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April 1, 2015

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

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

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

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

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

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

I am pleased to provide you with the second Maryland's All-Payer Model Biannual Report, prepared relative to Section 19-207(b)(9) of the Health-General Article of the Annotated Code of Maryland. This report discusses the State's progress during the period from January 1, 2014 through December 31, 2014, the first full 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, 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. 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 any questions about this report, or you may contact Steve Ports, Deputy Director, Policy and Operations, at Steve.Ports@Maryland.gov.

Sincerely,

Donna Kinzer

Donna Kinzer
Executive Director

Monitoring of Maryland's New Maryland All-Payer Model

Biannual Report

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

April 1, 2015

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.

State and Federal New Maryland All-Payer Mode Status Reporting Requirements

State New Maryland All-Payer Model Reporting Requirements

This report contains a summary of implementation, monitoring and other activities to inform the Maryland legislature regarding the status of the New Maryland All-Payer Model. This New Maryland All-Payer Model Biannual Report, prepared in accordance with Section 19-207(b)(9) of the Health-General Article of the Annotated Code of Maryland, discusses the State's progress during the period from January 1, 2014 through December 2014. The 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 relative to Health-General Section 19-207(b)(9) for Maryland's first twelve months under the New Maryland All-Payer Model .

Figure 1: State Biannual Reporting of Maryland's New Maryland 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 CY 2013 and CY 2014.	• Ongoing monthly measurement • Expecting continued favorable performance for Calendar Year 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 has gained access to preliminary CMMI data and has begun 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 payment structure (such as global budgets)	95% of hospital revenue shifted to global budgets	• All hospitals engaged in global budgets under Global Budget Revenue (GBR) agreements and Total Patient Revenue agreements • HSCRC continuing to refine TPR and GBR methodology

Section	Achievement Requirement	Metric Finding to Date	Ongoing Activities
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 calculation methodology • HSCRC has gained limited access to CMMI readmissions data and has begun work with an analytics contractor to approximate the calculation of the Medicare readmission rate • Monitoring progress within Maryland using data collected from hospitals by HSCRC • The HSCRC Readmission Reduction Incentive Program (RRIP) has been updated for SFY 2017 to increase hospital focus on reducing readmissions
I.5.	Cumulative reduction in hospital acquired conditions by 30% over 5 years	Reduction of 27.12% in hospital acquired conditions 2014 year to date compared to 2013 year to date (through September)	• HSCRC staff reviewing and auditing these findings • HSCRC staff set a statewide reduction target of 7% comparing state fiscal year (SFY) 2014 and CY 2015
Section	**Description**	**Report**	**Status**
II.	Work group actions	• All original work groups have reported to the HSCRC • Work groups have been restructured for Phase 2 of the stakeholder engagement process • Two additional work groups: Consumer Engagement & Outreach and Care Coordination	• Work groups meeting on a regular basis • Consumer Engagement & Outreach and Care Coordination Work Groups will make recommendations to the Commission in April 2015
III.	New alternative methods of rate determination	95% of hospital revenue now under global budgets arrangements, implemented in accordance with policies approved by the Commission	• Global budget agreements published on HSCRC website • New policies are being developed to refine and advance the GBR methodology
IV.	Ongoing reporting to CMMI of relevant policy development and implementation	See Appendix for report provided to CMMI	• Provided reports to CMMI on an ongoing basis

Federal New Maryland All-Payer Model Reporting Requirements

The New Maryland All-Payer Model agreement with CMMI establishes a number of requirements that the State must fulfill. CMMI must evaluate Maryland's performance under the model and provide reports on an annual basis. The evaluations will be made based on calendar year performance, with the first

evaluation due in July 2015.[1] In addition to the annual report, the HSCRC provides ongoing reporting to CMMI of relevant policy development and implementation. If Maryland fails to meet selected requirements, CMMI must provide notification and Maryland will have the opportunity to provide information for evaluation and to provide a corrective action plan if warranted. At this time, CMMI has not provided any notices of failure to Maryland.

Section I

1. Inpatient and Outpatient Hospital Per Capita Cost Growth

The New Maryland All-Payer Model agreement requires the State to limit the 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% growth rate). Over calendar year (CY) 2014, per capita revenue for Maryland residents rose 1.47% as compared to CY 2013. 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% 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 to 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 as there is a four to six month claims lag, and the HSCRC has not yet had an opportunity to validate the calculation.

The HSCRC has gained access to certain CMMI claims datasets for the purposes of model monitoring and evaluation and has 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. Preliminary validation results are expected from the contractor by the end of April.

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

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

As discussed in the October 2014 New Maryland All-Payer Model Biannual Report, the HSCRC has worked with Maryland hospitals to transition 95% of

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

Maryland hospitals' revenues from a per-case rate system into global budget structures. This exceeds the New Maryland All-Payer Model agreement requirement of shifting at least 80% of hospital revenue to global or population based budgets. All regulated Maryland hospitals not already under a Total Patient Revenue (TPR) agreement now operate under Global Budget Revenue (GBR) agreements under policies approved by the Commission. The remaining 5% of hospital revenue 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 has worked 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 that Maryland's hospital readmission rate for Medicare FFS beneficiaries must be at or below the national readmission rate by 2018. This metric uses national Medicare data.

While the HSCRC has gained access to some CMMI claims datasets, the HSCRC does not have access to all of the data necessary to validate this metric. Currently CMMI completes this calculation and provides an aggregate monthly report to the HSCRC. However, these reports are considered preliminary, as there is a four to six month claims lag and the HSCRC and CMMI are still working together to refine the readmission rate calculation methodology. A number of revisions have already been applied to an interim methodology to address issues such as planned readmissions and beneficiaries switching between FFS and Medicare Advantage.

While data is not yet available from CMMI to determine Maryland performance against the national trend for this biannual report, the HSCRC Readmission Reduction Incentive Program (RRIP) has set goals for hospitals to reduce their all-payer risk-adjusted readmission rate by 6.76% during CY 2014 as compared to CY 2013. Currently, only 15 out of 46 hospitals have met this target. The Commission recently changed its policy to strengthen this target.

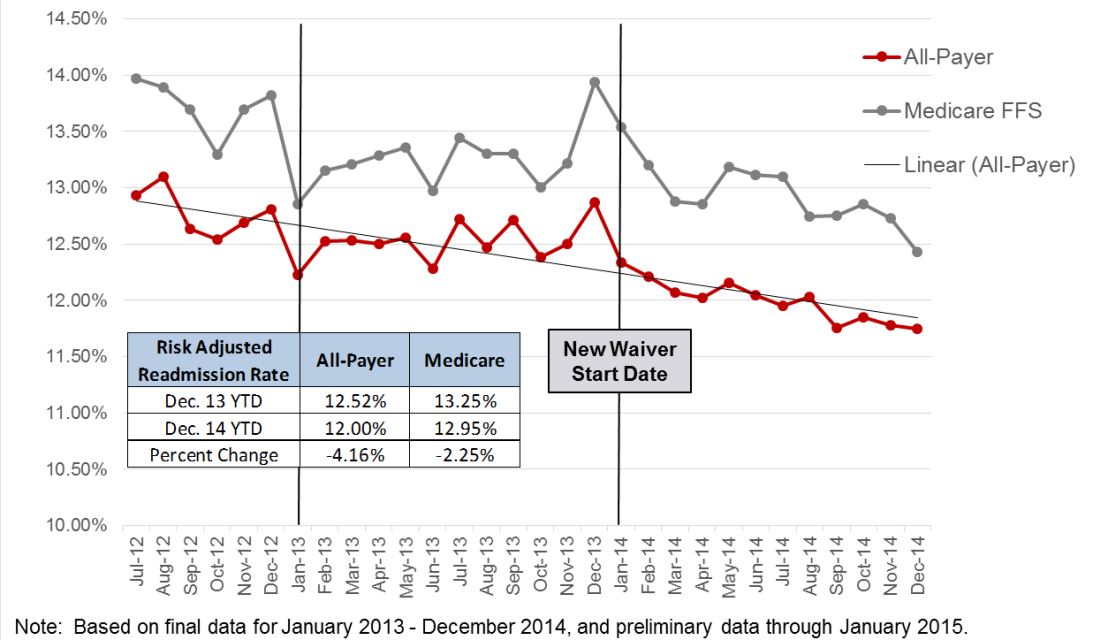
Overall, HSCRC Maryland hospital data show the monthly risk-adjusted readmission rate for January through October 2014 is trending lower than the rate for the previous year prior to the initiation of the New Maryland All-Payer Model (Figure 2). This analysis includes all Maryland inpatients, including Medicare FFS. Based on these available HSCRC data, the all-payer risk-adjusted readmission rate in CY 2014 was 12.0% compared to 12.52% during the same time period in 2013, a 4.16% reduction. The corresponding reduction for Medicare FFS beneficiaries is less, falling by 2.25%, but remains in a downward trend. Reducing readmissions is a difficult task that will require significant effort, investment and coordination in order to meet the New Maryland All-Payer

Model requirement. In order to draw focus to this goal, the Commission recently took action to increase the amount of revenue at risk for hospital performance under RRIP from 0.5% in SFY 2016 to 2.0% in SFY 2017, and set the CY 2015 all-payer case-mix adjusted readmission target at 9.5% cumulative reduction from CY 2013 base all payer case-mix adjusted readmission rates.

HSCRC staff has also begun working with the new Maryland Quality Improvement Organization, VHCQ, to analyze Maryland versus national readmission data to develop comparative national benchmarks and understand the gap between Maryland and the nation in readmission performance.

Finally, staff has been working with a multi-agency and stakeholder work group, the Care Coordination Work Group (see Section II), to focus on opportunities to improve infrastructure for care coordination for high needs and complex patients, and reduction of 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.

Figure 2. All-Payer and Medicare Fee-for-Service Risk-Adjusted Readmission Rates CY 2014 vs. CY 2013



Note: Based on final data for January 2013 - December 2014, and preliminary data through January 2015.

5. Cumulative Reduction in Hospital Acquired Conditions

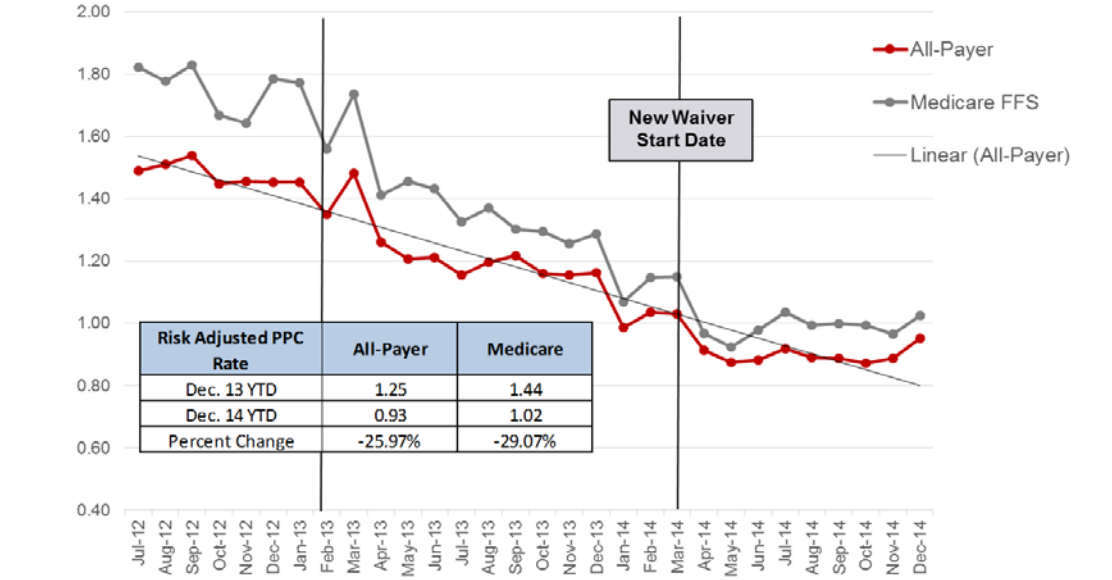
Maryland hospitals must achieve a 30% cumulative rate of reduction of hospital-acquired conditions (HAC) by 2018 to comply with the requirements of the New Maryland All-Payer Model agreement. Maryland measures hospital-acquired

conditions using 65 Potentially Preventable Complications (PPCs).[2] PPCs are defined as harmful events (for example, accidental laceration during a procedure) or negative outcomes (for example, hospital acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease.

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 measured, and use preset positions on a scale based on the base year scores for all PPCs to determine penalties and rewards. Figure 3 shows the all-payer risk-adjusted PPC/Complication rates for CY 2014 compared to CY 2013. In CY 2014, the all-payer risk-adjusted PPC rate was 0.93 per 1,000 compared to 1.25 per 1,000 for CY 2013, a 25.97% reduction. The HSCRC staff is currently auditing hospitals' coding to determine whether the reduction represents an improvement in documentation or an actual reduction in complications.

In order to support continued PPC improvement, the HSCRC has set a 7% statewide PPC reduction target comparing SFY 2014 and CY 2015 with 3% of hospital revenue at risk for performance relative to achieving the reduction target.

Figure 3. All-Payer Risk-Adjusted PPC/Complication Rates CY 2014 vs. CY 2013



Note: Based on final data for January 2013 - December 2014.

[2] 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.

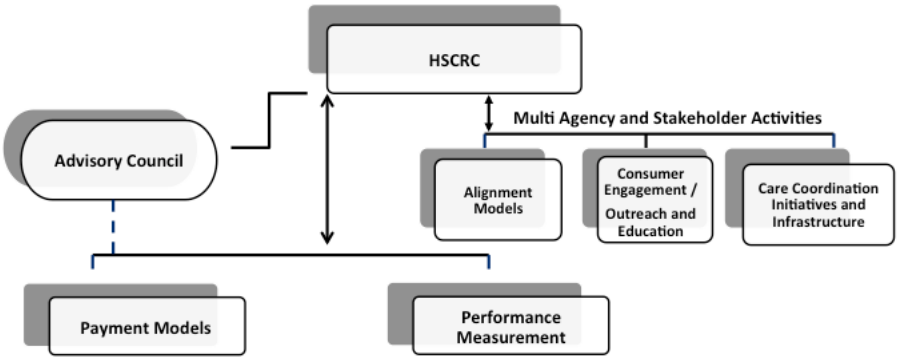
Section II.

