Monitoring of Maryland's All-Payer Model

Status Report

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Introduction

Effective January 1, 2014, the State of Maryland and the Center for Medicare & Medicaid Innovation (CMMI) entered into a new initiative 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.

State and Federal All-Payer Model Status Reporting Requirements

State All-Payer Model Reporting Requirements

This report contains a summary of implementation, monitoring and other activities related to the new All-Payer Model. Figure 1 provides an overview of status of the key elements of the All-Payer Model contract as of October 1, 2014.

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

Section	Achievement Requirement	Metric Finding	Status
I.1.	Limit the annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58% growth rate	Per capita revenue for Maryland residents grew 0.96%	• Ongoing monthly measurement • Expecting continued favorable performance for Calendar Year 2014
I.2.	Achieve aggregate savings in Medicare spending equal to or greater than $330 million over 5 years	*Data not yet available from CMS*	• HSCRC and CMS met on methodology • Testing data from Centers for Medicare & Medicaid Services (CMS), expect preliminary tests to conclude in November
I.3.	Shift at least 80% of hospital revenue to a population-based payment structure (such as global budgets)	95% of hospital revenue shifted to global budgets	• All hospitals engaged in global budgets under Global Budget Revenue agreements and Total Patient Revenue agreements
I.4.	Reduce the hospital readmission rate for Medicare beneficiaries to below the national rate over the 5 year period of the agreement	*Data not yet available from CMS*	• HSCRC and CMMI are refining methodology • HSCRC does not yet have Medicare data needed to measure progress • Monitoring progress within Maryland using data collected from hospitals by HSCRC
I.5.	Cumulative reduction in hospital acquired conditions by 30% over 5 years	Reduction of 24.27% in hospital acquired conditions 2014 year to date compared to 2013 year to date	• HSCRC staff reviewing and auditing these findings
Section	**Description**	**Report**	**Status**
II.	Workgroup actions	All workgroups have reported to the HSCRC	• Workgroups meeting on a regular basis. Two new workgroups established for fall 2014.

Section	Achievement Requirement	Metric Finding	Status
III.	New alternative methods of rate determination	95% of hospital revenue now under global budgets arrangements, implemented in accordance with policies approved by the Commission	• New global budget agreements published on HSCRC website • Ongoing modifications underway to refine approaches
IV.	Ongoing reporting to CMS of relevant policy development and implementation	See Appendices for reports provided to CMS	• Provided reports to CMS on an ongoing basis

Federal All-Payer Model Reporting Requirements

Maryland's All-Payer Model agreement with CMMI establishes a number of requirements that Maryland must fulfill. CMMI must evaluate Maryland's performance under the model and provide reports on an annual basis. The evaluations will be made based on calendar year performance, with the first evaluation due in July 2015.[1] In addition to the annual report, the HSCRC provides ongoing reporting to CMMI of relevant policy development and implementation. If Maryland fails to meet selected requirements, CMMI must provide notification and Maryland will have the opportunity to provide information for evaluation and to provide a corrective action plan if warranted. At this time, CMMI has not provided any notices of failure to Maryland.

Section I

1. Inpatient and Outpatient Hospital Per Capita Cost Growth

Maryland's All-Payer Model agreement requires the State to limit the annual growth in all-payer hospital per capita revenue for Maryland residents to the long-term growth rate in the State's economy (a 3.58% growth rate). Over the first six months of calendar year 2014, per capita revenue for Maryland residents rose 0.96%, well below the 3.58% ceiling. Although the revenue increase for the second half of calendar year 2014 is expected to be higher, continued favorable performance is expected throughout calendar year 2014 under the global budget agreements that have been implemented for each hospital (we discuss global budgets in Section I.3 and in Section III). Global budgets result in predictable statewide revenue performance enabling the HSCRC to actively manage compliance with the 3.58% target.

2. Aggregate Medicare Savings

The 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 increase in Medicare hospital payments per Maryland beneficiary as compared to the national rate of increase in payments per beneficiary.

[1] Initial Model metrics are due to CMS May 1, 2015 with the complete annual report due June 30, 2015.

