maryland
health services
cost review commission

602nd Meeting of the Health Services Cost Review Commission
January 11, 2023

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

EXECUTIVE SESSION
11:30 am

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

3. Update on Commission Response to COVID-19 Pandemic - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on December 14, 2022

2. Docket Status – Cases Closed
   2609A - Johns Hopkins Health System
   2610A - Johns Hopkins Health System

3. Docket Status – Cases Open
   2603R - Luminis Anne Arundel Medical Center
   2608R - Shady Grove Adventist Medical Center
   2611A - Johns Hopkins Health System
   2612A - Johns Hopkins Health System
   2613A - Johns Hopkins Health System

4. Confidential Data Request
   a. The University of Maryland School of Medicine (UMSOM) Shock Trauma and Anesthesiology Research Center, and the National Study Center for Trauma and EMS (NSC)
   b. The Johns Hopkins University (JHU) Center on Aging and Health

5. Report Extending the Readmission Reduction Incentive Policy

6. Quality Programs Performance Update
   a. Hospital Quality Program Exemption for FFY 2023
   b. Update on Population Health Quality Measure

7. Policy Update and Discussion
   a. Model Monitoring
   b. Commission Policy Overview
   c. Maryland Health Model Progression Plan Work Plan

8. Hearing and Meeting Schedule

Adam Kane, Esq
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

Stacia Cohen, RN, MBA

James N. Elliott, MD

Maulik Joshi, DrPH

Sam Malhotra

Katie Wunderlich
Executive Director

William Henderson
Director
Medical Economics & Data Analytics

Allan Pack
Director
Population-Based Methodologies

Gerard J. Schmith
Director
Revenue & Regulation Compliance

MINUTES OF THE
601st MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
December 14, 2022

Chairman Adam Kane called the public meeting to order at 11:40 am. In addition to Chairman Kane, in attendance were Commissioners Joseph Antos, PhD, Victoria Bayless, James Elliott, M.D., and Maulik Joshi, DrPH. Commissioner Sam Malhotra attended virtually. Upon motion made by Vice Chairman Antos and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:23 p.m.

STAFF UPDATE

Ms. Katie Wunderlich, Executive Director, announced that Amanda Vaughan, Associate Director Financial Data Administration, will be leaving the Commission. Ms. Wunderlich thanked Ms. Vaughan for all her dedicated work on behalf of the citizens of Maryland.

REPORT OF DECEMBER 14, 2022, CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the December 14, 2022, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE NOVEMBER 9, 2022, CLOSED SESSION, AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the November 9, 2022, Public Meeting and Closed Session.

ITEM II
CLOSED CASES

2589R - Shady Grove Adventist Medical Center
2601N - Luminis Doctors Community Medical Center
2609A- Johns Hopkins Health System
2610A- Johns Hopkins Health System

ITEM III
OPEN CASES\

2603R- Luminis Anne Arundel Medical Center

2608R- Shady Grove Adventist Medical Center
2611A- Johns Hopkins Health System
2612A- Johns Hopkins Health System
2613A- Johns Hopkins Health System

ITEM IV
RY 2025 MARYLAND HOSPITAL ACQUIRED CONDITIONS POLICY- FINAL RECOMMENDATION

Princess Collins, Chief, Quality Initiatives, presented staff's final recommendation on the Maryland Hospital Acquired Conditions Policy for RY 2025 (see "Final Recommendation for The Maryland's Hospital Acquired Conditions Policy for Rate Year 2025" available on the HSCRC website).

The quality programs operated by the HSCRC, including the Maryland Hospital Acquired Conditions program (MHAC), are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.

The MHAC program is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time.

The MHAC policy currently holds 2 percent of inpatient hospital revenue at-risk for complications that may occur during a hospital stay because of treatment rather than the underlying progression of disease. Examples of the types of hospital acquired conditions included in the current payment program are respiratory failure, pulmonary embolisms, and surgical-site infections.

This policy affects a hospital's overall GBR and so affects the rates paid by payers at that hospital. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital

The MHAC policy was redesigned in RY 2021 to modernize the program for the new Total Cost of Care Model. This RY 2025 draft recommendation, in general, maintains the measures and methodology that were developed and approved for RYs 2022 through 2024.

These are the final recommendations for the RY 2024 MHAC program:

1. Continue to use 3M Potentially Preventable Complications ("PPCs" to assess hospital acquired complications.
    - Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
    - Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.

- Engage hospitals on specific PPC increases as indicated/appropriate to understand trends and discuss potential quality concerns.

2. Use more than one year of performance data for small hospitals (i.e., less than 20,000 at-risk discharges and/or 20 expected PPCs). The performance period for small hospitals will be CYs 2022 and 2023.
3. Continue to assess hospital performance on attainment only.
4. Weigh the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.

Commissioner Elliott asked how the Staff determined the focused list of PPCs.

Ms. Collins noted that PPCs were chosen based on clinical significance, increased volume of observed events, and other additional factors.

Commissioner Elliott asked if a diabetes related PPC was included in the updated list.

Ms. Collins stated that a more encompassing diabetes measure is included in the PQIs.

Commissioner voted unanimously in favor of Staff's recommendation.

ITEM V
CY 2022 PERFORMANCE AND FINAL RECOMMENDATION ON ADJUSTMENTS TO MARYLAND TCOC PERFORMANCE

Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 8 months ending August 2022. Maryland's Medicare Hospital spending per capita growth was unfavorable when compared to the nation. Ms. Joyce noted that Medicare Nonhospital spending per-capita was trending closer to the nation. Ms. Joyce noted that Medicare Total Cost of Care (TCOC) spending per-capita was unfavorable when compared to the nation. Ms. Joyce noted that the Medicare TCOC guardrail position is 2.83% above the nation through August. Ms. Joyce noted that Maryland Medicare hospital and non-hospital growth through August shows a run rate erosion of $205,513,000.

CY 2022 Performance and Final Recommendation on Adjustments to Maryland TCOC Performance

Ms. Wunderlich presented Staff's draft recommendations on adjustments to Maryland Medicare TCOC performance (see "Final Recommendation on Adjustments to Maryland Medicare TCOC Performance" available on the HSCRC website)

The Commission is tasked with monitoring compliance of the TCOC Model contract agreement with CMMI, including attaining quality and population health targets and providing consistent savings to the Medicare program.

Staff is considering all-payer rate adjustments and Medicare-specific rate adjustments in recognition of the significant excess growth in Medicare costs in Maryland in calendar year 2022. Historically, the Commission has applied virtually all adjustments on an all-payer basis. The inclusion of Medicare-specific rate adjustments in the Staff's current draft recommendation is a recognition of the current challenge's size and timing, which requires that payers other than Medicare bear a more significant share of the shortfall given the challenge in the Medicare savings test. It does not represent a shift in the permanent focus of the Commission to adhere to an all-payer rate setting system. Moreover, the HSCRC remains committed to the goals and objectives of the Maryland TCOC Model to improve quality, reduce disparities, enhance access, and reduce costs for all Marylanders.

The TCOC Model builds on the successes of the All-Payer Model, a 5-year demonstration project with CMS, which began January 1, 2014, and ended December 31, 2018. The TCOC Model, which began on January 1, 2019, aims to control total healthcare costs, enhance the quality of care, and improve health by progressively transforming care delivery across the healthcare system.

While the All-Payer Model focused primarily on hospitals, the TCOC Model focuses on transforming care across the entire healthcare system. The Model will continue through 2028 so long as Maryland meets the following spending and quality requirements included in the TCOC State Agreement:

- Average annual hospital revenue growth per capita must stay at or below 3.58 percent on a cumulative basis since 2013;
- Annual savings in Maryland Medicare TCOC per Beneficiary must reach $120 million by (2019) and $300 million by 2023;
- The State's Medicare TCOC per Beneficiary growth cannot exceed national Medicare FFS growth by more than 1 percent in any given year or exceed the national growth two years in a row;
- The State must maintain the improvements made in specific hospital quality measures; and
- Ninety-five percent of in-state hospital regulated revenue must be under population-based budget agreements.

As of the end of CY 2021, Maryland successfully met all the annual spending requirements mandated under the State agreement, while 2020 to 2021 growth was above the nation (0.6%), i.e., Maryland's Medicare TCOC per beneficiary growth rate exceeded the nation by 0.60 percentage points. This resulted from very low trends in 2020 during the early stages of the COVID crisis, which drove a bounce-back in 2021.

Despite slightdissavings in CY 2021, the average per capita revenue growth of 3.08% from 2019 to 2021 is well below the 3.58% contractual limit. Maryland achieved $380 million in annual Medicare savings surpassing the $300 million annual savings requirement for Model Year 5.

Continued ripple effects from the COVID-19 pandemic, including unpredictable changes in utilization patterns and escalated costs in labor and supplies, have resulted in Maryland's growth rate exceeding the nation in CY 2021, and this trend, unfortunately, continues through CY 2022.

Ms. Wunderlich observed that Commission should remember the goals and principles of the Maryland Model when contemplating potential adjustments that would help the State get back into alignment with Cost growth. These goals and principles are as follows.

- **Broad Mandate** – Commission should consider actions that support the broad mandate of the Model to drive savings and cost growth reductions, appropriately fund hospital delivery to incentivize care transformation, and identify funding of population health efforts.
- **Recognition by State and Federal Partners** – Commission should advocate for state and federal consideration to support Model success and appropriate corrective actions
- **Balance All-Payer and Medicare-only savings tools** - Prioritize All-Payer tools to preserve the character of the Maryland Model, to the extent practicable
- **Balance Temporary vs. Permanent Adjustments** – While the 'miss' in 2022 appears to be attributable to a slower than expected national rebound, permanent policy adjustments should be considered if they contribute to long-term Model success.
- **Timing of Adjustments** – The corrective action should be implemented on January 1st to spread the disruption over the entire calendar year, understanding that additional steps can be taken during the July 2023 update factor discussion to ensure compliance.
- **Adhere to Implementation of Existing Policies** – Continue to implement existing policies, despite corrective action steps, to plan for long-term Model success.

Staff recommends proactive steps to mitigate the excess Medicare TCOC growth in Maryland that add to $100 million in Medicare savings. Staff believe that these steps are warranted to keep the State better aligned with national growth. Additional steps can be considered in July 2023 to ensure full compliance with the contractual obligations with CMMI.

Staff's final recommendations:

1. Staff recommends a permanent all-payer rate reduction of 0.40 percent that will be taken from the January rate orders across the board for global budget hospitals.
2. Staff recommends requesting an increase to the Public Payer Differential of 1 percent for the remainder of FY 2023 and the duration of FY 2024, as allowed under the terms of the State Model Agreement and contingent upon approval by CMMI.
3. Staff recommends implementation of the Medicare Performance Adjustment Savings Component of $50 million for global budget hospitals, scaled 25 percent according to statewide revenue and 75 percent according to the updated stand-in efficiency measure on a one-time basis; and
4. Staff recommends that the Commission send a formal request to the State to reduce the Medicaid Deficit Assessment by $50 million, contingent upon approval by the State Legislature.

Staff and Commissioners will continue to advocate to the State and federal government for additional allowances that can help the State meet the long-term goals and objectives of the Maryland Model.

Chairman Kane acknowledged the financial challenges faced by hospitals.

Chairman Kane stated that the recommendation is to make progress and generate savings aligned with the growth of national spending. He further stated that until Medicare recognizes inflation, the Commission must make decisions quickly to avoid intensifying corrective actions to the Update Factor in July 2023.

Dr. Steven Leonard, President & CEO, Tidal Health, emphasized the challenges that Tidal Health has faced recently, as its bond rating was downgraded for the first time since the 1970s.

Dr. Leonard said he supports tying rate reductions to inefficiency.

Dr. Leonard stated that the current Efficiency Policy unfairly penalizes rural hospitals and further noted the funding disparity between Baltimore City and rural areas.

Dr. Leonard stated his concern that until inefficient hospitals are identified, the Model's sustainability will continue to be challenging to maintain.

Ms. Tricia Roddy, Deputy Director, Medicaid, stated that Maryland is not an outlier to the Nation regarding hospitals' funding of Medicaid. Therefore, Maryland Medicaid supports an all-payer rate reduction rather than relying on adjustment to the back end.

Chairman Kane asked if Ms. Roddy had a sense that this year's Medicaid volumes were like last year's.

Ms. Roddy commented that volumes were lower this year than in the recent past and that she could provide further analysis.

Ms. Charlene MacDonald, Senior Vice President, Chief Government Affairs Officer, CareFirst, stated that the public payor differential recommendation is troubling as it undermines the all-payer nature of the TCOC model.

Ms. MacDonald stated that there are more complex topics to address, such as patient access, quality of care, improved outcomes, and alignment of supply and demand -- also expansion of the unregulated space hurts access for vulnerable populations who still rely on hospitals for care, while retained revenues dampen patient cost savings – a core tenet of the Model.

Ms. MacDonald emphasized that policy and payments must align for these difficulties to be addressed.

Commissioner Bayless asked how CareFirst would propose that the deficit be corrected if the adjustment to the public payer differential was not on the table.

Ms. MacDonald remarked that problems are not exclusive to Medicare only and should be addressed as an all-payer issue.

Chairman Kane posited that historically the Model has seen savings from reduced utilization and asked what payers are doing to control utilization in non-hospital settings.

Ms. MacDonald commented that CareFirst emphasizes care management inside and outside of the hospital and focuses on improving access to low-cost facilities.

Mr. John Miller, Executive Director, MidAtlantic Business Group on Health, supports the TCOC model and stated that corporations are also experiencing economic and financial challenges. Therefore, an increase in the public payer differential will trickle down to employees of these corporations, who will ultimately bear the weight of the cost.

Mr. David Johnson, Vice President, Bolton Health, stated that the public payer differential that shifts costs to commercial payors would shift the financial burden to employers who are already facing financial pressure. Mr. Johnson asked the Commission to consider the impact the spread between public and private payers would have on the individuals the Model seeks to protect.

Commissioner Elliott asked whether members of the MidAtlantic Business Group have benefited from the TCOC Model.

Mr. Johnson stated that lower premiums have had a positive effect, but this will no longer be the case if the differential is increased.

Chairman Kane asked if multistate employers see the difference in individual healthcare costs between Maryland and other states.

Mr. Miller s stated that multistate members prefer to negotiate with Virginia and D.C. because of the work done in Maryland to reduce costs.

Mr. Terry Forde, President and CEO, Adventist Health Care, noted a continued decline in operating margins across the system. Mr. Forde also noted that volume has increased compared to pre-pandemic numbers.

Mr. Forde stated that factors such as wage increases of 11%, $80 million spent in agency premiums, and reduced staffing capacity have contributed to the overall operating losses.

Chairman Kane asked Mr. Forde to expand on his comment on volume growth.

Mr. Forde stated that ambulatory care volumes have increased, which has improved physician coverage to underserved area populations that would otherwise have traveled outside of the state to receive care.

Mr. Bob Atlas, President and CEO, Maryland Hospital Association, supported the public payer differential increase.

Mr. Atlas stated that commercial insurers had achieved phenomenal earnings this year as private insurers in Maryland pay the second lowest price per capita in the nation.

Mr. Bret McCone, Senior Vice President, Health Care Payment, Maryland Hospital Association, stated the hospitals' support for the Medicare Performance Adjustment Savings Component recommendation.

Mr. Atlas stated his concern about instituting a permanent reduction based on what he characterized as an anomaly.

Commissioner Joshi asked which hospital services are at risk from a capacity standpoint.

Mr. Forde stated that non-core critical services, population health spend, physician support services, and diabetes care management would be the first to go.

Mr. Atlas stated that the original TCOC did not anticipate the government suppressing Medicare pricing. If Medicare does not grow its pricing, the Commission should evaluate how Maryland's cost differential compares to the rest of the nation.

Vice Chairman Antos stated that the impact and length of this emergency remain uncertain; therefore, the Commission must move forward with proposals and reevaluate in the next six months.

Commissioner Elliott put forth a motion to amend Staff's recommendation. Commissioner Elliott moved to reduce the all-payor reduction from 0.40 to 0.20 and increase the Medicare Performance Savings from $50 million to $64 million.

Commissioner Joshi added that all recommendations should be made temporary until there is more certainty regarding the future of the healthcare landscape.

Commissioners voted 5-1 in favor of the amendment to the recommendation. Commissioner Cohen , by proxy vote, dissented.

Commissioner Elliott put forth a motion to vote on the amended recommendation to reduce the all-payor reduction from $80 million to $40 million on a one-time basis and to increase the Medicare Performance Adjustment Savings Component from $50 million to $64 million while keeping the 1% increase to the Public Payor Differential and $50 million reduction to the Medicaid Deficit Assessment unchanged.

Commissioners voted 5-1 in favor of the revised recommendation. Commissioner Cohen, by proxy vote, dissented.

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ITEM VI
TRADITIONAL MPA – CY 2023 PERFORMANCE – DRAFT RECOMMENDATION

Mr. Willem Daniel, Deputy Director, Payment Reform, presented Staff's draft recommendation on the Medicare Performance Adjustment for CY 2023

The Medicare Performance Adjustment ("MPA") is a required element for the Total Cost of Care Model ("Model") and is designed to increase the hospital's individual accountability for TCOC in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area. In recognition of large risk borne by the hospitals collectively through the GBR, the MPA has a relatively low amount of revenue at risk (1 percent of Medicare fee-for-service revenue).

The MPA includes two "components": a Traditional Component, which holds hospitals accountable for the Medicare TCOC of an attributed patient population, and an Efficiency Component, which rewards hospitals for the care redesign interventions. These two components are added together and applied to the amount that Medicare pays each respective hospital. The MPA is applied as a discount to the amount that Medicare pays on each claim submitted by the hospital.

Currently, the HSCRC assigns patients to hospitals based on their geographic residence. In CY22, the Commission assigned patients to hospitals based on the hospital's Primary Service Areas ("PSAs") as designated in the original hospital GBR agreements. However, based on industry feedback, staff proposed to move towards a geographic algorithmic PSA Definition. For CY 2023, Staff recommends using the revised geographic attribution algorithm as follows:

- Hospitals are attributed the costs and beneficiaries in zip codes that comprise 60% of their volume. Beneficiaries in zip codes claimed by more than one hospital are allocated according to the hospital's share on equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMADs are calculated from Medicare FFS claims for Calendar Year 2019. ECMADs are also used in calculating the volumes in the 60% test.
- Zip codes not assigned to any hospital under step 1 are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed a 30-minute drive-time from the hospital's PSA.
- Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.
- An alternative attribution approach for the AMCs will be used, consistent with that approved for CY2022, where beneficiaries with a CMI of greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as the hospital under the standard attribution. AMCs will also have a geographic based attribution. Staff recommends that AMCs be assigned a set of zip codes based on a negotiation with the hospital, since the algorithm approach does not work as well for the AMCs.

Staff recommends three changes to the MPA for CY2023:

- Formalize the revision of the geographic attribution algorithm as described above.

- Eliminate the Supplemental MDPCP Adjustment; and
- Increase the weight placed on quality measures.

Once those changes are made, Staff recommends maintaining the MPA for CY2023 and CY2024, to create as much stability for hospitals as possible**.**

This is a draft recommendation, so no Commissioner action is required.

ITEM V1I
STATEWIDE INTEGRATED HEALTH IMPROVEMENT STRATEGY (SIHIS) OVERVIEW – 2021 PERFORMANCE

Dr. Alyson Schuster, Deputy Director, Quality Methodologies, and Ms. Erin Schurmann, Chief, Provider Alignment and Special Projects provided an overview of Statewide Integrated Health Improvement Strategy 2021 performance (see "Statewide Integrated Health Improvement Strategy Final 2021 Performance Review" available on the HSCRC website).