Work Group Actions

The HSCRC has implemented a broad stakeholder engagement approach. More than 100 stakeholders representing consumers, business, payers, providers, physicians, nurses, other health care professionals, and experts have participated in these work groups. All work group meetings have been conducted in public sessions, and comments from the public have been solicited at each meeting.

Based on work group and Advisory Council recommendations during the first six months of model implementation, the HSCRC restructured the stakeholder engagement process as shown in Figure 4. This was done to continue the progress of the HSCRC regulatory work groups (Payment Models and Performance Measurement); accommodate multi agency and stakeholder led work groups; broaden the scope of the Model development and implementation process to consumers and non-hospital based providers; and promote collaboration across the diverse range of stakeholders who can both benefit from and advance the goals of the Maryland All-Payer Model. The HSCRC added two additional work groups during this Phase: 1) the Consumer Engagement, Outreach and Education Work Group; 2) the Care Coordination Work Group. The HSCRC also established a number of subgroups to work through technical, data driven matters related to specific policies.

Figure 4. Phase 2 Stakeholder Engagement Process



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 consisted of a broad representation of hospitals, payers, physicians, providers, the Department of Health and Mental Hygiene, and health care experts. All meetings were open to the public and encouraged public comment.

The Advisory Council held five public meetings and put forth its final report on January 31, 2014, as discussed in the October 2014 New Maryland All-Payer

Model Biannual Report. Since that time, the Advisory Council has met once, on November 12, 2014 and provided broad input on the guiding principles for the HSCRC to consider in key challenges and possible strategies over the next two years of model implementation.

The Advisory Council made the following recommendations:

- Focus on Meeting the Early Model Requirements
  - Focus on All-payer and Medicare tests
  - Start with Global Budgets
  - Reduce avoidable utilization
- Meeting Budget Targets, Investments in Infrastructure, and Providing Flexibility for Private Sector Innovation
- HSCRC as a Regulator, Catalyst, and Advocate
- Consumer Involvement in Planning and Implementation
- Physician and Other Provider Alignment
- Transparency and 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
- Transparency of savings of New Maryland All-Payer Model and how they are apportioned
- More attention to social determinants
- Care management requires collaboration

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 Policy: 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 Policy: 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. GBR Infrastructure Investment Reporting Policy: Review of staff work in developing a reporting template for GBR hospital investment in

population health improvement and potentially avoidable utilization reduction.

4. Aggregate Revenue at Risk for Quality-Based Payment Programs for SFY 2017 Policy: Review of staff work in determining amount of revenue to potentially reward or penalize hospitals based on performance in the Maryland quality-based payment programs.
5. Report on the Cost of Defensive Medicine: Review of academic report and analysis on the impact and implications that defensive medicine has on hospital costs and the goals and requirements of the New Maryland All-Payer Model.

The Payment Models Work Group has also begun preliminary discussion of the Annual Update Policy and Uncompensated Care Policy for SFY 2016 as well as early considerations for developing a policy to address global budget hospital funding for major capital projects.

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 has temporarily recessed to allow HSCRC staff time to work with partner agencies to build off of the work group's June recommendations 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 ACO or MA 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 the Maryland Hospital Association (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), the Department of Health and Mental

Hygiene (DHMH), and other agencies to layout preliminary alignment approaches for the work group to consider. Chesapeake Regional Information System for our Patients (CRISP) has also worked with HSCRC staff to develop criteria for the technological infrastructure that may be needed to support such alignment models

4. Performance Measurement Work Group

The Performance Measurement Work Group is charged with developing recommendations for HSCRC consideration on measures that are reliable, informative, and practical for assessing a number of important quality and efficiency issues. The Performance Measurement Work Group has worked at length over the past six months to review staff recommendations to update the quality program for SFY 2017 as listed below:

1. Readmission Reduction Incentive Program (RRIP) Policy Update for SFY 2017: Review of staff work to update the RRIP Program which rewards hospitals with future revenue increases if they can meet a pre-determined percent reduction in their 30-day, all-cause, all-payer, risk-adjusted readmission rate relative to the previous year.
2. Maryland Hospital Acquired Condition (MHAC) Program Policy Update for SFY 2017: Review of staff work to update the MHAC program which encourages hospitals to reduce PPCs by adjusting future hospital revenue based on performance on a set of 65 PPCs
3. Quality Based Reimbursement (QBR) Program Policy Update for SFY 2017: Review of staff work to update the QBR program which adjusts future hospital revenue based on the relative results of certain quality assessments
4. Aggregate Revenue at Risk for Quality-Based Payment Programs for SFY 2017 Policy: Review of staff work in determining amount of revenue to potentially reward or penalize hospitals based on performance in the Maryland quality-based payment programs

The work group also met jointly with the Payment Models Work Group to review preliminary staff work on the Market Shift Adjustment Policy as well as the FY 2016 Annual Update and Uncompensated Care Policies.

5. Data and Infrastructure Work Group

The Data and Infrastructure Work Group was charged with developing recommendations on the data and infrastructure requirements needed to support oversight and monitoring of the New Maryland All-Payer Model. This work group has adjourned during Phase 2 to allow HSCRC staff time to work with partner agencies to build off of the work group's July recommendations.

6. Care Coordination Work Group

Since the previous New Maryland All-Payer Model Biannual Report, the Care Coordination and Infrastructure Work Group has been the most active. The work group was formed in Phase 2 based on recommendations from the Advisory Council and multiple work groups to explore successful care

coordination models as well as to consider the possibility of implementing shared infrastructure and common strategies. Specifically, the work group will make recommendations to the Commission regarding care coordination infrastructure that should be considered for statewide, regional and local resourcing and concerning a strategy to address high-needs patients including high utilizers, particularly Medicare FFS, and dual eligible patients.

A focus of this work group has been leveraging existing data resources to identify those who will benefit from care coordination efforts, understand characteristics of those patients and create targeted initiatives to meet their needs. Consensus has been reached among the work group members regarding the need for Medicare data for the purposes of care coordination.

The HSCRC has obtained Medicare beneficiary claims data for the purposes of monitoring and evaluating the Maryland All-Payer Model. However, a separate data request will have to be approved to give Maryland providers access to Medicare beneficiary data for the purposes of care coordination. The Care Coordination Work Group is considering how Medicare data might be commonly utilized to improve care coordination as well as other effective regional and statewide strategies and shared resources for improving care coordination.

During the 2014 Legislative Session, the General Assembly adopted the BRFA of 2014. This legislation provides that the Health Services Cost Review Commission may include an additional $15,000,000 in hospital revenue fiscal year 2015 for the purpose of:

> (1) Assisting hospitals in covering costs associated with the implementation of Maryland's all–payer model contract; or
>
> (2) Funding of statewide or regional proposals that support the implementation of Maryland's all–payer model contract.

Statewide or regional proposals for funding are to be submitted to the Commission and the Department of Health and Mental Hygiene ("the Department," or "DHMH") for approval. The Department and the Commission are required to establish a committee to review regional proposals and make recommendations to the Department and the Commission for funding. The review committee is required to include representatives from the Department and the Commission as well as subject matter experts, including individuals with expertise in areas such as public health, community–based health care services and supports, primary care, long–term care, end–of–life care, behavioral health, and health information technology.

The Commission may take action on a statewide or regional proposal that has reviewed by the review committee and approved by the Commission and the Department.

In order to achieve these goals and to pave a way for success of the all-payer model, on February 9, 2015 the Department, in collaboration with 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 are due by April 15, 2015. The RFP invites proposals to develop partnerships capable of identifying and addressing

their regional needs and priorities and, in turn, shaping the future of health care in Maryland. This should include developing care coordination and population health priorities, determining what resources are needed and available, and how resources and strategies should be deployed.

The Work Group is also currently considering statewide opportunities for investment in care coordination. One of the sources of such investment is utilization of the funds referred to in BRFA. Some of the potential priorities for such funding include:

- Building/securing a data infrastructure 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, post-acute care providers), patient advocates, public health, faith-based initiatives.
- Connecting providers to CRISP.

7. Consumer Engagement, Outreach and Education Work Group

The Consumer Engagement, Outreach, and Education Work Groups were created during Phase 2 through the effort of advocacy groups with organizational support from HSCRC, MHCC, and the MHA. Two groups were formed - one led by the Maryland Women's Coalition for Health Care Reform and the other by the Maryland Citizens Health Initiative – and will meet between January and July 2015 to make recommendations on the following topics:

- Health literacy and Consumer Engagement within the context of the New Maryland All-Payer Model and Related Reform Initiatives. The work group will provide a rationale for health literacy and consumer engagement structure. The work group will define the audiences, identify the messages, and propose education and communication strategies as appropriate.

- Consumer Communications related to Implementation of the Maryland All-Payer Model. This work group will address avenues/strategies to provide consumers with ways to a) engage with decision makers, regulators, etc. on the impact on individual and/or community health issues of the design and implementation of the reform initiatives and the Maryland All-Payer Model; and b) ensure an appropriate and consumer-friendly communications process for those directly impacted by the Maryland All-Payer Model's goals.

- Messaging of the New All-Payer Model to the Public. The Maryland Citizens Health Initiative (MCHI) has already begun connecting directly with consumers in their communities by hosting regional public forums. At these forums, regulators, payers, providers and community leaders discuss with consumers the Maryland All-Payer Model, hospital global budgets, and the State's effort to produce better outcomes for patients, keep people healthier,

and make it easier for consumers to navigate the Maryland health system. MCHI received grant funding from Community Catalyst to conduct these education and engagement activities. Prior to the forums, MCHI also spent several months conducting focus groups, refining materials, and developing methods to effectively communicate the appropriate level of information to Maryland citizens to help them to benefit from changes occurring in the health system and assist them with their efforts to engage with the state agencies, providers, payers and other stakeholders initiating these changes. MCHI will continue such education and engagement activities as global budgets and other policies evolve so that consumers remain active stakeholders in New Maryland All-Payer Model development.

- Maryland Faith Community Health Network - As Phase 2 continues, MCHI also intends to explore the application of a Maryland Faith Community Health Network. This innovative collaboration model, inspired by the Congregational Health Network in Memphis, Tennessee, intentionally strengthens relationships between hospitals, community health organizations, and faith-based organizations to improve the patient journey from home to medical care and back.

Section III.

1. Alternative Methods of Rate Determination

The New Maryland All-Payer Model agreement affords Maryland 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 Total Patient Revenue (TPR) agreement in GBR, as discussed in Section I of this report. Since some revenue is outside of the global budget (such as revenue from some out of state referrals), approximately 95% of acute hospital revenue is now under a global budget.

The GBR and TPR methodologies are central to achieving the three part aim set forth in the New 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[3], demographic driven volume increases, performance in quality-based or efficiency-based programs, changes in payer

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

mix, and changes in levels of approved uncompensated care. Annual revenue may also be modified for changes in service levels, market share, 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 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 New Maryland All-Payer Model implementation, 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 potentially avoidable utilization (PAU). HSCRC staff has 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 as the New Maryland All-Payer Model evolves.

a. Global Budget Charge Corridors

A unique feature of global budgets refined in the past six months is the capacity of a GBR hospital to increase or decrease its approved unit rates to achieve its overall approved global revenue. This mechanism allows a hospital the flexibility to compensate for fluctuations in service volume over the course of the year and still reach its annual revenue target. The hospital must vary these unit rates in unison and within a defined charge corridor or be subject to penalties. If a hospital is experiencing significant volume declines as a result of reduced PAU, it may submit a request to expand this corridor so that it can achieve the approved global revenue necessary for financial stability and population health investment. HSCRC staff has begun reviewing charge corridor requests to determine the cause of hospital volume increases and 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 each hospital must submit annually to report on investments to improve care delivery, population health, and care management including program descriptions, expenditures, and results.

This reporting will begin in July 2015 and 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 Policy Development

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 at for cases that had been transferred. Global budget hospitals are encouraged to reduce PAU as well as 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 advanced care they need as well as to reduce the high costs associated with such cases. The Transfer Case Adjustment Policy 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 has 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 base period data collection has already begun, and the policy will be fully implemented in SFY 2016.

d. Market Shift Adjustment (MSA) Policy Development

HSCRC staff and the Payment Models Work Group have also made considerable progress on the Market Shift Adjustment (MSA) Policy. The purpose of the MSA Policy is to provide a mechanism to appropriately shift revenue between hospitals when utilization shifts from one hospital to another or others. Since the beginning of the policy development process, HSCRC staff and work group members have emphasized the importance of distinguishing market shifts from volume growth that is not the result of unknowns in the market shares of the hospitals. HSCRC staff is refining an algorithm to clearly delineate market shift from volume growth by analyzing utilization patterns at the zip code and product line level. Hospital GBRs are adjusted at 50% variable cost (i.e., hospitals that receive additional volume due to market shifts receive GBR incentives at 50% of the associated costs of the additional volume, while hospitals that lose volume due to market shift lose 50% of the revenue associated with this lost volume). HSCRC staff is working with hospitals to advance both the algorithm and the data that will be used to identify and calculate market shift when the policy is implemented fully.

e. New Germantown Holy Cross Hospital

Another important policy issue that was addressed in the past six months was the determination of rates for new hospitals. In September 2014, the Commission approved permanent rates for the new Holy Cross Germantown

Hospital (HCGH). Holy Cross Hospital (HCH) expressed its intent to move services from HCH to HCGH. In order to maintain consistent pricing for patients and payers within the geographic area, HCGH rates were set at the same levels as HCH SFY 2015 Rate Order Rates. HCGH rates will remain linked to HCH rates until such time as volumes stabilize (which is expected to occur in SFY 2017), at which time the Hospital will work with HSCRC staff to transition to a global budget methodology.

Section IV.

Reports Submitted to CMMI

The All-Payer Model Agreement requires HSCRC to report to CMMI relevant policy development and implementation. To date, the HSCRC has met all of the reporting requirements outlined in the All-Payer Model Agreement by submitting to CMMI the following information:

- Commission Meeting Documents: The HSCRC has submitted all pre and post Commission meeting materials to CMMI. These documents are available on the HSCRC website (http://hscrc.maryland.gov/commission-meetings-2015.cfm).
- New Maryland All Payer Model Quarterly Report: This report, see Appendix 1, contains a summary of work group and HSCRC staff activities related to New Maryland All-Payer Model implementation and advancement.

Section V.

