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**Health Services Cost Review Commission**

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**557th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION  
December 12, 2018**

**EXECUTIVE SESSION**

**11:30 a.m.**

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

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104
2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

**PUBLIC SESSION**

**1:00 p.m.**

1. Review of the Minutes from the Public Meeting and Executive Session on November 14, 2018
2. New Model Monitoring
3. Docket Status – Cases Closed  
2460A – University of Maryland Medical Center    2461A – University of Maryland Medical Center
4. Docket Status – Cases Open  
2452A – Johns Hopkins Health System                      2453A – MedStar Health  
2458A – University of Maryland Medical Center        2459A – Maryland Physicians Care  
2462A – University of Maryland Medical Center        2463A – University of Maryland Medical Center  
2464A – Johns Hopkins Health System                    2465A – Johns Hopkins Health System  
2466A – Johns Hopkins Health System                    2467A – Johns Hopkins Health System  
2468A – Johns Hopkins Health System                    2469A – Johns Hopkins Health System
5. Final Recommendation on Adjustment to the Payer Differential
6. Final Recommendation on Updates to the Quality-Based Reimbursement (QBR) Policy for RY 2021
7. Draft Recommendation on Updates to the Readmission Reduction Incentive Program Policy for RY 2021
8. Draft Recommendation on Medicare Advantage Sequestration
9. Report on FY 2017 and 2018 Transformation Grants Activities

**10. Policy Update and Discussion**

- a. Update from Executive Director
- b. MDPCP Update
- c. Commissioner Discussion of Potentially Avoidable Utilization

**11. Hearing and Meeting Schedule**

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

**November 14, 2018**

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

1. Discussion on Planning for Model Progression– Authority General Provisions Article, §3-103 and §3-104
2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

The Closed Session was called to order at 11:40 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

In attendance in addition to Chairman Sabatini were Commissioners Antos, Bayless, Colmers, Elliott, Kane, and Keane.

In attendance representing Staff were Katie Wunderlich, Chris Peterson, Allan Pack, Jerry Schmith, Alyson Schuster, Geoff Dougherty, Amanda Vaughan, Joe Delenick, Bob Gallion, and Dennis Phelps.

Also attending were Eric Lindeman, Commission Consultant and Stan Lustman and Adam Malizio, Commission Counsel.

**Item One**

Katie Wunderlich, Executive Director, updated the Commission on Hospital CEO and Commissioner Focus Group meetings.

**Item Two**

Chris Peterson, Director-Clinical and Financial Information, updated the Commission on New Model activities and potential new care redesign programs.

**Item Three**

Ms. Wunderlich and Jerry Schmith, Director-Revenue and Regulation Compliance, updated the Commission on initiatives to adjust hospitals' Global Budget Revenue for shifts of services from regulated to unregulated.

#### **Item Four**

Allan Pack, Director-Population Based Methodologies, updated the Commission on the Volume and Community Benefits Investment workgroups.

#### **Item Five**

Ms. Wunderlich updated the Commission on personnel positions to be filled going forward.

#### **Item Six**

Ms. Wunderlich and Mr. Peterson updated the Commission on the Primary Care Model Program.

The Closed Session was adjourned at 12:46 p.m.



**MINUTES OF THE**  
**556th MEETING OF THE**  
**HEALTH SERVICES COST REVIEW COMMISSION**  
**November 14, 2018**

Chairman Nelson Sabatini called the public meeting to order at 11:40 a.m. Commissioners Joseph Antos, Victoria Bayless, John Colmers, James Elliott, M.D., Adam Kane and Jack Keane were also in attendance. Upon motion made by Commissioner Colmers and seconded by Commissioner Keane, the meeting was moved to Executive Session. Chairman Sabatini reconvened the public meeting at 1:02 p.m.

**REPORT OF NOVEMBER 14, 2018 EXECUTIVE SESSION**

Mr. Dennis Phelps, Associate Director, Audit & Compliance, summarized the minutes of the November 14, 2018 Executive Session.

**ITEM I**  
**REVIEW OF THE MINUTES FROM OCTOBER 10, 2018 EXECUTIVE SESSION AND**  
**PUBLIC MEETING**

The Commissioners voted unanimously to approve the minutes of the October 10, 2018 Public Meeting and Executive Session.

**ITEM 11**  
**PRESENTATION BY BALTIMORE HEALTH WORKFORCE COLLABORATIVE**

Anita Hammond, Executive Director, Baltimore Alliance for Careers in Healthcare (BACH) provided the Commission with an overview of the Baltimore Population Health Workforce Collaborative (BPHWC). The BPHWC was funded through the Population Health Workforce Support for Disadvantaged Areas Program in December of 2015. Nine Baltimore area hospitals are members the collaborative.

Magdalena Nowasadko, Program Director BACH, review the collaborative goals, the targeted workforce population, the program process, the training tracks, and the jobs associated with the training. As of June 2018, 207 participants started one of the three technical training programs, and 183 completed the training. The three programs are Community Health Worker, Peer Recovery Specialist, and Home Care Aide (CNA/GNAs). From those who completed the training, 114 received job placement at one of the collaborative hospitals.

Chairman Sabatini asked if there was data to show a return on investment in the program. Ms. Nowasadko stated that full funding had yet been used because the start of the program was delayed.

Commissioner Colmers asked if the jobs available offered opportunity for career growth. Ms. Nowasadko said that the jobs did have career growth, and that some early participants have received promotions. Chairman Sabatini asked if recruiting people for the program has been a challenge. Ms. Nowasadko stated that the biggest challenge is matching people with the needs of the hospitals.

Melvin Wilson, Co-Director of Turnaround Tuesday, gave an overview of the work of his organization, which prepares returning citizens and unemployed citizens to reenter the workforce. Participants who have benefitted from the program told the Commissioners about their experiences. Chairman Sabatini thanked the guests and committed to supporting the program.

**ITEM III**  
**DRAFT RECOMMENDATION AND RY 2017 & 2018 REPORT ON POPULATION HEALTH WORKFORCE SUPPORT FOR DISADVANTAGED AREA PROGRAM**

Erin Schurmann, Project Manager, presented the Staff's draft recommendation and overview on the Population Health Workforce Support for Disadvantaged Areas Activities for Fiscal Years 2017 and 2018 (See "Recommendation and Report on the Population Health Workforce Support for Disadvantaged Areas Activities for Fiscal Years 2017 and 2018" on the HSCRC website).

The draft recommendation summarizes fiscal years (FYs) 2017 and 2018 activities for the Population Health Workforce Support for Disadvantaged Areas (PWSDA) and provides a recommendation to extend the program for three years (FY 2020 – FY 2022) for the Baltimore Population Health Workforce Collaborative (Baltimore Collaborative), one of the two original grantees. In December 2015, the Commission authorized up to \$10 million in hospital rates for hospitals that committed to train and hire workers from geographic areas of high economic disparities and unemployment. Workers will fill new positions to support care coordination, population health, consumer engagement, and related positions. The PWSDA was developed in an effort to support job opportunities for individuals who reside in neighborhoods with a high area deprivation index, and thus enable low-income urban, suburban, and rural communities to improve their socioeconomic status while working to improve population health. The overall objective is to address the social determinants of health and assist hospitals in bolstering population health and meeting the goals of the All-Payer Model and the new Total Cost of Care Model.

When approved in 2015, the PWSDA program limited the award total to \$10 million in hospital rates over a three-year period, with the condition that hospitals provide matching funds of at least 50% of the amount included in their rates. The HSCRC awarded rate increases to two applicants: the Baltimore Collaborative and Garrett Regional Medical Center. The applicants were required to explain how they will use the increase in rates to support the training and hiring of individuals consistent with the goals of the program.

Hospitals report on three areas: training and hiring activities, patient care activities, and spending. Evaluators at the University of Maryland School of Medicine collect, review, and summarize these reports on behalf of the HSCRC.

The Baltimore Collaborative is a consortium of four major health systems that includes the following nine hospitals in the Baltimore Metropolitan Area:

- Johns Hopkins Hospital
- Johns Hopkins - Bayview
- Sinai Hospital
- Medstar – Good Samaritan
- Medstar – Harbor Hospital
- Medstar – Union Memorial
- Medstar – Franklin Square
- University of Maryland Medical Center
- University of Maryland – Midtown

In 2016, the Baltimore Collaborative submitted a proposal to hire individuals from high poverty communities to fill positions such as community health workers, peer recovery specialists (PRSs), certified nursing/geriatric nursing assistants, and other positions serving patients in the community. The Commission authorized \$6,675,666 across FY 2017 – FY 2019 to provide essential skills training to 444 individuals, provide technical skills training to 263 individuals, and employ 208 individuals by the third year of the project. The Baltimore Collaborative has partnered with BACH to implement and manage the recruiting and training process.

Garrett Regional Medical Center (GRMC) submitted a proposal to hire five individuals to provide health education and care coordination for high utilizers of inpatient care, in particular patients enrolled the Well Patient Program which is managed by a social worker and nurse navigator. Potential workers would be selected for training and employment from the same Well Patient Program under the premise that individuals struggling with chronic conditions may be best equipped to educate and assist other patients with similar health conditions.

The Commission authorized a total of \$221,485 in hospital rates to GRMC across three years. Additionally, due to GRMC's overlapping service areas with West Virginia, the Commission required that 50% of hired workers be from Maryland.

It should be noted that GRMC will leave the program on 6/30/19.

Staff recommendations are outlined below.

Staff is proposing a three year extension of the program for the Baltimore Collaborative. Due to the delayed start of the program in FY 2017 and a slower than anticipated ramp up, the Baltimore Collaborative is still working to meet the aggressive training and hiring counts articulated in their

2016 proposal. Staff proposes an extension through FY 2022 to the Baltimore Collaborative to maintain current training and hiring progress and reach intended employment goals.

Based on staff findings from the last two years of reporting, staff recommend the following:

- Extend the PWSDA program for three years through FY 2022.
- Make adjustments to rates to remove unspent PWSDA funds from population-based budgets from FY 2017-FY 2019, estimated to be approximately \$3.5 million from FY 2017 and FY 2018, pending staff audit conclusions.
- Provide \$5,875,804 in rates to the Baltimore Collaborative across FY 2020-FY 2022 with hospitals matching at least 50% of rate funding.

Chairman Sabatini requested immediate action on the Staff's draft recommendation, rather than delay action until the December Public meeting. Chairman Colmers requested that the collaborative provide an update to the commissioners halfway through the extension.

Commissioners voted unanimously to approve Staff's recommendation.

#### **ITEM IV** **NEW MODEL MONITORING**

Ms. Amanda Vaughan, Associate Director Clinical and Financial Information, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of September 2018 focuses on the fiscal year (July 1 through June 30) as well as calendar year results.

Ms. Vaughan reported that for the three months of the fiscal year ending September 30, 2018, All-Payer total gross revenue increased by 0.70% over the same period in FY 2018. All-Payer total gross revenue for Maryland residents increased by 0.82%. All-Payer gross revenue for non-Maryland residents decreased by 0.56%.

Ms. Vaughan reported that for the nine months of the calendar year ending September 30, 2018, All-Payer total gross revenue increased by 1.02% over the same period in CY 2017. All-Payer total gross revenue for Maryland residents increased by 1.32%; this translates to a per capita increase of 0.86%. All-Payer gross revenue for non-Maryland residents decreased by 2.22%.

Ms. Vaughan reported that for the three months of fiscal year ending September 30, 2018, Medicare Fee-For-Service gross revenue decreased by 1.50% over the same period in FY 2018. Medicare Fee-For-Service gross revenue for Maryland residents decreased by 1.29%. Maryland Fee-For-Service gross revenue for non-residents decreased by 3.78%.

Ms. Vaughan reported that for the nine months of the calendar year ending September 30, 2018, Medicare Fee-For-Service gross revenue increased by 0.50% over the same period in CY 2017.

Medicare Fee-For-Service gross revenue for Maryland residents increased by 0.83%; this translates to a per capita decrease of 0.52%. Maryland Fee-For-Service gross revenue for non-residents decreased by 3.26%.

Ms. Vaughan reported that for the three months of the fiscal year ending September 30, 2018 over the same period in FY 2017:

- All Payer in State per capita hospital revenue growth was 0.35%.
- Medicare Fee for Service hospital per revenue capita growth in the State decreased by 2.50%.

According to Ms. Vaughan, for the 3 months fiscal year ending September 30, 2018, unaudited average operating profit for acute hospitals was 2.44%. The median hospital profit was 2.20%, with a distribution of negative 1.20% in the 25<sup>th</sup> percentile and 5.35% in the 75<sup>th</sup> percentile. Rate Regulated profits were 6.63%.

Medicare savings were not presented because the State is reviewing data information provided by the Centers for Medicare & Medicaid Services (CMS).

**ITEM V**  
**DOCKET STATUS- CASES CLOSED**

2454A- MedStar Health

2455A- Johns Hopkins Health System

2456A- University of Maryland Medical Center

2457A- Johns Hopkins Health System

**ITEM VI**  
**DOCKET STATUS –OPEN CASES**

**2460A-University of Maryland Medical Center**

The University of Maryland Medical Center (“the Hospital”) filed a renewal application with the HSCRC on October 15, 2018 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for participation in a new global rate arrangement for solid organ and blood and bone marrow transplant services with Humana for a one-year period, effective December 1, 2018.

Staff recommends that the Commission approve the Hospital’s application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning December 1, 2018. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding with the Hospital for the approved contract.

Commissioners voted unanimously in favor of Staff's recommendation.

**2461A-University of Maryland Medical Center**

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on October 15, 2018 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 INTERLINK for a period of one year, effective December 1, 2018.

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 INTERLINK for a one year period commencing December 1, 2018. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding with the Hospital for the approved contract.

Commissioners voted unanimously in favor of Staff's recommendation.

**ITEM VII**  
**FINAL RECOMMENDATION ON THE MEDICARE PERFORMANCE ADJUSTMENT**  
**FOR RY 2021**

Chris Peterson, Director Clinical & Financial Information, presented the Staff's final recommendation on the Medicare Performance Adjustment (See "Final Recommendation for the Medicare Performance Adjustment Policy for Rate Year 2021" on the HSCRC website).

The State implemented a value-based payment adjustment, referred to as the Medicare Performance Adjustment (MPA) with performance beginning in Calendar Year (CY) 2018. The MPA brings direct financial accountability to individual hospitals based on the total cost of care for Medicare fee-for-service (FFS) beneficiaries attributed to them.

Mr. Peterson noted that the final recommendation remains largely unchanged compared to the draft, with the exception of specifying that the Maryland Primary Care Program (MDPCP) care management fees will be excluded from the MPA assessment of total cost of care in the RY2021 policy.

The Staff recommendation proposes gradually incorporating MDPCP expenditures into the MPA performance assessment. Some payments to providers under the MDPCP would be excluded in 2019, including care management fees and performance-based incentive payments, however, comprehensive primary care payments paid quarterly to Track 2 MDPCP practices and their reduced fee-for-service revenue will be included. In 2020, the HSCRC plans to include care management fees and performance-based incentives in both the performance and base periods.

The Staff recommendation further reiterates that hospitals in a region may choose collective accountability and be treated as a single hospital to calculate MPA performance. Hospitals had this option in 2018, but none chose the combined approach. In 2019, HSCRC recommends piloting an episode-based approach for the University of Maryland Rehabilitation and Orthopaedic Institute to determine whether this approach is more feasible than the physician-based model at other hospitals.

Staff recommends the following for RY 2021:

1. Measure Medicare Total Cost of Care (TCOC) by attributing Medicare fee-for-service beneficiaries to non-hospital providers, primarily based on use of primary care services, and then linking providers to hospitals based on existing relationships.
  - Use a hierarchy of MDPCP-actual, Accountable Care Organization (ACO)-like, PCP-like, and Geographic attribution for beneficiary-to-provider attribution
  - Use existing provider-hospital relationships to link providers to hospitals based on a hierarchy of hospital-affiliated Care Transformation Organizations (CTOs), hospital affiliated ACOs, hospital employment, and provider referral patterns
  - Implement official algorithm result review period
2. Set the maximum penalty at 1.0% and the maximum reward at 1.0% of federal Medicare revenue with maximum performance threshold of  $\pm 3\%$ .
3. Set the TCOC benchmark at each hospital's risk-adjusted (demographics only) TCOC from 2018, updated with a Trend Factor of 0.33% below the national Medicare FFS growth rate for CY 2019. In CY 2019, exclude MDPCP Care Management Fees and Performance-based Incentive Payments, but include Comprehensive Primary Care Payments for Track 2 practices.
4. Continue to assess performance on each hospital's own improvement in its attributed population's per capita TCOC
  - Adjust for year-over-year changes in the demographic characteristics of the hospital's attributed population
  - For future years, continue to explore incorporating attainment and further risk adjustment into the MPA's performance assessment
5. Include the MPA as part of the aggregate revenue at risk under HSCRC quality programs.

6. Continue to evaluate the MPA throughout the year and consider enhancements for future MPA policies, obtaining input through continued meetings of the TCOC Workgroup.
7. Provide national Medicare growth rate estimates relative to Maryland throughout the year to help hospitals monitor their progress.
8. Continue to work with CMS and the Chesapeake Regional Information System for our Patients (CRISP) to provide information to hospitals so they can more effectively engage in care coordination and quality improvement activities, assess their performance, and better manage the TCOC by working in alignment with both independent and affiliated providers whose beneficiaries they serve.

Traci La Valle, Vice President Rate Setting, Maryland Hospital Association, supported the recommendation and asked HSCRC to continue working toward an attainment target.

Leni Preston, Vice President, Consumer First, supported the staff recommendation and suggested adding race to the risk adjustment to ensure there are adequate resources to provide care to everyone; analyzing the impact of the policy on consumers to understand whether there are unintended consequences; and requiring primary care physicians to notify beneficiaries of the policy and tell them which hospital they are attributed to and allowing them to change hospitals.

Mr. Peterson responded that while each of the points raised is valuable, there are barriers to implementation. In particular, the Medicare data the HSCRC uses in the policy does not include race. He also noted that beneficiaries are able to opt out of data sharing by contacting Medicare or CRISP.

Commissioners voted 5-1 in favor of the Staff's recommendation. Commissioner Keane voted against the recommendation.

#### **ITEM VIII**

#### **DRAFT RECOMMENDATION FOR ADJUSTMENT TO THE PAYER DIFFERENTIAL**

Katie Wunderlich, Executive Director, Madeline Fowl, consultant and Dennis Phelps, Associate Director Audit and Compliance, presented the Staff's draft recommendation on the proposed adjustment to the payer differential (See "Draft Staff Recommendation for Adjustment to the Payer Differential" on the HSCRC website).

The State of Maryland has employed a differential since the 1970s whereby public payers (Medicare and Medicaid) pay less than other payers (primarily commercial payers) due to business practices that avert bad debt in hospitals and keep Maryland's hospital costs low. Hospital charges are adjusted via a markup to ensure that the differential's reduction in charges to public payers does not result in a decline in hospitals' total revenue.



The proposed increase in the public-payer differential by 1.7 percentage points (from 6% to 7.7%) will ensure that the increase in uncompensated care (UCC) attributable to the change in business practices of commercial insurers that increased out of pocket expense for the privately insured, is not shifted to Medicare and Medicaid.

This adjustment will result in a more equitable distribution of uncompensated care costs and will recognize the public payers who are averting UCC. The HSCRC staff is recommending an effective date of July 1, 2019 to allow for implementation by the Medicare intermediary and other payers. This differential change is not intended to supplant the work of providers to generate savings to Medicare under the All-Payer and Total Cost of Care Model Agreements with CMS, but rather to more accurately and fairly adjust for current trends in uncompensated care resulting from the plan design changes of private payers.

Staff recommends the following, effective July 1, 2019:

- Increase the differential by 1.7 percentage points (from the current 6.0% to 7.7%) to more equitably allocate higher uncompensated care costs incurred by commercially insured patients. This adjustment will be made through the hospital mark-up adjustment, which will provide a net revenue neutral result for hospitals.
- To assure that the savings from the differential adjustment is not used to justify an increase to rates in a future rate year, the staff recommends that the cost reduction to Medicare as a result of the change in the differential be removed from the Total Cost of Care performance evaluation when establishing future annual updates. Furthermore, the savings associated with the increased differential should not supplant hospital savings needed to meet the annual savings goals required by the TCOC contract.
- Similarly, the savings to Medicare resulting from the differential adjustment should not be included in the trend factor used to calculate a hospital's performance under the Medicare Total Cost of Care algorithm.
- The Commission should develop and adopt policies that prioritize the use of the All-Payer rate reductions and the Medicare Performance Adjustment as a means to account for costs and savings to the system. The success of the TCOC Model is dependent on improving care and health, reducing avoidable utilization, and providing efficient and effective quality health care services. To this end, the Commission should not use changes to the differential to meet Medicare total cost of care performance requirements.
- It is the intent of the Commission to make this a one-time adjustment at the beginning of the TCOC Model, as permitted by the contract, to correct for cost inequities and to avoid future changes to the public-payer differential to assure stability of the system and to preserve the all-payer nature of the Maryland Model.

No Commission action is required as this is a draft recommendation.

**ITEM IX**  
**DRAFT RECOMMENDATION ON UPDATES TO THE QUALITY-BASED**  
**REIMBURSEMENT POLICY FOR RY 2021**

Dianne Feeney, Associate Director Quality Initiatives, presented the Staff's draft recommendation to update the Quality- Based Reimbursement Program for Rate Year 2021 (See "Draft Staff to Recommendation for Updating the Quality-Based Reimbursement Program for Rate Year 2021" on the HSCRC website).

HSCRC's Quality Based Reimbursement (QBR) program is one of several pay for performance initiatives that provide incentives for hospitals to improve patient care and value over time. Under the current five-year All-Payer Model Agreement between Maryland and CMS, effective through December 2018, there are specific quality performance requirements, including reducing Medicare readmissions to below the national average, and reducing hospital complications by 30% over 5 years. Maryland is on target to meet or exceed both of these targets. The QBR program had no stated performance requirements in the All-Payer Model. However, the Commission has prioritized aligning the QBR program with the federal Value Based Purchasing (VBP) program and has attempted to encourage improvement in areas where Maryland has exhibited poor performance relative to the nation. As Maryland enters into a new Total Cost of Care (TCOC) Model Agreement with CMS on January 1, 2019, performance standards and targets in HSCRC's portfolio of quality and value-based payment programs will be updated. In the first year of the TCOC Model, staff will seek to revise two of the Commission's Quality programs, the Maryland Hospital Acquired Complications program and the Potentially Avoidable Utilization program, per directives from HSCRC Commissioners. The QBR program will include new measures but will largely remain similar to prior iterations of the policy.

A central tenet of the healthcare reform in Maryland since 2014 is that hospitals are funded under Population Based Revenue, a fixed annual revenue cap that is adjusted for inflation, quality performance, reductions in potentially avoidable utilization, market shifts, and demographic growth. Under the Population Based Revenue system, hospitals are incentivized to transition services across the continuum of care and may keep savings that they achieve via improved quality of care (e.g., reduced avoidable utilization, readmissions, and hospital acquired infections). On the other hand, constraining hospital resources can have unintended consequences, including declining quality of care. Thus, HSCRC Quality programs must reward quality improvements and reinforce the incentives of the Population Based Revenue system, as well as penalize poor performance and potential unintended consequences.

Maryland's exemptions from national quality programs are essential because the Population Based Revenue system benefits from having autonomous, quality-based measurement and payment initiatives that set consistent all-payer quality incentives. Furthermore, these exemptions afford Maryland the flexibility to select performance measures and targets in areas where improvement is needed, and allow Maryland to develop programs with greater potential for system transformation. For example, unlike the national VBP program, QBR does not

relatively rank hospitals, but instead provides all hospitals the opportunity to earn rewards, which are determined using a prospective revenue adjustment scale. Under the TCOC Model, the State will receive exemptions from the CMS Hospital Acquired Conditions program, Hospital Readmission Reduction program, and VBP program based on annual reports to CMS that demonstrate that Maryland's program results continue to be aggressive and progressive, meeting or surpassing those of the nation.

Based on the staff assessment and stakeholder deliberations to date, staff proposes that the Commission consider the draft recommendations below.

1. Implement the following measure updates:
  - o Add the Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA) Risk-Standardized Complication Rate measure to the Clinical Care Domain, and weight the measure at 5% to align with National VBP program;
  - o Remove the PC-01 and ED-1b measures commensurate with their removal from the CMS VBP and IQR programs respectively;
2. Continue Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement - 50%, Safety (NHSN measures) - 35%, Clinical Care - 15%.
3. Maintain the pre-set scale (0-80% with cut-point at 45%), and continue to hold 2% of inpatient revenue at-risk (rewards and penalties) for the QBR program.

Commissioner Colmers stated that he continues to have concerns about including emergency department (ED) wait times as part of the QBR policy.

Commissioner Keane also voice concern about ED wait times; however, his concern was that more progress in reducing wait times has not been made. He asked Staff about the status of the corrective action plans that some hospitals were required to submit.

Ms. Wunderlich responded that the Commission has looked for ways to monitor progress for ED wait times.

Chairman Sabatini also expressed frustration at the lack of improvement in wait times. He proposed that a portion of the annual update be tied to ED wait times.

Commissioner Colmers commented that the factors contributing to ED wait times are complex.

As this is a draft recommendation, no Commission action is necessary

**ITEM X**  
**PRESENTATION ON RECALIBRATING FUNDING UNDER POPULATION-BASED**  
**REVENUE MODEL**

**Shifting of Hospital Services from Regulated to Unregulated Setting**

Joe Delenick, Associate Director, Rate Regulation, presented a summary of revenues removed from hospital's global budgets due to shifting services from regulated to unregulated (see "Shifting of Hospital Services from Regulated to Unregulated Setting" on the HSCRC website).

Mr. Delenick reported that \$56 million of permanent revenue and \$16 million of one-time revenue were removed in rate years 2018 and 2019. Staff has also identified to the Commission additional revenue reductions of 11.4 million for rate year 2020.

Mr. Delenick noted that hospital global budget agreements require hospitals to disclose services that have moved to an unregulated setting. Staff reviewed the process for identifying shifts to unregulated services and is formalizing and strengthening its review process to improve the timeliness of adjustments. Staff plans to work with the volume and contract subgroups of the Payment Models Work Group to further refine the process.

**High-Cost Outlier Hospital Spend-downs – University of Maryland Midtown**

Allan Pack, Director Population Based Methodologies, and Jerry Schmith, Director Revenue and Rate Regulation presented a Staff recommendation to approve a five year, \$28 million dollar spend-down for the University of Maryland Medical Center- Midtown Campus (see "Rate Agreement Between The Health Services Cost Review Commission and University of Maryland Medical Center Midtown Hospital Campus" on the HSCRC website).

After four years of the global revenue agreements that were implemented for hospitals under the All-Payer Model, and with the suspension of the Reasonableness of Charges evaluation since 2011, the Commission requested that staff evaluate high cost outlier hospitals that have retained an excessive amount of revenue causing high charges for patients and payers. The University of Maryland Medical Center's Midtown Hospital Campus ("the Hospital") is one such hospital that was identified as an outlier. This proposed agreement outlines the steps that will be taken to bring the Hospital's approved revenue to reasonable levels.

Prior to 2011, the HSCRC used an adjusted charge per case comparison, referred to as the Reasonableness of Charges ("ROC") to identify hospitals with high charges per case and to scale annual updates based on performance. In 2011, this tool was suspended for rural hospitals that adopted global budgets under the Total Patient Revenue (TPR) system, recognizing that reductions of avoidable utilization could work against those hospitals in comparing charges per case. Other hospitals went under an episode payment arrangement in 2011 and 2012, which bundled

readmissions into an episode payment. Since the ROC could penalize hospitals with readmission declines, the ROC was suspended for the remaining hospitals.

After suspension of the ROC for more than six years, the Commission prioritized the development of an updated Inter-hospital Cost Comparison (ICC) tool and requested that staff evaluate high cost outlier hospitals that have retained an excessive amount of revenue causing high charges for patients and payers. The Total Cost of Care Model Agreement with CMS, signed in July 2018 and scheduled to begin on January 1, 2019, will require the State to contain the growth of costs for both hospital and non-hospital services on a per capita basis. With these considerations, staff used a combination of factors to identify high cost outlier hospitals taking into account cost per case efficiency under the ICC, performance on Medicare total cost of care (TCOC) per capita growth, potentially avoidable use (PAU) levels and reductions achieved, and quality indicators such as the Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement (QBR) performance.

During this evaluation, the UMMC-Midtown Hospital was identified by staff as an outlier hospital. Using the ICC for RY 2018 revenue, staff determined that the Hospital has the most unfavorable adjusted cost per case compared to other Maryland hospitals, with an inefficiency of -32.65% compared to the peer group standard. The Hospital is also in the least favorable quintile of hospitals for Medicare TCOC growth rate per capita, with a growth rate of 8.02% from 2013 to 2017, compared to the State average TCOC growth rate of 3.9%. The Hospital has been able to reduce the growth of PAU admissions more rapidly than the State, but still has high levels of PAU (30.8% of eligible revenue as compared to the statewide average of 18.3%), partially as a result of the health disparities of the population it serves. Finally, the Hospital has had mixed quality outcomes. While it ranked in the most favorable quintile for reductions in potentially preventable complications, as measured through the Maryland Hospital Acquired Conditions program, it was in the second least favorable quintile for patient satisfaction surveys, as measured through HCAHPS surveys in the Quality Based Reimbursement program, and the least favorable quintile for case-mix adjusted readmissions rates, as measured through the Readmissions Reductions Incentive program.

Based on Staff review the following recommendation is proposed:

After discussions about the reasonable level of efficiency improvement that should be expected, the Hospital and Staff have agreed to a 12% reduction to the Hospital's RY 2018 GBR, with an opportunity to assess the Hospital's efficiency level at two points during the five-year period as follows:

- RY 19: 3% reduction (Guaranteed Reduction)
- RY 20: 3% reduction (Guaranteed Reduction)

- RY 21: 2% reduction (Performance evaluation)
- RY 22: 2% reduction
- RY 23: 2% reduction (Performance evaluation)

**Spend-down Recommendation for University of Maryland Medical Center - Midtown**

Rate Year	Proposed Revenue Reduction (based on 2018 GBR)	\$ Impact (2018 denominator locked)	\$ Cumulative Impact
2019	3%	-\$7,134,794	-\$7,134,794
2020	3%	-\$7,134,794	-\$14,269,588
2021	2%	-\$4,756,529	-\$19,026,117
2022	2%	-\$4,756,529	-\$23,782,647
2023	2%	-\$4,756,529	-\$28,539,176

Commissioners Kane and Keane questioned the impact of adopting global budgets on the hospital efficiency measure. Staff noted that some services moved from the regulated hospital environment, but the hospital’s global budget had not been reduced.

Commissioner Antos questioned the ICC results, noting that the staff recommendation allows for an unknown amount of inefficiency to remain in its base.

Mohan Suntha, MD, President of University of Maryland Medical Center, and Robert Chrencik, President of the University of Maryland Medical System (UMMS), testified on behalf of the Hospital. Dr. Suntha and Mr. Chrencik on behalf of UMMS accepted the terms of the staff recommendation, while emphasizing the unique challenges of the patient population in the Hospital’s service area.

Commissioners voted 4-3 in favor of the Staff’s recommendation. Chairman Sabatini cast the deciding vote. Commissioners Antos, Kane, and Keane voted against the recommendation.

**ITEM XI**  
**POLICY UPDATE AND DISCUSSION**

**Executive Director Report**

Ms. Wunderlich stated that Staff is working on identifying potential new models programs to be proposed to CMMI in regard to the expansion in the Care Redesign Program. She noted that new models will be discuss at the next Stakeholder Innovation Group meeting.

Ms. Wunderlich noted that the State will be holding a Population Health Summit on December 4<sup>th</sup> at the BWI Hilton.

Ms. Wunderlich observed that two new payment subgroups have been formed. The new subgroup are the Volume subgroup and the Community Benefit subgroup.

Ms. Wunderlich stated that Staff has received requests from three Medicare Advantage (MA) Plans that they be permitted to take the 2% sequestration hospital payment adjustment to offset the impact of the reduction in their premiums in their premiums in 2013. Staff did not present a recommendation on this issue.

### **Commissioner Discussion of Capital Funding Consideration Under the TCOC Model**

Mr. Schmith presented an overview of Staff's capital funding policies (see "HSCRC Capital Funding Policies" on the HSCRC website).

Mr. Schmith initiated the discussion by reviewing the Commission's historical funding policies and offered suggestions for a future capital funding policy

## **ITEM XII** **LEGAL REPORT**

### **Proposed Action**

#### **Rate Application and Approved Procedures– COMAR 10.37.10.26-A**

The purpose of this action is to require hospitals to better inform patients of facility fees and their right to request and receive a written estimate of the total charges for the non-emergency hospital services, procedures, and supplies that reasonably are expected to be incurred and billed to the patient by the hospital.

The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register with a public comment period.

## **ITEM IX** **HEARING AND MEETING SCHEDULE**

December 12, 2018	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
January 9, 2019	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:45 p.m.



# Monitoring Maryland Performance Financial Data

Year to Date through October 2018

Source: Hospital Monthly Volume and Revenue  
Run: December 3, 2018

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**HSCRC**

Health Services Cost  
Review Commission



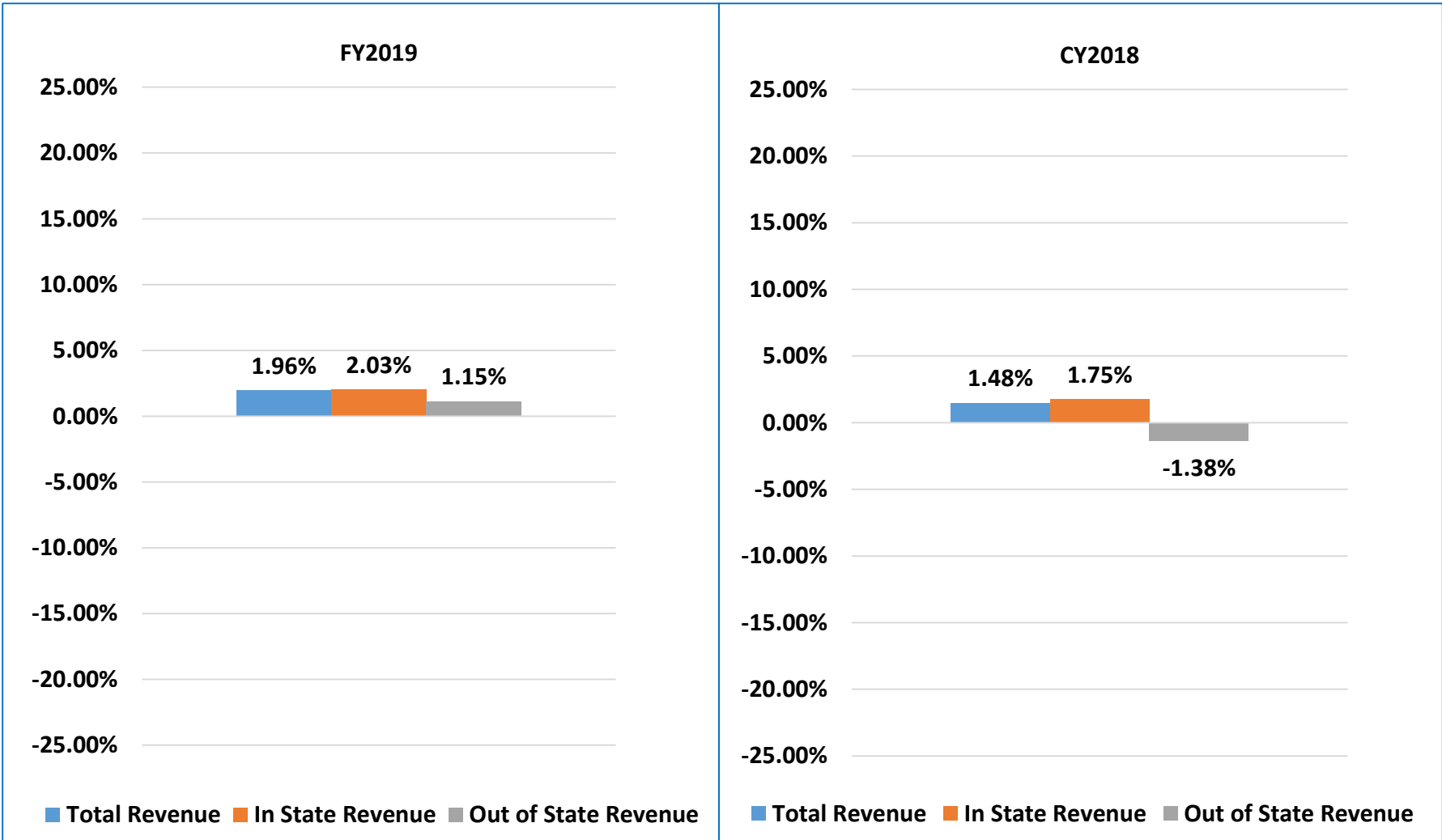


The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2017 have been revised. CMS has changed the enrollment source for the Chronic Condition Data Warehouse (CCW) from the Enrollment Database (EDB) to the Common Medicare Environment (CME) database. Part A changed very slightly and Part B is more noticeably changed. We have determined that the Beneficiary counts for CY 2018 are currently being understated, and we are working to resolve this issue with CMS.

The Population Estimates from the Maryland Department of Planning have been revised in December, 2017. The new FY 18 Population growth number is 0.46%.

# Gross All Payer Hospital Revenue Growth

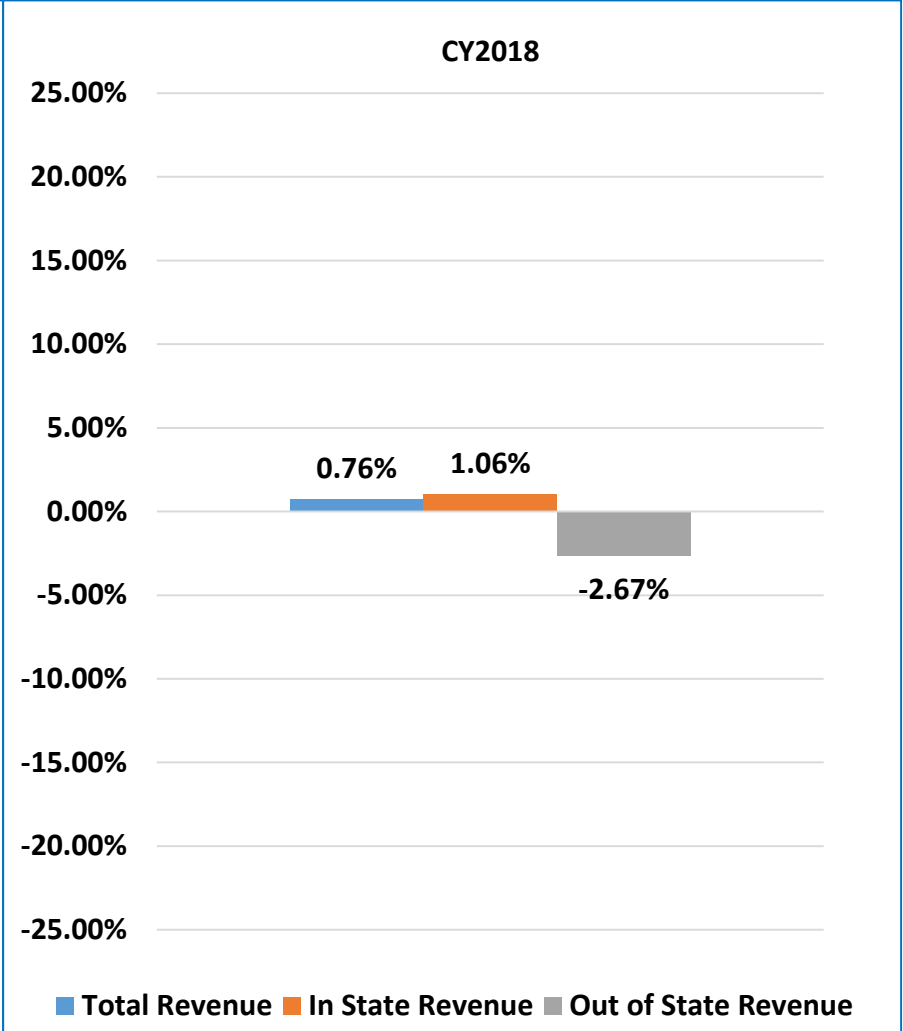
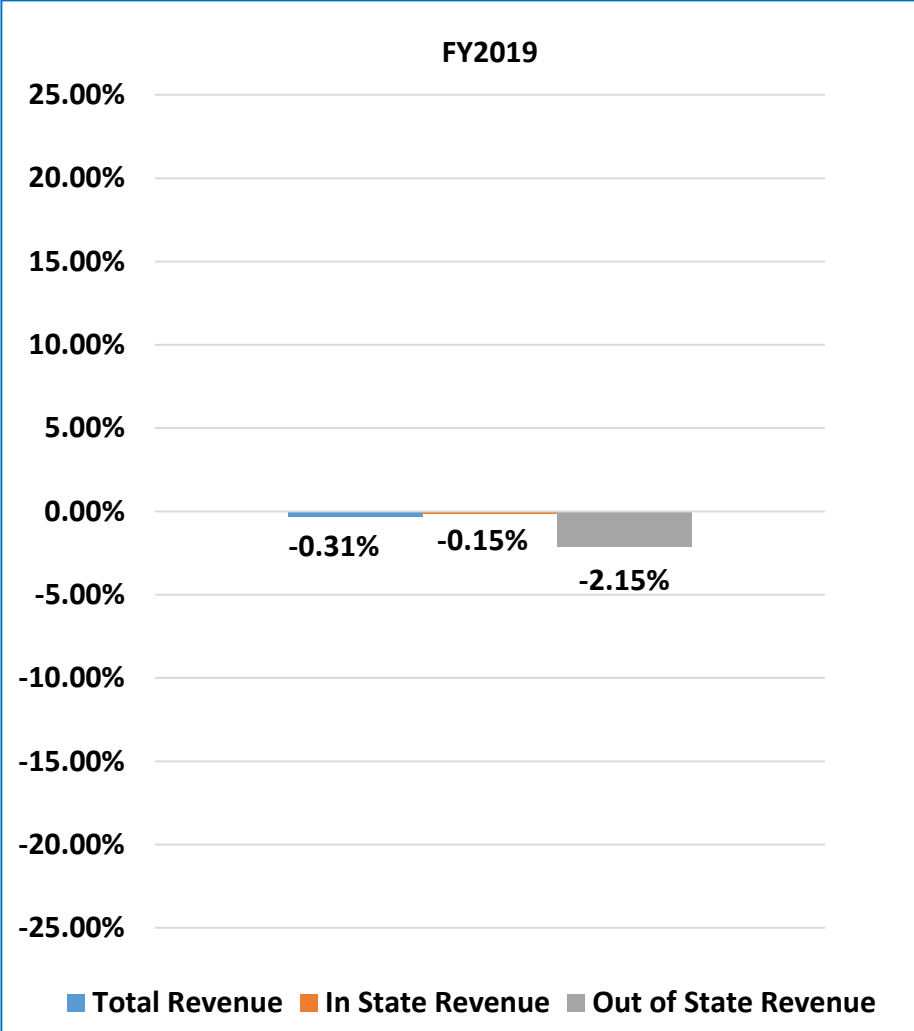
FY 2019 (July 18 – Oct 18 over July 17 – Oct 17) and CY 2018 (Jan - Oct 18 over Jan – Oct 17)



The State’s Fiscal Year begins July 1

# Gross Medicare Fee for Service Hospital Revenue Growth

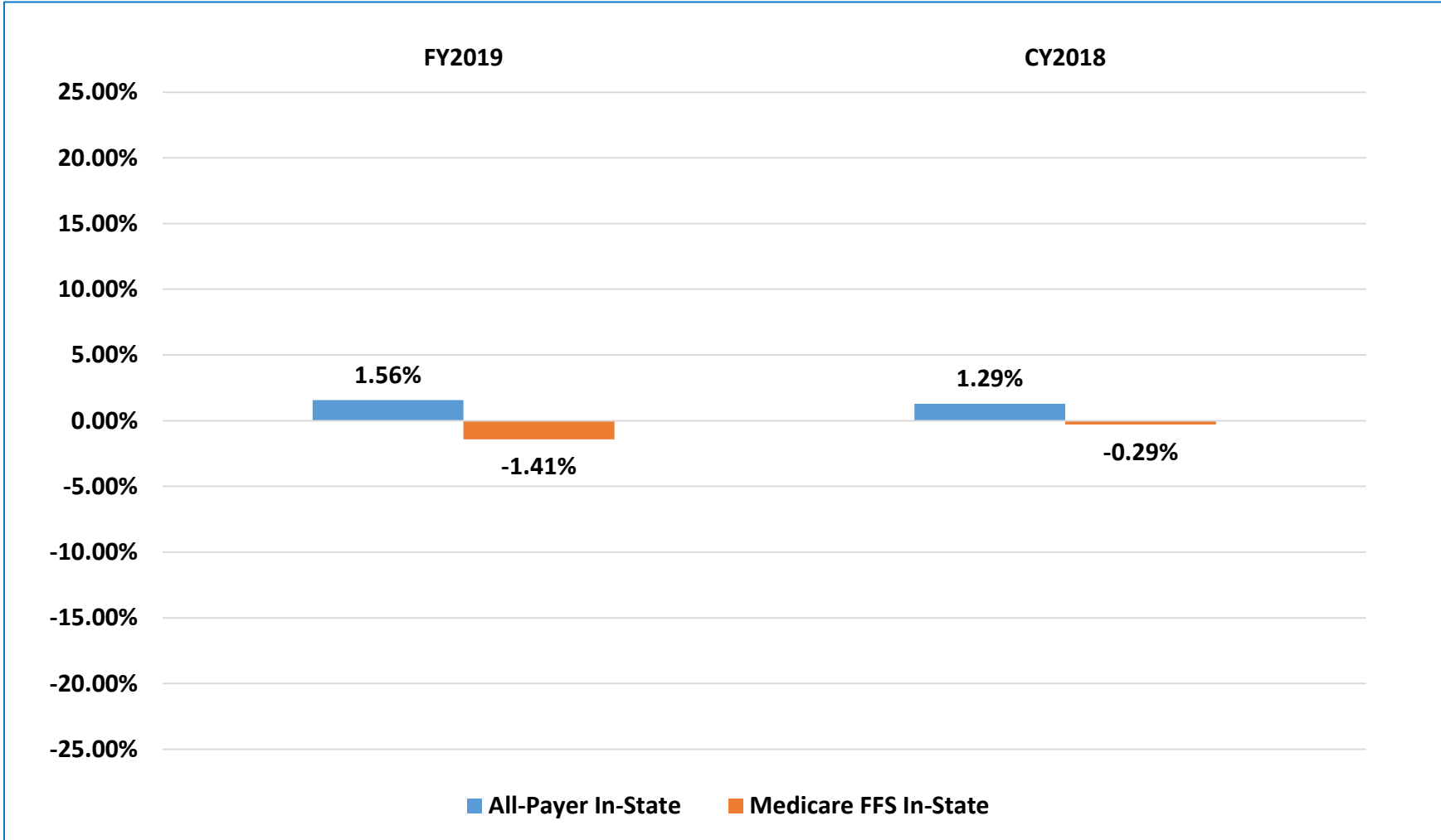
FY 2019 (July 18 – Oct 18 over July 17 – Oct 17) and CY 2018 (Jan - Oct 18 over Jan - Oct 17)



The State's Fiscal Year begins July 1

# Hospital Revenue Per Capita Growth Rates

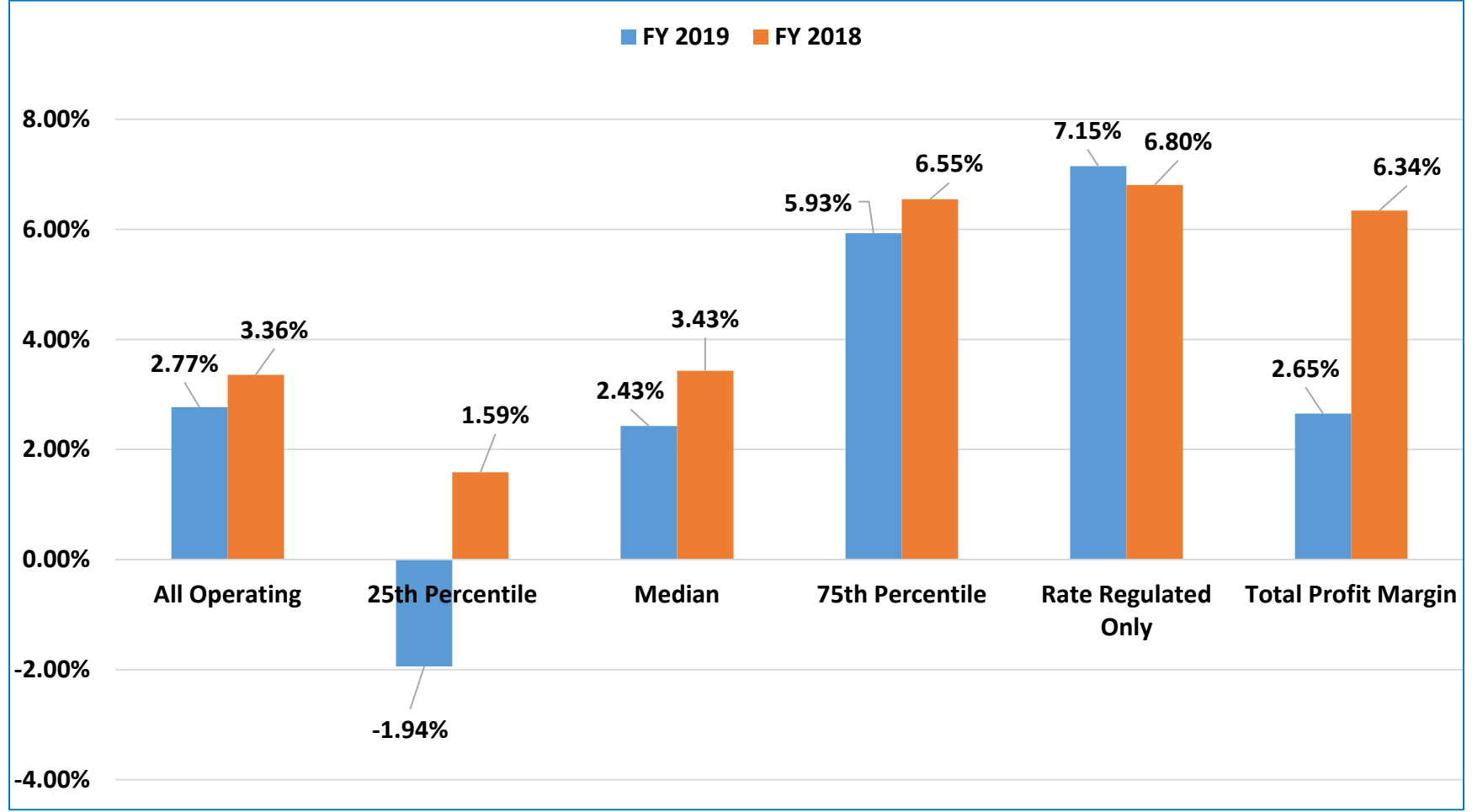
FY 2019 (July 18 – Oct 18 over July 17 – Oct 17) and CY 2018 (Jan - Oct 18 over Jan - Oct 17)



The State's Fiscal Year begins July 1

# Hospital Operating, Regulated and Total Profits

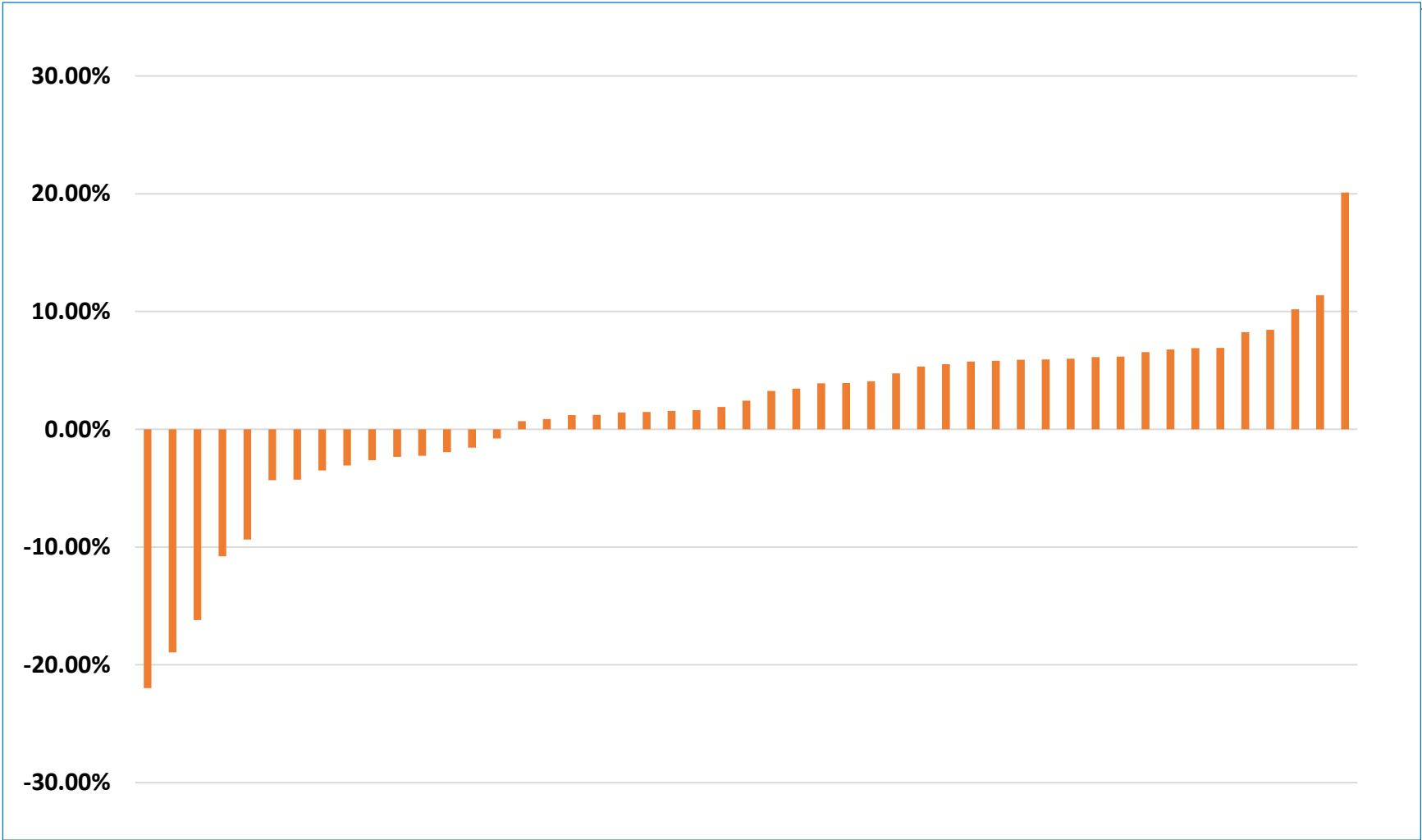
Fiscal Year 2019 (July 2018 – October 2018) Compared to Fiscal Year 2018 (July 2017 – October 2017)



FY 2019 unaudited hospital operating profits show a decline of .59 percentage points in total operating profits compared to FY 2018. Rate regulated profits for FY 2019 have increased .35 percentage points compared to FY 2018.

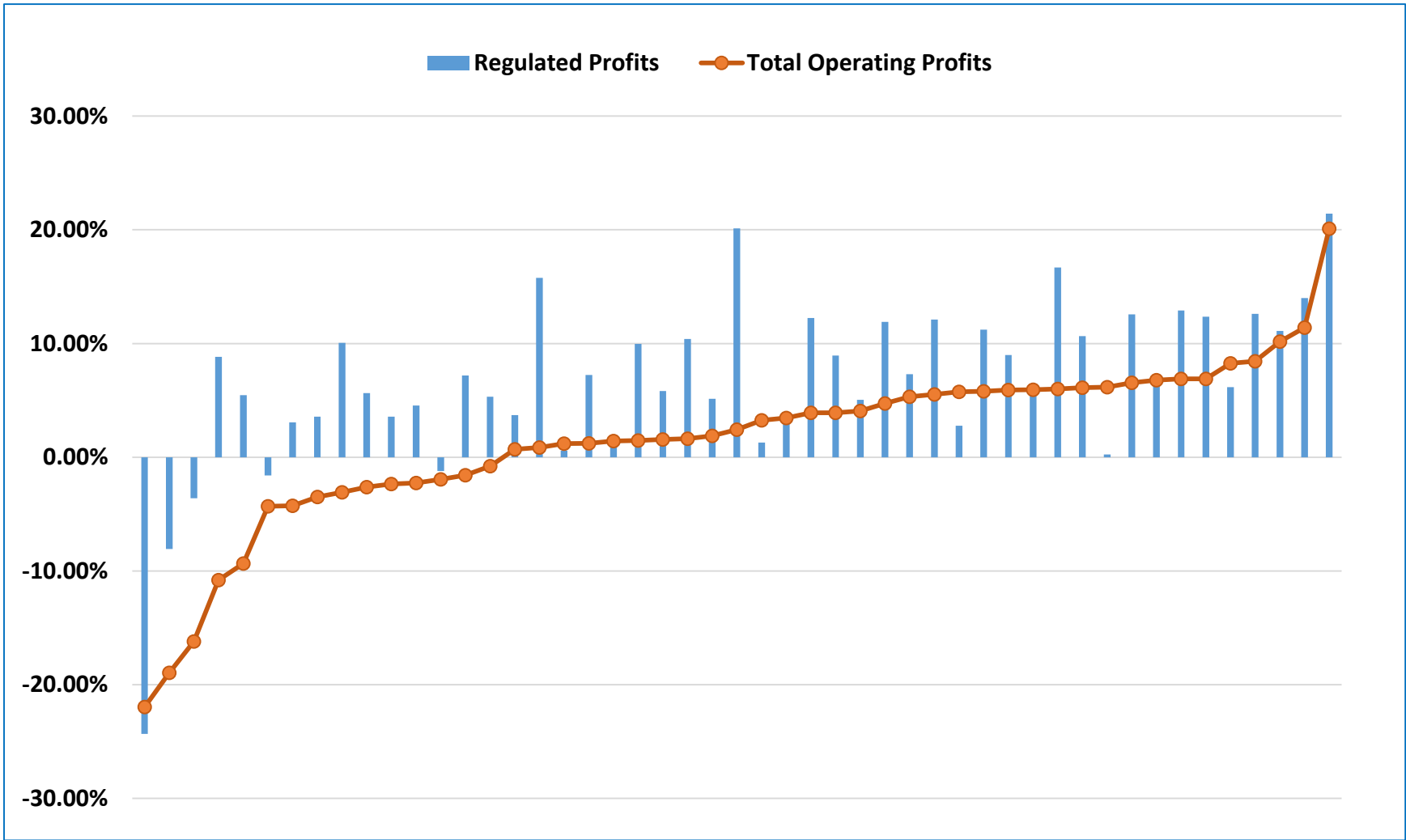
# Operating Profits by Hospital

Fiscal Year 2019 (July 2018 – October 2018)



# Operating and Regulated Profits by Hospital

Fiscal Year 2019 (July 2018 – October 2018)



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# Monitoring Maryland Performance Financial/Utilization Data

## Calendar Year to Date through October 2018

Source: Hospital Monthly Volume and Revenue Data

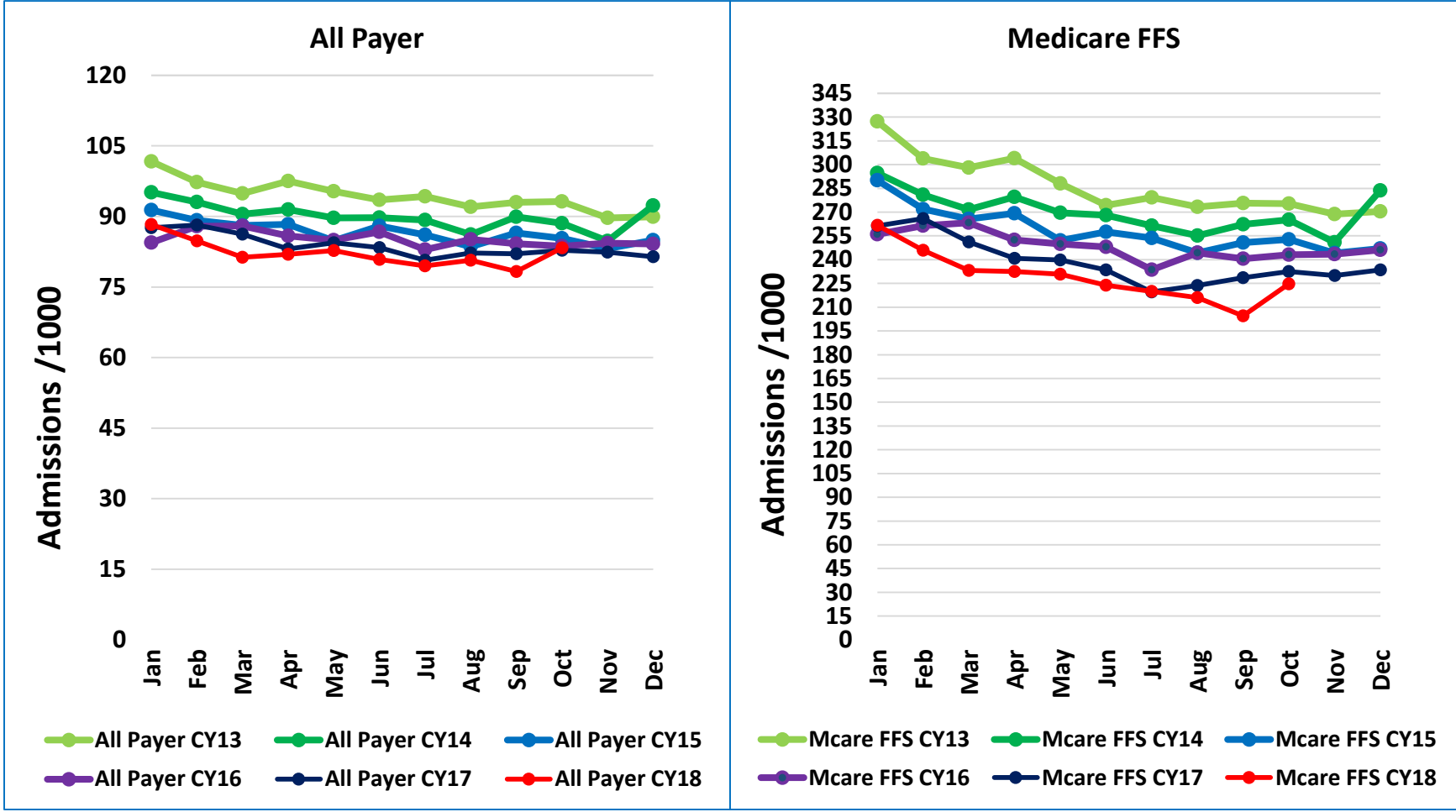
The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2017 have been revised. CMS has changed the enrollment source for the Chronic Condition Data Warehouse (CCW) from the Enrollment Database (EDB) to the Common Medicare Environment (CME) database. We have determined that the Beneficiary counts for CY 2018 are currently being understated, and we are working to resolve this issue with CMS.

