Report to the Governor

Fiscal Year 2018

Health Services Cost Review Commission
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Introduction

The State of Maryland is leading a transformative effort to improve care and lower healthcare spending growth through Maryland's All-Payer Model. The All-Payer Model (Model) serves as the central focus in this *Fiscal Year (FY) 2018 Report to the Governor from the Maryland Health Services Cost Review Commission* (HSCRC or Commission). This report, prepared in accordance with Section 19-207(b)(6) of the Health-General Article of the Annotated Code of Maryland, includes:[1]

- All-Payer Model policy implementation, state and federal reporting requirements, and stakeholder engagement,
- Other HSCRC activities during the reporting period of July 1, 2017 through June 30, 2018,
- Hospital financial performance in FYs 2017 and 2018,
- Hospital quality performance and updated quality initiatives; and,
- An overview of HSCRC staffing and budget infrastructure.

Section I - The Maryland All-Payer Model with CMS

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

Goals Established by the All-Payer Model

The All-Payer Model aims to transform Maryland's health care system by enhancing patient care, improving health, and lowering total costs. Under the All-Payer Model, Maryland remains committed to meeting the following cost and quality requirements:

Cost Requirements of the Model

- The all-payer per capita total hospital revenue growth will be limited over the five years of the Model (plus an adjustment for population growth) to 3.58

[1] Section 19-207(b)(6)(i) requires this Report to the Governor to include a copy of each report required by this subtitle. HSCRC posts all reports required by this subtitle on its website for public access and provides a link to those reports in this document.

percent per year, which is the 10-year compound annual growth rate in per capita gross state product (GSP).

- Medicare per beneficiary total hospital cost growth over five years must be at least $330 million less than the national Medicare per capita total hospital cost growth over five years. This number is estimated to represent a savings level of approximately one-half percent per year below the national Medicare spending growth rate beginning in year two of the Model.
- Total cost of care growth for Maryland Medicare beneficiaries may neither exceed the national growth rate by more than one percent in any given year, nor exceed the national growth rate for two consecutive years.

Quality Requirements of the Model

- Maryland will achieve a number of quality targets designed to promote better care, better health, and lower costs. Under the Model, the quality of care for all payers, including Medicare, Medicaid, Children's Health Insurance Program beneficiaries and commercial enrollees, will improve as measured by hospital quality and population health measures.
- Specific quality improvement requirements include the following:
    - The aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate will be reduced to the corresponding national rate over five years.
    - An annual reduction of 6.89 percent across all Potentially Preventable Conditions (PPCs) over five years, resulting in a cumulative 30 percent reduction in PPCs over the life of the Model.

Implementing Policies to Achieve Model Goals

The All-Payer Model continues to build upon decades of innovation and equity in hospital payment and health care delivery in Maryland. The HSCRC works closely with stakeholders and CMS to develop and deploy policies to enable the State to meet the goals established by the All-Payer Model. Several stakeholder workgroups (discussed in the Stakeholder Engagement section below), and regular meetings between HSCRC and CMS staff have facilitated policy implementation over the course of the Model demonstration period.

Initial policies toward the All-Payer Model's goals focused on allowing hospitals to voluntarily participate in global budget strategies. These policies expand on strategies adopted by various rural hospitals across the State three years prior to the adoption of the All-Payer Model.

Global Budgets Negotiated with All Hospitals

The Maryland All-Payer Model agreement affords the State the ability to innovate by developing alternative methods of rate determination. During the first six months of the 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. As of April 2017, 100 percent of Maryland regulated hospital revenues are contained within GBR agreements.

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

Under GBR contracts, each hospital's total annual revenue is known at the beginning of each fiscal year. Annual revenue is determined from a historical base period that is adjusted to account for inflation updates, demographic driven volume increases, performance on quality-based or efficiency-based programs, changes in payer mix, and changes in the levels of approved uncompensated care. Annual revenue may also be modified for changes in service levels, market shifts, or shifts of services to unregulated settings.

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

The HSCRC will continue to further develop payment policy and will report any future innovations in this section of the Annual Report.

Care Redesign Program

In April 2017, the State received approval from CMS for an amendment to the All-Payer Model contract to implement specific care redesign strategies and to provide hospitals and providers with the tools and flexibility necessary to achieve the goals of the All-Payer Model and transition to the Total Cost of Care Model. The Chesapeake Regional Information System for our Patients (CRISP) is serving as the administrator of the program.

Two care redesign tracks were designed to encourage hospital and physician alignment: the Hospital Care Improvement Program (HCIP) and the Complex and Chronic Care Improvement Program (CCIP). HCIP aims to facilitate care improvement and efficiency

within hospitals, while CCIP focuses on improving care for high-risk and rising needs patients through increased care coordination among hospitals and community physicians. As of July 2018, there is a total of 43 unique participants across both tracks, with 40 hospitals participating in HCIP and nine hospitals participating in CCIP. Participation in CCIP is expected to significantly decline in 2019 as hospitals opt to participate in the Maryland Primary Care Program (MDPCP) instead. HSCRC and stakeholders are considering efforts to revise or end the track for 2020.

The Episode Care Improvement Program (ECIP) was developed in 2018 and will allow hospitals to link payments across providers across certain clinical episodes of care. ECIP is modeled off of CMS' Bundled Payments for Care Improvement, Advanced program. This episode payment approach aligns incentives across hospitals, physicians, and post-acute care facilities to generate savings and improve quality through better care management during episodes, eliminating unnecessary care, and reducing post-discharge Emergency Department visits and hospital readmissions. CMS approved this track in June 2018 and hospital participation will begin in January 2019. Thirty-five hospitals submitted letters of intent to participate, although staff believe participation will be more modest when ECIP begins on January 1, 2019.

Medicare Performance Adjustment

The HSCRC recently implemented the Medicare Performance Adjustment (MPA) to assist the State in the transition to the Total Cost of Care Model (TCOC Model), which will focus on controlling total costs of care per capita, both inside and outside of the hospital. The MPA will adjust hospital Medicare payments based on Medicare TCOC performance. Commissioners voted on the initial policy in November 2017 to allow for a January 2018 implementation date, with payment adjustments beginning in July 2019 (RY 2020). The TCOC Workgroup worked throughout 2018 to refine the methodology of the MPA to guide implementation in CY 2019 and future years. A final vote on the CY 2019 policy, which will impact Medicare payment adjustments for RY 2021, is expected in November 2018.

Other Policies Supporting All-Payer Model Goals

Over the course of FY 2018, the Commission approved additional policies to support All-Payer Model goals.

Quality

The HSCRC amended the existing pay for performance programs included Quality-Based Reimbursement (QBR), Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Potentially Avoidable Utilization savings policy. These programs are all designed to achieve the model goals including reducing hospital acquired conditions and readmissions. Specific program changes, such measuring hospitals on both improvement and attainment to the FY 2018 RRIP policy, were implemented to incentivize continued hospital improvements while recognizing that high performers may have less opportunity to improve. As quality is a central

component of the All-Payer Model, the quality programs are discussed in greater detail in the Quality Performance section of this report.

