

**THE MARYLAND HEALTH CARE COMMISSION \$**

**FY 2016 BUDGET \$**

**PRESENTATION TO THE LEGISLATURE \$**

**M00R0101**

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**Department of Health and Mental Hygiene \$**

**MARYLAND HEALTH CARE COMMISSION \$**

**BUDGET PRESENTATION \$**

## I. OVERVIEW

*The mission of the Maryland Health Care Commission is to plan for health systems needs, promote informed decision-making, increase accountability, and improve access to care in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers, and the public.*

*Our vision is a state in which informed consumers hold the health care system accountable, and have access to affordable and appropriate health care services through programs that serve as national models.*

## II. DETAILS-MAJOR ACCOMPLISHMENTS

The Commission's activities over the past fiscal year focused upon collaborative initiatives related to broadening Marylanders' access to high quality and cost effective health care services. Particular attention was given to areas such as Access to Health Care, Quality and Patient Safety, Innovative Health Care Delivery, Health Information Technology (HIT), and Information for Policy Development. These accomplishments are consistent with MHCC's strategic priorities to expand public reporting of health system performance, advance the practice of primary care, modernize health planning to enhance the capacity needs of a high-performing, integrated health system, and promote HIT to maximize meaningful information sharing.

### ENHANCING HEALTH CARE QUALITY AND PATIENT SAFETY

The new website, [Maryland Health Care Quality Reports](http://www.mhcc.maryland.gov), was released in November 2014 (available online at [www.mhcc.maryland.gov](http://www.mhcc.maryland.gov)) and consolidates all of MHCC's quality reporting guides under a common canopy. MHCC has begun modernizing of each of the individual guides, starting with the Hospital Performance Evaluation Guide. A description of MHCC quality reporting initiatives follows.

#### Reporting on the Quality of Hospital Services

The Commission's Hospital Performance Evaluation Guide enables Marylanders to review information on various hospital facility characteristics and performance measures. Hospital characteristics include the location of the hospital, number of beds, services provided and accreditation status. Fifty high volume common medical conditions (All Patient Refined Diagnosis-Related Groups or APR-DRGs) are also featured. Marylanders are able to compare the volume and average length-of-stay by APR-DRG for each hospital. The Guide continues to provide general information, including patients' rights, how hospitals are regulated in Maryland, guidance on what to expect in a hospital setting, and a checklist to help consumers select a hospital. The Guide also includes performance data on twenty-nine process of care measures endorsed by the National Quality Forum (NQF), and adopted by the Centers for Medicare and Medicaid Services (CMS), the Joint Commission, (TJC) and the Hospital Quality Alliance (HQA). These nationally-endorsed process measures address hospital compliance with evidence-based standards for the treatment of Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PN),

Childhood Asthma Care (CAC) and for surgical patients (SCIP), including the prevention of surgical site infections.

Patients' perspectives on the care provided by hospitals are an important and valuable indicator of hospital quality and performance. The Commission utilizes the results of a national, standardized survey of hospital patients to obtain and report on measures of hospital performance. The data from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) includes 10 measures for four hospital service categories (maternity services, medical services, surgical services, and all services combined) reflecting key topics, including: communications with doctors and nurses, responsiveness of hospital staff, pain management, communication about medicine, discharge information, cleanliness of the hospital environment, and quietness of the hospital environment. In addition, the Guide includes data on how patients rate the hospital (10 for best, 0 for worst) and whether patients would recommend the hospital to friends and family.

The Commission's Quality Measures Data Center (QMDC) continues to serve as Maryland's repository of hospital performance measures data and includes a secure web portal for hospital submission of quality measures and patient experience data.

### **Reducing Healthcare-Associated Infections (HAIs)**

Several new reporting requirements have recently occurred with MHCC's focus shifting to align with those used by CMS. The National Healthcare Safety Network, an internet-based surveillance system that integrates patient and healthcare personnel safety surveillance systems, continues to be the vehicle for collecting these data. It is managed by the Division of Healthcare Quality Promotion of the Centers for Disease Control and Prevention (CDC).

The reporting requirements are: (1) Central-Line-Associated Bloodstream Infections (CLABSIs) in All Intensive Care Units; (2) Surgical Site Infections (SSIs) for coronary artery bypass graft (CABG), hip (HPRO), and knee (KPRO) surgeries, and (3) Health Care Worker(HCW) Influenza Vaccination. The expanded reporting requirements that took effect in FY 2014 are: (1) *Clostridium difficile* infections (CDI) in all inpatient locations (baby locations are excluded) (effective July 1, 2013), (2) Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia in all inpatient locations (effective January 1, 2014), and (3) the expansion of Surgical Site Infections (SSIs) to include colon (COLO) and abdominal hysterectomy (HYST) surgeries. Of note, the Health Care Worker (HCW) Influenza Vaccination reporting requirement moved from using an in-house survey to the National Healthcare Safety Network (NHSN) Health Care Personnel (HCP) Influenza Vaccination module with the 2013/2014 flu season.

### **Reporting on the Quality of Nursing Homes**

Users can view an extensive set of quality and performance measures for nursing homes and Medicare certified home health agencies, as well as several important measures for assisted living. Measures include: the results of the Office of Health Care Quality (OHCQ) annual and complaint surveys; staff influenza vaccination rates; results of the Experience of Care (satisfaction) surveys; and outcome and process measures on many clinical aspects of care. The Commission staff works with federal agencies such as the Centers for Medicare and Medicaid (CMS), the Agency for Healthcare Research and Quality (AHRQ) and other national organizations such as the National Quality Forum (NQF) to ensure that the quality measures reported within the Consumer Guide are reliable, validated, and suitable for public reporting.

Influenza infection causes considerable morbidity and mortality among older adults. Persons aged 65 years and older account for the majority of the 36,000 deaths that occur from flu and its complications each year. Results are reported for each facility in the Consumer Guide to Long Term Care in order to assist consumers; and are used by the DHMH Medicaid Office of Long Term Care and Community Support as one of four measures in the Medicaid Nursing Home Pay for Performance Program. Additional survey questions also assess:

- Adoption of a mandatory influenza vaccination policy by nursing homes;
- Measures to raise awareness among staff of the importance of influenza vaccination;
- Strategies to ensure compliance with flu policy or to limit the spread of influenza; and
- Methods used to document staff influenza vaccination status

The average vaccination rate for nursing home Health Care Workers (HCWs) for the 2013-2014 influenza season was 79.3%, an increase of nearly 13% from the prior year and a 27% increase since public reporting began. Maryland nursing homes report a significantly higher vaccination rate than the national estimates reported by CDC for LTC health care workers, which was 63% in 2013-2014.

Implementation of a mandatory influenza vaccination policy by nursing homes increased in the 2013-2014 collection year: 31.3 % of nursing homes reported implementation of a mandatory employee influenza vaccination policy compared to 22.4% for the prior year; another 19.6% reported no current mandatory employee influenza vaccination policy, but plan to implement a policy for the 2014-2015 flu season.

