



## NOTICE OF WRITTEN COMMENT PERIOD

Notice is hereby given that the public and interested parties are invited to submit written comments to the Commission on the staff draft recommendations and updates that will be presented at the December 9, 2020 Public Meeting:

1. Draft Recommendation on Readmissions Reduction Incentive Program (RRIP) for RY 2023

WRITTEN COMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATIONS ARE DUE IN THE COMMISSION'S OFFICES ON OR BEFORE DECEMBER 18, 2020, UNLESS OTHERWISE SPECIFIED IN THE RECOMMENDATION.

**579<sup>th</sup> Meeting of the Health Services Cost Review Commission  
December 9, 2020**

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

**EXECUTIVE SESSION  
11:30 am**

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104
2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104
3. Update on Commission Response to COVID-19 Pandemic - Authority General Provisions Article, §3-103 and §3-104

**PUBLIC MEETING  
1:00 pm**

1. Review of Minutes from the Public and Closed Meetings on November 12, 2020
2. Docket Status – Cases Closed  
2536A – University of Maryland Medical Center 2537A – University of Maryland Medical Center
3. Docket Status – Cases Open  
2538A – University of Maryland Medical Center 2539A – University of Maryland Medical Center  
2540A – Johns Hopkins Health System 2541N – Sheppard Pratt Hospital  
2542A – University of Maryland Medical Center 2543A – Johns Hopkins Health System 2544A  
– Johns Hopkins Health System 2545A – Johns Hopkins Health System
4. Policy Update and Discussion
  - a. COVID Surge Policy Discussion
  - b. Model Monitoring
  - c. Public Testimony on Statewide Integrated Health Improvement Strategy (SIHIS)
5. Final Recommendation on the Medicare Performance Adjustment (MPA) for RY 2022
6. Final Recommendation on the Quality-Based Reimbursement (QBR) Program for RY 2023
7. Draft Recommendation on the Readmission Reduction Incentive Program (RRIP) for RY 2023

## 8. Hearing and Meeting Schedule

## Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF DECEMBER 2, 2020

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
2539A	University of Maryland Medical System	11/1/2020	N/A	N/A	ARM	DNP	OPEN
2540A	Johns Hopkins Health System	11/2/2020	N/A	N/A	ARM	DNP	OPEN
2541N	Sheppard and Enoch Pratt Hospital	11/12/2020	12/12/2020	4/12/2021	TMS	WH	OPEN
2542A	University of Maryland Medical System	9/21/2020	N/A	N/A	ARM	DNP	OPEN
2543A	Johns Hopkins Health System	11/23/2020	N/A	N/A	ARM	DNP	OPEN
2544A	Johns Hopkins Health System	11/23/2020	N/A	N/A	ARM	DNP	OPEN
2545A	Johns Hopkins Health System	11/24/2020	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

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

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2020  
\* FOLIO: 2349  
\* PROCEEDING: 2539A**

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**Staff Recommendation**

**December 9, 2020**

## **I. INTRODUCTION**

The University of Maryland Medical Center (“the Hospital”) filed an application with the HSCRC on November 3, 2020 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with INTERLINK for a period of one year, effective December 1, 2020.

## **II. OVERVIEW OF APPLICATION**

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

## **III. FEE DEVELOPMENT**

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

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

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

## **V. STAFF EVALUATION**

Although there has been no activity under this arrangement in the last year, staff believes that the Hospital can achieve a favorable experience under this arrangement.

## **V I. STAFF RECOMMENDATION**

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services with INTERLINK for a one year period commencing December 1, 2020. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.



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

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2020  
\* FOLIO: 2334  
\* PROCEEDING: 2540A**

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**Staff Recommendation**

**December 9, 2020**

## **I. INTRODUCTION**

Johns Hopkins Health System (“System”) filed an application with the HSCRC on November 2, 2020 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (“the Hospitals”) for approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers. The System requests that the approval be for one year beginning December 1, 2020.

## **II. STAFF EVALUATION**

The Hospitals have successfully provided like services successfully in prior global arrangements and staff believes that the Hospitals can achieve favorable performance for Pediatric Liver Transplant services under this arrangement.

## **VI. STAFF RECOMMENDATION**

The staff recommends that the Commission approve the Hospitals’ application for solid organ and bone marrow transplant services for one year beginning December 1, 2020. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding (“MOU”) with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2020  
\* FOLIO: 2352  
\* PROCEEDING: 2542A**

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**Staff Recommendation**

**December 9, 2020**

## **I. INTRODUCTION**

University of Maryland Medical Center (“Hospital”) filed an application with the HSCRC on September 21, 2020 for an alternative method of rate determination under COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for solid organ transplant and blood and bone marrow transplants for one year with Aetna Health Inc. and Coventry Health Plan, Inc. beginning August 1, 2021.

## **II. OVERVIEW OF THE APPLICATION**

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

## **III. FEE DEVELOPMENT**

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

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

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

## **V. STAFF EVALUATION**

Staff reviewed the experience under this arrangement for the last year and found it to be unfavorable. The Hospital provided documentation of expected cost and utilization improvements over the next year. Staff continues to believe that the Hospital can achieve

favorable performance under this arrangement with the appropriate cost and utilization improvements.

## **VI. STAFF RECOMMENDATION**

Based on the Hospital's favorable performance, staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ transplant, and blood and bone marrow transplant services, for a one year period beginning August 1, 2020. The Hospital will need to file a renewal application to be considered for continued participation.

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

**IN RE: THE APPLICATION FOR  
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JOHNS HOPKINS HEALTH  
SYSTEM  
BALTIMORE, MARYLAND**

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2020  
\* FOLIO: 2353  
\* PROCEEDING: 2543A**

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**Staff Recommendation**

**December 9, 2020**

## **I. INTRODUCTION**

On November 23, 2020, Johns Hopkins Health System (“System”) filed an application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”) requesting approval to continue to participate in a global price arrangement with One Team Health, an international TPA, for cardiovascular services and for the new service of Spine Surgery. The Hospitals request that the Commission approve the arrangement for one year beginning January 1, 2020.

## **II. OVERVIEW OF APPLICATION**

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

## **III. FEE DEVELOPMENT**

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

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

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payers, 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 that 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 for the prior year under this arrangement was favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

## **VI. STAFF RECOMMENDATION**

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for the period beginning January 1, 2021. The Hospitals must file a renewal application annually for continued participation.

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



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

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2020  
\* FOLIO: 2354  
\* PROCEEDING: 2544A**

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**Staff Recommendation**

**December 9, 2020**

## **I. INTRODUCTION**

On November 23, 2020, 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 Hospital (the “Hospitals”) requesting approval to continue to participate in a revised global price arrangement with Life Trac (a subsidiary of Allianz Insurance Company of North America) for solid organ and bone marrow transplants and cardiovascular services. The Hospitals request that the Commission approve the arrangement for one year beginning January 1, 2020.

## **II. OVERVIEW OF APPLICATION**

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

## **III. FEE DEVELOPMENT**

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

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

The Hospitals will continue to submit bills to JHHC for all contracted and covered

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

## **V. STAFF EVALUATION**

The staff found that the experience under the arrangement has been favorable for the last year. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

## **VI. STAFF RECOMMENDATION**

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services and cardiovascular services for the period beginning January 1, 2020. The Hospitals must file a renewal application annually for continued participation.

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

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**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2020  
\* FOLIO: 2355  
\* PROCEEDING: 2545A**

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**Staff Recommendation**

**December 9, 2020**

## **I. INTRODUCTION**

Johns Hopkins Health System (“System”) filed an application with the HSCRC on November 24, 2020 on behalf of Johns Hopkins Hospital and its affiliated hospitals (“the Hospitals”) for renewal of a revised alternative method of rate determination arrangement, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in the global rate arrangement with Johns Hopkins International for hospital, physician services and certain non-medical services for patients who are not residents or citizens of the United States for a period of three years beginning January 1, 2021.

## **II. OVERVIEW OF APPLICATION**

The contract will be continue to be held and administered by Johns Hopkins International (“JHI), which is a subsidiary of the System. JHI 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 utilizing historical charges for patients at the Hospitals. The remainder of the global rate is comprised of physician service costs and the cost of certain non-medical services, i.e., coordination of care, interpreters, hotel and travel arrangements, etc.

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

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

## **V. STAFF EVALUATION**

Staff believes that the Hospitals can continue to achieve favorable performance under this arrangement.

## **VI. STAFF RECOMMENDATION**

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for the provision of hospital, physician and certain non-medical services to patients who are not residents or citizens of the United States for a period of three years commencing January 1, 2021. The Hospitals will provide information, in the fashion specified by the Commission staff, that the Hospitals are being reimbursed by JHI based on HSCRC-approved rates. 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, and 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.

## **Policy Update Report and Discussion**

Staff will present materials at the Commission Meeting.

**Maria Harris Tildon**  
Executive Vice President  
Marketing & Government Affairs

**CareFirst BlueCross BlueShield**  
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Baltimore, MD 21224-5744  
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November 19, 2020

Adam Kane, Chairman  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Chairman Kane:

CareFirst appreciates the opportunity to support the direction and progress of the Statewide Integrated Health Improvement Strategy (SIHIS) as presented at the November public meeting of the HSCRC. We have been involved with the State process to date and look forward to working with the State and the rest of the health care industry toward the stated SIHIS goals.

The guiding principles for the SIHIS as provided in the MOU between the State and CMMI include the following priorities:

- Goals, measures and targets should reflect an all-payer perspective;
- Measures should be focused on outcomes whenever possible; milestones, including process measures, may be used to signal progress toward the targets; and
- Maryland's strategy must promote public and private partnerships with shared resources and infrastructure.

We are pleased that the current direction of the SIHIS is consistent with these key goals. In addition, the focus on maternal and child health, diabetes, and behavioral health is consistent with CareFirst's health priorities for our members.

In particular, we strongly support the inclusion of the proposed maternal and child health measures in SIHIS and believe that it shows the State's commitment to improve population health on an all-payer basis, and not just for Medicare beneficiaries, as well as addressing longer term total cost of care and improved health outcomes. Moreover, now more than ever, it is important for the entire health care industry to be focus on driving health equity – both through the Model, and outside the Model. As the Maryland Department of Health (MDH) has highlighted on many occasions, there are stark racial and ethnic disparities in both maternal morbidity, and asthma-related ED and hospital visit rates. Greater accountability in both areas will help to put greater focus on health equity statewide and improve health care and outcomes for those who are most in need.

While we fully support the asthma-related ED and maternal morbidity rate measures, we also recommend consideration of non-emergency scheduled Cesarean section rates as an additional population health measure. Maryland has the 12th highest rate of Cesarean delivery, tied with New York.

In addition to the maternal and child health priority, we are very supportive of SIHIS's focus on diabetes, and we also applaud MDH's efforts to create a data-driven Diabetes Action Plan. According to MDH, more than 10 percent of Maryland's adult population currently has diabetes, and an additional 34 percent are estimated to have prediabetes. Diabetes is the sixth leading cause of death in Maryland and was the fifth leading cause of death for Black Marylanders in 2018. Currently, more than 200,000 CareFirst members, representing 8.3% of our 2.4 million commercial and federal employee populations have been diagnosed with diabetes, and this population accounts for approximately \$2.3 billion in annual health spending.



Finally, the recent pandemic has highlighted the dire need for a redoubled focus on solutions to the opioid crisis, and the need for accessible behavioral health services across the State. After some improvement in the number of opioid-related fatalities in 2019, deaths have surged during the first quarter of 2020. Even worse, opioid-related emergency department visits and EMS naloxone administrations were down substantially during that time, an indication that individuals in need of help are not getting it. We support the State's efforts to reduce opioid deaths and including this issue in the SIHIS plan.

We believe that the SIHIS can help to incent health care industry coordination and aligned resources around preventing and managing diabetes, reducing opioid-related deaths, as well as advancing the goals of the Diabetes Action Plan.

We are excited about how the SIHIS provides a wonderful opportunity for collaboration among health care providers, payers, consumers, and the State that is centered around the greatest health care needs of Marylanders. We look forward to enhancing our efforts and partnering with all stakeholders toward these critical goals.

Sincerely,

A handwritten signature in black ink, appearing to read "Maria Harris Tildon". The signature is fluid and cursive, with a long horizontal stroke at the end.

Maria Harris Tildon

Cc: Joseph Antos, Ph.D., Vice Chairman  
Victoria Bayless  
Stacia Cohen, R.N.  
John Colmers  
James N. Elliott, M.D.  
Sam Malhotra  
Katie Wunderlich, Executive Director

**Nicki Sandusky McCann**  
**VP Provider/Payer Transformation**  
**Johns Hopkins Health System**  
3910 Keswick Road  
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Baltimore, MD 21211



November 19, 2020

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

Dear Ms. Wunderlich,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the Statewide Integrated Health Improvement Strategy (SIHIS) goals. Johns Hopkins is supportive of the Total Cost of Care Model (Model) and welcomes the opportunity to help ensure the Model's future success. We acknowledge that advancing the health of all Marylanders requires improvement across the three domains – hospital quality, care transformation, and population health.

JHHS is encouraged that the SIHIS “is designed to engage State agencies and private sector partners to collaborate and invest in improving health, addressing disparities, and reducing costs for Marylanders.” Success under the Model requires participation and investment from all stakeholders who benefit from the Model, not only hospitals. Despite the goal to engage both the public and private sectors, there are stakeholders noticeably absent from SIHIS goals such as commercial payers, the Medicaid program, the Maryland Insurance Administration and elected officials. The goal of the Model to improve population health and care outcomes for individuals is achievable only when every stakeholder is collectively and collaboratively investing to achieve the SIHIS goals. The state must maintain and even increase its investment in population health initiatives in order for success to be attainable. If the SIHIS goals and the Model simply shift from state public health investments to hospital investments, achieving the goals will be impossible, threatening the entire Maryland Model.

The Domains, including the Total Population Health Goals, appropriately identify health disparities as a focus for improvement. Transformation in health disparities also requires action and investment from all stakeholders. Hospitalizations related to diabetes, opioids and asthma are often the result of failed or inadequate investments in social determinants of health, primary care, and public health for those who are most in need. Hospitals can and should play a role in addressing health disparities, but other public and private stakeholders must also contribute. JHHS is

encouraged that the General Assembly leadership has pledged to make health disparities a priority issue and we hope that this effort has a broad impact beyond hospitals.

Many of the Domains focus on Medicare beneficiaries or Medicare data only, with the caveat that Maryland will pursue adding and setting goals for additional payers as data becomes available. Maryland is six years into the Model, which remains an All-Payer Model. Not having actionable data from other payers is no longer acceptable. The HSCRC, working with colleagues across state government, including the General Assembly, should propose concrete actions that could be taken to align non-Medicare beneficiaries with the SIHIS goals. These could include legislative or regulatory requirements that Commercial and Medicaid payers align value-based programs with the SIHIS goals and provide appropriate data for the state to be able to track progress towards meeting them.

In addition to these broad concerns, JHHS also has comments and concerns related to specific domains.

### **Domain 1- Hospital Quality**

- The Readmission Disparity Gap (15% improvement by 2023; 25% improvement by 2026) may be too aggressive unless there is strong public investment in social determinants of health. Additionally, any payment incentive should appropriately recognize hospitals that have already reduced the disparity gap for readmissions.

### **Domain 2- Care Transformation Across the System**

#### *Improve care coordination for patients with chronic conditions*

- Adding the measure for timely follow up after acute exacerbations of chronic conditions is dependent on the ability to identify the patients and tracking of those patients. A significant percentage of patients may not be able to be identified or tracked if they are outside the respective facility or outside of the health care network. The HSCRC should work with CRISP to develop and leverage Health Information Exchange tools that provide real-time encounter-level patient information to assist hospital in tracking follow up for patients outside their facility or network. Otherwise, hospitals will be accountable for efforts without the appropriate tools.

#### *Increase the amount of Medicare TCOC or number of Medicare beneficiaries under CTIs/ CRPs*

- Expecting that Maryland will have either 50% of TCOC under CTIs or 30% of beneficiaries under CTI or a CRP program does not seem reasonable especially considering that the CTI program is launched during a public health pandemic when time and resources are focused elsewhere.
- In light of the HSCRC's likely adoption of increased financial risk for hospital operated Care Transformation Organizations (CTO), the HSCRC should also consider counting the Maryland Primary Care Program's (MDPCP) beneficiaries and attributed total cost of care towards meeting the threshold goals. A specific domain of MDPCP is care transformation,

requiring that the practices transform the way primary care is delivered with support from CTOs.

### **Domain 3- Total Population Health**

#### *Diabetes*

- Using BMI would require significant policy changes in order to create the environment that would make it easier for adults to achieve and maintain a healthy weight. This goal is not achievable by hospitals alone. Focusing solely on clinical interventions alone is also not sufficient. Hospitals do not have the expertise, outside of clinical interventions, to make changes necessary to ensure success within the goal. Public health professionals, payers, the business community and state and local governments would have to be engaged and accountable for the changes to be successful.
- Considering the limitations hospitals will have in addressing BMI, the state should consider creating greater alignment between the Diabetes Regional Partnership scale targets and the SIHIS diabetes goal.
- Sufficient consideration and vetting of the comparison and control states is necessary. The development of standards to evaluate the policy environment and select similar states is critical.

#### *Opioids*

- Sufficient consideration and vetting of the comparison and control states is necessary. The development of standards to evaluate the policy environment and select similar states is critical. For example, several states (NY, OH, MA and KY) received large, targeted federal grants to move the needle on opioid use and opioid overdoses. Comparing Maryland to states that have received significant public investments in opioid use disorder or that have fully integrated Medicaid (unlike Maryland's current bifurcated system) programs would not be appropriate.
- Increasing SBIRT in MDPCP practices is an important goal. The state should consider incentives or enhanced fee structure for buprenorphine induction in primary care practices. This action creates treatment on demand and will significantly reduce opioid use disorder.

#### *Maternal and Child Health*

- JHHS is pleased to see measures identified that address maternal and child health. Many HSCRC programs and targets are Medicare only. Focusing on maternal and child health demonstrates a strong commitment from the state to address population health as a long-term priority.

#### *Asthma*

- Addressing childhood asthma requires more engagement and accountability at a community level; hospitals cannot achieve the goal on their own. Reducing the ED rate for asthma for

Katie Wunderlich  
JHHS Response to SIHIS  
November 19, 2020

children 2-17 requires significant health care transformation, health education and changes in housing and education policies.

- A health equity lens reporting of data by race would be appropriate for the asthma goal considering the high prevalence of health disparities with childhood asthma.

*Maternal Morbidity*

- The language identifying this goal should be changed to “Address severe maternal morbidity rate stratified by race and ethnicity.” Using the language “decrease” could be interpreted to imply that an ongoing disparity is acceptable.
- Addressing disparities in maternal morbidity is an appropriate population health goal, however significant work must be done to optimize the outcome targets, identify appropriate interventions, and convene the appropriate complement of subject matter experts on maternal morbidity, health disparities/health equity, and structural determinants of health to get the interventions right.

Thank you for the opportunity to provide feedback on SIHIS. Success under SIHIS is critical to the future of the Maryland Model. All stakeholders must contribute to ensuring these goals are met. As noted with several other HSCRC policies, there is a need for consideration of the potential impact that COVID may have on implementation of these goals. There are strong indications that COVID will continue to disrupt our health care system through 2021.

Sincerely,



Nicki McCann  
Vice President Provider/Payer Transformation  
Johns Hopkins Health System

cc: Adam Kane, Chairman  
Joseph Antos, Ph.D., Vice Chairman  
Victoria W. Bayless  
Stacia Cohen, RN

John M. Colmers  
James Elliott, MD  
Sam Maholtra

November 19, 2020

Mr. Adam Kane  
Chairman  
Health Services Cost Review Commission

Dear Chairman Kane,

On behalf of Luminis Health, we strongly support the Statewide Integrated Health Improvement Strategy (SIHIS). The metrics and targets outlined in the proposal are impactful and appropriately ambitious. They reflect a necessary redesign of the healthcare system in Maryland to improve access, quality, equity, and costs of health. To meet these goals and ensure the continuation of the Total Cost of Care Model, hospitals, providers, payers, and state agencies must all contribute and work collaboratively.

### **Hospital Quality**

Maryland hospitals have focused on readmissions for several years and have made substantial improvements. Data shows that there is still opportunity to reduce readmissions further, especially by engaging community-based providers and facilities. Provider engagement programs, such as the Maryland Primary Care Program (MDPCP), incentivize collaborative efforts between hospitals and community providers to ensure patients have the appropriate supports and avoid unnecessary readmissions. Furthermore, focusing on reducing the readmissions disparity gap is an important step in improving health equity in Maryland. Lessons learned through this effort can inspire additional health equity improvements throughout the healthcare system.

### **Care Transformation**

Successful care transformation requires sophisticated data analysis, engaged care partners, and continuous improvement. The Care Transformation Initiatives (CTIs) and Care Redesign Programs (CRPs) provide hospitals and care partners the resources necessary to develop, adjust, and grow care transformation throughout the system. Sharing best practices across hospitals and provider practices is key to adopting and expanding successful strategies to improve quality and reduce costs. Although CTIs and CRPs focus specifically on Medicare FFS populations, the care processes developed to meet program goals often spread to all patients.

### **Population Health**

All Marylanders deserve to reach their full health potential. The true measure of success for healthcare systems is performance in population health. SIHIS' goals for improving diabetes, opioids, and maternal and child health will be challenging. However, they are necessary to move our system towards healthier living. Population health success requires investment in infrastructure, resources, and collaborative

partnerships. We are committed to doing the challenging work to meet these goals, and we trust that our provider, agency, and payer partners are as well.

We urge the Commission to be resolute in pursuing the hospital quality, care transformation, and population health objectives of this proposal. Policies and grants should reflect SIHIS goals so that we avoid creating competing priorities and pulling away resources. We also ask that the Commission support hospitals in engaging physicians, post-acute facilities, payers, and other healthcare partners. Hospitals alone cannot control the total cost of care or redesign the healthcare system. Changes of this magnitude require intentional partnership, resource planning, and aligned incentives.

Thank you for the opportunity to provide comments. We look forward to future collaboration.

Sincerely,

A handwritten signature in cursive script that reads "Sherry B. Perkins".

Sherry B. Perkins, PhD, RN, FAAN  
President, Luminis Health, Anne Arundel Medical Center

A handwritten signature in cursive script that reads "Deneen Richmond".

Deneen Richmond, MHA, RN  
Acting President, Luminis Health, Doctors Community Medical Center



Maryland  
Hospital Association

November 19, 2020

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

Dear Ms. Wunderlich:

As the advocate for Maryland's hospital field, MHA appreciates the opportunity to comment on the proposed Statewide Integrated Health Improvement Strategy (SIHIS).

The SIHIS offers a platform for public and private entities across the state to align around the chosen priorities to make a difference in the longer-term health of Marylanders. We applaud the enthusiasm, dialogue, and effort state partners have contributed to choose priorities and targets.

As you know, the SIHIS carries outsized significance by virtue of its role in the long-range prospects of the Maryland Total Cost of Care Model. Late in 2024, the Centers for Medicare & Medicaid Services (CMS) will decide whether our Model is worthy of "expansion," that is, being made permanent. That event is of great moment not only to the hospital field but also to the State and all other stakeholders. Continuation of the Model will bring economic gain, stability to major parts of the health sector, and the best chance to advance the health of all Marylanders.

It is vital that CMS's evaluation of Maryland's Model is favorable in 2021 and 2023—SIHIS measures included. The State must, therefore, choose areas of engagement on which Maryland can demonstrate progress within one to three years. And we are asked to do this while a pandemic ravages our entire nation, diverting precious resources from addressing the priorities everyone agrees upon.

We are especially concerned by the spike of COVID-19 in Maryland during the past two weeks, and the implications for the whole health care industry for the coming year. Since November 1, the number of new cases daily has more than doubled, from 900 per day to more than 2,000. Even more alarming, the number of hospital beds occupied by COVID patients has also more than doubled, from 520 to almost 1,200 beds yesterday. This constitutes an all-hands-on-deck situation for hospitals, health care practitioners, and the public health staffs of the State and localities. Even if the pandemic abates, the after-effects will be long-lasting.

Given these facts, we are deeply concerned about Maryland's ability to hit the targets set in the proposed SIHIS. We therefore encourage the State to submit these goals and targets as preliminary pending review once the pandemic is under control, the health care system is no longer operating in crisis, and social distancing is no longer a part of everyday life. This is



especially important for the maternal and child health goals as planning and implementation of activities are just getting started.

The memorandum of understanding that called for Maryland to create the SIHIS identified three domains, each of which must contain at least one goal: hospital quality, care transformation, and population health.

### **Hospital Quality and Care Transformation Goals**

The goals in the domains of hospital quality and care transformation will require hospitals to go beyond current efforts, try new things and expand their reach further into communities. We agree with all four goals in the two domains and all but one of the targets.

In the Care Transformation domain, we recommend setting the 2026 target for participation in downside risk arrangements at 40% of beneficiaries or 25% of total spend. Aligning ambulatory practices with the aims of the Total Cost of Care model is crucial. Investment in data systems, point-of-care tools, and resources to identify and meet patients' social, self-management and behavioral health needs is critical. As are policies and incentives to advance ambulatory capabilities.

Meeting the 2026 targets will require a large increase in the number of practices participating in an advanced track of the Maryland Primary Care Program. We hope that will happen, but the advanced track is still under development and no one can predict the rate of uptake.

### **Population Health Goals**

The proposed priority areas are rife with disparities and the legacy of systemic racism across much of society and its institutions. Changing the trajectory on the root causes and their impact on health will have lasting benefits, though to show tangible progress within just a few years is very, very difficult. Maryland hospitals will do the hard work of changing internal cultures and connecting with every patient in the way that works best for the patient. They are *all in*.

But hospitals cannot do this work alone. Success demands the full partnership of state and local government agencies, community organizations, health insurers, employers, and many others. Real resources—people and funding, plus leadership commitment—must be brought to bear.

