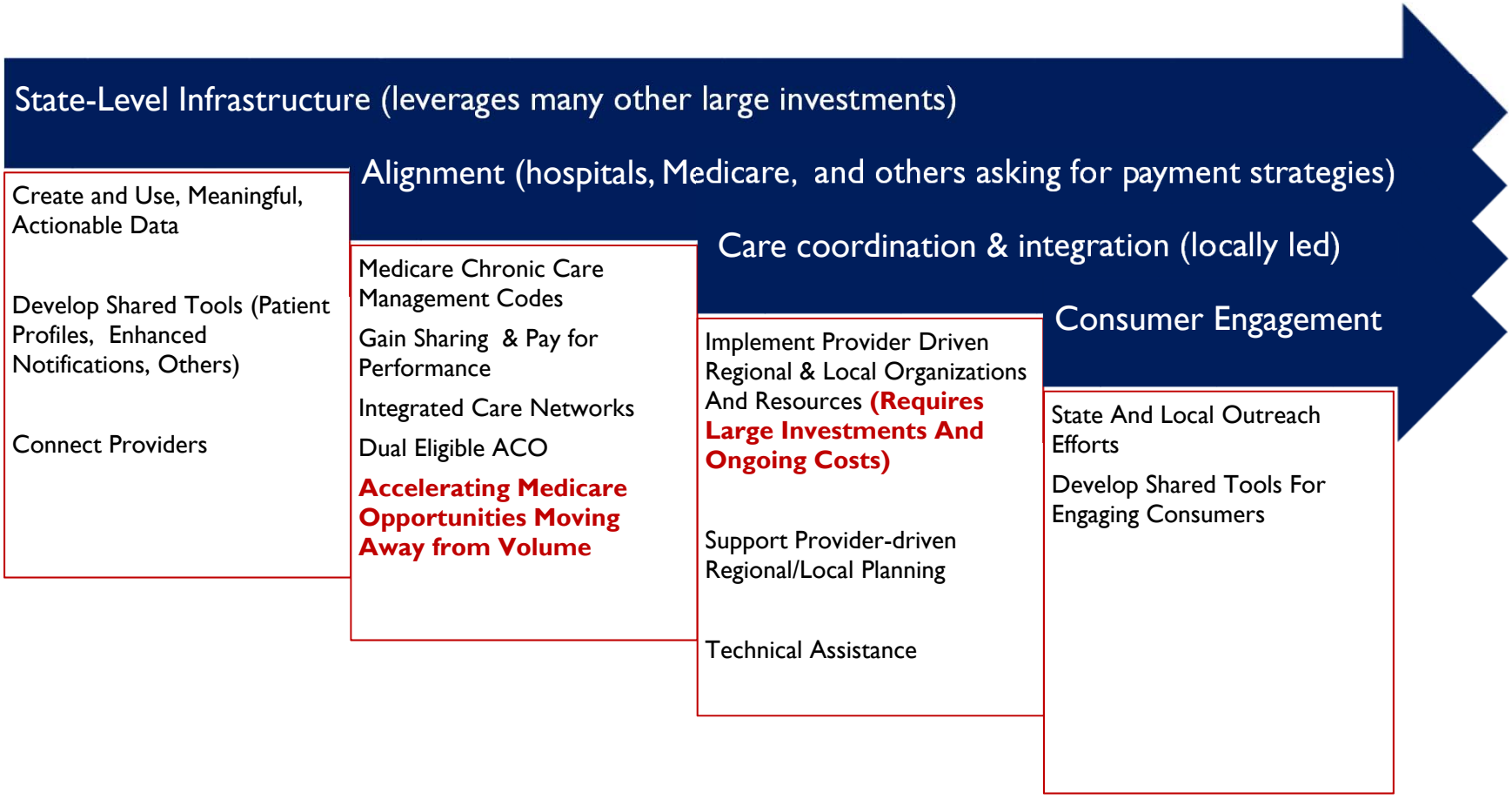
Implementation of the Maryland All Payer Model
Care Coordination, Integration, and Alignment

May 2015

HSCRC Strategic Roadmap



Care Coordination & Integration Efforts

- State level infrastructure
  - 90 day intense planning effort and short term implementation
- Regional and local planning and implementation
  - FY 14 and FY 15 expenditure and intervention reports due with hospital annual filings
  - Regional planning “grants” under BRFA—reports due December 1
  - Short term and longer term care coordination, care integration, and alignment plans due from each hospital December 1
  - Competitive proposals for funds of .25% due December 1, with approval by January 31 or earlier.

Significant Regional and Local Efforts Needed to Scale All Payer Model

- Delivery system changes, including:
  - Chronic disease supports
  - Long term and post acute care integration & coordination
  - Physical and behavioral health integration & coordination
  - Primary care supports, including support of Medicare Chronic Care Management fee requirements
  - Case management and other supports for high needs and complex patients
  - Episode improvements, including quality and efficiency improvements
  - Clinical consolidation and modernization to improve quality and efficiency

Significant Regional and Local Efforts Needed to Scale All Payer Model(cont.)

- Increased focus on integration with community needs and supports
  - Increased focus on community needs assessments
  - Focus on transportation and patient supports
  - Focus on population health
  - Patient and family engagement

- Technical assistance
  - Provided with BRFA funds through CRISP
  - Budget and scope provided at June Commission meeting

CRISP Care Coordination & Integration-- Tools Implementation Timeframes

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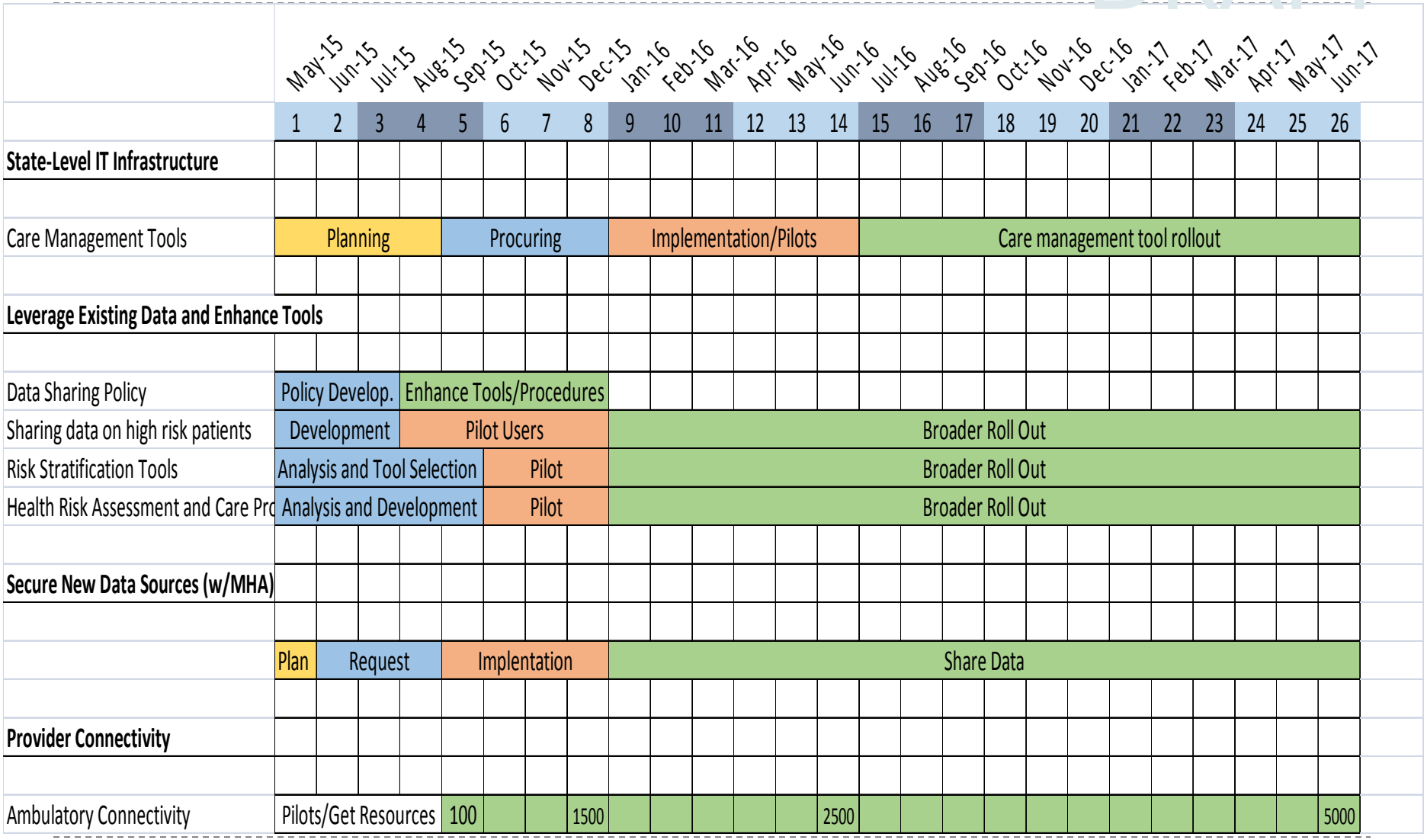