Reporting Adverse Consequences

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

A number of policies developed in this first twelve months of implementation guard against adverse consequences that HSCRC staff and stakeholder work groups have 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 Share 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.

Additionally, the HSCRC is continuing to develop tools to monitor changes in patterns of service, particularly shifts in utilization and expenditure 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 soon be available through the All Payer Claims Data (APCD) collected by MHCC. 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 market as well as those changes that occur among non-hospital healthcare providers.

The HSCRC has also focused on engaging consumers through the Consumer Engagement, Outreach and Education Work Group as described in Section II. In addition, consumer advocates are present on each of the HSCRC stakeholder work group panels. Consumer advocate organizations have described the HSCRC New Maryland All-Payer Model stakeholder engagement process as a model for consumer engagement in a major policy endeavor. The HSCRC staff has made significant efforts to be as transparent as possible in its initiatives and policy development 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, Deputy Director, Policy and Operations, at Steve.Ports@maryland.gov.

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

Appendix 1

Maryland Health Services Cost Review Commission

New Maryland All-Payer Model Quarterly Report

March 31, 2015

The New Maryland All-Payer Model Quarterly Update

This is the first of a series of quarterly reports that the HSCRC intends to produce to update CMS, stakeholders, and the public on the progress of New Maryland All-Payer Model implementation. This report contains a high level summary of HSCRC staff and stakeholder work group activities related to this statewide health system transformation effort.

Contents

Overview:

The State of Maryland is leading a transformative effort to improve care and lower the growth in health care spending. As the State's hospital rate setting authority, the Health Services Cost Review Commission (HSCRC) is playing a vital role in the implementation of this innovative approach to health reform. Stated in terms of the "Triple Aim," the goal is a health care system that enhances patient care, improves health, and lowers total costs. To achieve this, the State of Maryland worked closely with the Centers for Medicare and Medicaid Innovation (CMMI) to develop the Maryland All-Payer Model, which was approved January 10, 2014. In the past thirteen months, the State, in close partnership with providers, payers, and consumers has made significant progress in this statewide modernization effort. Some key accomplishments during this period include:

- Transitioning all Maryland hospitals from a payment system that was based on inpatient per-case and outpatient per visit incentives to a population-based payment system
- Engaging the public and a broad range stakeholders throughout the Model implementation process through one Advisory Council, five work groups, and multiple sub-work groups overall totaling more than one hundred stakeholders in membership
- Developing enhanced financial and quality data monitoring tools including acquiring access to confidential Medicare claims data for Model monitoring and evaluation, and working with CRISP to establish a unique patient index across hospitals.
- Developing preliminary strategies for financial alignment of physician and other providers with the Maryland All-Payer Model

This report provides a high level summary of New Maryland All-Payer Model experience over the past fifteen months and expected activities in the coming quarter. Links throughout the report provide additional detail as well as extensive documentation of Commission and work group activities available on the HSCRC website.

New Maryland All-Payer Model Overview

In contrast to the previous Maryland Medicare waiver, which focused on controlling growth in Medicare inpatient payments per case, the New Maryland All-Payer Model focuses on controlling growth in total hospital revenue per capita as well as improving population health and patient care in the State. The New Maryland All-Payer Model Agreement establishes a 5-year model demonstration period during which a series of key requirements must be met. The status of these requirements as of December 2014 is summarized in Figure 1.

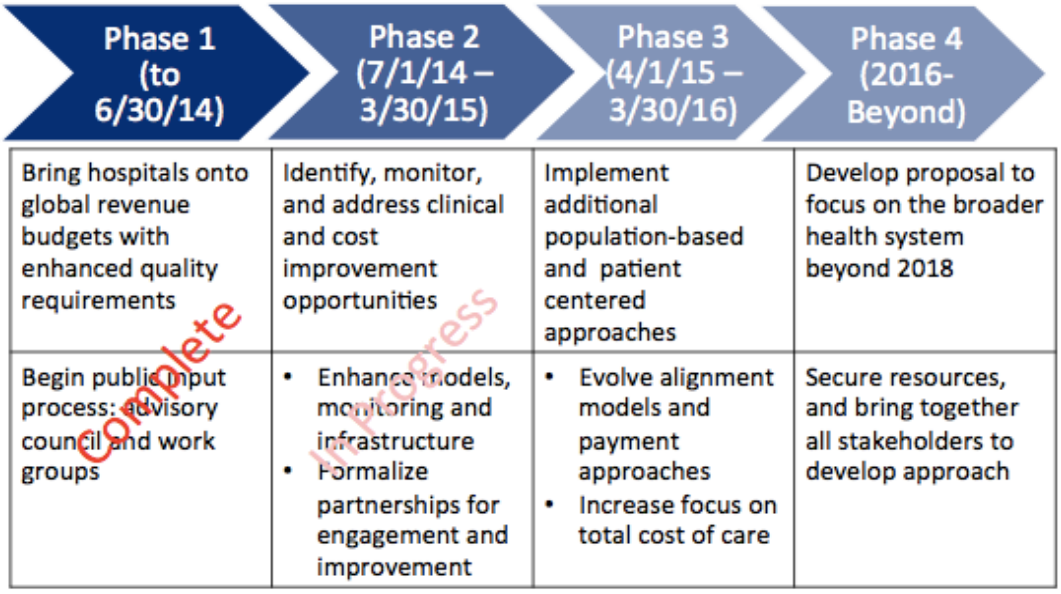
Figure 1: Status of Key Requirements in the New Maryland All-Payer Model Agreement

Agreement Requirement	Measurement Details	Accomplishments	Continued Activities
Limit the 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	▪ In CY's 2014, 2015 and 2016, the growth rate for regulated Maryland in-state hospital revenue per capita growth rate must be less than or equal the compound annual growth rate (2002-2012) = 3.58% per year ▪ In CY 2017 and beyond, the growth limit will be revised to include the most recently available GSP data	Per capita revenue for Maryland residents grew 1.47% for CY 2014 as compared to CY 2013	▪ Ongoing monthly measurement ▪ Expecting continued favorable performance for CY 2015
Achieve aggregate savings in Medicare spending equal to or greater than a cumulative $330 million	▪ CY 2013 Medicare Fee-for-Service (FFS) per beneficiary total hospital expenditure for Maryland residents is trended forward by the actual growth rate in national Medicare FFS per beneficiary total hospital expenditure to determine a benchmark. Savings are the difference between this benchmark and Medicare FFS per beneficiary total hospital expenditure for Maryland residents in a given year. ▪ Specified minimum annual targets	*Finalized data not yet available from CMS*	▪ HSCRC has gained access to preliminary CMS data and has begun work with an analytics contractor to examine the calculation of the per beneficiary amounts and growth rates
Shift at least 80% of hospital revenue to a population-based payments structure (such as global budgets)	▪ Percent of Maryland hospital regulated revenue under a fixed global budget for hospital services related to historical trends, the hospital service area and residents served ▪ Specified annual minimum targets	95% of hospital regulated revenue already shifted to global budgets	▪ All hospitals engaged in global budgets under Global Revenue agreements and Total Patient Revenue agreements ▪ HSCRC continues to refine global budget methodology
Reduce readmission rate for Medicare beneficiaries to at or below the national rate	▪ Reduce aggregate Medicare 30-day unadjusted all-cause, all-site hospital readmission rate for Medicare FFS beneficiaries such that the year 5 Maryland readmission rate is equal to or less than the year 5 national readmission rate ▪ Specific annual minimum targets ▪ HSCRC and CMMI are working together to refine the calculation methodology	*Finalized data not yet available from CMS*	▪ HSCRC and CMMI are refining calculation methodology ▪ HSCRC has gained limited access to CMS readmissions data and has begun work with an analytics contractor to approximate the calculation of the Medicare readmission rate ▪ Monitoring progress within Maryland using data collected from hospitals by HSCRC
Reduce Potentially Preventable Conditions (PPC) by 30%	▪ Cumulative 30% reduction in the statewide aggregate PPC rate across all 65 of the PPCs that compromise the Maryland Hospital Acquired Condition Program by December 31, 2018. ▪ Specified annual minimum targets	Reduction of 27.12% in PPCs in CY 2014 YTD (Jan-Sept) compared to CY 2013 YTD	▪ HSCRC staff reviewing and auditing these findings ▪ HSCRC staff set a statewide reduction target of 7% comparing state fiscal year (SFY) 2014 and CY 2015
Meet the level of aggregate revenue at risk for quality	▪ Percentage of Maryland hospital regulated revenue at risk for quality programs administered by the State	Based on preliminary calculations, the State	HSCRC staff working with stakeholders to finalize amounts at risk for quality programs for SFY 2017

programs under the national Medicare program	must be equal to or greater than that under national Medicare quality programs ▪ HSCRC and CMMI are working together to refine the calculation methodology	exceeds the requirement for CY 2014 and is positioned favorably for CY 2015	
Medical education innovation	▪ By January 1, 2016 the State must submit a 5- year blueprint for improvement to sustain health transformation initiatives	HSCRC staff has initiated partnership activities with Medical education leaders	▪ Established Graduate Medical Education (GME) innovation Work Group beginning in March 2015 ▪ Summit for a wider audience planned for May 2015
Monitoring requirements	▪ State must annually report a number of metrics (outlined in Appendix 7 of the Model Agreement) related to patient experience of care, population health and efficiency	Base year (CY 2013) metrics submitted	▪ Varying data lags and gaps ▪ HSCRC has begun work with a contractor to streamline data collection and reporting process
Model extension	▪ Prior to January 1, 2017 Maryland will submit a proposal for a new model for Stage II of the Model Agreement that shall limit, at a minimum, the Medicare per beneficiary total cost of care growth rate to go into effect no later than December 31, 2018. Total cost of care will include not only hospital services but also physician reimbursement, long term care, imaging services, ambulatory surgery, etc.	The HSCRC in partnership with its Stakeholder Workgroups and other Maryland Agencies are working on a number initiatives that will impact the development of the Stage II model design	HSCRC staff and work group members are exploring and progressing in the design and implementation of care coordination and provider alignment models on multiple fronts.

The HSCRC, with guidance from its All-Payer Modernization Advisory Council, developed a four-phase model implementation plan shown in Figure 2.

Figure 2: New Maryland All-Payer Model Implementation Timeline



A more detailed implementation timeline is available in Appendix 1.

Phase 1: Implementation of Hospital Global Budgets and Public Engagement:

Global Budget Implementation

A crucial tool for ensuring the success of the New Maryland All-Payer Model has been the establishment of a population-based payment methodology in the form of global budgets. During the first six months of the Model demonstration, HSCRC staff worked closely with Maryland hospitals as well as a number of stakeholder work groups to develop the Global Budget Revenue (GBR) methodology and transition Maryland hospitals to this population-based payment system.

As of July 2014, all Maryland hospitals are operating under global budgets. This represents more than 95%[1] of regulated hospital revenue, as compared to the 10% of regulated hospital revenue that was under a global budget methodology in calendar year (CY) 2013.GBR is an extension of Maryland's existing Total Patient Revenue (TPR) methodology. Both TPR and GBR allow Maryland hospitals to direct effort towards population-based health management by prospectively establishing a fixed annual revenue amount for each hospital. Current Global Budget Agreements are available on the HSCRC website.

Under GBR contracts, the total annual revenue for each hospital is known at the beginning of the fiscal year. Annual revenue is determined from a historical base period that is adjusted to account for

[1] The remaining 5% represents a small number of hospitals opting to exclude out-of-state revenue from GBR

inflation updates, infrastructure requirements, demographically driven volume changes, performance in quality-based and efficiency-based programs, changes in payer mix and changes in levels of uncompensated care (UCC). Annual revenue may also be modified for changes in services levels, market share, or shifts of services to unregulated settings. Based on these annual revenue amounts, the rates that hospitals may charge per unit of service are determined. As service volume may fluctuate during the course of a year, a global budget hospital may raise or lower its rates within a specified corridor in order to achieve the amount of overall revenue approved under its global budget.

An important part of the GBR methodology is the Demographic Adjustment, which provides adjustments in allowed revenue to reflect hospital service volume growth due to changes in aging and population but does not recognize volume growth associated with potentially avoidable utilization (PAU). The Demographic Adjustment is based on the hospital's virtual patient service area (VPSA). A VPSA is an aggregation of a hospital's service volume distributed across age/zip code cohorts. The HSCRC uses this service area distribution to virtually accredit population to each hospital based on the proportional amount of services it provides to patients in each zip code relative to services provided by all hospitals. Demographic changes that occur in a hospital's VPSA are used to determine expected changes in hospital service volume and, in turn, to update the hospital's annual approved revenue.

As noted above, the demographic adjustment does not allow for volume growth due to potentially avoidable utilization (PAU). The HSCRC staff is continuing to refine the PAU measurement methodology, but PAU is currently conceptualized as:

- **Readmissions/re-hospitalizations** that can be reduced through care coordination and quality improvements
- **Preventable admissions and ER Visits** that can be reduced with improved community based care
- **Avoidable admissions** from skilled nursing facilities and assisted living residents that can be reduced with improved care integration and prevention
- **Health care acquired conditions** that can be reduced with quality improvements
- **Admissions and ER visits for "high needs" patients** who can receive more appropriate care through improved chronic care and care coordination

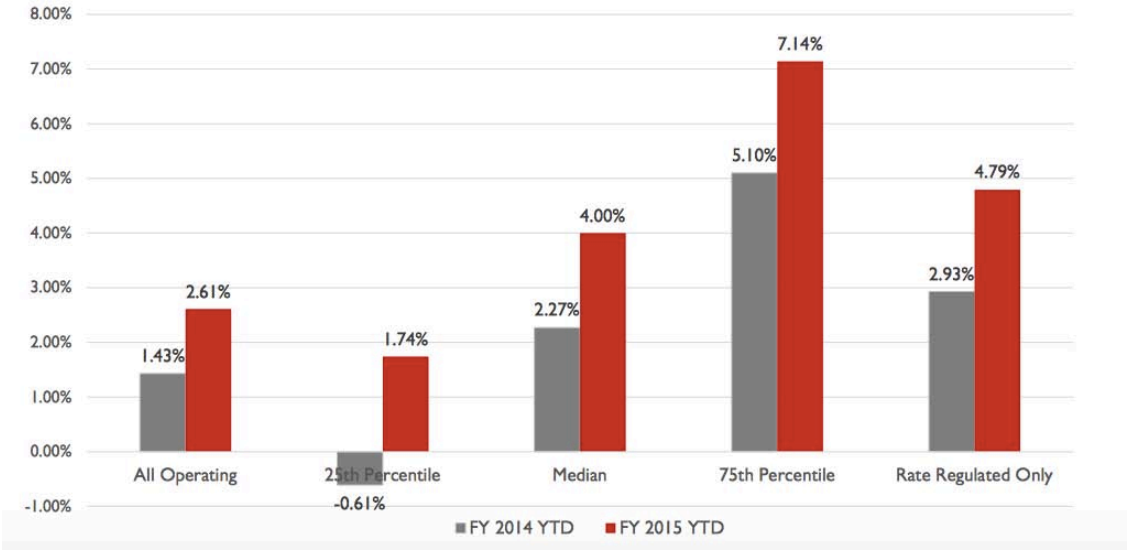
In developing global budgets for each hospital, the level of PAU was calculated as a certain proportion of hospital revenue. This portion of revenue is excluded from the Demographic Adjustment calculation on a hospital-specific focus. In turn, hospitals are encouraged to reduce PAU while maintaining high quality care under their global budgets, the hospitals retain the revenue associated with the PAU reductions and they can use that revenue to invest in future care improvement.

