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506th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
March 12, 2014

EXECUTIVE SESSION
12:00 p.m.

1. **Update on Hospital Contracting Process**
2. **Implementation Planning - Staffing and Resources**

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

1. **Review of the Minutes from the Executive Session and Public Meeting on February 5, 2014**

2. **Executive Director's Report**

3. **Status of Work Groups for All-Payer Hospital System Modernization**

4. **Docket Status – Cases Closed**

   2241A – Johns Hopkins Health System

5. **Docket Status – Cases Open**

   2242N – UM St. Joseph Medical Center
   2243A – University of Maryland Medical System
   2244A – Johns Hopkins Health System
   2245A – Johns Hopkins Health System
   2246A – Johns Hopkins Health System
   2247R – Garrett County Memorial Hospital

6. **Staff Draft Recommendation for Modifying the Maryland Hospital Acquired Conditions Programs for FY 2016**

7. **Staff Draft Recommendation on Readmission Reduction Program for FY 2016**

8. **Report on Status of Monitoring under the All-payer Model**

9. **Legislative Update**

10. **Legal Report**

11. **Hearing and Meeting Schedule**

Status of Work Groups for All-Payer Hospital System Modernization

March 12, 2014

Steve Ports, Principle Director, Policy and Operations
Sule Calikoglu, PhD., Deputy Director of Research and Methodology

Update

- Four Work Groups Appointed and Actively Meeting
  - Approximately 85 individuals appointed representing broad range of perspectives
  - In addition to Kick Off educational session, all groups will have met at least 2 times by mid-March; Performance Measurement has meet 3 times due to early deliverables
  - Attendance has been good – either in person or webinar and active discussions
- Public Input
  - Web Pages for each workgroup provide all content
  - Webinar accessible to public to listen

HSCRC Work Group Descriptions

Physician Alignment & Engagement

- Alignment with Emerging Physician Models
- Shared Savings
- Care Improvement
  - Care Coordination Opportunities
  - Post-Acute and Long-Term Care
  - Evidence-Based Care

Performance Improvement & Measurement

- Reducing Potentially Avoidable Utilization to achieve Three-Part Aim
  - Statewide Targets & Hospital Performance Measurement
  - Measuring Potentially Avoidable Utilization
- Value-Based Payments (integration of cost, quality, population health and outcomes)
- Patient Experience and Patient-Centered Outcomes

Payment Models

- Balanced Update
- Guardrails for Model Performance
- Market Share
- Initial and Future Models

Note: More Detailed Work Group Descriptions reviewed by Commission January 13, 2014 and available on HSCRC website

HSCRC Work Group Descriptions

Data and Infrastructure

- Data Requirements
- Care Coordination Data and Infrastructure
- Technical and Staff Infrastructure
- Data Sharing Strategy

Note: More Detailed Work Group Descriptions reviewed by Commission January 13, 2014 and available on HSCRC website

HSCRC New Model Workgroups – Work Plan and Commission Reporting Targets(

Month	Feb	March	April	May	June	July
Performance Management						
Potentially Avoidable Utilization (PAU)	CY 14 Rec				CY 15 & Beyond Report	
Potentially Avoidable Complications (PPC)	CY 14 Rec				CY 15 & Beyond Report	
Readmissions	CY 14 Rec				CY 15 & Beyond Report	
Pop-Based Patient-Centered Cost Measures				Report		
Patient Experience & Outcomes (PEO)						Report
Vision for Perf. Meas. and Value Purchasing						Report
Future Role of the Workgroup						Report
Physician Alignment & Engagement						
Overview Current Payment				Report		
Shared Savings/Gain Sharing		I		Interim report		Final Report
Care Coordination						Report
Post Acute						Report
Future Role of Workgroup						Report
Data						
Data Requirements			Report			
Care Coordination Data Needs				Report		
Technical & Staff Infrastructure					Report	Report
Data Sharing Strategy					Report	Report
Future Role of Workgroup					Report	Report
Payment Models						
Balanced Update		Principles	Recommendation			Report
Uncompensated Care (UCC)				Report		
Capital Projects						Report
Guardrails						Report
Market Share						Report
Future Role for Workgroup						Report

Performance Measurement Update

- Work Group highly focused on recommendations for CY 2014 Performance Year
  - Draft recommendation before Commission is staff draft based on input from work group. Additional input w/Performance Measurement workgroup (methods) and Payment Models workgroup (scaling)
- March- April meetings will shift focus to
  - Finalize guiding principles (in staff recommendation)
  - Review of model monitoring commitments and gap analysis
  - Efficiency and cost measures, timing and process to develop
  - Balanced scorecard
  - Population-Based measurement

Data Infrastructure

- Initial meeting focused on monitoring commitments under new model, HSCRC data and preliminary gap analysis
- 2nd meeting focused on data available through other state resources (MHCC, Medicaid, DHMH, CRISP)
- Focused on April report to Commission re: monitoring commitments
  - Total Cost of Care – consistent with white papers, discussion focused on need for payer reported data on total cost of care- Subgroup with payers to develop Total Cost of Care reporting template
  - Provider Participation reporting requirements – discussed data challenges and options to monitor
- Next Meeting is a joint meeting with Physician Alignments & Engagement work group and will shift focus to vision for data sharing and data needs for care coordination

Physician Alignment & Engagement

- Initial meeting had presentations and discussions on:
  - Current physician payment models, noting the emphasis on fee for service, and the potential for conflict with global budgets and population health management goal
  - Best practices in population health management and care coordination, from national speakers with deep understanding of Medicare Health Plans and Medicare Demonstrations & CMMI initiatives, as well as other population health management initiatives
- Interest in connections to other workgroups, as well as connections to other initiatives, such as the DHMH SIM grant, MHA Transitions Workgroup, etc.
  - 3rd meeting is joint meeting with data and infrastructure
  - Being careful to broaden our reach to avoid duplication, and coordinate all payer focused activities

Physician Alignment & Engagement

- Next meeting
  - Continue discussion on existing payment models, including to gain better understanding of existing landscape, including to what extent physician payment models in effect today conflict or are aligned with population health objectives
  - Strong range of experts, with experience in and outside of Maryland, making presentations on gain sharing and pay-for-performance options - Historically, gain sharing models have largely focused on cost-per-case; we are focused on broadening the vision to include a focus on volume
  - We will consider / evaluate what does and does not need CMS / regulatory approval, in order to work towards approvals if necessary
- First deliverables are in May, including an overview of existing payment models, and gain sharing / pay-for-performance recommendations

Payment Models

- Initial meeting focused on background and review of work plan
  - Focus on the clear goal of informing May Draft Recommendations on Update Framework and Short-Term Adj – next two meetings will focus on components, approach and principles for update and UCC policy
  - Added issues to work plan (timing of annual update and relationship to monitoring performance; benefit design changes and impact on utilization and UCC)
  - Prioritized issues they wanted to address early in process (such as new hospital opening; capital and exclusions)
  - Interest in many issues that overlap with other workgroups
    - Physician/Post Acute Alignment
    - Broader view of Efficiency measures

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

AS OF MARCH 4, 2014

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2242N	UM St. Joseph Medical Center	1/27/2014	3/12/2014	6/26/2014	RDL	CK	OPEN
2243A	University of Maryland Medical System	1/30/2014	N/A	N/A	ARM	DNP	OPEN
2244A	Johns Hopkins Health System	1/31/2014	N/A	N/A	ARM	DNP	OPEN
2245A	Johns Hopkins Health System	2/26/2014	N/A	N/A	ARM	DNP	OPEN
2246A	Johns Hopkins Health System	2/28/2014	N/A	N/A	ARM	DNP	OPEN
2247R	Garrett County Memorial Hospital	2/28/2014	3/31/2014	7/28/2014	TPR	GS	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*	**COST REVIEW COMMISSION**
UM ST. JOSEPH MEDICAL	*	**DOCKET: 2014**
CENTER	*	**FOLIO: 2052**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2242N**

Staff Recommendation

March 12, 2014

Introduction

On January 31, 2014, University of Maryland St. Joseph Medical Center ("UMSJMC" or "the Hospital"), a member of the University of Maryland Medical System, submitted a partial rate application to the Commission requesting a rate for Inpatient Renal Dialysis (RDL) services. The Hospital requests that the RDL rate be set at the lower of a rate based on its projected costs to provide RDL services or the statewide median and be effective March 1, 2014.

Staff Evaluation

To determine if the Hospital's RDL rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for RDL services for FY2014. Based on information received, it was determined that the RDL rate based on the Hospital's projected data would be $661.58 per treatment, while the statewide median rate for RDL services is $863.94 per treatment.

Recommendation

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

1. That a RDL rate of $661.58 per treatment be approved effective March 1, 2014;
2. That no change be made to the Hospital's Charge per Episode standard for RDL services; and
3. That the RDL rate not be rate realigned until a full year's cost experience data have been reported to the Commission.

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IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2014**
MEDICAL CENTER *		**FOLIO:**	**2053**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2243A**

Staff Recommendation

March 12, 2014

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on January 30, 2014 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. Network for a period of one year, effective April 1, 2014.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement among UPI, the Hospital, and the physicians holds the Hospital harmless from any shortfalls in payment from the global price contract. UPI maintains it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to the bear the risk of potential losses.

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement for the last year and found it to be favorable. After review of the application and additional information provided by the Hospital,

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

V I. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. for a one year period commencing April 1, 2014. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2014**
SYSTEM	*	**FOLIO:**	**2054**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2244A**

Staff Recommendation

March 12, 2014

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on January 31, 2014 on behalf of its member hospitals (the Hospitals), requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. Aetna Heath, Inc. recently acquired Coventry and this arrangement combines the approved arrangement for solid organ transplants between Coventry Transplant Network and the System as well as the approved arrangement of Aetna. The Hospitals request that the Commission approve the arrangement for one year beginning March 1, 2014.

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

The staff found that the actual experience under the prior arrangement for last year's solid organ transplants has been favorable.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period beginning March 1, 2014. The Hospitals must file a renewal application annually 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:**	**2014**
SYSTEM	*	**FOLIO:**	**2055**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2245A**

Staff Recommendation

March 12, 2014

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on February 3, 2014 on behalf of its member hospitals (the Hospitals), requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. Aetna Heath, Inc. acquired Coventry Transplant Network, and this arrangement adds the Coventry Transplant Network to the existing Aetna contract. In addition, the global prices in the new arrangement have been revised. The Hospitals request that the Commission approve the arrangement for one year beginning April 1, 2014.

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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 continue to manage all financial transactions related to the global price contract including payments to the hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

The staff found that the actual experience under the prior Aetna arrangement for the last year has been favorable. However, the prior Coventry arrangement was unfavorable. After review of the revised arrangement, staff is confident that the new global prices are sufficient to enable the Hospitals to achieve a favorable result.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period beginning April 1, 2014. The Hospitals must file a renewal application annually 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:**	**2014**
SYSTEM	*	**FOLIO:**	**2056**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2246A**

Staff Recommendation

March 12, 2014

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on February 28, 2014, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a revised global rate arrangement for solid organ and bone marrow transplants with Optum Health, a division of United HealthCare Services, for a period of one year beginning April 1, 2014.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the 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. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION ANDASSESSMENT OF RISK

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

maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

The staff reviewed the experience under this arrangement for the last year and found it to be unfavorable. However, after review of the revised arrangement, staff believes that the Hospitals will be able to achieve a favorable outcome moving forward.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period commencing April 1, 2014. 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.

Request for Extension of Approval
Staff Recommendation
March 12, 2014

Background

On November 21, 2013, in accordance with the authority granted to it by the Commission, staff approved a 3 month extension of the Commission's approval of the alternative rate arrangement between the Johns Hopkins Health System (JHHS) and OptumHealth, Proceeding 2191A. The extension expires on February 28, 2014. However, JHHS and OptumHealth have not yet completed negotiations to extend the arrangement.

