State of Maryland
Department of Health and Mental Hygiene

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

October 12, 2016

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

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

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

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

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

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

I am pleased to submit to you with the fourth Monitoring of Maryland's All-Payer Model Biannual Report, prepared under Section 19-207(b)(9) of the Health-General Article of the Annotated Code of Maryland. This report discusses the State's progress during the period from April 1, 2016 through September 30, 2016, which encompasses through the third quarter of the third year of Maryland's new agreement with the Center for Medicare & Medicaid Innovation (CMMI).

Effective January 1, 2014, the State of Maryland and CMMI entered into a new initiative to modernize Maryland's unique all-payer rate-setting system for hospital services. This initiative 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://www.hscrc.maryland.gov

Please contact me if you have any questions about this report, or you may contact Erin Schurmann at erin.schurmann@maryland.gov.

Sincerely,

Donna Kinzer
Executive Director

Monitoring of Maryland's New All-Payer Model

Biannual Report

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

October 2016

Executive Summary

Introduction

Effective January 1, 2014, the State of Maryland and the Centers for Medicare & Medicaid Services (CMS) entered into a new agreement to modernize Maryland's unique all-payer rate-setting system for hospital services. This initiative, replacing Maryland's 36-year-old Medicare waiver, allows Maryland to adopt new and innovative policies aimed at reducing per capita hospital expenditures and improving patient health outcomes. This biannual report, prepared in accordance with Maryland law,[1] contains a summary of implementation, monitoring, and other activities during the time period from January 1, 2014, through September 30, 2016. The purpose of this report is to inform the Maryland General Assembly on the status of the New Maryland All-Payer Model.

Highlights

The following bullets highlight the Maryland Health Services Cost Review Commission's (HSCRC's) progress in the nine reporting areas required by law.[2]

- **Inpatient and Outpatient Hospital Per Capita Cost Growth** - CMS requires Maryland to limit the annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58 percent. To date, Maryland has met this target, with a growth rate of 1.47 percent between calendar years (CYs) 2013 and 2014 and 2.31 percent between CYs 2014 and 2015. CY 2016 year-to-date (YTD) per capita revenue growth grew 1.47 percent over the same period in CY 2015 (as of June).

- **Aggregate Medicare Savings -** CMS requires Maryland to achieve an aggregate savings in Medicare spending that is greater than or equal to $330 million over the five years of the agreement. The HSCRC gained access to CMS data and is working with a contractor to perform analytics to validate the aggregate Medicare savings calculated by CMS. Maryland realized $116 million in savings in CY 2014 and $135 million in CY 2015. CY 2016 data are considered preliminary and have not yet been approved for public release by CMS.

- **Shifting from a Per-Case Rate System to a Global Budget –** CMS requires Maryland to shift at least 80 percent of hospital revenue to global or population-based budgets. Maryland exceeded this target and has shifted 96 percent of hospital revenues under global budget structures.

- **Reducing the Readmission Rate among Medicare Beneficiaries** – While the readmission rate in Maryland has decreased over the last several years, Maryland's readmission rate for Medicare beneficiaries remains higher than the national average. Under the New All-Payer Model, CMS requires Maryland's Medicare fee-for-service (FFS) hospital admission rate to be at or below the national readmission rate by the end of 2018. Final CMS data for CY 2015 show that the Maryland readmission rate decreased from 16.61 percent in CY 2013 to 15.95 percent in CY 2015, a decrease sufficient to meet the test of the New All-Payer Model for CY 2015. Additional analysis of HSCRC data show that Maryland continues to reduce

[1] Health-General Article §19-207(b)(9) Maryland Annotated Code.
[2] *Id.*

readmissions. The gap between the Maryland per-beneficiary readmission rate and the national rate decreased by 0.69 percent between CY 2013 and CY 2015.

- **Reducing Hospital-Acquired Conditions (HACs)** – CMS requires Maryland to reduce the cumulative rate of HACs by 30 percent by 2018. HSCRC measures HACs using 64 Potentially Preventable Complications (PPCs).[3] To date, Maryland has exceeded this target, with a 47.34 percent reduction in all-payer case-mix adjusted PPCs between fiscal year (FY) 2013 and FY 2016. This reduction in PPCs was even higher for Medicare FFS at 52.40 percent. Staff have set a statewide reduction target of 6 percent for CY 2016, and will continue to incentivize reductions in HACs through our quality incentive program.
- **Workgroup Activities –** The HSCRC continues to implement a broad stakeholder engagement approach, convening an Advisory Council and several workgroups with various subcommittees. The Payment Models and Performance Measurement work groups continue to operate and have established ad hoc subcommittees as needed. The Consumer work groups also continue their work, and pursuant to one of their recommendations, the Commission is establishing a Standing Consumer Advisory Committee to provide advice regarding Commission activities. Stakeholders representing consumers, businesses, payers, providers, physicians, nurses, other health care professionals, and experts have participated in these workgroups. All workgroup meetings are conducted in public sessions, and comments from the public are solicited at each meeting. The Commissioners have also been participating in work groups and meetings aimed at establishing value-based models for patients dually eligible for Medicare and Medicaid, as well as primary care.
- **Actions to Promote Alternative Methods of Rate Determination and Payment** – The New All-Payer Model agreement allows Maryland to develop alternative methods of rate determination. During the first six months of the performance period, the HSCRC developed the Global Budget Revenue (GBR) reimbursement model and moved 95 percent of acute hospital revenue under global budgets. As hospitals have pursued more effective models for coordinating and managing the care of chronically ill patients, several hospital systems are offering Medicare Advantage plans. The Commission continues to review these alternative methods of rate determination each year to ensure that they do not result in a loss contract. The HSCRC has begun to work with stakeholders on augmenting the existing global budget concept with a new, population-based arrangement in the future.
- **Reports to CMS** – To date, the HSCRC has met all of CMS's reporting requirements.
- **Reporting Adverse Consequences** – Under the All-Payer Model contract, CMMI monitors the total cost of care in Maryland to ensure that reductions in hospital potentially avoidable utilization (PAU) does not result in unreasonable increases in the total cost of care, which includes costs associated with all other health care providers. The All Payer Model contract provides that in any one calendar year, Medicare total cost of care growth in Maryland may not grow more that 1% above Medicare total cost of care growth nationally. However, in any two consecutive years, Maryland's Medicare total cost of care may not exceed the nation. In CY 2015, Maryland's total cost of care grew by .7% above the nation. The Commission is watching closely and prepared to take action to ensure that the two consecutive

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

year requirement is not breached. The HSCRC will continue to develop monitoring tools, measure performance, and engage stakeholders in order to identify and resolve any adverse consequences that may arise as quickly as possible.