MHA appreciates that HSCRC is committing \$165 million over five years to expand access to behavioral health crisis and diabetes prevention and management services through its Regional Partnership grants. Partnerships' requests for funding exceeded earmarked limits by \$100 million. For sure, \$165 million is a substantial investment. But \$100 million in shovel-ready initiatives on these two priorities alone will go unfunded. Regardless of the decisions made on the SIHIS, the \$50 million remaining in Regional Partnership funding should be awarded.

Katie Wunderlich  
November 19, 2020  
Page 3

Thank you again for the opportunity to share our views. We welcome further discussion.

And to you, the HSCRC staff, and commissioners, please stay safe.

Sincerely,

A handwritten signature in blue ink, appearing to read "Bob Atlas". The signature is fluid and cursive, with the first name "Bob" and last name "Atlas" clearly distinguishable.

Bob Atlas  
President & CEO

cc: Robert Neall, Secretary, Maryland Department of Health



900 Elkridge Landing Road  
4th Floor East  
Linthicum Heights, Maryland 21090  
[www.umms.org](http://www.umms.org)

Finance Shared Services

November 19, 2020

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

RE: UMMS Comments on SIHIS Measures

Dear Katie:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Statewide Integrated Health Improvement Strategy (SIHIS).

We would like to acknowledge the collaborative effort placed on developing the measurements for each domain of the Statewide Integrated Health Improvement Strategy (SIHIS). The industry greatly appreciates the opportunity to contribute to the development of these targets to ensure they are reasonable and achievable.

Our efforts remain strong and steady through an ever-changing healthcare environment related to the pandemic. While we make every effort to consistently drive practices we know improve care and patient safety, our ability to focus and sustain previous improvements is difficult while we are currently fighting, with all available resources, to manage the SARS-CoV-2 virus.

This challenge is now compounded by the recent increase in employee SARS-CoV-2 positivity rates. Across our health system we have seen our November employee positivity rates more than double those of September, growing from as low as 6% to a 7 day average of 13% to 15%. These percentages equate to a loss, on average, of 125 employees per week. As resources are limited and diverted to sustaining the safest environment for both patients and staff, we do have concerns that the expected pace of improvement in these quality metrics will not be consistent with those previously demonstrated.

### **Domain 1 – Hospital Quality Measures**

We agree with HSCRC staff's proposed targets for AHRQ Risk-Adjusted PQIs. We feel that these targets are consistent with previous performance and are reasonable. We do have concerns that the impact of the ongoing COVID pandemic may be greater than anticipated for CY 2020. We would recommend that this be monitored closely on a statewide basis, and if performance is found to be significantly different than anticipated for this metric, that a modification to the target should be considered.

We also in agreement with the overall goal of reducing disparity in hospital readmission rates and are supportive of studying this metric further and developing a reasonable target in the future.

### **Domain 2 – Care Transformation Targets**

We agree with the staff's recommendation to include NQF measure 3455 – Timely follow up after acute exacerbations of chronic condition. We feel timely follow up is a necessary part of successful care plans for patients with these chronic conditions. The ability to influence this metric is dependent on the ability to identify and track of those patients timely. We are worried that a significant percentage of patients (> 50%) may not be able to be identified or tracked if they're outside the respective facility or outside of the health care network. We would like the commission to consider a slight delay in including this metric until hospitals have the ability to consistently and accurately track these patients.

We support the staff's concept of including more patients and cost under the HSCRC defined Care Redesign Programs (CRP) and Clinical Transformation Initiatives (CTI) as a measure of care transformation. We are concerned, however, about the significant increase targeted for this metric over the next five years. As noted in MHA's comments, this increase would require a significant increase in the number of practices participating in track 3 of the MDPCP program, which is still being developed. UMMS supports MHA's suggestion to reduce the 2026 target for participation to 40% of beneficiaries or 25% of total spend.

### **Domain 3 – Population Health Measures**

We support the inclusion of broader population based measures. Both the diabetes and the opioid metrics align with the new catalyst regional partnership grants that were recently approved for Diabetes Prevention Programs and Behavioral Health Crisis Programs. This alignment will support and focus the efforts of hospitals and their care partners in these areas. We agree with MHA's comments that the remaining funding earmarked for Regional Partnerships that has not already been distributed should be awarded to support these population health efforts once the third metric in this domain has been solidified.

Katie Wunderlich  
November 19, 2020  
Page 3

Thank you for the opportunity to provide feedback. If you have any questions, please do not hesitate to contact me.

Sincerely,

A handwritten signature in cursive script that reads "Alicia Cunningham".

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services

Cc: Adam Kane, Chairman  
HSCRC Commissioners  
Mohan Suntha, MD, MBA, UMMS CEO  
Michelle Lee, UMMS CFO



maryland  
**health services**  
cost review commission

# Medicare Performance Adjustment

## Final Recommendation

December 2020

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## Final Recommendations For CY 2021 MPA Policy

Staff recommend the following revisions to the MPA policy for calendar year 2021 (CY2021):

1. Maintain the existing MPA attribution for the calendar year 2021 but with the intention to transition to a solely geographic attribution in the near future.
2. Adopt a 0.5 percent growth rate adjustment (the growth rate adjustment is the amount below national trend which has to be achieved to receive an MPA reward) and scale the adjustment based on the hospital's benchmarking results. Staff recommends that hospitals which have low per capita total cost of care (TCOC) in their service area relative to their peers have a lower growth rate adjustment while hospitals which have a high TCOC relative to their peers have a higher growth rate adjustment.
3. Calculate the MPA benchmark based on a constant 2019 baseline, updated by the national growth since the baseline year, less the growth rate adjustment compounded annually. Currently, a hospital that beats its benchmark is rebased for the next year. Staff recommends setting a per capita TCOC target so that a hospital which exceeds its benchmark by a substantial amount may roll over that success into future years.
4. Maintain the existing scaling of rewards / penalties, revenue at risk, and quality adjustments in the MPA.
5. Reduce any penalties that the hospital receives under the traditional MPA based on the hospital's participation in the Care Transformation Initiatives (CTI) program. The CTI allows for more precise attribution of beneficiaries to hospitals and therefore provides an appropriate balance to the potential penalties under the more rigid base MPA attribution.
6. Create a new supplemental MPA adjustment to hold hospitals accountable for the TCOC of their affiliated National Provider Identification numbers (NPIs) who are participating in the Maryland Primary Care Program. The MPA adjustment will penalize hospitals that are less successful in MDPCP than the State average while rewarding hospitals that are more successful in MDPCP.

Staff recommend keeping the remaining aspects (calculation of rewards and penalties, quality adjustments, etc.) of the MPA unchanged. In addition, MDPCP related fees will be incorporated into the standard MPA reward as documented in the MPA Recommendation for Calendar Year 2020 (CY2020) and amended by the Commission in May 2020.



## Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers
The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to (1) Attribute 95 percent of all Maryland Medicare Beneficiaries to some Maryland hospital; (2) Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and (3) Determine a payment adjustment based on the difference between the hospitals actual attributed TCOC and the benchmark.	This MPA recommendation fulfills the requirements to determine an MPA policy for CY 2021 and makes important improvements to the reward calculation methodology, and adds additional hospital flexibility through Care Transformation Initiatives.	The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care. Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments are a discount on the amount paid by the CMS and not on the amount changed by the hospital. In other words, this policy does not change the GBR or any other rate-setting policy that the HSCRC employs and – uniquely – is applied only on a Medicare basis.	This policy does not affect the rates paid by payers. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service area.

### MPA Purpose

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

Within the State, the MPA has been used to align the measurement of TCOC with hospital's clinical partners. The MPA allows hospitals' care partners under the Care Redesign Program to qualify as participation in an Advanced Alternative Payment Model – and therefore to earn additional payments from CMS. Additionally, the attribution model employed by the HSCRC has tried to increase the integration between physicians and hospitals by replicating Accountable Care Organizations (ACOs) and other primary care-based attribution methods.

### **Historical MPA Policy**

Historically, Commission policy with regard to the MPA has focused on two components: (1) a tiered attribution methodology; and (2) a growth rate adjustment. Over time, the MPA policy has grown to incorporate other care transformation efforts such as the Episode Care Improvement Program and the Care Transformation Initiatives. Those components are covered in other policies.

The MPA attribution methodology assigned beneficiaries to hospitals based on a hierarchical algorithm. First, beneficiaries are attributed based on participation in the Maryland Primary Care Program (MDPCP). Second, beneficiaries are attributed under an ACO-like attribution where HSCRC replicates CMS's attribution for the Medicare Shared Savings Program (SSP) ACOs and physicians voluntarily identified by hospitals as employed by their system. Third, any beneficiary not attributed based on the prior two attribution approaches could be attributed under a referral relationship where HSCRC assigned physicians to hospitals based on where the plurality of their patients hospitalization occurred and then attributed any beneficiary who received a plurality of their primary care services from the physician to that hospital. Finally, any beneficiary not attributed under the previous approaches would be attributed to a hospital based on the hospital's geographic service area.

The MPA then penalized or rewarded hospitals based on their attributed TCOC. The HSCRC calculated a benchmark equal to the prior year's attributed TCOC times the national Medicare TCOC growth rate minus an adjustment factor. Historically the adjustment factor was 0.33 percentage points. Results are calculated on a risk-adjusted basis.

This approach was a year-over-year comparison, based on each hospital's own improvement. The Commission has set a trend factor equal to national TCOC growth minus 0.33 percentage points. A hospital that beat its benchmark would receive a reward, while a hospital that failed to beat its benchmark would receive a penalty. The rewards / penalties are scaled so that each percentage point by which the hospital beats / exceeds its benchmark results in a 0.33 percentage point reduction in its Medicare fee-for-service revenue. The revenue at risk has been capped at 1 percent of the hospital's Medicare fee-for-service revenue.

### **MPA Review**

In November 2019, the Commission directed staff to explore potential changes to the MPA based on feedback from the industry and other stakeholders via its Total Cost of Care Workgroup and other meetings. The review period focused on three issues: (1) analysis of the MPA attribution algorithm; (2) discussion of the financial methodology for determining the rewards & penalties for hospitals; and (3) interactions between the traditional MPA and the Care Transformation Initiative policies. The conclusions of that review are summarized here.

### ***Attribution***

The multi-step attribution method has both strengths and weaknesses. Attribution based on primary care visits aligns with clinical relationships that, presumably, have significant influence over the TCOC of the attributed beneficiaries. However, the multi-step attribution method is complex. Hospitals and staff spend a significant amount of time and energy analyzing the MPA attribution and its complexity has led to questions about whether a hospital's performance is due to the hospital's efforts or due to the eccentricities of the attribution algorithm. In addition to the complexity, the attribution algorithm is volatile and unpredictable, meaning that a significant number of beneficiaries are attributed to different hospitals in successive years. This inhibits a hospital's ability to target interventions at the beneficiaries who will remain attributed to that hospital.

The current attribution algorithm was compared with simpler attribution methods, attribution methods based solely on geographic relationships. Geographic attribution performed just as well on a variety of measures as the current attribution algorithm for most hospitals. Geographic attribution performed particularly well for rural hospitals and performed significantly worse for the academic medical centers.

### ***Financial Methodology***

The current financial methodology compares a hospital's year-over-year change in TCOC to a national growth trend. This means that hospitals must continuously reduce the TCOC attributed to them, even if hospitals start from a low level of TCOC or make significant improvements in a single year. The year-over-year measurement creates some perverse incentives. Specifically, hospitals are incentivized to reduce the TCOC steadily but slowly, rather than deploying effective interventions as rapidly as possible.

The review discussed setting a stable per capita TCOC target for hospitals and scaling the target based on hospitals' level of TCOC relative to their peers. Establishing a stable TCOC target for hospitals has clear benefits but a longer and broader conversation is necessary before setting a long-term TCOC target for individual hospitals.

### ***Interactions with CTI***

Both the MPA and the CTI incentivize hospitals to reduce the TCOC. However, the two policies are different in terms of the flexibility that is available to hospitals. In the traditional MPA, the HSCRC creates a 'one-size-fits-all' attribution methodology. Additionally, the requirement that 95 percent of all Maryland beneficiaries be attributed to some hospitals requires a significantly complex attribution algorithm. Under the CTI, hospitals are able to create their own attribution rules that are tailored to the clinical interventions that the hospitals have deployed. Therefore, the CTI is better aligned with hospitals actual efforts to reduce the TCOC while the MPA attribution recognizes the responsibility of hospitals for the TCOC of all beneficiaries they serve but draws a much looser connection between efforts and outcomes.

## Recommendations for CY 2021

Based on the MPA review, staff recommends several changes to the MPA policy. Specifically:

1. Maintaining the existing MPA attribution for calendar year 2021 with the intention to transition to a purely geographic approach to attribution in future years
2. Scale the MPA growth rate adjustment based on the hospital's costs compared to their benchmark regions and peers
3. Adopt a cumulative TCOC target rather than a year-over-year improvement standard
4. Reduce the hospital's MPA penalties based on their CTI participation
5. Incorporate a supplemental MPA adjustment for hospitals affiliated with practices participating in the Maryland Primary Care Program (MDPCP)

Staff recommend keeping the remaining aspects (calculation of rewards and penalties, quality adjustments, etc.) of the MPA unchanged. In addition, MDPCP related fees will be incorporated into the standard MPA reward as documented in the MPA Recommendation for CY2020 and amended by the Commission in May 2020. The following discussion provides rationale and detail for each of these recommendations.

### ***MPA Attribution***

In the Draft Recommendation, staff recommended replacing the current 'tiered attribution' approach to the MPA with a purely geographic approach. Staff believe that geographic attribution would be substantially simpler and more stable than the current attribution algorithm. However, the industry's comments to the Draft Recommendation emphasized that geographic attribution would lose an important clinical link between the patients seen by the hospital's physician networks and the patients attributed to the hospitals. Stakeholders also noted the increase in workload associated with the COVID-19 pandemic could limit the ability to incorporate new attribution logics. Staff believe that the current MPA attribution does not accurately encompass hospital's clinical relationships for two reasons: 1) the MPA attribution is required to attribute 95 percent of all Maryland beneficiaries to some hospital and therefore each hospital will receive a significant number of non-clinically attributed beneficiaries; and 2) the MPA is a one-size fits all attribution that does not allow for the specifics of individual hospital's clinical strategies. Therefore, while a portion of the hospitals MPA performance represents the impact of the hospital's clinical networks on the total cost of care and a portion of the hospitals' MPA results are driven by the MPA attribution algorithm. Untangling the two effects is difficult and takes significant time and effort.

The HSCRC developed the CTI policy in order better capture the impact of hospitals' clinical strategies on the total cost of care. Hospitals may tailor the CTI to their own clinical programs and thus can more precisely target the attribution logic to their own clinical strategies. Additionally, the CTI measures the

impact of the hospital's interventions at the programmatic level and does not have the confounding impact of other beneficiaries attributed to the hospital in order to ensure that 95 percent of all Medicare beneficiaries are attributed to some hospitals. Staff therefore believe that the CTI will more accurately attribute beneficiaries and be a more valid measure of the direct clinical impact that hospitals have on the total cost of care.

However, the CTI program is entering its first performance period beginning on January 1, 2021, and hospitals are still becoming accustomed to the program and its attribution rules. Staff agree with industry comments that hospitals have not fully captured their clinical strategies under the CTI program. Therefore, staff recommend maintaining the existing attribution approach for calendar year 2021 to provide hospitals with sufficient time to implement their CTI. However, staff note that other aspects of HSCRC policy will become increasingly discordant with the MPA attribution over time. For example, staff propose using the hospitals' geographic Medicare total cost of care as an input to the Integrated Efficiency Policy. Additionally, overtime the hospital's clinical networks will change which makes comparing the hospital's total cost of care to a consistent base period, as proposed elsewhere in this recommendation, increasingly difficult. Staff believe that the stability offered by geographic attribution warrants continuing those policies and migrating the MPA attribution to a purely geographic approach as soon as practicable.

### ***Scaled Growth Rate Adjustment***

Staff recommend modifying the growth rate adjustment so that it is scaled based on each hospital's level of TCOC compared to a benchmark region. Over the prior two years, the HSCRC developed benchmarks for hospitals in Maryland with which to compare the hospitals' performance on a range of quality and cost metrics. The goal is to allow a comparison of Maryland hospitals' performance to geographic and demographically similar national hospitals' performance while recognizing differences that drive legitimate variation. The results<sup>1</sup> show that the State as a whole is more expensive than similar areas elsewhere in the country. However, the extent to which Maryland exceeds its comparison region varies significantly by hospital.

Some hospitals are in line to their comparison region costs while other hospitals are significantly more expensive, relative to their comparison group, than their peers. The MPA is designed to reduce the Medicare TCOC within the State but currently holds hospitals equally accountable for reducing the TCOC, without regard to the extent that individual hospitals contribute to the State's overall level of costs. Staff

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<sup>1</sup> A discussion of the benchmarking methodology can be found in the draft Integrated Efficiency Policy released in October 2020 and the results of the benchmark analysis and a detailed description of the methodology is available on the HSCRC's website at the following link:  
<https://hscrc.maryland.gov/Documents/August%202020%20Benchmarking%20Materials%208-31r%20Distribution.zip>

recommend scaling the TCOC growth rate adjustment so that hospitals which are relatively more expensive are more accountable for reducing the TCOC than hospitals which are relatively cheaper.

Staff recommend setting a target for the State to grow 0.5 percentage points slower than the national average TCOC. This is in line with the State’s historical performance under the All-Payer Model and the early years of the TCOC Model. Staff then recommends scaling the growth rate adjustments by comparing each hospital to their comparison region and ranking each hospital’s relative performance. Specifically, hospitals will be ranked according to the excess TCOC in their service areas (where service areas are defined consistently with the geographic approach above). Hospitals that are in the top (most effective quintile) will not have a growth rate adjustment. These hospitals are already in line with their comparison region costs and do not necessarily need to produce additional Medicare savings. The growth rate adjustment will be increased by 0.25 percentage points for each quintile, as shown in the table below.

*Table 1: Scaled Growth Rate Adjustment*

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
1 <sup>st</sup> Quintile (-15% to + 1% Relative to Benchmark)	0.00%
2 <sup>nd</sup> Quintile (+1% to +10% Relative to Benchmark)	-0.25%
3 <sup>rd</sup> Quintile (+10% to +15% Relative to Benchmark)	-0.50%
4 <sup>th</sup> Quintile (+15% to +21% Relative to Benchmark)	-0.75%
5 <sup>th</sup> Quintile (+21% to +28% Relative to Benchmark)	-1.00%

Scaling the growth rate adjustment will more equitably distribute the incidence of Medicare savings to hospitals that are more expensive relative to their comparison region. Scaling the growth rate adjustments requires lower-performing hospitals to improve more than their better-performing peers, but does not penalize them the way a fixed attainment target would.

Staff also recommend that the Commission and the TCOC workgroup discuss whether the MPA should target a specific level of savings, rather than a policy of continuing to beat national TCOC growth. While a 0.5 percentage point reduction relative to the national growth rate reflects the State’s historical performance, continuing this policy ad infinitum will eventually result in Maryland’s TCOC being below the comparison group costs, which staff considers to be undesirable. As the TCOC Model progresses, the State needs to consider the appropriate long-term savings goals. Therefore, staff recommends discussing a targeted level of savings after which additional savings are not required.

### Revised Total Cost of Care Targets

Staff recommend modifying the MPA's financial methodology to set a cumulative TCOC target, rather than a year-over-year growth rate target. Under the revised approach, each year a hospital will have a TCOC per capita target equal to the hospital's 2019 TCOC, multiplied by the national growth rate since 2019, less their growth rate adjustment factor calculated on a compounded basis. Further, staff recommend that the future MPA targets continue to use a 2019 baseline so that hospitals can build on their historical successes rather than constantly rebasing their performance. The calculation of the MPA TCOC Target is explained in the table below.

Table 2: Calculation of the MPA Targets

Variable		Source			
A = 2019 TCOC		Calculation from attributed beneficiaries			
B = 2020 National TCOC Growth		Input from national data			
C = 2021 National TCOC Growth		Input from national data			
D = Growth Rate Adjustment Factor		From Growth Rate Table			
E = MPA TCOC Target		$A \times (1 + B - D) \times (1 + C - D)$			
Example Calculation of MPA Targets					
Hospital	Quintile	Target Growth Rate	2019 TCOC	2020 MPA Target	2021 MPA Target
Hospital A	1	$3\% - 0.00\% = 3.00\%$	\$11,650	\$12,000	\$12,359
Hospital B	2	$3\% - 0.25\% = 2.75\%$	\$11,193	\$11,501	\$11,817
Hospital C	3	$3\% - 0.50\% = 2.50\%$	\$11,169	\$11,448	\$11,734
Hospital D	4	$3\% - 0.75\% = 2.25\%$	\$11,204	\$11,456	\$11,713
Hospital E	5	$3\% - 1.00\% = 2.00\%$	\$10,750	\$10,965	\$11,184

The cumulative TCOC target is designed to be more stable and predictable. Under the existing MPA methodology, a hospital that beats its TCOC target in one year would be required to repeat its performance in the next year as well. Under the recommended methodology, the hospital will have a stable target that they must achieve and receive credit for over-performance in prior years. Moreover, the hospital's long term MPA targets will be more predictable. A hospital could predict its MPA target in future years, using reasonable assumptions based on the national TCOC growth.

### Calculation of the MPA Reward / Penalty

Staff recommend maintaining the current methodology for calculating the hospital's reward or penalty based on their TCOC compared to the MPA target while incorporating the MDPCP fees as outlined in the CY2020 MPA recommendation as amended in May 2020. For each hospital, its TCOC performance will be compared to the MPA Target. As in prior years the rewards and penalties will be scaled such that the maximum reward or penalty is 1% which will be achieved at a 3% performance level. Essentially, each percentage point by which the hospital exceeds its TCOC benchmark results in a reward or penalty equal to one-third of the percentage.

The agreement with CMS also allows the State to cap the total amount of revenue at risk in the MPA. Staff continues to recommend that the maximum penalty be set at 1.0% and the maximum reward at 1.0% of hospital federal Medicare revenue. Furthermore, staff recommends that the MPA revenue at risk be included in the HSCRC's portfolio of value-based programs and be counted as part of the aggregate revenue at risk for HSCRC quality programs. The calculation of MPA performance is demonstrated in the table below.

*Table 3: Example of MPA Reward & Penalty Calculations (excluding quality adjustments)*

Variable	Input
E = MPA Target	See previous section
F = 2021 MPA Performance	Calculation
G = Percent Difference from Target	$(E - F) / E$
H = MPA Reward or Penalty	$(G / 3\%) \times 1\%$
I = Revenue at Risk Cap	Greater / lesser of H and $\pm 1\%$

Example MPA Performance Calculations				
Hospital	MPA Target	MPA Performance	% Difference	Reward (Penalty)
Hospital A	\$12,359	\$12,235	-1.0%	0.3%
Hospital B	\$11,817	\$11,905	0.8%	-0.3%
Hospital C	\$11,734	\$11,499	-2.0%	0.7%
Hospital D	\$11,771	\$12,124	3.0%	-1.0%
Hospital E	\$11,184	\$11,743	5.0%	-1.0%

In addition, the agreement with CMS requires that a quality adjustment be applied that includes the measures in the HSCRC's Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Conditions (MHAC). Staff recommends continuing the current policy of using the RRIP and MHAC all-payer revenue adjustments to determine these quality adjustments. Under the existing



approach the reward or penalty before the quality adjustment is multiplied by 1 + the quality adjustment. Regardless of the quality adjustment, the maximum reward and penalty of  $\pm 1.0\%$  will not be exceeded.

### **Weighting for CTI Participation**

Staff recommends adjusting the hospitals' traditional MPA penalties based on the hospitals' participation in CTI. As discussed previously, the MPA is a one-size-fits-all approach that is unlikely to ever capture the full nuance of the hospital's clinical interventions; on the other hand, the CTIs are designed by the hospitals themselves in order to capture the impact of their clinical interventions. Therefore, staff consider the CTI a more precise measure of the hospital's efforts to reduce the TCOC that should be recognized as attainment is introduced into the target setting.

Staff believes that the CTI weighting policy is an important complement to a purely geographic MPA attribution. The primary care-based tiers in the existing attribution serve the important purpose of linking the hospital's TCOC accountability to existing clinical relationships. However, hospitals have different clinical relationships that require different attribution approaches. The current MPA attribution does not allow for individually tailoring the algorithm to the individual hospital's clinical relationships. However, the CTI approach will allow hospitals to create CTIs that reflect the nuances of their own clinical relationships.

While CTIs better reflect a hospital's clinical interventions, the traditional MPA ensures that hospitals are individually contributing to the State's collective responsibility for managing the TCOC and taking accountability for healthcare in their community. Hospitals' participation in CTI is variable and does not necessarily reflect the hospitals share of hospitals' Medicare revenues. In order to emphasize the importance of CTI while also holding hospital's accountable for their equitable share of the TCOC, staff recommend calculating a CTI weight equal to the ratio of TCOC covered by the CTI to the TCOC covered by the MPA. Any traditional MPA penalty will be reduced by the CTI weight. Examples of the calculation are shown below.<sup>2</sup>

*Table 4: CTI Weighting Calculations*

Variable		Input			
F = 2021 MPA Performance		See Previous Section			
I = CTI TCOC		Calculation based on CTI Data			
J = CTI Weight		I / F			
J = Final Reward / Penalty		H if positive or $H \times (1 - J)$			
Example of CTI Weights & MPA Penalties					
Hospitals	2019 MPA Adjustment	2019 MPA TCOC	CTI TCOC	Weight	Weighted Adjustment

<sup>2</sup> Values are based on preliminary CTI participation. This table will be made publicly available once CTI submissions for 2021 are complete.