The Commission is developing enhanced functionality to transform data from the QMDC site into the [Maryland Health Care Quality Reports](#) consumer website that also highlights the Commission's guides for ambulatory surgery centers as well as the quality reports on health benefit plans

## **INNOVATIONS IN HEALTH CARE DELIVERY**

### **Establishing a New System of Oversight for Cardiac Surgery and PCI Services**

The Commission completed substantive work on a comprehensive update of the State Health Plan Chapter for cardiac surgery and percutaneous coronary intervention (PCI) in FY 2014. On September 30, 2013, Commission staff posted draft regulations for informal public comment that were intended to repeal and replace COMAR 10.24.17. These draft regulations represented a milestone in implementing major changes in regulatory oversight of cardiac surgery and PCI mandated by 2012 legislation and reflected input gathered from a Cardiac Advisory Group that met to provide advice on implementation of the law between the Fall of 2012 and the Spring of 2013. The new law uses program performance as a primary instrument of regulatory oversight and adds requirements for satisfactory on-going performance as a necessity for maintaining authorization to provide the services. On April 17, 2014, the Commission approved proposed permanent regulations to repeal and replace COMAR 10.24.17. Commission subsequently adopted final regulations that became effective August 18, 2014.

### **Establishing a New Model of Primary Care: The Patient Centered Medical Home (PCMH)**

Maryland law required MHCC to establish a Patient Centered Medical Home Program. In 2011, MHCC launched the Maryland Multi-Payor Patient Centered Medical Home Program (MMPP, or pilot) as a three year program established to analyze the effectiveness of the PCMH model of primary care. The

pilot consists of 52 practices and over 300 practitioners from urban, suburban, and rural settings with practices ranging from primary adult care to geriatric and pediatric groups.

The MHCC conducted an evaluation of the MMPP and *The Evaluation of the Maryland Multi-Payor Patient Centered Medical Home, First Annual Report* was released in December of 2013. The Commission expects to release the final evaluation report in March of 2015. Initial findings suggested that MMPP practices achieved pilot goals, which included: improving the patient experience, enhancing provider satisfaction, and increasing the quality of health care delivery. MMPP practices' specific reports from the 2012 performance year were distributed, which detailed practices' achievement of quality, utilization, and cost measures. Quality measures quantify a selected aspect of health care delivery by comparing it to evidence-based criteria that specify what constitutes better quality. Utilization measures quantify the extent to which a practice's patient population uses a particular service, such as inpatient hospitalization and emergency room services, within a specified time period. Cost measures quantify the change in health care costs from one time period to another. MMPP practices must meet or exceed the quality measure thresholds, as well as the utilization and cost measures, in order to qualify for shared savings incentive payments. Shared savings are a percentage of the savings a practice generates through improved care and patient outcomes. Commission staff provides guidance to payors in developing and distributing shared savings incentive payments to MMPP practices. For the 2012 performance year, approximately 21 practices collectively received approximately \$1.9 million in shared saving incentive payments.

Commission staff collaborated with the Maryland Learning Collaborative (MLC) to offer educational sessions for MMPP practices throughout the year. Among other things, sessions focused on care transitions, CRISP's Prescription Drug Monitoring Program, and MMPP practices' results from the 2012 quality measures and shared savings received. Several webinars were presented to MMPP practices: one educated MMPP practice participants on State regulations regarding the completion and distribution of the MOLST form; another two demonstrated an electronic version of the new care plan form that includes social and mental health components of health care delivery and the associated required reporting. In addition, a new website format for the MMPP was developed and released this year, including a portal, which MMPP practices use to report quality measures, care management metrics, and practice demographics. Practice-specific quality and care management reports and outgoing practice communications, such as quality measures and shared savings reports, are also posted to the portal by MHCC.

Commission staff also convened several meetings with the PCMH Transformation Workgroup (PTW) over the course of the past year. The PTW is responsible for developing recommendations for expanding advanced primary care models in the State when the MMPP concludes at the end of 2015. PTW members include payor representatives, primary care providers, and industry experts, as well as staff from the Maryland Hospital Association and DHMH. Workgroup discussions focused on establishing uniformity across integrated models of care delivery, identifying key elements of advanced primary care practices, and evaluating and reporting on advanced primary care programs in Maryland. These discussion items help staff to prepare reports to support advance care delivery legislative efforts. Topics addressed in MHCC's current reports include the role of advanced primary care in health system transformation, the State's promotion of advanced primary care, successes and lessons learned from State initiatives, and how the MMPP experience in Maryland compares to other state initiatives.

**FOSTERING THE DEVELOPMENT OF INFORMATION SYSTEMS THAT SUPPORT THE HEALTH CARE \$  
SYSTEM OF THE 21<sup>ST</sup> CENTURY \$**

**Medical Care Database (MCDB) Expansion**

In order to expand the breadth and timeliness of the MCDB data collection and leverage the data by linking it to other sources of health information, the Commission (1) updated the existing MCDB regulations (COMAR 10.25.06) and MCDB Data Submission Manual; (2) added an additional year of privately insured and Medicare, and two years of Medicaid, data to the database; and (3) with support of grant funds, hired an experienced actuary and developed an expanded scope of work and contract modification for the existing Database Vendor.

The Commission worked with the Hilltop Institute, Maryland Medicaid's database vendor, to develop cross-walks and programs to convert Medicaid MCO data into MCDB file formats for inclusion in the MCDB. An inter-agency MOU was established with the Hilltop Institute with funding support from the CCIIO Exchange Level II grant received by the Maryland Health Benefit Exchange.

The Commission pursued and received (September 2013) a grant worth \$2.9 million from CCIIO (Rate Review, Cycle III) to support MCDB-related activities. The grant funds expansion of the MHCC data center for the MCDB, development of data marts from the MCDB to support the Maryland Insurance Administration's (MIA) rate review process, hiring of an actuary, and development of a price transparency tool. These funds are crucial to implementing the MCDB expansion efforts that will extend into FY 2016. In order to ensure timely and efficient implementation of the MCDB expansion plans and grant deliverables, the contract with the existing database vendor, Social and Scientific Systems, was modified to include these new activities and extended through September 2016. A key deliverable in the contract is the development of an Extraction, Transform, and Load (ETL) system with a front-end web portal to automate data submission and processing. This system is expected to substantially expedite processing and availability of MCDB data. The Board of Public Works approved this contract modification on July 2, 2014.

The Commission prioritized decision support as a central goal for the MCDB and its products and established partnerships with other state agencies and developed decision support tools. Over the past year, the Commission: (1) released data to state partners; (2) developed a framework for analytic support for insurance rate review (MIA); (3) supported the development of total cost of care measures (HSCRC); (4) supported the Maryland Health Benefit Exchange (MHBE) through enhanced data collection and data release for studies; and (5) Supported DHMH through management of a project to evaluate primary care services in Maryland (DHMH, HSIA).

