## DRAFT FOR DISCUSSION

## REVISED RECOMMENDATIONS FOR RY 2017 BALANCED UPDATE

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

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

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

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

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

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

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

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

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

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

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

**CEHRT (Certified Electronic Health Record Technology)**

**Hospital and any Care Redesign Participants must**:

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

(pg 738, §414.1415 Advanced APM criteria)

Hospital has CEHRT technology implemented.

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

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

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