Key Aspects of Global Budgets
▪ Total hospital annual revenue (a global budget) is determined at the beginning of the fiscal year o Total hospital service volume is not known at the beginning of the fiscal year o Hospitals raise and lower unit rates in unison within a specified corridor to achieve the predetermined total hospital annual revenue amount
▪ Hospitals are encouraged to reduce PAU as hospitals retain the savings associated with that reduced volume o PAU is reduced through improved patient care, population health, care coordination and care management
▪ Global budgets are updated each year to account for factors such as: o Inflation o Volume changes caused by population growth and aging o Hospital performance in quality improvement programs o Uncompensated care levels and other payer mix changes ▪ Additional adjustments to global budgets can occur due to factors such as: o Market shifts (movement of service volume from one hospital to another) o Changes in transfer volumes to academic medical centers ▪ Global budgets are not updated each year to account for: o Service volume growth that is not associated with market shift or demographically driven volume changes.

Hospital Financial Condition and State Performance under Global Budgets

Hospital financial performance has been good in the first year after global budget expansion. According to the most recent data, hospital rate regulated operating margins for SFY 2014 averaged 2.93% percent; and, for SFY 2015, rate regulated operating margins have averaged 4.79% through December 2014. These performance levels are an improvement relative to recent levels of profitability.

Figure 3: Operating Profits FY 2015 Year to Date (YTD) July- December Compared to Same Period FY 2014



In addition to the fiscal year targets outlined in the GBR agreements, which are set for fiscal years defined as July-June, the hospitals have committed to achieving GBR targets on a calendar year basis compliant with what CMS specified in the Model Agreement. Revenue growth is below the 2.1% statewide global budget target for July through December 2014.

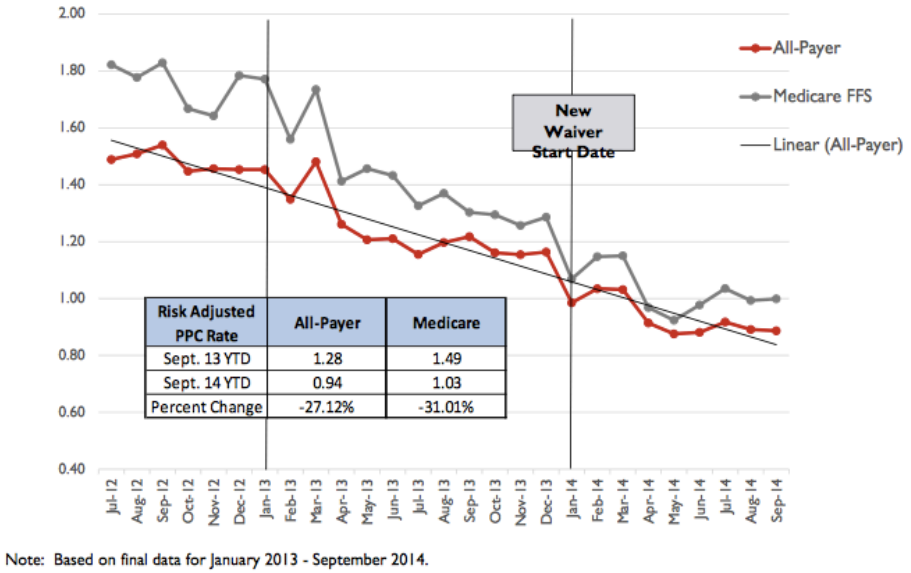
The implementation of global budgets has successfully maintained the All-Payer per capita hospital revenue growth with respect to the requirement outlined in the Maryland All-Payer Model. As of December2014, calendar year and state fiscal year trends for All-Payer per capita hospital revenue growth is below the model limit. All-Payer per capita revenue growth in SFY 2015 YTD is running at 1.81% and, in CY 2014 YTD, it was 1.47%. Both of these increases are well below the 3.58% per capita growth rate specified in the All-Payer target of the Model Agreement.

With respect to the Medicare payment savings requirement, the performance level of Maryland versus the national Medicare experience is uncertain. By April 2015, HSCRC staff expects to see relatively complete claims data from Medicare at which point they will work with contractors to evaluate the Maryland performance. Based on approved rate levels for SFY 2014, HSCRC staff expects favorable performance relative to Medicare payment savings target for January through June of 2014.

State Performance on Quality Targets

Maryland has long been a leader in innovative quality improvement programs and both the New Maryland All-Payer Model and the advent of global budgets place a renewed emphasis on quality. With the start of the Maryland All-Payer Model, the HSCRC has been restructuring its quality programs to align the incentives and goals with the new model so that programmatic targets reflect targets in the New Maryland All-Payer Model Agreement. Appendix 2 provides additional information on recent changes to the quality programs.

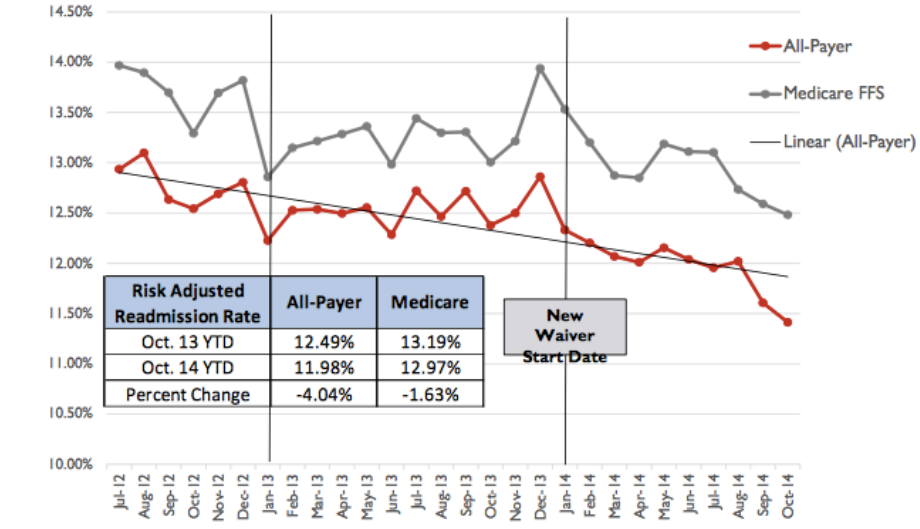
Figure 4. Monthly Risk-Adjusted PPC Rates



Note: Based on final data for January 2013 - September 2014.

In order to achieve the reduction in Potentially Preventable Conditions (PPCs) requirement set forth in the New Maryland All-Payer Model Agreement, the State is relying on the Maryland Hospital Acquired Condition Program (MHAC) which incentivizes hospitals to reduce PPCs by adjusting future hospital revenue based on performance on a set of 65 PPCs. In the first demonstration year, the State has already seen a reduction of 27.12% in PPCs in CY 2014 YTD (Jan-Sept) compared to CY 2013 YTD as shown in Figure 4. While these are preliminary data that are currently undergoing an independent auditing process, they do indicate that Maryland hospitals have made progress towards meeting the reduction goal of 30% over 5 years.

Figure 5. Monthly Risk-Adjusted Readmission Rates



Note: Based on final data for January 2013 - June 2014, and preliminary data through November 2014.

In order to achieve the reduce the Maryland Medicare FFS readmission rate to the national average, as required by the New Maryland All-Payer Model Agreement, the State is relying on the Readmission

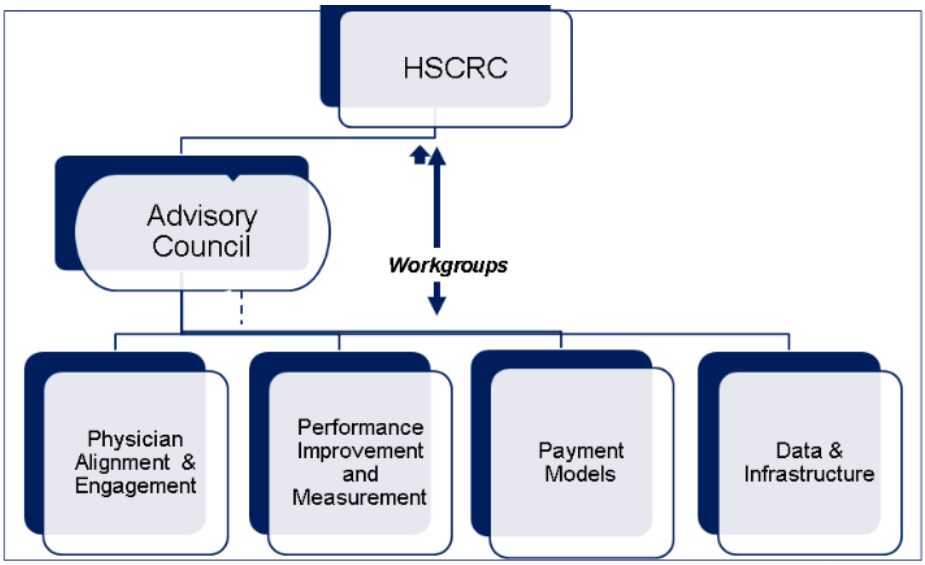
Reduction Incentive Program (RRIP) and Readmissions Shared Savings Program Readmission Shared Savings Program (RSSP) which work together to adjust hospital revenue based on readmission rate improvement and attainment.

While data is not yet available from CMMI to determine Maryland's performance against the national trend, RRIP has set goals for hospitals to reduce their all-payer adjusted readmission rate by 6.76% during CY 2014 compared to CY 2013. Currently, only 15 out of 46 hospitals have reduced their risk-adjusted rate by more than 6.76%. Reducing readmissions is a difficult task that will require significant effort, investment, and coordination in order to meet the New Maryland All-Payer Model requirement. In order to draw focus to this goal, the amount of revenue at risk for hospital performance under RRIP has been increased from 0.5% in SFY 2016 to 2.0% in SFY 2017. Additionally, the HSCRC is working with the Maryland QIO and the Care Coordination Work Group to develop strategies to address the State's lagging performance in readmissions.

Phase 1 Stakeholder Engagement

During phase 1, the HSCRC emphasized broad public engagement by convening an Advisory Council to provide guidance on design of the new system and work groups to advise on particular implementation activities. Figure 6 depicts the structure of the Phase 1 stakeholder engagement process.

Figure 6: Phase 1 Stakeholder Engagement



- **The Advisory Council** provided broad input on the guiding principles for the HSCRC to consider in implementation of the new payment systems design.
- **The Physician Alignment and Engagement Work Group** made recommendations for aligning hospital payment models with physicians and other health care providers to achieve the goals of the new model.
- **The Payment Models Workgroup** developed recommendations for the HSCRC on the structure of payment models and how to balance its approach to updates.

- **The Performance Improvement and Measurement Work Group** developed recommendations on measures that are reliable, informative, and practical for assessing issues such as reducing PAU to achieve the Triple Aim, value-based payment, and patient experience of care and patient-centered outcomes.
- **The Data and Infrastructure Work Group** developed recommendations to the HSCRC on the data and infrastructure requirements needed to support oversight and monitoring of the New Maryland All-Payer Model and successful performance.

Key Outcomes of Phase 1 Stakeholder Engagement Process

- Balanced approach to establishing an annual rate update under the New Maryland All-Payer Model
- Refinement of the GBR agreements
- Framework for short term and long term performance measurement improvements
- Recommendations for potential physician and other provider alignment models
- Consensus around the need for greater consumer education, engagement and outreach in relation to the health system modernization efforts being pursued under the New Maryland All-Payer Model
- Consensus around the need for strategies to improve care coordination across the state particularly for Medicare fee-for-service (FFS) beneficiaries

Phase 2: Enhance Models, Monitoring and Infrastructure & Formalize Partnership for Engagement and Improvement

Refining GBR Methodology

While the majority of Maryland hospitals transitioned to global budgets during Phase 1 of All-Payer Model implementation, 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. HSCRC staff has worked closely with the Payment Models Workgroup 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 as the All-Payer Model evolves. More detail on the GBR methodology and revisions is available in the Report on Global Budget Contracts and Rate Year 2015 Changes.

Global Budget Charge Corridors

A unique feature of global budgets refined during Phase 2 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 worked with the Payment Models Work Group and a technical sub-work

group to create an evaluation approach for charge corridor expansion outlined in Figure 7. Appendix 3 provides a more detailed summary of the GBR charge corridor policy.

Figure 7. Requirements for Submitting a Charge Corridor Expansion Request
▪ Comparison of base period and current volumes for each rate center o Explanation for any decrease in outpatient volumes o Updated attestation of know shifts of services to/ from regulated space
▪ Market shift analysis
▪ Comparison of case mix severity levels between base and current periods o Explanation for any reductions in severity level
▪ Description of interventions or actions that may have resulted in volume reduction o Comparison of PAU levels in base period and current period o Description of cost containment achieved
▪ Review of hospital efficiency using best available methodology[2]

HSCRC staff has begun reviewing charge corridor expansion requests using the information outlined above along with hospital financial and patient level case-mix data to determine if any of the following scenarios are the primary cause of a volume reduction:

- Declined market share
- Increased rate of transfer to other hospitals
- Shift of services to unregulated space
- Closure of services
- Systematic avoidance of high risk cases
- Operation as an extremely inefficient outlier
- Achieving no overall cost reduction as a result volume decline

If so, corridor expansion will not be permitted as these causes do not represent volume reduction as a result of reducing PAU and should not be addressed through the charge corridor expansion policy.

