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April 26, 2016

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: Monitoring Maryland's All-Payer Model: Biannual  
Report  
Health General Article §19-207(b)(9)

Dear Governor Hogan, President Miller, Speaker Busch, and Secretary Mitchell;

I am pleased to provide you with the third biannual 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. This report discusses the State's progress during the period from July 1, 2015 through December 31, 2015, which represents the last quarter of the first two years of Maryland's new agreement with the Center for Medicare & Medicaid Innovation (CMMI).

Effective January 1, 2014, the State of Maryland and 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. More information on the Health Services Cost Review Commission ("HSCRC") and Maryland hospital activities can be found on the HSCRC's website: <http://www.hsrc.state.md.us/>

Please contact me if you any questions about this report, or you may contact Steve Ports,  
HSCRC Director of the Center for Engagement and Alignment, at [steve.ports@maryland.gov](mailto:steve.ports@maryland.gov).

Sincerely,

A handwritten signature in blue ink that reads "Donna Kinzer". The signature is written in a cursive, flowing style.

Donna Kinzer  
Executive Director

# **Monitoring of Maryland's New All-Payer Model**

*Biannual Report*

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

April 2016

## Executive Summary

### Introduction

Effective January 1, 2014, the State of Maryland and the Centers for Medicare & Medicaid Services (CMS) 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. This biannual report, prepared in accordance with Maryland law,<sup>1</sup> contains a summary of implementation, monitoring, and other activities during the time period from January 1, 2015, through December 31, 2015. The purpose of this report is to inform the Maryland General Assembly on the status of the New Maryland All-Payer Model.

### Highlights

The following bullets highlight the Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) progress in the nine reporting areas required by law.<sup>2</sup>

- **Inpatient and Outpatient Hospital Per Capita Cost Growth** - CMS requires Maryland to limit the annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58 percent. To date, Maryland has met this target, with a growth rate of 1.47 percent between calendar years (CYs) 2013 and 2014 and 2.31 percent between CYs 2014 and 2015.
- **Aggregate Medicare Savings** - CMS requires Maryland to achieve an aggregate savings in Medicare spending that is greater than or equal to \$330 million over the five years of the agreement. During this reporting period, the HSCRC gained access to preliminary CMS data and secured a contractor to perform analytics to validate the aggregate Medicare savings calculated by CMS. Finalized CMS data showed that the New Maryland All-Payer Model saved Medicare \$116 million by comparing Maryland Medicare per beneficiary growth to national per beneficiary growth between CY 2013 and CY 2014. Maryland has made progress toward this target in CY 2014. Finalized national data are not yet available for CY 2015; however, Maryland per capita revenue grew by 1.14 percent over CY 2014.
- **Shifting from a Per-Case Rate System to a Global Budget** – CMS requires Maryland to shift at least 80 percent of hospital revenue to global or population-based budgets. Maryland exceeded this target and shifted 96 percent of hospital revenues under global budget structures.
- **Reducing the Readmission Rate among Medicare Beneficiaries** – While the readmission rate in Maryland has decreased over the last several years, Maryland's readmission rate for Medicare beneficiaries remains higher than the national average. Under the New All-Payer Model, CMS requires Maryland's Medicare fee-for-service (FFS) hospital readmission rate to be at or below the national readmission rate by 2018. To achieve this goal, Maryland is required to annually reduce the gap between the State and the nation by one-fifth and keep up with national trends. In CY 2014, Maryland closed the gap by 0.21 percent. While final

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<sup>1</sup> Health-General Article §19-207(b)(9) Maryland Annotated Code.

<sup>2</sup> Id.

2015 readmission numbers are not yet available from CMS, analysis of HSCRC data show that the Medicare FFS case-mix adjusted readmission rate decreased by 6.7 percent in CY 2015 compared to CY 2013, and the all-payer case-mix adjusted readmission rate decreased by 7.4 percent.

- **Reducing Hospital-Acquired Conditions (HACs)** – The HSCRC measures HACs using 65 Potentially Preventable Complications (PPCs).<sup>3</sup> CMS requires Maryland to reduce the cumulative rate of PPCs by 30 percent by 2018. To date, Maryland has exceeded this target, with a 33.34 percent reduction in all-payer case-mix adjusted PPCs comparing CY 2013 to CY 2015. This reduction in PPCs was slightly greater for Medicare FFS at 33.67 percent.
- **Work Group Activities** – The HSCRC continues to implement a broad stakeholder engagement approach, convening an Advisory Council and various work groups. More than 100 stakeholders representing consumers, businesses, payers, providers, physicians, nurses, other health care professionals, and experts have participated in these Work Groups. All Work Group meetings are conducted in public sessions, and comments from the public are solicited at each meeting. The Work Group materials may be found on the Maryland Department of Health and Mental Hygiene's (DHMH's) or Commission's websites. All Work Groups have submitted various reports and recommendations to the HSCRC, which staff are working on implementing.
- **Actions to Promote Alternative Methods of Rate Determination and Payment** – The New All-Payer Model agreement allows Maryland to develop alternative methods of rate determination. During the first six months of the performance period, the HSCRC developed the Global Budget Revenue (GBR) reimbursement model and moved 95 percent of acute hospital revenue under global budgets. Other than these global budgets, the HSCRC is not developing any new alternative methods of rate determination at this time. The HSCRC may consider augmenting the existing global budget concept with a new, population-based arrangement in the future.
- **Reports to CMS** – To date, the HSCRC has met all of CMS's reporting requirements.
- **Reporting Adverse Consequences** – The HSCRC has not observed any adverse consequences occurring as a result of the implementation of the New Maryland All-Payer Model at this time. The HSCRC will continue to develop monitoring tools, measure performance, and engage stakeholders in order to identify and resolve any adverse consequences that may arise as quickly as possible.