The Maryland Department of Planning released new population estimates in December 2017. The population numbers used to calculate the ADK, BDK and EDK have been revised accordingly.



# Annual Trends for ADK Annualized

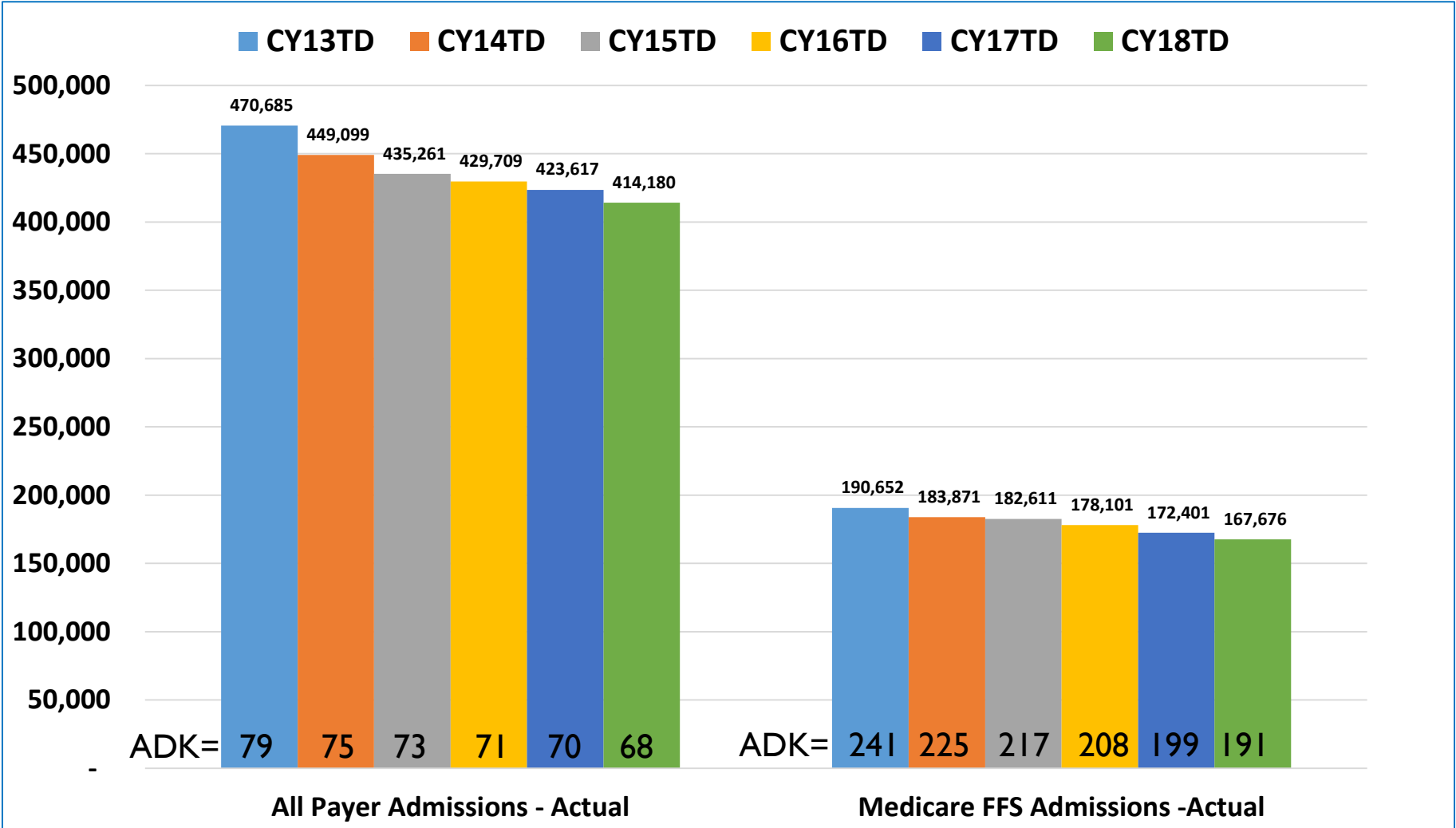
All Payer and Medicare Fee For Service (CY 2013 through CY 2018 October)



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

# Actual Admissions by Calendar YTD - October

(CY 2013 through CY 2018)



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



# Change in Admissions by Calendar YTD October

(CY 2013 through CY 2018)

**Change in All Payer Admissions CYTD13 vs. CYTD14 = -4.59%**  
**Change in All Payer Admissions CYTD14 vs. CYTD15 = -3.08%**  
**Change in All Payer Admissions CYTD15 vs. CYTD16 = -1.28%**  
**Change in All Payer Admissions CYTD16 vs. CYTD17 = -1.42%**  
**Change in All Payer Admissions CYTD17 vs. CYTD18 = -2.23%**

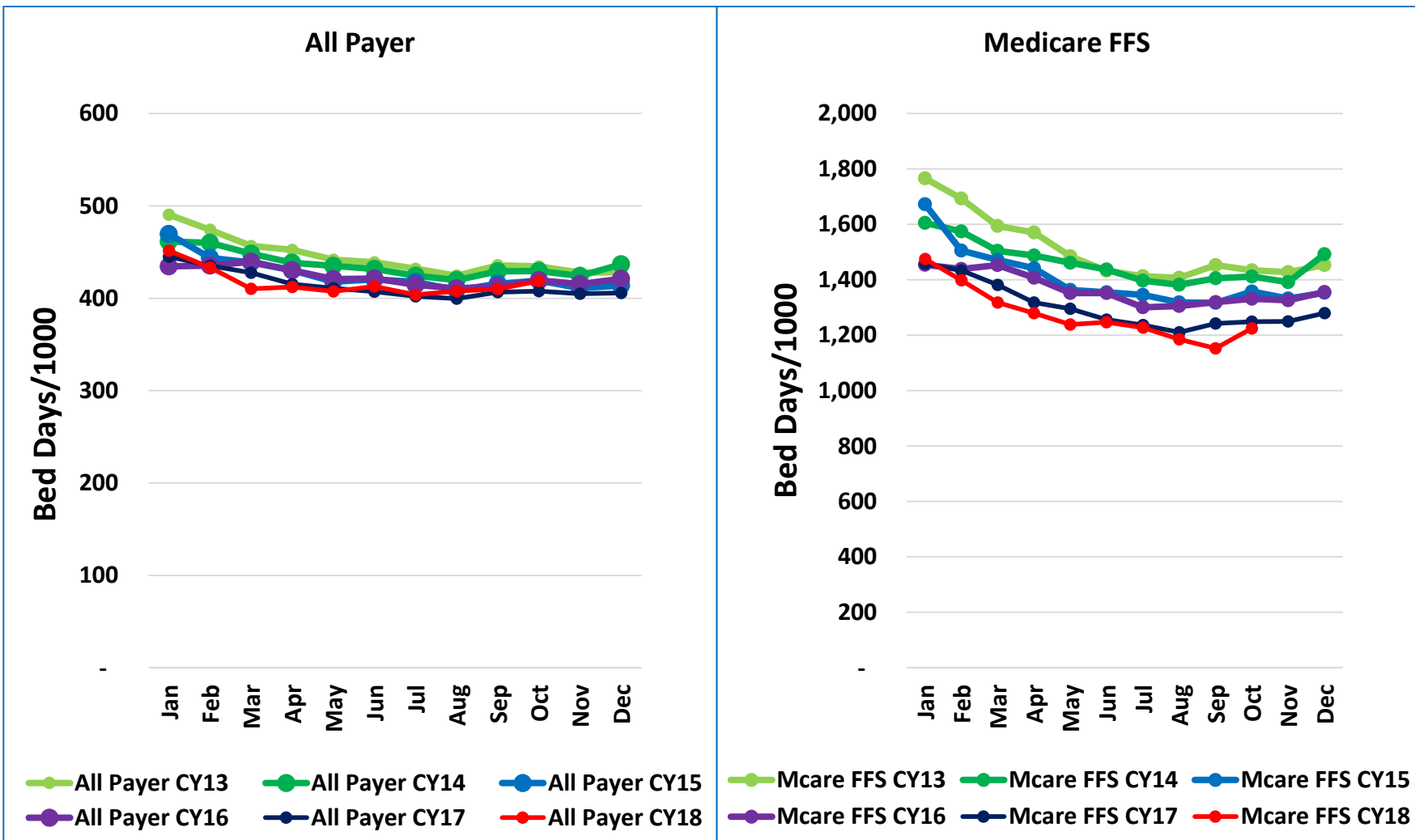
**Change in ADK CYTD 13 vs. CYTD 14 = -5.19%**  
**Change in ADK CYTD 14 vs. CYTD 15 = -3.57%**  
**Change in ADK CYTD 15 vs. CYTD 16 = -1.67%**  
**Change in ADK CYTD 16 vs. CYTD 17 = -1.86%**  
**Change in ADK CYTD 17 vs. CYTD 18 = -2.23%**

**Change in Medicare FFS Admissions CYTD13 vs. CYTD14 = -3.56%**  
**Change in Medicare FFS Admissions CYTD14 vs. CYTD15 = -0.69%**  
**Change in Medicare FFS Admissions CYTD15 vs. CYTD16 = -2.47%**  
**Change in Medicare FFS Admissions CYTD16 vs. CYTD17 = -3.20%**  
**Change in Medicare FFS Admissions CYTD17 vs. CYTD18 = -2.74%**

**Change in Medicare FFS ADK CYTD 13 vs. CYTD 14 = -6.59%**  
**Change in Medicare FFS ADK CYTD 14 vs. CYTD 15 = -3.70%**  
**Change in Medicare FFS ADK CYTD 15 vs. CYTD 16 = -4.10%**  
**Change in Medicare FFS ADK CYTD 16 vs. CYTD 17 = -4.21%**  
**Change in Medicare FFS ADK CYTD 17 vs. CYTD 18 = -4.27%**

# Annual Trends for BDK Annualized

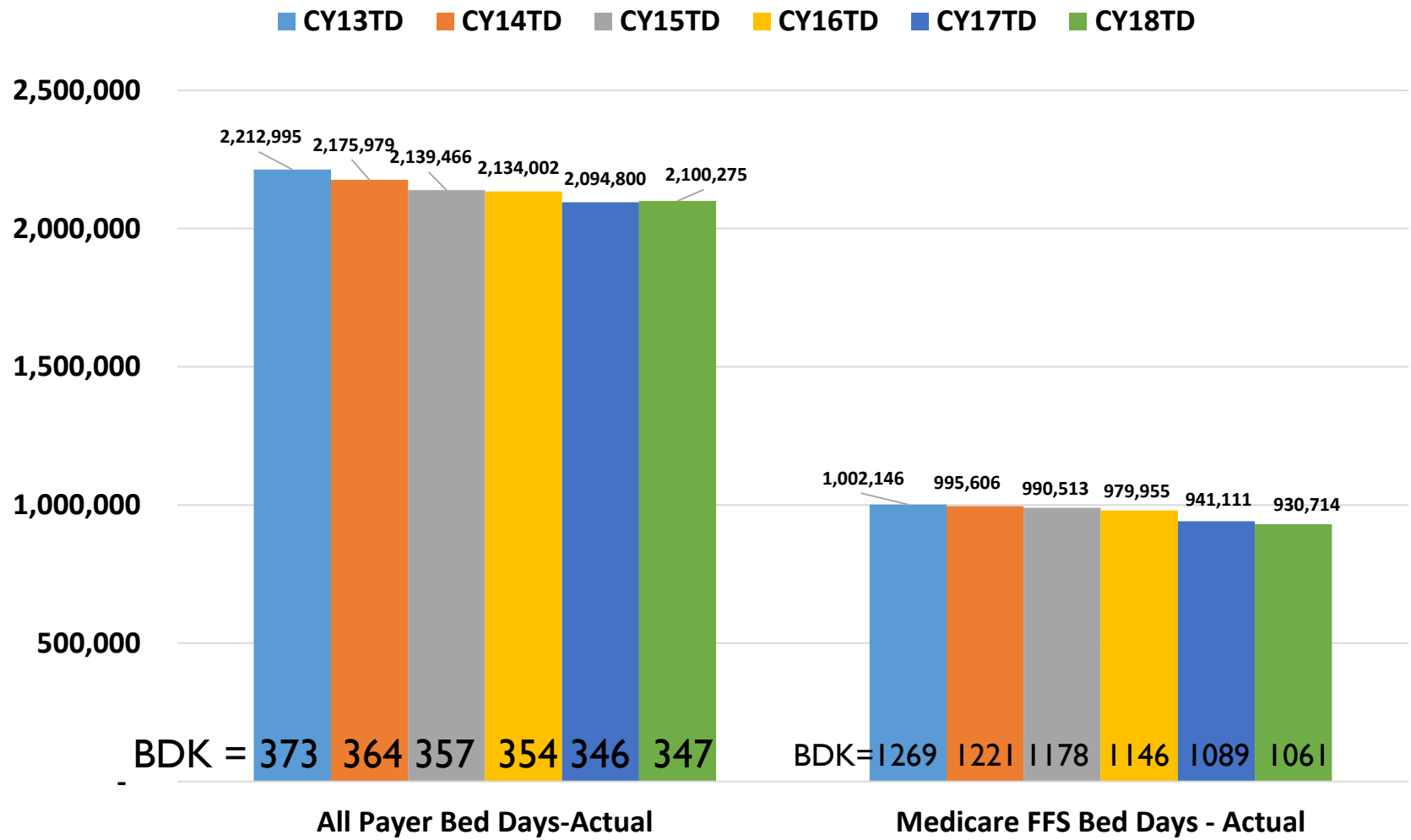
All Payer and Medicare Fee For Service (CY 2013 through CY 2018 October)



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

# Actual Bed Days by Calendar YTD October

(CY 2013 through CY 2018)



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

# Change in Bed Days by Calendar YTD October

(CY 2013 through CY 2018)

**Change in All Payer Bed Days CYTD13 vs. CYTD14 = -1.67%**

**Change in All Payer Bed Days CYTD14 vs. CYTD15 = -1.68%**

**Change in All Payer Bed Days CYTD15 vs. CYTD16 = -0.26%**

**Change in All Payer Bed Days CYTD16 vs. CYTD17 = -1.84%**

**Change in All Payer Bed Days CYTD17 vs. CYTD18 = 0.26%**

**Change in BDK CYTD 13 vs. CYTD 14 = -2.29%**

**Change in BDK CYTD 14 vs. CYTD 15 = -2.17%**

**Change in BDK CYTD 15 vs. CYTD 16 = -0.66%**

**Change in BDK CYTD 16 vs. CYTD 17 = -2.28%**

**Change in BDK CYTD 17 vs. CYTD 18 = 0.26%**

**Change in Medicare FFS Bed Days CYTD13 vs. CYTD14 = -0.65%**

**Change in Medicare FFS Bed Days CYTD14 vs. CYTD15 = -0.51%**

**Change in Medicare FFS Bed Days CYTD15 vs. CYTD16 = -1.07%**

**Change in Medicare FFS Bed Days CYTD16 vs. CYTD17 = -3.96%**

**Change in Medicare FFS Bed Days CYTD17 vs. CYTD18 = -1.10%**

**Change in Medicare FFS BDK CYTD 13 vs. CYTD 14 = -3.79%**

**Change in Medicare FFS BDK CYTD 14 vs. CYTD 15 = -3.53%**

**Change in Medicare FFS BDK CYTD 15 vs. CYTD 16 = -2.73%**

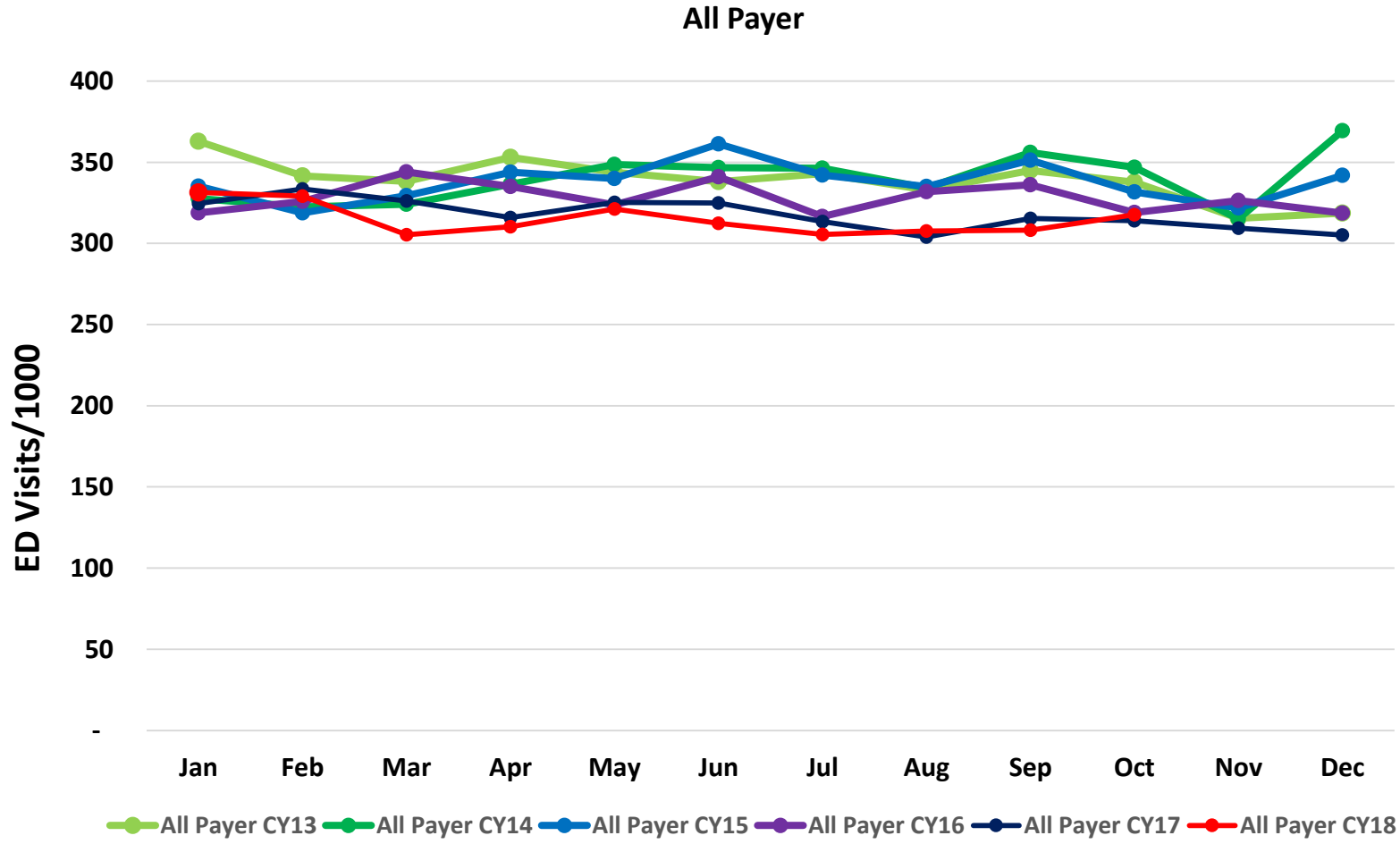
**Change in Medicare FFS BDK CYTD 16 vs. CYTD 17 = -4.97%**

**Change in Medicare FFS BDK CYTD 17 vs. CYTD 18 = -2.56%**



# Annual Trends for EDK Annualized

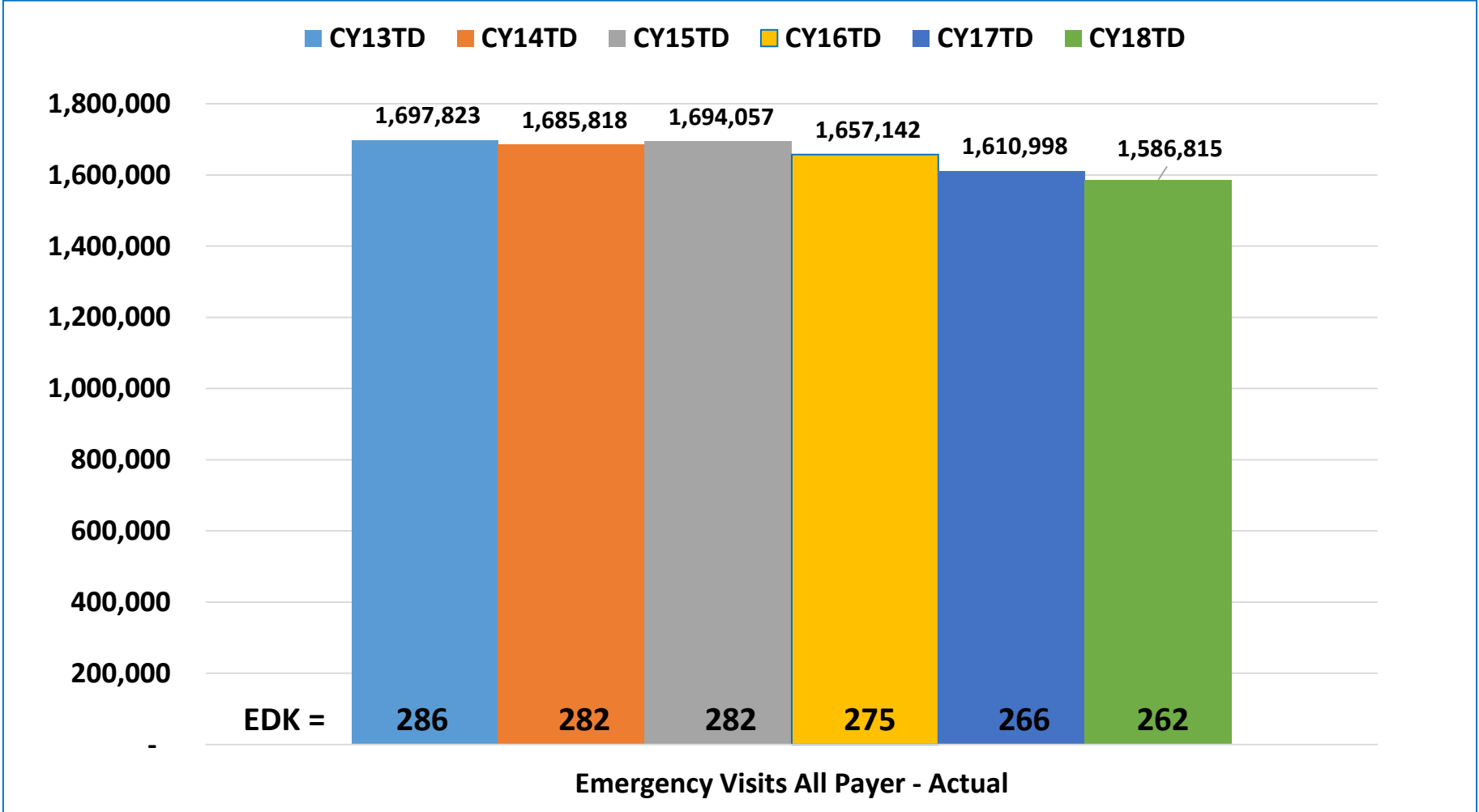
All Payer (CY 2013 through CY2018 October)



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

# Actual Emergency Dept. Visits by Calendar YTD October

(CY 2013 through CY 2018)



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



# Change in ED Visits by Calendar YTD October

(CY 2013 through CY 2018)

**Change in ED Visits CYTD 13 vs. CYTD 14 = -0.71%**

**Change in ED Visits CYTD 14 vs. CYTD 15 = .49%**

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

**Change in ED Visits CYTD 16 vs. CYTD 17 = -2.78%**

**Change in ED Visits CYTD 17 vs. CYTD 18 = -1.50%**

**Change in EDK CYTD 13 vs. CYTD 14 = -1.33%**

**Change in EDK CYTD 14 vs. CYTD 15 = -0.02%**

**Change in EDK CYTD 15 vs. CYTD 16 = -2.57%**

**Change in EDK CYTD 16 vs. CYTD 17 = -3.23%**

**Change in EDK CYTD 17 vs. CYTD 18 = -1.50%**

# Purpose of Monitoring Maryland Performance

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

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

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

# Data Caveats

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



# Monitoring Maryland Performance Quality Data

December 2018 Commission Meeting Update



**HSCRC**

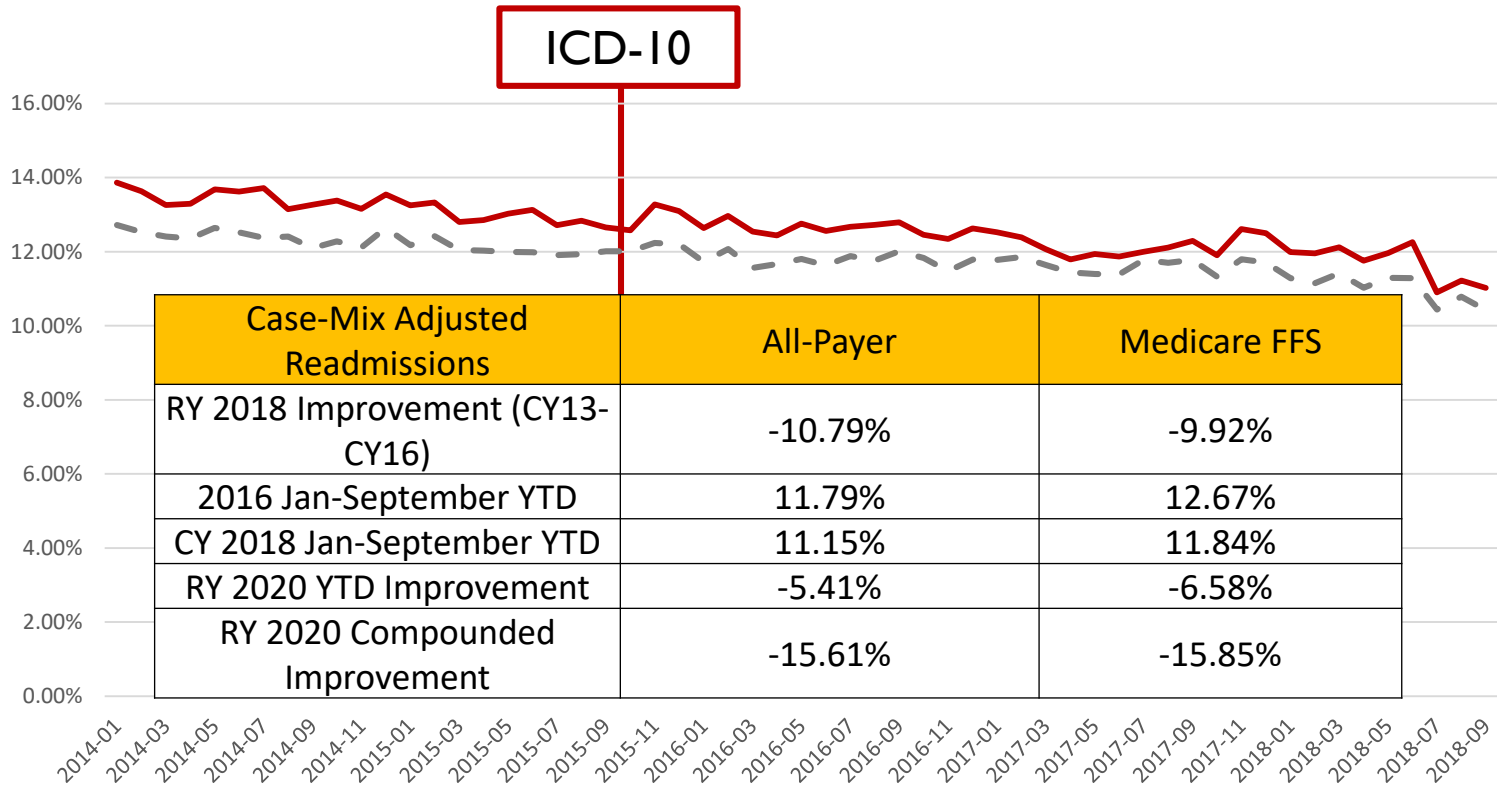
Health Services Cost  
Review Commission

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# Readmission Reduction Analysis

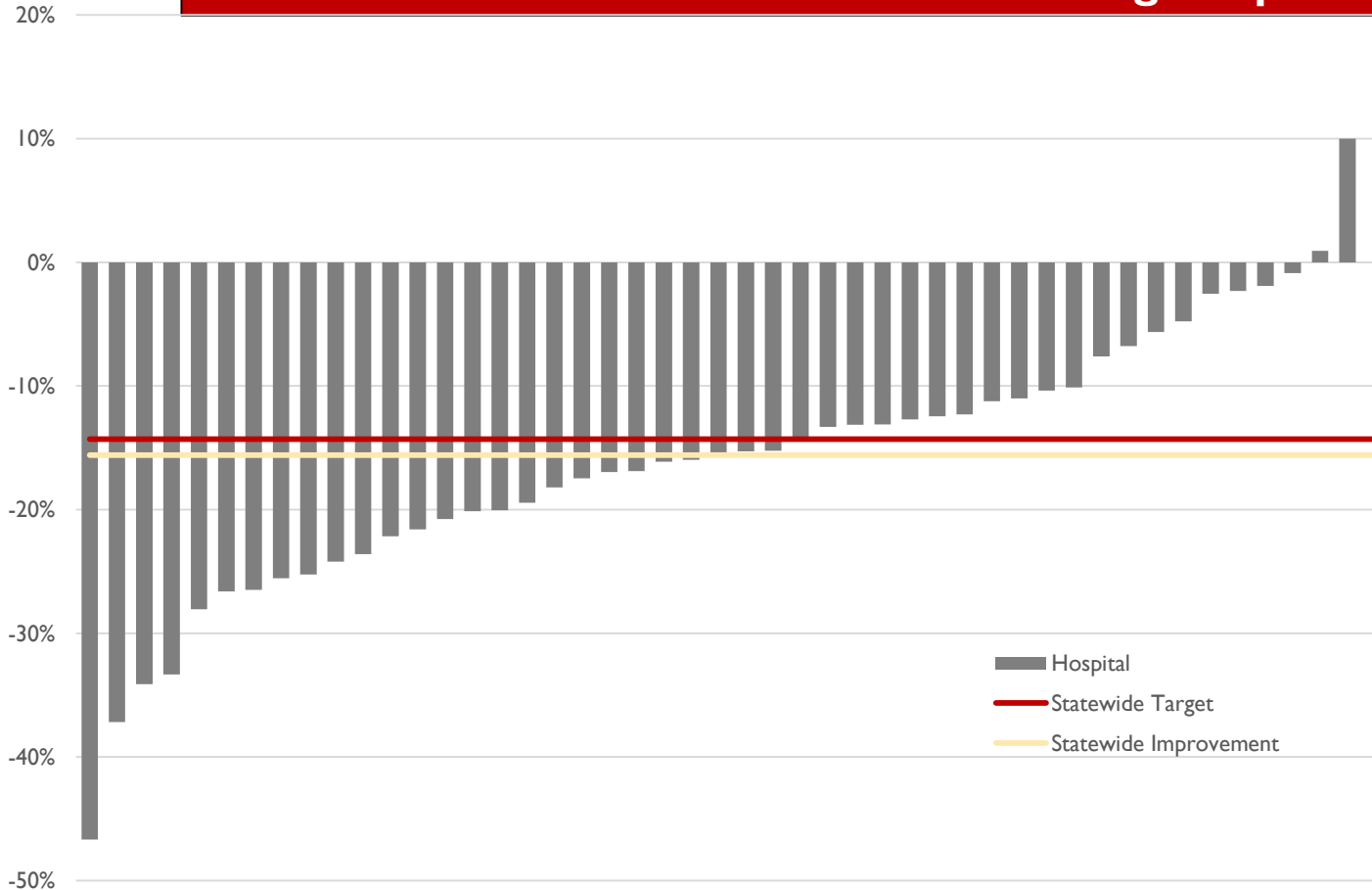
# Monthly Case-Mix Adjusted Readmission Rates



**Note: Based on final data for Jan 2013 – Mar 2018; Preliminary data through September 2018. Statewide improvement to-date in RY 2020 is compounded with RY 2018 improvement.**

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

**Cumulative change CY 2013 – CY 2016 (RY2018) Compounded with CY 2016 to CY 2018 YTD through September**



**26 Hospitals are on Track for Achieving Improvement Goal**

**Additional 9 Hospitals on Track for Achieving Attainment Goal**

**Note: Based on Final data for Oct 2015 – Jun 2018; Prelim through October 2018.**

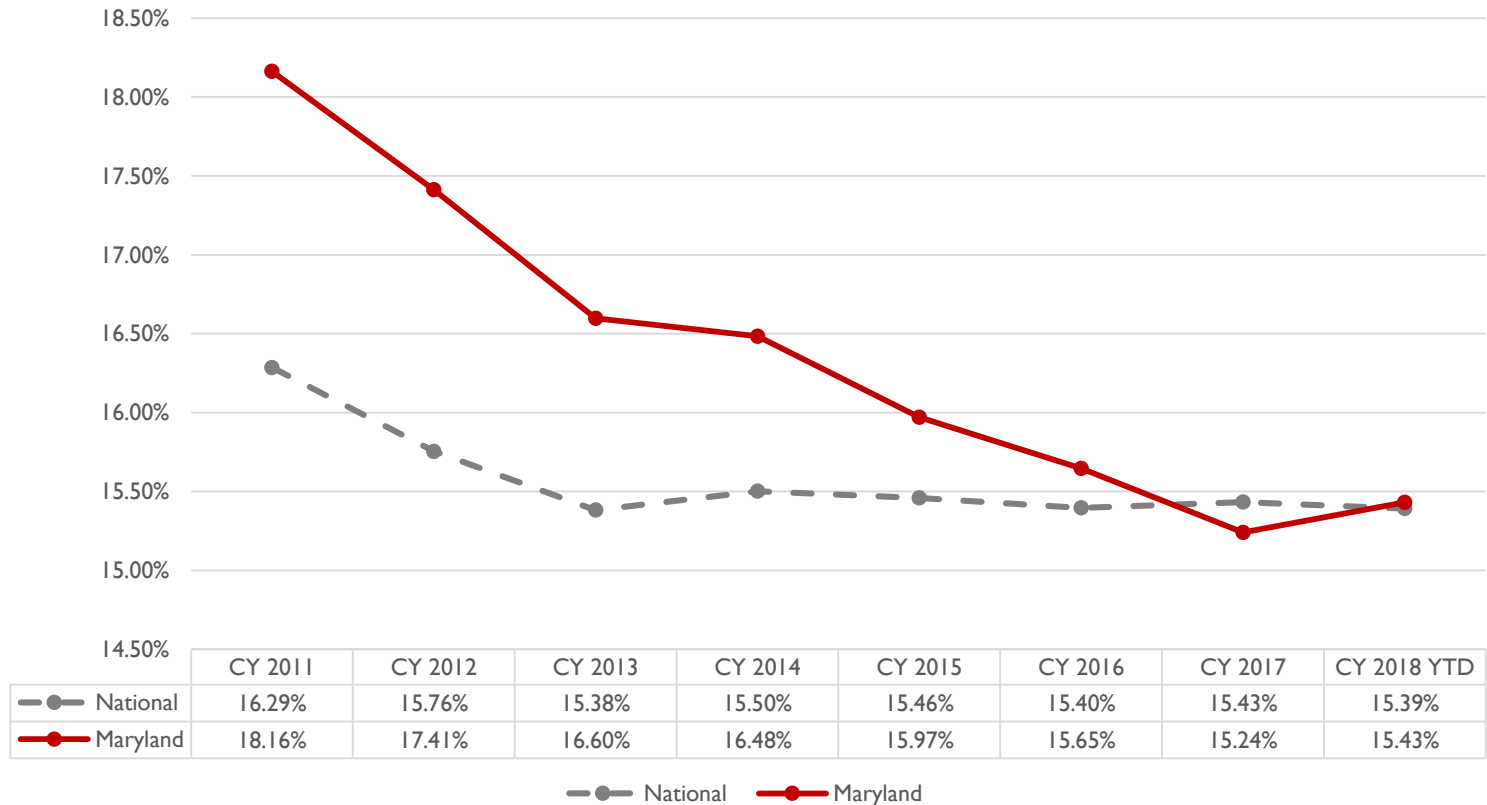
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# Medicare Readmission Model Test



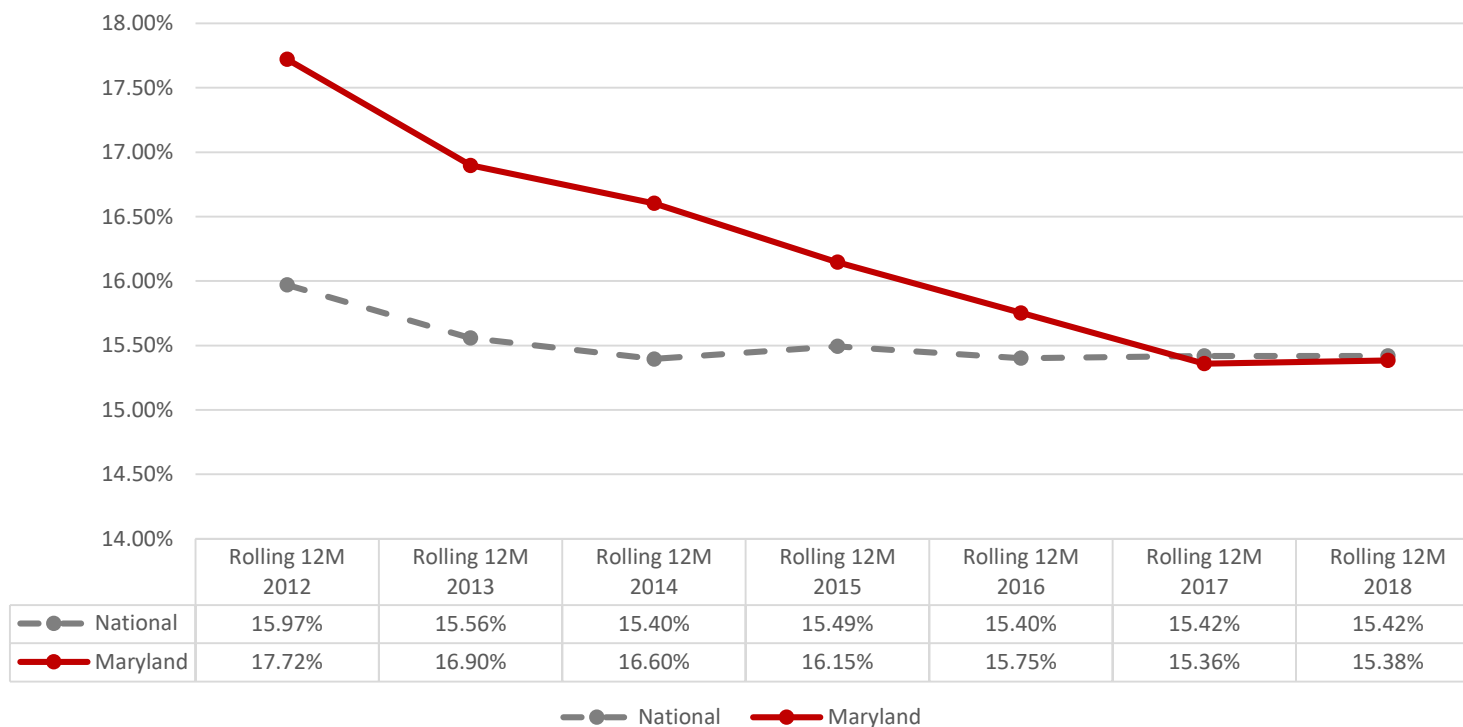
# Readmissions – 2011-2017; 2018 YTD through July

Readmissions - CY 2011 - CY 2017; CY 2018 YTD



# Medicare Readmissions – Rolling 12 Months Trend

Readmissions - Rolling 12M through July



Data are currently available through July 2018

## Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF DECEMBER 3, 2018

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
2452A	Johns Hopkins Health System	9/6/2018	N/A	N/A	ARM	AP	OPEN
2453A	MedStar Health	9/6/2018	N/A	N/A	ARM	AP	OPEN
2458A	University of Maryland Medical Center	10/1/2018	N/A	N/A	ARM	DNP	OPEN
2459A	Maryland Physicians Care	10/1/2018	N/A	N/A	ARM	AP	OPEN
2462A	University of Maryland Medical System	10/15/2018	N/A	N/A	ARM	DNP	OPEN
2463A	University of Maryland Medical System	10/15/2018	N/A	N/A	ARM	AP	OPEN
2464A	Johns Hopkins Health System	10/29/2018	N/A	N/A	ARM	DNP	OPEN
2465A	Johns Hopkins Health System	11/20/2018	N/A	N/A	ARM	DNP	OPEN
2466A	Johns Hopkins Health System	11/27/2018	N/A	N/A	ARM	DNP	OPEN
2467A	Johns Hopkins Health System	11/27/2018	N/A	N/A	ARM	DNP	OPEN
2468A	Johns Hopkins Health System	11/27/2018	N/A	N/A	ARM	DNP	OPEN
2469A	Johns Hopkins Health System	11/30/2018	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

<b>IN RE: THE ALTERNATIVE</b>	*	<b>BEFORE THE HEALTH</b>	
<b>RATE APPLICATION OF</b>	*	<b>SERVICES COST REVIEW</b>	
<b>THE JOHNS HOPKINS HEALTH</b>	*	<b>COMMISSION</b>	
<b>SYSTEM</b>	*	<b>DOCKET:</b>	<b>2018</b>
	*	<b>FOLIO:</b>	<b>2262</b>
<b>BALTIMORE, MARYLAND</b>	*	<b>PROCEEDING</b>	<b>2452A</b>

**Final Recommendation**

**December 12, 2018**

## **I. Introduction**

On September 6, 2018 Johns Hopkins Health System (“JHHS,” or the “System”) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Suburban Hospital, and Howard County General Hospital (“the Hospitals”). The System seeks renewal for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes the risk under the contract. The Commission most recently approved this contract under proceeding 2353A for the period from January 1, 2018 through December 31, 2018. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2019.

## **II. Background**

Under the Medicaid Health Choice Program, Priority Partners, a provider-sponsored Managed Care Organization (“MCO”) sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. Priority Partners was created in 1996 as a joint venture between Johns Hopkins Health Care (JHHC) and the Maryland Community Health System (MCHS) to operate an MCO under the Health Choice Program. Johns Hopkins Health Care operates as the administrative arm of Priority Partners and receives a percentage of premiums to provide services such as claim adjudication and utilization management. MCHS oversees a network of Federally Qualified Health Clinics and provides member expertise in the provision of primary care services and assistance in the development of provider networks.

The application requests approval for the Hospitals to continue to provide inpatient and

outpatient hospital services, as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. Priority Partners pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the initially revised Medicaid capitation rates.

Priority Partners is a major participant in the Medicaid Health Choice program, providing managed care services to 25.5% of the State's MCO population.

### **III. Staff Review**

This contract has been operating under the HSCRC's initial approval in proceeding 2353A. Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2017, 2018, and 2019. The statements provided by Priority Partners to staff represent both a "stand-alone" and "consolidated" view of Priority's operations. The consolidated picture reflects certain administrative revenues and expenses of Johns Hopkins Health Care. When other provider-based MCOs are evaluated for financial stability, their administrative costs relative to their MCO business are included as well; however, they are all included under the one entity of the MCO.

The consolidated financial performance of Priority Partners was favorable in CY 2017. Priority Partners is projecting to have unfavorable performance in CY 2018 and an unfavorable performance in CY 2019; however, the CY19 unfavorable performance is mainly due to the positing of a large premium deficiency reserve that may not be necessary given recent actions taken by the Maryland Department of Health to increase rates for childless adult population.

#### **IV. Recommendation**

Based on this three year analysis, HSCRC has concerns about whether this arrangement could be deemed a loss contract from an MCO ARM perspective.

**Therefore:**

- (1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2019; however, staff is placing Priority Partners on a watch list as described in item (2) below.**
- (2) Since sustained losses, such as those currently being experienced by Priority Partners may be construed as a loss contract necessitating termination of this arrangement, staff is recommending the following actions:**
  - a. On the earlier of July 1, 2019 or if/when Medicaid applies a mid-year adjustment, Priority Partners shall report to HSCRC staff on the impact that any such adjustment is expected to have on CY 2019 financial performance.**
  - b. HSCRC staff shall be cognizant of the MCO's financial performance and the potential for a loss contract in considering any requested adjustments to rates or global budgets of the associated hospitals during FYs 2019 and 2020.**
  - c. In addition to the report provided in (2)(a), Priority Partners shall report to Commission staff (on or before the September 2019 meeting of the**



**Commission) on the actual CY 2018 experience and preliminary CY 2019 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2020 using a prescribed template that the HSCRC will provide.**

- (3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.**

<b>IN RE: THE ALTERNATIVE</b>	<b>*</b>	<b>BEFORE THE HEALTH</b>	
<b>RATE APPLICATION OF</b>	<b>*</b>	<b>SERVICES COST REVIEW</b>	
<b>MEDSTAR HEALTH</b>	<b>*</b>	<b>COMMISSION</b>	
<b>SYSTEM</b>	<b>*</b>	<b>DOCKET:</b>	<b>2018</b>
	<b>*</b>	<b>FOLIO:</b>	<b>2263</b>
<b>COLUMBIA, MARYLAND</b>	<b>*</b>	<b>PROCEEDING:</b>	<b>2453A</b>

**Final Recommendation**

**December 12, 2018**

## **I. Introduction**

On September 6, 2018, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of the MedStar Hospitals (“the Hospitals”). MedStar Health seeks renewal for the continued participation of MedStar Family Choice (“MFC”) in the Medicaid Health Choice Program. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2358A for the period from January 1, 2018 through December 31, 2018. The Hospitals are requesting to renew this contract for one year beginning January 1, 2019.

## **II. Background**

Under the Medicaid Health Choice Program, MedStar Family Choice, a Managed Care Organization (“MCO”) sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services, as well as certain non-hospital services, while MFC receives a State-determined capitation payment. MFC pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. As of June 2018, MFC provided services to 7.8% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the Medicaid capitation rates.

### **III. Staff Review**

This contract has been operating under previous HSCRC approval (proceeding 2353A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2017, 2018, and 2019. Over this three year period, Medstar has sustained slightly favorable performance.

### **IV. Recommendation**

Based on past and projected performance, staff believes that the proposed renewal arrangement for Medstar is acceptable.

#### **Therefore:**

- 1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2019.**
- 2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance in CY 2018, and the MCOs expected financial status into CY 2019. Therefore, staff recommends that Medstar report to Commission staff (on or before the September 2019 meeting of the Commission) on the actual CY 2018 experience, and preliminary CY 2019 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2020 using a prescribed template that the HSCRC will provide.**

**3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.**

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

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2018  
\* FOLIO: 2268  
\* PROCEEDING: 2458A**

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**Staff Recommendation**

**December 12, 2018**

## **I. INTRODUCTION**

The University of Maryland Medical Center (“Hospital”) filed an application with the HSCRC on October 1, 2018 requesting approval to continue its participation in a global rate arrangement with BlueCross and BlueShield Association Blue Distinction Centers for solid organ and blood and bone marrow transplant services for a period of one year beginning November 1, 2018.

## **II. OVERVIEW OF APPLICATION**

The contract will continue to be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will continue to manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

## **III. FEE DEVELOPMENT**

The hospital portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

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

The 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 between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

## **V. STAFF EVALUATION**

The staff found that the experience under this arrangement for the prior year has been favorable.

## **VI. STAFF RECOMMENDATION**

The staff recommends that the Commission approve the Hospital’s application for an

alternative method of rate determination for blood and bone marrow transplant services, for a one year period commencing November 1, 2018. The Hospital 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 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.



<b>IN RE: THE ALTERNATIVE</b>	<b>*</b>	<b>BEFORE THE HEALTH</b>
<b>RATE APPLICATION OF</b>	<b>*</b>	<b>SERVICES COST REVIEW</b>
<b>SAINT AGNES HEALTH</b>	<b>*</b>	<b>COMMISSION</b>
<b>WESTERN MARYLAND</b>	<b>*</b>	<b>DOCKET: 2018</b>
<b>HEALTH SYSTEM</b>	<b>*</b>	<b>FOLIO: 2269</b>
<b>MERITUS HEALTH</b>	<b>*</b>	<b>PROCEEDING: 2459A</b>
<b>HOLY CROSS HEALTH</b>	<b>*</b>	

**Final Recommendation**

**December 12, 2018**

## **I. Introduction**

October 1, 2018 Saint Agnes Health System, Western Maryland Health System, Holy Cross Health, and Meritus Health (“the Hospitals”) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06. The Hospitals seek renewal for the continued participation of Maryland Physicians Care (“MPC”) in the Medicaid Health Choice Program. MPC is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2356A for the period January 1, 2018 through December 31, 2018. The Hospitals are requesting to renew this contract for one year beginning January 1, 2019.

## **II. Background**

Under the Medicaid Health Choice Program, MPC, a Managed Care Organization (“MCO”) sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. MPC pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MPC is a major participant in the Medicaid Health Choice program, and provides services to 18.5% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

### **III. Staff Review**

This contract has been operating under previous HSCRC approval (Proceeding 2356A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2017, 2018, and 2019. In CY 2017 MPC had favorable performance and is projecting marginal favorable performance in CY 2018; however, the MCO is projecting marginal unfavorable performance in CY 2019.

### **IV. Recommendation**

Based on past and projected performance, staff believes that the proposed renewal arrangement for MPC is acceptable.

**Therefore:**

- 1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2019.**
- 2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance in CY 2018, and the MCOs expected financial status into CY 2019. Therefore, staff recommends that MPC report to Commission staff (on or before the September 2019 meeting of the Commission) on the actual CY 2018 experience, and preliminary CY 2019 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2020 using a prescribed template that the HSCRC will provide.**

**Consistent with its policy paper outlining a structure for review and evaluation of**

**applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.**

<b>IN RE: THE ALTERNATIVE</b>	<b>*</b>	<b>BEFORE THE HEALTH</b>	
<b>RATE APPLICATION OF</b>	<b>*</b>	<b>SERVICES COST REVIEW</b>	
<b>UNIVERSITY OF MARYLAND</b>	<b>*</b>	<b>COMMISSION</b>	
<b>MEDICAL SYSTEM</b>	<b>*</b>	<b>DOCKET:</b>	<b>2018</b>
	<b>*</b>	<b>FOLIO:</b>	<b>2272</b>
<b>BALTIMORE, MARYLAND</b>	<b>*</b>	<b>PROCEEDING:</b>	<b>2462A</b>

**Revised**

**Staff Recommendation**

**December 12, 2018**

## **I. Introduction**

On October 15, 2018, the University of Maryland Medical System (UMMS) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of its constituent hospitals (the “Hospitals”). UMMS seeks approval for University of Maryland Health Advantage, Inc. (“UMHA”) to continue to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. UMHA is the UMMS entity that assumes the risk under this contract. UMHA is requesting an approval for one year beginning January 1, 2019.

## **II. Background**

CMS granted UMHA approval to operate a Medicare Advantage Plan to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Caroline, Carroll, Cecil, Charles, Dorchester, Harford, Howard, Kent, Montgomery, Prince George’s, Queen Anne’s, Talbot counties and Baltimore City. UMHA currently offers two products - - UMHA Complete, which is a general enrollment Medicare Advantage Plan that includes Medicare Part D prescription drug coverage, and UMHA Duel Special Needs Plan that limits membership to people with special needs that are eligible for both Medicare and Medicaid. For economic reasons UMHA plans to stop offering the UMHA Complete Plan and to provide only the UMHA Duel Special Needs Plan (in CY 2019). The application requests approval for UMHA to provide for inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. UMHA will pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees. UMHA supplied staff with a copy of its contract with CMS.

### **III. Staff Review**

Staff reviewed the reviewed the financial projections for CY 2019, as well as UMHA's experience and projections for CY 2018. The information reflected the anticipated negative financial results associated with the start-up of a Medicare Advantage Plan. According to UMHA its concentration on the Dual Special Needs market and its exit from the general enrollment market will result in a more favorable experience in CY 2019.

### **IV. Recommendation**

Based on the financial projections, staff believes that the proposed arrangement for UMHA is acceptable under Commission policy. Therefore, staff recommends that the Commission approve the Hospitals' request to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2018. UMHA must meet with HSCRC staff prior to August 31, 2019 to review its financial projections for CY 2020. In addition, UMHA must submit to the Commission a copy of its quarterly and annual National Association of Insurance Commissioners' (NAIC's) reports within 30 days of submission to the NAIC.

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 ALTERNATIVE** \* **BEFORE THE HEALTH**  
**RATE APPLICATION OF** \* **SERVICES COST REVIEW**  
**UNIVERSITY OF MARYLAND MEDICAL** \* **COMMISSION**  
**SYSTEM CORPORATION**  
\* **DOCKET: 2018**  
\* **FOLIO: 2273**  
\* **PROCEEDING: 2463A**

**Final Recommendation**

**December 12, 2018**

## **I. Introduction**

On October 15, 2018 University of Maryland Health Partners, Inc. (UMHP), a Medicaid Managed Care Organization (“MCO”), on behalf of The University of Maryland Medical System Corporation (“the Hospitals”), filed an application for an Alternative Method of Rate Determination (“ARM”) pursuant to COMAR 10.37.10.06. UMHP and the Hospitals seek approval for the MCO to continue to participate in the Medicaid Health Choice Program. UMHP is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2410A for the period from January 1, 2018 through December 31, 2018. The former MCO known as Riverside was purchased by University of Maryland Medical System Corporation in August 2015. UMHP and the Hospitals are requesting to implement this new contract for one year beginning January 1, 2019.

## **II. Background**

Under the Medicaid Health Choice Program, UMHP, an MCO owned by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. UMHP pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. UMHP is a relatively small MCO providing services to 3.9% of the total number of MCO enrollees in the HealthChoice Program.

UMHP supplied information on its most recent financial experience as well as its preliminary projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

### **III. Staff Review**

This contract has been operating under previous HSCRC approval (proceeding 2410A). Staff reviewed the operating financial performance under the contract. Staff reviewed available final financial information and projections for CYs 2017, 2018, and 2019. UMHP reported marginal favorable financial performance for CY 2017. Initial projections for CYs 2018 and 2019 are unfavorable; however, it should be noted that for CY 2019 UMHP has amended its projection to favorable because of implementing performance improvement options, including eliminating primary care practices with poor cost efficiency performance.

### **IV. Recommendation**

UMHP has only been in operations as a MCO for five years and has only had breakeven years and years of profitability. Nevertheless, staff does have concerns that UMHP's low market share and limited rate increases will make it difficult for them to not operate as a loss leader in CY 2018 and CY 2019.

**Therefore:**

- (1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2018; however, staff is placing UMHP on a watch list as described in item (2) below.**
- (2) Since sustained losses, such as those currently being experienced by UMHP, may be construed as a loss contract necessitating termination of this arrangement, staff is recommending the following actions:**
  - a. On the earlier of July 1, 2019 or if/when Medicaid applies a mid-year adjustment, UMHP shall report to HSCRC staff on the impact that any**

such adjustment is expected to have on CY 2019 financial performance.

- b. HSCRC staff shall be cognizant of the MCO's financial performance and the potential for a loss contract in considering any requested adjustments to rates or global budgets of the associated hospitals during FYs 2019 and 2020 using a prescribed template that the HSCRC will provide.
- c. In addition to the report provided in (2)(a), UMHP shall report to Commission staff (on or before the September 2019 meeting of the Commission) on the actual CY 2018 experience, preliminary CY 2019 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2020.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

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

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2018  
\* FOLIO: 2274  
\* PROCEEDING: 2464A**

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**Staff Recommendation**

**December 12, 2018**

## **I. INTRODUCTION**

Johns Hopkins Health System (the “System”) filed an application with the HSCRC on October 29, 2018 on behalf of its member Hospitals (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 new global rate arrangement for cardiovascular and joint replacement services with Health Design Plus, Inc. for a period of one year beginning December 1, 2018.

## **II. OVERVIEW OF APPLICATION**

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

This new arrangement combines and replaces two prior arrangements approved by the Commission. The experience under the prior arrangements were favorable over the last year.

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 cardiovascular and joint replacement services for a one year period commencing December 1, 2018. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

<b>IN RE: THE ALTERNATIVE</b>	<b>*</b>	<b>BEFORE THE HEALTH</b>	
<b>RATE APPLICATION OF</b>	<b>*</b>	<b>SERVICES COST REVIEW</b>	
<b>JOHNS HOPKINS HEALTH</b>	<b>*</b>	<b>COMMISSION</b>	
<b>SYSTEM</b>	<b>*</b>	<b>DOCKET:</b>	<b>2018</b>
	<b>*</b>	<b>FOLIO:</b>	<b>2275</b>
<b>BALTIMORE, MARYLAND</b>	<b>*</b>	<b>PROCEEDING:</b>	<b>2465A</b>

**Staff Recommendation**

**December 12, 2018**



## **I. Introduction**

On November 20, 2018, the Johns Hopkins Health System (JHHS) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of its constituent hospitals (the “Hospitals”). JHHS seeks approval for Hopkins Health Advantage, Inc. (“HHA”) to continue to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. HHA is the JHHS entity that assumes the risk under this contract. JHHS is requesting approval for one year beginning January 1, 2019.

## **II. Background**

On September 1, 2015, CMS granted HHA approval to operate a Medicare Advantage Plan to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Calvert, Carroll, Howard, Montgomery, Somerset, Washington, Wicomico, Worcester counties and Baltimore City. HHA is jointly controlled by Johns Hopkins HealthCare, LLC, Advanced Health Collaborative II, LLC (consisting of Adventist Healthcare, Inc., Frederick Regional Health System, Inc., Lifebridge Health, Inc., and Peninsula Regional Health System, Inc.), Anne Arundel Medical Center, and Mercy Health Services, Inc. The application requests approval for HHA to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. HHA will pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees. HHA has supplied the HSCRCV staff with a copy of its contract with CMS.

## **III. Staff Review**

Staff reviewed the reviewed the financial projections for CY 2019, as well as HHA’s

experience and projections for CY 2018. The information reflected the anticipated negative financial results associated with the start-up of a Medicare Advantage Plan.

#### **IV. Recommendation**

Based on the financial projections, staff believes that the proposed arrangement for HHA is acceptable under Commission policy. Therefore, staff recommends that the Commission approve the Hospitals' request to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2019. The Hospitals must file a renewal application annually for continued participation. In addition, HHA must meet with HSCRC staff prior to August 31, 2019 to review its financial projections for CY 2020. In addition, HHA must submit a copy of its quarterly and annual National Association of Insurance Commissioner's (NAIC's) reports within 30 days of submission to the NAIC.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2018  
\* FOLIO: 2276  
\* PROCEEDING: 2466A**

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**Staff Recommendation**

**December 12, 2018**

## **I. INTRODUCTION**

Johns Hopkins Health System (“System”) filed a renewal application with the HSCRC on November 28, 2018 on behalf of the Johns Hopkins Bayview Medical Center (the “Hospital”) requesting approval from the HSCRC for continued participation in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene (DHMH), and the Centers for Medicare and Medicaid Services (CMS). The Hospital, doing business as Hopkins Elder Plus (“HEP”), serves as a provider in the federal “Program of All-inclusive Care for the Elderly” (“PACE”). Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The requested approval is for a period of one year effective January 1, 2018.

## **II. OVERVIEW OF APPLICATION**

The parties to the contract include the System, DHMH, and CMS. The contract covers medical services provided to the PACE population. The assumptions for enrollment, utilization, and unit costs were developed on the basis of historical HEP experience for the PACE population as previously reviewed by an actuarial consultant. Johns Hopkins HealthCare, LLC assumes the risks under the agreement, and all Maryland hospital services are paid based on HSCRC rates.

## **III. STAFF EVALUATION**

Staff found that the experience under this arrangement for FY 2018 to be favorable.

## **III. STAFF RECOMMENDATION**

Staff recommends that the Commission approve the Hospital’s renewal application for an alternative method of rate determination for one year beginning January 1, 2019. The Hospital 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 Hospital for the approved contract.

This document formalizes the understanding between the Commission and the Hospital, and includes 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 also stipulates that operating losses under the contract cannot be used to justify future requests for rate increases.

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

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2018  
\* FOLIO: 2277  
\* PROCEEDING: 2467A**

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**Staff Recommendation**

**December 12, 2018**

## **INTRODUCTION**

Johns Hopkins Health System (System) filed a renewal application with the HSCRC on November 28, 2018 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons with mental health needs under the program title, Creative Alternatives. The arrangement is between the Johns Hopkins Health System and the Baltimore Mental Health Systems, Inc., with the services coordinated through the Hospital. The requested approval is for a period of one year beginning January 1, 2019.

## **II. OVERVIEW OF APPLICATION**

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

## **III. STAFF FINDINGS**

Staff found that the experience under this arrangement for FY 2017 was favorable. Staff believes that the Hospital can continue to achieve a favorable performance under this arrangement.

