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Department of Health

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549th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
March 14, 2018

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

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

2. **Update on Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104**

3. **Discussion of Administrative Processes – Authority General Provisions Article, §3-103 and §3-104**

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on February 14, 2018**

2. **New Model Monitoring**

3. **Docket Status – Cases Closed**

   2423A – Johns Hopkins Health System
   2424A – Johns Hopkins Health System
   2425A - Johns Hopkins Health System
   2426A - Johns Hopkins Health System
   2427A - Johns Hopkins Health System
   2428A - Johns Hopkins Health System

4. **Docket Status – Cases Open**

   2422A – University of Maryland Medical Center
   2429R – Garrett Regional Medical Center
   2430A – Johns Hopkins Health System
   2431R – Johns Hopkins Bayview Medical Center

5. **Presentation by Peninsula Regional Medical Center on Population Health Initiatives**

6. **Final Recommendation for Updates to the Readmissions Reduction Incentive Program for RY 2020**

7. **Policy Update Report and Discussion**

   a. **TCOC Model Update**

   b. **Stakeholder Innovation Group Update**

c. **Workgroup Update**

d. **Drugs Analysis**

8. **Legislative Update**

9. **Hearing and Meeting Schedule**

Closed Session Minutes
Of the
Health Services Cost Review Commission

February 14, 2018

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

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

2. Update on Contract and Modeling of the All-Payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104

3. Personnel Matters – Authority General Provisions Article, §3-305(b)(1)

The Closed Session was called to order at 11:35 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

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

In attendance representing Staff were Donna Kinzer, Katie Wunderlich, Chris Peterson, Allan Pack, Claudine Williams, Alyson Schuster, Amanda Vaughn, Madeline Jackson, Bob Gullion, and Dennis Phelps.

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

Item One

Mr. Peterson and Ms. Wunderlich presented and the Commission discussed the progression of the Model including the clearance process, Stakeholder Innovation Group, and the formation of an internal Design Alignment Group. In addition, they discussed the establishment of focus groups involving hospital CEOs.

Mr. Pack and Dr. Schuster discussed the timelines for critical actions associated with HSCRC Quality Programs.

Item Two

Mr. Lindeman updated the Commission on Medicare data and analysis vis-a-vis the All-Payer Model Agreement.

Item Three

No personnel matters were discussed

The Closed Session was adjourned at 1:00 p.m.

MINUTES OF THE
548th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
February 14, 2018

Vice Chairman Joseph Antos called the public meeting to order at 11:34 a.m. Commissioners Victoria Bayless, John Colmers, James Elliott, M.D., Adam Kane, and Jack C. Keane were also in attendance. Chairman Nelson Sabatini participated by telephone. Upon motion made by Commissioner Colmers and seconded by Commissioner Kane, the meeting was moved to Executive Session. Vice Chairman Antos reconvened the public meeting at 1:11 p.m.

REPORT OF FEBRUARY 14, 2018 EXECUTIVE SESSION

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

NEW COMMISSIONER DR. JAMES ELLIOTT

Vice Chairman Antos introduced Dr. James Elliott as the Commission's new commissioner. Dr. Elliott is a board certified Pathologist and serves as the Medical Director in the Division of Pathology and Laboratory Medicine at Doctors' Community Hospital in Lanham, Maryland. Dr. Elliott is also a Clinical Assistant Professor of Pathology at the George Washington University Medical School. He studied at the University of Liberia Medical School and did his pathology residency at George Washington University Medical School.

NEW STAFF

Chris Peterson, Director Clinical & Financial Information, introduced two new staff members Bob Gallion and William Henderson.

ITEM I
REVIEW OF THE MINUTES FROM THE JANUARY 8, 2018 EXECUTIVE SESSION AND JANUARY 10, 2018 EXECUTIVE SESSION AND PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the January 8, 2018 Executive Session and the January 10, 2018 Public Meeting and Executive Session.

ITEM II
NEW MODEL MONITORING

Ms. Caitlin Grim, Assistant Chief, Hospital Rate Regulation, reported that the total cost of care savings for the eleven months ending November 2017 was $150,434,644. Ms. Grim noted Medicare Total Cost of Care per Capita spending growth has been unfavorable to the nation for the same period.

Ms. Amanda Vaughan, Associate Director Financial Data Administration stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of December 31, 2017 focuses on the calendar year (January 1, 2017 through December 31, 2017) as well as fiscal year results. She stated that the calendar year results had been adjusted to reflect hospitals undercharge of the Global Budgets that occurred between July-December 2016.

Ms. Vaughan reported that for the twelve month period ended December 31 2017, All-Payer total gross revenue increased by 3.51% over the same period in CY 2016. All-Payer total gross revenue for Maryland residents increased by 3.52%. All-Payer gross revenue for non-Maryland residents increased by 3.35%.

Ms. Vaughan reported that for the twelve months of the calendar year ended December 31, 2017, Medicare Fee-For-Service gross revenue increased by 2.74% over the same period in CY 2016. Medicare Fee-For-Service gross revenue for Maryland residents increased by 2.52%. Maryland Fee-For-Service gross revenue for non-residents decreased by 5.30%.

Ms. Vaughan reported on hospital revenue per capita growth for the twelve months of the calendar year ended December 31, 2017 over the same period in CY 2016:

- All Payer in State capita growth was 3.05%.
- Medicare Fee for Service in State growth was 1.64%.

According to Ms. Vaughan, for the six months of the fiscal year ended December 31, 2017, unaudited average operating profit for acute hospitals was 2.92%. The median hospital profit was 3.57%, with a distribution of (.80%) in the 25th percentile and 7.94% in the 75th percentile. Rate Regulated profits were 6.25%.

ITEM III
DOCKET STATUS- CLOSED CASES

2419A – University of Maryland Medical System   2417A – Johns Hopkins Health System
2418A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS- OPEN CASES

2423A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application on January 23, 2018 for Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals"). The System is requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with MultiPlan, Inc. for a period of one year beginning March 1, 2018.

Staff recommends that the Commission approve the hospitals' application to continue to

participate in the global rate arrangement for solid organ and bone marrow transplant services with MultiPlan, Inc. for one year beginning on March 1, 2018, and that approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2424A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application on January 23, 2018 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center ("Hospitals"). The System is requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with INTERLINK Health Services, Inc. The System requests approval for a period of one year beginning March 1, 2018.

Staff recommends that the Commission approve the hospitals' application to continue to participate in the global rate arrangement for solid organ and bone marrow transplant services with INTERLINK Health Services, Inc. for one year beginning on March 1, 2018, and that approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2425A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application on January 23, 2018 on behalf of its member hospitals. The System is seeking approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with Preferred Health Care, LLC. The System is requesting approval for one year beginning March 1, 2018.

Staff recommends that the Commission approve the Hospitals' request to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with Preferred Health Care, LLC for a period of one year beginning March 1, 2018, and that approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2426A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application on January 23, 2018 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center ("Hospitals"). The System is seeking approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with 6 Degrees Health, Inc. The System is requesting approval for one year beginning March 1, 2018.

Staff recommends that the Commission approve the Hospitals' request to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with 6 Degrees Health Inc. for a period of one year beginning March 1, 2018, and that approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2427A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application with the HSCRC on January 25, 2018 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to participate in a global rate arrangement for bariatric surgery, bladder cancer surgery, anal and rectal cancer surgery, cardiovascular services, joint replacement surgery, pancreatic cancer surgery, spine surgery, and thyroid and parathyroid surgery with BridgeHealth Medical, Inc. for a period of one year beginning March 1, 2018.

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for bariatric surgery, bladder cancer surgery, anal and rectal cancer surgery, cardiovascular services, joint replacement surgery, pancreatic cancer surgery, spine surgery, and thyroid and parathyroid surgery for a one year period commencing March 1, 2018, and that approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2428A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application with the HSCRC on January 31, 2018 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to participate in a global rate arrangement for bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services with Accarent Health for a period of one year beginning March 1, 2018.

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, parathyroid

surgery, solid organ and bone marrow transplants, and Executive Health services for a one year period commencing March 1, 2018, and that approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2429R- Garrett Regional Medical Center

No action is required as Commissioners granted Staff a 30 day extension for review of Proceeding 2429R Garrett Regional Medical Center.

ITEM V
FINAL RECOMMENDATION FOR UPDATES TO THE MARYLAND HOSPITAL ACQUIRED CONDITIONS POLICY FOR RY 2020

Dr. Alyson Schuster Ph.D., Associate Director Performance Measurement, presented the staff's final recommendation for the Maryland Hospital Acquired Conditions (MHAC) Program for FY 2020 (See "Final Recommendation for the Maryland Hospital Acquired Conditions program for Rate Year 2020" on the HSCRC website).

Staff's final recommendations for the RY 2020 MHAC policy are unchanged from last month's draft recommendation and will adjust hospitals' revenue based on CY 2018 performance. The policy is similar to previous years and is aligned with the requirements of the current All Payer Model to reduce complications by 30% as measured in the final year of the Model.

Staff's final recommendations for the RY 2020 MHAC Program are as follows:

1. Continue to use established features of the MHAC program in its final year of operation:

    a. 3M Potentially Preventable Complications (PPCs) to measure complications:

    b. Observed/expected ratios to calculate hospital performance scores, assigning 0-10 points based on statewide threshold and benchmark standards;

    c. Better of improvement and attainment total scores for assessing hospital performance under the program;

    d. A linear preset scale based on the full mathematical score distribution (0-100%) with a revenue neutral zone (45-55%);

    e. Combine PPCs that experience a small number of observed cases into an aggregated complication measure (i.e., a combination PPC);

2. Set the maximum penalty at 2% and the maximum reward at 1% of hospital inpatient revenue;

3. Raise the minimum number of discharges required for pay-for-performance evaluation in each Diagnosis Related Group and Severity of Illness category from 2 discharges to 30 discharges;

4. Exclude low frequency Diagnosis Related Group and Severity of Illness pairings from pay-for-performance; and

5. Establish a complications subgroup to the Performance Measurement Workgroup that will consider measurement selection and methodological concerns, which will include appropriate risk adjustment, scoring, and scaling, and reasonable performance targets.

Commissioner Keane disagreed with Staff's proposal to address the low volume cells as moving from bad to slightly less bad and said that Staff should simply remove all the zero volume cells. He suggested that the proposal be amended now, and that action on the proposal be delayed until next month to allow time to consider amendments.

Dr. Schuster stated that Staff and the stakeholders decided that they did not want to make dramatic changes to the MHAC policy when CY 2018 is likely the last year of the MHAC policy. Staff noted that a sub group of the Performance Measurement Work Group has been formed to consider alternatives to the MHAC policy for CY 2018.

Robert Murray, CareFirst Consultant, stated that he appreciated the fact that in the next round, Staff will be looking at ways of preventing or anticipating the impact of enhanced coding and documentation. That is a positive step. Mr. Murray noted that there should be a thorough self scrutiny of the policy. Mr. Murray observed that it would be worthwhile to estimate what proportion of previous improvements was due to enhanced coding and documentation and what was due to actual improvement in quality.

Mr. Murray noted that the thing that was most troubling is "the hold harmless zone." The hold harmless zone is arbitrarily constructed and not doing what it was intending to do, focus on average performing hospital. It is an artifact of an old policy and is not used in any other HSCRC program. If modifications are to be made, Mr. Murray would suggest looking at a scale based around the median.

Mr. Murray recommended that moving forward Staff should try to simplify the methodology and if nothing else get rid of the hold harmless zone.

Traci LaValle, Vice President, Rate Setting, Maryland Hospital Association (MHA), spoke in support of the Staff recommendation. She stated that although the policy is not perfect, this is the final year of the policy and recommended that Staff spend its time and resources on developing methodologies for the next phase of the waiver.

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

ITEM VI
DRAFT RECOMMENDATION FOR UPDATES TO THE READMISSIONS REDUCTION INCENTIVE PROGRAM FOR RY 2020

Andrea Zumbrum, Chief Quality Analysis and Reporting, presented Staff's draft recommendation on the Readmission Incentive Program for FY 2020 (see "Draft Recommendation For the Readmissions Reduction Incentive Program For Rate Year 2020"- on the HSCRC website).

The United States healthcare system currently experiences an unacceptably high rate of preventable hospital readmissions. These excessive readmissions generate considerable unnecessary costs and substandard care quality for patients. A readmission is defined as an admission to a hospital within a specified time period after a discharge from the same or another hospital. Historically, Maryland's readmission rates have been high compared with the national levels for Medicare. Under authority of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) established its Medicare Hospital Readmissions Reduction Program (HRRP) in federal fiscal year (FFY) 2013.

Because of its long-standing Medicare waiver for its all-payer hospital rate-setting system, special considerations were given to Maryland, including exemption from the federal HRRP. Instead, the HSCRC implements various Maryland-specific quality-based payment programs which provide incentives for hospitals to improve their quality performance over time.

Maryland entered into a new All-Payer Model Agreement with CMS effective January 1, 2014. One of the requirements under this new agreement is for Maryland's hospital readmission rate to be equal to or below the national Medicare readmission rate by calendar year (CY) 2018. Maryland must also make scheduled, annual progress toward this goal. In order to meet this requirement, the HSCRC established the Readmissions Reduction Incentive Program (RRIP) in April 2014.

The purpose of this draft recommendation is to make recommendations for updating the RRIP for the state rate year (RY) 2020 methodology.

Staff's draft recommendation for the Maryland Rate Year (RY) 2020 Readmissions Reduction Incentive Program policy is as follows:

1. The RRIP policy provides incentives to reduce readmissions on an all-payer basis.
2. Hospital performance is measured as the better of attainment or improvement.
3. Due to ICD-10 transition, a compounded improvement target is used that combines Calendar Year (CY) 2013 to Calendar Year (CY) 2016 improvement (under ICD-9) and CY2016 to CY 2018 improvement (under ICD-10); the preliminary combined improvement target will be set at 14.34% percent for CY 2020.
4. The attainment threshold is set at the 25th percentile of hospital performance in CY 2017, with an improvement factor (currently 2% from previous calendar year); the preliminary attainment target is 10.70 percent for CY 2018.

5. Hospitals are eligible for a maximum reward of 1 percent, or a maximum penalty of 2 percent, based on the better of their attainment or improvement scores.

Staff will review the improvement target and attainment benchmark in April/May against finalized CY 2017 data in order to bring back to the Commission revised performance targets if data trends warrant the revision. This may necessitate an additional vote from Commissioners.

Mr. Murray noted that CareFirst still supports the idea of making the RRIP program a Medicare only policy, which would simplify the policy methodologies. Mr. Murray also supported the "cushion" added to the improvement target, in order to ensure Maryland achieves the waiver test. He also complimented the Commission and the hospitals for the progress that has been made given how far Maryland's results have come. Mr. Murray also stated he believes there is credible evidence that the proportion of dual-eligible patients a hospital treats impacts its readmission rates, and this should be considered in future policy development.

No action is required by the Commissioners as this is a draft recommendation.

ITEM VII
POLICY UPDATE REPORT AND DISCUSSION

Katie Wunderlich, Director Engagement and Alignment, and Mr. Peterson discussed the Commission's action plan for success of the enhanced Total Cost of Care (TCOC) Model (see "Health Services Cost Review Commission Action Plan"- on the HSCRC website).

Ms. Wunderlich noted that the TCOC Model action plan was result of four strategic planning sessions held from September to December 2017. Commissioners reviewed the objectives and commitments of the TCOC Model to prioritize critical actions for success, and develop critical action plan priorities. The resulting plan reflects a set of guiding principles and a timeline for critical action.

Mr. Peterson discuss the formation of the Stakeholder Innovation Group (SIG) to develop new provider led care redesign tracks and delivery models. SIG consists of 16 representatives. The first priority of the group is to create an inventory of innovations that already exists.

Ms. Wunderlich stated that letters were sent to 13 hospitals to request actions plans to improve emergency department access and throughput. The formation of an action plan group should place additional focus on throughput and will help improve performance in Maryland. A work group led by Commissioner Bayless will review the action plans and accompanying data.

Ms. Grimm reviewed the annual rate update timeline. She noted the rate update will be processed by Staff at the Payment Models Work Group. The first meeting for the workgroup will be held on February 22nd and focus on projected cost inflation and calendar year 2017 Maryland and national hospital and total spending per capita. Topics slated for future meetings include reviewing national Medicare spending projections, 2018 calendar year Maryland spending projections, Medicare inpatient and outpatient payment updates, and the draft and final staff recommendations for the fiscal year 2019 payment update.

Donna Kinzer, Executive Director, presented the Staff's analysis on hospital drug costs (See "Briefing Document- HSCRC Staff Analysis on Hospital Drug Costs"- on the HSCRC website).

Ms. Kinzer stated that the goal of this analysis is to provide information to help the Commission and stakeholders evaluate drug cost funding and support ongoing policy development. The analysis was limited to drugs administered in the hospital.

With the institution of the GBR, inpatient and outpatient drugs were incorporated into the global revenues. From FY14 – FY16, Staff provided full inflation on all hospital costs, and every hospital received the same amount of inflation for drugs, except for a few special fundings for categorical cases associated with AMC transplants, research cases, and burns. More recently, there has been extensive inflation in cancer drug prices, and some hospitals felt they were not being adequately funded. The HSCRC began to determine how they were going to help address these concerns. On July 1, 2016, Staff changed the distribution of drug inflation so that not every hospital's inflation was the same, and hospitals with a higher percentage of drug costs to total costs received greater drug inflation. Staff also provided onetime and permanent funding in FY 2017 and FY 2018 for the increases in high-cost outpatient chemotherapy drugs.

As a whole, Staff analysis indicates the State has been adequately funded for drug cost inflation through these mechanisms. However, there are some hospitals that have been underfunded, and others that have been overfunded since the institution of GBR. Staff plans to provide policy recommendations by July 1, 2018 to address drug funding disparity issues in the State.

ITEM VIII
LEGISLATIVE UPDATE

Ms. Wunderlich, presented a summary of the legislation of interest to the HSCRC (See Legislative List Feb. 2018- on the HSCRC website)

The Bills included: 1) House Bill 160/Senate Bill 185 – Budget Bill FY 2019, House Bill 161/Senate Bill 187- Budget Reconciliation and Financing Act of 2018, Senate Bill 387 - Health Insurance- Health Care Access Program, House Bill 660- Public Health- State Provided Health Care Benefits for State Benefits, Senate Bill 878/House Bill 1312- Health Insurance- Medicaid Buy-In Task Force, Senate Bill 1011/House Bill 1167 – Protect Maryland Health Care Act of 2018, Senate Bill/House Bill- Maryland Department of Health- Basic Health Program – Implementation, House Bill 289/Senate Bill 36- Civil Actions- Noneconomic Damages, Senate Bill 0862/House Bill 909- Maryland No-Fault Birth Injury, Senate Bill 1024/ House Bill 1519- Self Referrals- Oncology Group Practices- Exemption, House Bill 384 – Substance Use Facilities and Programs – Certificate of Need- Repeal of Requirement, Senate Bill 619/House Bill 1282- Health Maintenance Organization- Certificate of Need Requirements- Modification, House Bill 596/Senate Bill 234- Interstate Medical Licensure Compact, House Bill 0614/Senate Bill 390- Hospitals- Changes in Status- Hospital Employee Retraining and Placement, House Bill 562/Senate Bill 530- Hospitals- Patient's Bill of Rights, House Bill 855/ Senate Bill 1082- State Government- Regulations Impacting Small Businesses – Economic Impact Analysis, Senate Bill 0923 – Maryland All-Payer Model Agreement – Medicare Skilled Nursing Facility 3

– Day Rule – Waiver, Senate Bill 1056- Rural Health Collaborative Pilot, Senate House 0682- Medical Assistance Program and Health Insurance- Emergency Medical Services Providers – Coverage and Reimbursement of Services, Senate Bill 0017- Health Information Exchange- Definitions and Regulations, Senate Bill 0527 – Health- Standards of Involuntary Admissions and Petitions for Emergency Evaluation- Modification, Senate Bill 1023/House Bill 1194- Drug Cost Review Commission, Senate Bill 835- Maryland Medical Assistance Program- Collaborative Care Pilot Program, Senate Bill 0921- Task Force on the Premature Discharge of Patients With Substance Use Disorders, Senate Bill 994- Disclosure of Tax Benefits- Nonprofit Hospitals, House Bill 115/ Senate Bill 13- Electronic Prescription Records Cost Saving Act of 2018, and Hospitals- Community Benefit Report – Disclosure of Tax Exemption.

In regards to House Bill 161/Senate Bill 187 Budget Reconciliation and Financing Act of 2018, Chairman Sabatini said that he informed Speaker Mike Busch that the use of a hospital assessment to fund coverage initiatives "would be the death knell of the All-Payer Model."

Commissioner Colmers stated that Staff should let the bills' sponsors, as well as committee chairs know of the Commission's objection to consideration of any hospital assessments.

Commissioners recommended that Staff draft a letter stating the Commission's opposition to the bills.

ITEM IX
HEARING AND MEETING SCHEDULE

March 14, 2018	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
April 11, 2018	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:41 p.m.

Monitoring Maryland Performance
Medicare Fee-for-Service (FFS)

Data through December 2017 – Claims paid through January

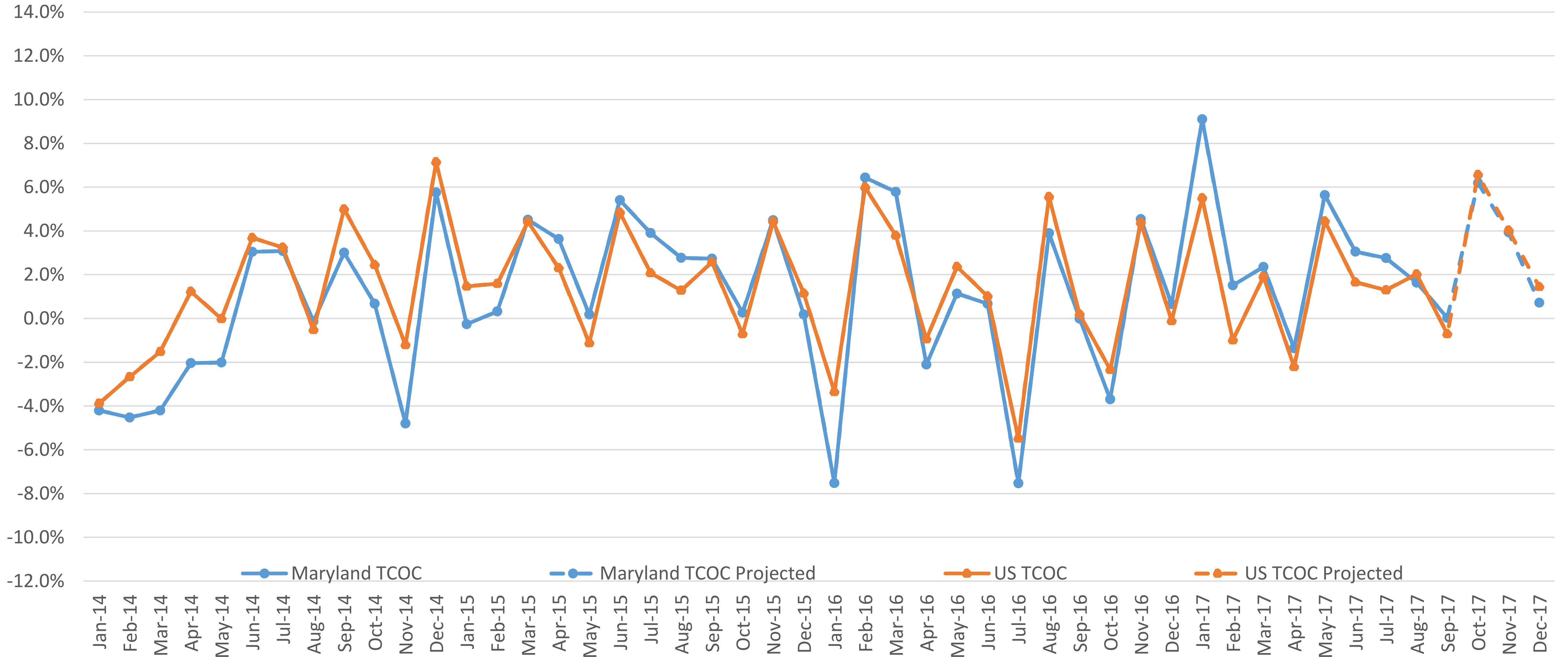
Source: CMMI Monthly Data Set

Disclaimer:

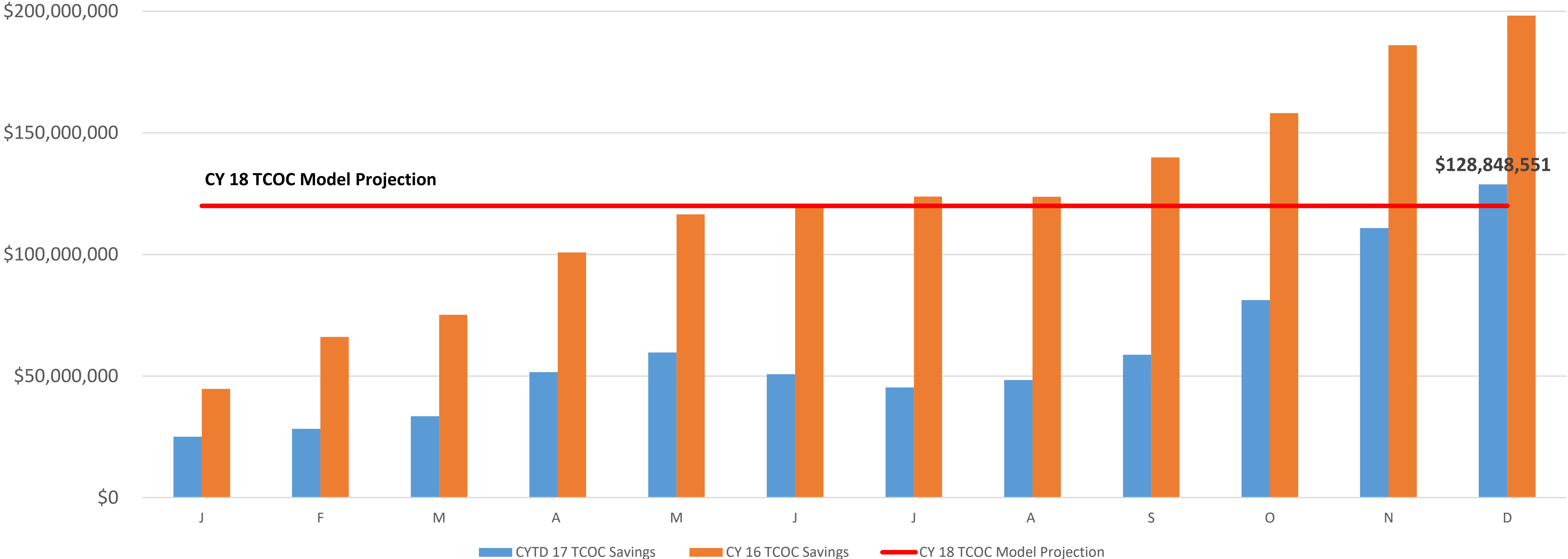
Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections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

Medicare Total Cost of Care per Capita

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



Annual Total Cost of Care Savings



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Health Services Cost Review Commission

Monitoring Maryland Performance Financial Data

Year to Date through January 2018*

Source: Hospital Monthly Volume and Revenue and Financial Statement Data
Run: March 2018

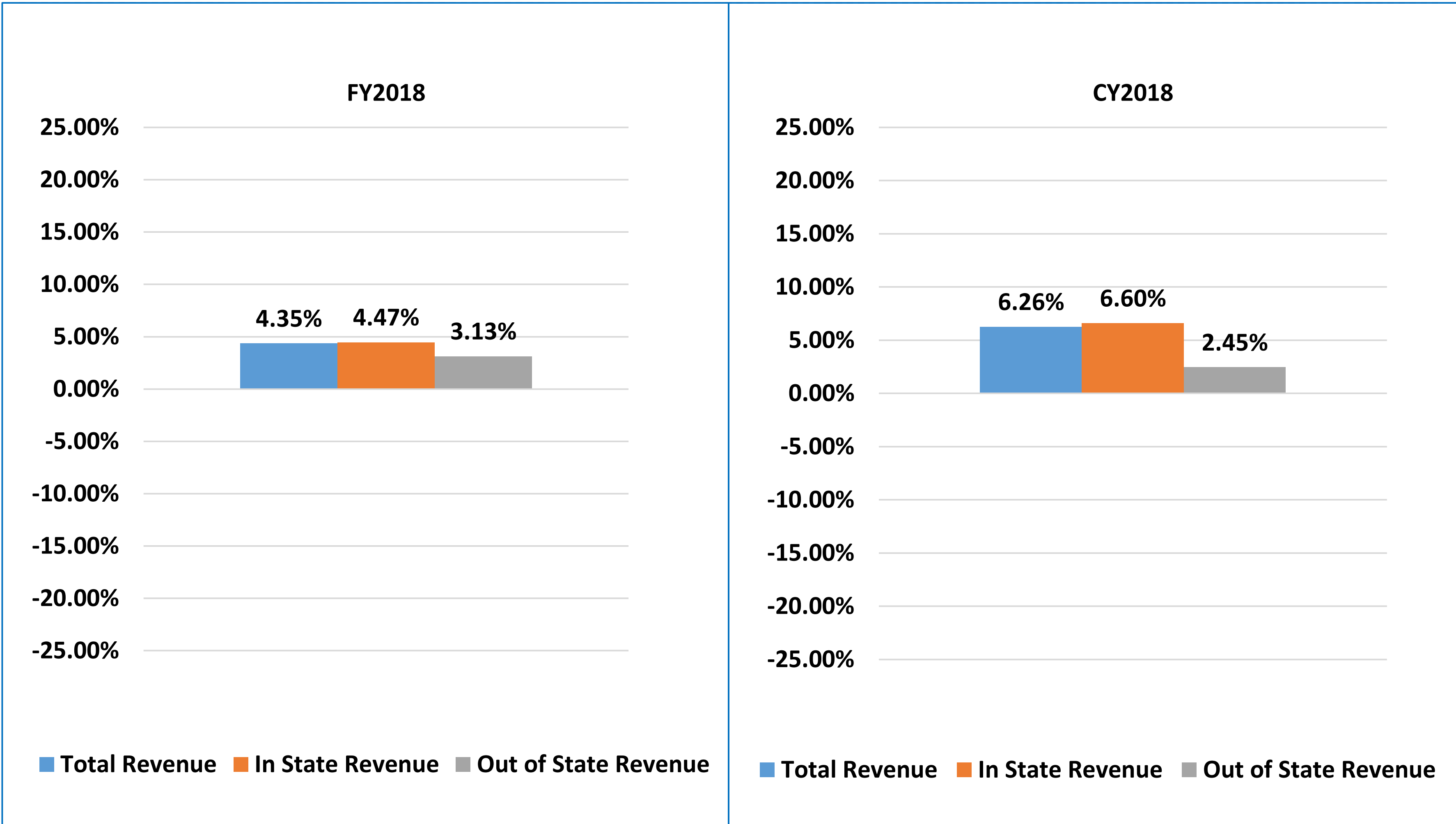
*Not adjusted for undercharge that occurred in Jul-Dec 2016

The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2017 have been revised. CMS has changed the enrollment source for the Chronic Condition Data Warehouse (CCW) from the Enrollment Database (EDB) to the Common Medicare Environment (CME) database. Part A changed very slightly and Part B is more noticeably changed.