Alignment Activities

- Meeting with CMMI
- Timeline for June Commission meeting
- Conversations with providers regarding additional demonstrations and models

Monitoring Maryland Performance

Financial Data

Year to Date thru March 2015

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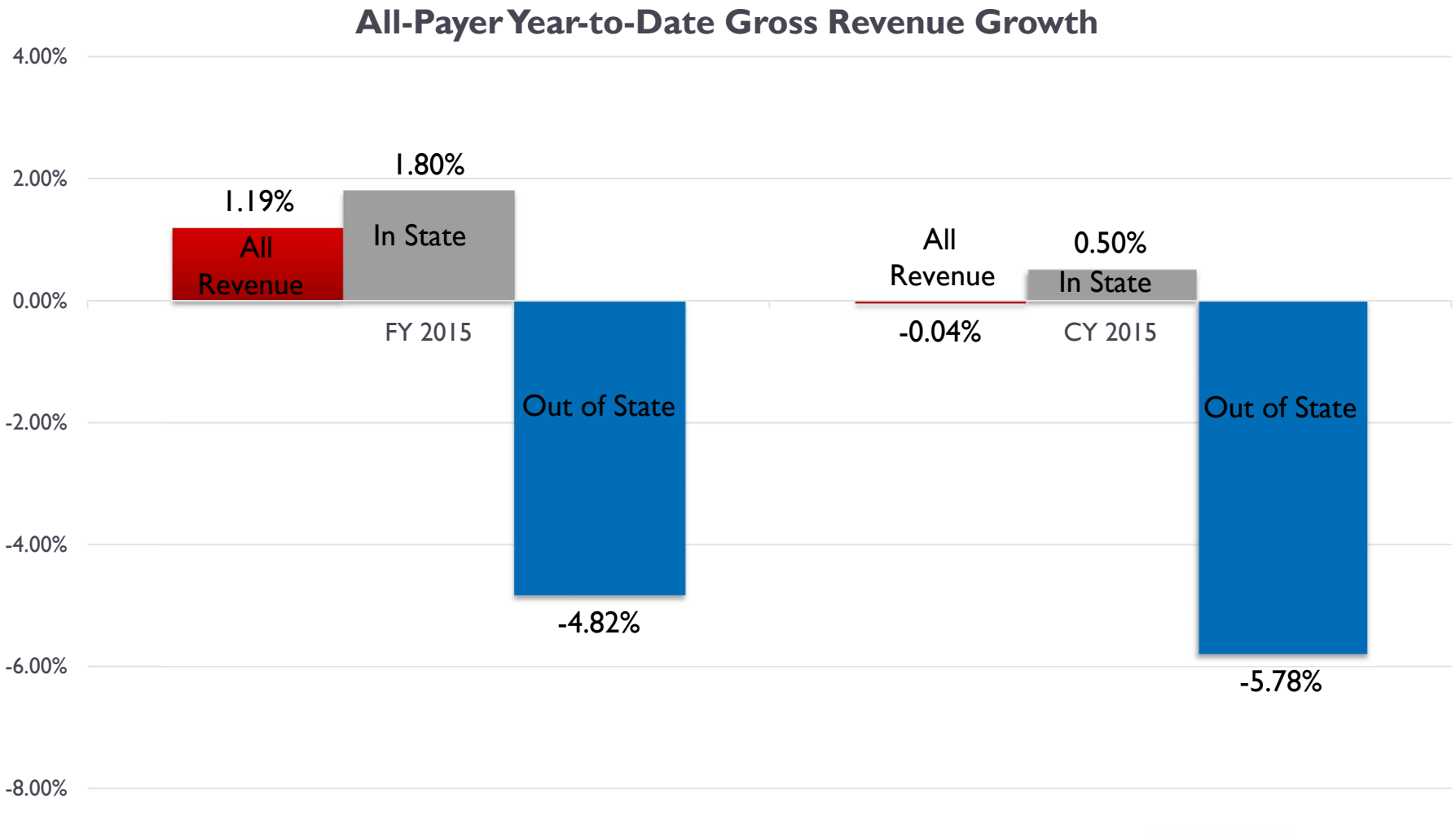
Gross All Payer Revenue Growth

Year to Date (thru March 2015) Compared to Same Period in Prior Year



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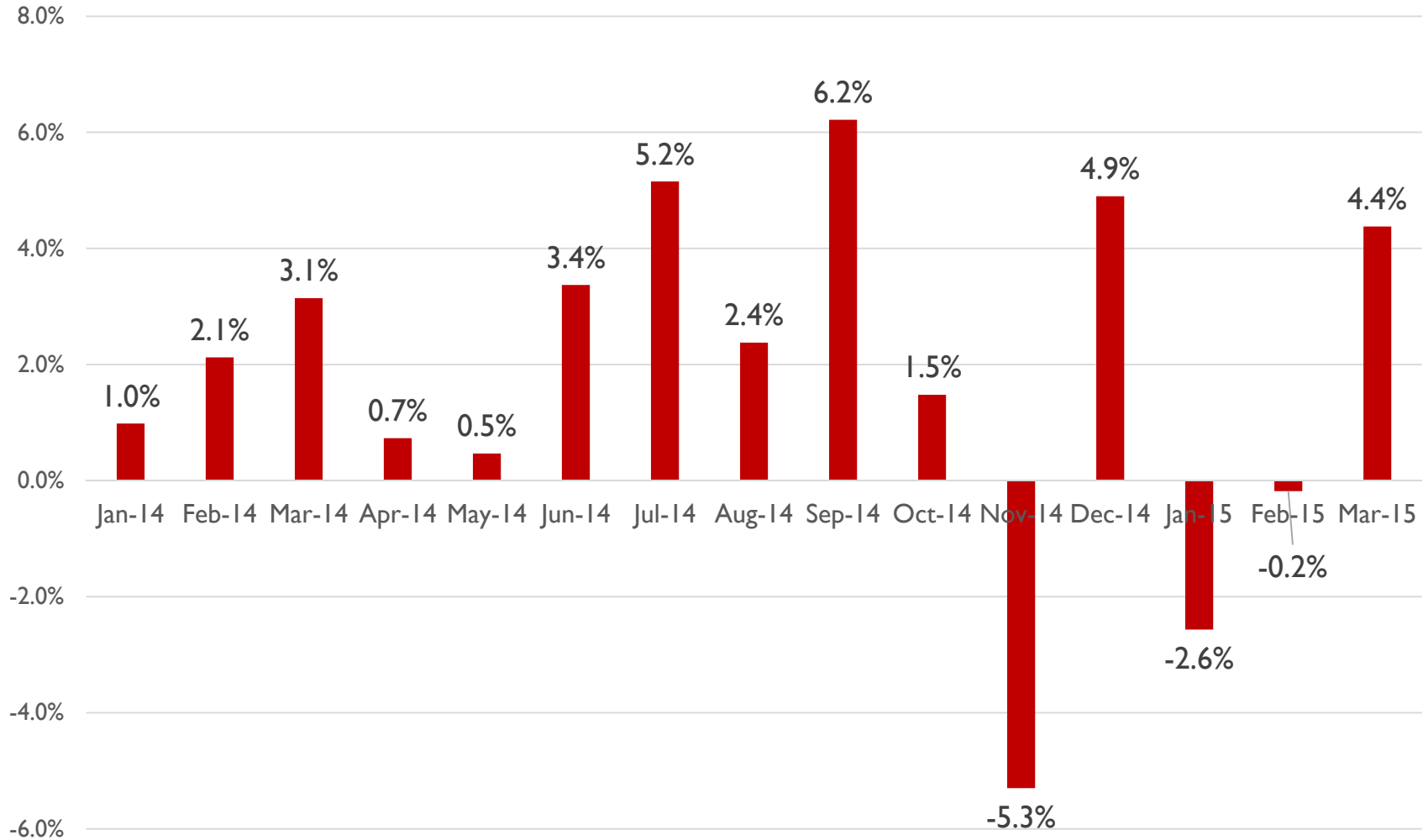
Gross All-Payer In-State Hospital Revenue
% Change from Same Month in Prior Year



