HSCRC Implementation of
Population-Based and Patient-Centered Payment Systems
Workgroup Descriptions

January 13, 2014

The Health Services Cost Review Commission (HSCRC) is establishing workgroups to support the implementation of the new Population-Based and Patient-Centered Payment Systems. The workgroups are designed to provide structured input to the HSCRC on key implementation activities, lending expertise on the state of the art and the feasibility of possible solutions. The workgroups will build on the work of the Advisory Council, which the HSCRC convened in November, 2013 to provide recommendations on the guiding principles for implementation, the priorities for implementation phasing, and issues that should be addressed by workgroups. The Advisory Council is still finalizing its work; however, clear consensus seems to be emerging that the HSCRC should focus on the most immediate tasks for implementation of the new model, meeting the significant requirements for containing increases in Medicare and All-Payer costs, and meeting requirements for improved care delivery and quality.

The HSCRC staff has developed a focused set of tasks, described below, for each of the workgroups. The majority of these tasks are the work that the HSCRC needs to address by July, 2014. There will be a need for continued input on implementation activities and the HSCRC will ask each workgroup to make recommendations on the issues that should be taken up by workgroups during the next phase of implementation activities. The HSCRC is requesting a report from each workgroup by July, 2014. The workgroups should make recommendations to the extent that they can in their July report and may also identify topics that are still works in progress. There are interim deliverables that will be needed before July to support the HSCRC's decisions for July rate orders. The HSCRC staff will work with each workgroup to establish a work plan that provides the HSCRC with input and guidance at different decision points for the HSCRC in the next six months and develops a work plan for the following six months. Many of these interim deadlines identified in this document include aggressive timelines, and the HSCRC staff and the Commission recognize that some dates may change as the workgroups get underway and the work plans for the Commission and the workgroups evolve. There is some overlap in the topics that the workgroups will address necessitating coordination, which may occur through strategies such as joint meetings, small subgroup meetings or coordination at the staff level.

The deliverables below are generally listed in order of priority, subject to input from the work groups.

Payment Models. In general, this workgroup will develop recommendations for the HSCRC on the structure of payment models and how to balance its approach to updates.

1. Balanced Updates: Recommendations for how the HSCRC should change its historic approach to annual updates, including what factors should be considered (weighting inflation, different types of volume and trends including demographic trends), innovation, capital and new services, efficiency, variable cost concepts, the "spread" between update factors for global budgets and fee-for-service budgets, the methodology used for Uncompensated Care given the significant changes in insurance coverage expected with health reform implementation, the timing of updates and the magnitude of revenue that is put at risk for meeting value-based performance goals, the use of positive incentives for quality and care improvement, and other adjustments to transitional policies adopted by HSCRC. **Recommendations on this topic are due to the HSCRC by April, 2014**.

2. Guardrails for Model Performance: Recommendations on whether there are certain performance targets the HSCRC should establish that, if not met, would trigger a policy change, mid-year course correction or other corrective action, including whether guardrails should be developed at the hospital, region, and/or state level. **Recommendations on this topic are due to the HSCRC by July, 2014**.

3. Market share: Recommendations on how the HSCRC should incorporate market share adjustments into payment and the timing of adjustments. **Initial recommendations on this topic are due by July, 2014**.

4. Initial and Future Models: Recommendations on how and when the HSCRC should evolve beyond the Global Payment Models that are expected to be in place for many hospitals, effective as of January, 2014. Considerations should begin to account for the Phase 2 application requirement in 2016 focused on the total cost of care, the role of episodes of care, physician alignment, post- acute care, and population health concepts. Advice should also be given on the use of population-based concepts with regard to assignment of accountability and accounting for market share in model development, and incorporating patient-centered concepts through payment incentives. **Initial strategic recommendations on this topic are due after July, 2014, with detail design work to follow**.

Physician Alignment & Engagement. In general, this workgroup will make recommendations on how the new hospital payment models should align and engage with physicians and other health care providers in partnership with patients to achieve the goals of the new model.

1. Alignment with Emerging Physician Models: identification of current physician payment models as background and a foundation for recommendations on shared savings, and informing the Payment Models workgroup. The report should include a discussion of payment models and hospital/physician payment arrangements for different types of physicians (employed, community, primary care, specialty), and under different physician engagement scenarios, such as Accountable Care Organizations (ACO), Patient-Centered Medical Home (PCMH), and any other existing alignment programs. The report should discuss new Medicare Value Based

Payments for physicians and role (if any) in model development. **The report on this topic is due by May, 2014**.

2. Shared Savings: Recommendations on how hospitals and physicians can create aligned incentive models on an All-Payer basis to share savings, such as through creating gain sharing or pay-for-performance structures, bundled payments, including relationship to ACO, PCMH, and Medicare fee-for-service models. Recommendations on developing standard approaches, accounting for unduplicated savings, and pursuing federal waivers and exemptions relative to operation of these models where necessary. **Initial recommendations are due by May, 2014**.

