

Report to the Governor

Fiscal Year 2016

Health Services Cost Review Commission
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Introduction

The State of Maryland is leading a transformative effort to improve care and lower healthcare spending growth through Maryland's New All-Payer Model. The All-Payer Model serves as the central focus in this *Fiscal Year (FY) 2016 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:¹

- All-Payer Model policy implementation, state and federal reporting requirements, and stakeholder engagement
- other HSCRC activities during the reporting period of July 1, 2015 through June 30, 2016
- hospital financial performance in FYs 2015 and 2016
- hospital quality performance and updated quality initiatives, and
- an overview of HSCRC staffing and budget infrastructure.

The New All-Payer Model with CMS

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 costs to purchasers of care—businesses, patients, insurers, Medicare, and Medicaid—and improve the quality of the care that patients receive both inside and outside of the hospital. In the past 33 months, the State, in close partnership with providers, payers, and consumers, has made significant progress toward 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 to 3.58 percent per year over the five years of the Model (plus an adjustment for

¹ 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.

population growth), which is the 10-year compound annual growth rate in per capita gross state product (GSP). This cap could be adjusted in years four and five based on more recent GSP trending.

- 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 about one-half of one percent per year below the national Medicare spending growth rate beginning in year two of the Model.

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 New 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. An Advisory Council, several stakeholder workgroups (discussed in the Stakeholder Engagement section below), and regular meetings with 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; establish 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, which is an expansion of what had been taking place at various rural hospitals across the State for three years prior to the adoption of the All-Payer Model.

Global Budgets Negotiated with All Hospitals

The Maryland All-Payer Model Agreement allows the State to innovate by developing alternative methods of rate determination. During the first six months of the Model, the HSCRC developed the Global Budget Revenue (GBR) reimbursement model. The HSCRC engaged all hospitals that were not already under a Total Patient Revenue (TPR) agreement in a GBR agreement. Since some revenue is outside of the global budget (such as revenue from some out-of-state referrals), 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 costs for all Maryland patients. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the New Maryland All-Payer Model focuses on controlling increases in total hospital revenue per capita. GBR and TPR agreements prospectively establish a fixed annual revenue cap for each hospital to encourage them 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,² demographic-driven volume increases, performance relative to 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 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. 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. The HSCRC will continue to innovate payment policy and will report any future innovations.

Other Policies Support All-Payer Model Goals

Over the course of FY 2016, the Commission approved additional policies to support the All-Payer Model goals.

- **Quality:** The HSCRC amended the existing Maryland Hospital Acquired Conditions (MHAC) program to further incentivize reductions in hospital acquired infections and convened a group to study the effects of the switch to the International

² TPR hospitals were previously provided allowances at the initiation of their agreements.

Classification of Diseases, Tenth Edition (ICD-10). The Commission continued the system of rewards and penalties for the Readmissions Reduction Incentive Program (RRIP), which started 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 effective July 1, 2016.³ The Commission adopted the following policies as a part of the FY 2017 update factor:
 - Updated the three categories of hospitals and revenues as follows:
 - Released the prospectively applied error correction factor of .56 percent for inflation to arrive at an approved rate year (RY) 2017 balanced update for revenues under global budgets of 2.72 percent (net of offsets), limiting the amount provided in the first six months to an increase of 2.16 percent by having a lower semi-annual target for the first half of the year and a higher semi-annual target for the second half of the year.
 - In order to receive the additional inflation allowance, each hospital agreed to charge no more than the mid-year target through the first half of the year. Each hospital also agreed to:
 - Monitor the growth of Medicare’s total cost of care and total hospital cost of care for its service area
 - Work with the Chesapeake Regional Information System for Our Patients (CRISP), HSCRC, and the Maryland Hospital Association to obtain available information to support monitoring and implementation efforts
 - Work with CRISP, HSCRC, and CMS to obtain data for care redesign activities as soon as it is available
 - Monitor the hospital’s performance on potential avoidable utilization (PAU) for both Medicare and all payers
 - Implement programs focused on complex and high needs patients with multiple chronic conditions, initially focusing on Medicare patients
 - Work with CRISP to exchange information regarding care coordination resources aimed at reducing duplication of

³ For more information on the update factor, see <http://www.hscrc.state.md.us/documents/commission-meeting/2016/06-08/Final-FY2017-Update-Factor-Recommendation-approved.pdf>

resources, ensuring more person-centered approaches, and bringing additional information to bear at the point of care for the benefit of patients

- Increase efforts to work in partnership with physicians, post-acute and long-term care facilities, and other providers to create aligned approaches and incentives to improve care, health, and reduce avoidable utilization for the benefit of patients. Work with physicians with the goal of developing and enhancing value-based approaches that are applied under the Medicare Access & CHIP Reauthorization Act of 2015
- Participate in the All-Payer Model progression planning efforts
 - Revenues that are not under global budgets but subject to the Medicare rate-setting waiver should increase by 1.24 percent.
 - Allocated 0.20 percent of the inflation allowance based on each hospital's proportion of drug costs to total costs. Additionally, earmarked up to 0.10 of the allowance for unforeseen adjustments for increases in costs related to new outpatient physician administered drugs.
 - 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. As always, the Commission has the authority to adjust rates as it deems necessary, consistent with the All-Payer Model.
 - Targets should be monitored both statewide and on a hospital-specific level.
 - If corrections become necessary, the Commission should consider whether to make the corrections based on hospital specific performance.
 - In order to receive the full update for FY 2018, hospitals must reduce PAU, and any increases in Medicare's non-hospital costs resulting from implementation will need to be at least offset by reductions in Medicare's hospital costs.
- 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. 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 first round 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 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. HSCRC and Maryland Department of Health and Mental Hygiene (DHMH) staff are currently reviewing the reports for FY 2016 expenditures which were submitted in early October.
- 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 awardees who are permitted to increase their global budgets, so that dollars can be generated to invest in strategies to reduce PAU by working with community partners. These programs are above and beyond the care transition initiatives that were funded in FYs 2014 and 2015. A second and final round was proposed in draft form to the Commission at its October 2016 public meeting. 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.

