Monitoring of Maryland's New All-Payer Model

Biannual Report

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

October 2015

Executive Summary

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. This biannual report, prepared in accordance with Maryland law,[1] contains a summary of implementation, monitoring, and other activities during the time period from January 1, 2014, through September 30, 2015. The purpose of this report is to inform the Maryland General Assembly on the status of the New Maryland All-Payer Model.

Highlights

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

- **Inpatient and Outpatient Hospital Per Capita Cost Growth -** CMMI 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 2.28 percent between CYs 2014 and 2015 (as of July).
- **Aggregate Medicare Savings -** CMMI 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. During this reporting period, the HSCRC gained access to preliminary CMMI data and secured a contractor to perform analytics to validate the aggregate Medicare savings calculated by CMMI. Finalized CMMI data on this measure are not yet available, but analysis of HSCRC data shows that Medicare fee-for-service (FFS) per capita revenue decreased by 1.12 percent between CYs 2013 and 2014. This suggests that Maryland is making progress toward this target.
- **Shifting from a Per-Case Rate System to a Global Budget –** CMMI requires Maryland to shift at least 80 percent of hospital revenue to global or population-based budgets. Maryland exceeded this target and has shifted 95 percent of hospital revenues under global budget structures.
- **Reducing the Readmission Rate among Medicare Beneficiaries** – While the readmission rate in Maryland has decreased over the last several years, Maryland's readmission rate for Medicare beneficiaries remains higher than the national average. Under the New All-Payer Model, CMMI requires Maryland's Medicare FFS hospital admission rate to be at or below the national readmission rate by 2018. Although finalized data for this measure are not yet available from CMMI, the HSCRC has been working with CMMI to refine the calculation methodology and is monitoring progress with its own data. Preliminary analysis of HSCRC data show that Medicare FFS readmissions decreased by 5.28 percent in CY 2015, suggesting that Maryland is making progress toward this target.

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

- **Reducing Hospital-Acquired Conditions (HACs)** – CMMI requires Maryland to reduce the cumulative rate of HACs by 30 percent by 2018. HSCRC measures HACs using 65 Potentially Preventable Complications (PPCs).[3] To date, Maryland has exceeded this target, with a 35.66 percent reduction in all-payer case-mix adjusted PPCs by June of CY 2015. This reduction in the PPCs was even higher for Medicare FFS at 38.46 percent.
- **Work Group Activities –** The HSCRC continues to implement a broad stakeholder engagement approach, convening an Advisory Council and six Work Groups— Payment Models, Physician Alignment and Engagement, Performance Measurement, Care Coordination, Consumer Engagement and Outreach, and the newly formed Innovation in Graduate Medicaid Education Work Groups. More than 100 stakeholders representing consumers, businesses, payers, providers, physicians, nurses, other health care professionals, and experts have participated in these Work Groups. All Work Group meetings are conducted in public sessions, and comments from the public are solicited at each meeting. All Work Groups have submitted various reports and recommendations to the HSCRC, which staff are working on implementing.
- **Actions to Promote Alternative Methods of Rate Determination and Payment** – The New All-Payer Model agreement allows Maryland to develop alternative methods of rate determination. During the first six months of the performance period, HSCRC developed the Global Budget Revenue (GBR) reimbursement model and moved 95 percent of acute hospital revenue under global budgets. Other than these global budgets, the HSCRC is not developing any new alternative methods of rate determination at this time. The HSCRC may consider augmenting the existing global budget concept with a new, population-based arrangement in the future.
- **Reports to CMMI** – To date, the HSCRC has met all of CMMI's reporting requirements.
- **Reporting Adverse Consequences** – The HSCRC has not observed any adverse consequences occurring as a result of the implementation of the New Maryland All-Payer Model at this time. 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.

[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.

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. 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 21 months, the State, in close partnership with providers, payers, and consumers, has made significant progress in this modernization effort.

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

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

This report contains a summary of implementation, monitoring, and other activities to inform the Maryland General Assembly on the status of the New Maryland All-Payer Model. This New Maryland All-Payer Model Biannual Report, prepared in accordance with Maryland law,[4] discusses the State's progress during the period from January 1, 2014, through September 30, 2015, based on the information available at the time. The Maryland Health Services Cost Review Commission (HSCRC, or Commission) will produce an updated report every six months. Figure 1 provides an overview of the reporting required by law[5] for the first 12 months under the New Maryland All-Payer Model.

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

Section	Achievement Requirement	Metric Finding to Date	Ongoing Activities
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 1.47% between calendar year (CY) 2013 and CY 2014. CY 2015 per capita revenue growth through July is up 2.28% over the same period in CY 2014.	• Ongoing monthly measurement • Expecting continued favorable performance for CY 2015
I.2.	Achieve aggregate savings in Medicare spending equal to or greater than $330 million over 5 years	*Finalized data not yet available from CMMI*	• HSCRC gained access to preliminary CMMI data and began work with an analytics contractor to examine the calculation of the per beneficiary amounts and growth rates
I.3.	Shift at least 80% of hospital revenue to a population-based	95% of hospital revenue shifted to global budgets	• All hospitals are engaged in global budgets under Global Budget

