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May 1, 2017

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

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

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

The Honorable Dennis Schrader
Secretary of DHMH
201 W. Preston Street
Baltimore, MD 21201

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

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

I am pleased to submit to you the fifth Monitoring of Maryland's All-Payer Model Biannual Report, prepared under Section 19-207(b)(9) of the Health-General Article of the Annotated Code of Maryland. This report discusses the State's progress during the period from July 1, 2016 through December 31, 2016, which encompasses through the fourth quarter of the third year of Maryland's new agreement with the Center for Medicare & Medicaid Innovation (CMMI).

Effective January 1, 2014, the State of Maryland and CMMI entered into a new initiative to modernize Maryland's unique all-payer rate-setting system for hospital services. This initiative which replaced Maryland's 36-year-old Medicare waiver allows Maryland to adopt new and innovative policies aimed at reducing per capita hospital expenditures and improving patient health outcomes. More information on the Health Services Cost Review Commission ("HSCRC") and Maryland hospital activities can be found on the HSCRC's website: http://www.hscrc.state.md.us/

Please contact me if you have any questions about this report, or you may contact Katie Wunderlich at katie.wunderlich@maryland.gov.

Sincerely,

Donna Kinzer
Executive Director

Monitoring of Maryland's New All-Payer Model

Biannual Report

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

April 2017

Executive Summary

Introduction

Effective January 1, 2014, the State of Maryland and the Centers for Medicare & Medicaid Services (CMS) entered into a new agreement to modernize Maryland's unique all-payer rate-setting system for hospital services. This initiative, replacing Maryland's 36-year-old Medicare waiver, allows Maryland to adopt new and innovative policies aimed at reducing per capita hospital expenditures and improving patient health outcomes. This biannual report, prepared in accordance with Maryland law, contains a summary of implementation, monitoring, and other activities during the time period from January 1, 2014 through December 31, 2016. [1] The purpose of this report is to inform the Maryland General Assembly on the status of the New Maryland All-Payer Model.

Highlights

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

- **Inpatient and Outpatient Hospital Per Capita Cost Growth –** CMS requires Maryland to limit the annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58 percent. To date, Maryland has met this target, with a growth rate of 1.47 percent between calendar years (CYs) 2013 and 2014 and 2.31 percent between CYs 2014 and 2015. Per capita revenue growth grew 0.29 percent between CYs 2015 and 2016.
- **Aggregate Medicare Savings –** CMS requires Maryland to achieve an aggregate savings in Medicare spending that is greater than or equal to $330 million over the five years of the agreement. The HSCRC gained access to CMS data and is working with a contractor to perform analytics to validate the aggregate Medicare savings calculated by CMS. Maryland realized $116 million in savings in CY 2014, $135 million in CY 2015, and $287 million[3] in CY 2016.
- **Shifting from a Per-Case Rate System to a Global Budget –** CMS requires Maryland to shift at least 80 percent of hospital revenue to global or population-based budgets. Maryland exceeded this target and has shifted 100 percent of regulated hospital revenues under global budget structures.
- **Reducing the Readmission Rate among Medicare Beneficiaries** – While the readmission rate in Maryland has decreased over the last several years, Maryland's readmission rate for Medicare beneficiaries remains higher than the national average. Under the New All-Payer Model, CMS requires Maryland's Medicare fee-for-service (FFS) hospital admission rate to be at or below the national readmission rate by the end of CY 2018. Preliminary CMS data for CY 2016 show that the

[1] Health-General Article §19-207(b)(9) Maryland Annotated Code.
[2] *Id.*
[3] The statewide savings noted here reflect an adjustment to account for undercharging that occurred in Maryland hospitals from July to December 2016. This adjustment reduces the amount of statewide savings otherwise shown in CY 2016. CY 2016 hospital savings without the undercharge adjustment is $312 million.

Maryland readmission rate decreased from 16.60 percent in CY 2013 to 15.60 percent in CY 2016. Should this decrease continue through December 2016, it will be sufficient to meet the test of the New All-Payer Model for CY 2016. The gap between the Maryland per-beneficiary readmission rate and the national rate decreased by 0.91 percent between CY 2013 and CY 2016. Additional analysis of HSCRC data show that Maryland continues to reduce readmissions on an all-payer basis; for CY 2016 the case-mix adjusted all-payer readmission rate was 10.75 percent lower than the CY 2013 readmission rate.

- **Reducing Hospital-Acquired Conditions (HACs)** – CMS requires Maryland to reduce the cumulative rate of HACs by 30 percent by the end of CY 2018. HSCRC measures HACs using a list of Potentially Preventable Complications (PPCs).[4] To date, Maryland has exceeded this target, with a 43.33 percent reduction in all-payer case-mix adjusted PPCs between CY 2013 and CY 2016. This reduction in PPCs was even higher for Medicare FFS at 45.43 percent. Staff continue to incentivize reductions in HACs through the quality incentive program.

- **Workgroup Activities –** The HSCRC continues to implement a broad stakeholder engagement approach, convening an Advisory Council and several workgroups with various subcommittees. The Payment Models and Performance Measurement Workgroups continue to meet and have established ad hoc subcommittees as needed. The Commission also established two new Workgroups: the Total Cost of Care Workgroup and the Consumer Standing Advisory Committee to provide advice regarding Commission activities. The Commission also established the Behavioral Health Performance Measurement subgroup under the Performance Measurement Workgroup. Stakeholders representing consumers, businesses, payers, providers, physicians, nurses, other health care professionals, and experts have participated in these Workgroups. All Workgroup meetings are conducted in public sessions, and comments from the public are solicited at each meeting. The Commission also participates in Workgroups and meetings aimed at establishing value-based models for patients dually eligible for Medicare and Medicaid.

- **Actions to Promote Alternative Methods of Rate Determination and Payment** – The New All-Payer Model agreement allows Maryland to develop alternative methods of rate determination. The HSCRC developed the Global Budget Revenue (GBR) reimbursement model and, as of April 2017, has moved 100 percent of acute hospital revenue under global budgets. As hospitals pursue more effective models for coordinating and managing the care of chronically ill patients, several hospital systems are offering Medicare Advantage plans. The Commission continues to review these alternative methods of rate determination each year to ensure that they do not result in a loss contract. The HSCRC has begun to work with stakeholders on augmenting the existing global budget concept with a new, population-based arrangement in the future.

