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Thomas R. Mullen

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Donna Kinzer
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

David Romans
Director
Payment Reform and Innovation

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Sule Calikoglu, Ph.D.
Deputy Director
Research and Methodology

510th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
July 9, 2014

EXECUTIVE SESSION
11:30 a.m.

1. **Administrative Issues**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Minutes from the Executive Session and Public Meeting on June 11, 2014**

2. **Executive Director's Report**

   a. **New Model Monitoring**

   b. **Report of the Data and Infrastructure Work Group**

   c. **Report of the Performance Measurement Work Group**

   d. **Work Group Plan July- December**

3. **Presentation on Care Management/Coordination Strategies and Demonstrations**

4. **Docket Status – Cases Closed – None**

5. **Docket Status – Cases Open**
   2248N Baltimore-Washington Medical Center
   2250A University of Maryland Medical Center
   2251A MedStar Health
   2252A Med Star Health
   2253N Fort Washington Medical Center

6. **Report on Global Budget Contracts and FY 15 Changes**

7. **Final Recommendation on Revisions to the Relative Value Units Scale for Laboratory Services**

8. **Legal Report**

9. **Hearing and Meeting Schedule**

Data and Infrastructure Work Group Report to the Commission:

Recommendations on Data Infrastructure to Support Care Coordination

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Health Services Cost Review Commission

4160 Patterson Avenue Baltimore, MD 21215

(410) 764-2605

July 9, 2014

This document contains recommendations from the Data and Infrastructure Work Group for addressing the data infrastructure needs for care coordination. The recommendations in this report are for discussion purposes and do not require formal action by the Commission.

Introduction

Beginning January 1, 2014, the State of Maryland entered into a five-year all-payer demonstration with Center of Medicaid and Medicare Innovation (CMMI), in which Maryland agreed to specific targets in cost and quality of hospital care.

In an effort to engage various stakeholders in the implementation process, the HSCRC convened four workgroups to make recommendations on implementation issues. The Data and Infrastructure Workgroup (Workgroup) was charged[1] with making recommendations on data and infrastructure requirements to support care coordination initiatives, with a focus on potential opportunities for using Medicare data to support these initiatives. The purpose of the report is to provide recommendations on the principles and desirable features of a data infrastructure to support care coordination with Medicare Data.

Background

The goal of the new All-payer Model is to improve health outcomes, enhance patient experiences and control costs across the State. Maryland has committed to meeting all-payer per capita revenue requirements as well as Medicare savings. The need for patient-level Medicare data to support care coordination has always been recognized as an important resource to support care coordination activities needed to achieve the objectives of the New All-payer Model. The State application to CMMI envisioned enhanced care coordination and the Advisory Council urged the HSCRC to focus attention on identifying high-risk Medicare patients where few beneficiaries are in managed care. Hospital discharge data, alone, is insufficient to support an understanding of the needs of Medicare patients and effective care coordination. Timely and complete patient-level Medicare data is essential to understanding the non-hospital utilization of Medicare patients, identify high risk patients, assessing their gaps in care and implementing effective care coordination strategies.

The Department of Health and Mental Hygiene, HSCRC and hospital leaders are engaged in a discussion with CMMI about accessing confidential Medicare data to support the needs of hospitals and other providers under the new hospital payment model. While discussions with CMMI are on-going, a more concrete understanding of how Maryland will use this data efficiently and effectively to achieve the goals of the new model is needed. The Workgroup was tasked with considering what the data infrastructure for care coordination would look like and how it can address different provider needs.

[1] The Data and Infrastructure Workgroup was charged with making recommendations on: 1. data requirements, 2. Care Coordination Data and Infrastructure, 3. Technical and Staff Infrastructure, and 4. data sharing strategy

The Data and Infrastructure Workgroup held a joint meeting with the Physician Alignment and Engagement Workgroup to better understand strategies already in place in Maryland to use data to support care coordination and the needs in Maryland. Providers, payers and others shared different care improvement strategies currently underway. The common element for most strategies was identifying high need individuals through predictive modeling tools, risk assessment and risk stratification. Different predictive modeling tools and risk assessment tools were discussed and there are pros and cons of different tools related to the availability of data, how the tools relate and support specific care improvement initiatives, and the sophistication of the infrastructure needed to support the predictive modeling, risk assessment and risk stratification process.

There was interest and discussion about a range of care improvement initiatives (see figure 1). Some strategies were used as part of a comprehensive initiative and many of the strategies are over-lapping or related.

Figure 1. Broad Range of Potential Care Improvement Strategies

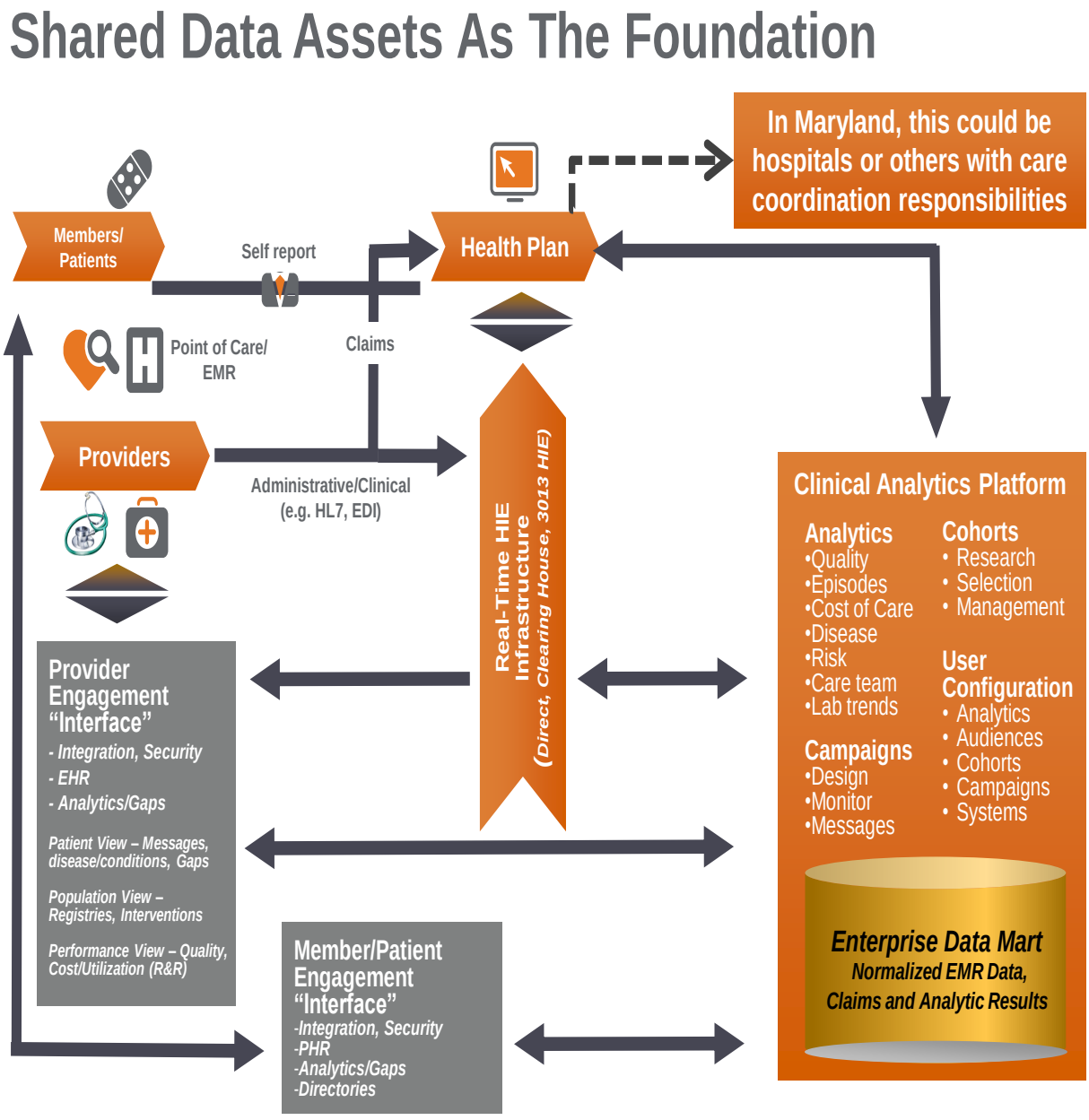
- Supporting care transitions between providers
- Designing readmission reduction initiatives
- Identifying gaps in care
- Diverting inappropriate use of Emergency Departments
- Focusing on episodes of care
- Providing patient and family education
- Coordinating handoffs to primary care providers

Note: This is only a summary of initiatives discussed and does not reflect all the care improvement strategies currently in practice

There was broad agreement in the Workgroup that there is a critical need for data to support care coordination and the importance of a data infrastructure designed to meet the new population health focus of the health care delivery system. The Workgroup recognized that there was a high degree of variability in the current infrastructure and capacity of hospitals and other providers to support their data needs. Building data infrastructures takes time and significant resources, making it critical to develop a roadmap based on a shared sense of needs and prioritizing efforts.