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

Section	Achievement Requirement	Metric Finding to Date	Ongoing Activities
	payment structure (such as global budgets)		Revenue (GBR) and Total Patient Revenue (TPR) agreements • HSCRC is continuing to refine the TPR and GBR methodologies
I.4.	Reduce the hospital readmission rate for Medicare beneficiaries to below the national rate over the 5-year period of the agreement	*Finalized data not yet available from CMMI*	• HSCRC and CMMI are refining the calculation methodology for the final readmission measure • HSCRC gained access to some CMMI readmission data, and the analytics contractor has replicated the calculation of the interim Medicare readmission rate • Monitoring progress within Maryland using data collected from hospitals by HSCRC; however national data for 2015 will not be available to the contractor until the end of the year • The HSCRC Readmission Reduction Incentive Program (RRIP) was updated for state fiscal year (SFY) 2017 to increase hospital focus on reducing readmissions, and readmissions decreased in CY 2015
I.5.	Cumulative reduction in hospital acquired conditions by 30% over 5 years	Reduction of greater than 30% has been achieved	• HSCRC staff continue to review and audit these findings and prepare for ICD-10 conversion • HSCRC staff set a statewide reduction target of 7%, comparing SFY 2014 with CY 2015 • Expecting continued favorable performance for CY 2015
Section	**Description**	**Report**	**Status**
II	Work Group actions	• All original Work Groups have reported to the HSCRC • HSCRC is convening one additional Work Group: Innovations in Graduate Medical Education	• Active Work Groups have continued to meet on a regular basis • Care Coordination Work Group reported to the Commission in April 2015 • Consumer Engagement & Outreach and Care Coordination Work Groups reported to the Commission in September 2015 • Staff are implementing the Model based on recommendations from the Work Groups
III	New alternative methods of rate determination	95% of hospital revenue is now under global budget arrangements, implemented in accordance with policies approved by the Commission	• Global budget agreements are published on HSCRC's website • New policies are being developed to refine and advance the GBR methodology

Section	Achievement Requirement	Metric Finding to Date	Ongoing Activities
IV	Ongoing reporting to CMMI of relevant policy development and implementation	HSCRC provided CMMI with an Annual Monitoring Report in July 2015. This is a draft pending CMMI approval.	• HSCRC provided reports to CMMI on an ongoing basis

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

Maryland's New All-Payer Model agreement with CMMI establishes a number of requirements that the State must fulfill. CMMI must evaluate and provide an annual report on Maryland's calendar year performance. The HSCRC submitted the Model's first Annual Monitoring Report to CMMI in July 2015.[6] In addition to the annual report, the HSCRC provides ongoing reporting to CMMI on relevant policy and implementation developments. If Maryland fails to meet selected requirements, CMMI must provide notification, and Maryland will have the opportunity to provide information and a corrective action plan if warranted. At this time, CMMI has not provided any failure notifications to Maryland.

Section I

1. Inpatient and Outpatient Hospital Per Capita Cost Growth

The New Maryland All-Payer Model agreement requires the State to limit the average annual growth in all-payer hospital per capita revenue for Maryland residents to the average growth in per capita gross state product (GSP) for the 2002-2012 period (a 3.58 percent growth rate). Per capita revenue for Maryland residents increased by 1.47 percent between CYs 2013 and 2014 and by 2.28 percent between CYs 2014 and 2015 (as of July). Continued favorable performance is expected as global budgets (discussed at greater length in Section III) result in predictable statewide revenue performance, enabling the HSCRC to actively manage compliance with the 3.58 percent target.

2. Aggregate Medicare Savings

The New Maryland All-Payer Model Agreement requires the State to achieve an aggregate savings in Medicare spending equal to or greater than $330 million over the five years of the agreement. Savings are calculated by comparing the rate of increase in Medicare hospital payments per Maryland beneficiary with the national rate of increase in payments per beneficiary. Currently, CMMI completes this calculation and provides an aggregate monthly report to the HSCRC. However, the data are considered preliminary and have not yet been approved for public release by CMMI.

The HSCRC gained access to certain CMMI claims datasets for the purposes of Model monitoring and evaluation and secured a Medicare analytics contractor to validate the aggregate Medicare savings calculation conducted by CMMI. It is in the interest of both parties that the calculation correctly captures hospital payments made on behalf of Medicare beneficiaries who are Maryland residents. The HSCRC's vendor

[6] Initial Model metrics were due to CMMI on May 1, 2015, and the complete annual report was due June 30, 2015.

successfully replicated CMMI's analysis of Maryland's data for 2013 and 2014. Analysis of the national data should be complete by the end of October 2015.

HSCRC has been tracking Medicare fee-for-service (FFS) per capita cost trends from its own Maryland data. Based on these data, the Medicare FFS per capita revenue declined by 1.12 percent between CYs 2013 and 2014.

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

As discussed in the April 2015 New Maryland All-Payer Model Biannual Report, 95 percent of Maryland hospital revenues are in global budget structures. This exceeds the New Maryland All-Payer Model agreement requirement of shifting at least 80 percent of hospital revenue to global or population based budgets. All regulated Maryland hospitals that were not already under a Total Patient Revenue (TPR) agreement now operate under a Global Budget Revenue (GBR) agreement, through policies approved by the Commission. The remaining 5 percent that is not under global budgets is excluded, out-of-state revenue for five hospitals. These hospitals are otherwise engaged in global budgeting. Global budget agreements are available on the Global Budget Web Page of the HSCRC website.

In the past six months, the HSCRC continued to work with stakeholder Work Groups 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 2018. Each year beginning in 2014, the Maryland readmission rate must keep up with national improvements and close the gap between Maryland and the nation by 1/5th. This metric uses national Medicare data.