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

Gross All Payer Hospital Revenue Growth

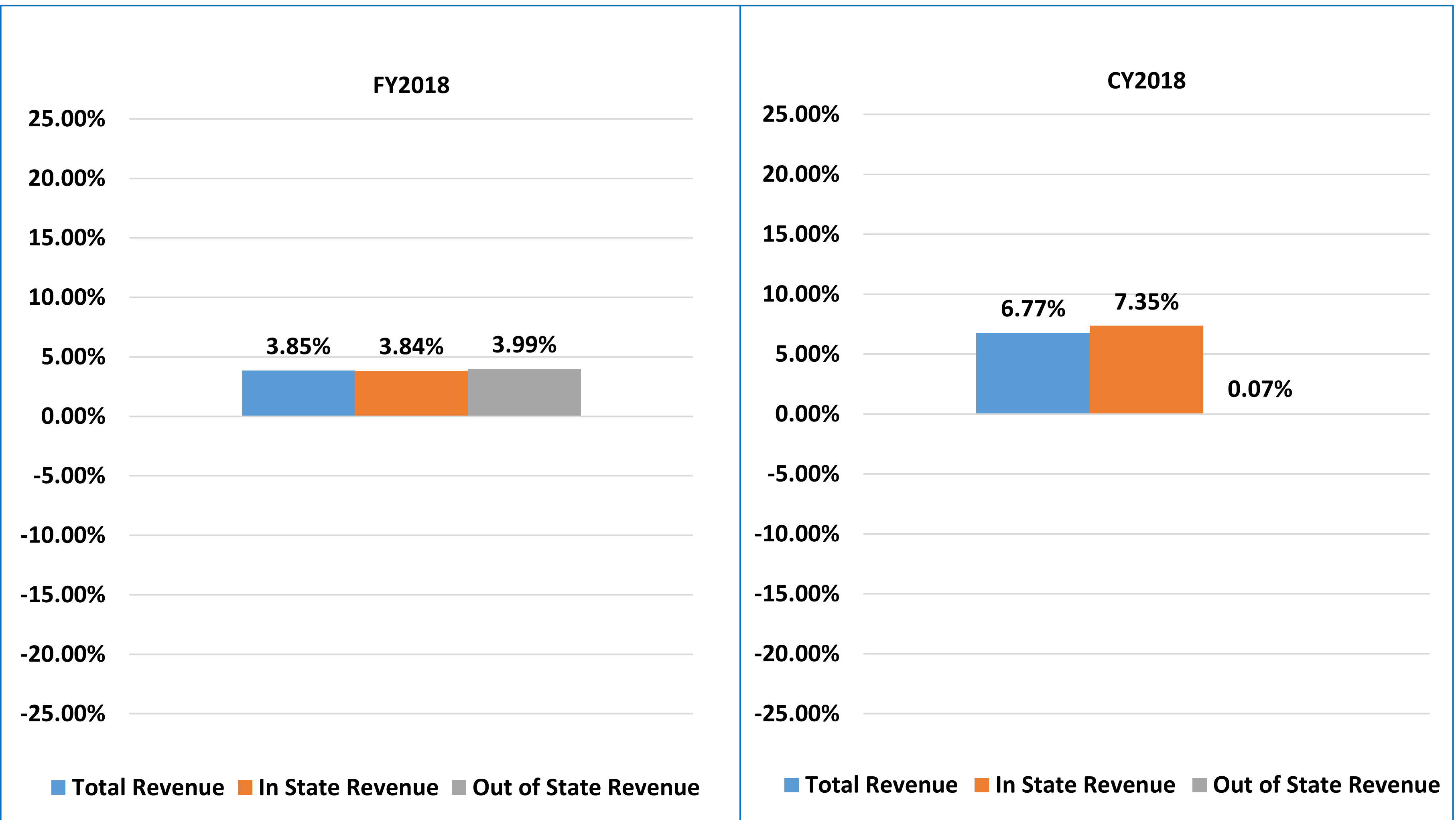
FY 2018 (July – January 2018 over July – January 2017) and CY 2018 (January 2018 over January 2017)



The State's Fiscal Year begins July 1

Gross Hospital Medicare Fee for Service Revenue Growth

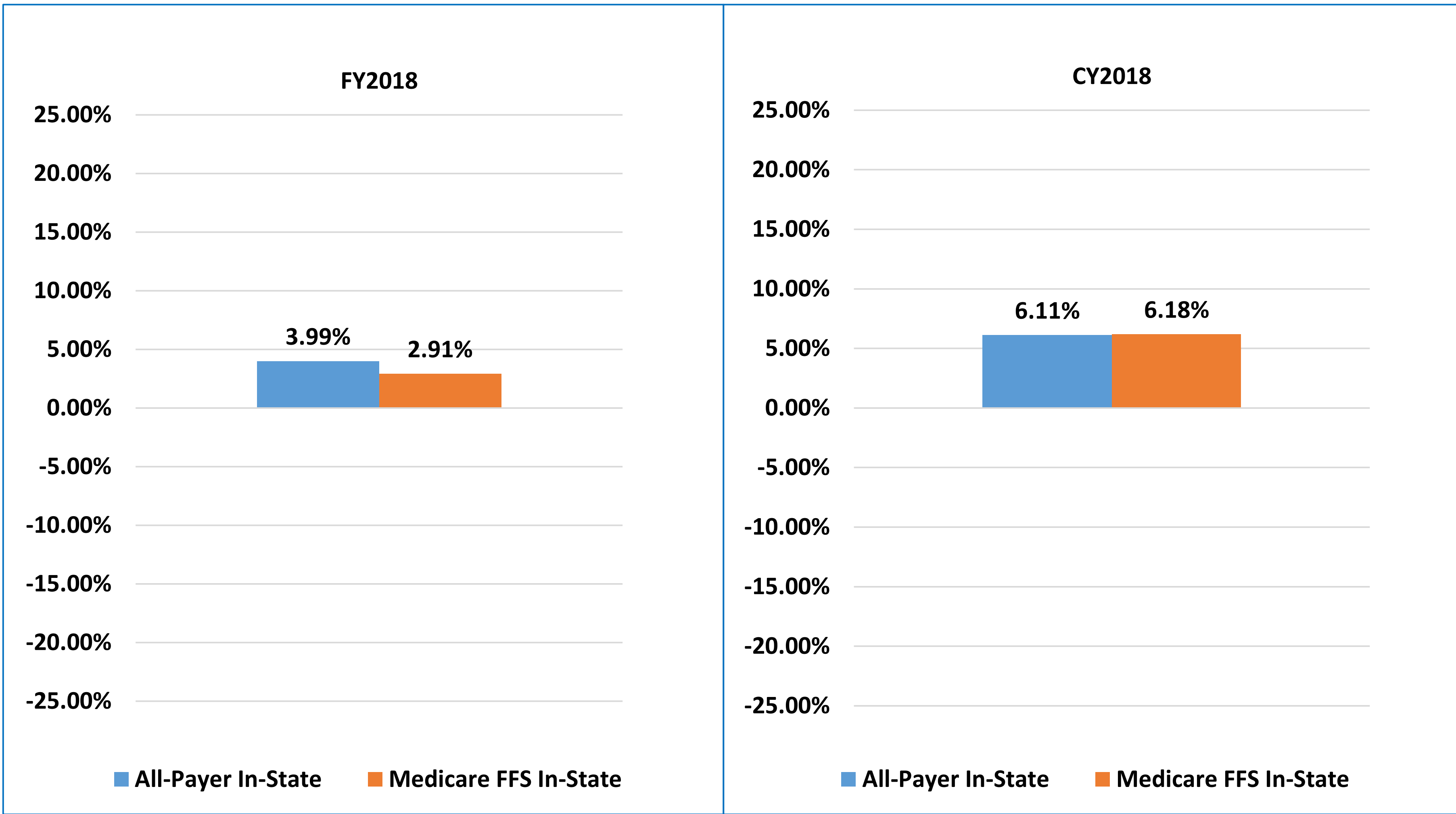
FY 2018 (July – January 2018 over July – January 2017) and CY 2018 (January 2018 over January 2017)



The State's Fiscal Year begins July 1

Hospital Revenue Per Capita Growth Rates

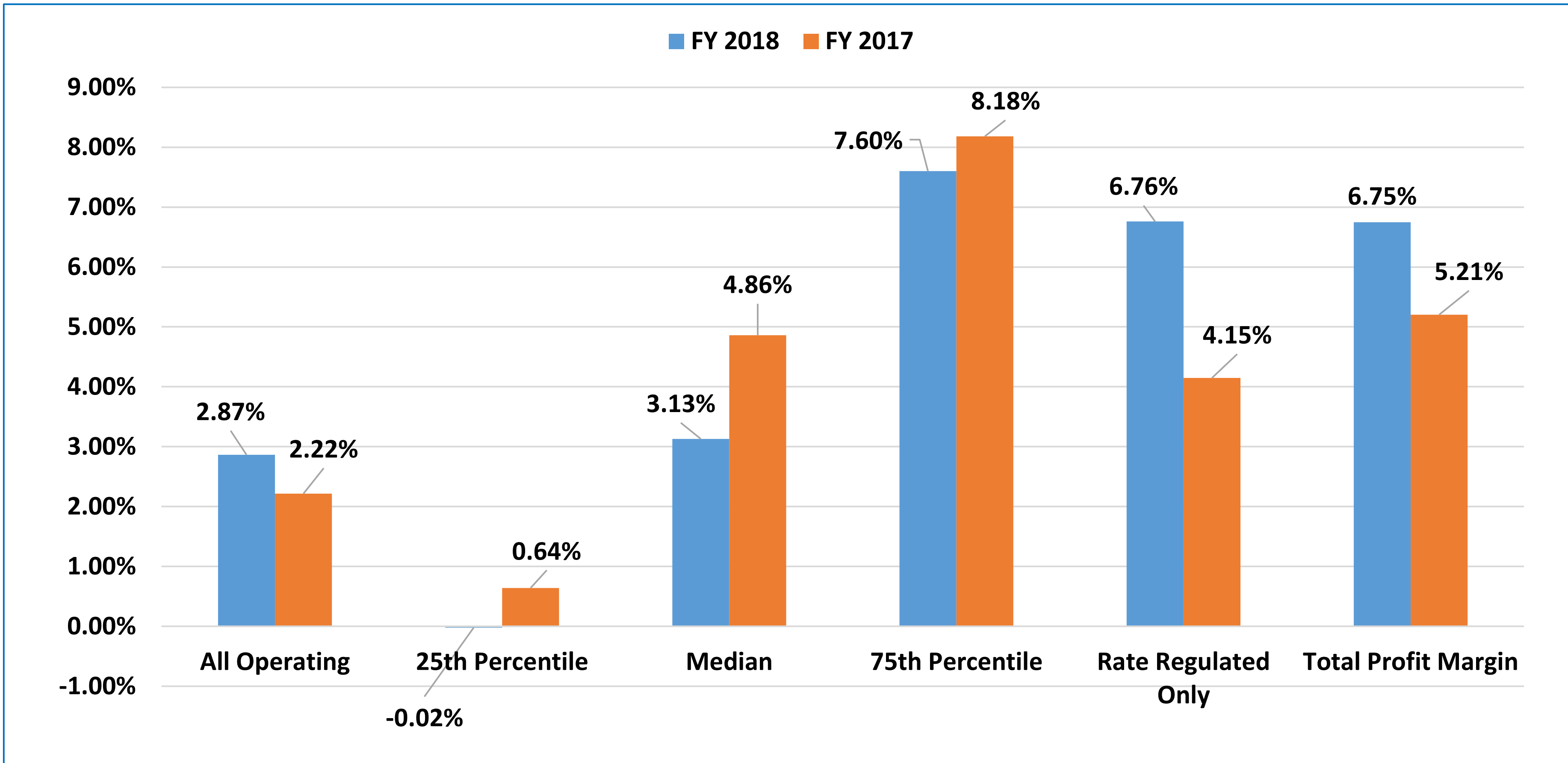
FY 2018 (July – January 2018 over July – January 2017) and CY 2018 (January 2018 over January 2017)



The State's Fiscal Year begins July 1

Hospital Operating and Total Profits

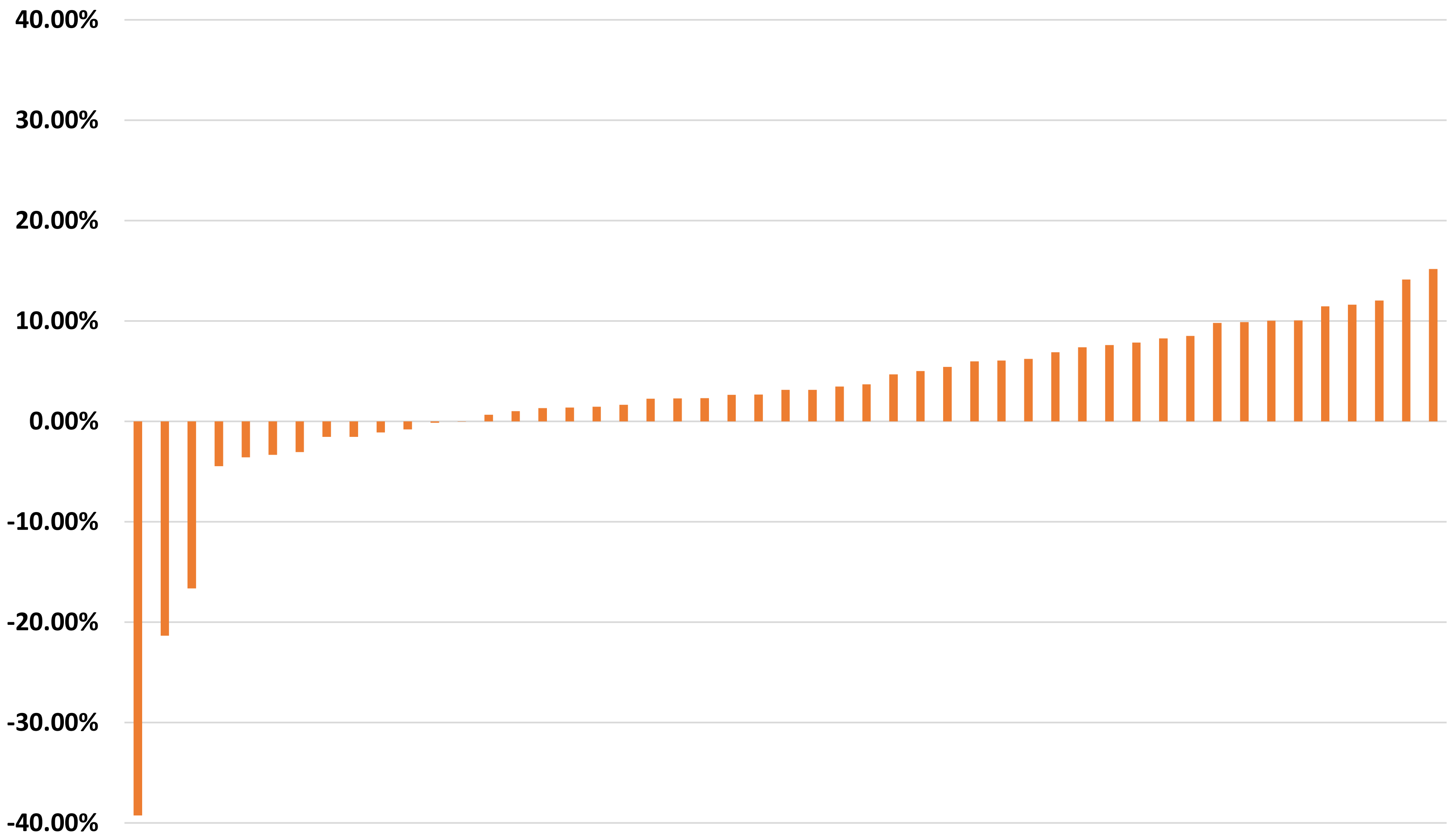
Fiscal Year 2018 (July 2017 – January 2018) Compared to Same Period in Fiscal Year 2017 (July 2016 – January 2017)



FY 2018 unaudited hospital operating profits to date show an increase of 0.65 percentage points in total operating profits compared to the same period in FY 2017. Rate regulated profits for FY 2018 have increased by 2.61 percentage points compared to the same period in FY 2017.

Operating Profits by Hospital

Fiscal Year 2018 (July 2017 – January 2018)



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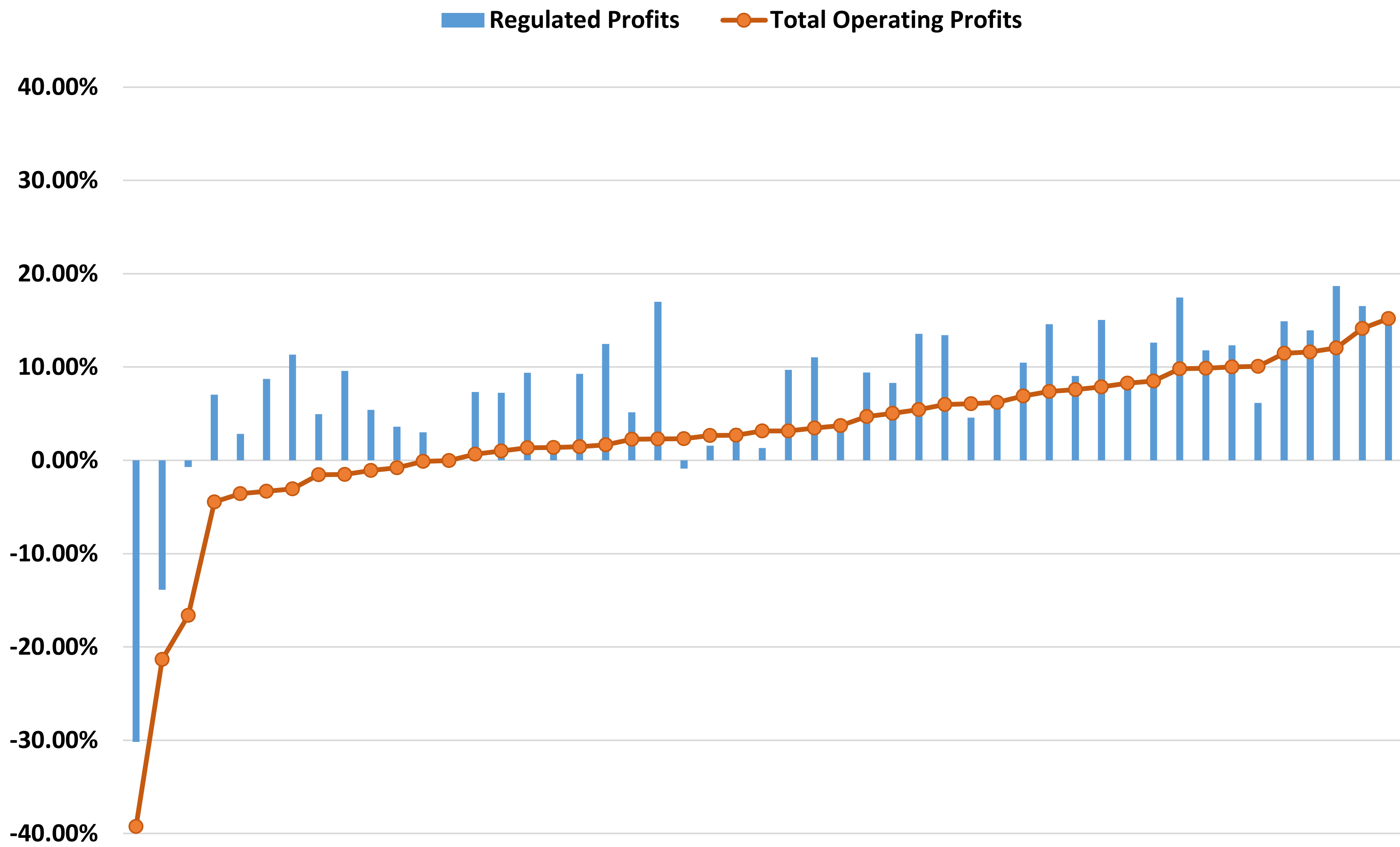
Regulated and Operating Profits by Hospital

Fiscal Year 2018 (July 2017 – January 2018)



Monitoring Maryland Performance Financial/Utilization Data

Calendar Year to Date through January 2018

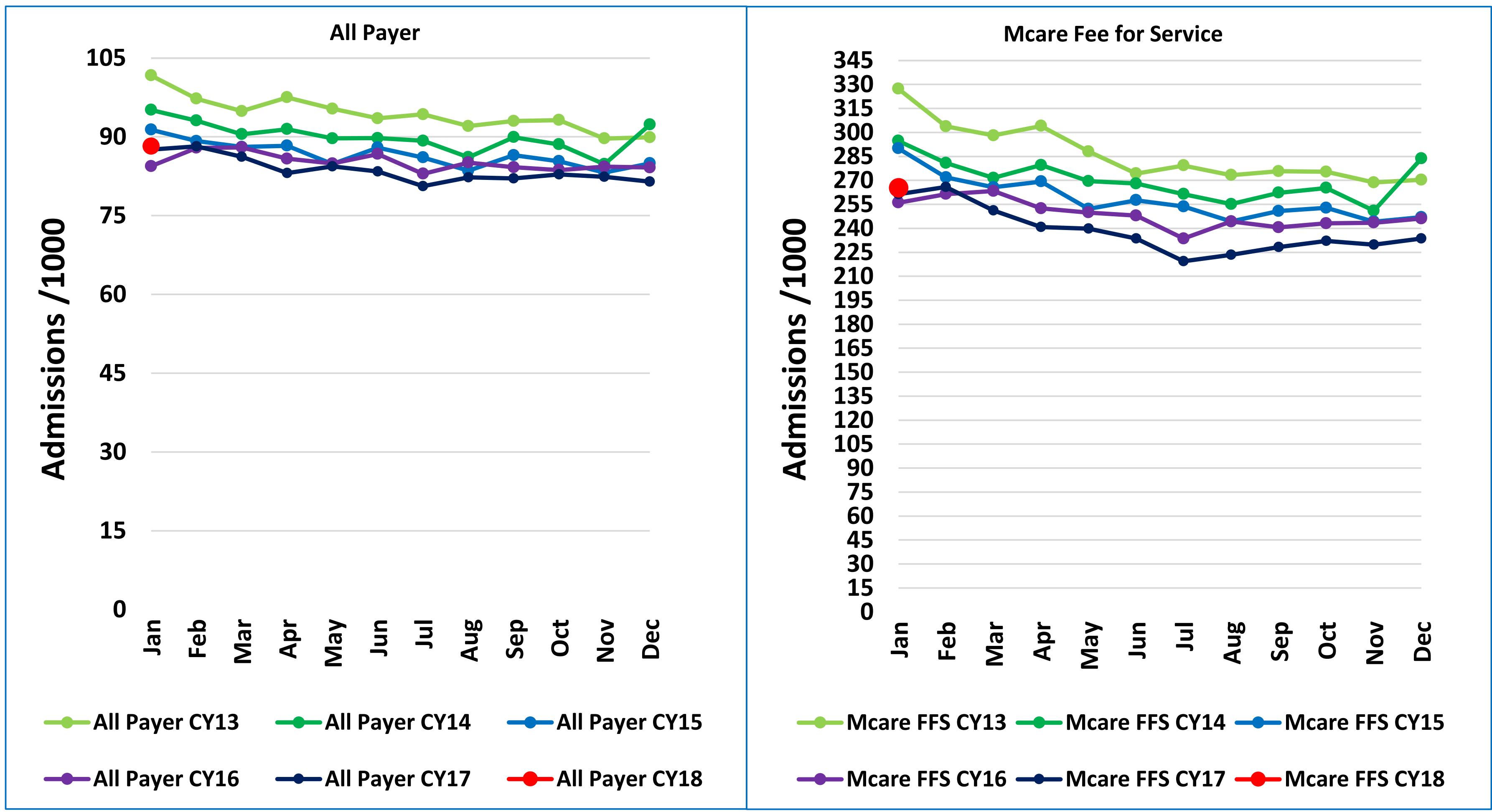
Source: Hospital Monthly Volume and Revenue Data

The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2017 have been revised. CMS has changed the enrollment source for the Chronic Condition Data Warehouse (CCW) from the Enrollment Database (EDB) to the Common Medicare Environment (CME) database. Part A changed very slightly and Part B is more noticeably changed.

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

Annual Trends for ADK Annualized

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

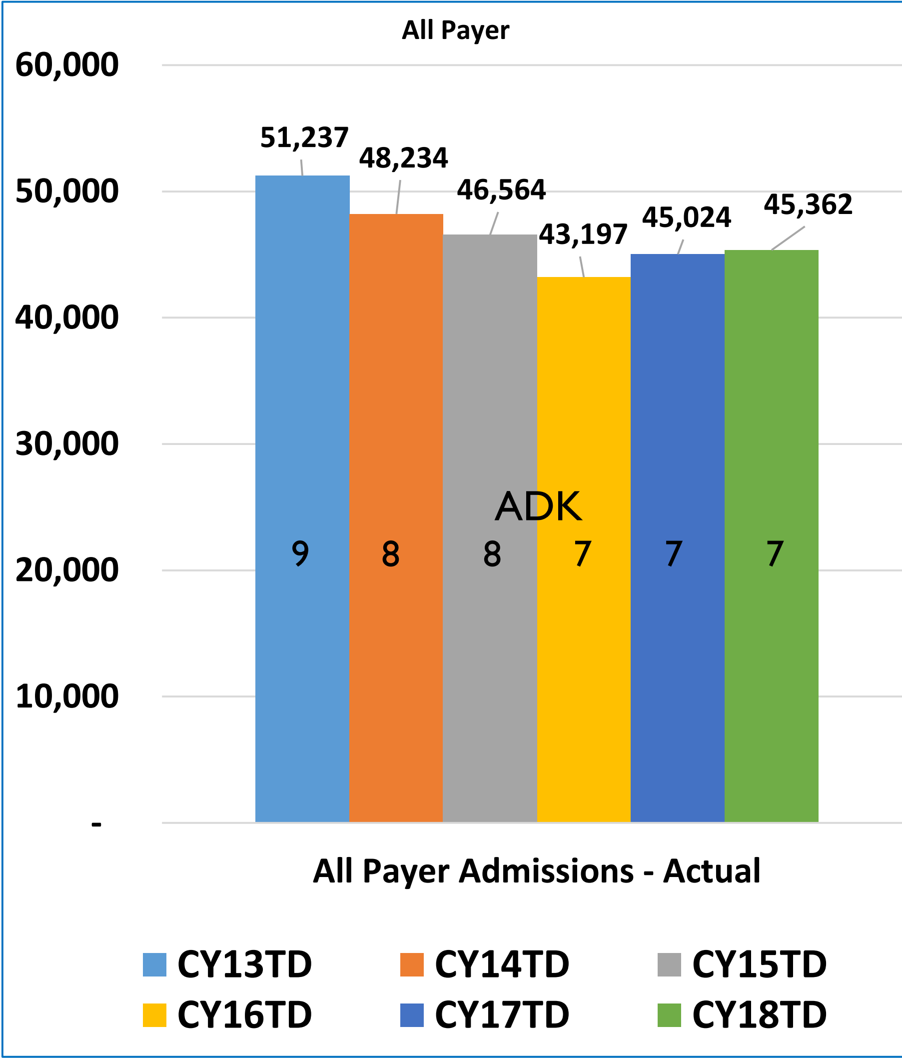


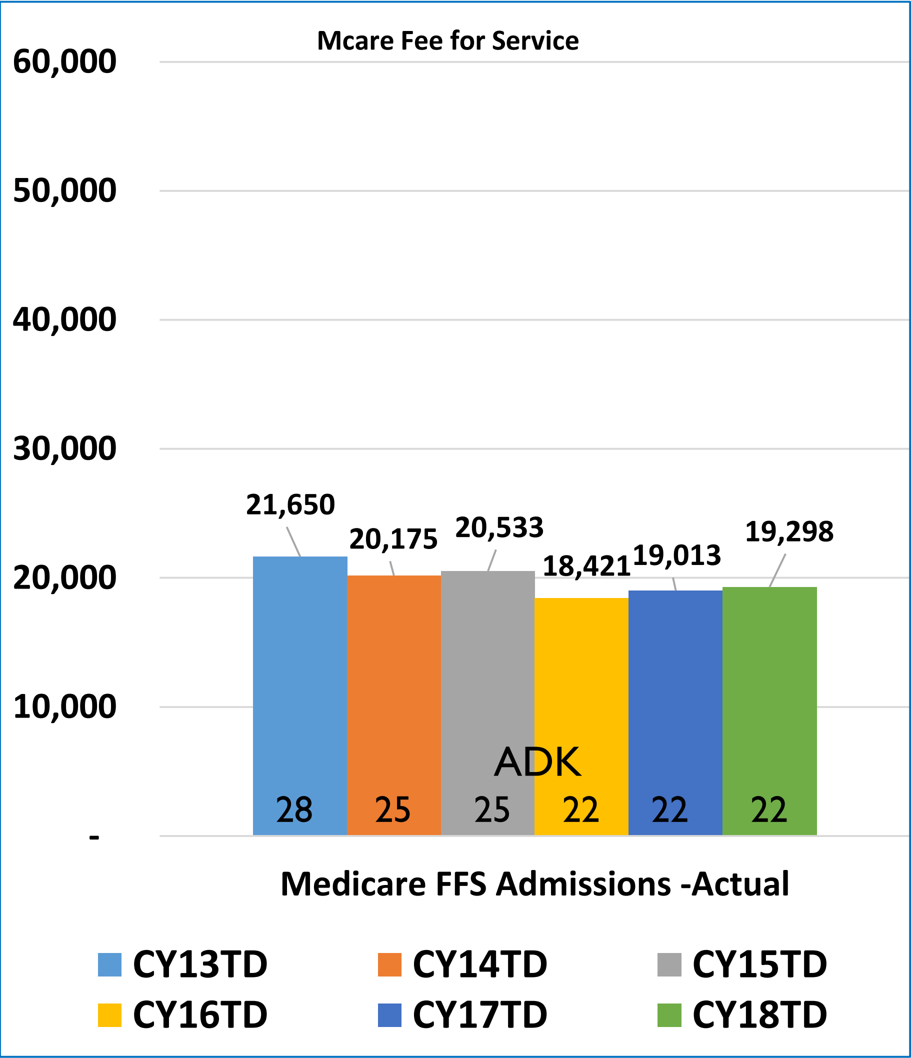
Note - The admissions do not include out of state migration or specialty psych and rehab hospitals.

