Data and Infrastructure Work Group Report to the Commission:

Recommendations on Data Requirements for Monitoring the All-Payer Model

Health Services Cost Review Commission

4160 Patterson Avenue Baltimore, MD 21215

(410) 764-2605

May 14, 2014

This document contains recommendations from the Data and Infrastructure Work Group for addressing the immediate data needs of all-payer model. The recommendations in this report are for discussion purposes and do not require formal action by the Commission.

I. Background

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

1. Maintain growth in Maryland acute hospital all-payer charge per capita, for Maryland residents, below 3.58%, the 10 year average of Maryland state GDP growth;

2. Maintain growth in acute hospital Medicare payment per Maryland beneficiary below the national average, resulting in at least $330m of savings by the end of five years;

3. Reduce the Medicare 30-day all-cause hospital readmission rate to below the national Medicare 30-day all-cause hospital readmission rate by the end of five years;

4. Achieve 30% aggregate reduction across all 65 Potentially Preventable Complications in Maryland's Hospital Acquired Conditions program in five years.

In light of these commitments, HSCRC convened four workgroups to make recommendations on implementation issues. One of the workgroups, Data and Infrastructure Workgroup ("Workgroup"), was charged[1] with making recommendations on the data and infrastructure requirements to support oversight and monitoring of the new hospital All-Payer Model. The workgroup considered the needs of the HSCRC, as well as, the needs of the health care industry and other stakeholders to achieve the goals of the model. The first task of the Workgroup was to make recommendations on data needed to:

- Support rate setting activities;
- Conduct evaluation activities using the key performance indicators;
- Monitor and evaluate model performance;
- Monitor shifts in care among hospitals and other providers; and
- Monitor the total cost of care.

This report includes recommendations on the best sources of data to meet the monitoring and compliance requirements of the new model. These initial recommendations are focused on the monitoring requirements included in the contract between Maryland and CMS and do not reflect the full range of data monitoring and infrastructure needs to achieve the goals of the new model. After considering the initial set of measures, the Workgroup in collaboration with other workgroups, will focus on the expanded performance measurement system and related infrastructure needs to support the broader goals of the model. In addition, the HSCRC will work with CMS to address the misalignment of the reporting requirement timelines because monitoring

[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

measures are due by June 30; however, data for most of the measures will be not be available until the summer or fall of the calendar year.

II. CMS Compliance and Monitoring Commitments

Appendix A contains a list of all measures to monitor the progress of the new All-Payer Model Demonstration. The measures in the list are grouped as follows:

Performance Target Data: This set of measures encompasses specific targets determined under the new model and will require close and timely monitoring of the data. HSCRC will provide the data on the All-Payer per capita test and Potentially Preventable Complications, while CMS will report results on Medicare per beneficiary hospital payments and readmissions.

Guardrails Data: In addition to performance targets, Maryland is committing to certain "guardrails" to ensure the success of the new model. These measures will be monitored and reported by the CMS and will trigger a review process if the conditions are not met.

Compliance Data: HSCRC is committing to collect and monitor these measures in the new model contract at least on an annual basis.

Monitoring Data: To monitor Maryland's progress in achieving the three-part aim (patient experience of care, population health measures, and hospital costs/efficiency measures) the new model contract identifies a set of measures in each domain. These domains and examples of these measures are as follows:

- Patient experience of care, such as patient satisfaction scores on HCAHPS
- Population health measures, such as rate of preventable utilization
- Hospital cost measures such as per capita total health care expenditures for all-payers, and efficiency of diagnostic imaging testing.

For more specific information on individual measures, please see Appendix A: "Monitoring Commitments and Gap Analysis."

III. Recommended Sources of Data and Gap Analysis

HSCRC staff reviewed the compliance documentation for the new All-Payer Model Demonstration and identified current available data sources for the majority of the data reporting and monitoring commitments. The Workgroup reviewed these data sources and provided feedback (please refer to Appendix A for the data sources identified for each compliance, guardrail or monitoring measure).

The evaluation of the measure list within the contract identified five areas with gaps in available data. Potential sources of data and strategies for monitoring required more detailed consideration by the Workgroup and are discussed below.

1. Shared Savings Amounts from Medicare Programs for Maryland Hospitals

The new model contract stipulates that "The State [of Maryland] shall require all Regulated Maryland Hospitals that are participating in Medicare programs, demonstrations, or models involving shared savings to provide information to the State no less than annually on the amount of any and all shared savings payments distributed to the hospital, regardless of the entity receiving the payment from CMS. The State [of Maryland] must transmit all such information to CMS no later than 60 days following receipt." Since the required information is not easily available from public resources or from CMS, the HSCRC's best approach is to develop an instrument to collect this information directly from hospitals and require submission of this data through regulation.

2. Physician Participation in Public Programs and Engagement in Innovative Models of Care

Physician participation and engagement is a critical success factor for the new model. The All-Payer Demonstration model requires the continued participation of providers in public programs and innovative models of care. As part of its reporting requirements on patient experience of care, CMS requires Maryland to report the number of physicians participating in Medicare and Medicaid, as well as, healthcare reform initiatives such as ACOs and bundled payments. This will allow Maryland to monitor access to physician's trends in as it aims to reduce hospital admissions and drive care to lower cost settings.

With input from the Workgroup, HSCRC staff identified several potential sources for physician participation data:

- <u>Provider participation in Patient Centered Medical Home Initiatives:</u>
  Several national organizations recognize or certify providers as Patient Centered Medical Homes (PCMH). The National Committee for Quality Assurance (NCQA) has the largest recognition program and is a potential source to identify the number of providers recognized as Medical Homes. NCQA has a readily available on-line directory of clinicians and sites that have received NCQA recognition as a medical home, including their level of recognition. The Joint Commission and URAC (another national accreditation organization) also recognize PCMH providers; however, their data is not as easily accessible on-line. An advantage of relying on the NCQA, Joint Commission or URAC recognition is that it represents a standardized definition of medical homes that enable cross state comparisons, as well as comparisons over time.

  However, relying solely on national accrediting organizations as a source of data could underestimate the number of providers participating in other medical home initiatives in

Maryland. The Workgroup stressed that the NCQA definition is too restrictive and does not capture the breadth and scope of all PCMH programs in the State. For instance, CareFirst has significant provider participation in its Medical Home initiative that does not require national accreditation. Other payers have similar initiatives and the MHCC leads the multi-payer PCMH, which all have different requirements. The Workgroup was interested in understanding participation in these types of initiatives, but acknowledged that there were challenges to getting consistent data. This information would have to be collected from payers who are engaged in PCMH initiatives and the various PCMH initiatives may have different definitions of medical home as well as, requirements for recognition. The State Innovation Model (SIM) Community Integrated Medical Home (CIMH) advisory board will be addressing this issue and investigating a broader definition of PCMH that reflects the innovation in Maryland and is not restricted to the NCQA definition.

In the meantime, the Workgroup recommended relying on the information available through the national accrediting organizations (primarily NCQA). Although the NCQA will not capture all of the providers participating in PCMH, it will allow HSCRC, in the short-term, to monitor trends that may reflect the broader PCMH environment. In the long term, HSCRC is looking to possibly work with the SIM Community Integrated Medical Home Advisory Board to leverage their work to develop broader definitions of PCMH and with MHCC to amend their annual report submitted by carriers to capture the number of participating physicians in PCMH programs.