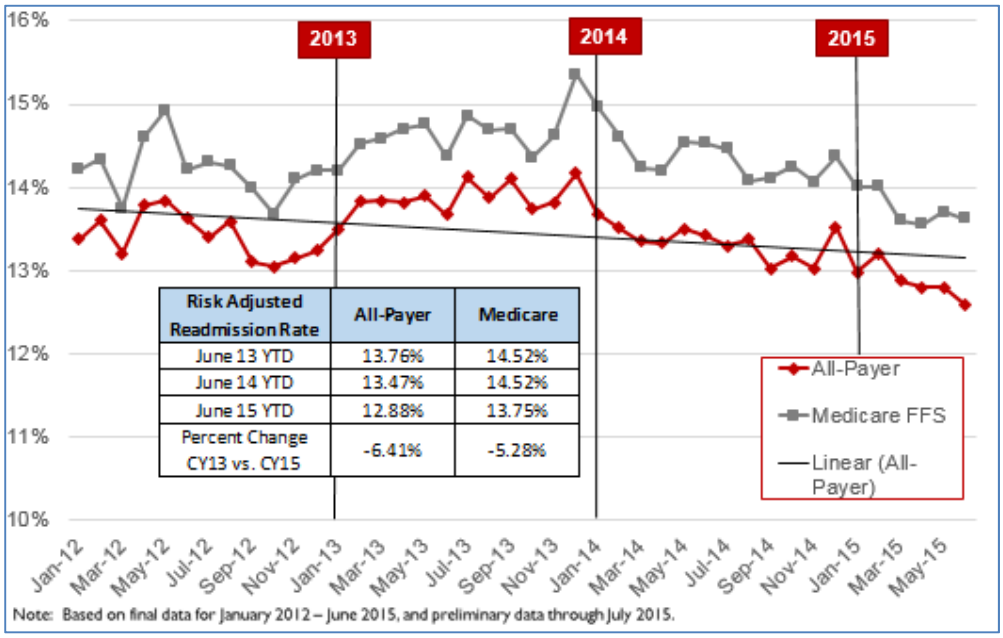
Since the last report in April of 2015, the HSCRC gained access to some of the CMMI claims datasets to calculate Medicare readmissions and validated the results for Maryland with those provided on a monthly basis by CMMI. However, the current readmission methodology is considered an interim measure applicable to Year 2 of the new waiver only, and national data for 2014 are incomplete because they require data from January 2015. The HSCRC staff are currently reviewing the proposed methodology from CMMI for the final waiver target readmission measure. The methodology involves some changes to the transfer logic and potential exclusions for psychiatric and rehabilitation patients in Maryland, since these patients are not included in national data for acute hospitals.

Based on preliminary data calculated by the HSCRC analytics contractor for the interim readmission measure, the reduction in the readmission rate between CY 2013 and CY 2014 may be insufficient for achieving the annual goal (final national rates for December 2014 are not available), although preliminary evidence suggests

that the gap between Maryland and national average declined in the first year. However, since the measure was not finalized until late 2014, CMMI is not going to assess readmission performance during Year 1 of the new Model. Regardless, due to concerns about progress, the HSCRC strengthened the Readmission Reduction Incentive Program (RRIP) for SFY 2017 to include scaled penalties of up to 2 percent and to increase and scale rewards up to 1 percent. The minimum improvement goal to avoid penalties in CY 2015, compared with CY 2013, is a 9.3 percent reduction in the all-payer case-mix adjusted readmission rate.

Overall, HSCRC's hospital data show that the monthly case-mix adjusted readmission rate for January through June 2015 is trending lower than the rate for the same time period in CY 2013 or CY 2014 (Figure 2). This analysis includes all Maryland inpatient stays, including Medicare FFS. Based on these available HSCRC data, the all-payer case-mix adjusted readmission rate in CY 2015 year-to-date (YTD) was 12.88 percent, compared with 13.76 percent during the same time period in 2013, a 6.41 percent reduction. The corresponding readmission reduction for Medicare FFS beneficiaries was lower (5.28 percent), and this reduction occurred only in CY 2015. In fact, there has been a greater readmission rate reduction for both the all-payer and Medicare FFS populations in Maryland in CY 2015. The reduction highlights the difficulty and time involved in achieving readmission reductions, as it requires significant effort, investment, and coordination across providers. In addition, staff believe that the addition of penalties to the RRIP is providing strong incentives to reduce readmissions compared with the SFY 2016 program that only had rewards. Finally, the Commission's focus on care coordination in Year 2 should improve the infrastructure for care coordination for high needs and complex patients and reduce the risks related to chronic conditions. Implementation of infrastructure, care coordination, and integration strategies will help create more comprehensive and sustainable approaches to reduce avoidable hospitalizations and readmissions. To help readmission reduction efforts, HSCRC focused on enhancing 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 2013-2015



5. Cumulative Reduction in Hospital Acquired Conditions

Maryland hospitals must achieve a 30 percent cumulative rate of reduction in hospital-acquired conditions (HACs) by 2018 to comply with the New Maryland All-Payer Model agreement. Maryland measures HACs using 65 Potentially Preventable Complications (PPCs).[7] 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.

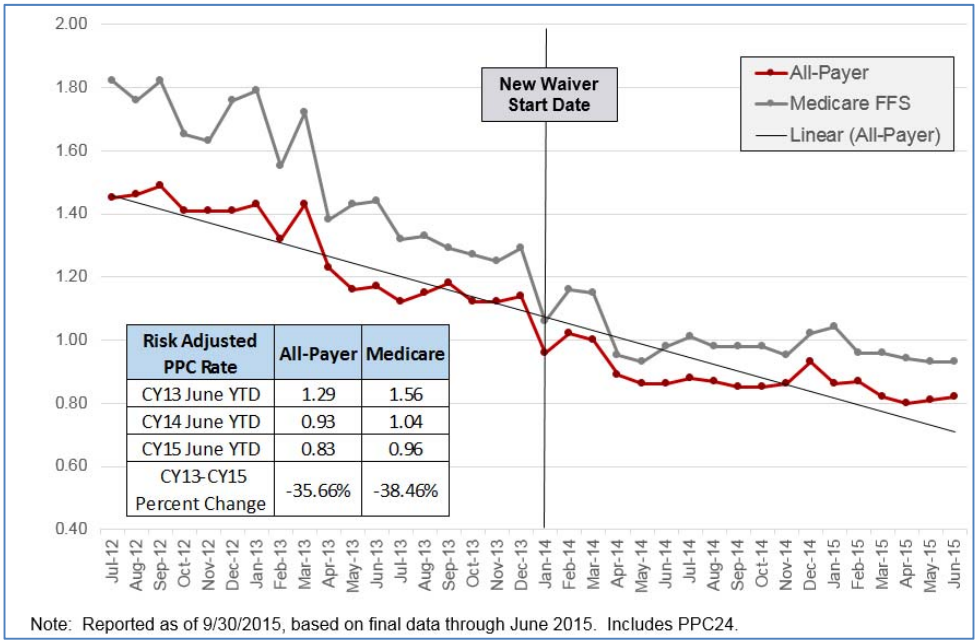
As discussed in the October 2014 New Maryland All-Payer Model Biannual report, the HSCRC approved major revisions to the Maryland Hospital Acquired Conditions (MHAC) program in April 2014 in order to support the goal of reducing PPCs. The MHAC program calculates hospital rewards and penalties for rates 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 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/complication rates by month for January through June of CY 2013, CY 2014, and CY 2015. In June of CY 2015, the YTD all-payer case-mix adjusted PPC rate was 0.83 per 1,000, compared with 1.29 per 1,000 for June CY 2013 YTD, which is a 35.66 percent reduction. The reduction in the case-mix adjusted complication rate for Medicare FFS was even higher at 38.46 percent. While this reduction in the case-mix adjusted complication rate exceeds the new waiver target of a 30 percent reduction by 2018, the HSCRC will continue to set annual improvement targets for hospitals to