HSCRC
Health Services Cost Review Commission

Actual Admissions by Calendar Year - January

(CY 2013 through CY 2018)





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

HSCRC
Health Services Cost Review Commission

Change in Admissions by Calendar YTD January

(CY 2013 through CY 2018)

Change in All Payer Admissions CYTD13 vs. CYTD14 = -5.86%
Change in All Payer Admissions CYTD14 vs. CYTD15 = -3.46%
Change in All Payer Admissions CYTD15 vs. CYTD16 = -7.23%
Change in All Payer Admissions CYTD16 vs. CYTD17 = 4.23%
Change in All Payer Admissions CYTD17 vs. CYTD18 = 0.75%

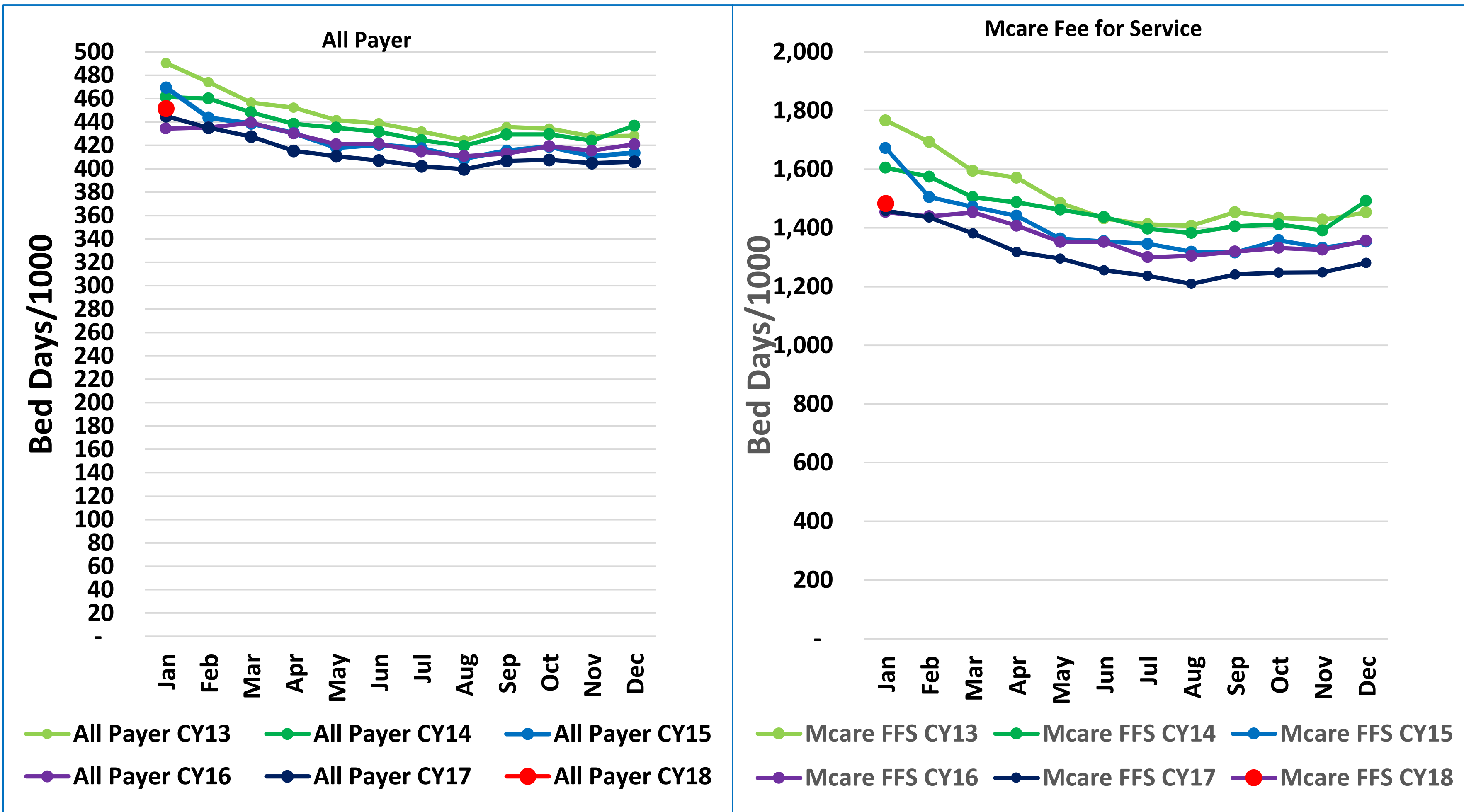
Change in ADK CYTD 13 vs. CYTD 14 = -6.45%
Change in ADK CYTD 14 vs. CYTD 15 = -3.95%
Change in ADK CYTD 15 vs. CYTD 16 = -7.60%
Change in ADK CYTD 16 vs. CYTD 17 = 3.76%
Change in ADK CYTD 17 vs. CYTD 18 = 0.75%

Change in Medicare FFS Admissions CYTD13 vs. CYTD14 = -6.81%
Change in Medicare FFS Admissions CYTD14 vs. CYTD15 = 1.77%
Change in Medicare FFS Admissions CYTD15 vs. CYTD16 = -10.28%
Change in Medicare FFS Admissions CYTD16 vs. CYTD17 = 3.21%
Change in Medicare FFS Admissions CYTD17 vs. CYTD18 = 1.50%

Change in Medicare FFS ADK CYTD 13 vs. CYTD 14 = -9.96%
Change in Medicare FFS ADK CYTD 14 vs. CYTD 15 = -1.57%
Change in Medicare FFS ADK CYTD 15 vs. CYTD 16 = -11.70%
Change in Medicare FFS ADK CYTD 16 vs. CYTD 17 = 2.08%
Change in Medicare FFS ADK CYTD 17 vs. CYTD 18 = 0.33%

Annual Trends for BDK Annualized

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

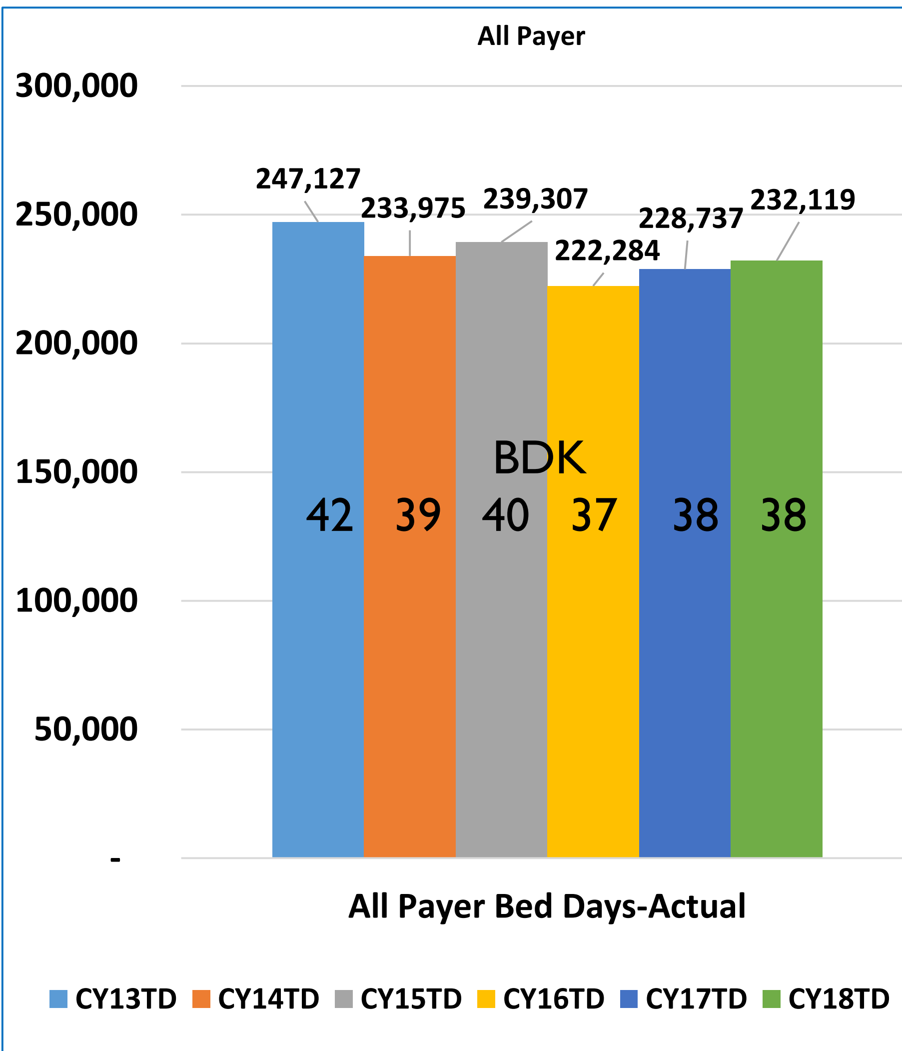


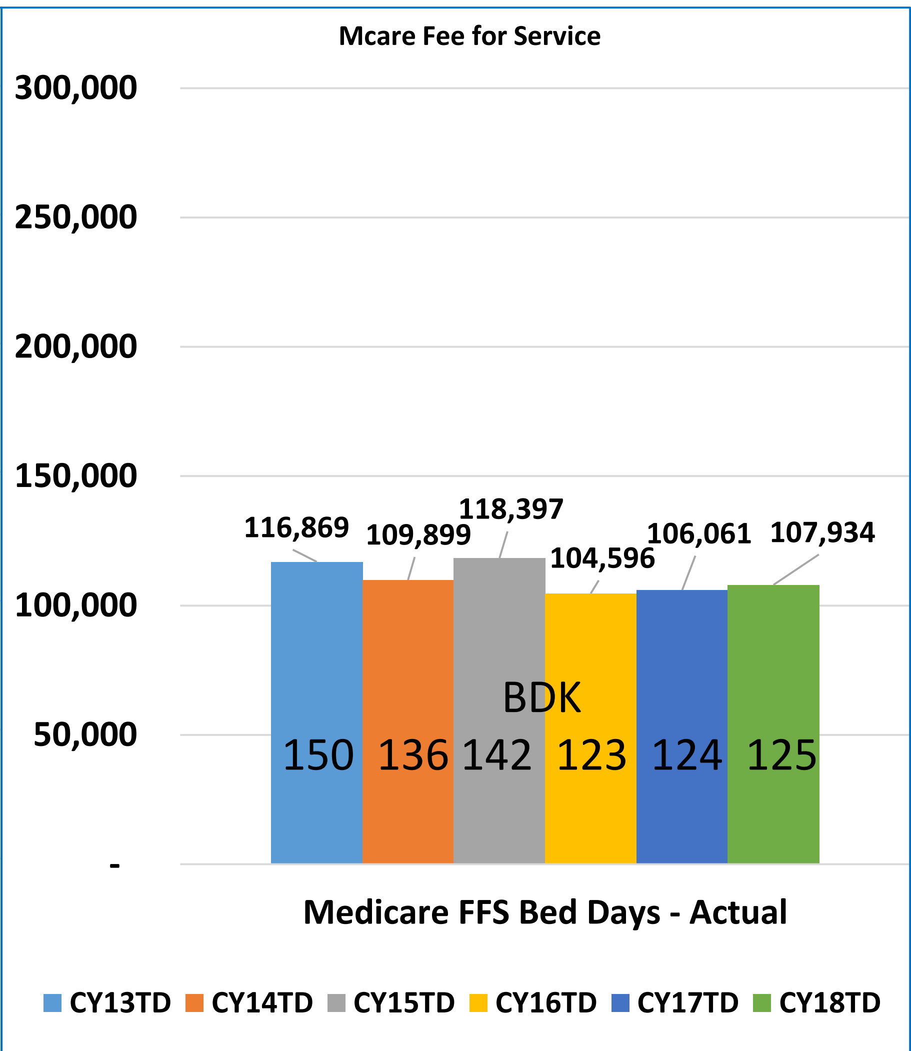
Note - The bed days do not include out of state migration or specialty psych and rehab hospitals.

HSCRC
Health Services Cost Review Commission

Actual Bed Days by Calendar YTD January

(CY 2013 through CY 2018)





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

Change in Bed Days by Calendar YTD January

(CY 2013 through CY 2018)

Change in All Payer Bed Days CYTD13 vs. CYTD14 = -5.32%
Change in All Payer Bed Days CYTD14 vs. CYTD15 = 2.28%
Change in All Payer Bed Days CYTD15 vs. CYTD16 = -7.11%
Change in All Payer Bed Days CYTD16 vs. CYTD17 = 2.90%
Change in All Payer Bed Days CYTD17 vs. CYTD18 = 1.48%

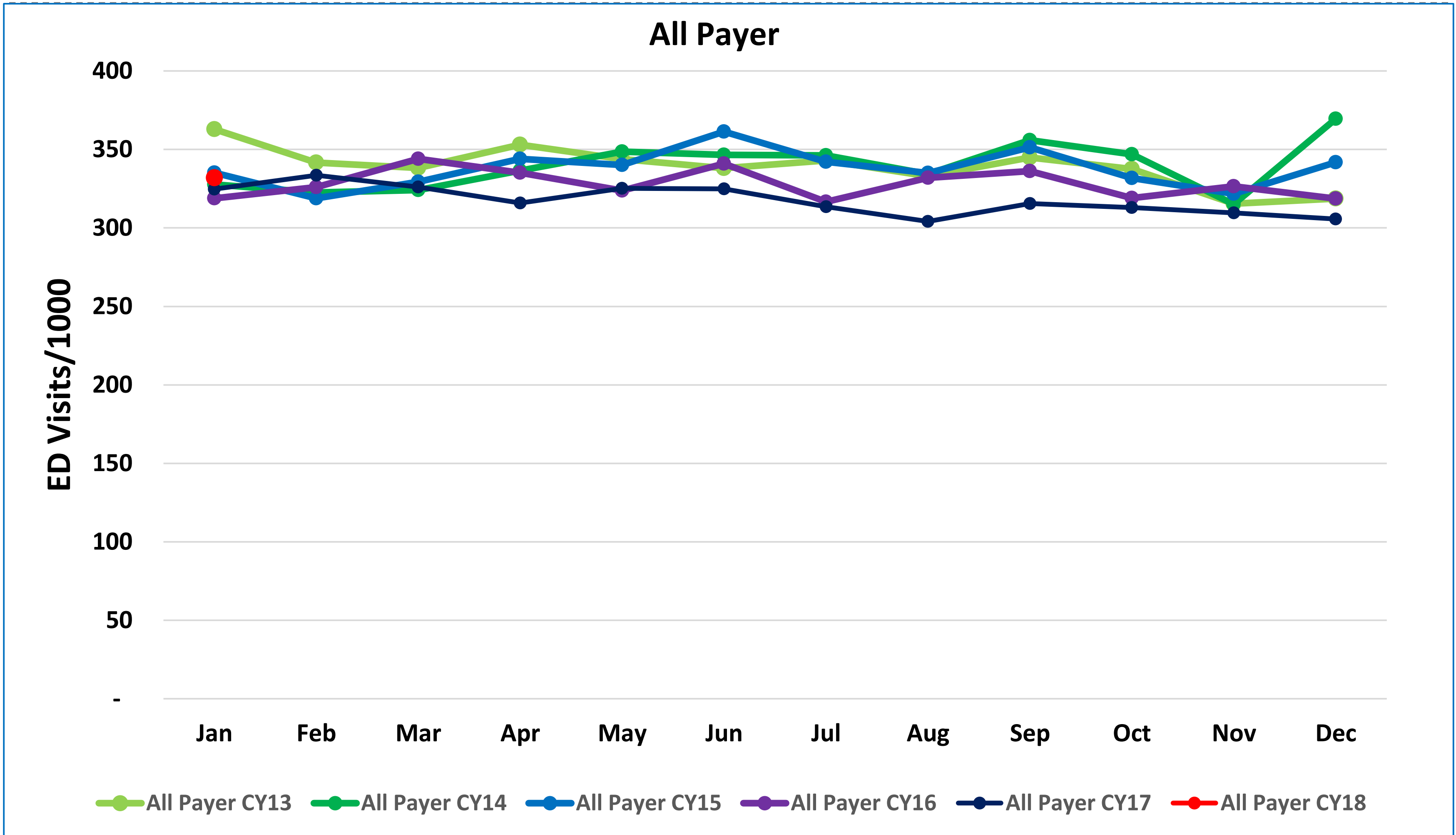
Change in BDK CYTD 13 vs. CYTD 14 = -5.92%
Change in BDK CYTD 14 vs. CYTD 15 = 1.76%
Change in BDK CYTD 15 vs. CYTD 16 = -7.49%
Change in BDK CYTD 16 vs. CYTD 17 = 2.44%
Change in BDK CYTD 17 vs. CYTD 18 = 1.48%

Change in Medicare FFS Bed Days CYTD13 vs. CYTD14 = -5.96%
Change in Medicare FFS Bed Days CYTD14 vs. CYTD15 = 7.73%
Change in Medicare FFS Bed Days CYTD15 vs. CYTD16 = -11.66%
Change in Medicare FFS Bed Days CYTD16 vs. CYTD17 = 1.40%
Change in Medicare FFS Bed Days CYTD17 vs. CYTD18 = 1.77%

Change in Medicare FFS BDK CYTD 13 vs. CYTD 14 = -9.14%
Change in Medicare FFS BDK CYTD 14 vs. CYTD 15 = 4.19%
Change in Medicare FFS BDK CYTD 15 vs. CYTD 16 = -13.05%
Change in Medicare FFS BDK CYTD 16 vs. CYTD 17 = 0.29%
Change in Medicare FFS BDK CYTD 17 vs. CYTD 18 = 0.59%

Annual Trends for EDK Annualized

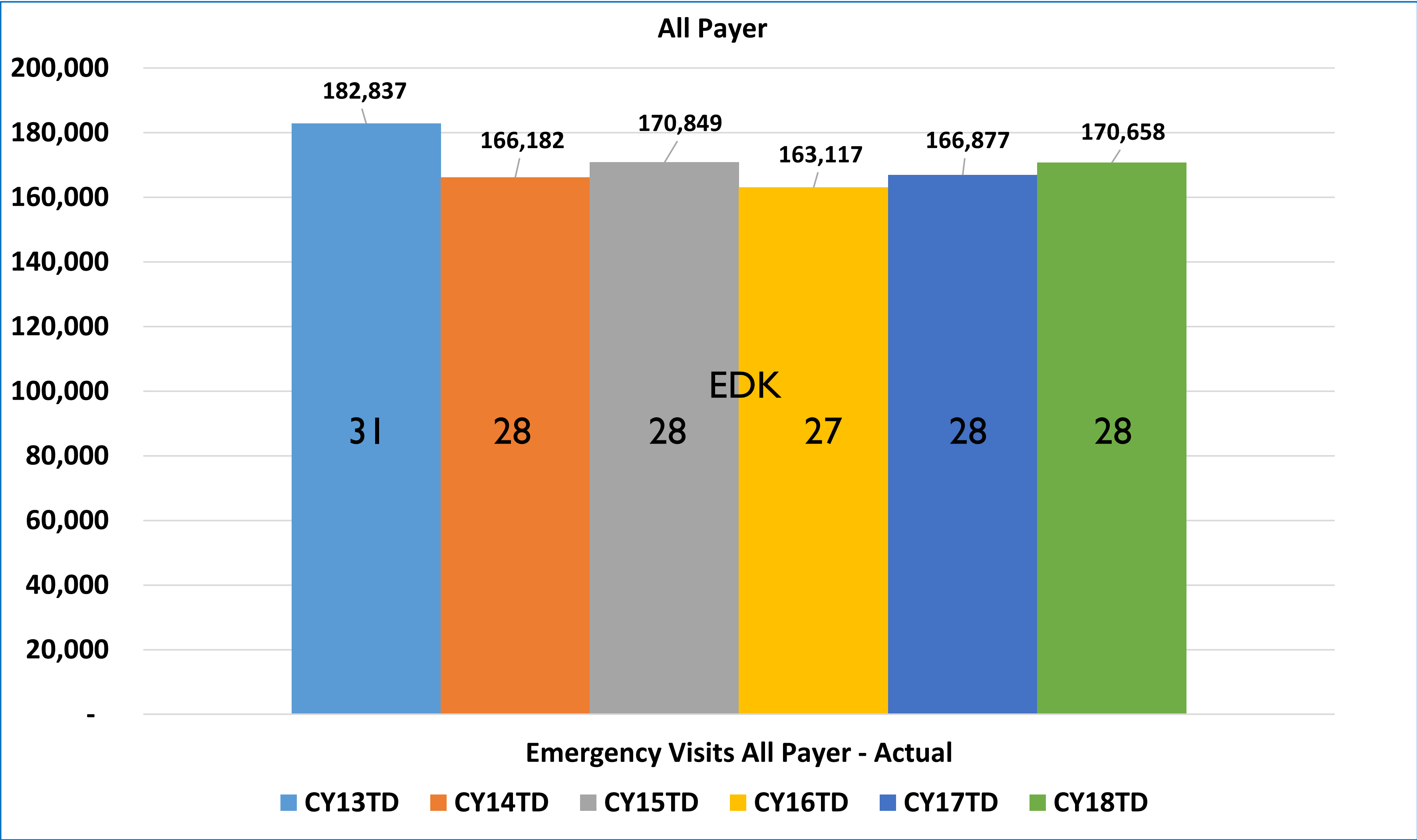
All Payer (CY 2013 through CY2018 January)



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

HSCRC
Health Services Cost Review Commission

Actual Emergency Department Visits by Calendar YTD January (CY 2013 through CY 2018)



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

Change in ED Visits by Calendar YTD January

(CY 2013 through CY 2018)

Change in ED Visits CYTD 13 vs. CYTD 14 = - 9.11%

Change in ED Visits CYTD 14 vs. CYTD 15 = 2.81%

Change in ED Visits CYTD 15 vs. CYTD 16 = -4.53%

Change in ED Visits CYTD 16 vs. CYTD 17 = 2.31%

Change in ED Visits CYTD 17 vs. CYTD 18 = 2.27%

Change in EDK CYTD 13 vs. CYTD 14 = -9.68%

Change in EDK CYTD 14 vs. CYTD 15 = 2.29%

Change in EDK CYTD 15 vs. CYTD 16 = -4.91%

Change in EDK CYTD 16 vs. CYTD 17 = 1.84%

Change in EDK CYTD 17 vs. CYTD 18 = 2.27%

Purpose of Monitoring Maryland Performance

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

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

- 3.58% annual growth rate

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

Data Caveats

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

Monitoring Maryland Performance
Quality Data

March 2018 Commission Meeting – No Updates this Month

HSCRC
Health Services Cost Review Commission

Quality Data Reporting Schedule

- Readmissions –
  - For analysis on the latest readmission rate trends, including progress on the Medicare Readmission Waiver Test, please see embedded figures and appendices in the RY 2020 Final RRIP Policy.
  - There are a few small data issues in the preliminary Q4 data; staff anticipates that these will be resolved by the December Final data, anticipated to be available in April 2018.
- MHAC -
  - Staff will provide an update to PPC rates on a quarterly basis, with final (closed) data; last provided through Sep 2017.
  - Final CY 2017 data is anticipated to be available in April 2018.
- PAU -
  - There is no Potentially Avoidable Utilization update this month due to additional data validation.

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF MARCH 6, 2018

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2422A	University of Maryland Medical Center	1/12/2018	N/A	N/A	ARM	DNP	OPEN
2429R	Garrett Regional Medical Center	2/1/2018	4/3/2018	7/3/2018	Full Rate	JS	OPEN
2430A	Johns Hopkins Health System	2/27/2018	N/A	N/A	ARM	DNP	OPEN
2431R	Johns Hopkins Bayview Medical Center	3/2/2018	4/3/2018	7/30/2018	Partial	CK	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2018**
MEDICAL CENTER	*	**FOLIO:**	**2232**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2422A**

Staff Recommendation

March 14, 2018

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on January 12, 2018 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. Network for a period of one year, effective April 1, 2018.

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. 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, 2018. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("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:**	**2018**
SYSTEM	*	**FOLIO:**	**2240**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2430A**

Staff Recommendation

March 14, 2018

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on February 27, 2018 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for transplant, joint replacement, and pancreatic cancer services with Crawford Advisors, LLC for a period of one year beginning April 1, 2018.

II. OVERVIEW OF APPLICATION

The contract will be continue to be held and administered by JHHC, which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Although there has been no experience under this arrangement, staff believes that the Hospitals can achieve favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

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

Peninsula Regional Health System
Peninsula Regional Medical Center

Population Health/System Update

March 14th, 2018

PENINSULA
REGIONAL HEALTH SYSTEM

PENINSULA
REGIONAL HEALTH SYSTEM

Founded in 1897 - Region's Oldest Most Experienced Healthcare Team

- **Located In Salisbury, Maryland**
- **281 Licensed Beds – 8th Largest in State**
- **Service Area > 480,000**
- **Provides Health Services to Three States**
  - -Maryland
  - -Delaware
  - -Virginia
- **Predominately Rural with Urban Influence in Greater Salisbury**
- **Popular Retirement Destination**
  (Retirees from Annapolis, Washington D.C. , Philadelphia, Baltimore , New York and the State of New Jersey continue to move into this geographic region)

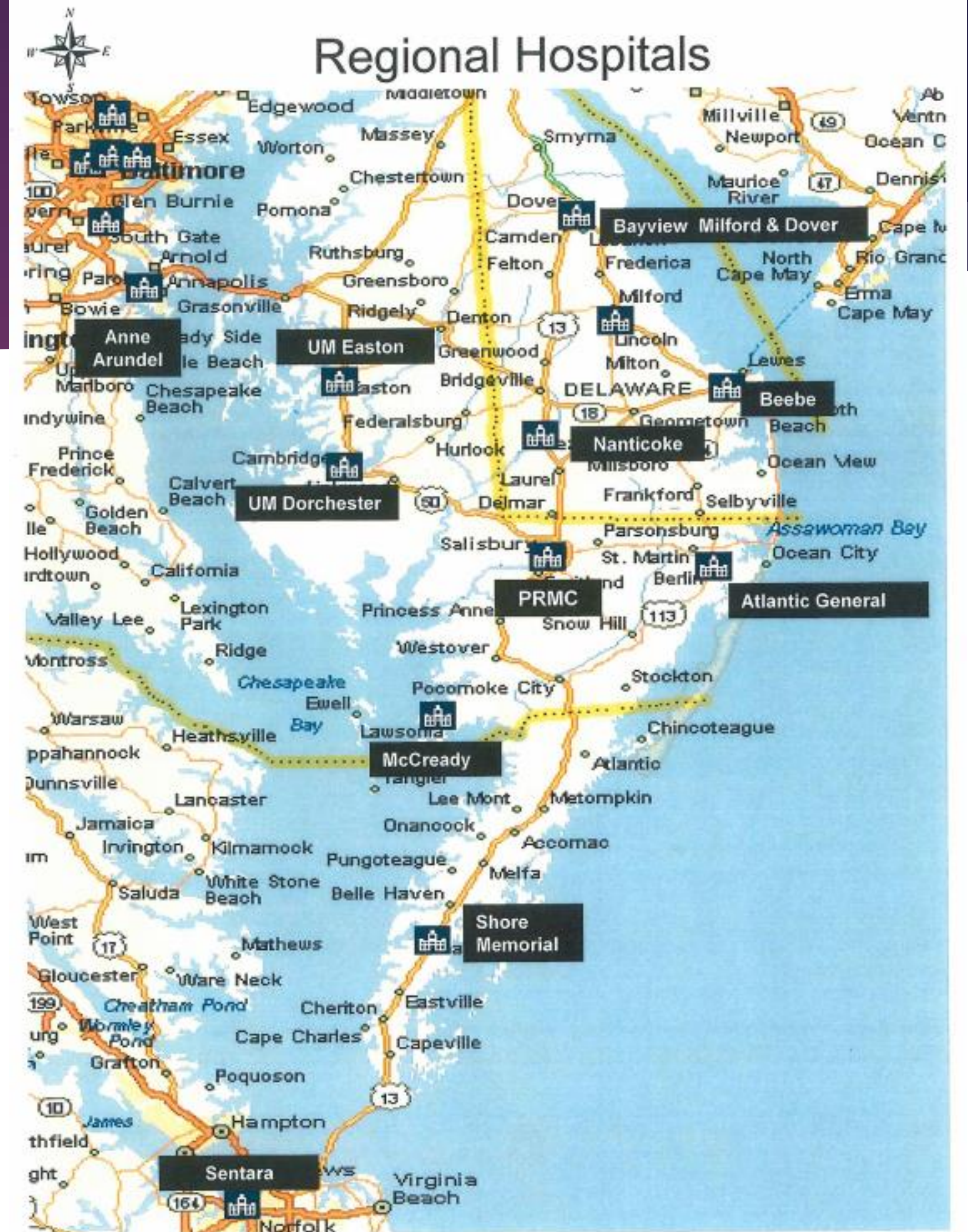
Offers Full Scope of Services

ED/Trauma
Open Heart Surgery
Designated STEMI (Rt. 404 South)
Special Care Nursery Level II
Robotic Surgery
Stroke Center
Orthopedics
Neurosurgery
Spine Center
Comprehensive Cancer Center
Behavioral Health
Community/ Population Health
Joint Ventures
Surgery Centers
Ambulatory Care
Primary Care Offices

FIVE STARS
by Centers for Medicare & Medicaid Services

Our Level of Service

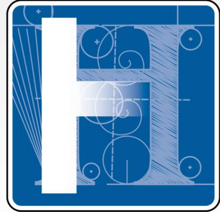
- Critical Access
- Community
- Tertiary Care
- Academic
- What you would find in most Metro areas



Primary Service Area

Service Area > 480,000
~20% are over Age 65

The Health System Today



- Revenue - $546M (Budgeted FYE2018)
- Other entities include:
  - Health Ventures
    - Peninsula Imaging
    - Delmarva Surgery Center
    - Peninsula Home Care
    - American Home Patient – Durable Medical Equipment
    - Genesis Nursing Home
    - Your Doc’s In – Urgent Care
    - CoreLife Delmarva (Weight loss centers)
  - Peninsula Surgery Center
  - Peninsula Regional Clinically Integrated Network
  - Advanced Health Collaborative, HealthVisions Delmarva
  - Johns Hopkins Medicare Advantage
  - YMCA Exclusive Agreement
  - LifeLine