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<sup>3</sup> 3M Health Information Systems developed PPCs. The PPC software relies on "present on admission" indicators from administrative data to calculate the actual versus expected number of complications for each hospital.

## Introduction

Effective January 1, 2014, the State of Maryland and the Centers for Medicare & Medicaid Services (CMS) entered into a new initiative to modernize Maryland’s unique all-payer rate-setting system for hospital services. The Center for Medicare and Medicaid Innovation (CMMI) oversees the Model under the authority of CMS. 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 Maryland 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 24 months, the State, in close partnership with providers, payers, and consumers, has made significant progress in this modernization effort.

## State and Federal Status Reporting Requirements for Maryland’s New All-Payer Model

### State Reporting Requirements for Maryland’s New All-Payer Model

This report contains a summary of implementation, monitoring, and other activities to inform the Maryland General Assembly on the status of the New Maryland All-Payer Model. This New Maryland All-Payer Model Biannual Report, prepared in accordance with Maryland law,<sup>4</sup> discusses the State’s progress during the period from January 1, 2015, through December 31, 2015, based on the information available at the time. The Maryland Health Services Cost Review Commission (HSCRC or Commission) will produce an updated report every six months. Figure 1 provides an overview of the reporting required by law<sup>5</sup> for the second 12 months under the New Maryland All-Payer Model.

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

Section	Achievement Requirement	Metric Finding to Date	Ongoing Activities
I.1.	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 is up 2.31% since CY 2014	<ul style="list-style-type: none"> <li>• Ongoing monthly measurement</li> <li>• Expecting continued favorable performance for CY 2015 and into CY 2016</li> </ul>
I.2.	Achieve aggregate savings in Medicare spending equal to or greater than \$330 million over 5 years	Aggregate savings in Medicare spending for the base year of the model (CY 2014) was \$116 million, well on pace to achieve the 5-year target of \$330 million	<ul style="list-style-type: none"> <li>• The HSCRC gained access to CMS data and is working with an analytics contractor to examine the calculation of the per beneficiary amounts and growth rates for CY 2015</li> </ul>
I.3.	Shift at least 80% of hospital revenue to a population-based	96% of hospital revenue shifted to global budgets	<ul style="list-style-type: none"> <li>• All hospitals (except the new Holy Cross Germantown Hospital) are engaged in global budgets under</li> </ul>

<sup>4</sup> Health-General Article §19-207(b)(9) Maryland Annotated Code.

<sup>5</sup> *Id.*

**Monitoring of Maryland's New All-Payer Model – Biannual Report**  
**April 2016**

Section	Achievement Requirement	Metric Finding to Date	Ongoing Activities
	payment structure (such as global budgets)		Global Revenue and Total Patient Revenue agreements <ul style="list-style-type: none"> <li>The HSCRC continues to refine the global budget methodology</li> </ul>
I.4.	Reduce the hospital readmission rate for Medicare beneficiaries to below the national rate over the 5-year period of the agreement	The gap between the Maryland per beneficiary readmission rate and the national rate decreased by 0.21% between CY 2013 and CY 2014. Final numbers are not yet available for CY 2015 performance from CMS  Based on HSCRC data, in CY 2015, the all-payer and Medicare FFS case-mix adjusted readmission rates decreased by 7.4% and 6.7%, respectively	<ul style="list-style-type: none"> <li>The HSCRC is monitoring progress within Maryland using data collected from hospitals by the HSCRC and continues to see declines in all-payer, Medicare FFS, and Medicaid readmissions</li> <li>The HSCRC Readmission Reduction Incentive Program (RRIP) for fiscal year (FY) 2018 is still under development</li> </ul>
I.5.	Cumulative reduction in hospital acquired conditions by 30% over 5 years	Reduction of 33% in all-payer case-mix adjusted potentially preventable complication (PPC) rates in CY 2015 compared to CY 2013	<ul style="list-style-type: none"> <li>HSCRC staff continue to review and audit PPC findings and monitor for ICD-10 issues</li> <li>For FY 2018, HSCRC staff set a statewide reduction target of 6%, comparing FY 2015 with CY 2016</li> </ul>
Section	Description	Report	Status
II	Work Group actions	<ul style="list-style-type: none"> <li>All original Work Groups have reported to the HSCRC</li> <li>The HSCRC is convening one additional Work Group: Innovations in Graduate Medical Education</li> </ul>	<ul style="list-style-type: none"> <li>The Advisory Council reconvened in February 2016 and will produce a report later in the year</li> <li>Active Work Groups have continued to meet on a regular basis</li> <li>The Consumer Engagement &amp; Outreach Work Group reported to the Commission in September 2015</li> <li>Staff are implementing the Model based on recommendations from the Work Groups</li> </ul>
III	New alternative methods of rate determination	96% of hospital revenue is now under global budget arrangements, implemented in accordance with policies approved by the Commission	<ul style="list-style-type: none"> <li>Global budget agreements are published on the HSCRC's website</li> <li>New policies are being developed to refine and advance the GBR methodology</li> </ul>
IV	Ongoing reporting to CMS of relevant policy development and implementation	The HSCRC provided CMS with the Annual Monitoring Report as required in the New All-Payer Model contract, as well as quarterly progress reports.	<ul style="list-style-type: none"> <li>The HSCRC continues to provide reports to CMS on an ongoing basis</li> </ul>

### **Federal Reporting Requirements for Maryland's New All-Payer Model**

Maryland's New All-Payer Model agreement with CMS establishes a number of requirements that the State must fulfill. CMS must evaluate and provide an annual report on Maryland's calendar year performance. The HSCRC submitted the Model's second Annual Monitoring Report to CMS in July and December 2015.<sup>6</sup> In addition to the annual report, the HSCRC provides ongoing quarterly reports to CMS on relevant policy and implementation developments. If Maryland fails to meet selected requirements, CMS must provide notification, and Maryland will have the opportunity to provide information and a corrective action plan if warranted. At this time, CMS has not provided any failure notifications to Maryland.

