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Department of Health

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**Health Services Cost Review Commission**

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**547th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION  
January 10, 2018**

**EXECUTIVE SESSION**

**11:30 a.m.**

(The Commission will begin in public session at 11:30 a.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 p.m.)

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104
2. Update on Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104
3. Personnel Matters – Authority General Provisions Article, §3-305 (b) (1)

**PUBLIC SESSION**

**1:00 p.m.**

1. Review of the Minutes from the Public Meeting and Executive Session on December 13, 2017
2. New Model Monitoring
3. Docket Status – Cases Closed
  - 2399A – Priority Partners
  - 2403A – MedStar Family Choice
  - 2407A – Johns Hopkins Health System
  - 2410A – University of Maryland Medical System
  - 2411A – University of Maryland Medical System
  - 2412A – University of Maryland Medical System
  - 2413A – University of Maryland Medical System
  - 2415A – Johns Hopkins Health System
  - 2417A – Johns Hopkins Health System
  - 2402A – MedStar Medicare Choice
  - 2406A – Maryland Physicians Care
  - 2409A – University of Maryland Medical System
  - 2014N – Garrett Regional Medical Center
  - 2416A – Johns Hopkins Health System
  - 2418A – Johns Hopkins Health System
4. Docket Status – Cases Open
  - 2419A – University of Maryland Medical System
  - 2420A – Johns Hopkins Health System
5. Presentation by UMMS and JHHS on Car T Cell Therapy and Spinraza
6. Draft Recommendation for Updates to the Maryland Hospital Acquired Conditions Policy for RY 2020
7. Executive Director’s Report

**a. Staff Analysis of Commissioner Policy Outline**

**8. Hearing and Meeting Schedule**

**Closed Session Minutes  
Of the  
Health Services Cost Review Commission**

**December 13, 2017**

Upon motion made in public session, Vice Chairman Antos called for adjournment into closed session to discuss the following items:

1. Discussion on Planning for Model Progression– Authority General Provisions Article, §3-103 and §3-104
2. Update on Contract and Modeling of the All-Payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104

The Closed Session was called to order at 9:43 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

In attendance in addition to Commissioner Antos were Commissioners Bayless, Colmers, Kane and Keane.

In attendance representing Staff were Donna Kinzer, Katie Wunderlich, Chris Peterson, Allan Pack, Jerry Schmith, Claudine Williams, Amanda Vaughn, Madeline Jackson, Erin Schurmann, and Dennis Phelps.

Also attending were Jack Myer, Stu Gutterman, Deborah Gracey, and Eric Lindeman, Commission Consultants, and Stan Lustman and Adam Malizio Commission Counsel.

**Item One**

Ms. Kinzer and the Commission discussed the progression of the Model and the vision going forward. The discussion was facilitated by Mr. Myer.

**Item Two**

Ms. Kinzer updated the Commission on Medicare data and analysis vis-a-vis the All-Payer Model Agreement.

**Item Three**

Ms. Kinzer updated the Commissioners on the federal clearance process.

The Closed Session was adjourned at 12:50 p.m.

**MINUTES OF THE**  
**546th MEETING OF THE**  
**HEALTH SERVICES COST REVIEW COMMISSION**  
**December 13, 2017**

Vice Chairman Joseph Antos called the public meeting to order at 9:43 a.m. Commissioners Victoria Bayless, John Colmers, Adam Kane, and Jack C. Keane were also in attendance. Chairman Nelson Sabatini participated by telephone in the public meeting. Upon motion made by Commissioner Colmers and seconded by Commissioner Bayless, the meeting was moved to Executive Session. Vice Chairman Antos reconvened the public meeting at 1:05 p.m.

**REPORT OF THE DECEMBER 13, 2017 EXECUTIVE SESSION**

Mr. Dennis Phelps, Associate Director, Audit & Compliance, summarized the minutes of the December 13, 2017 Executive Session.

**ITEM I**  
**REVIEW OF THE MINUTES FROM THE NOVEMBER 13, 2017**  
**EXECUTIVE SESSION AND PUBLIC MEETING AND NOVEMBER 29, 2017**  
**EXECUTIVE SESSION**

The Commissioners voted unanimously to approve the minutes of the November 13, 2017 Public Meeting and Executive Session and November 29, 2017 Executive Session.

**ITEM II**  
**DOCKET STATUS- CLOSED CASES**

2405N- Atlantic General Hospital

2408A- Johns Hopkins Health System

**ITEM III**  
**DOCKET STATUS- OPEN CASES**

**2399A- Johns Hopkins, Priority Partners, Inc.**

Mr. Allan Pack, Director Population Based Methodologies, summarized staff's final recommendation on the application filed by Johns Hopkins Health System (the "System") on behalf of John Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital, and Suburban Hospital (the "Hospitals"). The System is seeking approval for continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. The Hospitals are requesting to renew the contract for one year beginning on January 1, 2018.

Staff recommended:

- Approval of this alternative rate application for one-year period beginning January 1, 2018.

- Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance in CY 2017 and the MCO's expected financial status into CY 2017. Therefore, staff recommends that Priority Partners report to Commission staff (on or before the September 2017 meeting of the Commission) on the actual CY 2016 experience and preliminary CY 2017 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2019.
- That this approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from the discussion and vote.

#### **2402A- MedStar Family Choice**

On September 15, 2017, MedStar Health filed an application on behalf of their member hospitals (the Hospitals). MedStar Health seeks approval for MedStar Family Choice ("MFC") to continue to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. The Hospitals are requesting an approval for one year beginning on January 1, 2018.

Staff recommends conditional approval of the Hospital's request to continue to participate in the CMS Medicare Advantage Program for a period of one year beginning January 1, 2018. The Hospitals must file a renewal application annually for continued participation. MFC shall submit on a quarterly basis, 15 days after submitting its quarterly and annual NAIC reports, in the format provided by Staff, a comparison of MFC's budgeted financial data with its actual experience for CY 2018 as reported in the MFC's quarterly NAIC report. MFC shall also provide a detailed explanation of any materially unfavorable differences between the budget and actual experience. Also, the approval is contingent upon the execution of the standard Memorandum of Understanding.

Commission voted the unanimously to approve staff's recommendation.

#### **2403A- MedStar Family Choice**

Mr. Pack summarized Staff's final recommendation on the application of MedStar Health on behalf of their member hospitals. MedStar Health seeks renewal for continued participation of MedStar Family Choice ("MFC") in the Medicaid Health Choice Program for one year beginning in January 1, 2018.

Staff Recommended:

- Approval of this alternative rate application for one-year period beginning January 1, 2018; however, staff is placing MFC on a watch list as described below.
- Since sustained losses may be construed as a loss contract necessitating termination of

this arrangement, staff is recommending the following actions:

- ❖ On the earlier of July 1, 2018 or if/when Medicaid applies a mid-year adjustment, MFC shall report to HSCRC staff on the impact that any such adjustment is expected to have on CY 2018 financial performance.
- ❖ HSCRC staff shall be cognizant of the MCO's financial performance and the potential for a loss contract in considering any requested adjustments to rates or global budgets of the associated hospitals during FYs 2018 and 2019.
- ❖ MFC shall report to the Commission staff (on or before the September 2018 meeting of the Commission) on the actual CY 2017 experience and preliminary CY 2018 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2019.
- That this approval be contingent upon the execution of the standard Memorandum of Understanding.

Commission voted unanimously to approve staff's recommendation.

#### **2406A- Maryland Physician Care**

Mr. Pack summarized Staff's final recommendation on the application filed by Saint Agnes Health System, Western Maryland Health System, Holy Cross Health, and Meritus Health (the "Hospitals"). The Hospitals are seeking approval for continued participation of Maryland Physician Care (MPC) in the Medicaid Health Choice Program. The Hospitals are requesting to renew the contract for one year beginning on January 1, 2018.

Staff recommended:

- Approval of this alternative rate application for one-year period beginning January 1, 2018.
- Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance in CY 2017 and the MCO's expected financial status into CY 2018. Therefore, staff recommends that MPC report to Commission staff (on or before the September 2018 meeting of the Commission) on the actual CY 2017 experience and preliminary CY 2017 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2019.
- That this approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

#### **2407A- Hopkins Health Advantage**

Johns Hopkins Health System ("JHHS") filed an application on October 16, 2017 on behalf of its member hospitals. JHHS is seeking approval for Hopkins Health Advantage to continue to

participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Medicare Plan. JHHS is requesting approval for one year beginning January 1, 2018.

Staff recommends that the Commission approve the Hospitals' request to continue to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2018, and that approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Commissioner Colmers recused himself from the discussion and vote.

#### **2409A- University of Maryland Health Advantage**

University of Maryland Medical System ("UMMS") filed an application on November 2, 2017 seeking approval for University of Maryland Health Advantage, Inc. ("UMHA") on behalf of its constituent hospitals (the "Hospitals") to participate in the CMS approved Medicare Advantage Plan. UMHA is the UMMS entity that assumes the risk under this contract. UMHA is requesting an approval for one year beginning January 1, 2018.

Staff recommends that the Commission approve the Hospitals' request to participate in the CMS Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2017, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

#### **2410A- Maryland Health Partners, Inc.**

Mr. Pack summarized Staff's final recommendation on the application of Maryland Health Partners, Inc. (UMHP), a Medicaid Managed Care Organization (MCO), on behalf of the University of Maryland Medical System Corporation (the "Hospitals"). UMHP and the Hospitals seek approval for the MCO to continue to participate in the Medicaid Health Choice Program for one year beginning January 1, 2018.

Staff Recommended:

- Approval of this alternative rate application for one-year period beginning January 1, 2017; however, staff is placing UMHP on a watch list as described below
- Since sustained losses, such as those currently being experienced by UMPH, may be construed as a loss contract necessitating termination of this arrangement, staff is recommending the following actions:
  - ❖ On the earlier of July 1, 2018 or if/when Medicaid applies a mid-year adjustment, UMPH shall report to HSCRC staff on the impact that any such adjustment is expected to have on CY 2018 financial performance.

- ❖ HSCRC staff shall be cognizant of the MCO's financial performance and the potential for a loss contract in considering any requested adjustments to rates or global budgets of the associated hospitals during FYs 2018 and 2019.
- ❖ UMPH shall report to the Commission staff (on or before the September 2018 meeting of the Commission) on the actual CY 2017 experience and preliminary CY 2018 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2019.
- That this approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

#### **2411A- University of Maryland Health System**

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on November 9, 2017 requesting approval to continue its participation in a global rate arrangement with BlueCross and BlueShield Association Blue Distinction Centers for solid organ and blood and bone marrow transplant services for a period of one year beginning December 1, 2017.

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for blood and bone marrow transplant services, for a one year period commencing December 1, 2017. The Hospital will need to file a renewal application for review to be considered for continued participation. Also, approval is contingent upon the execution of the standard Memorandum of Understanding with the Hospital for the approved contract.

The Commission voted unanimously to approve staff's recommendation.

#### **2412A- University of Maryland Health System**

The University of Maryland Medical Center ("the Hospital") filed a renewal application with the HSCRC on November 9, 2017 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for participation in a new global rate arrangement for solid organ and blood and bone marrow transplant services with Humana for a one-year period, effective December 1, 2017.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning December 1, 2017. Also, approval is contingent upon the execution of the standard Memorandum of Understanding with the Hospital for the approved contract. The Commission voted unanimously to approve staff's recommendation.

The Commission voted unanimously to approve staff's recommendation.



### **2413A- University of Maryland Health System**

University of Maryland Medical Center (the "Hospital") filed an application on October 31, 2016 seeking approval for the hospital to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with INTERLINK for a period of one year effective December 1, 2017.

Staff recommends that the Commission approve the Hospital's request to continue to participate in a solid organ and blood and bone marrow transplant services with INTERLINK for one year beginning December 1, 2017, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

### **2414N- Garrett Regional Medical Center**

On November 27, 2017, Garrett Regional Medical Center (the "Hospital") submitted a partial rate application to the Commission for a new rate for Interventional Radiology/Cardiovascular (IRC) services to be provided to both inpatients and outpatients. This new rate will replace its currently approved rebundled IRC rate. A rebundled rate is approved by the Commission when a hospital provides certain non-physician services to inpatients through a third-party contractor off-site. By approving a rebundled rate, the Commission makes it possible for a hospital to bill for the services provided off-site, as required by Medicare. In this case, as of July 1, 2017, due to the reallocation of several CPT codes from the Radiology-Diagnostic rate center to the IRC rate center, the Hospital will be providing IRC services on-site to both inpatients and outpatients. The Hospital requests that the IRC rate be set at the state-wide median and be effective January 1, 2018.

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

1. That an IRC rate of \$59.15 per minute be approved effective January 1, 2018;
2. That the IRC rate center not be rate realigned until a full year of cost data has been reported to the Commission; and
3. That no change be made to the Hospital's Global Budget Revenue for IRC services.
4. The Commission voted unanimously to approve staff's recommendation.

### **2415A- Johns Hopkins Health System**

Johns Hopkins Health System ("System") filed an application on behalf of Johns Hopkins Bayview Medical Center (the "Hospital") to continue to participate in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene, and CMS. The Hospital, doing business as Hopkins Elder Plus ("HEP"), serves as a provider in the federal "Program of All-Inclusive Care for the Elderly" ("PACE"). Under this program, HEP provides

services for a Medicare and Medicaid dually eligible population of the frail elderly. The System requested approval for one year beginning January 1, 2018.

Staff recommends that the Commission approve the Hospital's request to participate in the PACE program for a period of one year beginning January 1, 2018, and that approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Commissioner Colmers recused himself from the discussion and vote.

#### **2416A- Johns Hopkins Health System**

Johns Hopkins Health System (the "System") on behalf of Johns Hopkins Bayview Medical Center (the "Hospital"), filed an application on November 28, 2017 requesting continued participation in a capitation arrangement serving persons with mental health needs under the program title, Creative Alternatives. The arrangement is between the System and the Baltimore Mental Health Systems, Inc., with the services coordinated through the Hospital. The Hospital requested approval for a period of one year beginning January 1, 2018.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for one year beginning January 1, 2018, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from the discussion and vote.

#### **2417A- Johns Hopkins Health System**

Johns Hopkins Health System ("System") filed an application with the HSCRC on November 29, 2017, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for heart failure services and solid organ and bone marrow transplants with Optum Health, a division of United HealthCare Services, for a period of one year beginning January 1, 2018.

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for heart failure, solid organ and bone marrow transplant services for a one year period commencing January 1, 2018. The Hospitals will need to file a renewal application for review to be considered for continued participation and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from the discussion and vote.

### **2418A- Johns Hopkins Health System**

Johns Hopkins Health System (the System) filed a renewal application with the HSCRC on November 29, 2017 on behalf of its member hospitals, the Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers for Tricare patients. The requested approval is for a period of one year beginning January 1, 2018.

The staff recommends that the Commission approve the Hospitals' renewal application for an alternative method of rate determination for a one year period beginning January 1, 2018. 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.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers recused himself from the discussion and vote.

### **ITEM IV** **RECOMMENDATION FOR REVENUE INCREASE FOR ANNE ARUNDEL MEDICAL CENTER**

Jerry Schmith, Director Revenue & Regulation Compliance, presented Staff's final recommendation for approval to increase Anne Arundel Medical Center Global Budget Revenue (see "Final Recommendations for Anne Arundel Medical Center Revenue Adjustment" on the HSCRC website).

The HSCRC staff and Anne Arundel Medical Center ("AAMC") have been meeting since the fall of 2016 to evaluate AAMC's request for a Global Budget Revenue (GBR) adjustment.

AAMC's request focused on the need to increase revenues to meet their ongoing expenditures and to support changes in care delivery that will be needed to deliver improved care and reduce avoidable and unnecessary care under the Enhanced Model with the Centers for Medicare and Medicaid Services (CMS). AAMC also requested funding for medical education programs that have been initiated.

In evaluating AAMC's request, staff has extensively analyzed AAMC's performance and efficiency. As a result of the analyses, staff recommends an increase of \$14 million. This represents an increase of approximately 2.3% to AAMC's approved revenues for the rate year ending June 30, 2018.

In November 2015, the Commission suspended full rate reviews to allow HSCRC to shift its rate review approach from a sole focus on cost per case efficiency to align with the new All-Payer

Model's requirements to limit growth in per capita costs and improve quality performance. The full rate review moratorium expired at the end of October 2017.

Because this request and analyses have been ongoing for some time, staff is recommending that AAMC obtain a revenue adjustment in lieu of filing a full rate review. Staff has done sufficient work over the last six months to make this recommendation. This recommendation lays out the review and analysis that staff has undertaken and its findings in reaching the recommendations contained in this report.

AAMC initially requested an increase in its approved revenues of \$53 million late in 2016, which included \$20 million for the direct and indirect costs of a new medical education program for physicians; \$13 million for adjustments to volumes and increases in drug costs during FY 2017; \$10 million for increased volume related to the opening of their 30 bed medical/surgical expansion; \$7 million related to the variable costs associated with the opening of the cardiac surgery program; and \$3 million for seed funding to pilot a Geographic Payment Model alternative reimbursement methodology.

In April 2017, AAMC submitted a formal request for an increase in its approved GBR revenue to fund the new physician residency program for both direct and indirect medical education costs. In this submission, AAMC requested an increase to its GBR revenue of \$7.9 million, with an increase of \$2.1 million effective July 1, 2017; a second increase of \$1.1 million on July 1, 2018; and a third increase of \$4.8 million on July 1, 2019. The funding encompassed 6 surgical residents on July 1, 2017, 3 additional surgical residents on July 1, 2018, and 3 additional surgical residents and 10 internal medicine residents on July 1, 2019.

Subsequently, in 2017, AAMC and HSCRC Staff continued to discuss the request after updates for market shift and drug adjustments through the FY 2018 rate order. HSCRC and AAMC discontinued discussions on the cardiac surgery program request. After extensive meetings, review, and analysis with the HSCRC staff, and with more recent volume statistics, AAMC and HSCRC met in October to discuss a potential settlement in lieu of a full rate application.

Based on a thorough consideration of all of the analyses performed and staff's findings, staff makes the following recommendations for Commission consideration:

1. A permanent revenue increase of \$14 million be provided effective January 1, 2018, inclusive of all settlements through December 31, 2017 except quality programs and price variances, with \$14 million collected during FY 2018. This amount includes any additional increases in drug costs related to increased use of high cost outpatient oncology drugs for FY 2017 over 2016. This does not include quality adjustments under the QBR, which have not yet been applied or other quality program adjustments that are due to be applied on January 1, 2018 or thereafter.
2. AAMC may not file a full rate application with the Commission for two years from the period beginning January 1, 2018. If a rate application is filed, AAMC would be required to pay back \$14 million per year. A future full rate application would be required for the Commission to approve any funding of medical education costs based on an evaluation of

need, under policies of the Commission. There can be no assurance that funding would be approved as part of a future rate base, given the high level of physician supply in the State.

3. Any incremental PAU savings and any rate reductions implemented by the Commission will fully apply.
4. AAMC believes strongly in managing the total cost of care for all residents in its service area and will continue to invest the necessary infrastructure to truly manage the health of the people it serves – that is its mission. Therefore, it will continue to invest in care transformation and work toward the goals of the enhanced Total Cost of Care Model success. AAMC must submit its plan for reducing avoidable and unnecessary care by July 1, 2018, inclusive of specific targets, approach, its funding of investments, and its measurement and reporting plan.
5. AAMC must submit a report of its physician arrangements and the extent to which physician compensation is tied to volume by July 1, 2018. It shall also submit its plans and timelines to modify contracts that provide compensation for volume growth. This report must be provided in sufficient detail, with attention to protecting confidential information, to ascertain the specific nature of each contract, its reliance on RVUs or volumes as a basis for payment, and the extent to which increases in RVUs affects total compensation under the contract. (The HSCRC is not aware of the extent of these contracts.).

The Commission vote was 4-0 to approve the staff recommendation. Commissioners Bayless, who was not present for the discussion, and Commissioner Kane abstained from voting. Vice Chairman Antos cast the fourth concurring vote.

**ITEM V**  
**FINAL RECOMMENDATION ON UPDATES TO THE QUALITY BASED**  
**REIMBURSEMENT POLICY FOR RY 2020**

Alyson Schuster, Ph.D., Associate Director Quality Initiatives, presented the Staff's quality update concerning the enhanced All-Payer Model quality programs for RY 2020 (see "Staff Draft Recommendations for Updating the Quality Based Reimbursement Program for Rate Year 2020" on the HSCRC website).

HSCRC's quality based measurement and payment initiatives are important policy tools for providing strong incentives for hospitals to improve their quality performance over time. Under the current All-Payer Model Agreement ("Agreement") between Maryland and CMS, effective January 2014 through December 2018, there are overarching quality performance requirements for reductions in readmissions and hospital acquired conditions as well as ongoing program and performance requirements for all of HSCRC's quality and value based programs.

As long as Maryland makes incremental progress towards the Agreement goals, the State receives automatic exemptions from the CMS Hospital Acquired Conditions program (HAC) and Readmission Reduction program, while the exemption from the CMS Medicare Value-Based Purchasing (VBP) program is requested annually. These exemptions from national quality programs are important because the State of Maryland's all-payer global budget system benefits

from having autonomous, quality-based measurement and payment initiatives that set consistent quality incentives across all-payers.

This final recommendation provides recommendations for updates to Maryland's Quality-Based Reimbursement (QBR) program for Rate Year (RY) 2020, which encompass the performance results from the final year (2018) of the Agreement. QBR is one of three core quality programs, and it places 2% of revenue at risk by scoring a hospital's performance relative to national thresholds and benchmarks for its Safety domain and Person and Community Engagement domain, and it utilizes Maryland specific benchmarks for its Clinical Care domain.

Last year, after experiencing difficulties in having the scale for revenue adjustments based on Maryland performance, the Commission approved a QBR scaling system that is tied to national performance. The Commission also set out the need to revise the Clinical Care portion of the program due to increases in the use and coding of palliative care. Likewise, over the last year, the Commission has been discussing the need to improve Emergency Department performance. This recommendation discusses the results of implementing the national performance pre-scale in RY 2019, proposes changes to address concerns related to the Clinical Care mortality measure, and introduces Emergency Department pay-for-performance incentives.

Except for the changes noted above, staff is recommending that the Commission minimize changes to the QBR for RY 2020. Staff will also recommend minimizing revisions to other existing quality programs, so that it can focus on future policy development to establish quality strategies and performance goals under the Enhanced Total Cost of Care Model, which will be effective beginning in CY 2019. For example, staff will establish a clinical subgroup to vet available complication measures, while transitioning hospitals from wholesale use of Potentially Preventable Complications (PPCs) found in the Maryland Hospital Acquired Conditions (MHAC) program. The future policy changes will be used to make quality-based payment adjustments in RY 2021 and beyond.

Staff final recommendations on the QBR program for RY 2020 are as follows:

1. Update the Maryland Mortality Measure to include palliative care cases (risk-adjusted for palliative care status) for calculating both attainment and improvement scores.
2. Include ED Wait Times measures in the Person and Community Engagement domain.
3. Weight the domains as follows for determining hospitals' overall performance scores: Person and Community Engagement - 50%, Safety - 35%, Clinical Care - 15%.
4. Maintain RY 2019 Pre-set Scaling Options, and continue to hold 2% of inpatient revenue at-risk for the QBR program.

The Commissioners agree with the Staff's recommendation with the following amendment added

The Commission directs Staff, working with leadership of MIEMMS and with industry input, to develop an ED wait time risk adjustment for implementation, if possible, by July 1, 2018.

Commissioners voted 4-1 in favor of Staff's amended final recommendation. Commissioner Colmers voted against the recommendation.

**ITEM VI**  
**NEW MODEL MONITORING**

Ms. Caitlin Grim, Assistant Chief, Hospital Rate Regulation, reported \$59.88 million of Medicare total spending per beneficiary savings for the nine months ending September 2017. Ms. Grim noted Medicare non-hospital Part B spending growth per capita has been unfavorable to the nation for the same period.

Ms. Amanda Vaughan, Associate Director, Financial Data Administration, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of October 31, 2017 focuses on the fiscal year (July 1, 2017 through October 31, 2017) as well as calendar year results.

Ms. Vaughan reported that for the four months of the fiscal year ended October 31 2017, All-Payer total gross revenue increased by 4.78% over the same period in CY 2016. All-Payer total gross revenue for Maryland residents increased by 4.97%. All-Payer gross revenue for non-Maryland residents increased by 2.71%.

Ms. Vaughan reported that for the ten months of the calendar year ended October 31, 2017, All-Payer total gross revenue increased by 4.94% over the same period in CY 2016. All-Payer total gross revenue for Maryland residents increased by 4.98%; this translates to a per capita increase of 4.60%. All-Payer gross revenue for non-Maryland residents increased by 4.51%.

Ms. Vaughan reported that for the four months of the fiscal year ended October 31, 2017, Medicare Fee-For-Service gross revenue increased by 3.86% over the same period in CY 2016. Medicare Fee-For-Service gross revenue for Maryland residents increased by 3.82%. Maryland Fee-For-Service gross revenue for non-residents increased by 4.32%.

Ms. Vaughan reported that for the ten months of the calendar year ended October 31, 2017, Medicare Fee-For-Service gross revenue increased by 4.18% over the same period in CY 2016. Medicare Fee-For-Service gross revenue for Maryland residents increased by 3.96%; this translates to a per capita increase of 3.05%. Maryland Fee-For-Service gross revenue for non-residents decreased by 6.72%.

Ms. Vaughan reported on hospital revenue per capita growth for the four months of the fiscal year ended October 31, 2017 over the same period in CY 2016:

- All Payer in State capita growth was 4.59%.
- Medicare Fee for Service in State growth was 2.91%.

According to Ms. Vaughan, for the four months of the fiscal year ended October 31, 2017,

unaudited average operating profit for acute hospitals was 3.12%. The median hospital profit was 3.69%, with a distribution of 1.59% in the 25<sup>th</sup> percentile and 6.72% in the 75<sup>th</sup> percentile. Total Profit margin was 6.16%.

Ms. Andrea Zumbrum, Chief, Quality Analysis and Reporting, presented a report on the current trends in hospital readmissions (through September 2017).

#### Readmissions

- The All-Payer risk adjusted readmission rate was 11.33% for September 2017 YTD. This is a decrease of 14.42% from the June 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 11.80% for September 2017 YTD. This is a decrease of 16.27% from the June 2013 YTD risk adjusted readmission rate.
- Based on the new Model, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction incentive program has set goals for hospitals to reduce their adjusted readmission rate by 14.5% during CY 2017 compared to CY 2016. Currently, 25 out of 46 hospitals have reduced their risk adjusted readmission rate by more than 14.5%. An additional 4 hospitals are on track for achieving the attainment goal.

Ms. Laura Mandel, HSCRC Analyst, presented the current trends for potentially avoidable utilization.

Potential Avoidable Utilization – Readmissions and Prevention Quality Indicators (PQIs) revenue as a percentage of hospital revenue:

- All-Payer readmission revenue declined from 7.47% in CY 2013 to 6.72% for CY October 31, 2017 as a percentage of all-payer hospital revenue.
- All-Payer readmission revenue September 2017 YTD has declined by .2% over the all-payer readmission revenue for the same period in 2016.
- All-Payer PQI revenue has been constant over the period from CY 2013 to CY August 31, 2017 between 4.18% and 4.15% of all-payer hospital revenue.
- Medicare Fee for Service readmission revenue has declined from 10.74% in CY 2013 to 9.27% in CY August 2017 as a percentage of Medicare Fee for Service revenue.
- Medicare Fee for Service readmission revenue August 2017 YTD has declined by 0.52% over the Medicare Fee for Service revenue for the same period in 2016.
- Medicare Fee for Service PQI revenue has been constant over the period from CY 2013 to CY 2017 with a decrease from 6.57% to 6.54% of Medicare Fee for Service hospital revenue.



**ITEM VII**  
**UPDATE ON CRISP ACTIVITIES**

David Finney and Jerry Reardon, Chesapeake Regional Information System for our Patients (CRISP) presented an update on CRISP activities (see “Presentation to HSCRC Commission Meeting” on the HSCRC website). The update included CRISP’s progress in securing Medicare patient based data and samples of Care Redesign Program reporting.

**ITEM VIII**  
**JOINT CHAIRMEN’S REPORT ON EMERGENCY DEPARTMENT  
OVERCROWDING**

Katie Wunderlich, Director of Engagement and Alignment, Pat Gainer, Maryland Institute for EMS Systems, presented an overview of the Joint Chairmen’s report on Emergency Department overcrowding (see “Joint Chairmen’s Report on Emergency Department Overcrowding” on the HSCRC website)

The 2017 Joint Chairmen’s Report directed the Maryland Institute for EMS Systems (MIEMSS) to work with the Health Services Cost Review Commission to evaluate the impact of hospital overcrowding on EMS response times and Maryland’s patient population and to develop a plan to address the overcrowding issue. The Report includes the following information:

- Excessive ED wait times and ambulance diversion from one hospital to another has been a long-standing challenge for the Maryland health care system and is a multifaceted problem that will require comprehensive system adjustments.
- ED overcrowding has been exacerbated by the following factors:
  - An increase in behavioral health patients treated at EDs, including overdose patients
  - Continuing staff shortages affecting hospital EDs
  - Increased patient care requirements in emergency departments
  - Increasing numbers of EMS transports in some EMS jurisdictions coupled with limited options for alternative modes of treatment
  - A misalignment of hospital reimbursement and EMS reimbursement policies
- Efforts undertaken to date, including utilization of Ambulance Yellow Alerts, have not resolved the problem and do not address underlying factors.
- The HSCRC has identified two strategies to incentivize hospitals to continue to improve ED efficiency and patient throughput: 1) adding an ED performance measure in the Quality-based Reimbursement program; and 2) requesting hospital efficiency improvement action plans from hospitals that have poor ED performance measures coupled with reduced patient days.

- MIEMSS and EMS jurisdictions will continue to develop new models of EMS care delivery and assess their utility in reducing ambulance transport of low acuity patients to hospital EDs.
- MIEMSS will work with the HSCRC to incorporate/engage EMS for participation in new care delivery programs under the State's Enhanced Total Cost of Care All-Payer Model, including the possibility of shared savings. MIEMSS will work with the Maryland Department of Health to identify potential opportunities for changes in the Medicaid program to reimburse EMS for new models of service delivery.
- MIEMSS will assess and determine whether the use of Yellow Alerts should be discontinued.
- MIEMSS will work with EMS jurisdictions to identify a reasonable standard time for ambulance off-load (the time between the arrival of an ambulance-transported patient and the time that the patient is moved off the EMS stretcher).

#### **ITEM IX** **CONFIDENTIAL DATA REPORT**

Ms. Claudine Williams, Associate Director Policy Analysis, presented Staff's final recommendation for confidential data request (See "Staff Recommendation on the University of Maryland, School of Medicine Baltimore's National Study Center for Trauma and EMS Request for Continued Access to HSCRC Confidential Patient Level Datasets" on the HSCRC website).

The University of Maryland, School of Medicine ("UM") - Baltimore's National Study Center for Trauma and EMS ("NSC") is requesting continued access to the HSCRC Confidential Inpatient and Outpatient Data. This request was originally approved by the Commission at the public meeting on September 2, 2009.

The confidential patient-level data has been used as part of the Crash Outcome Data Evaluation System (CODES). The CODES project is funded by the Maryland Department of Transportation's Highway Safety Office (MDOT/HSO) to make traffic safety and injury-related data available for analysis. The data has been used to analyze injuries to persons treated at Maryland hospitals. Additionally, to fulfill a key component of the CODES effort, this data has been linked (where possible) to police crash report data for further analysis.

Studies of injuries resulting from motor vehicle crashes have been a major focus of the NSC since its creation in 1986. The NSC's role was further defined in 1993, when the State of Maryland enacted legislation directing the NSC to "serve as the primary research center for the State Emergency Medical Services Systems." The NSC's first database-linking capabilities were initiated more than 20 years ago with a comprehensive study of all motorcycle crashes in Maryland between July 1987 and June 1988. All available medical and cost data were linked with police crash reports. Findings from this study helped to bring about the passage of the motorcycle helmet law in Maryland. Since then, multiple studies have been performed using

CODES data on a variety of highway safety topics resulting in numerous publications.

This data will not be used to identify individual hospitals or patients, as all personal identifiers are removed prior to any release of data, reports, or analysis. All data elements considered sensitive by the data owners are also removed from any analysis released.

The CODES Board of Directors includes representatives from each agency providing data to the project. The HSCRC has been represented on the CODES Board since its inception in 1996. Currently, Oscar Ibarra is the HSCRC representative. Additionally, the applicant filed annual progress reports to the Commission, detailing any changes in goals or design of project, or any changes in data handling procedures, work progress, and unanticipated events related to the confidentiality of the data. Furthermore, the requester submits copies of the final reports to HSCRC for review prior to public release.

The Staff recommendation is as follows:

1. HSCRC staff recommends that CODES continue to receive access for the inpatient and outpatient confidential data files on an annual basis, upon request.
2. Access to HSCRC data will be limited to the current objective of the research study. If the objective of the study changes, CODES would be required to receive Commission approval for the new use case.

The Commission voted unanimously to approve staff's recommendation.

## **ITEM X** **LEGAL REPORT**

### **Regulations**

### **Final Action**

#### **Rate Application and Approval Procedure- COMAR 10.37.10.03 and 10.37.10.03-1**

The purpose of this action is to set forth the process for filing a full rate application with the Commission; identify the methodologies to be used in approving permanent rates; describe the annual update factor vis-à-vis the All-Payer Model Agreement, including corrective action if necessary to maintain compliance with All-Payer Model Agreement, and provide options to hospitals for Commission review of a full rate application.

This action was proposed for adoption in 44:22 Md. R 1050-1054 (October 27, 2017).

The Commission voted unanimously to approve the final adoption of the proposed regulation.

## **ITEM XI** **EXECUTIVE DIRECTOR'S REPORT**

Donna Kinzer, Executive Director, updated the Commissioners on payment mechanisms and

preparation for implementation of TCOC Model. Ms. Kinzer noted that the expected schedule is as follows:

**January**

- Present Commission’s draft implementation plan/priorities for public review and comment
- Staff prepares and presents analysis regarding Keane/Colmers observations and recommendations with emphasis on GBR mechanisms, avoidable utilization, and other system mechanisms
- Obtain public comments regarding draft implementation plan/priorities and possible changes to GBR mechanisms by February 1, 2018

**February**

- Discuss and receive public input regarding potential changes to GBR mechanisms, avoidable utilization, and other mechanisms
- Staff prepares and presents analysis regarding Keane/Colmers observations and recommendations relative to policy direction of quality and value-based mechanisms, including TCOC mechanisms
- Obtain public comments regarding policy direction of quality and value-based payment mechanisms by March 1.

Ms. Kinzer reported that Brian Morton, Chief, Hospital Rate Regulation, will be leaving the HSCRC at the end of December. Ms Kinzer expressed her admiration and appreciation for all of the work performed for the HSCRC and the State of Maryland by Mr. Morton over the years and expressed her best wishes on his future endeavors.

Ms. Kinzer also reported on the passing of Ellen Englert in November. Ms. Englert was a longtime Associate Director Revenue & Regulation Compliance. Ms. Englert was a valued colleague and friend.

**ITEM XII**  
**HEARING AND MEETING SCHEDULE**

January 10, 2017	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
February 14, 2017	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:50 p.m.