ADVANTAGE MD
Johns Hopkins Medicine Medicare Plan

the YMCA
OF THE CHESAPEAKE

Peninsula Regional
Clinically Integrated Network LLC

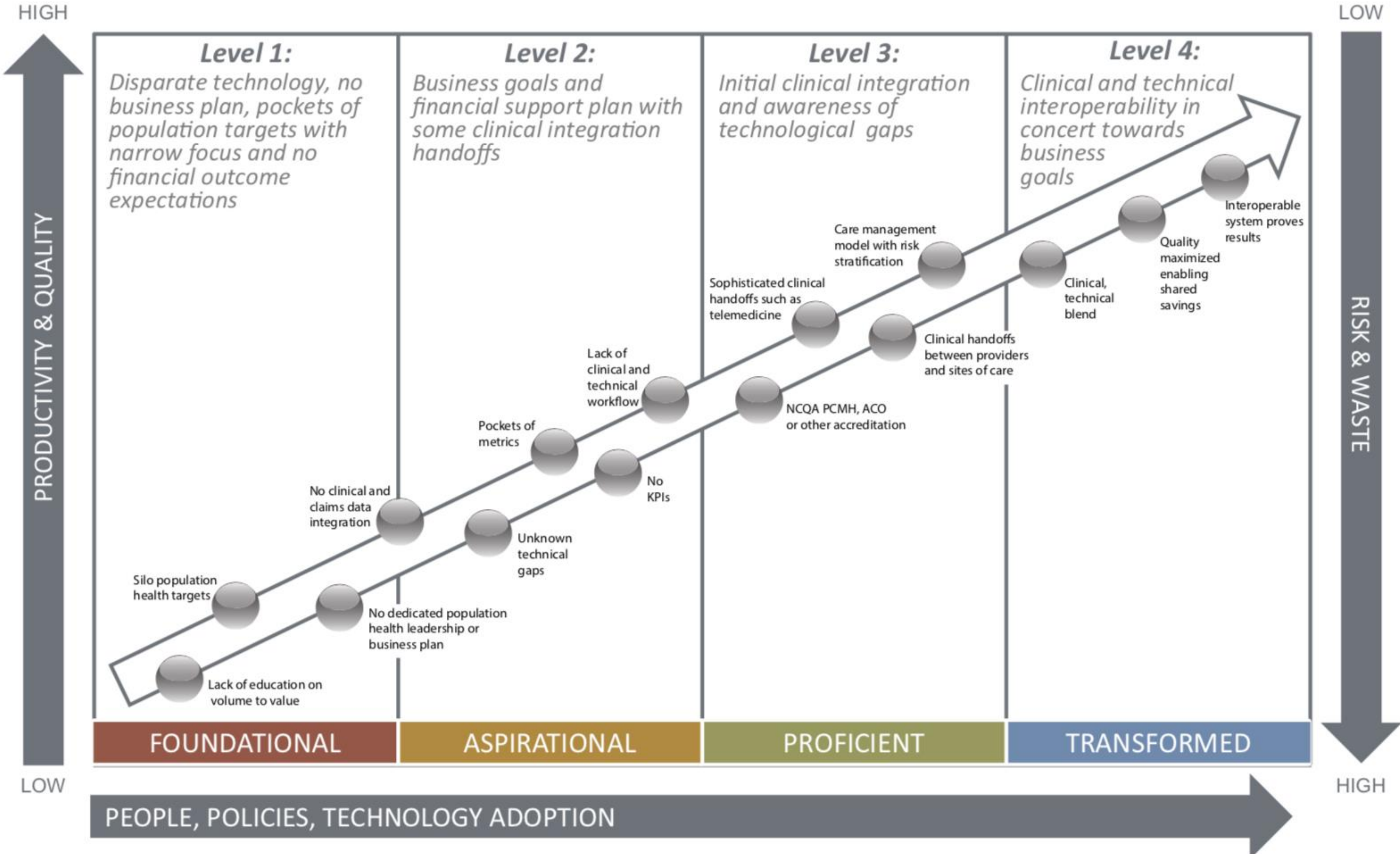
Peninsula Regional Health System
Peninsula Regional Medical Center

- Additional Offerings
  - Delmarva Health Pavilions
    - Millsboro
    - Ocean Pines
  - Peninsula Regional Medical Group
  - Comprehensive Breast Center

PENINSULA REGIONAL
FamilyLab™

PRMC
Home Scripts

Population Health Maturity Model



Population Health At PRMC

2013 Level 1 Foundational

Disparate technology, pockets of population health targets with narrow focus

- Employee diabetes program
- Lifeline (patient alert system at home)
- Heartline (CHF remote patient monitoring)
- McKesson (inpatient) and E Clinical Works (outpatient)
- Limited organizational competency

2014-2015 Aspirational Level 2

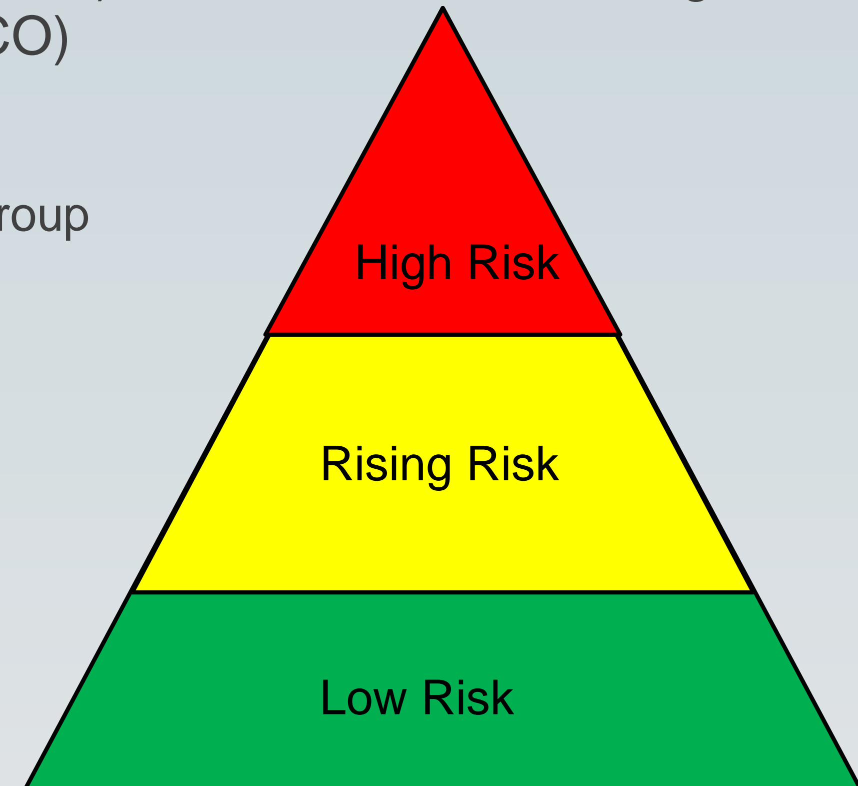
Business Goals and financial support plan with some clinical integration and handoffs

- People
  - Continuum of Care Services Team
- Programs
  - Significant focus on medication management
  - Focus on ED utilization
  - Community collaboration with MAC, Inc. (Area Agency on Aging), Behavioral Health, School System, Health Departments

2015-2017 Proficient Level 3

Initial clinical integration and awareness of technical gaps

- Peninsula Regional Clinically Integrated Network (PRCIN) Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO)
  - 150+ providers
    - Peninsula Regional Medical Center and Practice Group
    - Federally Qualified Health Center
    - 4 Community Physician Practices
  - As of 2018, Track 1 MSSP year 3 underway
    - Approximately 13k Lives



2015-2017 Proficient Level 3

Initial clinical integration and awareness of technical gaps

- Transforming Clinical Practice Initiative (TCPI)
  - 4 year grant $5.2 million CMS grant
  - Partnership with BayHealth
  - Promoting broad payment and practice reform in primary care and specialty care
  - Promoting improved quality and reduced cost by developing a collaborative of institutions that support practice transformation.
- Advanced Health Collaborative II/Medicare Advantage Clinically Integrated Network

HealthVisions
Delmarva

ADVANTAGE MD
Johns Hopkins Medicine Medicare Plan

TCPI Cost Savings

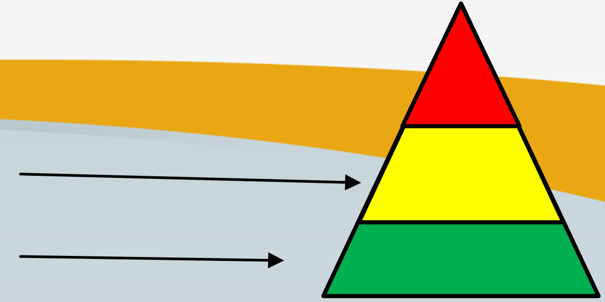
Key Intervention to Produce Result:

Readmissions: Collaboration with hospital ACO's to coordinate care using a clinically integrated network (CIN) model

Quality Measures: HgA1C and BP Control through risk stratification, team-based care and care coordination

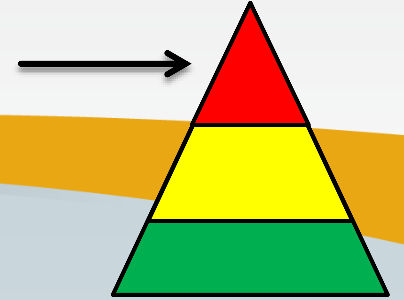
Testing Reductions: Specialty focused initiatives on a practice-by-practice basis

2015-2017 Proficient Level 3



- Risk Stratified Population Health Programs
  - Moderate Risk patients
    - Partnership with MAC, Inc. (Area Agency on Aging) Living Well Academy
    - Transitions of care support
    - ED post discharge follow up
    - Smith Island Telemedicine
    - Wagner Wellness Van
  - Low Risk patients
    - PCP Engagement and follow up
    - Targeted education and preventive care follow up
    - Focus on ED utilization monthly with payers, CareFirst, Priority Partners

2015-2017 Proficient Level 3



High Risk Patients

- ACO Embedded Care Managers (RN)
- CareWrap – Lower Shore Behavioral Health
- Salisbury Wicomico Integrated First Care Team (SWIFT)
- Regional Transformation Grant Partnership for Care Coordination

CRISP Potentially Avoidable Utilization

Detailed Dashboard

Month	Hospital Name	PSA
December 2017	Peninsula Regional	All Patients

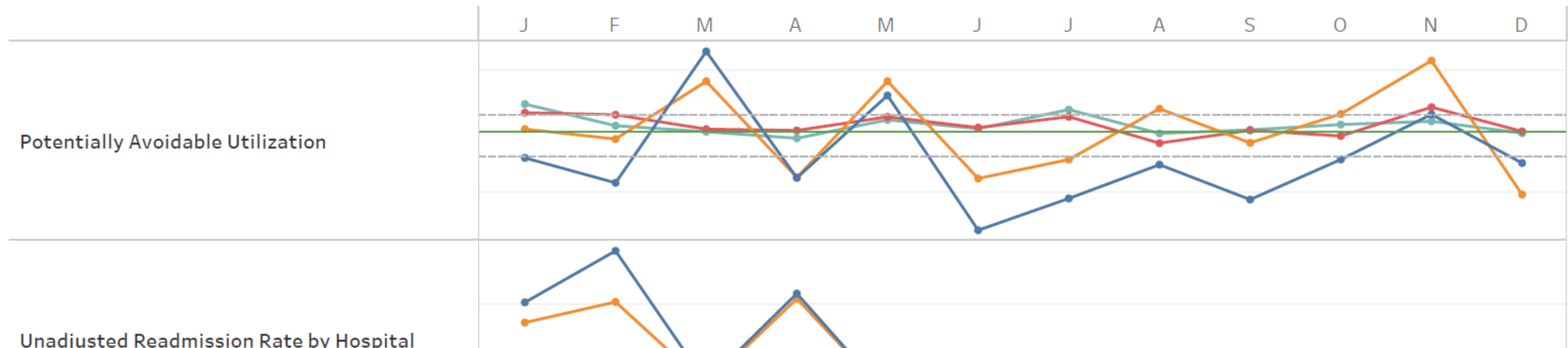
----25, 75 Percentiles — Zero

Hospital / PSA / Medicare / State

Peninsula Regional Quality Indicators - December 2017 / YTD Quality Indicators

Metric	Dec 17	Dec 16	Variance		YTD Dec 17	YTD Dec 16	YTD Variance	
Potentially Avoidable Utilization	$3,717,779	$4,142,492	-10.3%	↓	$44,811,921	$49,110,147	-8.8%	↓
Unadjusted Readmission Rate by Hospital		10.5%		↓	10.8%	10.6%	2.0%	↑

Peninsula Regional Quality Indicators - Trends

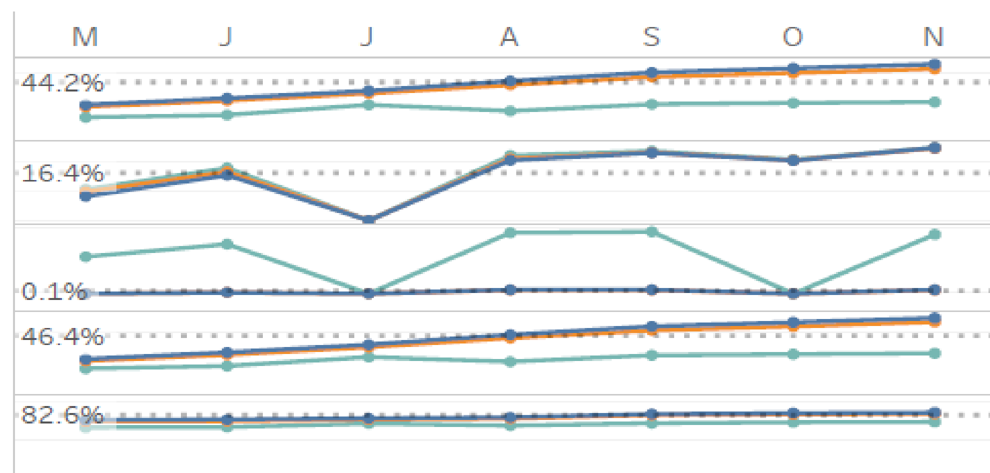


CRISP Executive Dashboard Care Management

High Needs Patients - CRISP Key Indicators - November 2017

Metric	Nov 17	Oct 17	Variance
% of patients with both PCP and CM recorded at CRISP	58.1%	55.0%	3.1%
% of patients with Care Alert recorded at CRISP	25.3%	20.8%	4.5%
% of patients with Care Plan recorded at CRISP	0.3%	0.0%	0.0%
% of patients with Case Manager (CM) recorded at CRISP	61.2%	57.8%	3.4%
% of patients with PCP recorded at CRISP	87.9%	87.1%	0.8%

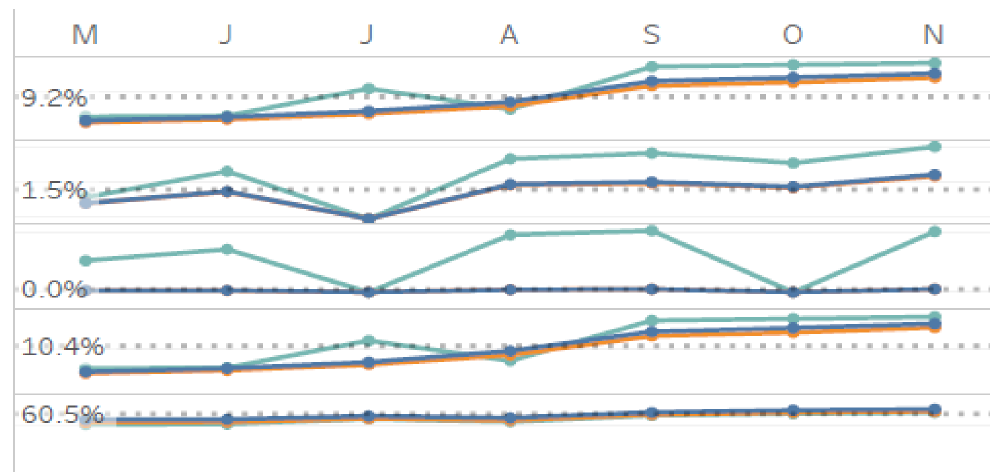
High Needs Patients - Key Indicators - Trends



Rising Needs Patients - CRISP Key Indicators - November 2017

Metric	Nov 17	Oct 17	Variance
% of patients with both PCP and CM recorded at CRISP	14.3%	13.4%	0.8%
% of patients with Care Alert recorded at CRISP	2.5%	1.8%	0.7%
% of patients with Care Plan recorded at CRISP	0.0%	0.0%	0.0%
% of patients with Case Manager (CM) recorded at CRISP	15.9%	14.9%	1.0%
% of patients with PCP recorded at CRISP	66.1%	65.2%	0.9%

Rising Needs Patients - Key Indicators - Trends



[1] *Potential Preventable Complication (PPC) Rate is a cumulative (YTD) metric. New performance periods begin in January.*

Case Mix Data Through: November 2017

CareWrap CRISP Analysis

Reports

Refresh | Revert | Pause | Print | User Guide | New Program

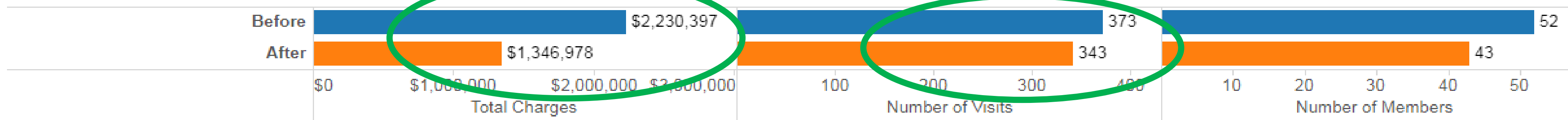
Summary | Panel Analysis | Overall Trend Analysis | Relative Trend Analysis | Breakdown of Charges | Notes

Pre/Post Analysis

Analysis of 6 Months of Visits Before and After the Enrollment Date For CareWrap Program (210019)

The analysis is based on admissions before and after the enrollment date. Please select the number of months, the types of visit to include in the analysis and sorting order for other hospitals. Depending on the number of months selected, some participants might not be included in the analysis, if they do not have data for the entire period before and after the analysis. Number of Members with data for the analysis shows, the number of members that are included in the report for a given selection.

All Hospitals



Hospital Details

Hospital	Before/After	Total Charges	Number of Visits	Number of Members
Peninsula Regional	Before	$1,976,170	340	51
	After	$964,779	288	42
Atlantic General	Before	$17,832	19	<11
	After	$39,109	25	<11
University of Maryland	Before	$165,199	<11	<11
	After	$159,975	<11	<11
McCready	Before	$539	<11	<11
	After	$15,977	<11	<11
UM Medical Center Midt..	After	$43,943	<11	<11
UM Shore Medical Center at Dorchester	Before	$1,071	<11	<11
	After	$15,583	<11	<11
Johns Hopkins	After	$62,207	<11	<11
Healthsouth Chesapeake Rehab Hospital	Before	$26,666	<11	<11
	After	$26,334	<11	<11
MedStar Franklin Square	After	$464	<11	<11
MedStar Good Samarita..	After	$5,312	<11	<11
Mercy Medical Center	After	$12,280	<11	<11

Axes: $0, $1,000,000, $2,000,000 Total Charges; 100, 200, 300 Number of Visits; 10, 20, 30, 40, 50 Number of Members

Total Number of Members in the Panel

62

Number of Members with Data for Analysis

54

Number of Members with Visits during Analysis Period

53

Before or After Enrollment
- Before
- After

Most Recent Payer: (All)

Time Period: 6 Months

Visit Type: (All)

Sorting Option: Total Visits - After Enrollment

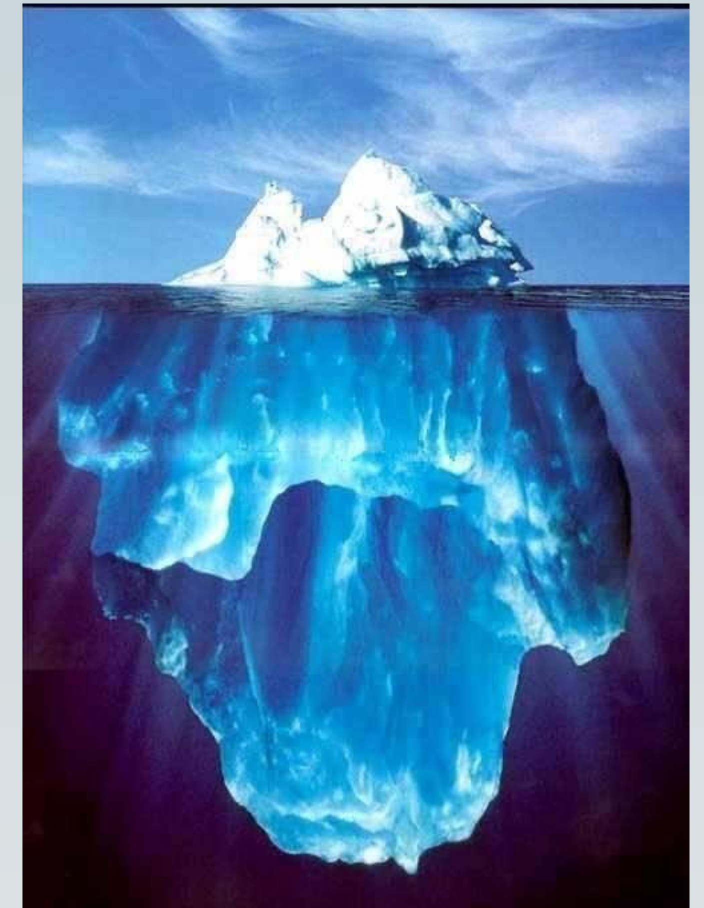
Hospital Name: (All)

Program Name: CareWrap Program (210019)

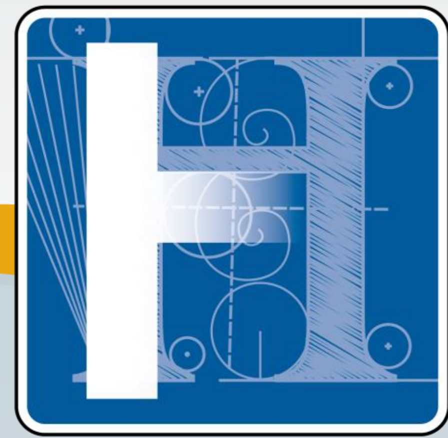
Chronic Conditions: All Patients

2017 – 2020 - Level 4 – Transformed Clinical and Technical Interoperability

- People
  - Building community engagement
  - Multidisciplinary patient centered care
- Policies and Programs
  - Growth of Medicare Advantage Plan
  - Work with other payers
  - Continued growth of collaborative programs within the community
- Technology
  - Interoperability through EPIC Community Connect
  - Predictive analytics and precision medicine
  - Telehealth
- Adoption
  - Practice transformation
  - Metrics and outcomes which support shared savings and growth



Emerging Strategic Themes
Rebuilding the "H" in HealthCare



Achieving comprehensive world-class health and wellness across the continuum of care

- Providing Exceptional Care at the Right Place and Right Time, Every Time
- Reduce the Cost of Healthcare in Our Communities
- Meet Consumer's Health Needs in All Stages of Life
- Improve Upon PRHS's Position as a Community Asset

VISION2020

Peninsula is a High Performing System

Our goals are to…

- Improve patient experience (Quality and Satisfaction)
- Improve the health of our populations
- Reduce the per capita cost of healthcare
- Improve healthcare team satisfaction

Continue to expand this competency into the community…Population Health and Wellness

The "System" does not adequately Support Our Efforts

Challenges in continuing our population health evolution

- Technology/EHR
- Rapidly increasing costs
  - Advanced clinical interventions
  - High cost drugs
- Patient Flow in the Maryland
- Engaged/robust medical staff

Engaged/Robust Medical Staff

Physician Employment

- Driven at PRMC by the need to maintain specialty coverage for open heart and trauma related services
- Unregulated losses are significant and should be considered when assessing organizational performance
  - Care is integrated today and recognition of physician costs for non-academics should be considered/improved
- Recruitment challenges in Maryland are worsened by the inability to provide access to latest technology

Peninsula is a High Performing System

Our goals are to…

- Improve patient experience (Quality and Satisfaction)
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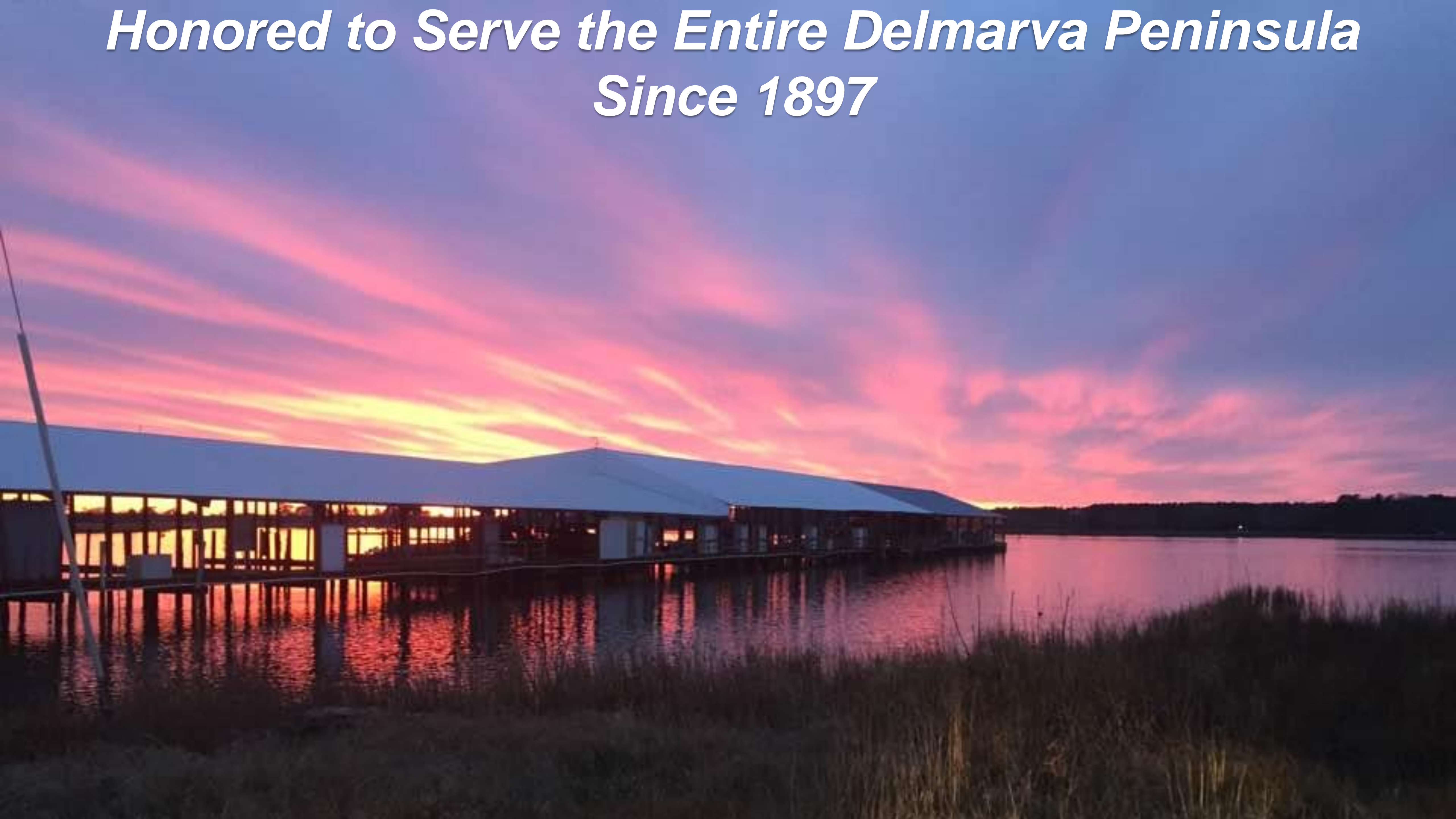
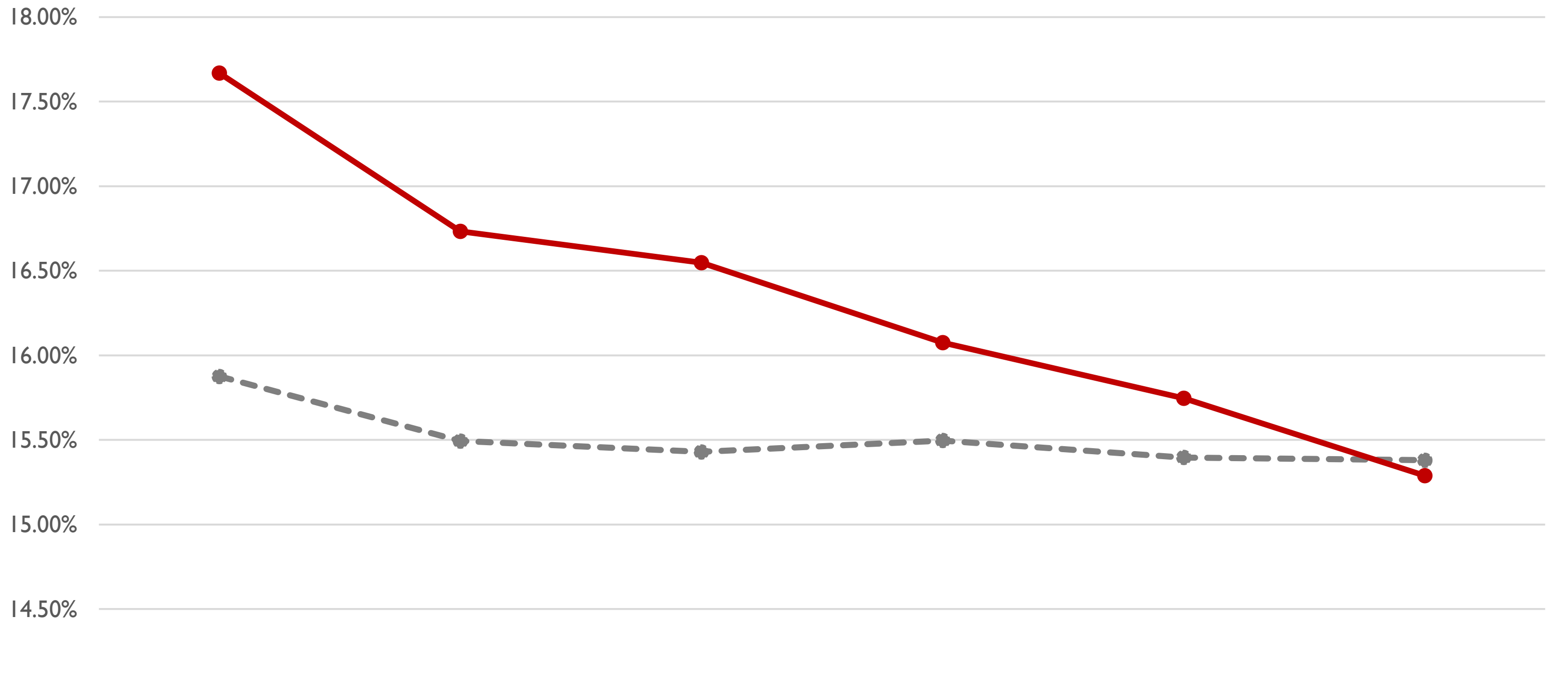

Honored to Serve the Entire Delmarva Peninsula
Since 1897

Questions?