## **Section I**

### **1. Inpatient and Outpatient Hospital Per Capita Cost Growth**

The New Maryland All-Payer Model agreement requires the State to limit the average annual growth in all-payer hospital per capita revenue for Maryland residents to the average growth in per capita gross state product (GSP) for the 2002 through 2012 period (a 3.58 percent growth rate). Per capita revenue for Maryland residents increased by 1.47 percent between calendar years (CYs) 2013 and 2014 and by 2.31 percent between CYs 2014 and 2015. Continued favorable performance is expected as global budgets (discussed at greater length in Section III) result in predictable statewide revenue performance, enabling the HSCRC to actively manage compliance with the 3.58 percent target.

### **2. Aggregate Medicare Savings**

The New Maryland All-Payer Model Agreement requires the State to achieve an aggregate savings in Medicare spending equal to or greater than \$330 million over the five years of the agreement. Savings are calculated by comparing the rate of increase in Medicare hospital payments per Maryland beneficiary with the national rate of increase in payments per beneficiary. Currently, CMS completes this calculation and provides an aggregate monthly report to the HSCRC. The aggregate savings in Medicare spending for the base year of the model (CY 2014) was \$116 million. CY 2015 data are considered preliminary and have not yet been approved for public release by CMS.

The HSCRC gained access to certain CMS claims datasets for the purposes of Model monitoring and evaluation and secured a Medicare analytics contractor to validate the aggregate Medicare savings calculation conducted by CMS. It is in the interest of both parties that the calculation correctly captures hospital payments made on behalf of Medicare beneficiaries who are Maryland residents. The HSCRC's vendor successfully replicated CMS's analysis of Maryland's data for 2013 and 2014. Analysis of the national data was completed as of October 2015.

The HSCRC has been tracking Medicare fee-for-service (FFS) per capita cost trends from its own Maryland data. Based on these data, the Medicare FFS per capita

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<sup>6</sup> This report was submitted in two parts due to the fact that 2014 data for most metrics were not available until the fall of 2015

revenue declined by 1.12 percent between CYs 2013 and 2014, and has grown by 1.14 percent in CY 2015.

### **3. Shifting from a Per-Case Rate System to Global Budgets**

As discussed in the October 2015 New Maryland All-Payer Model Biannual Report, 96 percent of Maryland hospital revenues are in global budget structures. This exceeds the New Maryland All-Payer Model agreement requirement of shifting at least 80 percent of hospital revenue to global or population based budgets. All regulated Maryland hospitals that were not already under a Total Patient Revenue (TPR) agreement now operate under a Global Budget Revenue (GBR) agreement, through policies approved by the Commission. The remaining 4 percent that is not under global budgets is excluded, out-of-state revenue for three hospitals. These hospitals are otherwise engaged in global budgeting. These global budget agreements are available on the [Global Budget Web Page](#) of the HSCRC's website.

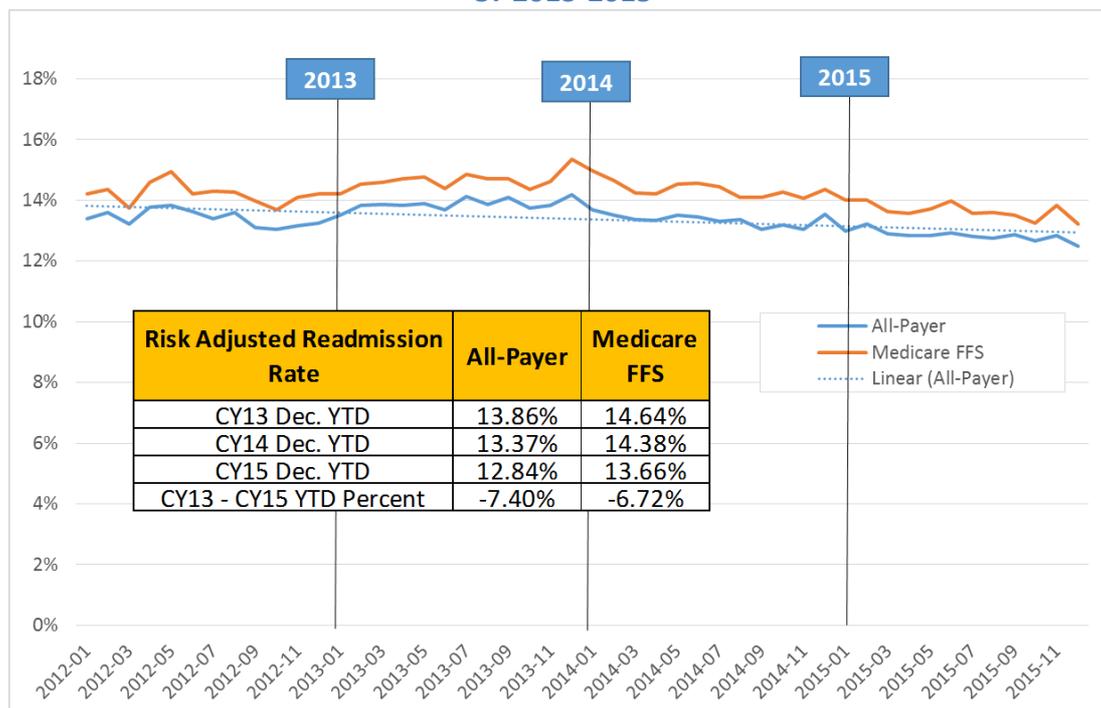
In the past six months, the HSCRC continued to work with stakeholder Work Groups to refine the GBR methodology and develop a number of policies discussed in Section III.