The data necessary to calculate the Medicare savings achieved by the model are not yet available. On an ongoing basis, HSCRC staff expects reports to be available with a four to six month lag, allowing CMS to process and report hospital claims. Given the importance of the calculation, the HSCRC staff is carefully reviewing the technical methodology proposed by CMMI and validating the Maryland specific data generated 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 and CMMI held meetings on the technical methodology throughout the summer and are continuing to refine the methodology. CMS began making the Maryland patient-level data available to the HSCRC in August. Additional data became available in mid-September. HSCRC staff, in conjunction with a contractor with expertise in Medicare and HSCRC data, is actively engaged in a data validation and review process. Preliminary validation of Maryland data is expected by November but will depend on the number of issues identified and the time it takes to resolve them. A calculation of Medicare savings to date will be included in the HSCRC's next Biannual Report.

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

The HSCRC has progressed toward shifting Maryland hospitals' revenues from a per-case rate system into global budget structures. All hospitals not already under a Total Patient Revenue (TPR) agreement were transitioned to Global Budget Revenue (GBR) agreements under policies approved by the Commission. With more than 95 percent of hospital revenue now under global budgeting, Maryland has exceeded the All-Payer Model agreement requirement of shifting at least 80 percent of hospital revenue to global or population based budgets. The remaining five percent of hospital revenue not under global budgets is excluded out-of-state revenue for five hospitals. These hospitals are otherwise engaged in global budgeting. The new Holy Cross Germantown Hospital that is opening in October 2014 will initially be excluded from global budgeting during its start up, but will be transitioned to a global or population based budget as soon as it reaches stable volumes. See section III of this report for a description of GBR methodology. Global budget agreements are available on the HSCRC's website at http://hscrc.maryland.gov/global-budgets.cfm.

4. Reducing the Hospital Readmission Rate among Medicare Beneficiaries

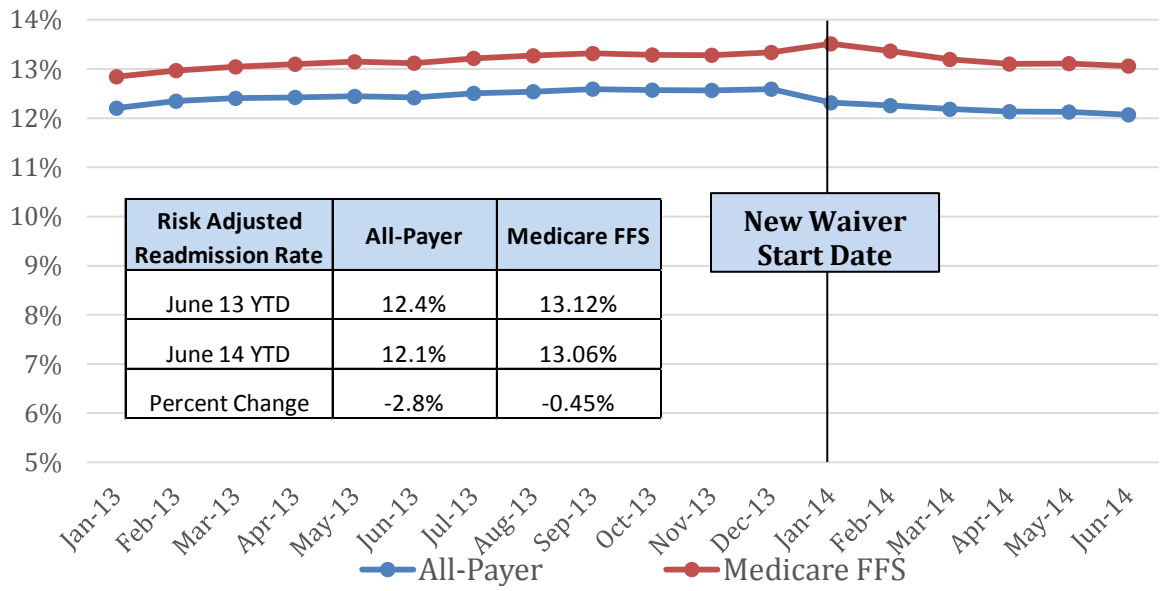
Reducing hospital inpatient readmission rates has been an aim of the HSCRC since 2011. While the readmission rate in Maryland has significantly fallen over the last several years, Maryland's readmission rate for Medicare beneficiaries remains higher than the national average. The All-Payer Model agreement requires that Maryland's hospital readmission rate for Medicare fee-for-service (FFS) beneficiaries must be at or below the national readmission rate by 2018. This metric uses national Medicare data. Currently, Maryland does not have access to the Medicare data needed to produce this metric. The HSCRC is working with the CMS and CMMI to receive access to the required data and to refine the readmissions methodology that will be used to calculate the readmissions metric.