Introduction

Effective January 1, 2014, the State of Maryland and the Centers for Medicare & Medicaid Services (CMS) entered into a new initiative to modernize Maryland's unique all-payer rate-setting system for hospital services. The Center for Medicare and Medicaid Innovation (CMMI) oversees the Model under the authority of CMS. This initiative, replacing Maryland's 36-year-old Medicare waiver, allows Maryland to adopt new and innovative policies aimed at reducing per capita hospital expenditures and improving patient health outcomes. Success of the New All-Payer Model will reduce cost to purchasers of care—businesses, patients, insurers, Medicare, and Medicaid—and improve the quality of the care that patients receive both inside and outside of the hospital. In the past 33 months, the State, in close partnership with providers, payers, and consumers, has made significant progress in this modernization effort.

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

State Reporting Requirements for Maryland's New All-Payer Model

This report contains a summary of implementation, monitoring, and other activities to inform the Maryland General Assembly on the status of the New Maryland All-Payer Model. This New Maryland All-Payer Model Biannual Report, prepared in accordance with Maryland law,[4] discusses the State's progress during the period from January 1, 2014, through September 30, 2016, based on the information available at the time. The Maryland Health Services Cost Review Commission (HSCRC, or Commission) will produce an updated report every six months. Figure 1 provides an overview of the reporting required by law under the New Maryland All-Payer Model. [5]

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

Section	Achievement Requirement	Accomplishments	Ongoing Activities
I.1.	Limit the annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58%	Per capita revenue for Maryland residents grew 1.47% between calendar year (CY) 2013 and CY 2014. CY 2015 per capita revenue growth grew 2.31% over CY 2014. CY 2016 YTD per capita revenue growth grew 1.47% over the same period in CY 2015.	• Ongoing monthly measurement • Expecting continued favorable performance for CY 2016
I.2.	Achieve aggregate savings in Medicare spending equal to or greater than $330 million over 5 years	$116m in Performance Year (PY) 1 and $135m in PY2. CY 2016 data is considered preliminary	• HSCRC gained access to CMS data and is working with an analytics contractor to examine the calculation of the per beneficiary amounts and growth rates

[4] Health-General Article §19-207(b)(9) Maryland Annotated Code.

[5] *Id.*

Section	Achievement Requirement	Accomplishments	Ongoing Activities
		and not yet approved for public release by CMS.	for CY 2016
I.3.	Shift at least 80% of hospital revenue to a population-based payment structure (such as global budgets)	96% of hospital revenue shifted to global budgets	• All hospitals are engaged in global budgets under Global Budget Revenue (GBR) and Total Patient Revenue (TPR) agreements • HSCRC continues to refine global budget methodology.
I.4.	Reduce the hospital readmission rate for Medicare beneficiaries to below the national rate over the 5-year period of the agreement	The gap between the Maryland per beneficiary readmission rate and the national rate decreased by 0.69% between CY 2013 and CY 2015.	• HSCRC is monitoring progress within Maryland using data collected from hospitals by HSCRC and continues to see declines in all-payer, Medicare FFS, and Medicaid readmissions • The HSCRC Readmission Reduction Incentive Program (RRIP) for fiscal year (FY) 2018 was approved in June 2016 and continues to incentivize readmission reductions. Beginning in FY 2018, the RRIP will reward hospitals that achieve strong attainment in lower readmissions.
I.5.	Cumulative reduction in hospital acquired conditions (HACs) by 30% over 5 years	Reduction of 33% in all-payer case-mix adjusted potentially preventable complication (PPC) rate in CY 2015 compared to CY 2013. The reduction between FY 2013 and FY 2016 is 47.34 percent.	• HSCRC continues to set a statewide annual improvement goal for the Maryland Hospital Acquired Conditions (MHAC) program, despite having achieved the 30% required reduction. • For FY 2018, HSCRC staff set a statewide reduction target of 6%, comparing FY 2015 with CY2016. • HSCRC continues to review and audit these findings and monitor ICD-10 conversion
I.6	Monitor Total Cost of Care (TCOC) for Medicare and maintain growth within guardrails	For CY 2015, the growth in TCOC for Maryland's Medicare beneficiaries exceeded the national growth rate when compared to CY 2014. However, when compared to the base year (CY 2013), the cumulative growth rate in Maryland is lower than the national growth rate, and Maryland is exceeding its savings requirements, even after considering the growth in non-hospital costs.	• HSCRC is closely monitoring TCOC growth for CY 2016. Through June 2016, the growth rate in cost per beneficiary in Maryland was lower than the national growth rate. However, the growth of non-hospital spending exceeded the national growth rate. HSCRC is investigating the sources of this growth.
II	Workgroup Actions	The HSCRC is convening an additional workgroup: the Consumer Standing Advisory Committee	• The Advisory Council reconvened in February 2016 and meets monthly to assist in developing the vision for Phase II of the All-Payer Model • Active workgroups have continued to meet on a regular basis

