Analytical Framework for State Cost Containment Models: Maryland

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
What types of administrative data does the state collect?	The Maryland Health Care Commission (MHCC), an independent regulatory agency, is responsible for collecting, maintaining, releasing, and reporting on a range of health care data to inform decision making by policy makers, payers, providers, and consumers. MHCC collects data from health care facilities and insurance companies, and requests and maintains data from quality reporting organizations, CMS, and Maryland and Washington, DC-area hospitals. It also maintains the state's All-Payer Claims Database. These data support a variety of policy and legislative reports, evaluations of demonstrations, and quality reporting initiatives. A separate consumer dedicated website provides quality reports on hospitals, physicians, long term care, ambulatory care, and health plans. *Sources:* *To learn more about the MHCC's data collection activities, click here.* *The MHCC's annual report to the Governor provides an overview of the MHCC's activities and can be accessed here.*
What types of clinical data does the state collect?	MHCC's *Comprehensive Quality Report* incorporates information on the clinical performance of commercial health plans along with information from the new quality measurement instrument called the Maryland RELICC Assessment that measures health benefit plan activities to reduce health care disparities. Clinical data is also captured in the Chesapeake Regional Information System for our Patients (CRISP) - Maryland's State-Designated HIE. MHCC has oversight responsibility for CRISP. The CRISP portal allows authorized users to access patient health information including demographics, lab and radiology results, discharge summaries, and prescription drug fill history. CRISP makes available via its portal information from Maryland's Prescription Drug Monitoring program. *Sources:* *The MHCC's 2015 Comprehensive Quality Report may be accessed here.* *For more information about Maryland's HIE, CRISP, click here.*
Does the state have a HIT strategy to promote use of clinical and administrative data to	Yes. The MHCC's Center for Health Information Technology and Innovative Care Delivery (Center) is responsible for advancing health IT statewide. The Center's HIT plan includes the following components: • Plan and implement a statewide HIE; • Identify challenges to health IT adoption and use, and formulate solutions and best practices that address these challenges; • Increase the availability and use of standards-based health IT through consultative, educational, and

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promote cost containment initiatives?	outreach activities; • Promote and facilitate the adoption and optimal use of health IT for the purposes of improving the quality and safety of health care; • Harmonize service area HIE efforts throughout the State; • Certify electronic health networks that accept electronic health care transactions originating in Maryland; • Develop programs to promote electronic data interchange between payers and providers; and • Designate management service organizations to promote the adoption and advanced use of EHRs. As a result of these efforts, EHR adoption among Maryland office-based physician has increased from 33.4 percent in 2011 (around the time the State incentive program went into effect) to 64.3 percent in 2014. It is important to note that the state requires State-regulated payers to provide incentives for the adoption of EHRs. These State incentives are separate and independent of federal incentives. In fact, Maryland is the first state to have required state-regulated payers to offer incentives for the adoption of EHRs. *Sources:* *For more information about the state's HIT plan, click here.* *For more information about MHCC's Center for Health Information and Innovative care Delivery, click here.* *For more information about Maryland's HIE, CRISP, click here.* *For more information about the state's requirement of payers to offer incentives for adoption of EHRs, click here.*
Does the state have a centralized agency responsible for collecting, analyzing and reporting health care data?	Yes. The Maryland Health Care Commission (MHCC) is responsible for collecting, maintaining, releasing, and reporting on a variety of health care data to inform decision-making by policy makers, payers, providers, and consumers. Within the MHCC, the Center for Analysis and Information Services oversees and is responsible for conducting analyses based on data from Maryland's APCD, described immediately below.
Does the state have a functioning APCD that it	Yes. The MHCC maintains Maryland's APCD, referred to as the Medical Care Data Base (MCDB). The MCDB is comprised of enrollment, provider, and claims data for Maryland residents enrolled in private insurance, Medicare, or Medicaid Managed Care Organizations. The MCDB contains data on approximately 3.6 million privately insured Maryland residents, and Medicaid claims for about 900,000 MCO enrollees annually. There is a

