All Payer Hospital System Modernization
Payment Models Workgroup

Meeting Agenda

June 30, 2016
9:30 am to 11:30 am
Health Services Cost Review Commission
Conference Room 100
4160 Patterson Avenue
Baltimore, MD 21215

I. Introductions and Meeting Overview

II. Psych/ Mt. Washington Update Amount

III. Measuring Success
- Final Recommendation
- Cost Trends
- Performance Measurement Dashboards

IV. Update on Access to Medicare Data

V. GBR Agreement Update
- TPR Hospital Agreements

VI. Market Shift Adjustment Update

VII. Commission Meeting Schedule Update
- Draft Jobs Program
- Draft Psych and Mt. Washington Update

ALL MEETING MATERIALS ARE AVAILABLE AT THE MARYLAND ALL-PAYER HOSPITAL SYSTEM MODERNIZATION TAB AT HSCRC.MARYLAND.GOV#

REVISED RECOMMENDATIONS FOR RY 2017 BALANCED UPDATE

The final recommendation for psychiatric hospitals and Mt. Washington Pediatrics is as follows and is offered conditioned on the adoption by the Commission of other policy recommendations of staff that affect the overall targets.

1. Release the productivity adjustment of 0.50 percent. This results in a new net amount of 2.05 percent, which can be reviewed in the chart below.

	Psych & Mt. Washington Revenues
Proposed Base Update	2.80%
ACA Adjustment	-0.75%
Proposed Update	2.05%

2. In addition to receiving a higher update amount, these hospitals must agree to the following:
    a. HSCRC staff will begin to implement quality measures and value based programs for psychiatric facilities/beds beginning in RY18. In order to successfully capture appropriate metrics, staff requests the following from the hospitals:
        i. Work with HSCRC staff to compile a list of Potentially Avoidable Utilization metrics and readmissions reduction targets. These may include measures to reduce high risk Medicare readmissions by ensuring satisfactory discharge plans and availability of outpatient services;
            a. Partner with community-based mental health services to improve care coordination and reduce potentially avoidable utilization;
            b. Improve access to community-based mental health services;
        ii. Work with CRISP, HSCRC, and MHA to obtain available information to support monitoring and implementation efforts;
        iii. Work with CRISP, HSCRC, and CMMI to obtain data for care redesign activities as soon as it is available;
        iv. Monitor the growth in Medicare's total cost of care and total hospital cost of care for its service area;
        v. Implement programs focused on complex and high needs patients with multiple chronic conditions, initially focusing on Medicare patients;

vi. Work with CRISP to exchange information regarding care coordination resources aimed at reducing duplication of resources, ensuring more person-centered approaches, and bringing additional information to the point of care for the benefit of patients and

vii. Increase efforts to work in partnership with physicians, post-acute and long term facilities, and providers to create aligned approaches and incentives to improve care, health, and reduce avoidable utilization for the benefit of patients. Work with physicians with the goal of developing and enhancing value-based approaches that are applied under MACRA.

DRAFT FOR DISCUSSION

REVISED RECOMMENDATIONS FOR RY 2017 BALANCED UPDATE

Update Requirement	Aim	Requirements/Measures
Agree to Mid-Year target that is .56% lower than annual target.	Ensure charges are lower in CY 2016 and that progress is being made	Amend GBR Agreement to add Penalties for overcharges on mid-year targets
Monitor the growth in Medicare's total cost of care and total hospital cost of care for its service area;	Reduce growth in Medicare's costs	Review monthly reports from HSCRC/CRISP for service area Prepare and review monthly hospital reports for Medicare charge growth and Medicare ECMAD growth, compared to the prior year, removing overcharges from the prior year Target growth rate lower than 0% Medicare charge growth for CY 2016 over CY 2015. December was low in CY 2015, so need to build cushion.

Update Requirement	Aim	Requirements/Measurements
Work with CRISP, HSCRC, and MHA to obtain available information to support monitoring and implementation efforts;	Gain access to LDS files and to plan and implement care interventions and monitor results	File letter of intent to evaluate participation in care redesign amendment There are public use files already available
Work with CRISP, HSCRC, and CMMI to obtain data for care redesign activities as soon as it is available;	Gain access to claims level detail data for care redesign—risk stratification, claims level monitoring, etc.	Participate in one or more aspects of care redesign amendment. No requirement to participate in gainsharing—this is optional
Monitor the hospital's performance on PAUs for both Medicare and All Payers.	Reduce PAUs to achieve better care and AIM of demonstration Year over year declining percentages of PAU.	Include current definitions + also include all medical admissions through ER

Update Requirement	Aim	Requirements/Measurements
Implement programs focused on complex and high needs patients with multiple chronic conditions, initially focusing on Medicare patients;	Implement programs for ~ 25,000 high risk and 80,000 rising risk Medicare beneficiaries Patients are receiving better system supports, admissions and ER visits are reduced	Select complex and high needs patients for ongoing care management and other interventions • Start with complex, using PaTH or other resources (25,000 benes) • Use Medicare claims data, EMRs and other resources to enhance selection processes Count patients with health risk assessment, care plan, and assigned care manager that have been reported to CRISP
Work with CRISP to exchange information regarding care coordination resources aimed at reducing duplication of resources, ensuring more person centered approaches, and bringing additional information to bear at the point of care for the benefit of patients	Ensure beneficiaries do not have duplicate resources and that MACRA requirements for electronic health records and information exchange are being met Person centered care	Populate care plans, care overviews, consents, health risk assessments, and assigned case managers Work with CRISP to identify any duplication and inter-hospital reconciliation process Continue work with regional partners to develop approaches to eliminate duplication and ensure person centeredness Sign amendment to GBR agreement that meets MACRA specifications (see below)

Update Requirement	Aim	Requirements/Measurements
Increase efforts to work in partnership with physicians, post-acute and long term facilities, and other providers to create aligned approaches and incentives to improve care, health, and reduce avoidable utilization for the benefit of patients. Work with physicians with the goal of developing and enhancing value based approaches that are applied under MACRA (Medicare Access and CHIP Reauthorization Act of 2015);	Reducing avoidable admissions from assisted living and long term care, readmissions from SNF, and SNF LOS Reducing avoidable hospitalizations with primary care and other community providers	Work with MHA, HSCRC, and non-hospital partners to specify priority programs for CY 17, CY 18, etc.
Participate in the All Payer Model progression planning efforts	Evaluate approaches and make recommendations to progress toward increased capability to take on additional responsibilities -Help develop models around medical homes, ACOs, geographic models	Work with DHMH, HSCRC, and MHCC in planning progression

1. The Commission should continue to closely monitor performance targets for Medicare, including Medicare's growth in Total Cost of Care and Hospital Cost of Care per beneficiary. As always, the Commission has the authority to adjust rates as it deems necessary, consistent with the All Payer Model.

    a. Targets should be monitored both state-wide and on a hospital specific level.

    b. If corrections become necessary, the Commission should consider whether to make the corrections based on hospital specific performance.

