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Department of Health and Mental Hygiene

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528th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
March 9, 2016

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

1. **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**

2. **Update on Hospital Rate Issue (JHH) - Authority General Provisions Article, §3-305 (7)**

PUBLIC SESSION
1:30 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on February 10, 2016**

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**

   2328A – MedStar Health
   2329A – University of Maryland Medical Center
   2330A – University of Maryland Medical Center
   2331A – Johns Hopkins Health System
   2332A – Johns Hopkins Health System
   2333A – Johns Hopkins Health System
   2334A – University of Maryland Medical Center
   2335A – Johns Hopkins Health System
   2336A – Johns Hopkins Health System

5. **Docket Status – Cases Open**

   2317R – Holy Cross Health
   2319R – Sheppard Pratt Health System
   2320N – Sheppard Pratt Health System
   2337R – LifeBridge Health, Inc.
   2338A – Johns Hopkins Health System

6. **Draft Recommendation for Modification to the Readmission Incentive Program for FY 2018**

7. **Draft Recommendations for Total Amount at Risk for Quality Programs for FY 2018**

8. **Update on Uncompensated Care Trends**

9. **Legislative Update**

10. **Update from CRISP on Implementation of Infrastructure and Analytics**

11. **Legal Report**

12. **Hearing and Meeting Schedule**

Closed Session Minutes
Of the
Health Services Cost Review Commission

February 10, 2016

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

1. Update on Contract and Modeling of the All-Payer Model vis-à-vis the All-Payer Model Contract - Administration of Model Moving into Phase II – Authority General Provisions Article §3-103 and §3-104
2. Update on Hospital Rate Issue – Authority General Provisions Article, §3-305(7)

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

In attendance, in addition to Chairman Colmers, were Commissioners Bone, Jencks, Keane, and Wong.

In attendance representing Staff were Donna Kinzer, Steve Ports, Jerry Schmith, Ellen Englert, Claudine Williams, Amanda Vaughn, Jessica Lee, and Dennis Phelps.

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

Item One

Donna Kinzer, Executive Director, and Eric Lindeman, Commission Consultant, presented and the Commission discussed analyses of Medicare per beneficiary data.

Item Two

Ms. Kinzer reported to the Commission and the Commission discussed rate charging issues involving Johns Hopkins Hospital.

Chairman Colmers and Mr. Lindeman, Commission Consultant, left the meeting and did not witness or participate in the discussion.

The Closed Session was adjourned at 1:20 p.m.

MINUTES OF THE
527th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

February 10, 2016

Chairman John Colmers called the public meeting to order at 12:06 pm. Commissioners George H Bone, M.D., Stephen F. Jencks, M.D., MPH, Jack C. Keane, and Herbert S. Wong, Ph.D. were also in attendance. Upon motion made by Commissioner Keane and seconded by Commissioner Wong, the meeting was moved to Executive Session. Chairman Colmers reconvened the public meeting at 1:23pm.

REPORT OF THE FEBRUARY 10, 2016 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the February 10, 2016 Executive Session.

ITEM I

REVIEW OF THE MINUTES FROM JANUARY 13, 2016 AND JANUARY 26, 2016 EXECUTIVE SESSIONS AND JANUARY 13, 2016 PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the January 13, 2016 and January 26, 2016 Executive Sessions and the January 13, 2016 Public Meeting.

ITEM II

EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, reported that the Health Services Cost Review Commission (HSCRC) and Department of Health and Mental Hygiene (DHMH) staffs together with the representatives from the Maryland Hospital Association (MHA) and the Maryland State Medical Society (MedChi) have been coordinating a request to the Center for Medicare & Medicaid Innovation (CMMI) to obtain approvals for incentive programs in Maryland. These incentive programs would allow hospitals to share savings from their Global Budget Revenue with hospital based physicians and physicians with admitting privileges participate in programs that results in cost savings to the hospital. Incentive programs would also extend to community providers who work together with hospitals to reduce avoidable utilization and readmissions.

HSCRC has been working with MedChi and a task force on a pay-for-outcomes approach that is organized around Medicare's Chronic Care Management fee. This approach would focus the joint efforts of hospitals and primary care and other community providers on complex high needs patients who need more intense support and interventions as well as patients with multiple chronic conditions who can benefit from chronic care management. The approach would allow

hospitals to share savings from their global budget with community providers when avoidable utilization such as Prevention Quality Indicators and readmissions are reduced. It would also allow hospitals to help support chronic care management activities in concert with community providers.

Ms. Kinzer stated that Staff is exploring a geographic total cost of care guardrail methodology for hospitals, which can be linked with global budgets for Medicare. The purpose of these guardrails is to ensure that incentive payments do not result in cost shifting to the non-hospital setting.

Ms. Kinzer noted that Staff is also seeking Medicare data, similar to that provided to Accountable Care Organizations, to be used in care coordination activities such as risk stratification, opportunity assessment, evaluation of model performance, and administering the payment model requirements of the agreement.

Ms. Kinzer reported that the Advisory Council has been reconvened to provide advice on progression of the All-Payer Model. The Council's first meeting was held on February 3, 2016. The next meeting will be held on February 19, 2016 at the HSCRC offices.

Ms. Kinzer stated that the Implementation Grant Proposals are being reviewed by a committee consisting of HSCRC, DHMH, the Chesapeake Regional Information System for Our Patients (CRISP), Maryland Community Health Resources Commission, payer staff, and two independent reviewers. The committee met on January 19th and February 1st to consider applications and evaluate their efficacy in achieving the identified transformation goals. Twenty two grant applications were received that involve 45 hospitals. The review team expressed the desire to obtain further clarification from many of the applicants and, therefore, will be sending letters to those applicants with a series of questions. Upon receipt of the responses, the review team will consider the applications and, as deemed appropriate, may meet with the applicants and their partners to discuss the grant applications in further detail. Staff anticipates submitting recommendations to the Commission during its April public meeting.

Ms. Kinzer stated that in the current year, Staff has seen several large market shifts. Staff is considering making market shift adjustments on a semi-annual basis. If shifts become smaller in the future, Staff may want to return to an annual basis. Reducing avoidable utilizations is critical to the success of the All-Payer Model. At the same time, we need to ensure that resources are aligned properly. Ms. Kinzer noted that during its review of potential market shift information, Staff found that ten hospitals have outpatient data problems, and that one hospital has an inpatient data problem.

Ms. Kinzer noted that the Commission indicated that as part of the 2016 update, it would expect to implement a return on investment from the infrastructure funds that were provided to hospitals in their rate increases. Currently, staff has several policies that are involved in this discussion. They include adjustments for shared savings of readmissions, the readmissions reduction incentives, and adjustments for Potentially Avoidable Utilizations. The Performance Work

Group has been engaged in revising the readmission reduction incentives policy to account for the relationship between low readmission rates and low readmission reductions. Staff is considering options to combine or reorganize these adjustments.

Ms. Kinzer noted that Staff has been working on a consumer dashboard. The Performance Work Group reviewed a list of potential measures that will be included on the dashboard to monitor the progress of the All-Payer Model. Staff will collaborate with the Maryland Health Care Commission (MHCC) to create a webpage to publish the dashboard.

Ms. Kinzer reported that Staff has started working on the Uncompensated Care (UCC) policy for FY 2017. Staff was able to match write off records to the case mix data by patient account number for records with service dates beginning July 1, 2014 through June 30, 2015. Staff intends to use the matched write off data in the formulation of the FY 2017 UCC Policy. Staff will be sending the unmatched records back to hospitals to allow for revisions to records with FY 2015 service dates. Staff will be releasing non-confidential patient level case mix UCC data to solicit input for the UCC methodology. Information regarding the request process will be posted on the HSCRC website.

Ms. Kinzer noted that Staff is currently focused on the following activities:

- Reviewing implementation plans and conducting discussions regarding proposals, plans, and reports that have been provided to HSCRC for the purpose of assessing and understanding implementation progress and gaps, and readiness to accelerate community based care coordination and management.
- Developing shared savings, readmission, and aggregate at risk recommendations.
- Organizing and preparing for the FY 2017 annual update.
- Reviewing several rate applications for capital that have been filed.
- Moving forward on updates to value based performance measures, including efficiency measures.
- Examining per capita costs and total cost of care, for purposes of monitoring and for progressing toward a focus on outcomes and costs across the health care system.
- Working with DHMH and stakeholders to focus on ensuring success of the All-Payer Model and providing a proposal for a new model no later than January 2017 as required under the Agreement with the CMS.
- Working on an All-Payer amendment for alignment activities.
- Working on a request to CMMI for Medicare data that can be used for care coordination, model monitoring, and other Model purposes.

ITEM III

NEW MODEL MONITORING

Amanda Vaughn, Program Manager, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of December focuses on fiscal year (July 1 through June

30) as well as calendar year results.

Ms. Vaughn reported that for the six month period ended December 31, 2015, All-Payer total gross revenue increased by 2.99% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 2.99%; this translates to a per capita growth of 2.46%. All-Payer gross revenue for non-Maryland residents increased by 2.96%.

Ms. Vaughn reported that for the twelve months of the calendar year ended December 31, 2015, All-Payer total gross revenue increased by 2.63% over the same period in CY 2014. All-Payer total gross revenue for Maryland residents increased by 2.85%; this translates to a per capita growth of 2.31%. All-Payer gross revenue for non-Maryland residents decreased by 0.47 %.

Ms. Vaughn reported that for the six months ended December 31, 2015, Medicare Fee-For-Service gross revenue increased by 3.44% over the same period in FY 2014. Medicare Fee-For-Service gross revenue for Maryland residents increased by 3.55%; this translates to a per capita growth of 0.64%. Maryland Fee-For-Service gross revenue for non-residents increased by 2.19%.

Ms. Vaughn reported that for the twelve months of the calendar year ended December 31, 2015, Medicare Fee-For-Service gross revenue increased by 3.82% over the same period in CY 2014. Medicare Fee-For-Service gross revenue for Maryland residents increased by 4.25%; this translates to a per capita growth of 1.13%. Maryland Fee-For-Service gross revenue for non-residents decreased by 0.99%.

Ms. Vaughn reported that for the twelve months of the calendar year ended December 31, 2015 over the same period in CY2013:

- Net per capita growth was 3.80%.
- Per capita growth before UCC and MHIP adjustments was 5.58%.
- Net per capita Medicare growth was (0.06%).
- Per capita growth Medicare before UCC and MHIP was 1.63%

According to Ms. Vaughn, for the six months of the fiscal year ended December 31, 2015, unaudited average operating profit for acute hospitals was 2.91%. The median hospital profit was 3.84%, with a distribution of .93% in the 25th percentile and 5.89% in the 75th percentile. Rate Regulated profits were 6.49%.

Ms. Vaughn reported that for the twelve months of the calendar year ended December 31, 2015 over the same period in CY2014:

- All-Payer admissions decreased by 3.52%;
- All-Payer admissions per thousand decreased by 4.02%;
- Medicare Fee-For-Service admissions decreased by 1.59%;
- Medicare Fee-For-Service admissions per thousand decreased by 4.51%;

- All-Payer bed days decreased by 2.18%;
- All-Payer bed days per thousand decreased by 2.69%;
- Medicare Fee-For-Service bed days decreased by 1.23%;
- Medicare Fee-For-Service bed days per thousand decreased by 4.16%;
- All-Payer Emergency visits decreased by 0.34%;
- All-Payer Emergency per thousand decreased by 0.85%.

Dr. Alyson Schuster, PhD., Associate Director Performance Management, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon potentially preventable complications (through September 2015) and readmission data on discharges (through November 2015).

Readmissions

- The All-Payer risk adjusted readmission rate was 12.84% for November 2015 YTD. This is a decrease of 7.17% from the November 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 13.67% for November 2015 YTD. This is a decrease of 6.24% from the November 2013 YTD risk adjusted readmission rate.
- Based on the New-Payer model, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction incentive program has set goals for hospitals to reduce their adjusted readmission rate by 9.3% during CY 2015 compared to CY 2013. Currently, only 15 out of 46 hospitals have reduced their risk adjusted readmission rate by more than 9.3%.

Potentially Preventable Complications

- The All-Payer risk adjusted PPC rate was 0.76 for September 2015 YTD. This is a decrease of 33.91% from the September 2013 YTD risk adjusted PPC rate.
- The Medicare Fee for Service risk adjusted PPC rate was 0.88 for September 2015 YTD. This is a decrease of 35.77% from the September 2013 risk adjusted PPC rate.
- These preliminary PPC results indicate that hospitals are on track for achieving the annual 6.89% PPC reduction required by CMMI to avoid corrective action.

ITEM IV

DOCKET STATUS CASES CLOSED

NONE

ITEM V

DOCKET STATUS- OPEN CASES

2328A- MedStar Health

On January 20, 2016, MedStar Health filed an application on behalf of Union Memorial Hospital (the "Hospital") requesting approval to continue to participate in a global rate arrangement for orthopedic and spinal services with the National Orthopedic & Spine Alliance for one year beginning February 6, 2016.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for orthopedic and spinal services for one year beginning February 6, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve Staff's recommendation.

2329A- University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital") filed an application on January 20, 2016 requesting continued participation in a global rate arrangement for blood and bone marrow transplant services with BlueCross and BlueShield Association Blue Distinction Centers beginning March 1, 2016.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for blood and bone marrow transplant services for one year beginning March 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve Staff's recommendation.

2330A- University of Maryland Medical Center

University of Maryland Medical Center (the "Hospital") filed an application on January 20, 2015 requesting approval to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with LifeTrac, Inc. Network for one year beginning April 1, 2016.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for one year beginning April 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve Staff's recommendation.

2331A- Johns Hopkins Health System

On January 27, 2016, Johns Hopkins Health System filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospitals (the "Hospitals') requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant with Preferred Health Care LLC for one year beginning March 1, 2016.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for one year beginning March 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2332A- Johns Hopkins Health System

On January 27, 2016, Johns Hopkins Health System filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with MultiPlan, Inc. beginning March 1, 2016.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for one year beginning March 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approves Staff's recommendation. Chairman Colmers recused himself from the discussion and the vote
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2333A- Johns Hopkins Health System

On January 27, 2016, Johns Hopkins Health System filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospitals (the "Hospitals) requesting approval to continue to participate in a global rate arrangement for cardiovascular procedures, solid organ, stem cell, and to add bariatric surgery, pancreatic cancer surgery, and joint replacement services to the arrangement with Corporate Medical Network for one year beginning March 1, 2016.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular procedures, solid organ, stem cell, bariatric surgery, pancreatic cancer surgery, and joint replacement services for one year

beginning March 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2334A- University of Maryland Medical Center

University of Maryland Medical Center (the "Hospital") filed an application on January 27, 2016 requesting approval to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with INTERLINK for one year beginning March 1, 2016.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for one year beginning March 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve Staff's recommendation.

2335A- Johns Hopkins Health System

On January 29, 2016, Johns Hopkins Health System filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with BlueCross and BlueShield Association Blue Distinction Centers for Transplants beginning March 1, 2016.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for one year beginning March 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2336A- Johns Hopkins Health System

On January 29, 2016, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospitals (the "Hospitals") requesting approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services and cardiovascular services with LifeTrac (a subsidiary of Allianz Insurance Company of North

America) for one year beginning April 1, 2016.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services and cardiovascular services for one year beginning April 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

ITEM VI

ADVANCING TELEHEALTH IN MARYLAND- AN MHCC UPDATE

Mr. David Sharp, MHCC Director of Center for Health Information Technology and Innovative Care Delivery, and Ms. Angela Evatt, Chief Health Information Exchange, updated the Commission on the work the MHCC is doing to support the advancement of telehealth in Maryland (see "Advancing Telehealth in Maryland- An MHCC Update" on the HSCRC website).

Per Maryland law, enacted in 2014, MHCC is authorized to directly award telehealth grants to non-profit organizations and qualified businesses. The MHCC grants provide an opportunity to test the effectiveness of telehealth with various technology, patients, providers, clinical protocols, and settings. In three rounds of funding since October 2014, $257,888 in telehealth grants have been rewarded, and grantees have contributed $610,180 in matching funds.

Mr. Colin Ward, Vice President Population Health & Clinical Integration for University of Maryland-Upper Chesapeake Health, Mr. Michael Franklin, President and CFO Atlantic General Hospital, and Dr. Carnell Cooper, Chief Medical Officer Dimensions Healthcare System, spoke about the implementation of their programs and provided feedback on some of their successes and challenges.

Upcoming telehealth priorities from the MHCC include a fourth round of grants that advance practice transformation and continue to align with value based care models.

ITEM VII

UPDATE FROM CRISP ON IMPLEMENTATION OF INFRASTRUCTURE AND ANALYTICS

Dr. Ross Martin, CRISP Integrated Care Network Infrastructure Program Director, provided an update on integrated care network activities (see "Integrated Care Network Infrastructure- Status Update"- on the HSCRC website).

The HSCRC has provided funding and charged CRISP with implementing the Care Coordination work group recommendations to provide infrastructure necessary to enhance Maryland's health care coordination and alignment capabilities. CRISP's implementation plans for an Integrated Care Network infrastructure are well underway. One of the strategic initiatives is to expand connectivity with ambulatory providers, a step many hospitals consider critical to enhanced patient care management. In addition to the Integrated Care Network Infrastructure, CRISP is pursuing access to patient level Medicare data on two tracks, via Qualified Entity status and a Maryland specific application directly to CMMI.

ITEM VIII

LEGISLATIVE UPDATE

Mr. Steve Ports, Deputy Director Policy Management, presented a summary of the legislation of interest to the HSCRC (see" Legislative Update- February 7, 2016" on the HSCRC website).

The Bills included: 1) Senate Bill 108 Nurse Support Program Assistance; 2) Senate Bill 513/House Bill 377 Maryland No-Fault Birth Injury Fund; 3) Senate Bill 510 Termination of MHIP and Transfer of Senior Prescription Drug Assistance Program; 4) Senate Bill 336 Hospital- Designation of Caregivers; and 5) Senate Bill 324/House Bill Prince George's County Regional Medical Center Act of 2016; 6) Senate Bill 661/ House Bill 587 Hospital- Patient's Bill of Rights; 7) Senate Bill 12 Health Care Facilities- Closures or Partial Closures of Hospital- County Board of Health Approval; 8) Hospital- Community Benefit Report- Disclosure of Tax Exemptions; Senate Bill 707- Freestanding Medical Facilities- Certificates of Need, Rates, and Definition.

ITEM IX

HEARING AND MEETING SCHEDULE

March 9, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
April 13, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:31 pm.

Executive Director's Report

Health Services Cost Review Commission

March 9, 2016

Progress on Planning for Progression of the All Payer Model

By January 2017, Maryland must submit a proposal for a new Model to CMS which shall limit, at a minimum, the Medicare per beneficiary total cost of care growth rate to take effect no later than January 2019.

Advisory Council--The Advisory Council recently held a second meeting as the All Payer Model moves forward to focus on system-wide costs and outcomes. The Advisory Council will provide an interim report to HSCRC and DHMH after its upcoming March meeting.

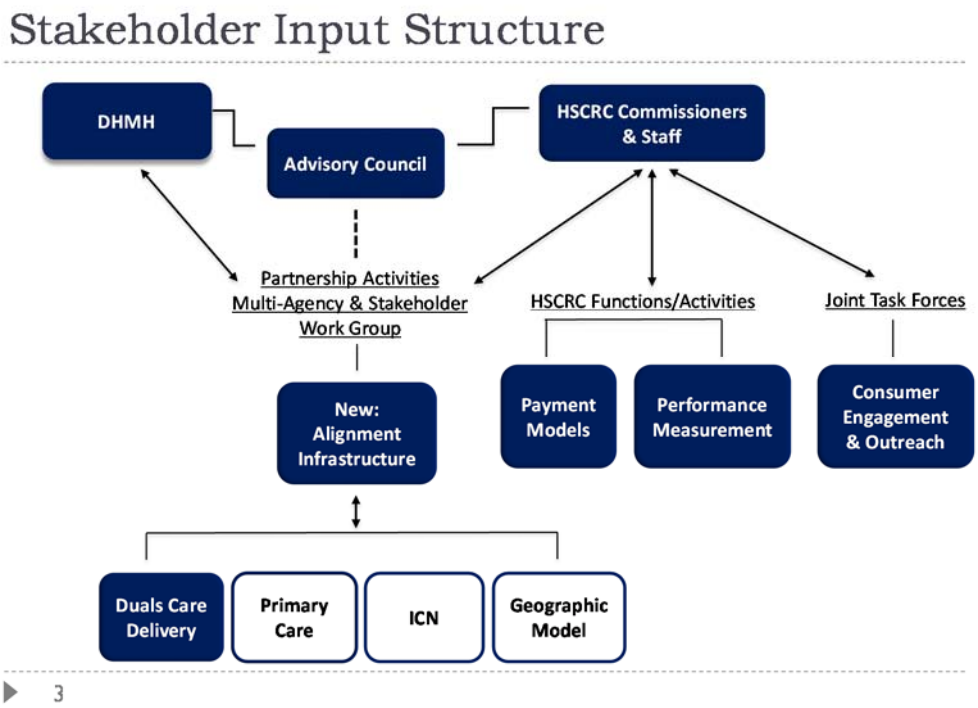
Amendment to All Payer Model—HSCRC and DHMH are continuing to work on a potential amendment to the All Payer Model Agreement with CMS to provide approvals needed to support alignment activities that would allow shared resources and make available incentive payments from hospitals to non-hospital providers when quality and outcomes are improved and avoidable utilization is reduced. We are also working to obtain data for use by providers in enhancing care delivery and providing additional resources to persons with the highest levels of need – those with the most complex and chronic conditions.

HSCRC does not have staff or resources to implement these modifications. Infrastructure will need to be developed to support these activities. Some of the infrastructure will come through the implementation activities of CRISP. However, additional resources will be required to design and review provider implementation plans, implement data collection, calculate savings, develop total cost of care guard rails, and conduct other requirements for implementation.

Duals Care Delivery Workgroup—DHMH has held two work group meetings on the development of potential models for dual eligible individuals (beneficiaries with both Medicare and Medicaid coverage). Payment models will need to dovetail with the progression of the All Payer Model.

Consulting Assistance--The State has just approved the award of a consulting contract to assist HSCRC and the State in planning for the progression of the All Payer Model.

Work Groups—HSCRC will focus with DHMH on initiating the Alignment/Infrastructure Work Group, as well as focusing on the initiation of other sub-groups and task forces.



Progress on Review of Implementation Grant Proposals

In June 2015, the Commission authorized an increase in hospital rates of up to 0.25% in FY 2016 (approximately $40 million) to be awarded on a competitive basis to hospitals that are ready to implement community-based care coordination initiatives that will have near term reductions in potentially avoidable utilization. An independent review committee consisting of HSCRC, DHMH, CRISP, Maryland Community Health Resources Commission (MCHRC), payer staff, and two contracted independent reviewers, met to consider the applications and evaluate their efficacy in achieving the identified transformation goals. During these meetings, the review team expressed the desire to obtain further clarification from many of the applicants. Letters have been sent to applicants with a series of questions. Also, a survey has been prepared to send to all hospitals to gain a better understanding of care coordination resources that have been deployed to date, and how that relates to the funding that has already been provided.

The Commission staff is in the process of getting this data and scheduling meetings with applicants to discuss their proposals. Steve Ports, who has directed this effort along with other HSCRC staff, has been involved in a very active legislative session. With the amount of information we need to understand the current levels of implementation and the additional information to be obtained on the proposals, together with other staff responsibilities, we do not expect to complete this process until the May Commission meeting.

Hospitals were given considerable resources for care coordination in their GBRs and in the FY 2016 update. The HSCRC expects hospitals and regional partnerships to work together to deploy the funding already provided.

Data Quality

Recently, we have had several major problems in receiving case mix data from hospitals. These quality problems are causing delays in reporting on ECMAD volume changes and in analyzing market shifts, readmissions, MHACs and other policies. This could cause a delay in the annual update process and deter the monitoring of the model, if not rectified.

Several systems are in the process of implementing EPIC EHR. It is possible that this could cause billing delays and inaccurate charge reporting. There may be restatements of monthly reports.

Data quality is of concern to the Commission staff. Rework will slow down our ability to progress in policy development and in the annual update process.

Annual Update

The HSCRC staff is convening the Payment Models Workgroup to commence with the annual update process.

Today, we will discuss the uncompensated care analysis (UCC) we have performed this year, in anticipation of a new approach to UCC determination post ACA coverage expansion.

We will also review analyses of Potentially Avoidable Utilization (PAU) as part of the Readmission FY18 draft recommendation today. As we proceed with the 2017 update, we need to consider how to ensure that we account for the expectation of reduced PAUs.

Non-Hospital Cost Increases

Under the All Payer Model, Maryland is required to monitor the Total Cost of Care for Medicare services to ensure that cost increases outside of hospitals do not undermine the Medicare savings that result from implementation of the All Payer Model by hospitals.

Through September 2015, we estimate that there is excess growth relative to the national growth rate in non-hospital costs for Medicare of approximately $43 million (for 9 months of Calendar Year 2015 over Calendar Year 2014).

HSCRC staff has analyzed increases in non-hospital “Part A” costs, which are comprised primarily of post-acute care, accounting for about half of the growth. Staff has not yet analyzed the growth in professional fees and other expenditures, “Part B” costs, which accounts for the other half of the growth.

The data analysis shows significant increases in SNF referrals for several hospitals. HSCRC staff will provide summary data to each hospital and to post-acute providers. HSCRC staff needs to understand the causes of change and develop approaches to address the increases. We also need to complete the analysis of Part B cost changes.

Even if these increases were offset against hospital savings to date, Maryland is ahead of its Medicare savings requirements.

All of these observations are using preliminary unaudited data. There may be material changes in results as the year progresses and final data is received.

Claudine Williams will review the statistics regarding these increases today.

Staff Focus

HSCRC staff is currently focused on the following activities:

- Reviewing implementation plans and conducting discussions regarding proposals, plans, and reports that have been provided to HSCRC for the purpose of assessing and understanding implementation progress and gaps, and readiness to accelerate community based care coordination and management.
- Developing shared savings, readmission, and aggregate at risk recommendations.
- Organizing and preparing for the FY 2017 annual update.
- Reviewing several rate applications for capital that have been filed.
- Moving forward on updates to value-based performance measures, including efficiency measures.
- Examining Medicare per capita costs and total cost of care, for purposes of monitoring and for progressing toward a focus on outcomes and cost across the health care system.
- Working with DHMH and stakeholders to focus on ensuring success of the All-Payer Model and providing a proposal for a new model no later than January 2017 as required under the Agreement with CMS.
- Working on an All-Payer Model amendment for alignment activities.
- Working on a request to CMMI for Medicare data that can be used for care coordination, model monitoring, and other Model purposes; and
- Working with legislators and stakeholders in Annapolis to ensure that the budget and proposed legislation being considered during the current General Assembly session are designed to meet the goals of the All-Payer Model.

Monitoring Maryland Performance

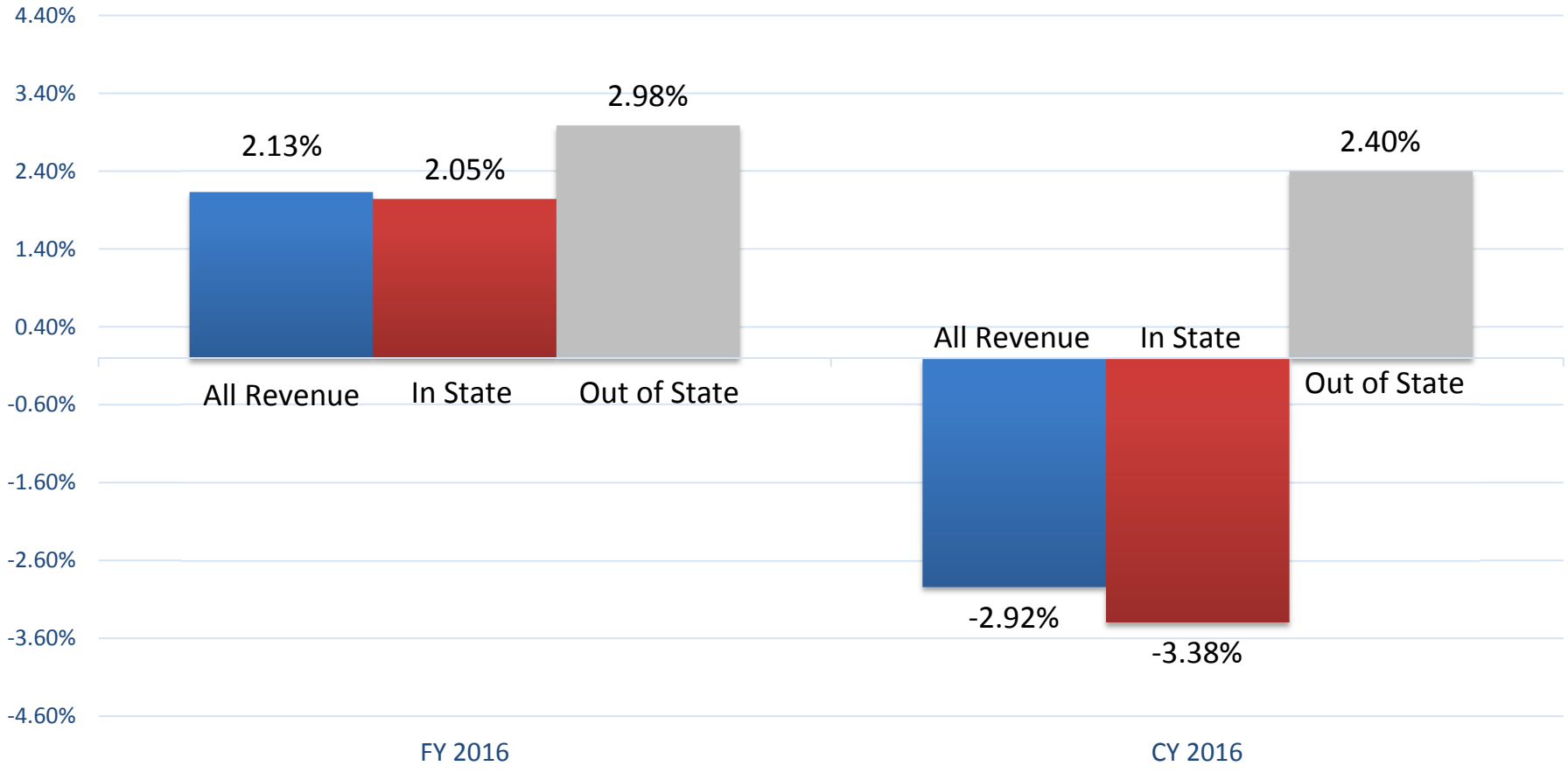
Financial Data

Year to Date thru January 2016

HSCRC
Health Services Cost Review Commission

Gross All Payer Revenue Growth

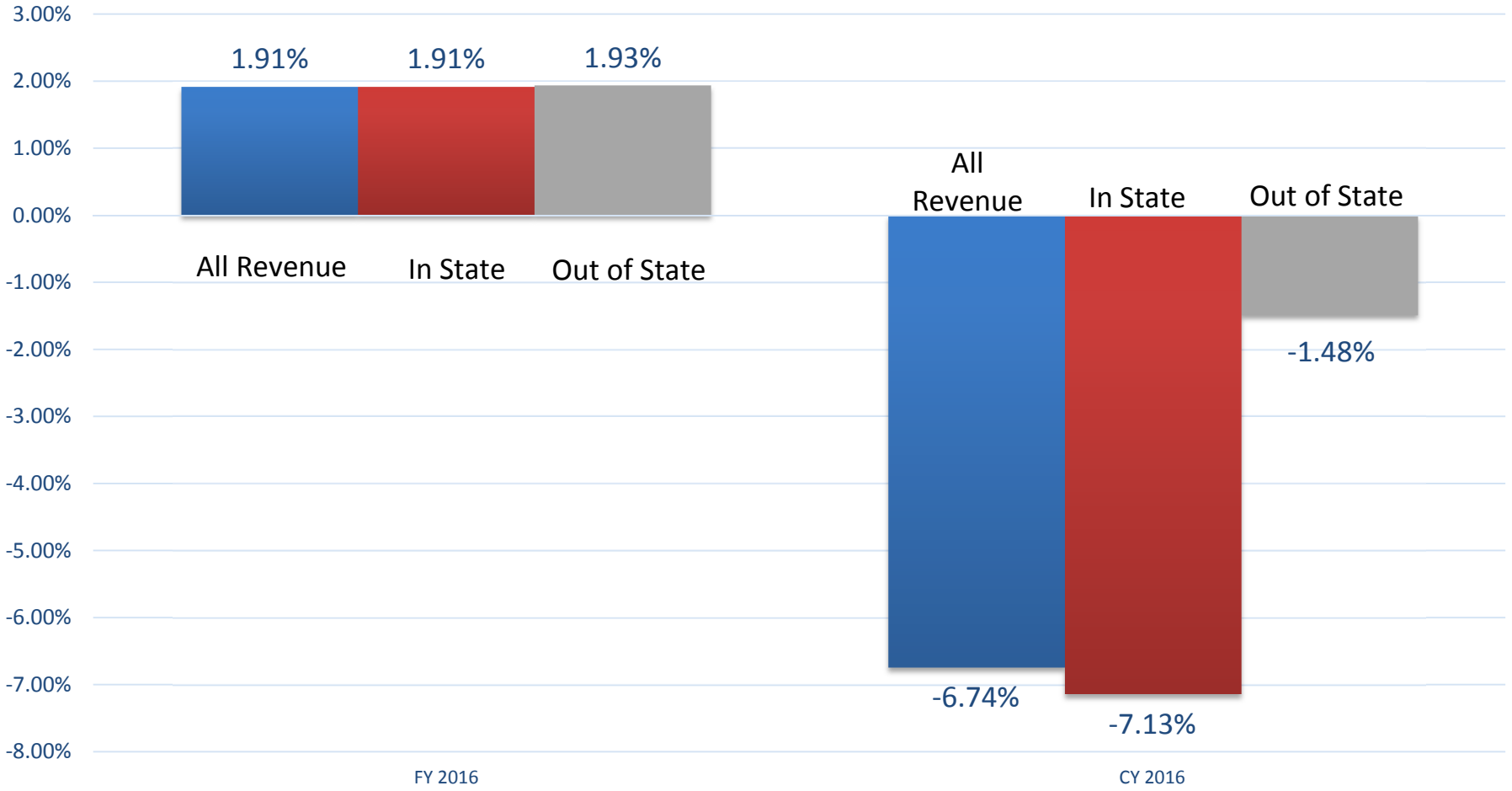
Year to Date (thru January 2016) Compared to Same Period in Prior Year



HSCRC
Health Services Cost Review Commission

Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru January 2016) Compared to Same Period in Prior Year



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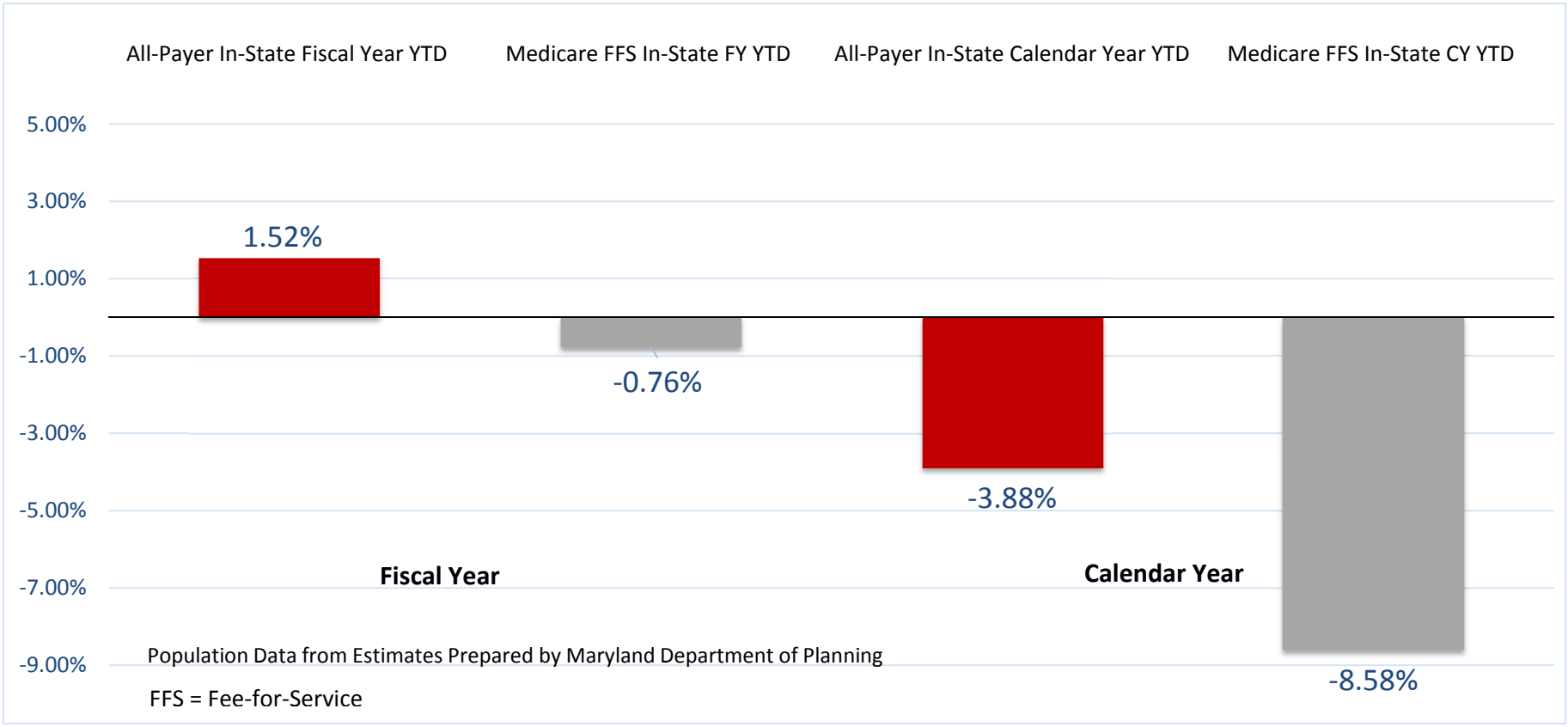
Per Capita Growth Rates
Fiscal Year 2016 and Calendar Year 2016 (2016 over 2015)



- **Calendar and Fiscal Year trends to date are below All-Payer Model Guardrail of 3.58% for per capita growth.**

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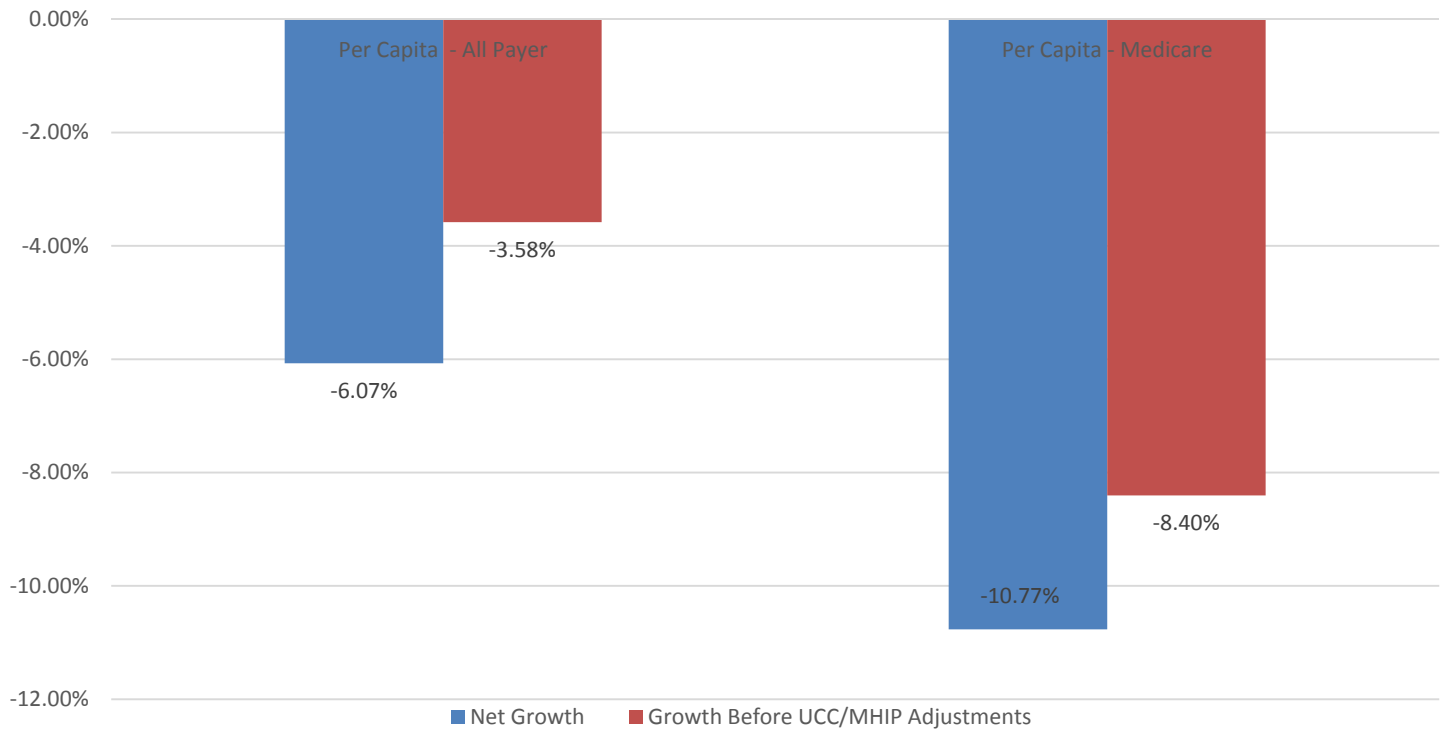
Per Capita Growth – Actual and Underlying Growth
CY 2016 Year to Date Compared to Same Period in Base Year (2013)



- Three year per capita growth rate is well below maximum allowable growth rate of 11.13% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY 16 revenue decreases that were budget neutral for hospitals. 2.52% hospital bad debts and elimination of MHIP assessment.

