State of Maryland
Department of Health and Mental Hygiene

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Research and Methodology

517th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
March 11, 2015

EXECUTIVE SESSION
12:00 p.m.
(The Commission will begin in public session at 12:00 p.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1PM.)

1. **Status of Medicare Data Submission and Reconciliation – Authority General Provisions Article, § 3-104**
2. **Contract and Modeling of the All-payer Model and Legal Consultation on Potential Alternate Medicare Payment for Hospital Services vis-a-vis the All-Payer Model Contract – Authority General Provisions Article, § 3-104, and 3-305(b)(7)**
3. **Personnel Issues – Authority General Provisions Article, § 3-305(b)(1)(i)(ii)**

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

1. **Review of the Minutes from the Executive Session and Public Meeting on February 11, 2015**

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**
   2287A- University of Maryland Medical Center
   2284R – Garrett County Memorial Hospital
   2285R - Johns Hopkins Bayview Medical Center

5. **Docket Status – Cases Open**
   2288R - MedStar Southern Maryland Hospital Center
   2289R – MedStar Franklin Square Hospital Center
   2290A - University of Maryland Medical Center
   2291A – Johns Hopkins Health System
   2292A – Johns Hopkins Health System
   2293A – Johns Hopkins Health System

6. **Final Recommendation for Modifications to the Readmission Reduction Incentive Program for FY 2017**

7. **Final Recommendations for Total Amount at Risk for Quality Programs for FY 2017**

8. **Draft Recommendation for Funding of Statewide Infrastructure, and Planning of Regional Partnerships for Health System Transformation**

9. **Demonstration of MHCC's Web-based Consumer Guide**

10. **Work Group Updates**

11. **Legislative Report**

12. **Legal Report**

13. **Hearing and Meeting Schedule**

Closed Session Minutes
Of the
Health Services Cost Review Commission

February 11, 2015

Upon motion made in public session, Chairman Colmers call for adjournment into closed session to discuss the following item:

1. Status of Medicare Data Submission and Reconciliation.

The Closed Session was called to order at 12:06 p.m. and held under authority of - §§ 3-104 and 3-305(b)(7) of the General Provisions Article.

In attendance, in addition to Chairman Colmers, were Commissioners Bone, Jencks, Keane, Loftus, and Wong. Commissioner Mullen participated by telephone.

In attendance representing Staff were Donna Kinzer, David Romans, Steve Ports, Sule Calikoglu, Jerry Schmith, Ellen Englert and Dennis Phelps.

Also attending were Leslie Schulman and Stan Lustman, Commission Counsel.

Item One

David Romans, Director-Payment Reform and Innovation, presented an updated analysis of Medicare per beneficiary data. Authority: General Provisions Article, § 3-104.

Item Two

Stan Lustman, Commission Counsel, advised the Commission on the legal authority to implement a differential.

Executive Director Kinzer and Director Romans presented, and the Commission discussed, potential alternative Medicare reimbursement for hospital services vis-s-vis the All-payer Model – Authority General Provisions Article, §§ 3-104, and 3-105.

Closed Session was adjourned at 12:47 p.m.

MINUTES OF THE
516th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

FEBRUARY 11, 2015

Chairman John Colmers called the public meeting to order at 12 pm. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., MPH, Jack C. Keane, Bernadette C. Loftus, M.D., and Herbert S. Wong Ph.D. were also in attendance. Commissioner Mullen participated by telephone. Upon motion made by Commissioner Jencks and seconded by Commissioner Wong, the meeting was moved to Executive Session. Chairman Colmers reconvened the public meeting at 1:00 pm.

REPORT OF THE FEBRUARY 11, 2015 EXECUTIVE SESSION

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the February 11, 2015 Executive Session.

ITEM I
REVIEW OF THE MINUTES FROM JANUARY 14, 2015 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the January 14, 2015 Executive Session and the Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, updated the Commission on several national initiatives and trends that could affect the performance of Maryland's All-Payer Model.

Ms. Kinzer noted that there was a recent downward trend in national Medicare per enrollee spending growth. The average spending growth from 2009-2012 was 2.3% compared to 6.3% in 2000-2008.

Ms. Kinzer stated that on January 26, 2015, the Department of Health and Human Services announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they render to patients.

Ms. Kinzer stated that the Center for Medicare & Medicaid Innovation (CMMI) and HSCRC staff have been discussing Maryland partnership strategies for Care Coordination and Infrastructure and Alignment on a monthly basis. While Maryland is initially ahead of the timelines in implementation, we will need to focus on partnership strategies to ensure that we

continue to stay ahead of requirements, in light of the Medicare savings requirements as well as the "guardrail" requirements relative to total cost of care.

Ms. Kinzer noted that:

- Nearly all of Maryland's hospitals' revenue are now under an alternative payment model with the implementation of the new All-Payer Model:
- The Department of Health and Mental Hygiene (DHMH) received a grant from CMMI of $2.5 million to develop parameters for Medicaid ACO model for dual eligibles;
- The work of the Care Coordination and Infrastructure and Alignment work groups will be crucial in recommending strategies that will move progress forward in Maryland;
- CRISP, MHCC and Med Chi worked together to submit a grant request to CMMI to participate in the Transforming Clinical Practice Initiative, which will invest up to $800 million nationally in providing hands on support to 150,000 physicians and other clinicians for developing the skills and tools needed to improve care delivery and transition to alternative payment models.

Ms. Kinzer stated that on January 1, 2015 Medicare introduced a non-visit based payment for chronic care management (CCM). A fee of $40 per month is available for primary care physician practices that care for beneficiaries with two or more chronic conditions. To be eligible for the CCM payment, physician practices must meet certain administrative criteria, including using electronic health records (EHR), offering round-the-clock access to staff who have access to EHR, designating a care practitioner for each patient, and coordinating care through transitions to and from the hospital, specialists, and other providers.

Ms. Kinzer reported that influenza levels in Maryland have decreased in January 2015. Should the incidence of influenza in FY 2015 exceed that of the GBR base year, staff may consider adding a one-time rate adjustment as specified in the GBR/TPR agreement. Staff is expected to complete their evaluation of influenza utilization by the March Commission meeting.

Ms. Kinzer noted that the 2015 Budget Reconciliation and Financing Act allows the Commission to include up to $15 million in hospital rates to support:

- Assisting hospitals cover costs associated with implementation of Maryland's All-Payer Model: and/or
- Funding of statewide and regional proposals that support the implementation of the All-Payer Model.

DHMH and the staff have developed a Request for Proposals for up to a total of $2.5 million in regional planning grants to support the development of multi-stakeholder health system transformation partnerships in 5 or more regions in Maryland.

Ms. Kinzer stated that the CMMI evaluation contractor will begin making site visits to hospitals and other stakeholders over the next several months. CMMI hopes to gain information about implementation of the All-Payer Model and the experiences of each set of stakeholders.

ITEM III
NEW MODEL MONITORING

Mr. David Romans, Director Payment Reform and Innovation, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of December will focus on fiscal year (July 1 through June 30) as well as calendar year results.

Mr. Romans reported that for the six months ended December 31, 2014, All-Payer total gross revenue increased by 1.82% over the same period in FY 2013. All-Payer total gross revenue for Maryland residents increased by 2.46%; this translates to a per capita growth of 1.81%. All-Payer gross revenue for non-Maryland residents decreased by 4.28%.

Mr. Romans reported that for the 12 months of the calendar year ended December 31, 2014, All-Payer total gross revenue increased by 1.72% over the same period in FY 2013. All- Payer total gross revenue for Maryland residents increased by 2.12%; this translates to a per capita growth of 1.47. %. All-Payer gross revenue for non-Maryland residents decreased by 2.11%.

Mr. Romans reported that for the six months ended December 31, 2014, Medicare Fee-For-Service gross revenue increased by 1.85% over the same period in FY 2013. Medicare Fee-For-Service for Maryland residents increased by 2.62%; this translates to a per capita growth (.56%). Maryland Fee-For-Service gross revenue for non-residents decreased by 6.04%.

Mr. Romans reported that for the 12 months of the calendar year ended December 31, 2014, Medicare Fee-For-Service gross revenue increased by 1.78%. Medicare Fee-For-Service for Maryland residents increased by 2.10%; this translates to a per capita growth (1.12%). Maryland Fee-For-Service gross revenue for non-residents decreased by 1.63%.

According to Mr. Romans, for the six months of the calendar year ended December 31, 2014, unaudited average operating profit for acute hospitals was 2.61%. The median hospital profit was 4.00%, with a distribution of 1.74% in the 25th percentile and 7.14% in the 75th percentile. Rate Regulated profits were 4.79%.

Dr. Alyson Schuster, Associate Director Data & Research, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon readmission data on discharges through November 2014.

Readmissions

- The All-Payer risk adjusted readmission rate was 11.98% for November 2014 YTD. This is a decrease of 4.08% from the November 2013 risk adjusted readmission rate.

- The Medicare Fee for Service risk adjusted readmission rate was 12.96% for November 2014 YTD. This is a decrease of 1.76% from the November 2013 YTD risk adjusted readmission rate.
- Based on the New-Payer model, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction incentive program has set goals for hospitals to reduce their adjusted readmission rate by 6.76% during CY 2014 compared to CY 2013. Currently, only 15 out of 46 hospitals have reduced their risk adjusted readmission rate by more than 6.76%.

Dr. Schuster noted that the Potentially Preventable Complication data will be presented on a quarterly basis, and that FY 2015 second quarter data were not available.

ITEM IV
DOCKET STATUS CASES CLOSED

2265A- Holy Cross Hospital
2282A- University of Maryland Medical Center
2283A- Johns Hopkins Health System
2286A- Johns Hopkins Health System

ITEM V
2285R- Johns Hopkins Bayview Medical Center

On December 23, 2014, Johns Hopkins Bayview Medical Center (the "Hospital") submitted a partial rate application to the Commission for a rate for Radiation Therapy (RAT) services to be provided to both inpatients and outpatients. This new rate would replace its currently approved rebundled RAT rate. The Hospital requests that the RAT rate be set at the lower of a rate based on its projected costs or the statewide median. The Hospital request that the RAT rate be effective on February 23, 2015.

After reviewing the Hospital application, Staff recommends the following:

- That the RAT rate of $28.06 per RVU be effective February 23, 2015;
- That no change be made to the Hospital's Global Budget Revenue for RAT services;
- That the RAT rate not be rate realigned until a full year of experience data have been reported to the Commission; and
- That these new RAT services will be subject to the provisions of the new volume or Global Budget Policies

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

2286A-Johns Hopkins Health Systems (Revised)

Johns Hopkins Health System (the "System"), on behalf its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital

(the "Hospitals"), filed an application on December 23, 2014 requesting approval to add heart failure services to its approved global rate arrangement with Optum Health, a division of United HealthCare. The Hospitals are requesting an approval for one year beginning February 1, 2015.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for heart failure services for one year beginning February 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2287A- University of Maryland Medical Center

University of Maryland Medical Center (the "Hospital"), filed an application on January 12, 2015 requesting approval to participate in a global rate arrangement for heart transplants and Ventricular Assist Device services with Cigna Health Corporation for one year beginning March 1, 2015.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for heart transplants and Ventricular Assist Device services for one year beginning March 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation

30 Day Extensions

Staff requested 30 day extensions for Proceeding # 2288R MedStar Southern Maryland Hospital Center and Proceeding #2289R MedStar Franklin Square Hospital Center. The Commission voted unanimously to approve these extensions.

ITEM VI
VHQC (MEDICARE QUALITY IMPROVEMENT ORGANIZATION) PRESENTATION ON MARYLAND READMISSION DATA

Ms. Carla Thomas, Director Care Transitions, presented an update on the Virginia Health Quality Center (VHQC) Care Transitions Project and Maryland Readmissions Data (See "VHQC Transitions Project and Maryland Readmissions Data" on the HSCRC website).

Ms. Thomas provided an overview of VHQC activities related to coordinating care to reduce admissions and adverse drug events. The Care Transitions Project focuses action by engaging and developing communities of clinical and local service/support partners. In addition to specific goals of reducing inpatient utilization, the project aims to increase effective community

intervention, build community capacity to qualify for formal program or grant funding, and spread successful care transitions interventions.

Currently, VHQC is working with the Health Partners Coalition in Montgomery County, which includes five hospitals, and the Primary Care Coalition and touches approximately 15% of the Maryland Medicare beneficiaries. VHQC would like to expand activity in Maryland to existing or new partnerships so they reach approximately 60% of Medicare Fee for Service beneficiaries in Maryland.

ITEM VII
DRAFT RECOMMENDATION FOR MODIFICATION TO THE READMISSION REDUCTION INCENTIVE PROGRAM FOR FY 2017

Sule Calikoglu Ph.D., Deputy Director Research and Methodology, presented an update on the draft recommendations for the Readmission Reduction Incentive Program for FY 2017 (See "Update on the Recommendations for the Readmission Reduction Incentive Programs for FY2017" on the HSCRC website).

Dr. Calikoglu noted that since presenting the draft recommendations for the Readmission Reduction Incentive Program for FY2017 at the December Commission meeting, staff has been discussing the recommendations with the payment and workgroup members and working with the Center for Medicare and Medicaid Innovation to update the readmission rates. Staff is planning to present the final recommendations at the March Commission meeting.

ITEM VIII
DRAFT RECOMMENDATIONS FOR TOTAL AMOUNT AT RISK FOR QUALITY PROGRAM FOR FY 2017

Dr. Calikoglu presented an update on the draft recommendations for the total amount at risk for Quality Program for FY 2017 (See "Update on the Recommendations for Aggregate Revenue Amount at Risk Under Maryland Hospital Quality Programs for FY2017" on the HSCRC website).

Dr. Calikoglu noted that since presenting the draft recommendations for Aggregate Revenue Amount at Risk Under Maryland Hospital Quality Programs for FY2017 at the December Commission meeting, staff has been discussing the recommendations with the payment and workgroup members. Staff is planning to present the final recommendations at the March Commission meeting.

ITEM IX
WORK GROUP UPDATES

Mr. Steve Ports, Deputy Director Policy and Operations, Dr. Calikoglu, and Mr. Romans presented an update on both the Care Coordination and Consumer Engagement and the Payment Models Workgroups (See "Update on Work Groups" on the HSCRC website).

Dr. Calikoglu updated the Commission on the continuing development of payment policies regarding market shift adjustments.

Mr. Romans reported on the potential update to the Uncompensated Care (UCC) methodology for FY 2016. Mr. Romans noted that the preliminary calculation indicates that beyond the $166 million prospective UCC reduction in fiscal year 2015 rates, as much as $133 million in additional prospective reductions could be made in FY 2016 rates.

ITEM X
LEGISLATIVE REPORT

Mr. Ports presented a summary of the legislation of interest to the HSCRC (see "Legislative Update- February 11, 2015" on the HSCRC website).

The Bills included: 1) Senate 57/House Bill 72 Budget Reconciliation Act of 2015; 2) Senate Bill 469/House Bill 367 Public Health- Maryland Behavioral Health Crisis Response System; 3) Senate Bill 513 Hospital-Rate Setting- Participation in 340B Program Under the Federal Public Health Service; 4) Senate Bill 572 Hospital- Designation of Caregivers; and 5) Senate Bill 585/House Bill 553 Maryland No-Fault Birth Injury Fund.

ITEM XI
HEARING AND MEETING SCHEDULE

March 11, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
April 15, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:19 pm.

Executive Director's Report

Health Services Cost Review Commission

March 10, 2015

Staff Focus

During the past several months, staff has been focused on the following:

- Ongoing regulatory activities
  - Updating and reformulating quality polices (March final recommendation)
  - Working on the rate year 2016 update (May preliminary recommendation)
  - Developing the uncompensated care update for 2016 (April preliminary recommendation)
  - Evaluating the impact of Medicaid expansion on utilization (April preliminary recommendation)
  - Market shift adjustment--staff is working on outpatient data verification with the field. There are some corrections to OP data that still need to be made. (Update Commission at April meeting)

- Partnership work group activities
  - Working with the care coordination work group to develop recommendations regarding infrastructure and approach for high needs patients and chronic care improvements (March draft recommendation regarding BRFA funds, April draft work group recommendations)
  - Working with consultants regarding alignment strategies
  - Working with consumer work groups for consumer outreach and consumer engagement and education planning

Future Performance Measurement Policies

Following the completion of policy development for this year, staff expects to "step back" and resume the process of developing a strategic view of where we should be heading with performance measurement, to ensure that we are focused on patient centered policies that measure and help drive better care, better health, and lower costs.

Staff has been preparing patient centered data for use by hospitals relative to the current policies. Our policies may need to be adjusted to be more patient centered and population

based, as well as focusing on information that can be obtained from EMRs. We expect to convene this discussion during the upcoming months, after completion of the FY 2016 policies.

Flu Update

As expected, the flu season tapered off in February, with the weekly activity reported as minimal for the entire month of February by DHMH. The following table from the February 28, 2015 DHMH flu report shows the admission levels over October through February. For the base year flu season (2012/2013)[1], there were 2,369 estimated flu related admissions. For the 2013/2014 season, flu admissions were low with a total of 1,446 reported, well below the base period year used for most hospitals. For the 2014/2015 year, the total admissions were estimated at 3,204, above the base year level. The two year average since the base year is 2,325.

Thank You

We want to give special thanks to Jessica O'Neill, who has been helping us for the past 18 months, serving as our liaison with CMMI and helping us with work group and other activities. Jessica will be attending medical school this fall.

Welcome

We have three new staff members to introduce:

[1] 2012/2013 was the base year for most GBR agreements.

- Xavier Colo is joining the staff as Associate Director of Information Technology. In this new position Xavier will help lead the Commission's efforts to evaluate and upgrade our IT infrastructure. Xavier comes with extensive IT experience including most recently the role of Information Technology Manager for Marriott International's National Harbor facility.
- Irene Cheng joined the staff in January as a HSCRC Chief I. She will provide analytic and programming support related to hospital financial data. She is currently developing analysis of the write-off and recovery data the Commission began collecting over the past year.
- Jessica Lee, has just joined our staff. She will be stepping in to take over the reins from Jessica O'Neill. She expects to be with us for the next 18 months, as she helps HSCRC with ongoing activities with CMMI and hones her health policy skills and prepares for admission to medical school.

Monitoring Maryland Performance

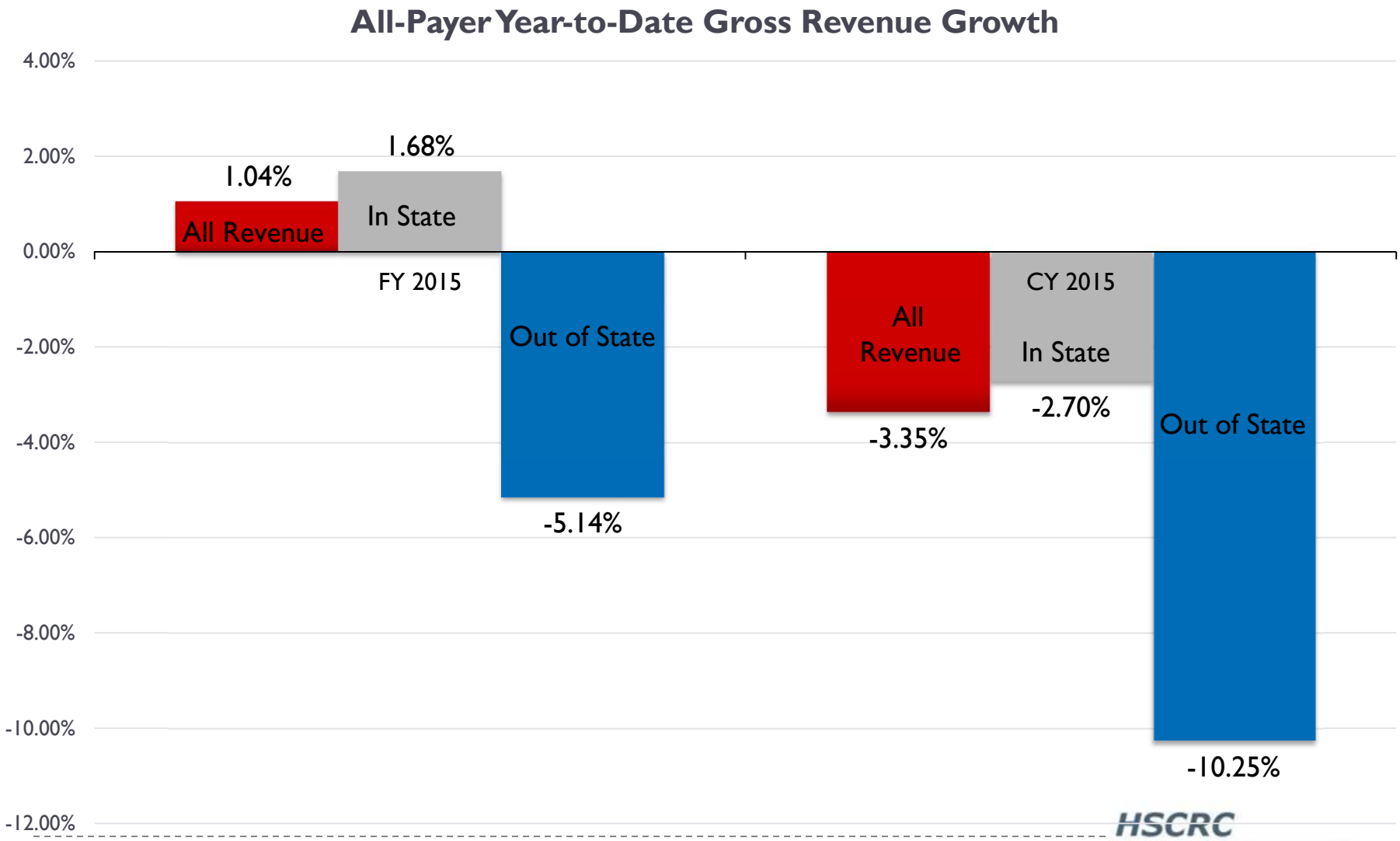
Financial Data

Year to Date thru January 2015

HSCRC
Health Services Cost Review Commission

Gross All Payer Revenue Growth

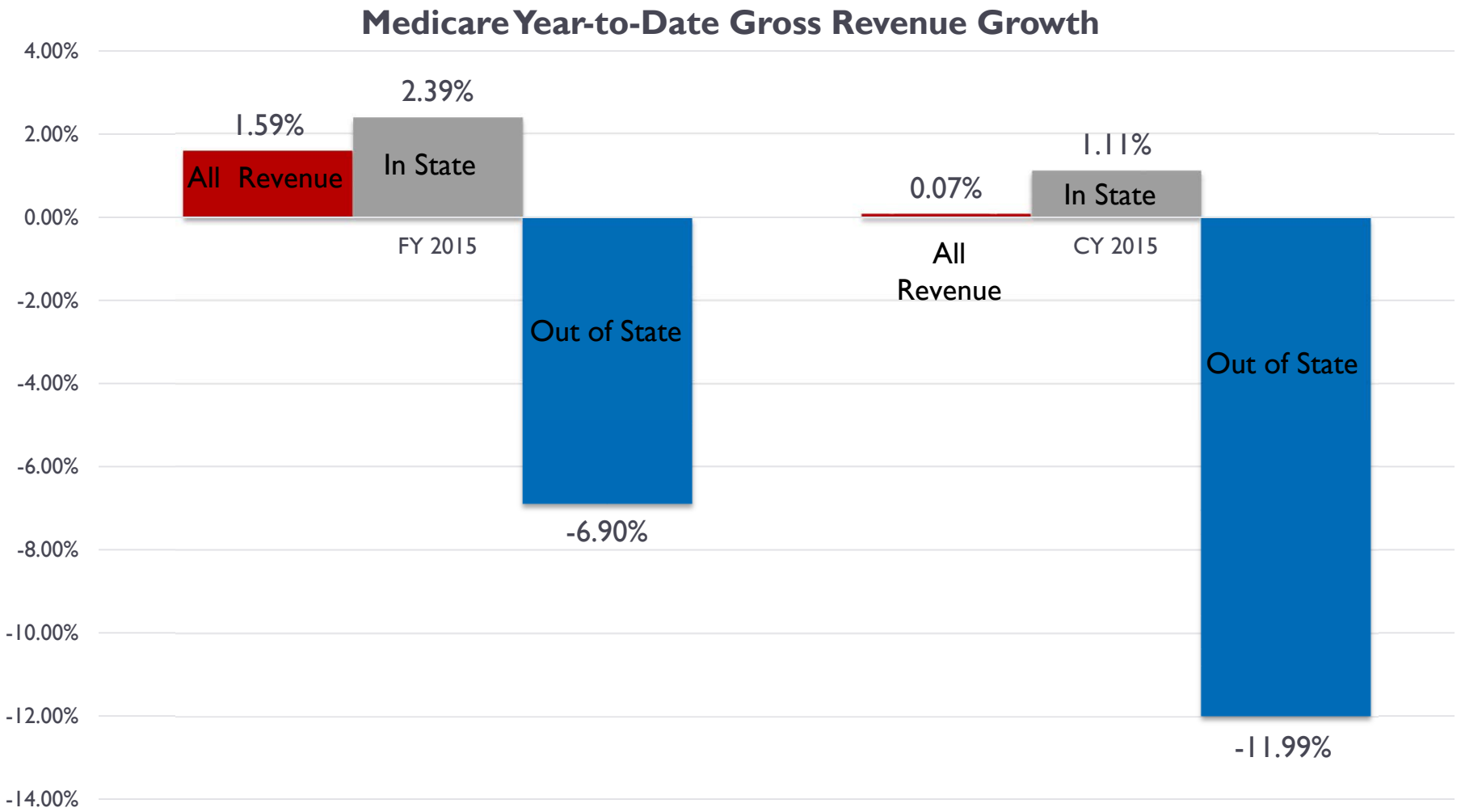
Year to Date (thru January 2015) Compared to Same Period in Prior Year



HSCRC
Health Services Cost Review Commission

Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru January 2015) Compared to Same Period in Prior Year



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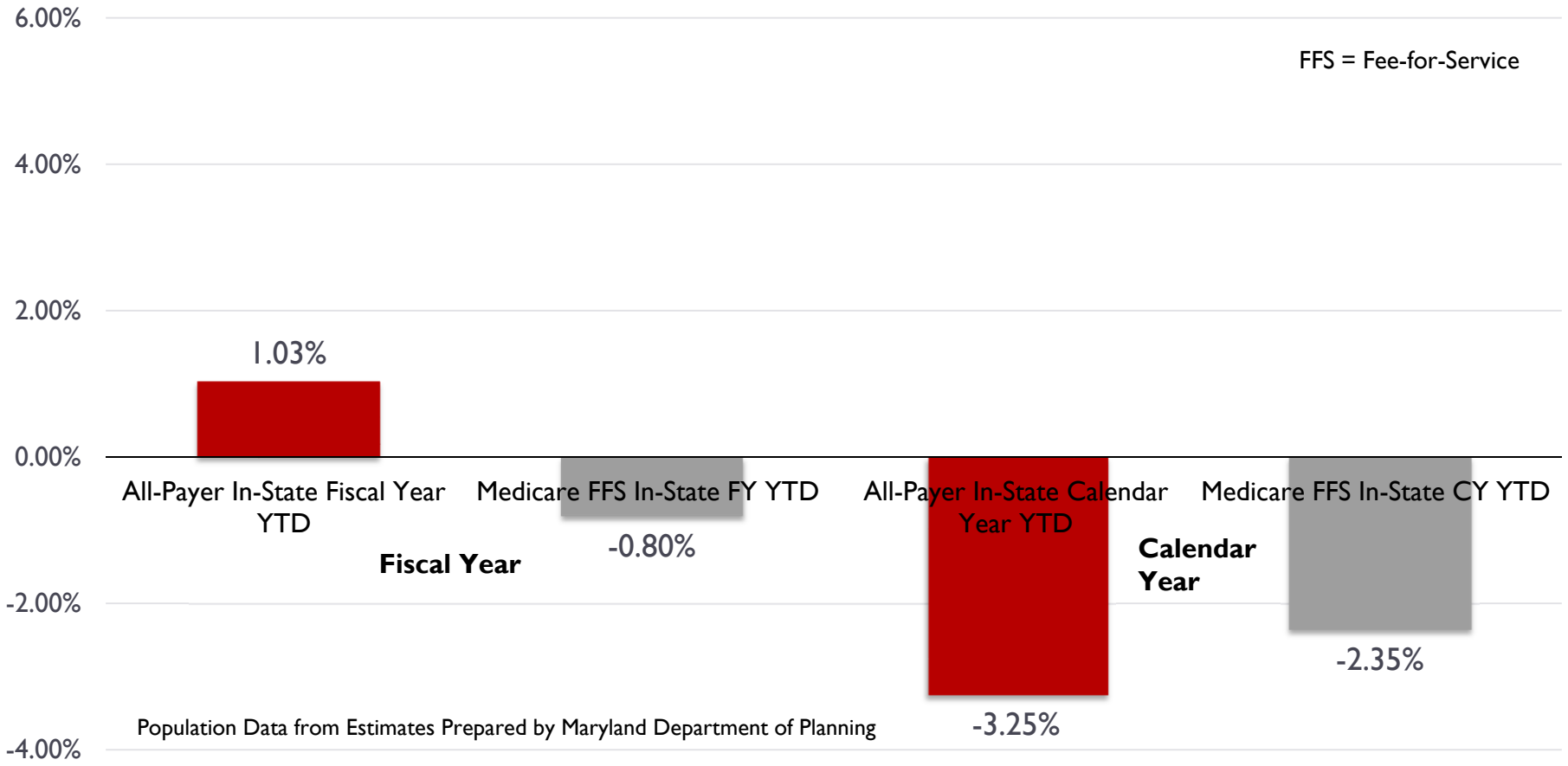
Per Capita Growth Rates
Fiscal Year 2015 and Calendar Year 2015



- **Calendar and Fiscal Year trends to date are below All-Payer Model Guardrail for per capita growth.**

