Performance Measures	Targets	CY 2014 Results
All-Payer Revenue Growth	≤ 3.58% per capita	1.47% per capita
Medicare Savings in Hospital Expenditures	≥ $330m over 5 years	$116m in Year 1
Medicare Savings in Total Cost of Care	Lower than the national average	1.5% lower than the national average
All-Payer Quality Improvement Reductions in PPCs under MHAC Program	30% reduction over 5 years	26% reduction in Year 1
Readmissions Reductions for Medicare	≤ National average over 5 years	0.21% gap decrease between Maryland & the Nation
Hospital Revenue to Global or Population-based	≥ 80% by Year 5	> 95% in Year 1

Monitoring Maryland Performance

Financial Data

Year to Date thru 2015

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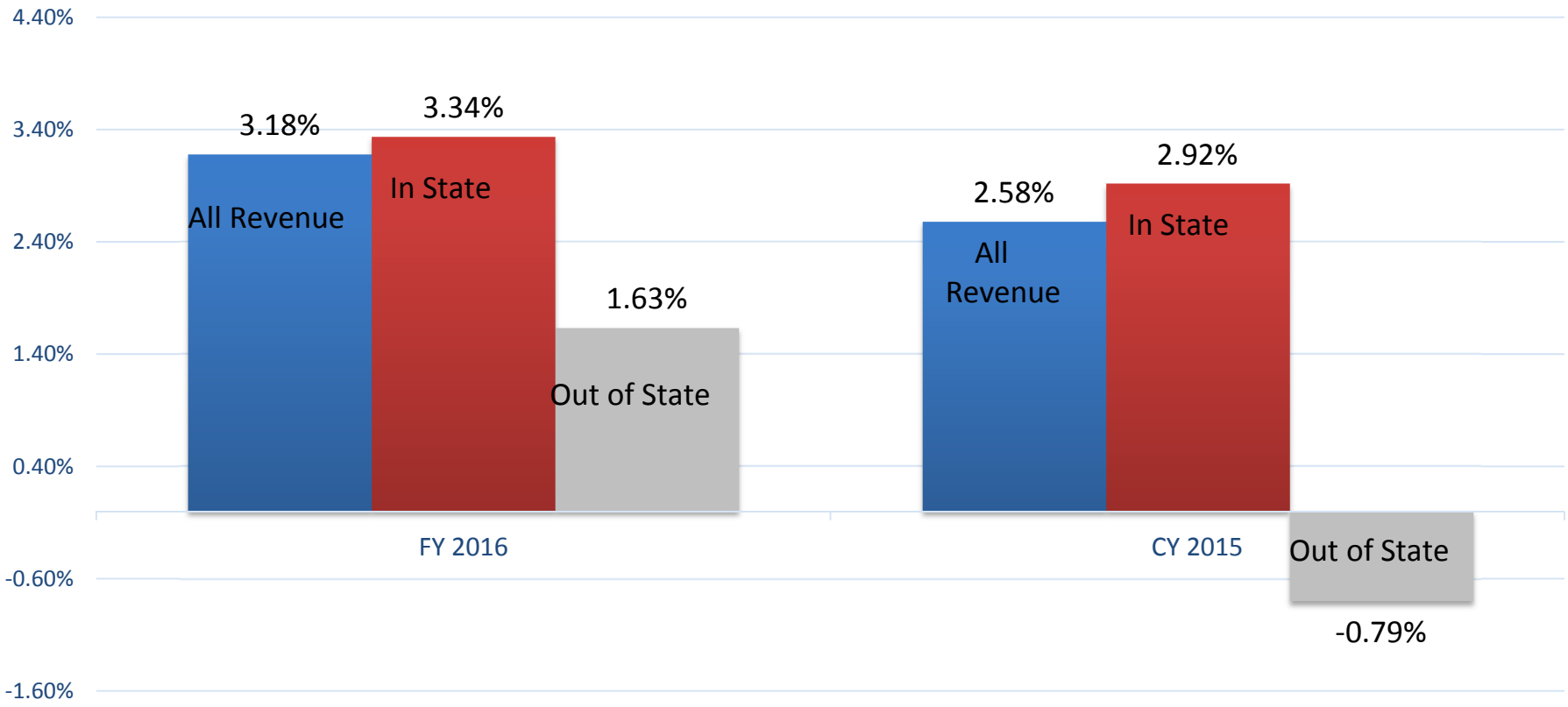
Gross All Payer Revenue Growth

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



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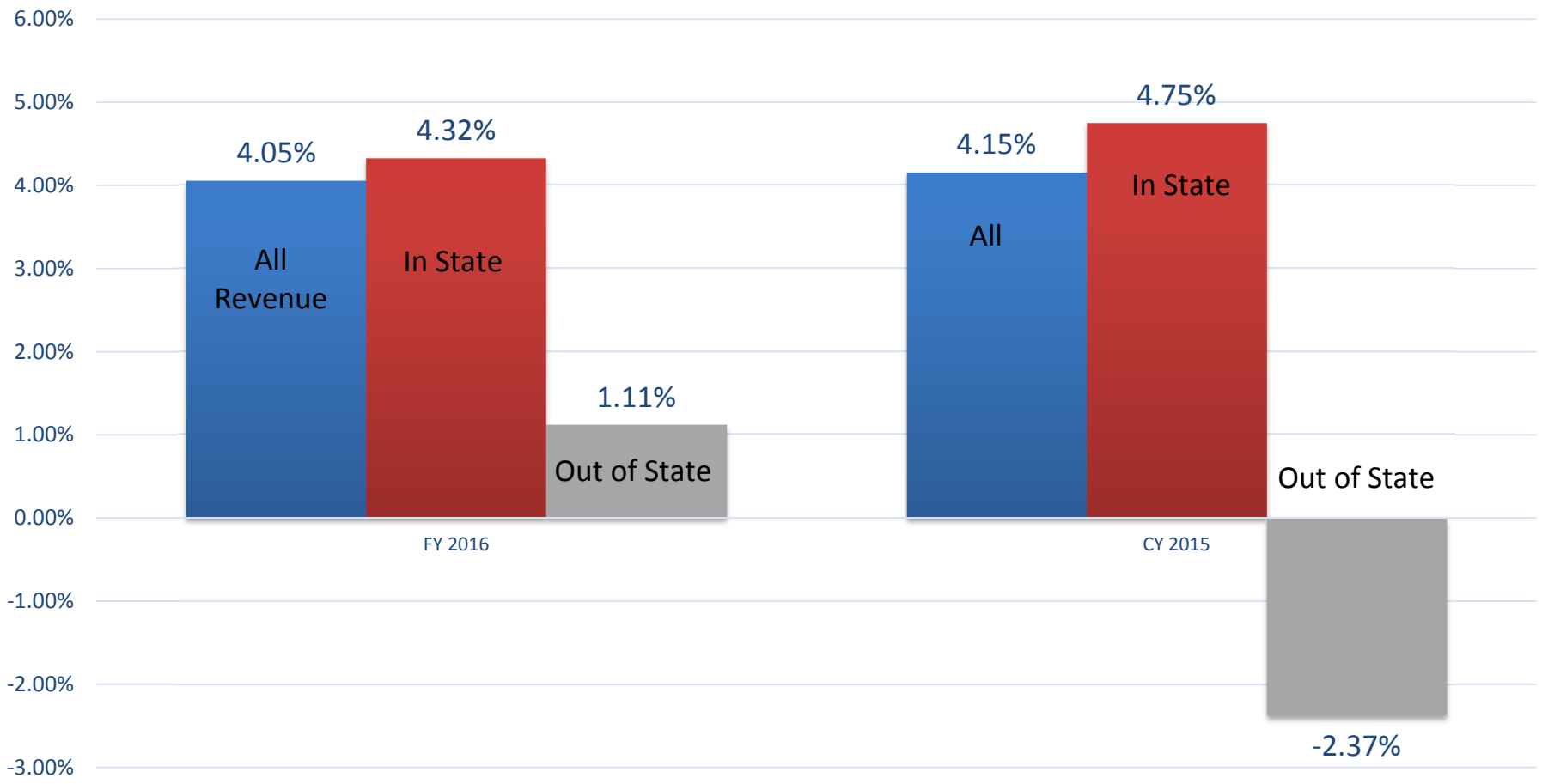
Gross Medicare Fee-for-Service Revenue Growth