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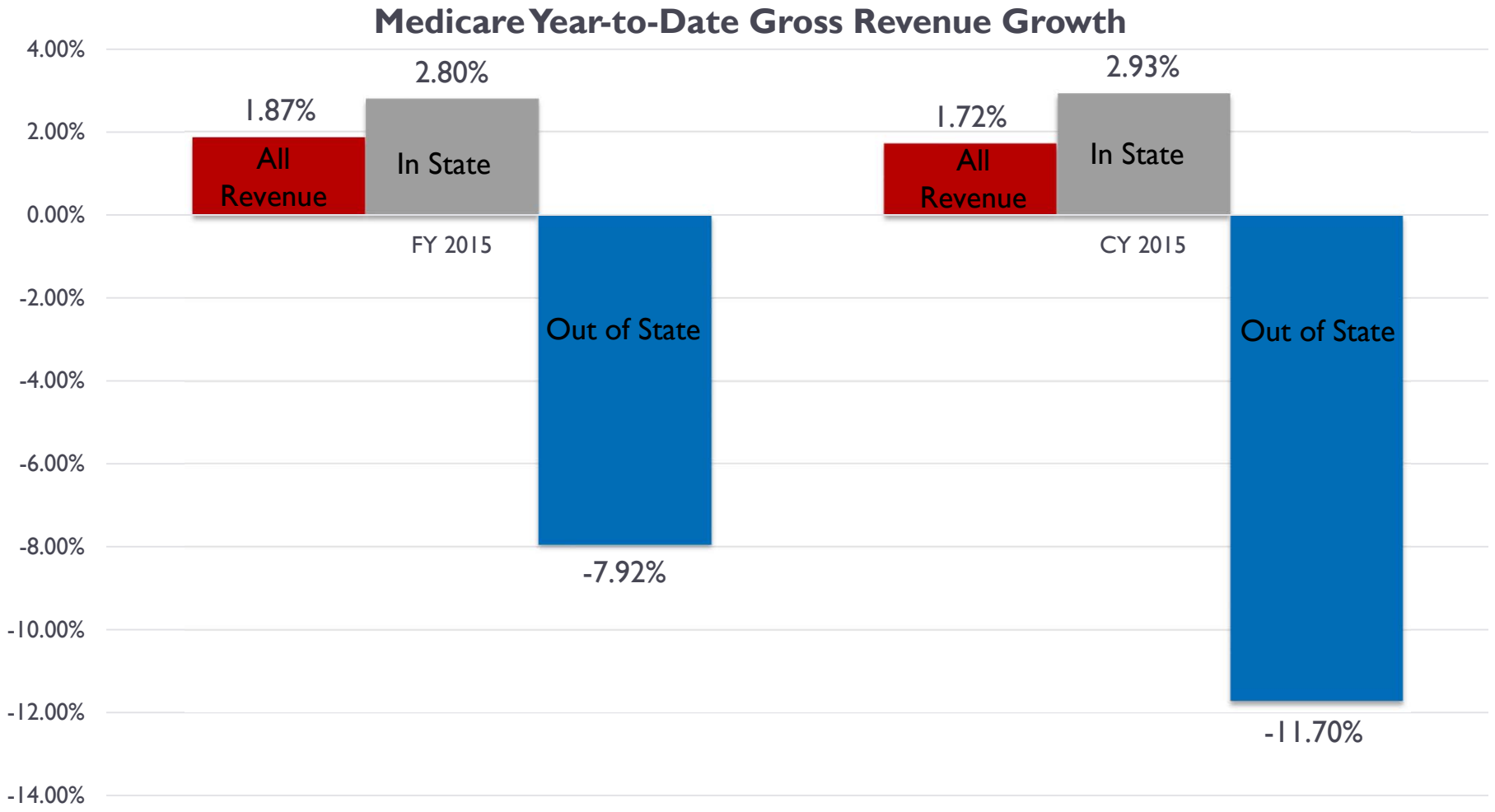
Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru March 2015) Compared to Same Period in Prior Year



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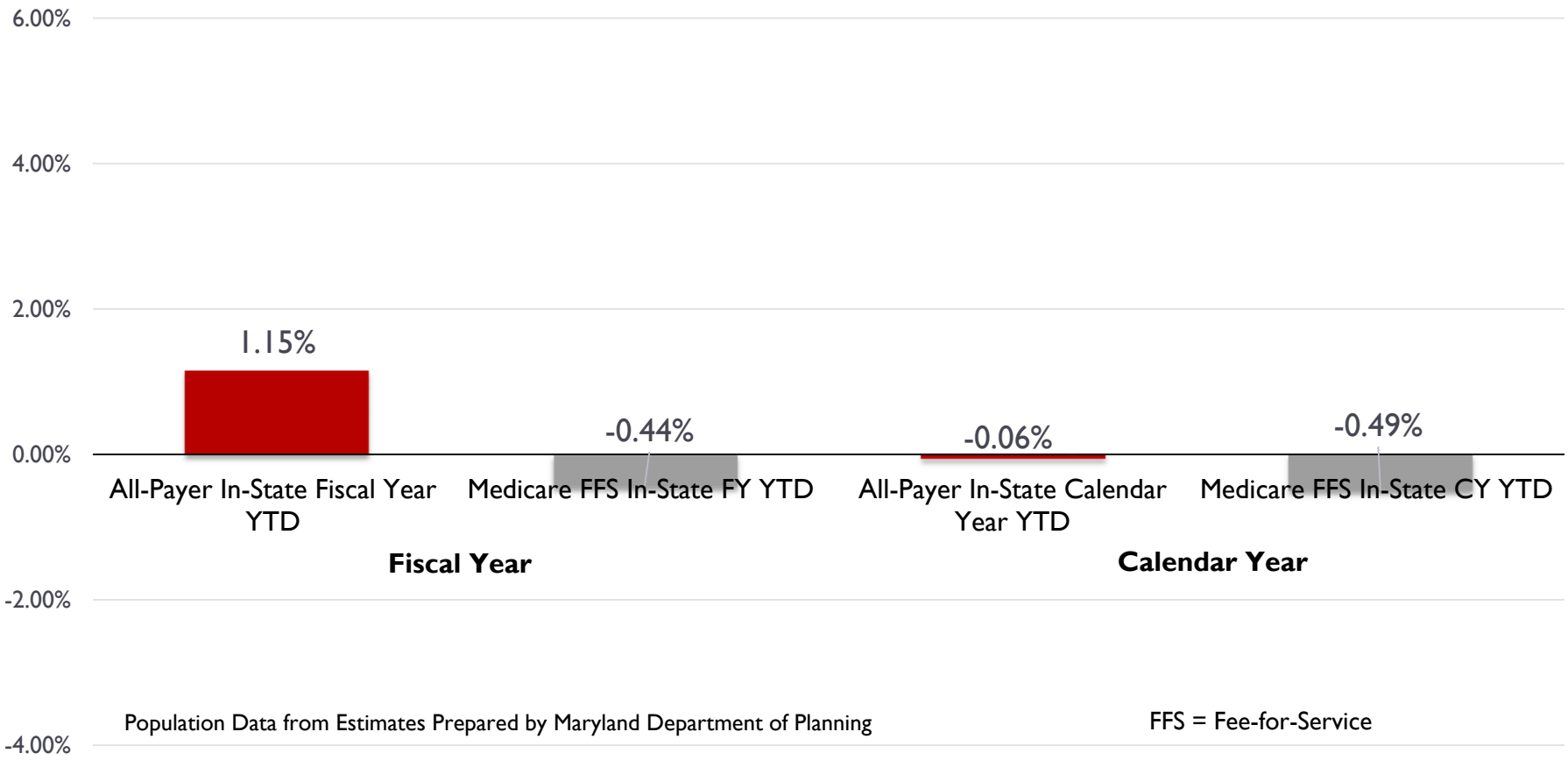
Per Capita Growth Rates
Fiscal Year 2015 and Calendar Year 2015