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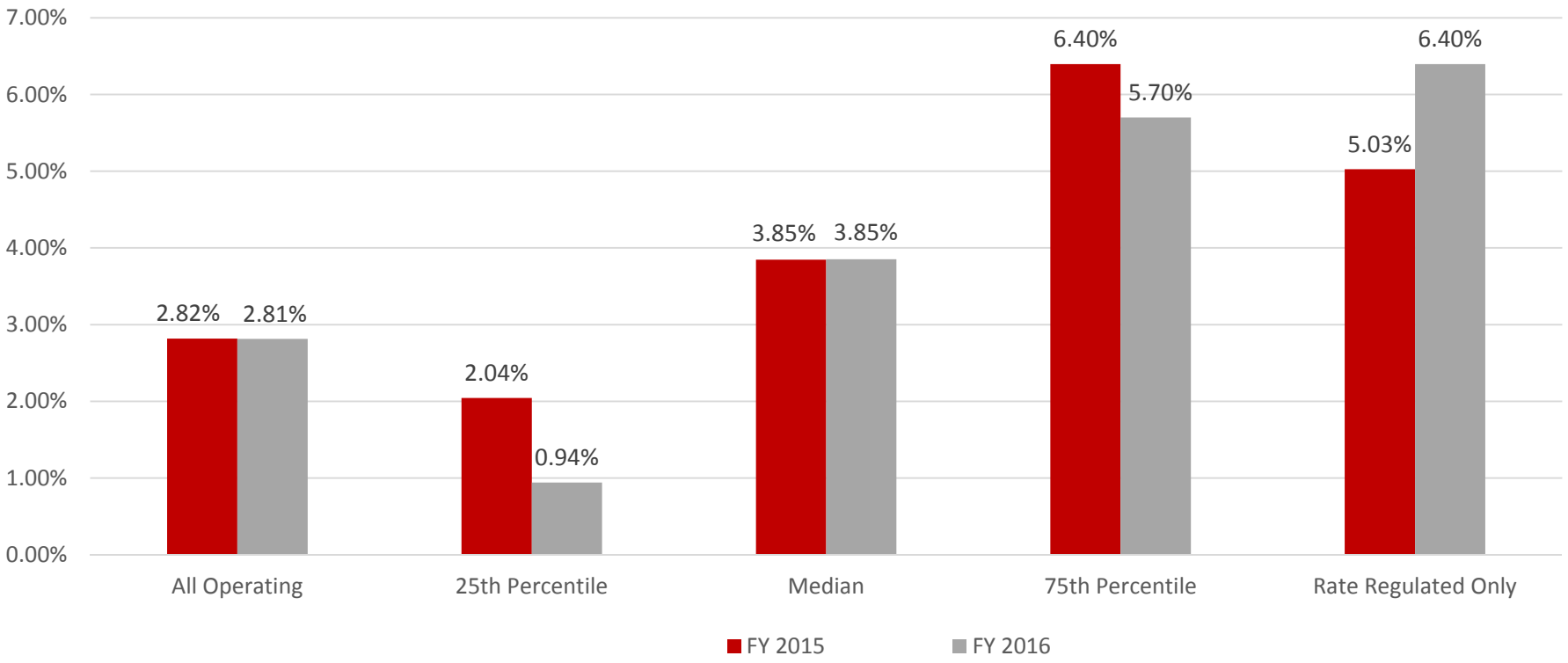
Operating Profits: Fiscal 2016 Year to Date (July-January) Compared to Same Period in FY 2015



- Year to date FY 2016 unaudited hospital operating profits show a 0.1% decrease in total profits compared to the same period in FY 2015. Rate regulated profits for FY 2016 have increased by 1.37% compared to the same period in FY 2015.

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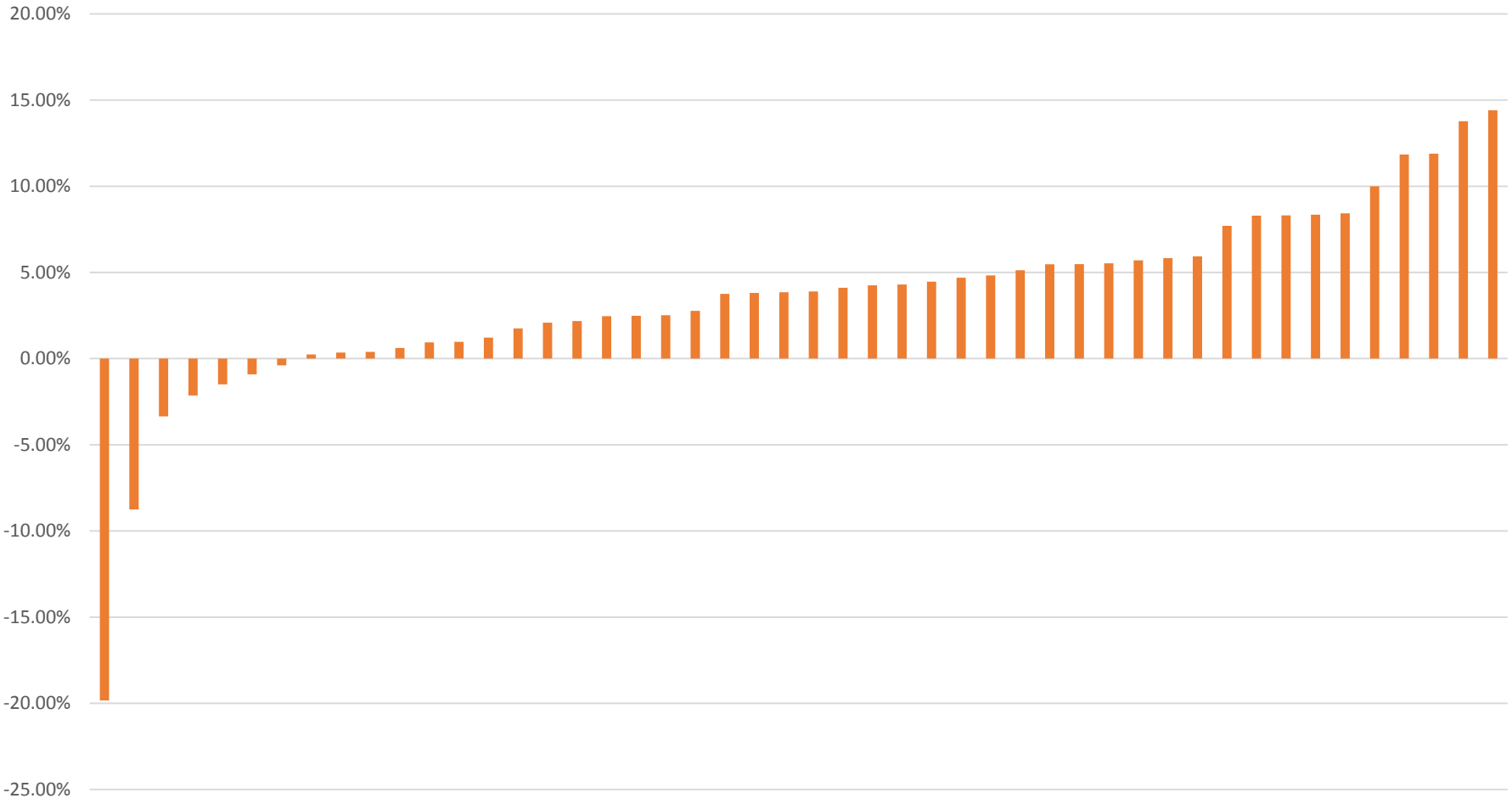
Operating Profits by Hospital

Fiscal Year to Date (July 2015 – January 2016)



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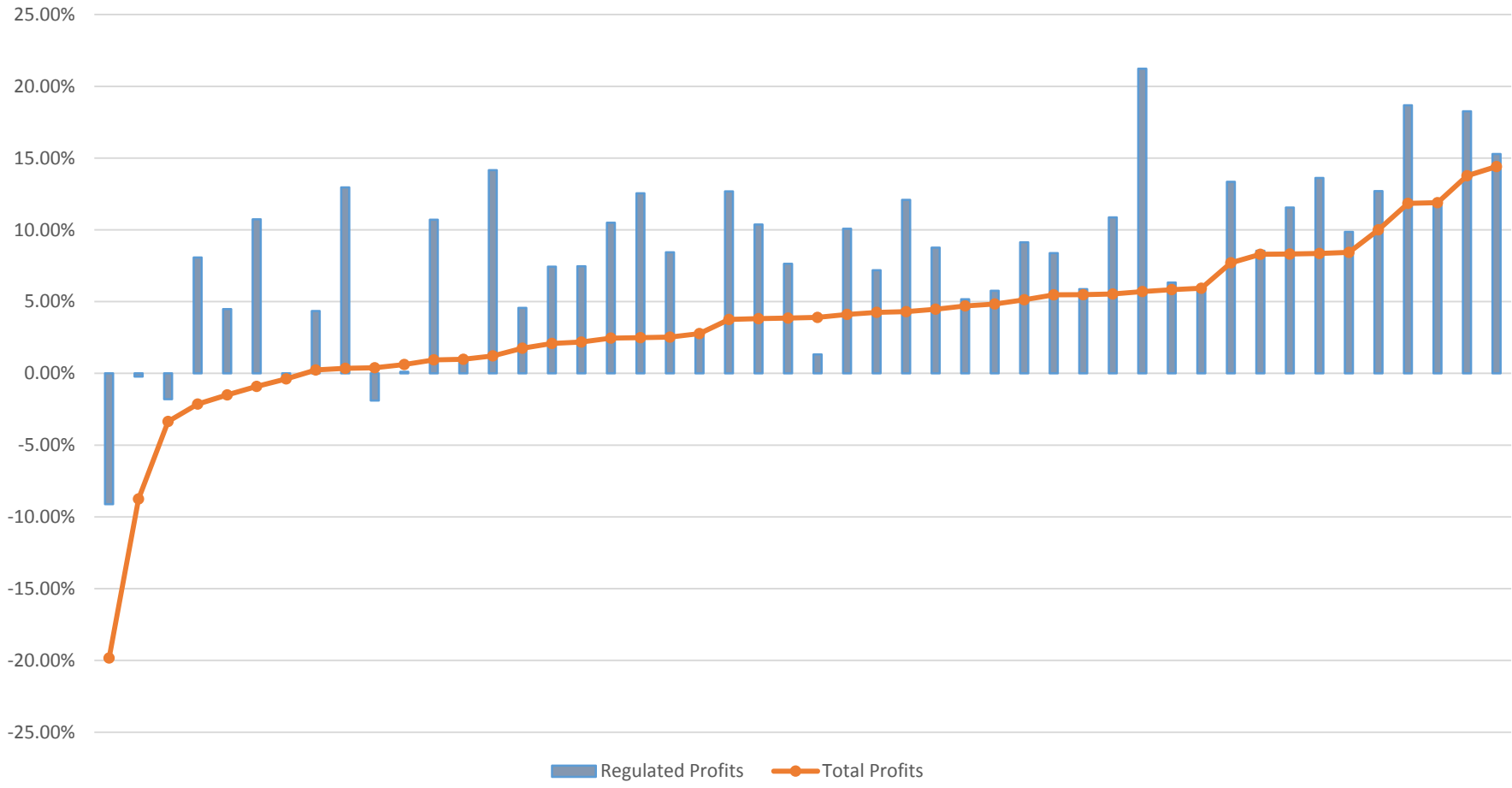
Regulated and Total Operating Profits by Hospital

Fiscal Year to Date (July 2015 – January 2016)



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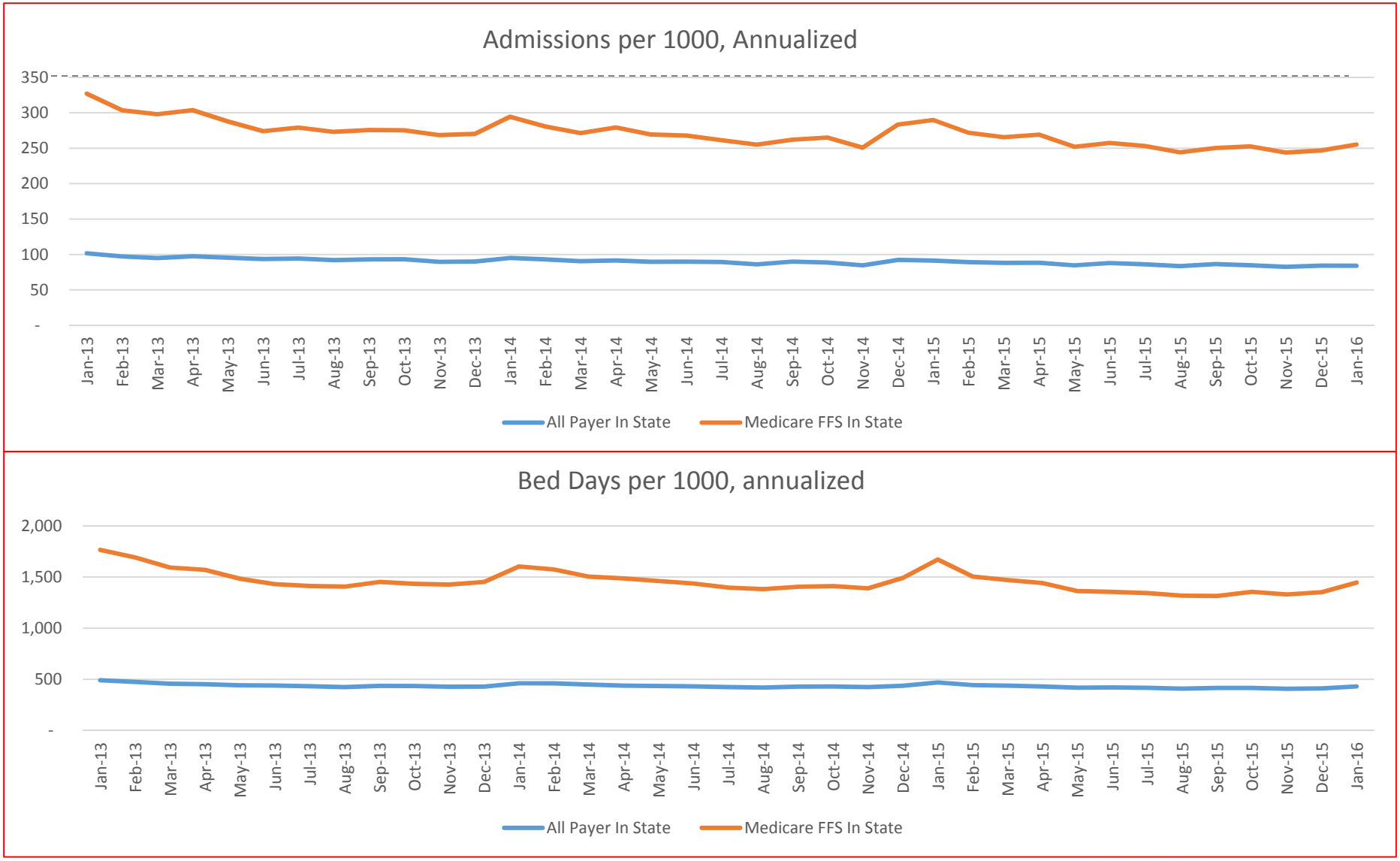
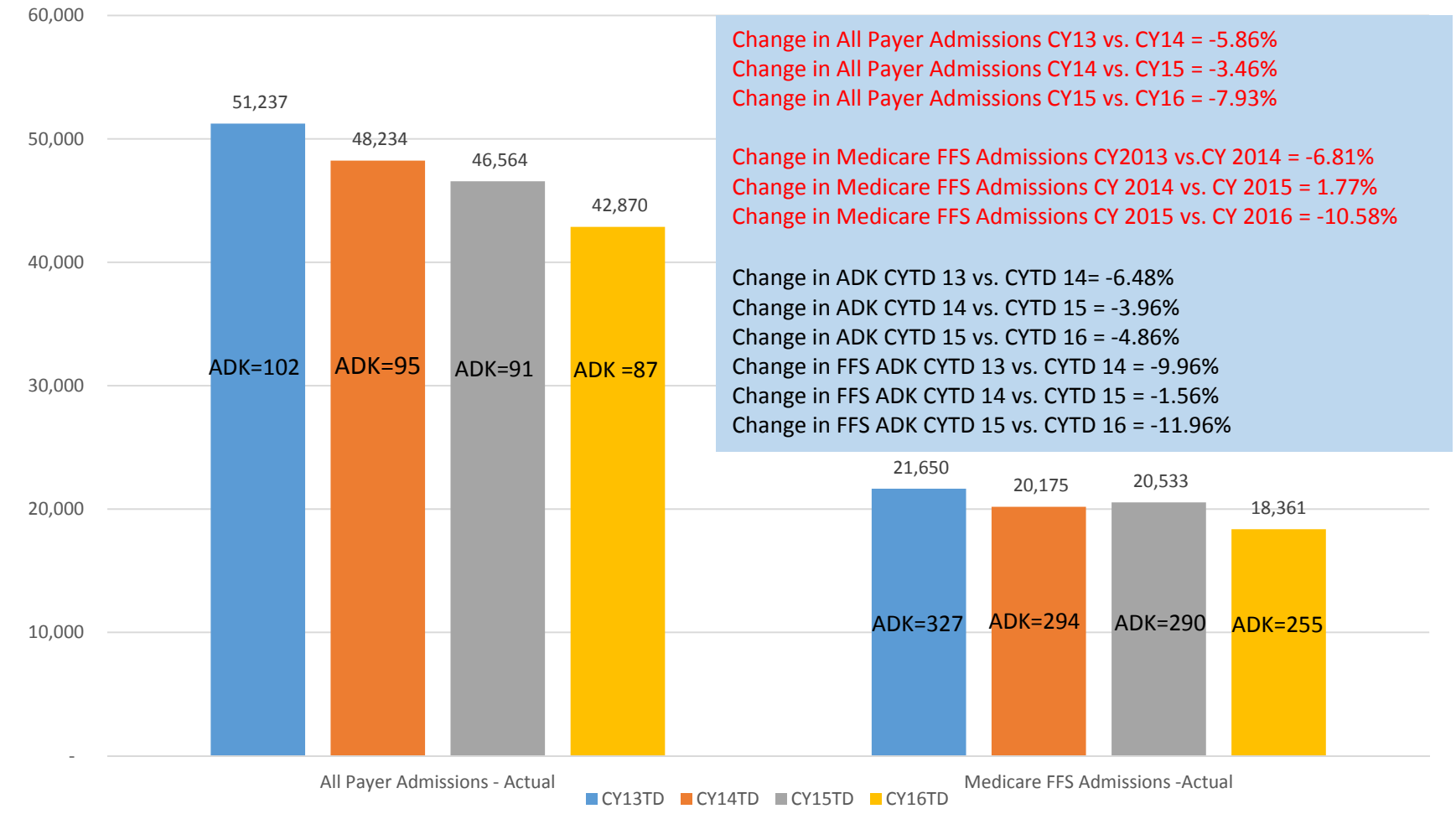
In State Admissions, Bed Days Per 1000, Annualized



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

In State Admissions by CYTD through January 2016



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

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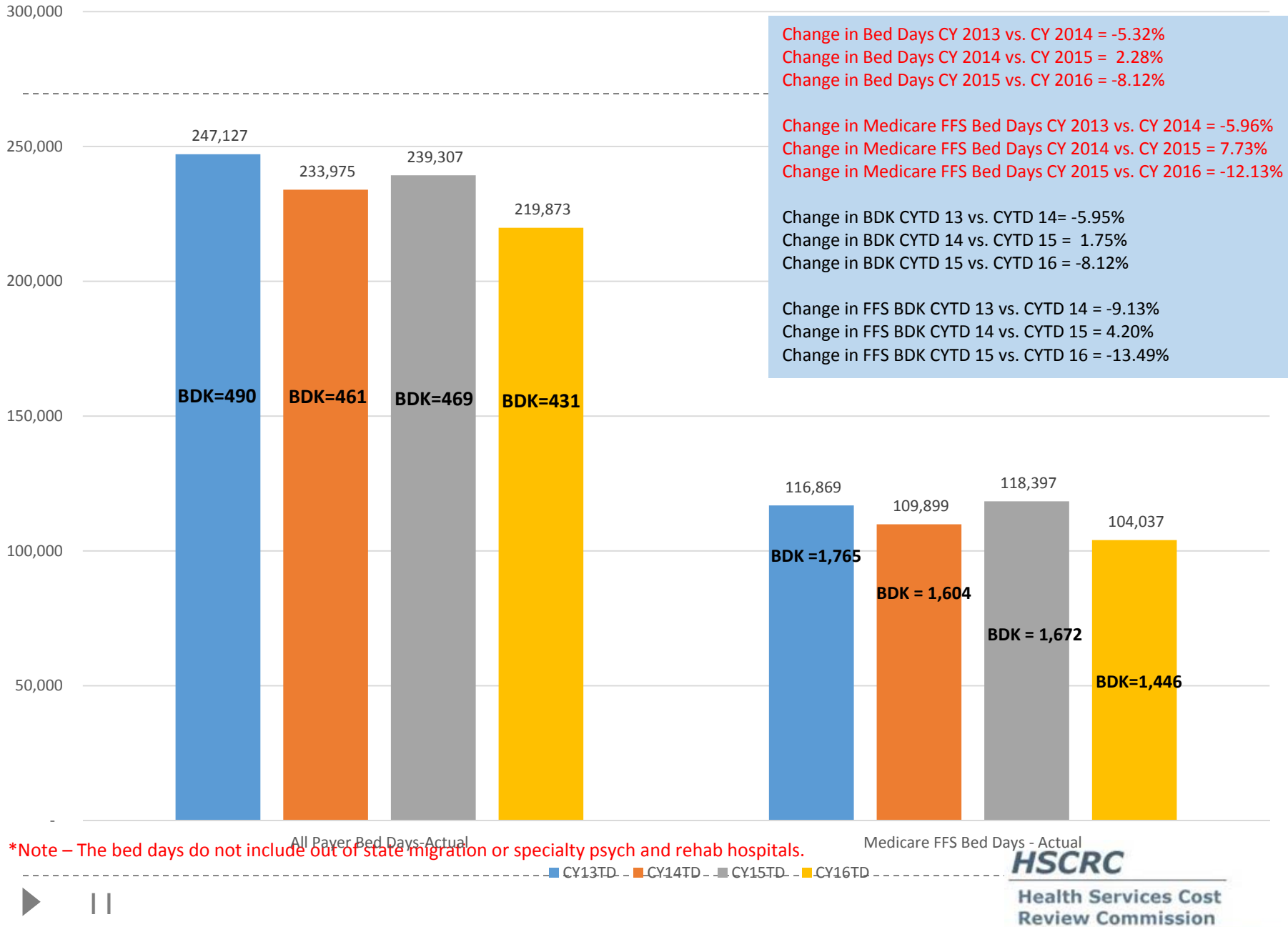
In State Bed Days by CYTD through January 2016



Change in Bed Days CY 2013 vs. CY 2014 = -5.32%
Change in Bed Days CY 2014 vs. CY 2015 = 2.28%
Change in Bed Days CY 2015 vs. CY 2016 = -8.12%

Change in Medicare FFS Bed Days CY 2013 vs. CY 2014 = -5.96%
Change in Medicare FFS Bed Days CY 2014 vs. CY 2015 = 7.73%
Change in Medicare FFS Bed Days CY 2015 vs. CY 2016 = -12.13%

Change in BDK CYTD 13 vs. CYTD 14= -5.95%
Change in BDK CYTD 14 vs. CYTD 15 = 1.75%
Change in BDK CYTD 15 vs. CYTD 16 = -8.12%

Change in FFS BDK CYTD 13 vs. CYTD 14 = -9.13%
Change in FFS BDK CYTD 14 vs. CYTD 15 = 4.20%
Change in FFS BDK CYTD 15 vs. CYTD 16 = -13.49%

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

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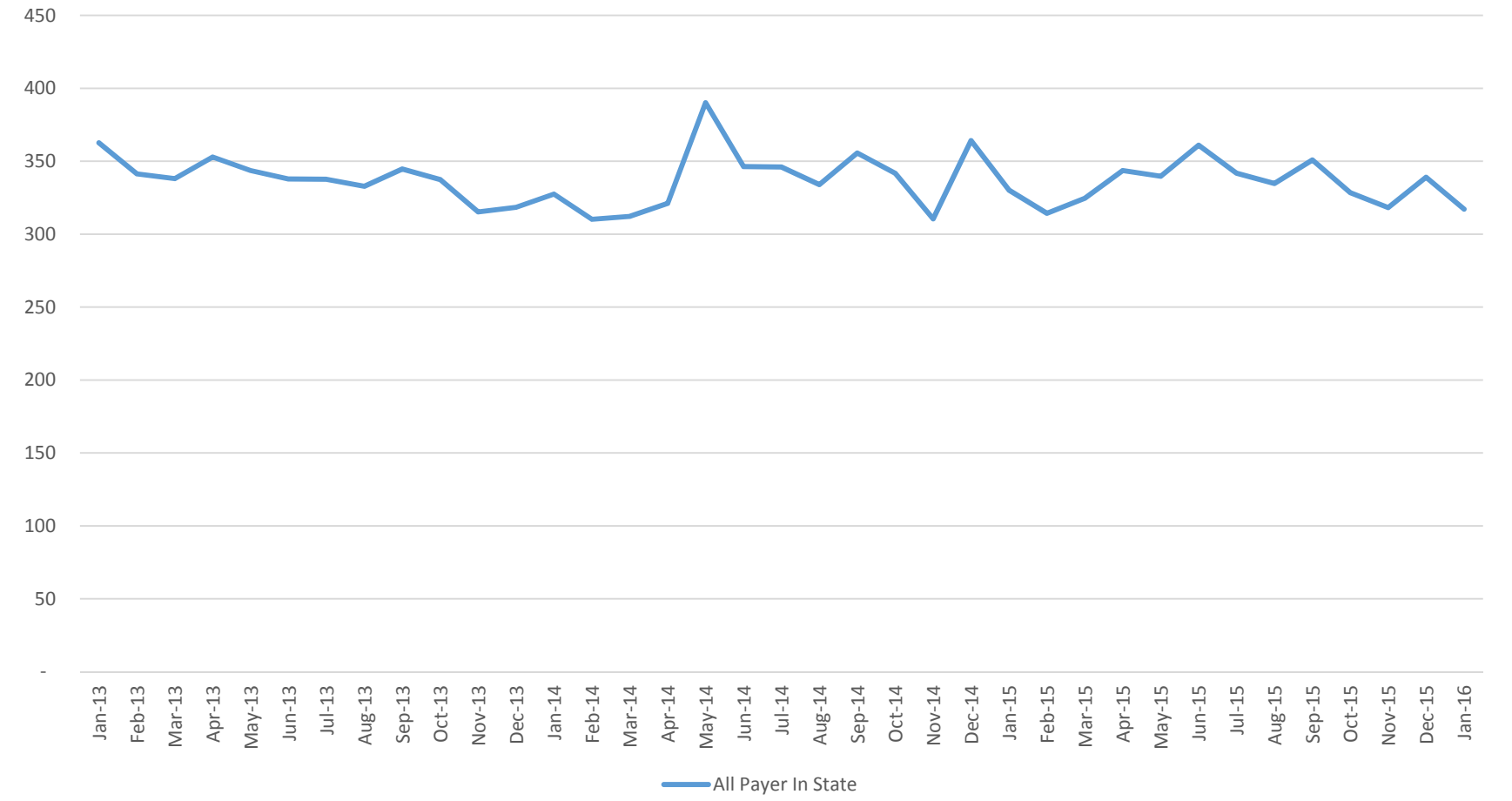
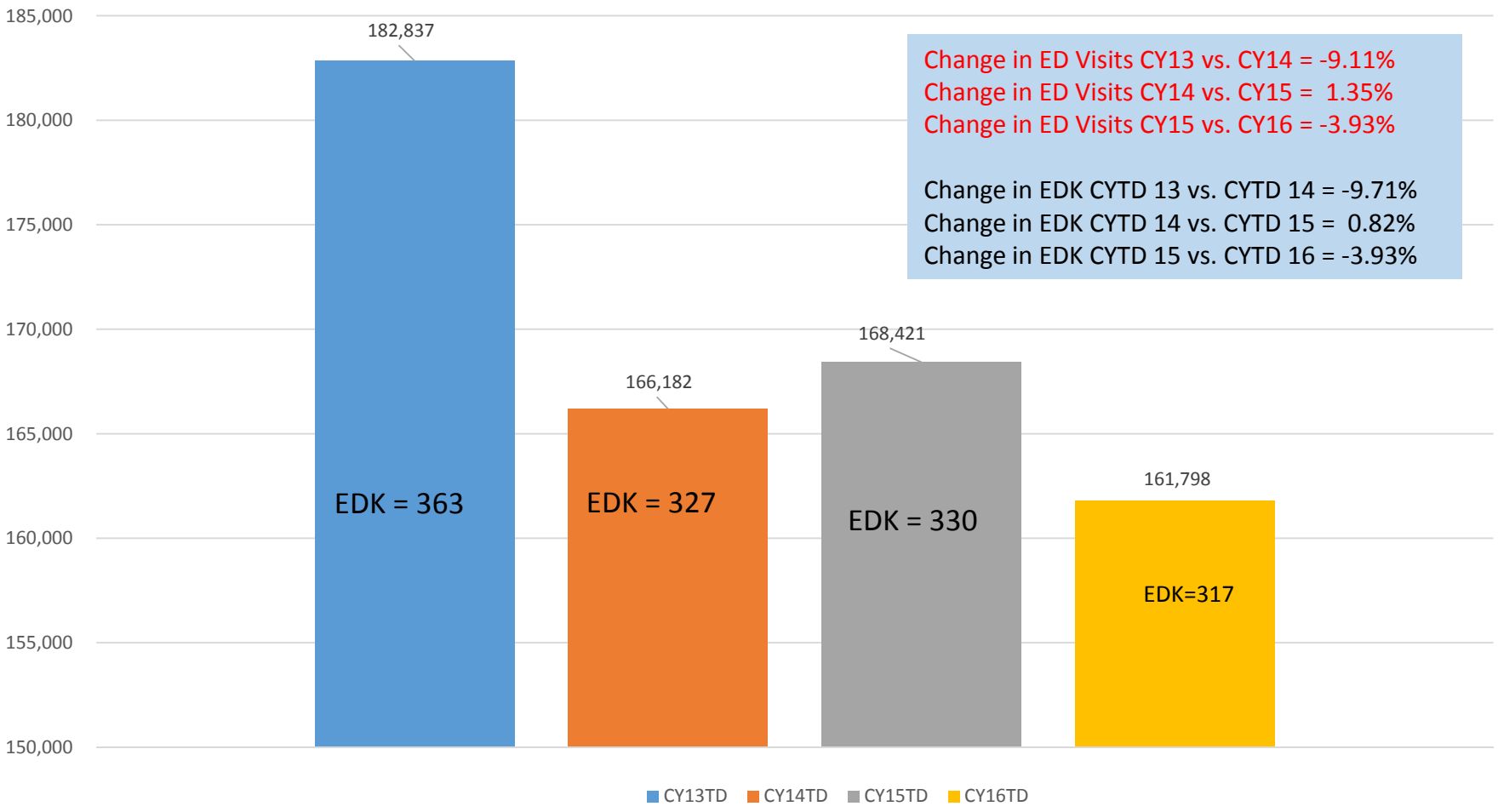
In State, All Payer ED Visits Per 1000 Annualized



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

In State All Payer ED Visits by CYTD through January 2016



Change in ED Visits CY13 vs. CY14 = -9.11%
Change in ED Visits CY14 vs. CY15 = 1.35%
Change in ED Visits CY15 vs. CY16 = -3.93%

Change in EDK CYTD 13 vs. CYTD 14 = -9.71%
Change in EDK CYTD 14 vs. CYTD 15 = 0.82%
Change in EDK CYTD 15 vs. CYTD 16 = -3.93%

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

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Purpose of Monitoring Maryland Performance

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

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

Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 and Fiscal 2016 rely on Maryland Department of Planning projections of population growth of .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.

Data Caveats cont.

- The source data is the monthly volume and revenue statistics.
- ADK – Calculated using the admissions multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- BDK – Calculated using the bed days multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- EDK – Calculated using the ED visits multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- All admission and bed days calculations exclude births and nursery center.
- Admissions, bed days, and ED visits do not include out of state migration or specialty psych and rehab hospitals.

