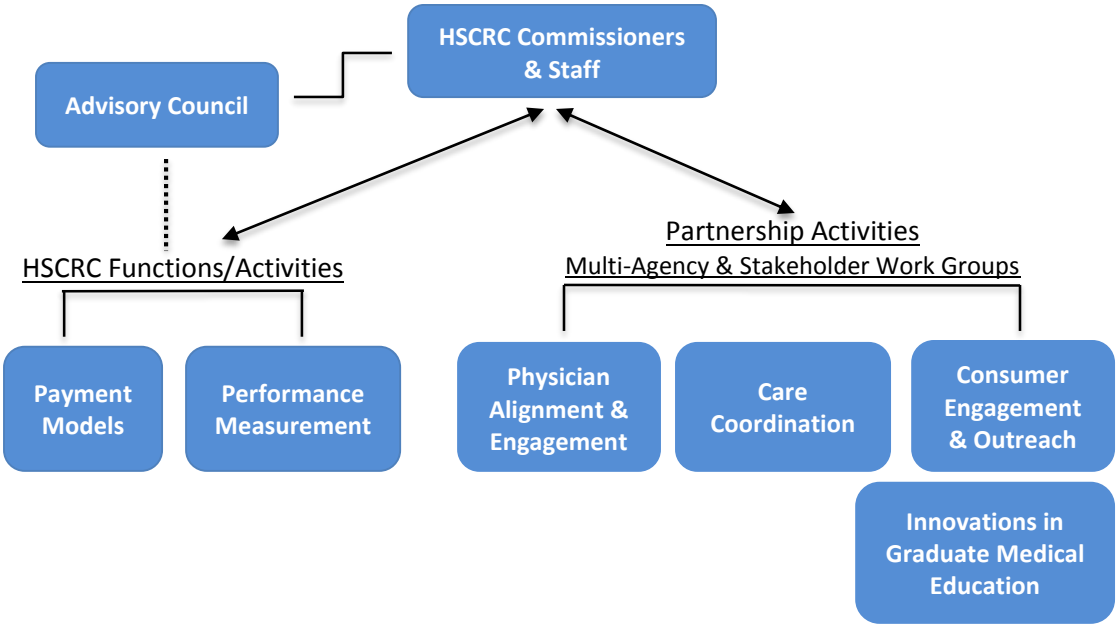
Achievement Requirement	Metric Finding to Date	Ongoing Activities
	implemented in accordance with policies approved by the Commission	• New policies are being developed to refine and advance the GBR methodology

Stakeholder Engagement

The HSCRC continued to implement a broad stakeholder engagement approach. More than 100 stakeholders representing consumers, businesses, payers, providers, physicians, nurses, other health care professionals, and experts have participated in these Work Groups. HSCRC staff conducted all Work Group meetings in public sessions and solicited comments from the public at each meeting.

Figure 2 depicts the current structure of stakeholder engagement. The HSCRC added three additional Work Groups over the past year: the Care Coordination Work Group, the Consumer Engagement and Outreach Work Group, and the Innovations in Graduate Medical Education Work Group. All proceedings and reports of the Work Group activities may be found on the Commission's website at http://www.hscrc.maryland.gov/index.cfm. The HSCRC has also continued to facilitate a number of sub-work group meetings to work through technical, data-driven matters related to specific policies.

Figure 2. Existing Stakeholder Engagement Structure



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 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 2014 and on an unaudited basis for FY 2015.

The HSCRC monitors financial performance of regulated hospitals. 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 – such as parking garages and gift shops.

Audited Financial Data—FY 2014

Data for FY 2014 show an increase in profitability on operations and an increase in total profitability, i.e., both operating and non-operating activities, compared with recent years. The increase in profitability may be attributed to the update factor approved by the Commission for FY 2014 and a heightened focus on reducing costs. In FY 2013, the update factor was 0.3 percent, the lowest update factor in many years. Based on Commission policies and strategies to improve on the former Waiver test, the Commission increased the update factor to 1.65 percent for FY 2014. This 1.65 percent increase was more in line with—although lower than—update factors applied over the past four or five years.