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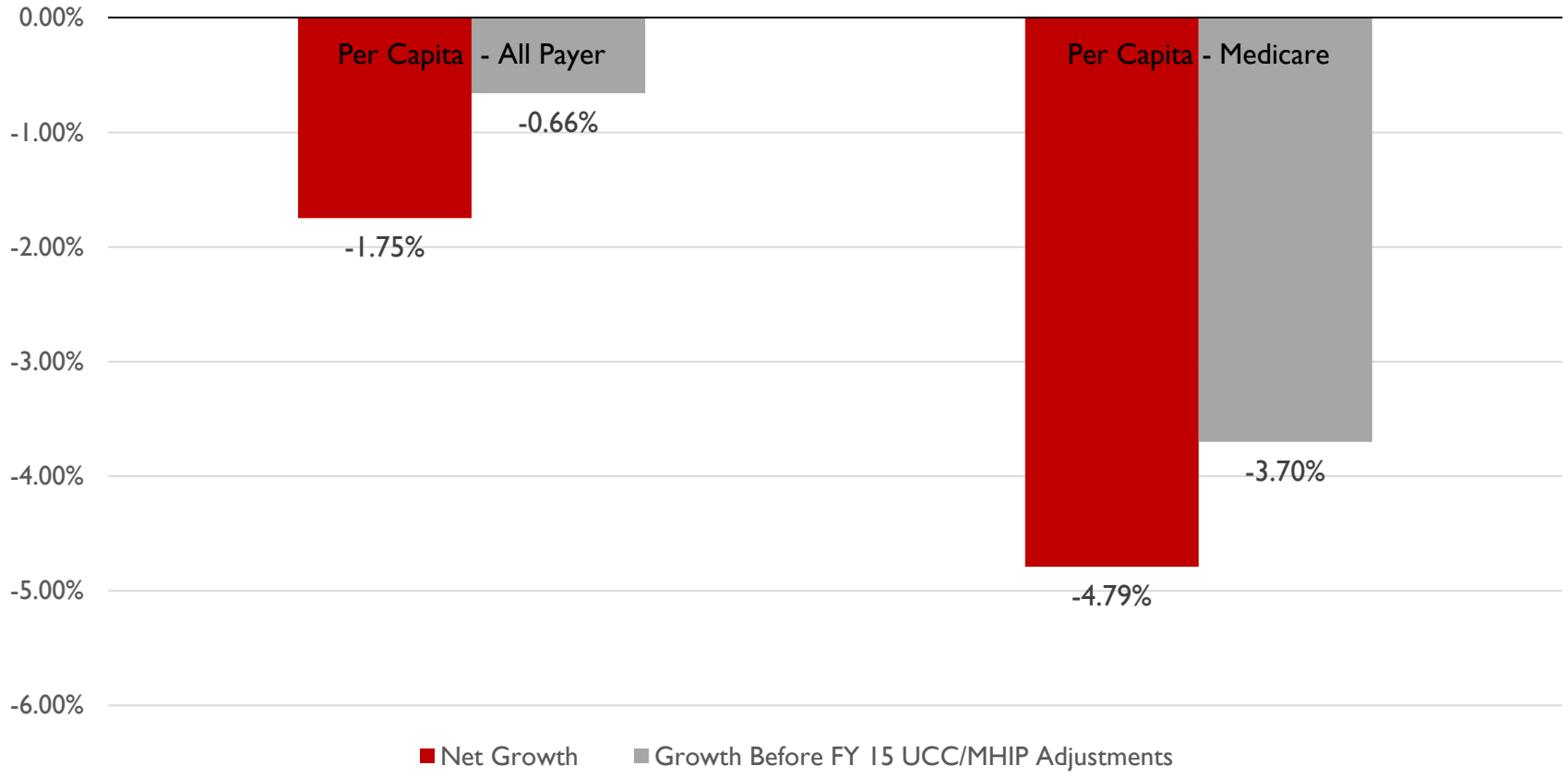
Health Services Cost Review Commission

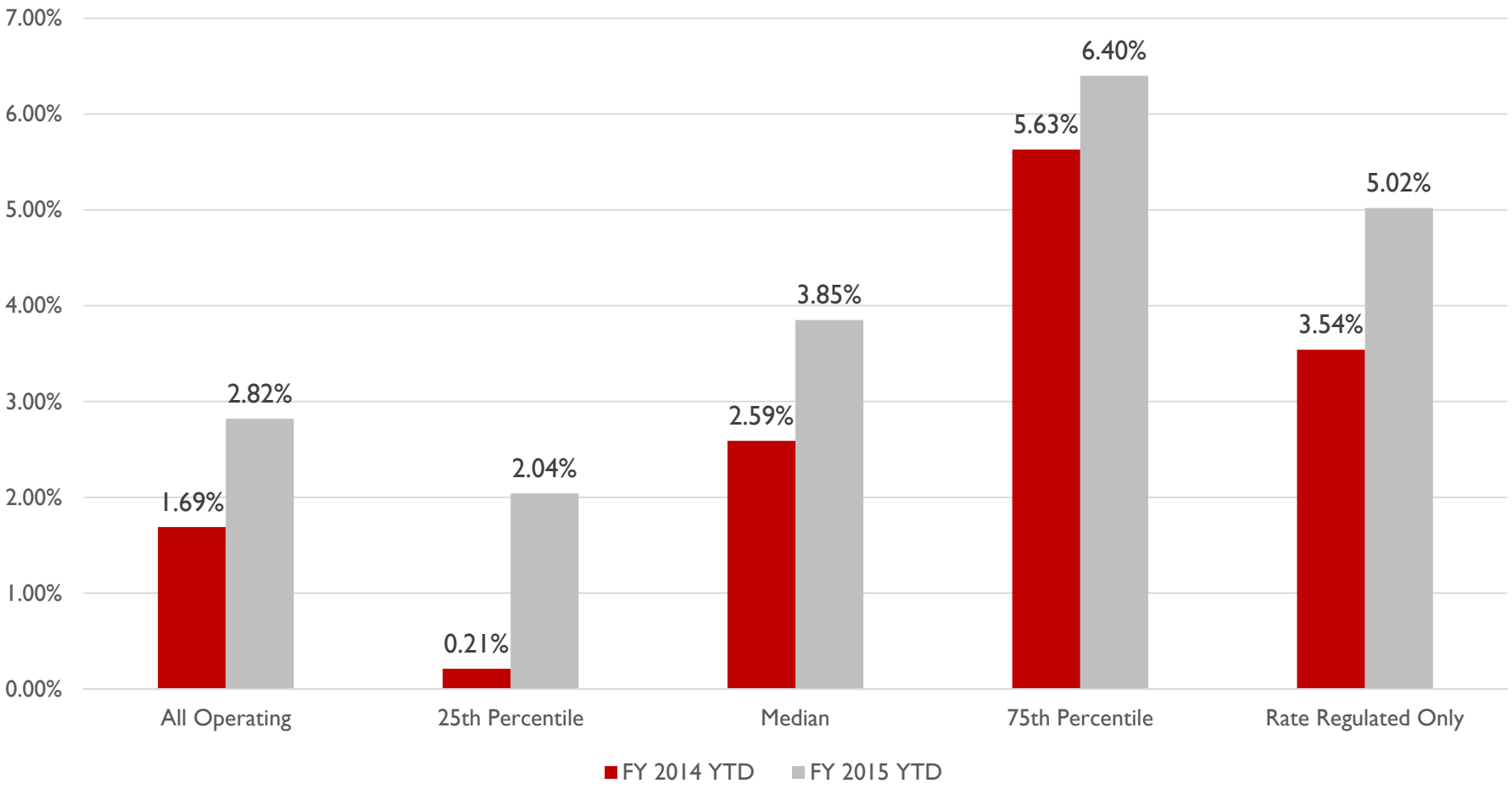
Per Capita Growth – Actual and Underlying Growth

CY 2015 Year to Date Compared to Same Period in Base Year (2013)



- Per capita growth rates distorted by the availability of only one month of CY 2015 data.
- Underlying growth reflects adjustment for FY 15 revenue decreases that were budget neutral for hospitals. 1.09% revenue decrease offset by reduction in MHIP assessment and hospital bad debts.

Operating Profits: Fiscal 2015 Year to Date (July-Jan.) Compared to Same Period in FY 2014



- Year-to-Date FY 2015 hospital operating profits improved compared to the same period in FY 2014.

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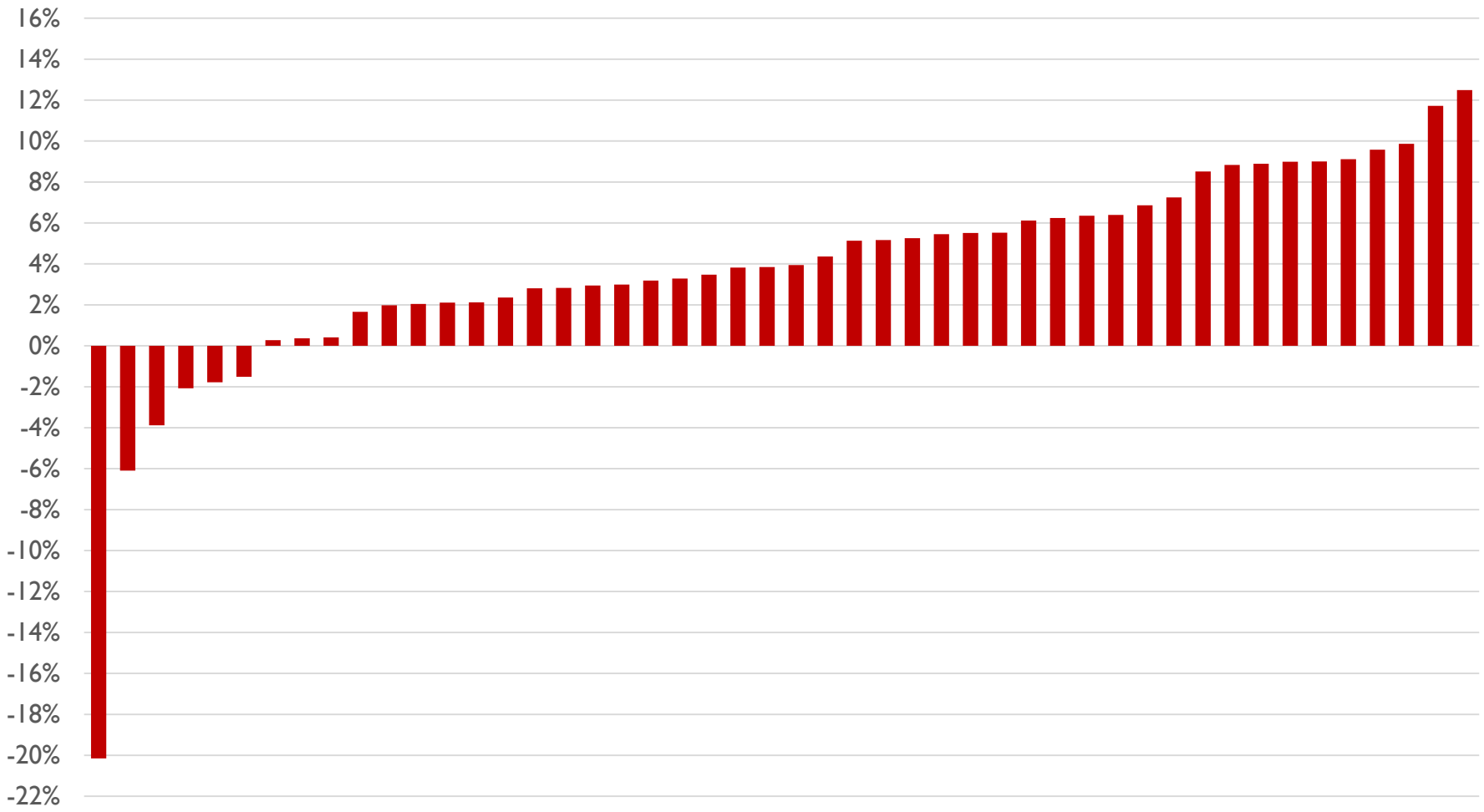
Operating Profits by Hospital

Fiscal Year to Date (July – January)



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Purpose of Monitoring Maryland Performance

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

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 and Fiscal 2015 rely on Maryland Department of Planning projections of population growth of .64% for FY 15 and .56% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

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 MARCH 3, 2015

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
2288R	MedStar Southern Maryland Hospital Center	1/29/2015	3/30/2015	6/29/2015	DEF/MSG	CK	OPEN
2289R	MedStar Franklin Square Hospital Center	1/29/2015	3/30/2015	6/29/2015	DEF/MSG	CK	OPEN
2290A	University of Maryland Medical Center	1/14/2015	N/A	N/A	N/A	DNP	OPEN
2291A	Johns Hopkins Health System	2/27/2015	N/A	N/A	N/A	DNP	OPEN
2292A	Johns Hopkins Health System	2/27/2015	N/A	N/A	N/A	DNP	OPEN
2293A	Johns Hopkins Health System	2/27/2015	N/A	N/A	N/A	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
MEDSTAR SOUTHERN MARYLAND	*	**DOCKET: 2015**
HOSPITAL CENTER	*	**FOLIO: 2098**
CLINTON, MARYLAND	*	**PROCEEDING: 2288R**

Staff Recommendation

March 11, 2015

Introduction

On January 29, 2015, MedStar Southern Maryland Hospital Center (the "Hospital"), a member of MedStar Health, submitted a partial rate application to the Commission requesting its July 1, 2014 Medical Surgical Acute (MSG) and Definitive Observation (DEF) approved rates be combined effective March 1, 2015.

Staff Evaluation

This rate request is revenue neutral and will not result in any additional revenue for the Hospital as it only involves the combining of two revenue centers. The Hospital wishes to combine these two centers, because the patients have similar staffing needs. DEF patients are cared for in the same area as MSG patients, and nursing to patient staffing ratios for both patient populations are very similar. The Hospital's currently approved rates and the new proposed rate are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical Surgical Acute	$841.45	18,467	$15,539,026
Definitive Observation	$992.82	24,245	$24,070,869
Combined Rate	$927.37	42,712	$39,609,895

Recommendation

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

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;

2. That a MSG rate of $927.37 per day be approved effective March 1, 2015; and

3. That no change be made to the Hospital's Global Budget Revenue for MSG services.

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
MEDSTAR FRANKLIN SQUARE	*	**DOCKET: 2015**
MEDICAL CENTER	*	**FOLIO: 2099**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2289R**

Staff Recommendation

March 11, 2015

Introduction

On January 29, 2015, MedStar Franklin Square Medical Center (the "Hospital"), a member of MedStar Health, submitted a partial rate application to the Commission requesting its July 1, 2014 Medical Surgical Acute (MSG) and Definitive Observation (DEF) approved rates be combined effective March 1, 2015.

Staff Evaluation

This rate request is revenue neutral and will not result in any additional revenue for the Hospital as it only involves the combining of two revenue centers. The Hospital wishes to combine these two centers, because the patients have similar staffing needs. DEF patients are cared for in the same area as MSG patients, and nursing to patient staffing ratios for both patient populations are very similar. The hospital's currently approved rates and the new proposed rate are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical Surgical Acute	$1,305.55	46,398	$60,574,724
Definitive Observation	$1,164.70	15,018	$17,491,439
Combined Rate	$1,271.10	61,416	$78,066,163

Recommendation

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

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;
2. That a MSG rate of $1,271.10 per day be approved effective March 1, 2015; and
3. That no change be made to the Hospital's Global Budget Revenue for MSG services.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION *		**COMMISSION**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2015**
MEDICAL CENTER *		**FOLIO: 2100**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2290A**

Staff Recommendation

March 11, 2015

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on January 30, 2015 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, 2015.

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 the 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. After review of the application and additional information provided by the Hospital,

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, 2015. 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**	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2015**
SYSTEM	*	**FOLIO:**	**2101**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2291A**

Staff Recommendation

March 11 2015

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on February 25, 2015 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 participate in a global rate arrangement for joint replacement services with Health Design Plus, Inc. for Pacific Business Group on Health clients for a period of one year beginning April 1, 2015.

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 updated global rates was developed by calculating mean historical charges for patients receiving similar joint replacement 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 is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this arrangement over the last year has been

favorable. Therefore, staff recommends approval of the Hospitals' request.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement services for a one year period commencing April 1, 2015. 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**	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2015**
SYSTEM	*	**FOLIO:**	**2102**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2292A**

Staff Recommendation

March 11, 2015

I. INTRODUCTION

Johns Hopkins Health System (the “System”) filed an application with the HSCRC on February 25, 2015 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 participate in a global rate arrangement for joint replacement and cardiovascular services with Health Design Plus, Inc. for clients other than those of Pacific Business Group on Health clients for a period of one year beginning April 1, 2015.

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 updated global rates was developed by calculating mean historical charges for patients receiving similar joint replacement and cardiovascular procedures 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 is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Although there has been no activity to date, 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 joint replacement and cardiovascular services for a one year period commencing April 1, 2015. 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.

Final Recommendation for Updating the Hospital Readmission Reduction Incentive Program for Rate Year 2017

HSCRC Commission Meeting 03/11/2015

Presentation Contents

- Background and Guiding Principles
- Readmission Trends and Targets
- Concerns and Options for modifying RRIP
- Next Steps
- Staff Recommendations for RY 2017

Background

- Maryland's readmission rates are high compared to the nation.
- Majority of MD hospitals are above U.S. average on Medicare condition-specific readmission rates.
- The new all-payer model contract requires Maryland's Medicare readmission rate to be at or below the National Medicare readmission rate by 2018, as well as annual reductions.

Figure 1: Maryland Hospitals Excess Readmission Ratios as Measured by the CMS' MHRRP and Applied to FFY 2015 Medicare Rates Outside of Maryland

	Pneumonia	Heart Failure	Acute Myocardial Infarction	Hip/Knee Arthroplasty	Chronic Obstructive Pulmonary Disease
Total Number of Cases in Maryland	***19,363***	***26,474***	***9,002***	***18,204***	***20,666***
Average Ratio of Readmissions in Maryland to U.S. Average	1.04	1.04	1.02	1.09	1.02
Percent of Maryland Hospitals Above the U.S. Average	61%	70%	61%	59%	59%

Source: FY 2015 IPPS Hospital Readmissions Reduction Program Supplemental Data File (Final Rule and Correction Notice)

Guiding Principles

- Measurements used for performance linked with payment must include all patients regardless of payer.
- The measurements must be fair to hospitals.
- Annual targets must be established to reasonably support the overall goal of equal or less than the National Medicare readmission rate by CY 2018.
- Measurement used should be consistent with the CMS Measure of Readmissions.
- The approach must include the ability to track progress.

Readmission Trends and Targets (based on latest data from CMMI)

National and MD Readmission Trends

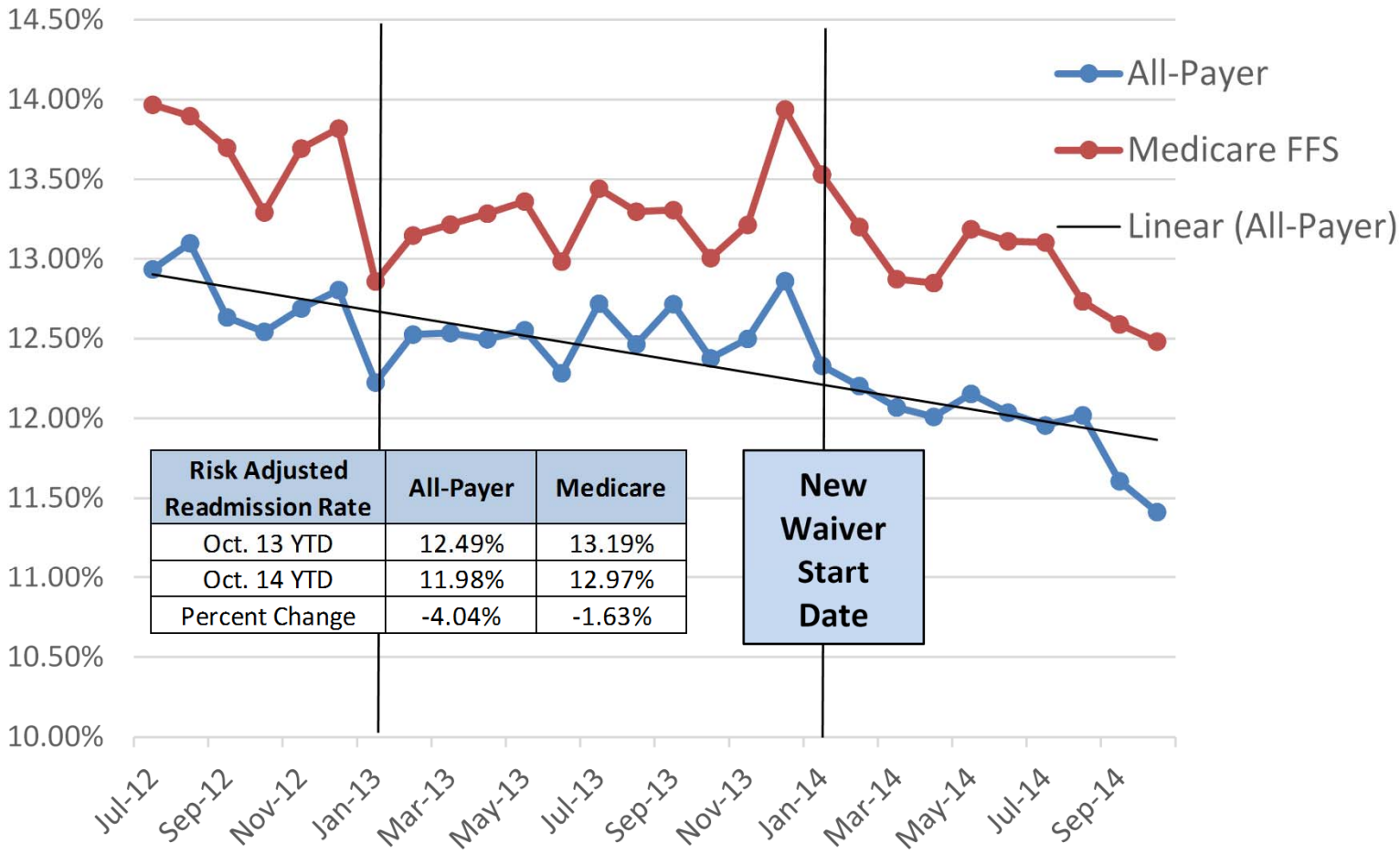
	Nation		MD		Nation vs. MD
	% Readmissions	Percent Change in Rate of Readmits	% Readmissions	Percent Change in Rate of Readmits	% Difference in Readmits
2011	16.68%		18.60%		11.51%
2012	16.16%	-3.10%	17.82%	-4.20%	10.24%
2013	15.78%	-2.34%	17.08%	-4.14%	8.21%
2014	15.73%	-0.35%	16.94%	-0.80%	7.72%

* Note: CY 2014 rates have been estimated by applying the October 2014/YTD October 2013 change in readmission rates to the CY 2013 readmission rates.

Minimum Annual Improvement Target = 8.21% / 5 Years (1.64%) + National Reduction

HSCRC Case Mix Adjusted Readmission Rates

Figure 3: All-Payer and Medicare FFS Monthly YTD Readmission Trends



Risk Adjusted Readmission Rate	All-Payer	Medicare
Oct. 13 YTD	12.49%	13.19%
Oct. 14 YTD	11.98%	12.97%
Percent Change	-4.04%	-1.63%

Note: Based on final data for January 2013 - June 2014, and preliminary data through November 2014.

CMMI Medicare Readmission Target

Figure 4: Historical and Projected Medicare Readmissions: Maryland vs. U.S. Using Two Year Average Reduction (Using the Most Recent Information Available from CMMI)

	Nation		MD		Nation vs. MD
	% Readmissions	Percent Change in Rate of Readmits	% Readmissions	Percent Change in Rate of Readmits	Percent Change in Rate of Readmits
CY2011	16.68%		18.60%		
CY2012	16.16%	-3.10%	17.82%	-4.20%	10.24%
CY2013	15.78%	-2.34%	17.08%	-4.14%	8.21%
CY2014*	15.73%	-0.35%	16.94%	-0.80%	7.72%
CY2014 Targeted**			16.76%	***-1.86%***	***6.57%***
CY2015	15.52%	-1.34%	16.28%	-3.90%	4.92%
CY2016	15.31%	-1.34%	15.81%	-2.89%	3.28%
CY2017	15.10%	-1.34%	15.35%	-2.91%	1.64%
CY2018	14.90%	-1.34%	14.90%	-2.94%	0.00%

* Note: the Actual CY 2014 rates have been estimated by applying the YTD October 2014/YTD October 2013 change in readmission rates to the CY 2013 readmission rates.

Adjustments for HSCRC Data: Medicare Unadjusted vs. All-Payer Case-mix Adjusted

	Medicare FFS Unadjusted		Medicare FFS Case-mix Adjusted		All Payer Unadjusted		All Payer Case-mix Adjusted		
	% Readmits	Percent Change in Rate of Readmits	% Readmits	Percent Change in Rate of Readmits	% Readmits	Percent Change in Rate of Readmits	% Readmits	Percent Change in Rate of Readmits	Medicare-All Payer
2012	18.65%		13.86%		12.85%		12.94%		
2013	17.86%	-4.21%	13.25%	-4.42%	12.51%	-2.63%	12.52%	-3.21%	-1.0%
2014	17.72%	-0.80%	13.07%	-1.37%	12.05%	-3.70%	12.05%	-3.76%	3.0%
2012-2014		-5.0%		-5.7%		-6.2%		-6.8%	1.9%

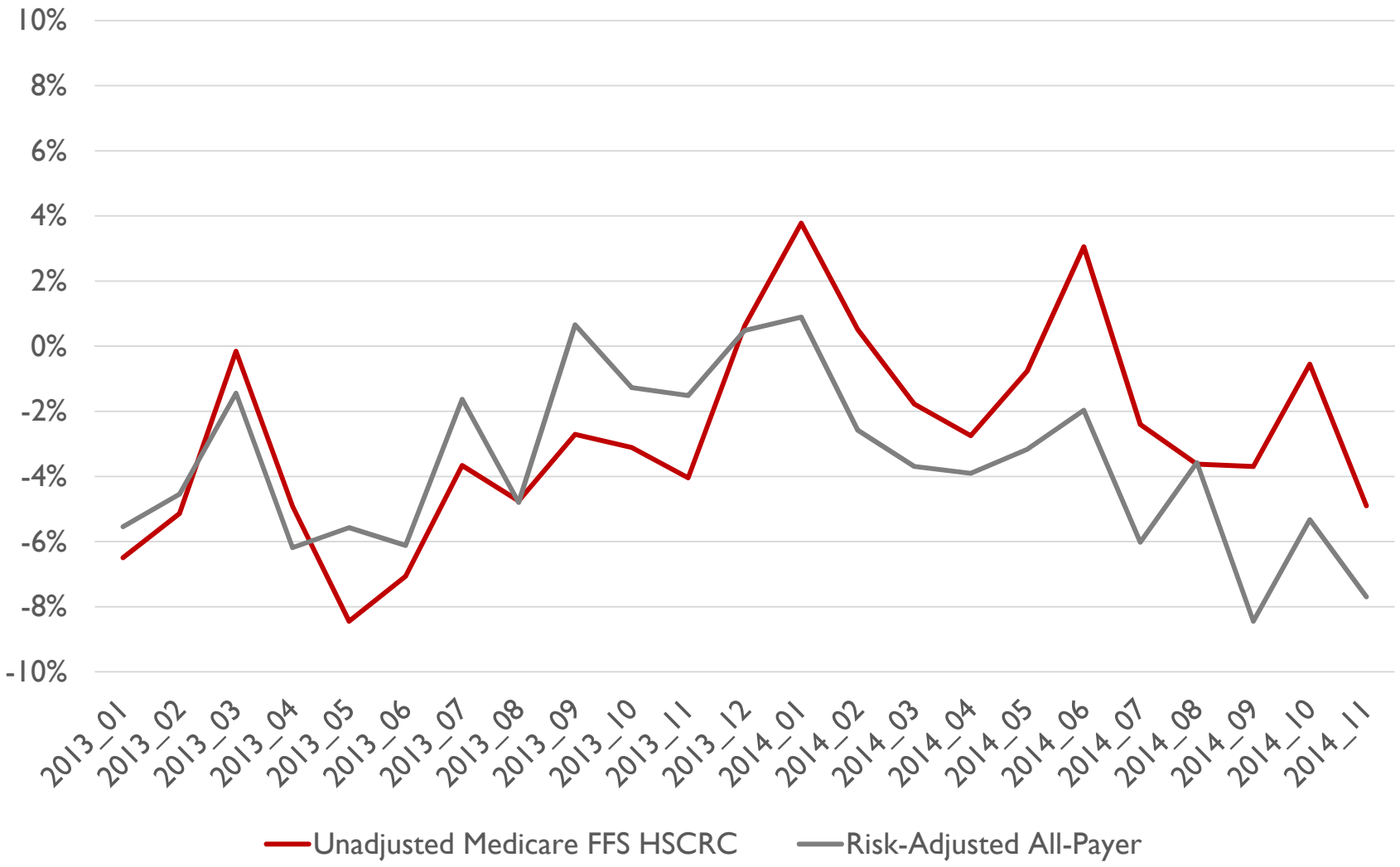
HSCRC Medicare and All-Payer Target

		% Readmission Rate Reduction
CMMI Medicare Unadjusted Targets		
CY14 Actual	A	-0.80%
CY15	B	-3.90%
Cumulative	C=(1+A)*(1+B)-1	**-4.67%**
HSCRC Medicare Casemix Adjusted Target		
CY14 Actual	D	-1.37%
CY15	E = B-0.57%	-4.47%
Cumulative	F = (1+D)*(1+E)-1	**-5.78%**
HSCRC All Payer Casemix Adjusted Target		
CY14 Actual	G	-3.76%
CY15	H = B-1.91%	-5.77%
Cumulative	**I =** (1+G)*(1+H)-1	**-9.31%**

Current Concerns for RRIP

- 30-Day Emergency Department (ED) Visits and Observation Stays
- Socioeconomic/Demographic Factors
- Annual vs. Cumulative Target
- Medicare vs. All Payer Readmission Targets
- The "Denominator" Issue

HSCRC MEDICARE AND ALL PAYER MONTHLY TRENDS (ANNUAL CHANGE)



Medicare vs. All Payer Readmission Targets

- Rationale for Medicare Target:
  - Adopting a Medicare FFS specific target for RY 2017 RRIP may better ensure the waiver goal is achieved and that MD does not lose its ability to establish its own readmissions reduction policies.
- Rationale for All-Payer Target:
  - Requires hospitals to focus on complex vulnerable patients driving majority of readmissions.
  - Hospitals are already focused on all-payer reductions.
  - Draws upon strengths of the all-payer system and is consistent with other MD quality programs.