- <u>Provider participation in ACOs or Bundled Payment Initiatives:</u>
  The HSCRC should rely on CMS to provide data for the number of providers participating in Medicare ACOs or Bundled Payment Initiatives. It is important to note that, to date, CMS does not permitted Maryland hospitals to participate in Medicare-funded bundled payment demonstrations; however, the agreement with CMS encourages Maryland to come forward with proposals under different CMMI initiatives.

  Through HSCRC rate-setting methodologies, Maryland hospitals have been engaging in bundled payment arrangements since the 1990's. The HSCRC is authorized by law to promote and approve alternative methods of rate determination and payment that are of an experimental nature in order "[t]o promote the most efficient and effective use of health care facility services, if it is in the public interest and consistent with the subtitle."

  The Alternative Rate-setting Methodology (ARM) was developed to encourage innovative and cost-saving payment arrangements without compromising the Commission's long-standing principles of equity and access. There are two types of ARM arrangements:

  - Capitation: This type involves significant risk to the hospital for a broad range of services, including regulated hospital services

- Global or Fixed Price: This type encompasses not only the hospital rates associated with a case but also the professional services provided during the course of treatment, usually negotiated between a hospital and a physician group as a joint venture.

HSCRC will develop a summary report of ARM statistics to address this measure.

- Medicare participating physicians per enrollee:
  Medicare maintains the Medicare.gov Physician Compare directory to provide information on physicians and other providers participating in Medicare. This data source has some challenges, including potential duplication in provider data and a lack of current information on whether providers are actively seeing Medicare beneficiaries or open for new patients. However, this data source is preferable to trying to collect self-reported data on participation in public programs through provider surveys.

- Medicaid participating physicians per enrollee:
  The Medicaid program maintains a directory for all providers participating in the HealthChoice program. Medicaid also issues ID numbers to all participating providers. There are some challenges to relying on the HealthChoice provider directory and Medicaid provider IDs as a resource, including potential duplication of providers, or providers who are not actively seeing Medicaid patients or other inaccuracies. Nonetheless, this is the best data source available. As this data is reported in the future it will be important to distinguish when changes in participating providers may actually be a result of further efforts to clean up the provider data.

3. "Discharges with Primary Care Provider Identified" modified to "Discharges where the 'Principal Provider of Care' was Notified"

The monitoring plan with CMS requires measures to assess patient experience of care. One of these measures is the frequency of the primary care provider (PCP) identified on discharge to support care transitions between providers. The Workgroup's recommendation for monitoring this data will build on a solution already being deployed in Maryland to support hospital efforts to meet meaningful use requirements (Stage 2 Summary of Care/Transitions of Care Measure) and redefine the measure as percent of discharges where the "principal provider of care" was notified. CRISP currently operates an Electronic Notification Service (ENS), that sends information on inpatient admissions and discharges, as well as emergency department visits, on a real-time basis to the Principal Provider of Care (PPC), which includes specialty providers and PCPs. ENS works by gathering patient panels directly from the providers rather than relying on self-reported data from patients during the admission process which is known to be unreliable in Maryland as well as nationally. Recently, CRISP started providing a service to send discharge summaries to the PPCs who subscribe to the ENS.

The Workgroup recommended using data from CRISP for the number of discharges for which there is an associated ENS alert to a provider. This standard is much higher than the CMS

required measure, which only considers whether a PCP was identified on discharge. The CRISP data source will allow us to provide information on the number of discharges where a discharge summary was sent to the provider via the ENS. While this measure is not exactly consistent with CMS requirement, there is a strong case to be made that this measure is a better indicator of supporting transitions in care and more consistent with meaningful use requirements. The Workgroup also suggested that the HSCRC should work with CRISP to create more specific information to capture primary care providers receiving notifications.

4. All-Payer Total Cost of Care Measures

The All-Payer Demonstration Model requires Maryland to monitor the total cost of care for Maryland Medicare beneficiaries, as well as, all Maryland residents. Specifically, Maryland must monitor trends in healthcare costs outside of its regulatory domain and any shifts of cost to unregulated settings. This measure is also of interest to many payers in Maryland.

In its application to CMMI, Maryland indicated it would leverage the existing Maryland Medical Care Data Base (MCDB) to monitor total cost of care trends and to ensure compliance with the monitoring requirement, in the contract, Maryland agreed "to make the best efforts to obtain data from Maryland Payers necessary to evaluate and monitor the model." In addition, the Maryland General Assembly passed legislation in 2013 that stated "each payer shall comply with the applicable terms and conditions of Maryland's All–Payer Model contract approved by the federal Center for Medicare and Medicaid Innovation."

The MCDB, Maryland's All Payer Claims Database (APCD), is managed by the Maryland Health Care Commission (MHCC). The MCDB contains claims-level information on approximately 3.6 million Maryland residents, who are privately insured. There are currently 4 types of claims-related files: professional services, institutional services, pharmacy services, and medical eligibility.

Under new MHCC regulations, the MCDB will include Medicaid data for approximately 900,000 MCO enrollees for calendar year 2012 by June 30, 2014. Discussions are ongoing regarding the timeline for subsequent Medicaid data submissions.

In the private insurance market, the MCDB includes a relatively complete representation of the fully-insured individual, small-group, and large group markets; however, data regarding the self-insured market has had gaps, particularly in the self-insured market as they were not required to report data to the MCDB in the past. To address this gap and to include plans sold on the Maryland Health Benefit Exchange (MHBE), MHCC revised its regulations in 2013 to require pharmacy benefit managers (PBM), behavioral health administrators, third party administrators (TPA), and all MHBE plans to report to the MCDB.2 Furthermore, the threshold for reporting was

[2] In 2014, four qualified health plans (CareFirst, AllSavers (United Health Care), Kaiser Permanente of the Mid-Atlantic, and Evergreen Health Insurance (Coop)) and eight qualified dental plans (Delta Dental (x2), United Concordia, Best Life

changed to be based on the covered lives, with all payors with 1,000 or more covered lives being required to report to the MCDB. The new regulations also added reports for plan benefit design and non-fee-for service claims for non-MHBE plans and for dental services on the MHBE. These new reports will be required starting with the 2014 quarterly data submissions.

For calendar year 2013, the existing entities will submit their annual report in July 31, 2014 and the cleaned database is expected to be available by the end of September 2014. Starting with 2014 claims data, files will be submitted quarterly, with the exception of the first two quarters, which will be submitted together on the new Extraction, Transform, and Load (ETL) system. For bills paid in the first two quarters of 2014, regardless of service date, the cleaned database is expected to be available by November 30, 2014.

Knowing the critical nature of this measure, the HSCRC requested white papers from interested stakeholders to help identify methods for monitoring total cost of care and potential shifts from inpatient and outpatient hospital settings to non-regulated providers. The topic was also discussed in the Workgroup. Based on the white papers and feedback from the Workgroup, the consensus was that the claims-level MCDB was the best long-term source for robust analysis of total cost of care. However, because of current limitations (i.e., timeliness of data and gaps in data for the self-insured market), this was considered a longer-term strategy. In the short-term, the Workgroup pursued a strategy of collecting aggregated data directly from the payers on a voluntary basis. The Workgroup agreed there is an added value of collecting both aggregate and claims-level data, similar to the how HSCRC collects both aggregated financial and patient-level case mix data from the hospitals.

A subgroup was convened to develop a reporting template for payers to report aggregate total care cost and utilization information. The subgroup tried to balance a number of different goals when developing the recommended template. Because the total cost data would be collected from payers on a voluntary basis, the subgroup agreed that the template needed to meet the following criteria:

- Must be simple enough to be feasibly reported on a regular basis;
- Provide clear definitions to ensure consistent reporting across payers and build on definitions that can be validated by other data sources;
- Build upon existing and well-documented reporting models; and
- Sufficiently disaggregate data to allow HSCRC and stakeholders to understand the shifts between regulated and non-regulated settings.

