Final, 9/30/13

Public Engagement and Implementation of
Population-Based and Patient-Centered Payment Systems
HSCRC Charge to Advisory Council

Need. With the State's application currently under review by the Centers for Medicare & Medicaid Services (CMS) for a new all-payer model, the Health Services Cost Review Commission (HSCRC) is now planning for implementation. The proposed model grants Maryland broad discretion in regulating Medicare hospital revenue within a rigorous per capita expenditure limit under the existing statutory authority of the HSCRC. The proposed model builds on decades of innovation and equity in health care payment and delivery by modernizing our all payer rate setting system for hospital services. Our shared goal is a health care system that enhances patient care, improves health outcomes, and lowers costs.

The last several years have been financially difficult for hospitals not only because of a sharp decrease in annual updates, but also because of unforeseen factors that made planning for managing under these decreased updates more difficult. These factors have included decreasing hospital admissions from improved care models, increasing cost per admission, the federal sequester, and uncertainty about the future of the Medicare waiver. At the same time, the HSCRC has had to make some difficult policy choices, with some payers experiencing higher cost increases for outpatient care.

If CMS approves Maryland's application , HSCRC intends to deploy new hospital payment models that will give hospitals a more stable planning environment and more predictable revenues. If total annual revenue is determined at the beginning of the year, then a hospital that controls utilization frees resources to provide care in more patient-centered and flexible ways instead of losing revenue to utilization changes. The new models have enormous potential to improve the efficiency and effectiveness of care and the health of Marylanders, but they are also complex and will affect the interests of everyone with a stake in Maryland's healthcare system. The exact shape of the new payment models is not clear, but Maryland committed in its application to new model designs that are more global, population-based and person-centered. The Commission and the stakeholders face an unprecedented need to work together to make design of the new system and implementation of the transition successful. The pressure on hospitals, payers, and HSCRC staff and Commissioners to succeed will make trust and cooperation especially important. As a result, HSCRC's plan must be timely and accurate but must also be done in a way that enhances transparency and builds trust. As one part of its strategy, the HSCRC is convening an Advisory Council to provide guidance on design of the new system and Work Groups to provide advice on implementation.

Overview of Proposed Framework. The purpose of the Advisory Council is to provide a forum for discussion and debate among stakeholders that can generate solutions and, when consensus is not possible, identify issues for the Staff's information and the Commissioners' consideration for action. The purpose of the Work Groups is to provide expertise, particularly on the state of the art and the feasibility of possible solutions. The Council and Work Groups are as important for their potential to create an environment of openness and trust as for the specific content they consider and the specific advice they provide.

The purpose of this document is to describe how these groups will work together and with the Commission, and to propose the charge for the Advisory Council. The Advisory Council will need to begin its work immediately and the Work Groups will need to begin their work in the coming months.

The Advisory Council will provide broad input on the guiding principles for the HSCRC to consider in implementation of the new payment systems design. Work Groups will be convened on more specific topics and will provide advice on both interim policy decisions and more permanent policy changes. Before the Work Groups begin their policy discussions, the HSCRC will solicit expert data analyses and papers on several methodological issues and policy questions that will be provided to the Work Groups to support an informed process. The HSCRC Commissioners will be provided with copies of all analyses and papers received. In its charge to the Advisory Council and Work Groups, the HSCRC will lay out a timeframe for providing advice to the HSCRC and a process for routine updates and feedback between the Work Groups and HSCRC.

> ***Membership***: The size of the Advisory Council and Work Group membership should balance the need to gain input from a wide variety of stakeholders, yet support an effective working relationship among its members. The HSCRC Commissioners will appoint the members of the Advisory Council with input from the HSCRC staff. Appointments to the Work Groups will be made by the HSCRC staff, with alterations to workgroup composition to be made upon request of Commissioners. Membership may not be delegated to a substitute representative.
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> ***Consensus***: The Advisory Council and Work Groups should seek to find consensus on key issues. When consensus cannot be achieved, their reports to the HSCRC should reflect the different perspectives that were provided. The Advisory Council and Work Groups are not decision-making organizations; therefore, they will not be expected to vote on policy issues or implementation activities.
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> ***Leadership and Staff***: Staff or consulting experts will be designated to facilitate the meetings of Advisory Council and Work Groups. Experts will also be designated to support the deliberations of the groups as needed. These lead staff will actively

participate in the HSCRC project management team and provide routine updates to the HSCRC to ensure coordination with the HSCRC and among the groups.

Transparency (Public Meetings and Materials): The Advisory Council and Work Groups will convene in public meetings. Meeting dates and materials will be posted on-line on the HSCRC website. Meeting agendas should include presentations from knowledgeable individuals and experts on policy or methodological issues.

Work Groups are designed to provide structured input to the HSCRC on key implementation activities. The purpose of the Work Groups is to provide expertise, particularly on the state of the art and the feasibility of possible solutions. The charge for the Work Groups will be provided in a future document.

Project Management Team. The HSCRC staff will establish a Project Management Team and will engage project management resources. The lead staff for the Advisory Council and each of the Work Groups will actively participate in this team to coordinate the activities of the different groups. The Project Management Team will develop a project management plan to be shared with the Commissioners and manage data analyses that will support the Work Groups.

