

State of Maryland
Department of Health and Mental Hygiene



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Health Services Cost Review Commission

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**537th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
February 8, 2017**

EXECUTIVE SESSION

11:00 a.m.

(The Commission will begin in public session at 11:00 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. Update on the Primary Care Model - 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. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104**
- 4. Personnel Matters – Authority General Provisions Article, §3-305 (b) (1)**
- 5. Discussion of Legislative Process – Authority General Provisions Article, §3-103 and §3-104**

PUBLIC SESSION

1:00 p.m.

- 1. Review of the Minutes from the Public Meeting and Executive Session on December 14, 2016**
- 2. Executive Director's Report**
- 3. New Model Monitoring**
- 4. Docket Status – Cases Closed**

2357A - Hopkins Health Advantage	2365A - University of Maryland Medical Center
2366A - Johns Hopkins Health System	2367A - Johns Hopkins Health System
2368A - Johns Hopkins Health System	
- 5. Docket Status – Cases Open**

2369A - Johns Hopkins Health System	2370A - Johns Hopkins Health System
2371R – MedStar Franklin Square Medical Center	2372A – Doctors Community Hospital
2373A – University of Maryland Medical Center	2374A - Johns Hopkins Health System
2375A - Johns Hopkins Health System	2376A - Johns Hopkins Health System
2377A - Johns Hopkins Health System	

- 6. Confidential Data Request**
- 7. Report on the Nursing Support Program I (NSP I)**
- 8. Final Recommendation for Updating the Quality-based Reimbursement Program for RY 2018 and RY 2019**
- 9. Draft Recommendation for the Maryland Hospital Acquired Condition (MHAC) Policy for RY 2019**
- 10. Legislative Update**
- 11. Recommendation on Implementation of Care Redesign Amendment**
- 12. CRISP Update**
- 13. Hearing and Meeting Schedule**

Executive Director's Report

The Executive Director's Report will be distributed during the Commission Meeting

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

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 JANUARY 31, 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
2369A	Johns Hopkins Health System	11/23/2016	N/A	N/A	N/A	DNP	OPEN
2370A	Johns Hopkins Health System	11/28/2016	N/A	N/A	N/A	DNP	OPEN
2371R	MedStar Franklin Square Medical Center	12/23/2016	3/8/2017	5/22/2017	Capital	GS	OPEN
2372A	Doctors Community Hospital	1/5/2017	N/A	N/A	N/A	DK	OPEN
2373A	University of Maryland Medical Center	1/4/2017	N/A	N/A	N/A	DNP	OPEN
2374A	Johns Hopkins Health System	1/18/2017	N/A	N/A	N/A	DNP	OPEN
2375A	Johns Hopkins Health System	1/18/2017	N/A	N/A	N/A	DNP	OPEN
2376A	Johns Hopkins Health System	1/18/2017	N/A	N/A	N/A	DNP	OPEN
2377A	Johns Hopkins Health System	1/18/2017	N/A	N/A	N/A	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

**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: 2016
* FOLIO: 2170
* PROCEEDING: 2369A**

Staff Recommendation

February 8, 2017

INTRODUCTION

Johns Hopkins Health System (System) filed a renewal application with the HSCRC on November 23, 2016 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") 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 with mental health needs under the program title, Creative Alternatives. The arrangement is between the Johns Hopkins Health System and the Baltimore Mental Health Systems, Inc., with the services coordinated through the Hospital. The requested approval is for a period of one year beginning January 1, 2017.

II. OVERVIEW OF APPLICATION

The parties to the contract include the System and the Baltimore Mental Health Systems, Inc. Creative Alternatives provides a range of support services for persons diagnosed with mental illness and covers medical services delivered through the Hospital. The System will assume the risk under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF FINDINGS

Staff found that the experience under this arrangement for FY 2015 was slightly unfavorable. However, staff believes that the Hospital can achieve a favorable performance under this arrangement.

IV. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's renewal application for an alternative method of rate determination for a one year period commencing January 1, 2017.

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: 2016
* FOLIO: 2180
* PROCEEDING: 2370A**

Staff Recommendation

February 8, 2017

I. INTRODUCTION

Johns Hopkins Health System (the System) filed a renewal application with the HSCRC on November 28, 2016 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, 2017.

II. OVERVIEW OF APPLICATION

The parties to the contract include the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare, a subsidiary of the System. The program provides a range of health care services for persons insured under Tricare including inpatient and outpatient hospital services. Johns Hopkins Health Care will assume the risk under the agreement, and the Hospitals will be paid based on their approved HSCRC rates.

III. STAFF EVALUATION

Staff found that the experience under this arrangement to be favorable for the last year. Staff believes that the Hospitals can continue to achieve favorable performance under this arrangement.

V. STAFF RECOMMENDATION

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, 2017. 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.

**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: 2183
* PROCEEDING: 2373A**

Staff Recommendation

February 8, 2017

I. INTRODUCTION

The University of Maryland Medical Center (“the Hospital”) filed an application with the HSCRC on January 4, 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, 2017.

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, 2017. 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: 2184
* PROCEEDING: 2374A**

Staff Recommendation

February 8, 2017

I. INTRODUCTION

Johns Hopkins Health System (the “System”) filed an application with the HSCRC on January 18, 2017 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (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 solid organ and bone marrow transplant services with MultiPlan, Inc. for a period of one year beginning March 1, 2017.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC (“JHHC”), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the 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 solid organ and bone marrow transplant services at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC will continue to be 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 the risk of potential losses.

V. STAFF EVALUATION

Although there has been no activity under this arrangement, staff believes that the

Hospitals can 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 solid organ and bone marrow transplant services, for a one year period commencing March 1, 2017. 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.

**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: 2185
* PROCEEDING: 2375A**

Staff Recommendation

February 8, 2017

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on January 18, 2017 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (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 solid organ and bone marrow transplants services with INTERLINK Health Services, Inc. The System requests approval for a period of one year beginning March 1, 2017.

II. OVERVIEW OF APPLICATION

The contract will continue to 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 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. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer and 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 the risk of potential losses.

V. STAFF EVALUATION

Although there has been no activity under this arrangement in the last year, staff believes that the Hospitals can 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 solid organ and bone marrow transplant services, for a one year period commencing March 1, 2017. The Hospitals will need to file a renewal application for review to be considered for continued participation, with approval contingent upon a favorable evaluation of performance. 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.

**IN RE: THE APPLICATION FOR
ALTERNATIVE METHOD OF RATE
DETERMINATION
JOHNS HOPKINS HEALTHCARE, LLC
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2017
* FOLIO: 2186
* PROCEEDING: 2376A**

Staff Recommendation

February 8, 2017

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on January 18, 2017 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (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 solid organ and bone marrow transplants services with 6 Degrees Health, Inc. The System requests approval for a period of one year beginning March 1, 2017.

II. OVERVIEW OF APPLICATION

The contract will continue to 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 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. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer and 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 the risk of potential losses.

V. STAFF EVALUATION

Staff found that the activity under this arrangement was favorable for FY 2016.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing March 1, 2017. 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.

**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: 2187
* PROCEEDING: 2377A**

Staff Recommendation

February 8, 2017

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed a renewal application with the HSCRC on January 18, 2017 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”) requesting approval from the HSCRC for continued participation in a global rate arrangement for solid organ and bone marrow transplants with Preferred Health Care LLC. The Hospitals request that the Commission approve the arrangement for one year beginning March 1, 2017.

II. OVERVIEW OF APPLICATION

The contract will continue to 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 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. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to 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 that it has been active in similar types of fixed fee contracts for several years, and that

JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Although there was no activity under this arrangement in the last year, staff is satisfied that the hospital component of the global prices, which has been updated with current data, is sufficient for the Hospitals to achieve 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 solid organ and bone marrow transplant services, for a one year period commencing March 1, 2017. 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 will formalize the understanding between the Commission and the Hospitals, and will 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.

**Final Staff Recommendation on the Johns Hopkins Blomberg School of Public
Health Request to Access HSCRC Confidential Patient Level Data.**

**Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, MD 21215**

February 8, 2017

This is a final recommendation for Commission consideration at the February 8, 2017 Public Commission Meeting.

SUMMARY STATEMENT

The Johns Hopkins Bloomberg School of Public Health, Department of Health Policy and Management is requesting to use limited confidential data to help develop and support programs that may decrease the rate of falls among the elderly that lead to hospital admissions.

OBJECTIVE

To accomplish this research, the Johns Hopkins Bloomberg School of Public Health, Department of Health Policy and Management will be using the confidential data elements, in conjunction with other publicly available data, to develop and validate the spatio-temporal risk prediction trajectory model and to evaluate the falls risk score. The limited dataset will include confidential variables such as dates of service and age, as well as location at a census block group level that will be provided by CRISP. Investigators received approval from the Johns Hopkins School of Public Health - Institutional Review Board (IRB) on August 24, 2016. These data will not be used to identify individual hospitals or patients. The data will be retained by John Hopkins until June 30, 2020; at that time, the files will be destroyed and a Certification of Destruction will be submitted to the HSCRC.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for Confidential Data are reviewed by the Health Services Cost Review Commission Confidential Data Review Committee. The role of the Review Committee is to review applications and make recommendations to the Commission at its monthly public meeting. Applicants requesting access to the confidential data must demonstrate:

1. that the proposed study/ research is in the public interest;
2. that the study/ research design is sound from a technical perspective;
3. that the organization is credible;
4. that the organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations;
5. that there are adequate data security procedures to ensure protection of patient confidentiality.

The independent Confidential Data Review Committee, comprised of representatives from HSCRC staff, the Department of Health and Mental Hygiene (“DHMH”), Anne Arundel County Department of Health, The Hilltop Institute at the University of Maryland Baltimore County and the University Of Maryland School of Medicine –National Study Center for Trauma and EMS, reviewed the application to ensure it meets the above minimum requirements as outlined in the application form.

The Confidential Review Committee unanimously agreed to recommend access to a confidential limited data set. As a final step in the evaluation process, the applicant will be required to file annual progress reports to the Commission, detailing any changes in goals or design of project, any changes in data handling procedures, work progress, and unanticipated events related to the confidentiality of the data. Additionally, the requester will submit to HSCRC a copy of the final report for review prior to public release.

STAFF RECOMMENDATIONS

1. HSCRC staff recommends that the request for the limited inpatient and outpatient confidential data files for Calendar Year 2013 through 2015 be approved.
2. This access will be limited to identifiable data for subjects enrolled in the research.



Maryland Health Services Cost Review Commission

Nurse Support Program I (NSP I) FY 2013 & 2014: Outcomes Evaluation & Recommendations

Claudine Williams, HSCRC
Dr. Joan Warren, Consultant
February 8, 2017



Background



Goals of NSP I

- ▶ **Grow & retain bedside hospital Registered Nurses (RNs)**
 - More than 60,000 RNs in the state of Maryland
 - More than half employed by hospitals
- ▶ **Advancement of the Nursing Workforce**
- ▶ **Improved Hospital Quality and Safety**

2012 NSP I Program Renewal

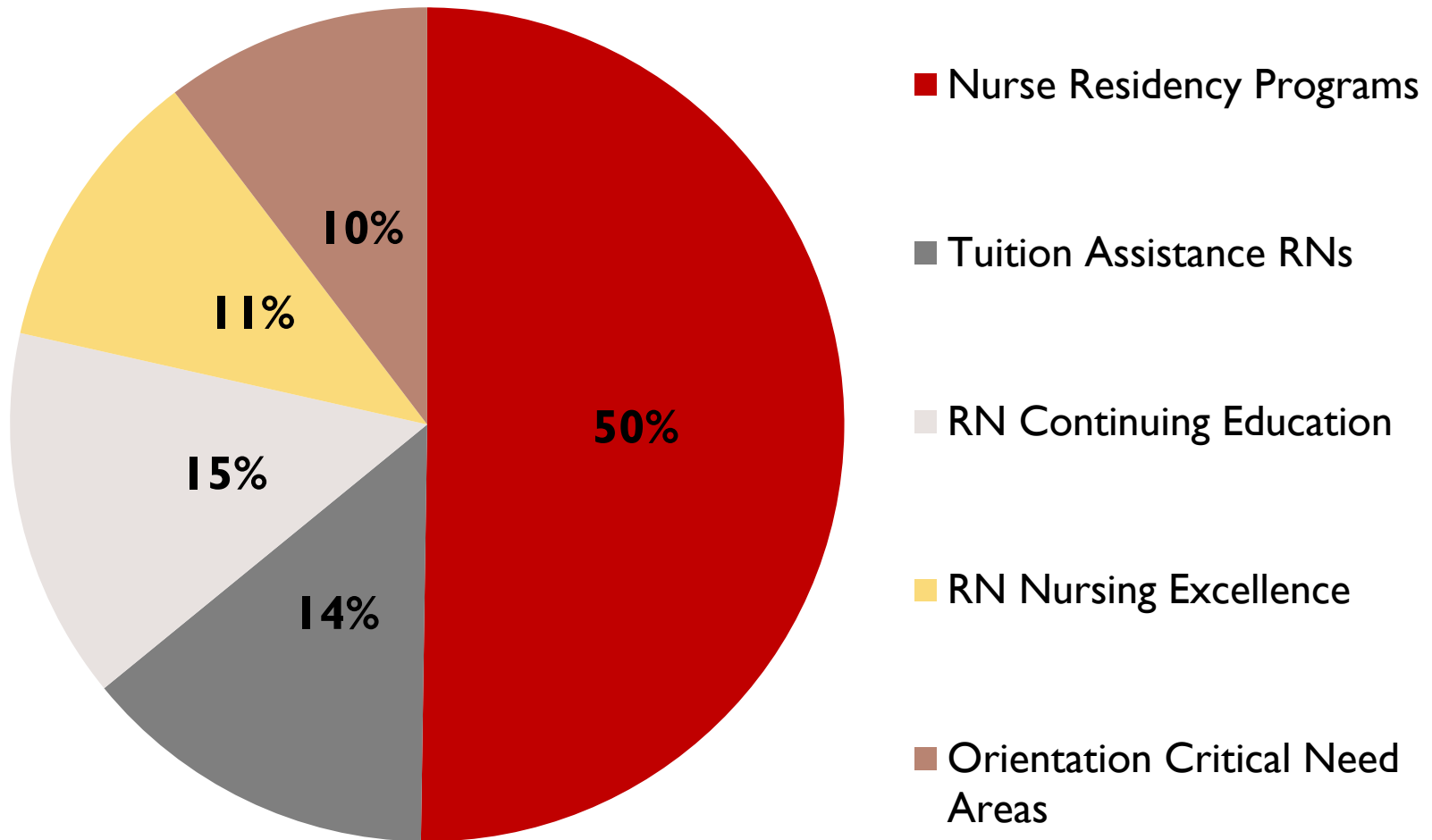
NSP I aims aligned with IOM Future of Nursing recommendations:

- ▶ Education and career advancement (nurse residency programs & advanced nursing degrees)
- ▶ Improved Quality and Safety of Our Hospitals (certification & continuing education)
- ▶ Advancement of the Nursing Workforce (achievement of Nursing Excellence- ANCC Magnet® or Pathway to Excellence® designation)

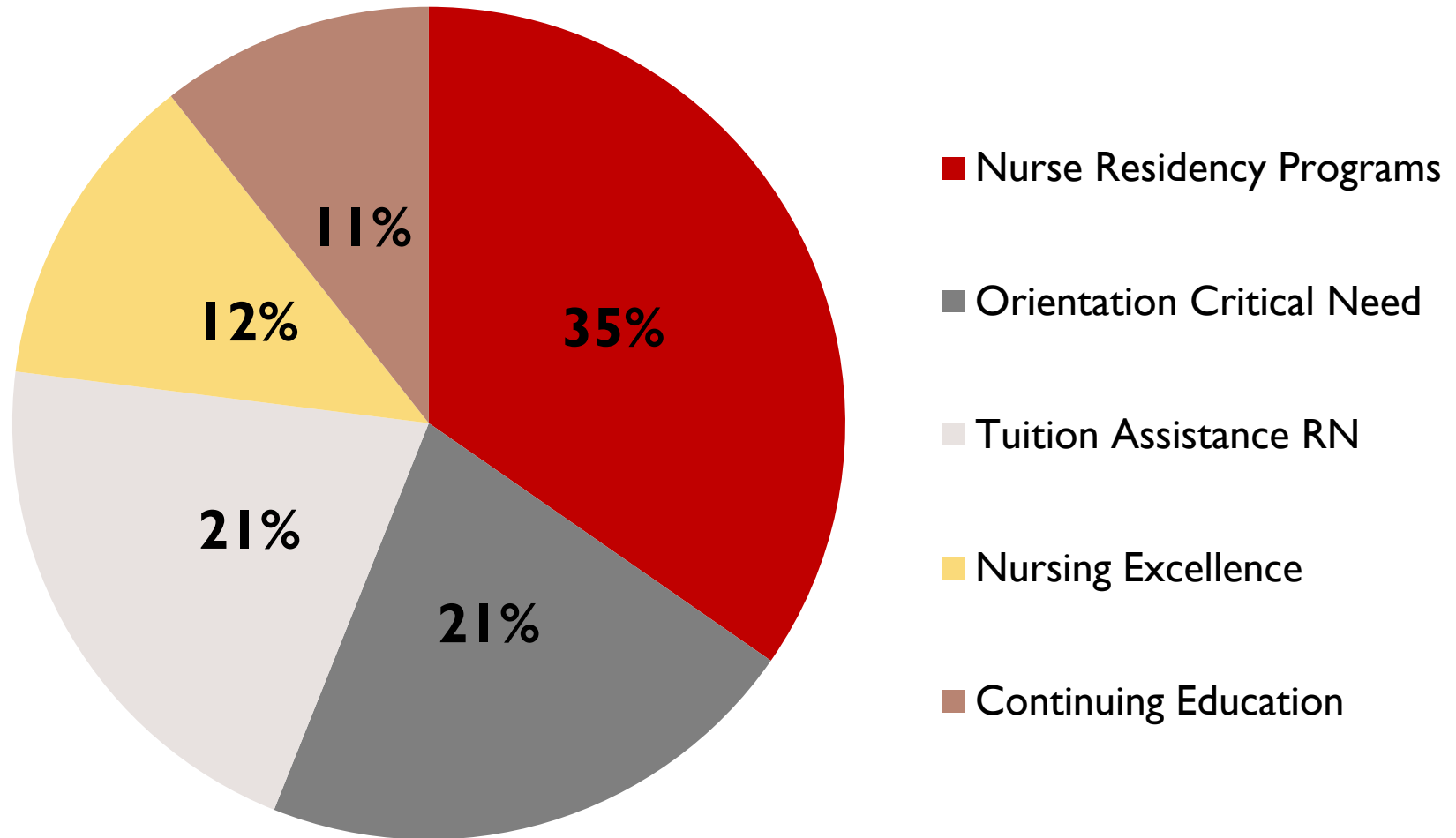
Summary of FY 2013-2014 Data



2013 Top Funding Categories




2014 Top Funding Categories



Education & Career Advancement

Nurse Residency Programs

- ▶ 2013 & 2014 > 2,000 newly licensed RNs completed hospital based nurse residency programs
- ▶  Turnover: 2013 - 12% (107) vs 2014 - 7% (70)

Education & Career Advancement

RN Advanced Nursing Degrees

- ▶ Double the number of RNs graduating with master's degrees
- ▶ Decreased attrition of RNs enrolled in advanced degree programs

Nursing Student Basic Licensure RN Degrees

- ▶ 6% increase in hiring after successfully completing basic RN degrees
- ▶ 9% decline in nursing student attrition



Education & Career Advancement

Orientation Programs for Critical Need Positions

- ▶ Investment in programs doubled, but turnover rates for critical need positions increased 25 percentage points between 2013 and 2014
- ▶ CNOs struggling with transitioning RNs in to hard to fill positions and roles:
 - ✓ Emergency Room
 - ✓ Critical Care
 - ✓ Operative Room/Peri-operative
 - ✓ Nurse Manager
 - ✓ Nurse Director
 - ✓ Hospital-based Nurse Educator



Patient Quality and Safety

Certifications

- ▶ 8% increase in the number of certified RNs working in hospitals

Magnet[®] Designation

- ▶ 7 hospitals attained/maintained
 - ▶ MedStar Franklin Square Medical Center
 - ▶ Mercy Medical Center
 - ▶ Sinai Hospital of Baltimore
 - ▶ The Johns Hopkins Hospital
 - ▶ University of Maryland Medical Center
 - ▶ UM Shore Medical Center at Easton
 - ▶ UM Shore Medical Center at Dorchester

Continued Monitoring/Improvement

- ▶ Improve reporting of NSP I program expenditures by hospitals
- ▶ Improve reliability and accuracy of outcome data
- ▶ Monitor orientation turnover data of RNs in areas of critical need
- ▶ Assess demand in Maryland for the offering of nurse refresher programs for re-entry into practice
- ▶ Track trending of recruitment and retention rates and agency use

Next Steps



Next Steps

- ▶ Analyze and report on 2013 – 2016 outcome data
- ▶ Convene NSP Steering Committee to draft recommendations for next 5-year renewal
- ▶ Develop instructional guide and educational webinar to improve hospital data reporting

**Nurse Support Program I (NSP I)
Outcomes Evaluation FY 2013 – FY 2014 and
Recommendations for Future Funding**

February 8, 2017

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

Transforming nursing, the single largest sector of the health care professions (almost 4 million registered nurses nationally and 60,602 in the state of Maryland), will dramatically impact not only the nation's health care system, but also Maryland's. Early on, the Maryland Health Services Cost Review Commission (HSCRC) recognized the importance of nursing to the health of the nation and the State. To that end, the HSCRC implemented the first phase of the Nurse Support Program I (NSP I) in June 2001 to address the short- and long-term issues of recruiting and retaining nurses in Maryland hospitals. Since program implementation, approximately \$96 million (fiscal year [FY] 2001 through FY 2014) has been funded in rates to support the NSP I.

In 2012, the NSP I aims were aligned with the Institute of Medicine's (IOM's) recommendations in its Future of Nursing report, including the following:

1. *Education and career advancement.* This area includes initiatives that increase the number of advance degree nurses, nursing residency programs, leadership initiatives, and succession planning.
2. *Patient quality and satisfaction.* This area includes data collection efforts that can demonstrate the link between improved nursing competency and better patient outcomes.
3. *Advancing the practice of nursing.* This area includes activities that advance the practice of nursing, such as nurse-driven evidenced-based research, attendance at symposiums and research conferences, and achieving or maintaining the American Nurses Credentialing Center's Magnet® designation.

With these recommendations came the development of nursing and organizational metrics to assess hospitals progress in achieving these program aims. This report contains the first two years of data for FYs 2013 and 2014 using the revised organizational metrics and a new secure, web-based data collection tool. Program achievements and areas for continued monitoring and improvement are highlighted below.

NSP I achievements in FYs 2013 and 2014 include:

- More than 2,000 newly licensed registered nurses completed hospital-based nurse residency programs, reducing new graduate turnover by 6 percent.
- Doubled the number of registered nurses graduating with master's degrees in nursing, while reducing the attrition rate of registered nurses enrolled in advanced degree programs from 3.6 to 2 percent.
- Increased the number of new registered nurse graduates hired by hospitals supporting their education through the NSP I by six percent.
- Reduced student nurse attrition by 9 percent.
- Increased the number of professionally certified registered nurses working in Maryland hospitals by 8 percent.

- Attained or maintained Magnet® designation in seven Maryland hospitals.

Areas for continued monitoring and improvement include the following:

- Improve hospital reporting of individual program expenditures supported by the NSP I.
- Improve reliability and accuracy of FY 2015 and 2016 outcome data.
- Monitor orientation programs turnover data of newly licensed and experienced registered nurses working in areas of critical need, such as emergency departments, critical care, and perioperative care.
- Determine the demand in Maryland for the offering of nursing transition (refresher) programs enabling registered nurses to re-enter the profession.
- Monitor recruitment and retention rates and agency usage for trends.

PURPOSE

This report summarizes the Nurse Support Program I (NSP I) hospital activities and resultant outcomes for fiscal years (FYs) 2013 and 2014.

BACKGROUND

The NSP I was instituted in response to forecasts of significant short- and long-term shortages of registered nurses (RNs) in the state of Maryland and nationally. To ebb these severe and cyclical nursing shortages in 1986, the Maryland Health Services Cost Review Commission (HSCRC) implemented the Nurse Education Support Program (NESP), which focused on supporting college- and hospital-based training of RNs and licensed practical nurses (LPNs). Over the next decade (1986 to 1995), the HSCRC allocated approximately \$7 million in hospital rates to 37 hospitals participating in this program.

After consecutive years of economic growth in the national economy in the late 1990s and early 2000s, new forecasts of nursing shortages again spurred the HSCRC into action, and NSP I was implemented. The intent of this five-year, non-competitive grant program was to increase the number of bedside hospital nurses through retention and recruitment activities. Annually, hospitals have been eligible to receive the lesser of their budget request or up to 0.1 percent of the hospital's gross patient revenue through hospital rate adjustments for approved projects that meet the goals of the NSP I. Since its inception in 2001, hospitals have taken significant action to successfully grow and sustain the state's hospital RN workforce.

Between FY 2001 and 2006, participating Maryland hospitals received nearly \$36 million in rates. In 2005, HSCRC staff evaluated program outcomes. Although the HSCRC supported renewing the NSP I for another five years (FY 2008-2012), staff recommended significant program changes. Changes focused on simplifying the application process and improving reporting of hospital activities by standardizing annual reports and financial and annual data reporting requirements.

As the NSP I approached its 2013 renewal date, HSCRC staff conducted a second program evaluation. Findings demonstrated that the Maryland hospital RN workforce grew significantly between FY 2007 and 2011, anywhere from 15 percent to more than 25 percent (as reported by 11 hospitals). Although difficult to measure the direct impact of NSP I funds, nurse leaders attributed much of the growth and retention of bedside hospital RNs to the NSP I. During these years, NSP I funds supported innovative programs, such as nurse residency programs for new nursing graduates, advanced nursing education and ongoing continuing education for clinical and non-clinical staff, nursing professional certification, and innovative programs to foster nursing excellence, improve patient care, and obtain recognition as a Magnet® or Pathway to Excellence® recognition—a top honor for hospitals that recognizes nursing excellence and quality patient care.