The subgroup reviewed examples of total cost of care reporting templates in order to develop the proposed reporting template (see Appendix C). The subgroup gave focused attention to the Medicaid program's HealthChoice Financial Monitoring Report (HFMR), which is a reporting

and Health, Dental Quest, Dominion Dental Services, Metropolitan Life and Health Insurance, Guardian Life of America) sold on the Maryland Health Benefit Exchange.

template that was developed by the Medicaid program to support their rate setting activities with managed care organizations and has been in place for over fifteen years. The HFMR provided a relatively simple model to collect cost and utilization information from different payers and was used as a starting point for subgroup to develop a proposed reporting template. Payers on the subgroup emphasized the importance of providing clear and detailed instructions for reporting in sufficient time to produce the requested data. Medicaid, Medicare Advantage and commercial payers were engaged in the subgroup discussions. Medicaid, in particular was actively engaged, noting the administrative challenges of reporting the data and the need to recognize the limitations of collecting aggregate data.

The work group recommendations for collecting total cost of care data include:

- **Collect aggregate total cost of care data from payers on a voluntary basis consistent with the initial reporting template developed by the subgroup (Total Cost of Care Report)**: This reporting template is designed to collect data that will help understand shifts in care settings from regulated to unregulated settings in the short-term. The reporting template relies on aggregate data and will not be able to replace a longer-term strategy of using the MCDB for robust analysis of claim level data. The services included in the template are intended to be sufficient to understand shifts. Reporting will need to be disaggregated by market segment so that shifts in care setting or changes total cost of care may be understood in the context of benefit design and changes in coverage. Data should be collected based on the county of residence of plan member and age cohorts that are consistent with other policies implemented by the Commission.

- **Develop detailed template reporting instructions in sufficient time for payers to report data**: The HSCRC should continue to engage the subgroup to review detailed reporting instructions for the Total Cost of Care Report. The goal is to finalize the reporting instructions by July 2014 with at least three months prior to reporting deadlines as requested by the payers. The template resembled the HFMR reporting tool, with additional population segments and service breakouts is already developed based on the discussions with the group (see Appendix C). The workgroup identified areas that would need very specific definitions to ensure consistent collection across payers: place of service, age categories, mapping zip code to counties, and expenses (allowed charges, out of pocket payments etc.).

- **Begin to collect data by October 2014 and establish a routine reporting schedule**: The goal is to collect the first payer Total Cost of Care Report by the fall of 2014 and to engage the subgroup to finalize the subsequent reporting schedule.

5. Outpatient Hospital Cost/Efficiency Measures

The monitoring list for hospital cost includes six outpatient imaging efficiency measures reported by the CMS Hospital Compare. All Maryland regulated hospitals signed permissions to allow CMS

to calculate and report these measures as of January 1, 2014. Based on review of the technical specifications for these measures, three of the efficiency measures should be able to be calculated using only outpatient hospital data. However three of the measures require non-hospital outpatient claims data. The workgroup identified that for measures requiring more than outpatient hospital claims that calculations of similar measures using all-payer claims should be considered within the timelines of all-payer claims data base.

Appendix A: Monitoring Commitments and Data Sources Outlined in the CMS Contract

Measurement	Data Files	Source Agency	Monitoring Timeline	Reporting Timeline	CY Data Availability
Performance Target Data					
All-Payer per Capita Test	HSCRC Financial Database	HSCRC	Monthly, 45 days after the end of the month	May 1st	March 1st
	Population Projections and Estimates	MD Dept. of Planning	Annual, December	May 1st	December 31st
Medicare per Beneficiary Hospital Payments	National and Maryland Medicare Part-A Claims	CMS	Monthly, with 4 month lag	May 1st	May 1st
	Beneficiary Enrollment Data	CMS	Monthly, with 4 month lag	May 1st	May 1st
Readmissions	National and Maryland Medicare Claims	CMS	Monthly, with 4 month lag	June 30th	May 1st
Potentially Preventable Complications	HSCRC Case mix Database	HSCRC	Monthly, with 2 month lag	June 30th	March 1st
Guardrails Data					
Medicare per Beneficiary Total Payments	National and Maryland Medicare Part A and Part B Claims	CMS	Monthly, with 4 month lag	May 1st	May 1st
	Beneficiary Enrollment Data	CMS			
Percent of Revenue from Out of State Patients in Maryland (Medicare and All-Payer)	Medicare Claims Data	CMS	Monthly, with 4 month lag	May 1st	May 1st
	HSCRC Financial Database	HSCRC			
Compliance Data					
Shared Savings Amounts from Medicare Programs for Maryland Hospitals (from ACO's, bundled payments, etc, paid outside of claims)	To be developed	HSCRC	At Least Annually	60 days after receipt	TBD
All-Payer Total Cost and Shifts to unregulated space	See Appendix B "Rec Data Source for Gaps"			TBD	Fall

Appendix A: Monitoring Commitments and Data Sources Outlined in the CMS Contract, cont.

Measurement	Data Files	Source Agency	Monitoring Timeline	Reporting Timeline	CY Data Availability
Monitoring Data					
PATIENT EXPERIENCE OF CARE MEASURES					
HCAHPS: Patient's rating of the hospital HCAHPS: Communication with doctors HCAHPS: Communication with nurses HCAHPS : Three-item care transition measure (CTM-3)	Survey	CMS	Annual	June 30th	October
Home Health CAHPS: Patient's rating of home health agency Home Health CAHPS: Communication with the home health team	Survey	CMS	Annual	June 30th	October
Nursing Home CAHPS (State-administered survey based on) : Family members' perceptions of nursing home care	Survey	CMS	Annual	June 30th	Summer
Clinician and Group CAHPS: Patient's perceptions of care provided by a physician in an office.	Survey	CMS	Annual	June 30th	TBD
Short Stay Nursing Home Resident's discharge needs met Short Stay Nursing Home Resident's Discharge planning and information about medicines and symptoms	Survey	MHCC	Annual	June 30th	Summer
Rate of physician follow up after discharge	Claims - Medicare, Medicaid, MCDB	CMS, DHMH, MHCC	Annual	June 30th	TBD
Discharges with PCP identified (Recommended Modification to the measure)	See Appendix B "Rec Data Source for Gaps"			June 30th	Fall
Medicaid participating physicians per Medicaid enrollee;	See Appendix B "Rec Data Source for Gaps"			June 30th	Fall
Medicare participating physicians per Medicare enrollee	See Appendix B "Rec Data Source for Gaps"			June 30th	Fall

Appendix A: Monitoring Commitments and Data Sources Outlined in the CMS Contract, cont.