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 each hospital must submit annually to report on investments to improve care delivery, population health, and care management including program descriptions, expenditures, and results.

This reporting will begin in July 2015 and will be referred to 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

[2] The HSCRC does not yet have an efficiency measure in place for hospitals on global budgets and currently relies upon a per case measure to identify extreme efficiency outliers. Ultimately the HSCRC's goal is to evaluate total cost of care per capita and per episode.

reducing PAUs as well as improving care delivery and population health. Appendix 4 provides a more detailed summary of GBR infrastructure reporting requirements.

Transfer Case Payment Adjustment Policy

An early concern with the expansion of global budgets was the possibility that transfer rates to academic medical centers (AMCs) would increase because documentation of high cost care would leave community hospitals with the associated revenue at for cases that had been transferred. Global budget hospitals are encouraged to reduce PAU as well as 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 advanced care they need as well as to reduce the high costs associated with such cases. The Transfer Case Adjustment Policy 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 has 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 base period data collection has already begun and the policy will be fully implemented in SFY 2016. The Draft Transfer Case Payment Adjustment Policy Report provides a more detailed summary of the Transfer Case Adjustment Policy.

Market Shift Adjustment (MSA) Policy and Preliminary Implementation for University of Maryland St. Joseph Medical Center

HSCRC staff and the Payment Models Work Group have also made considerable progress on the Market Shift Adjustment (MSA) Policy. The purpose of the MSA Policy is to provide a mechanism to appropriately shift revenue between hospitals when utilization shifts from one hospital to another. Since the beginning of the policy development process, HSCRC staff and work group members have emphasized the importance of distinguishing market shifts from volume growth that is not the result of unknowns in t he market shares of the hospitals. HSCRC staff is refining an algorithm to clearly delineate market shift from volume growth by analyzing utilization patterns at the zip code and product line level. Hospital GBRs are adjusted at 50% variable cost (i.e. hospitals that receive additional volume due to market shifts receive GBR incentives at 50% of the arranged costs of the additional volume and hospitals that lose volume due to market shift lose 50% of the revenue associated with this lost volume). In addition, reductions on volume associated with PAU do not generate GBR agreements.

While the MSA Policy has yet to be finalized, HSCRC staff employed a preliminary form of the MSA policy to adjust the GBR of University of Maryland St. Joseph Medical Center (UMSJMC) by $20.4 million (5.5% increase in total revenues) to reflect both a growth in market share and a separate increase in out-of-state volumes. HSCRC staff did not anticipate making MSAs for the year ended June 30, 2014. However between January-June 2014, UMSJMC experienced an in-state volume increase; when it applied the preliminary MSA algorithm, the HSCRC identified a portion of the volume growth as being due to a market shift. Staff applied the similar calculations to UMSJMC data for the first quarter of SFY2 015 and estimated the potential amount of a MSA for the UMSJMC for full SFY 2015 to calculate the final MSA.

This increase in the UMSJMC GBR will be funded partially by a negative adjustment at other UMMS hospitals, which experienced corresponding volume declines, and by population adjustment hold backs that were prospectively established by HSCRC staff in anticipation of volume growth at UMSJMC. Appendix 5 provides a more detailed summary of the MSA policy to date as well as the calculation used to determine the UMSJMC GBR adjustment for market shift and out-of-state volume growth.

New Germantown Holy Cross Hospital

Another important policy issue that was addressed in Phase 2 was the determination of rates for new hospitals. In September 2014, the Commission approved the permanent rate application for the new Holy Cross Germantown Hospital (HCGH) in the HCGA Certificate of Need (CON) application. Holy Cross Hospital (HCH) expressed its intent to move services from HCH to HCGH. In order to maintain consistent pricing for patients and payers within the geographic area, HCGH rates were set at the same levels as the Holy Cross Hospital (HCH) SFY 2015 Rate Order Rates. HCGH rates will remain linked to HCH rates until such time as volumes stabilize (which is expected to occur in SFY 2017), at which time the hospital will work with HSCRC staff to transition to a global budget methodology. For additional detail, the September 2014 Commission Meeting Packet contains the full approved HCGH rate application.

Aligning Quality Programs with GBR and the Maryland All-Payer Model

The HSCRC quality-based payment methodologies are important policy tools with great potential to provide strong incentives for hospitals to improve their quality performance over time. Maryland has been a leader in initiating quality based payment approaches. Historically, these programs have surpassed the requirements of similar federal programs and, as a result, Maryland has been exempted from the federal programs. Each of the current policies for quality-based payment programs holds revenue at risk directly related to specific performance targets.

HSCRC staff, with input from the Performance Measurement Work Group, made recommendations to update the quality programs. While the staff typically reviews the quality programs annually with input from stakeholder representatives, in the past two update cycles special emphasis has been placed on aligning the quality programs with global budgets and with the goals of the Maryland All-Payer Model. The quality programs have been restructured to motivate both individual hospital quality improvement and the sharing of best practices across the industry. As measurement tools advance and new value-based purchasing methodologies are developed, the HSCRC intends to enhance these programs and more closely merge them with population-based payment mechanisms with the ultimate goal of compensating a hospitals for direct advancement of the Triple Aim.

Potentially Avoidable Utilization (PAU) Efficiency Adjustment within the GBR Demographic Adjustment

The PAU Efficiency Adjustment has been an important step in linking advancement of the Triple Aim with hospital payment. Each year, the global budget of each GBR hospital is adjusted for a number of factors including demographic changes such as population growth and aging. The PAU Efficiency Adjustment reduces the amount of revenue a hospital will receive under its demographic adjustment based on the amount of PAU the hospital has had in the past. PAU is defined as “Hospital care that is unplanned and can be prevented through improved care, coordination, effective primary care, and

improved population health." While HSCRC staff is continuing to refine the PAU measurement methodology, PAU is conceptualized as:

- **Readmissions/re-hospitalizations** that can be reduced with care coordination and quality improvements
- **Preventable admissions and ER Visits** that can be reduced with improved community based care
- **Avoidable admissions** from skilled nursing facilities and assisted living residents that can be reduced with care integration and prevention
- **Health care acquired conditions** that can be reduced with quality improvements
- **Admissions and ER visits for high needs patients** where illness severity and utilization levels that can be moderated with better chronic care and care coordination

By limiting the revenue that hospitals can receive for PAU, the PAU Efficiency Adjustment encourages hospitals to support improved population health, care coordination and primary care and thereby limit the number of hospital admissions and ER visits that could be prevented through more suitable care delivery. HSCRC staff intends to continue work with the Performance Measurement Work Group and other stakeholders to refine the PAU measure and to work with hospitals to understand and share best practices for PAU reduction.

Aggregate Revenue at Risk for Quality Programs

When Maryland entered into the New Maryland All-Payer Model Agreement, the continuing exemption process was addressed through a requirement that the proportion of Maryland hospitals' revenues held at risk for quality programs be equal to or greater than the proportion of revenue that is held at risk under national Medicare programs. The objective of this requirement is two-fold: a) incentivize hospitals to deliver high quality care in support of the Triple Aim of better care, better health, and lower cost, and b) evaluate the extent to which Maryland quality programs are rewarding value as compared to those used in the national Medicare program.

It is important to note that under the All-Payer Model Agreement, Maryland is required to achieve specific reduction targets in total cost of hospital care, potentially preventable conditions, and readmissions in addition to its revenue at risk requirement. In an effort to meet these reduction targets, Maryland restructured its quality programs in such a way that financial incentives are established prior to the performance period in order to motivate quality improvement and sharing of best practices while holding hospitals accountable for their performance.

For SFY 2016 the following maximum amounts of revenue at-risk were already approved by the Commission:

- Quality Based Reimbursement Program: 1% maximum penalty, with rewards based on revenue neutral adjustments.
- Maryland Hospital Acquired Conditions Program: 4%maximum penalty if statewide improvement target is not met; 1% maximum penalty and revenue neutral rewards up to 1% if statewide improvement target is met.
- Readmission Reduction Incentive Program: 0.5% positive incentive for any hospital that improves by at least 6.76%.

During the upcoming annual revenue update process for SFY 2016, HSCRC staff expects that two additional quality adjustments will be applied:

- Readmissions Shared Savings Program: A savings of 0.6% total hospital revenue (approximating an average 1% and maximum reduction of 1.3% of inpatient revenue) based on risk adjusted readmission levels.
- PAU Efficiency Adjustment: A reduction of allowed revenue for volume increases associated with PAU that had a maximum revenue reduction of 0.9% and an average reduction of 0.3% in SFY 2015.

Staff is working with CMMI to finalize the methodology for comparing the Maryland and national Medicare aggregate amounts of revenue at risk. In addition to calculating maximum revenue at risk ("potential risk"), CMMI staff has asked the HSCRC to measure the actual revenues impacted by the programs ("realized risk") as an absolute value percentage of revenue adjustments that actually occur within each program cumulatively over the five-year demonstration period.

While the calculation methodology has yet to be finalized, the combination of the MHAC, QBR, RRIP, RSSP and PAU Efficiency Adjustment programs exceed the national requirements for potential risk and realized risk in SFY 2014 and SFY 2015. The March 2015 Commission Meeting Packet provides a more detailed summary of aggregate revenue at risk under the quality programs. Additionally, Appendix 2 provides a summary of changes to the MHAC, QBR and RRIP programs in SFY 2017. The RSSP and PAU Reduction Program are updated on a different timeline and will be considered by staff and the Payment Workgroup Members during Spring 2015.

Developing Regional Partnerships for Health System Transformation

While changes to hospital payment mechanisms are well underway, there is significant work needed to integrate the efforts of health systems, payers, community hospitals, independent ambulatory physicians, community providers, public health agencies and other entities to the health system. The formation of such partnerships for Model advancement is a key goal for Phase 2 of Model implementation.

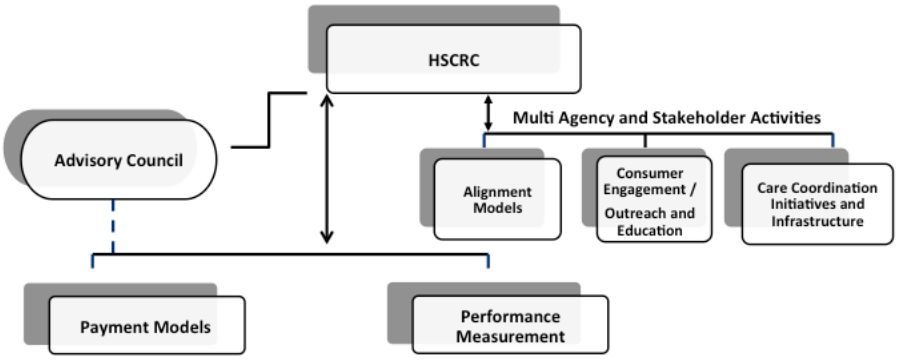
In order to accelerate and broaden Model implementation, the HSCRC will award at least five regional planning grants in May 2015 for multi-stakeholder health system transformation partnerships. These partnerships will identify care coordination and population health priorities and conduct analyses, develop common strategies and collaborative approaches to meet the specific needs of a population in a given region. Priority for funding will be given to applications proposing models that include the following:

- A comprehensive, diverse set of partnerships with established organizations in the region.
- Multiple targets for both high-cost conditions and populations, with initial focus on Medicare.
- Integration of primary care and prevention, efforts to address the multiple determinants of health.
- Sustainable and scalable concept that builds on the All Payer Model and other delivery/financing models.

Phase 2 Stakeholder Engagement

Building off of the recommendations coming out of the Phase 1 stakeholder engagement process, the HSCRC changed the work group structure. This was done to continue the progress of the HSCRC regulatory work groups (Payment Models and Performance Measurement) and to accommodate multi agency work groups, broaden the scope of the Model development and implementation process to consumers and non-hospital based providers, and promote collaboration across the diverse range of stakeholders that can both benefit from and advance the goals of the Maryland All-Payer Model. Figure 8 depicts the structure of Phase 2 stakeholder engagement.

Figure 8. Phase 2 Stakeholder Engagement



The Advisory Council met on November 12, 2014 and provided broad input on the guiding principles for the HSCRC to consider in key challenges and possible strategies over Phase 2 and 3 of Model implementation.

HSCRC Regulatory Work Groups: Payment Models and Performance Measurement

The Payment Models Workgroup has met frequently during Phase 2 of model implementation in order to review the progress of staff in developing global budget policies.

The Performance Measurement Work Group has worked at length during Phase 2to review the recommendations to update the quality program for SFY 2017 and to consider the aggregate revenue at risk across all quality programs.

Multi Agency Work Groups

The Alignment Models Work Group is a continuation of the Phase 1 Physician Engagement and Alignment Work Group. It is charged with the task of considering the various possible approaches to effectively implement the Phase 1 Physician Engagement and Alignment Work Group Recommendations summarized in Figure 9.

Figure 9: Phase 1 Physician Engagement and Alignment Work Group Recommendations to Be Considered by the Alignment Strategies Work Group
▪ 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 ACO or MA plan o Explore 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 the Maryland Hospital Association (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), the Department of Health and Mental Hygiene (DHMH) and other agencies to layout preliminary alignment approaches for the work group to consider. Chesapeake Regional Information System for our Patients (CRISP) has also worked with HSCRC staff to develop criteria for the technological infrastructure that may be needed to support such alignment models.

The Consumer Engagement, Outreach, and Education Work Group was created during Phase 2 through the effort of advocacy groups with organizational support from HSCRC, MHCC and the MHA. This group, formed in partnership with the Maryland Citizens Health Initiative and the Maryland Women's Coalition for Health Care Reform will meet between January and July 2015 and make recommendations on the following topics:

- Health literacy and Consumer Engagement within the context of the New Maryland All-Payer Model and Related Reform Initiatives. The work group will provide a rationale for health literacy and consumer engagement structure. The work group will define the audiences, identify the messages, and propose education and communication strategies as appropriate.

- Consumer Communications related to Implementation of the Maryland All-Payer Model. This work group will address avenues/strategies to provide consumers with ways to a) engage with decision makers, regulators, etc. on the impact on individual and/or community health issues of the design and implementation of the reform initiatives and the Maryland All-Payer Model; and b) ensure an appropriate and consumer-friendly communications process for those directly impacted by the Maryland All-Payer Model's goals.