The new payment model fundamentally alters the payment incentives for hospitals and will likely change their role in care coordination as well as the role of other providers. The data needed by hospitals and other providers to support population based models is similar to the data infrastructure used by Accountable Care Organizations and payers to manage population health and will require more data than exists with any one provider. Several Workgroup members expressed interest in a high level data framework shared by an expert presenter during the joint meeting (see Figure 1 below).

Figure 1



Source: Adapted from Dean Farley, OptumInsight, HSCRC Joint Work Group Meeting, 3/27/14

The Workgroup was challenged to consider the care coordination infrastructure roadmap without a concrete understanding of specific care coordination initiatives that will be used. Specific strategies are still evolving and require input from a broader set of stakeholders. Further, care coordination strategies are likely to continually evolve. The Workgroup recognized that while there are many unknowns in the strategies that will be used, there are many common data needs across care

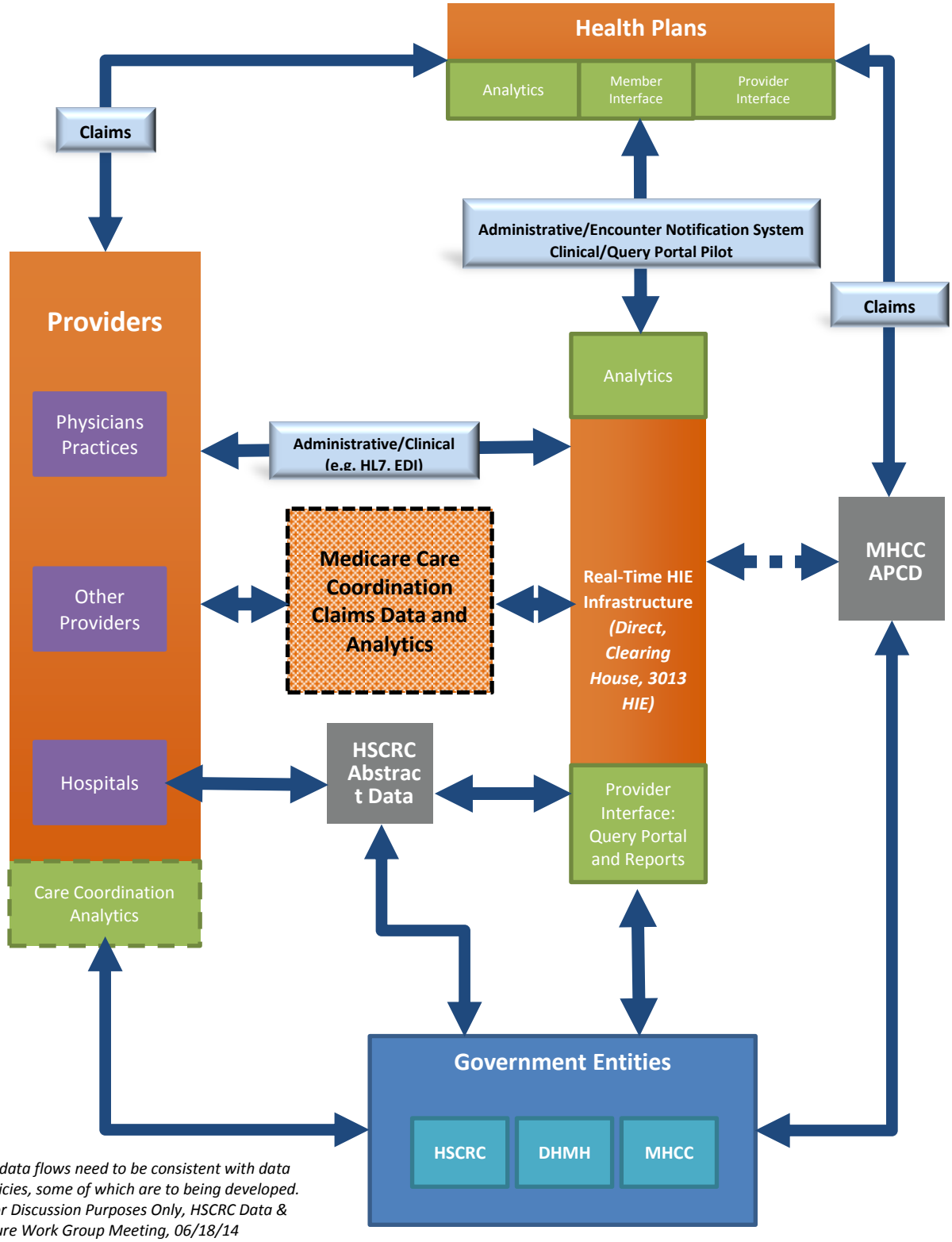
coordination initiatives and planning must begin. The Workgroup focused on broader discussions about the roadmap for data infrastructure.

A data infrastructure will ultimately be needed to support multiple purposes. Data is needed to support policy and program evaluation, operational management decisions and clinical decision-making. Clinically actionable data must be patient-level data and as real-time as possible to identify high risk patients and care improvement opportunities. Population based models will require getting data at the right time and right place to support clinical decision making.

The Workgroup discussed a high level roadmap (see Figure 2) for the technical data flows that currently exist in Maryland and what is needed to support care coordination. The Workgroup recommended that Medicare data be hosted in a way that fully leverages the foundation of data and analytic resources in Maryland. The State has robust data on hospital utilization through the hospital abstract data. The HSCRC and industry leaders are experienced with analyzing these data sets to support policy and operational needs. The policy and operational needs are evolving to require a broader population health focus. The investments Maryland has made in Health Information Exchange are particularly important to create a unique identity to support cross entity analyses that are essential to population health analytics. Medicaid and the Hilltop Institute at UMBC have significant experience analyzing Medicaid data and other data sets to support analyses of health care financing and delivery. The Maryland Health Care Commission manages the Medical Care Claims Data Base (MCDB), which has detailed information from commercial health plans. Enhancements to the MCDB are underway to make it timelier and address data gaps that will make it an important resource for population health analytics. The statewide Health Information Exchange, CRISP, provides clinical information to providers through a query portal. The Workgroup recommended the Medicare data be closely connected to CRISP. The portal includes Maryland's Prescription Drug Monitoring Program, which provides complete information on schedule II through V drugs. CRISP has real-time and complete administrative data from Maryland hospitals, which has enabled an encounter notification services to provide physicians, other providers and care coordinators information on patient admissions, discharges and transfers that some providers use in their care coordination efforts. There is an opportunity for CRISP to improve connectivity with ambulatory providers.

Roadmap of Data Flows to Support Care Coordination

Figure 2



**Technical data flows need to be consistent with data sharing policies, some of which are to being developed. DRAFT – For Discussion Purposes Only, HSCRC Data & Infrastructure Work Group Meeting, 06/18/14*

Principles and Desirable Features

The Workgroup developed principles and desirable features of data infrastructure designed to host Medicare data. The Workgroup considered what type of infrastructure is needed to support clinical decision making for Medicare beneficiaries by hosting data, applying analytic tools (such as predictive modeling algorithms) to support care coordination and sharing data with providers to support a varying level of need and capacity.

Principles

1. **Medicare Data should be accessible to different providers compliant with state and federal laws, policy and data use agreements for confidentiality and security and consistent with best practices**. The data infrastructure must be designed to support the protection of data, including role-based access to information.

2. **Data should be transparent to hospital and non-hospital providers to provide a uniform understanding of data findings (consistent with privacy and security requirements)**. Success under the new model will require collaboration among providers to meet the needs of the population. This collaboration is needed with hospitals and non-hospital providers, as well as among different hospitals that may be serving the same population. A uniform understanding of the data should be shared with providers consistent with the data use agreements and privacy and security protections.

3. **Gaps in Medicare data should be addressed through other data sources such as real-time HIE or DHMH.** Medicare claims data alone will not support comprehensive care coordination. Some ACOs have experienced delays in accessing data from CMS, which makes considering what can be done to address data gaps in the short run important. Clinical information that may be available through other resources or captured through risk assessments are important sources of information to support care coordination. Risk assessments can help identify additional factors that affect the need for care coordination, such as family support systems, ADL limitations, cognitive limitations, and other factors that may affect care management needs.