<b>Hospital A</b>	\$(1,820,852)	\$406,361,826	\$184,128,274	45%	\$(995,798)
<b>Hospital B</b>	\$(217,576)	\$94,778,292.69	\$21,828,897	23%	\$(167,465)
<b>Hospital C</b>	\$1,253,352	\$211,943,753	\$349,889,160	100%	\$1,253,352

This policy allows hospitals to focus on the CTI, where they define their own attribution rules in order to tailor them to their clinical interventions; however, a hospital that is participating in CTI only nominally would still maintain a significant weight on the traditional MPA in order to ensure that hospitals remain accountable for their equitable share of the State's collective mission of reducing the TCOC. For example, a hospital that participates in enough CTI to exceed the TCOC attributed to them under the TCOC would be able to focus exclusively on their CTI; a hospital that had only 50% of their MPA attributed dollars covered under a CTI would have a blend of traditional MPA and CTI performance.

Staff recommend that the CTI weight be applied solely to MPA penalties. A hospital that has successfully reduced its geographic TCOC and yet continues to participate in CTI should continue to be rewarded in both.

### ***Supplemental MDPCP Accountability***

The Commission directed staff to increase the accountability for managing the TCOC in the MDPCP. Therefore, staff recommend adding a supplemental MPA adjustment for hospitals that are affiliated with practices that are participating in MDPCP. HSCRC will measure the TCOC savings produced by the MDPCP and reward / penalize hospitals based on their performance relative to the State.

First, HSCRC will measure the 2019 TCOC per capita for all beneficiaries that CMMI attributed to the hospital-affiliated National Provider Identifier (NPI) number. Second, HSCRC will measure the 2021 TCOC per capita for all beneficiaries that CMMI attributed to the hospital-affiliated NPIs. Hospitals will be required to submit a list of the NPIs they are affiliated with for each performance year. For this purpose, "affiliated" will be defined as those NPIs employed by the regulated hospital entity, or an entity owned by the regulated hospital entity or its corporate parent or a sister entity also owned by its corporate parent. The NPIs that are participating in MDPCP may change over time; regardless, HSCRC will measure the TCOC attributed to the hospital based on the actual participation in MDPCP. Third, HSCRC will calculate the hospital's per capita savings by comparing the difference in per capita costs between 2019 and 2021 for the assigned beneficiaries.

Once the hospital's per capita savings is known, the HSCRC will calculate the difference between the Statewide average per capita savings on all MDPCP beneficiaries, and the hospital's individual savings. The supplemental MPA adjustment will be equal to the difference between the State average result and

the hospital's individual result times the number of beneficiaries assigned to the hospital's affiliated NPIs. The calculation and an example is shown below.

*Table 5: Supplemental MDPCP Adjustment Calculations*

Variable	Input					
A = Statewide 2019 Per Capita TCOC	Calculation					
B = Statewide 2021 Per Capita TCOC	Calculation					
C = Hospital 2019 Per Capita TCOC	Calculation					
D = Hospital 2021 Per Capita TCOC	Calculation					
E = Hospital 2021 MDPCP Beneficiaries	CMMI Attribution List					
F = Supplemental MPA Adjustment	$((A - B) - (C - D)) \times E$					
Example Supplemental MDPCP Adjustment for Hospital-Affiliated MDPCP Practices						
	Statewide		Hospital A		Hospital B	
	Baseline	Performance Period	Baseline	Performance Period	Baseline	Performance Period
<b>Benes</b>	250,000	300,000	20,000	25,000	30,000	40,000
<b>Claims-Based Payments</b>	\$3,437 mil.	\$4,017 mil.	\$275 mil.	\$326 mil.	\$412 mil.	\$542 mil.
<b>Care Management Fees for Affiliated NPIs</b>	\$63 mil.	\$108 mil.	\$5 mil.	\$9 mil.	\$7.6 mil.	\$14 mil.
<b>TCOC</b>	\$3,500 mil.	\$4,125 mil.	\$280 mil.	\$335 mil.	\$420 mil.	\$556 mil.
<b>TCOC per Capita</b>	\$14,000	\$13,750	\$14,000	\$13,400	\$14,000	\$13,900
<b>Per Capita Savings</b>		\$250		\$600		\$100
<b>Savings in Excess of State</b>		-		\$350		\$-150
<b>Net Payments</b>		-		\$8.7 mil.		\$-6 mil.

Staff recommends making the supplemental MPA adjustment based on savings relative to the State average for two reasons: (1) monies will be redistributed from hospitals that are underperforming in MDPCP to hospitals that are successful in MDPCP; and (2) hospitals will be encouraged to compete with one another to be the most successful in MDPCP – hopefully thereby increasing overall performance.

Staff recommend capping the MPA supplemental adjustment at the amount of the care management fees received by the hospital. For this purpose, care management fees received by the hospital would include both for their Affiliated NPIs included in the measurement above and fees received by the hospital for providing CTO services to non-Affiliated NPIs. MDPCP is an important part of the State’s delivery system transformation. If the magnitude of the penalty exceeded the amount of the care management fees that the hospital receives, it would be a disincentive for hospitals to participate in an important delivery system transformation.

Rewards and penalties under this Supplemental MDPCP Accountability will not count towards the 1% maximum fees at risk described above and will be incremental to the standard MPA reward or penalty.

## Stakeholder Feedback and Staff Responses

Six stakeholders (the Maryland Hospital Association, the Johns Hopkins Health System, Medstar Health System, the University of Maryland Health System, Luminis Health, and CareFirst) submitted comments on the draft MPA Recommendation. In general, most commentors recommended maintaining the existing MPA attribution methodology but were supportive of the other major technical changes to the MPA. All commentors, except for CareFirst recommended removing the supplemental MPA adjustment. Finally, numerous commentors noted that the MPA policy raised major questions about the strategic direction of the Maryland Model and emphasized that a broader conversation about the State’s strategic objectives was necessary.

### *Attribution Methodology*

The Maryland Hospital Association, Johns Hopkins Health System, Medstar Health System, the University of Maryland Health System, and Luminis Health, all indicated concern about transitioning to a geographic attribution methodology due to the loss of a clinical linkage between the hospital and its attributed beneficiaries.

**Staff Response:** As discussed above, clinical relationships between hospitals and the beneficiaries who are attributed to them is an important attribute of the attribution methodology. However, Staff believe that the existing attribution does not accurately measure the impact that hospitals’ clinical strategies have on the total cost of care given the churn in the attribution algorithm and the confounding impact of additional beneficiaries necessary to meet the requirement that 95 percent of beneficiaries are attributed. Further, Staff believe that the CTI program is better able to capture the hospitals clinical relationship. Therefore,

Staff recommend maintaining the existing attribution for calendar year 2021 to migrate the hospitals clinical relationships into the CTI program before moving to a geographic attribution in the future.

### ***Hospital Benchmarking***

The Maryland Hospital Association, Johns Hopkins Health System, Medstar Health System, the University of Maryland Health System, and Luminis Health, all indicated concern about using the Medicare benchmarking results in the MPA because hospitals have not had sufficient time to vet the benchmarking methodology. Additionally, some commentors noted that efficient hospitals tend to be located in wealthier jurisdictions and questioned whether the risk adjustment was sufficient.

**Staff Response:** The benchmarking work has been discussed with members of several HSCRC workgroup beginning two years ago. While the release of the final results was disrupted due to COVID-19, hospitals have had a significant amount of time to analyze the benchmarking results. Staff also emphasize that the benchmarking is introduced with relatively little revenue at risk. The MPA has a maximum revenue at risk of 1 percent of Medicare revenue and additionally the benchmarking results only adjusts the hospital's trend factor by a maximum of 1 percentage points relative to national average. Thus the impact on the hospitals is likely to be fairly limited. As discussed below, comparing Maryland to equivalent areas of the country is critical to the Maryland Model's sustainability and introducing the benchmarking in the context of the MPA will accustom the industry to the benchmarking results with relatively low stakes.

Additionally, staff have distributed substantial details on the extensive risk adjustment methodology included in the benchmarking methodology.

Finally, as the actual results of the CY2021 MPA policy won't be effective until July 2022 there will be extensive opportunity to revise the underlying benchmarking calculations should technical corrections be found.

### ***MPA Technical Adjustments***

The Maryland Hospital Association, Johns Hopkins Health System, Medstar Health, the University of Maryland Health System, and Luminis Health were generally favorable of the technical changes to the MPA. Commentors were favorable towards the fixed 2019 baseline and the CTI buyout. The MHA was favorable towards the trend rate factor discount of 0.5 percentage points while Luminis recommended maintaining the existing 0.33 percentage point discount relative to the nation.

**Staff Response:** Staff recommend the 0.5 percentage point discount relative to the nation, which is inline with the State historical performance on the Medicare waiver test. Given the State's average position relative to the benchmark region, Staff does not believe that a slowdown is warranted.

### ***Supplemental MDPCP Adjustments***

All commentors, except for CareFirst, recommended removing the MDPCP supplemental adjustment. Commentors noted that hospitals incur significant costs investing in their primary care networks and that adding additional risk to MDPCP would jeopardize their ability to invest in primary care. Additionally, commentors emphasized that hospitals have some risk under the MDPCP program and that only a single years' worth of data is available.

**Staff Response:** The MDPCP program includes relatively limited accountability for the total cost of care. Staff believe that increasing accountability for the total cost of care is best handled within the MDPCP itself and would recommend removing the Supplemental MDPCP Adjustment if and when the MDPCP incorporates an aspect of risk for the total cost of care.

### ***Model Goals***

Luminis Health noted the MPA policy has raised questions about the State's overall Model strategy and that those questions require a broader conversation with stakeholders. In particular, Luminis raised questions about the link between the level of the total cost of care in Maryland and the payment rates for Maryland hospitals, given that an advantage for the hospitals is that payments rates exceed the average cost of Medicare visits.

**Staff Responses:** Staff agree that a broader conversation about the Maryland Model strategy is necessary and anticipate strategic discussions with the industry over the next year. Staff also emphasize that the principal benefit of the Maryland Model and the global budget payment system is that Medicare payment rates can remain above costs even while overall revenues decline, so long as potentially avoidable utilization is eliminated.

**Maria Harris Tildon**  
Executive Vice President  
Marketing & Government Affairs

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November 6, 2020

Adam Kane, Chairman  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Chairman Kane:

Thank you for the opportunity to provide input regarding the “Draft Recommendation on the Medicare Performance Adjustment (MPA)”. CareFirst appreciates that the MPA is an important and direct driver of total cost of care savings. We applaud the Staff for their flexibility and exploration on attribution models at the request of the industry. We recognize that hospitals must understand and agree with the attribution methodology in order to perform well in this construct. We would also like to share our suggestions on future development of the policy.

**Avoidance of duplication:** Staff has made great efforts and strides to ensure that MPA rewards and penalties are not duplicative. Doing this clearly adds additional complexity to the policy, but the draft recommendation establishes a reasonable balance between fairness and complexity. As the MPA and other related policies evolve, we suggest that Staff continue efforts to ensure there is little or no overlap/duplication within or across incentive policies.

**Participation vs. Performance:** Additionally, the primary goal of the MPA is to ensure that individual hospitals are contributing toward the goals set under the Total Cost of Care Model which are based on a series of cost and outcome measures. Likewise, we believe that the incentives established in the MPA, to the extent practicable, should also be based on outcome measures. The draft recommendation reduces “any penalties that the hospital receives under the traditional MPA based on the hospital’s participation in the Care Transformation Initiatives (CTI) program.” CareFirst understands the need to utilize a participation metric during the rollout of the CTI program. However, as performance data become available, CareFirst recommends that the metric of MPA penalty reduction be based on CTI performance and not participation. This would make the policy consistent with the intent of the TCOC Model and the overall MPA.

**Accountability:** In the absence of a comprehensive element of down-side risk under the Maryland Primary Care Program (MDPCP), CareFirst supports the recommendation to include an adjustment based on success of affiliated NPIs participating in the MDPCP program.

Staff is making this recommendation based upon the provision in the TCOC Model Agreement that states that 95% of all Maryland Medicare Beneficiaries be attributed to some Maryland hospital, the attributed beneficiaries be compared to a TCOC benchmark, and that payments be adjusted based on the difference between the hospital’s actual attributed TCOC and the benchmark. Staff has gone through great lengths to normalize costs between Maryland hospitals and comparison groups. While we recognize that there are cost shifts from public payers to private payers nationally that are not present in Maryland, we still believe that comparing Medicare’s Maryland TCOC to TCOC nationally when the result is used to establish a relative ranking of hospitals for the purpose of a scaled rate of growth adjustment is a reasonable basis for a benchmark.

As indicated above, like most HSCRC policies, we believe this methodology will develop over time. Therefore, we support Staff's time frame for implementation which allows for iteration in the future.

Again, we are appreciative of the opportunity to comment on the MPA recommendation and look forward to working with you on the future development of the policy.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Harris Tildon', with a long horizontal flourish extending to the right.

Maria Harris Tildon

Cc: Joseph Antos, Ph.D., Vice Chairman  
Victoria Bayless  
Stacia Cohen, R.N.  
John Colmers  
James N. Elliott, M.D.  
Sam Malhotra  
Katie Wunderlich, Executive Director





Maryland  
Hospital Association

November 5, 2020

Adam Kane  
Chairman  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Chairman Kane:

On behalf of Maryland's 61 member hospitals and health systems, the Maryland Hospital Association (MHA) appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) proposed revisions to its Medicare Performance Adjustment (MPA) policy.

MHA respectfully recommends the following positions:

- **Maintain the hierarchical attribution rather than geographical**
- **Adopt the proposed target of national growth less 0.5%**
- **Forgo hospital-specific growth targets based on the benchmarking performance, at least until the following year**
- **Adopt proposed 2019 base period**
- **Retain existing scaling of rewards and penalties**
- **Adopt proposed Care Transformation Initiative (CTI) adjustments to the MPA**
- **Reject proposed Maryland Primary Care Program (MDPCP) supplemental adjustment**

**Maintain the hierarchical attribution.**

MHA recommends HSCRC continue using the hierarchical attribution to preserve direct clinical linkage to hospital accountability. Last year, we asked HSCRC staff to review the attribution methodology due to concerns over its stability. Following its review, HSCRC concluded a geographical attribution is no better or worse, statistically, than the hierarchical attribution, albeit simpler to administer.

While we appreciate a simpler approach, moving to a geographic attribution removes clinical links among patients, physicians, and hospitals. There is no one right way to attribute lives in this model. We are searching for the optimal way. Following extensive discussion with hospitals across the state, there is consensus that maintaining clinical linkage is more important than gaining a slightly greater degree of stability. In future, perhaps other refinements may be discovered that will more closely mirror the actual clinical ties between patients/beneficiaries and hospitals and their affiliated providers.

**Adopt national growth less 0.5% as the targeted growth rate.**

MHA supports the proposed target of national growth less 0.5%. This is a slight increase from the target in the first two years of national growth less 0.33%. Provided the scaling is retained, this

increase is reasonable. We also thank the staff for removing the earlier proposal of setting a future growth rate target in the MPA. We look forward to working with HSCRC to address this important matter.

**Forgo hospital-specific growth targets using the benchmarking methodology, at least until CY2021.**

We appreciate HSCRC staff's proposal to differentiate hospital growth targets using absolute performance versus a national peer group. Hospitals support an attainment measure. However, MHA recommends that HSCRC wait at least a year to adopt the measure to allow hospitals to review, understand, and validate HSCRC benchmarking methodology for this purpose.

We appreciate HSCRC staff's detailed work to introduce the benchmarking methodology. Hospitals have not had time to assess the methodology. The proposal would reallocate funding around the targeted growth rate, and it therefore should be revenue neutral. When policy results are revenue neutral, and thus not impactful to payers, we respectfully ask HSCRC to defer to the field's position.

**Adopt the proposal to fix the base period as 2019.**

MHA supports HSCRC's proposal to use 2019 as the fixed base period, updated by national growth. This proposal improves stability in the measure and allows hospitals showing strong performance in any year to retain that savings to apply in a future period.

**Retain the existing scaling of rewards and penalties.**

MHA supports maintaining the existing scaling of rewards and penalties, including the limit of 1% of Medicare revenue at risk (plus or minus).

**Adopt the proposed CTI adjustments to the MPA.**

MHA supports the proposed adjustments that will mitigate unfavorable MPA results by participating in care transformation initiatives (CTI). HSCRC allows hospitals to focus on their own efforts to reduce total cost of care through CTI participation. The proposal creates another incentive to grow CTI participation and helps mitigate the financial impact of any instability in the MPA adjustment.

**Reject the proposed Maryland Primary Care Program (MDPCP) supplemental adjustment.**

We ask the commission to reject the proposed MDPCP supplement adjustment that places hospitals at risk for care management fees (CMF). There are multiple reasons:

- The added risk double counts risks against the hospital borne in GBR, MPA, and other policies.
- Care Transformation Organizations (CTOs) must perform specified services not done by hospitals in the normal course and that are too expensive for one practice to supply on their own (e.g., pharmacist and nutrition counseling, referrals to social services, community health workers). Care management fees do not cover the full expense of these services.
- Hospitals' global budgets cannot cover every non-billable activity. HSCRC's MPA, efficiency and rate corridor policies already evaluate and limit GBR savings that can be repurposed for interventions outside the hospital.
- Hospitals are reaching out to small, independent practices that otherwise would not be engaged in the Model. This is a key point for Model alignment. Hospitals will be less

Chairman Adam Kane

November 5, 2020

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likely to invest in scalable programs like MDPCP with a timeline that is too short to determine success.

- The proposed policy lacks sufficient risk adjustment needed account for socioeconomic differences or dual-eligible populations.
- CTOs that not aligned with hospitals face no risk of any kind for health care costs, yet they receive same care management fees that hospital-affiliated CTOs do.
- MDPCP practices unaligned with CTOs get to keep all their CMF dollars even if they drive up health care costs.

Thank you again for your careful consideration of these matters. If you have any questions, please contact me.

Sincerely,



Brett McCone  
Senior Vice President, Health Care Payment

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

Sam Malhotra  
Katie Wunderlich, Executive Director  
Will Daniel, Deputy Director  
William Henderson, Principal Deputy Director

**Nicki Sandusky McCann**  
**VP Provider/Payer Transformation**  
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3910 Keswick Road  
Suite N-2200  
Baltimore, MD 21211



November 6, 2020

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

Dear Ms. Wunderlich,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the draft recommendation for the Medicare Performance Adjustment (MPA) Policy for Calendar Year 2021. JHHS supports the staff recommendation to:

- Maintain the existing scaling of rewards/penalties, revenue at risk, and quality adjustments to the MPA; and
- Calculate the MPA benchmark based on a constant 2019 baseline.

Additionally, JHHS supports the recommendation to reduce traditional MPA penalties based on participation in the Care Transformation Initiatives (CTI) program; however, this concept was introduced so close to the CTI deadline that hospitals were not afforded adequate time to assess the full opportunity of the program for each of our hospitals in order to maximize CTI participation. The previous CTI strategy was to focus on CTIs that could demonstrate savings compared to peer hospitals, rather than as a way to measure the Total Cost of Care (TCOC) for beneficiaries covered by the CTIs.

JHHS has concerns with the recommendations to:

- Remove the physician to hospital linkage in the attribution algorithm and pivot to a solely geographic model
- Use a new benchmarking methodology to scale adjustments; and
- Create a new supplemental MPA adjustment for hospital-affiliated providers participating in the Maryland Primary Care Program (MDPCP).

### **MPA Attribution**

JHHS appreciates the efforts and commitment of staff to evaluate and improve the MPA attribution methodology. All attribution models have both benefits and challenges. JHHS currently supports maintaining the hierarchical attribution. The hierarchical attribution preserves the clinical links between patients, providers and hospitals. Provider engagement is critical to the success of the TCOC Model, and we believe the current attribution is the best mechanism at this time to encourage provider alignment. Additionally, increased consistency and stability is necessary to evaluate HSCRC policies over time. Maintaining the current attribution will provide better insight into MPA performance over time.

However, should the HSCRC decide to pursue geographic attribution, a separate attribution methodology is required to reflect the unique role and patient populations that the state's Academic Medical Centers (AMC) serve. While JHHS prefers to maintain the current MPA attribution, we have collaborated with the University of Maryland Medical System (UMMS) and HSCRC on the development of a separate AMC attribution.

### **Benchmarking Methodology**

As noted in the JHHS comments on the Integrated Efficiency Policy, there are serious concerns with the benchmarking methodology developed by HSCRC staff. The benchmarking methodology needs further evaluation by the hospital industry and Commissioners, including the longer-term cost savings target proposed by staff. The proposed target would mark a fundamental shift in the goals and intents of the TCOC Model and warrants additional discussion with the industry, Commissioners, and Centers for Medicare and Medicaid Innovations (CMMI) leadership.

The benchmarking methodology and subsequent application to the MPA also does not take into account the ongoing differential between Medicare and Commercial payers and how this differential would be addressed if Medicare expenditures are significantly reduced over time. This could have the effect of creating an underfunded hospital system in the State, reducing the ability of hospitals to invest in critical technology, staff, and other resources that will continue to position us as leaders nationally.

As related to the MPA, staff are proposing that lower-performing hospitals should be required to improve more than their better-performing peers based on their relative standing in the benchmarking analysis. In theory this may be logical, however under the proposed benchmarking methodology, the "efficient" hospitals tend to be located in wealthier jurisdictions, or offer limited services, with hospitals serving poor rural or urban jurisdictions being considered less efficient. It is likely not the HSCRC's intent to disadvantage hospitals serving vulnerable communities, but the methodology as currently proposed has this unintended consequence. HSCRC staff should further explore mechanisms to adequately adjust for health and social disparities.

Katie Wunderlich  
JHHS Response to Medicare Performance Adjustment  
November 6, 2020

### **Supplemental MDPCP Accountability**

JHHS appreciates the concerns raised by HSCRC Commissioners and staff regarding TCOC accountability under the MDPCP model. The MDPCP model is intended to complement and not threaten the TCOC model. If successful, the MDPCP model will decrease hospital utilization through increased access to quality primary care. Considering the intersection between MDPCP and TCOC models, JHHS does understand interest from HSCRC Commissioners and staff in ensuring greater accountability under MDPCP.

The MDPCP model is intended to provide robust Medicare investments in primary care that have been neglected over time. Care Transformation Organizations (CTOs) and primary care practices (PCP) that have been successful under the MDPCP model have invested in pharmacy, social work, behavioral health and care management. The impact of these investments will not be realized within a short period, consistent with other CMMI demonstration programs nationally. The Commission recognized the downstream impact of the care management fees on June 13, 2018 when the Commission issued a Resolution recognizing that “hospitals should not be held financially liable for the cost of the MDPCP Care Management Fees.” It is not clear why the HSCRC has changed the policy and perspective on the MDPCP model. If certain hospital based CTOs or practices are not investing the Care Management Fees as required under the program or are increasing costs through other actions, those practices should be held directly accountable. Additionally, there are developments underway within the MDPCP model to transition more practices towards increased risk. It is not clear how the Supplemental MPA would intersect with those developments.

Thank you for the efforts of the HSCRC staff who have been thoughtful and transparent in their efforts around this complex issue and for their commitment to improve the MPA policy. We look forward to continued collaboration in our mutual efforts to reduce TCOC.

Sincerely,

Nicki McCann  
Vice President Provider/Payer Transformation  
Johns Hopkins Health System

Katie Wunderlich  
JHHS Response to Medicare Performance Adjustment  
November 6, 2020

cc: Adam Kane, Chairman  
Joseph Antos, Ph.D., Vice Chairman  
Victoria W. Bayless  
Stacia Cohen, RN

John M. Colmers  
James Elliott, MD  
Sam Maholtra

November 6, 2020

Mr. Adam Kane  
Chairman  
Health Services Cost Review Commission

Dear Chairman Kane,

On behalf of Luminis Health, thank you for the opportunity to provide written comments on the recent Medicare Performance Adjustment Policy from Health Services Cost Review Commission (HSCRC) staff. While we support aspects of the policy, we remain concerned with certain specific provisions.

### **Total Cost of Care (TCOC) Benchmarking**

HSCRC staff has developed a methodology to benchmark geographies in Maryland against national peers for both Medicare and Commercial TCOC per beneficiary. The goal is to use these metrics to introduce TCOC attainment as a metric into the CY2021 Medicare Performance Adjustment (MPA).

Major components of the national benchmarking methodology include setting TCOC benchmarks per beneficiary for a hospital's Primary Service Area against "like populations" nationwide (adjusting for case mix, teaching, and socioeconomic factors). These benchmarks are set differently for the hospital's Medicare and commercial populations. The Medicare calculation is a county-level TCOC per beneficiary calculation based on county-level comparisons. The commercial benchmark is based on metropolitan statistical areas (MSAs).

We have several concerns regarding this benchmarking approach and methodology:

1. The decision to make a long-term goal of the Waiver to be for Medicare expenditures in Maryland to be comparable to the nation is a fundamental shift, requiring further and extensive discussion between CMMI, the State, and hospital stakeholders on the purpose and future of the Waiver.
2. The benchmarks focus on Medicare and not All Payer targets:
  - a. The goal of driving Medicare to national benchmarks while preserving Commercial rates that are nearly 25% below the nation is counter to our All Payer Model and eliminates the value of the Waiver.
  - b. Methodologies that would eliminate the difference would preserve the problems of the Medicare fee-for-service system (inpatient rates barely above breakeven and outpatient rates that do not cover costs) while constraining hospitals from charging rates to commercial payers in line with the nation.
3. TCOC attainment includes price and utilization:
  - a. The benchmark comparison should be limited to utilization variances since price is addressed through the ICC calculation. Measuring only utilization would eliminate price differences due to the Maryland All Payer model.



- b. Limiting price considerations in the benchmarks may also eliminate some of the inequities resulting from the construction of the national peer groups.
  - i. It is notable that this policy has clear winners (Montgomery, Howard, Anne Arundel County) and losers (Baltimore City/County, Eastern Shore, other rural areas)
  - ii. Hospitals that are primarily compared to counties and MSAs on the East or West coast do relatively well, while hospitals compared to those in the rest of the country fare far worse.
4. Any benchmarking methodology needs to provide for both an attainment and improvement measure. This is consistent with the approach of other HSCRC programs such as the Readmissions Reduction Incentive Program.