In 2019, the State of Maryland collaborated with the Center for Medicare and Medicaid Innovation (CMMI) to establish the domains of health care quality and delivery that the State could impact under the Total Cost of Care (TCOC) Model. The collaboration also included an agreed-upon process and timeline by which the State would submit proposed goals, measures, milestones, and targets to CMMI. As a result of the collaboration with CMMI, the State entered into a Memorandum of Understanding that required Maryland to provide a proposal for the Statewide Integrated Health Improvement Strategy (SIHIS) to CMMI by December 31, 2020. The SIHIS aligns statewide efforts across three domains that are interrelated and, if addressed successfully, have the potential to make significant improvement in not just Maryland's healthcare system, but in the health outcomes of Marylanders.

The statewide goals across the three domains are as follows:

- Hospital Quality
    a) Reduce avoidable admissions
    b) Improve Readmission Rates by Reducing Within-Hospital Disparities
- Care Transformation Goals
    a) Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models
    b) Improve care coordination for patients with chronic conditions
- Total Population Health Goals
    a) Priority Area 1 Diabetes: Reduce the mean Body Mass Index (BMI) for adult Maryland Residents
    b) Priority Area 2 Opioids: Improve Overdose Mortality
    c) Priority Area 3 Maternal and Child Health
        - ❖ Reduce severe maternal morbidity rate
        - ❖ Decrease asthma related ED visit rates for age 2-17

FY 2021 Performance results:

Hospital Quality

Reduce avoidable admission

- 25.19% Improvement

Improve Readmission Rates by Reducing Within-Hospital Disparities

- Given current trends through August 2022, 10 Maryland Hospital are on track to meet the 2026 target.

Care Transformation Goals

Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models

- 33.11% of Medicare TCOC under a Care Transformation Program
- 25.68% of Medicare Beneficiaries under a Care Transformation Program

Improve care coordination for patients with chronic conditions

- Maryland 70.07 (Milestone not met)
  National 67.68%

Total Population Health Goals

Priority Area 1 Diabetes: Reduce the mean Body Mass Index (BMI) for adult Maryland Residents

- Launched the Diabetes Prevention and Management Program track of the HSCRC Regional Partnership Catalyst Program.
- Incorporated a quality measure for all MDPCP practices requiring BMI measurement for all patients, and for patients with an elevated BMI, requiring documentation of a follow-up plan
- Expanded the CRISP Referral Tool to Regional Partnerships to increase patient referrals for Diabetes Prevention Programs.

Priority Area 2 Opioids: Improve Overdose Mortality

- Massachusetts, New Jersey, Delaware, and DC were selected as the cohort of states to serve as the synthetic control group to measure progress.
- Launched the Behavioral Health Crisis Programs track of the HSCRC RP
- Expanded Screening Brief Intervention and Referral to Treatment (SBIRT) to 200 practices participating in MDPCP

Priority Area 3 Maternal and Child Health

Reduce severe maternal morbidity rate

- Re-launched the Perinatal Quality Collaborative.
- Piloted a Severe Maternal Morbidity Review Process with eight Birthing hospitals
- Completed Maryland Maternal Strategic Plan.
- Launched MCH investments to support Medicaid/MCO and Public Health initiatives.

Decrease asthma related ED visit rates for age 2-17

- Obtained Population Projections.
- Developed Asthma Dashboard.
- Launched MCH investments to support Medicaid/MCO and Public Health initiatives.
- Incorporated asthma-related ED visit as a Title V State Performance Measure and shifted some of the Title V funds for asthma-related interventions.

ITEM VIII
HEARING AND MEETING SCHEDULE

January 11, 2023, Times to be determined- 4160 Patterson Ave
HSCRC Conference Room

February 8, 2023, Times to be determined- 4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:20 pm.

Closed Session Minutes
of the
Health Services Cost Review Commission

December 14, 2022

Upon motion made in public session, Chairman Kane 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

3. Update on Commission Response to the COVID-19 Pandemic – Authority General Provisions Article, §3-103 and §3-104

The Closed Session was called to order at 11:40 a.m.

In attendance in addition to Chairman Kane were Commissioners Antos, Bayless, Elliott, and Joshi. Commissioner Malhotra participated via conference call.

In attendance representing Staff were Katie Wunderlich, Jerry Schmith, Allan Pack, William Henderson, Geoff Dougherty, Will Daniel, Alyson Schuster, Ph.D., Bob Gallion, Erin Schurmann, and Megan Renfrew. Cait Cooksey participated via conference call.

Also attending were Eric Lindemann, Commission Consultant and Stan Lustman Commission Counsel. Ari Elbaum, Commission Counsel participated via conference call.

Item One

Eric Lindemann, Commission Consultant, updated the Commission and the Commission discussed Maryland Medicare Fee-For-Service TCOC versus the nation.

Item Two

William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, presented and the Commission discussed an analysis of Maryland hospitals' length-of-stay.

Item Three

Jerry Schmith, Principal Deputy Director, Revenue and Compliance, updated the Commission and the Commission discussed deregulation of hospital services.

Item Four

Megan Renfrew, Associate Director, External Affairs, updated the Commission and the Commission discussed the statutorily required Report on the development of a process to identify patients who paid for hospital services who may have qualified for fee care during the period 2017 through 2021.

The Closed Session was adjourned at 1:15 p.m.

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

AS OF DECEMBER 28, 2022

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Purpose	Analyst's Initials	File Status
2603R	Luminis Anne Arundel Medical Center	7/22/2022	FULL	KW	OPEN
2608R	Shady Grove Adventist Medical Center	7/18/2022	CAPITAL	GS	OPEN
2611A	Johns Hopkins Health System	12/16/2022	ARM	DNP	OPEN
2612A	Johns Hopkins Health System	12/23/2022	ARM	DNP	OPEN
2613A	Johns Hopkins Health System	12/23/2022	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: **THE APPLICATION FOR**	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2022**
SYSTEM	*	**FOLIO:**	**2421**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2611A**

Staff Recommendation

January 11, 2022

I. INTRODUCTION

Johns Hopkins Health System (the “System”) filed an application with the HSCRC on December 16, 2022, 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 continue to participate in a global rate arrangement for cardiovascular, joint replacement services and oncology evaluation services with Health Design Plus, Inc. The Hospitals request approval for a period of one year beginning February 1, 2023.

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

The staff found that the actual experience under this arrangement for the last year has

been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular, joint replacement, and oncology evaluation services for a one-year period commencing February 1, 2023. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2022
SYSTEM	*	FOLIO:	2422
BALTIMORE, MARYLAND	*	PROCEEDING:	2612A

Staff Recommendation

January 11, 2023

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on December 23, 2022, on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center ("the Hospitals") for approval to add a new heart transplant procedure to the existing global rate arrangement for solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers. The System requests that the approval for the new procedure be effective beginning February 1, 2023.

II. STAFF EVALUATION

Staff found that the experience under the original arrangement has been favorable over the last year.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application to add a new heart transplant procedure beginning February 1, 2023. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2023**
SYSTEM	*	**FOLIO:**	**2423**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2613A**

Staff Recommendation

January 11, 2023

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on December 23, 2022, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) to combine arrangements 2571A and 2583A into to a single arrangement. The new arrangement would include: bariatric surgery, Oncology surgical procedures, rectal surgery, spine surgery, thyroid parathyroid, joint replacement, neurosurgery procedures, VAD procedures, pancreas surgery, cardiovascular services, Musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, eating disorders, Cochlear implants, gall bladder surgery, and CAR-T. The approval would be for one year effective February 1, 2023.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

V. STAFF EVALUATION

Staff found the experience under this arrangement have been slightly unfavorable for the last year, however, staff believes that the Hospitals can achieve a favorable experience under this revised arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's' application for an alternative method of rate determination to include: bariatric surgery, Oncology surgical procedures, rectal surgery, spine surgery, thyroid parathyroid, joint replacement, neurosurgery procedures, VAD procedures, pancreas surgery, cardiovascular services, Musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, eating disorders, Cochlear implants, gall bladder surgery, and CAR-T to be effective for one-year beginning February 1, 2023. 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.

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Final Staff Recommendation for the Release of HSCRC Confidential Patient Level Data to

The University of Maryland School of Medicine (UMSOM) Shock Trauma and Anesthesiology Research Center, and the National Study Center for Trauma and EMS (NSC)

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

January 11, 2023

This is a final recommendation for Commission consideration at the January 11, 2023, Public Commission Meeting.

SUMMARY STATEMENT

The University of Maryland School of Medicine (UMSOM), and the National Study Center for Trauma and EMS (NSC), is requesting access to the Health Services Cost Review Commission (HSCRC) Inpatient and Outpatient Hospital data, that includes limited confidential information ("the Data") for the Injury Outcome Data Evaluation System (IODES).

OBJECTIVE

The IODES project is designed to make data related to injury available for analysis. The Data will be used for analysis of injuries to persons treated at Maryland hospitals. To fulfill a key component of the IODES effort, the Data will be linked (where possible) to police crash reports, EMS run sheets, and other datasets as required for further analysis. The NSC has been working with the Maryland Department of Transportation, Maryland Highway Safety Office (MDOT MDHSO) and other partners on the Crash Outcome Data Evaluation Systems (CODES) project for more than a decade.

Investigators received approval from the Maryland Department of Health (MDH) IRB on October 25, 2022, and the MDH Strategic Data Initiative (SDI) office on December 5, 2022. The Data will not be used to identify individual hospitals or patients. This project is designed as an umbrella project that will continue to address individual approved projects and tasks to improve the public health of Marylanders with injuries, and has no end date. However, the Project Principal Investigator will notify the HSCRC if the project were terminated, and at that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee is composed of representatives from HSCRC and the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements described below and to make recommendations for approval to the HSCRC at its monthly public meeting.

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

The Review Committee unanimously agreed to recommend that UMSON be given access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by UMSON for the Data for Calendar Year 2020 be approved.

2. This access will include limited confidential information for subjects meeting the criteria for the research.

Final Staff Recommendation for the Release of HSCRC Confidential Patient Level Data to The Johns Hopkins University (JHU) Center on Aging and Health

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

January 11, 2023

This is a final recommendation for Commission consideration at the January 11, 2023, Public Commission Meeting.

SUMMARY STATEMENT

The Johns Hopkins University (JHU) Center on Aging and Health is requesting access to Health Services Cost Review Commission (HSCRC) Inpatient and Outpatient Hospital data ("the Data") through CRISP, containing limited confidential information to conduct a study looking at whether increased social engagement in Experience Corps examined in the Baltimore Experience Corps Trial (BECT), led to long-term reductions in medical care expenditures, as well as, lower risk for Alzheimer's disease, physical frailty, and mortality.

OBJECTIVE

The BECT was the first large-scale, randomized trial of 702 older adults to show that productive social engagement (as volunteers in elementary schools) increased lifestyle activity, generative purpose, and improved cognition and brain biomarkers for Alzheimer's disease over two years of exposure. JHU is submitting a panel of patients to CRISP to append case mix data for those in the study. Investigators received approval from the Maryland Department of Health (MDH) IRB on September 1, 2022, and the MDH Strategic Data Initiative (SDI) office on December 16, 2022. The Data will not be used to identify individual hospitals or patients. The Data will be retained by JHU until September 12, 2027; at that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee is composed of representatives from HSCRC and the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements described below and to make recommendations for approval to the HSCRC at its monthly public meeting.

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

The Review Committee unanimously agreed to recommend that JHU be given access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by JHU for the Data for Calendar Year 2013 through 2022 be approved.

2. This access will include limited confidential information for subjects meeting the criteria for the research.

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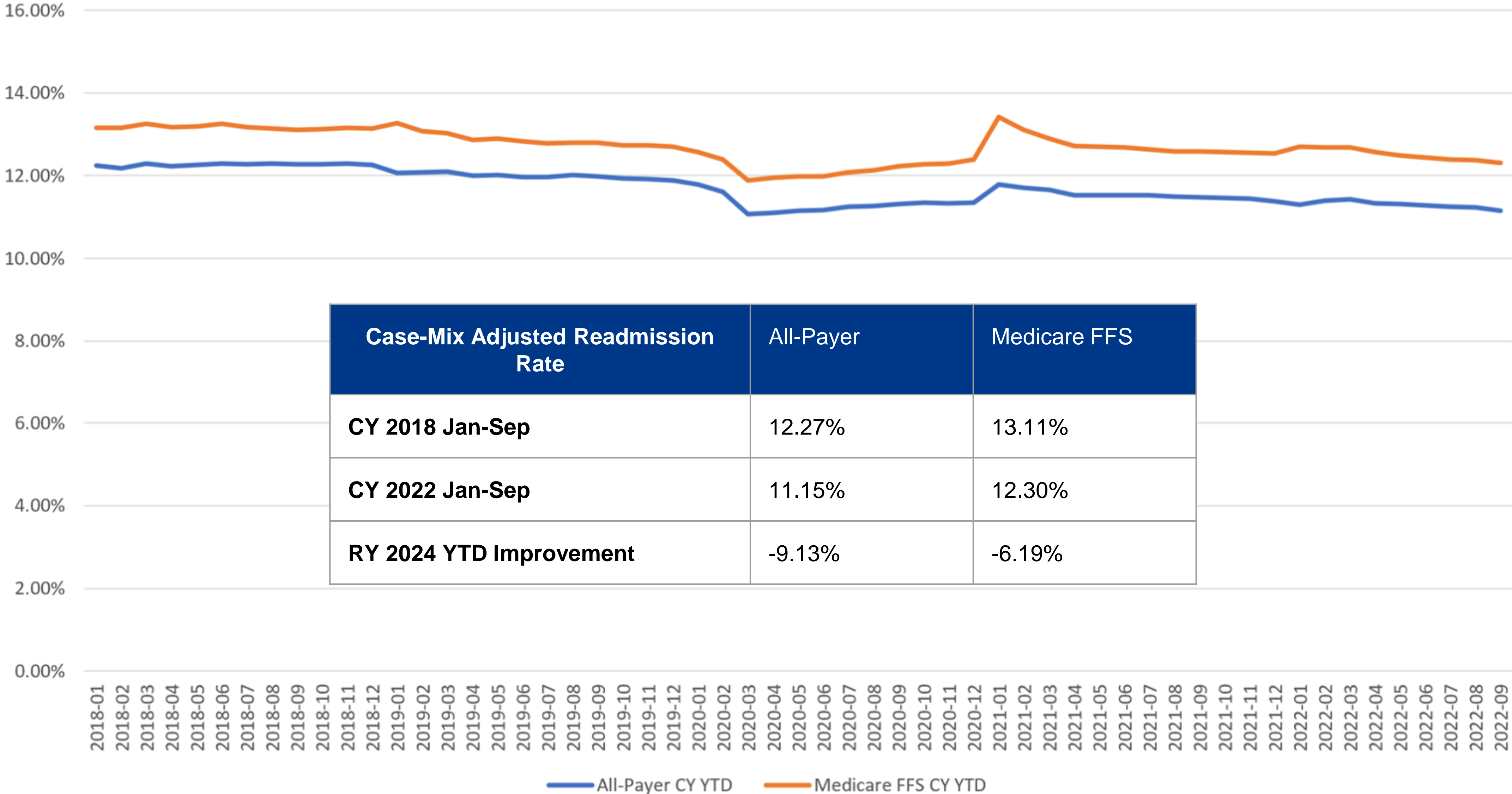
Report Extending the Readmission Reduction Incentive Program for Rate Year 2025

January 11, 2023



Case-Mix Adjusted Readmission Rate	All-Payer	Medicare FFS
CY 2018 Jan-Sep	12.27%	13.11%
CY 2022 Jan-Sep	11.15%	12.30%
RY 2024 YTD Improvement	-9.13%	-6.19%

Final RY 2023 RRIP Recommendations for RY 2025

1. Maintain the 30-day, all-cause readmission measure.
2. **Improvement Target** - Maintain the RY 2022 statewide 5-year improvement target of -7.5 percent from 2018
3. **Attainment Target -** Maintain the attainment target whereby hospitals at or better than the 65th percentile statewide performance receive scaled rewards for low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in **within-hospital readmission disparities**. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years, capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
6. Continue development of an all-payer **Excess Days in Acute Care** measure in order to account for readmission, emergency department, and observation revisits post-discharge.
7. Adjust the RRIP pay-for-performance program methodology as needed due to **COVID-19 Public Health Emergency** and report to Commissioners.

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Report Extending the Readmission Reduction Incentive Program for Rate Year 2025

January 11, 2023

This document extends the final staff recommendations for the Readmission Reduction Incentive Program, which was approved by the Commission on Jan 13, 2021, to RY 2025.

Introduction

With the commencement of the Total Cost of Care (TCOC) Model Agreement on January 1, 2019, the performance standards and targets in HSCRC's portfolio of quality and value-based payment programs have been reviewed and updated. In CY 2019, staff focused on the rate year (RY) 2022 RRIP program and convened a subgroup with clinical and measurement experts who made recommendations that were then further evaluated by the Performance Measurement Workgroup (PMWG). The RRIP subgroup and PMWG considered updated approaches for reducing readmissions in Maryland to support the goals of the TCOC Model. Specifically, the workgroup evaluated Maryland hospital performance relative to various opportunity analyses, including external national benchmarks, and developed a 5-year improvement target (2018-2023). In addition, the staff developed a within-hospital disparities metric for readmissions, which makes Maryland the first State in the nation for establishing a payment incentive that rewards hospitals that meet or surpass a specified disparity reduction goal. The readmission disparity incentive is linked with the Statewide Integrated Health Improvement Strategy (SIHIS) goal to have half of hospitals improve disparities by 50 percent.

The RY 2023 final recommendation, in general, maintained the measure updates and methodology determinations that were developed and approved for RY 2022.[1] For RY 2024 the RY 2023 policy was extended with no significant changes. As discussed below, the staff are recommending that the Commission extend the policy again for RY 2025.

Assessment

The RY 2025 performance period will be the final year of the 7.5 percent 5-year improvement goal from 2018. This improvement target, if met, would put Maryland's readmission at approximately the 75th percentile of national readmissions based on the CY 2018 benchmarking analysis. Through CY 2021, the state achieved almost a 9 percent improvement in the case-mix adjusted readmission rate compared to CY 2018. While this rate surpasses the current statewide goal,

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[1] See the RY 2022 policy for detailed discussion of the RRIP redesign, rationale for decisions, and approved recommendations

only half of the hospitals had an improvement that exceeds 7.5 percent and there are still concerns that lower utilization due to COVID may be impacting these rates.

Even though the State continues to make progress on the long-term goal of readmission rate reduction, in CY 2021, Maryland failed to be equal to or less than the national unadjusted, all-cause Medicare Readmission Rate, due in part to COVID-19 exogenous factors for which CMMI granted an exception. Staff continues to discuss with CMMI the opportunity to transition to a risk-adjusted readmission measure to more accurately reflect the work that is done in Maryland under the TCOC Model, which over time will increase the acuity of hospital admissions and thus make matching national performance on an unadjusted readmission measure infeasible. Based on staff analysis using the Medicare CCW data, in CY 2021, Maryland Medicare beneficiaries who were admitted to the hospital had a statistically significant lower odds of being readmitted than National Medicare beneficiaries.