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uses to collect data?	quarterly data submission requirement effective since 2014. The MCDB is enhanced with the state's HIE encrypted patient identifier that makes possible linkage of patient claims across payers and over time. All major TPAs and pharmacy benefit managers submit data to the MBCD. *Source:* *More about Maryland's APCD, the Medical Care Data Base, may be found here.*
Does the state report cost and quality to the public?	Yes. The Maryland Health Care Commission (MHCC) makes quality and cost data available to the public, both directly via reports and report cards, and to the Legislature and agencies for the purposes of cost analyses, program evaluations, and other policy purposes. Reports and data that are developed for consumers are accessible via a dedicated consumer website maintained by the MHCC. In addition, the MHCC's Center for Quality Measurement and Reporting publishes a *Hospital Guide* with information on: • CAHPS patient satisfaction survey results over the domains of Communication, Environment (e.g. cleanliness) and overall satisfaction; • Average ER wait times before treatment or admission to a hospital; • Hospital Acquired Infections (bloodstream infections, surgical site infections, Clostridium difficile infections, and percentage of healthcare personnel vaccinated for the flu); • Data on hospital performance on select quality measures in 14 different areas, including cardiac care, surgical care, and patient safety; • Maternity and newborn measures: data on practice patterns and results of care; and • Price transparency: average charges by hospital for common medical procedures. The Center publishes a *Long Term Care Guide* that provides information on: • Cost-per-day information for adult day care, assisted living residences and nursing homes; • Federal and state quality measures; and • Consumer ratings of care for each nursing home. The Center publishes several cost and quality information guides for its commercial insurers and health plans. • *Maryland Health Care Commission Comprehensive Quality Report: Comparing the Performance of Maryland's Commercial Health Benefit Plans*. This report provides information on health benefit plan performance for measures and indicators related to clinical performance, member satisfaction with the quality of health care

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	service delivery, behavioral health care information, carrier disparities initiatives, primary care and wellness for children and adults, women's health, major chronic diseases impacting Maryland residents, other quality improvement initiatives, plus an extensive list of consumer resources. There is a section dedicated to State Employees who have a defined selection of health plans. • A *Consumer Edition* of the MHCC's Quality Report provides feedback from health plan members on their satisfaction with their health plan. The guide describes available delivery systems, health plans by carrier with contact information, information on Maryland's racial composition and languages spoken, and carrier specific information on the number of physicians by specialty by county including information on board certification. The Maryland Department of Health and Mental Hygiene publishes a Medicaid health plan report which provides aggregate ratings of health plan performance. *Sources:* *The MHCC's dedicated consumer website may be accessed here.* *To access the MHCC's quality reports, click here.* *To access the MD DHMH Medicaid health plan report cards, click here.*
Does the state identify and track key cost drivers and high cost providers?	Yes, the Health Services Cost Review Commission (HSCRC), an independent state agency with seven Commissioners appointed by the Governor, publishes numerous reports on utilization and pricing of Maryland hospitals. The HSCRC provides comparative reporting on hospital pricing and quality (annual), peer-to-peer hospital comparisons on standardized charges per case/visit (semi-annual), and tracks the rates of growth in hospital charges and volume (monthly). *Source:* *For more information about HSCRC's analysis of health care costs in Maryland, click here.*
Does the state monitor health care cost growth?	Yes, the MHCC uses the state's APCD to monitor total cost of care under the state's new hospital payment model, described below. And the HSCRC monitors health care cost growth against targets created pursuant to the five year All-Payer Agreement with CMS to implement a new All-Payer payment model as described below. *Source:* *For more information, the HSCRC's annual report may be accessed here.*
Does the state define cost growth targets?	Yes, in 2014, the state negotiated a 5-year All-Payer Agreement with CMS and implemented Global Hospital Budgets. The state's all payer model establishes cost growth limits as follows. • The all-payer per capita total hospital per capita revenue growth ceiling for Maryland residents tied to long-term projected per capita state economic growth (GSP), 3.58 percent per year over the five years of the