RY 2020 Final RRIP Policy

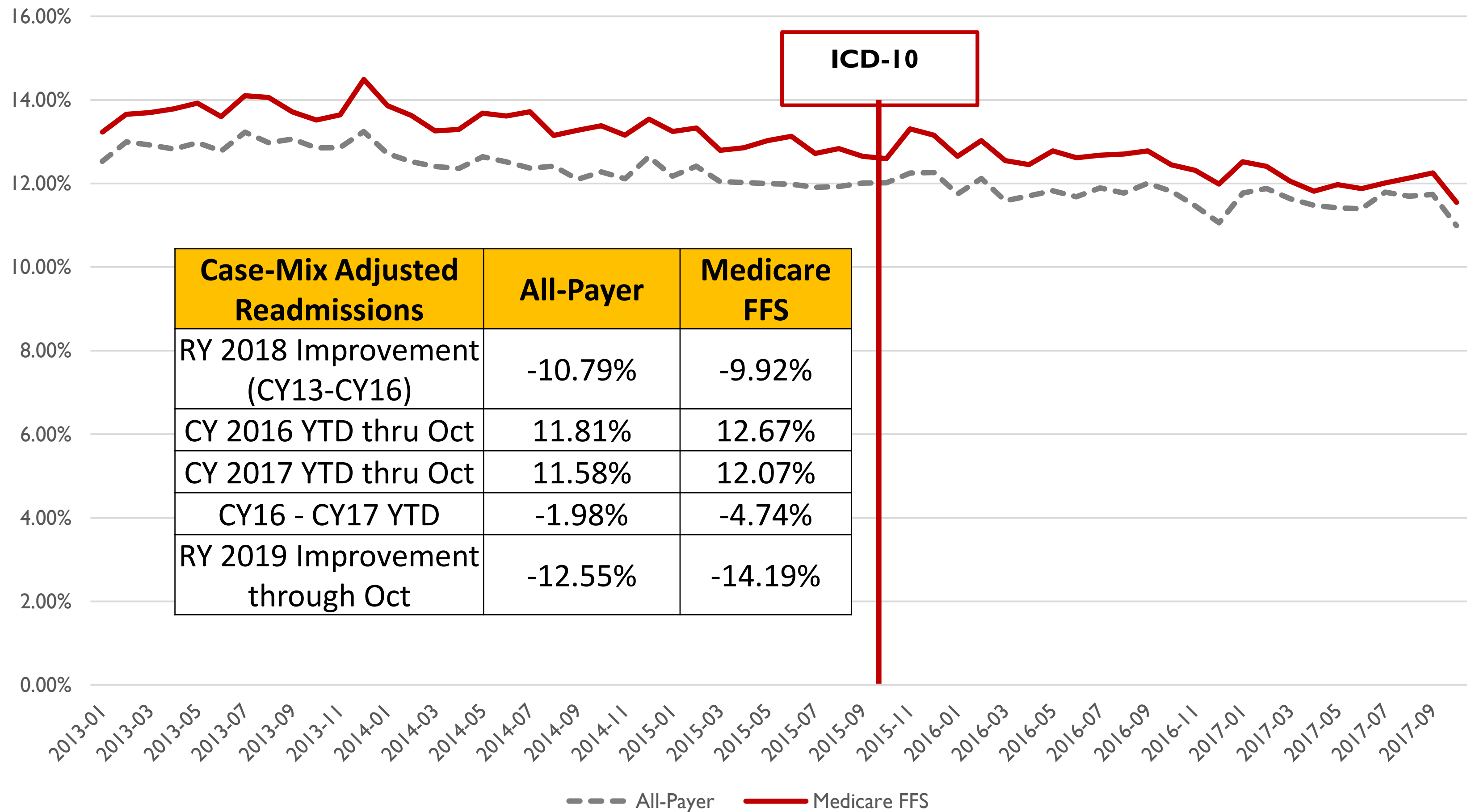
Medicare Waiver Test: At or below National Medicare Readmission Rate by CY 2018

With most recent Medicare Readmissions data, Maryland's Medicare Readmission Rate (15.29%) is *below* the National Medicare Readmission Rate (15.38%). Maryland will need to continue to reduce its readmissions, and match any additional reduction in the national rate.



	Rolling 12M 2012	Rolling 12M 2013	Rolling 12M 2014	Rolling 12M 2015	Rolling 12M 2016	Rolling 12M 2017
National	15.88%	15.49%	15.43%	15.50%	15.40%	15.38%
Maryland	17.67%	16.73%	16.55%	16.08%	15.75%	15.29%

Monthly Case-Mix Adjusted Readmission Rates



Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
RY 2018 Improvement (CY13-CY16)	-10.79%	-9.92%
CY 2016 YTD thru Oct	11.81%	12.67%
CY 2017 YTD thru Oct	11.58%	12.07%
CY16 - CY17 YTD	-1.98%	-4.74%
RY 2019 Improvement through Oct	-12.55%	-14.19%

Note: Based on final data for Jan 2012 – Sep 2017; Preliminary Data for Oct-Nov 2017. Statewide improvement to-date is compounded with complete RY 2018 and RY 2019 YTD improvement.

Flowchart of Predicting Improvement Target

Step 1
- **Test Past Accuracy of Medicare Predictive Models**

Step 2
- **Project CY 2018 National Medicare rates [15.28%]**

Step 3
- **Add a cushion to Medicare projections [15.18%; 15.08%; 14.98%]**

Step 4
- **Convert MD Medicare (projected) reduction to All-Payer Improvement Target [-2.03% to -3.96%]**

Step 5
- **Compound 2016-2018 Improvement Target (RY 2020) with 2013-2016 Improvement (RY 2018) [-14.30%]**

HSCRC expects to have more recent data to improve predictions for final policy.

Flowchart of Calculating Attainment Target

Step 1

- **Take Current All-Payer Casemix-Adjusted Readmission Rates**

Step 2

- **Adjust these rates for Out-of-State Readmissions**
- Using CMMI data, the ratio is as follows: $Total\ Readmissions : InState\ Readmissions$

Step 3

- **Calculate the 25th and 10th percentiles for the statewide distribution of scores**
- 25th Percentile is **threshold** to receive attainment point rewards [10.96%]
- 10th Percentile is **benchmark** to receive maximum attainment point rewards [10.40%]

Step 4

- **Adjust benchmark and threshold downward 2.33%, per principles of continuous quality improvement**
  - **Threshold [10.70%]; Benchmark [10.20%]**

RY 2020 Proposed Revenue Adjustment Scales (Better of Attainment or Improvement)

Improvement Scale

All Payer Readmission Rate Change CY13-CY18	RRIP % Inpatient Revenue Payment Adjustment
A	**B**
Improving Readmission Rate	1.0%
-24.80%	1.0%
-19.55%	0.5%
-14.30% (Target)	**0.0%**
-9.05%	-0.5%
-3.80%	-1.0%
1.45%	-1.5%
6.70%	-2.0%
Worsening Readmission Rate	-2.0%

Attainment Scale

All Payer Readmission Rate CY18	RRIP % Inpatient Revenue Payment Adjustment
A	**B**
Lower Absolute Readmission Rate	**1.0%**
10.20% (Benchmark)	1.0%
10.45%	0.5%
10.70% (Threshold)	**0.0%**
10.95%	-0.5%
11.20%	-1.0%
11.45%	-1.5%
11.70%	-2.0%
Higher Absolute Readmission Rate	**-2.0%**

Maximum rewards are set at the 10th percentile of performance for RY 2020, and maximum penalties are linearly scaled based on max reward and reward/penalty cut point

Stakeholder Feedback; Staff Responses

- All-Payer versus Medicare Readmission Program
  - Staff remains committed to All-Payer Readmission Improvement under the All-Payer Model; Medicaid supports this position
- Attainment-Only Readmissions
  - Under All-Payer Model Waiver Test, Improvement Target is necessary/appropriate.
  - If optimal level of readmissions is determined, State can consider Attainment-only targets in future.
    - Would need to revise attainment target calculation methodology; risk-adjustment; etc.
- Social Risk Factor Adjustments
  - Staff believes that Case-Mix Adjustment (at Diagnosis and Severity of Illness level) provides sufficient risk adjustment at this time.
  - Would need to re-visit in future if HSCRC moves to Attainment-Only Readmissions Policy.
- Readmission Definition Expansion – Observation Stays; ED Visits
  - Staff continue to monitor Observation Stays and ED Visits; consider for future expansion of readmission definition or PAU definition.

Staff Recommendations for RY 2020 RRIP Policy

1. The RRIP policy provides incentives to reduce readmissions on an **all-payer** basis.
2. Hospital performance is measured as the better of **attainment** or **improvement**.
3. Due to ICD-10 transition, a **compounded improvement target** is used that combines CY 2013 to CY 2016 improvement (under ICD-9) and CY 2016 to CY 2018 improvement (under ICD-10); the preliminary combined improvement target will be set at **14.30%** for RY 2020.
4. The **attainment threshold** is set at the 25th percentile of hospital performance in CY 2017, with an improvement factor (currently 2% better than previous calendar year); the preliminary target is **10.70%** for CY 2018.
5. Hospitals are eligible for a maximum reward of **1 percent**, or a maximum penalty of **2 percent**, based on the better of their attainment or improvement scores.

Final Recommendation for the Readmissions Reduction Incentive Program for Rate Year 2020

March 14, 2018

Health Services Cost Review Commission

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Baltimore, Maryland 21215
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This document contains the final staff recommendations for updating the Readmission Reduction Incentive Program for Rate Year 2020, ready for Commission discussion and vote.

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LIST OF ABBREVIATIONS

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

KEY METHODOLOGY CONCEPTS AND DEFINITIONS

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

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

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

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

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

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

RECOMMENDATIONS

This is a final recommendation for the Maryland Rate Year (RY) 2020 Readmission Reduction Incentive Program (RRIP) policy. It provides an updated improvement target, based on restated historical data and an additional month of CMS data through September 2018. At this time, the staff requests that Commissioners vote on the following final recommendations:

1. The RRIP policy provides incentives to reduce readmissions on an all-payer basis.
2. Hospital performance is measured as the better of attainment or improvement.
3. Due to ICD-10 transition, a compounded improvement target is used that combines Calendar Year (CY) 2013 to Calendar Year (CY) 2016 improvement (under ICD-9) and CY2016 to CY 2018 improvement (under ICD-10); the combined improvement target will be set at 14.30% percent for CY 2013 to CY 2018.
4. The attainment threshold is set at the 25th percentile of hospital performance in CY 2017, with an improvement factor (currently 2% from previous calendar year); the preliminary attainment target is 10.70 percent for CY 2018.
5. Hospitals are eligible for a maximum reward of 1 percent, or a maximum penalty of 2 percent, based on the better of their attainment or improvement scores.

Staff will review the improvement target and attainment benchmark in April/May against finalized CY 2017 data in order to bring back to the Commission revised performance targets if data trends warrant the revision. This may necessitate an additional vote from Commissioners.

INTRODUCTION

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) quality-based measurement and payment initiatives are important policy tools for providing strong incentives for hospitals to improve their quality performance over time. Under the current All-Payer Model Agreement (the Agreement) between Maryland and the Centers for Medicare & Medicaid Services (CMS), which began in January 2014, there are overarching quality performance requirements for reductions in readmissions and hospital acquired conditions as well as other ongoing program and performance requirements across HSCRC's quality and value-based programs.

As long as Maryland makes incremental progress towards the Agreement goals, the State receives automatic exemptions from the CMS Hospital Readmission Reduction program as well as the Hospital Acquired Conditions Reduction Program, while the exemption from the CMS Medicare Value-Based Purchasing program is requested annually. These exemptions from national quality programs are important, because the State of Maryland's all-payer global budget system benefits from having autonomous, quality-based measurement and payment initiatives that set consistent quality incentives across all-payers.

This report provides staff's final recommendations for updates to Maryland's Readmission Reduction Incentive Program (RRIP) for Rate Year 2020 (RY 2020), which is one of three core quality programs that the HSCRC administers for all payers. The RRIP program holds 2% of hospital revenue at-risk by assessing performance on 30-day all-cause all-payer readmission rates across all acute care hospitals in Maryland. The current all-payer model Agreement necessitates that Maryland hospitals reduce Medicare readmissions to at or below the national Medicare readmission rate by the end of Calendar Year (CY) 2018. Based on a 12-month rolling rate as of September 2017, Maryland's Medicare readmission rate of 15.29% is slightly below the national Medicare rate of 15.38%. However, it should be noted that this progress must continue to keep up with Medicare reductions through the end of CY 2018 in order to satisfy the State's contractual obligation.

For RY 2020, which reflects the performance results from the final year of the Agreement (CY 2018), staff is recommending minimal changes to the RRIP policy and the other existing quality programs in order to focus on future policy development. Future policy development includes establishing quality strategies and performance goals that are "aggressive and progressive" under the Total Cost of Care Model ("TCOC Model"). Staff will work with key stakeholders to develop all-payer readmission targets for RY 2021 and beyond that support the specific requirements and overall goals of the TCOC Model. Specifically, new targets will evaluate Maryland hospital performance relative to external benchmarks for Medicaid and commercial payer readmission rates to the extent they are available, in addition to Medicare. Staff will also consider options for modifying the readmission measure, such as the addition of specialty hospitals or observation stays. Furthermore, staff will work to develop and assess the feasibility of integrating social risk factors into the assessment of readmission rates under a modified RRIP policy based only on attainment.

BACKGROUND

Medicare Hospital Readmissions Reduction Program

The United States healthcare system currently has an unacceptably high rate of preventable hospital readmissions, which are defined as an admission to a hospital within a specified time period after a discharge from the same or another hospital.[1] Excessive readmissions generate considerable unnecessary costs and represent substandard quality of care for patients. A number of studies show that hospitals can engage in several activities to lower their rate of readmissions, such as clarifying patient discharge instructions, coordinating with post-acute care providers and patients' primary care physicians, and reducing medical complications during patients' initial hospital stays.[2] Efforts have been underway nationally to address excessive readmissions and their deleterious effects.

Under authority of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) established its Medicare Hospital Readmissions Reduction Program in federal fiscal year 2013. Under this program, CMS uses three years of data to calculate the average risk-adjusted, 30-day hospital readmission rates for patients with certain conditions. For federal fiscal year 2018, this includes patients with heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease, elective hip or knee replacement, and coronary artery bypass graft surgery. If a hospital's risk-adjusted readmission rate for such patients exceeds that average, CMS penalizes it in the following year by using an adjustment factor that is applied to Medicare reimbursements for care for patients admitted for any reason; the penalty is in proportion to the hospital's excess rate of readmissions. Penalties under the Medicare Hospital Readmissions Reduction Program were first imposed in federal fiscal year 2013, during which the maximum penalty was 1 percent of the hospital's base inpatient claims, and the maximum penalty has increased to 3 percent for federal fiscal year 2015 and beyond.

As required by the 21st Century Cures Act, CMS has modified the Medicare Hospital Readmissions Reduction Program starting in federal fiscal year 2019 to assess penalties based on a hospital's performance relative to other hospitals with a similar proportion of dually-eligible (Medicare and Medicaid) patients. Hospitals will be stratified into five peer groups based on their dual-eligible proportion, which is defined as the proportion of hospital stays for patients

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[1] Jencks, S. F. et al., "Hospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* Vol. 360, No. 14: 1418-1428, 2009.; Epstein, A. M. et al., "The Relationship between Hospital Admission Rates and Rehospitalizations," *New England Journal of Medicine* Vol. 365, No. 24: 2287-2295, 2011.

[2] Ahmad, F. S. et al., "Identifying Hospital Organizational Strategies to Reduce Readmissions," *American Journal of Medical Quality* Vol. 28, No. 4: 278-285, 2013.; Silow-Carroll, S. et al., "Reducing Hospital Readmissions: Lessons from Top-Performing Hospitals," *Commonwealth Fund Synthesis Report*, New York: Commonwealth Fund, 2011.; Jack, B. W. et al., "A Reengineered Hospital Discharge Program to Decrease Hospitalization: A Randomized Trial," *Annals of Internal Medicine* Vol. 50, No. 3: 178-187, 2009.; and Kanaan, S. B., "Homeward Bound: Nine Patient-Centered Programs Cut Readmissions," Oakland, CA: California HealthCare Foundation, 2009.

with dual eligibility for Medicare and full-benefit Medicaid. Hospital performance will be compared to the median of the hospital's peer group. The Cures Act also requires that estimated total penalties under the new methodology must equal estimated total penalties under the original methodology.

Beginning in CY 2018, CMS has also begun voluntary reporting of the Hybrid Hospital-Wide Readmission measure for hospitals in order to test collection of core clinical data elements and laboratory test results that stakeholders believe would enhance the administrative coding data that is utilized currently in the risk model variables.[3]

Overview of the Maryland RRIP Policy

The All-Payer Model Agreement with CMS replaced the requirements of the Affordable Care Act by establishing two sets of requirements. One set of requirements established performance targets for readmissions and complications in order to maintain Maryland exemptions from these programs, while the second set of requirements ensured that the amount of potential and actual revenue adjustments in Maryland's quality-based programs was at or above the CMS levels in aggregate but on an all-payer basis. Maryland has historically performed poorly compared to the nation on readmissions, ranked 50th among all states in a study examining Medicare data from 2003-2004.[4] Under the Agreement, Maryland's Medicare fee-for-service statewide hospital readmission rate must be equal to or below the national Medicare readmission rate by the end of Calendar Year (CY) 2018, and demonstrate annual progress toward this goal (also known as the "Waiver Test").

In order to meet the new Model requirements, the Commission approved a new readmissions program in April 2014—the RRIP—to further bolster the incentives to reduce unnecessary readmissions. The RRIP replaced a previous Commission policy, the Admission Readmission Revenue policy, which had been in place since RY 2012.[5] As recommended by the Performance Measurement Work Group, the RRIP is more comprehensive than the Medicare Hospital Readmission Program, as it includes all patients and payers, but it otherwise aligns – albeit with some minor differences – with the CMS readmission measure, and reasonably supports the goal of meeting or out-performing the national Medicare readmission rate.

The most notable difference between the Maryland model and the Federal model is that Maryland does not stratify hospitals into peer groups, which CMS does based on the proportion of stays for patients who are fully dually-eligible for Medicare and Medicaid. Staff does not plan on stratifying by Maryland-specific peer groups at this time. In addition, adopting the national

---

[3] For more information on Medicare Hospital Readmissions Reduction Program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.

[4] Jencks, S. F. et al., "Hospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* Vol. 360, No. 14: 1418-1428, 2009.

[5] http://hscrc.maryland.gov/Pages/archived-quality-initiatives.aspx

stratification determination for Maryland hospitals is not currently possible as this data is calculated retrospectively and will not be available until the start of federal fiscal year 2019. Staff will evaluate the CMS stratification approach and its applicability to Maryland as the data becomes available.

RRIP Methodology

Under the RRIP, the methodology evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges from consideration, due to data issues and clinical concerns, in order to increase the fairness of this all-payer measure, e.g. planned readmissions. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR-DRG) severity of illness (SOI), and the policy determines a hospital's score and revenue adjustment by the better of improvement or attainment, with scaled rewards of up to 1% of inpatient revenue and scaled penalties of up to 2%.[6] Figure 1 illustrates the readmission performance metric specifications.

Figure 1. Rate Year 2020 RRIP Measure

RRIP Performance Metric

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

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

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

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

Improvement: Change in readmission rate CY13-CY16 compounded with CY16-CY18 (due to ICD-10 transition)

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

The improvement target compares the performance year to CY 2013, as opposed to a new updated base period; this ensures that hospitals that made early investments to reduce readmissions receive credit for these early improvements. The attainment target is calculated by taking hospitals' all-payer case-mix adjusted readmission rates and adjusting them for out of

[6] See Appendix I for details of the indirect standardization method used to calculate a hospital's expected readmission rate.

state readmissions using Medicare data, with the attainment target then defined as the 25th percentile of hospital performance plus an additional reduction (currently 2% from previous CY) in order to set a more aggressive attainment target over time. Figure 2 shows the improvement and attainment targets for each rate year.

Figure 2. RRIP Program Improvement Target, Attainment Threshold, and Revenue at-Risk, Rate Years 2016-2020

Rate Year	Base Period	Performance Period	Improvement Target (cumulative from CY 2013)	Attainment Threshold	Revenue at Risk: Reward	Revenue at Risk: Penalty
RY 2016	CY 2013	CY 2014	6.76%	N/A	0.50%	N/A
RY 2017	CY 2013	CY 2015	9.30%	12.09%	1.0%	2.0%
RY 2018	CY 2013	CY 2016	9.50%	11.85%	1.0%	2.0%
RY 2019*	CY 2013	CY 2017	14.50%[7]	10.83%	1.0%	2.0%
RY 2020 (proposed)	CY 2013	CY 2018	14.30%	10.70%	1.0%	2.0%

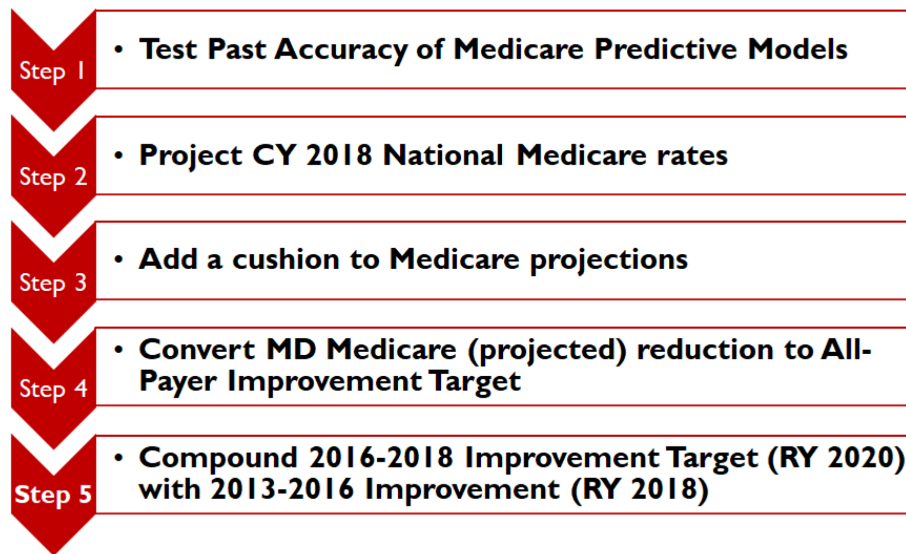
*Due to the ICD-10 transition and changes to the APR-DRG grouper, the cumulative improvement rate was calculated by adding the RY 2018 improvement (CY 2013 to CY 2016 improvement under APR-DRG grouper versions 32 and 33) to the RY 2019 one-year CY 2016 to CY 2017 improvement (both under APR-DRG grouper version 34).

[7] The compounded RY 2019 Improvement Target is 14.10%. The RY 2020 (proposed) Improvement Target of 14.30% represents a small increase on the Improvement Target.

Methodology for Determining Improvement Target

Developing an appropriate improvement target is a multi-step process to ensure that the State responsibly incorporates projections of the national Medicare readmissions rate with the latest federal data to determine the Maryland All-Payer Case-mix Adjusted Readmissions Rate. A simple flowchart of the necessary steps is included below in Figure 3.

Figure 3. Steps to Determine Improvement Target



In Step 1, staff worked with contractor, Mathematica Policy Research, to review past accuracy of seven forecasting models. Additional information on this analysis may be found in the assessment section below.

In Step 2, Mathematica Policy Research and staff projected the CY 2018 national Medicare readmission rate using trends based on data through September 2017. Given that the RY 2020 improvement target must yield the improvement to enable Maryland to achieve the Waiver Test by the end of CY 2018, or else trigger a corrective action from CMS, staff will closely monitor updated data through end of CY 2017, and **may revise the improvement target mid-year.** This would require Commissioners approving an amendment to the proposed policy, as the data will become available following the March Commission meeting, when presumably the RRIP policy will be formally approved.

In Step 3, given that predictions are fundamentally uncertain, staff has included a cushion to make the improvement target more aggressive in case the predictions are inaccurate, and to ensure that Maryland continues to improve beyond the initial goal of the national median.

In Step 4, staff compared improvement trends in unadjusted, Medicare readmission rates to case-mix adjusted, All-Payer readmission rates. Case-mix adjusted rates are required as the performance metric for the payment program in order to take into account the different types of patients seen at different hospitals and their varying acuity levels. This step is fundamentally

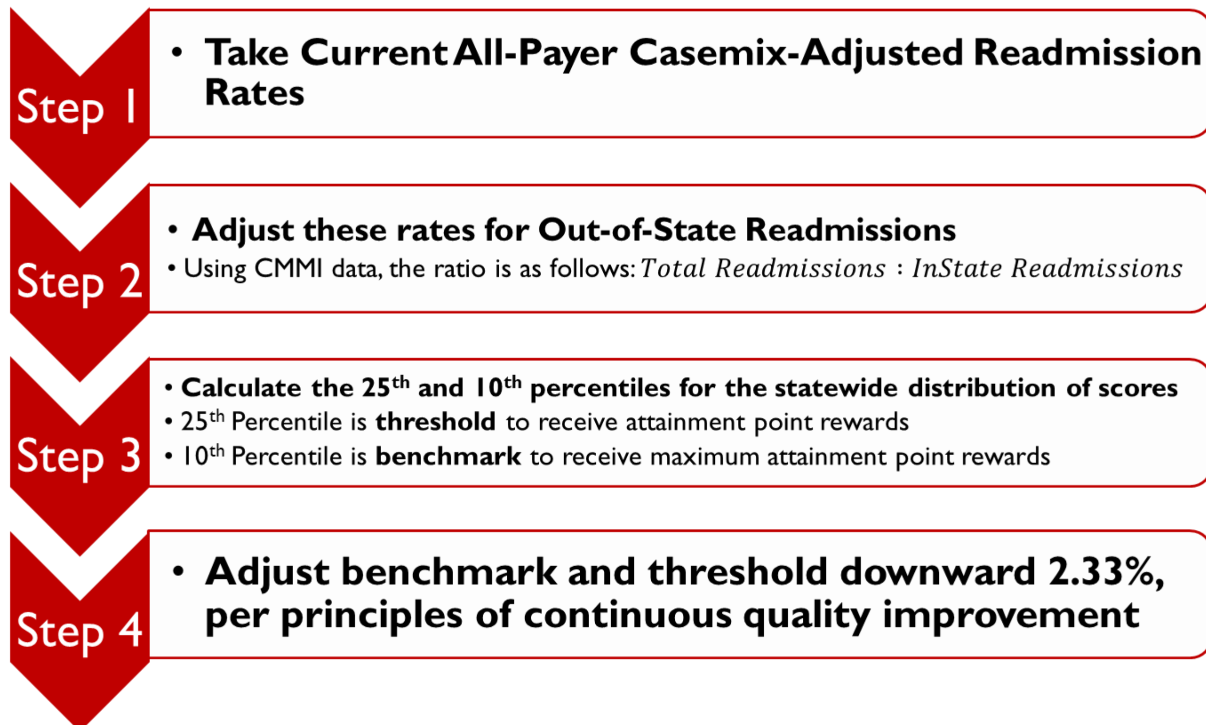
necessary, and would be even if the program was only assessing Medicare readmissions, as Medicare-only readmission rates would still need to be case-mix adjusted. Further discussion of this step is provided in the Assessment section.

Finally, in Step 5, staff has to compound the improvement target for CY 2016 to CY 2018 with the previously experienced RY 2018 improvement (CY 2013 to CY 2016). Step 5 is necessary because the RY 2018 and RY 2020 measures are based on fundamentally different datasets expressed in terms of percentages due to the conversion to ICD-10 in FFY 2016. The HSCRC has made it a policy to not penalize hospitals that made early investments to improve their readmission rates from CY 2013 to CY 2016, so the earlier data must be included.

Methodology for Determining Attainment Target

Beginning in RY 2017, HSCRC began including an attainment target, whereby hospitals with low case-mix adjusted readmission rates are rewarded for maintaining low readmission rates. A simple flowchart of the necessary steps to determine the attainment target is included below in Figure 4.

Figure 4. Steps to Determine Attainment Target



In Step 1, staff examine the current All-Payer, Case-mix Adjusted Readmission Rates (these data are current through October with preliminary data). These rates are then further adjusted to account for readmissions to out-of-state hospitals (Step 2), which is done by adjusting case-mix

adjusted rates by the ratio of Medicare readmissions that were outside-of-Maryland in the most recent four full quarters of data (currently September 2016-August 2017). From these adjusted trends, a threshold (25th percentile) and benchmark (10th percentile) are calculated, providing a range by which hospitals with low readmission rates can be assessed, should their attainment score be higher than their calculated improvement score. Finally, both the benchmark and threshold are adjusted downward by 2% from those prior CY numbers, reflecting the State's desire that all Maryland hospitals continue to improve over the next year. However, the modeling is currently using an adjustment of 2.33%,[8] given that this year's policy is projecting 14 months of performance as opposed to 12 months and hospitals may have improvements in the final two months of calendar year 2017 that are not reflected in the current data.

Scoring and Scaling Methodology

HSCRC will calculate a by-hospital revenue adjustment based on the difference between a hospital's score and the improvement and the attainment targets and benchmarks. Hospitals will receive the more favorable revenue adjustment (the better of their improvement or attainment adjustments). These rewards and penalties are linearly scaled between -2% and 1% using the improvement target and attainment threshold as the cut point. An illustration of the abbreviated scales is provided below in the tables in Figure 5.

Figure 5. RRIP Improvement and Attainment Revenue Adjustment Scales

Improvement Scale

All Payer Readmission Rate Change CY13-CY18	RRIP % Inpatient Revenue Payment Adjustment
A	**B**
Improving Readmission Rate	1.0%
-24.80%	1.0%
-19.55%	0.5%
-14.30% (Target)	0.0%
-9.05%	-0.5%
-3.80%	-1.0%
1.45%	-1.5%
6.70%	-2.0%
Worsening Readmission Rate	-2.0%

Attainment Scale

All Payer Readmission Rate CY18	RRIP % Inpatient Revenue Payment Adjustment
A	**B**
Lower Absolute Readmission Rate	**1.0%**
10.20% (Benchmark)	1.0%
10.45%	0.5%
10.70% (Threshold)	**0.0%**
10.95%	-0.5%
11.20%	-1.0%
11.45%	-1.5%
11.70%	-2.0%
Higher Absolute Readmission Rate	**-2.0%**

[8] (2% divided by 12) will yield one-month incremental increase in annual downward adjustment, which is multiplied by two, and then added to the 2%.

ASSESSMENT

Under the Maryland All-Payer Model Agreement, the State is required to reduce the Maryland Medicare Fee-For-Service readmission rate to at or below the national average by the end of CY 2018. Reducing readmissions is a difficult task that requires significant effort, investment, and coordination. To track progress on this Waiver Test, HSCRC staff prepares updates to the latest readmission data for each Commission. Based on the latest 12 months of data through September 2017, the Maryland Readmission Rate is 15.29%, while the National Readmission Rate is 15.38%. These numbers have been refreshed with the latest data, which reflects re-stated Medicare numbers under an updated definition of Medicare beneficiaries. This is very welcome news; however, it does not mean that Maryland has "met" the Waiver Test, given that Maryland must continue to discern where the national readmission rate will be in December 2018 and must match any additional national improvement.

