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To: Chief Financial Officers—Acute Hospitals

From: Alyson Schuster, Associate Director – Performance Measurement

Date: February 9, 2015

Re: Reporting Requirements for Global Budget Revenue Infrastructure Investments

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At the November 2014 Commission meeting, staff described the new reporting requirements for investments in infrastructure as recommended by the payment models subgroup. The requirement to report on population health infrastructure investments is included in each GBR contract and will be required for TPR hospitals as well. The final reporting requirements will be promulgated in Commission regulation.

The purpose of this memorandum is to notify hospitals of these new reporting requirements. While FY2014 and FY2015 reports will be due within 90 days after the end of FY2015, any hospital requesting an increase in global budgets or relief from rate corridors will be required to submit an interim report.

Attached you will find the subgroup report on the purpose and types of expenses to report, as well as reporting instructions. In addition, a draft excel workbook is available for hospitals (final reporting will be through an electronic format under development).

If you have any questions, please feel free to contact Alyson Schuster at 410-764-2673.

Global Budget Revenue (GBR) Reporting on Investment in Infrastructure

Background

The Health Services Cost Review Commission's (HSCRC) global budget revenue contracts state:

> *The Hospital shall provide an annual report of its investment in infrastructure to promote the improvement of care delivery and reductions of Potentially Avoidable Utilization. This report will be due 90 days following the end of each fiscal year, and will include program descriptions, expenditures, and results.*

This is required by the GBR contracts so that the HSCRC can understand the total investments that hospitals are making in care coordination and population health improvement given the additional revenue included in the base approved regulated revenue for GBR infrastructure investments. This is important for maximizing the potential for success under global budgets and to reduce potentially avoidable utilization, improve care coordination, and improve population health.

Purpose of Report

The purpose of this report is to inform the HSCRC and other stakeholders, including the Center for Medicaid and Medicare Services (CMS), on the amounts and types of investments all acute hospitals in Maryland are making over time to improve population health, and how effective these investments are in reducing potentially avoidable utilization and improving population health. The report may be used to increase global budgets or provide relief from rate corridors. The purpose of this report is not to determine whether a hospital spent the full amount of additional funds provided in the global budgets, nor is it intended to limit what hospitals report as their actual infrastructure investment to the amount of the GBR additional funds. The HSCRC staff also recognizes that some hospitals that signed GBR agreements late in FY2014 may not have spent the additional funds during FY2014. However, the commission is requesting hospitals to report on FY2014 investments in population health so that changes in spending overtime can be monitored and linked with outcomes. The HSCRC staff will work to try to make sure there is clarity between this reporting and other GBR and community benefits reporting, as well as work to see if this reporting can be incorporated into other reporting. The report will be available for any interested stakeholder.

Guiding Principles

1. Final fiscal year (FY) 2014 and FY2015 reports will be submitted together and be due 90 days after the end of FY2015. This will ensure hospitals have guidance on the types of investments to report and sufficient time to collect and report the data. However interim reports may be submitted to the HSCRC for feedback and will be required for any hospitals seeking increases in global budgets or relief from rate corridors.

2. Qualifying GBR investments reported by hospitals will be for new programs or technologies, or major expansions in existing programs or technologies, directly related to GBR incentives to achieve the triple aim and improve care coordination and population health. The reported investments are not limited to only those that were made with the additional GBR funding for infrastructure, but rather all major population health investments.
3. GBR investments included in the report should be broad in scope and have the potential to impact population health within the communities that each hospital serves.
4. GBR investments included in the report should be data driven and can be evaluated using measurable outcomes.
5. The HSCRC will review requests to include expenses associated with unique programs that do not specifically fall into the types of expenses listed below.
6. Reporting of GBR investments is important for educating CMS and other stakeholders on the new waiver model activities and results.

Types of Expenses to improve care delivery and population health, and reduce potentially avoidable utilization

Included expenses:

Patient centered interventions such as:

- Case management, care coordination, transitional care, and chronic disease management.
- Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center).
- Making/verifying post-discharge appointments.
- Reminding patients of physician appointments, lab tests or other appropriate contact with specific providers.
- Medication and care compliance initiatives, such as checking that the patient is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the patients in the management program to effectively monitor compliance, including expenses for transportation or prescription medications for patients who cannot afford them,
- Programs to support shared decision making with patients, their families and the patient's representatives.
- Programs to support patient education and self-management, including public education campaigns directing people to appropriate sites of care.

ii) Provider/care team interventions such as

- Providing coaching or other support to encourage compliance with evidence based medicine.
- Activities to identify and encourage evidence based medicine (e.g., incorporating Choosing Wisely information into decision making algorithms).