However, the economic recession that emerged in 2008 may have also substantially influenced the RN labor market in Maryland. With the slowing of the economy, RNs delayed retirement, and many RNs returned to the workforce to financially support their families. Although the increases in supply strengthened and stabilized the RN workforce, future impending shortages were projected as the economy improved. The number of health care consumers—many with chronic diseases—coupled with the aging of the population has contributed to an ever-increasing demand for finite health care services. The Health Resources and Services Administration (HRSA) predicted that Maryland would be one of 16 states to experience a nursing shortage, while the nation as a whole would have a mild surplus of 340,000 RNs (HRSA, 2014). Because of these impending trends, the HSCRC supported renewal of the NSP I for an additional five years from FY 2013 to FY 2018. Similar to its previous renewal, significant changes were made to the program based on a review of health care trends.

Unprecedented changes like the Affordable Care Act, the Quadruple Aim¹, and the Institute of Medicine's (IOM's) Future of Nursing Report (2010) reshaped the health care landscape. With the changes in payment models, health care access, and emphasis on better quality, safety, and experience for patients came the recognition that the role of professional nurses in the health care environment also must change.

To that end, the NSP I aims were aligned with the Institute of Medicine's 2010 Future of Nursing report, which included recommendations to better prepare the future hospital RN workforce in Maryland. Below are the recommended NSP I categories and hospital initiatives to achieve the eight IOM key recommendations for transforming the nursing workforce.

Education and career advancement. This area includes initiatives that support newly licensed or experienced RNs as they transition into practice or to new practice environments (i.e., nursing residency programs) and increase the number of new and advanced degree nurses (tuition assistance).

- Nurse residency program
- Orientation critical need
- Transitional (nurse refresher) program
- RN tuition assistance
- Nursing student tuition assistance

Patient quality and satisfaction. This area includes efforts that can demonstrate the link between improved nursing competency and better patient outcomes (certification) and develops nurses as lifelong learners and prepares them as leaders (continuing education).

- RN professional certification
- RN technical certification
- RN continuing education

Advancing the practice of nursing. This area includes activities that support an environment for nursing excellence, such as clinical staff-driven evidenced-based research in nursing, attendance at symposiums and research conferences, and the ability to support hospitals in achieving or maintaining Magnet® status.

- Nursing excellence (Magnet® or Pathway to Excellence® designation)
- Shared governance model
- Evidence-based practice, quality improvement, and/or research projects

With these recommendations came the development of nursing and organizational metrics to assess hospitals' progress in achieving the program aims. This report shares the most recent outcome data collected from hospitals participating in the NSP I from FY 2013 through FY 2014. This report discusses the continued growth of nurses as health care professionals and their impact on the health care delivery system in Maryland, as well as areas of continued improvement needed in optimizing the use of NSP I funds.

DATA COLLECTION

In 2013, nurse and hospital leaders and HSCRC staff revised the annual report to include standardized outcome metrics that addressed the varied programs for each of the three newly proposed program aims. For consistency in measurement, outcome metrics were operationalized using nationally accepted definitions. Unlike previous reports, the newly revised report also contained a financial section requesting hospitals to report actual expenditures (administrative and project costs) for each of the programs supported by the NSP I.

The revised annual report consists of three sections: an end-of-year financial report, hospital program outcome metrics, and overall hospital metrics, such as vacancy and turnover data. In Section 1, NSP I coordinators report their hospital's actual expenditures, including administrative and project costs. Additionally, respondents report individual program expenditures for each of the varied programs supported by the NSP I. In Section 2, hospitals report outcome metrics for each of the varied programs. For example, if the hospital invests NSP I funds in a nurse residency program, professional RN certification, tuition assistance, and Magnet® activities, the hospital must report outcome metrics associated with each of those programs. Section 3 collects standardized metrics about RN recruitment, retention, and vacancy rates, as well as hospital use of agency RNs.

HSCRC staff require hospitals to complete the online annual report and submit their reported actual expenditures for each fiscal year. A secure, web-based data collection tool is used for ease of data entry, costs, and data accuracy.

2013 – 2014 DATA SUMMARIES

The following is an interim summary of the NSP I annual report for FYs 2013 and 2014.

Hospital Reporting

In 2013, 47 of the 50 eligible Maryland hospitals submitted the required data collection tool and end-of-year expense report (94 percent response rate). Many of the data collection tools had large amounts of missing data. Of the 47 hospitals that submitted, only 45 were included in the final analysis due to incomplete data entry. In 2014, 46 hospitals (96 percent) out of the 50 eligible hospitals submitted reports. Again, one survey was excluded from the final analysis due to incomplete data entry.

Programs Supported through the NSP I

More than \$16 million of NSP I funds were invested in RNs at the participating hospitals in FYs 2013 and 2014. A comparison of the actual project, administrative, and total expenditures for both years found that hospitals evenly split their funds; they used half for project management and the other half for personnel costs.

Hospitals were also asked to report the distribution of NSP I funds by program (Figures 1 and 2). Almost 30 percent or more of NSP I funds supported nurse residency programs. Additionally, there was widespread support for tuition assistance, continuing education, and programs to achieve either Magnet® or Pathway to Excellence® designation. The biggest change in program funding between FYs 2013 and 2014 occurred in the category of orientation for nurses transitioning to critical need areas, which doubled from 9 percent to 18 percent, respectively.

Figure 1. Top NSP I Funding Categories, FY 2013

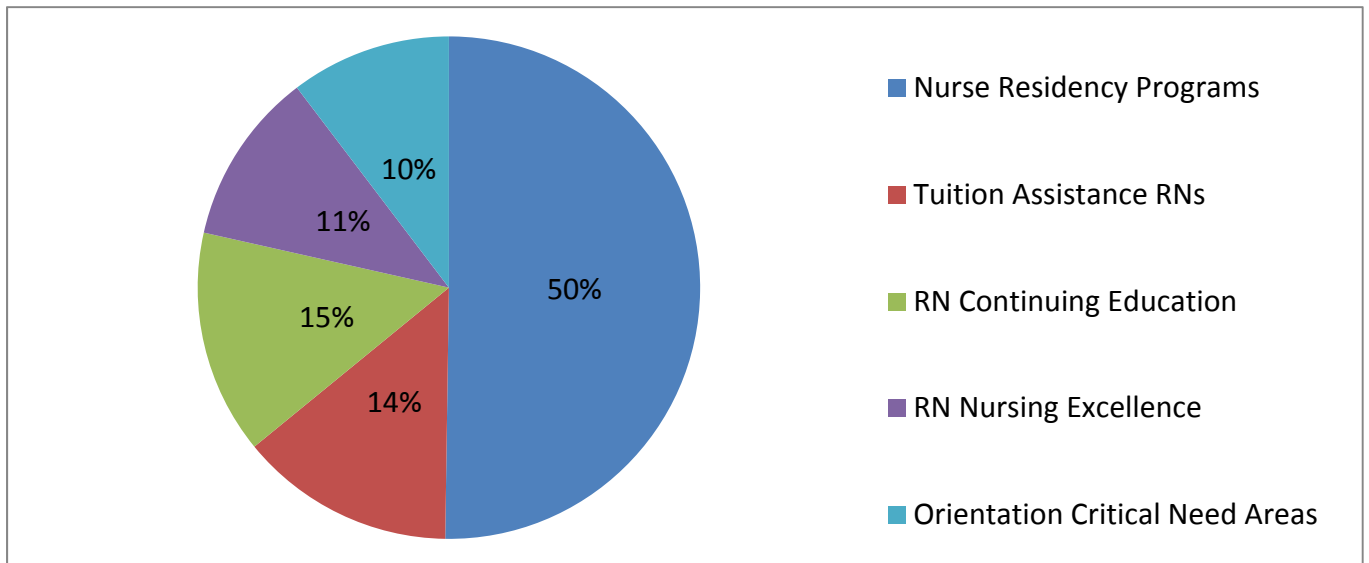
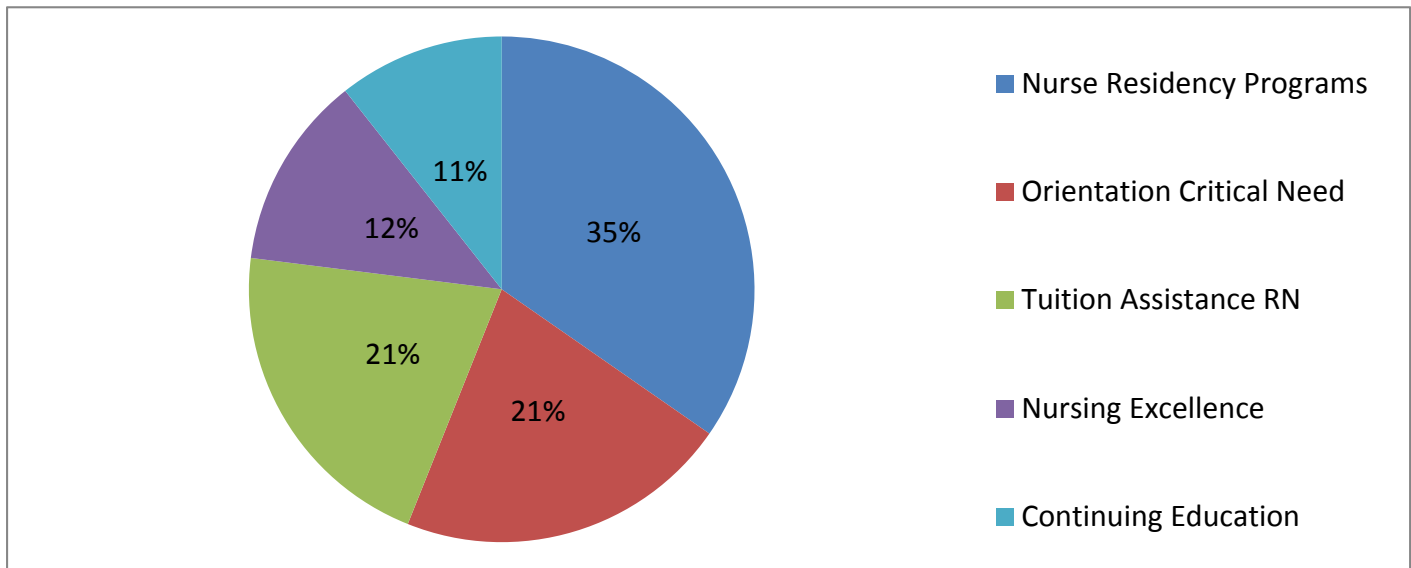


Figure 2. Top NSP I Funding Categories, FY 2014



However, the ability to make inferences about total expenditures by individual program is problematic. When comparing total individual program expenditures (i.e., the sum of individual program expenses) with the total reported NSP I expenditures, staff found an unexplained variance of 30 percent. NSP I coordinators attribute the underreporting of NSP I funds by program to a misunderstanding of the question, lack of knowledge of NSP I expenditures, and not meeting with financial officers for assistance.

Education and Career Advancement

Preparing a highly educated nursing workforce for Maryland is one of the primary focuses of the NSP I. Funds may be used by hospitals to support:

- Nurse residency programs to adequately train and retain newly licensed RNs.
- Nursing orientation programs for RNs transitioning practice to hard-to-fill or areas of critical need.
- Tuition assistance for RNs to advance their educational preparation or nursing students to increase the number of RNs for hospitals.
- Transitional or refresher courses for RNs who left nursing and require a Maryland Board of Nursing-approved refresher course to receive licensure to re-enter the profession.

Nurse Residency Programs

Approximately half of the responding hospitals invested NSP I funds into nurse residency programs. Through the use of NSP I funds, hospitals were able to fund program coordinators and

instructors, nurse residents' or other staff salaries that facilitate resident attendance, and program expenses such as educational materials. More than 2,000 residents graduated from these programs between 2013 and 2014. Further, the reported turnover rate was reduced by 5 percentage points, from 12 percent in 2013 to 7 percent in 2014. Comparing hospital hiring practices for baccalaureate-prepared (BSN) and associates degree (AD) RNs, it appeared hospitals preferred hiring BSN nurses. In fact, BSNs were twice as likely to be hired in both years compared to their AD counterparts.

Nurse residency programs prevent newly licensed RNs from leaving their employer or the profession entirely. Nurse residency programs improve organization, management, communication, and clinical skills, as well as retention of newly licensed RNs, and reduce hospital costs associated with attrition (IOM, 2010; National Academies of Sciences, Engineering, and Medicine, 2015). Unlike other professions in medicine, transition programs (referred to as residencies) have not been mandated by the nursing profession to integrate new graduates into the workplace. Maryland is recognized nationally as a leader in the nurse residency program, having one of the only statewide collaborative models and financial support through the NSP I promulgating these programs.

Orientation Programs for Hard-to-Fill Critical Need Positions

About half of the hospitals reported using NSP I funds to support implementation of orientation programs for hard-to-fill critical need positions. Although the numbers of hospitals reporting use of these funds declined in 2014, the amount of NSP I funds invested in these programs doubled. Unlike nurse residency programs, outcome metrics associated with orientation programs were discouraging. Even after doubling the investment into these programs, the turnover rate substantially increased from 41 percent in 2013 to 66 percent in 2014. Hospitals attribute this high turnover rate to the hiring of newly licensed nurses, who lack the preparation and skill sets to function in these highly complex and stressful work environments.

Nationally, nurse leaders are struggling with transitioning newly licensed RNs and experienced RNs into hard-to-fill and critical new leadership and clinical roles. Maryland hospital workforce data, collected from hospital Chief Nursing Officers (CNOs) to inform and align the goals of the NSP II (academic nursing programs) with the NSP I (hospital programs), found that the top three most difficult departments for which to hire RNs were emergency, critical care, and operating room/perioperative. Approximately 50 percent of the CNOs also identified nurse manager, director, and nursing professional development practitioner (hospital-based nurse educator) as difficult roles to fill. Furthermore, respondents cited a need for experienced clinical bedside nurses. Efforts to expand and encourage partnerships between academic and hospital nurse leaders to prepare nurses for present and future roles and produce the nurse with right skill sets to meet new care delivery models/workforce requirements in Maryland should continue to be promulgated by the NSP I. In addition, the quality of the transition to practice programs and current hiring practices should be evaluated by hospital nurse leaders.

Tuition Assistance

Tuition Support for RNs Enrolled in Advanced Nursing Degree Programs

The IOM Future of Nursing report called for 80 percent of RNs to hold a baccalaureate degree by 2020 (2010). As previously cited, RNs with advanced degrees are needed to fill a variety of leadership roles. In an effort to advance nursing education, about 15 hospitals spent \$3.4 million between FY 2013 and 2014 on tuition assistance for nursing education through the NSP I. Approximately 230 hospital RNs graduated with advanced nursing degrees. RNs completing master's degrees almost doubled from 19 to 40 in FY 2014. The student attrition rate also fell during these two years from 3.6 percent to 2 percent.

The surge in the number of master's-prepared RNs may be partially attributed to the synergistic effect of the NSP I and II programs. In 2006, an NSP II grant by Dr. Mills (University of Maryland School of Nursing), Dr. Warren (Franklin Square Medical Center) and Dr. Regier (University of Maryland Medical Center) was funded to fill expected vacancies in the nursing work force and reduce the shortage of clinical nursing instructors through a strategic partnership between the university school of nursing and two acute care hospitals. The specific aim of this proposal was to use shared resources of each hospital and the school of nursing to increase the pool of nurses available as clinical instructors. An additional aim was to develop a path for more graduate-educated nurses to serve as student nurse preceptors in Maryland by offering an easily accessible online master of science program to students at each institution. The original program has grown from the 2 hospitals to 18 participating hospitals.

Tuition Support for Nursing Students Enrolled in a Basic Licensure Program

Although the number of hospitals that reported offering tuition assistance to student nurses through the NSP I decreased by more than 25 percent, the number of students supported through these funds remained essentially unchanged at slightly over 120 recipients per year. Approximately 140 students graduated from their basic licensure programs. Of these graduates, their supporting hospitals increased their hiring rates from 85 percent in 2013 to 91 percent in 2014. Student attrition rates also fell by 9 percentage points, from 14 percent to 5 percent. Of interest, the number of students receiving tuition assistance enrolled in associates degree programs declined. It is unclear if the desire for a BSN degree is the student's or the hospital's preference. Although hospital-reported support through the NSP I for tuition assistance declined for students, the number of graduates has remained constant, and more hospitals are hiring new graduates to fill positions being vacated by older counterparts as they start to exit the workforce with the improving economy.

RN Transitional Program (Refresher Course)

The number of hospitals investing in refresher courses for RNs to renew their licensure to return to work fell from 16 in 2013 to 11 in 2014. Funding by hospitals was also substantially cut by approximately \$223,160 (\$276,300 in 2013 and \$53,140 in 2014). Mirroring this trend, the

number of RNs completing the refresher program decreased from 23 in 2013 to only 2 in 2014. The demand for these programs is unknown, making it difficult to determine if a greater number is needed in the future.

Patient Quality and Satisfaction

A well-educated nursing workforce is fundamental to transforming the nursing profession and will address the increasing demand for safe, high-quality, and effective health care services. Under this dimension, hospitals may use NSP I funds to support nursing certification and continuing education programs for gaining leadership skills and obtaining and maintaining competency, advancing evidence-based practice and research, or advancing nursing excellence programs (Magnet® and Pathway to Excellence®).

RN Certification and Continuing Education

Certification

Hospitals offering certification programs through the NSP I increased by 25 percent during the two years. Through the NSP I, the number of certified RNs increased by 8 percentage points, from 17 percent at the start of FY 2013 to 25 percent at the end of FY 2015. The majority of hospitals used a combination of online and face-to-face teaching methods to educate their staff. RNs obtained certification in multiple specialty nursing areas, ranging from medical-surgical, to women's health, to wound care, and nurse executive certifications. "After nurses obtain their degrees, lifelong learning is necessary to provide quality patient care" (National Academies of Sciences, Engineering and Medicine, 2015). Certification is one method of demonstrating continued learning and competence in a nursing specialty.

Continuing Education

Provision of ongoing continuing education is another method to foster lifelong learning. Almost half of the hospitals over the course of the two years reported use of NSP I funds to support internal and external continuing education programs for RNs. However, the amount invested in internal continuing education programs decreased by 30 percent in year two. As expected, the reported number of attendees at these courses also declined from 4,592 (hospital M=209) in 2013 to 3,494 (hospital M=159) in 2014. Unlike the offering of internal courses, the number of hospitals using funding for external continuing education courses increased and similarly attendance increased from 2,446 (hospital M=116) in 2013 to 3,494 (hospital M=159) in 2014. For both years, the majority of the continuing education courses focused on evidence-based practice.

Advancing the Practice of Nursing

Subsumed under the category of advancing the practice of nursing are funding categories to support nursing excellence programs including Magnet® and Pathway to Excellence® designation, shared governance models, and evidence-based practice and research.

Nursing Excellence

With funding from the NSP I, seven hospitals in Maryland have successfully achieved Magnet® designation. Of those hospitals, six were re-designated as Magnet® hospitals in FY 2013 and 2014. An additional 13 Maryland hospitals are pursuing either Magnet® or Pathway to Excellence® designation. Magnet designated hospitals and initial and re-designation dates are listed below.

- Mercy Medical Center (2011)
- Sinai Hospital of Baltimore (2008; 2013)
- MedStar Franklin Square Medical Center (2008; 2013)
- Johns Hopkins Hospital (2003; 2008; 2013)
- University of Maryland Medical Center (2009; 2014)
- UM Shore Medical Center at Easton (2009; 2014)
- UM Shore Medical Center at Dorchester (2009; 2014)

Shared Governance

Shared governance is an organizational structure that provides clinical nurses with a voice in determining nursing practice, standards, and quality of care. Approximately one-third of the reporting hospitals were able to support their shared governance models through the NSP I. Funding paid for staff to attend or backfill positions facilitating staff attendance at meetings. For example as one survey respondent wrote, “Paid education/council meeting time is built into every unit based budget. Nursing staff are scheduled to cover for each other at shorter meetings.”

Research

The NSP I supports the science of nursing. The numbers of hospitals involved in research studies has grown from five in 2013 to eight in 2014. Examples of these projects include studies about nurse residency retention, perinatal depression, and healthy work environments. Additionally, funds support nurse residents in conducting evidence-based practice projects as part of their learning experience.

Hospital Metrics (Vacancy, Turnover, Agency Use)

RN vacancy rates increased by 3 percentage points, and RN voluntary turnover rates increased by 2 percentage points between FY 2013 and 2014. However, RN involuntary turnover rates and

new hire retention rates remained unchanged. Although a slight increase in vacancy and turnover rates occurred, use of agency RNs declined. Hospitals reported using an additional 5,079 RN agency full time equivalents (FTEs) for 40,629 hours worked during a 2 week pay period that includes February 1, 2013 compared to 3,198 RN agency FTEs for 25,582 hours worked in the same two week pay period that includes February 1, 2014. Similarly, use of agency LPN FTEs decreased from 62 (493 hours worked) to 27 (213 hours worked).

Table 1. Hospital Vacancy, Turnover, and Retention Rates, FY 2013-2014

Metric	2013	2014
RN Vacancy Rate	9%	11%
RN Voluntary Turnover	12%	14%
RN Involuntary Turnover	4%	4%
RN New Hire Retention Rate	76%	76%

SUMMARY

This data analysis identified the need for hospitals to improve the reporting of organizational metrics and use of NSP I funds. HSCRC staff met with NSP I coordinators to discuss issues with reporting and methods to improve their ability to provide reliable and accurate data. To that end, staff developed a more complete instructional guide, added and revised operational definitions,, and offered a live educational webinar (which was recorded for later viewing) to NSP I coordinators. Data collection for FYs 2015 and 2016 was completed in December 2016 and will be analyzed in 2017.

As the economy improves, significant geographical shortages of health care providers and nurses are projected (HRSA, 2016). Workforce data will be monitored for the coming years to determine if these changes reflect impending trends and changes in the workforce. From these, data recommendations will be made for the NSP I.

The HSCRC's investment in nursing practice and education is as timely and relevant today as it was decades ago. Transforming nursing in Maryland will, by virtue of the sheer numbers in hospitals, have far reaching statewide effects on the quality and safety of the state's hospitals.

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ⁱ The Quadruple Aim includes the original Triple Aim components (enhancing patient experience, improving population health and reducing costs) and adding the goal of improving the work life of health providers, including clinicians and staff (Bodenheimer, T., & Sinsky, C. (2014)).

Final RY 2018 and RY 2019 QBR Recommendation

Commission Meeting
02/08/2017



RX 2018 QBR Program Scaling Proposal

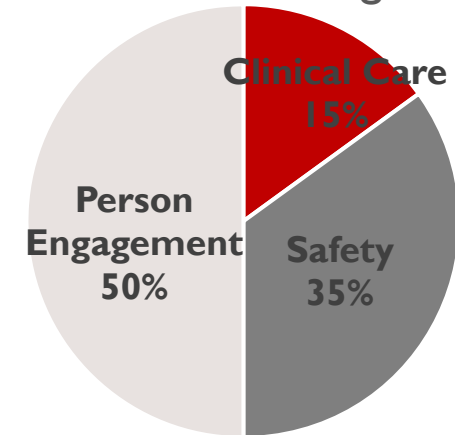
- ▶ Adjust retrospectively the RX 2018 QBR preset scale for determining rewards and penalties using final RX 2018 performance period scores
- ▶ Use a relative scale to linearly distribute rewards (above average) and penalties (below average) based on the final QBR scores, without revenue neutrality adjustment
 - ▶ Same methodology as approved retrospectively for RX 2017
 - ▶ Exploring options to obtain data earlier for QBR score calculation; anticipate RX 2018 revenue adjustments January 2018

RY19 QBR Updates

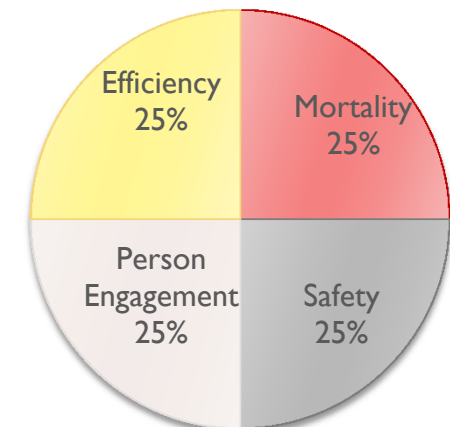
- ▶ **No change to RY 2019 measures and domain weighting:**
 - ▶ Update mortality measure to include palliative care
 - ▶ PSI-90 – currently no ICD-10 version

- ▶ **Measure Development and Monitoring CY 2017:**
 - ▶ ED wait times
 - ▶ THA/TKA complication measure

QBR Domain Weights



VBP Domain Weights



HSCRC

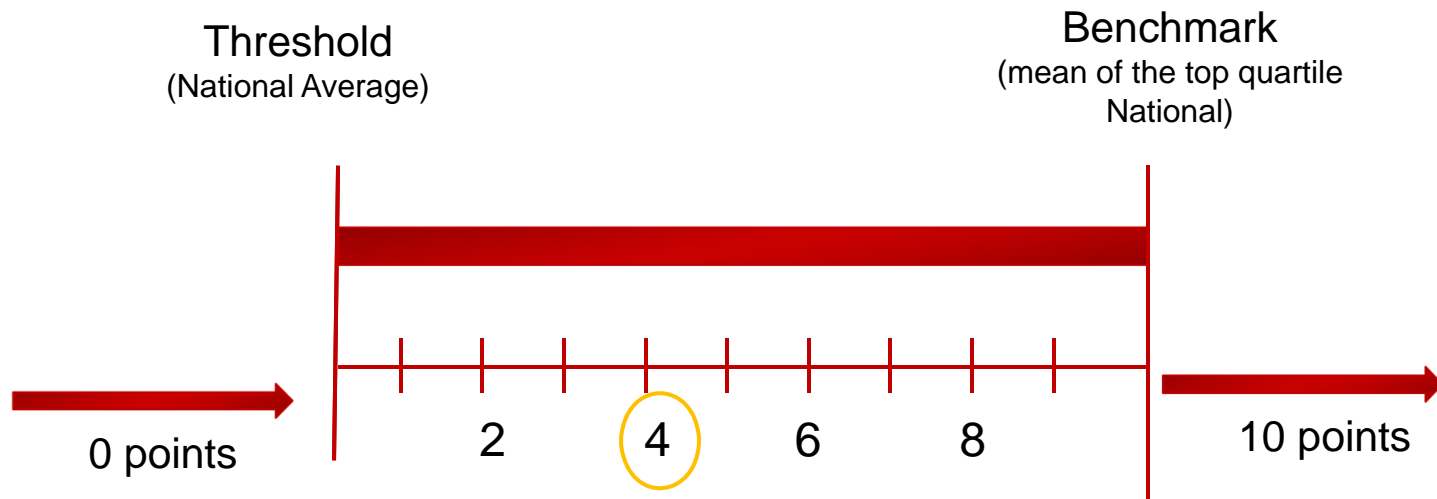
Health Services Cost
Review Commission

RY19 QBR Scaling

- ▶ Goal is to incentivize all MD hospitals to improve and achieve performance on par with the nation
- ▶ Final Score Scale vs. Prospective Scale
 - ▶ Predetermined performance targets and financial impact
 - ▶ Ensure performance aligns with revenue adjustments

Attainment Score Calculations

One QBR Measure-
Risk Adjusted Rate or Percent of Patients



*Mortality and PSI measures are based on state average and top performance benchmarks.