Update Factor

The FY 2019 update policy was implemented on July 1, 2018. The Commission adopted the following policies as a part of the FY 2019 update factor:

- Provide an overall increase of 1.83 percent for revenue (net of uncompensated care offset) and 1.37 percent per capita for hospitals under Global Budgets. In addition, staff is proposing to split the approved revenue into two targets, a mid-year target and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
- Allocate 0.31 percent of the total inflation allowance based on each hospital's proportion of drug cost to total cost to more equitably adjust hospitals' revenue budgets for increases in drug prices and high cost drugs. Continue to adjust for volume changes of high cost oncology drugs at the mid-year data point for RY 2018 over RY 2017. Evaluate the need for an additional adjustment for growth in high cost drugs during RY 2019.
- Hospitals should submit, 30 days after the fiscal year, their annual disclosures of their GBR Agreements to disclose any shifts from regulated to unregulated and unregulated to regulated; as well as changes in financial interest, ownership, or control f hospital or non-hospital services within the service area. Failure to submit these disclosures will result in a holdback of 0.50 percent of a hospital's update for RY 2019. HSCRC should convene a sub-group to outline additional guidance to hospitals in reporting shifts to unregulated settings, as well as outlining the expectations for revenue adjustments.
- Continued refinements should be made to adjust revenues for volume changes in high-cost drugs. Hospitals must report shifts to unregulated settings to avoid duplicate billing. Data collection should be expedited and improved and external resources consulted in order to improve the timeliness and ease of adjustments.

The Commission will continue to closely monitor performance targets for Medicare, including Medicare's growth in Total Cost of Care and Hospital Cost of Care per beneficiary during the performance year. As always, the Commission has the authority to adjust rates as it deems necessary.

Uncompensated Care Reduction

Since the HSCRC first started setting rates, the Commission has recognized the cost of uncompensated care within Maryland's unique hospital rate-setting system. As a result, patients who cannot pay for care are still able to access hospital services, and hospitals are credited for a reasonable level of uncompensated provided to those patients. Due to the Affordable Care Act (ACA) coverage expansion and the corresponding changes in utilization, uncompensated care has decreased from 7.25% of hospital revenue in FY 2013 to 4.51% in FY 2016. For FY 2018, the Commission approved a reduction in the

amount of uncompensated care included in rates from 4.69 percent in FY 2017 to 4.51 percent in FY 2018.

GBR Infrastructure Reporting

In FYs 2014 through 2016, the Commission included over $200 million in rates to support hospitals in developing services and mechanisms to improve care delivery, population health, and care management. Hospitals submitted reports on these investments with program descriptions, expenditures, and results. Key areas of investment over this time period included disease management, post-discharge and transitional care, community care coordination, case management, and consumer education and engagement. Reporting for GBR Infrastructure spending was suspended for FY 2017 to encourage hospitals to focus on developing care redesign initiatives and to avoid diverting staff attention from those efforts.

Currently, staff are exploring ways to combine community benefits reporting with GBR infrastructure reporting, as many of the investments may overlap and have similar goals to improve community and population health. Staff is still in nascent planning stages and anticipates this to be a long-term project that may be utilized in future hospital efficiency methodologies.

Transformation Implementation Grants

As part of its update factor process for FY 2017, the Commission authorized up to 0.25 percent of hospital rates to be used for intensive community-based care coordination activities for chronically ill patients. During the first round of a competitive application process, the Commission awarded $30 million to nine hospital partnerships to work with community partners to reduce PAU. These programs are above and beyond the care transitions initiatives that were funded in FYs 2014 and 2015. In October 2016, the Commission awarded an additional $6.5 million in funding to another five partnerships. Awardees submitted an annual report in September 2018. Ongoing reporting will be required of all awardees, and the Commission maintains the authority to curtail funding if it is not used in accordance with the proposals as approved by the Commission.

Statutory Updates

Although there were a number of bills passed during the legislative session that affect hospital and health system operation, only the budget bills (SB 185/Chapter 570 and SB 187/Chapter 10) directly affect the operations of the HSCRC. The annual budget bill and companion legislation (Budget Reconciliation and Financing Act) set the parameters for initiatives and programs in the upcoming fiscal year for the HSCRC. In the FY 2019 budget, the Governor included sufficient appropriations to allow the HSCRC to access funds needed to fulfill statutory obligations and to continue health care delivery transformation efforts in the State. Highlights from the budget that was passed by the General Assembly as they relate to the HSCRC are below.

- Appropriation of $16 million to support the operations of the Commission, including work needed to prepare for the Total Cost of Care Model beginning in January 2019.

- Reduction of $30 million in the Medicaid Deficit Assessment from $364,825,000 in FY 2018 to $334,825,000 in FY 2019. This reduction will lower hospital rates and produce savings to all payers in the system, including Medicare.

- Adoption of language directing Medicaid and HSCRC to develop, outside of the All-payer Model Contract, Medicaid-specific savings and total cost of care goals.

In addition to the budget bills, there was also a bill (SB 682/Chapter 605) that requires study of the reimbursement of EMS services in Maryland, led by the Maryland Institute for Emergency Medical Services Systems and the Maryland Health Care Commission. HSCRC will participate in this study as it relates to Medicare reimbursement for EMS services and the utilization of EMS services in Maryland resulting in hospital admissions.

Regulatory Update

Over the past fiscal year, the Commission has begun its regulatory review and evaluation, as required by law, and proposed and adopted amendments to the following existing regulations:

COMAR 10.37.01

This regulation concerns the Commission's use of a Uniform Accounting and Reporting System for Hospitals, which incorporates by reference a Commission-produced accounting and budget manual that is updated periodically. During the past fiscal year, the Commission proposed an amendment to this chapter.

- On April 11, 2018, the Commission proposed an amendment to COMAR 10.37.01.02. This amendment updates the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management" (August, 1987), which is incorporated by reference, including the addition of Supplement 24 to the Manual. On July 11, 2018, the Commission adopted the amendment as proposed.

COMAR 10.37.10

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

- On December 13, 2017, the Commission adopted amendments to COMAR 10.37.10.03, .03-1, .04, .04-1, .04-2, .04-3, .04-10, which were initially proposed on September 13, 2017. These amendments update the process for hospitals to

file a full rate application with the Commission, identify the methodologies to be used in approving permanent rates, describe the annual update factor vis-à-vis the All-Payer Model Agreement, including corrective action if necessary to maintain compliance with the All-Payer Model Agreement, and provide alternative methods to hospitals for Commission review (other than a formal hearing) of a full rate application.

Regulatory Review and Evaluation

The Commission's statutorily mandated regulatory review and evaluation (Md. Code Ann., State Govt. §§ 10-130 *et seq*.) is currently in progress. As of the date of this report, the Commission has completed its review and final evaluation reports, which will be submitted to the Joint Committee on Administrative, Executive, and Legislative Review (AELR Committee) for review. Once the AELR Committee's review is complete, the Commission will propose those regulatory amendments that the AELR Committee has approved.