While the HSCRC cannot report the hospital readmissions rate from CMS data for this biannual report, we are monitoring readmissions with data collected from Maryland hospitals by HSCRC. HSCRC's Maryland data show the monthly risk-adjusted readmission rate for January through June 2014 is trending lower than the rate for the previous year prior to the initiation of the All-Payer Model (Figure 2). This analysis includes all Maryland inpatients, including Medicare FFS. Based on this available HSCRC data, the all-payer risk-adjusted readmission rate year to date was 12.1% compared to 12.4% during the same time period in 2013, a 2.8% reduction. The corresponding reduction for Medicare FFS beneficiaries is less, falling by 0.45%, but remains in a downward trend.

To support readmission reduction in Maryland, the HSCRC approved the new Readmission Reduction Incentive program in April 2014, which provides a potential 0.5% revenue increase in rate year 2016 for hospitals that have at least a 6.76% reduction in risk-adjusted readmissions during calendar year 2014 compared to 2013.[2] HSCRC staff developed the 6.76% goal using assumptions about the difference between Maryland and national readmission rates, and by estimating national reductions based on historical trends.

[2] Readmission definition: Total readmissions/total admissions to any acute hospital. A discharge can both be initial and readmission; one readmission within 30 days is counted; transfers are combined into a single stay; and the 30-day period starts at the end of the combined stay, Left against medical advice is also included in the index. Admissions with discharge status of "Died" are excluded. For greater impact and potential for reaching the target, the measure includes all payers and any acute hospital readmission in the state. To enhance fairness of the methodology, planned admissions (using the CMS Algorithm V 2.1) and deliveries are excluded from readmission counts.

Figure 2. All-Payer and Medicare Fee-for-Service
Risk-Adjusted Readmission Rates Year-to-Date



Risk Adjusted Readmission Rate	All-Payer	Medicare FFS
June 13 YTD	12.4%	13.12%
June 14 YTD	12.1%	13.06%
Percent Change	-2.8%	-0.45%

Note: Based on final data for January 2013 - June 2014 and preliminary data for July 2014.

5. Cumulative Reduction in Hospital Acquired Conditions

Maryland hospitals must achieve a 30% cumulative rate of reduction of hospital acquired conditions (HAC) by 2018 to comply with the requirements of the All-Payer Model agreement. Maryland measures hospital acquired conditions using 65 Potentially Preventable Complications (PPCs).[3] PPCs are defined as harmful events (for example, accidental laceration during a procedure) or negative outcomes (for example, hospital acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease.

In order to support the goal of reducing PPCs, the HSCRC approved major revisions to the Maryland Hospital Acquired Conditions (MHAC) program in April 2014. The MHAC program calculates hospital rewards and penalties for rates of PPCs adjusted for patient mix. Specifically, these calculations now use observed to expected ratios as the basis of the measurement for all of the 65 PPCs measured, and use preset positions on a scale based on the base year scores for all PPCs to determine penalties and rewards. Figure 3 shows the all-payer risk-adjusted PPC/Complication rates year-to-date comparing July 2013 to July 2014. In July 2014, the all-payer risk-adjusted PPC rate was 0.99 per 1,000 compared to 1.30 per 1,000 for July 2013, a 24.27% reduction. The HSCRC staff is currently auditing hospitals' coding to determine whether reduction represents an improvement in documentation or an actual reduction in complications.

[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.