Measurement	Data Files	Source Agency	Monitoring Timeline	Reporting Timeline	CY Data Availability
Monitoring Data					
PATIENT EXPERIENCE OF CARE MEASURES, Cont.					
Participation of providers in patient centered medical home models	See Appendix B "Rec Data Source for Gaps"			June 30th	Fall
Participation of providers in ACOs and bundled payments	See Appendix B "Rec Data Source for Gaps"			June 30th	Fall
Quality score using process of care measures in AMI, HF, SCIP, PN, CAC	Hospital Inpatient Quality Reporting Program	CMS	Annual	June 30th	October
Quality score using process of care measures in outpatient setting	Hospital Outpatient Quality Reporting Program	CMS	Annual	June 30th	October
NHSN CLASBI SIR	Hospital Compare	CMS	Annual	June 30th	TBD
Admission Rates from Home Health Agencies to Acute Inpatient Hospital	Home Health Compare	CMS	Annual	June 30th	October
Unplanned, urgent visits to the Emergency Departments for patients receiving Home Health care				June 30th	October
Readmission rates from nursing home to acute care hospital (Readmission rate for Hospital Discharges to Nursing Homes)	Hospital Inpatient Discharge Abstract	HSCRC	Annual	June 30th	March 1st
Readmissions per 1000 residents	HSCRC Case Mix Database Population Estimates	HSCRC MD Dept. of Planning	Annual	June 30th	March 1st
Condition-Specific Hospital Readmissions Rates: • Heart Failure • Pneumonia • Acute Myocardial Infarction • Chronic Obstructive Pulmonary Disease • Hip/Total Knee Arthoplasty	Hospital Inpatient Discharge Abstract	HSCRC	Annual	June 30th	March 1st

Appendix A: Monitoring Commitments and Data Sources Outlined in the CMS Contract, cont.

Measurement	Data Files	Source Agency	Monitoring Timeline	Reporting Timeline	CY Data Availability
Monitoring Data					
POPULATION HEALTH MEASURES				June 30th	
SHIP Objective 1*: Increase life expectancy	Vital Statistics Data	DHMH	Annual	June 30th	July
Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization	HSCRC Case Mix Database	DHMH	Annual	June 30th	July
SHIP Objective 32: Reduce the % of adults who are current smokers	Behavioral Risk Factor Surveillance System (BRFSS)	DHMH	Annual	June 30th	March
SHIP Objective 33: Reduce the % of youth using any kind of tobacco product	Maryland Youth Tobacco Survey	DHMH	Annual	June 30th	June
SHIP Objective 24: Increase the % vaccinated annually for seasonal influenza	CDC National Immunization Survey; BRFSS	DHMH	Annual	June 30th	March
SHIP Objective 23: Increase % of children with recommended vaccinations	CDC National Immunization Survey	DHMH	Annual	June 30th	September
SHIP Objective 20: Reduce new HIV infections among adults and adolescents	MD HIV surveillance system; US Census Bureau; ACS 5 year Census	DHMH	Annual	June 30th	March
SHIP Objective 27: Reduce diabetes-related emergency department visits	HSCRC Case Mix Database	DHMH	Annual	June 30th	July
SHIP Objective 28: Reduce hypertension related emergency department visits	HSCRC Case Mix Database	DHMH	Annual	June 30th	July
SHIP Objective 31: Reduce the % of children who are considered obese	Maryland Youth Tobacco Survey	DHMH	Annual	June 30th	June
SHIP Objective 30: Increase the % of adults who are at a healthy weight	Behavioral Risk Factor Surveillance System (BRFSS)	DHMH	Annual	June 30th	March
SHIP Objective 17: Reduce hospital ED visits from asthma	HSCRC Case Mix Database	DHMH	Annual	June 30th	July
SHIP Objective 34: Reduce hospital ED visits related to behavioral health	HSCRC Case Mix Database	DHMH	Annual	June 30th	July
Fall-related death rate	Mortality database	Maryland Vital Statistics Admin	Annual	June 30th	July

Appendix A: Monitoring Commitments and Data Sources Outlined in the CMS Contract, cont.

Measurement	Data Files	Source Agency	Monitoring Timeline	Reporting Timeline	CY Data Availability
Monitoring Data					
HOSPITAL COST/EFFICIENCY MEASURES					
OP-8 : MRI Lumbar Spine for Low Back Pain OP-9: Mammography Follow-up Rates OP-10: Abdomen CT - Use of Contrast Material OP-11:Thorax CT - Use of Contrast Material OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)	HSCRC Case Mix Database (OP-10, 11, and 14 only) or Medicare Claims (Hospital Compare); See Appendix B "Rec Data Source for Gaps"	CMS, MHCC	Annual	June 30th	July
Per capita hospital expenditure growth (inpatient and outpatient) for: • All-payer • Medicare • Medicaid/CHIP • Private payer • Medicare/Medicaid Enrollees (Dual Eligible)	Hospital Inpatient and Outpatient Discharge Abstract; Insurance Enrollment Files	HSCRC	Annual	June 30th	March 1st
Per capita health expenditure growth (inpatient and outpatient) for: • All-payer • Medicare • Medicaid/CHIP • Private payer • Medicare/Medicaid Enrollees (Dual Eligible)	See Appendix B "Rec Data Source for Gaps"	TBD	June 30th	TBD	

Appendix B: Recommendations for Data Sources to Address Gaps Compliance Data

Measurement	Recommended Data Files	Recommended Data Source Agency	Monitoring Timeline	Limitations & Considerations
Compliance Data				
All-Payer Total Cost and Shifts to unregulated space	Total Cost of Care Template	Medicaid and Commercial Payers	Annually	Considerations include: easy to submit on regular basis; clear definitions to ensure consistent reporting; build upon existing and well-documented models; and sufficiently disaggregated
Monitoring Data				
PATIENT EXPERIENCE OF CARE MEASURES				
Discharges with PCP identified	To be developed	CRISP	Annual	Measure is not exactly consistent with CMS requirement, there is a strong case to be made that this measure is a better indicator of supporting transitions in care and more consistent with meaningful use requirements.
Medicaid participating physicians per Medicaid enrollee;	HealthChoice directory of participating providers	DHMH Medicaid	Annual	Potential duplication of providers, or providers who are not actively seeing Medicaid patients or other inaccuracies
Medicare participating physicians per Medicare enrollee	Medicare.gov Physician Compare directory	CMS	Annual	Potential duplication in provider data and a lack of current information on whether providers are actively seeing Medicare beneficiaries or open for new patients
Participation of providers in patient centered medical home models	On-line directory of clinicians and sites that have received NCQA reorganization as a medical home	National Committee for Quality Assurance (NCQA)	Annual	Does not include providers participating in other medical home initiatives in Maryland (i.e., CareFirst Initiative)

Measurement	Recommended Data Files	Recommended Data Source Agency	Monitoring Timeline	Limitations & Considerations
Monitoring Data				
PATIENT EXPERIENCE OF CARE MEASURES, cot.				
Participation of providers in ACOs and bundled payments	Medicare- Funded: To be developed; Alternative Rate Methodology Statistics	CMS; HSCRC	Annual	CMS has not permitted Maryland hospitals to participate in bundled payment demonstrations; however, the agreement with CMS encourages Maryland to come forward with proposals under different CMMI initiatives.
HOSPITAL COST/EFFICIENCY MEASURES				
OP-8 : MRI Lumbar Spine for Low Back Pain OP-9: Mammography Follow-up Rates OP-10: Abdomen CT - Use of Contrast Material OP-11:Thorax CT - Use of Contrast Material OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery OP-14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)	Claims (Hospital Compare); Other Payers (OP-8, 9, and 13 To Be Developed) (OP-10, 11, and 14 HSCRC Case Mix Database)	CMS; HSCRC; MHCC	Annual	Medicare specific measures are published at Hospital Compare website. All-payer Measures for OP-10, 11, and 14 should be able to be calculated from outpatient hospital data only. The other three efficiency measures need to be developed using all-payer claims data base.
Per capita health expenditure growth (inpatient and outpatient) for: • All-payer • Medicare • Medicaid/CHIP • Private payer • Medicare/Medicaid Enrollees (Dual Eligible)	Total Cost of Care Template for All-Payer, Medicaid & Private Payers; Medicare Data for Medicare and Dual eligible	Medicaid, Commercial Payers and Medicare	Annual	Considerations: See Total Cost of Care template above