Request

Therefore, on January 30, 2014, JHHS submitted a request that the Commission extend its approval for an additional month, to March 31, 2014, to complete negotiations.

Staff Recommendation

Staff recommends that the Commission grant JHHS's request for a one month extension of its approval, with the condition that if the negotiations are not completed before the expiration of this extension that the arrangement end and that no further services be provided under the arrangement until a new application is approved.

Request for Extension of Approval
Staff Recommendation
March 12, 2014

Background

On November 21, 2013, in accordance with the authority granted to it by the Commission, staff approved a 3 month extension of the Commission's approval of the alternative rate arrangement between the Johns Hopkins Health System (JHHS) and Coventry, Proceeding 2195A, for the provision of solid organ and bone marrow transplants. The extension expires on February 28, 2014. Since that time, Coventry has been acquired by Aetna and is submitting a renewal request replacing the existing Coventry and Aetna arrangements for solid organ transplants, Proceeding 2044A. However, JHHS and Aetna have not yet completed negotiations on the bone marrow transplant global prices. Therefore, on January 30, 2014, JHHS requested a one month extension on the bone marrow transplant portion of the Coventry arrangement.

Request

JHHS requests that the Commission extend its approval for an additional month, to March 31, 2014, to complete negotiations on the bone marrow transplant portion of Coventry arrangement.

Staff Recommendation

Staff recommends that the Commission grant JHHS's request for a one month extension of its approval on the bone marrow transplant portion of Coventry arrangement, with the condition that if the negotiations are not completed before the expiration of this extension that the arrangement end and that no further services be provided under the arrangement until a new application is approved.

Draft Recommendation for Modifying the Maryland Hospital Acquired Conditions Programs for FY 2016

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

March 12, 2014

This document contains the draft staff recommendations for updating the Maryland Hospital Acquired Conditions (MHAC) Program for FY 2016. Comments on the draft recommendation are due in writing to the Commission by COB Thursday March 27, 2014, attention: Dianne Feeney at the Commission address or to Dianne.feeney@maryland.gov.

A. Introduction

The HSCRC quality-based payment methodologies are important policy tools for providing strong incentives for hospitals to improve their quality performance over time.

Current HSCRC approved policy calls for the revenue neutral scaling of hospitals in allocating rewards and penalties based on performance on the HCSRC's Maryland Hospital Acquired Conditions ("MHAC") initiative, with the net increases in rates for better performing hospitals funded entirely by net decreases in rates for poorer performing hospitals. The term "scaling" refers to the differential allocation of a pre-determined portion of base regulated hospital revenue contingent on assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's revenue on a "one-time" basis (and not considered permanent revenue). In its January 2014 meeting, the Commission approved scaling 3% for the MHAC program (2% for performance and 1% for improvement) in a revenue neutral manner with a notification that there might be changes to the program to align with the Centers for Medicare and Medicaid Innovation (CMMI) All-payer model demonstration contract.

In order to enhance our ability to incentivize hospital care improvements and meet the targets proposed in the CMMI All-payer model demonstration contract that began on January 1, 2014, the Commission has convened three meetings of the Performance Measurement Workgroup to deliberate near-term issues related to the MHAC initiative. These may include, for example, shifting from revenue neutral scaling to pre-established performance targets where hospitals earn up to full credit if they meet the targets.

Within the context of the Workgroup activity, staff has developed this draft recommendation to update the measurement, scoring and scaling methodologies to translate scores into rate adjustments for the MHAC initiative for performance in calendar year 2014 (beginning January 1, 2014). These updates are to be applied to FY 2016 rates for each hospital.

B. Background

1. Centers for Medicare & Medicaid Services (CMS) Hospital Acquired Conditions (HAC) Program

The federal HAC program began in FFY 2012 when CMS disallowed an increase in DRG payment for cases with added complications in 14 narrowly defined categories. Beginning in FFY 2015, CMS established a second HAC program, which reduces payments of hospitals with scores in the top quartile for the performance period on their rate of Hospital Acquired Conditions as compared to the national average. In FY 2015, the maximum reduction is one percent of total DRG payments.

The CMS HAC measures for FY 2015 are listed in in Appendix I.

2. MHAC Measures, Scaling and Magnitude at Risk to Date

The MHAC program, which began in state FY 2011, currently uses a large subset of the 65 Potentially Preventable Complications (PPCs) developed by 3M Health Information Systems.

The PPC software computes actual versus expected number of complications adjusted for each patient by the All Patient Refined Diagnosis Related Group ("APR DRG"), and severity of illness ("SOI") category. The attainment scale measures the proportion of each hospital's inpatient revenue from excess PPCs (calculated as cost*(actual minus expected number of PPCs compared to the benchmarks). The cost of each PPC is determined by a regression analysis and is updated every year. For FY 15, the expected performance benchmark is calculated using a value of 15% below the statewide average for each PPC used in the MHAC program. The improvement scale was implemented for the first time in FY14 and focused on rewarding hospitals for improvements in five high cost high prevalence PPCs. For FYs 14 and 15, the Commission approved targeting improvement for scaling 1% of inpatient revenue, bringing the "at risk" revenue to 3% for the MHAC program. Appendix II lists the measures used for the MHAC program for FY 2015.

For the MHAC program, the earlier QBR MHAC work group convened in December 2013 to discuss modifications. Representing the industry, the MHA presented the following issues of concern (See Appendix III):

- the MHAC reduction goals should be more directly aligned with the new waiver targets;
- there is little hospital-level predictability of revenue rewards and penalties; and,
- the scaling approach also promotes competition rather than collaboration and sharing of best practices to reduce MHACs.

The MHA strongly advised the Commission to consider a revised MHAC approach that could be applied retroactively beginning January 1, 2014.

As a fall back to overhauling of the MHAC program methodology that could be successfully implemented for rate year 2016, Commission staff presented the following modifications to the current MHAC methodology:

- Through the effort of the Performance Measurement Workgroup to begin in January 2014, work to adapt the MHAC policy to the new waiver requirements with a reasonable implementation period that is consistent with the new all-payer model.
- Absent Commission approval of a revised MHAC policy, continue the current MHAC policy for FY 2016 (which provides for 2% at risk for attainment and 1% for improvement) and increase the benchmark to establish the expected MHAC values for attainment to 75% of the statewide average, which represents a more linear relationship between scaling and performance.

C. Assessment

Since the inception of the program and as is currently the case, HSCRC solicits input from stakeholder groups comprising the industry including payers to determine appropriate direction regarding areas of needed updates to the programs. These include the measures used, and the program's methodology components.

The Performance Measurement Workgroup has deliberated pertinent issues and potential changes to current Commission policy necessary to enhance our ability to successfully achieve the in-hospital complication reduction target set forth in the contract with CMMI— a 30% reduction in MHACs over five years. In its last three meetings, the Workgroup has considered

overall guiding principles, a revised approach for calculating hospital scores and translating them into payment, and incremental first year annual reduction targets for the MHAC program.

1. *Overall Guiding Principles*

Commission staff vetted several guiding principles for the revised MHAC program that overlap significantly with those identified by the MHA. They include:

- Program must improve care for all patients, regardless of payer.
- Breadth and impact of the program must meet or exceed the Medicare national program in terms of measures and revenue at risk.
- Program should identify predetermined performance targets and financial impact.
- First year target for the program must be established in context of the trends of complication reductions seen in the previous years as well as the need to achieve the new All-payer model goal of a 30% cumulative reduction by 2018.
- Program should prioritize high volume, high cost, opportunity for improvement and areas of national focus.
- Program design should encourage cooperation and sharing of best practices.
- Program scoring method should hold hospitals harmless for lack of improvement if attainment is highly favorable.
- Hospitals should have ability to track progress during the performance period.

2. *Proposed Revised Measurement Methodology*

The MHA and HSCRC staff presented the key methodology changes over the course of the Performance Measurement Workgroup meetings convened to date.

The discussion entailed a shift to using observed to expected ratios as the basis of the measurement for each PPC and establishing thresholds and benchmarks for each of the 65 PPC measures. It also involved calculating a hospital score of zero to ten for each PPC based on where a hospital's score falls between the thresholds and benchmarks for attainment, and the difference from the hospital's own base score for improvement. The final score is based on the better of an attainment or improvement score, and is the sum of each of the PPC scores.

To target high volume, high cost PPCs and those with potentially greater opportunity for improvement or of national focus, the revised methodology proposes tiering the PPCs in groups and assigning a higher weight of the scores for the "top tier" target PPCs of priority. The Workgroup also discussed rules to address measurement stability issues, e.g., hospitals must have at least 1 expected and 10 at risk cases for the PPC to be included.
To translate the scores into payment, HSCRC staff supports setting statewide goals and proposes to differentiate the maximum revenue at risk based on the target level. Appendix IV provides additional PPC measurement and scoring details.

As part of the CMMI contract, the aggregate maximum revenue at risk in Maryland quality/performance based payment programs must be equal to or greater than the aggregate maximum revenue at risk in the CMS Medicare quality programs. Appendix V compares Maryland with Medicare revenue magnitudes at risk for each program for FYs 2015-17, assuming a maximum of 4% at risk for the MHAC program in FY 2016.

Based on the trends in PPC reductions since FY 2010, as illustrated in Figure 1, staff recommends a risk adjusted PPC rate reduction target of 8.5% for CY 2014.

Figure 1. PPC Reduction Trends FY 10 to FY 13

Potentially Preventable Complication (PPC) Rates in Maryland- State FY2010-FY2013										
	PPC RATES					Annual Change				
	FY10	FY11	FY12	FY13		FY11	FY12	FY13	Average Annual Change	Total FY10-FY13 Change
TOTAL NUMBER OF COMPLICATIONS	53,494	48,416	42,118	34,200		-9.5%	-13.0%	-18.8%	**-13.8%**	-36.1%
UNADJUSTED COMPLICATION RATE PER 1,000 AT RISK CASES	1.92	1.82	1.65	1.41		-5.2%	-9.3%	-14.5%	**-9.7%**	-26.6%
RISK ADJUSTED COMPLICATION RATE PER 1,000 AT RISK CASES	1.92	1.77	1.58	1.3		-7.8%	-10.7%	-17.7%	**-12.1%**	-32.3%

Based on PPC v.30.

Potential risk tiering options based on state-wide MHAC performance will be further deliberated with Workgroup stakeholders. An example of a tiering option is illustrated below.

- If statewide minimum annual goal of 6.89% (one fifth of the 5-year target) reduction is **not** met, maximum possible penalty of 4% applies and all hospitals receive a penalty.
- If statewide minimum annual goal of 6.89% reduction is met but the CY2014 goal of 8.5% reduction is **not** met, maximum possible penalty is 3% and no penalties for highest performing hospital.
- If full CY2014 goal of 8.5% is met, maximum possible penalty 1% with rewards up to 1% for the highest performing hospital if enough revenue is collected from worse performing hospitals.

To provide predictability for the financial rewards and penalties, staff proposes continuous scaling with preset positions on the scale calculated using base year performance scores. Once the base year performance scores are calculated and percent reductions and rewards are determined, the same scale will be used to apply the rewards/penalties for each hospital based on its scores in the performance period.

In its written submission to HSCRC's call for white papers on Quality Based Reimbursement, MHA submitted an alternative proposal for a total maximum revenue at risk of 3% and a statewide target of 6.89% for CY 2014. MHA's full white paper submission entitled "Quality-Related Payment Policies HSCRC Waiver Implementation February 28, 2014" is in Appendix VI.

Staff is continuing to work on modeling performance score range options for scaling and will vet the scaling options with the Payment Models Workgroup in two meetings in March. Staff will then provide potential alternative(s) at the next Commission meeting before the final vote.

D. Recommendations

Staff provides the following draft recommendations effective for CY 2014 performance year that we will continue to vet with stakeholders.