- **Calendar and Fiscal Year trends to date are below All-Payer Model Guardrail for per capita growth.**

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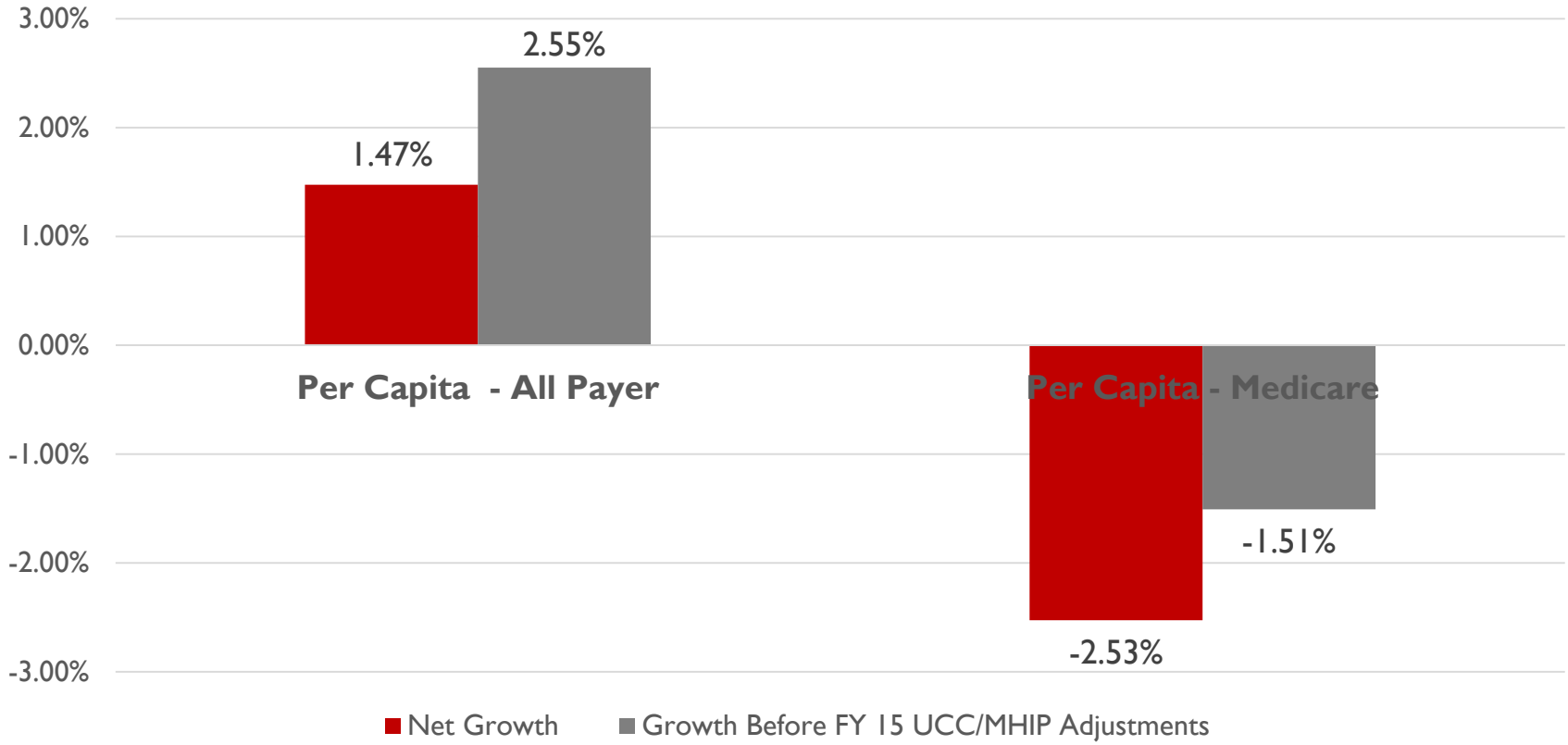
Per Capita Growth – Actual and Underlying Growth

CY 2015 Year to Date Compared to Same Period in Base Year (2013)



- Per capita growth rates distorted by the availability of only two months of CY 2015 data.
- Underlying growth reflects adjustment for FY 15 revenue decreases that were budget neutral for hospitals. 1.09% revenue decrease offset by reduction in MHIP assessment and hospital bad debts.