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

further reduce PPCs and to ensure that Maryland hospitals will continue to have a waiver from the Centers for Medicare & Medicaid Services (CMS) HAC program. The HSCRC staff review annual audits of approximately ten hospitals to ensure coding accuracy with the medical record documentation. Based on initial SFY 2014 auditing results and additional follow-up with one hospital, there are currently no significant concerns regarding the accuracy of the coding in the case-mix data that hospitals submit to the HSCRC. The HSCRC is also working closely with 3M, the Maryland Hospital Association (MHA), and the hospital industry around the International Classification of Diseases – 10th Edition (ICD-10) implementation that may result in significant changes in PPC rates.

For the SFY 2017 performance period, the HSCRC set a 7 percent statewide PPC reduction target comparing SFY 2014 with CY 2015, with 3 percent of hospital revenue at risk for performance relative to achieving the reduction target.

Figure 3. All-Payer Risk-Adjusted PPC Rates January – June CY 2013 vs. CY 2015



Risk Adjusted PPC Rate	All-Payer	Medicare
CY13 June YTD	1.29	1.56
CY14 June YTD	0.93	1.04
CY15 June YTD	0.83	0.96
CY13-CY15 Percent Change	-35.66%	-38.46%

Note: Reported as of 9/30/2015, based on final data through June 2015. Includes PPC24.

Section II

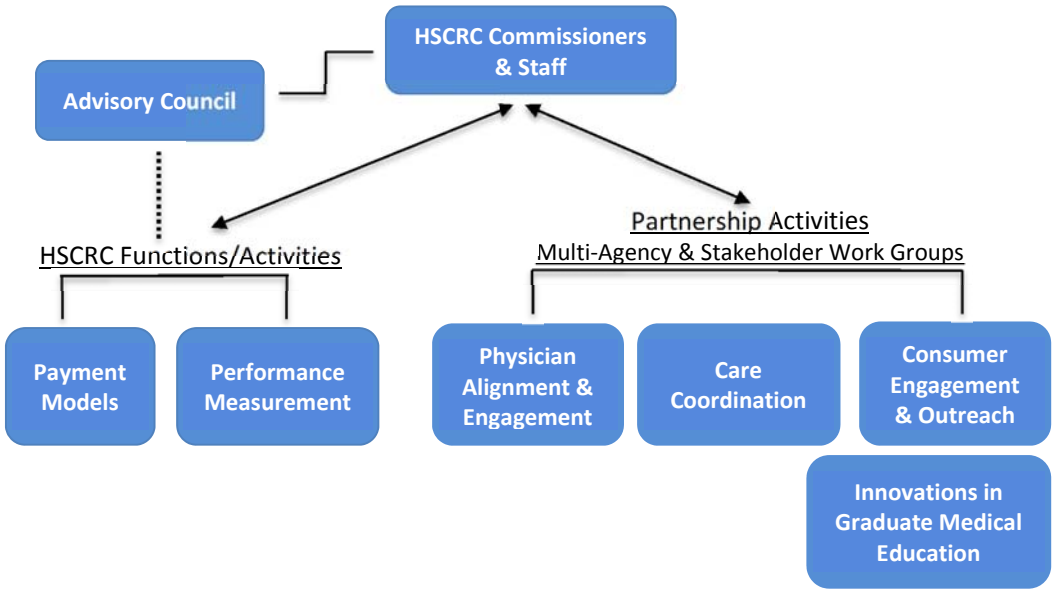
Work Group Actions

The HSCRC continued to implement a broad stakeholder engagement approach. More than 100 stakeholders representing consumers, businesses, payers, providers, physicians, nurses, other health care professionals, and experts have participated in these Work Groups. All Work Group meetings were conducted in public sessions, and comments from the public were solicited at each meeting.

Figure 4 depicts the current structure of stakeholder engagement. The HSCRC added one additional Work Group over the past nine months: the Innovations in Graduate Medical Education Work Group. The HSCRC also continued to facilitate a number of

sub-work group meetings to work through technical, data-driven matters related to specific policies.

Figure 4. 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, providers, the Department of Health and Mental Hygiene (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. The Council has temporarily recessed to allow HSCRC staff time to work on these suggestions.

November 2014 Advisory Council Recommendations

- Focus on meeting the early Model requirements
  - Focus on all-payer and Medicare tests
  - Start with global budgets
  - Reduce avoidable utilization
- Meet budget targets, invest in infrastructure, and provide flexibility for private sector innovation
- Focus on HSCRC's role as a regulator, catalyst, and advocate
- Involve consumers in planning and implementation
- Align physicians and other providers
- Be transparent and use the public engagement process
- Strengthen efforts to educate consumers about the New Maryland All-Payer Model and strive to communicate model goals and implementation steps

- Strike a balance between meeting the targets of the New Maryland All-Payer Model and investing in infrastructure
- Continue progress toward physician alignment
- Be transparent about the savings of the New Maryland All-Payer Model and how they are apportioned
- Pay more attention to social determinants
- Collaborate on care management

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. Over the past six months, the following issues have been considered:

1. Market Shift Adjustment: Review of staff work in developing a policy to adjust hospital global budgets for shifts in service volume from one hospital to another/others.
2. Transfer Case Payment Adjustment: Review of staff work in developing a policy to adjust hospital global budgets for changes in the volume of patients transferred from one hospital to another/others.
3. Aggregate Revenue at Risk for Quality-Based Payment Programs for SFY 2018 Policy: This fall, the Payment Models Work Group will review staff work in determining the amount of revenue to potentially reward or penalize hospitals based on performance in the Maryland quality-based payment programs.
4. Uncompensated Care Policy for FY 2016: Review of the impact of the Affordable Care Act's coverage expansion on uncompensated care levels at Maryland hospitals and the level of uncompensated care that should be included in hospital rates for FY 2016.
5. Impact of Medicaid Expansion on Utilization of Hospital Services: Review of staff work to determine whether hospital rates should be adjusted for the temporary and ongoing impact on utilization of the January 2014 Medicaid expansion.
6. Update to Rates for FY 2016: Review of staff work on the appropriate rate update for FY 2016.