Denominator Issue: Impact of Case Mix Adjustment

Base Period						Performance Period					
ACTUAL TOTAL ADMITS	ACTUAL PRIMARY ADMITS	ACTUAL READMITS	ACTUAL READMITS/ ACTUAL TOTAL ADMITS	ACTUAL READMITS / ACTUAL PRIMARY ADMITS	RISK-ADJUSTED READMISSION RATE	ACTUAL TOTAL ADMITS	ACTUAL PRIMARY ADMITS	ACTUAL READMITS	ACTUAL READMITS / ACTUAL TOTAL ADMITS	ACTUAL READMITS/ ACTUAL PRIMARY ADMITS	RISK-ADJUSTED READMISSION RATE
1,000	861	139	13.90%	16.14%	13.66%	855	736	119	13.92%	16.17%	13.44%
					Absolute Difference	-145	-125	-20	0.02%	0.02%	-0.22%
					Percent Difference	-14.50%	-14.52%	-14.39%	0.13%	0.15%	-1.62%

	Base Period						Performance Period					
APR DRGs (BY SOI)	ACTUAL TOTAL ADMITS	EXPECTED READMITS / ADMITS	EXPECTED READMITS	ACTUAL READMITS	ACTUAL READMITS/ ACTUAL TOTAL ADMITS	ACTUAL READMITS/ ACTUAL PRIMARY ADMITS	ACTUAL TOTAL ADMITS	EXPECTED READMITS/ ADMITS	EXPECTED READMITS	ACTUAL READMITS	ACTUAL READMITS/ ACTUAL TOTAL ADMITS	ACTUAL READMITS/ ACTUAL PRIMARY ADMITS
APR DRG 1	160	17.00%	27.20	27	16.88%	20.30%	150	17.00%	25.50	25	16.67%	20.00%
APR DRG 2	155	12.00%	18.60	12	7.74%	8.39%	110	12.00%	13.20	13	11.82%	13.40%
APR DRG 3	260	0.00%	0.00	0	0.00%	0.00%	220	0.00%	0.00	1	0.45%	0.46%
APR DRG 4	425	22.50%	95.63	100	23.53%	30.77%	375	22.50%	84.38	80	21.33%	27.12%
TOTALS	**1,000**	**14.14%**	**141.43**	**139**	**13.90%**	**16.14%**	**855**	**14.39%**	**123.08**	**119**	**13.92%**	**16.17%**

Next Steps

- Continue to work with CMMI to refine the final target calculations and monitor national trends.
- Continue to work to assess impact of SES/D on readmissions, changing denominator, and other concerns from stakeholders.
- Collaborate with VHQC (new QIO) to obtain comparative national benchmarks and additional analyses of national versus MD data.
- Evaluate recommendations from the Care Coordination Work Group, with the goal of creating payment policies that support more comprehensive and sustainable approaches to reduce both avoidable hospitalizations and readmissions.

Staff Final Recommendations for RY 2017

The Staff is providing the following recommendations for the RRIP for RY 2017 (which would compare performance in CY 2013 to performance in CY 2015):

1. Adopt a readmission payment incentive program with both rewards for hospitals achieving or exceeding the required readmission reduction benchmark and payment reductions for hospitals that do not achieve the minimum required reduction.
2. Use a continuous preset scaling approach to provide rewards and penalties in proportion to the each hospital's performance relative to the required reduction on a case-mix adjusted basis.
3. Continue to set a minimum required reduction benchmark on all-payer basis and re-evaluate the option to move to a Medicare specific performance benchmark for CY2016 performance period.
4. Set the all-payer case-mix adjusted readmission target at 9.5% cumulative reduction from CY 2013 base all payer case-mix adjusted readmission rates.
5. Continue to assess the impact of admission reductions, SES/D and all payer and Medicare readmission trends and make adjustments to the rewards or penalties if necessary.
6. Seek additional Medicare benchmarks that can help guide efforts in Maryland. Evaluate recommendations from the Care Coordination Work Group and request recommendations from Maryland's new QIO regarding specific areas for improvement.

Final Recommendation for Updating the Hospital Readmission Reduction Incentive Program for Rate Year (RY) 2017

Health Services Cost Review Commission

4160 Patterson Avenue Baltimore, MD 21215
(410) 764-2605

March 11, 2015

This final Staff recommendations was approved at the March 11, 2015 Commission Meeting as amended in Recommendation #4, changing 9.5% to 9.3%.

A. Introduction

The United States healthcare system currently experiences an unacceptably high rate of preventable hospital readmissions. These excessive readmissions are a symptom of our fragmented care system and they generate considerable unnecessary cost and substandard care quality for patients. Maryland's readmission rates are high compared to the national levels for Medicare. The Center for Medicare and Medicaid Innovation(CMMI) All-Payer Model Agreement (or "waiver"), which began on January 1, 2014, has established readmission reduction targets that require Maryland hospitals to be equal to or below the rates of Medicare readmissions by CY 2018 and to make scheduled annual progress toward this goal.

In order to incentivize hospital care improvements, encourage hospitals to meet the Medicare readmissions target and motivate hospitals to also reduce readmissions for other payers, the Commission approved a hospital Readmission Reduction Incentive Program (RRIP) in April of 2014. The RRIP established a uniform target reduction of 6.76% in all payer readmissions in CY 2014, relative to CY 2013, across all hospitals. The 6.76% target reduction for CY 2014 was based on the excess level of Medicare readmissions in Maryland (i.e., 8.78%) in FY 2013, divided by five, plus an estimate of the reduction (5.0%) in Medicare readmissions that would be achieved on a national basis in CY 2014.

The RRIP's incentive structure specified a maximum reward of 0.5% of permanent inpatient revenue which would be applied to the RY 2016 rates of hospitals that achieved or exceeded the target reduction. The RRIP for RY 2016 did not include any penalties for hospitals that did not achieve the targeted reduction in all payer readmissions and there was no separate adjustment tied to performance on Medicare readmissions.

The purpose of this recommendation is: to provide the latest available information regarding the results of the RRIP in CY 2014; to discuss the range of issues raised by Commissioners, stakeholders and Staff concerning the RRIP, including the pros and cons of various options for modifying the RRIP for RY2017; and to propose the Staff's final recommendations for changes in the RRIP for CY 2015 performance year. The draft recommendations were presented at the December 2014 Commission meeting.

B. Background

The fragmented US health services delivery and payment system has generally provided large disincentives for hospitals and other providers to construct efficient and effective coordinated care models. The fee-for-service system that has been prevalent has rewarded additional care while penalizing efforts to improve efficiency and health status by tying payments to the number of services rather than to outcomes.

Since the inception of hospital rate regulation in Maryland, the HSCRC has experimented with innovative methods of hospital reimbursement. Pursuant to the provisions of Health-General Article, Section 19-219 and COMAR 10.37.10.06, the Commission may approve experimental payment methodologies that are consistent with the HSCRC's legislative mandate to promote effective and efficient health service delivery and its primary policy objectives of cost containment, expanded access to care, equity in payment, financial stability, improved quality and public accountability.

The Commission made an initial attempt to encourage reductions in unnecessary readmissions when it created the Admission-Readmission Revenue (ARR) program in CY 2011. The ARR, which was adopted by most Maryland hospitals, established "charge per episode" (CPE) constraints on hospital revenue, providing strong financial incentives to reduce hospital readmissions. The Global Budget Revenue (GBR) and Total Patient Revenue (TPR) rate arrangements now in effect for all hospitals supply even stronger incentives for reductions in unnecessary readmissions by affording each hospital a specified, fixed revenue budget it is allowed to generate during a particular rate year, providing strong financial incentives for the hospital to construct efficient and effective coordinated care models designed to promote the delivery of timely, necessary care to their populations in the most appropriate settings.

Thus far, the GBR and TPR rate arrangements appear to be functioning well, as evidenced by a drop in the rate of increase in Maryland hospital expenditures that appears to be at or below the limits set in the Model Agreement with CMMI, improved hospital profitability, and multiple hospitals' investments in infrastructure capabilities designed to help them meet the challenges of population health management.

In Federal Fiscal Year (FFY) 2012, pursuant to the requirements of the Affordable Care Act (ACA), CMS adopted regulations that initiated the Medicare Hospital Readmissions Reduction Program (MHRRP). The national program was designed to drive reductions in Medicare readmissions by reducing Medicare's inpatient payment rates by a maximum of 1.0% in FFY 2013, 2.0% in FFY 2014 and 3.0% in FFY 2015 for hospitals that showed excess levels of Medicare readmissions for a prescribed set of inpatient conditions.

Section 3025 of the Affordable Care Act ("ACA") for FY 2014 as permitted by Section 3025(q)(2)(B)(ii) of the ACA required Maryland to have a similar program and achieve same or better results in cost and outcomes to receive an exemption from the MHRRP program. In May 2013, the Commission approved a Shared Savings Policy (SSP) for FY 2014, which reduced hospital inpatient revenues by 0.3% of inpatient revenue to achieve savings that would be approximately equal to those that were expected to arise out of the MHRRP. The SSP approved by the Commission for RY 2015 increased the rate reduction to 0.4% of total revenue. The SSP reductions were based on each hospital's actual/expected readmission rates, and thereby reflected the "attainment" levels of the hospitals with regard to readmissions, adjusting for the case-mix differences. The reductions were highest for the hospitals with the largest proportion of excess readmissions.

The new All-Payer contract established specific targets for reductions in Maryland's Medicare readmission rates by CY 2018. In April 2014, the Commission approved a second readmissions program—the Hospital Readmission Reduction Incentive Program (RRIP)—to bolster the incentives to reduce unnecessary readmissions that were created by the SSP and global budgets. The RRIP provided a positive rate adjustment of 0.5% of inpatient revenues for hospitals that were able to achieve or exceed pre-determined reduction target for readmissions in CY 2014 relative to CY 2013. Unlike the SSP, the RRIP focused on the improvements achieved by the hospitals in their readmission rates rather than on their readmission attainment levels.
The readmissions-related discussions that occurred during meetings of the Performance Measurement Workgroup (PMWG) in 2014 produced a set of guiding principles recommended to the Commission regarding the hospital readmission reduction program in Maryland:

- Measurements used for performance linked with payment must include all patients regardless of payer.
- The measurements must be fair to hospitals.

- Annual targets must be established to reasonably support the overall goal of equal or less than the National Medicare readmission rate by CY 2018.
- Measurement used should be consistent with the CMS Measure of Readmissions.
- The approach must include the ability to track progress.

C. Assessment

1. Maryland's High Readmission Rates

HSCRC Staff recently received updated readmissions information from CMMI. This information is reflected in this discussion and considered in the formulation of the Recommendations that are presented in Section F.

Figure 1 (below) shows data comparing Maryland hospitals' readmission rates to all US hospitals using CMS MHRRP data for 30-day readmission of patients with pneumonia, heart failure (CHF), heart attack (AMI), hip/knee arthroplasty and chronic obstruction pulmonary disease (COPD). This comparison reveals that the majority of Maryland hospitals have readmission rates above the national average for all conditions measured in the CMS program. Hospital specific rates were also presented to the Performance Measurement Workgroup (Appendix I).

Figure 1: Maryland Hospitals Excess Readmission Ratios as Measured by the CMS' MHRRP and Applied to FFY 2015 Medicare Rates Outside of Maryland

	Pneumonia	Heart Failure	Acute Myocardial Infarction	Hip/Knee Arthroplasty	Chronic Obstructive Pulmonary Disease
Total Number of Cases in Maryland	***19,363***	***26,474***	***9,002***	***18,204***	***20,666***
Average Ratio of Readmissions in Maryland to U.S. Average	1.04	1.04	1.02	1.09	1.02
Percent of Maryland Hospitals Above the U.S. Average	61%	70%	61%	59%	59%

Source: FY 2015 IPPS Hospital Readmissions Reduction Program Supplemental Data File (Final Rule and Correction Notice)

Previously, in the absence of data from CMMI, HSCRC Staff relied on readmission trends provided by the state Quality Improvement Organization, the Delmarva Foundation, to compare Maryland and national readmission rates in formulation of the CY 2014 target. HSCRC Staff and CMMI worked together to revise the readmission measure so that the Maryland rates are comparable to National rates.[1] These revisions thus far have reduced both Maryland and national readmission rates, slightly narrowed the gap between national and Maryland rates, and changed the trends for both

[1]The three main revisions applied are; 1. Removal of Medicare beneficiaries who are enrolled in Medicare Advantage plans within 30 days of an inpatient stay, 2. Removal of Medicare beneficiaries who have dies within 30 days of an inpatient stay, 3. Removal of planned readmissions.

Maryland and Nation. Figure 2 provides the comparison of the two data reports. Staff will continue to work with CMMI to finalize the measurement definitions during CY 2015 while using the CMMI interim IV measure definition to monitor the progress in readmission rates. Based on these interim definitions, Maryland statewide readmission rate is 8.21% higher than the national Medicare readmission rate in CY 2013, which is the base year for the RRIP program.

Figure 2: Maryland Readmission Rate vs National Readmission Rates: Comparison of CMMI Interim IV Measure vs Delmarva Readmission Reports

	Nation		MD		Nation vs. MD
	% Readmissions	Percent Change in Rate of Readmits	% Readmissions	Percent Change in Rate of Readmits	% Difference in Readmits
2011	16.68%		18.60%		11.51%
2012	16.16%	-3.10%	17.82%	-4.20%	10.24%
2013	15.78%	-2.34%	17.08%	-4.14%	8.21%
2014	15.73%	-0.35%	16.94%	-0.80%	7.72%

Delmarva Readmission Reports

2011	18.60%	0.22%	20.92%	-1.88%	12.47%
2012	18.35%	-1.34%	20.32%	-2.87%	10.74%
2013	17.66%	-3.76%	19.21%	-5.46%	8.78%

* Note: CY 2014 rates have been estimated by applying the October 2014/YTD October 2013 change in readmission rates to the CY 2013 readmission rates.

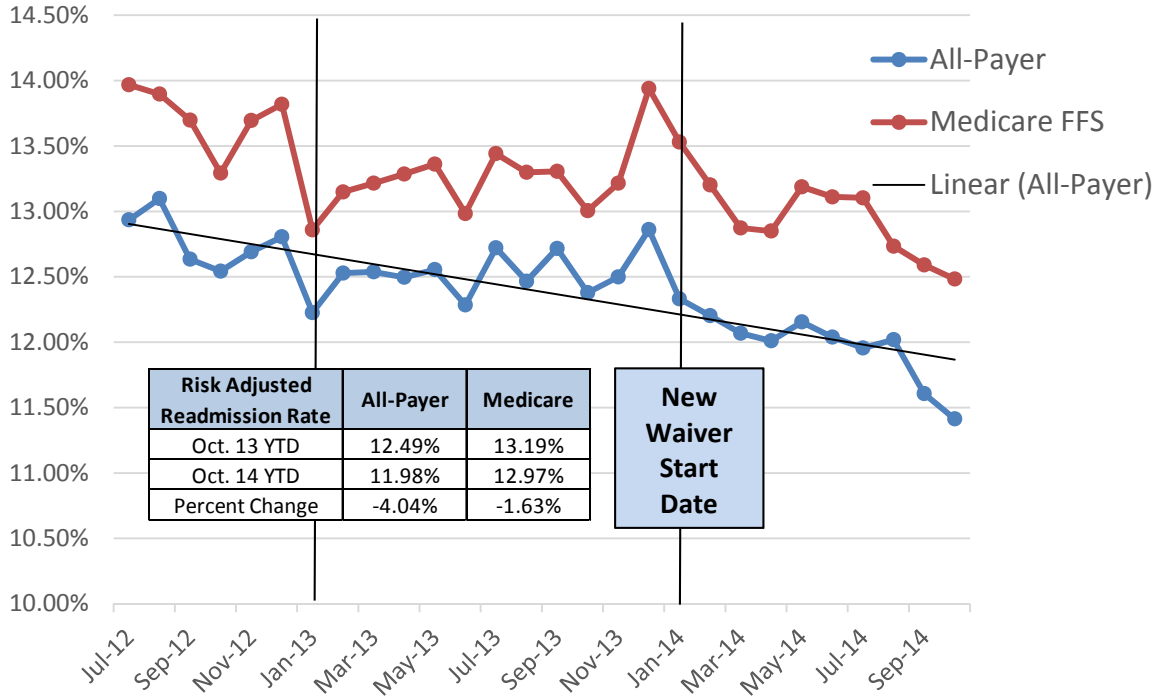
2. Maryland's Progress in Meeting Its Readmission Reduction Targets

The 6.76% RRIP reduction target for CY 2014 relative to CY 2013 was developed using the data that were available to the Staff when the final recommendation was presented to the HSCRC in April 2014. Those data, as shown in Figure 2 above, indicate that Maryland's Medicare unadjusted readmission rate in CY 2013 was 19.21%, or 8.78% higher than the national Medicare readmission rate of 17.66%. With no further reductions in the national Medicare readmissions rate from CY 2013 through CY 2018, the annual reduction in Maryland's Medicare readmission rates needed to meet the requirements of the Model Agreement would have been 1.76% (8.78% / 5 years). However, further decreases in the national Medicare readmission rate were expected, with readmission rates declining at a faster pace each year. The RRIP reduction target was, therefore, based on projection that Medicare's national rate of readmissions would drop by 5.0% in CY 2014. Accordingly, the target rate of readmission reductions included in the RRIP for CY 2016 was 6.76% (i.e., (1.76% + 5.0% = 6.76%), and was applied to all payers based on stakeholder workgroup recommendations.

RRIP results for CY 2014 show that there has been a reduction in readmissions for both all-payer and Medicare FFS patients in Maryland. As shown in Figure 3, Medicare case-mix adjusted readmission rates fell by 1.63%, and all-payer readmission rates fell by 4.04%, over the YTD October 2013 through YTD October 2014 period. Neither of these reductions, if they occurred for

the full twelve months of CY 2014, would meet the 6.76% reduction in readmission rates that was targeted for CY 2014. However, as shown above the drop in the national Medicare readmission rate from CY 2013 to CY 2014 also appears to have fallen well short of the 5% estimate (-0.35% actual vs. -5.00% assumed).

Figure 3: All-Payer and Medicare FFS Monthly YTD Readmission Trends



Risk Adjusted Readmission Rate	All-Payer	Medicare
Oct. 13 YTD	12.49%	13.19%
Oct. 14 YTD	11.98%	12.97%
Percent Change	-4.04%	-1.63%

Note: Based on final data for January 2013 - June 2014, and preliminary data through November 2014.

3. Establishing Readmission Reduction Target for RY 2017

Under the Model Agreement, Maryland is required to eliminate the excessive level of readmissions, and at least match any further declines in the national Medicare readmission rate, by CY 2018. As shown in Figure 4 below, the Medicare readmission rate is estimated to improve by 0.35% in CY 2014, while Maryland is estimated to improve by 0.80%. However, the required reduction for Maryland in year 1 would need to have been at least 1.86% to close the gap by 1/5th and keep up with National reductions (see footnote in Figure 4 for calculation of this required reduction). While CMMI has stated that they will not apply the readmission test in year 1 due to delays in establishing the base year data and remaining issues with the measurement, the Staff is recommending a target for CY 2016 that keeps the estimated shortfall for CY 2014 within the cumulative target that is being recommended for CY 2015--front loading the required improvement into the CY 2016 target rather than spreading it over the remaining four years. Thus in Figure 4, the Staff has projected the annual declines in Medicare readmission rates that Maryland would have to achieve (i.e., 3.90% in CY 2015, 2.89% in CY 2016, 2.91% in CY 2017 and 9.94% in CY 2018) to meet the Model Agreement's requirement. In the scenario calculating these estimates presented below, the annual reduction in the national rate of Medicare readmissions was estimated to be 1.34% in CY 2015 through CY 2018 period, which was the average reduction over the last two years. Alternative

scenarios using the lowest improvement, average three-year improvement, and highest improvement over the last three years are presented in Appendix II.

Figure 4: Historical and Projected Medicare Readmissions: Maryland vs. U.S. Using Two Year Average Reduction (Using the Most Recent Information Available from CMMI)

	Nation		MD		Nation vs. MD
	% Readmissions	Percent Change in Rate of Readmits	% Readmissions	% Readmissions	Percent Change in Rate of Readmits
CY2011	16.68%		18.60%		
CY2012	16.16%	-3.10%	17.82%	-4.20%	10.24%
CY2013	15.78%	-2.34%	17.08%	-4.14%	8.21%
CY2014*	15.73%	-0.35%	16.94%	-0.80%	7.72%
CY2014 Targeted**			16.76%	***-1.86%***	***6.57%***
CY2015	15.52%	-1.34%	16.28%	-3.90%	4.92%
CY2016	15.31%	-1.34%	15.81%	-2.89%	3.28%
CY2017	15.10%	-1.34%	15.35%	-2.91%	1.64%
CY2018	14.90%	-1.34%	14.90%	-2.94%	0.00%

* Note: the Actual CY 2014 rates have been estimated by applying the YTD October 2014/YTD October 2013 change in readmission rates to the CY 2013 readmission rates.

** The CY2014 Targeted magnitude of necessary Maryland Medicare readmission reductions of -1.86% is derived by first subtracting the minimum improvement target of -1.64% from the CY 2013 gap of 8.21%, which would make the "Gap" in CY 2014 6.57% and the Maryland readmission rate would be reduced to 16.76%. A 16.76% Medicare readmission rate for CY 2014 represents a 1.86% reduction relative to the CY 2013 Medicare readmission rate of 17.08%. The formula to derive this number= (National CY2014 rate * (1 + (CY2013 Gap - minimum estimated target) / CY2013 rate – 1)).

Figure 5 below contains the unadjusted and case-mix adjusted Medicare FFS and all-payer readmission rates using HSCRC case-mix data. The 0.80% reduction in Maryland Medicare unadjusted readmissions for CY 2014 reported by the most recent CMMI data, matches the results for Medicare based on the HSCRC data. However, given the absolute differences in readmission rates between data sources and the need to use a case mix adjusted rate for the purposes of evaluating individual hospital performance, the CMMI Medicare FFS targets calculated above need to be converted to a HSCRC case-mix adjusted target. Accordingly, Staff have calculated 2-year (CY 2014 and CY 2015) cumulative reduction targets of -5.78% for Medicare case-mix adjusted readmission rate and -9.31% for all-payer case-mix adjusted readmission rate. The precise methodology used to derive the cumulative adjusted Medicare specific and adjusted all-payer targets is described in Appendix III.

Figure 5: HSCRC Medicare FFS and All-Payer Readmission Rates

	Medicare FFS Unadjusted		Medicare FFS Case-mix Adjusted		All Payer Unadjusted		All Payer Case-mix Adjusted		
	% Readmits	Percent Change in Rate of Readmits	% Readmits	Percent Change in Rate of Readmits	% Readmits	Percent Change in Rate of Readmits	% Readmits	Percent Change in Rate of Readmits	Medicare-All Payer
2012	18.65%		13.86%		12.85%		12.94%		
2013	17.86%	-4.21%	13.25%	-4.42%	12.51%	-2.63%	12.52%	-3.21%	-1.0%
2014	17.72%	-0.80%	13.07%	-1.37%	12.05%	-3.70%	12.05%	-3.76%	3.0%
2012-2014		-5.0%		-5.7%		-6.2%		-6.8%	1.9%

4. Consequences of Not Achieving Waiver Target for Readmissions

In establishing a cumulative readmission reduction target for the RRIP for RY 2017, it is important to strike a reasonable balance between the desire to set a target that is not unrealistically high and the need to conform to the requirements of the Model Agreement. With each passing year, underachievement in any particular year becomes increasingly hard to offset in the remaining years before CY 2018. Again the consequence for not achieving the minimum annual reduction would be a corrective action plan and potentially loss of the waiver from the Medicare HRRP. The consequences of not meeting the target are stated in the Model Agreement:

> *If, in a given Performance Year, Regulated Maryland Hospitals, in aggregate, fail to outperform the national Readmissions Rate change by an amount equal to or greater than the cumulative difference between the Regulated Maryland Hospitals and national Readmission Rates in the base period divided by five, CMS shall follow the corrective action and/or termination provisions of the Waiver of Section 1886(q) as set forth in Section 4.c and in Section 14.*

The imposition of the national Medicare HRRP on Maryland would reduce our ability to design, adjust and integrate our reimbursement policies based on local input and conditions consistently across all payers. In particular, the national program is structured as a penalty-only system based on a limited set of conditions whereas the Commission prefers to have the flexibility of setting up a much broader incentive systems that reflect the full range of conditions and causes of readmissions on an all-payer basis. Therefore, the Staff believes that it is appropriate to consider changes to the RRIP for RY 2017.

D. Discussion of Issues, Options and Future Considerations in the Establishment of the RRIP for RY 2017Assessment

The Staff has conducted an extensive series of Payment Models (PWG) and Performance Measurement Work Group (PMWG) meetings, pursued more recent data from CMMI, performed data analyses, and gathered other available information for the purpose of designing appropriate modifications of the RRIP for RY 2017.

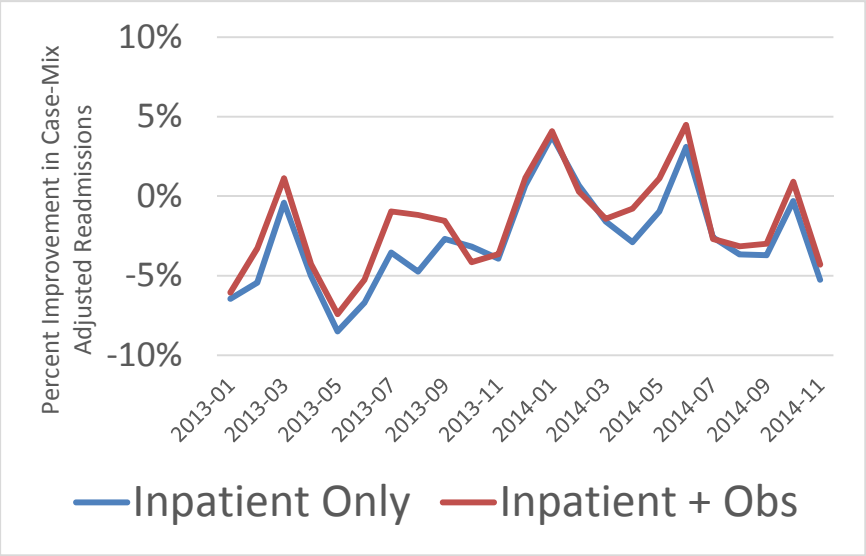
In formulating its recommendations for the RRIP for RY 2017, the Staff considered a host of different issues that were raised by Commissioners, workgroup members and other stakeholders concerning the RRIP, and examined various options for modifying the RRIP for RY 2017 to improve its fairness and effectiveness and to adapt it to the most recent readmission trends in Maryland and the U.S. In this section, and in the accompanying appendices, the Staff presents the most important issues that have been raised, the different viewpoints that have been expressed, and the pros and cons of the various actions that could be taken to establish an improved RRIP for RY 2017.

1. The Impact of Emergency Department (ED) Visits and Observation Stays

To some extent, ED visits and observation stays can be substituted for inpatient readmissions. In the Final Recommendation for the RRIP for RY 2016, the Staff acknowledged the possible confounding effects of changes in the use of ED and observation services and promised to monitor the frequency of ER visits and observation stays within thirty days after discharge. In addition, the recommendation stated that adjustments would be made in the RRIP incentive rewards to hospitals if their reductions in readmissions were accompanied by disproportionate increases in observation stays after discharges. This adjustment was specified for observation stays only because there was less certainty regarding the extent to which ED services can substitute for inpatient stays.

The Staff has examined data regarding the percent improvement in readmissions by using inpatient data only and by examining inpatient data plus observation stays. Figure 6 shows that the drop in readmission rates found when observation stays are included in the analysis is slightly less than, but generally consistent with, the decline in readmission rates found when observation stays are excluded from the analysis (this relationship is true except for August 2013 compared to August 2012). Based on this overall data, the Staff is less concerned about the possibility that the decline in readmission rates was caused by increases in the use of observation stays in CY 2014. However, the Staff will examine the observation visit trends for individual hospitals for the purposes of determining whether adjustments should be made to the RY 2016 RRIP rewards.

Figure 6: Medicare Unadjusted Monthly Improvement Trends for Inpatient Only vs. Inpatient + Observation Stays



2. The Impact of Socioeconomic/Demographic Factors on Readmission Rates

Substantial evidence exists that hospital readmission rates are affected to some degree by socioeconomic/demographic factors (SES/DS)—such as income, education, race, occupation, etc.—and that inclusion of these factors in the establishment of targets for readmission levels would probably improve the fairness of those targets for hospitals that have patient populations that are relatively disadvantaged. However, there is no consensus at this time regarding the precise impacts of these variables or about the best ways to collect such information on a patient-specific level. Research into the applicability and usefulness of indexes of socioeconomic deprivation that are computed on a geographic basis (e.g., census tracks or neighborhoods) rather than a patient-specific basis is ongoing and promising but in its formative stages. Such indices may have special relevance in the future in Maryland, given the GBR and TPR arrangements that exist with all of the hospitals, if a methodology can be devised to reliably link geographically-based indices of socioeconomic disadvantage to particular hospitals or groups of hospitals based on their patient service areas.

Finally, public health policy issues need to be considered as we explore SES/D adjustments. While reducing readmissions for disadvantaged populations may require additional investments and time, adjusting for SES/D may draw focus away from this important work.

In a preliminary effort to evaluate the impact of socioeconomic factors on readmission rates, the Staff used the percent of Medicaid patients at the individual Maryland hospitals as a proxy for the level of socioeconomic disadvantage at the individual Maryland hospitals and examined its relationship to their degree of improvement in readmission rates. In addition, the Staff examined the correlation between DSH payments and readmission rates and the observed improvement in readmission rates. The Staff did not find a strong correlation between these factors (see Appendix IV). This finding does not disprove the relevancy of SES/D factors in the establishment of readmission targets; in fact, SES/D factors probably do have impacts that ought to be considered. It merely indicates that the measures available to us at this time are probably inadequate.

Given these concerns, the Commission could elect to make some adjustments in the readmission targets and policies to be set in the RRIP for RY 2017 using relatively crude measures (such as the percentage of a hospital's total inpatient cases accounted for by Medicaid and/or low income Medicare patients) or it could elect to postpone any such adjustments to the RRIP for CY 2015, or even beyond, until more information and better techniques may be available for such adjustments. Currently, Staff is in the process of setting up a subgroup of stakeholders to review options for SES/D adjustments.

3. Medicare vs. All Payer Readmission Targets

As noted in Section B, the PMWG established a set of guiding principles for the RRIP, and included among those principles was the recommendation that the RRIP should establish all-payer readmissions targets. The key reason for this preference for an all payer test, rather than a Medicare-only test, was the desire to provide hospitals with an incentive to develop overall readmission reduction programs that would bring benefits to all patients and allow hospitals to operate with consistent financial incentives across patient populations and be consistent with other Maryland quality programs (i.e., Quality Based Reimbursement and Maryland Hospital Acquired Conditions programs).