## **IV. STAFF RECOMMENDATION**

Staff recommends that the Commission approve the Hospital's renewal application for an alternative method of rate determination for a one year period commencing January 1, 2019.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other

issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.



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

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2018  
\* FOLIO: 2278  
\* PROCEEDING: 2468A**

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**Staff Recommendation**

**December 12, 2018**

## **I. INTRODUCTION**

Johns Hopkins Health System (the System) filed a renewal application with the HSCRC on November 28, 2018 on behalf of its member hospitals, the Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers for Tricare patients. The requested approval is for a period of one year beginning January 1, 2019.

## **II. OVERVIEW OF APPLICATION**

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

## **III. STAFF EVALUATION**

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

## **V. STAFF RECOMMENDATION**

The staff recommends that the Commission approve the Hospitals’ renewal application for an alternative method of rate determination for a one year period beginning January 1, 2019. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding (“MOU”) with the Hospitals for the approved contract.

This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract, The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2018  
\* FOLIO: 2279  
\* PROCEEDING: 2469A**

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**Staff Recommendation**

**December 12, 2018**

## **I. INTRODUCTION**

Johns Hopkins Health System (the “System”) filed an application with the HSCRC on November 30, 2018 on behalf of its member Hospitals (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 new global rate arrangement for joint replacement and joint replacement consult services with Carrum Health, Inc. for a period of one year beginning January 1, 2019.

## **II. OVERVIEW OF APPLICATION**

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

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

The Hospitals will 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**

This new arrangement is similar to several other successful arrangements approved by the

Commission.

## **VI. STAFF RECOMMENDATION**

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular and joint replacement services for a one year period commencing January 1, 2019. 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.

# HSCRC Staff Final Recommendation for Adjustment to the Payer Differential

December 12, 2018

# Rationale for Recommendation

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- ▶ Private insurers' changing business practices and plan benefit design modifications have resulted in rising out of pocket costs to consumers, and higher private payer uncompensated care costs relative to governmental payers.
- ▶ This cost increase negatively impacts public payers since actual Uncompensated Care (UCC) is distributed across all payers through a uniform mark-up.
- ▶ The Staff recommendation to change the public payer differential will result in a more equitable distribution of uncompensated care costs and adjust for public payers who are averting more bad debt.



# Final Recommendation – Proposed Change

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- ▶ The HSCRC staff has calculated that an increase of 1.7 percentage points to the public payer differential is needed to compensate for higher private payer levels of UCC relative to governmental payers, resulting from changes in business practices of private Maryland payers.
  - ▶ Staff calculated the higher levels of private payer UCC using matched claim level write-off data and case-mix data to quantify the write-offs associated with each payer.
  - ▶ In 2017, private payer write-offs were 3.6% vs 1.8% for public payers, a difference of 1.9% (rounded). Similarly, private write-offs were 1.7% higher in 2016.
- ▶ Recommendation: Increase the public payer differential from 6.0 percent to 7.7 percent, effective July 1, 2019.

# Hospital, MedChi and Medicaid Comments

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- ▶ A majority of the comments received supported the proposed differential change.
- ▶ JHHS, MHA, Maryland Medicaid, MedChi, Mercy Health Services and UMMS noted this change was necessary to account for uncompensated care costs that have been shifted onto public payers from the private payers' changing business practices.
- ▶ Maryland Medicaid noted the significant expenditure increase from the expansion investment, which lowered uncompensated care. Medicaid supports addressing the shift of bad debt from private payers through the differential change.

# CareFirst and Commissioner Comments

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- ▶ CareFirst and some Commissioners questioned, or did not support, the proposed change:
  - ▶ CareFirst recognized that staff worked closely with CareFirst to add conditions that addressed concerns regarding the need to avoid using the differential change to meet Medicare savings requirements; however,
  - ▶ An analysis suggested that UCC is disproportionately funded by commercial payers;
  - ▶ There were questions regarding whether Individual Exchange enrollees are disproportionately contributing to bad debt and out-of-pocket spending; and,
  - ▶ There was an assertion that the rationale for the differential change is flawed.
- ▶ Staff addressed the uniform and equitable funding of UCC, provided details regarding Individual Exchange enrollees, and provided additional details regarding the contractual and legal basis for the differential change in the final recommendation.

# Final Recommendation – Conditions

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1. The cost reduction to Medicare as a result of the change in the differential be removed from the Total Cost of Care performance evaluation when establishing future annual updates. Furthermore, the savings associated with the increased differential should not supplant hospital savings needed to meet the annual savings goals required by the TCOC contract.
2. The savings to Medicare resulting from the differential adjustment should not be included in the trend factor used to calculate a hospital's performance under the Medicare Total Cost of Care algorithm.
3. The Commission should develop and adopt policies regarding the appropriate use of various rate-setting tools to meet Medicare total cost of care performance requirements. The Commission should not use changes to the differential to meet TCOC savings performance requirements.
4. It is the intent of the Commission to make a one-time adjustment at the beginning of the TCOC Model, as permitted by the contract to correct for cost inequities within the system and to avoid future changes to the public payer differential to assure the stability of the system and to preserve the all-payer nature of the Maryland Model.



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# Appendix: Recommendation Analysis

From November 2018 Commission Meeting



# Overview

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- ▶ Private payers are changing business practices and increasing out of pocket costs to consumers, resulting in increasing uncompensated care costs.
- ▶ This cost increase negatively impacts public payers since actual Uncompensated Care (UCC) is distributed across all payers through a uniform mark-up.
- ▶ The HSCRC staff has calculated and recommended an increase of 1.7 percentage points in the public payer differential to compensate for this difference and changes in business practices of private Maryland payers.

# History--Maryland's Public-Private Payer Differential

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- ▶ **Negotiated at the beginning of the All-Payer system in 1977**
  - ▶ The differential was designed to respond to payer practices that averted bad debt and accelerated payment of hospital bills, thus generating cost savings to hospitals.
  - ▶ This practice was supported by the Maryland Court of Appeals.
- ▶ **Public payers (Medicare and Medicaid) pay 6 percent less than approved charges.**
  - ▶ A 1995 contract amendment with the federal government set the Medicare differential at a minimum of 6.0 percent, for business practices and prompt payment practices.
  - ▶ The All-Payer Model contract requires that the differential, “be at a minimum 6.0 percent,” to account for Medicare’s, “business practices and prompt payment practices.”
  - ▶ The Medicaid differential is 4.0 percent for its business practices and an additional 2.0 percent conditioned on meeting prompt pay requirements. Medicaid MCOs receive the differential.

# History--Maryland's Public-Private Payer Differential, cont.

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- ▶ **Some private payers also received a discount, including:**
  - ▶ A 2.0 percent 'prompt pay' differential to private payers for working capital; and,
  - ▶ A 4 percent differential to payers participating in the substantial, available, and affordable coverage program (SAAC carriers) for averted bad debt via high-risk coverage and accepting all eligible individuals without medical screening and underwriting.
- ▶ **The private payer differential was changed in 2003 to eliminate the SAAC carriers 4 percent differential due to changes in their business practices. The MHIP program replaced coverage for non-group individuals.**
- ▶ **Presently, many private payers in Maryland receive a 2.0 to 2.25 percent differential for prompt payment practices.**
  - ▶ CareFirst is the only payer which has qualified for the 2.25 percent differential



# How the Differential Works

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- ▶ Hospital charges are increased, or marked up, to ensure that the reduction in payments resulting from applying the differential does not result in decreased revenues to hospitals.
- ▶ Maryland's payer differential between public and private payers is significantly less than the rest of the nation where private payers typically pay significantly more than public payers.

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# Analysis



# Increasing the Public-Private Payer Differential

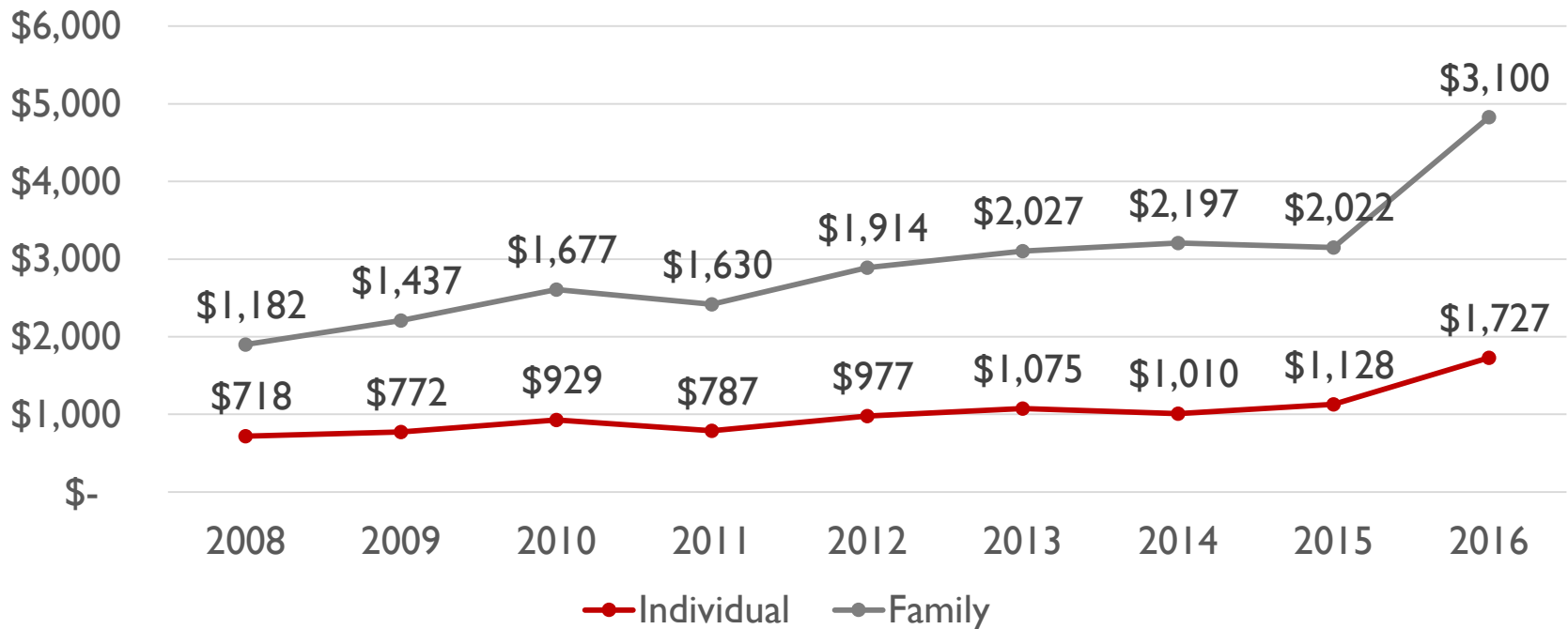
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- ▶ Private insurance plan design changes increasingly expose hospitals to bad debt as consumers are responsible for more cost sharing.
  - ▶ Out of pocket costs are increasing rapidly and more consumers are exposed to coinsurance and deductibles.
  - ▶ Private insurances plans are averting less bad debt than public payers due to these business practices.
- ▶ Staff has calculated that a change in the public payer differential of 1.7 percent to address these changes that are increasing hospitals' uncompensated care should be considered.
  - ▶ This proposed increase is recommended to respond to increasing bad debt write-offs in private coverage and to prevent cost shifting to Medicare and Medicaid.

# Private Insurance Deductibles Costs are Increasing Rapidly

- ▶ The share of privately insured Marylanders with a deductible has increased from 57.1 percent in 2008 to 88.7 percent as of 2016.
- ▶ Increases in deductibles outpace consumer and medical cost inflation.

Maryland Private Insurance Average Deductible  
CY2008-CY2016



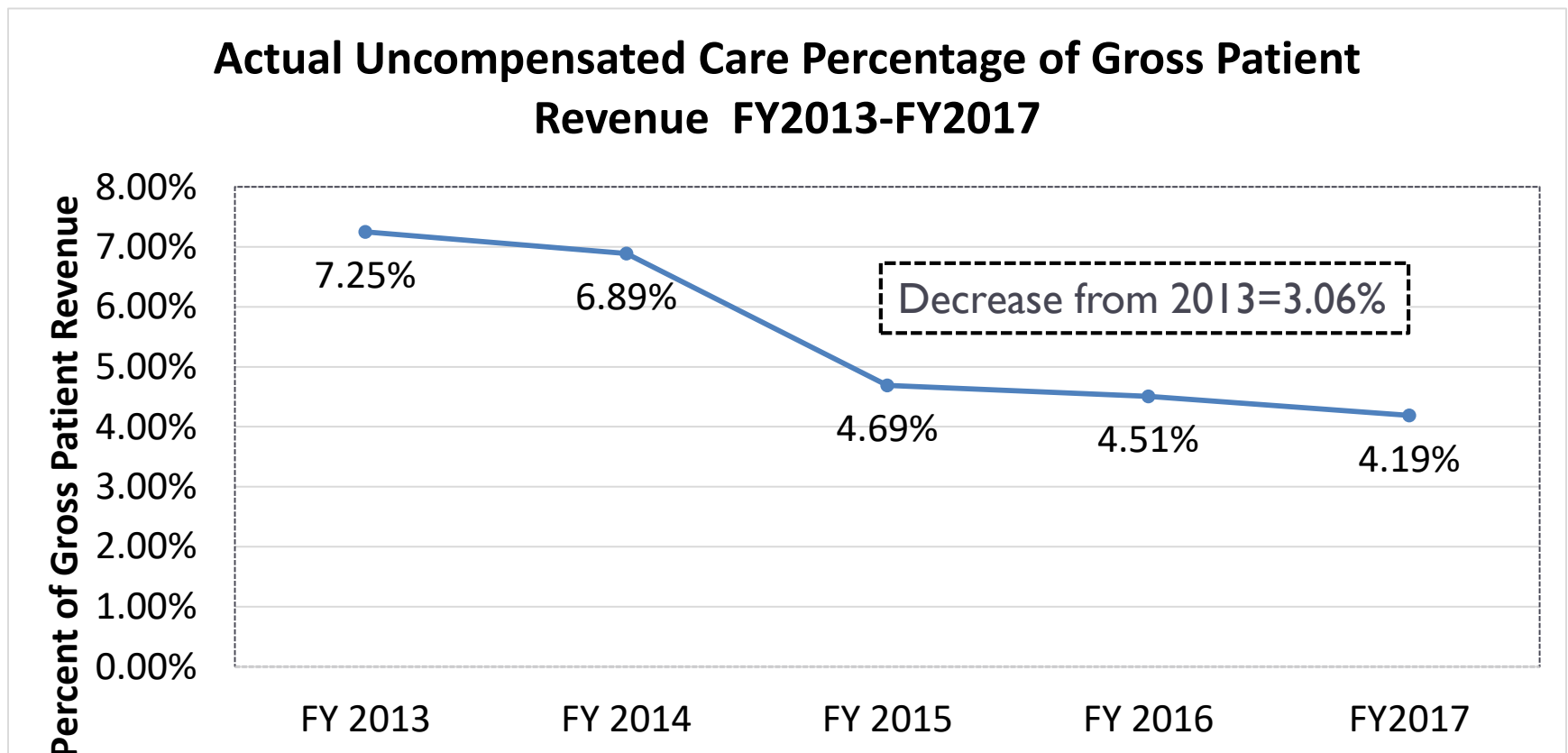
# Impact of Medicaid Expansion on Payers

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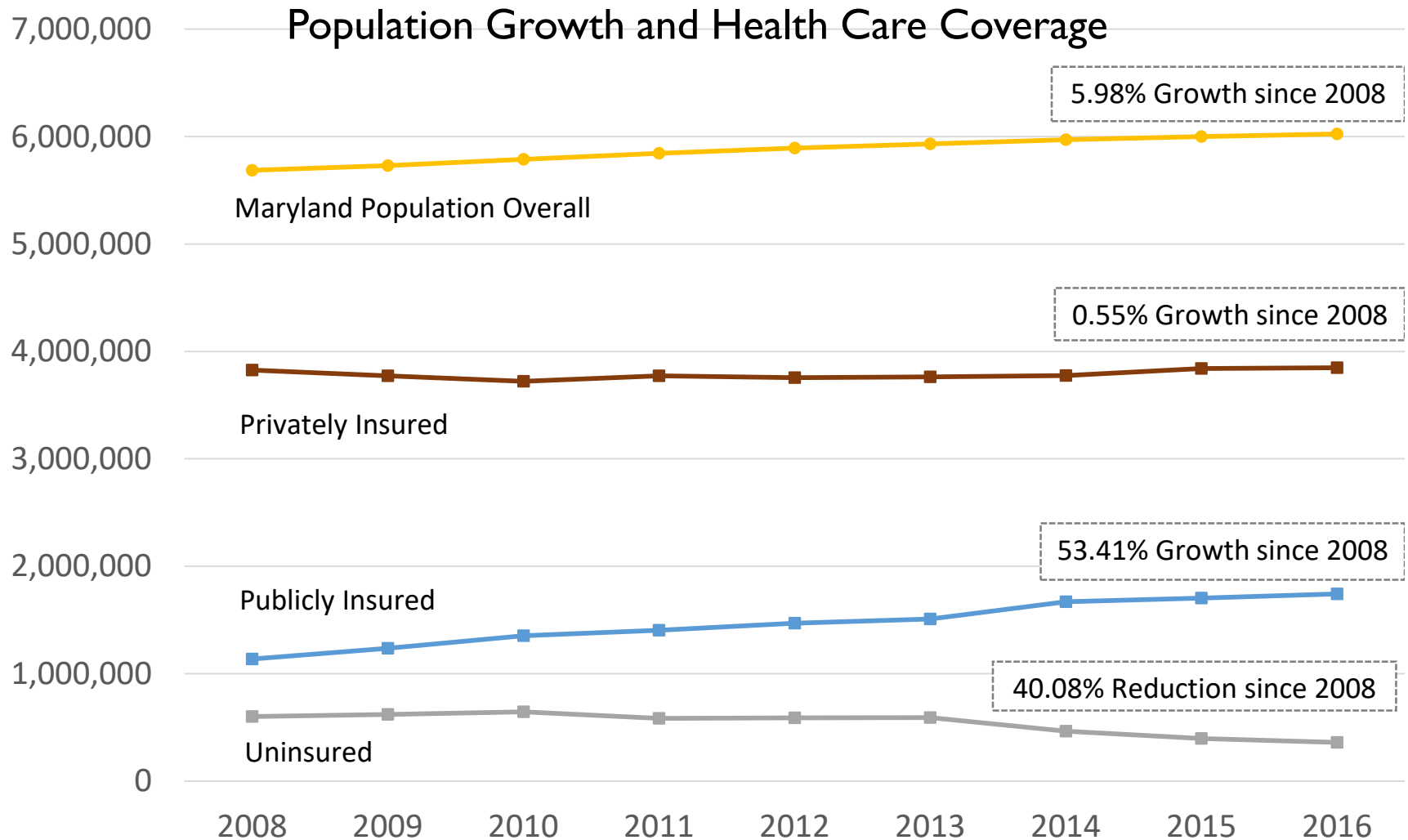
- ▶ There have been large reductions in uncompensated care, particularly related to the Medicaid expansion that took place in 2014 under the Affordable Care Act (ACA).
  - ▶ For the expansion that took place prior to 2011, the averted uncompensated care attributable to the Medicaid coverage expansion was allocated back to Medicaid through implementation of an all-payer assessment of 1.25 percent, which is paid to Medicaid each year.
  - ▶ From 2014 through 2017, there was a reduction in uncompensated care of 3.06 percent, much of which resulted from the expansion of Medicaid. While funded disproportionately by the federal government, the benefit of this reduction was provided to all payers through a hospital revenue decrease in Maryland.
- ▶ While private payers were benefitting from public payer investments that averted uncompensated care/bad debt under the ACA, public payers were being adversely impacted by increasing bad debts attributable to changing business practices of private payers.

# Uncompensated Care In Maryland has Considerably Reduced

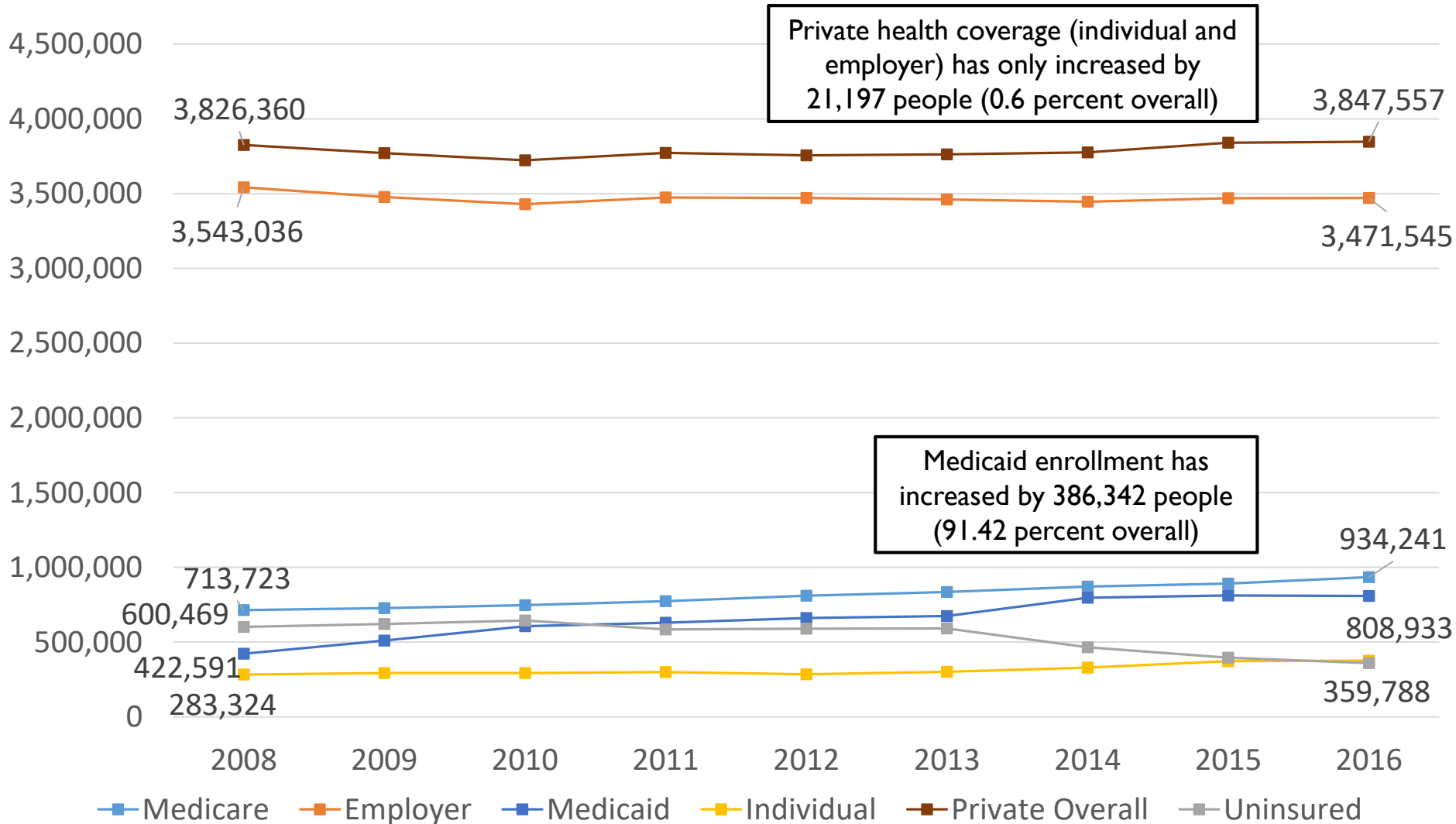
- ▶ Since 2013, Maryland has experienced a 42.2 percent decrease in uncompensated care



# Governmental Payers are Increasingly Providing Coverage for the Population



# Increases in Medicaid Coverage have Contributed the Largest Reductions in the Uninsured Population





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# Impact of Increasing Differential and Conditions



# Calculating the Increased Differential

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- ▶ HSCRC staff calculated the needed increase in the public differential to compensate for the difference in public/private payer write-off levels resulting from business practice changes.
  - ▶ Staff used matched claim level write-off data and case-mix data to quantify the write-offs associated with each payer.
  - ▶ The difference in the write-off rates between public and private payers was 1.9 percent in 2017.
  - ▶ The differential increase needed to eliminate the portion of this difference that is allocated to public payers is 1.7 percentage points.

	<b>Medicare and Medicaid</b>	<b>Commercial</b>	<b>Difference</b>
<b>FY 2015</b>	2.2%	3.6%	1.4%
<b>FY 2016</b>	2.1%	3.8%	1.7%
<b>FY 2017</b>	1.8%	3.6%	1.9%
<b>Change</b>	<b>-0.5%</b>	<b>0.0%</b>	

# Increase the Public Payer Differential by 1.7 Percentage Points

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- ▶ Effective July 1, 2019
- ▶ Public payer differential moves from 6.0 percent to 7.7 percent
- ▶ Charges increase by 1.2 percent to provide a revenue neutral impact to hospitals, consistent with current practice.
- ▶ This differential increase would result in:
  - ▶ A lower cost to Medicare of approximately \$40 million;
  - ▶ A lower cost to Medicaid of approximately \$27 million; and
  - ▶ An increase in overall private payer costs of \$67 million, or 0.4 percent, assuming hospital costs comprise approximately one-third of private payer costs.

# **Final Staff Recommendation for Adjustment to the Payer Differential**

December 12, 2018

Health Services Cost Review Commission  
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## FINAL RECOMMENDATION

Staff is presenting this final recommendation to increase the public-payer differential from 6.0 percent to 7.7 percent, effective July 1, 2019. Given recent trends of increasing bad-debt write-offs in commercial coverage, it is most equitable that the differential be increased 1.7 percentage points (from the current 6.0 percent to 7.7 percent) to ensure that these costs are not shifted to Medicare and Medicaid. This change accounts for the changes in business practices of private Maryland payers that have resulted in higher bad debt costs.

The State of Maryland has employed a differential since the 1970s whereby public payers (Medicare and Medicaid) pay less than other payers (primarily commercial payers) due to business practices that avert bad debt in hospitals and keep Maryland's hospital costs low. Hospital charges are adjusted via a markup to ensure that the differential's reduction in charges to public payers does not result in a decline in hospitals' total revenue.

This report presents analyses and the staff recommendation to adjust the public-payer differential in order to correct for excess bad-debt write-offs from commercial coverage, which is shifting costs onto Medicare and Medicaid. This adjustment will result in a more equitable distribution of uncompensated care costs and adjust the differential for payers who are averting more bad debt. The HSCRC staff is recommending an effective date of July 1, 2019 to allow for implementation by the Medicare intermediary and other payers. This differential change is not intended to supplant the work of providers to generate savings to Medicare under the All-Payer and Total Cost of Care Model Agreements with CMS, but rather to more accurately and fairly adjust for current trends in uncompensated care resulting from plan design changes of private payers.

This report also summarize comments received form stakeholders and Commissioners on this topic. Responses and additional analysis is included as appropriate with regards to the comments received.

## BACKGROUND AND HISTORY

The Maryland Health Services Cost Review Commission (“HSCRC,” or “Commission”) is a state agency with unique regulatory authority. Legally, the HSCRC is authorized to set the rates that Maryland hospitals may charge. These rates form the basis for which all payers in Maryland pay for the provision of hospital services. The federal government granted Maryland the authority to set hospital payment rates for Medicare as part of its all-payer hospital rate-setting system administered by the HSCRC. This all-payer rate-setting approach, which has been in place since 1977, eliminates cost-shifting among payers, while also appropriately accounting for certain differences among payers.

At the inception of the first Medicare waiver in 1977, a payer differential was established based on business practices of payers that helped to avert bad debt to hospitals such as prompt payment and insuring high-risk individuals. It is referred to as a differential rather than a discount, because the differential in payments is built into hospitals' rate structures.

Initially, the HSCRC allowed some private carriers to pay Maryland hospitals four percent less than a hospital's approved rates, with an additional reduction available contingent upon compliance with HSCRC prompt pay regulations. This four percent reduction program, known as Substantial, Available and Affordable Coverage (SAAC), encouraged the provision of health care coverage to high-risk individuals, thereby averting bad debt and reducing uncompensated care at Maryland hospitals. The HSCRC adopted specific requirements for a non-governmental payer to be eligible for the SAAC program. For example, in order to obtain the SAAC discount, a payer was required to provide annually, at a minimum, an open enrollment period of 60 days, comprised of two 30-day periods at least five months apart. Such open enrollment, required to be advertised to the public, would allow for individuals or families to purchase health insurance coverage, without a medical exam or medical screening (referred to as medical underwriting), at a standard, affordable price. The SAAC program and the provision of health insurance to those that may not otherwise have afforded health insurance helped to avert bad debt or non-payment to hospitals.

In 1999, however, the HSCRC decided to examine whether the SAAC policy was achieving its intended purposes in light of numerous complaints regarding changing payer practices. Among the complaints, it was reported that the coverage provided under these SAAC plans was not substantial. For example, many of the policies offered lacked substantial, or any, prescription drug coverage. There were also complaints about availability indicating the gradual shortening of open enrollment timeframes. Furthermore, the employer market became increasingly self-insured, and the SAAC differential was being passed on to the self-insured employers as an administrative benefit, rather than being used to lower the cost of coverage to high-risk individuals. Upon examination, the HSCRC determined that the cost of the SAAC discount greatly outweighed the hospital savings generated by the open enrollment program and the provision of health insurance afforded to high risk individuals. In 2001, recognizing shortcomings of the SAAC program, the legislature required SAAC providers to contribute 37.5

percent of the value of the differential to a Short-Term Prescription Drug Subsidy Plan. The SAAC program was finally discontinued in 2003.

The SAAC program was eventually replaced by the Maryland Health Insurance Program (MHIP), a program that subsidized high-risk individuals who could not obtain medically underwritten coverage or had to pay higher rates to obtain coverage. MHIP was funded through an assessment of the aggregate value of the SAAC discount, or 0.08128 of Net Patient Revenue. In FY 2009 the assessment on hospital rates was increased to one percent of Net Patient Revenue. The MHIP program was discontinued in 2014 after the implementation of the Affordable Care Act which increased availability of coverage for high-risk individuals and expanded Medicaid eligibility. The assessment to pay for the program was also rescinded and savings were generated to all payers in the system.

All payers were still allowed to pay Maryland hospitals two percent less than the hospitals' approved rates if the HSCRC requirements for prompt payment were met, and 2.25 percent less if they provided current financing equivalent to payment upon admission. The two percent reduction is currently made available to all payers other than Medicare.

## **ASSESSMENT OF CHANGING BUSINESS PRACTICES**

While expansion of coverage under the Affordable Care Act has contributed to a large increase in averted bad debt at hospitals and a subsequent decline in uncompensated care, rising deductibles and coinsurance have resulted in increased levels of uncompensated care for privately covered beneficiaries. The following section provides information on uncompensated care trends, health care coverage, and more detailed information on plan design trends for private payers in Maryland.

### Uncompensated Care Trends

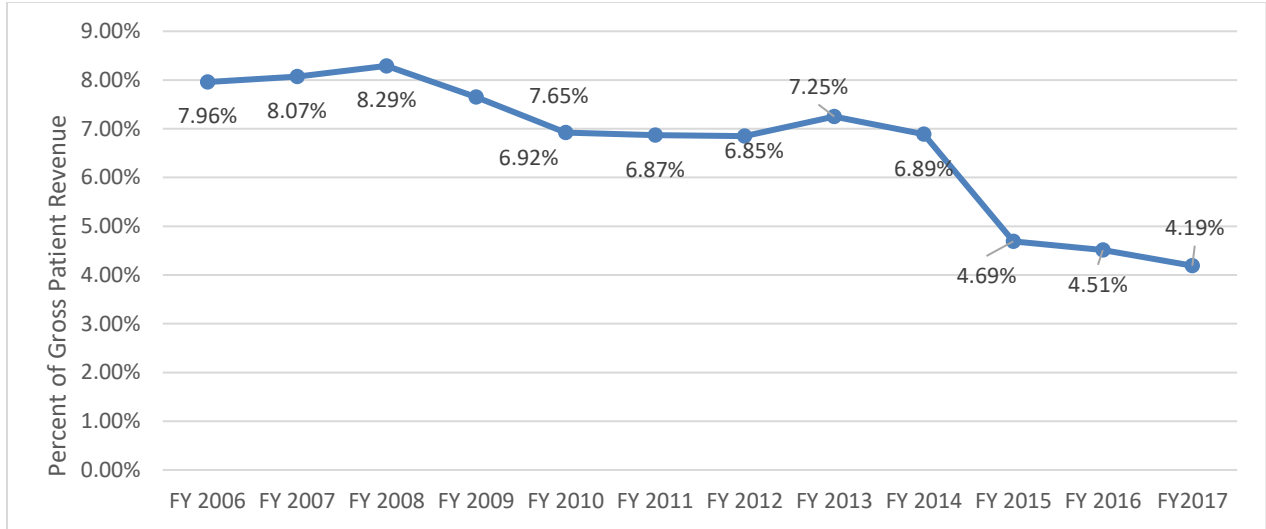
The share of hospital revenues attributed to uncompensated care has been declining in Maryland. This decline aligns with the increase in insurance coverage due to the 2007 Maryland Medicaid expansion and the expansion of Medicaid in 2014 under the Affordable Care Act (ACA). Uncompensated care, as a percentage of total patient revenue, has been reduced from 7.25 percent in 2013 (pre-ACA Medicaid Expansion) to 4.19 percent in 2017, a 3.06 percentage point reduction or a 42.2 percent decrease in uncompensated care. The HSCRC adjusts hospital rates overall to reflect state-wide levels of uncompensated care, based on state-wide averages derived from hospitals' most recent annual reports filed with the Commission. When the ACA provided a significant expansion of Medicaid in CY 2014, the HSCRC began reducing hospitals' rates on July 1, 2014 and July 1, 2015, before information was available from annual reports. While there was a lag in removing uncompensated care from rates, at the same time, there was an increase in Medicaid utilization resulting from the expansion. As a result, hospitals were overfunded for uncompensated care, but underfunded for utilization resulting from the expansion. This was resolved through a hospital specific adjustment for Medicaid expansion and a return to using annual reports and the source of uncompensated care for making the state-wide



## Recommendation for Adjustment to the Differential

uncompensated care adjustment beginning July 1, 2016. All payers received the benefit of the 3.06 percentage point reduction in uncompensated care through hospital revenue reductions.

**Figure 1.** Actual Uncompensated Care Percentage of Gross Patient Revenue FY2006-FY2017

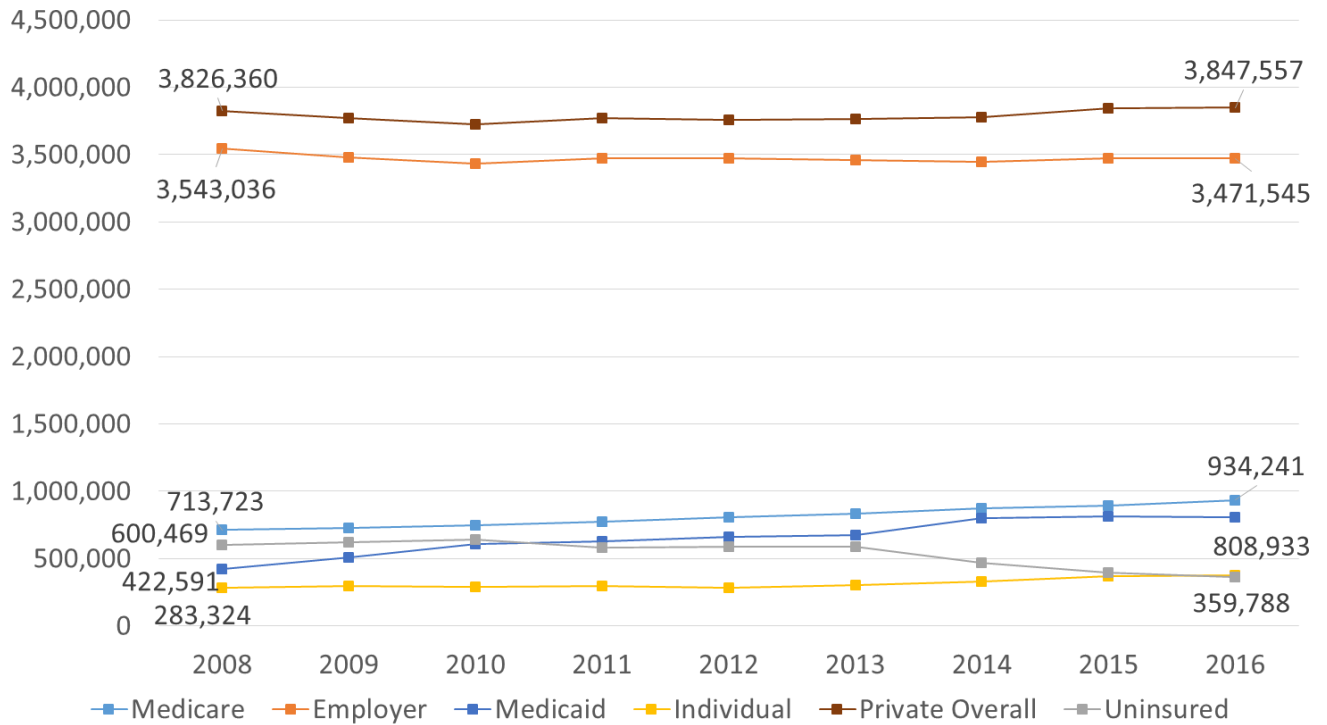


Source: HSCRC Historical Financial Data

### Changes in Payer Enrollment

The uncompensated care reduction resulted from an overall increase in health insurance coverage, mainly from the ACA Medicaid expansion. Figure 2 shows the trend of enrollment for Medicaid, individual insurance, employer-sponsored insurance, and aggregate private insurance (aggregate of individual, small group, and large group enrollees), as well as the trend for uninsured individuals, between 2008 and 2016.

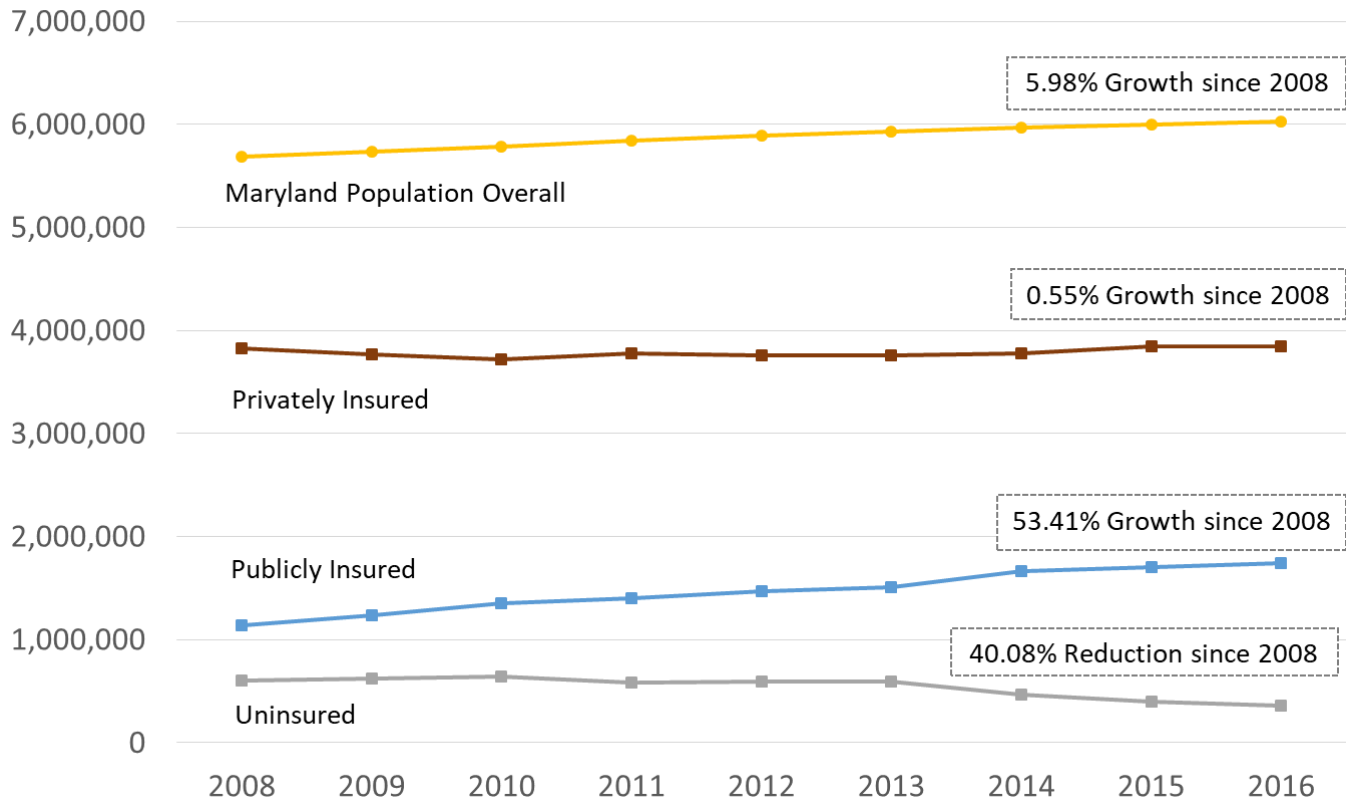
**Figure 2.** Maryland Health Insurance Coverage by Payer type and Uninsured, CY2008-CY2016.



Source: SHADAC Analysis of the American Community Survey (ACS). <http://statehealthcompare.shadac.org/trend/11/health-insurance-coverage-type-by-total#0/1/5/1.2.3.4.5.6.7.8.15/21> and Maryland Department of Health, Office of Healthcare Financing, Accessed June 2018.

While there is little increase overall in privately insured beneficiaries (small and large employers and individual combined), there was an increase of 92,688 people (32.7 percent) enrolled in the individual market. Employer coverage has decreased by 71,491 people, or 2.0 percent. Since 2008, Medicaid enrollment has increased by 386,342 people (91.4 percent overall), with a sharp uptick in Maryland’s Medicaid enrollment in 2014 as Maryland Medicaid expanded eligibility under the ACA. As a result of the ACA, the uninsured population has decreased by 240,681 people, or 40.1 percent. Over the same time period, aggregated private health coverage (individual and employer) has only increased by 21,197 people (0.6 percent), significantly less than the population growth rate (0.66 percent average and 5.98 percent growth since 2008) and the 606,860 people newly enrolled in public coverage from Medicare and Medicaid, a 53.4 percent increase. (Figure 3).

**Figure 3.** Maryland Population Growth and Health Care Coverage, CY2008-CY2016



*Private Insurance through the Maryland Health Benefit Exchange*

While the uninsured rate in Maryland dropped precipitously between 2012 and 2015 (during the ACA expansion), it appears that this decrease can be attributed more closely to increases in Medicaid enrollment than a large uptake on the individual exchanges. CY2016 estimates of Maryland’s marketplace enrollment among potential enrollees show that only 35 percent of eligible enrollees have signed up.<sup>1</sup> A Department of Legislative Services report from 2017 notes that the largest drops in the uninsured rate were for Marylanders at 0-138 percent and 139-200 percent brackets of the federal poverty guidelines (FPG); higher income Marylanders (201-400 percent FPG), who could enroll in private insurance on the exchanges, did not have the same magnitude decrease in their uninsured rates.<sup>1</sup>

Although Maryland already had a subsidized high risk product available to individuals prior to the ACA expansion with the Maryland Health Insurance Plan (“MHIP”), many other existing

<sup>1</sup>Maryland Department of Legislative Services. Assessing the Impact of Health Care Reform In Maryland. January 2017. <http://mgaleg.maryland.gov/pubs/legislegal/2017-impact-health-care-reform.pdf>

individual policies offered by private carriers were required to expand their benefits under the ACA. CareFirst and Kaiser Permanente provided most of the new individual policies. These policies resulted in losses due to low risk individuals enrolling at a level less than projected, and federal subsidies and premiums not adequately covering costs. During the 2018 legislative session, the State legislature passed legislation to provide relief for insurers providing these products. As a result, a reinsurance program will be established to provide stability in the individual markets and cover some of the losses from the adverse selection noted above.

#### *Private Insurance Offered by Employers*

Overall, uptake of employer-sponsored health insurance plans has also dropped in Maryland. Between 2012 and 2015, employee uptake with small group insurance dropped from 72.4 percent to 64.8 percent, and dropped from 78.0 percent to 74.0 percent for large group employers.<sup>1</sup> Medicaid expansion and individual market options may be contributing to this decline.

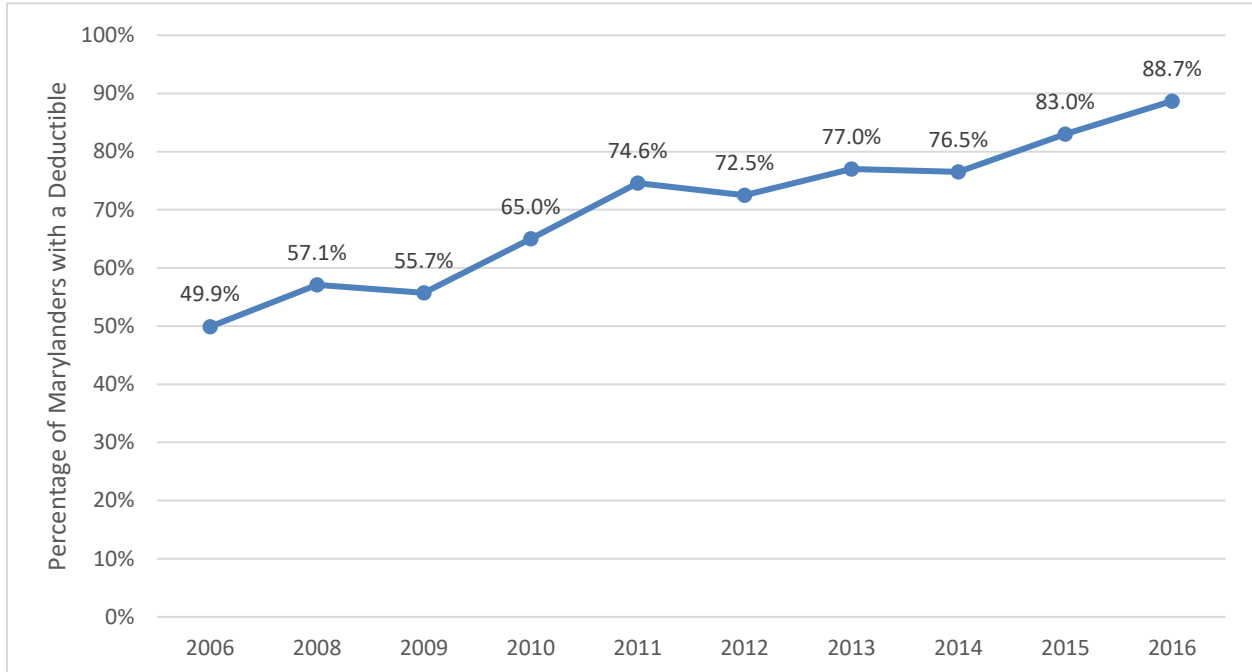
#### Commercial Insurance Plan Design Changes

In recent years, private payers have changed plan benefit design to help address growing healthcare costs, as well as address the plan design requirements for individual policies offered under the ACA guidelines. Plans in Maryland, and nationally, are increasingly reliant on beneficiaries to cover larger portions of their care. The share of privately insured Marylanders with a deductible has increased from 49.9 percent in 2006 to 88.7 percent as of 2016. Enrollment in high-deductible health plans has also increased: 44 percent of privately insured Marylanders are now enrolled in a plan with deductibles of at least \$1,300 for an individual and \$2,600 for a family.<sup>2</sup> Furthermore, average deductibles in Maryland have increased at a rate far outpacing the Consumer Price Index (CPI) for both urban consumers (CPI-U) and medical care (CPI-MC).

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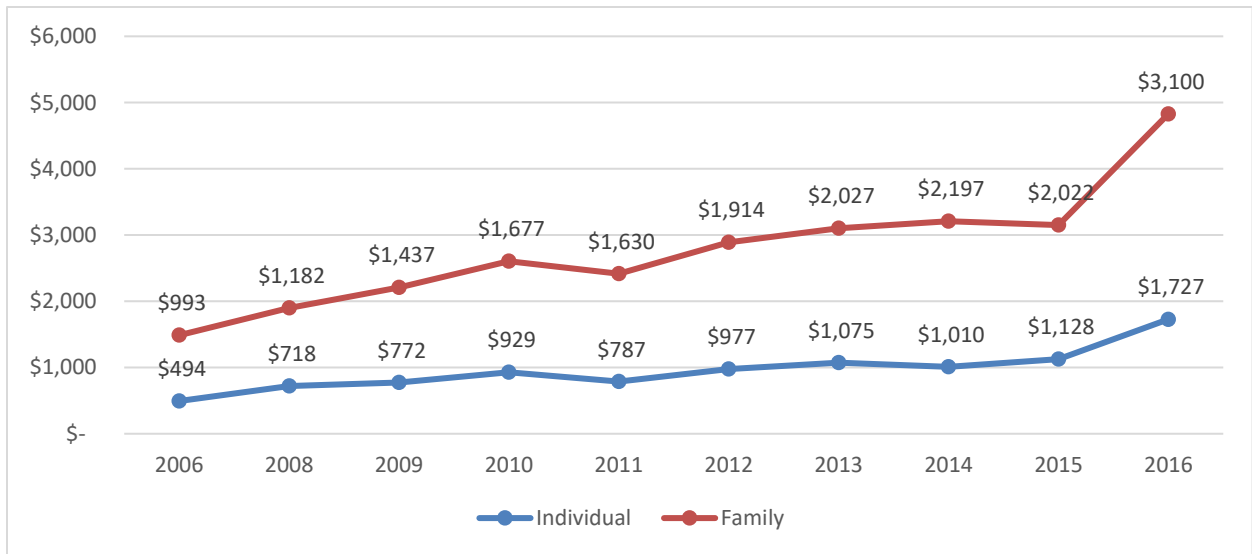
<sup>2</sup> Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017  
[https://meps.ahrq.gov/mepsweb/data\\_stats/MEPSnetIC.jsp](https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp)

**Figure 4.** Percent of Maryland private-sector employees enrolled in a health insurance plan with deductible (CY2002-CY2016)



Source: Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017.  
[https://meps.ahrq.gov/mepsweb/data\\_stats/MEPSnetIC.jsp](https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp)

**Figure 5.** Maryland Average Deductibles for Private Insurance, Unadjusted (CY2002-CY2016)



Source: Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017.  
[https://meps.ahrq.gov/mepsweb/data\\_stats/MEPSnetIC.jsp](https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp)

While the plan design changes are aimed at encouraging individual attention to cost levels, the HSCRC staff does not believe it is equitable to have the related uncompensated care allocated to

all payers. Deductibles have increased three-fold since 2006, and twice as many Marylanders are exposed to the rapidly increasing cost burden imposed by deductibles, thereby increasing the level of private payer uncompensated care at hospitals.

Hospital Bad Debt Share by Payer

As a result of the trends noted above, HSCRC staff is concerned that public payers are unduly burdened with the bad debts of private payers. Until recently, HSCRC did not have reliable data to evaluate the impact of increased bad debts for these changing plan designs. The HSCRC used a regression adjustment to estimate predicted bad debt levels for hospitals. Medicaid payer percentages were used to estimate expected charity levels, but with the expansion of Medicaid under the ACA, the relationships used in the regression were no longer valid. Since 2015, HSCRC collected actual write-offs at the account level and matched the write-offs to the case-mix data. Upon collection of this data, HSCRC was able to create new and more accurate estimates of predicted uncompensated care. Staff also evaluated differences in write-offs of patient balances for insured patients. The HSCRC has now collected and analyzed several years of actual write-off data. The data below show a consistent pattern: commercial payer write-off rates are significantly higher than Medicare and Medicaid write-off rates.

**Table 1.** Maryland Bad Debt to Hospitals, by Payer (FY2015-CY2017)

	Medicare and Medicaid	Commercial	Difference
FY 2015	2.2%	3.6%	1.4%
FY 2016	2.1%	3.8%	1.7%
FY 2017	1.8%	3.6%	1.9%
<b>Change</b>	<b>-0.5%</b>	<b>0.0%</b>	

According to FY 2017 write-off data, commercial payers’ bad-debt write-off rate (3.6 percent) is much higher than the combined rate for Medicare and Medicaid (1.8 percent). If these percentages were applied to FY 2019 revenues, they would translate to approximately \$100 million more in write-offs for commercial payers than for Medicare and Medicaid. Of this \$100 million, approximately \$67 million would be allocated to Medicare and Medicaid through uncompensated care payments funded through hospital rates.

Proposed Change in the Differential

The HSCRC staff believes that this allocation should be corrected through an increase in the differential by 1.7 percentage points in CY 2019. This increase would result in:

- A lower cost to Medicare of approximately \$40 million;
- A lower cost to Medicaid of approximately \$27 million; and
- An increase in overall commercial payer costs of \$67 million, or 0.4 percent, assuming commercial costs reflect approximately one-third of total hospital costs.

The adjustment in the differential is being made to change the allocation of uncompensated care to Medicaid and Medicare. When it is implemented, it will have a revenue neutral effect on hospitals, providing neither more nor less net revenue for each hospital through the formulaic adjustment that is made each year to the mark up for uncompensated care and payer differential. Private payers will see an increase in hospital payments of approximately 1.2 percent (which represents an overall increase of approximately 0.4 percent), while Medicare and Medicaid will see a corresponding decrease in their net payments of 0.7 percent as a result of the higher differential afforded.

This adjustment will ensure more equitable cost allocation going forward, consistent with the HSCRC's statutory mandate.

## COMMENTS

After staff presented its draft recommendation at the November Commission meeting, one Commissioner provided written comments that staff has considered and included in this document. Staff also received a number of written comments from stakeholders including CareFirst, the Johns Hopkins Health System (JHHS), the Maryland Hospital Association (MHA), the Maryland Medical Assistance Program (Maryland Medicaid), MedChi, Mercy Health Services and the University of Maryland Medical System (UMMS). Below are the staff responses to Commissioner and stakeholder comments. The responses have been consolidated where practical.

### Hospital, MedChi and Medicaid Comments

A majority of the comments supported the proposed differential change. JHHS, MHA, Maryland Medicaid, MedChi, Mercy Health Services and UMMS all expressed their support for changing the public payer differential to account for uncompensated care costs that have been shifted onto public payers from the private payers' changing business practices. Maryland Medicaid also noted the significant expenditures increase from the expansion investment (\$8.79 billion total, \$1.23 billion to hospitals), and that despite this influx into the system, a significant difference in write-offs between public and private payers remains. MedChi also noted this change was especially important as the system enters into the Total Cost of Care Model in 2019, and that failing to correct for the imbalance would serve as an "injustice" that, in its view, "would disadvantage Maryland's senior citizens and poorer residents as they would subsidize consumers who were fortunate enough to have private health insurance."

Hospital comments (JHHS and UMMS) as well as MHA included a request to change the proposed implementation of the differential change to January 1, 2019, as opposed to July 1, 2019. While staff understands these concerns, CMS has communicated that the change to the differential could not be effective January 1, but suggested a July 1 effective date instead. Staff also notes that the differential change will now naturally align with FY2020 for hospitals, thereby simplifying markup calculations.

Finally, JHHS commented that this differential change should not be excluded from the \$300 million total cost of care savings requirement included in the TCOC Agreement. Staff oppose this concept for a number of reasons. This proposed differential change is to correct for a system imbalance and changing business practices of commercial insurers. Additionally, the TCOC Agreement was signed to encourage health system transformation that works to improve outcomes and efficiency to achieve savings. The health care delivery system needs to be accountable for the savings amount the State has committed to the federal government and, therefore, staff included its recommendation that the savings resulting from this change be excluded from TCOC savings and update factor considerations. MHA and UMMS are in agreement with the staff recommendation to exclude the differential shift from TCOC savings performance.

### Rationale for Differential

Commissioner Keane's written comments suggest that the staff's logic regarding the rationale for recommending a change in the differential is flawed, as the original differential was not predicated on the basis of different relative write-offs and that Exchange enrollees may be a primary cause of the difference in uncompensated care.

### Response:

Staff respectfully disagrees with the assertion that it is necessary to demonstrate that the original differential was based on differences in write-offs. In fact, staff has shown that the original differential was based on Medicare business and prompt pay practices. This was evidenced in the July 20, 1976 contract negotiated with the Social Security Administration to add Skilled Nursing Facilities to the HSCRC prospective hospital payment methodology approved by the federal government ("the 1976 Contract" - Contract number: 600-76-0140) and reiterated in the 2014 All-Payer Model Agreement with CMS.<sup>3</sup> The 1976 contract states, "The minimum total differential (including working capital discount) which will be allowed to Medicare for their business practices and prompt payment practices to the nearest whole percent will be 6 percent. It should be emphasized that this 6 percent is the minimum differential that will be given to Medicare." The 6 percent differential was in effect for the duration of the initial waiver agreement with the federal government.

In contrast, staff's analysis shows that private payers have taken steps in recent years that have uniquely contributed to higher private payer uncompensated care levels through the introduction of more and higher deductibles and coinsurances. Evidence that this has contributed to higher hospital uncompensated care is reported in numerous articles and publications, such as a recent Moody's release.<sup>4</sup> Relative to the past decade in Maryland specifically, staff presented data from the Medical Expenditure Panel Survey (MEPS) demonstrating an increase in deductibles

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<sup>3</sup> Ultimately, chronic care beds were included in the Waiver via this methodology.

<sup>4</sup> Moody's: Preliminary medians for not-for-profit hospitals show expenses growing faster than revenues, April 2014  
[https://www.moody.com/research/Moodys-Preliminary-medians-for-not-for-profit-hospitals-show-expenses--PR\\_297735](https://www.moody.com/research/Moodys-Preliminary-medians-for-not-for-profit-hospitals-show-expenses--PR_297735)



for private insurance plans in the small and large group markets, which is contributing to higher uncompensated care levels for private payers.

Prior to 2014, staff did not collect information that would allow it to quantify the uncompensated care attributable to privately insured patients, or the difference relative to publicly insured patients. In 2014, HSCRC began collecting individual patient account write-offs to improve the approach to fund uncompensated care and help determine specific sources for uncompensated care. This recent data collection of account-specific uncompensated care along with the documented recent changes in private coverage provided HSCRC staff with the evidence that business practices of private payers have changed. With this new data, staff was able to quantify the difference in the uncompensated care levels between public and private payers. This change in business practices and the excess cost difference attributable to private payers justify the increase in the public payer differential.

The original public payer differential effective 1977 was consistent with a 1976 Maryland Court of Appeals decision that determined a differential can be applied for underlying practices that result in a cost difference among payers. The decision in *Blue Cross of Maryland, Inc. v. Franklin Square Hospital* upheld a payer differential using the same logic from which staff now approaches its analysis and recommendations. The court determined that rates must be set as the statute provided, that is, “equitably among all purchasers or classes of purchasers of services without undue discrimination or preference.”<sup>5</sup> The court further stated that “[i]f it can be demonstrated, for example, that any class of purchasers directly cause actual savings or additional expense to any particular hospital, then that class of purchasers may be accorded rates which reflect the actual savings or expenses.”<sup>2</sup> The court explained that if Blue Cross could prove that its business practices saved hospitals money, then the Commission could modify rates to a seemingly discriminatory point in Blue Cross’s favor, but this would not be considered “undue” discrimination to other payers because of the cost savings that Blue Cross provided.

The court’s reasoning in 1976 clarifies that the differential is permissible if the rates are set equitably among all purchasers or classes without “undue discrimination.” Staff asserts that if this recommended differential change is viewed as discriminatory, then it is “due” discrimination towards private payers because of their changing business practices and increased bad debt exposure to hospitals, which staff has demonstrated result in higher uncompensated care costs attributable to private payers when compared to public payers. The court’s reasoning in 1976 applied as well in 1977 when the first waiver agreement was in effect. Again, Medicare was originally afforded a 6 percent differential for “business practices and prompt payment practices,” and the existing 2014 contract with the federal government specifically refers to Medicare’s “business practices and prompt payment practices” as the basis for the differential.<sup>6</sup>

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<sup>5</sup> *Blue Cross of Md., Inc. v. Franklin Square Hosp.*, 277 Md. 93, 109 (1976) (quoting Md. Code, Art. 43 § 568U(a) (1957, 1971 Repl. Vol., 1975 Supp.), currently codified in Md. Code Ann., Health-Gen. § 19-219(a)(3) (2015)).

<sup>6</sup> 2014 All-Payer Model Agreement with CMS, Section 7.b.Federal Payment Waiver Agreement, p. 2, HEW Contract No. 600-76-0140, p. 2 (July 20, 1976); Maryland All-Payer Model Agreement § 7(b)(ii), p. 6 (Feb. 11, 2014).

### Impact of Individual Plan Exchanges on Bad Debt/Out-of-Pocket Spending

Several commenters questioned whether high deductibles for individual policies offered through the individual Exchanges implemented through the Affordable Care Act were major drivers of the rising out-of-pocket costs and increased uncompensated care associated with privately insured individuals.

Response:

Staff analysis shows that the likely impact of Exchange policies on uncompensated care costs for privately insured individuals is not a material driver of rising uncompensated care costs.

First, as noted above, staff presented data from 2008 that shows the growth in out-of-pocket costs for privately insured individuals preceded the implementation of the ACA and offering of Exchange policies. Staff has shown ten years of data in order to demonstrate that the increase in out-of-pocket costs has occurred over the last decade. As noted, until now, staff did not have the data to track the source of bad debt to hospitals and explore how these trends impacted hospitals.

Staff also wants to emphasize that the data it presented is for employer coverage in the private sector. All of the growth in out-of-pocket costs presented in the tables from MEPS are derived from the U.S. Census Bureau payroll reporting and, therefore, represent members covered through employer-sponsored coverage. These figures do not include individual coverage through the Exchange.