Appendix C: Draft Reporting Template for Total Cost of Care

MD Providers																											
Acute Hospital Inpatient						Acute Hospital Outpatient												Specialty Hospitals									
All Inpatient (except Psych& Rehab)		Psych		Rehab		ER		OP/PT		Diagnostic/ Imaging		Surgery		Clinic		All Other		Psych		Rehab		Cancer Hospitals		Children's Hospitals		Chronic/ LTC	
Exp	Adm	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	NA	NA	Exp	Visits	Exp	Visits

Out of State Providers																											
Acute Hospital Inpatient						Acute Hospital Outpatient												Specialty Hospitals									
All Inpatient (except Psych& Rehab)		Psych		Rehab		ER		OP/PT		Diagnostic/ Imaging		Surgery		Clinic		All Other		Psych		Rehab		Cancer Hospitals		Children's Hospitals		Chronic/ LTC	
Exp	Adm	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits

Ambulatory Care																								Enrollment
Non-Hospital Outpatient				Professional/Clinic						Long-TermCare/Post Acute								Other							
ASC		Urgent Care		PCP		Non-PCP		Therapies		SNF		Home Health		Hospice		HCBS		Lab		Pharmacy		Imaging X-Ray		All Other Medical		
Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Exp	Visits	Member Months

Exp = Expenses; Adm = Admissions

Reporting Levels

Age Groups

Enrollee County of Residents

Market Segment

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117
www.carefirst.com

Paper 5: Monitoring the Total Cost of Care

Submitted by CareFirst 1-10-2014

1. Introduction

1.1 – Under the Demonstration, the HSCRC is required to shift at least 80% of hospital revenue to Global Models by the fifth year. Global Models are arrangements, such as the existing Total Patient Revenue (TPR) model, or the Global Budget Rate (GBR) system, which establish a fixed Target Budget and thereby provide strong financial incentives to reduce unnecessary hospital service use.

1.2 - Under the Global Model structure, hospitals will be expected to attempt to eliminate unnecessary, marginal and duplicative services. These hospitals may engage in efforts that reduce the use of hospital care and increase the use of non-hospital services. For instance, Global Model hospitals will be incentivized to: 1) coordinate with local home health and long-term care providers to actively prevent hospital readmissions; 2) triage or redirect low acuity emergency cases to primary care physician (PCP) offices or urgent care centers; 3) encourage the referral of clinical lab, imaging and other ancillary services to lower cost, non-hospital providers; and 4) restrict physician access to surgical and procedure-based services at the hospital. This last action may result in increased use by surgeons and specialists of non-hospital ambulatory surgery capacity.

1.3 - Other provider organizations operating under the incentives of at-risk or shared savings programs (such as Medicaid MCOs, Medicare Advantage Plans, SSP-ACOs and PCMH programs) will face similar incentives to move care to less expensive non-hospital sites in order to generate cost savings. For instance, the preliminary results of the highly publicized Alternative Quality Contract (AQC) Shared Savings Arrangement organized by Blue Cross of Massachusetts showed that the largest proportion of savings generated under this program in its first year came from shifts in the site of service from high to low cost providers.

1.4 - While shifts in the site of service from hospitals to lower cost non-hospital providers are generally thought to be desirable, because the costs of providing the same services in these settings is less than the cost in the hospital setting, there is a concern that such shifts will not generate overall system savings. This concern issues from the fact that Medicare and the other payers would continue to pay the hospitals for the services that are shifted (if the hospitals on Global Models do not lose revenue when the services are shifted) and they would also pay the non-hospital providers for the services that are re-directed to them.

1.5 – The CMMI has expressed concern that this dynamic could lead to increases in the total cost of care for Medicare Beneficiaries. As a result, CMMI required the contract that will govern the Demonstration to include two limitations on the growth in Medicare per beneficiary costs: one covers hospital expenditures and one encompasses all services (i.e., hospital and non-hospital services). Private payers and the Medicaid program are also concerned about the potential for "double paying" for services that have been shifted from Global Model hospitals to non-hospital providers that are not governed by the HSCRC or included in the Demonstration.

1.6 – The purpose of this Paper is to consider this overall dynamic and to: 1) identify the best available data sources and possible approaches for monitoring trends in the total cost of health care in Maryland and potential shifts of care from regulated hospital to non-hospital settings; 2) suggest a strategy for monitoring trends in the total cost of care in Maryland by payer; and 3) address the feasibility and advisability of making adjustments to hospital Target Budgets in the case of shifts of services from Global Model hospitals to non-hospital providers.

2. Considerations regarding the Shifting of Hospital Services to Non-Hospital Sites of Care

2.1 –As noted above, the CMMI is requiring the Demonstration contract to include two additional payment limitations that are designed to protect CMS against an unintended increase in the total cost of care for Medicare beneficiaries: 1) The annual growth in Medicare per capita total cost of care for Maryland beneficiaries, regardless of the state in which the services are provided, can be no more than 1.5% greater than the national Medicare total cost of care growth rate; and 2) beginning in the second performance year (2015), annual growth in Medicare per beneficiary total cost of care for Maryland residents cannot exceed the national Medicare per beneficiary total cost of care growth rate in any two consecutive years.[1] These tests place a considerable burden and risk on the HSCRC and the Maryland hospitals because excessive increases in non-hospital spending levels, which are not regulated by the HSCRC, could threaten the continuation of the Demonstration.

2.2 – Monitoring the total cost of care trends in Maryland (particularly for Medicare) is thus extremely important in order to ensure that the overall cost containment goals of the Demonstration are met and to avoid the termination of the Demonstration by CMS for non-compliance on either of these two provisions. In particular, the second limitation (i.e., not exceeding the national Medicare trend over any two-year period) imposes an additional and very stringent condition on the Maryland system. Under this provision, if Maryland exceeded the national Medicare trend by, for example, 1% in 2014, it would then have to reduce Medicare costs in the subsequent to a level below nation trend (per 2.1, second term above). The provisions are also problematic for Maryland because the State will not have much notice from Medicare should it exceed either limitation in a given year.

---

[1] As noted, the CMMI/CMS limitations discussed here refer to the total cost of care per Medicare beneficiary (for both hospital and non-hospital) care. However, based on conversations with the HSCRC staff, there does not appear to be a consistent understanding regarding the definition of "non-hospital care" (i.e., whether it involves all non-hospital services, including professional services or whether it is restricted to just institutional non-hospital care). This definitional issue should be resolved with the CMMI/CMS.

2.3 - Medicaid and the private payers have expressed concern about Global Model hospitals retaining all of the savings from the shift of services to non-hospital sites. Shifts of this nature that are caused by hospital activities or brought about by insurer-sponsored activities (such as ACOs, MCOs, MA plans and the PCMH) will generally result in some level of overpayment if the hospitals retain their full prior payments and additional payments are made to the non-hospital providers that receive the shifted care. Because of the undesirable total cost implications of this dynamic, and the need to stay in compliance with the two Medicare total cost of care limitations imposed by the CMMI, the HSCRC staff has discussed the potential need for individual hospital rate adjustments to offset the windfall profits that would otherwise accrue to Global Model hospitals due to service shifts from such hospitals to non-hospital providers and to prevent the duplicative payments that would be made by payers for the shifted services.