- Infrastructure to set up pay-for-performance or shared savings models with providers including legal expenses for vetting P4P programs and infrastructure for gain-sharing.
- Seed funding and/or subsidies to recruit and retain primary care or other providers required to fill critical gaps in community health infrastructure and ensure continued access to care for certain health conditions (e.g., diabetes clinics) or populations (e.g., Medicaid).
- Activities to support effective collaborations between hospitals and other community providers.

iii) Health information technology expenses to support patient centered and provider/care team interventions including:

- Data extraction, surveillance, analysis and transmission in support of the activities described above.
- Predictive models or other mechanisms for identifying and stratifying patients for care coordination interventions, as well as expenses to create, document, execute, and update care plans.

<u>Excluded expenses:</u>

- Electronic health records or patient hotlines or portals that are used for care delivery and communication unless specifically implementing systems or modules for care coordination activities (e.g., electronic health record module for care manager to record activities or patient portal for contacting care manager).
- Billable services.
- Investments to improve coding or documentation, including upgrades to systems to be complaint with regulatory changes such as ICD-10.
- All retrospective and concurrent utilization review.
- Fraud prevention activities.
- Any expenses for acquiring physicians that do not clearly increase access to primary care or other healthcare services (i.e., expenses for acquiring existing physicians that does not result in any change in access but simply results in the existing physicians being owned by the hospital).
- Any expenses that are primarily for marketing purposes.
- Accreditation fees.
- Financial rewards to providers (e.g., pay-for-performance incentives).
- All other expenses that do not fall under care coordination and population health.

Reporting Instructions

Each hospital will be required to submit an individual hospital report using the HSCRC provided template. Any health system investments that impact multiple hospitals should be reported on each hospital report with the hospital-specific expenditures allocated. Hospitals do not need to report each expense as a separate investment, but rather they can report the investments made for specific programs designed to reduce PAU and improve population health by each investment category below.

The HSCRC will provide a GBR infrastructure investments excel template (see Appendix A). In Tab 1 of the excel template provided by the HSCRC, hospitals are asked to provide a brief narrative summary of all of their investments in population health. Then Tab 2 will be copied and sequentially numbered for hospitals to report information on each type of investment/initiative. For each type of investment, the hospitals should provide the following information using the excel template provided by the Commission (see Appendix B for examples):

1. **Investment Number:** Consecutively number each investment reported. Copy and paste the investment tab and add numbers to the tab name.
2. **Hospital Name**
3. **Investment Category:** 1. Patient centered investment; 2. Provider/care team investment; 3. Health information technology to support patient and/or provider investment.
4. **Investment Brief Description, including rationale for investment and primary objective:** Limit to 300 words or less. You can provide supplementary program descriptions if you deem necessary.
5. **Target population:** Population of patients who will benefit from the investment. If it is a provider or health information technology investment it should still be targeted to benefit a patient population.
6. **Total Expenses:** What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.
7. **Of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?**
8. **Is investment in regulated, unregulated space, or both?**
9. **Planning Start Date (Month/Year):** Date when planning for a program or initiative began.
10. **Hospital Start Date (Month/Year):** Date when the program or initiative went live.
11. **Type of staff** associated with the investment/initiative (e.g., Registered Nurse, community health worker, data analyst, IT programmer, physician, hospital management).
12. **Total annual FTEs** required for the development and implementation of an investment.
13. **External partners** in development/implementation (e.g., skilled nursing facilities, physician practices, external case managers, retail pharmacies).
14. **Links with existing statewide or regional infrastructure or initiatives** (e.g., such as Local Health Improvement Coalitions, Chesapeake Regional Information System for Patients, Department of Aging, local health departments, other social services).
15. **Outcomes or Proposed Outcome Measures:** What were the results of the initiative/investment in improving care delivery, population health, and reducing PAU? Outcomes can include quality indicators, care improvement indicators, return on investment, as well as health improvement outcomes. If outcomes are not yet available, then please provide proposed outcome measures.
16. **Effectiveness of investment in achieving goals.** Including discussion of any barriers or lessons learned?
17. **Additional Comments**