### **4. Reducing the Hospital Readmission Rate among Medicare Beneficiaries**

Reducing hospital inpatient readmission rates has been a primary objective of the HSCRC since 2011. While the readmission rate in Maryland has fallen over the last several years, Maryland's readmission rate for Medicare beneficiaries remains higher than the national average. The New Maryland All-Payer Model Agreement requires Maryland's hospital readmission rate for Medicare FFS beneficiaries to be at or below the national readmission rate by 2018. Each year beginning in 2014, the Maryland readmission rate must keep up with national improvements and close the gap between Maryland and the nation by one-fifth. This waiver test uses national Medicare FFS data, which are not yet finalized for CY2015.

The HSCRC's hospital data show that the monthly case-mix adjusted readmission rate for CY 2015 is lower than the rate for the same time period in CY 2013 or CY 2014 (Figure 2). This analysis includes all Maryland inpatient stays, including Medicare FFS. Based on these available HSCRC data, the all-payer case-mix adjusted readmission rate in CY 2015 was 12.84 percent, compared with 13.86 percent during the same time period in 2013, a 7.4 percent decrease. Staff believe that the addition of penalties to the Readmissions Reduction Incentive Program (RRIP) in fiscal year (FY) 2017 provided strong incentives to reduce readmissions compared with the FY 2016 program that only had rewards. Finally, the Commission's focus on care coordination in Year 2 should improve the infrastructure for care coordination for high needs and complex patients and reduce the risks related to chronic conditions. Implementation of infrastructure, care coordination, and integration strategies will help create more comprehensive and sustainable approaches to reduce avoidable hospitalizations and readmissions. To help the readmission reduction efforts, the HSCRC focused on enhancing readmission reporting capability by leveraging resources available in the state health information exchange and providing timely, monthly, patient-specific data to hospitals.

Figure 2. All-Payer and Medicare FFS Case-Mix Adjusted Readmission Rates, CY 2013-2015



Note: These data may change based on adjustments for ICD-10 differences.

### 5. Cumulative Reduction in Hospital-Acquired Conditions

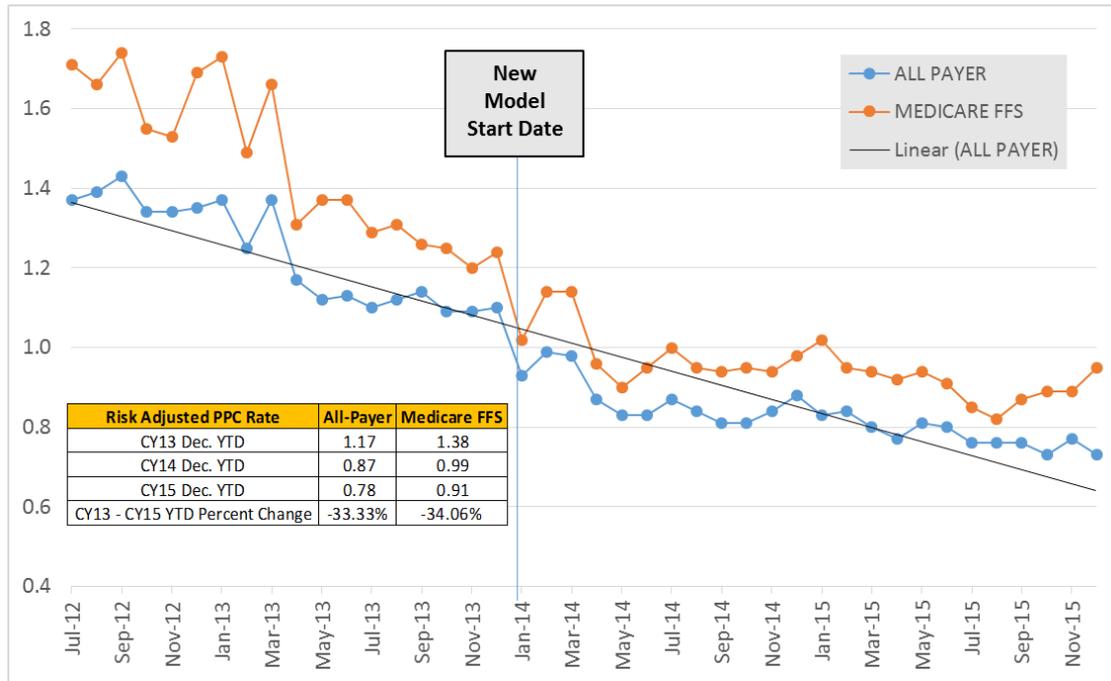
Maryland hospitals must achieve a 30-percent cumulative rate of reduction in hospital-acquired conditions (HACs) by 2018 to comply with the New Maryland All-Payer Model agreement. Maryland measures HACs using 65 potentially preventable complications (PPCs).<sup>7</sup> PPCs are defined as harmful events (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.