# Monitoring Maryland Performance Medicare Fee-for-Service (FFS)

Data through October 2017 – Claims paid through November

Source: CMMI Monthly Data Set



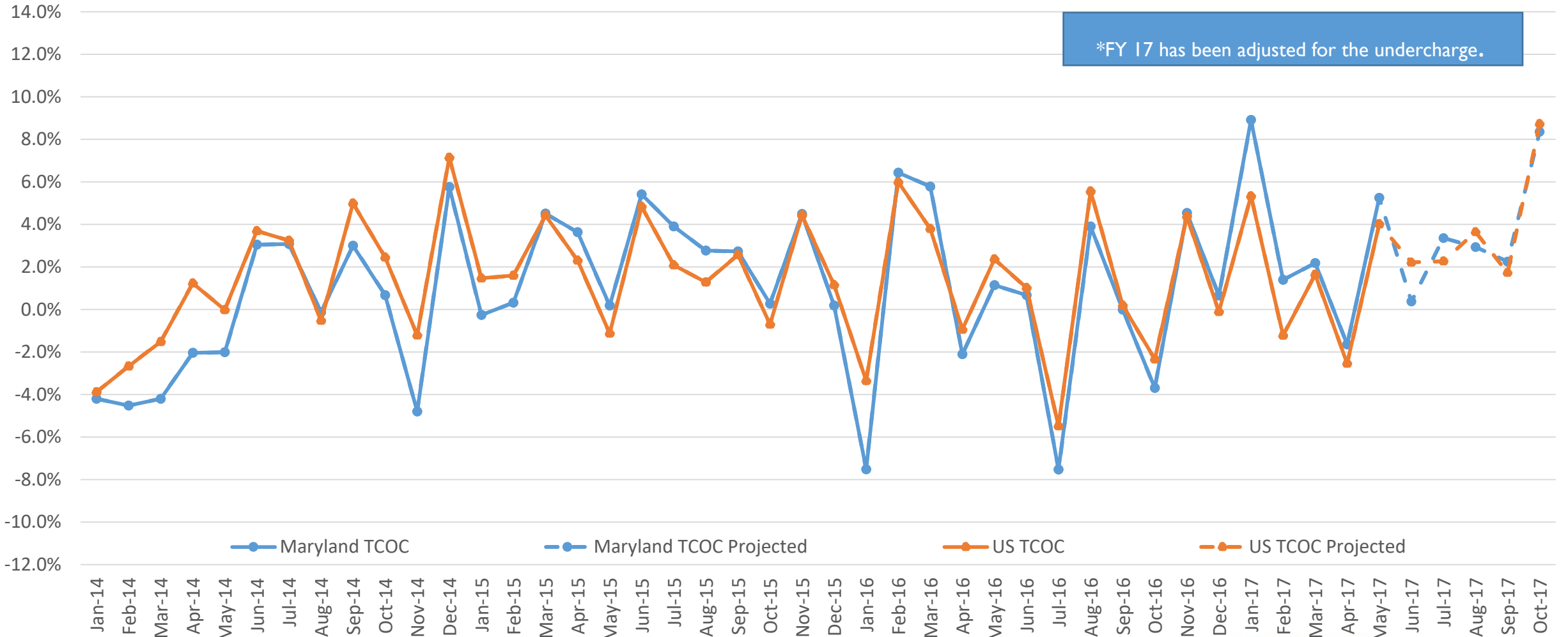
# Disclaimer:

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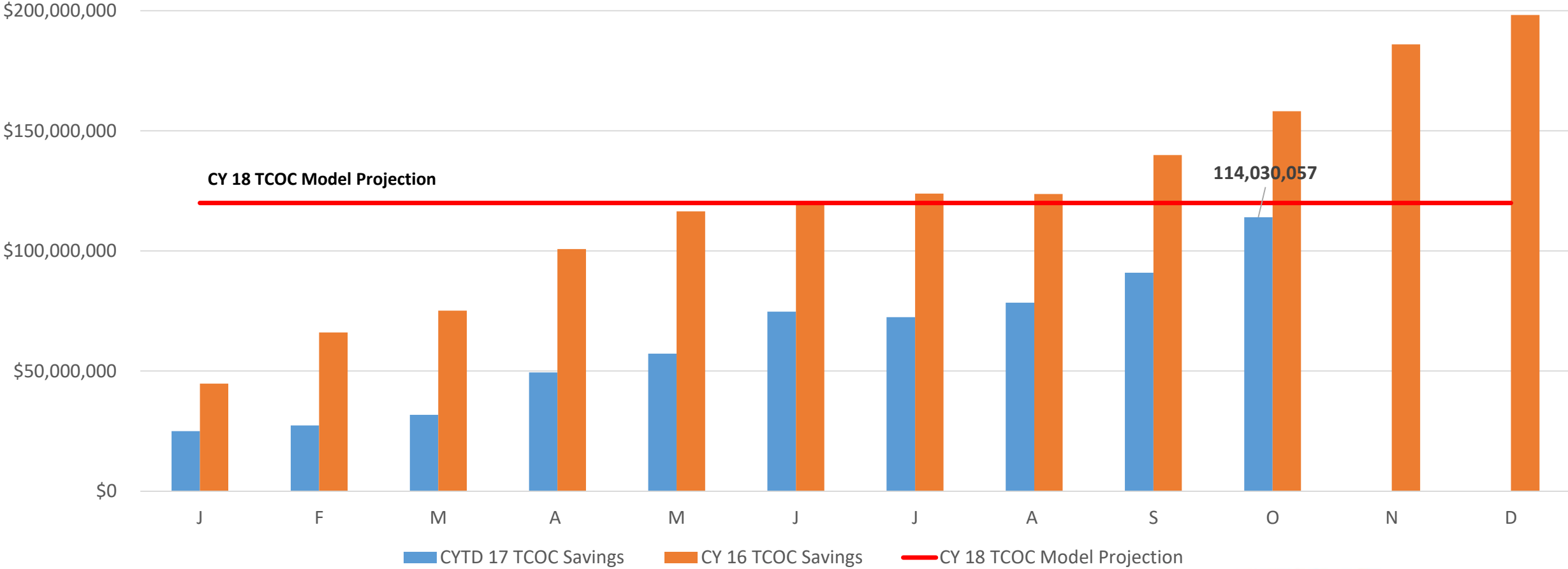
Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections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

# Medicare Total Cost of Care per Capita

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



# Annual Total Cost of Care Savings







# Monitoring Maryland Performance Financial Data

Year to Date through November 2017

Source: Hospital Monthly Volume and Revenue and Financial Statement Data  
Run: January 2018

**HSCRC**

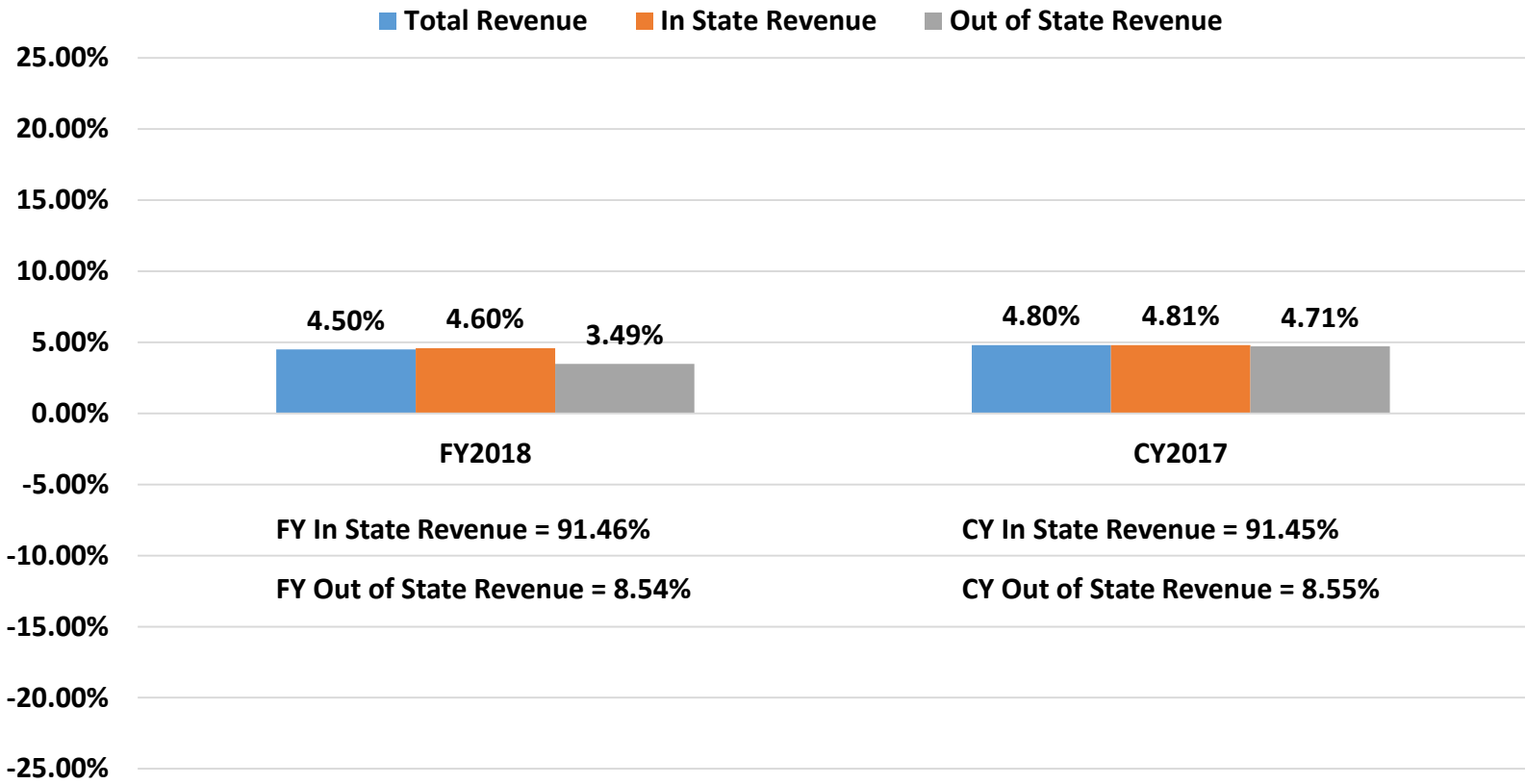
Health Services Cost  
Review Commission



The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2017 have been revised. CMS has changed the enrollment source for the Chronic Condition Data Warehouse (CCW) from the Enrollment Database (EDB) to the Common Medicare Environment (CME) database. Part A changed very slightly and Part B is more noticeably changed.

# Gross All Payer Revenue Growth

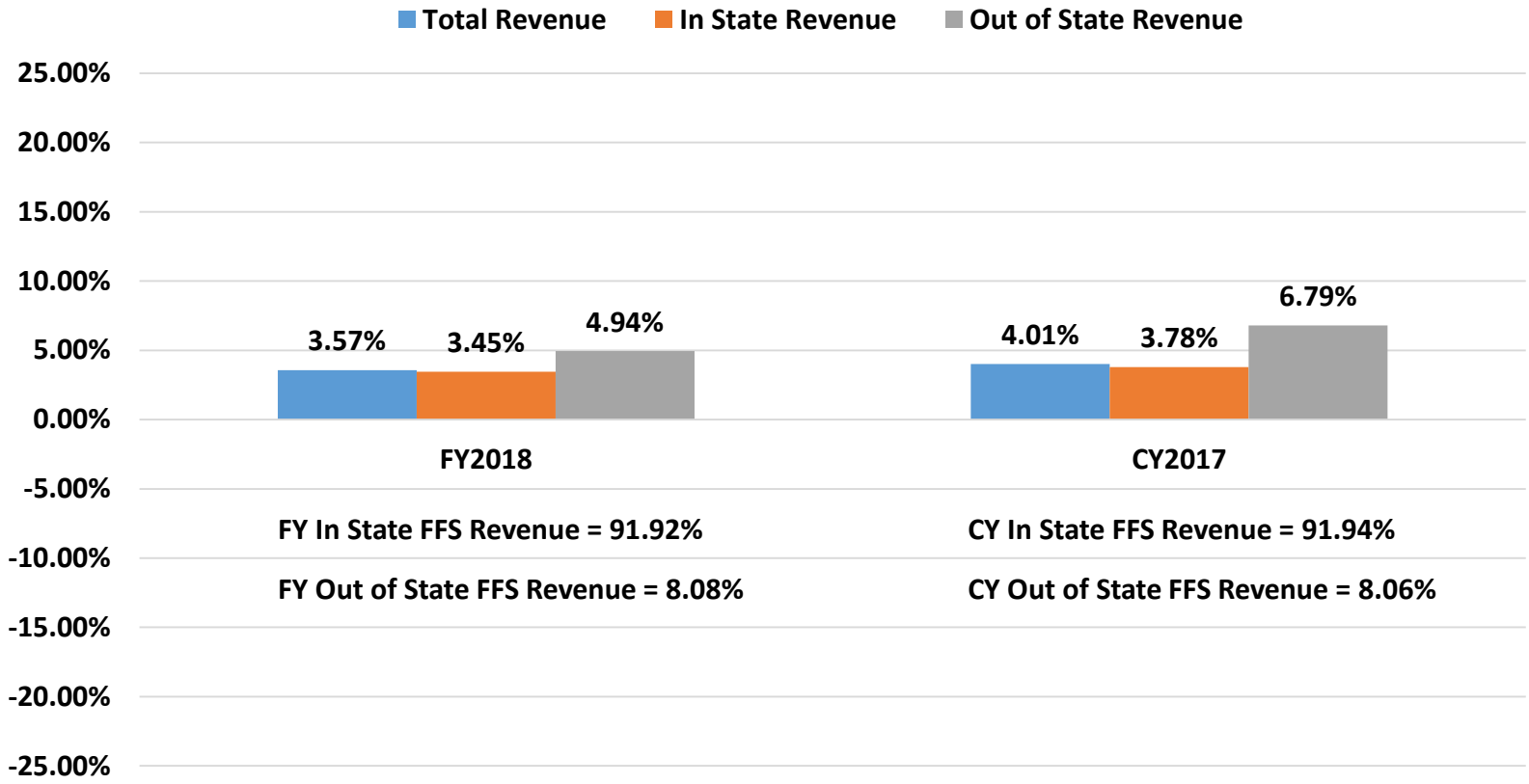
FY 2018 (July – November 2017 over July - November 2016) and CY 2017 (Jan - Nov 2017 over Jan – Nov 2016)



**These figures are not adjusted for the undercharge that occurred Jul-Dec 2016.  
The State’s Fiscal Year begins July 1**

# Gross Medicare Fee for Service Revenue Growth

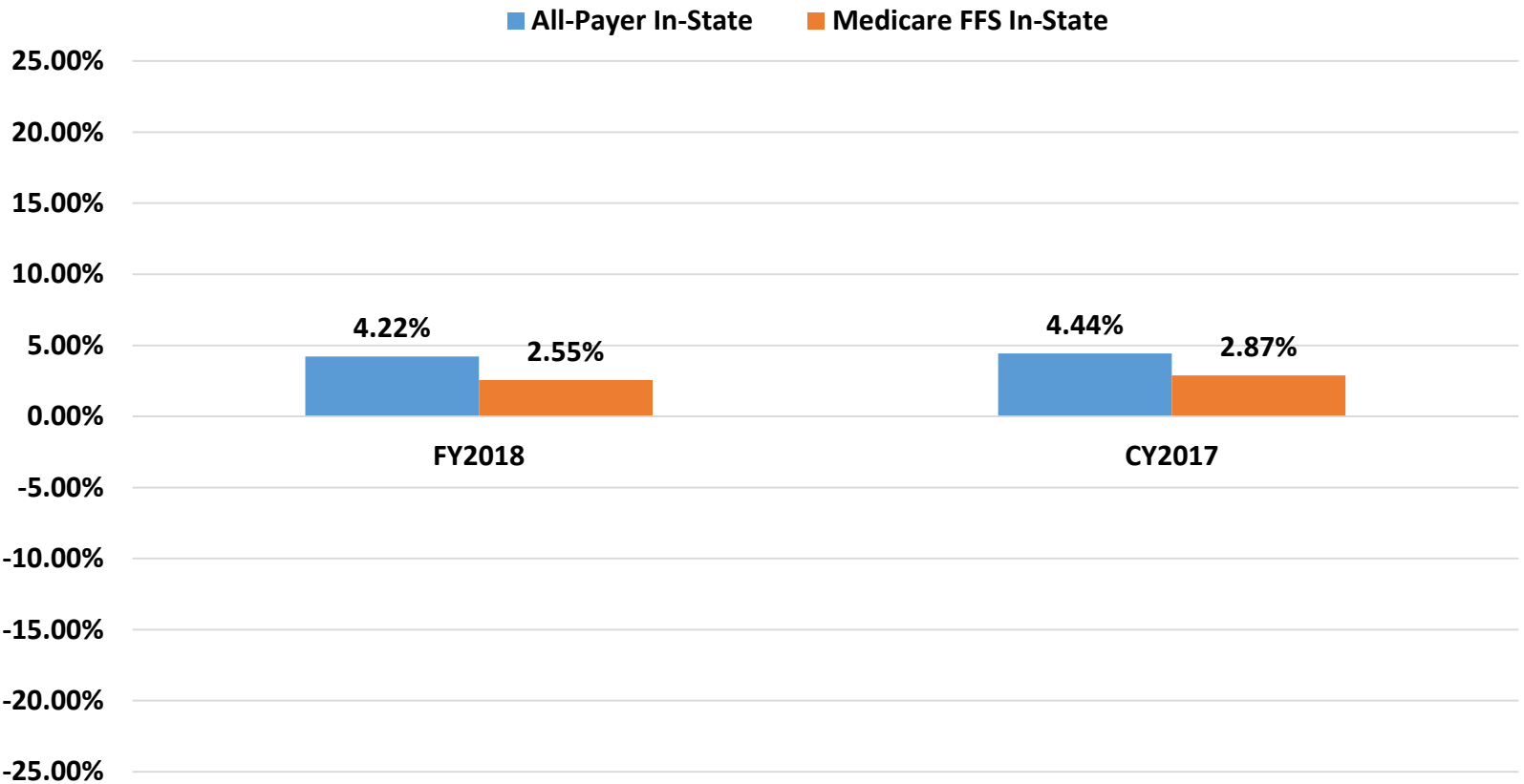
FY 2018 (July –November 2017 over July – November 2016) and CY 2017 (Jan-Nov 2017 over Jan-Nov 2016)



**These figures are not adjusted for the undercharge that occurred in Jul-Dec 2016.  
The State’s Fiscal Year begins July 1**

# Hospital Revenue Per Capita Growth Rates

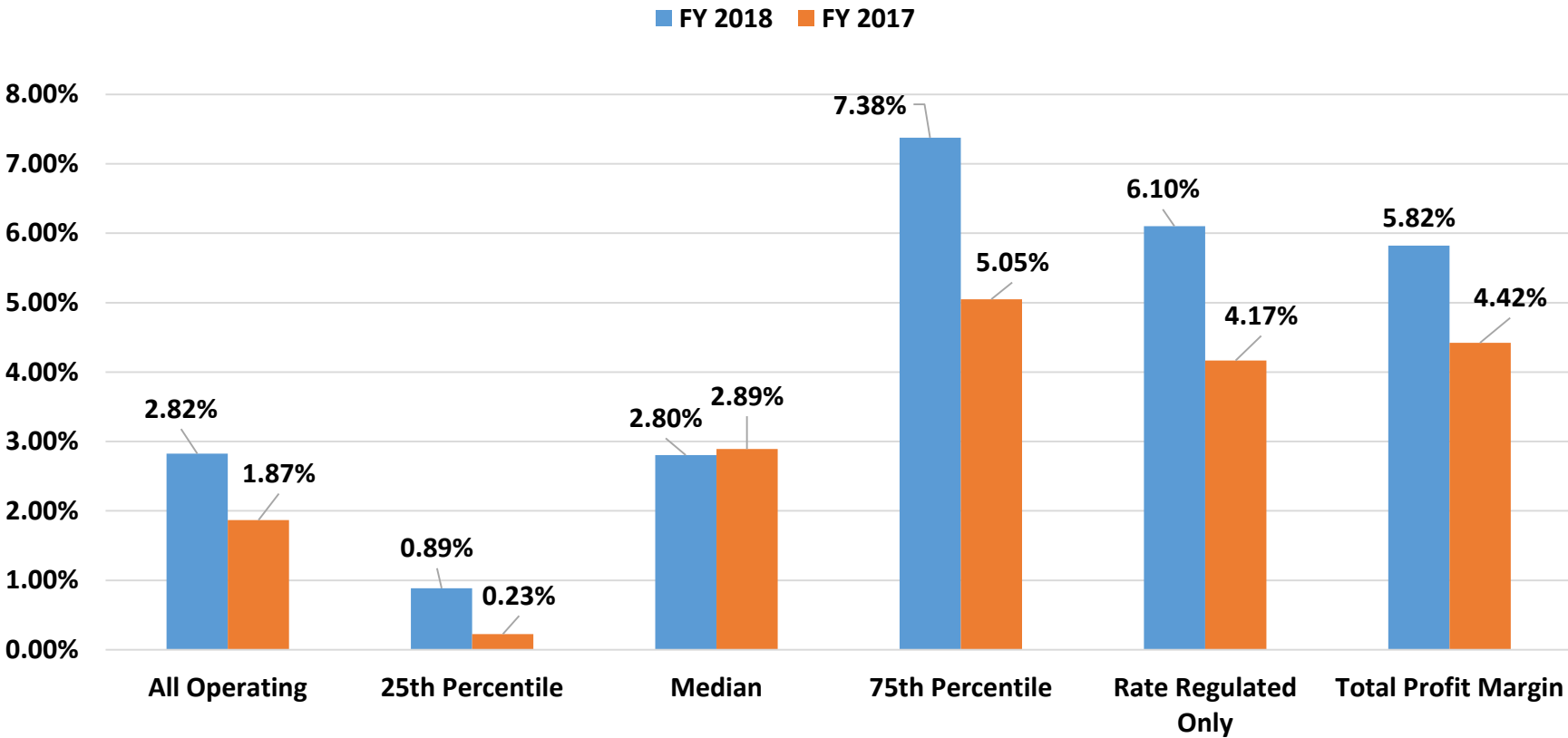
FY 2018 (July-November 2017 over July-November 2016) and CY 2017 (Jan-Nov 2017 over Jan-Nov 2016)



**These figures are not adjusted for the undercharge that occurred in July-December 2016.  
The State's Fiscal Year begins July 1**

# Operating and Total Profits

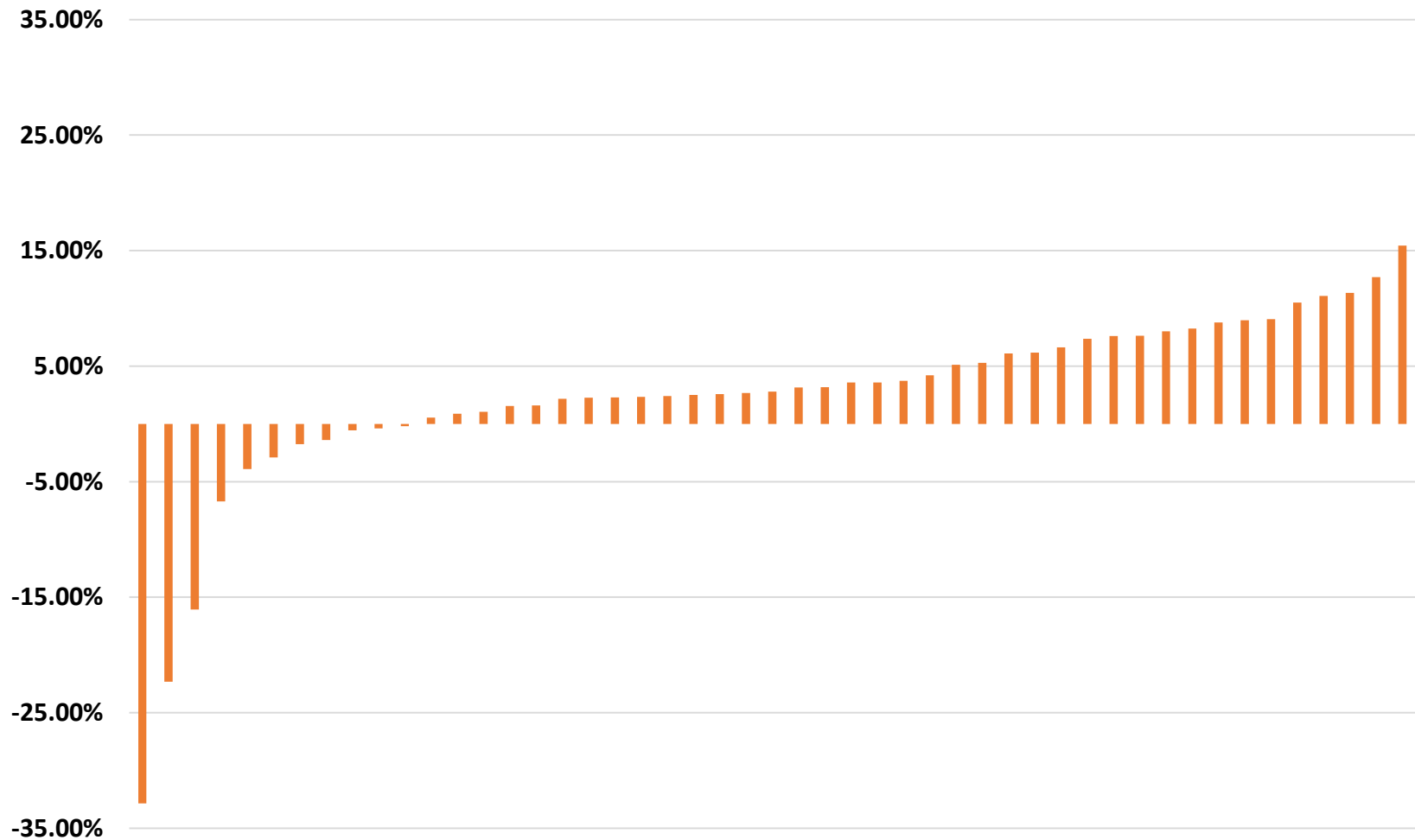
Fiscal Year 2018 (July – November 2017) Compared to Same Period in Fiscal Year 2017 (July - November 2016)



FY 2018 unaudited hospital operating profits to date show an increase of .95 percentage points in total operating profits compared to the same period in FY 2017. Rate regulated profits for FY 2018 have increased by 1.93 percentage points compared to the same period in FY 2017.

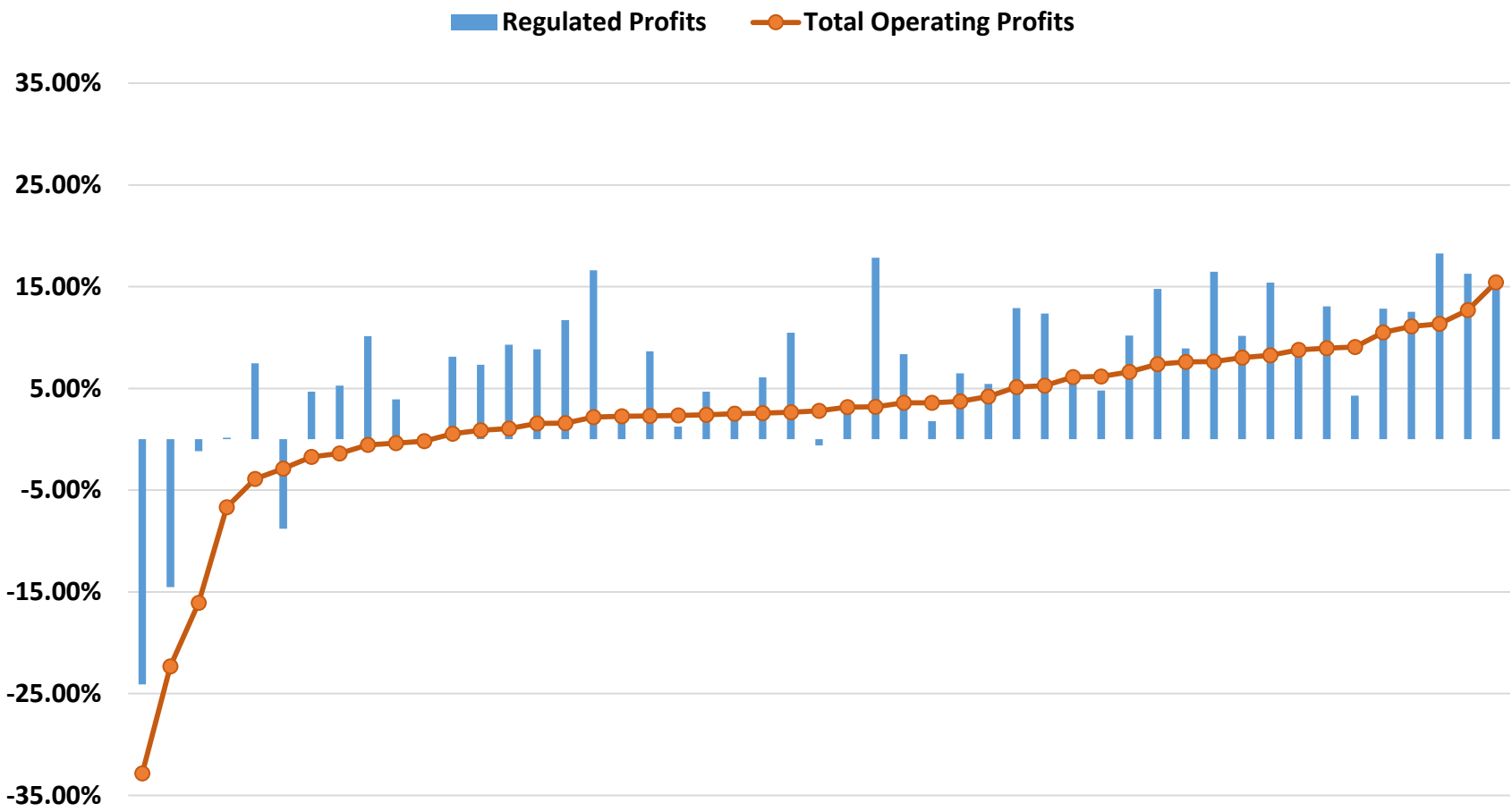
# Total Operating Profits by Hospital

Fiscal Year 2018 (July - November 2017)



# Regulated and Total Operating Profits

Fiscal Year 2018 (July – November 2017)





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# Monitoring Maryland Performance Financial/Utilization Data

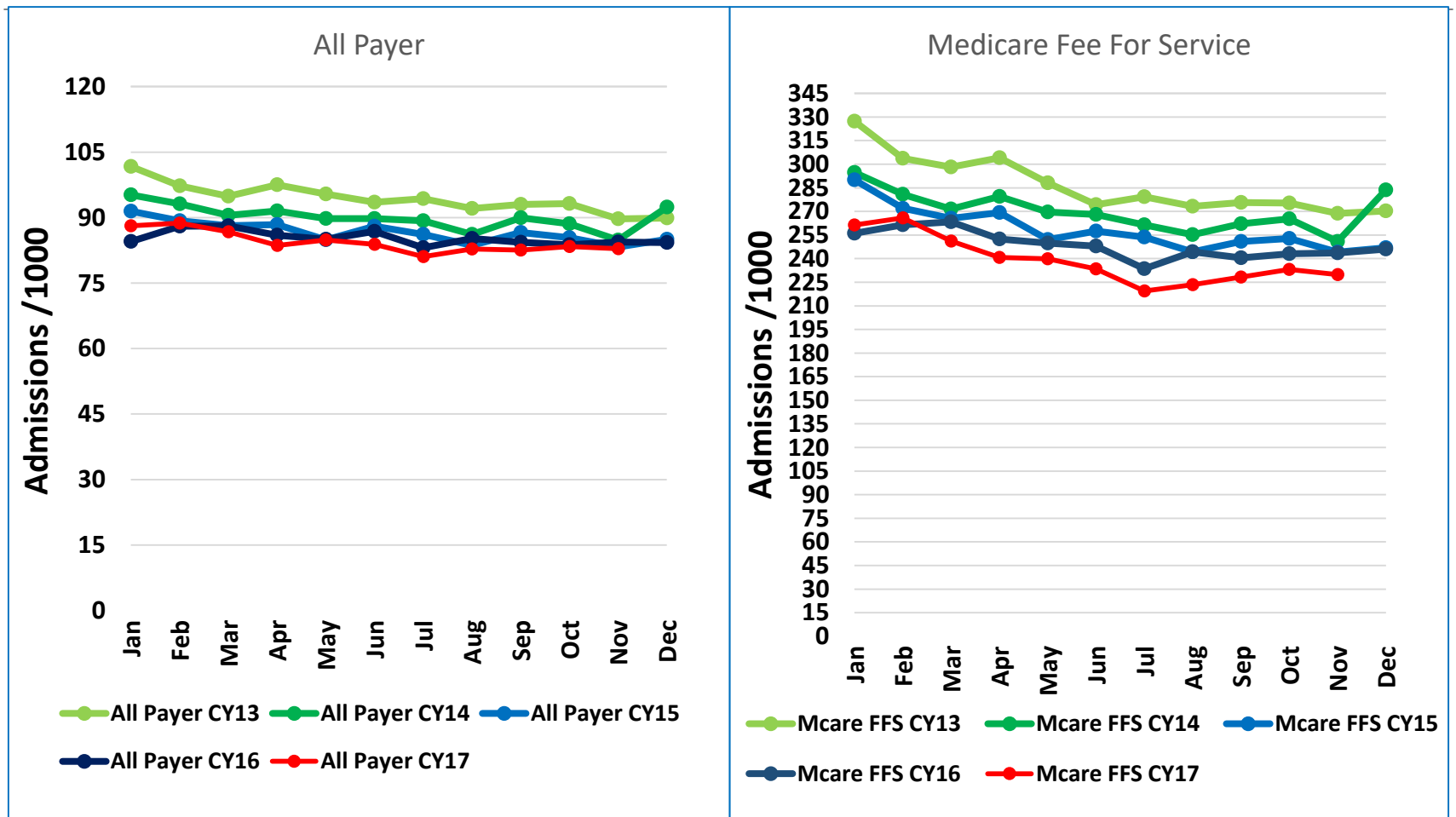
## Calendar Year to Date through November 2017

Source: Hospital Monthly Volume and Revenue Data

The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2017 have been revised. CMS has changed the enrollment source for the Chronic Condition Data Warehouse (CCW) from the Enrollment Database (EDB) to the Common Medicare Environment (CME) database. Part A changed very slightly and Part B is more noticeably changed.

# Annual Trends for ADK Annualized

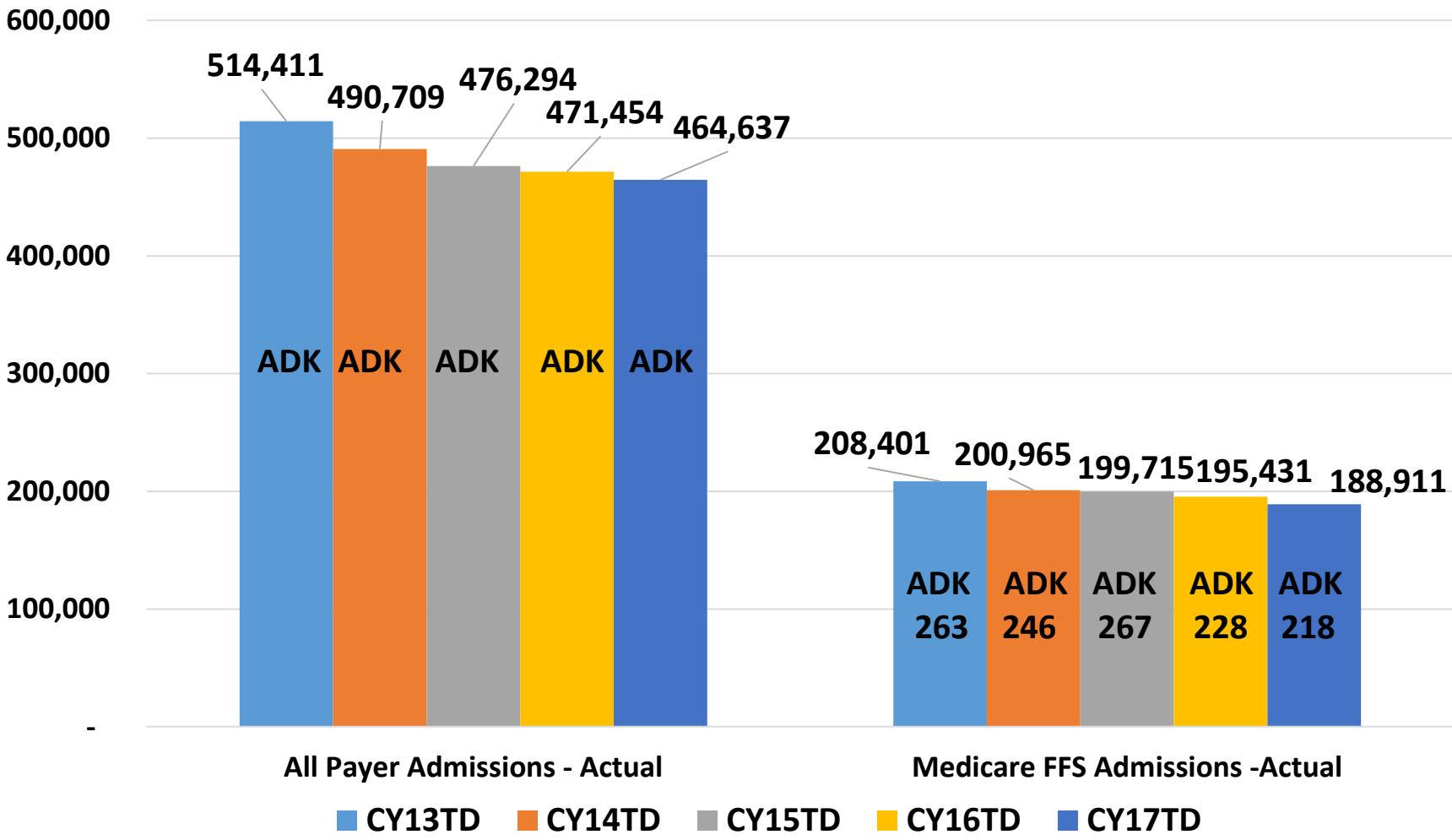
All Payer and Medicare Fee For Service (CY 2013 through CY 2017 November)



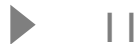
Note - The admissions do not include out of state migration or specialty psych and rehab hospitals.

# Actual Admissions by Calendar YTD November

(CY 2013 through CY 2017)



Note - The admissions do not include out of state migration or specialty psych and rehab hospitals.