To refine the improvement target and attainment benchmark for RY 2020, the HSCRC has solicited input from the Performance Measurement Work Group, and staff has worked with contractors to model the readmission rate improvement needed to achieve the All-Payer Model Waiver Test. This final recommendation is based on the most recent Center for Medicare and Medicaid Innovation readmission data (through September 2017) and HSCRC case-mix data (preliminary through October 2017); the improvement target has been updated since the draft policy.

Maryland's Performance to Date

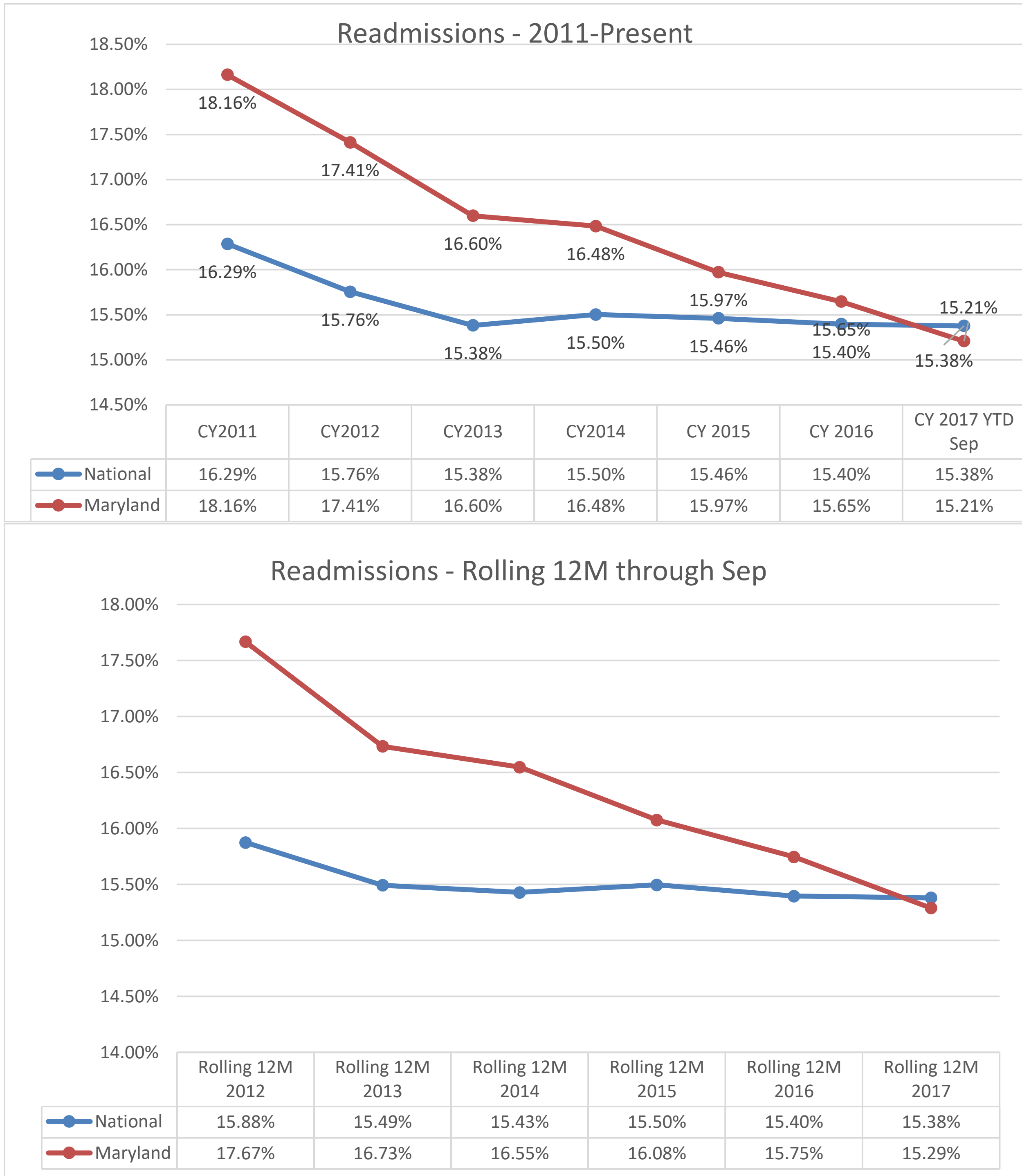
Maryland Waiver Test Performance

In the RY 2019 RRIP policy, calculations indicated that the gap between the national and the Maryland Medicare readmission rates for fee-for-service enrollees should be at or below 0.15 percentage points by the end of CY 2017 so that Maryland could close the remaining gap in the final year of the Waiver Test (CY 2018). The preliminary data for CY 2017, either year-to-date or with a rolling 12 month rate through September, indicate that Maryland's Medicare readmission rate is currently below the National rate. As shown in Figure 6, the 2017 year-to-date Maryland readmission rate of 15.21% is significantly lower than the national rate of 15.38%; while on a 12 month rolling basis the gap is less as the Maryland readmission rate is higher than YTD at 15.29% and the national rate is that same at 15.38%. On a rolling 12 month period basis, Maryland has improved more than the nation for CY 2017 compared to CY2016 (Maryland: 0.46 percentage point reduction, National: 0.02 percentage point reduction). Again this is refreshed data that includes re-stated beneficiaries. This re-stated data had minimal impact on the trends, but does make Maryland's improvement more favorable.

The progress Maryland has made in reducing readmissions in CY 2017 is very promising in terms of meeting the 2018 Waiver Test; however, the RY 2020 policy must set a higher improvement target to: a) account for any national readmission reductions during CY 2018, and

b) to ensure the Maryland program incentivizes continuous quality improvement beyond the initial Waiver Test goal. This principle of continuous quality improvement is similarly included in the MHAC program, where the state continued to set additional improvement goals even after the 30% reduction was achieved.

Figure 6. Medicare FFS Readmissions, National and Maryland, 2011 – Present



	CY2011	CY2012	CY2013	CY2014	CY 2015	CY 2016	CY 2017 YTD Sep
National	16.29%	15.76%	15.38%	15.50%	15.46%	15.40%	15.38%
Maryland	18.16%	17.41%	16.60%	16.48%	15.97%	15.65%	15.21%

	Rolling 12M 2012	Rolling 12M 2013	Rolling 12M 2014	Rolling 12M 2015	Rolling 12M 2016	Rolling 12M 2017
National	15.88%	15.49%	15.43%	15.50%	15.40%	15.38%
Maryland	17.67%	16.73%	16.55%	16.08%	15.75%	15.29%

All-Payer Performance

While the CMS readmission Waiver Test is based on the unadjusted readmission rate for Medicare patients, the RRIP incentivizes performance improvement on the All-Payer, case-mix adjusted readmission rate. Based on CY 2017 year-to-date data through October, the State has achieved a compounded reduction in the All-Payer, case-mix adjusted readmission rate of 12.55% since CY 2013, and 22 hospitals are on track to achieve the RY 2019 modified cumulative improvement target of 14.5 percent. Since the incentive program also includes an attainment target, an additional four hospitals are on track to achieve the attainment goal of a readmission rate lower than 10.83 percent. Appendix III provides current hospital-level year-to-date improvement and attainment rates for CY 2017.

Improvement Target Calculation Methodology RY 2020

In order to calculate the RY 2020 improvement target for Maryland, the Commission must forecast the national readmission rate for CY 2018. HSCRC staff and its contractor Mathematica Policy Research modeled seven different projections (Figure 7) for the CY 2018 national readmission rate. Mathematica Policy Research and staff also conducted an analysis of the accuracy of these predictive models, comparing their predictive output for various calendar years for which actual experienced data is available (Step 1). Analysis of the accuracy of the various predictive models did not clearly suggest any individual predictive method as being superior to the others; therefore, staff has averaged the forecasts derived from the seven different methods to determine the CY 2018 national Medicare readmission rate of 15.28% - see figure below (Step 2).

Figure 7. Improvement Target Model Projections

Model Abbreviation	Model Name	Model Description	CY 2018 Projection
AAC	Average Annual Change	Averages the annual change of 2016 over 2015, 2015 over 2014, 2014 over 2013	15.38%
MRAC	Most Recent Annual Change	2017 YTD over 2016 YTD	15.37%
12MMA	12 Month Moving Average	Moving average predictive method, using most recent 12M of data and moving trend forward	15.31%
24MMA	24 Month Moving Average	Moving average predictive method, using most recent 24M of data and moving trend forward	15.39%
PROC	PROC Forecast	Combination of deterministic time trend model (long-term) and autoregressive model (short-term)	15.07%
ARIMA	Auto-Regressive Integrated Moving Average	Parametric statistical model characterizing the time series data, which better incorporates seasonality and multiple evaluation criteria	15.17%
STL	Seasonal and Trend decomposition using Loess	Divides time series data into three components - seasonal, trend cycle, and remainder, to yield projection value	15.28%
	Average	**Average of Seven Models**	**15.28%**

Next, staff modeled the relationship between the Maryland Medicare Readmission Rate for CY 2016 (15.65%) and the projected national Medicare readmission rate for CY 2018 (15.28%). In order to reduce the Maryland Medicare rate from 15.65% to 15.28%, the Maryland Medicare FFS rate must be reduced 2.34% in CY 2018 compared to CY 2016.[9]

Given that this is the last year of a moving Waiver Test, staff has included a cushion to this improvement target, in case the projection is inaccurate and too lenient. The cushions under the

[9] Calculations may be vary due to rounding; components in the calculation of the improvement target are not rounded until the final step.

draft policy were set at 0.1% and 0.2%, but for the final policy a cushion of 0.3% was added to ensure the target was higher than RY 2019 target (Step 3), as shown in figure 8 below.

Figure 8. Improvement Target Calculation with Cushions

	National Actual Trend	National Actual Trend with -0.1% Cushion	National Actual Trend with -0.2% Cushion	National Actual Trend with -0.3% Cushion
CY 2016 MD Medicare Readmission Rate (A)	15.65%	15.65%	15.65%	15.65%
CY 2018 Projected National Readmission Rate (B)	15.28%	15.18%	15.08%	14.98%
Required Reduction (C) = Projected National Rate (B) / CY 2016 MD Medicare Readmission Rate (A) - 1				
CY 2018 Reduction Required in MD Medicare FFS Rate from CY 2016 (C)	-2.34%	-2.98%	-3.61%	-4.25%

Staff then converted the unadjusted, Medicare FFS improvement target to a Case-mix Adjusted, All-Payer improvement target (Step 4) to ensure fairness across Maryland hospitals with differing case-mix acuity. To convert to an all-payer improvement target, staff and Mathematica Policy Research have evaluated the ratio relationship between the unadjusted Medicare FFS readmission rates and the Case-Mix Adjusted All-Payer readmission rates. As shown in Figure 9 below, this ratio relationship appears to be stable over time. The Case-mix Adjusted All-Payer Readmission Rate has been approximately 75% of the unadjusted Medicare FFS readmission rate over the past several years. Therefore, staff has removed the multiple "conversion factors" used in the RY 2019 policy, and has instead converted the improvement target to an All-Payer target using the average of these ratios, which is 75.1%.

Figure 9. Unadjusted Medicare FFS to Case-mix Adjusted All-Payer Improvement Target Conversion

	CMMI (Unadjusted) MD Medicare FFS Readmissions Rate	HSCRC Case mix Adjusted All Payer Readmissions Rate	All Payer to Medicare Ratio of Readmissions Rates
CY 12	17.41%	12.49%	71.7%
CY 13 Rolling 12M thru Aug	16.73%	12.74%	76.1%
CY 14 Rolling 12M thru Aug	16.55%	12.58%	76.0%
CY 15 Rolling 12M thru Aug	16.08%	12.13%	75.4%
CY 16 Rolling 12M thru Aug	15.75%	11.90%	75.6%
CY 17 Rolling 12M thru Aug	15.29%	11.59%	75.8%
		Average of Ratios	**75.1%**

When converting the necessary Medicare Readmission Rate Improvement to the necessary Case-mix Adjusted All-Payer Readmission Rate Improvement, the improvement from figure 8 above will then be modified to reflect the 75.1% ratio, per figure 10 below.

Figure 10. Translating Converted Improvement Target to Improvement Percent

	National Actual Trend	National Actual Trend with -0.1% Cushion	National Actual Trend with -0.2% Cushion	National Actual Trend with -0.3% Cushion
CY 2018 (Projected) National Readmission Rate (A)	15.28%	15.18%	15.08%	14.98%
Conversion Ratio (B)	75.1%	75.1%	75.1%	75.1%
CY 2016 Maryland Case-mix Adjusted All-Payer Rate (C)	11.72%	11.72%	11.72%	11.72%
Maryland Case-Mix Adjusted, All-Payer Readmission Rate Improvement (D = (A*B)/C-1)	**-2.03%**	**-2.68%**	**-3.32%**	**-3.96%**
Required CY 2018 Statewide Maryland Case-Mix Adjusted, All-Payer Readmission Rate (E=C*(1+D))	**11.48%**	**11.35%**	**11.33%**	**11.26%**

Staff is recommending to use the orange-highlighted target, a -3.96% improvement for CY 2018 over CY 2016. For context, the final RY 2019 RRIP policy required a -3.75% improvement target over CY 2016. The incremental increase in the improvement target reflects the success

that Maryland has achieved in CY 2017. Expansion of the cushion in step 3 will further align the RRIP policy with the policy of continuous quality improvement and aggressive program targets.

Finally, RY 2018 improvement must be compounded with RY 2020 (CY 2016 to CY 2018) improvement. Under the RY 2019 policy, these two improvement rates were simply added together; however, given that these are fundamentally discrete data that are expressed as percentage changes, compounding would yield a more accurate indication of the change over time (Step 5). For a detailed explanation of compounding, please see Appendix I.

Compounding the rates of improvement over time yields a RY 2020 improvement target of 14.30%, which is only slightly higher than the RY 2019 compounded target (14.10%). This modest improvement goal is attributed to: a) the fact that the State has reduced its Medicare readmission rate to below the nation, and b) the national improvement in readmissions slowed down in CY 2017, according to the most recent rolling 12 months of data. It should be noted that 24 hospitals already have achieved a compounded improvement greater than the RY 2020 proposed target of 14.30%.

Attainment Target Calculation Methodology

Beginning in RY 2017, HSCRC has also included an attainment target, whereby hospitals with low case mix adjusted readmission rates are rewarded for maintaining low readmission rates. To update the attainment target, staff examines the current All-Payer, Case-mix Adjusted Readmission Rates (these data are current through October with preliminary data). These rates are then further adjusted to account for readmissions to out-of-state hospitals (Step 2; additional information provided in Appendix V). From these adjusted trends, a threshold (25th percentile) and benchmark (10th percentile) are calculated, providing potential rewards to hospitals with low readmission rates (Step 3), as illustrated in Figure 11.

Finally, both the benchmark and threshold are adjusted downward by 2% from those prior CY numbers, reflecting the State's desire that all Maryland hospitals continue to improve over the next year. However, the modeling uses an adjustment of 2.33%,[10] given that hospitals should continue to improve throughout the final month of CY 2017, as well as throughout 2018.

[10] (2% divided by 12) will yield one-month incremental increase in annual downward adjustment, which is multiplied by two, and then added to the 2%.

Figure 11. Attainment Target Threshold and Benchmark with Cushion

	CY17 Jan-Oct	With Cushion%*
CYTD17 Top 10%	10.40%	**10.20%**
CYTD17 Top 25%	10.96%	**10.70%**

*2.33% cushion based on 2% cushion adjusted for 14 months

Prospective Scaling for RY 2020 Policy

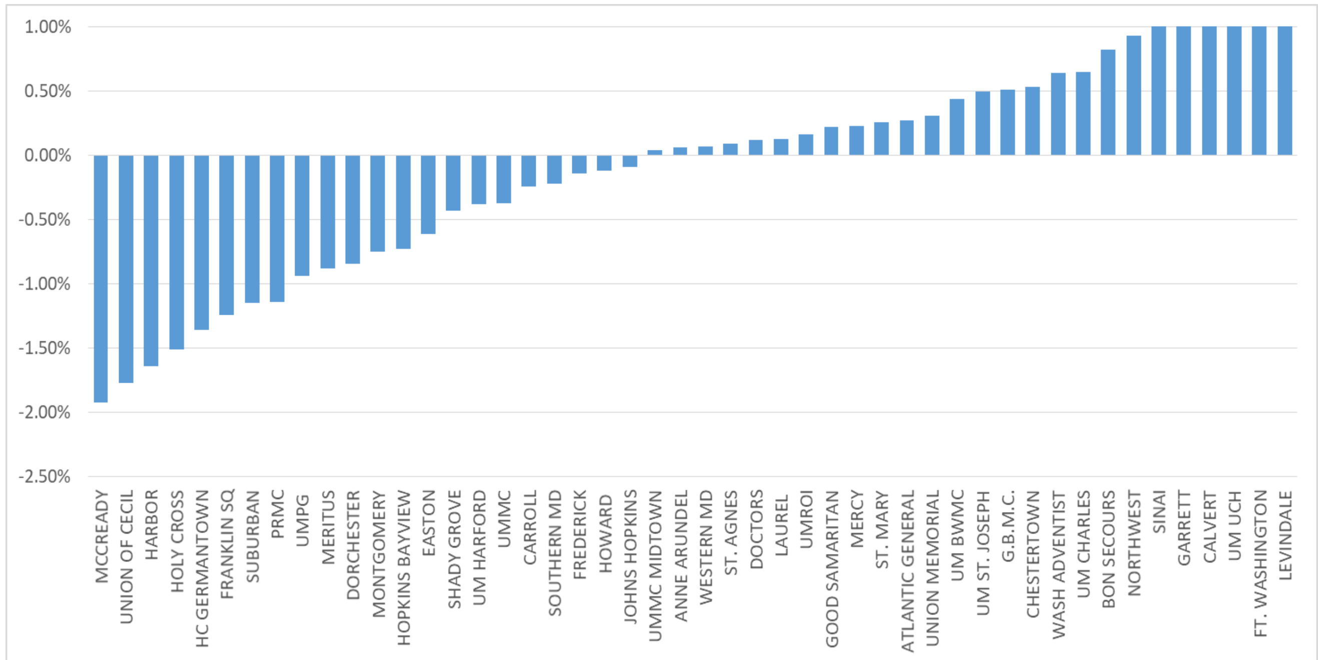
To determine by-hospital revenue adjustments, HSCRC creates a scoring scale based on prospectively determined targets (and attendant maximum and minimum rewards and penalties). This in keeping with three core principles of Maryland Quality programs: 1) Hospitals should know in advance of the performance period what they need to do to garner a positive revenue adjustment; 2) hospitals should not be evaluated relative to other hospitals because that potentially diminishes the incentive for improvement for various hospitals that may have inherent advantages, e.g., a patient population with higher socioeconomic status; and 3) hospitals should not be evaluated relative to other hospitals because the HSCRC wants to foster collaboration and shared best practices among hospitals that a relative ranking system would discourage.

Using assessed points and a linear scale, HSCRC assigns which scores are associated with the maximum reward and maximum penalties for improvement and attainment separately. Hospitals with a score at or above the maximum reward receive the maximum reward (1.0%), hospitals with a score at the target score receive no adjustment, and hospitals with a score at or below the maximum penalty score receive the maximum penalty (-2.0%). Hospitals with scores in the ranges between those points receive a scaled adjustment that is determined by the distance between a hospital's score and the targets and benchmarks. Hospitals will receive the more favorable revenue adjustment (the better of their improvement or attainment adjustments).

Staff has modeled revenue adjustments using RY 2019 year-to-date data through October 2017 and the proposed RY 2020 improvement and attainment scales (see Appendix IV). For this analysis, RY 2019 data was compounded to calculate the hospital improvement rate. Based on these analyses, 22 hospitals would be penalized for a total of $31.7 million, and 26 hospitals would be rewarded for a total of $16.1 million. Because the attainment thresholds and benchmarks are based on current performance plus a cushion, the majority of hospitals (37 out of

48) would receive their positive or negative revenue adjustment based on improvement and not attainment. This result highlights the need for greater scrutiny of risk-adjustment methods, as well as attainment threshold and benchmark calculation methodology, prior to migrating to an attainment only score. The revenue modeling for RY 2020 in Appendix IV, which uses RY 2019 year-to-date results, will result in higher penalties than what would be expected if hospitals continue to improve throughout CY 2018. Figure 12 presents the revenue adjustment percentages by hospital based on this modeling.

Figure 12. Modeled Revenue Adjustments by Hospital



FUTURE OF MODEL

For the Total Cost of Care (TCOC) Model, which will begin in January 2019, proposed contract terms do not define specific quality performance targets. The HSCRC, in consultation with staff and industry, has begun laying the framework for establishing specific quality performance targets under the TCOC Model. Specifically, performance targets must be aggressive and progressive, must align with other HSCRC programs, must be comparable to federal programs, and must consider rankings relative to the nation. Beyond guiding principles, nothing definitive has yet been established.

For the RY 2020 quality recommendations, staff considered recent Commission discussions as well as the white paper of November 15, 2017 co-authored by Commissioners John Colmers and Jack Keane regarding the overall strategy for the quality programs under the new TCOC Model. Staff notes the need to meet contractually obligated quality goals while making as few changes as possible to the final year of the current model in light of the additional work required to develop new targets and to better align measures with total cost of care. As highlighted in the

white paper, in addition to reducing Medicare readmissions compared to the nation, future considerations for updating the RRIP program for RY 2021 and beyond must include evaluating Maryland's performance compared to external benchmarks for non-Medicare patients. Analyses of modifying the denominator of included patients must also be considered, such as including patients receiving observation services, or those readmitted within longer timeframes than 30 days, or those receiving care in psychiatric and specialty facilities. Staff must also consider methodologies for adjusting readmission rates and the resulting payment adjustments for patient socioeconomic status and other social risk factors, critical to implementing "attainment only" measurement. As readmissions and overall admissions continue to decline, staff must also work with stakeholders to consider options for better population- and community-focused measurement, such as per capita admissions.

STAKEHOLDER COMMENTS AND RESPONSES

HSCRC Commissioners, as well as the hospital industry and payers, have given written and verbal comments to HSCRC staff regarding the RRIP program, applicable both in the short term, and as it evolves under the new TCOC model. Staff summarizes the comments and responses below.

All-Payer versus Medicare Readmission Program

There are opposing views on whether the RRIP program should include patients covered by all payers or only Medicare patients. Some Commissioners and other stakeholders have suggested that the RRIP shift to a Medicare-only program, because there are not definitive national benchmarks for non-Medicare readmission rates, and because the Global Budget Revenue hospital model already has incentives to reduce readmissions.

Additional public comments at the February Commission meeting from Robert Murray, representing Carefirst, echoed this position. In her letter on behalf of Medicaid, Tricia Roddy voiced support for the RRIP's inclusion of patients covered by all payers, noting that Medicaid would consider developing a separate readmission program if the HSCRC program were to include only Medicare patients. In Traci LaValle's comment letter on behalf of MHA, she supported an all-payer RRIP program, but notes that it will be important in the next demonstration to identify readmissions attainment benchmarks for a comparable set of hospitals outside Maryland.

Staff Response:

HSCRC staff has expressed concerns that the intention of the Maryland model is to improve care on an all-payer basis, and that having a Medicare-only readmission program would run contrary to the model's overarching goals. Staff maintains that the all-payer nature of the pay-for-performance programs is one of the Model's defining features, and believes that maintaining an all-payer RRIP is an important benefit from the perspective of consumers and other stakeholders.

Based on initial Performance Measurement Work Group input, staff believes that hospitals continue to support that the RRIP be maintained on an all-payer basis, and notes that other payers (notably Medicaid) are very interested in the continuation of an all-payer RRIP policy.

HSCRC staff will continue to work to obtain non-Medicare data and benchmarks in the coming years to address concerns that data limitations preclude the Commission from establishing reasonable non-Medicare readmission targets. Moreover, staff believes it is important to reinforce and align the incentives of the Global Budget Revenue hospital model by continuing to have a readmissions policy, especially when there is not a conclusive analysis that the statewide readmissions rate has reached an optimal level at this time.

Measure Readmissions Only on an Attainment Basis

During the February Commission meeting, CareFirst pointed out that the attainment threshold, where hospitals begin to earn credit, and the benchmark, where hospitals receive full credit, represent a narrow distribution (25th to 10th percentiles, respectively). CareFirst recommends widening the gap between the threshold and benchmark, as is done in other HSCRC quality programs (typically, the threshold is set at the 50th percentile and the benchmark is set at the 5th percentile). This expanded threshold-to-benchmark range would be more reflective of the distribution of hospital performance, and would better reflect Maryland hospital attainment levels, and (perhaps) render measurement of improvement unnecessary.

Regarding an attainment-only readmission program, MHA indicated in their comment letter that including both attainment and improvement targets helps address inherent differences in hospitals' populations that are difficult to measure and for which there are not clearly defined data at this time.

Staff Response:

Staff agrees that widening the range between threshold and benchmark would be more reflective of the distribution of Maryland hospital performance on attainment, but also notes that this change would not fully address the inherent differences in hospitals' populations, for which there are not standardized approaches for measurement at this time.

Staff believes it may be possible to shift to a program that measures attainment only under a future readmission program, when population differences are adequately understood and measured. Moreover, if future evaluation of all-payer benchmarks conclude that optimal readmission rates are reached, the Commission may be required to remove improvement performance targets and consider shifting its focus to admissions per capita.

However, given the complexity of this endeavor and given that this is the last year of the current hospital model, staff does not recommend altering the RY 2020 policy to evaluate attainment only. In the coming years, staff will work with contractors and stakeholders to evaluate the availability of data and a sufficient risk adjustment to potentially develop an attainment only readmissions policy as well as a per capita admissions policy.

Social Risk Factor Adjustments

When the draft recommendation was presented in the February Commission meeting, Mr. Murray supported Medicare's approach of using the proportion of dually eligible beneficiaries to stratify hospitals and make adjustments on readmission performance.

In their letter, MHA references the National Quality Forum (NQF)'s July 2017 report, *Evaluation of the NQF Trial Period for Risk Adjustment for Social Risk Factors*. Regarding the readmission measures evaluated, NQF did not recommend adjusting for social risk factors because, although there was a relationship with certain risk factors, the effect had limited impact on hospital performance scores, or the performance of the risk adjustment model. The MHA letter points out that this finding is consistent with HSCRC staff's finding in the spring of 2016, based on analysis done by Mathematica Policy Research. The MHA letter adds that the addition of social risk factors can add complexity with little additional explanatory value.

Staff Response:

Staff concurs that at this time there is limited explanatory value beyond what is already provided using the existing DRG-SOI adjustment. As noted above in the 'Overview of the Maryland RRIP Policy', staff does not plan on adopting the national stratification determination for Maryland hospitals, as it is not currently possible (this data is calculated retrospectively and will not be available until the start of federal fiscal year 2019). Again, staff will evaluate the CMS stratification approach and its applicability to Maryland as the data becomes available.

Consider Impact of Observation Stays and Emergency Department Visits

In the February Commission meeting, Mr. Murray pointed out that it is important to also look at observation stays and ED visits following hospital admissions, as care may be shifted to these settings.

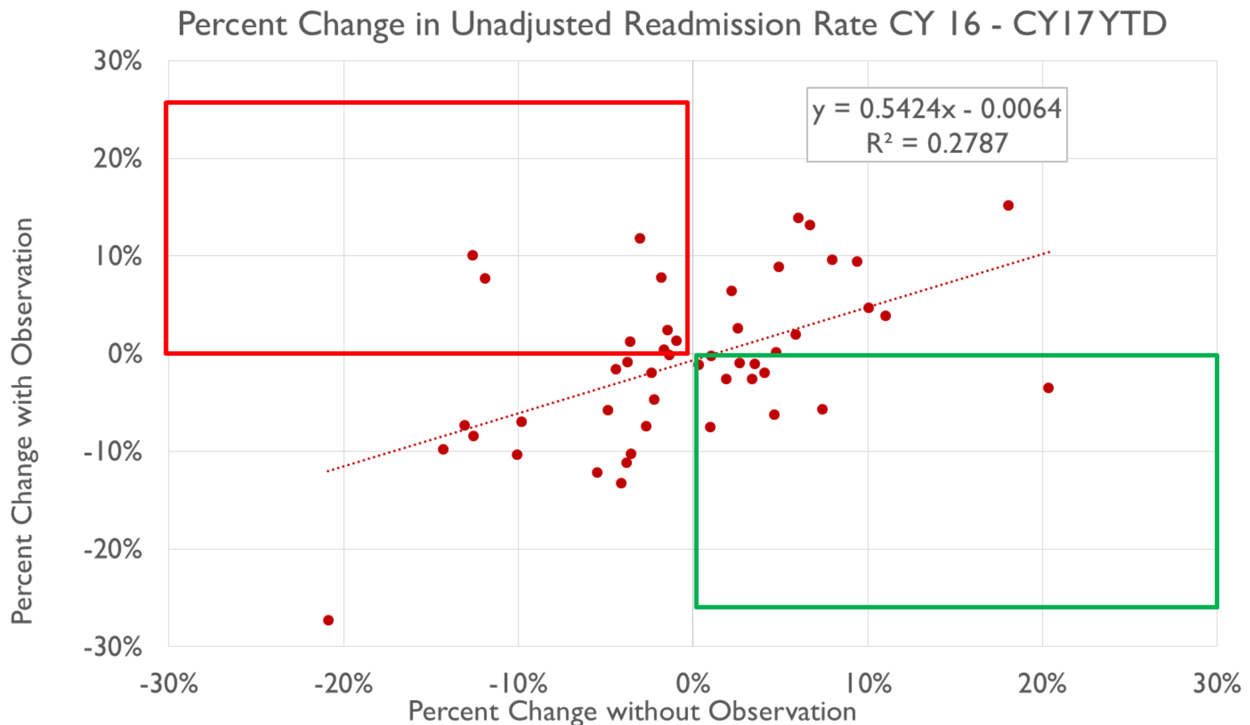
Staff Response:

Staff analyzed the potential impact of the use of observation services on readmission rates. Overall the statewide readmission rate for CY 2017 (January to November) increased by 2.80% (simple difference); however, improvement in readmission rates

from CY 2016 (January-November) to CY 2017 (January to November) decreased by 1.02% (simple difference)when observation stays are counted as readmissions.

Figure 13 is a scatterplot showing the unadjusted change in readmission rates CY16 YTD- CY17 YTD by hospital under current RRIP readmission measure and with observation stays added as readmissions (not counted in denominator). This analysis was designed to see whether the improvement in readmissions post-inpatient admission differed when observation stays were included. While additional analysis is warranted, especially for a handful of hospitals with significantly different trends (red box on top-left), statewide trends were inconsistent, and some hospitals have much higher improvement when observation stays are counted (green box on bottom-right). As the RRIP program is modified over the next couple of years, similar analysis should also include ED visits, and policy decisions will need to be made on whether and how to include observations stays and emergency department visits when measuring readmissions. It should also be noted that observation stays >23 hours are currently in the PAU measure, which theoretically will balance out potential incentives in the RRIP program to increase Observation Stays.