The Commission released MCDB data to the following state partners to support their programmatic goals: (1) Optumas, a consultant for Maryland Medicaid, in support of DHMH planning and analysis activities under the State Innovations Model (SIM) planning grant, which was used in calculating potential program return on investments; (2) Social and Scientific Systems was permitted to use the MCDB data in support of the Health Systems Infrastructure Administration's (HSIA's) planning for primary care services in Maryland; (3) Data was released to the Hilltop Institute in support of two studies for the MHBE – to support analyses of reinsurance for the individual market and tobacco use ratings; and (4) Data was released to the Health Services Cost Review Commission (HSCRC) to support their analyses of total costs of care as part of the new CMS hospital waiver and global budget model.

## **Health Information Technology (HIT)**

### **Telehealth**

The Commission reconvened the Telemedicine Task Force (Task Force) to study the use of telehealth throughout the State and to identify opportunities for telehealth expansion. Collectively, the Task Force advisory groups met approximately 28 times between July 2013 and June 2014. About 90 individuals, representing roughly 65 organizations from both the private and public sectors, participated in the Task Force meetings.

The Task Force developed recommendations for expanding telehealth adoption. The Clinical Advisory Group recommended ten telehealth use cases for implementation in pilot projects. The use cases aim to demonstrate how telehealth technology can be used in care delivery to improve patient outcomes and reduce costs, with an emphasis on vulnerable populations. The Finance and Business Model Advisory Group identified the financial and business challenges of implementing the use cases and recommended that organizations develop solutions unique to their patient populations in implementing the use cases. The Technology Solutions and Standards Advisory Group recommended the development of a telehealth provider directory, a publically available listing of telehealth practitioners that would be made available online through the State-Designated Health Information Exchange (HIE.) The Task Force also recommended transitioning from using the term *telemedicine* to *telehealth* as a way of encompassing a broader scope of health care delivery. The following definition for *telehealth* was proposed: *the delivery of health education and services using telecommunications and related technologies in coordination with a health care practitioner.*

A final report on the work of the Task Force was submitted to the Governor, Senate Finance Committee, and the House Health and Government Operations Committee in January 2015. The final report includes a funding request for the General Assembly to provide \$2.5 million to assist with the implementation of select telehealth use cases; with a portion of the funding be used to implement the telehealth provider directory. Funding appropriated by the General Assembly would enable MHCC to award telehealth pilot project grants under its grants-making authority.

### **Health Information Exchange**

MHCC continues to provide guidance to the State Designated HIE, CRISP, which facilitates the secure exchange of health information between Maryland's health care organizations, providers, and public health agencies in accordance with industry recognized best practices and standards. Currently in its sixth year of operation, CRISP continues to make progress towards building a robust statewide HIE. Participants in Maryland that submit clinical information to CRISP include all 46 general acute care hospitals, 2 specialty hospitals, 40 long-term care facilities, eight radiology facilities, and three laboratories. Additionally, CRISP has recently expanded to offer interstate connectivity to certain hospitals and providers in the District of Columbia and Delaware. Information made available through CRISP is accessible for query through an Internet-based portal. As of June 2014, there were about 258 health care organizations using the Query Portal averaging roughly 36,000 portal queries per month. The State-Designated HIE also offers real-time notification alerts to providers when one of their patients has an encounter at a participating hospital—the Encounter Notification Service (ENS). As of June 2014, about 108 organizations were receiving ENS alerts, which are generally used to help coordinate care and facilitate post-acute care follow up. During the last quarter of 2013, CRISP launched services under the Maryland Prescription Drug Monitoring Program (PDMP), where all Schedule II-V drugs prescribed at any Maryland pharmacy are made available to providers through the Query Portal. Approximately 3,500 prescribers, pharmacists and delegates utilized this service as of June 2014.

### **Advance Directives Registry**

The Commission awarded a contract to AdVault, Inc. (dba MyDirectives) to develop and implement an integrated electronic advance directives registry (registry) with the State-Designated HIE, CRISP. MyDirectives is an established web-based registry that allows consumers to create, update, and share their advance directive electronically. The registry's integration with CRISP enables authorized health care practitioners to search for patients' electronic advance directives at the point of care using the Query Portal, making advance directives more widely available. The Commission is also exploring opportunities to build awareness and use of the advance directive registry.

Maryland is one of the first states to implement an online registry that is connected to a State-Designated HIE. The Commission is exploring opportunities to also make the Maryland Medical Orders for Life-Sustaining Treatment (MOLST) form electronically available through CRISP. The MOLST form is standardized and different from an advance directive in that it is created and maintained by a health care practitioner. Maryland law requires that a MOLST form be completed and accompany a patient during certain transitions of care.

## **PROMOTING ACCESS TO HEALTH CARE**

### **Comprehensive Standard Health Benefit Plan and the Health Insurance Partnership (Partnership)**

The Commission took steps on January 1, 2014 to phase out the Partnership (COMAR 10.25.01), a premium subsidy program for low wage small employers that was launched in 2007. MHCC informed all employer groups and provided information on obtaining coverage through the Maryland Health Benefits Exchange (Exchange) and obtaining federal tax credits. Problems with the implementation of the Exchange website forced the Exchange to delay implementation of the SHOP Exchange in early 2014. MHCC (following its historical mission of supporting small employers) worked with the payors and producers to enable small employers to continue to renew products through the Health Insurance Partnership. Four major carriers (Aetna, CareFirst BlueCross BlueShield, Coventry Health Care, and United HealthCare), together with a number of Third Party Administrators (TPAs), continued renewing small businesses in the Partnership, with each carrier offering a variety of health benefit plans that qualify for a premium subsidy. The Commission modified the Partnership database and website to accommodate the federal rating rules required under the Affordable Care Act that became effective during the second half of FY 2014. The Partnership will continue until May 31, 2015 at which time all employers will be expected to migrate to SHOP products, small group products sold off the Exchange, or individual insurance products available through individual products off the Exchange.

On January 1, 2015, the MHCC published the 6th annual and final report on the implementation of the Partnership, indicating that many small employers in Maryland continued to renew their subsidized insurance for their employees and that several new businesses enrolled as well, with 423 businesses enrolled, covering 1,951 employees and their dependents. The average annual subsidy per enrolled employee exceeded \$2,400.

## **III. BUDGET**

The MHCC's budget allowance for FY 2016 is \$29,983,912 in special funds, \$14,683,912 for the MHCC, \$12,300,000 for the Maryland Trauma Physician Services Fund, and \$3,000,000 for the Maryland Emergency Medical System Operations Fund. Also included in the allowance is \$228,118 in federal

funds for the Commission's Health Insurance Rate Review grant, and \$172,500 in reimbursable funds from the Maryland Health Benefit Exchange for qualified health plan reporting.

The FY 2016 budget request funds the costs associated with 61.70 permanent staff and the expenditures associated with the mandatory requirements set before the Commission.