HSCRC WILL WORK TO PRODUCE MONITORING OF PROGRESS ON REDUCING PAUS AS WELL AS ADMISSIONS AND ER VISITS FOR MEDICARE PATIENTS AND HOSPITAL AND TCOC IN COUNTIES AND SERVICE AREAS. MIMIMUM TARGETS IN THE TESTS ARE FOR DETERMINING FAILURE. THE ALL PAYER MODEL AIMS TO DEMONSTRATE THAT WE CAN REDUCE AVOIDABLE UTILIZATION AND IMPROVE CARE FASTER THAN THE NATION. ASPIRATIONAL TARGETS WILL REACH COST GOALS.

2. In order to receive the full update for FY 18, hospitals will need to reduce Potentially Avoidable Utilization and any excess increases in Medicare's non-hospital costs resulting from implementation and will need to be at least offset by reductions in Medicare's hospital costs.

WITH CONCENTRATED INCREASE IN JANUARY THROUGH JUNE, THIS WILL ADD PERFORMANCE CHALLENGES FOR CY 17. HOSPITALS HAVE ARGUED THAT ADDITIONAL TIME WILL YIELD REDUCTIONS IN MEDICARE UTILIZATION AND COST. IF THIS DOES NOT HAPPEN, CY 18 RATES WILL NEED TO BE CONSTRAINED.

This will be included in a GBR amendment for MACRA to include EHR requirements:

CEHRT (Certified Electronic Health Record Technology)

Hospital and any Care Redesign Participants must:

Use CEHRT to document and/or communicate clinical care to their patients or other health care providers.

(pg 738, §414.1415 Advanced APM criteria)

Hospital has CEHRT technology implemented.

MIPS eligible clinician reports clinical quality measures (CQMs) using certified EHR technology under the quality performance category (pg 195, Section 1848(o)(2)(A)(iii)). For 2017, MIPS eligible clinicians would be able to use EHR technology certified to either the 2014 or 2015 Edition certification criteria (pg 200)

Attestation requirements related to health information exchange and information blocking from all eligible clinicians under the advancing care information performance category of MIPS, including eligible clinicians who report on the advancing care information performance category as part of an APM Entity group under the APM Scoring Standard (an EP, eligible hospital, or CAH under the Medicare and Medicaid EHR Incentive Programs) must attest to this three-part attestation (pg 43 – 44)

1. did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology
2. that it implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times: connected in accordance with applicable law; compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170; implemented in a manner that allowed for timely access by patients to their electronic health information; (including the ability to view, download, and transmit this information) and implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 USC 300jj(3)), including unaffiliated providers, and with disparate certified EHR technology and vendors
3. responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 USC 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor

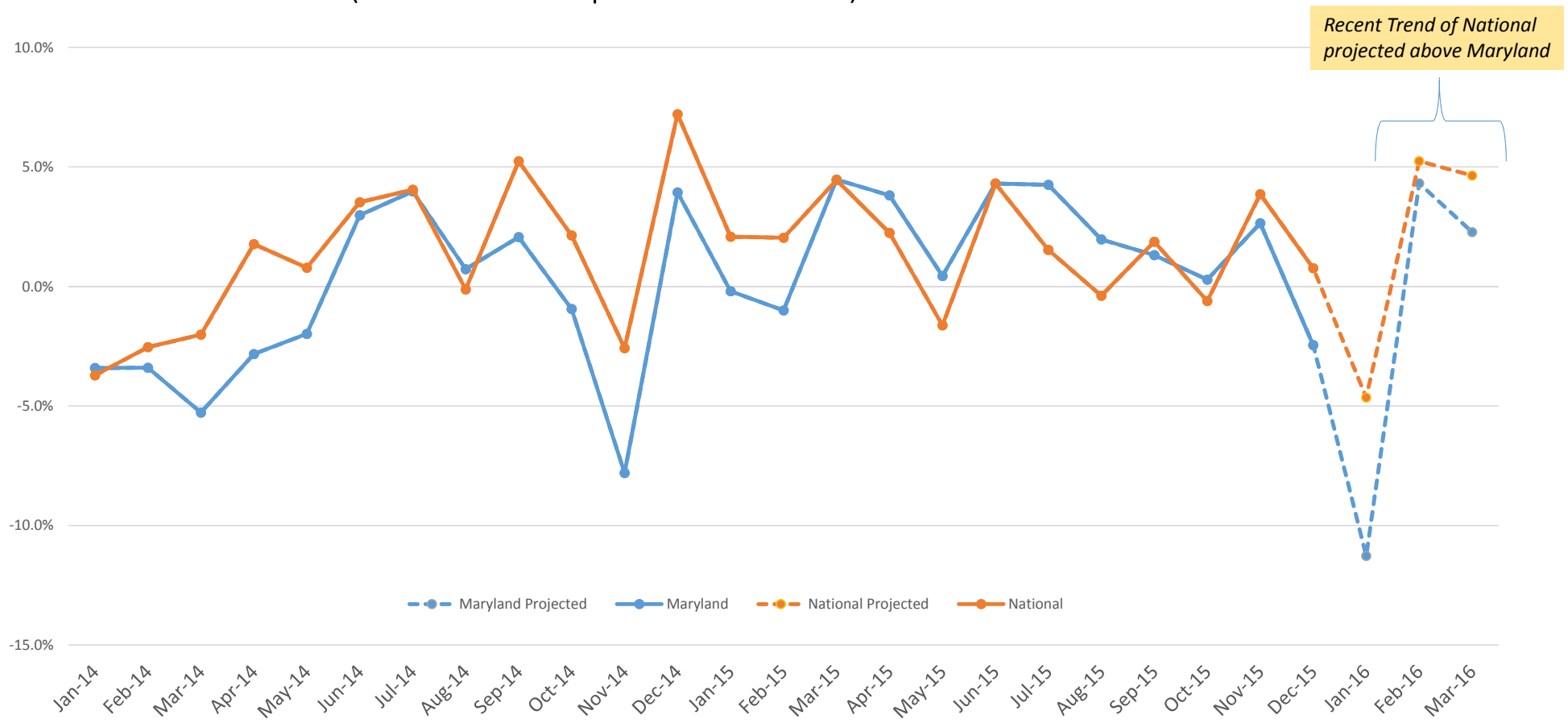
Hospital & TCOC Spending per Beneficiary

Disclaimer

Data contained in this document represent analyses prepared by MHA and HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