Section	Achievement Requirement	Accomplishments	Ongoing Activities
III	New alternative methods of rate determination	96% of hospital revenue is now under global budget arrangements, implemented in accordance with policies approved by the Commission	• Global budget agreements are published on the HSCRC's website • New policies are being developed to refine and advance the GBR methodology
IV	Ongoing reporting to CMS of relevant policy development and implementation	The HSCRC provided CMS with the Annual Monitoring Report as required in the New All-Payer Model contract, as well as quarterly progress reports	• The HSCRC continues to provide reports to CMS on an ongoing basis

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

Maryland's New All-Payer Model agreement with CMS establishes a number of requirements that the State must fulfill. CMS must evaluate and provide an annual report on Maryland's calendar year performance. The HSCRC submitted the Model's mid-year Annual Monitoring Report to CMS in July 2016, and will submit its second Annual Monitoring Report to CMS in December 2016.[6] In addition to the annual report, the HSCRC provides ongoing reporting to CMS on relevant policy and implementation developments. If Maryland fails to meet selected requirements, CMS would provide notification, and Maryland would have the opportunity to provide information and a corrective action plan if warranted. At this time, CMS has not provided any failure notifications to Maryland.

Section I

1. Inpatient and Outpatient Hospital Per Capita Cost Growth

The New Maryland All-Payer Model agreement requires the State to limit the average annual growth in all-payer hospital per capita revenue for Maryland residents to the average growth in per capita gross state product (GSP) for the 2002-2012 period (a 3.58 percent growth rate). Per capita revenue for Maryland residents increased by 1.47 percent between CYs 2013 and 2014 and by 2.31 percent between CYs 2014 and 2015. CY 2016 year-to-date (YTD) per capita revenue grew by 1.47 percent over the same period in CY 2015 (as of June). Continued favorable performance is expected as global budgets (discussed at greater length in Section III) result in predictable statewide revenue performance, enabling the HSCRC to actively manage compliance with the 3.58 percent target.

2. Aggregate Medicare Savings

The New Maryland All-Payer Model agreement requires the State to achieve an aggregate savings in Medicare spending equal to or greater than $330 million over the five years of the agreement. Savings are calculated by comparing the rate of

[6] The annual report is currently submitted in two parts due to timeliness of data availability. A partial report detailing CY 2015 is submitted in July, and a final report with full CY 2015 data is submitted in December as available.

increase in Medicare hospital payments per Maryland beneficiary with the national rate of increase in payments per beneficiary. Currently, CMS completes this calculation and provides an aggregate monthly report to the HSCRC. Maryland realized $116 million in savings in CY 2014 and $135 million in CY 2015. CY 2016 data are considered preliminary and have not yet been approved for public release by CMS.

The HSCRC is currently working with a Medicare analytics contractor to validate the aggregate Medicare savings calculation conducted by CMS. It is in the interest of both parties that the calculation correctly captures hospital payments made on behalf of Medicare beneficiaries who are Maryland residents. The HSCRC's vendor successfully replicated CMS's analysis of Maryland's data for CYs 2013, 2014, and 2015.

HSCRC has been tracking Medicare fee-for-service (FFS) per capita cost trends from its own Maryland data. Based on these data, the Medicare FFS per capita revenue declined by 1.12 percent between CYs 2013 and 2014, and grew by 1.14 percent in CY 2015. In CY 2016 YTD, the Medicare FFS per capita revenue has declined by 1.20 percent over the same time period in CY 2015 (as of June).

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

As discussed in the October 2015 and April 2016 New Maryland All-Payer Model Biannual Reports, 96 percent of Maryland hospital revenues are contained within global budget structures. This exceeds the New Maryland All-Payer Model agreement requirement of shifting at least 80 percent of hospital revenue to global or population based budgets. All regulated Maryland hospitals that were not already under a Total Patient Revenue (TPR) agreement now operate under a Global Budget Revenue (GBR) agreement, through policies approved by the Commission. The remaining 4 percent that is not under global budgets constitutes excluded, out-of-state revenue for five hospitals. These hospitals are otherwise engaged in global budgeting. Global budget agreements are available on the Global Budget Web Page of the HSCRC website.

The HSCRC has continued to work with stakeholder workgroups to refine the GBR methodology and develop a number of policies discussed in Section III.

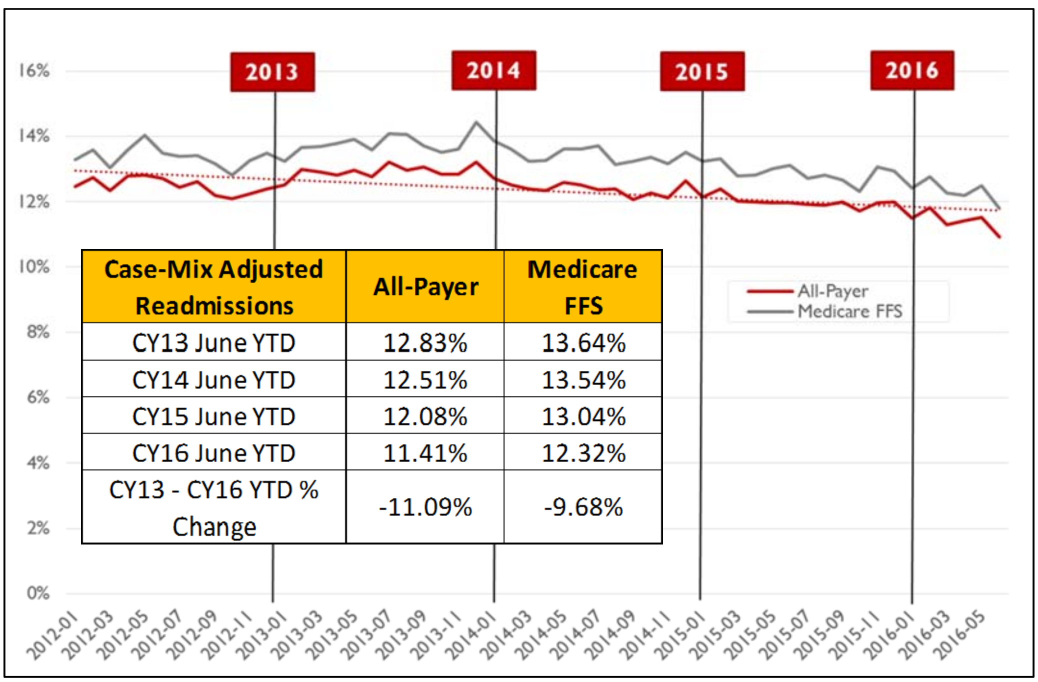
4. Reducing the Hospital Readmission Rate among Medicare Beneficiaries