Statutory Updates

The Governor signed three bills that were passed during the 2016 legislative session that directly affected Commission policy. The first is Senate Bill 108 (Chapter 159), which revises the HSCRC's existing statute relating to the Nurse Support Assistance Program (NSPII). The bill broadens the scope of the NSPII, which is supported by Maryland hospital rates through the authority of the HSCRC. Instead of being focused on "bedside" nurses only, this bill will allow the NSPII program to improve the pipeline for nurses (through supporting facility and nursing education) with broader skills, such as supporting the care coordination model.

The second bill, House Bill 489 (Chapter 321), repeals the Maryland Health Insurance Program (MHIP) and transfers the duties of the Senior Prescription Drug Assistance Program (SPDAP) to DHMH. The SPDAP program continues to be supported by funds transferred each year from a non-profit health service plan. HSCRC's statute is changed to eliminate the assessment on hospital rates that have been used to operate the MHIP program.

Finally, Senate Bill 707 (Chapter 420) provides an option for hospitals that wish to downsize to become a freestanding medical facility. Such a facility would not require a certificate of need through the Maryland Health Care Commission (MHCC), would not have inpatient beds, and would be rate regulated for emergency, observation, and outpatient services as determined by the HSCRC.

The legislation requires MHCC to establish specified requirements for a public informational hearing for hospitals proposing to close, partially close, or convert to a freestanding medical facility. A hospital must hold a public informational hearing in the county where the hospital is located if the hospital:

- (1) Files a notice of the proposed closing with MHCC;
- (2) Requests a certificate of need exemption to convert a hospital to a freestanding medical facility; or
- (3) Is located in a county with fewer than three hospitals and files a notice of the partial closing of the hospital with MHCC.

A public informational hearing must be held within 30 days after the hospital files a notice of intent to convert to a freestanding medical facility. Within 10 working days after a public informational hearing, the hospital is required to provide a written summary of the hearing to the Governor, the Secretary of DHMH, the governing body of the county in which the hospital is located, the local health department and local board of health, MHCC, and specified committees and members of the General Assembly.

The bill establishes a workgroup on rural health care delivery to oversee a study of rural health care needs in specified counties and authorizes certain funds to be used for the study in FYs 2017 and 2018.

Finally, the bill provides that any process established in a memorandum of understanding for the modernization and transformation of Laurel Regional Medical Center between University of Maryland Medical System and local government shall supplement the process for community engagement established in this legislation.

Regulatory Update

Over the past fiscal year, the Commission proposed and adopted amendments to a number of existing regulations.

COMAR 10.37.01

This regulation concerns the Commission's Uniform Accounting and Reporting System for hospitals. During the past fiscal year, amendments to this chapter were proposed and adopted by the Commission.

- On August 12, 2015, the Commission adopted amendments to Regulation .08, which were proposed for adoption on May 1, 2015. The purpose of this action was to conform to the requirements set forth in Chapter 23 of the acts of 2014, effective July 1, 2014, that require hospitals to notify the Commission, in writing, within 30 days before executing any financial transaction, contract, or other agreement that would result in more than 50 percent of all corporate voting rights or governance reserve powers being transferred to or assumed by another person or entity.
- On November 18, 2015, the Commission adopted amendments to Regulation .02, which were proposed for adoption on October 2, 2015. The purpose of this action was to update the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management (August 1987)," which has been incorporated by reference.

COMAR 10.37.10

This chapter concerns the Commission's Rate Application and Approval Procedures. During the past fiscal year, the Commission proposed and adopted several amendments to this chapter.

- On October 14, 2015, the Commission adopted amendments to Regulation .26-1, which were proposed for adoption on July 9, 2015. The purpose of this action was to impose a moratorium on the Commission's MHIP assessment for FY 2016 in response to the Budget Reconciliation Act of 2015 changes to the program as of July 1, 2015. The Commission also requested Emergency Action to these amendments, and the Administrative, Executive, and Legislative Review (AELR)

- Committee granted emergency status, commencing March 1, 2014 and ending July 30, 2014.
- On November 18, 2015, the Commission adopted amendments to Regulations .07-1 and .10, which were proposed for adoption on October 2, 2015. The purpose of this action was two-fold: to assure that rate applications are submitted in easily readable formats, and to allow the Commission to set rates for outpatient services associated with the federal 340B Program in anticipation of the hospital's obtaining federal provider-based status.
 - On March 9, 2016, the Commission adopted amendments to Regulations .03 and .03-1, which were proposed for adoption on January 8, 2016. The purpose of this action was to establish a moratorium on the filing of regular rate applications pending the development and approval of rate efficiency measures that are consistent with the All-Payer Model.
 - On April 13, 2016, the Commission adopted amendments to Regulation .07-1, which was proposed for adoption on January 22, 2016. The purpose of this action was to allow the Commission to set rates for outpatient services associated with the federal 340B Program, in anticipation of, and contingent upon, a hospital attaining federal provider-based status.