Figure 3. All-Payer Risk-Adjusted PPC/Complication Rates Year-to-Date

	All-Payer Risk Adjusted PPC Rate
July 13 YTD	1.30
July 14 YTD	0.99
Percent Change	-24.27%

Section II.

Workgroup Actions

The HSCRC has implemented a broad stakeholder engagement approach. More than 100 stakeholders representing consumers, payers, providers, physicians, nurses, other health care professionals, and experts have participated in these Work Groups. All Work Group meetings have been conducted in public sessions, and comments from the public have been solicited at each meeting. Technical white papers submitted by members of the research community and general public were also solicited and evaluated by the Work Groups.

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

Beginning in late 2013, in advance of the new All-Payer Model's approval, the HSCRC convened an Advisory Council, to develop guiding principles for implementation of the new globally budgeted all-payer model. The purpose of the Advisory Council was 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 consisted of a broad representation of hospitals, payers, physicians, providers, the Department of Health and Mental Hygiene, and health care experts. All meetings were open to the public and encouraged public comment.

The Advisory Council held five public meetings and put forth its final report on January 31, 2014, shortly after final approval of the new All-Payer Model. Its report made the following recommendations:

1. Focus on Meeting the Early Model Requirements
    - Focus on All-payer and Medicare tests
    - Start with Global Budgets
    - Reduce avoidable utilization
2. Meet Budget Targets, Investments in Infrastructure, and Providing Flexibility for Private Sector Innovation
3. The HSCRC should be a Regulator, Catalyst, and Advocate
4. Have Consumer Involvement in Planning and Implementation
5. Consider Physician and Other Provider Alignment
6. Transparency and the Public Engagement Process is important

The Commission received the recommendations of the Advisory Council and has taken those recommendations into account in its ongoing planning and implementation activities. At the completion of the Advisory Council meetings, the HSCRC convened four Work Groups -- Payment Models, Physician Alignment & Engagement, Performance Measurement, and Data and Infrastructure. The

Work Groups held public meetings and engaged numerous stakeholders in the implementation activities for the new All-Payer Model. Since many of the topics discussed below are inter-related, Work Groups held joint sessions or received updates on the activities of other relevant Work Groups.

2. The Payment Models Work Group

The Payment Models Work Group is charged with vetting potential recommendations for HSCRC consideration on the structure of payment models and how to balance its approach to payment updates. The following issues have been considered:

1. Balanced Updates: Recommendations for how the HSCRC should change its historic approach to annual updates, including what factors should be considered (weighting inflation, different types of volume and trends including demographic trends), innovation, capital and new services, efficiency, variable cost concepts, the "spread" between update factors for global budgets and fee-for-service budgets, the methodology used for Uncompensated Care given the significant changes in insurance coverage expected with health reform implementation, the timing of updates and the magnitude of revenue that is put at risk for meeting value-based performance goals, the use of positive incentives for quality and care improvement, and other adjustments to transitional policies adopted by HSCRC.
2. Guardrails for Model Performance: Recommendations on whether there are certain performance targets the HSCRC should establish that, if not met, would trigger a policy change, mid-year course correction or other corrective action, including whether guardrails should be developed at the hospital, region, and/or state level.
3. Market share: Recommendations on how the HSCRC should incorporate market share adjustments into payment and the timing of adjustments.

The Payment Models Work Group held seven meetings and made recommendations on various issues. Below is a summary of the Commission actions conducted related to these issues.

1. FY 2015 Balanced Update Factor and Elements – The Commission approved an update factor of 2.4% for hospitals on a global budget and 1.7% for hospital revenues under the waiver[4] but not included under a global budget. Hospitals were also provided a demographic adjustment under their global arrangements, and many GBR agreements provided for an additional infrastructure adjustment effective July 1. The revenue increase generated from these adjustments was reduced by offsetting a reduction in the MHIP assessment effective October 1, 2014, as approved by the legislature, as well as a net reduction in uncompensated care.
2. The Uncompensated Care (UC) Methodology for FY 2015 and the Impact of Full Coverage of the Primary Adult Care Program Enrollees – The Commission approved a new methodology for the UC that recognizes that the UC population

[4] The Medicare rate setting waiver authority applies to general acute hospitals and specific chronic hospitals. The Medicare rate setting waiver does not extend to psychiatric and rehabilitation hospitals or to other specialty facilities even though HSCRC sets rates for some of these facilities that apply to non-governmental payers.

is different after the passage of the Affordable Care Act (ACA). The Commission also reduced the amount of UC that would have otherwise been included in rates by 1.09% or approximately $160 million due to the PAC population receiving full coverage under the ACA.