Special Fund surplus will close at approximately \$2.0 million at the end of FY 2015. The Commission's current statutory cap is set at \$12 million and the budget allowance in FY 2016 is \$14.6 million. Assessments to the industries must stay within the statutory cap; therefore, we have a projected revenue shortfall of \$600,000, which includes spending the surplus to -zero. The Commission has operated within its last statutory cap increase of \$2 million dollars for 8 years.

***THE HEALTH SERVICES COST REVIEW \$  
COMMISSION \$***

***FY 2016 BUDGET \$***

***PRESENTATION TO THE BUDGET COMMITTEES OF THE  
MARYLAND GENERAL ASSEMBLY \$***

MOOR0102 '  
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## HEALTH SERVICES COST REVIEW COMMISSION - FY 2016 BUDGET PRESENTATION

### *I. OVERVIEW*

The Health Services Cost Review Commission (the “HSCRC,” or “Commission”) was established in 1971 with two principal responsibilities: to publicly disclose hospital financial data and trustee relationships, and to set payment levels for acute care hospital services.<sup>1</sup> Under its authority, The Commission has been able to address the issues of cost containment, access to care, equity in payment, financial stability, and accountability.

Under Maryland’s unique “All-Payer” system, all payers, including Medicare and Medicaid, pay hospitals on the basis of the rates established by the Commission. This “all-payer” nature of the system was originally made possible by the state’s Medicare Waiver that became effective in 1977.

### *II. THE NEW ALL PAYER MODEL*

The State of Maryland is leading a transformative effort to improve care and lower the growth in health care spending. These efforts will benefit consumers, business, government, and other purchasers of care. Stated in terms of the “Three Part Aim,” the goal is a health care system that enhances patient care, improves health, and lowers total costs.

Maryland worked closely with the Centers for Medicare & Medicaid Services (CMS) throughout 2013 to design an innovative plan that would make the State a national leader in achieving the Three Part Aim and permit the federal government to continue to participate in the four-decade long all-payer hospital payment system that has proven to be both successful and enduring. The federal government approved Maryland’s new Model Design application, and implementation began in January 2014.

The Model as approved by the Centers for Medicare & Medicaid Services (CMS) includes cost savings and quality improvement requirements including:

- All-Payer total hospital per capita annual revenue growth no greater than 3.58%;
- Medicare payment savings of \$330 million over five years relative to the national growth rate;
- Aggregate Medicare 30-day unadjusted, all-cause, all-site readmission rate reduction to the corresponding national average over five years;
- An annual aggregate reduction of 6.89% in Potentially Preventable Conditions (PPCs) over five years, which will result in a cumulative reduction of 30% in PPCs over the life of the model.
- Other outcomes and quality indicators to be measured and monitored.

Before the start of the fourth year of the model, Maryland will develop a proposal to extend the model beyond the initial five years to focus on the total cost of care and outcomes across the delivery system that encompasses both hospital and community providers and services.

In the past thirteen months, the State, in close partnership with providers, payers, and consumers has made significant progress in this statewide modernization effort. Accomplishments include:

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<sup>1</sup> The Commission consists of seven members appointed to four-year terms by the Governor and is staffed by 37 full-time positions. The Commission regulates an industry of 47 acute care hospitals, five private psychiatric hospitals, and three chronic care hospitals, with system revenues in excess of \$16 billion in gross charges.

- More than 95% of hospital revenues are now under global budgets, which assures that revenue growth can be maintained within the limits while shifting the focus to improve care delivery and focus on population health, both within hospitals and in the community;
- Key quality payment policy enhancements have been adopted to be consistent with the new Model;
- Overall hospital financial conditions have improved;
- Monthly progress monitoring shows performance within the limits of the all-payer requirements;
- Maryland Hospital Acquired Conditions have been reduced beyond the required targets; and
- Over one hundred stakeholders including consumers, physicians, hospitals, other community providers, payers, and business have been engaged in implementation workgroups.

The HSCRC has just recently obtained data from the CMS that it needs to evaluate its performance relative to the Medicare savings requirements and progress in reducing readmissions. It has hired a contractor to help it in this evaluation. The contractor has initiated the evaluation process together with the HSCRC staff.

### *Monitoring Performance*

Figure 1 below show the growth in per capita revenues for the first six months of the fiscal year ending June 30, 2015 (July 2014 through December 2014) and for the calendar year 2014. The All-Payer results are below the 3.58% limit of the new model, in line with the expectations of the Commission based on the hospital budgets that were approved. Medicare revenues per beneficiary have decreased. We do not yet have comparative national figures to evaluate whether the savings requirements for Medicare have been realized.

Figure 2 shows the risk adjusted readmission rates for Maryland over the past several years. Readmissions are declining, however, the declines in 2014 did not meet the targets set by HSCRC. We are aware that national readmissions reductions have also slowed in 2014. We are currently working with CMMI to evaluate 2014 progress relative to national levels and to set targets for the following year.

Figure 3 shows the reduction in Potentially Preventable Complications (PPCs) measured under the Maryland Hospital Acquired Condition program. Maryland has surpassed its targets in reducing PPCs.

**Figure 1. Per Capita Growth Rates in Hospital Revenues  
Fiscal Year 2015 and Calendar Year 2014 – Through December 2014**