1. Measure hospital performance using Observed (O)/Expected (E) value for each PPC. Define the minimum threshold value to begin earning points as the weighted mean of all O/E ratios (O/E =1). Define the benchmark value where a full 10 points is earned as the weighted mean of top quartile O/E ratio. Establish appropriate exclusion rules to enhance measurement fairness and stability.

2. Set benchmark at zero for PPCs that are never events.

3. Prioritize PPCs that are high cost, high volume, have opportunity to improve, and are of national priority by tiering the PPCs in groups and weighting the groups in the final hospital score commensurate with the level of priority.

4. Establish tiered scaling based on state-wide MHAC performance and update annually based on the trends and CMMI contract goals.

5. Calculate rewards/penalties using preset positions on the scale based on the base year scores.

6. For CY 2014 performance year:
    a. Set minimum MHAC target at 6.89% improvement with a maximum revenue at risk of 4% of permanent inpatient revenue if this target is missed.
    b. Set CY 2014 target at 8.5% improvement with a maximum revenue at risk of 2% of permanent inpatient revenue if this target is missed.
    c. Set maximum revenue at risk at 1% of permanent inpatient revenue if CY 2014 target stated in 6.b. is met.

Appendix I. CMS HAC Measures for FY 2015

CMS HAC MEASURES Implemented Since FY 2012

HAC 01: Foreign Object Retained After Surgery
HAC 02: Air Embolism
HAC 03: Blood Incompatibility
HAC 04: Stage III & Stage IV Pressure Ulcers
HAC 05: Falls and Trauma
HAC 06: Catheter-Associated Urinary Tract Infection
HAC 07: Vascular Catheter-Associated Infection
HAC 08: Surgical Site Infection - Mediastinitis After Coronary Artery Bypas Graft (CABG)
HAC 09: Manifestations of Poor Glycemic Control
HAC 10: Deep Vein Thrombosis/Pulmonary Embolism with Total Knee Replacement or Hip Replacement
HAC 11: Surgical Site Infection – Bariatric Surgery
HAC 12: Surgical Site Infection – Certain Orthopedic Procedure of Spine, Shoulder, and Elbow
HAC 13: Surgical Site Infection Following Cardiac Device Procedures
HAC 14: Iatrogenic Pneumothorax w/Venous Catheterization

CMS HAC Measures Implemented FY 2015

- Domain 1- the Agency for Health Care Research and Quality (AHRQ) composite PSI #90 which includes the following indicators:
    - Pressure ulcer rate (PSI 3);
    - Iatrogenic pneumothorax rate (PSI 6);
    - Central venous catheter-related blood stream infection rate (PSI 7);
    - Postoperative hip fracture rate (PSI 8);
    - Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT) (PSI 12);
    - Postoperative sepsis rate (PSI 13);
    - Wound dehiscence rate (PSI 14); and
    - Accidental puncture and laceration rate (PSI 15).
- Domain 2- two healthcare-associated infection measures developed by the Centers for Disease Control and Prevention's (CDC) National Health Safety Network:
    - Central Line-Associated Blood Stream Infection and
    - Catheter-Associated Urinary Tract Infection.

Appendix II: MHAC Measures, FY 2015

	MHAC Measures	Rate Year 2015 (Based on FY2012 Q1234 Data)			
PPC #	PPC Description	Adm $	Adm T	Cases	Notes
			T Value<1.96		Exclusion Reason
1	Stroke & Intracranial Hemorrhage	$13,527.00	34.48	825	
2	Extreme CNS Complications	$14,228.00	25.38	415	
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	$9,808.00	57.56	4635	
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	$32,783.00	80.64	780	
5	Pneumonia & Other Lung Infections	$20,888.00	102.53	3174	
6	Aspiration Pneumonia	$16,628.00	55.74	1423	
7	Pulmonary Embolism	$15,051.00	32.59	583	
8	Other Pulmonary Complications	$9,405.00	49.36	3659	
9	Shock	$19,321.00	65.17	1506	
10	Congestive Heart Failure	$6,375.00	19.93	1235	
11	Acute Myocardial Infarction	$8,294.00	23.2	985	
12	Cardiac Arrythmias & Conduction Disturbances	$2,586.00	6.22	977	
13	Other Cardiac Complications	$5,664.00	7.34	207	
14	Ventricular Fibrillation/Cardiac Arrest	$20,204.00	47.42	706	
15	Peripheral Vascular Complications Except Venous Thrombosis	$16,972.00	21.58	202	
16	Venous Thrombosis	$17,730.00	50.87	1047	
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding	$15,508.00	35.18	639	
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding	$20,802.00	29.6	250	
19	Major Liver Complications	$21,822.00	35.52	333	
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding	$14,443.00	25.43	388	
21	Clostridium Difficile Colitis	$17,412.00	60.61	1524	Clinical
22	Urinary Tract Infection	$0.00	.	0	
23	GU Complications Except UTI	$7,016.00	12.72	407	
24	Renal Failure without Dialysis	$8,248.00	59.86	6925	
25	Renal Failure with Dialysis	$41,311.00	49.57	179	
26	Diabetic Ketoacidosis & Coma	$8,617.00	5.22	45	
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	$6,618.00	19.35	1070	
28	In-Hospital Trauma and Fractures	$8,560.00	8.9	134	
29	Poisonings Except from Anesthesia	$-1,331	-1.31	119	t-value
30	Poisonings due to Anesthesia	$14,971.00	1.34	1	t-value+case
31	Decubitus Ulcer	$32,815.00	49.94	288	
32	Transfusion Incompatibility Reaction	$21,835.00	1.97	1	t-value+case
33	Cellulitis	$10,216.00	26.15	831	
34	Moderate Infectious	$22,835.00	50.37	621	
35	Septicemia & Severe Infections	$18,853.00	68.29	1823	
36	Acute Mental Health Changes	$3,787.00	8.76	659	
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	$16,777.00	46.81	1052	
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	$34,433.00	29.67	93	
39	Reopening Surgical Site	$16,986.00	19.38	163	
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D	$9,819.00	41.69	2283	
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Pr	$13,367.00	15.73	171	
42	Accidental Puncture/Laceration During Invasive Procedure	$6,503.00	19.09	1087	
43	Accidental Cut or Hemorrhage During Other Medical Care	$259.00	0.17	54	t-value
44	Other Surgical Complication - Mod	$14,852.00	22.46	284	
45	Post-procedure Foreign Bodies	$1,762.00	0.8	27	t-value
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body	$-8,577	-1.05	2	t-value+case
47	Encephalopathy	$11,772.00	36.2	1194	
48	Other Complications of Medical Care	$18,559.00	42	640	
49	Iatrogenic Pneumothrax	$9,534.00	23.58	782	
50	Mechanical Complication of Device, Implant & Graft	$16,993.00	34	495	
51	Gastrointestinal Ostomy Complications	$26,871.00	40.61	284	
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infec	$11,290.00	30.89	954	
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infus	$14,455.00	20.57	250	
54	Infections due to Central Venous Catheters	$29,152.00	45.6	315	
55	Obstetrical Hemorrhage without Transfusion	$406.00	1.39	1494	Clinical
56	Obstetrical Hemorrhage wtih Transfusion	$3,723.00	8.09	605	
57	Obstetric Lacerations & Other Trauma Without Instrumentation	$436.00	1.33	1160	t-value
58	Obstetric Lacerations & Other Trauma With Instrumentation	$609.00	1.11	409	t-value
59	Medical & Anesthesia Obstetric Complications	$1,239.00	2.8	646	
60	Major Puerperal Infection and Other Major Obstetric Complications	$-625	-0.58	107	t-value
61	Other Complications of Obstetrical Surgical & Perineal Wounds	$1,276.00	1.54	181	t-value
62	Delivery with Placental Complications	$688.00	1.03	281	t-value
63	Post-Operative Respiratory Failure with Tracheostomy	$103,152.00	62.65	46	Clinical
64	Other In-Hospital Adverse Events	$5,354.00	10.89	509	Clinical
65	Urinary Tract Infection without Catheter	$14,313.00	77.79	3794	
66	Catheter-Related Urinary Tract Infection	$11,718.00	10.18	93	

Note: Yellow and Gray Shaded PPCs are excluded. Green shaded PPCs are also used for the improvement measurement.

Appendix III. MHA MHAC Policy Change Considerations

Maryland
Hospital Association

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DRAFT

MHAC Payment Policy Changes

- Ensure we achieve waiver targets
- Match payment policy metrics to waiver target metrics as closely as possible
- Set targets and reward/penalty in advance—Eliminate scaling
- Straightforward methodology and easy to monitor progress
- Encourage cooperation and sharing of best practices

- Selecting PPCs on which to focus—asking for input from quality
  - Top 10 by dollar amount (Actual number of PPCs x PPC weight) + a few others
  - Sweet spot of high volume combined with high cost and ability to affect change

- Setting statewide targets
  - How much would the state save and how many PPCs would be reduced if all hospitals performed at the 75th percentile (for example) on all of the target PPCs

- Set targets for each hospital
  - Case-mix adjusted
  - May not expect same amount of improvement for each PPC—the improvement rate varies dramatically by PPC
  - Ability to improvement may depend on starting point—coding and documentation practices are highly influential for certain PPCs

- Create stepped or progressive targets tied to progressive earn back amounts

Appendix IV: Revised PPC Measurement Detail

Definitions

The PPC measure would then be defined as:

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

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

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

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

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

Weighted mean of top quartile O/E ratio

For PPCs that are never events, the benchmark will be set at 0.

Performance Points

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

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

The formulas to calculate the Attainment and Improvement points are as follows:

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

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

Appendix V. Maryland Performance Based Revenue at Risk Proposed for FY 2016

Program	Percent at Risk Medicare	Percent At Risk Maryland
VBP	FFY15 1.5% FFY16 1.75% FFY17 2% of Medicare Base DRG Payments	FFY15 0.5% FFY16 1.0%
Complications	FFY15 1% FFY16 1% FFY17 1% of Medicare Total DRG Payments	FFY15 3% FFY16 4%
Readmissions	FFY15 3% FFY16 3% FFY17 3% of Medicare Base DRG Payments	FFY15 0.3% (Shared Savings Program) FFY16 0.8% (Shared Savings and Readmission Improvement Incentive Program)
Total	FFY15 5.5% FFY16 5.75% FFY17 6%	FFY15 3.8% FFY16 5.8%

Click here: Appendix VI. MHA White Paper Submission on Quality Based Reimbursement Programs entitled "Quality-Related Payment Policies HSCRC Waiver Implementation February 28, 2014."

NOTE: This submission also addresses the Draft Recommendation for Implementing Readmissions Reduction Incentive Program for FY 2016 and is repeated in Appendix VI of that recommendation.

Draft Recommendation for Implementing a Hospital Readmission Reduction Incentive Program for FY 2016

Health Services Cost Review Commission
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March 12, 2014

This document contains the draft staff recommendations for implementing a Readmission Reduction Incentive Program for FY 2016. Comments on the draft recommendation are due in writing to the Commission by COB Thursday March 27, 2014, attention: Dianne Feeney at the Commission address or to Dianne.feeney@maryland.gov.

A. Introduction

The United States health care system currently experiences an unacceptably high rate of unnecessary hospital readmissions. These excessive readmissions are a symptom of our fragmented payment system and result in considerable unnecessary cost and substandard care quality. The purpose of this document is to describe the components of a proposed Readmission Reduction Incentive program designed to provide incentives for hospitals to improve overall care coordination and substantially reduce readmissions.

There are a number of economic and environmental factors motivating this effort – including the passage of National Health Insurance reform and concerns about the affordability of care and financial sustainability of our current health care system. Dramatic slowing in hospital volume growth and the Commission's need to mirror tight updates nationally have also brought many to the realization that we must look for other ways to ensure the financial sustainability of Maryland's hospital/health system.

Commensurate with these events is a recognized need to transition our health care delivery system toward a more coordinated care model, focusing on promoting health of populations and, at the same time, improving efficiency and quality of the care delivered.