Based on this performance, staff discussed with Performance Measurement Workgroup whether the improvement and attainment standards should be updated for RY 2025 (i.e., earlier than planned based on the 5-year improvement target). After these discussions, staff elected to maintain the methodology and performance standards developed in RY 2022 and then defer future development, e.g., a new improvement target, to the RY 2026 policy. The RY 2023 final policy is included in the appendix.

Recommendations

The final recommendations, as approved by the Commission for RY 2023 and extended to RY 2024, will continue for RY 2025 and are summarized here:

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the RY 2022 approved statewide 5-year improvement target of -7.5 percent from 2018 base period.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue,

5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years, capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
6. Continue development of an all-payer Excess Days in Acute Care measure in order to account for readmission, emergency department, and observation revisits post-discharge.
7. Adjust the RRIP pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report to Commissioners.

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Appendix: RY 2023 Final Policy

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Final Recommendation for the Readmission Reduction Incentive Program for Rate Year 2023

January 13, 2021

This document contains the final staff recommendations for the Readmission Reduction Incentive Program and was approved by the Commission on Jan 13, 2021.

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List of Abbreviations

ADI	Area Deprivation Index
AMA	Against Medical Advice
APR-DRG	All-patient refined diagnosis-related group
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
CRISP	Chesapeake Regional Information System for Our Patients
CY	Calendar year
eCQM	Electronic Clinical Quality Measure
EDAC	Excess Days in Acute Care
FFS	Fee-for-service
HCC	Hierarchical Condition Category
HRRP	Hospital Readmissions Reduction Program
HSCRC	Health Services Cost Review Commission
HWR	Hospital-Wide Readmission Measure
MCDB	Medical Claims Database
MPR	Mathematica Policy Research
MSA	Metropolitan Statistical Area
NQF	National Quality Forum
PAI	Patient Adversity Index
PMWG	Performance Measurement Workgroup
PQI	Prevention Quality Indicators
RRIP	Readmissions Reduction Incentive Program
RY	Rate Year
SIHIS	Statewide Integrated Healthcare Improvement Strategy
SOI	Severity of illness
TCOC	Total Cost of Care
YTD	Year-to-date

Key Methodology Concepts and Definitions

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.

Prevention Quality Indicator (PQI): a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Area Deprivation Index (ADI): A measure of neighborhood deprivation that is based on the American Community Survey and includes factors for the theoretical domains of income, education, employment, and housing quality.

Patient Adversity Index (PAI): HSCRC developed composite measure of social risk incorporating information on patient race, Medicaid status, and the Area Deprivation Index.

Excess Days in Acute Care (EDAC): Capture excess days that a hospital’s patients spent in acute care within 30 days after discharge. The measures incorporate the full range of post-discharge use of care (emergency department visits, observation stays, and unplanned readmissions).

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The quality programs operated by the Health Services Cost Review Commission, including the Readmission Reduction Incentive Program (RRIP), are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.	The RRIP policy is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time.	The RRIP policy currently holds 2 percent of hospital revenue at-risk for readmissions occurring within 30-days of discharge for all payers and all causes. Specific criteria for inclusion (oncology discharges) and exclusion (discharges leaving Against Medical Advice, Planned Admissions) are detailed in Appendix I.	This policy affects a hospital's overall GBR and so affects the rates paid by payers at that particular hospital. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	Currently, the RRIP policy measures within-hospital disparities in readmission rates, using an HSCRC-generated Patient Adversity Index (PAI), and provides rewards for hospitals that meet specified disparity gap reduction goals. The broader RRIP policy continues to reward or penalize hospitals on the better of improvement and attainment, which incentivizes hospitals to improve poor clinical outcomes that may be correlated with health disparities. It is important that persistent health disparities are not made permanent. Moving forward, the assessment of performance may evolve the existing PAI measure, and the reward structure for improvements in within-hospital disparities in readmission rates.

Recommendations

The RRIP policy was redesigned in Rate Year (RY) 2022 to modernize the program for the Total Cost of Care Model. This RY 2023 final recommendation, in general, maintains the measure updates and methodology determinations that were developed and approved for RY 2022.[2]

These are the final recommendations for the RY 2023 Readmission Reduction Incentive Program (RRIP) policy:

1. Maintain the 30-day, all-cause readmission measure.
    a. Remove Pediatric Oncology cases, in accordance with the intention of the oncology readmission measure.

[2] See the RY 2022 policy for detailed discussion of the RRIP redesign, rationale for decisions, and approved recommendations

2. Improvement Target - Maintain the RY 2022 approved statewide 5-year improvement target of -7.5 percent from 2018 base period.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile statewide performance receive scaled rewards for maintaining low readmission rates.
4. For improvement and attainment, increase the maximum reward hospitals can receive to 2 percent of inpatient revenue and maintain the maximum penalty at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years (>=15.91 percent reduction in disparity gap measure 2018 to 2021), capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years (>=29.29 percent reduction in disparity gap measure 2018 to 2021).
6. Continue development of an all-payer Excess Days in Acute Care measure in order to account for readmission, emergency department, and observation revisits post-discharge.
7. Adjust the RRIP pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report to Commissioners as follows:
    a. For RY 2022 (CY 2020 performance period)
        i. Exclude COVID-19 positive cases from the program.
        ii. Exclude the data for January to June 2020; evaluate whether to use the final six months of 2020 or whether to use a prior time period.
        iii. Evaluate case-mix adjustment and performance standards concerns arising from use of a pre-COVID time period to determine normative values.
    b. For RY 2023 (CY 2021 performance period) include COVID-19 positive cases but retrospectively assess any case-mix concerns, including the use of a pre-COVID time period to determine normative values.

Introduction

Since 2014, Maryland hospitals have been funded under a global budget system, which is a fixed annual revenue cap that is adjusted for inflation, quality performance, reductions in potentially avoidable utilization, market shifts, and demographic growth. Under the global budget system, hospitals are incentivized to transition services to the most appropriate care setting and may keep savings that they achieve via improved health care delivery (e.g., reduced avoidable utilization, such as readmissions or hospital-acquired infections). It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) Quality programs reward quality improvements that reinforce the incentives of the global budget system, while penalizing poor performance and guarding against unintended consequences.

The 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 currently holds up to 2 percent of inpatient hospital revenue at-risk in penalties and up to 1 percent at-risk in rewards based on improvement and attainment in case-mix adjusted readmission rates. In addition, the RRIP is the first quality policy to provide incentives for reducing disparities by rewarding hospitals up to 0.5 percent of inpatient hospital revenue for reducing within-hospital disparities in readmissions.

With the commencement of the Total Cost of Care (TCOC) Model Agreement on January 1, 2019, the performance standards and targets in HSCRC's portfolio of quality and value-based payment programs have been reviewed and updated. In CY 2019, staff focused on the RRIP program and convened a subgroup with clinical and measurement experts who made recommendations that were then further evaluated by the Performance Measurement Workgroup (PMWG). The RRIP subgroup and PMWG considered updated approaches for reducing readmissions in Maryland to support the goals of the TCOC Model. Specifically, the workgroup evaluated Maryland hospital performance relative to various opportunity analyses, including external national benchmarks, and staff developed a within-hospital disparities metric for readmissions in consultation with the workgroup.

Background

Brief History of RRIP program

Maryland made incremental progress each year throughout the All-Payer Model (2014-2018), ultimately achieving the Model goal for the Maryland Medicare FFS readmission rate to be at or below the unadjusted national Medicare readmission rate by the end of Calendar Year (CY) 2018. Maryland had historically performed poorly compared to the nation on readmissions; it ranked 50th among all states in a study examining Medicare data from 2003-2004.[3] In order to meet the All-Payer Model requirements, the Commission approved the RRIP program in April 2014 to further bolster the incentives to reduce unnecessary readmissions.

As recommended by the Performance Measurement Workgroup, the RRIP is more comprehensive than its federal counterpart, the Medicare Hospital Readmission Reduction Program (HRRP), as it is an all-cause measure that includes all patients and all payers.[4]

In Maryland, the RRIP methodology evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges (such as planned readmissions) from consideration, due to data issues and clinical concerns. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR-DRG) severity of illness (SOI), and the policy determines a hospital's score and revenue adjustment by the better of improvement or attainment, with scaled rewards of up to 1 percent of inpatient revenue and scaled penalties of up to 2 percent.[5]

RRIP Redesign

As part of the ongoing evolution of the All-Payer Model's pay-for-performance programs to further bring them into alignment under the Total Cost of Care Model, HSCRC convened a work group in CY 2019 to evaluate the Readmission Reduction Incentive Program (RRIP). The work group consisted of stakeholders, subject matter

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[3] 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.

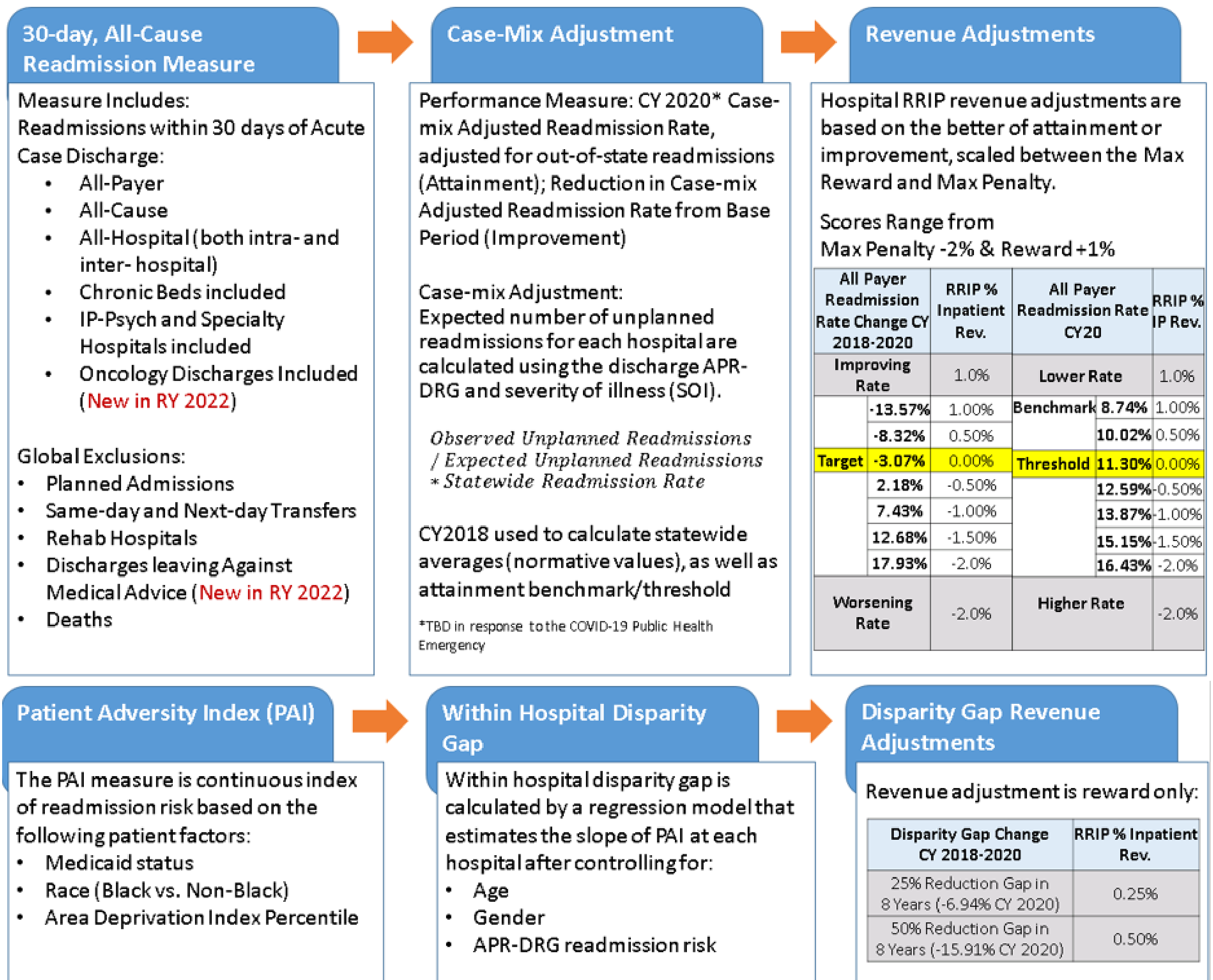
[4] For more information on the HRRP, please see: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program. Maryland remains exempted from the federal HRRP.

[5] See Appendix I for details of the current RRIP methodology.

experts, and consumers, and met six times between February and September 2019. The work group focused on the following six topics, with the general conclusions summarized below:

1. Analysis of Case-mix Adjustment and trends in Eligible Discharges over time to address concern of limited room for additional improvement;
    - Case-mix adjustment acknowledges increased severity of illness over time
    - Standard Deviation analysis of Eligible Discharges suggests that further reduction in readmission rates is possible
2. National Benchmarking of similar geographies using Medicare and Commercial data;
    - Maryland Medicare and Commercial readmission rates and readmissions per capita are on par with the nation
3. Updates to the existing All-Cause Readmission Measure;
    - Remove Eligible Discharges that left against medical advice (~7,500 discharges)
    - Include Oncology Discharges with more nuanced exclusion logic
        - Additionally, remove pediatric oncology cases from readmission eligibility
    - Analyze out-of-state ratios for other payers as data become available
4. Statewide Improvement and Attainment Targets under the TCOC Model;
    - 7.5 percent Improvement over 5 years (2018-2023)
    - Ongoing evaluation of the attainment threshold at 65th percentile
5. Social Determinants of Health and Readmission Rates; and
    - Methodology developed to assess within-hospital readmission disparities
6. Alternative Measures of Readmissions
    - Further analysis of per capita readmissions as broader trend; not germane to the RRIP policy because focus of evaluation is clinical performance and care management post-discharge
    - Observation trends under the All-Payer Model to better understand performance given variations in hospital observation use; future development will focus on incorporation of Excess Days in Acute Care (EDAC) measure in lieu of including observations in RRIP policy
    - Electronic Clinical Quality Measure (eCQM) may be considered in future to improve risk adjustment

Figure 1. Overview Rate Year 2022 RRIP Methodology



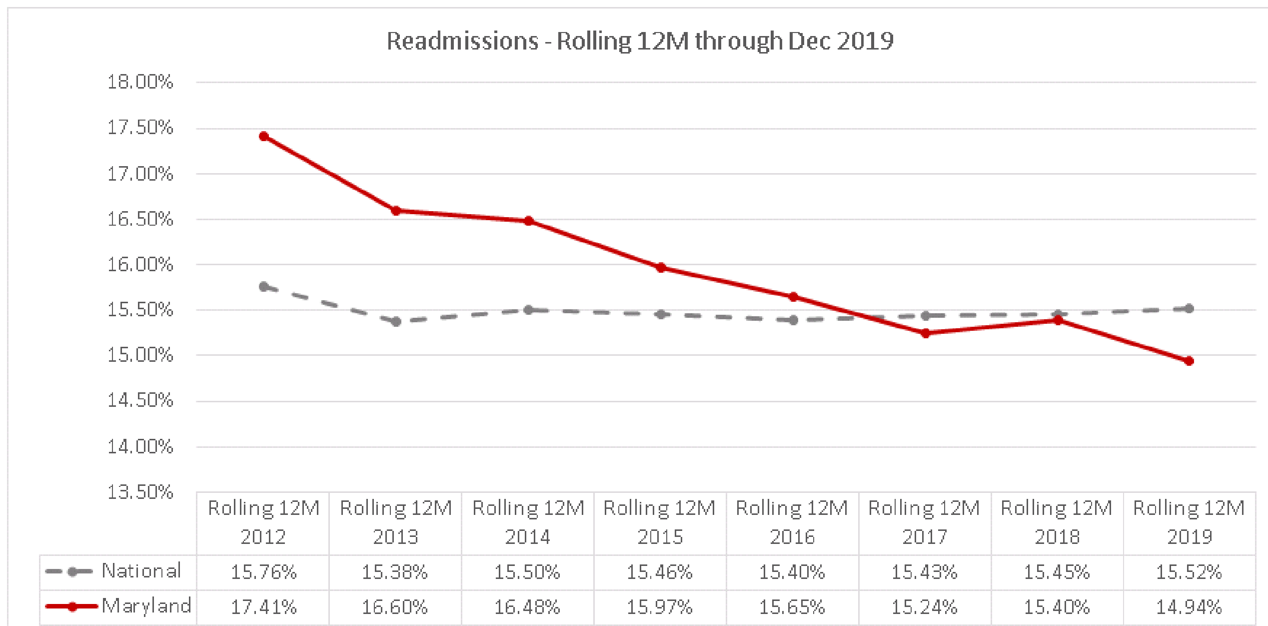
Assessment

In general, stakeholders support the staff's recommendation to not make major changes to the RY 2023 RRIP program. This section of the report provides an overview of the data and issues discussed by the PMWG, including analysis of CY 2019 statewide readmission rates, estimated hospital scores, and revenue adjustment modelling. Staff has not included CY 2020 YTD readmission rates due to the ongoing COVID-19 Public Health Emergency (see more below).

Statewide Readmissions Performance

In CY 2019, Maryland improved upon its All-Payer Model achievement of being at or below the National Medicare FFS Rate. In CY 2018 at the conclusion of the All-Payer Model, Maryland had an unadjusted Medicare readmission rate of 15.40%, compared to the national rate of 15.45%. Through CY 2019, Maryland further improved its readmission rate, concluding the year with a rate of 14.94% compared to the national rate of 15.52% (see Figure 2 below).

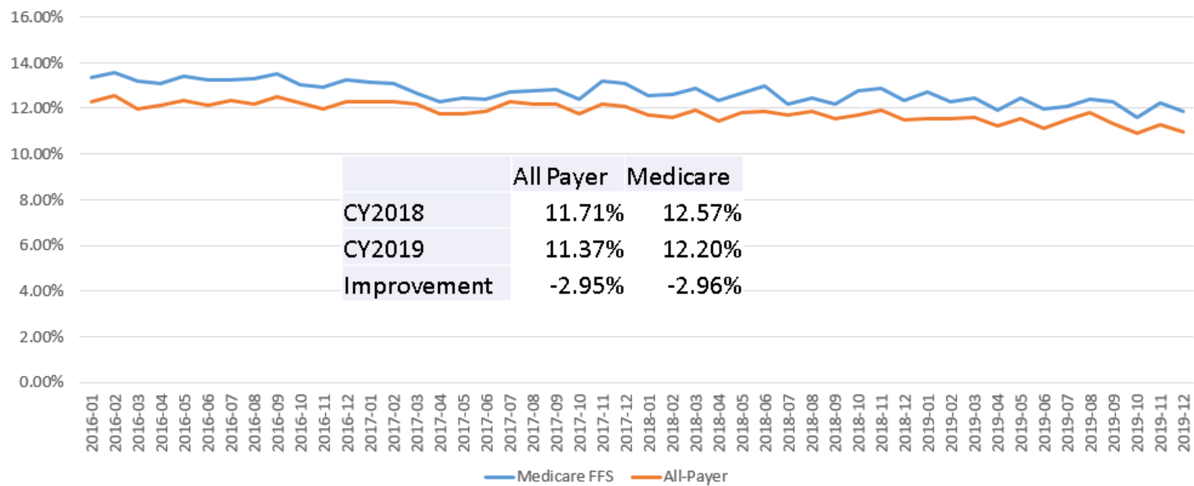
Figure 2. TCOC Model "Waiver Test" - Maryland and National Unadjusted Readmission Rates



	Rolling 12M 2012	Rolling 12M 2013	Rolling 12M 2014	Rolling 12M 2015	Rolling 12M 2016	Rolling 12M 2017	Rolling 12M 2018	Rolling 12M 2019
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%

Maryland also improved upon its Case-mix Adjusted Readmission rate in CY 2019, concluding CY 2019 with an all-payer case-mix adjusted readmission rate of 11.37%, a 2.90% reduction from the RY 2022 base period of CY 2018 (Figure 3, below). With the statewide improvement goal of 1.55% in CY 2020 (the compounded improvement needed to reach 7.5% over five years), 28 hospitals would have been "on track" to receive an incremental improvement reward for RY 2022, while 2 additional hospitals would have received the max reward for improvement.