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



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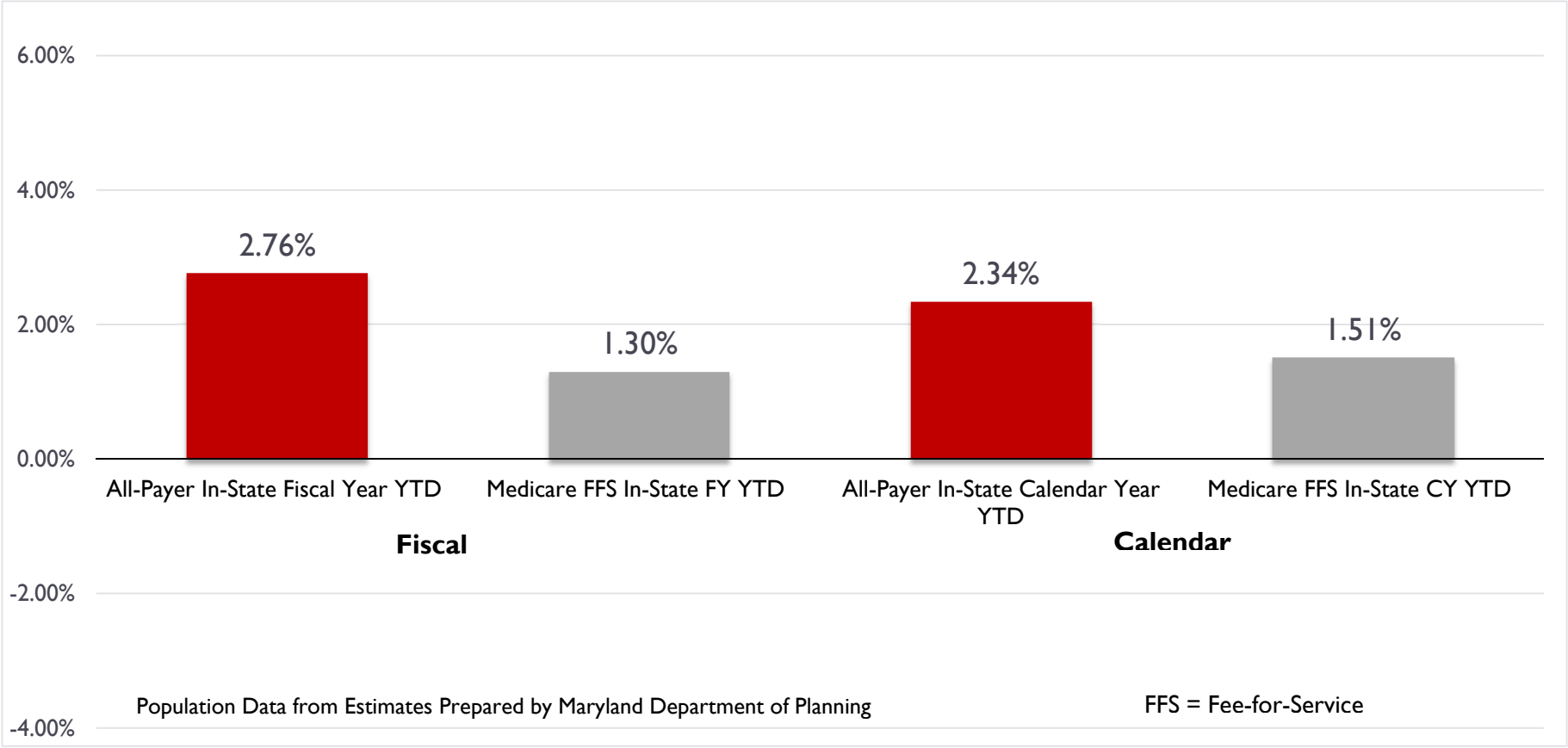
Per Capita Growth Rates
Fiscal Year 2016 and Calendar Year 2015