However, several commenters still felt that the Exchange policies may be a major driver of uncompensated care and bad debt for the privately insured. While commenters assumed that most Exchange enrollees choose a bronze level plan, data from the National Academy for State Health Policy (NASHP) suggest otherwise. According to a NASHP report published in 2018 only 22.5 percent of 153,584 individuals enrolling through Maryland's state-based exchange chose a bronze policy in 2018. In fact, a majority (55.3 percent) chose a silver policy, while 19.1 percent chose a gold policy, both of which have lower out-of-pocket costs. The silver plans are eligible for cost sharing reductions.<sup>7,8</sup> From the NASHP data of the total enrollment, 121,629 or 79.2 percent of the individuals enrolled had federally subsidized policies, some of which have cost sharing reductions applied.<sup>6</sup> The data also shows that those subsidized individuals with lower income levels had a slightly lower proportion of bronze policies. In total, a very small proportion of policyholders, 34,529 Marylanders, were enrolled in bronze level Exchange policies in 2018. This constitutes less than one percent of the privately insured population of nearly four million Marylanders, making the impact of these plans and their excess uncompensated care contributions minimal, if any.<sup>9</sup>

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<sup>7</sup> <https://nashp.org/how-elimination-of-cost-sharing-reduction-payments-changed-consumer-enrollment-in-state-based-marketplaces/>

<sup>8</sup> [https://nashp.org/wp-content/uploads/2018/03/CSR-Blog\\_metal-enrollment-chart.pdf](https://nashp.org/wp-content/uploads/2018/03/CSR-Blog_metal-enrollment-chart.pdf)

<sup>9</sup> Ibid.

Individuals enrolling through the Exchange whose premiums are subsidized by the federal government are eligible for cost sharing subsidies if they enroll in a ‘silver’ level plan. HSCRC sought additional information from the Maryland Health Benefit Exchange (MHBE) regarding cost sharing subsidies. The Exchange provided information on its policies for 2018. Currently, CareFirst offers HMO and PPO plans in addition to Kaiser Permanente Exchange products. According to MHBE, 87.9 percent of plans sold on the Exchange were eligible for cost sharing subsidies in 2018.

Staff analyzed the CareFirst HMO enrollment (61,301 beneficiaries) as a representative sample of about half of the exchange enrollment. MHBE staff indicated that enrollment behavior was similar across all three products offered on the Exchange. In Maryland, CareFirst’s HMO product on the Exchange had an enrollment of 8,908 beneficiaries with no federal assistance and 52,393 with assistance. Out of the 52,393 with assistance, 11,397 policies were bronze, which have a deductible and out-of-pocket maximum of \$6,550. Gold policies, which encompassed 17,260 enrollees, have a deductible of \$1,000 and a maximum out-of-pocket of \$6,550. Silver policies totaled 23,736 enrollees and are eligible for cost sharing subsidies. Eighty-nine percent of silver enrollees had cost sharing subsidies. Seventy-seven percent of silver plan enrollees (18,231) had *no deductible* and maximum-out-of-pocket of \$1,300 to \$2,250, and another 2,902 enrollees had a deductible of \$3,000 and a maximum-out-of-pocket of \$5,850. Finally, 2,603 individuals had no cost sharing subsidies and faced deductibles of \$3,500 and maximum out-of-pocket expenses of \$7,350.

Through enrollment in silver and gold level plans many lower income Exchange enrollees were protected from high levels of cost sharing.

In conclusion, staff has documented the rise in out-of-pocket costs for employer sponsored coverage over the last decade. Employer-sponsored coverage represents over 90 percent of total private coverage, while bronze policies offered through the individual Exchange represent only 0.9 percent of total private coverage. Of subsidized low income individuals, the majority have selected plans that shield them from higher levels of cost sharing and many have cost sharing reductions applied beyond the standard plan levels. Therefore, staff concludes that the rise in out-of-pocket costs and excess uncompensated care for the privately insured population is broad-based and not primarily driven by bronze policies offered through the individual Exchange that was initiated through the ACA.

#### Equitable Funding of Uncompensated Care

Commissioner Keane’s Memorandum asserts that uncompensated care is disproportionately funded by commercial payers.

Response:

This would suggest that uncompensated care is not funded uniformly in rates and that the funding of uncompensated care is not commensurate with a payer’s share of the market. Staff

respectfully disagrees with this assertion. Appendix 1 shows the staff calculation of uncompensated care by payer to show that it is uniformly funded by payers.

The funding of uncompensated care has historically been uniform and equitable under the Maryland All-Payer System, as Former Executive Director, Harold Cohen, PhD, described in the following excerpt:

*“In Maryland, because of the All-Payor system (which prevents this type of “cost-shifting”), all payers pay the HSCRC established rates for hospital services. These rates reflect a mark-up of approximately 18 percent. This mark-up has been **uniform** and steady over the life of the Rate Setting System. It includes a provision for financing of uncompensated care in the system. Thus, all payers are contributing **equitably** to the financing of care to the uninsured. There is no cost-shifting in Maryland. Patients and payors pay for the care they receive and also their fair share of social costs in the system”*.<sup>10</sup>

The computations in the Memorandum and CareFirst’s comment letter are inconsistent with these notions of uniform and equitable financing because they suggest uncompensated care funding is not consistent, i.e., that the funding is not a fixed percentage of charges. Currently, actual uncompensated care is 4.18 percent of the hospital market and is funded uniformly by payers as 4.18 percent of charges, although the level of uncompensated care has been as high as 8.0 percent historically.<sup>11</sup>

Moreover, the computation in the Memorandum also suggests that uncompensated care is not funded equitably, which is to say funded commensurate with a payer’s share of the market. In effect, the analysis confounds governmental payers’ enhanced differential discount with uncompensated care funding. Staff has examined the calculations submitted in the Memorandum, which show the same markup over cost for private payers as public payers. Staff believes this is a flawed calculation because the differential creates a four percent difference in the mark up over costs. Staff has replicated the analysis without this flaw and has determined that the distribution of uncompensated care funding is equitable, as reported in Dr. Cohen’s explanation of Maryland’s all-payer system.

The submitted comments from both Commissioner Keane and CareFirst also include historical uncompensated care funding trends that are calculated using the same assumptions. For the same concerns expressed above, staff does not believe these historical values are accurate. Staff does not agree with the claim that after the large reduction in uncompensated care under the ACA, funded primarily by the federal government through the expansion of Medicaid, that private payers’ contribution to uncompensated care was proportionally increased. In fact, the Medicaid expansion under the ACA was the primary contributor to the large decrease in uncompensated care of more than three percent, which resulted in hospital cost savings that was

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<sup>10</sup> <http://www.hscrc.state.md.us/Documents/pdr/GeneralInformation/MarylandAll-PayorHospitalSystem.pdf>

<sup>11</sup> HSCRC Data. Accessed October 2018.

equitably allocated to all payers in Maryland, including private payers, through hospital rate reductions.

### CareFirst's Comments

CareFirst commented that it disagrees with the conclusion that uncompensated care (UCC) costs have been shifted from commercial to government payers and disputes the factual basis of the analysis presented by staff to justify a differential change. CareFirst presented data in its comment letter claiming that since Rate Year 2013, as hospital UCC percentages have declined, the HSCRC's rate setting system has shifted the funding of UCC from government payers to commercial payers. CareFirst claims that as a result, commercial payers now fund approximately 58 percent of hospital UCC even though such payers account for only 33 percent of hospital charges – shifting \$65 million from governmental to commercial payers since the beginning of the Maryland Model Demonstration. The comment letter goes on further to state that while CareFirst believes a change in the differential level is unwarranted, it recognizes that staff intends to proceed with a one-time change to the differential and urges the Commission to ensure this one-time action does not result in future modification of the differential. CareFirst also mentioned that this change would result in additional cost shift to individuals, small and large businesses, county and municipal governments, and other groups already struggling with the high cost of purchasing or funding private health benefit coverage. CareFirst has voiced these concerns to staff and through industry workgroups and a number of meetings have been held with staff for specific discussion. HSCRC staff has agreed to include language in the Recommendation to address CareFirst's concerns.

### Response:

Staff appreciates that CareFirst's comment letter recognized that staff has worked with CareFirst to address concerns that the differential change would be used to alleviate the Total Cost of Care performance requirements, and that the differential would be subject to ongoing changes. Over the course of the last three months, staff has worked to address the concerns raised by CareFirst such that appropriate conditions would be placed on the final recommendation.

Staff disagrees with CareFirst's analysis that the differential is used to pay for actual uncompensated care. As stated earlier in this document, uncompensated care is adjusted each year through changes to hospitals' rates and is shared equitably by payers. The initial waiver contract indicated that the differential was for business practices and prompt pay practices, not to shift payment for actual uncompensated care onto private payers.

Staff has provided a more detailed analysis in response to comments regarding equitable uncompensated care funding in Appendix 1 of this recommendation.

## RECOMMENDATION

Based on the assessment above, staff recommends the following, effective July 1, 2019:

- 1) Increase the differential by 1.7 percentage points (from the current 6.0 percent to 7.7 percent) to more equitably allocate higher uncompensated care costs incurred by commercially insured patients. This adjustment will be made through the hospital mark-up adjustment, which will provide a net revenue neutral result for hospitals.
- 2) To assure that the savings from the differential adjustment is not used to justify an increase to rates in a future rate year, the staff recommends that the cost reduction to Medicare as a result of the change in the differential be removed from the Total Cost of Care performance evaluation when establishing future annual updates. Furthermore, the savings associated with the increased differential should not supplant hospital savings needed to meet the annual savings goals required by the TCOC contract.
- 3) Similarly, the savings to Medicare resulting from the differential adjustment should not be included in the trend factor used to calculate a hospital's performance under the Medicare Total Cost of Care algorithm.
- 4) The Commission should develop and adopt policies that prioritize the use of the All-Payer rate reductions and the Medicare Performance Adjustment as a means to account for costs and savings to the system. The success of the TCOC Model is dependent on improving care and health, reducing avoidable utilization, and providing efficient and effective quality health care services. To this end, the Commission should not use changes to the differential to meet Medicare total cost of care performance requirements.
- 5) It is the intent of the Commission to make this a one-time adjustment at the beginning of the TCOC Model, as permitted by the contract, to correct for cost inequities and to avoid future changes to the public-payer differential to assure stability of the system and to preserve the all-payer nature of the Maryland Model.



## APPENDIX 1

The Commissioner Keane Memorandum and CareFirst Comment letter assert that uncompensated care is disproportionately funded by commercial payers. This would suggest that uncompensated care is not funded uniformly in rates and that the funding of uncompensated care is not commensurate with a payer's share of the market. Staff does not agree with the computations that lead to this conclusion, because they use a statewide markup and ignore the differential when preparing a payer specific cost analysis. As a result, the calculation draws the inaccurate conclusion that private payers fund a disproportionate share of uncompensated care. Staff explains below the differences in the two conclusions.

Table One below was extracted from Section B of the Keane Memorandum. Table One shows the difference between charges (Line 1) and net revenues (Line 5) after removing any payments for uncompensated care (UCC) and removing the discounts for the payer differential that are afforded to each payer. Staff agrees with the calculations through Line 5.<sup>12</sup> The problems with the calculation presented in Table One begin with Line 7. In Line 8, the same mark up of 1.0939 (from Line 7) is removed from each payer's gross charges to estimate each payer's allowable costs. Staff disagrees with the use of a statewide markup value when narrowing the analysis to payer types because it fails to recognize the differential in costs. The differential accorded to governmental payers for cost differences attributable to business practices and prompt pay is 6 percent. The prompt pay discount is 2 percent for both governmental and private payers. Therefore there is a net difference (6 percent minus 2 percent) in the estimated underlying costs allocable to the government payers for their business practices. As a result, the mark down from gross charges to estimate payer specific costs must differ by approximately 4 percent. In Table Two below, staff has corrected the calculation shown in the Keane Memorandum to show the payer specific markup, which reflects the proper differential, to reduce gross charges to net revenue. The correct mark up to reduce charges to cost for governmental payers is approximately 11 percent, and the correct markup for private payers is approximately 7 percent, with the expected 4 percent differential.

The calculation in Table One applies all of the differential toward the payment of uncompensated care and draws the conclusion that private payers are shouldering a higher proportion of the burden. When the correct markup figures are used in Table Two reflecting the differential, the calculation shows that uncompensated care is equitably funded by all payers.

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<sup>12</sup> In Table One, it is important to note that the calculation assumes that the difference between net revenue, i.e., the funding a hospital will be reimbursed, and allowable costs is equivalent to the funding of uncompensated care. While the actual difference between net revenue and allowable cost has typically exceeded 18 percent, the assumption that the only difference is uncompensated care can be used for illustrative purposes. The actual markup over cost accounts for additional items, including hospital assessments, regulated profits, and other financial considerations.

**Table One:**

**Jack Keane Memorandum Calculations--Allowed Charges, Payments, UCC, Allowed Costs, Margins and Related Comparisons**

		GOVT PAYERS	COMM PAYERS	UCC	TOTAL
L1	Estimated Charges: RY 2017	\$10,934,432,000	\$5,908,305,000	\$735,272,000	\$17,578,009,000
L2	Share of Estimated Charges	0.6221	0.3361	0.0418	
L3	Differential or Discount	0.06	0.02	1.00	
L4	Payment Rate	0.94	0.98	0.00	
L5	Estimated Total Payments (I.e. Net Revenue)	\$10,278,366,080	\$5,790,138,900	\$0	\$16,068,504,980
L6	Share of Total Payments	0.6397	0.3603	0.0000	
L7	Markup	1.0939	1.0939	1.0939	
L8	Estimated Allowable Cost	\$9,995,442,353	\$5,400,931,848	\$672,130,833	\$16,068,505,035
L9	Margin of Payments Over Allowable Cost (= Estimated Net Revenue Minus Allowable Cost In \$)	\$282,923,727	\$389,207,052	-\$672,130,833	
L10	Margin Proportion Rel to Allowable Cost (= Estimated Net Revenue/Allowable Cost)	0.0283	0.0721		0.0000
L11	Margin Rel to Charges	0.0259	0.0659		0.0000
L12	Prop Allocation of UCC by Payer (= Share of Estimated Payments x UCC Cost)	\$429,934,631	\$242,196,202		\$672,130,833
L13	Payment Margin Minus Allocated UCC Allocation of UCC	-\$147,010,904	\$147,010,849		
L14	Payment Margin/Allocated UCC	0.6581	1.6070		
L15	Share of UCC Being Paid by the Government and Commercial Payers	0.4209	0.5791		

The calculations in Table Two are consistent with the equitable financing of uncompensated care that has been in place over time. (See quote from Dr. Cohen, above.)

The computations in the Keane Memorandum are inconsistent with the notions of uniform and equitable financing because they suggest uncompensated care funding is not uniform, i.e. that the funding is not a fixed percentage of charges. In effect, the analysis confounds governmental payers' enhanced differential discount with uncompensated care funding. The calculations in the Memorandum assumes that the differential funds actual bad debt, so that as bad debt increases, the private payers shoulder a lower proportion of the burden and as it goes down, they shoulder a greater portion of the burden. This leads to the incorrect conclusion that after the federal government funded Medicaid expansion and exchange policies under the ACA that private payers were shouldering more of the uncompensated care burden.



**Table Two:**

**HSCRC Staff Calculations Reflecting the Four Percent Differential between Government and Private (Commercial) Payers to Calculate Allowed Cost and UCC Funding<sup>13</sup>**

	Inputs		Government Payers	Commercial Payers	UCC	Total
L1	RY 2017 Payer Mix		62.21%	33.61%	4.18%	100%
L2	EST RY19 Allowable Charges		\$10,934,432	\$5,908,305	\$735,272	\$17,578,009
L3	Differential Discount		6.00%	2.00%	0%	
L4	Statewide Markup (rounded)		1.11	1.07	1.04	
<i>Calculations</i>						
L5	Magnitude of Differential	L2*L3	\$656,066	\$118,166	\$0	
L6	Net Revenue from Payer (after Differential is applied)	L2-L5	\$10,278,366	\$5,790,139	\$0	\$16,068,505
L7	Allowable Cost (after Statewide Markup for Differential)	L2/L4	\$9,820,989	\$5,543,000	\$704,516	\$16,068,505
L8	UCC Funding	L6-L7	\$457,377	\$247,139		\$704,516
L9	Share of Total UCC Funding	L8/(Total L8)	64.92%	35.08%	0%	100%
L10	UCC Funding in Rates	L8/L2	4.18%	4.18%		

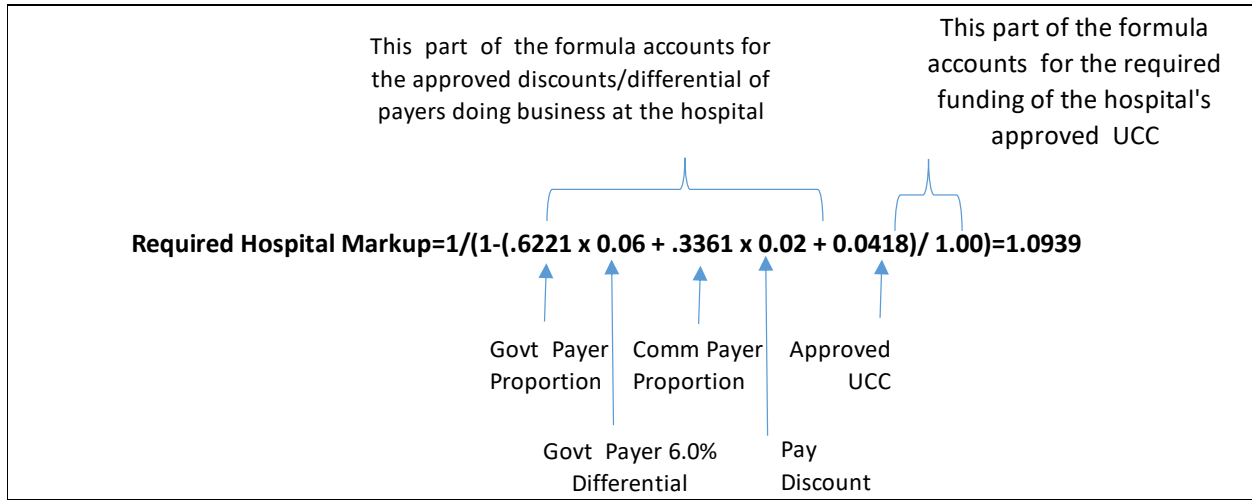
As noted above, the key flawed assumption in the Memorandum is the use of a statewide markup as opposed to a payer specific markup when reducing payer specific gross charges to payer specific “allowed cost.” It is important, therefore, to demonstrate how staff derived a payer specific markup. In Tables Three and Four, staff will illustrate how to calculate a statewide markup and a governmental payer markup:

<sup>13</sup> Please note that final governmental and commercial shares of uncompensated care are slightly higher than their proportion of the market to account for their removal of the uncompensated care payer type as a viable payer. As an example, the calculation for governmental payers proportion of uncompensated care funding is derived as follows:

Governmental Payer Share	=	Governmental Uncompensated Care Payer Share
Governmental Payer Share + Commercial Payer Share		
62.21%	=	64.92%
62.21%+33.61%		

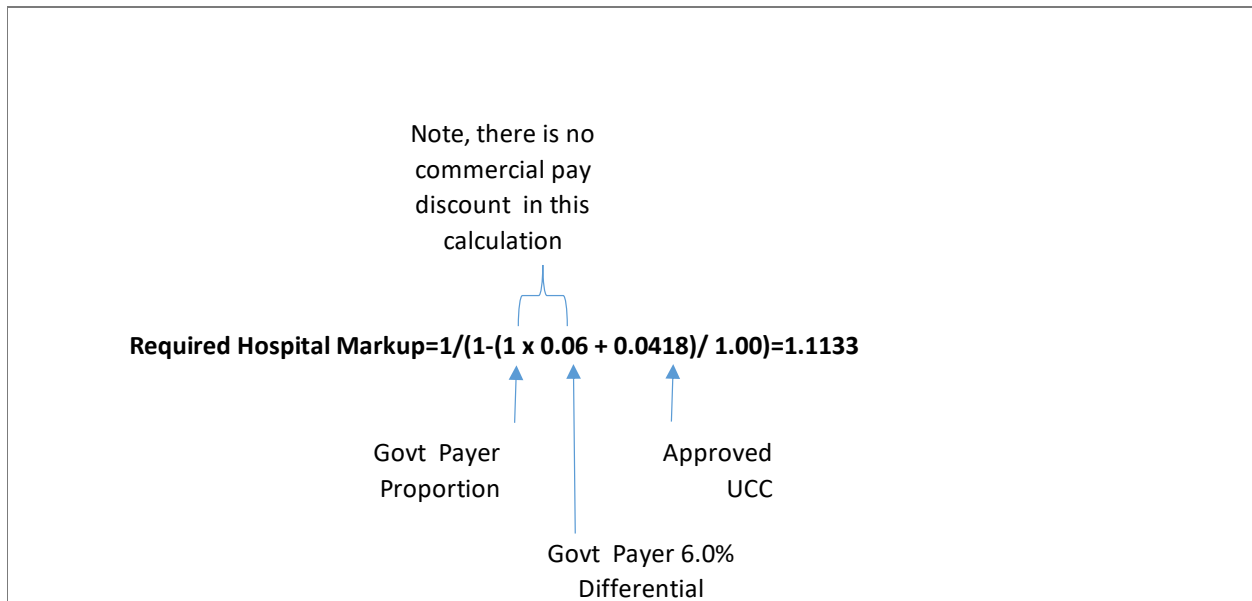
**Table Three:**

**Statewide Markup Calculation**



**Table Four:**

**Governmental Payer Markup Calculation**



In section C of the Memorandum, historical uncompensated care funding is calculated using the same statewide markup assumption. For the same concerns expressed above, staff does not believe these historical values or the conclusions derived from the calculations are accurate.



Maryland  
Hospital Association

November 9, 2018

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

Dear Chairman Sabatini:

On behalf of the Maryland Hospital Association's (MHA) 63 member hospitals and health systems, we are submitting comments in response to the updated draft policy recommendation for a small adjustment to the public payer differential, from 6 percent to 7.7 percent. With the exception of the proposed effective date, we *strongly support the proposed recommendation*, and we look forward to working with the commission on its speedy implementation.

We agree with the Health Services Cost Review Commission's (HSCRC) staff analysis that reveals a significant increase in hospital bad debts over the last few years due to high-deductible and other large cost-sharing plans. This added burden on Maryland's nearly 3 million commercially insured consumers has unfairly shifted uncompensated care costs to Medicare and Medicaid. This shift occurred at the same time that commercial payers disproportionately benefitted from the expansion of Medicaid coverage under the Affordable Care Act, which reduced uncompensated care in hospitals' rates – from over 7 percent to just 4.16 percent – in the latest global budget update approved by the HSCRC.

Staff estimate a modest increase in private payer premiums of no more than 0.4 percent as a result of this action *if, and only if, payers shift all of the impact of this proposal to the paying public*. That is a small price to pay as our state moves forward on the implementation of the Total Cost of Care (TCOC) model, which will require contribution from all stakeholders to ensure its success.

We believe the proposed differential change can take effect January 1—the start of the TCOC model—rather than next July as we were told the Centers for Medicare & Medicaid Services (CMS) asked. We would simply note that when the Medicare sequester was put into effect several years ago, there was virtually no delay in its implementation. We urge the HSCRC to make this change effective January 1 and to work with CMS to make it a higher priority for the earlier implementation date.

We also agree that the impact of the differential should be removed from consideration of the annual hospital payment update. This is similar to the action taken last June, in which the HSCRC voted to remove the impact of the costs of the Maryland Primary Care Program (MDPCP) from consideration during the annual update process. *Moreover, it would be helpful for the commission to remind stakeholders of the action it took in June regarding the MDPCP costs and the update.*

Nelson J. Sabatini  
November 9, 2018  
Page 2

Similarly, the condition to remove the differential from the trend factor used to calculate hospital-specific performance under the Medicare TCOC algorithm should be consistent with the recommendation in the final Medicare Performance Adjustment policy proposal to remove MDPCP Care Management Fees and Performance-Based Incentives from the TCOC trend factor calculated for 2019.

We look forward to discussing this proposed recommendation at the December meeting. If you have any questions, please do not hesitate to contact me.

Sincerely,



Michael B. Robbins  
Senior Vice President

cc: Joseph Antos, Ph.D., Vice Chairman  
Victoria W. Bayless  
John M. Colmers  
James N. Elliott, M.D

Adam Kane  
Jack Keane  
Katie Wunderlich, Executive Director

**Brian D. Pieninck**  
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November 20, 2018

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

Dear Mr. Sabatini and Ms. Wunderlich:

Thank you for the opportunity to comment on the HSCRC staff's Draft Recommendation to increase the Public Payer Differential (Differential). CareFirst has been a strong supporter of Maryland's Medicare Waiver since its inception in 1977. The waiver has greatly benefitted Marylanders, hospitals, payers and the state's entire health care system. The reliability of the differential has been a cornerstone in the waiver design and has ensured equitable funding of hospitals costs, including uncompensated care (UCC), by all-payers.

The staff's recommendation is based on the idea that increased bad-debt write-offs resulting from coverage and benefit changes in private health insurance plans are being disproportionately funded by government payers. Staff is proposing to increase the Differential by 1.7 percentage points – from 6.0% to 7.7% -- in order to “correct for excess bad-debt write-offs from commercial coverage, which is shifting costs onto Medicare and Medicaid.”

As previously communicated, CareFirst disagrees with the conclusion that UCC costs have been shifted from commercial to government payers and disputes the factual basis of the analysis presented by staff to justify a Differential change. CareFirst has presented data demonstrating that since Rate Year 2013, as hospital UCC percentages have declined, the HSCRC's rate setting system has shifted the funding of UCC from government payers to commercial payers. As a result, commercial payers now fund approximately 58% of hospital UCC even though such payers account for only 33% of hospital charges – shifting \$65 million from governmental to commercial payers since the beginning of the Maryland Model Demonstration. Our analysis was based on the unit cost rate setting methodology that aggregates payers' differentials into a single hospital mark-up but allocates payer specific discounts that results in actual payer funding proportions.<sup>1</sup> Accordingly, CareFirst believes there is no factual basis for the current staff Recommendation.

The 6% Differential was a negotiated number and was not based on a quantification of the amount of hospital bad debts “averted” by the presence of the governmental insurance programs or based on the distribution of UCC between government and commercial payers over time. UCC levels have changed over the life of the rate setting system due to coverage cutbacks and

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<sup>1</sup> A further description of this cost-based rate setting approach and the actual funding of approved hospital UCC approach now and over the past 41 years of the All-Payer system is provided in an attachment to this letter.

expansions by government and commercial payers, with no change in the Differential.<sup>2</sup> This is because UCC has always been viewed as a general cost of hospital business in a community without universal health insurance coverage. Any changes to the Differential would have caused increased instability and uncertainty to the rate setting system.

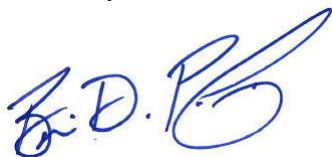
CareFirst has voiced these concerns to staff and through industry workgroups. In response, the staff has agreed to include language in the Recommendation to address our issues. While this language is clear and appreciated, if the Commission approves this recommendation, we request that the HSCRC emphasize:

- 1) this adjustment will be one-time only and it is not the intention of the Commission to adjust the Differential again during the life of the waiver model;
- 2) staff will factor out the impact of the Differential change from the annual TCOC Medicare savings performance targets;
- 3) staff will also factor out the impact of the Differential change from future annual hospital rate Updates; and
- 4) the staff and the Commission will rely exclusively on all-payer rate reductions and incentive-based mechanisms to moderate hospital volume growth to control hospital costs.

In conclusion, based on our analysis of stakeholder funding of UCC, a change in Differential levels is unwarranted. We recognize that staff intends to proceed with this one-time change to the Differential and urge the Commission to ensure this one-time action does not result in future modification of the Differential. Any such change would result in additional cost shift to individuals, small and large businesses, county and municipal governments, and other groups already struggling with the high cost of purchasing or funding private health benefit coverage.

Should the HSCRC enact future cost-shifts to meet the Medicare TCOC tests, we believe it will undermine the reputation of the Maryland Model as a credible, non-discriminatory and viable “all-payer” demonstration of cost control. CareFirst remains vigilant in its efforts to assist the Commission in ensuring that the State meets its required savings targets through actual cost control and reduction, to benefit the individuals, businesses, accounts, and communities that we mutually serve.

Sincerely,



Brian D. Pieninck  
President and Chief Executive Officer

---

<sup>2</sup> An example of a change in the practice of Governmental payers that contributed to large increases in hospital UCC were: 1) the imposition of day limits in the late 1980s and 2) the elimination of the Medicaid State-Only Program in the 1990s. These two changes contributed significantly to increases in hospital UCC and yet there was no change in the Differential.

Attachment I – Description of the HSCRC Cost-Based Rate Setting System and An Illustration of how Hospital UCC is Funded

- The HSCRC rate setting methodology has always been characterized as a “cost-based rate setting system” which is designed to set hospital unit rates at levels to provide Maryland hospitals with net payments sufficient to fund two categories of approved hospital costs: 1) the unit costs of patient services provided by Maryland hospitals to each payer’s beneficiaries; and 2) the Uncompensated Care Costs (UCC) that the Commission determined to be “reasonable.”
- The establishment of hospital rates must also account for the HSCRC approved deductions from charges (e.g., the Prompt Pay discount and the Public Payer Differential). The establishment of rate levels and accounting for approved deductions is achieved through the use of a hospital-specific Mark Up formula, that takes into consideration each hospital’s payer mix and level of approved UCC.
- The Hospital Mark Up, increases (or “marks up”) rates above a hospital’s Allowable Costs to provide hospitals with net payments (net patient revenue) sufficient to fund patient care costs and an additional and readily identifiable “margin” to fund approved UCC.
- Given this methodology, one can easily quantify both Net Payments and Allowable costs for any payer or any class of payer (i.e., Governmental payers and Commercial payers) at either a hospital specific level or in aggregate as shown in Table 1 below. The data in Table 1 is taken from the staff’s presentation of charges and net payments by payer class for the Rate Year (RY) 2017. Because the Mark Up is calculated to establish charge levels sufficient to fund both Allowable costs and UCC, while accounting for the approved discounts and the Differential, Allowable costs can be determined by dividing gross revenue by one plus the Mark Up (1.09394 in the staff’s example). Hospital Allowable Costs are shown on line 7 of Table 1.
- Net Payments to hospitals for each payer class are determined based on HSCRC approved charge levels less the applicable deductions from charges for each payer class (i.e., Government payers are eligible for the 6% Differential and pay 94% of charges and Commercial payers are eligible for the 2% prompt pay discount and pay 98% of charges). These net payments are shown on line 5 below.
- The amounts provided hospitals in their rates to fund UCC is merely the difference their net payments and their allowable costs (L5 – L7). Table 1 shows that based on RY 2017 data, Commercial payers funded 57.9% of approved levels of UCC while Government payers funded 42.1% of UCC (shown on L9 below).

**Table 1**  
**Funding of UCC by Payer Class**  
 Based on the 2017 Payer Mix (Dollars in \$000)

	<b>Current Situation</b>	<b>Government Payers</b>	<b>Commercial Payers</b>	<b>UCC</b>	<b>Total</b>
L1	RY 2017 Payer Mix	62.21%	33.61%	4.18%	100.00%
L2	Est RY 19 Allowable Charges	\$10,934,432	\$5,908,305	\$735,272	\$17,578,009
L3	Differential/Discount	6.0%	2.0%	100.0%	100.0%
L4	Magnitude	\$656,066	\$118,166		
L5	Net Revenue from Payer	\$10,278,366	\$5,790,139	\$0	
L6	Statewide Markup 1.09394				
L7	Allowable Cost	\$9,995,442	\$5,400,932	\$672,131	\$16,068,505
L8	Available to Fund UCC	\$282,924	\$389,207		\$672,131
L9	% Total UCC Funding	42.1%	57.9%		

- A key conclusion of our analysis is that each payer’s contribution to the funding of hospital UCC is not a function of its proportion of a hospital charges that it accounts for in the system, as is presumed by staff. This is crucial error in the staff’s analysis that renders the staff’s conclusions completely erroneous.
- Rather, under the cost-based rate setting approach of the HSCRC, the amount of excess funding (over and above the cost of care provided to a payer’s patients) available to fund hospital UCC can be precisely quantified by individual payer or payer class as shown above.
- Because the Hospital Mark Up formula depends on the level of approved UCC in the system, the Mark Up varies from year to year as the percentage of UCC changes. Table 2 shows that since RY 2013, UCC percentages have declined from 7.25% to 4.18% resulting in the Hospital Mark Up declining from 1.10 to 1.09394 as hospital UCC has been reduced. The mathematics of the Hospital Mark Up formula has then reallocated the funding of hospital UCC from nearly equal proportions in RY 2013, to the current 42.1% Government payer and 57.9% Commercial payer split.

**Table 2**  
**Funding of UCC by Payer Class**  
 Rate Years 2013-2017 (Dollars in \$000)

		<b>Government Payers</b>	<b>Commercial Payers</b>	<b>UCC</b>	<b>UCC %</b>
FY 2013	UCC Funding	\$584,634	\$544,970	\$1,129,604	7.25%
	UCC Funding Proportion	51.8%	48.2%		
FY 2014	UCC Funding	\$547,224	\$524,755	\$1,071,979	6.88%
	UCC Funding Proportion	51.0%	49.0%		
FY 2015	UCC Funding	\$325,795	\$405,109	\$730,904	4.69%
	UCC Funding Proportion	44.6%	55.4%		
FY 2016	UCC Funding	\$307,595	\$395,275	\$702,870	4.51%
	UCC Funding Proportion	43.8%	56.2%		
FY 2017	UCC Funding	\$282,924	\$389,207	\$672,131	4.18%
	UCC Funding Proportion	42.1%	57.9%		

- Moreover, since the beginning of the Model Demonstration given these changes in the hospital Mark Up, we calculate that there has been approximately \$65 million in additional UCC funding shifted from Government payers to Commercial payers. Based on our analysis, we also have determined that because Commercial payers are funding 57.9% of all hospital UCC, these payers are actually funding more than the total amount of Write-offs attributed to them by the HSCRC’s write-off data. This result is shown in Table 3.



**Table 3**  
**Write-offs and Actual UCC Funding by Payer Class**

	A	B	C	D	E	F
Payer Class	Total Charges	Write-Offs	Pct. Subtotal	Proportion of UCC Funding by Payer Class	Actual Funding of Write-Offs	Actual UCC Funding less Actual Write-offs
L1 Government	\$10,266,623,257	\$181,017,034	47.4%	42.1%	\$160,847,779	-\$20,169,255
L2 Commercial	\$5,534,497,764	\$201,044,199	52.6%	57.9%	\$221,213,454	\$20,169,255
L3 Total Govt + Commercial	\$15,801,121,021	\$382,061,233	100.0%	100.0%	\$382,061,233	

- As shown in Table 3, staff quantified Commercial write-offs as \$201 million and Government write-offs as \$181 million in RY 2017 (a total of \$382 m in aggregate write offs for both payer classes). Per our analysis, the Commercial payers are funding 57.9% of these aggregate write-offs (\$221 million as shown on L2, column E) or \$20.2 million (see L1, Column F) more than the incremental write-off amounts attributed to them by the staff's analysis (\$201 million in incremental write-offs attributed to them).



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Finance Shared Services

November 21, 2018

Katie Wunderlich  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Ms. Wunderlich:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's (HSCRC) draft policy recommendation for an increase to the Medicare payer differential. We strongly support the proposed recommendation, and we look forward to working with the HSCRC on its implementation.

We agree with the HSCRC's staff analysis that reveals an increase in hospital bad debts over the last few years. UMMS conducted a similar analysis for its member hospitals and the results are similar to those for the state. Commercial payer write-off rates are more than double the write-off rate for Medicare and Medicaid. In Fiscal Year 2017 (FY17) the Commercial bad debt write-off rate was 4.4% compared to 2.0% for Medicare and Medicaid. The write-off rate for Commercial payers increased by 0.5% between FY15 and FY17, while Medicare and Medicaid write-off rates declined by 0.5% during the same period. The portion of hospital total bad debts associated with Commercial payers also significantly increased over the past several years (17.9% in FY15 up to 22.4% in FY17) while the portion of bad debt write-offs associated with all other payers declined (82.1% in FY15 down to 78.6% in FY17). The 0.5% increase in Commercial uncompensated care rate is equivalent to an increase in annual bad debts totaling \$6 million for our organization.

We believe the proposed differential change should take effect January 1, 2019 with the start of the TCOC model, rather than next July. While we understand operational adjustments are needed and those modifications require time, we do not feel that these minor changes warrant an eight month delay. We urge the HSCRC to make this change effective January 1 and to work with CMS to make it a higher priority for the earlier implementation date.

Katie Wunderlich  
November 19, 2018  
Page 2

We support the removal of the differential adjustment from the trend factor used to calculate hospital-specific performance under the Medicare TCOC algorithm. We feel that the treatment of this adjustment is consistent with the final 2019 Medicare Performance Adjustment policy (approved at the November 14, 2018 Commission meeting) to remove MDPCP Care Management Fees and Performance-Based Incentives from the TCOC trend factor.

We look forward to the final staff recommendation at the December 2018 Commission meeting. If you have any questions, please do not hesitate to contact me.

Sincerely,



Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services

Cc: Chairman Sabatini  
HSCRC Commissioners  
Robert Chrencik, UMMS CEO  
Henry Franey, UMMS CFO



# MARYLAND Department of Health

*Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary*

November 19, 2018

Nelson Sabatini  
Chair  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Chairman Sabatini,

On behalf of the Maryland Medicaid program, I would like to thank you for the opportunity to provide comments on the draft recommendation for increasing the public payer differential from 6.0 percent to 7.7 percent. The Maryland Medicaid program has followed the conversation surrounding this change and is in support of the recommendation.

Historically, Medicaid payer percentages were used to estimate expected charity levels; this methodology was altered after Maryland expanded Medicaid under the Patient Protection and Affordable Care Act (ACA) in 2014. Since the enactment of the Medicaid expansion, expenditures for the expansion population have totaled over \$8.79 billion—including \$1.23 billion in hospital expenditures in 2017 alone. Recent analysis has demonstrated that write-offs for commercial coverage are much higher than for public payers, with the difference equating to approximately \$100 million. The proposed differential increase will reallocate a portion of that difference to Medicare (\$40 million) and Medicaid (\$27 million). This will become increasingly important as the State assumes a greater share of Medicaid expansion expenditures in the coming years.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Robert R. Neall  
Secretary



**Kevin W. Sowers, MSN, RN, FAAN**

*President*

**Johns Hopkins Health System**

*Executive Vice President*

**Johns Hopkins Medicine**

November 21, 2018

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

Dear Chairman,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the proposed Adjustment to the Payer Differential. JHHS strongly supports the staff recommendation to increase the differential from 6.0 to 7.7% and commends the thoughtful analysis of staff to support the modest increase in the differential. JHHS does, however, have concerns with some of the conditions outlined in the staff recommendation and offer suggested clarification.

The recent availability of reliable data analyzed by the HSCRC demonstrates a shift in uncompensated care. Due to commercial payer practices, public payers have inappropriately and unreasonably assumed more of the uncompensated care costs. At JHHS, we have witnessed the growing increase of uncompensated care as a result of rising deductibles and coinsurance as more and more of our patients are unable to meet the financial demands established under their insurance policies. The Johns Hopkins Hospital experienced a 12% shift in charity care for insured patients from 2013 to 2018, with charity care for insured patients increasing and self-pay decreasing. This increase in patient financial responsibility for co-pays and deductibles comes at a time when rising drug costs and high cost innovative therapies only widen the gap between what patients can afford to pay and what is covered by insurance. The practical impact has been an increase in hospital uncompensated care associated with private insurance. Across the Maryland hospitals within JHHS, there was a 10.6% increase in uncompensated care for the insured from 2017 to 2018.

Any concerns that an increase in the payer differential would result in an increase in premiums should be tempered by the reality that the increase would be small in comparison to the substantial benefit payers and consumers have received over the years as a result of the all payer system. Additionally, for the small portion of the commercial market included in the exchange market, the

impact is likely to be mitigated by the recent market stabilization efforts of the Hogan Administration and Maryland General Assembly during the 2018 legislative session. In addition to establishing a reinsurance program, lawmakers made over \$360 million available to decrease private insurer losses. Considering the recent influx of financial support to private insurers and the potential minimal impact of 0.4% to overall commercial payer costs, it seems highly unlikely that a \$67 million reallocation of uncompensated care through a 1.7% increase in the payer differential would result in a greater cost burden to the consumer.

While JHHS strongly supports the staff recommendation to increase the payer differential, we are concerned that it is premature to recommend that the Commission should not use changes to the differential to meet Medicare total cost of care performance requirements or that savings associated with the increased differential should not supplant hospital savings needed to meet the annual goals required by the Maryland Total Cost of Care Model State Agreement (Agreement). There is strong consensus that the differential should not be used as a mechanism to shift focus from the work already established by hospitals to reduce unnecessary care and costs; however, considering the uncertainty of the impact of Maryland Primary Care Program in potentially increasing Total Cost of Care (TCOC), all resources should remain available as potential options to help the state and hospitals meet the TCOC targets. The future use of the differential to meet savings targets is permissible under the Agreement. As stated in section 8.b.ii.1 of the Agreement, a request to change the differential “To enable the State to meet the Annual Savings Target” would be considered by CMS.

Additionally, JHHS has concerns with the intent of the Commission “to make this a one-time adjustment” or to “avoid future changes to the differential.” As noted above, outlined in the Agreement both the state and CMS anticipate the potential use of the differential to ensure success of the TCOC Model. The Agreement details an annual process by which changes to the differential may be requested in order to meet annual savings targets or “that may be necessary to adjust, recalibrate, or modernize Maryland’s rate-setting structure...” Any changes to the differential should be deliberate, justified, and thoughtful, but the Commission should not unilaterally remove any future change from consideration. This is the first time the differential has materially changed in decades, and any subsequent change would have to meet the scrutiny of both the Commission and CMS. Considering the commitment of state and federal governments, hospitals, insurers, and all Marylanders to the continuation of all-payer model, we believe that the differential should not be eliminated as a resource to help meet the targets of the Model when it is otherwise justifiable.

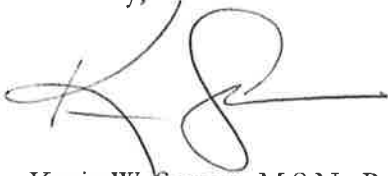
JHHS also supports the recommendation of our hospital colleagues to implement the change to differential January 1, 2019, instead of July 1, 2019. If a January 1 implementation date is not achievable for Medicare, considering the substantial savings to the state Medicaid program, we recommend proceeding with January 1 for Medicaid.

Thank you for the efforts of the HSCRC commissioners and staff who have demonstrated their willingness to ensure that all stakeholders contribute to the future success of the Total Cost of Care

Nelson Sabatini  
Response to Differential Adjustment  
November 21, 2018

Model. This fair and balanced approach fosters ongoing engagement in and enthusiasm for the new model. We look forward to continued collaboration in our mutual efforts to support the Total Cost of Care Model.

Sincerely,

A handwritten signature in black ink, appearing to read 'KS', with a long horizontal line extending to the right.

Kevin W. Sowers, M.S.N., R.N., F.A.A.N  
President, Johns Hopkins Health System  
Executive Vice President, Johns Hopkins Medicine

cc: Joseph Antos, Ph.D., Vice Chairman  
Victoria W. Bayless  
John M. Colmers  
Katie Wunderlich

James Elliott, MD  
Adam Kane  
Jack C. Keane

## Memorandum

To: Nelson Sabatini  
HSCRC Chairman

From: Jack Keane

Subj: Proposed Change in Medicare/Medicaid Differential

cc: J. Antos; V. Bayless; J. Colmers; J. Elliott, MD; A. Kane; K. Wunderlich; and S. Lustman

Date: 11/14/2018

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The agenda for the Public Session of 11/14/2018 includes a “Draft Staff Recommendation for Adjustment to the Payer Differential.” I believe the technical and conceptual bases for this proposed change in the Differential from 6.0% (where it has stood for approximately forty years despite myriad changes in the financing and delivery of health care services) to 7.7% are deeply flawed for the reasons which are presented below.

Accordingly, I would appreciate it if you would include this Memorandum in the post-meeting documents that are published on the HSCRC web site and direct the HSCRC staff to address the concerns raised below, and report back to the Commission in writing regarding them, prior to our upcoming December meeting when a vote is scheduled to be taken on the proposed modification of the Differential.

### **A. Basis for the Proposed Change in the Differential**

The Staff argues that the Differential should be increased from 6.0% to 7.7% because the write-off percentage associated with the Commercial payers (i.e., 3.63%) exceeds the write-off percentage associated with the Government payers (i.e., 1.76%) by 1.87% (i.e.,  $3.63\% - 1.76\% = 1.87\%$ ) and that this difference has the effect of unfairly charging the Government payers for an excessive level of Uncompensated Care Costs (UCC).

This logic is flawed for several reasons. First, the Differential of 6% that was given to Medicare and Medicaid (the Government payers) at the outset of the HSCRC’s waiver was not predicated on the relative write-off percentages of the Government and Commercial payers. Second, to my knowledge, there is no reliable information extant regarding the relative level of write-offs at the outset of the waived system. The Staff recommendation proposes to change the existing Differential based on a calculation of the relative write-offs of the Government and Commercial payers in RY 2017 projected to RY 2019. It seems reasonable to expect, under these circumstances, that this argument would be supported by at least two factual pillars: (1) documentation that the existing 6.0% Differential was created based on relative write-offs; and (2) evidence that the write-offs have changed from those that existed when the Differential was established. The proposed recommendation lacks both of these foundations.

Moreover, if the Commercial payers are to be required to pay higher hospital bills, as a result of the proposed change in the Differential, and the change in the Differential is to be justified by the higher level of write-offs associated with the Commercials, relative to the Government payers, it is important to consider the reasons underlying the level of Commercial write-offs and the policy implications of the proposed change.



As noted above, no evidence is available regarding the original relationship between Government and Commercial write-offs, or the changes in that relationship that undoubtedly occurred over the last forty years, but we do know that one factor that has recently increased Commercial write-offs, at least for Kaiser Permanente (KP) and CareFirst, is their participation in the ACA Exchange. Most persons who enroll in the Exchange choose a “bronze” level plan because they are typically strapped in their efforts to afford health insurance, even with the help of subsidies. The bronze plans carry with them substantial member cost-sharing obligations. The persons who are covered by KP and CareFirst through their Exchange products are, on average, less financially capable of affording health insurance than their non-Exchange members, and they very likely generate higher levels of bad debts and free care because their coverage is less comprehensive than the coverage enjoyed by other KP and/or CareFirst members. Consequently, the commitment by KP and CareFirst to offer products through the Exchanges can reasonably be assumed to have driven up the level of write-offs associated with their members.

Given these dynamics, it is reasonable to ask this question: “Why would the HSCRC elect to raise the Differential, and increase the costs incurred by Commercial plans (on the grounds that they have higher write-off percentages), when the higher write-offs have resulted, to at least some degree, from their participation in the Exchange products, especially when their participation has resulted in the socially beneficial effect of decreasing the level of Uncompensated Care Costs (and Averted Bad Debts)? The proposed increase in the Differential punishes the participation of the Commercials in the Exchanges and undermines the broadly endorsed goal of extending affordable health insurance coverage to as many Marylanders as feasible.

**B. The Current Funding of Uncompensated Care Costs (UCC) Already Allocates a Disproportionately High Share of UCC to the Commercial Payers**

The hallmark characteristic of the HSCRC system that has distinguished it from other hospital payment systems throughout its existence is the funding of UCC. Under the HSCRC system, the costs of persons who cannot afford to pay for hospital care, or default on their bills, are funded by the other payers. If it is timely to examine the Differential, which gives the Government payers a 6% reduction in their payment obligations, relative to the 2% reduction that generally applies to the Commercial payers, it is reasonable to examine the current levels of UCC funding that are provided by the Government and Commercial payers.

Table One provides information for the Government and Commercial payers that has been drawn or derived from the information provided by the HSCRC Staff in its formulations of the proposed Differential change from 6.0% to 7.7%. In particular, Table One shows the Allowed Charges, Differentials/Discounts, Payment Rates, Payment Amounts and Allowed Costs for the Government payers, the Commercial payers and the Total system in RY 2017. It also shows the relative proportion of Payments, the overall level of UCC in the system and the absolute and proportional amounts of UCC that are reasonably allocated to the Government and Commercial payers.

As shown in Table One, the Government payers accounted for \$10,278,366,080, or 64% (0.6397) of Total Payments, and the Commercials accounted for \$5,790,138,900, or 36% (0.3603) of Total Payments, in RY 2017. Total UCC amounted to \$672,130,833. If we follow the principle that the costs of UCC are to be allocated fairly across the Government and Commercial payers, we would assign UCC costs based on the share of Total Payments accounted for, respectively, by the Government and Commercial payers. This allocation would assign UCC costs of \$429,934,631 to the Government payers (i.e.,  $64\% \times \$672,130,833 = \$429,934,631$ ) and UCC costs of \$242,196,202 (i.e.,  $36\% \times 672,130,833 =$

\$242,196,202) to the Commercial payers. A reasonable case for changing the current Differential of 6% might be made if the amount of funding provided by the Government and Commercial payers, respectively, diverged substantially from their allocated UCC shares.

In order to pursue the question of whether the current funding of UCC is inequitable, and should be changed, it is necessary to compare the Total Payments made by the Government payers and the Commercial payers to their levels of Allowed Costs and their allocated shares of UCC. The Total Payments made by the payers are computed by applying their associated Differentials/Discounts to the Allowed Charges which they were billed by the hospitals for the services consumed by their members. The Total Payments attributable to the Government and Commercial payers are shown in Line 5 in Table One—specifically, they were \$10,278,366,080 by the Government payers and \$5,790,138,900 by the Commercial payers. The Allowed Costs attributable to the payers are easily derived by dividing their Allowed Charges by the Mark Up. The overall Mark Up for the Maryland hospital industry, as calculated by the HSCRC Staff, was 1.09394 in RY 2017. As shown in Table One, on Line 5, the Allowed Costs of the Government payers amounted to \$9,995,442,353 (i.e., Allowable Charges of \$10,934,432,000/1.09394 = \$9,995,442,353) and the Allowed Costs of the Commercial payers amounted to \$5,400,931,848 (i.e., Allowable Charges of \$5,908,305,000/1.09394 = \$5,400,931,848).

**Table One:  
Allowed Charges, Payments, UCC, Allowed Costs, Margins and Related Comparisons**

		GOVT PAYERS	COMM PAYERS	UCC	TOTAL
L1	Estimated Charges: RY 2017	\$10,934,432,000	\$5,908,305,000	\$735,272,000	\$17,578,009,000
L2	Share of Estimated Charges	0.6221	0.3361	0.0418	
L3	Differential or Discount	0.06	0.02	1.00	
L4	Payment Rate	0.94	0.98	0.00	
L5	Estimated Total Payments (i.e. Net Revenue)	\$10,278,366,080	\$5,790,138,900	\$0	\$16,068,504,980
L6	Share of Total Payments	0.6397	0.3603	0.0000	
L7	Markup	1.0939	1.0939	1.0939	
L8	Estimated Allowable Cost	\$9,995,442,353	\$5,400,931,848	\$672,130,833	\$16,068,505,035
L9	Margin of Payments Over Allowable Cost (= Estimated Net Revenue Minus Allowable Cost in \$)	\$282,923,727	\$389,207,052	-\$672,130,833	
L10	Margin Proportion Rel to Allowable Cost (= Estimated Net Revenue/Allowable Cost)	0.0283	0.0721		0.0000
L11	Margin Rel to Charges	0.0259	0.0659		0.0000
L12	Prop Allocation of UCC by Payer (= Share of Estimated Payments x UCC Cost)	\$429,934,631	\$242,196,202		\$672,130,833
L13	Payment Margin Minus Allocated UCC Allocation of UCC	-\$147,010,904	\$147,010,849		
L14	Payment Margin/Allocated UCC	<b>0.6581</b>	<b>1.6070</b>		
L15	Share of UCC Being Paid by the Government and Commercial Payers	<b>0.4209</b>	<b>0.5791</b>		

The Margin of Total Payments over Allowable Costs, which is shown on Line 9 in Table One, is the amount of money provided by the payers that is available to cover UCC expenses. In RY 2017, the Margin provided by the Government payers was \$282,923,727 and the Margin provided by the Commercial payers was \$389,207,052. The UCC costs allocated to these payers—by multiplying Total UCC of \$672.1 million by their share of Total Payments—are shown in Line 12: \$429,934,631 for the Government payers and \$242,196,202 for the Commercial payers. As shown on Line 14, the Margin provided by the Government payers over Allowed Cost amounted to only 65.8% of the amount of UCC

allocated to the Government payers whereas the Margin provided by the Commercial payers over Allowed Cost amounted to 161.7% of the amount of UCC allocated to them. As shown on Line 15, the Government payers provided 42.1% of the overall funding for Total UCC costs while the Commercial payers provided 57.9% of the funding for Total UCC costs.

In summary, the Government payers accounted for 62.2% of Allowed Charges, and 64.0% of Total Payments, but provided only 42.1% of the funding for UCC whereas the Commercial payers accounted for 33.6% of Allowed Charges, and 36.0% of Total Payments, and provided 57.9% of the funding for UCC. This distribution indicates that the Government payers are not shouldering an inequitably high share of UCC ; instead, they are paying for only 65.8% of the UCC costs that are reasonably allocated to them. If a change in the Differential is needed, the Differential should be reduced, not increased, to address the fact that the Commercials are paying 161.7% of the UCC costs that are reasonably attributed to them.

**C. Changes in the Share of UCC Funded by the Government and Commercial Payers: RY 2011 to RY 2017**

**Table Two:  
Changes in the Share of UCC Funding by Payer: FY 2011 to RY 2017**

		Government Payers	Commercial Payers	UCC	UCC %	
FY 2011	UCC Funding	\$547,668	\$524,995	\$1,072,663	6.87%	
	UCC Funding Proportion	51.1%	48.9%			
FY 2012	UCC Funding	\$545,123	\$523,621	\$1,068,744	6.85%	
	UCC Funding Proportion	51.0%	49.0%			
FY 2013	UCC Funding	\$584,634	\$544,970	\$1,129,604	7.25%	
	UCC Funding Proportion	51.8%	48.2%			
FY 2014	UCC Funding	\$547,224	\$524,755	\$1,071,979	6.88%	
	UCC Funding Proportion	51.0%	49.0%			
FY 2015	UCC Funding	\$325,795	\$405,109	\$730,904	4.69%	
	UCC Funding Proportion	44.6%	55.4%			
FY 2016	UCC Funding	\$307,595	\$395,275	\$702,870	4.51%	
	UCC Funding Proportion	43.8%	56.2%			
FY 2017	UCC Funding	\$282,924	\$389,207	\$672,131	4.18%	Original Case
	UCC Funding Proportion	42.1%	57.9%			

As shown in Table Two, the share of UCC funding provided by the Government payers was 51.1%, and the share provided by the Commercial payers was 48.9%, in RY 2011. The relative shares of UCC funding stayed relatively constant from RY 2011 through RY 2014. In RY 2015, the relative shares diverged substantially—specifically, the Government share dropped to 44.6% and the Commercial share rose to 55.4%. The decline in the Government share continued after RY 2014 and reached 42.1% in RY 2017 while the increase in the Commercial share continued and reached 57.9% in RY 2017.

Table Two shows that UCC funding has shifted away from the Government payers, and toward the Commercial payers, since RY 2011. This pattern undermines the Staff argument that the Differential should be increased from 6.0% to 7.7% to achieve a more equitable funding of UCC.

Finally, it is important to observe that the decline in the Government share of UCC funding occurred during the period when UCC was declining sharply because of the Medicaid expansion and the coverage provided by the ACA Exchange. As UCC declines, the Differential should be decreased to prevent inequitable shifts of UCC funding away from the Government payers to the Commercial payers. This relationship is clearly illustrated by the fact that a decline of UCC from its current levels to 2.0% would bring the Mark Up down to approximately 1.06. With a 1.06 Mark Up, and an unchanged Differential of 6.0%, the Government payers would pay nothing to cover the costs of UCC—at that point, all of the UCC costs would be borne by the Commercial payers.

\* \* \* \* \*

Note: Some amounts in the Tables above do not perfectly tie out because of rounding and other factors.



*A University  
Affiliated  
Center  
Conducted  
by the  
Sisters  
of Mercy*

November 12, 2018

Katie Wunderlich, Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Ms. Wunderlich:

Mercy Health Services supports the HSCRC Staff Recommendation to adjust the public payer differential from 6 percent to 7.7 percent.

The Mercy Health Services team appreciates the hard work and efforts of the Commission and its staff to continue to evaluate and make recommendations to the Total Cost of Care Model.

Sincerely,

A handwritten signature in blue ink, appearing to read "JACD", written over a white background.

Justin C. Deibel  
Sr. Vice President/CFO

cc Mike Robbins, MHA



The Honorable Nelson J. Sabatini  
Chairman  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215  
Sent Via Email to [katie.wunderlich@maryland.gov](mailto:katie.wunderlich@maryland.gov)

Dear Chairman Sabatini:

On behalf of MedChi, The Maryland State Medical Society, who represents thousands of Maryland physicians and their patients, we are writing today to strongly support the proposed draft policy recommendation for a small adjustment to the public payer differential from 6 percent to 7.7 percent.

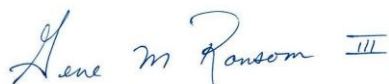
MedChi believes it is both logical and fair to make this adjustment since we are entering into a new contract with CMMI. We would further suggest that the Commission consider adopting a formal policy to review the differential each time the contract is updated with an analysis and study as completed by the staff this year. MedChi supports the Commission's staff analysis that reveals a significant increase in hospital bad debts over the last few years due to high-deductible and other large cost-sharing plans.

Failing to fix this inequity for nearly 3 million commercially-insured consumers in Maryland who have subsidized, uncompensated healthcare costs for Medicare and Medicaid would be an injustice. It is important that we monitor and judicially manage this issue this year and beyond. A failure to act would disadvantage Maryland's senior citizens and poorer residents as they would subsidize consumers who were fortunate enough to have private health insurance.

MedChi appreciates the efforts of the Commission and looks forward to continuing their leadership role as Maryland works to implement the new All Payer contract and the directly-related Maryland Primary Care Program.

Please feel free to reach out to me if you have any questions.

Sincerely,



Gene M. Ransom, III  
Chief Executive Officer

cc: Members of the HSCRC

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# RX 2021 Final Quality Based Reimbursement Policy

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**HSCRC**

Health Services Cost  
Review Commission

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# Stakeholder Comments and Responses on Draft Recommendation: **Overall Policy**

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- ▶ **QBR policy is generally flawed** (MHA letter) because:
  - ▶ Data on performance is delayed (9 month lag)
  - ▶ Patient experience HCAHPS measures are difficult to improve
  - ▶ National concerns raised about the risk adjustment and measure data validation; particularly infection measures are volatile and low-volume events
  
- ▶ **Staff responses**
  - ▶ Hospitals have access on a timelier basis to the measure data
  - ▶ While statewide HCAHPS scores show small improvements, select hospitals have significant improvements
  - ▶ Maryland must meet or exceed performance levels in quality and cost under TCOC Model agreement, is beholden to national VBP measures



# Stakeholder Comments and Responses on Draft Recommendation: **Measure Updates**

---

## **Ed Wait Times should/should not be included in the RY 2021 QBR Policy:**

- ▶ Commissioners' verbal comments, stakeholder letters (MD Chapter American College of Emergency Physicians, Johns Hopkins Hospital)
  - ▶ Should be included:
    - ▶ Maryland performance has not improved;
    - ▶ Efficiency Improvement Action Plan status?
  - ▶ Should not be included:
    - ▶ Lack of adjustment for hospital occupancy rates, behavioral health system,
    - ▶ OP 18-b may be at odds with care coordination initiatives in the ED
  
- ▶ **Staff responses**
  - ▶ Measure Improvement: Performance period not yet available for ED measures
  - ▶ Action plans: 13 hospitals - qualitative in nature, implementing strategies
  - ▶ Lack of Adjustment: Achievement bar is not aggressive
  - ▶ QBR should monitor OP 18-b (not include in QBR), and retain ED 2-b

# Stakeholder Comments and Responses on Draft Recommendation: **Measure Updates**

---

## **Hip /Knee Replacement Complication Measure:**

- ▶ JHH letter requested they receive credit for other system hospital scores given their practice to channel less complex cases out of JHH
- ▶ **Staff response:** Staff disagrees. Measure is weighted 5% of Clinical Care domain (of 15% total); VBP adjusts weight of mortality if measure is missing.

## **Mortality Measure:**

- ▶ JHH letter expressed concerns regarding the inclusion of palliative care cases in the inpatient mortality measure and the inadequacy of the risk-adjustment.
- ▶ **Staff response:** Inclusion of palliative care cases more accurately assesses mortality rate; however, staff recognizes need to risk-adjust mortality rate for palliative care status.
  - ▶ Staff is unclear as to the issues with the current risk adjustment, but is willing to discuss concerns and how they could be addressed in future years.

# Stakeholder Comments and Responses on Draft Recommendation: **Scoring/Revenue Adjustments**

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- ▶ Various hospital stakeholders (MHA, Medstar, UMMS) indicated:
  - ▶ The aggressive payment scale is overly punitive with cut point at 45%, which is amplified by the QBR domain weights; support re-weighting the measurement domains to align with the VBP program.
    - ▶ In RY 2019 QBR, 43 of 45 hospitals received penalties
    - ▶ FY 2018 analysis suggests national cut point 41% under QBR logic, and 37% under VBP logic
- ▶ Payer stakeholders (CareFirst) support keeping the domain weights as focus on needed improvement areas in Maryland
  
- ▶ **Staff responses**
  - ▶ Staff recognizes that the 45% cut point is aggressive and penalizes more hospitals than the VBP program.
  - ▶ To compare scores you must adjust the domain weighting to be consistent across Maryland and the nation
    - ▶ Even if the 37% cut point were used, FFY 2019 data indicates that 34 hospitals would still be penalized
    - ▶ Of those 34 hospitals, approximately half of them have scores in the lowest quartile of national performance and would likely receive significant penalties.