Figure 3. RY 22 Monthly Case-mix Adjusted Readmission Rates, thru CY 2019



Given these favorable trends in readmission rates and given the challenges with assessing CY 2020 case-mix data during the COVID-19 Public Health Emergency (more below), staff is not recommending large changes to the RY 2023 RRIP policy, including maintaining the improvement and attainment methodologies for a planned CY 2021 performance period. The incremental improvement rate is assessed to be -4.57 percent, see Figure 4 below, while the attainment target benchmark and threshold will be calculated off of the most recent actionable case-mix data, adjusted for the proposed improvement (presently, CY 2019 under v37.1 of the APR-DRG grouper, yielding an attainment threshold of 10.96 percent and attainment benchmark of 8.16 percent). Based on the 2018 to 2019 readmission performance, there are 20 hospitals who have already exceeded the 4.57 percent improvement target such that if they maintain their 2019 readmission rates in 2021 they should receive an improvement reward.[6]

Figure 4. Compounded Improvement Rate to Achieve 7.5% Five-Year Improvement

Year	2019	2020	2021	2022	2023
Improvement	-1.55%	-3.07%	-4.57%	-6.05%	-7.50%

[6] Based on this preliminary attainment target one additional hospital would receive an attainment reward despite not meeting the improvement target.

COVID-19 Program Considerations

Staff notes that, on September 2, 2020, CMS published an Interim Final Rule (IFR) in response to the COVID-19 PHE. In this IFR, they announced that:

- CMS will not use CY Q1 or CY Q2 of 2020 quality data even if submitted by hospitals.
- CMS is still reserving the right to suspend application of revenue adjustments for FFY 2022 for all hospital pay for performance programs at a future date in 2021; changes will be communicated through memos ahead of IPPS rules.

It is not known at this time if Maryland has flexibility in suspending our RY 2022 programs. However, CMMI has strongly suggested that the State must have quality program adjustments, and has further suggested that the State pursue alternative strategies, such as reusing portions of CY 2019 (as is being done for the Skilled Nursing Facility VBP program) to create a 12-month performance period, should that be necessary for data reliability and validity.

In context of the CMS announcement and CMMI comments, staff has evaluated the data issues and options for the RY 2022 RRIP policy in Maryland, as illustrated in Figure 5 below.

Figure 5. RY 2022 COVID-Related Data Concerns and Options

COVID Data Concerns	Options
Only 6 months of data for CY 2020: 1. Is July-December data reliable? 2. What about seasonality?	• Use 6-months data, adjust base as needed for seasonality concerns • Merge 2019 and 2020 data together to create a 12 month performance period • Use 2019 data or revenue adjustments
Clinical concerns over inclusion of COVID patients	• Remove COVID patients from CY 2020 Eligible Discharges or Readmissions
Case-mix adjustment, performance standard and revenue adjustment scale concerns: 1. Inclusion of COVID patients when not in normative values 2. Impacts on other DRG/SOI of COVID PHE	• Remove COVID patients from CY 2020 evaluation • Develop concurrent norms and performance standards for comparison and possible use • Use 2019 data or revenue adjustments • Modify revenue adjustment scale to recognize COVID related concerns

At this stage, staff believes the most appropriate approach for the RRIP policy is to exclude the COVID-19 patients[7] if any CY 2020 data is used. Over the coming months, staff will work to assess any case-mix adjustment and performance standard issues due to the absence of COVID-19 patients in the base period and normative values, and to finalize the performance period. Staff will provide updates to the Commission in February, at the earliest, on the final decisions for any adjustments to all RY 2022 quality policies.

For RY 2023, the program will use v38 of the APR-DRG grouper, however, unlike the v38 PPC grouper, this updated grouper does not make changes to the readmission flags to account for COVID-19. Staff will need to consider any additional modifications to address case-mix adjustment and performance standard concerns that may arise from inclusion of COVID-19 positive patients in the performance period, especially since COVID-19 cases were not part of the statewide normative values. Furthermore, based on stakeholder comments, analyses should be done on case-mix adjustment and performance standards concerns for non-COVID patients.

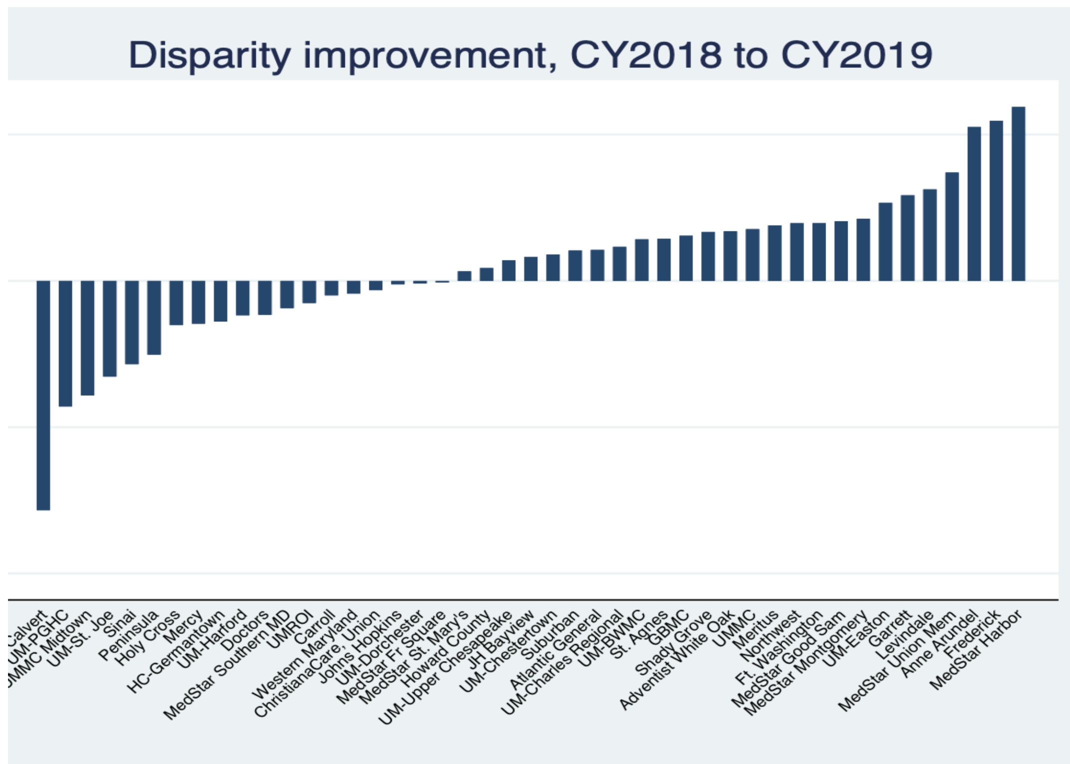
Within-Hospital Disparities in Readmissions

In March 2020 the Commission approved rewards for hospitals reducing socioeconomic disparities in readmission rates between CY2018 and CY2020.[8] Evaluation of performance for CY2019 showed 26 of 45 hospitals improved on the disparity measure (Figure 6).

[7] COVID-19 cases are defined as those coded with the ICD10 code U07.1

[8] Details on the methodology for calculating within hospital disparities can be found in the RY 2022 RRIP policy

Figure 6: CY2019 Disparity Improvement[9]



Of those that improved, four would be ineligible for disparity reward due to overall RRIP performance requirement of some improvement, and one was not on track to attain the minimum disparity gap improvement threshold. Two hospitals are on track for a reward of 0.25% IP revenue and 19 are on track for a reward of 0.50% IP revenue.

Staff recommended the currently approved reward targets after reviewing analytics suggesting significant change in disparities would be difficult and time consuming for hospitals to achieve. However, as the program developed, Staff implemented a change in the calculation procedure to better account for shifting PAI values at individual hospitals. Specifically, initial analytics for the program were developed with the Patient Adversity Index (PAI), which measures patient socioeconomic exposures, using claims from CY2016 to 2018, which had the effect of stabilizing hospital disparity levels estimated annually during that three-year period. Ultimately, however, Staff elected to measure PAI, and to calculate mean PAI for each hospital, using data only from CY2018 to more accurately reflect PAI values, readmission risk, and performance during the base year, rather than during years not included in the base. This led to a larger-than-anticipated number of hospitals qualifying for the maximum reward category for RY 2022.

[9] This graph does not show the absolute difference in readmission rates between Medicaid and other payers, black vs non black, and high ADI vs low ADI, and nor does it represent the change in readmission rates for these groups, but rather this graph shows the change in the disparity gap over time between the groups as determined through an evaluation of the change in slope for readmissions across all levels of patient adversity at each hospital.

Because of this methodology change, Staff recommends updating the reward structure to provide rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years (>=15.91 percent reduction in disparity gap measure 2018 to 2021), and 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years (>=29.29 percent reduction in disparity gap measure 2018 to 2021).[10] Under this approach, six hospitals are currently on track to receive the lower reward, and 13 on track to receive the higher one. Staff also tends to evaluate approaches to scaling rewards between the lower and higher points.

Staff has received feedback from stakeholders suggesting that a review of initial program results to evaluate the possibility of unintended consequences related to the policy, such as shifts in coding of patient race. This work is planned for early 2021. Additionally, Staff is aware of the need to develop an approach to accounting for the effect of COVID-19 on disparities measurement.

Hospital Score and Revenue Adjustment Modeling

For this final policy, staff modeled hospital performance and revenue adjustments as if the policy had been applied from the base of 2018 to the 2019 performance year. This was done by calculating the one-year improvement targets for both case-mix adjusted readmissions and the disparity gap, i.e. 1.55 percent for readmissions and 3.53 percent (25 percent target) and 8.30 percent (50 percent target) for disparities. Furthermore, the attainment target was updated to what it would have been if it had been set at the 65th percentile of CY 2018 performance.

Using the readmission measure that was approved for RY 2022, staff modeled improvement for 2018 to 2019 and 2019 attainment.[11] The revenue adjustment scales for improvement and attainment were created as if the RY 2022 policy had been in place for 2019 performance. In addition staff modeled the disparity gap in 2018 and 2019 to assess improvement compared to the one year improvement goal needed to achieve a 25 and 50 percent reduction in disparities over 8 years. Based on the combined revenue adjustments for the better of improvement or attainment and the disparity gap reward, 13 hospitals would be penalized for a total of $7.5 million and 32 hospitals would be rewarded for a total of $41.7 million. Approximately half of the rewards ($20.3 million) are due to reductions in disparities between 2018 and 2019. Specifically, 19 hospitals had disparity gap reductions of greater than 8.30 percent (putting them on track to reduce disparities by 50 percent over 8 years and earning then 0.50 percent inpatient revenue reward) and 2 hospitals had disparity gap reductions of greater than 3.53 percent (putting them on track for 25 percent reduction over 8 years and earning them a 0.25 percent inpatient revenue reward). Based on this modeling, staff have proposed to raise the expectations for disparity reductions in order to begin earning a reward and plan to scale the rewards (i.e., make continuous) from those on track for a 50 percent improvement starting to earn reward and those on track for a 75 percent reward getting the full 0.50 percent reward.

Figure 7: Modeling of 2018-2019 Readmissions Performance

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[10] Five hospitals have already improved by greater than 29.29 percent CY 2018 to CY 2019

[11] Please note that this modeling was not updated to exclude pediatric oncology - per the Stakeholder Feedback section, pediatric oncology discharges are approximately 50 eligible discharges annually.

Statewide Revenue Adjustment Modeling	Improvement/Attainment Case-Mix Adjusted Readmission Rate		Disparity Gap Reduction Reward		Total Combined Revenue Adjustment	
	$	%	$	%	$	%
Net	$13,947,627	0.14%	$20,288,666	0.21%	$34,236,293	0.35%
Penalties	-$7,891,071	-0.08%			-$7,478,827	-0.08%
Rewards	$21,838,698	0.23%	$20,288,666	0.21%	$41,715,120	0.43%
# Hospitals Penalized	16		21		13	
# Hospitals Rewarded	29		24		32	

Additional Future Considerations

It remains important that the HSCRC continue to compare Maryland readmission rates against national readmission rates to evaluate relative Maryland performance. Staff is presently working with CMMI to better understand the federal Hospital-wide Readmission (HWR) measure, which is publicly posted on CMS Hospital Compare once a year. It may be advantageous to better understand the federal HWR measure, as it includes a risk-adjustment; the "Waiver Test" readmission rate for Maryland is presently an unadjusted readmission rate, which may present future challenges as Maryland reduces unnecessary utilization and simultaneously increases the case-mix index of remaining eligible discharges. Additionally, a Hybrid HWR Measure was adopted by CMS in 2018 as a voluntary measure under the Hospital Inpatient Quality Reporting Program. The Hybrid HWR Measure differs from the claims-based HWR measure, as it merges electronic health record (EHR) data elements with claims data to calculate the risk-standardized readmission rate.[12] Staff will consider potential use(s) of the HWR/HWR Hybrid measure in the future.

As mentioned above, staff will need to evaluate the implications of the COVID-19 Public Health Emergency on all pay-for-performance programs, including the RRIP. Finally, staff continue to work with Mathematica Policy Research (MPR), our contractor, to operationalize an all-payer measure of Excess Days in Acute Care, which would incorporate admissions, observation stays, and ED visits within 30 days of an acute care discharge. Staff appreciates the opportunity to continue to evolve this policy under the TCOC Model.

Stakeholder Feedback and Staff Response

The HSCRC received three comment letters, from the Maryland Hospital Association, the Johns Hopkins Healthcare System, and Luminis Health. The letters shared broad agreement with maintaining the recently redesigned RRIP as is, and made the following topical suggestions:

1. **Lower the improvement target from three-years (4.57%) to two-years (3.07%)** in acknowledgement of the COVID-19 pandemic and the unreliability of the CY 2020 data.

[12] For additional information, see: https://qualitynet.cms.gov/inpatient/measures/hybrid

Response: Per the "Assessment" section above, just under half of MD hospitals (20) improved greater than 4.57% in one year, 2018-2019. We believe the five-year improvement remains reasonable and achievable; staff does not agree with the suggestion.

2. **Increase the maximum reward to 2%**, to align with the other quality, pay-for-performance programs.

   Response: Staff appreciates the commitment to symmetry across the pay-for-performance quality programs; and notes the historical improvement of Maryland hospitals with regard to readmission rates.

   Staff would also note the following:

   - A required further reduction of 7.5% over the 5 years of the TCOC Model after successfully reducing readmissions by ~15% during the All-Payer Model and the ultimate goal of moving the State to the 25th percentile of benchmark peers will require additional resources.
   - RRIP is the only Quality pay-for-performance policy that does not have symmetrical risk, which adds complexity to the policy.
   - The Commission routinely incentivizes hospitals to reduce readmissions through the Potentially Avoidable Utilization Shared Savings program by removing inflation from readmissions and avoidable admissions, thereby maintaining a greater emphasis on downside risk in readmissions.

   Staff therefore agrees with this suggestion to raise the maximum reward to 2 percent.

3. **"Blend" the base year to be a combination of multiple years**, so that one particularly good or bad base year does not have an outsized influence on potential improvement.

   Response: Currently the Maryland quality programs that assess improvement have a one year base period (or equal base period time frame as the performance period). This has been true for RRIP since its start where the base period was locked in at 2013 or 2016 (post ICD-10) and staff do not recall this being brought up as a stakeholder concern during the RRIP redesign. In addition, at a statewide level there is fairly high correlation in readmission rates year over year despite overall reductions in readmissions, suggesting that there is limited year over year volatility in hospital's readmission rate and widespread improvement in readmissions, which hospitals get credit for in the RRIP policy. Last, hospitals with a low readmission rate in the base period still have opportunities for attainment rewards under the policy.

4. In agreement with Commissioner Elliott, **remove pediatric oncology cases** from readmission eligibility.

   Response: Staff agrees, and thanks Commissioner Elliott for bringing this to our attention.

   Preliminary modeling suggests that the removal of pediatric oncology cases will result in little material impact, with approximately 50 annual eligible discharges affected. However, this measure update will further align the oncology discharges within the readmission measure with the intention of the measure steward.

5. JHHS recommended changing the **RRIP disparity component to provide rewards for past progress already achieved.**

   Response: Staff does not support inclusion of attainment rewards over the near term. The Commission's approach with the overall RRIP policy has been to focus on incenting improvement during the initial years of the policy, and the current disparity component is consistent with that approach. Secondly, unless the disparity threshold were set at zero, an attainment policy would have the effect of classifying some level of disparity as acceptable and suitable for reward. Staff does not believe this approach would ultimately result in an equitable healthcare system.

6. Continue to **evaluate the validity of the Excess Days in Acute Care (EDAC) measure**, including "factors that contribute to Emergency Department and Observation Revisits".

   Response: Staff appreciates this feedback and will continue to work with our stakeholder workgroup as we evaluate this measure. Currently staff have engaged Mathematica to develop an all-payer version of this measure, which staff at this time would see as additive to the program and not designed to necessarily replace the current readmission measure.

7. One stakeholder letter requested clarification on the **flags defining COVID positive patients**, and how COVID-positive cases transferred to a hospital would be accounted for in the RRIP policy.

   Response: COVID positive flag is presently U07.1 per CDC guidelines. Should these guidelines change we will follow the updated CDC guidelines. All patients transferred from one acute care hospital to another (discharged and then admitted within the same day or next-day) are excluded from counting as a readmission from the transferring hospital within the RRIP. These patients are counted as an eligible discharge for the receiving hospital. The current case-mix adjustment severity of illness will reflect the higher risk of readmission to transfer patients. However, the HSCRC can examine the specific risk to COVID positive patients retrospectively.

8. Finally, the Maryland Hospital Association reiterates that the COVID-19 public health emergency is ongoing and unprecedented. As such, MHA notes that the **CY 2020 data is unreliable and should not be used in any RY 2022 pay-for-performance assessment of quality, and that RY 2022 pay-for-performance programs should be suspended.**

Response: Staff appreciates this viewpoint and notes that Maryland currently has no latitude to discontinue RY 2022 pay-for-performance revenue adjustment, as CMS and by extension CMMI have not as yet agreed to a blanket suspension of RY 2022 pay-for-performance programs. Should the federal government decide to suspend these programs, staff will advocate to include Maryland in that suspension. At present, staff is working with statisticians, subject-matter experts, and stakeholders to ascertain how best to apply revenue adjustments in FY 2022 (for RY 2022 programs). We appreciate stakeholder feedback on this endeavor.