- **Reports to CMS** – To date, the HSCRC has met all of CMS's reporting requirements.

- **Progression Plan Submission** – The All-Payer Model Agreement called for Maryland to submit a proposal for a new model no later than January 2017, which shall limit, at a minimum, the Medicare beneficiary total cost of care growth rate. On December 16, 2016, Governor Larry J. Hogan Jr. submitted the "Progression Plan" to

[4] 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.

CMS. The Progression Plan describes Maryland's proposal to accomplish the Model's expanded system-wide goals.[5]

- **Reporting Adverse Consequences** – Under the All-Payer Model contract, CMMI monitors the total cost of care in Maryland to ensure that reductions in hospital potentially avoidable utilization (PAU) does not result in unreasonable increases in the total cost of care, which includes costs associated with all other health care providers. The All Payer Model contract provides that in any one calendar year, Medicare total cost of care growth in Maryland may not grow more that 1% above Medicare total cost of care growth nationally. However, in any two consecutive years, Maryland's Medicare total cost of care may not exceed the nation. While the growth of total cost of care in Maryland exceeded that of the nation's total cost of care growth rate in CY 2015, the growth rate in CY 2016 was below that of the nation's, ensuring compliance with the terms of the contract. In CY 2016, Maryland's total cost of care was approximately 0.70 percent below the national growth rate. The Commission continues to closely monitor this metric and will take action to ensure that the two consecutive year requirement is not breached. The HSCRC will continue to develop monitoring tools, measure performance, and engage stakeholders in order to identify and resolve any adverse consequences that may arise as quickly as possible.

[5] For more information on the Progression Plan, see http://www.hscrc.maryland.gov/progression.cfm.

Introduction

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

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

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

This report contains a summary of implementation, monitoring, and other activities to inform the Maryland General Assembly on the status of the New Maryland All-Payer Model. This New Maryland All-Payer Model Biannual Report, prepared in accordance with Maryland law, discusses the State's progress during the period from January 1, 2014, through December 31, 2016, based on the information available at the time.[6] The Maryland Health Services Cost Review Commission (HSCRC or Commission) will update the report every six months. Figure 1 provides an overview of the reporting required by law under the New Maryland All-Payer Model. [7]

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

Section	Achievement Requirement	Accomplishments	Ongoing Activities
I.1.	Limit the annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58%	Per capita revenue for Maryland residents grew 1.47% between CY 2013 and CY 2014. CY 2015 per capita revenue grew 2.31% over CY 2014. Per capita revenue grew 0.29% between CYs 2015 and 2016.	• Ongoing monthly measurement • Expecting continued favorable performance for CY 2016
I.2.	Achieve aggregate savings in Medicare spending equal to or greater than $330 million over 5 years	$116 million in Performance Year (PY) 1 (CY 2014), $135 million in PY2 (CY 2015), and $287 million in PY 3 (CY 2016)[8].	• The HSCRC is working with an analytics contractor to examine and replicate CMS calculations of Medicare savings and per beneficiary growth rates for CY 2017

[6] Health-General Article §19-207(b)(9) Maryland Annotated Code.
[7] *Id.*
[8] The statewide savings noted here reflect an adjustment to account for undercharging that occurred in Maryland hospitals from July to December 2016. This adjustment reduces the amount of statewide savings otherwise shown in CY 2016. CY 2016 hospital savings without the undercharge adjustment is $312 million.

Section	Achievement Requirement	Accomplishments	Ongoing Activities
I.3.	Shift at least 80% of hospital revenue to a population-based payment structure (such as global budgets)	100% of hospital revenue shifted to global budgets	• All hospitals are engaged in global budgets under Global Budget Revenue (GBR) agreements • HSCRC continues to refine global budget methodology
I.4.	Reduce the hospital readmission rate for Medicare beneficiaries to below the national rate over the 5-year period of the agreement	The gap between the Maryland per beneficiary readmission rate and the national rate decreased by 0.93% between CY 2013 and CY 2016.	• HSCRC is monitoring progress within Maryland using data it collects from hospitals and continues to see declines in all-payer, Medicare FFS, and Medicaid readmissions • The HSCRC is updating its Readmission Reduction Incentive Program (RRIP) for rate year (RY) 2019
I.5.	Cumulative reduction in hospital acquired conditions (HACs) by 30% over 5 years	Reduction of 33% in all-payer, case-mix adjusted potentially preventable complication (PPC) rate in CY 2015 compared to CY 2013. The all-payer reduction between CY 2013 and CY 2016 is 43.33%.	• HSCRC continues to incentivize PPC reductions through the Maryland Hospital Acquired Conditions (MHAC) program, despite having achieved the 30% required reduction • HSCRC continues to review and audit these findings and monitor International Classification of Diseases – 10th Edition (ICD-10) conversion
I.6	Monitor Total Cost of Care (TCOC) for Medicare and maintain growth within guardrails	Using preliminary data for CY 2016, the growth in TCOC for Maryland's Medicare beneficiaries was .70% below the national growth rate when compared to CY 2015. When compared to the base year (CY 2013), the cumulative growth rate in Maryland is lower than the national growth rate, and Maryland is exceeding its savings requirements, even after considering the growth in non-hospital costs.	• HSCRC is closely monitoring TCOC growth for CY 2017.
II	Workgroup Actions	The Advisory Council reconvened in February 2016 and met monthly through October 2016 to assist in developing the vision for Phase II of the All-Payer Model. The HSCRC convened two new workgroups: the Total Cost of Care Workgroup and the Consumer Standing Advisory Committee, as well as a subgroup of Performance	• Active workgroups continue to meet on a regular basis

Section	Achievement Requirement	Accomplishments	Ongoing Activities
		Measurement on Behavioral Health.	
III	New alternative methods of rate determination	100% of hospital revenue is now under global budget arrangements, implemented in accordance with policies approved by the Commission.	• Global budget agreements are published on the HSCRC's website • New policies are being developed to refine and advance the GBR methodology
IV	Ongoing reporting to CMS of relevant policy development and implementation	The HSCRC provided CMS with the Annual Monitoring Report as required in the New All-Payer Model contract, as well as quarterly progress reports.	• The HSCRC continues to provide reports to CMS on an ongoing basis
V.	Submission of Phase II Progression Plan to CMS	The HSCRC submitted its application for Phase II of the All-Payer Model to CMS in December 2016	• The Commission has started negotiations with CMS for Phase II of the All Payer Model

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

Maryland's New All-Payer Model agreement with CMS establishes a number of requirements that the State must fulfill. CMS must evaluate and provide an annual report on Maryland's calendar year performance. The HSCRC submitted the Model's Annual Monitoring Report to CMS in December 2016 and will submit its mid-year Annual Monitoring Report to CMS in July 2017.[9] In addition to the annual report, the HSCRC provides ongoing reporting to CMS on relevant policy and implementation developments. If Maryland fails to meet selected requirements, CMS would provide notification, and Maryland would have the opportunity to provide information and a corrective action plan, if warranted. At this time, CMS has not provided any failure notifications to Maryland.