Skilled Nursing Facility Utilization and Expenditures

Year to Date Thru September 2015

Growth in Part A Expenditures

- In Year 2, Part A expenditures significantly contributing to growth in TCOC spending:
  - Non-Hospital growing at a much faster rate than hospital Part A
  - Largest growth in Home Health, but largest % in spending per bene in SNF expenditures
- Causing pressure on the TCOC guardrail for Maryland

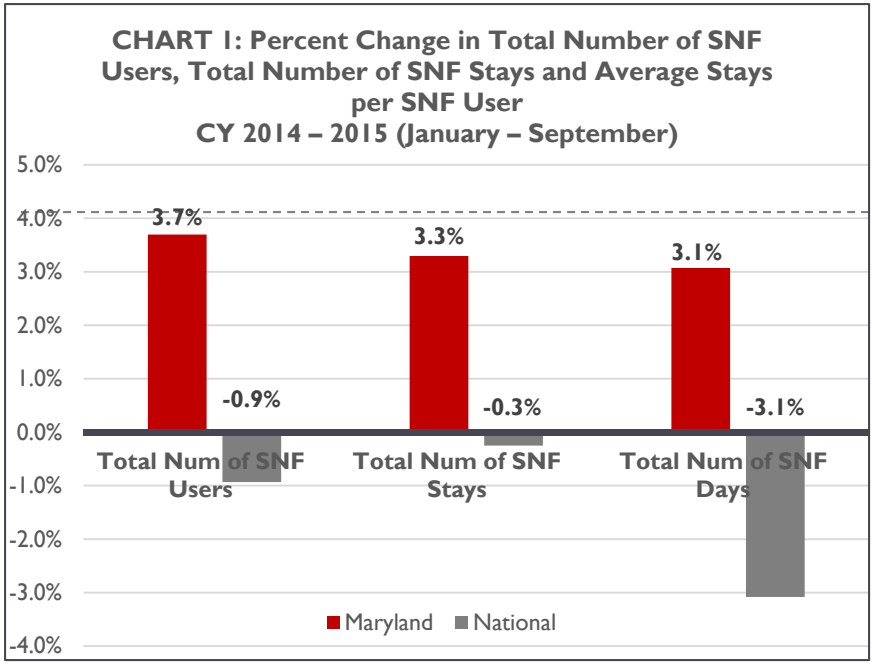
Estimated Maryland Medicare Part A Spending per Beneficiary, CYTD Sept 2014 vs CYTD Sept 2015

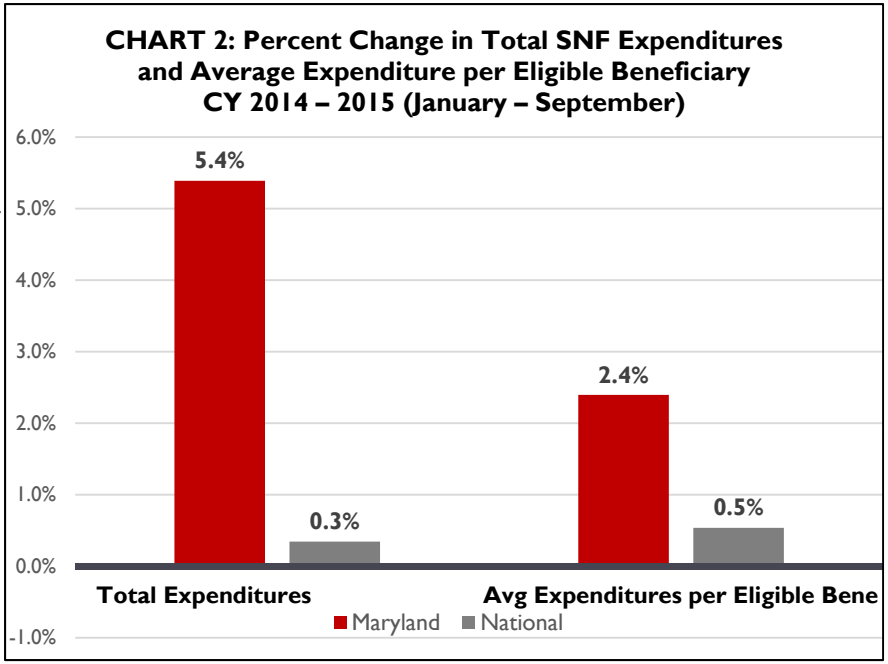
Provider Type	CYTD 2014 Spend	CYTD 2014 Spend Per Beneficiary	CYTD 2015 Spending	CYTD 2015 Spending Per Beneficiary	Spending Change	Spending per Beneficiary Change	% per Beneficiary Change
Non Hospital							
SNF	$473,442,116	$580.98	$499,985,384	$594.87	$26,543,268	$13.89	2.4%
HHA	$193,894,382	$237.94	$213,178,547	$253.64	$19,284,165	$15.70	6.6%
Hospice	$126,391,856	$155.10	$135,720,859	$161.48	$9,329,003	$6.38	4.1%
Non Hospital Subtotal	**$793,728,354**	**$974.02**	**$848,884,790**	**$1,009.98**	**$55,156,436**	**$35.97**	**3.7%**

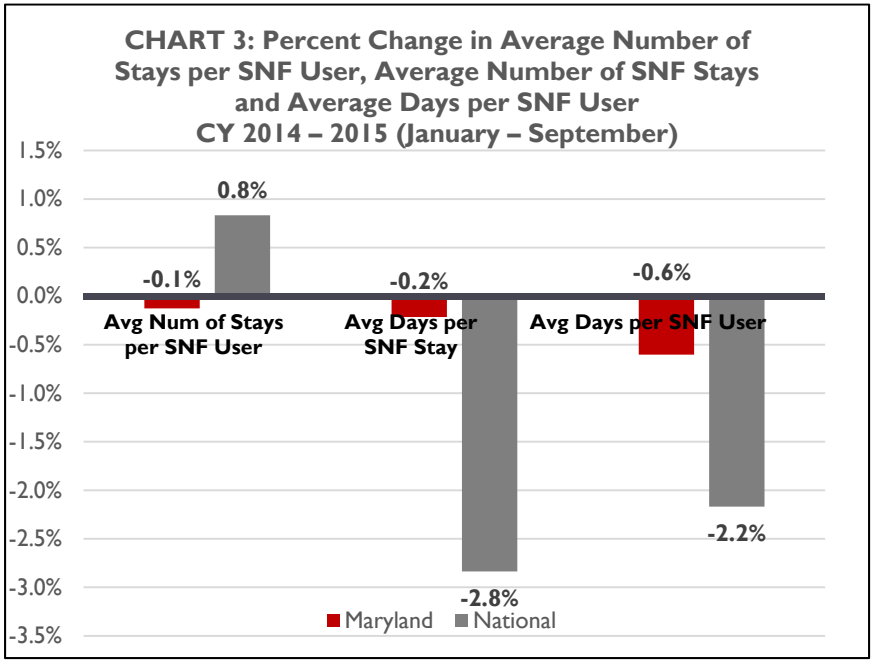
Trends in SNF Utilization & Expenditures

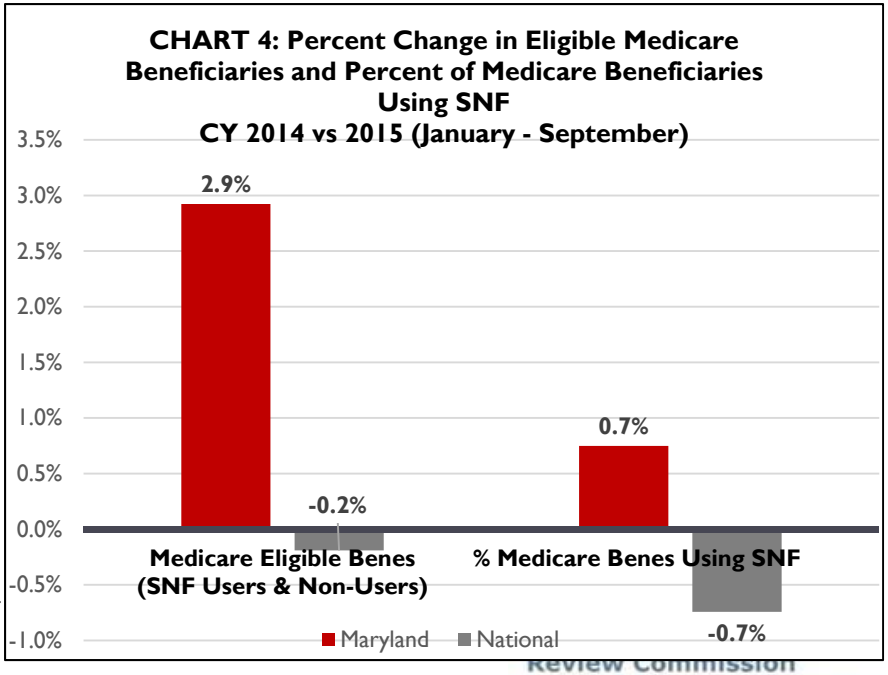
The number of Medicare beneficiaries' using SNF, as well as total SNF expenditures, are increasing at a much higher rate in Maryland, compared to the Nation

- SNF users increasing by 4%, both SNF stays and days increasing by 3% (Chart 1)
- Expenditures increasing by 5% and average expenditure per eligible beneficiary increasing by 2% (Chart 2)
- SNF LOS is also declining in MD, though not as fast as Nationally, illustrated by the average number of days per SNF user, average number of days per SNF stay and the average number of days per SNF user (Chart 3)
- Maryland has a higher increase in beneficiaries in Medicare FFS, which accounts for some of the difference (Chart 4)

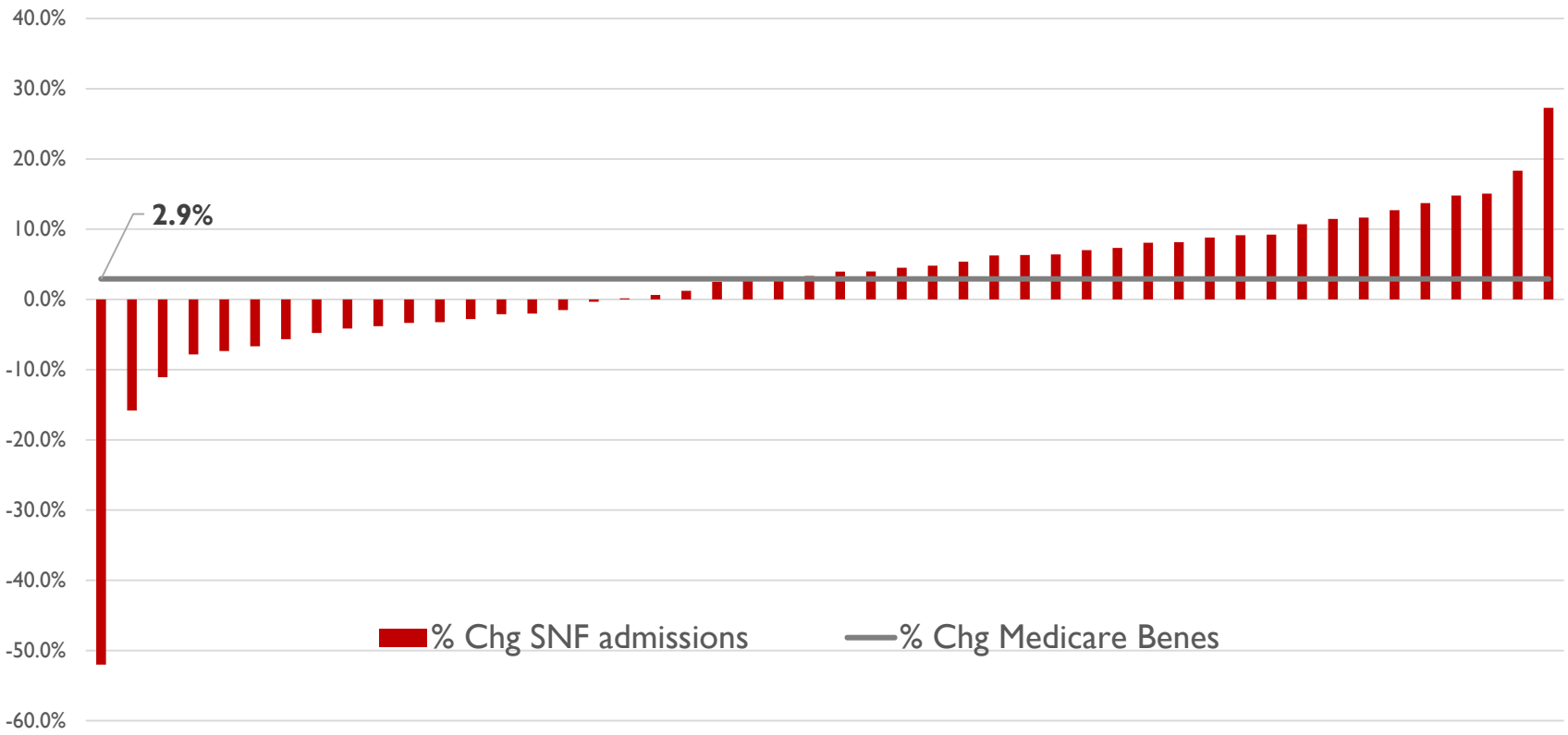








Percent Change in SNF Admissions from Inpatient Discharges By Hospital CY 2014 vs 2015 (January - September)



Data Note: This graph represents a subset of SNF admissions for MD Medicare Beneficiaries and includes discharges from out-of-state hospitals to MD SNFs and discharges from MD Non-Regulated IP Hospitals to MD SNFs

Data Caveats

- Data contained in this document represent analyses prepared by HSCRC staff based on data provided by the Federal Government.
- Maryland data represents a subset of SNF admissions and does not include admissions from inpatient discharges during which substance abuse treatment was provided ("SAMSHA claims").
- National data is based on analysis of a 5% sample of national SNF claims and also excludes SAMSHA claims.
- The intent of this analysis is to provide early indications of the spending trends in Maryland for Medicare patients, relative to national trends.
- This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation 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.

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

AS OF MARCH 2, 2016

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
2317R	Holy Cross Health	11/6/2015	2/10/2016	4/4/2016	CAPITAL	GS	OPEN
2319R	Sheppard Pratt Health System	11/24/2015	3/9/2016	4/22/2015	CAPITAL	GS	OPEN
2320N	Sheppard Pratt Health System	11/24/2015	3/9/2016	4/22/2015	OBV	DNP	OPEN
2337R	LifeBridge Health, Inc.	2/11/2016	3/14/2016	7/11/2016	Cancer Center	GS	OPEN
2338A	Johns Hopkins Health System	2/26/2016	N/A	N/A	ARM	DNP	OPEN

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2014**
SYSTEM	*	**FOLIO:**	**2148**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2338A**

Staff Recommendation

March 9, 2016

I. INTRODUCTION

Johns Hopkins Health System (System) filed an application with the HSCRC on February 26, 2016 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in an amended global rate arrangement for solid organ transplant, bone marrow transplant, and cardiovascular services with Olympus Managed Health for a period of one year beginning April 1, 2016.

II. OVE RVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving kidney, bone marrow transplants, and cardiovascular services at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that the experience under this arrangement for the last year was favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ, bone marrow transplant, and cardiovascular services for a one year period commencing April 1, 2016. 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.

DRAFT Recommendation for Updating the Readmissions Reduction Incentive Program for Rate Year 2018

HSCRC Commission Meeting

03/09/2016

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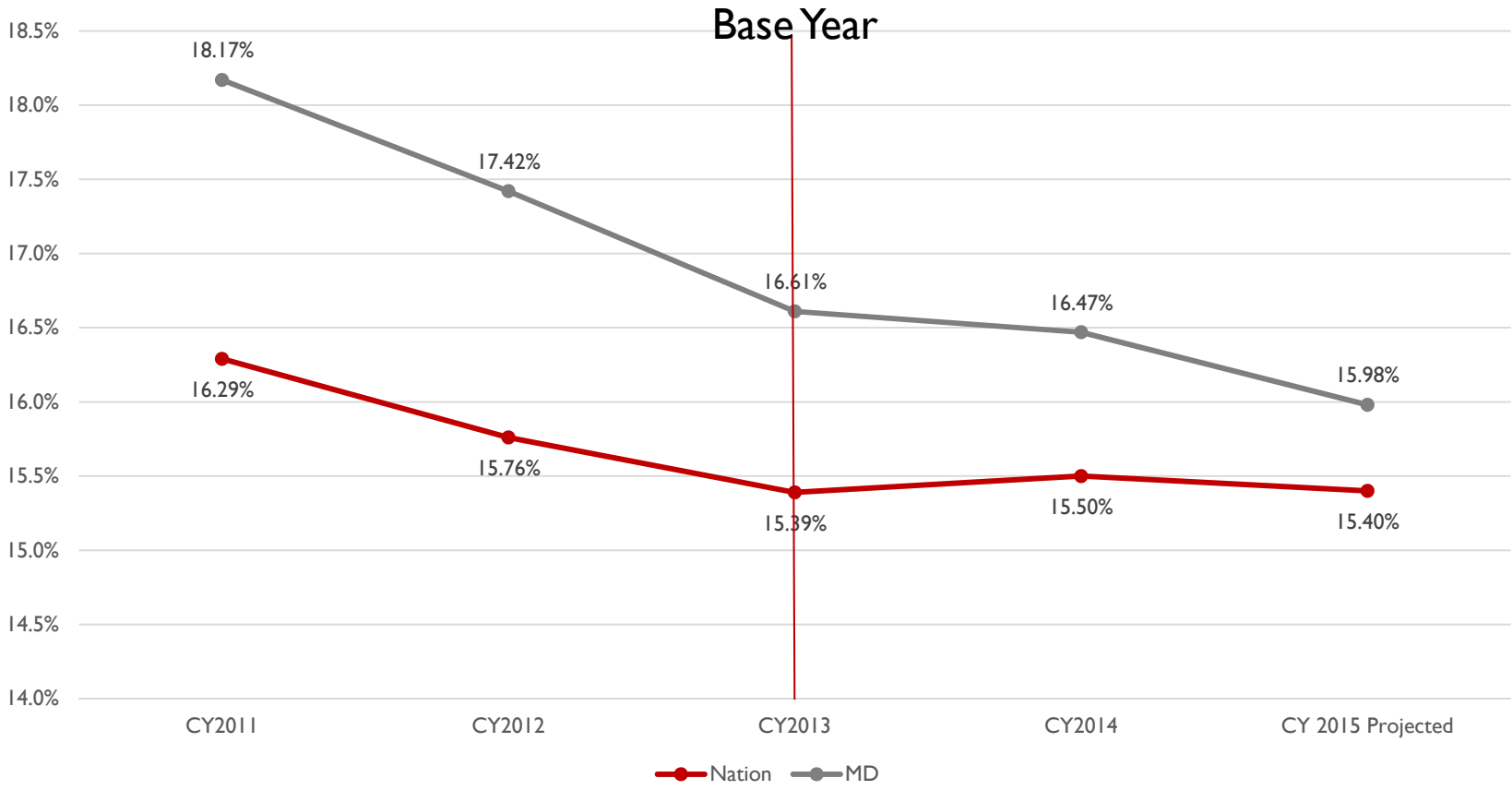
RRIP Background

- Started in CY 2014 performance year with 0.5% inpatient revenue bonus if a hospital reduced its case-mix adjusted readmission rate by 6.76% in one year.
- Last year
  - Improvement target was set at 9.3% over two years (CY 2015 compared to CY 2013 rates)
  - Rewards scaled up to 1% commensurate with improvement rates
  - Penalties scaled up to -2% were introduced for hospitals that were below the improvement target commensurate with improvement rates
  - Continue to evaluate factors that may impact performance and meeting Medicare readmission benchmarks

Medicare Benchmark: At or below National Medicare Readmission Rate by CY 2018

Maryland is reducing readmission rate faster than the nation. Maryland is projected to reduce the gap from 7.93% in the base year to 3.74 % in CY 2015



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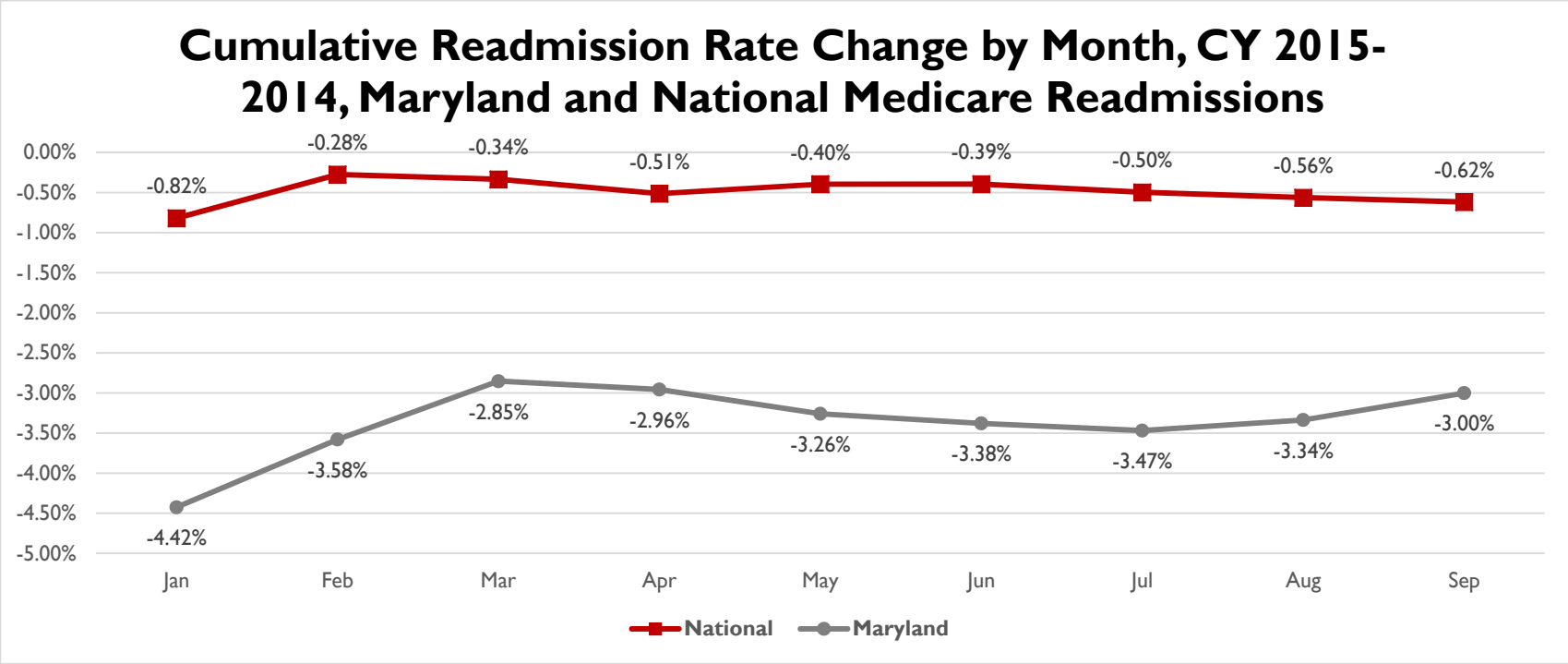
Maryland is projected to meet Medicare Readmission Target in CY 2015 based on data through September 2015

- National Readmission Rate Change = -0.62%
- Maryland Target = -2.08%
- Maryland Readmission Rate Change = -3.00%



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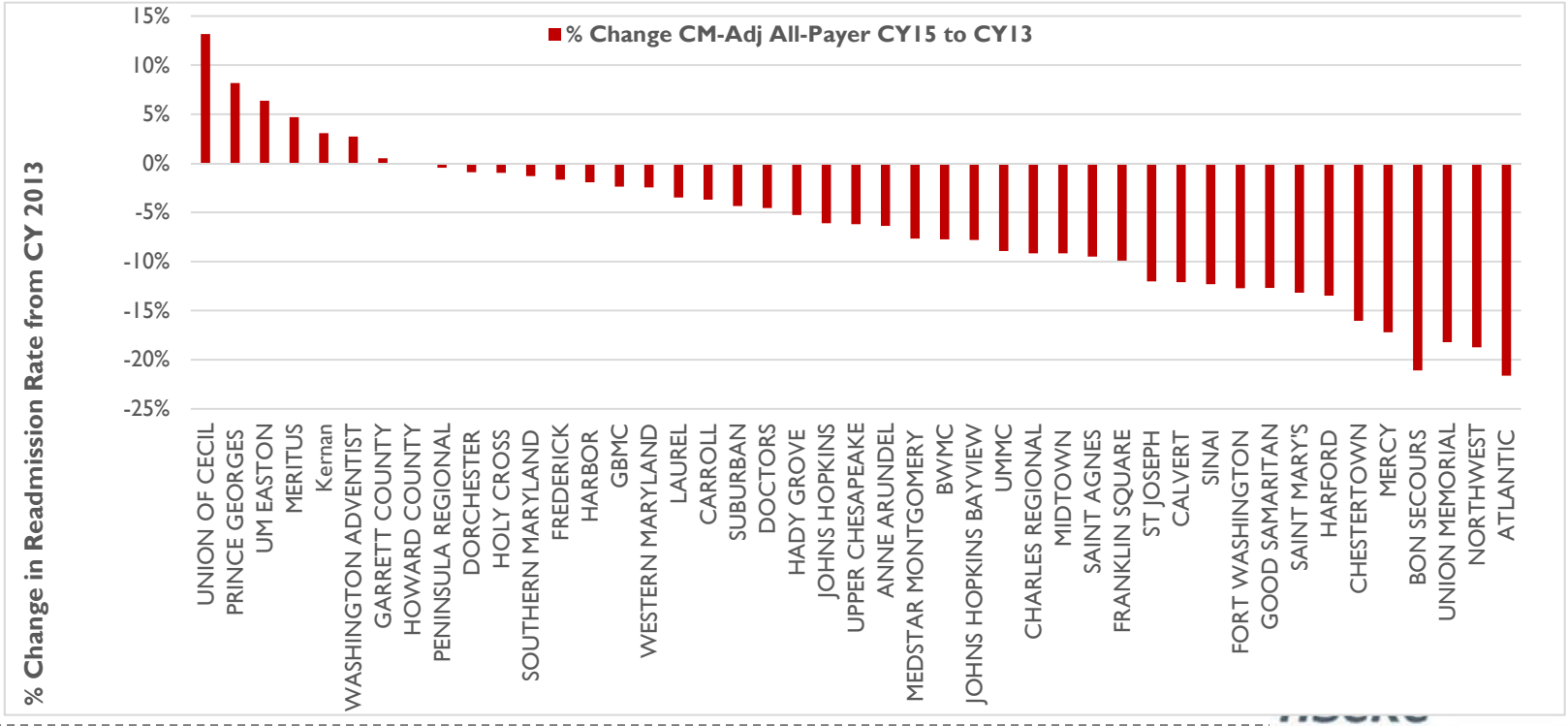
Calculation of CY 2016 Target

Measurement Years	Base Year MD/ National Readmission Rate	Assumed National Rate of Change	Actual National Rate of Change	Actual National Cumulative Change	MD Cumulative Medicare Rate of Target	All Payer to Medicare Readmission Rate Percent Change Difference	Cumulative All Payer Target
CY 14	8.88%	**-5.00%**	0.71%	0.71%	-6.76%		**-6.76%**
CY15	7.70%	**-1.34%**	-0.62%	0.09%	-4.67%	-4.63%	**-9.30%**
Modeling Results for CY16:							
CY16 - Current Rate of Change	7.93%	**-0.62%**			-5.53%	-3.53%	-9.06%
CY16 -Lowess Model Lowest Bound	7.93%	**-0.84%**			-5.84%	-3.53%	-9.37%
CY 16 Long Term Historial Trend	7.93%	**-1.76%**			-9.18%	-3.53%	-12.71%

Overall, All-Payer readmission rates declined by 7.2 percent Jan-October 2014

- One-third of the hospitals meeting or exceeding the 9.3% reduction target. Seven hospitals had an increase in their readmission rates, with the highest increase of 13%.



Analyses of Issues Discussed in FY 2017 Policy

- Should we set the improvement target for Medicare vs All-Payer
  - Stronger relationship between Medicare and All-Payer Readmission improvements with CY 2015 performance at the state-level, some hospitals have better improvements in Medicare compared to All-Payer and vice versa.
- Would a hospital with overall reductions in admissions have a lower reduction in readmissions
  - CY 2015 analysis show hospitals with overall admission reductions also have larger reductions in readmission rates (see Appendices III and IV).

Analyses of Issues Discussed in FY 2017 Policy - Continued

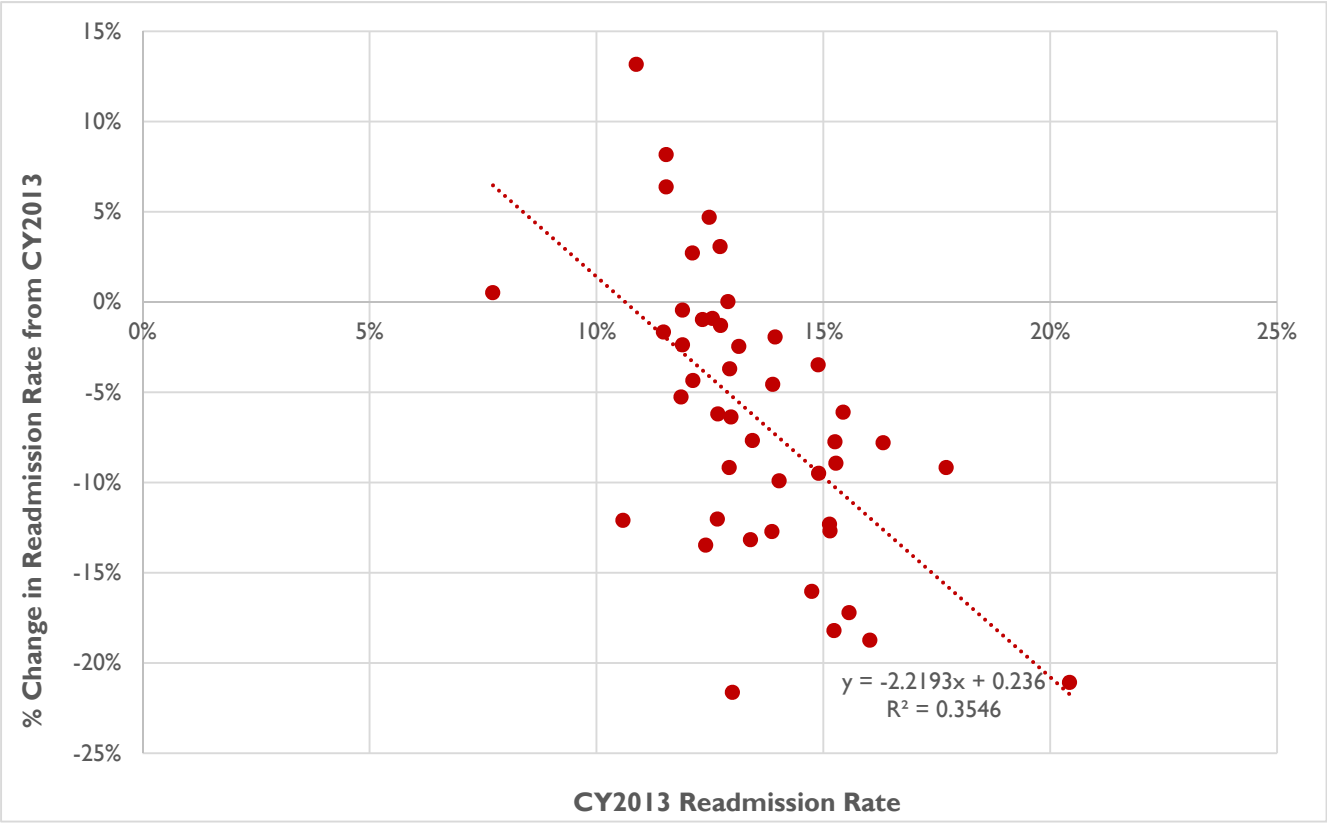
- Does the performance vary by the socio-economic and demographic (SES/D) characteristics of patients served?
  - Research on the impact of socio-economic and demographic factors on readmission rates is growing.
  - Staff is working on developing an appropriate measure of SES/D such as Area Deprivation Index (ADI).
  - Preliminary analysis indicates that there is no correlation between high ADI and readmission rate reductions.
- Does the use of Observation for the emergency cases impact the readmission trend ?
  - The statewide improvement rate is slightly lower when we include observation stays in the calculations. Staff will evaluate hospital level results and may make modifications to the RRIP payment adjustments.

Readmission Rate vs Improvement

- Stakeholders expressed interest in developing a risk adjustment model to measure whether a hospital has a low or high readmission rate (i.e. attainment).
- Several technical challenges to develop accurate readmission risk adjustment.
  - SES/D impact
  - Readmissions occurring at out-of-state hospitals
  - Benchmarks, state data would not be sufficient to set best practice benchmarks
  - Payment adjustments to combine improvement vs attainment

Correlation between CY 2013 Readmission Rate and Improvement

- Hospitals with lower CY 2013 Readmission Rates appear to have lower reductions.



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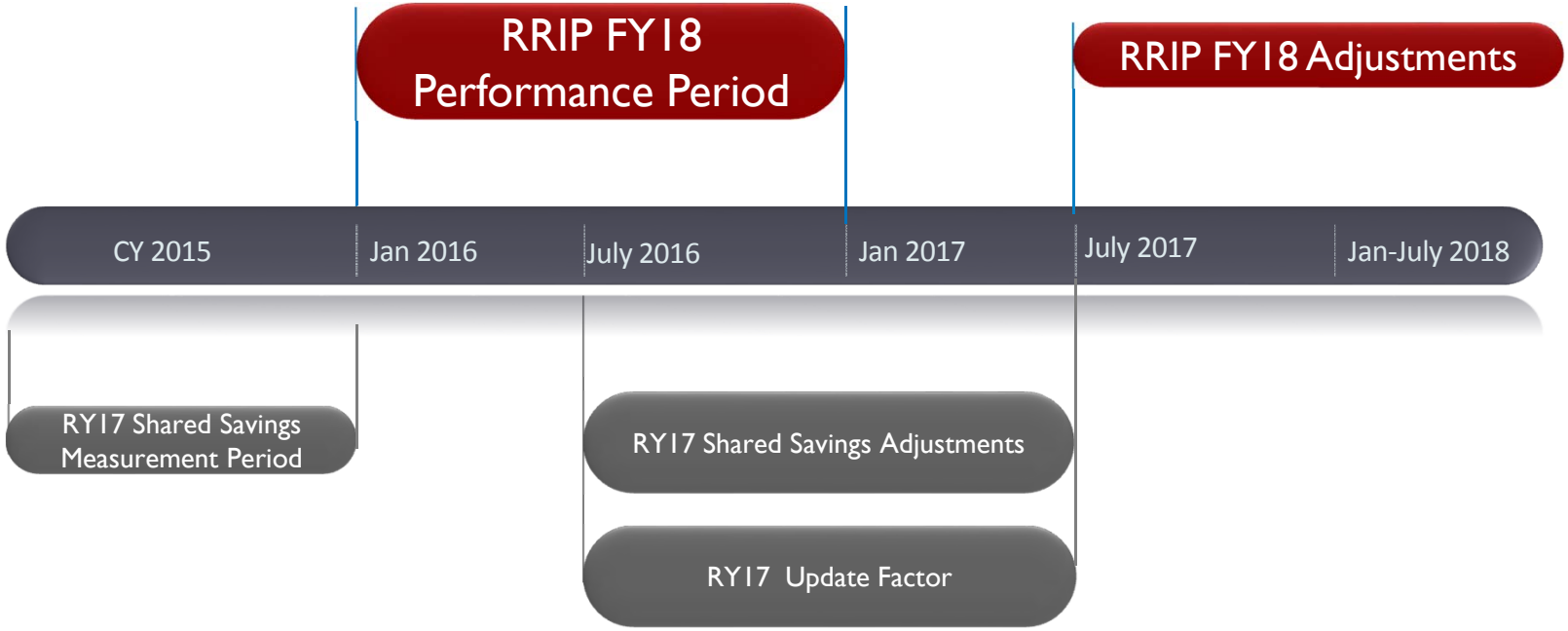
Adjusting Readmission Improvement Target

- CY 2015 performance year indicates a stronger relationship between improvement rates and base year readmission rates at the state-level analysis.
- Examples exist where two hospitals with the same base year low readmission rates have very different trends: one has an increase in its readmission rate, the other has a decline.
- Staff's initial recommendation is to adjust the readmission improvement rate downward for hospitals with lower readmission rates but expect some level of improvement from all hospitals.

Shared Savings and RRIP linkage

- Although we do not have "attainment" measurement under RRIP, shared savings adjustments have been based on historical case-mix adjusted readmission rates.
- For RY 2016, the average net adjustment was -0.30% of inpatient revenue with the highest reduction at -0.46% and minimum at -0.10% .
- Staff will be evaluating and discussing other options for shared savings to focus attention more broadly on avoidable admissions/hospitalizations (Potentially Avoidable Utilization, or PAUs).

RRIP and Shared Savings Timelines



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PAU distribution: All-Payer vs Medicare

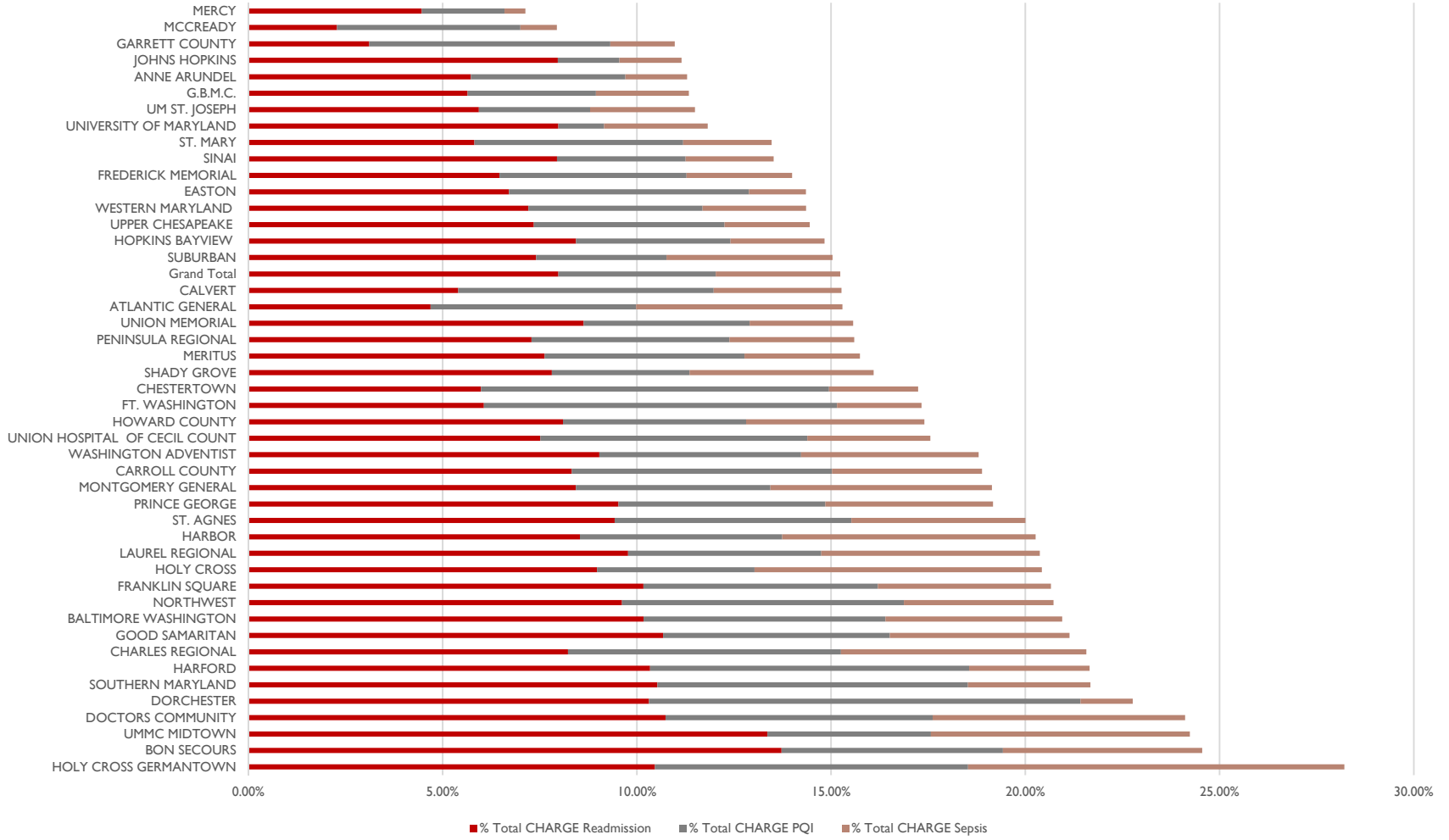
- Staff is proposing to add sepsis admissions and remove MHACs from PAU to focus more on utilization reductions.
- Overall, PAUs are 15% of total hospital charges in Maryland in CY 2015; 55% of total PAUs are for Medicare patients. Compared to CY 2013 levels, PAUs decreased by -0.5% for All-Payer and increased by 1.8% for Medicare patients.

	All Payer					Medicare					
	Total Charge CY15	ECMAD CY15	ECMAD CY13	% ECMAD Change CY13-CY15	% Grand Total Charge	Total Charge CY15	ECMAD CY15	ECMAD CY13	% ECMAD Change CY13-CY15	% Grand Total Charge	% Medicare
Readmission	$1,288,435,419	90,260	95,614	-5.6%	8.0%	$680,347,206	50,068	52,034	-3.8%	11.2%	53%
PQI	$651,465,870	51,679	52,100	-0.8%	4.1%	$391,016,430	30,914	29,969	3.2%	6.4%	60%
Sepsis	$516,098,092	39,131	34,251	14.2%	3.2%	$288,257,794	22,887	20,013	14.4%	4.7%	56%
PAU Total	**$2,455,999,381**	**181,069**	**181,966**	**-0.5%**	**15.3%**	**$1,359,621,430**	**103,868**	**102,016**	**1.8%**	**22.4%**	**55%**
Grand Total	**16,073,397,565**	**1,155,421**	**1,161,441**	**-0.5%**	**100%**	**$6,079,614,526**	**447,172**	**440,416**	**1.5%**	**100.0%**	**38%**

	Total Charge CY15	PPC Count CY15	PPC Count CY 13	% PPC Count Change CY13-CY15	% Grand Total Charge	Total Charge CY15	ECMAD CY15	ECMAD CY13	% PPC Count Change CY13-CY15	% Grand Total Charge	% Medicare
PPCs/MHACs	$231,919,620	21,026	29,740	-29.30%	1.44%	$129,912,439	11,143	10,910	-27.50%	2.14%	56%

Annualized based on Jan-September 2015 Final data. Updated 02-29-2016

% Total Charges in PAU varies between 7% to 28% - CY 2015 All-Payer Jan-Sept.



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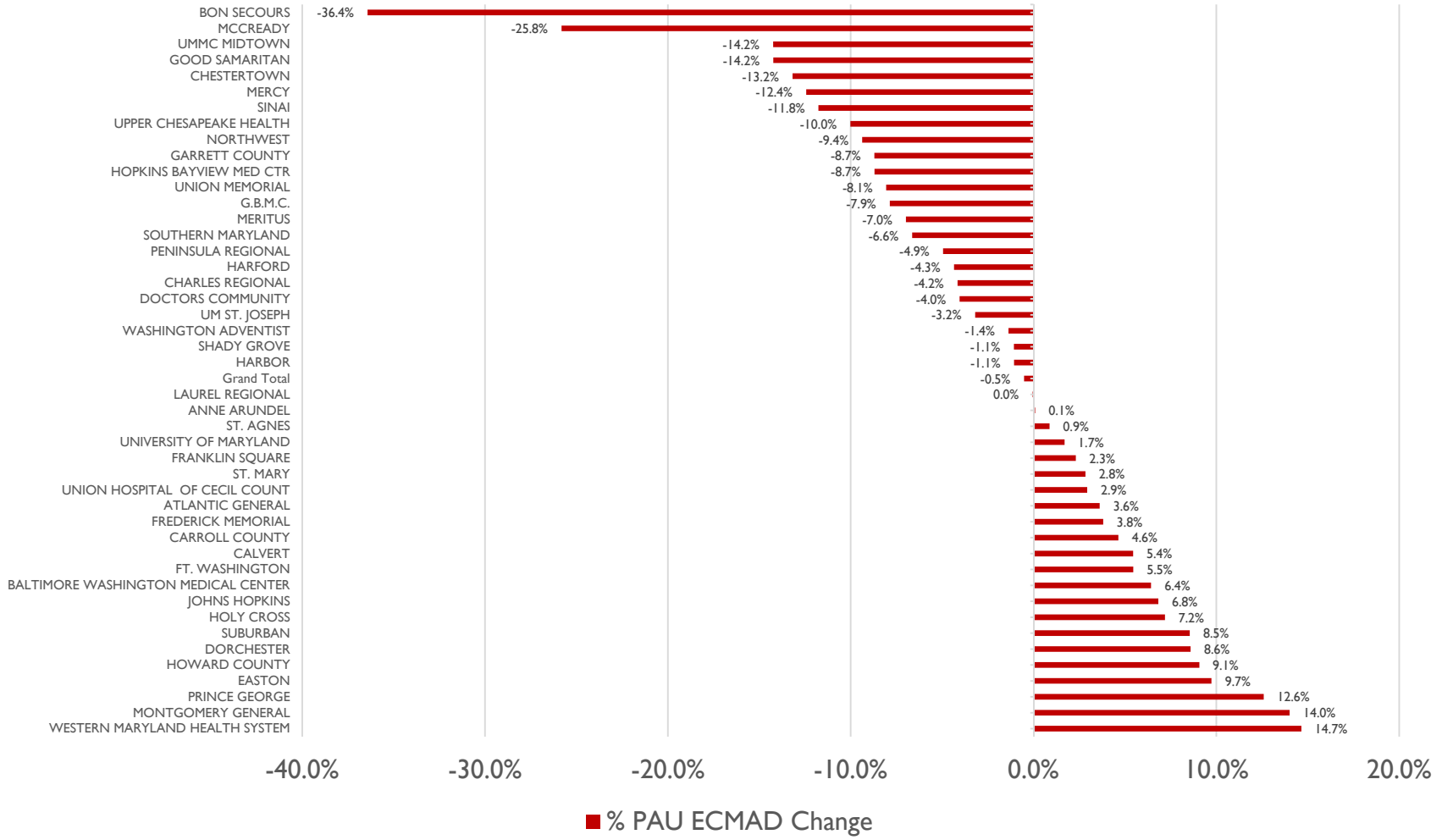
Average PAU ECMAD change between CY 2013 vs CY 2015 Was -0.5 %



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Considerations for the RY 2017 RRIP Policy

- Recognize improvement in the Medicare readmission rates.
- Adjust the All-Payer readmission target for hospitals whose readmission rates are lower than the statewide average as proposed for the RY 2018 policy.
- The Maryland Hospital Association is proposing to reduce the RY 2017 target to the statewide average reduction rate (current trend is at 7.2% decline) and remove all of the penalties if a hospital's readmission rate was in the lowest quintile in both CY 2013 and CY 2015. Staff does not agree with changing the overall target.