### **Medicare Performance Adjustment**

Under the MPA, hospitals receive one-time penalties/rewards based on their change in TCOC per beneficiary for an attributed population. To date, a hospital receives awards if TCOC per beneficiary in its attributed population grows slower than the amount required to meet CY2023 Waiver targets.

Pivoting away from a provider to hospital attribution methodology in favor of a geographic attribution is not consistent with the care delivery models being pursued under the TCOC model. Each of the programs currently being implemented by HSCRC – Care Redesign Programs, CTIs, etc. – are premised on the close link between physician alignment and success management of TCOC. The movement away from this attribution logic fractures this link and will make it more difficult for hospitals to operationalize physician alignment strategies based on MPA performance.

The policy proposal does not explain why the savings targets are designed to make it more difficult to achieve rewards under the MPA. During workgroup discussions, the staff noted that the more aggressive targets were designed to achieve \$800M in Medicare savings by 2030, a goal that has never been vetted with Maryland stakeholders. The draft policy proposal removed the language about the change in Medicare savings targets, but the recommended increases in the trend factor continue to reflect achievement of \$800M savings by 2030. The Commission should continue to operate under the 2023 targets (0.33% trend factor) as required by the State's agreement with the Centers for Medicare and Medicaid Services, not an arbitrary future target established in a policy without stakeholder input.

Finally, the introduction of additional risk on the hospital CTOs that are participating in MDPCP is duplicative and could provide a disincentive for future hospital participation in the program. The CTOs already hold financial risk for the utilization and quality performance of attributed beneficiaries through the Performance Based Incentive Payment (PBIP). In addition, CTOs are unable to either choose the primary care providers they work with or terminate a relationship due to poor performance. Holding the hospital CTOs at risk for the care management fees received for independent providers creates a disincentive for ongoing participation in the program. This same potential risk does not exist for non-hospital CTOs, creating a potential scenario whereby hospital CTOs exit the program, hindering a key physician alignment strategy between the hospitals and primary care providers.

Mr. Adam Kane  
November 6, 2020  
Page 3

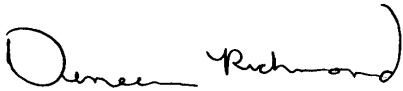
### **Conclusion**

Thank you for the opportunity to provide comments on these two policies. We look forward to future collaboration.

Sincerely,

A handwritten signature in cursive script that reads "Sherry B. Perkins". The signature is written in black ink on a white background.

Sherry B. Perkins, PhD, RN, FAAN  
President, Luminis Health, Anne Arundel Medical Center

A handwritten signature in cursive script that reads "Deneen Richmond". The signature is written in black ink on a white background.

Deneen Richmond, MHA, RN  
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November 6, 2020

Mr. Adam Kane, Chairman  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Chairman Kane:

On behalf of MedStar Health System and our Maryland Hospitals, we wish to comment on the Health Services Cost Review Commission's (HSCRC) proposed revisions to the Medicare Performance Adjustment (MPA) policy. We appreciate the Commission Staff's work on this during the last several months and also emphasize that the pace of suggested changes and policies during the most significant public health crisis of our time is quite challenging for providers. We support the MHA comment letter and offer additional perspectives based on our experience and in support of the Total Cost of Care (TCOC) goals.

**Supportive of Adjustment related to CTI** – MedStar Health supports the staff's recommendation to implement MPA adjustments related to participation in care transformation initiatives that would mitigate unfavorable MPA results. We believe our state model's success is largely dependent upon providers' ability to develop and scale clinical models that will improve quality and bend the cost curve. To-date, CTIs have encouraged hospitals to make prudent investments in a variety of programs and models in order to reduce total cost of care. Recent proposals requiring hospitals to commit to extending CTI programs before data is available to understand past or current performance, as well as claw-back provisions requiring recoupment of funds long after investments have been made are a significant deterrent to hospitals' continued participation in these important care transformation initiatives.

**Disapprove MDPCP Supplemental Adjustment** – MedStar Health is not supportive of the MDPCP supplemental adjustment and respectfully asks that the Commission reject this policy. We have participated in MDPCP since its inception through participation of our employed practices, as well as through investment in a Care Transformation Organization which supports not only employed practices but also a few private practices as well. Our participating practice locations and our CTO each have an agreement with CMS and the State Program Office that outlines program regulations and requirements. The care management fees that the HSCRC proposal seeks to put at risk, is invested to meet the rigorous program requirements. The HSCRC proposal places the hospitals in a double-jeopardy situation, given that there are already provisions within the program

that allow for claw-back of funds for underperformance. As MHA points out in their letter, this is in addition to the risks against the hospitals borne in GBR, MPA, and other policies. This position is further supported by the following:

- Policy appears to be driven by analysis of MDPCP year 1 performance. Given that attributed lives and data were not available until well into 2019 and given that practices and CTOs were starting up the program, it is too early to expect to see TCOC savings in 2019.
- Policy would evaluate all hospital-affiliated practices against a state-wide average, yet data shows not all practices are the same, and HCCs alone do not account for the vast differences in complexity of patients among the practices (especially those that are hospital campus-based). There must be sufficient risk-adjustment to account for these differences (high percentages of dual eligible, social determinants of health, etc.)
- Policy places additional expectations on hospital-based practices not borne by private practice providers and provides a disincentive of hospital-based practices to participate in MDPCP. However, the data shows patients treated at these locations are often those that would most benefit from care management services and have the most impact on TCOC, if managed.
- Care Transformation Organizations (CTOs) allow for engagement of small, independent practices that encourage their involvement in Maryland TCOC. Policy provides a disincentive for continued participation and investment.
- Hospitals' global budgets cannot support the level of care management services required under MDPCP.

In closing, we appreciate the opportunity to comment on these important policy proposals. We sincerely appreciate the Commission's consideration of our comments.

Sincerely,



Susan K. Nelson  
Executive Vice President & Chief Financial Officer



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

cc: Adam Kane, Chairman  
Joseph Antos, Ph.D., Vice Chairman  
Victoria W. Bayless  
Stacia Cohen, RN  
Will Daniel, Deputy Director

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James N. Elliott, M.D.  
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November 6, 2020

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

**RE: UMMS Comment Letter for Medicare Performance Adjustment**

Dear Katie,

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Medicare Performance Adjustment (MPA) Policy.

UMMS appreciates the HSCRC's decision to place workgroup meetings and vetting processes for proposed methodology changes on hold resulting from the COVID-19 pandemic. As always, we do appreciate the HSCRC leading industry workgroups and providing analyses to evaluate new methodologies. We do have concerns, however, that the pause has now caused an acceleration of the process, which has resulted in the lack of proper vetting of both the MPA and Efficiency Measure methodologies.

UMMS appreciates the additional time to provide comments and offers the following concerns regarding the MPA Methodology:

**Current MPA Attribution should be retained**

We understand the HSCRC's good intentions to simplify the attribution methodology, but are in favor of retaining the current attribution. The current tiered MPA attribution logic was carefully vetted by hospitals and relevant stakeholders. It considers the physician relationship and population health investments to better manage patients regardless of hospital touch. This logic is better aligned with the central tenets of the TCOC Agreement and the Care Redesign Programs and resulting relationships with community care providers. The geographic attribution logic would fail to capture these relationships. Furthermore, the geographic attribution would not adequately address the 'free rider' issue in which hospitals may end up with rewards under the methodology when they themselves did not contribute to the positive performance. Likewise, hospitals could also be penalized unfairly for poor performance of the geographic region.

**An Alternative AMC methodology should be explored**

University of Maryland Medical Center (UMMC) and John Hopkins Hospital (JHH) have long been recognized for providing critical and lifesaving tertiary and quaternary care to all the citizens of Maryland. In addition, both UMMC and JHH provide community care to all patients in the immediate surrounding areas. Given that the geographic reach of these two facilities is vast, a full geographic attribution logic does not produce a reasonable and consistent attribution, due to the number of localities that are included for these two facilities. We appreciate the opportunity to explore alternatives for the AMCs with the Commission staff and will continue that work in conjunction with JHH.

**CTI Buyout is a fair approach to ensure direct incentives**

The Commission has proposed Care Transformation Initiatives (CTIs) as a means to reward hospitals for directly managing patient populations. UMMS is in favor of the CTI buyout to encourage hospital participation in CTIs.

**TCOC Benchmark should be further evaluated**

As mentioned earlier, the short reprieve to workgroups has placed a tight time constraint on hospital vetting opportunities. The HSCRC staff has worked on the benchmark methodology and corresponding policy for substantial periods of time, beginning last year or earlier, but the staff introduced these policies to the industry in a few workgroup meetings in August and quickly looked for hospital understanding on the proposals. This short time period has not allowed hospitals adequate time to evaluate and understand such a complex analysis and we feel that more time is warranted to vet the methodology. During the course of our high level and quick review of the proposed methodology, UMMS has identified areas of concern and a few suggestions we would like to explore further with the HSCRC Staff:

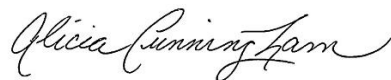
- Hospitals located in wealthier jurisdictions tend to have better TCOC results while hospitals serving poor rural or urban jurisdictions perform poorly
- The inclusion of price in the benchmark analysis skews results and tends to place urban and suburban areas at a disadvantage
- Utilization performance should be considered as an alternative to measuring performance to eliminate some of the price disparity caused by our all-payer model
- Border hospitals tend to perform better in the Medicare benchmarking due to the number of patients who seek care outside Maryland at lower payment rates
- TCOC measure should include both attainment and improvement, similar to the approach taken with the quality policies

**HSCRC should not put MDPCP Care Management Fees at further risk**

CTOs and practices are already at risk for the Performance Based Incentive Program (PBIP) under MDPCP. In addition, CTOs are required to utilize their CMFs to assist practices in managing the care of their patient populations. They are used to fund support services such as pharmacy, social work, practice transformation and direct care management support. Placing CMFs at risk may result in a disincentive to program participation, eliminating a key care delivery alignment strategy between the hospitals and the primary care community. UMMS understands the concerns regarding additional financial support provided to hospital-based CTOs and their hospital-employed practices, however placing the care management fees (CMF) they receive at risk should not be enacted. We believe investments in primary care will support our collective goal of improving the health of Marylanders and managing TCOC, however, the value of any population health investment will not necessarily be seen in a short period of time and definitely not in the first year of a new program. Program performance should continue to be evaluated for a period of time before considering additional CMF risk.

We appreciate the HSCRC's goal to continually evaluate and improve methodologies and hope to have the opportunity to provide additional input into both the MPA as well as the Efficiency Measure methodologies. Thank you for the opportunity to provide feedback.

Sincerely,



Alicia Cunningham  
Senior Vice President, Corporate Finance & Revenue Advisory Services

cc: Adam Kane, Chairman  
HSCRC Commissioners

Mohan Suntha, MD, UMMS CEO  
Michelle Lee, UMMS CFO



maryland  
**health services**  
cost review commission

# Final Recommendations for Updating the Quality-Based Reimbursement (QBR) Program for RY 2023

December 9, 2020

This is the final staff recommendation for the RY 2023 Quality Based Reimbursement Program.



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## LIST OF ABBREVIATIONS

CDC	Centers for Disease Control & Prevention
CAUTI	Catheter-associated urinary tract infection
CDIFF	Clostridium Difficile Infection
CLABSI	Central Line-Associated Blood Stream Infection
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-Related Group
ED	Emergency Department
FFY	Federal Fiscal Year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commission
MRSA	Methicillin-Resistant Staphylococcus Aureus
NHSN	National Health Safety Network
PQI	Prevention Quality Indicators
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year (Coincides with State Fiscal Year (SFY) July-Jun; signifies the timeframe in which the rewards and/or penalties would be assessed)
SIR	Standardized Infection Ratio
SSI	Surgical Site Infection
THA/TKA	Total Hip and Knee Arthroplasty Risk Standardized Complication Rate
VBP	Value-Based Purchasing

## Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/ Consumers	Effect on Health Equity
The quality programs operated by the Health Services Cost Review Commission, including the Quality-Based Reimbursement (QBR) program, are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC’s quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.	The QBR program is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time.	The QBR policy currently holds 2 percent of hospital revenue at-risk for Patient Experience of Care/Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results, and in other measures in domains of Safety (Healthcare Associated Infections), and Clinical Care (inpatient mortality, hip/knee arthroplasty complications).	This policy affects a hospital’s overall GBR and so affects the rates paid by payers at that particular hospital. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	The quality programs that assign hospitals credit for the better of attainment or improvement on the measures (QBR and RRIP) better allow the policies to target improvements in hospitals that serve patient populations impacted more by disparities in care. In the future, the QBR policy may provide direct hospital incentives for reducing disparities, similar to the approved readmission disparity gap improvement policy.

## RECOMMENDATIONS

This document puts forth the RY 2023 Quality-Based Reimbursement (QBR) final policy recommendations that include maintaining the RY 2022 quality domains, scoring approach, and pre-set revenue adjustment scale. This final recommendation also proposes minimal changes to the program measures, as outlined below.

Recommendations for RY 2023 QBR Program:

1. Continue **Domain Weighting** as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 50 percent, Safety (NHSN measures) - 35 percent, Clinical Care - 15 percent.
2. Implement the following **measure updates**:
  - A. Add an exclusion for hospitals with lower case volumes and higher Case Mix Index (CMI) for the hip/knee complication measure.
  - B. Add follow-up after acute exacerbations for chronic conditions measure to the PCE Domain.
  - C. Add PSI-90 measure composite to the Safety domain
3. Maintain the **pre-set scale** (0-80 percent with cut-point at 41 percent), and continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) for the QBR program.
4. Convene a QBR Redesign Work Group in 2021 that targets the CMS concerns and implements identified strategic priorities for quality.
5. Adjust retrospectively the RY 2022 and RY 2023 QBR pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report changes to Commissioners.

# INTRODUCTION

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) Quality-Based Reimbursement (QBR) program is one of several pay-for-performance initiatives that provide incentives for hospitals to improve patient care and value over time. While the current Total Cost of Care (TCOC) Model Agreement between Maryland and the Centers for Medicare & Medicaid Services (CMS) does not have explicit performance requirements for Maryland's QBR program, the Commission has prioritized aligning the QBR program with the federal Value Based Purchasing (VBP) program, and has attempted to encourage improvement in areas where Maryland has exhibited poor performance relative to the nation.

Maryland has been working to update performance standards and targets in HSCRC's portfolio of quality and value-based payment programs with the onset of the Total Cost of Care (TCOC) Model Agreement with CMS. Per directives from HSCRC Commissioners<sup>1</sup> and upon approval of the TCOC Model, staff worked with stakeholders over the last two years to revise the Maryland Hospital Acquired Complications program, the Potentially Avoidable Utilization program<sup>2</sup>, and the Readmissions Reduction Incentive Program for RY 2022 (Performance Period - CY 2020). It was the staff's intent to convene a subgroup to redesign the QBR program during CY 2020; however, HSCRC postponed convening the group due to the COVID-19 public health emergency (PHE) until next year. The QBR program will include minor updates this year, but will largely remain similar to prior iterations of the policy with the understanding that the program will be re-designed in CY 2021 for the RY 2024 policy.

Under the TCOC Model, the State must request exemptions from the CMS Hospital Acquired Conditions (HAC) program, Hospital Readmission Reduction program (HRRP), and Hospital Value-Based Purchasing (HVBP) program based on annual reports to CMS that demonstrate that Maryland's program results continue to be aggressive and progressive, meeting or surpassing those of the nation. HSCRC submitted a report this year with its exemption request and received notification from CMS on September 29, 2020 that the exemptions were granted for Federal Fiscal Year 2021; the notification of exemption may be found in Appendix I.

Staff notes that, while the exemptions were granted, CMS raised concerns about Maryland's relatively poor performance in two of the VBP domains, specifically the HCAHPS measures in the Person and Community Engagement Domain and the CDC NHSN Infection measures in the Safety Domain.

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

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

Furthermore, as part of the exemption approval, CMS stipulated that a high-level work plan for the QBR Redesign needs to be submitted as part of the annual monitoring report (due December 31, 2020) and a QBR Redesign summary report is needed in 2021.

Maintaining Maryland's exemption from the national Value-based Purchasing program is important because it enables the state (via the HSCRC) to generate autonomous, quality-based measurement and payment initiatives that set consistent all-payer quality incentives.<sup>3</sup> Furthermore, this exemption affords Maryland the flexibility to select performance measures and targets in areas where statewide improvement is needed, and allows Maryland to develop programs with greater potential for system transformation. For example, unlike the national VBP program, QBR does not relatively rank hospitals, but instead provides all hospitals the opportunity to earn rewards, which are determined using a prospective revenue adjustment scale.

The QBR program measures and domains are similar to those of the VBP program, but there are a few differences. Most notably, HSCRC has put higher weight on the Person and Community Engagement and Safety domains to encourage improvement on measures of patient experience, and QBR does not include an Efficiency domain. Staff recommends retaining this approach for the RY 2023 policy, while also targeting Maryland's underperforming areas with the QBR Redesign Subgroup.

Generally the HSCRC tries to align the QBR program to measures of national import, and where feasible, the Commission incorporates more comprehensive measurement relative to the VBP program,<sup>4</sup> most notably an all-cause, inpatient Maryland mortality measure versus VBP's condition-specific 30-day mortality measures. During the coming year, staff will work with contractor support to continue developing an all-cause, all-condition 30-day mortality measure applicable to all payers, expanding further the QBR mortality measure's potential to incentivize better outcomes outside the hospital walls, which is a central tenet of the TCOC Model.

This report provides final recommendations for updates to Maryland's QBR program for Rate Year (RY) 2023, with minimal updates from RY 2022. The QBR program has potential scaled penalties or rewards of up to 2 percent of inpatient revenue. Hospital performance is assessed relative to national standards for its Safety and Person and Community Engagement domains. For the Clinical Care domain, the program uses Maryland-specific standards for the inpatient mortality measure, and the program uses national standards for the hip and knee replacement (THA/TKA) complications measure.

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<sup>3</sup> For more information on the VBP Exemption (granted annually by CMMI), please see Appendix I.

<sup>4</sup> For more information on the VBP program, see <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html>, last accessed 10/28/19.

## BACKGROUND

The Affordable Care Act established the hospital Medicare Value-Based Purchasing (VBP) program,<sup>5</sup> which requires CMS to reward hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. Figure 1 below compares the RY 2022 QBR measures and domain weights to those used in the CMS VBP program.

Figure 1. RY 2022 QBR Measures and Domain Weights Compared with CMS VBP Program

	Maryland QBR Domain Weights and Measures	CMS VBP Domain Weights and Measures
<b>Clinical Care</b>	15 percent -2 measures: all cause inpatient Mortality, THA/TKA complications measure	25 percent -5 measures: 4 condition-specific Mortality, THA/TKA complications measure
<b>Person and Community Engagement</b>	50 percent-8 HCAHPS measures	25 percent- 8 HCAHPS measures
<b>Safety</b>	35 percent -5 measures: 6 CDC NHSN HAI measure categories (2 are combined)	25 percent 5 measures: CDC NHSN HAI measures
<b>Efficiency</b>	N/A	25 percent-Medicare Spending Per Beneficiary measure

With the selected measures from above, the QBR program assesses hospital performance based on the national average (threshold) and the top performance (benchmark) values for all measures, except the HSCRC calculated in-hospital mortality rate (which uses state data to calculate performance standards). Thus, a score of 0 percent means that performance on all measures is below the national average or not improved, while a score of 100 percent means performance on all measures is at or better than the top 5 percent best performing rates. This scoring methodology is the same as the national VBP program. However, unlike the VBP program that relatively ranks all hospitals, the QBR program uses a preset scale to determine each hospital's revenue adjustment, offering hospitals far more predictability.

<sup>5</sup> Details of CMS VBP measures may be found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html>.



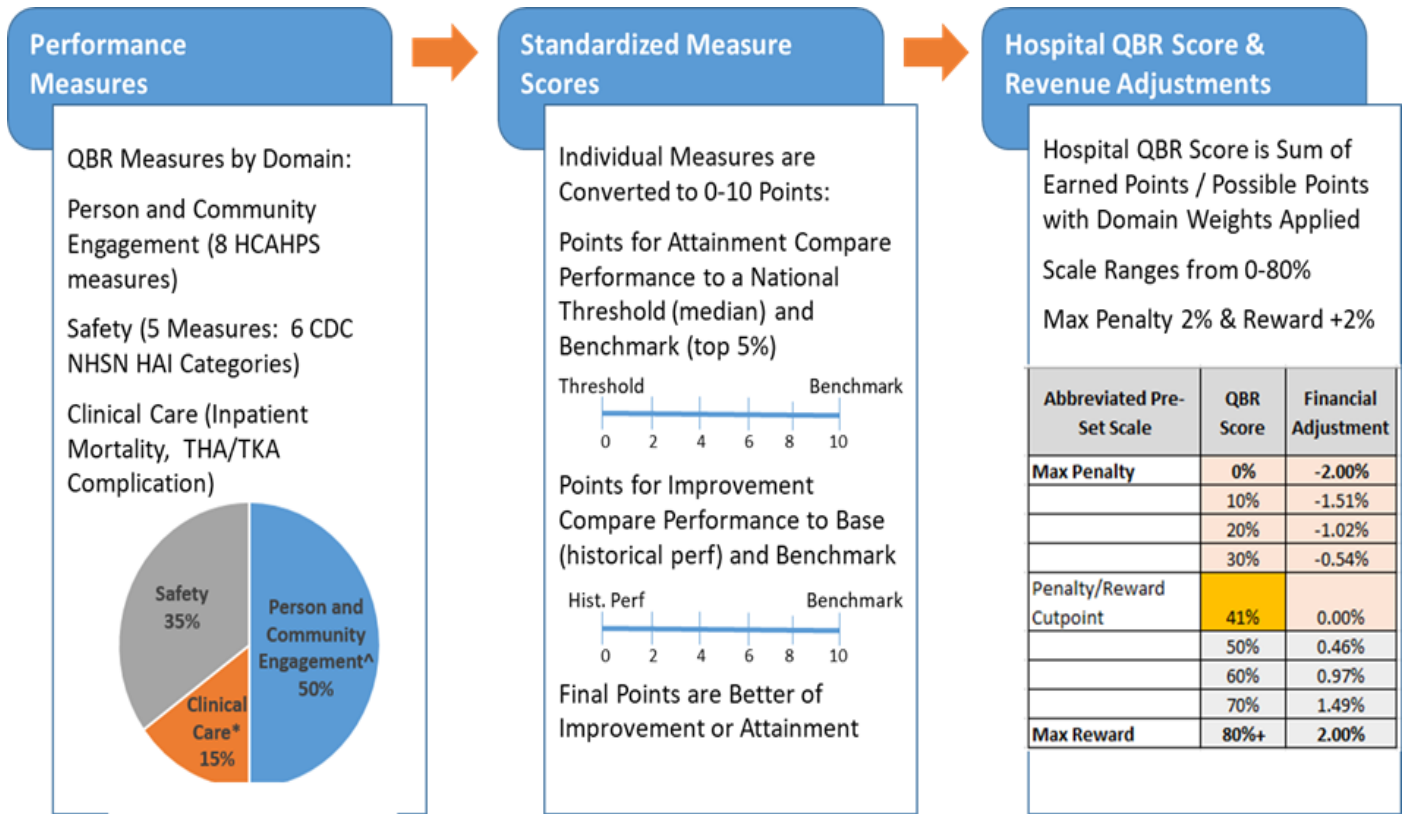
In the RY 2019 QBR recommendation, the Commission approved using a preset scale based on national performance to ensure that QBR revenue adjustments are linked to Maryland hospital performance relative to the nation. Prior to RY 2019, Maryland hospitals were evaluated by national thresholds and benchmarks, but their scores were then scaled in accordance with Maryland performance, resulting in Maryland hospitals receiving financial rewards despite falling behind the nation in performance. Consequently, the scale is now 0 to 80 percent regardless of the score of the highest performing hospital in the state, and the cut-point at which a hospital earns rewards in RYs 2021 and 2022 is 41 percent. This reward and penalty cut-point was based on an analysis of FFY16-FFY18 national Value-Based Purchasing scores, which indicated the average national score using Maryland domain weights (i.e., without the Efficiency domain) was around 41 percent (range 39.9 to 42.7). While staff originally proposed a 45 percent cut-point for RY 2021 to further ensure Maryland hospitals that received rewards were performing better than the nation, the Commission amended the recommendation to have the cut-point be at the national average of 41.

As a recap, the methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019, and involves:

- 1) assessing performance on each measure in the domain;
- 2) standardizing measure scores relative to performance standards;
- 3) calculating the total points a hospital earned divided by the total possible points for each domain;
- 4) finalizing the total hospital QBR score (0-100 percent) by weighting the domains based on the overall percentage or importance the Commission has placed on each domain; and
- 5) converting the total hospital QBR scores into revenue adjustments using the preset scale that ranges from 0 to 80 percent.

The methodology is illustrated in Figure 2 below.

Figure 2. Process for Calculating RY 2022 QBR Scores



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

## ASSESSMENT

The purpose of this section is to present an assessment, using the most current data available, of Maryland’s performance on measures used in QBR as well as other measures where national comparisons are available. The assessment together with the deliberations of the Performance Measurement Workgroup (PMWG) serve as the basis for the final recommendations for the RY 2023 QBR program. In addition, staff has modeled the QBR revenue adjustments with the recommended changes.