Section I

1. Inpatient and Outpatient Hospital Per Capita Cost Growth

The New Maryland All-Payer Model agreement requires the State to limit the average annual growth in all-payer hospital per capita revenue for Maryland residents to the average growth in per capita gross state product (GSP) for the period of 2002 through 2012 (a 3.58 percent growth rate). Per capita revenue for Maryland residents increased by 1.47 percent between CYs 2013 and 2014 and by 2.31 percent between CYs 2014 and 2015. Per capita revenue growth grew 0.29 percent between CYs 2015 and 2016. Continued favorable performance is expected as global budgets (discussed at greater length in Section III) result in predictable statewide revenue performance, enabling the HSCRC to actively manage compliance with the 3.58 percent target.

[9] The annual report is currently submitted in two parts due to timeliness of data availability. A partial report detailing CY 2016 is submitted in July, and a final report with full CY 2016 data is submitted in December, as available.

2. Aggregate Medicare Savings

The New Maryland All-Payer Model agreement requires the State to achieve an aggregate savings in Medicare spending equal to or greater than $330 million over the five years of the agreement. Savings are calculated by comparing the rate of increase in Medicare hospital payments per Maryland beneficiary with the national rate of increase in payments per beneficiary. Currently, CMS completes this calculation and provides an aggregate monthly report to the HSCRC. Maryland realized $116 million in savings in CY 2014, $135 million in CY 2015, and $287 million in CY 2016[10].

The HSCRC is currently working with a new Medicare analytics contractor to validate the aggregate Medicare savings calculation conducted by CMS. The new vendor was brought on board in February 2017. It is in the interest of both parties that the calculation correctly captures hospital payments made on behalf of Medicare beneficiaries who are Maryland residents. The HSCRC's new vendor is working on replicating CMS's analysis of Maryland's data for CY 2016. Prior years (CYs 2013 through 2015) were reconciled by the old vendor.

HSCRC has been tracking Medicare fee-for-service (FFS) per capita cost trends from its own Maryland data. Based on these data, the Medicare FFS per capita revenue declined by 1.12 percent between CYs 2013 and 2014, and grew by 1.14 percent in CY 2015. In CY 2016, the Medicare FFS per capita revenue declined by 1.91 percent over the same time period in CY 2015 (as of April 2017).

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

As of April 2017, 100 percent of Maryland regulated hospital revenues are contained within global budget structures. This exceeds the New Maryland All-Payer Model agreement requirement of shifting at least 80 percent of hospital revenue to global or population based budgets. All regulated Maryland hospitals now operate under GBR agreements, through policies approved by the Commission. Global budget agreements are available on the Global Budget Web Page of the HSCRC website.

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

4. Reducing the Hospital Readmission Rate among Medicare Beneficiaries

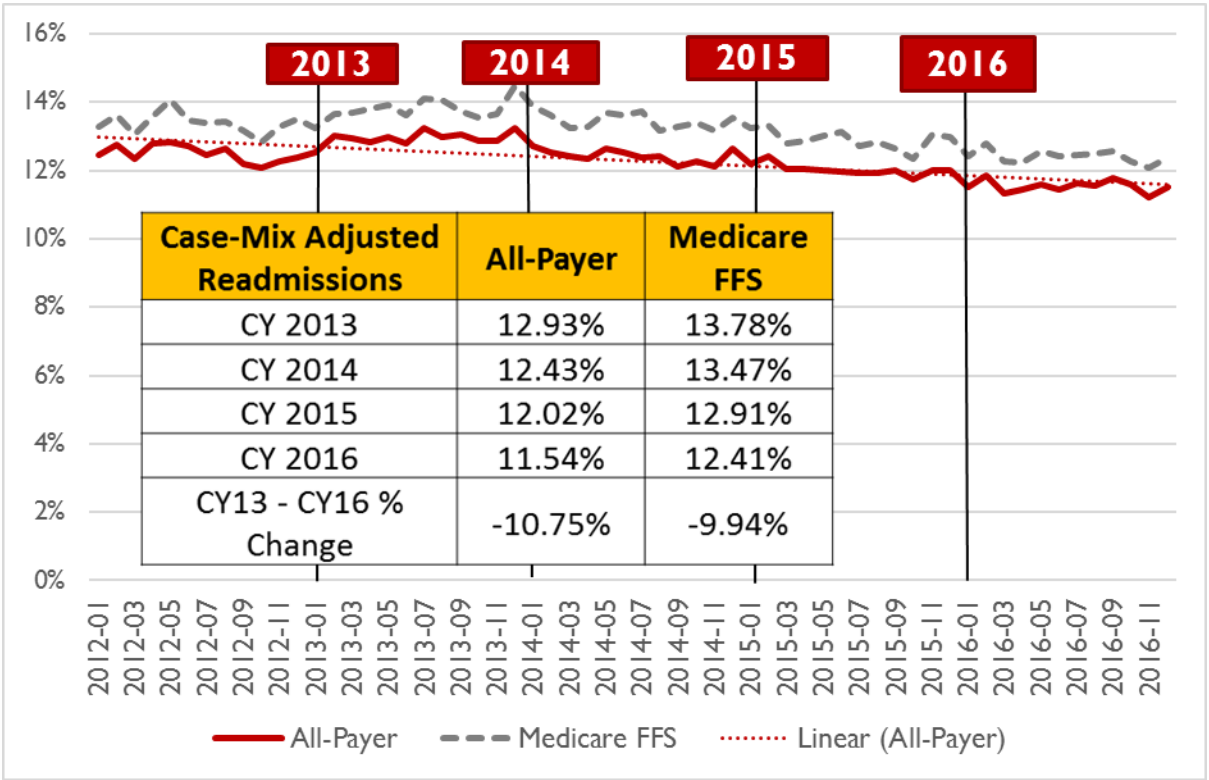
Reducing hospital inpatient readmission rates has been an aim of the HSCRC since 2011. While the readmission rate in Maryland has fallen over the last several years, Maryland's readmission rate for Medicare beneficiaries remains higher than the national average. The New Maryland All-Payer Model agreement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

[10] The statewide savings noted in this paragraph reflect an adjustment to account for undercharging that occurred in Maryland hospitals from July to December 2016. This adjustment reduces the amount of statewide savings otherwise shown in CY 2016. CY 2016 hospital savings without the undercharge adjustment is $312 million.