QBR Score Calculations

- ▶ Better of Attainment or Improvement = 0-10 points
- ▶ Maximum Available Points= 10 Points* Number of Measures
- ▶ Actual Hospital Points= Sum of Hospital Points
- ▶ QBR Final Score= Actual Hospital Points/Maximum Available Points
 - ▶ 0% = None of the rates are at the average
 - ▶ 100%= All of the rates are at the top 5 %

Applying Final Score to Scaling

- ▶ Full Score: Range 0-100%, mid-point 50%
- ▶ State distribution: 7%-57%, average 37%
- ▶ Scaling based on state distribution recalibrates the payment adjustments back to state performance
- ▶ Predetermined scores should be more specifically tied to the state's performance compared to national rates
 - ▶ Performance benchmarks for each measure (Thresholds and benchmarks) are based on national rates
 - ▶ Scaling methodology does not reflect performance standards as the total scores are lower

Scaling Considerations

- ▶ Which scores should be used for maximum rewards and penalties?
- ▶ Which score should be used as cut point to turn from penalty to reward zones?
 - ▶ 80% represents realistic max possible score
 - ▶ Rewards can be increased in commensurate with higher points
 - ▶ Increase the maximum reward from 1% to 2% inpatient revenue

QBR Scaling Options

FY 2017

FY 2017 Final QBR Score Based Scaling	
Final QBR Scores	% Revenue Impact
0.07	-2.00%
0.20	-1.13%
0.31	-0.40%
0.31	-0.40%
0.37	0.00%
0.40	0.15%
0.49	0.60%
0.57	1.00%

Full Score Range

Final QBR Score	Payment Adjustment
0.00	-2.00%
0.10	-1.60%
0.20	-1.20%
0.30	-0.80%
0.40	-0.40%
0.50	0.00%
0.60	0.40%
0.70	0.80%
0.80	1.20%
0.90	1.60%
1.00	2.00%
Payment Threshold	0.50

Option 1

Final QBR Score	Payment Adjustment
0.00	-2.00%
0.10	-1.50%
0.20	-1.00%
0.30	-0.50%
0.40	0.00%
0.50	0.50%
0.60	1.00%
0.70	1.50%
0.80	2.00%
0.80	2.00%
Payment Threshold	0.40

Option 2

Final QBR Score	Payment Adjustment
0.00	-2.00%
0.10	-1.56%
0.20	-1.11%
0.30	-0.67%
0.40	-0.22%
0.45	0.00%
0.50	0.29%
0.60	0.86%
0.70	1.43%
0.80	2.00%
0.80	2.00%
Payment Threshold	0.45

Modeling of QBR Scaling Results

RY 19 Scaling Options	Min	Cut Point	Max	Statewide Penalties	Statewide Rewards
Final Scores (max reward 1%)	7%	37%	57%	-\$20M	+11M
Full Scale Options Max Reward 2%					
Full Score Range	0%	50%	100%	-49M	+1M
Option 1	0%	40%	80%	-24M	+7M
Option 2	0%	45%	80%	-37M	+3M
<i>Note: Modeling based on RY17 Final Scores</i>					

Final RY19 Recommendations

- ▶ Staff recommends the following for RY 2019:
 - ▶ Maintain RY 2018 domain weights: 50 percent for Patient Experience/Care Transition, 35 percent for Safety, and 15 percent for Clinical Care.
 - ▶ Move to a modified full score distribution ranging from 0-80%, and linearly scale penalties and rewards at 45% cut point.
 - ▶ Maintain 2% maximum penalty and increase the maximum reward to 2 percent as the achieving rewards will be based on full score distribution.

Final Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2018 and 2019

February 8, 2017

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This recommendation is final recommendation ready for Commission action. Final recommendations are updated from the draft recommendations presented at October 19th and December 14th, 2016 Commission meetings. Updated sections are **highlighted and bolded** in the text.

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
CDC	Centers for Disease Control & Prevention
CY	Calendar year
CAUTI	Catheter-associated urinary tract infection
CLABSI	Central line-associated blood stream infections
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-related group
ED	Emergency department
FY	Fiscal year
FFY	Federal fiscal year
HAI	Healthcare Associated Infections
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commission
MRSA	Methicillin-resistant staphylococcus aureus
NHSN	National Health Safety Network
PQI	Prevention quality indicators
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year
SIR	Standardized infection ratio
SSI	Surgical site infection
THA/TKA	Total hip and knee arthroplasty
VBP	Value-Based Purchasing

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. These initiatives hold amounts of hospital revenue at risk directly related to specified performance benchmarks. Maryland's Quality-Based Reimbursement (QBR) program, in place since July 2009, employs measures that are similar to those in the federal Medicare Value-Based Purchasing (VBP) program, in place since October 2012. Because of its long-standing Medicare waiver for its all-payer hospital rate-setting system and the implementation of the QBR program, the Centers for Medicare & Medicaid Services (CMS) has given Maryland various special considerations, including exemption from the federal Medicare VBP program.

Similar to the VBP program, the QBR program currently measures performance in clinical care, patient safety, and experience of care domains. Despite higher weighting of financial incentives on the experience of care domain (50%) which employs the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey instrument, Maryland has continued to perform below the national average over the last several years with little or no improvement, including for the Rate Year (RY) 2017 completed performance year. The patient safety domain was weighted second highest, and scores on average for this domain were next lowest.

The purpose of this report is to make draft recommendations for the QBR program for fiscal year (FY) 2019. The report also recommends updates to the approach for scaling rewards and penalties retrospectively for RY 2017 and 2018 in order to assign rewards and penalties consistent with hospital performance levels based on data now finalized for RY 2017.

BACKGROUND

Federal VBP Program

The Affordable Care Act (ACA) established the hospital VBP program,¹ which requires CMS to reward hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. The program assesses hospital performance on a set of measures in clinical care, experience of care, safety, and efficiency (i.e., Medicare spending per beneficiary) domains. The incentive payments are funded by reducing the base operating diagnosis-related group (DRG) amounts that determine the Medicare payment for each hospital inpatient discharge.² The ACA

¹ For more information on the VBP program, see <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/>

² 42 USC § 1395ww(o)(7).

set the reduction at 1 percent in federal fiscal year (FFY) 2013 and required that it increase incrementally to 2 percent by FFY 2017.³

CMS will calculate FFY 2018 hospital final scores based on measures in the four equally weighted domains (Appendix I). Although not final, CMS has proposed no changes to the domain weights for the FFY 2019 program from those used for FFY 2018.

Maryland’s Current QBR Program (RY 2018 Performance Period)

For the RY 2018 performance period, Maryland’s QBR program like the federal VBP program, assesses hospital performance on similar (or the same where feasible) measures, and holds 2% of hospital revenue at risk based on performance. (See Appendix II for more detail, including the timeline for base and performance years impacting RYs 2017-2019).

For RY 2018, the QBR domains are weighted differently than those of the VBP program as illustrated in Figure 1 below. Main changes for this performance year are that the three-item Care Transition Measure (CTM-3)⁴ dimension was added to the HCAHPS survey, and the PC01-Early Elective Delivery measure was added to the Safety domain. The QBR program does not include an efficiency domain within the QBR program; however, Maryland has implemented an efficiency measure in relation to global budgets based on potentially avoidable utilization as measured by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQI) and readmissions. HSCRC staff will continue to work with key stakeholders to complete development of an efficiency measure that incorporates population-based cost outcomes.

Figure 1. RY 2018 Measures and Domain Weights for CMS VBP⁵ and Maryland QBR Programs

	Maryland QBR Domains and Measures	CMS VBP Domain Weights and Measure Differences
Clinical Care	15% (1 measure: all cause inpatient mortality)	25% (3 measures: condition-specific mortality)
Experience of Care⁶	50% (9 measures: HCAHPS 8 dimensions + CTM 3 dimension)	25% Same

³ 42 USC § 1395ww(o)(7)(C).

⁴ The Care-Transitions Measure is a composite of three questions related to patients’ and caregivers’ understanding of necessary follow-up care post-discharge, detailed in questions 23-25 of the HCAHPS survey. For specifics on the measure, including question language, please see:

[https://mhd0.maine.gov/pdf/CTM%20Microspecifications%20Manual %20Nov%202013_final.pdf](https://mhd0.maine.gov/pdf/CTM%20Microspecifications%20Manual%20Nov%202013_final.pdf).

⁵ Details of CMS VBP measures may be found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html>

⁶ For the FFY 2018 VBP program, CMS changed the name of this domain from “Patient experience of care” to “Patient and Caregiver-Centered Experience of Care/Care Coordination,” and for the 2019 VBP program, CMS changed the name to “Patient and Community Engagement.” For purposes of this report, this domain will be referred to as “experience of care” across the program years.

	Maryland QBR Domains and Measures	CMS VBP Domain Weights and Measure Differences
Safety	35% (8 measures: CDC NHSN, all-payer PSI 90, PC01)	25% PSI 90 Medicare only; others same
Efficiency	N/A	25% (Medicare spending per beneficiary measure)

ASSESSMENT

This section summarizes Maryland hospital performance including scores for RY 2017 (completed), and the most updated performance data on a select subset of measures currently in use for the RY 2018 QBR or VBP program.

Performance Results on QBR and VBP Measures with Most Recent Data Available

For a **subset** of the measures across the domains used for the RY 2018 QBR and/or VBP programs based on the most current data available from CMS, Figure 2 below provides Maryland’s performance levels (Most Recent Rate), the change from the previous 12-month period (Improvement from Previous Year), and the difference between the most recent national VBP program performance and the most recent Maryland rates (Difference from National Rates). The colors of the cells illustrate comparisons to national or previous year’s rates (see color key). Figure 2 is designed to provide a concise snapshot on performance, but detailed data for this Figure and additional comparison calculations are available in the series of tables found in Appendix III. Additional highlights regarding Maryland’s performance on the measures by domain are provided in the text just following Figure 2.

Figure 2. Selected QBR/VBP Measures: Maryland Current Rates, Improvement from Previous Year, and Change in Difference from National Performance

Color Codes	Worse than the National Rate	Worse than MD Previous Year	MD-National gap worse than previous yr. gap
	Better than the National Rate	Improved from MD Previous Year	MD National gap better than Previous year gap
	At National Average	No Change	No Change Not Available
Domain (RY 2018) Measure	Most Recent Rate	Improvement From Previous Year	Difference from National Rate
Experience of Care Domain (HCAHPS Percent “top box” or most positive response reported)			
Responsiveness	59%	-1%	-9%
Overall Rating	65%	0%	-7%
Clean/Quiet	62%	0%	-7%
Explained Medications	60%	0%	-5%
Nurse Communication	76%	0%	-4%
Pain Management	68%	1%	-3%
Doctor Communication	79%	1%	-3%
Discharge Info	86%	0%	-1%
Three-Part Care Transitions Measure	48%	0%	-4%
Clinical Care- Outcome Domain (Mortality Risk Adjusted Rates)			
30-day AMI	14.06%	-0.44%	-0.14%
30-day Heart Failure	10.86%	-0.04%	-0.74%
30-day Pneumonia	10.64%	-0.21%	-0.86%
Safety Domain			
PC-01 Early Elective Delivery (% Deliveries)	5%	2%	2%
NHSN SIR: Standardized Infection Ratios			
CLABSI	0.50	-5.12%	-0.50%
CAUTI	0.86	-48.04%	-0.14%
SSI – Colon	1.19	12.32%	0.19%
SSI - Abdominal Hysterectomy	0.92	-28.49%	-0.08%
MRSA	1.20	-10.71%	0.20%
C.diff.	1.15	-0.26%	0.15%
Measurement time periods for HCAHPS and Safety measures: Q4-2013 to Q3-2014 and Q4-2014 to Q3-2015 (most recent rate); for 30-day mortality Q3-2010 to Q2-2013 and Q3-2011 to Q2-2014 (most recent rate). For measures reported as a percentage, the improvement and National gap are reported as percentage points; for SIRs, the improvement and National gap are reported as percent differences.			

Safety Measures

For the early elective induction or Cesarean section delivery measure (PC-01), staff notes that Maryland performed better than the nation in the earlier time period but worse with a sharp increase in the later period. By contrast, the nation improved from the earlier to the latter period.

For Centers for Disease Control National Health Safety Network (CDC NHSN) Standardized Infection Ratio (SIR) measures compared to a national reference period (2008-2011) where the SIR was established at the value of 1 (See Appendix III, Table 4 for detailed data), Maryland statewide performance appears better on average than the national average for some of the measures and worse for others in both the earlier and later time periods. Staff was unable to compare changes in the national rate from a previous time period (indicated in Figure 2 above as grey “not available”).

Experience of Care Measures

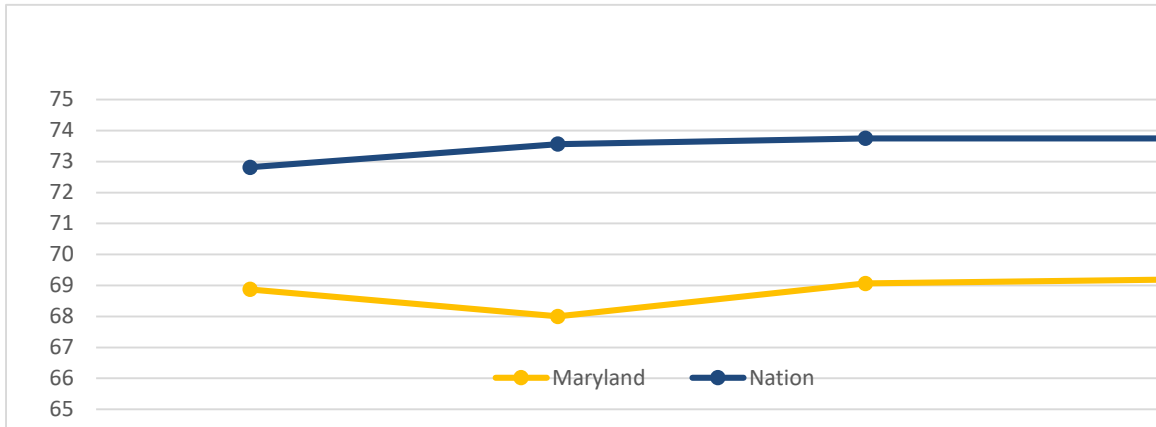
As noted previously, the experience of care domain is weighted most heavily in the Maryland QBR Program (45 percent in RY2017 and 50 percent in RY 2018). Staff compared the most recently available two years of data for experience of care with that of the nation (Figure 2; see Appendix III, Table 1 for detailed data) and notes that compared to the nation, Maryland’s most recent rates are worse for all nine of the experience of care HCAHPS dimensions (indicated in Figure 2 as all red).

Maryland’s performance has not changed significantly overall, and the nation has had modest improvement year over year from 2012 to 2015. In their letters exempting Maryland from the VBP program in 2015 and 2016 (see Appendix II), CMS also notes Maryland’s ongoing significant lag behind national medium performance levels and has been strongly in favor of increasing weight for this domain in the QBR program. Additional analysis of experience of care scores (an aggregate of eight dimensions available since 2012) comparing Maryland to the nation shows that, as illustrated in Figure 3 below, Maryland’s performance declined in 2013 and improved in 2014 to 2012 levels. Given that 2013 was the base period for RY 2017, some of the improvement seen in the RY 2017 QBR scores is due to declines in performance in the base year.

Staff notes that, consistent with the VBP program determination in the FY 2017 Outpatient Prospective Payment System (PPS) Final Rule,⁷ the pain management question will be prospectively removed from the QBR program for RY 2019.

⁷ FY 2017 OPPS Final Rule found at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1656-P.html>, last accessed December 1, 2016.

**Figure 3. Maryland vs. National Experience of care
Aggregate Scores over Time**



Clinical Care Mortality Measures

On the three CMS condition-specific mortality measures used in the VBP program—30 day heart attack (AMI), heart failure (CHF), and pneumonia— Maryland performs better than the nation with the gap narrowing over time (Figure 2 above; See Appendix III, Table 2 for detailed data).

For the Maryland inpatient, all-payer, all-cause mortality measure used for the QBR program, Maryland’s mortality rate declined from 2.87 percent to 2.15 percent between RY 2014 and calendar year (CY) 2015 (see Appendix III, Table 3). Staff analyzed the trend in mortality rates and concluded that the palliative care exclusion has contributed to the decline in the all-payer, all-cause mortality rates. As illustrated in Figure 4 below, the percentage of deaths with palliative codes increased from 42.92 percent to 61.09 percent over the last two years. To prevent further impact of changes in palliative care trends on mortality measurement, the palliative care case exclusion will be eliminated for RY 2019, and these cases will now be included in calculating benchmarks, thresholds, and risk-adjusted hospital mortality rates.

Figure 4. Maryland Statewide Hospital Total and Palliative Care Cases, CY 2013-2015

Calendar Year	Total Discharges	Discharges w/ Palliative Care (PC) Diagnosis (Dx)	Total Deaths	Total Deaths w/ PC Dx	% of Total Discharges w/PC Dx	% of Deaths w/PC Dx	% Live Discharges w/PC Dx
2013	664,849	14,038	13,105	5,625	2.11%	42.92%	1.29%
2014	642,139	17,464	12,670	6,802	2.72%	53.69%	1.69%
2015	624,202	19,447	12,114	7,401	3.12%	61.09%	1.97%

Additional Measure Results

For the newly published Total Hip and Knee Arthroplasty THA/TKA complication measure, performance results were only available for the latter time period. *Hospital Compare*⁸ reports that all Maryland hospitals perform “as expected” on this measure (with the exception of one hospital that is better and one that is worse than expected) compared with the nation.

In draft recommendations, staff supported adopting this measure for the RY 2019 QBR program to be consistent with CMS VBP. Upon further analysis of data available from the CMS website, staff now recommends delaying the adoption of this measure to RY 2020 pending resolution of data issues.

As part of the strategic plan to expand the performance measures, staff started to examine other measures available in public reporting. Staff notes that Maryland performs poorly on the ED wait time measures compared to the nation. In addition, Maryland and national performance is declining over time. Therefore, staff strongly advocates “active” monitoring of the ED wait times measures with consideration as to the feasibility of adding these measures to the QBR program in future years (See Appendix III, Table 5).

RY 2019 VBP and QBR Measures, Performance Standards, and Domain Weighting

HSCRC staff are proposing to keep the QBR measures, domain weights, and inclusion criteria for RY 2019 the same as they were for RY 2018, per Figure 5 below. Appendix I details the measures by domain and the available published performance standards for each measure. It also indicates the measures that will be included in the VBP and QBR Programs. Staff note that currently there is no ICD-10 compatible risk-adjusted Patient Safety Indicator 90 (PSI-90) measure but that this measure will be included in the future.

Figure 5. Final Measure Domain Weights for the CMS Hospital VBP Program and Proposed Domain Weights for the QBR Program, FY 2019

	Clinical Care	Patient Experience of Care; Care Coordination	Safety	Efficiency
QBR FY 2018	15% (1 measure - mortality)	50% (9 measures - HCAHPS + CTM)	35% (8 measures - Infection, PSI, PC-01)	PAU
Proposed QBR FY 2019	15% (1 measure - mortality)	50% (8 measures - HCAHPS + CTM)	35% (7 measures - Infection + PC-01)	PAU
CMS VBP FY 2019	25% (4 measures - condition-specific mortality; THA/TKA)	25% (8 measures - HCAHPS + CTM)	25% (8 measures - Infection, PSI, PC-01)	25%

⁸ See <https://www.medicare.gov/hospitalcompare/search.html> for more information.

QBR RY 2017 Final Scores and Reward and Penalty Preset Scale

Similar to other quality-based programs, the Commission voted to modify fundamentally the QBR program methodology for calculating rewards and penalties for RY 2017, such that the level of rewards or penalties is determined based on performance points achieved relative to a preset scale, rather than a relative ranking and scaling of the hospitals determined after the performance period. This transition coincided with major changes in the measures used for the QBR program, which entailed removing the process measures (which had higher scores), increasing the weight of experience of care (which had lower scores), and tying the benchmarks to the national distribution. At the time, staff did not have sufficient data to model the implications of these changes on the performance points thoroughly and, therefore, set the payment adjustment scale based on the base year attainment-only performance results relying on input from the Performance Measurement Workgroup.

Hospital pay-for-performance programs implemented nationally and in Maryland generally score hospitals on both attainment (level of rates compared to benchmarks) and on improvement (rate of change from the baseline). Hospitals may earn two scores on the measure specified within each domain—one for attainment (0-10) and one for improvement (0-9). The final score awarded to a hospital for each measure is the higher of these two scores. For experience of care measures, there are also consistency points. All measure scores, with exception of the HSCRC-derived measures using Maryland all-payer case mix data (e.g., PSI 90, all-cause inpatient mortality), include assignment of points between 0 and 10 based on the national average rate for 0 points and the top 25 percent national performance for 10 points. Details regarding the scoring calculations are found in Appendix II.

Figure 5 below provides descriptive statistics on the final statewide total QBR scores and scores by each domain for RY 2017. These aggregate level domain scores reflects the proportion of total available points received by the hospital. A 0 score represents none of the measures in that domain were better than the national average or did not improve. A score of 1 represents all measures are at or better than the top 25 percent performance. Experience of care is the most heavily weighted domain, and Maryland scores are lowest for this domain, with an average score of 0.24 and maximum score of 0.54. The domain with the next lowest distribution of scores is safety, with an average score of 0.40; this domain is also weighted second highest in calculating hospitals' total QBR scores. Appendix IV presents RY 2017 final QBR score results by hospital and domain.

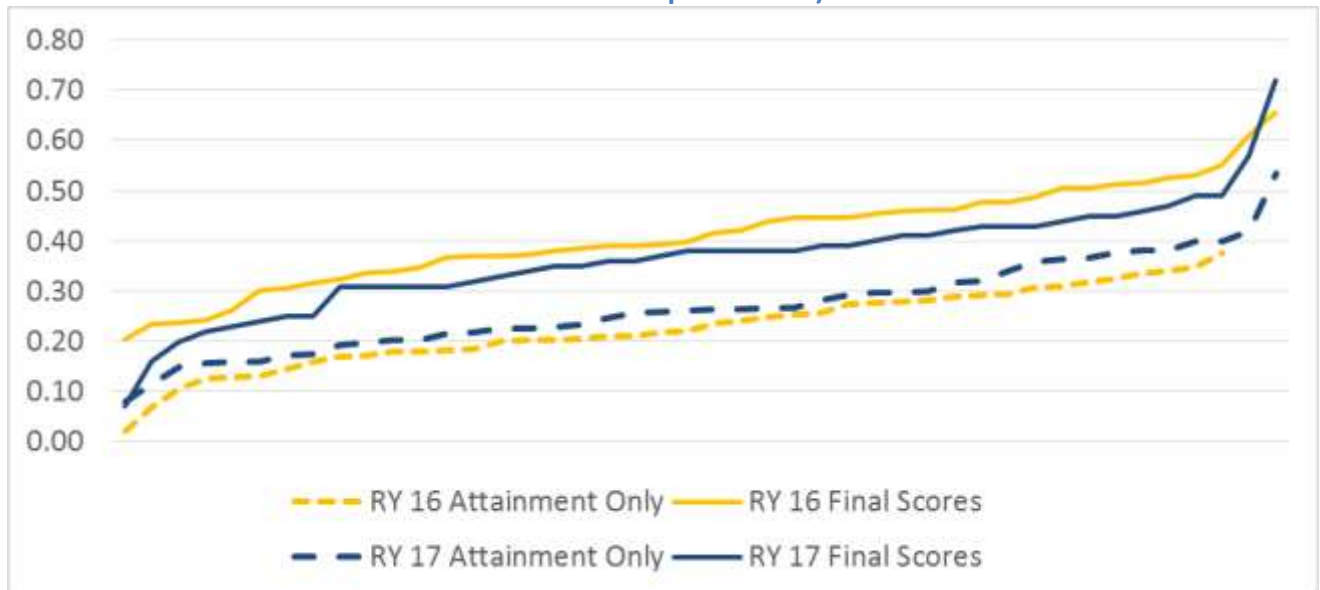
Figure 5. RY 2017 Final QBR Scores Distribution Overall and by Domain

Domains	Experience of Care	Clinical Care- <i>(Process Sub-domain retired after RY 2017)</i>	Clinical Care- (Outcome Sub-domain)	Safety	Total QBR Score
Measure Description	HCAHPS	AMI 7a-Fibrinolytic Therapy IMM 2- Influenza Immunization	Inpatient All DRG Mortality	CDC NHSN Infection (3 measures), PSI 90	

Ry 2017 Weights	45%	5%	15%	35%	100%
Minimum Score	0.03	0.00	0.00	0.00	0.07
25th percentile	0.16	0.40	0.33	0.25	0.31
Median	0.23	0.60	0.60	0.39	0.38
Average	0.24	0.56	0.60	0.40	0.37
75th Percentile	0.30	0.80	0.88	0.54	0.43
Maximum Score	0.54	1.00	1.00	1.00	0.72
Coefficient of Variation	46%	59%	48%	54%	30%

While the figure 5 provides information for the FY 2017 Final QBR scores, Figure 6 below shows the difference between the base period attainment-only scores for RYs 2016 and 2017 versus the final scores for each period, illustrating a significant increase in the final scores when improvement is taken into account. Absent data, staff was unable to model the final scale for RY 2017 and agreed to set the points for the attainment-only scale given the major changes in the program described above.