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

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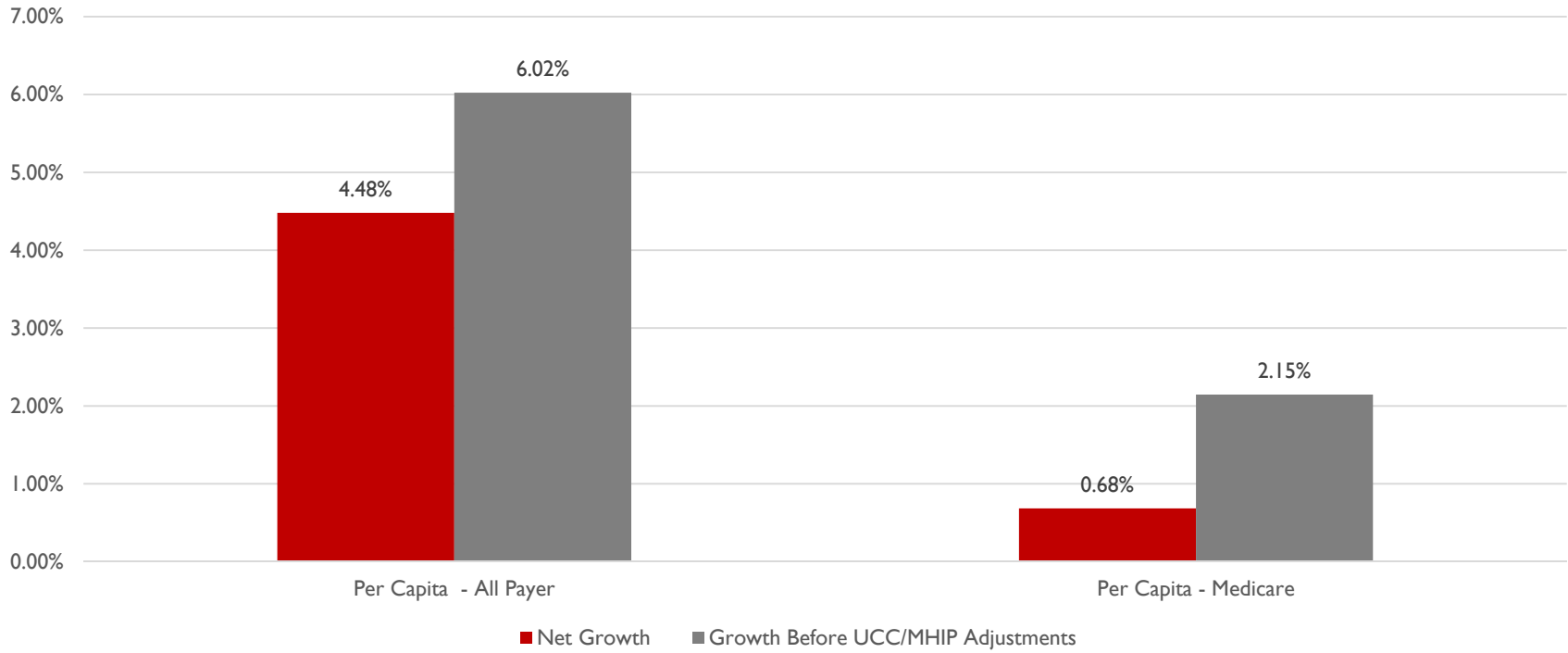
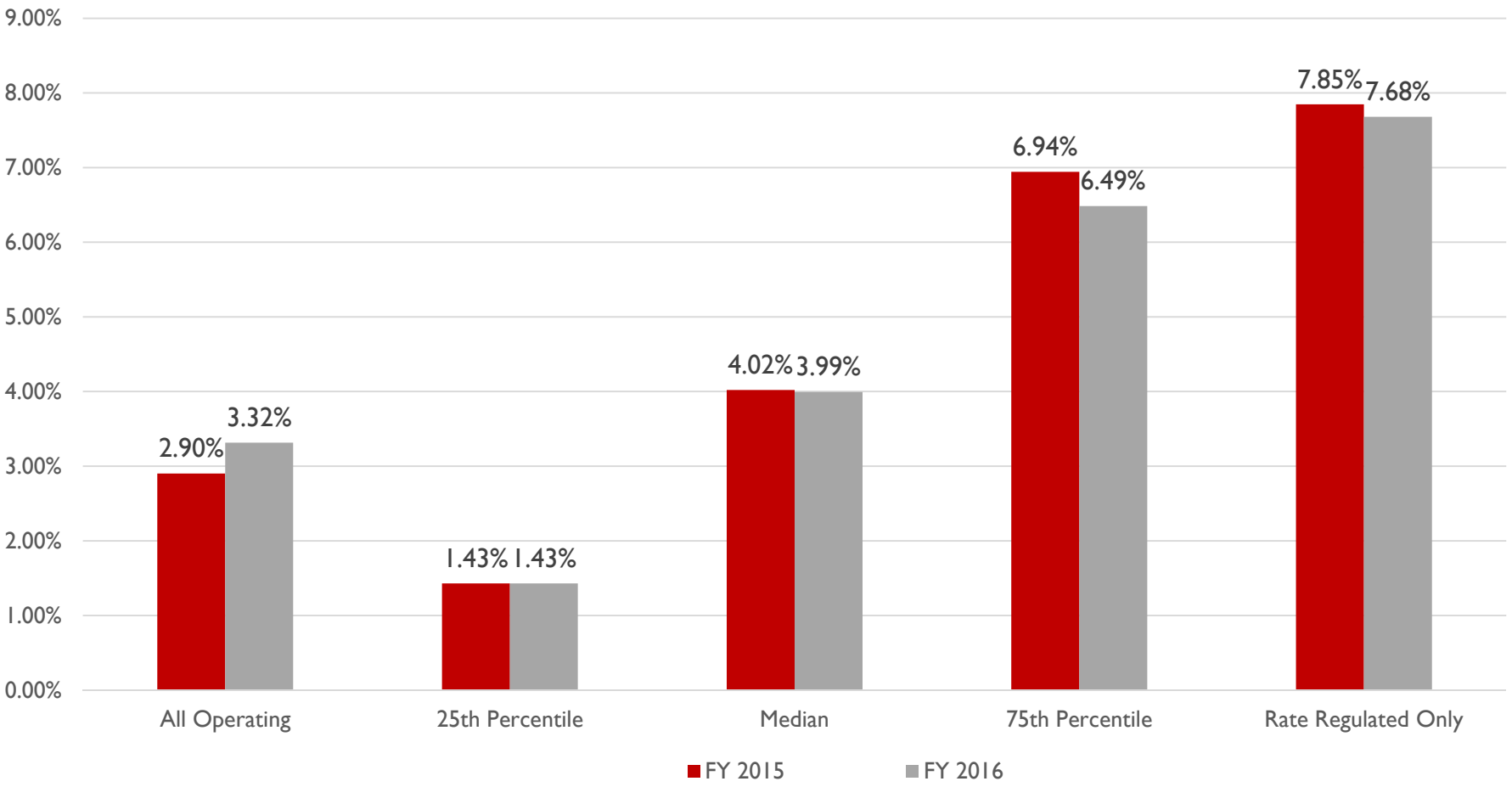
Per Capita Growth – Actual and Underlying Growth

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



- Two year per capita growth rate is well below maximum allowable growth rate of 7.29% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY 15 & FY 16 revenue decreases that were budget neutral for hospitals. 1.09% decrease from MHIP assessment and hospital bad debts in FY 15. Additional 1.41% adjustment in FY 16 due to further reductions to hospital bad debts and elimination of MHIP assessment.

Operating Profits: Fiscal 2016 Year to Date (July-September) Compared to Same Period in FY 2015



- Year to date FY 2016 unaudited hospital operating profits shows little change compared to the same period in FY 2015.

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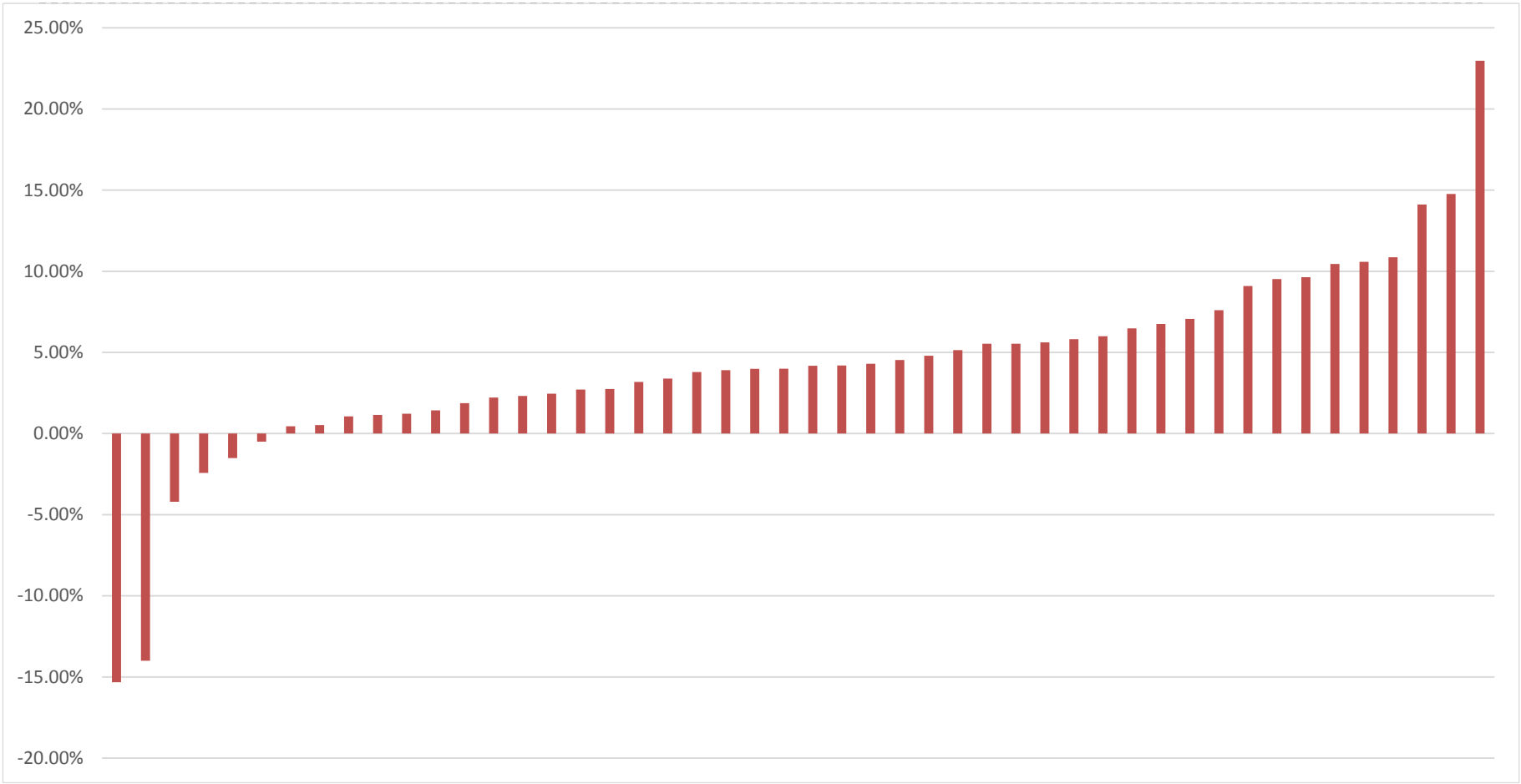
Operating Profits by Hospital