State and Federal All-Payer Model Status Reporting Requirements

On April 1, 2016, and October 1, 2016, the HSCRC submitted reports summarizing implementation, monitoring, and other activities to inform the Maryland General Assembly regarding the status of the New 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 September 30, 2016, based on the 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 New 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://www.hscrc.maryland.gov/legal_reports.cfm.

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

Achievement Requirement	Accomplishments	Ongoing Activities
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 year-to-date (YTD) per capita revenue growth grew 1.47% over the same period in CY 2015.	<ul style="list-style-type: none"> • Ongoing monthly measurement • Expecting continued favorable performance for CY 2016
Achieve aggregate savings in Medicare spending equal to or greater than \$330 million over 5 years	\$116 million in Performance Year (PY) 1, \$135m in PY 2. CY 2016 data is preliminary and has not yet been approved for release by CMS.	<ul style="list-style-type: none"> • HSCRC gained access to CMS data and is working with an analytics contractor to examine the calculation of the per beneficiary amounts and growth rates for CY 2016.
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.	<ul style="list-style-type: none"> • All hospitals are engaged in global budgets under GBR and TPR agreements. • HSCRC continues to refine global budget methodology.
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.	<ul style="list-style-type: none"> • HSCRC is monitoring progress within Maryland using data collected from hospitals by HSCRC and continues to see declines in all-payer, Medicare fee-for-service (FFS), and Medicaid readmissions. • The HSCRC RRIP for FY 2018 was approved in June 2016 and continues to incentivize readmission reductions. Beginning in FY 2017, the RRIP will reward hospitals that achieve a significantly lower rate of readmissions.
Cumulative reduction in hospital acquired conditions by 30% over 5 years	Reduction of 33% in all-payer case-mix adjusted PPC rate in CY 2015 compared to CY 2013. The reduction between FY 2013 and FY 2016 is 47.34%.	<ul style="list-style-type: none"> • HSCRC continues to set a statewide annual improvement goal for the 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 CY 2016. • HSCRC continues to review and audit these findings and monitor ICD-10 conversion.

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Achievement Requirement	Accomplishments	Ongoing Activities
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.	<ul style="list-style-type: none"> 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.
Description	Report	Status
Workgroup Actions	The HSCRC is convening an additional workgroup: the Consumer Standing Advisory Committee.	<ul style="list-style-type: none"> The Advisory Council reconvened in February 2016 to assist in developing the vision for Phase II of the All-Payer Model. Active workgroups have continued to meet on a regular bases.
New alternative methods of rate determination	96% of hospital revenue is now under global budget arrangements, implemented in accordance with policies approved by the Commission.	<ul style="list-style-type: none"> Global budget agreements are published on the HSCRC’s website. New policies are being developed to refine and advance the GBR methodology.
Ongoing reporting to CMS of relevant policy development and implementation	The HSCRC provided CMS with the Annual Monitoring Report as required in the New All-Payer Model contract, as well as quarterly progress reports.	<ul style="list-style-type: none"> The HSCRC continues to provide reports to CMS on an ongoing basis.

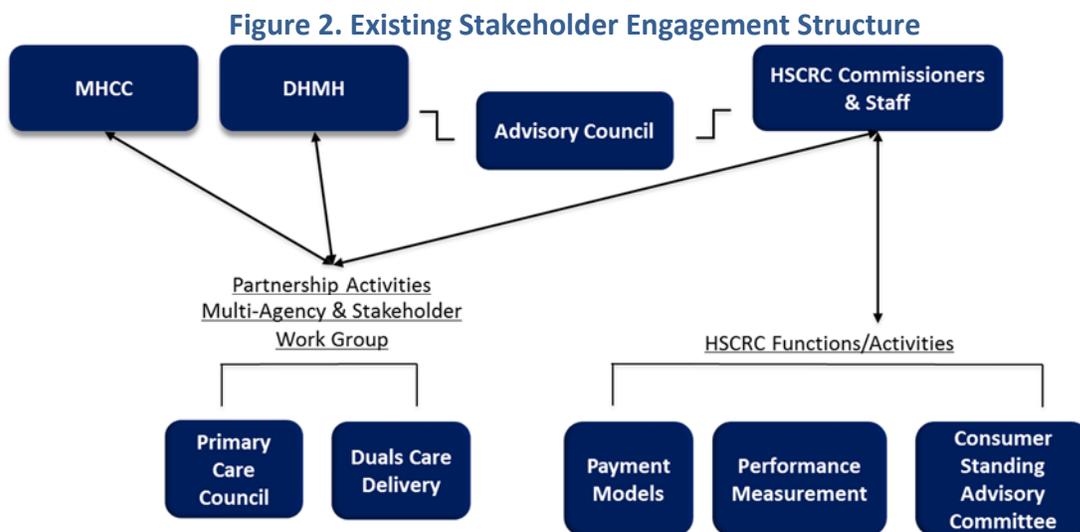
Stakeholder Engagement

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 MHCC and 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, consumers/families, 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. Three workgroups, the Care Coordination Workgroup, the Consumer Engagement and Outreach Workgroup, and the Innovations in Graduate Medical Education Workgroup, concluded and submitted reports detailing their recommendations on transformation efforts in Maryland.