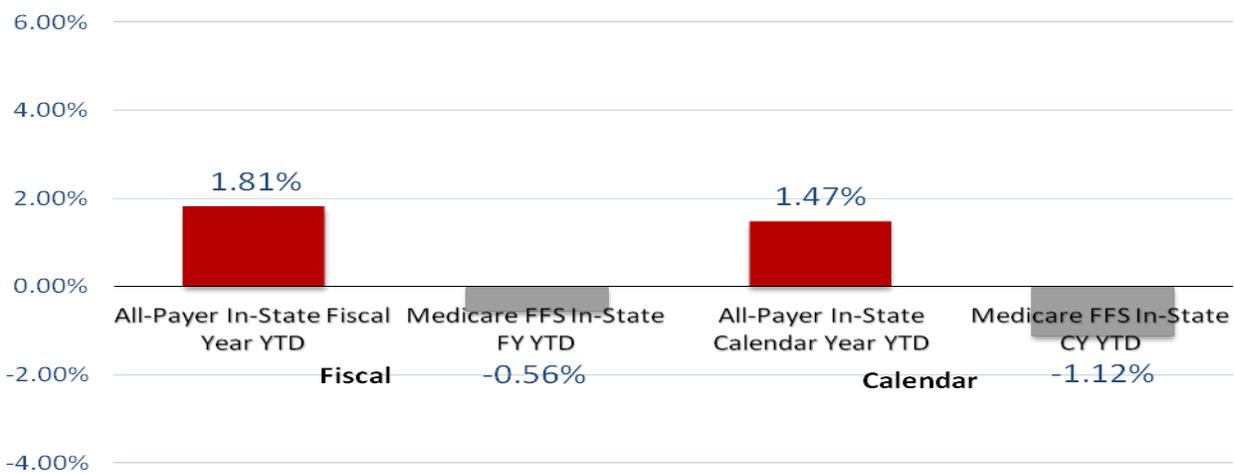


Figure 2. Readmission Rates

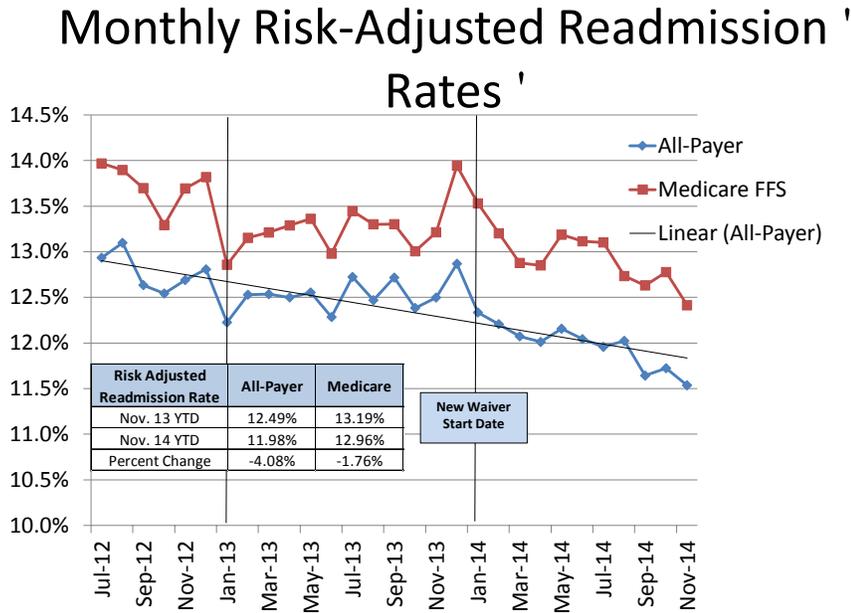
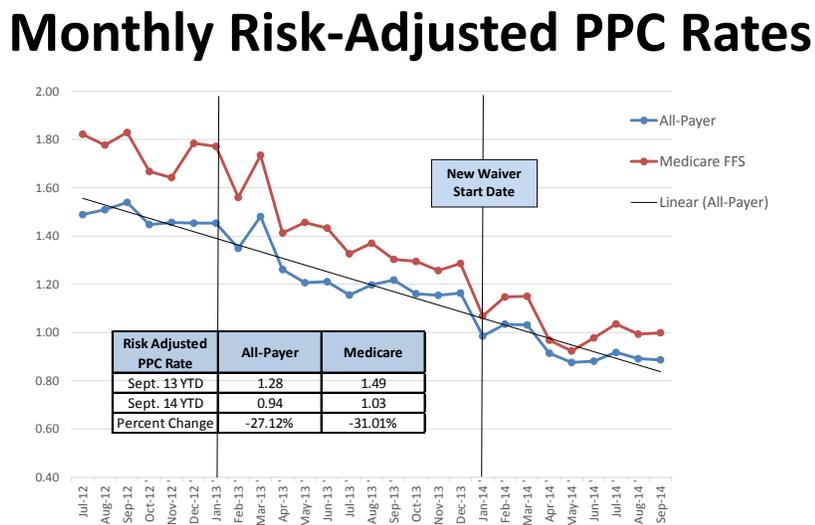


Figure 3. Maryland Potentially Preventable Complication Rates

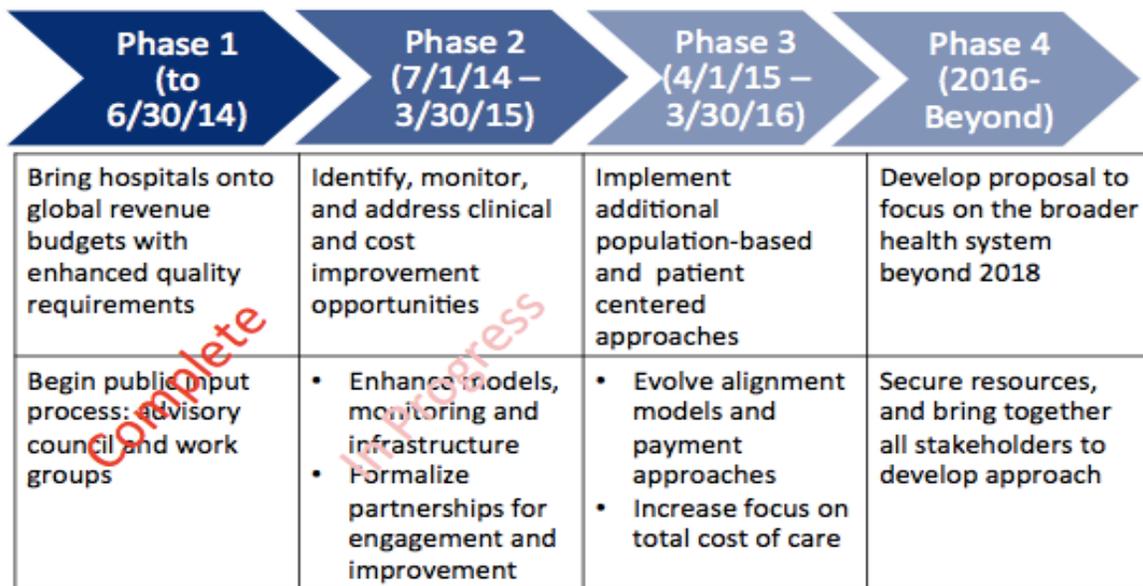


Note: Based on final data for January 2013 - September 2014.

### *Implementation and Stakeholder Engagement*

As the State’s rate setting authority, HSCRC is playing a vital role in the implementation of this innovative approach to health reform. The HSCRC with guidance from its All-Payer Modernization Advisory Council developed a four-phase model implementation plan shown in Figure 4.

**Figure 4: All-Payer Model Implementation Plan**



### *Phase 1 Public Engagement*

During phase 1 of its public engagement strategy, the HSCRC emphasized broad public engagement by convening an Advisory Council to provide guidance on the design of the new system and work groups to advise on particular implementation activities.

- **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 care coordination and improvement activities and for opportunities to improve financial alignment 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 Potentially Avoidable Utilization (PAU), value-based payment, 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 hospital All-Payer Model and successful performance.

The activities of the Advisory Council and Work Groups (as well as those of the Commission) can be found on the Commission’s website. All Commission, Advisory Council and Work group meetings are open to the public and provide opportunity for public comment. Consumer/patient representatives have been included on all Work Groups.

With the update of payment models complete, the HSCRC has begun the process of initiating partnerships and stakeholder activities, together with the Department of Health and Mental Hygiene (DHMH) and Maryland Health Care Commission (MHCC), focused on improving care and population health, engaging and educating consumers, and continuing the development of infrastructure and model enhancements for the regulatory and monitoring activities of the HSCRC.