Profitability based on audited data for total operations, hospital operations regulated by the HSCRC, and for total hospital activities is presented below:

- The total combined audited regulated and unregulated profit margins for FY 2014 were:
    - Operating Margin: 3.0 percent
    - Total Margin: 6.3 percent
- The audited profit margin for FY 2014 for services regulated by the HSCRC was
    - Operating Margin: 7.4 percent

Unaudited Financial Data—FY 2015

Based on unaudited financial data for FY 2015, operating profit margins improved over FY 2014, while total profit margins fell. Operating profitability improved as:

- The Commission adopted a more robust update factor than in the prior few years and invested in the care coordination infrastructure hospitals require for success under the new Model. Hospital revenues were increased by a net 3.08 percent, reflecting the impact of inflation, a 0.28percent infrastructure investment, population growth, and expected declines in uncompensated care and the MHIP assessment.
- Hospitals contained volume growth reflecting the new Model's focus on reducing PAU.
- Actual uncompensated care fell below the level provided in rates. The Commission reduced funding for uncompensated care at the beginning of FY 2015 to capture the expected impact of the ACA coverage expansion. The coverage expansion had a larger than expected impact on uncompensated care, reducing the level from the expected 6.14 percent of revenues to 5.22 percent. The favorable impact on hospital bottom lines was partially offset by the pent-up demand for services associated with the newly insured population.

Overall hospital margins declined in FY 2015 due to decreases in investment income and other non-operating profits. Profitability in FY 2015, based on unaudited data, is shown below. Please note that final audited data, when available, may adjust these margins:

- The total combined unaudited regulated and unregulated profit margins for FY 2014 were:
    - Operating Margin: 3.21 percent
    - Total Margin: 3.54 percent
- The unaudited profit margin for FY 2015 for services regulated by the HSCRC was:
    - Operating Margin: 5.86 percent

Uncompensated Care

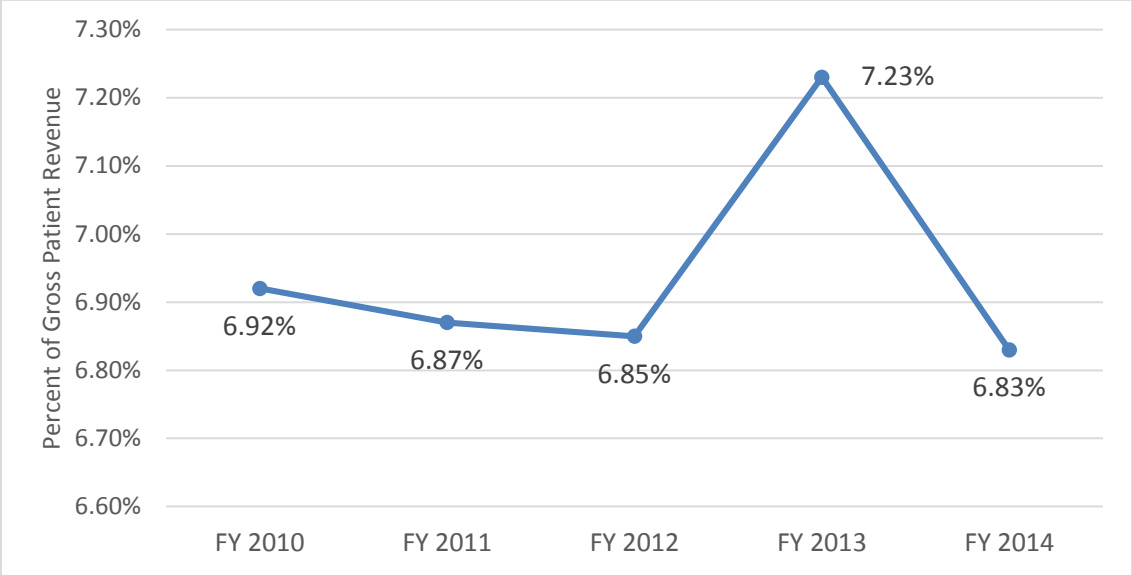
The HSCRC provides an amount for uncompensated care as a component of hospital rates. This is one of the unique features of rate regulation in Maryland. Recognizing reasonable levels of bad debt and charity care in hospital rates enhances access to hospital care for those who cannot pay for care.