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 taskforces to discuss technical, data-driven matters related to specific policies, which report back to the workgroups. Input is also solicited in informal meetings with stakeholders.

All proceedings and reports of the Work Group activities may be found on the Commission’s website at <http://www.hscrc.maryland.gov/index.cfm>.



Hospital Financial Performance

Hospital Profitability

The HSCRC monitors hospital financial performance of regulated hospitals through hospital financial data submissions. 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 2015 and on an unaudited basis for FY 2016.

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 2015

Data for FY 2015 show an increase in profitability on operations and a decrease in total profitability, i.e., both operating and non-operating activities, compared with the prior year. The increase in regulated operating profitability may be attributed to the update factor approved by the Commission for FY 2015 and a heightened focus on reducing costs. The decrease on total profitability may be attributed to losses in hospitals' unregulated business.

Profitability based on audited data for total operations, hospital operations regulated by the HSCRC, and for total hospital activities is presented below:

- The total combined audited regulated and unregulated profit margins for FY 2015 were:
 - Operating margin: 3.54 percent
 - Total margin: 3.52 percent
- The audited profit margin for FY 2015 for services regulated by the HSCRC was:
 - Operating margin: 8.39 percent

Unaudited Financial Data—FY 2016

Based on unaudited financial data for FY 2016, operating profit margins remained relatively flat over FY 2015, while total profit margins fell. Operating profitability remained relatively constant as:

- The Commission adopted an update factor that was relatively flat 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 3.19 percent, reflecting the impact of inflation, infrastructure investment, population growth, expected declines in uncompensated care, and the end of the MHIP assessment.
- 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 2016 in order to adjust for the lasting impact of the ACA coverage expansion. The coverage expansion had a larger than expected impact on uncompensated care, reducing the level from the expected 5.25 percent of revenues to 4.76 percent.

Overall, hospital margins declined in FY 2016 due to decreases in investment income and other non-operating losses. Profitability in FY 2016, based on unaudited data, is shown below. Please note that final audited data, when available, may adjust these margins:

- The total combined unaudited regulated and unregulated profit margins for FY 2016 were:
 - Operating margin: 3.06 percent
 - Total margin: 1.99 percent
- The unaudited profit margin for FY 2016 for services regulated by the HSCRC was:
 - Operating margin: 6.75 percent

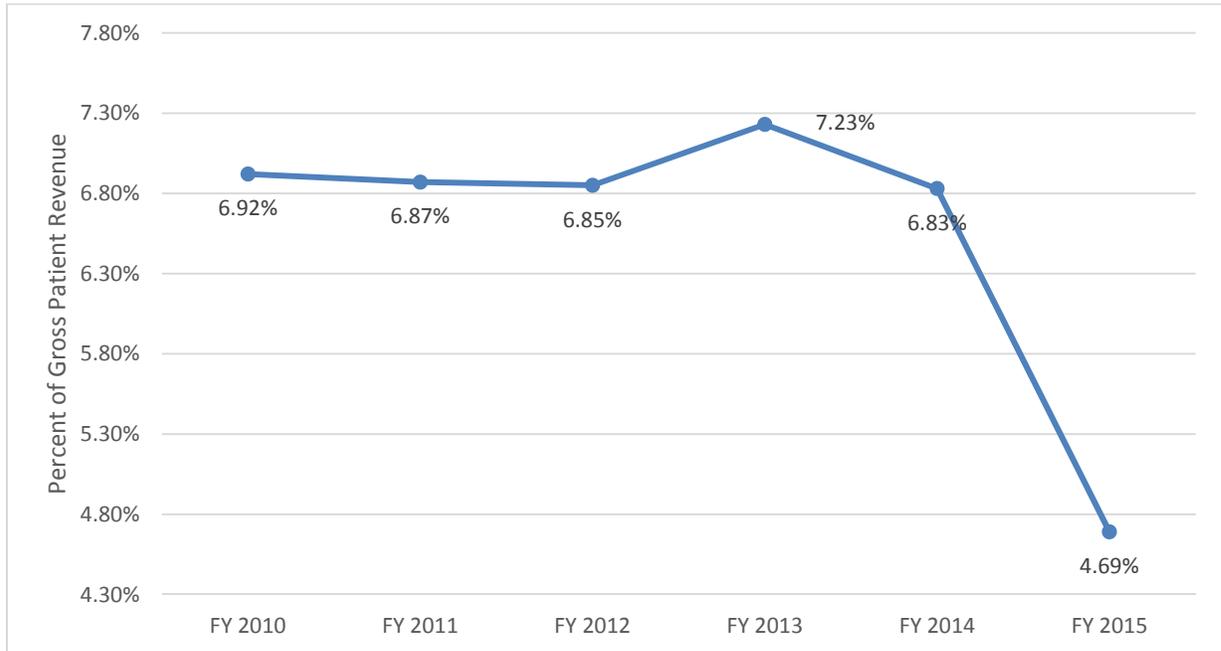
Uncompensated Care

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 standard policy provides for uncompensated care statewide based on the most recent two years of actual statewide experience, as well as a hospital's expected performance based on a regression analysis. However, the Commission modified this uncompensated care policy for both FY 2015 and FY 2016 to reflect the impact of expanded health insurance and Medicaid coverage resulting from the ACA.