### Maryland Performance by QBR Domain

#### Person and Community Engagement

During RY 2021, the **Person and Community Engagement** domain measured performance using the HCAHPS patient survey, as well as one emergency department (ED) wait time measure for admitted patients (ED-2b Decision to admit time to actual admission time) that was part of the CMS Inpatient

Quality Reporting (IQR) program; the addition of the emergency department wait time measures was an example of Maryland's quality programs differing from the nation to target an area of concern as Maryland has had extended ED wait times compared to the nation over a number of years. However, as of CY 2020, the CMS IQR program no longer requires submission of the measure, so the measure was removed in the RY 2022 policy. Staff does note that CMS has made optional an electronic clinical quality measure (eCQM) version of the ED-2b measure for hospitals to submit. Some stakeholders, including members of the Commission, have voiced support for including an ED wait time measure for patients not admitted to the hospital (OP 18-b- time of arrival to departure from the ED); in the policy deliberations for RYs 2021 and 2022, adoption of this measure was not approved as concerns were raised about increased wait times due to hospitals' efforts to treat and provide care management services as appropriate in the ED rather than admit this subset of patients. Options for ED wait time measures will again be considered for future adoption through the work of the QBR redesign subgroup staff will convene in CY 2021.

### **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)**

Figures 3 and 4 below provide graphic and numeric representations respectively of the HCAHPS measure results for the RY 2021 base and performance periods for Maryland compared to the Nation, revealing that Maryland continues to lag behind the Nation, but both the nation and Maryland are improving at similar rates overall.

For each HCAHPS measure, the changes over time from the base to the performance period for Maryland and the Nation, and the gaps in performance between Maryland and the Nation, are provided below.

- **Communication with nurses-** Maryland remained the same and the nation improved by 1 percent, and the gap widened by -1 percent, with Maryland -5 percent below (worse than) the Nation.
- **Communication with doctors-** Maryland and nation remained the same, as did the gap, with Maryland at -4 percent below the Nation.
- **Responsiveness of hospital staff-** Maryland improved by 1 percent while the nation remained the same, and the gap narrowed (improved) for Maryland from -9 percent to -8 percent below the Nation.
- **Communication about medicine-** Maryland improved by 1 percent and the nation remained the same, and the gap decreased for Maryland from -6 percent to -5 percent below the Nation.
- **Cleanliness and quietness-** Maryland improved by 1.5 percent and the nation improved by 0.5 percent, and the gap decreased for Maryland from -6.5 percent to -5 percent below the Nation.
- **Discharge information-** Maryland and the nation remained the same, and the gap remained the same for Maryland at -1 percent below the Nation.
- **Post discharge care understood-** Maryland remained the same and the nation improved by 1 percent, and the gap widened by -1 percent with Maryland at -5 percent below the Nation.

- **Overall hospital rating**- Maryland declined by -1 percent and the nation remained the same, and the gap widened for Maryland by -1 percent to -7 percent below the Nation.

Figure 3. HCAHPS Results: Maryland Compared to the Nation, RY 2021

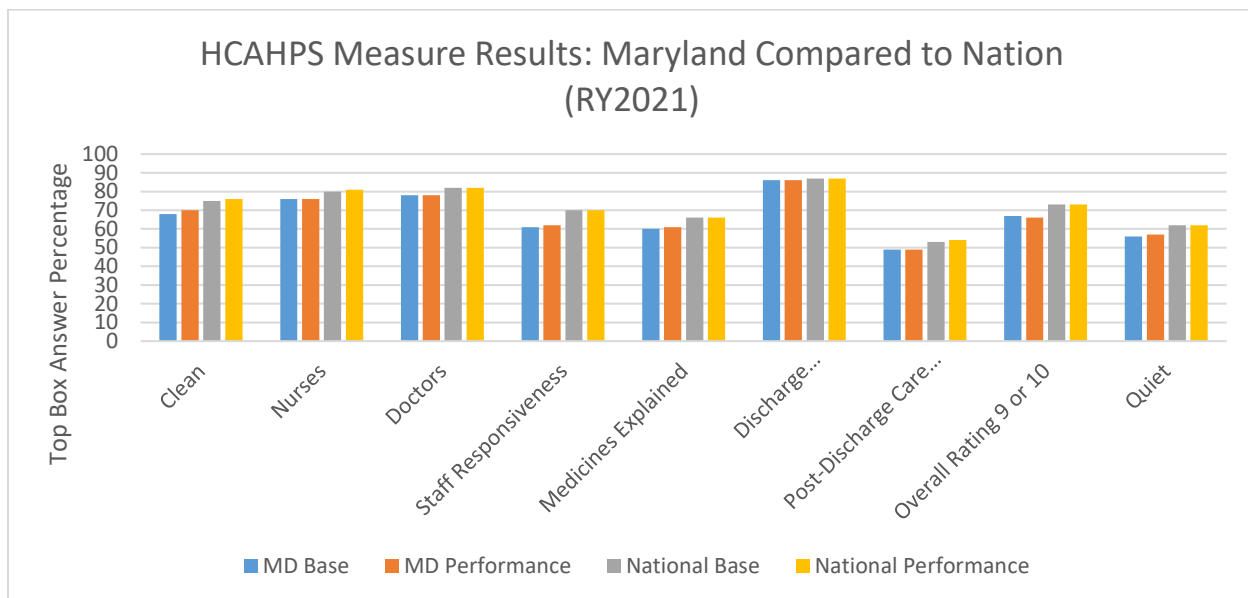


Figure 4. HCAHPS Numeric Results: Maryland Compared to the Nation, RY 2021<sup>6</sup>

	Clean/Quiet	Nurses	Doctors	Staff Responsiveness	Medicines Explained	Discharge Information Provided	Post-Discharge Care Strongly Understood	Overall Rating 9 or 10
<b>MD Base</b>	62	76	78	61	60	86	49	67
<b>MD Performance</b>	63.5	76	78	62	61	86	49	66
<b>National Base</b>	68.5	80	82	70	66	87	53	73
<b>National Performance</b>	69	81	82	70	66	87	54	73

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

Stakeholders on the PMWG have previously raised concerns about HCAHPS performance. Payers have raised concern about the lack of improvement in the HCAHPS measures, and hospitals about the potential impact of the patient mix adjustment changes that the CMS VBP program updates between the base and performance periods at the federal level. Regarding the lack of improvement, alternative

<sup>6</sup> This Figure provides the percent of patients surveyed that rated the hospitals for each of the HCAHPS categories in Maryland and the nation a score of 9 or 10 on a scale of 1-10 in the base and performance periods for RY 2021.

incentive methodology approaches to target HCAHPS will be considered as part of the QBR redesign. Regarding the patient mix adjustment changes, as noted in the RY 2022 policy, CMS has advised staff that these changes occur on an ongoing basis, and are not considered materially significant for the VBP program. Further, staff recognizes that the use of the prospective preset scale may make this a potential issue to consider in Maryland.<sup>7</sup> Therefore, staff proposes again to work with QBR redesign subgroup to be convened in CY 2021 and the PMWG to evaluate the impact, if any, of the patient mix adjustment.

### **Timely Follow-up after Acute Exacerbations of Chronic Conditions**

As part of the TCOC model, the State is required to establish Statewide Integrated Health Improvement Strategies (SIHIS) across three domains that include hospital quality, care transformation across the system, and total population health.<sup>8</sup> Within the care transformation across the system domain, a goal has been established to improve care coordination for patients with chronic conditions. To assess this goal, staff identified a National Quality Forum (NQF) endorsed health plan measure that evaluates the percentage of ED visits, observation stays, and inpatient admissions for exacerbations of six conditions where a patient received follow-up within time frames recommended by clinical practices;<sup>9</sup> the chronic conditions and follow-up time frames include:

- Hypertension (7 days)
- Asthma (14 days)
- Heart Failure (14 days)
- CAD (14 days)
- COPD (30 days)
- Diabetes (30 days)

It should be noted that since non-hospital outpatient data is required for this measure that the HSCRC staff can only calculate follow-up for Medicare FFS beneficiaries at this time using Medicare claims.<sup>10</sup> Figure 5 provides a comparison of Maryland versus national Medicare performance for each condition, as well as the total follow-up rate across all conditions for CY 2019.<sup>11</sup> This figure shows that Maryland performs slightly worse on four of the conditions and the same or better on two of the conditions. Since the TCOC model includes a Maryland specific primary care model, it is highly likely that CMS will include

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<sup>7</sup>The Patient-Mix Adjustment document for the October 2020 Public Report period can be found at: [https://www.hcahponline.org/globalassets/hcahps/mode-patient-mix-adjustment/october\\_2020\\_pma\\_web\\_document.pdf](https://www.hcahponline.org/globalassets/hcahps/mode-patient-mix-adjustment/october_2020_pma_web_document.pdf)

<sup>8</sup> For more information, refer to the [Performance Measurement Workgroup meeting slides for August, September and October, 2020](#).

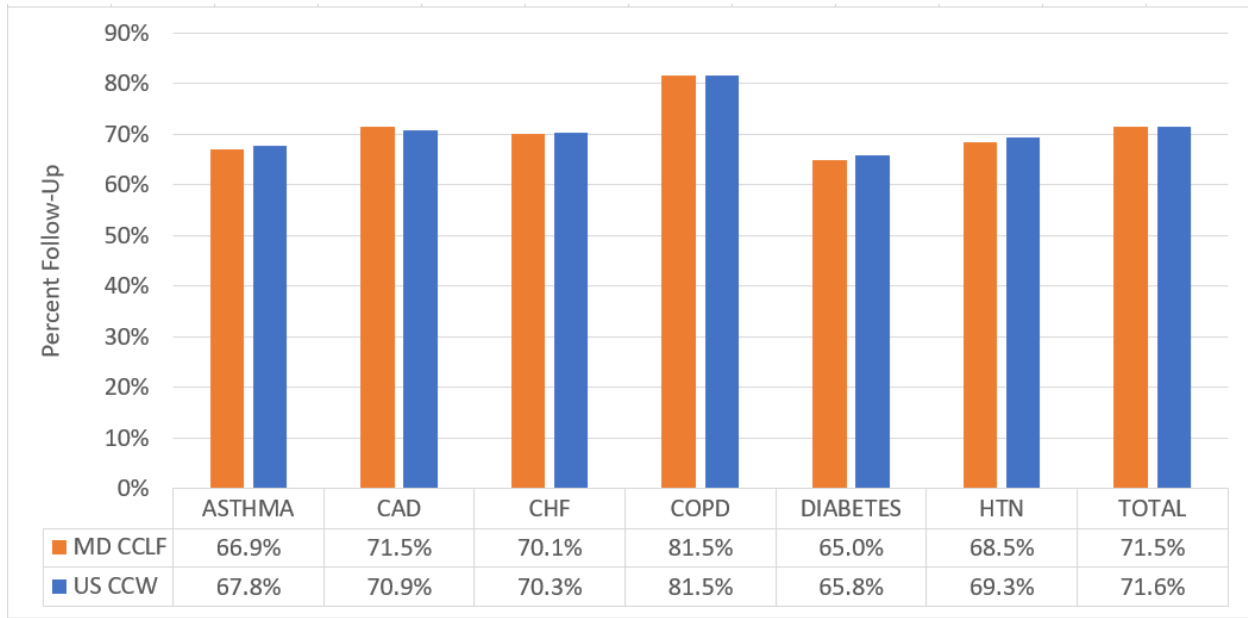
<sup>9</sup> The measure, NQF 3455, was developed by IMPAQ on behalf of CMS.

<sup>10</sup> HSCRC staff is working with Medicaid and other payers to explore whether we can calculate an all-payer version of this measure in the future.

<sup>11</sup> Maryland rates are calculated from the Claims and Claims-line Feed (CCLF) data, while the national rates are calculated from the 5 percent sample in the CMS Chronic Condition Warehouse (CCW).

timely follow-up care in its overall evaluation of the TCOC Model; staff notes that timely follow-up care was also evaluated under the All-Payer Model.<sup>12</sup> Thus, there are many reasons why Maryland should focus on improving rates of timely follow-up care relative to the nation.

**Figure 5. Follow-Up Rate for Medicare FFS in 2019, Maryland vs. National**



Once this measure was selected for SIHIS, staff worked with stakeholders to develop performance targets for Year 3, 5, and 8 as shown in Figure 6. To bolster the State’s efforts in meeting these SIHIS targets, staff proposes to add a hospital-level QBR measure to the PCE Domain for RY 2023. The PCE domain was selected since discharge info (of which getting appropriate follow-up should be included) is one of the HCAHPS measures. In general, PMWG members and other stakeholders have been supportive of this SIHIS goal and understand the rationale to include a hospital-level incentive (see additional feedback recommending that a delay in implementing this measure in the Stakeholder Feedback section). Staff will implement this measure using the methodology that is used for other QBR measures. Specifically, staff will use a CY 2019 base period to calculate a threshold (statewide hospital median rate) and benchmark (mean of the top 10 percent of Maryland hospitals) and then assign hospital scores on this measure (0-10 points) by comparing CY 2021 performance to the threshold and benchmark for attainment and CY 2019 rates for improvement. Similar to other measures in the QBR program, staff will provide opportunities to earn points on this measure as the higher of attainment and improvement. Furthermore, staff will work with CRISP to leverage health information exchange tools for

<sup>12</sup> The CMS evaluation of the MD All-Payer Model, conducted by RTI, included an all condition evaluation of follow-up after discharge within fourteen days; staff believes that the NQF condition-specific follow-up measure is more clinically precise and actionable.

hospitals to track patient follow-up and to develop monitoring reports so that hospitals can track hospital progress during the performance period.

**Figure 6. Follow-Up Targets for SIHIS**

<b>Domain 2: Care Transformation Domain</b>				
Goal: Improve care coordination for patients with chronic conditions				
<u>Measure</u>	<u>2018 Baseline</u>	<u>2021 Year 3 Milestone</u>	<u>2023 Year 5 Interim Target</u>	<u>2026 Year 8 Final Target</u>
Timely Follow-up After Acute Exacerbations of Chronic Conditions^ (NQF# 3455)	71.36%	72.26% 1.25 percent improvement	73.16% 2.52 percent improvement	75.00% 5.10 percent improvement or 0.50 percent better than the national rate

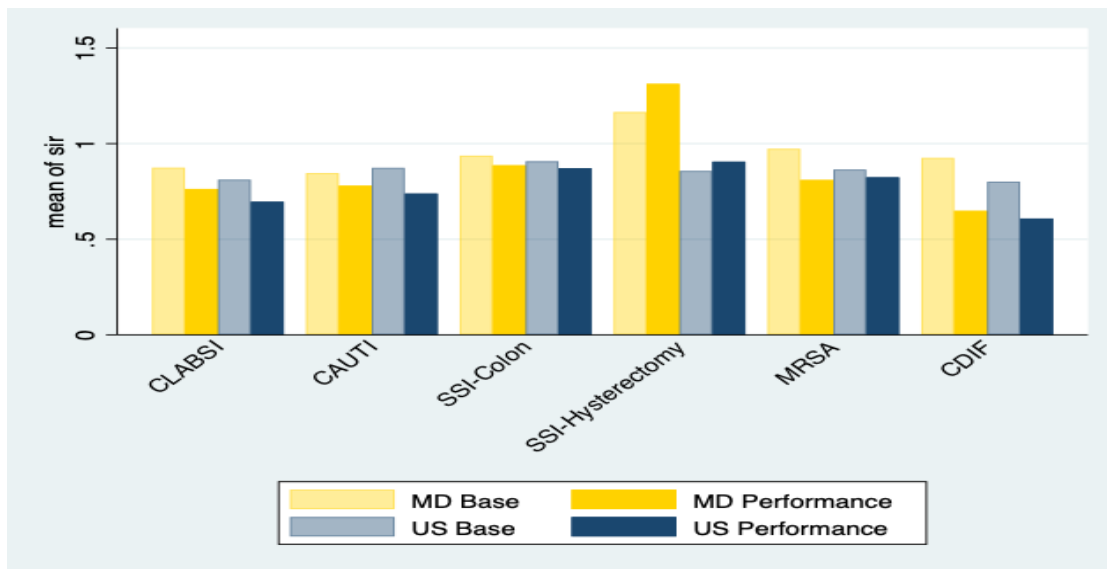
Based on the analysis of the Person and Community Engagement domain, HSCRC staff proposes to continue to weight this domain at 50 percent of the QBR score, with the follow-up measure added to the HCAHPS measures in the domain. Staff proposes to consider ED wait time measure options, including the eCQM version of the ED-2b measure, as part of the QBR redesign during CY 2021 with potential re-adoption of an ED throughput measure for the RY 2024 policy.

## Safety Domain

The **Safety** domain comprises five measures of six CDC National Health Safety Network (NHSN) healthcare associated infection (HAI) categories. As illustrated in Figure 7 below, Maryland's performance on the NHSN measures has been mixed (lower scores are better). Average hospital standardized infection ratios (SIRs) for five of the six HAI categories declined (improved) both nationally and for Maryland in the performance period compared to the base.<sup>13</sup> Maryland's improvement from the base was: better than that of the nation for three of the six measures (SSI colon, MRSA, and CDIF), and; on par with the nation for two measures (CLABSI CAUTI). Both Maryland and the nation were worse in the performance period than the base period for SSI Hysterectomy. Finally, in the performance period, Maryland's infection rates were better (lower) for MRSA; on par for SSI colon and CDIFF, slightly worse (higher) for CLABSI and CAUTI; and, markedly worse for SSI hysterectomy.

<sup>13</sup> While there are six Healthcare Associated Infection categories, the two SSI colon and hysterectomy categories are combined resulting in five Safety domain measures.

Figure 7. Maryland vs. National Mean Hospital SIRs on NHSN HAI Safety Measures (Base period Calendar Year 2017, Performance period October 1, 2018 to September 30, 2019)



### Patient Safety Indicator (PSI)-90

The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI) were developed<sup>14</sup> and released in 2003 to help assess the quality and safety of care for adults in the hospital. PSIs focus on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth.

AHRQ's specified PSI uses include:

- Assess, monitor, track, and improve the safety of inpatient care
- Comparative public reporting, trending, and pay-for-performance initiatives
- Identify potentially avoidable complications that result from a patient's exposure to the health care system
- Detect potential safety problems that occur during a patient's hospital stay

The discharge weighted average of the observed-to-expected ratios for the following subset of AHRQ's PSIs comprise the PSI-90 composite measure:

- PSI 03 Pressure Ulcer Rate
- PSI 06 Iatrogenic Pneumothorax Rate

<sup>14</sup> AHRQ contracted with the University of California, San Francisco, Stanford University Evidence-based Practice Center, and the University of California Davis for development. For additional information: [https://www.qualityindicators.ahrq.gov/Modules/psi\\_resources.aspx](https://www.qualityindicators.ahrq.gov/Modules/psi_resources.aspx)



- PSI 08 In-Hospital Fall With Hip Fracture Rate
- PSII 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

CMS first adopted the composite in the VBP program in FFY 2015 and removed the measure in FY 2019-FY 2022 due to operational constraints from the International Classification of Diseases, Tenth Revision (ICD-10) transition. The HSCRC had used the ICD-9 version of this measure in the QBR program. CMS adopted the updated NQF endorsed ICD-10 version of the measure that will be used beginning with the FY 2023 Hospital VBP program.<sup>15</sup>

To align with the VBP program and expand the QBR program's measurement of preventable complications that cause patient harm and increase the cost of hospital care, staff vetted the inclusion of the all-payer version of the PSI-90 measure in QBR with the PMWG stakeholders. In general, staff and stakeholders are supportive of including this measure, as it was used previously and is part of national VBP program. Maryland statewide performance has improved (lower rates) on the PSI-90 overall composite as well as the majority of the component indicator measures between 2016 and 2018 as illustrated in Figure 8 below.

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<sup>15</sup> For more information on the measure removal and adoption, reference the [FY 2018 IPPS/LTCH PPS final rule](#) (82 FR 38242-38244) and (82 FR 38251-38256).

Figure 8. Maryland Statewide All-Payer Performance on PSI-90 and Component Indicators, 2016-2018

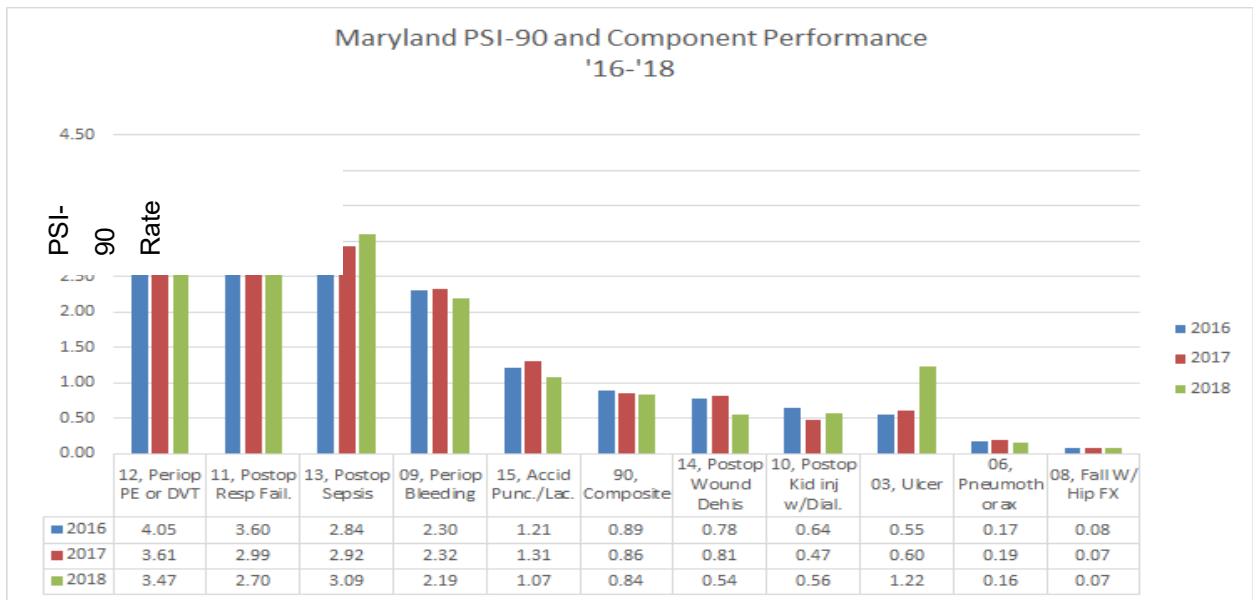
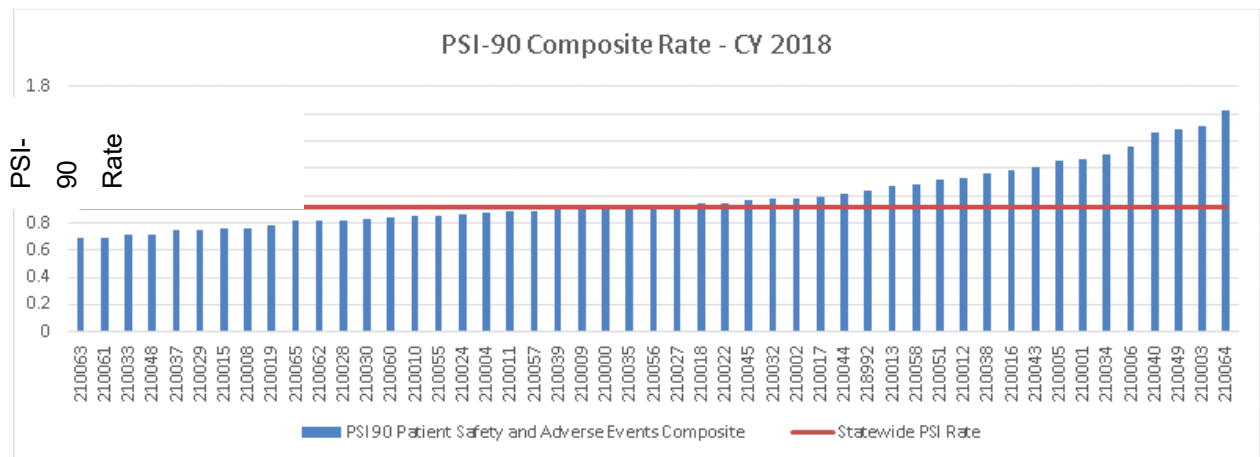


Figure 9 below illustrates the hospital-level performance on the PSI-90 composite measure for CY 2018; the wide variation in performance by hospital suggests there is opportunity for improvement on this measure.

Figure 9. PSI-90 Hospital-Level Performance, CY 2018



**Based on assessment of the Safety domain, Staff proposes continuing to weight the domain at 35 percent of the total QBR score, and to include the PSI-90 composite measure back into the program. Regarding Maryland performance on the NHSN HAI measures, staff proposes to consider options for alternative methodologies to further assess performance and to target improvement as part of the QBR redesign work in CY 2021; this will include evaluating statewide**

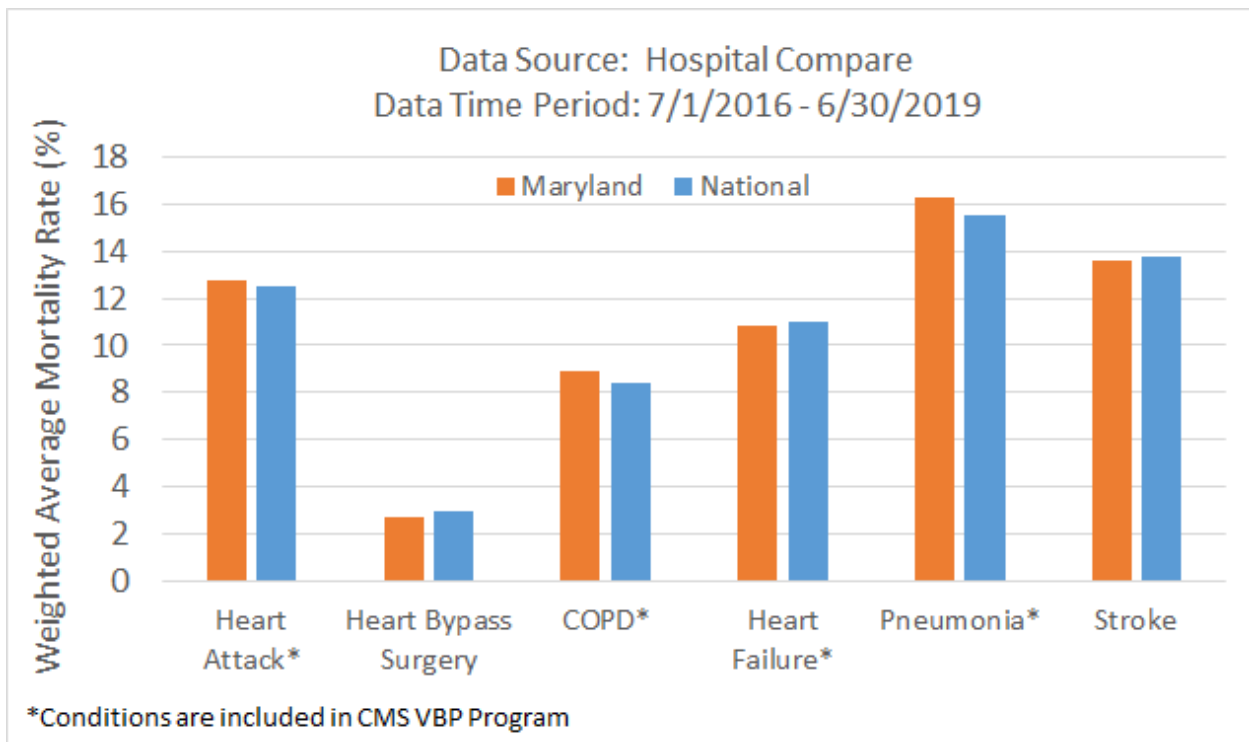
performance against the VBP benchmark and threshold values for the most current performance period, among other evaluation and incentive design approaches.