### ***III. RESPONSES TO BUDGET QUESTIONS***

The budget analysis requests the Commission to “comment on how it plans to reduce readmissions within the waiver test, what plans it may have for the remaining of the coordination support funds, and what if any new outreach programs it has planned for Phase II”.

#### ***Readmission Reduction***

Maryland’s readmission rates are high compared to the nation. As previously indicated, as part of the new All Payer Model, Maryland has committed to reducing the readmission rate for Medicare patients to the national level over a five year period.

In order to focus hospitals on reducing readmissions to the national average, HSCRC established the [Readmission Reduction Incentive Program](#) for FY 2015, and continued the [Readmission Shared Savings Program](#) initiated in FY 2013, which work together to adjust hospital revenue based on readmission rate improvement and attainment.

Hospitals have engaged in numerous activities focused on improving transitions and reducing readmissions and significant progress has occurred over the last several years. While data is not yet available from CMMI to determine Maryland’s performance against the national Medicare trend for Calendar Year 2014, the All-Payer readmission reduction is less favorable than the goal set under the Readmissions Reduction Incentive Program for hospitals to reduce their adjusted readmission rate by 6.76% during CY 2014 compared to CY 2013. Currently, only 15 out of 46 hospitals have reached or exceeded this targeted reduction.

HSCRC is in the process of obtaining updated Medicare data, and will make changes to the readmission policies to strengthen the financial incentives while also updating the targets to reflect an evaluation of both national and Maryland trends. HSCRC expects to present final policy proposals for readmission reductions at its March 2015 public meeting.

Enhancing care coordination across provider settings and focusing efforts on individuals with complex needs and high numbers of chronic conditions is important for success in reducing readmissions. The Care Coordination Work Group has had several meetings to discuss efficient and effective implementation of patient-centered care coordination to augment and accelerate care improvements. The Commission expects

to have recommendations on care coordination and how statewide and regional efforts can support these efforts by April 2015.

### *Coordination Support Funds*

The 2014 BRFA established an approach for the Commission to fund statewide or regional proposals that support the implementation of the all-payer model contract through hospital rates in FY 2015. The BRFA indicated that up to \$15 million could be used for that purpose. The Commission has taken two approaches to best utilize some or all of these resources to best meet the goals of the new model and improve care for patients. The first is to provide up to \$2.5 million in planning grants for regional partnerships for health system transformation.

The Department of Health and Mental Hygiene, in collaboration with the HSCRC, has released a request for proposals to develop regional partnerships that can target services based on patient and population needs, and plan and develop care coordination and population health improvement approaches. Proposals are expected to address resources that are needed, and how obtain and deploy them in a coordinated approach across providing settings and in concert with public health resources.

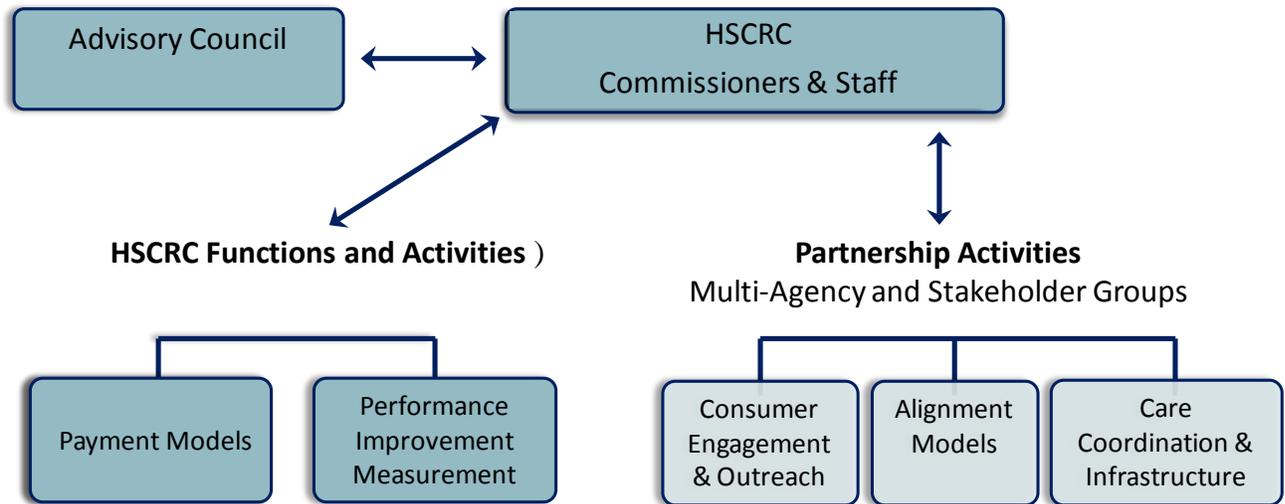
Up to \$400,000 may be awarded for five or more promising proposals that involve hospitals in collaboration with community partners, payers, consumers and patients, physicians, long-term care providers, local health improvement coalitions, and other community-based organizations. The application deadline is April 15, 2015 and awards are expected to be announced on May 1, 2015.

The Care Coordination Work Group is currently discussing infrastructure needs and how to best augment and accelerate coordination across the continuum of health care. In particular, the Work Group is focused on identifying those activities that could be supported at a statewide or regional level, and the cost of implementation. The remaining funds (approximately \$10 to \$12 million) could be used to provide infrastructure to support these strategies. Such infrastructure could include obtaining and analyzing data, risk stratification, supporting chronic care improvement in collaboration with community providers, and facilitating development and use of care plans for complex patients and patients with multiple chronic conditions.

### *Phase II of the Public Engagement Process*

The Commission is currently implementing Phase 2 of its public engagement strategy. Building off of the recommendations coming out of the Phase 1, the HSCRC restructured the work groups to continue the progress of the HSCRC regulatory work groups (Payment Models and Performance Measurement) and to utilize multi agency and stakeholder work groups (Care Coordination, Alignment Models, and Consumer Engagement, Education, and Outreach). Figure 5 depicts the structure of Phase 2 stakeholder engagement.

**Figure 5. Phase 2 Public Engagement Model**



The Care Coordination Work Group includes a very broad set of stakeholders and is focused on efforts to improve chronic care and focus on the needs of complex patients, utilizing resources in the community setting.

The Alignment Models Work Group is addressing Phase 1 alignment recommendations, including:

- Consider an Integrated Care Network (ICN) infrastructure to coordinate care and align financial incentives to improve care, particularly for the Medicare FFS population not already enrolled in an Accountable Care Organization or Medicare Advantage plan
- 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
- 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)

The Consumer Engagement, Outreach, and Education Work Group was created with advocacy groups together with organizational support from HSCRC, MHCC and the MHA. These efforts were formed in partnership with the Maryland Citizens Health Initiative and the Maryland Women’s Coalition for Health Care Reform. These groups will meet between January and July 2015 and make recommendations on the following topics:

- Health Literacy and Consumer Engagement within the context of the All-Payer Model and related initiatives. The effort will provide a rationale for health literacy and consumer engagement, with core principles. It will also define the audiences, identify the messages, and propose education and communication strategies.