2.4 – Overall, the situation described above presents a complicated set of circumstances and policy alternatives for the HSCRC. On one hand, there is a desire on the part of HSCRC staff and the major payers for the use of negative adjustments to the rate base of Global Model hospitals in the event that services shift away from these hospitals to less expensive non-hospital providers. On the other hand, there are a number of subtle dynamics that must be considered regarding these service shifts.

2.5 - Organizations operating under at-risk or shared savings arrangements, such as ACOs, face strong financial incentives to shift services to less expensive non-hospital-based settings. These shifts are usually applauded and encouraged if they are payer-sponsored activities and they result in lower total health care costs. Most such organizations pay on a straight fee-for-service (FFS) basis so, when they eliminate volume at a hospital, and purchase it instead from a lower cost provider, as has occurred in the AQC, they eliminate the payments to the hospital and pay only the lower costs at the non-hospital provider. Similarly, under the HSCRC's long-standing DRG-based per case constraint system, Maryland hospitals have been incentivized to reduce LOS and ancillary use per case without adjustment for observed shifts in cases from acute to post-acute settings. Global Model hospitals operating under much stronger incentives to control costs will understandably attempt to reduce the frequency of unnecessary admissions, readmissions, emergency room visits and other hospital services. While there is a legitimate concern about possible overpayment for care as a result of these dynamics, the HSCRC should be careful not to unnecessarily discourage hospitals from engaging in these activities.

2.6 - These considerations raise a fundamental question; namely, under what circumstances should rate adjustments to the Target Budgets of Global Model hospitals take place? In a previous Paper, we argued that upward rate adjustments to Target Budgets are necessary to promote and accommodate the channeling of market demand by "Market Sponsoring Organizations" from low value to high value hospitals, or to respond to other circumstances such as a service closure or a shift of patient volume/demand that is caused by circumstances beyond the particular hospital's control. Unfortunately, in the case of general pressure in the system to migrate services from hospitals to non-hospital providers, it will be difficult to distinguish between deliberate attempts to "shed" hospital-based services and service shifts that occur for other reasons.

2.7 – This problem of how and when to adjust Target Budgets for service shifts into non-hospital settings is extraordinarily complex. Many difficulties will be involved in accurately measuring the

shifts that take place, in attributing causation to these shifts, and in appropriately implementing related reductions to hospital Target Budgets. Nevertheless, given the adverse implications of exceeding the limitations on the growth in Medicare total cost of care that are included in the Maryland Demonstration, and the potential for overpayment by other payers, it will be very important for the HSCRC to monitor trends in hospital and non-hospital care in Maryland at an aggregate level and, as needed, at a disaggregated level. The primary goal of this monitoring exercise should be to measure the total cost of care growth for Medicare on a quarterly basis and to give the HSCRC the information it would need to formulate proactive adjustments to hospital rates to ensure that the Medicare total cost of care limitations that are included in the Demonstration are not exceeded. The secondary goal would be to monitor all payer trends in total cost of care and to develop mechanisms that can curb any excessive increases and help to position the State to submit an effective strategy for a second stage of the Demonstration that would encompass all services, across all payers, rather than just for Medicare.

2.8 - Through this monitoring effort, the HSCRC may learn more about how hospitals (and the Maryland health delivery system overall) are responding to the incentives of the Demonstration and what, if any, policy interventions will be required to meet the State's and CMS's cost containment goals.

3. Sources of Data and Potential Monitoring Effort

3.1 – Successful monitoring of the total cost of care will require access to comprehensive and timely claims data from each major payer. The Maryland Health Care Commission has long maintained a database—i.e., the Medical Care Database (MCDB)—that was meant to collect all health care claims from all payers. However, the MCDB has significant gaps and is not available on a timely basis (The MCDB is only available annually with a lag of 24 months). Efforts that are now underway to enhance the MCDB will likely take many years. Thus, in the short term, these data will need to be generated directly from the major payers (Medicare, Medicaid through UMBC, CareFirst, United Healthcare, and possibly, from other payers including Aetna, Cigna, Coventry and other smaller payers). Comprehensive claims from even the four major payers would constitute about 85% of all health care expenditures for Maryland residents. Trends in per capita payments to hospital, non-hospital providers and for all services that would be computed using the data from the four major payers would be highly reliable indicators of overall trends.

3.2 – More specifically, in its monitoring efforts, the HSCRC might arrange to have direct access to raw claims data (and/or summary reports that it specifies) from the following sources:

- **Medicare**: Per the terms of the Maryland Demonstration, the HSCRC will be receiving total Medicare FFS claims data (including both hospital and non-hospital claims) each quarter three to six months after the quarterly reporting period. The HSCRC staff will be the primary custodian of these data and should have the primary responsibility for analyzing these data and producing the necessary reports to monitor trends in total Medicare costs per Maryland Beneficiary.
- **Medicaid**: Theoretically, Maryland Medicaid should be able to generate comprehensive claims data for all Medicaid beneficiaries. However, based on analyses performed by the HSCRC, Medicaid data suffer from serious gaps: for example, not all MCOs submit complete

encounter data and the HSCRC staff has observed many inconsistencies in the data available through the State's vendor i.e., the Hilltop Institute at the University of Maryland Baltimore Campus (UMBC). Despite these historical limitations, the Medicaid program has indicated that it will participate in any necessary data monitoring activities and has indicated it will be able to prepare periodic reports requested by the HSCRC for this purpose.

- **Private Payers**: Large insurers, such as CareFirst Blue Cross of Maryland and United Healthcare, have the ability to provide raw data (with sufficient patient confidentiality and other non-disclosure protections) and summary quarterly reports of both hospital and non-hospital claims and expenditures in a manner prescribed by the HSCRC staff.[2]
- **Chesapeake Regional Information System for Our Patients (CRISP)**: CRISP is the State-designated regional health information exchange. Although the data collected by CRISP is limited, it could be expanded with appropriate funding through the hospital rate setting system. CRISP may ultimately be the best source for timely data on both hospital and non-hospital expenditures and utilization.

3.3 – Given the availability of data from at least the major payers (i.e., Medicare, Medicaid, CareFirst and United), the HSCRC should consider organizing a coordinated "team-based" data monitoring effort with participation of representatives from the Commission, Medicaid/UMBC, CareFirst and United (The Data-Monitoring Team). The HSCRC could take the lead in this effort by providing specifications to each payer for the type of data and reports that would be needed to match the analyses and reports that the HSCRC staff would perform on the Medicare claims data. The reports specified by the HSCRC would be shared with HSCRC staff on a quarterly basis with the general results reported to the Commissioners.[3]

3.4 – We recommend that the analysis of the Medicare and individual payer data should begin by establishing the baseline historical relationship between hospital and non-hospital expenditures on a county-specific basis over a 5-year period (from CY 2008 – CY 2013). These aggregate level reports would provide the HSCRC with a sense of the historical trends and year-to-year fluctuations in hospital vs. non-hospital expenditures. The Data Monitoring Team could track hospital, non-hospital and total per capita expenditures by county on an ongoing (e.g., quarterly) basis during the Demonstration and could generate "drill down" reports (by type of service, etc.) as needed in any locations that show problematic trends. The historical data (for the State or by county or other designated regions) would be used to establish baseline parameters and triggers for monitoring and comparison purposes during the Demonstration. For instance, if a particular region experienced "significant" decreases in services that are thought to be substitutable hospital services (e.g., simple ambulatory surgery services or CT/MRI or other imaging services), and corresponding increases in non-hospital services of these same types, the HSCRC staff and the individual payers could perform consistent and more detailed analyses of the hospitals and services involved in the identified shifts. The fact that over 50% of hospital outpatient services are

[2] We would need to verify CareFirst's ability and willingness to produce both quarterly reports on hospital and non-hospital expenditures for Maryland residents.