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	model (plus an adjustment for population growth). • The Medicare payment savings for Maryland beneficiaries is compared to a dynamic national trend with a minimum of $330 in savings over five years. The agreement with CMS requires Maryland to expand the model to contain per capita cost increases to full spectrum of services and providers by 2019. The state's vision is all-payer total cost of care budgets with quality targets. The state's all-payer hospital global budget launched January 1, 2014. All payers pay same rates for inpatient and outpatient services at individual hospitals. Each hospital's annual revenue is determined from a historical base period adjusted for inflation, demographic volume increases, performance based on quality and efficiency, changes in payer mix and uncompensated care. The state is proactive in managing costs and has been setting hospital FFS rates for all payers since 1974 under the direction of the Maryland Health Services Cost Review Commission (HSCRC). *Source:* *The All Payer Model's cost growth targets are described in the HSCRC's 2015 annual report to the Governor, found here.*

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
Does the state coordinate Medicaid and state employee health plan performance requirements and cost control strategies?	Yes, while there does not appear to be any explicit strategy to coordinate health plan performance requirements and cost containment strategies between these programs, both the Medicaid and state employee health plan are parties to the All Payer Model; in addition, both were participants in the Multi-Payer Patient Centered Medical Home (MMPP), described below. Medicaid MCOs continued their participation in the MMPP until the end of 2016.
Is the state pursuing an all-payer or Medicare waiver with CMS in order to align cost control	Yes, Maryland negotiated a new CMS all-payer agreement under a Section 1115 Research and Demonstration Waiver, effective January 1, 2014. Of note, the all payer hospital global budget that launched in January 2014 will incentivize hospitals to reduce readmissions, complications and lengths of stay in the short-term; in the long term, the hospital global budget

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strategies?	will encourage hospitals to partner with community-based providers to prevent hospitalizations, inappropriate ED utilization, improve population health, and manage their highest cost patients.
What other waivers, grants or federal demonstrations is Medicaid pursuing to promote cost containment?	Maryland received a $2.4 million Round One and a $2.5 million Round Two State Innovation Model (SIM) Design Award Grant from the Center for Medicare and Medicaid Innovation (CMMI) in Round One and Round Two. The SIM Model Design Award is to develop its 2014 State Health Care Innovation Plan. The centerpiece of this plan is to develop Community-Integrated Medical Homes (CIMH), building on the Maryland Multi-Payer Patient-Centered Medical Home Program (MMPP). The CIMH model integrates patient-centered medical care with community resources and local health entities to improve the health of individuals and communities. Community health teams will provide public health and community-based wraparound services to participating primary care providers. Under the CIMH model, Maryland's Patient-Centered Medical Homes (PCMHs), Medicare Accountable Care Organizations (ACOs), Chronic Health Homes, and Federally Qualified Health Centers (FQHCs) will expand to offer defined clinical interventions. The state will identify patients who might benefit from the community-integrated approach of the CIMH model via 'hot spotting' and other tools made possible by Maryland's data infrastructure, in addition to referrals from providers and hospitals. *Source:* *Information about Maryland's 2014 State Health Care Innovation Plan may be accessed here.*
What APMs are being pursued by Medicaid?	Maryland's payment and delivery system reform efforts are inextricably linked. For more information on the payment reform associated with delivery system reform efforts, see below.
What delivery system redesign strategies are being pursued by Medicaid?	Maryland is pursuing several APMs within its Medicaid program, and more broadly, under its all-payer waiver program. • **All-Payer Model.** Effective January 1, 2014, Maryland begin implementation of an all-payer model, which ushered in policies aimed at both reducing per capita hospital expenditures and improving patient health outcomes. ⇨ The waiver establishes an all-payer total hospital per capita revenue growth ceiling for Maryland residents, which is tied to the long-term projected per capita state economic growth, yielding an effective 3.58 percent annual growth rate. ⇨ The state must achieve Medicare spending savings of at least $330 million over the five years of the