# Stakeholder Comments and Responses on Draft Recommendation: **Scoring/Revenue Adjustments**

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- ▶ Regarding the **amount of revenue at-risk for performance**, MHA raised concerns that the amount is substantially larger in Maryland programs compared to the national programs. MHA supports lowering the amount at-risk in QBR, in deference to revenue at-risk under the Medicare Performance Adjustment (MPA).
  
- ▶ **Staff responses**
  - ▶ Staff acknowledges need to build comprehensive analysis of Maryland-National revenue at-risk.
    - ▶ Initial analysis suggest that TCOC Model revenue at-risk test is different than the MHA analysis; Staff will continue to work to identify and reconcile the discrepancies.
    - ▶ Supplemental analyses may consider how payers in other states implement their own revenue at-risk policies for pay-for-performance programs that are not included in the national Medicare numbers.
  - ▶ MPA is Medicare-only adjustment; All-payer nature of the Maryland quality programs is critical as it enables the state to receive waivers from the national quality programs,
  - ▶ The Commission may consider revisiting the revenue at-risk in the RY 2021 policies, in conjunction with broad array of stakeholders.

# Staff Final Recommendations for RY 2021

## QBR Policy

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- ▶ Implement the following **measure updates**:
  - ▶ Add the **Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA) Risk-Standardized Complication Rate** measure to the Clinical Care Domain, and weight the measure at 5% to align with National VBP program;
  - ▶ Remove the **PC-01 and ED-1b** measures commensurate with their removal from the CMS VBP and IQR programs respectively;
- ▶ Continue **Domain Weighting** as follows for determining hospitals' overall performance scores: Person and Community Engagement - 50%, Safety (NHSN measures) - 35%, Clinical Care - 15%.
- ▶ Maintain the **pre-set scale** (0-80% with cut-point at 45%), and continue to hold 2% of inpatient revenue at-risk (rewards and penalties) for the QBR program.

# **Final Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2021**

December 12, 2018

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

This document contains the final staff recommendations for updating the Quality Based Reimbursement Program for RY 2021 as amended and approved by the Commission at the 12/12/18 meeting.

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## LIST OF ABBREVIATIONS

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



## EXECUTIVE SUMMARY

This document puts forth RY 2021 Quality-Based Reimbursement (QBR) final policy recommendations that include maintaining the RY 2020 quality domains, scoring approach, and pre-set revenue adjustment scale. This final recommendation also proposes minimal changes to the program measures, as outlined below.

### Final Recommendations for RY 2021 QBR Program

1. Implement the following **measure updates**:
  - A. **Add the Total Hip Arthroplasty/Total Knee Arthroplasty Risk-Standardized Complication Rate measure** to the Clinical Care Domain, and weight the measure at 5% to align with the National VBP program;
  - B. **Remove the PC-01 and ED-1b measures** commensurate with their removal from the CMS VBP and IQR programs respectively.
2. Continue **Domain Weighting** as follows for determining hospitals' overall performance scores: Person and Community Engagement - 50%, Safety (NHSN measures) - 35%, Clinical Care - 15%.
3. Maintain the **pre-set scale** (0-80% with cut-point at 45%), and continue to hold 2% of inpatient revenue at-risk (rewards and penalties) for the QBR program.  
**Amendment: Establish cut-point of 41%.**

## INTRODUCTION

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) Quality Based Reimbursement (QBR) program is one of several pay for performance initiatives that provide incentives for hospitals to improve patient care and value over time. Under the current five-year All-Payer Model Agreement between Maryland and the Centers for Medicare & Medicaid Services (CMS), effective through December 2018, there are specific quality performance requirements, including reducing Medicare readmissions to below the national average and reducing hospital complications by 30% over 5 years. Maryland is on target to meet or exceed both of these targets. The QBR program had no stated performance requirements in the All-Payer Model. However, the Commission has prioritized aligning the QBR program with the federal Value Based Purchasing (VBP) program and has attempted to encourage improvement in areas where Maryland has exhibited poor performance relative to the nation. As Maryland enters into a new Total Cost of Care (TCOC) Model Agreement with CMS on January 1, 2019, performance standards and targets in HSCRC's portfolio of quality and value-based payment programs will be updated. In the first year of the TCOC Model, staff will seek to revise two of the Commission's Quality programs, the Maryland Hospital Acquired Complications program and the Potentially Avoidable Utilization program, per directives from HSCRC Commissioners.<sup>1</sup> The QBR program will include new measures but will largely remain similar to prior iterations of the policy.

A central tenet of the healthcare reform in Maryland since 2014 is that hospitals are funded under Population Based Revenue, a fixed annual revenue cap that is adjusted for inflation, quality performance, reductions in potentially avoidable utilization, market shifts, and demographic growth. Under the Population Based Revenue system, hospitals are incentivized to transition services across the continuum of care and may keep savings that they achieve via improved quality of care (e.g., reduced avoidable utilization, readmissions, hospital acquired infections). On the other hand, constraining hospital resources can have unintended consequences, including declining quality of care. Thus, HSCRC Quality programs must reward quality improvements and reinforce the incentives of the Population Based Revenue system, as well as penalize poor performance and potential unintended consequences.

Maryland's exemptions from national quality programs are essential because the Population Based Revenue system benefits from having autonomous, quality-based measurement and payment initiatives that set consistent all-payer quality incentives. Furthermore, these exemptions afford Maryland the flexibility to select performance measures and targets in areas where improvement is needed, and allow Maryland to develop programs with greater potential for system transformation. For example, unlike the national VBP program, QBR does not

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<sup>1</sup> In the fall of 2017, HSCRC Commissioners with staff support conducted several strategic planning sessions to outline priorities and guiding principles for the upcoming Total Cost of Care Model. Based on these sessions, the HSCRC developed a Critical Action Plan that delineates timelines for review and possible revisions of financial and quality methodologies, as well as other staff operations.

relatively rank hospitals, but instead provides all hospitals the opportunity to earn rewards, which are determined using a prospective revenue adjustment scale. Under the TCOC Model, the State will receive exemptions from the CMS Hospital Acquired Conditions (HAC) program, Hospital Readmission Reduction program (HRRP), and Value-Based Purchasing (VBP) program based on annual reports to CMS that demonstrate that Maryland's program results continue to be aggressive and progressive, meeting or surpassing those of the nation.

The QBR program measures and domains are similar to those of the VBP program, but there are a few differences. Most notably, QBR does not include an Efficiency domain, and HSCRC has put higher weight on the Person and Community Engagement and Safety domains to encourage improvement. Staff recommends retaining this approach for the final RY 2021 policy. The HSCRC staff plans to expand the Potentially Avoidable Utilization (PAU) definition to incorporate other categories of unnecessary and avoidable utilization, and to incorporate other measures of efficiency based on per beneficiary measures.<sup>2</sup> In addition, the Medicare Performance Adjustment is also a measure of TCOC Efficiency that can be considered under the aggregate revenue at-risk across quality programs.

The HSCRC incorporates more comprehensive measures relative to the VBP program, most notably an all-cause, Maryland mortality measure versus VBP's condition-specific mortality measures, but generally the Commission tries to align the QBR program to measures of national import. For this reason, staff is recommending to incorporate into the RY 2021 QBR policy complication measures related to elective total hip and knee arthroplasties. Staff will also recommend to discontinue the use of various measures that will no longer have a federal data source (e.g., early elective delivery and emergency room wait time from time of arrival to admission), and staff will not recommend to adopt additional emergency room wait time measures at this time.

This report provides final recommendations for updates to Maryland's QBR program for Rate Year (RY) 2021. The QBR program has potential scaled penalties or rewards of up to 2% of inpatient revenue. Hospital's performance is assessed relative to national standards for its Safety and Person and Community Engagement domains. For the Clinical Care domain, the program uses Maryland-specific standards for the inpatient mortality measure, and proposes to use national standards for the new hip and knee complication measure.

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<sup>2</sup> Maryland has implemented an efficiency measure in the Population Based Revenue system, based on a calculation of potentially avoidable utilization (PAU), but it has not made efficiency part of its core quality programs as a domain because the revenue system fundamentally incentivizes improved efficiency. PAU is currently defined as the costs of readmissions, and of admissions measured by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQIs).

## BACKGROUND

The Affordable Care Act established the hospital Medicare Value-Based Purchasing (VBP) program,<sup>3</sup> which requires CMS to reward hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. While the QBR program has many similarities to the federal Medicare VBP program, it differs in some ways as Maryland’s unique Model Agreements and autonomous position allow the State to be innovative and progressive. Figure 1 below compares the RY 2020 QBR measures and domain weights to those used in the CMS VBP program.

**Figure 1. RY 2020 QBR Measures and Domain Weights Compared with CMS VBP Programs<sup>4</sup>**

	<b>Maryland QBR Domain Weights and Measures</b>	<b>CMS VBP Domain Weights and Measures</b>
<b>Clinical Care</b>	15% (1 measure: all cause inpatient Mortality)	25% (4 measures: 3 condition-specific Mortality, THA/TKA measure)
<b>Person and Community Engagement</b>	50% (8 HCAHPS measures, 2 ED wait time measure)	25% (Same HCAHPS measures, no ED wait time measures)
<b>Safety</b>	35% (6 measures: CDC NHSN HAI)	25% (7 measures: 6 CDC NHSN, PSI-90)
<b>Efficiency</b>	N/A	25% (Medicare Spending Per Beneficiary measure)

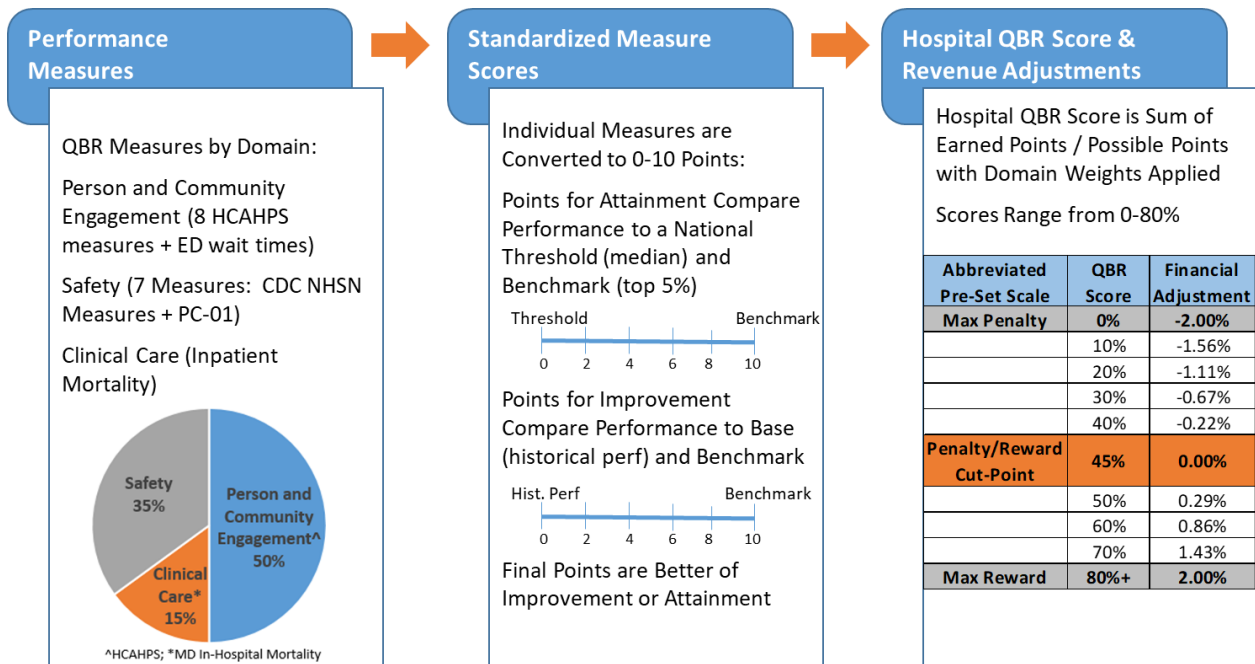
In the RY 2019 QBR recommendation, the Commission also approved moving to a preset scale based on national performance to ensure that QBR revenue adjustments are linked to Maryland hospital performance relative to the nation. Prior to RY 2019, Maryland hospitals were evaluated by national thresholds and benchmarks, but their scores were then scaled in accordance with Maryland performance, i.e., if the top performing hospital had an overall score of 57%, this became the high end of the scale by which all other Maryland hospitals were judged. This policy resulted in Maryland hospitals receiving financial rewards despite falling behind the nation in performance. Consequently, the scale is now 0 to 80% regardless of the highest performing hospital’s score, and the cutoff by which a hospital earns rewards is 45%. This reward cutoff was based on an analysis of FFY 2017 data that indicated that the average national score using Maryland domain weights (i.e., without the Efficiency domain) was 41%; thus, the 45% incentivizes performance better than the nation.

<sup>3</sup> For more information on the VBP program, see <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/>

<sup>4</sup> Details of CMS VBP measures may be found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html>.

The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019, and involves: 1) assessing performance on each measure in the domain; 2) standardizing measure scores relative to performance standards; 3) calculating the total points a hospital earned divided by the total possible points for each domain; 4) finalizing the total hospital QBR score (0-100%) by weighting the domains based on the overall percentage or importance the Commission has placed on each domain; and 5) converting the total hospital QBR scores into revenue adjustments using the preset scale that ranges from 0 to 80%, as aforementioned. The methodology is illustrated in Figure 2 below.

Figure 2. Process for Calculating RY 2020 QBR Scores



Appendix I contains further background and technical details about the QBR and VBP programs.

## ASSESSMENT

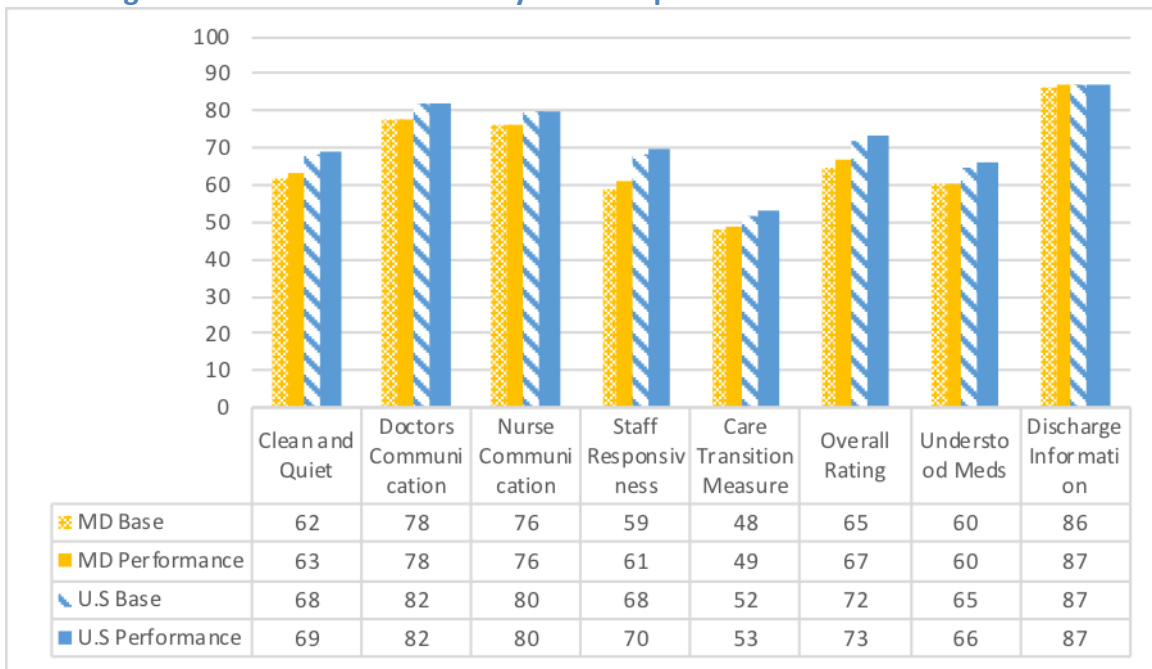
The purpose of this section is to assess Maryland’s performance on current and potential QBR measures within each domain that, together with the deliberations of the Performance Measurement Workgroup (PMWG), serve as the basis for the recommendations for the RY 2021 QBR program. In addition, the staff have modeled the QBR revenue adjustments with the recommended changes.

## Maryland Performance by QBR Domain

The **Person and Community Engagement** domain measures performance using the HCAHPS patient survey, as well as two emergency department wait time measures for admitted patients. The addition of the emergency department wait time measures is an example of Maryland’s quality programs differing from the nation to target an area of concern.

Figure 3 provides the HCAHPS measure results for the RY2019 base and performance periods for Maryland and the Nation. It shows that Maryland improved by 1-3% on 5 out of 8 of the measures; however, the nation also improved on five of the measures. In summary, the gap between Maryland and the nation was reduced by approximately 1% for the “discharge information” measure and the “overall rating” measure; the gap between Maryland and nation for “understood medication” widened by 1% because Maryland’s score remained constant and the nation improved; and for all other measures, the gap remained the same.

**Figure 3. HCAHPS Results: Maryland Compared to the nation for RY 2019**



**\*Time period Calendar Year 2015 (Base); 10/2016 to 9/2017 (Performance)**

While the statewide data suggests that Maryland continues to lag behind the nation on HCAHPS measures, there is variability in performance across individual hospitals, with some performing better than the national average on each measure. Furthermore, while the statewide improvements were modest, there were individual hospitals with significant improvements on each measure (Appendix II).

It should be noted that hospital stakeholders have raised concerns about HCAHPS patient mix adjustment changes between the base and performance periods. CMS has advised staff that these changes occur on an ongoing basis, and that the most recent changes are not considered

materially significant for the VBP program. Further, staff believes that the changes in any given year may slightly benefit or disadvantage each hospital on their respective QBR scores, but recognize the use of the prospective preset scale may make this issue more of a concern in Maryland. Therefore, staff will evaluate the impact of the patient mix adjustment changes for RY 2019 and RY 2020, but does not support retrospective QBR revenue adjustments. Staff may re-visit this position with the Commission should analysis determine the patient mix adjustment changes are materially significant. For RY2021 it is unknown whether there will be any patient mix adjustment changes, but staff will assess any changes that occur.

Emergency department wait time measures have been publicly reported nationally on Hospital Compare since 2012 for patients admitted (ED-1b and ED-2b), and since 2014 for patients treated and released (OP-18b). Based upon Maryland’s sustained poor performance on these ED throughput measures, the Commission voted to include the two ED Wait Time measures for admitted patients as part of the QBR program for RY 2020.<sup>5</sup> However, staff notes that the impact of adding the measures to the QBR program cannot be assessed at this time, since the data are lagged by 9 months and will not be available for the complete RY 2020 performance period until the fall of 2019. As the Hospital Compare quarterly data is released, staff will assess any emerging changes in the trends. The measure definitions are provided below in Figure 4.

**Figure 4. CMS ED Wait Time Measures**

<b>Measure ID</b>	<b>Measure Title</b>
ED-1b	Median time from emergency department arrival to emergency department departure for admitted emergency department patients
ED-2b	Admit decision time to emergency department departure time for admitted patient
OP-18*	Emergency department arrival time to departure time for discharged patients.

\*OP-18 is not recommended to be a measure in the RY 2021 Program. OP-18b strata includes non-psychiatric patients and OP-18c strata includes psychiatric patients.

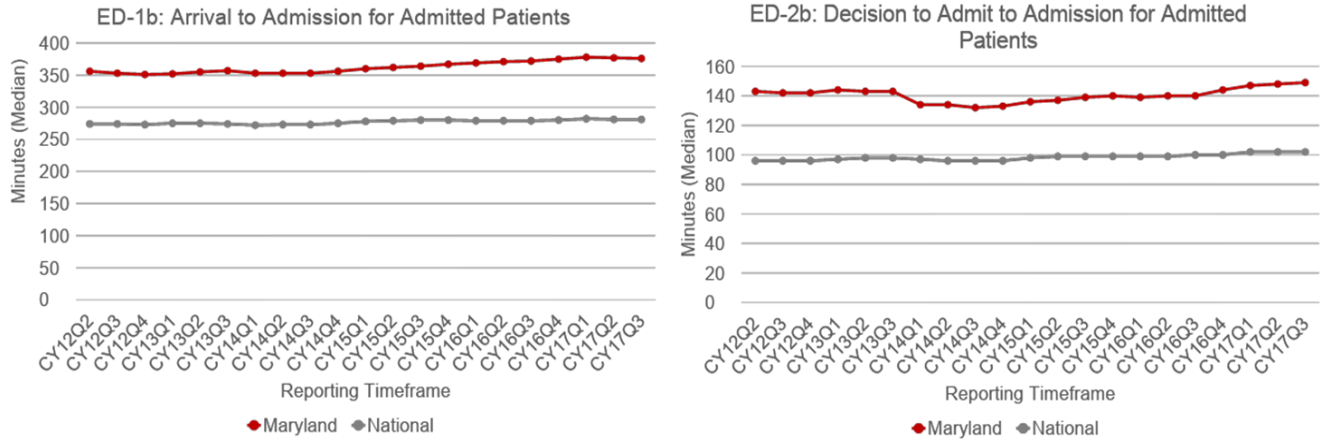
Based on the most current data available, Maryland continues to perform poorly on the ED wait time measures compared to the nation, as illustrated in Figure 4 below. At the hospital level, the most recent data show approximately 85% of Maryland hospitals perform worse than the national median in ED wait times.<sup>6</sup>

<sup>5</sup> Staff believes that poor ED wait times may also be contributing to less favorable hospital HCAHPS scores, based on analysis of statistical correlation done last year when the RY 2020 policy was adopted.

<sup>6</sup> 93% of Maryland hospitals perform worse than the nation in ED-1b, 78% perform worse than the nation in ED-2b, and 82% perform worse on OB-18b. The median wait times are adjusted based upon ED volume. These results are similar to the 80% reported in RY2020 policy.



**Figure 5. Maryland Statewide ED Wait Time Trends for Admitted Patients Compared to the Nation, Q2 2012 to Q3 2017.**



For RY 2021, staff recommends that the QBR program include only the ED-2b measure, as CMS has discontinued mandatory data collection for ED-1b after CY 2018. In the latest final rule, CMS removed or de-duplicated 39 measures from the hospital Inpatient Quality Reporting program to focus measurement on the most critical quality issues with the least burden for clinicians and providers. While ED-1b was removed from CMS reporting, it should be noted that the Joint commission has retained the measure and given statewide performance this is a more critical quality issue for Maryland than the nation.

Based on stakeholder interest last year and the removal of ED-1b, staff and the PMWG reconsidered whether to propose inclusion of OP-18 (non-admitted patients) for RY 2021. Maryland currently performs poorly on the wait time for non-admitted/discharged patients for both the non-psychiatric patients “b” strata measure, and the psychiatric patients “c” strata measure (OP-18c is newly added to Hospital Compare in latest public reporting release), as illustrated in Figure 6. Some stakeholders voiced support for inclusion of the OP-18b measure but others suggested the measure is at odds with hospitals’ efforts to reduce inpatient admissions through ED care coordination.



**Figure 6. Maryland Performance and National Benchmarks for ED Wait Times  
10-1-2016 to 9-30-2017**

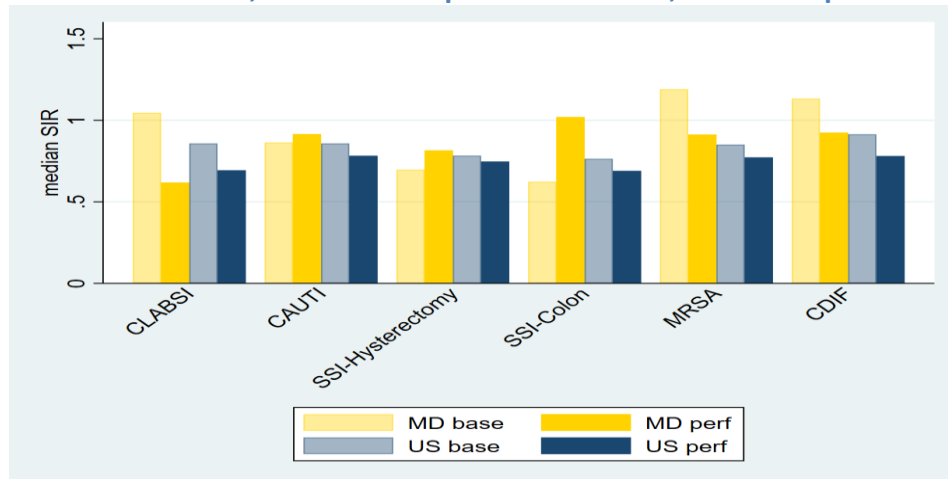
<b>OP-18b (non-psychiatric patients)</b>	<b>MD</b>	<b>National</b>
Low Volume	131	111
Moderate Volume	182	142
High Volume	190	161
Very High Volume	213	171
<b>OP-18c (psychiatric patients)</b>	<b>MD</b>	<b>National</b>
Low Volume	194	245
Moderate Volume	349	164
High Volume	324	218
Very High Volume	359	279

Based on this feedback, staff intends to actively monitor performance on the OP-18 measure (both OP-18b and OP-18c) over the next program year. Staff acknowledges that there are difficulties with the behavioral health system in the State, such as aging behavioral health system infrastructure and labor shortages, which exacerbate emergency department throughput problems. However these issues are not unique to Maryland. Furthermore, staff believes that continuing to include the measure of admit decision time to emergency department departure time for admitted patients will have spillover effects on outpatient emergency department wait times. However, if improvements are not seen in outpatient ED wait times, staff will reconsider a proposed recommendation for inclusion of OP-18b next year. Staff will pay particular attention to this issue in light of the fact that Maryland’s higher wait times are paired with declining statewide ED visits.

**Based on the analysis of the Person and Community Engagement domain, HSCRC staff recommends continuing to weight this domain at 50% of the QBR score, and retaining the ED-2b measure along with HCAHPS in the domain.**

The **Safety** domain consists of six CDC National Health Safety Network (NHSN) healthcare associated infection (HAI) measures, and one measure of perinatal care (PC-01 Early Elective Delivery). Staff does not recommend any changes to this domain in RY 2021 beyond discontinuance of the PC-01 measure, which is being removed from the VBP program for FY 2021 due to relatively high performance of all hospitals. As illustrated in Figure 7 below, Maryland's performance on the NHSN measures has been mixed (lower scores are better). While median hospital standardized infection ratios (SIR) for all six HAI categories declined nationally during the performance period, Maryland hospitals experienced higher SIRs in three out of six of the infection categories. However, for the three infections in which Maryland hospitals also experienced declining standardized rates in the base period, the declines in Maryland were larger than national peers.

**Figure 7. Maryland vs. National Median Hospital SIRs on NHSN HAI Safety Measures (Base period Calendar Year 2015, Performance period October 1, 2016 to September 30, 2017)**

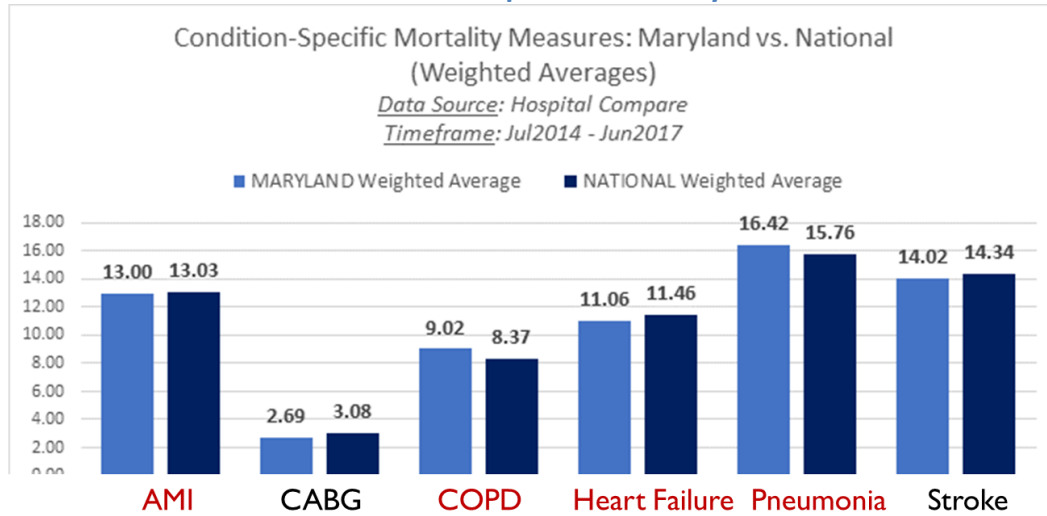


The QBR **Safety** domain does not include the Patient Safety Index Composite (PSI-90) measure that is included in VBP. Currently, the Agency for Healthcare Research and Quality (AHRQ) has yet to release a PSI-90 risk-adjustment methodology under ICD-10 for all payers. The HSCRC plans to consider options for re-adopting the PSI-90 composite measure on an all-payer basis as soon as the risk-adjustment is available. To this end, staff intends to vet with stakeholders the PSI composite measure in context of the QBR and MHAC complications programs as we consider its use under the TCOC Model starting in RY 2022.

**Staff recommends continuing to weight the Safety domain at 35% of the total QBR score.**

The QBR **Clinical Care** domain consists of one all-payer, all-cause inpatient mortality measure in the QBR program, while the federal Medicare VBP program measures four 30-day condition-specific Mortality measures (Heart Attack, Heart Failure, Pneumonia and COPD), as well as a Total Hip and Knee Arthroplasty (THA/TKA) complication measure on patients with elective primary procedures. Medicare also monitors two additional mortality measures for Coronary Artery Bypass Graft and Stroke, but does not include these measures in VBP. Based on the data obtained from Health Quality Innovators, Maryland performs similarly to the nation for all condition-specific measures of 30-day mortality (Figure 9).

**Figure 9. Maryland Hospital Performance Compared with the nation on CMS Condition-Specific Mortality Measures**

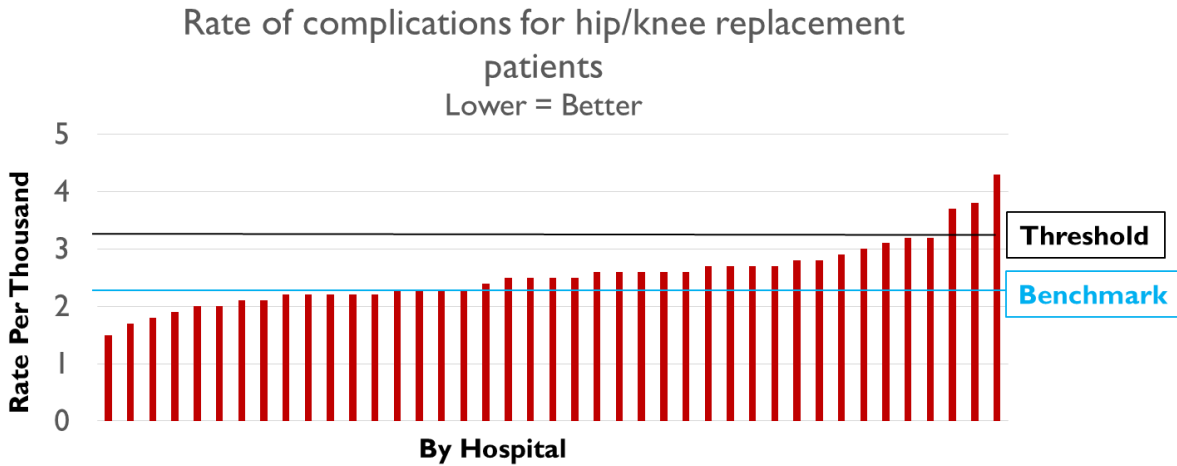


Source: Health Quality Innovators (HQI). Red are conditions included in VBP.

In terms of performance on the QBR inpatient mortality measure, 25 hospitals have shown a decrease in their risk-adjusted inpatient mortality rate through June 2018 compared to the RY2020 base period. An additional 7 hospitals have mortality rates that are better than the 95<sup>th</sup> percentile of state performance in the base period (i.e., they have exceeded the statewide benchmark and would earn full 10 points if performance continued through end of 2018). Finally, 8 hospitals that did not improve earned at least one attainment point for performance greater than the statewide average (i.e., threshold) during the base period.

For the hip and knee complication measure, Figure 10 illustrates that of the hospitals that qualify for the measure, all but 3 hospitals perform better than the current VBP threshold, and close to half of the hospitals perform better than the benchmark, but variation in performance remains. To qualify for the hip and knee complication measure a hospital must perform a minimum of 25 elective primary procedures.

**Figure 10. Maryland THA/TKA Measure Performance Compared to VBP Standards, Base Period April 2011-March 2014, Performance Period April 2016-March 2019**



Staff notes that adding the hip and knee complication measure to the QBR program is consistent with the goals of the TCOC model, namely expanding beyond the initial hospital stay since complications measured may occur up to 90 days postoperatively.

**Staff recommends including the hip and knee replacement measure in the Clinical Care domain consistent with the VBP program, and continuing to weight the Clinical Care domain at 15%<sup>7</sup>.**

Appendix III details the available published performance standards (for VBP measures) for each measure by domain for RY2021; staff will calculate and disseminate the inpatient mortality standards within the next two months when v. 36 of the APR DRG grouper is implemented.

The Assessment section outlines Maryland’s performance for available measures, and highlights those proposed for RY 2021. Appendix IV contains additional discussion of the QBR program and potential future changes under the Maryland Total Cost of Care Model.

### Revenue Adjustment Modeling

HSCRC staff modeled hospital QBR scores and revenue adjustments consistent with the preset scaling approach approved for RY 2020. With the exception of the HSCRC-derived measures, the thresholds and benchmarks for the QBR scoring methodology are based on the national average (threshold) and the top performance (benchmark) values for all measures. A score of 0% means that performance on all measures are below the national average or not improved, while a score of 100% means all measures are at or better than the top 5% best performing rates. The

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<sup>7</sup> If a hospital does not qualify for THA/TKA measure, then mortality will remain weighted at 15%.

Commission moved to a preset scale that reflects a full distribution of potential scores and raised the reward potential to 2% of inpatient revenue for RY 2019. Given Maryland's mixed performance relative to the nation, staff believes that the more aggressive scaling is warranted and proposes to continue this scale for RY 2021 QBR program.

This preset scale uses a modified full score distribution ranging from 0% to 80%, and sets the reward/penalty cut-point at 45%. The 45% cutoff was originally established by estimating the national average VBP scores for FFY2017 without the efficiency domain and with RY 2017 Maryland QBR-specific weights applied, which was 41%. Therefore, HSCRC staff recommended 45% as the cut-point for RY 2019 in order to establish an aggressive bar for receiving rewards. This analysis was updated for FFY 2016 through FFY 2018 (FFY 2019 data not yet publicly available) using the proposed RY2021 QBR domain weights, and the average national scores were relatively consistent at 42% for FFY16, 40% FFY17, and 42% FFY18. Staff plan to analyze FFY2019 results when publicly available to assess national average scores and may use this as basis to decide whether the HCAHPS patient mix adjustment changes are significant.

Staff modeled hospital scores for RY 2021 QBR using the aforementioned preset scale with a cutoff point of 45% and RY 2019 data using the base period of calendar year 2015, and the performance period of Q4 2016-Q3 2017. In order to assess the impact of removed measures and the addition of THA/TKA, the results of the following two models are provided:

- Model 1: Removal of PC-01 and Removal of ED-1b
- Model 2: Same as above, and addition of THA/TKA measure

Hospital-specific domain scores and total QBR scores for both models are included in Appendix V. The modeled hospital-specific and statewide revenue impacts are found in Appendix VI. With ED-1b and PC-01 excluded, 4 hospitals receive rewards of approximately \$427 thousand and the remaining hospitals receive penalties of approximately \$69 million. With the THA/TKA included, 4 hospitals receive rewards of approximately \$485 thousand, and the remaining hospitals receive penalties of approximately \$64 million.

## STAKEHOLDER COMMENTS AND RESPONSES

HSCRC Commissioners as well as hospital industry, payer and physician stakeholders have given verbal and written comments to HSCRC staff regarding the RY 2021 QBR program, applicable both in the short term, and as it evolves under the new TCOC Model. Staff summarizes the comments and responses below and the comment letters are included in Appendix VII.

### *OVERALL CONCERNS*

The letter from MHA states that the **QBR policy is generally flawed** because the data on performance is delayed (9 month lag after performance period before data is available), the patient experience HCAHPS measures are difficult to improve upon, the infection measures are

volatile because of the low volume of events, and national concerns have been raised about the adequacy of the risk adjustment and measure data validation.

**Staff Response:**

**Staff notes that the concerns raised about the QBR policy are all issues that impact the national VBP program and have been debated in previous QBR policies. Stakeholders must keep in mind that Maryland must meet or exceed performance levels in quality and cost under our Model agreement with CMS. Specifically, each year Maryland must submit to CMS our outcomes on VBP and other quality measures to receive an annual exemption from the CMS VBP program. While Maryland could maintain the all-payer rate setting system without this exemption, Maryland hospitals could be required to participate in the national VBP program. Under the VBP program, all US hospitals are held accountable to performance levels on the HCAHPS and NHSN measures.**

**Additionally, in response to specific concerns raised in this year's letter from MHA, staff notes that while the data is delayed for public posting on Hospital Compare, hospitals have access on a timelier basis to the data they submit to CMS as well as the data associated with the inpatient mortality measure that is calculated by the HSCRC. Thus, there is data during the performance period that can be used for quality improvement. Next, while the HCAHPS measures at a statewide level have shown only small improvements, there have been significant improvements at select hospitals. Appendix II shows hospital changes for RY 2019.**

***MEASURE UPDATES***

During the November Commission meeting, some Commissioners raised concerns at the continued excessive **ED Wait Times** in Maryland compared to the Nation. Their concern centered on the ability to put the appropriate incentives in place, especially with the removal of the ED 1-b measure (wait time from arrival to admission) from the QBR program<sup>8</sup>. The OP 18-b measure (wait time from arrival to departure for patients not admitted) was also discussed as a possible consideration for use in the QBR program. Commissioners also inquired about the status of the Efficiency Improvement Action Plans that certain hospitals with the longest wait times were requested to submit earlier this year. The Maryland Chapter of the American College of Emergency Physicians (MD ACEP) continues to support the inclusion of the ED 2-b measure in light of extended wait times, but voiced concern in their letter regarding the addition of OP 18-b in the payment program because of time needed for care coordination to avoid admissions. As expressed last year, Johns Hopkins Hospital continues to raise concerns regarding inclusion of the one remaining ED 2-b measure (wait time from decision to admit to admission) due to occupancy rate impacts at their hospital, and behavioral health systems concerns.

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<sup>8</sup> Data for the ED 1-b measure will no longer be available from Hospital Compare after CY 2018 because of the measure's discontinuance in the hospital Inpatient Quality Reporting program.

**Staff Response:**

Staff notes that, due to the data lag, the impact of adding the ED 1-b and 2-b measures to the RY 2020 QBR program, and potential spillover impacts on OP 18-b, are not yet known. Staff conducted preliminary analysis of one quarter of data from the RY 2020 QBR performance period after the draft policy was released, which reveals there may be marginal improvements on the measures for about half of the hospitals but cautions that one quarter of data is insufficient for evaluating performance trends. Moreover, the RY 2020 QBR program was not approved by Commissioners until December 2017, 2 months after the start of the performance period, so it would be difficult to suggest that the first three months of the performance period were impacted by the Commission decision to include ED wait time measures.

Regarding the hospital high occupancy rate and behavioral health system impact concerns raised at the November Commission meeting and by JHH in their letter, staff notes that the bar is not aggressive for this measure as hospitals receive full credit for the measure if they reach the national median. Additionally, there are protections to ensure that as long as the hospital improves on ED wait times, they are not hurt by the measure's inclusion in the policy. Staff notes that the literature demonstrates that decreases in hospital wait times for admitted patients is achievable, as is a decrease in the rate of patients that leave without being seen, when hospitals improve their inpatient efficiency and throughput.<sup>9</sup> In addition, staff believes that the stratification of hospital wait time measures by ED volume will further mitigate some of these concerns.

Regarding the addition of OP 18-b, staff supports monitoring of the measure but does not recommend adding the measure to the QBR program in light of hospitals' continued efforts to prevent avoidable admissions and employ care coordination activities in the ED. However if OP-18b does not improve over time as care coordination becomes more efficient, the staff may recommend inclusion of this measures in the RY 2022 QBR program.

Regarding the Efficiency Improvement Action Plans, 13 hospitals submitted Plans that described a wide variety of approaches, including efforts to change care processes, enhance facilities, and improve staffing. For example:

- Union Hospital of Cecil County in 2016 sought to move low-acuity patients more quickly through the ED by including a provider in the triage process.

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<sup>9</sup>Artenstein, Andrew, MD, et al., Decreasing Emergency Department Walkout Rate and Boarding Hours by Improving Inpatient Length of Stay, [West J Emerg Med](#). 2017 Oct; 18(6): 982–992., Last accessed: December 4, 2018.



Additionally, UHCC developed a marketing plan to encourage non-emergent patients to use affiliated urgent care centers rather than the ED, and organized a workgroup to address delays in diagnostic imaging.

- University of Maryland Medical Center (UMMC) stationed a medical admitting officer in the ED 16 hours per day, and staffs an RN flow coordinator position to work with physicians on improving patient flow. The hospital has also partnered with the UM School of Nursing on an urgent care strategy, and opened an urgent care center across the street from the ED to handle low-acuity patients.
- Medstar Harbor instituted the ED FlexCare program, which routes non-emergent patients to primary care treatment options. The hospital also developed a "vertical care" track within the ED, in which intermediate-acuity patients remain seated for the duration of their stay, freeing ED beds for higher-acuity patients.

Since the Plans were qualitative in nature, staff is determining the best way going forward to evaluate such information, and will again analyze ED wait time trends as the data becomes available.

Staff continues to support the use of ED 2-b in QBR program with its focus on hospital efficiencies to move patients to inpatient beds once the decision is made for admission.

The **addition of the hip and knee arthroplasty complication measure** to align with the CMS VBP program was generally supported by the hospitals and insurers. A concern was raised by Johns Hopkins Hospital related to deliberate actions to move uncomplicated hip and knee replacement surgeries to community hospitals within their system so the hospital does not have sufficient volume to qualify for the measure. As specified in the draft policy, JHH notes that hospitals that do not qualify for the hip and knee measure will have the inpatient mortality measure weighted at the full 15% of the Clinical Care domain. JHH recommended that the Commission consider attributing other system hospitals' scores to them for the QBR program. JHH also recommended that the Commission **consider in future years adopting the Medicare 30 day condition-specific mortality measures** in lieu of the all-payer, all condition inpatient mortality measure currently used in the QBR measure. Furthermore, JHH raises concerns regarding the inclusion of palliative care cases in the inpatient mortality measure and the inadequacy of the risk-adjustment.

#### **Staff Response:**

Staff continues to support general alignment with the national VBP program by **adopting the hip/knee complication measure**. With regard to the concern raised by Johns Hopkins, staff does not support giving credit for other system hospitals' performance, as this does not align with the measurement approach of the national program. Staff notes that at 5%, the measure is not heavily weighted; staff also does not believe the re-weighting of the inpatient mortality measure to the full 15%



of the Clinical Care domain justifies departing from the national measurement approach by attributing other system hospitals' scores to the academic facility with insufficient case volume. Staff adds that the Clinical Care domain is weighted at 15%, which is 10% less than the national VBP program.

Regarding the use of the Medicare 30 day condition-specific measures in lieu of the all payer measure in the future, staff notes that the Commission is working with contractors to develop a 30 day all-payer all condition mortality measure and will consider the Medicare mortality measures for future use as well.

In terms of the JHH concerns regarding the inclusion of palliative care cases, the staff remind the Commission that this was done to more accurately assess improvement as the use of palliative care was increasing. However, when assessing attainment the staff recognized the need to risk-adjust for palliative care status. In terms of the inadequacy of the risk-adjustment, staff is unclear as to the issues with the current risk adjustment but would be willing to discuss concerns and how they could be addressed in future years. Options for consideration include a) going back to the hybrid approach from RY 2019 that assessed improvement with palliative care included and attainment without palliative care, b) moving to an attainment only model with an exclusion for palliative care, or c) revising the risk adjustment. Finally, despite these concerns staff also notes that one hospital did report that including palliative care patients in the measure has incentivized them to work with nursing homes to provide better care within the nursing home for patients receiving end of life care.

### ***SCORING AND REVENUE ADJUSTMENTS***

Various hospital stakeholders (MHA, Medstar, UMMS) indicated they believe that the **aggressive payment scale is overly punitive** and that this is **amplified by the domain weights** we use for QBR. Specifically, hospital stakeholders point out that the **reward/penalty cut point** is too aggressive at 45% and resulted in RY 2019 with all but two hospitals receiving penalties. Thus, stakeholder input recommends that the QBR program should align the payment scale with the national VBP (Medstar, MHA, UMMS). Based on the most recently available data, the national average score, and hence the cut point, would be 41% with Maryland measurement domains weights applied, and 37% with national domain weights applied (Medstar).

Commenters had varying perspectives on the measurement domain weights that should be used in the QBR program. The MHA letter and others also state that the higher weight on HCAHPS has not resulted in improvement relative to the nation. Payer stakeholders (CareFirst) support keeping the domain weights as focus on needed improvement areas in Maryland, while hospital stakeholders (MHA, Medstar and UMMS) support re-weighting the measurement domains to align with the VBP program. Regarding the **amount of revenue at risk for performance**, MHA raises concerns that the amount is substantially larger in Maryland programs compared to the national programs and supports lowering the amount to levels more comparable to the

national programs, with consideration for the Medicare Performance Adjustment (MPA) in addition to the other quality adjustments.

**Staff Response:**

**Staff believes that to compare scores you must adjust the domain weighting to be consistent across Maryland and the nation. As such, staff reweighted the national scores for FFY 2016 through FFY 2018 and found the average score range was 40%-42%. Staff does not believe that the 37% average score for the Nation (derived using national domains and weights) is an appropriate comparison since Maryland does not have the efficiency domain, which in FFY 2018 was the domain with the worst average scores and thus lowers the overall VBP average score. Regardless, even if the 37% cut point were to be used, FFY 2019 performance data from CMMI on the VBP measures for Maryland hospitals indicates that 34 hospitals would be penalized.**

**Staff believes under a prospective system an improvement factor should be added to the cut point but recognizes that the 45% cut point is aggressive and penalizes more hospitals than the VBP program. However, the number of hospitals penalized does not reflect the size of potential penalties Maryland hospitals could receive under the VBP program. As a reminder the VBP program uses a linear scale to assign rewards or penalties up to 2% by relatively ranking hospitals. Staff notes that of the 34 hospitals that would be estimated to receive VBP penalties, approximately half of them have scores in the lowest quartile of national performance and as such could receive significant penalties.**

**Next, staff agrees with Carefirst that the domain weights should emphasize areas of needed improvement in Maryland, most notably HCAHPS, and does not support the industry's recommendation to weight the domains equally. Staff has recently been informed about and is encouraged by hospital pilots that have been newly established for improving HCAHPS. Staff believes, therefore, that a long-term consistent policy is needed to emphasize the importance of these measures and to incentivize further investments. Moreover, reducing the weight on HCAHPS now would send the incorrect message to Maryland hospitals, especially hospitals that are engaging in pilot programs to improve their HCAHPS performance, and would be difficult to justify to CMS when requesting a waiver from CMS VBP.**

**Staff acknowledge the need for a more comprehensive analysis and comparison between Maryland's aggregate at-risk for performance based payments and the nation's aggregate at-risk. Staff looks forward to working with consumers, payers, and hospitals to help balance hospital concerns of high revenue at-risk on Medicare with the importance of continued quality improvement and revenue at-risk for all other consumers and payers. As part of this conversation, supplemental analyses may consider looking at how payers in other states implement their own revenue at-risk policies that are not included in the national Medicare numbers. The**

Commission may consider revisiting the revenue at-risk in the RY 2021 policies in light of these conversations.

In addition, staff notes that the Maryland aggregate at-risk test is not the same as the MHA provided analysis. HSCRC is responsible for ensuring Maryland meets the current all-payer inpatient revenue aggregate at-risk tests agreed to by CMS. The numbers staff have currently calculated, illustrated below in Figure XX, are based on the percent of inpatient revenue potentially at-risk and the absolute dollar value exchanged based on quality. This differs from MHA’s calculations that present the percent of total hospital charges, although staff does not believe this is the only difference between our estimates and MHA’s, and will continue to work to identify other discrepancies. As a reminder, the all-payer nature of the Maryland quality programs is critical as it enables the state to receive waivers from the national quality programs, allowing for state innovations such as preset scaling and opportunities for rewards.

**Figure 11. HSCRC Estimate of Maryland Compared to Medicare Potential and Realized Revenue at Risk for Quality Programs**

CURRENT TEST	Maryland All-Payer Inpatient Revenue (State Fiscal Year 2019)		National Medicare Inpatient Revenue (Federal Fiscal Year 2018)	
	Maximum adjustment (potential risk) <sup>1</sup>	Actual adjustment (realized risk) <sup>2</sup>	Maximum adjustment (potential risk) <sup>1</sup>	Actual adjustment (realized risk) <sup>2</sup>
QBR/VBP, Complications, readmissions	6%	1.47%	6%	1.33%
PAU savings (cumulative)	5.81%	3.57%	N/A	N/A
MPA (begins in FY2020) <sup>3</sup>	N/A	N/A	N/A	N/A
Total	11.81%	5.04%	6%	1.33%

<sup>1</sup> Maximum revenue at-risk (aka potential) is the absolute value of the largest penalty or reward a hospital could receive in a specific fiscal year for a program. Commission sets these values for the three core quality programs and the MPA, but not PAU savings, which is defined as the largest non-outlier adjustment received by a hospital.  
<sup>2</sup> Actual adjustments (Realized at-risk) are calculated as the average of the absolute value of all inpatient adjustments for that program.  
<sup>3</sup> As noted in the MHA table, the MPA adjustments do not begin until FY 2020, so the MPA is not included in the potential risk for RY 2019

As part of HSCRC negotiations to agree on aggregate at-risk calculations for the Total Care of Cost Model, CMMI has indicated concern with the use of cumulative PAU savings numbers instead of net PAU savings numbers. While this calculation is still under discussion, preliminary staff analyses indicate that it will be difficult to justify continuing to use the cumulative PAU savings numbers every year, as the cumulative amount does not represent additional annual revenue at-risk based on quality. Figure 12 below illustrates the same data as the previous table but with net PAU savings instead of cumulative savings. In the updated table, Maryland potential and realized risk is still above the national numbers.

**Figure 12. HSCRC Estimate of Maryland Compared to Medicare Revenue at Risk for Quality Programs, with Net PAU Savings**

POTENTIAL FUTURE TEST USING RY19	Maryland All-Payer Inpatient Revenue (State Fiscal Year 2019)		National Medicare Inpatient Revenue (Federal Fiscal Year 2018)	
	Maximum adjustment (potential risk) <sup>1</sup>	Actual adjustment (realized risk) <sup>2</sup>	Maximum adjustment (potential risk) <sup>1</sup>	Actual adjustment (realized risk) <sup>2</sup>
QBR/VBP, Complications, readmissions	6%	1.47%	6%	1.33%
PAU savings (net)	2%	0.61%	N/A	N/A
MPA (begins in FY2020) <sup>3</sup>	N/A	N/A	N/A	N/A
Total	8%	2.08%	6%	1.33%

<sup>1</sup> Maximum revenue at-risk (aka potential) is the absolute value of the largest penalty or reward a hospital could receive in a specific fiscal year for a program. Commission sets these values for the three core quality programs and the MPA, but not PAU savings, which is defined as the largest non-outlier adjustment received by a hospital.

<sup>2</sup> Actual adjustments (Realized at-risk) are calculated as the average of the absolute value of all inpatient adjustments for that program.

<sup>3</sup> As noted in the MHA table, the MPA adjustments do not begin until FY2020, so the MPA is not included in the potential risk for RY2019

## FINAL RECOMMENDATIONS FOR RY 2021 QBR PROGRAM

Based on the staff assessment and stakeholder deliberations to date, staff proposes that the Commission consider the final recommendations below.

1. Implement the following **measure updates**:
  - A. **Add the Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA) Risk-Standardized Complication Rate measure** to the Clinical Care Domain, and weight the measure at 5% to align with National VBP program;
  - B. **Remove the PC-01 and ED-1b measures** commensurate with their removal from the CMS VBP and IQR programs respectively;
2. Continue **Domain Weighting** as follows for determining hospitals' overall performance scores: Person and Community Engagement - 50%, Safety (NHSN measures) - 35%, Clinical Care - 15%.
3. Maintain the **pre-set scale** (0-80% with cut-point at 45%), and continue to hold 2% of inpatient revenue at-risk (rewards and penalties) for the QBR program.
4. Maintain the **pre-set scale** (0-80% with cut-point at 45%), and continue to hold 2% of inpatient revenue at-risk (rewards and penalties) for the QBR program.  
**Amendment: Establish cut-point of 41%.**

## APPENDIX I. HSCRC QBR PROGRAM BACKGROUND

The Affordable Care Act established the hospital Medicare Value-Based Purchasing (VBP) program,<sup>10</sup> which requires CMS to reward hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. The program assesses hospital performance on a set of measures in Clinical Care, Person and Community Engagement, Safety, and Efficiency domains. The incentive payments are funded by reducing the base operating diagnosis-related group (DRG) amounts that determine the Medicare payment for each hospital inpatient discharge.<sup>11</sup> The Affordable Care Act set the maximum penalty and reward at 2% for federal fiscal year (FFY) 2017 and beyond.<sup>12</sup>

Maryland's Quality-Based Reimbursement (QBR) program, in place since July 2009, employs measures that are similar to those in the federal Medicare VBP program, under which all other states have operated since October 2012. Similar to the VBP program, the QBR program currently measures performance in Clinical Care, Safety, and Person and Community Engagement domains, which comprise 15%, 35%, and 50% of a hospital's total QBR score, respectively. For the Safety and Person and Community Engagement domains, which constitute the largest share of a hospital's overall QBR score (85%), performance standards are the same as those established in the national VBP program. The Clinical Care Domain, in contrast, uses a Maryland-specific mortality measure and benchmarks. In effect, Maryland's QBR program, despite not having a prescribed national goal, reflects Maryland's rankings relative to the nation by using national VBP benchmarks for the majority of the overall QBR score.

In addition to structuring two of the three domains of the QBR program to correspond to the federal VBP program, the Commission has increasingly emphasized performance relative to the nation through benchmarking, domain weighting, and scaling decisions. For example, beginning in RY 2015, the QBR program began utilizing national benchmarks to assess performance for the Person and Community Engagement and Safety domains. Subsequently, the RY 2017 QBR policy increased the weighting of the Person and Community Engagement domain, which is measured by the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey instrument to 50%<sup>13</sup>. The weighting was increased in order to raise incentives for HCAHPS improvement, as Maryland has consistently scored in the lowest decile nationally on these measures.

While the QBR program has many similarities to the federal Medicare VBP program, it does differ because Maryland's unique Model Agreements and autonomous position allow the State to

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<sup>10</sup> For more information on the VBP program, see <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/>

<sup>11</sup> 42 USC § 1395ww(o)(7).

<sup>12</sup> 42 USC § 1395ww(o)(7)(C).

<sup>13</sup> The HCAHPS increase reduced the Clinical Care domain from 20% to 15%.

be innovative and progressive. Figure 13 below compares the RY 2020 QBR measures and domain weights to those used in the CMS VBP program.

**Figure 13. RY 2020 QBR Measures and Domain Weights Compared with CMS VBP Program<sup>14</sup>**

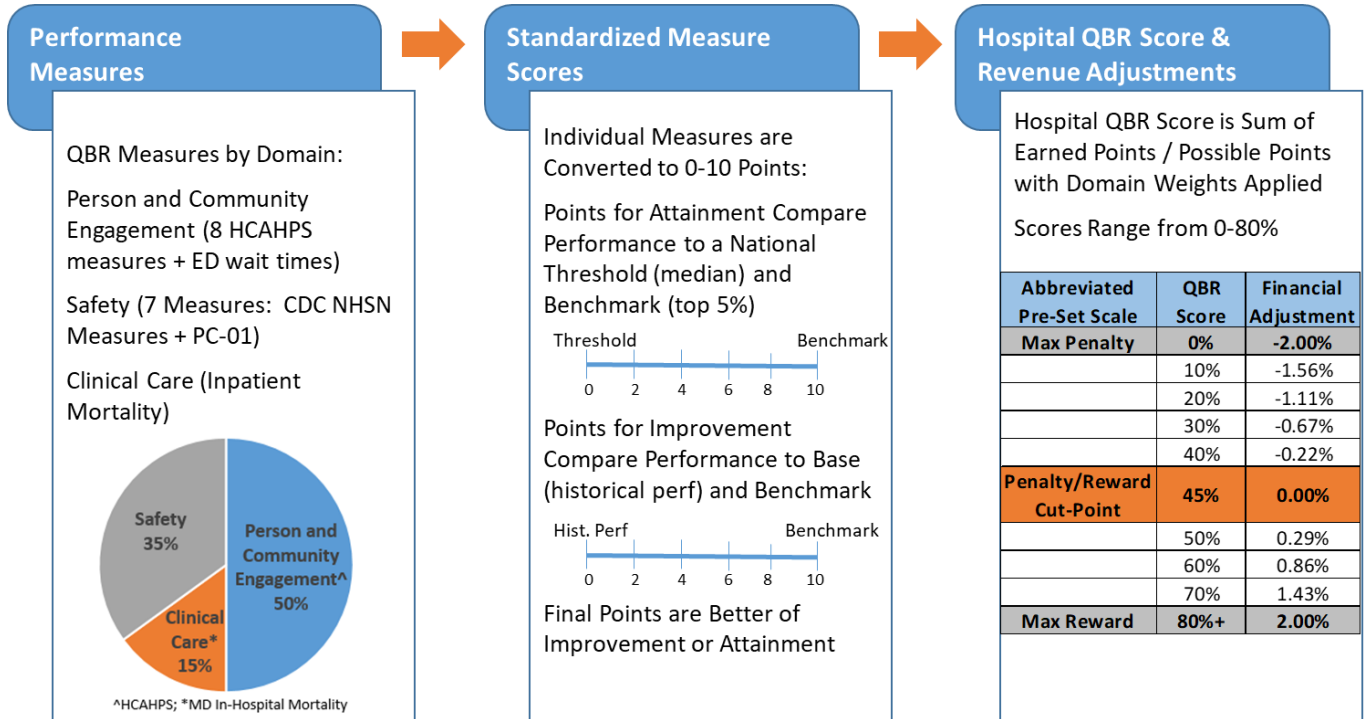
	<b>Maryland QBR Domains and Measures</b>	<b>CMS VBP Domain Weights and Measure Differences</b>
<b>Clinical Care</b>	15% (1 measure: all cause inpatient Mortality)	25% (4 measures: condition-specific Mortality, THA/TKA Complication)
<b>Person and Community Engagement</b>	50% (8 HCAHPS measures, 2 ED wait time measures)	25% Same HCAHPS measures, no ED wait time measures
<b>Safety</b>	35% (7 measures: CDC NHSN, PC-01)	25% (8 measures: CDC NHSN, PC-01, PSI-90)
<b>Efficiency</b>	N/A	25% (Medicare Spending Per Beneficiary measure)

The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019, and involves: 1) assessing performance on each measure in the domain; 2) standardizing measure scores relative to performance standards; 3) calculating the total points a hospital earned divided by the total possible points for each domain; 4) finalizing the total hospital QBR score (0-100%) by weighting the domains based on the overall percentage or importance the Commission has placed on each domain; and 5) converting the total hospital QBR scores into revenue adjustments using the preset scale that ranges from 0 to 80%, as aforementioned. The methodology for RY 2020 is illustrated in Figure 14 below.

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<sup>14</sup> Details of CMS VBP measures may be found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html>.

Figure 14. Process for Calculating RY 2020 QBR Scores



### Domain Weights and Revenue At Risk

As illustrated in the body of the report, for the RY 2021 QBR program, the HSCRC proposed to weight the clinical care domain at 15 % of the final score, the Safety domain at 35 %, and the Person and Community Engagement domain at 50 %. The measures by domain are listed with their data sources in the table below (Figure 15).

Figure 15. Proposed RY 2021 QBR Domains, Measures and Data Sources

	Clinical Care	Person and Community Engagement	Safety
<b>Proposed QBR RY 2021</b>	15% 2 measures ▶ Inpatient Mortality (HSCRC case mix data) ▶ THA TKA (CMS Hospital Compare, Medicare claims data)	50% 9 measures ▶ 8 HCAHPS domains (CMS Hospital Compare patient survey) ▶ 1 ED wait time (CMS Hospital Compare chart abstracted)	35% 6 measures ▶ 6 CDC NHSN HAI measures (CMS Hospital Compare chart abstracted)

The HSCRC sets aside a percentage of hospital inpatient revenue to be held “at risk” based on each hospital’s QBR program performance. Hospital performance scores are translated into



rewards and penalties in a process that is referred to as scaling.<sup>15</sup> Rewards (referred to as positive scaled amounts) or penalties (referred to as negative scaled amounts) are then applied to each hospital's update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered permanent revenue. The Commission previously approved scaling a maximum reward of 1% and a penalty of 2% of total approved base inpatient revenue across all hospitals for RY 2019.

HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the CMS VBP program where feasible,<sup>16</sup> allowing the HSCRC to use data submitted directly to CMS.<sup>17</sup> As mentioned above, Maryland implemented an efficiency measure in relation to population based revenue budgets based on potentially avoidable utilization outside of the QBR program. The potentially avoidable utilization (PAU) savings adjustment to hospital rates is based on costs related to potentially avoidable admissions, as measured by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQIs) and avoidable readmissions. HSCRC staff will continue to work with key stakeholders to complete development of an efficiency measure that incorporates population-based cost outcomes.

### QBR Proposed Measures Update: THA/TKA

In addition to the measure details provided above, the detail of the newly proposed THA/TKA measure already in use by the CMS VBP program is outlined below.

