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**Health Services Cost Review Commission**

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November 1, 2017

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 Dennis Schrader  
Secretary of MDH  
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

Dear Governor Hogan, President Miller, Speaker Busch, and Secretary Schrader:

I am pleased to submit to you the FY 2017 Report to the 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 2017.

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 which replaced 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://hscrc.maryland.gov/>.

Please contact me if you have any questions about this report, or you may contact Katie Wunderlich at [katie.wunderlich@maryland.gov](mailto:katie.wunderlich@maryland.gov).

Sincerely,

A handwritten signature in blue ink that reads 'Donna Kinzer'.

Donna Kinzer  
Executive Director

# **Report to the Governor**

*Fiscal Year 2017*

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Health Services Cost Review Commission  
4160 Patterson Avenue  
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November 2017

## Table of Contents

<b>Introduction .....</b>	<b>1</b>
<b>Section I - The Maryland All-Payer Model with CMS .....</b>	<b>1</b>
Goals Established by the All-Payer Model.....	1
<i>Cost Requirements of the Model</i> .....	1
<i>Quality Requirements of the Model</i> .....	2
Implementing Policies to Achieve Model Goals .....	2
<i>Global Budgets Negotiated with All Hospitals</i> .....	3
<i>Care Redesign Amendment</i> .....	3
<i>Medicare Performance Adjustment</i> .....	4
<i>Other Policies Supporting All-Payer Model Goals</i> .....	4
<i>Statutory Updates</i> .....	6
<i>Regulatory Update</i> .....	7
State and Federal All-Payer Model Status Reporting Requirements .....	7
Stakeholder Engagement.....	9
<b>Section II - Quality Performance .....</b>	<b>10</b>
Quality-Based Reimbursement.....	11
Maryland Hospital Acquired Conditions.....	13
Readmissions Reduction Incentive Program .....	14
Potentially Avoidable Utilization Savings.....	16
Maximum Revenue at Risk for Quality Programs .....	17
<b>Section III - Hospital Financial Performance .....</b>	<b>17</b>
Hospital Profitability.....	17
<i>Audited Financial Data—FY 2016</i> .....	18
<i>Unaudited Financial Data—FY 2017</i> .....	18
Uncompensated Care .....	19
Averted Bad Debt (AVBD).....	20
Community Benefits .....	21
<b>Section IV – Commission Infrastructure .....</b>	<b>22</b>
Commissioners .....	22
Staff Structure .....	22
Budget .....	22
<b>Section V - Future Outlook .....</b>	<b>23</b>
Progression towards Total Cost of Care Model.....	23
<i>Total Cost of Care Model Builds on Existing Momentum</i> .....	23
Key Elements of the New Model.....	24
<b>Contact and More Information.....</b>	<b>24</b>

## Introduction

The State of Maryland is leading a transformative effort to improve care and lower healthcare spending growth through Maryland’s All-Payer Model. The All-Payer Model (Model) serves as the central focus in this *Fiscal Year (FY) 2017 Report to the Governor from the Maryland Health Services Cost Review Commission* (HSCRC or Commission). This report, prepared in accordance with Section 19-207(b)(6) of the Health-General Article of the Annotated Code of Maryland, includes:<sup>1</sup>

- All-Payer Model policy implementation, state and federal reporting requirements, and stakeholder engagement
- Other HSCRC activities during the reporting period of July 1, 2016 through June 30, 2017
- Hospital financial performance in FYs 2016 and 2017
- Hospital quality performance and updated quality initiatives, and
- An overview of HSCRC staffing and budget infrastructure.

## Section I - The Maryland All-Payer Model with CMS

Effective January 1, 2014, the State of Maryland and the Centers for Medicare & Medicaid Services (CMS) entered into an initiative to modernize Maryland’s unique all-payer rate-setting system for hospital services. The Centers 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 All-Payer Model will reduce costs to purchasers of care—patients, businesses, insurers, Medicare, and Medicaid—and improve the quality of the care that patients receive both inside and outside the hospital. In the past 45 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 over the five years of the Model (plus an adjustment for population growth) to 3.58 percent per year, which is the 10-year compound annual growth rate in per capita gross state product (GSP).

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<sup>1</sup> 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.

- Medicare per beneficiary total hospital cost growth over five years must be at least \$330 million less than the national Medicare per capita total hospital cost growth over five years. This number is estimated to represent a savings level of approximately one-half percent per year below the national Medicare spending growth rate beginning in year two of the Model.
- Total cost of care growth for Maryland Medicare beneficiaries may neither exceed the national growth rate by more than one percent in any given year, nor exceed the national growth rate for two consecutive years.

### **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 beneficiaries, will improve as measured by hospital quality and population health measures.
- Specific quality improvement requirements 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 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 CMS to develop and deploy policies to enable the State to meet the goals established by the All-Payer Model. Several stakeholder workgroups (discussed in the Stakeholder Engagement section below), and regular meetings between HSCRC and CMS staff have facilitated policy implementation over the course of the Model demonstration period.

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; maintain 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. These policies expand on strategies adopted by various rural hospitals across the State three years prior to the adoption of the All-Payer Model.

### **Global Budgets Negotiated with All Hospitals**

The 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 Maryland All-Payer Model, the HSCRC developed the global budget revenue (GBR) reimbursement model and engaged all hospitals not already under a total patient revenue (TPR) agreement. As of April 2017, 100 percent of Maryland regulated hospital revenues are contained within GBR agreements.

The GBR methodology is central to achieving the goals set forth in the Maryland All-Payer Model: promoting better care, better health, and lower cost for all Maryland patients. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the Maryland All-Payer Model focuses on controlling increases in total hospital revenue per capita. GBR 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 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, demographic driven volume increases, performance on quality-based or efficiency-based programs, changes in payer mix, and changes in the 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 majority of Maryland hospitals transitioned to global budgets during the first six months of the 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). HSCRC staff have worked closely with the Payment Models Workgroup, as well as a number of technical sub-workgroups to develop policies to address these issues. Additionally, HSCRC staff and Workgroup members have emphasized that these policies will continually progress as underlying data resources improve as the Maryland Model evolves.

The HSCRC will continue to further develop payment policy and will report any future innovations in this section of the Annual Report.

### **Care Redesign Amendment**

The Commission is also focusing on integrated care incentives, such as integrated care networks, pay-for-performance programs, and gain-sharing programs to achieve the goals of care coordination and provider alignment. In May 2017, the State received approval from CMS for an amendment to the existing All-Payer Model contract to

implement specific care redesign strategies and to provide hospitals and providers with the tools and flexibility necessary to achieve the goals of the All-Payer Model.

Since then, two care redesign tracks were designed to encourage hospital and provider alignment: the Hospital Care Improvement Program (HCIP) and the Complex and Chronic Care Improvement Program (CCIP). HCIP aims to facilitate care improvement and efficiency within hospitals, while CCIP focuses on improving care for high-risk and rising needs patients through increased care coordination among hospitals and community physicians. In the first performance period, ten hospitals are participating in HCIP and six hospitals are participating in CCIP. The Chesapeake Regional Information System for our Patients (CRISP) is serving as the administrator of the program. The first performance period began on July 1, 2017, with potential gain-sharing payment distributed in calendar year (CY) 2018 for those hospitals that opt for this portion of the given program. A second performance period for HCIP and CCIP will begin on January 1, 2018 with an anticipated significant increase in participation by hospitals across the State. The State and stakeholders are currently working on updates to the care redesign programs to support increased care transitions efforts between hospitals and primary care providers.