Recommendations

1. Maintain the 30-day, all-cause readmission measure.
    a. Remove Pediatric Oncology cases, in accordance with the intention of the oncology readmission measure.
2. Improvement Target - Maintain the RY 2022 approved statewide 5-year improvement target of -7.5 percent from 2018 base period.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile statewide performance receive scaled rewards for maintaining low readmission rates.
4. For improvement and attainment, increase the maximum reward hospitals can receive to 2 percent of inpatient revenue and maintain the maximum penalty at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years (>=15.91 percent reduction in disparity gap measure 2018 to 2021), capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years (>=29.29 percent reduction in disparity gap measure 2018 to 2021).
6. Continue development of an all-payer Excess Days in Acute Care measure in order to account for readmission, emergency department, and observation revisits post-discharge.
7. Adjust the RRIP pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report to Commissioners as follows:
    a. For RY 2022 (CY 2020 performance period)
        i. Exclude COVID-19 positive cases from the program.
        ii. Exclude the data for January to June 2020; evaluate whether to use the final six months of 2020 or whether to use a prior time period.
        iii. Evaluate case-mix adjustment and performance standards concerns arising from use of a pre-COVID time period to determine normative values.
    b. For RY 2023 (CY 2021 performance period) include COVID-19 positive cases but retrospectively assess any case-mix concerns, including the use of a pre-COVID time period to determine normative values.

Appendix I. Readmission Measure Specifications and Revenue Adjustment Methodology

1) 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 planned admissions.[13] Unique patient identifiers from CRISP are used to be able to track patients across hospitals for readmissions.

The measure is similar to the readmission rate that is calculated by CMMI to track Maryland performance versus the nation, with some exceptions. The most notable exceptions are that the HSCRC measure includes psychiatric patients in acute care hospitals, and readmissions that occur at specialty hospitals. 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, an additional adjustment is made to account for differences in case-mix. See below for details on the readmission calculation for the RRIP program.

2) 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 added all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs, rather than principal diagnosis.[14] Planned admissions are counted as eligible discharges in the denominator, because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.[15]
- New in RY 2022: Remove DRG oncology exclusion but continue to exclude bone marrow transplants and liquid tumor patients by making these discharges not eligible to have an unplanned readmission or count as an unplanned readmission.[16]
- New in RY 2022: Exclude patients with a discharge disposition of Left Against Medical Advice (PAT_DISP = 71, 72, or 73 through FY 2018; 07 FY 2019 onward)
- Rehabilitation cases as identified by APR-860 (which are coded under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after 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.
- APR-DRG-SOI categories with less than two discharges statewide are removed.
- A hospitalization within 30 days of a hospital discharge where a patient dies is counted as a readmission;

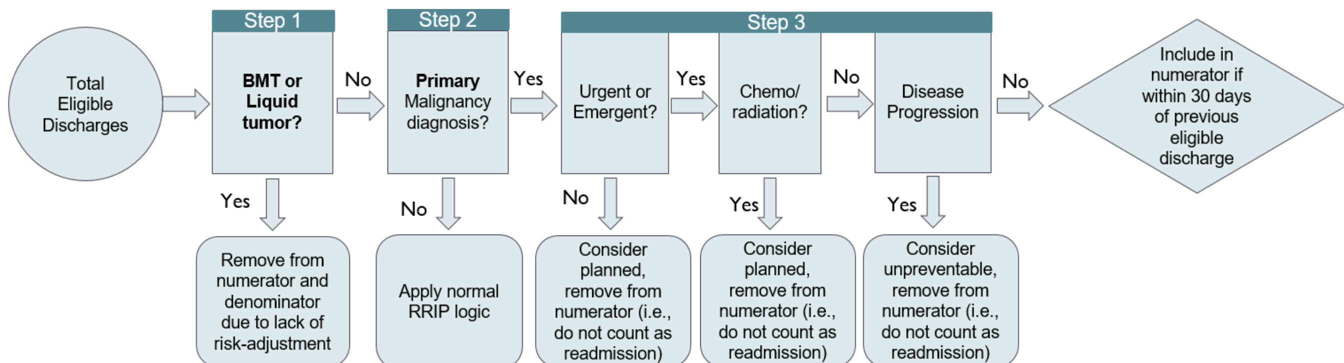
[13] Planned admissions defined under [CMS Planned Admission Logic version 4 – updated March 2018].
[14] **Rehab** DRGs: 540, 541, 542, 560, and 860; **OB Deliveries and Associated DRGs**: 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.
[15] **Newborn APR-DRGs:** 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.
[16] **Bone Marrow Transplant:** Diagnosis code Z94.81 or CCS Procedure code 64; **Liquid Tumor:** Diagnosis codes C81.00-C96.0. See section below for additional details on the oncology logic.

however, the readmission is removed from the denominator because the case is not eligible for a subsequent readmission.

- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same or next day as the admission date of the subsequent admission, are removed from the denominator. Thus, only one admission is counted in the denominator, and that is the admission to the transfer hospital (unless otherwise ineligible, i.e., died). It is the second discharge date from the admission to the transfer hospital that is used to calculate the 30-day readmission window.
- Beginning in RY 2019, HSCRC started discharges from chronic beds within acute care hospitals.
- In addition, the following data cleaning edits are applied:
    - Cases with null or missing 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.

Additional Details on Oncology Logic:

Flow Chart for Revised Oncology Logic



*Items that are **bolded** are adaptations from NQF measure

This updated logic replaces the RY 2021 measure logic that removes all oncology DRGs from the dataset, such that an admission with an oncology DRG cannot count as a readmission or be eligible to have a readmission.

Step 1: Exclude discharges where patients have a bone marrow transplant procedure, bone marrow transplant related diagnosis code, or liquid tumor diagnosis. This logic varies from the NQF cancer

hospital measure that risk-adjusts for bone marrow transplant and liquid tumors. HSCRC staff recommended removing these discharges (similar to current DRG exclusion) because the current indirect standardization approach did not allow for additional risk-adjustment but based on conversations with clinicians staff agreed these cases were significantly more complicated and at-risk for an unpreventable readmission.

Step 2: Flag discharges with a primary malignancy diagnosis to apply cancer specific logic for determining readmissions. This varies from the NQF cancer hospital measure that flags patients with primary or secondary malignancy diagnosis being treated in a cancer specific hospital. Staff think we should only flag those with a primary diagnosis since in a general acute care hospital there may be differences in the types of patients with a secondary malignancy diagnosis. Further, we remove the bone marrow and liquid tumor discharges regardless of malignancy diagnosis, thus ensuring the most severe cases are removed. Last, our initial analyses did not show a large impact on overall hospital rates when primary vs primary and secondary malignancies were flagged. It should be noted however that the current modeling in this policy uses readmission rates where both primary and secondary are flagged.

Step 3: Flag planned admissions using additional criteria beyond the CMS planned admission logic:

a) Nature of admission of urgent or emergent considered unplanned, all other nature of admission statuses are planned
b) Any admission with primary diagnosis of chemotherapy or radiation is considered planned
c) Any admission with primary diagnosis of metastatic cancer is not considered preventable, and thus gets excluded from being a readmission

In step 3, admissions are deemed not eligible to be a readmission but they are eligible to have a subsequent unplanned readmission.

3) 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, with an additional 30 day runout. To calculate the case-mix adjusted readmission rate for CY 2018 base period and CY 2020 performance period, data from January 1 through

December 31, plus 30 days in January of the next year are used. The base period data are used to calculate the normative values, which are used to determine a hospital's expected readmissions, as detailed below, as well as the estimated CY 2018 readmission rates.

Please note that, the base year readmission rates are not "locked in", and may change if there are CRISP EID or other data updates. The HSCRC does not anticipate changing the base period data, and does not anticipate that any EID updates will change the base period data significantly; however, the HSCRC has decided the most up-to-date data should be used to measure improvement. For the performance period, the CRISP EIDs are updated throughout the year, and thus, month-to-month results may change based on changes in EIDs.

SOFTWARE: APR-DRG Version 38 for CY 2018-CY 2021.

Calculation:

Case-Mix Adjusted Readmission Rate = (Observed Readmissions) ------------------------------------ * Statewide Base Year Readmission Rate (Expected Readmissions)

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.

Risk Adjustment Calculation:

Calculate the Statewide Readmission Rate without Planned Readmissions.

- Statewide Readmission Rate = Total number of readmissions with exclusions removed / Total number of hospital discharges with exclusions removed.

For each hospital, enumerate the number of observed, unplanned readmissions.

For each hospital, calculate the number of expected unplanned readmissions at the APR-DRG SOI level (see Expected Values for description). For each hospital, cases are removed if the discharge APR-DRG and SOI cells have less than two total cases in the base period data.

Calculate at the hospital level the ratio of observed (O) readmissions over expected (E) readmissions. A ratio of > 1 means that there were more observed readmissions than expected, based upon a hospital's case-mix. A ratio of < 1 means that there were fewer observed readmissions than expected based upon a hospital's case-mix.

Multiply the O/E ratio by the base year statewide rate, which is used to get the case-mix adjusted readmission rate by hospital. Multiplying the O/E ratio by the base year state rate converts it into a readmission rate that can be compared to unadjusted rates and case-mix adjusted rates over time.

Expected Values:

The expected value of readmissions is the number of readmissions a hospital would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals, given its mix of patients as

defined by discharge APR-DRG category and SOI level. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being “eligible” for a readmission. All discharges will either have zero readmissions or will have one readmission. The readmission rate is the proportion or percentage of admissions that have a readmission.

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

Let:

N = norm
P = Number of discharges with a readmission
D = Number of eligible discharges
i = An APR DRG category and a single SOI level

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

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 are applied to each hospital’s DRG and SOI distribution. In the example below, the computation presents expected readmission rates for a single diagnosis category and its four severity levels. This computation could be expanded to include multiple diagnosis categories, by simply expanding the summations.

Consider the following example for a single diagnosis category.

Expected Value Computation Example – Individual APR-DRG

A Severity of Illness Level	B Eligible Discharges	C Discharges with Readmission	D Readmissions per Discharge (C/B)	E Normative Readmissions per Discharge	F Expected # of Readmissions (A*E)
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
Total	**500**	**45**	**.09**		**56.5**

For the diagnosis category, the number of discharges with a readmission is 45, which is the sum of discharges with readmissions (column C). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of eligible discharges with a readmission (sum of column C) by the total number of discharges at risk for readmission (sum of column B), i.e., 0.09 = 45/500. From the normative population, the proportion of discharges with readmissions for each severity level for that diagnosis category is displayed in column E. The expected number of readmissions for each severity level shown in column F is calculated by multiplying the number of eligible discharges (column B) by the normative readmissions per discharge rate (column E) The total number of readmissions expected for this diagnosis category is the sum of the expected numbers of readmissions for the 4 severity levels.

In this example, the expected number of readmissions for this diagnosis 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 diagnosis category. This difference can also be expressed as a percentage or the O/E ratio.

4) Revenue Adjustment Methodology

The RRIP assesses improvement in readmission rates from base period, and attainment rates for the performance period with an adjustment for out-of-state readmissions. 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. The figure below provides a high level overview of the RY 2021 RRIP methodology for reference. For RY 2022 RRIP methodology, please see figure 1 within the policy.

Overview Rate Year 2021 RRIP Methodology

RRIP Performance Metric

Measure: All-Payer, 30-day, all-cause readmissions using CRISP unique identifier to track patients across acute hospitals in Maryland

Case-Mix Adjustment: Indirect standardization by diagnosis and severity of illness levels to calculate hospital expected readmissions given the patient mix and acuity

Discharges Ineligible for Readmission: transfers, deaths, oncology, rehab, newborns, APR-DRG SOI cells <2 discharges statewide, missing or ungroupable data

Unplanned Readmissions Only: Planned admissions (based on CMS logic) are not counted as readmissions (but are eligible for an unplanned readmission)

Improvement: Change in readmission rate from base period (RY 2022: CY16-CY19)

Attainment: All-payer readmission rate is adjusted to account for out of state readmissions using Medicare ratio of in-state vs. out-of-state readmissions

Revenue Adjustments:
Better of Improvement or Attainment

Improvement

	Change in Readmission Rate	Percent Adjustment
Improving	**-14.40%**	1.00%
	-9.15%	0.50%
	-3.90%	0.00%
	1.35%	-0.50%
	6.60%	-1.00%
	11.85%	-1.50%
Worsening	**17.10%**	-2.0%

Max Penalty = 2%
Max Reward = 1%

Attainment

	Readmission Rate w/ Out-of-State	Percent Adjustment
Benchmark	**8.94%**	1.00%
	10.03%	0.50%
Threshold	**11.12%**	0.00%
	12.21%	-0.50%
	13.30%	-1.00%
	14.39%	-1.50%
	15.47%	-2.0%

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Appendix II. RRIP Revenue Adjustment Modeling

Please note: These figures model RY 22 RRIP with CY 2018 Base period and CY 2019 Performance Period (i.e., using a one-year improvement target based on the RY 2022 readmission measure and the RY 22 at-risk amounts for rewards of 1% and penalties of 2%).

RY 22 RRIP for Modeling – CY 18 Base; CY 19 Perf				Imp	Attainment Scaling		Improve/Attain Final Adjustment			Disparity Gap				Combined Revenue Adjustment	
HOSP ID	HOSP NAME	RY 19 Estimated Permanent Inpatient Revenue	CY18-CY19 % Δ in CM Adj Rate	% Rev Adj For Imp - 1.55%	CY18 CM Adj Rate w OOS Adj	% Rev Adj 35th % 10.7%	$ Better of Att or Imp	RY20 Final % Rev Adj	Imp or Att	CY18-CY19 % Δ in Gap	Elig?	% Rev Adj	$ Rev Adj	% Rev Adj	$ Rev Adj
210001	MERITUS	$219,551,750	-6.24%	0.45%	11.06%	-0.12%	$987,983	0.45%	Imp	-18.99%	Yes	0.5%	$1,097,759	0.95%	$2,085,742
210002	UMMC	$1,203,673,856	-3.15%	0.15%	13.14%	-0.82%	$1,805,511	0.15%	Imp	-17.68%	Yes	0.5%	$6,018,369	0.65%	$7,823,880
210003	UM-PG	$282,929,188	-5.11%	0.34%	12.43%	-0.58%	$961,959	0.34%	Imp	42.94%	Yes	0.0%	$0	0.34%	$961,959
210004	HOLY CROSS	$355,608,692	-2.47%	0.09%	12.40%	-0.57%	$320,048	0.09%	Imp	15.12%	Yes	0.0%	$0	0.09%	$320,048
210005	FREDERICK	$232,665,827	-1.23%	-0.03%	10.96%	-0.09%	-$69,800	-0.03%	Imp	-54.71%	Yes	0.5%	$1,163,329	0.47%	$1,093,529
210006	UM-HARFORD	$54,181,186	0.00%	-0.15%	11.62%	-0.31%	-$81,272	-0.15%	Imp	11.76%	No	0.0%	$0	-0.15%	-$81,272
210008	MERCY	$226,492,002	-3.57%	0.19%	12.75%	-0.69%	$430,335	0.19%	Imp	14.65%	Yes	0.0%	$0	0.19%	$430,335
210009	JHH	$1,456,687,424	0.08%	-0.15%	13.67%	-0.99%	-$2,185,031	-0.15%	Imp	1.20%	No	0.0%	$0	-0.15%	-$2,185,031
210010	UM-DORCHEST	$22,653,845	-4.50%	0.28%	9.64%	0.36%	$81,554	0.36%	Att	0.90%	Yes	0.0%	$0	0.36%	$81,554
210011	ST. AGNES	$238,757,730	-4.94%	0.32%	11.61%	-0.30%	$764,025	0.32%	Imp	-14.38%	Yes	0.5%	$1,193,789	0.82%	$1,957,814

210012	SINAI	$399,817,673	-6.66%	0.49%	11.05%	-0.12%	$1,959,107	0.49%	Imp	28.48%	Yes	0.0%	$0	0.49%	$1,959,107
210015	MS-FR SQ	$306,898,504	-5.36%	0.36%	12.62%	-0.64%	$1,104,835	0.36%	Imp	0.53%	Yes	0.0%	$0	0.36%	$1,104,835
210016	WASH ADV	$164,197,283	-3.17%	0.15%	11.71%	-0.34%	$246,296	0.15%	Imp	-16.96%	Yes	0.5%	$820,986	0.65%	$1,067,282
210017	GARRETT	$23,714,400	-32.57%	1.00%	7.94%	0.92%	$237,144	1.00%	Imp	-29.27%	Yes	0.5%	$118,572	1.50%	$355,716
210018	MS-MONTG	$84,721,645	-13.13%	1.00%	10.91%	-0.07%	$847,216	1.00%	Imp	-21.21%	Yes	0.5%	$423,608	1.50%	$1,270,824
210019	PRMC	$249,228,264	-10.55%	0.86%	10.49%	0.07%	$2,143,363	0.86%	Imp	25.22%	Yes	0.0%	$0	0.86%	$2,143,363
210022	SUBURBAN	$208,954,270	-9.41%	0.75%	11.31%	-0.20%	$1,567,157	0.75%	Imp	-10.38%	Yes	0.5%	$1,044,771	1.25%	$2,611,928
210023	AAMC	$294,544,506	2.44%	-0.38%	12.15%	-0.49%	-$1,119,269	-0.38%	Imp	-52.60%	No	0.0%	$0	-0.38%	-$1,119,269
210024	MS-UNION	$243,156,679	-3.35%	0.17%	11.99%	-0.43%	$413,366	0.17%	Imp	-37.04%	Yes	0.5%	$1,215,783	0.67%	$1,629,149
210027	WESTERN MARYLAND	$169,462,000	2.60%	-0.39%	12.65%	-0.65%	-$660,902	-0.39%	Imp	4.34%	No	0.0%	$0	-0.39%	-$660,902
210028	MS-ST. MARY	$79,141,046	-5.85%	0.41%	12.41%	-0.57%	$324,478	0.41%	Imp	-3.28%	Yes	0.0%	$0	0.41%	$324,478
210029	JHBAYVIEW	$366,607,627	-3.64%	0.20%	13.76%	-1.02%	$733,215	0.20%	Imp	-8.22%	Yes	0.25%	$916,519	0.45%	$1,649,734
210030	UM-CHESTER	$17,859,942	-7.44%	0.56%	7.80%	0.97%	$173,241	0.97%	Att	-9.04%	Yes	0.5%	$89,300	1.47%	$262,541
210032	UNION OF CECIL	$65,426,887	3.91%	-0.52%	13.34%	-0.88%	-$340,220	-0.52%	Imp	3.19%	No	0.0%	$0	-0.52%	-$340,220
210033	CARROLL	$140,291,849	3.14%	-0.45%	12.35%	-0.55%	-$631,313	-0.45%	Imp	4.95%	No	0.0%	$0	-0.45%	-$631,313
210034	MS-HARBOR	$110,392,040	-6.97%	0.52%	13.42%	-0.91%	$574,039	0.52%	Imp	-59.46%	Yes	0.5%	$551,960	1.02%	$1,125,999
210035	UM-CHARL	$76,930,098	-1.92%	0.04%	12.07%	-0.46%	$30,772	0.04%	Imp	-11.66%	Yes	0.5%	$384,650	0.54%	$415,422
210037	UM-EASTON	$103,481,053	-5.16%	0.34%	9.31%	0.47%	$486,361	0.47%	Att	-26.70%	Yes	0.5%	$517,405	0.97%	$1,003,766
210038	UM-MID	$111,141,002	-3.05%	0.14%	14.52%	-1.28%	$155,597	0.14%	Imp	39.17%	Yes	0.0%	$0	0.14%	$155,597