### Clinical Care Domain

The QBR **Clinical Care** domain consists of one all-payer, all-cause, all-condition inpatient mortality measure, while the Medicare VBP program includes four 30-day condition-specific mortality measures (Heart Attack, Heart Failure, Pneumonia, and COPD). Medicare also monitors two additional 30-day mortality measures for Coronary Artery Bypass Graft and Stroke, but does not include these measures in VBP. Both QBR and VBP include the Total Hip and Knee Arthroplasty (THA/TKA) complication measure on Medicare patients with elective primary procedures.

Based on the analysis of the weighted average rates for Maryland versus the nation for the condition specific mortality measures, Maryland performs similarly to the nation for all condition-specific measures of 30-day mortality (Figure 10).

Figure 10. Maryland Hospital Performance Compared with the nation on CMS Condition-Specific Mortality Measures



For the QBR all-payer inpatient mortality measure for RY 2021, which assesses hospital services where 80% of the mortalities occur (80% DRG exclusion), statewide survival rate increased (improved) from

95.57% in the base period to 96.00% in the performance period. As illustrated in Figure 11 below, all but three hospitals earned points for either attainment or improvement on the mortality measure; 34 hospitals performed better than the statewide threshold (50th percentile) as they earned at least one attainment point.

**Figure 11. Maryland Hospital Performance, FY 2021 QBR  
Inpatient All Condition, All Payer Mortality Measure**

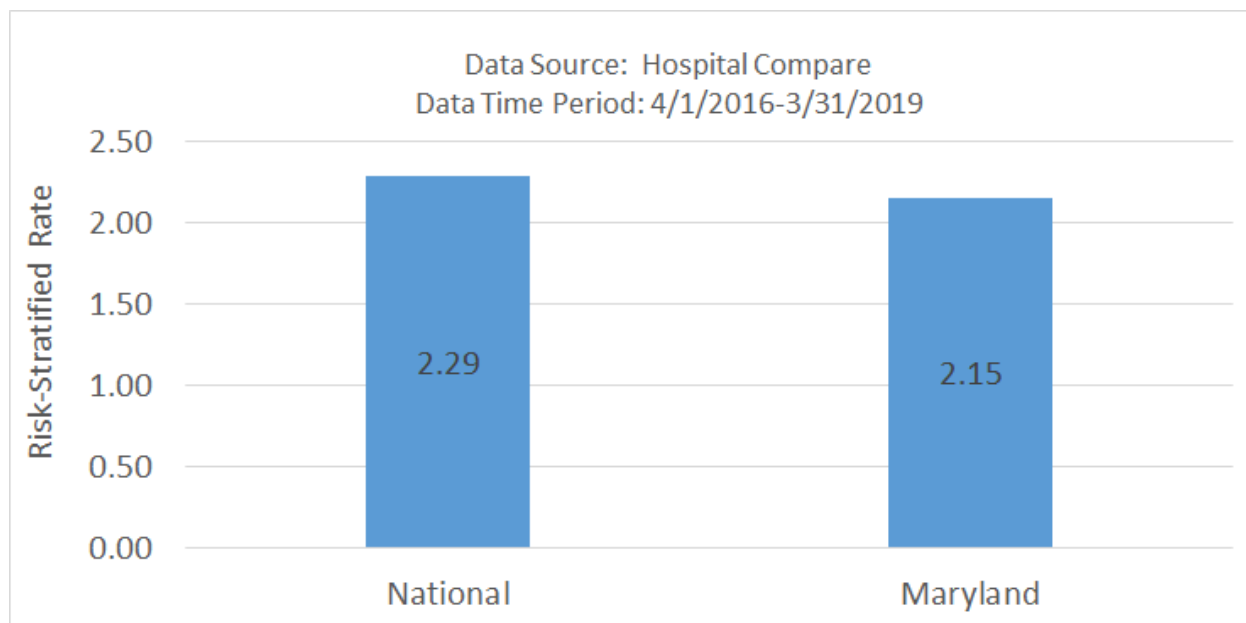
Number of Hospitals Scoring Points		Attainment Points	
		Yes	No
Improvement Points	Yes	29	3
	No	5	8

For RY 2023, staff is not proposing any significant methodology changes to the inpatient mortality measure. However, staff continue to work with contractor support to develop an all-payer, all-cause mortality measure and plan to develop reports for monitoring this measure during CY 2021. Furthermore, this new mortality measure will require additional vetting with the QBR redesign subgroup and the PMWG during the course of the coming year, with potential plans for inclusion of the measure in the RY 2024 QBR program.

**Hip and Knee Arthroplasty Complications**

For the hip and knee complication rate measure for RY 2021, Figure 12 illustrates that, based on analysis of the weighted average rates for Maryland and the nation, Maryland performed better than the nation on this measure.

**Figure 12. Maryland THA/TKA Measure Performance  
Compared to the Nation**



Since this measure is calculated by Hospital Compare using Medicare claims data using 3-year base and performance periods and includes only Medicare patients, payer stakeholders of the PMWG have voiced support for expanding this measure to the commercial population and other payers if feasible. In addition, staff notes that this measure is applicable only to patients in the inpatient setting. With the removal of elective hip and knee replacement procedures from the Medicare “inpatient only” list--procedures for which Medicare will reimburse only if performed in the inpatient setting--, and the shift of these procedures to the outpatient setting, staff believes the QBR redesign subgroup should consider both payer and care setting applicability options for measure expansion.

#### **THA-TKA and Low Case Volumes and Complexity Exclusion**

Staff proposed at the November PMWG meeting a low case volume and high complexity exclusion. Currently Johns Hopkins is excluded from the THA-TKA measure because they do not have 25 elective THA-TKA procedures during the three year performance period; UMMS however was included in RY 2021 with 29 cases several of which UMMS does not believe should have been classified as elective. Given these concerns, staff propose that for RY 2023 hospitals with less than 50 elective procedures over three years that are in the top 10<sup>th</sup> percentile of complexity as defined by the average case-mix index are excluded. To prospectively determine the measure exclusion, the RY 2023 policy will use the RY 2021 THA-TKA results for case counts and CY 2018 and CY 2019 inpatient HSCRC case-mix data for average case-mix. Appendix IV provides this data by hospital and shows that the only hospital excluded is

UMMC.

**Staff proposes continuing to include the inpatient mortality measure and hip and knee replacement complication measure in the Clinical Care domain consistent with the VBP program, and continuing to weight the Clinical Care domain at 15 percent.**

Appendix V details the available published performance standards (for VBP measures) for each measure by domain for RY2024; staff will calculate and disseminate the inpatient mortality standards when Version 38 of the 3M APR DRG grouper is implemented.

## **COVID-19 Public Health Emergency Program Adjustments**

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

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

It is not known at this time if Maryland has flexibility in suspending our RY 2022 pay-for-performance programs, and furthermore, Maryland's decision must be made prior to CMS making their decision due to the prospective nature of our pay-for-performance programs. However, CMMI has strongly suggested that the State must have quality program adjustments, and has further suggested that the State pursue alternative strategies to achieve reliable and valid RY 2022 quality measurement, such as reusing some or all of CY 2019 data (as is being done for the Skilled Nursing Facility VBP program).

In context of the CMS announcement and subsequent CMMI comments, staff has evaluated the data issues and options for the RY 2022 QBR program in Maryland, as illustrated in Figure 13 below.

Figure 13. RY 2022 COVID-Related Data Concerns and Options

COVID Data Concern	Inpatient Mortality (source: HSCRC case mix data)	HCAHPS, CDC NHSN, Hip Knee Complications (source: CMS Hospital Compare)
<p>If only 6 months of data for CY 2020:</p> <ul style="list-style-type: none"> <li>• Is 6-months data reliable?</li> <li>• What about seasonality?</li> <li>• How will HSCRC access the six months of Hospital Compare data, typically presented on a rolling 12-months basis?</li> </ul>	<ul style="list-style-type: none"> <li>• Remove COVID patients from July-December 2020</li> <li>• Consider combining with 6 months of CY 2019 data.</li> </ul>	<ul style="list-style-type: none"> <li>• Consider using CY 2019 data, re-using 3 quarters of RY 2021 data and 1 quarter of RY 2022 data (HCAHPS, CDC NHSN)</li> <li>• Consider suspending from the program (Hip Knee Complic.)</li> </ul>
<p>If no data for CY 2020</p>	<ul style="list-style-type: none"> <li>• Consider using CY 2019 data, (re-using 4 quarters of RY 2021) or combining CY 2018 (re-using 4 quarters of RY 2020) with CY 2019 and using 2 year average.</li> </ul>	<ul style="list-style-type: none"> <li>• Consider using CY 2019 data, re-using 3 quarters of RY 2021 data and 1 quarter of RY 2022 data (HCAHPS, CDC NHSN)</li> <li>• Consider suspending from the program (Hip Knee Complic.)</li> </ul>
<p>Clinical concerns over inclusion of COVID patients</p>	<ul style="list-style-type: none"> <li>• Use 6-months data, adjust base as needed for seasonality concerns</li> <li>• Merge 2019, and 2020 data (if available), together to create a 12 month performance period</li> <li>• Use 2019 data or revenue</li> </ul>	<ul style="list-style-type: none"> <li>• Consider using CY 2019 data, re-using 3 quarters of RY 2021 data and 1 quarter of RY 2022 data (HCAHPS, CDC NHSN)</li> <li>• Consider suspending from the program (HIP KNEE COMPLIC.)</li> </ul>
<p>Case-mix adjustment and performance standard concerns:</p> <ul style="list-style-type: none"> <li>• Inclusion of COVID patients when not in normative values</li> <li>• Impacts on other DRG/SOI of COVID PHE</li> </ul>	<ul style="list-style-type: none"> <li>• Remove COVID patients from CY 2020</li> <li>• Develop concurrent norms and performance standards for comparison and possible use</li> <li>• Use 2019 data or revenue adjustments</li> </ul>	<p>N/A</p>

At this stage, staff believes the most appropriate approach for the QBR program is to exclude the COVID-19 patients<sup>16</sup> from the inpatient mortality measure if any CY 2020 data is used. Over the coming months, staff will work to assess any case-mix adjustment and performance standard issues due to the absence of COVID-19 patients in the base period and normative values, and to finalize the performance period. Staff will provide updates to the Commission in February, at the earliest, on the final decisions for any adjustments to all RY 2022 quality policies.

For RY 2023, the program to calculate the mortality measure will use v38 of the APR DRG grouper, which is updated with additional clinical logic changes impacting Risk of Mortality for COVID-19 positive patients. Staff will need to consider any additional modifications to address case-mix adjustment and performance standard concerns that may arise from inclusion of COVID-19 positive patients in the performance period, especially since COVID-19 cases were not part of the statewide normative values. Furthermore, based on stakeholder comments, analyses should be done on case-mix adjustment and performance standards concerns for non-COVID patients. For the other CMS Hospital Compare measures, staff will wait for updates from CMS in the coming months on how they will address the data issues for the FFY 2023 VBP program and adopt their approach if feasible.

## Score and Revenue Adjustment Modeling

For this final policy, staff compared the RY 2021 scores and revenue adjustments without the ED wait time measure and with the incremental addition of the PSI-90 and follow-up measures. This modeling has been updated since the draft policy with updated PSI<sup>17</sup> and follow-up data. Beyond the measure changes, the QBR scores and revenue adjustments were calculated using the methodology approved for RY 2021 and RY 2022. This includes maintaining the reward/penalty cut-point at 41 percent. Since the draft policy, staff have calculated what the average VBP score would be nationally if the VBP program had the QBR domains and weights. While the national average score for FFY 2020 was slightly lower than the FFY2019 (40.2 percent vs 40.9 percent, respectively), the average VBP score for the last five years is 41.2 percent, which supports the cutpoint remaining at 41 percent. Specifically, these are the three models included in this policy:

- Model 1: RY 2021 data and time periods without ED wait time measure
- Model 2: Model 1 + PSI-90 (FY 18 base, CY19 performance)
- Model 3: Model 2 + follow-up measure (CY17 base, CY19 performance)

Hospital-specific domain scores and total QBR scores for each model are included in Appendix VI. The modeled hospital-specific and statewide revenue impacts are found in Appendix VII. Figure 14 provides

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<sup>16</sup> COVID-19 cases are defined as those coded with the ICD10 code U07.1

<sup>17</sup> The PSI-90 version was updated to the latest AHRQ v2020 logic; however staff only had FY2019 data so the scoring for this measure in the modeling is for attainment only and that may underestimate scores.



descriptive statistics for the total QBR scores for each model. This indicates that inclusion of the PSI measure (Model 2) reduces the average hospital score slightly, while inclusion of the follow-up measure with PSI (Model 3) raises the average score slightly, albeit they are still less than Model 1. Staff believes, however, that the changes in scores are not significant enough to warrant a change to the revenue adjustment scale.

**Figure 14. Hospital Score Models**

<b>Descriptive Statistics</b>	<b>Model 1: RY 2021 without ED wait times</b>	<b>Model 2: Model 1 with PSI</b>	<b>Model 3: Model 2 with Follow Up</b>
Median	32.98%	30.78%	31.55%
Average	33.33%	32.10%	32.30%
Min	14.30%	12.08%	12.90%
Max	49.33%	50.17%	50.48%
25th Percentile	25.58%	24.33%	26.81%
75th Percentile	41.83%	38.65%	38.24%

Using the scores presented above, staff modeled revenue adjustments using the RY 2022 preset scale. This scale is designed to not reward hospitals for performance that lag behind the nation. Figure 15 provides the estimated statewide revenue adjustments and counts of hospitals receiving a reward and penalty. Overall, the estimated revenue adjustments are fairly similar across the models, although penalties are the highest and rewards the lowest in Model 3. While the lower scores in Model 2 and Model 3 might call into question the current cut point of 41 percent, given CMS concerns on QBR performance, staff does not think this can be lowered at this time and believes that with incentives on PSI and the follow-up measure, performance will be better than shown in the modeling.

**Figure 15. Revenue Modeling**

<b>Descriptive Statistics</b>	<b>Model 1: RY 2021 - ED wait times</b>		<b>Model 2: RY 2021 - ED + PSI</b>		<b>Model 3: RY 21 - ED + PSI + Follow Up</b>	
	<b>\$</b>	<b>%</b>	<b>\$</b>	<b>%</b>	<b>\$</b>	<b>%</b>
Net Adjustments	-\$48,681,640	-0.49%	-\$52,506,794	-0.50%	-\$53,698,992	-0.54%
Penalties	-\$50,932,110	-0.51%	-\$54,410,613	-0.52%	-\$55,720,686	-0.56%
Rewards	\$2,250,470	0.02%	\$1,903,819	0.02%	\$2,021,694	0.02%
# Hospitals Penalized	30		36		35	
# Hospitals Rewarded/ Not Penalized	12		6		7	

## **QBR Future Updates**

As previously mentioned, staff intends to convene a sub-group of the Performance Measurement Workgroup, comprised of key stakeholders and subject-matter experts, to consider an overhaul of the QBR program in the first half of CY 2021. This redesign was originally scheduled to occur during CY 2020 but was put on hold in light of the ongoing COVID-19 public health emergency. Subsequently, CMS has reviewed QBR performance as part of the FFY 2021 exemption request, and has raised concerns about

Maryland's performance. Thus, CMS has asked that the HSCRC submit a QBR sub-group work plan to them as part of the annual monitoring report that is due December 31st, 2020 and a report detailing the sub-group's activities and recommendations in 2021. Staff previously developed a workplan for this sub-group and will meet these deadlines, but does note the additional effort required by both staff and stakeholders.

This QBR Redesign sub-group will review the existing QBR policy and goals of the TCOC model, and will develop recommendations to modify the QBR program for the RY 2024 QBR Policy and beyond. Because the QBR policy assesses multiple domains of hospital quality, this program is particularly well suited for expanding into new areas that are relevant under the TCOC model. To accomplish this redesign, which will necessitate consideration of measures and domains outside of those in the current program, the sub-group will consider 1) measurement selection, which will include evaluating the feasibility of including other CMS inpatient and outpatient measures, as well as retaining measures currently used, or adopting other measures that cover important all-payer clinical areas that may not be addressed by CMS measurement and reporting; and 2) methodological concerns, which will include appropriate risk adjustment, scoring, and scaling, and establishing reasonable performance targets.

Among the topics the sub-group may consider are the following:

**Strengthen the current incentives to improve patient experience (HCAHPS) and safety measures, including methodology updates that better target underperforming measures.**

- Explore potential new QBR measures for **outpatient care** adopted or adapted from those already in the CMS hospital reporting pipeline, including measures not currently used in pay-for-performance.
- Consider options for re-adoption of **ED wait time measures**.
- Evaluate **disparities in performance** on the QBR measures and consider incentives for achieving health equity.
- Develop hospital pay-for-performance programs that foster accountability for broader care transformation and population health initiatives. Specifically, the QBR program could be utilized to support goals developed for the State Integrated Health Improvement Strategy (SIHIS) that do not fit under other quality programs.
- Evaluate additional **data sources** needed for performance measurement under the TCOC model such as eCQMs.

Staff acknowledges that this program redesign will require substantial work in concert with industry and a broad array of other stakeholders, including consumers, payers, cross-continuum providers, quality measurement experts, and government agencies (local, state, and federal). Staff welcomes additional

topics for consideration related to the QBR sub-group, and encourages those interested in participating in the sub-group to contact the Quality team at [hscrc.quality@maryland.gov](mailto:hscrc.quality@maryland.gov).<sup>18</sup>

## Stakeholder Feedback and Responses

Comment letters on the draft QBR recommendations were submitted by the Maryland Hospital Association (MHA), the Johns Hopkins Health System (JHHS) and University of Maryland Medical System (UMMS) in a combined letter, and Luminis Health. All three commenters generally support the RY 2023 QBR policy and continued use of the current QBR methodology, with MHA recommending no specific modifications.

However, some targeted concerns were raised and suggestions provided for modifying specific aspects of the draft recommendations. These comments and suggestions are summarized below along with staff's responses.

### Impact of SARS-CoV-2 on PSI-90 and Mortality

The JHHS/UMMS letter notes the significant shifts in the care delivery model because of the COVID-19 pandemic that include resource allocation, initial and ongoing assessment of patient condition and risk, family engagement, and clinical management. The letter points to a national documented increase in healthcare associated infections, and notes that infection prevention experts reference the fact that the full impact of the pandemic on health systems and traditional health associated complications remains to be determined. The letter recommends that HSCRC exclude COVID-19 patients from the RY 2023 (CY 2021 performance) for PSI 90 and for inpatient mortality measurement until the PSI COVID risk adjustment is defined by AHRQ and the impact on mortality is better understood.

**Staff Response:** Staff agrees that the pandemic impact is far reaching and the full impact is not understood on the larger care delivery model. Per the staff recommendation, staff supports retrospective adjustments to the QBR revenue impacts on hospitals related to COVID. Staff does continue to support including the COVID patients in the RY 2023 program and implementing the PSI 90 measure as specified by AHRQ, and monitoring for any COVID-related updates to the measure issued by AHRQ, and again evaluating data retrospectively for these measures and making appropriate adjustments.

### PSI-90 Composite Measure

The JHHS/UMMS letter notes that the PSI measures include complications similar to the PPCs in the MHAC program and they are concerned about hospitals being penalized twice for the same outcome on the same patient. They recommend removing PSIs that are similar to PPCs from the PSI composite.

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<sup>18</sup> Stakeholders who were previously selected to participate will be contacted to verify continued ability and interest.

They also note a concern about low volume consequences related to Bayesian smoothing used for calculating the measure that can create a scenario where a small hospital may have zero events but have a non-zero PSI-90 measurement result; they recommend adding an exclusion for small hospitals or using a 2-year measurement for small hospitals, similar to the MHAC program.

**Staff Response:** Staff notes that the CMS VBP and HACRP programs use the same PSI-90 composite measure, which consists of ten individual PSI measures, in both programs. Staff further notes that in the RY 2021 MHAC policy document, an overlap analysis was presented for the PPCs and PSIs. Specifically, staff with the assistance of Mathematica Policy Research (MPR) used Maryland hospital discharge data to evaluate the performance of individual PPCs considered “overlapping” with PSI 90 component measures. Results of this analysis in the table below show significant variability in the numerator and denominator populations, as evidenced by the fact that overlapping PSI and PPC’s never constituted more than 25 percent of the assessed hospital complications, i.e. the numerator – average overlap for each PPC/PSI pairing was 15 percent. While there was greater overlap in the denominator (average of 30 percent), it is important to note that the principal concern with PPC’s and PSI’s being duplicative is the possibility of a hospital receiving two revenue negative revenue adjustments for the same complication.

**Figure 16. Comparison of PSI 90 Component PSI vs. “Matching” PPC Category Discharges, Maryland Hospitals (2016-2017)**

Measures Compared	Measure Inclusion	Numerator Cases		Denominator Cases	
		Frequency	Percent	Frequency	Percent
PSI 03: Pressure Ulcer PPC 31: Pressure Ulcers	PSI and PPC	78	5%	232,044	40%
	PSI Only	1,580	95%	347,286	59%
	PPC Only	0	0%	4,511	1%
PSI 06: Iatrogenic Pneumothorax Rate PPC 49: Iatrogenic Pneumothorax	PSI and PPC	62	26%	678,312	67%
	PSI Only	85	35%	174,105	17%
	PPC Only	95	39%	158,280	16%
PSI 08: In Hospital Fall with Hip Fracture Rate PPC 28: In-Hospital Trauma and Fractures	PSI and PPC	46	24%	639,474	66%
	PSI Only	71	37%	76,032	8%
	PPC Only	77	40%	252,146	26%
PSI 09: Perioperative Hemorrhage or Hematoma Rate PPC 41: Peri-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Procedure	PSI and PPC	124	21%	186,281	65%
	PSI Only	407	69%	34,501	12%
	PPC Only	62	10%	65,793	23%
PSI 10: Postoperative Acute Kidney Injury Requiring Dialysis Rate	PSI and PPC	18	11%	117,181	16%
	PSI Only	86	51%	17,122	2%
	PPC Only	66	39%	610,198	82%

Measures Compared	Measure Inclusion	Numerator Cases		Denominator Cases	
		Frequency	Percent	Frequency	Percent
PPC 25: Renal Failure with Dialysis					
PSI 11: Postoperative Respiratory Failure Rate PPC 03: Acute Pulmonary Edema and Respiratory Failure without Ventilation	PSI and PPC	79	5%	103,100	14%
	PSI Only	411	24%	12,119	2%
	PPC Only	1,234	72%	603,232	84%
PSI 11: Postoperative Respiratory Failure Rate PPC 04: Acute Pulmonary Edema and Respiratory Failure with Ventilation	PSI and PPC	122	9%	103,282	14%
	PSI Only	368	28%	11,937	2%
	PPC Only	819	63%	603,420	84%
PSI 12: Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate PPC 07: Pulmonary Embolism	PSI and PPC	327	25%	193,929	22%
	PSI Only	876	67%	41,913	5%
	PPC Only	104	8%	646,464	73%
PSI 12: Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate PPC 16: Venous Thrombosis	PSI and PPC	136	10%	193,882	22%
	PSI Only	1,067	77%	41,960	5%
	PPC Only	174	13%	646,632	73%
PSI 13: Postoperative Sepsis Rate PPC 35: Septicemia & Severe Infections	PSI and PPC	132	11%	25,838	6%
	PSI Only	305	26%	104,487	26%
	PPC Only	727	62%	270,936	68%
PSI 14: Postoperative Wound Dehiscence Rate PPC 38: Post-Procedural Infection and Deep Wound Disruption with Procedure	PSI and PPC	9	8%	44,734	16%
	PSI Only	56	53%	25,974	10%
	PPC Only	41	39%	201,391	74%
PSI 15: Unrecognized Abdominopelvic Accidental Puncture or Laceration Rate PPC 42: Accidental Puncture/Laceration During Invasive Procedure	PSI and PPC	102	19%	118,342	13%
	PSI Only	89	16%	35,575	4%
	PPC Only	351	65%	770,804	83%

Known differences in populations and measure specifications account for some of these results. As an example, both PSI 13 and PPC 35 address sepsis, however PSI 13 covers only postoperative sepsis while PPC 35 is for all inpatients. Other differences include age and the Major Diagnostic Category (MDC) variables used in the measure specifications. Overall, these data suggest the measure specifications are not sufficiently aligned for PSIs and PPCs to be considered comparable across most of the “overlapping” measure sets. Based on these prior analyses, staff does not support removing any of the component PSIs from the composite and supports using the composite as specified by AHRQ, the measure steward.