#### **Medicare Performance Adjustment**

The HSCRC is developing the Medicare Performance Adjustment (MPA), which will adjust hospital Medicare payments based on TCOC performance. This modifier will be implemented at the beginning of CY 2018, with payment adjustments beginning in July 2019 (rate year 2020). The MPA is expected to assist the State in the transition to a new Total Cost of Care Model (discussed in Section V), which will focus on controlling TCOC. The recommendation for the MPA was brought before Commissioners in October, with a final vote expected in November, to allow for a January 2018 implementation date.

#### **Other Policies Supporting All-Payer Model Goals**

Over the course of FY 2017, the Commission approved additional policies to support All-Payer Model goals.

#### **Quality**

The HSCRC amended the existing Maryland Hospital Acquired Conditions (MHAC) program to further incentivize reductions in hospital acquired infections. The Commission continued the system of rewards and penalties for the Readmissions Reduction Incentive Program (RRIP), which began in FY 2014, and added positive incentives to hospitals that achieve a specified level of readmissions, in addition to incentivizing reductions in readmissions. As quality is a central component of the All-Payer Model, these and other quality programs are discussed in greater detail in the Quality Performance section of this report.

### *Update Factor*

The balanced update policy was implemented on July 1, 2017. The Commission adopted the following policies as a part of the FY 2018 update factor:

- Provide an overall increase of 3.14 percent for revenue (net of UCC offset) and 2.77 percent per capita for hospitals under Global Budgets. In addition, staff is proposing to split the approved revenue into two targets, a mid-year target and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
- Allocate 0.28 percent of the inflation allowance based on each hospital's proportion of drug cost to total cost. In addition to an adjustment for drug prices, staff is also proposing a 0.20 percent adjustment for drug volume/utilization, 0.10 percent prospectively allocated to hospitals using the FY 2016 outpatient oncology drug utilization and standard costs filed by hospitals, and the other 0.10 percent based on actual growth for FY 2017 over FY 2016. These adjustments will help fund the rising cost of new outpatient, physician-administered drugs.
- Continue to consider on an ongoing basis whether to differentiate hospital updates based on progress relative to high needs patients and other aligned efforts with physicians and other providers.

The Commission will continue to closely monitor performance targets for Medicare, including Medicare's growth in Total Cost of Care and Hospital Cost of Care per beneficiary during the performance year. As always, the Commission has the authority to adjust rates as it deems necessary.

### *Uncompensated Care Reduction*

The HSCRC implemented an uncompensated care reduction based on an 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 5.25 percent in FY 2016 to 4.69 percent in FY 2017.

### *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 PAU (discussed further in Section II). HSCRC staff updated the annual hospital reporting template on investments to improve care delivery, population health, and care management. The template includes program descriptions, expenditures, and results. The second round of the reports was due in October 2016. The HSCRC received infrastructure reports from hospitals detailing over 700 infrastructure investments made during FY 2016. Hospitals reported a total infrastructure investment of \$199 million over that time period. Key areas of investment included: 1) disease management, 2) post-discharge and transitional care, 3) community care coordination, 4) case management, and 5) consumer education and engagement. Reporting for GBR



Infrastructure spending has been suspended for FY 2017 to encourage hospitals to focus on developing care redesign initiatives and divert staff attention to those efforts. The reporting requirement will be evaluated later in FY 2018 and may be incorporated into other hospital reporting requirements at a later time.

#### *Transformation Implementation Grants*

As part of its update factor process for FY 2017, the Commission authorized up to 0.25 percent of hospital rates to be used for intensive community-based care coordination activities for chronically ill patients. During the first round of a competitive application process, the Commission awarded \$30 million to nine hospital partnerships to work with community partners to reduce PAU. These programs are above and beyond the care transitions initiatives that were funded in FYs 2014 and 2015. In October 2016, the Commission awarded an additional \$6.5 million in funding to another five partnerships. The first report from awardees was due at the end of August 2017. Ongoing reporting will be required of all awardees and the Commission maintains the authority to curtail funding if it is not used in accordance with the proposals as approved by the Commission.

#### *Statutory Updates*

Three important pieces of legislation passed during the 2017 Legislative Session that directly affect Commission operation and policy. The first is Senate Bill 369 (Chapter 226 of 2017), which creates another exemption to the Maryland Patient Referral Law for a health care practitioner who has a compensation arrangement with a health care entity, if that compensation arrangement is funded or paid under a program approved by the Federal Centers for Medicare and Medicaid Services. Eligible programs include Medicare ACO, Advanced Payment ACO, Pioneer ACO, Next Generation ACO, an alternative payment model approved by CMS, or another model approved by CMS that may be applied to health care services provided to both Medicare and non-Medicare patients. Review and approval by the Maryland Insurance Administration (MIA) is required for models that include both Medicare and non-Medicare patients and involve any cash compensation. The legislation creates a process by which MIA reviews the participation agreements to determine whether the agreements constitute insurance and comply with State law. This change in State law allows hospitals to implement the Care Redesign Amendment programs, a critical component for success in the All-Payer Model and future iterations of the Model.

The other two bills relate to the HSCRC's operating budget and flexibility needed to implement the All-Payer Model and to plan for the next phase of the Model (HB 150/Chapter 150 and HB 152/Chapter 123). The annual budget bill and companion legislation (Budget Reconciliation and Financing Act) set the parameters for initiatives and programs in the upcoming fiscal year for the HSCRC. In the FY 2018 budget, the Governor included sufficient appropriations to allow the HSCRC to access funds needed to fulfill statutory obligations and to continue health care delivery transformation

efforts in the State. Highlights from the budget that was passed by the General Assembly as they relate to the HSCRC are below.

- Increased the cap on hospital user fees from \$12 million to \$16 million annually. This will allow the Commission to have sufficient resources moving forward to design, develop, and implement the All-Payer Model.
- Increased the amount of indirect costs paid by the HSCRC to DHMH for overhead expenses from 18% to 30.5% annually, resulting in a decrease to the HSCRC budget of approximately \$470,000 based on our current staffing levels.
- Adopted recommendation to require a report evaluating the impact of emergency department overcrowding. Report will be co-authored by Maryland Institute for Emergency Medical Services Systems and HSCRC.

### **Regulatory Update**

Over the past fiscal year, the Commission proposed and adopted amendments to the following existing regulations:

#### **COMAR 10.37.10**

This regulation concerns the Commission’s Rate Application and Approval Procedures. During the past fiscal year, amendments to this chapter were proposed and adopted by the Commission.

- On December 14, 2016, the Commission adopted amendments to Regulation .03, which were proposed for adoption on September 30, 2016. The purpose of this action was to extend a moratorium on the filing of regular rate applications given the progression of the All-Payer Model.
- On December 14, 2016, the Commission adopted amendments to Regulation .07-2, which were proposed for adoption on September 14, 2016. The purpose of this action was to designate those outpatient services provided at a freestanding medical facility that are subject to Health Services Cost Review Commission rate regulation in conformance with newly enacted law.
- In September 2017, the Commission submitted proposed changes to COMAR 10.37.10.03, .03-1, .04, .04-1, .04-2, .04-3, .04-10 that are intended to update the process for filing a full rate application with the Commission, identify the methodologies to be used in approving permanent rates, describe the annual update factor vis-à-vis the All-Payer Model Agreement, including corrective action if necessary to maintain compliance with the All-Payer Model Agreement and provide options to hospitals for Commission review of a full rate application. As of this publication date, those regulations are still pending approval.