Figure 6. QBR RY 2016-2017 Attainment-Only and Final Scores (Reflecting the better of Attainment or Improvement)



Staff calculated hospital RY 2017 QBR scores and analyzed the scores relative to the QBR preset scale determined last year and notes that almost all hospitals receive a reward for RY 2017 despite relatively poor performance (Appendix V). With the recommendation to make retrospective adjustments to the readmission policy, staff had noted the issue with the QBR scaling at the June 2016 Commission meeting and has been working since then to understand the

implications. Expecting changes to the results, July RY 2017 rate orders and global budgets were sent without QBR program adjustments.

Based on the analysis comparing attainment and improvement points, staff asserts that the RY 2017 preset scale was too low, because it was developed using base period data to calculate attainment-only scores and, again, did not account for improvement trends. The intention to use a preset scale was to improve predictability of the payment adjustments, not to lower the scale as Maryland has been progressively “raising the bar” for performance. Staff is proposing the following for RY 2017 scaling adjustment to correct the issue of the current preset scale being too low:

- Revise preset scale to use final RY 2017 QBR scores. This would result in a relative ranking within the State that penalizes hospitals with QBR scores below the statewide average and reward hospitals with scores above the statewide average (i.e., RY 2017 State average score is 0.37). Staff has provided modeling of the RY 2017 scores using the final scores for FY 2017 in Appendix V.

HSCRC has received input from stakeholders regarding the draft recommendation updating the QBR program presented in the October Commission meeting. As mentioned earlier, HSCRC has also received VBP exemption approval letters from CMS directly addressing the experience of care domain performance lag in Maryland (Appendix II). Highlights of the issues raised during the meeting and in the letters submitted to the Commission by CMS, the Maryland Hospital Association (MHA) and Consumer Health First (CHF), along with staff responses, is provided below, and the MHA and CHF comment letters are provided in Appendix VI.

- ***Consistency with the CMS VBP approval letters (CMS)***- Staff asserts that Maryland has committed to adjusting incentives to support improvement in experience of care as part of the conditions for seeking the Maryland exemptions from year to year from the VBP program. In their responses, CMS has voiced strong support for increasing the weight of the experience of care domain to improve Maryland’s poor performance. Staff asserts that using a scale that rewards poor performance is not consistent with Maryland’s commitments to, and recommendations from, CMS.
- ***Need for predictability (MHA, hospital stakeholders)***- Staff supports the principle of predictability and asserts this must be balanced with the principle of fairness. Staff, for example, made retrospective changes to the Readmission policy in June 2016 to reduce penalties for hospitals with low readmission rates and low improvement. Staff also voiced the concern regarding the low bar for the QBR program scaling in the same June 2016 meeting.
- ***Approach must maintain trust between stakeholders and Commission (MHA, hospitals, CHF)***- Staff asserts that justified corrections, just as they have been made historically, will continue to strengthen trust, and providing rewards not aligned with performance has potential to erode public trust.

- **QBR must support patient-centered care and the goals emphasized by the All-Payer Model (CMS, CHF)**- Staff is in strong agreement that improved performance on experience of care is of high importance and priority as part of Maryland’s patient centered care model as it strives to achieve better care, better outcomes, and lower costs.
- **No error in policy was made in determining RY 2017 scaling approach (MHA, hospitals)**- The distribution of the scores used to set the payment scale (Figure 6 above) using base year attainment only scores was done with the assumptions that changes in the measures and benchmarks would precipitate lower scores for RY 2017. Preliminary performance score calculations in May 2016 showed a \$30M net positive impact despite low performance scores. Staff again believes there was an error and supports a technical correction to the point intervals used for scaling.
- **Burdensome to make mid-year GBR adjustment (MHA, hospitals)**- Although not preferable, if the retroactive scaling adjustment is approved for RY 2017, MHA will support it without a “retroactive budget change” in the current fiscal year. Staff proposes to limit negative revenue adjustments during the current RY with partial penalties up to the amount indicated in the preset scale in the January RY 2017 rate adjustments, and the remaining penalties July RY 2018 rate adjustment. Staff supports hospitals receiving their full rewards under the revised scaling for RY 2017 in the January rate update. Figure 7 below shows the partial rate adjustment implementation scenarios

Figure 7. Examples of Implementation of Revenue Adjustments for RY2017

	Original Preset Scale	Revised Revenue Adjustment	January Adjustment	July Adjustment
Hospital A	-100,000	-120,000	-100,000	-20,000
Hospital B	10,000	-30,000	0	-30,000
Hospital C	100,000	60,000	60,000	0

QBR RY 2018 Payment Adjustment Scaling Options

For RY 2018, a retrospective change to the preset payment scale is proposed, as the payment scale was set with the same points as original RY 2017 and will therefore be similarly incorrect. Staff is recommending to recalibrate the scaling in the same way that was approved for RY 2017, whereby final scores will be used to create a scale that penalizes those hospitals with below average performance. It is anticipated that the RY 2018 payment adjustments may not be implemented until January 2018 due to data delays. However, staff is working with CMS to determine if the state can receive the Hospital Compare data earlier to calculate QBR scores.

QBR RY 2019 Payment Adjustment Scaling

While staff agrees that there are limited options for RY 2018 adjustments since the performance period is completed, RY 2019 scaling approach can be modified to ensure the payment amounts are more directly linked with the states performance against national trends. Therefore, for RY 2019, staff is proposing a prospective scaling approach that uses the national full score range with adjustments to assess Maryland hospital performance. Based on stakeholder input, including a comment letter from the Maryland Hospital Association (MHA) (Appendix VII), the hospital industry prefers using a prospective scale, over using a scale based on final scores. However, staff believes that continuing to use the statewide distribution of scores to set the payment adjustment scale does not incentivize all Maryland hospitals to improve and achieve performance on par with the nation.

With the exception of the HSCRC-derived measures, which utilize Maryland all-payer case mix data (e.g., all-cause inpatient mortality), the thresholds and benchmarks for the QBR scoring methodology are based on the national average (threshold) and the top performance (benchmark) values for all measures. A score of 0 means that performance on all measures are below the national average or not improved, while a score of 1 mean all measures are at or better than top 5 percent best performing rates. Although hospital scores reflect performance relative to the national thresholds and benchmarks, the use of a statewide distribution to set the scaling for financial incentive payment adjustments creates a disconnect between Maryland and national performance, resulting in rewards for scores at or above 37% and the maximum reward to scores of 57%. The problem resulting from using Maryland scaling was evident in the initial results for RY2017, which provided significant reward payments despite the state's unfavorable collective performance.

Adjusting the scale to reflect the full distribution of scores (0% to 100%) ensures that QBR revenue adjustments are linked with Maryland hospital performance relative to the nation. As Maryland raises the bar that must be cleared to obtain rewards with this approach, the potential rewards should be commensurately increased from 1 percent to 2 percent. The full scale approach allows the HSCRC to set the scaling prospectively, meaning that hospitals will not be relatively ranked after the performance period. Most importantly, the use of the full score scale ensures that hospitals that perform better than the national average will be rewarded, and hospitals that perform worse than the national average will be penalized.

The staff modeled the following options for the RY 2019 scaling adjustments using the final RY 2017 hospital scores (see Figure 8 for statewide adjustments and Appendix Y for Hospitals specific results):

- **Prospective Scale set on RY2017 Final Scores Range: 7-57% with 37% reward/penalty cutoff**
- **Full Score Range: 0-100% with 50% reward/penalty cutoff**

- **Adjusted Full Score Range Option 1: 0-80% (max realistic score) with 40% reward/penalty cutoff**
- **Adjusted Full Score Range Option 2: 0-80% (max realistic score) with 45% reward/penalty cutoff**

Figure 8. RY 2019 Scaling Options and Statewide Revenue Adjustments

RY 19 Scaling Options	Min	Cut Point	Max	Statewide Penalties	Statewide Rewards
Final Scores (max reward 1%)	7%	37%	57%	-\$20M	+11M
Full Scale Options Max Reward 2%					
Full Score Range	0%	50%	100%	-49M	+1M
Option 1	0%	40%	80%	-24M	+7M
Option 2	0%	45%	80%	-37M	+3M
<i>Note: Modeling based on RY17 Final Scores</i>					

The MHA comment letter models an additional option where the prospective scale is based on RY 2017 scores (range 7% - 57%) but with a revenue neutral zone between 34% and 38%. The staff does not support a revenue neutral zone given state performance compared to the nation and the need for all hospitals to be incentivized to improve.

Staff recommends Option 2, an adjusted full score distribution scale that ranges from 0 to 80% where hospitals scoring greater than 45% are rewarded. The maximum score for the full 2% reward was set at 80% because this represents a realistic max score. The staff propose the cut off point for penalties/rewards be 45%. The staff note that while the National average VBP score ranges from 36% to 41% according to the MHA comment letter, these VBP scores have different measures, domains, and weights. An analysis of FFY 2017 VBP scores indicates that the national average VBP score would be approximately 5% higher (36% vs 41%) without the efficiency domain and with RY 2017 QBR weights applied.

Recommendations

Staff notes the State’s improvement trends in the Maryland inpatient, all-cause, all-payer mortality rate used for the QBR program as well as the CMS condition-specific mortality measures used for the VBP program but cautions these observations should be tempered with the knowledge that the previous palliative care exemption will not be applied going forward. Staff also recognizes the gap that remains between Maryland and national performance on the experience of care measures in particular, the domain that constitutes 45 percent for RY 2017 and 50 percent for RY 2018 of the hospitals’ QBR total scores. **In this section of the report, staff presents previously approved final recommendations for RY 2017 and final recommendations for RYs 2018 and 2019.**

Final Recommendations for RY 2017—Approved at December 14, 2017 Commission Meeting

Based on the analysis and observations presented above, staff recommends the following retrospective adjustments to the RY 2017 QBR program:

- Adjust retrospectively the RY 2017 QBR preset scale for determining rewards and penalties such that the scale accounts for both attainment and improvement trends.
- Use a relative scale to linearly distribute rewards and penalties based on the final QBR scores, without revenue neutrality adjustment.
- Adjust rates in the updated rate orders to reflect the proposed updated QBR scaling approach.
- Limit negative revenue adjustments during the current RY by partially implementing penalties (up to the amount indicated in preset scale) in the January RY 2017 rate adjustments, and implementing the remaining penalties in the July RY 2018 rate adjustments.

Final Recommendation for RY 2018

Staff recommends the following for RY 2018:

- **Calculate the scaling points based on RY 2018 performance periods and provide rewards to hospitals that are above the average score, with a maximum penalty of 2 percent and maximum reward of 1 percent of inpatient revenue distributed linearly in proportion to calculated scores.**

Final Recommendations for RY 2019

Staff recommends the following for RY 2019:

- **Maintain RY 2018 domain weights: 50 percent for Patient Experience/Care Transition, 35 percent for Safety, and 15 percent for Clinical Care.**
- **Move to a modified full score distribution ranging from 0-80%, and linearly scale penalties and rewards at 45% cut point.**
- **Maintain 2% maximum penalty and increase the maximum reward to 2 percent as the achieving rewards will be based on full score distribution.**

APPENDIX I. CMS FFY 2019 VBP MEASURES AND PERFORMANCE PERIODS

FY 2019 Value-Based Purchasing Domain Weighting
(Payment adjustment effective for discharges from October 1, 2018 to September 30, 2019)



PERSON AND COMMUNITY ENGAGEMENT			
Baseline Period		Performance Period	
January 1, 2015 – December 31, 2015		January 1, 2017 – December 31, 2017	
HCAHPS Survey Dimensions	HCAHPS Performance Standard		
	Floor (%)	Threshold (%)	Benchmark (%)
Communication with nurses	28.10	78.69	86.97
Communication with doctors	33.46	80.32	88.62
Responsiveness of hospital staff	32.72	65.16	80.15
Communication about medications	11.38	63.26	73.53
Cleanliness and quietness	22.85	65.58	79.06
Discharge information	61.96	87.05	91.87
CTM-3 3-item Care Transitions Measure	11.30	51.42	62.77
Overall rating of hospital	28.39	70.85	84.83

SAFETY		
Complication/Patient Safety for Selected Indicators		
Baseline Period		Performance Period
July 1, 2011 – June 30, 2013		July 1, 2015 – June 30, 2017
Measure	Threshold	Benchmark
AHRQ PSI 90 composite*	0.840335	0.589462
Perinatal		
Baseline Period		Performance Period
January 1, 2015 – December 31, 2015		January 1, 2017 – December 31, 2017
Measure	Threshold	Benchmark
PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation	0.010038	0.000
Healthcare-Associated Infections:		
Baseline Period		Performance Period
January 1, 2015 – December 31, 2015		January 1, 2017 – December 31, 2017
Measure	Threshold (‡)	Benchmark (‡)
CLABSI [†]	0.427	0.000
CAUTI [†]	0.464	0.000
SSI Colon [‡]	0.832	0.000
Abdominal Hysterectomy [‡]	0.698	0.000
C. difficile	0.816	0.012
MRSA Bacteremia	0.823	0.000

*Potential removal in future rulemaking.
[†]Includes selected ward (non-ICU) locations.
[‡]Standardized infection ratios.
[§]There will be one SSI measure score that will be a weighted average based on predicted infections for both procedures.

CLINICAL CARE		
Mortality		
Baseline Period		Performance Period
July 1, 2009 – June 30, 2012		July 1, 2014 – June 30, 2017
Measure (Displayed as survival rate)	Threshold (%)	Benchmark (%)
30-day mortality, AMI	85.0671	87.3283
30-day mortality, heart failure	88.3472	90.8094
30-day mortality, pneumonia	88.2334	90.7908
Complications		
Baseline Period		Performance Period
July 1, 2010 – June 30, 2013		January 1, 2015 – June 30, 2017
New [†] THA/TKA – Total hip/total knee arthroplasty complications	03.2229	02.3178

EFFICIENCY AND COST REDUCTION		
Baseline Period		Performance Period
January 1, 2015 – December 31, 2015		January 1, 2017 – December 31, 2017
Measure	Threshold (%)	Benchmark (%)
MSPB-1 Medicare spending per beneficiary	Median Medicare spending per beneficiary ratio across all hospitals during performance period.	Mean of lowest decile of Medicare spending per beneficiary ratios across all hospitals during performance period.

The Lake Superior Quality Innovation Network serves Michigan, Minnesota, and Wisconsin, under the Centers for Medicare & Medicaid Services Quality Improvement Organization Program.

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This material was prepared by the Lake Superior Quality Innovation Network, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The materials do not necessarily reflect CMS policy.
 11SOW-MI/MN/WI-D1-14-12 010517

Appendix II. HSCRC QBR Program Details: Domain Weights, Revenue at Risk, Points Calculation, Measurement Timeline and Exemption from CMS VBP Program

Domain Weights and Revenue at Risk

As illustrated in the body of the report, for the RY 2018 QBR program, the HSCRC will weight the clinical care domain at 15 percent of the final score, the safety domain at 35 percent, and the experience of care domain at 50 percent.

The HSCRC sets aside a percentage of hospital inpatient revenue to be held “at risk” based on each hospital’s QBR program performance. Hospital performance scores are translated into rewards and penalties in a process that is referred to as scaling.⁹ Rewards (referred to as positive scaled amounts) or penalties (referred to as negative scaled amounts) are then applied to each hospital’s update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered permanent revenue. The Commission previously approved scaling a maximum reward of one percent and a penalty of two percent of total approved base inpatient revenue across all hospitals for RY 2018.

HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the CMS VBP program where feasible,¹⁰ allowing the HSCRC to use data submitted directly to CMS. As alluded to in the body of the report, Maryland implemented efficiency measure in relation to global budgets based on potentially avoidable utilization outside of QBR program. The HSCRC does apply a potentially avoidable utilization savings adjustment to hospital rates based on costs related to potentially avoidable admissions, as measured by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQIs) and avoidable readmissions. HSCRC staff will continue to work with key stakeholders to complete development of an efficiency measure that incorporates population-based cost outcomes.

QBR Score Calculation

Attainment Points: During the performance period, attainment points are awarded by comparing an individual hospital’s rates with the threshold, which is the median, or 50th percentile of all hospitals’ performance during the baseline period, and the benchmark, which is the mean of the top decile, or approximately the 95th percentile during the baseline period. With the exception of the mortality and AHRQ PSI 90 measure applied to all payers, the benchmarks and thresholds are the same as those used by CMS for the VBP program measures. For each measure, a hospital that has a rate at or above benchmark receives 10 attainment points. A hospital that has a rate

⁹ Scaling refers to the differential allocation of a pre-determined portion of base-regulated hospital inpatient revenue based on assessment of the quality of hospital performance.

¹⁰ HSCRC has used data for some of the QBR measures (e.g., CMS core measures, CDC NHSN CLABSI, CAUTI) submitted to the Maryland Health Care Commission (MHCC) and applied state-based benchmarks and thresholds for these measures to calculate hospitals’ QBR scores up to the period used for RY 2017.

below the attainment threshold receives 0 attainment points. A hospital that has a rate at or above the attainment threshold and below the benchmark receives 1-9 attainment points

Improvement Points: The improvement points are awarded by comparing a hospital's rates during the performance period to the hospital's rates from the baseline period. A hospital that has a rate at or above benchmark receives 9 improvement points. A hospital that has a rate at or below baseline period rate receives 0 improvement points. A hospital that has a rate between the baseline period rate and the benchmark receives 0-9 improvement points

Consistency Points: The consistency points relate only to the experience of care domain. The purpose of these points is to reward hospitals that have scores above the national 50th percentile in all of the eight HCAHPS dimensions. If they do, they receive the full 20 points. If they do not, the dimension for which the hospital received the lowest score is compared to the range between the national 0 percentile (floor) and the 50th percentile (threshold) and is awarded points proportionately.

Domain Scores: Composite scores are then calculated for each domain by adding up all of the measure scores in a given domain divided by the total possible points x 100. The better of attainment and improvement for experience of care scores is also added together to arrive at the experience of care base points. Base points and the consistency score are added together to determine the experience of care domain score.

Total Performance Score: The total Performance Score is computed by multiplying the domain scores by their specified weights, then adding those totals and dividing them by the highest total possible score. The Total Performance Score is then translated into a reward/ penalty that is applied to hospital revenue.

QBR Base and Performance Periods Impacting RYs 2017-2019

HSCRC QBR Base, Performance Periods and Rate Year Impacted											ICD 9		ICD 10																
Rate Year (Maryland FY)	FY13-Q2	FY13-Q3	FY13-Q4	FY14-Q1	FY14-Q2	FY14-Q3	FY14-Q4	FY15-Q1	FY15-Q2	FY15-Q3	FY15-Q4	FY16-Q1	FY16-Q2	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		
Calendar Year	CY12-Q4	CY13-Q1	CY13-Q2	CY13-Q3	CY13-Q4	CY14-Q1	CY14-Q2	CY14-Q3	CY14-Q4	CY15-Q1	CY15-Q2	CY15-Q3	CY15-Q4	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		
Quality Programs that Impact Rate Year 2017																													
QBR	Federal Standards	Maryland QBR Core Process, HCAHPS, CLABSI Base Period																											
		QBR Core process, HCAHPS, CLABSI, PSI 90 performance Period											Rate Year Impacted by QBR Results																
		Maryland Mortality, PSI Base Period																											
		QBR SSI (Colon, hysterectomy) Base Period																											
QBR Maryland Mortality, CAUTI*, SSI Performance Period																													
Quality Programs that Impact Rate Year 2018																													
QBR	Federal Standards	QBR PC-01, HCAHPS, NHSN Safety Base Period																											
		QBR Mortality Base Period											QBR PC-01, HCAHPS, NHSN Safety Performance Period											Rate Year Impacted by QBR Results					
		QBR Mortality Performance Period																											
Quality Programs that Impact Rate Year 2019																													
QBR	Federal Standards	QBR PC-01, HCAHPS, NHSN Safety Base Period																											
		Maryland Mortality Base Period***											Rate Year Impacted by QBR Results																
		QBR Maryland PSI 90* Base Period																											
		**Medicare Total Hip/Knee Arthroplasty Risk Standardized Complication Rate (THA/TKA RSCR) Performance Period																											
QBR PC-01, HCAHPS, NHSN Safety Performance Period																													
QBR Maryland Mortality, PSI 90*, Performance Period																													
<p>*Rate Year 2017 Catheter Associated UTI (CAUTI) measure scored on attainment only.</p> <p>**Rate Year 2019 use of PSI 90 subject to AHRQ Development of ICD 10 measure specifications</p> <p>***Rate Year 2019 Base Period for THA/TKA RSCR measure 7/1/2010-6/30/2013; use of this measure contingent on Medicare claims data availability.</p> <p>****Proposed base period to allow shift to 3M Grouper version 34, exclusively ICD-10 Compatible.</p>																													

Maryland VBP Exemption

Under Maryland's previous Medicare waiver, VBP exemptions were requested and granted for FYs 2013 through 2015. The CMS FY 2015 Inpatient Prospective Payment rule stated that, although exemption from the hospital VBP program no longer applies, Maryland hospitals will not be participating in the VBP program because §1886(o) of the ACA¹¹ and its implementing regulations are waived under Maryland's New All-Payer Model, subject to the terms of the Model agreement as excerpted below:

“4. Medicare Payment Waivers. Under the Model, CMS will waive the requirements of the following provisions of the Act as applied solely to Regulated Maryland Hospitals:

e. Medicare Hospital Value Based Purchasing. Section 1886(o) of the Act, and implementing regulations at 42 CFR 412.160 - 412.167, only insofar as the State submits an annual report to the Secretary that provides satisfactory evidence that a similar program in the State for Regulated Maryland Hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under 1886(o) of the Act....”

Under the New All-Payer Model, HSCRC staff submitted exemption requests for FYs 2016 and 2017 and received approvals from CMS on August 27, 2015, and April 22, 2016, included below.

¹¹ Codified at 42 USC § 1395ww(o).



August 27, 2015

Ms. Donna Kinzer
Executive Director, Maryland Health Services Cost Review Commission
State of Maryland Department of Health and Mental Hygiene
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Kinzer:

Thank you for your letter, on behalf of the State of Maryland, requesting an exemption from the FY 2016 Hospital Value-Based Purchasing (VBP) Program. As you know, Section 4(e) of the Maryland All-Payer Model Agreement provides that CMS will waive the VBP Program requirements for Maryland hospitals, as set out in Section 1886(o) of the Social Security Act and implementing regulations at 42 CFR 412.160 - 412.167, provided that the State submits "an annual report to the Secretary that provides satisfactory evidence that a similar program in the State for Regulated Maryland Hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under 1886(o) of the Act."

The Centers for Medicare & Medicaid Services (CMS) has reviewed your exemption request and supporting documentation. We officially grant the State of Maryland's exemption request for its hospitals as authorized by Section 1886(o)(1)(C)(iv) of the Act based on the fact that the Maryland program achieved or exceeded patient health outcomes measured in the Hospital VBP Program. CMS has also determined that the Maryland program meets the cost savings requirement for exemption from the Hospital VBP Program for FY 2015 because both programs reward high performers in a revenue-neutral manner.

Last year, when approving your request for an exemption from the Hospital VBP Program for FY 2014, we noted that your state's performance in the Patient Experience of Care domain significantly lagged behind national medium performance levels, and we strongly encouraged you to take steps to improve performance in that domain. Maryland's performance continues to lag behind the nation in Patient Experience of Care, however, as you indicated in your exemption request, you have assigned comparatively more weight to Hospital Consumer Assessment of Healthcare Providers and Systems performance in the Maryland program, and you are considering increasing that weight by an additional 5%. We support these efforts to improve Patient Experience of Care and we are eager to assist you in helping hospitals improve in this domain by other means.

Should you have any questions, please do not hesitate to contact the Maryland All Payer Model Team.

Sincerely,

A handwritten signature in black ink that reads "Patrick Conway, MD". The signature is written in a cursive, slightly slanted style.

Patrick Conway, MD, MSc

Acting Principal Deputy Administrator, CMS

Chief Medical Officer, CMS

Deputy Administrator for Innovation and Quality, CMS

Director, Center for Medicare and Medicaid Innovation

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850



Center for Medicare and Medicaid Innovation

April 22, 2016

Ms. Donna Kinzer

Executive Director, Maryland Health Services Cost Review Commission State of Maryland
Department of Health and Mental Hygiene
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Kinzer:

Thank you for your letter, on behalf of the State of Maryland, requesting an exemption from the FY 2017 Hospital Value-Based Purchasing (VBP) Program. As you know, Section 4(e) of the Maryland All-Payer Model Agreement provides that CMS will waive the Hospital VBP Program requirements for Maryland hospitals, as set out in Section 1886(0) of the Social Security Act and implementing regulations at 42 CFR 412.160-412.167, provided that the State submits "an annual report to the Secretary that provides satisfactory evidence that a similar program in the State for Regulated Maryland Hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under 1886(0) of the Act."

The Centers for Medicare & Medicaid Services (CMS) has reviewed your exemption request and supporting documentation. We officially grant the State of Maryland's exemption request for its hospitals as authorized by Section 1886(o)(1)(C)(iv) of the Act based on the fact that the Maryland program achieved patient health outcomes and clinic process scores not significantly different from those measured in the Hospital VBP Program. CMS has also determined that the Maryland program meets the cost savings requirement for exemption from the Hospital VBP Program for FY 2017 because both programs reward high performers in a revenue-neutral manner.