# Change in Admissions by Calendar YTD October

(CY 2013 through CY 2017)

**Change in All Payer Admissions CYTD13 vs. CYTD14 = -4.61%**

**Change in All Payer Admissions CYTD14 vs. CYTD15 = -2.94%**

**Change in All Payer Admissions CYTD15 vs. CYTD16 = -1.02%**

**Change in All Payer Admissions CYTD16 vs. CYTD17 = -1.45%**

**Change in ADK CYTD 13 vs. CYTD 14 = -5.19%**

**Change in ADK CYTD 14 vs. CYTD 15 = -3.39%**

**Change in ADK CYTD 15 vs. CYTD 16 = -1.37%**

**Change in ADK CYTD 16 vs. CYTD 17 = -1.45%**

**Change in Medicare FFS Admissions CYTD13 vs. CYTD14 = -3.57%**

**Change in Medicare FFS Admissions CYTD14 vs. CYTD15 = -0.62%**

**Change in Medicare FFS Admissions CYTD15 vs. CYTD16 = -2.15%**

**Change in Medicare FFS Admissions CYTD16 vs. CYTD17 = -3.34%**

**Change in Medicare FFS ADK CYTD 13 vs. CYTD 14 = -6.59%**

**Change in Medicare FFS ADK CYTD 14 vs. CYTD 15 = -3.62%**

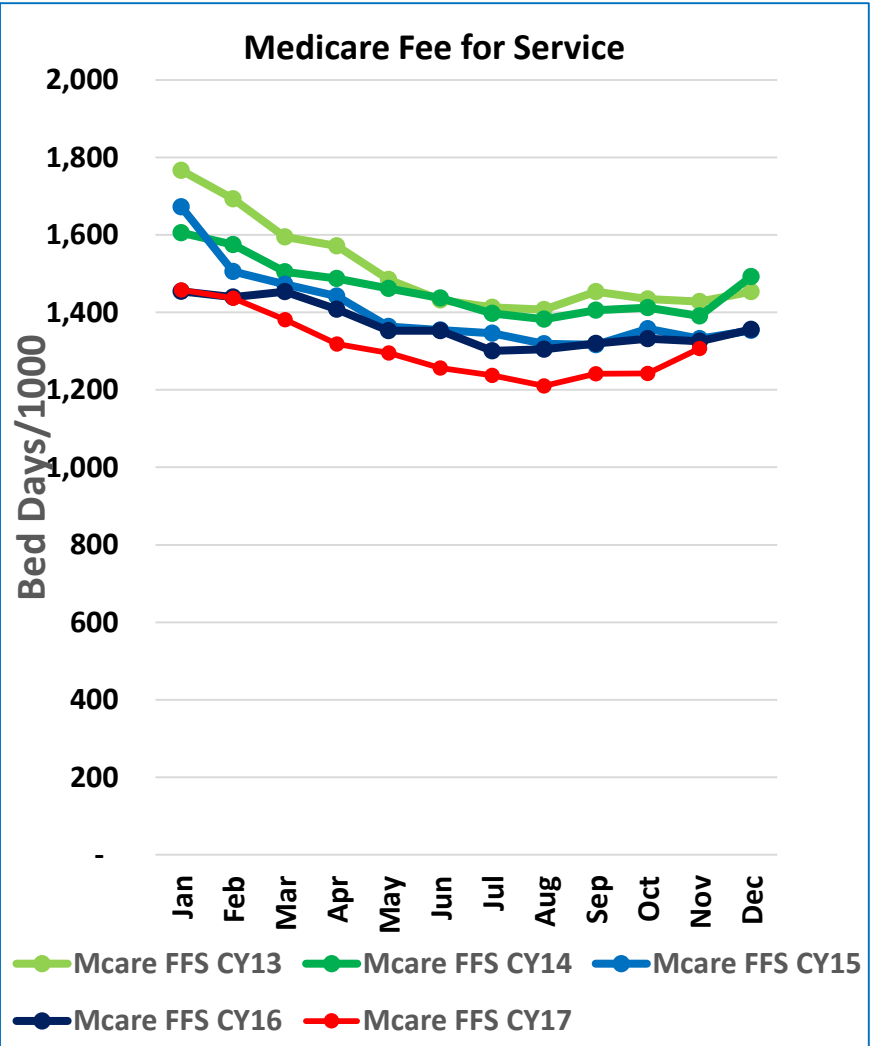
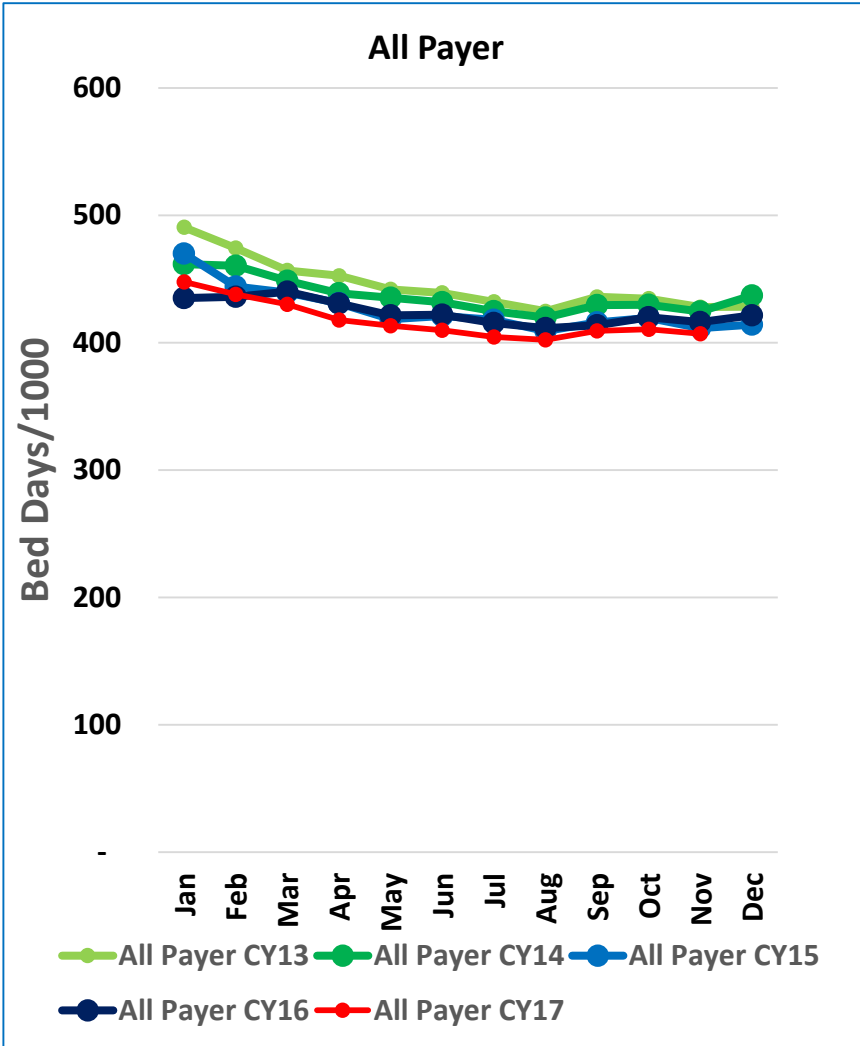
**Change in Medicare FFS ADK CYTD 15 vs. CYTD 16 = -3.77%**

**Change in Medicare FFS ADK CYTD 16 vs. CYTD 17 = -4.34%**



# Annual Trends for BDK Annualized

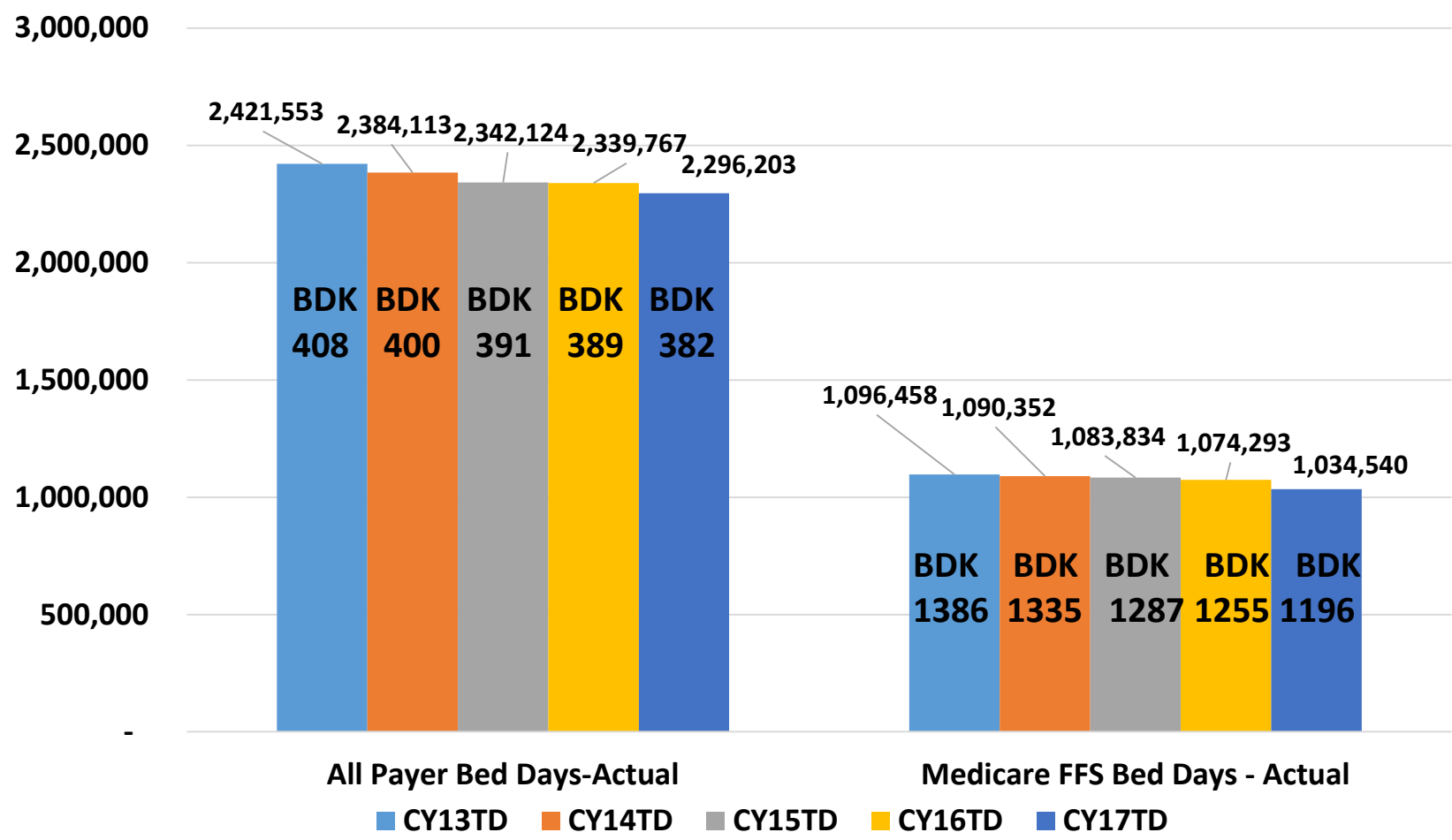
All Payer and Medicare Fee For Service (CY 2013 through CY 2017 November)



Note - The bed days do not include out of state migration or specialty psych and rehab hospitals.

# Actual Bed Days by Calendar YTD November

(CY 2013 through CY 2017)



Note - The bed days do not include out of state migration or specialty psych and rehab hospitals.

# Change in Bed Days by Calendar YTD November

(CY 2013 through CY 2017)

**Change in All Payer Bed Days CYTD13 vs. CYTD14 = -1.55%**

**Change in All Payer Bed Days CYTD14 vs. CYTD15 = -1.76%**

**Change in All Payer Bed Days CYTD15 vs. CYTD16 = -0.10%**

**Change in All Payer Bed Days CYTD16 vs. CYTD17 = -1.86%**

**Change in BDK CYTD 13 vs. CYTD 14 = -2.14%**

**Change in BDK CYTD 14 vs. CYTD 15 = -2.21%**

**Change in BDK CYTD 15 vs. CYTD 16 = -0.46%**

**Change in BDK CYTD 16 vs. CYTD 17 = -1.86%**

**Change in Medicare FFS Bed Days CYTD13 vs. CYTD14 = -0.56%**

**Change in Medicare FFS Bed Days CYTD14 vs. CYTD15 = -0.60%**

**Change in Medicare FFS Bed Days CYTD15 vs. CYTD16 = -0.88%**

**Change in Medicare FFS Bed Days CYTD16 vs. CYTD17 = -3.70%**

**Change in Medicare FFS BDK CYTD 13 vs. CYTD 14 = -3.69%**

**Change in Medicare FFS BDK CYTD 14 vs. CYTD 15 = -3.59%**

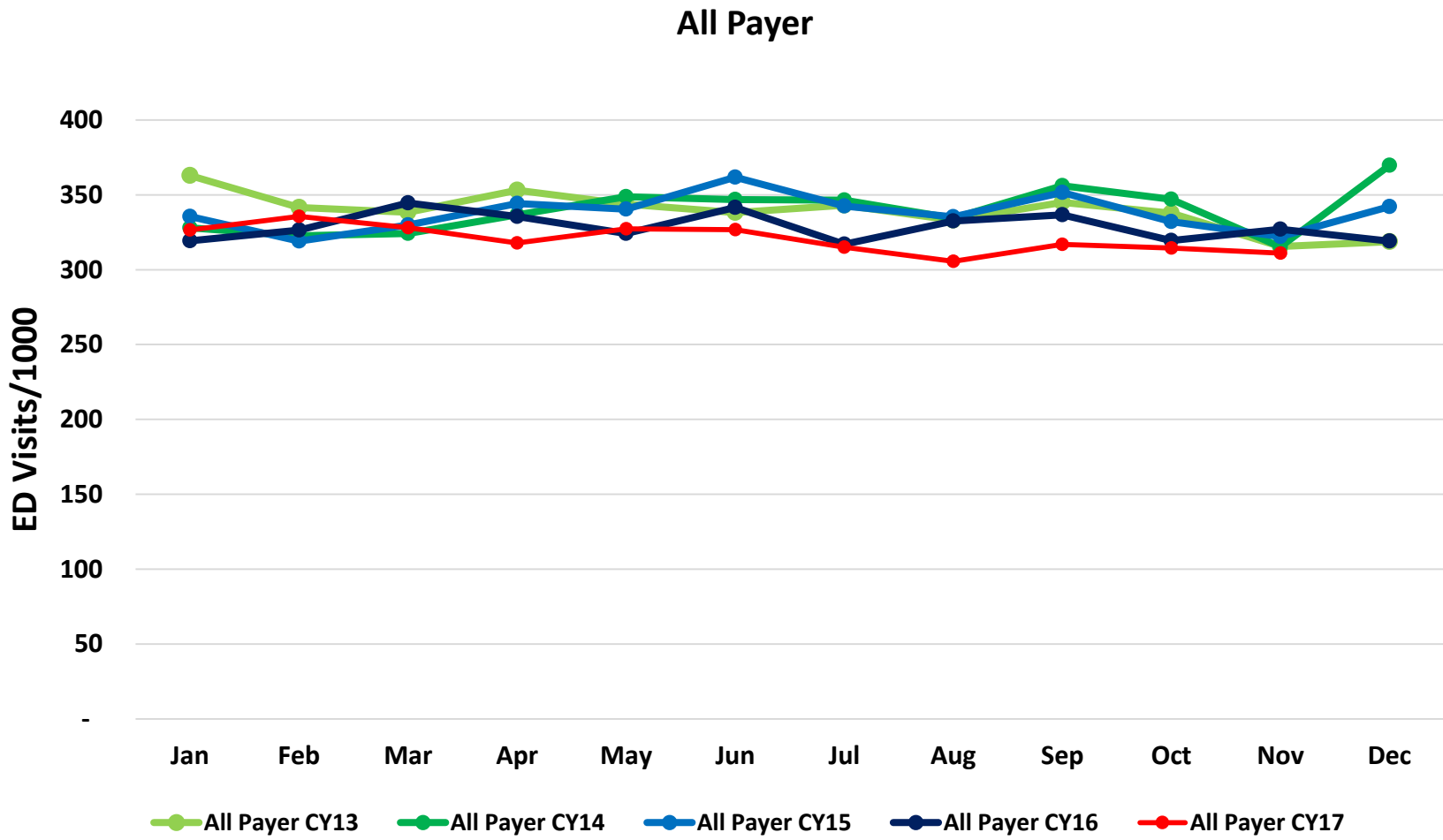
**Change in Medicare FFS BDK CYTD 15 vs. CYTD 16 = -2.54%**

**Change in Medicare FFS BDK CYTD 16 vs. CYTD 17 = -4.70%**



# Annual Trends for EDK Annualized

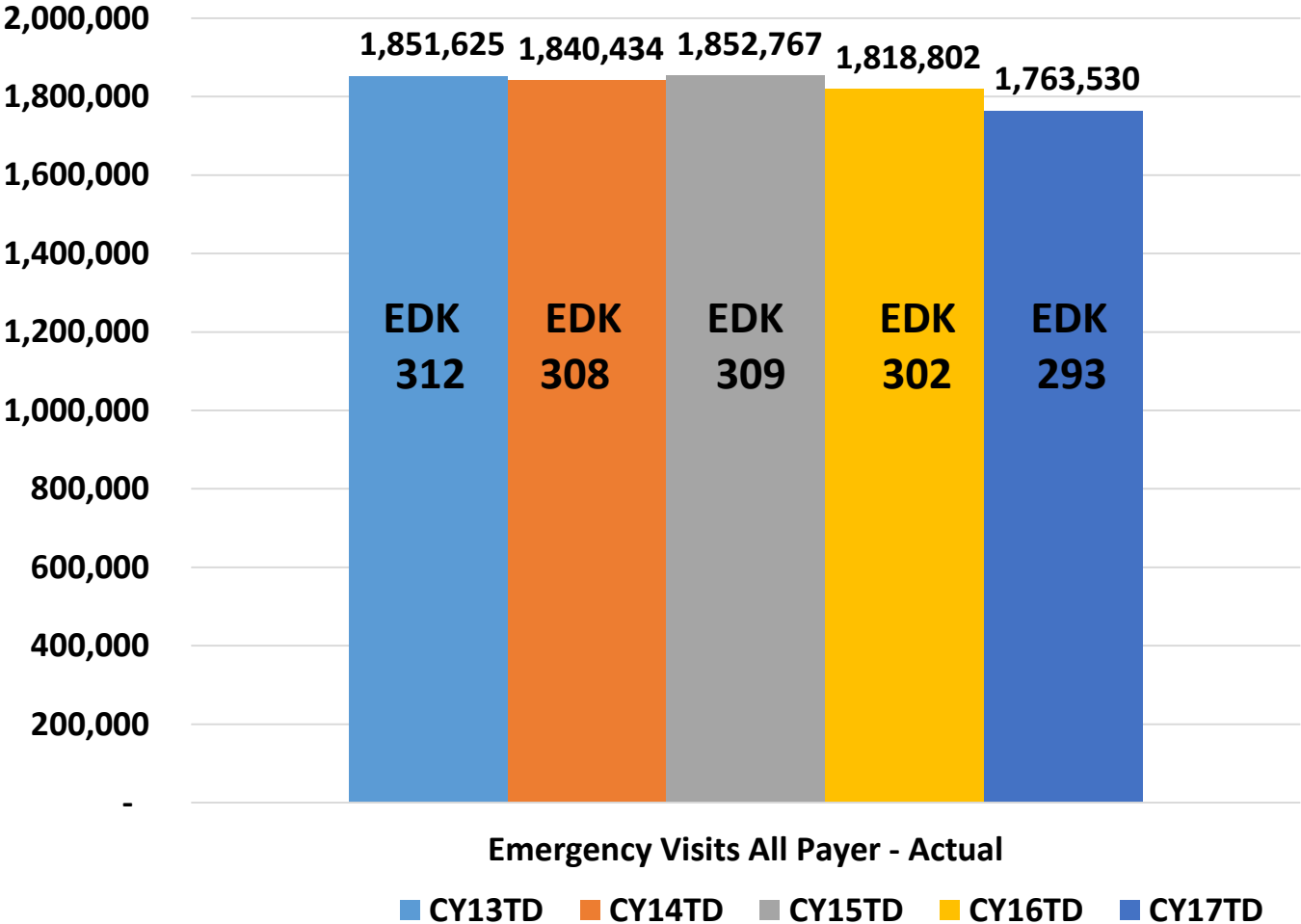
All Payer (CY 2013 through CY2017 November)



Note - The ED Visits do not include out of state migration or specialty psych and rehab hospitals.



# Actual Emergency Department Visits by Calendar YTD November (CY 2013 through CY 2017)



Note - The ED Visits do not include out of state migration or specialty psych and rehab hospitals.

# Change in ED Visits by Calendar YTD November

(CY 2013 through CY 2017)

**Change in ED Visits CYTD 13 vs. CYTD 14 = -0.60%**

**Change in ED Visits CYTD 14 vs. CYTD 15 = 0.67%**

**Change in ED Visits CYTD 15 vs. CYTD 16 = -1.83%**

**Change in ED Visits CYTD 16 vs. CYTD 17 = -3.04%**

**Change in EDK CYTD 13 vs. CYTD 14 = -1.21%**

**Change in EDK CYTD 14 vs. CYTD 15 = 0.21%**

**Change in EDK CYTD 15 vs. CYTD 16 = -2.18%**

**Change in EDK CYTD 16 vs. CYTD 17 = -3.04%**



# Purpose of Monitoring Maryland Performance

Evaluate Maryland's performance against All-Payer Model requirements:

**All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita

- 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of \$330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

# Data Caveats

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- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 CY 2016 and FY 2017 rely on Maryland Department of Planning projections of population growth of .36% for FY18 and FY17, .52% for FY 16, and .52% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.



# Monitoring Maryland Performance Quality Data

January 2018 Commission Meeting Update



**HSCRC**

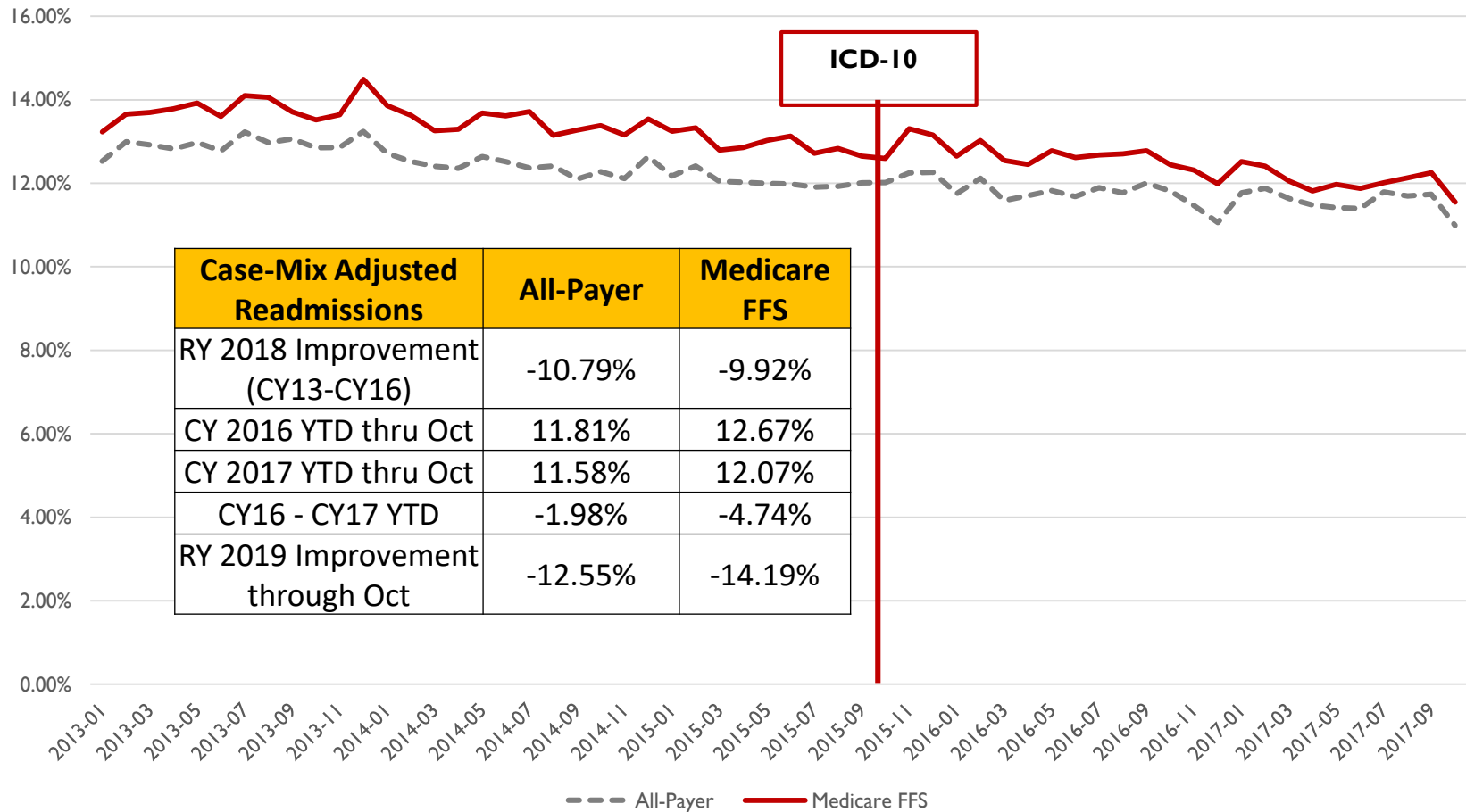
Health Services Cost  
Review Commission

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# Readmission Reduction Analysis

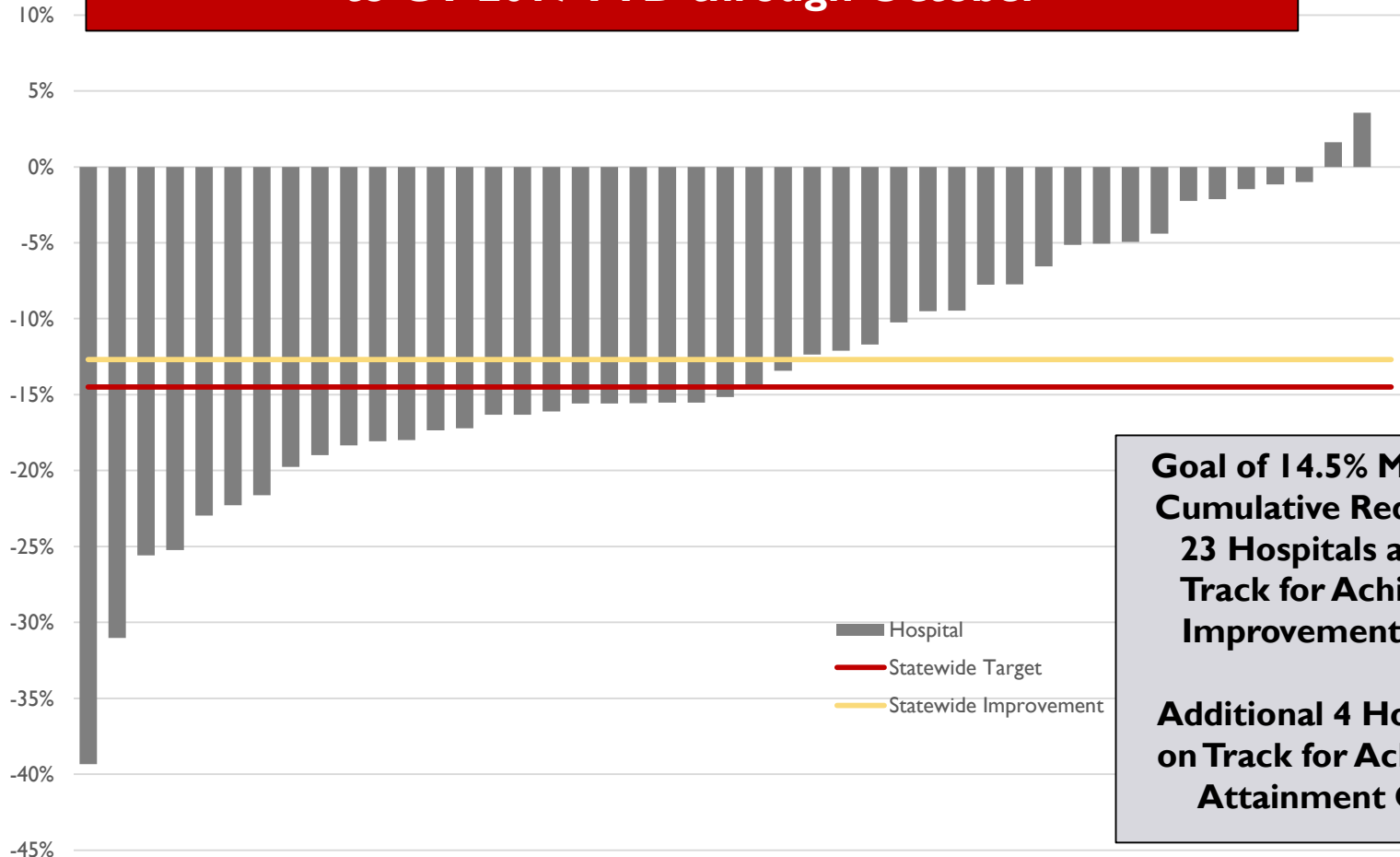
# Monthly Case-Mix Adjusted Readmission Rates



**Note: Based on final data for Jan 2012 – Sep 2017; Preliminary Data for Oct-Nov 2017. Statewide improvement to-date is compounded with complete RY 2018 and RY 2019 YTD improvement.**

# Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital

**Cumulative change CY 2013 – CY 2016 + CY 2016YTD to CY 2017YTD through October**



**Goal of 14.5% Modified Cumulative Reduction  
23 Hospitals are on Track for Achieving Improvement Goal**

**Additional 4 Hospitals on Track for Achieving Attainment Goal**

**Note: Based on Final data for Jan 2013- Sep 2017, Prelim through Nov 2017.**

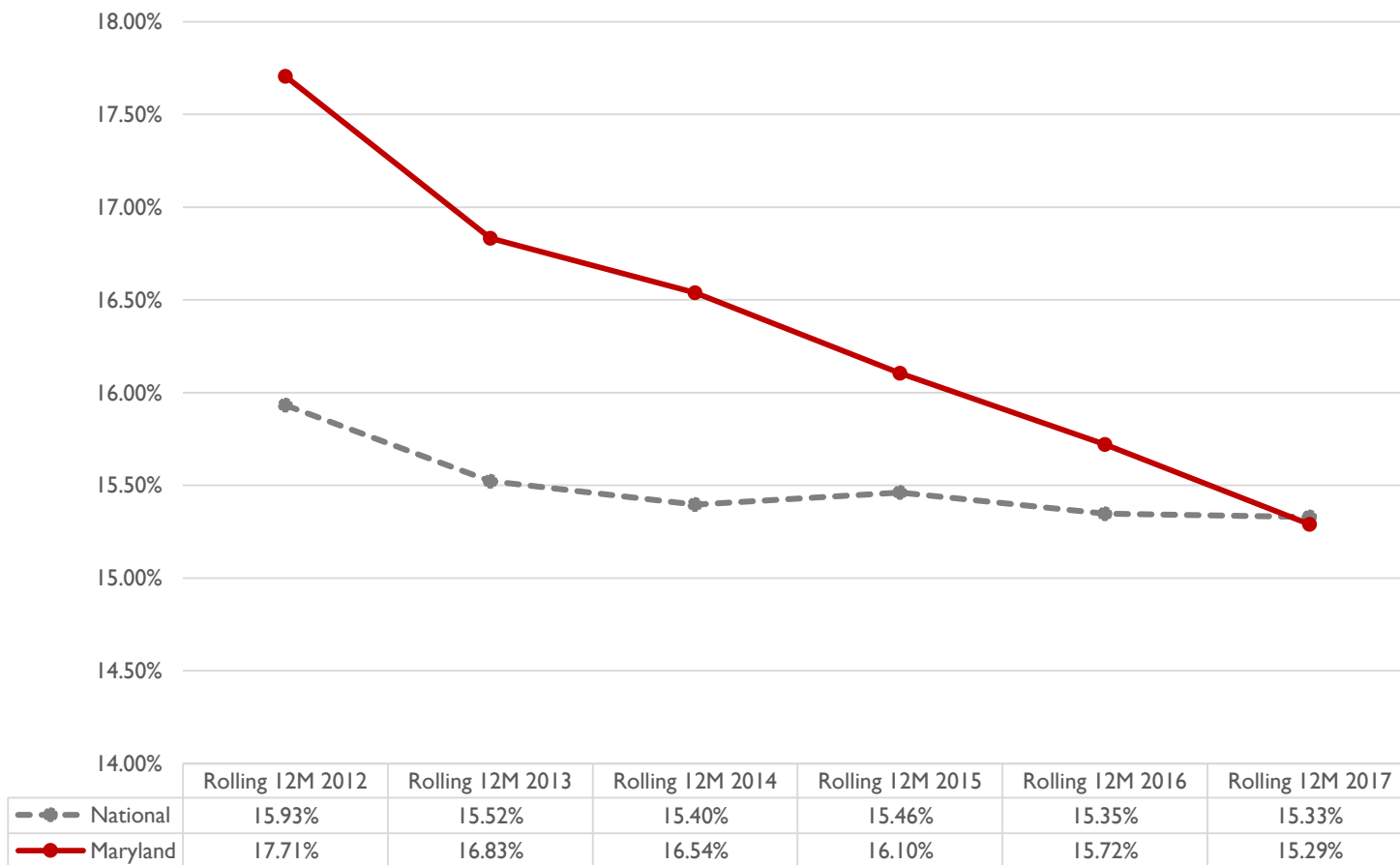


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# Medicare Readmission Model Test

# Medicare Readmissions – Rolling 12 Months Trend

Readmissions - Rolling 12M through Aug



## Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF DECEMBER 28, 2017

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
2419A	University of Maryland Medical System	12/18/2017	N/A	N/A	ARM	DNP	OPEN
2420A	Johns Hopkins Health System	12/28/2017	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

**IN RE: THE APPLICATION FOR  
ALTERNATIVE METHOD OF RATE  
DETERMINATION  
UNIVERSITY OF MARYLAND  
MEDICAL CENTER  
BALTIMORE, MARYLAND**

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2017  
\* FOLIO: 2229  
\* PROCEEDING: 2419A**

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**Staff Recommendation**

**January 10, 2018**

## **I. INTRODUCTION**

The University of Maryland Medical Center (“the Hospital”) filed an application with the HSCRC on December 18, 2017 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. Network for a period of one year, effective April 1, 2018.

## **II. OVERVIEW OF APPLICATION**

The contract will continue to be held and administered by University Physicians, Inc. (UPI). UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

## **III. FEE DEVELOPMENT**

The hospital component of the global rates was developed by calculating mean historical charges for patients receiving like procedures. 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 among UPI, the Hospital, and the physicians holds the Hospital harmless from any shortfalls in payment from the global price contract. UPI maintains it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to bear the risk of potential losses.

## **V. STAFF EVALUATION**

Staff reviewed the experience under this arrangement for the last year and found it to be

favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

## **V I. STAFF RECOMMENDATION**

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. for a one year period commencing April 1, 2018. 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, 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  
ALTERNATIVE METHOD OF RATE  
DETERMINATION  
JOHNS HOPKINS HEALTH  
SYSTEM  
BALTIMORE, MARYLAND**

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2017  
\* FOLIO: 2230  
\* PROCEEDING: 2420A**

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**Staff Recommendation**

**January 10, 2018**



## **I. INTRODUCTION**

Johns Hopkins Health System (“System”) filed an application with the HSCRC on December 28, 2017 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (“the Hospitals”) and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement for Executive Health Services with Under Armor, Inc. for a period of one year beginning February 1, 2018

## **II. OVERVIEW OF APPLICATION**

The contract will be held and administered by Johns Hopkins HealthCare, LLC (“JHHC”), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

## **III. FEE DEVELOPMENT**

The hospital portion of the global rates was developed by calculating 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.

## **IV. IDENTIFICATION AND ASSESSMENT OF RISK**

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from

any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

## **V. STAFF EVALUATION**

The experience in the last year has been favorable. 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' application for an alternative method of rate determination for Executive Health Services for a one year period commencing February 1, 2018. The Hospitals 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.

# **The Role of Academic Medical Centers in the Evaluation of Emerging Innovative Therapies**

Presentation to the Health Services Cost Review Commission

January 10, 2018

# The Role of AMCs in the Development of Innovative Treatments and Therapies

- Academic Medical Centers (AMCs) play an essential role in the evolution of disease management and treatment
- Each year, new treatments and therapies emerge that have the potential to significantly improve survival and quality of life for people with diseases that were previously considered untreatable
  - Requires rigorous clinical testing prior to broader dissemination
- As these new, innovative treatments come online, they are administered and evaluated by physicians in the Academic Medical Center setting
  - AMCs provide the infrastructure and physician expertise to administer the therapy, collect outcomes data, and, ultimately, assess the treatment's value
- This process of developing and assessing the efficacy of new technologies and treatments is vital to the ultimate goal of curing disease and promoting population health
  - AMCs are the primary setting for this

# Recent Examples of Innovative Therapies Developed at Academic Medical Centers

FDA Approval	Therapy	Disease Process	Historical Treatment	Improved Outcome	Estimated Cost
2013	MitraClip	Mitral valve repair	Open-heart surgery	Minimally invasive, avoids open-heart surgery and use of heart-lung machine	\$30k per device
2015	Pipeline Embolization Device	Brain aneurysm	Craniotomy	Minimally invasive, avoids open surgery, eliminates inpatient hospitalization	\$12k-15k per device
2016	Transcatheter aortic valve replacement (TAVR)	Aortic valve stenosis/failure	Open-heart surgery	Minimally invasive, avoids open-heart surgery and use of heart-lung machine	\$30k per device, \$80k per procedure
2016	Spinraza	Spinal muscular atrophy	None, disease is often fatal	Only approved treatment for SMA, halts disease progression	\$750k drug cost per patient in first year, \$375k annually rest of life
	Extracorporeal Membrane Oxygenation (ECMO)	End-stage lung disease/ lung transplant	Mechanical ventilation	Better survival rate and reduced hospital stays	\$70k per procedure

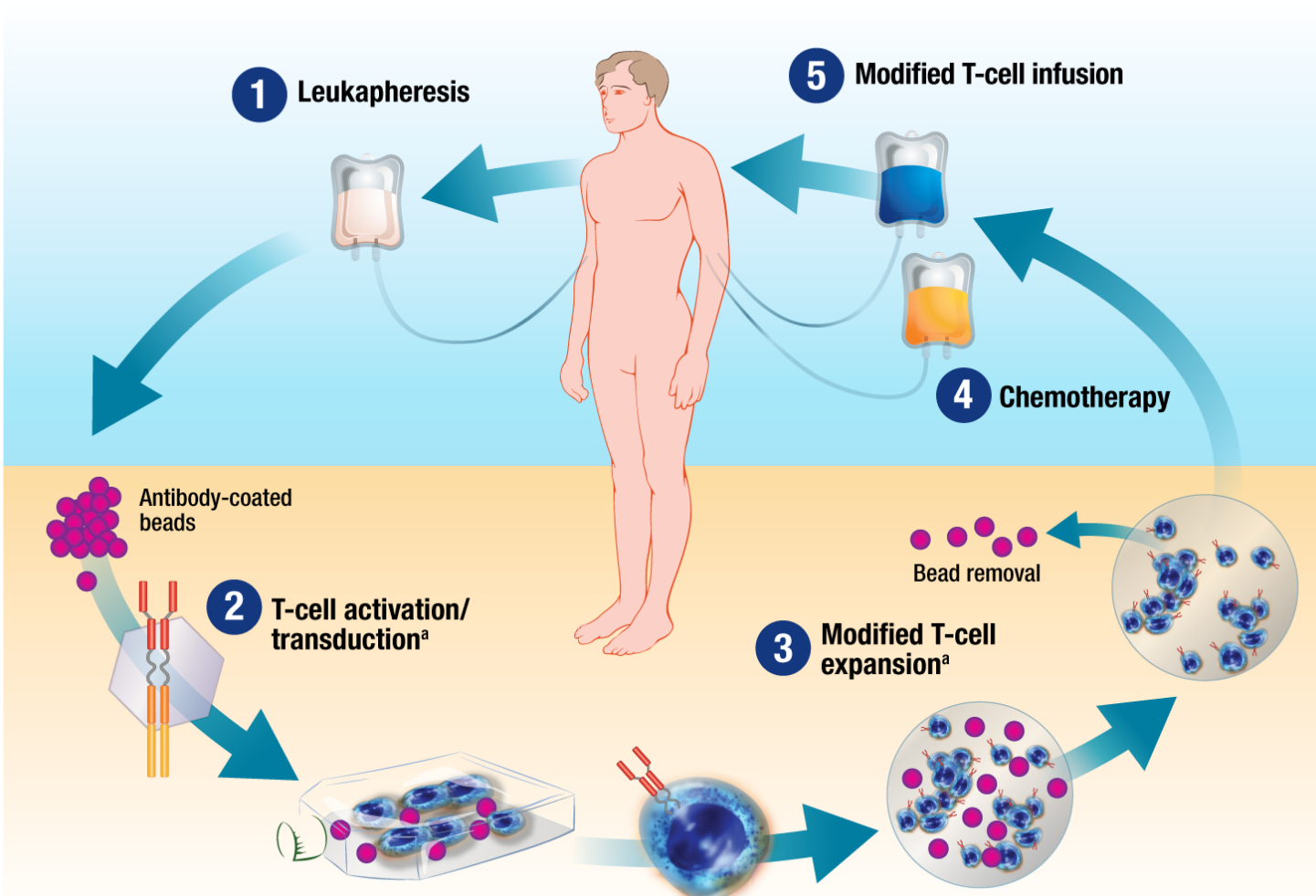
# Emerging Innovative Therapies Coming On Line at UMMC and The JHH

FDA Approval	Therapy	Disease Process	Historical Treatment	Improved Outcome	Estimated Cost
2017	Fetal therapy	Congenital diaphragmatic hernia (CDH), spina bifida	Surgery after birth	Minimally invasive, improves fetal development, improves survival	
2017	Chimeric Antigen Receptor T-Cell (CAR-T) Therapy	Lymphoma/ leukemia	Chemotherapy	Used for patients that do not respond to chemotherapy, 50% remission	\$375k per patient for biologic, \$500k per patient for hospital recovery
2018	Transcatheter mitral valve replacement (TMVR)	Aortic valve stenosis/failure	Open-heart surgery	Minimally invasive, avoids open-heart surgery and use of heart-lung machine	\$30k per device, \$80k per procedure
2018	Luxturna	Inherited retinal dystrophy	None, blindness occurs in most cases	First drug treatment for an inherited retinal disease	\$850k per treatment (\$425k per eye), one treatment needed

# **Chimeric Antigen Receptor T-Cell (CAR-T) Therapy**

## *Engineered Autologous T-Cells: CAR vs. TCR T-Cells*

# Chimeric Antigen Receptor T-Cell (CAR-T) Therapy Overview





# Chimeric Antigen Receptor T-Cell (CAR-T) Therapy

## *The Promise of Genetically Modified T-Cells*

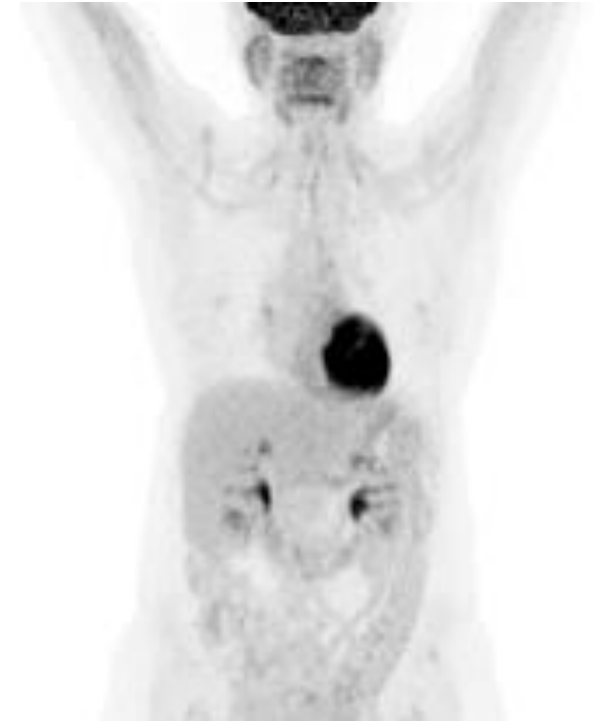
**Before Treatment**



**1 Month After Treatment**



**6 Months After Treatment**



# Chimeric Antigen Receptor T-Cell (CAR-T) Therapy

## *The Promise of Genetically Modified T-Cells*

- It is hard to believe, but Emma, then 6, was near death from leukemia. She had relapsed twice after chemotherapy, and doctors had run out of options
- Desperate to save her, her parents sought an experimental treatment at the Children's Hospital of Philadelphia.
- The experiment, in April 2012, used a disabled form of the virus that causes AIDS to reprogram Emma's immune system genetically to kill cancer cells.
- The treatment very nearly killed her. But she emerged from it cancer-free, and about 5 years later is still in complete remission.