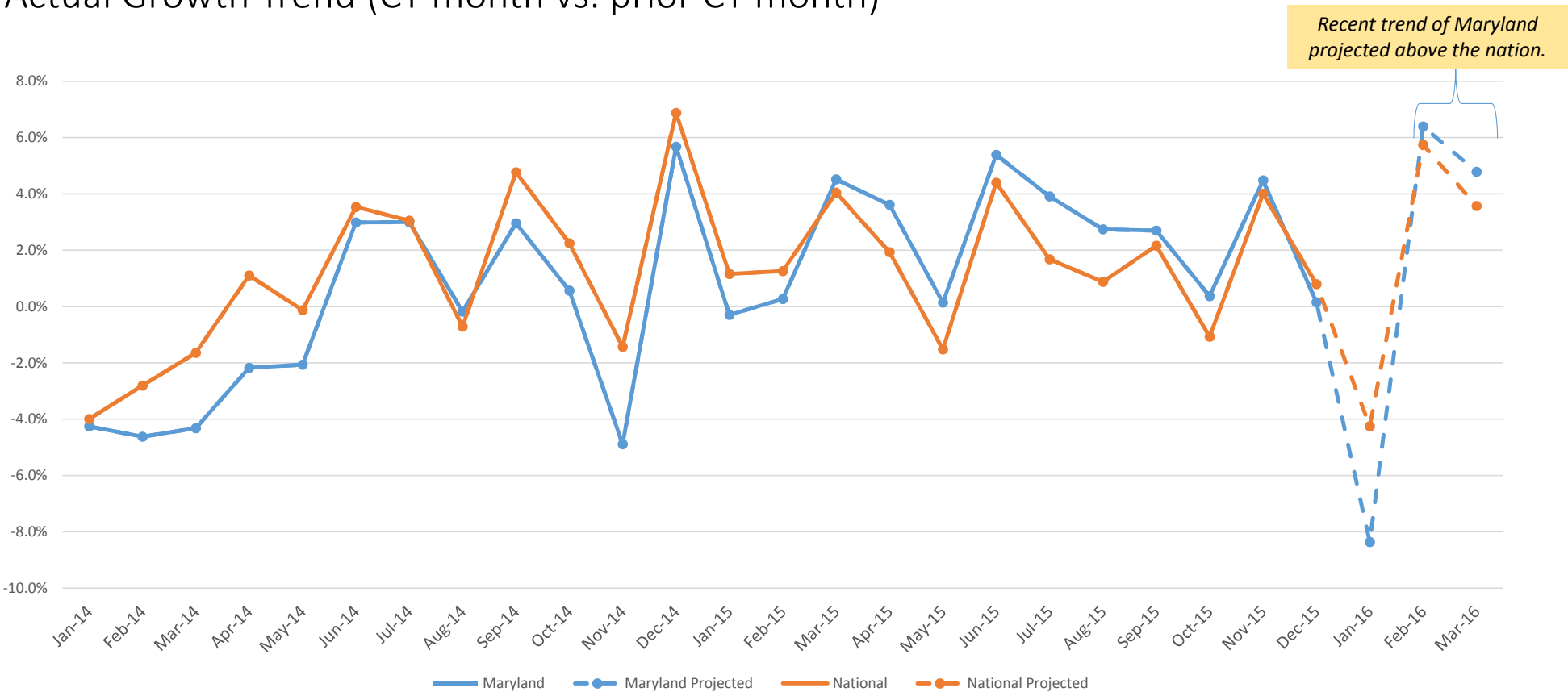
Monthly Total Hospital Spending per Medicare Beneficiary

Actual Growth Trend (CY month vs. prior CY month)



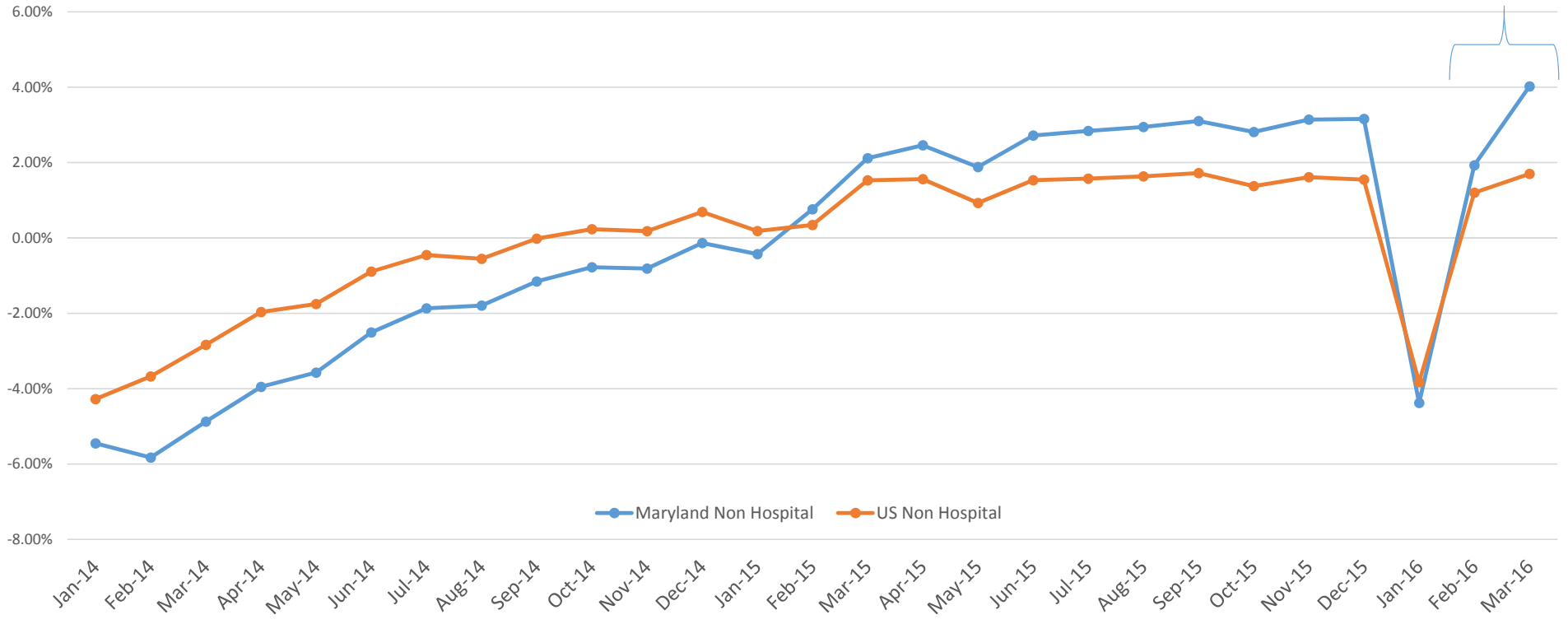
Monthly Total Spending per Medicare Beneficiary

Actual Growth Trend (CY month vs. prior CY month)