In terms of the small hospital exclusion, the program is currently using the standard for excluding small hospitals, similar to the approach under the ICD-9 version of the PSI measure that was previously

included in QBR. Staff agrees that we should consider an extended performance period for small hospitals as is done in the MHAC program. However, given the COVID-19 PHE it may be difficult to obtain a timely longer data period for CY 2021 since January-June 2020 data cannot be used (and with the recent surge the October-December data may also be need to be excluded). Thus, staff proposes keeping the one-year time period for RY 2023 and aligning with the national small hospital exclusion criteria, but revisiting this issue when addressing retrospective COVID-PHE related changes and/or for future rate years.

### **Timely Follow-up after Acute Exacerbation of Chronic Conditions Measure**

The Luminis Health and JHHS/UMMS letters agree with the need to measure timely follow-ups after acute exacerbations of chronic conditions and promote alignment with the Statewide Integrated Health Improvement Strategy (SIHIS). However, they are concerned about understanding baseline hospital-specific data, and the ability for hospitals to track this data on a timely basis; they request that the Commission delay incorporating this measure until hospitals are able to see their baseline data and establish mechanisms for tracking performance on a timely basis using CRISP tools.

**Staff Response:** Staff does acknowledge that, as indicated in the Assessment section, this measure is based upon Medicare claims, including encounters outside the hospital. Staff further acknowledges that non-Medicare patients' follow up rates are not feasible to measure and report at the current time. Staff does also note that baseline rates by hospital for CY 2019 were provided to the PMWG at the November meeting (Appendix VIII). Further, staff has been working with CRISP to implement timely reports to hospitals through the CRS portal for the measure in CY 2021 and is on track to provide these reports. Finally, staff continues to support adopting this measure that is important to help achieve improvement in the domain of care transformation across the system, and to achieve the SIHIS goal established for this domain.

## Final Recommendations for RY 2023 QBR Program

### Recommendations for RY 2023 QBR Program

1. Continue **Domain Weighting** as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 50 percent, Safety (NHSN measures) - 35 percent, Clinical Care - 15 percent.
2. Implement the following **measure updates**:
  - A. Add an exclusion for hospitals with lower case volumes and higher Case Mix Index (CMI) for the hip/knee complication measure.
  - B. Add follow-up after acute exacerbations for chronic conditions measure to the PCE Domain.
  - C. Add PSI-90 composite measure to the Safety domain
3. Maintain the **pre-set scale** (0-80 percent with cut-point at 41 percent), and continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) for the QBR program.
4. Convene a QBR Redesign Work Group in 2021 that targets the CMS concerns and implements identified strategic priorities for quality.
5. Adjust retrospectively the RY 2022 and RY 2023 QBR pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report changes to Commissioners.

# APPENDIX I. CMS NOTIFICATION OF MARYLAND QUALITY PROGRAMS EXEMPTION, FFY 2021

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid  
Services 7500 Security Boulevard  
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE AND MEDICAID INNOVATION



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September 29, 2020

Katie Wunderlich  
Executive Director,  
HSCRC 4160 Patterson  
Avenue  
Baltimore, Maryland 21215

Re: Maryland's Request for Hospital Quality Program Exemption for Federal Fiscal Year

2021 Dear Ms. Wunderlich,

CMS has received your letter on behalf of the State of Maryland that requests an exemption from the national hospital quality and value-based payment programs for federal fiscal year (FFY) 2021 which include the Hospital Value-Based Purchasing (HVBP) program, Hospital Acquired Conditions Reduction (HAC) program, and the Hospital Readmissions Reduction program (HRRP). Under Section 8.d.iii. of the Maryland Total Cost of Care Model (MDTCOC model) Agreement, the Centers for Medicare & Medicaid Services (CMS) will waive Maryland from participating in the national hospital quality and value-based payment programs as long as the State implements hospital quality and value-based payment programs that achieve or surpass the measured results in terms of patient outcomes and cost savings in HVBP, HAC, and HRRP.

Under section 12.d.i.3 and 12.d.i.4 if CMS determines that the State has not improved quality or failed to demonstrate that the State's hospital and value-based payment program achieves or surpasses the measured results in terms of patient outcomes and cost savings in relation to the national program of equivalent, the result could qualify as an *other event*, and CMS may pursue corrective action as described in section 12.d.ii, including requiring the State to submit a formal *Corrective Action Plan* (CAP) or *termination* of the HVBP, HAC, or HRRP Medicare payment waivers.



CMS has reviewed your exemption request and is concerned with the State's performance under the QBR program; appendix A includes the QBR performance results for RY 2021 (performance June 2018-July 2019), as provided by the State. The Nation performed better than Maryland on five of the six safety measures in both the base and performance periods. Maryland's performance on five of six safety measures also failed to meet or exceed performance in comparison to the State specified base period.

Additionally, the Nation also performed better than Maryland on all eight HCAHPS measures in both the base and performance periods. Should this trend continue for future performance years (FFY 2022 and beyond), CMS may consider this an other event and pursue corrective action.

For FFY 2021, we have used our discretion to grant the State of Maryland's exemption from HVBP, HAC, and HRRP on the basis of expected QBR performance improvement, favorable performance improvement under MHAC, and consistent performance under RRIP that has exceeded national outcomes. CMS strongly encourages the State to consider the QBR related requests, outlined below.

**Quality Based Reimbursement (QBR):** CMS reviewed each of the three domains under the QBR program, which includes clinical care, safety measures, and person and community engagement. Maryland's performance continues to lag behind the nation under the person and community engagement and safety measure domains. As a result, CMS agrees with the State's approach to propose a QBR program redesign for implementation in RY 2023 and supports the creation of a QBR focused subgroup tasked with leading this initiative. In the interim, CMS requests that the State integrate a high-level work plan to address CMS' concerns related to QBR and other program performance into the progress report defined at 16.b and Appendix D, due at the end of CY 2020. This work plan should include QBR redesign subgroup objectives, detail outlining the actionable strategies required to accomplish each objective, and an associated project milestone timeline. CMS requests the receipt of a more comprehensive report detailing QBR redesign subgroup findings and formalized plans to improve quality performance by the end of June 2021. This report and subsequent QBR policy changes will be heavily considered in evaluating the State's national hospital quality and value-based payment programs exemption request for FFY 2022.

In addition to addressing person and community engagement and safety measure domains, we support HSCRC's plans to consider ED Wait Time measure options as part of the QBR redesign during CY 2021 with potential re-adoption of measures for RY 2023 and beyond. The State has had a longstanding issue with extended ED wait times compared to the nation. Therefore, CMS encourages the State to consider patient-centered care as a guiding principal when redesigning the QBR program.

Finally, as discussed in the FFY 2020 Hospital Quality Program Exemption approval memo, CMS encourages the State to hold hospitals accountable for high quality obstetric care. The State may consider integrating maternal and child health clinical topic areas into the QBR program redesign to improve the patient care experience in Maryland hospitals.

**Potentially Avoidable Utilization (PAU) Savings:** CMS supports expanding the definition of avoidable utilization to include ED and additional categories of unplanned admissions or other types of

unnecessary utilization, as it encourages a broader range of accountability and alignment of financial incentives across the TCOC Model. As a result of the Commission approved shift to a per capita PAU performance evaluation for Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs),

CMS expects the State set a concrete per capita PQI reduction target, and looks forward to reviewing the State's proposed per capita avoidable admissions target via the SIHIS by December 31, 2020.

**Medicare Performance Adjustment (MPA):** CMS understands the State plans to redesign components of the MPA, including the beneficiary attribution algorithm and moving to an attainment target under the program. CMS reaffirms its commitment to ensure the MPA incentivizes hospitals to extend their reach to include beneficiaries who are attributed to a hospital but do not have an associated hospital stay or participate in a CTI; CMS supports the State's initiative to transition to a pure geographic method of attribution as it simplifies the algorithm and provides predictability when assessing Total Cost of Care performance. In addition, CMS reiterates its request that the State consider increasing the amount of revenue at risk under the MPA to progressively incentivize care coordination and alignment between hospitals, hospital-based physicians/clinicians, and community based clinicians/physician. Increased accountability between hospital and non-hospital entities under the MPA provides the State with greater flexibility to control Medicare total cost of care without simultaneously changing all-payer hospital revenues; it is critical that revenue at risk under the MPA continue to increase to account for expenditure growth beyond hospital walls.

**Improvement Strategy:** CMS supports the HSCRC's approach to evaluate the efficacy of Maryland's hospital quality programs through ensuring key clinical topic areas, such as obstetric care and maternal/child health, are adequately addressed by the current measures. We support State efforts to explore opportunities to achieve greater health equity through reducing disparities, to assess how complications can be measured outside the inpatient setting, and to determine if expanding the quality adjustment under the MPA would continue to improve hospital pay-for-performance programs.

Ultimately, CMS expects the State to progressively align hospital pay-for-performance programs with the broader population health strategies of the model. CMS recognizes that the COVID-19 pandemic has caused quality program delays, data concerns, and other unforeseen model challenges. CMS remains committed to our partnership with the State and supports efforts to collaboratively work through these challenges on an ongoing basis.

Thank you for your continued efforts to improve the quality of hospital care in Maryland. Should you have any questions, please do not hesitate to contact the MDTCOC Model team.

Sincerely,



Pierre Yong, MD, MPH  
Director, Division of All-Payer Models  
Center for Medicare and Medicaid Innovation

**Appendix A.** sourced from “Maryland All-Payer Model and TCOC Model Quality Programs Update and Request for further VBP Exemption in Federal Fiscal Year 2021”

**Appendix A.**

RY 2021 QBR (CY2017 Base; Jul2018-Jun2019 YTD Perf unless otherwise specified)

Measures	MD Base	MD YTD Performance	MD Base Performance Difference	US Base	US YTD Performance	US Base Performance Difference	MD-US Diff in Base	MD-US Diff in YTD Performance
<b>CLINICAL CARE - OUTCOMES</b>								
Observed Mortality IP All-Cause (Maryland All-Payer) [1]	4.43%	4.00%	-0.43%	N/A	N/A	N/A	N/A	N/A
30-day mortality, AMI (Medicare) [2]	12.99	12.77	-0.21	13.01	12.67	-0.35	0.03	-0.11
30-day mortality, CABG (Medicare)	2.69	2.76	0.06	3.08	3.00	-0.08	0.39	0.24
30-day mortality, COPD (Medicare)	9.02	8.94	-0.08	8.37	8.52	0.15	-0.65	-0.43
30-day mortality, HF (Medicare)	11.03	11.02	0.00	11.39	11.18	-0.21	0.36	0.16
30-day mortality, PN (Medicare)	16.40	16.27	-0.13	15.71	15.63	-0.08	-0.69	-0.64
30-day, Mortality STK (Medicare)	14.02	13.71	-0.31	14.34	13.95	-0.38	0.32	0.24
Complications Hip/Knee [3]	2.38	2.32	-0.06	2.43	2.41	-0.02	0.05	0.09
<b>SAFETY [4]</b>								
AHRQ PSI composite (MD All-Payer)								
CLABSI	0.78	0.87	0.09	0.71	0.81	0.10	-0.07	-0.06
CAUTI	0.80	0.85	0.04	0.77	0.87	0.11	-0.04	0.03
SSI Colon	0.86	0.94	0.08	0.87	0.91	0.04	0.01	-0.03
SSI Abdominal Hysterectomy	1.44	1.17	-0.27	0.90	0.86	-0.04	-0.54	-0.31
MRSA	0.83	0.97	0.14	0.83	0.86	0.04	-0.01	-0.11
C.diff.	0.68	0.93	0.24	0.64	0.80	0.16	-0.04	-0.12
<b>PATIENT EXPERIENCE OF CARE - HCAHPS Top-Box Scores [4]</b>								
Communication with nurses	76%	76%	0%	80%	81%	1%	-4%	-5%
Communication with doctors	78%	77%	-1%	82%	82%	0%	-4%	-5%
Responsiveness of Hospital Staff	61%	61%	0%	70%	70%	0%	-9%	-9%
Communication about medicines	60%	61%	1%	66%	66%	0%	-6%	-5%
Cleanliness and Quietness	62%	63%	1%	69%	69%	0%	-6%	-6%
Discharge Information	86%	87%	1%	87%	87%	0%	-1%	0%
Care Transitions Measure	49%	49%	0%	53%	53%	0%	-4%	-4%
Overall Rating of Hospital	67%	66%	-1%	73%	73%	0%	-6%	-7%

## APPENDIX II. HSCRC QBR PROGRAM BACKGROUND, DETAILED OVERVIEW

The Affordable Care Act established the hospital Medicare Value-Based Purchasing (VBP) program,<sup>19</sup> which requires CMS to reward hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. The program assesses hospital performance on a set of measures in Clinical Care, Person and Community Engagement, Safety, and Efficiency domains. The incentive payments are funded by reducing the base operating diagnosis-related group (DRG) amounts that determine the Medicare payment for each hospital inpatient discharge.<sup>20</sup> The Affordable Care Act set the maximum penalty and reward at 2 percent for federal fiscal year (FFY) 2017 and beyond.<sup>21</sup>

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

In addition to structuring two of the three domains of the QBR program to correspond to the federal VBP program, the Commission has increasingly emphasized performance relative to the nation through benchmarking, domain weighting, and scaling decisions. For example, beginning in RY 2015, the QBR program began utilizing national benchmarks to assess performance for the Person and Community Engagement and Safety domains. Subsequently, the RY 2017 QBR policy increased the weighting of the Person and Community Engagement domain, which was measured by the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey instrument to 50 percent. The weighting was increased in order to raise incentives for HCAHPS improvement, as Maryland has consistently lagged behind the nation on these measures. In RY 2020, ED-1b, and ED-2b wait time measures for admitted patients were added to this domain with the domain weight remaining at 50 percent; in RY 2021, the domain weight remained constant but the ED-1b measure was removed from

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<sup>19</sup> 42 USC § 1395ww(o)(7).

<sup>20</sup> 42 USC § 1395ww(o)(7)(C).

<sup>21</sup> The HCAHPS increase reduced the Clinical Care domain from 20 percent to 15 percent.

the program. For RY 2022, ED-2b was removed from QBR as CMS no longer required submission of the measure for the Inpatient Quality Reporting (IQR) program.

While the QBR program has many similarities to the federal Medicare VBP program, it does differ because Maryland’s unique Model Agreements and autonomous position allow the State to be innovative and progressive. Figure 1 below compares the RY 2022 QBR measures and domain weights to those used in the CMS VBP program.

**Figure 1. RY 2022 QBR Measures and Domain Weights Compared with CMS VBP Program<sup>22</sup>**

	<b>Maryland QBR Domains and Measures</b>	<b>CMS VBP Domain Weights and Measure Differences</b>
<b>Clinical Care</b>	15 percent (2 measures: all cause inpatient Mortality; THA/TKA Complication)	25 percent (5 measures: 4 condition-specific Mortality, THA/TKA Complication)
<b>Person and Community Engagement</b>	50 percent (8 HCAHPS measures)	25 percent Same HCAHPS measures
<b>Safety</b>	35 percent (5 measures: CDC NHSN)*	25 percent (5 measures: CDC NHSN)*
<b>Efficiency</b>	N/A	25 percent (Medicare Spending Per Beneficiary measure)

\*While there are six Healthcare Associated Infection categories, the two SSI colon and hysterectomy categories are combined resulting in five Safety domain measures.

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

<sup>22</sup> Details of CMS VBP measures may be found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html> ; last accessed 10./28/19.

## Domain Weights and Revenue At-Risk

As illustrated in the body of the report, for the RY 2021 QBR program, the policy weighted the clinical care domain at 15 percent of the final score, the Safety domain at 35 percent, and the Person and Community Engagement domain at 50 percent.

The HSCRC sets aside a percentage of hospital inpatient revenue to be held “at-risk” based on each hospital’s QBR program performance. Hospital performance scores are translated into rewards and penalties in a process that is referred to as scaling.<sup>23</sup> Rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital’s update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered permanent revenue. The Commission previously approved scaling a maximum reward of 2 percent and a penalty of 2 percent of total approved base inpatient revenue across all hospitals.

HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the CMS VBP program where feasible,<sup>24</sup> allowing the HSCRC to use data submitted directly to CMS. As mentioned above, Maryland implemented an efficiency measure in relation to population based revenue budgets based on potentially avoidable utilization outside of the QBR program. The potentially avoidable utilization (PAU) savings adjustment to hospital rates is based on costs related to potentially avoidable admissions, as measured by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQIs) and avoidable readmissions. HSCRC staff will continue to work with key stakeholders to complete development of an efficiency measure that incorporates population-based cost outcomes.

## QBR Score Calculation

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

**Attainment Points:** During the performance period, attainment points are awarded by comparing an individual hospital’s rates with the threshold and the benchmark. With the exception of the MD Mortality measure and ED Wait Time measures, the benchmarks and thresholds are the same as those used by CMS for the VBP program measures.<sup>25</sup> For each measure, a hospital that has a rate at or above

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<sup>23</sup> Scaling refers to the differential allocation of a pre-determined portion of base-regulated hospital inpatient revenue based on assessment of the quality of hospital performance.

<sup>24</sup> VBP measure specifications may be found at: [www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html)

<sup>25</sup> As an exception, for the ED wait time measures, attainment points are not calculated; instead full 10 points are awarded to hospitals at or below (more efficient) than the national medians for their respective volume categories in the performance period.

benchmark receives 10 attainment points. A hospital that has a rate below the attainment threshold receives 0 attainment points. A hospital that has a rate at or above the attainment threshold and below the benchmark receives 1-9 attainment points

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

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

**Domain Denominator Adjustments:** In particular instances, QBR measures will be excluded from the QBR program for individual hospitals. In the Person and Community Engagement domain, ED wait time measures (if included in the RY 2020 program) will be excluded for protected hospitals. As described in the body of the report, a hospital may exclude the ED-2b measure if it has earned at least one improvement point and if its improvement score would reduce its overall QBR score. If this measure is excluded, the Person and Community Engagement domain will reduce from 110 total points to 100 points.

Similarly, hospitals are exempt from measurement for any of the NHSN Safety measures for which there is less than 1 predicted case in the performance period. If a hospital is exempt from an NHSN measure, its Safety domain score denominator reduces from 50 to 40 points. If it is exempt from two measures, the Safety domain score denominator would be 30 total possible points. Hospitals must have at least 2 of 5 Safety measures in order to be included in the Safety domain.

**Domain Scores:** The better of attainment and improvement for each measure is used to determine the measure points for each measure, which are then summed and divided by the total possible points in each domain and multiplied by 100.

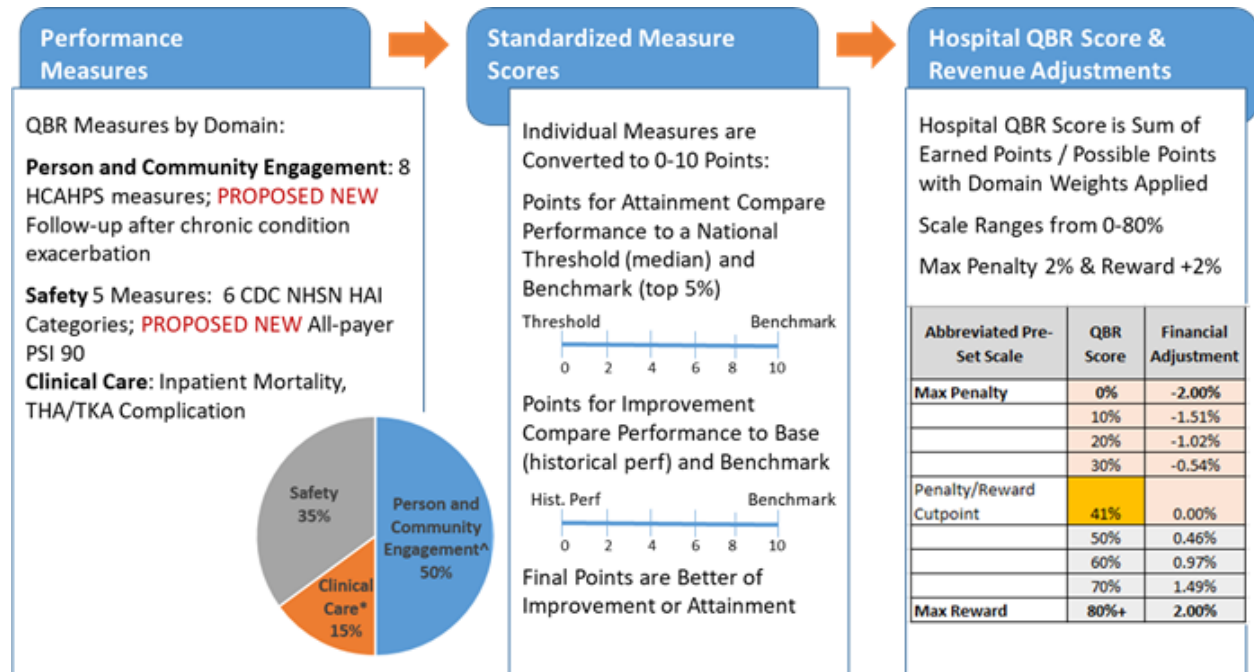
**Total Performance Score:** The total Performance Score is computed by multiplying the domain scores by their specified weights, then adding those totals. The Total Performance Score is then translated into a reward/ penalty that is applied to hospital revenue.

## Proposed RY 2023 QBR Program Updates

For RY 2023, no fundamental changes to the methodology, and the addition of the follow-up after acute exacerbation of chronic conditions and PSI-90 composite measures.

Figure 2 below depicts the steps for converting the measure scores to standardized scores for each measure, and then to rewards and penalties based upon total scores earned, with the proposed updates for RY 2023.

Figure 2. Proposed RY 2023 Process for Calculating QBR Scores



There are no fundamental changes proposed for the measures and domain weighting for RY 2023, as illustrated in Figure 3 below.

Figure 3. Proposed RY 2023 QBR Domains, Measures and Data Sources

	Clinical Care	Person and Community Engagement	Safety
<b>Proposed QBR RY 23</b>	15 percent 2 measures <input type="checkbox"/> Inpatient Mortality (HSCRC case mix data) <input type="checkbox"/> THA TKA (CMS Hospital Compare, Medicare claims data)	50 percent 9 measures <input type="checkbox"/> 8 HCAHPS domains (CMS Hospital Compare patient survey) <input type="checkbox"/> <b>NEW PROPOSED:</b> Follow up after acute exacerbation of Chronic Conditions (Medicare claims )	35 percent 7 measures <input type="checkbox"/> 6 CDC NHSN HAI measures (CMS Hospital Compare chart abstracted) <input type="checkbox"/> <b>NEW PROPOSED:</b> PSI 90 All-payer (HSCRC case mix data)



### PSI 90 Measure (PROPOSED for RY 2023)

Newly proposed for RY 2023, the Patient Safety Indicators were developed by the Agency for Healthcare Research and Quality (AHRQ) in 2003.<sup>26</sup> PSI 90 comprises the weighted average of the observed-to-expected ratios for the following component indicators:

- PSI 03 Pressure Ulcer Rate
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall With Hip Fracture Rate
- PSI 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

PSI 90 combines the smoothed (empirical Bayes shrinkage) indirectly standardized morbidity ratios (observed/expected ratios) from selected AHRQ Patient Safety Indicators (PSIs). The weights of the individual component indicators are based on two concepts: the volume of the adverse event and the harm associated with the adverse event. The volume weights were calculated based on the number of safety-related events for the component indicators in the all-payer reference population. The harm weights were calculated by multiplying empirical estimates of the probability of excess harms associated with each patient safety event by the corresponding utility weights (1–disutility). Disutility is the measure of the severity of the adverse events associated with each of the harms (i.e., outcome severity, or least preferred states from the patient perspective). The harm weights were calculated using linked claims data for two years of Medicare Fee for Service beneficiaries. Figure 3 below details the most current volume and harm weights for the PSI 90 component measures.

The PSI 90 measure scores are converted to program scores as outlined in the QBR Score Calculation section above.

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<sup>26</sup> Source:

<https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2020/TechSpecs/PSI%2090%20Patient%20Safety%20and%20Adverse%20Events%20Composite.pdf>

Figure 3. Composite Weights for PSI 90 v. 2020

INDICATOR	HARM WEIGHT	VOLUME WEIGHT	COMPONENT WEIGHT
PSI 3 Pressure Ulcer Rate	0.3080	0.1149	0.181
PSI 6 Iatrogenic Pneumothorax Rate	0.1381	0.0513	0.036
PSI 8 In Hospital Fall With Hip Fracture Rate	0.1440	0.0164	0.012
PSI 9 Perioperative Hemorrhage or Hematoma Rate	0.0570	0.1621	0.047
PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate	0.3584	0.0340	0.062
PSI 11 Postoperative Respiratory Failure Rate	0.2219	0.1485	0.168
PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate	0.1557	0.2569	0.204
PSI 13 Postoperative Sepsis Rate	0.3102	0.1510	0.239
PSI 14 Postoperative Wound Dehiscence Rate	0.1441	0.0137	0.010
PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate	0.1474	0.0512	0.038

Source: 2017 State Inpatient Databases, Healthcare Cost and Utilization Program, Agency for Healthcare Research and Quality. 2012-2013 Medicare Fee-for-Service claims data.

### Follow up after acute exacerbation for chronic conditions (PROPOSED for RY 2023)

Newly proposed for RY 2023, the measure was developed by IMPAQ on behalf of CMS.<sup>27</sup> Technical details for calculating measure scores are provided below.