The HSCRC provides for uncompensated care statewide based on the most recent two years of actual statewide experience, as well as a hospital's expected performance based on a regression analysis. The Commission modified its uncompensated care policy for both FY 2015 and FY 2016 to reflect the impact of expanded health insurance and Medicaid coverage resulting from the ACA.

Figure 3 shows the actual total uncompensated care rate for all regulated Maryland hospitals between FY 2010 and FY 2014. After declining slightly between FY 2010 and FY 2012, there was a 0.38 percentage point increase in the total uncompensated care rate

for all regulated Maryland hospitals in FY 2013. This increase may be attributed to several factors. The proportion of outpatient hospital services increased, and the patient responsibility portion of outpatient bills is typically larger than for inpatient bills, resulting in higher levels of uncompensated care. A greater prevalence of high deductibles, coinsurance, and copayments among commercial insurance plans may also have contributed to the increase. Implementation of the ACA's coverage expansions in January 2014 produced the 0.40 percentage point decrease in uncompensated care in FY 2014.

Figure 3. Uncompensated Care as a Percentage of Gross Patient Revenue, FY 2010-2014



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, uncompensated care was $1 billion in FY 2013, this model would establish rates that would deliver $1 billion in FY 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 uncompensated care pool. Distribution policies reflect both actual and expected levels of uncompensated care, based on each hospital's patient mix. For FY 2015, the total amount of uncompensated care included in rates after applying the Commission's uncompensated care policy was 6.14 percent.

Averted Bad Debt

Section 19-214(e) of the Health General Article requires the HSCRC to report reductions in uncompensated and the number of individuals enrolled in Medicaid as a result of eligibility changes to the Governor and the General Assembly. See Figure 4 for a summary of the report submitted in January 2015 for FY 2014. The report is available at

http://www.hscrc.maryland.gov/documents/Legal-Legislative/Reports/HSCRC-Final-2014-AVBD-annual-report-to-GA-12-31-14.pdf.

Figure 4. Averted Bad Debt Reporting for FY 2014

Reporting Requirement	Reference	Finding
Aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage	Chapter 7, Acts of the General Assembly, 2007 Special Session	HSCRC estimate: $164.3 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: 108,743 individuals

Community Benefits

The Internal Revenue Code requires non-profit organizations to report the amount of community benefits that they provide in exchange for not having to pay federal, state, or local taxes. Maryland law also requires hospitals to report similar data and qualitative information on community benefit expenditures and operations to the HSCRC. Community benefits are defined as activities that are intended to address community needs and priorities primarily through disease prevention and improvements in 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
- Health education screening and prevention services

The most recently available report from hospitals reflects community benefits for FY 2014. In that year, Maryland hospitals expended a total of $1.5 billion in community benefits or 10.6 percent 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 benefit spending is $725 million or 5.1 percent of operating expenses.

FY 2014 was the second year that all hospitals were required to conduct a community health needs assessment. The Commission obtains information annually on each hospital's community health needs assessments, related collaborations, how their community benefit functions are organized, and a summary of each of the primary community benefit initiatives. Those reports may be found on the Commission's Community Benefit website at http://www.hscrc.maryland.gov/init_cb.cfm.

Quality Performance

Maryland continues to be a national leader in implementing innovative hospital payment systems to achieve the 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.

Each of the quality-based payment programs that impacted hospital payment rates in FY 15 allocated a portion of hospital revenue at risk for meeting performance targets. These programs will provide strong incentives for hospitals to continuously improve quality performance over time. The hospital quality-based payment programs are listed below and are described in the subsections that follow.

i. Quality-Based Reimbursement Program (QBR)
ii. Maryland Hospital Acquired Conditions Program (MHAC)
iii. Readmission Reduction Incentive Program (RRIP)
iv. Readmission Shared Savings Program (RSSP)

Figure 5 illustrates the base and performance periods for FYs 2015 and 2016 for the QBR, MHAC, and RRIP programs.