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	agreement; savings are determined by comparing the rate of increase in Medicare hospital payments per Maryland beneficiary to the national rate of increase in payments per Medicare beneficiary. ⇨ Hospitals receive a fixed global budget with revenues capped for both inpatient and outpatient services, thereby discouraging unnecessary utilization and improved outcomes. • **Multi-Payer Medical Home Program (MMPP).** The state's MMPP concluded in December 2015. This legislatively mandated, all payer, 3-year PCMH pilot included 52 primary and multi-specialty practices and covered enrollees of the state's four largest plans. Medicaid MCOs, state employee health benefit plan participants, federal employees, TRICARE and Medicare Advantage beneficiaries all participated on a voluntary basis. The MMPP officially ended in December 2015, although Medicaid MCOs will continue to participate until the end of FY 2016. ⇨ The payment model under the MMPP consisted of a PMPM payment for achievement of NCQA recognition and care coordination, and a shared savings initiative based on total cost of care and quality. ⇨ Participating primary care practices delivered team-based care, chronic disease management and increased primary care access. ⇨ The state offered technical assistance to participating practices through the Maryland Health Care Innovations Collaborative. • **LTSS Pay-for-Performance (P4P) and Pay-for-Improvement (P4I)**. The state's Pay-for-Performance program awards nursing facilities who perform highly on certain quality indicators; the program awards approximately $5.9 million annually. The state makes small awards to facilities that have shown improvement over prior year performance under its P4I program. *Sources:* *For more information about Maryland's all-payer model, click here.* *For more information about the Maryland MMPP program, click here.* *To read more about the Maryland Health Care Innovations Collaborative, click here.* *For more information about the state's LTSS P4P and P4I programs, click here.*
What benefit designs are being pursued by Medicaid to incentivize effective use of health care	No evidence of particular benefit designs related to effective use of health services was found.

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services?	
Does Medicaid use MMCOs to manage care?	Yes. Approximately 75 percent of all Medicaid enrollees are required to enroll in Maryland's managed care program, called HealthChoice. Currently, eight managed care organizations (MCOs) participate in the program. • Those not eligible for HealthChoice include dual eligible and institutionalized individuals. Disabled individuals are required to enroll in an MCO unless otherwise excluded under another category. • Neither Behavioral Health services nor Long Term Care services are included in the MCOs' contracts. *Sources:* *For more information about Maryland's Medicaid managed care program, HealthChoice, click here.*
What reimbursement policies has Medicaid implemented to promote cost containment?	No additional strategies identified beyond those incorporated in delivery system initiatives described above.
What initiatives has Medicaid pursued to manage cost of special populations of beneficiaries?	Maryland's Chronic Health Homes program targets populations with behavioral health needs who are also at high risk for additional chronic conditions, including serious persistent mental illness and opioid substance use disorders. These health homes offer enhanced care coordination services from providers from whom these populations regularly receive care, including psychiatric rehabilitation programs and opioid treatment programs. The program operates under a State Plan Amendment approved by CMS in 2013. In addition, under the HealthChoice program, MCOs must implement the following standards for treating special needs populations as follows: • ensuring that Pediatric and adult Primary Care Providers (PCPs), and specialists are clinically qualified to provide or arrange for specialized services; • developing referral protocols that demonstrate the conditions under which PCPs will make the arrangements for referrals to specialty care networks; • coordinating case management as part of enrollee's comprehensive plan of care; • identifying a special needs coordinator as a point of contact for health services information and referral; • making efforts to contact and educate enrollees who fail to appear for appointments or who have been non-compliant with a regimen of care; and

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	• after documented unsuccessful outreach efforts, the MCOs must refer the case of the non-compliant enrollee to the local health department for assistance in returning the enrollee to care. The state has also established specific requirements and protocols for treating the following special needs populations: 1) children with special health care needs; 2) individuals with a physical disability; 3) individuals with a developmental disability; 4) pregnant and postpartum women; 5) individuals who are homeless; 6) individuals with HIV/AIDS; 7) individuals with a need for substance abuse treatment; and 8) children under state supervision. For example, to treat individuals with physical disabilities, the MCOs must document that their providers are clinically qualified to provide durable medical equipment and assistive technology services. Another example is that MCOs must attempt to identify homeless individuals and link them to the appropriate service provider. Under HealthChoice, the Rare and Expensive Case Management Program (REM) meets the health care needs of Medicaid recipients with specific rare and expensive conditions. If a HealthChoice enrollee is accepted into the REM program, he or she is disenrolled from the MCO and instead receive fee-for-service benefits and may receive an expanded set of benefits as outlined in the regulations. *Sources:* *For more information about Maryland's Chronic Health Homes, click here.* *For more information about Maryland's HealthChoice program, click here.* *To read more about Maryland's REM program, click here.*