Fiscal Year to Date (July – September)



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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

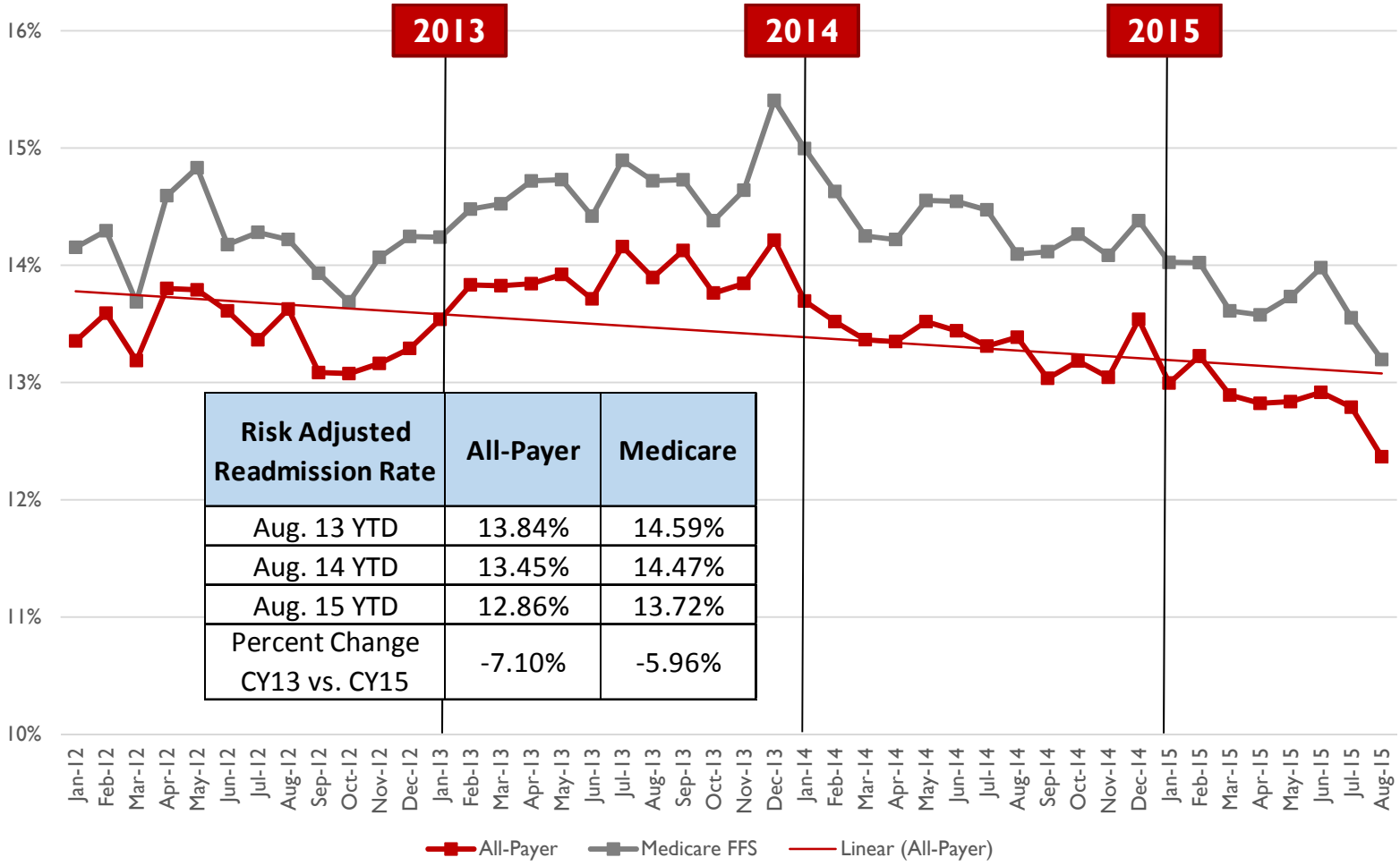
Data Caveats

- 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 2016 rely on Maryland Department of Planning projections of population growth of .56% for FY 16 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

November 2015 Commission Meeting Update

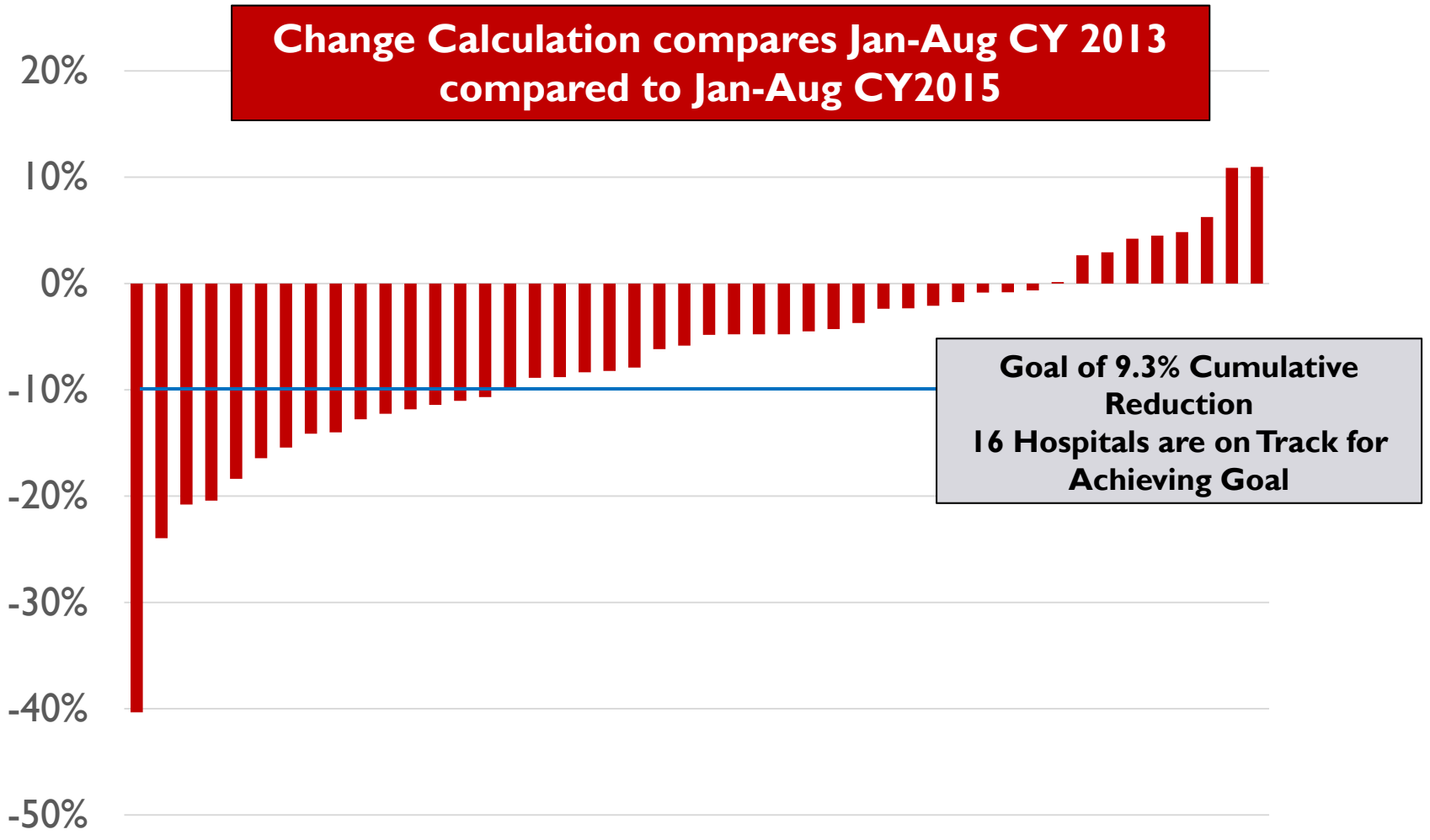
Monthly Risk-Adjusted Readmission Rates



Risk Adjusted Readmission Rate	All-Payer	Medicare
Aug. 13 YTD	13.84%	14.59%
Aug. 14 YTD	13.45%	14.47%
Aug. 15 YTD	12.86%	13.72%
Percent Change CY13 vs. CY15	-7.10%	-5.96%

Note: Based on final data for January 2012 – June 2015, and preliminary data through September 2015.