Figure 5. Base and Performance Periods Impacting FYs 2015 and 2016

Rate Year (Maryland Fiscal Year)	FY12-Q1	FY12-Q2	FY12-Q3	FY12-Q4	FY13-Q1	FY13-Q2	FY13-Q3	FY13-Q4	FY14-Q1	FY14-Q2	FY14-Q3	FY14-Q4	FY15-Q1	FY15-Q2	FY15-Q3	FY15-Q4	FY16-Q1	FY16-Q2	FY16-Q3	FY16-Q4
Calendar Year	CY11-Q3	CY11-Q4	CY12-Q1	CY12-Q2	CY12-Q3	CY12-Q4	CY13-Q1	CY13-Q2	CY13-Q3	CY13-Q4	CY14-Q1	CY14-Q2	CY14-Q3	CY14-Q4	CY15-Q1	CY15-Q2	CY15-Q3	CY15-Q4	CY16-Q1	CY16-Q2
Quality Programs that Impact Rate Year 2015																				
MHAC: Hospital Attainment	MHAC Attainment Base Period (expected values, regression)												Rate Year Impacted by MHAC Results							
							MHAC Attainment Performance Period													
MHAC: Hospital Improvement	MHAC Improvement Base Period (Base-line PPC Rate)																			
							MHAC Improvement Performance Period													
QBR	Maryland QBR Core_HCAHPS Base												Rate Year Impacted by QBR Results							
						New Core_HCAHPS Performance Period														
				Mortality Base																
								Mortality Performance												
Quality Programs that Impact Rate Year 2016																				
MHAC: Better of Attainment or Improvement							MHAC Improvement and Attainment Base (expected values)										Rate Year Impacted by MHAC Results			
											MHAC Better of Attainment or Improvement Performance									
QBR			QBR Core Process_HCAHPS CLABSI Base																	
																	Rate Year Impacted by QBR Results			
										QBR Core process, HCAHPS, CLABSI Performance Period										
					Maryland Mortality and PSI 90 Base Period															
											Maryland Mortality, PSI 90 Performance Period									
Readmission Reduction Incentive							Readmission Reduction Base Period										Rate Year Impacted by Readmission Reduction Results			
											Readmission Reduction Performance Period									

QBR

The QBR program adjusts hospital payments based on performance on a number of quality-of-care measures. These include clinical care process measures, patient experience of care measures, and clinical care outcomes measures. Each domain is weighted to determine the hospitals' final scores on the program, as illustrated in Figure 6 below.

Figure 6. QBR Measure Domain Weights for FY 2015

Measure Domain	Weight
Clinical Care - Process	0.400
Patient Experience of Care (HCAHPS)	0.500
Clinical Care - Outcomes	0.100

For FY 2015, hospital revenues were adjusted using a revenue neutral scaling methodology with 0.5 percent of hospital revenue allocated at risk for program performance. Higher performing hospitals receive revenue increases that are funded by proportional revenue decreases at lower performing hospitals.[3]

Maryland's QBR program is similar in design and detail to the federal Medicare Value-Based Purchasing Program. Under these programs, Maryland performed favorably during the measurement period spanning the fourth quarter of CY 2012 through the third quarter of CY 2013 in a number of areas. For example:

- Maryland improved at a slightly higher rate and/or performed slightly better than the national average for all but one of the process of care measures.
- Maryland continued to have a considerably lower composite mortality rate of 11.4 percent, as compared with the national average of 12.6 percent. Maryland also had lower condition-specific, 30-day mortality rates for heart attack, heart failure, pneumonia, and stroke.
- Maryland outperformed the nation on the CDC Central Line Associated Blood Stream Infection (CLABSI) measure with a standardized infection ratio (SIR) of 0.53, as compared with 1.0 for the nation. Maryland also saw a reduction in CLABSI SIR from 0.55 in the base period to 0.53 in the measurement period.

It should also be noted that Maryland lags behind the nation in performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient survey measures. The HSCRC made recommendations that were approved to continue substantial weighting of these measures in determining hospitals' overall scores in order to incentivize improvement in performance on these measures.