When the RRIP for CY 2016 was being formulated, the Staff examined the available data and found a strong positive correlation between reductions in all-payer readmissions and reductions in Medicare readmissions (see Appendix IV). However, more recent data indicate that the relationship between all-payer and Medicare readmission trends changed in CY 2014. As shown in Figure 3, all payer readmissions dropped by 4.04%, whereas Medicare readmissions dropped by only 1.63%, during the YTD October 2013 to YTD October 2014 period. Appendix V also shows the monthly improvement in readmissions compared to the previous year and highlights that, in CY 2013, the unadjusted Medicare improvement was slightly higher or the same as the all-payer risk adjusted readmission improvement, but for CY 2014 the Medicare improvement was consistently lower. While these findings raise the important question of whether the establishment of all payer readmission targets is a reliable way to achieve the required reductions in Medicare readmissions, it is difficult to predict whether the most recent trend will continue.

The primary reasons to establish a Medicare-only test include the following supporting arguments. First, the Model Agreement establishes very clear requirements for Medicare readmission reductions and places Maryland at risk for losing its ability to establish its own readmissions reduction policies for the Medicare program if it fails to meet these requirements. Second, as evidenced by the most recent data, improvements in all payer readmissions rates may or may not be accompanied by required Medicare readmission reductions that are consistent with the requirements imposed by the Model Agreement. Third, Maryland needs to lower its Medicare readmission rate by 1.93% per year, over the remaining four years of the Model Agreement (the CY 2014 of 7.72% Gap shown on Figure 4 divided by the 4 remaining years), even if the national rate of Medicare readmissions does not decline, and failure to achieve the needed decline in CY 2015 could put Maryland in the very difficult position of needing to make very large (or impossible) reductions over the final three years of the waiver.

On the other hand, moving to a Medicare specific quality benchmarks has the following drawbacks. First, the change in the payment policy may drive quality improvement projects away from other vulnerable populations, such as complex vulnerable patient populations, especially Medicaid

patients. Second, as part of the all-payer system Maryland hospitals have been organizing their efforts from a broader perspective, and a change in the direction of these policies towards more Medicare specific approaches may delay the progress that more targeted approaches are assumed to provide. Third, as the Medicare readmissions comprise 50% of the readmissions in the state, all-payer strategies will require successful results in Medicare readmissions as well. Improving the effectiveness of the existing programs that are on an all payer basis may provide a more timely strategy rather than redesigning the incentives around Medicare readmission. Fourth, although recent Medicare data received from CMMI showed readmission trends that were similar to those that have been found in the HSCRC's data, but these data have not yet been validated by HSCRC Staff. The current readmission measure is considered to be an "interim" measure by both HSCRC and CMMI Staff and both parties intend to continue to work to revise the Medicare readmission measure to include a comparable patient population and suitable risk adjustments. For example, Medicare's national numbers may not include the utilization of special licensed beds in acute hospitals, such as chronic and psychiatry beds, and the patients who are treated in these beds may have relatively high readmission risks. These issues complicate the establishment of an appropriate Medicare-only readmission target, since it is unclear what the actual gap is between Maryland and the nation. Finally, a Medicare-specific target might create challenges in the balancing of payment incentives between hospitals with relatively high concentrations of Medicare patients vs. Medicaid patients.

Staff has also considered the option of establishing two separate RRIP targets (one for Medicare and one for non-Medicare) accompanied by two scales, or a blended scale, for the determination of rewards and penalties. While this option would be more difficult to implement, it could ensure that the Medicare target is given equal but separate attention by hospitals and maintain incentives for the hospitals to pursue readmission reductions for other payers. This approach might cause hospitals to re-evaluate their readmission improvement strategies and this could lead to lesser improvements for Medicare and other payers. In fact having two separate goals will almost certainly require hospitals to ensure their current interventions work on an all-payer basis or they may need to implement different strategies to achieve improvements in both. As mentioned previously, this may also create additional challenges to balance incentives across hospitals with differences in payer mix and lessen hospitals abilities to set their own priorities for focus. Finally, measuring and setting targets for different payers, could fragment its efforts to set broad, all-payer incentives for all-quality programs and would be a fundamental shift away from the strengths of the all-payer system.

Staff supports maintaining the all payer test for another year, while making other modifications to the RRIP, or it could adopt a Medicare-specific test (with or without a separate non-Medicare target).The choice between an all payer target and a Medicare-specific target depends, at least in part, on an assessment of the consequences of missing the Medicare target and an assessment of how a Medicare specific target or two different payer targets will impact the quality programs in the state. The CMMI staff has indicated that the Medicare readmissions trends in CY 2015 will be assessed using either the interim measure or the final measure developed during CY 2015. If Maryland does not achieve the required Medicare readmission reduction, the state will be required to submit a corrective action plan. See Appendix V for specific contract language regarding corrective action plans.

4. Rewards, Penalties and Scaling Methodology

As described above, the RRIP reward that was available to hospitals that met the 6.76% all payer readmissions reduction target was 0.5% of permanent inpatient revenue. No penalty was assessed against hospitals that failed to meet the targeted reduction. Hospitals that improved by more than 6.76% got no additional reward for their performance, and hospitals that fell just short of the 6.76% "step" received no reward, even though the difference between their performance and the performance of a hospital that just made the step, and received the reward, could be infinitesimally small.

Based on feedback from Commissioners and stakeholders, the Staff have considered the question of whether the reward of 0.5% of inpatient revenue is sufficient to create a cost/benefit opportunity that will motivate hospitals to make the investments of time, money and other resources that are needed to tackle the complex problem of reducing unnecessary readmissions. The average Maryland hospital has approximately $200 million of permanent inpatient revenue; therefore, 0.5% of this amount is $1,000,000. The costs of hiring qualified Staff and making the related investments needed to conduct an effective readmissions strategy can easily consume a large share of this incentive reward. Therefore, it is important to consider whether the establishment of a larger incentive reward, such as 1.0% of permanent inpatient revenue, is warranted.

The two primary arguments against the creation of a larger reward are, first, that any rewards must be funded within the overall revenue increase caps imposed by the Model Agreement, and there might be better uses for these funds; and, second, that the GBR and TPR incentive structures already give hospitals powerful financial incentives to reduce unnecessary utilization, including readmissions, and putting additional money (or any money) into the RRIP incentive program is a superfluous exercise.

The key arguments for introducing a penalty into the RRIP for CY RY 2017 are that positive incentives may not create necessary momentum for substantial quality improvements; and the combined use of a positive reward (which might be raised above 0.5% to 1.0%) and a penalty would raise the stakes for hospitals and make effective actions more economically justifiable and likely.

5. Annual vs. Cumulative Measurements

In the Draft Recommendation for the RRIP for RY 2017, which the Staff presented to the Commission on December 10, 2014, the Staff advocated the use of a cumulative measurement—rather than a current, year-specific measurement—to assess improvements in readmission levels on a hospital-specific basis. In a year-specific structure, the determination of a hospital's progress in reducing readmission rates would be based solely on the change in its readmission rate, relative to its expected rate, from the previous performance year to the most recent performance year (i.e., from CY 2014 to CY 2015 for the RRIP for CY RY 2017). A cumulative measurement would compute the hospital's progress to date in lowering its readmission rate relative to its readmission rate in CY 2013 (which was the base year for the RRIP for RY 2016).

The Staff had two primary reasons for recommending that the Commission should adopt a cumulative measure. First, the Model Agreement sets a cumulative requirement—namely, Maryland must bring its Medicare readmission rate to a level that is at or below the national Medicare readmission rate by CY 2018 and we must make scheduled, cumulative progress toward

that goal. Hospitals that make progress in any given year may jeopardize our continued exemption from the national Medicare readmissions reduction program if they have not achieved cumulative progress that is consistent with the Model's requirements. Second, we believe that reductions in readmissions may become harder and harder over time because the simplest, most easily implemented interventions will probably be tried first, and will probably achieve considerable success, and the problem of achieving additional improvements may become tougher over time.

The primary objection to the use of a cumulative measure—which is that hospitals that fall behind on a cumulative basis may see no prospect of earning a reward in a given year if measured on a cumulative basis and may, therefore, elect not to make the needed efforts—would be undercut if the Commission adopts two other changes that have been discussed for the RRIP for CY RY 2017. Specifically, if the Commission moves to continuous scaling, rather than the "step" or "threshold" approach, hospitals will have an ongoing incentive to achieve whatever improvements they can generate because the "either or" implications that are associated with the step approach to incentive calculations will be eliminated; and, second, if the Commission introduces penalties into the RRIP for CY RY 2017, in conjunction with continuous scaling, all hospitals will have an incentive to improve by whatever increments they believe are achievable in any particular year and over the CY 2015 through CY 2018 period.

6. The "Denominator" Issue

During the meetings with the Performance Measurement Work Group, participants expressed concerns that the calculation used to measure progress in readmission reductions in the RRIP for FY 2016—which is consistent with the calculation that is being used by CMS and CMMI—may work to the detriment of hospitals that are achieving reductions in their overall level of admissions, including both "primary" admissions and readmissions, and may undermine the incentives to reduce total admissions that are a core feature of the GBR and TPR arrangements. [2] However, this effect applies both to Maryland and to the nation because the Model Agreement stipulates that the readmissions/discharges formula must be used when comparing Medicare readmission rates in Maryland and elsewhere in the U.S. While this formula masks some of the improvements in Maryland and in the U.S, the Staff and CMMI will also monitor per capita readmission improvements as well.

In terms of the RRIP, the Staff believes that the use of the case-mix adjusted observed to expected readmission rate as the hospital-specific performance metric lessens most of the concerns regarding the denominator issue (see Appendix VII for readmission measurement specifics, including exclusions, and Appendix VIII for details on case-mix adjustment). The case-mix adjusted readmission rate is calculated using the observed to expected readmissions ratio at each hospital multiplied by the statewide readmission rate during the base period. Because the expected number of readmissions is based on the same denominator as the observed readmissions, the changes in the total admissions are reflected in both the observed and expected numbers. Appendix IIX provides an example in which the unadjusted readmission rate increases overtime due to a decline in total admissions, but the case-mix adjusted readmission rate declines. However, concerns have

[2] In the CMS readmission logic, all discharges are considered as index admissions; therefore, a readmission is also part of the denominator count. We are using the term "primary" to indicate index admissions that are not readmissions.

been raised about the possible changes and adequacy of case-mix adjustment. Staff will continue to work with the stakeholder and experts to assess the impact of the denominator during CY 2015.

E. Improvement Action Plans

The Staff has recommended changes to the RRIP program that strengthen the incentives to reduce readmissions as required under the agreement with CMMI. The Staff has also recommended a cumulative target for CY 2015 that would make up for the estimated shortfall relative to the CY 2014. The Staff will continue to work with CMMI to refine the final target calculations and monitor national trends.

In the past, Maryland's QIO provided some condition specific information to help target efforts. As illustrated earlier in this document, hospitals have made significant strides in reducing readmissions and in closing the gap between the higher rate of readmissions in Maryland and the national average. Maryland could benefit from more comparative national benchmarks and analysis of national versus Maryland data as it renews its efforts to close the gap and understand the drivers of variation. HSCRC Staff have begun to work with the new Maryland QIO, VHQC, and now participates as an invited participant on the VHQC Quality Reporting and Incentive Program Advisory Committee. Staff will continue to collaborate with both VHQC and CMMI Staff to focus on obtaining additional benchmarks and recommendations for improvements.

Staff has been working with a multi-agency and stakeholder work group, the Care Coordination Work Group, to focus on opportunities to improve infrastructure for care coordination for high need and complex patients and reduction of risks related to chronic conditions. Implementation of infrastructure and care coordination and integration strategies will help create more comprehensive and sustainable approaches to reduce avoidable hospitalizations and readmissions. The Commission will evaluate the recommendations from this process and should continue to seek advice regarding those strategies that are best suited to improve care and produce the sustainable results we are seeking.

F. Recommendations

After consideration of the information, issues and options that have been discussed above in this document, the Staff is providing the following recommendations for the RRIP for RY 2017 (which would compare performance in CY 2013 to performance in CY 2015):

1. Adopt a readmission payment incentive program with both rewards for hospitals achieving or exceeding the required readmission reduction benchmark and payment reductions for hospitals that do not achieve the minimum required reduction.

2. Use a continuous preset scaling approach to provide rewards and penalties in proportion to the each hospital's performance relative to the required reduction on a case-mix adjusted basis.

3. Continue to set a minimum required reduction benchmark on all-payer basis and re-evaluate the option to move to a Medicare specific performance benchmark for CY2016 performance period.

4. Set the all-payer case-mix adjusted readmission target at 9.3% cumulative reduction from CY 2013 base all payer case-mix adjusted readmission rates.

5. Continue to assess the impact of admission reductions, SES/D and all payer and Medicare readmission trends and make adjustments to the rewards or penalties if necessary.

6. Seek additional Medicare benchmarks that can help guide efforts in Maryland. Evaluate recommendations from the Care Coordination Work Group and request recommendations from Maryland's new QIO regarding specific areas for improvement.

Appendix I. CMS Medicare Readmission Rates for FFY2015

Hospital Name	Number of Pneumonia Cases	Excess Readmission Ratio for Pneumonia	Number of Heart Failure Cases	Excess Readmission Ratio for Heart Failure	Number of Acute Myocardial Infarction Cases	Acute Myocardial Infarction Excess Readmission Ratio	Number of Hip/Knee Arthroplasty Cases	Hip/Knee Arthroplasty Excess Readmission Ratio	Number of Chronic Obstructive Pulmonary Disease Cases	Chronic Obstructive Pulmonary Disease Excess Readmission Ratio	Average
NORTHWEST HOSPITAL CENTER	628	1.21	797	1.20	151	1.07	180	0.92	599	1.15	1.11
DOCTORS' COMMUNITY HOSPITAL	410	1.25	490	1.01	38	0.99	170	1.33	371	0.93	1.10
SINAI HOSPITAL OF BALTIMORE	391	1.09	928	1.02	466	1.01	676	1.38	363	1.00	1.10
MEDSTAR MONTGOMERY MEDICAL CENTER	429	1.04	437	1.17	99	1.10	314	1.15	380	1.05	1.10
SHADY GROVE ADVENTIST HOSPITAL	677	1.07	515	1.09	194	1.04	574	1.23	430	1.07	1.10
SAINT AGNES HOSPITAL	862	1.01	761	1.07	184	0.89	390	1.51	670	1.00	1.10
UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	348	1.07	428	1.00	25	1.09	190	1.28	608	1.01	1.09
SOUTHERN MARYLAND HOSPITAL CENTER	386	1.12	694	1.07	171	1.08	161	1.03	427	1.14	1.09
UNIVERSITY OF MARYLAND MEDICAL CENTER	165	1.13	329	1.14	512	1.12	57	1.04	122	1.00	1.09
UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	190	0.96	265	1.01	29	1.03	77	1.33	263	1.10	1.08
MEDSTAR HARBOR HOSPITAL	278	0.91	409	1.16	64	0.97	209	1.30	436	1.06	1.08
LAUREL REGIONAL MEDICAL CENTER	103	1.02	176	1.02	46	1.09	78	1.20	127	1.07	1.08
CALVERT MEMORIAL HOSPITAL	380	1.10	556	1.02	70	0.97	149	1.33	403	0.98	1.08
UNION HOSPITAL OF CECIL COUNTY	353	1.02	290	1.05	87	1.07	206	1.25	590	1.01	1.08
PRINCE GEORGES HOSPITAL CENTER	102	1.10	265	1.11	144	1.06	25	1.00	157	1.11	1.08
MERCY MEDICAL CENTER INC	199	1.06	340	1.03	28	1.09	1037	1.19	239	0.98	1.07
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	485	1.15	850	1.10	181	1.10	432	0.91	575	1.09	1.07
UNIVERITY OF MD BALTO WASHINGTON MEDICAL CENTER	1014	1.19	1198	1.16	264	0.93	404	0.99	1167	1.06	1.07
MEDSTAR GOOD SAMARITAN HOSPITAL	352	1.25	1037	1.01	150	1.11	578	0.91	518	1.06	1.07
ANNE ARUNDEL MEDICAL CENTER	849	1.08	1151	1.09	365	1.09	1849	1.01	785	1.05	1.06
HOWARD COUNTY GENERAL HOSPITAL	692	1.15	590	1.11	131	0.96	104	1.05	654	1.03	1.06
MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	726	1.00	1297	0.99	314	1.00	308	1.27	1134	1.02	1.06
HOLY CROSS HOSPITAL	391	1.03	607	1.07	142	1.03	314	1.10	373	0.99	1.05
ATLANTIC GENERAL HOSPITAL	297	0.98	311	0.89	27	1.10	232	1.14	369	1.05	1.03
UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL	173	1.01	263	0.98	51	1.02	55	1.08	311	1.04	1.03
FREDERICK MEMORIAL HOSPITAL	982	1.04	926	0.98	280	0.99	608	1.05	904	1.05	1.02
CARROLL HOSPITAL CENTER	600	1.04	760	0.98	213	1.01	535	1.10	702	0.98	1.02
UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	558	1.01	931	0.99	105	1.06	511	1.03	779	1.02	1.02
UNIVERSITY OF M D UPPER CHESAPEAKE MEDICAL CENTER	410	0.94	800	1.02	269	1.06	388	1.05	788	0.98	1.01
SUBURBAN HOSPITAL	557	0.97	637	1.04	360	1.02	997	0.95	269	1.06	1.01
CENTER	756	1.05	881	1.05	393	1.02	605	0.94	939	0.98	1.01
WASHINGTON ADVENTIST HOSPITAL	222	1.00	480	1.09	439	1.01	106	0.99	252	0.95	1.01
CENTER	80	0.96	157	0.98	40	1.01	45	1.00	122	1.06	1.00
MEDSTAR SAINT MARY'S HOSPITAL	300	0.92	440	1.08	70	1.00	318	0.88	459	1.02	0.98
GARRETT COUNTY MEMORIAL HOSPITAL	137	0.90	173	1.08	38	0.98	177	0.84	149	1.06	0.97
GREATER BALTIMORE MEDICAL CENTER	569	0.93	540	0.92	47	0.98	510	1.12	369	0.89	0.97
MEDSTAR UNION MEMORIAL HOSPITAL	253	0.97	636	0.94	653	0.99	1146	0.96	308	0.90	0.95
SAINT JOSEPH MEDICAL CENTER	299	1.00	784	0.96	543	0.87	1158	0.98	395	0.94	0.95
UNIVERSITY OF MARYLAND ST JOSEPH MEDICAL CENTER	50	0.95	160	0.96	82	0.97	266	0.93	82	0.93	0.95
MERITUS MEDICAL CENTER	1174	0.97	587	0.99	281	0.91	781	0.78	717	0.99	0.93
PENINSULA REGIONAL MEDICAL CENTER	857	0.91	1290	0.92	734	0.91	931	0.88	670	0.87	0.90
FORT WASHINGTON HOSPITAL	105	0.99	189	1.13	3		71	1.08	148	1.23	1.11
JOHNS HOPKINS HOSPITAL, THE	323	1.10	730	1.02	496	1.06	12		227	0.98	1.04
BON SECOURS HOSPITAL	86	0.99	188	1.06	9		2		112	1.02	1.03
UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	110	1.03	144	1.04	9		14		146	1.00	1.02
EDWARD MCCREADY MEMORIAL HOSPITAL	52	0.96	50	1.00	5		0		56	0.95	0.97
UNIV OF MD REHABILITATION & ORTHOPAEDIC INSTITUTE	3		7		0		254	1.28	2		1.28
LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL	0		0		0		0		0		NA
Number of Cases		19,363		26,474		9,002		18,204		20,666	
Hospital Average Ratio		1.04		1.04		1.02		1.09		1.02	1.04
Percent of Hospitals Above National Average		**61%**		**70%**		**61%**		**59%**		**59%**	**83%**

Appendix II: Maryland Readmission Targets Based on 4 Scenarios for National Trend

	Lowest Improvement	2 Year Average	3 Year Average	Highest Improvement
National Trend CY12-14	-0.35%	-1.34%	-1.93%	-3.10%
CMMI Medicare Unadjusted Targets				
CY14 Actual	-0.8%	-0.8%	-0.8%	-0.8%
CY15 Target	-2.9%	-3.9%	-4.5%	-5.6%
Cumulative	**-3.71%**	**-4.67%**	**-5.24%**	**-6.36%**
HSCRC Medicare Casemix Adjusted Target				
CY14 Actual	-1.4%	-1.4%	-1.4%	-1.4%
CY2015	-3.5%	-4.5%	-5.0%	-6.2%
Cumulative	**-4.83%**	**-5.78%**	**-6.34%**	**-7.46%**
HSCRC All Payer Casemix Adjusted Target				
CY14 Actual	-3.8%	-3.8%	-3.8%	-3.8%
CY2015	-4.8%	-5.8%	-6.3%	-7.5%
Cumulative	**-8.38%**	**-9.31%**	**-9.86%**	**-10.96%**

Appendix III: Conversion of CMMI Medicare Unadjusted Target to an HSCRC Case-mix Adjusted Target

CMMI Medicare Unadjusted Targets		% Readmission Rate Reduction
CY14 Actual	A	-0.80%
CY15	B	-3.90%
Cumulative	C=(1+A)*(1+B)-1	**-4.67%**
HSCRC Medicare Casemix Adjusted Target		
CY14 Actual	D	-1.37%
CY15	E = B-0.57%	-4.47%
Cumulative	F = (1+D)*(1+E)-1	**-5.78%**
HSCRC All Payer Casemix Adjusted Target		
CY14 Actual	G	-3.76%
CY15	H = B-1.91%	-5.77%
Cumulative	I = (1+G)*(1+H)-1	**-9.31%**

Because the HSCRC Staff is recommending the use of an adjusted all-payer cumulative target for the RY 2017 RRIP, the targets established for Medicare (based on the most recent data from the CMMI) must be converted to an HSCRC all-payer case mix adjusted target.

This conversion is illustrated in the table above and involves the following steps:

1) The Staff starts with the amount that it has calculated to be the required reduction in CY 2015 for Medicare FFS unadjusted readmission rates of -3.90%, necessary to bring Maryland back on pace to be at or below U.S. Medicare readmission rates by the end of CY 2018 (the -3.90% Medicare unadjusted target is shown in the table above on line B and also calculated and highlighted in yellow in Figure 4 on page 7);

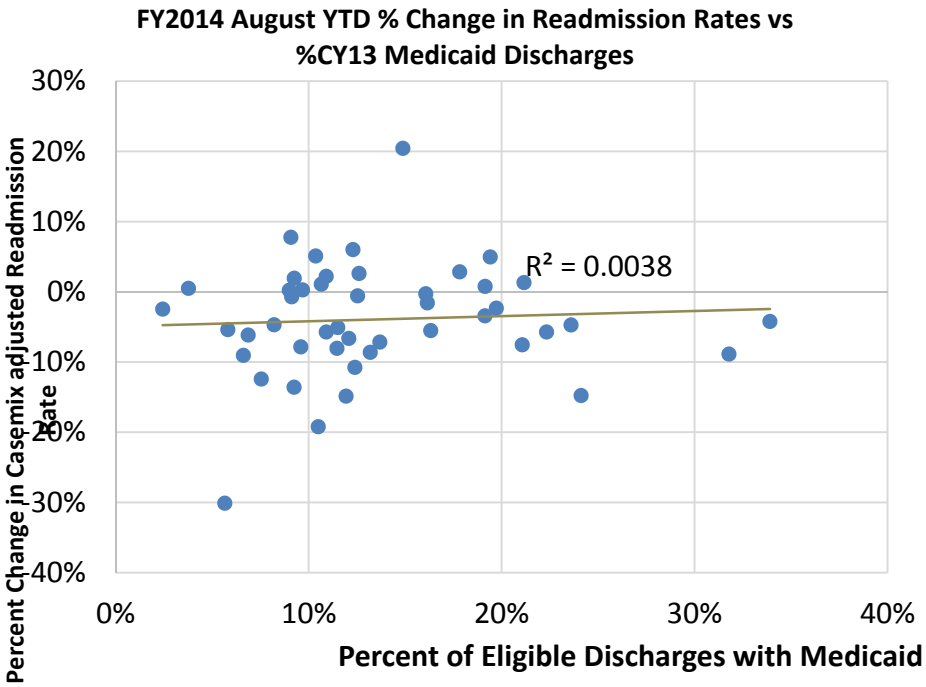
2) Over the period CY 2012 to CY 2014 Staff has observed that the HSCRC all-payer adjusted readmission rate has declined 1.91% more than the HSCRC Medicare unadjusted readmission rate column (6.8% = the two year average all-payer adjusted readmission reduction – 5.0%= the two year average Medicare unadjusted readmission reduction);

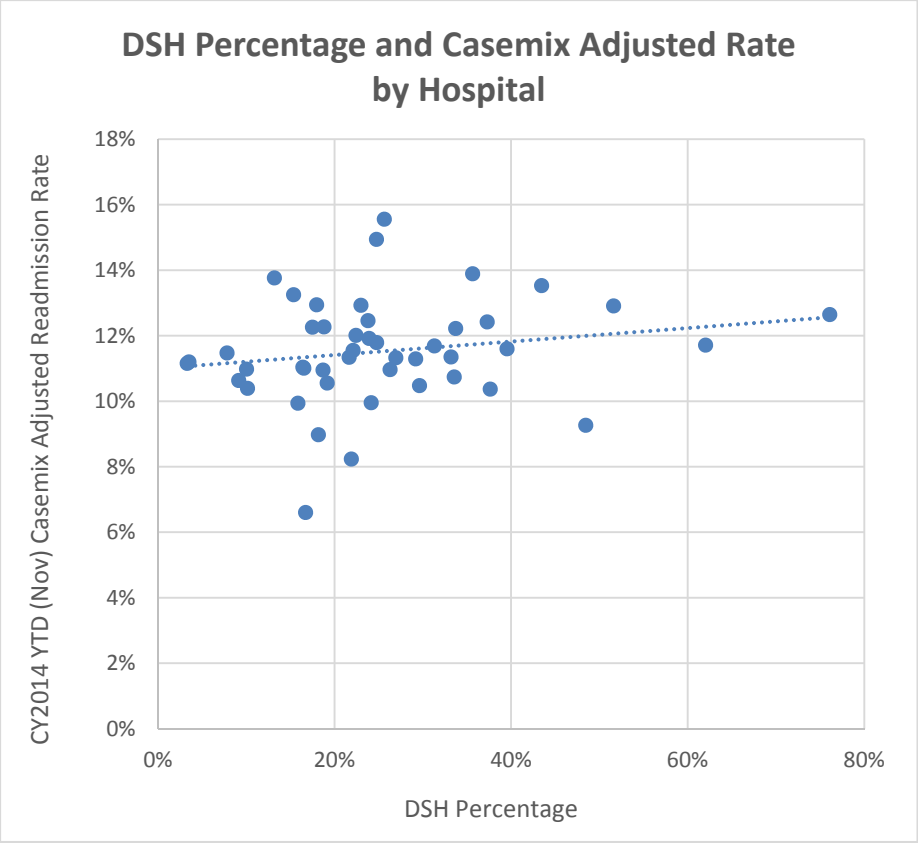
3) This average difference in the all-payer and Medicare adjusted readmission rate reductions is then added to the original unadjusted Medicare readmission reduction target of -3.90% to calculate the all-payer adjusted readmission reduction target for CY 2015 (-3.90% - 1.91% = -5.77% shown on line H above);

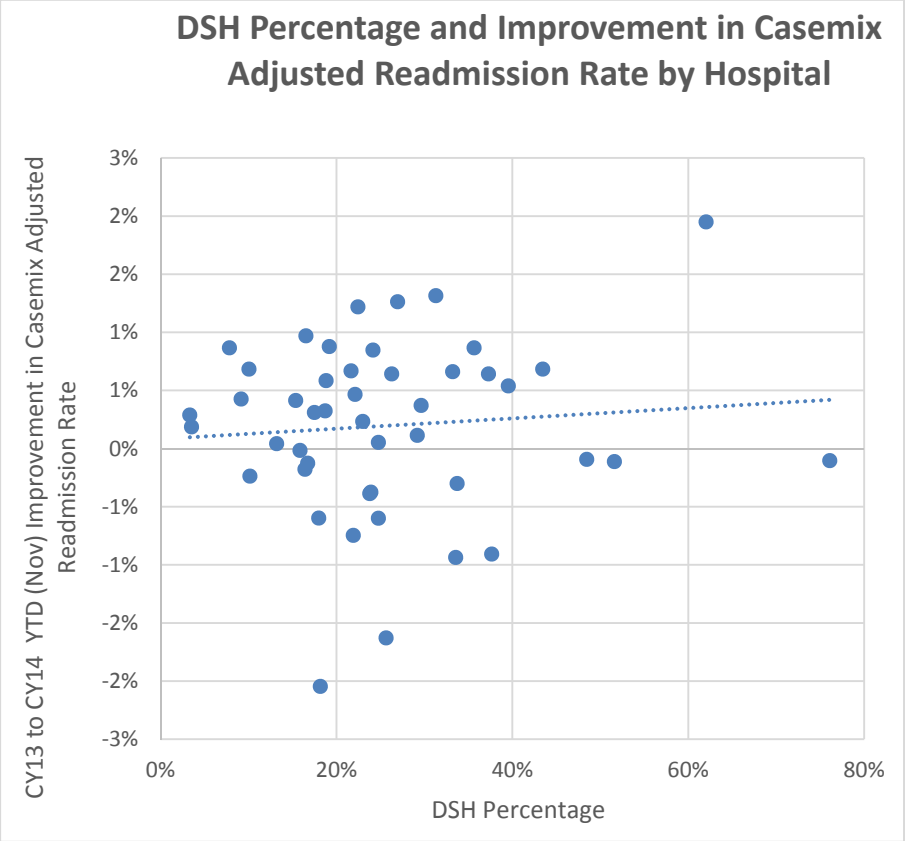
4) Because the Staff intends to use a cumulative two-year all-payer readmission reduction target actual CY 2014 all-payer adjusted readmission result (of -3.76%) must be combined with the

targeted all-payer adjusted readmission (-5.77%) calculated in step 3. The compounding of these two percentage reductions results in the calculated cumulative all-payer adjusted readmission reduction target of -9.31% (as shown on line I above).