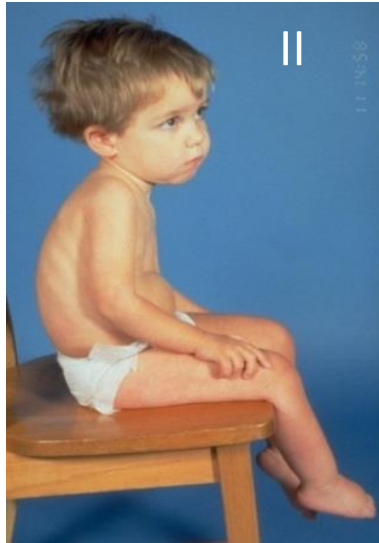
# Spinraza Genetic Therapy

## *Overview of Spinal Muscular Atrophy*

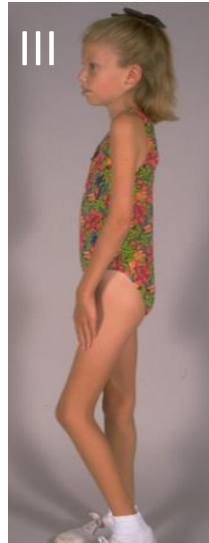
**60%**



**25%**



**15%**

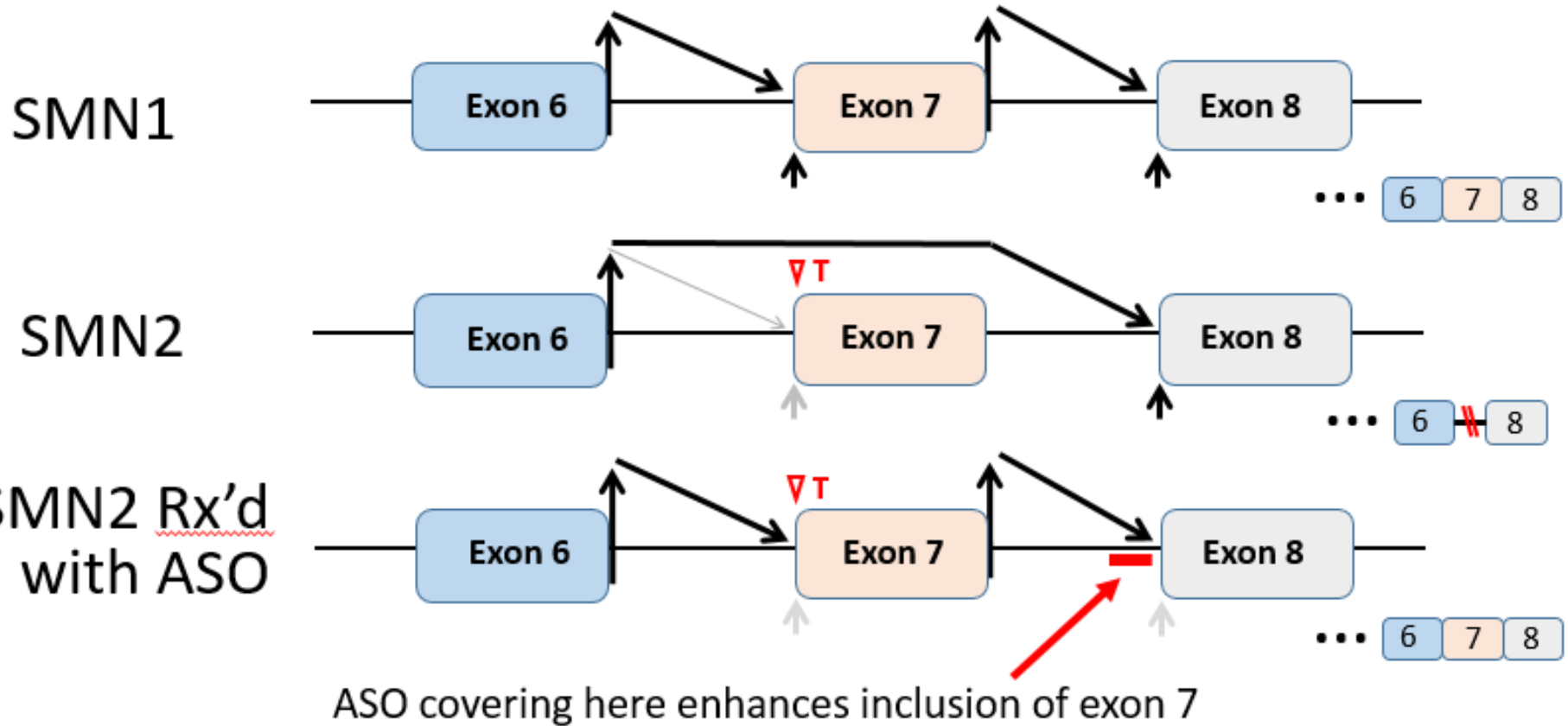


- Most common genetic cause of death in infants, all races
- All experience profound weakness
- Common genetic disease:  
1:10,000 infants, 1:50 are carriers
- A continuum of disease
  - Type 1: limited survival out of infancy
  - Type 2: Wheelchair mobility
  - Type 3: Limited ambulation

**All are caused by loss of the  
*SMN1* gene,  
but a backup *SMN2* gene  
partially rescues**

# Spinraza Genetic Therapy

## *A Stunningly Innovative Therapy*

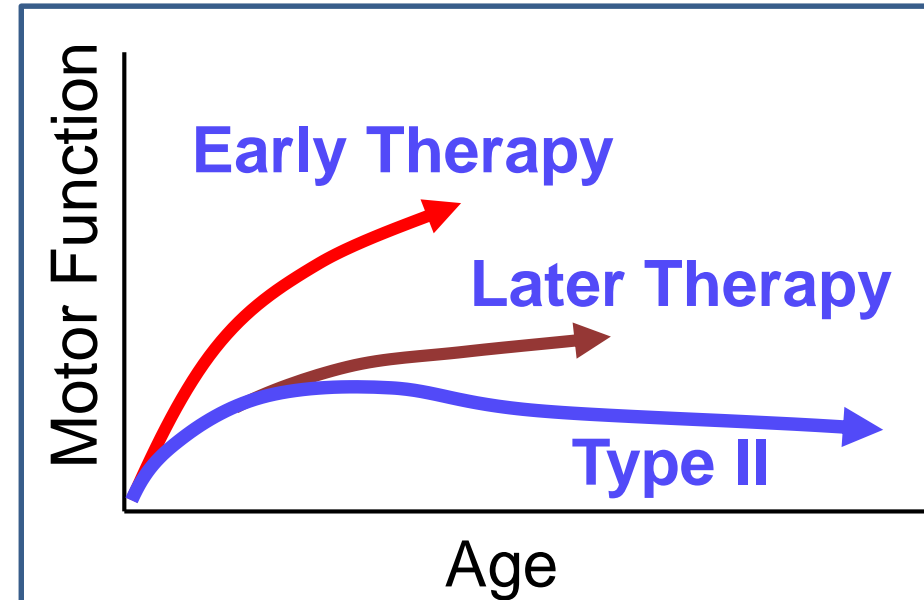
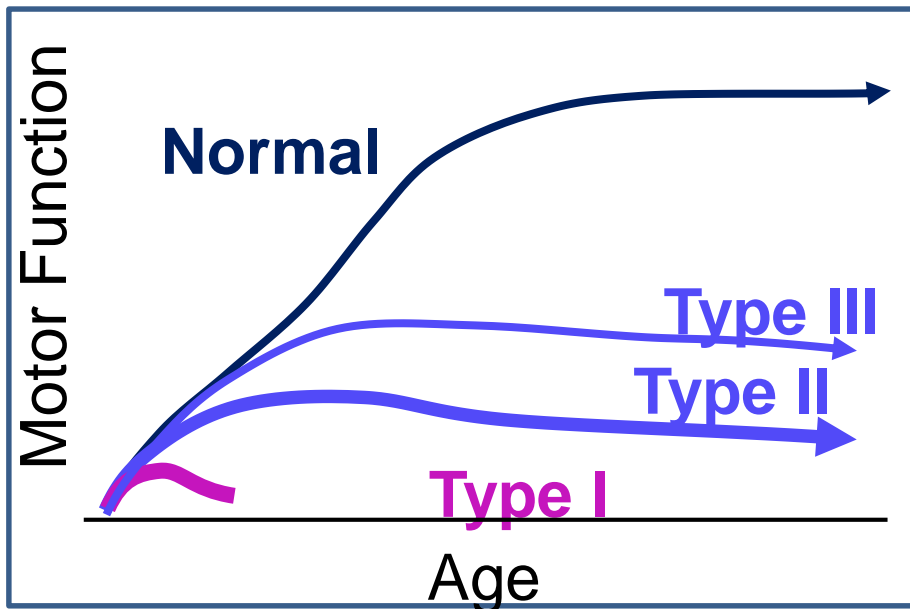


# **Spinraza Genetic Therapy**

## *A Life Changing Therapy*

# Spinraza Genetic Therapy

## *A Life Changing Therapy*



- Spectacular effect in the very young; meaningful to all who receive it
- But the price is equally spectacular at a price of \$125,000 per dose
  - 6 doses first year = \$750,000
  - Subsequent years: 3 doses/year = \$375,000 annually

# **Spinraza Genetic Therapy**

## *Newborn Screening Coming in 2018*

- RUSP recommendation expected in February
- Maryland expected to adopt quickly, Missouri already has
- Newborns will arrive home, days later comes the bad news
- Predict 4-8 infants/year in Maryland

# The Role of Academic Medical Centers in the Healthcare Delivery System

- AMCs play a significant role in the emergence and evaluation of these innovative therapies and treatments
  - Determining the value of these therapies is essential to the continuing evolution of disease management and, ultimately, improves lives
- This aligns with the population health goals of the Demonstration Model
  - However, these innovative therapies carry a significant cost
- The Global Budget Revenue (GBR) model has been a significant step toward achieving the goals of constraining cost and improving population health
  - While the GBR does not intend to constrain innovation, as constructed, the model does not include a defined mechanism to provide funding for these often prohibitively expensive treatments
- The University of Maryland Medical System and The Johns Hopkins Hospital are committed to working with the HSCRC to define appropriate mechanisms to fund this essential aspect of the healthcare delivery system



# Proposal to Address High Cost Emerging Treatments and Therapies

- Guiding principles
  - Well-defined criteria and mechanism for inclusion
  - Reasonably covers the costs of providing these treatments
  - Funding should reflect the actual costs that are incurred
    - i.e. variability for both growth and decline
- Proposed funding mechanism
  - Define emerging treatments and therapies as categorical exclusions
  - 100% VCF funding mechanism for both growth and decline
  - Establish an annual review process to add/subtract therapies
    - Annual report to Commission on actual costs incurred and estimate of costs in following year



# Maryland Hospital Acquired Conditions Program RY 2020 Draft Recommendation

1/10/2018

# RY 2020 DRAFT MHAC Policy

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- ▶ **No vote is required at this time**
  
- ▶ **Staff proposes minimal changes for RY 2020:**
  - ▶ Continue to use established features of the MHAC program in its final year of operation.
  - ▶ Continue to set the maximum penalty at 2% and the maximum reward at 1% of hospital inpatient revenue.
  
- ▶ **Updates to RY 2020 MHAC Policy:**
  - ▶ Raise the minimum number of discharges required for pay-for-performance evaluation in each APR-DRG SOI category from 2 discharges to 30 discharges.
  - ▶ Exclude low frequency APR-DRG-PPC groupings from pay-for-performance.
  - ▶ Establish a subgroup that will consider Hospital-acquired Complications in RY 2021 and beyond.

# MHAC Program - Background

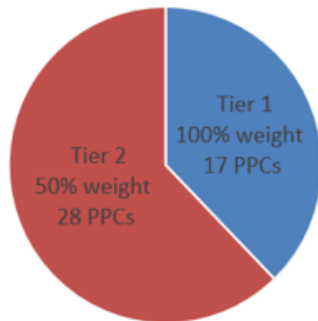
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- ▶ Based on **Potentially Preventable Complications** classification system developed by 3M, which initially included 65 PPC measures.
- ▶ PPCs, like national HAC measures, **rely on present-on-admission (POA)** codes to identify post-admission complications.
- ▶ Reliance on POA codes - improvement could be achieved through better documentation and coding, as opposed to real clinical improvement.
  - ▶ HSCRC has employed targeted and randomized audits to ensure the integrity of the data in each year of the program.

# MHAC Program Current Methodology

## Potentially Preventable Complication Measures

RY 2019: 43 Individual PPCs and 2 Combos (w/6 PPCs) included in payment program



### Global Exclusions:

- Palliative care
- Discharges >6 PPCs
- Apr-DRG SOI cells with less than 2 at-risk discharges

### Hospital PPC Exclusions:

- <10 at-risk discharges
- <1 expected PPC

## Case-Mix Adjustment and Standardized Scores

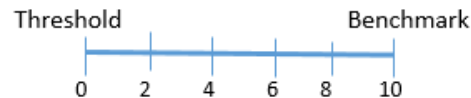
PPC scores (0-10 points) calculated using observed to expected ratios.

Expected calculated by applying statewide average PPC rates by APR-DRG-SOI to hospitals case-mix (i.e., indirect standardization).

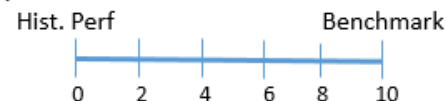
Threshold: State Median (O/E=1)

Benchmark: Top performing hospitals w/ 25% discharges

Attainment Points:



Improvement Points:



Final Points are Better of Improvement or Attainment

## Hospital MHAC Score & Revenue Adjustments

Hospital MHAC Score is Sum of Earned Points / Possible Points with Tier Weights Applied

Scores Range from 0-100%, with revenue neutral zone 45-55%

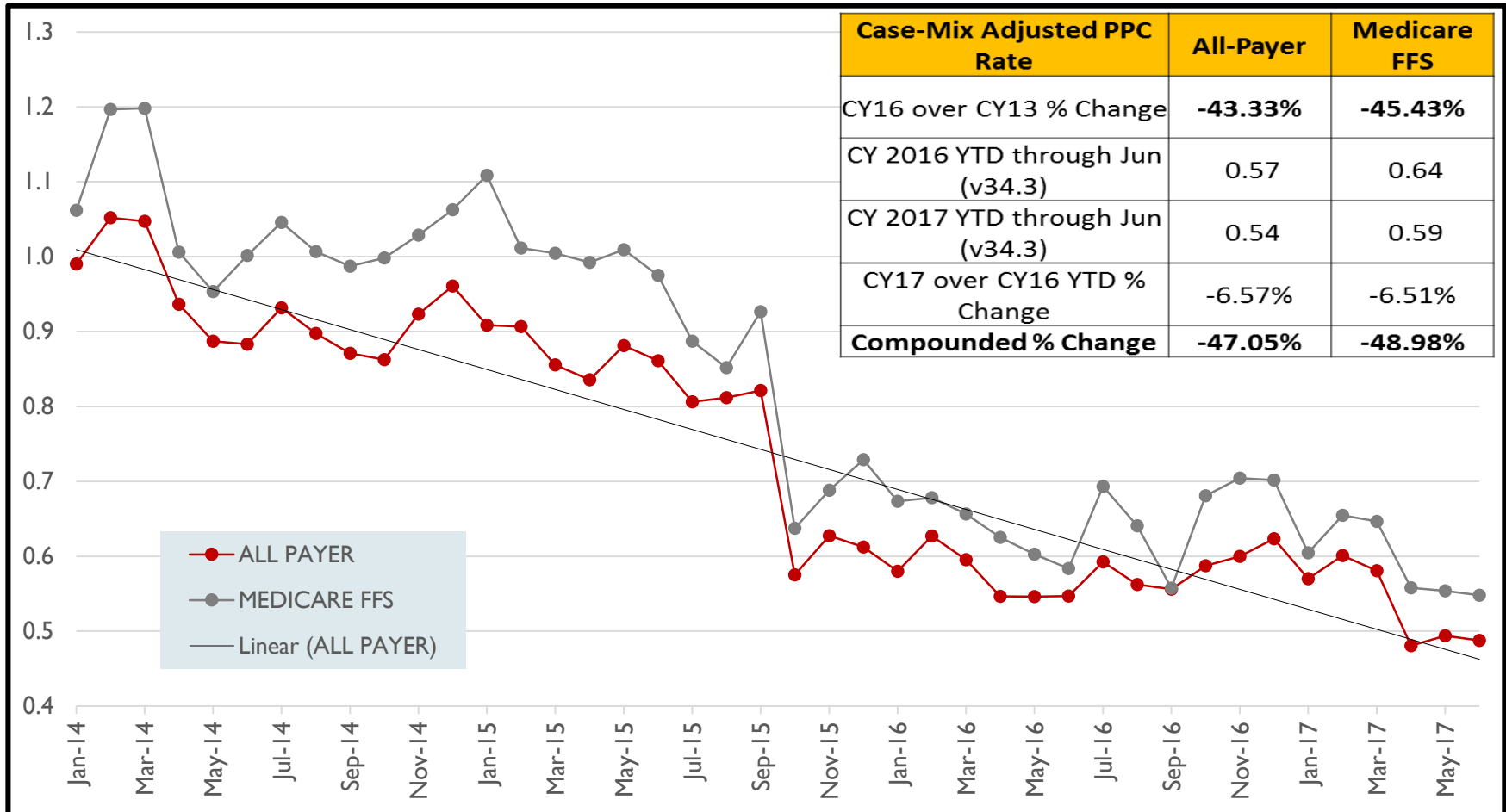
Max Penalty 2% & Reward +1%

Abbreviated Preset Scale	MHAC Score	Financial Adjustment
<b>Max Penalty</b>	<b>0%</b>	<b>-2.00%</b>
	10%	-1.56%
	20%	-1.11%
	30%	-0.67%
	40%	-0.22%
<b>Penalty/Reward Cut Point (Range)</b>	<b>45-55%</b>	<b>0.00%</b>
	60%	0.11%
	70%	0.33%
	80%	0.56%
	90%	0.78%
<b>Max Reward</b>	<b>100%</b>	<b>1.00%</b>



# MHAC Program Statewide Performance

## Case-Mix Adjusted Cumulative PPC Rates as of June 2017



# MHAC Program Concern

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MHAC may penalize random variation in PPC occurrence, as opposed to poor performance, due to an **increasing number of APR-DRG SOI cells with a normative value of zero**

- ▶ Program has a very granular indirect standardization
  - ▶ Complications are measured at the diagnosis and severity of illness level (APR-DRG SOI), of which there are approximately 1,200 combinations *before* considering clinical logic and PPC variation.
- ▶ Program rebases every year
  - ▶ Assesses observed complications using a more recent baseline, which is only one year of evaluation that has multiple years of improvement built into it

Zero norm issue has always existed in MHAC, but has increased over time

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<b>RY</b>	<b>Zero Norms</b>	<b>Total Cells</b>	<b>% Zero of Total Cells</b>	<b>Cells with Norms</b>	<b>% Zero of Cells with Norms</b>
<b>RY 2015</b>	40,418	80,916	49.95%	50,626	<b>79.84%</b>
<b>RY 2020</b>	33,503	57,150	58.62%	37,969	<b>88.24%</b>



# Potential Solutions to Concern

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- ▶ 3M proposed **extending the base period** and **raising the minimum number** of discharges at-risk from 2 to 30 discharges per APR-DRG SOI cell.
  - ▶ Reduced the number of cells with a norm of zero from **89% → 82%**.
- ▶ UMMS/JHHS proposed focusing on the APR-DRG and PPC groupings, where at least 80% of the complications occur (similar to the approach used to measure mortality)
  - ▶ In combination with raising at-risk discharges from 2 to 30, reduced the number of cells with a norm of zero from **89% → 70%**.
- ▶ Other proposals staff considered, not modeled in draft policy:
  - ▶ Adjust the **revenue adjustment scale** from a linear scale to a quadratic or exponential scale;
  - ▶ Move away from indirect standardization for **case-mix adjustment**

# 80% APR-DRG-PPC Groupings

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- ▶ Proposal maintains current methodology but restricts P4P program assessment to the types of patients and PPCs where at least 80% of complications occur.
- ▶ Advantages
  - ▶ Reduces the number of cells with a normative value of zero
  - ▶ Aligns P4P incentives with quality improvement initiatives, which may increase provider engagement
- ▶ Disadvantages
  - ▶ Removes APR-DRGs and PPCs where up to 20% of PPCs occur
  - ▶ Does not match waiver test, under which MD must continue to report PPCs for all patients

# Example 80% Restriction

- ▶ APR-DRG-PPC Groupings: Each combination of APR-DRG (328 in total) and clinically eligible PPC included in payment program (44 PPC/PPC combos in total).

APR-DRG	PPC	Sorted by Observed Counts (highest to lowest)	% of Total Observed PPCs	Cumulative Percent
720	14	45	23%	23%
181	39	36	18%	41%
540	59	25	13%	53%
194	14	22	11%	64%
720	21	21	11%	75%
230	42	11	6%	80%
230	9	11	6%	86%
540	60	9	5%	90%
560	59	9	5%	95%
166	8	6	3%	98%
190	52	3	2%	99%
201	6	2	1%	100%
Observed PPCs across all groupings		200		

# MHAC Modeling

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## ▶ **Model 1:**

- ▶ Raise minimum number of at-risk discharges per APR-DRG SOI from 2 to 30 discharges

## ▶ **Model 2:**

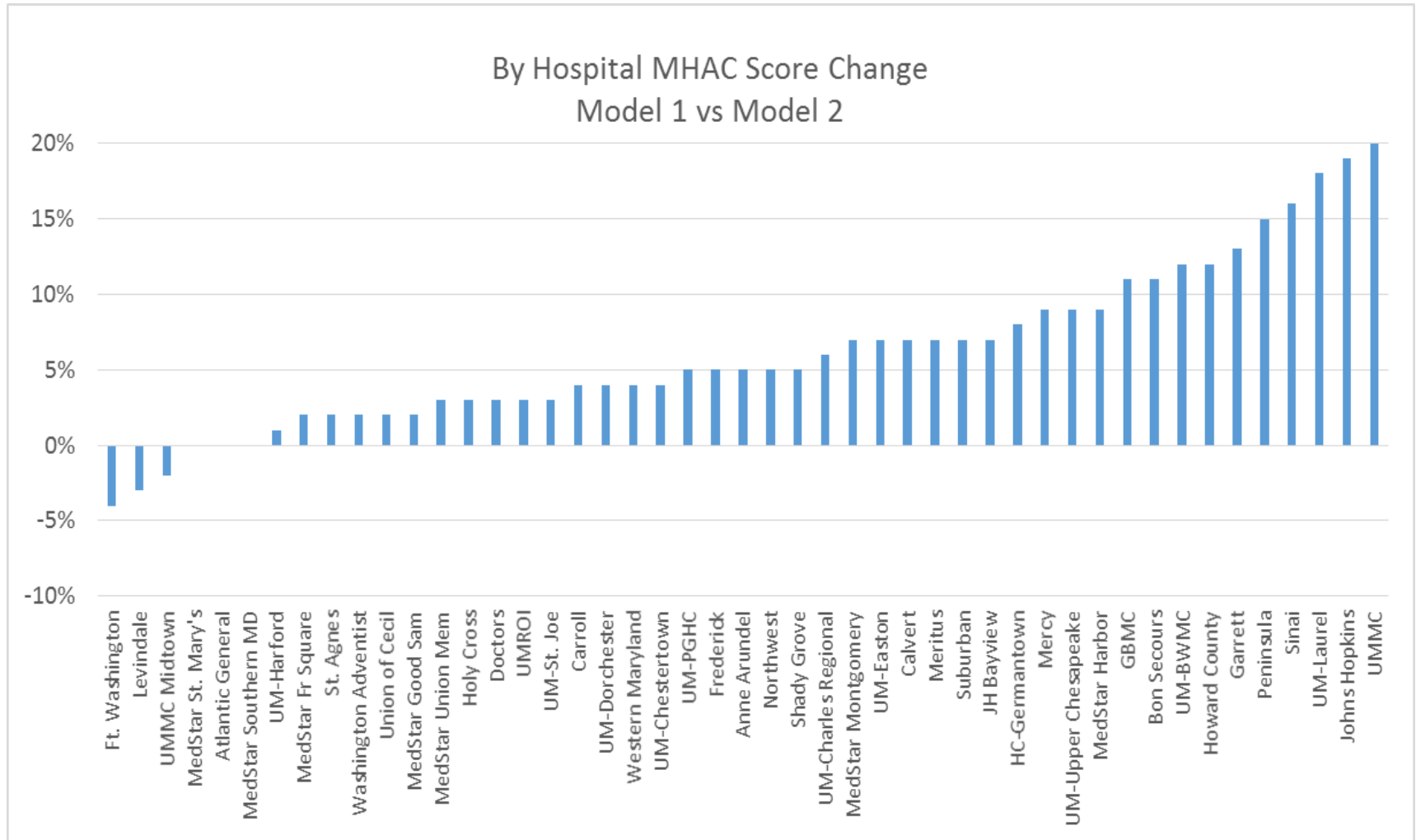
- ▶ Raise minimum number of at-risk discharges per APR-DRG SOI cell from 2 to 30 discharges
- ▶ Restrict to the APR-DRG-PPC groupings where at least 80% of PPCs occur in the base to reduce number of cells with a norm of zero in the base period,

# MHAC Modeling Results

Model #	Model Description	Statewide Total At-Risk Discharges	Statewide Total PPCs	PPC Rate per 1,000 Discharges	Cells w/ Norms >0	Zero Norms	% Zero Norm
1	>30 change only	13,220,025	8,688	0.66	5,173	43,676	89%
2	>30 + 80% APR-DRG-PPC Combos	5,405,445	7,429	1.37	3,190	7,437	70%

- ▶ Model 2 retains 85.5% of eligible PPCs in base period.
- ▶ Other areas staff evaluated for Model 1 and Model 2 include:
  - ▶ The impact on benchmarks
  - ▶ PPC counts by hospital
  - ▶ Attainment-only scores, and
  - ▶ Associated revenue adjustments.

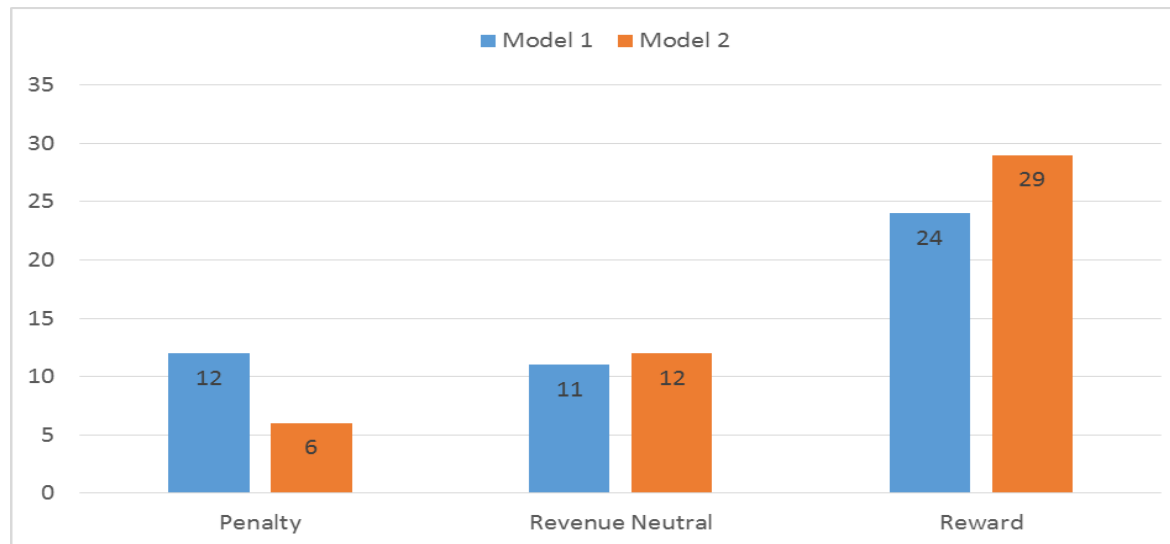
# MHAC Scores – Model 1 → Model 2



# MHAC Revenue Adjustments – Model 1 → Model 2

Model #	Model Description	Statewide Penalties	Statewide Rewards	Net Revenue Adjustments
1	>30 At-Risk Discharges	-13.5 M	6.1 M	-7.3 M
2	>30 + 80% APR-DRG-PPC Groupings	-3.7 M	14.1 M	+10.5 M

**Count of Hospitals in the Penalty, Reward, or Revenue Neutral Zone by Model**



- ▶ 14 Revenue adjustments are based on scores using better of attainment/improvement with RY 2019 Base (Oct15-Sep16); RY 2019 Performance YTD (Jan17-Sep17)

# RY 2020 MHAC Draft Recommendations

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- ▶ Continue to use established features of the MHAC program in its final year of operation;
- ▶ Set the maximum penalty at 2% and the maximum reward at 1% of hospital inpatient revenue;
- ▶ Raise the minimum number of discharges required for pay-for-performance evaluation in each APR-DRG SOI category from 2 discharges to 30 discharges (**NEW!**);
- ▶ Exclude low frequency APR-DRG-PPC groupings from pay-for-performance (**NEW!**); and
- ▶ Establish a complications subgroup to the Performance Measurement Workgroup (**NEW!**).

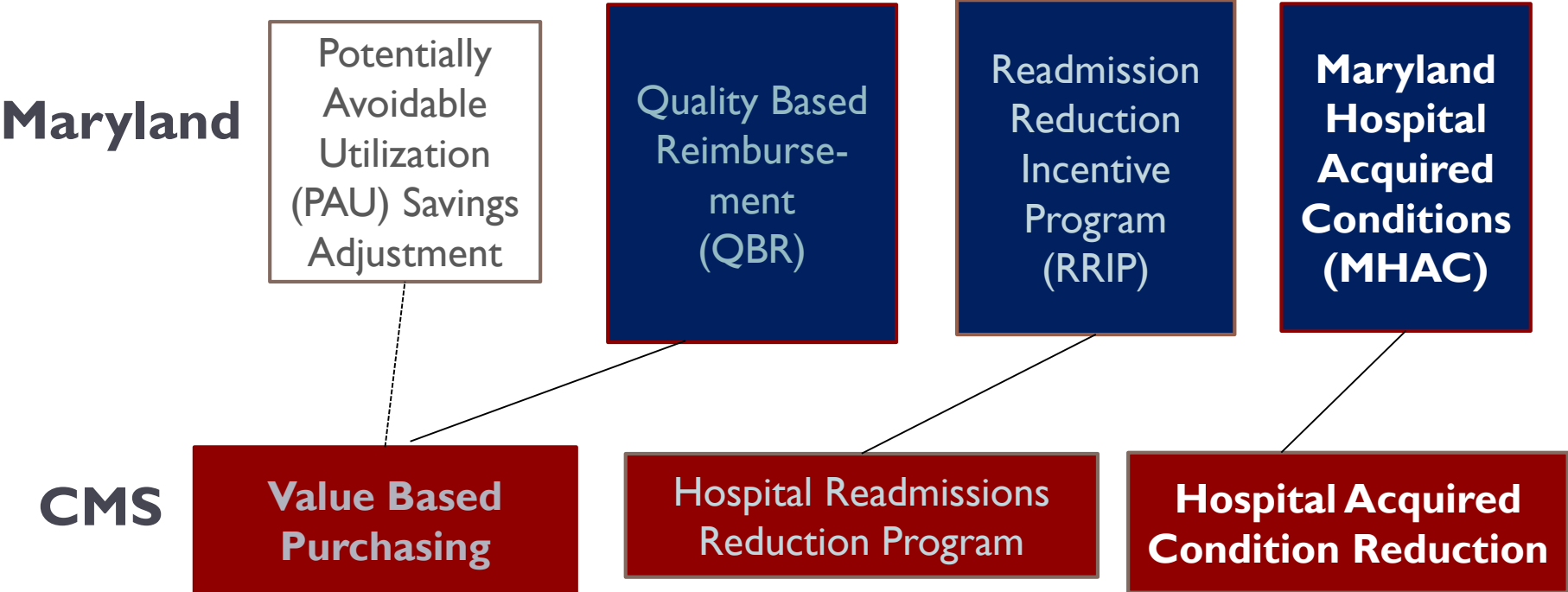


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# Appendix

# MHAC Program is One of Three Core Performance-Based Payment Programs

Maryland Programs must: be comparable to Federal programs; have aggressive and progressive annual targets; meet annual potential and realized at-risk targets; and meet contractually obligated targets, where specified, by end of 2018.



# Hospital Acquired Conditions (HACs)

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- ▶ Defined as harmful events that develop *after* the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness.
- ▶ For example, an adverse drug reaction or an infection at the site of a surgery are referred to as hospital-acquired conditions or complications. \*
- ▶ HACs can lead to:
  - ▶ 1) poor patient outcomes, including longer hospital stays, permanent harm, and death, and
  - ▶ 2) increased costs.

# National Medicare Efforts Targeting HACs- Background

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- ▶ CMS operates two programs targeting HACs
  - ▶ DRA HAC Program- beginning in Federal Fiscal Year 2009 (FFY 2009), CMS stopped assigning patients to higher-paying DRGs for certain conditions if they were *not* present on the patient's admission,
  - ▶ ACA Hospital-Acquired Condition Reduction Program (HACRP) - beginning in FFY 2015, the HACRP focused on a narrower list of complications in two domains,<sup>^</sup> with penalties applied to worst 25% of hospitals based on relative ranking.

<b>HACRP Domain 1 – Recalibrated Patient Safety Indicator (PSI) measure:</b>
Recalibrated PSI 90 Composite
<b>HACRP Domain 2 – National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures:*</b>
Central Line-Associated Bloodstream Infection (CLABSI)
Catheter-Associated Urinary Tract Infection (CAUTI)
Surgical Site Infection (SSI) – colon and hysterectomy
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia
Clostridium Difficile Infection (CDI)

\*Measures also included in the QBR program

<sup>^</sup>Of note, the measures used for the HACRP program are the same measures used under the Safety Domain of the CMS Value Based Purchasing (VBP) and the Maryland Quality Based Reimbursement (QBR) Programs

# Maryland HAC (MHAC) Program

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- ▶ Initial methodology estimated the percentage of inpatient revenue associated with excess numbers of PPCs, penalized hospitals that had higher estimated PPC costs
- ▶ Beginning in RY 2016, methodology fundamentally changed to evaluate hospital performance based on case-mix adjusted PPC rates rather than excess PPC costs.
- ▶ In RY 2019, there were two major changes to the revenue adjustment scale:
  - ▶ Removed the two-scale approach, whereby achievement of a minimum statewide reduction goal determined the scale (i.e. contingent scaling).
  - ▶ Shifted from using the statewide average performance to determine the revenue adjustment scale to instead using the full range of scores (0% to 100%), with a revenue neutral zone between 45% and 55%.

# Rate Year 2020 MHAC Timeline

- ▶ Base Period = **FY 2017**
  - ▶ Used for normative values for case-mix adjustment
- ▶ Performance Period = **CY 2018**
- ▶ Grouper Version: **3M APR-DRG and PPC Grouper Version 35**

Rate Year	FY16-Q3	FY16-Q4	FY17-Q1	FY17-Q2	FY17-Q3	FY17-Q4	FY18-Q1	FY18-Q2	FY18-Q3	FY18-Q4	FY19-Q1	FY19-Q2	FY19-Q3	FY19-Q4	FY20-Q1	FY20-Q2	FY20-Q3	FY20-Q4
Calendar Year	CY16-Q1	CY16-Q2	CY16-Q3	CY16-Q4	CY17-Q1	CY17-Q2	CY17-Q3	CY17-Q4	CY18-Q1	CY18-Q2	CY18-Q3	CY18-Q4	CY19-Q1	CY19-Q2	CY19-Q3	CY19-Q4	CY20-Q1	CY20-Q2

## Quality Programs that Impact Rate Year 2020

MHAC: Better of Attainment or Improvement ▶ 21	MHAC Base Period (Proposed)						MHAC Performance Period: Better of Attainment or Improvement (Proposed)						Rate Year Impacted by MHAC Results	

# Next Steps:

## Complications under the New Model

---

- ▶ HSCRC procured a **vendor to convene a sub-group** of clinical and performance measurement experts.
  - ▶ Sub-group will build plan to measure and report complications under the TCOC Model
    - ▶ Scope will include review of potential all-payer, clinically valid complication measures, including risk adjustment
- ▶ Anticipated **timeline:**
  - ▶ Sub-group will meet beginning in early 2018
  - ▶ Sub-group will recommend measures options to the PMWG by Summer/early Fall 2018
  - ▶ PMWG to develop payment adjustment methodology Fall 2018



# **Draft Recommendation for the Maryland Hospital-Acquired Conditions Program for Rate Year 2020**

January 10, 2018

Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215  
(410) 764-2605  
FAX: (410) 358-6217

This document contains the draft staff recommendations for updating the Maryland Hospital-Acquired Conditions Program for rate year 2020. Please submit comments on this draft to the Commission by Friday, January 26, 2017, via email to [hscrc.quality@maryland.gov](mailto:hscrc.quality@maryland.gov).



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This is a draft recommendation of the RY 2020 Maryland Hospital Acquired Conditions (MHAC) policy. At this time, the staff requests that Commissioners consider the following recommendations:

## Draft Recommendations for RY 2020 MHAC Program

1. Continue to use established features of the MHAC program in its final year of operation:
  - a. 3M PPCs to measure complications;
  - b. Observed/expected ratios to calculate hospital performance scores, assigning 0-10 points based on statewide threshold and benchmark standards;
  - c. Better of improvement and attainment total scores for assessing hospital performance under the program;
  - d. A linear preset scale based on the full mathematical score distribution (0-100%) with a revenue neutral zone (45-55%);
  - e. Combine PPCs that experience a small number of observed cases into an aggregated complication measure (i.e., a combination PPC);
2. Set the maximum penalty at 2% and the maximum reward at 1% of hospital inpatient revenue;
3. Raise the minimum number of discharges required for pay-for-performance evaluation in each APR-DRG SOI category from 2 discharges to 30 discharges (NEW!);
4. Exclude low frequency APR-DRG-PPC groupings from pay-for-performance (NEW!); and
5. Establish a complications subgroup to the Performance Measurement Workgroup that will consider measurement selection and methodological concerns, which will include appropriate risk adjustment, scoring, and scaling, and reasonable performance targets.