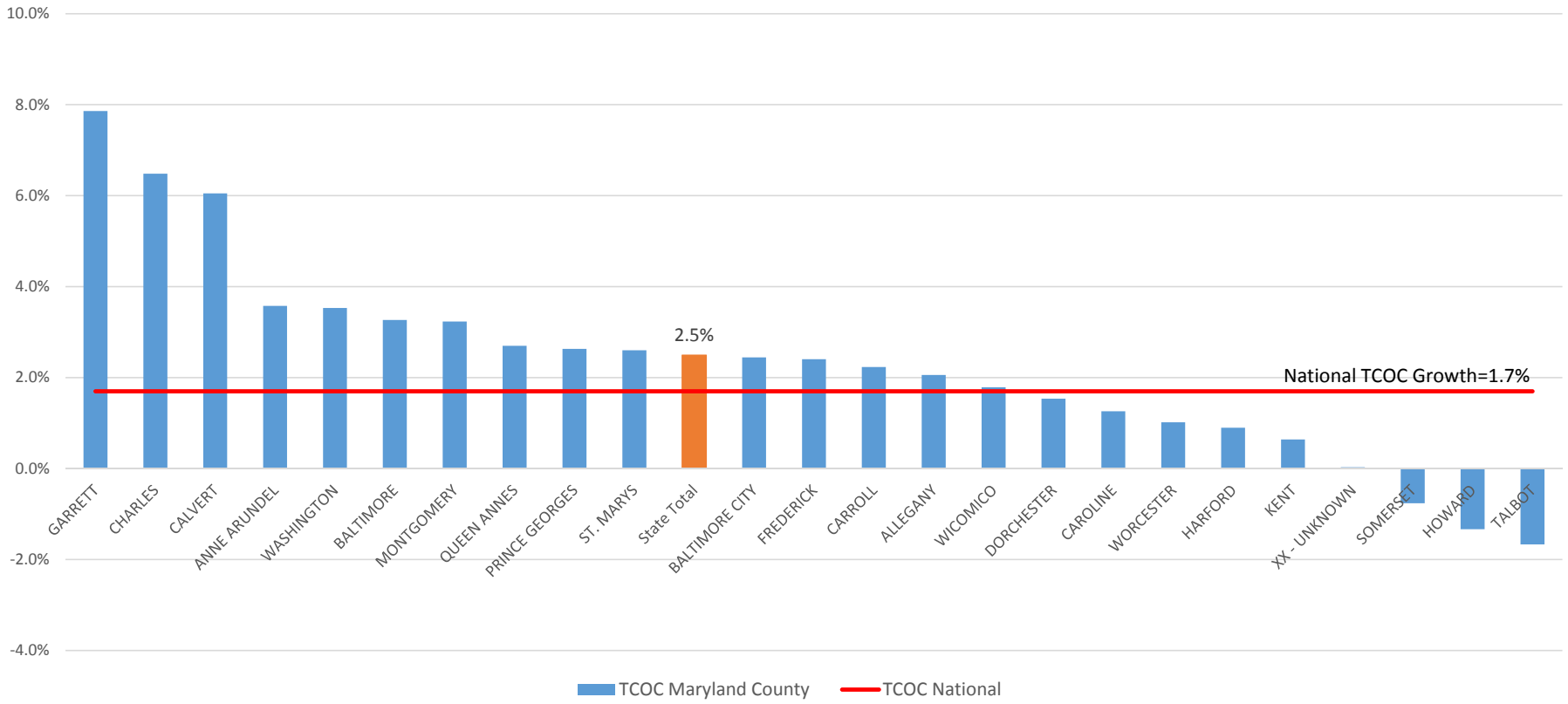


Monthly Non-Hospital Spending per Medicare Beneficiary Actual Growth Trend (CY month vs. prior CY month)

Recent trend of Maryland projected above the nation.



Medicare Total Spending per Beneficiary Growth By County: CY 2014 – CY 2015 (Maryland vs National)



Source: Geographic Variation File, 2011-2015, created by CMS for HSCRC

CRISP

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS

CRISP Reporting Services

Report to HSCRC Payment Workgroup

Ross D. Martin, MD, MHA
Program Director, Integrated Care Network

June 30, 2016

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CRISP Services

Clinical Query Portal

- Patient information accessible at the point of care, including: lab results, radiology reports, PDMP, discharge summaries, and more

Encounter Notification Service (ENS)

- Real-time hospital admission, discharge, and transfer notifications available to providers who submit a patient list
- Auto-subscriptions for hospitals to receive alerts for readmissions within 30-days across Maryland, DC, and Delaware hospitals

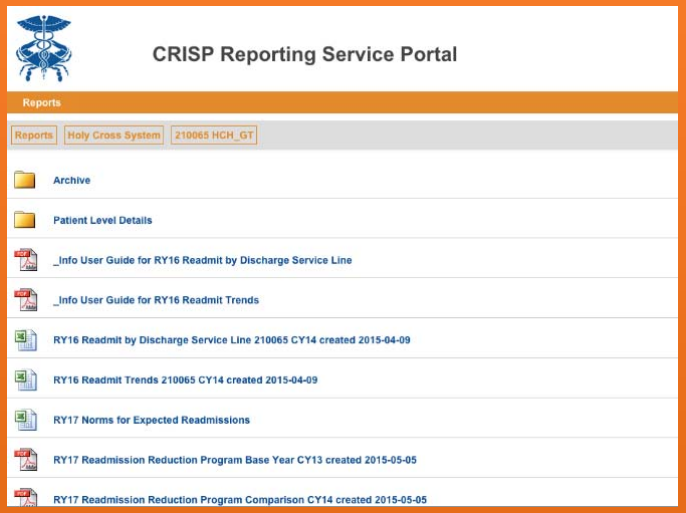
CRISP Reporting Services (CRS)

- Reporting and analytic tools to support patient identification, care coordination, and performance measurement

CRISP Methods for Reporting

Portal

- Internet-based
- Distributes static reports, includes archived reports
- Evolved from emailing users
- In use for over 3 years
- Patient-level data
- Target audience: Hospital Admin



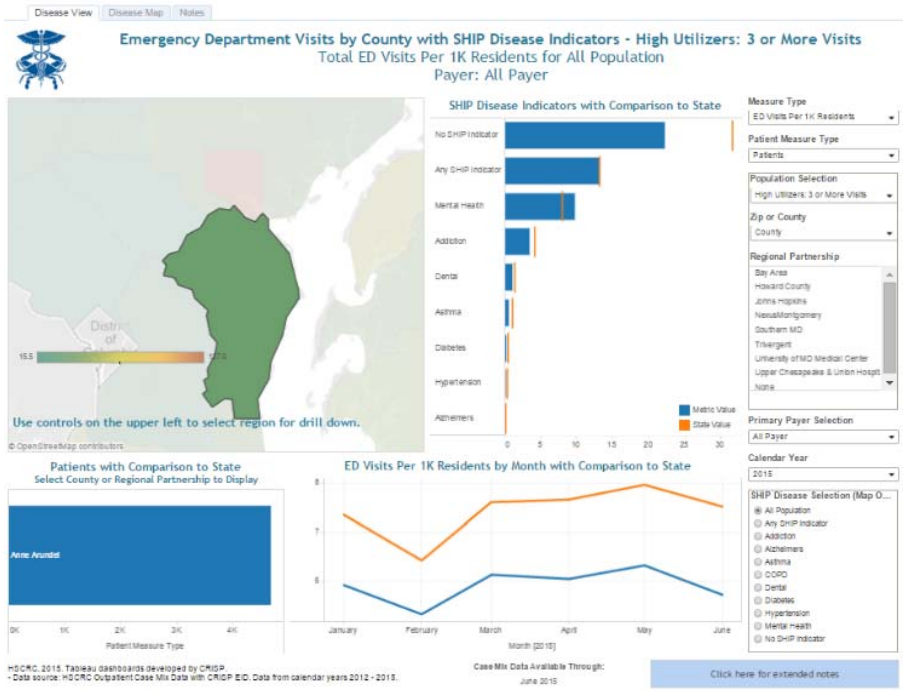
Dashboards

- Internet-based
- Separate entry point from Portal, shared credentialing
- Aggregated data and patient level data for care coordination
- Portals for Hospitals, Ambulatory Providers, and Populations