Overall, HSCRC's hospital data show that the monthly case-mix adjusted readmission rate for CY 2016 is trending lower than the rate for CY 2013, CY 2014, and CY 2015 (Figure 2). This analysis includes all Maryland inpatient stays, including Medicare FFS. Based on these HSCRC data, the all-payer, case-mix adjusted readmission rate YTD through December 2016 was 11.54 percent, compared with 12.93 percent during 2013, a 10.75 percent reduction. The corresponding readmission reduction for Medicare FFS beneficiaries was slightly lower (9.94 percent). This reduction highlights the difficulty and time involved in reducing readmissions, as it requires significant effort, investment, and coordination across providers.

Staff believe that the addition of penalties to the Readmission Reduction Incentive Program (RRIP) provides strong incentives to reduce readmissions compared with the RY 2016 program that only had rewards. In the RY 2018 policy, staff modified the policy to reward both improvement and attainment. Staff are currently updating the RY 2019 policy and recommend that hospitals continue to be measured based on improvement and attainment. To help readmission reduction efforts, the HSCRC continues to improve its readmission reporting capability by leveraging resources available in the state Health Information Exchange and providing timely, monthly, patient-specific data to hospitals.

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



Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
CY 2013	12.93%	13.78%
CY 2014	12.43%	13.47%
CY 2015	12.02%	12.91%
CY 2016	11.54%	12.41%
CY13 - CY16 % Change	-10.75%	-9.94%

5. Cumulative Reduction in Hospital Acquired Conditions

Maryland hospitals must achieve a 30 percent cumulative reduction in HACs by 2018 to comply with the New Maryland All-Payer Model agreement. Maryland measures HACs using a list of PPCs.[11] PPCs are defined as harmful events (e.g., accidental laceration during a procedure) or negative outcomes (e.g., hospital-acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease.

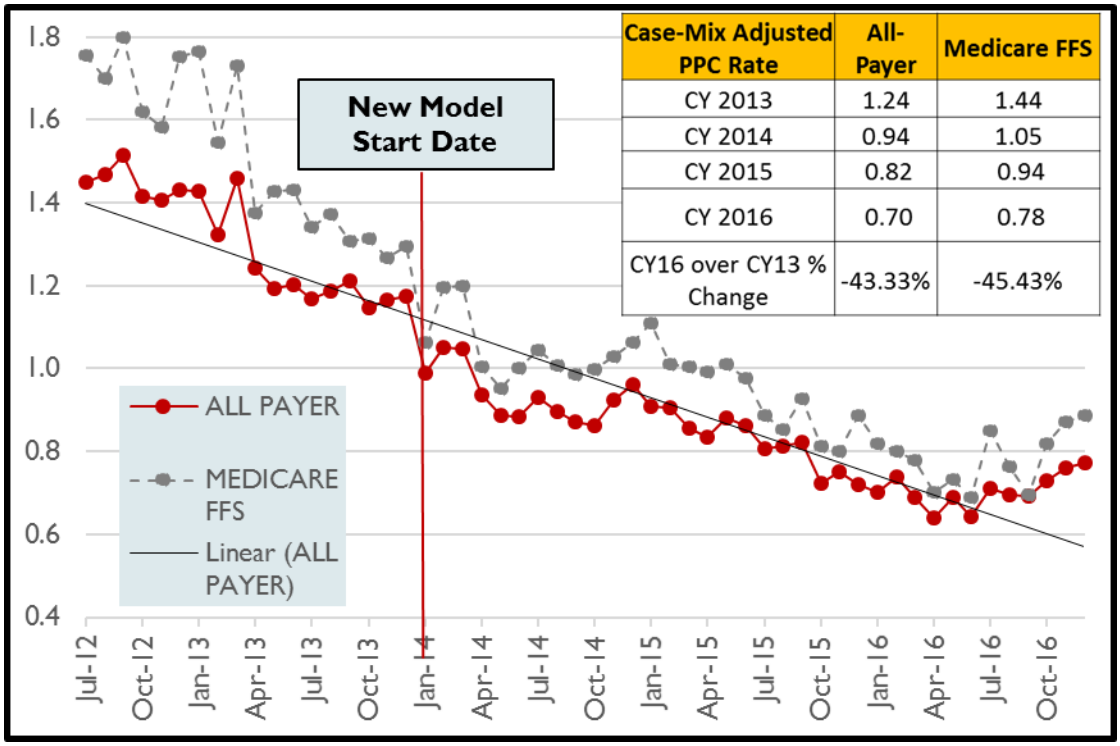
As discussed in the October 2014 New Maryland All-Payer Model Biannual report, the HSCRC approved major revisions to the Maryland Hospital Acquired Conditions (MHAC) program in April 2014 in order to support the goal of reducing PPCs. The MHAC program calculates hospital rewards and penalties for case-mix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

Figure 3 shows the all-payer and Medicare FFS case-mix-adjusted PPC rates by month and year. In CY 2016, the all-payer case-mix adjusted PPC rate was 0.70 per 1,000, compared with 1.24 per 1,000 for CY 2013, which is a 43.33 percent reduction. The reduction in the case-mix adjusted complication rate for Medicare FFS was even higher at 45.43 percent. While this reduction in the case-mix adjusted complication rate exceeds the new waiver target of 30 percent by 2018, the HSCRC will continue to incentivize hospitals to further reduce PPCs in future years, and to ensure that Maryland hospitals will continue to have a waiver from the CMS HAC program.