The Maryland Citizens Health Initiative (MCHI) has already begun connecting directly with consumers in their communities by hosting regional public forums. At these forums, regulators, payers, providers

and community leaders discuss with consumers the Maryland All-Payer Model, hospital global budgets and the State's effort to produce better outcomes for patients, keep people healthier, and make it easier for consumers to navigate the Maryland health system.

MCHI received grant funding from Community Catalyst to conduct these education and engagement activities. Prior to the forums, MCHI also spent several months conducting focus groups, refining materials and developing methods to effectively communicate the appropriate level of information to Maryland citizens to help them to benefit from changes occurring in the health system and assist them with their efforts to engage with the state agencies, providers, payers and other stakeholders initiating these changes. MCHI will continue such education and engagement activities as global budgets and other policies evolve so that consumers remain active stakeholders in New Maryland All-Payer Model development. As Phase 2 continues, MCHI also intends to explore the application of a Maryland Faith Community Health Network. This innovative collaboration model, inspired by the Congregational Health Network in Memphis, Tennessee, intentionally strengthens relationships between hospitals, community health organizations, and faith-based organizations to improve the patient journey from home to medical care and back.

Finally, the Care Coordination and Infrastructure Work Group was formed in Phase 2 based on recommendations from the Advisory Council and multiple work groups to explore successful care coordination models as well as to consider the possibility of implementing shared infrastructure and common strategies. Specifically, the work group will make recommendations to the Commission in April regarding care coordination infrastructure that should be considered for statewide, regional and local resourcing and concerning a strategy to address high-needs patients including high utilizers, particularly Medicare FFS and dual eligible patients.

An early focus of this work group has been leveraging existing data resources to identify those who will benefit from care coordination efforts, understand characteristics of those patents and create targeted initiatives to meet their needs. Consensus has already been reached among the work group members regarding the need for Medicare data for the purposes of Care Coordination. The HSCRC has attained Medicare beneficiary claims data for the purposes of monitoring and evaluating the Maryland All-Payer Model. However, a separate data request will have to be approved by members to give Maryland providers access to Medicare beneficiary data for the purposes of care coordination. Over the next few months, the Care Coordination Work Group will consider how Medicare data might be commonly utilized to improve care coordination. This use will have to be determined prior to requesting data access from CMMI and it will be necessary to outline how the data will be stored and shared with providers.

Expected New Maryland All-Payer Model Activities in the Coming Quarter

HSCRC Staff

As Phase 2 comes to a close and the State embarks on Phase 3 of Model implantation, there are a number of topics that the HSCRC staff must address in the short term. In addition to continued global budget and quality program monitoring, HSCRC staff must determine SFY 2016 Update. The Update is the annual rate update for hospitals to account for such factors as inflation, population growth, quality performance, and a number of other factors. Key considerations for SFY 2016 will be:

- Compliance with the All-Payer growth limit and Medicare savings requirement guardrails
- The expected growth in Medicare hospital payments
- Inflation
- Population and demographic adjustments
- Financial condition of hospitals
- Uncompensated care and the impact of the Affordable Care Act (ACA) Expansion
- Infrastructure Adjustments
- Shared Savings Adjustments
- Impact of Payments to Holy Cross Germantown Hospital on Total Expenditures
- Changes to hospital assessments such as the Medicaid and Maryland Health Insurance Plan (MHIP) assessments
- Other trends in factors such as categorical exclusions and transfer rates

The FY 2015 Report on Balanced Update and Short Term Adjustments provides additional detail on this process.

As part of the Update, the Uncompensated Care (UCC) Policy must be determined for SFY 2016. In Maryland, UCC is funded by the hospital rate system through a statewide pool, which hospitals draw from or contribute to depending on relative amounts of UCC. The SFY 2015 UCC Policy in the July 2014 Commission Meeting Packet provides additional detail on this mechanism. In SFY 2015, the HSCRC reduced the total amount of funding allocated to the pool because of the Medicaid Expansion under the Affordable Care Act (ACA). According to hospital financial data through November 2014, UCC was overfunded by 14%. HSCRC staff is working with the hospital industry and CRISP to analyze utilization patterns of the Expansion population to determine the appropriate level of UCC reduction for SFY 2016.

Other important policy issues staff will work to address in the near term are:

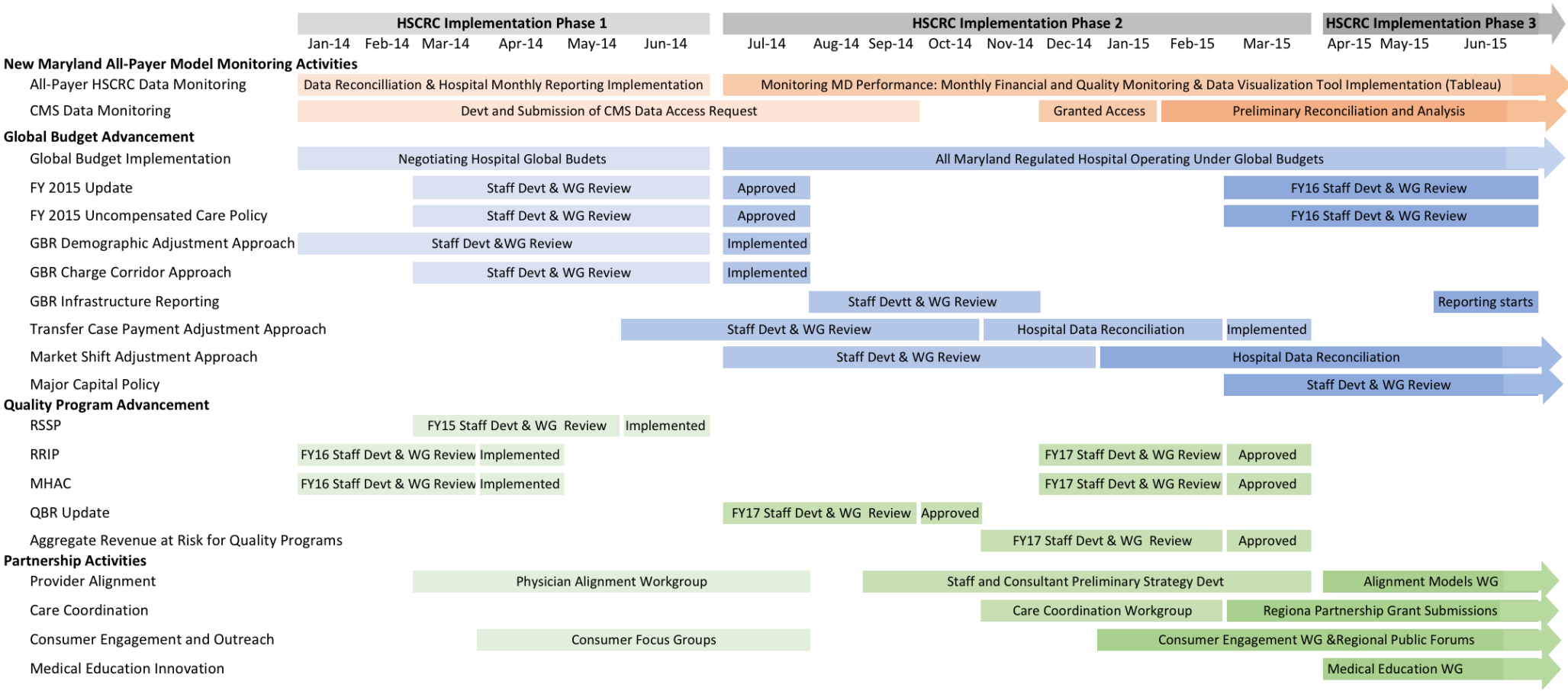
- Develop a major capital project funding policy application and review process to align it with the MHCC Certificate of Need (CON) process, global budgets and the goals of the Maryland All-Payer Model
- Finalize the MSA Policy, Transfer Case Payment Adjustment Policy and other tools to monitor shifts in utilization between regulated and unregulated services
- Refine methods for monitoring GBR and TPR contract compliance

Finally, in the next few months HSCRC will be rolling out enhanced data visualization tools using Tableau Software. This structure will allow HSCRC staff and hospitals and other stakeholders to analyze HSCRC financial and case-mix data with unprecedented ease and will contribute to improved monitoring and evaluation of hospital performance, new policies, and Maryland performance against the New Maryland All-Payer Model requirements.

Stakeholder Workgroup and Partnership Activities

Figure 10:Expected Stakeholder Work Group Activities March-June 2015
Payment Models Work Group
Review MSA Policy development
Review Aggregate Revenue at Risk for value based purchasing programs
Review policy development for major capital project funding
Review regional planning grants for health system transformation
Review SFY 2016 Uncompensated Care Policy development
Review SFY 2016 Update Policy Development
Performance Measures Work Group
Review QBR measures for SFY 2018 and beyond
Consider a socio-demographic adjustment to readmissions programs
Review 3M PPC clinical vetting for the MHAC program
Recommend new efficiency measurement methodologies for hospitals global budgets
Alignment Strategies Work Group
Continue development of the ICN model to provide a support structure for community-based providers and organizations to work together to reduce avoidable hospitalizations and reduce total cost of care
Continue development of gain sharing and pay-for-performance models for community-based physicians
Partnership Activities: MHA led continued development of gain sharing “New Jersey Model” for inpatient hospital services
Partnership Activities: DHMH led continued development of Dual ACO model
Consumer Engagement, Outreach, and Education Work Group
Develop recommendations on health literacy and consumer engagement
Develop recommendations on consumer communication
Host a series of additional regional public forums to educate consumers and community leaders
Support launch of pilot Faith Community Health Networks
Care Coordination Work Group
Develop Recommendations on strategies, priorities and implementation timeline for regional and statewide care coordination activities to be presented to Commission in April
Develop consensus around a statewide strategy to utilize Medicare data for care coordination efforts

Appendix 1: Detailed New Maryland All-Payer Model Implementation Timeline



Appendix 2: Summary of Changes to MHAC, QBR and RRIP for SFY 2017

The following section summarizes the recent changes to the MHAC, QBR and RRIP programs to impact SFY 2017 revenue.

Maryland Hospital Acquired Conditions Program (MHAC)

Overview: The MHAC program adjusts future hospital revenue based on performance on a set of 65 Potentially Preventable Complications (PPC) developed by 3M Health Information Systems. PPCs are complications not present when a patient is first admitted that are unlikely to be a consequence of the natural progression of an underlying illness. Within this program, a hospital is assigned an overall point value based on the hospital observed to expected ratio for each PPC relative to predetermined attainment and improvement benchmarks and thresholds.

For SFY 2016, a statewide reduction target was set at 8%. If this target were met, one-time penalties and rewards of up to 1% of permanent inpatient revenue could be applied based on MHAC performance. If the target were missed, only penalties of up to 4% of permanent inpatient revenue could be applied. However, overall penalties were limited to 0.5% of permanent inpatient revenue statewide.

Maryland has seen a significant drop from year to year from 2010 to 2014 in the statewide PPC rates with a total rate per 1,000 decrease of 39.6% unadjusted and an average annual risk-adjusted decrease of 13.9%. As the figure 8 illustrates, there was a sharp decrease in the rate in January 2014, but the linear trend line decrease is constant and consistent for September 2013 year to date (YTD) compared to September 2014 YTD. Present on Admission (POA) coding drives PPC assignment within the MHAC program. Therefore, POA auditing is regularly conducted, and is currently underway for the 2014 YTD data. Staff will present findings of the POA audits in public Work Group meetings and discuss any implications for considering adjustments to the MHAC program based on the findings.

Summary of Approved Changes for SFY 2017:

1. The statewide reduction target for risk-adjusted PPC rates should be set at 7% using SFY 2014 as a base period and CY 2015 as performance period.

2. The program should continue to use a tiered approach where a lower level of revenue at risk is set if the statewide target is met versus not met as modeled in FY 2016 policy.

3. Rewards should be distributed only if the statewide target is met and should not be limited to the penalties collected

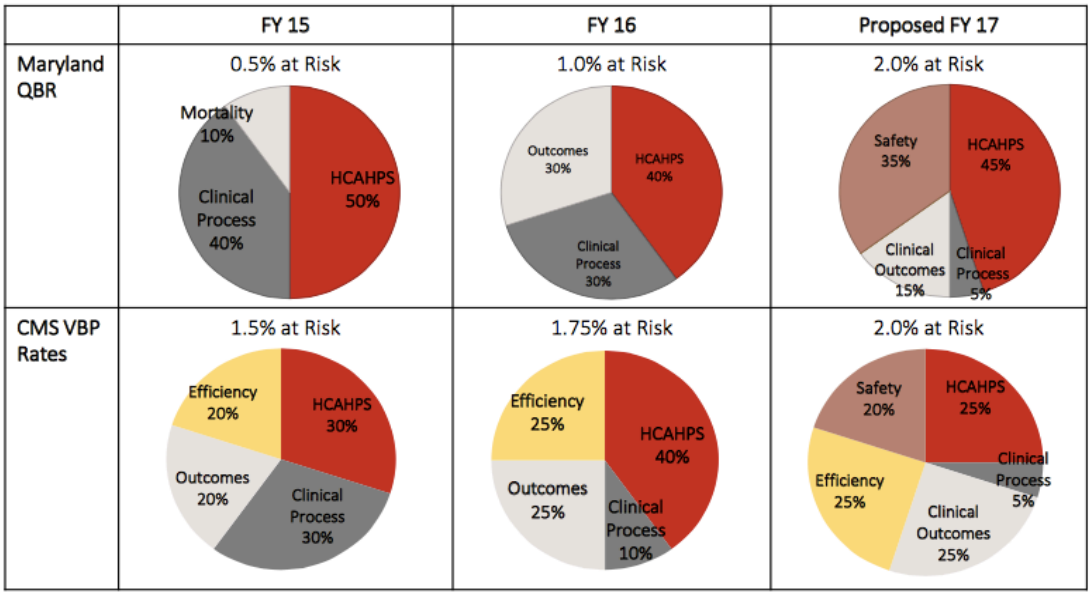
   For the most up-to-date full draft recommendations, see the January 2015 Commission Meeting Packet

Quality Based Reimbursement (QBR)

Overview: The QBR program adjusts future hospital revenue based on the relative results of certain quality assessments. Hospitals are scaled by an overall point value based on the hospital's performance on a series of clinical process of care, outcome and patient experience of care domains relative to predetermined benchmarks and thresholds. This scaling is then used to allocate a portion of approved base inpatient hospital revenue as one-time rewards or penalties.