210039	CALVERT	$67,111,996	8.12%	-0.92%	12.26%	-0.52%	-$348,982	-0.52%	Att	78.42%	No	0.0%	$0	-0.52%	-$348,982
210040	NORTHWE	$138,719,920	-11.31%	0.93%	10.47%	0.08%	$1,290,095	0.93%	Imp	-19.72%	Yes	0.5%	$693,600	1.43%	$1,983,695
210043	BWMC	$250,217,336	-0.85%	-0.07%	11.79%	-0.37%	-$175,152	-0.07%	Imp	-14.23%	Yes	0.5%	$1,251,087	0.43%	$1,075,935
210044	G.B.M.C.	$237,787,317	1.13%	-0.25%	10.93%	-0.08%	-$190,230	-0.08%	Att	-15.43%	No	0.0%	$0	-0.08%	-$190,230
210048	HOWARD	$182,870,977	2.42%	-0.38%	11.62%	-0.31%	-$566,900	-0.31%	Att	-4.38%	No	0.0%	$0	-0.31%	-$566,900
210049	UM-UCH	$128,686,091	-0.17%	-0.13%	11.83%	-0.38%	-$167,292	-0.13%	Imp	-7.06%	Yes	0.25%	$321,715	0.12%	$154,423
210051	DOCTORS	$141,094,311	-9.17%	0.73%	10.88%	-0.06%	$1,029,988	0.73%	Imp	11.59%	Yes	0.0%	$0	0.73%	$1,029,988
210056	MS-GOOD SAMARITAN	$146,901,579	-6.93%	0.51%	12.98%	-0.76%	$749,198	0.51%	Imp	-20.37%	Yes	0.5%	$734,508	1.01%	$1,483,706
210057	SHADY GR	$251,748,234	-8.49%	0.66%	10.09%	0.21%	$1,661,538	0.66%	Imp	-16.74%	Yes	0.5%	$1,258,741	1.16%	$2,920,279
210058	UMROI	$72,350,285	31.86%	-2.00%	11.30%	-0.20%	-$23,152	-0.03%	Att	7.57%	No	0.00%	$0	-0.03%	-$23,152
210060	FT. WASH	$19,890,383	11.19%	-1.21%	14.10%	-1.14%	-$226,750	-1.14%	Att	-19.73%	No	0.00%	$0	-1.14%	-$226,750
210061	ATLANTIC GENERAL	$36,931,910	-5.31%	0.36%	10.01%	0.23%	$132,955	0.36%	Imp	-10.59%	Yes	0.50%	$184,660	0.86%	$317,615
210062	MS-SO MD	$162,087,856	4.01%	-0.53%	13.02%	-0.78%	-$859,066	-0.53%	Imp	9.33%	No	0.00%	$0	-0.53%	-$859,066
210063	UM ST. JOE	$223,399,907	-0.44%	-0.11%	11.48%	-0.26%	-$245,740	-0.11%	Imp	32.73%	Yes	0.00%	$0	-0.11%	-$245,740
210064	LEVINDALE	$57,510,719	-8.68%	0.68%	10.00%	0.24%	$391,073	0.68%	Imp	-31.28%	Yes	0.50%	$287,554	1.18%	$678,627
210065	HC GTOWN	$59,062,315	-5.79%	0.40%	11.90%	-0.40%	$236,249	0.40%	Imp	13.92%	Yes	0.00%	$0	0.40%	$236,249
STATEWIDE		**$9,685,539,404**			**Net Reward/Penalty**		**$13,947,627**						**$20,288,666**		**$34,236,293**
Penalty					Penalty		-$7,891,071						$0		-$7,478,827
Reward					Reward		$21,838,698						$20,288,666		$41,715,120

Values for PG hospital represent just PG Hospital

Percentages have been rounded for display. Final scaling values are rounded to two decimal places.

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Hospital Quality Program Exemption for FFY 2023

January 11, 2023

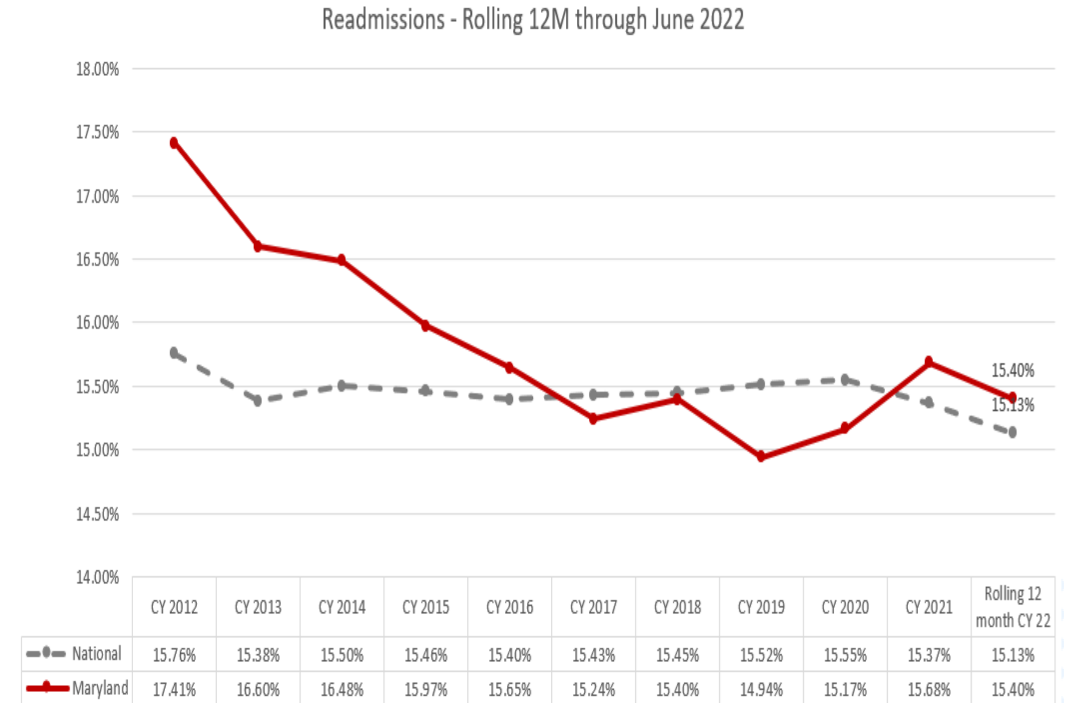
FFY 2023 Exemption Request Approval

- On December 29, 2022 received letter exempting Maryland hospitals from CMS national programs:
  - Hospital Value-Based Purchasing (HVBP) program
  - Hospital Acquired Conditions Reduction (HAC) program
  - Hospital Readmissions Reduction program (HRRP)

"Based on CMS' analysis of Maryland's hospital quality performance which took into consideration the State's response to requests made by CMS in past exemption request approvals, analysis of CY 2021 performance, and exogenous factors impacting CY 2021 performance, **CMS uses its discretion to grant the State of Maryland's exemption from HVBP, HAC, and HRRP for FFY 2023. However, we strongly encourage the State to consider the feedback regarding inpatient readmissions outlined below, as well as other opportunities to continue to improve quality across the Model."**

CMS Feedback on Readmissions

- CMS approved State's exogenous factor request for CY 2021 performance, but does not expect that these exogenous factors will impact CY 2022
  - Currently MD unadjusted readmission rates are above national average in CY 2022.
  - HSCRC staff will be working on risk-adjusted metric with CMMI; in meantime CMMI will continue to monitor unadjusted rate and may require corrective action plan if test is failed.



	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	Rolling 12 month CY 22
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.13%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.40%

CMS requests that state develop strategy to facilitate collaboration between providers and stakeholders to ensure quality of care improves (e.g., focus groups, learning collaboratives), focus on limiting impact of COVID on quality, and advance health equity.

Other feedback

- CMS letter emphasized:
  - Continued HCAHPS performance concerns
  - Expectation that State continue and expand on hospital quality improvement, total population health, and health equity
  - Still reviewing MPA proposal

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Update on Population Health Screening Measure

Geoff Dougherty, PhD, MPH
Deputy Director, Population Health

Today's discussion

- Stakeholder comments
- Policy developments
- Review of Northwell Health screening program
- Monitoring for unintended consequences
- Next steps

Stakeholder Comments

- HSCRC received a number of comment letters
- Broad themes
  - Program is better suited to primary care
  - ED lacks resources to effectively run program
  - May adversely impact ED throughput/patient experience
  - Program may result in excess testing
- Policy developments and implementation details address many of these concerns

Policy Developments

Following stakeholder suggestions, HSCRC proposes:

- Monitoring the MDPCP A1c control measure during CY23
- Focusing CY23 hospital A1c screening measure on admitted patients as suggested in UMMS/MedStar/Hopkins comment letter
- Piloting broader ED A1c measure among willing hospitals
- Considering hospital-initiated submission of additional measures

Inpatient A1c Screening

Additional questions related to the shift in focus from ED to admitted patients

- Screen all IP or only patients that admit through ED?
  - OBS?
- Data collection
  - CRISP
  - Addition of A1c field to IP casemix
- Tracking of primary care/follow up for patients with dysglycemia
- Monitoring to begin shortly

Hospital-Initiated Measure Submission

- Deadline: TBD
- Draft criteria:
  - Targets primary/secondary diabetes prevention
  - Targets defined population of size similar to ED measure
  - Reasonable expectation of meaningful improvement in diabetes incidence or screening prevalence
  - Relies on existing data/does not require prospective monitoring
- Measures will be evaluated by panel of pop health/diabetes experts
- Selected measures may be implemented statewide if concerns regarding A1c measures arise during monitoring or if need for additional measures arises

Northwell Health Diabetes Screening Program

- Long Island Jewish Medical Center: 583-bed tertiary care hospital on border of Queens, NY and Long Island, ~100k 2019 ED visits
- Dr. Rifka Schulman-Rosenbaum, director of inpatient diabetes at LIJ, presented details to Performance Measurement Work Group
- Project described in several peer-reviewed papers from LIJ team
  - Silverman, Robert A., et al. "Hemoglobin A1c as a screen for previously undiagnosed prediabetes and diabetes in an acute-care setting." Diabetes care 34.9 (2011): 1908-1912.
  - Silverman, Robert A., et al. "Increased A1c among adult emergency department patients with type 2 diabetes." Annals of emergency medicine 57.6 (2011): 575-581.
  - Silverman, Robert A., et al. "Prevalence of undiagnosed dysglycemia in an emergency department observation unit." Diabetes/Metabolism Research and Reviews 32.1 (2016): 82-86.
  - Schulman-Rosenbaum, Rifka C., et al. "Use of Endocrine Consultation for Hemoglobin A1C≥ 9.0% as a Standardized Practice in an Emergency Department Observation Unit." Endocrine Practice 27.11 (2021): 1133-1138. **(Included in meeting packet)**

- **EDOU**
  - Increased utilization
  - Extended time frame vs ED
  - Lower acuity patients
- PI project at LIJ in 2014
- Patients **without known DM /pre-DM** offered HbA1c testing while in EDOU.
- No additional blood draw, as prior samples drawn in the ED were utilized.
- 256 EDOU patients
  - **9% with newly diagnosed DM**
  - **52% newly diagnosed pre-DM**
- All adult age groups screened positive for dysglycemia
  - Higher rates found in ages ≥ **45**

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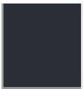
DIABETES/METABOLISM RESEARCH AND REVIEWS
Diabetes Metab Res Rev 2016; **32**: 82–86.
Published online 18 August 2015 in Wiley Online Library (wileyonlinelibrary.com) **DOI:** 10.1002/dmrr.2674

RESEARCH ARTICLE



Prevalence of undiagnosed dysglycemia in an emergency department observation unit

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Abstract

Background The proposed 2015 US Preventive Services Task Force guidelines recommend diabetes screening for individuals ≥45 years or demonstrating other risk factors for dysglycemia. Still, many patients with dysglycemia remain undiagnosed, and opportunities for early intervention are lost.

Methods To test novel approaches for diagnosis using the haemoglobin A_{1c} (HbA_{1c}) test, we screened adult patients who were admitted to an observation unit from the emergency department with no known history of pre-diabetes or diabetes.

Results Of 256 subjects, 9% were newly diagnosed with diabetes and 52% were newly diagnosed with pre-diabetes. Of those aged 18–29 years, 33% were newly diagnosed with dysglycemia, while 55% of those aged 30–44 years and 70% of those aged ≥45 years were newly diagnosed with dysglycemia.

Conclusions Our results suggest that regardless of age, a large proportion of patients in the emergency department observation unit have undiagnosed dysglycemia, an important finding given the large number of observation admissions. Copyright © 2015 John Wiley & Sons, Ltd.

Keywords dysglycemia; observation unit; screening; hospital; haemoglobin A_{1c}

HbA1c Screening in the EDOU

- HbA1c for 3,688 EDOU patients (1 year)
- **7.0%** (n=258) with **HbA1c >9%**
- Endocrine consults completed for 73.6% (n=190)
- 92.1% with discharge medication adjustments
- For known DM: injectable medication increased from 47.2% to 78.2%.
- Newly diagnosed DM 72.9% injectable meds at dc
- 1 month follow up phone calls –
  - 94.9% taking DM medication compared to 68.2% before
  - Increased point of care glucose testing
  - Adverse effects in prescribed meds in 1.5%
  - 88.4% patients reported finding consult helpful.

Schulman-Rosenbaum RC et al. Use of endocrine consultation for HbA1c ≥ 9.0% as a standardized practice in an Emergency Department Observation Unit. Endocrine Practice. 2021; 27(11):1133-1138.

Table 2
Types of Medication Adjustments at The Time of Endocrine Consult

Medication adjusted	Endocrine consult, no past history DM ($n = 48$)	Endocrine consult, known DM history ($n = 142$)
Oral added or changed	13 (27.1%)	16 (11.3%)
Subcutaneous added or changed	26 (54.2%)	64 (45.1%)
Both oral and subcutaneous added or changed	9 (18.8%)	47 (33.1%)
No medication changes made	0 (0%)	15 (10.6%)

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Assessment of Unintended Consequences

- ED throughput
  - Monitoring of OP18b
  - Monitoring of MIEMSS EMS ED handoff delay data
- Length of Stay extension
- Patient follow up/program impact on diabetes control
  - Currently, we have data to track outpatient follow-up for Medicare/Medicaid patients with diabetes diagnosed in ED
  - Structure similar to timely follow up quality measure
  - Need to identify data sources for patients with commercial coverage

Next Steps

- Finalize data collection approach
- Develop reporting for hospital A1c screening and MDPCP A1c measures
- Develop monitoring for unintended consequences

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Update on Medicare FFS Data & Analysis

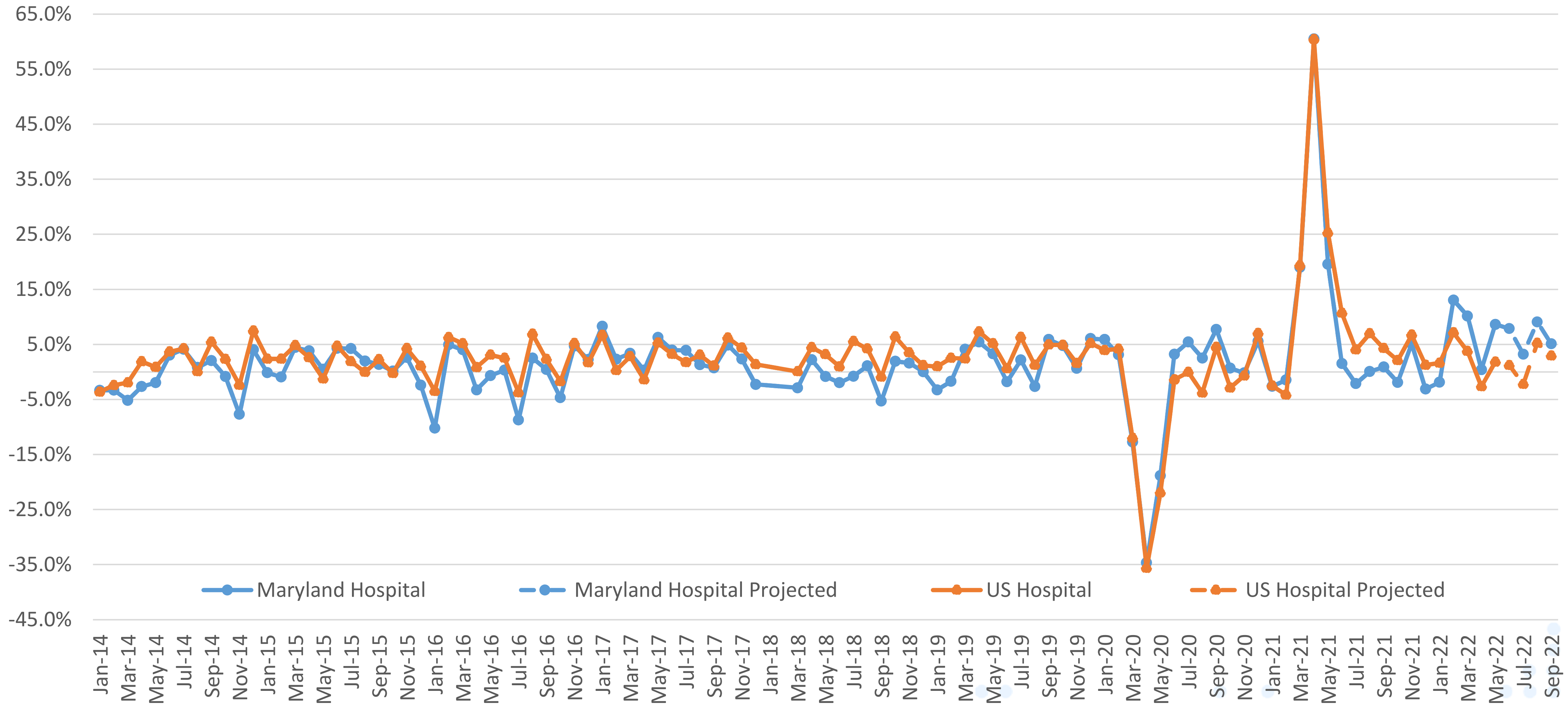
January 2023 Update

Data through September 2022, Claims paid through November 2022

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

Medicare Hospital Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)



CY16 has been adjusted for the undercharge.