- Consumer Communications related to implementation of the All-Payer Model. This effort 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 All Payer Model; and b) ensure an appropriate and consumer-friendly communications process for those directly impacted by the All-Payer Model's goals.

The Maryland Citizens Health Initiative (MCHI) has begun connecting directly with consumers and communities by hosting regional [public forums](#). At these forums, regulators, payers, providers and community leaders discuss the All-Payer Model, changes in payment approaches, as well as the efforts to produce better outcomes for patients, keep people healthier, and make it easier for consumers to navigate the Maryland health system. Using grant funding, MCHI also spent several months conducting focus groups, refining materials and developing methods to effectively communicate the appropriate level of information for Maryland consumers. MCHI is also explore the potential to use a [Maryland Faith Community Health Network](#) to help meet the needs of patients and families in the community setting as they transition to home from hospital settings.

**Maryland Community Health (**  
**Resources Commission (**

**Mark Luckner**  
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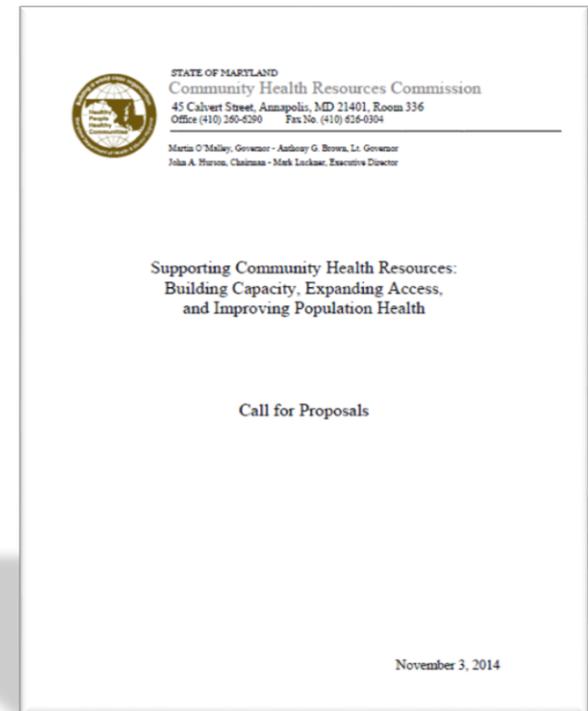
# **BACKGROUND ON THE CHRC (**



- **The Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 to expand access to health care for low-income Marylanders and underserved communities in the state.**
- **The CHRC is an independent agency operating within the Maryland Department of Health and Mental Hygiene. Its 11 members are appointed by the Governor.**
- **The Maryland General Assembly approved legislation (Chapter 328) in 2014 (vote was unanimous) that re-authorized the CHRC for another ten years, until 2025.**

# BACKGROUND ON THE CHRC (

- The CHRC has issued eight Calls for Proposals (RFP) over nine years. These RFPs have focused on promoting the following public health priorities:
- Reducing infant mortality
- Increasing access to dental care
- Promoting ED diversion programs
- Expanding primary care access
- Integrating behavioral health
- Investing in health information technology
- Addressing childhood obesity
- Building safety net capacity



# BACKGROUND ON THE CHRC (

- Since its inception, the CHRC has awarded 143 grants totaling \$49.6 million, supporting programs in all 24 jurisdictions. These programs have collectively served more than 195,000 Marylanders.
- Over the same time period, the Commission received 593 requests for \$276.2 million.
- Grantees have utilized CHRC grant funding to leverage \$15.4 million in additional federal and private/non-profit resources.

# **FY 2015 CALL FOR PROPOSALS (**

- **This year's Call for Proposals was issued in early November and contained the following three strategic priorities:**
  - (1) Expand capacity;
  - (2) Reduce health disparities; and
  - (3) Promote efforts to reduce avoidable hospital utilization.
- **The FY 2015 Call for Proposals targeted four types of projects:**
  - Reducing infant mortality
  - Expanding primary care access
  - Increasing access to dental care
  - Building safety net provider capacity
- **The CHRC received 43 Letters of Intent requesting approximately \$7.7 million in year one funding (total funding request was \$18.6 million). The Commission is in a position to award approximately \$1.3 million in FY 2015.**

# **FY 2015 CALL FOR PROPOSALS (**

**Following are twelve applicants that have been invited to present to the Commissioners on February 19, 2015 (later this week):**

## **DENTAL CARE**

- Allegany Health Right
- Frederick Memorial Hospital
- Total Health Care, Inc.
- Health Partners

## **CAPACITY OF SAFETY NET PROVIDERS**

- Family Services, Inc.
- Calvert Health Department

## **ACCESS TO PRIMARY CARE**

- Harford Health Department
- Union Memorial Hospital
- Esperanza Center
- HealthCare Access Maryland
- La Clinical del Pueblo

## **INFANT MORTALITY**

- Community Clinic, Inc.

# PROMOTING COMMUNITY- HOSPITAL PARTNERSHIPS (

## CHRC released last month white paper, “Sustaining Community-Hospital Partnerships to Improve Population Health”

- Sponsored four regional forums that were held this past fall (forums involved participation from Maryland Hospital Association, DHMH, HSCRC, and CRISP)
- Engaged independent consultant (Frances B. Phillips) to analyze 5 grants that involve hospital-community partnerships
- Develop recommendations to replicate and sustain these types of partnerships

### Key recommendations include:

- Providing access to toolkits and support for future grant proposals;
- Determining a return on investment of grants aimed at upstream improvements to a community’s social or economic conditions; and
- Exploring multi-investor partnerships around projects of mutual interest.

# PROMOTING COMMUNITY- HOSPITAL PARTNERSHIPS (

## Impact of CHRC-supported programs

### 1. Cecil County HD with Union Hospital of Cecil County

Over a 15-month period, 160 individuals received services. The program helped reduce avoidable hospital utilization (ED visits and admissions) for chronic conditions (diabetes, heart disease, others), and the hospital partner estimated savings of more than \$662,000 (more than \$4,100 per participant). Adjusted for program expenses, the result was a net savings of \$460,000.

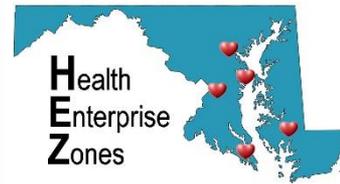
### 2. Worcester County HD with Atlantic General and Peninsula Regional

Over a 12-month period, 59 individuals received services. When comparing pre- vs. post-enrollment, the program estimated a total of \$189,000 in savings due to averted diabetes-related ED visits and reduced hospitalizations (\$45,000 in avoided ED visits and \$144,000 in avoided hospitalizations).