3. Readmission Shared Savings - The Commission approved a readmission shared savings methodology. Under this methodology, the HSCRC calculates a case mix adjusted readmission rate, using intra-hospital readmissions excluding 0-1 day stays and planned admission, for each hospital for the base period and determines a statewide required percent reduction in readmission rates to achieve the revenue for shared savings. The case mix adjustment is based on observed vs. expected readmissions for each Diagnosis Related Group (DRG) and Severity of Illness (SOI) level., HSCRC staff then applies a shared savings benchmark to the risk-adjusted readmission rate to calculate the required savings contribution from each hospital. The shared savings benchmark is the required percent reduction in readmissions necessary to achieve the predetermined revenue for shared shavings. The Commission set the value of the shared savings amount to 0.4 % of total hospital revenue exclusive of one-time adjustments.

In addition to the above actions, the Commission has received frequent presentations and updates in its monthly public meetings from staff on global budget approaches and issues that are in development or being implemented operationally, including:

- Demographic Adjustment
- Market Share Adjustment
- Transfer Adjustment Methodology
- Global Budget Agreement Template

3. Physician Alignment and Engagement Work Group

The Physician Alignment and Engagement Work Group discussed how the new hospital payment models should align and engage with physicians and other health care providers in partnership with patients to achieve the goals of the new model. The Work Group was charged with considering the following issues:

1. Alignment with Emerging Physician Models: Identification of current physician payment models as background and a foundation for recommendations on shared savings, and informing the Payment Models workgroup including payment models and hospital/physician payment arrangements for different types of physicians (employed, community, primary care, specialty), and under different physician engagement scenarios, such as Accountable Care Organizations (ACO), Patient-Centered Medical Home (PCMH), and any other existing alignment programs.
2. Shared Savings: How hospitals and physicians can create aligned incentive models on an All-Payer basis to share savings, such as through creating gain sharing or pay-for-performance structures, bundled payments, including relationship to ACO, PCMH, and Medicare fee-for-service models. The Work Group discussed developing standard approaches, accounting for unduplicated savings, and

pursuing federal waivers and exemptions relative to operation of these models where necessary.

3. Care Improvement: The need for a multi-stakeholder campaign to support care improvement and the extent to which existing efforts could be leveraged to support the goals of the new All-Payer Model and enhance overall efficiency. Consider the role for the HSCRC in convening stakeholders, encouraging standardization and facilitating the acquisition and use of data, and how the HSCRC role should be coordinated among State agencies and other stakeholders.

The Work Group held seven meetings and made the following recommendations to move forward with promoting alignment and engagement:

- The HSCRC could serve as a catalyst to encourage the hospital industry, providers, and providers to consider ways to:
  - Share infrastructure, analytics, and other resources
  - Improve reporting between and for hospitals and providers
  - Make the practice of medicine more efficient for providers
  - Promote broad awareness of the objectives of the new model financial incentives and promote the various types of programs designed to support it
- HSCRC could serve as catalyst for hospitals, physicians, and other providers to work collaboratively toward models that are consistent with the goals of the Three-Part Aim and the new All-Payer Model.
- HSCRC should work with the field to pursue confirming with CMS/OIG (and/or other appropriate regulatory bodies) the ability of Maryland hospitals to pursue pay-for-performance models, without additional regulatory approval.
- The Maryland Hospital Association and MedChi work collaboratively to pursue a New Jersey type physician incentive model that is modified to be consistent with the goals of the new All-Payer Model (with input and advocacy from the HSCRC).
- The HSCRC should work with the State and key stakeholders to pursue a Maryland-specific ACO-like care integration and shared savings option, which would require infrastructure development and regulatory approval, and provide Maryland with increased flexibility in the development of a model for beneficiaries not already in ACOs, Medicare Advantage, or other CMS demonstration projects.
- HSCRC should serve as catalyst for encouraging and expanding alignment models across all payers, and consistency regarding incentives, including working with stakeholders to determine if legislative or regulatory changes are necessary to achieve the options above and to sponsor or promote those changes, as appropriate.
- HSCRC should serve as catalyst for encouraging models that are possible today (e.g., Primary Care Medical Homes and pay for performance enhancements to fee-for-service and salary models), while pursuing broader population-based models that require regulatory approvals and additional infrastructure development.