### **State and Federal All-Payer Model Status Reporting Requirements**

On May 1, 2017 and October 17, 2017, the HSCRC submitted reports summarizing implementation, monitoring, and other activities to the Centers for Medicare & Medicaid Services (CMS) and the Maryland General Assembly respectively, regarding the status of the 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 June 30, 2017, based on 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 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://hscrc.maryland.gov/Pages/legal-reports.aspx>.

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

Achievement Requirement	Accomplishments	Ongoing Activities
<b>Limit the annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58%</b>	Per capita revenue for Maryland residents grew 1.47% between CY 2013 and CY 2014; 2.31% between CYs 2014 and 2015; and 0.29% between CYs 2015 and 2016. CYTD 2017 shows a per capita growth rate of 3.61%. <sup>2</sup>	<ul style="list-style-type: none"> <li>• Ongoing monthly measurement</li> <li>• Continued favorable performance is expected as global budgets result in predictable statewide revenue performance</li> </ul>
<b>Achieve aggregate savings in Medicare spending equal to or greater than \$330 million over 5 years</b>	\$116 million in Performance Year (PY) 1 (CY 2014), \$135 million in PY 2 (CY 2015), and \$287 million in PY 3 (CY 2016) CY 2017 data is preliminary and has not yet been approved for release by CMS	<ul style="list-style-type: none"> <li>• HSCRC is working with an analytics contractor to examine and replicate CMS calculations of Medicare savings and per beneficiary growth rates for CY 2017</li> </ul>
<b>Shift at least 80% of hospital revenue to a population-based payment structure (such as global budgets)</b>	100% of hospital revenue shifted to global budgets	<ul style="list-style-type: none"> <li>• All hospitals are engaged in global budgets under GBR agreements</li> <li>• HSCRC continues to refine global budget methodology</li> </ul>
<b>Reduce the hospital readmission rate for Medicare beneficiaries to below the national rate over the 5-year period of the agreement</b>	At the beginning of the model, Maryland’s readmission rate was 1.24 percent higher than the nation. With the most recent twelve months of data through May 2017, Maryland’s readmission rate is 0.09 percent higher than the nation. Compounded with previous reductions, there has been a 12.38% reduction in all-payer case-mix adjusted readmissions since CY 2013.	<ul style="list-style-type: none"> <li>• HSCRC is monitoring progress within Maryland using data it collects from hospitals by HSCRC and continues to see declines in all-payer, Medicare fee-for-service (FFS), and Medicaid readmissions.</li> <li>• HSCRC is updating its Readmission Reduction Incentive Program (RRIP) for rate year (RY) 2019</li> </ul>
<b>Cumulative reduction in hospital acquired conditions by 30% over 5 years</b>	Compounded with previous reductions, there has been a 45.84% reduction in all-payer case-mix adjusted PPCs since CY 2013.	<ul style="list-style-type: none"> <li>• HSCRC continues to incentivize PPC reductions through the Maryland Hospital Acquired Conditions (MHAC) program, despite having achieved the 30% required reduction</li> </ul>

<sup>2</sup> The all-payer per capita growth rate reflects a subtraction in all payer revenue of approximately \$75.5 million. This neutralizes an adjustment to hospitals’ revenues due to undercharging in July to December CY 2016.

**Health Services Cost Review Commission – Report to the Governor  
Fiscal Year 2017**

<b>Achievement Requirement</b>	<b>Accomplishments</b>	<b>Ongoing Activities</b>
<b>Monitor Total Cost of Care (TCOC) for Medicare and maintain growth within guardrails</b>	The growth in TCOC for Maryland’s Medicare beneficiaries was 0.70% below the national growth rate in CY 2016.	<ul style="list-style-type: none"> <li>• HSCRC is continuing to closely monitor TCOC growth trends for hospital and total cost of care</li> </ul>
<b>Description</b>	<b>Report</b>	<b>Status</b>
<b>Workgroup Actions</b>	The Payment Models and Performance Measurement Workgroups reviewed the annual update factor and associated quality policies which were approved by the Commission in Spring 2017. Joint Workgroups with the Maryland Department of Health and the Maryland Health Care Commission met in CY 2017 to address cross agency initiatives, including the Primary Care Council, Duals Delivery Workgroup, and the Consumer Standing Advisory Committee.	<ul style="list-style-type: none"> <li>• Active workgroups continue to meet on a regular basis</li> </ul>
<b>New alternative methods of rate determination</b>	100% of hospital revenue is now under global budget arrangements. The TCOC Workgroup continued discussion on Medicare Performance Adjustment (MPA).	<ul style="list-style-type: none"> <li>• Global budget agreements are published on the HSCRC website.</li> <li>• Stakeholders and CMS are still reviewing the MPA. A final recommendation will be brought to Commissioners in December</li> </ul>
<b>Care Redesign Amendment</b>	Sixteen hospitals are participating Care Redesign programs that began on July 1, 2017.	<ul style="list-style-type: none"> <li>• Additional care redesign tracks are being considered and developed</li> <li>• Second performance period will begin on January 1, 2018</li> </ul>
<b>Ongoing reporting to CMS of relevant policy development and implementation</b>	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>• HSCRC continues to provide reports to CMS on an ongoing basis</li> </ul>
<b>Progress of Total Cost of Care (TCOC) Model</b>	The HSCRC concluded negotiations and finalized a term sheet with CMS for the TCOC Model.	<ul style="list-style-type: none"> <li>• Commission leadership is conducting various stakeholder meetings to ensure State and stakeholder alignment</li> <li>• HSCRC is pushing for prompt clearance of the model by CMS</li> </ul>

**Stakeholder Engagement**

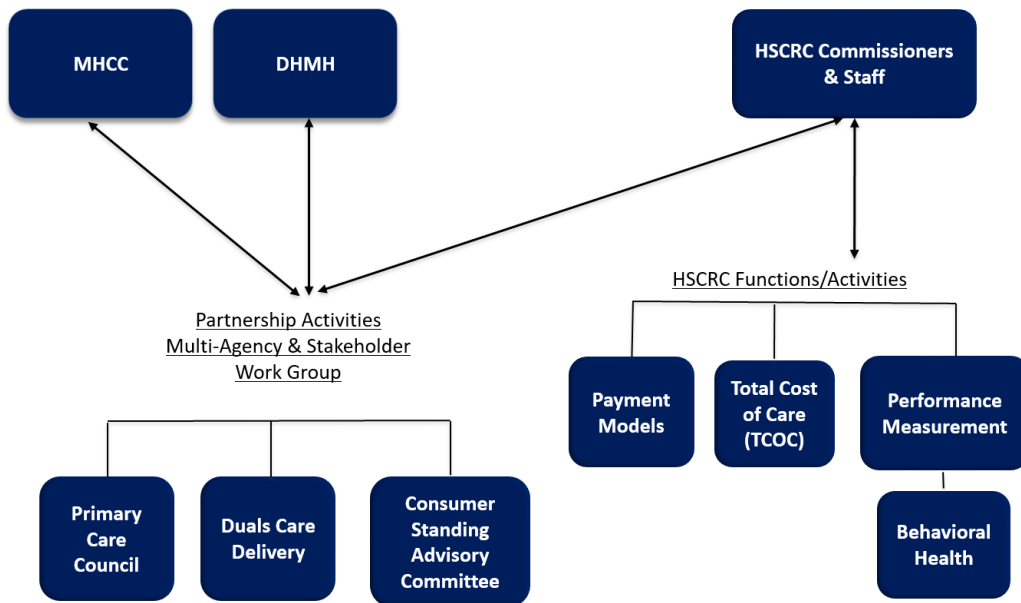
The HSCRC continues to implement a broad stakeholder engagement approach to healthcare transformation through stakeholder Workgroups. As the All-Payer Model progression broadens to include providers and delivery systems beyond hospitals, the HSCRC has focused on coordinating Workgroup efforts across agencies. In partnership with the Maryland Health Care Commission (MHCC) and the Maryland Department of Health (MDH), the HSCRC has participated in a Primary Care Council and the Duals Care Delivery Workgroup. The Payment Models, Performance Measurement, and Total Cost of Care Workgroups met monthly through June 2017. The Consumer Standing Advisory

Committee and the Behavioral Health Performance Measurement subgroup met quarterly.