Draft Recommendations for the RY 2018 RRIP Policy

- The reduction target should continue to be set for all-payers.
- The All-Payer reduction target should be set at 9.5 percent.
- The reduction target should be adjusted downward for hospitals whose readmission rates are below the statewide average.

CY 2015 Readmission Year to Date Results

Provider ID	Hospital Name	CY 2013 CM-Adj All-Payer Readmission Rate	HSCRC CY15 YTD Case-Mix Adjusted Readmission Rate	% Change CM-Adj All-Payer CY14 to CY13	% Change CM-Adj All-Payer CY15 to CY13	% Change in Adj Readmission Rate for Medicare FFS	% Change in Eligible Discharges CY13 to CY15 YTD	All-Payer Mean ADI	% All-Payer Patients >=85th ADI Percentile	% Medicaid Discharges of All-Payer
210061	ATLANTIC	13.0%	9.87%	-5.85%	-21.63%	-24.48%	0.65%	101.41	13.72%	15.44%
210013	BON SECOURS	20.4%	16.08%	-14.39%	-21.08%	-17.65%	-25.33%	130.83	62.82%	59.16%
210040	NORTHWEST	16.0%	13.06%	-9.79%	-18.74%	-19.52%	-20.54%	105.29	16.42%	33.62%
210024	UNION MEMORIAL	15.2%	12.73%	-8.99%	-18.21%	-10.37%	-15.75%	114.38	33.11%	34.16%
210008	MERCY	15.6%	13.07%	-9.12%	-17.21%	-9.79%	-15.71%	115.64	36.41%	40.88%
210030	CHESTERTOWN	14.8%	12.46%	-11.73%	-16.03%	-15.40%	-12.22%	102.92	8.08%	28.30%
210006	HARFORD	12.4%	10.79%	-2.66%	-13.47%	-10.05%	-13.19%	102.64	15.05%	27.77%
210028	SAINT MARY'S	13.4%	11.98%	-15.90%	-13.17%	3.86%	-2.13%	93.70	3.00%	26.62%
210060	FORT WASHINGTON	13.9%	11.71%	1.66%	-12.72%	-1.72%	0.27%	96.78	7.95%	24.65%
210056	GOOD SAMARITAN	15.2%	13.18%	-4.29%	-12.68%	-15.48%	-17.51%	110.71	30.22%	29.01%
210012	SINAI	15.1%	13.23%	-6.87%	-12.31%	-11.63%	-15.86%	111.75	28.87%	38.23%
210039	CALVERT	10.6%	9.21%	-14.07%	-12.10%	-16.13%	-18.44%	91.89	1.06%	27.46%
210063	ST JOSEPH	12.7%	11.27%	-4.74%	-12.03%	-12.57%	1.17%	97.17	8.21%	17.42%
210015	FRANKLIN SQUARE	14.0%	12.69%	-1.43%	-9.91%	-12.43%	-4.74%	101.93	12.23%	36.23%
210011	SAINT AGNES	14.9%	13.44%	-9.60%	-9.49%	-7.81%	-5.82%	108.37	25.13%	33.17%
210035	CHARLES REGIONAL	12.9%	11.71%	2.78%	-9.17%	-9.78%	-21.00%	93.97	1.85%	26.91%
210038	MIDTOWN	17.7%	16.26%	-5.65%	-9.17%	-4.66%	-26.18%	130.44	58.47%	63.76%
210002	UMMC	15.3%	13.92%	-1.31%	-8.93%	-11.84%	-17.79%	110.25	29.41%	43.67%
210029	JOHNS HOPKINS BAYVIEW	16.3%	14.91%	-6.07%	-7.80%	-5.45%	-9.67%	111.45	29.11%	42.78%
210043	BWMC	15.3%	14.00%	-3.60%	-7.74%	-4.18%	-4.74%	96.11	4.59%	24.87%
210018	MEDSTAR MONTGOMERY	13.4%	12.43%	-7.74%	-7.67%	-6.84%	-5.75%	93.49	3.84%	18.75%
210023	ANNE ARUNDEL	13.0%	12.26%	-3.16%	-6.37%	-12.27%	-6.26%	92.59	3.92%	17.57%
210049	UPPER CHESAPEAKE	12.7%	11.55%	2.37%	-6.20%	-4.38%	-9.96%	95.34	8.47%	20.00%
210009	JOHNS HOPKINS	15.4%	14.42%	0.19%	-6.10%	-4.91%	-2.22%	110.56	29.67%	35.68%
210057	HADY GROVE	11.9%	11.28%	-4.80%	-5.26%	-5.44%	-19.66%	92.89	3.07%	26.14%
210051	DOCTORS	13.9%	12.90%	-14.18%	-4.56%	-1.06%	-15.74%	99.95	8.62%	25.48%
210022	SUBURBAN	12.1%	11.43%	-1.57%	-4.35%	-9.44%	0.92%	91.50	2.83%	11.57%
210033	CARROLL	12.9%	12.41%	-2.40%	-3.70%	-6.76%	-4.90%	92.62	4.28%	24.53%
210055	LAUREL	14.9%	14.41%	-7.39%	-3.48%	-13.35%	-15.06%	96.88	5.42%	40.30%
210027	WESTERN MARYLAND	13.1%	12.96%	-0.46%	-2.46%	-1.32%	-3.26%	108.27	18.74%	31.82%
210044	GBMC	11.9%	11.63%	-5.29%	-2.37%	-2.19%	-3.26%	97.61	9.47%	15.24%
210034	HARBOR	13.9%	13.70%	-2.37%	-1.94%	-5.19%	-14.36%	111.19	27.71%	48.60%
210005	FREDERICK	11.5%	11.23%	0.78%	-1.66%	-1.13%	-10.48%	93.48	3.80%	23.90%
210062	SOUTHERN MARYLAND	12.7%	12.44%	-4.00%	-1.30%	1.31%	-11.27%	97.99	8.73%	32.24%
210004	HOLY CROSS	12.3%	12.29%	5.43%	-0.97%	-6.10%	-0.35%	97.45	6.41%	28.44%
210010	DORCHESTER	12.6%	12.08%	-0.08%	-0.91%	9.92%	2.10%	109.28	27.82%	43.76%
210019	PENINSULA REGIONAL	11.9%	11.72%	2.77%	-0.45%	0.88%	-4.01%	109.29	27.75%	31.45%
210048	HOWARD COUNTY	12.9%	12.63%	-3.72%	0.02%	4.02%	7.04%	92.69	3.90%	20.49%
210017	GARRETT COUNTY	7.7%	7.70%	-5.70%	0.52%	-9.72%	0.06%	101.82	4.24%	36.29%
210016	WASHINGTON ADVENTIST	12.1%	12.45%	5.45%	2.72%	4.32%	-10.77%	101.84	10.83%	44.06%
210058	Kernan	12.7%	13.49%	0.16%	3.07%	8.11%	-9.90%	102.11	16.44%	25.35%
210001	MERITUS	12.5%	12.84%	2.24%	4.70%	5.26%	4.07%	101.70	14.97%	29.42%
210037	UM EASTON	11.5%	12.09%	14.99%	6.38%	0.47%	-2.74%	101.35	11.70%	33.30%
210003	PRINCE GEORGES	11.5%	12.50%	-6.76%	8.17%	10.18%	15.58%	103.78	14.60%	55.95%
210032	UNION OF CECIL	10.9%	12.67%	-0.83%	13.17%	19.70%	9.38%	98.99	7.42%	41.93%

CY 2015 (Jan-September) Percent Total Charge by PAU

Hospital Name	% Total CHARGE-NonPAU	% Total CHARGE PQI	% Total CHARGE Readmission	% Total CHARGE Sepsis	% Total CHARGE PAU TOTAL
HOLY CROSS GERMANTOWN	71.79%	8.06%	10.47%	9.69%	28.21%
BON SECOURS	75.45%	5.70%	13.72%	5.13%	24.55%
UMMC MIDTOWN	75.77%	4.21%	13.36%	6.66%	24.23%
DOCTORS COMMUNITY	75.89%	6.87%	10.74%	6.50%	24.11%
DORCHESTER	77.24%	11.11%	10.31%	1.34%	22.76%
SOUTHERN MARYLAND	78.32%	7.99%	10.53%	3.15%	21.68%
HARFORD	78.35%	8.21%	10.34%	3.10%	21.65%
CHARLES REGIONAL	78.43%	7.03%	8.23%	6.32%	21.57%
GOOD SAMARITAN	78.86%	5.83%	10.68%	4.63%	21.14%
BALTIMORE WASHINGTON MEDICAL CENTER	79.05%	6.23%	10.17%	4.55%	20.95%
NORTHWEST	79.27%	7.26%	9.62%	3.85%	20.73%
FRANKLIN SQUARE	79.34%	6.03%	10.17%	4.46%	20.66%
HOLY CROSS	79.57%	4.05%	8.97%	7.40%	20.43%
LAUREL REGIONAL	79.63%	4.97%	9.77%	5.63%	20.37%
HARBOR	79.74%	5.21%	8.53%	6.52%	20.26%
ST. AGNES	80.00%	6.09%	9.43%	4.48%	20.00%
PRINCE GEORGE	80.83%	5.32%	9.53%	4.32%	19.17%
MONTGOMERY GENERAL	80.86%	5.01%	8.43%	5.70%	19.14%
CARROLL COUNTY	81.12%	6.70%	8.32%	3.86%	18.88%
WASHINGTON ADVENTIST	81.20%	5.19%	9.04%	4.57%	18.80%
UNION HOSPITAL OF CECIL COUNT	82.45%	6.87%	7.51%	3.17%	17.55%
HOWARD COUNTY	82.60%	4.71%	8.10%	4.59%	17.40%
FT. WASHINGTON	82.67%	9.09%	6.06%	2.18%	17.33%
CHESTERTOWN	82.76%	8.96%	5.99%	2.29%	17.24%
SHADY GROVE	83.91%	3.54%	7.81%	4.74%	16.09%
MERITUS	84.26%	5.14%	7.63%	2.97%	15.74%
PENINSULA REGIONAL	84.40%	5.09%	7.29%	3.22%	15.60%
UNION MEMORIAL	84.43%	4.27%	8.63%	2.67%	15.57%
ATLANTIC GENERAL	84.71%	5.29%	4.69%	5.31%	15.29%
CALVERT	84.73%	6.58%	5.40%	3.29%	15.27%
Grand Total	**84.76%**	**4.05%**	**7.98%**	**3.20%**	**15.24%**
SUBURBAN	84.96%	3.36%	7.41%	4.27%	15.04%
HOPKINS BAYVIEW MED CTR	85.17%	3.98%	8.43%	2.42%	14.83%
UPPER CHESAPEAKE HEALTH	85.55%	4.91%	7.35%	2.19%	14.45%
WESTERN MARYLAND HEALTH SYSTEM	85.64%	4.48%	7.21%	2.66%	14.36%
EASTON	85.65%	6.18%	6.71%	1.47%	14.35%
FREDERICK MEMORIAL	86.01%	4.82%	6.46%	2.71%	13.99%
SINAI	86.48%	3.31%	7.94%	2.27%	13.52%
ST. MARY	86.53%	5.37%	5.82%	2.28%	13.47%
UNIVERSITY OF MARYLAND	88.17%	1.17%	7.98%	2.67%	11.83%
UM ST. JOSEPH	88.50%	2.87%	5.93%	2.70%	11.50%
G.B.M.C.	88.66%	3.30%	5.64%	2.39%	11.34%
ANNE ARUNDEL	88.71%	3.98%	5.73%	1.59%	11.29%
JOHNS HOPKINS	88.85%	1.59%	7.96%	1.60%	11.15%
GARRETT COUNTY	89.02%	6.20%	3.11%	1.66%	10.98%
MCCREADY	92.06%	4.72%	2.28%	0.94%	7.94%
MERCY	92.87%	2.13%	4.46%	0.54%	7.13%
REHAB & ORTHO	99.67%	0.00%	0.30%	0.03%	0.33%

PAU Trend: % ECMAD Change Cy13 vs CY15 Jan-September

Hospital	CY13 ECMAD Non-Pau	CY13 PAU	CY15 ECMAD Non-Pau	CY15 PAU	% PAU Change
WESTERN MARYLAND HEALTH SYSTEM	15,718	2,520	15,840	2,890	14.7%
MONTGOMERY GENERAL	8,559	1,916	8,107	2,184	14.0%
PRINCE GEORGE	9,893	2,422	10,833	2,727	12.6%
EASTON	9,495	1,337	8,871	1,467	9.7%
HOWARD COUNTY	15,192	3,471	15,713	3,786	9.1%
DORCHESTER	2,476	569	2,114	618	8.6%
SUBURBAN	14,864	2,975	15,770	3,229	8.5%
HOLY CROSS	24,952	5,527	24,130	5,924	7.2%
JOHNS HOPKINS	82,681	8,268	85,619	8,832	6.8%
BALTIMORE WASHINGTON MEDICAL CENTER	20,551	5,108	20,017	5,436	6.4%
FT. WASHINGTON	2,590	587	2,429	619	5.5%
CALVERT	7,374	1,212	6,647	1,278	5.4%
CARROLL COUNTY	11,888	2,629	11,760	2,750	4.6%
FREDERICK MEMORIAL	18,657	3,570	19,592	3,706	3.8%
ATLANTIC GENERAL	5,928	1,185	5,932	1,228	3.6%
UNION HOSPITAL OF CECIL COUNT	7,653	1,466	6,569	1,509	2.9%
ST. MARY	8,952	1,554	9,259	1,599	2.8%
FRANKLIN SQUARE	23,560	6,095	24,112	6,236	2.3%
UNIVERSITY OF MARYLAND	53,048	6,719	51,771	6,833	1.7%
ST. AGNES	19,474	4,829	20,055	4,871	0.9%
ANNE ARUNDEL	34,497	4,368	36,706	4,372	0.1%
LAUREL REGIONAL	5,057	1,364	4,529	1,364	0.0%
Grand Total	**734,758**	**136,322**	**730,961**	**135,615**	**-0.5%**
HARBOR	9,666	2,321	7,987	2,296	-1.1%
SHADY GROVE	18,749	3,961	18,311	3,919	-1.1%
WASHINGTON ADVENTIST	11,767	2,776	11,445	2,738	-1.4%
UM ST. JOSEPH	20,588	3,015	21,872	2,919	-3.2%
DOCTORS COMMUNITY	9,450	3,354	9,680	3,218	-4.0%
CHARLES REGIONAL	7,105	2,104	6,720	2,017	-4.2%
HARFORD	4,971	1,390	4,602	1,329	-4.3%
PENINSULA REGIONAL	23,770	4,070	22,808	3,869	-4.9%
SOUTHERN MARYLAND	11,062	3,695	10,839	3,450	-6.6%
MERITUS	16,321	3,780	16,237	3,516	-7.0%
G.B.M.C.	25,680	3,257	23,490	3,001	-7.9%
UNION MEMORIAL	20,315	3,473	18,731	3,193	-8.1%
HOPKINS BAYVIEW MED CTR	26,153	4,696	27,517	4,288	-8.7%
GARRETT COUNTY	2,941	360	3,297	328	-8.7%
NORTHWEST	11,370	3,542	9,957	3,210	-9.4%
UPPER CHESAPEAKE HEALTH	16,227	3,411	17,139	3,070	-10.0%
SINAI	31,597	5,411	29,267	4,775	-11.8%
MERCY	27,803	2,242	28,571	1,964	-12.4%
CHESTERTOWN	2,406	571	2,248	495	-13.2%
GOOD SAMARITAN	15,136	4,369	13,097	3,747	-14.2%
UMMC MIDTOWN	6,191	2,518	6,374	2,159	-14.2%
MCCREADY	659	107	689	80	-25.8%
BON SECOURS	4,003	2,167	3,313	1,378	-36.4%
REHAB & ORTHO	5,501	38	5,082	17	-56.3%

DRAFT Recommendation for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018

HSCRC Commission Meeting

03/09/2016

HSCRC
Health Services Cost Review Commission

Background

- Maryland quality based programs are exempt from Medicare Programs.
  - Exemption from the Medicare Value-Based Purchasing (VBP) program is evaluated annually
  - Exceptions from the Medicare Hospital Readmissions Reduction Program and the Medicare Hospital-Acquired Condition Reduction Program are granted based on achieving performance targets
  - Maryland aggregate at-risk amounts are compared against Medicare programs

Maryland surpasses National Medicare Aggregate Revenue at Risk in Quality Payments

Figure 1. Potential Revenue at Risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2017

% of MD All-Payer Inpatient Revenue	FY 2014	FY 2015	FY 2016	FY 2017
MHAC - Complications	2.00%	3.00%	4.00%	3.00%
RRIP - Readmissions			0.50%	2.00%
QBR – Patient Experience, Mortality, Safety	0.50%	0.50%	1.00%	2.00%
Shared Savings	0.41%	0.86%	1.16%	*1.16%**
GBR Potentially Avoidable Utilization (PAU)	0.50%	0.86%	1.10%	*1.10%**
MD Aggregate Maximum At Risk	3.41%	5.22%	7.76%	9.26%

*Italics are based on RY 2016 results, and subject to change based on RY 2017 policy, which is to be finalized at June 2016 Commission meeting.

Medicare National				
% of National Medicare Inpatient Revenue	FFY 2014	FFY 2015	FFY 2016	FFY 2017
Hospital Acquired Complications (HAC)		1.00%	1.00%	1.00%
Readmissions	2.00%	3.00%	3.00%	3.00%
VBP	1.25%	1.50%	1.75%	2.00%
Medicare Aggregate Maximum At Risk	3.25%	5.50%	5.75%	6.00%

Cumulative MD-Medicare National Difference	0.16%	-0.12%	1.89%	5.15%

Payment Adjustment Methodologies - "Scaling": QBR, MHAC, RRIP

- Preset payment scale: Payment adjustments are determined using scores in the base year. (e.g. A score of 0.10 = -1% payment adjustment.)
- Continuous adjustments: Payment adjustments vary based on score differences. (e.g. If a score of 0.10= -1% payment adjustment, a score of 0.20= -0.98 % payment adjustment).
- Contingent scale: Payment adjustment scale depends on predetermined statewide performance. (If the state did not meet MHAC reduction target, maximum penalty was 3% and no rewards, otherwise maximum penalty was reduced to 1% and awards were provided up to 1%.)
- Payment adjustments are no longer "revenue neutral," i.e. statewide overall impact could be negative or positive.
- Maximum penalties and reward amounts are set by the Commission before the performance year starts, usually the calendar year.

RY 2016 Payment Adjustments: Total Net Adjustment is -$38.3 mil, -0.4 % of State Inpatient Revenue

	MHAC	RRIP	QBR	Shared Savings	PAU	Aggregate (Sum of All Programs)	Net Hospital Adjustment Across all Programs
Potential At Risk (Absolute Value)	4.00%	0.50%	1.00%	1.16%	1.10%	7.76%	
Maximum Hospital Penalty	-0.21%	NA	-1.00%	-0.29%	-1.10%	-2.59%	-1.95%
Maximum Hospital Reward	1.00%	0.50%	0.73%	NA	NA	2.23%	1.09%
Average Absolute Level Adjustment	0.18%	0.15%	0.30%	0.93%	0.39%	1.95%	0.70%
Total Penalty	-$1,080,406	NA	-$12,880,046	-$27,482,838	-$26,900,004	-$68,343,293	
Total Reward	$7,869,585	$9,233,884	$12,880,046	NA	NA	$29,983,515	
Total Net Adjustments	$6,789,180	$9,233,884	$0	-$27,482,838	-$26,900,004	-$38,359,778	

RY 2017 Year to Date Results

	MHAC	RRIP**	QBR***	Shared Savings/PAU*	Aggregate (Sum of All Programs)	Net Hospital Adjustment Across all Programs
Potential At Risk (Absolute Value)	3.00%	2.00%	2.00%		7.00%	
Maximum Hospital Penalty	0.00%	-2.00%			-2.00%	-1.92%
Maximum Hospital Reward	1.00%	1.00%			2.00%	2.00%
Average Absolute Level Adjustment	0.37%	0.71%			1.08%	0.78%
Total Penalty	$0	-$38,994,508			-$38,994,508	
Total Reward	$26,338,592	$11,586,425			$37,925,017	
Total Net Adjustments	$26,338,592	-$27,408,083			-$1,069,491	

**Shared Savings and PAU adjustments will be determined with the FY2017 Update Factor.*
***RRIP results are preliminary results as of October 2015 and do not reflect any potential protections that may be developed based on the approved RY 2017 recommendation.*
**** QBR YTD results are not available due to 9 month data lag for measures from CMS. Staff will provide updated calculations for the final recommendation.*

Focus on Performance-Based Adjustments and PAUs

- Maryland hospitals improved their performance in reducing complications and more recently in improving readmissions.
- All-Payer Model financial success will depend on further reductions in PAU. Accordingly, the Commission's funding of infrastructure focused on reducing PAUs more broadly than readmissions.
- Staff intends to shift more focus on PAUs in quality-based payment programs in the future and reduce penalties in other areas.
- If Maryland increases the prospective adjustment for these PAUs, we may moderate the maximum penalty under the RRIP program.

RY 2018 Draft Recommendations

1. QBR: The maximum penalty should be 2 percent, while the maximum reward should be 1 percent.
2. MHAC: There should be a 3 percent maximum penalty if the statewide improvement target is not met; there should be a 1 percent maximum penalty and a reward up to 1 percent if the statewide improvement target is met.
3. RRIP: The maximum penalty should be 2 percent, and the reward should be 1 percent for hospitals that reduce readmission rates at or better than the minimum improvement.
4. Maximum penalty guardrail: The hospital maximum penalty guardrail should continue to be set at 3.5 percent of total hospital revenue.
5. The quality adjustments should be applied to inpatient revenue centers, similar to the approach used by CMS.

DRAFT Recommendation for Updating the Readmissions Reduction Incentive Program for Rate Year 2018

March 2, 2016

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This document contains the draft staff recommendations for updating the Maryland Hospital Readmissions Reduction Incentive Program. Please submit comments on this draft to the Commission by Monday April 4th, 2016, via hard copy mail or email to Dianne.feeney@maryland.gov.

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LIST OF ABBREVIATIONS

APR-DRG	All-patient refined diagnosis-related group
ARR	Admission-Readmission Revenue Program
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
ED	Emergency department
FFS	Fee-for-Service
FFY	Federal fiscal year
FY	Fiscal year
HRRP	Hospital Readmissions Reduction Program
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital-Acquired Conditions Program
PPC	Potentially Avoidable Complications
RRIP	Readmissions Reduction Incentive Program
RSSP	Readmission Shared Savings Program
RY	Rate year
SES/D	Socio-economic and demographic
YTD	Year-to-date

INTRODUCTION

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.[1] 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 Maryland Health Services Cost Review Commission (HSCRC or Commission) 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 on 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 HSCRC made some further adjustments to the program in the following year, which are discussed in the background section of this report.

The purpose of this report is to provide background information on the RRIP program and to make recommendations for updating the state rate year (RY) 2018 methodology and readmissions reduction targets. The RY 2017 approved recommendation stated that staff would assess the impact of admission reductions, sociodemographic factors, and all payer versus Medicare readmission trends and make adjustments to the rewards or penalties if necessary. This draft recommendation details these analyses, as well as analyses examining the relationship between the base period readmission rate and improvement rates since hospitals with low readmission rates may have more difficulty meeting the minimum improvement target. Based on these analyses, staff provides options for moderating adjustments in light of recent analysis for RY2017 adjustments, and a recommendation for RY 2018 to reduce the minimum improvement target for hospitals with lower base year readmission rates. Staff is also working on refining and broadening the existing Readmission Shared Savings Program (RSSP) policy for RY2017, which is currently based on inpatient readmission rates. Staff will be evaluating options to include prevention quality indicators and Sepsis admissions in the shared savings program, as well as the program's impact in consonance with RY 2017 update factor analyses. The final recommendation for the RRIP may require alignment with any revisions to what is currently the RSSP policy to estimate impact of these programs overall in tandem.

[1] 42 CFR 412.152

BACKGROUND

Federal Readmissions Program

The Affordable Care Act established the Medicare HRRP[2], which requires CMS to reduce payments to inpatient prospective payment system hospitals with excess readmissions for patients in traditional Medicare.[3] The program started in FFY 2013 and applies to most acute care hospitals.[4] Under this program, hospitals with readmission rates that exceed the national average are penalized by a reduction in payments across all of their Medicare admissions. CMS will adjust for certain demographic and clinical characteristics of both a hospital's readmitted patients and the hospital's overall patient population. CMS will then calculate a rate of excess readmissions; the greater a hospital's rate of excess readmissions, the higher the penalty. Each year, CMS publishes each hospital's penalty for the upcoming year online.

Penalties under the HRRP were first imposed in FFY 2013, during which the maximum penalty was one percent of the hospital's base inpatient claims. The maximum penalty increased to two percent for FFY 2014 and three percent for FFY 2015 and beyond. CMS uses three years of previous data to calculate each hospital's readmission rate. For penalties in FFYs 2013 and 2014, CMS focused on readmissions occurring after initial hospitalizations for three conditions: heart attack, heart failure, and pneumonia. For penalties in FFY 2015, CMS included two additional conditions: chronic obstructive pulmonary disease and elective hip or knee replacement. In the future, CMS intends to continue with these conditions, and will add the assessment of performance following initial diagnosis of coronary artery bypass graft surgery to the list for FFY 2017.

Overview of the Maryland RRIP Program

As discussed in the introduction section of this report, Maryland is exempt from the federal Medicare HRRP. Instead, the Affordable Care Act requires Maryland to have a similar program and achieve the same or better results in costs and outcomes in order to maintain this exemption. The Commission made an initial attempt to encourage reductions in unnecessary readmissions when it created the Admission-Readmission Revenue (ARR) program in RY 2012. The ARR program, which was adopted by most Maryland hospitals, established "charge per episode" constraints on hospital revenue, providing strong financial incentives to reduce hospital readmissions. The ARR program was replaced with global budgets in RY 2014.

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[2] For more information on HRRP, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.
[3] 42 CFR 412.150(a)
[4] Boccuti, C., & Casillas, G. (January 2015). Aiming for fewer hospital u-turns: The Medicare hospital readmission reduction program. Retrieved from http://kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/

In May 2013, the Commission also approved the RSSP policy for RY 2014 to achieve savings that would be approximately equal to those that would have been expected from the federal Medicare HRRP. Based on hospital achievement levels in reducing readmissions, the RSSP decreased hospital inpatient revenues on average by 0.3 percent of state inpatient revenue in its first year.

The new All-Payer Model Agreement further established specific targets for reductions in Maryland's Medicare readmission rates by CY 2018. In April 2014, the Commission approved a new readmissions program—the RRIP—to further bolster the incentives to reduce unnecessary readmissions. The RRIP provided a positive increase of 0.5 percent of inpatient revenues for hospitals that were able to meet or exceed a pre-determined reduction target for readmissions in CY 2014 relative to CY 2013. HSCRC did not impose penalties in the first year of the RRIP program. For the RSSP, the revenue reduction for this second year was, on average, 0.4 percent of inpatient revenue. Unlike the RSSP, the RRIP focused on the improvements achieved by the hospitals in their readmission rates rather than on their readmission attainment levels. The initial guiding principles of the RRIP included:

- The measurements used for performance linked with payment must include all patients, regardless of payer.
- The measurements must be fair to hospitals.
- Annual targets must be established to reasonably support the overall goal of meeting or outperforming the national Medicare readmission rate by CY 2018.
- The measurements used should be consistent with the CMS readmissions measure.
- The approach must include the ability to track progress.

The key methodology of the initial program included the components below.

- Readmission definition-Case-mix adjusted readmissions are calculated by estimating readmissions for each hospital based on statewide averages per all-patient refined diagnosis-related group (APR-DRG) severity of illness.
- Broad patient inclusion-For greater impact and potential for reaching the statewide target, the measure included all payers and any acute hospital readmission in the state.
- Patient exclusion adjustments-To enhance the fairness of the methodology, planned admissions (using the CMS algorithms[5]) and maternal deliveries were excluded from the readmission counts.
- Positive incentive-Hospitals that reached or exceeded the target earned the incentive.

[5] For more information on planned readmissions for each specific measure (e.g. hospital-wide all cause readmissions), the process is described in the corresponding measure updates and specifications reports located at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

- Performance measurement consistency across hospitals- A uniform achievement benchmark for all hospitals was established for the first year, and performance is measured cumulatively in subsequent years.
- Monitoring for unintended consequences- Observation room and emergency department (ED) visits occurring within 30 days of an inpatient stay were monitored; adjustments to the positive incentive were made if emergency department observation room cases within 30 days increased faster than the other observations in a given hospital.
- Reduction target- The readmissions reduction target for the first year of the program was set at 6.76 percent for all payers. This target was based on the excess levels of Medicare readmissions in Maryland in RY 2013 (8.78 percent), divided by five (representing each year of the Model Agreement performance period), plus an estimate of the reduction in Medicare readmission rates that would be achieved nationally (5.0 percent).

The RRIP methodology was updated for rate year (RY) 2017 to include both higher potential rewards for hospitals that achieved or exceeded the readmission reduction targets and payment reductions to hospitals that did not achieve the required readmission reductions. Rewards and payment reductions were allocated along a scale commensurate with hospital performance levels. The readmission rate reduction target for RY 2017 was set at 9.30 percent, comparing CY 2015 with CY 2013 performance, which was based on a 1.34 percent decline in the national Medicare readmission rates in CY 2015. The RY 2017 policy also used an updated version of the CMS planned admission algorithm and removed newborn APR-DRGs from the calculations.

ASSESSMENT

In order to refine the methodology and develop the targets for RY 2018, the HSCRC solicited input from the Performance Measurement Workgroup.[6] The Workgroup discussed pertinent issues and potential changes to Commission policy for RY 2018 that may be necessary to enhance the HSCRC's ability to continue to improve the quality of care, reduce costs related to readmissions, and continue to meet the waiver targets established by the Center for Medicare and Medicaid Innovation (CMMI). In its January meeting, the Workgroup reviewed data related to 1) Maryland's performance to date, 2) the target calculation methodology, and 3) and analyses of other considerations for the readmission rate.

Maryland's Performance to Date

Medicare Waiver Test Performance

With the onset of the All-Payer Model Agreement, HSCRC and CMMI staff worked to refine the Medicare readmission measure specifications used to determine contract compliance. These changes narrowed the gap between the Maryland and national Medicare readmission rates to 7.9

[6] For more information on the Performance Measurement Workgroup, see http://www.hscrc.state.md.us/hscrc-workgroup-performance-measurement.cfm.

percent for CY 2013, the base measurement period for the model. Otherwise stated, with these revised definitions, Maryland's Medicare readmission rate was 16.6 percent compared with the national rate of 15.4 percent for CY 2013. Below are the specification changes made to allow 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 due to data limitations. In contrast, HSCRC includes psych and rehab readmissions in the all-payer readmission measure used for payment policy.
- 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).

Using the revised final measurement methodology, Maryland performed better than the nation in reducing readmission rates in both CY 2014 and CY 2015. Figures 1 and 2 below compare the cumulative readmission rate changes by month between Maryland and the national Medicare program. Figure 1 shows the changes between CY 2013 and 2014, and Figure 2 shows changes between CY 2014 and CY 2015.

For the month of January 2014 in Figure 1, Maryland experienced a 2.18 percent increase compared with January 2013. Throughout the year, this trend shifted, with Maryland achieving a 0.56 percent decrease in readmissions between January and August 2014, compared with the same time period in CY 2013. For CY 2014, the readmission rates for Maryland declined by 0.85 percent in comparison to January to December 2013. In contrast, the national readmission rate, represented by the blue line, increased by 0.71 percent during the same period.

Figure 1. Cumulative Readmission Rate Change by Month, CY 2014-2013, Maryland vs. National Medicare Readmissions

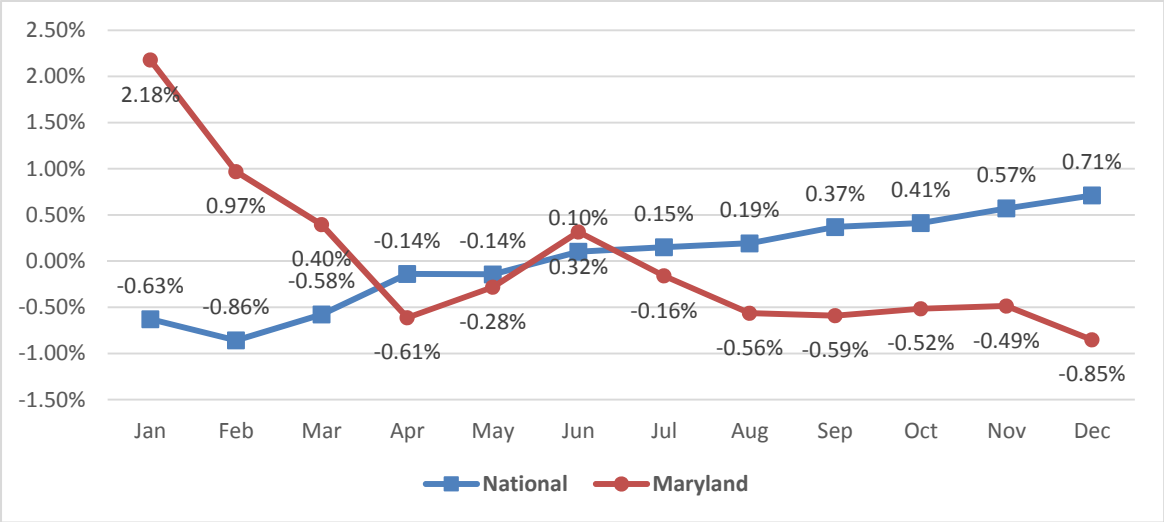
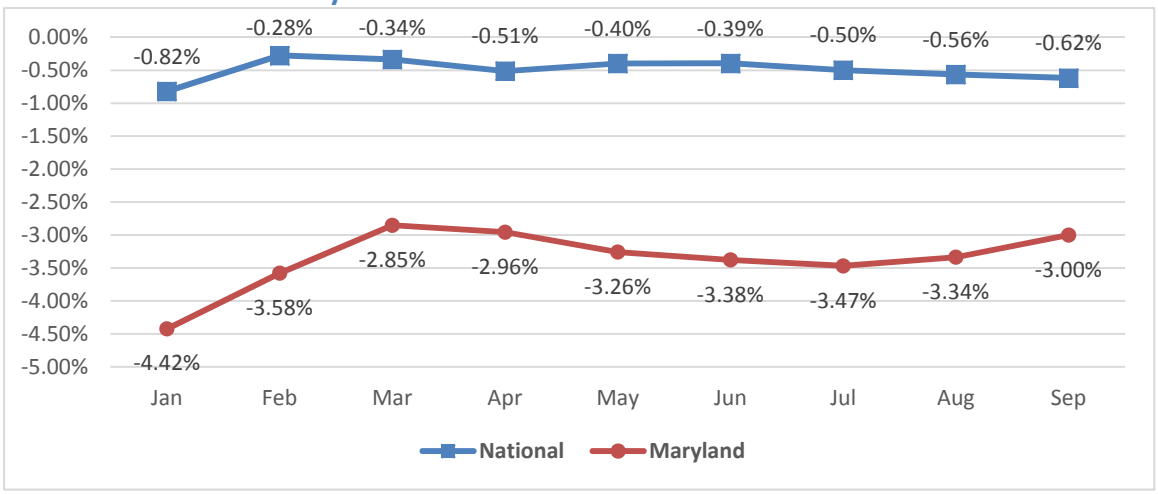


Figure 2 presents preliminary data for the first three quarters of CY 2015, indicating that Maryland has experienced a 3 percent reduction in Medicare readmission rate compared with CY 2014 and exceeded the national decrease in Medicare readmission rate of 0.62 percent.

Figure 2. Cumulative Readmission Rate Change by Month, CY 2015-2014, Maryland vs. National Medicare Readmissions



All-Payer Performance

The RRIP measures the all-payer case-mix adjusted readmission rate. The RRIP measure was refined to incorporate many of the elements of the CMS Medicare measure (i.e., planned admissions and transfer logic). See Appendix I for more details on the RRIP methodology.

Maryland made progress in CY 2015 towards meeting the Medicare readmission reduction contract requirement, although this may be mainly attributed to a slower than expected rate of decline in the national readmission rates. Despite this progress, the all-payer readmission rate decline has fallen short of the statewide CY 2015 cumulative target of 9.3 percent thus far. Appendix II provides hospital-level improvement rates for discharges occurring through October 2015. Overall, all-payer readmission rates declined by 7.2 percent Jan-October 2014, compared with January through October 2013, with one-third of the hospitals meeting or exceeding the 9.3 percent reduction target. Seven hospitals had an increase in their readmission rates, with the highest increase of 13 percent.

Target Calculation Methodology for Rate Year 2018

As previously stated, under the All-Payer Model Agreement, Maryland is required at minimum to close 1/5 of the gap between national and Maryland readmission rates and match the national decline in Medicare readmission rates to eliminate the excessive level of readmissions by CY 2018. To achieve this goal, the HSCRC set a target to reduce readmissions by 6.76 percent for RY 2016 (CY 2014 performance compared to CY2013 base year) and by 9.3 percent for RY 2017 (CY 2015 performance compared to CY2013 base year).[7] Figure 3 below provides the historical projections used for setting the target and the actual performance observed in measurement years 2014 and 2015. In addition, it provides the cumulative change since the initiation of the Agreement. For example, in CY 2015, readmissions were reduced by 0.6 percent nationally in one year. This reduction combined with the 0.7 percent increase in CY 2014, resulted in a 0.1 percent increase in cumulative rate change since CY 2013 for Medicare.

Figure 3 also provides alternative estimates of the cumulative Medicare and all-payer targets for measurement year 2016. HSCRC staff modeled three alternatives using three different assumed rates for the estimated annual rate of change, including the current rate of change for CY2015 and the historical rate of change over the past several years. This yielded cumulative all-payer targets ranging from 9.1 to 12.7 percent, depending on the assumptions used for the Medicare national rate of change.

[7] The RRIP reduction targets are determined by the National vs Maryland readmission gap and a projection of rate of change in the national Medicare readmission rates. For RY 2016 Medicare's national rate of readmissions was assumed to drop by 5.0 percent in CY 2014. Accordingly, the target rate of readmission reductions included in the RRIP for CY 2014 was 6.76 percent (i.e., (1.76 percent + 5.0 percent = 6.76 percent), and was applied to all payers based on stakeholder workgroup recommendations. For the CY 2015 target calculation, the remaining gap divided by 4 was 1.64 percent, and the national readmission reduction estimate was 1.3 percent. Based on HSCRC trends indicating that all payer risk-adjusted readmission rates were declining much more rapidly, 4.5 percent was added to convert the Medicare target to an all payer target.