Appendix IV: Analysis of Medicaid and DSH payments and Readmission Rates No Correlation in Readmission Rates with % of Medicaid Admissions

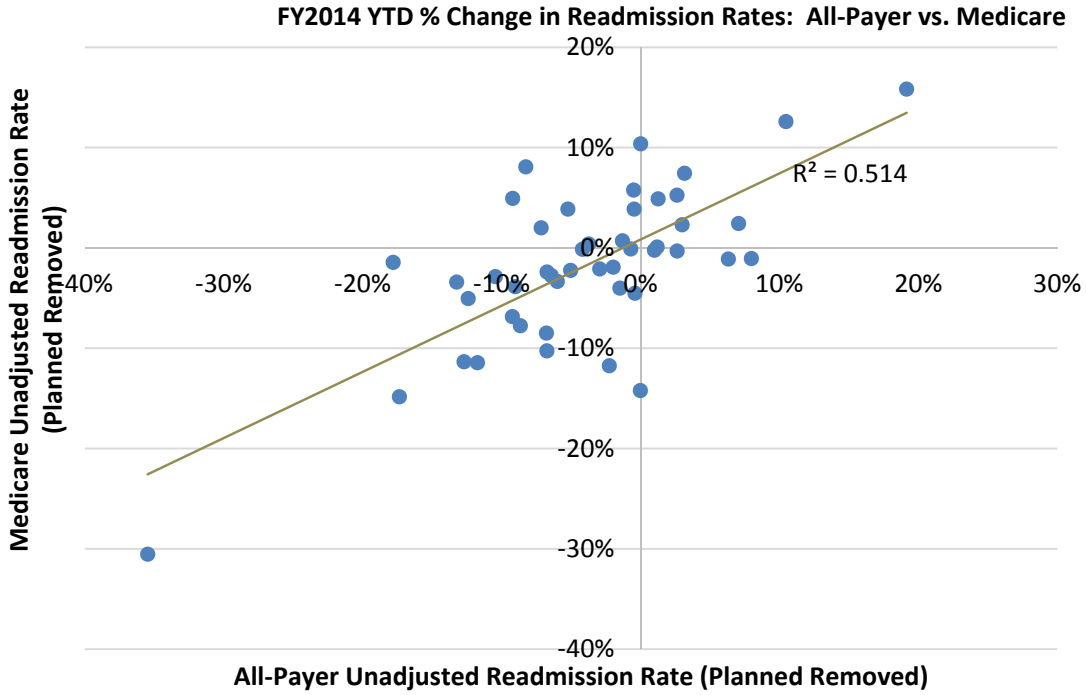



DSH Percentage and Casemix Adjusted Rate by Hospital
CY2014 YTD (Nov) Casemix Adjusted Readmission Rate
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
0%
20%
40%
60%
80%
DSH Percentage

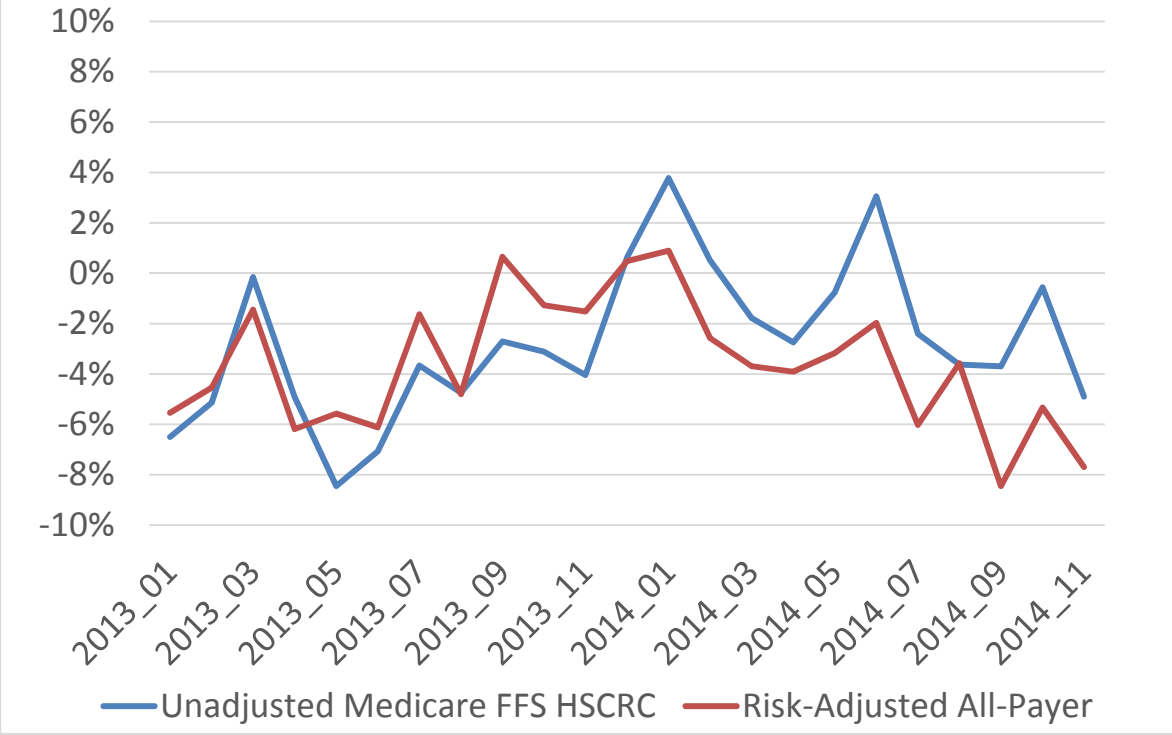

DSH Percentage and Improvement in Casemix Adjusted Readmission Rate by Hospital
CY13 to CY14 YTD (Nov) Improvement in Casemix Adjusted Readmission Rate
3%
2%
2%
1%
1%
0%
-1%
-1%
-2%
-2%
-3%
0%
20%
40%
60%
80%
DSH Percentage

Appendix V: All-Payer vs. Medicare FFS Improvement

Higher Correlation of Medicare and All-Payer Readmission Rates



Monthly Improvement Trends (Annual Change) in Unadjusted Medicare vs. Case-mix Adjusted All-Payer Readmissions



Appendix VI: Contract Language on Corrective Action Plans

1. **Corrective Action and Termination of Model and/or Waivers.**
    a. **Warning notice and corrective action plan ("CAP").** If CMS determines that a Triggering Event (as defined in this section) has occurred, CMS shall provide written notice to the State that it is not meeting a requirement of this Agreement ("Warning Notice") with an explanation and, as permitted by applicable law, data supporting its determination. CMS shall provide the State with the Warning Notice no later than six months following the end of the applicable Performance Year for any Triggering Event specified in Section 14.c.ii-vii; CMS may provide the Warning Notice at any time for all other Triggering Events in Section 14.c. Within 90 calendar days of receipt of the Warning Notice, the State must submit a written response to CMS. CMS will review the State's response within 90 calendar days and will either accept the response as sufficient or require the State to submit a CAP within 30 calendar days addressing all actions the State and/or participants in the Model will take to correct any deficiencies and remain in compliance with this Agreement. Options for the CAP may include, but are not limited to, new safeguards or programmatic features, modification to the Model, and/or prospective adjustments to hospital payment levels. In developing its CAP, the State shall consult with CMS as to whether the CAP fully corrects any deficiencies. Approval of the CAP shall be at the sole discretion of CMS.

        i. **Review factors considered by CMS.** A Triggering Event may or may not require corrective action, depending on the totality of the circumstances. CMS will consider whether the State can demonstrate a factor unrelated to the Model caused the Triggering Event (e.g., a localized disease outbreak solely in Maryland, expansion of health insurance coverage under the Affordable Care Act, the construction of the new hospital facility in Prince George's County). Notwithstanding the above, CMS, in its sole discretion, will determine the sufficiency of the State's response to any Warning Notice issued pursuant to this section.

    b. **Implementation of CAP.** The State shall successfully implement any required CAP as approved by CMS, by no later than 365 calendar days from the date of postmark of the Warning Notice. If the Triggering Event is related to an aspect of the Model involving a Waiver from the Act, as specified in Section 4.c., d., e., and f., CMS, in its sole discretion, shall decide whether to allow the State to maintain such Waiver during the time period that the State is under the CAP. In making this determination, CMS shall consider whether the State can demonstrate that it is implementing a program for Regulated Maryland Hospitals and, as applicable, other hospitals in Maryland that achieves or surpasses the measured results in terms of patient outcomes and cost savings established under the applicable section of the Act from which it was waived.

Appendix VII. HSCRC Methodology for Readmissions RY2017

READMISSIONS

CY 2013 inpatient data, with EIDs (base year), is used to calculate the readmission rates for all-payer and Medicare patients.

EXCLUSIONS

The following were removed from the readmission rate calculations:

1. Rehab hospitals (provider ids 213028,213029, 213300)
2. Cases with null or missing EIDs
3. Duplicates
4. Negative interval days
5. Newborn related APRDRGs.
6. For risk adjustment, based on admission DRGs, exclude DRG and SOI cells with < 2
7. Exclude those who have died (from denominator) and those with same day transfers (interval days = 0) (from readmissions)

RESULTS

1. Two numerators (readmissions within 30 days of a hospitalization)
   a. Unadjusted readmissions (comparable to CMS)
   b. Adjusted readmissions (exclude planned admissions, based on the Clinical Classification System (CCS) to flag planned admissions)
2. Denominator – Total number of discharges
3. Expected Readmissions based on Discharge DRG and Severity of Illness.
4. Calculate Ratio – Adjusted readmissions / expected readmissions
5. Risk Adjusted Readmission Rate – Ratio*Overall state rate

The key methodology components of the Readmission Reduction Incentive Program are described below.

- **Readmission definition**- Total readmissions/total admissions to any acute hospital[3]
- **Broad patient inclusion-** For greater impact and potential for reaching the target the measure should include all payers and any acute hospital readmission in the state.

[3]Discharge can both be initial and readmission; one readmission within 30 days is counted; transfers are combined into a single stay; and the 30-day period starts at the end of the combined stay, Left against medical advice is also included in the index. Admissions with discharge status of "Died" are excluded.

- **Patient exclusion adjustments–** To enhance fairness of the methodology, planned admissions (using the updated CMS Algorithm) and deliveries should be excluded from readmission counts.
- **Scale positive and negative incentives**- If statewide Medicare readmission reduction target is met, hospitals that reach or exceed the hospital-specific improvement target have the opportunity to earn the incentives and hospital will be assessed penalties if they have in increase in readmission rates. If the statewide Medicare readmission reduction target is not met, hospitals will have an opportunity to earn a reduced incentive, and hospitals will be assessed penalties if they do not meet the minimum improvement target.
- **Performance measurement consistent across hospitals**- A uniform improvement benchmark for all hospitals was established for the first year and will be evaluated annually. Given the debate whether socio-economic and demographic factors should be used in readmission risk adjustment and that arguments could be made to lower readmission targets for high readmission hospitals if they serve hard to reach populations, Staff recommends using a uniform achievement benchmark for all hospitals.

  Monitor for unintended consequences- Observation and ED visits within 30 Days of an inpatient stay will be monitored; adjustments to the positive incentive will be made if observation cases within 30 days increase faster than the other observations in a given hospital.

Appendix VIII: Case-Mix Adjustment Methodology in Readmission Reduction Incentive Program

Expected Values:
The expected value of readmissions is the number of readmissions a hospital, given its mix of patients as defined by discharge APR DRG category and severity of illness level, would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected value or expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being "at risk" for a readmission. All discharges will either have no readmissions or will have one readmission. The readmission rate is proportion or percent of admissions which have a readmission.

The rates of readmissions in the normative database are calculated for each APR DRG category and its severity of illness levels by dividing the observed number of readmissions by the total number of discharges. The readmission norm for a single APR DRG severity of illness level is calculated as follows:

Let:

N = norm

P = Number of discharges with a readmission

D = Number of discharges that can potentially have a readmission

i = An APR DRG category and a single severity of illness level

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

For this example, this number is displayed as readmissions per discharge to facilitate the calculations in the example. Most reports will display this number as a rate per one thousand.

Once a set of norms has been calculated, they can be applied to each hospital. For this example, the computation is for an individual APR DRG category and its severity of illness levels. This

computation could be expanded to include multiple APR DRG categories or any other subset of data, by simply expanding the summations.

Consider the following example for an individual APR DRG category.

Table 1 Expected Value Computation Example

1 Severity of illness Level	2 Discharges at risk for readmission	3 Discharges with Readmission	4 Readmissions per discharge	5 Normative Readmissions per discharge	6 Expected # of Readmissions
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
Total	500	45	.09		56.5

For the APR DRG category, the number of discharges with readmission is 45, which is the sum of discharges with readmission (column 3). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of discharges with a readmission (sum of column 3) by the total number of discharges at risk for readmission (sum of column 2), i.e., 0.09 = 44/500. From the normative population, the proportion of discharges with readmissions for each severity of illness level for that APR DRG category is displayed in column 5. The expected number of readmissions for each severity of illness level shown in column 6 is calculated by multiplying the number of discharges at risk for a readmission (column 2) by the normative readmissions per discharge rate (column 5) The total number of readmissions expected for this APR DRG category is the expected number of readmissions for the severity of illness levels.

In this example, the expected number of readmissions for this APR DRG category is 56.5 compared to the actual number of discharges with readmissions of 45. Thus the hospital had 11.5 fewer actual discharges with readmissions than were expected for this APR DRG category. This difference can be expressed as a percentage difference as well.

APR DRG by SOI categories are excluded from the computation of the actual and expected rates when there are only zero or one at risk admission statewide for the associated APR DRG by SOI category.

Appendix IIX: Denominator Impact of Case-mix Adjustment

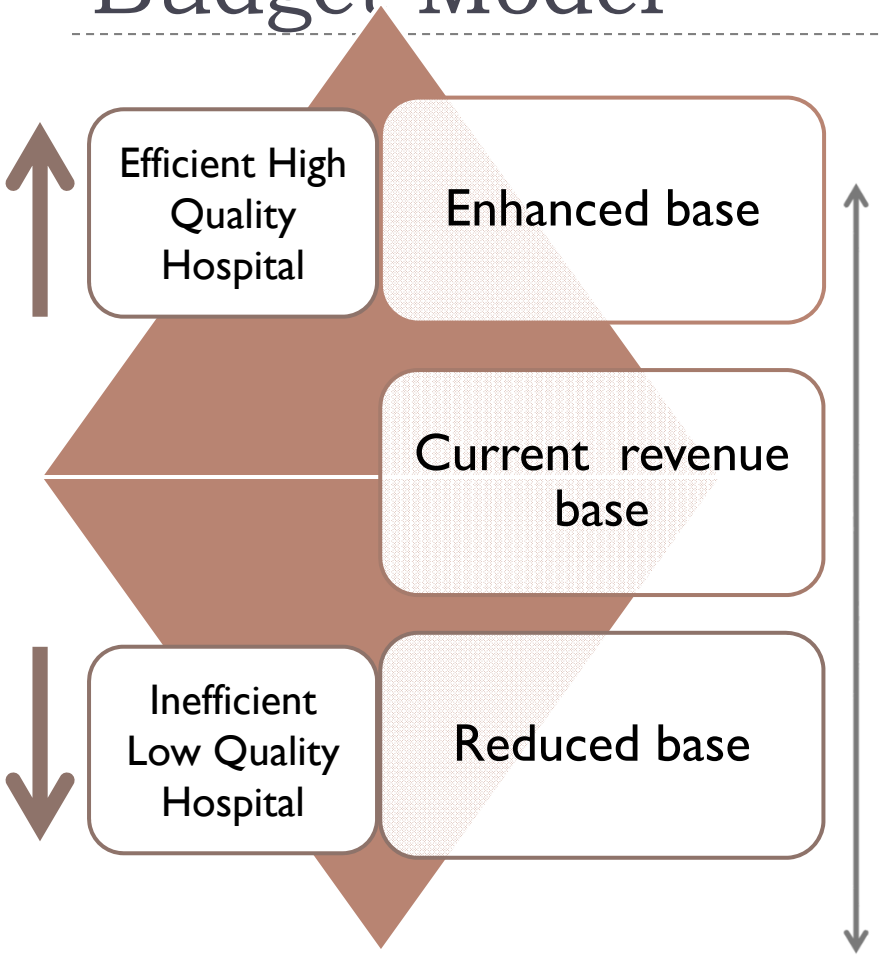
Base Period						Performance Period					
ACTUAL TOTAL ADMITS	ACTUAL PRIMARY ADMITS	ACTUAL READMITS	ACTUAL READMITS/ ACTUAL TOTAL ADMITS	ACTUAL READMITS / ACTUAL PRIMARY ADMITS	RISK-ADJUSTED READMISSION RATE	ACTUAL TOTAL ADMITS	ACTUAL PRIMARY ADMITS	ACTUAL READMITS	ACTUAL READMITS / ACTUAL TOTAL ADMITS	ACTUAL READMITS/ ACTUAL PRIMARY ADMITS	RISK-ADJUSTED READMISSION RATE
1,000	861	139	13.90%	16.14%	13.66%	855	736	119	13.92%	16.17%	13.44%
					Absolute Difference	-145	-125	-20	0.02%	0.02%	-0.22%
					Percent Difference	-14.50%	-14.52%	-14.39%	0.13%	0.15%	-1.62%

	Base Period						Performance Period					
APR DRGs (BY SOI)	ACTUAL TOTAL ADMITS	EXPECTED READMITS / ADMITS	EXPECTED READMITS	ACTUAL READMITS	ACTUAL READMITS/ ACTUAL TOTAL ADMITS	ACTUAL READMITS/ ACTUAL PRIMARY ADMITS	ACTUAL TOTAL ADMITS	EXPECTED READMITS/ ADMITS	EXPECTED READMITS	ACTUAL READMITS	ACTUAL READMITS/ ACTUAL TOTAL ADMITS	ACTUAL READMITS/ ACTUAL PRIMARY ADMITS
APR DRG 1	160	17.00%	27.20	27	16.88%	20.30%	150	17.00%	25.50	25	16.67%	20.00%
APR DRG 2	155	12.00%	18.60	12	7.74%	8.39%	110	12.00%	13.20	13	11.82%	13.40%
APR DRG 3	260	0.00%	0.00	0	0.00%	0.00%	220	0.00%	0.00	1	0.45%	0.46%
APR DRG 4	425	22.50%	95.63	100	23.53%	30.77%	375	22.50%	84.38	80	21.33%	27.12%
TOTALS	**1,000**	**14.14%**	**141.43**	**139**	**13.90%**	**16.14%**	**855**	**14.39%**	**123.08**	**119**	**13.92%**	**16.17%**

Final Recommendation for Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2017

HSCRC Commission Meeting 03/11/2015

Revenue Adjustments under Global Budget Model



GBR Revenue Adjustments

- Volume Growth: Population Growth and Aging
- Market Shifts
- Changes in the service provision: Deregulation, new services/hospital etc.
- Quality Programs

All Payer New Model Contract Requirement

- *Regulated Revenue at risk: [Maryland] must ensure that the aggregate percentage of Regulated Revenue at risk for quality programs administered by the State is equal to or greater than the aggregate percentage of revenue at risk under national Medicare quality programs. Quality programs include, but are not limited to, readmissions, hospital acquired conditions, and value-based purchasing programs.*

Scaling Methodologies

Relative Ranking Scaling

Hospital Name	Hospital Quality Performance Score	Scaling Adjustment
Hospital A	**5**	-1.00%
Hospital B	**6**	-0.50%
Hospital C	**7**	0.00%
Hospital D	**8**	0.50%
Hospital E	**9**	1.00%

Preset Point Scaling

Base Year Quality Scores	Preset Scaling Adjustments
2	-1.00%
3	-0.75%
4	-0.50%
5	0.00%
6	0.25%
7	0.50%
8	0.75%
9	1.00%

Hospital Name	Hospital Quality Performance	Scaling Adjustment
Hospital A	5	0.00%
Hospital B	6	0.25%
Hospital C	7	0.50%
Hospital D	8	0.75%
Hospital E	9	1.00%

Continuous vs. Step Approach Scaling

Base Year Quality Scores	Continuous Scaling Adjustments (QBR, RRIP)	Step Approach (MHAC)
2	-1.00%	-1.00%
3	-0.75%	-0.50%
4	-0.50%	0.00%
5	0.00%	0.00%
6	0.25%	0.00%
7	0.50%	0.00%
8	0.75%	0.50%
9	1.00%	1.00%

Scaling Benchmarks

- Penalties/Rewards Benchmarks:
  - QBR: Median Base Year Score
  - RRIP: Statewide Readmission Target
  - MHAC: Penalty: Bottom 1/3rd , Reward: Top 1/3rd

Statewide Aggregate Maximum At Risk

RY 2017 Proposed Maximum Penalties and Rewards

	Max Penalty	Max Reward
MHAC Below target	-3.0%	0.0%
MHAC Above Target	-1.0%	1.0%
RRIP	-2.0%	1.0%
QBR	-2.0%	1.0%

Aggregate At Risk Calculations

Potential At Risk

Maryland - Potential Inpatient Revenue at Risk absolute values

% Inpatient Revenue	SFY 2014	SFY 2015	SFY 2016	SFY2017 (Proposed/estimated)
MHAC	2.0%	3.0%	4.0%	*3.0%*
RRIP			0.5%	*2.0%*
QBR	0.50%	0.50%	1.00%	*2.0%*
Shared Savings	0.41%	0.86%	0.86%	*0.86%*
GBR PAU:	*0.50%*	*0.86%*	*0.86%*	*0.86%*
MD Aggregate Maximum At Risk	3.41%	5.22%	7.22%	8.72%

**Italics are estimated numbers based on current policy.*

Medicare National - Potential IP revenue at risk absolute values

% IP Rev	FFY 2014	FFY 2015	FFY 2016	FFY 2017
HAC		1.00%	1.00%	1.00%
Readmits	2.00%	3.00%	3.00%	3.00%
VBP	1.25%	1.50%	1.75%	2.00%
Medicare Aggregate Maximum At Risk	3.25%	5.50%	5.75%	6.00%
Annual MD-US Difference	0.16%	-0.28%	1.47%	2.72%
Cumulative MD-US Difference		-0.28%	1.19%	4.19%

Realized at Risk

Maryland: (SFY 15)

%tile (FY 15)	MHAC	Readmis.	QBR	GBR PAU	Sum with PAU
100%	0.13%	-0.08%	0.28%	0.00%	
75%	0.06%	-0.59%	0.08%	-0.14%	
50%	0.05%	-0.64%	0.01%	-0.29%	
25%	0.02%	-0.72%	-0.15%	-0.44%	
0%	-1.00%	-0.86%	-0.50%	-0.86%	
FY15 Absolute % Average	**0.11%**	**0.64%**	**0.14%**	**0.29%**	**1.18%**
FY15 Total Value Percent	**0.09%**	**0.67%**	**0.13%**	**0.22%**	**1.11%**

CMS National: (FFY 15)

%tile (FY 15)	HAC	Readmit.	VBP	Sum
100%	0.00%	0.00%	1.06%	
75%	0.00%	-0.06%	0.15%	
50%	0.00%	-0.31%	0.00%	
25%	0.00%	-0.77%	-0.21%	
0%	-1.00%	-3.00%	-1.37%	
FY15 Absolute % Average	**0.22%**	**0.52%**	**0.24%**	**0.97%**

Maximum Revenue at Risk Hospital Guardrail

- Significance of quality-based payment adjustments increased under GBR.
- A strategic plan to be developed on how much revenue should be allocated through quality-based performance results and how to combine existing quality programs.
- Probability of receiving maximum penalties in all programs are low in the existing programs.
- Hospital aggregate adjustment guardrail is proposed to balancing financial risk.
- Staff used Medicare aggregate amount at risk total as the benchmark for calculating hospital maximum penalty guardrail (e.g. 6% x %Percent Inpatient Revenue).

Staff Recommendations

- **QBR**:
  - 2% maximum penalty.
  - Staff recommend that a preset scale be used, and that rewards and penalties not be revenue neutral starting with RY 2017 results.

- **MHAC**:
  - 3%maximum penalty if statewide improvement target is not met; 1% maximum penalty and up to 1% if statewide improvement target is met.
  - Staff recommends removing the revenue neutrality requirement for the rate year RY 2016 to recognize the large improvements in PPCs achieved by the hospitals during this performance period.

- **RRIP**: 2% scaled maximum penalty and 1% reward for hospitals that reduce readmission rates at or better than the minimum improvement.

- **Maximum penalty guardrail:** Hospital maximum penalty guardrail to be set at 3.5% of total revenue for RY2017.

Final Recommendation for Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2017

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

March 11, 2014

These final staff recommendations were approved at the March 11, 2015 Commission Meeting.

I. Introduction

The HSCRC quality-based payment methodologies are important policy tools with great potential to provide strong incentives for hospitals to improve their quality performance over time. Each of the current policies for quality-based payment programs holds revenue at risk directly related to specified performance targets.

- The Quality Based Reimbursement (QBR) program employs measures in several domains, namely clinical process of care, patient experience, outcomes and safety similar to the Medicare Value Based Purchasing program (VBP). Since the beginning of the program financial adjustments have been based on revenue neutral scaling of hospitals in allocating rewards and reductions based on performance, with the net increases in rates for better performing hospitals funded by net decreases in rates for poorer performing hospitals.[1] The distribution of rewards/penalties have been based on relative points achieved by the hospitals and are not known before the end of performance period.

- The Maryland Hospital Acquired Conditions (MHAC) program measures hospital performance using potentially preventable complications observed to expected ratios compared to statewide benchmarks for each complication and revenue allocations are performed using pre-established performance targets. The revenue at risk and reward structure is based on a tiered approach that requires statewide targets to be met for higher rewards and lower reductions.

- The Readmission Reduction Incentive Program (RRIP) policy initiated in RY 2015 is designed to be a positive incentive program to reward hospitals that achieve a specified readmission reduction target. The statewide target is established to eliminate the gap between the national Medicare readmission rate and Maryland Medicare readmission rate. For RY 2017, staff is proposing to strengthen this program by increasing the amount of revenue at risk and including both rewards and reductions.[2]

- In addition to the three programs where hospital performance is measured for base and performance periods, two additional quality payment adjustments are implemented to hospital revenues prospectively. The Readmission Shared Savings Program reduces each hospital's approved revenues prospectively based on its risk adjusted readmission rates. Potentially Avoidable Utilization efficiency reductions are applied to global budgets to reduce allowed volume growth based on percent of revenue associated with potentially avoidable utilization for each hospital.

[1] The term "scaling" refers to the differential allocation of a pre-determined portion of base regulated hospital revenue contingent on assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or reductions (negative scaled amounts) are then applied to each hospital's revenue on a "one-time" basis (and not considered permanent revenue).

[2] Please see "Final Recommendation for Updating the Hospital Readmission Reduction Incentive Program for Rate Year (RY) 2017" for details.

This final recommendation proposes changes for the amount of hospital revenue at-risk and scaling methodologies for the following programs: 1. Quality-Based Reimbursement; 2. Maryland Hospital Acquired Conditions; and, 3. Readmission Reduction Incentive Program.

The Shared Savings for Readmissions Policy[3] and Potentially Avoidable Utilization global budget efficiency reductions that also hold revenue at risk based on performance are determined annually commensurate with the hospital rate update factor process.

II. Background

Maryland has been a leader in initiating quality based payment approaches. Historically, these programs have surpassed the requirements of similar federal programs and as a result Maryland has been exempt from the federal programs. When Maryland entered into the All-Payer Model Agreement with CMS effective January 1, 2014, the continuing exemption process was addressed in the Agreement. The Agreement requires that the proportion of Maryland hospitals' revenues held at risk for quality programs be equal to or greater than the proportion of revenue that is held at risk under national Medicare programs. The objective of this requirement is two-fold: a) incentivize hospitals to deliver high quality care in support of the Triple Aim of better care, better health, and lower cost, and b) evaluate the extent to which Maryland quality programs are rewarding value as compared to those of the national Medicare program. The relevant agreement language is as follows.

> *Regulated Revenue at risk: [Maryland] must ensure that the aggregate percentage of Regulated Revenue at risk for quality programs administered by the State is equal to or greater than the aggregate percentage of revenue at risk under national Medicare quality programs. Quality programs include, but are not limited to, readmissions, hospital acquired conditions, and value-based purchasing programs.*

It is important to note that under the All-Payer Model Agreement, Maryland is required to achieve specific reduction targets in total cost of hospital care, potentially preventable conditions, and readmissions in addition to its revenue at risk requirement. In an effort to meet these reduction targets, Maryland restructured its quality programs in such a way that financial incentives are established prior to the performance period in order to motivate quality improvement and sharing of best practices while holding hospitals accountable for their performance.

For RY 2016 following maximum amounts of revenue at-risk were already approved by the Commission:

- QBR: 1% maximum penalty, with revenue neutral scaled rewards up to 1%.
- MHAC—4%maximum penalty if statewide improvement target is not met; 1% maximum penalty and revenue neutral rewards up to 1% if statewide improvement target is met.
- RRIP—0.5% positive incentive for any hospital that improves all payer readmission rate by at least 6.76%.

During the upcoming annual revenue update process for RY 2016, HSCRC staff expects that two additional quality adjustments will be applied. The following adjustments were applied in RY2015 rates:

[3] For the Readmission Shared Savings adjustment, the HSCRC calculates a case mix adjusted readmission rate for each hospital for the base period and determines a statewide required percent reduction in readmission rates to achieve the revenue for shared savings. Current policy is posted at: http://hscrc.maryland.gov/init-shared-savings.cfm

- Readmissions Shared Savings Program—A savings of 0.4% total hospital revenue (approximating an average 0.60% and maximum reduction of 0.86% of inpatient revenue) based on risk adjusted readmission levels.
- PAU Reduction Program—A reduction of allowed revenue for volume increases associated with potentially avoidable utilization that had a maximum revenue reduction of 0.86% and an average reduction of 0.30% of inpatient revenue.

III. Assessment

a. Aggregate Revenue At-Risk Comparison with Medicare Programs

Currently staff is in discussions with CMMI regarding the methodology for comparing the Maryland aggregate amount of revenue at risk and the national Medicare aggregate amount-at-risk provided for in the Agreement. In addition to calculating maximum at risk ("potential risk"[4]), CMMI staff expressed a need to measure the actual revenues impacted by the programs ("realized risk"). Discussions on "realized risk" are in progress.

CMMI staff proposed that measurement of both the potential and realized aggregate percentage of revenue at-risk occur annually across all quality programs comparing the State fiscal year (July 1 – June 30) to the Federal fiscal year (October 1 – September 30). For example, Maryland's SFY 2015 (July 2014 – June 2015) will be evaluated against CMS' FFY 2015 (October 2014 – September 2015). Some Maryland quality program adjustments are applied to both inpatient and outpatient revenue. For these programs, outpatient revenues at risk will be converted to an equivalent inpatient revenue base (Formula: percent of revenue at risk/percent inpatient revenue). Where applicable, both upside and downside risk will be considered. CMMI staff accepted to include all current measures, including PAUs in Maryland's aggregate at risk amount totals.