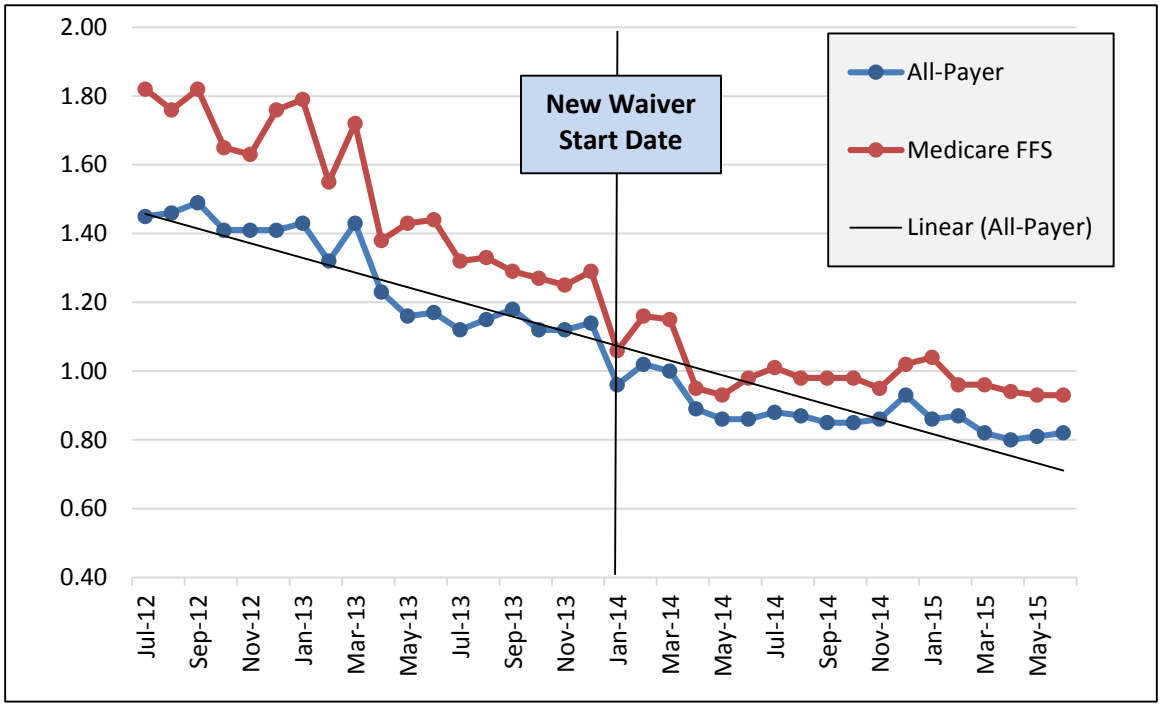
[3] The term "scaling" refers to the differential allocation of a pre-determined portion of base regulated hospital revenue contingent on the assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or reductions (negative scaled amounts) are then applied to each hospital's revenue on a "one-time" basis (and not considered permanent revenue).

MHAC

The MHAC program provides the needed incentives to achieve hospital care improvements and meet the target established in the New Maryland All-Payer Model Agreement. The target is a 30 percent reduction in the statewide aggregate PPC rate over the 5-year demonstration period. For the MHAC program for FY 2015, actual versus expected rates of complications for 51 of the 65 PPCs were calculated and risk-adjusted using All Patient Refined Diagnosis-Related Group (APR-DRG) and severity of illness (SOI) categories. The calculation of hospital scores also accounted for the amount of additional charges for PPCs. For FY 2015, the maximum amount of penalties/rewards was 3 percent, with 2 percent allocated for attainment and 1 percent allocated for improvement on a subset of five PPCs that account for a greater number of high-cost events. This translated into total penalties of about $3.76 million for FY 2015.

As shown in Figure 7, the overall risk-adjusted hospital-acquired PPC rates declined by 34.6 percent since the first quarter of FY 2011.

Figure 7. Monthly Risk-Adjusted Potentially Preventable Complication Rates through June 2015



Note: Reported as of 9/30/2015, based on final data through June 2015.