Figure 3. Maryland and National Medicare Historical and Projected Readmission Rate Reductions Based on Varying Assumptions

Measurement Years	Base Year MD/National Readmission Rate	Assumed National Annual Rate of Change	Actual National Annual Rate of Change	Actual National Cumulative Change	MD Cumulative Medicare Rate of Target	All Payer to Medicare Readmission Rate Percent Change Difference	Cumulative All Payer Target
CY 2014	8.9%	**-5.0%**	0.7%	0.7%	-6.8%		**-6.8%**
CY 2015	7.7%	**-1.3%**	-0.6%	0.1%	-4.7%	-4.6%	**-9.3%**
CY 2016 Modeling Results:							
CY16 - Current Rate of Change	7.7%	-0.6%			-5.5%	-3.6%	-9.1%
CY16 -Lowess Model Lowest Bound	7.7%	-0.8%			-5.8%	-3.6%	-9.4%
CY 16 Long Term Historical Trend	7.7%	-1.8%			-9.2%	-3.6%	-12.7%

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

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

Requiring Maryland to conform to the national Medicare HRRP would reduce our ability to design, adjust, and integrate our reimbursement policies consistently across all payers based on local input and conditions. In particular, the national program is structured as a penalty-only system based on a limited set of conditions, whereas the Commission prefers to have the flexibility to implement much broader incentive systems that reflect the full range of conditions and causes of readmissions on an all-payer basis. Given that Maryland's readmission rate is still high compared with the national rate, some Workgroup members supported a more aggressive target. Other Workgroup members felt that because Maryland is making good progress toward meeting the Model Agreement requirement, the target should be less aggressive.

Analyses of Other Considerations

Prior to the RY 2017 RRIP policy adoption, HSCRC staff conducted a number of analyses to determine whether other factors should be considered in the methodology. The Commission adopted the recommendations below in context of uncertainty around risk adjustment, the relationship between Medicare and all payer readmission rates, and the impact of reductions in overall admissions on readmission rate changes (i.e., the denominator effect) at the time the RY 2017 recommendation was developed and adopted.

1. Continue to set a minimum required reduction benchmark on an all-payer basis and re-evaluate the option to move to a Medicare-specific performance benchmark for the CY 2016 performance period.
2. Continue to assess the impact of admission reductions, socio-economic and demographic (SES/D) factors, and all-payer and Medicare readmission trends, and make adjustments to the rewards or penalties if necessary.
3. Seek additional Medicare benchmarks that can help guide efforts in Maryland. Evaluate recommendations from the Care Coordination Workgroup and request recommendations from Maryland's new quality improvement organization regarding specific areas for improvement.

To develop the RY 2018 recommendation, HSCRC staff analyzed the CY 2015 year-to-date (YTD) trends in an effort to examine the issues previously raised during the development of the RY 2017 recommendation. State-level analysis produced the following results:

- Strong correlations between the change in all-payer and Medicare readmission rates (Pearson's correlation[8] coefficient r = 0.65); this suggests that as all-payer readmission rates decline, the Medicare readmission rates also decline.
- Positive statistically significant correlation between the change in overall admissions and readmission rates (Pearson's r = 0.29); this suggests hospitals that are reducing overall admissions are also reducing their readmission rates (see Appendices III and IV).

HSCRC formed a subgroup to discuss details on SES/D and readmission rates. In addition to individual measures such as age, payer status, and race/ethnicity, the subgroup assessed the use of a geographic measure called the Area Deprivation Index (ADI). The ADI is a validated census-based measure available at the block-group (neighborhood) level, first created in 2003 based upon the 2000 census by Singh and colleagues.[9] The ADI is a factor-based index with 17 census-based indicators assessing education, income, poverty, housing costs, housing quality,

[8] Pearson's correlation describes the strength of the linear relationship between two variables. Pearson's correlation coefficients range from -1.0 to 1.0. A coefficient of 0 indicates no relationship. A correlation of 1.0 indicates a strong positive linear relationship; as one variable increases, the other also increases. A value of -1.0 indicates a strong negative relationship, as one variable increases, the other decreases. For additional information, see: http://www2.sas.com/proceedings/sugi31/170-31.pdf

[9] For more information on the ADI, see http://www.hipxchange.org/ADI

employment, and single parent households. The ADI has been shown to be correlated with multiple health outcomes and with readmissions. In 2014-2015, the HSCRC contracted with Dr. Amy Kind, the lead author of a seminal article showing a strong relationship between ADI and Medicare readmission rates, to update the 2000 ADI based on the 2009-2013 American Community Survey using a very similar methodology as Singh.

The initial analyses, presented in Appendix V, provide evidence that hospitals with a higher proportion of patients from the most deprived areas have higher readmission rates than hospitals with a lower proportion of patients from deprived areas (Pearson correlation coefficient is 0.42). However, this relationship is not as strong once the two outlier hospitals (Bon Secours and University of Maryland Midtown hospitals, with 62 and 58 percent of patients from the highest deprived areas, respectively) are removed from the analysis. The relationship between ADI and readmission rates is a complex one and complicated statistical analyses may be needed to distinguish the hospital-level factors contributing to high readmission rates from patient-level factors, such as ADI. Furthermore, the application of socio-economic/demographic adjustments to hospital quality measures is a subject of national debate, requiring extensive discussions and stakeholder input to determine policy implications and alternative methods of controlling for SES/D factors.

Since the current RRIP policy is based on improvement rates rather than the level of readmission rates, the relationship between readmission reduction and SES/D would be more appropriate to consider and could be less complicated than adjusting readmission rates themselves. Correlation analysis does not support the assumption that hospitals with high deprivation burden experience lower improvement rates; hospitals with higher ADIs, in fact, were shown to have modestly higher rates of improvement.

The Impact of Emergency Department Observation Stays

To some extent, ED visits and observation stays can be substituted for inpatient readmissions. In the Final Recommendation for the RRIP for RY 2016, HSCRC staff acknowledged the possible confounding effects of changes in the use of ED and observation services and promised to monitor the frequency of ER visits and observation stays within 30 days after discharge. In addition, the recommendation stated that adjustments would be made in the RRIP incentive rewards to hospitals if their reductions in readmissions were accompanied by disproportionate increases in observation room stays after discharge. This adjustment was specified for observation stays only because there was less certainty regarding the extent to which ED services can substitute for inpatient stays.

Staff examined data regarding the improvement rate in readmissions by using inpatient data only and by examining inpatient data plus observation stays that were 24 hours or longer and within 30 days of an admission. Appendix VI shows that the change in readmission rates with observations stays included is slightly less than the decline in readmission rates when observation stays are excluded. For example, a hospital may have an 8.3 percent reduction in readmissions when observation room stays are considered a readmission, but a 13.0 percent decline when observation room stays are not counted as a readmission. Based on these findings,

staff is less concerned about the possibility that the decline in readmission rates was caused by increases in the use of the observation stays in CY 2015. However, staff will examine the observation visit trends for individual hospitals for the purposes of determining whether adjustments should be made to the RY 2017 RRIP rewards.

The Impact of Readmission Rates on Improvement

Due to concerns with the measurement of readmission rates, staff were not able to create a performance metric to measure whether a particular hospital has a low or high readmission rate, commonly referred as "attainment" in quality improvement. In addition to a debate on the impact of SES/D status on readmission rates and whether adjustment should be made for these factors, staff need to develop a methodology to adjust for readmissions at non-Maryland hospitals, as the current HSCRC data set provides only in-state readmissions. Furthermore, benchmarks should be set in alignment with the RRIP's objective to reduce the hospital readmission rate to match or outperform the national Medicare rate. Current benchmarks are based on the statewide readmission rate, which remain higher than the national average and may not illustrate the level of improvement required from hospitals. Based on the CMS hospital-wide risk-adjusted Medicare readmission measure, only two Maryland hospitals are statistically significantly below (outperforming) the national average readmission rates (see Appendix VII).

While the work continues to develop a methodology to compare readmission rates, staff analyzed the relationship between base year readmission rates and cumulative improvement rates. Although we did not see a strong relationship between the CY 2013 readmission rates with the CY 2013 to CY 2014 rate of change, there appears to be a stronger relationship between the CY 2013 readmission rates and the rate of change from CY 2013 to CY 2015 (Pearson's r = 0.35, Appendix VIII). This suggests that hospitals who began with greater readmission rates in CY 2013, reported larger decreases in readmission rates through the measurement period. However, this trend was not consistent when making individual hospital-level comparisons; there is large variation in performance among hospitals that began with similar readmission rates. For example, one hospital with a CY 2013 readmission rate of 10.6 percent reduced its readmission rate by 12 percent, while another hospital with a 10.9 percent readmission rate had an increase of 13 percent over the two-year period.

Due to the statewide relationship in base year and cumulative improvement rates, staff propose to adjust the minimum required readmission rate reductions based on base year readmission rates. Staff propose to keep the statewide target for hospitals with readmission rates that are higher than the statewide average, as these hospitals are more likely to have a higher burden of SES/D and would need additional resources to reduce their readmission rates. For hospitals with readmission rates that are lower than the statewide average, the minimum required readmission reductions can be reduced in proportion to the hospital's difference from state average readmission rate (Appendix IX).

The Link between Shared Savings and RRIP

As mentioned in the overview, the HSCRC shared savings program prospectively adjusts hospital rates to achieve a specified statewide savings amount. For the past several years, the shared savings adjustment for each hospital was based upon historical readmission rates. Staff will be evaluating and discussing other options for shared savings to focus attention more broadly on avoidable admissions/hospitalizations (Potentially Avoidable Utilization, or PAUs). The Commission's funding of infrastructure included in RY 2016 revenue focused on reducing PAUs more broadly than readmissions. Also, the staff is proposing to add sepsis to the PAUs and removing the cost of complications from the PAU definitions. The need for greater reductions of PAUs requires focus on opportunities for improvement beyond readmissions, including reductions in admissions for ambulatory care-sensitive conditions (measured using prevention quality indicators (PQIs)), and for sepsis. Figure 4 provides summary statewide statistics on PAUs for All-Payer and Medicare patients. PAUs comprise 15 percent of the total hospital revenue for all-payer and 22 percent for Medicare patients. While we have 5.6 percent reduction in readmissions, PQIs declined by 0.8 percent, and sepsis admissions increased by 14 percent between CY 2013 and CY2015. If Maryland increases the prospective adjustment for these PAUs, we may moderate the maximum penalty under the RRIP program.

Figure 4. Potentially Avoidable Utilization Summary, All-Payer and Medicare

All Payer

	Total Charge CY15	ECMAD CY15	ECMAD CY13	% ECMAD Change CY13-CY15	% Grand Total Charge
Readmission	$1,288,435,419	90,260	95,614	-5.6%	8.0%
PQI	$651,465,870	51,679	52,100	-0.8%	4.1%
Sepsis	$516,098,092	39,131	34,251	14.2%	3.2%
PAU Total	**$2,455,999,381**	**181,069**	**181,966**	**-0.5%**	**15.3%**
Grand Total	**16,073,397,565**	**1,155,421**	**1,161,441**	**-0.5%**	**100%**

	Total Charge CY15	PPC Count CY15	PPC Count CY 13	% PPC Count Change CY13-CY15	% Grand Total Charge
PPCs/MHACs	$231,919,620	21,026	29,740	-29.30%	1.4%

PAUs are based on Inpatient and 23+ hour observation cases. Annualized based on Jan-Sept Final Data

	MEDICARE					
	Total Charge CY15	**ECMAD CY15**	**ECMAD CY13**	**% ECMAD Change CY13-CY15**	**% Grand Total Charge**	**% Medicare**
Readmission	$680,347,206	50,068	52,034	-3.8%	11.2%	53%
PQI	$391,016,430	30,914	29,969	3.2%	6.4%	60%
Sepsis	$288,257,794	22,887	20,013	14.4%	4.7%	56%
PAU Total	**$1,359,621,430**	**103,868**	**102,016**	**1.8%**	**22.4%**	**55%**
Grand Total	**$6,079,614,526**	**447,172**	**440,416**	**1.5%**	**100.0%**	**38%**

	Total Charge CY15	**ECMAD CY15**	**ECMAD CY13**	**% PPC Count Change CY13-CY15**	**% Grand Total Charge**	**% Medicare**
PPCs/MHACs	$129,912,439	11,143	15,370	-27.5%	2.1%	56%

PAUs are based on Inpatient and 23+ hour observation cases. Annualized based on Jan-Sept Final Data

Considerations for the RY 2017 RRIP Policy

One of the guiding principles for Maryland's hospital quality programs is to set the policy and benchmarks ahead of the performance periods. Last year, the Commission made an exception to allow for staff to examine the developing policy results during the performance period in light of some potential payment equity issues. In approving a policy that set improvement targets equally for all hospitals, there were concerns that individual hospitals might be penalized even though they were performing relatively well. For example, if the initial readmission rate for a hospital was relatively low, it may be harder to reduce the same percentage of readmissions as other hospitals with higher initial rates. Staff is considering the options below for moderating adjustments in light of recent analysis.

- Recognize improvement in the Medicare readmission rates. Even though statewide numbers do not warrant a change in the overall measurement approach from the use of all-payer to Medicare-specific benchmarks, hospital-level performance may vary. We could recognize

faster improvement in Medicare readmission rates if a hospital reduces its Medicare readmission rates faster than the all-payer readmission rates (Appendix X).

- Adjust the all-payer readmission target for hospitals whose readmission rates are lower than the statewide average as proposed for the RY 2018 policy.

- The Maryland Hospital Association is proposing to reduce the RY 2017 target to the statewide average reduction rate, (current trend is at 7 percent decline), and remove all of the penalties if a hospital's readmission rate was in the lowest quintile in both CY 2013 and CY 2015. Staff does not agree with changing the overall target.

Given Maryland's high rate of readmissions, staff believe that all hospitals should aim to reduce readmissions, albeit there could be diminishing opportunity for reductions if the base year readmission rates are lower. Staff also believe the principle of setting benchmarks and targets ahead of the performance period should be maintained. Staff will work with the Performance Measurement Workgroup to evaluate these alternatives and finalize the recommendation based on our analysis and the input from the stakeholders and the Commissioners.

RECOMMENDATION

Based on this assessment, HSCRC staff recommend the following updates to the RRIP program for RY 2018:

1. The reduction target should continue to be set for all-payers.

2. The all-payer reduction target should be set at 9.5 percent.

3. The reduction target should be adjusted downward for hospitals whose readmission rates are below the statewide average.

APPENDIX I. HSCRC METHODOLOGY FOR READMISSIONS FOR RATE YEAR 2018

1) Performance Metric

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

The measure is very similar to the readmission rate that will be calculated for the new All-Payer Model with a few exceptions. For comparing Maryland's Medicare readmission rate to the national readmission rate, the Center for Medicare and Medicaid Innovation (CMMI) 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 program.

2) Adjustments to Readmission Measurement

The following discharges are removed from the numerator and/or denominator for the readmission rate calculations:

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 3.0. The HSCRC has also added all vaginal and C-section deliveries as planned using the APR-DRGs rather than principal diagnosis (APR-DRGs 540, 541, 542, 560). Planned admissions are counted in the denominator because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.
- Admissions with ungrouable 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 where a patient dies is counted as a readmission, 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 or next day as the admission date of the subsequent admission, are removed from the denominator counts. Thus, only one admission is counted in the denominator and that is the admission to the 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, Bowie Health 210333).
- Holy Cross Germantown is excluded from the program until they have one full year of base period data; Levindale is included in the program; and chronic beds within acute care hospitals are excluded for this year but will be included in future years.

- In addition, the following data cleaning edits are applied:

    a. Cases with null or missing Chesapeake Regional Information System unique patient identifiers (CRISP EIDs)
    b. Duplicates
    c. Negative interval days
    d. 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, 99 percent of inpatient discharges have a CRISP EID.

3) Details on the Calculation of Case-Mix Adjusted Readmission Rate

Data Source:

To calculate readmission rates for the RRIP, the inpatient abstract/case mix data with CRISP EIDs (so that patients can be tracked across hospitals) is used for the measurement period plus an extra 30 days. To calculate the case mix adjusted readmission rate for the CY 2013 base period and the CY 2016 performance period, data from January 1 through December 31, plus 30 days in January of the next year would be used.

SOFTWARE: APR-DRG Version 32

Calculation:

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

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 2013).
- Calculate the ratio of observed (O) readmissions over expected (E) readmissions. A ratio of > 1 means that there were more observed readmissions than expected based upon that hospital's case mix. A ratio < 1 means that there were fewer observed readmissions than expected based upon that hospital's case mix.
- Multiply 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, given its mix of patients as defined by discharge APR DRG category and SOI level, would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected value or expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being "at risk" for a readmission. All discharges will either have no readmissions or will have one readmission. The readmission rate is the proportion or percent 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, this number is displayed as readmissions per discharge to facilitate the calculations in the example. Most reports will display this number as a rate per one thousand.

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

Appendix I. Figure 1. Expected Value Computation Example

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

For the APR DRG category, the number of discharges with readmission is 45, which is the sum of discharges with 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., 0.09 = 45/500. 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 shown in column 6 is calculated by multiplying the number of discharges at risk for a readmission (column 2) by the normative readmissions per discharge rate (column 5) The total number of readmissions expected for this APR DRG category is the expected number of readmissions for the SOI.

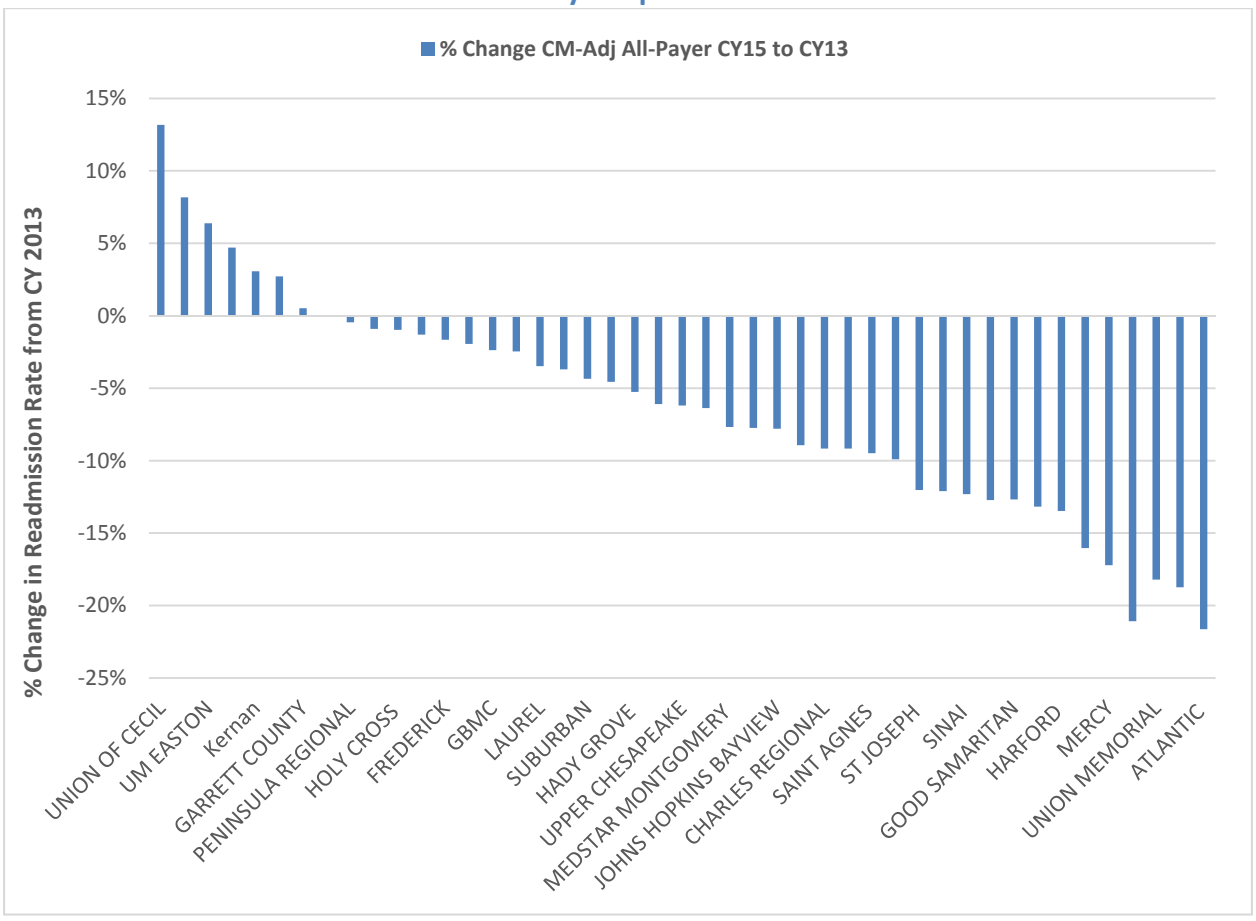
In this example, the expected number of readmissions for this APR DRG category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had 11.5 fewer actual discharges with readmissions than were expected for this APR DRG category. This difference can be expressed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

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

APPENDIX II. ALL-PAYER HOSPITAL-LEVEL READMISSION RATES

The following figure presents the change in all-payer case-mix adjusted readmissions by hospital between CY 2013 and the data available through October of CY 2015.

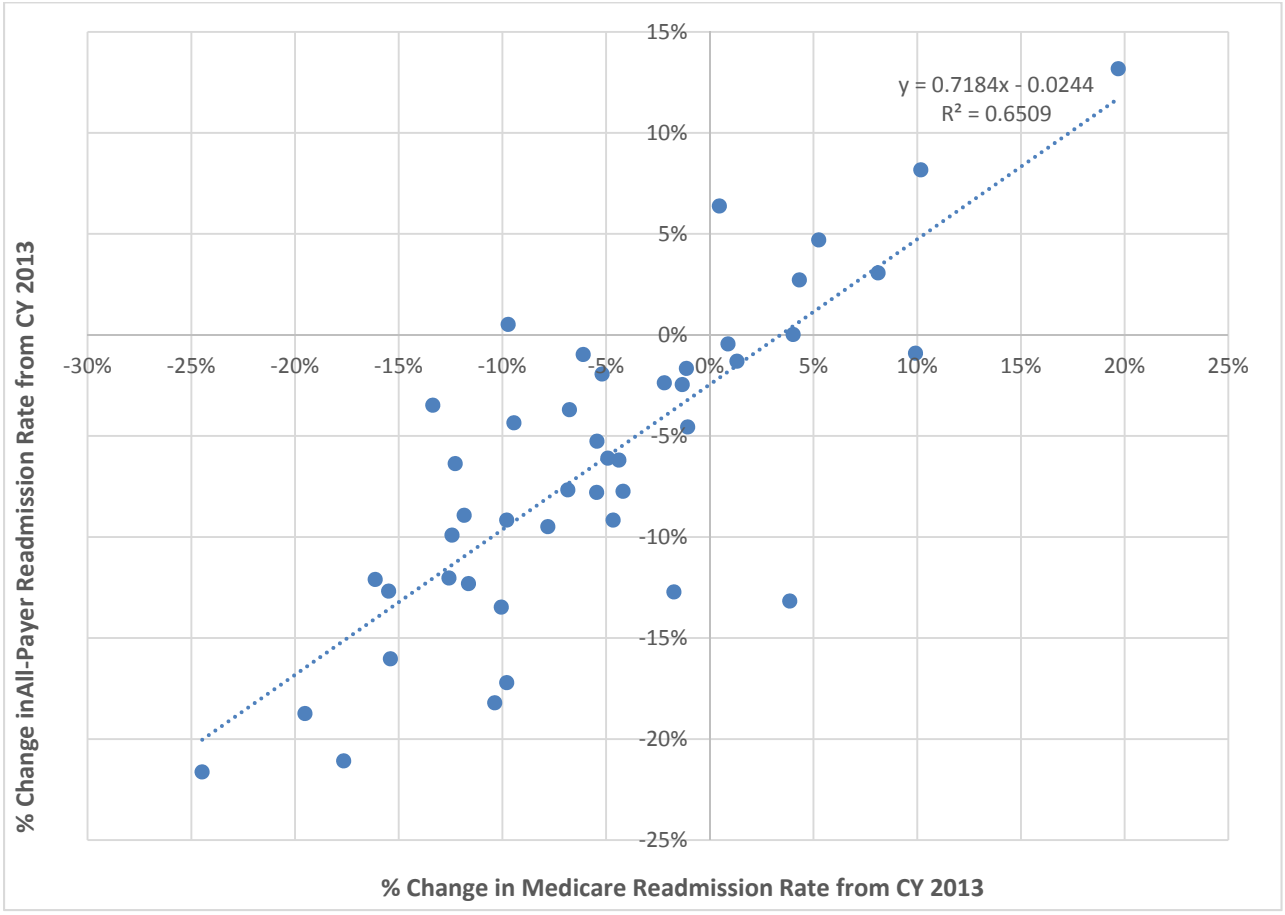
Appendix II. Figure 1. Case-Mix Adjusted All-Payer Readmission Rate Change, CY 2015 2013, by Hospital



APPENDIX III. ALL-PAYER AND MEDICARE READMISSION RATES

The following figure shows the relationship between changes in all-payer and Medicare readmission rates between CY 2013 and the data available through October of 2015. The x-axis shows the percent change in the Medicare readmission rate, and the y-axis shows the percent change in the all-payer readmission rate. Each blue dot represents one of the hospitals. The data show a strong correlation between the changes in all-payer and Medicare readmission rates.

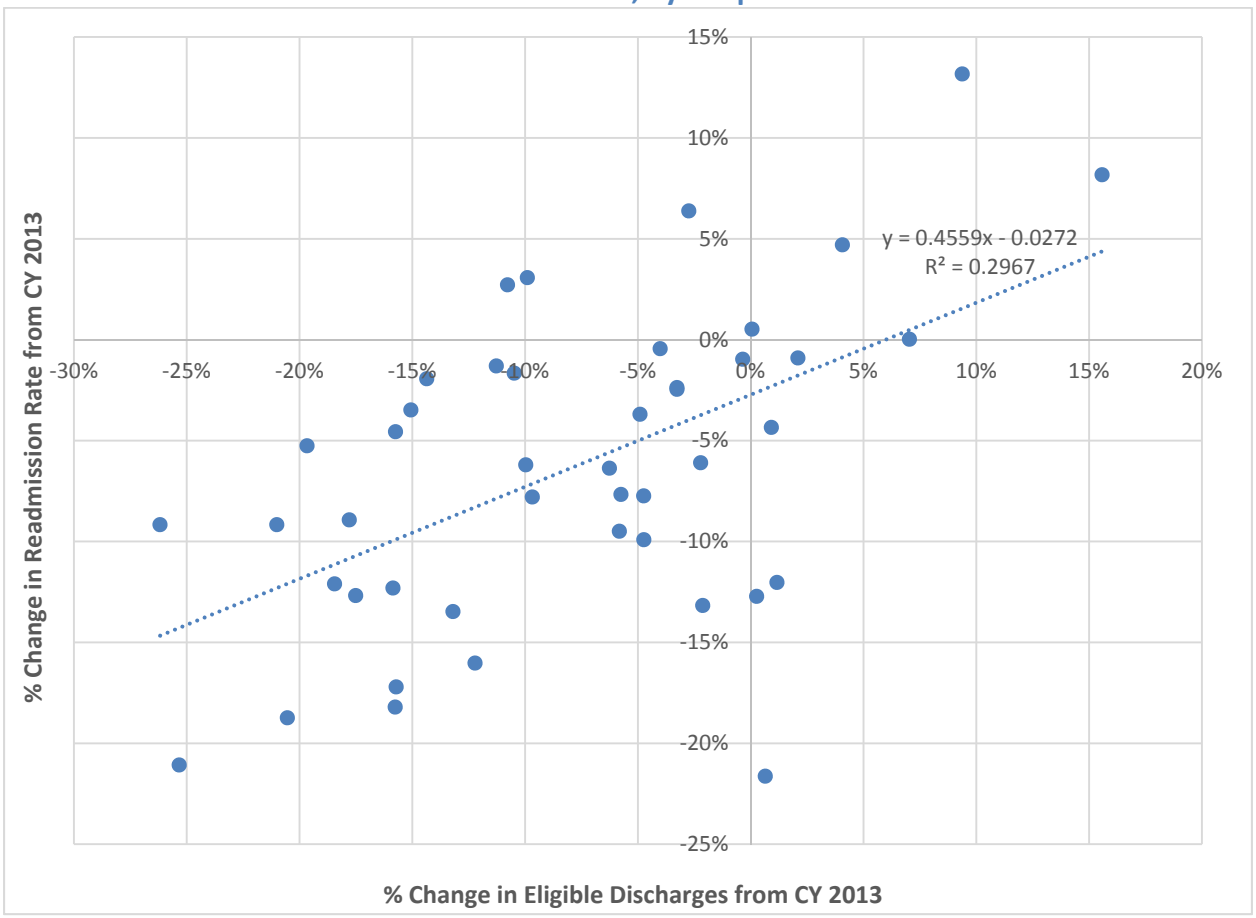
Appendix III. Figure 1. Change in All-Payer vs. Medicare Readmission Rates, CY 2015-2013, by Hospital



APPENDIX IV. ALL-PAYER ELIGIBLE DISCHARGES AND READMISSION RATES

The following figure shows the relationship between all-payer eligible discharges (x-axis) and the percent change in the all-payer readmission rate (y-axis). Each blue dot represents one of the hospitals. The data show a correlation between the rate of discharges and the rate of readmissions.

Appendix IV. Figure 1. Change in All-Payer Eligible Discharges vs. Readmission Rates, CY 2015-2013, by Hospital



APPENDIX V. AREA DEPRIVATION INDEX ANALYSES

The following figures show analyses of the relationship between the Area Deprivation Index (ADI) and readmissions. The ADI is a neighbor block-group measure of socio-economic and demographic factors based on 17 census-based indicators assessing education, income, poverty, housing costs, housing quality, employment, and single parent households. Figure 1 shows the relationship between hospitals in the most deprived areas (x-axis) and readmissions (y-axis). Each blue dot represents one of the hospitals. The data show that hospitals with a higher proportion of patients from deprived areas have higher readmission rates than hospitals with a lower proportion of patients from deprived areas. However, this relationship is not as strong when the two outlier hospitals are excluded (see Figure 2).

Appendix V. Figure 1. Percentage of All-Payer Patient Populations with >=85th ADI Percentile vs. Readmission Rate CY 2015, by Hospital

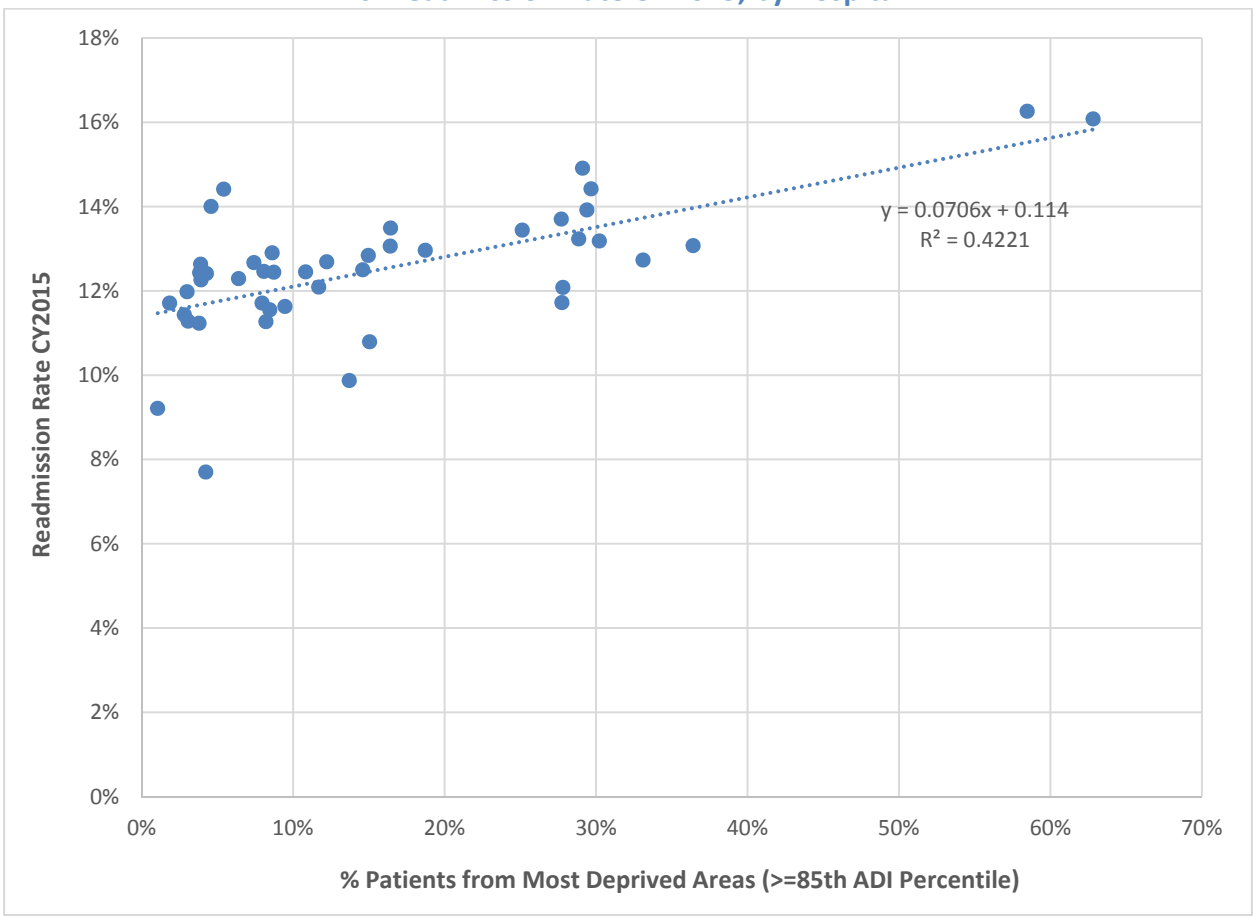
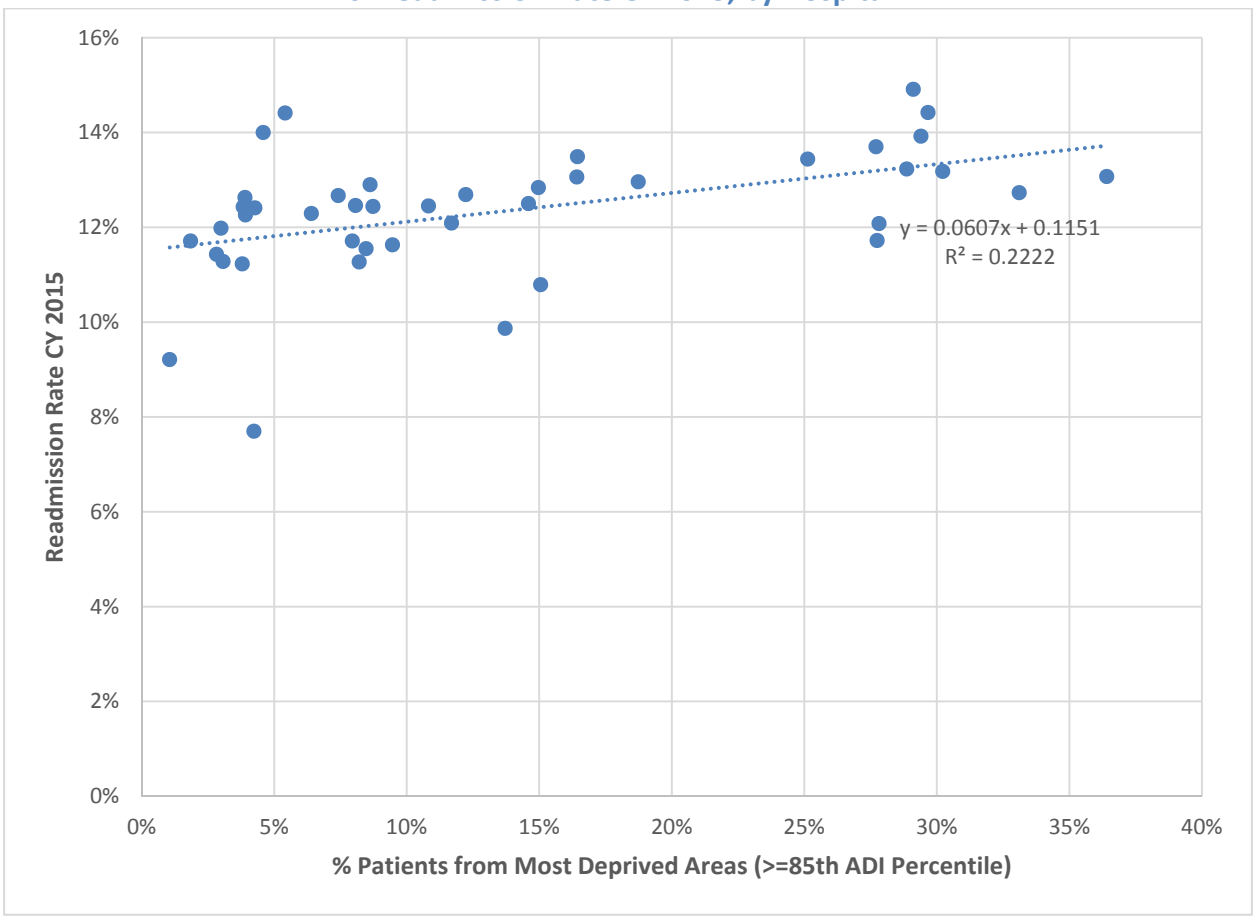


Figure 2 presents the same data as Figure 1, but excludes the two outlier hospitals. As noted above, the relationship between ADI and readmissions diminishes when these outliers are excluded.

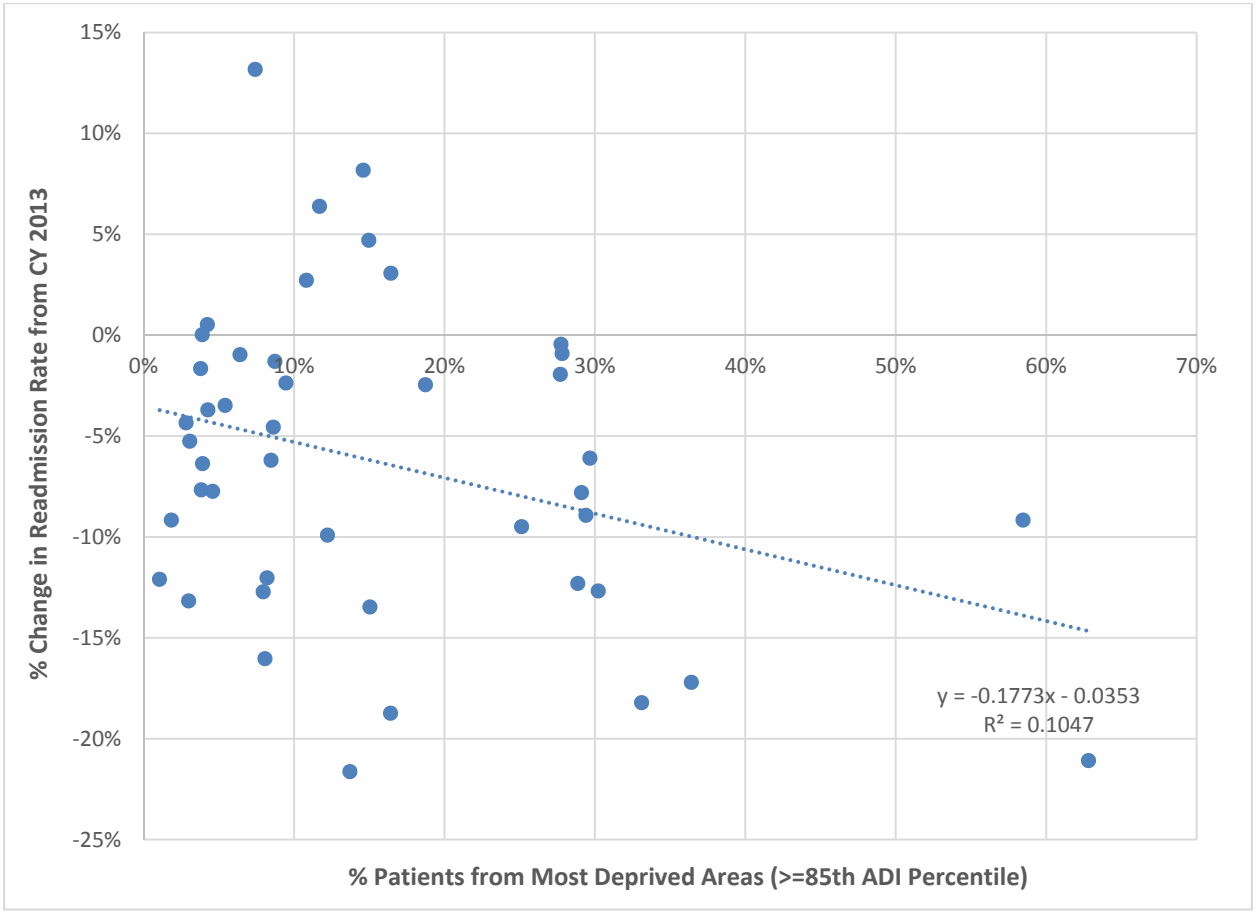
Appendix V. Figure 2. Percentage of All-Payer Patient Populations with >=85th ADI Percentile vs. Readmission Rate CY 2015, by Hospital[10]



[10] Two outlier data points from Bon Secours and University of Maryland Hospitals are removed from this figure.