Maryland's readmission rates are high compared to the nation. The Center for Medicare and Medicaid Innovation (CMMI) All-payer model demonstration contract, which began on January 1, 2014, has established readmission reduction targets that require Maryland hospitals to be equal or below rates of Medicare readmissions by 2018. In order to enhance our ability to incentivize hospital care improvements and meet the target, the Commission has convened three meetings of the Performance Measurement Workgroup to vet a proposed methodology and deliberate near-term issues related to providing incentives to reduce readmissions.

B. Background

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

Our fragmented system for reimbursing health services in this country, for the most part, has provided large disincentives for hospitals and other providers to construct efficient and effective coordinated care models. To address these deficiencies, the HSCRC has implemented episode-based reimbursement and broad-based quality of care Pay-for-Performance ("P4P) methods designed to promote lower cost and higher quality care.

The Global Budget Revenue (GBR), Total Patient Revenue, (TPR) and Admission Readmission Revenue (ARR) arrangements impose a constraint on the amount of revenue a hospital may keep during a particular year. Of note, lacking the ability to assign patients unique patient

identifiers, the ARR program measures and bundles payments for readmissions that occur within the same hospital only. Hospitals are paid HSCRC approved unit rates – rates based on the units of service provided for any given case. In May 2013, the Commission approved a Shared Savings Policy where hospital revenues are adjusted by 0.3% of inpatient revenues to provide similar cost savings as the federal Centers for Medicare and Medicaid Services (CMS) Readmission Reduction program. Hospitals' unit rates are updated on an annual basis per the Commission's normal inflation update process, with any associated adjustments for price compliance, case mix change, volume change, and MHAC and QBR scaling provisions; this recommendation proposes adding an additional positive incentive adjustment for high performing hospitals that meet pre-determined reduction targets for readmissions.

C. Assessment

1. *Maryland's High Readmission Rates*

Figure 1 reviews the status of Maryland hospitals compared to all US hospitals using CMS' FY2013 IPPS Final Rule: Hospital Readmissions Reduction Program-Supplemental Data (Revised March 2013).

Figure 1: Maryland Hospitals Ranked By Excess Readmissions in CMS' Hospital Readmissions Reduction Program*

National Quartiles: Hospital Ranked From Least to Most Excess Readmissions	Excess Readmissions Due To:		
	Pneumonia	Heart Failure	Heart Attack
Quartile 1 (Least Excess Readmissions)	4 (9%)	4 (9%)	2 (5%)
Quartile 2	4 (9%)	6 (14%)	7 (19%)
Quartile 3	7 (16%)	14 (32%)	10 (27%)
Quartile 4 (Most Excess Readmissions)	**29 (66%)**	**20 (45%)**	**18 (49%)**
Total hospitals included in analysis	3,123	3,110	2,262

Source: HSCRC analysis of CMS Readmission data, April 2013.
Note: Based on CMS data from July 1, 2008 to June 30, 2011. Some Maryland hospital did not have enough cases for CMS to calculate excess readmission figures (pneumonia= 1 hospital, health failure=1 hospital, heart attack=8 hospitals).

As illustrated in Figure 1, the majority of Maryland hospitals were ranked below the national average for Medicare's Hospital Readmission indicators, and many were in the lowest 25 percent. Four Maryland hospitals were ranked in the worst 100 hospitals in the nation for each of the three indicators. For pneumonia readmissions, one-fifth of Maryland hospitals (n=9) were ranked among the worst 200 hospitals in the nation for excess readmissions.

Based on data HSCRC has received from the Colorado Foundation for Medical Care on Medicare readmissions in CY 2012, Maryland continues to perform poorly and has one of the highest readmission rates of all states. In addition, quarterly trend data from the Delmarva Foundation through September 2013 on Medicare readmissions continue to reveal that Maryland's readmission rate is substantially higher than the national average.

2. *Master Patient Index Enables Measurement of Across-Hospital Readmissions*

Since HSCRC does not collect sufficient patient level data indicators to identify patients across care settings, staff has worked with the Chesapeake Regional Information System for our Patients (CRISP) to assign patients in our data set unique patient identifiers using the CRISP Master Patient Index technology. HSCRC is now able to match patients across hospitals and calculate reliable inter-hospital readmission rates.

3. *Readmissions Reduction Incentive Program Guiding Principles*

Staff vetted the guiding principles for implementing incentives to reduce readmissions listed below with the Performance Measurement Workgroup.

- Measurement used for performance linked with payment must include all patients regardless of payer.
- Measurement must be fair to hospitals.
- A first year target must be established to reasonably support the overall goal of equal or less than the National Medicare readmission rate by CY 2018.
- Measure specifications used for the program should be consistent with the CMS measure of readmissions (also used by Partnership for Patients Program).

4. *Key Methodology Components that Support the Guiding Principles*

The key methodology components of the proposed readmission reduction program vetted with the Workgroup are described below. (See Appendix I for Complete Measure Calculation Specifications).

- **Readmission definition**- Total readmissions/total admissions to any acute hospital[1]
- **Broad patient inclusion-** For greater impact and potential for reaching the target the measure should include all payers and any acute hospital readmission in the state. Staff examined the relationship between improvements in all-payer readmission rates and Medicare readmission rates since the CMMI contract is based on Medicare readmission rates only. The analysis indicated that there is a strong correlation between the Medicare and all-payer measures (Appendix IV).
- **Patient exclusion adjustments–** To enhance fairness of the methodology, planned admissions (using the CMS Algorithm V 2.1) and deliveries should be excluded from readmission counts.
- **Positive incentive**- For hospitals that reach or exceed the goal, they have the opportunity to earn the incentive.
- **Performance measurement consistent across hospitals**- A Uniform achievement benchmark for all hospitals will be established for the first year, and performance will be measured cumulatively for future years. The Workgroup discussed using a segmented approach, where hospitals with high readmission rates would be required to have higher benchmarks for improvement. Staff examined whether hospitals with high readmission rates in the base year had higher reductions in the following year using intra-hospital

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

readmissions and did not find a significant impact of base year readmission rates on readmission reductions the following year (Appendix V). Given the debate whether socio-economic and demographic factors should be used in readmission risk adjustment and that arguments could be made to lower readmission targets for high readmission hospitals if they serve hard to reach populations, staff recommends using a uniform achievement benchmark for all hospitals.

- **Monitor for unintended consequences**- Observation and ED visits within 30 Days of an inpatient stay will be monitored; possible adjustments may be made if observation cases within 30 days increase faster than the overall observations.

5. Readmission Reduction Target, Revenue at Risk for Positive Incentive

Setting targets annually for the next five years is problematic as there are no national projected numbers for admissions or readmissions nor are there projected reduction targets. Therefore, staff has modeled and is recommending a one year target we believe is not overly aggressive but may have potential to incrementally close the large gap that must be bridged in five years. According to the (CMMI) all-payer model demonstration contract, "If in a given Performance Year Regulated Maryland Hospitals, in aggregate, fail to outperform the national Readmissions Rate change by an amount equal to or greater than the cumulative difference between the Regulated Maryland Hospital and national Readmission Rates in the base period divided by five, CMS shall follow the corrective action and/or termination provisions of the Waiver of Section 1886(q) as set forth in Section 4.c and in Section 14."

As illustrated in Figure 2 below, if a 5% annual reduction in Medicare readmissions is assumed, for FY 2014, reaching a 6.76% reduction target would enable Maryland to begin to close the gap between Maryland and the nation.

Figure 2. FY 2014 Readmission Reduction Target with 5% Medicare Reduction Modeled

	National Medicare					Maryland Medicare					
	Admissions	Readmis-sions	% Readmis-sions	Percentage Point Change	Percent Change in Rate of Readmits	Admissions	Readmis-sions	% Readmis-sions	Percentage Point Change	Percent Change in Rate of Readmits	MD- US Differ-ence
FY2010	11,043,196	2,049,473	18.56%			253,320	54,019	21.32%			14.9%
FY2011	11,129,694	2,070,250	18.60%	0.04%	0.22%	248,731	52,032	20.92%	-0.40%	-1.88%	12.5%
FY2012	10,857,862	1,991,886	18.35%	-0.25%	-1.34%	241,681	49,100	20.32%	-0.60%	-2.87%	10.7%
FY2013	10,458,098	1,847,036	17.66%	-0.69%	-3.76%	235,532	45,244	19.21%	-1.11%	-5.46%	8.8%
FY 2014			16.78%	-0.88%	-5.00%			17.91%	-1.30%	-6.76%	6.8%
CY 2014			**16.34%**	**-1.32%**	**-7.50%**			**17.26%**	**-1.95%**	**-10.13%**	**5.7%**

In addition to a reduction target, CMMI requires that all Maryland performance programs linked with payment have revenues at risk comparable to the national programs. Appendix III compares Maryland with Medicare revenue magnitudes at risk for each program for FYs 2015-17 and illustrates Maryland designating 0.5% as a positive incentive for reaching readmission reduction targets.

For Maryland's Readmission Reduction Incentive Program, staff believes the amount must not be overly aggressive but sufficient to incentivize positive behavior change and contribute to meeting or exceeding the CMS percentages of revenue at risk.

In its written submission to HSCRC's call for white papers on Quality Based Reimbursement, MHA submitted an alternative proposal for a readmission reduction program. MHA's full white paper submission entitled "Quality-Related Payment Policies HSCRC Waiver Implementation February 28, 2014" is in Appendix VI.

D. Recommendations

Staff provides the following draft recommendations for CY 2014 performance applied to rate year 2016:

1. The Commission should implement a Readmissions Reduction Incentive Program.
2. The CMS readmission measure definition specifications should be used with the Maryland adjustments to enhance the fairness of the measure.
3. The annual target for the first year, CY 2014, should be a 6.76% readmission reduction with the percentage reevaluated annually.
4. The Payment Models Workgroup should consider a positive incentive magnitude of 0.5% for hospitals that meet or exceed the 6.76% target the first year.

Appendix I. HSCRC Methodology for Readmissions FY2016

READMISSIONS

FY2013 inpatient data, with EIDs (base year), was used to calculate the readmission rates for all-payer and Medicare patients.

EXCLUSIONS

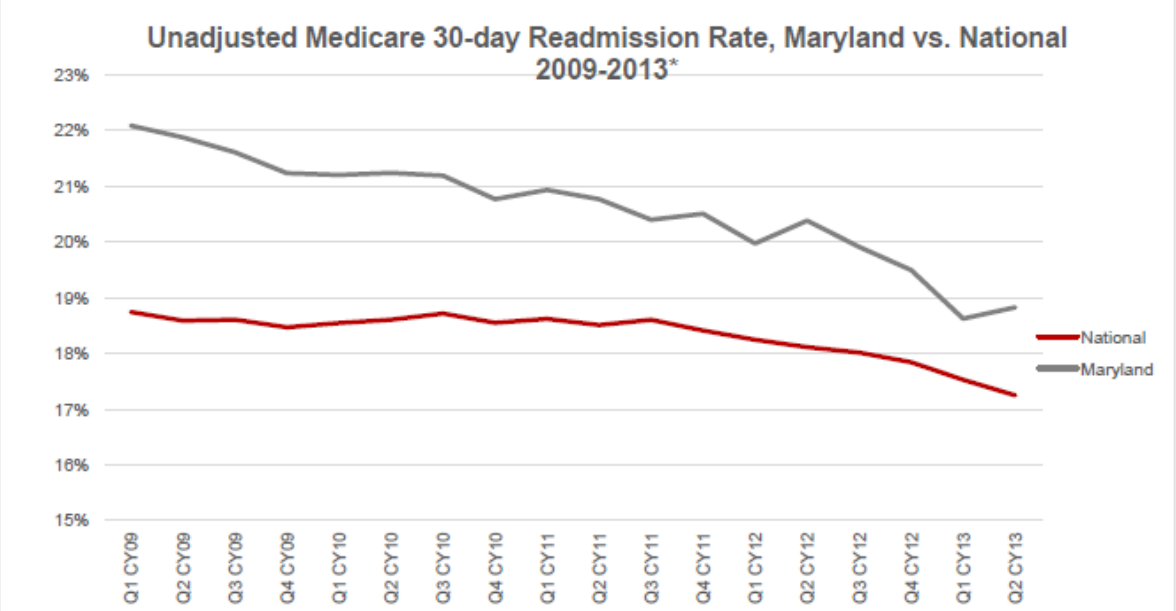
The following were removed from the readmission rate calculations:

1. Rehab hospitals (provider ids 213028,213029, 213300,210083,210089,210333)
2. Cases with null or missing EIDs
3. Duplicates
4. Negative interval days
5. For risk adjustment, based on admission DRGs, exclude DRG and SOI cells with < 2
6. Exclude those who have died and those with same day transfers (interval days = 0)

RESULTS

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

Appendix II. Medicare Readmissions Quarterly Trend Data from the Delmarva Foundation

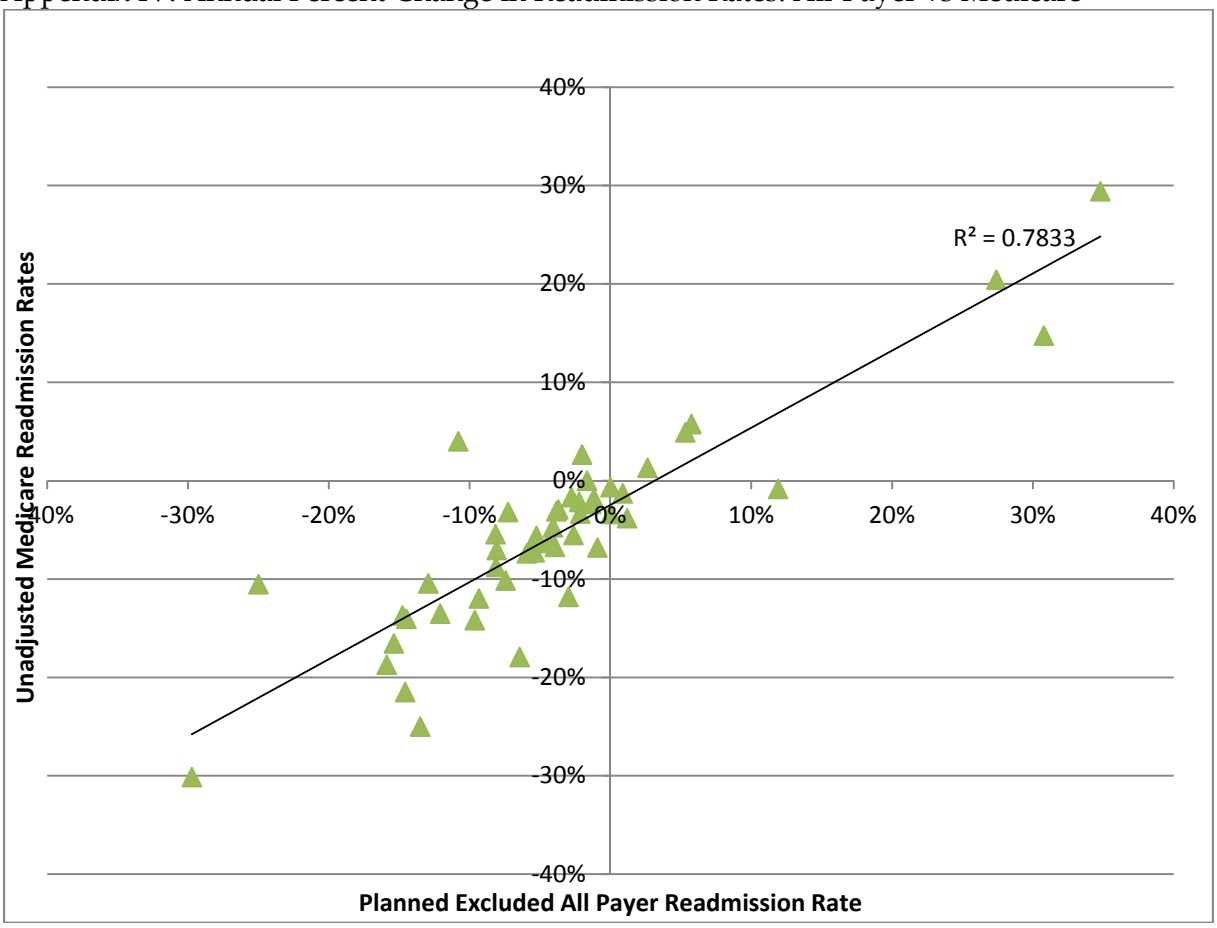


	CY 2009		CY 2010		CY 2011		CY 2012		CY 2013*	
	Maryland	National	Maryland	National	Maryland	National	Maryland	National	Maryland	National
Admissions	256,702	11,073,489	250,750	11,100,099	246,407	11,042,259	238,001	11,042,259	119,320	5,241,930
Readmissions	55,741	2,060,324	52,926	2,065,268	50,915	2,047,174	47,474	1,930,871	22,343	911,769
% Readmissions	21.71%	18.61%	21.11%	18.61%	20.66%	18.54%	19.95%	17.49%	18.73%	17.39%

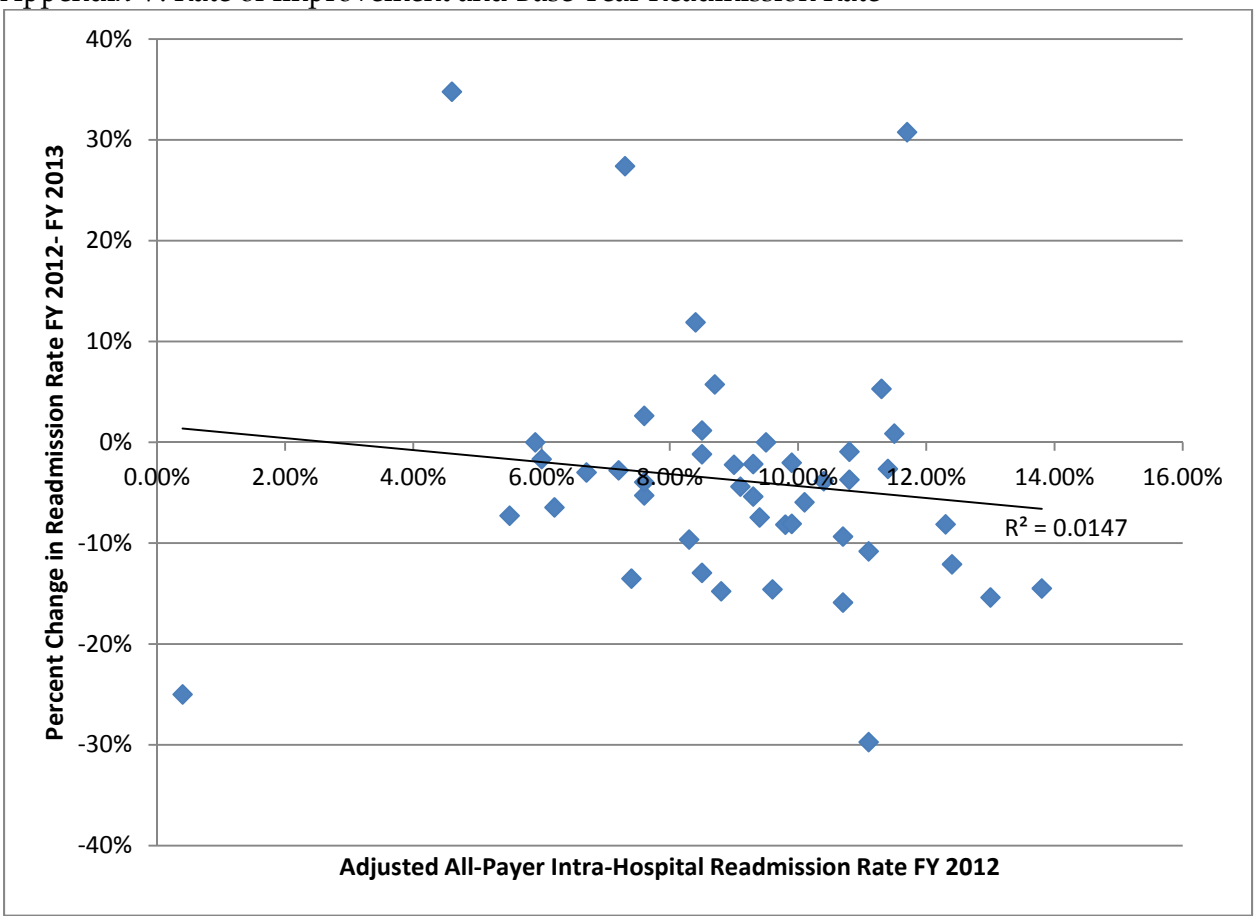
Appendix III. Maryland Performance Based Revenue at Risk Proposed for FY 2016

Program	Percent at Risk Medicare	Percent At Risk Maryland
VBP	FFY15 1.5% FFY16 1.75% FFY17 2% of Medicare Base DRG Payments	FFY15 0.5% FFY16 1.0%
Complications	FFY15 1% FFY16 1% FFY17 1% of Medicare Total DRG Payments	FFY15 3% FFY16 4%
Readmissions	FFY15 3% FFY16 3% FFY17 3% of Medicare Base DRG Payments	FFY15 0.3% (Shared Savings Program) FFY16 0.8% (Shared Savings and Readmission Improvement Incentive Program)
Total	FFY15 5.5% FFY16 5.75% FFY17 6%	FFY15 3.8% FFY16 5.8%

Appendix IV. Annual Percent Change in Readmission Rates: All-Payer vs Medicare



Appendix V. Rate of Improvement and Base Year Readmission Rate



Click here: Appendix VI. MHA White Paper Submission on Quality Based Reimbursement Programs entitled "Quality-Related Payment Policies HSCRC Waiver Implementation February 28, 2014."

NOTE: This submission also addresses the Draft Recommendation for Modifying the Maryland Hospital Acquired Conditions Programs for FY 2016 and is repeated in Appendix VI of that draft recommendation.