Last year, when approving your request for an exemption from the Hospital VBP Program for FY 2016, we noted that your state's performance in the Patient Experience of Care domain using data from 2014 significantly lagged behind national medium performance levels, and we strongly encouraged you to take steps to improve performance in that domain. Maryland's performance continues to lag behind the nation in Patient Experience of Care. As indicated in your exemption request, you have assigned comparatively more weight to Hospital Consumer Assessment of Healthcare Providers and Systems performance in the Maryland program, and you are continuing to increase the weight even more in the coming years. We support these efforts to improve Patient Experience of Care and we are eager to assist you in helping hospitals improve in this domain in any way possible.

Should you have any questions, please do not hesitate to contact the Maryland All Payer Model Team.

Sincerely,

A handwritten signature in black ink, appearing to read 'Stephen Cha', written in a cursive style.

Stephen Cha, MD, MHS
Director, State Innovations Group,
Center on Medicare and Medicaid Innovation,
Centers for Medicare and Medicaid Services

APPENDIX III. RY 2017 QBR PERFORMANCE SCORES

Table 1. HCAHPS Analysis

Measure	Maryland (Q413-Q314)	National (Q413-Q314)	Percent difference MD-US	Maryland (Q414-Q315)	Change from Base	National (Q414-Q315)	Change from Base	Percent difference MD-US
Responsiveness	60	68	-8	59	-1	68	0	-9
Overall Rating	65	71	-6	65	0	72	1	-7
Clean/Quiet	61.5	68	-7	61.5	0	68	0	-7
Explained Medications	60	65	-5	60	0	65	0	-5
Nurse Communication	76	79	-3	76	0	80	1	-4
Pain Management	67	71	-4	68	1	71	0	-3
Doctor Communication	78	82	-4	79	1	82	0	-3
Discharge Info	86	86	0	86	0	87	1	-1
8 Item Aggregate TOTAL	69.1875	73.75	-4.56	69.31	0.13	74.1	0.38	-4.81
Three-Part Care Transitions Measure	48	52	-4	48	0	52	0	-4

Table 2. CMS Condition-Specific Mortality Measures

Mortality Measures	Maryland (Q310-Q213)	National (Q310-Q213)	Percent difference MD-US	Maryland (Q311-Q214)	Change from Base	National (Q311-Q214)	Change from Base	Percent difference MD-US
30-day AMI	14.50%	14.90%	-0.40%	14.06%	-0.44%	14.20%	-0.70%	-0.14%
30-day Heart Failure	10.90%	11.90%	-1.00%	10.86%	-0.04%	11.60%	-0.30%	-0.74%
30-day Pneumonia	10.85%	11.90%	-1.05%	10.64%	-0.21%	11.50%	-0.40%	-0.86%

Table 3. Maryland All-Payer Inpatient Mortality Measure

Mortality Measures	Maryland RY2014	Maryland CY2015	Change from Base
MD Mortality Measure	2.87%	2.15%	-0.72%

Table 4. Safety Measures

Safety Measures	Maryland (Q413-Q314)	National (Q413-Q314)	Percent difference MD-US	Maryland (Q414-Q315)	Change from Base	National (Q414-Q315)	Change from Base	Percent difference MD-US	Change from Base Period
CLABSI	0.527	1	-47.30%	0.5	NOTE: Change from base is not calculated because MD SIR is in relation to national SIR of 1	1	NOTE: Change from base is not calculated because MD SIR is in relation to national SIR of 1	-50.00%	-0.027
CAUTI	1.659	1	65.90%	0.862		1		-13.80%	-0.797
SSI - Colon	1.055	1	5.50%	1.185		1		18.50%	0.13
SSI - Abdominal Hysterectomy	1.281	1	28.10%	0.916		1		-8.40%	-0.365
MRSA	1.344	1	34.40%	1.2		1		20.00%	-0.144
C.diff.	1.15	1	15.00%	1.147		1		14.70%	-0.003
PC-01 Elective Delivery	3	4	-1	5		3		2	

Table 5. Measures for Monitoring

Other Measures - Monitoring Status	Maryland (Q413-Q314)	National (Q413-Q314)	Percent difference MD-US	Maryland (Q414-Q315)	Change from Base	National (Q414-Q315)	Change from Base	Percent difference MD-US
<i>IMM-2 Influenza Immunization</i>	96	93	3.23%	97	1	94	1	3.19%
ED1b - Arrive to admit	353	273	29.30%	364	11	280	7	30.00%
ED2b - Admit decision to admit	132	96	37.50%	139	7	99	3	40.40%
OP20 - Door to diagnostic eval	46	24	91.67%	48	2	23	-1	108.70%

APPENDIX IV. QBR MEASURES PERFORMANCE TRENDS

QBR Performance Scores						
Hospital ID	Hospital Name	HCAHPS Score	Clinical/ Process Score	Clinical/ Mortality Score	Safety Score	QBR Score
210001	MERITUS	0.17	1.00	0.30	0.53	0.36
210002	UNIVERSITY OF MARYLAND	0.25	0.80	0.80	0.33	0.39
210003	PRINCE GEORGE	0.03	0.70	0.10	0.50	0.24
210004	HOLY CROSS	0.09	0.80	0.30	0.30	0.23
210005	FREDERICK MEMORIAL	0.22	0.60	1.00	0.53	0.46
210006	HARFORD	0.30	0.80	0.40	0.33	0.35
210008	MERCY	0.49	0.00	0.20	0.45	0.41
210009	JOHNS HOPKINS	0.33	0.40	0.90	0.15	0.36
210010	DORCHESTER	0.24	0.80	0.90	.	0.44
210011	ST. AGNES	0.16	0.20	0.80	0.33	0.32
210012	SINAI	0.27	0.80	0.40	0.25	0.31
210013	BON SECOURS	0.15	0.00	0.00	0.00	0.07
210015	FRANKLIN SQUARE	0.13	0.40	0.60	0.40	0.31
210016	WASHINGTON ADVENTIST	0.23	0.80	0.70	0.00	0.25
210017	GARRETT COUNTY	0.27	0.60	0.70	.	0.40
210018	MONTGOMERY GENERAL	0.22	0.40	0.60	0.68	0.45
210019	PENINSULA REGIONAL	0.32	0.00	0.40	0.50	0.38
210022	SUBURBAN	0.37	0.00	0.50	0.65	0.47
210023	ANNE ARUNDEL	0.18	0.60	0.70	0.28	0.31
210024	UNION MEMORIAL	0.34	0.40	0.30	0.25	0.31
210027	WESTERN MARYLAND	0.32	1.00	0.80	0.08	0.34
210028	ST. MARY	0.51	1.00	0.60	1.00	0.72
210029	HOPKINS BAYVIEW MED CTR	0.25	0.80	0.50	0.43	0.38
210030	CHESTERTOWN	0.10	1.00	1.00	.	0.38
210032	UNION OF CECIL COUNT	0.29	0.40	0.40	0.47	0.37
210033	CARROLL COUNTY	0.21	0.80	0.60	0.58	0.43
210034	HARBOR	0.19	0.40	0.70	0.68	0.45
210035	CHARLES REGIONAL	0.22	0.00	0.50	0.70	0.42
210037	EASTON	0.24	0.80	0.50	0.25	0.31
210038	UMMC MIDTOWN	0.09	0.40	0.30	0.27	0.20
210039	CALVERT	0.25	0.40	1.00	.	0.43
210040	NORTHWEST	0.19	1.00	0.30	0.10	0.22
210043	BWMC	0.16	0.60	0.90	0.28	0.33
210044	G.B.M.C.	0.54	0.60	1.00	0.20	0.49
210048	HOWARD COUNTY	0.38	1.00	0.80	0.65	0.57
210049	UPPER CHESAPEAKE	0.12	0.80	1.00	0.38	0.38
210051	DOCTORS COMMUNITY	0.10	0.60	0.30	0.65	0.35
210055	LAUREL REGIONAL	0.16	0.00	0.20	.	0.16
210056	GOOD SAMARITAN	0.33	0.60	0.60	0.63	0.49
210057	SHADY GROVE	0.28	0.60	1.00	0.23	0.38
210060	FT. WASHINGTON	0.23	0.80	0.80	.	0.41
210061	ATLANTIC GENERAL	0.28	0.10	0.90	0.35	0.39
210062	SOUTHERN MARYLAND	0.17	0.00	0.10	0.45	0.25
210063	UM ST. JOSEPH	0.21	1.00	1.00	0.40	0.43

APPENDIX V. MODELING OF QBR SCALING OPTIONS

(Table not updated from December recommendation).

HOSPITAL NAME	RY 16 Permanent Inpatient Revenue	RY 2017 QBR FINAL POINTS	1.RY 2017 Current Scale		2a.Proposed RY 2017 Scale		2b. January 2017 and July 2017 Implementations		3. RY 2018	4. National Scale (Draft Recommendation for RY 2019)	
			% Impact	\$ Impact	% Impact	\$ Impact	Jan 2017 Rate Order Adjustment effective July 2016	Rate Order FY18 GBR (July 2017)	Use Relative Scale or National	% Impact	\$ Impact
Bon Secours Hospital	\$74,789,724	0.07	-2.00%	-\$1,495,794	-2.00%	-\$1,495,794	-\$1,495,794	\$0	TBD	-1.65%	-\$1,234,030
Laurel Regional Hospital	\$60,431,106	0.16	-1.11%	-\$670,785	-1.40%	-\$846,035	-\$670,785	-\$175,250	TBD	-1.20%	-\$725,173
Maryland General Hospital	\$126,399,313	0.20	-0.67%	-\$846,875	-1.13%	-\$1,432,526	-\$846,875	-\$585,650	TBD	-1.05%	-\$1,327,193
Northwest Hospital Center	\$114,214,371	0.22	-0.44%	-\$502,543	-1.00%	-\$1,142,144	-\$502,543	-\$639,600	TBD	-0.95%	-\$1,085,037
Holy Cross Hospital	\$316,970,825	0.23	-0.33%	-\$1,046,004	-0.93%	-\$2,958,394	-\$1,046,004	-\$1,912,391	TBD	-0.90%	-\$2,852,737
Prince Georges Hospital Center	\$220,306,426	0.24	-0.22%	-\$484,674	-0.87%	-\$1,909,322	-\$484,674	-\$1,424,648	TBD	-0.85%	-\$1,872,605
Southern Maryland Hospital Center	\$156,564,761	0.25	-0.11%	-\$172,221	-0.80%	-\$1,252,518	-\$172,221	-\$1,080,297	TBD	-0.80%	-\$1,252,518
Washington Adventist Hospital	\$155,199,154	0.25	-0.11%	-\$170,719	-0.80%	-\$1,241,593	-\$170,719	-\$1,070,874	TBD	-0.80%	-\$1,241,593
Sinai Hospital	\$415,350,729	0.31	0.18%	\$747,631	-0.40%	-\$1,661,403	\$0	-\$1,661,403	TBD	-0.50%	-\$2,076,754
Memorial Hospital at Easton	\$101,975,577	0.31	0.18%	\$183,556	-0.40%	-\$407,902	\$0	-\$407,902	TBD	-0.50%	-\$509,878
Anne Arundel Medical Center	\$291,882,683	0.31	0.18%	\$525,389	-0.40%	-\$1,167,531	\$0	-\$1,167,531	TBD	-0.50%	-\$1,459,413
Franklin Square Hospital Center	\$274,203,013	0.31	0.18%	\$493,565	-0.40%	-\$1,096,812	\$0	-\$1,096,812	TBD	-0.50%	-\$1,371,015
Union Memorial Hospital	\$238,195,335	0.31	0.18%	\$428,752	-0.40%	-\$952,781	\$0	-\$952,781	TBD	-0.50%	-\$1,190,977
St. Agnes Hospital	\$232,266,274	0.32	0.21%	\$487,759	-0.33%	-\$774,221	\$0	-\$774,221	TBD	-0.45%	-\$1,045,198
Baltimore Washington Medical Center	\$237,934,932	0.33	0.25%	\$594,837	-0.27%	-\$634,493	\$0	-\$634,493	TBD	-0.40%	-\$951,740
Western MD Regional Medical Center	\$167,618,972	0.34	0.29%	\$486,095	-0.20%	-\$335,238	\$0	-\$335,238	TBD	-0.35%	-\$586,666
Harford Memorial Hospital	\$45,713,956	0.35	0.32%	\$146,285	-0.13%	-\$60,952	\$0	-\$60,952	TBD	-0.30%	-\$137,142

HOSPITAL NAME	RY 16 Permanent Inpatient Revenue	RY 2017 QBR FINAL POINTS	1.RY 2017 Current Scale		2a.Proposed RY 2017 Scale		2b. January 2017 and July 2017 Implementations		3. RY 2018	4. National Scale (Draft Recommendation for RY 2019)	
			% Impact	\$ Impact	% Impact	\$ Impact	Jan 2017 Rate Order Adjustment effective July 2016	Rate Order FY18 GBR (July 2017)	Use Relative Scale or National	% Impact	\$ Impact
Doctors Community Hospital	\$132,614,778	0.35	0.32%	\$424,367	-0.13%	-\$176,820	\$0	-\$176,820	TBD	-0.30%	-\$397,844
Meritus Hospital	\$190,659,648	0.36	0.36%	\$686,375	-0.07%	-\$127,106	\$0	-\$127,106	TBD	-0.25%	-\$476,649
Johns Hopkins Hospital	\$1,244,297,900	0.36	0.36%	\$4,479,472	-0.07%	-\$829,532	\$0	-\$829,532	TBD	-0.25%	-\$3,110,745
Union of Cecil	\$69,389,876	0.37	0.39%	\$270,621	0.00%	\$0	\$0	\$0	TBD	-0.20%	-\$138,780
Johns Hopkins Bayview Medical Center	\$343,229,718	0.38	0.43%	\$1,475,888	0.05%	\$171,615	\$171,615	\$0	TBD	-0.15%	-\$514,845
Shady Grove Adventist Hospital	\$220,608,397	0.38	0.43%	\$948,616	0.05%	\$110,304	\$110,304	\$0	TBD	-0.15%	-\$330,913
Peninsula Regional Medical Center	\$242,318,199	0.38	0.43%	\$1,041,968	0.05%	\$121,159	\$121,159	\$0	TBD	-0.15%	-\$363,477
Upper Chesapeake Medical Center	\$135,939,076	0.38	0.43%	\$584,538	0.05%	\$67,970	\$67,970	\$0	TBD	-0.15%	-\$203,909
Chester River Hospital Center	\$21,575,174	0.38	0.43%	\$92,773	0.05%	\$10,788	\$10,788	\$0	TBD	-0.15%	-\$32,363
University of Maryland Hospital	\$906,034,034	0.39	0.46%	\$4,167,757	0.10%	\$906,034	\$906,034	\$0	TBD	-0.10%	-\$906,034
Atlantic General Hospital	\$37,750,252	0.39	0.46%	\$173,651	0.10%	\$37,750	\$37,750	\$0	TBD	-0.10%	-\$37,750
Garrett County Memorial Hospital	\$19,149,148	0.40	0.50%	\$95,746	0.15%	\$28,724	\$28,724	\$0	TBD	-0.05%	-\$9,575
Fort Washington Medical Center	\$19,674,774	0.41	0.54%	\$106,244	0.20%	\$39,350	\$39,350	\$0	TBD	0.00%	\$0
Mercy Medical Center	\$214,208,592	0.41	0.54%	\$1,156,726	0.20%	\$428,417	\$428,417	\$0	TBD	0.00%	\$0
Civista Medical Center	\$67,052,911	0.42	0.57%	\$382,202	0.25%	\$167,632	\$167,632	\$0	TBD	0.05%	\$33,526
Carroll Hospital Center	\$136,267,434	0.43	0.61%	\$831,231	0.30%	\$408,802	\$408,802	\$0	TBD	0.10%	\$136,267
Calvert Memorial Hospital	\$62,336,014	0.43	0.61%	\$380,250	0.30%	\$187,008	\$187,008	\$0	TBD	0.10%	\$62,336
UM ST. JOSEPH	\$234,223,274	0.43	0.61%	\$1,428,762	0.30%	\$702,670	\$702,670	\$0	TBD	0.10%	\$234,223
Dorchester General Hospital	\$26,999,062	0.44	0.64%	\$172,794	0.35%	\$94,497	\$94,497	\$0	TBD	0.15%	\$40,499
Montgomery General Hospital	\$75,687,627	0.45	0.68%	\$514,676	0.40%	\$302,751	\$302,751	\$0	TBD	0.20%	\$151,375
Harbor Hospital Center	\$113,244,592	0.45	0.68%	\$770,063	0.40%	\$452,978	\$452,978	\$0	TBD	0.20%	\$226,489
Frederick Memorial	\$190,413,775	0.46	0.71%	\$1,351,938	0.45%	\$856,862	\$856,862	\$0	TBD	0.25%	\$476,034

HOSPITAL NAME	RY 16 Permanent Inpatient Revenue	RY 2017 QBR FINAL POINTS	1.RY 2017 Current Scale		2a.Proposed RY 2017 Scale		2b. January 2017 and July 2017 Implementations		3. RY 2018	4. National Scale (Draft Recommendation for RY 2019)	
			% Impact	\$ Impact	% Impact	\$ Impact	Jan 2017 Rate Order Adjustment effective July 2016	Rate Order FY18 GBR (July 2017)		Use Relative Scale or National	% Impact
Hospital											
Suburban Hospital	\$193,176,044	0.47	0.75%	\$1,448,820	0.50%	\$965,880	\$965,880	\$0	TBD	0.30%	\$579,528
Greater Baltimore Medical Center	\$207,515,795	0.49	0.82%	\$1,701,630	0.60%	\$1,245,095	\$1,245,095	\$0	TBD	0.40%	\$830,063
Good Samaritan Hospital	\$160,795,606	0.49	0.82%	\$1,318,524	0.60%	\$964,774	\$964,774	\$0	TBD	0.40%	\$643,182
Howard County General Hospital	\$165,683,744	0.57	1.00%	\$1,656,837	1.00%	\$1,656,837	\$1,656,837	\$0	TBD	0.85%	\$1,408,312
St. Mary's Hospital	\$69,169,248	0.72	1.00%	\$691,692	1.00%	\$691,692	\$691,692	\$0	TBD	1.60%	\$1,106,708
Statewide Total	\$8,730,031,841			\$27,058,414		-\$9,883,530	\$5,229,972	-\$15,113,502			-\$21,514,008
			Total Penalties	-5,389,617		-20,503,119	-5,389,617	-15,113,502			-27,442,552
			% Inpatient Revenue	-0.06%		-0.23%	-0.06%	-0.17%			-0.31%
			Total Rewards	32,448,031		10,619,589	10,619,589	0			5,928,544
			% Inpatient Revenue	0.37%		0.12%	0.12%	0.00%			0.07%

APPENDIX VI. RY 2019 SCALING OPTIONS

HOSPID	HOSPITAL NAME	FY 16 Permanent Inpatient Revenue	RY 2017 QBR FINAL POINTS	RY 2017 Scale		Full Scale Range		Option 1: Modified Full Scale 0.40		Option 2: Modified Full Scale 0.45	
				% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact
A	B	C	D	I	J	P	Q	P	Q	P	Q
210013	Bon Secours Hospital	\$74,789,724	0.07	-2.00%	-\$1,495,794	-1.72%	-\$1,286,383	-1.65%	-\$1,234,030	-1.69%	-\$1,263,115
210055	Laurel Regional Hospital	\$60,431,106	0.16	-1.40%	-\$846,035	-1.36%	-\$821,863	-1.20%	-\$725,173	-1.29%	-\$778,890
210038	Maryland General Hospital	\$126,399,313	0.20	-1.13%	-\$1,432,526	-1.20%	-\$1,516,792	-1.00%	-\$1,263,993	-1.11%	-\$1,404,437
210040	Northwest Hospital Center	\$114,214,371	0.22	-1.00%	-\$1,142,144	-1.12%	-\$1,279,201	-0.90%	-\$1,027,929	-1.02%	-\$1,167,525
210004	Holy Cross Hospital	\$316,970,825	0.23	-0.93%	-\$2,958,394	-1.08%	-\$3,423,285	-0.85%	-\$2,694,252	-0.98%	-\$3,099,270
210003	Prince Georges Hospital Center	\$220,306,426	0.24	-0.87%	-\$1,909,322	-1.04%	-\$2,291,187	-0.80%	-\$1,762,451	-0.93%	-\$2,056,193
210062	Southern Maryland Hospital Center	\$156,564,761	0.25	-0.80%	-\$1,252,518	-1.00%	-\$1,565,648	-0.75%	-\$1,174,236	-0.89%	-\$1,391,687
210016	Washington Adventist Hospital	\$155,199,154	0.25	-0.80%	-\$1,241,593	-1.00%	-\$1,551,992	-0.75%	-\$1,163,994	-0.89%	-\$1,379,548
210012	Sinai Hospital	\$415,350,729	0.31	-0.40%	-\$1,661,403	-0.76%	-\$3,156,666	-0.45%	-\$1,869,078	-0.62%	-\$2,584,405
210037	Memorial Hospital at Easton	\$101,975,577	0.31	-0.40%	-\$407,902	-0.76%	-\$775,014	-0.45%	-\$458,890	-0.62%	-\$634,515
210023	Anne Arundel Medical Center	\$291,882,683	0.31	-0.40%	-\$1,167,531	-0.76%	-\$2,218,308	-0.45%	-\$1,313,472	-0.62%	-\$1,816,159
210015	Franklin Square Hospital Center	\$274,203,013	0.31	-0.40%	-\$1,096,812	-0.76%	-\$2,083,943	-0.45%	-\$1,233,914	-0.62%	-\$1,706,152

HOSPID	HOSPITAL NAME	FY 16 Permanent Inpatient Revenue	RY 2017 QBR FINAL POINTS	RY 2017 Scale		Full Scale Range		Option 1: Modified Full Scale 0.40		Option 2: Modified Full Scale 0.45	
				% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact
A	B	C	D	I	J	P	Q	P	Q	P	Q
210024	Union Memorial Hospital	\$238,195,335	0.31	-0.40%	-\$952,781	-0.76%	-\$1,810,285	-0.45%	-\$1,071,879	-0.62%	-\$1,482,104
210011	St. Agnes Hospital	\$232,266,274	0.32	-0.33%	-\$774,221	-0.72%	-\$1,672,317	-0.40%	-\$929,065	-0.58%	-\$1,341,983
210043	Baltimore Washington Medical Center	\$237,934,932	0.33	-0.27%	-\$634,493	-0.68%	-\$1,617,958	-0.35%	-\$832,772	-0.53%	-\$1,268,986
210027	Western MD Regional Medical Center	\$167,618,972	0.34	-0.20%	-\$335,238	-0.64%	-\$1,072,761	-0.30%	-\$502,857	-0.49%	-\$819,471
210006	Harford Memorial Hospital	\$45,713,956	0.35	-0.13%	-\$60,952	-0.60%	-\$274,284	-0.25%	-\$114,285	-0.44%	-\$203,173
210051	Doctors Community Hospital	\$132,614,778	0.35	-0.13%	-\$176,820	-0.60%	-\$795,689	-0.25%	-\$331,537	-0.44%	-\$589,399
210001	Meritus Hospital	\$190,659,648	0.36	-0.07%	-\$127,106	-0.56%	-\$1,067,694	-0.20%	-\$381,319	-0.40%	-\$762,639
210009	Johns Hopkins Hospital	\$1,244,297,900	0.36	-0.07%	-\$829,532	-0.56%	-\$6,968,068	-0.20%	-\$2,488,596	-0.40%	-\$4,977,192
210032	Union of Cecil	\$69,389,876	0.37	0.00%	\$0	-0.52%	-\$360,827	-0.15%	-\$104,085	-0.36%	-\$246,720
210029	Johns Hopkins Bayview Medical Center	\$343,229,718	0.38	0.05%	\$171,615	-0.48%	-\$1,647,503	-0.10%	-\$343,230	-0.31%	-\$1,067,826
210057	Shady Grove Adventist Hospital	\$220,608,397	0.38	0.05%	\$110,304	-0.48%	-\$1,058,920	-0.10%	-\$220,608	-0.31%	-\$686,337
210019	Peninsula Regional Medical Center	\$242,318,199	0.38	0.05%	\$121,159	-0.48%	-\$1,163,127	-0.10%	-\$242,318	-0.31%	-\$753,879

HOSPID	HOSPITAL NAME	FY 16 Permanent Inpatient Revenue	RY 2017 QBR FINAL POINTS	RY 2017 Scale		Full Scale Range		Option 1: Modified Full Scale 0.40		Option 2: Modified Full Scale 0.45	
				% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact
A	B	C	D	I	J	P	Q	P	Q	P	Q
210049	Upper Chesapeake Medical Center	\$135,939,076	0.38	0.05%	\$67,970	-0.48%	-\$652,508	-0.10%	-\$135,939	-0.31%	-\$422,922
210030	Chester River Hospital Center	\$21,575,174	0.38	0.05%	\$10,788	-0.48%	-\$103,561	-0.10%	-\$21,575	-0.31%	-\$67,123
210002	University of Maryland Hospital	\$906,034,034	0.39	0.10%	\$906,034	-0.44%	-\$3,986,550	-0.05%	-\$453,017	-0.27%	-\$2,416,091
210061	Atlantic General Hospital	\$37,750,252	0.39	0.10%	\$37,750	-0.44%	-\$166,101	-0.05%	-\$18,875	-0.27%	-\$100,667
210017	Garrett County Memorial Hospital	\$19,149,148	0.40	0.15%	\$28,724	-0.40%	-\$76,597	0.00%	\$0	-0.22%	-\$42,554
210060	Fort Washington Medical Center	\$19,674,774	0.41	0.20%	\$39,350	-0.36%	-\$70,829	0.05%	\$9,837	-0.18%	-\$34,977
210008	Mercy Medical Center	\$214,208,592	0.41	0.20%	\$428,417	-0.36%	-\$771,151	0.05%	\$107,104	-0.18%	-\$380,815
210035	Civista Medical Center	\$67,052,911	0.42	0.25%	\$167,632	-0.32%	-\$214,569	0.10%	\$67,053	-0.13%	-\$89,404
210033	Carroll Hospital Center	\$136,267,434	0.43	0.30%	\$408,802	-0.28%	-\$381,549	0.15%	\$204,401	-0.09%	-\$121,127
210039	Calvert Memorial Hospital	\$62,336,014	0.43	0.30%	\$187,008	-0.28%	-\$174,541	0.15%	\$93,504	-0.09%	-\$55,410
210063	UM ST. JOSEPH	\$234,223,274	0.43	0.30%	\$702,670	-0.28%	-\$655,825	0.15%	\$351,335	-0.09%	-\$208,198
210010	Dorchester General Hospital	\$26,999,062	0.44	0.35%	\$94,497	-0.24%	-\$64,798	0.20%	\$53,998	-0.04%	-\$12,000
210018	Montgomery General	\$75,687,627	0.45	0.40%	\$302,751	-0.20%	-\$151,375	0.25%	\$189,219	0.00%	\$0

HOSPID	HOSPITAL NAME	FY 16 Permanent Inpatient Revenue	RY 2017 QBR FINAL POINTS	RY 2017 Scale		Full Scale Range		Option 1: Modified Full Scale 0.40		Option 2: Modified Full Scale 0.45			
				% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact		
A	B	C	D	I	J	P	Q	P	Q	P	Q		
	Hospital												
210034	Harbor Hospital Center	\$113,244,592	0.45	0.40%	\$452,978	-0.20%	-\$226,489	0.25%	\$283,111	0.00%	\$0		
210005	Frederick Memorial Hospital	\$190,413,775	0.46	0.45%	\$856,862	-0.16%	-\$304,662	0.30%	\$571,241	0.06%	\$108,808		
210022	Suburban Hospital	\$193,176,044	0.47	0.50%	\$965,880	-0.12%	-\$231,811	0.35%	\$676,116	0.11%	\$220,773		
210044	Greater Baltimore Medical Center	\$207,515,795	0.49	0.60%	\$1,245,095	-0.04%	-\$83,006	0.45%	\$933,821	0.23%	\$474,322		
210056	Good Samaritan Hospital	\$160,795,606	0.49	0.60%	\$964,774	-0.04%	-\$64,318	0.45%	\$723,580	0.23%	\$367,533		
210048	Howard County General Hospital	\$165,683,744	0.57	1.00%	\$1,656,837	0.28%	\$463,914	0.85%	\$1,408,312	0.69%	\$1,136,117		
210028	St. Mary's Hospital	\$69,169,248	0.72	1.00%	\$691,692	0.88%	\$608,689	1.60%	\$1,106,708	1.54%	\$1,067,183		
	Statewide Total	\$8,730,031,841			-\$9,883,530		-\$48,787,350		-\$17,334,029		-\$34,058,155		
					Total Penalties		-20,503,119		-49,859,954		-24,113,371		-37,432,890
					% Inpatient Revenue		-0.23%		-0.57%		-0.28%		-0.43%
					Total rewards		10,619,589		1,072,604		6,779,342		3,374,735
					% Inpatient revenue		0.12%		0.01%		0.08%		0.04%



Maryland
Hospital Association

January 3, 2017

Dianne Feeney
Associate Director, Quality Initiatives
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Feeney:

On behalf of the 64 hospital and health system members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the December *Draft Recommendations for Updating the Quality Based Reimbursement Program for Rate Year 2018 and 2019*.