## List of Abbreviations

AHIMA	American Health Information Management Association
AHRQ	Agency for Healthcare Research and Quality
APR-DRG	All Patients Refined Diagnosis Related Groups
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DRA HAC	Deficit Reduction Act Hospital-Acquired Condition
DRG	Diagnosis-Related Group
FFY	Federal Fiscal Year
FY	State Fiscal Year
HAC	Hospital-Acquired Condition
HACRP	HAC Reduction Program
HRRP	Hospital Readmission Reduction Program
HSCRC	Health Services Cost Review Commission
ICD	International Statistical Classification of Diseases and Related Health Problems
MHAC	Maryland Hospital-Acquired Condition
NHSN	National Healthcare Safety Network
NQF	National Quality Forum
PMWG	Performance Measurement Work Group
POA	Present on Admission
PPC	Potentially Preventable Complication
PSI	Patient Safety Indicator
QBR	Quality-Based Reimbursement
RY	Rate Year
SIR	Standardized Infection Ratio
SOI	Severity of Illness
TCOC	Total Cost of Care
VBP	Value-Based Purchasing
YTD	Year to Date

## Introduction

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) quality-based measurement and payment initiatives are important policy tools for providing strong incentives for hospitals to improve their quality performance over time. Under the current All-Payer Model Agreement (the Agreement) between Maryland and the Centers for Medicare & Medicaid Services (CMS) there are overarching quality performance requirements for reductions in readmissions and hospital acquired conditions as well as ongoing program and performance requirements for all of HSCRC's quality and value-based programs.

As long as Maryland makes incremental progress towards the Agreement goals, the State receives automatic exemptions from the CMS Hospital Acquired Conditions Reduction Program (HACRP) and Hospital Readmission Reduction program (HRRP), while the exemption from the CMS Medicare Value-Based Purchasing (VBP) program is requested annually. Furthermore, because Maryland sets all-payer rates and has all acute hospitals under all-payer global budgets, Maryland is further exempt from the Federal Deficit Reduction Act Hospital-Acquired Condition program (DRA HAC), which eliminates additional fee-for-service payments associated with select hospital-acquired conditions. These exemptions from national quality programs are important, because the State of Maryland's all-payer global budget system benefits from having autonomous, quality-based measurement and payment initiatives that set consistent quality incentives across all-payers.

This draft report provides recommendations for updates to Maryland's Hospital Acquired Conditions (MHAC) program for Rate Year 2020 (RY 2020), which is one of three core quality programs that the HSCRC administers. The MHAC program, which was first implemented in state fiscal year 2011 (FY 2011), places 2% of revenue at-risk by scoring a hospital's performance based on a broad set of Potentially Preventable Complication (PPC) measures developed by 3M Health Information Systems. One of the requirements under the current Agreement, effective January 2014, is for Maryland to reduce the incidence of PPCs for all-payers by 30 percent by 2018. This goal was achieved within the first two years of the Agreement - the cumulative reduction as of June 2017 is 47.05%. However, it should be noted that this progress must be sustained through the five-year term of the Agreement in order to satisfy the State's contractual obligation.

For RY 2020, which encompasses the performance results from the final year of the Agreement (CY 2018), staff is recommending minimal changes to the MHAC policy, with the notable exception of focusing the pay-for-performance incentives on the subset of patients for whom most complications occur.<sup>1</sup>

The staff's recommendation will focus on the areas of inpatient care (APR-DRG-PPC groupings) in which the majority of PPCs occur (>80%). This proposed change addresses issues with cells with a norm of zero, i.e. where no PPCs are expected because none were observed in the base period, as this phenomenon potentially penalizes hospitals for random variation as opposed to poor performance. Staff is also proposing to aggregate a few PPCs with small numbers of

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<sup>1</sup> Appendix I details the base and performance periods and includes a description of the proposed RY 2020 methodology for score calculations.

observed cases for measurement (i.e., creating a new Combination PPC) and raise the minimum number of discharges required in each APR-DRG SOI category from 2 to 30, to further address the cells with a norm of zero issue.

The reason staff is recommending minimal revisions to the MHAC program and other existing quality programs is so that it can focus on future policy development to establish quality strategies and performance goals under the Total Cost of Care (TCOC) Model (“TCOC Model”), which will be effective beginning in CY 2019. Staff will work with key stakeholders to develop new approaches for reducing HACs in Maryland for RY 2021 and beyond that support the goals of the TCOC Model. Specifically, new approaches will evaluate Maryland hospital performance relative to the nation, while at the same time affording the State the opportunity to be aggressive and progressive in its program(s). To accomplish this redesign, which will necessitate the discontinuation of the MHAC program in its current form, staff will convene a subgroup of the Performance Measurement Workgroup (PMWG) that will consider 1) measurement selection, which will include evaluating movement to CMS HAC measures, as well as retaining various PPC measures or adopting other complication measures that cover important all-payer clinical areas that may not be addressed by the CMS HAC programs; and 2) methodological concerns, which will include appropriate risk adjustment, scoring, and scaling, and reasonable performance targets.

## Background

### Overview of the Federal HAC Programs

Medicare’s system for the payment of inpatient hospital services is called the inpatient prospective payment system. Under this system, patients are assigned to a payment category called a diagnosis-related group (DRG), which are based on a patient’s primary diagnosis and the presence of other conditions. An average cost is calculated for each DRG relative to the average cost for all Medicare hospital stays, and these relative costs (or DRG weights) are used to calculate Medicare’s payment to the hospital; patients with more co-morbidities or complications generally are categorized into higher-paying DRGs.<sup>2</sup> Historically, Medicare payments under this system were based solely on the DRG weights and the volume of services. However, beginning in Federal Fiscal Year 2009 (FFY 2009), with the advent of the DRA HAC Program, patients were no longer assigned to higher-paying DRGs if certain conditions were *not* present on the patient’s admission, or, in other words, if the condition was acquired in the hospital and could have reasonably been prevented through the application of evidence-based guidelines.

CMS expanded the use of HACs in payment adjustments in FFY 2015 with a new program, entitled the Hospital-Acquired Condition Reduction Program (HACRP), under authority of the Affordable Care Act. That program focused on a narrower list of complications and penalizes hospitals in the bottom quartile of performance. Of note, the measures used for the HACRP program are the same measures under the CMS Value Based Purchasing (VBP) and the Maryland Quality Based Reimbursement (QBR) Programs with the exception of PSI 90, as detailed in Figure 1 below.

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<sup>2</sup> Ibid.

**Figure 1. CMS HACRP FFY 2018 Measures**

<b>HACRP Domain 1 – Recalibrated Patient Safety Indicator (PSI) measure:</b>
Recalibrated PSI 90 Composite
<b>HACRP Domain 2 – National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures:*</b>
Central Line-Associated Bloodstream Infection (CLABSI)
Catheter-Associated Urinary Tract Infection (CAUTI)
Surgical Site Infection (SSI) – colon and hysterectomy
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia
Clostridium Difficile Infection (CDI)

\* All Measures included in the Maryland QBR Program

While there is overlap between Maryland’s complications programs and the Federal programs, most notably the HACRP, Maryland has its own complications programs and does not directly participate in these federal programs because of the State’s unique all-payer hospital model and its global budget system. The Maryland Hospital Acquired Conditions program (MHAC) is the State’s quality program solely dedicated to evaluating hospital complications that allows Maryland to be exempt from the national HACRP, and the State’s entire capitated hospital system makes it incompatible with the national DRA HAC program, which reduces payments in a fee-for-service model. Nevertheless, in Maryland’s efforts to further improve its performance relative to the nation, per industry recommendations and Commissioners’ directives, staff will work with stakeholders to further evaluate various aspects of the existing federal complications programs when redesigning complications measures for RY 2021 and beyond.<sup>3</sup>

### Maryland Hospital Acquired Condition Program (MHAC) Overview

The MHAC program, which was first implemented for RY 2011, is based on a classification system developed by 3M Health Information Systems (3M), using what are called potentially preventable complications (PPCs). 3M originally developed 65 PPC measures, which are defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness. For example, an adverse drug reaction or an infection at the site of a surgery are referred to as hospital-acquired complications that are counted as PPCs and included in the MHAC program.<sup>4</sup> These complications can lead to 1) poor patient outcomes, including longer hospital stays, permanent harm, and death, and 2) increased costs.<sup>5</sup>

PPCs or MHACs, like national HAC measures, rely on present-on-admission (POA) codes to identify these post-admission complications. Reliance on POA codes has made all hospital-acquired complications programs susceptible to criticism, because improvement can be achieved

<sup>3</sup> For more information on the Federal HAC Programs and Measures, please see Appendix II.

<sup>4</sup> Cassidy, A. (2015, August 6). Health Policy Brief: Medicare’s Hospital-Acquired Condition Reduction Program. *Health Affairs*. Retrieved from [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=142](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=142).

<sup>5</sup> Ibid.

through better documentation and coding as opposed to real clinical improvement. However, it should be noted that the HSCRC has employed targeted and randomized audits to ensure the integrity of the data in each year of the program.

#### MHAC Methodology

The initial methodology for the MHAC program estimated the percentage of inpatient revenue associated with excess numbers of PPCs, and penalized hospitals that had higher estimated PPC costs than the statewide average and provided revenue neutral rewards to hospitals with lower PPC costs than the statewide average.

Beginning in RY 2016, the MHAC methodology was fundamentally changed to evaluate hospital performance based on case-mix-adjusted PPC rates rather than excess PPC costs. These case-mix adjusted rates are calculated by estimating the expected number of PPCs at each hospital. The expected number of PPCs at a hospital is calculated through indirect standardization, in which a statewide rate for each PPC (i.e., normative value or “norm”) is calculated for each diagnosis and severity level. The diagnosis and severity levels are determined by 3M software that groups all diagnosis and procedure codes into one of 328 All-Patient Refined-Diagnosis Related Groups (APR-DRG) and one of four Severity of Illness (SOI) levels for each discharge.<sup>6</sup> Because there are 45 PPC/PPC combinations proposed for RY2020, this means there are over 56,000 cells to be assessed. As discussed in more detail in the next section, the number of APR-DRG and SOI categories used for the indirect standardization is quite granular and thus the majority of the cells have a normative value of zero.

Figure 2 provides an overview of how PPC rates are measured on a calendar year basis, converted to scores, and then these scores are used in the hospitals’ rate calculations (i.e., revenue adjustments). First, PPCs are grouped and weighted into tiers according to their level of priority and then scored (0-10 points) based on the better of improvement or attainment using the same scoring methodology that is used for CMS VBP and QBR. To determine payment rewards and penalties, the revised methodology uses a preset linear point scale that is set prospectively rather than relatively ranking of hospitals after the performance period.

Since RY 2016, the MHAC program has been updated annually to adjust which PPCs are included in the payment program, and to what extent, and to modify revenue adjustment scales, but the fundamental scoring methodology has generally remained the same. That is, performance (attainment and improvement) is assessed using observed to expected ratios, and these ratios are then converted into points (0-10 per PPC) by comparing hospital ratios relative to historical and statewide performance standards.<sup>7</sup>

Examples of changes to PPC measurement over time include reducing the number of PPC tiers (from 3 to 2), creating some combination PPCs for low volume PPCs that are clinically

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<sup>6</sup> 328 is the number of APR-DRGs under version 35. This number is prone to change slightly each year. Version 35 was implemented in October 2017

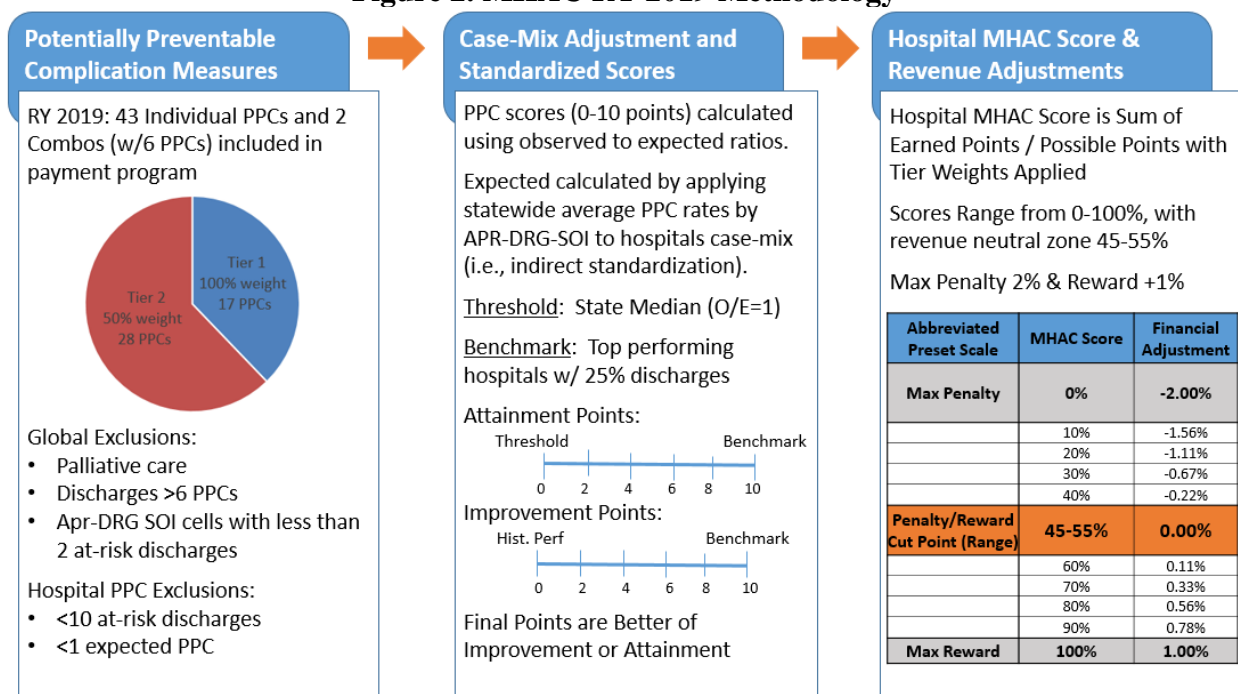
<sup>7</sup> Beginning in RY 2018, the benchmark was shifted from the weighted mean of the O/E ratios for the top quartile to the weighted mean for top performing hospitals that account for a minimum 25% of statewide discharges. This change was done to ensure that small hospitals were not defining the benchmark. Otherwise, the methodology has remained relatively unchanged since the advent of the All-Payer Model.



important, moving some PPCs with low volume or validity/reliability concerns to monitoring-only status, and changing which PPCs are included in Tier 1 (high-priority PPCs).

In terms of the revenue adjustment scale, there have been two major changes, both of which were approved by the commission for RY 2019. The first change removed the two-scale approach, whereby achievement of a minimum statewide reduction goal determined the scale (i.e., hospitals could not receive a reward unless the State overall achieved a prescribed annual reduction in PPC rates, known as contingent scaling). Removing the contingent scale is consistent with recent Commissioner recommendations to not base a hospital’s pay-for-performance incentive on how other hospitals or the State performs. The second change involved how the preset scale was determined. Originally the preset scale was determined by calculating attainment only scores for Maryland hospitals—with the lowest and highest score being where the maximum penalty and reward were set and the statewide average being the penalty/reward cut point. Use of the statewide scores to set the scale provided hospital with significant rewards and thus as with QBR the staff recommended moving towards the use of a full mathematical scale. Thus starting in RY 2019 the commission approved using the full range of scores (0% to 100%) with a revenue neutral zone between 45% and 55%. Under this scenario Figure 2 below demonstrates the current scoring and scaling methodologies, reflective of all changes made through RY 2019.

**Figure 2. MHAC RY 2019 Methodology**



## RY 2020 Measurement Concerns

In vetting options with stakeholders for the RY 2020 updates, staff has heard concerns from members of the PMWG suggesting that the MHAC program methodology is penalizing random variation in PPC occurrence, as opposed to poor performance. Specifically, there is an ever-increasing number of cells with low or zero expected PPCs, which means there are infrequent and potentially random PPCs that determine a hospital's expected level of complications. This is problematic because the expected PPCs are the standards by which hospital performance is measured under the MHAC program.

There are two principal reasons cited for the ever increasing number of cells with low or zero expected PPCs. First, the program rebases every year, i.e. assesses observed complications using a more recent baseline, which is only one year of evaluation that has multiple years of improvement built into it, in order to estimate expected complications in the upcoming performance year. Second, the program has a very granular indirect standardization, i.e. complications are measured at the diagnosis and severity of illness level (APR-DRG SOI), of which there are approximately 1,200 combinations before one accounts for clinical logic and PPC variation. With so many different groupings, if a PPC occurs in one APR-DRG SOI, for instance SOI 1, and then occurs the following year in SOI 2, which had no expected PPCs, the hospital may be penalized despite the fact that there was not necessarily an increase in its overall complication rate.

Some members of the PMWG have suggested that the processes by which the Commission estimates complications will result in the MHAC program penalizing in its seventh year very low frequency events that clinical interventions could not prevent. Moreover, it has been suggested that these penalties would behave mathematically like "never events" due to their expected value of zero. This means that these events would garner large penalties for the occurrence of just one PPC similar to true "never events" that the methodology has always severely penalized because of their gravity. The concern is that, as a result, clinical attention may be diverted from clinical subgroups with higher frequency complications that could be prevented.

Given these concerns and given that Commissioners have communicated that the State should move away from the MHAC program in the TCOC Model, staff must balance the level of effort required to update the MHAC Program for the last performance year (CY 2018) with the imperative to overhaul the MHAC Program to increase its national focus, as well as its simplicity, fairness, and transparency for RY 2021 and beyond. In the Assessment section below, staff presents the immediate issues of concern more fully, along with analyses and options to address the cells with a norm of zero issue.

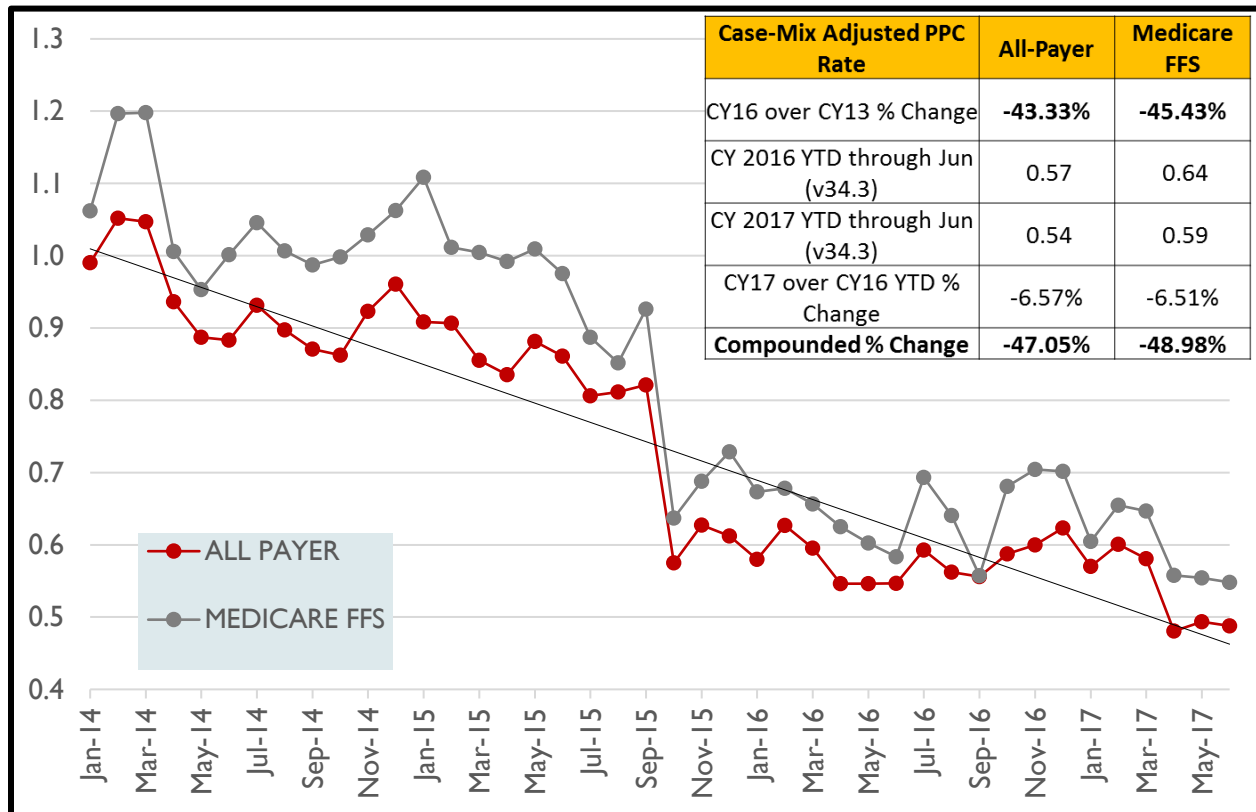
## Assessment

In this section, staff analyzes statewide PPC trends, RY 2020 PPC measurement and methodology considerations given the reliability of expected PPC rates due to cells with a norm of zero, and modelling on proposed measurement and methodology changes.

### Statewide PPC performance trends

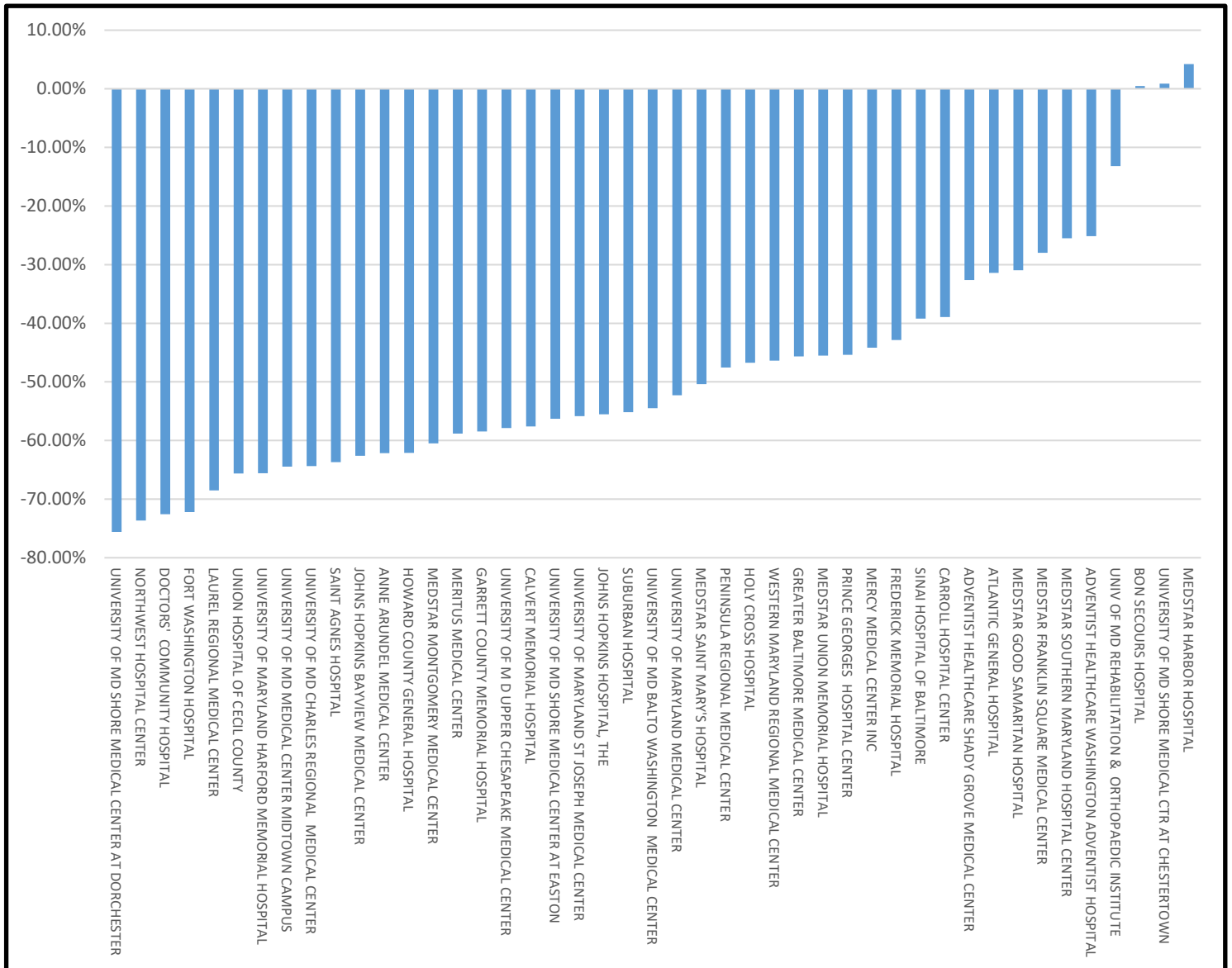
As noted previously, the State has made dramatic progress in reducing PPCs under the MHAC Program and has continued this improvement under the All-Payer Model, reaching its 30% reduction target under the Agreement in the second year. Most recently, available performance trends reveal a cumulative All-Payer case-mix adjusted PPC rate reduction of 47% (compared to the base period of CY 2013) as illustrated in Figure 3 below.

**Figure 3. Case Mix Adjusted Cumulative PPC Rates as of June 2017**



Staff has also analyzed the individual performance of the 48 hospitals in the MHAC program and found that the cumulative PPC reduction through June 2017 was on average -51.88% when you exclude hospitals with unavailable data (e.g., Holy Cross Germantown, which was not operational in CY 2013) and when you exclude the three hospitals that actually saw cumulative growth in their PPC rates. Figure 4 shows a breakdown of individual hospitals' cumulative PPC performance.

**Figure 4. Case Mix Adjusted Cumulative PPC Rate as of June 2017 by Hospital\***



\*Excludes McCready, Levindale, and Holy Cross Germantown hospitals because all three either had omitted data from CY13 to CY16 or CY16 to June of CY17.

#### Hospital Coding Audits

Because the HSCRC is concerned that improvements in the rates of PPCs may be linked to coding practices, the Commission has conducted targeted and randomized audits of hospital coding practices, including POA coding, that are among the key data elements to assign PPCs under the MHAC Program.

For the audit conducted during RY 2017 (for discharges in RY 2016), HSCRC's independent contractor selected and reviewed 230 inpatient cases per hospital, targeting cases that may have

been prone to coding irregularities.<sup>8</sup> For the auditing work conducted through FY 2017, as illustrated in Figure 5, the average overall POA accuracy rate was 97.4%, which is above the 95% threshold established by HSCRC and well above the industry standard as recommended by the American Health Information Management Association (AHIMA) (the AHIMA 95% threshold is recommended as a measure of individual codes and not cases).<sup>9</sup> All hospitals audited during this timeframe were better than the threshold. In addition, the accuracy rate has improved steadily since FY 2014. Diagnosis and procedure coding accuracy is also evaluated, with results also above the 95% threshold on average, as well as for each hospital audited.

**Figure 5. Maryland Hospital Coding Audit Results as of FY 2017 (% of Cases)**

<b>RY Audited</b>	<b>Diagnoses Accuracy</b>	<b>Procedures Accuracy</b>	<b>Total Accuracy Rate</b>	<b>POA Accuracy</b>
<b>2013</b>	93.9%	97.3%	94.4%	91.0%
<b>2014</b>	95.9%	98.5%	96.4%	90.2%
<b>2015</b>	96.6%	99.5%	97.1%	96.3%
<b>2016</b>	98.0%	99.5%	98.2%	97.4%

While improved documentation and coding may be contributing to improvements in PPC rates, given the audit results staff believes that the improvements in PPC rates are not being driven primarily by inappropriate coding. Furthermore, while hospitals acknowledge valid improvements in documentation and coding, they also point to specific care improvements as the cause of PPC rate reductions. Appendix III provides a list of system-based care improvement activities that have been implemented by hospitals in concert with providers to prevent events through learning and process improvement. HSCRC will continue to monitor coding and billing practices to ensure that Maryland hospitals are compliant with national standards.

### RY 2020 PPC Measurement and Methodology Considerations

This section discusses proposed changes to RY 2020 measurement and methodology, both of which will aim to address the issue of cells with a norm of zero that is thought to subject hospitals to penalties for random variation as opposed to poor performance.

#### PPC Measure Modifications

For RY 2020, staff is recommending minimal changes to the current methodology. Staff proposes to continue use of the PPCs for measuring complications in order to ensure the State meets the requirement under the Agreement to reduce PPC incidence by 30% by the end of CY 2018. Based on clinical review and modeling, staff supports making some minor changes to the

<sup>8</sup> In general, ten hospitals per year are audited, resulting in each hospital in Maryland undergoing an audit about every four years.

<sup>9</sup> <http://campus.ahima.org/audio/2008/RB072408.pdf>, 13-15, 33

PPC measures under the program by combining a few of the PPCs for payment program measurement, detailed in Figure 6.

**Figure 6. PPC Combos in MHAC Program**

Combination	PPC Number	PPC Name
<b>Combo 1</b>	25	Renal Failure with Dialysis
<b>Combo 1</b>	26	Diabetic Ketoacidosis & Coma
<b>Combo 1</b>	63	Post-Operative Respiratory Failure with Tracheostomy
<b>Combo 1</b>	64	Other In-Hospital Adverse Events
<b>Combo 2</b>	17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding
<b>Combo 2</b>	18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding
<b>NEW Combo 3</b>	34	Moderate Infectious
<b>NEW Combo 3</b>	54	Infections due to Central Venous Catheters
<b>NEW Combo 3</b>	66	Catheter Associated Urinary Tract Infection

#### Cells with a Norm of Zero Issue and Clinical Quality Improvement

Staff has also considered PMWG concerns brought forth by University of Maryland Medical System and Johns Hopkins Health System (UMMS/JHHS) regarding the high percentage of APR DRG SOI cells in the FY 2017 base period with a normative value of zero. Because expected levels of PPCs are determined by statewide levels of observed PPCs, a large volume of cells with a value of zero means that many more PPCs behave mathematically like “never events” - events where the occurrence of just one PPC are penalized severely because they are typically reserved for grave and highly irregular complications, such as post-operative foreign bodies. This “cells with a norm of zero” issue has become a greater concern as PPC rates have decreased over time; in RY 2015 the percentage of cells with a zero norm was 79.84% and in RY 2020 the percentage is 88.24%.

#### Proposed Modifications to MHAC Methodology

There are several ways that the MHAC program could be modified to address cells with a norm of zero. The main entities that proposed modifications were 3M, the PMWG, and staff. All are examined in some detail below.

To address the cells with a norm of zero issue, 3M proposed extending the base period over which PPCs are observed and raising the minimum number of discharges at-risk from 2 to 30

discharges per APR-DRG SOI cell. While staff believes that extending the minimum number of discharges at-risk from 2 to 30 discharges has merit and should be incorporated into the RY 2020 policy, initial analysis indicated that these two modifications together only reduced the number of cells with a norm of zero from 88% to 82%. Therefore, staff believes that these proposed modifications will not sufficiently address the issue that the MHAC program is spreading clinical focus too dispersedly and thus targeted clinical improvement is lost. Furthermore, extending the base period may artificially benefit hospitals, because an expected rate based on the latest 12 months of data would be lower compared to an expected rate based on 21 months of data, given the significant improvement that has occurred over time.

The PMWG, more specifically the members of the workgroup from UMMS/JHHS, proposed focusing the payment program on the APR-DRG and PPC combinations (heretofore known as the APR-DRG-PPC groupings) in which the majority (at least 80%) of the complications occur, to address the issue of cells with a norm of zero. This approach is similar to the approach used by the Commission to measure mortality, which focuses on the APR-DRGs in which 80 percent of mortalities occur during the base period. This approach does not remove all cells with a norm of zero, but in combination with raising at-risk discharges from 2 to 30 it does result in a reduction in the number of APR-DRG SOI cells having a norm of zero to 70%, which is a 21% reduction from the current methodology. It should also be noted that this approach would not alter the normative value of zero for the five serious reportable events (“never events”), which would still be applicable to all clinically relevant APR-DRGs.

Focusing on the subset of patients by assessing the APR-DRG-PPC groupings in which the majority of PPCs occur has the advantage of aligning the payment program with one of the key guiding principles of the MHAC program that was established in RY 2016:

- The MHAC program should prioritize PPCs that have high volume, high cost, opportunity for improvement, and are areas of national focus.

This principle is achieved by aligning the program with clinical quality improvement interventions that target patients where the vast majority of complications occur, as this represents the greatest opportunity for improvement. Under the current program, hospitals ostensibly already would be expected to focus on the types of patients where majority of complications occur, but their MHAC scores can be significantly impacted by single events that occur in other types of patients. Stakeholders have stated that this is frustrating to hospitals and their providers because they believe these to be random events that are difficult to prevent with system-based learning. The focus of the payment program incentives on patients most at-risk is important for engaging providers and staff in the clinical interventions that can have the most benefits to patients.

Based on staff assessment, the UMMS/JHHS proposal may be a reasonable solution for addressing the issue of cells with a norm of zero without fundamentally changing the methodology for the final year of the current MHAC program. However, there are several concerns with this proposal, most notably the removal of some potentially important APR-DRGs from consideration in the MHAC program. For example, under the existing methodology, Spinal Disorders and Injuries (APR-DRG 40) and Abdominal Pain (APR-DRG 251) both have 3

observed PPCs and 5,675 and 40,770 at risk discharges, respectively, but will not be evaluated under the proposed methodology, as they do not make the 80% cutoff.<sup>10</sup>

Limiting the number of APR-DRGs to be evaluated is a serious concern. Staff analysis indicates that in the RY 2020 base period (FY 2017) there are 271 APR-DRGs with 8,688 PPCs eligible for evaluation statewide under the current methodology, i.e. no changes plus the minor modification of increasing the at risk discharges minimum from 2 to 30. Under the proposed methodology there are only 178 APR-DRGs with 7,429 PPCs, a 34% reduction in DRGs and 15% reduction in PPCs. However, while a 34% reduction in APR-DRGs is significant, it should be noted that these APR-DRGs only constituted 6.2% of at-risk discharges and 1.6% of all PPCs in the current methodology. In effect, the 80% cutoff is not eliminating APR-DRGs where a material number of PPCs occurred.

Another concern with the methodology proposed by UMMS/JHHS is the effect it has on the absolute number and the number of types of PPCs to be evaluated. However, as noted earlier, the reduction in PPCs in total is 14.5% and no PPCs are wholly eliminated, suggesting that the extensive complication coverage offered by all-payer PPCs is not substantially affected by the UMMS/JHHS proposal.

Other proposals staff considered but are not recommending in this draft policy are to adjust the scale from a linear scale to a quadratic or exponential scale or to move away from indirect standardization for case-mix adjustment and employ statistical techniques, such as Bayesian smoothing to address low occurrence events that are more heavily influenced by measurement error than data sets with large cell sizes. While both are worthy of consideration in RY 2021 they either did not address the core methodological concerns raised by staff and the PMWG or they were too significant a methodological change for RY 2020 at this juncture.

Non-linear scaling would reduce the revenue adjustments near the middle of the scale and increase the adjustments for hospitals performing at the high or low ends of the scale. The staff could consider this approach for the final MHAC policy based on Commissioner input; however, at present staff is advocating to maintain the linear scale, and to modify the payment program to concentrate only on the APR-DRG-PPC groupings where the majority of PPCs occur. The staff recommends to maintain the linear scale and adjust what the methodology measures, i.e. the APR-DRGs where 80% of PPCs occur, because this will address the methodological concerns. Moving to non-linear scaling would merely mitigate the revenue impact of the policy, while not addressing the core methodological concerns.

The other proposal from the PMWG is to move away from indirect standardization for case-mix adjustment and employ statistical techniques to calculate expected or predicted PPC rates, such as Bayesian smoothing, which better addresses low occurrence events by incorporating the results of prior probability tests, i.e. the accuracy of prior expected PPC rates, to better predict future expected PPC rates. This type of statistical technique is similar to AHRQ PSI risk-adjustment and would better ensure that small time period windows, such as one year of observation, with very granular approaches to identifying and projecting PPC occurrence are less

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<sup>10</sup> For a complete list of APR-DRGs and associated PPCs that will be included in the existing methodology and under the proposed Performance Measurement Workgroup methodology, see Appendix IV.



susceptible to penalizing or rewarding random variation, as opposed to poor clinical performance. Staff did not move forward with this recommendation because while these types of complex statistical techniques may be warranted, they do pose additional considerations for small hospitals where Bayesian smoothing may estimate observed events where none actually occur (this has and continues to be a concern with the AHRQ PSI risk-adjustment methodology). More importantly though, staff believes that this approach would be too significant a methodological change for RY 2020 at this juncture. Staff, however, will certainly consider Bayesian modelling for RY 2021 and beyond if PPCs are still used in some fashion.

The next section presents modeling to assess the impact of focusing the payment program on the APR-DRG-PPC groupings where the majority (at least 80%) of the complications occur.

### RY 2020 MHAC Preliminary Modeling

To address concerns raised, staff has developed two models that are listed below.<sup>11</sup>

- **Model 1:** Raise minimum number of at-risk discharges per APR-DRG SOI from 2 to 30.
- **Model 2:** Raise minimum number of at-risk discharges per APR-DRG SOI cell from 2 to 30 **and** restrict to the APR-DRG-PPC groupings to those in which at least 80% of PPCs occurred in the base year, to reduce number of cells with a norm of zero.

In evaluating the UMMS/JHHS proposal (Model 2) versus the existing methodology (Model 1), staff and PMWG stakeholders brought up several questions that staff has been working to address. The first question was regarding consistency over time (i.e. do the PPCs occur in the performance period in the same APR-DRG-SOI cells as they did in prior years). This is important because staff wants to avoid a cut point that produces a random representation of the most prolific APR-DRG-PPC groupings. Using the RY 2019 base period (October 2015 to September 2016), modeling from UMMS/JHHS indicates that 87% of the observed PPCs occur among the APR-DRG-PPC groupings that would be selected for the RY 2020 base (July 2016 to June 2017) using UMMS/JHHS proposed methodology, suggesting that PPC occurrence is concentrated and consistent.

Another question raised was regarding the number of hospitals that had each PPC included in the payment program under the different methodologies. As a reminder, the number of PPCs included for each hospital has always varied because of the hospital exclusion logic, i.e. each hospital must have at least 10 at-risk cases and 1 expected PPC for all non-serious reportable event PPCs. Comparing Model 1 and Model 2 using the RY 2020 base period, there were 36 hospitals on average with each PPC in the payment program in Model 1, and 33 hospitals on

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<sup>11</sup> These models use the RY 2020 base period (FY 2017) grouped under an early release of Version 35 (this will be updated in final policy with the latest release of v35) for evaluating the impact of the Model 2 proposed change on the PPCs that would be included in the RY 2020 program. For examining impacts of Model 2 on **hospitals scores and revenue adjustments**, staff used the RY 2019 base period (October 2015 – September 2016) and the YTD performance period (January 2017 – September 2017), grouped under Version 34. Hospital scores and revenue adjustments are modeled under the older version of the rate year logic and with more complete data so that both attainment and improvement are assessed in determining a hospital's modeled scores and revenue adjustment.

average with each PPC in Model 2.<sup>12</sup> The consistent number of hospitals graded on each PPC in both models suggests that Model 2 limits the issues with cells with zero norms without significantly reducing the broad array of complication types covered in the MHAC program.<sup>13</sup> Overall, Model 2 retains 85.5% of the observed PPCs from Model 1, including 90% of tier 1 PPCs<sup>14</sup>, which are weighted more heavily in the MHAC program because they pose a greater danger to patients, and 100% of serious reportable events (“never events”), which are omitted from the cutoff methodology entirely because of their expected infrequency and gravity.