Appendix VI

Quality-Related Payment Policies
HSCRC Waiver Implementation
February 28, 2014

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Presentation Overview

Appendix VI

- Quality-Based Reimbursement
- Readmissions
- Potentially Avoidable Utilization
- Maryland Hospital Acquired Conditions

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Quality-Based Reimbursement

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Quality-Based Reimbursement

Appendix VI

- MHA supported January 2014 Quality-Based Reimbursement (QBR) final recommendations that updated existing policy to ensure the program meets or exceeds the national Medicare policy on Value-Based Purchasing
- 1.0 percent of inpatient revenue will be “at risk” based on performance and applied to 2016 rates
- Recommendations:
  - Publish any changes to methodology details for CY 2014 performance (e.g., transfer-in logic for mortality measure)
  - Reconvene HSCRC’s QBR work group in July to discuss revisions for CY 2015
    - Mortality (use of age cohort; transfers-in to include only acute care; adjust for one-day stays)
    - Weighting of domains

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Readmissions

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Readmissions

Appendix VI

- Waiver Target: Maryland must be at or below the national average Medicare readmission rate by the end of the five year demonstration period
- Maryland must "close the gap" that exists in CY 2013 between Maryland and the nation by one-fifth of the difference each year

	National Medicare						Maryland Medicare				
	Admissions	RA	RA rate	Percent rate change	Percent change in number of RAs		Admissions	RA	RA rate	Percent rate change	Percent change in number of RAs
FY 2010	11,043,196	2,049,473	18.56%				253,320	54,019	21.32%		
FY 2011	11,129,694	2,070,250	18.60%	0.23%	1.01%		248,731	52,032	20.92%	-1.90%	-3.68%
FY 2012	10,857,862	1,991,886	18.35%	-1.38%	-3.79%		241,681	49,100	20.32%	-2.88%	-5.63%
FY 2013	10,458,098	1,847,036	17.66%	-3.73%	-7.27%		235,532	45,244	19.21%	-5.45%	-7.85%
CY 2013		1,779,878	17.33%	-1.86%	-3.64%			43,467	18.69%	-2.72%	-3.93%

Readmissions

Appendix VI

Closing the Gap

- Maryland RA rate – National RA Rate = 1.55 percentage points
- 1.55/5 = 0.31 percentage points per year

	National readmission rate	Maryland readmission rate	Maryland percent change prior yr	Pct point difference	Percent difference
FY 2013	17.66%	19.21%		1.55%	8.76%
FY 2014	17.66%	18.90%	-1.61%	1.24%	7.01%
FY 2015	17.66%	18.59%	-1.64%	0.93%	5.26%
FY 2016	17.66%	18.28%	-1.67%	0.62%	3.51%
FY 2017	17.66%	17.97%	-1.69%	0.31%	1.75%
FY 2018	17.66%	17.66%	-1.72%	0.00%	0.00%

Readmissions—Statewide Goals

Appendix VI

Beyond closing the gap, Maryland will need to keep pace with the national readmission rate improvement

- It is unclear how much improvement can be expected nationally
  - Medicare readmission payment policies continue to penalize for readmissions above “expected”
  - National readmission payment policy has been in place since October 2012
  - When will national readmission rates stop declining?
  - As hospitals reduce avoidable admissions and move utilization to lower acuity settings, the inpatient severity of illness is likely to increase and readmission increases are likely to follow
- Set statewide quality improvement targets annually

Readmissions—Hospital Specific Goals

Appendix VI

Comparing hospitals' readmission rates to one another or to a benchmark standard results in erroneous conclusions

- High readmission rates associated with:
  - Limited relationships and coordination with community partners
  - More challenging social and economic circumstances
  - Limited access to primary and specialty care
  - Patients with higher prevalence of chronic conditions and more severe illnesses
  - Lower use of "observation"
- Low readmission rates associated with:
  - Better care transitions
  - Careful discharge and follow up planning
  - Location near a state border
  - Readmissions to other hospitals
  - Higher use of "observation"
  - Lower severity of illness
  - Patient population with fewer social needs and more resources

Readmissions—Hospital Specific Goals

Appendix VI

- Experts do not yet agree on how to adjust for risk of readmission—severity of illness, age, payer mix, socioeconomic status affect rates
- Interventions must target specific needs of the patient population—the same strategy does not work for all
- Data availability can limit the choice of readmissions metric
  - Readmissions to other Maryland hospitals (addressed with a unique Maryland ID)
  - Readmissions that occur outside the state (requires patient-level data from the payer; e.g., Medicare, commercial plan)
  - Without this information, only intra-hospital readmission rates can be calculated

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Readmissions—Hospital Specific Goals

Appendix VI

- Hospitals need access to timely and complete data to monitor payment metrics
  - CRISP readmission data is a valuable tool for quality improvement interventions. The data source is from hospital registration systems.
  - It does not, and cannot match exactly a payment policy since payment is determined by a patient's status at discharge, not at time of registration
  - In the future, it could be possible for CRISP to receive monthly case-mix data, apply the unique ID, calculate an inter-hospital readmission metric and provide that information to all hospitals by the end of the following month.

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Readmissions: MHA Recommendations

Appendix VI

- Global budgets provide a strong incentive to reduce readmissions—no additional incentive is needed, especially in the first year
- Continue work to develop a readmissions payment policy if Maryland's progress on readmissions is not sufficient
- Establish a payment policy before the start of the performance period

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Readmissions: MHA Recommendations

Appendix VI

- When a payment policy is established, the metric should match the waiver metric as closely as possible
  - Medicare only
  - Inter-hospital—only if data available
  - Consider stratifying hospitals in lieu of risk adjustment
  - Make sure psychiatric and rehabilitation admissions are out
- Address concerns about influence of “observation” and out-of-state or inter-hospital readmissions by monitoring inter-hospital readmissions and an “observation” metric

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Potentially Avoidable Utilization

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Potentially Avoidable Utilization

Appendix VI

- Assess potentially avoidable utilization opportunities using AHRQ Prevention Quality Indicators (PQIs)
- AHRQ recommends measuring PQIs at the population level as an indication of where to focus resources
- AHRQ does not recommend using PQIs at the hospital level, or for payment
- The health status of the hospital's community and its access to primary care drive the PQI rate

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Appendix VI

FY 16 MHAC Methodology Redesign HSCRC Performance Measurement Work Group February 20, 2014

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Maryland Hospital Acquired Conditions

Appendix VI

- Background: Reason to change, guiding principles, timing
- Measurement Methodology
- Payment Methodology
- Remaining Issues to Address

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Maryland Hospital Acquired Conditions

Appendix VI

Background

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Why Change Existing Policy?

Appendix VI

- Use of 3M Proprietary Software: Potentially Preventable Complications (PPC)
- Waiver Goal: 30% reduction in all 65 PPCs
- Target list of 20 PPCs—high volume, high cost, opportunity for improvement and areas of national focus
- Revenue at risk commensurate with CMS policies

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Guiding Principles

Appendix VI

- Meet CMS waiver test and goals on an annual and long-term basis
  - Focus on areas of greatest opportunity
  - Match payment metric to policy goal
- Predetermined performance targets and financial impact
- Encourage cooperation and sharing of best practices
- Do not penalize a lack of improvement if attainment is highly favorable
- Ability to track progress

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Implementation Timing

Appendix VI

Waiver Goal for Complication Reduction

- CY 2013 base period
- Measurement period began January 2014
- 30% cumulative reduction by 2018

Maryland Hospital Acquired Conditions Policy

- FY 2013 base period
- CY 2014 first measurement period

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Measurement Methodology

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Components of Redesign

Appendix VI

- Measurement Methodology
  - All 65 PPCs vs current 50 PPCs
  - Selecting PPCs for focus
  - Design and calculation of “MHAC Score”
  - Thresholds and benchmarks
  - Better of **attainment** or **improvement** score
- Payment Methodology
  - Translating score to payment impact

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MHAC Score Design Options

Appendix VI

Ideally, measure would be similar to Waiver Goal metric

	Definition	Risk Adj	Vol Adj
Total # MHACs	# Actual MHACs	N	N
Unadjusted MHAC Rate	# Actual ÷ At Risk Cases	N	Y
O/E Ratio	# Actual ÷ # Expected	Y	Y

Observed to expected ratio
Lower numbers are more favorable

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Target PPC List

Appendix VI

- 20 PPCs
- High volume, high cost, and opportunity for improvement and national focus
- Heavier weight than non-target PPCs

Since target PPCs are those with high cost and high volume statewide, reducing these will contribute more to the overall waiver goal

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Target PPC List: Top 10 by Volume * Cost

Appendix VI

PPC	ALL PAYER PPC Description	PPCs Expected	PPCs Actual	PPC Weighted Impact
PPC 4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1,069.72	1,209	$ 39,634,647
PPC 65	Urinary Tract Infection without Catheter	2,388.77	2,048	$ 29,313,024
PPC 14	Ventricular Fibrillation/Cardiac Arrest	1,250.11	1,375	$ 27,780,500
PPC 24	Renal Failure without Dialysis	3,660.69	3,355	$ 27,672,040
PPC 5	Pneumonia & Other Lung Infections	1,288.80	1,169	$ 24,418,072
PPC 3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	2,326.32	2,209	$ 21,665,872
PPC 9	Shock	1,141.40	1,063	$ 20,538,223
PPC 35	Septicemia & Severe Infections	1,052.88	1,060	$ 19,984,180
PPC 21	Clostridium Difficile Colitis	1,028.00	1,030	$ 17,934,360
PPC 40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Proc	1,515.83	1,512	$ 14,846,328

PPC	MEDICARE PPC Description	PPCs Expected	PPCs Actual	PPC Weighted Impact
PPC 4	Acute Pulmonary Edema and Respiratory Failure with Ventilatior	605.40	788	$ 25,833,004
PPC 14	Ventricular Fibrillation/Cardiac Arrest	788.81	989	$ 19,981,756
PPC 65	Urinary Tract Infection without Catheter	1,314.70	1,356	$ 19,408,428
PPC 24	Renal Failure without Dialysis	1,994.09	2,153	$ 17,757,944
PPC 5	Pneumonia & Other Lung Infections	699.79	757	$ 15,812,216
PPC 9	Shock	657.09	728	$ 14,065,688
PPC 3	Acute Pulmonary Edema and Respiratory Failure without Ventila	1,238.41	1,408	$ 13,809,664
PPC 21	Clostridium Difficile Colitis	634.11	725	$ 12,623,700
PPC 35	Septicemia & Severe Infections	600.34	657	$ 12,386,421
PPC 6	Aspiration Pneumonia	496.70	607	$ 10,093,196

Target PPC List: Proposed List

Appendix VI

		CMS HAC (PSI 90)	Top Volume * Cost	Other (Pair, Opportunity, etc)
3	Respiratory Failure without Ventilation		x	
4	Respiratory Failure with Ventilation		x	
5	Pneumonia & Other Lung Infections		x	
6	Aspiration Pneumonia		x	
7	Pulmonary Embolism	PSI #12		
9	Shock	PSI #13	x	
14	Cardiac Arrest		x	
16	Venous Thrombosis	PSI #12		
24	Renal Failure without Dialysis		x	
28	In-Hospital Trauma and Fractures	PSI #8		
31	Decubitus Ulcer	PSI #3		
35	Septicemia & Severe Infections	PSI #13	x	
37	Post-Operative Infection & Deep Wound Disruption Without Procedure			x
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	PSI #14		
40	Post-operative Hemorrhage and Hematoma		x	
42	Accidental Puncture/Laceration During Invasive Procedure	PSI #15		
49	Iatrogenic Pneumothrax	PSI #6		
54	Infections due to Central Venous Catheters	PSI# 7		
65	Urinary Tract Infection		x	
66	Catheter-Related Urinary Tract Infection			x

MHAC/PPC Tiers

Appendix VI

- Two or three 'tiers' of MHACs/PPCs
  - Tier A – Target list of 20 PPCs – highest weight
  - Tier B – PPCs not on target list, but have high percentage attributed to Medicare patients (> 60%) and affect majority of hospitals (> 43)
  - Tier C – All other PPCs, including those with very low volume, affecting low number of hospitals, obstetric-related PPCs
- Each tier can be weighted differently to put more emphasis on the target PPCs

	Weighting	PPCs	Total Points	FY12 Actual PPCs	FY13 Actual PPCs
Tier A	100%	20	200	23,102	17,451
Tier B	60%	9	54	5,166	4,074
Tier C	40%	36	144	12,259	10,452
Total		65	398	40,527	31,977

MHAC/PPC Tiers

Appendix VI

Tier A
Selected as high cost, high volume statewide plus those that match CMS HAC policy of AHRQ Patient Safety Indicators
3 Acute Pulmonary Edema and Respiratory Failure without Ventilation
4 Acute Pulmonary Edema and Respiratory Failure with Ventilation
5 Pneumonia & Other Lung Infections
6 Aspiration Pneumonia
7 Pulmonary Embolism
9 Shock
14 Ventricular Fibrillation/Cardiac Arrest
16 Venous Thrombosis
24 Renal Failure without Dialysis
28 In-Hospital Trauma and Fractures
31 Decubitus Ulcer
35 Septicemia & Severe Infections
37 Post-Operative Infection & Deep Wound Disruption Without Procedure
38 Post-Operative Wound Infection & Deep Wound Disruption with Procedure
40 Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc
42 Accidental Puncture/Laceration During Invasive Procedure
49 Iatrogenic Pneumothrax
54 Infections due to Central Venous Catheters
65 Urinary Tract Infection without Catheter
66 Catheter-Related Urinary Tract Infection