- ▶ The measure applies to patients **aged 65 or older** with **elective** primary **THA/TKA** procedure enrolled in Medicare fee-for-service.
- ▶ The **risk-standardized complication rate** (RSCR) is calculated as the ratio of the number of "predicted" to the number of "expected" admissions with a complication, multiplied by the national unadjusted complication rate. The numerator of the ratio is the number of admissions with a complication predicted on the basis of the hospital's performance with its observed case-mix.
- ▶ During the index hospital admission or within **seven days** from the date of index admission, the following complications acute myocardial infarction (AMI), pneumonia, and sepsis/septicemia/shock are measured;
- ▶ During the index hospital admission or within **30 days** of admission, death, surgical site bleeding, and pulmonary embolism are measured.

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<sup>15</sup> Scaling refers to the differential allocation of a pre-determined portion of base-regulated hospital inpatient revenue based on assessment of the quality of hospital performance.

<sup>16</sup> HSCRC has used data for some of the QBR measures (e.g., CMS core measures, CDC NHSN CLABSI, CAUTI) submitted to the Maryland Health Care Commission (MHCC) and applied state-based benchmarks and thresholds for these measures to calculate hospitals' QBR scores up to the period used for RY 2017.

<sup>17</sup> VBP measure specifications may be found at: [www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html)

- ▶ During the index hospital admission or within **90 days** of admission, mechanical complications and periprosthetic joint infection/wound infection are measured.
- ▶ Complications are counted only if they occur during the index hospital admission or during a readmission.

## QBR Score Calculation

QBR Scores are evaluated by comparing a hospital's performance rate to its base period rate, as well as the threshold (which is the median, or 50<sup>th</sup> percentile, of all hospitals' performance during the baseline period), and the benchmark, (which is the mean of the top decile, or approximately the 95<sup>th</sup> percentile, during the baseline period).<sup>18</sup>

**Attainment Points:** During the performance period, attainment points are awarded by comparing an individual hospital's rates with the threshold and the benchmark. With the exception of the MD Mortality measure applied to all payers, the benchmarks and thresholds are the same as those used by CMS for the VBP program measures.<sup>19</sup> For each measure, a hospital that has a rate at or above benchmark receives 10 attainment points. A hospital that has a rate below the attainment threshold receives 0 attainment points. A hospital that has a rate at or above the attainment threshold and below the benchmark receives 1-9 attainment points

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

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

**Domain Denominator Adjustments:** In particular instances, QBR measures will be excluded from the QBR program for individual hospitals. In the Person and Community Engagement domain, ED wait time measures (if included in the R.Y. 2020 program) will be excluded for protected hospitals. As described in the body of the report, a hospital may exclude one or both of the ED wait time measures if it has earned at least one improvement point and if its improvement

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<sup>18</sup> The ED wait time measures do not have a benchmark; the methodology calculates hospital improvement relative to the national threshold, which is the national median for each respective ED volume category.

<sup>19</sup> For the ED wait time measures, attainment points are not calculated; instead full 10 points are awarded to hospitals at or below (more efficient) than the national medians for their respective volume categories in the performance period.

score would reduce its overall QBR score. If a measure is excluded, the Person and Community Engagement domain will reduce from 120 total points to 110 points.

Similarly, hospitals are exempt from measurement for any of the NHSN Safety measures for which there is less than 1 predicted case in the performance period. If a hospital is exempt from an NHSN measure, its Safety domain score denominator reduces from 60 to 50 points. If it is exempt from two measures, the Safety domain score denominator would be 40 total possible points. Hospitals must have at least 3 of 6 Safety measures in order to be included in the Safety domain.

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

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

**Ry 2021 Proposed Timeline (Base and Performance Periods; Financial Impact)**

Rate Year (Maryland Fiscal Year)	Q3-16	Q4-16	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20	Q3-20	Q4-20	Q1-21	Q2-21	Q3-21	Q4-21					
Calendar Year	Q1-16	Q2-16	Q3-16	Q4-16	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20	Q3-20	Q4-20	Q1-21	Q2-21					
<b>Rate Year 2021</b>																											
<b>QBR</b>					Hospital Compare Base Period (HCAHPS measures, ED-2b; All NHSN Measures)																Rate Year Impacted by QBR Results						
											Hospital Compare Performance Period ( HCAHPS measures, ED- 2b, All NHSN measures)																
							QBR Maryland Mortality Base Period																				
												QBR Maryland Mortality Performance Period															
		POTENTIAL NEW MEASURE: Hospital Compare THA/TKA Performance Period**																									

\*\*Hospital Compare THA /TKA Base Period April 1, 2011-March 31, 2014

**APPENDIX II. RY 2019 PATIENT EXPERIENCE MEASURE RESULTS BY HOSPITAL**

HCAHPS Measures		Care Transitions		Clean/Quiet		Understood Meds		Doctor Communication		Nurse Communication		Discharge Info		Overall Rating		Staff Responsive-ness	
Hospital ID	Hospital Name	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base
210001	Meritus	46%	1%	63%	1%	59%	-1%	75%	-1%	77%	2%	88%	-1%	67%	3%	59%	0%
210002	UMMC	54%	-1%	55%	-4%	62%	-4%	79%	-1%	79%	1%	88%	1%	70%	1%	58%	-3%
210003	PG Hospital	39%	2%	53%	-2%	49%	0%	74%	1%	63%	1%	78%	0%	47%	3%	43%	2%
210004	Holy Cross	44%	-1%	65%	10%	55%	2%	74%	-1%	71%	-1%	80%	0%	64%	5%	55%	-1%
210005	Frederick	50%	-2%	70%	2%	62%	-2%	78%	-1%	80%	1%	89%	2%	70%	3%	59%	-2%
210006	UM-Harford	45%	-9%	57%	-3%	58%	-14%	75%	-6%	77%	-5%	81%	-3%	65%	0%	61%	3%
210008	Mercy	55%	-1%	71%	-1%	70%	5%	82%	-2%	81%	-1%	89%	0%	79%	1%	68%	6%
210009	Johns Hopkins	59%	0%	68%	1%	64%	0%	80%	0%	81%	0%	88%	-1%	81%	-1%	60%	-2%
210010	UM-Dorchester	48%	-2%	66%	4%	63%	2%	80%	-2%	81%	1%	86%	0%	66%	2%	68%	1%
210011	St. Agnes	48%	1%	60%	2%	61%	3%	78%	0%	75%	1%	86%	2%	66%	4%	59%	5%
210012	Sinai	48%	-2%	65%	-3%	63%	1%	78%	0%	79%	1%	88%	3%	69%	-1%	61%	1%
210013	Bon Secours	44%	11%	64%	3%	59%	-4%	80%	7%	73%	10%	87%	-1%	54%	4%	59%	15%
210015	MedStar Fr Square	46%	4%	56%	0%	61%	-3%	78%	0%	75%	-5%	87%	0%	68%	0%	56%	-3%
210016	Washington Adventist	43%	-2%	61%	-1%	58%	-1%	76%	-1%	73%	-1%	85%	-1%	67%	-1%	58%	1%
210017	Garrett	49%	-3%	64%	2%	67%	-1%	82%	-1%	79%	0%	91%	4%	69%	2%	69%	3%

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HCAHPS Measures		Care Transitions		Clean/Quiet		Understood Meds		Doctor Communication		Nurse Communication		Discharge Info		Overall Rating		Staff Responsive-ness	
Hospital ID	Hospital Name	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base
210018	MedStar Montgomery	43%	2%	63%	4%	54%	-5%	75%	-3%	72%	1%	87%	-1%	62%	1%	54%	-3%
210019	Peninsula	50%	-2%	62%	-3%	62%	1%	76%	-4%	79%	1%	89%	2%	69%	1%	61%	-4%
210022	Suburban	51%	0%	67%	3%	58%	-3%	80%	-2%	77%	-3%	84%	0%	70%	-2%	64%	-3%
210023	Anne Arundel	54%	-1%	67%	5%	62%	1%	81%	2%	81%	4%	85%	-2%	78%	5%	70%	6%
210024	MedStar Union Mem	50%	-4%	69%	3%	63%	2%	83%	1%	79%	0%	88%	-2%	74%	-2%	63%	1%
210027	Western Maryland	52%	1%	67%	3%	68%	4%	79%	1%	80%	1%	92%	0%	70%	3%	63%	2%
210028	MedStar St. Mary's	51%	-3%	66%	-3%	59%	-8%	79%	-3%	79%	-4%	90%	-1%	67%	-5%	62%	-5%
210029	JH Bayview	54%	1%	59%	3%	62%	3%	78%	1%	76%	1%	87%	2%	68%	0%	62%	4%
210030	UM-Chestertown	47%	5%	61%	5%	57%	3%	80%	6%	79%	10%	86%	4%	62%	10%	69%	9%
210032	Union of Cecil	47%	-3%	62%	4%	62%	0%	75%	-1%	76%	-2%	86%	-4%	65%	-1%	60%	-1%
210033	Carroll	48%	-1%	66%	3%	60%	-3%	75%	-1%	79%	-1%	87%	1%	67%	-5%	65%	1%
210034	MedStar Harbor	46%	1%	65%	3%	62%	2%	80%	-1%	76%	-1%	85%	-2%	67%	1%	62%	1%
210035	UM-Charles Regional	50%	2%	61%	-5%	63%	2%	73%	-2%	78%	3%	86%	-2%	65%	3%	65%	9%

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HCAHPS Measures		Care Transitions		Clean/Quiet		Understood Meds		Doctor Communication		Nurse Communication		Discharge Info		Overall Rating		Staff Responsive-ness	
Hospital ID	Hospital Name	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base
210037	UM-Easton	48%	-2%	66%	4%	63%	2%	80%	-2%	81%	1%	86%	0%	66%	2%	68%	1%
210038	UMMC Midtown	47%	6%	65%	1%	62%	7%	77%	1%	75%	6%	86%	9%	61%	4%	64%	12%
210039	Calvert	48%	-4%	65%	4%	62%	2%	75%	-3%	79%	2%	88%	1%	65%	0%	62%	1%
210040	Northwest	49%	1%	64%	-3%	61%	-2%	77%	1%	77%	0%	88%	4%	68%	0%	67%	1%
210043	UM-BWMC	47%	-1%	61%	0%	58%	-3%	76%	1%	75%	-2%	85%	1%	65%	-5%	56%	-4%
210044	GBMC	52%	-5%	58%	-5%	58%	-10%	81%	-5%	77%	-4%	90%	5%	72%	-6%	64%	-5%
210048	Howard County	50%	4%	64%	2%	58%	-3%	78%	0%	78%	1%	86%	1%	71%	3%	60%	-4%
210049	UM-Upper Chesapeake	51%	2%	64%	3%	64%	1%	78%	3%	79%	3%	86%	2%	70%	3%	64%	8%
210051	Doctors	44%	0%	60%	-3%	60%	8%	75%	0%	73%	1%	86%	0%	66%	3%	56%	7%
210055	Laurel Regional	39%	-1%	54%	-5%	50%	-1%	71%	-4%	62%	-6%	80%	1%	50%	-5%	53%	1%
210056	MedStar Good Sam	47%	-1%	62%	1%	64%	5%	75%	-7%	77%	-1%	90%	2%	67%	-1%	61%	6%
210057	Shady Grove	49%	3%	61%	4%	59%	6%	79%	0%	77%	3%	86%	-1%	70%	6%	59%	7%
210060	Ft. Washington	38%	-8%	59%	-4%	54%	-4%	77%	-2%	72%	-1%	86%	2%	60%	2%	63%	5%
210061	Atlantic	53%	2%	59%	2%	65%	5%	79%	-2%	78%	-1%	90%	1%	67%	-3%	66%	0%

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HCAHPS Measures		Care Transitions		Clean/Quiet		Understood Meds		Doctor Communication		Nurse Communication		Discharge Info		Overall Rating		Staff Responsive-ness	
Hospital ID	Hospital Name	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base
	General																
<b>210062</b>	MedStar Southern MD	42%	5%	57%	1%	57%	4%	75%	-2%	70%	0%	82%	0%	54%	4%	53%	0%
<b>210063</b>	UM-St. Joe	55%	0%	67%	1%	61%	-3%	82%	2%	82%	3%	88%	0%	78%	3%	68%	2%
<b>210065</b>	HC-Germantown	47%	2%	66%	2%	56%	6%	77%	4%	68%	-2%	82%	0%	68%	1%	50%	-2%



**APPENDIX III. RY 2021 QBR PERFORMANCE STANDARDS**

**Person and Community Engagement Domain\***

Dimension	Benchmark	Achievement Threshold	Floor
Communication with Nurses	87.36%	79.06%	42.06
Communication with Doctors	88.10%	79.91%	41.99
Responsiveness of Hospital Staff	81.00%	65.77%	33.89%
Communication about Medicines	74.75%	63.83%	33.19%
Cleanliness and Quietness of Hospital Environment	79.58%	65.61%	30.60%
Discharge Information	92.17%	87.38%	66.94%
3-Item Care Transition	63.32%	51.87%	6.53%
Overall Rating of Hospital	85.67%	71.80%	34.70%

\*The Person and Community Engagement performance standards displayed in this table were calculated using four quarters of calendar year 2017 data, and published in the CMS Inpatient Prospective Payment System FFY 19 Final Rule.

**Safety Domain\***

Measure Short ID	Measure Description	Benchmark	Achievement Threshold
CAUTI	Catheter-Associated Urinary Tract Infection	0	0.774
CDI	Clostridium <i>difficile</i> Infection	0.067	0.748
CLABSI	Central Line-Associated Blood Stream Infection	0	0.687
MRSA	Methicillin-Resistant Staphylococcus <i>aureus</i>	0	0.763
SSI	SSI - Abdominal Hysterectomy	0	0.726
	SSI - Colon Surgery	0	0.754

\*The Safety Domain performance standards were published in the CMS Inpatient Prospective Payment System FFY 19 Final Rule.

<b>Clinical Care Domain</b>			
Measure Short ID	Measure Description	Benchmark	Achievement Threshold
Mortality	All Condition Inpatient Mortality	TBD*	TBD*
THA/TKA RSCR**	Total Hip/Knee Arthroplasty Risk Standardized Complication Rate	0.022418	0.031157

\*Mortality standards will be calculated and disseminated with implementation of v. 36 of the APR DRG grouper.

\*\*THA/TKA standards were published in the CMS Inpatient Prospective Payment System FFY 19 Final Rule.

## APPENDIX IV: FUTURE OF QBR IN TOTAL COST OF CARE MODEL

To date, Maryland hospitals have met all of the Agreement goals laid out in the current contract with CMS. For the TCOC Model, contract terms do not define specific quality performance targets, but dictate that performance targets must be aggressive and progressive, must align with other HSCRC programs, must be comparable to federal programs, and must consider rankings relative to the nation. Maryland must submit annual reports to CMS demonstrating that our quality programs' design elements, operational impacts, and results meet or exceed those of national Medicare program. The HSCRC, in consultation with staff, industry and other key stakeholders, continues to lay the framework and has begun to the process to determine specific quality performance targets in the TCOC Model.

Staff has started developing new policy targets and to align measures for success under the TCOC Model. This will entail considering options for bundling outcomes across quality programs, evaluating opportunities for performance standards outside the hospital walls, ensuring that financial incentives under the population-based revenue system are compatible, and developing reporting measures that are more holistic and patient-centered. This longer-term work has begun with the convening a clinical subgroup to evaluate candidate measures of complications that Maryland should include in its pay for performance regimen. In addition, work has begun to evaluate external data sources to determine if the Commission can utilize them to incentivize improvement inside<sup>20</sup> and outside the hospital; revisit financial methodologies and cultivate new ones, such as Inter-Hospital Cost Comparison, to ensure resources are being disseminated in accordance with TCOC Model goals; and consider options for establishing an overarching service line approach to the hospital quality programs so as to break down silos and promulgate a more holistic and patient-centered environment. Staff acknowledges this will require a lot of work in concert with industry and a broad array of other stakeholders—consumers, payers, cross-continuum providers, quality measurement experts, and government agencies (local, state and federal)— as the success of the TCOC Model depends on reducing cost on a per capita basis without compromising quality of care.

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<sup>20</sup> For example, staff notes that, although ED-1b is retired from CMS Inpatient Hospital Reporting and that PC-01 (early elective delivery) is retired from VBP after CY 2018, these measures continue to be optional for reporting to the Joint Commission. Therefore, staff could explore Joint Commission data for potential use in our quality programs in future years.

**APPENDIX V. MODELING OF SCORES BY DOMAIN: RY 2019 QBR DATA WITH RY 2021 MEASURES**

This appendix includes modeling of the removal of PC-01 and ED-1b (Model 1) versus these changes plus the addition of THA-TKA measure (Model 2).

		Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Difference
Hospital ID	Hospital Name	HCAHPS Final Score	HCAHPS Final Score	Mortality Final Score	Mortality Final Score	Safety Final Score	Safety Final Score	Total Score	Total Score	Total Score
210001	Meritus	17%	17%	10%	33%	18%	18%	16.30%	19.80%	3.50%
210002	UMMC	20%	20%	0%	33%	8%	8%	12.80%	17.80%	5.00%
210003	UM-PGHC	5%	5%	10%	10%	14%	14%	9.13%	9.13%	0.00%
210004	Holy Cross	12%	12%	60%	40%	26%	26%	24.10%	21.10%	-3.00%
210005	Frederick	24%	24%	100%	70%	6%	6%	29.10%	24.60%	-4.50%
210006	UM-Harford	27%	27%	20%	47%	40%	40%	30.64%	34.64%	4.00%
210008	Mercy	55%	55%	50%	67%	28%	28%	44.57%	47.07%	2.50%
210009	Johns Hopkins	38%	38%	20%	20%	24%	24%	30.40%	30.40%	0.00%
210010	UM-Dorchester	33%	33%	60%	63%	28%	28%	35.30%	35.80%	0.50%
210011	St. Agnes	17%	17%	20%	40%	0%	0%	11.50%	14.50%	3.00%
210012	Sinai	22%	22%	40%	60%	28%	28%	26.80%	29.80%	3.00%
210013	Bon Secours	35%	35%	60%	60%	40%	40%	40.50%	40.50%	0.00%
210015	MedStar Fr Square	23%	23%	80%	87%	32%	32%	34.56%	35.56%	1.00%
210016	Washington Adventist	15%	15%	50%	60%	28%	28%	24.80%	26.30%	1.50%
210017	Garrett	37%	37%	10%	27%			30.79%	34.79%	4.00%
210018	MedStar Montgomery	12%	12%	10%	33%	14%	14%	12.40%	15.90%	3.50%

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		Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Difference
Hospital ID	Hospital Name	HCAHPS Final Score	HCAHPS Final Score	Mortality Final Score	Mortality Final Score	Safety Final Score	Safety Final Score	Total Score	Total Score	Total Score
210019	Peninsula	23%	23%	100%	100%	36%	36%	39.10%	39.10%	0.00%
210022	Suburban	17%	17%	30%	53%	18%	18%	19.30%	22.80%	3.50%
210023	Anne Arundel	34%	34%	40%	60%	10%	10%	26.32%	29.32%	3.00%
210024	MedStar Union Mem	28%	28%	0%	33%	28%	28%	23.80%	28.80%	5.00%
210027	Western Maryland	42%	42%	20%	47%	36%	36%	36.51%	40.51%	4.00%
210028	MedStar St. Mary's	25%	25%	80%	87%	32%	32%	35.93%	36.93%	1.00%
210029	JH Bayview	17%	17%	40%	60%	30%	30%	25.00%	28.00%	3.00%
210030	UM-Chestertown	30%	30%	100%	100%			46.10%	46.10%	0.00%
210032	Union of Cecil	17%	17%	10%	33%	50%	50%	27.50%	31.00%	3.50%
210033	Carroll	22%	22%	90%	93%	32%	32%	35.70%	36.20%	0.50%
210034	MedStar Harbor	20%	20%	90%	70%	30%	30%	34.00%	31.00%	-3.00%
210035	UM-Charles Regional	35%	35%	70%	77%	25%	25%	36.98%	37.98%	1.00%
210037	UM-Easton	33%	33%	50%	57%	28%	28%	33.80%	34.80%	1.00%
210038	UMMC Midtown	24%	24%	100%	90%	10%	10%	30.50%	29.00%	-1.50%
210039	Calvert	26%	26%	100%	93%	67%	67%	51.52%	50.52%	-1.00%
210040	Northwest	28%	28%	100%	93%	48%	48%	45.89%	44.89%	-1.00%
210043	UM-BWMC	13%	13%	90%	77%	24%	24%	28.40%	26.40%	-2.00%
210044	GBMC	24%	24%	90%	77%	58%	58%	45.80%	43.80%	-2.00%

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		Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Difference
Hospital ID	Hospital Name	HCAHPS Final Score	HCAHPS Final Score	Mortality Final Score	Mortality Final Score	Safety Final Score	Safety Final Score	Total Score	Total Score	Total Score
210048	Howard County	17%	17%	40%	30%	36%	36%	27.24%	25.74%	-1.50%
210049	UM-Upper Chesapeake	35%	35%	60%	73%	28%	28%	36.53%	38.53%	2.00%
210051	Doctors	17%	17%	30%	47%	80%	80%	41.00%	43.50%	2.50%
210055	UM-Laurel	10%	10%	20%	47%	13%	13%	12.67%	16.67%	4.00%
210056	MedStar Good Sam	34%	34%	60%	60%	16%	16%	31.60%	31.60%	0.00%
210057	Shady Grove	31%	31%	0%	0%	34%	34%	27.35%	27.35%	0.00%
210060	Ft. Washington	24%	24%	0%	27%			18.20%	24.60%	6.40%
210061	Atlantic General	34%	34%	100%	83%	0%	0%	31.82%	29.32%	-2.50%
210062	MedStar Southern MD	13%	13%	0%	10%	34%	34%	18.40%	19.90%	1.50%
210063	UM-St. Joe	44%	44%	70%	80%	28%	28%	42.12%	43.62%	1.50%
210065	HC-Germantown	15%	15%	80%	80%	50%	50%	36.77%	36.77%	0.00%

**APPENDIX VI. MODELING OF QBR PROGRAM REVENUE ADJUSTMENTS**

HOSPID	HOSPITAL NAME	RY18 Permanent Inpatient Revenue	Model 1: Removed PC-01 and ED-1b			Model 2: Model 1 + THA/TKA Measure		
			RY 2021 Prelim QBR Points	% Revenue Impact	\$ Revenue Impact	RY 2021 Prelim QBR Points	% Revenue Impact	\$ Revenue Impact
210001	MERITUS	\$190,799,459	16.30%	-1.28%	-\$2,442,233	19.80%	-1.12%	-\$2,136,954
210002	UNIVERSITY OF MARYLAND	\$919,253,797	12.80%	-1.43%	-\$13,145,329	17.80%	-1.21%	-\$11,122,971
210003	PRINCE GEORGE	\$215,464,625	9.13%	-1.59%	-\$3,425,888	9.13%	-1.59%	-\$3,425,888
210004	HOLY CROSS	\$340,412,069	24.10%	-0.93%	-\$3,165,832	21.10%	-1.06%	-\$3,608,368
210005	FREDERICK MEMORIAL	\$220,972,343	29.10%	-0.71%	-\$1,568,904	24.60%	-0.91%	-\$2,010,848
210006	HARFORD	\$48,557,781	30.64%	-0.64%	-\$310,770	34.64%	-0.46%	-\$223,366
210008	MERCY	\$223,932,822	44.57%	-0.02%	-\$44,787	47.07%	0.12%	\$268,719
210009	JOHNS HOPKINS	\$1,378,259,901	30.40%	-0.65%	-\$8,958,689	30.40%	-0.65%	-\$8,958,689
210010	DORCHESTER	\$26,021,222	35.30%	-0.43%	-\$111,891	35.80%	-0.41%	-\$106,687
210011	ST. AGNES	\$237,889,236	11.50%	-1.49%	-\$3,544,550	14.50%	-1.36%	-\$3,235,294
210012	SINAI	\$398,036,508	26.80%	-0.81%	-\$3,224,096	29.80%	-0.68%	-\$2,706,648
210013	BON SECOURS	\$65,798,042	40.50%	-0.20%	-\$131,596	40.50%	-0.20%	-\$131,596
210015	FRANKLIN SQUARE	\$300,623,972	34.56%	-0.46%	-\$1,382,870	35.56%	-0.42%	-\$1,262,621
210016	WASHINGTON ADVENTIST	\$158,337,604	24.80%	-0.90%	-\$1,425,038	26.30%	-0.83%	-\$1,314,202
210017	GARRETT COUNTY	\$21,075,334	30.79%	-0.63%	-\$132,775	34.79%	-0.45%	-\$94,839
210018	MONTGOMERY GENERAL	\$77,808,657	12.40%	-1.45%	-\$1,128,226	15.90%	-1.29%	-\$1,003,732
210019	PENINSULA REGIONAL	\$241,466,813	39.10%	-0.26%	-\$627,814	39.10%	-0.26%	-\$627,814
210022	SUBURBAN	\$197,431,392	19.30%	-1.14%	-\$2,250,718	22.80%	-0.99%	-\$1,954,571
210023	ANNE ARUNDEL	\$299,264,995	26.32%	-0.83%	-\$2,483,899	29.32%	-0.70%	-\$2,094,855

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			Model 1: Removed PC-01 and ED-1b			Model 2: Model 1 + THA/TKA Measure		
HOSPID	HOSPITAL NAME	RY18 Permanent Inpatient Revenue	RY 2021 Prelim QBR Points	% Revenue Impact	\$ Revenue Impact	RY 2021 Prelim QBR Points	% Revenue Impact	\$ Revenue Impact
210024	UNION MEMORIAL	\$235,346,415	23.80%	-0.94%	-\$2,212,256	28.80%	-0.72%	-\$1,694,494
210027	WESTERN MARYLAND	\$171,000,183	36.51%	-0.38%	-\$649,801	40.51%	-0.20%	-\$342,000
210028	ST. MARY	\$76,303,058	35.93%	-0.40%	-\$305,212	36.93%	-0.36%	-\$274,691
210029	HOPKINS BAYVIEW MED CTR	\$357,620,585	25.00%	-0.89%	-\$3,182,823	28.00%	-0.76%	-\$2,717,916
210030	CHESTERTOWN	\$21,139,936	46.10%	0.06%	\$12,684	46.10%	0.06%	\$12,684
210032	UNION HOSPITAL OF CECIL	\$66,514,320	27.50%	-0.78%	-\$518,812	31.00%	-0.62%	-\$412,389
210033	CARROLL COUNTY	\$132,801,017	35.70%	-0.41%	-\$544,484	36.20%	-0.39%	-\$517,924
210034	HARBOR	\$112,526,840	34.00%	-0.49%	-\$551,382	31.00%	-0.62%	-\$697,666
210035	CHARLES REGIONAL	\$75,199,112	36.98%	-0.36%	-\$270,717	37.98%	-0.31%	-\$233,117
210037	EASTON	\$105,222,295	33.80%	-0.50%	-\$526,111	34.80%	-0.45%	-\$473,500
210038	UMMC MIDTOWN	\$117,217,727	30.50%	-0.64%	-\$750,193	29.00%	-0.71%	-\$832,246
210039	CALVERT	\$63,677,722	51.52%	0.37%	\$235,608	50.52%	0.32%	\$203,769
210040	NORTHWEST	\$133,828,758	45.89%	0.05%	\$66,914	44.89%	0.00%	\$0
210043	BALTIMORE WASHINGTON	\$229,151,792	28.40%	-0.74%	-\$1,695,723	26.40%	-0.83%	-\$1,901,960
210044	G.B.M.C.	\$225,145,722	45.80%	0.05%	\$112,573	43.80%	-0.05%	-\$112,573
210048	HOWARD COUNTY	\$183,348,539	27.24%	-0.79%	-\$1,448,453	25.74%	-0.86%	-\$1,576,797
210049	UPPER CHESAPEAKE HEALTH	\$130,150,364	36.53%	-0.38%	-\$494,571	38.53%	-0.29%	-\$377,436
210051	DOCTORS COMMUNITY	\$144,686,192	41.00%	-0.18%	-\$260,435	43.50%	-0.07%	-\$101,280
210055	LAUREL REGIONAL	\$58,931,276	12.67%	-1.44%	-\$848,610	16.67%	-1.26%	-\$742,534
210056	GOOD SAMARITAN	\$140,674,848	31.60%	-0.60%	-\$844,049	31.60%	-0.60%	-\$844,049

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			Model 1: Removed PC-01 and ED-1b			Model 2: Model 1 + THA/TKA Measure		
HOSPID	HOSPITAL NAME	RY18 Permanent Inpatient Revenue	RY 2021 Prelim QBR Points	% Revenue Impact	\$ Revenue Impact	RY 2021 Prelim QBR Points	% Revenue Impact	\$ Revenue Impact
210057	SHADY GROVE	\$231,939,525	27.35%	-0.78%	-\$1,809,128	27.35%	-0.78%	-\$1,809,128
210060	FT. WASHINGTON	\$19,548,527	18.20%	-1.19%	-\$232,627	24.60%	-0.91%	-\$177,892
210061	ATLANTIC GENERAL	\$37,316,219	31.82%	-0.59%	-\$220,166	29.32%	-0.70%	-\$261,214
210062	SOUTHERN MARYLAND	\$163,844,003	18.40%	-1.18%	-\$1,933,359	19.90%	-1.12%	-\$1,835,053
210063	UM ST. JOSEPH	\$237,924,618	42.12%	-0.13%	-\$309,302	43.62%	-0.06%	-\$142,755
210065	HC-GERMANTOWN	\$60,632,167	36.77%	-0.37%	-\$224,339	36.77%	-0.37%	-\$224,339
	<b>Statewide Total</b>	<b>\$9,093,098,329</b>			<b>-\$68,910,681</b>			<b>-\$63,837,724</b>



## **APPENDIX VII. STAKEHOLDER COMMENT LETTERS**



Maryland  
Hospital Association

November 19, 2018

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

Dear Dianne:

On behalf of the Maryland Hospital Association's 63 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC's) *Draft Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2021*. The Quality Based Reimbursement (QBR) policy includes measures of in-hospital safety and outcomes such as infections, patient experience of care and mortality. Of all Maryland's value-based policies, this one aligns most closely with national Medicare policies, in this case, the Value Based Purchasing (VBP) program. Two years ago, commissioners approved the staff's recommendation to set an aggressive payment scale for the rate year 2019 QBR policy in order to provide additional incentive for Maryland's hospitals to improve performance relative to the nation. As expected, Maryland's hospitals improved – as did the nation's – and all but two Maryland hospitals are being penalized in fiscal 2019 for a total revenue reduction of 0.36 percent, or over \$6 million.

Although the HSCRC's intention was to strengthen incentives to close the performance gap relative to the nation, in this case, it has not produced the hoped-for results. Our view is that attempting to strengthen the incentive through a tougher payment scale and larger penalties did not work because the policy is flawed.

A number of concerns have been raised with the VBP program and those concerns have weakened its ability to drive performance improvement. The program was the first Medicare program to tie performance to payment. The programs implemented since then are simpler and easier to monitor. The concerns plaguing this policy include:

- The lag between performance period, data publication and payment adjustment is long, making it difficult to tie specific interventions and behaviors to outcomes
- Performance improvement on patient experience of care measures moves slowly, making it difficult to notice the impact of new interventions. This measure accounts for half of Maryland's QBR score
- Infections occur infrequently, making measurement of performance volatile. This component accounts for 35 percent of Maryland's score.
- Questions have been raised nationally about whether risk adjustment and validation of the measures are adequate, calling into question the validity of results

### **Our recommendations**

The staff's recommendation to align the measures with national Medicare policies is a step in the right direction, but do not go far enough. We also recommend weighting the domains and payment scale to align with national Medicare policy. Each domain is weighted equally in the national policy, and the score to begin earning rewards tends to be 37 percent to 40 percent. The Maryland scale requires a hospital to score above 45 percent to avoid a penalty and begin earning a reward. Based on the most recent Medicare data, the national average score in the VBP program would be 37 percent. (Details enclosed.)

HSCRC staff has said that the Medicare Performance Adjustment (MPA) will be included in the accounting of Maryland's revenue at risk. The MPA risk should not just be added to the already high risk in Maryland; it should offset some of the risk.

Nearly 8 percent of Maryland's all-payer revenue is tied to performance-based policies – compared to 4 percent of Medicare revenue nationally tied to performance measures. The national risk on an all-payer basis is 1.6 percent (4 percent x an assumption of 40 percent Medicare). Even considering that hospitals may have some performance-based contracts with private payers, Maryland's risk – on these measures alone – is substantially higher than the nation. (Details enclosed.)

As Maryland's hospitals focus on managing total cost of care, working with physician and community partners, and meeting the aims of the total cost of care demonstration, it is important to keep the focus on the measures that matter. Our recommendations noted above will provide that greater focus if implemented.

We appreciate the commission's consideration of our feedback. Should you have any questions, please call me at 410-540-5087.

Sincerely,



Traci La Valle, Vice President

cc: Nelson Sabatini, Chairman  
Joseph Antos, Ph.D., Vice Chairman  
Victoria W. Bayless  
John M. Colmers

James N. Elliott, M.D  
Adam Kane  
Jack Keane  
Katie Wunderlich, Executive Director

Enclosure

## Almost 8 Percent of Maryland's Hospitals' All-Payer Revenue is Tied to Value Compared to 4 Percent of Medicare Revenue in the Nation

### Comparison of Maryland All-Payer and National Medicare Value-Based Risk

	Maryland All-Payer		National Medicare	
	Maximum Penalty Risk	FY 2019 Actual Penalties	Maximum Penalty Risk	FY 2018 Actual Penalties
QBR/VBP, Complications and Readmissions	3.9%	-0.51%	3.9%	-0.46%
MPA (Begins in FY 2020)	0.2%	N/A	-	-
PAU Savings	3.8%	-1.69%	-	-
<b>Total</b>	<b>7.9%</b>	<b>-2.20%</b>	<b>3.9%</b>	<b>-0.46%</b>

To compare the nation's 0.46% Medicare penalty to Maryland's 2.20% all-payer penalty, multiply the 0.46% national penalty x an assumption of 40% Medicare share. The resulting national all-payer penalty is 0.18%. Maryland's hospitals' actual risk is more than 10 times greater than the nation's.

Notes: In Maryland, a total of 6 percent of inpatient all-payer revenue is at risk on QBR, Complications and Readmissions. In CY 2018/FY 2020, 0.5 percent of total Medicare revenue is at risk on the Medicare Performance Adjustment. 5.85 percent of all-payer inpatient is at risk on PAU Savings. In the nation, a total of 6 percent of Medicare inpatient revenue is at risk on VBP, Complications, and Readmissions. Actual penalties are the revenue-weighted statewide and national adjustments and the net of penalties and rewards. Actual amounts are provided for the nation in FY 2018 instead of estimating FY 2019 national Medicare hospital payments.

Percentages of total revenue are based on the national inpatient/outpatient proportion of 65%/35% and the assumption that Medicare payments are 40 percent of all-payer.

## MHA Recommendation: FY 2021 Quality Weighting

### CMS FFY 2019

### Maryland

	National		Maryland CY 18/FY 2020		MHA Recommendation: CY 2019/FY 2021	
	Weight	Risk	Weight	Risk	Weight	Risk
<b>VBP/QBR</b>						
NHSN, PC-01, PSI-90*	25%	0.50%	35%	0.70%	25%	0.50%
HCAHPS	25%	0.50%	50%	1.00%	25%	0.50%
Mortality* and THA/TKA Complications	25%	0.50%	15%	0.30%	25%	0.50%
Efficiency*	25%	0.50%		-	25%	0.50%
<b>Total</b>	<b>100%</b>	<b>2.00%</b>	<b>100%</b>	<b>2.00%</b>	<b>100%</b>	<b>2.00%</b>
<b>Complications</b>						
NHSN, PC-01 and PSI-90*		1.00%		-		-
PPCs				2.00%		1.00%
<b>Readmissions</b>		3.00%		2.00%		1.50%
<b>PAU</b>				1.75%		1.75%
<b>Total</b>		<b>6.00%</b>		<b>7.75%</b>		<b>6.25%</b>

\* PC-01 is early elective delivery and PSI-90 is a composite patient safety indicator (PSI-90 is currently on hold). CMS measures 30-day mortality rate for acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease and coronary artery bypass graft. Maryland measures all-payer in-hospital mortality. THA and TKA are total hip and knee 90-day complications—not included in Maryland policy. Efficiency in the national program is measured as Medicare spending per beneficiary. In Maryland, the risk on the new Medicare Payment Adjustment policy can be counted as an efficiency measure in QBR.

## Maryland's Hospitals Would Still Bear Significantly More Risk than Hospitals Nationally by Adopting MHA Recommendations

### Comparison of Maryland All-Payer and National Medicare Value-Based Risk with MHA Recommendations for FY 2021

	Maryland All-Payer		National Medicare	
	Maximum Penalty Risk	FY 2019 Actual Penalties	Maximum Penalty Risk	FY 2018 Actual Penalties
QBR/VBP, Complications and Readmissions	2.6%	-0.51%	3.9%	-0.46%
MPA	0.4%	N/A	-	-
PAU Savings	3.8%	-1.69%	-	-
<b>Total</b>	<b>6.8%</b>	<b>-2.20%</b>	<b>3.9%</b>	<b>-0.46%</b>

Notes: In Maryland, a total of 6 percent of inpatient all-payer revenue is at risk on QBR, Complications and Readmissions. In CY 2018/FY 2020, 0.5 percent of total Medicare revenue is at risk on the Medicare Performance Adjustment. 5.85 percent of all-payer inpatient is at risk on PAU Savings. In the nation, a total of 6 percent of Medicare inpatient revenue is at risk on VBP, Complications, and Readmissions. Actual penalties are the revenue-weighted statewide and national adjustments and the net of penalties and rewards. Actual amounts are provided for the nation in FY 2018 instead of estimating FY 2019 national Medicare hospital payments.

Percentages of total revenue are based on the national inpatient/outpatient proportion of 65%/35% and the assumption that Medicare payments are 40 percent of all-payer.

**Brian D. Pieninck**  
President and Chief Executive Officer

**CareFirst BlueCross BlueShield**  
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November 20, 2018

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

Dear Mr. Sabatini and Ms. Wunderlich:

Thank you for this opportunity to provide comments on the HSCRC Staff's Draft Recommendations for the Quality Based Reimbursement (QBR) program for Rate Year (RY) 2020.

We strongly support efforts to improve the HSCRC QBR program by: better aligning it with the federal Value Based Purchasing (VBP) program; encouraging improvement in areas where Maryland hospitals have performed less favorably than hospitals nationally; and to use the flexibility afforded the State to expand and augment the QBR program so that it provides an appropriate balance against any tendency toward reduced quality of care resulting from the unique incentives facing Maryland hospitals under their global budgets.

We also applaud the Commission's decision last year to move to a pre-set scale that more directly compared Maryland hospital performance to national hospital performance. This change allowed for more aggressive scaling of Maryland hospital performance, which was appropriate particularly given the State's relatively poor performance in the Person and Community Engagement Domain.<sup>1</sup>

With regards to this year's Draft set of recommendations, we make the following comments and suggestions:

- 1) CareFirst supports the continuation of the current Domain weights and the recommendation to add the Total Hip Arthroplasty/Total Knee Arthroplasty complication rates to the Clinical Care Domain at 5% to better align the QBR with the national VBP.
- 2) We are disappointed that the Staff is not recommending the inclusion of measure OP-18b (time from arrival to departure from the ED for non-admitted patients) to the Person and Community Engagement Domain to augment the focus on improving Maryland's ED wait time performance. Staff indicated during Performance Measurement Work Group

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<sup>1</sup> We would note, that Staff characterizes this change as reflecting "the full distribution of hospital scores nationally." However, scale range adopted is not 0-100% as would be expected given this assertion, it is 0-80%. Staff may wish to comment on this apparent contradiction and the rationale for the use of a 0-80% scale instead of the full 0-100% range.

discussions that it was strongly considering the inclusion of OP-18b given that outpatient ED visits account for over 85% of all ED visits, the observation by at least one Maryland hospital that OP-18b was a key indicator of ED efficiency and the strong correlation between high ED wait times and low HCAPHS scores, which remain low relative hospital scores nationally. We also note that data provided by the Maryland Institute for Emergency Medical Services System (MIEMSS) and the HSCRC showed that outpatient ED wait times were continuing to increase in recent years. Although Staff did not provide data on trends in outpatient ED wait times in this Draft Recommendation, we expect that wait times increased once again in the most recent measurement period. The need to include OP-18b in the QBR is also heightened by the recent elimination of the ED-1b measure from QBR in future years.

Despite these circumstances, Staff continues to be concerned that use of the OP-18b measure in the QBR would “be at odds with hospitals’ efforts to reduce inpatient admissions through ED care coordination.” In contrast, we would suggest that the failure to include this important measure is at odds with the need to balance the resource constraining incentives of the GBR system with the need to protect against unintended declines in hospital quality. “Active monitoring” of what is clearly a deteriorating situation will not address this critical issue. Accordingly, we strongly recommend that the Staff reconsider this strategy and instead recommend inclusion of the OP-18b measure for purposes of calculating RY 2020 QBR hospital performance.

Finally, at a previous public meeting, the Commission Chairman recommended that the staff pursue alternative approaches to incentivize the lowest performing hospitals on ED wait times and either require the submission of “corrective action plans” or make direct negative adjustments to these hospitals’ Annual Updates if they failed to improve. We strongly supported this approach but have not seen information about any alternative approaches to date. We also would suggest that this type of more targeted approach could be effective in addressing Maryland’s continued poor performance on its HCAPHS scores.

Sincerely,



Brian D. Pieninck  
President and Chief Executive Officer



Peter Hill, MD, MsC, FACEP  
Senior Vice President Medical Affairs, Johns Hopkins Health System  
Vice President Medical Affairs, The Johns Hopkins Hospital  
Associate Professor Emergency Medicine, Johns Hopkins School of Medicine



JOHNS HOPKINS  
MEDICINE

Renee J. Demski, MSW, MBA  
Vice President of Quality  
The Johns Hopkins Hospital and Johns Hopkins Health System  
Armstrong Institute for Patient Safety and Quality  
Office (410) 955-4313  
Email: rdemski@jhmi.edu

November 20, 2018

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

Dear Chairman,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the proposed Quality Based Reimbursement (QBR) Program for RY 2021. JHHS strongly supports efforts to improve alignment with national measures as appropriate. We also appreciate the thoughtful analysis by staff to avoid duplication of the same or similar measures in multiple Maryland pay for performance programs. JHHS does have concerns with some of the details outlined in the draft recommendations and proposes some solutions for consideration.

The inclusion of emergency department (ED) wait time measures in a pay for performance program, specifically the Person and Community Engagement domain of QBR, remains a concern. JHHS remains passionately engaged in improving patient experience, and maximizing the capacity and efficiency at each of our EDs. For example, the Johns Hopkins Hospital (JHH) ED team's commitment to improvement reduced wait times down to an average time of four minutes from arrival to triage nurse. Rather than penalizing individual hospitals, we continue to advocate for systemic evaluation of the factors beyond the control of hospitals, such as surges in patients brought in under emergency petition and an ongoing lack of placements for psychiatric patients. Over the past decade, there has been an increasing demand for behavioral health services, while the funding for and availability of state run behavioral health services has decreased dramatically. This has put stress on Maryland EDs as they struggle to find the appropriate placements for patients with complex behavioral health needs, resulting in patients languishing in EDs, often in a medical bed, well beyond what is medically necessary and contributing to overall increases in ED wait times.

Inpatient occupancy also has a major impact on patient flow. ED boarding time and admitted patient throughput is difficult to improve when inpatient occupancy remains high. Occupancy averages 90% at Johns Hopkins Bayview Medical Center (JHBMC), 85% at Howard County General Hospital, and 87% at Suburban Hospital. At JHH, occupancy in the Department of Medicine, where most patients from the ED are admitted, is consistently at 96-98%. The lack of available beds results in extended ED wait times. Our analysis indicates that when the occupancy rate is below 93%, boarding time is more reasonable for patients going to the Department of Medicine. However, once beyond 93% occupancy, boarding time rises rapidly. For these reasons, we recommend that ED wait time measures be closely monitored along with other relevant statewide performance measures, but not included in QBR at this time.



With respect to the Safety domain, we strongly support the continued suspension of PSI-90 until reliable base and performance data is readily available.


In the Clinical Care domain, JHHS has two areas of concern and associated recommendations. First, we support consideration of national mortality measures and would like to collaborate with staff on analysis to determine the accuracy and viability for consideration in future years. Rather than adding the national mortality measures to the current program, with inherent duplication of similar measures, we would like to explore future use of the national measures in lieu of the Maryland-unique mortality measure. We support continuing with the Maryland mortality measure for RY 2021.

The second concern in the Clinical Care domain relates to the addition of the Total Hip and Knee Arthroplasty (THA/TKA) complication measure. Under the proposed policy, if a hospital has insufficient volume and does not qualify for the measure, then the full domain weight will apply to mortality. Overweighting mortality relative to other Maryland hospitals seems inequitable and misses an opportunity to highlight another important initiative. JHHS has taken a thoughtful and deliberate approach regarding the location of our hip and knee surgery program. As these surgeries are becoming more "routine", they are provided in a setting that is both lower cost and closer to a patient's residence. JHH serves as both a specialty hospital serving the nation and the world, and as a community hospital serving East Baltimore. For the past several years, JHH has operated at approximately 95% capacity, with our medical and surgical beds consistently in high demand. In order to meet the needs of patients seeking highly specialized care that is unique to JHH, we must take a system approach in establishing robust programs at our community hospitals for lower intensity care. For years, JHBMC has served as the JHHS primary Baltimore location for hip and knee replacement surgery. Suburban Hospital has become the primary hip and knee joint replacement hospital of JHHS for residents of Montgomery County and the broader National Capital Region. This system approach of expanding hip and knee program at JHBMC and Suburban is overseen and managed by our Johns Hopkins University School of Medicine Faculty, ensuring the same level of expertise, quality and standards of care that would be provided at JHH. Therefore, for purposes of this QBR measure, we request the THA/TKA performance of JHBMC or Suburban Hospital be reflected both for JHH and the respective JHHS Hospital selected. If this is not possible, then we request that palliative care be included for the JHH mortality measure to mitigate the effects of the full domain weighting.

In addition, for the Maryland mortality measure, JHHS remains concerned about the exclusion of palliative care. For the clinical reasons stated in our prior letter on the topic, we recommend reinstatement of the palliative care exclusion. The risk adjustment factor for palliative care is insufficient. Many of our population want to come back into the hospital, for various reasons, even when we have addressed terminal and end of life care choices. Restoration of the palliative care exclusion would help to differentiate care that is helping to save lives from terminal illnesses that are being cared for in a clinically appropriate manner.

Thank you to HSCRC commissioners and staff who have demonstrated their willingness to ensure that all stakeholders contribute the ongoing success of the QBR Program. This collaborative approach fosters ongoing engagement. We look forward to continued collaboration in our mutual efforts to support these critically important performance improvement initiatives.

Sincerely,



Peter Hill, MD

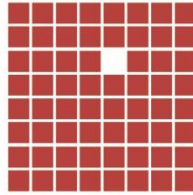


Renee Demski

cc: Joseph Antos, Ph.D., Vice Chairman  
Victoria W. Bayless  
John M. Colmers  
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**Maryland Chapter  
AMERICAN COLLEGE OF  
EMERGENCY PHYSICIANS**

November 19, 2018

Ms. Katie Wunderlich  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

RE: Draft Recommendation on Updates to the Quality-Based Reimbursement (QBR)  
Policy for RY 2021

Dear Ms. Wunderlich:

On behalf of the Maryland Chapter of the American College of Emergency Physicians (MD ACEP), we are writing to express our support for the above-referenced draft recommendation. ACEP fully supported the inclusion of the ED-1b and ED-2b measures as part of the QBR program for RY2020 to address Maryland's continuing poor performance in emergency department wait times. While we are disappointed that the ED-1b measure will be removed from the QBR program for RY2021, we understand that it is a result of CMS removing the measure from its VBP and IQR programs. We maintain our support and are pleased that the Commission staff recommends the continued inclusion of the ED-2b measure for RY2021.

With regards to the OP-18, MD ACEP agrees that this measure should be carefully monitored but that it is premature to include this measure under the QBR program. For this measure, we do believe that there may be several factors in Maryland at odds with this measurement, including hospitals' efforts to reduce inpatient admissions through care coordination programs. Over the next year, MD ACEP would like to work with the Commission staff to monitor the OP-18 measure to determine if its inclusion would be appropriate in later rate years.

Again, MD ACEP is pleased that the Commission staff continues to recommend inclusion of the ED-2b measure in the QBR program and looks forward to continuing to work with the Commission to not only monitor the OP-18 measure but Maryland's overall performance in addressing ED wait times. Thank you.

Sincerely,

*Orlee Panitch*

Orlee Panitch, MD, FACEP  
MD ACEP President



# MedStar Health

8010 Suite O Corporate Dr.  
Nottingham, MD 21236  
410-933-2300 PHONE  
medstarhealth.org

November 21, 2018

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

Dear Dianne:

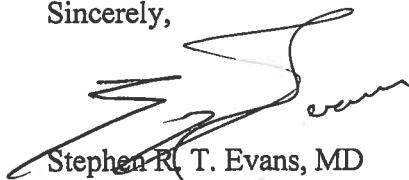
We support the continued improvement in policies that recognizes and rewards high quality care and MedStar Health appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC's) *Draft Recommendations for Updating the Quality-Based Reimbursement Program (the "Program") for Rate Year 2021*.

We support HSCRC's staffs continued movement to align the Program more closely with Medicare's Value Based Purchasing and agree to the measure changes that have been recommended. However, we are requesting the following areas be reconsidered:

- That the penalty/reward cut-off point does not increase and if anything decreases. The proposal increases the cut-off point from 41% to 45%. Currently, with the 41% cut-off point, 46 Hospitals have penalties and 2 Hospitals have rewards. Increasing the cut-off point will make it more difficult to achieve a reward and most likely will increase the \$58m penalty received in Fiscal Year 2019. CMS's Value Based Purchasing Program has a cut-off point of 37%, which is substantially lower than HSCRC's recommendation of 45%. Under CMS's value based purchasing, we believe MedStar Health would be in a reward situation in aggregate, instead of a significant penalty under the QBR program. This better reflects the positive work we are doing and shows we are better performing than the Nation.
- We support MHA's comment letter to reduce the total dollars at risk for performance based policies based on Maryland's percentage of dollars of risk being significantly higher than Medicare. As a first step, we would recommend reducing the QBR dollars at risk to offset the appropriate addition of the Medicare Performance Adjustor and therefore, holding the risk % constant.

Thank you for the opportunity to comment and allowing us to actively participate in these important workgroups to move forward and improve pay for performance policies.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen R. T. Evans". The signature is fluid and cursive, with a large initial "S" and "E".

Stephen R. T. Evans, MD  
Executive Vice President, Medical Affairs & Chief Medical Officer  
MedStar Health

Cc: Nelson Sabatini, Chairman  
Joseph Antos, Ph.D., Vice Chairman  
Victoria W. Bayless  
John M. Colmers

James Elliott, M.D.  
Adam Kane  
Jack Keane  
Katie Wunderlich, Executive Director



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24<sup>th</sup> Floor  
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CORPORATE OFFICE

November 20, 2018

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

Dear Dianne:

On behalf of the University of Maryland Medical System, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC's) *Draft Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2021*. The Quality Based Reimbursement (QBR) policy has been designed specifically to align closely with the national Value Based Purchasing (VBP) program. In recent years we understand the staff recommended an aggressive payment scale in order to provide additional incentive for Maryland hospitals to improve performance relative to the nation. While Maryland hospitals have improved, the result of that aggressive payment scale led to all but two Maryland hospitals being penalized in fiscal 2019 for a total revenue reduction of 0.36 percent, or over \$6 million.

We accept underperformance should not be financially rewarded and the intention of the program is to strengthen incentives to close the performance gap. However, we believe the domain weight adjustments have placed significant emphasis on those metrics where performance has been most criticized, specifically in patient experience and hospital acquired infections. National advisors admit performance improvement on patient experience measures moves slowly. Our own experience has demonstrated it is very difficult to sustain top ranking scores from quarter to quarter. This measure accounts for half of Maryland's QBR score.

Maryland hospitals continue to strive for these improvements. With the domain weights distributed to drive incentive, the added aggressive payment scale places undue financial burden on hospitals and penalizes performance that would otherwise be rewarded in the national program. HSCRC staff calculated the comparable payment scale cut off between penalty and reward to be 41%, yet they are recommending the Maryland QBR program cut off to be 45%. While a change of 4% seems minor, the financial impact to Maryland hospitals is significant at approximately \$12.2M.

Dianne Feeney  
November 20, 2018  
2 | Page

We believe the MHA recommendation to align both domains and payment scale to the national Medicare policy is most appropriate. Minimally we ask the payment scale be aligned with national Medicare policy.

We appreciate the Commission's consideration of our feedback.

Sincerely,



Henry J. Franey  
Executive Vice President & Chief Financial Officer  
UMMS

cc: Nelson Sabatini, Chairman  
Joseph Antos, Ph.D., Vice Chairman  
Victoria W. Bayless  
John M. Colmers

James N. Elliott, M.D  
Adam Kane  
Jack Keane  
Katie Wunderlich, Executive Director

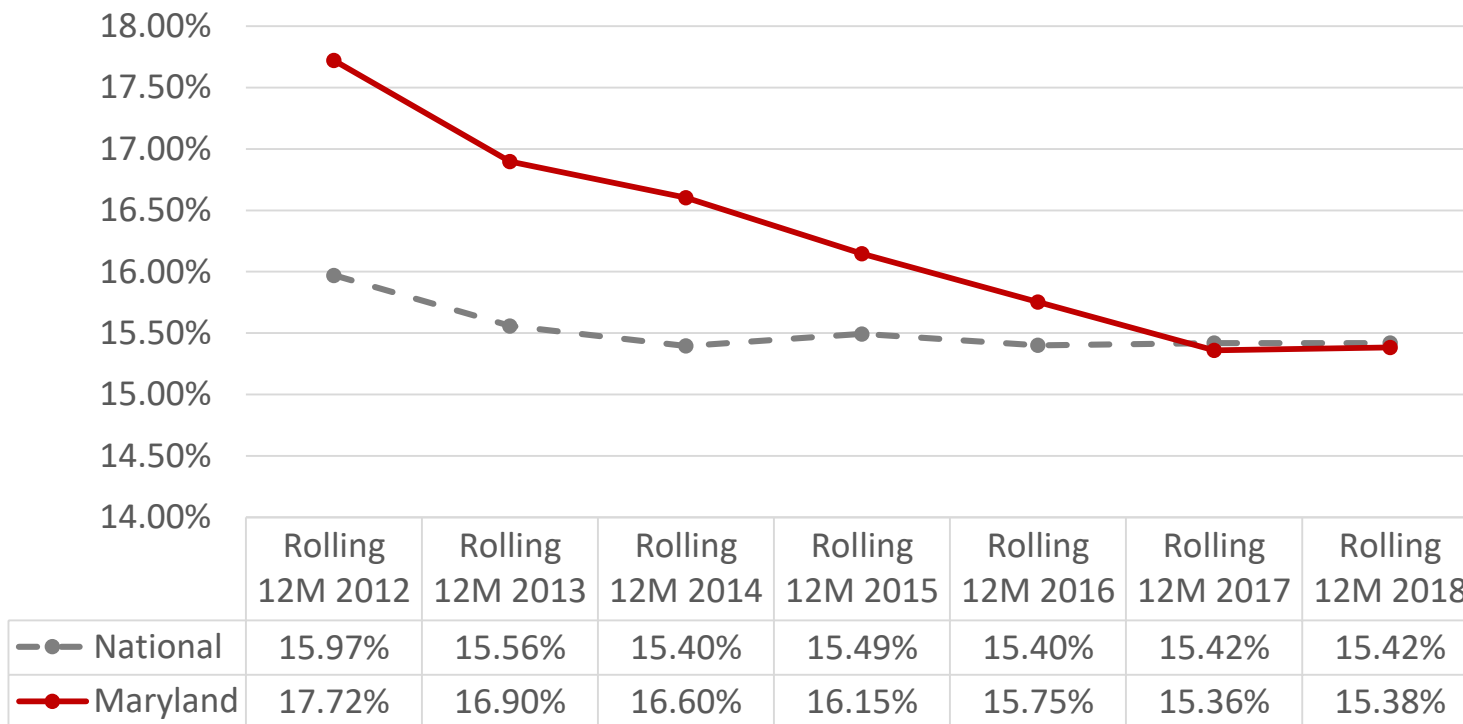
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# RY 2021 DRAFT RRIP Policy

# Medicare Waiver Test: At or below National Medicare Readmission Rate by CY 2018

With most recent Medicare Readmissions data, Maryland's Medicare Readmission Rate (15.38%) is *just below* the National Medicare Readmission Rate (15.42%). Maryland will need to continue to reduce its readmissions, and match any additional reduction in the national rate.

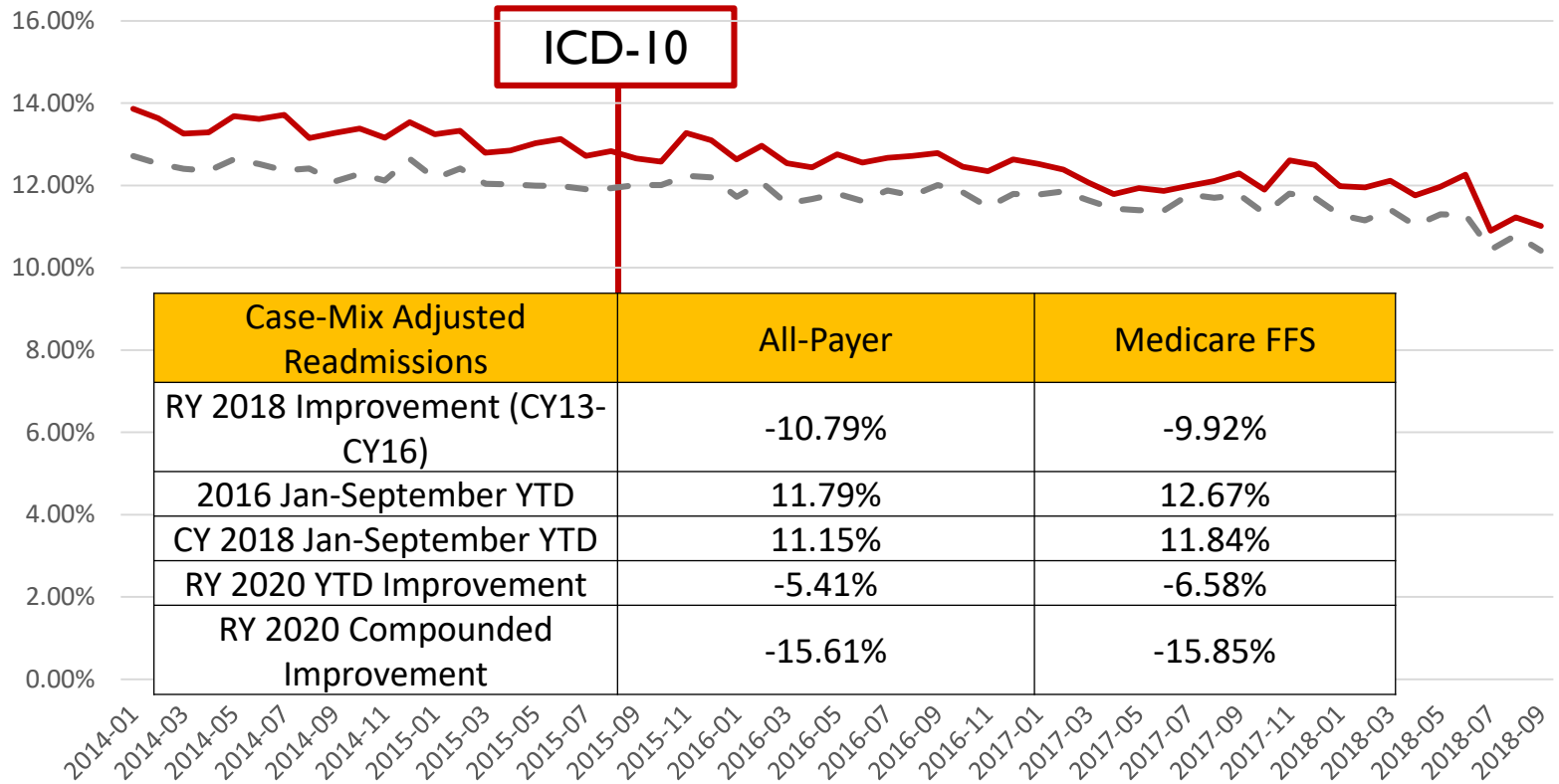
Readmissions - Rolling 12M through July



Data are currently available through July 2018



# Monthly Case-Mix Adjusted Readmission Rates



3 Note: Based on final data for Jan 2013 – Mar 2018; Preliminary data through September 2018. Statewide improvement to-date in RY 2020 is compounded with RY 2018 improvement.