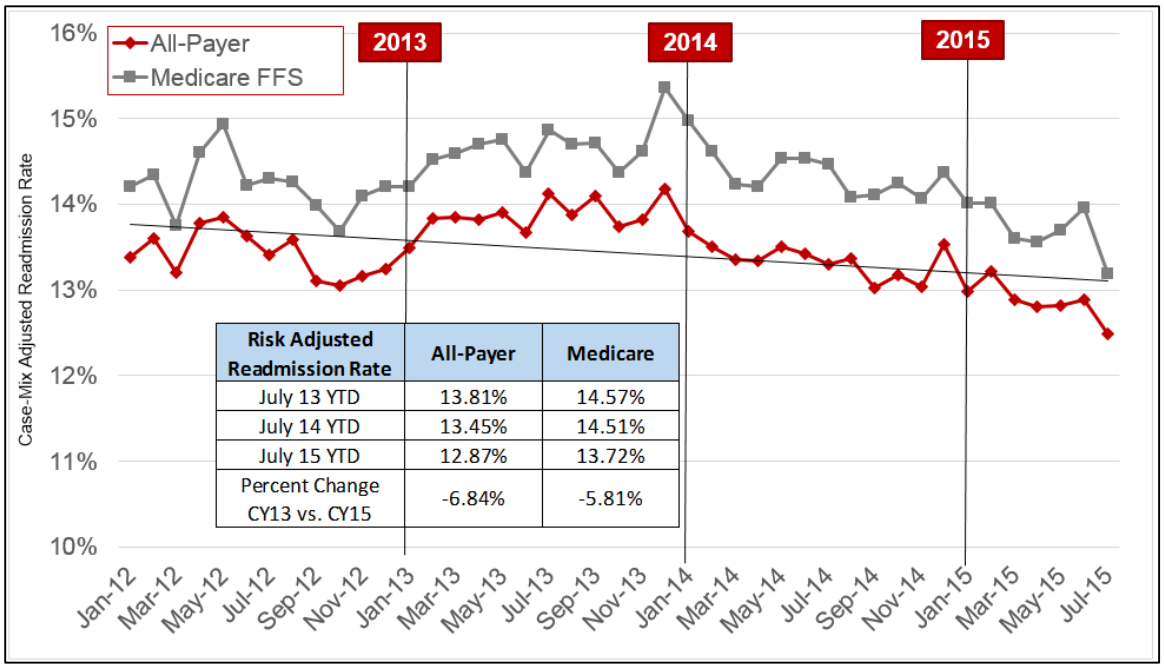
RRIP

Maryland's readmission rates are high compared with the rest of the nation. The New Maryland All-Payer Model Agreement requires Maryland hospitals to be equal to or below the national average for Medicare readmissions by 2018.

In early 2014, HSCRC, together with key stakeholders, vetted a methodology that provides incentives to reduce readmissions. This methodology will be applied to FY 2016 hospital payment rates. In April 2014, the Commission approved the RRIP starting on January 1, 2014. The RRIP uses a continuous preset payment scale to provide rewards and penalties in proportion to each hospital's improvement in their case-mix adjusted readmission rate. The RRIP is a positive incentive program that rewards hospitals that reduce their readmission rates by a pre-determined percent compared with the previous year. The RRIP specifically measures the 30-day, all-cause, all-payer, inter- and intra-hospital readmission rates, excluding planned readmissions.

The RRIP directly links hospital payment to the achievement of this statewide goal, as the annual RRIP reduction target is contingent on the remaining gap between national and Maryland Medicare readmission rates. RRIP impact on hospital payment rates will be reported in the FY 2016 Governor's report. Figure 8 below illustrates hospitals' aggregate positive performance from 2014 going forward on reducing readmissions over time for Medicare and all payers.

Figure 8. Maryland Hospital Readmission Reduction Trends



Risk Adjusted Readmission Rate	All-Payer	Medicare
July 13 YTD	13.81%	14.57%
July 14 YTD	13.45%	14.51%
July 15 YTD	12.87%	13.72%
Percent Change CY13 vs. CY15	-6.84%	-5.81%

RSSP

The RSSP prospectively reduces hospital revenues based on each hospital's intra-hospital readmission rate. For FY 2015, a maximum of 0.86 percent of hospital inpatient revenue was allocated and captured for the hospital shared savings program. The program prospectively established a statewide readmission reduction benchmark. If the benchmark is achieved, hospitals received a portion of the savings associated with those avoided readmissions. The RSSP specifically measured the 30-day all-cause, all-payer intra-hospital readmission rate (excluding 0-1 day stays and planned admissions) for FY

2015. For FY 2016, the RSSP was updated to include inter-hospital (across hospital) readmissions in evaluating performance. The RSSP works in conjunction with the RRIP to reward hospitals for reducing readmission rates and to financially align hospitals with the New Maryland All-Payer Model readmission reduction requirement.