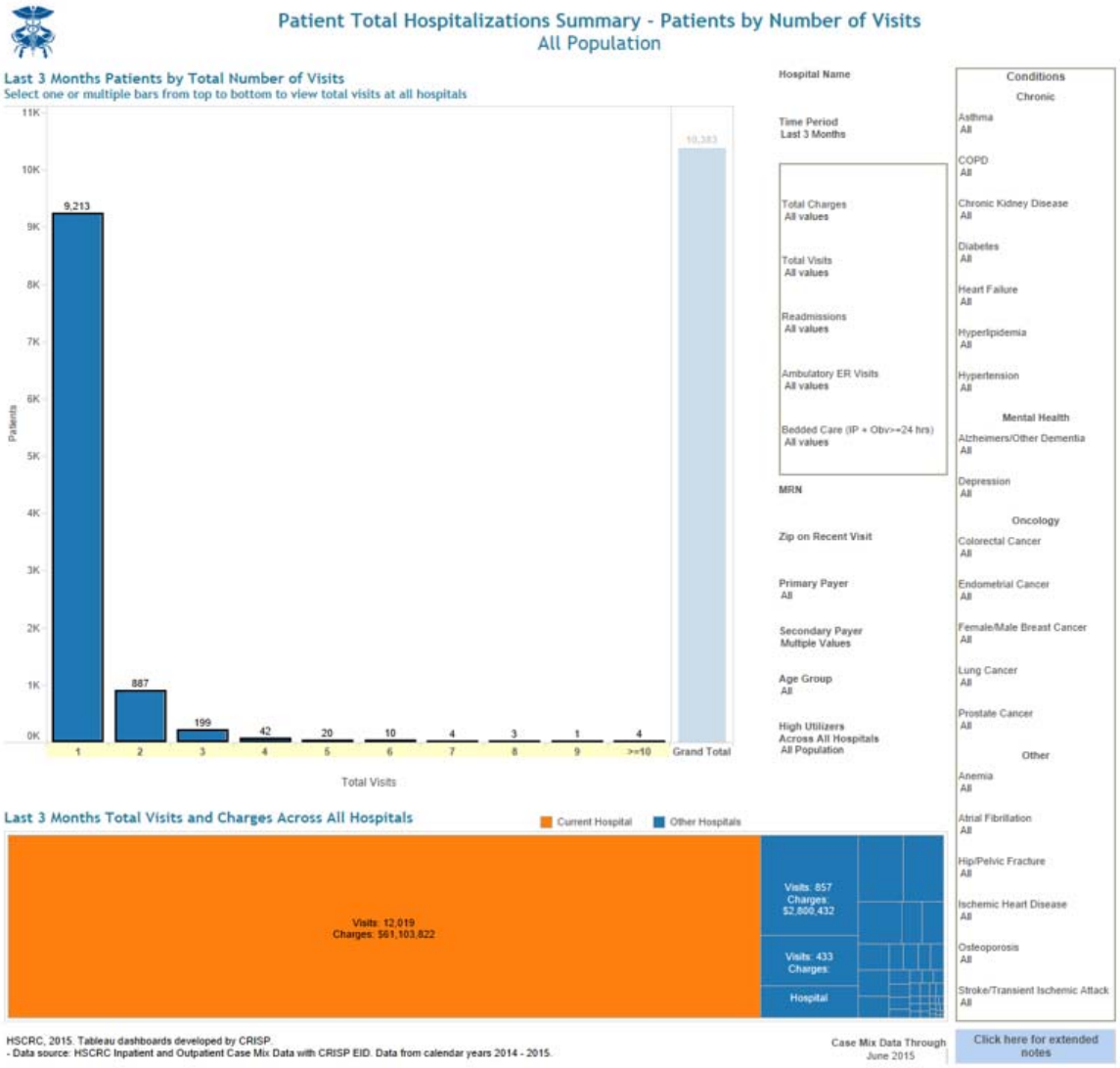
New Reporting and Analytics Tools

- The CRS team is enhancing the care network infrastructure for reporting and analytics
- Developing tools and information to support:

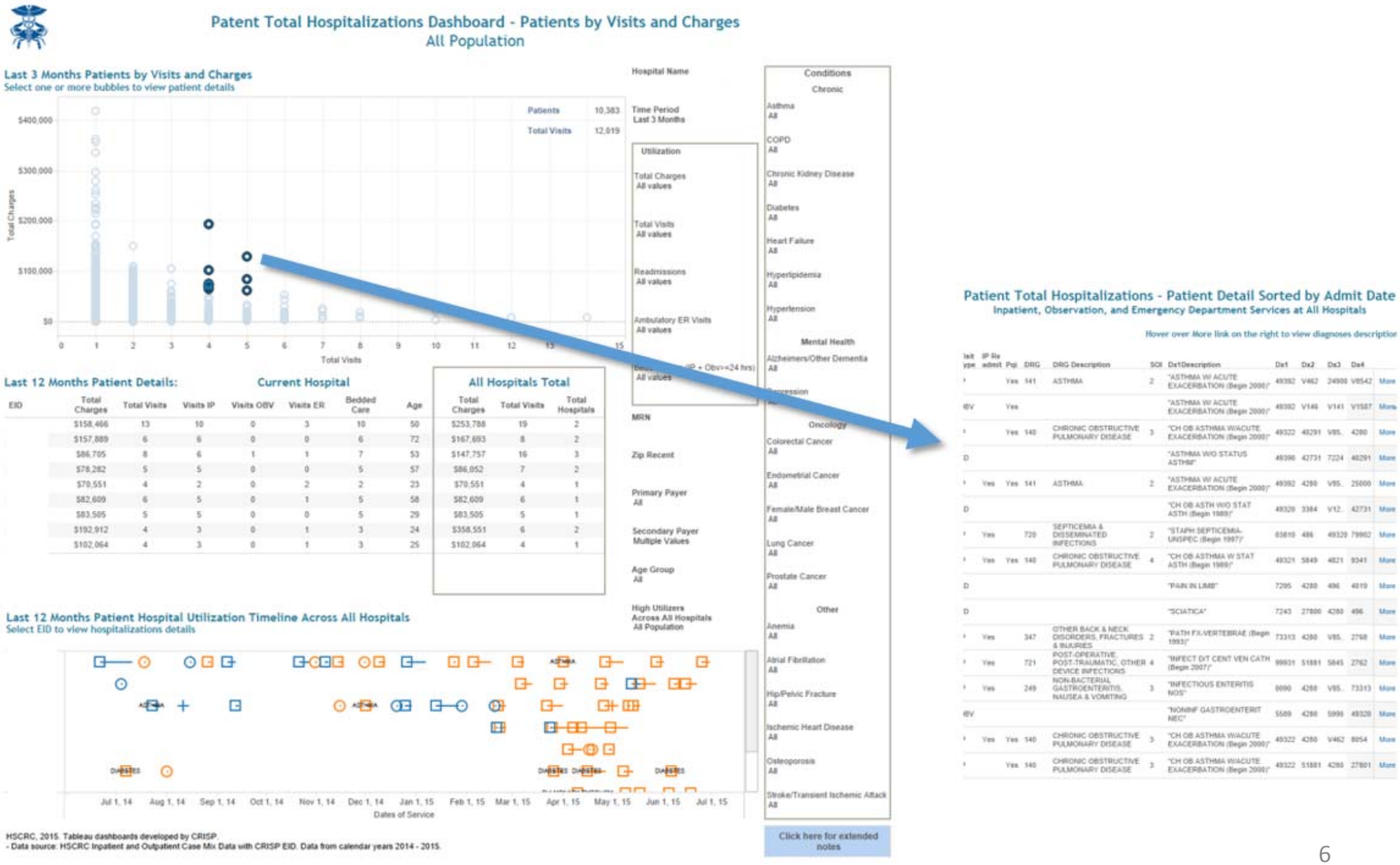
1. High-Risk Patient Identification
2. Regional Coordination and Planning
3. Performance Measurement