Domain #3: State Employee Health Plan Coverage and Payment Strategies to Contain Costs	
What APMs is the state employee health plan using to control health care costs?	The state employee plan was a voluntary participant in the Multi-payer Medical Home Program, and is a participant in the hospital All Payer Model.
What benefit design is the state employee health plan using to control health care costs?	In 2014, the state announced changes to the state employee health plan designed to offer state employees rewards for taking proactive steps to staying healthy, and introducing penalties for noncompliance. Rewards for participation in the wellness program include waived PCP copays. While the state initially charged a surcharge for non-participation, that has since been eliminated. *Source:*

	For more information about the state employees' health plan wellness program, click here.

Domain #4: State Actions to Enhance Competition in the Marketplace	
Does the state certify or otherwise regulate Accountable Care Organizations?	No.
Does the state collect data regarding the structure of the state's health care market, such as ACO information on number of participating physicians?	No.
Does the state use the collected data to produce reports to encourage marketplace competition, such as hospital quality and cost report cards, cost impact reports?	Yes, as described in Domain #1 above.
Does the state promote or set limits on consolidation of health care providers of similar services?	No such limits identified.
Does the state promote or set limits on vertical integration of health care providers of different services?	No such limits identified.
Does the state promote or limit other types of affiliations among health care providers that impact	Yes. The MHCC formed a Health Care Provider Carrier Workgroup to develop recommendations for modernizing the Maryland Patient Referral Law (MPRL). The MPRL prohibits a health care provider from referring a patient to a health care entity in which the provider has a beneficial interest or compensation arrangement unless the provider meets one of eleven specific exemptions set forth in the

Domain #4: State Actions to Enhance Competition in the Marketplace	
referral and utilization practices?	statute, including one that is known as the "in-office ancillary services" exemption. The MPRL is broader than the federal self-referral law, the 'Stark Law.' *Source:* *For more information about the Maryland Patient Referral Law and the recommendations of the MHCC's Health Care Provider Carrier Workgroup, click here.*
What strategies, if any, has the state's insurance department taken to ease insurer entry into the marketplace to enhance insurer competition?	No reference to such strategies found.
Does the state have consumer protection regulations that promote cost containment?	No evidence of specific consumer protection regulations that promote cost containment.

Domain #5: State Regulatory Actions to Contain Health Care Costs	
Does the state directly (vs indirectly through setting or approving insurer rates) limit price increases by providers?	Yes, Maryland has been setting hospital FFS rates for all payers since 1974. The enabling legislation is broadly written, allowing the Health Services Cost Review Commission (HSCRC) flexibility to evolve rate setting methodology. With its CMS all-payer agreement, effective January 2014, Maryland moved to a global budget model for hospital reimbursement as described in Domain # 2.
Has the state mandated payment and delivery system reform?	Under the global budget model described in Domain #1, hospitals must comply with an annual prospectively established total budget or face penalties the following year. Maryland's Multi-Payer Patient-Centered Medical Home Program (MMPP) required the five largest State-regulated health insurance carriers to financially support the program by providing up-front and