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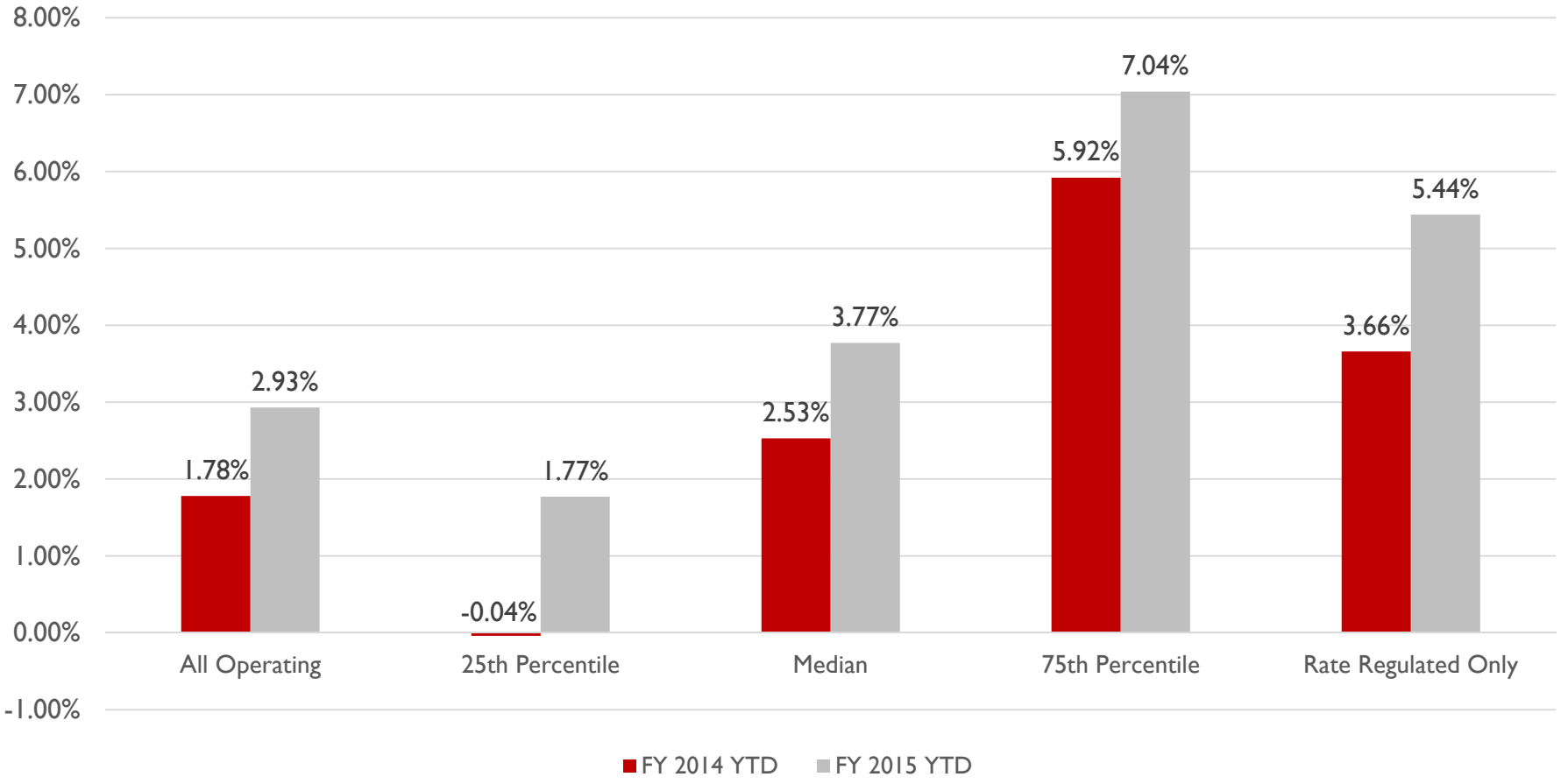
Operating Profits: Fiscal 2015 Year to Date (July-March) Compared to Same Period in FY 2014



- Year-to-Date FY 2015 hospital operating profits improved compared to the same period in FY 2014.

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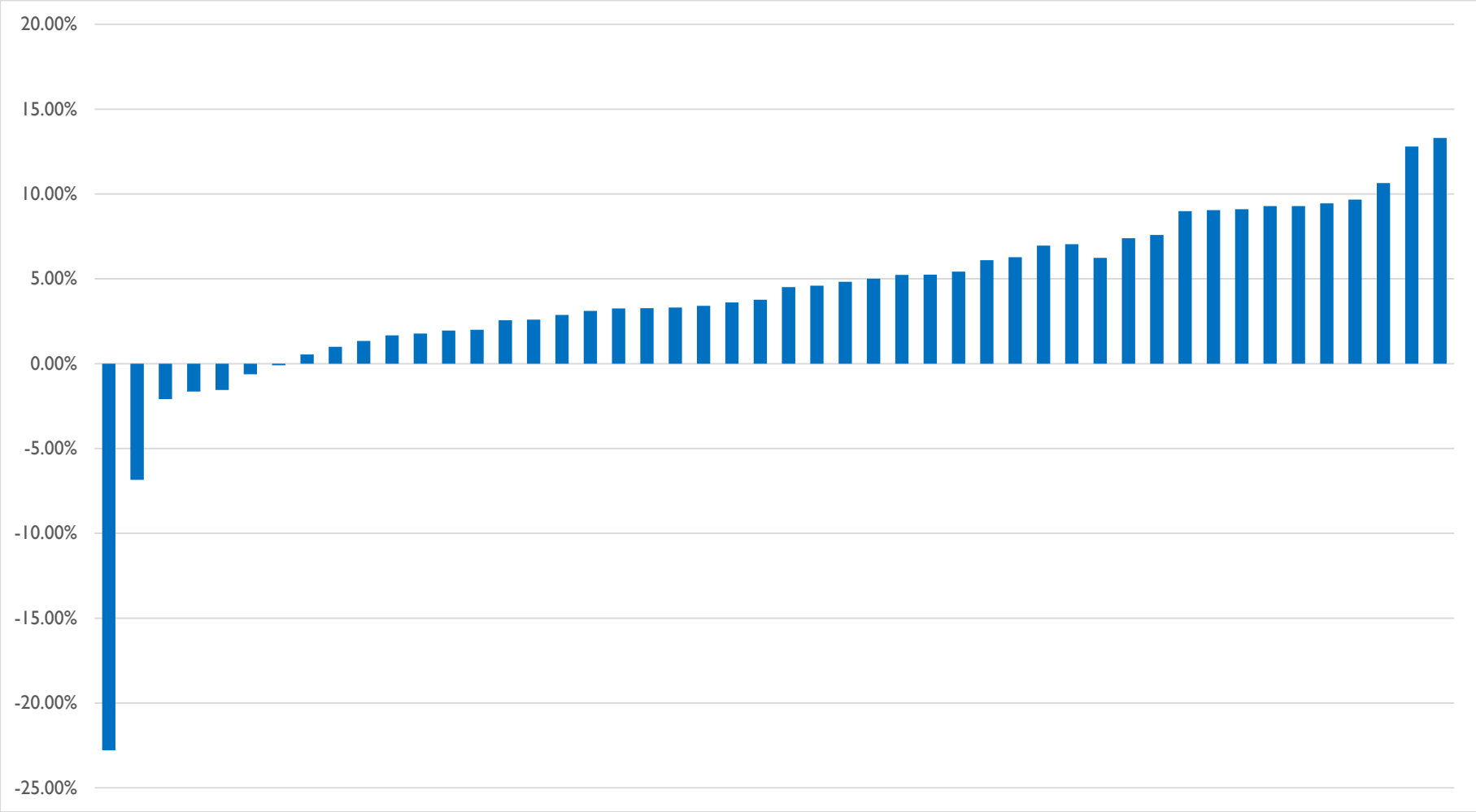
Operating Profits by Hospital

Fiscal Year to Date (July – March)



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Purpose of Monitoring Maryland Performance

Evaluate Maryland's performance against All-Payer Model requirements:

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 and Fiscal 2015 rely on Maryland Department of Planning projections of population growth of .64% for FY 15 and .56% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