The HSCRC staff review annual audits of approximately ten hospitals to ensure coding accuracy with the medical record documentation. If audit issues are found, staff will follow up with the hospital to understand the issue(s) and take appropriate action. Currently, the HSCRC is working with one hospital with audit results that exceeded the HSCRC thresholds. The HSCRC also works closely with 3M, the Maryland Hospital Association (MHA), and the hospital industry around International Classification of Diseases – 10th Edition (ICD-10) implementation. To date, the HSCRC has not seen significant changes in PPC rates due to ICD-10.

[11] 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 Rates CY2013-CY2016



Case-Mix Adjusted PPC Rate	All-Payer	Medicare FFS
CY 2013	1.24	1.44
CY 2014	0.94	1.05
CY 2015	0.82	0.94
CY 2016	0.70	0.78
CY16 over CY13 % Change	-43.33%	-45.43%

6. Medicare Savings and Total Cost of Care Performance

Under the New All-Payer Model agreement, the total cost of care growth for Maryland Medicare beneficiaries may not exceed the national growth rate by more than 1 percent in any given year and may not exceed the national growth for two consecutive years. The results for Medicare for the first year of the All-Payer Model were positive, while the second year results were mixed. Staff estimates results for the third year are positive (see Figures 4-6).

- In the first year of the Model, non-hospital costs were contained, and Medicare saved money on both hospital and non-hospital costs.
- In the second year of the Model, Maryland Medicare hospital cost growth remained stable, but non-hospital costs increased and even offset some of the hospital savings achieved in the first year. Maryland exceeded the national Medicare total cost of care growth rate in CY 2015 by about 0.70 percent.
- Based on preliminary data for CY 2016, HSCRC staff estimates the Medicare total cost of care growth in Maryland to be lower than the nation by .70 percent. Staff estimates this may change slightly when final data is submitted. With monthly fluctuations, Medicare total cost of care continues to be of concern.

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

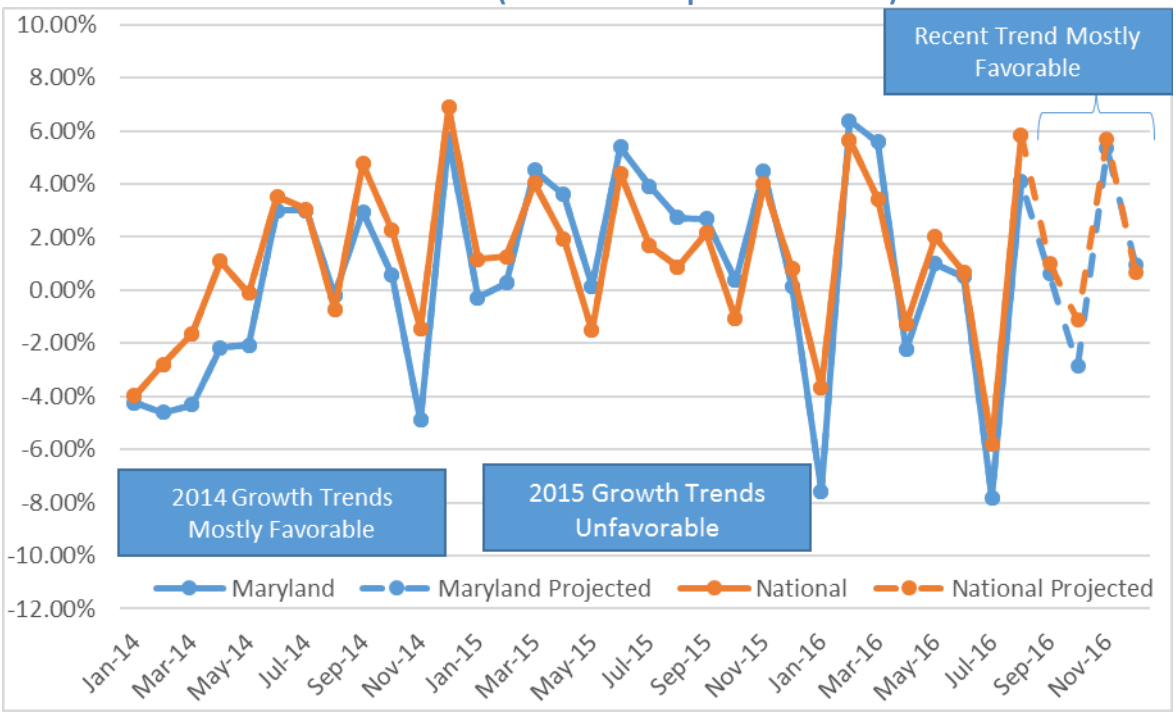


Figure 5. Medicare Hospital Spending per Capita
Actual Growth Trend (CY month vs. prior CY month)