Figure 2 depicts the current structure of the stakeholder engagement Workgroups. All Workgroup meetings are conducted in public sessions, and comments are solicited from the public at each meeting. There are also a number of sub-workgroup meetings and task forces to discuss technical, data-driven matters related to specific policies, which report back to the larger Workgroups. Input is also solicited in informal meetings with stakeholders.

All proceedings and reports of the Workgroup activities may be found on the Commission’s website at <http://hscrc.maryland.gov/Pages/Workgroups-Home.aspx>.

Figure 2. Stakeholder Engagement Structure



## Section II - 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 corresponding federal programs in design and scope, and that encompass a robust set of performance measures with strong 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 a 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 2018 allocated a portion of hospital revenue at risk for meeting performance targets. These programs provide strong incentives for hospitals to continuously improve quality performance. The hospital quality-based payment programs are listed below and are described in the subsections that follow.

- Quality-Based Reimbursement (QBR) Program
- Maryland Hospital Acquired Conditions (MHAC) Program
- Readmission Reduction Incentive Program (RRIP)
- Potentially Avoidable Utilization Savings (PAU Savings)

### Quality-Based Reimbursement

The QBR program adjusts hospital payments based on their 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 hospitals’ final scores on the program (Figure 3).

**Figure 3. QBR Measure Domain Weights for FY 2019**

Measure Domain	Weight
Clinical Care	0.150
Patient Experience of Care (HCAHPS)	0.500
Safety	0.350

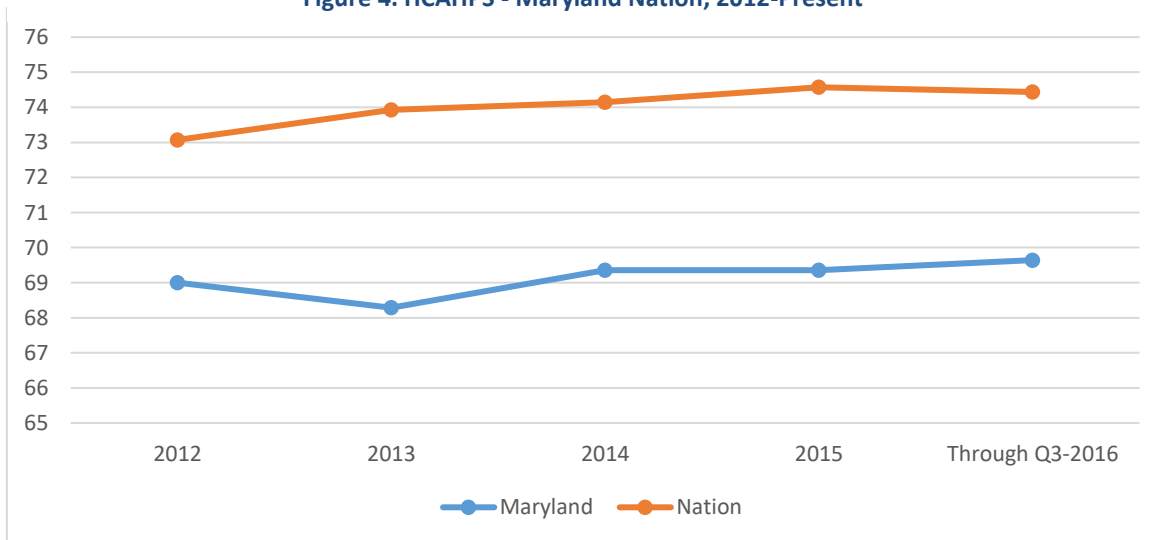
In the FY 2019 policy update, the HSCRC maintained the weights and the measurement domains from the FY 2018 policy to be as consistent as possible with the CMS Value-Based Purchasing (VBP) Program. In FY 2019, the amount of total hospital revenue at-risk for scaling was held to a two percent maximum penalty. However, because the scaling of rewards and penalties was expanded to incentivize greater improvement, the maximum reward was correspondingly increased to two percent (from one percent the previous year). Maryland has not yet developed and implemented an efficiency measure as part of the QBR Program, but it does apply a PAU savings adjustment to hospital global budgets, and is developing the Medicare Performance Adjustment to evaluate and adjust Medicare payments based on hospitals’ total cost of care performance.

Beginning again in FY 2019, reward and penalty adjustments to global budgets are determined based on a preset scale rather than relatively ranking hospital performance and penalizing those with less than average performance. This change was designed to provide hospitals with predictable revenue adjustments and to ensure that all high performing hospitals could receive rewards.

Maryland’s QBR program is similar in design and detail to the federal Medicare VBP Program. Data trends for the most recently available data (third quarter of CY 2016 as compared to CY 2014) suggest that:

- Maryland is performing on par with or better than the nation in terms of safety measures for all measures except Methicillin-resistant Staphylococcus aureus (MRSA). These measures include: Central Line-associated Blood Stream Infection (CLABSI), Cather-associated Urinary Tract Infection (CAUTI), and Surgical Site Infection (SSI) after Hysterectomy or Colon Surgery; as well as Clostridium Difficile (C-Diff.). Of note, given how the data is presented, Maryland is currently performing better than the nation performed in CY 2013.
- Maryland is performing slightly better than the nation on condition-specific mortality measures, according to most recently available data.<sup>3</sup>
  - Heart Attack- Maryland's state performance of 11.8% is better than the nation of 12.1%
  - Heart Failure- Maryland's state performance of 9.5% is better than the nation of 10.1%
  - Pneumonia- Maryland's state performance of 14.6% is worse than the nation of 13.6%
  - Chronic Obstructive Pulmonary Disease- Maryland's state performance of 6.9% is similar to the nation of 6.8%
  - Acute Ischemic Stroke- Maryland's state performance of 12.2% is better than the nation of 12.6%
- Maryland continues to lag behind the nation in performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience measures (Figure 4).

Figure 4. HCAHPS - Maryland Nation, 2012-Present



<sup>3</sup> Thirty day mortality rate data from the third quarter of CY 2013 through the second quarter of CY 2016 as displayed on [whynotthebest.org](http://whynotthebest.org) are available for Maryland compared to the nation for the top 10% of performers.



HSCRC staff remain concerned about Maryland HCAHPS performance. CMS shares this concern, as indicated in its most recent VBP waiver approval letter. In the FY 2018 QBR policy, the HSCRC increased the weighting of the HCAHPS measures in determining hospitals' overall scores in order to incentivize improvement in patient satisfaction, and has kept this domain weighting through the FY 2019 policy.