[3] The Private Payers may not wish to have the results of their total cost experience made public.

concentrated in ambulatory surgery and other procedure-based services would make it possible to focus much of the detailed analyses on these services. [4]

3.5 – Simultaneously, for informational purposes, the HSCRC staff might wish to generate hospital-specific monitoring reports focusing on services that the staff identifies that can be provided by non-hospital entities. Unusually large annualized reductions of some pre-determined magnitude (say 10%) could trigger additional analyses, especially where the reductions in hospital services seem to be linked with increases in services at non-hospital providers (e.g., free standing ASCs, labs, imaging centers, etc.) owned by or affiliated with the particular hospitals.[5]

3.6 - The HSCRC staff should require all Global Budget hospitals to file (and regularly update) a comprehensive list of all entities that they own, control, share ownership with or with which they are affiliated to facilitate the HSCRC's efforts to track service utilization shifts that may warrant budget adjustments. This requirement would be similar to the requirement to identify such entities that is currently included in the TPR agreements.

4. Suggested Policy Action with Regard to Hospital Rate Adjustments for Volume Shifts

4.1 – Based on the discussion above, we recommend that the primary focus of the HSCRC's monitoring effort should be on aggregate trends in hospital versus non-hospital services and costs and the growth in total costs relative to historical baseline and expected national trends by payer. Given the importance of meeting the total cost of care limitations imposed by the Demonstration, there should be an extra focus on monitoring the trend in Medicare cost per Maryland beneficiary and on alerting the Commission in a timely way of the need for a proactive policy response if it

[4] For the purposes of any more detailed analyses, it might behoove the HSCRC to identify non-hospital provider types and services that are most readily substitutable for hospital care and focus these enhanced monitoring efforts in these areas. For instance, the outpatient services most at risk for movement to non-hospital providers might include: ambulatory surgery, other procedure-based care, clinical laboratory; imaging services, such as CAT scan and MRI; low acuity emergency room visits, and outpatient primary care clinic services provided by hospital-based physician practices. The services least at risk for migration to non-hospital providers might include: hospital pharmacy, hospital supplies, specialty clinic services, "high-end" outpatient procedures and surgeries.

[5] For the purposes of any more detailed analyses, it might behoove the HSCRC to identify non-hospital provider types and services that are most readily substitutable for hospital care and focus these enhanced monitoring efforts in these areas. For instance, the outpatient services most at risk for movement to non-hospital providers might include: ambulatory surgery, other procedure-based care, clinical laboratory; imaging services, such as CAT scan and MRI; low acuity emergency room visits, and outpatient primary care clinic services provided by hospital-based physician practices. The hospital OP services least at risk for migration to non-hospital providers might include: hospital pharmacy, hospital supplies, specialty clinic services, "high-end" outpatient procedures and surgeries.

appears the Maryland growth rate in total Medicare payments per beneficiary exceeds the projected trend in total per capita Medicare payments per beneficiary on a national basis.

4.2 – In regards to general increases in non-hospital services that are substitutions for hospital care, we suggest that there should be hospital specific adjustments only in limited circumstances. In the suburban and urban areas it will be virtually impossible to tie increases in free-standing surgery, lab, imaging, or urgent care to reductions in the services of particular hospitals (unless the HSCRC sees that the shift is between a hospital and a non-hospital entity that has been identified as either owned by or affiliated with the hospital in the TPR and GBR agreements. Also as demonstrated by the ACQ experience in Massachusetts, relocating the site of service can result in significant system savings.

4.3 - Consistent with the principle of providing hospitals with incentives to shift care to less expensive settings, we recommend that the HSCRC should establish a policy whereby it would apply rate offsets associated with the growth in Medicare's non-hospital care in the form of an across-the-board rate reduction equal to, say, 125% of the increase in Medicare's non-hospital care statewide, measured as a percentage of the hospitals' Medicare charges, in any county in which the rate of increase exceeded a specified limit. Hospital-specific rate offsets, rather than county-wide offsets, would be applied whenever the shifts could be tied to particular hospitals and (especially) any non-hospital entities associated with them.

The key point of this proposal is to recognize that significant cost savings can be achieved if all parties (both hospitals and payer-sponsored entities) are incentivized to shift care to lower cost settings. But total cost levels can be driven upward if service shifts result in duplicative payments. It would be appropriate to give the individual hospitals general incentives to redirect care to non-hospital settings but to offset at least a portion of the costs of the redirected services against the hospitals in general (except where the shifts can be tied to specific hospitals and non-hospital providers (especially here they are associated by ownership, etc.). The HSCRC would then debit the hospital industry in the aggregate (by county or at a more aggregated level) to reduce Medicare and other payer payments in line with the waiver requirements by offsetting a bit more than the incremental costs of the redirected services. In other words, we should encourage the desired activity and then assess the industry for a little more than the incremental costs of the care they shift through their collective enterprise.

4.4 – Certainly, the effectiveness of the monitoring effort and the potential for appropriate rate action will become clearer after the effort is underway and the HSCRC and the Data Monitoring Team members can see how hospitals appear to be responding to the incentives under the Demonstration. However, given the complicated nature of the incentives and dynamics at play, and the relatively tight nature of the Target Budgets being established for hospitals under the HSCRC's Global Models, it may be most appropriate and efficient for the HSCRC to focus on monitoring trends in the cost of hospital and non-hospital care and to make adjustments only in situations where it finds that total Medicare cost growth is in excess of the projected national trends.

May 5, 2014

3601 O'Donnell Street
Baltimore, MD 21224
Telephone 410.864.4404
Facsimile 855.280.0660
Frank.Campbell@Healthspring.com

Donna Kinzer
Executive Director
State of Maryland
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Kinzer,

Cigna-HealthSpring wishes to express its support and commitment to the Maryland's New Waiver Redesign Demonstration.

Our health plan appreciates the opportunity to share a voice with other stakeholders via participation on the Data and Infrastructure Work Group and we look forward to our continued participation. We support the effort to collect aggregate data on the total cost of care and will continue to work closely with the HSCRC to share information that can be helpful to understand potential shifts in utilization.

Cigna-HealthSpring is committed to working collaboratively with the HSCRC to implement the New Waiver. This is an important step to improving population health, enhancing patient outcomes and experience, and mitigating per-capita cost of care trends for the benefit of our community.

Sincerely yours,

Frank P. Campbell
Director, Informatics
Mid-Atlantic/Pennsylvania Market

Cc. Brent Sanders, CFO Mid-Atlantic/Pennsylvania Market
Health Services Cost Review Commissioners
Chairman John Colmers
Commissioner George Bone, M.D.
Commissioner Jack Keane
Commissioner Thomas Mullen
Commissioner Herbert Wong, Ph.D.
Commissioner Stephen Jencks, M.P.H.
Commissioner Bernadette Loftus, M.D.

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

May 6, 2014

John M. Colmers
Chairman
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Letter of Support – Total Cost of Care template

Dear Chairman Colmers and Members of the Commission:

The Maryland Department of Health and Mental Hygiene (DHMH) is pleased to offer support to the Health Services Cost Review Commission (HSCRC) in its continuing effort to establish a Total Cost of Care template. With the goals of reducing health care costs and improving population health, the Maryland Medicaid program has been participating in HSCRC's Data and Infrastructure Workgroup. The Workgroup is developing a data infrastructure for the monitoring and evaluation of Maryland's new All-Payer Rate-Setting System in cooperation with providers, including the Maryland Hospital Association (MHA), and other payers and interested stakeholders.