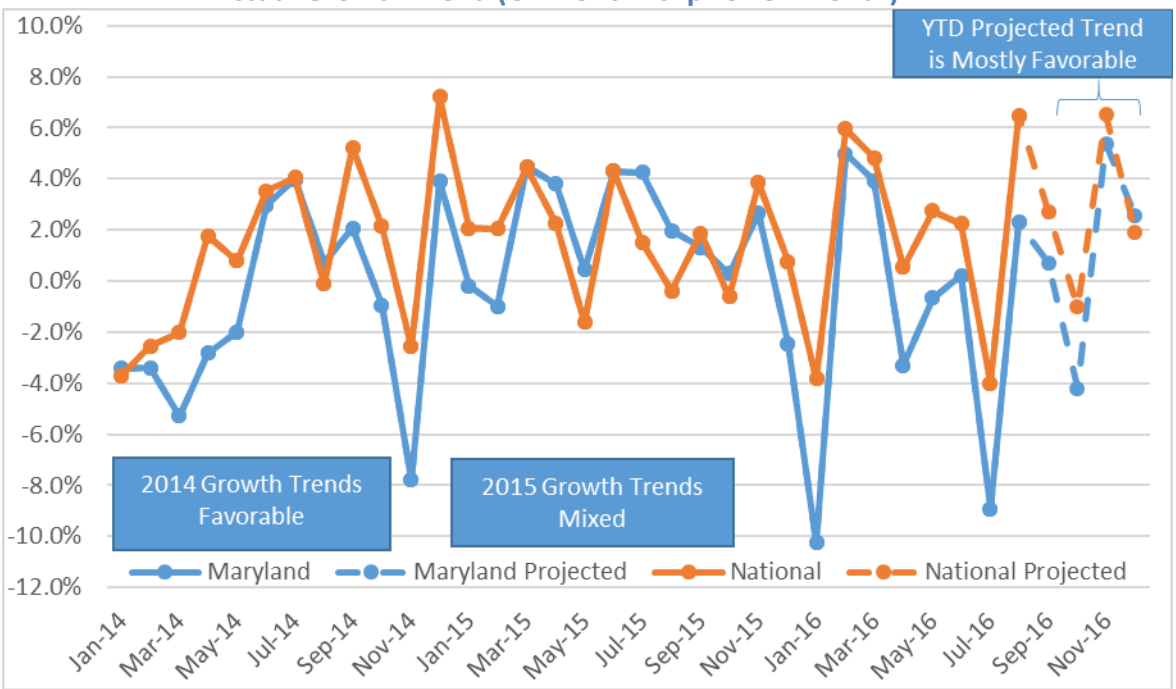
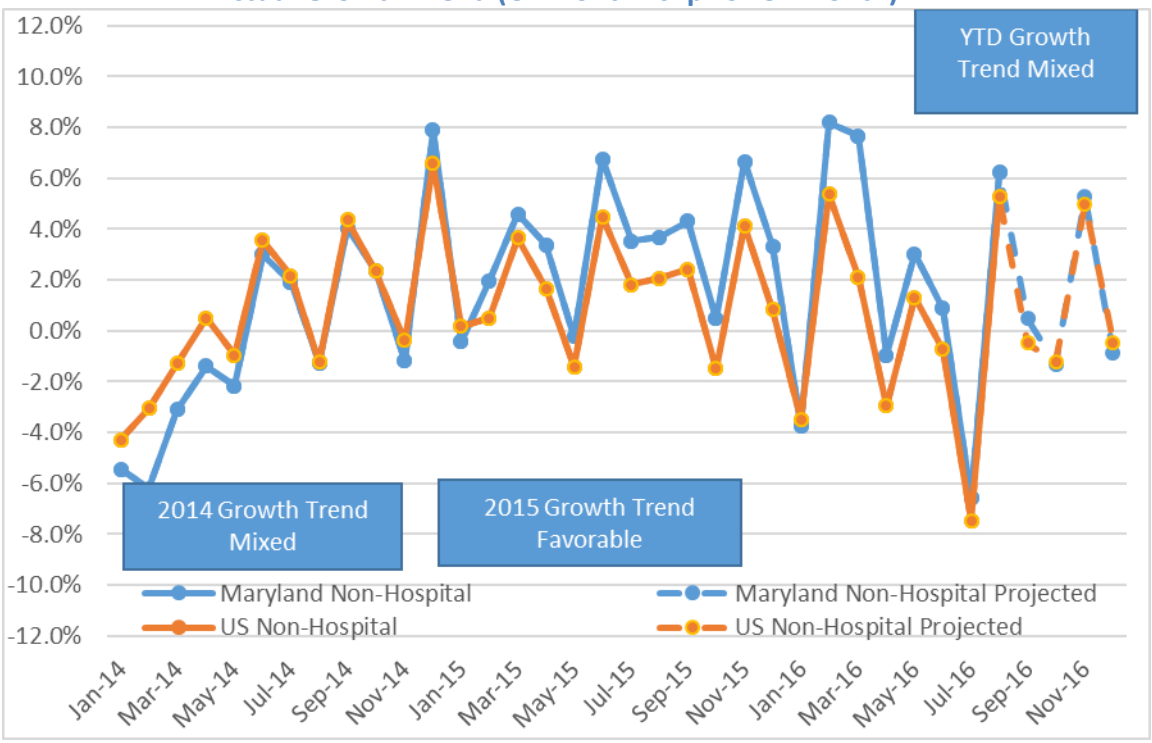


Figure 6. Non-Hospital Spending per Capita
Actual Growth Trend (CY month vs. prior CY month)



Section II

Workgroup Actions

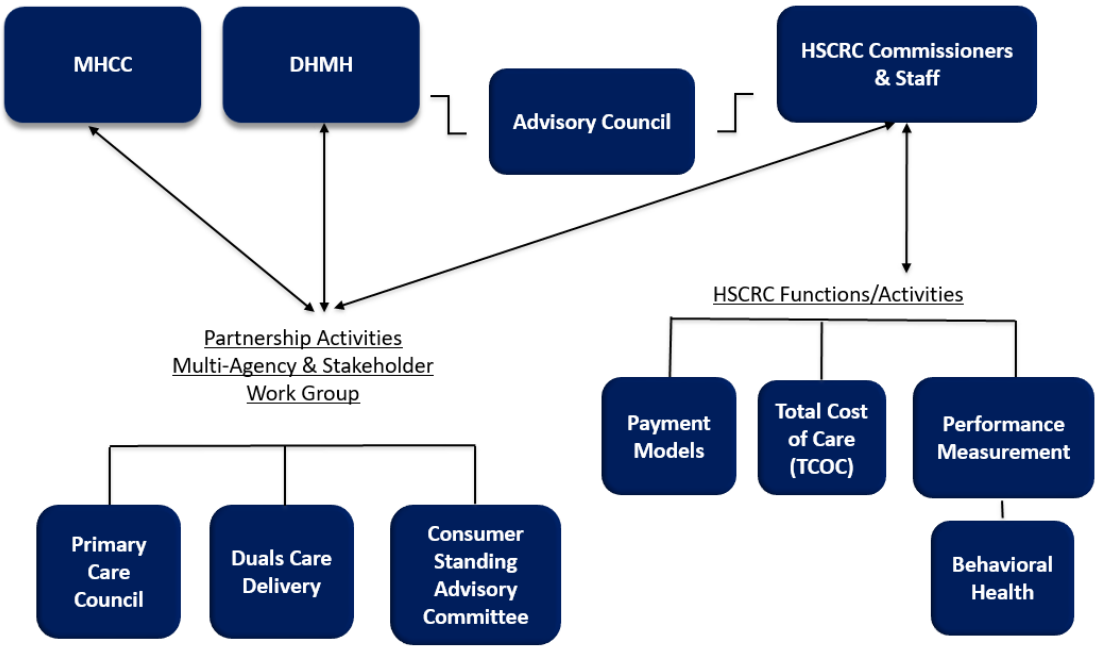
The HSCRC continues to implement a broad stakeholder engagement approach to healthcare transformation through stakeholder Workgroups. As the All-Payer Model progression broadens to include providers and delivery systems beyond hospitals, the HSCRC has focused on coordinating Workgroup efforts across agencies. In partnership with the Maryland Health Care Commission (MHCC) and the Maryland Department of Health and Mental Hygiene (DHMH), the HSCRC has participated in a Primary Care Council and the Duals Care Delivery Workgroup. In February 2016, the Commission and DHMH reconvened an Advisory Council to assist in developing the vision for Phase II of the All-Payer Model, which moves to a broader total cost of care model. The Council included a broad set of stakeholders representing hospitals, the insurance industry, long-term care providers, post-acute care providers, physicians, and other providers. The Advisory Council adjourned in September, but may reconvene in 2017 as negotiations for Phase II of the All-Payer Model progress. The Payment Models and Performance Measurement Workgroups continued to meet regularly throughout CY 2016. The HSCRC also established two new workgroups and one subgroup in the fall: the Consumer Standing Advisory Committee, the Total Cost of Care Workgroup, and the Behavioral Health