The following figure shows the relationship between hospitals in the most deprived areas (x-axis) and the *change* in readmission rates (y-axis). The data do not show a correlation between ADI and the change in readmission rates and do not support the assumption that hospitals with higher deprivation burden have lower improvement rates.

Appendix V. Figure 3. Percentage of All-Payer Patient Populations with >=85th ADI Percentile vs. Change in Readmission Rate from CY 2013, by Hospital



APPENDIX VI. CHANGE IN READMISSION RATES INCLUDING OBSERVATION ROOMS

Stakeholders and HSCRC staff expressed concern that observation room stays can be substituted for readmissions. The following figure shows the relationship between the change in readmission rates that include observation room stays in the count of readmissions (x-axis) and the change in readmission rates that exclude observation room stays from the count of readmissions (y-axis). Each blue dot represents one hospital. The data show that the decline in the readmission rate that counts observation room stays is slightly less than the decline in the readmission rate that does not count observation room stays.

Appendix VI. Figure 1. Change in All-Payer Readmission Rates vs. Change in Readmission Rate Including Observations Stays from CY 2015-2013, by Hospital

APPENDIX VII. CMS HOSPITAL-WIDE MEDICARE READMISSIONS

The following figure shows the Centers for Medicare & Medicaid Services (CMS) readmission measures for each Maryland hospital.

Appendix VII. Figure 1. Medicare Readmission Rates, July 1, 2011-June 30, 2014

	Hospital Wide Rate	AMI	HF	Pneumonia	Hip/Knee	Unplanned CABG	Unplanned COPD	Unplanned Stroke
FREDERICK MEMORIAL HOSPITAL*	**13.8%**	16.5%	20.7%	16.8%	5.8%	0.0%	20.4%	11.5%
GREATER BALTIMORE MEDICAL CENTER*	**14.0%**	16.4%	19.8%	15.5%	4.9%	0.0%	17.6%	11.1%
MEDSTAR UNION MEMORIAL HOSPITAL	**14.1%**	15.7%	19.3%	16.4%	3.9%	13.3%	18.3%	11.9%
GARRETT COUNTY MEMORIAL HOSPITAL	**14.2%**	16.9%	22.2%	15.8%	4.1%	0.0%	19.7%	12.3%
ADVENTIST HEALTHCARE WASHINGTON ADVENTIST HOSPITAL	**14.4%**	16.4%	24.0%	17.1%	4.8%	13.8%	19.7%	13.2%
UNIVERSITY OF MARYLAND ST JOSEPH MEDICAL CENTER	**14.4%**	17.0%	20.0%	17.4%	4.2%	14.7%	18.3%	12.0%
CALVERT MEMORIAL HOSPITAL	**14.5%**	16.1%	21.8%	19.0%	6.5%	0.0%	18.2%	12.7%
UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	**14.5%**	17.5%	21.3%	18.1%	4.6%	0.0%	19.6%	11.9%
ANNE ARUNDEL MEDICAL CENTER	**14.7%**	17.9%	23.1%	17.5%	4.8%	0.0%	20.2%	13.6%
PENINSULA REGIONAL MEDICAL CENTER	**14.8%**	15.2%	20.6%	16.9%	5.0%	14.4%	16.7%	13.0%
SUBURBAN HOSPITAL	**14.8%**	15.9%	21.3%	17.0%	4.0%	13.9%	20.7%	13.6%
MEDSTAR HARBOR HOSPITAL	**14.9%**	17.5%	23.2%	15.5%	6.0%	0.0%	19.9%	12.9%
ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER	**15.0%**	16.6%	23.1%	17.4%	6.1%	0.0%	20.8%	13.5%
MERITUS MEDICAL CENTER	**15.0%**	15.6%	23.2%	17.2%	3.8%	0.0%	21.2%	12.9%
HOLY CROSS HOSPITAL	**15.1%**	18.4%	22.6%	16.8%	4.8%	0.0%	20.6%	13.4%
LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL	**15.1%**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
UNION HOSPITAL OF CECIL COUNTY	**15.1%**	17.9%	22.0%	16.0%	5.0%	0.0%	19.2%	12.2%
EDWARD MCCREADY MEMORIAL HOSPITAL	**15.2%**	0.0%	21.4%	17.7%	0.0%	0.0%	19.0%	0.0%

	Hospital Wide Rate	AMI	HF	Pneumonia	Hip/Knee	Unplanned CABG	Unplanned COPD	Unplanned Stroke
UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL	**15.2%**	16.6%	20.4%	18.1%	4.8%	0.0%	20.5%	13.2%
UNIVERSITY OF M D UPPER CHESAPEAKE MEDICAL CENTER	**15.3%**	17.2%	21.2%	16.9%	5.5%	0.0%	20.4%	12.1%
CARROLL HOSPITAL CENTER	**15.4%**	14.7%	21.1%	17.3%	4.2%	0.0%	19.1%	12.9%
SAINT AGNES HOSPITAL	**15.4%**	16.1%	23.0%	17.2%	6.9%	0.0%	19.3%	16.6%
MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	**15.5%**	17.1%	20.9%	16.4%	6.2%	0.0%	20.1%	12.1%
UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	**15.5%**	17.3%	21.3%	16.2%	5.2%	0.0%	21.3%	12.1%
MEDSTAR SAINT MARY'S HOSPITAL	**15.6%**	16.2%	24.5%	15.7%	5.1%	0.0%	20.8%	14.2%
WESTERN MARYLAND REGIONAL MEDICAL CENTER	**15.6%**	16.1%	22.3%	17.6%	4.8%	12.7%	19.1%	13.9%
ATLANTIC GENERAL HOSPITAL	**15.7%**	18.4%	22.1%	18.1%	5.5%	0.0%	19.8%	13.5%
UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	**15.8%**	0.0%	22.4%	17.1%	6.3%	0.0%	20.4%	12.6%
MEDSTAR GOOD SAMARITAN HOSPITAL	**15.9%**	18.2%	22.9%	20.4%	5.5%	0.0%	20.6%	11.8%
SINAI HOSPITAL OF BALTIMORE	**15.9%**	16.8%	22.6%	18.5%	6.1%	14.9%	20.8%	15.4%
PRINCE GEORGES HOSPITAL CENTER	**16.0%**	17.7%	24.4%	17.4%	0.0%	0.0%	21.7%	13.9%
BON SECOURS HOSPITAL	**16.1%**	0.0%	22.8%	17.1%	0.0%	0.0%	20.4%	13.3%
DOCTORS' COMMUNITY HOSPITAL	**16.1%**	16.6%	21.9%	19.4%	5.3%	0.0%	19.2%	12.8%
LAUREL REGIONAL MEDICAL CENTER	**16.2%**	18.1%	23.0%	18.8%	5.7%	0.0%	20.4%	14.0%
UNIVERSITY OF MD BALTO WASHINGTON MEDICAL CENTER	**16.4%**	15.7%	25.8%	20.2%	5.1%	0.0%	20.8%	13.2%
MERCY MEDICAL CENTER INC	**16.5%**	18.2%	23.8%	17.9%	5.2%	0.0%	20.4%	15.3%
NORTHWEST HOSPITAL CENTER	**16.6%**	18.5%	26.3%	20.8%	4.9%	0.0%	22.7%	13.9%
HOWARD COUNTY GENERAL HOSPITAL	**16.8%**	17.2%	25.2%	18.9%	4.6%	0.0%	20.9%	12.0%
MEDSTAR MONTGOMERY MEDICAL CENTER	**16.8%**	17.2%	23.8%	19.0%	5.9%	0.0%	22.6%	14.9%
MEDSTAR SOUTHERN MARYLAND HOSPITAL	**16.9%**	18.1%	22.7%	16.1%	4.9%	0.0%	21.1%	15.4%

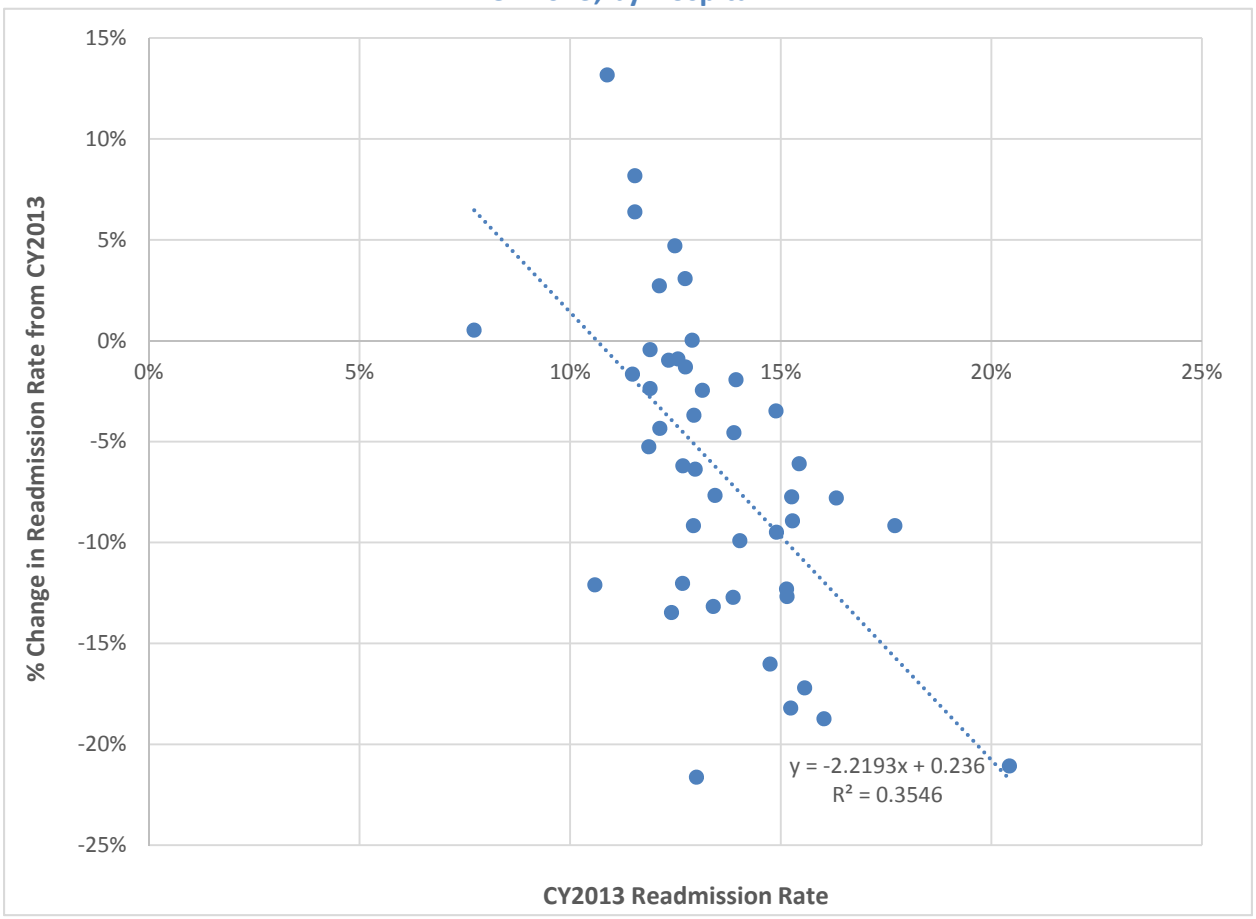
	Hospital Wide Rate	AMI	HF	Pneumonia	Hip/Knee	Unplanned CABG	Unplanned COPD	Unplanned Stroke
CENTER								
UNIVERSITY OF MARYLAND MEDICAL CENTER	**17.0%**	17.9%	25.1%	18.9%	4.8%	15.6%	19.8%	13.0%
FORT WASHINGTON HOSPITAL	**17.1%**	0.0%	24.8%	15.8%	5.1%	0.0%	24.2%	13.7%
UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	**17.6%**	0.0%	23.2%	17.6%	0.0%	0.0%	22.1%	13.0%
JOHNS HOPKINS HOSPITAL, THE	**17.8%**	18.8%	21.7%	17.9%	0.0%	15.5%	20.4%	14.5%
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	**17.9%**	17.6%	25.0%	19.0%	5.6%	0.0%	22.8%	14.7%
National Average	**15.2%**	**17.0%**	**22.0%**	**16.9%**	**4.8%**	**14.9%**	**20.2%**	**12.7%**

*Statistically lower readmission rate than national average

APPENDIX VIII. CHANGE IN THE ALL-PAYER READMISSION RATE SINCE CY 2013

The following figure shows the relationship between the CY 2013 base year readmission rate (x-axis) and the change in the readmission rate between CY 2013 and October of CY 2015 (y-axis). Each blue dot represents one hospital. The data show a relationship between a hospital's base year readmission rate and the rate of change through October of CY 2015.

Appendix VIII. Figure 1. Change in All-Payer Readmission Rates from CY 2015-2013 vs. CY 2013, by Hospital



APPENDIX IX. CY 2016 READMISSION TARGET RATES

The following figure compares the CY 2013 readmission rate for each hospital with the statewide average. The first column displays the hospital's name. The second column shows the hospital's actual readmission rate for CY 2013. The third column shows the statewide average readmission rate for CY 2013. The fourth column shows the difference between each hospital's CY 2013 readmission rate and the statewide average. The fifth column shows each hospital's readmission reduction target for CY 2016, and the sixth column shows each hospital's target readmission rate for CY 2016. The seventh column shows each hospital's actual change in readmission rate for CY 15 compared with CY 13.

Appendix IX. Figure 1. CY 2013 Readmission Rates, and CY 2016 Target Readmission Rates, by Hospital

1. HOSPITAL NAME	2. CY13 YTD RISK- Adjusted Rate	3. Average State Readmission Rate	4. Difference from State Average	5. Adjusted Target Reduction	6. CY16 Target Readmission Rate	7. % Change in Readmission Rate CY 15 vs CY13 YTD
GARRETT COUNTY	7.66%	13.84%	-6.18%	-1.00%	7.58%	0.5%
CALVERT	10.48%	13.84%	-3.36%	-4.34%	10.03%	-12.1%
UNION HOSPITAL OF CECIL COUNT	11.19%	13.84%	-2.65%	-5.18%	10.61%	13.2%
EASTON	11.36%	13.84%	-2.48%	-5.38%	10.75%	6.4%
FREDERICK MEMORIAL	11.42%	13.84%	-2.42%	-5.45%	10.80%	-1.7%
PRINCE GEORGE	11.55%	13.84%	-2.29%	-5.61%	10.90%	8.2%
PENINSULA REGIONAL	11.77%	13.84%	-2.07%	-5.87%	11.08%	-0.4%
SHADY GROVE	11.91%	13.84%	-1.93%	-6.03%	11.19%	-5.3%
G.B.M.C.	11.91%	13.84%	-1.93%	-6.03%	11.19%	-2.4%
SUBURBAN	11.95%	13.84%	-1.89%	-6.08%	11.22%	-4.4%
WASHINGTON ADVENTIST	12.12%	13.84%	-1.72%	-6.28%	11.36%	2.7%
DORCHESTER	12.19%	13.84%	-1.65%	-6.36%	11.41%	-0.9%
MERITUS	12.27%	13.84%	-1.57%	-6.46%	11.10%	4.6%

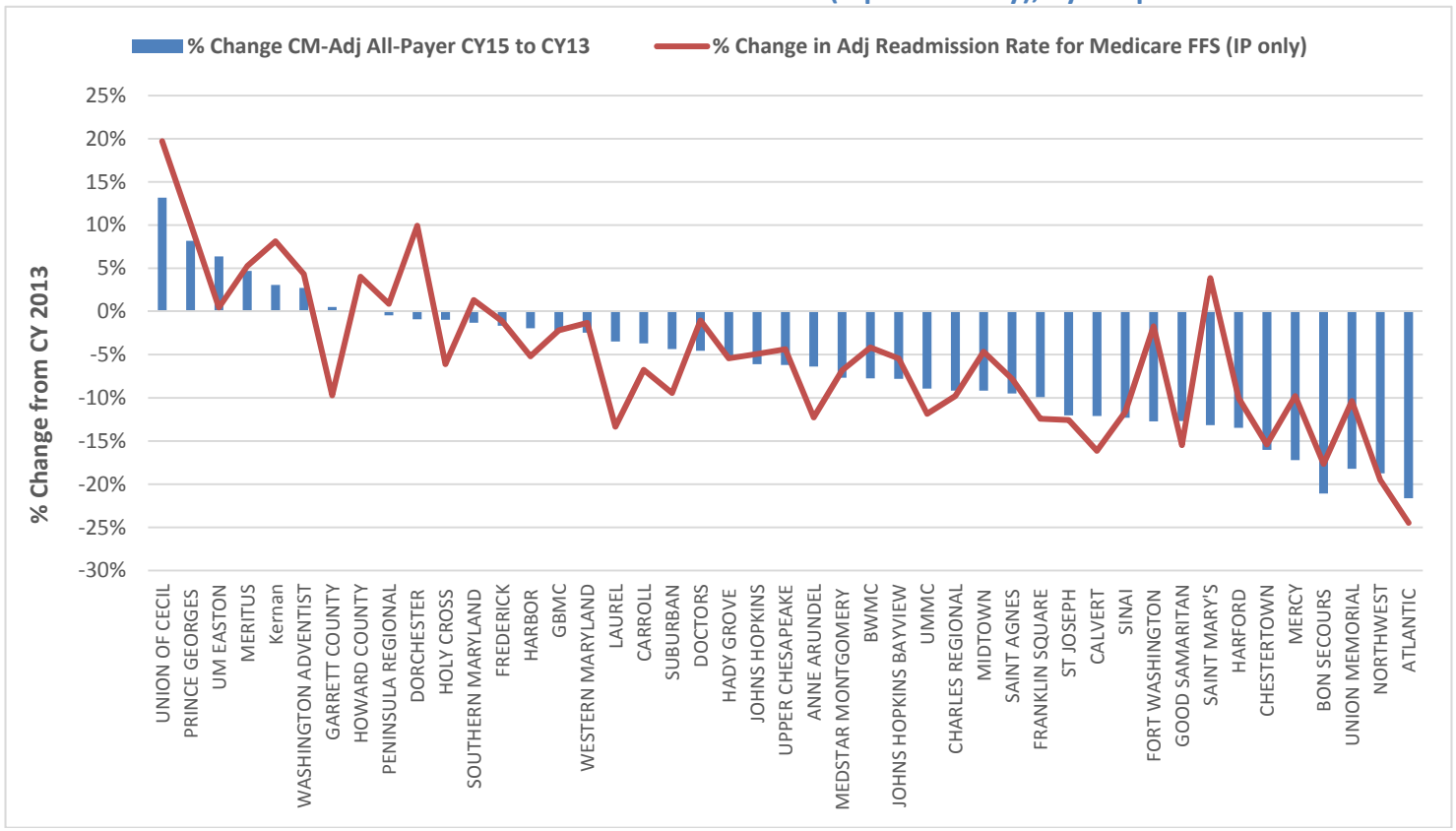
1. HOSPITAL NAME	2. CY13 YTD RISK- Adjusted Rate	3. Average State Readmission Rate	4. Difference from State Average	5. Adjusted Target Reduction	6. CY16 Target Readmission Rate	7. % Change in Readmission Rate CY 15 vs CY13 YTD
UPPER CHESAPEAKE HEALTH	12.31%	13.84%	-1.53%	-6.50%	11.51%	-6.2%
HOLY CROSS	12.41%	13.84%	-1.43%	-6.62%	11.59%	-1.0%
HARFORD	12.47%	13.84%	-1.37%	-6.69%	11.64%	-13.5%
ATLANTIC GENERAL	12.59%	13.84%	-1.25%	-6.84%	11.73%	-21.6%
SOUTHERN MARYLAND	12.61%	13.84%	-1.23%	-6.86%	11.74%	-1.3%
HOWARD COUNTY	12.62%	13.84%	-1.22%	-6.87%	11.75%	0.1%
UM ST. JOSEPH	12.81%	13.84%	-1.03%	-7.10%	11.90%	-12.0%
CHARLES REGIONAL	12.89%	13.84%	-0.95%	-7.19%	11.96%	-9.2%
CARROLL COUNTY	12.89%	13.84%	-0.95%	-7.19%	11.96%	-3.7%
REHAB & ORTHO	13.08%	13.84%	-0.76%	-7.42%	12.11%	3.1%
ANNE ARUNDEL	13.09%	13.84%	-0.75%	-7.43%	12.12%	-6.3%
WESTERN MARYLAND HEALTH SYSTEM	13.29%	13.84%	-0.55%	-7.67%	12.27%	-2.5%
FT. WASHINGTON	13.41%	13.84%	-0.43%	-7.81%	12.36%	-12.7%
MONTGOMERY GENERAL	13.47%	13.84%	-0.37%	-7.88%	12.41%	-7.7%
DOCTORS COMMUNITY	13.52%	13.84%	-0.32%	-7.94%	12.45%	-4.6%
MCCREADY	13.58%	13.84%	-0.26%	-8.01%	12.49%	-47.6%
ST. MARY	13.80%	13.84%	-0.04%	-8.27%	12.66%	-13.2%
HARBOR	13.97%	13.84%	0.13%	-9.50%	12.64%	-1.9%
FRANKLIN SQUARE	14.09%	13.84%	0.25%	-9.50%	12.75%	-9.9%
CHESTERTOWN	14.84%	13.84%	1.00%	-9.50%	13.43%	-16.0%
ST. AGNES	14.85%	13.84%	1.01%	-9.50%	13.44%	-9.5%
LAUREL REGIONAL	14.92%	13.84%	1.08%	-9.50%	13.50%	-3.4%

1. HOSPITAL NAME	2. CY13 YTD RISK- Adjusted Rate	3. Average State Readmission Rate	4. Difference from State Average	5. Adjusted Target Reduction	6. CY16 Target Readmission Rate	7. % Change in Readmission Rate CY 15 vs CY13 YTD
SINAI	15.08%	13.84%	1.24%	-9.50%	13.65%	-12.3%
GOOD SAMARITAN	15.10%	13.84%	1.26%	-9.50%	13.67%	-12.7%
BALTIMORE WASHINGTON MEDICAL CENTER	15.18%	13.84%	1.34%	-9.50%	13.74%	-7.8%
UNIVERSITY OF MARYLAND	15.29%	13.84%	1.45%	-9.50%	13.84%	-9.0%
JOHNS HOPKINS	15.36%	13.84%	1.52%	-9.50%	13.90%	-6.1%
UNION MEMORIAL	15.56%	13.84%	1.72%	-9.50%	14.08%	-18.2%
MERCY	15.78%	13.84%	1.94%	-9.50%	14.28%	-17.2%
NORTHWEST	16.07%	13.84%	2.23%	-9.50%	14.54%	-18.7%
HOPKINS BAYVIEW MED CTR	16.17%	13.84%	2.33%	-9.50%	14.63%	-7.8%
UMMC MIDTOWN	17.90%	13.84%	4.06%	-9.50%	16.20%	-9.2%
BON SECOURS	20.37%	13.84%	6.53%	-9.50%	18.43%	-21.1%

APPENDIX X. CHANGE IN ALL-PAYER AND MEDICARE READMISSIONS

The following figure compares the change in case-mix adjusted readmissions for all-payers with the change for Medicare fee-for-service for each hospital. The figure shows the rate of change between CY 2013 and October of CY 2015. In general, all-payer and Medicare trends are similar, but some hospitals show greater improvements for Medicare, while other hospitals show greater improvement for all payers.

Appendix X. Figure 1. Change in Case-Mix Adjusted All-Payer Readmissions from CY 2015-2013 and Change in Adjusted Readmissions for Medicare Fee-for-Service (Inpatient only), by Hospital



DRAFT Recommendation for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018

March 2, 2016

Health Services Cost Review Commission
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(410) 764-2605
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This document contains the draft staff recommendations for updating the aggregate amount at-risk under Maryland hospital quality programs for rate year 2018. Please submit comments on this draft to the Commission by Monday April 4th, 2016, via hard copy mail or email to Dianne.feeney@maryland.gov.

Table of Contents

LIST OF ABBREVIATIONS

CMMI	Center for Medicare and Medicaid Innovation
FFY	Federal fiscal year
FY	State fiscal year
RY	State rate year
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital-Acquired Conditions Program
QBR	Quality-based reimbursement
RRIP	Readmissions Reduction Incentive Program
VBP	Value-based purchasing
PAU	Potentially avoidable utilization
PQI	Prevention quality indicator

INTRODUCTION

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) quality-based payment methodologies are important policy tools with great potential to provide strong incentives for hospitals to improve their quality performance over time. These quality-based payment programs hold amounts of hospital revenue at risk directly related to specified performance benchmarks. Maryland's Quality-Based Reimbursement (QBR) program employs measures that are similar to those in the federal Medicare Value-Based Purchasing (VBP) program. 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 Medicare quality-based programs. Instead, the HSCRC implements various Maryland-specific quality-based payment programs, which are discussed in further detail in the background section of this report.

Maryland entered into a new All-Payer Model Agreement with the Center for Medicare and Medicaid Services (CMS) on January 1, 2014. One of the requirements under this new agreement is that the proportion of hospital revenue that is held at risk under Maryland's quality-based payment programs must be greater than or equal to the proportion that is held at risk under national Medicare quality programs. The Model Agreement also requires Maryland to achieve specific reduction targets in potentially preventable conditions, and readmissions, in addition to the revenue at risk requirement. In an effort to meet these reduction targets, Maryland restructured its quality programs in such a way that financial incentives are established prior to the performance period in order to motivate quality improvement and the sharing of best practices while holding hospitals accountable for their performance.

The purpose of this report is to make recommendations for the amount of revenue that should be held at risk for rate year RY 2018. Except for some QBR measures that are based on CMS timelines, performance year for the quality based payments is a calendar year, base year from which the improvement is calculated is fiscal year and the adjustments are applied in the following rate year. For RY2018, which starts in July 2017, the performance year is CY2016 and base year is FY2015. The timeline for RY 2018 aggregate at risk recommendation was postponed to align with RY 2018 RRIP recommendation. Final recommendations for both policies may require alignment with Readmission Shared Savings Policy to estimate overall impact of all programs in tandem including shared savings adjustments, as revisions are contemplated to the shared savings policy.

BACKGROUND

1. Federal Quality Programs

Maryland's amount of revenue at risk for quality-based payment programs is compared against the amount at risk for the following national Medicare quality programs:

- The Medicare Hospital Readmissions Reduction Program, which reduces payments to inpatient prospective payment system hospitals with excess readmissions.[1]
- The Medicare Hospital-Acquired Condition Reduction Program, which ranks hospitals according to performance on a list of hospital-acquired condition quality measures and reduces Medicare payments to the hospitals in the lowest performing quartile.[2]
- The Medicare VBP program, which adjusts hospitals' payments based on their performance on four domains that reflect hospital quality: the clinical care domain, the patient experience of care domain, the outcome domain, and the efficiency domain.[3]

Across these programs, 5.75 percent of inpatient revenue was at risk for federal fiscal year (FFY) 2016 and 6.0 percent in FFY 2017.

2. Maryland's Quality-Based Programs

As discussed in the introduction section of this report, Maryland is exempt from the federal Medicare hospital quality programs. Instead, Maryland implements the following quality-based payment programs:

- The QBR program employs measures in several domains, including the clinical care, patient experience, outcomes, and patient safety. Since the beginning of the program, financial adjustments have been based on revenue neutral scaling of hospitals in allocating rewards and reductions based on performance, with the net increases in rates for better performing hospitals funded by net decreases in rates for poorer performing hospitals.[4] The distribution of rewards/penalties has been based on relative points achieved by the hospitals and were not known before the end of performance period. Starting in state fiscal year (FY) 2017, the QBR program revenue neutrality requirement has been removed from the program, and payment adjustments have been linked to a point-based scale (i.e., present payment scale) instead of relatively ranking hospitals, all of which was designed to provide hospitals with more predictable revenue adjustments based on their performance.

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

[2] For more information on the Medicare Hospital-Acquired Condition Reduction program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html.

[3] For information on the Medicare VBP program, see https://www.medicare.gov/hospitalcompare/Data/hospital-vbp.html.

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

- The Maryland Hospital Acquired Conditions (MHAC) program measures hospital performance using 3M's potentially preventable complications. HSCRC calculates observed-to-expected ratios for each complication and compares them with statewide benchmarks and thresholds. This program was modified substantially with CY2014 performance period to align with the All-Payer Model Agreement. Revenue adjustments are determined using a preset payment scale. The revenue at risk and reward structure is based on a tiered approach that requires statewide targets to be met for higher rewards and lower reductions.
- The Readmission Reduction Incentive Program (RRIP) establishes a readmission reduction target and rewards/penalties for hospitals. The statewide minimum improvement target is established to eliminate the gap between the national Medicare readmission rate and the Maryland Medicare readmission rate.
- In addition to the three programs described above, two additional quality-based payment adjustments are implemented to hospital revenues prospectively. The Readmission Shared Savings Program reduces each hospital's approved revenues prospectively based on its case-mix adjusted readmission rates. Potentially avoidable utilization (PAU) efficiency reductions are applied to global budgets to reduce allowed volume growth based on the percent of revenue associated with PAU for each hospital. These adjustments are considered within the context of update factor discussions and measurement periods are based on a previous calendar year. For FY2017, the measurement period will be based on CY 2015 period.

The Commission approved the following amounts of inpatient revenue to be held at-risk for rate year 2016:

- QBR– A maximum penalty of 1 percent of inpatient revenue, with revenue-neutral scaled rewards up to 1 percent.
- MHAC– A maximum penalty of 4 percent of inpatient revenue if the statewide improvement target is not met; a 1 percent maximum penalty and rewards up to 1 percent if the statewide improvement target is met.
- RRIP– A reward of 0.5 percent of inpatient revenue for any hospital that improves its all-payer readmission rate by at least 6.76 percent.
- Readmission Shared Savings- Average reduction of 0.6 percent of total hospital revenue.

The Commission approved the following amounts to be held at-risk for rate year 2017:

- QBR– A maximum penalty of 2 percent of inpatient revenue, with rewards scaled up to a maximum of 1 percent.
- MHAC– A maximum penalty of 3 percent of inpatient revenue if the statewide improvement target is not met; a 1 percent maximum penalty and rewards up to 1 percent if the statewide improvement target is met.

- RRIP– A maximum penalty of 2 percent of inpatient revenue, and a 1 percent maximum reward for hospitals that reduce readmission rates at or better than the minimum improvement target.
- Maximum penalty guardrail– A maximum penalty guardrail of 3.5 percent of total hospital revenue. This means, for example, that a hospital that received the maximum penalty for all three quality-based payment programs would have a maximum penalty of 7 percent inpatient revenue, which is equal to 4.2 percent of total hospital revenue. Staff used the Medicare aggregate amount at risk total as the benchmark for calculating the hospital maximum penalty guardrail (e.g. 6 percent * 58 percent (percent Inpatient Revenue).

ASSESSMENT

In order to develop the amount of revenue at risk for rate year 2018, HSCRC staff consulted with CMMI, conducted analyses, and solicited input from the Performance Measurement Workgroup.[5] During its January meeting, the Performance Measurement Workgroup reviewed (1) data comparing the amount of revenue at risk in Maryland with the national Medicare programs, and (2) staff's proposal for the amount at risk for rate year 2018.

Aggregate Revenue At-Risk Comparison with Medicare Programs

After discussions with CMMI, HSCRC staff performed analyses of both "potential" and "realized" revenue at risk. Potential revenue at risk refers to the maximum amount of revenue that is at risk in the measurement year. Realized risk refers to the actual amounts imposed by the programs. The comparison with the national amounts is calculated on a cumulative basis. Figure 1 compares the potential amount of revenue at risk in Maryland with the amount at risk in the national programs. The difference between the national Medicare and Maryland all-payer annual amounts are summed after each year's experience to compare the cumulative difference over the Model agreement term.

The top half of Figure 1 displays the percentage of potential inpatient revenue at risk in Maryland for all payers for each of Maryland's quality-based payment programs for rate years 2014 through 2017. The bottom half of the figure displays the percentage of potential national Medicare inpatient revenue at risk for quality-based payment programs for FFYs 2014 through 2017. Due to efforts to align Maryland's quality-based payment programs with the national programs and the increasing emphasis on value-based payment adjustments, Maryland exceeded the national aggregate maximum at risk amounts in both rate years 2016 and 2017. Cumulatively, Maryland's maximum at risk total was 5.15 percent higher than the nation in FFY 2017.

[5] For more information on the Performance Measurement Workgroup, see http://www.hscrc.state.md.us/hscrc-workgroup-performance-measurement.cfm.

Figure 1. Potential Revenue at Risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2017

% of MD All Payer Inpatient Revenue	FY 2014	FY 2015	FY2016	FY2017
MHAC	2.00%	3.00%	4.00%	3.00%
RRIP			0.50%	2.00%
QBR	0.50%	0.50%	1.00%	2.00%
Shared Savings	0.41%	0.86%	1.16%	*1.16%**
GBR PAU	0.50%	0.86%	1.10%	*1.10%**
MD Aggregate Maximum At Risk	3.41%	5.22%	7.76%	9.26%

*Italics are based on RY 2016 results, and subject to change based on RY 2017 policy, which is to be finalized at June 2016 Commission meeting.

Medicare National - Potential Inpatient Revenue at Risk Absolute Values

% of National Medicare Inpatient Revenue	FFY 2014	FFY 2015	FFY2016	FFY2017
HAC		1.00%	1.00%	1.00%
Readmissions	2.00%	3.00%	3.00%	3.00%
VBP	1.25%	1.50%	1.75%	2.00%
Medicare Aggregate Maximum At Risk	3.25%	5.50%	5.75%	6.00%
Cumulative MD-Medicare National Difference	**0.16%**	**-0.12%**	**1.89%**	**5.15%**

As Maryland's programs moved away from revenue neutral rewards and penalties and toward payment adjustments based on preset payment scales, the actual amounts imposed in quality-based programs differ from the maximum amounts established in the policies. For example, the maximum penalty is set to the lowest attainment score in the base year measurement. As hospitals improve their scores during the performance year, none of the hospitals may be subject to the maximum penalty when the payment adjustments are implemented. On the other hand, the national Medicare programs may make payment adjustments only to the lowest performing hospitals, limiting the reach of the performance-based adjustments. CMMI and HSCRC staff worked on a methodology to compare the actual payment adjustments in total by summing absolute average payment adjustments across all programs, namely aggregate realized at risk. Maryland is expected to meet or exceed both potential and realized at risk amounts of national programs.

Figure 2 summarizes the statewide totals and average payment adjustments for Maryland hospitals for RY 2016. The first five blue columns display the results for each of the quality-based payment programs. The sixth blue column displays the aggregate amount of revenue at risk, summed across all five programs. The final blue column, "Net Adjustment Across all Programs," represents the maximum penalty and reward for an individual hospital (row 2 and 3), and the average absolute adjustments across all hospitals (row 4). The final row shows the total net adjustments, accounting for both penalties and rewards. While aggregate potential at risk was at 7.76 percent, the sum of average adjustments across all programs was equal to 1.95 percent of inpatient revenue, which is higher than the estimated CMS rate of 1.01 percent. When

we sum penalties and rewards across the hospital, the maximum penalty and reward received by one hospital was 1.95 percent, and 1.09 percent respectively. In RY 2016, the total net adjustments were $38.3 million, with $68.3 million in total penalties and $29.9 million in total rewards. When summarized at the hospital level, the net penalties were $45.6 million and net rewards were $7.2 million.

Figure 2. Actual Revenue Adjustments and Potential at Risk Percent Inpatient Revenue for Maryland's Quality-Based Payment Programs, RY 2016

	MHAC	RRIP	QBR	Shared Savings	PAU	Aggregate (Sum of All Programs)	Net Hospital Adjustment Across all Programs
Potential At Risk (Absolute Value)	4.00%	0.50%	1.00%	1.16%	1.10%	7.76%	
Maximum Hospital Penalty	-0.21%	NA	-1.00%	-0.29%	-1.10%	-2.59%	-1.95%
Maximum Hospital Reward	1.00%	0.50%	0.73%	NA	NA	2.23%	1.09%
Average Absolute Level Adjustment	**0.18%**	**0.15%**	**0.30%**	**0.93%**	**0.39%**	**1.95%**	**0.70%**
Total Penalty	-$1,080,406	NA	-$12,880,046	-$27,482,838	-$26,900,004	-$68,343,293	
Total Reward	$7,869,585	$9,233,884	$12,880,046	NA	NA	$29,983,515	
Total Net Adjustments	**$6,789,180**	**$9,233,884**	**$0**	**-$27,482,838**	**-$26,900,004**	**-$38,359,778**	

Figure 3 summarizes preliminary statewide totals and average payment adjustments for Maryland hospitals for RY 2017 for the MHAC, readmission, and QBR programs. Figure 3 follows the same format as Figure 2. Reflecting higher amounts at risk approved for RRIP and QBR approved by the Commission for RY 2017, the aggregate maximum penalty under three programs is 7 percent. Year to date actual adjustment calculations are based on MHAC and readmission rates as of October discharges. It is likely that these results will change with the final data submissions and with complete performance year. Furthermore, Commission may implement changes to the RY 2017 RRIP payment adjustments, which is included in the draft RRIP recommendation presented in March Commission meeting. With these data caveats, the average absolute payment adjustment across two programs is 1.08 percent of inpatient revenue. On a hospital specific basis, maximum penalty received by a single hospital is calculated to be -1.92 percent, and maximum reward is 2.0 percent. On aggregate, two program adjustments are neutralizing each other with -$1 million statewide net impact. There are no penalties for the MHAC program and RRIP penalties are equal to $39.0 million. Total rewards of $37.9 million include $26.3 million in MHAC rewards, $11.6 million in RRIP rewards.

Figure 3. Actual Revenue at Risk for Maryland's Quality-Based Payment Programs, RY 2017 Year-to-Date

	MHAC	RRIP**	QBR***	Shared Savings/PAU*	Aggregate (Sum of All Programs)	Net Hospital Adjustment Across all Programs
Potential At Risk (Absolute Value)	3.00%	2.00%	2.00%		7.00%	
Maximum Hospital Penalty	0.00%	-2.00%			-2.00%	-1.92%
Maximum Hospital Reward	1.00%	1.00%			2.00%	2.00%
Average Absolute Level Adjustment	**0.37%**	**0.71%**			**1.08%**	**0.78%**
Total Penalty	$0	-$38,994,508			-$38,994,508	
Total Reward	$26,338,592	$11,586,425			$37,925,017	
Total Net Adjustments	**$26,338,592**	**-$27,408,083**			**-$1,069,491**	

**Shared Savings and PAU adjustments will be determined with the FY2017 Update Factor.*

***RRIP results are preliminary results as of October 2015 and do not reflect any potential protections that may be developed based on the approved RY 2017 recommendation.*

****These QBR YTD results are not available due to 9 month data lag for measures from CMS. Staff will provide updated calculations for the final recommendation.*

In summary, Maryland outperformed the national programs in both the scope of the measurements and in the aggregate payment amounts at risk. Maryland hospitals improved their performance in reducing complications and more recently in improving readmissions. All-Payer Model financial success will depend on further reductions in PAU, and staff intends to shift more focus on potentially avoidable admissions in quality-based payment programs in the future and reduce penalties other areas. Staff will continue to discuss the appropriate amounts for quality-based payment programs with the Performance Measurement and Payment Models Workgroups in March.