Monitoring Maryland Performance
Quality Data

May 2015 Commission Meeting Update

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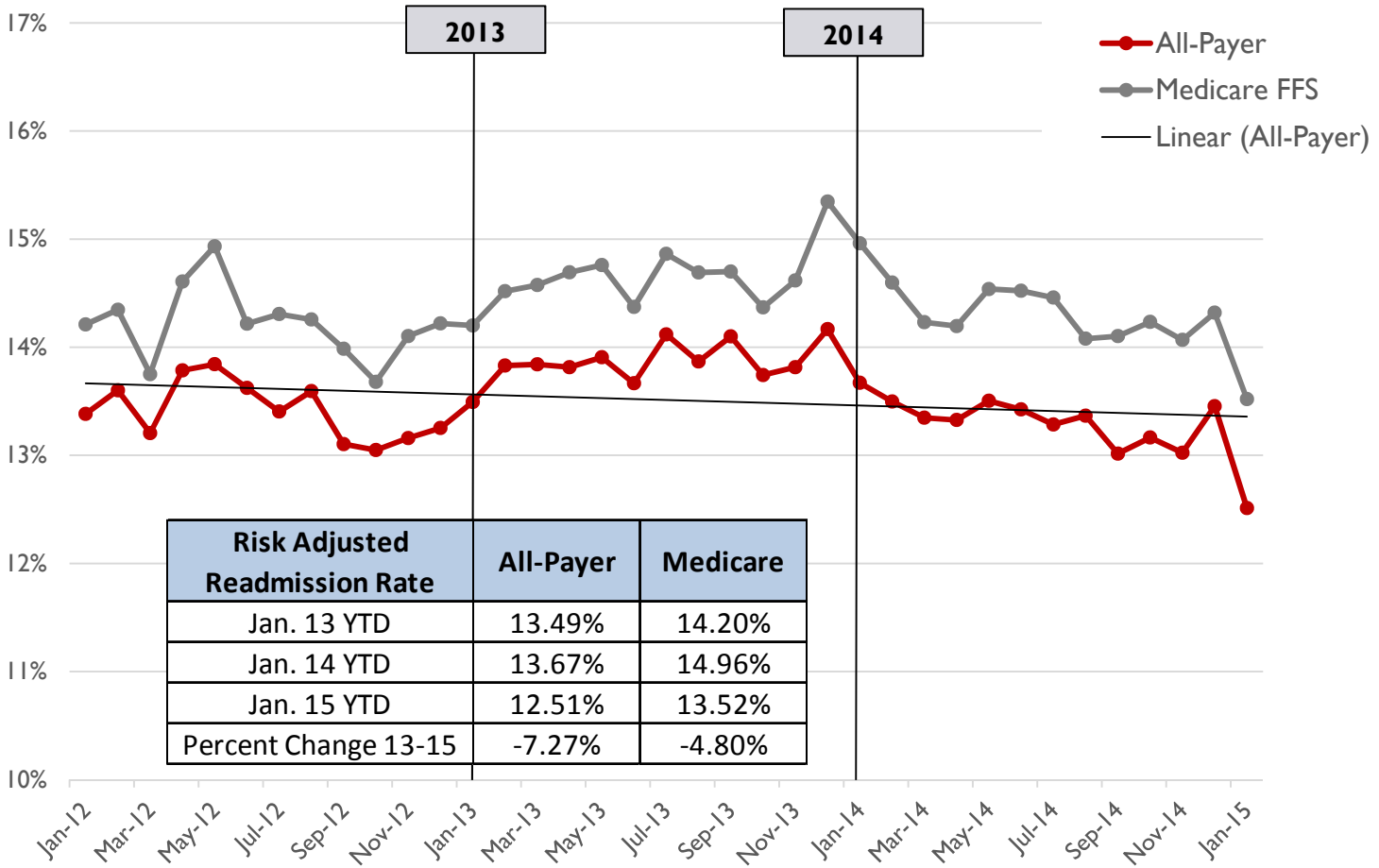
Health Services Cost Review Commission

Monthly Risk-Adjusted Readmission Rates



Risk Adjusted Readmission Rate	All-Payer	Medicare
Jan. 13 YTD	13.49%	14.20%
Jan. 14 YTD	13.67%	14.96%
Jan. 15 YTD	12.51%	13.52%
Percent Change 13-15	-7.27%	-4.80%

Note: Based on final data for January 2012 - December 2014, and preliminary data through February 2015.

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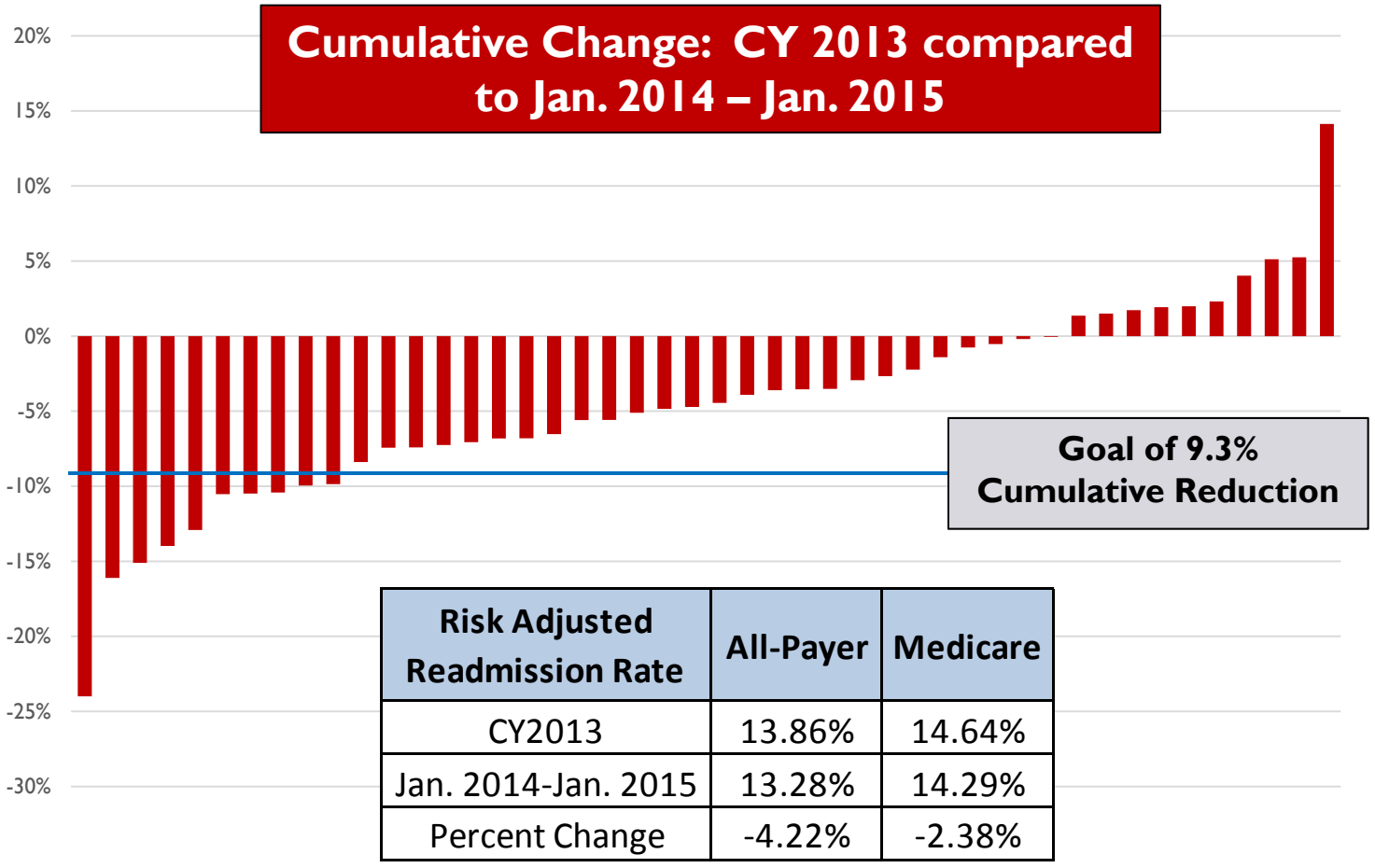
Change in All-Payer Risk-Adjusted Readmission Rates by Hospital



Risk Adjusted Readmission Rate	All-Payer	Medicare
CY2013	13.86%	14.64%
Jan. 2014-Jan. 2015	13.28%	14.29%
Percent Change	-4.22%	-2.38%

Note: Based on final data for January 2012 - December 2014, and preliminary data through February 2015.