Other factors that staff has evaluated for Model 1 and Model 2 include:

- The impact on benchmarks
- PPC counts by hospital
- Hospital Scores, and
- Associated revenue adjustments.

In terms of impacts on the benchmarks for the RY 2020 base period, two thirds of the Observed/Expected ratio benchmarks are lower under Model 2 and thus hospital performance must be better in order to receive full attainment points. See Appendix VI for the benchmarks under each model.

Appendix VII contains the number of PPCs included in payment program for each hospital, as well as the at-risk, observed, and expected PPC counts in the RY 2020 base period. In total there is a maximum of 45 PPCs and PPC combinations included in the payment program (42 individual PPCs and 3 combination PPCs), with the median number of PPCs included in the payment program for all hospitals being 41 PPCs (91% of PPCs) under Model 1 and 34 (76%) under Model 2. Despite this reduction in number of PPCs, 85.5% of PPCs observed in Model 1 are still included under Model 2.

Appendix VIII shows the hospital scores and revenue adjustments by-hospital under each model using RY 2019 base and year-to-date (September) performance periods. Staff modeled the scores and revenue adjustments using the RY 2019 base and YTD performance periods so that both attainment and improvement could be evaluated. For Model 1 and Model 2, the median scores across all hospitals were 58% and 63% respectively. The higher scores under Model 2 would be expected since the expected PPC rates would generally be higher when you focus on the patients where majority of complications occur. Specifically, under Model 2 there were 40 hospitals that had a score increase when compared with their score in Model 1. Figure 7 shows the score change by hospital with the maximum increase in terms of simple difference being 20% and the maximum decrease being 3%.

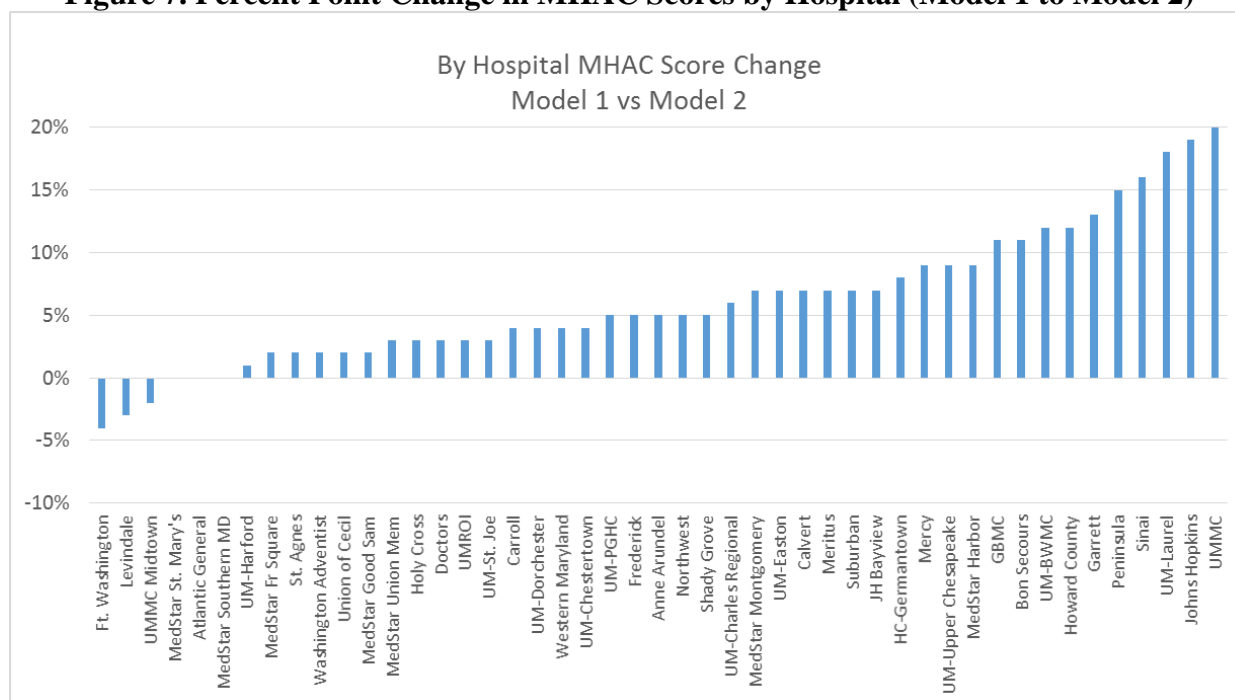
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<sup>12</sup> Appendix V contains analysis by PPC of: A) the number of hospitals with each PPC in payment program; B) the number of at-risk discharges; and C) the number of observed PPCs under each Model. Appendix V also includes the Tier for each PPC.

<sup>13</sup> Of note, three infection-related PPCs (PPC 34 - Moderate Infectious, PPC 54 - Infections due to Central Venous Catheters, and PPC 66 - Catheter-related Urinary Tract Infection) were initially dropped from all hospitals under Model 2. To prevent these important PPCs from being dropped completely, staff created an infection-related combination PPC that included these three PPCs.

<sup>14</sup> There are no proposed changes to the tiered PPCs from RY 2019 except that the infection PPC combination is in Tier 2

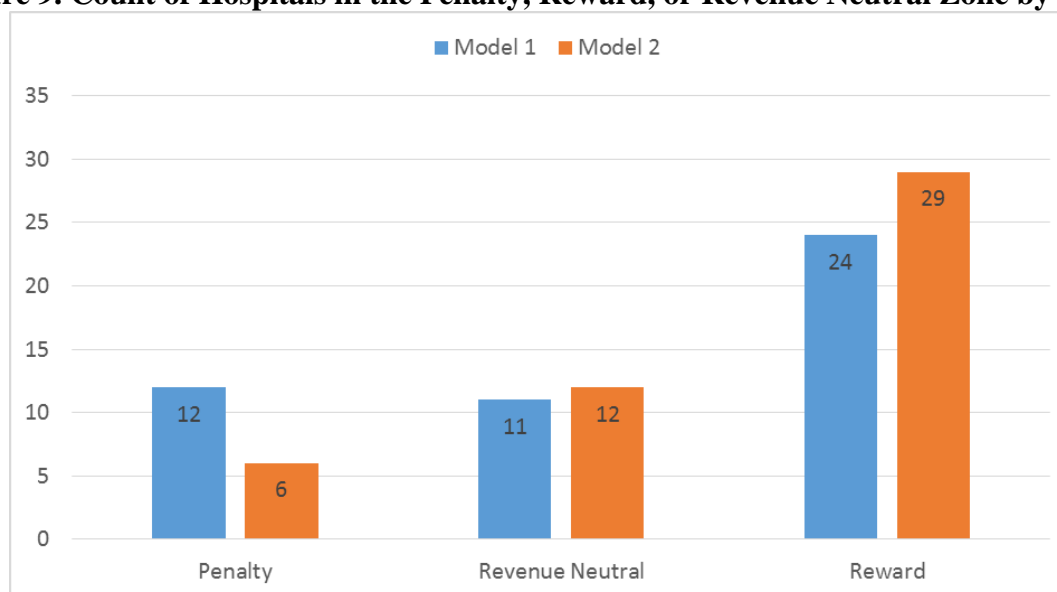
**Figure 7. Percent Point Change in MHAC Scores by Hospital (Model 1 to Model 2)**



In terms of revenue adjustments, Figure 8 contains the statewide rewards and penalties using the better of attainment and improvement scores (i.e., using RY 2019 base and YTD performance periods). These revenue adjustments are using the RY 2019 approved scale from 0-100% with a revenue neutral zone between 45% and 55%. Figure 9 shows the number of hospitals in the penalty, reward, or revenue neutral zone for each Model. This shows that while the dollar value of the revenue adjustment change is large (delta of \$17.8 million), under Model 2 there is only a shift of 6 hospitals moving from a penalty to the revenue neutral zone and 5 hospitals moving from the revenue neutral zone to a reward. The large difference in revenue adjustments is due to both Johns Hopkins and University of Maryland, which combined make up 46% of the \$17.8 million dollar difference. Finally, staff notes that the Model 2 distribution yields 38% of hospitals receiving a penalty or no reward and 62% of hospitals receiving a reward.

**Figure 8. Statewide Revenue Adjustments by Model**

Model Number	Model Description	Statewide Penalties	Statewide Rewards	Net Revenue Adjustments
1	>30 At-Risk Discharges	-13.5 M	6.1 M	-7.3 M
2	>30 + 80% APR-DRG-PPC Groupings	-3.7 M	14.1 M	+10.5 M

**Figure 9. Count of Hospitals in the Penalty, Reward, or Revenue Neutral Zone by Model**

Based on its assessment, staff concurs with the work group’s concern that over time there may be issues regarding the MHAC methodology penalizing hospitals for random variation as opposed to poor performance. Again, staff believes this is due to the granular indirect standardization in the methodology, and the annual rebasing, which builds new performance standards off of already achieved improvement. These issues relating to cells with zero norms should continue to be evaluated as part of the future model considerations (see below). In the meantime, staff also believes the proposed approach of targeting APR-DRG-PPC groupings in which at least 80% of PPCs occur does not compromise the program’s integrity and will not risk achievement of the 30% PPC reduction requirement under the CMS agreement.<sup>15</sup> This is because the modeling shows that majority of complications are retained and it does not arbitrarily limit APR-DRG-PPC Groupings because PPCs occur consistently in these cells. Moreover, the observed to expected ratios are lower under Model 2, thereby requiring greater hospital performance, and more severe PPCs (tier 1 and never events) are not meaningfully diminished. Furthermore, the idea of aligning the payment programs focus with the targets of clinical quality improvement initiatives is compelling and may serve to better engage providers in quality improvement. As such, staff will recommend to adopt the proposed cutoff methodology outlined under Model 2.

## Future Model Considerations

For the Total Cost of Care (TCOC) Model, which will begin in January 2019, proposed contract terms do not define specific quality performance targets. The HSCRC, in consultation with staff and industry, has begun laying the framework for establishing specific quality performance targets under the TCOC Model. Specifically, performance targets must be aggressive and progressive, must align with other HSCRC programs, must be comparable to federal programs,

<sup>15</sup> For purposes of the Waiver Test, Maryland will continue to be assessed based on the Specifications outlined in Appendix 6 of the All-Payer Model Agreement – that is to say, irrespective of any changes made to the MHAC pay-for performance program, the complication rate that Maryland reports to CMS will remain unchanged.

and must consider rankings relative to the nation. Beyond guiding principles, nothing definitive has yet been established.

For the RY 2020 quality recommendations, staff considered recent Commission discussions regarding the overall strategy for the quality programs under the new TCOC Model – most notably, meeting contractually obligated quality goals while making as few changes as possible to the final year of the current model in light of the additional work required to develop new targets and to better align measures with total cost of care.

Specific to the MHAC program for RY 2021 and beyond, the HSCRC has procured a contractor to support and convene a complications subgroup to the PMWG. The contractor will first assist staff with identifying available complications measures that should be considered (e.g., PPC measures; NHSN measures; other AHRQ or NQF approved hospital-acquired complications measures). The contractor, alongside the HSCRC, will particularly focus on measures that are of national import and that could be barometers for Maryland’s performance relative to the nation.

With this list of potential measures, the subgroup will then need to consider measure validity, as well as relevant risk adjustment, and any out-standing clinical concerns. The subgroup will make recommendations regarding the option to move to the federal HAC measures, as suggested by some stakeholders, and will consider retaining various PPC measures or other measures that are not addressed by the HAC program but could be important for a comprehensive program. The revised approach will also need to address methodological concerns, such as those related to cells with a norm of zero, as well as various Commissioners’ recommendations to increase simplicity, fairness, and transparency.

Figure 10 below outlines a tentative work plan for the subgroup (subject to revision, pending review from Contractor):

**Figure 10. Tentative Work Plan for Complications Sub-group**

Timeline and Work Plan	Purpose of Meetings
January 2018	<ul style="list-style-type: none"> <li>• Call for nominations for membership</li> <li>• Selection of sub-group members</li> <li>• Finalize and distribute meeting schedule</li> <li>• Finalize work plan</li> </ul>
Sub-group - 1st Meeting February 2018	<ul style="list-style-type: none"> <li>• Discuss scope of subgroup</li> <li>• Review of deliverables and timeline</li> <li>• Identification of priorities and principles</li> </ul>
Sub-group – 2nd Meeting March 2018	<ul style="list-style-type: none"> <li>• Review draft measures inventory, existing state and national measures (including risk adjustment methodologies)</li> <li>• Review data sources</li> </ul>
Sub-group – 3 <sup>rd</sup> Meeting April 2018	<ul style="list-style-type: none"> <li>• Review updated draft measures inventory</li> <li>• Begin review of analysis of existing measures and associated risk adjustment</li> </ul>

Sub-group meetings continue monthly through September 2018 and may include additional input from non-member stakeholders, at which point, the sub-group will present its findings and recommendations to the broader Performance Measurement Work Group.

The Performance Measurement Work Group will consider the recommendations of the sub-group as it assists the HSCRC staff to build the Draft and Final Hospital-Acquired Complications Program for RY 2021 in late fall 2018.

## Draft Recommendations

Based on the issues outlined and the results from its assessment, staff makes the following recommendations:

1. Continue to use established features of the MHAC program in its final year of operation:
  - a. 3M PPCs to measure complications;
  - b. Observed/Expected ratios to calculate hospital performance scores, assigning 0-10 points based on statewide threshold and benchmark standards;
  - c. Better of improvement and attainment total scores for assessing hospital performance under the program;
  - d. A linear preset scale based on the full mathematical score distribution (0-100%) with a revenue neutral zone (45-55%);
  - e. Combine PPCs that experience a small number of observed cases into an aggregated complication measure (i.e., a combination PPC);
2. Set the maximum penalty at 2% and the maximum reward at 1% of hospital inpatient revenue;
3. Raise the minimum number of discharges required for pay-for-performance evaluation in each APR-DRG SOI category from 2 discharges to 30 discharges (NEW!); and
4. Exclude low frequency APR-DRG-PPC groupings from pay-for-performance (NEW!).
5. Establish a complications subgroup to the Performance Measurement Workgroup that will consider measurement selection and methodological concerns, which will include appropriate risk adjustment, scoring, and scaling, and reasonable performance targets.

## Appendix I: MHAC Program Details: Base and Performance Periods, PPC Measurement Definition and Points Calculation

### Base and Performance Periods Timeline

Rate Year	FY16-Q3	FY16-Q4	FY17-Q1	FY17-Q2	FY17-Q3	FY17-Q4	FY18-Q1	FY18-Q2	FY18-Q3	FY18-Q4	FY19-Q1	FY19-Q2	FY19-Q3	FY19-Q4	FY20-Q1	FY20-Q2	FY20-Q3	FY20-Q4	
Calendar Year	CY16-Q1	CY16-Q2	CY16-Q3	CY16-Q4	CY17-Q1	CY17-Q2	CY17-Q3	CY17-Q4	CY18-Q1	CY18-Q2	CY18-Q3	CY18-Q4	CY19-Q1	CY19-Q2	CY19-Q3	CY19-Q4	CY20-Q1	CY20-Q2	
<b>Quality Programs that Impact Rate Year 2020</b>																			
<b>MHAC:</b>			<b>MHAC Base Period (Proposed)</b>															<b>Rate Year Impacted by MHAC Results</b>	
									<b>MHAC Performance Period: Better of Attainment or Improvement (Proposed)</b>										

### Performance Metric

The methodology for the MHAC program measures hospital performance using the Observed (O) /Expected (E) ratio for each PPC. Expected number of PPCs are calculated using the base year statewide PPC rates by APR-DRG SOI. (See below for calculation details).

### Observed and Expected PPC Values

The MHAC scores are calculated using the ratio of *Observed* : *Expected* PPC values.

Given a hospital’s unique mix of patients, as defined by APR-DRG category and severity of illness (SOI) level, the HSCRC calculates the hospital’s expected PPC value, which is the number of PPCs the hospital would have experienced if its PPC rate were identical to that experienced by a normative set of hospitals.

The expected number of PPCs is calculated using a technique called indirect standardization. For illustrative purposes, assume that every hospital discharge is considered “at-risk” for a PPC, meaning that all discharges would meet the criteria for inclusion in the MHAC program. All discharges will either have no PPCs, or will have one or more PPCs. In this example, each discharge either has at least one PPC, or does not have a PPC. The unadjusted PPC rate is the percent of discharges that have at least one PPC.

The rates of PPCs in the normative database are calculated for each APR-DRG category and SOI level by dividing the observed number of PPCs by the total number of admissions. The PPC norm for a single APR-DRG SOI level is calculated as follows:

Let:

N = norm

P = Number of discharges with one or more PPCs

D = Number of “at-risk” discharges

i = An APR-DRG category and SOI level

$$N_i = \frac{P_i}{D_i}$$

In the example, each normative value is presented as PPCs per discharge to facilitate the calculations in the example. Most reports will display this number as a rate per one thousand discharges.

Once the normative expected values have been calculated, they can be applied to each hospital. In this example, the normative expected values are computed for one APR-DRG category and its four SOI levels.

Consider the following example for an individual APR-DRG category.

**Table 1 Expected Value Computation Example for one APR-DRG**

<b>A</b> Severity of illness Level	<b>B</b> At-risk Discharges	<b>C</b> Observed Discharges with PPCs	<b>D</b> PPCs per discharge (unadjusted PPC Rate)  = (C / B)	<b>E</b> Normative PPCs per discharge  (Calculated from Normative Population)	<b>F</b> Expected # of PPCs  = (B x E)	<b>G</b> Observed: Expected Ratio  = (C / E) rounded to 4 decimal places
1	200	10	.05	.07	14.0	0.7143
2	150	15	.10	.10	15.0	1.0000
3	100	10	.10	.15	15.0	0.6667
4	50	10	.20	.25	12.5	0.8000
<b>Total</b>	500	45	.09		56.5	0.7965

For the APR-DRG category, the number of discharges with PPCs is 45, which is the sum of discharges with PPCs (column C). The overall rate of PPCs per discharge in column D, 0.09, is calculated by dividing the total number of discharges with PPCs (sum of column C) by the total number of discharges at risk for PPCs (sum of column B), i.e.,  $0.09 = 45/500$ . From the normative population, the proportion of discharges with PPCs for each SOI level for that APR-DRG category is displayed in column E. The expected number of PPCs for each SOI level shown in column F is calculated by multiplying the number of at-risk discharges (column B) by the normative PPCs per discharge rate (column E). The total number of PPCs expected for this APR DRG category is the expected number of PPCs for the SOI levels.



In this example, the expected number of PPCs for the APR DRG category is 56.5, which is then compared to the observed number of discharges with PPCs (45). Thus, the hospital had 11.5 fewer observed discharges with PPCs than were expected for 500 at-risk discharges in this APR DRG category. This difference can be expressed as a percentage difference as well.

All APR-DRG categories and their SOI levels are included in the computation of the observed and expected rates, except when the APR-DRG SOI level has one or fewer at-risk discharge statewide (see column G).

### PPC Exclusions

If all 65 PPCs for each APR-DRG SOI category were included, there would be more than 78,000 APR-DRG SOI PPC cells under which a statewide normative value would theoretically be calculated. There are four general criteria under which PPCs are excluded from consideration under the current MHAC program: Categorical Exclusions, Clinical Exclusions, Monitoring-Only PPCs, and (Proposed) PPCs not included in the APR-DRG-PPC Groupings where 80% of PPCs occur. These exclusions ensure that the PPCs in the MHAC program are clinically valid, statistically reliable, and that efforts to reduce complications in Maryland are focused to ensure success.

### Categorical Exclusions

Consistent with prior MHAC policies, the number of at-risk discharges is determined prior to the calculation of the normative values (hospitals with <10 at-risk discharges are excluded for a particular PPC) and the normative values are then re-calculated after removing PPCs with <1 complication expected. The following exclusions will also be applied:

For each hospital, discharges will be removed if:

- An APR-DRG SOI cell has less than 30 total cases (Proposed increase from 2 to 30 for RY 2020)
- Discharge has a diagnosis of palliative care (this exclusion will be removed in the future once POA status is available for palliative care in base period)
- Discharge has more than 6 PPCs (i.e., catastrophic cases that are probably not preventable)

For each hospital, PPCs will be removed if:

- The number of cases at-risk is less than 10
- The expected number of PPCs is less than 1.

PPC exclusion criteria is only applied to the base period and not the performance period. This is done so that scores can be reliably calculated during the performance period from a pre-determined set of PPCs.

### Clinical Exclusions

Throughout the life of the MHAC program, 3M has continued to evaluate the clinical validity of the Potentially Preventable Complications. As certain PPCs have been deemed clinically invalid, 3M has removed from the grouper or recommended we remove pending further development. To date, the removed PPCs are:

- 12 – Cardiac Arrhythmia
- 22 – Urinary Tract Infection
- 24 – Renal Failure without Dialysis
- 57 – OB Lacerations & Other Trauma Without Instrumentation
- 58 – OB Lacerations & Other Trauma With Instrumentation

### Monitoring-Only PPCs

PPCs with lower reliability are in monitoring-only status and will not be scored for payment program purposes. Monitoring-only status is determined through an extensive stakeholder process involving 3M, MHA, the HSCRC, and the Performance Measurement Work Group. Two PPCs (36 and 66) are in monitoring-only status under the RY 2019 methodology due to no hospital meeting the minimum threshold for their inclusion. At this time, the PPCs in monitoring-only status are:

- 2 – Extreme CNS Complications
- 15 – Peripheral Vascular Complications (except Venous Thrombosis)
- 20 – Other Gastrointestinal Complications without Transfusion or Significant Bleeding
- 29 – Poisonings except from Anesthesia
- 33 – Cellulitis
- \*36 – Acute Mental Health Changes
- \*\*39 – Reopening Surgical Site
- 55 – Obstetric Hemorrhage Without Transfusion
- 56 – Obstetric Hemorrhage With Transfusion
- 62 – Delivery with Complications
- \*\*\*66 – Catheter-related Urinary Tract Infection

\* PPC 36 is in monitoring-only status due to no hospital meeting the minimum threshold for its inclusion.

\*\* PPC 39 is suspended due to clinical concerns in RY 2019 policy. These clinical concerns have been addressed by 3M in version 35 of the PPC grouper, and it will be re-added to the RY 2020 policy.

\*\*\* PPC 66 is in monitoring-only status due to no hospital meeting the minimum threshold for its inclusion. In RY 2020, staff is proposing that it be included in a combination PPC with PPCs 34, 54, and 66.

## 80% APR-DRG PPC Inclusion (Proposed)

Under the Proposed Model 2 (outlined in further detail within the policy), APR-DRG-PPC groupings will be included in the MHAC payment policy if they are groupings under which 80% of the PPCs occur. As an abbreviated example, take the figure below:

	APR-DRG	PPC	Sorted by Observed Counts (highest to lowest)	% of Total Observed PPCs	Cumulative Percent
	A	B	D	E	F
1	720	14	45	23%	23%
2	181	39	36	18%	41%
3	540	59	25	13%	53%
4	194	14	22	11%	64%
5	720	21	21	11%	75%
6	230	42	11	6%	80%
7	230	9	11	6%	86%
8	540	60	9	5%	90%
9	560	59	9	5%	95%
10	166	8	6	3%	98%
11	190	52	3	2%	99%
12	201	6	2	1%	100%
		<b>ALL APR-DRG-PPC Groupings</b>	<b>200</b>		

This figure presents 12 rows of APR-DRG-PPC groupings. In reality, there are many more potential groupings, given the granularity of the MHAC program methodology, but for this example, assume there are just 12. To focus improvement upon APR-DRG-PPC groupings under which 80% of PPCs occur:

1. Calculate Observed PPC counts by APR-DRG-PPC Grouping in the Base Period (Presented in Column D).
2. Sort Observed PPC counts from highest to lowest, and sum the total Observed PPCs. (the sum of Observed PPCs in Column D in this example is 200).
3. For each APR-DRG-PPC Grouping, divide the Observed PPC count / the Total Observed PPCs to calculate a % of Total Observed PPCs (Column E).
  - a. As an example,  $45 \text{ Observed PPCs} / 200 \text{ Total Observed PPCs} = 23\%$ .
4. Sum the percentages in Column E to calculate a cumulative percent (Column F)
5. Using the cumulative percentages in Column F, locate the grouping where **at least** 80% of PPCs occur. In this example, this is row 6, APR-DRG-PPC Grouping 230-42.

However, in Row 6, 11 PPCs occurred. The methodology will include all APR-DRG-PPC groupings where 11 PPCs occurred, meaning that Row 7 (230-9) will **also** be included (even though that increases the 80% included PPCs to 86%). Effectively, this step further ensures that only APR-DRG-PPC groupings with very low occurrence are excluded from the MHAC program.

- a. Rows 1-7 are shaded to indicate that these PPCs will be included in the MHAC program.

### Combination PPCs

Some PPCs have low occurrence, and may be statistically unreliable. However, given their clinical importance, staff and stakeholders believe that they should remain in the policy. These PPCs are included (in Tier 2) as Combination PPCs. The RY 2020 (proposed) Combination PPCs are:

- PPC 67 (25, 26, 63, 64)
- PPC 68 (17, 18)
- PPC 71 – Proposed – (34, 54, 66)

Previous combination PPCs 69 (55, 56) and 70 (57, 58) are no longer included in the MHAC program, as PPCs 55-56 are in Monitoring Only, and PPCs 57-58 have been discontinued.

### Benchmarks and Thresholds

For each PPC, a threshold and benchmark value is calculated using the base period data. For each PPC, the threshold value is statewide average of 1. The benchmark is the weighted mean of the O:E ratio for top performing hospitals that account for at least 25% of all discharges. This benchmark calculation is done to avoid the phenomenon of small hospitals driving the benchmark calculation.

One category of PPCs is calculated differently from these benchmark and threshold calculations. There are five PPCs which are considered **serious reportable events**, a designation meaning that they should never occur. For these serious reportable events, the threshold and benchmark are both 0, meaning that hospitals will either receive 10 points per PPC if they do not occur, or 0 points per PPC if they do. The serious reportable event PPCs for the base and performance period are the following:

- PPC 30 – Poisonings due to Anesthesia
- PPC 31 – Decubitus Ulcer
- PPC 32 – Transfusion Incompatibility Reaction
- PPC 45 – Post-procedure Foreign Bodies
- PPC 46 – Post-Operative Substance Reaction and Non-OR Procedure for Foreign Body

### Attainment and Improvement Points

For each hospital, PPC performance is evaluated based on the higher of “Attainment Points” achieved in the performance period, or “Improvement Points” earned by comparing a hospital’s PPC performance period results to the base period.

#### Attainment Points (possible points 0-10)

If the PPC ratio for the performance period is greater than the threshold, the hospital scores zero points for that PPC for attainment.

If the PPC ratio for the performance period is less than or equal to the benchmark, the hospital scores a full 10 points for that PPC for attainment.

If the PPC ratio is between the threshold and benchmark, the hospital scores partial points for attainment. The formula to calculate the Attainment points is as follows:

- $\text{Attainment Points} = [9 * ((\text{Hospital's performance period score} - \text{Threshold}) / (\text{Benchmark} - \text{Threshold}))] + 0.5$

#### Improvement Points (possible points 0-9)

If the PPC ratio for the performance period is greater than the base period, the hospital scores zero points for that PPC for improvement.

If the PPC ratio for the performance period is less than or equal to the Benchmark, the hospital scores 9 points for that PPC for improvement. However, in this case an attainment score of 10 will be higher than the improvement score, and the attainment score will therefore be used to calculate the final score.

If the PPC ratio is between historical performance and Benchmark, the hospital scores partial points for improvement. The formula to calculate the Improvement points is as follows:

- $\text{Improvement Points} = [10 * ((\text{Hospital performance period score} - \text{Hospital baseline period score}) / (\text{Benchmark} - \text{Hospital baseline period score}))] - 0.5$

### Calculation of Hospital Overall MHAC Score

To calculate the final score for each hospital, the final points (better of attainment or improvement) for each PPC in tier 1 are added up and divided by the total possible tier 1 points to calculate a percent score tier 1. This calculation is repeated for tier 2. The PPCs are grouped in tiers so that PPCs that are high-cost and high-volume have opportunity to improve, and that national priority PPCs can be weighted more heavily. The total possible points for each PPC is 10, and hospitals may have different total possible points depending upon which PPCs, if any, are excluded for that hospital (see exclusion criteria in Section II above). A list of excluded PPCs by hospital will be provided with the monthly and quarterly PPC results.

The final score is then calculated using the following formula:

$\text{Final Score} = ((\text{Score Tier 1} * 1) / (\text{Denominator Tier 1} * 1)) +$

$((\text{Score Tier 2} * 0.5) / (\text{Denominator Tier 2} * 0.5))$

### Rounding

For the purposes of calculating scores, the benchmarks and O: E ratios are rounded to 4 decimal places. The attainment and improvement points are rounded to the nearest whole number. The tier percentages and final score for each hospital is rounded to 2 decimal places.

### Financial Impact of MHAC Performance (Scaling)

In RY 2019, the Commission moved to a single scale, setting the maximum penalty at 2%, and the maximum reward at 1% of hospital inpatient revenue.

The Commission also approved the staff recommendation to use the full range of scores to set the payment scale, rather than basing the scale on the statewide distribution of scores. Thus, the maximum penalty of 2% is for a score of 0%; and the max reward of 1% is for a score of 100%. A revenue neutral zone is maintained in RY 2019, between 45% and 55%.

The staff proposes that the Commission maintain the RY 2019 scale in RY 2020 with no changes.

## Appendix II. CMS HAC Programs

### Deficit Reduction Act Hospital-Acquired Conditions Program (DRA HAC)

The DRA HAC Program, which was established by the Deficit Reduction Act of 2005, requires the HHS Secretary to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines. CMS initially included 10 categories of conditions that were selected for the HAC payment provision (see current list of 14 HACs). Payment implications began in FFY 2009 for these Hospital Acquired Conditions. For discharges occurring on or after October 1, 2008 hospitals no longer receive additional Medicare payment for cases in which one of the selected conditions occurred but was not present on admission. That is, the case would be paid as though the condition were not present. .

#### CMS DRA HAC Measures

HAC 01: Foreign Object Retained After Surgery

HAC 02: Air Embolism

HAC 03: Blood Incompatibility

HAC 04: Stage III & Stage IV Pressure Ulcers

HAC 05: Falls and Trauma

HAC 06: Catheter-Associated Urinary Tract Infection

HAC 07: Vascular Catheter-Associated Infection

HAC 08: Surgical Site Infection - Mediastinitis After Coronary Artery Bypass Graft

HAC 09: Manifestations of Poor Glycemic Control

HAC 10: Deep Vein Thrombosis/Pulmonary Embolism with Total Knee Replacement or Hip Replacement

HAC 11: Surgical Site Infection – Bariatric Surgery

HAC 12: Surgical Site Infection – Certain Orthopedic Procedure of Spine, Shoulder, and Elbow

HAC 13: Surgical Site Infection Following Cardiac Device Procedures

HAC 14: Iatrogenic Pneumothorax w/Venous Catheterization

### Hospital-Acquired Reduction Program (HACRP)

The Hospital-Acquired Reduction Program (HACRP) initiated by the ACA was effective FFY 2015. The HACRP program requires the Secretary of the Department of Health and Human Services to adjust payments to applicable hospitals that rank in the worst-performing 25 percent of risk-adjusted HACRP quality measures, which have limited overlap with DRA HAC measures.

#### CMS HACRP Measures:

HAI 01: Central Line-Associated Bloodstream Infection (CLABSI)

HAI 02: Catheter-Associated Urinary Tract Infection (CAUTI)

HAI 03: Surgical Site Infection (SSI) – Hysterectomy

HAC 04: Surgical Site Infection (SSI) – Colon

HAI 05: Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteremia

HAC 06: Clostridium Difficile Infection (CDI)

Background information regarding the HACRP measures, scoring methodology, review and corrections process, and hospital specific reports can be found on the QualityNet webpage: <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166>.

### Performance on CDC NHSN Measures Used for Medicare HACRP

As illustrated in Figure 1, Domain 2 of the CMS HACRP Program includes measures that are also included in the **Safety** domain of the CMS VBP and Maryland QBR programs. In an effort to understand how Maryland compares to the nation given our current unique complication programs and given that Commissioners have instructed the HSCRC to modify its complication program(s) to focus on measures of national import, staff has reviewed Maryland’s statewide performance compared to both the national median established under the VBP program for FFY 2020, and compared to the Standardized Infection Ratio (SIR) of 1 in CY 2015, the latter of which is the national observed to expected ratio for various hospital acquired infections.

As illustrated in Figure 1 below, Maryland performs consistent with the national SIR on 4 of the 6 measures, and above the SIR on 2 of the measures - scores less than the SIR of 1 indicate lower rates of infection relative to the national baseline. Maryland performs worse, however, compared to the national VBP threshold (median) values for all 6 measures – scores higher than the National VBP threshold values indicate worse performance than the median.

**Figure 1. NHSN HAI Measures; Maryland Compared to VBP National Median and Baseline SIR Calendar 2016**

Measure	Maryland Performance Score CY 16	National SIR (Rebased CY 2015)	National VBP Threshold (Median) CY 16
SSI-Colon	1.032	1	0.781
SSI-Hysterectomy	1.02	1	0.722
MRSA	1.154	1	0.815
C.Diff.	0.998	1	0.852
CAUTI	1.034	1	0.828
CLABSI	1.125	1	0.784

It is apparent from this performance and from national rankings that utilize these measurements (CMS Stars) that Maryland still has a lot of room for improvement in hospital-acquired conditions despite nearly seven years of the MHAC program and nearly five years of the QBR program, which incorporates these measures into its Safety Domain.





## Hospital-Acquired Condition Reduction Program Fiscal Year 2018 Fact Sheet

### Overview

Section 3008 of the Patient Protection and Affordable Care Act (ACA) established the Hospital-Acquired Condition (HAC) Reduction Program to encourage eligible hospitals to reduce HACs.

Beginning in Fiscal Year (FY) 2015 (i.e., discharges beginning on October 1, 2014), the HAC Reduction Program requires the Secretary of the Department of Health and Human Services (HHS) to adjust payments to hospitals that rank in the worst-performing quartile of all subsection (d) non-Maryland hospitals with respect to risk-adjusted HAC quality measures. Hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores (i.e., the worst-performing quartile) will be subject to a 1 percent payment reduction.

### FY 2018 Results

The cutoff for the 75th percentile of Total HAC Scores is 0.3687. The 75th percentile cutoff was 6.5700 in FY 2017. Hospitals cannot directly compare Total HAC Scores or the 75th percentile cutoff between FY 2018 and previous program years because these results are on different scales due to the Winsorized z-score method, which CMS adopted in FY 2018. Please refer to the Scoring Methodology section below for more information.

### Public Reporting

CMS will report the following FY 2018 HAC Reduction Program information for each hospital on *Hospital Compare* in December 2017:

- Recalibrated PSI 90 Composite measure score
- Central Line-Associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTI), Surgical Site Infection (SSI), Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia, and *Clostridium difficile* Infection (CDI) measure scores
- Domain 1 and Domain 2 scores
- Total HAC Score
- Payment Reduction Indicator

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<sup>1</sup> The recalibrated PSIs used in CMS hospital quality reporting programs focus on the Medicare Fee-for-Service (FFS) population. CMS refers to PSIs as “recalibrated” to differentiate from the all-payer population for AHRQ.

## Measure Selection and Calculation

In the FY 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, CMS adopted the PSI 90 Composite and CDC CLABSI, CAUTI, SSI (Abdominal Hysterectomy and Colon Procedures), MRSA bacteremia, and CDI measures. In the FY 2017 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, CMS adopted the modified Recalibrated PSI 90 Composite for the FY 2018 HAC Reduction Program.

### Recalibrated PSI 90 Composite

The Recalibrated PSI 90 Composite includes the following ten PSIs:

- PSI 03 – Pressure Ulcer Rate
- PSI 06 – Iatrogenic Pneumothorax Rate
- PSI 08 – In-Hospital Fall with Hip Fracture Rate
- PSI 09 – Perioperative Hemorrhage or Hematoma Rate
- PSI 10 – Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 – Postoperative Respiratory Failure Rate
- PSI 12 – Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
- PSI 13 – Postoperative Sepsis Rate
- PSI 14 – Postoperative Wound Dehiscence Rate
- PSI 15 – Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate

The recalibrated version 6.0.2 of the software is modified so that software parameters (i.e., risk-adjustment coefficients, signal variance, and component weights in the Recalibrated PSI 90 Composite) derive from data from July 2013 through June 2015 Medicare Fee-for-Service (FFS) claims. Recalibration does not affect the individual PSI measure specifications, or which PSIs CMS includes in the composite. The Recalibrated PSI 90 Composite is a weighted average of the risk- and reliability-adjusted versions (i.e., smoothed versions) of the recalibrated PSIs.

Hospitals' absolute and relative performance on the modified Recalibrated PSI 90 Composite will likely differ from their performance on previous versions of the Recalibrated PSI 90 Composite. In FY 2018, CMS bases hospitals' Recalibrated PSI 90 Composite performance on 15 months of data rather than 24 months. More hospitals' will have PSI 90 Composite results close to the mean. The extent to which results are smoothed to the mean during reliability adjustment increases as case size decreases.

### CDC NHSN Healthcare-Associated Infection Measures

The CDC calculates standardized infection ratios (SIRs) for the CLABSI, CAUTI, SSI, MRSA bacteremia, and CDI measures. SIRs compare observed-to-predicted numbers of healthcare-associated infections (HAIs).

The CLABSI, CAUTI, SSI, MRSA bacteremia, and CDI measures are risk-adjusted at the hospital level and patient care unit level. CDC used chart-abstracted and laboratory surveillance data from NHSN for infections occurring from January 1, 2015 through December 31, 2016.

Hospitals' Domain 2 measure results will differ between FY 2018 and previous program years due to rebaselining and the expansion of the CLABSI and CAUTI measures to include ward

data.

## Scoring Methodology

CMS finalized the adoption of the Winsorized z-score methodology in the FY 2017 IPPS/LTCH PPS Final Rule. The Winsorized z-score methodology replaced the decile-based scoring methodology CMS used in FY 2015, 2016, and 2017. To calculate measure scores, the previous decile-based scoring method categorized each hospital into ten groups, assigning a score from 1 to 10 for each Domain 1 and Domain 2 measure. The Winsorized z-score methodology is a continuous scoring method that relies on the actual measure value. It ranks hospitals on a continuous spectrum from best performing to worst performing. The Winsorized z-score method improves precision and leads to fewer ties in Total HAC Scores across hospitals, better distinguishing hospital performance.

Hospitals cannot directly compare measure scores, domain scores, and Total HAC Scores between FY 2018 and previous program years. These results are on different scales. Under the decile-based scoring approach, a hospital's measure score represented the decile of a hospital's measure result. Measure scores, domain scores, and Total HAC Scores ranged between 1 and 10. Under the Winsorized z-score method, a hospital's measure score indicates the difference between the measure result and the mean score in standard deviations. Winsorized z-scores for measures tend to range between -3 and 3. The domain scores and Total HAC Score tend to fall within that range as well.

The Winsorized z-score method affects the calculation of the measures scores, but does not affect how CMS determines domain scores, Total HAC Scores, and the worst-performing quartile.