The Maryland Hospital-Acquired Conditions (MHAC) program is a quality-based payment program designed to incentivize hospitals to reduce HACs. Specifically, the program calculates observed-to-expected ratios as the basis of the measurement for all of the 65 PPCs and a preset payment scale to determine hospital revenue adjustments based on performance. Figure 3 shows the all-payer and Medicare FFS case-mix-adjusted PPC rates by month and year. In CY 2015, the all-payer case-mix adjusted PPC rate was 0.78 per 1,000, compared with 1.17 per 1,000 for CY 2013, which is a 33.33 percent reduction. The reduction in the case-mix adjusted complication rate for Medicare FFS was slightly greater at 34.06 percent. While this reduction in the all payer case-mix adjusted complication rate exceeds the new waiver target of a 30 percent reduction by 2018, the HSCRC continues to set annual improvement targets for hospitals to further reduce PPCs and to ensure that Maryland hospitals will continue to have a waiver from the CMS HAC program. For

<sup>7</sup> 3M Health Information Systems developed PPCs. The PPC software relies on “present on admission” indicators from administrative data to calculate the actual versus expected number of complications for each hospital.

the FY 2018 MHAC program, the Commission approved a statewide reduction target of 6 percent, comparing FY 2015 with CY 2016. The HSCRC reviews annual audits of approximately ten hospitals to ensure coding accuracy with the medical record documentation. If audit issues are found, staff will follow up with the hospital to understand the issue(s) and take appropriate action. The HSCRC is also working closely with 3M, the Maryland Hospital Association (MHA), and the hospital industry around the International Classification of Diseases – 10<sup>th</sup> Edition (ICD-10) implementation that may result in significant changes in PPC rates.

Figure 3. All-Payer Risk-Adjusted PPC Rates CY 2013 - CY 2015



Note: These results are based on final data through December 2015; however, results may change if issues with ICD-10 or other revisions are identified.

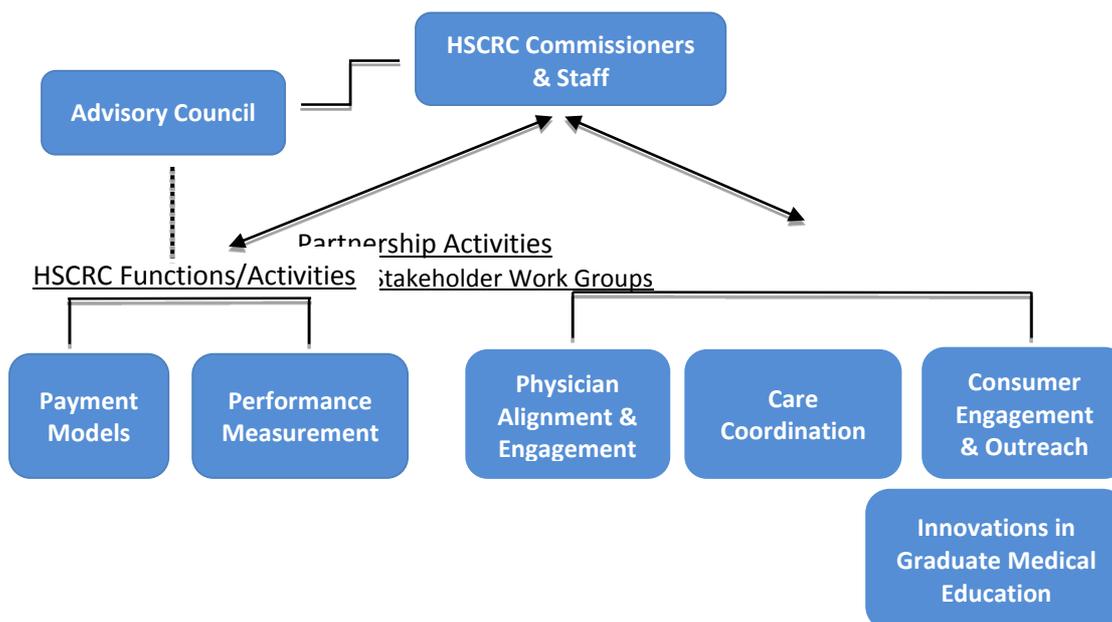
## Section II

### Work Group Actions

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. All Work Group meetings were conducted in public sessions, and comments from the public were solicited at each meeting. All Work Group materials are available on the Commission’s website.

Figure 4 depicts the structure of stakeholder engagement during CY 2015. The HSCRC added several Work Groups and sub-groups to address the transition to design alignment activities and begin to discuss Phase II of the Model. Last year, the Commission also added the Innovations in Graduate Medical Education (IGME) Work Group. The HSCRC also continued to facilitate a number of sub-work group meetings to work through technical, data-driven matters related to specific policies.

Figure 4. Existing Stakeholder Engagement Structure



### 1. Advisory Council on Modernization of the Maryland All-Payer Waiver

The purpose of the [Advisory Council](#) is to provide the HSCRC with senior-level stakeholder input on guiding principles for the overall implementation of population-based and patient-centered payment systems. The Advisory Council consists of a broad representation of hospitals, payers, physicians, consumers, providers, the Department of Health and Mental Hygiene (DHMH), and health care experts. The Advisory Council suggested guiding principles for the HSCRC to consider as it addresses key challenges and possible strategies over the next two years of Model implementation. The Council temporarily recessed during 2015 to allow HSCRC staff time to work on these suggestions, but reconvened as of February 2016 to allow senior stakeholders to provide further vision and input. The Council will have preliminary recommendations later this year.