Future work topics for the Work Group include:

- Further develop Maryland specific ACO-like option
- Coordinate with Stakeholder led alignment efforts
- Outreach and Education Plan
- Care Coordination
- Post-Acute/LTC Coordination
- Evidence Based Care
- Tort Reform/Cost of Defensive Medicine

4. Performance Measurement Work Group

The Performance Measurement Work Group is charged with developing recommendations for HSCRC consideration on measures that are reliable, informative, and practical for assessing a number of important issues. This Work Group coordinated with the Payment Models Work Group which designed the overall structure through which the results of these measures are applied to payment updates and rate orders. Specifically, the Work Group discussed the following issues:

1. Reducing Potentially Avoidable Utilization to Achieve the Three-Part Aim: Recommendations on measuring volume of services that could be avoided and establishing incentives to improve patient care and reduce health care costs.
    a. Development of Statewide Targets and Hospital Performance Measurement: Recommendations on establishing statewide targets for readmissions and potentially preventable conditions and how to achieve these targets through hospital performance measurement. The new All-Payer Model requires reductions in Medicare readmissions to national levels within five (5) years and a thirty percent (30%) reduction in Maryland Hospital Acquired Conditions (MHACs). It also requires that the combination of value-based purchasing programs for Maryland put comparable revenues at risk to the national Medicare programs.
    b. Measuring potentially avoidable utilization: Recommendations on developing a comprehensive set of measures for volume of services that could be avoided with benefit to patients and health care costs. The initial set of measures under consideration includes hospital acquired conditions (safety issues), readmissions and re-hospitalizations (care planning and coordination), ambulatory sensitive conditions (effective primary and community based care), and enhanced care coordination for high needs patients (identification and planning of care).
2. Value-based Payment (Integration of Cost, Quality, Population Health and Outcomes): Recommendations on what specific measures of cost, care and health should be considered for adoption, retention or development in order to evaluate and incentivize the population-based All-Payer Model. This measurement and payment approach relates to the policy objectives of establishing payment levels that are reasonably related to the cost of providing services on an efficient basis and in accordance with the value concepts embodied in the new All-Payer Model.

3. Patient Experience and Patient-Centered Outcomes: Recommendations on integrating patient-centered concepts in the performance measurement work as well as the measures used, including, but not limited to, patient perspective measures, whether gathered through CAHPS-type instruments or in other ways, and outcome measures that are valued by patients to improve efficiency, effectiveness, and outcomes of care.

Since early February 2014, the Work Group held nine meetings and made the following recommendations to the Commission that were subsequently adopted:

1. New Measures and Methods under the Commission's Maryland Hospital Acquired Conditions Program – The Commission approved a recommendation to change the MHAC program for CY 2014 performance year in the following manner:
   - Set minimum MHAC statewide target at 8% improvement with a maximum revenue at risk of 4% of permanent inpatient revenue if this target is missed.
   - Set maximum revenue at risk at 1% of permanent inpatient revenue if CY 2014 target is met. Provide rewards to hospitals with more than 0.60 score up to 1% of permanent inpatient revenue provided sufficient funds are collected through penalties.
   - Set a maximum statewide total penalty limit at 0.5% of permanent inpatient revenue.
2. Readmission Measurement Policy: Staff provides the following recommendations for a new readmission reduction incentive program that would have CY 2014 performance applied to rate year 2016:
   - The Commission should implement a Readmissions Reduction Incentive Program.
   - The CMS readmission measure definition specifications should be used with limited adjustments to enhance the fairness of the measure.
   - The annual target for the first performance year, CY 2014, should be based on an all-payer readmission rate.
   - The risk adjusted readmission reduction target for the first year, CY 2014, should be a 6.76% compared to CY 2013 risk adjusted readmission rates. The readmission reduction target will be determined annually.
   - A positive incentive magnitude of up to 0.5% of the hospital's inpatient permanent revenue should be provided for hospitals that meet or exceed the target set forth in recommendation provided that the FY 2016 update factor has favorable conditions.