### Winsorized z-Score Calculation

For each measure, CMS calculates Winsorized measure results for each hospital based on raw measure results and the 5th and 95th percentile result for all eligible hospitals. If a hospital's measure result falls between the minimum and 5th percentile, CMS sets the hospital's measure result equal to the 5th percentile. If a hospital's measure result falls between the 95th percentile and maximum, CMS sets the hospital's measure results equal to the 95th percentile. Winsorization does not affect hospitals with a measure result between the 5th percentile and 95th percentile. These hospitals' Winsorized measure results equal the hospital's raw measure result.

For each measure, CMS subtracts the mean Winsorized measure result for all eligible hospitals from a hospital's Winsorized measure result, and divides by the standard deviation of Winsorized measure results for all eligible hospitals.

Winsorized z-score formula for “Hospital i” is:

$$\frac{X_i - \bar{X}}{SD(x)}$$

- $X_i$  is hospital i’s Winsorized measure result.
- $\bar{X}$  is the mean Winsorized measure result calculated across all subsection (d) hospitals.
- $SD(x)$  is the standard deviation of Winsorized measure results calculated across Maryland and subsection (d) hospitals.

CMS grants exceptions for new hospitals, hospitals that submit an approved HAI exception form (SSI, MRSA, and CDI), or outliers (CDI only).

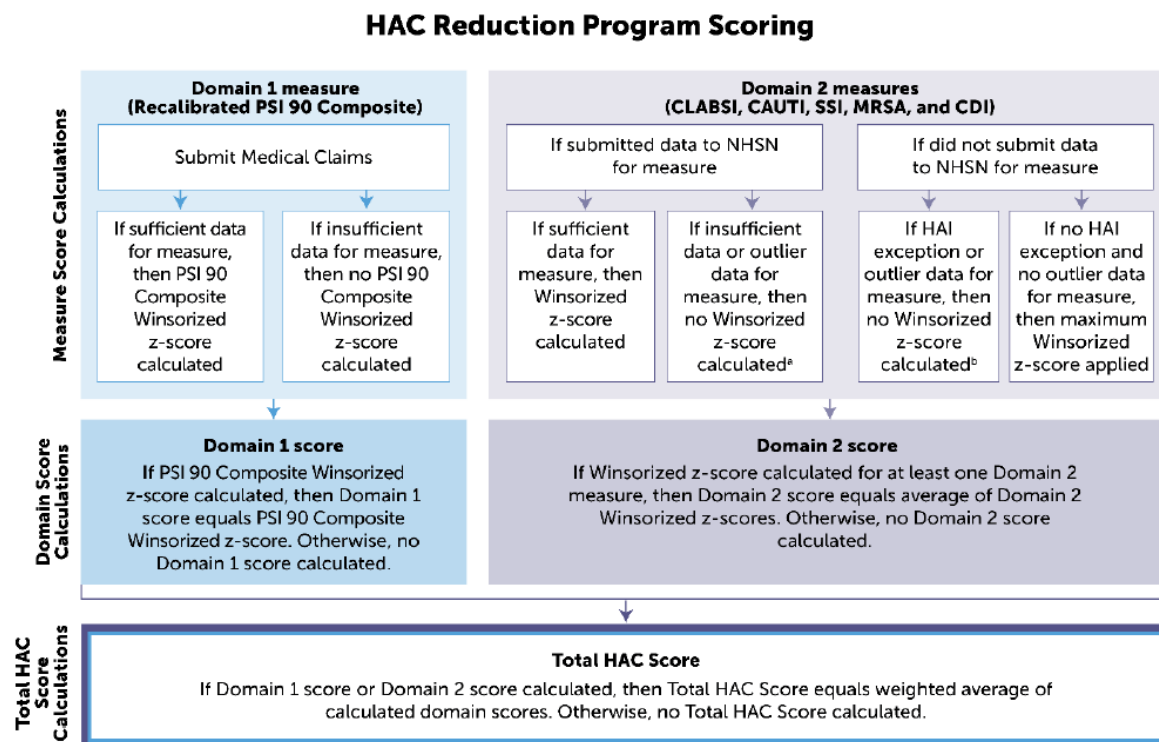
Negative domain scores indicate better performance, reflecting measure values above the national mean. Positive domain scores indicate worse performance, reflecting measure values below the national mean.

The domain weights for FY 2018 are the same as FY 2017. CMS applies a weight of 15 percent for Domain 1 and 85 percent for Domain 2 to determine the Total HAC Score for hospitals that receive a Domain 1 score and a Domain 2 score. If a hospital has only one domain score, then CMS applies a weight of 100 percent to the domain for which the hospital has a score. Hospitals with a Total HAC Score above the 75th percentile of the Total HAC Score distribution will receive a payment reduction.

Please see the FY 2018 HAC Reduction Program Hospital-Specific Report User Guide, located at <https://qualitynet.org> (Hospitals-Inpatient>HAC Reduction Program>Hospital-Specific-Reports). For more information on the scoring methodology CMS used for the FY 2018 HAC Reduction Program, reference the Winsorized z-scores infographic at: [www.qualitynet.org](http://www.qualitynet.org): >Hospitals-Inpatient>Hospital-Acquired Condition (HAC) Reduction Program>Resources

Figure 1 presents a visual overview of the scoring methodology.

Figure 1 – Overview of Scoring Methodology



a: The CDC will not calculate an SIR for CDI if the community-onset prevalence rates are within outlier bounds (i.e., above 2.6).

b: CMS will not calculate a measure score if the hospital received an HAI exception. Hospitals may receive an exception for CLABSI, CAUTI, and SSI by submitting an HAI Exception Form.

### Contacts and Additional Resources

For more information, please reference the following resources:

- Please send questions about CMS’s calculations, issues accessing the HSR, and discharge-level data to: QualityNet Help Desk at [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org) or (866) 288-8912.
- HAC Reduction Program Methodology and General Information
  - *QualityNet* HAC Reduction Program page: [www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166](http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166)
  - Submit a question to the HAC Reduction Program Question and Answer Tool: <https://cms-ip.custhelp.com/app/homehacrp/p/842>
- Scores
  - Hospital Compare HAC Reduction Program page: [www.medicare.gov/hospitalcompare/HAC-reduction-program.html](http://www.medicare.gov/hospitalcompare/HAC-reduction-program.html)
  - CMS HAC Reduction Program page: <http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html>

- PSI 90
  - *QualityNet* AHRQ Resources page:  
<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228695355425>
  - AHRQ Quality Indicator Support: [www.qualityindicators.ahrq.gov/](http://www.qualityindicators.ahrq.gov/) or email [QIsupport@ahrq.hhs.gov](mailto:QIsupport@ahrq.hhs.gov).
- CLABSI, CAUTI, SSI, MRSA bacteremia, and CDI
  - *QualityNet* Healthcare-Associated Infections page: [www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228760487021](http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228760487021)
  - CDC NHSN 2015 Rebaseline page: <https://www.cdc.gov/nhsn/2015rebaseline/index.html>
  - NHSN support: [nhsn@cdc.gov](mailto:nhsn@cdc.gov)

## Appendix III. Maryland Hospital Care Improvements Examples

As of October 10, 2017

1. Development of a Colorectal Bundle for reduction in SSI complications.
  - a. Also working on a bundle to reduce respiratory complications post-surgery
2. Development of a System CAUTI Bundle
3. Development and implementation of an Oral Care Program for reduction of Pneumonia
4. Development and implementation of an HAI Reduction Bundle – includes horizontal strategies including: hand hygiene, CHG bathing house-wide, improved environmental cleaning, antimicrobial stewardship, minimize invasive devices, compliance with established care bundles (e.g. CLABSI and CAUTI)
5. Development of Elective Joint Practice Guidelines:
  - a. Guidelines for morbidly obese and diabetic patients
  - b. Development of a revised rehabilitation pathway
  - c. Standardize practice for pain management – resulting in reduced LOS
6. System-wide implementation of the Nursing Early Warning Scoring System to recognize early patient deterioration
7. Interventional Cardiology
  - a. Development of a patient hydration protocol to reduce AKI
  - b. Standardize reduced contrast dosing to reduce AKI
8. Cardiac Surgery: protocol development to reduce prolonged ventilation
9. Sepsis reductions:
  - a. Implementation of “Code Sepsis” for early identification and treatment of sepsis
  - b. Collaboration with Antimicrobial Stewardship Program for development of antibiotic protocols related to cause of sepsis
10. Developed system palliative care clinical improvement workgroup to improve early intervention and referrals to hospice. System increased discharges to hospice three fold.
11. Antimicrobial Stewardship: integration of improved diagnostic tests to improve and expedite diagnosis, enabling personalized treatment
12. Development of Nursing PPC report to improve nursing care related to complications (e.g. pressure ulcers).
13. Expanded use of Incentive Spirometry
14. Reinforcing basics of nursing such as bathing
15. New VTE risk assessment standardization
16. New method of assessment of blood loss in obstetrical department
17. Incorporation of an Aspiration Risk Assessment for all inpatients
  - a. Patients at high risk made NPO until swallow study completed
18. New fall prevention protocols
19. Reinforcement of specimen collection techniques
20. Sepsis Bundle

21. C-Difficile bundles, Daily rounding / Specimen collection protocols
22. Documentation templates and risk assessments for anesthesia
23. IV insertion / maintenance education
24. Evaluation of type of anesthesia for total joint patients
25. Evaluation of tourniquet time for total joint patients



## Appendix IV. List of APR-DRGs and Associated PPCs in Current Methodology and Proposed 80% Cutoff Methodology\*

APR-DRG	Model 1 >30 At-Risk Discharges		Model 2 >30 At-Risk Discharges + 80% APR-DRG-PPC		Difference	
	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide
1	271	0	271	0	-	0
2	114	0	114	0	-	0
4	76	0	76	0	-	0
5	1,483	24	797	22	(686)	-2
6	30	0	30	0	-	0
7	164	0	164	0	-	0
8	98	0	98	0	-	0
9	282	1	282	1	-	0
10	-	0	-	0	-	0
20	347	0	347	0	-	0
21	53,470	109	26,852	99	(26,618)	-10
22	12,127	7	2,035	4	(10,092)	-3
23	14,043	14	2,896	8	(11,147)	-6
24	68,660	95	28,760	90	(39,900)	-5
26	12,380	17	2,713	9	(9,667)	-8
40	6,373	3	698	0	(5,675)	-3
41	-	0	-	0	-	0
42	41,552	47	16,059	41	(25,493)	-6
43	20,387	6	2,274	0	(18,113)	-6
44	29,972	26	10,123	23	(19,849)	-3
45	236,119	104	124,289	97	(111,830)	-7
46	6,001	0	640	0	(5,361)	0
47	54,728	5	6,848	2	(47,880)	-3
48	48,346	16	8,411	8	(39,935)	-8
49	6,490	7	1,092	2	(5,398)	-5
50	10,291	9	1,526	3	(8,765)	-6
51	5,309	0	643	0	(4,666)	0
52	43,831	31	12,756	22	(31,075)	-9
53	118,380	41	33,780	25	(84,600)	-16
54	35,133	1	3,338	0	(31,795)	-1
55	-	0	-	0	-	0
56	-	0	-	0	-	0
57	6,330	4	825	3	(5,505)	-1
58	78,470	45	30,746	38	(47,724)	-7
59	-	0	-	0	-	0
73	1,851	1	358	0	(1,493)	-1
82	14,302	1	1,380	0	(12,922)	-1
89	11,507	38	3,482	27	(8,025)	-11
91	3,790	24	1,122	15	(2,668)	-9
92	12,484	8	1,937	5	(10,547)	-3
95	298	0	94	0	(204)	0
97	322	0	193	0	(129)	0
98	13,659	16	2,021	6	(11,638)	-10
110	146	0	146	0	-	0
111	22,503	0	2,170	0	(20,333)	0
113	47,385	10	6,380	2	(41,005)	-8
114	4,544	1	534	0	(4,010)	-1

Draft Maryland Hospital-Acquired Conditions Program Recommendations for Rate Year 2020

APR-DRG	Model 1 >30 At-Risk Discharges		Model 2 >30 At-Risk Discharges + 80% APR-DRG-PPC		Difference	
	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide
115	26,727	7	3,923	4	(22,804)	-3
120	27,101	95	12,302	82	(14,799)	-13
121	45,157	92	20,528	83	(24,629)	-9
130	11,458	64	5,935	61	(5,523)	-3
131	6,435	4	1,030	3	(5,405)	-1
132	295	0	131	0	(164)	0
133	182,805	112	111,373	98	(71,432)	-14
134	93,002	33	29,436	25	(63,566)	-8
135	84	0	84	0	-	0
136	10,925	9	1,934	5	(8,991)	-4
137	66,998	65	32,809	58	(34,189)	-7
138	6,188	1	1,642	0	(4,546)	-1
139	253,843	71	108,856	67	(144,987)	-4
140	353,583	71	128,655	62	(224,928)	-9
141	70,657	10	11,077	4	(59,580)	-6
142	16,818	12	3,344	7	(13,474)	-5
143	45,102	16	8,533	8	(36,569)	-8
144	13,845	4	1,890	2	(11,955)	-2
145	34,579	5	3,955	2	(30,624)	-3
160	25,523	136	14,700	125	(10,823)	-11
161	659	0	411	0	(248)	0
162	1,758	7	540	3	(1,218)	-4
163	28,629	137	14,496	128	(14,133)	-9
165	27,384	130	13,059	113	(14,325)	-17
166	64,735	205	34,195	192	(30,540)	-13
167	8,764	30	2,638	19	(6,126)	-11
169	16,747	111	7,897	91	(8,850)	-20
170	163	0	163	0	-	0
171	41,973	50	11,806	40	(30,167)	-10
174	124,291	139	55,781	123	(68,510)	-16
175	77,286	138	43,505	122	(33,781)	-16
176	14,709	17	3,347	13	(11,362)	-4
177	1,361	1	353	0	(1,008)	-1
180	13,019	18	3,095	12	(9,924)	-6
181	86,195	320	66,671	308	(19,524)	-12
182	44,967	107	23,109	95	(21,858)	-12
190	129,383	95	57,808	78	(71,575)	-17
191	28,642	11	4,001	8	(24,641)	-3
192	86,994	55	25,218	38	(61,776)	-17
193	2,479	3	488	0	(1,991)	-3
194	447,785	220	311,479	212	(136,306)	-8
196	-	0	-	0	-	0
197	75,984	29	22,827	21	(53,157)	-8
198	54,871	5	7,555	2	(47,316)	-3
199	64,496	14	12,604	8	(51,892)	-6
200	6,875	2	852	0	(6,023)	-2
201	220,854	70	74,998	57	(145,856)	-13
203	36,270	2	3,667	0	(32,603)	-2
204	75,174	5	8,033	2	(67,141)	-3
205	3,400	0	448	0	(2,952)	0
206	19,106	10	3,590	7	(15,516)	-3

Draft Maryland Hospital-Acquired Conditions Program Recommendations for Rate Year 2020

APR-DRG	Model 1 >30 At-Risk Discharges		Model 2 >30 At-Risk Discharges + 80% APR-DRG-PPC		Difference	
	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide
207	41,869	20	8,636	10	(33,233)	-10
220	38,552	144	22,187	130	(16,365)	-14
222	6,024	12	1,158	4	(4,866)	-8
223	18,001	50	5,653	40	(12,348)	-10
224	18,445	35	6,583	27	(11,862)	-8
226	5,496	1	717	0	(4,779)	-1
227	51,752	90	20,413	79	(31,339)	-11
228	13,370	17	2,644	12	(10,726)	-5
229	17,802	25	4,772	19	(13,030)	-6
230	73,704	394	52,684	370	(21,020)	-24
231	121,208	287	89,404	271	(31,804)	-16
232	182	0	182	0	-	0
233	21,080	9	3,805	7	(17,275)	-2
234	26,290	2	3,889	2	(22,401)	0
240	5,327	0	621	0	(4,706)	0
241	107,906	51	41,483	36	(66,423)	-15
242	12,184	5	1,772	2	(10,412)	-3
243	24,913	8	3,942	4	(20,971)	-4
244	110,323	30	35,757	20	(74,566)	-10
245	45,386	3	4,616	0	(40,770)	-3
246	13,637	9	1,433	0	(12,204)	-9
247	108,859	43	37,552	35	(71,307)	-8
248	69,753	16	15,161	8	(54,592)	-8
249	110,287	23	20,245	9	(90,042)	-14
251	29,208	3	2,901	0	(26,307)	-3
252	29,087	19	6,390	10	(22,697)	-9
253	80,503	36	20,740	22	(59,763)	-14
254	125,956	52	51,978	38	(73,978)	-14
260	18,518	82	10,143	71	(8,375)	-11
261	1,789	3	384	3	(1,405)	0
263	134,028	144	72,938	132	(61,090)	-12
264	673	0	431	0	(242)	0
279	24,923	17	5,489	12	(19,434)	-5
280	32,119	22	7,359	17	(24,760)	-5
281	6,383	2	633	0	(5,750)	-2
282	142,962	81	70,242	75	(72,720)	-6
283	24,511	15	3,625	4	(20,886)	-11
284	56,060	33	18,519	24	(37,541)	-9
301	298,262	129	132,194	111	(166,068)	-18
302	535,527	217	353,282	205	(182,245)	-12
303	16,957	43	6,441	36	(10,516)	-7
304	208,035	176	120,768	163	(87,267)	-13
305	39,224	103	20,667	93	(18,557)	-10
308	4,444	1	3,620	0	(824)	-1
309	20,044	22	5,575	16	(14,469)	-6
310	38,780	23	9,065	13	(29,715)	-10
312	6,418	8	1,173	5	(5,245)	-3
313	98,738	65	40,858	54	(57,880)	-11
314	53,774	38	17,823	32	(35,951)	-6
315	64,710	46	23,286	37	(41,424)	-9
316	9,433	3	1,117	0	(8,316)	-3

Draft Maryland Hospital-Acquired Conditions Program Recommendations for Rate Year 2020

APR-DRG	Model 1 >30 At-Risk Discharges		Model 2 >30 At-Risk Discharges + 80% APR-DRG-PPC		Difference	
	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide
317	25,373	18	4,872	7	(20,501)	-11
320	38,864	19	6,860	8	(32,004)	-11
321	113,413	80	50,615	69	(62,798)	-11
322	27,360	7	3,817	2	(23,543)	-5
340	85	1	85	1	-	0
341	21	0	21	0	-	0
342	39,311	15	6,655	7	(32,656)	-8
343	211	0	211	0	-	0
344	35,903	19	7,459	10	(28,444)	-9
346	21,543	20	5,426	13	(16,117)	-7
347	82,863	32	27,964	23	(54,899)	-9
349	16,520	4	1,790	1	(14,730)	-3
351	100,424	26	29,383	19	(71,041)	-7
361	20,691	13	3,580	6	(17,111)	-7
362	16,884	21	3,249	15	(13,635)	-6
363	16,017	21	3,142	14	(12,875)	-7
364	46,031	30	12,369	21	(33,662)	-9
380	32,416	9	4,294	2	(28,122)	-7
381	1,762	0	357	0	(1,405)	0
382	93	0	93	0	-	0
383	229,640	39	79,326	28	(150,314)	-11
384	23,587	6	2,925	4	(20,662)	-2
385	19,779	2	2,002	0	(17,777)	-2
401	3,197	5	414	0	(2,783)	-5
403	138,425	51	41,385	41	(97,040)	-10
404	6,264	8	1,184	4	(5,080)	-4
405	2,965	10	688	4	(2,277)	-6
420	175,023	44	66,205	34	(108,818)	-10
421	16,921	8	1,999	0	(14,922)	-8
422	50,268	12	7,968	5	(42,300)	-7
423	3,313	0	447	0	(2,866)	0
424	10,509	4	1,132	0	(9,377)	-4
425	51,453	20	13,603	15	(37,850)	-5
426	58,596	24	18,029	17	(40,567)	-7
427	8,786	2	910	0	(7,876)	-2
440	369	0	369	0	-	0
441	7,915	18	1,931	11	(5,984)	-7
442	27,753	57	10,651	48	(17,102)	-9
443	31,387	31	10,178	26	(21,209)	-5
444	5,356	13	956	5	(4,400)	-8
445	4,412	6	704	0	(3,708)	-6
446	17,972	15	3,439	9	(14,533)	-6
447	1,682	11	529	7	(1,153)	-4
461	984	2	246	0	(738)	-2
462	2,507	2	384	0	(2,123)	-2
463	232,338	64	105,005	57	(127,333)	-7
465	28,913	8	3,919	2	(24,994)	-6
466	54,184	32	19,383	22	(34,801)	-10
468	30,830	11	3,994	3	(26,836)	-8
469	203,548	135	109,919	119	(93,629)	-16
470	38,810	20	10,968	14	(27,842)	-6

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APR-DRG	Model 1 >30 At-Risk Discharges		Model 2 >30 At-Risk Discharges + 80% APR-DRG-PPC		Difference	
	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide
480	42,101	12	8,573	9	(33,528)	-3
482	10,076	11	1,160	0	(8,916)	-11
483	4,651	12	932	10	(3,719)	-2
484	16,258	7	2,670	4	(13,588)	-3
500	35	0	35	0	-	0
501	20,168	4	2,119	0	(18,049)	-4
510	683	0	370	0	(313)	0
511	1,411	5	988	4	(423)	-1
512	9,331	13	1,911	9	(7,420)	-4
513	50,549	47	15,160	35	(35,389)	-12
514	3,396	2	414	0	(2,982)	-2
517	1,030	1	304	0	(726)	-1
518	5,733	8	939	4	(4,794)	-4
519	72,779	61	21,120	49	(51,659)	-12
530	177	0	177	0	-	0
531	14,414	3	1,438	0	(12,976)	-3
532	9,787	1	952	0	(8,835)	-1
540	929,187	282	443,030	248	(486,157)	-34
541	27,807	13	4,039	9	(23,768)	-4
542	38,509	12	5,543	6	(32,966)	-6
544	6,860	2	814	0	(6,046)	-2
545	1,765	0	333	0	(1,432)	0
546	3,577	4	483	0	(3,094)	-4
560	1,479,126	68	317,415	60	(1,161,711)	-8
561	27,374	1	2,573	0	(24,801)	-1
563	10,135	0	911	0	(9,224)	0
564	1,676	0	248	0	(1,428)	0
565	63	0	63	0	-	0
566	61,808	4	5,894	0	(55,914)	-4
580	-	0	-	0	-	0
581	-	0	-	0	-	0
583	12	0	12	0	-	0
588	118	0	118	0	-	0
589	-	0	-	0	-	0
591	214	0	154	0	(60)	0
593	464	0	308	0	(156)	0
602	465	0	311	0	(154)	0
603	56	0	56	0	-	0
607	541	0	376	0	(165)	0
608	160	0	119	0	(41)	0
609	99	0	99	0	-	0
611	250	0	209	0	(41)	0
612	774	0	527	0	(247)	0
613	60	0	60	0	-	0
614	1,277	0	844	0	(433)	0
621	346	0	226	0	(120)	0
622	767	0	509	0	(258)	0
623	69	0	69	0	-	0
625	933	0	619	0	(314)	0
626	-	0	-	0	-	0
630	116	0	116	0	-	0

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APR-DRG	Model 1 >30 At-Risk Discharges		Model 2 >30 At-Risk Discharges + 80% APR-DRG-PPC		Difference	
	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide
631	146	0	146	0	-	0
633	1,955	0	1,131	0	(824)	0
634	2,120	0	1,319	0	(801)	0
636	860	0	570	0	(290)	0
639	4,247	0	2,605	0	(1,642)	0
640	-	0	-	0	-	0
650	268	0	268	0	-	0
651	2,272	1	432	0	(1,840)	-1
660	13,589	7	2,101	2	(11,488)	-5
661	18,530	6	3,085	5	(15,445)	-1
662	59,301	25	15,319	18	(43,982)	-7
663	79,805	18	13,927	9	(65,878)	-9
680	5,957	15	1,482	9	(4,475)	-6
681	1,189	0	587	0	(602)	0
690	-	0	-	0	-	0
691	2,531	1	355	0	(2,176)	-1
692	17	0	17	0	-	0
694	5,412	1	687	0	(4,725)	-1
695	-	0	-	0	-	0
696	10,332	0	1,027	0	(9,305)	0
710	66,389	217	57,912	205	(8,477)	-12
711	31,968	47	13,141	40	(18,827)	-7
720	434,465	313	359,625	303	(74,840)	-10
721	65,556	17	11,357	8	(54,199)	-9
722	14,818	1	1,617	0	(13,201)	-1
723	15,531	5	2,098	2	(13,433)	-3
724	16,794	13	4,228	10	(12,566)	-3
740	1,790	0	314	0	(1,476)	0
750	215,720	22	52,794	14	(162,926)	-8
751	287,258	29	60,794	15	(226,464)	-14
752	2,666	0	346	0	(2,320)	0
753	267,236	23	59,489	13	(207,747)	-10
754	92,920	5	10,603	0	(82,317)	-5
755	25,646	1	2,756	0	(22,890)	-1
756	23,919	1	2,628	0	(21,291)	-1
757	31,000	49	12,396	42	(18,604)	-7
758	4,605	0	944	0	(3,661)	0
759	1,777	1	324	0	(1,453)	-1
760	3,191	1	483	0	(2,708)	-1
770	-	0	-	0	-	0
772	20,376	1	2,103	0	(18,273)	-1
773	74,467	6	6,858	1	(67,609)	-5
774	8,327	2	877	0	(7,450)	-2
775	137,011	36	49,190	32	(87,821)	-4
776	7,470	1	862	0	(6,608)	-1
792	9,878	31	3,547	22	(6,331)	-9
793	17,756	14	3,904	9	(13,852)	-5
794	1,532	0	358	0	(1,174)	0
810	11,699	6	1,209	0	(10,490)	-6
811	14,733	1	1,578	0	(13,155)	-1
812	63,785	26	12,849	14	(50,936)	-12

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APR-DRG	Model 1 >30 At-Risk Discharges		Model 2 >30 At-Risk Discharges + 80% APR-DRG-PPC		Difference	
	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide	At-Risk Discharges	# Observed Statewide
813	24,075	9	3,657	6	(20,418)	-3
815	3,377	1	430	0	(2,947)	-1
816	32,704	19	5,753	8	(26,951)	-11
817	22,540	4	2,424	0	(20,116)	-4
841	20	0	20	0	-	0
842	116	0	116	0	-	0
843	-	0	-	0	-	0
844	3,817	0	449	0	(3,368)	0
850	24,237	28	4,928	13	(19,309)	-15
860	174,080	130	114,864	109	(59,216)	-21
861	62,105	16	12,213	11	(49,892)	-5
862	13,983	17	2,485	13	(11,498)	-4
863	174	0	143	0	(31)	0
890	-	0	-	0	-	0
892	-	0	-	0	-	0
893	-	0	-	0	-	0
894	-	0	-	0	-	0
910	115	0	115	0	-	0
911	353	0	353	0	-	0
912	834	0	834	0	-	0
930	-	0	-	0	-	0
950	45,315	190	30,204	175	(15,111)	-15
951	51,124	97	26,522	88	(24,602)	-9
952	22,331	24	5,163	15	(17,168)	-9
955	3	0	3	0	-	0
956	244	0	244	0	-	0
STATEWIDE Totals	14,944,561	9,152	5,580,557	7,549	(9,364,004)	(1,603)

\*DRG Analysis presented by Berkeley Research Group. Total PPC counts do not match Appendix V and total PPCs in program, as hospital specific exclusions have not yet been implemented, i.e. the PPC counts are reduced slightly more once hospital specific exclusion is applied. HSCRC staff will confirm this analysis in final recommendation.

## Appendix V. Number of Hospitals, At-Risk Discharges, and Observed PPCs by PPC (RY 2020 base period)

PPC #	PPC DESCRIPTION	Model 1 >30 At-Risk Discharges				Model 2 >30 At-Risk Discharges + 80% APR-DRG-PPC				Difference			PPC Tier
		# of Hosp.	% of Hosp.	At-Risk Discharges	# Obs. Statewide	# of Hosp.	% of Hosp.	At-Risk Discharges	# Obs. Statewide	# Hosp.	# At-Risk	# Observed	
1	Stroke & Intracranial Hemorrhage	43	91.5%	423,226	335	42	89.4%	180,343	295	-1	(242,883)	-40	2
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	46	97.9%	350,493	653	46	97.9%	203,584	614	0	(146,909)	-39	1
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	45	95.7%	348,000	428	44	93.6%	158,618	377	-1	(189,382)	-51	1
5	Pneumonia & Other Lung Infections	47	100.0%	188,802	418	46	97.9%	123,959	376	-1	(64,843)	-42	1
6	Aspiration Pneumonia	43	91.5%	350,328	249	41	87.2%	157,935	215	-2	(192,393)	-34	1
7	Pulmonary Embolism	40	85.1%	402,665	204	38	80.9%	93,085	160	-2	(309,580)	-44	1
8	Other Pulmonary Complications	39	83.0%	278,288	282	38	80.9%	143,860	240	-1	(134,428)	-42	2
9	Shock	46	97.9%	417,932	512	44	93.6%	228,712	481	-2	(189,220)	-31	1
10	Congestive Heart Failure	35	74.5%	340,661	101	32	68.1%	98,734	71	-3	(241,927)	-30	2
11	Acute Myocardial Infarction	43	91.5%	416,549	303	43	91.5%	177,806	251	0	(238,743)	-52	2



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PPC #	PPC DESCRIPTION	Model 1 >30 At-Risk Discharges				Model 2 >30 At-Risk Discharges + 80% APR-DRG-PPC				Difference			PPC Tier
		# of Hosp.	% of Hosp.	At-Risk Discharges	# Obs. Statewide	# of Hosp.	% of Hosp.	At-Risk Discharges	# Obs. Statewide	# Hosp.	# At-Risk	# Observed	
13	Other Cardiac Complications	28	59.6%	339,884	66	21	44.7%	65,817	42	-7	(274,067)	-24	2
14	Ventricular Fibrillation/Cardiac Arrest	47	100.0%	367,688	656	47	100.0%	206,102	619	0	(161,586)	-37	1
16	Venous Thrombosis	42	89.4%	407,493	178	38	80.9%	122,404	135	-4	(285,089)	-43	1
19	Major Liver Complications	25	53.2%	333,090	55	12	25.5%	19,158	21	-13	(313,932)	-34	2
21	Clostridium Difficile Colitis	47	100.0%	65,009	368	47	100.0%	42,328	334	0	(22,681)	-34	2
23	GU Complications Except UTI	27	57.4%	353,248	55	15	31.9%	38,745	22	-12	(314,503)	-33	2
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	41	87.2%	315,949	267	40	85.1%	110,128	237	-1	(205,821)	-30	1
28	In-Hospital Trauma and Fractures	28	59.6%	363,054	49	11	23.4%	17,350	13	-17	(345,704)	-36	2
30	Poisonings due to Anesthesia*	47	100.0%	452,543	0	47	100.0%	452,543	0	0	-	0	2
31	Decubitus Ulcer*	47	100.0%	126,359	41	47	100.0%	126,359	41	0	-	0	2
32	Transfusion Incompatibility Reaction*	47	100.0%	469,683	0	47	100.0%	469,683	0	0	-	0	2
35	Septicemia & Severe Infections	47	100.0%	145,479	422	46	97.9%	97,079	382	-1	(48,400)	-40	1
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	33	70.2%	62,406	156	32	68.1%	16,700	139	-1	(45,706)	-17	1

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PPC #	PPC DESCRIPTION	Model 1 >30 At-Risk Discharges				Model 2 >30 At-Risk Discharges + 80% APR-DRG-PPC				Difference			PPC Tier
		# of Hosp.	% of Hosp.	At-Risk Discharges	# Obs. Statewide	# of Hosp.	% of Hosp.	At-Risk Discharges	# Obs. Statewide	# Hosp.	# At-Risk	# Observed	
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	4	8.5%	34,663	9	4	8.5%	2,607	8	0	(32,056)	-1	1
39	Reopening Surgical Site	30	63.8%	108,051	170	30	63.8%	38,289	161	0	(69,762)	-9	2
40	Post-Op Hemorrhage & Hematoma w/o Hemorrhage Control Procedure or I&D Proc	42	89.4%	152,519	576	42	89.4%	117,808	554	0	(34,711)	-22	1
41	Post-Op Hemorrhage & Hematoma w/Hemorrhage Control Procedure or I&D Proc	26	55.3%	112,810	86	21	44.7%	43,976	57	-5	(68,834)	-29	1
42	Accidental Puncture/Laceration During Invasive Procedure	37	78.7%	432,009	242	36	76.6%	78,290	205	-1	(353,719)	-37	1
44	Other Surgical Complication - Mod	16	34.0%	81,027	25	9	19.1%	7,881	11	-7	(73,146)	-14	2
45	Post-procedure Foreign Bodies*	47	100.0%	151,145	12	47	100.0%	151,145	12	0	-	0	2
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body*	47	100.0%	446,991	0	47	100.0%	446,991	0	0	-	0	2

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PPC #	PPC DESCRIPTION	Model 1 >30 At-Risk Discharges				Model 2 >30 At-Risk Discharges + 80% APR-DRG-PPC				Difference			PPC Tier
		# of Hosp.	% of Hosp.	At-Risk Discharges	# Obs. Statewide	# of Hosp.	% of Hosp.	At-Risk Discharges	# Obs. Statewide	# Hosp.	# At-Risk	# Observed	
47	Encephalopathy	28	59.6%	250,214	73	23	48.9%	37,958	47	-5	(212,256)	-26	2
48	Other Complications of Medical Care	30	63.8%	379,947	83	24	51.1%	46,384	46	-6	(333,563)	-37	2
49	Iatrogenic Pneumothorax	31	66.0%	376,207	69	29	61.7%	46,712	50	-2	(329,495)	-19	1
50	Mechanical Complication of Device, Implant & Graft	40	85.1%	417,641	229	40	85.1%	109,769	184	0	(307,872)	-45	2
51	Gastrointestinal Ostomy Complications	34	72.3%	392,701	85	31	66.0%	66,824	59	-3	(325,877)	-26	2
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	43	91.5%	426,713	309	42	89.4%	163,962	261	-1	(262,751)	-48	2
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusions	31	66.0%	385,174	68	12	25.5%	28,797	14	-19	(356,377)	-54	2
59	Medical & Anesthesia Obstetric Complications	29	61.7%	63,991	105	29	61.7%	63,991	105	0	-	0	2
60	Major Puerperal Infection and Other Major Obstetric Complications	20	42.6%	55,491	58	20	42.6%	55,491	58	0	-	0	2

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PPC #	PPC DESCRIPTION	Model 1 >30 At-Risk Discharges				Model 2 >30 At-Risk Discharges + 80% APR-DRG-PPC				Difference			PPC Tier
		# of Hosp.	% of Hosp.	At-Risk Discharges	# Obs. Statewide	# of Hosp.	% of Hosp.	At-Risk Discharges	# Obs. Statewide	# Hosp.	# At-Risk	# Observed	
61	Other Complications of Obstetrical Surgical & Perineal Wounds	18	38.3%	52,937	42	18	38.3%	51,630	42	0	(1,307)	0	2
65	Urinary Tract Infection without Catheter	28	59.6%	318,278	51	6	12.8%	8,132	9	-22	(310,146)	-42	2
67	Combined PPC 1 (PPC 25, 26, 63, 64) General Combo	44	93.6%	443,372	253	42	89.4%	228,144	206	-2	(215,228)	-47	2
68	Combined PPC 2 (PPC 17, 18) GI Combo	44	93.6%	415,509	274	44	93.6%	223,833	240	0	(191,676)	-34	2
71	Combined PPC 3 (PPC 34, 54,66) Infection Combo	31	66.0%	403,806	71	20	42.6%	35,799	35	-11	(368,007)	-36	2
	STATEWIDE Totals			13,220,025	8,688			5,405,445	7,429			-1259	
	STATEWIDE Average	36	77.2%			33	70.0%			-1			
	Percent of PPCs Retained in Model 2								85.5%				

\*Serious Reportable Events

### Appendix VI. PPC Benchmarks (RY 2020 Base Period)

PPC NUMBER	PPC DESCRIPTION	Model 1 >30 At-Risk Discharges	Model 2 >30 + 80% APR-DRG-PPC	Simple Differences Model 1 vs Model 2	Tier
		Benchmark	Benchmark	Benchmark	
1	Stroke & Intracranial Hemorrhage	0.4595	0.4132	-0.0463	2
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	0.5813	0.5469	-0.0344	1
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	0.5599	0.5624	0.0025	1
5	Pneumonia & Other Lung Infections	0.654	0.626	-0.028	1
6	Aspiration Pneumonia	0.3916	0.4239	0.0323	1
7	Pulmonary Embolism	0.3226	0.1432	-0.1794	1
8	Other Pulmonary Complications	0.3844	0.2257	-0.1587	2
9	Shock	0.4151	0.4132	-0.0019	1
10	Congestive Heart Failure	0.1922	0.177	-0.0152	2
11	Acute Myocardial Infarction	0.3905	0.2903	-0.1002	2
13	Other Cardiac Complications	0.0617	0.1521	0.0904	2
14	Ventricular Fibrillation/Cardiac Arrest	0.5726	0.5538	-0.0188	1
16	Venous Thrombosis	0.1862	0.1774	-0.0088	1
19	Major Liver Complications	0.0677	0	-0.0677	2
21	Clostridium Difficile Colitis	0.4459	0.4306	-0.0153	2
23	GU Complications Except UTI	0.2014	0	-0.2014	2
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	0.2722	0.2648	-0.0074	1
28	In-Hospital Trauma and Fractures	0.2232	0	-0.2232	2
30	Poisonings due to Anesthesia	0	0	0	2
31	Decubitus Ulcer	0	0	0	2
32	Transfusion Incompatibility Reaction	0	0	0	2
35	Septicemia & Severe Infections	0.4565	0.4459	-0.0106	1

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PPC NUMBER	PPC DESCRIPTION	Model 1 >30 At-Risk Discharges	Model 2 >30 + 80% APR-DRG-PPC	Simple Differences Model 1 vs Model 2	Tier
		Benchmark	Benchmark	Benchmark	
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	0.3179	0.2915	-0.0264	1
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	0.3548	0	-0.3548	1
39	Reopening Surgical Site	0.4059	0.2616	-0.1443	2
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	0.5583	0.5512	-0.0071	1
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	0.2917	0.154	-0.1377	1
42	Accidental Puncture/Laceration During Invasive Procedure	0.302	0.3851	0.0831	1
44	Other Surgical Complication - Mod	0.349	0	-0.349	2
45	Post-procedure Foreign Bodies	0	0	0	2
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body	0	0	0	2
47	Encephalopathy	0.156	0.0937	-0.0623	2
48	Other Complications of Medical Care	0.2061	0.0902	-0.1159	2
49	Iatrogenic Pneumothorax	0.1275	0.0757	-0.0518	1
50	Mechanical Complication of Device, Implant & Graft	0.4661	0.3827	-0.0834	2
51	Gastrointestinal Ostomy Complications	0.3174	0.2301	-0.0873	2
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	0.4157	0.4181	0.0024	2
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusions	0.0575	0	-0.0575	2
59	Medical & Anesthesia Obstetric Complications	0.2625	0.2625	0	2
60	Major Puerperal Infection and Other Major Obstetric Complications	0.1321	0.1321	0	2
61	Other Complications of Obstetrical Surgical & Perineal Wounds	0.1592	0.1592	0	2
65	Urinary Tract Infection without Catheter	0	0	0	2
67	Combined PPC 1 (PPC 25, 26, 63, 64)	0.0842	0.0658	-0.0184	2