3. Physician Alignment and Engagement Work Group

The Physician Alignment and Engagement Work Group is charged with recommending strategies to align and engage with physicians and other health care providers in partnership with patients to achieve the goals of the New Maryland All-Payer Model. The Work Group is still in recess to allow HSCRC staff time to work with partner agencies in building off of the Work Group's June 2014 recommendations, which are outlined below.

June 2014 Physician Engagement and Alignment Work Group Recommendations
▪ Consider an Integrated Care Network (ICN) infrastructure to coordinate care and align financial incentives of different providers to improve care, particularly for the Medicare FFS population not already enrolled in an Accountable Care Organization (ACO) or Medicare Advantage plan o Explore whether existing ACOs could make use of this infrastructure o Identify necessary waivers to support shared savings or gain sharing arrangements within the ICN o Align with the effort to create a dual eligible ACO led by Maryland Medicaid
▪ Expand access to pay-for-performance models that are designed to improve care delivery and care coordination by providing payments from hospitals to community-based providers when quality is improved o Explore additional models with other providers o Identify waivers to support extension of pay for performance models
▪ Support the development of a gain sharing model by the hospital and physician communities to encourage savings for specific services provided in inpatient settings with leadership of this effort undertaken by MHA in coordination with the Maryland State Medical Society (MedChi)

In preparation for reconvening the Work Group, the HSCRC began work with consulting resources to support the activities of this group and worked with the Maryland Health Care Commission (MHCC), DHMH, and other agencies to lay out preliminary alignment approaches for the Work Group to consider. The Chesapeake Regional Information System for our Patients (CRISP) also worked with HSCRC staff to develop criteria for the technological infrastructure that may be needed to support such alignment models.

The Commission is in the process of reconstituting this Work Group or establishing a sub-group to allow for stakeholder input on specific alignment payment methods, infrastructure, and functions.

4. Performance Measurement Work Group

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

HSCRC staff convened a special session of this Work Group in June 2015. Members were joined by key national and state stakeholders, leaders, and experts to help determine key objectives and needed ongoing stakeholder involvement to develop a statewide, incentive-based performance measurement strategy that supports better care coordination, population health, and patient-centered care. HSCRC staff will continue to work with key stakeholders to develop this strategic plan.

5. Care Coordination Work Group

The purpose of the Care Coordination Work Group is to facilitate multi-stakeholder discussions regarding efficient and effective implementation of population-based and patient-centered care coordination to support the New Maryland All-Payer Model. The Care Coordination Work Group met with a focus on exploring successful

care coordination models and considering shared infrastructure and common strategies.

In April 2015, the Care Coordination Work Group submitted a series of findings and recommendations in a final report to the Commission. The Work Group found the following:

1. Numerous care coordination activities are already underway in Maryland, led by hospitals, payers, medical groups, community-based organizations, health departments, and other groups. Smart public investments can support these promising initiatives and help bring them to scale.
2. Given the large number of individuals and providers involved in care management, it is important to develop shared tools, such as reports on high-utilizing patients, risk stratification, care gap analyses, strategies for coordinating the managers, and shared patient care profiles. New investment in this infrastructure will reduce duplication of effort, increase efficiency, and improve health outcomes.
3. The challenge is to create opportunities to cooperate even while healthcare organizations compete in other ways.
4. There is a consensus on pursuing the care coordination approach of beginning with high-needs patients in the Medicare FFS system and developing care innovations to include shared care profiles to reduce potentially avoidable utilization (PAU).
5. The approach should capitalize on and support medical homes and other primary care providers in serving high-needs patients and leverage funding from Medicare's new Chronic Care Management payment, which generally offers an additional per-member-per-month sum for providing enhanced services to patients with multiple chronic conditions.
6. To better serve this population by moving toward reliability and efficiency, the Work Group recommends a dual-track process of data acquisition: (1) organizing, synthesizing, and using existing data, and (2) acquiring more timely and identified data from CMS.
7. A three-step sequence to care coordination can prove valuable: (1) an effective risk stratification approach to identify people with complex medical and social needs; (2) the development of health risk assessments to ascertain patients' needs; and (3) the formation of patient-driven care profiles and plans addressing the medical and social needs of patients.
8. Key ingredients of an effective care coordination strategy include immediate alerts to notify a patient's medical home and any other care managers about emergency department visits and hospitalizations; face-to-face interaction between care managers and patients on a regular basis; designating a primary care manager for patients to avoid duplication of services; medication management; data sharing; patient engagement and education for self-care; the integration of behavioral and physical health care; support of medical care in post-acute and long-term care settings; integration of medical and supportive services; smooth transitions between care settings; ensuring an adequate supply and quality of social services; and the use of health information technology to promote data sharing and help providers better serve patients.
9. Partnerships at the regional and local levels are critical to effective care coordination. Success requires a global approach that engages both ambulatory and

community partners. Ambulatory partners (e.g., clinics, health centers, and physician offices) and community partners (e.g., public health, community-based, and faith-based organizations) must address non-medical factors affecting health and build community interest and support.