# Flowchart of Predicting Improvement Target

Step 1

- Project CY 2019 National Medicare rates [**15.34%**]

Step 2

- Add a cushion to Medicare projections [15.24%, 15.14%; **15.04%**]

Step 3

- Convert National (projected) rate to All-Payer Case-mix Adjusted Rate\* [11.55%; 11.48%; **11.40%**]

Step 4

- Calculate 2016-2019 Improvement Target (RY 2021) [-3.24%; -3.88%; **-4.51%**]

HSCRC

Health Services Cost  
Review Commission

# Flowchart of Predicting Attainment Target

## Step 1

- Take Current All-Payer Case-mix Adjusted Readmission Rates (**2018 YTD through Aug**)

## Step 2

- Increase these rates for Out-of-State Readmissions (**Jul 17-Jun 18**)
- Using CMMI data, the ratio is as follows: *Total Readmissions : InState Readmissions*

## Step 3

- Calculate the 35<sup>th</sup> and 5<sup>th</sup> percentiles for the statewide distribution of scores
- 35<sup>th</sup> Percentile is **threshold** to receive attainment point rewards (**10.96%**)
- 5<sup>th</sup> Percentile is **benchmark** to receive maximum attainment point rewards (**8.59%**)

## Step 4

- Adjust benchmark and threshold downward **2.01%**, per principles of continuous quality improvement

# RY 2021 Proposed Revenue Adjustment Scales (Better of Attainment or Improvement)

All Payer Readmission Rate Change CY16-CY19		RRIP % Inpatient Revenue Payment Adjustment
	A	B
Improving Readmission Rate		1.0%
	-15.01%	1.00%
	-9.76%	0.50%
<b>Target</b>	<b>-4.51%</b>	<b>0.00%</b>
	0.74%	-0.50%
	5.99%	-1.00%
	11.24%	-1.50%
	16.49%	-2.0%
Worsening Readmission Rate		-2.0%

All Payer Readmission Rate CY19		RRIP % Inpatient Revenue Payment Adjustment
	A	B
Lower Absolute Readmission Rate		1.0%
Benchmark	8.59%	1.00%
	9.77%	0.50%
<b>Threshold</b>	<b>10.96%</b>	<b>0.00%</b>
	12.15%	-0.50%
	13.34%	-1.00%
	14.52%	-1.50%
	15.71%	-2.0%
Higher Absolute Readmission Rate		-2.0%

# Staff Draft Recommendations for RY 2021 RRIP Policy

---

- ▶ Measure hospital performance as the better of attainment or improvement.
- ▶ Set the all-payer case-mix adjusted readmission rate improvement target at **4.51 percent for CY 2016 to CY 2019.**
- ▶ Set the attainment performance standards for CY 2019 with an expanded benchmark and threshold range as follows:
  - ▶ Use CY 2018 YTD hospital performance results with an improvement factor added.
  - ▶ Increase the **threshold** where hospitals start to earn rewards from the 25th percentile to the 35th percentile, which is **10.96 percent.**
  - ▶ Decrease the **benchmark** where hospital receive the full 1 percent reward from the 10th percentile to the 5th percentile at **8.59 percent.**
- ▶ Include admissions **to specialty hospitals** in the calculation of acute care hospital readmission rates and monitor readmission rates of specialty hospitals.
- ▶ Set the maximum reward hospitals can receive at 1 percent of inpatient revenue and the maximum penalty at 2 percent of inpatient revenue.

# Draft Recommendation for the Readmissions Reduction Incentive Program for Rate Year 2021

December 12, 2018

Health Services Cost Review Commission

4160 Patterson Avenue  
Baltimore, Maryland 21215  
(410) 764-2605  
FAX: (410) 358-6217

This document contains the draft staff recommendations for updating the Maryland Hospital Readmissions Reduction Incentive Program (RRIP) for RY 2021. Please submit comments on this draft to the Commission by **Thursday, December 20, 2018**, via email to [hsrc.quality@maryland.gov](mailto:hsrc.quality@maryland.gov).

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## **LIST OF ABBREVIATIONS**

ACA	Affordable Care Act
APR-DRG	All-patient refined diagnosis-related group
ARR	Admission-Readmission Revenue Program
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
CRISP	Chesapeake Regional Information System for Our Patients
CY	Calendar year
FFS	Fee-for-service
FFY	Federal fiscal year
HRRP	Hospital Readmissions Reduction Program
HSCRC	Health Services Cost Review Commission
ICD-10	International Classification of Disease, 10 <sup>th</sup> Edition
RRIP	Readmissions Reduction Incentive Program
RY	Rate year
SOI	Severity of illness
YTD	Year-to-date



## KEY METHODOLOGY CONCEPTS AND DEFINITIONS

**Diagnosis-Related Group (DRG):** A system to classify hospital cases into categories that are similar in clinical characteristics and in expected resource use. DRGs are based on a patient's primary diagnosis and the presence of other conditions.

**All Patients Refined Diagnosis Related Groups (APR-DRG):** Specific type of DRG assigned using 3M software that groups all diagnosis and procedure codes into one of 328 All-Patient Refined-Diagnosis Related Groups.

**Severity of Illness (SOI):** 4-level classification of minor, moderate, major, and extreme that can be used with APR-DRGs to assess the acuity of a discharge.

**APR-DRG SOI:** Combination of diagnosis-related groups with severity of illness levels, such that each admission can be classified into an APR-DRG SOI "cell" along with other admissions that have the same diagnosis-related group and severity of illness level.

**Observed/Expected Ratio:** Readmission rates are calculated by dividing the observed number of readmissions by the expected number of readmissions. Expected readmissions are determined through case-mix adjustment.

**Case-Mix Adjustment:** Statewide rate for readmissions (i.e., normative value or "norm") is calculated for each diagnosis and severity level. These **statewide norms** are applied to each hospital's case-mix to determine the expected number of readmissions, a process known as **indirect standardization**.

## RECOMMENDATIONS

This is a draft recommendation for the Maryland Rate Year (RY) 2021 Readmission Reduction Incentive Program (RRIP) policy. At this time, the staff requests that Commissioners consider the following draft recommendations:

- A. Measure hospital performance as the better of attainment or improvement.
- B. Set the all-payer case-mix adjusted readmission rate improvement target at 4.51 percent for CY 2016 to CY 2019.
- C. Set the attainment performance standards for CY 2019 with an expanded benchmark and threshold range as follows:
  1. Use CY 2018 YTD hospital performance results with an improvement factor added.
  2. Increase the threshold where hospitals start to earn rewards from the 25th percentile to the 35th percentile, which is 10.96 percent.
  3. Decrease the benchmark where hospital receive the full 1 percent reward from the 10th percentile to the 5th percentile at 8.51 percent.
- D. Include admissions to specialty hospitals in the calculation of acute care hospital readmission rates and monitor readmission rates of specialty hospitals.
- E. Set the maximum reward hospitals can receive at 1 percent of inpatient revenue and the maximum penalty at 2 percent of inpatient revenue.

Staff will review the improvement target and attainment standards in April/May against finalized CY 2018 data in order to bring back to the Commission revised performance targets if data trends warrant the revision. This may necessitate an additional vote from Commissioners.

## INTRODUCTION

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) Readmissions Reduction Incentive Program (RRIP) is one of several pay for performance initiatives that provide incentives for hospitals to improve patient care and value over time. The RRIP policy holds 2% of hospital revenue at-risk for performance on 30-day all-cause all-payer readmission rates across all acute care hospitals in Maryland. Under the current All-Payer Model Agreement between Maryland and the Centers for Medicare & Medicaid Services (CMS), there are specific quality performance requirements, including reducing Medicare readmissions to below the national average by the end of CY 2018. Maryland is currently on target to meet this requirement. Maryland has reduced the Medicare fee-for-service readmission rate from 16.90% in 2013 to 15.38% in 2018 and is currently below the national average based on the latest 12-months of data through July of 2018.

As Maryland enters into a new Total Cost of Care (TCOC) Model Agreement with CMS on January 1, 2019, performance standards and targets in HSCRC's portfolio of quality and value-based payment programs will be updated. In CY 2018, staff focused on revising two of the Commission's Quality programs, the Maryland Hospital Acquired Complications program and the Potentially Avoidable Utilization program, per directives from HSCRC Commissioners.<sup>1</sup> In CY 2019, staff will focus on revising Maryland's readmission policies by convening an expert sub-group to make recommendations for RY 2022 and beyond (see Future of the Model section for more details).

Under the All-Payer Model agreement, if Maryland made incremental progress toward reducing readmissions the state received an automatic exemption from the CMS national Hospital Readmissions Reduction Program (HRRP). Under the TCOC Model, the State will maintain its exemption from the CMS national readmission program as long as Maryland's Medicare fee-for-service readmission rate continues to be at or below the national rate. This exemption from the national readmission program is important because the State of Maryland's all-payer global budget system benefits from having autonomous, quality-based measurement and payment initiatives that set consistent quality incentives across all-payers. This report provides staff's draft recommendations for updates to Maryland's RRIP for Rate Year (RY) 2021

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<sup>1</sup> In the fall of 2017, HSCRC Commissioners with staff support conducted several strategic planning sessions to outline priorities and guiding principles for the upcoming Total Cost of Care Model. Based on these sessions, the HSCRC developed a Critical Action Plan that delineates timelines for review and possible revisions of financial and quality methodologies, as well as other staff operations.

## BACKGROUND

### Medicare Hospital Readmissions Reduction Program

The United States healthcare system currently has had an unacceptably high rate of preventable hospital readmissions, which are defined as an admission to a hospital within a specified time period after a discharge from the same or another hospital.<sup>2</sup> Excessive readmissions generate considerable unnecessary costs and represent substandard quality of care for patients. A number of studies show that hospitals can engage in several activities to lower their rate of readmissions, such as clarifying patient discharge instructions, coordinating with post-acute care providers and patients' primary care physicians, and reducing medical complications during patients' initial hospital stays.<sup>3</sup>

Efforts have been underway nationally to address excessive readmissions and their deleterious effects. Under authority of the Affordable Care Act, CMS established its Medicare Hospital Readmissions Reduction Program in federal fiscal year 2013. Under this program, CMS uses three years of data to calculate the average risk-adjusted, 30-day hospital readmission rates for patients with certain conditions. Additional details on the HRRP can be found in Appendix I.

### Overview of the Maryland RRIP Policy

Under the All-Payer Model Agreement, Maryland's Medicare fee-for-service statewide hospital readmission rate must be equal to or below the national Medicare readmission rate by the end of Calendar Year (CY) 2018 (also known as the "Waiver Test"). In order to meet this Model requirement, the Commission built a Readmission Reduction Incentive Program (RRIP) beginning in 2014. As required by CMS, the RRIP is more comprehensive than the Medicare Hospital Readmission Program, as it includes all patients and payers, but it otherwise mostly aligns with the CMS readmission measure, and reasonably supports the goal of meeting or out-performing the national Medicare readmission rate (see Appendix I for additional background information).

With the migration from the All-Payer Model (2014-2018) to the Total Cost of Care (TCOC) Model (2019-), the State of Maryland will need to overhaul many of its existing inpatient quality pay-for-performance programs. The RRIP is slated for careful review with the sub-group of expert key stakeholders beginning in 2019, meaning that the RY 2021 policy presents minimal methodological changes. These changes include factoring in specialty hospitals when calculating acute hospital readmissions, updating improvement targets to align with projected CY 2019

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<sup>2</sup> Jencks, S. F. et al., "Hospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* Vol. 360, No. 14: 1418-1428, 2009.; Epstein, A. M. et al., "The Relationship between Hospital Admission Rates and Rehospitalizations," *New England Journal of Medicine* Vol. 365, No. 24: 2287-2295, 2011.

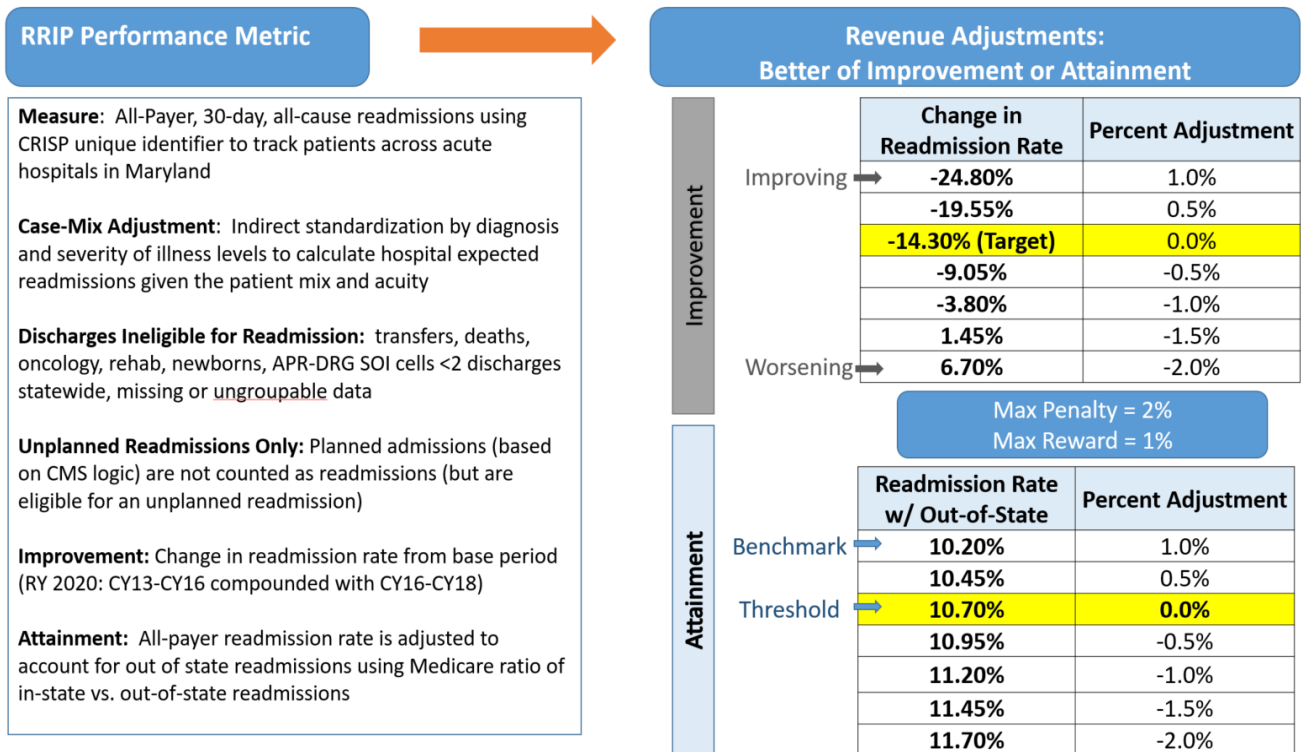
<sup>3</sup> Ahmad, F. S. et al., "Identifying Hospital Organizational Strategies to Reduce Readmissions," *American Journal of Medical Quality* Vol. 28, No. 4: 278-285, 2013.; Silow-Carroll, S. et al., "Reducing Hospital Readmissions: Lessons from Top-Performing Hospitals," *Commonwealth Fund Synthesis Report*, New York: Commonwealth Fund, 2011.; Jack, B. W. et al., "A Reengineered Hospital Discharge Program to Decrease Hospitalization: A Randomized Trial," *Annals of Internal Medicine* Vol. 50, No. 3: 178-187, 2009.; and Kanaan, S. B., "Homeward Bound: Nine Patient-Centered Programs Cut Readmissions," Oakland, CA: California HealthCare Foundation, 2009.

national Medicare FFS readmission projections, and expanding the attainment scale to reflect additional gradations of performance.

### RRIP Pay-for Performance Methodology

Under the RRIP, Maryland evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across acute care hospitals. In order to increase the fairness of the program related to data limitations and clinical concerns, the all-payer readmission measure excludes certain types of discharges from consideration, e.g., newborns and planned readmissions. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related groups (APR-DRG) and severity of illness (SOI)<sup>4</sup>. The readmission rate during the performance period is then compared to historical rate during a base period to assess improvement and to a threshold and benchmark to assess attainment. The policy then determines a hospital’s revenue adjustment for improvement and attainment and takes the better of the two revenue adjustments, with scaled rewards of up to 1 percent of inpatient revenue and scaled penalties of up to 2 percent of inpatient revenue. Figure 1 provides a high level overview of the RY 2020 RRIP methodology. Additional details on the calculation of the improvement target and attainment performance standards are provided in the assessment section.

Figure 1. Overview Rate Year 2020 RRIP Methodology



<sup>4</sup> See Appendix II for details of the indirect standardization method used to calculate a hospital’s expected readmission rate.

## **ASSESSMENT**

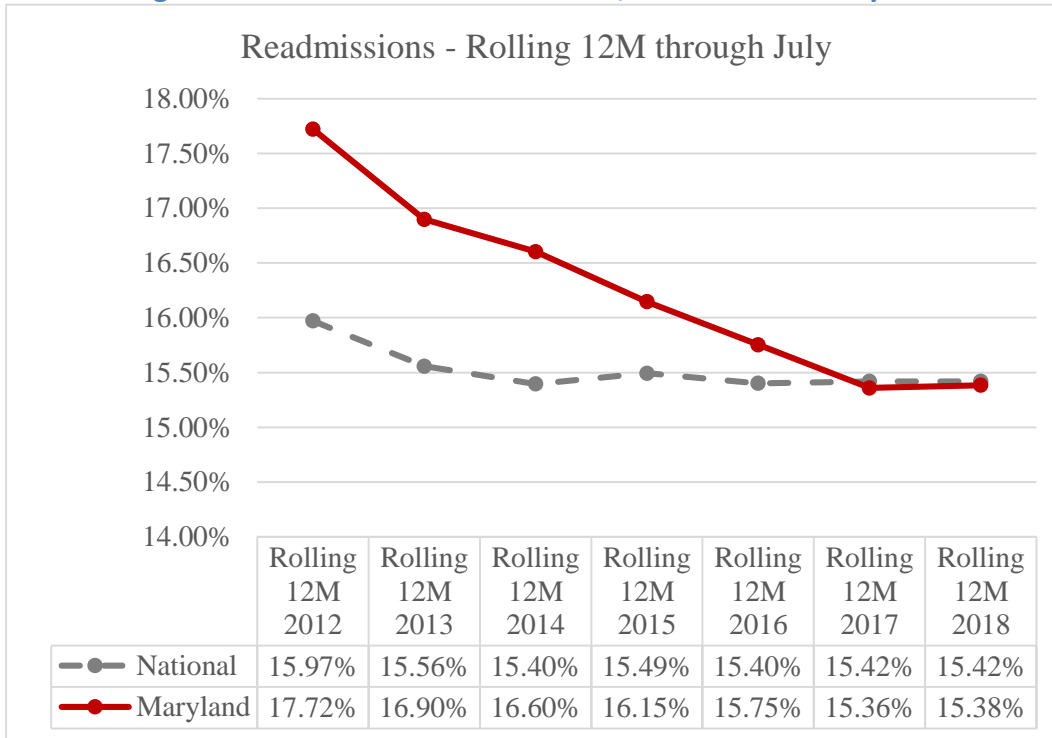
Under the Maryland All-Payer Model Agreement, the State receives data from CMS to track progress on the unadjusted Medicare FFS readmission waiver test. The following assessment section presents this data on current readmission performance, details the calculation of the RY 2021 improvement target and attainment standards, and provides modeling of revenue adjustments.

### **Maryland's Performance to Date**

#### *Maryland Waiver Test Performance*

As mentioned previously, the waiver test requires that Maryland reduce its unadjusted Medicare FFS readmission rate to below the national average by the end of 2018. Figure 2 provides the CMS data for 2012 through 2018 on a rolling 12 month basis through July, and it indicates that Maryland's Medicare readmission rate is currently below the National rate. While it should be noted that the CY 2018 YTD readmission rate is higher than the CY 2017 YTD readmission rate, the progress that Maryland hospitals have made to reduce readmissions since 2013 is to be commended. Furthermore, it should be noted that the rolling 12 month readmission rate through June 2018 is the first time since September 2017 that Maryland did not have a readmissions cushion greater than 0.10%. This fluctuation is partly a function of Maryland's small numerator (readmissions) and denominator (admissions) relative to the nation, which has not experienced a change in its readmissions rate greater than .02% since December of 2015. Meanwhile, Maryland regularly has changes in the rolling readmission rate greater than .05%, and June 2018 was the largest change in the rolling readmission rate since the start of the All-Payer Model, suggesting that June 2018 may have been an outlier.

**Figure 2. Medicare FFS Readmissions, National and Maryland**



**All-Payer Case-Mix Adjusted Performance**

While the CMS readmission Waiver Test is based on the unadjusted readmission rate for Medicare patients, the RRIP incentivizes performance on the All-Payer, case-mix adjusted readmission rate. Based on CY 2018 year-to-date data through September under the RY 2020 methodology, the State has achieved a compounded reduction in the All-Payer, case-mix adjusted readmission rate of 15.60% since CY 2013, and 26 hospitals are on track to achieve the compounded cumulative improvement target of 14.30 percent. Since the incentive program also assesses attainment, an additional nine hospitals are on track to achieve the attainment goal of a readmission rate lower than 10.70 percent. Appendix III provides current hospital-level year-to-date improvement and attainment rates for CY 2018.

For RY 2021, the staff recommends that specialty hospitals be included when calculating acute care hospital readmission rates to increase the comprehensiveness and fairness of the measure. However, staff does not recommended including specialty hospitals in the payment program (due to lack of data regarding cross-border trends for purposes of an attainment target). Staff will provide data to specialty hospitals in CY 2019 so that they can track their readmissions.<sup>5</sup> The

<sup>5</sup> The specialty hospitals are: 213028 - Chesapeake Rehab; 213029 - Adventist Rehab Maryland; 213300 - Mt Washington Pediatric Hospital; 214000 - Sheppard Pratt; 214003 - Brook Lane. A sixth hospital, 214013 - Adventist Behavioral Health - Rockville, will merge with 210057 - Shady Grove Adventist, but has been included for modeling purposes.

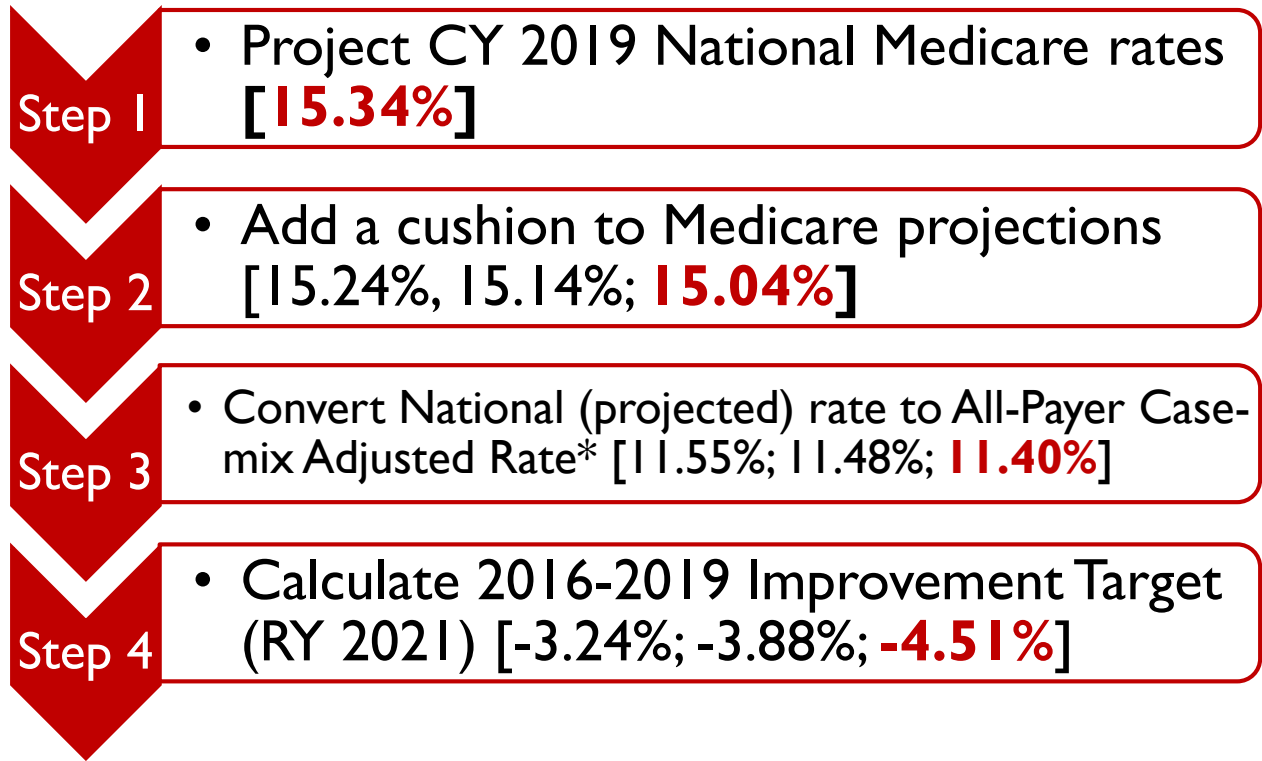
inclusion of specialty hospitals has two impacts on acute care hospitals: 1) it removes index admissions from acute care hospitals that were transfers to a specialty hospital, i.e., it potentially decreases the denominator of eligible discharges for acute care hospitals; and 2) it counts readmissions from an acute to a specialty hospital, i.e., it potentially increases the numerator.. For the September Performance Measurement Workgroup meeting, staff provided CY 2017 data showing the statewide impact of including specialty hospitals on the readmission rate for acute care hospitals was an increase of 0.20% (11.63% to 11.83%). Appendix IV provides the CY 2017 readmission rates with and without specialty hospitals. Based on the staff recommendation, the calculations of the improvement and attainment standards use case-mix data with specialty hospitals included.

### **Improvement Target Calculation Methodology RY 2021**

Under the RY 2021 policy, staff recommends setting a new improvement target to: a) account for projected national readmission reductions during CY 2019, and b) to ensure the Maryland program incentivizes continuous quality improvement beyond the initial Waiver Test goal. Developing an appropriate improvement target is a multi-step process to ensure that the State responsibly incorporates projections of the national Medicare readmissions rate with the latest federal data to determine the Maryland All-Payer Case-mix Adjusted Readmissions Rate and provides incentives for additional improvement. A flowchart of the steps to determine an improvement target and the current calculations is detailed below in Figure 3.



Figure 3. Steps to Determine Improvement Target



\*Conversion factor for the Draft Policy is 75.8%. HSCRC expects to have more recent data to improve predictions for the final policy.

In Step 1, Mathematica Policy Research (MPR) and staff projected the CY 2019 national Medicare readmission rate using trends based on data through June or July 2018. Given that the RY 2021 improvement target must yield the improvement to enable Maryland to maintain a readmission rate lower than the national rate, staff will closely monitor updated data through the end of CY 2018, and **may revise the improvement target mid-year**. A mid-year revision would require Commissioners to approve an amendment to the proposed policy.

HSCRC staff and its contractor Mathematica Policy Research (MPR) modeled seven different projections (Figure 4) for the CY 2019 national readmission rate. As in RY 2020, staff then averaged the forecasts derived from the seven different methods to determine the CY 2019 national Medicare readmission rate of 15.34%.

**Figure 4. Improvement Target Model Projections**

<b>Model Abbreviation</b>	<b>Model Name</b>	<b>Model Description</b>	<b>CY 2019 Projection</b>
<b>AAC</b>	Average Annual Change	Averages the annual changes from 2013 to present	<b>15.43%</b>
<b>MRAC</b>	Most Recent Annual Change	2018 YTD over 2017 YTD	<b>15.42%</b>
<b>12MMA</b>	12 Month Moving Average	Moving average predictive method, using most recent 12M of data and moving trend forward	<b>15.40%</b>
<b>24MMA</b>	24 Month Moving Average	Moving average predictive method, using most recent 24M of data and moving trend forward	<b>15.40%</b>
<b>PROC</b>	PROC Forecast	Combination of deterministic time trend model (long-term) and autoregressive model (short-term)	<b>15.07%</b>
<b>ARIMA</b>	Auto-Regressive Integrated Moving Average	Parametric statistical model characterizing the time series data, which better incorporates seasonality and multiple evaluation criteria	<b>15.36%</b>
<b>STL</b>	Seasonal and Trend decomposition using Loess	Divides time series data into three components - seasonal, trend cycle, and remainder, to yield projection value	<b>15.31%</b>
	<b>Average</b>	<b>Average of Seven Models</b>	<b>15.34%</b>

In Step 2, given that predictions are fundamentally uncertain, staff has included a cushion to make the improvement target more aggressive in case the predictions are inaccurate, and to ensure that Maryland continues to improve beyond the initial goal of the national median. The cushions under the draft policy were set at 0.1%, 0.2%, and 0.3%.

In Step 3, staff converted the projected CY 2019 National Medicare Readmission rates to a Case-mix Adjusted, All-Payer improvement target to ensure fairness across Maryland hospitals with differing case-mix acuity. To convert to an all-payer readmission rate, staff evaluated the ratio between the unadjusted Maryland Medicare FFS readmission rates and the Case-Mix Adjusted, All-Payer readmission rates. As shown in Figure 5 below, this ratio appears to be relatively stable over time. The Case-mix Adjusted All-Payer Readmission Rate has been approximately 75% of the unadjusted Medicare FFS readmission rate over the past several years; staff has updated this ratio with YTD data through Jun 2013-2018, yielding a ratio relationship of 75.8%.

**Figure 5. Unadjusted Medicare FFS to Case-mix Adjusted All-Payer Improvement Target Conversion**

Year	National Medicare FFS Rate	CMMI (Unadjusted) MD Medicare FFS Rate	HSCRC Case-mix Adjusted All Payer Readmissions Rate	All Payer to Medicare Ratio of Readmission Rates
CY 13 YTD Jun	-15.59%	16.95%	12.72%	75.04%
CY14 YTD Jun	-15.39%	16.64%	12.97%	77.95%
CY 15 YTD Jun	-15.50%	16.20%	12.36%	76.31%
CY 16 YTD Jun	-15.40%	15.78%	11.51%	72.97%
CY 17 YTD Jun	-15.42%	15.42%	11.81%	76.62%
CY 18 YTD Jun	-15.42%	15.38%	11.67%	75.88%
			Average of Ratios	<b>75.80%</b>

Finally, in Step 4, staff takes the percent change between the projected Case-mix Adjusted, All-Payer Readmission rate (between 11.40%) and the CY 2016 Case-mix Adjusted, All-Payer Readmission Rate (11.94%) to determine the required improvement target for the RY 2021 policy (Figure 6 below). For purposes of the draft RY 2021 RRIP Policy modeling, staff has selected the three-year improvement target (CY 2016 to CY 2019) of -4.51%.

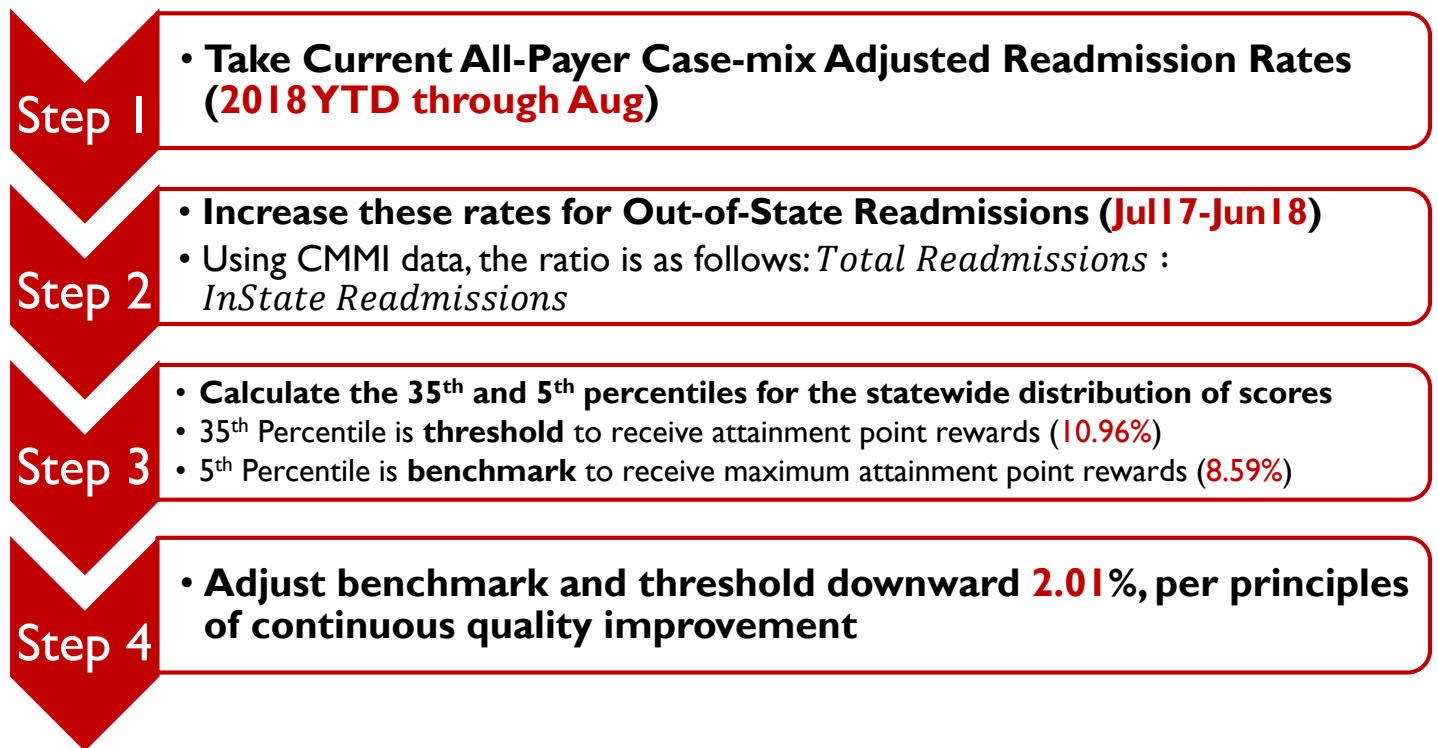
**Figure 6. Converting Projected Unadjusted Medicare FFS Readmission Rate to Case-mix Adjusted, All-Payer Readmission Rate, Calculating Improvement Target**

	Actual Trend	Actual Trend + -0.1% Cushion	Actual Trend + -0.2% Cushion	Actual Trend + -0.3% Cushion
<b>Assuming CY 2019 National Rate</b>	15.34%	15.24%	15.14%	15.04%
<b>Ratio Approach</b>	11.63%	11.55%	11.48%	11.40%
<b>Improvement under Ratio Approach</b>	-2.61%	-3.24%	-3.88%	<b>-4.51%</b>

### Attainment Target Calculation Methodology

Beginning in RY 2017, HSCRC began including an attainment target, whereby hospitals with relatively low case-mix adjusted readmission rates are rewarded for maintaining low readmission rates. A simple flowchart of the necessary steps to determine the attainment target and the current calculations are included below in Figure 7.

Figure 7. Steps to Determine Attainment Target



In Step 1, staff examine the current All-Payer, Case-mix Adjusted Readmission Rates (these data are current through August). These rates are then increased to account for readmissions to out-of-state hospitals (Step 2), which is done by adjusting case-mix adjusted rates by the ratio of Medicare readmissions that were outside-of-Maryland in the most recent four full quarters of data (currently July 2017 - June 2018; additional information in Appendix V). From these adjusted trends, a threshold where hospitals begin to receive rewards (35th percentile) and benchmark where hospitals receive full 1% reward (5th percentile) are calculated, providing a range by which hospitals with relatively low readmission rates can be rewarded, should their attainment score be higher than their calculated improvement score (Step 3). The window of rewards between the 5th and 35th percentiles has been expanded from the prior years' policy to acknowledge Maryland's strong improvement relative to the nation. Last, both the benchmark and threshold are adjusted downward by an improvement factor to reflect the improvement target calculated previously and the State's expectation that all Maryland hospitals continue to improve over the next year (Step 4).<sup>6</sup> Figure 8 shows the attainment standards calculated based on the CY 2018 YTD data through August; the current percentiles and the proposed wider percentile range with and without the improvement factor are presented.

<sup>6</sup> The improvement target of -4.51% must be achieved over 36 months (2016-2019); -2.01% reflects the proportion of the improvement that should be achieved in the remaining 16 months between August 2018 and December 2019.

**Figure 8. Attainment Target Threshold and Benchmark with Improvement Factor**

<b>Attainment Standards</b>	<b>Actual</b>	<b>Plus Improvement Factor</b>
<b>Current RY 2020 Policy</b>		
Threshold 10th Percentile	9.98%	9.78%
Benchmark 25th Percentile	10.87%	10.65%
<b>Proposed RY 2021 Policy</b>		
Threshold 5th Percentile	8.76%	8.59%
Benchmark 35th Percentile	11.19%	10.96%

### Prospective Scaling for RY 2021 Policy

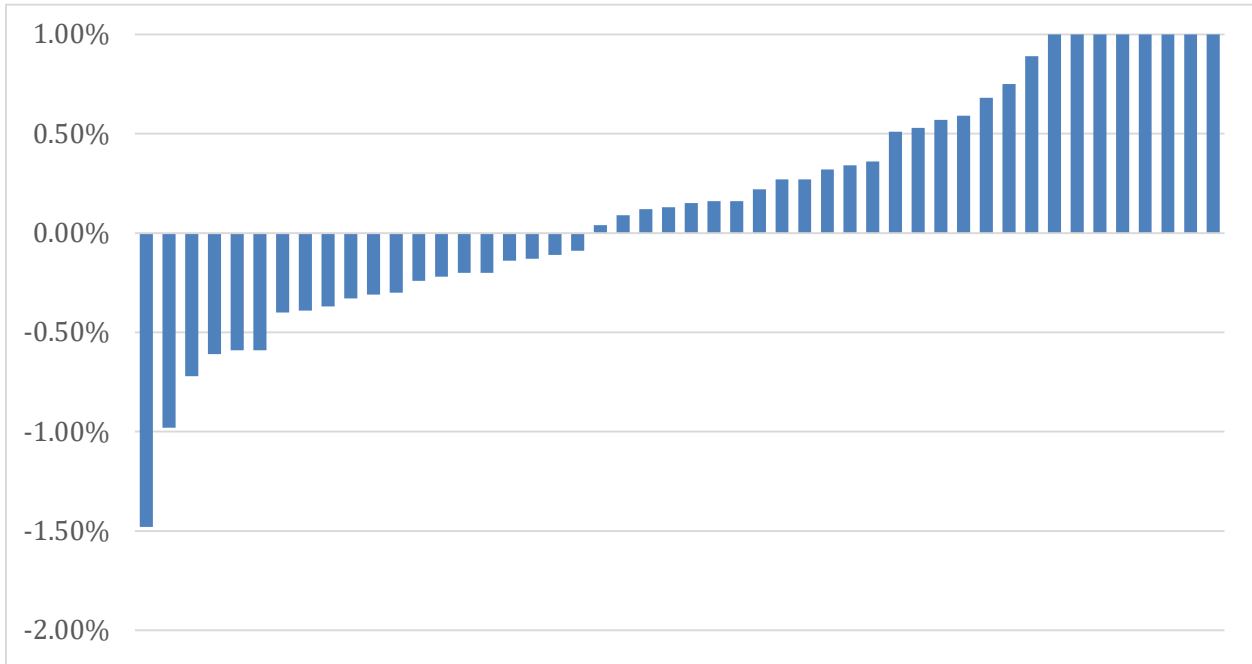
HSCRC will calculate a by-hospital revenue adjustment based on percent improvement and performance relative to the attainment standards. Hospitals will receive the more favorable revenue adjustment (the better of their improvement or attainment adjustments). For both improvement and attainment the rewards and penalties are linearly scaled between -2% and 1% using the improvement target and attainment threshold as the cut point. An illustration of the abbreviated scales is provided below in the tables in Figure 9. The use of preset revenue adjustment scales aligns with the core principles of Maryland Quality programs to provide hospitals with prospective performance standards, ways to track performance and revenue adjustments on an ongoing basis, and evaluate hospital performance independently of other hospitals, as the HSCRC wants to foster collaboration among hospitals that a relative ranking system would discourage.

**Figure 9. RRIP Improvement and Attainment Revenue Adjustment Scales**

All Payer Readmission Rate Change CY16-CY19		RRIP % Inpatient Revenue Payment Adjustment	All Payer Readmission Rate CY19		RRIP % Inpatient Revenue Payment Adjustment
	A	B		A	B
<b>Improving Readmission Rate</b>		1.0%	<b>Lower Absolute Readmission Rate</b>		1.0%
	-15.01%	1.00%	<b>Benchmark</b>	8.59%	1.00%
	-9.76%	0.50%		9.77%	0.50%
<b>Target</b>	<b>-4.51%</b>	<b>0.00%</b>	<b>Threshold</b>	<b>10.96%</b>	<b>0.00%</b>
	0.74%	-0.50%		12.15%	-0.50%
	5.99%	-1.00%		13.34%	-1.00%
	11.24%	-1.50%		14.52%	-1.50%
	16.49%	-2.0%		15.71%	-2.0%
<b>Worsening Readmission Rate</b>		-2.0%	<b>Higher Absolute Readmission Rate</b>		-2.0%

Staff has modeled revenue adjustments using RY 2020 year-to-date data through August 2018 and the proposed RY 2021 improvement and attainment scales (see Appendix VI). For this analysis, RY 2020 YTD data with specialty hospitals was compared against the proposed improvement and attainment targets. Based on these analyses, 20 hospitals would be penalized for a total of \$15.8 million, and 28 hospitals would be rewarded for a total of \$19.9 million. Because the improvement target, reflecting a relatively flat projected national readmission rate, is rather low, the majority of hospitals (34 out of 48) would receive their positive or negative revenue adjustment based on improvement and not attainment. Should the Commission decline to expand the attainment threshold and benchmark, and remain at the 25th and 10th percentiles, respectively, initial modeling suggest that 26 hospitals would receive rewards totaling \$20.2M, and 22 would receive penalties totaling \$-19.7M. The higher rewards under the narrower attainment range are because the full reward can be earned at the 10th, as opposed to the 5th, percentile of performance. The revenue modeling for RY 2021 in Appendix V, which uses RY 2020 year-to-date results, results in higher penalties than what would be expected if hospitals continue to improve throughout CY 2019. Figure 10 presents the revenue adjustment percentages by hospital based on this modeling.

**Figure 10. Modeled Revenue Adjustments by Hospital**



## FUTURE OF MODEL

As previously mentioned, staff intends to convene a sub-group of the Performance Measurement Work Group, comprised of key stakeholders and subject-matter experts, to consider an overhaul of the Readmission pay-for-performance program in CY 2019. This group will review the existing policy to make recommendations for measure updates, and the approach for developing all-payer performance standards for the RY 2022 Readmission Policy and beyond. Among the topics the sub-group may review are the following:

- Goal-setting for statewide performance relative to available national standards for Medicare and other payers
- Continued measurement of improvement and attainment versus feasibility and appropriateness of attainment only with sociodemographic risk adjustment
- Readmission measure specification updates (e.g., inclusion of oncology admissions or other admissions currently excluded, assessment of CMS electronic clinical quality readmissions measures (eCQMs))
- Shrinking denominator concerns and potential solutions, including measurement of readmissions on a per capita basis
- Trends in observation stays commensurate with inpatient readmissions
- Interaction with readmissions as defined under the Potentially Avoidable Utilization (PAU) measure

Staff notes that in the draft RY 2021 RRIP policy, the improvement target is set to the national CY 2019 projection (plus a cushion). The sub-group may consider whether to set a more aggressive improvement target than the national average in future years.

Staff welcomes additional topics for consideration related to the readmission sub-group, and welcomes those interested in participating in the sub-group to contact the Quality team at [hsrcr.quality@maryland.gov](mailto:hsrcr.quality@maryland.gov).

## RECOMMENDATIONS

This is a draft recommendation for the Maryland Rate Year (RY) 2021 Readmission Reduction Incentive Program (RRIP) policy. At this time, the staff requests that Commissioners consider the following draft recommendations:

- A. Measure hospital performance as the better of attainment or improvement.
- B. Set the all-payer case-mix adjusted readmission rate improvement target at 4.51 percent for CY 2016 to CY 2019.
- C. Set the attainment performance standards for CY 2019 with an expanded benchmark and threshold range as follows:
  1. Use CY 2018 YTD hospital performance results with an improvement factor added.
  2. Increase the threshold where hospitals start to earn rewards from the 25th percentile to the 35th percentile, which is 10.96 percent.
  3. Decrease the benchmark where hospital receive the full 1 percent reward from the 10th percentile to the 5th percentile at 8.59 percent.
- D. Include admissions to specialty hospitals in the calculation of acute care hospital readmission rates and monitor readmission rates of specialty hospitals.
- E. Set the maximum reward hospitals can receive at 1 percent of inpatient revenue and the maximum penalty at 2 percent of inpatient revenue.

Staff will review the improvement target and attainment standards in April/May against finalized CY 2018 data in order to bring back to the Commission revised performance targets if data trends warrant the revision. This may necessitate an additional vote from Commissioners.



## APPENDIX I. ADDITIONAL BACKGROUND

### CMS Hospital Readmission Reduction Program

For federal fiscal year 2019, the HRRP includes patients with heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease, elective hip or knee replacement, and coronary artery bypass graft surgery. As required by the 21st Century Cures Act, beginning in FY 2019, hospital performance in the HRRP is assessed relative to the performance of hospitals within the same peer group. Hospitals are stratified into five peer groups, or quintiles, based on the proportion of dual eligible stays. A hospital's dual proportion is the proportion of Medicare fee-for-service (FFS) and Medicare Advantage stays where the patient was dually eligible for full-benefit Medicaid. If a hospital's risk-adjusted readmission rate for such patients exceeds that average, CMS penalizes it in the following year by using an adjustment factor that is applied to Medicare reimbursements for care for patients admitted for any reason; the penalty is in proportion to the hospital's excess rate of readmissions.

Penalties under the Medicare Hospital Readmissions Reduction Program were first imposed in federal fiscal year 2013, during which the maximum penalty was 1 percent of the hospital's base inpatient claims, and the maximum penalty has increased to 3 percent for federal fiscal year 2015 and beyond.

Beginning in CY 2018, CMS has also begun voluntary reporting of the Hybrid Hospital-Wide Readmission measure for hospitals in order to test collection of core clinical data elements and laboratory test results that stakeholders believe would enhance the administrative coding data that is utilized currently in the risk model variables.<sup>7</sup>

### Maryland Readmission Reduction Incentive Program

The All-Payer Model Agreement with CMS replaced the requirements of the Affordable Care Act by establishing two sets of requirements. One set of requirements established performance targets for readmissions and complications in order to maintain Maryland exemptions from these programs, while the second set of requirements ensured that the amount of potential and actual revenue adjustments in Maryland's quality-based programs was at or above the CMS levels in aggregate but on an all-payer basis.

Maryland has historically performed poorly compared to the nation on readmissions, ranked 50th among all states in a study examining Medicare data from 2003-2004.<sup>8</sup> Under the All-Payer Model Agreement, Maryland's Medicare fee-for-service statewide hospital readmission rate must be equal to or below the national Medicare readmission rate by the end of Calendar Year (CY) 2018, and demonstrate annual progress toward this goal (also known as the "Waiver Test").

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<sup>7</sup> For more information on Medicare Hospital Readmissions Reduction Program, see <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>.

<sup>8</sup> Jencks, S. F. et al., "Hospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* Vol. 360, No. 14: 1418-1428, 2009.

In order to meet this new Model requirement, the Commission built a Readmission Reduction Incentive Program (RRIP) beginning in 2014 to further bolster the incentives to reduce unnecessary readmissions. The RRIP replaced a previous Commission policy, the Admission Readmission Revenue policy, which had been in place since RY 2012.<sup>9</sup> As recommended by the Performance Measurement Work Group, the RRIP is more comprehensive than the Medicare Hospital Readmission Program, as it includes all patients and payers, but it otherwise mostly aligns – albeit with some minor differences – with the CMS readmission measure, and reasonably supports the goal of meeting or out-performing the national Medicare readmission rate. The most notable difference between the Maryland model and the Federal model is that Maryland does not stratify hospitals into peer groups, which CMS does based on the proportion of stays for patients who are fully dually-eligible for Medicare and Medicaid.

Staff does not plan on stratifying by Maryland-specific peer groups at this time, but may consider the feasibility and *methodological soundness* of this stratification in the overhaul of the readmissions program in 2019. In addition, adopting the national stratification determination for Maryland hospitals is not currently possible as this data is calculated retrospectively and will not be available until the start of federal fiscal year 2019. Staff will evaluate the CMS stratification approach and its applicability to Maryland as the data becomes available.

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<sup>9</sup> <http://hscrc.maryland.gov/Pages/archived-quality-initiatives.aspx>

## APPENDIX II. HSCRC CURRENT READMISSIONS MEASURE SPECIFICATIONS

### Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra- and inter-hospital) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and with the exclusion of planned admissions.<sup>10</sup>

This measure is similar to the readmission rate that will be calculated under the All-Payer Model, with some exceptions. The most notable exceptions are that the HSCRC measure includes psychiatric patients and excludes oncology admissions. In comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, adjustments had to be made to the metric that accounted for planned admissions and severity of illness. See below for details on the readmission calculation for the RRIP program.

### Inclusions and Exclusions in Readmission Measurement

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 4.0. The HSCRC has also counts all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs, rather than principal diagnosis (APR-DRGs 540, 541, 542, 560, 860). Planned admissions are counted in the denominator because they could have an unplanned readmission.
- Discharges for the newborn APR-DRG are removed.
- Oncology cases are removed prior to running the readmission logic (APR-DRGs 41, 110, 136, 240, 281, 343, 382, 442, 461, 500, 511, 512, 530, 680, 681, 690, 691, 692, 693, 694, 695, and 696).
- Rehabilitation cases as identified by APR-DRG 860 (which are coded under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after the readmission logic is run.
- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission, but can be a readmission for a previous admission.
- Hospitalizations within 30 days of a hospital discharge for a patient who dies during the second admission are counted as readmissions, however, the readmission is removed from the denominator because there cannot be a subsequent readmission.
- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same as or the next day after the admission date of the subsequent admission, are removed from the denominator counts. Thus, only one admission is counted in the denominator, and that is the admission to the receiving transfer hospital. It is this discharge date that is used to calculate the 30-day readmission

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<sup>10</sup> Defined under [CMS Planned Admission Logic version 4 – updated October 2017.]

window.

- Discharges from rehabilitation hospitals (provider IDs Chesapeake Rehab 213028, Adventist Rehab 213029, and Bowie Health 210333) are not included when assessing readmissions.
- Holy Cross Germantown 210065 and Levindale 210064 are included in the program.
- Starting in January 2016, HSCRC is receiving information about discharges from chronic beds within acute care hospitals in the same data submissions as acute care discharges.
- In addition, the following data cleaning edits are applied:
  - Cases with null or missing Chesapeake Regional Information System for our Patients (CRISP) unique patient identifiers (EIDs) are removed.
  - Duplicates are removed.
  - Negative interval days are removed.
  - HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, hospitals are required to make sure 99.5 percent of inpatient discharges have a CRISP EID.

## Details on the Calculation of Case-Mix Adjusted Readmission Rate

### Data Source:

To calculate readmission rates for RRIP, inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) are used for the measurement period, plus an additional 30 days. To calculate the case-mix adjusted readmission rate for CY 2016 base period and CY 2018 performance period, data from January 1 through December 31, plus 30 days in January of the next year are used.

**SOFTWARE:** APR-DRG Version 35 (ICD-10) for CY 2016-CY 2018.

### Calculation:

$$\text{Risk-Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions)}}{\text{(Expected Readmissions)}} * \text{Statewide Readmission Rate}$$

**Numerator:** Number of observed hospital-specific unplanned readmissions.

**Denominator:** Number of expected hospital-specific unplanned readmissions based upon discharge APR-DRG and severity of illness. See below for how to calculate expected readmissions adjusted for APR-DRG SOI.



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

Once a set of norms has been calculated, the norms can be applied to each hospital. In this example, the computation presents expected readmission rates for an individual APR-DRG category and its SOI 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.

**Expected Value Computation Example**

<b>1</b> Severity of Illness Level	<b>2</b> Discharges at Risk for Readmission	<b>3</b> Discharges with Readmission	<b>4</b> Readmissions per Discharge	<b>5</b> Normative Readmissions per Discharge	<b>6</b> 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
<b>Total</b>	<b>500</b>	<b>45</b>	<b>.09</b>		<b>56.5</b>

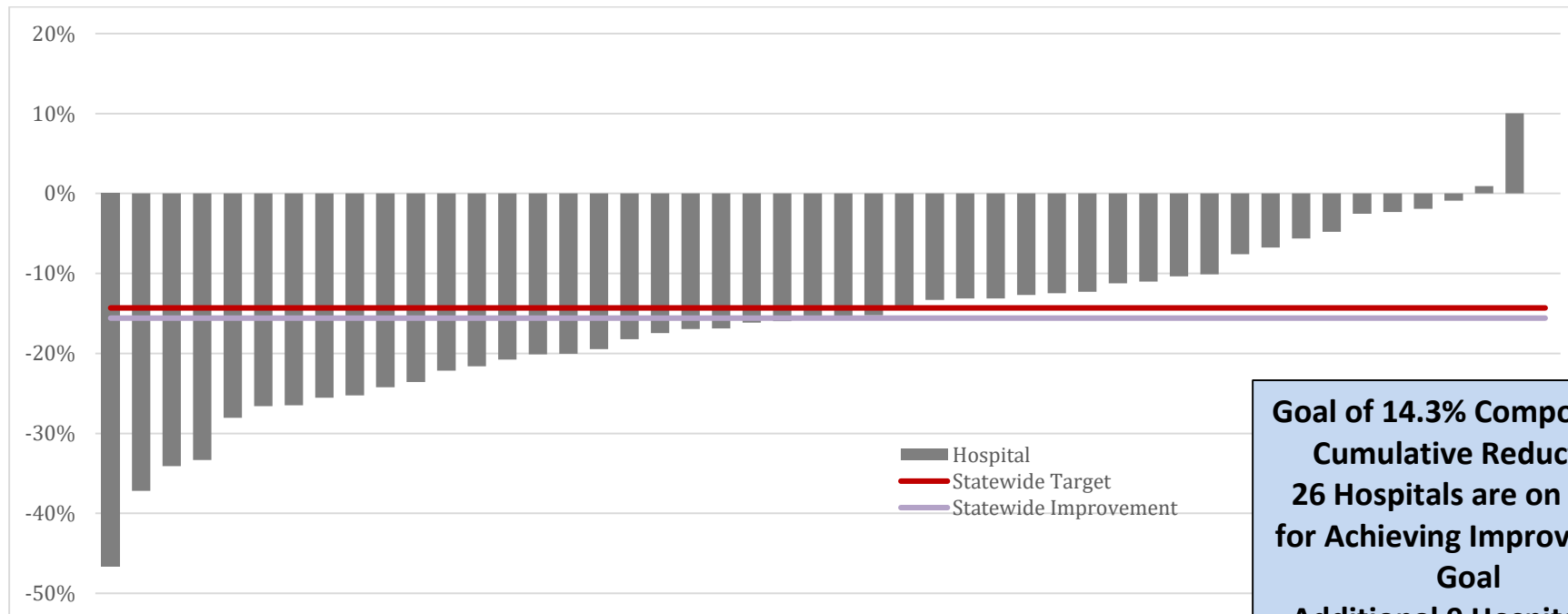
For the APR-DRG category, the number of discharges with a readmission is 45, which is the sum of discharges with readmissions (column 3). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of discharges with a readmission (sum of column 3) by the total number of discharges at risk for readmission (sum of column 2), i.e.,  $45/500 = 0.09$ . From the normative population, the proportion of discharges with readmissions for each SOI level for that APR-DRG category is displayed in column 5. The expected number of readmissions for each SOI level (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 sum of the expected numbers of readmissions for the 4 SOI 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 also be expressed as a percentage (79.65% of expected readmissions).

APR-DRGs 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 III. RY 2020 BY-HOSPITAL READMISSION CHANGES

**Compounded Cumulative Change CY 2013- CY2018 YTD through September**



**Goal of 14.3% Compounded Cumulative Reduction**  
**26 Hospitals are on Track for Achieving Improvement Goal**  
**Additional 9 Hospitals on Track for Achieving Attainment Goal**

**Case-mix Adjusted, All-Payer Readmission Rates – RY 2020 YTD through September by-Hospital**

Hospitals		CY2018 Performance Period (YTD, Jan-Sep 2018)									
A	B	C = Obs/Exp * 11.78%	D	E	F = E/D	G	H = E/G	I = E/G * 11.78%	J = I/C - 1	K	L = J + K
HOSPITAL ID	HOSPITAL NAME	Case-Mix Adjusted Readmission Rate	Total # of IP Disch.	Total # of Readmits	Percent Readmits	Total # of Expected Readmits	Readmit Ratio	Case-Mix Adjusted Readmit Rate	Change in Case-mix Adjusted Rate from CY2016	RY 2018 % Change	CY17 Modified Cumulative Improvement Readmission Rate
210001	Meritus	11.29%	8,969	963	10.74%	1,130	0.852	10.03%	- 11.16%	- 6.44%	- 16.88%
210002	UMMC	12.92%	17,041	2,504	14.69%	2,289	1.094	12.87%	- 0.39%	- 11.95%	- 12.29%
210003	UM-PGHC	11.00%	8,337	993	11.91%	1,086	0.914	10.75%	- 2.27%	- 0.28%	- 2.54%
210004	Holy Cross	11.68%	17,638	1,448	8.21%	1,521	0.952	11.20%	- 4.11%	2.30%	- 1.90%
210005	Frederick	9.51%	11,094	1,161	10.47%	1,372	0.846	9.95%	4.63%	- 9.81%	- 5.63%
210006	UM-Harford	12.79%	2,947	398	13.51%	445	0.895	10.52%	- 17.75%	5.38%	- 13.32%
210008	Mercy	12.41%	9,506	809	8.51%	837	0.967	11.38%	- 8.30%	- 18.48%	- 25.25%
210009	Johns Hopkins	13.16%	27,926	4,108	14.71%	3,818	1.076	12.66%	- 3.80%	- 12.66%	- 15.98%
210010	UM-Dorchester	12.23%	1,311	160	12.20%	196	0.815	9.59%	- 21.59%	4.31%	- 18.21%
210011	St. Agnes	12.04%	10,365	1,256	12.12%	1,280	0.981	11.54%	- 4.15%	- 13.36%	- 16.96%
210012	Sinai	12.40%	10,251	1,221	11.91%	1,313	0.930	10.94%	- 11.77%	- 16.68%	- 26.49%
210013	Bon Secours	15.13%	2,239	484	21.62%	373	1.297	15.25%	0.79%	- 22.77%	- 22.16%
210015	MedStar Fr Square	12.40%	14,566	1,997	13.71%	1,856	1.076	12.66%	2.10%	- 4.33%	- 2.32%
210016	Washington Adventist	10.68%	6,972	639	9.17%	787	0.812	9.56%	- 10.49%	- 10.77%	- 20.13%
210017	Garrett	5.74%	1,470	97	6.60%	173	0.561	6.60%	14.98%	- 17.19%	- 4.79%
210018	MedStar Montgomery	10.62%	4,722	542	11.48%	608	0.891	10.48%	- 1.32%	- 14.22%	- 15.35%
210019	Peninsula	10.40%	11,840	1,361	11.49%	1,472	0.925	10.88%	4.62%	- 5.26%	- 0.88%
210022	Suburban	11.18%	9,796	1,067	10.89%	1,237	0.863	10.15%	- 9.21%	- 1.97%	- 11.00%
210023	Anne Arundel	11.31%	17,142	1,579	9.21%	1,658	0.952	11.20%	- 0.97%	- 9.50%	- 10.38%



Draft Recommendations for the Readmissions Reduction Incentive Program for Rate Year 2021

Hospitals		CY2018 Performance Period (YTD, Jan-Sep 2018)									
A	B	C = Obs/Exp * 11.78%	D	E	F = E/D	G	H = E/G	I = E/G * 11.78%	J = I/C - 1	K	L = J + K
HOSPITAL ID	HOSPITAL NAME	Case-Mix Adjusted Readmission Rate	Total # of IP Disch.	Total # of Readmits	Percent Readmits	Total # of Expected Readmits	Readmit Ratio	Case-Mix Adjusted Readmit Rate	Change in Case-mix Adjusted Rate from CY2016	RY 2018 % Change	CY17 Modified Cumulative Improvement Readmission Rate
210024	MedStar Union Mem	12.68%	7,395	904	12.22%	937	0.964	11.34%	- 10.57%	- 14.56%	- 23.59%
210027	Western Maryland	11.33%	7,447	880	11.82%	999	0.881	10.36%	- 8.56%	- 9.75%	- 17.48%
210028	MedStar St. Mary's	11.38%	4,559	455	9.98%	502	0.907	10.67%	- 6.24%	- 16.39%	- 21.61%
210029	JH Bayview	14.38%	12,769	1,883	14.75%	1,645	1.145	13.47%	- 6.33%	- 7.25%	- 13.12%
210030	UM-Chestertown	13.83%	704	62	8.81%	103	0.605	7.11%	- 48.59%	3.71%	- 46.68%
210032	Union of Cecil	10.83%	3,590	411	11.45%	461	0.891	10.48%	- 3.23%	4.29%	0.92%
210033	Carroll	11.59%	7,189	868	12.07%	896	0.969	11.40%	- 1.64%	- 8.62%	- 10.12%
210034	MedStar Harbor	11.79%	5,125	750	14.63%	634	1.182	13.91%	17.98%	- 6.76%	10.00%
210035	UM-Charles Regional	9.98%	4,435	489	11.03%	584	0.837	9.85%	- 1.30%	- 19.00%	- 20.05%
210037	UM-Easton	10.81%	4,400	385	8.75%	500	0.770	9.06%	- 16.19%	2.37%	- 14.20%
210038	UMMC Midtown	15.49%	2,918	567	19.43%	482	1.175	13.82%	- 10.78%	- 11.20%	- 20.77%
210039	Calvert	9.52%	3,870	420	10.85%	501	0.839	9.87%	3.68%	- 10.08%	- 6.77%
210040	Northwest	12.62%	6,815	909	13.34%	1,027	0.885	10.41%	- 17.51%	- 19.18%	- 33.33%
210043	UM-BWMC	12.65%	10,623	1,382	13.01%	1,495	0.924	10.87%	- 14.07%	- 13.35%	- 25.54%
210044	GBMC	10.50%	12,257	978	7.98%	1,183	0.827	9.73%	- 7.33%	- 6.26%	- 13.13%
210045	McCready	12.28%	160	17	10.63%	19	0.901	10.60%	- 13.68%	7.04%	- 7.60%
210048	Howard County	11.37%	9,956	994	9.98%	1,120	0.888	10.44%	- 8.18%	- 4.92%	- 12.70%
210049	UM-Upper Chesapeake	11.22%	7,049	789	11.19%	877	0.899	10.58%	- 5.70%	- 5.87%	- 11.24%
210051	Doctors	11.88%	6,689	801	11.97%	988	0.811	9.54%	- 19.70%	- 10.41%	- 28.06%
210055	UM-Laurel	11.72%	2,370	341	14.39%	341	1.000	11.77%	0.43%	- 16.49%	- 16.13%

Draft Recommendations for the Readmissions Reduction Incentive Program for Rate Year 2021

Hospitals		CY2018 Performance Period (YTD, Jan-Sep 2018)									
A	B	C = Obs/Exp * 11.78%	D	E	F = E/D	G	H = E/G	I = E/G * 11.78%	J = I/C - 1	K	L = J + K
HOSPITAL ID	HOSPITAL NAME	Case-Mix Adjusted Readmission Rate	Total # of IP Disch.	Total # of Readmits	Percent Readmits	Total # of Expected Readmits	Readmit Ratio	Case-Mix Adjusted Readmit Rate	Change in Case-mix Adjusted Rate from CY2016	RY 2018 % Change	CY17 Modified Cumulative Improvement Readmission Rate
210056	MedStar Good Sam	12.32%	4,933	879	17.82%	786	1.119	13.16%	6.82%	- 18.05%	- 12.46%
210057	Shady Grove	10.05%	11,138	833	7.48%	1,039	0.801	9.43%	- 6.17%	- 9.73%	- 15.30%
210058	UMROI	10.36%	373	19	5.09%	29	0.649	7.64%	- 26.25%	- 10.65%	- 34.10%
210060	Ft. Washington	9.44%	1,504	155	10.31%	223	0.695	8.17%	- 13.45%	- 27.41%	- 37.17%
210061	Atlantic General	8.76%	2,287	251	10.98%	314	0.800	9.41%	7.42%	- 25.02%	- 19.46%
210062	MedStar Southern MD	11.08%	6,922	707	10.21%	915	0.773	9.09%	- 17.96%	- 7.63%	- 24.22%
210063	UM-St. Joe	10.89%	10,243	954	9.31%	1,091	0.875	10.29%	- 5.51%	- 10.29%	- 15.23%
210064	Levindale	11.77%	781	115	14.72%	111	1.032	12.14%	3.14%	- 28.84%	- 26.61%
210065	HC-Germantown	10.43%	3,231	358	11.08%	371	0.965	11.36%	8.92%		
	<b>STATEWIDE</b>	<b>11.79%</b>	<b>355,864</b>	<b>41,343</b>	<b>11.62%</b>	<b>43,624</b>	<b>0.948</b>	<b>11.15%</b>	<b>- 5.43%</b>	<b>- 10.75%</b>	<b>- 15.60%</b>

**APPENDIX IV. RY 2021 RRIP – READMISSION RATES WITH AND WITHOUT SPECIALTY HOSPITALS**

ID	HOSPITAL NAME	CY17 with Specialty			CY17 Acute IP Only		
		Inpatient Discharges	Readmissions	Case-Mix Adjusted Readmission Rate	Inpatient Discharges	Readmissions	Case-Mix Adjusted Readmission Rate
210001	Meritus	13,853	1,712	11.81%	13,858	1,687	11.55%
210002	UMMC	23,047	3,557	13.53%	23,223	3,536	13.22%
210003	UM-PGHC	10,403	1,259	10.69%	10,451	1,242	10.56%
210004	Holy Cross	24,259	2,066	11.98%	24,397	2,074	11.73%
210005	Frederick	14,839	1,628	10.74%	14,877	1,611	10.52%
210006	UM-Harford	3,955	550	10.78%	3,956	540	10.76%
210008	Mercy	12,418	1,104	12.92%	12,419	1,102	12.72%
210009	Johns Hopkins	39,529	5,948	13.42%	39,745	5,944	13.22%
210010	UM-Dorchester	2,088	299	11.63%	2,100	285	11.21%
210011	St. Agnes	13,978	1,708	12.01%	13,979	1,703	11.78%
210012	Sinai	13,666	1,605	10.98%	13,684	1,589	10.80%
210013	Bon Secours	3,404	752	15.34%	3,408	722	15.15%
210015	MedStar Fr Square	19,870	2,853	13.54%	19,883	2,771	13.15%
210016	Washington Adventist	9,257	964	10.31%	9,609	925	9.60%
210017	Garrett	1,964	117	6.49%	1,968	117	6.37%
210018	MedStar Montgomery	6,628	867	12.07%	6,683	845	11.68%
210019	Peninsula	15,335	1,682	10.81%	16,140	1,784	10.78%
210022	Suburban	12,596	1,477	11.54%	12,961	1,474	11.17%
210023	Anne Arundel	24,483	2,072	10.97%	24,510	2,059	10.72%
210024	MedStar Union Mem	10,182	1,345	12.94%	10,185	1,340	12.67%
210027	Western Maryland	9,946	1,205	10.87%	9,949	1,204	10.79%
210028	MedStar St. Mary's	6,751	712	11.13%	6,755	696	10.87%
210029	JH Bayview	17,613	2,841	14.88%	17,631	2,816	14.65%
210030	UM-Chestertown	1,413	176	10.88%	1,413	176	10.73%
210032	Union of Cecil	4,972	568	10.54%	4,974	567	10.49%
210033	Carroll	9,099	1,104	11.51%	9,103	1,066	11.06%
210034	MedStar Harbor	6,739	983	13.62%	6,742	947	13.29%
210035	UM-Charles Regional	6,314	677	10.06%	6,316	675	9.87%
210037	UM-Easton	6,268	617	10.80%	6,275	617	10.63%
210038	UMMC Midtown	4,278	887	15.24%	4,283	864	15.05%
210039	Calvert	5,096	498	9.15%	5,101	481	8.81%
210040	Northwest	9,451	1,407	11.97%	9,460	1,379	11.78%
210043	UM-BWMC	14,699	2,024	12.02%	14,706	1,999	11.76%
210044	GBMC	15,726	1,274	10.53%	15,794	1,267	10.24%

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		CY17 with Specialty			CY17 Acute IP Only		
ID	HOSPITAL NAME	Inpatient Discharges	Readmissions	Case-Mix Adjusted Readmission Rate	Inpatient Discharges	Readmissions	Case-Mix Adjusted Readmission Rate
210045	McCready	213	23	10.18%	214	24	10.47%
210048	Howard County	15,134	1,553	10.99%	15,155	1,529	10.73%
210049	UM-Upper Chesapeake	9,525	914	9.65%	9,529	912	9.48%
210051	Doctors	8,458	1,187	11.40%	8,476	1,190	11.22%
210055	UM-Laurel	2,715	426	12.19%	2,726	417	11.95%
210056	MedStar Good Sam	6,946	1,122	12.36%	6,948	1,117	12.12%
210057	Shady Grove	15,048	1,232	10.41%	15,522	1,274	10.17%
210058	UMROI	592	34	9.20%	593	34	9.05%
210060	Ft. Washington	1,975	207	8.60%	1,977	206	8.42%
210061	Atlantic General	2,787	312	9.73%	2,927	348	10.25%
210062	MedStar Southern MD	9,491	1,143	10.83%	9,500	1,107	10.49%
210063	UM-St. Joe	14,075	1,270	10.71%	14,111	1,253	10.43%
210064	Levindale	1,040	152	11.43%	1,041	145	11.45%
210065	HC-Germantown	4,348	520	12.40%	4,383	510	11.95%
213029	Adv Rehab MD	L	L	0.00%			
213300	Mt. Washington Peds	303	27	8.62%			
214000	Sheppard Pratt	8,332	1,077	10.41%			
214003	Brook Lane	1,522	144	9.89%			
214013	Adventist BH-Rockville	3,684	528	11.14%			
	<b>STATEWIDE</b>	<b>500,310</b>	<b>60,409</b>	<b>11.83%</b>	<b>489,640</b>	<b>58,170</b>	<b>11.63%</b>
	Acute IP Only w/Specialty	486,466	58,633	11.83%			

**APPENDIX V. OUT-OF-STATE MEDICARE READMISSION RATIOS**

**Out-of-State Readmission Ratios for RRIP Attainment**

Based on CMMI Data July 2017 – June 2018.