State and Federal All-Payer Model Status Reporting Requirements

On May 15, 2018 and November 1, 2018, the HSCRC submitted reports summarizing implementation, monitoring, and other activities to the Centers for Medicare & Medicaid Services (CMS) and the Maryland General Assembly respectively, regarding the status of the All-Payer Model. The Monitoring of Maryland's All-Payer Model Biannual Report, prepared relative to Section 19-207(b)(9) of the Health-General Article of the Annotated Code of Maryland, discussed the State's progress during the period from January 1, 2014 through June 30, 2017, based on information available at the time. Table 1 provides an overview of the reporting required relative to Health-General Section 19-207(b)(9) for Maryland's All-Payer Model. The HSCRC will continue to produce an updated Biannual Report every six months and will also report the key findings here in the annual Report to the Governor. The complete reports are available at http://hscrc.maryland.gov/Pages/legal-reports.aspx.

Table 1. State Annual Reporting of Maryland's All-Payer Model

Achievement Requirement	Accomplishments	Ongoing Activities
Limit the annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58%	Per capita revenue for Maryland residents grew 1.47% between CYs 2013-2014; 2.31% between CYs 2014-2015; and 0.80% between CYs 2015-2016. CY 2017 per capita growth rate is 3.54%.[2], and the first six	• Ongoing monthly measurement • Continued favorable performance is expected as global budgets result in predictable statewide revenue performance

[2] The all-payer per capita growth rate reflects an adjustment to revenues to account for Maryland hospitals undercharging their global budgets from July to December 2016

Achievement Requirement	Accomplishments	Ongoing Activities
	months of CY 2018 growth is 1.09%. CY 2018 is on track to come in below the 3.58% target.	
Achieve aggregate hospital savings in Medicare spending equal to or greater than $330 million over 5 years	$120 million in Performance Year (PY) 1 (CY 2014), $155 million in PY 2 (CY 2015), and $311 million in PY 3 (CY 2016),[3] and $330 million in PY 4 (CY 2017). Preliminary amounts through June 2018 show Maryland saving $218 million, bringing cumulative savings to $1.134 billion.	• HSCRC is working with an analytics contractor to examine and replicate CMS calculations of Medicare savings and per beneficiary growth rates for CY 2018
Shift at least 80% of hospital revenue to a population-based payment structure (such as global budgets)	100% of hospital revenue shifted to global budgets.	• All hospitals are engaged in global budgets under Global Budget Revenue (GBR) agreements • HSCRC continues to refine global budget methodology
Reduce the hospital readmission rate for Medicare FFS beneficiaries to be below the national rate over the 5-year period of the agreement	At the beginning of the model, Maryland's readmission rate was 1.22 percent higher than the nation. Maryland has narrowed its gap from the nation each year of the model and now has a readmission rate that is 0.08 percentage points **below** the national readmission rate.	• HSCRC is monitoring progress within Maryland across all-payers using data it collects from hospitals and is working to maintain improvements and remain below the national Medicare readmission rate. • HSCRC maintains an aggressive improvement target for hospitals under the Readmission Reduction Incentive Program (RRIP), while recognizing the high performing hospitals may have less opportunity to improve.
Cumulative reduction in hospital acquired conditions (HACs) by 30% over 5 years	Compounded with previous reductions, there has been a 51.54% reduction in all-payer case-mix adjusted PPCs since CY 2013.	• HSCRC continues to incentivize PPC reductions through the Maryland Hospital Acquired Conditions (MHAC) program, despite having achieved the 30% required reduction
Monitor Total Cost of Care (TCOC) for Medicare and maintain growth within guardrails	For CYs 2014 through CY 2017, Maryland TCOC growth has met the requirements of the All-Payer Model.	• HSCRC is continuing to closely monitor TCOC growth trends for hospital and total cost of care to ensure that the two consecutive year requirement is not breached.
Workgroup Actions	The Performance Measurement Workgroup reviewed the annual quality policies that were approved by the Commission in Spring 2018. The Payment Models Workgroup reviewed the annual update factor which	• Active workgroups continue to meet on a regular basis • Staff have convened new subgroups to discuss quality policies and rate setting methodologies.

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

Achievement Requirement	Accomplishments	Ongoing Activities
	was approved by the Commission in June 2018.	
New alternative methods of rate determination	100% of hospital revenue is now under global budget arrangements.	• Global budget agreements are published on the HSCRC website • Staff continues to refine rate setting methodologies.
Ongoing reporting to CMS of relevant policy development and implementation	The HSCRC provided CMS with the Annual Monitoring Report as required in the All-Payer Model contract, as well as quarterly progress reports.	• HSCRC continues to provide reports to CMS on an ongoing basis.
Progress of Total Cost of Care (TCOC) Model	The State signed the TCOC Model Contract with CMS on July 9, 2018.	• HSCRC continues to work on implementation activities for the January 1, 2019 Model start date, including operationalizing the Maryland Primary Care Program.
Medicare Performance Adjustment (MPA)	The TCOC Workgroup refined the MPA Year 2 policy for RY 2021.	• Commissioners will vote on the MPA in November 2018.
Care Redesign Program	Forty-three hospitals are participating in the third performance period for Care Redesign programs, effective July 1, 2018.	• A third care redesign track, the Episode Care Improvement Program, has been approved by CMS for hospital participation beginning January 1, 2019.