For SFY 2016, up to 1% of approved base hospital inpatient revenue was at risk under the QBR program. As quality assessments, the HSCRC used CMS/ Joint Commission core process measures, HCAHPS measures, three outcome measures (AHRQ PSI 90, CDC-NHSC CLABSI, and all-cause inpatient mortality) and weighted these domains as shown in figure 14.

Figure 14. Weighted Domains for QBR and VBP



Staff analyzed changes in performance on the QBR and VBP measures used for SFY 2015 performance for Maryland versus the US for October 2012 through September 2013 compared with the immediately prior 12-month period. Figure 15 lists each of the measures used for the VBP and QBR programs. The data indicate that Maryland improved at a slightly higher rate and/or performed slightly better for all but one of the process of care measures. Maryland also performed significantly better than the US on the CLABSI measure for both time periods and also improved on this measure. For HCAHPS, Maryland declined slightly in performance for almost half (4 out of 10) of the measures, and performed below the US on all measures with the exception of "Patient given information about recovery at home" where Maryland improved significantly and now performs at the same level as the US.

Figure 15. VBP and QBR Results Oct 2012-Sep 2013 vs. Previous Year

	CLINICAL OUTCOME Mortality						
		MD Base Period	MD Most Current Performance		US Base Period	US Most Current Performance	
		Q308-Q211	Q309-Q212	Difference	Q308-Q211	Q309-Q212	Difference
	Combined CHF, AMI, Pneumonia 30 day mortality	11.56	11.38	-0.18	12.34	12.31	-0.03
	CLINICAL PROCESS						
		Maryland Base Period	MD Performance Period		US Base Period	US Performance Period	
		Q311-Q212	Q312-Q213	Difference	Q311-Q212	Q312-Q213	Difference
AMI 8a	Primary PCI within 90 minutes	89.96	94.68	4.72	95.22	96.25	1.03
HF 1	Discharge instructions	92.94	94.28	1.34	92.59	93.9	1.31
IMM 1	Pneumococcal vaccination*	91.59	94	2.41	88.28	92	3.72
IMM 2	Influenza vaccination*	90.19	94	3.81	84.16	90	5.84
PN 3b	Blood culture before first antibiotic	96.53	97.03	0.5	96.93	97.4	0.47
PN 6	Initial antibiotic selection	95.82	97.29	1.47	94.63	95.19	0.56
SCIP INF 1	Antibiotic given within 1 hour	97.79	97.7	-0.09	97.96	98.3	0.34
SCIP INF 4	Cardiac surgery patients with controlled 6am postop serum glucose	94.23	96.51	2.28	95.88	96.47	0.59
SCIP INF 9	Urinary catheter removed postop day 1 or 2	93.69	97.74	4.05	94.98	96.84	1.86
Clinical Process	***Average Total Score***	93.64	95.91	2.28	93.40	95.15	1.75
	PATIENT EXPERIENCE (HCAHPS)						
HCAHPS	Doctors always communicated well	77.51	78	0.49	81.34	82	0.66
HCAHPS	Nurses always communicated well	74.84	75	0.16	78.18	79	0.82
HCAHPS	Patients always received help as soon as they wanted	59.19	58	-1.19	66.63	68	1.37
HCAHPS	Staff explained about medication	59.02	58	-1.02	63.47	64	0.53
HCAHPS	Pain was always controlled	67.67	67	-0.67	70.63	71	0.37
HCAHPS	Patient room always kept quiet	56.05	57	0.95	60.35	65	4.65
HCAHPS	Patient room always kept clean	65.21	64	-1.21	72.78	73	0.22
HCAHPS	Patient given information about recovery at home	82.93	85	2.07	84.21	85	0.79
HCAHPS	Patient would definitely recommend hospital to friends and family	66.88	67	0.12	70.76	71	0.24

HCAHPS	***Average Total Score***	***67.70***	***67.67***	***-0.03***	***72.04***	***73.11***	***1.07***
	SAFETY**						
		MD Base Period	MD Most current performance	Difference	US Base Period	US Most current performance	Difference
	CLABSI	0.55	0.53	-0.02	1	1	N/A
	CAUTI	1.59	1.78	0.19	1	1	N/A
	MRSA	N/A	1.83	N/A	N/A	1	N/A
	C-diff	N/A	1.16	N/A	N/A	1	N/A
	SSI Colon	N/A	0.95	N/A	N/A	1	N/A
	SSI Hysterectomy	N/A	1.51	N/A	N/A	1	N/A
	PSI 90	Data Unavailable			Data Unavailable		
*Data collection periods for Immunization measures differ than those for other measures.							

**Safety measures are ratios where a decrease indicates improvement. An average score for the safety domain was not calculated due to incomplete data.

Summary of Approved Changes for SFY 2017: For the QBR program, the Commission approved the following staff recommendations in October 2014.

1. Allocate up to 2% of hospital approved inpatient revenue for QBR relative performance in SFY 2017.
2. The precise percent at risk allocated for the QBR program will be determined by the end of CY 2014 and will entail broader stakeholder discussions and subsequent Commission action about the percentage of revenue at risk for the performance-based payment policies as a whole, and will be contingent upon feedback from and compliance with CMMI under the Maryland All-payer Model.
3. Adjust measurement domain weights to include 5% for process, 15% for outcomes (mortality), 35% for safety, and 45% patient experience of care.

   For the full recommendation, see the October 2014 Commission Meeting Packet.

Readmissions Reduction Incentive Program (RRIP)

Overview: RRIP is a positive incentive program which rewards hospitals with future revenue increases if they can meet a pre-determined percent reduction in their 30-day, all-cause, all-payer, risk-adjusted readmission rate relative to the previous year. The HSCRC also conducts a Readmission Shared Savings Program.

For SFY 2016, the readmission reduction target was set at 6.76% compared to CY 2013 readmission rates. Hospitals that met this target were entitled to receive a one-time reward of up to 0.5% of their permanent inpatient revenue.

As Figure 5 illustrates, Maryland's all-payer risk adjusted readmission rate for calendar YTD August 2014 is 3.37% lower than the calendar YTD August 2013 rate. According to data through August 2014, approximately one third of the hospitals improved beyond the target. As a result, it is projected that

these hospitals will be eligible to receive the reward subject to a confirmation that the improvement was not achieved through a substantial increase in observation cases. On the other hand, one third of hospitals experienced increases in their readmission rates, which is concerning to both staff and stakeholders.

Since access to national Medicare data has been delayed, HSCRC staff has not been able to verify trends in Maryland and national readmission rates. CMMI staff is working to revise the readmission calculation and is currently reporting an interim methodology to the HSCRC. This uncertainty in trend may delay the final recommendation for RRIP.

Summary of Approved Changes for SFY 2017: The Commission approved the following staff recommendations in March 2015 for the RRIP for SFY 2017 budget impact comparing performance in CY 2013 to performance in CY 2015.

1. Adopt a readmission payment incentive program with both rewards for hospitals achieving or exceeding the required readmission reduction benchmark and payment reductions for hospitals that do not achieve the minimum required reduction.
2. Use a continuous preset scaling approach to provide rewards and penalties in proportion to the each hospital's performance relative to the required reduction on a case-mix adjusted basis.
3. Continue to set a minimum required reduction benchmark on all-payer basis and re-evaluate the option to move to a Medicare specific performance benchmark for CY2016 performance period.
4. Set the all-payer case-mix adjusted readmission target at 9.3% cumulative reduction from CY 2013 base all payer case-mix adjusted readmission rates.
5. Continue to assess the impact of admission reductions, SES/D and all payer and Medicare readmission trends and make adjustments to the rewards or penalties if necessary.
6. Seek additional Medicare benchmarks that can help guide efforts in Maryland. Evaluate recommendations from the Care Coordination Work Group and request recommendations from Maryland's new QIO regarding specific areas for improvement.

For the full recommendation, see the March 2015 Commission Meeting Packet.

Appendix 3: Summary of GBR Charge Corridors and Charge Corridor Expansion Requests

Overview of Unit Rate Charge Corridors

Both the TPR and GBR agreements allow hospitals to increase or decrease their approved unit rates in order to achieve the overall approved global revenue for the hospital. However, hospitals may only vary their approved unit rates within a charge corridor. Specifically, hospitals may not increase or decrease their approved unit rates by more than 5% without receiving permission from the HSCRC. If permission is granted, the hospital will be allowed to expand the charge corridor to 10%. Neither the TPR nor the GBR agreements specify a process whereby the charge corridors might be expanded beyond 10%. Under this policy, underages below 10% r will not be added back to hospitals' approved revenues for the following year.

These corridors serve several purposes. They limit the ability of hospitals to cross subsidize or cost shift through undercharging in one center in order to overcharge in another center. Additionally, if a hospital's volume falls by more than 10%, this provision limits the ability of the hospital to charge up to its approved global revenue. A 10% decline in overall volume is substantial. Several purchasers have expressed concern about increasing unit rates when volumes are reduced. The HSCRC staff believes that this mechanism will help ensure that the money follows the patient and that a hospital experiencing a substantial volume decrease will not be able to retain the revenue associated with that lost volume by increasing its unit rates without demonstrating the source of reductions. Volume shifted to other hospitals or to unregulated settings will result in an appropriate reduction in the hospital's global budget. Consumer representatives have agreed that this and other contract mechanisms are vital to helping protect consumers and ensure the patient-centeredness of the Maryland All-Payer Model.

Some hospitals and payer organizations have raised the concern that the charge corridors could undermine the efforts of hospitals to reduce PAU by restricting their ability to keep and reinvest savings. Hospitals must make substantial investments in medical interventions, quality improvement, community based and primary care interventions, funding alignment models, internal care coordination and care coordination with other providers such as assisted living and skilled nursing facilities in order to improve population health and achieve the desired results of the Maryland All-Payer Model. After making these considerable investments, hospitals are concerned that they may not be permitted to charge the full-approved global budget necessary to sustain these investments. Additionally, payers are concerned that hospitals will not continue efforts to reduce PAU once the maximum volume reduction of 10% is reached within the charge corridor.

The HSCRC staff wants to address the concerns raised on both a short term and a longer-term basis. For now, HSCRC staff has identified factors that should be taken into consideration before a hospital will be granted permission to exceed the 10% charge corridor. At this time, we are not seeking to address undercharges that are beyond the 10% corridor. Although this could occur, volume reductions this large it is a situation that would need to be addressed based on the surrounding facts and circumstances, because it would not result from successful application of the Maryland All-Payer Model. Finally, charge variances that result from volume changes related to market share shifts or shifts to unregulated sites of care that fall within the 10% corridor will also be considered in the evaluation of market share adjustments and administration of the global budget agreements

Considerations for 10% Charge Corridor Relief

If a hospital requests permission from the HSCRC to exceed the 10% charge corridor, this request must appeal for relief in all rate centers. It is not the intent of the staff to allow concentration of rate adjustments resulting from volume declines in one or only a portion of centers or to allow cross-subsidization across centers. As outlined in the global agreements, staff expects these "balancing" rate adjustments to be spread evenly across all centers. The main purpose of granting relief is to provide stability and investment resources to hospitals and allow them the needed flexibility to adjust for significant volume declines as a result of reducing PAU. There will be circumstances where HSCRC staff will not grant corridor relief. For example, it is possible that the volume declines may have resulted from market share changes, shifts to unregulated settings, temporary closures of services, or other actions which would not warrant an expansion of the corridors. Additionally, there may be some level of rate increase that would warrant an efficiency or shared savings adjustment due to the relative per capita or per episode efficiency of the hospital. In the near term, the HSCRC staff will need to focus on identifying and understanding the source of volume reductions and in turn, granting relief from the corridors when the volume reductions are consistent with the goals of the new Model.

Market Share Decline: If a volume decrease is due to a decline in market share, 10% charge corridor relief should not be granted. Rather, through the market share policy, the variable portion of revenue associated with that market share decline should be removed from the global budget of the hospital experiencing the market share decline and added into the global budget of the hospital or hospitals that have realized a corresponding market share increase.

Shifts: Under the TPR and GBR agreements, hospitals are required to notify the HSCRC of shifts of services to unregulated settings. If volume is lost due to shifts to unregulated settings, 10% charge corridor relief should not be granted. The global budget of the hospital should be decreased to an extent that it will ensure a net savings to the system and to Medicare.

Transfers: If a loss in volume is due to an increase in a hospital's transfer rate, 10% charge corridor relief should not be granted. Rather the variable revenue associated with those transferred patients should be removed from the global budget of the transferring hospital and added into the global budget of the receiving hospital or hospitals through the transfer policy.

Service Closures: Under the TPR and GBR agreements, hospitals are required to notify the HSCRC of a service closure. Loss of volume due to service closures should not result in 10% charge corridor relief and should result in a reduction of the global budget. Risk Avoidance: HSCRC staff should monitor any changes in the severity level of the requesting hospital to ensure that the requesting hospital is not experiencing a volume decline due to systematic avoidance of high-risk cases. HSCRC will focus on case mix and severity changes of the requesting hospital to evaluate the potential avoidance of providing necessary care.

Efficiency Outliers: The HSCRC does not yet have efficiency measures in place for hospitals on global budgets. Ultimately, the HSCRC's goal will be to evaluate the total cost of care per capita and per episode. These measures are not available to guide the process in SFY 2015. The staff does have some charge per case tools that have been used in the past. HSCRC staff will employ these tools and may

choose to limit corridor relief when extreme outliers in existing charge per case measures or in rate comparisons are seen. Extremely inefficient outliers may not be granted permission to exceed the 10%.

Cost Containment and Investment Plans: Loss in volume should result in reduced hospital costs. HSCRC staff will need to evaluate measures such as supply cost per adjusted discharge and labor cost per adjusted discharge to ensure that the requesting hospital is taking the necessary steps to reduce costs when volumes are decreased.