On January 1, 2014, Maryland's new All-Payer Rate-Setting System moved to a per capita total hospital cost test. Starting January 1, 2019, the system will move to a per capita total cost of care test. Not only is Maryland committed to reporting per capita health expenditure growth under the terms and conditions of the waiver with the Centers for Medicare and Medicaid Services (CMS), but the Maryland Medicaid program is particularly interested in monitoring how the slowing of the growth rate of hospital costs impacts other expenditures, such as physician services and long-term care services. For instance, hospital expenditures may decrease. At the same time, long-term care expenditures may increase by a greater amount. This would cause total cost of care to increase for the Medicaid population.

In its current form, the service categories have been defined only in general terms in the Total Cost of Care Template. In order for the Template to generate information that can be reported to CMS, very detailed reporting specifications must be developed. This will ensure consistency across the various payers. As such, Medicaid will continue to work with the Data and Infrastructure

Workgroup to establish a more detailed and clearly defined template between now and the first reporting period in October 2014.

Sincerely,

Charles Lehman
Acting Deputy Secretary
Health Care Financing

Chet Burrell
President and Chief Executive Officer

CareFirst BlueCross BlueShield
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-605-2558
Fax: 410-781-7606
chet.burrell@carefirst.com

May 9, 2014

Donna Kinzer
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: HSCRC Total Cost of Care Template

Dear Ms. Kinzer,

I would like to express CareFirst's general support for the development of the Cost of Care Template and data collection process. We truly understand the challenge of developing a process to capture, track and monitor care trend shifts, especially outside the regulatory framework to non-regulated settings and as the largest commercial payer in Maryland would like to lend our support and assistance. The data collection process is extremely important under the new Waiver model and will assist Maryland in meeting our financial targets.

While we fully support the process, we caution that the details associated with the data collection process need to be thoroughly assessed and clarified to ensure a uniform reporting process that delivers accurate and reliable data. We stand ready to assist staff over the next few months to work through this clarification process.

While we will not be available to participate on the panel discussion at the next public meeting, we wanted you to know that we do support this effort and would like to work with you in fully developing the Cost of Care Template and data collection process.

Sincerely,

Chet Burrell
President and Chief Executive Officer

Data and Infrastructure Workgroup

Final Report on Data Requirements for Monitoring

Maryland Health Services Cost Review Commission

May 14, 2014

Purpose of Report Summary

- Recommend data sources to meet CMS Required Monitoring Requirements
  - Reviewed current Maryland sources of data
  - Identify gaps in available data and make recommendations
- Future reports:
  - Identify data sources for additional monitoring requirements
  - Make recommendations data infrastructure to support care coordination

Recommended Data Sources

- Most data sources were identified in CMS monitoring requirements
- Workgroup focused on more challenging measures
  - *Physician Participation in Public Programs and Engagement in Innovative Models of Care*
    - Provider participation in Patient Centered Medical Home Initiatives – recommend using NCQA data
    - Provider Participation in ACOs or Bundled Payment Initiatives – recommend using CMMI data
    - Medicare participating physicians – recommend using Medicare.Gov Directory
    - Medicaid participating physicians per enrollee – recommend using Medicaid provider numbers and HealthChoice provider directory
  - *Discharges with Primary Care Provider (PCP) Identified*
    - *Recommend proposed modification of measure to number of discharges that have an associated Encounter Notification alert, using the CRISP ENS data.*

Monitoring Total Cost of Care

- CMS Contract requires monitoring of Total Cost of Care:
  - Medicare per beneficiary total payments (guardrail)
  - All Payer Total Cost and Shifts to unregulated space
- In the long-term, the Medical Care Data Base (MCDB) will likely be a resource to provide robust analysis, which is only possible through claim-level data. However, current limitations:
  - Timeliness of data
  - Potential gaps (coverage segments, carve outs)
- Workgroup discussions and Total Cost of Care papers – recommend collecting aggregate data from major payers to monitor total cost of care and shifts to unregulated space
- Subgroup formed to develop reporting template

Balancing different needs

- Collecting data from payers on a voluntary basis
  - Need to be simple enough to minimize reporting burdens
  - Comprehensive enough to trend all payer total cost
  - Provide sufficient detail to identify shifts
- Proposed Criteria:
  - Simple enough that it can be produced
  - Clear definitions so that there is consistency in reporting
  - Build on existing and well-documented models
  - Build on other data definitions so findings can be correlated and validated to other data sources
  - Sufficiently disaggregated to:
    - Understand shifts from regulated to non-regulated settings
    - Understand whether shifts have to do with underlying change in coverage or health status

Building a Total Cost of Care Template

- Categories of Services
  - Level of detail sufficient to understand potential shifts from regulated to unregulated settings
- Geographic granularity
  - Enrollee residence by County, including out of state providers
- Demographic
  - Align with payment workgroup recommendation on demographic adjustment for global budgets - age breaks from Claritas data: 0-5, 6-14, 15-44, 45-64, 65-74, 75-84, 85+ - possibly disaggregating <1
- Market Segment

Monitoring Total Cost of Care Recommendations

- Collect aggregate total cost of care data from payers on a voluntary basis consistent with the initial reporting template developed by the subgroup (Total Cost of Care Report)
- Develop detailed template reporting instructions in sufficient time for payers to report data by July 2014
- Begin to collect data by October 2014 and establish a routine reporting schedule thereafter

Work Group Members

Alicia Cunningham

Vice President of Reimbursement & Revenue Advisory Services
University of Maryland Medical System

Alan Kimmel, MD
MidAtlantic Health Care

Andy Fitzsimmons

Vice President, Data & Informatics, CareFirst

Barbara Baldwin

Chief Information Officer, Anne Arundel Medical Center

Claudia A. Steiner, M.D., M.P.H

Senior Research Physician

Agency for Healthcare Research and Quality (AHRQ)

David Horrocks

President and CEO, CRISP Health

Frank Campbell

Director, Informatics, CIGNA/Healthspring

Dr. Frank J. Genova

Associate Medical Director

Kaiser Permanente Mid-Atlantic Permanente

Gene Ransom

CEO, MedChi
(The Maryland State Medical Society)

Kathy Talbot

Vice President, Rates & Reimbursement, MedStar health

Linda Bartnyska

Director, Center for Analysis & Information Systems, Maryland Health Care Commission

Long Thai

Assistant CFO, MidAtlantic Kaiser Permanente

Mary Lou Fox

Steering Committee, Maryland Women's Coalition for Health Care Reform

Mitch Lomax

Director, Reimbursement and Compliance

Saint Agnes Hospital

Patricia Travis, RN, Ph.D., CCRP

Associate Director Clinical Research

Johns Hopkins University School of Medicine

Paul Allen

Director, CIMD, Johns Hopkins Health System

Raquel Samson

Deputy Director, Health System & Infrastructure Administration, Maryland Department of Health and Mental Hygiene

Salliann Alborn

CEO, Maryland Community Health System & Community Integrated Partnership

Steve Johnson, Ph.D, MS

Vice President, The Lewin Group

Traci LaValle

Vice President, Financial Policy & Advocacy

Maryland Hospital Association

Tricia Roddy

Director, Office of Planning

Maryland Department of Health and Mental Hygiene