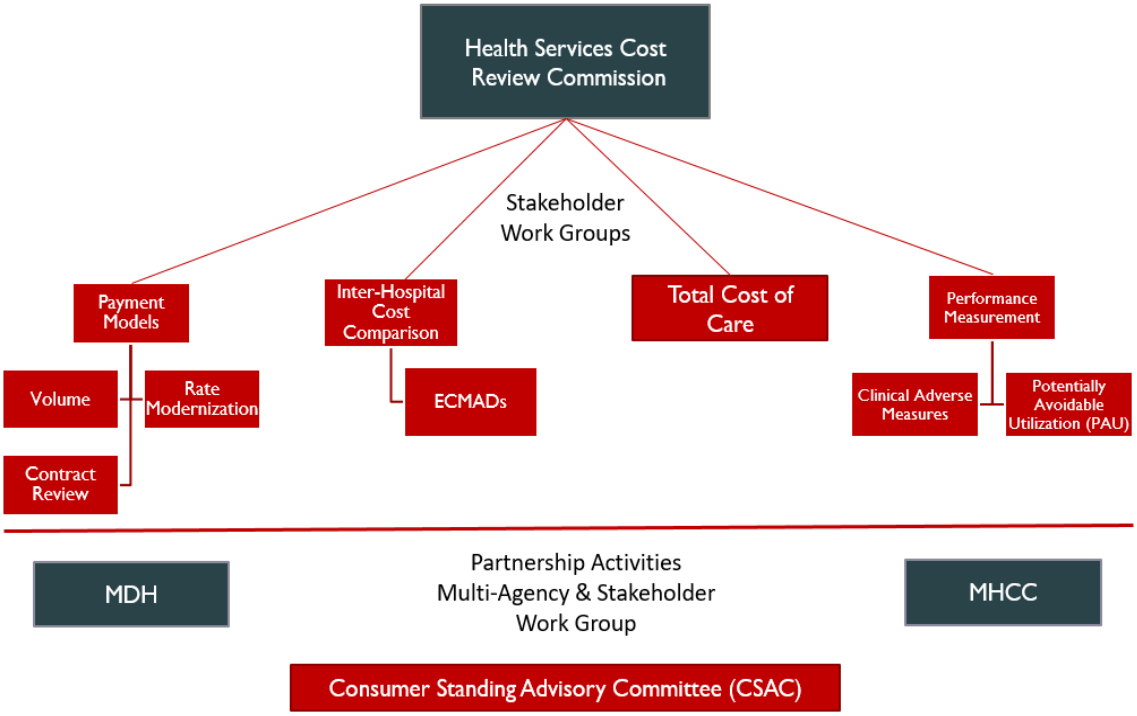
Stakeholder Engagement

The HSCRC continues to engage broadly with stakeholders in guiding policy and methodology development through various workgroup meetings throughout CY 2018. The Performance Measurement and Total Cost of Care Workgroups have met monthly and the Payment Models Workgroup re-convened for monthly meetings in February 2018. Various subgroups have been convened to help further refine new policies and methodologies impacting hospitals.

Figure 1 depicts the current structure of the stakeholder engagement Workgroups. All Workgroup meetings are conducted in public sessions, and comments are solicited from the public at each meeting. There are also a number of sub-workgroup meetings and task forces to discuss technical, data-driven matters related to specific policies, which report back to the larger Workgroups. Input is also solicited in informal meetings with stakeholders.

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

Figure 1. Stakeholder Engagement Structure



Section II - Quality Performance

Maryland continues to be a national leader in implementing innovative hospital payment systems to achieve the goals of cost containment, access to care, equity in payment, financial stability, and quality improvement. Maryland's achievements in recent years have resulted in hospital pay-for-performance programs that are broader than corresponding federal programs in design and scope, and that encompass a robust set of performance measures with strong emphasis on all-payer patient outcomes. Maryland has steadily expanded the magnitude and scope of its quality payment reform initiatives since 2008. Maryland's hospital quality initiatives are part of a comprehensive set of emerging healthcare delivery reform efforts and activities in the State to achieve the three-part aim of better care for individuals, better health for populations, and reduced expenditures for all patients.

Each of the quality-based payment programs places hospital revenue at-risk for meeting performance targets. These programs provide strong incentives for hospitals to continuously improve quality performance. The hospital quality-based payment programs are listed below and are described in the subsections that follow.

- Quality-Based Reimbursement (QBR) Program
- Maryland Hospital Acquired Conditions (MHAC) Program
- Readmission Reduction Incentive Program (RRIP)

- Potentially Avoidable Utilization Savings (PAU Savings)

Quality-Based Reimbursement

The QBR program adjusts hospital payments based on their performance on a number of quality-of-care measures. These include clinical care measures, patient experience of care measures, and safety measures. Each domain is then weighted to determine hospitals' final scores on the program (Table 2).

Table 2. QBR Measure Domain Weights for FY 2019

Measure Domain	Weight
Clinical Care	0.15
Patient Experience of Care (HCAHPS)	0.50
Safety	0.35

In the FY 2020 policy update, the HSCRC maintained the weights and the measurement domains from the FY 2019 policy to be as consistent as possible with the CMS Value-Based Purchasing (VBP) Program. In FY 2020, the amount of total hospital revenue at-risk for scaling was held to a two percent maximum penalty. Since the scaling of rewards and penalties was expanded, the maximum reward was correspondingly maintained at two percent. Maryland does not include an efficiency measure as part of the QBR Program, but it does apply a PAU savings adjustment to hospital global budgets, and evaluates Medicare payments based on hospitals' total cost of care performance under the Medicare Performance Adjustment.

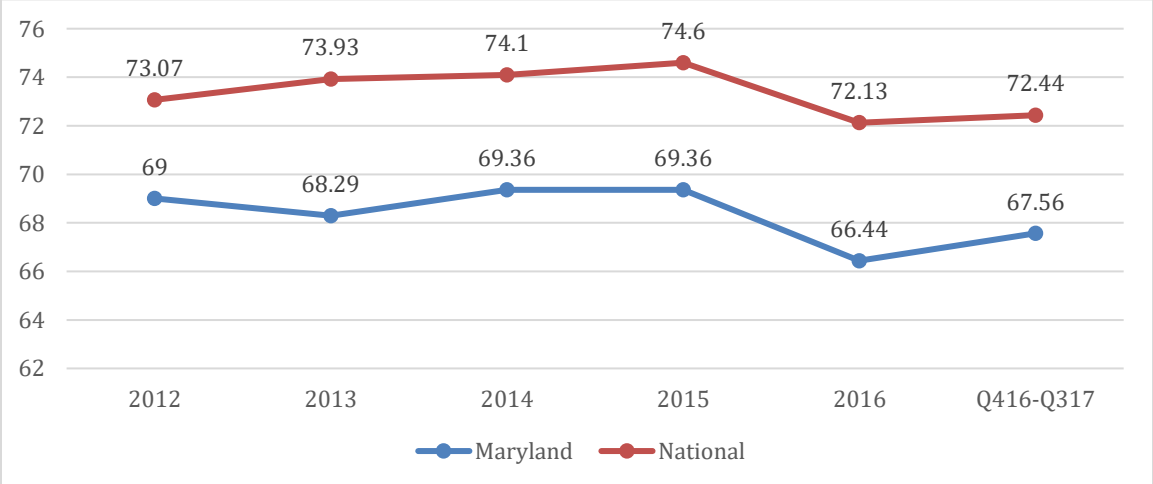
Beginning again in FY 2019, reward and penalty adjustments to global budgets are determined based on a preset scale rather than relatively ranking hospital performance and penalizing those with less than average performance. This change was designed to provide hospitals with predictable revenue adjustments and predetermined quality improvement targets.

Maryland's QBR program is similar in design and detail to the federal Medicare VBP Program. Data trends for the most recently available data (third quarter of CY 2017 as compared to CY 2015) suggest that:

- Maryland is performing on par with or better than the national Standardized Infection Ratio (SIR) of 1 in terms of safety measures for all measures except Surgical Site Infection after Hysterectomy. These measures include: Central Line-associated Blood Stream Infection (CLABSI), Cather-associated Urinary Tract Infection (CAUTI), and Surgical Site Infection (SSI) after Colon Surgery; as well as Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C-Diff.). Of note, given how the data is presented, Maryland is currently performing better than the nation performed in CY 2015.