4. **Hospital, providers and policy makers should work collaboratively to leverage shared infrastructure to the extent it is feasible to minimize duplication, encourage efficiency and work from a uniform understanding of the data**. The data infrastructure needed to support care coordination under the new model will be costly and leveraging shared infrastructure will reduce wasteful spending on duplicate efforts. Shared infrastructure can also be used to focus on reducing duplication of care coordination resources assigned to support the same individual where multiple facilities are accessed by a patient.

5. **Achieving population health goals will require the interoperability of data systems to allow the exchange of data among providers**. Making data clinically actionable requires building it into provider workflows and getting it to providers who can act on it.

6. **The data infrastructure should maximize existing infrastructure and capacities and promote partnerships among providers and systems to coordinate and improve care.** There is varying capacity among Maryland hospitals and other providers to support population based care coordination. Maryland has organizations with advanced analytic skills. Maryland has already invested in some shared data resources such as the MCDB to support policy and operational analysis, and CRISP to support clinical decision making.

Desirable Features

1. Have independent and broad-based governance;
2. Ensure data security and confidentiality;
3. Be efficient and scalable;
4. Provide access to data and analytic tools to providers with varying level of capacity, including hospitals and non-hospital providers;
5. Have the ability to easily integrate with other systems, such as the HIE, while maintaining patient identity integrity across datasets;
6. Be flexible to support different uses of the data (i.e., predictive modeling, care management tools, quality improvement, etc.).

Recommendations and Next Steps

The Workgroup made the following recommendations and identified next steps.

1. **The State public and private sector health leaders need to develop a roadmap for its health care infrastructure**. Medicare data to support care coordination is only one part of a larger data infrastructure to support health care coordination and improvement. The planning to host Medicare data should be considered in the context of existing data infrastructure and other data needs of the all payer model.

2. **There should be a focused effort to get access to Medicare data because of its importance to care coordination and achieving the goals of the new model**. Identifying high risk Medicare patients and standing up care coordination initiatives are an important to achieving the Medicare savings goals of the new model. The HSCRC should continue to work closely with the Department of Health and Mental Hygiene, hospitals and CMMI to gain access to the data for Maryland providers.

3. **The HSCRC and stakeholders should pursue the use of other data sources, in addition to comprehensive Medicare data, to support care coordination.** It may take time to secure access to comprehensive Medicare data and tap into its potential value for care coordination. Other data sources could provide intermediate strategies to support care coordination or long-term strategies to address gaps in Medicare data.

4. **The most efficient and effective way to host Medicare data is through a shared infrastructure that is accessible hospitals and other providers**. Medicare data should be hosted in a shared infrastructure that can include other shared data sources and analytic tools (such as predictive modeling) that can be applied to enhance the value of data for care coordination purposes. The infrastructure would need to be flexible, to accommodate innovations in clinical decision making by providers, but also be uniform in how providers understand the underlying metrics related to payment. The Workgroup mandating a particular predictive modeling tool but recommended providing several alternatives and flexibility to accommodate different provider capabilities and needs. While some providers may have robust care management platforms and need to leverage additional data feeds, other providers may have limited capacity and need more basic tools. Regardless of the level of need, the infrastructure would need to promote transparency so providers are working from a uniform understanding of the metrics used to evaluate the data, as well as, the results.

5. **Defining specific use of data will be important to preparing Maryland to standup an infrastructure efficiently as well as supporting the case to CMMI to secure the data**. More work is needed to better understand the potential care coordination strategies and the data needed to support them. Implementation planning tasks should include defining the different providers and stakeholders with data needs and what data infrastructure is needed to support role-based access. Hospitals are likely to have data needs to support different roles in their organizations. Other providers and organizations will have data needs, including physicians, other health care professionals, post-acute and long term care providers, ACOs, Local Health Departments, DHMH and potential new organizations that may be created as a part of the State Innovation Model (SIM) Community Integrated Medical Home. Implementation tasks should also include engaging stakeholders in identifying and potentially procuring predictive modeling tool(s) and other analytic resources.

6. **There needs to be an analysis of potential use cases of data to identify gaps in data sharing policy that should be addressed**. Care coordination strategies and data needs are likely to evolve, requiring a process to address data sharing policy that can anticipate potential gaps in policy and be proactive in addressing policy gaps. Access to Medicare data will be limited to Medicare approved use cases and based on well-established Medicare data use agreements that govern policy on data sharing. There is existing federal and state policy that will affect data sharing policy, including HIPAA, Maryland Confidentiality of Medicare Records Act and the HSCRC Data Use Polices for abstract data. The MHCC Policy

Committee, which has consumer participation, can be a resource for additional policy development as needed.

7. **Other infrastructure needs will need to be addressed.** This report was narrowly focused on the data infrastructure needed to support care coordination. There will be other infrastructure needs, including human capital and training, which will need to be addressed as part of the broader discussion of the healthcare data infrastructure.

Performance Measurement Work Group Report to the Commission:

Strategy for Population Based, Patient Centered

Performance Measurement

Health Services Cost Review Commission

4160 Patterson Avenue Baltimore, MD 21215

(410) 764-2605

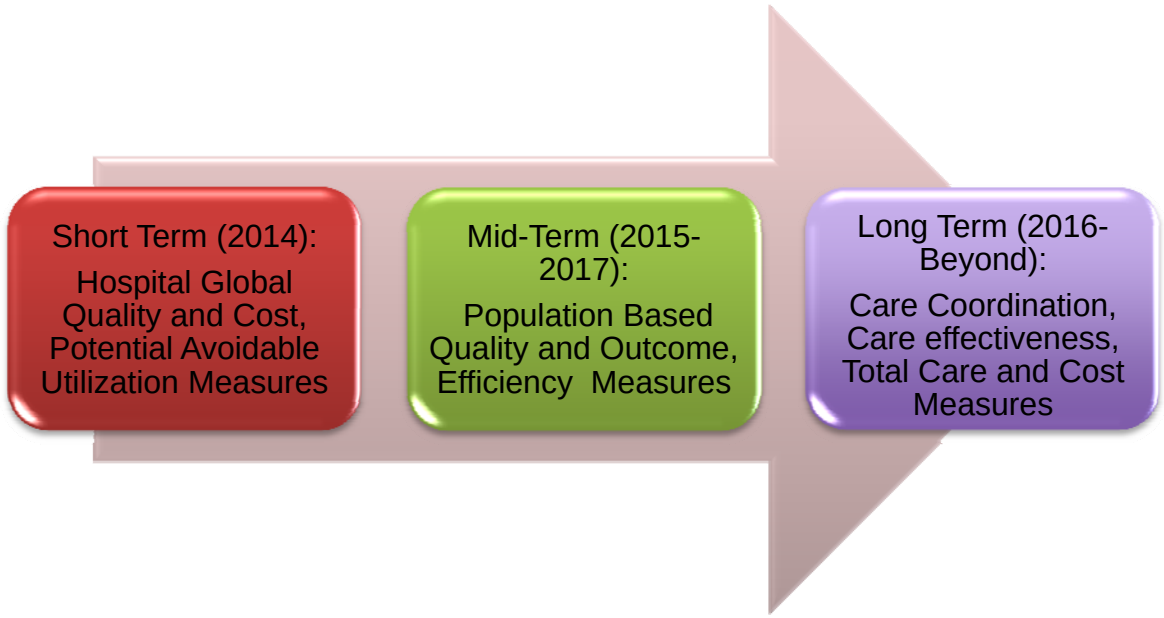
July 9, 2014

This document summarizes the deliberations of the Performance Work Group on aligning performance measurement with the new All-Payer Model. This report is intended for the purpose of discussion related to a strategy and direction for performance measurement, and does not require formal action by the Commission.

INTRODUCTION

The charge of the Performance Measurement Workgroup is to provide input on what specific measures of cost, care and health should be considered for adoption, retention or development in order to evaluate and incentivize performance improvements under the population-based All-Payer Model. A comprehensive measurement strategy must first be developed to support achievement of the Model goals; this strategy must align with the All-payer Model development and implementation timeline as well as recognize and support the priorities at each phase of the process. In beginning to address this charge, the Workgroup acknowledged that the performance measurement strategy must first focus on measurement of global hospital-based services and care that support immediate success in achieving the new All-payer Model targets, then expand to measurement of population-based quality and efficiency, and ultimately measurement that supports patient-centered, coordinated, cost-effective care that achieves better outcomes (Figure 1).