In addition to the above action items, the Commission received presentations on the following topics that are in development or being implemented operationally.

- White papers on methods to reduce potentially avoidable utilization
- Efficiency and cost measures
- Review of measures for ambulatory care settings
- Potential future population-based measures including hospital dashboards
- Changes to the Commission's existing quality-based reimbursement policy

5. Data and Infrastructure Work Group

The Data and Infrastructure Work Group considered policy implications regarding data and infrastructure requirements needed to support oversight and monitoring of the new hospital All-Payer Model and successful performance. The Work Group considered the needs of the HSCRC, as well as the needs for the health care industry and other stakeholders to achieve the goals of the model. This Work Group emphasized collaboration with other state agencies and other stakeholders to build upon the available resources and existing models for data governance. The Work Group held six meetings and discussed the following topics:

1. Data Requirements: Recommendations on the data needed to support rate setting activities; conduct evaluation activities using the key performance indicators; monitor and evaluate model performance; monitor shifts in care among hospitals and other providers; and, monitor the total cost of care.
2. Care Coordination Data and Infrastructure: Recommendations on the potential opportunities to use Medicare data to support care coordination initiatives, including: identifying the gaps in Medicare data; the best practices in predictive modeling and targeting care coordination resources; the most efficient infrastructure to support the needs of the State, hospitals, and other health care providers to meet the goals of the new model; and the relationship to initiatives supported by CMMI State Innovation Model (SIM) funding.
3. Technical and Staff Infrastructure: Recommendations on the technical infrastructure, staff resources and external resources needed to build, maintain and optimize the use of the data.
4. Data Sharing Strategy: Recommendations on the data that should be shared among the HSCRC, MHCC, SIM , DHMH, hospitals and others to manage and implement the new payment models, including the data sharing strategy to ensure protection of patient confidentiality and compliance with federal and state requirements and best practices.

The Work Group reported to Commission on the best sources of data to meet the monitoring and compliance requirements of the new model. The recommendations were focused on the monitoring requirements included in the contract between Maryland and CMS. The Work Group made a series of general recommendations as a foundation for developing unified and effective data and infrastructure policies:

- The State public and private sector health leaders need to develop a roadmap for its health care infrastructure.
- There should be a focused effort to get access to Medicare data because of its importance to care coordination and achieving the goals of the new model.
- The HSCRC and stakeholders should pursue the use of other data sources, in addition to comprehensive Medicare data, to support care coordination.
- The most efficient and effective way to host Medicare data is through a shared infrastructure that is accessible hospitals and other providers.

- Defining specific use of data will be important to prepare Maryland for implementing an infrastructure efficiently as well as supporting the case to CMMI to secure the data.
- Analysis of potential use cases of data needed to identify gaps in data sharing policy that should be addressed.

The Work Group also made specific recommendations on collecting total cost of care. They include:

- Collect aggregate total cost of care data from payers on a voluntary basis consistent with the initial reporting template developed by the subgroup (Total Cost of Care Report)
- Develop detailed template reporting instructions in sufficient time for payers to report data
- Begin to collect data by October 2014 and establish a routine reporting schedule

This Commission is pursuing these approaches toward addressing data and infrastructure needs to support the new all-payer model.

6. Phase II of the Work Group Process

Beginning in October, the Commission will engage in Phase II of the Work Group Process. The Payment Models, Alignment, and Performance Measurement work groups will continue to pursue the work identified above. The Commission will be working with two new Work Groups that will include multi-stakeholder and multi-State representation. The industry and key consumer representatives will lead these groups, and the Commission will help support and participate on these work groups. They include the Care Coordination Initiatives and Infrastructure Work Group and the Work Group on Consumer Engagement, Outreach, and Education.