- Maryland is performing slightly better than the nation on condition-specific mortality measures, according to most recently available data.[4]
    - Heart Attack- Maryland's state performance of 13.00% is better than the nation of 13.03%
    - Heart Failure- Maryland's state performance of 11.06% is similar to the nation of 11.46%
    - Pneumonia- Maryland's state performance of 16.42 % is worse than the nation of 15.76%
    - Chronic Obstructive Pulmonary Disease- Maryland's state performance of 9.02% is worse than the nation of 8.37%
    - Acute Ischemic Stroke- Maryland's state performance of 14.02% is better than the nation of 14.34%
    - Coronary Artery Bypass Graft Surgery – Maryland's state performance of 2.69^ is better than the nation of 3.08%
- Maryland continues to lag behind the nation in performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience measures (Figure 2). HSCRC staff remain concerned about Maryland HCAHPS performance. In the FY 2018 QBR policy, the HSCRC increased the weighting of the HCAHPS measures in determining hospitals' overall scores in order to incentivize improvement in patient satisfaction, and has kept this domain weighting through the FY 2019 and FY 2020 policies.

Figure 2. HCAHPS – Maryland vs Nation, 2012-Present



Maryland Hospital Acquired Conditions

The MHAC program provides incentives to achieve hospital care improvements and meet the target established in the Maryland All-Payer Model Agreement. The target is a

[4] Thirty day mortality rate data from the third quarter of CY 2014 through the second quarter of CY 2017 as displayed on Hospital Compare are available for Maryland compared to the nation.

30 percent reduction in the statewide aggregate PPC rate over the five-year demonstration period.

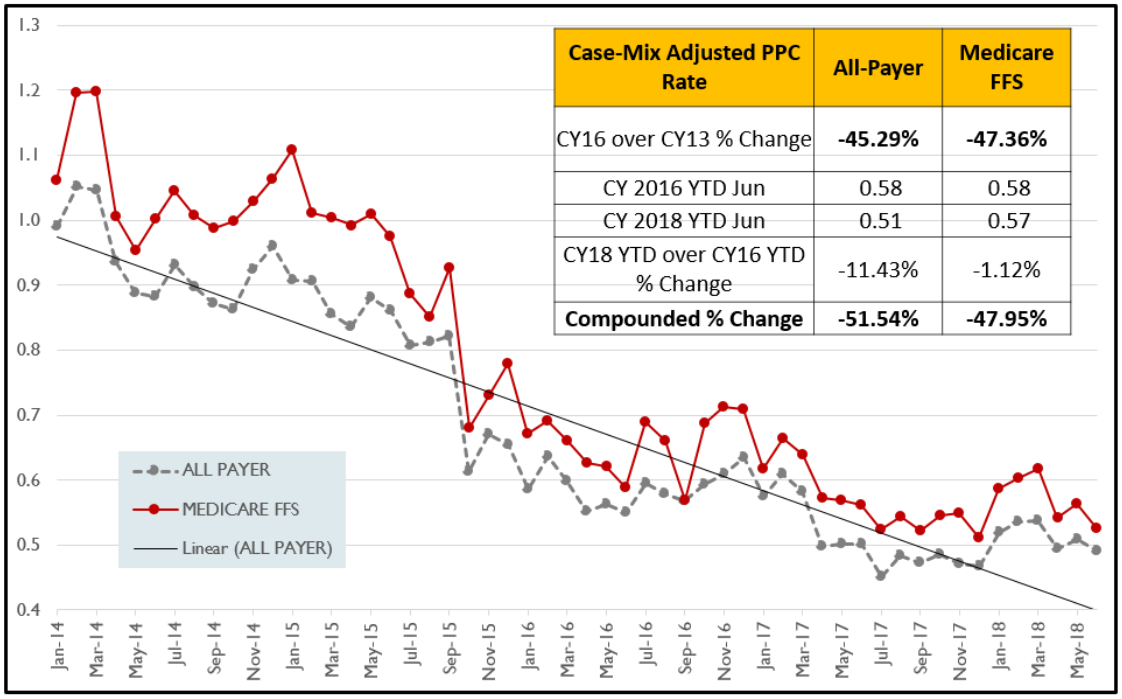
During the February 2018 Commission Meeting, staff presented the FY 2020 MHAC program policy. Staff proposed minimal changes to the MHAC program policy and recommended to set the maximum penalty at 2 percent and the maximum reward at 1 percent of hospital inpatient revenue.

These final recommendations were developed by HSCRC staff based on input from the Performance Measurement Workgroup and other stakeholders. Based on this input, the HSCRC staff made slight modifications to the FY 2020 MHAC methodology, recommending to raise the required numbers of at-risk discharges and exclude low frequency PPCs from pay-for-performance evaluation.

Figure 3 shows the all-payer and Medicare FFS case-mix-adjusted PPC rates by month and year. In CY 2018 YTD through Jun, the all-payer case-mix adjusted PPC rate was 0.51 per 1,000, compared with 0.58 per 1,000 during the same time period CY 2016, which is an 11.43 percent reduction. Compounded with previous reductions in complications since CY 2013, the state of Maryland has achieved a 51.54 percent reduction in all-payer, case-mix adjusted PPC rates. The reduction in the case-mix adjusted complication rate for Medicare FFS was slightly lower at 47.95 percent. While this reduction in the case-mix adjusted complication rate exceeds the new waiver target of 30 percent by 2018, the HSCRC will continue to incentivize hospitals to further reduce hospital-acquired infections and complications in future years. The HSCRC is currently convening a sub-group of clinical and subject-matter experts to examine how best to measure and incentivize improvement on hospital-acquired infections and complications under the Total Cost of Care Model.

The HSCRC staff review annual audits of approximately ten hospitals to ensure coding accuracy with the medical record documentation. If audit issues are found, staff checks with the hospital to understand the issue(s) and take appropriate action.

Figure 3. Case-Mix Adjusted PPC Rates in Maryland, CY 2014 – CY 2018 YTD through June



Case-Mix Adjusted PPC Rate	All-Payer	Medicare FFS
CY16 over CY13 % Change	**-45.29%**	**-47.36%**
CY 2016 YTD Jun	0.58	0.58
CY 2018 YTD Jun	0.51	0.57
CY18 YTD over CY16 YTD % Change	-11.43%	-1.12%
Compounded % Change	**-51.54%**	**-47.95%**