PaTH Summary View



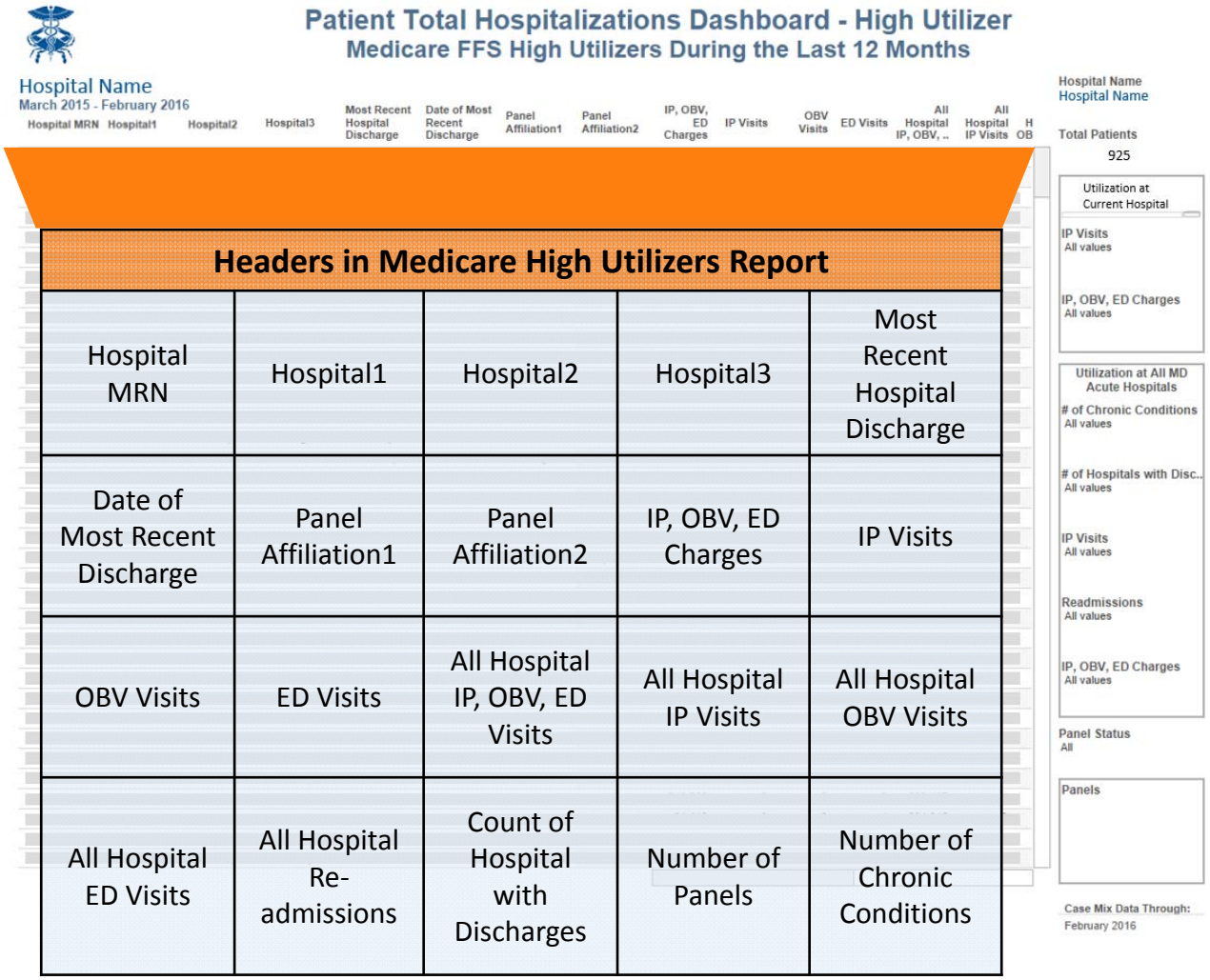
PaTH Patient-Level Details



Medicare High Utilizers

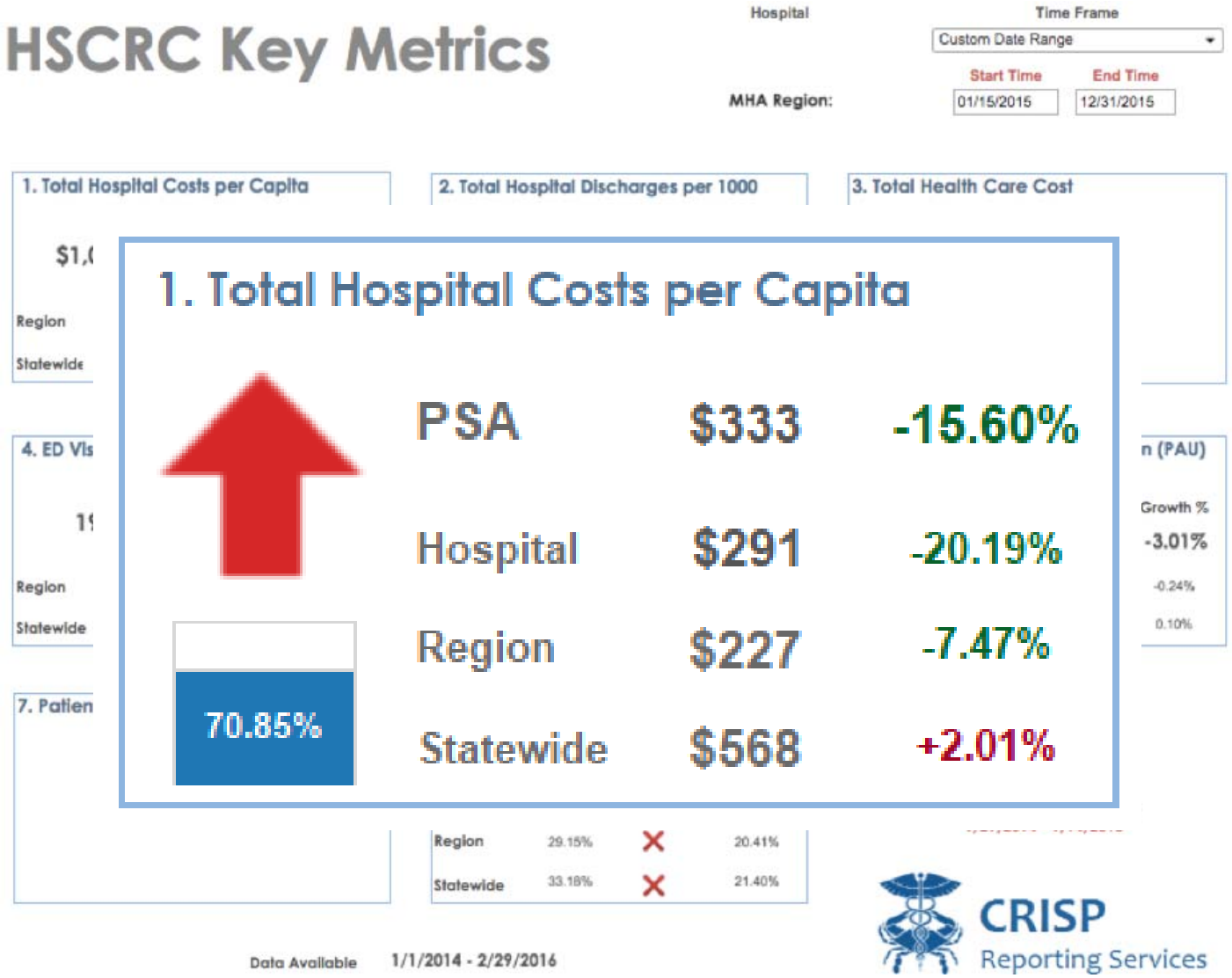
Purpose is to allow hospitals to view Medicare high utilizers of inpatient services and gather enough information to make care management decisions

- High utilizer = 3 or more bedded care admissions (IP and Obs >24hrs) in 12 months
- Information included: hospitals visited, dates, subscribed panels, utilization counts, chronic conditions



Headers in Medicare High Utilizers Report				
Hospital MRN	Hospital1	Hospital2	Hospital3	Most Recent Hospital Discharge
Date of Most Recent Discharge	Panel Affiliation1	Panel Affiliation2	IP, OBV, ED Charges	IP Visits
OBV Visits	ED Visits	All Hospital IP, OBV, ED Visits	All Hospital IP Visits	All Hospital OBV Visits
All Hospital ED Visits	All Hospital Re-admissions	Count of Hospital with Discharges	Number of Panels	Number of Chronic Conditions

Key Metrics Sample



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Contract Addendum to GBR & TPR Agreements

- Contract Addendum will include language that describes:
  - Overcharge penalties for mid year targets
  - Limit on charge increases or decreases to <10% on an interim basis
  - The conditions to receive increased inflation dollars
  - EHR Requirement: CEHRT (Certified Electronic Health Record Technology)

Market Shift Adjustments Update

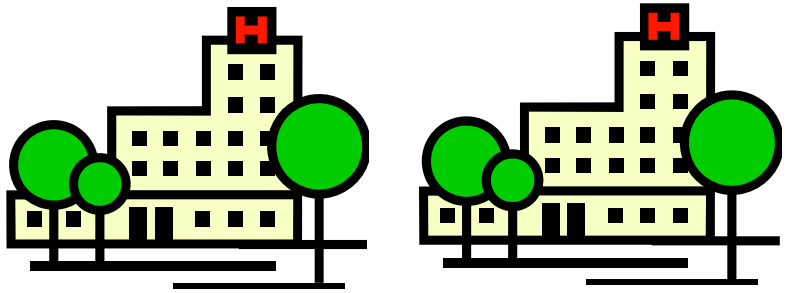
HSCRC
Health Services Cost Review Commission

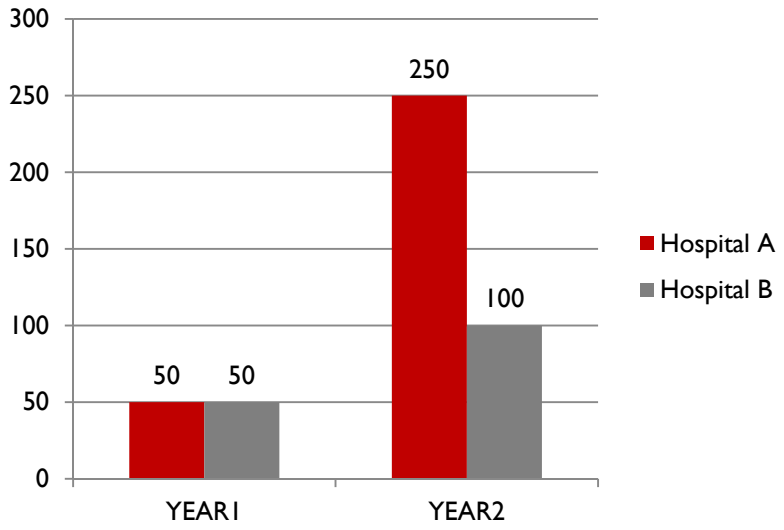
Market Shift Adjustments

- Market shift adjustment should not undermine the incentives to reduce avoidable utilization
- Market shift adjustment should provide necessary resources for services shifted to another hospital
- Calculations are based on
  - 66 inpatient and outpatient service lines
  - Zip codes and county level
  - Excludes Potentially Avoidable Utilization
  - Hospital service line average charge per ECMAD**
  - 50% variable cost factor applied
- Staff send out preliminary results for outpatient oncology service lines

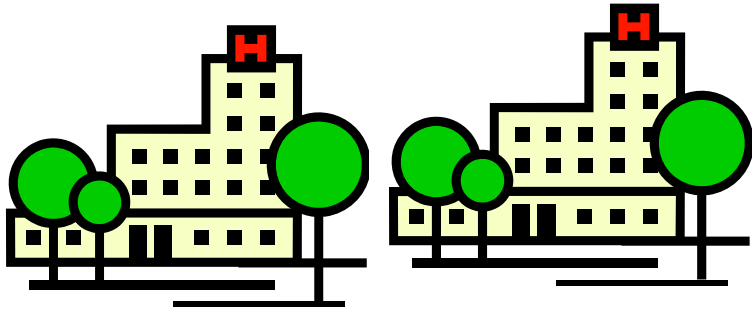
*AHRQ Prevention Quality Indicators
**Equivalent CaseMix Adjusted Discharges