### 2. Performance Measurement Work Group

The [Performance Measurement Work Group](#) develops recommendations for the HSCRC’s consideration on measures that are reliable, informative, and practical for assessing a number of important quality and efficiency issues. In the final quarter of CY 2015, the Work Group continued to work on updating the current pay for performance programs in place, and to develop additional detail on the key strategic areas identified for potential implementation for the near term future to help achieve the three-part aim. The Work Group finalized recommendations approved by the Commission to update the Quality-Based Reimbursement program that increased emphasis on patient-centered/patient experience of care measures. For the MHAC program, the Work Group developed a set of draft recommendations to update the statewide target for reducing complications, refine the list of complications used, and refine the methodology for counting the complications in the program. For the RRIP, staff presented data for the Work Group’s consideration modeling the impact of socio-demographic factors on readmission rates; staff will

continue the work to update the RRIP in the first half of CY 2016. In terms of future strategic work, the Work Group will continue to consider the following: measures of the quality of hospital care; measures of care coordination, particularly for chronic conditions; measures that target high-cost, common procedures; and measures that cut across settings of care.

### **3. Payment Models Work Group**

The [Payment Models Work Group](#) is charged with vetting potential recommendations for the HSCRC's consideration on the structure of payment models and how to balance its approach to payment updates. During CY 2015, the following issues were considered:

1. Update Factor: Review of staff work on the appropriate rate update for FY 2016.
2. Market Shift Adjustment: Review of staff work in developing a policy to adjust hospital global budgets for shifts in service volume from one hospital to another/others. Additional information on the market shift adjustment can be found below in the discussion of global budget methodologies.
3. Uncompensated Care Policy for FY 2016: Review of the impact of the Affordable Care Act's coverage expansion on uncompensated care levels at Maryland hospitals and the level of uncompensated care that should be included in hospital rates for FY 2016.
4. Aggregate Revenue at Risk for Quality-Based Payment Programs for FY 2018 Policy: Review staff work in determining the amount of revenue to potentially reward or penalize hospitals based on performance in the Maryland quality-based payment programs.

### **4. Consumer Engagement and Outreach Work Group**

The [Consumer Engagement and Consumer Outreach Work Group](#) consists of two task forces: the Consumer Engagement Task Force (CETF) and the Consumer Outreach Task Force (COTF). The purpose of these consumer-focused Task Forces is to help ensure that people who are using Maryland's health system understand the State's health system transformation and what it means to them, and that they have the information and resources to become more actively involved in their individual health and in improving the health of the community.

#### ***Consumer Engagement Task Force***

In September 2015, the CETF submitted a series of findings and recommendations in a final report to the Commission. The overarching themes and concepts that emerged during the research phase largely informed the CETF's recommendations.

The CETF recommended the following to the HSCRC:

1. Allow for a meaningful, ongoing role for consumers at the HSCRC through continued representation of Commissioner(s) with primary consumer interest and through a newly created standing advisory committee (SAC) with diverse representation.
2. In collaboration with key stakeholders, develop a statewide public education campaign specific to the New Maryland All-Payer Model that is part of a broader campaign to promote health and wellness.
3. Convene an interagency task force that allows consumers to participate in the

design and implementation of a statewide public education campaign.

4. Provide options and opportunities that support regular, longitudinal, and effective consumer engagement in the development of policies, procedures, and programs by hospitals, health care providers, health care payers, and government.
5. In coordination with the HSCRC SAC, the Maryland Health Care Commission (MHCC), and other key stakeholders, consider the development of a Consumer Gold Star system for hospitals based on consumer engagement standards.
6. Define community benefit dollars to include consumer engagement initiatives and promote these dollars for this use, particularly for those supporting vulnerable populations.
7. Continue to encourage and incentivize independent and collaborative approaches to support people who are at risk of becoming high utilizers.
8. Encourage hospitals to provide current, consistent, and transparent information on average procedure costs using the data made readily available by MHCC ([www.marylandqmdc.org](http://www.marylandqmdc.org)) and other new pricing transparency tools being created, and make this information available on the New Maryland All-Payer Model's website and/or other appropriate websites.
9. Include discussions about patient and family decision-making and preferences about advanced directives in the context of consumer engagement and educating consumers.

#### ***Consumer Outreach Task Force***

In September 2015, the COTF submitted a series of findings and recommendations in a final report to the Commission. During 2015, the COTF held 11 forums and engaged over 800 Marylanders, including members of community groups, civic organizations, faith-based organizations, provider groups, and government agencies in a discussion about Maryland's New All-Payer Model.

The forums and resulting discussions provided valuable feedback from consumers about transforming the health system. The COTF found that in general, consumers and local leaders believe that an understanding the health care delivery system is empowering on multiple levels and that there is a great deal of interest in having accessible, timely, and easy-to-understand information on the changing healthcare landscape.

The COTF offered the following recommendations to guide future efforts to integrate and respond to consumer experiences as the New Maryland All-Payer Model progresses:

1. Periodically convene stakeholders and consumers to provide updates on the progress of health system transformation.
2. Continue to give consumers a voice in the transformation of Maryland's health system.
3. Encourage local leaders to develop and join a dynamic Faith Community Health Network.
4. Collaborate to educate primary care providers on—and engage them in—health system transformation.

#### 4. Innovation in Graduate Medical Education Work Group

The [IGME Work Group](#) was convened by DHMH to oversee the development of a five-year plan to advance innovations in medical education as required under the New Maryland All-Payer Model Agreement with CMS. For long-term success in this new Model, physicians and other health professionals must be trained to both thrive and lead in this new environment. Therefore, graduate medical education in Maryland must be innovative and forward-thinking to produce a workforce with these skills.