Readmissions Reduction Incentive Program

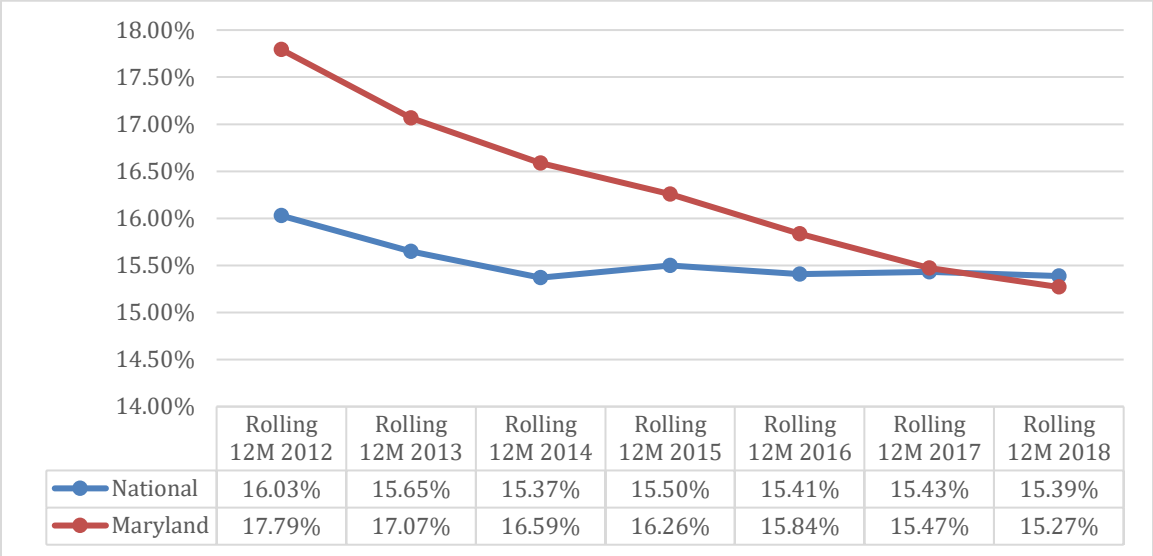
Under the All-Payer Model, CMS requires Maryland's Medicare fee-for-service (FFS) hospital readmission rate to be at or below the national readmission rate by the end of CY 2018. In early 2014, the HSCRC and key stakeholders vetted a methodology that provides incentives to reduce readmissions. In April 2014, the Commission approved the Readmissions Reduction Incentive Program (RRIP) starting on January 1, 2014. The RRIP was originally a positive incentive program only, but due to concerns regarding reductions in readmissions, the program has evolved to provide scaled rewards up to one percent and scaled penalties up to two percent of inpatient revenue.

The Commission approved an updated RRIP policy for RY 2020 at the March 2018 Commission meeting. In concert with the Performance Measurement Workgroup and HSCRC contractors, staff developed a policy that rewards hospitals for the better of improvement or attainment. The improvement target for RY 2020 was set at 14.30 percent. The attainment benchmark for FY 2018 was set prospectively at 10.70 percent, which is two percent lower than the projected statewide 25th percentile for CY 2017. To account for out-of-state readmissions at border hospitals, the State will continue to adjust the all-payer readmission rates using Medicare data to estimate the proportion of out-of-state readmissions.

At the beginning of the All-Payer Model, the Maryland readmission rate was 1.22 percentage points higher than the nation. Readmission rates have continued to steadily decline over the course of the All-Payer Model, and, with most recent twelve months' data through May 2018, the Maryland Medicare FFS Readmission Rate is 0.08

percentage points lower than the National Medicare FFS Readmission Rate. Thus Maryland is working to maintain this improvement, and to further achieve any additional improvement that the nation experiences. The All-Payer Model requirement uses national Medicare data, which is summarized in Figure 4 below.

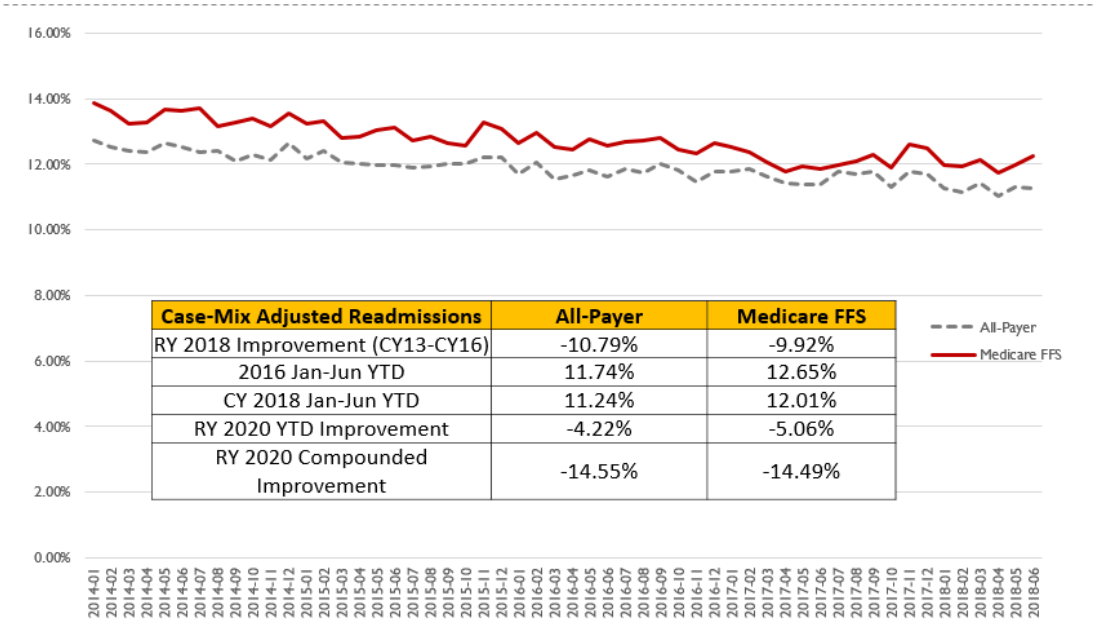
Figure 4. Medicare Readmissions - Rolling 12 Months Trend, Data through May 2018



	Rolling 12M 2012	Rolling 12M 2013	Rolling 12M 2014	Rolling 12M 2015	Rolling 12M 2016	Rolling 12M 2017	Rolling 12M 2018
National	16.03%	15.65%	15.37%	15.50%	15.41%	15.43%	15.39%
Maryland	17.79%	17.07%	16.59%	16.26%	15.84%	15.47%	15.27%

Additionally, HSCRC's hospital data show that the monthly all-payer case-mix adjusted readmission rate through CY 2018 YTD through Jun is substantially improved when compared to CY 2013 (Figure 5). This analysis includes all Maryland inpatient stays, including Medicare FFS. Based on these HSCRC data, the all-payer, case-mix adjusted readmission rate in CY 2018 YTD through Jun was 11.24 percent, compared to 11.74 percent during the same time period in CY 2016, a 4.22 percent reduction. Compounded with previous reductions in readmissions since CY 2013, the state of Maryland has achieved a 14.55 percent reduction in the all-payer, case-mix adjusted readmission rate. The corresponding compounded readmission rate reduction for Medicare FFS beneficiaries was slightly lower at 14.49 percent. This reduction is significant given the difficulty and time involved in reducing readmissions, as it requires sustained effort, investment, and coordination across providers.

Figure 5. Case-Mix Adjusted Readmissions in Maryland, CY 2013 - CY 2017



Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
RY 2018 Improvement (CY13-CY16)	-10.79%	-9.92%
2016 Jan-Jun YTD	11.74%	12.65%
CY 2018 Jan-Jun YTD	11.24%	12.01%
RY 2020 YTD Improvement	-4.22%	-5.06%
RY 2020 Compounded Improvement	-14.55%	-14.49%

Note: Based on final data for Jan 2013 – Jun 2018; Preliminary data through Aug 2018. Statewide improvement to-date in RY 2020 is compounded with RY 2018 improvement.