Maximum Revenue at Risk for Quality Programs

To strengthen the quality programs' impact, the HSCRC recommended increases in the amount of hospital revenue that is at risk for quality program performance over time. The Commission approved this recommendation. Figure 9 illustrates the revenue at risk for FYs 2014 through 2016. It is anticipated that the amount at risk in the aggregate will continue to increase for performance-based programs.

Figure 9. Revenue at Risk for Quality Programs

Program	SFY 2014	SFY 2015	SFY2016
MHAC	2.0%	3.0%	4.0%
RRIP			0.5%
QBR	0.50%	0.50%	1.00%
Shared Savings (RSSP)	0.41%	0.86%	1.35%
Total Aggregate At Risk	**2.91%**	**4.36%**	**6.85%**

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 DHMH. Seven Governor-appointed Commissioners oversee the HSCRC. Figure 10 provides a list of current Commissioners.

Figure 10. 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 5 specialty hospitals, an industry with annual revenues in excess of $16 billion. This responsibility is accomplished by a relatively small and highly skilled staff of 35 full-time equivalents (FTEs). HSCRC staff HAS historically been organized in three divisions: Rate Setting and Compliance, Research and Methodology, and Quality Performance. The Commission altered this structure to be consistent with the demands of the new All-Payer Model and established four centers:

- The Center for Revenue and Compliance
- The Center for Clinical and Financial Information
- The Center for Engagement and Alignment
- The Center for Population Based Methodologies

A small user fee assessed on hospital rates in Maryland supports Commission staff salaries and 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 2015 was $10.1 million. 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 FY 2015 was $2,627,736. This balance will be utilized in conjunction with a reduced FY 2016 user fee assessment in order to bring the fund balance to a reasonable 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

Over the last two years, the Commission has expanded its hospital data collection and reconciliation efforts to enable timely monitoring of the success of the New All-Payer Model metrics. These enhanced data collection and monitoring activities allow staff to provide the Commission with nearly real time data on hospital revenue and volumes at monthly Commission meetings.

The Commission also receives monthly feeds of Maryland and national Medicare fee-for-service data from CMMI. These data allow the Commission to monitor Maryland's performance against the nation, confirm CMMI calculations of Maryland's progress toward the Medicare savings goal, and understand the factors driving Medicare fee-for-service spending in Maryland and the rest of the nation. Staff is currently working with CMMI to obtain authorization to publicly release information on Maryland's performance.

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 the 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 the reasonableness of rates when volumes fall
- Gaining more consumer input and engagement
- Strengthening the use of quality, outcomes, and consumer input in rate setting and payment
- Improving performance on patient experience at Maryland hospitals
- Developing measures to evaluate performance on total cost of care and patient-centered outcomes

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, the agency will continue the public engagement process by bringing stakeholders together to encourage collaborative activity, especially through the HSCRC's robust and inclusive Work Groups:

- The Care Coordination Work Group, which involved broad set of stakeholders, made a series of recommendations to allow various providers to share patient information and best practices, develop common successful tools and strategies, and implement effective approaches to address the needs of high utilizers of care. The Commission is working with various groups, including CRISP, to implement these recommendations.
- The Commission is also working with stakeholders to implement a series of recommendations related to aligning the interest and incentives of hospitals and other providers. Recommendations include working on gain-sharing models, pay-for-performance models that 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.
- The Commission has also begun to work with stakeholders on a vision for Phase II of the All-Payer Model, which moves to a broader total cost of care model. This will involve a broader set of stakeholders, including long-term care, post-acute care, physicians, and other providers.
- Cutting across all of the Commission's activities, the HSCRC received reports from two Consumer Task Forces – the Consumer Engagement Task Force and the

Consumer Outreach Task Force. These task forces are led by key consumer leaders and will continue to help hospitals, the State, and other providers understand how to improve patient experience and education. This will help individuals understand why the delivery system is changing and how it affects them. The Commission will continue to work with these task forces as they work to implement a series of recommendations that were presented to the Commission.

As the Commission continues to transition to the New All-Payer Model, it is important to note that success is dependent upon 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 the providers that will determine the Model's 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.