Domain #5: State Regulatory Actions to Contain Health Care Costs	
	incentive payments to qualifying MMPP practices. Other state and federal payors joined the program voluntarily. The MMPP officially ended in December 2015. *Sources:* *To read more about how Maryland's all-payer global budget cap model works, click here.* *To view the final evaluation report for Maryland's MMPP program, click here.*
Does the state have a Determination or Certificate of Need program or other programs to limit introduction of high cost services?	The Center for Health Care Facilities Planning and Development regulates the supply and distribution of facilities and services through Certificate of Need and related oversight programs; the Center administers the Certificate of Need (CON), Certificate of Conformance, and Certificate of On-going Performance programs, which regulate certain aspects of health care service delivery by health care facilities. The Maryland CON program is intended to ensure that new health care facilities and services are developed in Maryland only as needed and that, if determined to be needed, that they are the most cost-effective approach to meeting identified needs, of high quality, and geographically and financially accessible, among other criteria. Maryland law requires that the Commission consider a range of criteria in its review of CON applications, including the availability of more cost-effective alternatives. More specifically, the Commission compares the cost effectiveness of proposed projects with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review. *Source:* *For a comprehensive description of Maryland's CON process and criteria for evaluation of CON applications, click here.*
Are there any requirements of commercial payers to provide comparative cost and quality data regarding contracted providers?	Yes. Commercial health plans, are required to submit data for quality and performance measures using either the NCQA Interactive Data Submission System (IDSS) tool or the free Healthcare Data Company Benchmarking tool. *Source:* *For information on MHCC's requirements of health plans related to submission of quality and performance data, click here.*
Is the state insurance department implementing any strategies to limit	No.

Domain #5: State Regulatory Actions to Contain Health Care Costs	
provider cost increases?	

Domain #6: Payment Reform and Delivery System Reform	
What entities are driving payment and delivery system reform in the state?	As described in earlier Domains, the Maryland Health Care Commission and the Health Services Cost Review Commission are the primary drivers of payment and delivery system reform in the state.
What support has the state received to promote payment and delivery system reform?	Maryland received a State Innovation Model (SIM) Design Award Grant from the Center for Medicare and Medicaid Innovation (CMMI) in Round One and Round Two, totaling $5 million. *Source:* *For more information regarding Maryland's SIM grants, click here.*

Domain #7: Environmental Context for the Cost Containment Strategies	
Does the state's culture promote cost reform?	Yes, Maryland has historically been a leader in promoting health care cost reform with the establishment of the HSCRC in 1971 and of the MHCC in 1999. The HSCRC has strong, capable leadership to develop, implement and adjust complex rate setting and now global hospital budget system. The agency has sufficient staffing and a sophisticated system to oversee and implement its work.
What are/were the governmental facilitators?	The key governmental facilitators in Maryland are the MHCC and the HSCRC.
Are there any key insurers that are driving cost containment strategies?	Yes, CareFirst has implemented a Primary Care Advanced Medical Home Initiative, as described below.
Do health plans promote use of high-quality, low cost providers in their plan designs?	CareFirst views PCMH as an important cost management strategy. It's specific PCMH approach involves: • Directing referrals to cost-effective specialists and hospitals. • Engaging high-cost, high need patients in care management. • Effectively managing medications.

Domain #7: Environmental Context for the Cost Containment Strategies	
	• Reducing gaps in care and quality deficits. • Engaging PCPs in transformation. CareFirst members who participate in the PCMH and have a care plan may receive lower copays or waiver of coinsurance. *Source:* *For more information about benefit design for CareFirst PCMH members, click here.*
Have health plans implemented alternative payment models with providers?	Yes, CareFirst (the principal insurer in Maryland's commercial market with 68 percent of the individual and small group market) has implemented the Primary Care Advanced Medical Home Initiative, a voluntary program focused on patients with chronic conditions. Under CareFirst's PCMH initiative, participating providers can receive reimbursement increases of three types: 1) 12 percentage point increase added to fee schedule; 2) new fees for implementing care plans for select patients with certain chronic or multiple conditions; and 3) additional fee schedule increases of up to 80 point increase based on providers' engagement with their patients, the quality of care delivered, and the cost of care compared to expected. Primary care providers who reduce spending for their chronically ill patients, when compared to prior spending levels, qualify to earn 30 percent of the savings they've generated. CareFirst will continue its PCMH initiative, even though the state's MMPP officially ended in December 2015. *Sources:* *For more information about CareFirst's Patient Centered Medical Home program, click here. For more about the shared savings model under the CareFirst PCMH program, the Urban Institute prepared a 2012 site visit report, which may be accessed here.*
How have health plans promoted delivery system transformation?	See above for description of CareFirst's Primary Care Advanced Medical Home Initiative.
Are there any multi-stakeholder coalitions facilitating cost containment strategies?	No.
Is there a strong employer purchaser coalition in the market facilitating cost	No, the MidAtlantic Business Group on Health, has a presence in Maryland but it is not necessarily a strong employer purchaser coalition. The MidAtlantic Business Group on Health is a not-for-profit membership organization for employers and healthcare stakeholders in Maryland, Washington, DC