Reducing hospital inpatient readmission rates has been an aim of the HSCRC since 2011. While the readmission rate in Maryland has fallen over the last several years, Maryland's readmission rate for Medicare beneficiaries remains higher than the national average. The New Maryland All-Payer Model agreement requires Maryland's hospital readmission rate for Medicare FFS beneficiaries to be at or below the national readmission rate by the end of 2018. Each year beginning in 2014, the Maryland readmission rate must keep up with national improvements and close the gap between Maryland and the nation by one-fifth. This All-Payer Model requirement uses national Medicare data.

Overall, HSCRC's hospital data show that the monthly case-mix adjusted readmission rate YTD through June 2016 is trending lower than the rate for the same time period in CY 2013 or CY 2014 (Figure 2). This analysis includes all Maryland inpatient stays, including Medicare FFS. Based on these HSCRC data, the all-payer case-mix adjusted readmission rate YTD through June 2016 was 11.41 percent, compared with 12.83 percent during the same time period in 2013, an 11.1 percent reduction. The corresponding readmission reduction for Medicare FFS beneficiaries was lower (9.68 percent). The reduction highlights the difficulty and time involved in reducing readmissions, as it requires significant effort, investment, and coordination across providers.

Staff believe that the addition of penalties to the RRIP provides strong incentives to reduce readmissions compared with the State FY 2016 program that only had rewards. In the FY 2018 policy, staff modified the policy to reward both improvement and attainment. Thus hospitals with low readmission rates (those with a rate 2 percent below the 25th percentile from previous year) had the opportunity to receive a reward regardless of improvement (this was also retrospectively applied to FY 2017 adjustments). To help readmission reduction efforts, HSCRC continues to improve its readmission reporting capability by leveraging resources available in the state Health Information Exchange and providing timely, monthly, patient-specific data to hospitals.

Figure 2. All-Payer and Medicare FFS Case-Mix Adjusted Readmission Rates, CY 2013-2016 YTD through June



Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
CY13 June YTD	12.83%	13.64%
CY14 June YTD	12.51%	13.54%
CY15 June YTD	12.08%	13.04%
CY16 June YTD	11.41%	12.32%
CY13 - CY16 YTD % Change	-11.09%	-9.68%

5. Cumulative Reduction in Hospital Acquired Conditions

Maryland hospitals must achieve a 30 percent cumulative reduction in hospital-acquired conditions (HACs) by 2018 to comply with the New Maryland All-Payer Model agreement. Maryland measures HACs using 64 Potentially Preventable Complications (PPCs).[7] PPCs are defined as harmful events (e.g., accidental

[7] 3M Health Information Systems developed PPCs. The PPC software relies on "present on admission" indicators from administrative data to calculate the actual versus expected number of complications for each hospital.

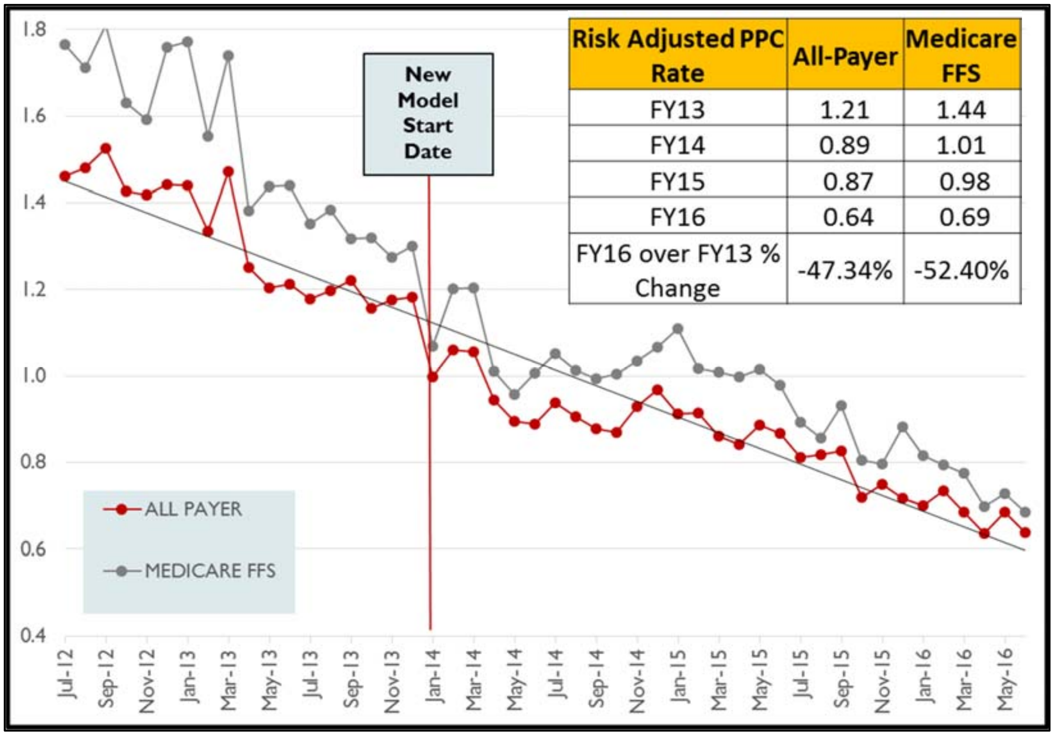
laceration during a procedure) or negative outcomes (e.g., hospital-acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease.