Draft Recommendations for Balanced Update

May 13, 2015

HSCRC
Health Services Cost Review Commission

Balanced Update Model

Components of Revenue Change Linked to Hospital Cost Drivers/Performance

			Weighted Allowance
Adjustment for inflation/policy adjustments		A	2.40%
Adjustment for volume		B	0.57%
-Demographic Adjustment			
-Transfers ($1 M -$5 M impact)	0.1%		
-Categoricals			
-Market share adjustments ($4 M est. impact)			
Utilization Impact of Medicaid Expansion ($60 M)		C	0.38%
Infrastructure allowance provided		D	0.59%
- 0.40% included in GBR rates on 7/1/15 (Net .34% adjustment since TPR & non-global revenues are excluded))			
- Upto another 0.25% allocated via a competitive process in January 2016			
CON adjustments-			
-Opening of Holy Cross Germantown Hospital		E	0.21%
Net increase before adjustments		F = A + B+ C+ D + E	4.15%
Other adjustments (positive and negative)			
-Set aside for unknown adjustments		G	0.50%
-Reverse prior year's shared savings reduction		H	0.40%
-Positive incentives (Readmissions and Other Quality)		I	0.15%
-Shared savings/negative scaling adjustments		J	-0.60%
Net increase attributable to hospitals		K = F + G + H + I+ J	4.60%
Per Capita		L = (1+K)/(1+0.57%)	4.00%

Components of Revenue Change - Not Hospital Generated

-Uncompensated care reduction, net of differential	M	-0.84%
-MHIP (Assumes $0 MHIP in 2016)/2015 BRFA adjustment	N	-0.57%
Net decreases	O = M + N	-1.41%
Net revenue growth	P = K + O	3.19%
Per capita revenue growth	Q = (1+P)/(1+0.57%)	2.61%

Proposed Update Maintains Compliance with All-Payer Test

Compliance with All-Payer Test	A	B	C	D=(1+A)*(1+B)*(1+C)
	Actual Jan to June 2014	Staff Est. FY 2015	Proposed FY 2016	Cumulative Thru FY 2016
Maximum Per Capita Revenue Growth Allowance (E)	1.79%*	3.58%	3.58%	**9.21%**
Per Capita Growth for Period	0.57%**	1.99%	2.61%	**5.24%**
Per Capita Growth with Savings from Uncompensated Care and MHIP Declines (that do not adversely impact hospital bottom lines) removed (F)	0.57%	3.07%	4.00%	**7.80%**
Per Capita Difference Between Cap & Projection (G = E–F)				**1.41%**

Proposed Update is Aligned with FY 2016 Medicare Savings Goal

Comparison of Medicare Savings Goal to Staff Recommendation

Comparison to Modeled Requirements	All-Payer Maximum to Achieve Medicare Savings	Staff Recommended All-Payer Growth	Difference
Revenue Growth	3.45%	3.19%	-0.26%
Per Capita Growth	2.87%	2.61%	-0.26%

Summary of Recommendations

- Base Update
  - 2.4% for revenues under global budgets
  - 1.6% for revenues subject to waiver but excluded from global budgets
  - 1.9% for psychiatric hospitals and Mt. Washington Pediatric Hospital

- Infrastructure
  - Require all hospitals to submit multi-year plans for improving care coordination, chronic care, and provider alignment by December 1, 2015
  - 0.4% adjustment to FY 2016 GBR budgets to provide new infrastructure funding
  - Upto an additional 0.25% available through competitive awards to hospitals implementing or expanding innovative care coordination, physician alignment, and population health strategies.

- Medicaid Deficit Assessment
  - Calculate for FY 2016 at same total amount as FY 2015 and apportion it between hospital funded and rate funded in same total amounts as FY 2015.

Uncompensated Care

Summary of Recommendations

- Reduce uncompensated care provision in rates from 6.14% to 5.25% effective July 1, 2015.
- Re-use combined results of regression model and two years of historical data underpinning the FY 2015 UCC policy.
- Continue to collect data on write-offs and recoveries to better understand factors impacting UCC.
- Continue to collect data on outpatient denials to facilitate understanding of trends.
- Continue suspension of charity care adjustment indefinitely.
- Develop new UCC policy for FY 2017 that reflects patterns of uncompensated care observed in FY 2015 and projected for FY 2016.

Maryland Health Services Cost Review Commission

Market Shift Adjustments Update
05/13/2015

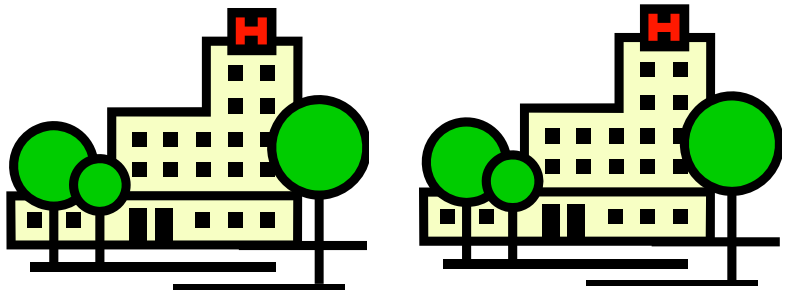
Two Overarching Principles

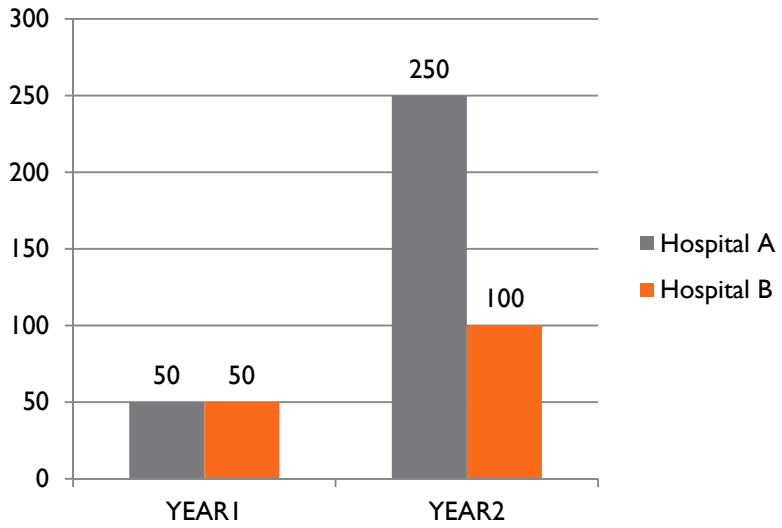
- Market shift adjustment should not undermine the incentives to reduce avoidable utilization
  - Separate shifts from utilization increase
- Market shift adjustment should provide necessary resources for services shifted to another hospital
  - Money follows the patient

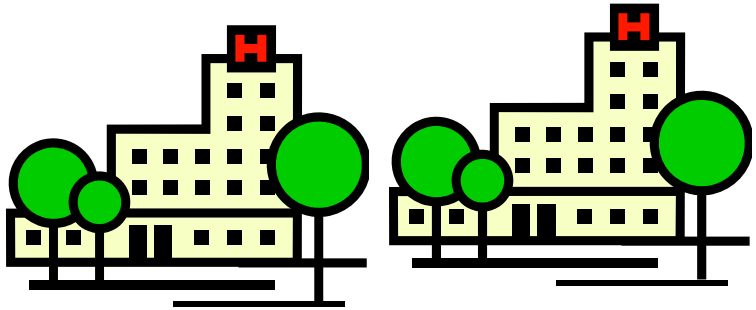
Volume Adjustments under Global Budgets

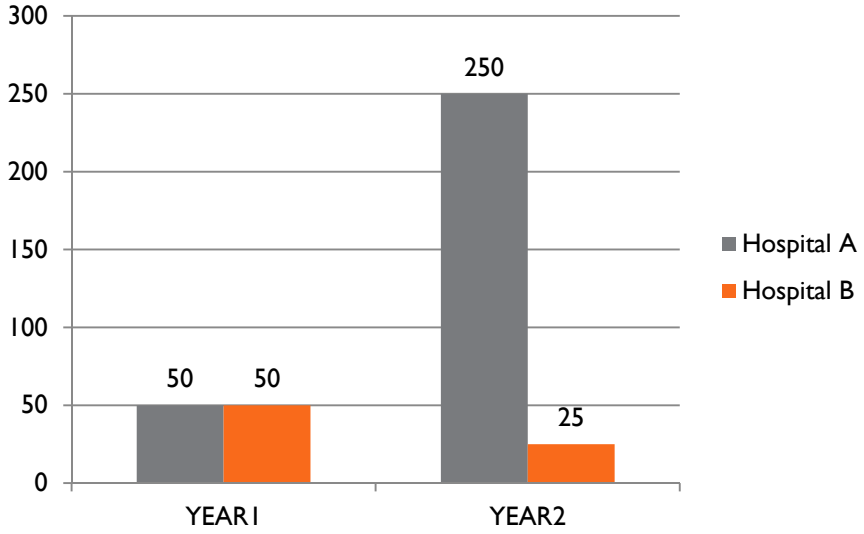
- Demographic adjustment: Population growth and aging
- Utilization increases due to ACA: Medicaid Expansion
- Transfer adjustments: Complex Patients transferred to Academic Medical Centers
- Market Shift: Shifts between acute care MD hospitals for services provided to MD residents
- Out of state utilization
- Changes in services provided
- Shifts to unregulated settings