Bridge Process. The Advisory Council and Work Groups will be considering long-term changes to the payment system to meet the goals of the new model and adapt to the emerging delivery system changes underway and being introduced. In addition, a Bridge Process is needed to identify the short term changes necessary in the context of existing payment systems. The Bridge Process will be managed by the HSCRC staff Project Management Team, and recommendations will be made to the HSCRC. Ad hoc input will be sought from stakeholders to review the staff recommendations.

Staff will prepare hospital revenue models, settlements for preceding rate periods, application of policies under Maryland Hospital Acquired Conditions, Quality Based Reimbursement, Admissions and Readmissions Revenue, and Total Patient Revenue policies. In addition, staff will evaluate interim approaches for implementing the new model approach, effective January 2014, that will remain in place while more permanent approaches are developed. The staff will consult with experts, payers, providers, and Commissioners as it develops plans in a transparent manner to implement temporary payment models. Staff's plans and any required policy changes will follow existing processes and use the existing work group structure as it proceeds to implement the new model.

The Advisory Council

The Commission is forming the Advisory Council because it believes that the Council's input is essential for successful implementation of the new payment model. The Council will have such access to the Commissioners and the Commission staff as it requests, including regular reports

and joint meetings with the Commission. The Advisory Council needs to form and begin its work immediately, because the need to design the new payment system is so urgent.

Charge: The purpose of the Advisory Council is to provide the HSCRC with senior-level stakeholder input on guiding principles for the overall implementation of population-based and patient-centered payment systems. Implementing a new payment model and meeting the terms of the CMS demonstration will require the input and support of hospitals, payers, providers and other stakeholders, including patients and families.

Initial Work:

1. The initial meeting of the Advisory Council should be held as early in October 2013 as possible and should be a joint session with HSCRC Commissioners to review: the task of developing plans for the delivery system including the State Innovation Model; the new model approach introduced under the pending application with CMS; and the Advisory Council charge in detail.
2. The Advisory Council will provide a report to the HSCRC by January 27, 2014. In this report, the Council will propose guiding principles to the HSCRC. Preliminary reports should be provided to the HSCRC by November 25, 2013 and December 30, 2013. These reports should update the HSCRC on the Advisory Council's progress and identify areas of consensus. The Council should also select and prioritize tasks and issues to be addressed from the following list along with the issues included in the "HSCRC Statement of Implementation Guidelines," with the freedom to modify the list:
    - How can the payment models support a vision for Maryland's health care financing and delivery systems, including the ways in which the new models might work in tandem with other delivery reform initiatives in the State, such as the State Innovation Model, Primary Care Medical Homes, Accountable Care Organizations and other major initiatives?
    - How should implementation of the new payment models encourage the cooperation and alignment of the entire health care delivery system to meet the goals of the new all payer model and help prepare Maryland to submit a proposal to expand the model beyond hospitals before the fourth year of the Demonstration?
    - How should revenue allowances be adjusted in response to actual or anticipated volume changes, with specific attention to what types of volumes changes should be funded or discouraged? In particular, the Council should consider the question of how the rate setting system should accommodate volume changes resulting from changes in population, market share, new services, and new technology in the context of the opportunity to improve care and increase population-based efficiency of the health care system through reductions in potentially preventable hospitalizations for ambulatory sensitive conditions, unnecessary rehospitalizations, potentially avoidable complications, and volumes for practices that are not evidence-based?

- In what ways should capital costs be reflected in the new payment system within the overall revenue cap? What funding mechanisms and approaches can help redirect the focus to health improvement? How will hospitals participate in this change in focus?
- What value-based concepts should the HSCRC promote? What should be the scope and magnitude of financial incentives in the system, such as production efficiency, quality, outcomes, population health, cost per capita and cost per episode? What considerations should be made in developing methodologies, such as improvement vs. attainment, or benchmarks vs. relative performance?
- What principles should be applied when looking at services that can be performed in different settings--hospital, freestanding facility, and physician offices?
- To what extent and how should productivity improvement expectations be reflected in new payment methodologies?
- How should the payment system address revenue underages or overages both on an aggregate and a hospital-by-hospital basis? How should the payment system address underages, given the multiple potential contributing factors? How can the HSCRC create the right incentives?
- What changes in the dissemination of information on policies and performance should be made both on an aggregate, market area, and hospital-by-hospital basis to achieve necessary transparency?
- When and how should the HSCRC establish new efficiency and financial condition policies?
- When and how should we discuss funding mechanisms and approaches for medical education?
- What assessments should be funded, and how should they be handled going forward?
- Are there any key legislative or regulatory barriers that need to be addressed to ensure success?
- Are there other key issues that should be considered to make the implementation more successful?
- Are there other things that should be done to incentivize hospitals to make special efforts to reduce Medicare costs to increase the likelihood of compliance with the Medicare-specific test under the Demonstration's overall cap on revenue increases?

3. Provide a report by January 27, 2014, providing advice on the guiding principles for the implementation of new payment system(s).

4. The HSCRC reviews proposed guiding principles in a public meeting process; it receives and considers comments; and it modifies and adopts the guiding principles as deemed appropriate in a public meeting process consistent with applicable laws.

5. Based on this work, the Advisory Council, as directed by the HSCRC, may further change its priorities, deadlines, and intensity of work.

6. The Advisory Council should review the interim and final reports of the work groups and provide comments to the HSCRC.