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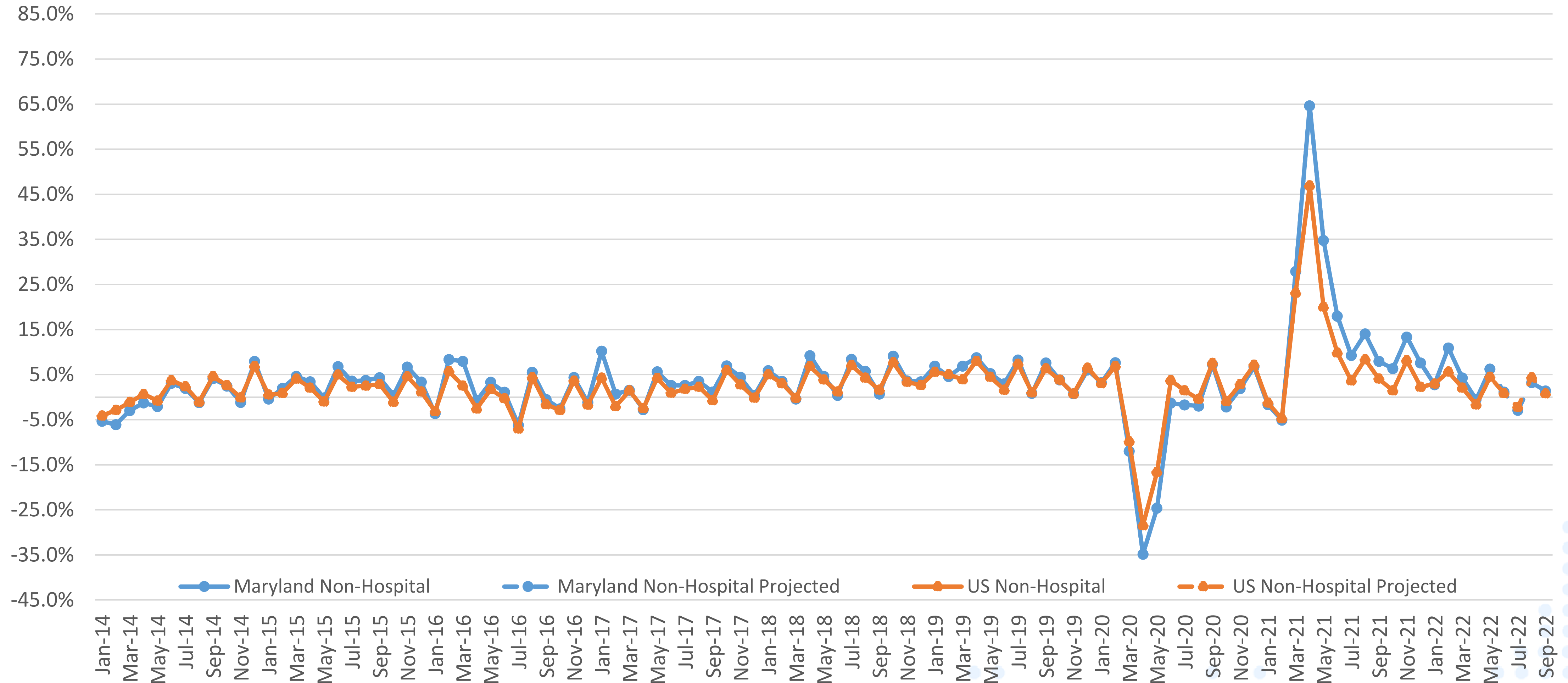
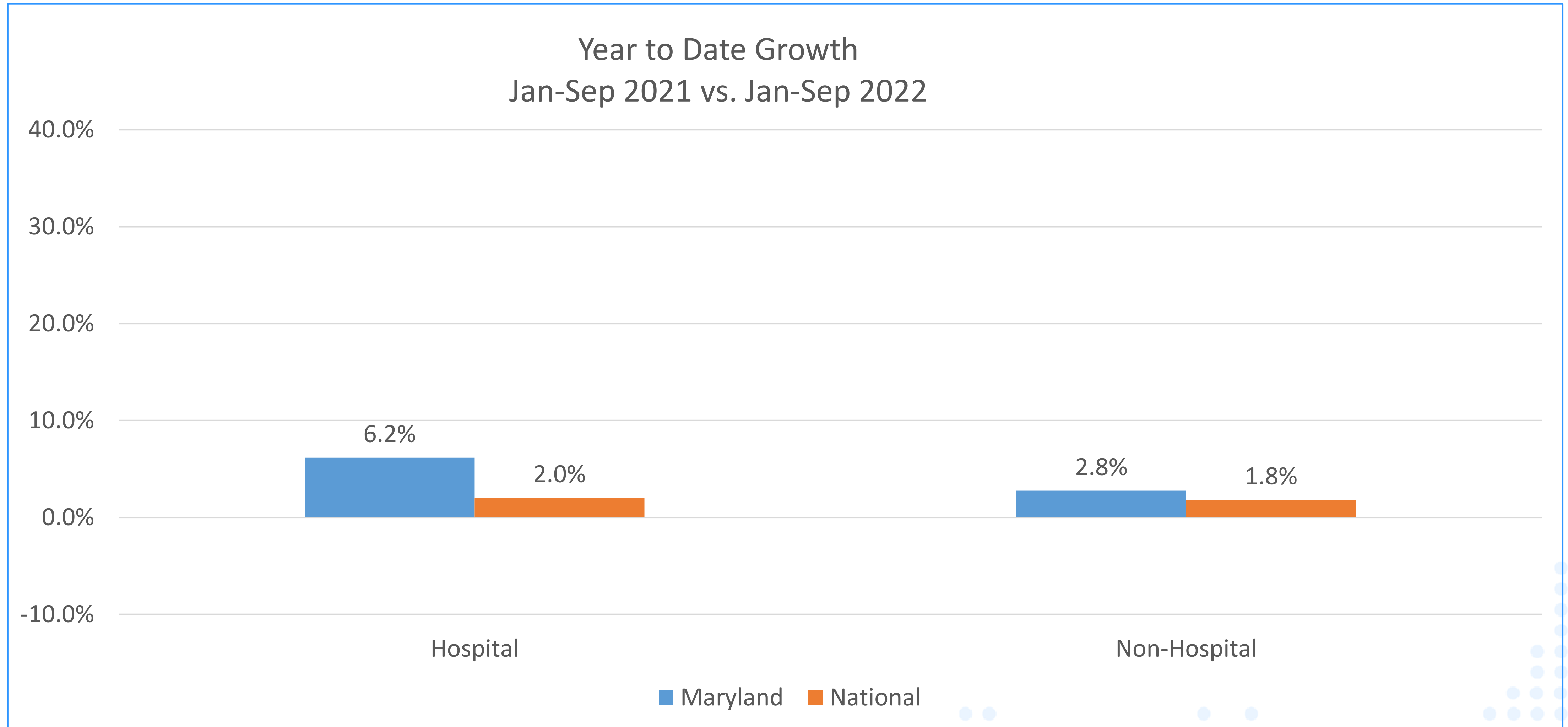
Medicare Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)

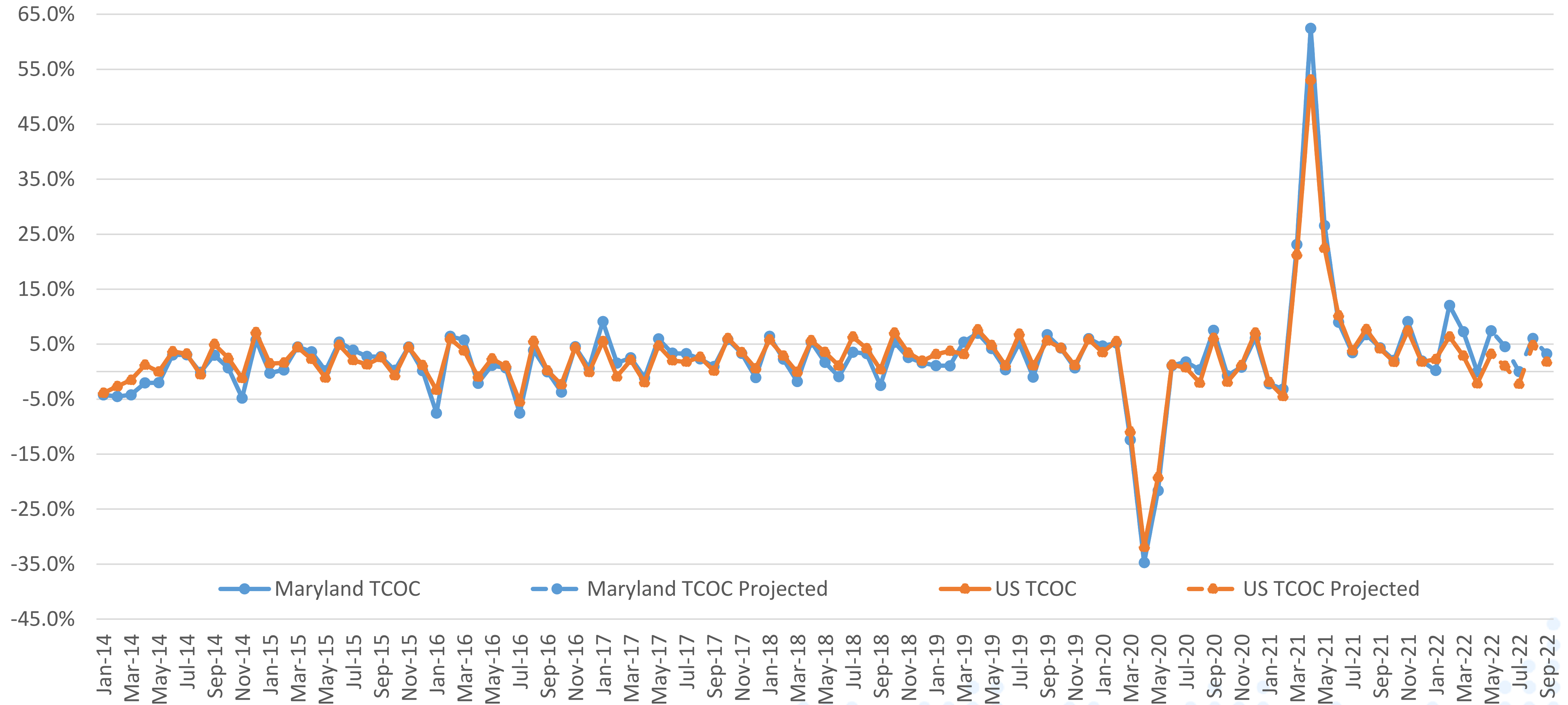


Medicare Hospital and Non-Hospital Payments per Capita



Medicare Total Cost of Care Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)



CY16 has been adjusted for the undercharge

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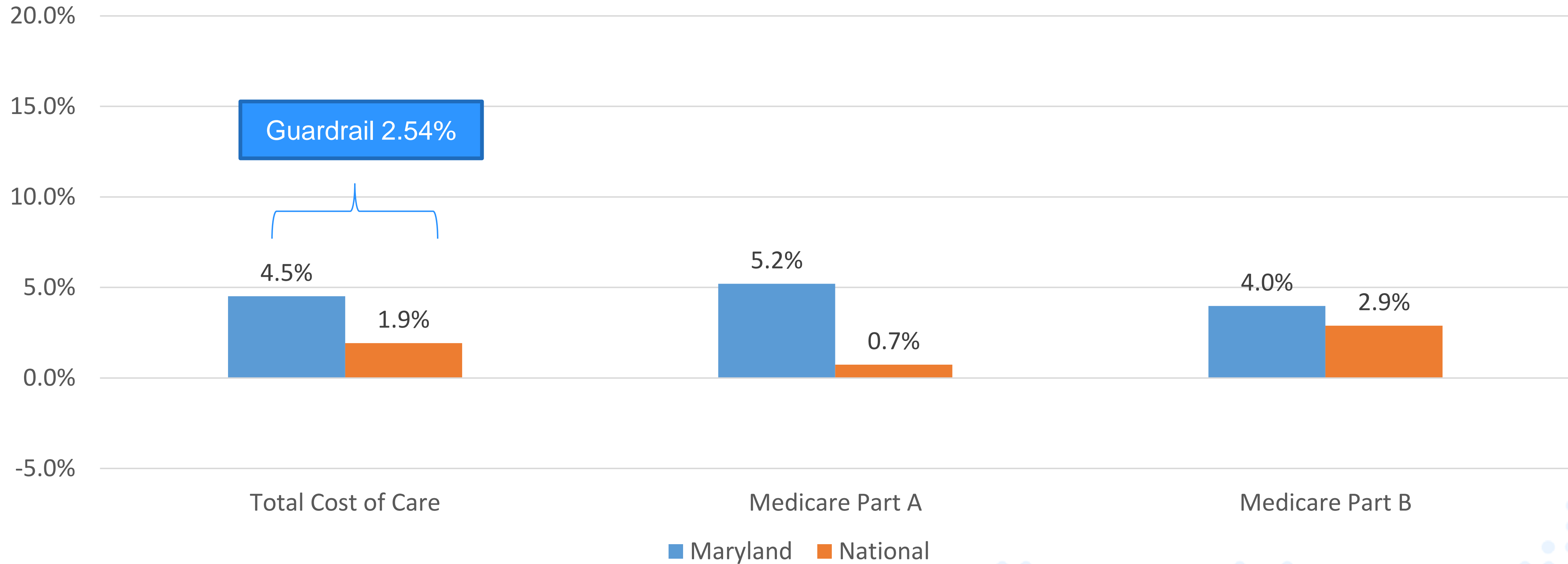
Medicare Total Cost of Care Payments per Capita



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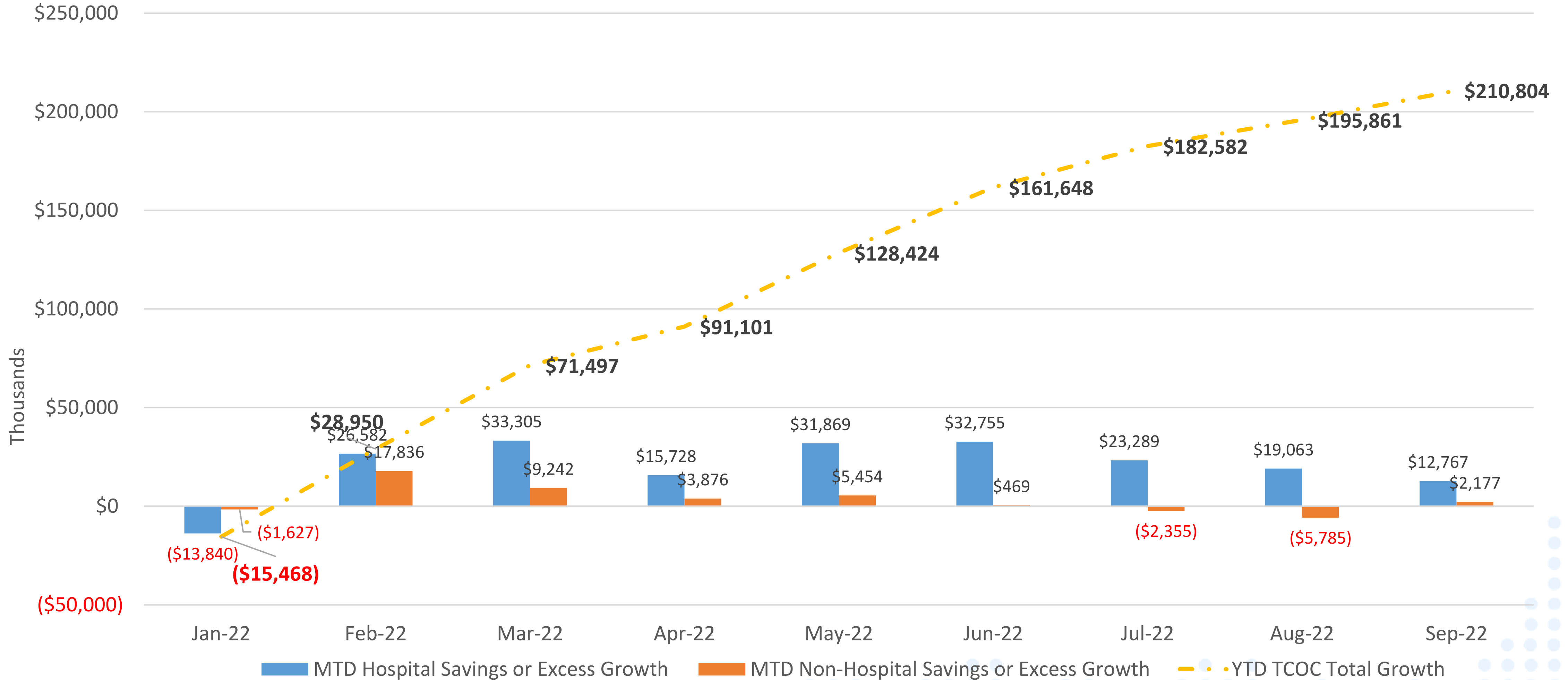
Maryland Medicare Hospital & Non-Hospital Growth

CYTD through September 2022



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HSCRC Policy Discussion

Maryland Health Model

Maryland Model Vision: The Maryland Model, stabilized and embracing a population health approach for all providers, will serve as the nation's leader in health equity, quality, access, total cost, and consumer experience by leveraging value-based payment methodologies across all payers.

TCOC Goals: Achieve person-centered care, foster clinical innovation and excellence in care, improve population health, and moderate the growth in costs, on a statewide basis and in the all-payer environment through the transformation of the health care delivery system.

Maryland plans to achieve its vision by working toward three key goals:

(1) Improve population health;

(2) Improve outcomes for individuals; and

(3) Control growth of total cost of care.

Mathematica 2022 TCOC Evaluation Highlights

Positive Findings and Opportunities (2019-2021)

APM and TCOC are considered as an overarching Maryland Model for estimating impacts

The Maryland Model reduced total Medicare fee-for-service Part A and B spending by 2.5%, creating a $781 million reduction in total spending.

Hospital global budgets have had a strong and growing influence on hospital outcomes that cannot be isolated from new TCOC model components

Results suggest that efforts to improve efficiency have not measurably changed patient satisfaction ratings

Several quality-of-care measures improved under the Maryland Model:

- **16.1% decrease in potentially preventable admissions**
- **9.5% decrease in unplanned hospital readmissions**
- **2.5% increase in timely follow-up after hospital discharge**

In most outcomes, the impacts were more favorable for TCOC than the APM period, indicating further improvement*

* For example, all-cause admissions impacts were 6.1 percentage points larger (16.1 versus 10.0 percent), total Medicare spending impacts were 1.5 percentage points larger (2.5 versus 1.0 percent), and impacts on the likelihood of readmission were 1.6 percentage points larger (9.5 versus 7.9 percent)

Are We Achieving the Broad Mandate?

Accountability through GBR, MPA, EQIP

Transforms Care through CTIs, CRP (including EQIP), MDPCP

Drives Affordable Healthcare through all-payer rate setting revenue limits, de-regulation adjustment

Improves Population Health through investment in RP Catalyst Program, other special funding programs

Broad Mandate

- Fosters Accountability and Aligns Incentives Across Delivery System
- Transforms Care
- Drives Affordable Healthcare
- Improves Population Health

Are we doing enough to drive investments and system transformation in these areas?