Potentially Avoidable Utilization (PAU) Savings

The HSCRC adopted a final PAU Savings policy for FY 2019 at its June 2018 Commission meeting. The PAU Savings policy includes savings realized from readmissions reductions as well as savings that should be realized from reducing avoidable admissions, defined under the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator logic. For FY 2019, the Commission increased the prospective savings requirement to 1.75 percent of total hospital revenue, which is distributed based on a hospital's share of revenue deemed to be potentially avoidable. The HSCRC has also placed a guardrail on the PAU Savings for hospitals with high socioeconomic burden, which caps the prospective reduction to the state average; however, staff plan to solicit input on phasing out or adjusting this for subsequent years. The HSCRC convened a subgroup in August 2018 to evaluate the expansion and refinement of the PAU measure for future years.

Section III - Hospital Financial Performance

Hospital Profitability

The HSCRC monitors hospital financial performance of regulated hospitals through hospital financial data submissions. Specifically, the HSCRC conducts monthly monitoring of unaudited data and annual monitoring of audited data. The financial data provide a metric to monitor the efficiency and effectiveness of hospitals pursuant to the

HSCRC's statutory charge. While each hospital may adjust and correct its unaudited data throughout the year, the unaudited data provide a good indicator of the direction of trends in statewide hospital revenue, expenditures, utilization, and profitability. Below is a summary of key data regarding the profitability of hospitals on an audited basis in FY 2017 and on an unaudited basis for FY 2018.

The HSCRC regulates inpatient and outpatient hospital services located at the hospital. The HSCRC does not regulate the rates of physicians, nor does it regulate those continuing revenue-producing activities which, while not related directly to the care of patients, are business-like activities commonly found in hospitals for the convenience of employees, physicians, patients, and/or visitors—such as parking garages and gift shops.

Audited Financial Data—FY 2017

Data for FY 2017 show decreases in profitability for total operating activities, however there is an increase in profitability of non-operating activities, compared with the prior year. There was also an increase in profitability for services regulated by the HSCRC over the prior year. The increases in non-operating profitability may be attributed, in large part, to gains on investments. The decrease in total operating profitability can be attributed to losses on the provision of unregulated hospital services, including physician subsidies or investments.

Profitability based on audited data for total operations, i.e., hospital operations regulated by the HSCRC and for unregulated hospital operations, and for total hospital activities both operating and non-operating is presented below:

- The total combined audited regulated and unregulated operating margin was 2.86 percent,
- The total margin, i.e., the combined operating and non-operating margins was 6.08 percent; and,
- The operating margin for services regulated by the HSCRC was 8.01 percent.

Unaudited Financial Data—FY 2018

Based on unaudited financial data for FY 2018, operating margins, both for services regulated by the HSCRC and those services not regulated by the HSCRC, increased over FY 2017, while total profit margins declined very slightly. Operating profitability increased as hospitals experienced the following factors:

- Hospital revenues increased by a net 2 percent, reflecting the impact of inflation, infrastructure investment, population growth, and expected declines in uncompensated care.
- Hospitals contained volume growth reflecting the new Model's focus on reducing PAU.
- Actual uncompensated care fell below the level provided in rates.

Overall, hospital total margins increased primarily due to increases in investment income and unrealized investment gains. Profitability in FY 2018, based on unaudited data, is shown below. Please note that final audited data, when available, may result in adjustments to these margins:

- The total combined unaudited regulated and unregulated operating margin was 3.46 percent.
- The total margin, i.e., the combined operating and non-operating margins was 5.64 percent.
- The operating margin for services regulated by the HSCRC was 7.56 percent.

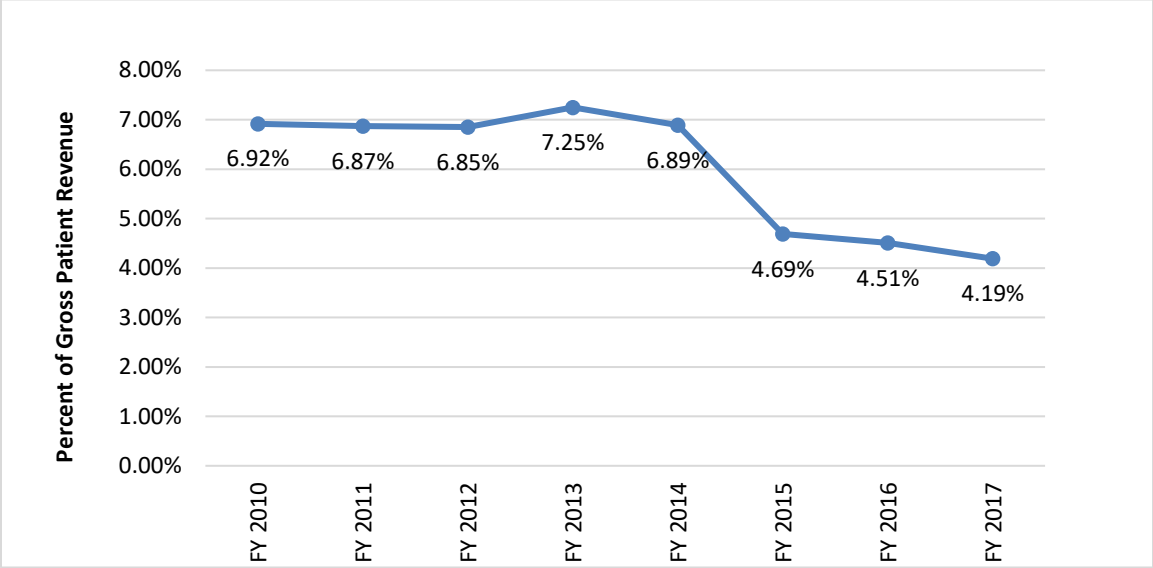
Uncompensated Care

The HSCRC provides an amount for uncompensated care as a component of hospital rates. This is one of the unique features of rate regulation in Maryland. Recognizing reasonable levels of bad debt and charity care in hospital rates enhances access to hospital care for those who cannot pay for care.

The HSCRC's current policy provides for uncompensated care statewide at the level of the most recent year's actual statewide experience. Hospital-specific uncompensated care provisions were determined by a blend of a hospital's most recent year's actual experience and its expected performance based on a regression analysis. Figure 9 shows the actual total uncompensated care rate for all regulated Maryland hospitals between FY 2010 and FY 2017. After declining slightly between FY 2010 and FY 2012, there was a 0.4 percentage point increase in the total uncompensated care rate for all regulated Maryland hospitals in FY 2013. This increase may be attributed to several factors. The proportion of outpatient hospital services increased, and the patient responsibility portion of outpatient bills is typically larger than for inpatient bills, resulting in higher levels of uncompensated care. A greater prevalence of high deductibles, coinsurance, and copayments among commercial insurance plans may also have contributed to the increase

Implementation of the ACA's coverage expansions in January 2014 produced a decrease in uncompensated care of 0.36 percentage points in FY 2014. Uncompensated care reported by hospitals continues to drop from 4.51 percent in FY 2016 to 4.19 percent in FY 2017, a decrease of 0.32 percentage points (Figure 6).