10. Encouraging the development of adequate patient care plans, mobilizing services to the home, and ensuring adequate supply and quality of services to support very fragile people in the community are essential to improving health outcomes for high-need patients.
11. HSCRC needs to ensure that other players are involved, such as commercial payers and Medicaid managed care organizations (MCOs). With all of the potential funding sources for the many health care initiatives that are being explored and implemented across the State, HSCRC also needs to avoid duplication of effort and carefully coordinate the various initiatives. Regional collaborative initiatives can pursue this goal.
12. It is important to design care coordination initiatives in a way that yields a positive rate of return on the infrastructure development called for in this report. Many of the recommendations in this report can help ensure a positive rate of return.

In response to these findings, the Work Group recommended the following to the HSCRC:

1. **Engage Maryland healthcare leadership** – The conclusions of the Care Coordination Work Group and the recommendations included in the Work Group's report have potentially far-reaching implications for Maryland's health care delivery system. It will be critical to engage Maryland's healthcare leaders, including hospital leadership, ambulatory providers, payers, and consumers in understanding the proposed direction and gaining support, particularly as more specific implementation plans and funding needs are developed.
2. **Develop specific budget estimates and implementation plans** – Initial estimates of the potential budget provided Work Group members with a broad sense of the potential range of start-up and ongoing funding needs. This is critical planning work that will be needed in the short term. These implementation plans should also address the timeline for implementation.
3. **Initiate data process** – Enhance data privacy procedures to enable the analysis and sharing of existing data, as well as Medicare data, in support of care coordination.
4. **Tap CRISP to organize data** – Designate CRISP to serve in the role of a "general contractor" in the data synthesis, acquisition, cleaning, and storage process. By engaging and overseeing the work of various subcontractors, or vendors, CRISP can also support other promising care coordination initiatives already underway.
5. **Build data infrastructure and identify target populations** – Build and secure a data infrastructure to facilitate the identification and risk stratification of individuals who would benefit most from care coordination. This will permit the identification of the patients with the most complex needs. The investment in data acquisition, along with a parallel effort to organize and synthesize the data already in hand, will allow acceleration of the process of creating individualized care profiles in a standardized format.
6. **Designate CRISP to identify consistent information that can be shared among providers and support different care management platforms—**Enhance data

sharing capabilities already built into the CRISP Health Information Exchange (HIE). This holds the promise of ultimately connecting the various provider and payer care coordination initiatives.

7. **Design standardized care profiles** – Encourage patient-centered care through the development of readily visible and usable patient care profiles. These profiles would possess standard data elements and should be made visible across the continuum of care. Key elements in the care profiles would include patients' problem lists; medication lists; medical history; and allergies. A longer-term activity involves using the data elements in the care profiles to develop a workflow that generates actual care plans and aggregates them usefully for local system management.
8. **Establish consumer outreach strategy** – Promote patient engagement and self-care through various strategies, including patient education and ability to view data. Adequate resources should be devoted to produce statewide, simplified patient education materials to reduce confusion and patient concerns about this care coordination process. Such an effort could go a long way to encourage patient participation in the care management process. State and county health departments can play a role in this outreach process, bolstered by leadership from the major State health care agencies, such as DHMH. Consumer groups and other stakeholders should also be involved. The HSCRC patient engagement task force may be a good place to start this effort, but it would need resources as well.
9. **Care coordination programmatic efforts** – Encourage (a) health system collaboration by avoiding duplication of resources across provider entities, (b) the use of Medicare's new Chronic Care Management payments, and (c) increased integration between physical and behavioral health. Connect a wide range of providers, including those in ambulatory and long-term care settings, to the data infrastructure.
10. **Develop a plan for sustainability of care coordination infrastructure** – including operating costs of the model and helping providers obtain chronic care management (CCM) payments.

HSCRC staff have been working to implement many of these recommendations to pave a way for the success of the All-Payer Model. For instance, DHMH, in collaboration with the HSCRC, held a competitive application process to establish *Regional Partnerships for Health System Transformation*, focusing on collaborating on analytics, targeting services based on patient and population needs, and planning and developing care coordination and population health improvement approaches. On February 9, 2015, DHMH and the HSCRC released a request for proposals (RFP) for funding to support planning, development initiatives, and operational plans for regional partnerships for health system transformation. Applications were received by April 15, 2015. Pursuant to the Budget Reconciliation and Financing Act of 2015 (BRFA) language, DHMH and the HSCRC established a multi-stakeholder review committee to evaluate applications. In May 2015, DHMH and HSCRC approved an adjustment in rates of $2.5 million for eight regional planning grantee hospitals. These partnerships have been working on their plans while also receiving technical assistance (e.g., one-on-one consulting, webinars, and collaborative educational sessions) to assist them in their initiatives over the past five months. The HSCRC received interim reports from the regional partnership

grantees by September 1, 2015. The regional partnership grantees will submit final reports by December 7, 2015.

In June 2015, as part of its update factor process, the Commission approved setting aside up to 0.25 percent in hospital rates in FY 2016 to provide competitive grants to exemplary hospitals for implementing and expanding innovative care coordination, provider alignment, and population health strategies. Hospitals will submit proposals to the Commission by December 7, 2015. Funding will only be provided to projects that are ready to be implemented immediately in CY 2016, are focused on major opportunities to reduce PAU in a patient-centered manner, and create a return on investment for the hospital and purchasers of hospital care.

BRFA funding has also been used to implement some of the critical statewide infrastructure that the Care Coordination Work Group has deemed necessary to ensure that care is patient-centered and coordinated. Some of the priorities for such funding have been:

- Building/securing data infrastructure needed to facilitate identification of individuals who would benefit from care coordination.
- Encouraging patient-centered care and patient engagement, including sharing common information regarding patient care among providers and care coordinators.
- Encouraging collaboration among providers (including social services, behavioral health, long-term care, and post-acute care providers) and those engaged in patient advocacy, public health, and faith-based initiatives.
- Connecting providers to CRISP.