Fiscal Year 2017 Background

With the fiscal 2017 Quality-Based Reimbursement (QBR) policy, a fundamental change was made to the payment scale to create more predictable payment adjustments that hospitals can monitor throughout the performance year. The changes, supported by the hospital field, eliminated a payment scale that required penalties to fund rewards in a revenue-neutral manner and replaced it with a non-revenue neutral scaling using pre-set adjustments based on specific performance targets. The discussions around the fiscal 2017 outcomes brought to light questions about statewide performance expectations.

Recommendations

MHA offers two suggestions to better align QBR policy and methodology with HSCRC expectations:

1. The QBR payment scale is set in advance so clinicians can understand performance goals. However, while the HSCRC approves the weights to be applied to each measure and the maximum amount of rewards and penalties, it has not set explicit performance targets and does not approve how hospitals' performance will be arrayed within those reward and penalty boundaries. For example, the "break point" – the point chosen within the distribution of Maryland's hospitals that defines where rewards end and penalties begin – is a critically important decision and more strongly influences the outcome than does the decision about where the maximum rewards and penalties are set. **The HSCRC should expand its discussion and the commission should explicitly approve additional elements of the QBR policy, to include setting a break point that determines the penalty and reward zones in advance.**
2. Of greater importance, as noted at the October commission meeting, is a big picture question: what are we trying to achieve? Performing at the highest levels is desirable, but,

as in all incentive-based programs, the objective is to apply an incentive that yields a specific result. What are the goals for each measure? What level of improvement in each of the metrics do the HSCRC and the Centers for Medicare & Medicaid Services (CMS) consider meaningful? What do the evidence and research show about how quickly any particular measure can be improved, about the mix of providers and interventions needed to achieve that change, or about the time needed to achieve the desired change? These questions are critical for commission discussion and consideration, both in setting targets for improvement and in informing the staff's development of current and future goals and methods. **The HSCRC should expand its discussion of QBR policy to include these broader questions and discuss performance expectations.**

Fiscal Year 2018 Background

The fiscal 2018 performance period ended September 30 for some metrics and December 31 for others. Statewide performance results will not be available for at least another six months, although hospitals are able to track their individual performance with less lag.

Recommendation

Since the performance period has ended, there is little value in setting a performance target for fiscal 2018. **Instead, we recommend basing the payment scale on the actual fiscal 2018 scores, similar to the way in which HSCRC staff recommended revising the fiscal 2017 payment scale.** The payment scale could be tied to actual scores in the following manner:

The highest score would be “anchored” to the maximum reward, in this case 1 percent of inpatient revenue. The lowest score would be anchored to the maximum penalty, previously set at 2 percent of inpatient revenue. A third anchor would be set at the “break point” or the score above which a hospital receives a reward and below which a hospital is penalized. The break point would be set at the average score. Payment adjustments would be linearly proportional between the average and highest score and likewise, proportional between the average and lowest score.

Under this scenario, roughly half the hospitals would receive a reward and half penalized, but the positive and negative adjustments would not need to balance to zero. This change should occur after the performance period ended, but before hospitals' fiscal 2018 budgets are set because it reduces the risk of having statewide performance and payment adjustments fall out of line with expectations.

Fiscal Year 2019 Background

Several options have been considered for the fiscal 2019 payment scale:

1. *Returning to a relative scale*

This option is undesirable because the payment adjustments are not known until all hospitals' final performance scores are calculated. The lag in publicly available data means that the payment adjustment is uncertain until a few months after the start of the fiscal year

in which the adjustment applies, making it difficult for hospitals to budget for the payment adjustment.

2. *Pre-set scale based on Maryland performance in a current or prior period*

While we support this approach for fiscal 2018 only, improvements are needed for 2019 and future years. Simply setting the payment scale on the most recent year's performance does not account for volatility in overall scores as measures are added to the program. This approach risks another misalignment of actual payment adjustments and performance expectations.

3. *National scale based on possible points (range from 0 - 1, with a break point set at 0.5.)*

This option is also undesirable. Under CMS' Value-Based Payment program, hospitals can score anywhere between 0 and 1.0 total points. However, the program adjusts for relative ranking, effectively grading on a curve. Using the 0-1 range and 0.5 as the break point would create a significantly higher performance standard in Maryland than the nation. To earn a score of 0.5, a hospital would need to perform at the national level or improve at the national improvement rate for each metric. Actual national average scores over the last several years range from 0.36-0.41.

Recommendation

MHA proposes setting the payment scale using three anchor points: a top score tied to the maximum reward, a low score tied to the maximum penalty and the average score tied to the break point. Between the break point and the maximum reward and between the break point and the maximum penalty, payment adjustments would be proportionally scaled. Because hospitals above the break point receive positive adjustments and hospitals scoring below the break point are penalized, deciding where to set the three anchor points would make an explicit statement about performance expectations.

To address the difficulty in predicting a "good score," as metrics are added to or removed from the program each year, HSCRC should create a zone in the mid-range where no payment adjustment is made. This would create a "buffer zone" to protect against volatility in outcomes that results from changing metrics and is therefore beyond anyone's ability to predict. The no-adjustment zone would be set at a quarter of the standard deviation, centered on either side of an average score. Although a buffer zone raises concerns because of the idea that all hospitals should have a performance incentive, a small buffer zone would not detract from overall performance incentives.

Compared to the nation, Maryland's performance scores are more tightly clustered around the median, and a few points lower than the median. This suggests that moving the Maryland payment scale closer to national performance would move the Maryland performance curve to the right, indicating better statewide performance. The challenge in simply setting the Maryland scale with the break point a few points higher than the most recent Maryland average, or at the

most recent year's national median score, is that the national scores frequently move up or down by a few basis points, depending on which metrics are included.

The results of model of this alternative, using Maryland fiscal 2017 scores with a break point set at 0.36 (two basis points higher than the Maryland median and one point lower than the national median for 2017, are attached.

We appreciate the commission's consideration of our comments and the opportunity to continue working with the HSCRC.

Sincerely,



Traci La Valle
Vice President

Enclosure

cc: Nelson J. Sabatini, Chairman
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FY 2019 Option

HOSPITAL NAME	FY 16 Permanent Inpatient Revenue	QBR FINAL POINTS	MHA Option	
			% Revenue Impact	\$ Revenue Impact
Bon Secours Hospital	\$ 74,789,724	0.07	-2.00%	-\$1,495,794
Laurel Regional Hospital	\$ 60,431,106	0.16	-1.33%	-\$805,748
Maryland General Hospital	\$ 126,399,313	0.20	-1.04%	-\$1,310,808
Northwest Hospital Center	\$ 114,214,371	0.22	-0.89%	-\$1,015,239
Holy Cross Hospital	\$ 316,970,825	0.23	-0.81%	-\$2,582,725
Prince Georges Hospital Center	\$ 220,306,426	0.24	-0.74%	-\$1,631,899
Southern Maryland Hospital Center	\$ 156,564,761	0.25	-0.67%	-\$1,043,765
Washington Adventist Hospital	\$ 155,199,154	0.25	-0.67%	-\$1,034,661
Sinai Hospital	\$ 415,350,729	0.31	-0.22%	-\$923,002
Memorial Hospital at Easton	\$ 101,975,577	0.31	-0.22%	-\$226,612
Anne Arundel Medical Center	\$ 291,882,683	0.31	-0.22%	-\$648,628
Franklin Square Hospital Center	\$ 274,203,013	0.31	-0.22%	-\$609,340
Union Memorial Hospital	\$ 238,195,335	0.31	-0.22%	-\$529,323
St. Agnes Hospital	\$ 232,266,274	0.32	-0.15%	-\$344,098
Baltimore Washington Medical Center	\$ 237,934,932	0.33	-0.07%	-\$176,248
Western MD Regional Medical Center	\$ 167,618,972	0.34	0.00%	\$0
Harford Memorial Hospital	\$ 45,713,956	0.35	0.00%	\$0
Doctors Community Hospital	\$ 132,614,778	0.35	0.00%	\$0
Meritus Hospital	\$ 190,659,648	0.36	0.00%	\$0
Johns Hopkins Hospital	\$ 1,244,297,900	0.36	0.00%	\$0
Union of Cecil	\$ 69,389,876	0.37	0.00%	\$0
Johns Hopkins Bayview Medical Center	\$ 343,229,718	0.38	0.00%	\$0
Shady Grove Adventist Hospital	\$ 220,608,397	0.38	0.00%	\$0
Peninsula Regional Medical Center	\$ 242,318,199	0.38	0.00%	\$0
Upper Chesapeake Medical Center	\$ 135,939,076	0.38	0.00%	\$0
Chester River Hospital Center	\$ 21,575,174	0.38	0.00%	\$0
University of Maryland Hospital	\$ 906,034,034	0.39	0.05%	\$476,860
Atlantic General Hospital	\$ 37,750,252	0.39	0.05%	\$19,869
Garrett County Memorial Hospital	\$ 19,149,148	0.40	0.11%	\$20,157
Fort Washington Medical Center	\$ 19,674,774	0.41	0.16%	\$31,065
Mercy Medical Center	\$ 214,208,592	0.41	0.16%	\$338,224
Civista Medical Center	\$ 67,052,911	0.42	0.21%	\$141,164
Carroll Hospital Center	\$ 136,267,434	0.43	0.26%	\$358,599
Calvert Memorial Hospital	\$ 62,336,014	0.43	0.26%	\$164,042
UM ST. JOSEPH	\$ 234,223,274	0.43	0.26%	\$616,377
Dorchester General Hospital	\$ 26,999,062	0.44	0.32%	\$85,260
Montgomery General Hospital	\$ 75,687,627	0.45	0.37%	\$278,849
Harbor Hospital Center	\$ 113,244,592	0.45	0.37%	\$417,217
Frederick Memorial Hospital	\$ 190,413,775	0.46	0.42%	\$801,742
Suburban Hospital	\$ 193,176,044	0.47	0.47%	\$915,044
Greater Baltimore Medical Center	\$ 207,515,795	0.49	0.58%	\$1,201,407
Good Samaritan Hospital	\$ 160,795,606	0.49	0.58%	\$930,922
Howard County General Hospital	\$ 165,683,744	0.57	1.00%	\$1,656,837
St. Mary's Hospital	\$ 69,169,248	0.72	1.00%	\$691,692
FY17 Statewide Total	\$8,730,031,841			-\$5,232,563
		Total Penalties		-14,377,891
		% Inpatient Revenue		-0.16%
		Total rewards		9,145,329
		% Inpatient revenue		0.10%

DRAFT Recommendation for the Maryland Hospital-Acquired Conditions Program for Rate Year 2019

February 8, 2017

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This document contains the draft staff recommendations for updating the Maryland Hospital-Acquired Conditions Program for rate year 2019. Please submit comments on this draft to the Commission by February 24, 2017, via email to hsrcr.quality@maryland.gov.

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LIST OF ABBREVIATIONS

CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
DRG	Diagnosis-related group
FFY	Federal fiscal year
FY	State fiscal year
HAC	Hospital-acquired condition
HSCRC	Health Services Cost Review Commission
ICD	International Statistical Classification of Diseases and Related Health Problems
MHAC	Maryland hospital-acquired condition
PPC	Potentially preventable complication
RY	Rate Year

INTRODUCTION

A hospital-acquired condition (HAC) occurs when a patient goes to the hospital for one condition but develops another condition during that hospital stay. The second condition—for example, an adverse drug reaction or an infection at the site of a surgery—is referred to as hospital-acquired.¹ HACs can lead to 1) poor patient outcomes, including longer hospital stays, permanent harm, and death, and 2) increased costs.² Over the past decade, the Centers for Medicare & Medicaid Services (CMS) have implemented several programs to improve the quality of care for Medicare participants, including a program to reduce the frequency of HACs. Because of the state’s long-standing Medicare waiver for its all-payer hospital rate-setting system, special considerations are given to Maryland hospitals, including exemption from the federal Medicare hospital quality programs, one of which is the HAC program. Instead, the Maryland Health Services Cost Review Commission (HSCRC or Commission) implements various Maryland-specific quality-based payment programs, which provide incentives for hospitals to improve their quality performance over time. The HSCRC first implemented the Maryland Hospital-Acquired Conditions (MHAC) program in state fiscal year (FY) 2011.

Maryland entered into a new All-Payer Model Agreement with CMS on January 1, 2014. One of the requirements under this Agreement is for Maryland to reduce the incidence of HACs by 30 percent by 2018. In order to meet this target, the Commission approved several methodological changes to the program for Rate Year (RY) 2016, which are discussed in further detail in the background section of this report. The Commission approved additional revisions to the methodology for RYs 2017 and 2018. The purpose of this report is to provide background information on the MHAC program and to make recommendations for the RY 2019 MHAC methodology and targets. The performance period for the RY 2019 MHAC adjustments is Calendar Year 2017.

In October 2015, health providers transitioned to the 10th version of the International Statistical Classification of Diseases (ICD-10). Since staff is still evaluating the effect of the ICD-10 transition, staff believes it is not possible to set a reasonable target for a statewide improvement rate at this time. Considering these challenges, staff is proposing that the MHAC program adopt a single scale, rather than a contingent scale based on the statewide improvement rate. Staff developed multiple options under a single scale methodology and is discussing these options with the Performance Measurement Work Group. Staff also adjusted the base period for the program to use 12 months of hospital data under ICD-10 (October 2015 to September 2016).

¹ 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.

² Ibid.

BACKGROUND

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 is a method of categorizing costs so that Medicare can determine how much to pay for the hospital stay. DRGs are based on a patient's primary diagnosis and the presence of other conditions; patients with higher co-morbidities or complications are categorized into higher-paying DRGs.³ Historically, Medicare payments under this system were based on the volume of services. However, beginning in federal fiscal year (FFY) 2009, CMS stopped assigning patients 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 identified 11 conditions that are presumed to be acquired in the hospital if the diagnosis is not present on the patient's admission. CMS will not assign these patients to more expensive DRGs, and thus does not pay, for these HACs.⁴ This policy is referred to as the HAC (present on admission indicator) program.⁵ Since non-payment on a case-by-case basis affects only a small fraction of claims, the impact of this program was estimated to be very limited. The program resulted in \$21 million in savings in FFY 2010.⁶ Maryland hospitals were exempt from the payment adjustments under this program.

CMS expanded the use of HACs in payment adjustments in FFY 2015 with a new program entitled the "Hospital-Acquired Condition Reduction Program" under authority of the Affordable Care Act. In this program, CMS ranks hospitals according to performance on a list of HAC quality measures and reduces Medicare payments to the hospitals in the lowest performing quartile. Since the HAC program began, the maximum penalty has been set at 1 percent of total DRG payments. The CMS HAC measures for FFY 2017 are listed in Appendix I of this report and include measures of patient safety developed by the Agency for Healthcare Research and Quality and measures of healthcare-associated infections developed by the Centers for Disease Control and Prevention.⁷ These will be updated to reflect FFY 2018 once 2018 measures and specifications are available. Prior to the new All-Payer Model Agreement, CMS required the HSCRC to submit an annual exemption request demonstrating that the outcomes and cost savings of the Maryland-specific program met or exceeded those of the CMS federal program.

³ Ibid.

⁴ Ibid.

⁵ For more information on the federal HAC Present on Admission program, see

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html>

⁶ CMS. (2012, December). Report to Congress: Assessing the Feasibility of Extending the Hospital Acquired Conditions (HAC) IPPS Payment Policy to Non-IPPS Settings. Retrieved from

<https://innovation.cms.gov/Files/x/HospAcquiredConditionsRTC.pdf>

⁷ For more information on the federal HAC Reduction program, see <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html>.

Under Maryland's new All-Payer Model agreement, this requirement was replaced by a requirement that Maryland reduce its HACs by at least 30% throughout the duration of the All-Payer Model, as well as a requirement to match the aggregate amount of revenue at risk in quality-based payment adjustments with the amount at risk in the Medicare programs.

Overview of the MHAC Program

Maryland is exempt from the federal HAC programs, and, instead, the HSCRC has implemented the MHAC program since FY 2011. The MHAC program is based on a classification system developed by 3M, using what are called potentially preventable complications (PPCs). PPCs 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. Therefore, these events are considered potentially preventable. 3M developed 65 PPC measures that are identified through secondary diagnosis codes that are not present on the patient's admission. Examples of PPCs include accidental puncture/laceration during an invasive procedure or infections related to central venous catheters.

The initial methodology for the MHAC program was in place until FY 2016. This methodology estimated the percentage of inpatient revenue associated with an excess number of PPCs. The excess number of PPCs was estimated by comparing hospitals' observed PPC rate to a statewide average PPC rate, given the diagnoses and severity of illness (or case-mix) of the hospital's patient population. The marginal cost of each PPC was estimated using a statewide regression analysis. Next, the payment adjustment approach penalized hospitals that had higher PPC costs than the statewide average and rewarded hospitals with lower PPC costs than the statewide average. The payment adjustments were proportional to a hospital's difference from the statewide average (this methodology is also known as continuous scaling). Rewards were adjusted to ensure that the final net impact was revenue neutral. In general, the payment adjustment process resulted in fewer hospitals receiving penalties, and consequently limited the amount of revenue available for rewards.

The HSCRC modified the guiding principles of those originally established for the MHAC program to conform to the goals of its new All-Payer Model agreement; they include the following:

- The program must improve care for all patients, regardless of payer.
- The breadth and impact of the program must meet or exceed the Medicare national program in terms of measures and revenue at risk.
- The program should identify predetermined performance targets and financial impact.
- An annual target for the program must be established in the context of the trends of complication reductions seen in the previous years, as well as the need to achieve the new All-Payer Model goal of a 30 percent cumulative reduction by 2018.
- The program should prioritize PPCs that have high volume, high cost, opportunity for improvement, and are areas of national focus.

- Program design should encourage cooperation and sharing of best practices.
- The scoring method should hold hospitals harmless for a lack of improvement if attainment is highly favorable.
- Hospitals should have the ability to track their progress during the performance period.

The HSCRC modified the program’s methodology to achieve these new goals and guiding principles for performance years beginning with calendar year (CY) 2014, which were applied to rate adjustments beginning in RY 2016.⁸ The key changes to the methodology are listed below (see Appendix II for a more detailed description of the revised methodology).

- Determine hospital scores based on case-mix-adjusted PPC rates rather than excess PPC costs. This change simplified and aligned the measurement with the quality improvement methods, where hospitals focus shifted to the PPC rates rather than the number of excess PPCs and costs.
- Prioritize PPCs that are high cost, high volume, have opportunity to improve, and are of national concern by grouping and weighting the PPCs into tiers according to their level of priority. This tiered approach replaced the previous PPC-specific weighting approach that used marginal costs.
- Use the better of attainment or improvement scores. This change strengthened incentives for low-performing hospitals to improve. Previously, payment adjustments were calculated separately for hospital attainment and improvement rates that were based on a few PPCs.
- To determine payment rewards/penalties, use a preset point scale that can be set prospectively. This change replaced the original payment adjustment determinations, which were calculated based on the relative ranking of hospitals. This change attempted to improve the financial predictability of the MHAC program. In addition, the revised methodology removes the revenue neutrality requirement in scaling payments (i.e., the statewide total amount of rewards can exceed the total amount of penalties) to reward hospitals with better performance adequately.
- Link individual hospital performance with statewide performance by creating a “contingent” payment adjustment scale, where penalties are increased if the state does not reach pre-determined PPC reduction targets. Staff and the hospital industry believe that “contingent” scaling creates a balanced approach by maintaining hospital-level incentives with hospital-specific payment adjustments that are also tied to a statewide improvement goal. In addition to contingent scaling, “hold-harmless zones” were created to focus payment adjustments on better and worse performing hospitals.

⁸ The performance period for PPCs is measured on a calendar year basis, and the results of these measures are then used in the hospitals’ rate calculations, which are set on a fiscal year basis.

The HSCRC used the same methodology for RY 2018, but made adjustments to the tiering system and PPCs. Staff is suggesting additional changes for the RY 2019 policy to accommodate the ICD-10 transition and other stakeholder input, as discussed below.

ASSESSMENT

In order to develop the MHAC methodology for RY 2019, the HSCRC solicited input from many stakeholder groups including consumers, hospitals, payers, researchers, and other industry experts. The Performance Measurement Workgroup discussed pertinent issues and potential changes to Commission policy for RY 2019.⁹ Specifically, the Workgroup reviewed analyses and discussed issues related to 1) statewide PPC trends, 2) the list of PPCs and relevant tiers, 3) the current palliative care exclusion, and 4) the payment adjustment methodology. This section of the report provides an overview of the issues discussed by the Workgroup.

Statewide PPC Trends

The State continued to make significant progress in reducing complications, as measured both in terms of the actual number of PPCs and case-mix adjusted PPC rates in FY 2016. Figure 1 below presents the PPC reduction trends in Maryland between FY 2013 and FY 2016. In this figure, the gray columns labeled “PPC Rates” display the number of PPC complications occurring in each year, the unadjusted PPC rate, and the case-mix adjusted rate of PPC complications, which may be interpreted as the number of PPCs per 1,000 at-risk discharges. The yellow columns in the figure labeled “Annual Change” show the percent change between each year, e.g., from FY 2013 to 2016. Finally, the green column displays the percent change over the entire measurement period of FY 2013 through 2016. Because the goal of the program is to reduce PPCs, the negative percent changes in this figure may be interpreted as a performance improvement. Overall, the number and rate of PPCs decreased significantly, with a cumulative case-mix adjusted improvement rate of 47.8 percent between FY 2013 and 2016. It should be noted that HSCRC contractors are still analyzing whether the ICD-10 transition is impacting the case-mix adjusted PPC rates.

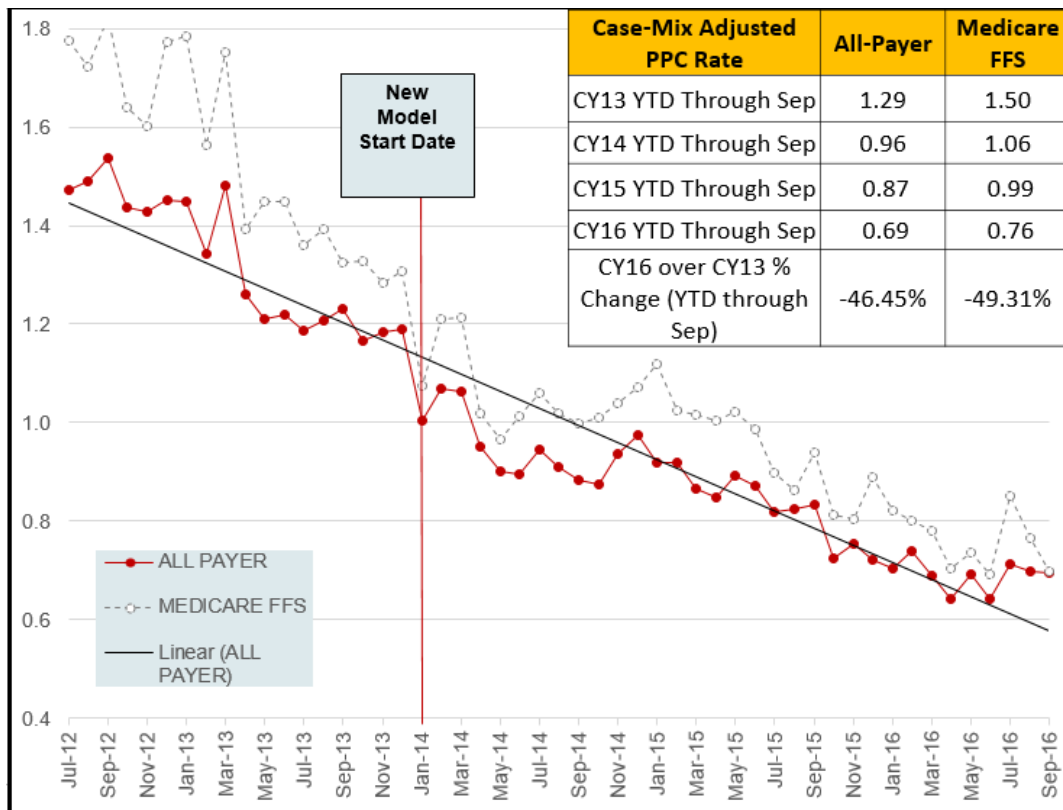
⁹ For more information on the Performance Measurement Workgroup, see <http://hscrc.maryland.gov/hscrc-workgroup-performance-measurement.cfm>.