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



Note: Based on final data for January 2012 – June 2015, and preliminary data through September 2015.

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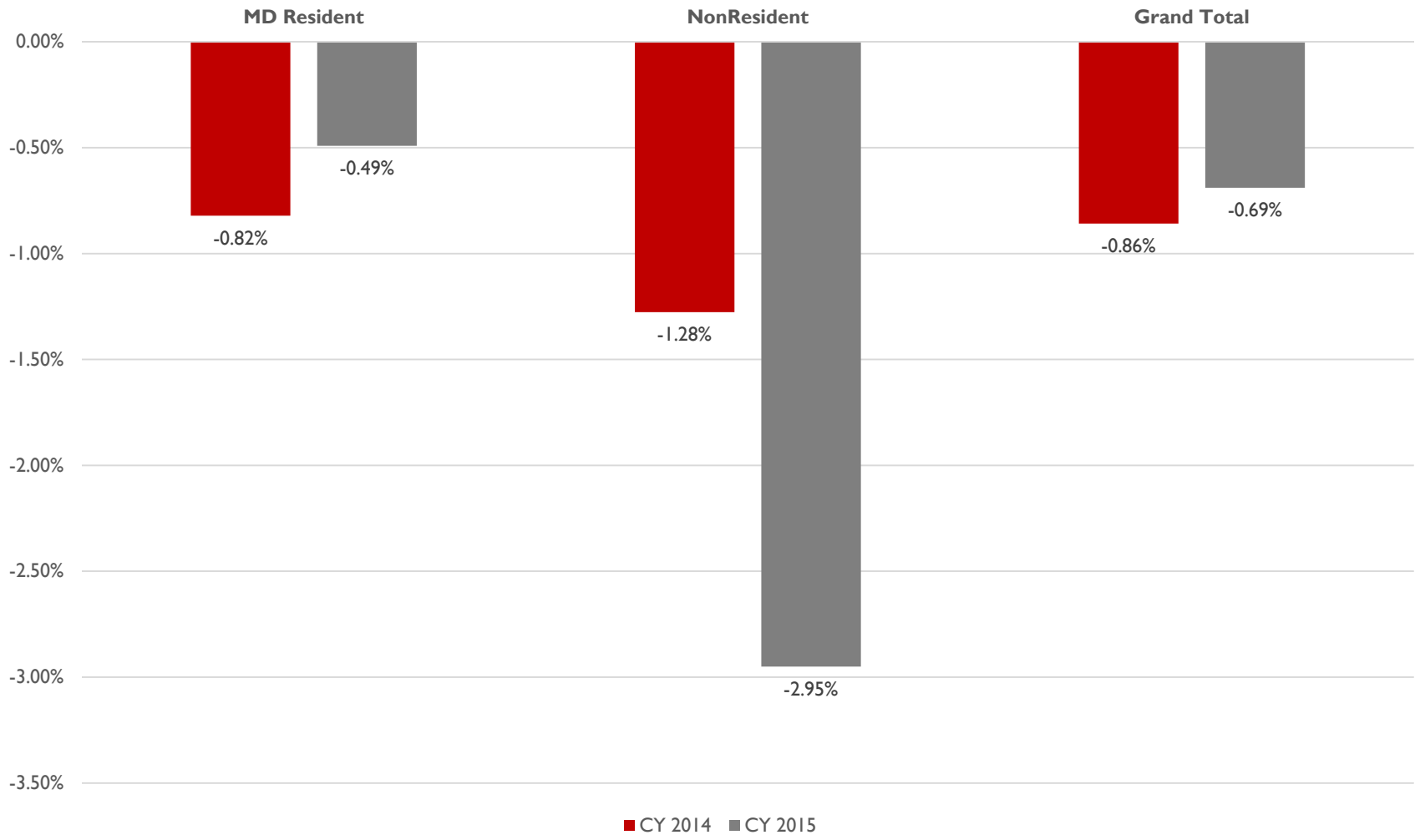
Monitoring Maryland Performance
Preliminary Utilization Trends

Year to Date thru August 2015

All Payer ECMAD GROWTH - Calendar Year to Date (thru August 2015) Compared to Same Period in Prior Year



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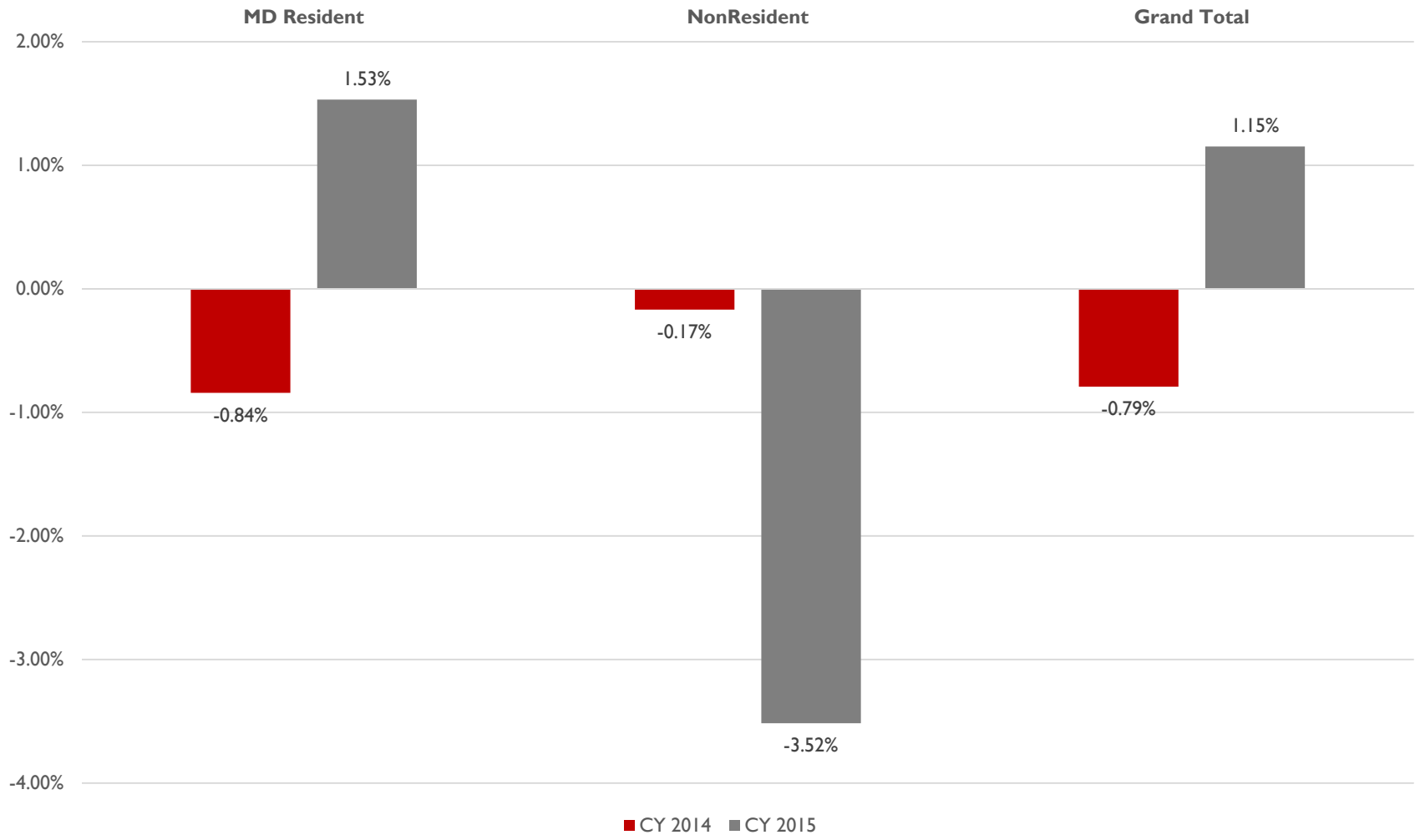
Medicare ECMAD GROWTH - Calendar Year to Date (thru August 2015) Compared to Same Period in Prior Year