Figure 6. Uncompensated Care as a Percentage of Gross Patient Revenue, FY 2010-2017



Actual audited data to determine the actual amount of uncompensated care in FY 2018 is not yet available. Development of the FY 2019 uncompensated policy occurred in a less dynamic insurance market place and a more data rich environment. Four years of post-ACA implementation data, audited financial statements for FY 2017, and a full year of data on hospital patient-level write-offs were used to update the regression model to better capture the continuing sources of uncompensated care.

Community Benefits

The Internal Revenue Code requires nonprofit organizations to report the amount of community benefits that they provide in exchange for not having to pay federal, state, or local taxes. Maryland law also requires hospitals to report similar data and qualitative information on community benefit expenditures and operations to the HSCRC. Community benefits are defined as activities that are intended to address community needs and priorities primarily through disease prevention and improvements in health status, including:

- Health services provided to vulnerable or underserved populations
- Financial or in-kind support of public health programs
- Donations of funds, property, or other resources that contribute to a community priority
- Health care cost containment activities
- Health education screening and prevention services

The most recently available report from hospitals reflects community benefits for FY 2017. In that year, Maryland hospitals expended just over $1.56 billion in community benefits, or 9.9 percent of total hospital operating expenses. After offsetting expenditures related to amounts that are included in rates and not generated through

hospital resources, the amount of community benefit spending is $896.9 million or 6.9 percent of operating expenses.

Beginning in tax years after March 23, 2012, each nonprofit hospital is required to conduct a community health needs assessment every three years, which they report to the federal government. The Commission obtains information annually on each hospital's community health needs assessments, related collaborations, how their community benefit functions are organized, and a summary of each of the primary community benefit initiatives. Those reports may be found on the Commission's Community Benefit website at http://hscrc.maryland.gov/Pages/init_cb.aspx.

Section IV – Commission Infrastructure

Commissioners

The HSCRC is the only agency in the country with the mission of setting all-payer rates for hospital services within a state. The HSCRC functions as an independent Commission within MDH. Seven Governor-appointed Commissioners oversee the HSCRC. Table 3 provides a list of current Commissioners.

Table 3. HSCRC Commissioners

Commissioner	Term Start Date
Nelson J. Sabatini, Chairman	February 2, 2016
Joseph Antos, Ph.D.	July 1, 2016
John M. Colmers	July 1, 2013
Victoria W. Bayless	February 11, 2016
Jack C. Keane	July 1, 2011
Adam Kane	July 1, 2017
James N. Elliott, M.D.	January 24, 2018

Staff Structure

The State charges the HSCRC with regulating the rates and revenues of Maryland's 48 acute care and 4 specialty hospitals, an industry with annual revenues in excess of $17 billion. This responsibility is accomplished by a relatively small and highly skilled staff of 47 full-time equivalents and contractual employees. To meet the demands of the All-Payer Model, the Commission organized its staff structure under four centers:

- The Center for Revenue and Compliance
- The Center for Clinical and Financial Information
- The Center for Engagement and Alignment
- The Center for Population Based Methodologies

As the State moves towards the Total Cost of Care Model, the HSCRC plans to hire more FTEs and re-organize staff structure to provide more resources dedicated to medical economics, data analytics, and policy innovation and development.

Budget

A small user fee assessed on hospital rates in Maryland supports Commission staff salaries and operations. Due to the technical nature of the work of the Commission, expenses are driven primarily by personnel costs and contracts. The total user fee assessment in FY 2018 was $11.1 million and the fund balance at the end of the fiscal year was $6.6 million. Although this balance is above the normal range, the HSCRC is taking on additional tasks related to the implementation of TCOC Model that will require additional resources. This balance will be utilized in conjunction with the FY 2019 user fee assessment in order to implement the critical new tasks required by the TCOC Model and will bring the fund balance to a reasonable level at the end of FY 2019.

Section V - Future Outlook

Progression towards Total Cost of Care Model

On July 9, 2018, Governor Hogan, alongside CMS and other State leaders, signed the Maryland Total Cost of Care Contract, authorizing the 2019 start of the TCOC Model. Under the new Model, Maryland will be expected to progressively transform care delivery across the health care system with the objective of improving health and quality of care. At the same time, State growth in Medicare spending must be maintained lower than the national growth rate. The new Total Cost of Care Model will give the State flexibility to tailor initiatives to the Maryland health care context, and encourage providers to drive health care innovation. The Total Cost of Care Model will also encourage continued Care Redesign, provide new tools and resources for primary care providers in the Maryland Primary Care Program to better meet the needs of patients with complex and chronic conditions, and help Marylanders achieve better health status overall.

Total Cost of Care Model Builds on Existing Momentum

The new Total Cost of Care Model will leverage the foundation already developed by Maryland for hospitals and build on the investments that hospitals have made since 2014. Maryland will continue to encourage provider- and payer-led development of Care Redesign programs to support innovation. Maryland is also continuing efforts to implement a new Maryland Primary Care Program (MDPCP), which is voluntary to all qualifying Maryland primary care providers and incentivizes the delivery of advanced primary care throughout the State. The MDPCP supports the overall health care transformation process and allows primary care providers to play an increased role in prevention, management of chronic disease, and avoiding unnecessary hospital utilization. CMS will finalize program acceptances, match practices with their preferred Care Transformation Organizations, and release participation agreements in Fall 2018. The State is working closely with CMS in these implementation activities. The State will

also commit its public health resources to broadly support population health improvements that are aligned with Model goals and Marylanders' needs.

Key Elements of the Total Cost of Care Model

Core requirements and expectations of the new Total Cost of Care Model include the following:

- The new Total Cost of Care Model will begin on January 1, 2019 for a 10-year term, so long as Maryland meets the model savings and performance requirements.
- Hospital cost growth per capita for all payers must not exceed 3.58% per year. The State has the opportunity to adjust this growth limit based on economic conditions, subject to federal review and approval.
- Maryland commits to saving $300 million in annual total Medicare spending for Medicare Part A and Part B by the end of 2023. The Medicare savings required in the TCOC Model will build off of the ongoing work of Maryland stakeholders, which began in 2014.
- Resources will be invested in primary care and delivery system innovations, consistent with national and State goals to improve chronic care and population health.
- The Model will help physicians and other providers leverage voluntary initiatives and federal programs to align participation in efforts focused on improving care and care coordination, and participation in incentive programs that reward those results. These programs will be voluntary, and the State will not undertake setting Medicare and private fee schedules for physicians and clinicians.
- Maryland will set aggressive quality of care goals.
- Maryland will set a range of population health goals.

Throughout the development of implementation plans, the State will continue its commitment to privately led innovation, voluntary participation in Care Redesign programs, and meaningful and ongoing stakeholder engagement to achieve the State's vision for person-centered care, clinical innovation and excellence, and improved population health. Additional information on the new Total Cost of Care Model can be found at https://hscrc.maryland.gov/Pages/tcocmodel.aspx.

Contact and More Information

For questions about this report or more information, please contact Katie Wunderlich, HSCRC Executive Director, at katie.wunderlich@maryland.gov.

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