Domain #7: Environmental Context for the Cost Containment Strategies	
containment strategies?	and Northern Virginia. The group represents over 500,000 lives.
Are there any individual employers that are driving cost control discussions and actions within the state?	No.
Does the state have a centralized agency or designated work group responsible for overseeing/driving health care cost strategies?	Yes. The Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) serve as the state's lead agencies in overseeing health care cost strategies. The MHCC is organized into four centers: • Center for Health Care Facilities Planning and Development, and the • Center for Quality Measurement and Reporting addresses cost, quality, and access in the state's health care system. • Center for Information Services and Analysis conducts broad studies using both Maryland databases and national surveys. • Center for Health Information and Innovative Care Delivery has broad responsibility for adoption of EHRs, enabling secure and private transfer of personal health information, and managing the Commission's Patient Centered Medical Home program. As described in Domain #1 the HSCRC is an independent state agency that publishes numerous reports on utilization and pricing of Maryland hospitals. *Source:* *For more information about the MHCC and its structure, click here.* *For more information about the HSCRC, click here.*
Has the state or any of its executive branch agencies adopted a formal cost control strategy or roadmap?	Yes. The agreement between Maryland and CMS is described as an historic 'roadmap.' *Source:* *Click here for Health Affairs article that discusses Maryland's historic "Triple Aim Roadmap."*
Does the state have any funding mechanism to support cost containment initiatives by unaffiliated providers such as	Yes, the HSCRC allocated $15 million in planning grants for regional partnerships for health system transformation. Together, DHMH and HSCRC released an RFP in early 2015 for funding to support planning, development initiatives, and plans for regional partnerships to support health system transformation. The agencies expressed interest in proposals that would establish care coordination and

Domain #7: Environmental Context for the Cost Containment Strategies	
independent primary care practices, small community hospitals or safety-net hospitals?	population health priorities, and identify resources available and needed, especially for high needs patients. The grants were designated for up to $400,000 each for five or more proposals. HSCRC reports that in 2014 and 2015, recognizing the need for seed funding to invest in best practices to improve care coordination activities, it increased most hospital's that are subject to the global budget revenue model rates by a total of 0.65%, for investments in infrastructure that promote the improvement of care delivery and reductions of potentially avoidable utilization. An additional 0.40% was provided in Fiscal Year 2016. • All hospitals are required to submit an annual Investment Report to HSCRC on investments they have made and will make to improve population health, and how effective these investments are in reducing potentially avoidable utilization and improving population health. *Sources:* *For more information about planning grants, click here.* *To read more about HSCRC's GBR report requirements, click here.*
Does the state have any resources and program initiatives to assist health care providers to increase quality and efficiency?	Yes, the state provided a learning collaborative for practices transforming under the state's MMPP model. In addition, the state provides technical assistance to providers in adopting health IT and EHRs as follows: • State designated management service organizations (MSOs) provides technical assistance to health care providers in their adoption and use of health information technology (health IT), including implementing electronic health records (EHRs), achieving meaningful use, reporting for quality initiatives, redesigning workflows, engaging in practice transformation, and facilitating patient engagement with health IT. *Sources:* *To read more about the Maryland Health Care Innovations Collaborative, click here.* *To read more about the state designated MSOs, click here.*