### 3. HealthCare Access Maryland (HCAM) with Sinai Hospital

A sample of 7 frequent utilizers was selected for a pre- vs. post-comparison. Four months prior to participating in the program, these 7 individuals visited the ED 24 times. Four months after participating in the program, these individuals visited the ED 6 times. With average costs estimated at \$3,452 per visit, the program estimates savings of \$62,118 from reduced/avoided ED visits from these 7 individuals.

# IMPLEMENTING HEALTH ENTERPRISE ZONES

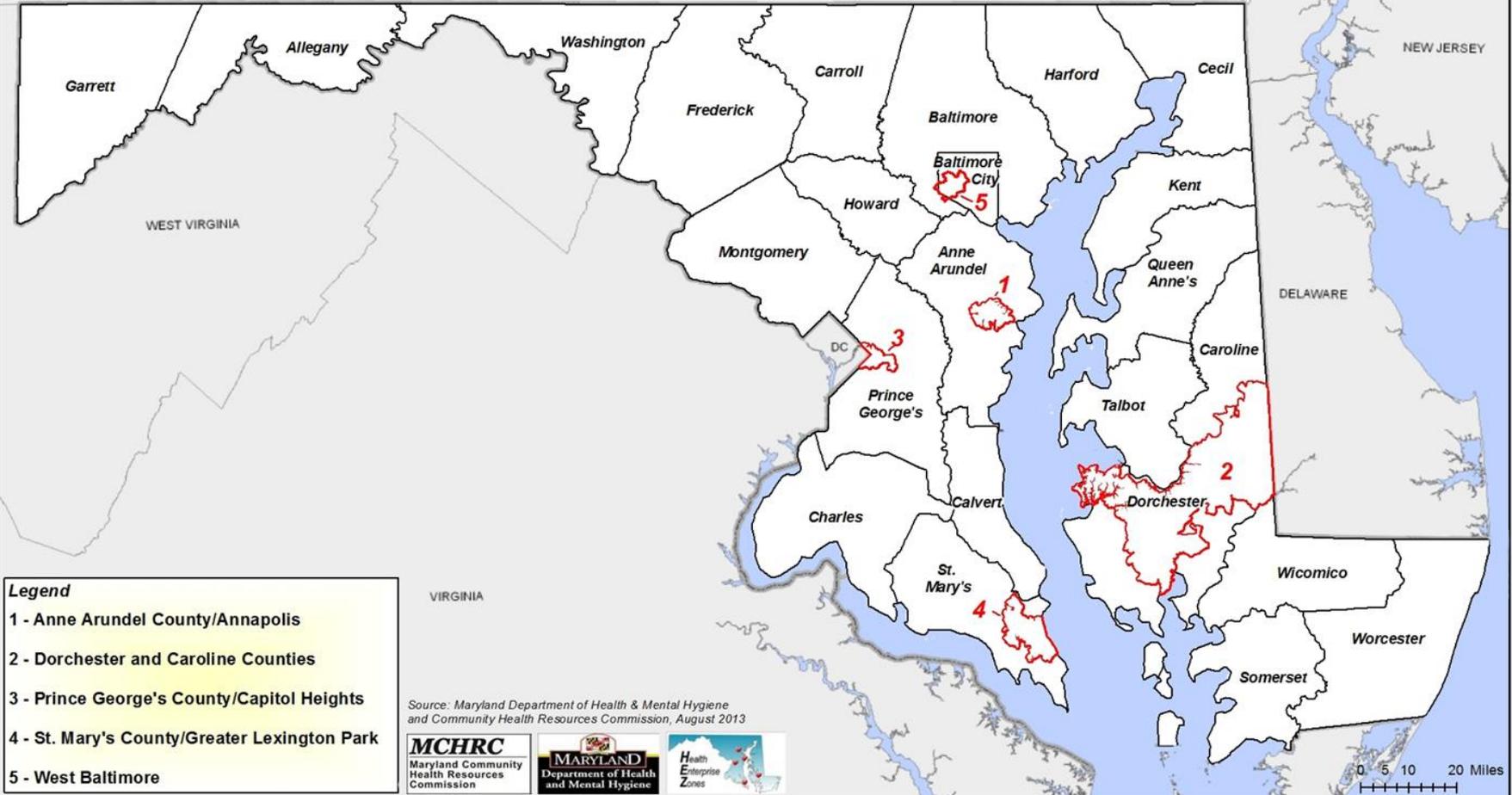


- **SB 234 (Chapter 3 - 2012) established framework for creation of Health Enterprise Zones (HEZs) and provides \$4 million per year to support HEZs over the four-year duration of the Act.**
- **The HEZ fund is administered by the Community Health Resources Commission. Day-to-day program administration is executed by the CHRC and DHMH.**
- **The purposes of HEZs are to:**
  1. Reduce health disparities;
  2. Expand access in underserved areas and improve health outcomes; and
  3. Reduce health costs and hospital admissions and readmissions in specific areas of the State.

# MARYLAND'S HEALTH ENTERPRISE ZONES



## Maryland's Health Enterprise Zones

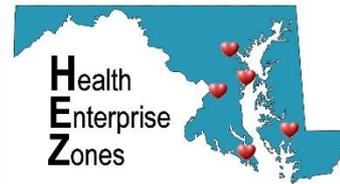


- Legend**
- 1 - Anne Arundel County/Annapolis
  - 2 - Dorchester and Caroline Counties
  - 3 - Prince George's County/Capitol Heights
  - 4 - St. Mary's County/Greater Lexington Park
  - 5 - West Baltimore

Source: Maryland Department of Health & Mental Hygiene and Community Health Resources Commission, August 2013



# IMPLEMENTING HEALTH ENTERPRISE ZONES



- **The DHMH Secretary designated the following five HEZs:**
  - Annapolis – Morris Blum (suburban)
  - Capitol Heights - Prince George’s County HD (suburban)
  - Dorchester/Caroline Health Departments (rural)
  - Greater Lexington Park - St. Mary’s County (rural)
  - West Baltimore CARE - Bon Secours (urban)
- **The five Zones began program implementation in April 2013. The Zones are now completing year two and are providing health care and other support services.**
- **All five Zones include a focus on diabetes. Other clinical goals include cardiovascular disease, hypertension, obesity, and asthma.**
- **An evaluation of the Initiative is being conducted by the Johns Hopkins Bloomberg School of Public Health’s Center for Health Disparities Solutions.**

# IMPLEMENTING HEALTH ENTERPRISE ZONES



- **As mentioned in the analysis by the Department of Legislative Services, the HEZs are making strides to support reductions in hospital admissions and readmission rates.**
- **Year two achievements include:**
  - Opening or expanding 15 health care delivery sites;
  - Recruiting 37.43 practitioner FTEs in HEZ; and
  - Providing 93,495 visits to 50,290 patients.