See Appendix I for hospital-level results.

Maximum Revenue at Risk Hospital Guardrail

As the HSCRC increases the maximum revenue adjustments statewide, the potential for a particular hospital to receive large revenue reductions that may cause unmanageable financial risk has raised concerns. As hospitals improve quality in the state, the variation between individual hospitals is expected to decline, increasing the chances of a single hospital receiving the maximum penalties from all programs. Similar to the risk corridors in other value-based purchasing programs, a maximum penalty guardrail may be necessary to mitigate the detrimental financial impact of unforeseen large adjustments in Maryland programs. Given the increases in risk levels in other programs, a hospital-specific guardrail will provide better protection than a statewide limit. In RY 2017, the hospital maximum penalty guardrail was set at 3.5 percent of

total hospital revenue. One hospital's current year-to-date calculations result in a net penalty of 3.3 percent of inpatient revenue, which equates to 2 percent of the hospital's total revenue before the adjustments for PAU and shared savings reductions.

RECOMMENDATION

Based on this assessment, HSCRC staff recommends the following maximum penalties and rewards for QBR, MHAC and RRIP for RY 2018:

1. QBR: The maximum penalty should be 2 percent, while the maximum reward should be 1 percent.

   The maximum penalty matches the penalty in Medicare's VBP program and increases the incentive for hospitals to improve their Hospital Consumer Assessment of Healthcare Providers and Systems survey scores, which continue to be low compared with the nation.

2. MHAC: There should be a 3 percent maximum penalty if the statewide improvement target is not met; there should be a 1 percent maximum penalty and a reward up to 1 percent if the statewide improvement target is met.

3. RRIP: The maximum penalty should be 2 percent, and the reward should be 1 percent for hospitals that reduce readmission rates at or better than the minimum improvement.

   Staff will be evaluating and discussing other options for shared savings to focus attention more broadly on avoidable admissions/hospitalizations (Potentially Avoidable Utilization, or PAUs). The Commission's funding of infrastructure as part of the RY 2016 revenue focused on reducing PAUs more broadly than readmissions. Also, the staff is proposing to add sepsis to the PAUs. With the need to increase the reductions of PAUs, there is a need to focus on opportunities for improvement beyond readmissions to include reductions in admissions for ambulatory care-sensitive conditions, measured using prevention quality indicators (PQIs) and sepsis admissions. If Maryland increases the prospective adjustment for these PAUs, we may moderate the maximum penalty under the RRIP program.

4. Maximum penalty guardrail: The hospital maximum penalty guardrail should continue to be set at 3.5 percent of total hospital revenue.

5. The quality adjustments should be applied to inpatient revenue centers, similar to the approach used by CMS. The HSCRC staff can apply the adjustments to hospitals' medical surgical rates to concentrate the impact of this adjustment to inpatient revenues, consistent with federal policies.

APPENDIX I. RY 2016 HOSPITAL-LEVEL SCALING RESULTS FOR QUALITY-BASED PAYMENT PROGRAMS

Appendix 1 contains the following figures for rate year 2016:

1. The consolidated revenue adjustments across all quality-based payment programs, by hospital
2. The adjustments for the quality-based reimbursement (QBR) program, by hospital
3. The adjustments for the Readmission Reduction Incentive Program (RRIP), by hospital
4. The adjustments for the Maryland Hospital-Acquired Conditions program, by hospital

Figure 1. Consolidated Adjustments for All Quality-Based Payment Programs for Rate Year 2016, by Hospital

Hospital Name	FY 2015 Permanent Inpatient Revenue	MHAC % Revenue Adjustment	RRIP % Revenue Adjustment	QBR % Revenue Adjustment	NET Shared Savings % Revenue Adjustment	PAU % Revenue Adjustment	Net Impact %	Net Impact $
SOUTHERN MARYLAND	$161,253,766	-0.21%	0.00%	-0.51%	-0.31%	-0.92%	-1.95%	$(3,138,427)
DORCHESTER	$23,804,066	0.00%	0.00%	-0.54%	-0.29%	-0.75%	-1.58%	$(374,986)
PRINCE GEORGE	$176,633,177	0.00%	0.00%	-1.00%	-0.30%	-0.27%	-1.57%	$(2,773,413)
GOOD SAMARITAN	$178,635,338	0.00%	0.00%	-0.46%	-0.39%	-0.31%	-1.15%	$(2,059,395)
ANNE ARUNDEL	$308,739,341	0.00%	0.00%	-0.42%	-0.23%	-0.35%	-1.00%	$(3,087,905)
CHARLES REGIONAL	$76,417,734	0.21%	0.00%	-0.06%	-0.37%	-0.85%	-1.07%	$(816,786)
UNION MEMORIAL	$239,732,514	0.00%	0.50%	-0.85%	-0.43%	-0.31%	-1.09%	$(2,602,721)
FRANKLIN SQUARE	$282,129,812	0.00%	0.00%	-0.35%	-0.28%	-0.30%	-0.93%	$(2,614,927)
HOLY CROSS	$319,832,140	0.00%	0.00%	-0.31%	-0.35%	-0.25%	-0.91%	$(2,900,125)
CARROLL COUNTY	$136,537,813	-0.17%	0.00%	0.31%	-0.24%	-0.70%	-0.80%	$(1,090,207)
HARBOR	$122,412,282	0.00%	0.00%	-0.36%	-0.33%	-0.18%	-0.87%	$(1,066,772)
WASHINGTON ADVENTIST	$160,049,373	0.00%	0.00%	-0.15%	-0.35%	-0.42%	-0.93%	$(1,484,691)
SUBURBAN	$182,880,097	0.00%	0.00%	-0.10%	-0.28%	-0.47%	-0.84%	$(1,534,715)
ATLANTIC GENERAL	$38,616,313	0.63%	0.00%	-0.72%	-0.33%	-0.41%	-0.82%	$(318,359)
BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,798	0.00%	0.00%	0.42%	-0.36%	-0.72%	-0.67%	$(1,492,281)
FT. WASHINGTON	$17,901,765	0.95%	0.00%	-0.18%	-0.43%	-1.10%	-0.77%	$(137,591)
SHADY GROVE	$231,030,092	0.00%	0.00%	-0.22%	-0.22%	-0.29%	-0.72%	$(1,672,839)
DOCTORS COMMUNITY	$136,010,794	-0.17%	0.50%	0.10%	-0.27%	-0.88%	-0.72%	$(982,849)
GARRETT COUNTY	$18,608,187	0.00%	0.50%	-0.81%	-0.15%	-0.47%	-0.94%	$(173,989)
EASTON	$95,655,306	0.00%	0.00%	0.03%	-0.41%	-0.36%	-0.74%	$(707,029)
UMMC MIDTOWN	$137,603,928	0.00%	0.00%	-0.20%	-0.46%	-0.13%	-0.79%	$(1,089,137)
HOWARD COUNTY	$167,430,727	0.00%	0.00%	0.19%	-0.23%	-0.51%	-0.54%	$(910,182)
MERITUS	$188,367,776	0.05%	0.00%	0.01%	-0.21%	-0.27%	-0.41%	$(778,226)
FREDERICK MEMORIAL	$190,475,901	0.00%	0.00%	0.13%	-0.18%	-0.42%	-0.47%	$(889,726)

Hospital Name	FY 2015 Permanent Inpatient Revenue	MHAC % Revenue Adjustment	RRIP % Revenue Adjustment	QBR % Revenue Adjustment	NET Shared Savings % Revenue Adjustment	PAU % Revenue Adjustment	Net Impact %	Net Impact $
HARFORD	$46,774,506	0.00%	0.00%	0.15%	-0.35%	-0.37%	-0.58%	$(270,103)
UNIVERSITY OF MARYLAND	$869,783,534	0.00%	0.00%	-0.09%	-0.23%	-0.14%	-0.46%	$(3,997,336)
UNION HOSPITAL OF CECIL COUNT	$67,638,499	0.05%	0.00%	0.23%	-0.10%	-0.57%	-0.39%	$(263,934)
MONTGOMERY GENERAL	$87,866,458	0.00%	0.50%	-0.12%	-0.28%	-0.53%	-0.43%	$(380,174)
UPPER CHESAPEAKE HEALTH	$153,131,633	0.00%	0.00%	0.35%	-0.34%	-0.43%	-0.42%	$(636,439)
LAUREL REGIONAL	$77,138,956	0.00%	0.50%	-0.20%	-0.30%	-0.40%	-0.40%	$(310,923)
G.B.M.C.	$200,727,665	-0.14%	0.00%	0.20%	-0.29%	-0.23%	-0.45%	$(909,220)
JOHNS HOPKINS	$1,303,085,115	0.00%	0.00%	0.30%	-0.40%	-0.14%	-0.24%	$(3,063,257)
ST. AGNES	$238,960,906	0.05%	0.50%	-0.10%	-0.36%	-0.34%	-0.25%	$(592,138)
BON SECOURS	$75,937,922	0.47%	0.50%	-0.84%	-0.33%	0.00%	-0.20%	$(148,483)
PENINSULA REGIONAL	$232,896,408	0.16%	0.00%	0.08%	-0.20%	-0.13%	-0.09%	$(204,159)
HOPKINS BAYVIEW MED CTR	$354,237,613	0.37%	0.00%	0.15%	-0.25%	-0.19%	0.07%	$242,340
MERCY	$232,326,849	0.00%	0.50%	0.28%	-0.46%	-0.19%	0.13%	$293,111
WESTERN MARYLAND HEALTH SYSTEM	$182,494,313	0.00%	0.00%	0.73%	-0.15%	-0.11%	0.46%	$846,736
REHAB & ORTHO	$69,116,851	0.37%	0.00%		-0.42%	-0.15%	-0.20%	$(138,972)
NORTHWEST	$141,883,177	0.68%	0.50%	0.10%	-0.26%	-0.48%	0.55%	$775,801
SINAI	$428,400,532	0.32%	0.50%	0.28%	-0.34%	-0.19%	0.57%	$2,422,359
CHESTERTOWN	$29,287,619	0.53%	0.50%	0.15%	-0.23%	-0.25%	0.70%	$205,232
CALVERT	$67,061,373	0.63%	0.50%	0.11%	-0.13%	-0.54%	0.57%	$382,528
UM ST. JOSEPH	$230,010,193	0.58%	0.00%	0.58%	-0.32%	-0.26%	0.58%	$1,335,237
ST. MARY	$69,990,405	0.68%	0.50%	0.34%	-0.11%	-0.40%	1.01%	$710,270
MCCREADY	$ 3,571,064	1.00%	0.50%	N/A	-0.36%	-0.04%	1.09%	$39,024

Figure 2. Adjustments for the QBR Program for Rate Year 2016, by Hospital

Hospital Name	FY 2015 Permanent Inpatient Revenue	QBR Final Points	Scaling Basis	Revenue Impact of Scaling	Revenue Neutral Adjusted Revenue Impact of Scaling	Revenue Neutral Adjusted % Payment Adjustment
A	B	C	D	E=B*D	F	G=(B+F)/B-1
PRINCE GEORGE	$176,633,176.79	0.204	-1.000%	-$1,766,332	-$1,766,332	-1.000%
UNION MEMORIAL	$239,732,514.10	0.236	-0.848%	-$2,032,700	-$2,032,700	-0.848%
BON SECOURS	$75,937,921.77	0.237	-0.842%	-$639,466	-$639,466	-0.842%
GARRETT COUNTY	$18,608,187.37	0.243	-0.811%	-$150,839	-$150,839	-0.811%
ATLANTIC GENERAL	$38,616,312.78	0.262	-0.721%	-$278,422	-$278,422	-0.721%
DORCHESTER	$23,804,066.20	0.300	-0.536%	-$127,696	-$127,696	-0.536%
SOUTHERN MARYLAND	$161,253,765.94	0.306	-0.506%	-$815,828	-$815,828	-0.506%
GOOD SAMARITAN	$178,635,337.98	0.316	-0.457%	-$817,238	-$817,238	-0.457%
ANNE ARUNDEL	$308,739,340.58	0.324	-0.420%	-$1,297,299	-$1,297,299	-0.420%
HARBOR	$122,412,281.84	0.337	-0.355%	-$434,912	-$434,912	-0.355%
FRANKLIN SQUARE	$282,129,811.54	0.338	-0.351%	-$990,065	-$990,065	-0.351%
HOLY CROSS	$319,832,140.30	0.347	-0.309%	-$989,139	-$989,139	-0.309%
SHADY GROVE	$231,030,091.92	0.366	-0.215%	-$497,403	-$497,403	-0.215%
LAUREL REGIONAL	$77,138,956.35	0.369	-0.203%	-$156,364	-$156,364	-0.203%
UMMC MIDTOWN	$137,603,928.30	0.370	-0.199%	-$273,596	-$273,596	-0.199%
FT. WASHINGTON	$17,901,765.04	0.373	-0.183%	-$32,819	-$32,819	-0.183%
WASHINGTON ADVENTIST	$160,049,372.87	0.379	-0.153%	-$245,350	-$245,350	-0.153%
MONTGOMERY GENERAL	$87,866,457.56	0.387	-0.117%	-$102,775	-$102,775	-0.117%
ST. AGNES	$238,960,906.16	0.390	-0.099%	-$236,680	-$236,680	-0.099%
SUBURBAN	$182,880,097.32	0.391	-0.095%	-$174,048	-$174,048	-0.095%
UNIVERSITY OF MARYLAND	$869,783,533.93	0.392	-0.089%	-$777,220	-$777,220	-0.089%
CHARLES REGIONAL	$76,417,733.97	0.399	-0.057%	-$43,855	-$43,855	-0.057%
MERITUS	$188,367,775.67	0.415	0.020%	$37,886	$23,050	0.012%
EASTON	$95,655,306.19	0.420	0.045%	$42,869	$26,081	0.027%

Hospital Name	FY 2015 Permanent Inpatient Revenue	QBR Final Points	Scaling Basis	Revenue Impact of Scaling	Revenue Neutral Adjusted Revenue Impact of Scaling	Revenue Neutral Adjusted % Payment Adjustment
PENINSULA REGIONAL	$232,896,407.52	0.439	0.139%	$323,230	$196,651	0.084%
NORTHWEST	$141,883,177.42	0.446	0.169%	$240,213	$146,144	0.103%
DOCTORS COMMUNITY	$136,010,793.59	0.446	0.169%	$230,271	$140,095	0.103%
CALVERT	$67,061,372.88	0.447	0.174%	$116,461	$70,854	0.106%
FREDERICK MEMORIAL	$190,475,900.63	0.455	0.216%	$411,978	$250,644	0.132%
HOPKINS BAYVIEW MED CTR	$354,237,613.19	0.460	0.239%	$845,105	$514,157	0.145%
HARFORD	$46,774,506.17	0.461	0.245%	$114,535	$69,683	0.149%
CHESTERTOWN	$29,287,619.34	0.462	0.250%	$73,134	$44,494	0.152%
HOWARD COUNTY	$167,430,726.52	0.476	0.318%	$531,634	$323,443	0.193%
G.B.M.C.	$200,727,664.89	0.478	0.327%	$656,806	$399,596	0.199%
UNION HOSPITAL OF CECIL COUNT	$67,638,499.19	0.488	0.375%	$253,429	$154,185	0.228%
MERCY	$232,326,849.10	0.504	0.453%	$1,052,795	$640,513	0.276%
SINAI	$428,400,532.05	0.505	0.456%	$1,953,758	$1,188,653	0.277%
JOHNS HOPKINS	$1,303,085,115.22	0.512	0.490%	$6,390,980	$3,888,230	0.298%
CARROLL COUNTY	$136,537,812.51	0.516	0.510%	$696,104	$423,505	0.310%
ST. MARY	$69,990,405.25	0.525	0.554%	$387,680	$235,862	0.337%
UPPER CHESAPEAKE HEALTH	$153,131,633.20	0.531	0.583%	$892,707	$543,117	0.355%
BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,797.59	0.552	0.684%	$1,533,183	$932,778	0.416%
UM ST. JOSEPH	$230,010,193.37	0.609	0.961%	$2,209,908	$1,344,493	0.585%
WESTERN MARYLAND HEALTH SYSTEM	$182,494,313.32	0.657	1.192%	$2,175,921	$1,323,816	0.725%
Statewide	**$8,904,474,715**			**$8,290,541**	**$0**	**0%**

Figure 3. Adjustments for the Readmissions Program for Rate Year 2016, by Hospital

HOSPITAL NAME	FY 2015 Permanent Inpatient Revenue	CY 13 Base Year Risk-Adjusted Readmission Rate	CY 14 Performance Period Risk-Adjusted Readmission Rate	CY 14 Readmission Improvement	% Payment Adjustment	Revenue Impact of Scaling
A	B	C	D	E=D/C-1	H	I=H*B
MCCREADY	$3,571,064.06	11.82%	9.30%	-21.30%	0.50%	$17,855
ST. MARY	$69,990,405.25	12.09%	10.21%	-15.52%	0.50%	$349,952
CALVERT	$67,061,372.88	9.63%	8.16%	-15.30%	0.50%	$335,307
BON SECOURS	$75,937,921.77	18.43%	15.79%	-14.31%	0.50%	$379,690
DOCTORS COMMUNITY	$136,010,793.59	12.52%	10.77%	-13.97%	0.50%	$680,054
CHESTERTOWN	$29,287,619.34	13.29%	11.79%	-11.24%	0.50%	$146,438
NORTHWEST	$141,883,177.42	14.52%	13.11%	-9.70%	0.50%	$709,416
ST. AGNES	$238,960,906.16	13.43%	12.15%	-9.53%	0.50%	$1,194,805
UNION MEMORIAL	$239,732,514.10	13.78%	12.53%	-9.08%	0.50%	$1,198,663
MERCY	$232,326,849.10	13.96%	12.77%	-8.56%	0.50%	$1,161,634
MONTGOMERY GENERAL	$87,866,457.56	12.03%	11.11%	-7.58%	0.50%	$439,332
SINAI	$428,400,532.05	13.67%	12.67%	-7.34%	0.50%	$2,142,003
LAUREL REGIONAL	$77,138,956.35	13.18%	12.23%	-7.27%	0.50%	$385,695
GARRETT COUNTY	$18,608,187.37	7.21%	6.69%	-7.24%	0.50%	$93,041
HOPKINS BAYVIEW MED CTR	$354,237,613.19	14.71%	13.86%	-5.78%	0.00%	$0
PRINCE GEORGE	$176,633,176.79	10.04%	9.49%	-5.47%	0.00%	$0
G.B.M.C.	$200,727,664.89	10.67%	10.09%	-5.43%	0.00%	$0
UMMC MIDTOWN	$137,603,928.30	15.97%	15.16%	-5.07%	0.00%	$0
ANNE ARUNDEL	$308,739,340.58	11.99%	11.38%	-5.06%	0.00%	$0
HOWARD COUNTY	$167,430,726.52	11.81%	11.21%	-5.04%	0.00%	$0
UM ST. JOSEPH	$230,010,193.37	11.40%	10.83%	-4.97%	0.00%	$0
ATLANTIC GENERAL	$38,616,312.78	11.65%	11.09%	-4.86%	0.00%	$0
HARBOR	$122,412,281.84	12.81%	12.28%	-4.15%	0.00%	$0

HOSPITAL NAME	FY 2015 Permanent Inpatient Revenue	CY 13 Base Year Risk-Adjusted Readmission Rate	CY 14 Performance Period Risk-Adjusted Readmission Rate	CY 14 Readmission Improvement	% Payment Adjustment	Revenue Impact of Scaling
SHADY GROVE	$231,030,091.92	10.84%	10.42%	-3.87%	0.00%	$0
SOUTHERN MARYLAND	$161,253,765.94	11.39%	10.96%	-3.83%	0.00%	$0
GOOD SAMARITAN	$178,635,337.98	13.62%	13.10%	-3.80%	0.00%	$0
BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,797.59	13.77%	13.30%	-3.38%	0.00%	$0
CARROLL COUNTY	$136,537,812.51	11.86%	11.53%	-2.77%	0.00%	$0
UNIVERSITY OF MARYLAND	$869,783,533.93	13.78%	13.55%	-1.63%	0.00%	$0
WESTERN MARYLAND HEALTH SYSTEM	$182,494,313.32	11.89%	11.73%	-1.31%	0.00%	$0
SUBURBAN	$182,880,097.32	10.94%	10.81%	-1.27%	0.00%	$0
FRANKLIN SQUARE	$282,129,811.54	12.63%	12.50%	-1.05%	0.00%	$0
HARFORD	$46,774,506.17	11.04%	10.95%	-0.80%	0.00%	$0
REHAB & ORTHO	$69,116,850.62	11.46%	11.47%	0.01%	0.00%	$0
JOHNS HOPKINS	$1,303,085,115.22	13.97%	13.97%	0.04%	0.00%	$0
UNION HOSPITAL OF CECIL COUNT	$67,638,499.19	9.77%	9.82%	0.51%	0.00%	$0
UPPER CHESAPEAKE HEALTH	$153,131,633.20	11.45%	11.59%	1.27%	0.00%	$0
FREDERICK MEMORIAL	$190,475,900.63	10.38%	10.51%	1.30%	0.00%	$0
MERITUS	$188,367,775.67	11.38%	11.53%	1.36%	0.00%	$0
FT. WASHINGTON	$17,901,765.04	12.53%	12.74%	1.65%	0.00%	$0
DORCHESTER	$23,804,066.20	11.07%	11.28%	1.89%	0.00%	$0
CHARLES REGIONAL	$76,417,733.97	11.57%	11.90%	2.82%	0.00%	$0
PENINSULA REGIONAL	$232,896,407.52	10.77%	11.08%	2.88%	0.00%	$0
HOLY CROSS	$319,832,140.30	11.12%	11.69%	5.09%	0.00%	$0
WASHINGTON ADVENTIST	$160,049,372.87	10.79%	11.42%	5.77%	0.00%	$0
EASTON	$95,655,306.19	10.47%	11.93%	13.98%	0.00%	$0
	$8,977,162,630				**Rewards:**	**$9,233,884**

Figure 4. Adjustments for the MHAC Program for Rate Year 2016, by Hospital

Hospital Name	FY 2015 Permanent Inpatient Revenue	Final MHAC Score	% Payment Adjustment	Revenue Impact of Scaling
A	B	C	D	E
SOUTHERN MARYLAND	$161,253,765.94	0.40	-0.2069%	-$333,628
DOCTORS COMMUNITY	$136,010,793.59	0.41	-0.1724%	-$234,501
CARROLL COUNTY	$136,537,812.51	0.41	-0.1724%	-$235,410
G.B.M.C.	$200,727,664.89	0.42	-0.1379%	-$276,866
SUBURBAN	$182,880,097.32	0.47	0.0000%	$0
LAUREL REGIONAL	$77,138,956.35	0.48	0.0000%	$0
WASHINGTON ADVENTIST	$160,049,372.87	0.48	0.0000%	$0
ANNE ARUNDEL	$308,739,340.58	0.48	0.0000%	$0
HARBOR	$122,412,281.84	0.49	0.0000%	$0
MONTGOMERY GENERAL	$87,866,457.56	0.50	0.0000%	$0
DORCHESTER	$23,804,066.20	0.52	0.0000%	$0
PRINCE GEORGE	$176,633,176.79	0.52	0.0000%	$0
FREDERICK MEMORIAL	$190,475,900.63	0.53	0.0000%	$0
UNION MEMORIAL	$239,732,514.10	0.53	0.0000%	$0
FRANKLIN SQUARE	$282,129,811.54	0.54	0.0000%	$0
HOWARD COUNTY	$167,430,726.52	0.54	0.0000%	$0
HOLY CROSS	$319,832,140.30	0.54	0.0000%	$0
HARFORD	$46,774,506.17	0.54	0.0000%	$0
BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,797.59	0.54	0.0000%	$0
GARRETT COUNTY	$18,608,187.37	0.55	0.0000%	$0
WESTERN MARYLAND HEALTH SYSTEM	$182,494,313.32	0.55	0.0000%	$0
JOHNS HOPKINS	$1,303,085,115.22	0.56	0.0000%	$0
UNIVERSITY OF MARYLAND	$869,783,533.93	0.57	0.0000%	$0
UPPER CHESAPEAKE HEALTH	$153,131,633.20	0.57	0.0000%	$0
SHADY GROVE	$231,030,091.92	0.58	0.0000%	$0

Hospital Name	FY 2015 Permanent Inpatient Revenue	Final MHAC Score	% Payment Adjustment	Revenue Impact of Scaling
A	B	C	D	E
GOOD SAMARITAN	$178,635,337.98	0.58	0.0000%	$0
UMMC MIDTOWN	$137,603,928.30	0.60	0.0000%	$0
EASTON	$95,655,306.19	0.60	0.0000%	$0
MERCY	$232,326,849.10	0.61	0.0000%	$0
UNION HOSPITAL OF CECIL COUNT	$67,638,499.19	0.62	0.0526%	$35,599
ST. AGNES	$238,960,906.16	0.62	0.0526%	$125,769
MERITUS	$188,367,775.67	0.62	0.0526%	$99,141
PENINSULA REGIONAL	$232,896,407.52	0.64	0.1579%	$367,731
CHARLES REGIONAL	$76,417,733.97	0.65	0.2105%	$160,879
SINAI	$428,400,532.05	0.67	0.3158%	$1,352,844
HOPKINS BAYVIEW MED CTR	$354,237,613.19	0.68	0.3684%	$1,305,086
REHAB & ORTHO	$69,116,850.62	0.68	0.3684%	$254,641
BON SECOURS	$75,937,921.77	0.70	0.4737%	$359,706
CHESTERTOWN	$29,287,619.34	0.71	0.5263%	$154,145
UM ST. JOSEPH	$230,010,193.37	0.72	0.5789%	$1,331,638
ATLANTIC GENERAL	$38,616,312.78	0.73	0.6316%	$243,893
CALVERT	$67,061,372.88	0.73	0.6316%	$423,546
ST. MARY	$69,990,405.25	0.74	0.6842%	$478,882
NORTHWEST	$141,883,177.42	0.74	0.6842%	$970,780
FT. WASHINGTON	$17,901,765.04	0.79	0.9474%	$169,596
MCCREADY	$3,571,064.06	0.83	1.0000%	$35,711
	$8,977,162,630			**$6,789,180**

Maryland Health Services Cost Review Commission

Overview of the Uncompensated Care Data

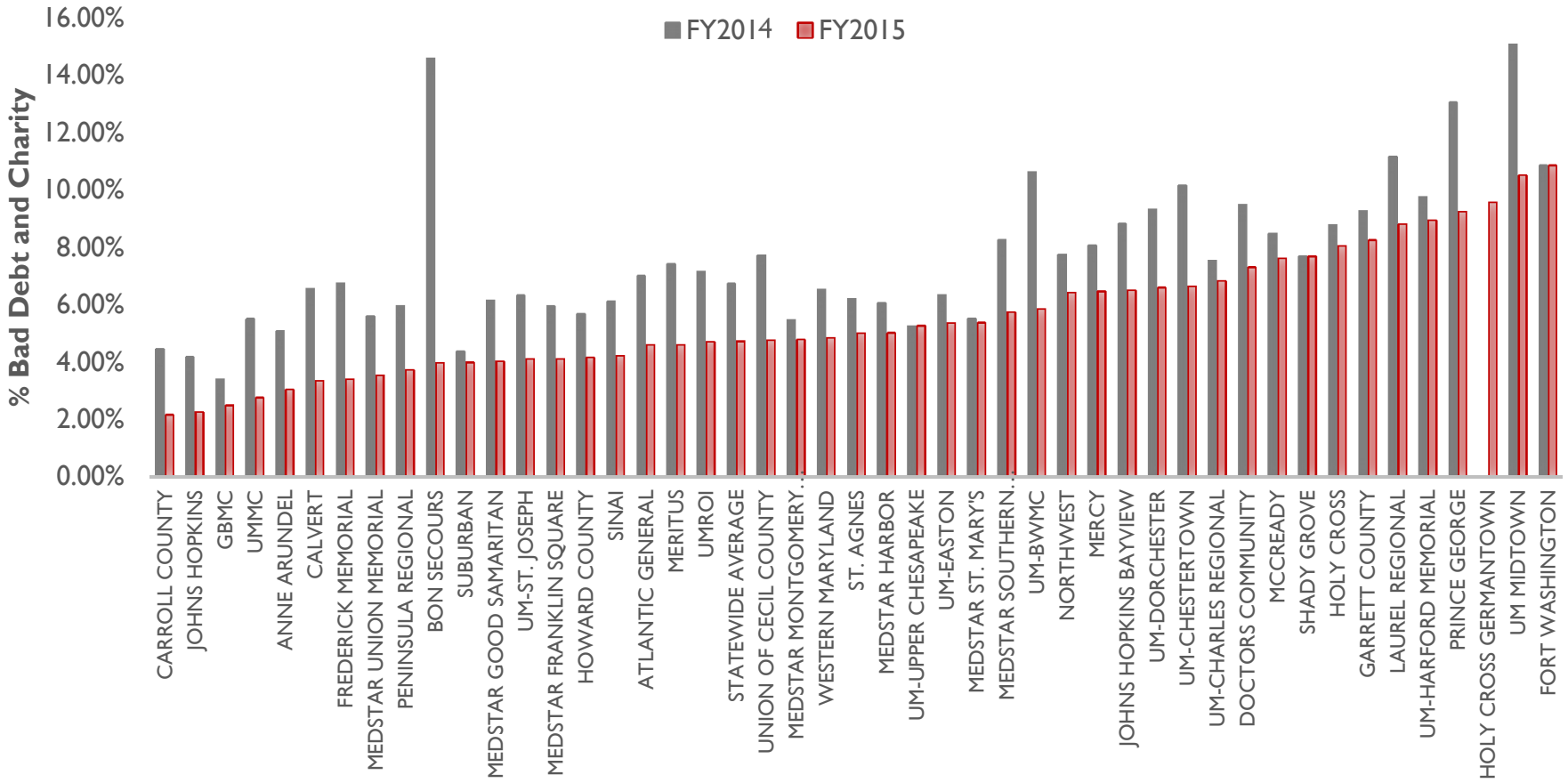
03/02/2016

HSCRC
Health Services Cost Review Commission

What is Uncompensated Care (UCC) in Maryland?

- The HSCRC's provision for uncompensated care in hospital rates is one of the unique features of rate regulation in Maryland.
- Uncompensated care (UCC) includes bad debt and charity care.
- By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those who cannot pay for care.

Reductions in UCC vary by Hospital in post-ACA period



HSCRC
Health Services Cost Review Commission

Is UCC increasing in FY16 ?

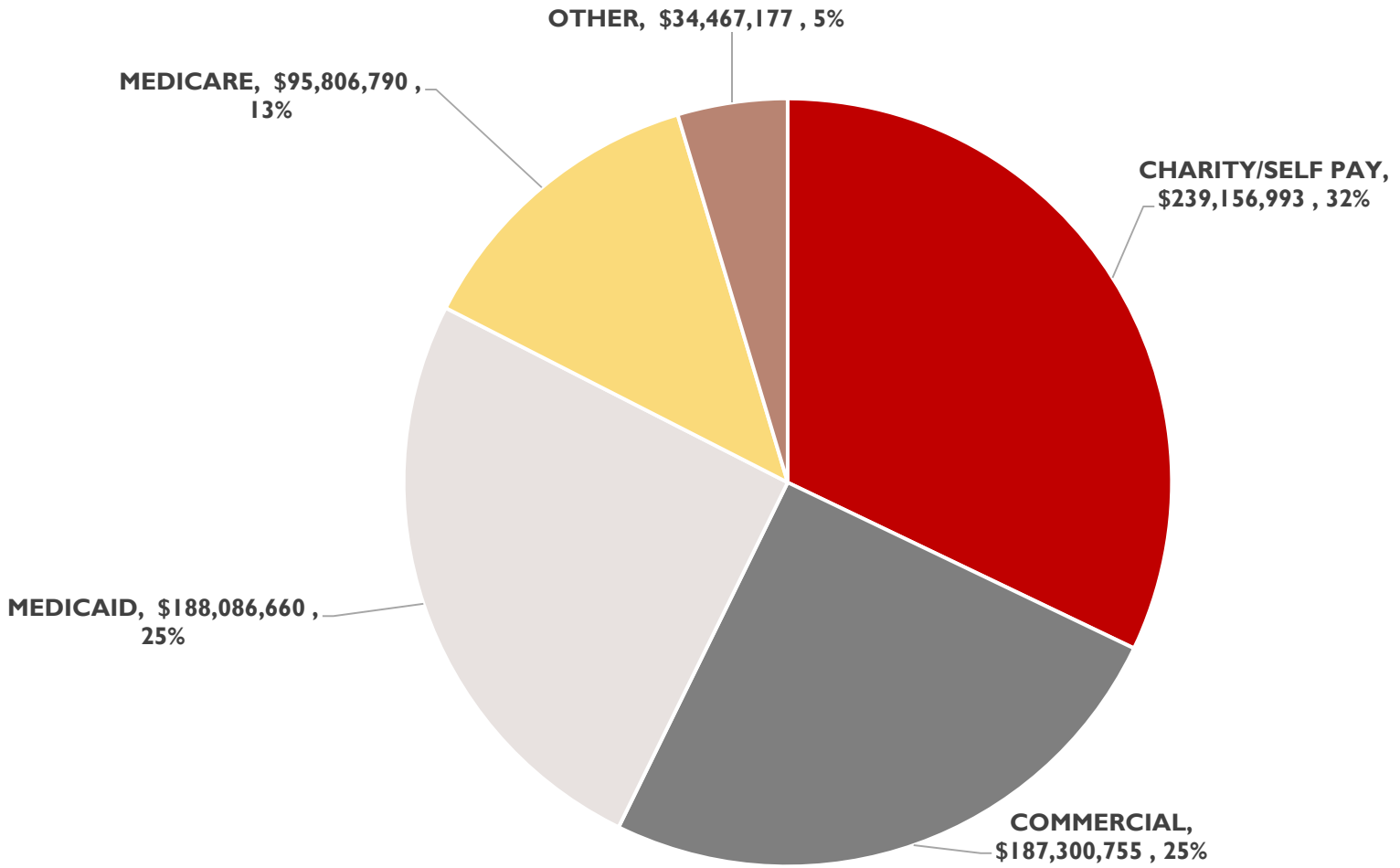
- Due to disenrollment levels in Medicaid program, concerns have been raised about increasing UCC levels in recent time period
- Comparing audited FY2015 rates to July-Dec 2015 unaudited data, there is no significant change at the state-level UCC levels.
- Staff is working to understand hospital level variations, distinguishing changes due to reporting vs actual trend.

Write-off Data Preliminary Results

HSCRC started collecting account level write-off data

- Analysis focused on service dates in FY 2015, which could be recorded in FY2015 or FY2016 UCC financial data due to time lags in data processing
- Matched the accounts to case-mix records
- State level matching is 98 % of charges reported in write-off records
- Two additional quarterly reports are needed to include more than 98% of total write-offs due to time lags in account processing
- One more reporting cycle in March (third reporting cycle for FY15Q4) will provide almost complete data for services provided in FY2015

UCC Distribution by Payer: Self-Pay and Charity comprise more than half of UCC



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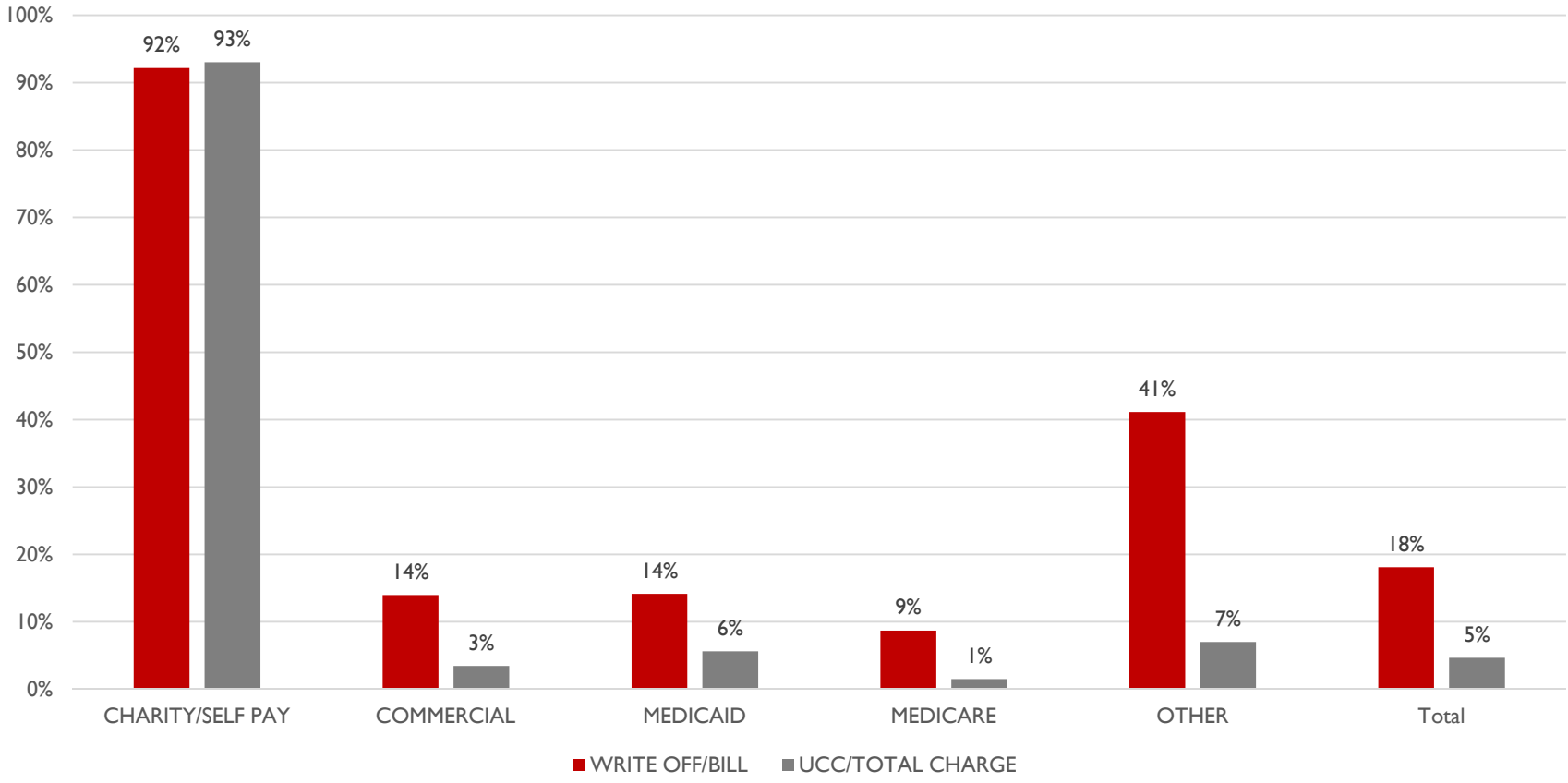
Payer Source is Still A Strong Predictor

92% of the patient bill is written off for self-pay charity patients (almost all of the bill).
Overall UCC amount is 93 % of total self-pay charity charges (almost all patients).