### Maryland Hospital Acquired Conditions

The MHAC program provides the needed incentives to achieve hospital care improvements and meet the target established in the Maryland All-Payer Model Agreement. The target is a 30 percent reduction in the statewide aggregate PPC rate over the five-year demonstration period.

During the April 2017 Commission Meeting, Staff presented the FY 2019 MHAC program policy. Most notably, staff recommended:

- Modify scaling methodology to be a single payment scale, ranging from 0% to 100%, with a revenue neutral zone between 45% and 55%.
- Set the maximum penalty at 2% and the maximum reward at 1%.

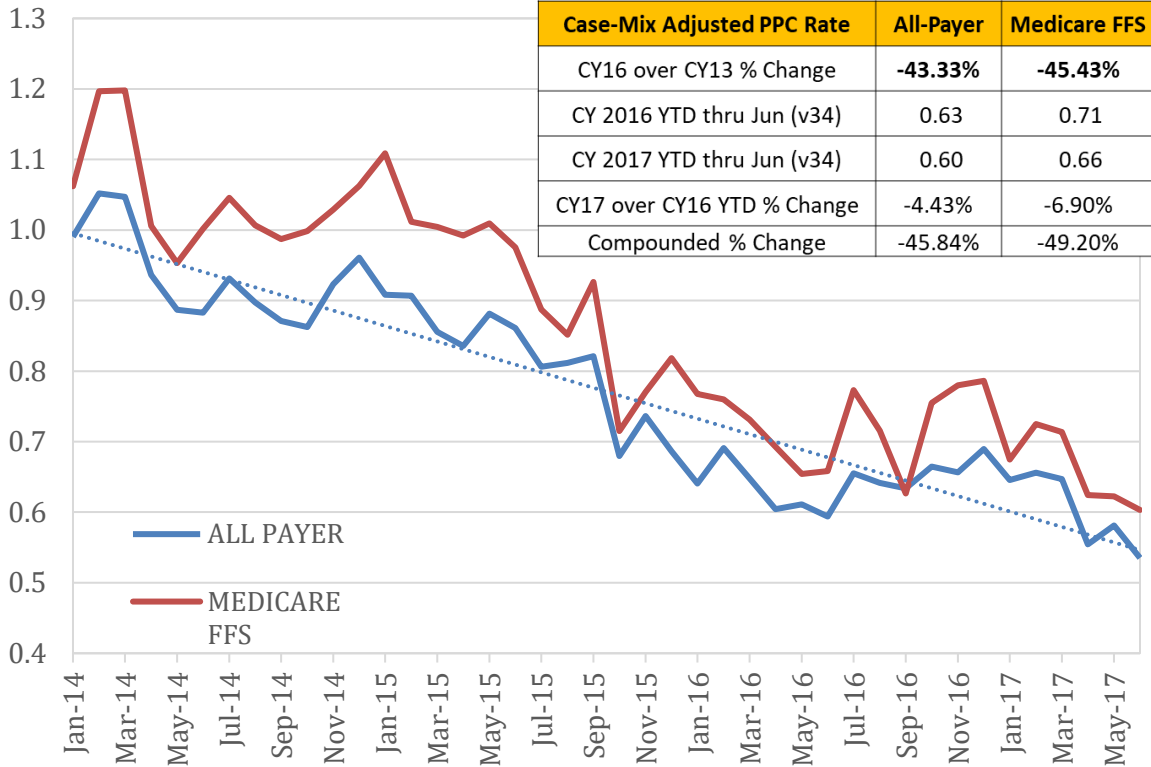
These final recommendations were developed by HSCRC staff based on input from the Performance Measurement Workgroup, 3M, and other stakeholders. Based on this input, the HSCRC staff made slight modifications to the FY 2019 MHAC methodology in terms of included PPCs, domain/tier weights, and benchmark calculations; however all available PPCs will continue to be reported to hospitals and CMS for monitoring purposes.

Figure 5 shows the all-payer and Medicare FFS case-mix-adjusted PPC rates by month and year. In the first six months of CY 2017, the all-payer case-mix adjusted PPC rate was 0.60 per 1,000, compared with 0.63 per 1,000 for the same time period in CY 2016, which is a 4.43 percent reduction. Compounded with previous reductions in complications since CY 2013, the state of Maryland has achieved a 45.84 percent reduction in all-payer case mix adjusted PPC rates. The reduction in the case-mix adjusted complication rate for Medicare FFS was even higher at 49.20 percent. While this reduction in the case-mix adjusted complication rate exceeds the new waiver target of 30 percent by 2018, the HSCRC will continue to incentivize hospitals to further reduce PPCs in future years. The HSCRC is currently considering how to best incentivize complication reductions in the proposed Total Cost of Care Model.

The HSCRC staff review 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. Currently, the HSCRC is working with one hospital to further review audit results that exceeded HSCRC thresholds.



Figure 5. Case-Mix Adjusted PPC Rates in Maryland through June 2017



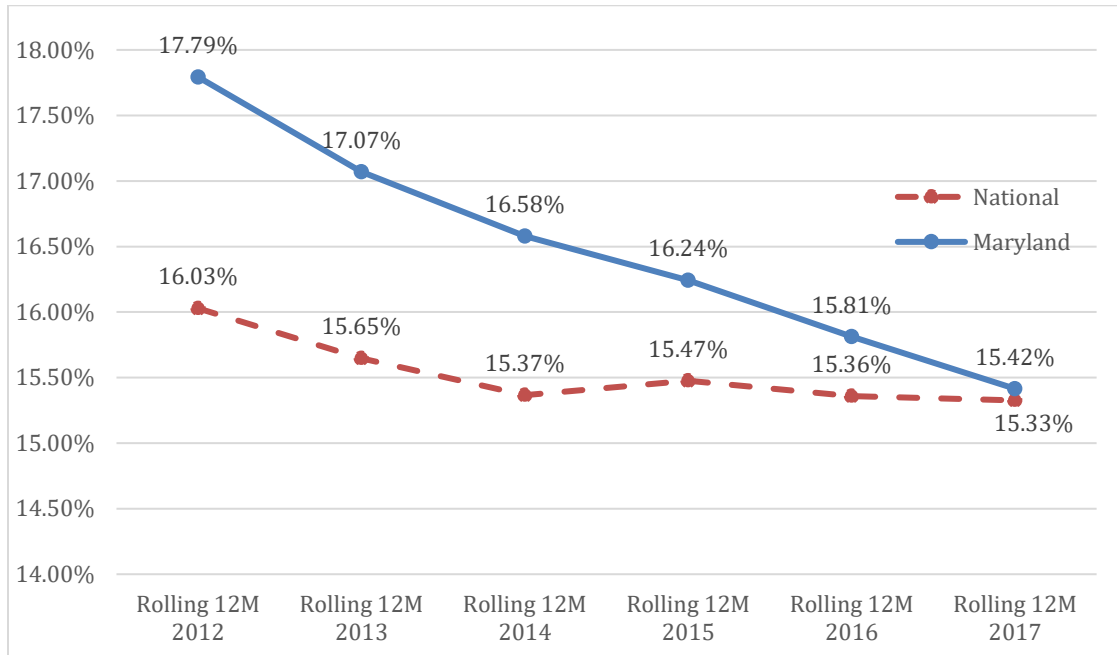
### Readmissions Reduction Incentive Program

Under the All-Payer Model, CMS requires Maryland’s Medicare fee-for-service (FFS) hospital admission rate to be at or below the national readmission rate by the end of CY 2018. In early 2014, the HSCRC and key stakeholders vetted a methodology that provides incentives to reduce readmissions. In April 2014, the Commission approved the Readmissions Reduction Incentive Program (RRIP) starting on January 1, 2014. The RRIP was originally a positive incentive program only, but due to concerns regarding reductions in readmissions, the program has evolved to provide scaled rewards up to one percent and scaled penalties up to two percent of inpatient revenue.