Figure 1: Performance Measurement Strategy Priorities Over Time



The Performance Measurement Workgroup discussed the context for developing an overall measurement strategy, and presentations on specific measures in some relevant categories of measures in which we need to expand over time. The Workgroup also discussed the need to monitor performance in "real time" to the extent possible, and to this end vetted draft dashboards at the hospital/system- and statewide-level to be finalized and put into place in the short term.

This report summarizes the Workgroup's efforts to date as well as other important proposed considerations toward fleshing out a robust performance measurement strategy.

PPERFORMANCE MEASUREMENT STRATEGY CONSIDERATIONS

Regarding the potential array of purposes or uses of measures, Figure 2 illustrates the key principles and stakeholders that must be considered in the overall performance measurement strategy for each of the domains and measures identified to support the All-payer Model. Although the HSCRC has traditionally been focused on payment related measures, the workgroup acknowledged a need for coordinated effort in addressing emerging needs of performance measurement related to public reporting and monitoring in the context of All-payer Model.

Figure 2. Measurement Strategy Principles and Stakeholders

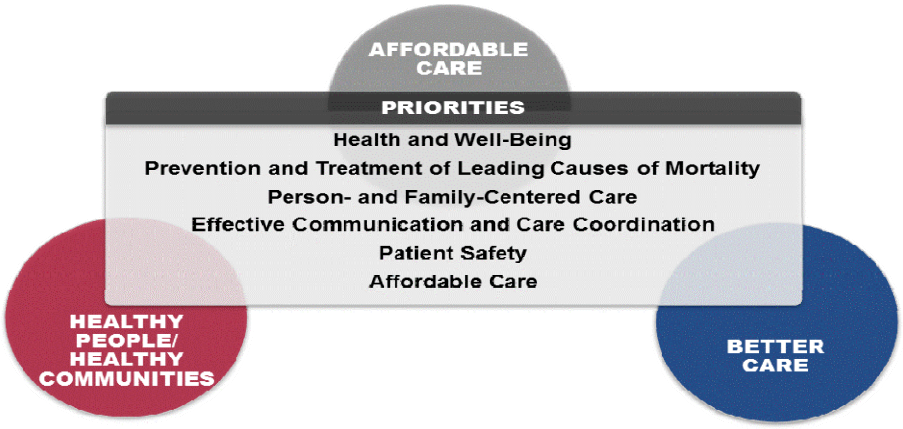
Principles/criteria to guide measure domains to be implemented:
❖ Accountability
➢ Payment
➢ Public reporting
➢ Program monitoring and evaluation
❖ Improvement
❖ Alignment with Model targets and monitoring commitments
Stakeholders
❖ Policymakers – CMS, HSCRC (commission, staff), MHCC, DHMH
❖ Providers – hospitals, physicians, others
❖ Payers/purchasers – health plans, employers
❖ Patients – consumers

Achieving the Three-Part Aim of Better Care, Better Health and Lower Cost

The National Quality Strategy (NQS) first published in March 2011 and led by the Agency for Healthcare Research and Quality on behalf of the U.S. Department of Health and Human Services (HHS) articulated the three-part aim. Maryland's All-payer Model has directly aligned its aims with those of the NQS's three-part aim. So too, Maryland's performance measurement strategy needs to address the NQS priorities and use the available levers as identified by the NQS, either directly through policy implementation or indirectly in working with partners, to maximize success in achieving the aims.

To advance the aims, the NQS focuses on six priorities, as illustrated in Figure 3.

Figure 3. National Quality Strategy Priorities.



Each of the nine NQS levers, listed below, represents a core business function, resource, or action that Maryland can use to align to the NQS and maximize our opportunity for improvement and success under the new Model. HSCRC already uses several of the levers in its performance measurement programs.

- Measurement and Feedback: Provide performance feedback to plans and providers to improve care
- Public Reporting: Compare treatment results, costs and patient experience for consumers
- Learning and Technical Assistance: Foster learning environments that offer training, resources, tools, and guidance to help organizations achieve quality improvement goals
- Certification, Accreditation, and Regulation: Adopt or adhere to approaches to meet safety and quality standards
- Consumer Incentives and Benefit Designs: Help consumers adopt healthy behaviors and make informed decisions
- Payment: Reward and incentivize providers to deliver high-quality, patient-centered care
- Health Information Technology: Improve communication, transparency, and efficiency for better coordinated health and health care
- Innovation and Diffusion: Foster innovation in health care quality improvement, and facilitate rapid adoption within and across organizations and communities
- Workforce Development: Investing in people to prepare the next generation of health care professionals and support lifelong learning for providers

MEASUREMENT UPDATES AND NEW DOMAINS

The Workgroup vetted near term measurement updates for the Maryland Hospital Acquired Conditions (MHAC) and Readmission Reduction Policies, and provided important input on efficiency measurement, a topic that is addressed in a separate report.

The Workgroup also considered options for implementing hospital- and regional-level dashboards that present of a mixture of key financial and non-financial measures that would be monitored closely (mostly monthly) and consistently across hospitals and for the state or other defined regions, and provide a "snapshot" of trends over time. The dashboard is intended as a

tool to articulate the links between leading inputs, processes, and lagging outcomes and focuses on the importance of managing these components to achieve the strategic priorities. The Workgroup noted the dashboard is not meant to replace traditional financial or operational reports but is intended to provide a succinct summary to help users with situational awareness. In vetting the hospital/system- and regional-level draft dashboard templates, there was agreement among the Workgroup members to begin by including the domains and measures for monitoring listed in Appendix A. As the All-Payer model includes reducing racial/ethnic disparities as part of the quality improvement strategy in achieving three-part aim, the dashboard will also be adapted to look at racial/ethnic disparities at the state-wide level. HSCRC staff will coordinate with the DHMH Office of Minority Health in determining the most appropriate measurement strategy to effectively monitor the racial and ethnic disparities in quality of care and patient outcomes.

In addition, the Workgroup discussed measurement domains/areas where there is great added potential for success in reaching the three-part aim, but which are still the most aspirational in terms of achieving robust valid and reliable measurement**.** These "new frontiers" of measures include Population Health and Patient Centered Care measures.

Population Health Measures

According to the World Health Organization, health is defined as "A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Population health entails improving overall health status and health outcomes of interest to individuals, the clinical care system, the government public health system, and stakeholder organizations. It is influenced by physical, biological, social and economic factors in the environment, by personal health behavior, and by access to and effectiveness of healthcare services.Sub-domains of population health measures with specific measure examples are listed below.

- Health Outcomes- high-level indicators
  Measure examples: mortality, longevity, Infant mortality/ low birth weight/ preterm birth, Injuries/ accidents/homicide, suicide rate

- Access- availability and use of services
  Health insurance status; primary care access; access to needed services; condition specific hospital admissions; Measure examples:
  (NQF#1337) Children with Inconsistent Health Insurance Coverage in the Past 12 Months,
  (NQF #718) Children Who Had Problems Obtaining Referrals When Needed,
  (NQF #277) Heart Failure Admission Rate (PQI 8)

- Healthy Behaviors- choices by individuals and communities
  Addictive substances assessment and counseling; weight assessment and physical activity counseling; Measure examples:
  (NQF #2152) Preventive Care and Screening and Counseling: Unhealthy Alcohol Use
  (NQF #1656) Tobacco Use Treatment Offered at Discharge

(NQF #1406) Risky Behavior Assessment or Counseling by Age 13 Years
(NQF #421) Body Mass Index (BMI) Screening and Follow-Up

- Prevention- screening and early intervention
  Disease and condition screening; immunizations; maternity care; newborn and child development; Measure examples:
  (NQF #34) Colorectal Cancer Screening
  (NQF #1659) Influenza Immunization
  (NQF #278) Low Birth Weight Rate (PQI 9)
  (NQF #1385) Developmental screening using a parent completed screening tool
  (NQF #104) Adult Major Depressive Disorder: Suicide Risk Assessment

- Social Environment- health literacy and attention to disparities
  Health literacy; education (e.g., graduation rate); community safety; poverty level; disparities-sensitive measures; Measure example:
  (NQF #720) Children Who Live in Communities Perceived as Safe