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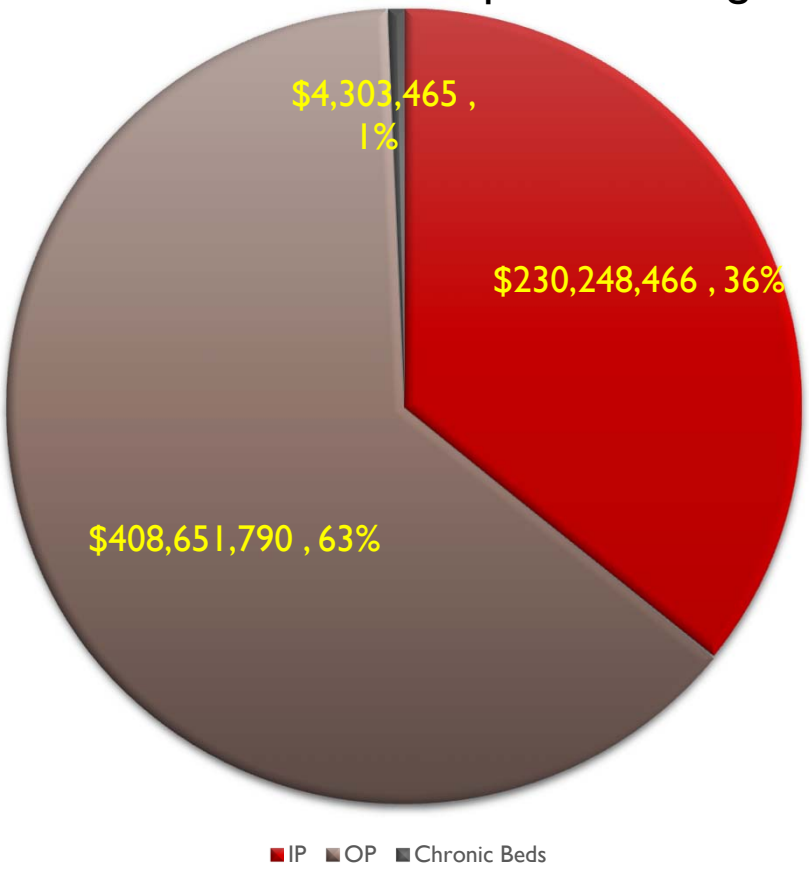
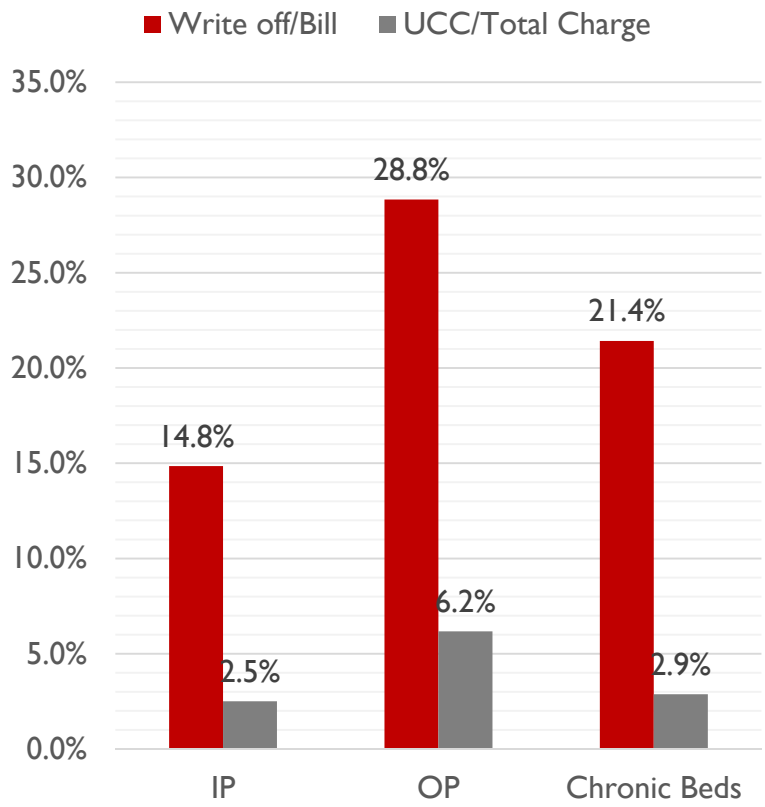
Outpatient services constitute the majority of UCC dollars.

- Higher proportion of the patient bill is written-off for outpatient services (29%).
- 6 % of Total Outpatient Charges are UCC.





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UCC Policy 2017 Considerations

- Focus on post ACA period
- Evaluate the current hospital level regression model
  - Payer source is still a strong predictor
  - Use Write-off data to clean payer classifications
- Evaluate geographical statistics and other predictive models
  - Poverty, unemployment, income level, deprivation, undocumented immigrants etc.

UCC Trends by Hospital: FY13 -FY15 (updated on 03-02-2016)

	Total Patient Revenue in $1,000s			% Bad-Debt and Charity			Annual Change			Total UCC $ in 000's		
Hospital Name	**2013**	**2014**	**2015**	**2013**	**2014**	**2015**	**2013**	**2014**	**2015**	**2013**	**2014**	**2015**
ANNE ARUNDEL	$541,868	$554,132	$562,953	5.21%	5.06%	3.04%		-0.2%	**-2.2%**	$ 28,229	$ 28,030	$ 17,108
ATLANTIC GENERAL	$99,487	$102,693	$102,371	7.68%	6.98%	4.58%		-0.7%	**-3.1%**	$ 7,638	$ 7,165	$ 4,685
BON SECOURS	$121,044	$129,714	$117,218	18.12%	14.58%	3.96%		-3.5%	**-14.2%**	$ 21,935	$ 18,908	$ 4,640
CALVERT	$138,863	$141,935	$144,500	6.16%	6.53%	3.34%		0.4%	**-2.8%**	$ 8,548	$ 9,269	$ 4,822
CARROLL COUNTY	$249,075	$251,985	$254,038	4.70%	4.44%	2.15%		-0.3%	**-2.5%**	$ 11,695	$ 11,186	$ 5,474
DOCTORS COMMUNITY	$216,855	$222,145	$226,463	9.29%	9.49%	7.28%		0.2%	**-2.0%**	$ 20,138	$ 21,083	$ 16,475
Fort Washington	$46,157	$48,566	$48,566	13.63%	10.85%	10.85%		-2.8%	**-2.8%**	$ 6,289	$ 5,271	$ 5,271
FREDERICK MEMORIAL	$337,094	$339,661	$346,610	6.03%	6.72%	3.39%		0.7%	**-2.6%**	$ 20,319	$ 22,832	$ 11,735
GARRETT COUNTY	$42,302	$45,203	$44,694	10.86%	9.27%	8.25%		-1.6%	**-2.6%**	$ 4,593	$ 4,192	$ 3,688
GBMC	$421,138	$426,965	$432,708	3.12%	3.38%	2.48%		0.3%	**-0.6%**	$ 13,136	$ 14,449	$ 10,737
HOLY CROSS	$461,351	$468,877	$480,562	9.26%	8.78%	8.05%		-0.5%	**-1.2%**	$ 42,720	$ 41,182	$ 38,697
HOLY CROSS GERMANTOWN			$43,305			9.57%				$ -	$ -	$ 4,143
HOWARD COUNTY	$278,902	$281,806	$286,303	5.99%	5.66%	4.14%		-0.3%	**-1.8%**	$ 16,702	$ 15,945	$ 11,859
Johns Hopkins	$2,132,419	$2,172,518	$2,209,869	4.27%	4.16%	2.25%		-0.1%	**-2.0%**	$ 90,951	$ 90,419	$ 49,710
Johns Hopkins Bayview	$596,807	$605,106	$618,221	9.28%	8.82%	6.49%		-0.5%	**-2.8%**	$ 55,404	$ 53,366	$ 40,097
LAUREL REGIONAL	$121,542	$118,865	$106,468	14.23%	11.16%	8.81%		-3.1%	**-5.4%**	$ 17,299	$ 13,263	$ 9,377
MCCREADY	$17,976	$16,638	$15,060	8.32%	8.49%	7.62%		0.2%	**-0.7%**	$ 1,495	$ 1,412	$ 1,147
MedStar Franklin Square	$469,792	$486,467	$491,173	7.06%	5.93%	4.10%		-1.1%	**-3.0%**	$ 33,166	$ 28,841	$ 20,159
MedStar Good Samaritan	$295,737	$299,250	$303,789	6.60%	6.12%	4.02%		-0.5%	**-2.6%**	$ 19,525	$ 18,308	$ 12,199
MedStar Harbor	$201,141	$205,146	$207,453	8.59%	6.04%	5.00%		-2.6%	**-3.6%**	$ 17,276	$ 12,385	$ 10,376
MedStar Montgomery General	$166,869	$167,893	$174,302	6.59%	5.44%	4.76%		-1.1%	**-1.8%**	$ 10,998	$ 9,139	$ 8,301
MedStar Southern Maryland	$144,983	$261,812	$262,673	6.84%	8.25%	5.72%		1.4%	**-1.1%**	$ 9,923	$ 21,607	$ 15,034
MedStar St. Mary's	$154,603	$157,936	$166,124	8.47%	5.49%	5.35%		-3.0%	**-3.1%**	$ 13,099	$ 8,667	$ 8,891
MedStar Union Memorial	$406,582	$415,164	$419,375	8.13%	5.58%	3.53%		-2.6%	**-4.6%**	$ 33,074	$ 23,164	$ 14,810
MERCY	$470,760	$489,187	$495,806	8.29%	8.07%	6.44%		-0.2%	**-1.8%**	$ 39,008	$ 39,463	$ 31,936
MERITUS	$301,351	$305,142	$312,302	7.20%	7.39%	4.59%		0.2%	**-2.6%**	$ 21,682	$ 22,552	$ 14,333
NORTHWEST	$248,253	$249,135	$254,116	8.41%	7.76%	6.39%		-0.7%	**-2.0%**	$ 20,882	$ 19,328	$ 16,247
PENINSULA REGIONAL	$412,642	$416,389	$422,384	6.87%	5.94%	3.72%		-0.9%	**-3.1%**	$ 28,335	$ 24,744	$ 15,711
PRINCE GEORGE	$249,193	$267,282	$279,091	15.51%	13.05%	9.24%		-2.5%	**-6.3%**	$ 38,640	$ 34,868	$ 25,794
SHADY GROVE	$375,190	$383,323	$383,323	6.76%	7.68%	7.68%		0.9%	**0.9%**	$ 25,364	$ 29,443	$ 29,443
SINAI	$684,517	$699,430	$717,312	5.41%	6.09%	4.20%		0.7%	**-1.2%**	$ 37,060	$ 42,572	$ 30,113
ST. AGNES	$404,670	$410,191	$418,877	7.96%	6.17%	4.99%		-1.8%	**-3.0%**	$ 32,204	$ 25,327	$ 20,902
SUBURBAN	$280,579	$289,287	$295,845	5.07%	4.35%	3.97%		-0.7%	**-1.1%**	$ 14,223	$ 12,582	$ 11,753
UM Midtown	$216,174	$222,428	$228,796	15.22%	15.08%	10.51%		-0.1%	**-4.7%**	$ 32,904	$ 33,532	$ 24,054
UM-BWMC	$376,813	$393,182	$402,011	9.78%	10.63%	5.82%		0.9%	**-4.0%**	$ 36,844	$ 41,794	$ 23,400
UM-Charles Regional	$137,004	$144,786	$148,386	7.46%	7.52%	6.81%		0.1%	**-0.6%**	$ 10,219	$ 10,882	$ 10,106
UM-Chestertown	$62,792	$64,509	$64,477	10.13%	10.16%	6.62%		0.0%	**-3.5%**	$ 6,363	$ 6,551	$ 4,266
UM-Dorchester	$59,898	$58,994	$56,007	6.99%	9.33%	6.57%		2.3%	**-0.4%**	$ 4,186	$ 5,505	$ 3,681

UM-Easton	$186,359	$187,483	$192,832	5.86%	6.32%	5.34%	0.5%	**-0.5%**	$ 10,917	$ 11,857	$ 10,294
UM-Harford Memorial	$103,499	$53,719	$104,704	12.44%	9.76%	8.94%	-2.7%	**-3.5%**	$ 12,876	$ 5,243	$ 9,365
UMMC	$1,241,602	$1,296,211	$1,313,671	5.40%	5.49%	2.75%	0.1%	**-2.6%**	$ 67,007	$ 71,156	$ 36,135
UMROI	$115,227	$118,262	$120,365	5.20%	7.13%	4.69%	1.9%	**-0.5%**	$ 5,988	$ 8,436	$ 5,641
UM-St. Joseph	$337,662	$362,416	$390,826	5.13%	6.30%	4.09%	1.2%	**-1.0%**	$ 17,305	$ 22,836	$ 15,978
UM-Upper Chesapeake	$290,001	$157,472	$320,268	6.08%	5.23%	5.25%	-0.8%	**-0.8%**	$ 17,640	$ 8,243	$ 16,807
Union of Cecil County	$153,373	$157,914	$157,025	8.69%	7.73%	4.74%	-1.0%	**-3.9%**	$ 13,324	$ 12,201	$ 7,442
WASHINGTON ADVENTIST	$245,900	$260,306	$260,306	14.08%	12.20%	12.20%	-1.9%	**-1.9%**	$ 34,627	$ 31,746	$ 31,746
Western Maryland	$314,237	$317,899	$322,959	6.89%	6.50%	4.83%	-0.4%	**-2.1%**	$ 21,638	$ 20,654	$ 15,588
Grand Total	**$14,930,279**	**$15,225,426**	**$15,726,482**	**7.06%**	**6.71%**	**4.71%**	**-0.3%**	**-2.3%**	**$ 1,053,389**	**$ 1,021,596**	**$ 740,173**

Legislative Update – March 9, 2016

Nurse Support Program Assistance Fund - SB108

SB 108 is a Departmental bill that broadens the scope of the Nurse Support Assistance Program (NSPII) which is supported by the rates of Maryland hospitals through the authority of the HSCRC. Instead of being focused on "bedside" nurses only this bill will allow the NSPII program to improve the pipeline for nurses (through supporting facility and nursing education) with broader skills than providing care at the bedside include supporting the care coordination model.

Hearing: 3/15 Opposite House

Status: Bill passed the Senate. Staff Testified as Co-Sponsor with MHEC

Maryland No-Fault Birth Injury Fund – HB377/SB513

The bills establish a Fund and adjudication system for birth- related neurological injury. The Maryland birth injury fund provides an exclusive "no-fault" remedy to claimants with an injury that falls within the statutory eligibility criteria for the birth injury program. The birth injury fund program provides notification to patients and their families through Maryland hospitals regarding participation in the program, benefits, eligibility, rights under the program, and ways in which the program provides exclusive remedy. The bill also requires the Maryland Patient Safety Center to convene a Perinatal Clinical Advisory Committee to oversee the general dissemination of initiatives, guidance, and the best practices to health care facilities for perinatal care.

This bill establishes a fund as well as an adjudication system for birth related neurological injury. Moneys in the fund will derive from hospital assessments established by the HSCRC.

By July 1 of each year, HSCRC must assess premiums for all Maryland hospitals and increase hospital rates totaling the amount determined by the board to be required to finance and administer the fund. HSCRC must adopt regulations specifying the methodology for the assessment of premiums. The methodology must (1) account for geographic differences among hospitals; (2) account for differences among hospitals' historical claims experience involving births in each hospital; and (3) distinguish between hospitals that provide obstetrical services and those that do not. In determining hospital rates, HSCRC must increase rates to account fully for the amount of the premiums; the resulting increase may not be considered in determining the reasonableness of rates or hospital financial performance under HSCRC methodologies.

By September 1 of each year, each hospital must pay the assessed premiums to HSCRC. HSCRC must forward the payments to the fund.

The Bill would apply to causes of action arising on or after January 1, 2018.

Hearing: House: 2/12; Senate 2/25

Course of Action: Submitted the same Letter of Information the Commission provided last year.

Termination of MHIP and Transfer of Senior Prescription Drug Assistance Program – HB510

House Bill 489 repeals the Maryland Health Insurance Program (MHIP) and transfers the duties of the Senior Prescription Drug Assistance Program (SPDAP) to the Department of Health and Mental Hygiene. The SPDAP program continues to be supported by funds transferred each year for a non-profit health service plan. HSCRC's statute is changed to eliminate the assessment on hospital rates that have been used to operate the MHIP program.

Hearing: 2/11

Course of Action: Letter of Information the need to remove the assessment when MHIP terminates.

Hospitals – Designation of Lay Caregivers – SB336

SB 336 requires hospitals to provide a patient or legal guardian with an opportunity to designate a lay caregiver before discharge. If a caregiver is designated, the hospital shall record it in the medical record, and request written consent from the patient to release medical information to the caregiver.

The hospital is required to notify the lay caregiver of the patient's discharge or transfer as soon as practicable. As soon as practicable before discharge, the hospital shall attempt to consult with the lay caregiver to prepare the caregiver for aftercare issue a discharge plan that describes the after-care tasks needed by the patient.
Hearing: 2/11

Course of Action: No Position

Prince George's County Regional Medical Center Act of 2016 – SB324/HB309

This bill requires the State and Prince George's County to provide specified operating and capital funding for a new Prince George's County Regional Medical Center (PGCRMC). The bill is contingent on the transfer of the governance of PGCRMC to the University of Maryland Medical System (UMMS) within 90 days after a certificate of need (CON) is approved. The bill takes effect June 1, 2016, and terminates June 30, 2021. However, if the Department of Legislative Services (DLS) has not received notice of the transfer of governance, the bill terminates on December 31, 2016.

The bill as amended would mandate a total of $461 million for this purpose as follows:

- $55 million in State operating subsidies,
- $55 million in Prince George's operating subsidies;
- $115 million in State capital funds in FYs 2018 and 2019; and
- $208 million in Prince George's County capital funds.

The bill also provides intent that the MHCC shall give timely consideration to the CON and make every effort to make a determination on or before July 1, 2016.

Status: *Senate and House have amended the bill as shown above and to provide that up to $8 million of the capital funding under the bill will be used for the development and transformation plan for Laurel Regional Hospital.*

Course of Action: No position

Hospital – Patient's Bill of Rights – SB661/HB587

These bills require hospitals to provide patients with a written copy of the patient's bill of rights adopted pursuant to Joint Commission guidelines, and a translator or interpreter for patients who need one. It also requires hospitals to provide annual training to certain hospital staff to ensure that there is adequate knowledge and understanding of the patient's bill of rights. The bill lists out the rights that must be included in each hospital patient's bill of rights.

Hearing: *House 2/18*

Course of Action: *No position*

Health Care Facilities – Closures or Partial Closures of Hospital – County Board of Health Approval – SB12/HB1121

This bill prohibits a hospital that receives State or County funding from closing or partially closing unless the hospital notifies the local board of health at least 90 days prior the proposed closing date and receive the local health board's approval.

Before deciding to permit a closure, the local board must hold a public hearing within 5 miles of the hospital within 30 days of the notice to close and consider whether alternatives are available.

Hearing: *2/24, 3/10*

Course of Action: *Letter of concern regarding consideration of the continuation of a hospital that has financial difficulties or quality issues.*

Hospitals – Community Benefit Report – Disclosure of Tax Exemptions – SB601, HB1189

The bill requires hospitals to submit an itemization of the value of their tax exemptions with their community benefit reports.

Hearing: *2/24, 3/10*

Status: *SB 601 received an unfavorable report*

Course of Action: *Letter of Information regarding the Community Benefit reports*

Freestanding Medical Facilities – Certificate of Need, Rates, and Definition – SB707/HB1350

The bill provides an option for hospitals that wish to downsize to become a freestanding medical facility. Such a facility would not require a Certificate of Need through the Maryland Health

Care Commission, would not have inpatient beds, and would be rate regulated for emergency and observation services, and outpatient services as determined by the HSCRC.

Hearing: 2/24, 3/10

Course of Action: Letter of support - We are in the midst of health care delivery transformation that is based on improving patient care, ensuring access to care in the most appropriate setting, and reducing PAU. The legislation provides a delivery system modernization option for hospitals and communities. As the Commission has done for the three existing FMF pilot projects, if the bill would pass, the Commission would consider the reasonable costs of those facilities and set appropriate rates for the ED and OBS services as well as for any outpatient services that would be authorized through HSCRC regulations.

Civil Actions – Noneconomic Damages – Catastrophic Injury – SB574/HB869

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

Hearing: Senate 2/25, 3/2

Course of Action: Submit the same letter of information as was submitted last year

Health – Collaborations to Promote Provider Alignment – SB866/HB1272

This bill exempts from the State self-referral law collaborations that are established to promote provider alignment to achieve the goals of Maryland's All-Payer Model contract approved by the Federal Center for Medicare and Medicaid Innovation.

Hearing: 3/7, 3/10

Course of Action: Letter of support with developing consensus amendments to limit the bill to types of risk-sharing arrangements that will assist with meeting the All-Payer Model requirements.

Health Occupations – Prohibited Patient Referrals – Exceptions – SB1032/HB929

This bill would change Maryland's self-referral law by allowing for specific exceptions that are permitted in federal law.

Hearing: 3/9

Course of action: Monitor

Integrated Community Oncology Reporting Program – SB739/HB1422

This bill exempts oncology centers that are participating in a new ten year Integrated Community Oncology Pilot Program that is established in the bill. The Program may include no more than

five oncology centers that meet certain criteria. An eligible practice in one that is composed solely of oncologists, receives more than 50,000 encounters per year, participates in Medicare and Medicaid, has treated patients in Maryland for at least 10 years, and has the capability to meet the reporting requirements. The program will be administered by the Secretary of DHMH in consultation with MHCC. Regulations will require quarterly reporting on referral rates; and the impact that each pilot has on out-of-pocket costs, emergency room and inpatient utilization, health care costs, the All-Payer Model contract, and health outcomes.

The Secretary is required to make annual reports to the Governor and the General Assembly, and make an evaluation by January 1, 2028 with recommendations on whether the exemption should be made permanent.

Hearing: 3/7, 3/9

Course of action: Monitor

Hospitals – Establishment of Substance Use Treatment Programs – Requirements – HB908

requires each hospital in the State to establish a substance abuse treatment program to identify patients in need of substance abuse treatment, and either admit the patients found to be in need of treatment to the appropriate substance use setting or direct the patient to an appropriate outpatient setting. It requires each hospital to operate an inpatient and outpatient substance use treatment unit, or contract to provide those services in the hospital or with an outside entity. The program must include the availability of a substance abuse counselor to provide screening, intervention, referral, and treatment for patients in the emergency room, outpatient clinics, and inpatient units.

The bill also provides that the aggregate and hospital-specific rates shall include a sufficient amount to fund the capital and operating costs of these substance abuse programs. The Commission is also required to develop a methodology to evaluate the effectiveness of the program.

Hearing: 2/23

Course of Action: Letter of Information on strategic commitment to behavioral health, the impact that increased costs could have on the All-Payer Model especially if not well planned regionally, and lack of understanding of capacity for these services. The Commission would need to contract to evaluate effectiveness of such programs.

CRISP

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS

Integrated Care Network Infrastructure – Status Update

HSCRC Commission Meeting

09 March 2016

7160 Columbia Gateway Drive, Suite 230
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

Bright Spots

- HIE I-APD funding was awarded to DHMH
  - Brings federal dollars to support ICN activities

- Care Profiles are available for patients in the clinical query portal
  - Helps clinicians understand who else is involved in a patient's care and the scope of services received
  - More features and data sources will be added over time

- Basic ambulatory connectivity accelerating (>2,000 providers)!

- MIRTH Care is in production

Other Notes

- The ICN team is putting significant energy into expanding a “field presence” with providers
  - For instance, initial efforts to educate about the PaTH report are increasing utilization among those who were previously credentialed
  - Beyond signing up a ambulatory clinicians to use ENS, we are promoting best practices for using the tool, and we plan to do much more of this

- A structured “Customer Success Program” has been launched
  - Entering MOUs (or “CSPs”)with stakeholders, putting their priorities onto our project management timeline
  - Reflective of the fact that the strategies of various stakeholders, and corresponding infrastructure priorities, do not exactly align
  - We are still focused on shared infrastructure and common platforms, but with implementation timeframes and configurations that are customer specific

- Stakeholders have asked for more structure around appropriate data use protocols, including on ways to improve patient education

Ambulatory Connectivity: CRISP Connectivity Tiers

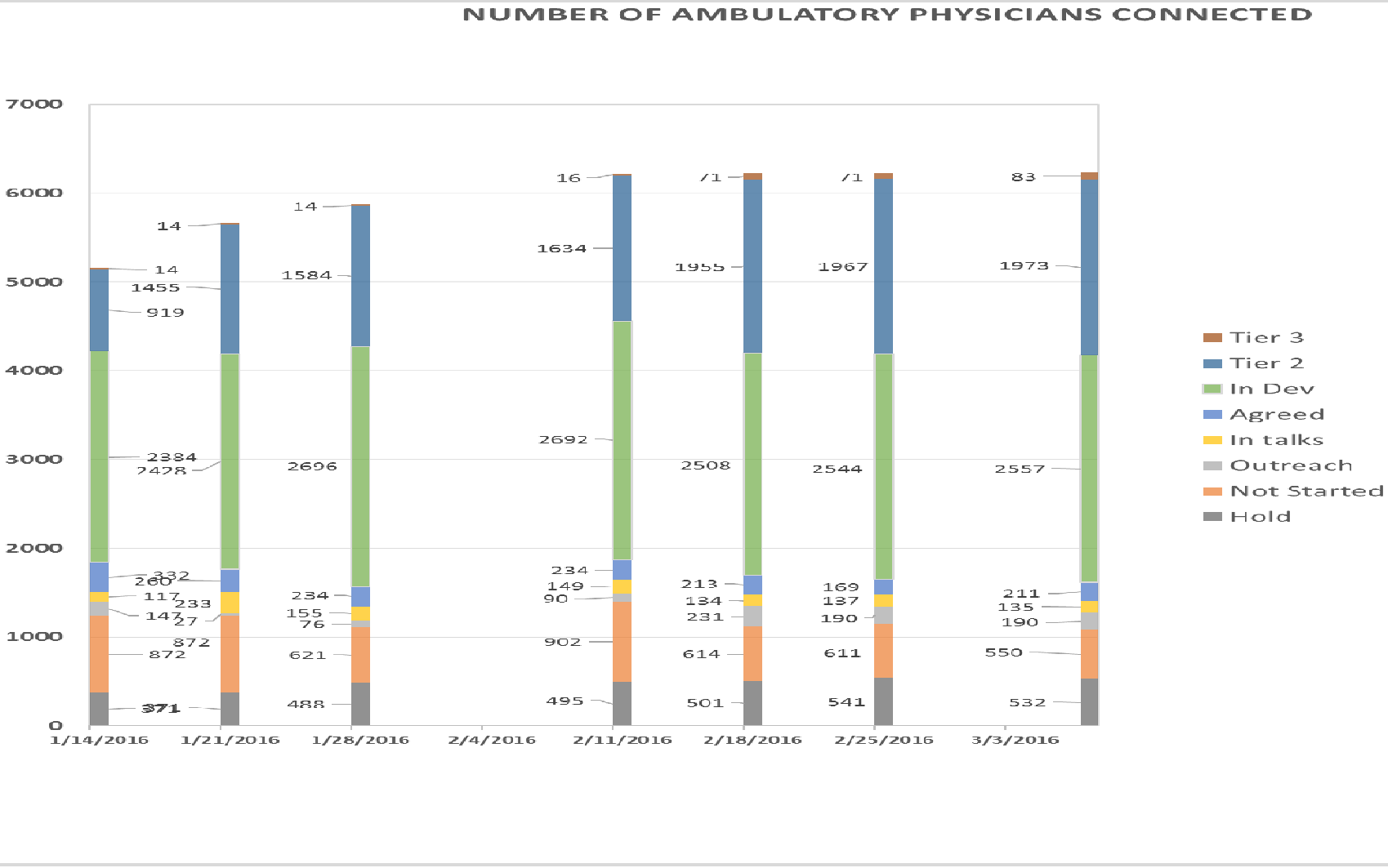
Tier 1: View Clinical Data and Receive Hospitalization Alerts

Tier 2: Send Encounter Information About Your Patients, and Automate Patient Panel Submission

Tier 3: Send Clinical Information About Your Patients (e.g., C-CDAs)

Ambulatory Connectivity Trends

as of March 9, 2016



Pace and Funding

ICN TOTAL BUDGET SUMMARY						
Workstream	FY2016 State & Federal Budget	FY2016 Approved HSCRC	Actuals Through January	FY2016 Current Estimate	FY2016 HSCRC Change Request	Full Project "Planning Budget"
1. Ambulatory Connectivity	$4,499,326	$449,933	$497,483	$2,838,000	$2,250,000	$31,435,691
2. Data Router	$1,853,630	$463,408	$336,216	$924,000	$450,000	$2,184,206
3. Clinical Portal Enhancements	$1,550,379	$775,489	$142,174	$490,000	($300,000)	$2,409,735
4. Alerts & Notifications	$1,321,180	$1,321,180	$124,519	$682,000	($655,000)	$3,739,997
5. Reporting & Analytics	$2,468,110	$2,468,110	$1,110,701	$2,497,000	$0	$23,660,628
6. Basic Care Management Software	$505,804	$505,804	$161,798	$506,000	$0	$3,902,765
7. Practice Transformation	$262,411	$262,411	$96,406	$264,000	$0	$7,963,601
8. Patient & Caregiver Engagement	$0	$0	$0	$0	$0	$1,320,001
TOTAL	**$12,460,840**	**$6,246,335**	**$2,469,298**	**$8,201,000**	**$1,745,000**	**$76,616,624**

IAPD funding was awarded

- We are tracking well below budget, though our rate of spend is accelerating.
- Working with HSCRC staff on the FY2017 budget. We anticipate the spend will increase, but will fall below the initial projections in the 'planning budget'.

Near-Term Objectives

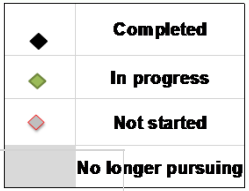
- Accelerate Ambulatory Connectivity for Tier 3 clinical connections
- Expand Care Plan Exchange
  - Engage additional partners to share Care Plans through the Care Plan Exchange capability which recently went live.
- Succeed with a Medicare Data Request, working with HSCRC staff
- Make Risk Stratification tools more accessible
  - Incorporate HCC into casemix data and reports per the direction of the Reporting and Analytics Committee
  - Continue to explore ACG, LACE, and other more advanced risk models and functionality
- Execute on Regional Partnership Projects
  - Begin project execution against the Regional Partnership commitments included in the RP – CRISP MOUs
- Better “package” the new tools so their usefulness can be more readily understood by the provider community

Timeline and Status Highlights

◆	Completed
◇	In progress
◇	Not started
	No longer pursuing

	2015					2016						
Deliverable	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**% Complete**
Program Management												
ICN Steering Committee Established	◆											100%
Workstream Lead Assigned			◆									100%
Supporting Regional Partnerships/MOUs established						◆						100%
1.0 Ambulatory Connectivity												
Identify all hospital-owned ambulatory practices							◇					80%
Complete list of ambulatory practices by Regional Partnerships						◇						80%
Establish EMR Collaboration (Athena site live)					◆							100%
ECW CRISP hub live									◇			50%
2.0 Data Router												
RFP awarded			◆									100%
v.5 Consent module deployment						◆						100%
v1.0 Consent module deployment						◆						100%
3.0 Clinical Portal Enhancements												
ENS subscriber list live						◆						100%
Care alerts available in clinical portal							◇					95%
Care plans available					◆							100%

Timeline and Status Highlights - Cont



Deliverable	2015 Aug	Sept	Oct	Nov	Dec	2016 Jan	Feb	Mar	Apr	May	Jun	% Complete
4.0 Alerts and Notifications												
Readmission patient notification pilot live			◆									100%
Care alerts live at AAMC							◇					95%
Care Alerts live at BWMC								◇				40%
5.0 Reporting and Analytics												
Data Sharing Policy for Interhospital care coordination					◆							100%
PaTH Detail Dashbaord available to credentialed hospital care managers						◆						100%
Pilot Risk Stratification tools							◇					75%
Plan for requesting and managing Medicare Data for Care Coordination use						◆						100%
Request Medicare data							◇					25%
6.0 Basic Care Management Software												
Mirth pilot initiation						◆						100%
Caradigm pilot initiation						◆						100%
eQHealth pilot initiation						◆						100%
7.0 Practice Transformation												
ENS webinar						◆						100%

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-207, 19-219. and 19-222, Annotated Code of Maryland

NOTICE OF FINAL ACTION

On March 9, 2016, the Health Services Cost Review Commission adopted amendments to Regulation **.03 and .03-1** under **COMAR 10.37.10 "Rate Application and Approval Procedure."** This action, which was proposed for adoption in 43:01 Md. R. 64-65 (January 8, 2016), has been adopted as proposed.

Effective Date: April 11, 2016

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

(b) Violations [of the Act] were not found; and
(c) (text unchanged)
(15) (text unchanged)
(16) "Licensee" means an individual licensed by the Board of Morticians *and Funeral Directors* against whom a complaint has been filed.

(17) "Mortuary services" means any service provided to a decedent or their family that requires any license issued by the Board.

.03 Filing of Complaint.

A. [A complaint to the Board against a licensee shall be filed by the complainant on a form devised by the Board or in a letter addressed to the Board and mailed, sent by facsimile, or hand-delivered to the Board.] *A complaint may come to the Board by any means from the public or a Board member.*

[B. If the complaint to the Board against a licensee is filed in a letter form, the following information shall be included:
(1) Full name, address, and telephone number of complainant;
(2) Full name, address, and telephone number of the licensee against whom the complaint is being filed;
(3) Full name, address, and telephone number of each witness who should be contacted; and
(4) A detailed description of the nature of the complaint explaining what occurred, including dates and times]

B. A complaint received by the Board shall be recorded on a complaint log.

C. (text unchanged)

D. In an emergency situation the Board may act upon a complaint received by telephone if that complaint is followed up in writing [as specified in §A of this regulation].

E. The Board may also act upon a complaint [of] *signed by a* Board member if the complaint is recorded *on the log* and the Board member refrains from further participation in the discussion or vote in the matter.

.04 Disposition of Complaint by Complaint Committee.

A. Upon receipt of a complaint, the administrative personnel shall present the complaint to the [complaint committee] *Complaint Committee* of the Board.

B. (text unchanged)

C. If the Committee determines that the complaint does not fall within the Board's jurisdiction [because the complaint addresses activities not governed by the Act], the determination [is] *shall be* reported to the Board at its next regularly scheduled Board meeting. If the Board concurs with the recommendation of the Committee, the Board shall [notify the complainant and licensee in writing within 2 weeks of the Board's meeting] *vote to close the complaint with no Board action.*

D. If the Board determines that the complaint falls under the jurisdiction of another agency, the Board staff shall refer the complaint to the appropriate agency.

[D.] *E.* If the Committee determines that the complaint [falls] *would fall* within the Board's jurisdiction, [it may authorize that an investigation of the complaint be undertaken by sending a copy of the complaint to the licensee requesting a written response within 2 weeks which is to include the records, files, contracts, and other documents of the transaction. The Board may also instruct an investigator, as an agent of the Board, to conduct an investigation by issuing subpoenas, and conducting interviews with the licensee, the complainant, and other pertinent witnesses] *the Board shall vote to open the complaint for investigation.*

[E.] *F.* (text unchanged)

[F.] *G.* (text unchanged)

.05 Board Action on Complaints.

A.—D. (text unchanged)

E. In addition, following the Board's vote, the Board shall issue a written document regarding the action taken. All of these documents will be sent to the licensee. The Board shall notify the complainant of the resolution of the complaint, as permitted by [State Government Article, §10-617] *General Provisions Article, §4–333*, Annotated Code of Maryland.

.06 Confidentiality.

A. (text unchanged)

B. An educational letter *and a letter of admonishment* is treated as a confidential record maintained by the Board on the licensee.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207, 19-219 and 19-222, Annotated Code of Maryland

Notice of Proposed Action

[16-022-P]

The Health Services Cost Review Commission proposes to amend Regulations .03 and .03-1 under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on November 18, 2015, notice of which was given pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about March 14, 2016.

Statement of Purpose

The purpose of this action is to establish a moratorium on the filing of regular rate applications pending the development and approval of rate efficiency measures that are consistent with the all-payer model.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. Hospitals will not be able to file full rate applications during the moratorium, and the general public and third-party payers will not be paying higher rates associated with full rate applications during the moratorium.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	(-)	Minimal

E. On other industries or trade groups: (+) Minimal

F. Direct and indirect effects on public: (+) Minimal

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

D. This assumption is based on the belief that although hospitals will not be able to file full rate applications during the moratorium, they have other administrative remedies and opportunities available for obtaining rate relief during the moratorium. Also, it is expected that approval of rate efficiency standards will be forthcoming on or about July 1, 2016.

E. This assumption is based on the belief that third-party payers will not be paying higher rates associated with a full rate application during the moratorium. However, the filing of full rate applications has become the exception, and the moratorium period will last only until new rate efficiency standards are approved, expected to be on or about July 1, 2016.

F. This assumption is based on the belief that the public will not be paying higher rates associated with a full rate application during the moratorium. However, the filing of full rate applications has become the exception, and the moratorium period will last only until new rate efficiency standards are approved, expected to be on or about July 1, 2016.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Diana Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or call 410-764-2576, or email to diana.kemp@maryland.gov, or fax to 410-358-6217. Comments will be accepted through February 8, 2016. A public hearing has not been scheduled.

.03 Regular Rate Applications.

A. A hospital may not file a regular rate application with the Commission until [November 1, 2008, or until an earlier date as designated by the Commission] *rate efficiency measures are adopted by the Commission which are consistent with the all-payer model contract approved by the Centers for Medicare & Medicaid Services (CMS).* During this interim period of time, a hospital may seek a rate adjustment under any other administrative remedy available to it under existing Commission law, regulation, or policy. [As of November 1, 2008 or as of the earlier date if so designated by the Commission,] *The rate efficiency measures shall be adopted by the Commission on or about July 1, 2016. In no event shall the moratorium continue in effect beyond September 30, 2016. Once the moratorium is lifted,* a hospital may file a regular rate application with the Commission at any time if:

(1) — (2) (text unchanged)

B. — D. (text unchanged)

.03-1 Partial Rate Applications.

A. (text unchanged)

B. A hospital may file a partial rate application with the Commission at any time, consistent with the provisions of Regulation .03A of this chapter. [The moratorium provisions associated with Regulation .03A apply only to partial rate applications associated with a capital project.] A partial rate application is not a contested case under the provisions of the Administrative Procedure Act.

C. — D. (text unchanged)

JOHN M. COLMERS
Chairman

Subtitle 41 BOARD OF EXAMINERS FOR AUDIOLOGISTS, HEARING AID DISPENSERS, AND SPEECH-LANGUAGE PATHOLOGISTS

Notice of Proposed Action

[16-024-P]

The Secretary of Health and Mental Hygiene proposes to:

(1) Amend Regulation **.03** and adopt new Regulation **.07** under **COMAR 10.41.03 Licensure and Continuing Education**;

(2) Amend Regulation **.02** and adopt new Regulation **.13** under **COMAR 10.41.08 Hearing Aid Dispensers**; and

(3) Amend Regulation **.03** and adopt new Regulation **.10** under **COMAR 10.41.11 Speech-Language Pathology Assistants.**

This action was considered at a public meeting on October 15, 2015, notice of which was given by publication on the Board's website at http://dhmh.maryland.gov/boardsahs/SitePages/Home.aspx, pursuant to State Government Article § 10-506(c)(1), Annotated Code of Maryland.

Statement of Purpose

The purpose of this action is to:

(1) Require an official transcript as part of an application for the license to the Board; and

(2) Require that licensees notify the Board within 30 days of the change of a mailing address, name, or email address and to authorize the Board to impose a $100 administrative penalty for failure to notify the Board of such changes.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499 (TTY 800-735-2258), or email to dhmh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through February 8, 2016. A public hearing has not been scheduled.

10.41.03 Licensure and Continuing Education

Authority: Health Occupations Article, §§2–205, 2–302, 2–310, 2–310.2, and 2–314(11), Annotated Code of Maryland

.03 Requirements for Licensure.

A. Limited Licensure.

(1)—(2) (text unchanged)

(3) Application.

(a) An individual applying for limited licensure shall submit a complete application.

State of Maryland
Department of Health and Mental Hygiene

John M. Colmers
Chairman

Herbert S. Wong, Ph.D.
Vice-Chairman

Victoria W. Bayless

George H. Bone, M.D.

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Vacant

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Vacant, Director
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Gerard J. Schmith, Director
Center for Revenue Regulation and Compliance

Sule Gerovich, Ph.D., Director
Center for Population Based Methodologies

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **March 9, 2016**

RE: **Hearing and Meeting Schedule**

April 13, 2016	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
May 11, 2016	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:45 a.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at http://www.hscrc.maryland.gov/commission-meetings-2016.cfm

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