As discussed in the October 2014 New Maryland All-Payer Model Biannual report, the HSCRC approved major revisions to the Maryland Hospital Acquired Conditions (MHAC) program in April 2014 in order to support the goal of reducing PPCs. The MHAC program calculates hospital rewards and penalties for case-mix adjusted rates of PPCs. Specifically, these calculations now use observed-to-expected ratios as the basis of the measurement for all of the 64 PPCs and preset positions on a scale constructed using the base year scores for all PPCs to determine penalties and rewards.

Figure 3 shows the all-payer and Medicare FFS case-mix-adjusted PPC rates by month and year. In FY 2016, the all-payer case-mix adjusted PPC rate was 0.64 per 1,000, compared with 1.21 per 1,000 for FY 2013, which is a 47.34 percent reduction. The reduction in the case-mix adjusted complication rate for Medicare FFS was even higher at 52.40 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 set annual improvement targets for hospitals to further reduce PPCs and to ensure that Maryland hospitals will continue to have a waiver from the CMS HAC program. For the FY 2018 performance period, the HSCRC set a 6 percent statewide PPC reduction target comparing FY 2015 with CY 2016.

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 that had audit results that exceeded the HSCRC thresholds. The HSCRC has also worked closely with 3M, the Maryland Hospital Association (MHA), and the hospital industry around the International Classification of Diseases – 10th Edition (ICD-10) implementation, and to date have not seen significant changes in PPC rates due to ICD-10.

Figure 3. All-Payer Risk-Adjusted PPC Rates FY2013-FY2016



6. Medicare Savings and Total Cost of Care Performance

Under the New All-Payer Model agreement, the total cost of care growth for Maryland Medicare beneficiaries should not exceed the national growth rate by more than 1 percent in any given year and should not exceed the national growth for two consecutive years. The results for Medicare for the first year of the All-Payer Model were positive, while the second year results were mixed.

- In the first year of the Model, non-hospital costs were contained, and Medicare saved money on both hospital and non-hospital costs.
- In the second year of the Model, Maryland Medicare hospital cost growth remained stable, but non-hospital costs increased and even offset some of the hospital savings achieved in the first year. Based on preliminary data, Maryland exceeded the national Medicare total cost of care growth rate in CY 2015 by about 0.7 percent. While Maryland is still ahead of the promised savings levels to date, the total cost of care growth trend line is of concern.
- For calendar YTD through June 2016, HSCRC staff estimates the Medicare total cost of care growth in Maryland to be lower than the nation. With monthly fluctuations, Medicare total cost of care continues to be of concern.

Figure 4. Total Cost of Care per Capita
Actual Growth Trend (CY month vs. prior CY month)

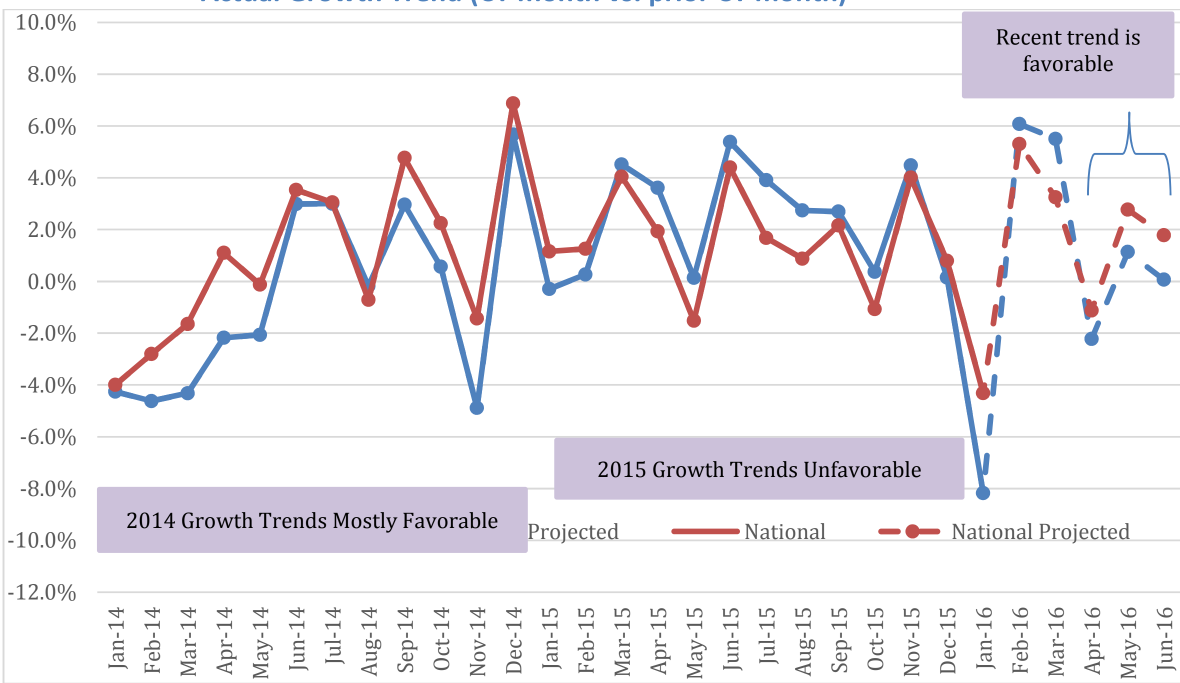


Figure 5. Medicare Hospital Spending per Capita
Actual Growth Trend (CY month vs. prior CY month)