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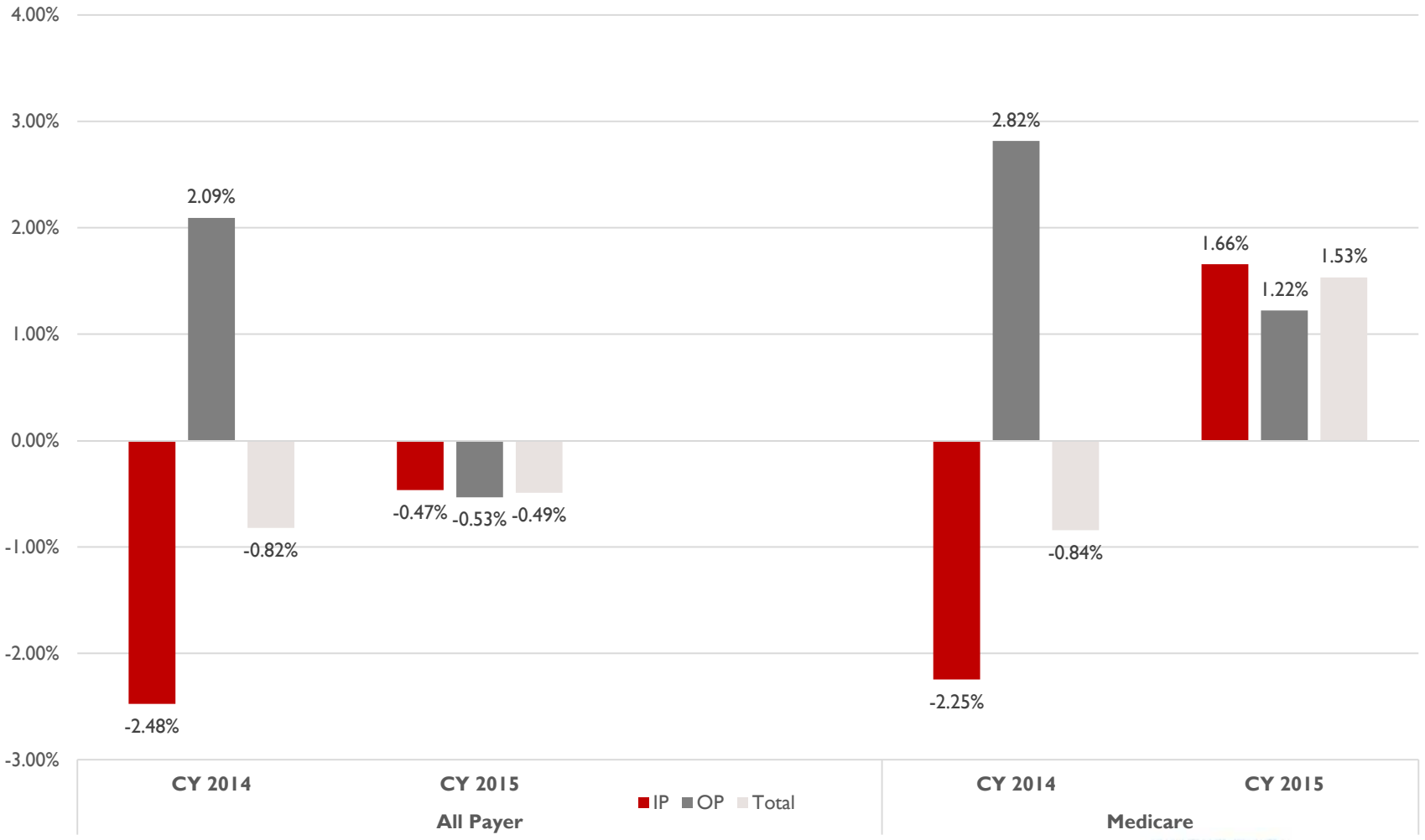
MD Resident ECMAD GROWTH by Location of Service - Calendar Year to Date (thru August 2015) Compared to Same Period in Prior Year



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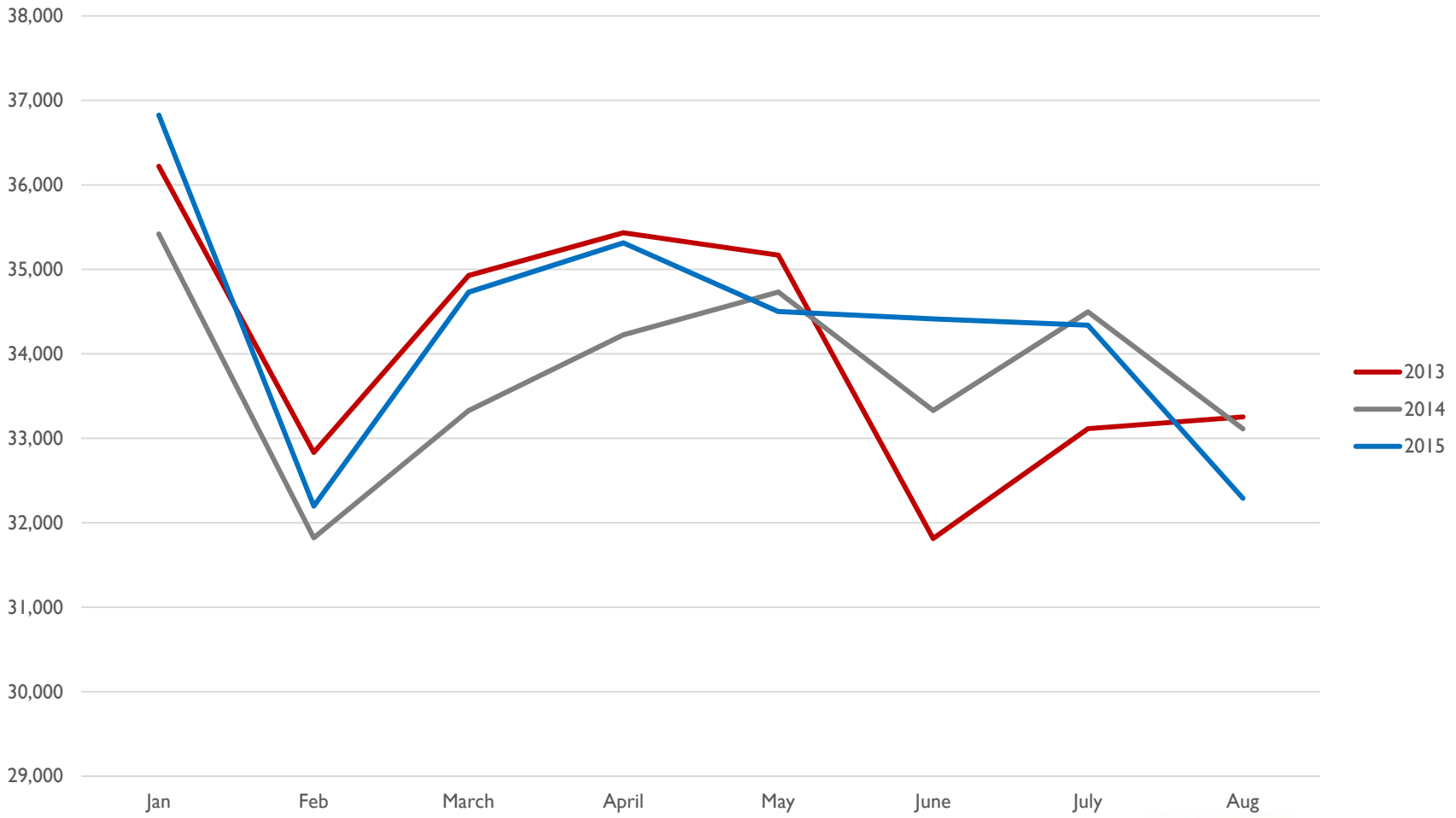
Medicare MD Resident ECMAD GROWTH by Month