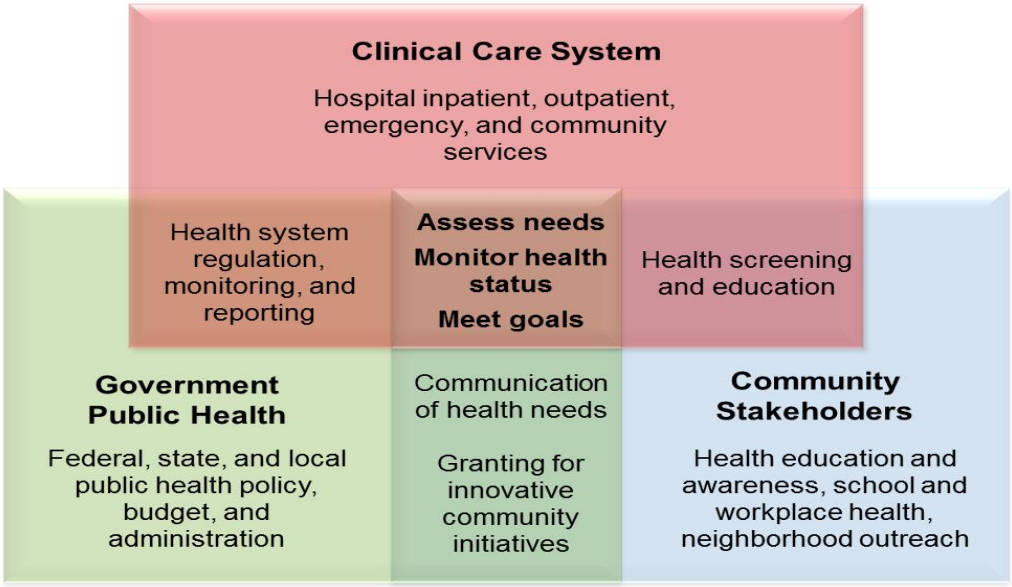
- Physical Environment- built infrastructure and natural resources
  Healthy food options, neighborhood walkability, air quality; Measure example:
  (NQF 1346) Children Who Are Exposed To Secondhand Smoke Inside Home

Hospitals have an interest in population health management for many reasons, including:

- Caregivers are passionate about promoting health.
- Length of stay, readmissions, and complications are linked to health and wellness of patients before and after hospital stay.
- Increased policy efforts can improve care coordination between hospitals, primary care, pharmacy, and the entire medical neighborhood.
- Hospital data can be used to assess community health.
- Community health initiatives build goodwill and reinforce non-profit status.
- Hospitals are themselves parts of the communities in which they are located.

Hospitals' expanded interest and work to improve population health overlaps significantly with their own quality measurement and performance, as illustrated in Figure 4 below.

Figure 4. Hospital Measurement Overlap with Population Health Measurement



Maryland state health agencies must continue to collaborate in both measurement and improvement of quality in our broader community. Hospitals, for example, engage in community needs assessments and link these assessment findings in their community benefit activities summarized in their Community Benefits Reports updated each year. In terms of phasing of implementation and use of population health measures for potential use in hospital payment incentive programs, the Workgroup discussed first measuring healthy behaviors and preventive services for hospital patients, then expanding to assessing community health needs and developing a measurement strategy around improvement, and finally collaborating with public health officials and community services on measuring progress in addressing community needs. Some of the population health measures could directly be applicable for measuring hospital performance; however; existing measurement definitions often times capture a geography or group of people and would require further methodological development to adapt to hospital specific performance measurement in this phasing approach.

Person (Patient and Family) Centered Care Measures

NQF conducted a Person-Centered Care Measure Gaps Project that defined Patient and Family Centered Care as "an approach to the planning and delivery of care across settings and time that is centered on collaborative partnerships among individuals, their defined family, and providers of care." This care also "supports health and well-being by being consistent with, respectful of, and responsive to an individual's priorities, goals, needs, and values." Key principles for these measures include:

- They are meaningful to consumers and built with the involvement of consumers
- They are focused on their entire care experience, rather than a single setting or program

- They are measured from the person's perspective and experience (i.e., generally patient-reported unless the patient/consumer is not the best source of the information)

Person centered care measure sub-domains with examples of measures are listed below.

- Experience of Care
  Measure examples:
  (NQF #166) HCAHPS- Survey for Hospital Inpatients on Communication with doctors, Communication with nurses, Responsiveness of hospital staff, Pain control, Communication about medicines, Cleanliness and quiet of the hospital environment, Discharge information.
  Communication Climate Assessment Toolkit (C-CAT)- American Medical Association Survey Tool Measure domains: Health literacy, Cross-cultural communication, Individual engagement, Language services Provider leadership commitment, Performance evaluation.

- Health-Related Quality of Life
  Functional Status; mental health assessment; "whole person" well-being; Measure examples:
  (NQF #260)Assessment of Health-Related Quality of Life (Physical and Mental Functioning) Using KDQOL-36
  (NQF #'s 0422-0428)Functional States Change for Patients with Orthopedic Impairments
  (NQF #0418) Screening for Clinical Depression and Follow-Up Plan

- Burden of Illness
  Symptom management (pain, fatigue); treatment burden (patients, family, community); Measure examples:
  (NQF #0050)Osteoarthritis: Function and Pain Assessment
  (NQF #0420)Pain Assessment and Follow-up
  (NQF #0101)Falls: Screening, Risk Assessment and Plan of Care to Prevent Future Falls

- Shared Decision-Making
  Communication with patient and family; advance care planning; establishing goals; care concordant with individual preferences; Measure examples:
  (NQF #326)Advance Care Plan
  (NQF #0310)Back Pain: Shared Decision-Making
  (NQF #557)Psychiatric Post-discharge Continuing Care Plan Created
  (NQF #1919)Cultural Competency Implementation Measure

- Patient Navigation and Self-Management
  Patient activation; health literacy; caregiver support; Measure examples:
  (NQF #1340)Children with Special Health Care Needs (CSHCN) Who Receive Services Needed for Transition to Adult Health Care
  (NQF #0603)Adults Taking Insulin with Evidence of Self-Management

A phased approach for person centered care measurement and its potential use in payment incentive models may begin by measuring experience of care (HCAHPS) which HSCRC has measured for Quality Based Reimbursement since 2009. The next phase could expand to measuring burden of illness (pain), cultural competency, and shared decision-making (care plans/procedures) measures, and finally advance to measuring improvement in functional status and patient self-management. Performance in this domain is important not only for policymakers and providers but would have particular significance for consumers.

Collaboration is Essential to Improving Population-Based, Patient Centered Care

Some of the most important potential gains in patient centered care and improving hospital efficiency and population health require community-wide interventions, outside hospital walls. Global budgets alone are unlikely to lead most GBR hospitals to collaborate around community initiatives in this area. An approach recommended by the Maryland Citizens Health Care Initiative Education Fund, Inc. in their white paper submission to HSCRC on Hospital Collaboration would directly incentivize such collaboration by rewarding a hospital, not just for its own efficiency, population health and patient centered care improvement gains, but also for those throughout its service area (link to the white paper: http://hscrc.maryland.gov/documents/md-maphs/wp-sub/HCFA-White-Paper-2-Multi-Hospital-Collaboration-060914.pdf). The white paper further suggests that DHMH should further encourage collaboration by sponsoring forums at which hospitals and other local stakeholders can develop arrangements, including gain-sharing and shared savings agreements, to reduce unnecessary costs by improving community-based care, including through investing in care coordination, perhaps starting with chronically ill Medicare patients. If successful, this approach will further integrate Maryland's new hospital financing system with the delivery system and financing reforms that are taking place outside the state's hospitals, synergistically strengthening innovations in both realms to help accomplish the Triple Aim.

NEXT STEPS: PERFORMANCE MEASUREMENT PLANNING STRUCTURE

Many factors come to bear in implementing a robust and successful performance measurement strategy that is population based and patient centered. Priorities and levers for achieving the three-part aim, performance measurement principles/criteria, and stakeholders that must have a voice will require collaboration among agencies, workgroups and stakeholders. Going forward, an updated Performance Improvement and Measurement Workgroup, for example, may work with multi-agency and multi- stakeholder groups such as those focused on consumer engagement and care coordination and infrastructure, and potential ad hoc subgroups focused on, for example, efficiency, ongoing monitoring activities, and total cost of care. Much work will need to focus on developing and implementing measures where there are gaps in important measurement areas/domains. To this end, staff will work with all the identified stakeholders through the various workgroups and ad-hoc groups to review inventories of currently available measures for each targeted domain where measurement must occur, and to identify where new measures will be required. For each of the domains and measures proposed, the Workgroup will again need to consider the purpose(s) for use of the measures—accountability (payment, public

reporting, program monitoring and evaluation), improvement, and alignment with Model targets and monitoring— as well as the stakeholders for whom these data are intended—policymakers (CMS, HSCRC, MHCC, DHMH), providers (hospitals, physicians, etc.), payers/purchasers, health plans, employers, patients, consumers.