Figure 1. PPC Reduction Trends in Maryland, FY 2013-2016

	PPC RATES				Annual Change			Cumulative Improvement
	FY13	FY14	FY15	FY16	FY13-FY14	FY14-FY15	FY15-FY16	FY13-FY16
TOTAL NUMBER OF COMPLICATIONS	27,934	21,056	17,341	14,508	-24.6%	-17.6%	-16.3%	-48.1%
UNADJUSTED PPC RATE PER 1,000 AT-RISK	1.18	0.94	0.80	0.69	-20.5%	-14.6%	-13.5%	-41.3%
CASE-MIX ADJUSTED COMPLICATION RATE PER 1,000 AT-RISK	1.40	1.09	0.90	0.73	-22.4%	-16.8%	-19.2%	-47.8%

HSCRC staff also analyzed monthly PPC rates for Medicare fee-for-service and all payers for July 2012 through September 2016 (Figure 2). The gray line in this figure shows the monthly case-mix adjusted PPC rate for Medicare fee-for-service, while the red line shows the monthly PPC rate for all payers, including Medicare fee-for-service patients. Both lines show a fairly consistent downward trend between July 2012 and September 2016.

Figure 2. All-Payer Case-Mix Adjusted PPC Rates FY2013-FY2016 YTD through September



PPC List and Tier Adjustments

Two of the major strengths of the MHAC program compared with the CMS HAC programs is that the MHAC program includes a wide range of complications, and includes all patients who are at risk of developing these complications. For RY 2019 the HSCRC will be using the 3M PPC grouper version 34 (v34), which has been developed to take into account the increased specificity of ICD-10 coding. Hospitals and other stakeholders are very supportive of moving to v34. In order to use v34, the base period will be adjusted forward by one quarter to obtain 12 months of ICD-10 data (October 2015-September 2016). Under v34 many PPC definitions have been updated, and 3M has discontinued some PPCs for clinical reasons. Specifically under v34, 3M removed PPC 12 (cardiac arrhythmia) and PPCs 57 and 58 (OB Lacerations). 3M also made significant clinical changes to PPC 36 (Acute mental health changes) and PPC 66 (Catheter related UTI), such that no Maryland hospital meets minimum inclusion criteria. Two additional changes were made prior to v. 34 1) PPC 24 (Renal Failure without Dialysis) was suspended from payment policy based on 3M clinical recommendations, and 2) PPC 43 was combined with PPC 42 to make comparable to ICD-9 PPC 42.

As a reminder, in RY 2018, several changes were made to the PPC list and tiering methodology including: 1). Moving from a three-tiered PPC weighting system to a two-tiered weighting system, with tier 1 weighted at 100 percent and tier 2 weighted at 50 percent in the scoring calculations. 2. Combining some PPC measures that are clinically similar for scoring purposes. 3. Moving a small subset of PPCs to a “monitoring” status, suspending their use for payment calculation for FY 2018.

For RY 2019, staff is proposing to keep to the RY 2018 two-tier structure, and make no changes to the combined PPCs, serious reportable events, or monitoring-only PPCs. The only change to PPC tiers is to move PPC 21 (c. Diff) to tier 2 based on 3M clinical input. Thus for RY 2019, there are 53 PPCs (48 with combinations) in the payment program and five monitoring-only PPCs. Appendix III lists the PPCs included in the payment program with the tier, as well as a comparison of the RY 2018 and RY 2019 benchmarks.

Palliative Care Exclusion

Based on input from the work group participants, palliative care cases have been historically excluded from the MHAC program due to clinical concerns that including these cases would incentivize unwarranted care. However, since 2012, the number of palliative cases has more than doubled and the percent of discharges has steadily increased (Figure 3). Between 2012 and 2016, the percentage of PPCs counted in the MHAC program has dropped from greater than 95% to around 82% (Figure 4). Although these are significant changes, palliative care exclusion appears to have a limited impact on the statewide improvement trends. Statewide, the case-mix adjusted PPC rate (including palliative care cases) improved by only 41%, compared to 46% when palliative care cases were excluded.

Figure 3. Percent of Total Discharges with Palliative Care, 2012 – March 2016

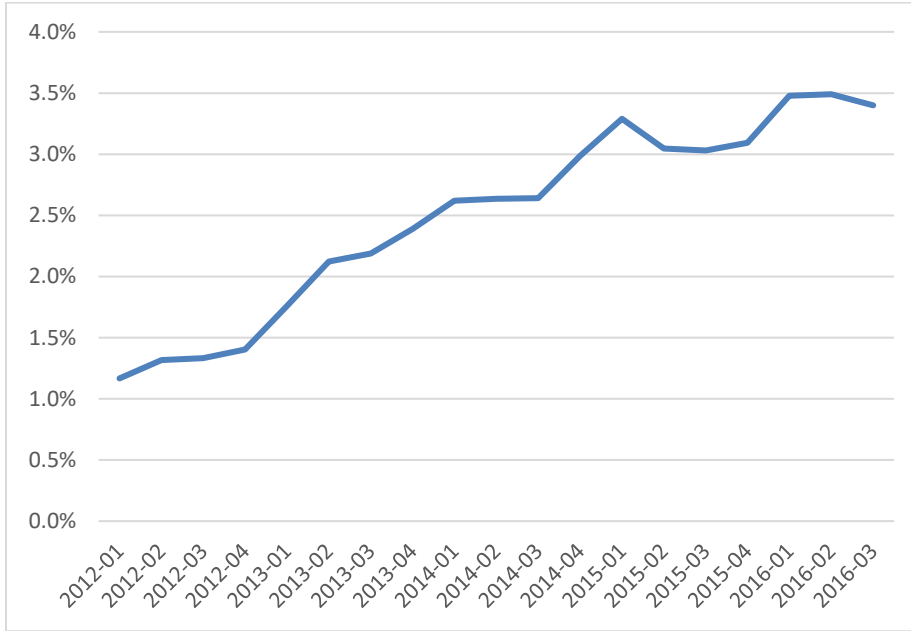
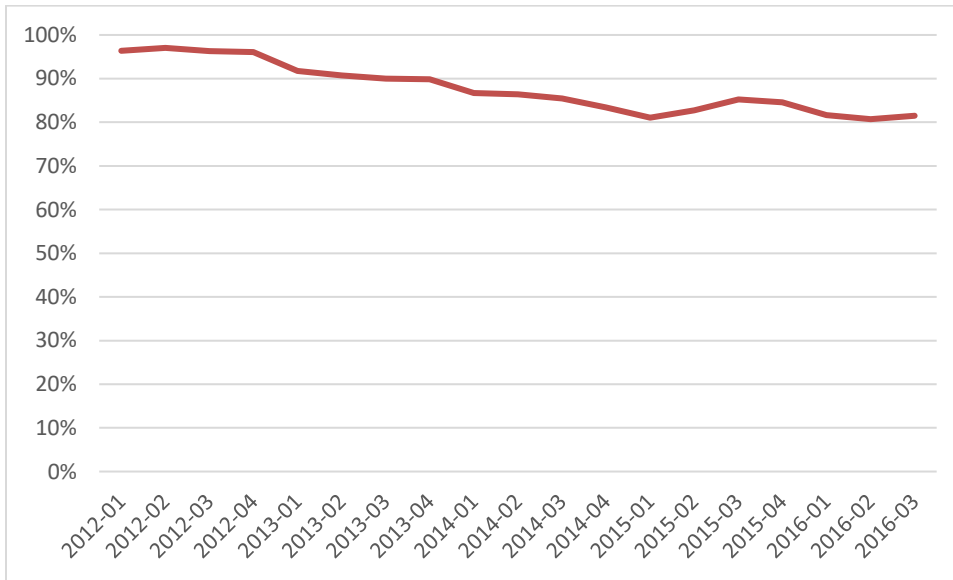


Figure 4. Percent of Total PPCs in MHAC Program, 2012 – March 2016



After careful consideration and input from clinical experts, the staff is proposing to remove the palliative care exclusion starting with the RY 2019 MHAC program. Although there is a concern that such a policy change may incentivize unwarranted treatments for palliative care patients, this concern must be balanced with the need to include palliative cases resulting from a hospital-acquired complication. Furthermore, analysis of the change in the palliative codes showed a wide variation among hospitals, which warrants further examination of coding and documentation practices. Appendix IV shows case-mix adjusted rates and total at-risk with and without palliative care by hospital. HSCRC regular audits have not revealed any issues with the

palliative codes, however, audit samples may be too limited to detect the inaccuracies. Staff is currently working with the audit contractor to create a special sample for these cases.

Payment Adjustment Methodology

For RY 2019, staff is proposing several changes to the payment adjustment methodology. First, staff is recommending to remove the two-scale structure that has been used since RY 2016, whereby achievement of a minimum statewide reduction goal determined scale (i.e. the contingent scaling approach). Staff proposes this change for two reasons: a) the State has already achieved the 30% reduction goal, and b) under ICD-10 and v34, staff and work group members agreed that it is difficult to estimate a statewide reduction target. Hospital performance will continue to be scored as the better of the hospital’s attainment or improvement scores, as detailed in Appendix II. Both base year and performance periods will be under ICD-10 v34.

To move to a single scale, staff proposes to set the maximum penalty for the single scale at 2% and maximum reward at 1% of hospital inpatient revenue.

Second, as with the RY 2019 QBR policy, staff proposes to use the full range of scores to set the payment scale, rather than basing the scale on the statewide distribution of scores. The staff built the following models in considering the RY 2019 scaling adjustments using the final RY 2017 scores (see Figure 5 for statewide adjustments and Appendix V for hospital-specific results):

- Current RY2018 Scale (assuming minimum improvement target met): 17-80% with 40% penalty cutoff and 50% reward threshold (neutral zone)
- Option 1: Full Score Range without Neutral Zone: 0-100% with 50% reward/penalty cutoff
- Option 2: Full Score Range with Neutral Zone: 0-100% with neutral zone between 45% and 55%

Figure 5. RY 2019 MHAC Scaling Models – Statewide Results

MHAC Scaling Models*	Min	Penalty/Reward Cut Point	Max	Statewide Penalties	Statewide Rewards
Current RY18 Scale	17%	40%/50%	80%	-\$2M	+22M
Full Range Scale without Neutral Zone	0%	50%	100%	-\$10M	+\$13M
Full Range Scale with Neutral Zone	0%	45%/55%	100%	-\$6M	+\$9M

*These scaling models were created to analyze fiscal impact of different scaling options utilizing final scores from RY 2017, the most recent available final scores.

Staff will continue to vet these options to create a single scale with the performance measurement work group members. Staff recommends using a full score scale that ranges from 0 to 100%, where hospitals scoring below 45% are penalized, and hospitals scoring above 55% are rewarded. Staff recommends the continuation of a revenue-neutral zone for the MHAC program given positive statewide performance.

RECOMMENDATIONS

Based on this assessment, HSCRC staff recommends the following for RY 2019:

1. Include discharges with palliative care in program, and perform a special hospital audit on palliative care coding.
2. Modify scaling methodology to be a single payment scale, ranging from 0% to 100%, with a revenue neutral zone between 45% and 55%.
3. Set the maximum penalty at 2% and the maximum reward at 1%.

APPENDIX I. MEASURES FOR THE FEDERAL HAC PROGRAM

CMS HAC MEASURES Implemented Since FFY 2012

- 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

CMS HAC Reduction Program Measures Implemented Since FFY 2015

- Domain 1- the Agency for Health Care Research and Quality composite patient safety indicator (PSI) #90 which includes the following indicators:
 - Pressure ulcer rate (PSI 3);

- Iatrogenic pneumothorax rate (PSI 6);
- Central venous catheter-related blood stream infection rate (PSI 7);
- Postoperative hip fracture rate (PSI 8);
- Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (PSI 12);
- Postoperative sepsis rate (PSI 13);
- Wound dehiscence rate (PSI 14); and
- Accidental puncture and laceration rate (PSI 15).
- Domain 2- two healthcare-associated infection measures developed by the Centers for Disease Control and Prevention's National Health Safety Network:
 - Central Line-Associated Blood Stream Infection and
 - Catheter-Associated Urinary Tract Infection.

For the FY 2017 CMS HAC Reduction program, CMS decreased the Domain 1 weight from 25 percent to 15 percent and increased the Domain 2 weight from 75 percent to 85 percent.

CMS also expanded the data used for central line-associated blood stream infection and catheter-associated urinary tract infections and will include data from pediatric and adult medical ward, surgical ward, and medical/surgical ward locations, in addition to data from adult and pediatric intensive care unit locations.

APPENDIX II. PPC MEASUREMENT DEFINITION AND POINTS CALCULATION

Definitions

The PPC measure would then be defined as:

Observed (O)/Expected (E) value for each measure

The threshold value is the minimum performance level at which a hospital will be assigned points and is defined as:

Weighted mean of all O/E ratios (O/E =1)

(Mean performance is measured at the case level. In addition, higher volume hospitals have more influence on PPCs' means.)

The benchmark value is the performance level at which a full 10 points would be assigned for a PPC and is defined as:

Weighted mean of top quartile O/E ratio that include at least 25% of statewide discharges

For PPCs that are serious reportable events, the threshold and benchmark will be set at 0.

Performance Points

Performance points are given based on a range between a “Benchmark” and a “Threshold,” which are determined using the base year data. The Benchmark is a reference point defining a high level of performance, which is equal to the mean of the top quartile. Hospitals whose rates are equal to or above the benchmark receive 10 full attainment points.

The Threshold is the minimum level of performance required to receive minimum attainment points, which is set at the weighted mean of all the O/E ratios which equals to 1. The improvement points are earned based on a scale between the hospital's prior year score (baseline) on a particular measure and the Benchmark and range from 0 to 9.

The formulas to calculate the attainment and improvement points are as follows:

- Attainment Points: $[9 * ((\text{Hospital's performance period score} - \text{threshold}) / (\text{benchmark} - \text{threshold}))] + .5$, where the hospital performance period score falls in the range from the threshold to the benchmark

Improvement Points: $[10 * ((\text{Hospital performance period score} - \text{Hospital baseline period score}) / (\text{Benchmark} - \text{Hospital baseline period score}))] - .5$, where the hospital performance score falls in the range from the hospital's baseline period score to the benchmark

APPENDIX III.
MHAC RY 2019 PPC LIST, TIERS, AND BENCHMARKS

PPC Number	PPC Description	RY 19 Tier	Benchmark RY18 (based on FY15)	Benchmark RY19 (based 10/15-9/16) with Palliative Care	Difference RY18 vs RY19
1	Stroke & Intracranial Hemorrhage	2	0.5707	0.4634	-0.1073
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	1	0.5502	0.5437	-0.0065
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1	0.5994	0.5754	-0.0240
5	Pneumonia & Other Lung Infections	1	0.5440	0.4788	-0.0652
6	Aspiration Pneumonia	1	0.5021	0.6295	0.1274
7	Pulmonary Embolism	1	0.3555	0.4481	0.0926
8	Other Pulmonary Complications	2	0.4387	0.4781	0.0394
9	Shock	1	0.5528	0.4875	-0.0653
10	Congestive Heart Failure	2	0.2236	0.2953	0.0717
11	Acute Myocardial Infarction	2	0.5728	0.5374	-0.0354
12	Cardiac Arrhythmias & Conduction Disturbances	NA	0.3270	NA	NA
13	Other Cardiac Complications	2	0.0785	0.1562	0.4358
14	Ventricular Fibrillation/Cardiac Arrest	1	0.6793	0.5143	-0.3233
16	Venous Thrombosis	1	0.3001	0.3560	0.1031
19	Major Liver Complications	2	0.3577	0.4032	0.1300
21	Clostridium Difficile Colitis	2	0.5634	0.4877	-0.4264
23	GU Complications Except UTI	2	0.2362	0.1370	-0.0393

Draft Recommendations for the Maryland Hospital-Acquired Conditions Program for Fiscal Year 2019

PPC Number	PPC Description	RY 19 Tier	Benchmark RY18 (based on FY15)	Benchmark RY19 (based 10/15-9/16) with Palliative Care	Difference RY18 vs RY19
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	1	0.5659	0.1969	-0.4019
28	In-Hospital Trauma and Fractures	2	0.0619	0.1640	-0.0619
30	Poisonings due to Anesthesia	2	0.0000	0.0000	0.0000
31	Decubitus Ulcer	2	0.0000	0.0000	0.0000
32	Transfusion Incompatibility Reaction	2	0.0000	0.0000	0.2067
34	Moderate Infectious	2	0.3734	0.2067	0.1462
35	Septicemia & Severe Infections	1	0.4251	0.5196	0.0972
36	Acute Mental Health Changes	NA	0.2297	NA	NA
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	1	0.4159	0.5223	-0.0065
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	1	0.5989	0.4264	0.0205
39	Reopening Surgical Site	2	0.0795	0.4094	0.2549
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	1	0.6266	0.6194	-0.2222
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	1	0.2031	0.3344	0.1967
42	Accidental Puncture/Laceration During Invasive Procedure	1	0.4414	0.4044	-0.4414

Draft Recommendations for the Maryland Hospital-Acquired Conditions Program for Fiscal Year 2019

PPC Number	PPC Description	RY 19 Tier	Benchmark RY18 (based on FY15)	Benchmark RY19 (based 10/15-9/16) with Palliative Care	Difference RY18 vs RY19
44	Other Surgical Complication - Mod	2	0.3442	0.3998	-0.3442
45	Post-procedure Foreign Bodies	2	0.0000	0.0000	0.1584
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body	2	0.0000	0.0000	0.1348
47	Encephalopathy	2	0.1372	0.1584	-0.0493
48	Other Complications of Medical Care	2	0.3403	0.1348	0.0862
49	Iatrogenic Pneumothrax	1	0.3514	0.0879	-0.0889
50	Mechanical Complication of Device, Implant & Graft	2	0.3919	0.4265	0.0287
51	Gastrointestinal Ostomy Complications	2	0.3631	0.2625	-0.2639
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	2	0.5058	0.4206	-0.4406
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusions	2	0.1967	0.0992	0.1503
54	Infections due to Central Venous Catheters	1	0.0877	0.0652	0.3984
59	Medical & Anesthesia Obstetric Complications	2	0.5325	0.3470	-0.3404
60	Major Puerperal Infection and Other Major Obstetric Complications	2	0.0798	0.4861	0.1829
61	Other Complications of Obstetrical Surgical & Perineal Wounds	2	0.2060	0.1921	-0.2060

Draft Recommendations for the Maryland Hospital-Acquired Conditions Program for Fiscal Year 2019

PPC Number	PPC Description	RY 19 Tier	Benchmark RY18 (based on FY15)	Benchmark RY19 (based 10/15-9/16) with Palliative Care	Difference RY18 vs RY19
62	Delivery with Placental Complications	2	0.3366	0.2627	-0.1391
65	Urinary Tract Infection without Catheter	1	0.5645	0.0000	-0.1721
66	Catheter-Related Urinary Tract Infection	NA	0.0000	NA	NA
Combo 1	General Combination PPC: PPC 25, 26, 63	2	0.2139	0.1975	-0.0164
Combo 2	Gastrointestinal Complications: PPC 17 and 18	2	0.4640	0.3924	-0.0716
Combo 3	OB Hemorrhage: PPC 55 and 56	2	0.6396	0.5660	-0.0736
Combo 4	OB Lacerations: PPC 57 and 58	NA	0.5331	NA	NA

APPENDIX IV.
PPC RATES WITH AND WITHOUT PALLIATIVE CARE

CY 2016 YTD September		Case Mix Adjusted PPC Rate			At Risk Discharges		
Hospital ID		Without PC	With PC	% Difference between with and without PC	Without PC	With PC	% Difference between with and without PC
210001	Meritus	0.71	0.79	11.44%	449,261	458,166	1.98%
210002	UMMC	0.72	0.84	16.44%	597,222	609,480	2.05%
210003	PG Hospital	0.76	0.88	16.37%	338,738	341,217	0.73%
210004	Holy Cross	0.51	0.61	19.83%	802,186	819,225	2.12%
210005	Frederick	0.71	0.85	20.71%	448,923	466,093	3.82%
210006	UM-Harford	0.69	0.84	21.69%	129,436	132,809	2.61%
210008	Mercy	0.61	0.67	10.03%	450,333	452,015	0.37%
210009	Johns Hopkins	0.79	0.97	22.99%	992,480	1,008,774	1.64%
210010	UM- Dorchester	0.68	1.05	54.99%	70,759	72,305	2.18%
210011	St. Agnes	0.59	0.69	16.66%	460,571	469,387	1.91%
210012	Sinai	0.71	0.83	16.53%	542,444	550,036	1.40%
210013	Bon Secours	1.00	1.02	1.65%	111,098	111,792	0.62%
210015	MedStar Fr Square	0.65	0.73	11.58%	596,079	605,869	1.64%
210016	Washington Adventist	0.98	1.09	11.40%	304,336	308,416	1.34%
210017	Garrett	0.54	0.63	18.07%	59,896	61,167	2.12%
210018	MedStar Montgomery	0.73	0.80	8.80%	193,168	197,434	2.21%
210019	Peninsula	0.82	0.98	19.22%	490,191	503,354	2.69%
210022	Suburban	0.66	0.78	18.56%	362,774	378,041	4.21%
210023	Anne Arundel	0.70	0.78	11.30%	823,210	849,224	3.16%
210024	MedStar Union Mem	0.58	0.74	27.32%	345,145	350,046	1.42%
210027	Western Maryland	0.88	1.05	19.95%	324,583	331,871	2.25%
210028	MedStar St. Mary's	0.44	0.53	19.82%	241,036	244,214	1.32%
210029	JH Bayview	0.50	0.53	7.39%	529,866	537,606	1.46%
210030	UM- Chestertown	0.89	1.06	19.63%	43,732	44,877	2.62%
210032	Union of Cecil	0.66	0.74	13.21%	165,087	170,274	3.14%
210033	Carroll	0.71	0.88	23.56%	284,965	292,575	2.67%
210034	MedStar Harbor	0.56	0.76	36.01%	206,612	210,663	1.96%
210035	UM-Charles Regional	0.67	0.76	13.03%	180,982	183,101	1.17%
210037	UM-Easton	0.62	0.78	25.45%	230,143	235,778	2.45%
210038	UMMC Midtown	0.10	0.11	9.62%	116,459	117,083	0.54%
210039	Calvert	0.56	0.59	5.67%	146,475	148,457	1.35%
210040	Northwest	0.52	0.79	50.46%	317,426	324,147	2.12%
210043	UM-BWMC	0.67	0.85	26.94%	486,260	500,814	2.99%
210044	GBMC	0.93	0.98	5.12%	512,405	517,967	1.09%
210045	McCready	0.24	0.24	0.00%	8,251	8,251	0.00%

Draft Recommendations for the Maryland Hospital-Acquired Conditions Program for Fiscal Year 2019

210048	Howard County	0.72	0.81	13.76%	509,712	520,528	2.12%
210049	UM-Upper Chesapeake	0.70	0.82	16.87%	336,573	349,182	3.75%
210051	Doctors	0.58	0.76	30.64%	276,776	281,780	1.81%
210055	Laurel Regional	0.58	0.70	20.34%	106,623	108,058	1.35%
210056	MedStar Good Sam	0.58	0.63	8.70%	278,913	282,609	1.33%
210057	Shady Grove	0.80	0.90	12.17%	528,778	534,827	1.14%
210058	UMROI	0.94	0.94	0.00%	64,211	64,211	0.00%
210060	Ft. Washington	0.12	0.14	17.80%	63,439	63,930	0.77%
210061	Atlantic General	0.41	0.48	17.76%	94,316	100,961	7.05%
210062	MedStar Southern MD	0.71	0.83	16.08%	314,039	318,399	1.39%
210063	UM-St. Joe	0.65	0.71	8.78%	488,064	494,568	1.33%
210064	Levindale	2.69	2.78	3.48%	40,202	40,900	1.74%
210065	HC-Germantown	0.58	0.64	10.16%	137,209	140,325	2.27%
210000	Statewide	0.69	0.80	16.52%	15,601,387	15,912,806	2.00%