The Commission approved an updated RRIP policy for FY 2019 at the May 2017 Commission meeting. In concert with the Performance Measurement Workgroup and HSCRC contractors, staff carefully built a policy that rewards hospitals for the better of improvement or attainment. The improvement target for FY 2019 was set at 14.50 percent. The attainment benchmark for FY 2018 was set prospectively at 10.83 percent, which is two percent lower than the statewide 25<sup>th</sup> percentile for CY 2016. To account for out-of-state readmissions at border hospitals, the State will adjust the all-payer readmission rates using Medicare data to estimate the proportion of out-of-state readmissions.

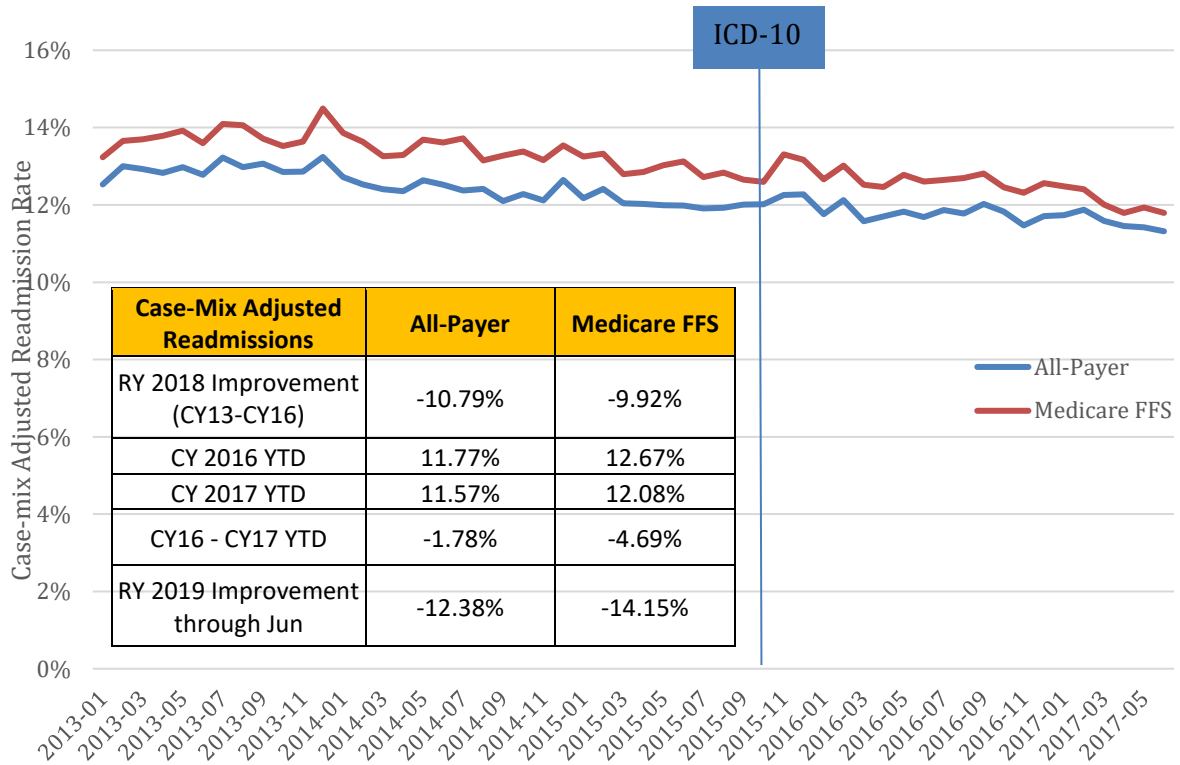
While Maryland’s readmission rate for Medicare beneficiaries remains slightly higher than the national average, it has steadily declined over the course of the All-Payer Model. The All-Payer Model requires Maryland’s hospital readmission rate for Medicare FFS beneficiaries to be at or below the national readmission rate by the end of 2018. This All-Payer Model requirement uses national Medicare data. To date, Maryland has experienced substantial improvements in its Medicare readmission rate relative to the national rate (Figure 6).

Figure 6. Medicare Readmissions – Rolling 12 Months Trend through May 2017



Additionally, HSCRC’s hospital data show that the monthly case-mix adjusted readmission rate for the first six months of CY 2017 is substantially improved as compared to the same time periods from CY 2013 through CY 2016 (Figure 7). This analysis includes all Maryland inpatient stays, including Medicare FFS. Based on these HSCRC data, the all-payer, case-mix adjusted readmission rate CYTD through June 2017 was 11.57 percent, compared to 11.77 percent during the same time period in CY 2016, a 1.78 percent reduction. Compounded with previous reductions in readmissions since CY 2013, the state of Maryland has achieved a 12.38 percent reduction in all-payer case mix adjusted readmissions. The corresponding readmission reduction for Medicare FFS beneficiaries was slightly higher at 14.15 percent. This reduction highlights the difficulty and time involved in reducing readmissions, as it requires significant effort, investment, and coordination across providers.

Figure 7. Case-Mix Adjusted Readmission Rates in Maryland through June 2017



In the RY 2019 policy, hospitals will continue to be measured based on improvement and attainment. To help readmission reduction efforts, the HSCRC continues to improve its readmission reporting capability by leveraging resources available in the state Health Information Exchange and providing timely, monthly, and patient-specific data to hospitals.

### Potentially Avoidable Utilization Savings

The HSCRC adopted a final PAU Savings policy for FY 2018 at its June 2017 Commission meeting. The PAU Savings policy includes savings realized from readmissions reductions, as well as savings that should be realized from reducing avoidable admissions, defined under the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator logic. For FY 2018, the Commission increased the prospective savings requirement to 1.45 percent of total hospital revenue. The HSCRC has also placed a guardrail on the PAU Savings for hospitals with high socioeconomic burden, so as to not be greater than the state average.

The HSCRC will continue to build upon the PAU Savings policy in future years, and is looking to expand the definition of avoidable utilization to include additional categories of unplanned admissions, as well as to incorporate sepsis cases into the definition, as data reliability allows.

### Maximum Revenue at Risk for Quality Programs

The Aggregate At-Risk policy itemizes the percentage of inpatient revenue that is subject to penalties and rewards under HSCRC performance based policies (MHAC, RRIP, QBR, and PAU Savings). For FY 2018, the Commission approved the maximum penalties and rewards for each quality program within each of the individual policies rather than in an aggregate-at-risk policy. The Commission approved FY 2018 policies that maintained FY 2017 at-risk levels for QBR, MHAC, and RRIP programs, and increased the total amount at-risk in PAU Savings. Aggregate At-Risk is one of the factors considered in Maryland’s exemption from the CMS quality programs, an exemption that is reviewed annually. HSCRC continues to hold more revenue at risk than the current CMS Value-Based Purchasing programs. Figure 8 illustrates the revenue at risk for FYs 2014 through 2018.