6. Consumer Engagement and Outreach Work Group

The Consumer Engagement and Consumer Outreach Work Group consists of two task forces: the Consumer Engagement Task Force and the Consumer Outreach Task Force. The purpose of these consumer-focused Task Forces is to help ensure that people who are using Maryland's health system understand the State's health system transformation and what it means to them, and have the information and resources to become more actively involved in their individual health and in improving the health of the community.

Consumer Engagement Task Force (CETF)

In September 2015, the CETF submitted a series of findings and recommendations in a final report to the Commission. The overarching themes and concepts that emerged during the research phase largely informed the CETF's recommendations. The themes include the following:

1. Consumer engagement efforts must offer a clear call to action. Consumers' continued engagement is dependent on their input and perception that their actions have an impact.
2. Because individuals' motives are different than institutions' motives, successful engagement efforts must ascertain the motivating factors for both groups.
3. Health care information should be disseminated and consumer engagement activities should be led by sources that consumers trust.

4. Sensitivity to diversity and the multitude of cultural differences are critical in engagement efforts.
5. Consumer engagement requires extraordinary commitment from health care leadership at all levels.
6. Ideally, consumers should be engaged both prior to and at the point of contact with the health care system.
7. A more robust and consumer-friendly feedback process (i.e., concerns, complaints, and commendations) is needed.
8. Advanced directives planning is indicative of consumer engagement.

In response to these findings, the CETF recommended the following to the HSCRC:

1. Allow for a meaningful, ongoing role for consumers at the HSCRC through continued representation of Commissioner(s) with primary consumer interest and through a newly created standing advisory committee (SAC) with diverse representation.
2. In collaboration with key stakeholders, develop a statewide public education campaign specific to the New All-Payer Model that is part of a broader campaign to promote health and wellness.
3. Convene an interagency task force that allows consumers to participate in the design and implementation of a statewide public education campaign
4. Provide options and opportunities that support regular, longitudinal, and effective consumer engagement in the development of policies, procedures, and programs by hospitals, health care providers, health care payers, and government.
5. In coordination with the HSCRC SAC, the MHCC, and other key stakeholders, consider the development of a Consumer Gold Star system for hospitals based on consumer engagement standards.
6. Define community benefit dollars to include consumer engagement initiatives and promote these dollars for this use, particularly for those supporting vulnerable populations.
7. Continue to encourage and incentivize independent and collaborative approaches to support people who are at risk of becoming high utilizers.
8. Encourage hospitals to provide current, consistent, and transparent information on average procedure costs using the data made readily available by MHCC (www.marylandqmdc.org) and other new pricing transparency tools being created, and make this information available on the New All-Payer Model's website and/or other appropriate websites.
9. Include discussions about patient and family decision-making and preferences about advanced directives in the context of consumer engagement and educating consumers.

Consumer Outreach Task Force (COTF)

As the leader of the COTF, the Maryland Citizens' Health Initiative Education Fund, Inc. (MCHI) collaborated with Local Health Improvement Coalitions (LHICs), health departments, hospitals, local community and faith leaders, and MHA to hold 11 public forums all across the State about health system transformation from January through July 2015. Over 800 Marylanders representing over 300 community, health,

faith, business, government, union, and policy organizations have heard the message that their local hospitals, healthcare providers, and community-based organizations are working together to help Marylanders be as healthy as possible. Feedback shows that Marylanders are unaware of the State's unique and long-standing all-payer system or of the New All-Payer Model that is further transforming the health system in Maryland. Once informed, however, consumers are eager to be engaged. They want a clear call to action and follow-up steps for ongoing collaboration.

In September 2015, the COTF submitted a series of findings and recommendations in a final report to the Commission. The COTF recognized that the forums were an exciting and productive first step in engaging consumers in health system transformation. Based on the COTF's experience with the public forums, it recommended that the State and local organizations continue this work by collaborating to provide easy-to-understand information that is consistent and available in a wide variety of formats, and to continuously integrate and respond to consumers' experiences. The unifying message should emphasize that health care providers are working together to keep the public healthy and that it is empowering to learn how the health care system can help consumers with health and costs.

In order for the State to build on these forums and ensure that the consumer voice is heard in health system transformation in Maryland, the COTF recommended the following to the HSCRC:

1. Periodically convene stakeholders and consumers to provide updates on the progress of health system transformation.
2. Continue to give consumers a voice in the transformation of Maryland's health system.
3. Encourage local leaders to develop and join a dynamic Faith Community Health Network.
4. Collaborate to educate primary care providers on—and engage them in—health system transformation.
5. Maximize communications with consumers via traditional and new media.

The HSCRC staff are working on implementing many of the recommendations from both the CETF and COTF to provide a comprehensive picture of the current state of consumer outreach and engagement and specific guidance for engaging consumers and creating a health care environment that supports consumers' full, informed participation in managing their health and health care.

7. Innovation in Graduate Medical Education Work Group

The Innovation in Graduate Medical Education (IGME) Work Group was convened in early 2015 to oversee the development of a five-year plan to advance innovations in medical education as required under the new Model agreement with CMS. For long-term success in this new Model, physicians and other health professionals must be trained to both thrive and lead in this new environment. Therefore, graduate medical education in Maryland must be innovative and forward-thinking to produce

a workforce with these skills. A report detailing recommendations on changes to medical education is due to CMS by January 1, 2016.

Given the nature of the task at hand, the IGME Work Group is being led by interests broader than the HSCRC. DHMH played a key role in establishing the Work Group. Details on Work Group members and meetings can be found on the DHMH website. To obtain a wide range of stakeholder input, the IGME Work Group and DHMH co-sponsored an all-day summit with the University of Maryland and the Johns Hopkins School of Medicine on the future of graduate medical education. The summit brought together over 100 graduate medical education and healthcare experts from around the State to discuss what the goals of a new graduate medical education model should be and steps that would be needed to reform graduate medical education in Maryland.

Based on Work Group discussions and input from the summit, the draft recommendations focus on the following five goals and provide recommendations to achieve these goals:

1. Achieving the three part aim
2. Focusing on population health
3. Equitable and efficient funding
4. Augment what's good about graduate medical education today
5. Optimal workforce distribution

The Work Group will submit the draft report to DHMH before final submission from DHMH to CMS.