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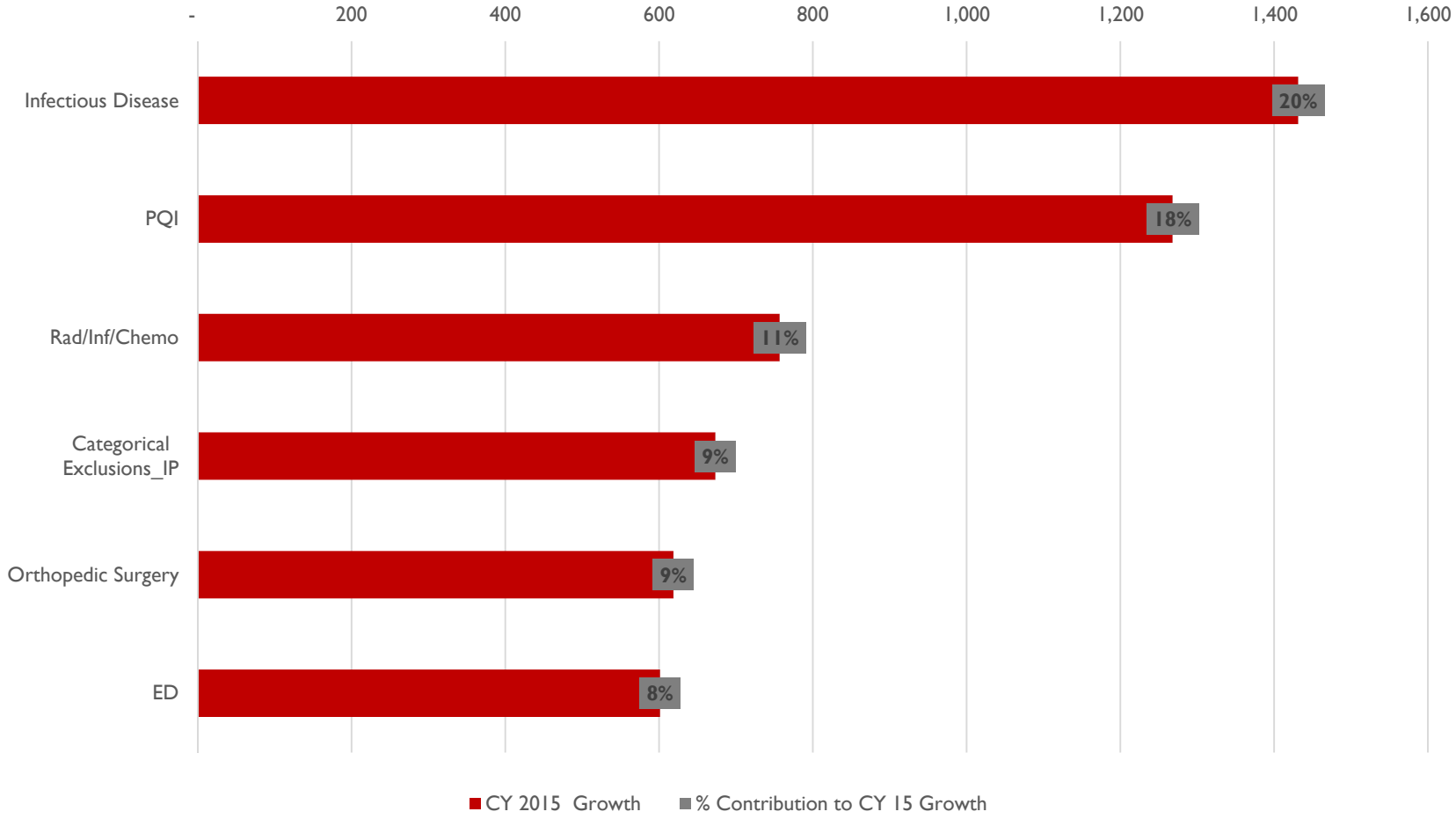
Medicare MD Resident ECMAD Growth by Service Line
Calendar Year to Date ECMAD Growth (thru August)



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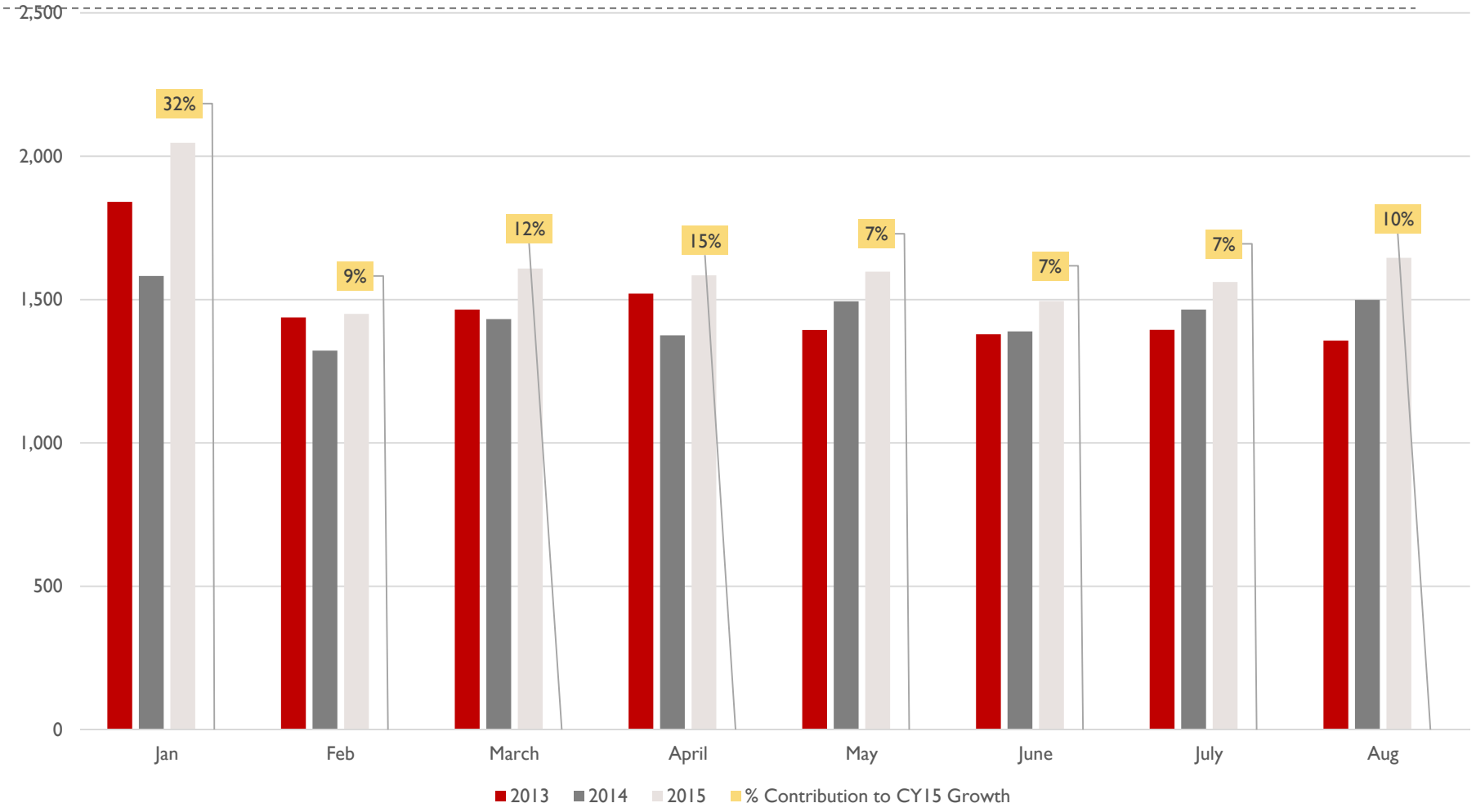
Medicare MD Resident Infectious Disease Service Line ECMAD GROWTH by Month