Figure 8. Revenue at Risk for Quality Programs

Program	SFY 2014	SFY 2015	SFY2016	SFY 2017	SFY 2018
MHAC	2.0%	3.0%	4.0%	3.0%	3.0%
RRIP			0.5%	2.0%	2.0%
QBR	0.50%	0.50%	1.00%	2.0%	2.0%
Shared Savings	0.41%	0.86%	1.35%	4.50%	5.89%
GBR PAU	0.50%	0.86%	1.10%	1.30%	0.55%
<b>Total Aggregate At Risk</b>	<b>3.41%</b>	<b>5.22%</b>	<b>7.95%</b>	<b>12.80%</b>	<b>13.44%</b>

## Section III - Hospital Financial Performance

### Hospital Profitability

The HSCRC monitors hospital financial performance of regulated hospitals through hospital financial data submissions. Specifically, the HSCRC conducts monthly monitoring of unaudited data and annual monitoring of 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 2016 and on an unaudited basis for FY 2017.

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 2016**

Data for FY 2016 show decreases in profitability, i.e., both total operating and non-operating activities, compared with the prior year. There was, however, an increase in profitability for services regulated by the HSCRC over the prior year. The increase in regulated profitability may be attributed to the continued focus on reducing costs. The decrease in total operating profitability can be attributed to losses on the provision of unregulated hospital services.

Profitability based on audited data for total operations, i.e., hospital operations regulated by the HSCRC and for unregulated hospital operations, and for total hospital activities both operating and non-operating is presented below:

- The total combined audited regulated and unregulated operating margin was 3.29 percent.
- The total margin, i.e., the combined operating and non-operating margins was 2.33 percent.
- The operating margin for services regulated by the HSCRC was 8.56 percent.

#### **Unaudited Financial Data—FY 2017**

Based on unaudited financial data for FY 2017, operating margins, both for services regulated by the HSCRC and those services not regulated by the HSCRC, decreased over FY 2016, while total profit margins increased. Operating profitability declined as hospitals experienced the following factors:

- The Commission adopted a slightly larger update factor when compared to the prior year and invested in the care coordination infrastructure hospitals require for success under the new Model. Hospital revenues increased by a net 2.02 percent, reflecting the impact of inflation, infrastructure investment, population growth, and expected declines in uncompensated care.
- 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 again reduced funding for uncompensated care in FY 2017 in order to adjust for the lasting impact of the ACA coverage expansion.

Overall, total hospital margins increased due to increases in investment income. Profitability in FY 2017, based on unaudited data, is shown below. Please note that final audited data, when available, may result in adjustments to these margins:

- The total combined unaudited regulated and unregulated operating margin was 2.80 percent.
- The total margin, i.e., the combined operating and non-operating margins was 5.70 percent.
- The operating margin for services regulated by the HSCRC was 5.12 percent.

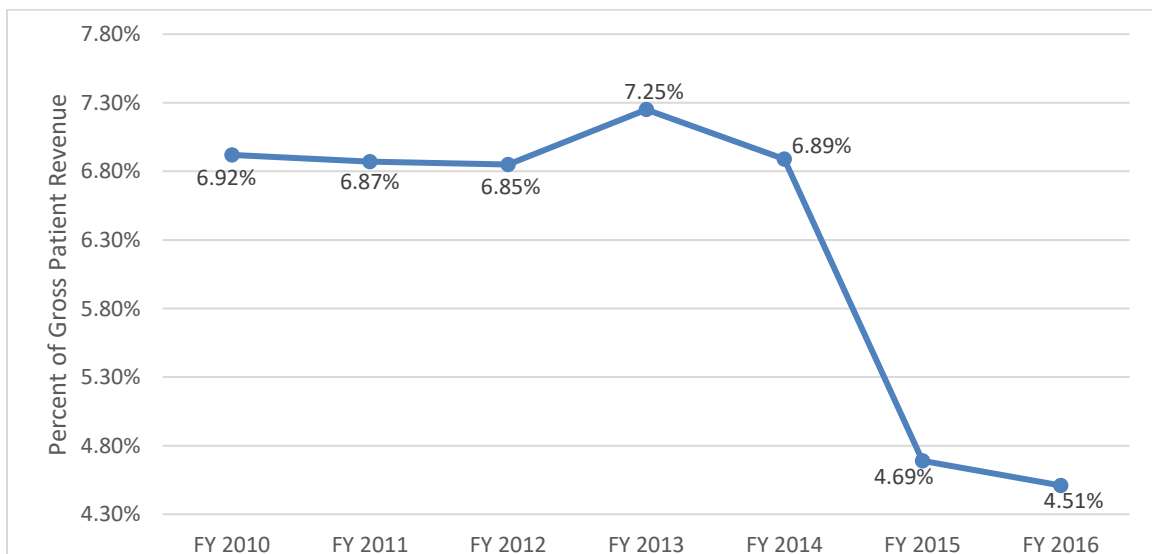
### Uncompensated Care

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’s current policy provides for uncompensated care statewide at the level of the most recent year’s actual statewide experience. Hospital-specific uncompensated care provisions were determined by a blend of a hospital’s most recent year’s actual experience and its expected performance based on a regression analysis. Unlike the prior two years, the uncompensated care policy was not modified for the impact of the ACA because, although more people were being insured, underinsurance and increases in the purchase of high-deductible health plans were creating upward pressure on uncompensated care.

Figure 9 shows the actual total uncompensated care rate for all regulated Maryland hospitals between FY 2010 and FY 2016. After declining slightly between FY 2010 and FY 2012, there was a 0.4 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 a decrease in uncompensated care of 0.36 percentage points in FY 2014. Uncompensated care reported by hospitals continues to drop from 4.69 in FY 2015 to 4.51 percent in FY 2016, a decrease of 0.18 percentage points.

**Figure 9. Uncompensated Care as a Percentage of Gross Patient Revenue, FY 2010-2016**



Actual audited data to determine the actual amount of uncompensated care in FY 2017 is not yet available. Development of the FY 2018 uncompensated policy occurred in a less dynamic insurance market place and a more data rich environment. Three years of post-ACA implementation data, audited financial statements for FY 2016, and a full year of data on hospital patient-level write-offs were used to update the regression model to better capture the continuing sources of uncompensated care.

### **Averted Bad Debt (AVBD)**

Section 19-214(e) of the Health General Article requires the HSCRC to report reductions in uncompensated care and the number of individuals enrolled in Medicaid as a result of eligibility changes under Section 15-103(A)(2)(ix) and (x) of the Health-General Article in 2007.

The 2007 Maryland General Assembly enacted Chapter 7 of the Laws of Maryland, The Working Families and Small Business Health Coverage Act (The 2007 Act), which expanded access to health care coverage for Maryland residents in the following ways:

- Beginning in fiscal year (FY) 2009, expanded Medicaid eligibility to parents and caretaker relatives with household income up to 116 percent of the federal poverty level (FPL), an increase from approximately 46 percent of the FPL
- Contingent on available funding, incrementally expanded the Primary Adult Care (PAC) program benefit over three years, to be phased in from FY 2010 through FY 2013. PAC offered limited benefits to childless adults with household income up to 116 percent of the FPL.
- Established a Small Employer Health Insurance Premium Subsidy Program, to be administered by the Maryland Health Care Commission.