Section III

1. Alternative Methods of Rate Determination

The Maryland All-Payer Model agreement affords the State the ability to innovate by developing alternative methods of rate determination. During the first six months of the New Maryland All-Payer Model, the HSCRC developed the GBR reimbursement model and engaged all hospitals not already under a TPR agreement in GBR, as discussed in Section I of this report. While some revenue is outside of the global budget (such as revenue from some out-of-state referrals), approximately 95 percent of acute hospital revenue is currently under a global budget.

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

Under GBR and TPR contracts, each hospital's total annual revenue is known at the beginning of each fiscal year. Annual revenue is determined from a historical base period that is adjusted to account for inflation updates, infrastructure requirements for GBR hospitals,[8] demographic driven volume increases, performance on quality-based or efficiency-based programs, changes in payer mix, and changes in levels of approved uncompensated care. Annual revenue may also be modified for changes in service levels, market shift, 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. Other than global budgets, there are no other new general alternative methods of rate determination or experimental rate methods being developed at this time. The Commission considered whether it should participate in Medicare's Comprehensive Care for Joint Replacement Payment Model, a mandatory bundled payment initiative for single-joint total hip and knee replacements. After consideration, the Commission found that the State is not yet prepared for this initiative because timely total cost of care Medicare data would be critical for success of such a bundled payment program. The Commission is instead focusing on integrated care incentives, such as integrated care networks, pay-for-performance programs, and gain sharing programs to achieve the same goals as bundled payments, but on a broader statewide basis. The HSCRC will continue to innovate payment policy and will report any future innovations in this section of the Biannual Report.

2. Refining Global Budget Methodologies

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

a. Global Budget Charge Corridors

A unique feature of global budgets that has been refined in the past six months is the capacity of a GBR hospital to increase or decrease its approved unit rates to achieve its overall approved global revenue. This mechanism allows a hospital the flexibility to compensate for fluctuations in service volume over the course of the year and still reach its annual revenue target. The hospital must vary these unit rates in unison and within a defined charge corridor or be subject to penalties. If a hospital is experiencing significant volume declines as a result of reduced PAU, it may submit

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

a request to expand this corridor so that it can achieve the approved global revenue necessary for financial stability and population health investment. HSCRC staff review charge corridor requests to determine the cause of hospital volume increases and the impact of the charge corridor expansion on the patient population, surrounding hospitals, and other factors related to the goals and requirements of the New Maryland All-Payer Model.

b. GBR Infrastructure Reporting

A vital step in evaluating charge corridor expansion requests is evaluating the efforts a hospital has taken to improve care delivery, population health, and care management, as those efforts will reduce PAU. HSCRC staff finalized a template that each hospital must submit annually to report 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 and DHMH staff are currently reviewing these reports and assessing that the investments reported meet the report criteria. The information in these reports will be utilized during global budget updates and charge corridor expansion requests to understand the magnitude and impact of a hospital's investments. The report will also inform the HSCRC and other stakeholders of the amount and types of investments Maryland hospitals are making over time and how effective these investments are in reducing PAUs as well as improving care delivery and population health.

c. Transfer Case Payment Adjustment Implementation

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

d. Market Shift Adjustment (MSA) Development

HSCRC staff and the Payment Models Work Group continued to make considerable progress on the Market Shift Adjustment (MSA). The purpose of the MSA is to provide a mechanism to appropriately shift revenue between hospitals when utilization shifts from one hospital to another/others. Hospital GBRs are adjusted at

50 percent of the variable cost (i.e., hospitals that receive additional volume due to market shifts receive GBR incentives at 50 percent of the associated costs of the additional volume, while hospitals that lose volume due to market shift lose 50 percent of the revenue associated with this lost volume). HSCRC staff finalized the calculations for MSAs for all inpatient and outpatient services, except for radiation therapy, infusion, and chemotherapy, for inclusion in rate year 2016 global budgets. These adjustments relate to shifts occurring during the six months ending on December 31, 2014, as compared with the same six month period in the preceding year. These calculations were finalized after staff received corrections of outpatient encounter data from hospitals and made some modifications to the outpatient weights based on input received through the process, in addition to other refinements. Staff are working on reviewing radiation therapy, infusion, and chemotherapy MSAs with stakeholders.

Section IV

Reports Submitted to CMMI

The All-Payer Model agreement requires HSCRC to report to CMMI 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 CMMI.

- Maryland All-Payer Model Monitoring Report: This draft report was submitted to CMMI in July 2015. It contains preliminary data for performance year 2014 and 2013 baseline measures. This is a draft pending CMMI Approval.

Section V

Reporting Adverse Consequences

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

A number of policies developed in this first 12 months of implementation guard against adverse consequences that HSCRC staff and stakeholder Work Groups identified as possible unintended outcomes of implementation. The GBR agreements initiated by HSCRC for implementation of the global budgets contain consumer protection clauses. The HSCRC, in conjunction with the Payment Models Work Group, developed the Transfer Adjustment Policy and a Market Shift Policy to help ensure that "the money will follow the patient" when shifts in utilization occur between hospitals or other health care settings. These policies aim to guard against hospitals inappropriately limiting the number of high-cost, high-risk cases admitted and to provide open access and resources when patients need to be transferred to receive highly specialized care offered in AMCs.

Additionally, the HSCRC is continuing to develop tools to monitor changes in patterns of service, particularly shifts in utilization and expenditures across all

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

The HSCRC also focused on engaging consumers through the Consumer Engagement and Outreach Work Group as described in Section II. In addition, consumer advocates participate in each of the HSCRC stakeholder Work Group panels. Consumer advocacy organizations have described the HSCRC stakeholder engagement process as a model for consumer engagement in a major policy endeavor. The HSCRC has made significant efforts to be as transparent as possible in its initiatives and policy developments by making these Work Group meetings open to the public and by posting the meeting materials and recordings on the HSCRC's website (http://www.hscrc.maryland.gov/index.cfm)

Contact and More Information

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

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