The IGME Work Group supported an all-day summit on the future of graduate medical education on May 20, 2015. The summit was co-sponsored by DHMH, the University of Maryland, and Johns Hopkins Medicine. Outside speakers for the summit included Dr. Eric Holmboe from the Accreditation Council for Graduate Medical Education, Dr. Bruce Blumberg from Kaiser Permanente of Northern California, and Ankit Patel from CMMI. The summit brought together over 100 graduate medical education and healthcare leaders from around the State to discuss what the goals of a new graduate medical education model should be and steps that would need to be undertaken to modernize graduate medical education in Maryland.

The IGME Work Group continued to meet throughout CY 2015 to finalize and submit the report to DHMH; [this report](#) was submitted by DHMH to CMS in December 2015. The IGME Work Group developed five principles of redesign and seven recommendations on how to reform graduate medical education in Maryland so that it can better control costs and improve population health. A high-level list of these principles and recommendations are presented below.

##### *Five Goals Guiding IGME Workgroup Recommendations*

1. Achieve the triple aim
2. Focus on population health
3. Provide equitable and efficient funding
4. Enhance the strengths of the current graduate medical education system
5. Optimize workforce distribution

##### *IGME Workgroup Recommendations*

1. Continue statewide coordination and engagement
2. Adapt training programs to support physicians in a changing environment
3. Encourage community-based training venues, including non-clinical sites
4. Focus recruitment and retention efforts on strategies that develop the physician workforce necessary to provide population health
5. Increase transparency and awareness of graduate medical education funding and indirect medical education costs
6. Conduct partial rate reviews for hospitals seeking funding to make changes to or establish new residency programs
7. Dedicate specific funding for innovation in training

## Section III

### 1. Alternative Methods of Rate Determination

The New Maryland All-Payer Model agreement affords the State the ability to innovate by developing alternative methods of rate determination. During the first six months of the New Maryland All-Payer Model, the HSCRC developed the GBR reimbursement model and engaged all hospitals not already under a TPR agreement in GBR, as discussed in Section I of this report. While some revenue is outside of the global budget (such as revenue from some out-of-state referrals), approximately 96 percent of acute hospital revenue is currently under a global budget.

The GBR and TPR methodologies are central to achieving the triple aim set forth in the New 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 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. Annual revenue is determined from a historical base period that is adjusted to account for inflation updates, infrastructure requirements for GBR hospitals,<sup>8</sup> demographic driven volume increases, performance on 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. Other than global budgets, there are no other new general alternative methods of rate determination or experimental rate methods being developed at this time. The HSCRC will continue to innovate payment policy and will report any future innovations in this section of the Biannual Report.

### 2. Refining Global Budget Methodologies

While the majority of Maryland hospitals transitioned to global budgets during the first six months of the New Maryland All-Payer Model, a number of essential policies had not yet been finalized to address issues such as adjusting global budgets for market shifts or changes to inter-hospital transfer rates, establishing rates for new hospitals, and providing hospitals flexibility to achieve annual GBR revenue while reducing potentially avoidable utilization (PAU). As shown in this report, HSCRC staff have worked closely with the Payment Models Work Group, as well as a number of technical sub-work groups, to develop policies to address these issues. Additionally,

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<sup>8</sup> TPR hospitals were previously provided allowances at the initiation of their agreements.

HSCRC staff and Work Group members emphasized that these policies will continually progress as underlying data resources improve and the New Maryland All-Payer Model evolves.

### *Market Shift Policy*

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 for all inpatient and outpatient services, except for radiation therapy, infusion, and chemotherapy, for inclusion in rate year 2016 global budgets. These adjustments relate 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, in addition to other refinements. Staff are working on reviewing radiation therapy, infusion, and chemotherapy MSAs with stakeholders. Staff will update the market shift policy annually.

### *GBR Infrastructure Reporting*

In FYs 2014 and 2015, the Commission included over \$160 million in rates to support hospitals in developing services and mechanisms to improve care delivery, population health, and care management. Hospitals must submit annual reports on these investments with program descriptions, expenditures, and results.

The first round of these reports was due at the end of September 2015. To date, the HSCRC has received infrastructure reports from 44 hospitals, detailing over 850 infrastructure investments made during fiscal years 2014 and 2015.<sup>9</sup> While hospitals were directed to submit separate reports for each fiscal year, some hospitals submitted a combined report that covered both years. Hospitals reported a total infrastructure investment of \$231 million dollars over the past two years, and reported enlisting over 3,300 full-time equivalents (FTEs) to complete the work of infrastructure investment.<sup>10</sup> Based on the committee's review, staff estimate that between \$116 million (conservative estimate) and \$170 million (moderate estimate) were itemized for infrastructure investments that met the guiding principles for this report. In comparison to the \$90 million that were included in the rates of GBR

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<sup>9</sup> At this time, the HSCRC has not received a GBR Infrastructure Investment report from McCready Foundation or Calvert Memorial Hospital, both TPR hospitals.

<sup>10</sup> FTEs listed are as reported by hospitals. For hospitals with combined reports, FTEs were doubled, assuming the hospital reported annual FTEs. Also, FTEs are not necessarily new positions and often reflect re-purposing employees to more cost-efficient initiatives.

hospitals, it is estimated that the amount invested ranges from \$87 million to \$173 million.