Tier B
Selected as remaining PPCs with high Medicare percentage (>60%) and high number of Maryland hospitals (>43)
8 Other Pulmonary Complications
10 Congestive Heart Failure
11 Acute Myocardial Infarction
17 Major Gastrointestinal Complications without Transfusion or Significant Bleeding
18 Major Gastrointestinal Complications with Transfusion or Significant Bleeding
19 Major Liver Complications
27 Post-Hemorrhagic & Other Acute Anemia with Transfusion
41 Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc
48 Other Complications of Medical Care

Tier C
Remaining PPCs
1 Stroke & Intracranial Hemorrhage
2 Extreme CNS Complications
12 Cardiac Arrythmias & Conduction Disturbances
13 Other Cardiac Complications
15 Peripheral Vascular Complications Except Venous Thrombosis
20 Other Gastrointestinal Complications without Transfusion or Significant Bleeding
21 Clostridium Difficile Colitis
23 GU Complications Except UTI
25 Renal Failure with Dialysis
26 Diabetic Ketoacidosis & Coma
29 Poisonings Except from Anesthesia
30 Poisonings due to Anesthesia
32 Transfusion Incompatibility Reaction
33 Cellulitis
34 Moderate Infectious
36 Acute Mental Health Changes
39 Reopening Surgical Site
43 Accidental Cut or Hemorrhage During Other Medical Care
44 Other Surgical Complication - Mod
45 Post-procedure Foreign Bodies
46 Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body
47 Encephalopathy
50 Mechanical Complication of Device, Implant & Graft
51 Gastrointestinal Ostomy Complications
52 Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection
53 Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusions
55 Obstetrical Hemorrhage without Transfusion
56 Obstetrical Hemorrhage wtih Transfusion
57 Obstetric Lacerations & Other Trauma Without Instrumentation
58 Obstetric Lacerations & Other Trauma With Instrumentation
59 Medical & Anesthesia Obstetric Complications
60 Major Puerperal Infection and Other Major Obstetric Complications
61 Other Complications of Obstetrical Surgical & Perineal Wounds
62 Delivery with Placental Complications
63 Post-Operative Respiratory Failure with Tracheostomy
64 Other In-Hospital Adverse Events

Measurement Methodology

Appendix VI

- In Quality-Based Reimbursement (QBR) methodology:
  - Each measure receives separate points for attainment (compared to the state's performance) and improvement (hospital performance year over year)
  - The higher of attainment or improvement points for each measure becomes the final points for that measure
- Define *Threshold* and *Benchmark* for each measure (PPC)
  - Threshold is minimum performance required to score points
    - median of all hospitals (50th percentile)
      - Mean performance is measured at the hospital level—including small hospitals with expected values less than 1
      - Assumes that case-mix adjusts adequately for all factors affecting a hospital's performance
    - weighted mean of all O/E ratios (will equal O/E of 1)
      - Mean performance is measured at the case level
      - Inherently includes other factors that affect performance
      - Higher volume hospitals have more influence on PPCs mean
  - Benchmark is performance required to score maximum points
    - weighted mean of top quartile O/E ratio

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Attainment Example

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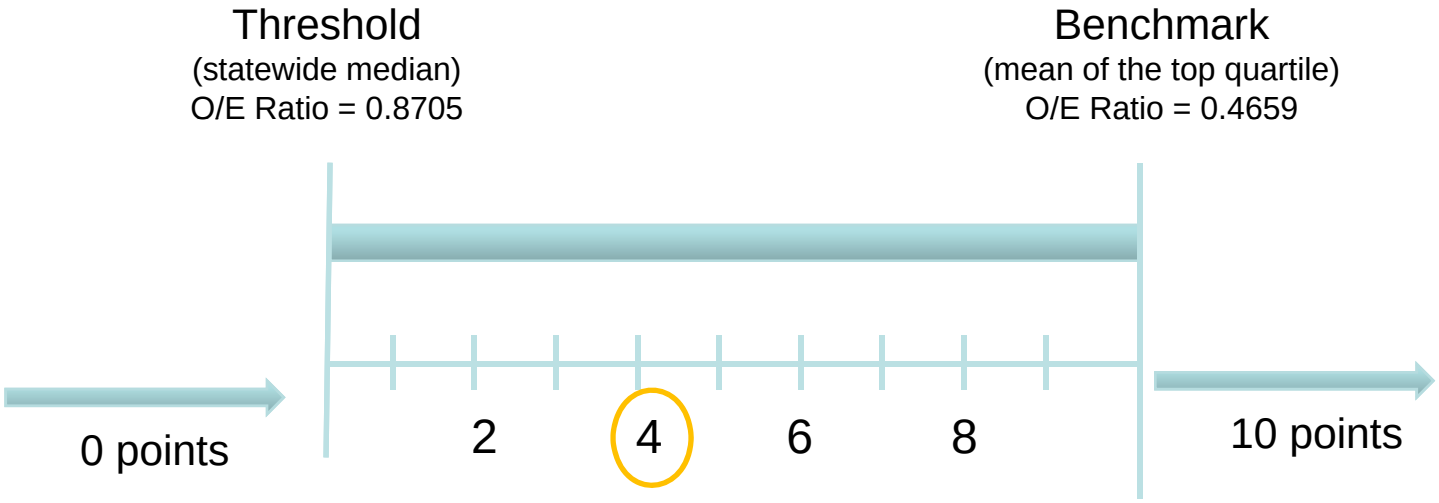
PPC 24 – Renal Failure



Hospital O/E = 0.7012

Calculates to an attainment score of 4

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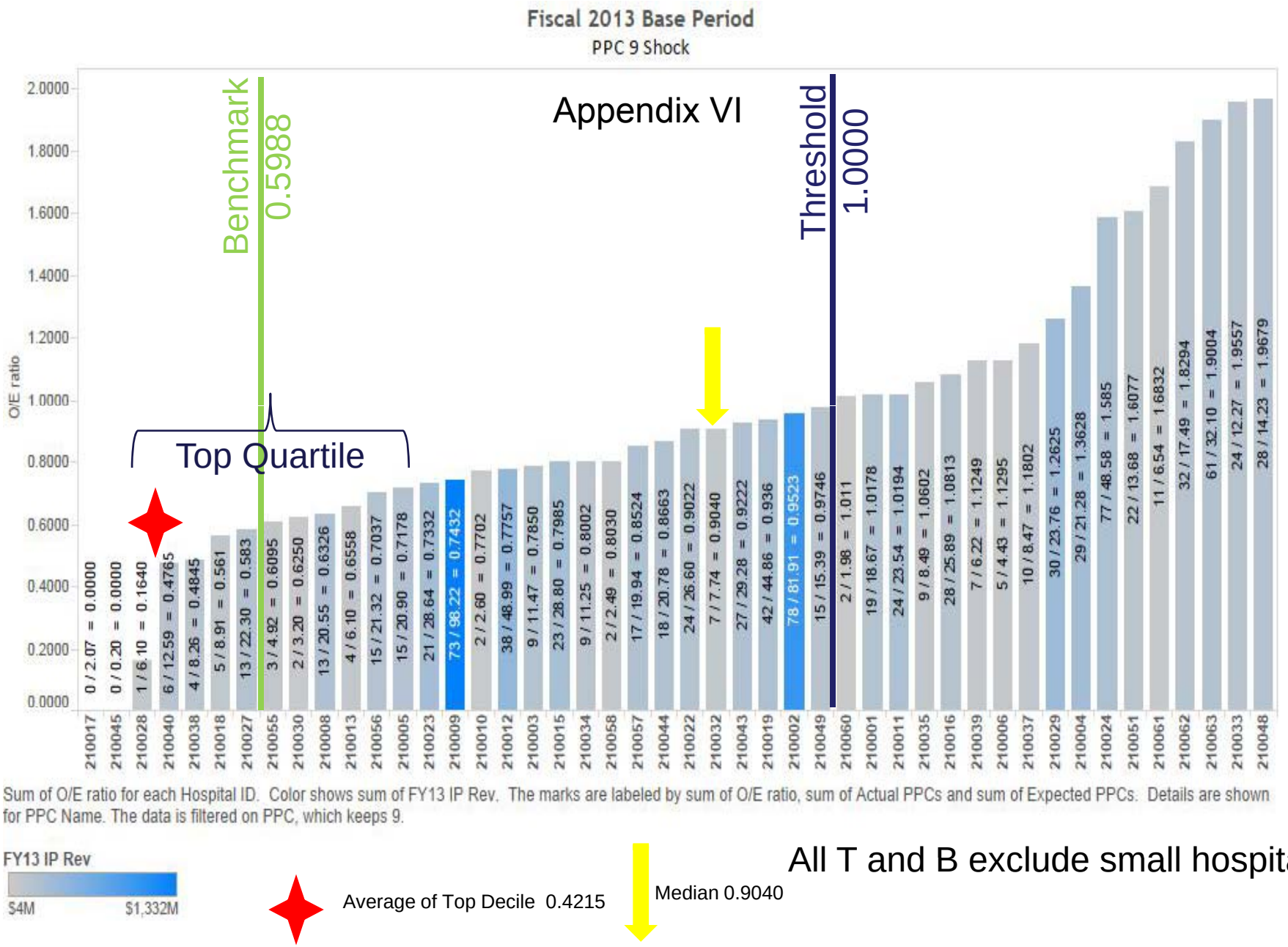


Sum of O/E ratio for each Hospital ID. Color shows sum of FY13 IP Rev. The marks are labeled by sum of O/E ratio, sum of Actual PPCs and sum of Expected PPCs. Details are shown for PPC Name. The data is filtered on PPC, which keeps 9.