Figure 3 shows the actual total uncompensated care rate for all regulated Maryland hospitals between FY 2010 and FY 2015. After declining slightly between FY 2010 and FY 2012, there was a 0.38 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 0.40 percentage points in FY 2014. In FY 2015 hospitals reported 4.69 percent total uncompensated care as a percentage of gross patient revenue, a decrease of 2.14 percentage points from FY 2014.

Figure 3. Uncompensated Care as a Percentage of Gross Patient Revenue, FY 2010-2015



Actual audited data to determine the actual amount of uncompensated care in FY 2016 is not yet available. Development of the FY 2017 uncompensated policy occurred in a less dynamic insurance market place and a more data rich environment. Two years of post-ACA implementation data, audited financial statements for FY 2015, 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 and the number of individuals enrolled in Medicaid as a result of eligibility changes to the Governor and the General Assembly 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.

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 rather than applying a calculation to estimate the actual amount averted bad debt resulting from the FY.

See Figure 4 for a summary of the report submitted in January 2016 for FY 2015. The report is available at <http://www.hscrc.maryland.gov/documents/legal-legislative/reports/hscrc-avbd-2015.pdf>.

Figure 4. Averted Bad Debt Reporting for FY 2015

Reporting Requirement	Reference	Finding
The Calculated AVBD based on 1.25% of NPR	Chapter 7, Acts of the General Assembly, 2007 Special Session	HSCRC estimate: \$164.3 million
Number of individuals who enrolled in Medicaid as a result of the change in eligibility standards	Health-General Section 15-103(A)(2)(ix) and (x) of the Health General Article	Maryland Medicaid projection: 113,500 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 2015. In that year, Maryland hospitals expended just under \$1.5 billion in community benefits, or 10.05 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 \$731.2 million or 4.98 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://www.hscrc.maryland.gov/init_cb.cfm.

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 any other 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 an overall, 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 2016 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.

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

Quality-Based Reimbursement

The QBR program adjusts hospital payments based on 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 the hospitals' final scores on the program, as illustrated in Figure 5 below.

Figure 5. QBR Measure Domain Weights for FY 2018

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

In the FY 2018 policy update, the HSCRC adjusted the weights and the measurement domains to be as consistent as possible with the CMS Value-Based Purchasing (VBP) Program and held the amount of total hospital revenue at risk for scaling to a two percent maximum penalty and a one percent maximum reward for the QBR Program. As such, the clinical care domain weight was lowered to 15 percent, and the patient experience of care/care coordination weight was raised to 50 percent, while the patient safety weight remained the same at 35 percent. Maryland has not yet developed and implemented an efficiency measure as part of the QBR Program, but it does apply a PAU adjustment to hospital global budgets, as well as a shared savings adjustment based on hospitals' readmission rates.

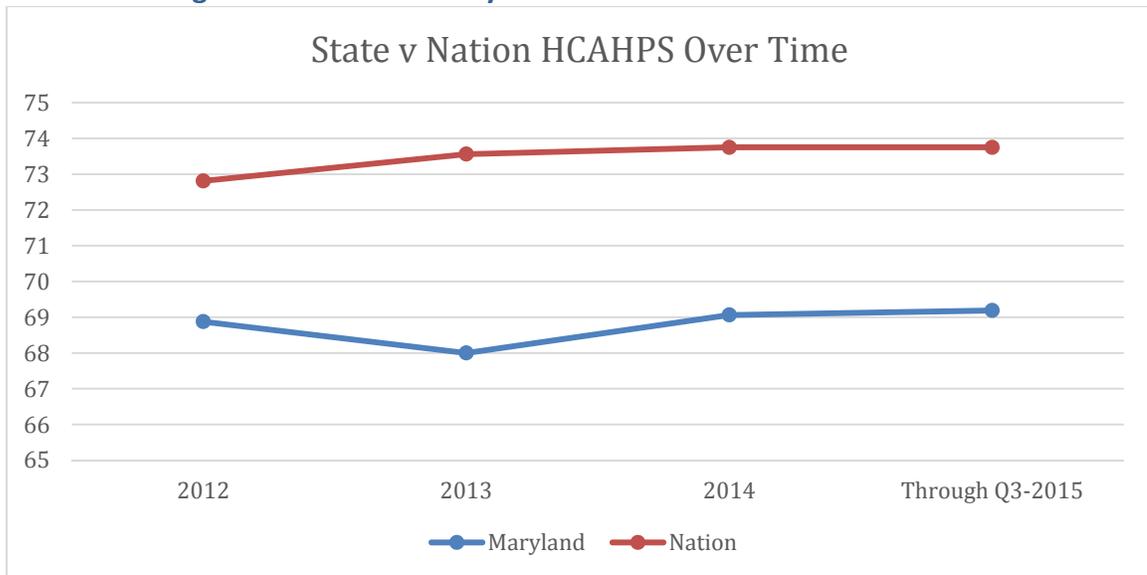
Starting in FY 2017, reward and penalty adjustments to global budgets are determined based on a preset scale rather than relatively ranking hospital performance and penalizing those with less than average performance. This change was designed to provide hospitals with predictable revenue adjustments 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 2015 as compared to third quarter of CY 2014) suggest that:

- Maryland is performing on par with the nation in terms of safety measures; performing better than the nation for Central Line-associated Blood Stream Infection, Cather-associated Urinary Tract Infection, and Surgical Site Infection after Hysterectomy safety measures; and worse than the nation for Surgical Site Infection after Colon Surgery, Methicillin-resistant Staphylococcus aureus, and Clostridium Difficile infection safety measures.