Market Share vs. Market Shift









Calculation of Costs

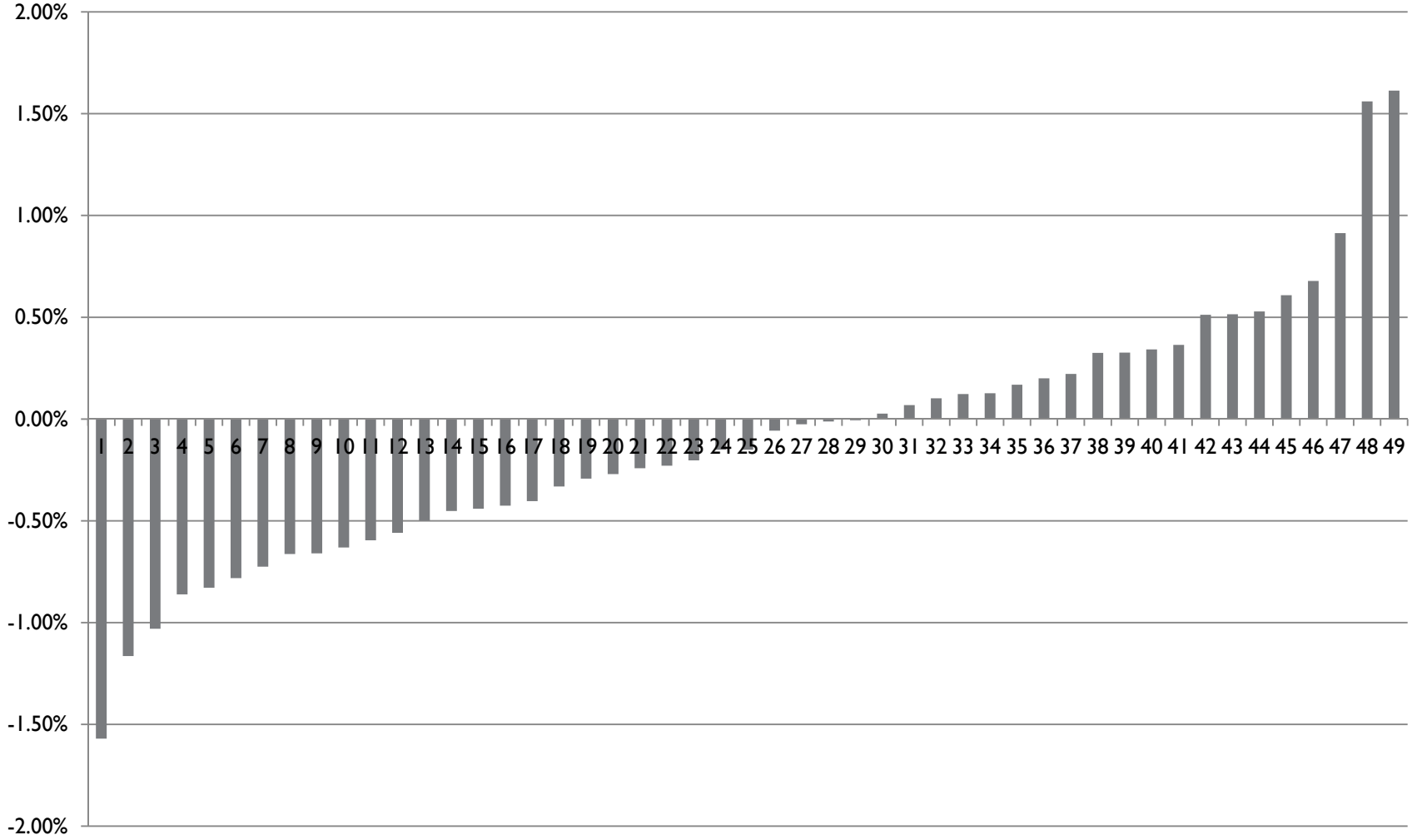
Market Shift *Average Cost*50% Variable Cost Factor*Price Inflator

- Average Cost Options:
  - Option 1: Hospital Overall Average Cost per ECMAD
    - Range=$19,069-$10,456
  - Option 2: Hospital Service Line Specific Cost per ECMAD

Statewide Impact-Preliminary Data

Statewide Impact	1.Market Shift Adjustment Using Hospital Average Charge	3.Market Shift Adjustment Using Hospital Service Line Specific Average	Difference From Hospital Average
A	B	C	D=C-B
Grand Net Total	**-$792,587**	**$524,359**	**$1,316,946**
Positive Adjustment Total	$31,214,203	$30,689,285	$3,831,250
Negative Adjustment Total	-$32,006,790	-$30,164,926	-$2,514,303
Absolute Adjustment Total	$63,220,992	$60,854,210	$6,345,553

Preliminary Hospital Level Impact as % of Revenue



Not Undermining GBR Incentives

- Exclude Potentially Avoidable Utilization
  - Readmissions, Prevention Quality Indicators (PQIs)

- Limit market shift to the lesser of loses or gains

Loses<Gains	Loses>Gains
Loses=100 Admissions	Loses=200 admissions
Gains=200 Admissions	Gains=100 admissions
Market Shift Adjustment=+100	Market Shift Adjustment=+100

Money Follows the Patient

- Included observation stays with 24 hours or greater to inpatient counts
- Service Specific calculations
  - eg. shifts in orthopedic surgery are calculated independently from cardiac surgery
- Zip code level calculations
  - County level aggregation for low population density, concentrated markets
    - Garrett, Allegany , Washington, Carroll, Cecil, Kent, Queen Anne's, Caroline, Talbot , Dorchester, Wicomico, Somerset, Calvert, Charles, Saint Mary's, Worcester, Frederick, Harford

Market Shift Adjustment Timing

- Prospective Adjustments
  - Prior notifications for planned changes
- Annual calculations
  - FY2016 : July 2014-Dec 2014
  - FY2017: Jan 2015-Dec 2015

Recommended Regional Planning Grants Awards for Regional Partnerships for Health System Transformation

May 13, 2015

DHMH and HSCRC

Consent Calendar of Awards

Regional Group Name	Award Amount	Lead Hospital
Trivergent Health Alliance	$ 133,334	Western Maryland Health System
	$ 133,333	Frederick Regional Health System
	$ 133,333	Meritus Medical Center
Bay Area Tranformation Partnership	$ 400,000	Anne Arundel Medical Center
Howard County Regional Partnership for Health System Transformation	$ 200,000	Howard County General Hospital
U of M Upper Chesapeake Health and Hospital of Cecil County Partnership	$ 200,000	University of Maryland Upper Chesapeake
Total	**$ 1,200,000**	

Other Recommended Proposals

Regional Group Name	Award Amount	Lead Hospital
Regional Planning Community Health Partnership	$ 400,000	Johns Hopkins Hospital(s)
Baltimore Health System Transformation Partnership	$ 400,000	University of Maryland Medical Center
NexusMontgomery	$ 300,000	Holy Cross Hospital
Southern Maryland Regional Coalition for Health System Transformation	$ 200,000	Doctors Community Hospital
Total	**$ 1,300,000**	