What has been the effectiveness of state strategies on cost control according to formal evaluation activity, including independent party evaluations and self-reported studies?	
Key Findings	**Summary and Citation**
1. <u>Inpatient and Outpatient Hospital Per Capita Cost Growth</u>. Under its agreement with CMS, Maryland must limit annual growth in all-payer hospital per capita revenue for Maryland residents to 3.58 percent. Maryland succeeded in doing so, with a growth rate of 1.47 percent between CYs 2013 and 2014, and 2.28 percent between CYs 2014 and 2015 (as of July). **2. <u>Aggregate Medicare Savings</u>. Under its agreement with CMS, Maryland must achieve an aggregate savings in Medicare spending of at least $330 million over the five years of the agreement. Initial data showed that Maryland is making progress toward this target based on analysis of HSCRC data showing that Medicare FFS per capita revenue decreased 1.12 percent between CY 2013 and 2014.** **3. Shifting from a per-case rate system to a global budget. Maryland exceeded CMS' target of shifting at least 80 percent of hospital revenue to global budgeting. In fact, Maryland has shifted 95 percent of hospital revenues into global budget structures.** **4. Reducing Readmission Rate for Medicare Beneficiaries. Maryland's readmission rate for Medicare beneficiaries is still higher than the national average.** **5. Reducing Hospital-Acquired Conditions (HACs). HSCRC measures HACs using 65 potentially preventable complications (PPCs). Maryland achieved a 35.66 percent reduction in all-payer case-mixed adjusted PPCs by June of CY2015.**	Effective January 2014, Maryland and CMS entered into a new agreement aimed at lowering per capita hospital expenditures and improving health outcomes. This biannual report is required by law and was prepared by the Health Services Cost Review Commission. The report provides a summary of implementation, monitoring and other activities. *<u>Source:</u>* *Click here to access the October 2015 report, Monitoring of Maryland's New Maryland All-Payer Model Biannual Report 2015.*
Key findings from the final evaluation of Maryland's MMPP program include the following: **1. The MMPP maintained providers' high satisfaction with their job, patient care, and positive perceptions of several**	In 2015, the Maryland Health Care Commission (MHCC) commissioned an independent evaluation of the Maryland Multi-Payor Patient Centered Medical Home Program pilot. The evaluation assessed the impact of the PCMH model on practice

What has been the effectiveness of state strategies on cost control according to formal evaluation activity, including independent party evaluations and self-reported studies?	
team-functioning measures, but program effects were mixed relative to change in non-MMPP (comparison) practices. **2. Patient surveys showed that at the end of the pilot period, more adult patients rated patient-provider communication highly than early in the pilot period. Respondents for children were highly satisfied with care. Findings showed some differences in patient experience ratings among patient subgroups, including lower scores on some measures for African Americans and the chronically ill. Other measures showed higher scores among the chronically ill and Medicaid populations.** **3. Chronic disease management of some ambulatory care sensitive conditions (ACSCs) improved and results indicated a reduction in emergency department visits and inpatient stays among Medicaid patients with these conditions.** **4. There was some evidence to suggest that the MMPP may have slowed growth of some inpatient and outpatient payments, especially among Medicaid patients.** **5. Disparities by practice location (small metro versus large metro area) were the most likely to be reduced by the MMPP.**	transformation, provider satisfaction, patient satisfaction, quality of care, costs of care, and health care disparities. *Source:* *For access to the evaluation, click here.*
The BlueCross BlueShield of Maryland reported on the following successes of its PCMH program, in the second year of the program. **1. Health care costs for 1 million CareFirst members covered by the program were $98 million less than anticipated, representing 2.7 percent savings on the total 2012 projected health care costs for PCMH members, and improvement on the 1.5 percent savings experienced in the prior year.** **2. Quality scores for PCMH panels increased by 9.3 percent**	A 2013 review of BCBS Maryland's CareFirst PCMH program found that expenses associated with the more than 1 million members served under the program were $98 million dollars lower than expected; quality improvements were also reported. *Source:* *To learn more about the early successes of the CareFirst PCMH program, click here.*

What has been the effectiveness of state strategies on cost control according to formal evaluation activity, including independent party evaluations and self-reported studies?	
from 2011 to 2012. **3. Panels that earned incentive awards (increased reimbursements based on practice panel savings and quality performance) received quality scores that were 3.7 percent higher than those received by panels who did not earn the incentives.**	