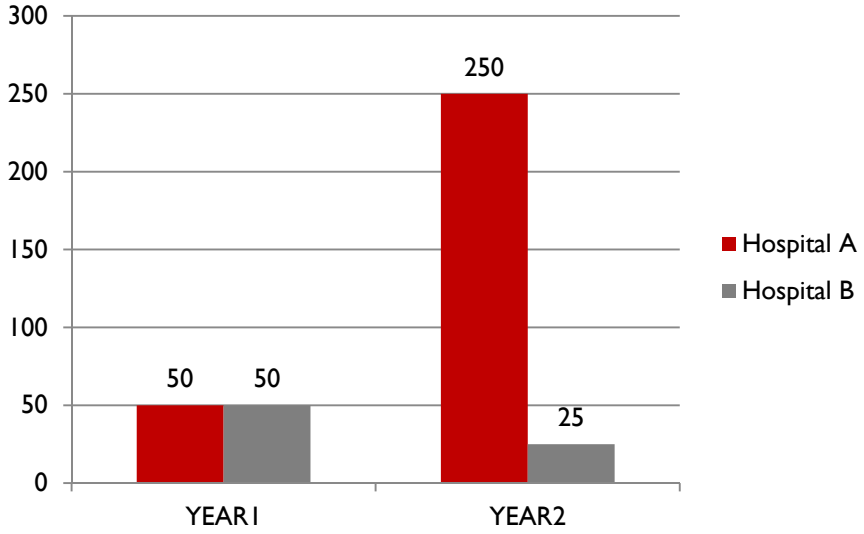
Market Share vs. Market Shift





Market Shift Adjustment=0





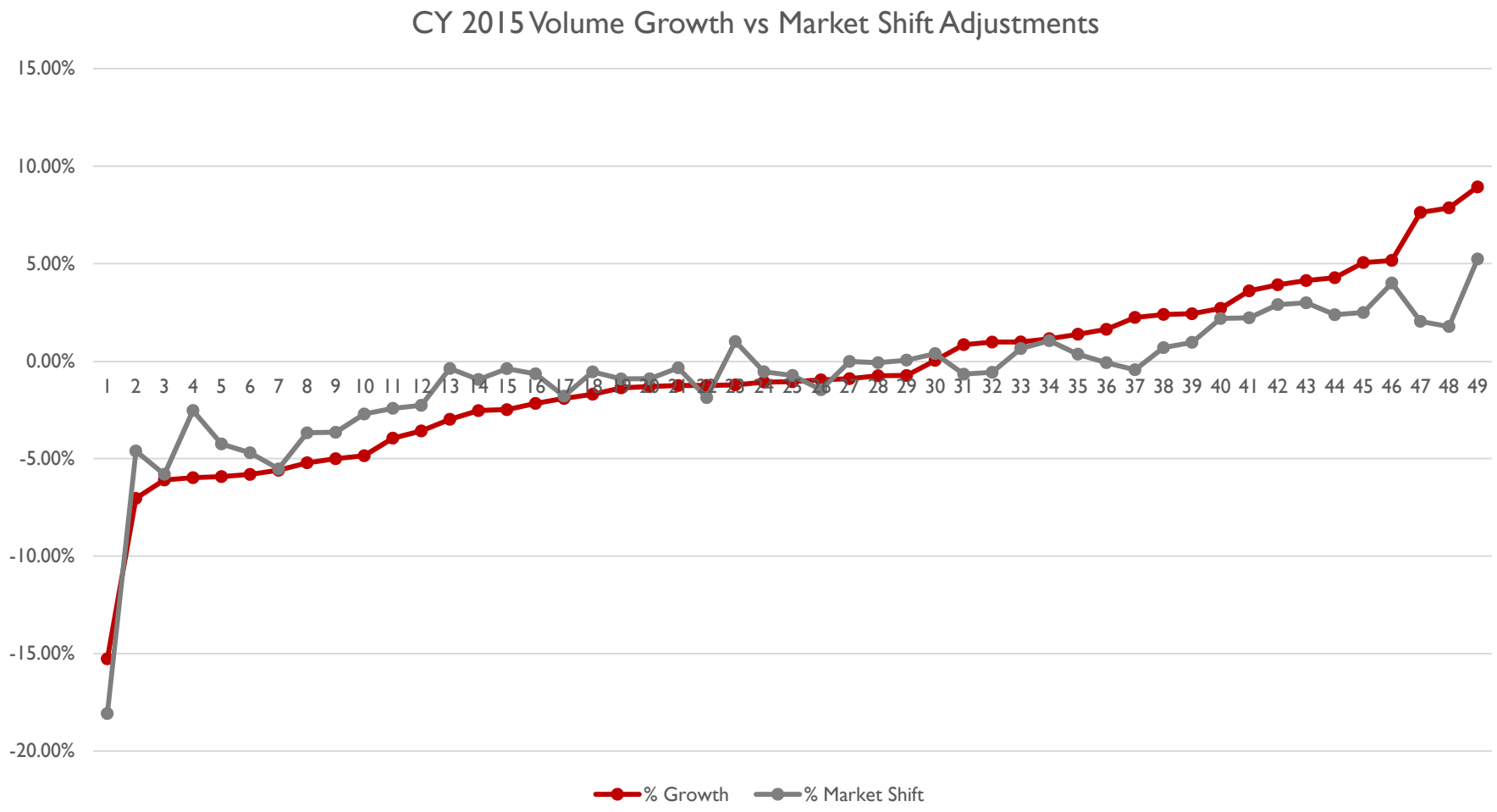
Market Shift Adjustment=25

RY 2016 and FY 2017 Year to Date Statewide Impact*

Statewide Impact	FY 2016	FY 2017
A	B	C
Grand Net Total	**-$756,341**	**-$5.7 mil**
Positive Adjustment Total	$27.7 mil.	$53.6 mil.
Negative Adjustment Total	-$28.5 mil.	-$46,8 mil.
Absolute Adjustment as Percent of Total Charges in MSA	1.02%	0.98%

*excludes oncology/radiation therapy/infusion service line and other manual adjustments

Market shift adjustments and volume growth is more closely linked in the FY 2017 period



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Market Shift Updated for CY 2016 Measurement period

- CY 2015 was based on an annual adjustment except for a few large market shift cases which was done mid-year
- CY 2016 is moving to a semi annual adjustments
  - Jan-June 2016 period will be added to FY 2017 GBRs in January
  - Jan-December 2016 period will be reconciled and adjusted in FY 18 GBRs in July 2017.
- Any changes in hospital service provisions (closure of services, deregulation etc) are reflected immediately.
- Service line updates for CY2016
  - Add Sepsis cases to PAU exclusions
  - Alignment of inpatient and outpatient cases (cardiac procedures etc.)
  - Possible update to weight calculations