Performance Measurement subgroup under the Performance Measurement Workgroup.

Figure 7 depicts the current structure of the stakeholder engagement Workgroups. All Workgroup meetings are conducted in public sessions, and comments are solicited from the public at each meeting. There are also a number of sub-workgroup meetings and task forces to discuss technical, data-driven matters related to specific policies, which report back to the larger Workgroups. Input is also solicited in informal meetings with stakeholders.

All proceedings and reports of the Workgroup activities may be found on the Commission's website at http://www.hscrc.maryland.gov/.

Figure 7. Existing Stakeholder Engagement Structure



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

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

In September, the Council finalized a report for HSCRC and DHMH to consider in their planning efforts. These recommendations revolved around the following six major domains: 1) vision; 2) roadmap, focus, and progression; 3) person-centered care; 4) data; 5) accountability; and 6) alignment.

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

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

2. The Payment Models Workgroup

The Payment Models Workgroup is charged with vetting potential recommendations for HSCRC consideration on the structure of payment models and how to balance its approach to payment updates. During CY 2016, the Workgroup reviewed several policies described above, including the FY 2017 Update Factor, the FY 2017 Uncompensated Care (UCC) Policy, and the FY 2017 Potentially Avoidable Utilization (PAU) Savings policy. Additionally, the Payment Models Workgroup discussed market shift adjustments, which are included in rate orders. For RY 2017, these were incorporated on a semi-annual basis, increasing the frequency of the adjustment. The Workgroup also discussed the increases in total cost of care for Medicare. Staff is currently working on updating these policies for FY 2018.

3. Performance Measurement Workgroup

The Performance Measurement Workgroup develops recommendations for HSCRC consideration on measures that are reliable, informative, and practical for assessing a number of important quality and efficiency issues. In the final quarter of CY 2016, the Performance Measurement Workgroup reviewed the Quality-Based Reimbursement (QBR) Policy for RY 2017, RY 2018, and RY 2019. Current objectives include updating quality incentive program policies for RY 2019 and resolving data issues.

4. Behavioral Health Performance Measurement Subgroup

The Behavioral Health Performance Measurement Subgroup convened at the end of CY 2016 with the goal of identifying quality metrics, reliable data sources, and measurement approaches to monitor behavioral health care provided in psychiatric units in Maryland acute care and free-standing psychiatric hospitals. The group will continue to meet throughout CY 2017 to analyze performance measurement options related to behavioral healthcare.

5. Consumer Standing Advisory Committee

The Consumer Standing Advisory Committee builds on existing consumer engagement and involvement across various HSCRC and DHMH Workgroups in an effort to bring together a diverse cross-section of consumers, consumer advocates, relevant subject matter experts, and other stakeholders. Workgroup goals include: ensuring that the consumer perspective is reflected in and remains central to the All Payer Model and ongoing modernization efforts; promoting understanding of the All-Payer Model and its impact on improving healthcare for patients; and gathering

input from consumers to ensure those perspectives are used to inform the policymaking process. The group convened at the end of CY 2016 and will continue to meet throughout CY 2017.

6. Total Cost of Care Workgroup

The Total Cost of Care (TCOC) Workgroup is charged with providing feedback to the HSCRC on the development of specific methodologies and calculations for TCOC. The group convened at the end of CY 2016 and will continue to meet throughout CY 2017 to assist in determining the technical aspects of TCOC for the State's All-Payer Model.

Section III

1. Alternative Methods of Rate Determination

The Maryland All-Payer Model agreement affords the State the ability to innovate by developing alternative methods of rate determination. During the first six months of the New Maryland All-Payer Model, the HSCRC developed the global budget revenue (GBR) reimbursement model and engaged all hospitals not already under a TPR agreement in GBR. As of April 2017, 100 percent of Maryland regulated hospital revenues are contained within GBR agreements. In addition to regulated acute hospital revenue under global budgets, the HSCRC sets the rates of non-governmental payers and purchasers for psychiatric hospitals and Mount Washington Pediatric Hospital.

The GBR methodology is central to achieving the goals set forth in the Maryland All-Payer Model: promoting better care, better health, and lower cost for all Maryland patients. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the New Maryland All-Payer Model focuses on controlling increases in total hospital revenue per capita. GBR agreements prospectively establish a fixed annual revenue cap for each hospital to encourage hospitals to focus on care improvement and population-based health management.

Under GBR 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, demographic driven volume increases, performance on quality-based or efficiency-based programs, changes in payer mix, and changes in the levels of approved uncompensated care. Annual revenue may also be modified for changes in service levels, market shifts, population growth, or shifts of services to unregulated settings.

The Commission is also focusing on integrated care incentives, such as integrated care networks, pay-for-performance programs, and gain-sharing programs to achieve the goals of care coordination and provider alignment. The State received approval from CMS for an amendment to the existing All-Payer Model contract to implement specific care redesign strategies. One such strategy is the development of the Complex and Chronic Care Improvement Program (CCIP), which will permit hospitals to share data and resources with community-based patient designated

providers in order to improve care coordination, reduce costs, and align the incentives of hospitals and physicians. A similar program for hospital-based physicians is referred to as the Hospital Care Improvement Program (HCIP). The Chesapeake Regional Information System for our Patients (CRISP) is serving as the administrator of the program. The first performance period begins on July 1, 2017, with potential gain-sharing payment distributed in CY 2018 for those hospitals that opt for this portion of the given program.