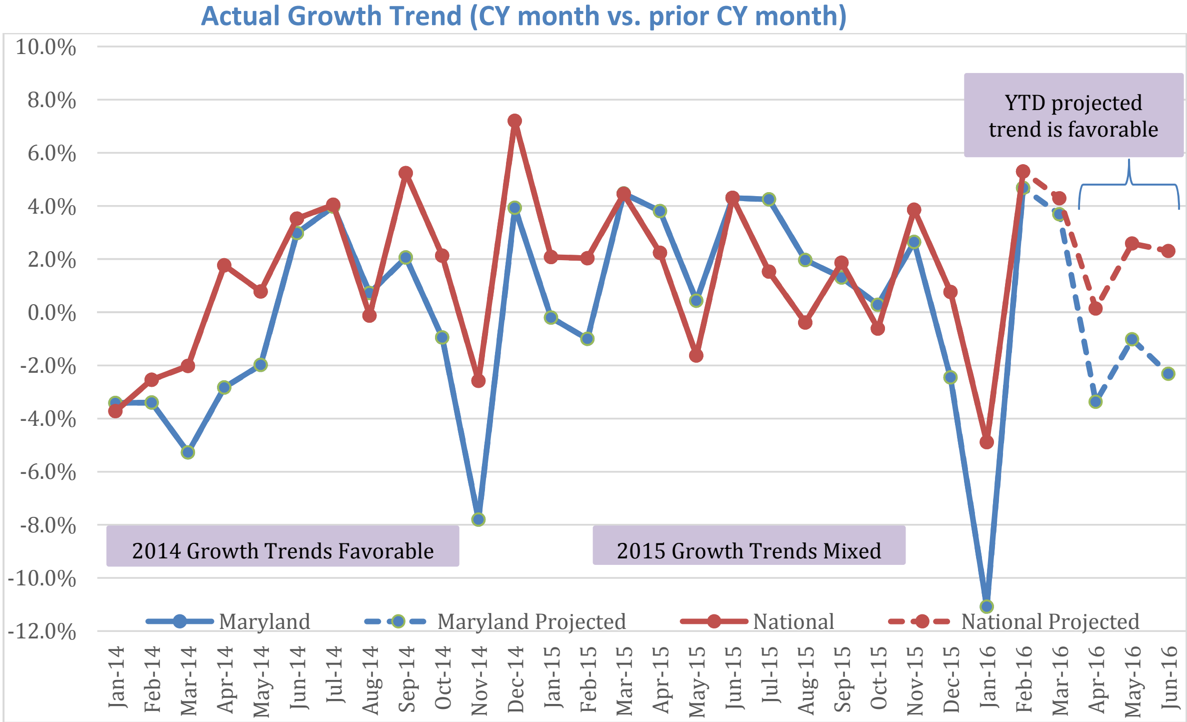
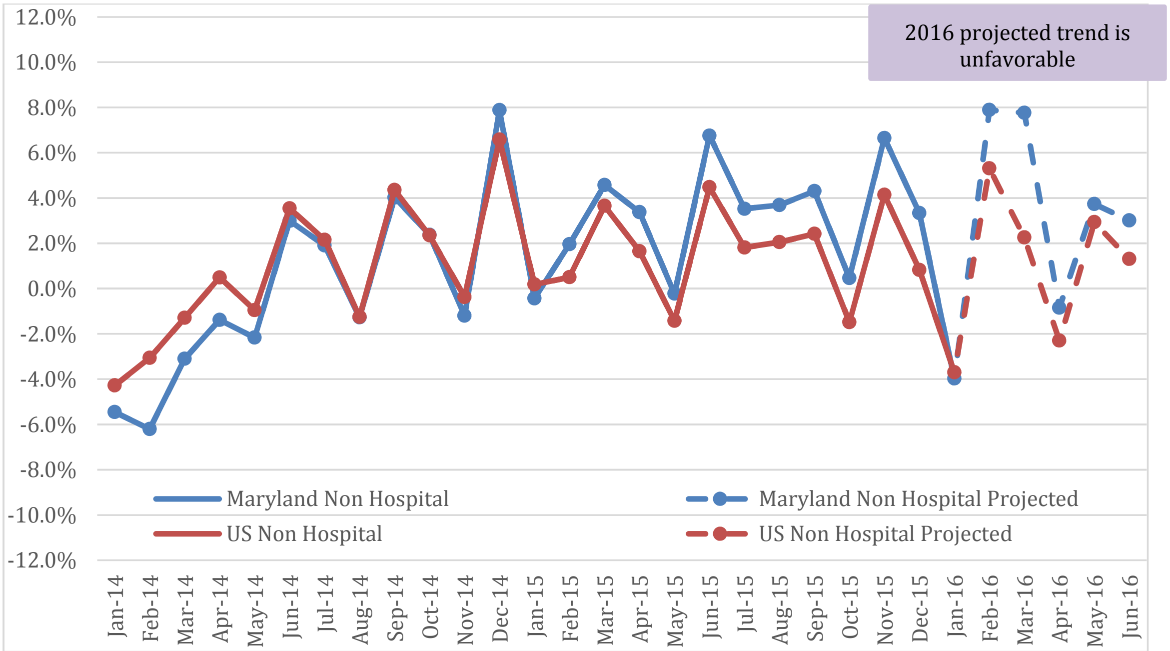


Figure 6. Non-Hospital Spending per Capita
Actual Growth Trend (CY month vs. prior CY month)