Appendix A: GBR Investments in Infrastructure Template

Tab 1: Overview

Hospital:		**Number of Investments Reported:**	
Date of Submission:		**Total Investments ($)**	
Health System Affliation:			
Narrative Summary on GBR Investments in Population Health:			

Tab 2: Investment #X

1	**Investment Number**	
2	**Hospital Name**	
3	**Investment Category (click in cell to select from drop down)**	
4	**Investment Brief Description, including rationale and primary objective**	
5	**Target Patient Population**	
6	**Total Expenses**	
7	**Total costs covered by restricted grant or donation?**	
8	**Is investment in regulated, unregulated space, or both?**	
9	**Planning Start Date (Month/Year)**	
10	**Hospital Start (Month/Year)**	
11	**Types of Staff**	
12	**Total Annual FTEs**	
13	**External Partners**	
14	**Links with existing state-wide or regional infrastructure**	
15	**Outcome(s) or Proposed Outcome Measures**	
16	**Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned**	
17	**Additional Comments**	

Appendix B: GBR Investments in Infrastructure Reporting Examples

Example 1

1	**Investment Number**	Example 1
2	**Hospital Name**	Hospital A
3	**Investment Category (click in cell to select from drop down)**	Health information technology to support patient or provider investment
4	**Investment Brief Description, including rationale and primary objective**	Population Health analytics data system utilized to mine claims and other data for high risk patients that require care coordination for improving ambulatory care and self management, as well as interventions focused upon educating providers as to where their costs lie. Both of these interventions are targeted at informing decisions aimed at decreasing PAU.
5	**Target Patient Population**	High Risk for increased utilization patients
6	**Total Expenses**	$325,000/year
7	**Total costs covered by restricted grant or donation?**	$0
8	**Is investment in regulated, unregulated space, or both?**	Investment functions in both
9	**Planning Start Date (Month/Year)**	13-Aug
10	**Hospital Start (Month/Year)**	14-Apr
11	**Types of Staff**	IT Analysts, ACO Director
12	**Total Annual FTEs**	2.1
13	**Partners**	CRISP
14	**Links with existing state-wide or regional infrastructure**	CRISP
15	**Outcome(s) or Proposed Outcome Measures**	Monitoring number of patients referred to care management; Cost of care pre and post care management
16	**Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned**	program. While internal hospital data can be of use in targeting patients for readmissions, etc, a wider scope of data is required for managing the patients who do not reach an inpatient facility but could at any time. In order to manage these patients well, a system that pulls data form outside the facility must be utilized.
17	**Additional Comments**	

Example 2

1	**Investment Number**	Example 2
2	**Hospital Name**	Hospital B
3	**Investment Category (click in cell to select from drop down)**	Patient centered investment
4	**Investment Brief Description, including rationale and primary objective**	We have off-site substance abuse programs that have patients with chronic medical conditions who are not receiving primary care. We hired a nurse practitioner with a behavioral health and substance abuse background to go to the off-site locations to provide basic primary care at the clinics and coordinate the transition of the patient to our Primary Care Medical Home. Our goal is to improve the health of these patients by hardwiring the care coordination between our off-site substance abuse clinics and Primary Care Medical Home. We are also utilizing CRISP alerts to help coordinate with other providers.
5	**Target Patient Population**	Substance abuse patients with chronic medical conditions.
6	**Total Expenses**	$123,000
7	**Total costs covered by restricted grant or donation?**	$0
8	**Is investment in regulated, unregulated space, or both?**	Both
9	**Planning Start Date (Month/Year)**	14-Apr
10	**Hospital Start (Month/Year)**	14-Aug
11	**Types of Staff**	Nurse Practitioner
12	**Total Annual FTEs**	1.0
13	**External Partners**	CRISP and external providers identified through CRISP
14	**Links with existing state-wide or regional infrastructure**	CRISP
15	**Outcome(s) or Proposed Outcome Measures**	Decrease in PAU metrics for this patient population.
16	**Effectiveness of Investment in Achieving goals, including discussion of any barriers or lessons learned**	The program has been live for less than 60 days. Initial results are not available yet.
17	**Additional Comments**	