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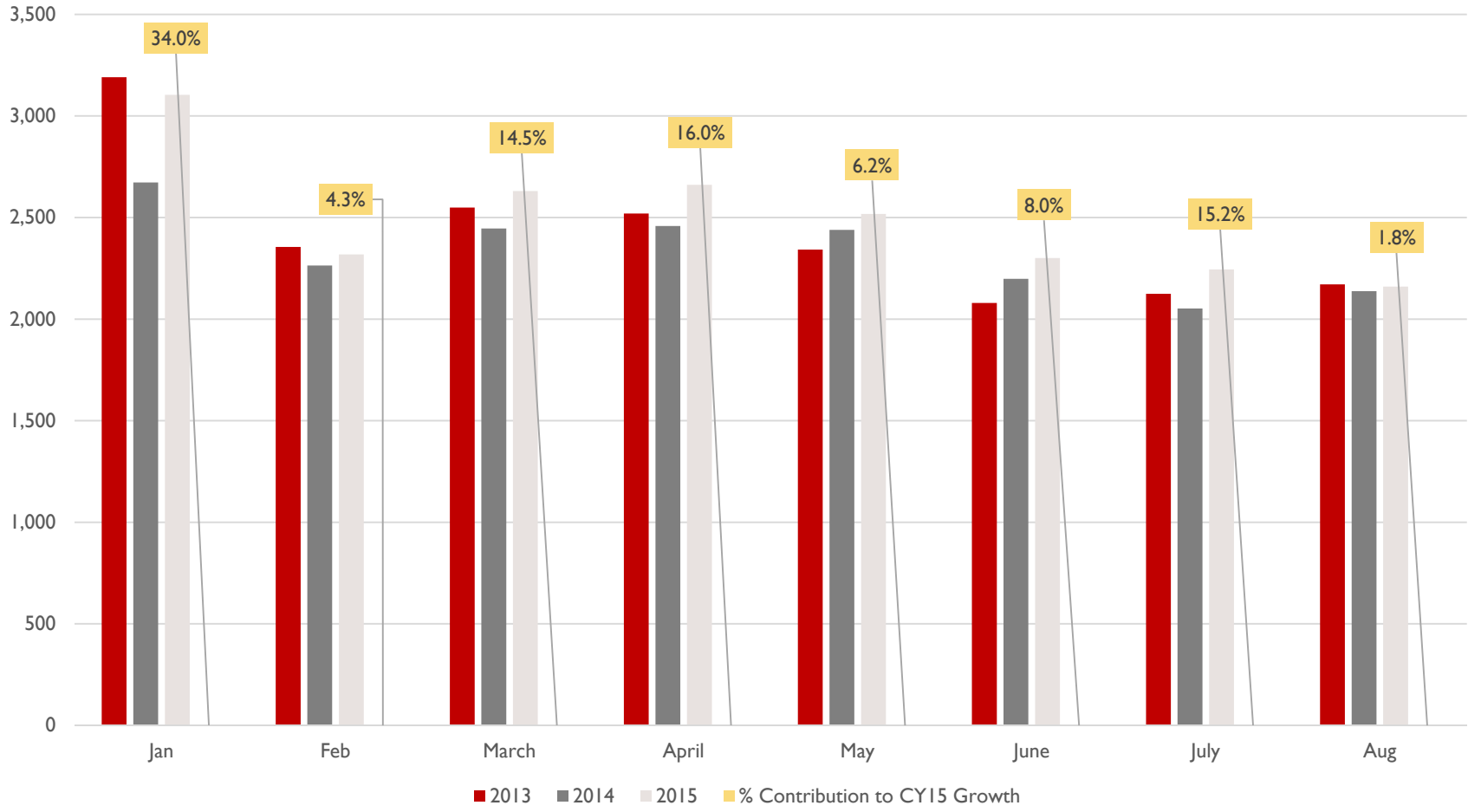
Medicare MD Resident PQI Service Line ECMAD GROWTH by Month



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Utilization Analytics – Data Notes

- Utilization as measured by Equivalent Case-mix Adjusted Discharges (ECMAD)
  - 1 ECMAD Inpatient discharge=1 ECMAD Outpatient Visit
- Observation stays with more than 23 hour are included in the inpatient counts
  - IP=IP + Observation cases >23 hrs.
  - OP=OP - Observation cases >23 hrs.
- Preliminary data, not yet reconciled with financial data
- Careful review of outpatient service line trends is needed
- Tableau Visualization Tools

Service Line Definitions

- Inpatient service lines:
  - APR DRG to service line mapping
  - Readmissions and PQIs are top level service lines (include different service lines)
- Outpatient service lines:
  - Highest EAPG to service line mapping
  - Hierarchical classifications (ED, major surgery etc)
- Market Shift technical documentation

Performance Measurement Workgroup Update

HSCRC Commission Meeting 11/18/2015

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Reviewed Guiding Principles For Performance-Based Payment Programs

- Program must improve care for all patients, regardless of payer
- Program incentives should support achievement of all payer model targets
- Program should prioritize high volume, high cost, opportunity for improvement and areas of national focus
- Predetermined performance targets and financial impact
- Hospital ability to track progress
- Encourage cooperation and sharing of best practices
- Consider all settings of care

RY2018 Readmission Reduction Incentive Program Update Considerations

- Measure updates (e.g., planned admissions definitions, transfer logic)
- Medicare versus all payer rates
- Consideration of non-Maryland peer group rates
- Improvement target
- Payment adjustment structure and amounts
- Adjustments/protections based on socio-economic and other factors
- Draft recommendation in January 2016 and Final in February 2016

RY2018 MHAC Update Considerations

- Analysis of statistical validity and reliability and small hospital, small cell size issues
- Evaluation of PPC tier groups
- Setting the statewide target
- Maximum at risk determination
- Monitoring of ICD-10 Impact
- Draft recommendation in December 2015 and final in January 2016

Potentially Avoidable Utilization Measure

- Expanding the definition to other areas (9 Months)
  - Nursing home admissions
  - High risk patient utilization
  - Sepsis admissions
  - Avoidable Emergency Department Visits
- Risk adjusted measure of PAUs (18 months)

Efficiency Measure Considerations

- Measurement of Total Cost of Care (need all payer claims)
- Risk Adjustment
  - Demographics (Age, Sex, Social/economic factors)
  - Risk Adjustment Methodology
- Denominator
  - Virtual Patient Service Area
- Out of State Utilization Adjustment
- Benchmarks
- Timelines
  - Per Case measure revisions (next 3 months)
  - Per Capita Hospital Cost (next 9 months)
  - Per Capita Total Cost (next 18 months)

Key Strategic Considerations

- Prioritization
  - Leverage IT tools and measures
  - Use existing data and measures if possible
- Care coordination
  - Measures must be developed/adopted
  - Consider measures that are important to patients (functional status, quality of life)
- Condition-specific bundles
  - Target high cost, common procedures
  - Cut across measurement domains and settings of care
  - Consider "value"