Based upon this proposal, Figure 1 shows the potential risk for each quality program and in aggregate for Maryland and Medicare, as well as the cumulative difference between Maryland and Medicare from 2014 to 2016.

[4] Potential risk is defined as maximum percentage of revenue that an individual hospital stands to gain or lose based on their performance within a given quality program.

Figure 1: Maryland Versus Medicare Quality Programs' Potential Revenue at Risk, 2014-2016

Maryland - Potential Inpatient Revenue at Risk absolute values

% Inpatient Revenue	SFY 2014	SFY 2015	SFY2016	SFY2017 (Proposed/ estimated)
MHAC	2.0%	3.0%	4.0%	**3.0%**
RRIP			0.5%	**2.0%**
QBR	0.50%	0.50%	1.00%	**2.0%**
Shared Savings[5]	0.41%	0.86%	***0.86%***	***0.86%***
GBR PAU:	0.50%	0.86%	***0.86%***	***0.86%***
MD Aggregate Maximum At Risk	3.41%	5.22%	7.22%	8.72%

Blue are estimated numbers based on current policy.

Medicare National - Potential IP revenue at risk absolute values

% IP Rev	FFY 2014	FFY 2015	FFY2016	FFY2017
HAC		1.00%	1.00%	1.00%
Readmits	2.00%	3.00%	3.00%	3.00%
VBP	1.25%	1.50%	1.75%	2.00%
Medicare Aggregate Maximum At Risk	3.25%	5.50%	5.75%	6.00%

Annual MD-US Difference	0.16%	-0.28%	1.47%	2.72%
Cumulative MD-US Difference			**1.19%**	**4.19%**

Staff discussed two alternative methods to measure realized risk with the CMMI. One option is to compare Maryland and Medicare hospital average percent revenue allocated in quality programs by taking the average of absolute value of revenue adjustments within each program. A second option is to calculate the total revenue adjustments as a percent of total inpatient revenue in the state by summing all absolute values in each program and dividing the result by the state total inpatient revenue. Staff calculated Maryland and Medicare percentages for FY2015 for these options (see Figure 2), revealing that Maryland is slightly above Medicare in terms of average absolute percent for FY2015. Since the payment adjustments are highly depended on hospital performance in the measurement period, it's not possible to calculate realized at risk totals for future years.

[5] Staff will consider the shared savings policy adjustment together with the new RRIP program in conjunction with the balanced update.

Figure 2. Maryland versus Medicare Quality Programs Realized Revenue at Risk, 2015

Maryland: (SFY 15)

%tile (FY 15)	MHAC	Readmits	QBR	GBR PAU	Sum with PAU
100%	0.13%	-0.08%	0.28%	0.00%	
75%	0.06%	-0.59%	0.08%	-0.14%	
50%	0.05%	-0.64%	0.01%	-0.29%	
25%	0.02%	-0.72%	-0.15%	-0.44%	
0%	-1.00%	-0.86%	-0.50%	-0.86%	
FY 15 Absolute % Average	**0.11%**	**0.64%**	**0.14%**	**0.29%**	**1.18%**
FY 15 Total Value Percent	**0.09%**	**0.67%**	**0.13%**	**0.22%**	**1.11%**

CMS National: (FFY 15)

%tile (FY 15)	HAC	Readmits	VBP	Sum
100%	0.00%	0.00%	1.06%	
75%	0.00%	-0.06%	0.15%	
50%	0.00%	-0.31%	0.00%	
25%	0.00%	-0.77%	-0.21%	
0%	-1.00%	-3.00%	-1.37%	
FY 15 Absolute % Average	**0.22%**	**0.52%**	**0.24%**	**0.97%**

b. Scaling Methodology Changes

i. Relative vs Preset Scaling

There is general agreement that the scaling methodologies for the quality programs should use a preset scale, and should not rank hospitals relative to each other based on the concurrent measurement scores; this is to provide predictable benchmarks, and to promote collaboration to improve quality of care. A similar change was already approved last year by the Commission for the RY 2016 MHAC program, and hospitals were never ranked for the RRIP as it was based on a fixed amount of reward for hospitals that achieved the readmission reduction target. Thus the only program currently using relative scaling is the QBR program, and staff has received positive feedback from both the payment models and performance measurement workgroups on changing the QBR program to a preset point scale for rate year 2017.

ii. Revenue Neutrality

Staff have also discussed with the workgroups changing the reward and penalty structures to not be revenue neutral. This change would mean the net aggregate impact of quality program adjustments may either be positive or negative. A methodology that requires revenue neutrality restricts the aggregate amount for the rewards to the aggregate amount collected through reductions in a given program. Commission approved removing this cap for RY 2017 MHAC program at the January 2015 meeting. Based on the preliminary analysis for results for RY 2016 MHAC, it is likely that, under the

revenue neutrality adjustment, hospitals that would receive rewards will receive 5% or less of the total reward they should have earned. Workgroup members discussed the impact of a revenue neutrality adjustment to the quality programs, specifically noting that limiting the rewards to the penalties collected does not recognize the efforts expended to achieve the performance levels for the better performing hospitals. Based upon these discussions, staff supports removing the cap on rewards for RY 2016 as well.

iii. Maximum Revenue at Risk Hospital Guardrail

As we increase the maximum revenue adjustments statewide, concerns have been raised about the potential for a particular hospital to receive large revenue reductions that may cause unmanageable financial risk for a particular hospital in the state. As hospitals improve quality in the state, the variation between individual hospitals is expected to lessen increasing the chances of a single hospital receiving maximum penalties from all programs. According to simulations staff performed, the maximum penalty one hospital may receive may go up as much as 4.4% of the inpatient revenue (Figure 3) in RY 2017 based on the proposed maximum revenues at risk. The summary results of these simulations are provided in the Appendix for each program. Similar to the risk corridors in other value-based purchasing programs, maximum penalty guardrail may be necessary to mitigate the detrimental financial impact of unforeseen large adjustments in Maryland programs. A statewide guardrail was put in place for the MHAC program for RY 2016 based on similar concerns last year. Given the increases in risk levels in other programs, a hospital specific guardrail will provide a better protection than a state-wide limit. As the state increases the revenues associated with the quality based programs and implements national benchmarks, the maximum revenue at risk guardrail will need to be updated in parallel.

Figure 3: Estimated Aggregate Impact of Maryland Quality Based Programs

		Statewide Total Penalties	Statewide Total Rewards	Net Revenue Impact
Program Specific Impact		**C1**	**C2**	**C1+C2 = C3**
MHAC Below Target	**L1**	-$123,076,937	$0	-$123,076,937
MHAC (8% Improvement)	**L2**	-$16,997,460	$3,906,130	-$13,091,330
RRIP (Continuous Scale)	**L3**	-$22,052,191	$15,492,625	-$6,559,566
QBR (Preset Scaling)	**L4**	-$25,015,762	$21,335,875	-$3,679,887
Net Impact				
MHAC (Below Target)	**L5**	-$136,615,973	$3,299,583	-$133,316,391
Percent Inpatient Revenue	**L6**	-1.5%	0.0%	-1.5%
Percent Total Revenue	**L7**	-0.9%	0.0%	-0.9%
Maximum Hospital Specific Adjustment	**L8**	**-4.4%**	**2.0%**	
MHAC (8% Improvement)	**L9**	-$39,716,213	$16,385,430	-$23,330,783
Percent Inpatient Revenue	**L10**	-0.4%	0.2%	-0.3%
Percent Total Revenue	**L11**	-0.3%	0.1%	-0.2%
Maximum Net Impact as Percent Inpatient	**L12**	**-2.5%**	**2.4%**	

IV. Recommendations

Based upon the above assessment, current quality results for CY2014 YTD, and discussions with CMMI on our quality programs, staff's position and rationale for revenue amounts at-risk and scaling methodology for RY2017 are outlined below. Staff is determining the maximum at risk amounts according to the specifics of each program and ensuring that we fulfill the requirements of the contract rather than using the Medicare aggregate amounts at risk as the target amounts for value-based purchasing.

1. **QBR**: 2% maximum penalty.

   This matches Medicare's VBP program and increases the incentive for hospitals to improve HCAHPS scores, which continue to be low compared to the Nation. Staff recommend that a preset scale be used, and that rewards and penalties not be revenue neutral starting with RY 2017 results.

2. **MHAC**: 3%maximum penalty if statewide improvement target is not met; 1% maximum penalty and up to 1% if statewide improvement target is met.

   The reduction from 4% to 3% recognizes the improvements that were made in CY2014, but continues to place a significant amount of revenue at-risk to ensure continued quality improvement

3. Staff recommends removing the revenue neutrality requirement for the rate year RY 2016 to recognize the large improvements in PPCs achieved by the hospitals during this performance period.

4. **RRIP**: 2% scaled maximum penalty and 1% reward for hospitals that reduce readmission rates at or better than the minimum improvement.

   The decision to add reductions and increase potential rewards is based on staff and stakeholder concerns regarding the CY2014 YTD improvement.

5. **Maximum penalty guardrail:** Hospital maximum penalty guardrail to be set at 3.5% of total revenue for RY2017.

   Staff used Medicare aggregate amount at risk total as the benchmark for calculating hospital maximum penalty guardrail (e.g. 6% x %Percent Inpatient Revenue).

Appendix 1: RRIP Modeling Results for RY 2017

2. Readmission Reduction Program Modeling for FY2017									RRIP Proposed Scaling for FY2017		
HOSPITAL ID	HOSPITAL NAME	CY 13 YTD Risk Adjusted Readmission Rate	PERCENT CHANGE in CY 14 IN RISK ADJUSTED RATE	FY16 Scaling	FY16 Reward	CY 15 ESTIMATED CUMULATIVE REDUCTION	TARGET	Over/Under Target	FY 17 Scaling	FY 17 Adjustment	Revenue Savings from Reductions
A	B	D	F	H	I	J	L	M	N	O	Q
210045	MCCREADY	11.53%	-22.16%	0.50%	$18,673	**-26.7%**	-9.5%	-17.2%	1.00%	$37,346	$114,747
210013	BON SECOURS	18.45%	-15.69%	0.50%	$391,064	**-20.6%**	-9.5%	-11.1%	1.00%	$782,128	$2,966,426
210028	ST. MARY	12.21%	-15.09%	0.50%	$347,602	**-20.0%**	-9.5%	-10.5%	1.00%	$695,203	$1,696,075
210051	DOCTORS COMMUNITY	12.37%	-13.23%	0.50%	$681,127	**-18.2%**	-9.5%	-8.7%	1.00%	$1,362,254	$3,074,119
210039	CALVERT	9.41%	-12.52%	0.50%	$336,926	**-17.6%**	-9.5%	-8.1%	0.92%	$621,982	$1,113,914
210030	CHESTERTOWN	13.37%	-11.86%	0.50%	$147,083	**-16.9%**	-9.5%	-7.4%	0.85%	$250,607	$666,505
210024	UNION MEMORIAL	13.91%	-10.41%	0.50%	$1,212,528	**-15.6%**	-9.5%	-6.1%	0.70%	$1,686,873	$5,252,823
210055	LAUREL REGIONAL	13.18%	-9.59%	0.50%	$387,510	**-14.8%**	-9.5%	-5.3%	0.61%	$470,350	$1,511,973
210063	UM ST. JOSEPH	11.42%	-9.06%	0.50%	$1,081,676	**-14.3%**	-9.5%	-4.8%	0.55%	$1,190,190	$3,535,780
210011	ST. AGNES	13.40%	-8.81%	0.50%	$1,195,608	**-14.1%**	-9.5%	-4.6%	0.52%	$1,251,767	$4,509,573
210018	MONTGOMERY GENERAL	12.06%	-8.55%	0.50%	$438,261	**-13.8%**	-9.5%	-4.3%	0.49%	$433,863	$1,461,955
210008	MERCY	14.07%	-8.30%	0.50%	$1,165,818	**-13.6%**	-9.5%	-4.1%	0.47%	$1,092,139	$4,460,399
210040	NORTHWEST	14.09%	-8.15%	0.50%	$710,934	**-13.5%**	-9.5%	-4.0%	0.45%	$643,411	$2,695,390
210003	PRINCE GEORGE	10.00%	-7.36%	0.50%	$886,216	**-12.7%**	-9.5%	-3.2%	0.37%	$650,508	$2,252,404
210012	SINAI	13.60%	-7.02%	0.50%	$2,145,773	**-12.4%**	-9.5%	-2.9%	0.33%	$1,418,519	$7,230,111
210038	UMMC MIDTOWN	15.99%	-6.54%	0.00%	$0	**-11.9%**	-9.5%	-2.4%	0.28%	$372,249	$2,551,708
210044	G.B.M.C.	10.63%	-6.53%	0.00%	$0	**-11.9%**	-9.5%	-2.4%	0.28%	$559,435	$2,555,145
210023	ANNE ARUNDEL	12.06%	-6.37%	0.00%	$0	**-11.8%**	-9.5%	-2.3%	0.26%	$805,997	$4,400,852
210017	GARRETT COUNTY	7.03%	-6.08%	0.00%	$0	**-11.5%**	-9.5%	-2.0%	0.23%	$42,880	$151,333
210029	HOPKINS BAYVIEW MED CTR	14.57%	-5.56%	0.00%	$0	**-11.0%**	-9.5%	-1.5%	0.17%	$615,946	$5,717,315
210056	GOOD SAMARITAN	13.63%	-5.11%	0.00%	$0	**-10.6%**	-9.5%	-1.1%	0.12%	$225,290	$2,609,338
210034	HARBOR	12.88%	-4.87%	0.00%	$0	**-10.4%**	-9.5%	-0.9%	0.10%	$121,813	$1,654,675
210048	HOWARD COUNTY	11.77%	-4.86%	0.00%	$0	**-10.3%**	-9.5%	-0.8%	0.10%	$161,876	$2,037,839
210062	SOUTHERN MARYLAND	11.35%	-3.53%	0.00%	$0	**-9.1%**	-9.5%	0.4%	-0.05%	-$76,309	$1,683,664
210027	WESTERN MARYLAND HEALTH SYS	11.91%	-3.03%	0.00%	$0	**-8.6%**	-9.5%	0.9%	-0.10%	-$184,589	$1,895,597
210043	BALTIMORE WASHINGTON MEDIC	13.66%	-3.01%	0.00%	$0	**-8.6%**	-9.5%	0.9%	-0.10%	-$229,520	$2,622,108
210057	SHADY GROVE	10.79%	-2.90%	0.00%	$0	**-8.5%**	-9.5%	1.0%	-0.11%	-$260,981	$2,098,281
210058	REHAB & ORTHO	11.64%	-2.48%	0.00%	$0	**-8.1%**	-9.5%	1.4%	-0.16%	-$110,068	$652,199
210022	SUBURBAN	10.89%	-2.35%	0.00%	$0	**-8.0%**	-9.5%	1.5%	-0.17%	-$314,171	$1,577,347
210061	ATLANTIC GENERAL	11.42%	-2.33%	0.00%	$0	**-8.0%**	-9.5%	1.5%	-0.18%	-$67,929	$351,397
210002	UNIVERSITY OF MARYLAND	13.80%	-1.94%	0.00%	$0	**-7.6%**	-9.5%	1.9%	-0.22%	-$1,881,126	$9,055,047
210015	FRANKLIN SQUARE	12.66%	-1.88%	0.00%	$0	**-7.5%**	-9.5%	2.0%	-0.22%	-$639,789	$2,727,485
210033	CARROLL COUNTY	11.77%	-1.46%	0.00%	$0	**-7.1%**	-9.5%	2.4%	-0.27%	-$372,061	$1,162,586
210060	FT. WASHINGTON	12.41%	-1.13%	0.00%	$0	**-6.8%**	-9.5%	2.7%	-0.30%	-$54,143	$150,866
210009	JOHNS HOPKINS	13.95%	-0.46%	0.00%	$0	**-6.2%**	-9.5%	3.3%	-0.38%	-$4,878,181	$11,186,553
210032	UNION HOSPITAL OF CECIL COUN	9.97%	-0.14%	0.00%	$0	**-5.9%**	-9.5%	3.6%	-0.41%	-$279,210	$399,301
210006	HARFORD	10.99%	-0.10%	0.00%	$0	**-5.9%**	-9.5%	3.6%	-0.42%	-$196,225	$303,137
210049	UPPER CHESAPEAKE HEALTH	11.27%	0.66%	0.00%	$0	**-5.1%**	-9.5%	4.4%	-0.50%	-$742,075	$863,459
210010	DORCHESTER	10.86%	0.90%	0.00%	$0	**-4.9%**	-9.5%	4.6%	-0.52%	-$131,821	$134,203
210005	FREDERICK MEMORIAL	10.37%	1.77%	0.00%	$0	**-4.1%**	-9.5%	5.4%	-0.62%	-$1,171,437	$805,182
210001	MERITUS	11.18%	2.61%	0.00%	$0	**-3.3%**	-9.5%	6.2%	-0.71%	-$1,328,446	$693,233
210019	PENINSULA REGIONAL	10.66%	3.23%	0.00%	$0	**-2.7%**	-9.5%	6.8%	-0.78%	-$1,811,871	$679,724
210035	CHARLES REGIONAL	11.46%	4.82%	0.00%	$0	**-1.2%**	-9.5%	8.3%	-0.95%	-$722,556	$107,621
210016	WASHINGTON ADVENTIST	10.79%	4.95%	0.00%	$0	**-1.1%**	-9.5%	8.4%	-0.96%	-$1,553,168	$193,395
210004	HOLY CROSS	11.03%	5.88%	0.00%	$0	**-0.2%**	-9.5%	9.3%	-1.06%	-$3,392,679	$79,569
210037	EASTON	10.44%	12.21%	0.00%	$0	**5.7%**	-9.5%	15.2%	-1.74%	-$1,653,836	-$567,760
		--									
	STATE	**12.45%**	**-3.84%**		**$ 11,146,798**	**-7.7%**	-9.5%			**$ (6,559,566)**	**$ 103,074,594**
	Penalties									$ (22,052,191)	
	Rewards									$ 15,492,625	

CY 14 is based on Jan-October Data

CY15 reductions are estimated to be the same as CY14.

Revenue estimates are based on FY15.

Appendix 2: QBR Scaling Modeling Results for RY 2017

HOSPID	HOSPITAL NAME	Estimated Inpatient Revenue (FY15*2.6%)	QBR FINAL POINTS*	FY 17 Proposed Scaling %	Fy 2017 Proposed Scaling $
A	B	C	D	E	C*E= F
210062	Southern Maryland Hospital Center	$ 163,208,213	0.050	-2.00%	-$3,264,164
210003	Prince Georges Hospital Center	$ 177,243,165	0.110	-1.68%	-$2,979,837
210048	Howard County General Hospital	$ 167,386,497	0.230	-1.04%	-$1,746,915
210013	Bon Secours Hospital	$ 78,212,787	0.251	-0.93%	-$730,176
210019	Peninsula Regional Medical Center	$ 233,728,496	0.269	-0.84%	-$1,956,368
210044	Greater Baltimore Medical Center	$ 201,533,345	0.279	-0.79%	-$1,583,193
210029	Johns Hopkins Bayview Medical Cente	$ 356,396,901	0.285	-0.75%	-$2,678,042
210055	Laurel Regional Hospital	$ 77,501,975	0.294	-0.70%	-$544,137
210060	Fort Washington Medical Center	$ 17,776,133	0.295	-0.70%	-$124,129
210022	Suburban Hospital	$ 181,410,188	0.310	-0.62%	-$1,122,192
210001	Meritus Hospital	$ 187,434,497	0.310	-0.62%	-$1,159,458
210040	Northwest Hospital Center	$ 142,186,717	0.316	-0.59%	-$836,376
210057	Shady Grove Adventist Hospital	$ 228,731,775	0.320	-0.57%	-$1,293,393
210018	Montgomery General Hospital	$ 87,652,208	0.335	-0.49%	-$425,785
210011	St. Agnes Hospital	$ 239,121,556	0.335	-0.49%	-$1,161,572
210015	Franklin Square Hospital Center	$ 285,691,170	0.345	-0.43%	-$1,236,001
210016	Washington Adventist Hospital	$ 161,698,669	0.367	-0.31%	-$508,634
210024	Union Memorial Hospital	$ 242,505,500	0.374	-0.28%	-$669,791
210033	Carroll Hospital Center	$ 138,209,278	0.380	-0.25%	-$340,930
210004	Holy Cross Hospital	$ 319,596,342	0.400	-0.14%	-$448,760
210056	Good Samaritan Hospital	$ 180,861,011	0.405	-0.11%	-$205,909
210061	Atlantic General Hospital	$ 38,640,762	0.426	0.00%	$0
210012	Sinai Hospital	$ 429,154,679	0.446	0.07%	$302,433
210038	Maryland General Hospital	$ 133,787,811	0.451	0.09%	$119,716
210035	Civista Medical Center	$ 76,338,049	0.455	0.11%	$80,358
210034	Harbor Hospital Center	$ 124,002,220	0.469	0.16%	$192,535
210032	Union of Cecil	$ 67,852,189	0.482	0.21%	$139,280
210002	University of Maryland Hospital	$ 863,843,449	0.484	0.21%	$1,828,715
210039	Calvert Memorial Hospital	$ 67,385,287	0.491	0.24%	$161,370
210049	Upper Chesapeake Medical Center	$ 148,917,096	0.495	0.25%	$376,216
210043	Baltimore Washington Medical Center	$ 223,155,126	0.495	0.25%	$563,766
210005	Frederick Memorial Hospital	$ 189,480,763	0.500	0.27%	$513,598
210037	Memorial Hospital at Easton	$ 94,828,132	0.509	0.31%	$289,472
210030	Chester River Hospital Center	$ 29,416,674	0.539	0.41%	$121,539
210051	Doctors Community Hospital	$ 136,225,391	0.540	0.42%	$570,000
210027	Western MD Regional Medical Center	$ 184,484,266	0.589	0.60%	$1,106,900
210008	Mercy Medical Center	$ 233,163,594	0.609	0.67%	$1,568,340
210017	Garrett County Memorial Hospital	$ 18,724,074	0.611	0.68%	$127,128
210023	Anne Arundel Medical Center	$ 310,117,075	0.615	0.69%	$2,154,509
210006	Harford Memorial Hospital	$ 47,089,618	0.632	0.76%	$356,893
210009	Johns Hopkins Hospital	$ 1,292,515,919	0.634	0.76%	$9,864,012
210010	Dorchester General Hospital	$ 25,127,935	0.647	0.81%	$203,891
210028	St. Mary's Hospital	$ 69,520,305	0.698	1.00%	$695,203
	Statewide Total	$8,671,856,840			-$3,679,887
* Based on FY2015 Scores.		Minimum Score	0.05	Total Penalty	-25,015,762
		Median Score	0.43		
		Maxium Score	0.70	Total Rewards	21,335,875

				Scenario 1: Scaling for Below State Quality Target				io 2: Scaling for Exceed Target		
Hospital ID	Hospital Name	Estimated Inpatient Revenue (FY15*2.6%)	Base FY2014 Score	Projected MHAC SCORE For Performance Year with 5 % Improvement	% Adjustment	$ Adjustment	Adjusted Amounts	Projected MHAC SCORE For Performance Year with 8 % Improvement	% Adjustment	$ Adjustment
A	B	C	D	E	F	C*F= G	G/adj ratio = H	I	J	C*J = K
210019	peninsula regional	$233,728,496	0.19	0.22	-2.56%	$ (5,980,700)	$ (2,177,225)	0.27	-0.58%	$ (1,363,416)
210004	holy cross	$319,596,342	0.21	0.22	-2.56%	$ (8,177,906)	$ (2,977,100)	0.27	-0.58%	$ (1,864,312)
210022	suburban	$181,410,188	0.2	0.23	-2.47%	$ (4,481,899)	$ (1,631,599)	0.27	-0.58%	$ (1,058,226)
210062	southern maryland	$163,208,213	0.23	0.24	-2.38%	$ (3,888,196)	$ (1,415,466)	0.29	-0.50%	$ (816,041)
210044	g.b.m.c.	$201,533,345	0.25	0.27	-2.12%	$ (4,267,765)	$ (1,553,645)	0.31	-0.42%	$ (839,722)
210048	howard county	$167,386,497	0.24	0.27	-2.12%	$ (3,544,655)	$ (1,290,403)	0.31	-0.42%	$ (697,444)
210009	johns hopkins	$1,292,515,919	0.25	0.29	-1.94%	$ (25,090,015)	$ (9,133,816)	0.32	-0.38%	$ (4,846,935)
210002	university of maryland	$863,843,449	0.25	0.29	-1.94%	$ (16,768,726)	$ (6,104,518)	0.33	-0.33%	$ (2,879,478)
210024	union memorial	$242,505,500	0.28	0.29	-1.94%	$ (4,707,460)	$ (1,713,712)	0.33	-0.33%	$ (808,352)
210033	carroll county	$138,209,278	0.29	0.31	-1.76%	$ (2,438,987)	$ (887,893)	0.35	-0.25%	$ (345,523)
210023	anne arundel	$310,117,075	0.29	0.32	-1.68%	$ (5,199,022)	$ (1,892,661)	0.36	-0.21%	$ (646,077)
210043	baltimore washington medica	$223,155,126	0.3	0.32	-1.68%	$ (3,741,130)	$ (1,361,928)	0.37	-0.17%	$ (371,925)
210051	doctors community	$136,225,391	0.32	0.34	-1.50%	$ (2,043,381)	$ (743,876)	0.38	-0.13%	$ (170,282)
210040	northwest	$142,186,717	0.33	0.36	-1.32%	$ (1,881,883)	$ (685,084)	0.40	-0.04%	$ (59,244)
210012	sinai	$429,154,679	0.33	0.37	-1.24%	$ (5,301,323)	$ (1,929,903)	0.40	-0.04%	$ (178,814)
210034	harbor	$124,002,220	0.35	0.37	-1.24%	$ (1,531,792)	$ (557,636)	0.40	-0.04%	$ (51,668)
210016	washington adventist	$161,698,669	0.34	0.36	-1.32%	$ (2,140,129)	$ (779,097)	**0.41**	0.00%	$ -
210049	upper chesapeake health	$148,917,096	0.33	0.37	-1.24%	$ (1,839,564)	$ (669,678)	0.41	0.00%	$ -
210063	um st. joseph	$216,335,128	0.34	0.37	-1.24%	$ (2,672,375)	$ (972,856)	0.41	0.00%	$ -
210001	meritus	$187,434,497	0.36	0.38	-1.15%	$ (2,149,984)	$ (782,684)	0.41	0.00%	$ -
210005	frederick memorial	$189,480,763	0.36	0.38	-1.15%	$ (2,173,456)	$ (791,229)	0.42	0.00%	$ -
210011	st. agnes	$239,121,556	0.36	0.39	-1.06%	$ (2,531,875)	$ (921,709)	0.42	0.00%	$ -
210018	montgomery general	$87,652,208	0.37	0.39	-1.06%	$ (928,082)	$ (337,861)	0.42	0.00%	$ -
210008	mercy	$233,163,594	0.38	0.40	-0.97%	$ (2,263,058)	$ (823,848)	0.44	0.00%	$ -
210010	dorchester	$25,127,935	0.4	0.40	-0.97%	$ (243,889)	$ (88,786)	0.44	0.00%	$ -
210027	western maryland health syste	$184,484,266	0.38	0.41	-0.88%	$ (1,627,802)	$ (592,588)	0.44	0.00%	$ -
210055	laurel regional	$77,501,975	0.40	0.41	-0.88%	$ (683,841)	$ (248,947)	0.45	0.00%	$ -
210015	franklin square	$285,691,170	0.38	0.41	-0.88%	$ (2,520,804)	$ (917,678)	0.46	0.00%	$ -
210057	shady grove	$228,731,775	0.42	0.45	-0.53%	$ (1,210,933)	$ (440,830)	0.48	0.00%	$ -
210038	ummc midtown	$133,787,811	0.44	0.46	-0.44%	$ (590,240)	$ (214,872)	0.49	0.00%	$ -
210006	harford	$47,089,618	0.48	0.49	-0.18%	$ (83,099)	$ (30,252)	**0.51**	0.03%	$ 15,697
210037	easton	$94,828,132	0.45	0.48	-0.26%	$ (251,016)	$ (91,380)	0.52	0.07%	$ 63,219
210058	rehab & ortho	$69,104,846	0.47	0.49	-0.18%	$ (121,950)	$ (44,395)	0.53	0.10%	$ 69,105
210032	union hospital of cecil count	$67,852,189	0.49	**0.51**	0.00%	$ -	$ -	0.54	0.13%	$ 90,470
210039	calvert	$67,385,287	0.48	0.51	0.00%	$ -	$ -	0.55	0.17%	$ 112,309
210003	prince george	$177,243,165	0.50	0.52	0.00%	$ -	$ -	0.55	0.17%	$ 295,405
210017	garrett county	$18,724,074	0.50	0.53	0.00%	$ -	$ -	0.57	0.23%	$ 43,690
210056	good samaritan	$180,861,011	0.52	0.54	0.00%	$ -	$ -	0.57	0.23%	$ 422,009
210029	hopkins bayview med ctr	$356,396,901	0.55	0.58	0.00%	$ -	$ -	0.60	0.33%	$ 1,187,990
210028	st. mary	$69,520,305	0.55	0.58	0.00%	$ -	$ -	0.61	0.37%	$ 254,908
210060	ft. washington	$17,776,133	0.55	0.58	0.00%	$ -	$ -	0.61	0.37%	$ 65,179
210061	atlantic general	$38,640,762	0.58	0.59	0.00%	$ -	$ -	0.62	0.40%	$ 154,563
210035	charles regional	$76,338,049	0.59	0.61	0.00%	$ -	$ -	0.63	0.43%	$ 330,798
210013	bon secours	$78,212,787	0.64	0.65	0.00%	$ -	$ -	0.68	0.60%	$ 469,277
210030	chestertown	$29,416,674	0.81	0.82	0.00%	$ -	$ -	0.84	1.00%	$ 294,167
210045	mccready	$3,734,618	1	1	0.00%	$ -	$ -	1.00	1.00%	$ 37,346
Total		$ 8,961,031,432				$ (123,076,937)	$ (44,805,157)			$ (13,091,330)
Penalty						-$123,076,937	-$44,805,157			**-$16,997,460**
% Inpatient										**-0.2%**
Reward						$0	$0			**$3,906,130**
Overall Limit for Reductions as % of Statewide Total Inpatient Revenue						**-0.50%**				
Overall Limit for Reductions as $						**-$44,805,157**				
Adjustment Ratio							2.7469			