Section II

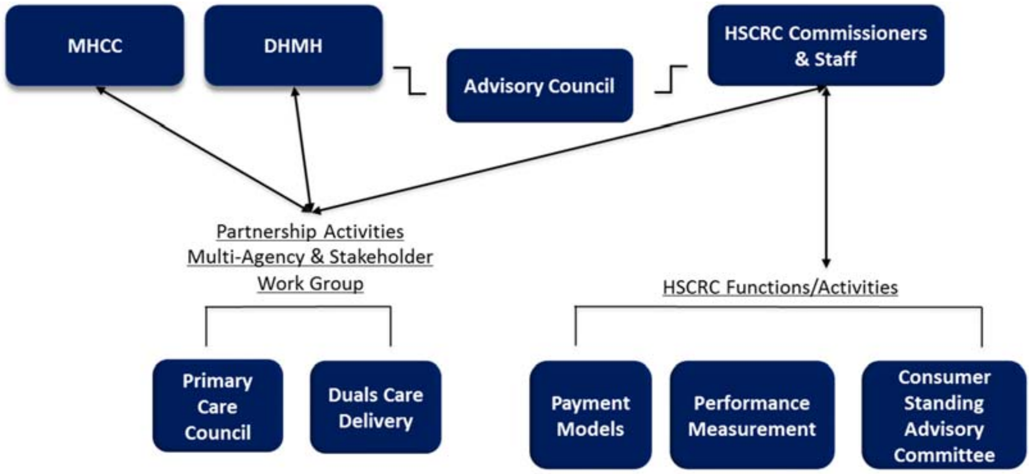
Workgroup Actions

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 and Mental Hygiene (DHMH), the HSCRC has participated in a Primary Care Council and the Duals Care Delivery Workgroup. In February 2016, the Commission and DHMH reconvened an Advisory Council to assist in developing the vision for Phase II of the All-Payer Model, which moves to a broader total cost of care model. The Council includes a broad set of stakeholders representing hospitals, the insurance industry, long-term care, post-acute care, physicians, and other providers. The Payment Models and Performance Measurement Workgroups continued to meet regularly throughout CY 2016, and the HSCRC is working to build a Consumer Standing Advisory Committee in the fall of 2016.

Figure 7 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://www.hscrc.maryland.gov/index.cfm.

Figure 7. Existing Stakeholder Engagement Structure



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

The purpose of the Advisory Council is to provide the HSCRC with senior-level stakeholder input on guiding principles for the overall implementation of population-based and patient-centered payment systems. The Advisory Council consists of a broad representation of hospitals, payers, physicians, consumers, providers, DHMH, and health care experts. The Advisory Council suggested guiding principles for the HSCRC to consider as it addresses key challenges and possible strategies over the next two years of Model implementation.

During the three meetings from April through June 2016, Advisory Council members drafted interim recommendations for the HSCRC and DHMH to consider in their planning efforts. These recommendations revolved around the following six major domains: 1) vision; 2) roadmap, focus and progression; 3) person-centered care; 4) data; 5) accountability; and 6) alignment.

The Council also discussed priorities for Maryland's progression, including the following:

- Potential outline of a progression plan
- Guiding principles for the HSCRC staff as they draft the progression plan
- Proposed care redesign amendment
- Long-term, health care delivery and payment model developments and associated timelines for design and implementation
- Possible implications of the Medicare Access and CHIP Re-authorization Act and the Comprehensive Primary Care Plus Model policies on strategic planning

2. The Payment Models Workgroup

The Payment Models Workgroup is charged with vetting potential recommendations for HSCRC consideration on the structure of payment models and how to balance its approach to payment updates. During CY 2016, the workgroup reviewed several policies described above, including the FY 2017 Update Factor, the FY 2017 Uncompensated Care (UCC) Policy, and the FY 2017 Potentially Avoidable Utilization (PAU) Savings policy. Additionally, the Payment Models Workgroup discussed market shift adjustments, which are included in rate orders. For rate year (RY) 2017, these will be incorporated on a semi-annual basis, increasing the frequency of adjustment. The workgroup also discussed the increases in total cost of care for Medicare.

3. Performance Measurement Workgroup

The Performance Measurement Workgroup develops recommendations for HSCRC consideration on measures that are reliable, informative, and practical for assessing a number of important quality and efficiency issues.

Since April 2016, the Performance Measurement Workgroup has finalized the Readmissions Reduction Incentive Program for FY 2018, as well as the PAU Savings Policy and the Aggregate Revenue-at-Risk policy. Current objectives include updating quality incentive program policies for FY 2019 and resolving data issues.

Section III

1. Alternative Methods of Rate Determination

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 New Maryland All-Payer Model, the HSCRC developed the GBR reimbursement model and engaged all hospitals not already under a TPR agreement in GBR, as discussed in Section I of this report. While some revenue is outside of the global budget (such as revenue from some out-of-state referrals), approximately 96 percent of acute hospital revenue is currently under a global budget.

The GBR and TPR methodologies are central to achieving the triple aim set forth in the 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 New Maryland All-Payer Model focuses on controlling increases in total hospital revenue per capita. GBR and TPR agreements prospectively establish a fixed annual revenue cap for each hospital to encourage hospitals to focus on care improvement and population-based health management.

Under GBR and TPR contracts, each hospital's total annual revenue is known at the beginning of each fiscal year. Annual revenue is determined from a historical base period that is adjusted to account for inflation updates, infrastructure requirements for GBR hospitals,[8] 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.

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

While the HSCRC may consider augmenting the existing global budget concept with new population-based arrangements in the future, it is important to first evaluate the effectiveness of the existing global budget mechanism.

Looking to the future, the Commission is 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. The State received preliminary approval from CMMI for an amendment to the existing All-Payer Model contract to implement specific care redesign strategies. One such strategy is the development of the Chronic Care Improvement Program, which will permit hospitals to share data and resources with community-based patient designated providers in order to improve care coordination, reduce cost, and align the incentives of hospitals and physicians. A similar program for hospital based physicians is referred to as the Hospital Care Improvement Program. Both programs are voluntary and are expected to begin implementation in CY 2017, with potential gain sharing payment distributed in CY 2018 for those hospitals who opt for this portion of the given program.

The HSCRC will continue to further develop payment policy and will report any future innovations in this section of the Biannual Report. Specifically, DHMH and Medicaid are developing primary care and dual eligible models that will create even greater alignment across various providers to better meet the needs of chronically ill patients. The Commission also anticipates expanding the global budget model to geographic populations. We anticipate various pilot projects to begin in 2018.

2. Refining Global Budget Methodologies

While the majority of Maryland hospitals transitioned to global budgets during the first six months of the New Maryland All-Payer Model, a number of essential policies had not yet been finalized to address issues such as adjusting global budgets for market shifts or changes to inter-hospital transfer rates, establishing rates for new hospitals, and providing hospitals flexibility to achieve annual GBR revenue while reducing PAU. As shown in this report, 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 and the New Maryland All-Payer Model evolves.