The Performance Measurement Workgroup has reviewed a proposal of the staff as a part of the strategy for moving performance measurement work forward; Appendix B illustrates a draft plan that sketches out performance measurement expansion over time, including potential purposes, domains and potential audiences of measures/domains.

Appendix A. DRAFT Hospital and Regional Dashboard Domains and Measures

Hospital and Regional (State, County, etc.) Measures	Measurement Interval	Applicability
Revenue		
Total Inpatient Revenue	Monthly	Hospital and Regional
Total Outpatient Revenue	Monthly	Hospital and Regional
Total Revenue	Monthly	Hospital and Regional
Total Revenue Resident	Monthly	Hospital and Regional
Total Revenue Medicare Resident	Monthly	Hospital and Regional
Total Resident Revenue per Capita	Monthly	Hospital and Regional
Total Medicare Resident Revenue per beneficiary	Monthly	Hospital and Regional
Volume		
Total Inpatient Discharges	Monthly	Hospital and Regional
Total Inpatient Discharges- Resident	Monthly	Hospital and Regional
Total Inpatient Discharges, Medicare Resident	Monthly	Hospital and Regional
Total ED Visits	Monthly	Hospital and Regional
Total ED Visit - Resident	Monthly	Hospital and Regional
Total ED Visits- Medicare Resident	Monthly	Hospital and Regional
Total Equivalent Case Mix Adjusted Discharges (ECMAD)	Monthly	Hospital and Regional
Total ECMAD - Resident	Monthly	Hospital and Regional
Data Sharing		
Principle Provider Notification	Quarterly	Hospital and Regional
BETTER HEALTH		
Rates of Acute Composite AHRQ Prevention Quality Indicators	Monthy	Regional Only
Rates of Chronic Composite AHRQ Prevention Quality Indicators	Monthy	Regional Only
Maryland State Health Improvement Process		
SHIP 33- Diabetes-related ED visits	Monthly	Hospital and Regional
SHIP 34- Hypertension-related ED visits	Monthly	Hospital and Regional
SHIP 36- ED visits for mental health conditions	Monthly	Hospital and Regional
SHIP 37- ED visits for addictions-related conditions	Monthly	Hospital and Regional
SHIP 41- ED visits for asthma	Monthly	Hospital and Regional
SHIP 2- Low Birth Weight Births	Monthly	Hospital and Regional
BETTER CARE		
HCAHPS: Patient's rating of the hospital	Quarterly	Hospital and Regional

Hospital and Regional (State, County, etc.) Measures	Measurement Interval	Applicability
HCAHPS: Communication with doctors	Quarterly	Hospital and Regional
HCAHPS: Communication with nurses	Quarterly	Hospital and Regional
Maryland Hospital Acquired Condition Rates	Monthly	Hospital and Regional
All Cause Readmission Rate (CMS Methodology with exclusions)	Monthly	Hospital and Regional
Rates of ED/Observation visits within 30 days post discharge	Monthly	Hospital and Regional
Numbers/Percent of ED to Inpatient Transfers	Monthly	Hospital and Regional
Numbers/Percent of Inpatient to Inpatient Transfers	Monthly	Hospital and Regional
REDUCE COSTS		
Potentially Avoidable Utilization Costs		
Inpatient- All Hospital, All Cause 30 Day Readmissions using (CMS with adjustment)	Monthly	Hospital and Regional
ED/Observation – any visit within 30 days of an inpatient admission	Monthly	Hospital and Regional
Potentially Avoidable Admissions (as measured by AHRQ PQIs)	Monthly	Hospital and Regional
Hospital Acquired Conditions as measured by Potentially Preventable Complications (PPCs)	Monthly	Hospital and Regional

Appendix B

Measure Domains, Potential Uses and Target Audiences

	Purposes/Uses					Target Audiences			
Measure Domains	**Improve-ment**	**Account-ability**	**Pay-ment**	**Public Reporting/ Trans-perancy**	**Program Monitoring/ Evaluation**	**Policy Makers**	**Providers**	**Payers**	**Patients**
SHORT TERM									
QBR	X	X	X	X	X	X	X	X	X
MHAC	X	X	X	X		X	X		
PAU	X				X	X	X		
PQI	X (statewide / regional)				X (statewide/ regional)	X	X		
FALL 2014 UPDATES									
QBR	X	X	X	X	X	X	X	X	X
MHAC	X	X	X	X	X	X	X		
PAU	X	X	X	X	X	X	X		
PQI	X (statewide				X (statewide/	X	X		

	Purposes/Uses					Target Audiences			
Measure Domains	**Improve-ment**	**Account-ability**	**Pay-ment**	**Public Reporting/ Trans-perancy**	**Program Monitoring/ Evaluation**	**Policy Makers**	**Providers**	**Payers**	**Patients**
	/ regional				regional)				
Cost Efficiency Measures	X	X	X	X	X	X	‘X	X	X
JULY 2014- JUNE 2015 DEVELOPMENT									
Risk Adjusted Readmis-sions	X	X	X	X	X	X	X	X	X
Care Improve-ment	X				X	X	X		
Patient-Centered Care	X				X	X	X		
EHR Measures	X				X	X	X		
Care Coordi-	X				X	X	X		

	Purposes/Uses					Target Audiences			
Measure Domains	**Improve-ment**	**Account-ability**	**Pay-ment**	**Public Reporting/ Trans-perancy**	**Program Monitoring/ Evaluation**	**Policy Makers**	**Providers**	**Payers**	**Patients**
nation									
Total Cost of Care	X				X	X	X		
LONG TERM									
QBR	X	X	X	X	X	X	X	X	X
MHAC	X	X	X	X	X	X	X		
PAU	X	X	X	X	X	X	X		
PQI	X (statewide / regional				X (statewide/ regional)	X	X		
Cost Efficiency Measures	X	X	X	X	X	X	X	X	X
Risk Adjusted Readmis-sions	X	X	X	X	X	X	X	X	X

	Purposes/Uses					Target Audiences			
Measure Domains	**Improve-ment**	**Account-ability**	**Pay-ment**	**Public Reporting/ Trans-perancy**	**Program Monitoring/ Evaluation**	**Policy Makers**	**Providers**	**Payers**	**Patients**
Care Improve-ment	X	X	X	X	X	X	X	X	X
Patient-Centered Care	X	X	X	X	X	X	X	X	X
EHR Measures	X	X	X	X	X	X	X	X	X
Care Coordi-nation	X	X	X	X	X	X	X	X	X
Total Cost of Care	X	X	X	X	X	X	X	X	X

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF JULY 1, 2014

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2248N	Baltimore Washington Medical Center	5/1/2014	7/9/2014	9/29/2014	ANS/ORC	CK	OPEN
2250A	University of Maryland Medical Center	6/4/2014	N/A	N/A	N/A	DNP	OPEN
2251A	MedStar Health	6/19/2014	N/A	N/A	N/A	DNP	OPEN
2252A	MedStar Health	6/19/2014	N/A	N/A	N/A	DNP	OPEN
2253N	Fort Washington Medical Center	6/26/2014	7/26/2014	11/24/2014	CL	CK	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
BALTIMORE WASHINGTON	*	**DOCKET: 2014**
MEDICAL CENTER	*	**FOLIO: 2058**
GLEN BURNIE, MARYLAND	*	**PROCEEDING: 2248N**

Staff Recommendation

July 9, 2014

Introduction

On May 1, 2014, University of Maryland Baltimore Washington Medical Center (the "Hospital"), a member of the University of Maryland Medical System, submitted a partial rate application to the Commission requesting a new rate for Anesthesiology (ANS) and Operating Room Clinic Services (ORC). The Hospital requests that the ANS and ORC rates be set at the lower of a rate based on its projected costs to provide ANS and ORC services or the statewide median and be effective July 1, 2014.

Staff Evaluation

To determine if the Hospital's ANS and ORC rates should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for ANS and ORC for FY 2014. Based on information received it was determined that the ANS and ORC rate based on the Hospital's projected data would be $4.99 per minute and $17.05 per minute respectively while the statewide median for ANS and ORC services is $2.15 per minute and $16.57 per minute respectively.