Appendix IV: MHAC, QBR and RRIP Consolidated Modeling Results for RY 2017

ID	Hospital Name	Estimated Inpatient Revenue (FY15*2.6%)	MHAC (Below Target)	MHAC (Above Target)	QBR	RRIP	Net Impact (Below Target)		Net Impact (Above Target)	
210019	peninsula regional	$233,728,496	-2.56%	-0.58%	-0.84%	-0.78%	-4.17%	$ (9,748,939)	-2.2%	$ (5,131,655)
210004	holy cross	$319,596,342	-2.56%	-0.58%	-0.14%	-1.06%	-3.76%	$ (12,019,345)	-1.8%	$ (5,705,751)
210062	southern maryland	$163,208,213	-2.38%	-0.50%	-2.00%	-0.05%	-4.43%	$ (7,228,668)	-2.5%	$ (4,156,514)
210016	washington adventist	$161,698,669	-1.32%	0.00%	-0.31%	-0.96%	-2.60%	$ (4,201,931)	-1.3%	$ (2,061,802)
210001	meritus	$187,434,497	-1.15%	0.00%	-0.62%	-0.71%	-2.47%	$ (4,637,888)	-1.3%	$ (2,487,904)
210022	suburban	$181,410,188	-2.47%	-0.58%	-0.62%	-0.17%	-3.26%	$ (5,918,262)	-1.4%	$ (2,494,590)
210048	howard county	$167,386,497	-2.12%	-0.42%	-1.04%	0.10%	-3.06%	$ (5,129,694)	-1.4%	$ (2,282,483)
210033	carroll county	$138,209,278	-1.76%	-0.25%	-0.25%	-0.27%	-2.28%	$ (3,151,978)	-0.8%	$ (1,058,514)
210005	frederick memorial	$189,480,763	-1.15%	0.00%	0.27%	-0.62%	-1.49%	$ (2,831,295)	-0.3%	$ (657,839)
210049	upper chesapeake health	$148,917,096	-1.24%	0.00%	0.25%	-0.50%	-1.48%	$ (2,205,423)	-0.2%	$ (365,859)
210037	easton	$94,828,132	-0.26%	0.07%	0.31%	-1.74%	-1.70%	$ (1,615,380)	-1.4%	$ (1,301,145)
210044	g.b.m.c.	$201,533,345	-2.12%	-0.42%	-0.79%	0.28%	-2.63%	$ (5,291,523)	-0.9%	$ (1,863,480)
210035	charles regional	$76,338,049	0.00%	0.43%	0.11%	-0.95%	-0.84%	$ (642,198)	-0.4%	$ (311,400)
210009	johns hopkins	$1,292,515,919	-1.94%	-0.38%	0.76%	-0.38%	-1.56%	$ (20,104,183)	0.0%	$ 138,897
210002	university of maryland	$863,843,449	-1.94%	-0.33%	0.21%	-0.22%	-1.95%	$ (16,821,137)	-0.3%	$ (2,931,889)
210010	dorchester	$25,127,935	-0.97%	0.00%	0.81%	-0.52%	-0.68%	$ (171,819)	0.3%	$ 72,070
210060	ft. washington	$17,776,133	0.00%	0.37%	-0.70%	-0.30%	-1.00%	$ (178,272)	-0.6%	$ (113,093)
210024	union memorial	$242,505,500	-1.94%	-0.33%	-0.28%	0.70%	-1.52%	$ (3,690,378)	0.1%	$ 208,730
210015	franklin square	$285,691,170	-0.88%	0.00%	-0.43%	-0.22%	-1.54%	$ (4,396,594)	-0.7%	$ (1,875,789)
210040	northwest	$142,186,717	-1.32%	-0.04%	-0.59%	0.45%	-1.46%	$ (2,074,849)	-0.2%	$ (252,210)
210003	prince george	$177,243,165	0.00%	0.17%	-1.68%	0.37%	-1.31%	$ (2,329,329)	-1.1%	$ (2,033,924)
210057	shady grove	$228,731,775	-0.53%	0.00%	-0.57%	-0.11%	-1.21%	$ (2,765,307)	-0.7%	$ (1,554,374)
210055	laurel regional	$77,501,975	-0.88%	0.00%	-0.70%	0.61%	-0.98%	$ (757,628)	-0.1%	$ (73,787)
210043	baltimore washington medi	$223,155,126	-1.68%	-0.17%	0.25%	-0.10%	-1.53%	$ (3,406,884)	0.0%	$ (37,679)
210018	montgomery general	$87,652,208	-1.06%	0.00%	-0.49%	0.49%	-1.05%	$ (920,004)	0.0%	$ 8,078
210011	st. agnes	$239,121,556	-1.06%	0.00%	-0.49%	0.52%	-1.02%	$ (2,441,680)	0.0%	$ 90,195
210032	union hospital of cecil cou	$67,852,189	0.00%	0.13%	0.21%	-0.41%	-0.21%	$ (139,930)	-0.1%	$ (49,461)
210034	harbor	$124,002,220	-1.24%	-0.04%	0.16%	0.10%	-0.98%	$ (1,217,444)	0.2%	$ 262,680
210063	um st. joseph	$216,335,128	-1.24%	0.00%	0.00%	0.55%	-0.69%	$ (1,482,185)	0.6%	$ 1,190,190
210012	sinai	$429,154,679	-1.24%	-0.04%	0.07%	0.33%	-0.83%	$ (3,580,370)	0.4%	$ 1,542,138
210051	doctors community	$136,225,391	-1.50%	-0.13%	0.42%	1.00%	-0.08%	$ (111,127)	1.3%	$ 1,761,972
210023	anne arundel	$310,117,075	-1.68%	-0.21%	0.69%	0.26%	-0.72%	$ (2,238,516)	0.7%	$ 2,314,428
210013	bon secours	$78,212,787	0.00%	0.60%	-0.93%	1.00%	0.07%	$ 51,952	0.7%	$ 521,229
210061	atlantic general	$38,640,762	0.00%	0.40%	0.00%	-0.18%	-0.18%	$ (67,929)	0.2%	$ 86,634
210006	harford	$47,089,618	-0.18%	0.03%	0.76%	-0.42%	0.16%	$ 77,570	0.4%	$ 176,365
210029	hopkins bayview med ctr	$356,396,901	0.00%	0.33%	-0.75%	0.17%	-0.58%	$ (2,062,096)	-0.2%	$ (874,107)
210038	ummc midtown	$133,787,811	-0.44%	0.00%	0.09%	0.28%	-0.07%	$ (98,275)	0.4%	$ 491,965
210008	mercy	$233,163,594	-0.97%	0.00%	0.67%	0.47%	0.17%	$ 397,420	1.1%	$ 2,660,479
210027	western maryland health sy	$184,484,266	-0.88%	0.00%	0.60%	-0.10%	-0.38%	$ (705,492)	0.5%	$ 922,311
210045	mccready	$3,734,618	0.00%	1.00%	0.00%	1.00%	1.00%	$ 37,346	2.0%	$ 74,692
210056	good samaritan	$180,861,011	0.00%	0.23%	-0.11%	0.12%	0.01%	$ 19,381	0.2%	$ 441,390
210039	calvert	$67,385,287	0.00%	0.17%	0.24%	0.92%	1.16%	$ 783,353	1.3%	$ 895,662
210030	chestertown	$29,416,674	0.00%	1.00%	0.41%	0.85%	1.27%	$ 372,146	2.3%	$ 666,313
210058	rehab & ortho	$69,104,846	-0.18%	0.10%	0.00%	-0.16%	-0.34%	$ (232,018)	-0.1%	$ (40,964)
210017	garrett county	$18,724,074	0.00%	0.23%	0.68%	0.23%	0.91%	$ 170,008	1.1%	$ 213,698
210028	st. mary	$69,520,305	0.00%	0.37%	1.00%	1.00%	2.00%	$ 1,390,406	2.4%	$ 1,645,314
Total		**$ 8,961,031,432**								

Net Total Adjustment	$ (133,316,391)	$ (23,330,783)
Max Reduction	-4.4%	-2.5%
Percent Inpatient Rev	-1.5%	-0.3%
Percent Total Rev	-0.89%	-0.16%

Draft Recommendation on Funding of Statewide Infrastructure, and Planning of Regional Partnerships for Health System Transformation under BRFA of 2014

March 2015 Commission Meeting

Background--Funding to Support Implementation of All-Payer Model

- 2014 Budget Reconciliation and Financing Act established the option "to fund statewide or regional proposals that support the implementation of Maryland's all-payer model contract"
- Up to $15 million during FY 2015
- Funded through hospital rates

HSCRC's Infrastructure Focus

- HSCRC convened an Advisory Council to advise on implementation of new All-Payer Model
- Advisory Council indicated the need to focus first on meeting the new waiver tests, but to invest for the sustainability of the model. In particular, to focus on:
  - Physician alignment
  - High needs patients and related care coordination infrastructure
- 3 Approaches to use of Funds:
  - Regional Planning Grants
  - Statewide Infrastructure
  - Evaluation and Planning Resources

Statewide Infrastructure

- The Care Coordination WG has been considering options, priorities and costs for statewide infrastructure to support care coordination, transitions and management:
  - Building/securing a data infrastructure to facilitate identification of individuals who would benefit from care coordination
  - Encourage patient-centered care and patient engagement including sharing common information regarding patient care among providers and care coordinators
  - Encouraging collaboration among providers (including social services, behavioral health, long-term care, post-acute care providers), patient advocates, public health, faith-based initiatives
  - Connect providers to CRISP

Planning Grants for Regional Partnerships for Health System Transformation

- Regional approach is needed to assure focus on needs, patient centered focus, and coordination of resources between hospitals, physicians and community health
- DHMH and HSCRC released an RFP for funding to support planning, development initiatives, and operational plans for regional partnerships for health system transformation
- Proposal should include developing care coordination and population health priorities, determining what resources are needed and available, and how resources and strategies should be deployed – particular for high needs patients
- Application due April 15, 2015
- Grants of up to $400,000 for 5 or more proposals
- A review Committee will make recommendations to the Commission on proposals to select

Evaluation and Planning

- In October 2015, as part of the a CRISP funding recommendation, the Commission approved using $1 million of the BRFA funding for consulting and expert resources to develop:
  - Provider alignment initiatives
  - Care coordination initiatives
  - Determine infrastructure needs
- This work is ongoing and has brought us close to conclusion on care coordination recommendations, and continuing development of provider alignment strategies

Recommendation

- Staff Recommends increasing hospital rates in May and June of 2015 to provide up to $15 million to support:
  - Planning grants for regional partnerships for health system transformation (up to $2.5 million)
  - Common care coordination infrastructure to provide support on a Statewide basis for specific opportunities to improve care coordination and chronic condition management(up to $12 million)
  - The existing engagement of resources to assist (in conjunction with stakeholders) in further evaluation and planning of possible statewide infrastructure and approaches for care coordination and provider alignment ($1 million)
- More detail on statewide strategies and regional proposals will be available at the April Meeting

Draft Recommendation:

Funding of Statewide Infrastructure, and Planning of Regional Partnerships for Health System Transformation under the Budget Reconciliation and Financing Act of 2014

March 11, 2015

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

This is a draft recommendation to be presented at the March 11, 2015 HSCRC public meeting. A final recommendation is expected to be presented at the April 15, 2015 meeting. Please submit any comments on or before April 3, 2015 to Steve Ports at Steve.Ports@Maryland.gov.

Funding of Statewide Infrastructure, and Planning of Regional Partnerships for Health System Transformation under the Budget, Reconciliation, and Financing Act of 2014

Overview

In accordance with the provisions of the Budget Reconciliation and Financing Act of 2014 (BRFA), this recommendation is to authorize Commission staff to increase rates (in FY 2015) effective May 1, 2015 to provide up to $15 million for the purpose of funding the planning of regional partnerships for health system transformation throughout the State, along with statewide infrastructure to support care management, transitions, coordination, and planning.

Background

During the 2014 Legislative Session, the General Assembly adopted the BRFA of 2014. This legislation provides that the Health Services Cost Review Commission ("HSCRC" or "Commission") may include an additional $15,000,000 in hospital revenue when determining hospital rates that are effective in fiscal year 2015 for the purpose of:

> (1) Assisting hospitals in covering costs associated with the implementation of Maryland's all–payer model contract; or
>
> (2) Funding of statewide or regional proposals that support the implementation of Maryland's all–payer model contract.

Statewide or regional proposals for funding are to be submitted to the Commission and the Department of Health and Mental Hygiene ("the Department" or "DHMH") for approval. The Department and the Commission are required to establish a committee to review regional proposals and make recommendations to the Department and the Commission for funding. The review committee is required to include representatives from the Department and the Commission as well as subject matter experts, including individuals with expertise in areas such as public health, community–based health care services and support, primary care, long–term care, end–of–life care, behavioral health, and health information technology.

The Commission may take action on a statewide or regional proposal that has been reviewed by the committee and approved by the Commission and the Department.

Rate Adjustment Request

Beginning in late 2013, the HSCRC convened an Advisory Council to develop Guiding Principles for implementation of the new All Payer Model. The Advisory Council put forth its Final Report on January 31, 2014.

The Advisory Council indicated that HSCRC should work with providers, payers, and consumers to analyze data for identifying opportunities that would improve patient care and health outcomes. In particular, patients with complex medical needs and chronic conditions, who are frequent users of the health care system, can be appropriately identified without infringing on their confidentiality rights, and they can be targeted for better care coordination and health improvement.

The recommendations of the Advisory Council are summarized below:

- Focus on meeting early Model requirements (Note: including through hospitals being on global budgets supported by multi-disciplinary care coordination especially for high-risk Medicare fee-for-service patients, to enable meeting the state-wide ceilings and Medicare savings requirements
- Meet budget targets while making important investments in infrastructure and providing flexibility for private sector innovation
- HSCRC should play the roles of regulator, catalyst and advocate
- Consumers should be involved in planning and implementation
- Physician and other provider alignment is essential
- An ongoing, transparent public engagement process is needed

In the Advisory Council meetings, members advised that care coordination is an area in which we should focus attention on models that have demonstrated success rather than on many untested and different strategies. The Data and Infrastructure Work Group and Physician Alignment and Engagement Work Group recommended considering shared infrastructure and common approaches to care coordination. Based on this advice, the HSCRC's goal is to facilitate consideration of some shared infrastructure and common approaches that might limit confusion and improve effectiveness for providers and patients.

Subsequently, the Care Coordination Work Group was created and has been discussing opportunities that can best provide success in meeting the all-payer model requirements. From the deliberations thus far, it is clear that access to robust data and

improved care coordination are considered major factors in success. This success will require hospitals, community-based providers, long-term care, and post-acute care providers to work together to effectively coordinate patient care, reducing the need for hospitalizations.

Below are three proposed uses of BRFA funds that are designed to reach the goals of improving regional collaboration for care coordination, improving statewide infrastructure to enable proven care coordination strategies to be successful, and providing evaluation and planning resources.

Planning Grants for Regional Partnerships for Health System Transformation

In order to improve population health, it is essential that regional collaborations develop across the State. Enabling Maryland's health care system to be highly reliable, highly efficient, and a point of pride in our communities will require increased collaboration between health systems, payers, community hospitals, ambulatory physician practices, long-term care providers, and many other community-based organizations. It will also require effectively engaging patients and consumers.

In order to achieve these goals and to pave a way for success of the All-Payer Model, the Department, in collaboration with the HSCRC, released a Request for Proposals ("RFP") on February 9, 2015 for funding to support planning, development initiatives, and operational plans for regional partnerships for health system transformation. Applications are due by April 15, 2015.

The RFP invites proposals to develop partnerships capable of identifying and addressing their regional needs and priorities and, in turn, shaping the future of health care in Maryland. The proposals should include developing care coordination and population health priorities, determining what resources are needed and available, and how resources and strategies should be deployed. While the model concept itself should focus on particular patient populations (e.g., patients with multiple chronic conditions and high resource use, frail elders with support requirements, dual-eligibles with high resource needs), the proposals may include a strategy for improving overall population health in the region over the long-term, with particular attention paid to reducing risk factors. This population health strategy should incorporate and build upon those existing population health action plans developed by Local Health Improvement Coalitions together with Community Health Needs Assessments, and

expand to address chronic conditions and frail elders, and other specific resource needs relevant to aging populations that are proven or expected to move Maryland toward meeting the goals and requirements of the All-Payer Model.

Under the RFP, DHMH and HSCRC will provide a maximum of $400,000 for each approved application. The application process will be competitive, with five or more awards being made in the State. It is anticipated that up to a total of $2.5 million will be used to fund selected proposals. Some areas of the State may require more time to prepare for this undertaking or may benefit from joining forces with other applicants. Funding will be allocated via HSCRC-approved rate increases for hospitals participating in partnerships that receive awards. For this reason, applications are to be submitted by a hospital in consultation with partner organizations. Individual applicant partners may be included in more than one application due to the nature of the process.

The evaluation committee will provide preference to those models that include the following characteristics/features:

- A comprehensive, diverse set of partners with standing in the region
- Multiple target high-cost conditions/populations, with initial focus on Medicare
- Integrating primary care, prevention, and addressing multiple determinants of health
- Sustainability concept that builds on the All Payer Model and other delivery/financing models

Successful bidders are required to submit an interim report to the Department and HSCRC by September 1, 2015, and a final report is due on December 1, 2015.

Funding of Common Care Coordination Infrastructure to Provide Support on a Statewide Basis

The Care Coordination Work Group has been considering statewide, regional and provider-based strategies to improve care coordination, transitions, management, and planning. The Work Group to date has clearly expressed that access to meaningful, actionable data is one important tool to achieve effective care coordination. The Work Group has identified a two-track approach for using data to inform and support care coordination:

Track 1 – Use Existing Data Sources: First, it is important to use information from *existing data sources* that could be used to identify patients with the most complex medical needs. These data would include data currently available through CRISP such as real time Hospital Admit, Discharge, and Transfer (ADT), hospital inpatient and outpatient data available on a monthly basis through the HSCRC abstract, and potentially other clinical data available through CRISP. Additionally, other sources of data should be evaluated for possible use in these efforts, including: pharmacy data obtained from pharmacy benefit managers (PBMs), Outcome and Assessment Information Set (OASIS) data on home care, Minimum Data Set (MDS) records on nursing home care, and other information sources.

Track 2 – Acquire Medicare data: On a parallel track, Maryland should take steps as soon as possible to acquire Medicare claims data under its existing CMMI grant. Medicare data that include physician encounters as well as skilled nursing facility and other post-acute providers linked with hospital data, clinical data, ADT, and HSCRC abstract data will create powerful tools for care coordination.

The Work Group is currently considering opportunities for investment in care coordination. One of the sources of such investment is utilization of the funds referred to in BRFA. Some of the potential priorities for such funding include:

- Building/securing a data infrastructure to facilitate identification of individuals who would benefit from care coordination
- Encourage patient-centered care and patient engagement including sharing common information regarding patient care among providers and care coordinators
- Encouraging collaboration among providers (including social services, behavioral health, long-term care, post-acute care providers), patient advocates, public health, faith-based initiatives
- Connect providers to CRISP

The Work Group is continuing to consider, prioritize, and quantify the cost of these functions. The Work Group anticipates providing more detail on such strategies and recommendations prior to the April Commission meeting. Staff anticipate that up to

$12 million may be used for this purpose, based on recommendations of the Work Group.

Evaluation and Planning Resources

On October 15, 2014, the Commission approved a staff recommendation to increase rates of approximately $1 million to fund consulting and expert resource needs to support more detailed planning, evaluation, and stakeholder input relative to provider alignment and care coordination initiatives and infrastructure needs through CRISP. Under a Memorandum of Understanding with CRISP, the vendors obtained under this recommendation have been critical in bringing the Care Coordination Work Group activities to their current level of progression, as well as in considering options, challenges, and barriers for establishing regional integrated care networks in Maryland. The October recommendation specifically stated that BRFA funds should be used to support this activity, since it is directly related to supporting statewide and regional planning and infrastructure.

The approved October recommendation provided that the planning and implementation funding shall reduce the amount of BRFA funding available for implementation of the All-Payer Model from $15 million to $14 million. This is because the HSCRC will have allocated revenue capacity to implement a planning and implementation process that is needed to ensure stakeholder and public input into the approach that will be recommended to the Commission.

The Maryland Hospital Association supported this funding approach but has advocated for caution to ensure that funded activities benefit hospitals in the implementation of the new All-Payer Model. HSCRC staff agrees with this cautious approach, and we have focused our recommendations to limit resource allocation to those activities that result from the recommendations of the Advisory Council, the Work Groups, and public input received during the planning process.

Draft Recommendation

Based on the above, HSCRC staff recommends that hospital rates be increased in FY 2015 beginning May 1, 2015 to provide up to $15 million to support:

- Planning grants for regional partnerships for health system transformation (up to $2.5 million) - Rates will be increased only for those hospitals that are part of a collaborative RFP chosen by the review committee and approved by the Department and the Commission pursuant to the process outlined in the RFP.

- Common care coordination infrastructure to provide support on a statewide basis for specific opportunities to improve care coordination and chronic condition management (up to $12 million) – Rates will be increased for all or a subset of hospitals to support this activity.

- The existing engagement of resources to assist (in conjunction with stakeholders) in further evaluation and planning of possible statewide infrastructure and approaches for care coordination and provider alignment ($1 million) - Rates will be increased for all or a subset of hospitals to support this activity.

Refinement of the allocation of funds to projects that support common care coordination infrastructure will be provided in further detail at the April Commission meeting.

The Maryland Health Care Quality Reports

Vision, Strategy & Execution

A Briefing to the Health Services Cost Review Commission

Theressa Lee, Director, Center for Quality Measurement and Reporting

March 11, 2015

The Mission

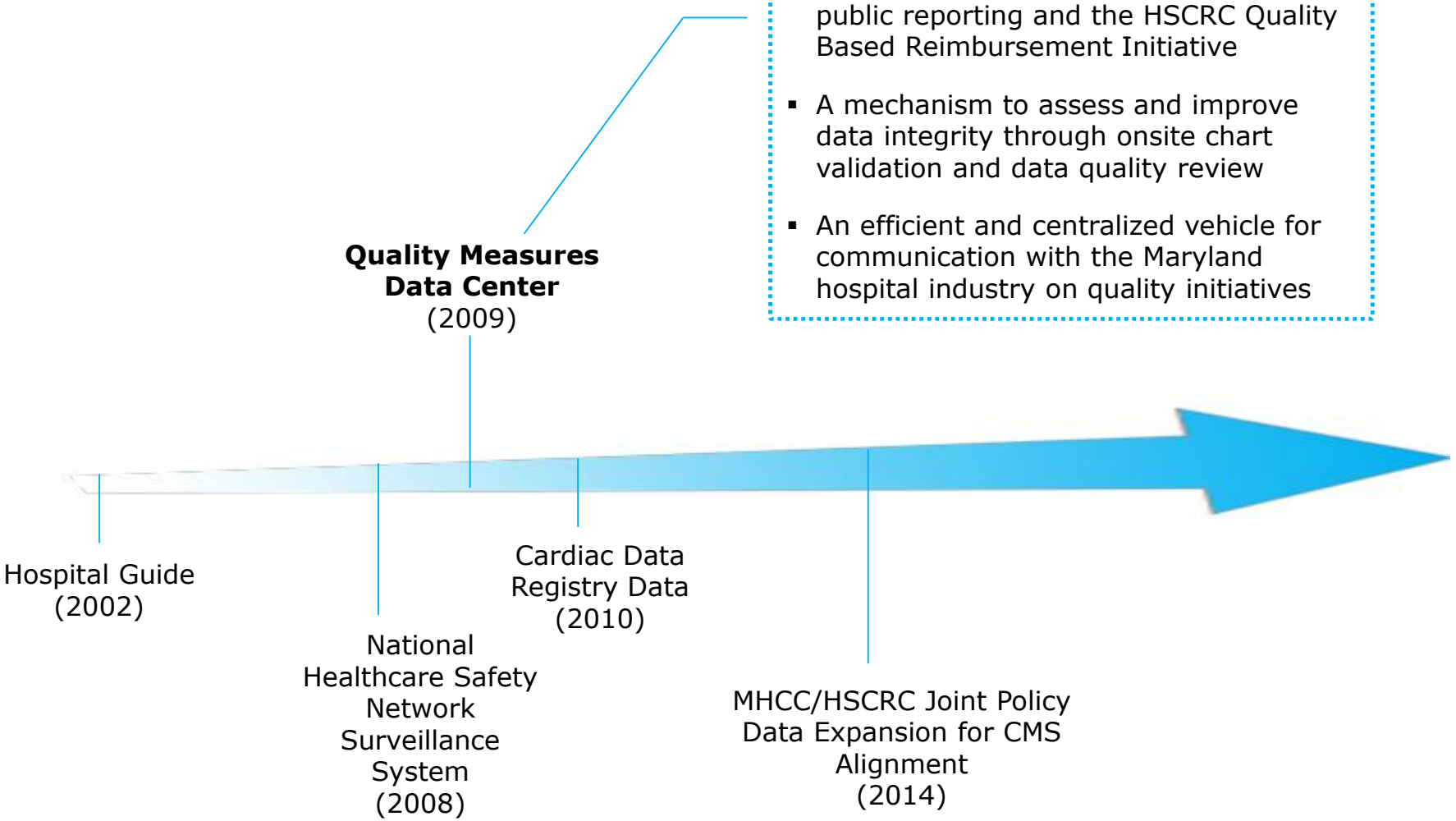
Establish a comprehensive, integrated online resource that enables consumers to access meaningful, timely, and accurate healthcare information reported by healthcare providers and payers in Maryland

Presentation Outline

- The Hospital Performance Evaluation System
- The *new* Maryland Health Care Quality Reports website
- Transforming the MHCC System for Quality Data Reporting
  - Collaboration
  - Consumer Outreach

The Hospital Performance Evaluation System

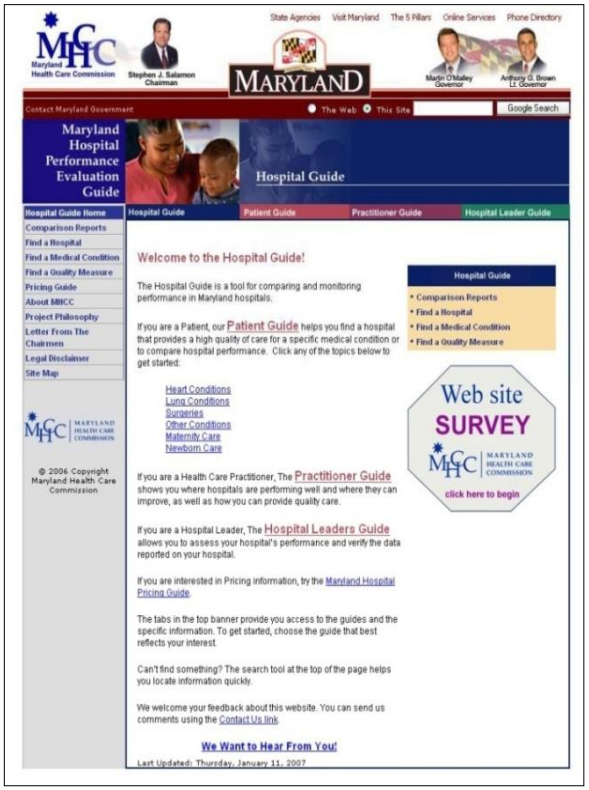
- A web-based tool for hospitals to report and preview quality measures and patient experience data collected for public reporting and the HSCRC Quality Based Reimbursement Initiative
- A mechanism to assess and improve data integrity through onsite chart validation and data quality review
- An efficient and centralized vehicle for communication with the Maryland hospital industry on quality initiatives



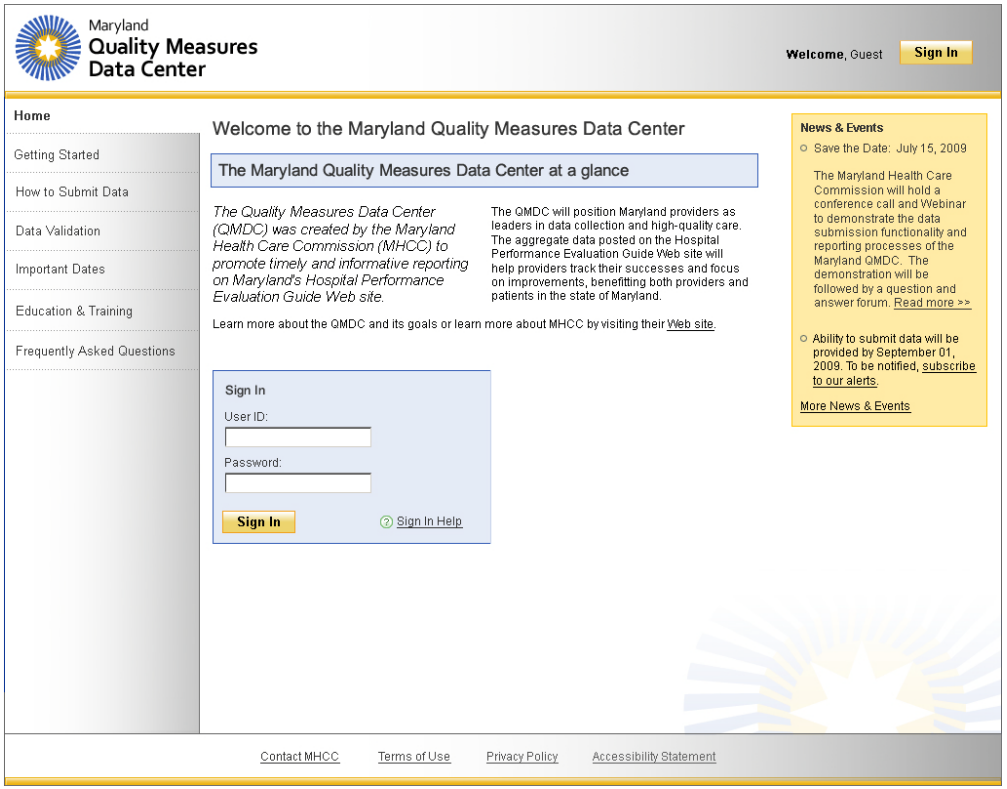
The Hospital Performance Evaluation System

Existing ("old") System

Hospital Guide



Quality Measures Data Center



Maryland Health Care Quality Reports

A Single Point of Access to Information About Health Care Quality ("new" system)

One platform to …

- Eliminate parallel processing system for measures calculation
- Address the evolving data needs of the HSCRC / Medicare Waiver Modernization Project
- Strengthen the role of the Consumer
- Enhance communication with hospitals
- Utilize current technology
- Integrate other data sets
- Create the framework to include additional provider settings – "The Maryland Health Care Quality Reports"