- Maryland is performing slightly better than the nation on condition-specific mortality measures.
- Maryland continues to lag behind the nation in performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience measures (see Figure 6).

Figure 6. HCAHPS – Maryland and Nation 2012-Present



The HSCRC staff remain concerned about Maryland HCAHPS performance. CMS shares this concern, as indicated in its 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.

Maryland Hospital Acquired Conditions

The MHAC program provides the needed incentives to achieve hospital care improvements and meet the target established in the New 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 January 2016 Commission meeting, staff put forward the following final recommendations for updating the MHAC program:

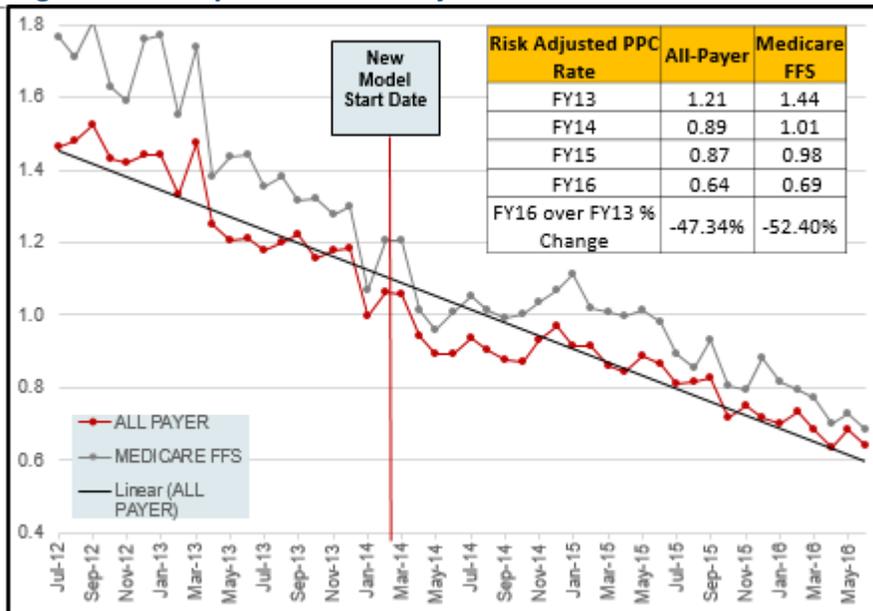
- The program should continue to use the same scaling approach:
 - The program should continue the contingent scaling approach, where a higher level of revenue is at risk if the statewide improvement target is not met. Rewards should only be distributed if the statewide improvement target is met.

- Hold-harmless zones should be created to focus the payment adjustments to both ends of the performance spectrum.
- Rewards should not be limited to the penalties collected.
- The statewide reduction target should be set at six percent, comparing FY 2015 with CY 2016 risk-adjusted PPC rates.

These final recommendations were developed by HSCRC staff based on input from the Performance Measurement Workgroup, methodological contractor, 3M, and other stakeholders. Based on this input, the HSCRC staff made slight modifications to the FY 2018 MHAC methodology in terms of included PPCs, domain/tier weights, and benchmark calculations; however all PPCs will continue to be reported to hospitals and CMS for monitoring purposes.

As shown in Figure 7, the overall case-mix adjusted hospital acquired PPC rates declined by 47.34 percent between FY 2013 and FY 2016. The HSCRC staff continues to monitor these reductions and to audit 10 hospitals annually, specifically to assess quality of present on admission indicators.

Figure 7. All-Payer Case-Mix--Adjusted PPC Rates FY 2013 – FY 2016



Readmissions Reduction Incentive Program

Maryland’s readmission rates are high compared with the rest of the nation. The New Maryland All-Payer Model Agreement requires Maryland hospitals to be equal to or below the national average for Medicare readmissions by 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 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.

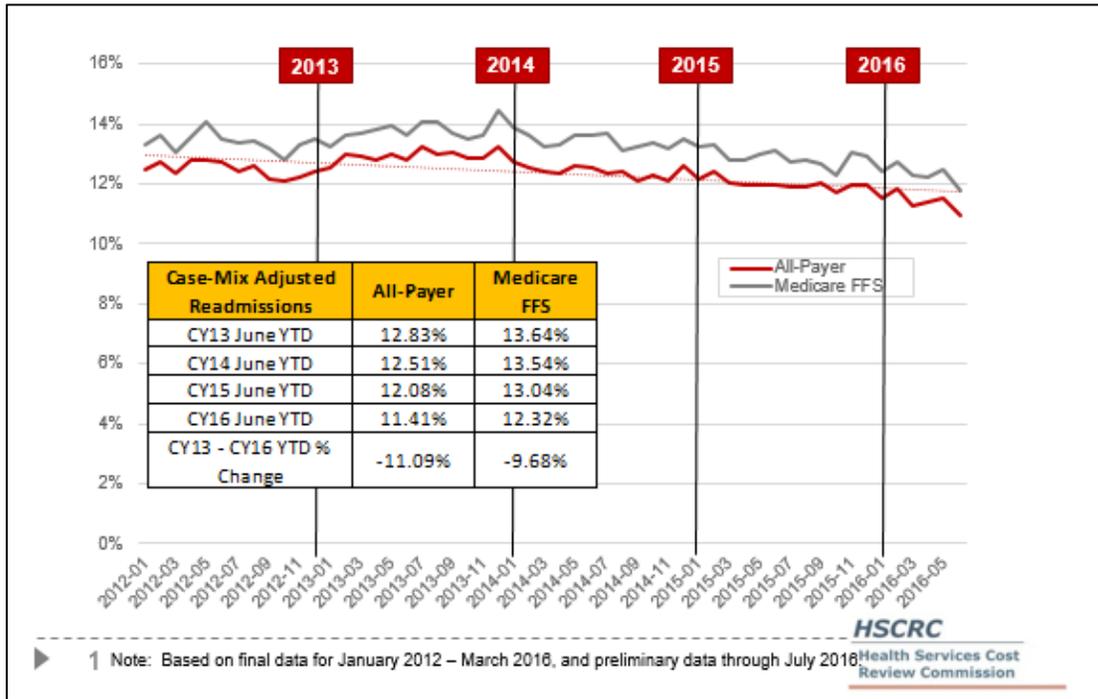
The Commission approved an updated RRIP policy for FY 2018, which also retroactively updated the FY 2017 policy, at its June 2016 Commission meeting. In concert with the Performance Measurement Workgroup and HSCRC contractors, HSCRC staff carefully considered stakeholder concerns about various issues outlined in the FY 2017 policy, including the ability of hospitals with low readmissions rates to improve and sociodemographic risk adjustments.