Draft Maryland Hospital-Acquired Conditions Program Recommendations for Rate Year 2020

PPC NUMBER	PPC DESCRIPTION	Model 1 >30 At-Risk Discharges	Model 2 >30 + 80% APR-DRG-PPC	Simple Differences Model 1 vs Model 2	
		Benchmark	Benchmark	Benchmark	Tier
68	Combined PPC 2 (PPC 17, 18)	0.2423	0.226	-0.0163	2
69	Combined PPC 3 (PPC 34, 54,66) Infection Combo	0.1701	0.1235	-0.0466	2

Appendix VII. PPCs by Hospital (RY 2020 Base Period)

CMS ID	HOSPITAL NAME	Model 1 No Changes					Model 2 80% APR-DRG-PPC					Percent Differences Model 1 vs Model 2		
		# PPCs	At-Risk	OBS. Base Pd.	EXP. Base Pd.	O/E Ratio	# PPCs	At-Risk	OBS. Base Pd.	EXP. Base Pd.	O/E Ratio	AT-RISK BASE PERIOD	OBS. Base Pd.	O/E Ratio
210001	Meritus	43	407,534	238	214.10	1.11	39	162,081	196	182.00	1.08	-60.23%	-17.65%	-2.70%
210002	UMMC	45	534,838	652	687.36	0.95	43	208,534	562	594.00	0.95	-61.01%	-13.80%	0.00%
210003	UM-PGHC	41	262,505	129	146.96	0.88	32	90,402	112	118.92	0.94	-65.56%	-13.18%	6.82%
210004	Holy Cross	44	720,384	268	336.76	0.80	42	282,784	228	292.59	0.78	-60.75%	-14.93%	-2.50%
210005	Frederick	43	430,602	235	236.50	0.99	39	168,630	201	198.98	1.01	-60.84%	-14.47%	2.02%
210006	UM-Harford	21	60,472	27	35.89	0.75	20	30,798	27	30.58	0.88	-49.07%	0.00%	17.33%
210008	Mercy	43	383,043	222	232.16	0.96	37	162,077	189	198.15	0.95	-57.69%	-14.86%	-1.04%
210009	Johns Hopkins	45	931,895	980	911.69	1.07	45	345,415	811	771.45	1.05	-62.93%	-17.24%	-1.87%
210010	UM-Dorchester	13	21,305	7	11.70	0.60	11	12,207	5	8.39	0.60	-42.70%	-28.57%	0.00%
210011	St. Agnes	44	409,484	163	254.53	0.64	42	166,639	142	218.23	0.65	-59.31%	-12.88%	1.56%
210012	Sinai	44	455,939	432	365.83	1.18	42	196,008	377	321.56	1.17	-57.01%	-12.73%	-0.85%
210013	Bon Secours	19	47,287	51	32.20	1.58	18	24,928	42	27.17	1.55	-47.28%	-17.65%	-1.90%
210015	MedStar Fr Square	44	563,017	324	315.04	1.03	43	223,558	285	272.99	1.04	-60.29%	-12.04%	0.97%



Draft Maryland Hospital-Acquired Conditions Program Recommendations for Rate Year 2020

CMS ID	HOSPITAL NAME	Model 1 No Changes					Model 2 80% APR-DRG-PPC					Percent Differences Model 1 vs Model 2		
		# PPCs	At-Risk	OBS. Base Pd.	EXP. Base Pd.	O/E Ratio	# PPCs	At-Risk	OBS. Base Pd.	EXP. Base Pd.	O/E Ratio	AT-RISK BASE PERIOD	OBS. Base Pd.	O/E Ratio
210016	Washington Adventist	43	285,597	215	186.62	1.15	39	107,087	194	163.31	1.19	-62.50%	-9.77%	3.48%
210017	Garrett	11	11,914	5	8.01	0.62	9	8,664	4	5.56	0.72	-27.28%	-20.00%	16.13%
210018	MedStar Montgomery	31	135,397	59	76.71	0.77	30	65,062	48	65.81	0.73	-51.95%	-18.64%	-5.19%
210019	Peninsula	44	447,929	335	337.34	0.99	43	193,052	293	300.57	0.97	-56.90%	-12.54%	-2.02%
210022	Suburban	40	341,630	235	229.81	1.02	35	147,137	195	194.41	1.00	-56.93%	-17.02%	-1.96%
210023	Anne Arundel	45	737,567	313	378.73	0.83	42	297,430	251	324.06	0.77	-59.67%	-19.81%	-7.23%
210024	MedStar Union Mem	41	306,458	285	277.70	1.03	36	133,196	243	241.80	1.00	-56.54%	-14.74%	-2.91%
210027	Western Maryland	41	290,122	204	183.20	1.11	36	115,366	163	156.38	1.04	-60.24%	-20.10%	-6.31%
210028	MedStar St. Mary's	29	133,444	50	72.46	0.69	28	65,679	45	63.80	0.71	-50.78%	-10.00%	2.90%
210029	JH Bayview	43	520,336	290	318.84	0.91	41	191,072	240	268.79	0.89	-63.28%	-17.24%	-2.20%
210030	UM-Chestertown	12	11,419	11	9.91	1.11	11	9,091	8	8.37	0.96	-20.39%	-27.27%	-13.51%
210032	Union of Cecil	27	91,039	65	55.85	1.16	26	44,482	59	48.95	1.21	-51.14%	-9.23%	4.31%
210033	Carroll	39	241,876	166	128.85	1.29	31	92,492	140	105.07	1.33	-61.76%	-15.66%	3.10%
210034	MedStar Harbor	31	136,275	89	80.25	1.11	30	70,066	74	70.14	1.05	-48.58%	-16.85%	-5.41%

Draft Maryland Hospital-Acquired Conditions Program Recommendations for Rate Year 2020

CMS ID	HOSPITAL NAME	Model 1 No Changes					Model 2 80% APR-DRG-PPC					Percent Differences Model 1 vs Model 2		
		# PPCs	At-Risk	OBS. Base Pd.	EXP. Base Pd.	O/E Ratio	# PPCs	At-Risk	OBS. Base Pd.	EXP. Base Pd.	O/E Ratio	AT-RISK BASE PERIOD	OBS. Base Pd.	O/E Ratio
210035	UM-Charles Regional	33	138,420	59	79.14	0.75	29	61,515	47	64.68	0.73	-55.56%	-20.34%	-2.67%
210037	UM-Easton	30	145,344	99	81.45	1.22	28	73,837	85	69.42	1.22	-49.20%	-14.14%	0.00%
210038	UMMC Midtown	27	78,759	54	66.67	0.81	26	35,932	50	58.46	0.86	-54.38%	-7.41%	6.17%
210039	Calvert	25	79,266	35	42.60	0.82	22	39,434	31	34.99	0.89	-50.25%	-11.43%	8.54%
210040	Northwest	37	269,837	96	124.33	0.77	29	98,722	82	98.52	0.83	-63.41%	-14.58%	7.79%
210043	UM-BWMC	42	429,757	296	299.30	0.99	41	174,472	262	257.28	1.02	-59.40%	-11.49%	3.03%
210044	GBMC	44	472,241	283	233.11	1.21	37	180,205	238	194.66	1.22	-61.84%	-15.90%	0.83%
210048	Howard County	43	452,022	208	192.40	1.08	40	172,598	173	161.11	1.07	-61.82%	-16.83%	-0.93%
210049	UM-Upper Chesapeake	43	289,973	159	186.81	0.85	36	113,771	124	155.88	0.80	-60.76%	-22.01%	-5.88%
210051	Doctors	40	248,769	149	184.76	0.81	34	99,628	129	151.10	0.85	-59.95%	-13.42%	4.94%
210055	UM-Laurel	26	64,358	58	45.03	1.29	24	31,946	51	38.64	1.32	-50.36%	-12.07%	2.33%
210056	MedStar Good Sam	41	240,814	158	172.70	0.91	34	106,918	138	145.74	0.95	-55.60%	-12.66%	4.40%
210057	Shady Grove	43	458,572	233	223.66	1.04	40	184,776	198	191.67	1.03	-59.71%	-15.02%	-0.96%
210058	UMROI	23	47,786	60	53.92	1.11	23	44,548	59	52.61	1.12	-6.78%	-1.67%	0.90%

Draft Maryland Hospital-Acquired Conditions Program Recommendations for Rate Year 2020

CMS ID	HOSPITAL NAME	Model 1 No Changes					Model 2 80% APR-DRG-PPC					Percent Differences Model 1 vs Model 2		
		# PPCs	At-Risk	OBS. Base Pd.	EXP. Base Pd.	O/E Ratio	# PPCs	At-Risk	OBS. Base Pd.	EXP. Base Pd.	O/E Ratio	AT-RISK BASE PERIOD	OBS. Base Pd.	O/E Ratio
210060	Ft. Washington	18	24,232	16	19.48	0.82	15	14,545	13	14.59	0.89	-39.98%	-18.75%	8.54%
210061	Atlantic General	25	47,780	28	39.47	0.71	22	26,028	27	32.07	0.84	-45.53%	-3.57%	18.31%
210062	MedStar Southern MD	41	281,292	217	136.34	1.59	31	97,036	194	109.87	1.77	-65.50%	-10.60%	11.32%
210063	UM-St. Joe	44	432,558	299	298.58	1.00	40	183,182	276	263.20	1.05	-57.65%	-7.69%	5.00%
210064	Levindale	15	15,702	83	32.25	2.57	14	11,674	79	30.75	2.57	-25.65%	-4.82%	0.00%
210065	HC-Germantown	27	83,235	48	48.03	1.00	25	40,741	39	40.44	0.96	-51.05%	-18.75%	-4.00%
	<b>STATEWIDE Totals</b>		<b>13,220,025</b>	<b>8,688</b>	<b>8,685.08</b>	<b>1.00</b>		<b>5,405,445</b>	<b>7,429</b>	<b>7,417.72</b>	<b>1.00</b>	<b>-59.11%</b>	<b>-14.49%</b>	<b>0.00%</b>
	<b>STATEWIDE Median</b>	<b>41</b>					<b>34</b>							

Appendix VIII. Hospital MHAC Scores and Revenue Adjustments (RY 2019 Base and YTD September Performance)

CMS ID	HOSPITAL NAME	RY17 Permanent Inpatient Revenue	Model 1 No Changes			Model 2 80% APR-DRG-PPC			Simple Differences Model 1 vs Model 2	
			FINAL Weighted SCORE	% Adjustment	Revenue Adjustment	FINAL Weighted SCORE	% Adjustment	Revenue Adjustment	FINAL Weighted SCORE	Revenue Adjustment
210062	MedStar Southern MD	\$163,339,853	27%	-0.80%	-\$1,306,719	27%	-0.80%	\$1,306,719	0%	\$0
210064	Levindale	\$54,805,171	32%	-0.58%	-\$316,652	29%	-0.71%	-\$389,726	-3%	-\$73,074
210024	MedStar Union Mem	\$231,121,787	34%	-0.49%	-\$1,129,929	37%	-0.36%	-\$821,766	3%	\$308,162
210033	Carroll	\$116,510,378	34%	-0.49%	-\$569,606	38%	-0.31%	-\$362,477	4%	\$207,130
210027	Western Maryland	\$171,858,929	35%	-0.44%	-\$763,817	39%	-0.27%	-\$458,290	4%	\$305,527
210048	Howard County	\$176,085,796	29%	-0.71%	-\$1,252,166	41%	-0.18%	-\$313,041	12%	\$939,124
210001	Meritus	\$185,173,878	39%	-0.27%	-\$493,797	46%	0.00%	\$0	7%	\$493,797
210002	UMMC	\$874,727,573	34%	-0.49%	-\$4,276,446	54%	0.00%	\$0	20%	\$4,276,446
210005	Frederick	\$178,853,951	47%	0.00%	\$0	52%	0.00%	\$0	5%	\$0
210012	Sinai	\$397,073,246	32%	-0.58%	-\$2,294,201	48%	0.00%	\$0	16%	\$2,294,201
210013	Bon Secours	\$62,008,295	43%	-0.09%	-\$55,118	54%	0.00%	\$0	11%	\$55,118
210015	MedStar Fr Square	\$287,510,180	45%	0.00%	\$0	47%	0.00%	\$0	2%	\$0
210022	Suburban	\$189,851,798	41%	-0.18%	-\$337,514	48%	0.00%	\$0	7%	\$337,514
210029	JH Bayview	\$348,529,477	48%	0.00%	\$0	55%	0.00%	\$0	7%	\$0
210030	UM-Chestertown	\$18,989,104	50%	0.00%	\$0	54%	0.00%	\$0	4%	\$0
210044	GBMC	\$216,554,825	38%	-0.31%	-\$673,726	49%	0.00%	\$0	11%	\$673,726
210057	Shady Grove	\$219,319,153	50%	0.00%	\$0	55%	0.00%	\$0	5%	\$0
210058	UMROI	\$67,555,816	52%	0.00%	\$0	55%	0.00%	\$0	3%	\$0
210034	MedStar Harbor	\$107,761,881	47%	0.00%	\$0	56%	0.02%	\$23,947	9%	\$23,947
210063	UM-St. Joe	\$234,995,507	53%	0.00%	\$0	56%	0.02%	\$52,221	3%	\$52,221

Draft Maryland Hospital-Acquired Conditions Program Recommendations for Rate Year 2020

CMS ID	HOSPITAL NAME	RY17 Permanent Inpatient Revenue	Model 1 No Changes			Model 2 80% APR-DRG-PPC			Simple Differences Model 1 vs Model 2	
			FINAL Weighted SCORE	% Adjustment	Revenue Adjustment	FINAL Weighted SCORE	% Adjustment	Revenue Adjustment	FINAL Weighted SCORE	Revenue Adjustment
210004	Holy Cross	\$339,593,506	59%	0.09%	\$301,861	62%	0.16%	\$528,257	3%	\$226,396
210008	Mercy	\$216,281,427	54%	0.00%	\$0	63%	0.18%	\$384,500	9%	\$384,500
210032	Union of Cecil	\$68,179,037	61%	0.13%	\$90,905	63%	0.18%	\$121,207	2%	\$30,302
210051	Doctors	\$132,931,890	61%	0.13%	\$177,243	64%	0.20%	\$265,864	3%	\$88,621
210019	Peninsula	\$235,729,906	51%	0.00%	\$0	66%	0.24%	\$576,229	15%	\$576,229
210040	Northwest	\$125,696,184	61%	0.13%	\$167,595	66%	0.24%	\$307,257	5%	\$139,662
210011	St. Agnes	\$233,151,492	65%	0.22%	\$518,114	67%	0.27%	\$621,737	2%	\$103,623
210056	MedStar Good Sam	\$158,579,215	65%	0.22%	\$352,398	67%	0.27%	\$422,878	2%	\$70,480
210009	Johns Hopkins	\$1,357,164,899	49%	0.00%	\$0	68%	0.29%	\$3,920,699	19%	\$3,920,699
210016	Washington Adventist	\$150,097,509	66%	0.24%	\$366,905	68%	0.29%	\$433,615	2%	\$66,710
210038	UMMC Midtown	\$114,950,934	70%	0.33%	\$383,170	68%	0.29%	\$332,080	-2%	-\$51,089
210018	MedStar Montgomery	\$79,298,762	62%	0.16%	\$123,354	69%	0.31%	\$246,707	7%	\$123,354
210039	Calvert	\$63,319,998	62%	0.16%	\$98,498	69%	0.31%	\$196,996	7%	\$98,498
210043	UM-BWMC	\$227,399,457	58%	0.07%	\$151,600	70%	0.33%	\$757,998	12%	\$606,399
210028	MedStar St. Mary's	\$77,346,008	71%	0.36%	\$275,008	71%	0.36%	\$275,008	0%	\$0
210049	UM-Upper Chesapeake	\$133,152,736	62%	0.16%	\$207,126	71%	0.36%	\$473,432	9%	\$266,305
210065	HC-Germantown	\$62,086,212	63%	0.18%	\$110,375	71%	0.36%	\$220,751	8%	\$110,375
210003	UM-PGHC	\$215,010,869	67%	0.27%	\$573,362	72%	0.38%	\$812,263	5%	\$238,901
210060	Ft. Washington	\$19,371,986	76%	0.47%	\$90,403	72%	0.38%	\$73,183	-4%	-\$17,220
210061	Atlantic General	\$38,966,012	72%	0.38%	\$147,205	72%	0.38%	\$147,205	0%	\$0
210035	UM-Charles Regional	\$68,387,041	68%	0.29%	\$197,563	74%	0.42%	\$288,745	6%	\$91,183
210037	UM-Easton	\$100,000,562	67%	0.27%	\$266,668	74%	0.42%	\$422,225	7%	\$155,556

Draft Maryland Hospital-Acquired Conditions Program Recommendations for Rate Year 2020

CMS ID	HOSPITAL NAME	RY17 Permanent Inpatient Revenue	Model 1 No Changes			Model 2 80% APR-DRG-PPC			Simple Differences Model 1 vs Model 2	
			FINAL Weighted SCORE	% Adjustment	Revenue Adjustment	FINAL Weighted SCORE	% Adjustment	Revenue Adjustment	FINAL Weighted SCORE	Revenue Adjustment
210006	UM-Harford	\$46,975,749	76%	0.47%	\$219,220	77%	0.49%	\$229,659	1%	\$10,439
210017	Garrett	\$21,836,267	64%	0.20%	\$43,673	77%	0.49%	\$106,755	13%	\$63,083
210023	Anne Arundel	\$296,168,973	72%	0.38%	\$1,118,861	77%	0.49%	\$1,447,937	5%	\$329,077
210055	UM-Laurel	\$59,724,224	59%	0.09%	\$53,088	77%	0.49%	\$291,985	18%	\$238,897
210010	UM-Dorchester	\$24,256,573	74%	0.42%	\$102,417	78%	0.51%	\$123,978	4%	\$21,561
	<b>Statewide Median</b>		<b>58%</b>			<b>64%</b>				

<b>State Total</b>		<b>-\$7,333,081</b>	<b>State Total</b>		<b>\$10,453,300</b>
Penalty		\$13,469,692	Penalty		-\$3,652,019
% Inpatient			% Inpatient		
Reward		\$6,136,611	Reward		\$14,105,319
% Inpatient			% Inpatient		



January 5, 2018

Ms. Donna Kinzer, Executive Director  
Health Services Cost Review Commission

Mr. Nelson Sabatini, Chairman  
Health Services Cost Review Commission

Dear Ms. Kinzer and Chairman Sabatini:

*This letter is being filed on behalf of:*

- *LifeBridge Health - Sinai Hospital of Baltimore, Carroll Hospital, Northwest Hospital, Levindale Hebrew Geriatric Center & Hospital*
- *Adventist HealthCare System - Washington Adventist Hospital, Shady Grove Medical Center, Germantown Emergency Center*
- *Peninsula Regional Health System*
- *Union Hospital Cecil County*
- *Frederick Regional Health System*

The purpose of this letter is to offer our comments on the ideas proposed in the white paper introduced by Commissioners Colmers and Keane (C-K) at the November 2017 Commission meeting.

The C-K paper offers many valuable suggestions. However, we believe that its core proposal – reintroducing a direct linkage between volume and revenue – would take the State backwards, undermining many of the cost savings and care improvements that have resulted from the Global Budget Revenue (GBR) methodology. Indeed, we believe that to reintroduce a 50% variable cost factor as they recommend will jeopardize the State’s ability to meet the terms of the proposed new agreement with CMS and could ultimately endanger the All Payer Model. We also have concerns about the C-K paper’s proposed approach to rate realignment, incentives for reductions in potentially avoidable utilization (PAUs) and quality metrics.

As you know, Maryland’s All Payer Model, implemented in January 2014, has proven to be highly successful. Designed to change the economic incentives from a volume-based approach to an emphasis on value in the delivery of services, the State agreed to a cap on revenue for the entire hospital system and to implement population-based payment methods. The goal was to provide strong incentives for hospitals to improve quality and to promote coordination with other providers, shifting economic incentives toward improving care rather than driving volume. Under the GBR model, the State has achieved or exceeded the quality improvements required of the system and has substantially exceeded the financial savings required by Medicare. Other payers, and ultimately patients, have benefited substantially from both the financial and the quality outcomes that the GBR model has produced.

#### *Volume*

To implement the GBR model, the HSCRC entered into hospital-specific agreements that define the key terms under which the GBR would operate. This proposal effectively abrogates those agreements, even though they form the basis for much planning, strategy and investment on the part of the State’s hospitals. Hospitals entering into these agreements did so with the understanding that this policy was put into place to change the economic incentives under the All Payer Model. This proposal seems to reverse those incentives that were so carefully designed, and it seems inconsistent with the goals of the Phase II model going forward.

Had the HSCRC moved to a 50% variable cost factor as the initial paradigm for the All Payer Model, it is unlikely that the system would have experienced the volume reductions that have been seen across most hospitals. Those volume reductions have only been achieved through serious – and expensive – efforts on the part of the State’s hospitals to coordinate care, improve patient transitions, and promote population health. As the Commission is well aware, hospitals have made massive investments in a vast array of programs aimed at reducing utilization of hospital services, particularly inpatient and emergency care. While some of these programs have been able to make a near-immediate impact, in many cases the impact will be seen only over many years. It is only because hospitals have been able to retain their full GBR amounts up to the specified corridors that they have been able to fully fund these initiatives. A 50% variable cost factor would take away all or nearly all of the cost savings realized from volume reductions, leaving insufficient to fund preventive and population health activities, especially when total revenue growth within the system is constrained.

It is important to remember that the current system does contain meaningful limits on hospitals’ ability to retain revenue in the face of volume reductions – most significantly, the rate corridors that limit unit prices. With volume declines, the only method for achieving the global budget is to increase charges, but the HSCRC staff limits those charges to a maximum 10% increase. If higher prices are required, hospitals have not been able to realize all the revenue under their approved budget.

Additionally, the Medicare Performance Adjustment (MPA) will limit hospital revenue if the HSCRC’s expectations for total cost of care performance for attributed patients are not met.

The C-K paper also recommends eliminating the demographic adjustment, suggesting that legitimate increases in demand should be funded solely through the variable cost adjustment. We believe this is inappropriate. There are legitimate reasons for per capita cost growth such as aging of the population. As discussed above, only by retaining the full GBR amount can hospitals gain the funds needed to invest in preventive care and other population health activities. Under the C-K proposal, for hospitals facing demographically-driven increases in demand, the only way to fund these increases in volume going forward will be to cut services for patients or reduce investments in care coordination and population health activities. Surely this is not the outcome the Commission seeks.

Finally, using the update factor or overall system controls as a safety valve for controlling system performance has the potential to create a perverse incentive. A system governor on volume, without individual hospital accountability, can create an incentive for hospitals to race to increase volume, vying to capture a larger slice of the pie before any system correction is applied. This approach could inadvertently create a “tragedy of the commons” problem that is not an issue under current policy.

#### *Rate Realignment*

The C-K paper correctly notes that rate realignment has not occurred for some time, in large part because of a desire to preserve the State’s performance on Medicare performance metrics. The paper correctly identifies a number of items that need to be fixed through rate realignment. The C-K paper acknowledges that these adjustments could have negative effects on the system’s measured Medicare performance, but suggests that the update factor could be used to offset the effect of realignment on Medicare performance. We believe that the update factor is the wrong way to deal with the impact of rate realignment on Medicare performance metrics. Other payers have been substantial beneficiaries of the All Payer Model, as the Commission has constrained hospital rates to meet Medicare savings requirements.

Congressionally-mandated limits on Medicare payment rates nationally have effectively capped Maryland rate increases at levels well below the 3.58% originally contemplated. These constraints have resulted in savings of over \$1 billion for the non-Medicare payers. Accordingly, rather than reducing payments across the board through the update factor, the proper method of addressing the impact on Medicare



savings from rate realignment would be to change the Medicare differential. This approach would allow a cost-based rationalization of rates while preserving the system's Medicare gains to date.

#### *Potentially Avoidable Utilization*

The C-K proposal calls for an expanded definition of potentially avoidable utilization, arguing that the current definition is too narrow, inpatient-centric, and highly dependent on the primary care resources present in a hospital's service area. The proposed solution is to allow hospitals to construct their own utilization measures of unnecessary care and the proportion that could be successfully eliminated over a specific time frame.

The proposed approach sounds appealing on the surface but is not a viable program. Putting aside potential legal and financial liability arising from providers acknowledging that they have been providing unnecessary services, the suggested approach is likely to create an administrative nightmare. With an agency staff that is already stretched thin, the PAU program envisioned in the C-K proposal is likely to be difficult to monitor, and the enforcement of different definitions across hospitals could create substantial inequities. We could envision an approach, however, that expands the PAU definition based on scientific research combined with analysis of Maryland data, applied to the entire system with appropriate economic incentives. The Commission could convene a task force of stakeholder representatives (with both clinical and financial members) to undertake this assignment.

#### *Quality*

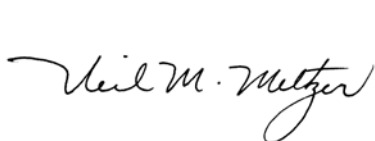
For quality, efforts to align measurement under the All Payer Model with the federal system would simplify hospital compliance and potentially improve Maryland performance under national comparisons.

#### *Conclusion*

In summary, while we can support many elements of the C-K paper, we believe it includes several items – most notably, the proposal to reintroduce a 50% variable cost factor – that would move the system backwards, undermine the gains achieved to date, and impair hospitals' ability to achieve the goals of the next iteration of the All Payer Model.

We welcome the Commissioners' review of the current model's performance and a debate on its merits. We appreciate the opportunity to offer our initial comments and look forward to providing additional input if there is further detail supporting the whitepaper concepts. If you have any questions, please contact us.

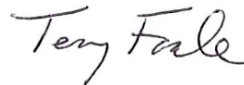
Sincerely,



Neil M. Meltzer  
President & CEO  
LifeBridge Health



Richard C. Szumel, M.D.  
President & CEO  
Union Hospital Cecil County



Terry Forde  
President & CEO  
Adventist HealthCare System



Thomas A. Kleinhanzl  
President & CEO  
Frederick Regional Health System



Steven Leonard  
President & CEO  
Peninsula Regional Health System

cc: Mike Robbins, MHA  
Meghan Allen, MHA



MedStar Health

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Columbia, MD 21044  
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January 5, 2018

Nelson Sabatini, Chairman  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Chairman Sabatini:

We appreciate the opportunity to provide our initial comments on the ideas proposed in the white paper introduced by Commissioners Colmers and Keane (C-K) at the November 2017 Commission meeting. As you are aware, this white paper includes an extensive list of recommendations which would have significant implications for healthcare in the state of Maryland. Although we are providing initial feedback, we believe a more detailed analysis and thoughtful review process involving Commissioners, HSCRC staff, hospitals and other stakeholders is required.

The C-K paper offers many valuable suggestions; however, we believe that its core proposal – reintroducing a direct linkage between volume and revenue – would take the State backwards, potentially reversing many of the cost savings and care improvements that have resulted from the Global Budget Revenue (GBR) methodology. We also have concerns about the C-K paper's proposed approach to rate realignment, potentially avoidable utilization (PAUs) reductions and quality metrics.

As you know, Maryland's All Payer Model, implemented in January 2014, has proven to be highly successful. Designed to change the economic incentives from a volume-based approach to an emphasis on value in the delivery of services, the State agreed to cap revenue for the entire hospital system and to implement population-based payment methods. The goal was to provide strong incentives for hospitals to improve quality and to promote coordination with other providers, shifting economic incentives toward improving care rather than driving volume. Under the GBR model, the State has achieved or exceeded the quality improvements required of the system and has exceeded the financial savings required by Medicare. Other payers, and ultimately patients, have benefited substantially from both the financial and the quality outcomes that the GBR model has produced.

*Volume*

To implement the GBR model, the HSCRC entered into hospital-specific agreements that define the key terms under which the GBR would operate. Hospitals entering into these agreements did so with the understanding that this policy was a long-term, fundamental change, put into

*Knowledge and Compassion*  
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place to change the economic incentives, provider behavior and care design under the All Payer Model. This proposal seems to reverse those incentives that were so carefully designed, and it seems inconsistent with the goals of the Phase II model going forward. We recognize the current market share policy is not perfect and believe that improvements could be made; however, the proposed reintroduction of a policy that directly links revenue to volume, defining market share based on a simple activity count, is not the answer.

Had the HSCRC moved to a 50% variable cost factor proposed in the C-K white paper as the initial paradigm for the All Payer Model, it is unlikely that the system would have experienced the volume reductions that have been seen across most hospitals. Those volume reductions have only been achieved through thoughtful planning, investment, and execution on the part of the State's hospitals to coordinate care, improve patient transitions, and promote population health. As the Commission is aware, hospitals have made significant investments in a vast array of programs aimed at reducing utilization of hospital services, particularly inpatient and emergency care, and providing alternative care delivery settings such as house call programs and urgent care sites. While some of these programs have been able to make a near-immediate impact, in many cases the impact will be seen only over many years. It is only because hospitals have been able to retain their full GBR amounts up to the specified corridors that they have been able to fund these initiatives. A 50% variable cost factor would take away all or nearly all of the cost savings realized from volume reductions, leaving insufficient funding for preventative and population health activities, especially when total revenue growth within the system is constrained.

It is important to remember that the current system does contain additional meaningful limits on hospitals' ability to retain revenue in the face of volume reductions – most significantly, the rate corridors that limit unit prices. With volume declines, the only method for achieving the global budget is to increase charges, but the HSCRC staff limits those charges. Additionally, the recently approved Medicare Performance Adjustment (MPA) Policy that aligns with Phase 2 of the Waiver will limit hospital revenue if the HSCRC's expectations for total cost of care performance for attributed patients are not met.

The C-K paper also recommends eliminating the demographic adjustment, suggesting that legitimate increases in demand should be funded solely through the variable cost adjustment. We believe this is inappropriate. There are legitimate reasons for per capita cost growth, such as aging of the population. As discussed above, only by retaining the full GBR amount can hospitals maintain the funds needed to invest in preventative care and other population health activities. Under the C-K proposal, for hospitals facing demographically-driven increases in demand, the only way to fund these increases in volume going forward will be to cut services for patients or reduce investments in care coordination and population health activities.

Finally, using the update factor or overall system controls as a safety valve for controlling system performance has the potential to create a perverse incentive. A system governor on volume, without individual hospital accountability, can create an incentive for hospitals to race to increase volume, vying to capture a larger slice of the pie before any system correction is applied.

### *Rate Realignment*

The C-K paper correctly notes that rate realignment has not occurred for some time, in large part because of a desire to preserve the State's performance on Medicare performance metrics. The paper correctly identifies a number of items that need to be fixed through rate realignment. The C-K paper acknowledges that these adjustments could have negative effects on the system's measured Medicare performance, but suggests that the update factor could be used to offset the effect of realignment on Medicare performance.

We believe that there is a better way than the update factor to deal with the impact of rate realignment on Medicare performance metrics. Other payers have been substantial beneficiaries of the All Payer Model, as the Commission has constrained hospital rates to meet Medicare savings requirements. Congressionally-mandated limits on Medicare payment rates nationally have effectively capped Maryland rate increases at levels well below the 3.58% originally contemplated. These constraints have resulted in estimated savings of over \$1 billion for the non-Medicare payers. Accordingly, rather than reducing payments across the board through the update factor, we believe an adjustment to the Medicare differential would be a more appropriate method of addressing the impact on Medicare savings from rate realignment. This approach would allow a cost-based rationalization of rates while preserving the system's Medicare gains to date.

### *Potentially Avoidable Utilization*

The C-K proposal calls for an expanded definition of potentially avoidable utilization, arguing that the current definition is too narrow, inpatient-centric, and highly dependent on the primary care resources present in a hospital's service area. The proposed solution is to allow hospitals to construct their own utilization measures of unnecessary care and the proportion that could be successfully eliminated over a specific time frame.

The proposed approach sounds appealing on the surface but is difficult to implement. With an agency staff that is already stretched thin, the PAU program envisioned in the C-K proposal is likely to be difficult to monitor, and the enforcement of different definitions across hospitals could create substantial inequities. However, we could envision an approach that expands the PAU definition based on scientific research combined with analysis of Maryland data, applied to the entire system with appropriate economic incentives. The Commission could convene a task force of stakeholder representatives (with both clinical and financial members) to undertake this assignment.

### *Quality*

For quality measurements, our clinical leaders strongly support alignment with the federal system and believe it would enable Maryland to show improvement in performance under national comparisons. It would also allow for more consistent communication with our clinical providers as we prioritize our quality and safety objectives.

*Conclusion*

In summary, while we can support elements of the C-K paper, we believe it includes several items – most notably, the proposal to reintroduce a volume based approach – that would move the system backwards, reverse the gains achieved to date, and impair hospitals' ability to achieve the goals of the next iteration of the All Payer Model.

We appreciate the opportunity to offer our initial comments and we would welcome the opportunity to participate in a stakeholder group to further review the details of the whitepaper and perhaps develop other alternative solutions to issues of concern. We look forward to working cooperatively with you, the Commission and staff as we move forward together.

Sincerely,



Kenneth A. Samet  
President and CEO  
MedStar Health



Susan K. Nelson  
Executive Vice President and CFO  
MedStar Health

cc: Donna Kinzer  
Executive Director  
Maryland Health Services Cost Review Commission

**Chet Burrell**  
President and Chief Executive Officer

**CareFirst BlueCross BlueShield**  
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December 13, 2017

Nelson J. Sabatini, Chairman  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Chairman Sabatini:

I am writing to express our preliminary comments on the outline entitled "Review, Comments and Recommendations Regarding HSCRC Rate Setting Policies" (the "Outline") included in the pre-meeting packet for the Commission's December 2017 public meeting.

As the State embarks on Phase 2 of the All-Payer Model, we agree with your assessment that it is appropriate to review the HSCRC's core policies and methodologies to make sure they are reasonable, understandable, predictable and effective. We commend the Commission for taking this opportunity to engage in this examination and to initiate a process to improve the overall functionality of the rate setting system.

Based on our preliminary reading of the Outline, we believe the recommended policy modifications to be sensible and appear in many cases, to be consistent with suggested changes that CareFirst has offered to the Commission over the past several years. We would offer the following preliminary observations below:

As noted in the Outline, the MSA has failed to generate timely, predictable and appropriate adjustments for shifts in volumes among hospitals. In the past, we have been strong proponents of the use of Variable Cost Factors (VCFs) that are predictable and timely in order to provide hospitals with rate adjustments which reflect volume-related changes in their cost structures. We believe the use of VCFs can achieve these objectives.

We have consistently encouraged the HSCRC to broaden its definition of PAUs to include additional categories of unnecessary care, such as certain diagnostic tests and imaging services, and surgical and non-surgical procedures. We support a move to expand the definition of PAU and other modifications to the current PAU Savings Policy to improve the overall fairness of this methodology.

We have been concerned with the HSCRC's departure in recent years from rate setting methodologies that align with costs in efforts to meet the State's Medicare Waiver Test. A return to the establishment of cost-based rates by revenue center will create a fairer overall system, help

improve resource allocation decisions by hospitals and promote the efficient and effective provision of hospitals services.

While the HSCRC's quality-based payment initiatives are important policy tools, the growing complexity of these methodologies has worked to obscure and dilute the financial incentives presented to hospitals. We support attempts to streamline and enhance these methodologies so that financial incentives are clear and to assure that the policies do not discriminate against hospitals that serve large proportions of economically disadvantaged patients.

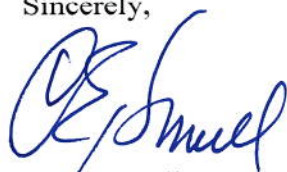
At recent HSCRC meetings we have expressed serious concerns regarding the overall efficacy of the HSCRC's Medicare Performance Adjustment (MPA) methodology. In particular, we believe that the staff's multi-level attribution algorithm: 1) fails to establish any coherent or actionable care management link between beneficiaries and hospitals; 2) will generate hospital-specific Medicare Total Cost of Care (TCOC) Target Budgets that are unstable from year to year; and 3) will not provide the budgetary accountability necessary for the successful control TCOC growth in Phase 2. Thus, we strongly encourage the HSCRC to investigate alternative approaches for establishing hospital accountability for overall Medicare TCOC.

In sum, we support the principles articulated in the Outline for clarifying and improving the HSCRC's current rate setting methodologies. We share concern with the extreme complexity of current rate setting programs and with methodologies that are not well understood by industry participants.

The proposed timing of the consideration and eventual implementation of any policy modifications deemed appropriate by the HSCRC seems sensible and feasible. CareFirst expects to be active in the discussion of the proposed changes and we look forward to participating in what we anticipate will be a robust and open review process. We also appreciate your invitation to join other interested parties in providing more extensive comments on the discussion in time for consideration of these proposals at the February public meeting.

We strongly encourage you to pursue the direction on the topics raised in your outline and look forward to participating in the subsequent discussions of these topics.

Sincerely,



Chet Burrell  
President & CEO

Cc: Joseph Antos  
Victoria Bayless  
George Bone  
John Colmers  
Adam Kane  
Jack Keane



# MARYLAND Department of Health

Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

## **Update: Maryland Total Cost of Care Medicare Model Contract Negotiations**

**January 8, 2018**

The federal government has agreed to approve a one-year extension of Maryland's All-Payer Hospital Model Contract. The mutually agreed-upon extension of time will allow the federal government to complete its review and to consider four years of performance through the end of 2017. The Centers for Medicare & Medicaid Services (CMS) will have the opportunity to evaluate 2017 Medicare data in early 2018. Maryland's current All-Payer Hospital Model Contract and amendments will be extended from an expiration date of December 31, 2018 to December 31, 2019, and a savings target consistent with the first five of the years of the model will be agreed to.

Working together, CMS and Maryland are actively discussing development of the next phase of the model to extend efforts beyond hospitals. Maryland and CMS are committed to improving residents' health and healthcare quality while reducing costs. The Maryland-proposed Total Cost of Care (TCOC) Model is an innovative Medicare per capita savings model aimed at maintaining financial stability in rural hospitals and providing opportunities for health care providers to transform care delivery model by improving health and quality. The continuing federal/Maryland negotiations incorporate the latest directions received from stakeholders in the hospital, physician, insurance, and patient sectors, as well as from federal partners.

CMS and Maryland anticipate executing the All-Payer Medicare Model Contract extension at the beginning of 2018, and will work on proceeding forward with the following common priorities:

- **Further discussions of the TCOC model, including the Maryland Primary Care Program, by CMS and the U.S. Department of Health and Human Services.** Should the TCOC model be finalized and executed in 2018, it will take effect at a mutually agreeable start date.
- **Additional updates to the Care Redesign Participation Agreement,** including efforts to obtain MACRA eligibility for Care Redesign Program participants.



State of Maryland  
Department of Health

Nelson J. Sabatini  
Chairman

Joseph Antos, PhD  
Vice-Chairman

Victoria W. Bayless

John M. Colmers

Adam Kane

Jack C. Keane



**Health Services Cost Review Commission**

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Executive Director

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Allan Pack, Director  
Population Based  
Methodologies

Chris Peterson, Director  
Clinical & Financial  
Information

Gerard J. Schmith, Director  
Revenue & Regulation  
Compliance

**TO: Commissioners**

**FROM: HSCRC Staff**

**DATE: January 10, 2018**

**RE: Hearing and Meeting Schedule**

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February 14, 2018 To be determined - 4160 Patterson Avenue  
HSCRC/MHCC Conference Room

March 14, 2018 To be determined - 4160 Patterson Avenue  
HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:15 a.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 at <http://hsrcr.maryland.gov/Pages/commission-meetings.aspx>.

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