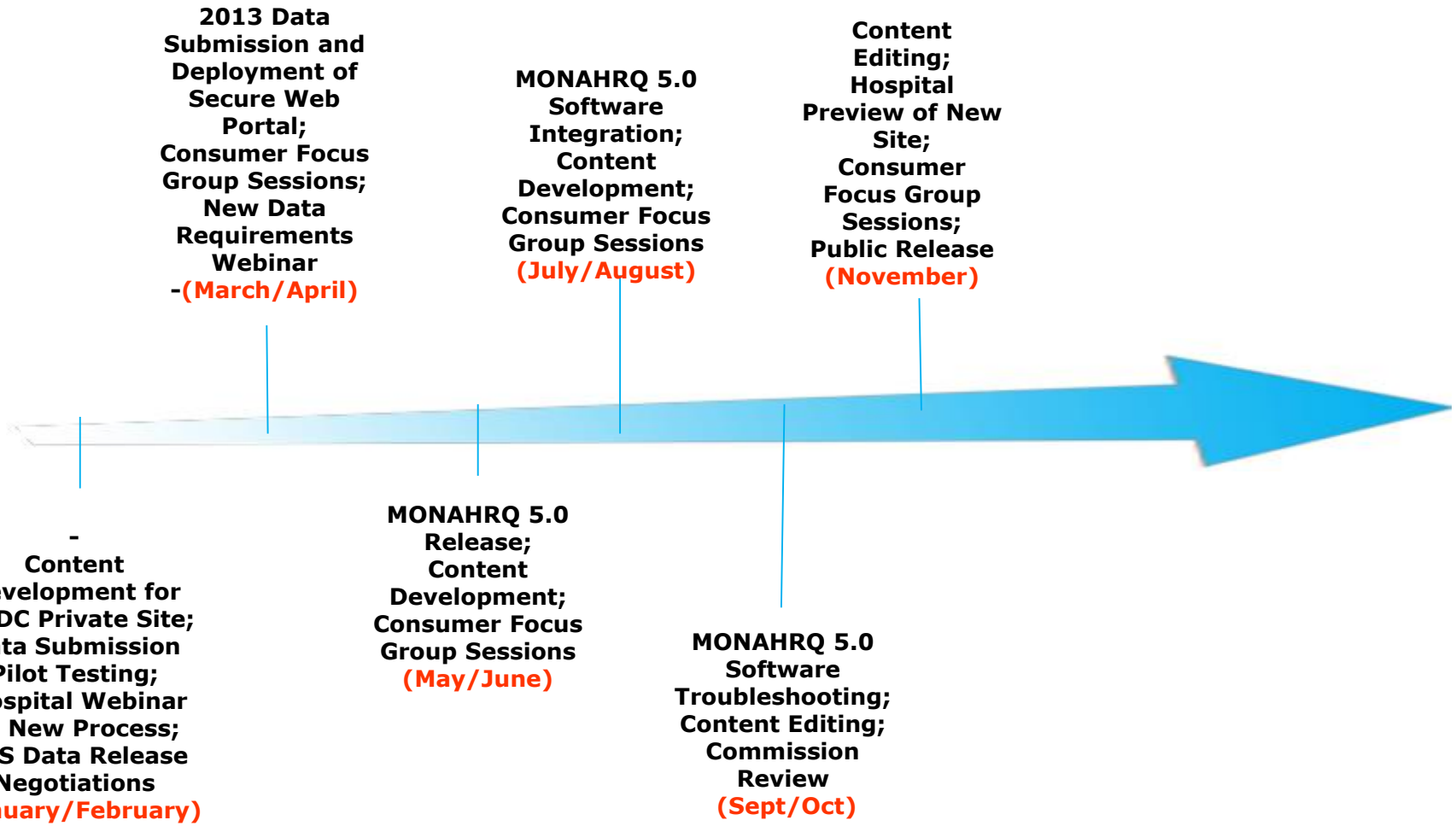
The Maryland Health Care Quality Reports

- Lays the foundation for a more integrated and interactive public reporting system focusing on information for the consumer audience
- Establishes a platform and infrastructure for expansion to other provider settings and Health Plan information
- Includes new updated hospital performance and pricing data
- Supports flexible content management -- the system can evolve over time

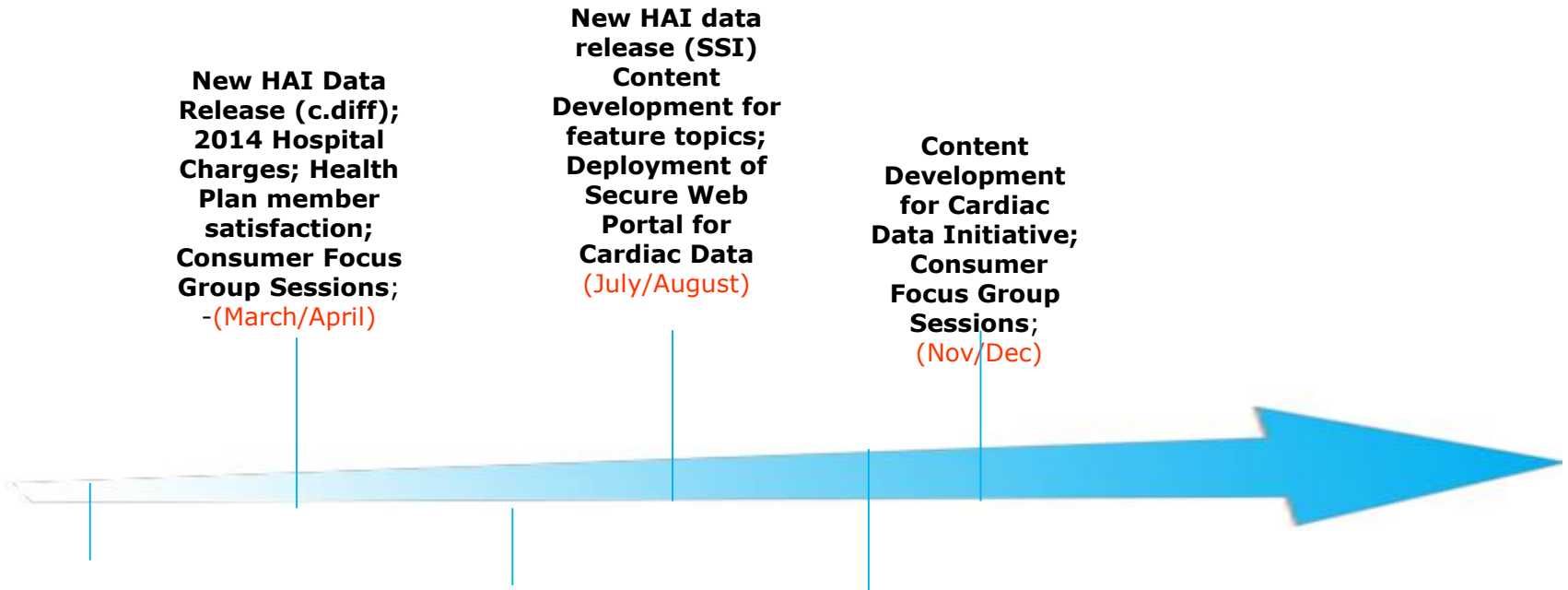
Collaboration and Consumer Engagement

- Health Services Cost Review Commission
  - Support for streamlined quality measures data processing
  - Sharing of Price transparency methodology
  - Quality measures align with new hospital payment model
- CMS -- Approval of data sharing protocol
- Agency for Healthcare Research and Quality (AHRQ) – integration of MONAHRQ quality reporting
- Consumer Engagement
  - Consumer involvement throughout the development process
  - Ongoing review of content, new design, format and functionality

2014 Milestones



2015 Objectives



Demonstration

Update on Work Groups

March 11, 2015

Consumer Engagement Task Force
Consumer Outreach and Education Task Force
Cost of Defensive Medicine
Care Coordination Work Group

HSCRC
Health Services Cost Review Commission

Health Services Cost Review Commission

Consumer Engagement Task Force

Update

Leni Preston, Chair

11 March 2015

Task Force: Members

- Linda Aldoory, Herschel Horowitz Center for Health Literacy, UMD
- Barbara Brookmyer, Frederick County Health Officer
- Kim Burton, Mental Health Association of Maryland
- Michelle Clark*, Maryland Rural Health Association
- Tammy Bresnahan, AARP
- Shannon Hines, Kaiser Permanente MAS
- Donna Jacobs, University of Maryland Medical System
- Michelle LaRue*, CASA DE MARYLAND
- Karen Ann Lichtenstein*, The Coordinating Center
- Susan Markley*, HealthCare Access Maryland
- Doug Rose, formerly volunteer with Equality Maryland [Invited]
- Suzanne Schlattman, Maryland Citizens Health Initiative
- Hillery Tsumba*, Primary Care Coalition of Montgomery County
- Gary Vogan*, Holy Cross Hospital

* indicates member of Charge #1 Subgroup – also includes Novella Tascoe, Keswick Multi-Care Center

Task Force: Charge #1

- Health literacy and Consumer Engagement (HL/CE) within the context of the New All-Payer Model (NAPM) and related reform initiatives, for example Community Integrated Home Model (CIHM). The primary charge is to provide a rationale for HL/CE, with core principles and, from that, define the audiences, identify the messages, and based upon that, propose education and communication strategies as appropriate. This work should reflect the outcomes from both the Communications & Community Outreach (C&CO) task force and other workgroups, principally Care Coordination (CC).

Task Force: Charge #2

- Consumer Communications related to implementation of the New All-Payer Model. This work would address avenues/strategies to provide consumers with ways to: (i) engage with decision makers, regulators, etc. on the impact on individual and/or community health issues of the design and implementation of the reform initiatives and principally the NAPM; and (ii) ensure an appropriate and consumer-friendly communications process for those directly impacted by the NAPM's goals.

Consumer Engagement: Definitions & Principles

Definitions

- Consumers & Consumer Engagement
- Community & Community Engagement

Principles

- Participation
- Person-centered
- Accessible and Inclusive
- Partnership
- Diversity
- Mutual Respect and Value
- Support
- Influence
- Continuous Improvement

Operational Plan: Tasks & Timelines

- Define the Charges *Jan. – Feb.*
- Research Phase (MD & National) *Jan. – June*
- Communications Strategy: *Feb. - May*
  - Audience/Stakeholders
  - Proposed Messages – including Timing
  - Strategies for Dissemination
- Preparation of Final Report with Communications Strategic Plan *July – Sept.*

Communications Strategy: NAPM Message Dissemination

- Audience/Stakeholders
  - High Utilizers
  - Dual Eligibles
  - Medicare Beneficiaries
- Stakeholder Categories
  - Health Care Providers – Hospitals, etc.
  - Social Service Providers & Agencies
  - Community-Based & Civic Organizations
  - Consumer Policy & Advocacy Organizations
  - Elected Officials & Decision Makers
  - Businesses, “Influencers” & Others

Questions

- Leni Preston – leni@mdchcr.org
- Tiffany Tate – tiffany_tate@msn.com
- Dianne Feeney – dianne.feeney@maryland.gov

Update from Consumer Outreach and Education Task Force

Vincent DeMarco
Steve Raabe

Consumer Outreach and Education Workgroup:
Interim Report

March 2015

The Consumer Outreach and Education Workgroup endeavors to educate community leaders about trends in health system transformation efforts underway in Maryland. Our accomplishments to date are detailed below:

- Commissioned OpinionWorks LLC to conduct five independent focus groups with consumers in different regions of the state to learn more about attitudes and perceptions of hospital care and proposed health system transformation under the modernized Medicare all-payer hospital waiver.
- The report from these focus groups has been presented to all key stakeholders in an effort to facilitate consistent and effective messaging to maximize consumer engagement in support of health system transformation efforts.
- Findings from the report informed our approach to planning a series of public forums to spur discussions about local and regional responses to population health with community leaders. Five forums have been conducted to date in Carroll County, Howard County, Lower Shore and Mid Shore and Prince George's County. Materials and recordings of these forums are available online at www.healthcareforall.com. At least five more forums will be held in the coming months.
- Over 350 community leaders have participated in these forums to date. Feedback from these forums indicate that the public is eager for more information about how to support efforts that will help our health care system function more efficiently. They are especially interested in a proposed Faith Community Health Network to organize and align all available resources in the community to achieve population health goals.

Maryland Citizens' Health Initiative Education Fund, Inc.
Health Care for All! Coalition
2600 St. Paul Street, Baltimore, MD 21218
(410)235-9000
www.healthcareforall.com

- Maryland Citizens' Health Initiative Education Fund, Inc.
- **Maryland Hospital Waiver**
- ***Consumer Perspective***

OPINIONWORKS
PUBLIC SPIRITED RESEARCH

Maryland Hospital Waiver
Focus Group Method

5 Groups

- Columbia (October 29)
- Easton (October 30)
- Baltimore (Urban, people of color; November 5)
- Baltimore (Suburban, Caucasian; November 5)
- Bowie (November 6)

120-minute sessions, professionally facilitated

Tested:

1. Attitudes, Perceptions of Hospital Care
2. Reaction to Waiver Concept
3. Hopes and Worries

Maryland Hospital Waiver

Consumer Audience B

- Older and chronically ill, or caregivers
- Experience with inpatient hospital care and scheduled procedures
- Higher baseline satisfaction with hospital care
- Translates into concern about change

The Waiver Concept

"Global Budget"

"Lump Sum"

Audience

B=Concerned

Community-Based Care

=

Privacy Concerns

Maryland Hospital Waiver

The Waiver Concept: History

- 37 years
- Since the Waiver was first introduced
- $45 billion
- Saved under the Waiver

- What I Like Best about the Waiver...?
- Proactive. Not Reactive

Maryland Hospital Waiver

Testing Ideas: Top Tier: Practicalities

"The hospital will make sure you have your prescriptions in hand before you leave the hospital."

"After patients leave the hospital, they will get more of the help they need to remain healthy and stay out of the hospital – like clear instructions about medicines and the name and phone number of someone to call if they need help."

Consumers Appreciate a Watchdog.

- **Monitor budgets**
- **Watch for abuse**
- **Protect consumers**
- **Make sure hospitals have what they need.**

Recommendations

Maryland Hospital Waiver

Recommendations

1. Look forward, not back.
   - Is this old or new?
   - But I thought it was started in the 1970s.
   - Where's my $45 billion?!

"Proactive. Not Reactive."

Recommendations

2. De-emphasize the payment model.
   - Global budget concept raises worries.
   - Forces consumers to contemplate what hospitals are *not* going to do.
   - Blocks our ability to converse with consumers.

"Better outcomes for patients."

Maryland Hospital Waiver

Recommendations

3. Emphasize the practicalities.
   - Prescription in hand.
   - Knowing who to call.
   - Consumers' real world.

Don't be a wonk.

Recommendations

4. Emphasize coordination of care.
   - Consumers like knowing hospitals will be part of a larger plan to coordinate care.
   - It's attractive that more care will be provided by a primary care provider.
5. Be mindful of privacy concerns
   - Consumers want strict limits on sharing.
   - Want to feel like they are in control.

Recommendations

6. Identify a watchdog.
   - Pacifying effect on skeptical consumers.
   - It may take them some time to believe it.
7. Partner with the Faith Community
   - Deep trust in faith leaders.
   - Strong bonds within families of faith.
   - Helps navigate confusing health system.

Maryland Hospital Waiver

Key Concepts & Language

Better outcomes for patients.

Giving hospitals a stake in helping people stay healthy.

Easier for consumers to navigate the health care system.

Putting consumers in control.

Always protecting patients' privacy.

Expanding the network of support people need to get well and stay healthy.

Ensuring that hospitals have the resources to deliver the level of care patients need.

Presentation on Defensive Medicine

March 11, 2015

Diane E. Hoffmann, JD, MS
Professor of Law
Director, Law & Health Care Program
University of Maryland Carey School of Law

Bradley Herring, PhD
Associate Professor of Health Economics
Department of Health Policy and Management
Johns Hopkins Bloomberg School of Public Health

Prepared for the Maryland Health Services Cost Review Commission

Scope of Work

- Research – conduct a literature review
- Report and Analysis
  - Define defensive medicine
  - Examine:
    - Extent to which health care costs (with a focus on hospital costs) related to defensive medicine
    - Extent to which tort reform impacts hospital costs related to defensive medicine
    - How DM may impact the growth in the cost and quality of hospital care in Maryland and implications for the Commission's ability to manage cost growth under the New All-Payer model.

Background/context/approach

- Controversial nature of issue
  - Often tied to tort reform
- In part, explains varying results; range of estimates of cost of defensive medicine to health care system
- Our approach – looked to reports by government agencies, peer reviewed articles in recognized academic journals
- Screened out potentially biased studies and studies that were poorly designed and unlikely to yield reliable results
- Collected available data – Maryland ADR Office, NPDB
- Interviews with hospital medical malpractice insurers

Measuring Defensive Medicine

- Three methodological approaches to measuring cost and impact of defensive medicine:
  - (A) Direct physician surveys, e.g., Does fear or threat of malpractice liability influence whether you use additional diagnostic or therapeutic procedures?
  - (B) Physician clinical scenario surveys, e.g., give physicians a clinical scenario and ask them to choose specified clinical actions and then ask them what influenced their choices
  - (C) Statistical analyses of the impact of malpractice liability risk (as measured by whether a physician has been sued, premiums, tort reforms) on utilization of one or more procedures –e.g. caesarean sections

Source: OTA Report, p. 41

Study Limitations:

- Results of direct physician surveys "*highly suspect . . . Because they invariably prompt[ed] responding physicians to consider malpractice liability as a factor in their practice choices." OTA*
- Scenarios – so specific can't be generalized
- Statistical studies – look at differences between physician practices based on liability risk but cannot provide a baseline estimate of the extent of defensive medicine. Represent a lower bound.

OTA Report (1994)– Selected findings

- Physicians are very conscious of the risk of being sued and tend to overestimate that risk. A large number of physicians believe that being sued will adversely affect their professional, financial and emotional status.

- Defensive medicine is a real phenomenon that has a discernible influence in certain select clinical situations. E.g., Caesarian deliveries in childbirth and the management of head injuries in emergency rooms.*

OTA Report – Selected Findings

- "Effect of tort reforms on defensive medicine practice "are largely unknown and are likely to be small."

- "It is impossible to accurately measure the overall level and national cost of defensive medicine."
  - Limits to methods of measurement*

OTA Report – selected findings

- The fee-for-service system "both empowers and encourages physicians to practice very low risk medicine."

- Health care reform may change financial incentives toward doing fewer rather than more tests and procedures.

CBO - 2006

- CBO's 2006 Background Paper
- Looked at impact of five types of tort reforms on health care spending, including hospital spending.
- Significant findings:
  - Cap on noneconomic damages - reduce spending (1.6%)
  - Modification of J&S liability – increase spending (4.7%)
- *Results for hospital spending:* based on study most likely lower bound of extent of defensive medicine in hospital setting: 2.7%.

Other factors: Incentives and Payment Models

- Kessler and McClellan's 2002 *JPubEcon*
  - The effects of state tort reforms on Medicare heart disease patients' inpatient spending were concentrated in areas with low managed care enrollment. Concluded that "managed care and liability reform are substitutes"
- Avraham et al.'s 2012 *JLEO*
  - ". . . reductions [in healthcare premiums resulting from state tort reforms] are concentrated in PPOs rather than HMOs, suggesting that HMOs can reduce 'defensive' healthcare costs even absent tort reform."

- **What do national studies tell us about Maryland?**

Defensive Medicine in Maryland

- No specific studies of defensive medicine in Maryland
- How does Maryland compare in terms of medical malpractice claims (frequency and severity) when compared to other states?

Frequency and Severity of Claims

- Anecdotal reports from Maryland hospital and physician insurer:
  - Decline in the number of malpractice claims in last few years in Maryland and nationwide
  - Severity of payouts is higher
  - Value of injuries went up in Maryland and Nationally in FYs 11, 12 and 13
    - Mostly due to LTC related to catastrophic injuries, e.g. birth injuries

Implications for Maryland: Tort Reform

- Maryland is among states with cap on noneconomic damages and has not changed Joint and Several Liability rule
- Based on studies of impact of tort reform on DM Maryland may have a lower level of DM than national average
  - Caveats – (1) prior studies do not distinguish amount of cap; (2) claim severity in Maryland is higher than the national avg; (3) Maryland does not have cap on economic or total damages.

Implications for Maryland: Incentives and Payment Models

- Literature indicates that managed care is at least as effective as tort reform in reducing DM; HMOs can reduce DM even absent tort reform

- If reduction in costs to payment model rather than other approaches, such as utilization review, then Maryland's shift from a FFS model (with no volume constraint) to an overall global budget may reduce DM

.

Care Coordination Work Group Update

Steve Ports, HSCRC

February 27 Care Coordination WG Meeting

- CRISP presented on actions to date and feasibility of connecting ambulatory providers and facilities through the HIE
- Confirmed desire to take two track approach:
  - Use existing available data sets (including HIE and HSCRC data) to conduct risk stratification and identifying high-risk patients
  - Obtain provider access, in a secure and protected way, to confidential Medicare data for care coordination consistent with the All-payer model for defining patient-provider relationships, risk stratification, care management, and care planning.
- Agreed to have an additional meeting with the intent of reporting to the Commission in April

Efforts that Could be Facilitated with Statewide Infrastructure—Under Discussion

- Data infrastructure and sharing
  - Leverage existing data and new sources (Medicare) to support risk stratification and identification of individuals who would benefit from care coordination
- Care planning
  - Develop patient consent process and standard forms and education materials
  - Develop care plan elements that could be visualized through CRISP
  - Organize training, engagement, and activation approaches
- Encourage collaboration
  - Promote regional efforts to organize and avoid overlap of resources
  - Encourage community and volunteer efforts
  - Develop approaches for integrating care (mental and somatic, hospital and long term/post acute
- Connecting community based providers to CRISP
  - Need to set direction, determine funding sources, and begin work

Next Steps

- Prioritize and Cost out Infrastructure Needs
- Recommend use of BRFA funds and other resources
- Draft the Final Report
- Report to the Commission in April

Legislative Update – March 11, 2015

Budget Reconciliation Act of 2015 – SB 57/HB 72

These bills include several provisions relating to the Commission:

- Delay for one year, the provision added in the 2014 BRFA last year which requires the Commission and DHMH to calculate the savings to Medicaid resulting from the all-payer model and reduce that savings from the Medicaid deficit assessment each year.

- Requires the Commission to enact polices, in recognition of savings due to reduced uncompensated care (UC), that will achieve General Fund savings for Medicaid by at least:

    - $8 million in FY 2015 (as provided in former BPW action); and
    - $16.7 million in FY 2016.

- The bill states that if a UC adjustment cannot achieve the desired savings, the Commission shall enact policies to lower billing rates for Medicare and Medicaid patients to achieve the savings. If neither of these approaches to achieve the desired savings amount, the remaining savings would result from an increase in the deficit assessment.

- The calculated $14.5 million in Medicaid savings may not be counted toward the desired savings.

- The bill also permits the use of approximately $45 million (the non-federal share) of the MHIP surplus to be used for provider reimbursements in the Medicaid program.

Amendments were offered by the Department of Budget and Management (DBM) and the Department of Legislative Services (DLS) at the hearing as follows:

DBM

- Removes the requirement that the Commission achieve $8 million in savings in FY15 from UCC reduction, differential, or increased Medicaid deficit assessment.
- Requires Medicaid savings from a UC reduction in FY16 in the amount of $16.7 million.
- If UC does not result in $16.7 million FY 16 in Medicaid saving, the HSCRC, by September 2015, is required to submit an alternative plan for General Fund savings to DHMH and DBM for approval.
- increases the amount from the MHIP fund that may be used for Medicaid from $45 to $55 million in FY 2015 as an alternative to the $8.0 million FY 2015 Medicaid savings requirement.

DLS

- Recommends that $53 million of the MHIP balance be used for provider reimbursements in Medicaid.
- Rejects the $8 million savings requirement in FY15.
- Eliminates the existing MHIP assessment to generate Medicaid savings.
- Reduce the Medicaid Deficit Assessment by $20 million each year beginning in FY 2017.

Hospital – Rate-Setting – Participation in 340B Program Under the Federal Public Health Service Act – SB513/HB613

SB 513 alters the definition of hospital services in HSCRC law to clarify that merged asset hospitals in Maryland may operate a 340B program at another system hospital provided that it meets the requirements that apply to hospitals nationally under the 340B program regulations under the federal law.

Hearings Scheduled for March 12
Position: Support

Maryland No-Fault Birth Injury Fund – SB 585/HB 553

The bills establish a Fund and adjudication system for birth- related neurological injury. The Maryland birth injury fund provides an exclusive "no-fault" remedy to claimants with an injury that falls within the statutory eligibility criteria for the birth injury program. The birth injury fund program provides notification to patients and their families through Maryland hospitals regarding participation in the program, benefits, eligibility, rights under the program, and ways in which the program provides exclusive remedy. Moneys in the fund will derive from premiums/subsidies on hospitals, obstetrical physicians and medical malpractice insurers.

The two bills have different provision regarding funding through hospital rates. The Senate version of the bill provides that the Fund shall be supported by premiums paid by hospitals and obstetric physicians. These hospital premiums are to be assessed on a hospital's obstetric services. The hospital premium is set at:

- Metropolitan hospitals:
  - $175 per live birth and may not exceed $525,000
  - A hospital with 100 or fewer births shall pay not less than $17,500.
- Rural hospitals
  - $150 per live birth and may not exceed $450,000
  - A hospital with 100 or fewer births shall pay not less than $15,000.

The House version of the bill requires the Commission to increase hospital rates to support the birth injury fund. The Commission is required to adopt regulations on a methodology of how the assessment shall be applied to individual hospitals based on:

- Geographic differences;
- Difference in hospitals' historical claims experience; and
- Whether a hospital provides obstetrical services.

Position: Submitted a letter of information

Civil Actions – Noneconomic Damages – Catastrophic Injury – SB479/HB398

This bill would require triple non-economic damages for a cause of action in which the court or the health claims arbitration panel determined negligence or other wrongful conduct resulted in catastrophic injury.

Position: Submitted a letter of information

Public Health - Maryland Behavioral Health Crisis Response System – SB469/HB367

This bill changes the name of the Maryland Mental Health Crisis Response System to the Maryland Behavioral Health Crisis Response System. It also requires the program to provide 24 hour walk-in crisis communication services and transportation coordination to access services, including transportation to urgent appointments and emergency psychiatric facilities. The DHMH administration is required to maintain a community crisis bed and hospital bed registry.

The bill also provides that any hospital financial or in-kind support of the Maryland Behavioral Health Crisis Response System constitutes a community benefit expense for the purposes of community benefit reporting.

No position

Hospitals – Designation of Caregivers – SB572

SB 572 requires hospitals to provide a patient or legal guardian with at least one opportunity to designate a caregiver. If a caregiver is designated, the hospital shall record it in the medical record, and request consent from the patient to release medical information to the caregiver.

Before discharge, the hospital is required to consult with the caregiver and patient regarding the capabilities and limitations of the caregiver, and issue a discharge plan that describes the after-care tasks needed by the patient. The discharge plan shall provide:

- Instruction for after-care tasks including a demonstration of the after-care tasks performed by a hospital employee;
- An opportunity for the caregiver and patient to ask questions; and
- Answers to any questions.
-

No position

Patient Referrals - Oncologists - Radiation Therapy Services and Nondiagnostic Computer Tomography Scan Services – SB539/HB944

These bills permit oncology group practices that provide radiation therapy services or non-diagnostic CT scan services to plan to deliver radiation therapy to self-refer for radiation therapy, MRI, or CT scan services. Currently, radiologist group practices are exempt from the self-referral provisions in State law. Specified for-profit oncology group practices or offices that are exempt from the self-referral provision must report annually to the Department of Health and Mental Hygiene (DHMH) on the number of patients they treat who are covered by Medicare, Medicaid, or MCHP.

No position but on watch list

Health Occupations - Magnetic Resonance Imaging Services and Computed Tomography Scan Services - Patient Referrals – HB683

This bill permits any health care practitioner to self-refer for CTs and MRIs under certain circumstances including:

- The service is provided by an individual who is employed or supervised by the referring practitioner;
- It is provided in the same building of the referring practitioner;
- Billed through the group practice that the practitioner performing or supervising is a member;
- Meet certain accreditation requirements;
- Share with patients the name, address and telephone numbers for at least five other locations within 25 miles of the practitioners office that are capable of providing the service; and
- Notify the Maryland Health Care Commission that they are self-referring patients.

The Maryland Health Care Commission is required to conduct a study of the provision of MRI and CTs by health care entities that provide notice under that they are self-referring under this bill.

No position but on watch list

Garrett County - Memorial Hospital - Board of Governors – SB870/HB1261

This bill makes changes to the local law pertaining to the Board of Governors of Garrett County Memorial Hospital. The changes clarify the term requirements for Board members and that the Board has the power to implement, not prescribe, the rates set by the HSCRC.

No position

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals

Authority: Health-General Article, § 19-217; Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.08** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on March 11, 2015, notice of which was given pursuant to General Provisions Article, § 3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about June 2, 2015.

Statement of Purpose

The purpose of this action is to conform to the requirements set forth in Chapter 263, Acts of 2014, effective July 1, 2014, that require hospitals to notify the Commission, in writing, within 30 days before executing any financial transaction, contract, or other agreement that would result in more than 50% of all corporate voting rights or governance reserve powers being transferred to or assumed by another person or entity.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until May 18, 2015. A hearing may be held at the discretion of the Commission.

.08 Notification of Certain Financial Transactions.

A. (text unchanged)

(1) Pledge more than 50 percent of the operating assets of the facility as collateral for a loan or other obligation*; or*

(2) Result in more than 50 per cent of the operating assets of the facility being sold, leased, or transferred to another person or entity[.]*; or*

(3) Result in more than 50 percent of all corporate voting rights or governance reserve powers being transferred to or assumed by another person or entity.

B. (text unchanged)

(1) [The name and address of the person or entity to whom the operating assets of the facility are being sold, leased, transferred, or pledged as collateral for a loan or other obligations; and]*The name and address of the person or entity to whom:*

(a) The operating assets of the facility are being sold, leased, transferred, or pledged as collateral for a loan or other obligation; or

(b) The corporate voting rights or governance reserve powers are being transferred or assumed.

C. – E. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

State of Maryland
Department of Health and Mental Hygiene

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Chairman

Herbert S. Wong, Ph.D.
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Deputy Director
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TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **March 4, 2015**

RE: **Hearing and Meeting Schedule**

April 15, 2015	Time to be determined, 4160 Patterson Avenue HSCRC/MHCC Conference Room
May 13 , 2015	Time 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.hscrc.maryland.gov/commission-meetings-2015.cfm

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