This rate request is revenue neutral and will not result in any additional revenue for the Hospital as it only involves carving out ANS and ORC services from the current approved revenue for Operating Room services. The Hospital currently charges ANS and ORC as a rollup to its OR rate. The Hospital wishes to carve these services out to reflect a more accurate cost finding. The new proposed rates are as follows:

	Rate	Budgeted Volume	Approved Revenue
Operating Room	$26.19	1,314,479	$34,430,155
Anesthesiology	$2.15	1,442,813	$3,076,489
Operating Room Clinic Services	$16.57	187,208	$3,102,048

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That an ANS rate of $2.15 per minute be approved effective July 1, 2014;

2. That an ORC rate of $16.57 per minute per be approved effective July 1 2014;
3. That an OR rate of $26.19 per minute be approved effective July 1, 2014;
4. That the ANS, ORC, and OR rates not be rate realigned until a full year's cost experience data have been reported to the Commission; and
5. That these new services will be subject to the provisions of the new volume or Global Budget policies.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2014**
MEDICAL CENTER *		**FOLIO: 2060**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2250A**

Staff Recommendation

July 9, 2014

I. INTRODUCTION

University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on June 4, 2014 for an alternative method of rate determination pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for solid organ transplant and blood and bone marrow transplants for one year with Aetna Health, Inc. beginning August 1, 2014.

II. OVERVIEW OF THE APPLICATION

The contract will be continue to be held and administered by University Physicians, Inc. ("UPI"), which is a subsidiary of the University of Maryland Medical System. UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating recent historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement and found it to be favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

Based on the Hospital's favorable performance, staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ transplant, gamma knife, and blood and bone marrow transplant services, for a one year period beginning August 1, 2014. The Hospital will need to file a renewal application to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
MEDSTAR HEALTH	*	**DOCKET: 2014**
	*	**FOLIO: 2061**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2251A**

Staff Recommendation

July 9, 2014

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on June 19, 2014 on behalf of Union Memorial Hospital (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year beginning August 1, 2014.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was renegotiated in 2007. The remainder of the global rate is comprised of physician service costs. Also in 2007, additional per diem payments were negotiated for cases that exceed the outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to HRMI for all contracted and covered services. HRMI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between HRMI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the results of last year's experience under this arrangement and found that they were favorable. Staff believes that the Hospital can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's request for continued participation in the alternative method of rate determination for cardiovascular services for a one year period commencing August 1, 2014. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
MEDSTAR HEALTH	*	**DOCKET: 2014**
	*	**FOLIO: 2062**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2252A**

Staff Recommendation

July 9, 2014

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on June 19, 2014 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for orthopedic services with MAMSI for a one year period beginning September 1, 2014.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to HRMI for all contracted and covered services. HRMI is responsible for billing the payer, collecting payments; disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The Hospitals contend that the arrangement between HRMI and the Hospitals holds the Hospitals harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the experience under this arrangement for the last year and found that it

was favorable. The staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for continued participation in the alternative method of rate determination for orthopedic services, for a one year period, commencing September 1, 2014. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

REPORT

ON

EXISTING GLOBAL BUDGET CONTRACTS

AND CHANGES FOR RATE

YEAR 2015 AND BEYOND

Health Services Cost Review Commission
4160 Patterson Avenue Baltimore, MD 21215
(410) 764-2605

July 9, 2014

This report has been prepared for presentation to the Commission at the July 2014 Public Commission Meeting. No action is required.

A. Introduction

During the last six months, all hospitals in Maryland have chosen to have their revenues regulated in a manner consistent with the new All Payer Model. The All Payer Model reflects the transition from a rate setting system that has been focused on cost-per-case to one that has a three part aim of promoting better care, better health, and lower cost. In contrast to the previous Medicare waiver, which focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model is focused on controlling increases in total hospital revenue per capita.

At the core of the All-Payer Model are global revenue models that encourage hospitals to focus on population health and care improvement by prospectively establishing an annual revenue budget for each hospital. The HSCRC is currently using two global models: the Total Patient Revenue (TPR) model, which has existed for more than thirty years, and which now covers ten (10) hospitals located in relatively rural areas of the State; and the Global Budget Revenue (GBR) model, which was introduced in 2013, based on the pre-existing TPR methodology, and which is available to all hospitals in the State, including those in urban and suburban areas.

Under both the GBR and TPR models, each hospital's total annual approved revenue is established by formal agreement at the beginning of the fiscal year. Total annual revenue is derived from a historical base period level of revenue that is adjusted to the rate year for inflation, retroactive (plus or minus) changes (for compliance, etc.), volume levels, and other factors in accordance with HSCRC-approved policies.

The HSCRC staff believes it is timely and appropriate to evaluate the need for any immediate changes in the GBR and TPR agreements and to address policy issues that arose during or after the implementation process. Accordingly, the HSCRC staff developed a summary of the key provisions of the GBR and TPR contract "templates" and provided that summary to a subgroup of the Payment Models Work Group for review and discussion. The reviewers were asked to provide their recommended changes. The subgroup that engaged in the review was representative of stakeholders from consumers, payers, employers, and providers. The results of the detailed review by the subgroup were shared with the Payment Models Work Group. Additional input from the Payment Models Work Group was also considered by the HSCRC staff.

This Report summarizes the recommendations that arose from the review of the TPR and GBR templates. These recommendations will require both short-term and long-term consideration by the staff and the Commissioners before any changes are implemented.

A. Overview of Global Budgets

The TPR and GBR agreements provide for the operation of global revenue budgets within the following framework:

- Total annual revenue is determined from a historical base period that is adjusted to account for several factors.
- A fixed revenue base is set for a 12 month period with annual adjustments.
- Hospitals retain revenue related to reductions in potentially avoidable utilization (PAU)
- Hospitals can invest savings in care improvement, use the revenue capacity to provide enhanced services, or make other use of the savings.
- Annual updates are provided for inflation, based on Commission approved levels.
- Annual quality adjustments are provided based on Commission approved policies.
- An allowance is provided for demographic changes based on the agreements.
- The revenues are subject to adjustment for efficiency and other adjustments determined by HSCRC policy. Revenues are subject to adjustments to maintain compliance with the All-Payer Model.
- The agreements provide for potential adjustments for shifts in service loads between regulated hospitals (referred to as market share adjustments) or to unregulated settings.
- Other annual adjustments include those for payer mix differential, changes in assessments, price variances, overages and underages from the approved global budget, and uncompensated care.

Once the overall revenues are approved, unit rates are calculated for each hospital by HSCRC staff based on historical volumes and existing rate setting principles. The Commission issues hospital-specific rate orders that contain unit rates and overall allowed revenues.

Hospitals are permitted to increase or decrease their approved unit rates in order to generate their overall approved revenue. If volumes decrease, the hospitals are permitted to raise their unit rates to generate the approved level of revenue. Conversely, if volumes increase, the hospitals are expected to decrease their unit rates so that they will remain in compliance with their overall approved revenue budgets.

B. Review of Global Agreements and Recommendations

1. *Updates*

Many of the specific provisions in the GBR and TPR agreements are identical or similar to each other. This similarity is not surprising because the GBR agreement was modeled on the pre-existing TPR agreement. The most significant differences between the GBR agreements and the previous TPR agreements consist of modifications that were needed to conform the new TPR and GBR agreements to the new All-Payer Model and to add some consumer protections (e.g., assurances that needed services will be provided in a high quality manner, etc.). The TPR agreements do not include some of the specific clauses that have been included in the GBR

agreements to address these issues, but they do include general clauses that the HSCRC staff believes are sufficiently encompassing.

The review group ("Commenters") agreed that it would be appropriate to move to a single agreement, which would cover both TPR and GBR arrangements, when the current GBR agreement template is redrafted. The reviewers acknowledged that some differences in the terms of the agreements will be appropriate on a hospital-specific basis due to the location of the hospitals, the varying lengths of time that the hospitals have operated under the models, and other factors. The reviewers recommended that the HSCRC staff should develop a new standard template agreement for FY 2016 and address any immediate changes that are needed before FY 2016 through addenda to existing agreements. This schedule would give the HSCRC staff adequate time to update the existing TPR and GBR agreements into a new model template and would allow the staff to address any immediate concerns through adjustments to particular existing agreements.

2. Reporting Templates

The GBR agreement requires the hospitals to submit monthly reports on compliance and other aspects of the operations and impact of the GBR model. The GBR agreement also requires the hospitals to report on their investments in infrastructure support (e.g., case managers, care coordinators, etc.) that are designed to promote achievement of the various goals of the All Payer Model. The HSCRC staff will convene subgroups of the Payment Models Work Group with a goal of providing reporting templates by early fall.

3. Underage and Overages

As described above, each of the GBR and TPR hospitals is provided with an aggregate revenue budget for the upcoming rate year. A hospital is permitted to adjust its unit rates, within defined maximum corridors, to generate the approved aggregate revenue. If a hospital charges less than the aggregate approved revenue, this difference is referred to as an underage. Conversely, charges above the approved aggregate revenue are referred to as an overage. The GBR and TPR agreements address underages and overages, relative to the global budgets, by providing that underages (or overages) will be added to (or subtracted) from the total approved budget for the succeeding rate year as one-time adjustments.