HSCRC GBR Policy Inventory

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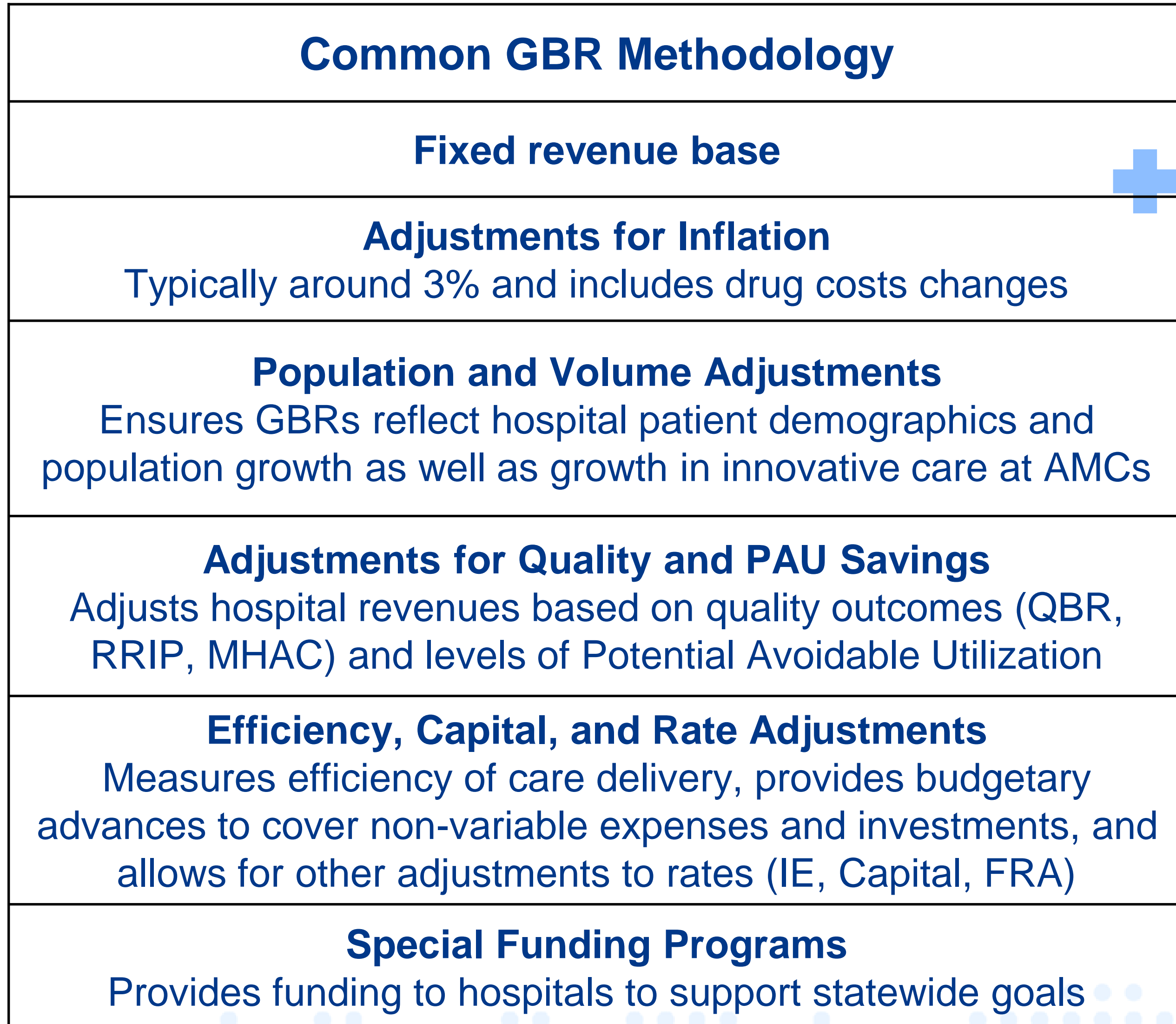
Key Components of the Global Budget Revenue (GBR)



Common GBR Methodology
Fixed revenue base
Adjustments for Inflation Typically around 3% and includes drug costs changes
Population and Volume Adjustments Ensures GBRs reflect hospital patient demographics and population growth as well as growth in innovative care at AMCs
Adjustments for Quality and PAU Savings Adjusts hospital revenues based on quality outcomes (QBR, RRIP, MHAC) and levels of Potential Avoidable Utilization
Efficiency, Capital, and Rate Adjustments Measures efficiency of care delivery, provides budgetary advances to cover non-variable expenses and investments, and allows for other adjustments to rates (IE, Capital, FRA)
Special Funding Programs Provides funding to hospitals to support statewide goals

Other GBR Components
HSCRC assesses hospital GBR to help pay for CRISP, HSCRC (User Fees), Medicaid Deficit Assessment, Uncompensated Care (UCC), and other programs (e.g. Nurse Support Program)

Marketshift and De-Regulation Adjustments Adjustments to hospital GBR to reflect movement of services
Medicare Performance Adjustment (MPA) Includes a Traditional MPA program and the MPA Framework
New Model Programs Includes the Care Transformation Initiatives and Care Redesign Programs (Episode Care Improvement Program)

Are We Achieving the Broad Mandate?

- Do we have the right policies and incentives in place?
  - Do our policies sufficiently incentivize utilization reduction in order to drive savings and retained revenue?
  - Are we clear about how hospitals should spend revenue retained through utilization reductions?
  - Are we clear about the expectations of community investments?
  - Are we clear about quality and health disparity goals?
  - Are there additional policies or incentives we should put in place?
- Future work
  - Analysis of historic TCOC savings to-date and opportunities for future utilization reductions/savings and de-regulation (Winter 2023)
  - Evolution of hospital quality programs to measure disparities and population health (Winter/Spring 2023)
  - **Revisit Revenue for Reform to clarify expectations around retained revenue and exemptions from IE (buy out) (Winter/Spring 2023)**
  - **Modify Integrated Efficiency policy to align with goals of Model and broad mandate (Winter-Spring 2023)**
  - Revise hospital cost schedules to better understand unregulated expenses, including physicians (Spring/Summer 2023)
  - Engage in future Model consideration with broad stakeholder groups (Fall-Spring 2023)

Revenue for Reform and Integrated Efficiency Discussion

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Background

- TCOC Model is a capitated model in that Maryland hospitals in aggregate are held accountable for per capita TCOC Medicare growth
  - Excess TCOC growth is penalized with reduced statewide Update Factors and to lesser extent MPA penalties
  - TCOC savings is rewarded with full inflation on hospital global budget revenues with declining volumes (i.e., retained revenue) and to a lesser extent MPA rewards
- The original global budgets were not developed with a population-based methodology.
  - GBR's were derived from 2013 hospital-based budgets and then adjustments in future years were based on population-based methodologies:
    - Marketshift Policy
    - Demographic Adjustment
  - Consequently, there is potentially a maldistribution of global budget revenue because 2013 hospital-based budgets
    - Did not reflect the underlying population that hospitals would be responsible for under TCOC policies like the MPA
    - Reflect varying levels of hospital utilization (i.e. not all hospitals had the same opportunity to reduce avoidable utilization)
- The All-Payer and TCOC Model did not alter Maryland statute that requires the Commission to set hospitals rates based on a reasonable costs and charges reasonably related to those costs.

Integrated Efficiency Policy Overview

- The principal aim of the Integrated Efficiency Policy is to formulaically penalize and reward total cost of care AND hospital cost per case efficiency with approved objective standards while:
  - Maintaining the Model's incentive to reduce avoidable utilization
  - Keeping fidelity to the Commission's statutory mandate to ensure costs are reasonable and charges are reasonably related to costs
- Policy is not intended to produce model savings but will redistribute funding from poor performers to excellent performers
  - Overtime it should correct the maldistribution of global budgets
  - By focusing on outliers and gradually implementing the redistribution of global budget revenues, the policy minimizes the dilution of incentives
- Without a Revenue for Reform complement, the Integrated Efficiency Policy may result in elimination of retained revenue that is otherwise used to further TCOC Model goals
- Modifications to Integrated Efficiency Policy are needed to recognize R4R and other important policy changes (April/May 2023)

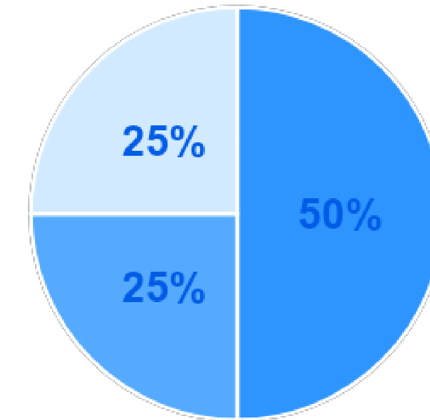
Overview of Efficiency Matrix and Application

- The IE Policy is a relative ranking methodology that arrays hospitals into quartiles (known as the Efficiency Matrix) based on the combination of:
  - TCOC efficiency using Medicare and Commercial TCOC benchmark performance
  - Cost per case efficiency using the Volume Adjusted Interhospital Cost Comparison (ICC)
    - Includes credit for reductions in Potentially Avoidable Utilization
- To ensure efficiency evaluation does not disincentivize care transformation and aligns with Maryland statute on hospital rate setting, the Efficiency Matrix identifies hospitals in the worst and best quartiles
- Efficiency adjustments are only applied to the best and worst quartiles to bring hospitals over time closer to peer average standards
  - Poor performing hospitals will not receive a full update factor increase
  - Excellent performing hospitals will receive funding from poor performing hospitals and the annual set aside

Efficiency Matrix Weighting

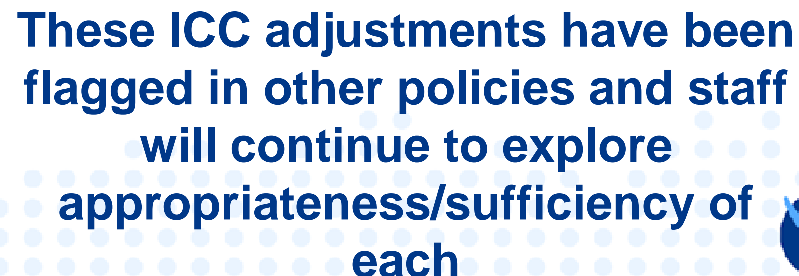
- Because global budgets are based on hospital budgets from 2013, staff proposed that ICC performance be worth 50% of the Integrated Efficiency Policy
- Current TCOC Weighting in IE is 50%
  - 25% Medicare benchmark performance, 25% Commercial benchmark performance
    - Medicare FFS represents 37% of hospital payments
    - Commercial represents 36% of hospital payments
    - Excluding all other payers, which are not accounted for in national TCOC analyses at present, the effective weighting is 51% Medicare, 49% commercial

Efficiency Matrix



Concerns with the Integrated Efficiency Policy

- Potentially a disincentive to care transformation since hospitals with the largest reductions in utilization will not fare as well in the ICC
- In the absence of a Revenue for Reform policy, retained revenue from lower utilization could be inadvertently removed instead of safeguarded for community investment
- Concerns over technical measurement of efficiency evaluation and associated adjustments
  - TCOC Benchmarking
  - ICC New Cost Allowances
    - Expected Physician Subsides
    - Surge Readiness (Social Good)
  - ICC Peer Groups/DSH Adjustment
  - ICC Medical Education Adjustment
  - ICC Trauma Subsidy



Proposals to Alleviate Concerns with the Integrated Efficiency Policy

- Currently, there are three ways in which the Integrated Efficiency Policy attempts to address concerns that the policy is a disincentive to the larger TCOC goals of the Model
  1. 50% of the evaluation is a TCOC assessment
  2. Credit is provided in the ICC for reductions in Potentially Avoidable Utilization
  3. The policy protects the underlying incentives of the Model by not scaling all hospitals and limiting the extent of the policy to annual inflation
- Staff believe the final way to address this overarching concern is to implement the Revenue for Reform policy (r4r).
  - Allows hospitals that have successfully reduced utilization and yet have relatively poor TCOC and hospital cost per case performance to “buy-out” from efficiency reductions through investments in community health
    - Modelled after Bon Secours/Grace Medical Center FMF transition
- Alternative: Abolish Integrated Efficiency Policy and:
  - Engage in population, zero-based budgeting approach to hospital GBR’s or
  - Dramatically increase the risk of the Medicare Performance Adjustment policy to more than 1% of Medicare revenue; potentially expand to all-payer approach

Potential Policy Adjustments to IE Policy cont.

- TCOC Benchmarking: Some stakeholders have raised concerns about the validity of the benchmarking methodology and the fact the historical TCOC performance relative to national benchmarks will take years to undo and thus hospitals are stuck with perpetually lower inflation factors
    - This is especially problematic in areas of the state with market saturation where one hospital's improvements in TCOC can be masked/overshadowed by another hospital's poor performance (i.e., free rider problem)
- Staff will continue to address concerns about the validity of the Commission's TCOC benchmarking methodology in keeping with the HSCRC ethos to constantly improve methodologies, but notes that the tool has been vetted in numerous workgroups and Commission meetings
- Staff is considering using TCOC improvement as outlined in MPA policy in lieu of TCOC benchmarks
    - Blends TCOC attainment with improvement by scaling the expected, cumulative improvement levels based on TCOC benchmark performance
    - Benefit of this is:
        - Hospitals that generate TCOC savings in line with the Model's overarching incentives do not get stuck with lower inflation
        - It is more reliable than YOY improvement assessments because it is cumulative
        - It recognizes that various parts of the State do not need to improve TCOC as fast as other parts of the State due to historically good performance in TCOC
    - Staff would also consider analogous TCOC approach to Commercial evaluation

Potential Policy Adjustments to IE Policy cont.

- Expected Physician Subsidies: Hospitals continue to raise concerns that some level of investment in **unregulated** physician subsidies in necessary to operate a hospital
  - Staff is currently working to develop the uniform data infrastructure that would be required to assess the reasonableness of physician subsidies by speciality
    - Timeline: RY 2024
  - Following this work, staff will then need to work with stakeholders to determine how to incorporate expected physician subsidies into HSCRC hospital cost per case efficiency assessments **GIVEN THE REGULATORY HURDLES**
- Should the Commission consider any new cost allowances in the ICC that are deemed a social good, such as surge readiness?

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Update on TCOC Model Progression

Public Session

January 11, 2023

Progression Plan Development Timeline

Oct 2022-April 2023
- Small Workgroups begin

April 2023
- Small Workgroups Conclude
- Written workgroup recommendations finalized by HSCRC and State staff

May-June 2023
- Draft Progression Plan finalized (May)
- Draft plan circulated to HSCRC Commission and SVG for initial comment (June)

June - Sept 2023
- Draft Progression Plan circulated for public comment
- Socialize with other important stakeholders (elected officials, others as needed)

Oct 2023
- Public comments reviewed and integrated into final Progression Plan

Nov- Dec 2023
- Final Progression Plan submitted to CMMI

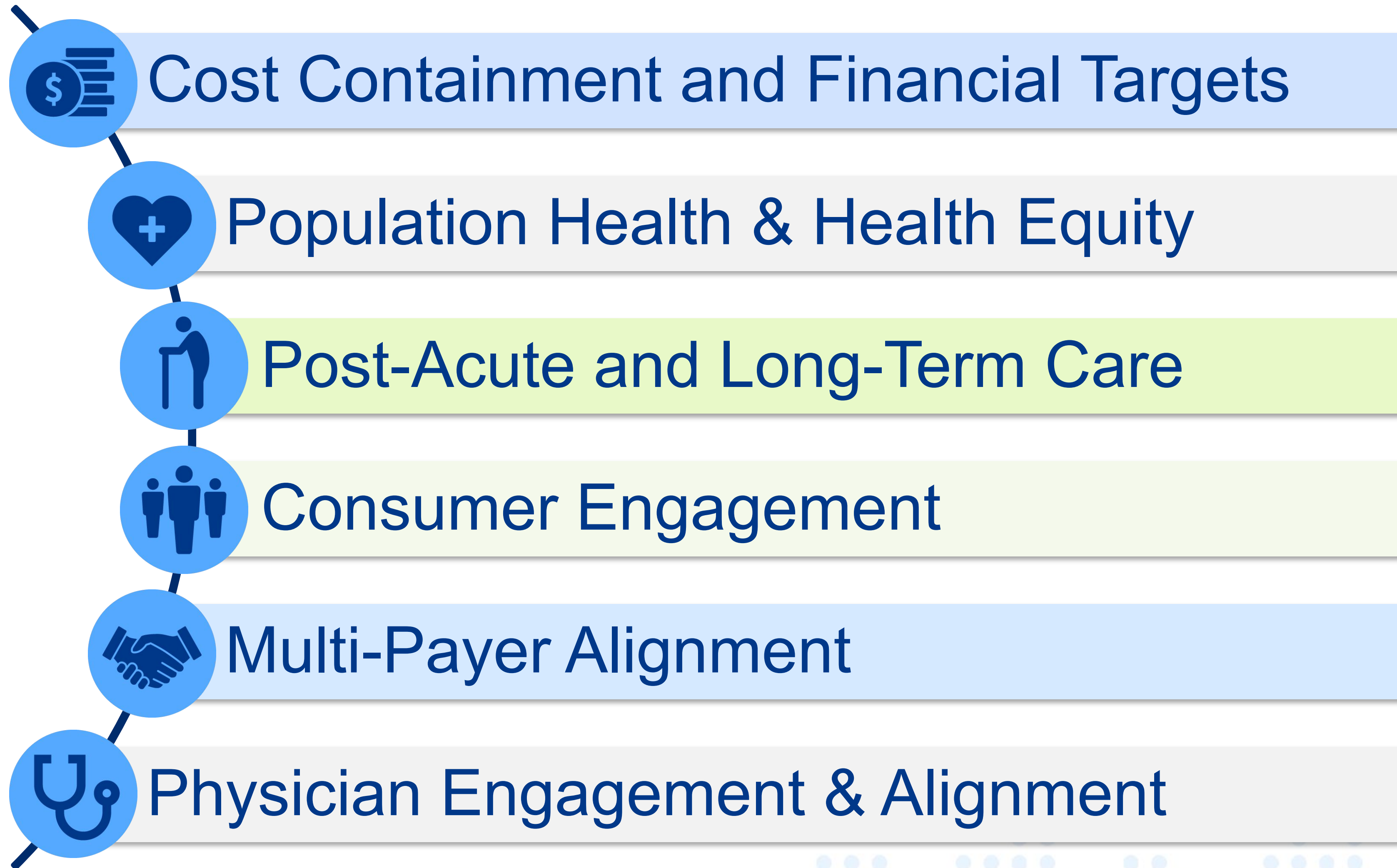
Stakeholder Engagement Approach

- HSCRC and other State staff have begun the process for stakeholder engagement meetings to develop content for a written Progression Plan for the expansion of the Model (or a new Model) beyond 2026.
- Small groups will meet on priority topics, October - April 2023.
  - To the extent possible, staff will utilize existing workgroup structures; new groups will be created for select topics
  - Staff leading the small groups have reached out to Commissioners for input and direction
- Progression Plan drafted for review, May-June 2023
  - Commission will receive updates on progress and also view a draft of the Progression Plan before the public comment period.
  - MDH Secretary and Governor's Office will also be asked to review and comment
- Public Comment and Final Submission to CMMI, June-December 2023
  - Public comment period will allow for additional comments from all stakeholders before presented to CMMI
  - Begin negotiation process with CMMI on future of Model based on vision in Progression Plan

Guiding Principles of Progression Plan development

1. The Progression Plan should further the goals of the Maryland Health Model to lead the nation in health equity, quality, access, cost of care and consumer experience through aligned incentives and value-based payment methodologies across providers and payers.
2. The Progression Plan should include high-level recommendations that are feasible to implement and build upon existing initiatives and programs, where possible.
3. The Progression Plan should utilize State flexibility in order to tailor delivery system and payment reform efforts unique to Maryland.
4. The Progression Plan recommendations should adhere to the all-payer nature of the system to align quality and cost incentives across payers.
5. The Progression Plan recommendations should be established through a collaborative public process.

Stakeholder Small Group Focus Areas



Workgroup Focus Areas and Contacts

Workgroup Focus	Staff Lead	Contact Information
Cost Containment and Financial Targets	Jerry Schmith, HSCRC	hscrc.tcoc@maryland.gov
Population Health and Health Equity	Alyson Schuster, HSCRC	hscrc.performance@maryland.gov
Post Acute and Long Term Care	Paul Parker, MHCC	ruby.potter@maryland.gov
Consumer Engagement	Megan Renfrew, HSCRC	megan.renfrew1@maryland.gov
Medicaid Integration and Multi-Payer Alignment	Laura Goodman, Medicaid	laura.goodman@maryland.gov
Physician Engagement and Alignment	William Henderson, HSCRC	william.henderson@maryland.gov

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Director
Population-Based Methodologies

Gerard J. Schmith
Director
Revenue & Regulation Compliance

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: January 11, 2022

RE: Hearing and Meeting Schedule

Feb 8, 2023 To be determined - HSCRC Offices/GoTo Webinar

Mar 8, 2023 To be determined - HSCRC Offices/GoTo Webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

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