<b>ID</b>	<b>Hospital Name</b>	<b>Total Admissions</b>	<b>Total Readmissions</b>	<b>Total Readmissions in Maryland</b>	<b>Out-of-State Ratio</b>
210001	MERITUS MEDICAL CENTER	6,025	1,083	1,036	1.0454
210002	UNIVERSITY OF MARYLAND MEDICAL CENTER	6,854	1,402	1,350	1.0385
210003	UM-PRINCE GEORGE'S HOSPITAL CENTER	3,034	576	477	1.2075
210004	HOLY CROSS HOSPITAL	4,263	699	644	1.0854
210005	FREDERICK MEMORIAL HOSPITAL	6,287	897	868	1.0334
210006	UM-HARFORD MEMORIAL HOSPITAL	1,527	229	224	1.0223
210008	MERCY MEDICAL CENTER	3,911	454	448	1.0134
210009	JOHNS HOPKINS HOSPITAL	11,038	2,082	1,919	1.0849
210011	ST. AGNES HOSPITAL	4,489	703	698	1.0072
210012	SINAI HOSPITAL	5,218	727	716	1.0154
210013	BON SECOURS HOSPITAL	483	96	94	1.0213
210015	MEDSTAR FRANKLIN SQUARE	7,096	1,290	1,286	1.0031
210016	WASHINGTON ADVENTIST HOSPITAL	2,854	481	424	1.1344
210017	GARRETT COUNTY MEMORIAL HOSPITAL	838	79	47	1.6809
210018	MEDSTAR MONTGOMERY MEDICAL CENTER	3,042	447	396	1.1288
210019	PENINSULA REGIONAL MEDICAL CENTER	7,807	1,149	1,084	1.0600
210022	SUBURBAN HOSPITAL	6,107	743	664	1.1190
210023	ANNE ARUNDEL MEDICAL CENTER	8,702	1,078	1,039	1.0375
210024	MEDSTAR UNION MEMORIAL HOSPITAL	4,663	595	583	1.0206

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ID	Hospital Name	Total Admissions	Total Readmissions	Total Readmissions in Maryland	Out-of-State Ratio
210027	WESTERN MARYLAND REGIONAL MEDICAL CENTER	4,987	750	674	1.1128
210028	MEDSTAR ST. MARY'S HOSPITAL	2,544	389	324	1.2006
210029	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	6,436	1,257	1,233	1.0195
210030	UM-SHORE REGIONAL HEALTH AT CHESTERTOWN	719	83	76	1.0921
210032	UNION HOSPITAL OF CECIL COUNTY	1,896	321	250	1.2840
210033	CARROLL HOSPITAL CENTER	4,438	682	655	1.0412
210034	MEDSTAR HARBOR HOSPITAL CENTER	1,864	353	349	1.0115
210035	UM-CHARLES REGIONAL MEDICAL CENTER	2,658	383	324	1.1821
210037	UM-SHORE REGIONAL HEALTH AT EASTON	3,857	517	493	1.0487
210038	UMMC MIDTOWN CAMPUS	1,225	299	295	1.0136
210039	CALVERT HEALTH MEDICAL CENTER	2,053	272	240	1.1333
210040	NORTHWEST HOSPITAL CENTER	4,024	587	584	1.0051
210043	UM-BALTIMORE WASHINGTON MEDICAL CENTER	6,216	955	941	1.0149
210044	GREATER BALTIMORE MEDICAL CENTER	4,786	524	511	1.0254
210045	MCCREADY MEMORIAL HOSPITAL	133	12	12	1.0000
210048	HOWARD COUNTY GENERAL HOSPITAL	5,530	838	825	1.0158
210049	UM-UPPER CHESAPEAKE MEDICAL CENTER	4,425	558	547	1.0201
210051	DOCTORS COMMUNITY HOSPITAL	3,663	544	483	1.1263
210055	UM-LAUREL REGIONAL HOSPITAL	1,127	203	194	1.0464
210056	MEDSTAR GOOD SAMARITAN	3,418	603	600	1.0050
210057	SHADY GROVE ADVENTIST HOSPITAL	4,730	618	582	1.0619

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<b>ID</b>	<b>Hospital Name</b>	<b>Total Admissions</b>	<b>Total Readmissions</b>	<b>Total Readmissions in Maryland</b>	<b>Out-of-State Ratio</b>
210058	UM-REHABILITATION & ORTHOPAEDIC INSTITUTE	176	L	L	1.0000
210060	FORT WASHINGTON MEDICAL CENTER	942	156	103	1.5146
210061	ATLANTIC GENERAL HOSPITAL	1,776	256	241	1.0622
210062	MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	3,331	559	413	1.3535
210063	UM-ST. JOSEPH MEDICAL CENTER	5,852	706	696	1.0144
210064	LEVINDALE	190	23	23	1.0000
210065	HOLY CROSS HOSPITAL-GERMANTOWN	1,034	152	148	1.0270

**APPENDIX VI. RY 2021 IMPROVEMENT AND ATTAINMENT SCALING – MODELED RESULTS**

The following figure presents the proposed RY 2021 modeling, using preliminary CYTD 2018 readmission rate results. Column A shows the hospital’s RY 2018 permanent inpatient revenue. Column B and C show the CY 2016 YTD and CY 2018 in-state case-mix adjusted readmission rates. Columns D shows percent change in the case-mix adjusted rate from CY 16 to CY 18 YTD. Column E shows the actual case-mix adjusted rate with out-of-state adjustment for CYTD 2018. Columns F and G present the scaling results using the proposed RY 2021 improvement methodology, and columns H and I present the scaling results using the proposed RY 2021 attainment methodology. Columns J and K shows the revenue adjustment that is the better of attainment or improvement.

RY 2021 Readmission Reduction Incentive Program Modeling							Improvement		Attainment		Final Adjustment	
HOSP ID	HOSPITAL NAME	RY 18 Permanent Inpatient Revenue	CYTD16 Case Mix Adj. Readmit Rate	CYTD18 Casemix adj. readmit rate	CYTD18 % Change Case mix adj. Rate	CYTD18 Case mix adj. rate adj. for out of state	TARGET	Percent Rev. Adj.	TARGET (35 <sup>th</sup> perc)	Percent Rev. Adj.	RY20 Better of Attainment/ Improvement	Percent Rev. Adj.
		A	B	C	D=C/B-1	E	F	G	H	I	J	K=J/A
210001	Meritus	\$190,799,459	11.35%	10.21%	-10.04%	10.67%	-4.51%	0.53%	10.99%	0.13%	\$1,011,237.00	0.53%
210002	UMMC	\$919,253,797	13.13%	13.07%	-0.46%	13.57%	-4.51%	-0.39%	10.99%	-1.09%	-\$3,585,090.00	-0.39%
210003	UMPG	\$215,464,625	10.92%	10.89%	-0.27%	13.15%	-4.51%	-0.40%	10.99%	-0.91%	-\$861,859.00	-0.40%
210004	Holy Cross	\$340,412,069	11.84%	11.44%	-3.38%	12.42%	-4.51%	-0.11%	10.99%	-0.60%	-\$374,453.00	-0.11%
210005	Frederick	\$220,972,343	9.71%	10.51%	8.24%	10.86%	-4.51%	-1.21%	10.99%	0.05%	\$110,486.00	0.05%
210006	UM Harford	\$48,557,781	12.95%	10.93%	-15.60%	11.17%	-4.51%	1.00%	10.99%	-0.08%	\$485,578.00	1.00%
210008	Mercy	\$223,932,822	12.71%	11.77%	-7.40%	11.93%	-4.51%	0.27%	10.99%	-0.40%	\$604,619.00	0.27%
210009	Johns Hopkins	\$1,378,259,901	13.40%	12.98%	-3.13%	14.08%	-4.51%	-0.13%	10.99%	-1.31%	-\$1,791,738.00	-0.13%
210010	Dorchester	\$26,021,222	13.15%	9.98%	-24.11%	10.47%	-4.51%	1.00%	10.99%	0.22%	\$260,212.00	1.00%
210011	St. Agnes	\$237,889,236	12.15%	11.72%	-3.54%	11.80%	-4.51%	-0.09%	10.99%	-0.34%	-\$214,100.00	-0.09%
210012	Sinai	\$398,036,508	12.56%	11.21%	-10.75%	11.38%	-4.51%	0.59%	10.99%	-0.16%	\$2,348,415.00	0.59%
210013	Bon Secours	\$65,798,042	15.62%	15.24%	-2.43%	15.56%	-4.51%	-0.20%	10.99%	-1.94%	-\$131,596.00	-0.20%



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RY 2021 Readmission Reduction Incentive Program Modeling							Improvement		Attainment		Final Adjustment	
HOSP ID	HOSPITAL NAME	RY 18 Permanent Inpatient Revenue	CYTD16 Case Mix Adj. Readmit Rate	CYTD18 Casemix adj. readmit rate	CYTD18 % Change Case mix adj. Rate	CYTD18 Case mix adj. rate adj. for out of state	TARGET	Percent Rev. Adj.	TARGET (35 <sup>th</sup> perc)	Percent Rev. Adj.	RY20 Better of Attainment/ Improvement	Percent Rev. Adj.
		A	B	C	D=C/B-1	E	F	G	H	I	J	K=J/A
210015	Franklin Sq	\$300,623,972	12.70%	12.92%	1.73%	12.96%	-4.51%	-0.59%	10.99%	-0.83%	-\$1,773,681.00	-0.59%
210016	Wash Adventist	\$158,337,604	11.23%	9.92%	-11.67%	11.25%	-4.51%	0.68%	10.99%	-0.11%	\$1,076,696.00	0.68%
210017	Garrett	\$21,075,334	5.76%	6.80%	18.06%	11.43%	-4.51%	-2.00%	10.99%	-0.19%	-\$40,043.00	-0.19%
210018	Montgomery	\$77,808,657	10.72%	10.99%	2.52%	12.41%	-4.51%	-0.67%	10.99%	-0.60%	-\$466,852.00	-0.60%
210019	PRMC	\$241,466,813	10.38%	11.02%	6.17%	11.68%	-4.51%	-1.02%	10.99%	-0.29%	-\$700,254.00	-0.29%
210022	Suburban	\$197,431,392	11.52%	10.59%	-8.07%	11.85%	-4.51%	0.34%	10.99%	-0.36%	\$671,267.00	0.34%
210023	AAMC	\$299,264,995	11.51%	11.36%	-1.30%	11.79%	-4.51%	-0.31%	10.99%	-0.34%	-\$927,721.00	-0.31%
210024	Union Mem	\$235,346,415	13.15%	11.52%	-12.40%	11.76%	-4.51%	0.75%	10.99%	-0.32%	\$1,765,098.00	0.75%
210027	Western Md	\$171,000,183	11.27%	10.44%	-7.36%	11.62%	-4.51%	0.27%	10.99%	-0.26%	\$461,700.00	0.27%
210028	St. Mary	\$76,303,058	11.32%	10.97%	-3.09%	13.17%	-4.51%	-0.14%	10.99%	-0.92%	-\$106,824.00	-0.14%
210029	Bayview	\$357,620,585	14.54%	13.65%	-6.12%	13.92%	-4.51%	0.15%	10.99%	-1.24%	\$536,431.00	0.15%
210030	Chestertown	\$21,139,936	14.11%	7.29%	-48.33%	7.96%	-4.51%	1.00%	10.99%	1.00%	\$211,399.00	1.00%
210032	Union Of Cecil	\$66,514,320	10.98%	10.35%	-5.74%	13.29%	-4.51%	0.12%	10.99%	-0.97%	\$79,817.00	0.12%
210033	Carroll	\$132,801,017	11.86%	11.73%	-1.10%	12.21%	-4.51%	-0.33%	10.99%	-0.52%	-\$438,243.00	-0.33%
210034	Harbor	\$112,526,840	11.95%	14.31%	19.75%	14.47%	-4.51%	-2.00%	10.99%	-1.48%	-\$1,665,397.00	-1.48%
210035	UM Charles	\$75,199,112	10.15%	9.95%	-1.97%	11.76%	-4.51%	-0.24%	10.99%	-0.33%	-\$180,478.00	-0.24%
210037	Easton	\$105,222,295	10.79%	9.29%	-13.90%	9.74%	-4.51%	0.89%	10.99%	0.52%	\$936,478.00	0.89%
210038	Midtown	\$117,217,727	15.60%	14.30%	-8.33%	14.49%	-4.51%	0.36%	10.99%	-1.48%	\$421,984.00	0.36%
210039	Calvert	\$63,677,722	10.12%	10.14%	0.20%	11.49%	-4.51%	-0.45%	10.99%	-0.21%	-\$133,723.00	-0.21%
210040	Northwest	\$133,828,758	13.11%	10.85%	-17.24%	10.91%	-4.51%	1.00%	10.99%	0.04%	\$1,338,288.00	1.00%

Draft Recommendations for the Readmissions Reduction Incentive Program for Rate Year 2021

RY 2021 Readmission Reduction Incentive Program Modeling							Improvement		Attainment		Final Adjustment	
HOSP ID	HOSPITAL NAME	RY 18 Permanent Inpatient Revenue	CYTD16 Case Mix Adj. Readmit Rate	CYTD18 Casemix adj. readmit rate	CYTD18 % Change Case mix adj. Rate	CYTD18 Case mix adj. rate adj. for out of state	TARGET	Percent Rev. Adj.	TARGET (35 <sup>th</sup> perc)	Percent Rev. Adj.	RY20 Better of Attainment/ Improvement	Percent Rev. Adj.
		A	B	C	D=C/B-1	E	F	G	H	I	J	K=J/A
210043	UM BWMC	\$229,151,792	13.03%	10.99%	-15.66%	11.15%	-4.51%	1.00%	10.99%	-0.07%	\$2,291,518.00	1.00%
210044	G.B.M.C.	\$225,145,722	10.54%	9.94%	-5.69%	10.19%	-4.51%	0.11%	10.99%	0.33%	\$742,981.00	0.33%
210045	McCready	\$3,033,907	11.81%	10.01%	-15.24%	10.01%	-4.51%	1.00%	10.99%	0.41%	\$30,339.00	1.00%
210048	Howard	\$183,348,539	11.49%	10.82%	-5.83%	10.99%	-4.51%	0.13%	10.99%	0.00%	\$238,353.00	0.13%
210049	UM-UCH	\$130,150,364	11.38%	10.60%	-6.85%	10.81%	-4.51%	0.22%	10.99%	0.07%	\$286,331.00	0.22%
210051	Doctors	\$144,686,192	12.15%	9.90%	-18.52%	11.15%	-4.51%	1.00%	10.99%	-0.07%	\$1,446,862.00	1.00%
210055	Laurel	\$58,931,276	11.73%	12.10%	3.15%	12.66%	-4.51%	-0.73%	10.99%	-0.71%	-\$418,412.00	-0.71%
210056	Good Sam	\$140,674,848	12.55%	13.27%	5.74%	13.34%	-4.51%	-0.98%	10.99%	-0.99%	-\$1,378,614.00	-0.98%
210057	Shady Grove	\$231,939,525	10.30%	9.97%	-3.17%	10.59%	-4.51%	-0.13%	10.99%	0.17%	\$394,297.00	0.17%
210058	UMROI	\$69,966,359	10.39%	6.99%	-32.72%	6.99%	-4.51%	1.00%	10.99%	1.00%	\$111,946.00	0.16%
210060	Ft. Washington	\$19,548,527	9.08%	8.13%	-10.46%	12.31%	-4.51%	0.57%	10.99%	-0.56%	\$111,427.00	0.57%
210061	AGH	\$37,316,219	8.84%	9.18%	3.85%	9.75%	-4.51%	-0.80%	10.99%	0.52%	\$194,044.00	0.52%
210062	Southern MD	\$163,844,003	11.14%	9.16%	-17.77%	12.40%	-4.51%	1.00%	10.99%	-0.60%	\$1,638,440.00	1.00%
210063	UM St Joes	\$237,924,618	10.95%	10.59%	-3.29%	10.74%	-4.51%	-0.12%	10.99%	0.10%	\$237,925.00	0.10%
210064	Levindale	\$56,105,767	11.80%	11.83%	0.25%	11.83%	-4.51%	-0.45%	10.99%	-0.35%	-\$196,370.00	-0.35%
210065	HC German	\$60,632,167	11.05%	12.03%	8.87%	12.36%	-4.51%	-1.27%	10.99%	-0.58%	-\$351,667.00	-0.58%
<b>STATEWIDE</b>		<b>\$9,222,204,362</b>	11.77%	-5.10%							<b>\$4,307,052.00</b>	

# **Draft Recommendation on Medicare Advantage Sequestration Adjustment**

December 12, 2018

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

This is a draft recommendation. Please submit comments on this draft to the Commission by Wednesday, December 19, 2018 via email to [katie.wunderlich@maryland.gov](mailto:katie.wunderlich@maryland.gov).

## **REQUEST**

On September 18, 2018, three Maryland Medicare Advantage plans (UM Health Advantage, Hopkins Advantage, and Cigna HealthSpring) requested that HSCRC make a formal determination regarding whether Medicare Advantage plans are permitted to take the two percent sequestration reduction from the final payments issued to Maryland hospitals. The Medicare Advantage Plans contend that the reduction is applicable, and that they should receive the benefit of the reduction in payments due to Maryland hospitals as a result of the Medicare sequestration. This report provides background and HSCRC staff's analysis, along with a draft recommendation that the Commission adopt a formal policy allowing Medicare Advantage plans to take the sequestration reduction on payments to hospitals made after January 1, 2019.

## **BACKGROUND**

On March 1, 2013, the President signed a sequestration order directing a series of across-the-board reductions in federal spending. The sequestration order included a two percent reduction in Medicare fee-for-service (FFS) payments, effective April 1, 2013. The Health Services Cost Review Commission voted to make no change in hospital rates in response to the sequestration.

Initially, the HSCRC deferred taking a position as to whether Medicare Advantage Organizations in Maryland were entitled to take the two percent reduction on payments to Maryland hospitals under the Medicare waiver. On April 17, 2014, the CMS Administrator wrote a letter to the American Hospital Association on this topic. The letter indicated that sequestration did not change fee schedules -- only the final payment. The letter indicated that payments to contracted providers are governed by the terms of the contract between the Medicare Advantage plan and the provider. As a result, a Medicare Advantage plan could only alter its contracted payment schedule by mutual agreement with the provider. On May 21, 2014, HSCRC issued a memorandum to hospital CFOs. Following the logic in the letter from the CMS Administrator, the HSCRC memorandum indicated that Medicare Advantage plans in Maryland may not alter their contracted payment schedule (HSCRC approved rates) with a hospital in Maryland in order to pass on the sequestration cuts unless its contract permits such an adjustment.

## **ANALYSIS**

Recently, the Maryland Medicare Advantage plans provided additional documentation to HSCRC regarding the sequestration discount, which included a memorandum dated March 22, 2013, from CMS regarding "Additional Information Regarding the Mandatory Payment Reductions in the Medicare Advantage, Part D, and Other Programs" (Attachment 1). Although dated prior to the CMS letter to the American Hospital Association, HSCRC staff was not aware of this documentation in 2014 when it issued its memorandum to hospital CFOs about this issue. The March 22, 2013 document informed Medicare Advantage plans that they are entitled to take the two percent sequestration reduction on the Medicare payable amount when the plan makes payments to providers not contracted with the plan because, by regulation, a non-contract provider must "accept FFS [fee-for-service] payment amounts as payment in full." The March

22 document was supplemented by a May 1, 2013 memorandum from CMS to Medicare Advantage Organizations (Attachment 2).

Given the differing direction from CMS regarding contracted versus non-contracted providers, HSCRC staff requests that the Commission adopt a formal policy regarding the availability of the two percent sequestration payment reduction for Medicare Advantage plans in Maryland. The health plans have indicated that the two percent reduction is being taken for other provider types (e.g., physicians, nursing homes, etc.) in Maryland, and that plans are applying the sequestration reduction outside of Maryland. Further, as part of CMS's Sequestration policy, premiums for Medicare Advantage plans were reduced by two percent.

Staff researched the status of the sequestration discount in other states. Apparently, the discrepancy between the treatment of contracted and non-contracted providers in other states also led to the need to adopt new policies. For example, a large health plan in North Carolina adopted a new policy that took effect in August 2015 after the discrepancy developed:

“Because Section 1854(a)(6)(B)(iii) of the Social Security Act puts the contractual arrangements between MAOs [Medicare Advantage Organizations] and their network providers largely beyond CMS's regulatory reach, CMS's Sequestration policy for MAOs did not directly effectuate or implement a 2% adjustment to the payments made by MAOs to their contracted providers for services supplied to members of Medicare Advantage plans administered by the MAOs. As a result, a discrepancy has developed between the reimbursement policies applied by CMS in the original Medicare program (i.e., Part A and Part B) and the reimbursement policies applied by MAOs in the Medicare Advantage program (i.e., Part C). To align the reimbursement policies applicable to provider payments made in connection with [the Health Plan's] Medicare Advantage plans with the Sequestration methodology applied to provider payments made by CMS in connection with Part A and Part B of Medicare, [the Health Plan] will reduce by 2% payments made to participating providers for items and services supplied to members of [the Plan's] Medicare Advantage plans. This policy will apply to payments made by [the Health Plan] for covered items and services supplied to members covered by [the Health Plan's] Medicare Advantage health plans. The Sequestration payment adjustment will be applied at the final payment level after all other edits, rules, and adjustments have been applied.”<sup>1</sup>

Similar to the situation that has required clarification and prospective policy adjustment in other states, the Maryland Medicare Advantage plans have called upon the Commission to resolve this matter formally.

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<sup>1</sup>[https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/medicare\\_sequestration\\_alignment\\_policy.pdf](https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/medicare_sequestration_alignment_policy.pdf)

Staff believes it is in the best interest of Maryland’s Medicare beneficiaries for the Commission to permit Medicare Advantage Plans to apply the two percent sequestration reduction on payments to Maryland hospitals consistent with the CMS requirement for non-contracted providers to “accept FFS [fee-for-service] payment amounts as payment in full.” Because HSCRC sets the rates to be paid by Medicare Advantage plans in Maryland, it is necessary for the Commission to adopt a formal policy. Medicare Advantage policies offer seniors enhanced benefits and services relative to Medicare fee-for-service options, and the approach offered by Medicare Advantage is consistent with the All-Payer and Total Cost of Care Models. Tightly managed patient care serves to reinforce the incentives for improving patient outcomes while controlling the total cost of providing that care. It should also be noted that Commission rate orders explicitly allow the 6 percent differential for both Medicare and Managed Care Organizations that contract with Medicare.

In sum, it is important to have Medicare Advantage plans available for seniors and other Medicare enrollees in Maryland. These plans offer a comprehensive package of services and pharmacy coverage for a low monthly premium. Plans also offer additional customer supports, such as care management supports for critically ill patients and help with managing chronic conditions as well as other supports to help enrollees stay healthier. Additionally, some plans offer supplemental benefits for vision and dental services.

Staff believes, therefore, that the Commission should be proactive in enhancing their presence in Maryland. Affording them the two percent sequestration reduction is consistent with CMS advice and with the goals of the Total Cost of Care Model; it is consistent with what other states do; it is consistent with how the HSCRC sets rates for Medicare recipients; and it is legally authorized under the Commission’s authority to set rates equitably among all purchasers of health care hospital services without undue discrimination. Staff recommends that this policy be implemented effective January 1, 2019.

Finally, when Medicare initiated the sequestration adjustment in 2013, the Commission adopted a policy to make no changes to hospital rates as a result of the sequestration. The staff recommends likewise that there be no adjustment to hospital rates as a result of sequestration amounts that would be taken by Medicare Advantage plans under the proposed policy recommendation.

## **RECOMMENDATION**

The HSCRC staff makes the following recommendations for Commission consideration.

1. That the Commission adopt a formal policy effective January 1, 2019, that permits Medicare Advantage plans to take a two percent sequestration reduction on the final payments due to Maryland hospitals for Medicare Advantage beneficiaries, so long as the sequestration continues in effect.

2. That the Medicare Advantage Plans be directed to apply the sequestration payment reduction at the final payment level after all other edits, rules, and adjustments have been applied, consistent with how Medicare applies the reduction.
3. Consistent with the Commission policy regarding the Medicare sequestration, there should be no adjustment to hospital approved rates or revenues as a result of the reduction taken by Medicare Advantage plans for the sequestration.

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Center for Medicare  
7500 Security Boulevard, Mail Stop C1-13-07  
Baltimore, Maryland 21244-1850



**MEDICARE PLAN PAYMENT GROUP**

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**DATE:** March 22, 2013

**TO:** All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, PACE Organizations, and Demonstrations

**FROM:** Cheri Rice /s/  
Director

**SUBJECT: Medicare Advantage Prescription Drug System (MARx) April 2013 Payment – INFORMATION**

This letter provides information about the April payment, which is scheduled for receipt on April 1, 2013, and other payment related items that may require plan action.

**Mandatory Payment Reductions in the Medicare Advantage and Part D Programs – “Sequestration”**

As required by law, President Obama issued a sequestration order on March 1, 2013 requiring a series of across-the-board reductions in Federal spending. The Administration continues to urge Congress to take prompt action to replace sequestration with balanced deficit reduction.

Beginning April 1, 2013, payments made to Medicare Advantage (MA) plans and Part D sponsors will generally be reduced by two percent in accordance with the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. For the MA and Part D programs, sequestration will be applied to payments associated with enrollment periods beginning on or after April 1, 2013. Certain payments are exempt from sequestration under the law, including the Low Income Premium Subsidy, Low Income Cost Sharing Subsidy, reinsurance, and amounts paid to plans on behalf of beneficiaries for premium amounts withheld from their Social Security checks.

CMS will report sequestration adjustments to plans on the Monthly Plan Payment Report. Adjustments will appear in the Special Adjustments section of the report with an Adjustment Type of “SEQ”.

**Premium Payment Option not changed from Social Security Administration (SSA) to Direct Bill**

CMS processed a data clean-up on the weekend of March 1, 2013 to correct an issue related to the Premium Payment Option (PPO) not changing from SSA withhold to Direct Bill for beneficiaries who elect to have premiums withheld but the election is not executed by SSA



within two months of accepting the CMS request. The premium periods involved in the clean-up are from March 2011 to June 2011. As a result of the clean-up, an affected beneficiary's PPO will be set to Direct Bill and the MARx User Interface will display the appropriate value.

Affected plans received corrected data in their normal Daily Transaction Reply Reports dated March 4 or 5, 2013 (plans would have received a TRC 144: PPO changed to Direct Bill), and should evaluate whether the data should be processed.

### **SSA Premium Withholding Limit Change**

SSA limits the amount of total Part C and D premiums that can be withheld from one benefit check, which may include retroactive amounts that could be due. Previously, that amount was \$200. Effective January 2013, SSA has raised the "safety net limit" to \$300.

### **Reconciliation of Plans That Terminated in 2011**

CMS conducts final reconciliations for terminated plans to settle amounts that were processed after their termination dates, including the final risk adjustment reconciliation for 2011 that was completed in December 2012, and the Coverage Gap Discount (CGD) reconciliation scheduled to be completed in May 2013. Once the CGD reconciliation is completed, CMS will begin processing final settlements. Plans should begin receiving the results of these settlements in July 2013.

### **End Stage Renal Disease (ESRD) Payment Discrepancies**

CMS has been notified that there has been a change in how ESRD status information is processed. Previously, the renal networks were responsible for inputting the 2728 forms into the ESRD system and CMS used the information to compute payment at the ESRD level. Effective May 2012, the ESRD facilities are responsible for inputting the 2728 forms into the ESRD system. If plans have issues with the ESRD status of their members, they should contact the facilities that are treating their members. Division of Payment Operations (DPO) staff are working with the CMS staff who oversee this process to address the ESRD cases that existed prior to May 2012.

### **Medicare Secondary Payer – Electronic Correspondence Referral System (ECRS) Changes**

The updates listed below have been made to the ECRS Web User Guide effective April 1, 2013.

- Chapter 1 has been added to provide an overview of all significant revisions to the ECRS Web User Guide.
- Chapter 6 (Prescription Drug Inquiry Transactions) was revised. The Insurance Company Name field on the Prescription Coverage page of the Prescription Drug Inquiry transaction is now a required field.
- The Prescription Drug Inquiry (PDI) Layout Detail Record was modified to show that the Insurance Company Name is now required on a PDI transaction.
- The values that are considered invalid Insurance Company Names have been revised. As of April 22, 2013, if the Insurance Company Name is blank or only contains one of the following values, then it is considered an error: ATTORNEY, BC, BCBS, BCBX, BLUE CROSS, BLUE SHIELD, BS, BX, CMS, COB, COBC, COORDINATION OF BENEFITS CONTRAC, HCFA, INSURER, MEDICARE, MISC, MISCELLANEOUS, N/A, NA, NO, NONE, SUPPLEMENT, SUPPLEMENTAL, UNK, XX, or UNKNOWN.

- New Action 'ID' has been added for Common Working File (CWF) Assistance Request records. This Action is to be used when asking the Coordination of Benefits Contractor (COBC) to investigate a possible duplicate Medicare Secondary Payer (MSP) record for deletion from the Common Working File (CWF). Note: Contractors should no longer use Action 'DR' to investigate possible duplicate MSP record for deletion from CWF. Action 'DR' should only be used when asking the COBC to investigate/redevelop a closed or deleted record.
- Action 'ID' cannot be submitted with any other Action codes.
- When Action 'ID' is submitted on a CWF Assistance Request and the COBC determines that a duplicate record exists, the MSP record will be deleted from CWF, and the CWF Assistance Request will be returned with a Status/Reason CM50.
- When Action 'ID' is submitted on a CWF Assistance Request and the COBC determines that a duplicate record does not exist, the CWF Assistance Request will be returned with a Status/Reason CM83. The response will include any relevant comments.
- The MSP Inquiry Additional Information page has been revised to prevent entering Diagnosis Codes when the MSP Type (entered on the MSP Information page) is A (Working Aged), B (ESRD), or G (Disabled).

The ECRS Web User Guide can be found at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html>.

If you have any questions about these ECRS changes, please contact:  
[Erica.Watkins@cms.hhs.gov](mailto:Erica.Watkins@cms.hhs.gov)

Please contact the appropriate DPO Representative (list attached) if you have any questions about the information in this letter or need assistance with other payment or premium related issues. Thank you.

cc: DPO Representatives  
Director, DPO  
MAPD Customer Support

**CENTERS FOR MEDICARE  
MEDICARE PLAN PAYMENT GROUP  
DIVISION OF PAYMENT OPERATIONS (DPO)  
REGIONAL REPRESENTATIVES – 2013**

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DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Center for Medicare  
7500 Security Boulevard, Mail Stop C1-13-07  
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**CENTER FOR MEDICARE**

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DATE: May 1, 2013

TO: Medicare Advantage Organizations  
Medicare Advantage-Prescription Drug Organizations  
Sections 1876 and 1833 Cost Contractors  
PACE Organizations  
Demonstrations  
Prescription Drug Plan Sponsors  
Employer/Union-Sponsored Group Health Plans  
Medicare-Medicaid Plans

FROM: Cheri Rice  
Director, Medicare Plan Payment Group

Danielle R. Moon, J.D., M.P.A.  
Director, Medicare Drug & Health Plan Contract Administration Group

**SUBJECT: Additional Information Regarding the Mandatory Payment Reductions in the Medicare Advantage, Part D, and Other Programs**

On March 22, 2013, the Centers for Medicare & Medicaid Services (CMS) released a memorandum notifying Medicare Advantage Organizations (MAOs), Part D plans, and other programs (including Managed Care Organizations) that, beginning April 1, 2013, payments made to MAOs, Part D sponsors, and other programs will generally be reduced by two percent in accordance with the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA), as amended. This process of payment reduction is referred to as sequestration. This memorandum provides additional information about the application of sequestration to the Medicare Advantage (MA) program, Part D, and other specified program payments.

**Calculation of Amount Being Sequestered**

In its March 22, 2013 memorandum, CMS explained that the two percent sequestration reduction will be applied to MA, Part D, and other program payments associated with enrollment periods beginning on or after April 1, 2013. CMS has received a number of questions asking for more details about how the sequestration applies to the MA, Part D, and other program payments.

Payments to all plans and plan types are subject to sequestration, including MAOs, Prescription Drug Plans, Sections 1876 and 1833 Cost Plans, Health Care Prepayment Plans, PACE plans, and demonstration plans of all types. The two percent reduction is applied to the Net Capitation Payment (NCP) made to plans. All non-exempt capitation payments are included in the NCP. For example, Part C Risk Adjusted payments (after MSP reduction) and MA rebates are included. For Part D, Direct Subsidy payments and Coverage Gap Discount payments are included. Part D payments for Low Income Subsidies and Reinsurance are exempt from sequestration and therefore not reduced.

Beginning April 1, 2013 (and for the duration of the sequestration period), prospective payments in the payment categories identified above are netted against adjustments to capitation payments for enrollment periods beginning or continuing in effect on or after April 1, 2013. The resulting NCP amount, whether positive or negative, is then multiplied by two percent to account for reductions that need to be made, and any reductions that were previously made for payments that are being adjusted (e.g., a retroactive disenrollment adjustment that is being processed for an enrollment payment that was previously reduced due to sequestration).

Only NCPs associated with enrollment periods beginning on or after April 1, 2013 are subject to sequestration. That means, for example, that the April 1, 2013 prospective payment made to a plan for members who were enrolled on April 1, 2013 is subject to the two percent reduction, but any payment adjustments to prospective payments made for those members for periods prior to April 1, 2013 are not subject to sequestration, even if those payment adjustments occur on or after April 1, 2013. Similarly, the 2012 final risk score reconciliation occurring later this year will not be affected by the sequester.

If there are any adjustments for periods that straddle April 1, 2013, the portion of the adjustment for the enrollment period starting on April 1, 2013 will be subject to sequestration. For example, if the State and County Code (SCC) for an enrollee changes for the May 1st payment and the SCC change is retroactive to January 2013, the portion of the adjustment relating to the January, February, and March payments will not be reduced due to the sequester, but the portion of the adjustment related to April payment will be reduced.

Cost Plans: The monthly payments made to Section 1876 and 1833 cost-based Managed Care Organizations (MCOs) are subject to sequestration in the same manner described above for MAOs. In addition, the reduction in payment will apply to the cost reports submitted by Sections 1876 and 1833 cost-based MCOs. The two percent reduction will be prorated based on the portion of the cost reporting period covered by the sequestration order, which became effective for Medicare programs on April 1, 2013. CMS will provide specific cost report preparation instructions at a later date.

Coverage Gap Discount Program (CGDP) Payments: Prospective CGDP payments from CMS to plans are subject to sequestration. Therefore, CMS will reduce the prospective CGDP payments by two percent. However, the actual discounts collected from the pharmaceutical manufacturers are not subject to sequestration. Because CMS is reducing payments associated with enrollment periods beginning April 1, 2013, any offsets that CMS makes for prospective CGDP payments made before April 1, 2013 are not subject to sequestration. CMS will make the

appropriate adjustments to the offset amount to reflect the required reductions, as well as to the prospective CGDP payment, when conducting the CGDP reconciliation for this time period.

Part D Risk Corridor Reconciliation: In accordance with Section 256(d) of BBEDCA, CMS will not take into account any reductions in prospective payment amounts due to sequestration for purposes of computing the Part D risk corridor reconciliation under section 1860D-15(e) of the Social Security Act. In other words, the “Target Amount” will not include any sequester reductions in prospective payments. In addition, Section 256(d)(7) of the BBEDCA exempts payments made under section 1860D-15(e)(2)(B) of the Social Security Act from sequestration. Therefore, any payment resulting from the Part D Reconciliation (i.e., payments made as a result of risk sharing) would not be subject to sequestration.

Electronic Health Records (EHR) Incentive Program Payments: Under section 256(d) of BBEDCA, incentive payments made under the EHR Incentive Program are subject to sequestration. Following the approach of applying sequestration to payments associated with enrollment periods beginning April 1, 2013, CMS will reduce the incentive payments by two percent when the last day of the EHR reporting period is on or after April 1, 2013. Note that the two percent reduction will be applied to the total incentive amount for that reporting period regardless of whether some of the EHR use accounted for in that reporting period occurred prior to April 1, 2013. The MA EHR incentive payments that CMS will make in June 2013 are for the 2012 reporting period and therefore will not be reduced due to sequestration.

### **Reducing Payments to Contracted Providers**

Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in the payment arrangements between MAOs and contract providers. The statute specifies that CMS “may not require any MA organization to...require a particular price structure for payment under such a contract...” Thus, whether and how sequestration might affect an MAO’s payments to its contracted providers are governed by the terms of the contract between the MAO and the provider. We note that MAOs must follow the prompt pay provisions established in their contracts with providers and to pay providers under the terms of those contracts (see 42 CFR sections 422.520(b)(1) and (2)). Similarly, the question of whether and how sequestration might affect a Part D plan sponsor’s payment to its contracted providers is governed by the payment terms of the contract between the plan sponsor and its network pharmacy providers. We note that Part D plan sponsors must follow the prompt pay provisions established in their contracts with network pharmacy providers and to pay the providers under the terms of those contracts (see 42 CFR sections 423.520(b)(1) and (2)).

### **Beneficiary Liability Under Sequestration**

Sequestration does not affect the basic and supplemental benefits offered by the MAO or Part D sponsor, nor does it change the plan’s approved premium or cost sharing requirements for CY 2013. As a result, MAOs and Part D sponsors are not permitted to modify the currently-approved benefit or cost sharing structure in any way. This includes increases in premiums or cost sharing, or reductions in benefits in an attempt to offset the lower payments due to sequestration.

## **Reducing Payments to Non-Contract Providers**

Pursuant to the Medicare regulations at 42 CFR § 422.214, a non-contract provider must accept, as payment in full, the amount that it could collect if the beneficiary were enrolled in the Medicare Fee-for-Service program. On March 8, 2013, CMS sent a bulletin titled “Mandatory Payment Reductions in the Medicare Fee-for-Service (FFS) Program – Sequestration” via the Medicare Learning Network. That bulletin provided the following guidance regarding how the reduction applies to payments under the Medicare FFS program (i.e., Part A and Part B):

In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will be reduced by 2 percent based upon whether the date-of-service or the start date for rental equipment or multi-day supplies is on or after April 1, 2013.

The claims payment adjustment shall be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.

Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare’s payment to beneficiaries for unassigned claims is subject to the 2 percent reduction.

For example, if a provider bills for a service with a Medicare approved amount of \$100.00 and \$50.00 is applied to the deductible, a balance of \$50.00 remains. Medicare FFS normally would pay 80 percent of the approved amount after the deductible is met, which is \$40.00 ( $\$50.00 \times 80 \text{ percent} = \$40.00$ ). The patient is responsible for the remaining 20 percent coinsurance amount of \$10.00 ( $\$50.00 - \$40.00 = \$10.00$ ). However, due to the sequestration reduction, 2 percent of the \$40.00 calculated payment amount is not paid, resulting in a payment of \$39.20 instead of \$40.00 ( $\$40.00 \times 2 \text{ percent} = \$0.80$ ).

MAOs may apply a similar process to determine the amount owed to a non-contract provider. The MAO should calculate the net payment owed to the non-contract provider by subtracting the member’s out-of-network (OON) cost-sharing amount from the total Medicare approved amount under FFS for that particular service. The minimum payment amount due to the non-contract provider would be equal to the net payment amount reduced by 2 percent due to sequestration. As an example, if a non-contract provider bills an MAO for a service with a FFS approved amount of \$100.00 and the member has a 20 percent OON cost-sharing obligation, the member would be responsible for paying the \$20 coinsurance amount ( $\$100 \times 20 \text{ percent} = \$20$ ) and the MAO would normally pay the non-contract provider \$80 ( $\$100 \times 80\% = \$80$ ). However, due to the sequestration reduction, the \$80.00 calculated payment amount would be reduced by 2 percent ( $\$80.00 \times 2 \text{ percent} = \$1.60$ ), resulting in a payment of \$78.40 instead of \$80.00 ( $\$80.00 - \$1.60 = \$78.40$ ).

We would note, however, that the requirement for a non-contract provider to accept FFS payment amounts as payment in full serves as a floor on MAOs' payments to these providers. As a result, it is at the MAOs' discretion as to whether to impose a reduction due to sequestration for these payments. Additionally, MAOs must continue to meet the prompt payment requirements for paying non-contract providers (see 42 CFR section 422.520(a)(3)).

If you have any questions about the guidance in the memorandum, please contact Jean Stiller at [Jean.Stiller@cms.hhs.gov](mailto:Jean.Stiller@cms.hhs.gov).



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# HSCRC Transformation Grants: Updates to the Commission

December 12, 2018



# Background of Regional Partnerships and Transformation Grants

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- ▶ **Proposals to address needs of particular geographic regions, often with hospitals partnering with neighbor hospital**
    - ▶ 14 partnerships representing 42 hospitals
    - ▶ \$37.0M awarded in FY 2017 (0.25% of global budget), with reductions of 10% each year through FY2020, while partnership investment should remain stable
  - ▶ **Successful awardees will reduce PAU and per capita costs, improve quality, and achieve a positive ROI, particularly for high-utilizing Medicare beneficiaries**
  - ▶ **Ongoing monitoring of partnership activities include:**
    - ▶ Biannual financial and narrative reports
    - ▶ Presentations to Commissioners
    - ▶ Presentations to Community, as in recent Population Health Summit
  - ▶ <sup>2</sup> Site visits
-

## Year 1 (FY 2017) of Transformation Grants

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- ▶ Partnerships submitted budgetary expenditure reports and narrative reports detailing Year 1 efforts.
  - ▶ Partnerships were allowed to roll over unspent funds in the first year, reflecting staffing and patient enrollment ramp ups for new programs
  - ▶ FY 2017 Awards budgetary expenditures were audited
- ▶ **Successes -**
  - ▶ Partnerships began serving patients with innovative interventions
  - ▶ Partnership-led Learning Collaborative to share best practices
  - ▶ CRISP work to provide actionable data to Partnerships

# Targeted Populations, Interventions, and Community Partners

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## ▶ Who:

- ▶ Medicare beneficiaries, and high-risk and high-utilizing individuals, often with multiple complex and chronic conditions
- ▶ Community partners including local health departments, provider organizations and community health workers, and behavioral health supports

## ▶ What:

- ▶ Behavioral health integration
- ▶ Care transitions
- ▶ Home-based care
- ▶ Mobile health
- ▶ Patient engagement and community education

## ▶ How:

- ▶ Multidisciplinary teams for care coordination and care management
- ▶ Using CRISP and Partnership data to identify targeted population and monitor patient outcomes

## Sample of Interventions

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### ▶ Multi-disciplinary teams -

- ▶ Healthcare Providers include: Physicians, RNs and CRNPs, CHWs, LCSWs
- ▶ Services include: Home assessments or rounding, longitudinal care planning, coordination of chronic condition management, connection with behavioral and social services, medication reconciliation, ED alternatives

### ▶ Behavioral Health Interventions –

- ▶ Transitional support team
- ▶ Expanded community capacity for mental health
- ▶ Integration of behavioral health in primary care

### ▶ Skilled Nursing Facility (SNF) Collaboratives -

- ▶ Sharing best practices and data trends between hospitals and SNFs within Partnerships' geography



# Year 2 (FY 2018) of Transformation Grants - Monitoring and Tools

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## ▶ Updates to FY 2018 Reporting Requirements

- ▶ HSCRC worked with CRISP and Partnership-led Learning Collaborative to update the Transformation Grant reporting template
- ▶ Enable HSCRC to evaluate across Partnerships' interventions for success

## ▶ CRISP Tools for Partnership Evaluation

- ▶ Analytic Files
- ▶ Total Cost of Care for Regional Partnerships
- ▶ Regional Partnership Executive Dashboard

# Executive Dashboard for Regional Partnerships

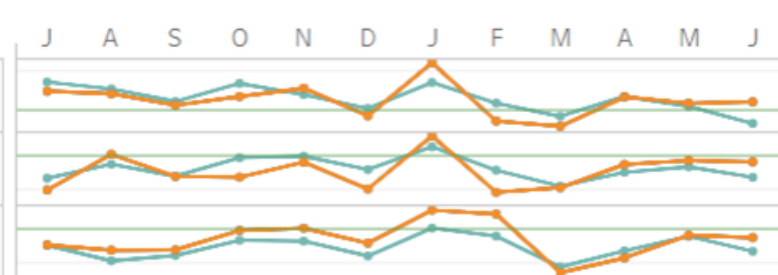
Month: 
 Regional Partnership: 
 Hospital Name: 
 Payer: 
 Legend: 
 

- .....Average
- Zero
- Hospital
- State

### Nexus Montgomery Utilization - June, 2018

Metric	Jun 17	Jun 18	Variance	
Total Hospital Charges	\$176,711,821	\$179,684,597	1.7%	
Inpatient Discharges	8,066	7,983	-1.0%	
Outpatient ED Visits	28,442	28,039	-1.4%	

### YTD Hospital Utilization

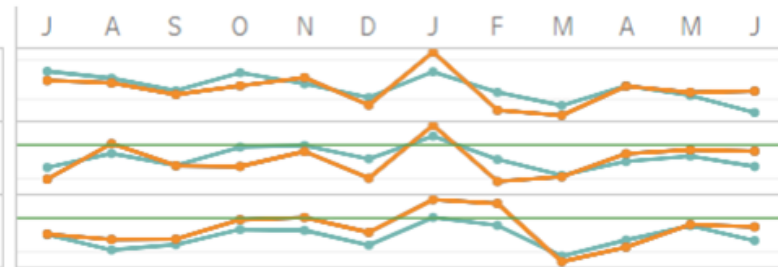


### Regional Partnership Per Capita Utilization - June, 2018

Per Capita Utilization at Selected Hospitals for Nexus Montgomery

Metric	Jun 17	Jun 18	Variance	
Hospital Charges per Capita	\$133	\$135	1.7%	
Hospital Discharges per 1000	6	6	-1.0%	
Outpatient ED Visits per 1000	21	21	-1.4%	

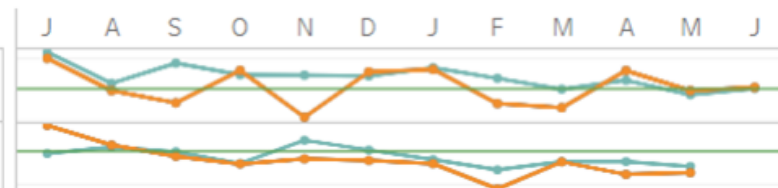
### Per Capita Utilization - Trends



### Nexus Montgomery Quality Indicators - June, 2018

Metric	Jun 17	Jun 18	Variance	
Potentially Avoidable Utilization	\$19,712,743	\$19,770,604	0.3%	
Unadjusted Readmission Rate by Hospital	10.6%	Null	Null	

### Nexus Montgomery Quality Indicator -Trends



# Year 2 (FY 2018) of Transformation Grants - Financial Update and Successes

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## Financial Update:

- ▶ In FY 2018, grant monies were reduced 10% in hospital rate orders to pass through some ROI to payers, per grant award terms (total \$33.3M)
  - ▶ Hospitals are still responsible to spend the full Year 1 award amount and compensate for the 10% award reduction
- ▶ HSCRC plans to adjust rates to remove unspent Partnership funds from FY 2018
- ▶ In FY 2019, these grant monies were further reduced to 20% below initial grant award (total \$29.6M)

## Successes:

- Partnership-level Process and Outcome Metrics
  - Reductions in Readmissions, PAU, ED Visits
  - Improved health outcomes for enrolled patients
- Individual reports are posted to the [website](#)



## FY 2019 Considerations

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- ▶ Better distinguish between successful and improving partnerships
- ▶ ROI measure and assessment of ongoing financial viability
- ▶ Prepare for FY 2020 and beyond
- ▶ Alignment with TCOC Model goals
- ▶ Moving the needle on population health targets will take time
  - ▶ Transformation Grants, in conjunction with infrastructure investments and TCOC Model components, including Care Redesign, the Maryland Primary Care Program, and statewide population health priorities, will work to improve population health for Marylanders



# PAU Discussion

December 12, 2018

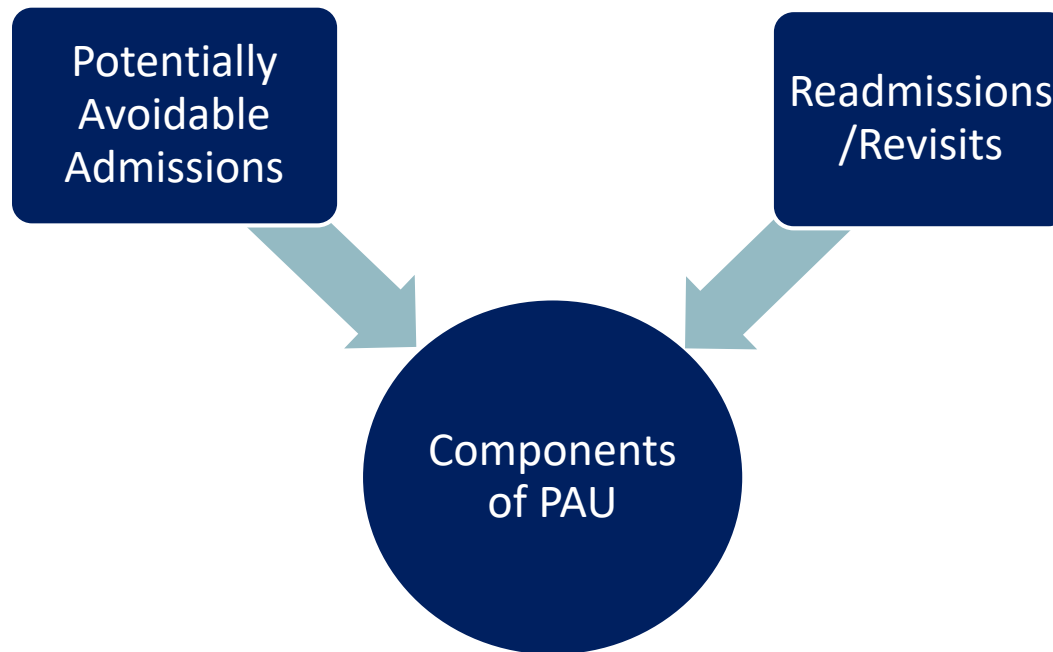
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# PAU Measure Discussion

# PAU: Purpose and Measure

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**Definition:** “Hospital care that is unplanned and can be prevented through improved care coordination, effective primary care and improved population health.”



HSCRC Calculates Percent of Revenue Attributable to PAU

# Current PAU measures

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## ▶ Revenue from Readmissions

- ▶ 30 day readmissions (inpatient and observation stays > 23 hours) at the receiving hospital
- ▶ Includes readmission clinical logic, such as excluding planned admissions

## ▶ Revenue from AHRQ Preventable Quality Indicators (PQIs)

- ▶ Hospitalizations from ambulatory-care sensitive conditions that may be preventable through effective primary care and care coordination.

### List of included PQIs (PQI version 6)

PQI 01 Diabetes Short-Term Complications

PQI 02 Perforated Appendix Admission

PQI 03 Diabetes Long-Term Complications Admission

PQI 05 COPD or Asthma in Older Adults Admission

PQI 07 Hypertension Admission

PQI 08 Heart Failure Admission

PQI 10 Dehydration Admission

PQI 11 Bacterial Pneumonia Admission

PQI 12 Urinary Tract Infection Admission

PQI 14 Uncontrolled Diabetes Admission

PQI 15 Asthma in Younger Adults Admission

PQI 16 Lower-Extremity Amputation among Patients with Diabetes

# Current use of PAU measures

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- ▶ **PAU Savings Program**
  - ▶ Statewide PAU
  - ▶ Hospital-specific scaling of savings adjustment
- ▶ **Market Shift**
- ▶ **Demographic Adjustment**
- ▶ **Consideration in Rate Reviews**

# Limitations and Considerations for Current PAU Measures

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- ▶ **PQI's are a per capita measure expressed against hospitals admissions**
  - ▶ Staff is working to reflect the correct denominator, i.e. population, in RY 2021 PAU savings policy
- ▶ **Readmissions are attributed to receiving hospital**
  - ▶ Original thought was to incentivize greater care coordination between hospitals and population health interventions. May have decoupled appropriate clinical link to readmissions.
  - ▶ Staff is working to change definition of PAU readmission measure in RY 2020 PAU savings policy to the sending hospital but with population as the denominator in the RY 2021 policy
- ▶ **Current measures only represent ~11% of total hospital revenue**
  - ▶ Staff is working to add pediatric PQI's in RY 2021 savings policy and will create monitoring tools for utilization metrics (low value care and broad utilization measures) that may be incorporated into future PAU policies.
    - ▶ Pediatric Avoidable Admissions measures are for asthma, diabetes, gastroenteritis, perforated appendix, urinary tract infection
  - ▶ Should staff consider additional measures, and if so what measures?

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# PAU Savings Program



# Potentially Avoidable Utilization (PAU) Savings at a glance

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## ▶ PAU Savings Concept

- ▶ The Global Budget Revenue (GBR) system assumes that hospitals will be able to reduce their PAU as care transforms in the state
- ▶ The PAU Savings Policy prospectively reduces hospital GBRs in anticipation of those reductions

## ▶ Mechanism

- ▶ Statewide reduction for each hospital is based on the PAU revenue received at the hospital in a prior year (not a rate!!!)
  - ▶ Example: In RY 2019, PAU revenue statewide was reduced on net by 2.89%, which equates to a total net revenue reduction of .30%.

	PAU Revenue	PAU Revenue Reduction	% Net Reduction*
Hospital A	\$39,638,600	-\$1,145,492	-2.89%
Hospital B	\$64,172,002	-\$1,854,469	-2.89%

# Summary of current methodology

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1

- Determine statewide % reduction in PAU revenue

2

- Calculate scaled revenue reductions for each hospital based on prior CY PAU revenue

3

- Apply protection for hospitals meeting certain criteria

4

- Apply adjustments to total hospital revenue



# PAU Methodology Considerations

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- ▶ How does staff move away from simply reducing PAU revenue to creating more variation in revenue adjustments based on performance, i.e. using rates?
- ▶ When moving to per capita approaches, what is the best way to attribute PQI's (numerator) as well as the population (denominator)? Should staff use existing attribution methodologies to better focus providers?
- ▶ Should staff further explore self-defined PAU and how would that affect the performance evaluation of other hospitals?

State of Maryland  
Department of Health



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**Health Services Cost Review Commission**

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**TO: Commissioners**

**FROM: HSCRC Staff**

**DATE: December 10, 2018**

**RE: Hearing and Meeting Schedule**

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January 9, 2019 To be determined - 4160 Patterson Avenue  
HSCRC/MHCC Conference Room

February 13, 2019 To be determined - 4160 Patterson Avenue  
HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:15 a.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at <http://hsrc.maryland.gov/Pages/commission-meetings.aspx>.

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