3. Care Improvement: Recommendations on the need for a multi-stakeholder campaign to support care improvement and the extent to which existing efforts could be leveraged to support the goals of the new All-Payer Model and enhance overall efficiency. The recommendations should address the role for the HSCRC in convening stakeholders, encouraging standardization and facilitating the acquisition and use of data, and how the HSCRC role should be coordinated among State agencies and other stakeholders. Recommendations on care improvement should address the following topics:

    a. Care Coordination Opportunities: Opportunities to improve quality and reduce costs by planning and coordinating for the needs of high risk patients. Consider the relationship to initiatives supported by the Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) funding. **Initial recommendations are due by July, 2014**.

    b. Post-Acute and Long-Term Care: Opportunities to facilitate the creation of aligned incentives for hospitals, physicians, and other providers to provide well-coordinated post-acute and long-term care, improve care transitions and reduce readmissions in Skilled Nursing Facilities and other long term care settings, including the need for models and incentives that require federal approval**. Initial recommendations are due by July, 2014**.

    c. Evidence-Based Care: How to identify opportunities, accelerate the introduction, and align incentives to improve care and lower costs using evidence based practices. **Recommendations on this topic will be due to the HSCRC after July, 2014**.

Performance Measurement. In general, this workgroup will develop recommendations for the HSCRC on measures that are reliable, informative, and practical for assessing a number of important issues. The Payment Models workgroup will design the overall structure through which the results of these measures are applied to payment updates and rate orders. The topics are listed in priority order that reflect a combination of program impact and how fast work can be completed, given the state of the art.

1. Reducing potentially avoidable utilization to achieve the Three-Part Aim: Recommendations on measuring volume of services that could be avoided and establishing incentives to improve patient care and reduce health care costs. **Initial recommendations are due by the end of February, 2014 to facilitate the efforts of the Payment Models workgroup**. The recommendations should address the following topics:

    a. Development of Statewide Targets and Hospital Performance Measurement: Recommendations on establishing statewide targets for readmissions and potentially preventable conditions and how to achieve these targets through hospital performance measurement. The new All-Payer Model requires reductions in Medicare readmissions to national levels within five (5) years and a thirty percent (30%) reduction in Maryland Hospital Acquired Conditions (MHACs). It also requires that the combination of value-based purchasing programs for Maryland put comparable revenues at risk to the national Medicare programs. The workgroup should initially focus on Calendar Year 2014 targets and their relationship to the MHAC, Quality Based reimbursement (QBR), and readmissions revenue at risk and incentive programs for FY 2015.

    b. Measuring potentially avoidable utilization: Recommendations on developing a comprehensive set of measures for volume of services that could be avoided with benefit to patients and health care costs. The initial set of measures under consideration includes hospital acquired conditions (safety issues), readmissions and re-hospitalizations (care planning and coordination), ambulatory sensitive conditions (effective primary care), and care coordination for high needs patients (identification and planning of care). Beyond the July timeframe, the workgroup should make recommendations for evaluation of other opportunities for focus, such as use of emergency room, practice variation, studies and tests that are needlessly duplicated (information systems) or not evidence based, and other identifiable opportunities.

2. Value-based payment (integration of cost, quality, population health and outcomes): Recommendations on what specific measures of cost, care and health should be considered for adoption, retention or development in order to evaluate and incentivize the population-based All-Payer Model. This measurement and payment approach relates to the policy objectives of establishing payment levels that are reasonably related to the cost of providing services on an efficient basis and in accordance with the value concepts embodied in the new All-Payer Model. Recommendations should consider both the evidence supporting the approach and the improvement in health likely to result. Recommendations on whether or not access to hospital-based care should be measured and monitored. The aim should focus on ensuring that Maryland's approaches exceed those being developed by CMS while focusing on the opportunities of the All-Payer Model and recognizing its fundamental differences from the national

Medicare fee-for-service program. **Initial strategy recommendations are due by July, 2014 with detail design work to follow**.

3. Patient Experience and Patient-Centered Outcomes: Recommendations on integrating patient-centered concepts in the performance measurement work as well as the measures used, including, but not limited to, patient perspective measures, whether gathered through CAHPS-type instruments or in other ways, and outcome measures that are valued by patients to improve efficiency, effectiveness, and outcomes of care. **Initial recommendations are due by July, 2014**.

Data and Infrastructure. In general, this workgroup will develop 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. Recommendations should take into consideration the needs of the HSCRC, as well as the needs for the health care industry and other stakeholders to achieve the goals of the model. This workgroup should work in careful collaboration with other state agencies and other stakeholders to build upon the available resources and existing models for data governance.

1. Data Requirements: Recommendations on the data needed to: support rate setting activities; conduct evaluation activities using the key performance indicators; monitor and evaluate model performance; monitor shifts in care among hospitals and other providers; and, monitor the total cost of care. The recommendations should also consider the need for patient-centered, timely and hospital-specific data needs as well as identification of reliable sources outside of the HSCRC, including the All-Payer Claims Database, data available through the Chesapeake Regional Information Systems for Patients (CRISP) or other sources that could support the new payment model**. Initial recommendations are due by April, 2014**.

2. Care Coordination Data and Infrastructure: Recommendations on the potential opportunities to use Medicare data to support care coordination initiatives, including: identifying the gaps in Medicare data; the best practices in predictive modeling and targeting care coordination resources; the most efficient infrastructure to support the needs of the state, hospitals, and other health care providers to meet the goals of the new model; and the relationship to initiatives supported by CMMI SIM funding. **Initial recommendations are due by May, 2014**.

3. Technical and Staff Infrastructure: Recommendations on the technical infrastructure, staff resources and external resources needed to build, maintain and optimize the use of the data. **Initial recommendations are due by July, 2014**.

4. Data Sharing Strategy: Recommendations on the data that should be shared among the HSCRC, MHCC, SIM, DHMH, hospitals and others to manage and implement the new payment models, including the data sharing strategy to ensure protection of patient confidentiality and compliance with federal and state requirements and best practices. **Recommendations are due by July, 2014**.