Global Budget Charge Corridors

A unique feature of global budgets that has been refined in the past six months is the capacity of a GBR hospital to increase or decrease its approved unit rates to achieve its overall approved global revenue. This mechanism allows a hospital the flexibility to compensate for fluctuations in service volume over the course of the year and still reach its annual revenue target. The hospital must vary these unit rates in unison and within a defined charge corridor or be subject to penalties. If a hospital is experiencing significant volume declines as a result of reduced PAU, it may submit a request to expand this corridor so that it can achieve the approved global revenue necessary for financial stability and population health investment. HSCRC staff review charge corridor requests to determine the cause of hospital volume increases and the impact of the charge corridor expansion on the patient population, surrounding hospitals, and other factors related to the goals and requirements of the New Maryland All-Payer Model.

GBR Infrastructure Support

In FYs 2014 through 2016, the Commission included over $200 million in rates to support hospitals in developing services and mechanisms to improve care delivery, population health, and care management. Hospitals must submit annual reports on these investments with program descriptions, expenditures, and results.

The first of these reports was due at the end of September 2015. The HSCRC received infrastructure reports from hospitals detailing over 850 infrastructure investments made during FYs 2014 and 2015. Hospitals reported a total infrastructure investment of $231 million dollars over that time period.

Key areas of investment included: 1) expanding case management and care transition services; 2) increasing access to non-hospital provider care; 3) removing barriers to social services necessary for improved population health; 4) promoting patient education; and 5) increasing post-discharge support and follow-up care.

The HSCRC hopes to see more healthcare delivery transformation in coming years. To that end, staff met with a sub-group of the Performance Measurement Workgroup to improve the reporting template for FY 2016 reports. These reports are due in early October 2016.

As part of its update factor process for FY 2017, the Commission authorized up to .25% 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 award $30 million to 9 awardees who are permitted to increase their global budgets, so that dollars can be generated to reduce potentially avoidable utilization by working with community partners. These programs are above and beyond the care transitions initiatives that were funded in FYs 2014 and 2015.

A second and final round will be proposed to the Commission in October 2016. Regular reporting will be required of all awardees and the Commission maintains the authority to curtail or claw-back funding if it is not used in accordance with the proposals as approved by the Commission.

Transfer Case Payment Adjustment Implementation

An early concern with the expansion of global budgets was the possibility that transfer rates to academic medical centers (AMCs) would increase as high cost care would leave community hospitals with the associated revenue for cases that had been transferred. Global budget hospitals are encouraged to reduce PAU and promote care management and quality improvement. This could result in hospitals transferring a greater number of complex cases to AMCs in order to both provide patients with the advanced care they need, as well as to reduce the high costs associated with such cases. The Transfer Case Adjustment addresses these concerns by ensuring that “receiving” hospitals have the capacity to take on a possible influx of complex cases without facing financial penalties under a global budget. The HSCRC accomplished this objective by establishing a process to monitor and adjust for changes in transfer rates to AMCs and from sending hospitals on a periodic basis. The Transfer Case Adjustment Policy began in State FY 2016.

Market Shift Adjustment (MSA) Development

In CY 2016, the HSCRC worked extensively with stakeholders to understand and adequately account for shifts in market volume, which are reflected in RY 2017 rate orders. Staff believes it is important to move money when patients shift from one institution to another, whereby the receiving institution receives a marginal cost adjustment of 50 percent to care for the larger share of patients. Given the dynamic healthcare market in Maryland, the HSCRC has decided to make market shift adjustments on a semi-annual basis, instead of an annual basis, beginning with the CY 2016 measurement period.

Staff continues to track emergency department volumes and alert trends, whereby patients may be diverted from one hospital's emergency department to another. Based on its findings, staff may incorporate these data into market shift adjustments. Additionally, staff continues to monitor any services shifting to unregulated sites, which is not represented by the current hospital market shift calculations.

As always, the HSCRC will continue to make market shift adjustments when significant events occur (e.g., movement of a service, closure of a service, or other very large shifts).

Section IV

Reports Submitted to CMS

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

- Maryland All-Payer Model Monitoring Report: This annual report was submitted to CMS in July 2016 is currently being updated for submission in December 2016. It contains data for performance years 2014 and 2015, as well as 2013 baseline measures.

Please find the most recent annual report submitted to CMS in Appendix 1.

Section V

Reporting Adverse Consequences

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

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

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

In CY 2015, the HSCRC also focused on engaging consumers through the Consumer Engagement and Outreach Workgroups. Although these workgroups have concluded, consumer advocates participate in each of the HSCRC stakeholder workgroup panels, and the HSCRC is working to build a Consumer Standing Advisory Committee in the fall of 2016. Consumer advocacy organizations have described the HSCRC stakeholder engagement process as a model for consumer engagement in a major policy endeavor. The HSCRC has made significant efforts to be as transparent as possible in its initiatives and policy developments by making these workgroup meetings open to the public and by posting the meeting materials and recordings on the HSCRC's website (http://www.hscrc.maryland.gov/index.cfm).

One area of caution, however, is the recent trending in the total cost of care. In the All-Payer Model contract, CMMI monitors the total cost of care in Maryland to ensure that reductions in hospital potentially avoidable utilization do not result in unreasonable increases in the total cost of care, which includes cost related to all health care providers, not just hospitals. The All Payer Model contract provides that in any one calendar year, Medicare total cost of care growth in Maryland may not grow more that 1% above Medicare total cost of care growth nationally. However, in any two consecutive years, Maryland's Medicare total cost of care may not exceed the nation. In CY 2015, Maryland's total cost of care grew by .7% above the nation. The Commission is watching this issue very closely and is prepared to take action to ensure that the two consecutive year requirement is not breached. The HSCRC will continue to develop monitoring tools, measure performance, and engage stakeholders in order to ensure compliance with the requirements of the All-Payer Model contract.

Contact and More Information

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

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