The GBR agreement provides for a penalty of 40% when underages or overages exceed 0.5%. The HSCRC staff established this strict compliance policy because of the pressing need for enhanced compliance under the new All-Payer Model. Additionally, the HSCRC staff does not want to carry forward underages beyond a reasonable level to the budget of the following year, because that practice could yield unexpected and detrimental fluctuations in revenue budgets. It might also result in overall revenue budgets and unit charges that are unreasonable, if the underages resulted from the inability of particular hospitals to charge up to the level of their revenue budget because of large overall volume reductions. Nevertheless, some reviewers felt that a corridor of 0.5% may be too tight.

The TPR agreement, which was crafted before the new All Payer Model was conceptualized or implemented, does not include penalties for overages or limits on the carryover of underages.

The HSCRC staff is planning to change the corridors for GBR hospitals and to introduce the same corridors for TPR hospitals, as shown in Table 1. These corridors would be implemented through addenda to the existing TPR and GBR agreements during the rate update process for FY 2015.

Table 1

Corridors for Overages	
Overages 0 to .5% above total approved revenue budget .5% to 1% above total approved revenue budget 1% and more above total approved revenue budget	 No penalty 20% penalty 50% penalty
Corridors for Underages	
Underages 0 to .5% below total approved revenue budget .5% to 1% below total approved revenue budget 1% to 2% below total approved revenue budget Above 2%	 No penalty 20% penalty applied to reduce carryover 50% penalty applied to reduce carryover No carryover

Intentional overcharges are not permitted under the TPR/GBR agreements. If HSCRC staff observes a pattern of overcharges by some hospitals, it will reduce the overcharge corridor and increase the penalties on a hospital-specific basis.

4. Unit Rate Charge Corridors

As discussed above, both the TPR and GBR agreements allow hospitals to increase or decrease their approved unit rates to generate the overall approved global revenue for the hospital. However, the HSCRC's rate system includes a corridor that limits increases or decreases. If rate changes exceed or are lower than 5% of approved unit rates, then the hospital must seek permission to expand the charge corridor to 10%. Neither the TPR nor the GBR agreements specify a process whereby the corridors might be expanded beyond 10%. In particular, underages below 10% are not added back to hospitals' approved revenues. The HSCRC staff intends to address several issues of concern that have been raised concerning this policy based on initial input from the Work Group. A subgroup of the Payment Models Workgroup is being formed with the intent to address these issues by early fall.

Table 2

Policy Intent of Corridors	Commentary
HSCRC staff does not want to allow cross subsidization or shifting through undercharging in one center that is made up by overcharging in another center.	The limits provide assurance that this will not occur beyond the corridors.
If volume decreases would require rate increases beyond 10% to reach the approved revenue budget, the HSCRC staff wants to review the volume reductions to ensure that they are not the result of a shift of services to another regulated hospital, a shift to a non-regulated setting, or a failure to provide needed services.	There is a concern that the agreement does not specify how the intended policy will be addressed in evaluating requests for corridor relief. There is also a concern that there should be corridor relief beyond 10% to allow hospitals to continue to reduce avoidable utilization. Recommendation: HSCRC staff should form a subgroup to develop clear approaches to management of the agreement that will promote achievement of the goals of the global budget (e.g., promoting clinical improvement and reducing potentially avoidable utilization), while also addressing concerns relative to shifts or failure to provide services. This review should be done promptly in order to reduce uncertainty about the operation of global budgets and the investments that hospitals will need to make to reduce avoidable utilization and improve care and clinical management.
In order for the corridors to function, HSCRC staff indicated that the base period volumes would be maintained in place unless the revenue was rebased. This maintains consistency between the revenue budget and the initial volumes that established the budget.	There was a concern raised that rate realignment cannot occur effectively if volumes are not updated. HSCRC staff agrees with the importance of rate realignment. HSCRC staff will work with the subgroup referred to above to address this issue and make recommendations for consideration by the Payment Models Work Group.

5. December 31 Revenue Targets

While the TPR and GBR agreements are for fiscal years, the hospitals need to maintain compliance with calendar year targets, since both the All-Payer Model revenue limits and Medicare savings requirements are measured on a calendar year basis. The HSCRC Staff will provide a contract addendum for FY 2015 and beyond that will specify December 31 revenue targets that should not be exceeded on a hospital-specific basis.

C. Demographic Adjustment

As indicated above, the TPR and GBR agreements adjust approved hospital revenue levels to reflect demographic changes (i.e., increases/decreases in population and changes in the age/sex mix). In the past, the HSCRC staff developed a revenue adjustment based on county level

population estimates, which was used for the TPR hospitals. For GBR hospitals, most of which are located in urban or suburban areas, the HSCRC staff developed a newer, more precise demographic adjustment using a "virtual patient service area" (VPSA) for each hospital. This VPSA-based method adjusts the revenue budgets to reflect hospital service volume changes that are expected due to changes in the demographics of each hospital's VPSA. The adjustments do not permit increases in hospital service volumes that are due to potentially avoidable utilization (PAU).

The new, VPSA-based volume adjustment approach also includes a per capita efficiency factor that is designed to bring the overall demographic adjustment under the GBR models within the level of volume growth that is permitted under the new All-Payer Model (which is based solely on population growth).

The reviewers recommended that the HSCRC should use an expanded number of age cohorts in the volume adjustment. The HSCRC staff has accepted this recommendation and applied it in the updated calculations. The reviewers were also concerned about the initial (i.e., FY 2014) demographic calculation because it used statewide PAU percentages in reducing the age-adjusted weights, whereas the levels of PAU vary across the State. The staff has responded by removing the PAU percentages from the weights and applying the overall PAU adjustment on a hospital-specific basis. A more detailed description of the updated demographic adjustment can be found at: http://www.hscrc.state.md.us/pdr_clarifications.cfm .

D. Summary

The TPR and GBR global budget agreements are already similar to each other and should be consolidated when new templates are developed. Appropriate differences associated with individual hospitals should be retained. The target date for completion of a new template covering both TPR and GBR hospitals is FY 2016.

The demographic adjustment used for the GBR agreement for FY 2014 has been updated for FY 2015.

The HSCRC staff needs to develop several TPR/GBR reporting templates and will proceed to do so with input from the work group.

The following TPR/GBR contract provisions require immediate action as described:

- Corridors: The HSCRC staff has developed a new provision regarding overall corridors for the agreements and intends to implement this provision through an addendum to the existing agreements.
- December Revenue Targets: The HSCRC staff will provide each hospital with a December 31 revenue target. These targets will be implemented through an agreement addendum.

- Implementation of Corridor Limits: The HSCRC staff needs to remove uncertainty regarding the way in which the corridors will be implemented. This activity should be undertaken and completed by the fall. The staff intends to work with a subgroup of the Payment Models Work Group to review the operation of corridors. Staff will provide the Commission with an update on this activity in the fall.

Staff Recommendation

July 9, 2014

The Commission staff recommends for final adoption revisions to the Relative Value Unit (RVU) Scale for Laboratory services. The revisions are specific to Appendix D of the Accounting and Budget Manual. A workgroup comprised of experienced hospital and clinical personnel was formed to address concerns regarding EKG. The RVU scale was updated to reflect the addition of new codes added to the Current Procedural Terminology (CPT) codes in 2013 to reflect new technology and to reflect the move of Apheresis and the costs of Bone, Organ and Tissue to the Clinic and Medical Surgical Supplies cost centers respectively for a more appropriate classification of these services. The proposed changes were sent to all hospitals for comment. Comments were received; and all participants are in agreement with the proposed changes. Hospitals will be required to shift costs related to Apheresis and Bone/Tissue Organ to assure no change in hospital revenue as a result of this revision. Hospitals will begin using these revised RVUs effective July 1, 2014.

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

TO: Commissioners

FROM: Legal Department

DATE: July 9, 2014

RE: Hearing and Meeting Schedule

Public Session:

***NOTE:** The next public meeting is currently scheduled for August 13, 2014 at 1:00 p.m. at 4160 Patterson Avenue, HSCRC Conference Room. It is possible that this meeting could be cancelled so please monitor the HSCRC website for more information.

September 10, 2014 at 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

Please note that the Commissioner's packets will be available in the Commission's office at 11:45 p.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website.
http://hscrc.maryland.gov/commissionMeetingSchedule2014.cfm

Post-meeting documents will be available on the Commission's website following the Commission meeting.