Key areas of investment included: 1) expanding case management and care transitions; 2) increasing access to non-hospital provider care; 3) removing barriers to social services necessary for improved population health; 4) promoting patient education; and 5) increasing post-discharge support and follow-up care. Based on the analysis, the top three categories (excluding “Other”) are related to expansion of case management (15.8 percent), IT and data analysis (11.9 percent), and post-discharge or transitional care (11.4 percent). Around 50 percent of all investments and 44 percent of total reported spending are made up of case management, post-discharge/transitional care, social services, disease management, patient education, and community based care coordination.

Reviewers observed large-scale monetary investments for acquiring providers/physicians. While just 5.9 percent of investments were for acquiring providers/physicians, this category represented 26 percent of total reported spending (\$61.0 million). As specified in the reporting instructions under excluded expenses, the HSCRC did not intend to fund physician acquisition or subsidies with infrastructure funds. However, some limited subsidies to support disease management activities may be appropriate relative to the objectives of care coordination. While hospitals may make investments to recruit and retain primary care or other providers required to fill critical gaps in community health infrastructure, HSCRC staff do not believe this is an ideal strategy for improving care coordination and reducing avoidable utilization. Failure to concentrate resources in these areas may result in the inability to reduce avoidable utilization. In future reporting cycles, this will be one area where HSCRC staff will need to clarify instructions.

As the HSCRC and the health providers of Maryland move toward care transformation during the upcoming several years, staff are hopeful that hospitals will further efforts to invest in partnerships with existing community healthcare and service providers. These providers include federally-qualified health centers, long-term care facilities, community primary care physicians, community-based behavioral health providers, patients and families, health clinics, local health departments, faith-based organizations, and many others. Of the investments the HSCRC reviewed, approximately 57 percent reported partnerships with external partners or existing statewide/regional infrastructure or initiatives. To increase the success of the healthcare transformation in Maryland, the HSCRC hopes to continue progress toward more integrated care delivery in future years.

## **Section IV**

### **Reports Submitted to CMS**

The New Maryland All-Payer Model agreement requires the HSCRC to report to CMS on relevant policy and implementation developments. To date, the HSCRC has met all of the reporting requirements outlined in the New Maryland All-Payer Model agreement by submitting the following information to CMS.

- Commission Meeting Documents: The HSCRC has submitted all pre and post Commission meeting materials to CMS. These documents are available on the HSCRC's website (<http://hscrc.maryland.gov/commission-meetings-2015.cfm>).
- Maryland All-Payer Model Monitoring Report: This draft report was submitted to CMS in July 2015 and updated in December 2015. It contains data for performance year 2014 and 2013 baseline measures.

The prior annual report submitted to CMS was included as an appendix to the October 2015 Biannual Report. The October 2016 Biannual Report will include the next available annual report to CMS.

## **Section V**

### **Reporting Adverse Consequences**

At this time, the HSCRC has not observed any adverse consequences occurring as a result of the implementation of the New Maryland All-Payer Model.

A number of policies developed in the first 24 months of implementation guard against adverse consequences that HSCRC staff and stakeholder Work Groups identified as possible unintended outcomes of implementation. The GBR agreements initiated by the HSCRC for implementation of the global budgets contain consumer protection clauses. The HSCRC, in conjunction with the Payment Models Work Group, developed the Transfer Adjustment Policy and a Market Shift Policy to help ensure that “the money will follow the patient” when shifts in utilization occur between hospitals or other health care settings. These policies aim to guard against hospitals inappropriately limiting the number of high-cost, high-risk cases admitted and to provide open access and resources when patients need to be transferred to receive highly specialized care offered in academic medical centers.

Additionally, the HSCRC is continuing to develop tools to monitor changes in patterns of service, particularly shifts in utilization and expenditures across all healthcare providers. This includes a Total Cost of Care Reporting Template through which a group of public and private healthcare payers have agreed to submit both hospital and non-hospital claims data. Some of these data may become available through the All Payer Claims Data (APCD) collected by MHCC. The HSCRC will work with MHCC and payers to obtain the needed data in the most efficient and timely manner possible. The HSCRC will use this reporting tool to assess the growth and shifts that occur within the regulated and unregulated hospital markets, as well as those changes that occur among non-hospital healthcare providers.

The HSCRC also focused on engaging consumers through the Consumer Engagement and Outreach Work Group as described in Section II. In addition, consumer advocates participate in each of the HSCRC stakeholder Work Group panels. Consumer advocacy organizations have described the HSCRC stakeholder engagement process as a model for consumer engagement in a major policy endeavor. The HSCRC has made significant efforts to be as transparent as possible in its initiatives and policy developments by making these Work Group meetings open

to the public and by posting the meeting materials and recordings on the HSCRC's website (<http://www.hscrc.maryland.gov/index.cfm>).

As recommended by the Advisory Council, the Physician Alignment Work Group, and the Care Coordination Work Group, it is essential to promote physician and provider alignment with the incentives of the hospital global budgets and the All-Payer Model. The Commission has been working with CMS to obtain safe harbors to allow appropriate gain-sharing and pay-for-performance arrangements between hospitals and physicians (and potentially other providers). To the extent to which Maryland's Patient Referral Law inhibits hospital and physician oriented value-based strategies from taking place, it is essential that Maryland law be changed to allow any such arrangements to be established that are approved by CMS so that hospitals and physicians may work together to improve population health.

## **Contact and More Information**

For questions about this report or more information, please contact Steve Ports, the HSCRC Director of the Center for Engagement and Alignment, at [Steve.Ports@maryland.gov](mailto:Steve.Ports@maryland.gov).

More information is available on the HSCRC's website:  
<http://www.hscrc.maryland.gov/index.cfm>