Review

To request relief, a hospital will need to submit the following information to staff:

1) A comparison of its base period volumes to the current volumes for each rate center, separated between inpatient and outpatient volumes.
    a) An explanation for any decrease in outpatient volumes will be necessary to ensure that shifts to unregulated settings or other hospitals have been accounted for.
    b) Staff will work with the hospital to gain information on the detected reductions. The hospital will need to update its annual attestation statement regarding known shifts of services.
2) A market share analysis should be completed.
    a) Staff has been working on several formats for this evaluation to evaluate volume changes by service line and to separately account for PAU.
    b) Staff will work with the hospital to evaluate changes in market share. This should include an evaluation of transfers, temporary closures, or service discontinuation.
3) A comparison of case mix and severity levels between the base and current periods should be conducted.
    a) Any reductions in severity levels treated should be adequately explained.
4) The hospital should explain the actions it has taken and interventions implemented that have resulted in volume reductions.
    a) The hospital should show a reduction in PAU
    b) The hospital should describe the level of cost containment it has achieved.
5) The staff and hospital should review available information regarding efficiency, although as previously noted that the staff has not yet developed any per capita tools.

This process will become more automated over the course of the year as staff completes development of new tools and monitoring reports. The HSCRC recognizes that the corridor relief review process will take time for both the hospital staff and HSCRC staff to conduct the review. HSCRC staff may grant temporary corridor relief during the review process.

Appendix 4: Summary of GBR Infrastructure Investment Reporting Requirements

Background

The Health Services Cost Review Commission's (HSCRC) global budget revenue contracts state:

> *The Hospital shall provide an annual report of its investment in infrastructure to promote the improvement of care delivery and reductions of Potentially Avoidable Utilization. This report will be due 90 days following the end of each fiscal year, and will include program descriptions, expenditures, and results.*

This repos it is required by the GBR contracts so that the HSCRC can understand the total investments that hospitals are making in care coordination and population health improvement given the additional revenue included in the base approved regulated revenue for GBR infrastructure investments. These reports are important for HSCRC's efforts to maximize the potential for success under global budgets and to reduce PAU, improve care coordination, and improve population health.

Purpose of Reporting

The purpose of this report is to inform the HSCRC and other stakeholders, including the Center for Medicaid and Medicare Services (CMS), about the amounts and types of investments all acute hospitals in Maryland are making over time to improve population health, and how effective these investments are in reducing PAU and improving population health. The report may be used to increase global budgets or provide relief from rate corridors. The purpose of this report is not to determine whether a hospital spent the full amount of additional funds provided in the global budgets, nor is it intended to limit what hospitals report as their actual infrastructure investment to the amount of the GBR additional funds. The HSCRC staff also recognizes that some hospitals that signed GBR agreements late in FY 2014 may not have spent the additional funds during FY 2014. However, the Commission is requesting hospitals to report on FY 2014 investments in population health so that changes in spending over time can be monitored and linked with outcomes. The HSCRC staff will work to make sure there is clarity between this reporting and other GBR and community benefits reporting and work to see if this reporting can be incorporated into other reporting. The report will be available for any interested stakeholder. For more detail, including the GBR Investment in Infrastructure Reporting Template, see the November Commission Meeting Packet.

Guiding Principles

2) Final fiscal year (FY) 2014 and available FY 2015 reports will be submitted together and will be due 90 days after the end of FY2015. This will ensure hospitals have guidance on the types of investments to report and sufficient time to collect and report the data. However, interim reports may be submitted to the HSCRC for feedback and will be required for any hospitals seeking increases in global budgets or relief from rate corridors.
3) Qualifying GBR investments reported by hospitals will be for new programs or technologies, or major expansions in existing programs or technologies, directly related to GBR incentives to achieve the triple aim and improve care coordination and population health. The reported

investments are not limited to those that were made with the additional GBR funding for infrastructure, but rather must include all major population health investments.

4) GBR investments included in the report should be broad in scope and have the potential to impact population health within the communities that each hospital serves.
5) GBR investments included in the report should be data driven and should be capable of being evaluated using measurable outcomes
6) The HSCRC will review requests to include expenses associated with unique programs that do not specifically fall into the types of expenses listed below.
7) Reporting of GBR investments is important for educating CMS and other stakeholders on the new waiver model activities and results.

Types of Expense to Report:

Patient Centered Investments

- Case management, care coordination, transitional care, and chronic disease management.
- Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center).
- Making/verifying post-discharge appointments.
- Reminding patients of physician appointments, lab tests or other appropriate contact with specific providers.
- Medication and care compliance initiatives, such as checking that the patient is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the patients in the management program to effectively monitor compliance, including expenses for transportation or prescription medications for patients who cannot afford them,
- Programs to support shared decision making with patients, their families and the patient's representatives.
- Programs to support patient education and self-management, including public education campaigns directing people to appropriate sites of care.

Provider/Care Team Investments

- Providing coaching or other support to encourage compliance with evidence based medicine.
- Activities to identify and encourage evidence based medicine (e.g., incorporating Choosing Wisely information into decision making algorithms).
- Infrastructure to set up pay-for-performance or shared savings models with providers including legal expenses for vetting P4P programs and infrastructure for gain-sharing.
- Seed funding and/or subsidies to recruit and retain primary care or other providers required to fill critical gaps in community health infrastructure and ensure continued access to care for certain health conditions (e.g., diabetes clinics) or populations (e.g., Medicaid).
- Activities to support effective collaborations between hospitals and other community providers.

Health Information Technology Investments

- Health information technology expenses to support patient centered and provider/care team interventions including:

- Data extraction, surveillance, analysis and transmission in support of the activities described above.
- Predictive models or other mechanisms for identifying and stratifying patients for care coordination interventions, as well as expenses to create, document, execute, and update care plans.

Excluded Expenses

- Electronic health records or patient hotlines or portals that are used for care delivery and communication unless specifically implementing systems or modules for care coordination activities (e.g., electronic health record module for care manager to record activities or patient portal for contacting care manager).
- Billable services.
- Investments to improve coding or documentation, including upgrades to systems to be complaint with regulatory changes such as ICD-10.
- All retrospective and concurrent utilization review.
- Fraud prevention activities.
- Any expenses for acquiring physicians that do not clearly improve access to primary care services (i.e., expenses for acquiring existing physicians that does not result in any change in access but simply results in the existing physicians being owned by the hospital).
- Any expenses that are primarily for marketing purposes.
- Accreditation fees.
- Financial rewards to providers (e.g., pay-for-performance incentives).
- All other expenses that do not fall under care coordination and population health.

Appendix 5: Summary of Market Shift Adjustment Policy and Application to University of Maryland Saint Joseph Medical Center

HSCRC staff and the Payment Models Work Group have also made considerable progress on the Market Shift Adjustment (MSA) Policy. Similar to the Transfer Case Payment Adjustment Policy, the purpose of the Market Shift Adjustment Policy is to ensure that revenue appropriately follows the patient when shifts in utilization occur between hospitals. MSAs are fundamentally different from volume adjustments. Hospitals under a population-based payment system have a fixed budget for providing services to the population in their service area. A global budget is not fixed if it is subject to volume adjustments. Therefore, it is imperative that MSAs reflect shifts in patient volumes independent of general volume increases in the market.

Through the Payment Models Work Group process, a series of guiding principles were created, that will be centrally considered as the MSA policy development continues.

Figure 11. Guiding Principles for Market Share Adjustment
1. Provide clear incentives
1.1. Promote the Triple Aim
1.2. Emphasize value, recognizing that this concept will take some time to develop
1.3. Promote investments in care coordination
1.4. Encourage appropriate utilization and delivery of high quality care
1.5. Avoid paying twice for the same service
2. Reinforce the maintenance of services to the community.
2.1. Encourage competition to promote responsive provision of services
2.2. Competition should be based on value
2.3. Revenue should generally follow the patient
2.4. Support strategies pursued by entities such as ACOs, PCMH, MCOs seeking to direct patients to low cost, high quality settings.
3. Changes constituting market share shifts should be clearly defined.
3.1. Volume increase alone is not a market share change.
3.2. Market share shifts should be evaluated in combination with the overall volume trend to ensure that shift has occurred, rather than volume growth.
3.3. If one hospital has higher volume and other hospitals serving the same area do not have corresponding declines in volume, a market share shift should not be awarded.
3.4. Increases in the global budget of one hospital should be funded fully by the decrease in other hospitals' budgets.
3.5. Market share changes should reflect services provided by the hospital.
3.6. Substantial reductions at a facility may result in a global budget reduction even if not accompanied by shift to other facilities in service area. (Investigate shift to unregulated, limitations on types of procedures).
3.7. Closures of services or discrete readily identifiable events should result in a global budget adjustment and a market share adjustment as needed.
3.8. Market shifts in PAU should be evaluated separately.

While HSCRC staff is still refining the MSA algorithm, which will likely be applied at the zip code and service line level, based on the guiding principles, the MSA calculation methodology will largely reflect the rubric outlined in Figure 12.

Figure 12. Overview of MSA Calculation Methodology

Hospital X for Area 1	Aggregate of Other Hospitals in Area 1	MSA for Hospital X
Volume Increase	Volume Increase	No MSA
Volume Decrease	Volume Decrease	No MSA
Volume Increase	Volume Decrease	Yes: Increase If increase at hospital X > the absolute value of the decrease at the other hospitals: MSA = absolute value of the decrease of the other hospitals If increase at hospital X < the absolute value of the decrease at the other hospitals: MSA = the increase at hospital X
Volume Decrease	Volume Increase	Yes: Decrease If the absolute value of the decrease at hospital X > the increase at the other hospitals: MSA = the increase of the other hospitals If the absolute value of the decrease at hospital X < the increase at the other hospitals: MSA = absolute value of the decrease at hospital X

HSCRC staff will work with stakeholder work groups over the next few months to refine the MSA calculation methodology. Analysis files have been shared with Maryland hospitals and those organizations are in the process of validating the data that will support the final methodology.

Once the MSA calculation methodology has been established; HSCRC staff and work group members will address the following topics:

1. Adjusting budgets for substantial shift in market share.
2. Using corridors to avoid shifts for minor variations.
3. Adjusting budgets gradually to reflect the fixed nature of capital and other costs
4. Determining the timing of MSAs
5. Assessing the relative value of market shifts

HSCRC staff has employed a preliminary MSA policy to adjust the GBR of UMSJMC. The MSA policy implementation is dependent on a multitude of factors that may alter this timeline. Additionally, this policy, like others developed for global budgets, will continue to evolve over the lifetime of the Maryland All-Payer Model.

University of Maryland St. Joseph Medical Center Market Shift Adjustment

In negotiating GBR agreements, HSCRC staff informed hospitals that they did not anticipate making market shift adjustments (MSAs) for the year ended June 30, 2014. However, given the financial condition of University of Maryland St. Joseph Medical Center (UMSJMC), and the rapid rise in its volumes in the first six months of the fiscal year, HSCRC staff plans to make the MSA outlined below, and to rebase UMSJMC out-of-state revenues given current performance. HSCRC staff also plans to reduce other UMMS global budgets as a result of market shift reductions, and to maintain revenue constraints for nearby hospitals that already had constraints in population adjustments due to volume reductions.

The HSCRC staff found that, between January-June 2014, UMSJMC experienced large increases in Maryland resident volumes. When reviewing the MSA algorithms applied at a service line and zip code level, staff found approximately $9.2 million in growth that would be characterized as market shift under the algorithms mentioned above. Staff also found growth of sixty percent increases in out-of-state revenues and cases beyond the amounts included in the GBR for this period a sixty percent increase over the same period in the prior year, which totaled approximately $3.8 million.
Staff applied the volume growth market share calculations to the case mix data for the first quarter of SFY 2015 and estimated the potential amount of a market shift adjustment for the UMSJMC for SFY 2015 based on the amount of shift found in the first quarter of CY 2015. For the quarter ended September 30, 2014, UMSJMC showed an increase in revenues attributable to a market shift of approximately $5.6 million. Annualizing this figure results in an annual estimate of $22.4 million. The growth in out-of-state revenues and cases for this period amounted to $200,000. Annualized, this represents a growth of $800,000.

In considering the UMSJMC request for a MSA for SFY 2015, staff evaluated case mix data to identify the most important sources of the market shift. Staff found that several University of Maryland Medical System (UMMS) facilities showed reductions in service lines where UMSJMC has been experiencing volume increases. Staff will make annualized MSA (i.e., decreases) to the GBRs of these other UMMS hospitals that will total $6,400,000. The adjustments that will be applied at this time to hospitals' GBRs with an effective date of July 1, 2014 are summarized in Figure 13.

Figure 13. Market Shift Adjustment Calculation for UMSJMC		
Jan-Jun 2014 Market Shift at 50% VC	**A**	**$4,600,000**
Jan-Jun 2014 Out-of-State Rebasing	B	$3,800,000
Jan-Jun 2014 Total	A+B=C	$8,400,000
SFY 2015 Market Shift at 50% VC	D	$11,200,000
SFY 2015 Out-of-State Rebasing	E	$800,000
SFY 2015 Total	D+E=F	$12,000,000
Proposed Increase to UMSJMC GBR	**C+F=G**	**$20,400,000**
Total Market Shift Increase at 50% VC for UMSJMC	A+D=H	$15,800,000
Total Market Shift Decrease at 50% VC for other UMMS	I	$6,400,000
Net MSA	H-I=J	$9,400,000
Total Out-of-State Rebasing	B+E=K	$4,600,000
Grand Total Revenue Adjustments	**J+K=L**	**$14,000,000**

HSCRC staff did not provide population adjustments in the GBR budgets for several of the surrounding hospitals that compete with UMSJMC for the January through June 2014 period because these facilities were showing volume decreases in the first half of SFY 2014. Additionally, several nearby hospitals did not receive population adjustments in SFY 2015. The SFY 2014 and SFY 2015 constraints, in addition to the MSAs (i.e., decreases) that will be applied to the GBRs of the other UMMS hospitals, will fund all of the MSA increases of $15.8 million that is being proposed for UMSJMC. The staff does not wish to open up other GBR agreements at this time as other constraints are already in place.

The current GBR for UMSJMC is $369 million. The proposed increase of $20.4 million represents a 5.5% increase in total revenues. For the first half of SFY 2014, UMSJMC had to undercharge its approved rates to stay in line with the approved global budget in light of the volume increases. UMSJMC will need to raise rates for the remainder of the SFY to recover the proposed increase.

Staff will continue to meet with leadership to evaluate progress on financial and operational improvements as well as PAUs. Staff will also continue to evaluate reporting of uncompensated care for UMSJMC by SFY end. Staff will complete its evaluation of a sample of physician contracts to determine their consistency with the balanced values of the Triple Aim.

For additional detail, see the January 2015 Commission Meeting Packet.