Based on analysis of the issues, the State adopted a policy that rewards hospitals for the better of improvement or attainment. The improvement target for FY 2018 was set at 9.50 percent. The attainment benchmark for FY 2018 was set prospectively at 11.85 percent, which is two percent lower than the statewide 25th percentile for CY 2015. 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. Additionally, the HSCRC staff examined the issue of sociodemographic risk adjustments. Ultimately, risk adjustment models that include sociodemographic adjustments based on a revised Area Deprivation Index suggest that further risk adjustment based on sociodemographic status is unwarranted as long as improvement is considered in the model.

The HSCRC will continue to closely monitor the readmissions rate and further incentivize hospital readmissions reductions to meet the national readmissions rate by the end of 2018.

Figure 8 below illustrates hospitals' aggregate positive performance through June 2016 on reducing readmissions over time for Medicare and all payers. These data show that the state has reduced case-mix adjusted readmissions by 11.10 percent and 9.70 percent for all-payers and Medicare FFS, respectively. The HSCRC staff are currently modeling further reductions that will be necessary to achieve the waiver test by 2018.

Figure 8. All-Payer and Medicare FFS Case-Mix Adjusted Readmission Rates, CY 2013-2016 YTD through June



Potentially Avoidable Utilization Savings

The HSCRC also adopted a final PAU Savings policy at its June 2016 Commission Meeting. The HSCRC expanded the types of avoidable utilization for which hospitals should have prospective global budget reductions, building off of the historical Readmissions Shared Savings Program, which shared savings from readmissions reductions with payers. The newly adopted 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 Prevention Quality Indicator logic. In addition to expanding the PAU definitions, the Commission increased the prospective savings requirement to 1.25 percent of total hospital revenue in RY 2017. 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). The Commission approved an Aggregate At-Risk policy that maintains FY 2017 at-risk levels for QBR, MHAC, and RRIP programs, and increases the total amount at-risk PAU Savings. The Aggregate At-Risk policy 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 9 illustrates the revenue at risk for FYs 2014 through 2017.

Figure 9. Revenue at Risk for Quality Programs

Program	SFY 2014	SFY 2015	SFY2016	SFY 2017
MHAC	2.0%	3.0%	4.0%	3.0%
RRIP			0.5%	2.0%
QBR	0.50%	0.50%	1.00%	2.0%
Shared Savings	0.41%	0.86%	1.35%	4.30%
GBR PAU	0.50%	0.86%	1.10%	1.12%
Total Aggregate At Risk	3.41%	5.22%	7.95%	12.41%

Infrastructure

HSCRC Staff Structure and Budget

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 DHMH. Seven Governor-appointed Commissioners oversee the HSCRC. Figure 10 provides a list of current Commissioners.

Figure 10. HSCRC Commissioners

Commissioner	Term Start Date
Nelson J. Sabatini, Chairman	February 2, 2016
Herbert S. Wong, Ph.D., Vice Chairman	July 1, 2013
George H. Bone, M.D.	July 1, 2010
John M. Colmers	July 1, 2013
Victoria W. Bayless	February 11, 2016
Jack C. Keane	July 1, 2011
Joseph Antos, Ph.D.	July 1, 2016

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 \$16

billion. This responsibility is accomplished by a relatively small and highly skilled staff of 34 full-time equivalents. To meet the demands of the New All-Payer Model, the Commission recently reorganized its staff structure and established 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

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 2016 was \$10.4 million. Due to prudent spending and vacancies that occurred during the first and second quarters of the fiscal year, the fund balance at the end of FY 2016 was \$3.7 million. This balance will be utilized in conjunction with a reduced FY 2017 user fee assessment in order to bring the fund balance to a reasonable level. User fees will continue to be adjusted throughout the year as necessary to achieve a reasonable reserve threshold.