Figure 13. Observation Analysis



RECOMMENDATIONS

This is a final recommendation for the Maryland Rate Year (RY) 2020 Readmission Reduction Incentive Program (RRIP) policy. At this time, the staff requests that Commissioners consider the following draft recommendations:

1. The RRIP policy provides incentives to reduce readmissions on an all-payer basis.
2. Hospital performance is measured as the better of attainment or improvement.
3. Due to ICD-10 transition, a compounded improvement target is used that combines Calendar Year (CY) 2013 to Calendar Year (CY) 2016 improvement (under ICD-9) and CY2016 to CY 2018 improvement (under ICD-10); the combined improvement target will be set at 14.30% percent for RY 2020.
4. The attainment threshold is set at the 25th percentile of hospital performance in CY 2017, with an improvement factor (currently 2% from previous calendar year); the preliminary attainment target is 10.70 percent for CY 2018.
5. Hospitals are eligible for a maximum reward of 1 percent, or a maximum penalty of 2 percent, based on the better of their attainment or improvement scores.

Staff will review the improvement target and attainment benchmark in April/May against finalized CY 2017 data in order to bring back to the Commission revised performance targets if data trends warrant the revision. This may necessitate an additional vote from Commissioners.

APPENDIX I. HSCRC CURRENT READMISSIONS MEASURE SPECIFICATIONS

Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra- and inter-hospital) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and with the exclusion of planned admissions.[11]

This measure is similar to the readmission rate that will be calculated under the All-Payer Model, with some exceptions. The most notable exceptions are that the HSCRC measure includes psychiatric patients and excludes oncology admissions. In comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, adjustments had to be made to the metric that accounted for planned admissions and severity of illness. See below for details on the readmission calculation for the RRIP program.

Inclusions and Exclusions in Readmission Measurement

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 4.0. The HSCRC has also counts all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs, rather than principal diagnosis (APR-DRGs 540, 541, 542, 560, 860). Planned admissions are counted in the denominator because they could have an unplanned readmission.
- Discharges for the newborn APR-DRG are removed.
- Oncology cases are removed prior to running the readmission logic (APR-DRGs 41, 110, 136, 240, 281, 343, 382, 442, 461, 500, 511, 512, 530, 680, 681, 690, 691, 692, 693, 694, 695, and 696).
- Rehabilitation cases as identified by APR-DRG 860 (which are coded under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after the readmission logic is run.
- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission, but can be a readmission for a previous admission.
- Hospitalizations within 30 days of a hospital discharge for a patient who dies during the second admission are counted as readmissions, however, the readmission is removed from the denominator because there cannot be a subsequent readmission.
- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same as or the next day after the admission date of the subsequent admission, are removed from the denominator counts. Thus, only one admission is

[11] Defined under [CMS Planned Admission Logic version 4 – updated October 2017.]

counted in the denominator, and that is the admission to the receiving transfer hospital. It is this discharge date that is used to calculate the 30-day readmission window.

- Discharges from rehabilitation hospitals (provider IDs Chesapeake Rehab 213028, Adventist Rehab 213029, and Bowie Health 210333) are not included when assessing readmissions.
- Holy Cross Germantown 210065 and Levindale 210064 are included in the program.
- Starting in January 2016, HSCRC is receiving information about discharges from chronic beds within acute care hospitals in the same data submissions as acute care discharges. These discharges were excluded from RRIP for RY 2018.
- In addition, the following data cleaning edits are applied:
  - Cases with null or missing Chesapeake Regional Information System for our Patients (CRISP) unique patient identifiers (EIDs) are removed.
  - Duplicates are removed.
  - Negative interval days are removed.
  - HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, hospitals are required to make sure 99.5 percent of inpatient discharges have a CRISP EID.

Details on the Calculation of Case-Mix Adjusted Readmission Rate

Data Source:

To calculate readmission rates for RRIP, inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) are used for the measurement period, plus an additional 30 days. To calculate the case-mix adjusted readmission rate for CY 2016 base period and CY 2018 performance period, data from January 1 through December 31, plus 30 days in January of the next year are used.

SOFTWARE**:** APR-DRG Version 35 (ICD-10) for CY 2016-CY 2018.

Calculation**:**

$$\text{Risk-Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions)}}{\text{(Expected Readmissions)}} * \text{Statewide Readmission Rate}$$

Numerator: Number of observed hospital-specific unplanned readmissions.

***Denominator*:** Number of expected hospital-specific unplanned readmissions based upon discharge APR-DRG and severity of illness. See below for how to calculate expected readmissions adjusted for APR-DRG SOI.

Risk Adjustment Calculation:

- Calculate the Statewide Readmission Rate without Planned Readmissions.
    - Statewide Readmission Rate = Total number of readmissions with exclusions removed / Total number of hospital discharges with exclusions removed.
- For each hospital, calculate the number of observed, unplanned readmissions.
- For each hospital, calculate the number of expected unplanned readmissions based upon discharge APR-DRG SOI (see below for description). For each hospital, cases are removed if the discharge APR-DRG and SOI cells have less than two total cases in the base period data (CY 2016).
- Calculate the ratio of observed (O) readmissions over expected (E) readmissions. A ratio >1 means that there were more observed readmissions than expected, based upon a hospital's case-mix. A ratio <1 means that there were fewer observed readmissions than expected based upon a hospital's case-mix.
- Multiply the O/E ratio by the statewide rate to get risk-adjusted readmission rate by hospital.

Expected Values*:*

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

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

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

Let:

N = norm
P = Number of discharges with a readmission

D = Number of discharges that can potentially have a readmission
i = An APR DRG category and a single SOI level

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

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

Once a set of norms has been calculated, the norms can be applied to each hospital. In this example, the computation presents expected readmission rates for an individual APR-DRG category and its SOI levels. This computation could be expanded to include multiple APR-DRG categories or any other subset of data, by simply expanding the summations.

Consider the following example for an individual APR DRG category.

Expected Value Computation Example

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

For the APR-DRG category, the number of discharges with a readmission is 45, which is the sum of discharges with readmissions (column 3). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of discharges with a readmission (sum of column 3) by the total number of discharges at risk for readmission (sum of column 2), i.e., 45/500 = 0.09. From the normative population, the proportion of discharges with readmissions for each SOI level for that APR-DRG category is displayed in column 5. The expected number of readmissions for each SOI level (column 6) is calculated by multiplying the number of discharges at risk for a readmission (column 2) by the normative readmissions per discharge rate (column 5) The total number of readmissions expected for this APR-DRG category is the sum of the expected numbers of readmissions for the 4 SOI levels.

In this example, the expected number of readmissions for this APR-DRG category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had

11.5 fewer actual discharges with readmissions than were expected for this APR-DRG category. This difference can also be expressed as a percentage (79.65% of expected readmissions).

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

A Brief Note on Compounding Improvement

For RY 2020, the rate of improvement used in RY 2018 (CY 2013-CY2016) will be **compounded** with the rate of improvement from CY 2016 to CY2018, as the datasets are fundamentally discrete and are expressed in terms of percentages.

- Formula for Compounded Improvement:

$$\boldsymbol{(1 + a) * (1 + b) - 1}$$

Where a = the percentage improvement during period 1 and b = the percentage improvement during period 2.

For example, suppose Hospital A improves its readmission rate by 50% (written as -.5) under RY 2018 logic (the change between CY 2013 and CY 2016), and improves an additional 50% under between CY 2016 and CY 2018:

$$(1 + -.5) * (1 + -.5) - 1$$

$$(-.5) * (-.5) - 1$$

$$.25 - 1$$

$$-.75$$

In this example, Hospital A has achieved a 75% reduction in Readmissions, rather than a 100% reduction, as a 50% improvement upon the original 50% improvement is a compounded 75% improvement.

The **RY 2019** improvement target (-3.75%) compounded with statewide RY 2018 improvement (-10.75%) would be ~ -14.10%

$$\boldsymbol{(1 -.1075) * (1 -.0375) - 1}$$

$$\boldsymbol{\sim 14.10\%}$$

The **RY 2020 Modeled Improvement Target** (-3.96%) compounded with experienced RY 2018 Improvement (-10.75%) yields a compounded **RY 2020 Improvement Target** of 14.30%.

$$\mathbf{(1-.1075) * (1-.0396) - 1}$$

$$\sim \mathbf{14.28\%}$$

The 14.28% is rounded to 14.30%.

APPENDIX II. CMS MEDICARE READMISSION TEST MODIFICATIONS - VERSIONS 5 AND 6

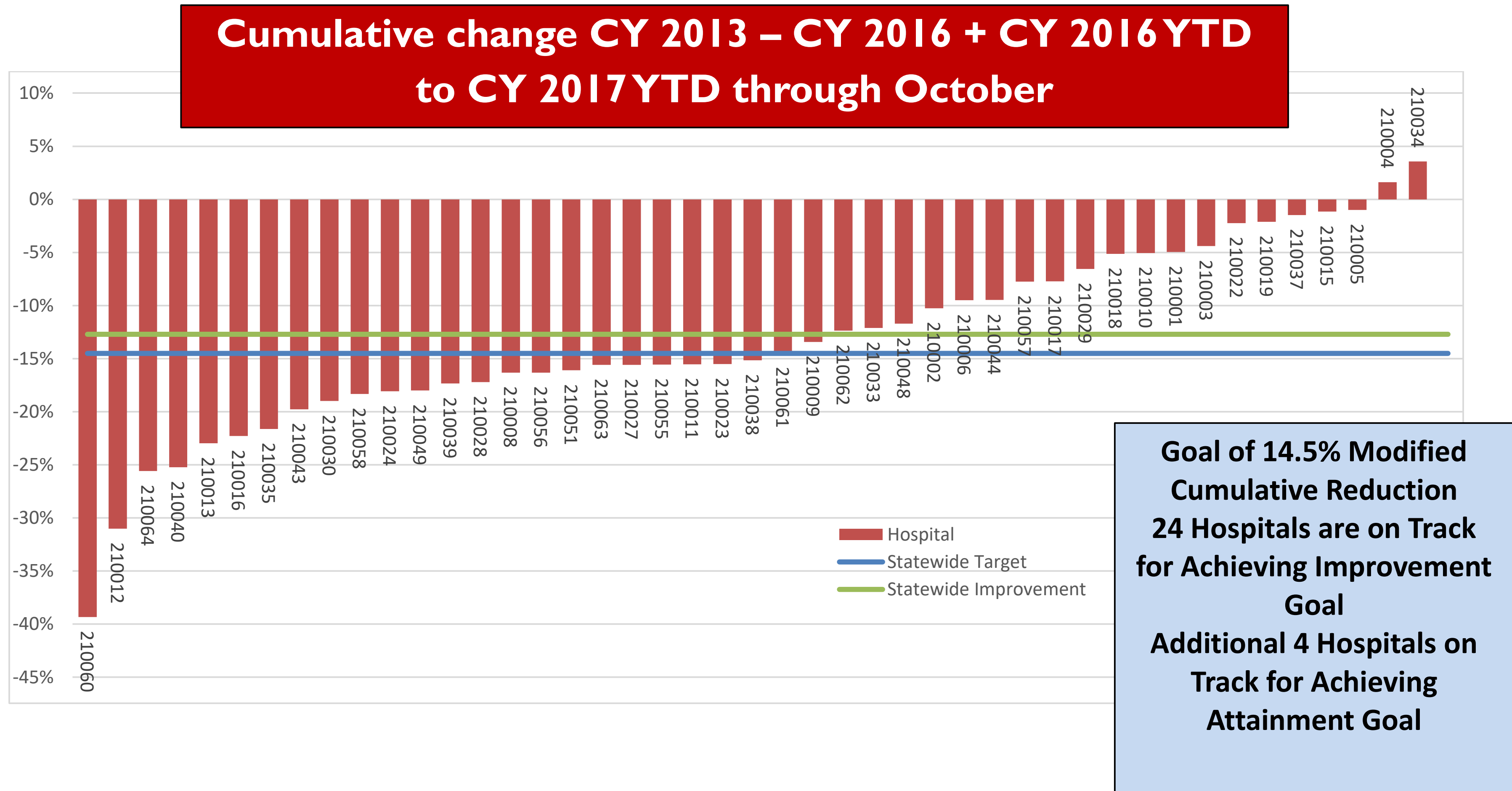
As presented last year, currently the HSCRC and CMS are evaluating the Waiver Test performance under the current Readmission definition (version 6).

In the RY 2018 policy, HSCRC included an itemized list of changes in version 5 of the CMS Medicare Readmission Test. These changes are listed below as a reminder. Beginning in CY 2016, the rehabilitation discharges are identified using Universal Billing (UB) codes to account for definition changes under ICD-10.

Below are the specification changes made to allow an accurate comparison of Maryland's Medicare readmission rates with those of the nation.

- Requiring a 30-day enrollment period in fee-for-service (FFS) Medicare after hospitalization to fully capture all readmissions.
- Removing planned readmissions using the CMS planned admission logic for consistency with the CMS readmission measures.
- Excluding specially-licensed rehabilitation and psychiatric beds from Maryland rates due to inability to include these beds in national estimates because of data limitations. In contrast, the HSCRC includes psychiatric and rehabilitation readmissions in the all-payer readmission measure used for payment policy.
    - Version 6 of the CMS measure changed to using UB codes to identify rehabilitation discharges due to ICD-10.
- Refining the transfer logic to be consistent with other CMS readmission measures.
- Changing the underlying data source to ensure clean data and inclusion of all appropriate Medicare FFS claims (e.g., adjusting the method for calculating claims dates and including claims for patients with negative payment amounts).

APPENDIX III. BY-HOSPITAL READMISSION CHANGES



Case-mix Adjusted, All-Payer Readmission Rates – RY 2019 YTD through October by-Hospital

Hospitals		CY2016 Base Period (YTD, Jan-Oct 2016)	CY2017 Performance Period (YTD, Jan-Oct 2017)								
A	B	C = Obs/Exp * 11.78%	D	E	F = E/D	G	H = E/G	I = E/G * 11.78%	J = I/C - 1	K	L = J + K
HOSP ID	HOSPITAL NAME	Case-Mix Adjusted Readmission Rate	Total # of IP Disch.	Total # of Readmits	Percent Readmits	Total # of Expected Readmits	Readmit Ratio	Case-Mix Adjusted Readmit Rate	Change in Case-mix Adjusted Rate from CY2016	RY 2018 % Change	CY17 Modified Cumulative Improvement Readmission Rate
210001	Meritus	11.41%	11,599	1,418	12.23%	1,443	0.983	11.58%	1.49%	- 6.44%	- 4.95%
210002	UMMC*	12.91%	19,166	2,918	15.22%	2,619	1.114	13.13%	1.70%	- 11.95%	- 10.25%
210003	UM-PGHC	10.92%	8,606	1,014	11.78%	1,140	0.889	10.47%	- 4.12%	- 0.28%	- 4.40%
210004	Holy Cross	11.71%	20,466	1,714	8.37%	1,736	0.987	11.63%	- 0.68%	2.30%	1.62%
210005	Frederick	9.53%	12,533	1,322	10.55%	1,502	0.880	10.37%	8.81%	- 9.81%	- 1.00%
210006	UM-Harford	12.49%	3,321	445	13.40%	493	0.902	10.63%	- 14.89%	5.38%	- 9.51%
210008	Mercy	12.49%	10,459	922	8.82%	851	1.083	12.76%	2.16%	- 18.48%	- 16.32%
210009	Johns Hopkins	13.21%	33,321	4,932	14.80%	4,431	1.113	13.11%	- 0.76%	- 12.66%	- 13.42%
210010	UM-Dorchester	12.60%	1,798	249	13.85%	257	0.970	11.42%	- 9.37%	4.31%	- 5.06%
210011	St. Agnes	11.98%	11,694	1,417	12.12%	1,424	0.995	11.72%	- 2.17%	- 13.36%	- 15.53%
210012	Sinai	12.34%	11,399	1,298	11.39%	1,447	0.897	10.57%	- 14.34%	- 16.68%	- 31.02%
210013	Bon Secours	15.41%	2,911	621	21.33%	476	1.305	15.38%	- 0.19%	- 22.77%	- 22.96%
210015	MedStar Fr Square	12.59%	16,548	2,278	13.77%	2,066	1.103	12.99%	3.18%	- 4.33%	- 1.15%
210016	Washington Adventist	10.60%	8,016	757	9.44%	950	0.797	9.38%	- 11.51%	- 10.77%	- 22.28%
210017	Garrett	5.92%	1,610	96	5.96%	174	0.550	6.48%	9.46%	- 17.19%	- 7.73%
210018	MedStar Montgomery	10.78%	5,633	719	12.76%	720	0.999	11.76%	9.09%	- 14.22%	- 5.13%
210019	Peninsula	10.51%	13,437	1,497	11.14%	1,627	0.920	10.84%	3.14%	- 5.26%	- 2.12%
210022	Suburban	11.20%	10,824	1,226	11.33%	1,293	0.948	11.17%	- 0.27%	- 1.97%	- 2.24%
210023	Anne Arundel	11.29%	20,543	1,701	8.28%	1,889	0.901	10.61%	- 6.02%	- 9.50%	- 15.52%
210024	MedStar Union Mem	12.79%	8,525	1,090	12.79%	1,041	1.047	12.34%	- 3.52%	- 14.56%	- 18.08%
210027	Western Maryland	11.49%	8,322	1,013	12.17%	1,103	0.918	10.82%	- 5.83%	- 9.75%	- 15.58%
210028	MedStar St. Mary's	10.99%	5,669	589	10.39%	637	0.925	10.90%	- 0.82%	- 16.39%	- 17.21%
210029	JH Bayview	14.29%	15,113	2,371	15.69%	1,941	1.222	14.39%	0.70%	- 7.25%	- 6.55%
210030	UM-Chestertown	14.14%	1,224	154	12.58%	166	0.928	10.93%	- 22.70%	3.71%	- 18.99%
210032	Union of Cecil	10.51%	4,197	480	11.44%	538	0.892	10.51%	0.00%	4.29%	4.29%

Hospitals		CY2016 Base Period (YTD, Jan-Oct 2016)	CY2017 Performance Period (YTD, Jan-Oct 2017)								
A	B	C = Obs/Exp * 11.78%	D	E	F = E/D	G	H = E/G	I = E/G * 11.78%	J = I/C - 1	K	L = J + K
HOSP ID	HOSPITAL NAME	Case-Mix Adjusted Readmission Rate	Total # of IP Disch.	Total # of Readmits	Percent Readmits	Total # of Expected Readmits	Readmit Ratio	Case-Mix Adjusted Readmit Rate	Change in Case-mix Adjusted Rate from CY2016	RY 2018 % Change	CY17 Modified Cumulative Improvement Readmission Rate
210033	Carroll	11.51%	7,578	893	11.78%	947	0.943	11.11%	- 3.48%	- 8.62%	- 12.10%
210034	MedStar Harbor	11.91%	5,694	789	13.86%	707	1.116	13.14%	10.33%	- 6.76%	3.57%
210035	UM-Charles Regional	9.88%	5,257	546	10.39%	668	0.817	9.62%	- 2.63%	- 19.00%	- 21.63%
210037	UM-Easton	10.95%	5,233	507	9.69%	567	0.894	10.53%	- 3.84%	2.37%	- 1.47%
210038	UMMC Midtown	15.42%	3,618	708	19.57%	563	1.257	14.81%	- 3.96%	- 11.20%	- 15.16%
210039	Calvert	9.21%	4,260	387	9.08%	534	0.725	8.54%	- 7.27%	- 10.08%	- 17.35%
210040	Northwest	12.55%	7,907	1,150	14.54%	1,149	1.001	11.79%	- 6.06%	- 19.18%	- 25.24%
210043	UM-BWMC	12.77%	12,330	1,704	13.82%	1,680	1.014	11.95%	- 6.42%	- 13.35%	- 19.77%
210044	GBMC	10.59%	13,014	1,038	7.98%	1,192	0.870	10.25%	- 3.21%	- 6.26%	- 9.47%
210045	McCready	11.70%	181	23	12.71%	23	0.990	11.66%	- 0.34%	7.04%	6.70%
210048	Howard County	11.36%	12,654	1,262	9.97%	1,404	0.899	10.59%	- 6.78%	- 4.92%	- 11.70%
210049	UM-Upper Chesapeake	11.06%	8,064	797	9.88%	966	0.825	9.72%	- 12.12%	- 5.87%	- 17.99%
210051	Doctors	11.78%	7,138	989	13.86%	1,048	0.943	11.11%	- 5.69%	- 10.41%	- 16.10%
210055	UM-Laurel	11.82%	2,272	348	15.32%	344	1.012	11.93%	0.93%	- 16.49%	- 15.56%
210056	MedStar Good Sam	12.14%	5,906	970	16.42%	925	1.048	12.35%	1.73%	- 18.05%	- 16.32%
210057	Shady Grove	10.11%	12,946	1,083	8.37%	1,238	0.875	10.31%	1.98%	- 9.73%	- 7.75%
210058	UMROI	10.66%	480	30	6.25%	36	0.835	9.84%	- 7.69%	- 10.65%	- 18.34%
210060	Ft. Washington	9.81%	1,699	181	10.65%	247	0.734	8.64%	- 11.93%	- 27.41%	- 39.34%
210061	Atlantic General	8.90%	2,464	282	11.44%	337	0.836	9.84%	10.56%	- 25.02%	- 14.46%
210062	MedStar Southern MD	11.20%	7,999	949	11.86%	1,048	0.906	10.67%	- 4.73%	- 7.63%	- 12.36%
210063	UM-St. Joe	10.95%	11,750	1,041	8.86%	1,183	0.880	10.37%	- 5.30%	- 10.29%	- 15.59%
210064	Levindale	11.40%	869	125	14.38%	125	0.999	11.77%	3.25%	- 28.84%	- 25.59%
210065	HC-Germantown	10.67%	3,711	437	11.78%	426	1.027	12.09%	13.31%		13.31%
	STATEWIDE	**11.81%**	**409,958**	**48,480**	**11.83%**	**49,321**	**0.983**	**11.58%**	**- 1.95%**	**- 10.75%**	**- 12.70%**

*Currently the UMMS numbers do not include Shock Trauma due to an issue with the CRISP unique identifier; UMMS readmission rate does not impact attainment target.

APPENDIX IV. RY 2020 IMPROVEMENT AND ATTAINMENT SCALING – MODELED RESULTS

The following figure presents the proposed RY 2020 model scaling, using preliminary CYTD 2017 readmission rate results. Column A shows the hospital's RY 2017 permanent inpatient revenue. Column B shows the percent change in in-state actual case-mix adjusted readmission rates between CY 2016 and CY 2013 (RY 2018 % Change). Columns C and D show the actual case-mix adjusted readmission rates for in-state readmission for CYTD 2016 and CYTD 2017 respectively. Column E shows the actual case-mix adjusted rate with out-of-state adjustment for CYTD 2017. Column F presents the percent change in case-mix adjusted in-state readmission rate for CYTD 2017. Column G compounds the improvement readmission rates for RY2018 and RY19 to calculate the hospital's CYTD17 modified cumulative improvement readmission rate. Columns H through I present the scaling results using the proposed RY 2020 cumulative improvement methodology, and columns J through K present the scaling results using the proposed RY 2020 attainment methodology. Columns L and M shows the revenue adjustment that is the better of attainment or improvement. (RY 2017 Permanent Global Budgets and Readmission Rates, used to calculate the revenue adjustments, may be updated in the final recommendation). The modeled results for RY 2020 using CYTD 2017 actual data show an overall negative adjustment. This result is expected, since the proposed policy requires an improvement beyond the actual CY 2017 results.

RY 2020 Readmission Reduction Incentive Program									Improvement		Attainment		Final Adjustment	
HOSP ID	HOSPITAL NAME	RY 17 Permanent Inpatient Revenue	RY2018 % Change	RY19 (CYTD16) BASE Case Mix Adj. Readmit Rate	CYTD17 Case Mix Adj. Readmit rate	CYTD17 Case mix Adj. rate Adj for out of state	CYTD17 % Change in instate Case mix adj. Rate	CYTD17 Modified Cumulative Improve Readmit Rate (compounded)	Target	RY20 Scaling %	Target	RY20 Scaling %	RY20 Better of Attain/ Improve	RY20 Scaling %
		A	B	C	D	E	F = D/C-1	G = (1+F)*(1+B)-1	H	I	J	K	L	M = L/A
210001	MERITUS	$185,173,878	-6.44%	11.41%	11.58%	12.11%	1.49%	-5.05%	-14.3%	-0.88%	10.7%	-2.00%	-$1,629,530	-0.88%
210002	UMMC	$874,727,573	-11.95%	12.91%	13.13%	13.63%	1.70%	-10.45%	-14.3%	-0.37%	10.7%	-2.00%	-$3,236,492	-0.37%
210003	UM - PG	$215,010,869	-0.28%	10.92%	10.47%	13.24%	-4.12%	-4.39%	-14.3%	-0.94%	10.7%	-2.00%	-$2,021,102	-0.94%
210004	HOLY CROSS	$339,593,506	2.30%	11.71%	11.63%	12.90%	-0.68%	1.60%	-14.3%	-1.51%	10.7%	-2.00%	-$5,127,862	-1.51%
210005	FREDERICK	$178,853,951	-9.81%	9.53%	10.37%	10.77%	8.81%	-1.86%	-14.3%	-1.18%	10.7%	-0.14%	-$250,396	-0.14%
210006	HARFORD	$46,975,749	5.38%	12.49%	10.63%	11.16%	-14.89%	-10.31%	-14.3%	-0.38%	10.7%	-0.92%	-$178,508	-0.38%
210008	MERCY	$216,281,427	-18.48%	12.49%	12.76%	12.98%	2.16%	-16.72%	-14.3%	0.23%	10.7%	-2.00%	$497,447	0.23%
210009	JOHNS HOPKINS	$1,357,164,899	-12.66%	13.21%	13.11%	14.19%	-0.76%	-13.32%	-14.3%	-0.09%	10.7%	-2.00%	-$1,221,448	-0.09%
210010	DORCHESTER	$24,256,573	4.31%	12.60%	11.42%	11.94%	-9.37%	-5.46%	-14.3%	-0.84%	10.7%	-2.00%	-$203,755	-0.84%
210011	ST. AGNES	$233,151,492	-13.36%	11.98%	11.72%	11.89%	-2.17%	-15.24%	-14.3%	0.09%	10.7%	-2.00%	$209,836	0.09%
210012	SINAI	$397,073,246	-16.68%	12.34%	10.57%	10.72%	-14.34%	-28.63%	-14.3%	1.00%	10.7%	-0.03%	$3,970,732	1.00%

RY 2020 Readmission Reduction Incentive Program									Improvement		Attainment		Final Adjustment	
HOSP ID	HOSPITAL NAME	RY 17 Permanent Inpatient Revenue	RY2018 % Change	RY19 (CYTD16) BASE Case Mix Adj. Readmit Rate	CYTD17 Case Mix Adj. Readmit rate	CYTD17 Case mix Adj. rate Adj for out of state	CYTD17 % Change in instate Case mix adj. Rate	CYTD17 Modified Cumulative Improve Readmit Rate (compounded)	Target	RY20 Scaling %	Target	RY20 Scaling %	RY20 Better of Attain/ Improve	RY20 Scaling %
		A	B	C	D	E	F = D/C-1	G = (1+F)*(1+B)-1	H	I	J	K	L	M = L/A
210013	BON SECOURS	$62,008,295	-22.77%	15.41%	15.38%	15.51%	-0.19%	-22.92%	-14.3%	0.82%	10.7%	-2.00%	$508,468	0.82%
210015	MEDSTAR FRANKLIN	$287,510,180	-4.33%	12.59%	12.99%	13.09%	3.18%	-1.29%	-14.3%	-1.24%	10.7%	-2.00%	-$3,565,126	-1.24%
210016	WASH ADVENTIST	$150,097,509	-10.77%	10.60%	9.38%	10.65%	-11.51%	-21.04%	-14.3%	0.64%	10.7%	0.11%	$960,624	0.64%
210017	GARRETT	$21,836,267	-17.19%	5.92%	6.48%	9.44%	9.46%	-9.36%	-14.3%	-0.47%	10.7%	1.00%	$218,363	1.00%
210018	MONTGOMERY	$79,298,762	-14.22%	10.78%	11.76%	12.56%	9.09%	-6.42%	-14.3%	-0.75%	10.7%	-2.00%	-$594,741	-0.75%
210019	PRMC	$235,729,906	-5.26%	10.51%	10.84%	11.61%	3.14%	-2.29%	-14.3%	-1.14%	10.7%	-1.82%	-$2,687,321	-1.14%
210022	SUBURBAN	$189,851,798	-1.97%	11.20%	11.17%	12.60%	-0.27%	-2.23%	-14.3%	-1.15%	10.7%	-2.00%	-$2,183,296	-1.15%
210023	AAMC	$296,168,973	-9.50%	11.29%	10.61%	10.98%	-6.02%	-14.95%	-14.3%	0.06%	10.7%	-0.57%	$177,701	0.06%
210024	UNION MEMORIAL	$231,121,787	-14.56%	12.79%	12.34%	12.49%	-3.52%	-17.57%	-14.3%	0.31%	10.7%	-2.00%	$716,478	0.31%
210027	WESTERN MD	$171,858,929	-9.75%	11.49%	10.82%	11.89%	-5.83%	-15.01%	-14.3%	0.07%	10.7%	-2.00%	$120,301	0.07%
210028	ST. MARY	$77,346,008	-16.39%	10.99%	10.90%	13.54%	-0.82%	-17.08%	-14.3%	0.26%	10.7%	-2.00%	$201,100	0.26%
210029	HOPKINS BAYVIEW	$348,529,477	-7.25%	14.29%	14.39%	14.78%	0.70%	-6.60%	-14.3%	-0.73%	10.7%	-2.00%	-$2,544,265	-0.73%
210030	CHESTERTOWN	$18,989,104	3.71%	14.14%	10.93%	11.88%	-22.70%	-19.83%	-14.3%	0.53%	10.7%	-2.00%	$100,642	0.53%
210032	UNION OF CECIL	$68,179,037	4.29%	10.51%	10.51%	12.69%	0.00%	4.29%	-14.3%	-1.77%	10.7%	-2.00%	-$1,206,769	-1.77%
210033	CARROLL	$116,510,378	-8.62%	11.51%	11.11%	11.40%	-3.48%	-11.80%	-14.3%	-0.24%	10.7%	-1.39%	-$279,625	-0.24%
210034	HARBOR	$107,761,881	-6.76%	11.91%	13.14%	13.26%	10.33%	2.87%	-14.3%	-1.64%	10.7%	-2.00%	-$1,767,295	-1.64%
210035	UM CHARLES	$68,387,041	-19.00%	9.88%	9.62%	11.30%	-2.63%	-21.13%	-14.3%	0.65%	10.7%	-1.20%	$444,516	0.65%
210037	EASTON	$100,000,562	2.37%	10.95%	10.53%	11.00%	-3.84%	-1.56%	-14.3%	-1.21%	10.7%	-0.61%	-$610,003	-0.61%
210038	UMMC MIDTOWN	$114,950,934	-11.20%	15.42%	14.81%	14.96%	-3.96%	-14.72%	-14.3%	0.04%	10.7%	-2.00%	$45,980	0.04%
210039	CALVERT	$63,319,998	-10.08%	9.21%	8.54%	9.97%	-7.27%	-16.62%	-14.3%	0.22%	10.7%	1.00%	$633,200	1.00%
210040	NORTHWEST	$125,696,184	-19.18%	12.55%	11.79%	12.00%	-6.06%	-24.08%	-14.3%	0.93%	10.7%	-2.00%	$1,168,975	0.93%
210043	UM BWMC	$227,399,457	-13.35%	12.77%	11.95%	12.15%	-6.42%	-18.91%	-14.3%	0.44%	10.7%	-2.00%	$1,000,558	0.44%
210044	G.B.M.C.	$216,554,825	-6.26%	10.59%	10.25%	10.44%	-3.21%	-9.27%	-14.3%	-0.48%	10.7%	0.51%	$1,104,430	0.51%
210045	MCCREADY	$2,930,574	7.04%	11.70%	11.66%	11.66%	-0.34%	6.68%	-14.3%	-2.00%	10.7%	-1.92%	-$56,267	-1.92%
210048	HOWARD COUNTY	$176,085,796	-4.92%	11.36%	10.59%	10.76%	-6.78%	-11.37%	-14.3%	-0.28%	10.7%	-0.12%	-$211,303	-0.12%
210049	UMUCH	$133,152,736	-5.87%	11.06%	9.72%	9.85%	-12.12%	-17.28%	-14.3%	0.28%	10.7%	1.00%	$1,331,527	1.00%