Special funds, including savings from averted uncompensated care and federal matching funds, cover a portion of the costs of these expansions. Chapters 244 and 245 of the Laws of Maryland were adopted in 2008 to require the Commission to implement a uniform assessment on hospital rates that reflects the aggregate reduction in hospital uncompensated care realized from the expansion of the Medicaid/PAC programs under The 2007 Act. To qualify for federal matching funds, Chapters 244 and 245 require the assessment to be broad-based, prospective, and uniform.

During the 2011 session, the Maryland General Assembly enacted Chapter 397 (the Budget Reconciliation and Financing Act of 2011), which established an averted bad debt assessment at 1.25 percent of projected regulated net patient revenue.

Figure 10 summarizes the report submitted in January 2017 for FY 2016. The report is available at <http://hscrc.maryland.gov/Documents/legal-legislative/reports/hscrc-avbd-2016.pdf>.

Figure 10. Averted Bad Debt Reporting for FY 2016

Reporting Requirement	Reference	Finding
<b>The Calculated AVBD based on 1.25% of NPR</b>	Chapter 7, Acts of the General Assembly, 2007 Special Session	HSCRC estimate: \$165.2 million
<b>Number of individuals who enrolled in Medicaid as a result of the change in eligibility standards</b>	Health-General Section 15-103(A)(2)(ix) and (x) of the Health General Article	Maryland Medicaid projection: 117,463 individuals

### Community Benefits

The Internal Revenue Code requires nonprofit 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 2016. In that year, Maryland hospitals expended just over \$1.5 billion in community benefits, or 9.3 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 \$827.2 million or 5.07 percent of operating expenses.

Beginning in tax years after March 23, 2012, each nonprofit hospital is required to conduct a community health needs assessment every three years, which they report to the federal government. 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://hscrc.maryland.gov/Pages/init\\_cb.aspx](http://hscrc.maryland.gov/Pages/init_cb.aspx).



## Section IV – Commission Infrastructure

### Commissioners

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 MDH. Seven Governor-appointed Commissioners oversee the HSCRC. Figure 11 provides a list of current Commissioners.

Figure 11. HSCRC Commissioners

Commissioner	Term Start Date
<b>Nelson J. Sabatini, Chairman</b>	February 2, 2016
<b>Joseph Antos, Ph.D.</b>	July 1, 2016
<b>George H. Bone, M.D.</b>	July 1, 2010
<b>John M. Colmers</b>	July 1, 2013
<b>Victoria W. Bayless</b>	February 11, 2016
<b>Jack C. Keane</b>	July 1, 2011
<b>Adam Kane</b>	July 1, 2017

### Staff Structure

The State charges the HSCRC with regulating the rates and revenues of Maryland’s 48 acute care and 4 specialty hospitals, an industry with annual revenues in excess of \$17 billion. This responsibility is accomplished by a relatively small and highly skilled staff of 40 full-time equivalents. To meet the demands of the New All-Payer Model, the Commission has organized its staff structure under 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

### Budget

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 2017 was \$10.5 million and the fund balance at the end of the fiscal year was \$5.1 million. Although this balance is above the normal range, the HSCRC is preparing to take on additional tasks related to both the current All-Payer Model and the proposed Enhanced Total Cost of Care All-Payer Model that will require additional resources. This balance will be utilized in conjunction with the FY 2018 user fee assessment in order to plan for and implement the critical new tasks required by the All-payer Model and will bring the fund balance to a reasonable level at the end of FY 2018.

## Section V - Future Outlook

### Progression towards Total Cost of Care Model

The All-Payer Model agreement called for Maryland to submit a proposal for a new model no later than January 2017, which shall limit, at a minimum, the Medicare beneficiary total cost of care growth rate. To prepare this proposal, the State engaged in a robust stakeholder process, working with hundreds of stakeholders representing consumers, hospitals, physicians, skilled nursing and post-acute care facilities, payers, experts, and various State agencies. The State also solicited comments from the public. On December 16, 2016, Governor Larry J. Hogan Jr. submitted the “Progression Plan” to CMS, describing Maryland’s proposal to accomplish the Model’s expanded system-wide goals. In early 2017, the federal government and State officials, with input from Maryland health care leaders, began negotiations for a new model that will begin on January 1, 2019. The new Model must move beyond hospitals to address the total costs of Medicare patients’ care in the community.

Under the proposed new “Maryland Total Cost of Care Model,” Maryland will be expected to progressively transform care delivery across the health care system with the objective of improving health and quality of care. At the same time, State growth in Medicare spending must be maintained lower than the national growth rate. The new Total Cost of Care Model will give the State flexibility to tailor initiatives to the Maryland health care context, and encourage providers to drive health care innovation. The Total Cost of Care Model also encourages continued Care Redesign, and provides new tools and resources for primary care providers to better meet the needs of patients with complex and chronic conditions and help Marylanders achieve better health status overall.

### Total Cost of Care Model Builds on Existing Momentum

The new Total Cost of Care Model will leverage the foundation already developed by Maryland for hospitals and build on the investments that hospitals have made since 2014. Maryland will continue to encourage provider- and payer-led development of Care Redesign programs to support innovation. Maryland is also continuing efforts to implement a new Maryland Primary Care Program, which is intended to bring care coordination and support to approximately 400,000 Medicare beneficiaries and 2,000 physicians. The State will commit its public health resources to support population health improvements that are aligned with Model goals and Marylanders’ needs.

At this stage, the State and the federal government have completed negotiations regarding the basic structure of the new Total Cost of Care Model, described in the Progression Plan submitted in December 2016, and the Model is now undergoing federal clearance and approval. As a result, Maryland’s progression can evolve from concept to planning for the implementation activities necessary to assure successful progression over time. Throughout the development of implementation plans, the State will continue its commitment to privately led innovation, voluntary participation in

Care Redesign programs, and meaningful and ongoing stakeholder engagement to achieve the State’s vision for person-centered care, clinical innovation and excellence, and improved population health.

### Key Elements of the New Model

Core requirements and expectations of the new model, which are subject to federal approval, include the following:

- The new Total Cost of Care Model will begin on January 1, 2019 for a 10-year term, so long as Maryland meets the model performance requirements.
- Hospital cost growth per capita for all payers must not exceed 3.58% per year. The State has the opportunity to adjust this growth limit based on economic conditions, subject to federal review and approval.
- Maryland commits to saving \$300 million in annual total Medicare spending for Medicare Part A and Part B by the end of 2023. The Medicare savings required in the TCOC All-Payer model will build off of the ongoing work of Maryland stakeholders, which began in 2014.
- Federal resources will be invested in primary care and delivery system innovations, consistent with national and State goals to improve chronic care and population health.
- The Model will help physicians and other providers leverage other voluntary initiatives and federal programs to align participation in efforts focused on improving care and care coordination, and participation in incentive programs that reward those results. These programs will be voluntary, and the State will not undertake setting Medicare and private fee schedules for physicians and clinicians.
- Maryland will set aggressive quality of care goals.
- Maryland will set a range of population health goals.

The new Total Cost of Care Model is anticipated to begin on January 1, 2019; this provides a full year—calendar year 2018—for Maryland to engage stakeholders on planning and preparations prior to the new model’s start. The State of Maryland remains committed to a robust process for input and feedback on the development and implementation of the new model. Additional information on the new Total Cost of Care Model can be found at <http://hscrc.maryland.gov/Pages/progression.aspx>.

### Contact and More Information

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

More information is available on HSCRC’s website: <http://www.hscrc.maryland.gov>.