**APPENDIX V.
PAYMENT ADJUSTMENT – HOSPITAL-SPECIFIC SCALING MODELING**

MHAC Hospital Modeling (using RY2017 Final Scores)				RY 2018 Scale		Option 1: Full Scale without Neutral Zone	Option 2: Full Scale with Neutral Zone		
Hospital ID	Hospital Name	FY 16 Permanent Inpatient Revenue	RY 17 Final MHAC score	% Adjustment	\$ Adjustment	% Adjustment	\$ Adjustment	% Adjustment	\$ Adjustment
	MAXIMUM PENALTY			-1.00%	\$	-2.00%	\$	-2.00%	\$
210003	PRINCE GEORGE	\$220,306,426	0.29	-0.50%	-\$1,101,532	-0.84%	-\$1,850,574	-0.71%	-\$1,566,623
210016	WASHINGTON ADVENTIST	\$155,199,154	0.32	-0.38%	-\$581,997	-0.72%	-\$1,117,434	-0.58%	-\$896,706
210062	SOUTHERN MARYLAND	\$156,564,761	0.36	-0.21%	-\$326,177	-0.56%	-\$876,763	-0.40%	-\$626,259
210013	BON SECOURS	\$74,789,724	0.40	-0.04%	-\$31,162	-0.40%	-\$299,159	-0.22%	-\$166,199
210009	JOHNS HOPKINS	\$1,244,297,900	0.41	0.00%	\$0	-0.36%	-\$4,479,472	-0.18%	-\$2,212,085
210044	G.B.M.C.	\$207,515,795	0.43	0.00%	\$0	-0.28%	-\$581,044	-0.09%	-\$184,458
210051	DOCTORS COMMUNITY	\$132,614,778	0.44	0.00%	\$0	-0.24%	-\$145,035	-0.04%	-\$58,940
210055	LAUREL REGIONAL	\$60,431,106	0.44	0.00%	\$0	-0.24%	-\$318,275	-0.04%	-\$26,858
210027	WESTERN MARYLAND HEALTH SYSTEM	\$167,618,972	0.47	0.00%	\$0	-0.12%	-\$264,730	0.00%	\$0
210057	SHADY GROVE	\$220,608,397	0.47	0.00%	\$0	-0.12%	-\$201,143	0.00%	\$0
210023	ANNE ARUNDEL	\$291,882,683	0.49	0.00%	\$0	-0.04%	-\$64,318	0.00%	\$0
210056	GOOD SAMARITAN	\$160,795,606	0.49	0.00%	\$0	-0.04%	-\$116,753	0.00%	\$0
210033	CARROLL COUNTY	\$136,267,434	0.50	0.00%	\$0	0.00%	\$0	0.00%	\$0

Draft Recommendations for the Maryland Hospital-Acquired Conditions Program for Fiscal Year 2019

MHAC Hospital Modeling (using RY2017 Final Scores)				RY 2018 Scale		Option 1: Full Scale without Neutral Zone	Option 2: Full Scale with Neutral Zone		
Hospital ID	Hospital Name	FY 16 Permanent Inpatient Revenue	RY 17 Final MHAC score	% Adjustment	\$ Adjustment	% Adjustment	\$ Adjustment	% Adjustment	\$ Adjustment
	MAXIMUM PENALTY			-1.00%	\$	-2.00%	\$	-2.00%	\$
210037	EASTON	\$101,975,577	0.50	0.00%	\$0	0.00%	\$0	0.00%	\$0
210001	MERITUS	\$190,659,648	0.51	0.03%	\$63,553	0.02%	\$22,843	0.00%	\$0
210024	UNION MEMORIAL	\$238,195,335	0.51	0.03%	\$79,398	0.02%	\$38,132	0.00%	\$0
210040	NORTHWEST	\$114,214,371	0.51	0.03%	\$38,071	0.02%	\$47,639	0.00%	\$0
210005	FREDERICK MEMORIAL	\$190,413,775	0.53	0.10%	\$190,414	0.06%	\$22,650	0.00%	\$0
210048	HOWARD COUNTY	\$165,683,744	0.53	0.10%	\$165,684	0.06%	\$114,248	0.00%	\$0
210061	ATLANTIC GENERAL	\$37,750,252	0.53	0.10%	\$37,750	0.06%	\$99,410	0.00%	\$0
210035	CHARLES REGIONAL	\$67,052,911	0.54	0.13%	\$89,404	0.08%	\$53,642	0.00%	\$0
210022	SUBURBAN	\$193,176,044	0.55	0.17%	\$321,960	0.10%	\$193,176	0.00%	\$0
210038	UMMC MIDTOWN	\$126,399,313	0.57	0.23%	\$294,932	0.14%	\$176,959	0.04%	\$56,177
210012	SINAI	\$415,350,729	0.58	0.27%	\$1,107,602	0.16%	\$664,561	0.07%	\$276,900
210018	MONTGOMERY GENERAL	\$75,687,627	0.59	0.30%	\$227,063	0.18%	\$115,442	0.09%	\$67,278
210058	REHAB & ORTHO	\$64,134,443	0.59	0.30%	\$192,403	0.18%	\$136,238	0.09%	\$57,008
210008	MERCY	\$214,208,592	0.60	0.33%	\$714,029	0.20%	\$475,870	0.11%	\$238,010
210043	BALTIMORE WASHINGTON MEDICAL CENTER	\$237,934,932	0.60	0.33%	\$793,116	0.20%	\$428,417	0.11%	\$264,372
210011	ST. AGNES	\$232,266,274	0.62	0.40%	\$929,065	0.24%	\$166,536	0.16%	\$361,303

Draft Recommendations for the Maryland Hospital-Acquired Conditions Program for Fiscal Year 2019

MHAC Hospital Modeling (using RY2017 Final Scores)				RY 2018 Scale		Option 1: Full Scale without Neutral Zone	Option 2: Full Scale with Neutral Zone		
Hospital ID	Hospital Name	FY 16 Permanent Inpatient Revenue	RY 17 Final MHAC score	% Adjustment	\$ Adjustment	% Adjustment	\$ Adjustment	% Adjustment	\$ Adjustment
	MAXIMUM PENALTY			-1.00%	\$	-2.00%	\$	-2.00%	\$
210032	UNION HOSPITAL OF CECIL COUNTY	\$69,389,876	0.62	0.40%	\$277,560	0.24%	\$557,439	0.16%	\$107,940
210015	FRANKLIN SQUARE	\$274,203,013	0.63	0.43%	\$1,188,213	0.26%	\$712,928	0.18%	\$487,472
210063	UM ST. JOSEPH	\$234,223,274	0.65	0.50%	\$1,171,116	0.30%	\$702,670	0.22%	\$520,496
210004	HOLY CROSS	\$316,970,825	0.66	0.53%	\$1,690,511	0.32%	\$435,005	0.24%	\$774,818
210030	CHESTERTOWN	\$21,575,174	0.66	0.53%	\$115,068	0.32%	\$362,383	0.24%	\$52,739
210034	HARBOR	\$113,244,592	0.66	0.53%	\$603,971	0.32%	\$69,041	0.24%	\$276,820
210049	UPPER CHESAPEAKE HEALTH	\$135,939,076	0.66	0.53%	\$725,008	0.32%	\$1,014,307	0.24%	\$332,296
210002	UNIVERSITY OF MARYLAND	\$906,034,034	0.67	0.57%	\$5,134,193	0.34%	\$3,080,516	0.27%	\$2,416,091
210029	HOPKINS BAYVIEW MED CTR	\$343,229,718	0.68	0.60%	\$2,059,378	0.36%	\$1,235,627	0.29%	\$991,553
210019	PENINSULA REGIONAL	\$242,318,199	0.71	0.70%	\$1,696,227	0.42%	\$1,017,736	0.36%	\$861,576
210010	DORCHESTER	\$26,999,062	0.74	0.80%	\$215,992	0.48%	\$332,012	0.42%	\$113,996
210028	ST. MARY	\$69,169,248	0.74	0.80%	\$553,354	0.48%	\$129,595	0.42%	\$292,048
210006	HARFORD	\$45,713,956	0.77	0.90%	\$411,426	0.54%	\$246,855	0.49%	\$223,490
210039	CALVERT	\$62,336,014	0.78	0.93%	\$581,803	0.56%	\$349,082	0.51%	\$318,606
210017	GARRETT COUNTY	\$19,149,148	0.81	1.00%	\$191,491	0.62%	\$118,725	0.58%	\$110,640
210060	FT. WASHINGTON	\$19,674,774	0.90	1.00%	\$196,748	0.80%	\$157,398	0.78%	\$153,026

Draft Recommendations for the Maryland Hospital-Acquired Conditions Program for Fiscal Year 2019

MHAC Hospital Modeling (using RY2017 Final Scores)				RY 2018 Scale		Option 1: Full Scale without Neutral Zone	Option 2: Full Scale with Neutral Zone		
Hospital ID	Hospital Name	FY 16 Permanent Inpatient Revenue	RY 17 Final MHAC score	% Adjustment	\$ Adjustment	% Adjustment	\$ Adjustment	% Adjustment	\$ Adjustment
	MAXIMUM PENALTY			-1.00%	\$	-2.00%	\$	-2.00%	\$
210045	MCCREADY	\$2,815,158	1.00	1.00%	\$28,152	1.00%	\$28,152	1.00%	\$28,152
State Total		\$8,796,981,441			\$20,043,788	State Total	\$2,990,533		\$3,644,677
Penalty					(\$2,040,868)	Penalty	(\$10,314,700)		(\$5,738,130)
% Inpatient					0.0%	% Inpatient	-0.1%		-0.1%
Reward					\$22,084,656	Reward	\$13,305,234		\$9,382,806
% Inpatient					0.3%	% Inpatient	0.2%		0.1%

Legislative Report – February 8, 2017

Maryland Patient Referral Law – Compensation Arrangements Under Federally Approved Programs and Models (HB 403/SB 369)

HB 403/SB 369 creates another exemption to the Maryland Patient Referral Law for a health care practitioner who has a compensation arrangement with a health care entity, if that compensation arrangement is funded or paid under a program approved by the Federal Centers for Medicare and Medicaid Services. Eligible programs include Medicare ACO, Advanced Payment ACO, Pioneer ACO, Next Generation ACO, an alternative payment model approved by CMS, or another model approved by CMS that may be applied to health care services provided to both Medicare and non-Medicare patients.

Review and approval by the Maryland Insurance Administration (MIA) is required for models that include both Medicare and non-Medicare patients and involve any cash compensation. The bill creates a process by which MIA reviews the participation agreements to determine whether the agreements constitute insurance and comply with State law.

This bill is needed to allow hospitals to implement the Care Redesign Amendment programs.

Status: First Reading; Assigned to House Health and Government Operations Committee and Senate Finance Committee

Recommended Position: Support with Written and Oral Testimony

Hospitals – Substance Use Treatment Demonstration Program – Requirements (HB 189)

HB 189 creates a substance abuse treatment demonstration program for up to 5 hospitals to identify best practices to identify and screen patients who may be in need of substance abuse treatment and provide inpatient and outpatient substance abuse services. Inpatient and outpatient services provided through the demonstration program shall include 24/7 counseling either on-site or on-call, screening, intervention, and treatment in the hospital's facility, and referral to the next appropriate level of care. The legislation directs the HSCRC to select the participants and develop a methodology to evaluate the effectiveness of the program. While Commission staff can select the participants, a contractor would be needed to evaluate the effectiveness of the program as that is not within the staff's purview.

HB 189 is similar to a bill submitted last year, for which the Commission ultimately submitted a letter of support with a caveat that funding be provided to procure a contract to evaluate the effectiveness of the program.

Status: First Reading in the House; Assigned to House Health and Government Operations Committee

Recommended Position: No Position/Monitor

Hospitals - Establishment of Substance Use Treatment Program - Requirements

HB 515 requires all hospitals to have a substance use treatment program to identify patients that need services and to admit the patients to the appropriate level of care. It also requires the Commission to provide an update in rates to cover capital and operating costs of the program.

Status: First Reading; Assigned to House Health and Government Operations

Recommended Position: Monitor

Hospitals – Changes in Status – Hospital Employee Retraining and Economic Impact Statements (SB 379)

SB 379 requires a hospital that voluntarily converts to a freestanding medical facility or is acquired by another hospital or health system to pay a fee directly to the State Department of Labor, Licensing, and Regulation if workers are displaced not to exceed 0.01 percent of total revenue approved by the Commission for the preceding fiscal year. The funds will be deposited into the Hospital Employees Training Fund. The bill also requires a hospital that closes or converts to a freestanding medical facility to produce an economic impact study related to the dislocation of the hospital's employees including the number of potential layoffs and the categories of employment affected by the potential layoffs.

Status: Hearing 2/9 in Senate Finance

Recommended Position: Monitor

Civil Actions – Noneconomic Damages – Catastrophic Injury (SB 225)

SB 225 increases the maximum amount of noneconomic damages that may be recovered in health care malpractice and other civil actions for a catastrophic injury.

SB 225 is similar to a bill introduced last session, for which the Commission sent a letter of information stating the Commission's concern that increasing the cap for noneconomic damages could increase the cost of claims and have a negative impact on access to critical services.

Status: Unfavorable Report by Judicial Proceedings Committee; Withdrawn

Budget Bill (Fiscal Year 2018) (HB 150/SB 170)

Fiscal 2017 Deficiency Appropriation

The annual budget bill usually includes deficiency appropriations and adjustments for the current fiscal year (Fiscal 2017), while also proposing an operating budget for the coming fiscal year (Fiscal 2018). The Fiscal 2017 deficiency appropriation includes a \$10 million transfer from the Uncompensated Care Fund to Medicaid, which we oppose.

Fiscal 2018 Operating Budget

The proposed budget for Fiscal 2018 for the Commission totals \$140 million, slightly more than the request submitted by the Commission in the fall. One of the reasons for the increased proposed appropriation is a higher indirect cost rate for overhead expenses provided by the Department. This item increases special fund appropriation by \$469,000 to be remitted to DHMH from HSCRC.

Budget Hearings

Budget hearings for the Regulatory Commissions are scheduled for February 10th at 1 pm in the Senate and February 13th at 3 pm in the House.

Status: First Reading; Assigned to House Appropriations Committee and Senate Budget and Taxation Committee

Recommended Position: Monitor

Budget Reconciliation and Financing Act of 2017 (HB 152/SB 172)

In order to balance the Fiscal 2017 and 2018 budget, a Budget Reconciliation and Financing Act (BRFA) is proposed that alters distribution of certain revenue and makes changes to appropriations that are ordered in statute. One item affecting the hospital industry is the Medicaid Deficit Assessment, which was included in law in 2011 and amended in 2013, 2014, and 2015 and totaled \$389,825,000 in fiscal year 2016. Beginning in fiscal year 2017, the deficit assessment was scheduled to be reduced by \$25 million per year. While that reduction is reflected for fiscal year 2017, HB 152 amends that law to delay the annual reduction to fiscal year 2019. For fiscal year 2018, the previously scheduled \$25 million reduction is not realized and the deficit assessment remains at \$364,825,000.

Status: First Reading; Assigned to House Appropriations Committee and Senate Budget and Taxation Committee

Recommended Position: Monitor

DRAFT Recommendation for CRISP as Administrator of the Care Redesign Programs

February 8, 2017

Health Services Cost Review Commission
4160 Patterson Avenue
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This document contains the draft staff recommendations for CRISP as Administrator of the Care Redesign Programs. Please submit comments on this draft to the Commission by Wednesday February 22, 2017, via hard copy mail or email to hsrc.care-redesign@maryland.gov.

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LIST OF ABBREVIATIONS

CCIP	Complex and Chronic Care Improvement Program
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
HCIP	Hospital Care Improvement Program
HSCRC	Health Services Cost Review Commission
ICN	Integrated Care Network
MACRA	Medicare Access and CHIP Reauthorization Act
MHIP	Maryland Health Insurance Program

INTRODUCTION

The Maryland Health Services Cost Review Commission (“HSCRC,” or “Commission”), in conjunction with the Maryland Department of Health and Mental Hygiene (“Department,” or “DHMH”) was recently granted an Amendment to the 2014 Maryland All-Payer Model (“Amendment”) to procure additional data and waivers necessary to the ongoing success of the All-Payer Model. Chesapeake Regional Information System for our Patients (“CRISP”) is a private not-for-profit organization focused on acting as the State’s Health Information Exchange and supporting infrastructure needs through its sophisticated reporting service and corresponding data analytic capacity. HSCRC staff is recommending that CRISP act as the administrator for the Amendment’s Care Redesign Programs, while HSCRC maintains its policy decision-making role and regulatory oversight.

BACKGROUND

Overview of Maryland’s Care Redesign Amendment

In response to Maryland stakeholders’ requests for greater provider alignment and transformation tools under the All-Payer Model, the State proposed, and the Centers for Medicare & Medicaid Services (CMS) approved, a Care Redesign Amendment (“Amendment”) to the Agreement in September 2016. The Amendment aims to modify the Model by:

- Implementing effective care management and chronic care management;
- Incentivizing efforts to provide high-quality, efficient, and well-coordinated episodes of care; and
- Supporting hospitals’ ability, in collaboration with their non-hospital care partners, to monitor and control Medicare beneficiaries’ total cost of care growth.

The Amendment gives Maryland hospitals the opportunity to implement Maryland-designed Care Redesign Programs intended to improve health outcomes. By participating in a Care Redesign Program, hospitals will have the opportunity to access comprehensive Medicare data, share resources, and offer incentives to community physicians and practitioners, physicians that practice at hospitals, and other providers, collectively known as Care Partners. Hospitals and their care partners can leverage Medicare data for implementing, monitoring, and improving their Care Redesign Programs.

Amendment’s Care Redesign Programs

Under the Care Redesign Amendment, Participating Hospitals will have the opportunity to participate in at least one of two initial Care Redesign Programs, the Hospital Care Improvement Program (“HCIP”) and Complex and Chronic Care Improvement Program (“CCIP”).

- HCIP: Implemented by Participant Hospitals and hospital-based providers, the HCIP aims to improve inpatient medical and surgical care delivery; provide effective transitions

of care; ensure an effective delivery of care during acute care events, beyond hospital walls; encourage the effective management of inpatient resources; and reduce potentially avoidable utilization with a byproduct of reduced cost per acute care event.

- CCIP: Implemented by Participant Hospitals and community providers and practitioners, the CCIP aims to strengthen primary care supports for complex and chronic patients in order to reduce avoidable hospital utilization; enhance care management through tools such as effective risk stratification, health risk assessments, and patient-driven care profiles and plans; and facilitate overall practice transformation towards person-centered care that produces improved outcomes and meets or exceeds quality standards.

Benefits of the Care Redesign Programs

Both HCIP and CCIP are voluntary programs. Hospitals who choose to participate in HCIP and/or CCIP will have access to patient identified Medicare claims data; achieve closer alignment with their Care Partners through a focus on common goals; enhance their person-centered focus of care; increase quality scores and improve outcomes; and generate greater savings and reductions of potentially avoidable utilization under global budgets. Care Partners who choose to participate in HCIP and/or CCIP will have access to transformation tools and incentives made available by the Participant Hospital(s), as well as the potential for other support for requirements under the Medicare Access and CHIP Reauthorization Act (“MACRA”).

Because the Care Redesign Amendment is a “living document,” the Care Redesign Programs also will continue to evolve to meet the changing needs of Maryland providers. Stakeholders and the State may choose to modify or eliminate Care Redesign Programs over time as they are replaced with more comprehensive delivery and payment approaches. The Amendment gives Maryland the flexibility to expand and refine Care Redesign Programs based on outcomes, learnings, and the changing levels of sophistication of Maryland’s health care system players, as well as the needs of healthcare consumers. The State will deploy a process by which providers and stakeholders make recommendations on enhancements to current programs or for the introduction of new programs to meet the unique needs of Maryland’s patients, payers, and health care providers. This flexibility also improves the State’s responsiveness to external changes brought on by MACRA and other new federal regulations and initiatives. Through this flexible framework, the Amendment will facilitate the State’s ongoing success and progression towards addressing system-wide health care outcomes and costs under the All-Payer Model.

Given the additional flexibility provided under the Amendment, CMS is requiring that Maryland have State oversight and administration responsibilities to ensure the success of the Care Redesign Programs. In particular, Program administration responsibilities under the Amendment will require intense data reporting and analytics capabilities. As such, the HSCRC is recommending that CRISP act as the administrator the Amendment’s Care Redesign Programs, while HSCRC maintains its policy decision-making role and regulatory oversight.

OVERSIGHT AND ADMINISTRATION OF THE CARE REDESIGN PROGRAMS

Public-Private Partnership Strategy

The HSCRC is focused on ensuring the availability of tools to support all types of providers in achieving transformation goals. As described in the Progression Plan to the All-Payer Model, Maryland’s strategy is to leverage private resources and public-private resources where implementation is best accomplished cooperatively to support transformation. The HSCRC employs a public-private partnership strategy for several reasons:

- Responsiveness—Resources under stakeholder governance can be more responsive to needs
- Lower costs—Providers and government need some of the same resources, and joint production decreases costs and increases sophistication. The HSCRC wants to avoid having providers pay for staff and consultants to recreate the data analytics and other tools that the State is developing, and visa-versa.
- Transparency—Providers have immediate access to the work of the State regulatory staff, improving the transparency of actions in an increasingly data-driven environment. Transparency creates a better opportunity for input and ongoing improvements.
- Agility—The private sector can be more agile in making changes (e.g., scaling size of resources based on needs).

HSCRC & CRISP’s Oversight and Administrator Roles

Based on Maryland’s public-private partnership strategy, the HSCRC is recommending that CRISP act as the administrator of the Amendment’s Care Redesign Programs while HSCRC maintains its policy decision-making role and regulatory oversight. Figure 1 provides a high level description of the functions of the different entities involved for the first two Care Redesign Programs, HCIP and CCIP. Future Care Redesign Programs would also require design and development work.

Figure 1: Care Redesign Programs - Entity Functions

CMS <i>Federal Regulator</i>	HSCRC <i>State Regulator</i>	CRISP <i>Administrator</i>	PROVIDER COMMUNITY
<ul style="list-style-type: none"> • Approve terms of Care Redesign Programs. 	<ul style="list-style-type: none"> • Set and interpret policy. • Develop methodology for total cost of care. • Approve incentive payment methodology. 	<ul style="list-style-type: none"> • Communication and consulting hub. • CCIP administration and coordination. • HCIP administration and coordination. 	<ul style="list-style-type: none"> • Establish and implement Care Redesign Programs.

	<ul style="list-style-type: none"> • Review and resolve disputes. • Coordinate with statewide regulatory activities. • Funding source and approval. 	<ul style="list-style-type: none"> • Analytic support, including data collection and reporting. • Budget development. 	
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As a private not-for-profit organization focused on acting as the State’s Health Information Exchange and supporting infrastructure needs that can best be accomplished cooperatively, CRISP will offer the provider-led structure to lead the implementation of the programs. The Care Redesign Programs need to be led by the provider community to be successful. CRISP’s inclusive governance structure makes it well-positioned to ensure that implementation is responsive to provider needs and consumers. Moreover, while CRISP would be the administrator of the program, the HSCRC will work with CRISP to ensure that the administration will meet the needs of the filings that must be made with the State and CMS.

Funding for CRISP’s Administrator Role

Currently through FY 2018, the care redesign administration is funded through the Integrated Care Network (ICN) budget that the legislature designated from former Maryland Health Insurance Program (MHIP) funds. The HSCRC staff’s position is that future assessments, like MHIP, provide the most stable and equitable source for long-term funding of Care Redesign Programs. However, the HSCRC staff is interested in CRISP’s ICN governance structure and the provider industry’s recommendations on the best strategy for long-term financing. It should be noted that the Commission will need to review and approve recommendations for long-term funding.

In terms of the size of the funding request, the HSCRC staff will ask CRISP staff for advice, particularly based on their experience with the budgets of existing care redesign efforts. However, the HSCRC staff would generally be supportive of a budget request that meets the needs of the stakeholders engaging in this work. As mentioned, the Care Redesign Programs must be provider-led initiatives to be successful, and the HSCRC staff will follow the lead of industry in terms of the administrative support required for implementation.

RECOMMENDATION

Based on HSCRC’s public-private partnership strategy and analysis of how CRISP’s governance structures and capabilities position them well for implementation capability, the HSCRC staff is recommending that CRISP act as the administrator the Amendment’s Care Redesign Programs, while HSCRC maintains its policy decision-making role and regulatory oversight.

APPENDIX: ADDITIONAL BACKGROUND ON CRISP

CRISP Vision, Mission, and Guiding Principles

First Adopted 2007, Updated April 2014

Vision

To advance health and wellness by deploying health information technology solutions adopted through cooperation and collaboration.

Mission

We will enable and support the healthcare community of Maryland and our region to appropriately and securely share data in order to facilitate care, reduce costs, and improve health outcomes.

Guiding Principles

1. Begin with a manageable scope and remain incremental.
2. Create opportunities to cooperate even while participating healthcare organizations still compete in other ways.
3. Affirm that competition and market-mechanisms spur innovation and improvement.
4. Promote and enable consumers' control over their own health information.
5. Use best practices and standards.
6. Serve our region's entire healthcare community.

CRS Principles

First Adopted 2015, Update January 2017

1. CRISP will provide reporting and analytics services when cooperation and collaboration is appropriate. CRISP will serve providers, regulators, investigators, public health officials, and patients – particularly when the engagement of multiple stakeholder groups is required.
2. CRISP will not seek to replicate services which are readily available commercially, but will work to assist those who provide commercial analytics services when that is requested by our participants.
3. CRISP will strive to make report creation efficient in effort and expense, internally and for those submitting and receiving data, so as to limit the burden for our participants.
4. CRISP will not report performance measures to regulators for individual hospitals/providers, unless the hospitals/providers have agreed for us to do so through our governance

committees. When we do create performance measure reports, we will seek to create transparency for participants to view, understand, and validate the data.

5. CRISP will be honest and trustworthy in all reports we create. We will not assist with any reporting in which we believe a participant may be falsifying data.
6. When CRISP is creating progress measures or comparison measures, for its own work or for that of a jurisdiction as a whole, it will endeavor to keep cell-level data de-identified.
7. CRISP will support approaches allowing consumer control and consent, and assist participants as they navigate these issues.
8. CRISP will serve our health care community in an evenhanded manner. We will prioritize reporting and analytics intended to facilitate care, reduce costs, and improve health outcomes. CRISP will not advocate the adoption of particular policies, although we sometimes function as a convener for stakeholders to make decisions cooperatively.

Additional information on CRISP can be found at <https://www.crisphealth.org/>.

State of Maryland
Department of Health and Mental Hygiene



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Health Services Cost Review Commission

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TO: Commissioners
FROM: HSCRC Staff
DATE: February 8, 2017
RE: Hearing and Meeting Schedule

March 8, 2017 To be determined - 4160 Patterson Avenue
HSCRC/MHCC Conference Room
April 12, 2017 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 11:45 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://www.hsrc.maryland.gov/commission-meetings-2016.cfm>

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