RY 2020 Readmission Reduction Incentive Program									Improvement		Attainment		Final Adjustment	
HOSP ID	HOSPITAL NAME	RY 17 Permanent Inpatient Revenue	RY2018 % Change	RY19 (CYTD16) BASE Case Mix Adj. Readmit Rate	CYTD17 Case Mix Adj. Readmit rate	CYTD17 Case mix Adj. rate Adj for out of state	CYTD17 % Change in instate Case mix adj. Rate	CYTD17 Modified Cumulative Improve Readmit Rate (compounded)	Target	RY20 Scaling %	Target	RY20 Scaling %	RY20 Better of Attain/ Improve	RY20 Scaling %
		A	B	C	D	E	F = D/C-1	G = (1+F)*(1+B)-1	H	I	J	K	L	M = L/A
210051	DOCTORS	$132,931,890	-10.41%	11.78%	11.11%	12.26%	-5.69%	-15.51%	-14.3%	0.12%	10.7%	-2.00%	$159,518	0.12%
210055	LAUREL	$59,724,224	-16.49%	11.82%	11.93%	12.36%	0.93%	-15.71%	-14.3%	0.13%	10.7%	-2.00%	$77,641	0.13%
210056	GOOD SAMARITAN	$158,579,215	-18.05%	12.14%	12.35%	12.43%	1.73%	-16.63%	-14.3%	0.22%	10.7%	-2.00%	$348,874	0.22%
210057	SHADY GROVE	$219,319,153	-9.73%	10.11%	10.31%	10.92%	1.98%	-7.94%	-14.3%	-0.61%	10.7%	-0.43%	-$943,072	-0.43%
210058	UMROI	$67,555,816	-10.65%	10.66%	9.84%	9.84%	-7.69%	-17.52%	-14.3%	0.31%	10.7%	1.00%	$108,089	0.16%
210060	FT. WASH	$19,371,986	-27.41%	9.81%	8.64%	11.41%	-11.93%	-36.07%	-14.3%	1.00%	10.7%	-1.42%	$193,720	1.00%
210061	ATLANTIC GENERAL	$38,966,012	-25.02%	8.90%	9.84%	10.95%	10.56%	-17.10%	-14.3%	0.27%	10.7%	-0.50%	$105,208	0.27%
210062	SOUTHERN MD	$163,339,853	-7.63%	11.20%	10.67%	13.26%	-4.73%	-12.00%	-14.3%	-0.22%	10.7%	-2.00%	-$359,348	-0.22%
210063	ST. JOSEPH	$234,995,507	-10.29%	10.95%	10.37%	10.45%	-5.30%	-15.04%	-14.3%	0.07%	10.7%	0.50%	$1,174,978	0.50%
210064	LEVINDALE	$54,805,171	-28.84%	11.40%	11.77%	12.28%	3.25%	-26.53%	-14.3%	1.00%	10.7%	-2.00%	$548,052	1.00%
210065	HC GERMAN	$62,086,212		10.67%	12.09%	12.88%	13.31%		-3.55%	-1.36%	10.7%	-2.00%	-$844,372	-1.36%
STATEWIDE		**$8,971,214,597**	-10.75%	11.81%	11.58%		-1.95%						**-$15,594,938**	

UMROI is adjusted to 16% of total RY 17 Permanent Inpatient Revenue
Some percentages have been rounded for display. Final scaling values are rounded to two decimal places.
Holy Cross Germantown has an adjusted improvement target

State Total	**-$15,594,938**
Penalty	**-$31,721,897**
% Inpatient	**-0.35%**
Reward	**$16,126,959**
% Inpatient	**0.18%**

APPENDIX V. OUT-OF-STATE MEDICARE READMISSION RATIOS

Out-of-state readmission ratios displayed below are for September 2016 - August 2017.

Out-of-State Readmission Ratios for RRIP Attainment

Based on CMMI Data September 2016 – August 2017

Hospital Name	Medicare FFS Readmission Rate	In-State Medicare FFS Readmission Rate	Out-of-State (OOS) Ratio	Case-Mix Adjusted Readmission Rate	Case-Mix Adjusted Rate with OOS Adjustment
210001 - MERITUS	18.15%	17.28%	1.05	11.58%	12.16%
210002 - UNIVERSITY OF MARYLAND	18.70%	18.04%	1.04	13.13%	13.61%
210003 - PRINCE GEORGE	18.17%	14.50%	1.25	10.47%	13.11%
210004 - HOLY CROSS	15.59%	14.11%	1.11	11.63%	12.85%
210005 - FREDERICK MEMORIAL	13.00%	12.46%	1.04	10.37%	10.82%
210006 - HARFORD	17.65%	16.88%	1.05	10.63%	11.12%
210008 - MERCY	12.21%	11.98%	1.02	12.76%	13.01%
210009 - JOHNS HOPKINS	18.87%	17.49%	1.08	13.11%	14.14%
210010 - DORCHESTER			1.04	11.42%	11.86%
210011 - ST. AGNES	15.41%	15.22%	1.01	11.72%	11.87%
210012 - SINAI	14.40%	14.23%	1.01	10.57%	10.69%
210013 - BON SECOURS	20.30%	20.30%	1.00	15.38%	15.38%
210015 - FRANKLIN SQUARE	18.46%	18.30%	1.01	12.99%	13.10%
210016 - WASHINGTON ADVENTIST	14.29%	12.67%	1.13	9.38%	10.57%
210017 - GARRETT COUNTY	9.94%	6.86%	1.45	6.48%	9.38%
210018 - MONTGOMERY GENERAL	14.56%	13.80%	1.06	11.76%	12.41%
210019 - PENINSULA REGIONAL	14.98%	14.09%	1.06	10.84%	11.52%
210022 - SUBURBAN	12.60%	11.35%	1.11	11.17%	12.41%
210023 - ANNE ARUNDEL	12.28%	11.84%	1.04	10.61%	11.01%
210024 - UNION MEMORIAL	12.50%	12.32%	1.01	12.34%	12.51%
210027 - WESTERN MARYLAND	14.40%	13.13%	1.10	10.82%	11.87%
210028 - ST. MARY	14.27%	11.69%	1.22	10.90%	13.31%

Hospital Name	Medicare FFS Readmission Rate	In-State Medicare FFS Readmission Rate	Out-of-State (OOS) Ratio	Case-Mix Adjusted Readmission Rate	Case-Mix Adjusted Rate with OOS Adjustment
210029 - HOPKINS BAYVIEW MED CTR	21.25%	20.67%	1.03	14.39%	14.79%
210030 - CHESTERTOWN	15.33%	14.05%	1.09	10.93%	11.93%
210032 - UNION HOSPITAL OF CECIL	16.51%	13.70%	1.21	10.51%	12.67%
210033 - CARROLL COUNTY	14.36%	13.96%	1.03	11.11%	11.43%
210034 - HARBOR	16.43%	16.28%	1.01	13.14%	13.26%
210035 - CHARLES REGIONAL	15.02%	12.97%	1.16	9.62%	11.14%
210037 - EASTON	13.84%	13.32%	1.04	10.53%	10.94%
210038 - UMMC MIDTOWN	23.75%	23.58%	1.01	14.81%	14.92%
210039 - CALVERT	12.57%	10.92%	1.15	8.54%	9.83%
210040 - NORTHWEST	15.00%	14.73%	1.02	11.79%	12.01%
210043 - UMBWMC	15.69%	15.40%	1.02	11.95%	12.17%
210044 - G.B.M.C.	12.44%	12.22%	1.02	10.25%	10.43%
210045 - MCCREADY	14.72%	14.72%	1.00	11.66%	11.66%
210048 - HOWARD COUNTY	15.44%	15.12%	1.02	10.59%	10.81%
210049 - UPPER CHESAPEAKE HEALTH	12.90%	12.70%	1.02	9.72%	9.87%
210051 - DOCTORS COMMUNITY	16.61%	14.95%	1.11	11.11%	12.35%
210055 - LAUREL REGIONAL	21.56%	20.53%	1.05	11.93%	12.53%
210056 - GOOD SAMARITAN	16.81%	16.73%	1.00	12.35%	12.41%
210057 - SHADY GROVE	13.20%	12.46%	1.06	10.31%	10.92%
210058 - REHAB & ORTHO	3.66%	3.66%	1.00	9.84%	9.84%
210060 - FT. WASHINGTON	15.17%	11.61%	1.31	8.64%	11.29%
210061 - ATLANTIC GENERAL	11.54%	10.24%	1.13	9.84%	11.09%
210062 - SOUTHERN MARYLAND	19.26%	15.27%	1.26	10.67%	13.46%
210063 - UM ST. JOSEPH	10.54%	10.44%	1.01	10.37%	10.47%
210064 - LEVINDALE	16.56%	15.95%	1.04	11.77%	12.22%
210065 - HOLY CROSS GERMANTOWN	14.66%	13.60%	1.08	12.09%	13.03%

Maryland
Hospital Association

February 27, 2018

Alyson Schuster, Ph.D.
Associate Director, Performance Measurement
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Alyson:

On behalf of the Maryland Hospital Association's 64 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) *Draft Recommendation for the Readmissions Reduction Incentive Program for Rate Year 2020*. We agree with staff's recommendation to leave unchanged many features of the policy, as the current version has been constructed to provide additional incentive to meet the requirements of the final year of the All-Payer Model. We also support the improvement and attainment targets proposed by staff, barring any extreme changes or volatility based on more recent data.

Including both attainment and improvement targets helps address inherent differences in hospitals' populations, and the influence on readmissions rates. While it has been clearly documented that differences in health status, health literacy, community and social resources affect readmissions, it is difficult to capture those differences with data in a way that can be used to adjust readmissions rates. Further, the National Quality Forum (NQF) in its July 2017 report, *Evaluation of the NQF Trial Period for Risk Adjustment for Social Risk Factors*, documented its experience evaluating the possibility of including adjustments for social risk factors in over 300 measures. As it relates to readmissions, NQF did not recommend adjusting for social risk factors because, although a relationship could be demonstrated between certain social risk factors and readmissions, the effect had limited impact on hospital performance scores or the performance of the risk adjustment model. This finding is consistent with HSCRC staff's finding in the spring of 2016, when Mathematica Policy Research modeled Maryland all-payer readmissions outcomes. It was demonstrated that HSCRC's existing DRG-SOI adjustment explained most of the variation in hospital readmissions rates, and that after including adjustments for age and gender, adding a composite social risk variable – the area deprivation index – had very little impact. The addition of social risk factors can add complexity with little additional explanatory value.

In the next demonstration, it will be important to identify readmissions attainment benchmarks for hospitals or groups of hospitals outside Maryland. Reducing readmissions has been a key indicator of success in hospitals' commitment to patients post discharge, and in managing chronic conditions in a cost effective setting. While that commitment will continue into the next demonstration, it will be wise to set realistic and not overly aggressive readmissions targets, as there is an inverse relationship between readmissions rates and mortality rates – hospitals with higher readmissions rates tend to have lower mortality rates.

6820 Deerpath Road, Elkridge, MD 21075 ▪ 410-379-6200 ▪ www.mhaonline.org

We look forward to continuing to work with the commission on the readmissions policy for performance year 2019 (fiscal year 2021). Should you have any questions, please call me at 410-540-5087.

Sincerely,

Traci La Valle, Vice President

cc: Nelson J. Sabatini,Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James N. Elliott, M.D.
Adam Kane
Jack Keane
Donna Kinzer, Executive Director
Dianne Feeney, Associate Director, Quality Initiatives
Allan Pack, Director, Population-Based Methodologies

MARYLAND
Department of Health

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

March 2, 2018

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

Dear Chairman Sabatini,

The Medicaid program has reviewed the draft recommendation of the Health Services Cost Review Commission's (HSCRC) Staff for the Readmissions Reduction Incentive Program (RRIP) for rate year (RY) 2020. We are writing in support of the Staff's draft recommendation, in particular the recommendation to continue to set the minimum required reduction benchmark on an all-payer basis.

While the national readmissions program conducted by the Centers for Medicare & Medicaid Services (CMS) focuses on Medicare only, Maryland stakeholders have expressed the need for Maryland's program to include all patients, regardless of payer. The Medicaid program applauds the HSCRC's foresight in implementing its quality programs to benefit all factions of Maryland's population. Maintaining the all-payer approach to quality programs under the All-Payer Model will ensure the development of strategies that improve the health of all Marylanders.

The singularity of the Maryland model stems from its all-payer nature—were the RRIP to transition to a Medicare-only program, we would support moving to the national, Medicare-only Hospital Readmission Reduction Program. The Department would also be prepared to develop a Medicaid-only readmissions program. Several other states—such as Pennsylvania, New York and Texas—operate Medicaid-only programs, ranging from payment adjustments to non-payment of readmissions.

The application of a more stable all-payer conversion factor for RY 2020 further strengthens Maryland's unique approach. In addition, given the need to match the national Medicare readmissions rate by the end of calendar year (CY) 2018, the Medicaid program also supports the

inclusion of the 0.3 percentage point cushion built into the calculation of the improvement and attainment targets (-14.3 percent and 10.7 percent, respectively).

We look forward to working with the HSCRC and other stakeholders as the policy is finalized, pending the receipt of final CY 2017 data, for RY 2020. If you have any questions, please do not hesitate to contact me at via phone at 410-767-5809 or email at tricia.roddy@maryland.gov.

Sincerely,

Tricia Roddy
Director, Planning Administration

Subject	Number / Chapter (Cross File / Chapter)	Title	Bill Summary	Update	Primary Sponsor	Status	HSCRC Position
Budget							
	HB 160/SB 185	Budget Bill (Fiscal Year 2019)	Annual Budget Bill	HSCRC appropriations reductions- Senate subcommittee adopted the recommendation to reduce the UCC fund appropriation by $20 million and the ICN by $6 million. We concurred with both appropriation reductions. ICN submission was a budgeting error. UCC fund appropriation reduction is in line with FY 17 and FY 18 actual levels.	Speaker	Passed Senate; Pending House	Support
	HB 161/SB 187	Budget Reconciliation and Financing Act of 2018	Reduction of Medicaid Deficit Assessment by $25 million in FY 19, $45 million in FY 20, and $25 million annually thereafter. The BRFA also delays capital funds for the construction of the new Prince George's County Regional Medical Center from $48 million to $19 million in FY 2019. Capital funds are extended to FY 2021.	1. Medicaid Deficit Assessment – Senate subcommittee modified the spend down from $25 million in FY 19 to $30 million in FY 19. 2. Medicaid Total Cost of Care language- Senate subcommittee added BRFA language directing Medicaid and HSCRC to develop, outside of the All-payer Model Contract, Medicaid-specific savings and total cost of care goals.	Speaker	Passed Senate; Pending House	Support
Insurance- Market Stabilization							
	HB 1782	Maryland Health Care Access Act of 2018 (Emergency bill)	Requires the HSCRC to assess fees (not exceeding 0.5% of each hospital's net patient revenue) on each hospital for FY 19, to support the Health Care Access Program and to reflect the aggregate reduction in hospital UCC realized from coverage expansion. HSCRC may not raise rates as part of the annual update factor for FY 19 to offset the fee. Also requres carriers to pay a 3% assessment on gross premiums if it fails to offer inidivudal health benefit plans. Certain health insurance entities must pay a 2.75% assessment on all amounts used to calculate the entity's premium tax liability, in order to recoup the health insurance provider fee assessed under the ACA. Certain individuals must maintain minimum essental coverage or pay a penalty.	HSCRC letter of support with amendment to strike the provision related to the hospital assessment to fund the reinsurance program in FY 19.	Delegate Pena-Melnyk	Hearing HGO 3/12	Letter of support with amendment

Subject	Number / Chapter (Cross File / Chapter)	Title	Bill Summary	Update	Primary Sponsor	Status	HSCRC Position
	HB 1795	Maryland Health Benefit Exchange - Establishment of a Reinsurance Program	The Exchange must establish a Health Care Access Program to provide reinsurance to carriers that offer inidivudal health benefit plans in Maryland in order to mitigate the impact of high-risk individuals on rates in the individual insurance market inside and outside the exchange. Authorizes funding to be made from any available State or federal funding source. State funding would be contingent on CMS approval of a 1332 waiver.	Letter of information expressing support for emergency legislation.	Delegate Pena-Melnyk	Passed the House on 2nd reader	Letter of information
	SB 387	Health Insurance - Health Care Access Program - Establishment (Maryland Health Care Access Act of 2018)	Requires a carrier to pay a 3% assessment on insurance premiums sold outside of the Exchange. The assessment is to be distributed annually to the Maryland Health Benefit Exchange Fund for the purposes of operating and administering a Health Care Access Program, designed to mitigate the impact of high-risk individuals on rates for health benefit plans in the individual market in the State. This bill requires a 1332 waiver to waive one of several ACA standards.		Senator Middleton	Hearing 2/21 in Finance	No Position
	HB 660	Public Health - State-Provided Health Care Benefits for State Residents (HealthcareMaryland)	Establishes an Office of Health Care Coverage within MDH to set up the HealthcareMaryland Program to provide health insurance benefits to Maryland residents who do not receive benefits through Medicare, Tricare, plans that are subject to ERISA, or any other federal medical program. The program would be funded through a 10% payroll tax.		Delegate Reznik	Hearing 3/5 in HGO	No Position
	SB 878 / HB 1312	Health Insurance - Medicaid Buy-In Task Force	Creates a Task Force to study the feasibility of a Medicaid buy-in program to expand health care coverage choices available to individuals purchasing individual insurance.		Senator Feldman, Delegate Kelly	Hearing 2/21 in Senate Finance - Favorable with Amendments; Hearing 3/22 in HGO	No Position

Subject	Number / Chapter (Cross File / Chapter)	Title	Bill Summary	Update	Primary Sponsor	Status	HSCRC Position
	SB 1011/ HB 1167	Protect Maryland Health Care Act of 2018	Establishes a system for the purchase of and enrollment in health insurance coverage. The Comptroller and the Health Benefit Exchange are tasked with developing a system to encourage an individual to use the individual's insurance tax credit to purchase health insurance beginning January 1, 2020.		Senator Feldman, Delegate Pena-Melnyk	Reassigned to Senate Budget and Taxation; HB1167 Hearing 2/22 in HGO	No Position
	SB 690/ HB 726	Maryland Department of Health - Basic Health Program - Implementation	Requires MDH and the Maryland Health Benefit Exchange to explore the possibility of offering a Basic Health Program for individuals up to 200% of the federal poverty level beginning in 2020. The State must report if it can implement the BHP, access federal funds to pay for the BHP services, implement with existing State resources, and retain enough covered lives in health plans offered through the Exchange to assure market stability.		Senator Benson,	Senate Finance hearing 2/21 - Favorable with Amendments Report Adopted; Hearing 3/22 in HGO	No Position
Malpractice							
	SB 30 / HB 1581	Health Care Malpractice Qualified Expert	Repeals requirement that a health care provider attesting in a certificate of a qualified expert or in relation to an arbitration panel/court proceeding concerning compliance with or departure from standards of care may not devote more than 20% of the expert's profesional acitivites to those involving testimony in personal injury claims. A health care provider will be able to qualify as an expert in more cases.		Senator Ramirez	Favorable Report Adopted, Second Reading Passed 3/7	Letter of information
	HB0289/SB 36	Civil Actions - Noneconomic Damages	Increases the cap on non-economic damages for a wrongful death action arising on or after October 1, 2018. HSCRC submitted a letter of concern.		Delegate Sydnor, Senator Smith	Hearing 1/31 at 2:00 p.m.	Letter of concern

Subject	Number / Chapter (Cross File / Chapter)	Title	Bill Summary	Update	Primary Sponsor	Status	HSCRC Position
	SB0862/HB 909	Maryland No-Fault Birth Injury Fund	Creates a Birth Injury Fund for adjudication and compensation of claims arising from birth-related neurological injuries. The bill establishes the governance, administration, funding, and purposes of the fund. The Maryland Patient Safety Center (MPSC) is charged with developing patient safety initiatives and, through its Perinatal Clinical Advisory Committee (PCAC), must also review fund claims.		Senator Kelley, Delegate Cullison	Hearing 2/21 in JPR	Letter of support
Exemptions							
	HB0384	Substance Use Facilities and Programs - Certificate of Need - Repeal of Requirement	MDH bill to repeal the CON requirement for a substance use disorder facility that offers nonhospital substance abuse outpatient, residential, or inpatient treatment services licensed by the Behavioral Health Administration		Chair, Health and Government Operations Committee	Hearing 2/13 in HGO	No Position
	SB 619/ HB 1282	Health Maintenance Organizations - Certificate of Need Requirements - Modification	Repeals the Certificate of Need requirement for an ambulatory surgical facility or other project under the direction of an HMO if 90% of the potential patients served by the facility will be enrolled in that particular HMO.	Senate Bill passed with amendment; pending House HGO	Senator Klausmeier, Delegate Kelly	Senate Bill passed with amendment; pending House HGO	No Position
Workforce							
	HB 596/SB 234	Interstate Medical Licensure Compact	Allows Maryland to enter into the Interstate Medical Licensure Compact that allows physicians from member states to expedite licensure in Maryland. A similar interstate compact is in place for nurses in Maryland and surrounding states.	Senate bill amended; passed Second Reader	Delegate Hill, Senator Middleton	Senate bill passed with amendments; Hearing in HGO 2/15.	No Position
Hospital							
	HB 614/ SB 390	Hospitals - Changes in Status - Hospital Employee Retraining and Placement	Requires the HSCRC to levy an assessment for the Hospital Employees Training Fund when a hospital downsizes, defined as a reduction in force of 10 FTEs over a 3-month period.	Potential amendment to add conversion to a Freestanding Medical Center to statute triggering an assessment for the Hospital Employees Training Fund.	Delegate Lisanti, Senator Feldman	Hearing Senate Finance 2/8; House HGO 2/20	Letter of information
	HB 562/ SB 530	Hospitals - Patient's Bill of Rights	Requires each hospital to have a patient's bill of rights with certain provisions; and to provide patients with a copy of the patient's bill of rights, conspicuously post the bill of rights and provide a translator if needed.	Senate bill amended; House bill withdrawn.	Delegate K. Young, Senator Young	Hearing 2/15 in Senate Finance, 2/20 in HGO	No Position
Other							

Subject	Number / Chapter (Cross File / Chapter)	Title	Bill Summary	Update	Primary Sponsor	Status	HSCRC Position
	HB 855 / SB 1082	State Government - Regulations Impacting Small Businesses - Economic Impact Analyses	Alters the period before a proposed regulation is submitted to the Maryland Register and to the AELR Committee for review. HB 855 would elongate the process for regulations from 15 days to 30 days before the proposal is submitted for publication.		Delegate Brooks, Senator DeGrange	Hearing House HGO 2/20; SB1082 Hearing 3/13 in EHEA	Letter of concern from MDH with HSCRC comments
	SB0923	Maryland All-Payer Model Agreement - Medicare Skilled Nursing Facility 3-Day Rule - Waiver	Requires MDH to apply for a waiver from the Medicare Skilled Nursing 3-Day Rule by September 1, 2018. Request for a waiver should be included with the extension of the All-Payer Model.		Senator Hershey	Hearing 3/01 in Senate Finance	Letter of information
	SB 682	Medical Assistance Program and Health Insurance - Emergency Medical Services Providers - Coverage and Reimbursement of Services	Creates reimbursement for services provided by emergency medical services providers for health assessments, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, hospital discharge follow-up care and minor medical procedures provided within the scope of the provider and provided in a home or other community-based settings. Reimbursement is also required for transportation to an urgent care center for patients that do not need emergency services.		Senator Hershey	Hearing 3/01 in Senate Finance	Letter of Information
	SB1056	Rural Health Collaborative Pilot	Establishes a Rural Health Collaborative to lead a regional partnership in building a rural health system that enhances access to and utilization of health care services designed to provide health care, align with the State's Medicare waiver, and improve population health in rural areas.	Passed Senate; Pending House HGO	Senator Hershey	Passed Senate; pending House HGO	No Position
	SB 17	Health Information Exchanges - Definitions and Regulations	Departmental bill to expand the definition of "health information exchange" to include entities that govern, as well as provide, certain health information.		Chair, Finance Committee	Passed Senate; Hearing 3/22 in HGO	No Position
	SB 527	Health - Standards for Involuntary Admissions and Petitions for Emergency Evaluation - Modification	Expands the circumstances under which a patient can be admitted to an inpatient facility on an involuntary basis to include individuals who have experienced an overdose, history of chronic and persistent substance abuse or presents a danger to the life or safety of the individual or others.		Senator Astle	Hearing 2/14 in Senate Finance	No Position

Subject	Number / Chapter (Cross File / Chapter)	Title	Bill Summary	Update	Primary Sponsor	Status	HSCRC Position
	SB 1023/HB 1194	Health - Drug Cost Review Commission	Establishes a Drug Cost Review Commission in State government to "protect State residents, State and local governments, commercial health plans, health care providers, pharmacies licensed in the State, and other stakeholders within the health care system from excessive costs of prescription drugs." Legislation requires a drug (or biological) manufacturer to notify the Commission if the wholesale cost of the drug is increasing by more than 10% or by more than $10,000 during any 12-month period, or if the manufacturer intends to introduce a brand-name drug that has a wholesale cost of $30,000 per calendar year or per course of treatment. The Commission, along with stakeholders, will determine other thresholds that would require manufacturer reporting. Legislation also allows the Commission to set reimbursement rates for drugs that have been identified as creating excess costs for payors and consumers.		Senator Conway/Delegate Pena-Melnyk	Hearing 2/28 in Senate Finance; HGO hearing 3/6	No Position
	SB 835/ HB 1682	Maryland Medical Assistance Program - Collaborative Care Pilot Program	Creates a Collaborative Care Pilot Program within MDH to integrate somatic and behavioral health care in primary care settings for enrollees of HealthChoice (4-year program)		Senator Madaleno, Delegate Morales	SB 835 Passed Second Reader with Amendment	No Position
	SB 921/HB 1531	Task Force on the Premature Discharge of Patients With Substance Use Disorders	Creates a Task Force to collect information on treatment practices of patients with substance use disorders at facilities designed to treat substance use disorders, including reasons why patients may be prematurely discharged and "abandonment practices". Task Force is charged with making recommendations to improve patient care, staff training, and the possibility of required reporting on the frequency of early patient discharge.		Senator Hershey, Delegate Seth Howard	Hearing 3/01 in Senate Finance	No Position
	SB 994 / HB 1541	Disclosure of Tax Benefits - Nonprofit Hospitals	Requires nonprofit hospitals to submit to the Comptroller an itemized list of the tax benefits that the hospital received during the previous taxable year. The Comptroller is directed to review the submission and prepare a report that summarizes the aggregate value of the tax benefits received by each nonprofit hospital.		Senator Peters	Hearing 3/15 in Finance; Hearing HGO 3/2	No Position

Subject	Number / Chapter (Cross File / Chapter)	Title	Bill Summary	Update	Primary Sponsor	Status	HSCRC Position
	HB 115/SB 13	Electronic Prescription Records Cost Saving Act of 2018	This bill requires a dispenser to submit prescription drug information to the State's HIE in order to make it available to a health care providers for purposes of care coordination.	HB 115 was amended to direct MHCC to convene stakeholders to assess and report on bill.	Delegate Morhaim, Senator Rosapepe	HB 115 Passed Second Reader; Hearing 1/31 in Senate Finance	No Position
	HB 1804	Health - University of Maryland Medical System - Grant	This bill authorizes a grant in FY 2020 of $2.5 million to the University of Maryland Medical System from the fund balance of the Maryland Trauma Physicians Services Fund. The grant is intended to to establish a partnership between the Institute of Human Virology, the University of Maryland School of Medicine, and UMMS for the purpose of immunotherapy research.		Speaker	Hearing 3/13 House Appropriations	No Position
Withdrawn							
	HB0041	Hospitals - Community Benefit Report - Disclosure of Tax Exemptions	Requires hospitals to include an itemized list of taxable deductions in the hospital's community benefit report.		Delegate Angel	Hearing canceled	
	SB 1024/ HB 1519	Self-Referrals - Oncology Group Practices - Exemption	Creates an exemption from physician self-referral for an oncology group practice that provides radiation therapy services or nondiagnostic CT scan services. One exemptions will be available in each of three regions of the State- Eastern Shore, Southern, or Western Maryland. Integrated community oncology practices must be able to safely and appropriately delivery radiation therapy to patients, achieve the goals and milestones of the State's All-Payer Model contract. Practice must submit an annual performance report to MHCC for review and to retain the exemption		Senator Conway, Delegate Pena-Melnyk (HB 1519)	Hearing 3/07 in EHEA Canceled; HB1519 Withdrawn	

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Compliance

TO: Commissioners

FROM: HSCRC Staff

DATE: March 14, 2018

RE: Hearing and Meeting Schedule

April 11, 2018 — To be determined - 4160 Patterson Avenue
HSCRC/MHCC Conference Room

May 9, 2018 — To be determined - 4160 Patterson Avenue
HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:15 a.m.

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

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