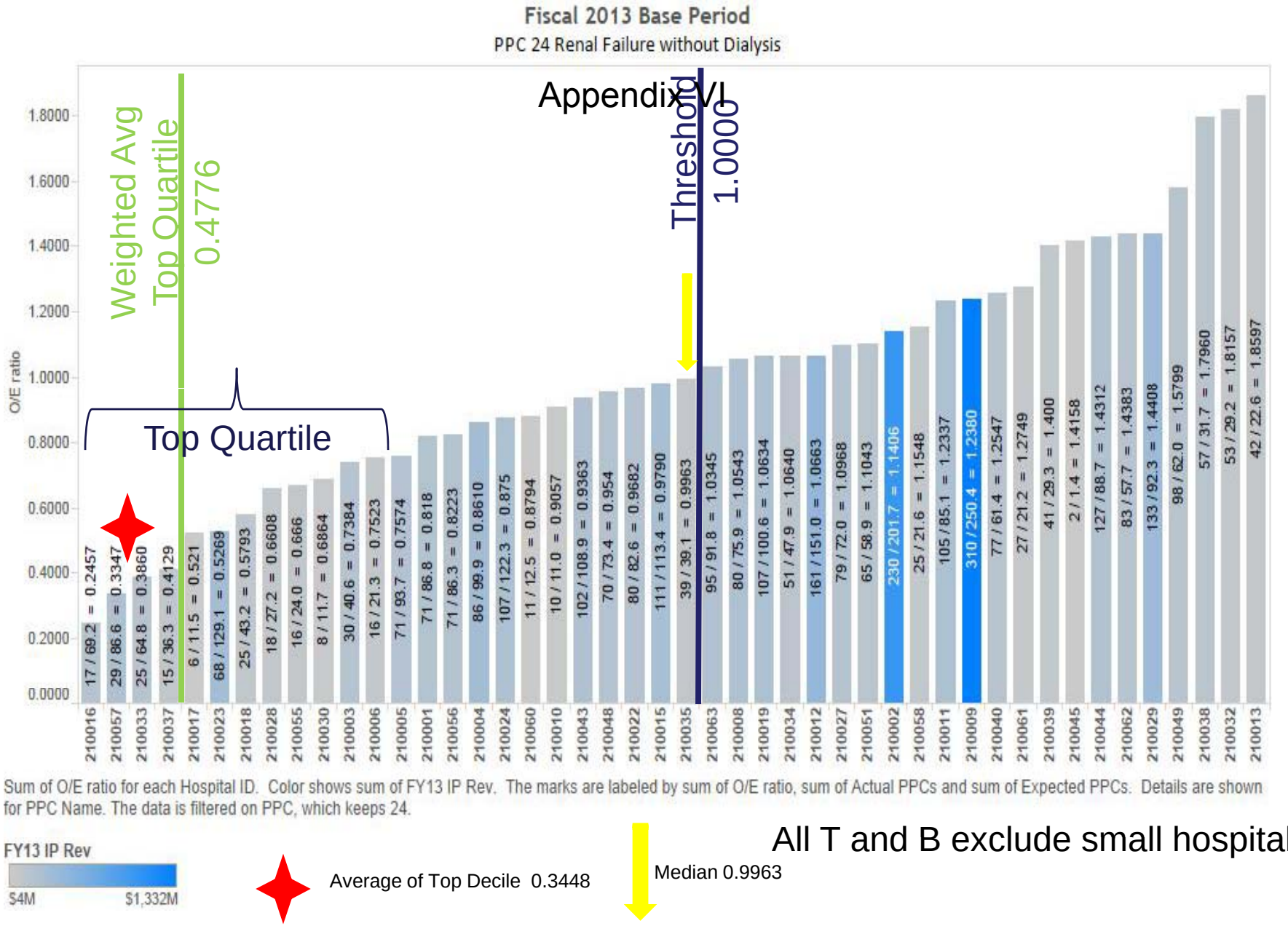
FY13 IP Rev

$4M $1,332M

Average of Top Decile 0.4215

Median 0.9040

All T and B exclude small hospitals



Sum of O/E ratio for each Hospital ID. Color shows sum of FY13 IP Rev. The marks are labeled by sum of O/E ratio, sum of Actual PPCs and sum of Expected PPCs. Details are shown for PPC Name. The data is filtered on PPC, which keeps 24.

FY13 IP Rev

$4M $1,332M

Average of Top Decile 0.3448

Median 0.9963

All T and B exclude small hospitals

Payment Methodology

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Translating the Score to Payment Impact

Appendix VI

- MHA proposes 3% revenue at risk on Medicare revenue
- Individual hospital payment impact depends on combination of statewide aggregate performance and individual hospital performance
- CMS waiver goal is 30 percent PPC reduction over five years, which will require sustained annual improvement of just under 7%

CY 14	CY 15	CY 16	CY 17	CY 18	5-Year Cumulative
6.89%	6.89%	6.89%	6.89%	6.89%	30.02%

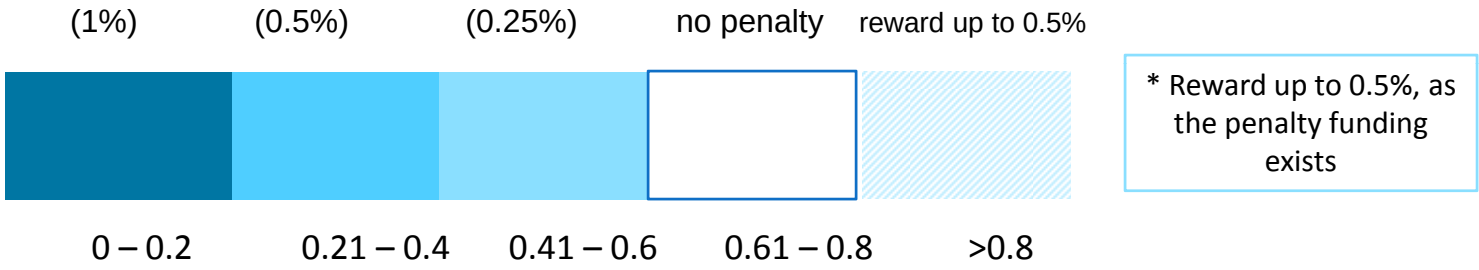
- If annual goal is not met, maximum possible penalty applies
- If annual goal is met, maximum possible penalty is discounted to 1% of Medicare revenue with possibility of rewards for highest performing hospitals

Translating the Score to Payment Impact

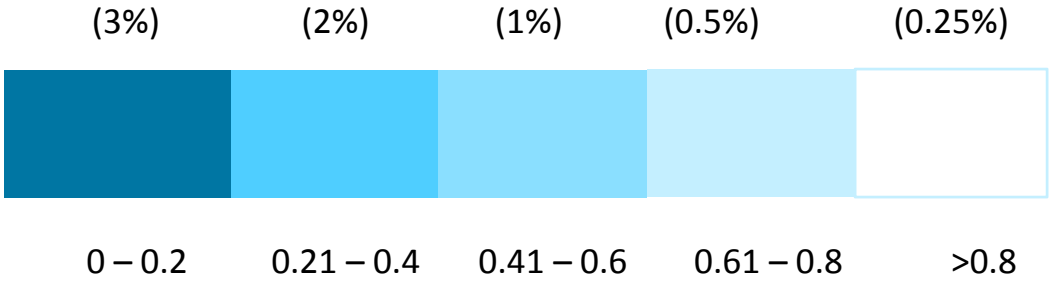
Appendix VI

Preset corridors of MHAC score (0-1) corresponding to payment impact

- Statewide Target Met: Targets and penalty scale "discounted" if statewide performance achieves policy target; max possible penalty = 1%



- Statewide CMS Target Not Met: All hospitals penalized if CMS target not met; max possible penalty = 3%



Measurement Issues to be Addressed

Appendix VI

Methodology

- Address small hospitals
  - Hospitals with expected values < 1 score 0 or 10
  - Combine PPCs for an aggregate O/E, peer group, set minimum for expected value
- Ongoing discussion with 3M to refine PPC logic
  - Example…PPC 12 cardiac arrhythmia. This PPC occurs in 25% of open heart surgery cases. Pre-existing atrial fibrillation increases likelihood of arrhythmia after surgery. Request to 3M is adjust PPC logic.
- Define top performance—how high should the benchmark be set? How low can each PPC rate go? “Never” events—close to zero, but others are *potentially* preventable.

Status of Monitoring Under the All-Payer Model
March 12, 2014

Claudine Williams, Associate Director, Policy Analysis
Amanda Vaughan, Program Manager
Josh Campbell, Director Healthcare Advisory, KPMG LLP

Presentation Outline

- Background
- Reconciliation Process and Preliminary Results
- Data Considerations and Next Steps
- Access to Medicare Claims and Reconciliation

Background

Additional Data to Monitor New Waiver: Financial Data

In November 2013, the Commission approved regulations to expand the Volume and Revenue Report to collect billed charges and related volumes by rate center, patient residence status and Medicare Payer:

- In-state or out-of-state determined by zip code
- In-state or out-of-state by zip code with Medicare as payer
- In-state or out-of-state by zip code with Medicare FFS or Medicare Non-FFS (HMO) as payer

Staff Worked With Industry to Capture Necessary Data

- HSCRC staff met with hospital representatives to discuss the feasibility of submitting expanded data on a monthly basis and process for pulling information from multiple systems
- Over 3 month period, hospitals submitted 18 months of historical data collected via excel worksheet (Jul 2012-Dec 2013)
- Maryland Hospital Data Repository System was updated to accommodate new data elements and beginning with the February 2014 data submission, hospitals will be able to submit directly via EXCEL upload

Additional Data to Monitor New Waiver: Case Mix Data

- In October 2013, Commission staff approved regulations to change the case mix data submissions from quarterly to monthly, effective January 1, 2014.
- Beginning in March 2014, hospitals will submit January and February 2014 data
- Monthly reporting of case mix data will allow staff to reconcile charges by payer and residency and provide feedback to hospitals in a timely manner.

Reconciliation Process & Results

Compared Charges and Volume by Residency and Payer

HSCRC staff worked with KPMG (contracting with MHA) to compare Financial to Case Mix Data by Hospital for FY 2013 and CY 2013:

- Total All-Payer Charges
- In-state and Out-of-state All-Payer Charges
- Medicare and Non-Medicare Charges
- In-state and Out-of-state Medicare Charges
- Medicare FFS and Non-Medicare FFS (HMO) Charges
- In-state and Out-of-state Medicare FFS Charges

Statewide: Total Charges Reconcile Within Less Than 1%

- Hospital Quarterly submissions are expected to tie within 2%
- Total charges for All-Payer and Medicare reconcile within less than1%
- Total charges do not reconcile within 2%
  - Residency (Maryland/Non Maryland)
  - Medicare FFS and Medicare HMO
- HSCRC staff is contacting hospitals with large variances to resolve data issues

By Hospital: Wide Variation Between Sources

- Hospital-level variation due to:
  - Difficulty reconciling residency and payer breakouts to previously reported totals
  - Hospitals under-reporting or missing data in breakouts from non-FFS Medicare
  - IT challenges
  - Unclear residency assignment of patients with Invalid, Unknown/Missing or International ZIP codes

Next Steps

Next Steps in Reconciliation Process

- Contact hospitals with significant variation between financial and case mix data
- Audit base year (CY 2013) financial data with a focus on payer source and residency
- Instruct hospitals on how to report MD Residents in case mix and financial data consistently
  - Using comprehensive list of Maryland ZIP Codes provided HSCRC staff
  - Inclusion of Unknown, Missing and Invalid zip codes with Maryland residents
  - Using data element “County Code” “89” or zip code of “77777” to identify International patients
- Continue to reconcile case mix financial data on a monthly basis

Access to Medicare Claims Data and Reconciliation

Meetings with CMMI

- The goal is to have regular meetings with CMMI staff to discuss implementation details particularly, the data sources and the specific calculations to produce the data for the new waiver model test
- Discussion topics covered up-to-date include:
  - Criteria that will be used to calculate the Maryland per capital hospital expenditures
  - Data sources for expenditures and beneficiary residency
  - Reconciling hospitals that will be included in the per capita test
  - Overview of Global Budget methodology
  - Clarified how HSCRC can obtain access to claim-level National (including MD) data on a monthly basis for monitoring and compliance

High Priority Items to be Addressed

- Filing application for the release of National and Maryland Resident data to HSCRC for monthly monitoring and validation of waiver test calculations
  - National Claims will be accessed through CMS data ware-house and will take 45 days after the official request is submitted
  - Maryland Resident claims, which will include confidential elements may take longer period due to HIPPAA clearance process
- Develop plan to create a mechanism to implement Medicare EHR penalties that will go into effect in October 1, 2014
- Reconcile information from Medicare claims data with HSCRC data sets.

Title 10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207, 19-212, and 19-219, Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend **Regulation .26** under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on March 12, 2014, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about July 7, 2014.

Statement of Purpose

The purpose of this action is to bring about greater uniformity in the calculation of current financing.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or call (410) 764-2576, or fax to (410) 358-6217, or email to dkemp@hscrc.state.md.us. The Health Services Cost Review Commission will consider comments on the proposed amendments until May 4, 2014. A hearing may be held at the discretion of the Commission.

.26 Patient Rights and Obligations: Hospital Credit and Collection and Financial Assistance Policies.

A. (text unchanged)

B. Working Capital Differentials—Payment of Charges.

(1) (text unchanged)

(a)—(b) (text unchanged)

(c) Outstanding charges shall be calculated by an amount equal to the hospital's current average daily payment by the payer, multiplied by the hospital's and third party payer's processing and payment time. *The precise calculation shall be made in accordance with the guidelines specified by Commission staff.*

(d)—(e) (text unchanged)

(2)—(5) (text unchanged)

C. (text unchanged)

John M. Colmers
Chairman
Health Services Cost Review Commission

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Chairman

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TO: Commissioners

FROM: Legal Department

DATE: March 6, 2014

RE: Hearing and Meeting Schedule

Public Session:

April 9, 2014 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room
May 14, 2014 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

Please note, Commissioner's packets will be available in the Commission's office at 11:45 p.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website.
www.hscrc.maryland.gov/commission-meetings-2014.cfm

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