Future Outlook

Data Acquisition and Integrity

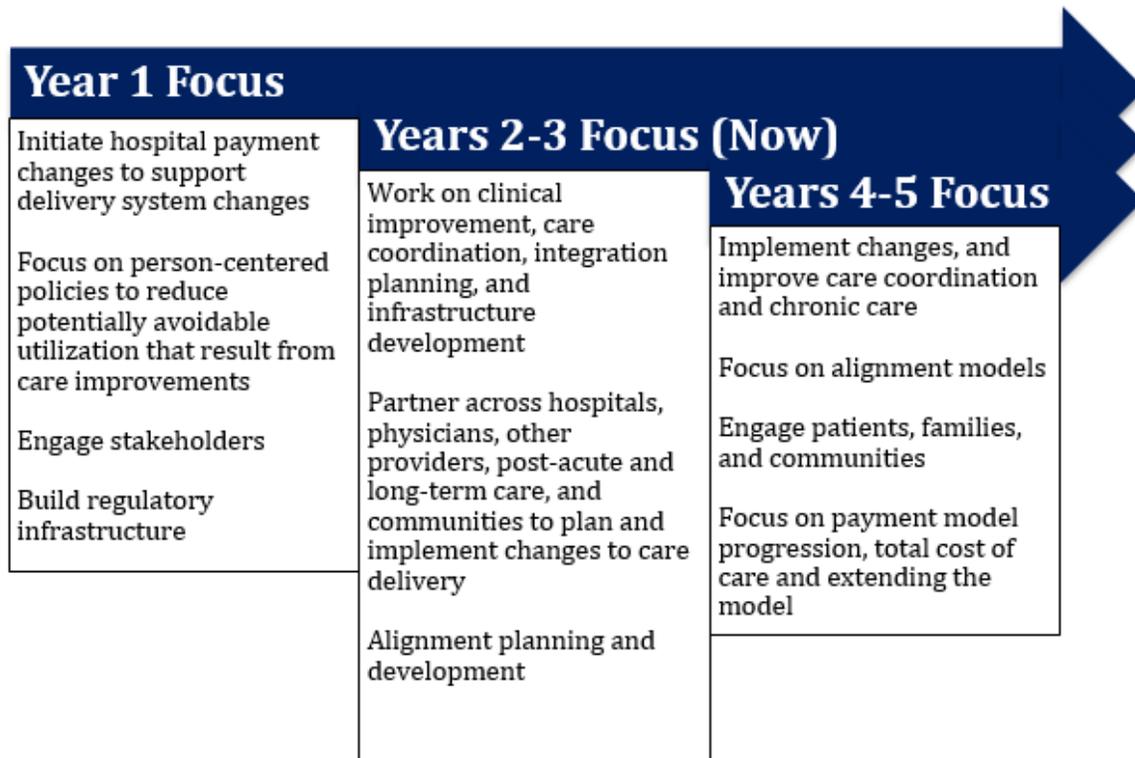
Over the last three years, the Commission has expanded its hospital data collection and reconciliation efforts to enable timely monitoring of the success of the New All-Payer Model metrics. These enhanced data collection and monitoring activities allow staff to provide the Commission with nearly real time data on hospital revenue and volumes at monthly Commission meetings.

The Commission also receives monthly feeds of Maryland and national Medicare FFS data from CMS. These data allow the Commission to monitor Maryland's performance against the nation, confirm CMS calculations of Maryland's progress toward the Medicare savings goal, and understand the factors driving Medicare FFS spending in Maryland and the rest of the nation. Staff has begun to publicly release information on Maryland's performance to the hospital industry to inform them on the State's progress on the All-Payer Model. HSCRC staff have partnered with the Maryland Hospital Association and CRISP to provide monthly, hospital-specific Medicare reports in order for the industry to engage provider partners to reduce costs inside and outside of the hospital.

Population-Based Policies

The Commission continues to implement and develop models that can improve population health, reduce PAU, and help the State meet the requirements under the All-Payer Model. Success to date has been driven by the incentives under the global budget model. As the State progresses toward a total cost of care model, it is essential to align the incentives of providers across the health care system. Figure 11 is a summary of the Commission implementation strategy toward total cost of care alignment and engagement.

Figure 11. Implementation Strategy toward TCOC Alignment and Engagement



In addition, the Commission will continue to develop per-capita based incentives that are intended to improve population health. This includes revising existing quality incentive programs to reflect per-capita performance rather than per-case performance. In a broader sense, the Commission will look at how to reflect the per-capita efficiency of hospitals under the new system. With the movement to global budgets, the HSCRC will focus on adjustments for shifts in patients between hospitals and from hospitals to unregulated sites. This will include:

- Evaluating the reasonableness of rates when volumes fall
- Gaining more consumer input and engagement

- Strengthening the use of quality, outcomes, and consumer input in rate setting and payment
- Improving performance on patient experience at Maryland hospitals
- Developing measures to evaluate performance on total cost of care and patient-centered outcomes

Building and Strengthening Partnerships

The HSCRC will continue to facilitate education and collaboration among hospitals and community providers to improve transitions of care and to promote the alignment of incentives among hospitals and other providers. While many of these activities will occur outside the HSCRC, the agency will continue the public engagement process by bringing stakeholders together to encourage collaborative activity, as described in the section on Stakeholder Involvement earlier in the report.

As the Commission progresses under the New All-Payer Model, it is important to note that success is dependent upon a robust partnership with hospitals, payers, DHMH, physicians, other providers of care, and consumers. The financial incentives put into place by the HSCRC are but one of the drivers of change and improvement. It is the many initiatives implemented by the State, the partners, and the providers that will determine the Model's ultimate success. The HSCRC's financial incentives are consistent with other State initiatives and tools, which are working in concert to improve population health and reduce costs.