The HSCRC is also developing the Medicare Performance Adjustment (MPA) which will adjust hospital payments based on TCOC performance. This modifier will be implemented at the beginning of CY 2018, with payment adjustments beginning in July 2019 (RY 2020). This adjustment is expected to assist the State in the transition to Phase II of the All-Payer Model, which will focus on controlling TCOC. The policy is still in the early stages of development, and the HSCRC will provide an update on progress in the October biannual report. Additionally, DHMH and Medicaid are developing primary care and dual eligible models that will create even greater alignment across various providers to better meet the needs of chronically ill patients. The HSCRC will continue to further develop payment policy and will report any future innovations in this section of the Biannual Report.

Refining Global Budget Methodologies

While the majority of Maryland hospitals transitioned to global budgets during the first six months of the New Maryland All-Payer Model, a number of essential policies had not yet been finalized to address issues such as adjusting global budgets for market shifts or changes to inter-hospital transfer rates, establishing rates for new hospitals, and providing hospitals flexibility to achieve annual GBR revenue while reducing PAU. As shown in this report, HSCRC staff have worked closely with the Payment Models Workgroup, as well as a number of technical sub-workgroups to develop policies to address these issues. Additionally, HSCRC staff and Workgroup members have emphasized that these policies will continually progress as underlying data resources improve and the New Maryland All-Payer Model evolves.

Global Budget Charge Corridors

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

GBR Infrastructure Support

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

Reports detailing FY 2016 investments were due in early October 2016. The HSCRC received infrastructure reports from hospitals detailing over 700 infrastructure investments made during FY 2016. Hospitals reported a total infrastructure investment of $199 million dollars over that time period.

Key areas of investment included: 1) disease management, 2) post-discharge and transitional care, 3) community care coordination, 4) case management, and 5) consumer education and engagement.

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 hospital partnerships to work with community partners to reduce PAU. These programs are above and beyond the care transitions initiatives that were funded in FYs 2014 and 2015. In October 2016, the Commission awarded an additional $6.5 million in funding to another five partnerships. Regular reporting will be required of all awardees, and the Commission maintains the authority to curtail funding if it is not used in accordance with the proposals as approved by the Commission.

Transfer Case Payment Adjustment Implementation

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

Market Shift Adjustment (MSA) Development

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

adjustments on a semi-annual basis, instead of annually, beginning with the CY 2016 measurement period.

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

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

Section IV

Reports Submitted to CMS

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

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

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

Section V

Progression Plan Submission

The All-Payer Model agreement called for Maryland to submit a proposal for a new model no later than January 2017, which shall limit, at a minimum, the Medicare beneficiary total cost of care growth rate. To prepare this proposal, the State engaged in a robust stakeholder process, working with hundreds of stakeholders representing consumers, hospitals, physicians, skilled nursing facilities, payers, and experts. The State also solicited comments from the public.

On December 16, 2016, Governor Larry J. Hogan Jr. submitted the "Progression Plan" to CMS. The Progression Plan describes Maryland's proposal to accomplish the Model's expanded system-wide goals and address the State's goal of including the Medicaid costs for dual eligible beneficiaries. As described in the proposal, Maryland will leverage and build upon Maryland's hospital per capita model by expanding efforts to align hospitals, physicians, and other providers in delivery system reforms to improve outcomes, engage patients, and contain costs. The Progression Plan outlines a broad effort to deploy delivery system transformation aimed at supporting chronic care management, and coordinated efforts to address complex and high

needs patients, which will be implemented through private-sector efforts with state and federal oversight. The Plan also continues to strengthen local initiatives and ensure the sustainability of rural health care. These efforts to improve care and health, which are expected to reduce preventable utilization in higher acuity settings, are designed to limit the growth in Medicare and Medicaid spending and keep costs down for individuals and businesses.

The HSCRC and DHMH will continue to work with CMS on the Progression Plan implementation.

Section VI

Reporting Adverse Consequences

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

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

Additionally, the HSCRC is continuing to refine tools to monitor changes in patterns of service, particularly shifts in utilization and expenditures across all healthcare providers. This includes a Total Cost of Care Reporting Template, which was developed with the aim of compiling public and private payer hospital and non-hospital claims in order to assess the growth and shifts that occur within the regulated and unregulated hospital markets, as well as those changes that occur among non-hospital healthcare providers. Claims data is compiled from the All Payer Claims Data operated by MHCC and from data submitted to the HSCRC by public payers. The HSCRC continues to improve its processes with MHCC and payers to obtain the needed data in the most efficient and timely manner possible to appropriately monitor changes in utilization and expenditures.

In CY 2016, the HSCRC also continued its work to engage consumers through a Consumer Standing Advisory Committee (CSAC), which builds on the foundation laid by the Consumer Engagement and Outreach Workgroup in 2015. Consumer advocacy organizations have described the HSCRC stakeholder engagement process as a model for consumer engagement in a major policy endeavor. Stakeholder engagement is key to the development and success of the next phase of the All-

Payer Model that will expand to all care settings. The HSCRC has made significant efforts to be as transparent as possible in its initiatives and policy developments by making these workgroup meetings open to the public and by posting the meeting materials and recordings on the HSCRC's website: http://www.hscrc.maryland.gov/.

One area of caution, however, is the fluctuation in trends of the total cost of care. In the All-Payer Model contract, CMMI monitors the total cost of care in Maryland to ensure that reductions in hospital potentially avoidable utilization do not result in unreasonable increases in the total cost of care, which includes cost related to all health care providers, not just hospitals. The All-Payer Model contract provides that in any one calendar year, Medicare total cost of care growth in Maryland may not grow more that 1 percent above Medicare total cost of care growth nationally. However, in any two consecutive years, Maryland's Medicare total cost of care may not exceed the nation. In CY 2015, Maryland's total cost of care grew by 0.70 percent above the nation. While the Commission is projecting a growth rate of 0.70 percent below the national average in CY 2016, the metric continues to be monitored closely to ensure that the two consecutive year requirement is not breached. The HSCRC will continue to develop monitoring tools, measure performance, and engage stakeholders in order to ensure compliance with the requirements of the All-Payer Model agreement.

Contact and More Information

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

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