**Measure Full Title:** Timely Follow-up After Acute Exacerbations of Chronic Conditions

**Measure Steward:** IMPAQ International

**Description of Measure:** The percentage of issuer-product-level acute events requiring either an emergency department (ED) visit or hospitalization for one of the following 6 chronic conditions: hypertension, asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), or diabetes mellitus (Type I or Type II), where follow-up was received within the timeframe recommended by clinical practice guidelines in a non-emergency outpatient setting

**Unit of Analysis:** Issuer-by-product

**Numerator Statement:** The numerator is the sum of the issuer-product-level denominator events (Emergency Room [ED], observation hospital stay or inpatient hospital stay) for acute exacerbation of hypertension, asthma, heart failure (HF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), or diabetes where follow-up was received within the timeframe recommended by clinical practice guidelines, as detailed below:

<sup>27</sup> Source: <https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions>

- Hypertension: Within 7 days of the date of discharge
- Asthma: Within 14 days of the date of discharge
- HF: Within 14 days of the date of discharge
- CAD: Within 14 days of the date of discharge
- COPD: Within 30 days of the date of discharge
- Diabetes: Within 30 days of the date of discharge

**Numerator Details:**

This measure is defined at the issuer-by-product level, meaning that results are aggregated for each qualified insurance issuer and for each product. For clarity, a product is a discrete package of health insurance coverage benefits that issuers offer in the context of a particular network type, such as health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), point of service (POS), or indemnity. Issuers are broadly defined as health insurance providers who participate in the Federally-facilitated Marketplaces and health insurance contracts offered in the Medicare Advantage market.

Timely follow-up is defined as a claim for the same patient after the discharge date of the acute event that is a non-emergency outpatient visit and has a CPT or HCPCS code indicating a visit that constitutes appropriate follow-up, as defined by clinical guidelines and clinical coding experts. The follow-up visit may be a general office visit or telehealth and take place in certain chronic care or transitional care management settings. The follow-up visit must occur within the condition-specific timeframe to be considered timely and for the conditions of the numerator/measure to be met. For a list of individual codes, please see the data dictionary attached in S.2b.

The follow-up visit timeframes for each of the 6 chronic conditions are based on evidence-based clinical practice guidelines (CPGs) as laid out in the evidence form.

**Denominator Statement:** The denominator is the sum of the issuer-product-level acute exacerbations that require either an ED visit, observation stay, or inpatient stay (i.e., acute events) for any of the 6 conditions listed above (hypertension, asthma, HF, CAD, COPD, or diabetes).

**Denominator Details:**

Acute events are defined as either an ED visit, observation stay, or inpatient stay. If a patient is discharged and another claim begins for the same condition on the same day or the following day, the claims are considered to be part of one continuous acute event. In this case, the discharge date of the last claim is the beginning of the follow-up interval. The final claim of the acute event must be a discharge to community.

An acute event is assigned to [condition] if:

1. The primary diagnosis is a sufficient code for [condition].

OR

2. The primary diagnosis is a related code for [condition] AND at least one additional diagnosis is a sufficient code for [condition].
  - a. In cases where the event has two or more conditions with a related code as the primary diagnosis and a sufficient code in additional diagnosis positions, **assign the event to the condition with a sufficient code appearing in the “highest” (closest to primary) diagnosis position.**

If the visits that make up an acute event are assigned different conditions, the event is assigned the condition that occurs last in the sequence. Following this methodology, only one condition is recorded in the denominator per acute event. For a list of individual codes, please see the data dictionary attached in S.2b.

#### **Denominator Exclusions:**

The measure excludes events with:

1. Subsequent acute events that occur two days after the prior discharge, but still during the follow-up interval of the prior event for the same reason. To prevent double-counting, only the first acute event will be included in the denominator.
2. Acute events after which the patient does not have continuous enrollment for 30 days in the same product.
3. Acute events where the discharge status of the last claim is not “to community” (“Left against medical advice” is not a discharge to community.)
4. Acute events for which the calendar year ends before the follow-up window ends (e.g., acute asthma events ending fewer than 14 days before December 31)
5. Acute events where the patient enters a skilled nursing facility (SNF), non-acute care, or hospice care within the follow-up interval

#### **Measure Scoring:**

- 1) Denominator events are identified by hospitalization, observation, and ED events with appropriate codes (i.e., codes identifying an acute exacerbation of 1 of the 6 included chronic conditions).
- 2) Exclusions are applied to the population from step 1) to produce the eligible patient population for the measure (i.e., the count of all qualifying events).
- 3) For each qualifying event, it is determined whether or not claims included a subsequent code that satisfies the follow-up requirement for that particular qualifying event (e.g., a diabetes event received follow-up within the appropriate timeframe for diabetes, from an appropriate provider).

Each event for which the follow-up requirement was satisfied is counted as 'one' in the numerator. Each event for which the follow-up requirement was not satisfied is counted as a 'zero' in the numerator.

- 4) The percentage score is calculated as the numerator divided by the denominator.

### **Measure Scoring Logic**

Following NQF's guideline, we employ **Opportunity-Based Weighting** to calculate the follow-up measure. (1) This means that each condition is weighted by the sum of acute exacerbations that require either an ED visit or an observation or inpatient stay for all the six conditions that occur, as reflected in the logic below.

$$[\text{NUM}(\text{ASM}) + \text{NUM}(\text{CAD}) + \text{NUM}(\text{HF}) + \text{NUM}(\text{COPD}) + \text{NUM}(\text{DIAB}) + \text{NUM}(\text{HTN})] / [\text{DENOM}(\text{ASM}) + \text{DENOM}(\text{CAD}) + \text{DENOM}(\text{HF}) + \text{DENOM}(\text{COPD}) + \text{DENOM}(\text{DIAB}) + \text{DENOM}(\text{HTN})]$$

\*\*\*Please note that, while the development team designed the measure to aggregate each condition score in the manner described above into a single overall score, programs may choose to also calculate individual scores for each chronic condition when implementing the measure. Individual measure scores would simply be calculated by dividing the condition-specific numerator by the condition specific denominator, as in the example for failure:  $\text{NUM}(\text{HF}) / \text{DENOM}(\text{HF})$

The Follow up measure scores are converted to QBR scores as outlined in the QBR Score Calculation section above.

### **QBR RY 2023 Base and Performance Periods by Measure**

Figure 4 below illustrates the proposed base and performance period timeline for the RY 2023 QBR program.

Figure 4. RY 2023 Proposed Timeline (Base and Performance Periods; Financial Impact)

Rate Year (Maryland Fiscal Year)	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20	Q3-20	Q4-20	Q1-21	Q2-21	Q3-21	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23	Q3-23	Q4-23			
Calendar Year	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20	Q3-20	Q4-20	Q1-21	Q2-21	Q3-21	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23			
<b>Quality Based Reimbursement (QBR) Base and Performance Periods</b>					CMS Hospital Compare Base Period (HCAHPS measures, all CDC NHSN measures )																				
													CMS Hospital Compare Performance Period (HCAHPS measures, all CDC NHSN measures)												
					Base Period Inpatient Mortality, <b>PROPOSED PSI-90,</b> <b>Follow-up Chronic Conditions</b>																	Rate Year Impacted by QBR Results			
													Performance Period Inpatient Mortality, <b>PROPOSED PSI-90,</b> <b>Follow-up Chronic Conditions</b>												
		CMS Hospital Compare THA/TKA Performance Period*X																							
*Hospital Compare THA/TKA Complications Base Period April 1, 2013-March 31, 2016																									
X CMS announced they will not use data for CY Quarters 1 and 2 for the quality pay for performance programs due to COVID-19 PHE; staff will consider options as CMS publishes updated measure base period.																									

## APPENDIX III. RY 2021 PATIENT EXPERIENCE MEASURE RESULTS BY HOSPITAL

CMS ID	HCAHPS Measure Hosp Name	Clean/Quiet		Nurse Comm		Doctor Comm		Staff Responsive		Understood Medications		Discharge Information		Understood Post-Disch Care		Hospital Rating 9 or 10	
		Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base
210001	MERITUS MEDICAL CENTER	62.5	-0.5	79	2	77	1	62	1	60	1	89	1	47	0	65	-2
210002	UNIVERSITY OF MARYLAND MEDICAL CENTER	58	2	80	2	81	3	61	3	61	-2	88	0	51	-1	70	1
210003	UNIVERSITY OF MD PRINCE GEORGE'S HOSPITAL CTR	46.5	-6	60	-3	66	-7	37	-7	45	-4	79	2	32	-6	41	-5
210004	HOLY CROSS HOSPITAL	61.5	-4	73	1	75	1	58	3	59	4	83	2	41	-3	69	5
210005	FREDERICK MEMORIAL HOSPITAL	68	-2	81	1	78	-1	62	2	63	1	89	0	51	1	70	0
210006	UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL	58	0.5	78	0	78	2	56	-4	63	8	83	2	46	0	62	-3
210008	MERCY MEDICAL CENTER INC	73	1	80	-1	82	0	71	3	62	-9	90	2	58	3	77	-1
210009	JOHNS HOPKINS HOSPITAL, THE	70	0.5	83	2	82	2	63	2	65	1	90	2	62	4	84	3
210011	SAINT AGNES HOSPITAL	60.5	1.5	75	-1	77	-2	59	-1	60	-2	85	-1	47	-2	63	-4
210012	SINAI HOSPITAL OF BALTIMORE	63	1	75	-3	78	1	58	-2	57	-5	85	-2	49	0	65	-4
210013	BON SECOURS HOSPITAL	60.5	-5	66	-11	73	-9	53	-11	57	-6	84	-6	51	5	51	-6
210015	MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	64	5.5	78	3	79	1	64	4	65	0	89	1	48	0	68	-2
210016	ADVENTIST HEALTHCARE WASHINGTON ADVENTIST HOSPITAL	66.5	6	77	4	80	5	64	5	62	3	89	5	47	4	73	6
210017	GARRETT COUNTY MEMORIAL HOSPITAL	70	4	84	5	88	7	81	11	65	-3	89	-2	55	4	75	4

CMS ID	HCAHPS Measure Hosp Name	Clean/Quiet		Nurse Comm		Doctor Comm		Staff Responsive		Understood Medications		Discharge Information		Understood Post-Disch Care		Hospital Rating 9 or 10	
		Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base
210018	MEDSTAR MONTGOMERY MEDICAL CENTER	63.5	3.5	68	-3	72	-2	59	6	53	-2	85	-1	44	0	61	0
210019	PENINSULA REGIONAL MEDICAL CENTER	65	3	80	1	79	1	64	1	65	5	88	-2	52	-2	73	2
210022	SUBURBAN HOSPITAL	61	-4.5	76	-1	80	0	60	-3	59	2	85	1	52	1	68	-3
210023	ANNE ARUNDEL MEDICAL CENTER	65	-2.5	79	-2	79	-2	65	-4	62	0	87	2	53	-1	74	-3
210024	MEDSTAR UNION MEMORIAL HOSPITAL	63.5	-4.5	77	-2	83	1	63	0	67	2	89	0	54	4	69	-4
210027	WESTERN MARYLAND REGIONAL MEDICAL CENTER	68	0.5	79	0	75	-3	61	-2	64	-3	90	-1	51	-1	67	-3
210028	MEDSTAR SAINT MARY'S HOSPITAL	64	-2	80	2	77	-1	64	3	66	6	89	-1	51	2	68	0
210029	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	57.5	-0.5	78	2	81	2	60	-2	63	1	88	0	54	0	68	-1
210032	UNION HOSPITAL OF CECIL COUNTY	58	-2.5	74	-3	69	-7	61	-1	57	-4	85	-1	43	-3	61	-3
210033	CARROLL HOSPITAL CENTER	64.5	-1	75	-4	71	-2	63	0	58	-4	89	2	48	1	66	2
210034	MEDSTAR HARBOR HOSPITAL	62	-3.5	73	-3	75	-5	61	-4	60	-5	86	0	48	1	63	-6
210035	UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	68	5	77	-1	73	0	61	-3	62	0	86	1	43	-6	65	2
210037	UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	66.5	-0.5	80	-1	79	0	67	-1	61	-1	86	0	49	-1	65	-1
210038	UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	65	1.5	75	1	79	3	62	-2	59	-1	82	-2	50	2	67	4
210039	CALVERTHEALTH MEDICAL CENTER	64	-0.5	75	-6	75	-1	59	-5	56	-8	85	-3	44	-6	61	-5
210040	NORTHWEST HOSPITAL CENTER	68.5	5	76	0	75	-1	68	2	61	-1	87	-1	49	2	66	1



CMS ID	HCAHPS Measure Hosp Name	Clean/Quiet		Nurse Comm		Doctor Comm		Staff Responsive		Understood Medications		Discharge Information		Understood Post-Disch Care		Hospital Rating 9 or 10	
		Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base	Perf Pd	Δ frm Base
210043	UNIVERSITY OF MD BALTO WASHINGTON MEDICAL CENTER	65	3.5	78	1	77	0	63	7	63	4	87	1	49	-1	69	3
210044	GREATER BALTIMORE MEDICAL CENTER	55.5	-2.5	78	-1	79	-2	58	-5	62	2	83	-6	50	-2	72	-1
210048	HOWARD COUNTY GENERAL HOSPITAL	64.5	1	78	-1	77	-1	61	0	60	1	86	0	52	0	68	-4
210049	UNIVERSITY OF M D UPPER CHESAPEAKE MEDICAL CENTER	60	-3	76	-3	75	-3	58	-3	62	-1	86	0	48	-3	64	-5
210051	DOCTORS' COMMUNITY HOSPITAL	58	-1	70	-3	74	-2	57	-2	53	-8	82	-4	43	1	59	-7
210056	MEDSTAR GOOD SAMARITAN HOSPITAL	62.5	1	77	-2	79	1	63	3	62	-2	88	-2	50	2	66	-1
210057	ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER	61.5	-0.5	74	-3	73	-6	51	-9	55	-6	87	0	50	0	67	-4
210060	FORT WASHINGTON HOSPITAL	52	-4.5	70	-3	74	-3	58	-8	50	-5	81	-2	45	3	54	-2
210061	ATLANTIC GENERAL HOSPITAL	62.5	2	82	4	84	5	70	2	66	2	92	4	54	2	75	6
210062	MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	61	3.5	72	3	77	2	57	2	56	-1	84	1	41	-1	51	-4
210063	UNIVERSITY OF MARYLAND ST JOSEPH MEDICAL CENTER	65.5	-2	82	1	81	0	68	-1	61	-1	88	-1	54	-1	76	-2
210064	LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL	57.5	16	58	-1	66	0	44	-1	49	8	88	3	44	-6	44	-12
210065	HOLY CROSS GERMANTOWN HOSPITAL	62.5	-4	72	6	76	0	57	8	58	3	86	4	44	-3	68	3



# APPENDIX V. RY 2023 QBR PERFORMANCE STANDARDS

Previously Established and Newly Established Performance Standards for the FY 2023 Program Year		
Measure Short Name	Achievement Threshold	Benchmark
<b>Safety Domain</b>		
CMS PSI 90* <sup>^</sup> + <b>(PROPOSED NEW)</b>	(Prelim): 0.873	(Prelim): 0.587
CAUTI* <sup>+</sup>	0.676	0
CLABSI* <sup>+</sup>	0.596	0
CDI* <sup>+</sup>	0.544	0.01
MRSA Bacteremia* <sup>+</sup>	0.727	0
Colon and Abdominal Hysterectomy SSI* <sup>+</sup>	0.734 0.732	0 0

<b>Clinical Outcomes Domain</b>		
Inpatient Mortality	TBD	TBD
COMP-HIP-KNEE* <sup>#</sup>	0.027428	0.019779

\* Lower values represent better performance.

<sup>^</sup>Preliminary using CY 2019 data.

<sup>#</sup> Previously established performance standards

<sup>+</sup> The newly established performance standards displayed in this table for the CDC NHSN measures (CAUTI, CLABSI, CDI, MRSA Bacteremia, and Colon and Abdominal Hysterectomy SSI) were published in CMS FY 2021 IPPS Final Rule and calculated using four quarters of CY 2019 data.

<b>New Proposed Measure for FY 2023</b>	<b>Person and Community Engagement Domain<sup>±</sup></b>	
	<b>Achievement Threshold</b>	<b>Benchmark</b>
Follow Up after Exacerbation for Chronic Conditions	72.57	79.68

## APPENDIX VI. MODELING OF SCORES BY DOMAIN: RY 2021 QBR DATA WITH RY 2023 MEASURE UPDATES

Hospital ID	Hospital Name	HCAHPS Final Score without ED Wait Times	HCAHPS Final Score without ED and with Follow-up	Mortality Final Score	THA-TKA Score	Safety Final Score	Safety Final Score with PSI-90	Model 1. Total Score without ED Wait Times	Model 2. Total Score without ED plus PSI-90	Model 3. Total Score without ED Wait Times with PSI-90 and Follow-Up
210001	MERITUS MEDICAL CENTER	21.00%	27.27%	90.00%	100.00%	40.00%	35.00%	38.50%	36.75%	39.89%
210002	UNIVERSITY OF MARYLAND MEDICAL CENTER	22.00%	20.00%	20.00%	40.00%	30.00%	26.67%	25.50%	24.33%	23.33%
210003	UM-PRINCE GEORGES	2.00%	3.64%	0.00%		38.00%	31.67%	14.30%	12.08%	12.90%
210004	HOLY CROSS HOSPITAL	21.00%	20.91%	20.00%	0.00%	16.00%	13.33%	18.10%	17.17%	17.12%
210005	FREDERICK HEALTH HOSPITAL, INC	26.00%	30.00%	100.00%	20.00%	52.00%	43.33%	42.20%	39.17%	41.17%
210006	UM-HARFORD MEMORIAL HOSPITAL	19.00%	20.91%	100.00%	50.00%	33.33%	25.00%	33.67%	30.75%	31.70%
210008	MERCY MEDICAL CENTER	46.00%	41.82%	0.00%	100.00%	6.00%	6.67%	30.10%	30.33%	28.24%
210009	JOHNS HOPKINS HOSPITAL	52.00%	47.27%	40.00%		6.00%	5.00%	34.10%	33.75%	31.39%
210010	UM-SHORE REGIONAL HEALTH AT DORCHESTER	20.00%	20.91%	60.00%	90.00%	58.00%	48.33%	40.80%	37.42%	37.87%
210011	ST. AGNES HOSPITAL	15.00%	13.64%	10.00%	90.00%	36.00%	30.00%	25.60%	23.50%	22.82%
210012	SINAI HOSPITAL	15.00%	14.55%	40.00%	100.00%	16.00%	13.33%	22.10%	21.17%	20.94%
210015	MEDSTAR FRANKLIN SQUARE	27.00%	25.45%	90.00%	60.00%	32.00%	26.67%	36.70%	34.83%	34.06%
210016	ADVENTIST WHITE OAK HOSPITAL	38.00%	36.36%	0.00%	90.00%	56.00%	46.67%	43.10%	39.83%	39.02%
210017	GARRETT COUNTY MEMORIAL HOSPITAL	59.00%	60.00%	0.00%	40.00%		46.67%	48.63%	47.83%	48.33%
210018	MEDSTAR MONTGOMERY MEDICAL CENTER	15.00%	19.09%	40.00%	50.00%	60.00%	48.00%	35.00%	30.80%	32.85%
210019	PENINSULA REGIONAL MEDICAL CENTER	28.00%	31.82%	10.00%	100.00%	16.00%	28.33%	25.60%	29.92%	31.83%
210022	SUBURBAN HOSPITAL	20.00%	25.45%	20.00%	100.00%	14.00%	20.00%	21.90%	24.00%	26.73%

Hospital ID	Hospital Name	HCAHPS Final Score without ED Wait Times	HCAHPS Final Score without ED and with Follow-up	Mortality Final Score	THA-TKA Score	Safety Final Score	Safety Final Score with PSI-90	Model 1. Total Score without ED Wait Times	Model 2. Total Score without ED plus PSI-90	Model 3. Total Score without ED Wait Times with PSI-90 and Follow-Up
210023	ANNE ARUNDEL MEDICAL CENTER	23.00%	23.64%	40.00%	100.00%	16.00%	25.00%	26.10%	29.25%	29.57%
210024	MEDSTAR UNION MEMORIAL HOSPITAL	32.00%	30.00%	80.00%	100.00%	35.00%	28.00%	41.25%	38.80%	37.80%
210027	UPMC - WESTERN MARYLAND	25.00%	30.00%	30.00%	60.00%	20.00%	16.67%	25.50%	24.33%	26.83%
210028	MEDSTAR ST. MARY'S HOSPITAL	29.00%	30.91%	30.00%	100.00%	76.67%	70.00%	49.33%	47.00%	47.95%
210029	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	22.00%	22.73%	30.00%	100.00%	28.00%	31.67%	28.80%	30.08%	30.45%
210032	CHRISTIANACARE, UNION HOSPITAL	14.00%	12.73%	10.00%	50.00%	42.50%	34.00%	25.38%	22.40%	21.76%
210033	CARROLL HOSPITAL CENTER	19.00%	19.09%	100.00%	90.00%	62.00%	51.67%	45.70%	42.08%	42.13%
210034	MEDSTAR HARBOR HOSPITAL CENTER	15.00%	13.64%	40.00%	0.00%	36.00%	33.33%	24.10%	23.17%	22.48%
210035	UM-CHARLES REGIONAL MEDICAL CENTER	20.00%	19.09%	40.00%	100.00%	50.00%	51.67%	36.50%	37.08%	36.63%
210037	UM-SHORE REGIONAL HEALTH AT EASTON	20.00%	20.91%	80.00%	90.00%	58.00%	65.00%	42.80%	45.25%	45.70%
210038	UMMC MIDTOWN CAMPUS	18.00%	16.36%	70.00%		52.50%	52.00%	37.88%	37.70%	36.88%
210039	CALVERT HEALTH MEDICAL CENTER	14.00%	15.45%	100.00%	90.00%	60.00%	45.00%	42.50%	37.25%	37.98%
210040	NORTHWEST HOSPITAL CENTER	22.00%	20.00%	100.00%	100.00%	18.00%	15.00%	32.30%	31.25%	30.25%
210043	UM-BALTIMORE WASHINGTON MEDICAL CENTER	25.00%	25.45%	80.00%	10.00%	56.00%	55.00%	40.60%	40.25%	40.48%
210044	GREATER BALTIMORE MEDICAL CENTER	16.00%	16.36%	80.00%	100.00%	20.00%	16.67%	28.00%	26.83%	27.02%
210048	HOWARD COUNTY GENERAL HOSPITAL	18.00%	20.91%	50.00%	80.00%	40.00%	33.33%	32.00%	29.67%	31.12%
210049	UM-UPPER CHESAPEAKE MEDICAL CENTER	15.00%	18.18%	80.00%	100.00%	28.00%	23.33%	30.30%	28.67%	30.26%
210051	DOCTORS COMMUNITY MEDICAL CENTER	12.00%	10.91%	70.00%	70.00%	72.00%	61.67%	41.70%	38.08%	37.54%
210056	MEDSTAR GOOD SAMARITAN	20.00%	18.18%	60.00%	50.00%	34.00%	28.33%	30.40%	28.42%	27.51%
210057	SHADY GROVE ADVENTIST HOSPITAL	10.00%	14.55%	0.00%	40.00%	42.00%	36.67%	21.70%	19.83%	22.11%

Hospital ID	Hospital Name	HCAHPS Final Score without ED Wait Times	HCAHPS Final Score without ED and with Follow-up	Mortality Final Score	THA-TKA Score	Safety Final Score	Safety Final Score with PSI-90	Model 1. Total Score without ED Wait Times	Model 2. Total Score without ED plus PSI-90	Model 3. Total Score without ED Wait Times with PSI-90 and Follow-Up
210060	ADVENTIST HEALTHCARE FORT WASHINGTON	11.00%	10.00%	0.00%	100.00%			16.47%	16.47%	15.70%
210061	ATLANTIC GENERAL HOSPITAL	47.00%	44.55%	0.00%	80.00%	43.33 %	47.50%	42.67%	44.13%	42.90%
210062	MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	12.00%	10.91%	20.00%	0.00%	68.00 %	56.67%	31.80%	27.83%	27.29%
210063	UM-ST. JOSEPH MEDICAL CENTER	33.00%	33.64%	100.00%	100.00%	44.00 %	53.33%	46.90%	50.17%	50.48%
210065	HOLY CROSS HOSPITAL-GERMANTOWN	23.00%	20.91%	50.00%		70.00 %	56.00%	43.50%	38.60%	37.55%

NOTE: 210013 - Grace is removed from FINAL SCORES due to transition to Free-standing Medical Facility

NOTE: 210030 - UM-Chestertown is removed from FINAL SCORES due to insufficient HCAHPS completed surveys; insufficient inclusion criteria for Safety Domain measures.

NOTE: 210017 - Garrett is now included in Safety Domain with 3 of 6 measures (C.Diff, SSI-Colon and PSI-90)

NOTE: 210060 - Ft Washington remains excluded from the Safety domain with 2 of 6 measures (C Diff and PSI-90)

# APPENDIX VII. MODELING OF QBR PROGRAM REVENUE ADJUSTMENTS

RY 2021 QBR SCALING		RY 21 without ED Wait Times		RY21 without ED Wait Times and with PSI		RY21 without ED Wait Times and with PSI and Follow-Up	
HOSPID	HOSPITAL NAME	% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact	% Revenue Impact	\$ Revenue Impact
210001	MERITUS	-0.12%	-\$259,257	-0.21%	-\$453,700	-0.05%	-\$108,024
210002	UNIVERSITY OF MARYLAND	-0.76%	-\$9,373,280	-0.81%	-\$9,989,943	-0.86%	-\$10,606,606
210003	PRINCE GEORGE	-1.30%	-\$3,423,711	-1.41%	-\$3,713,410	-1.37%	-\$3,608,065
210004	HOLY CROSS	-1.12%	-\$4,078,744	-1.16%	-\$4,224,414	-1.16%	-\$4,224,414
210005	FREDERICK MEMORIAL	0.06%	\$140,965	-0.09%	-\$211,448	0.01%	\$23,494
210006	HARFORD	-0.36%	-\$196,560	-0.50%	-\$273,000	-0.45%	-\$245,700
210008	MERCY	-0.53%	-\$1,299,473	-0.52%	-\$1,274,955	-0.62%	-\$1,520,139
210009	JOHNS HOPKINS	-0.34%	-\$5,225,852	-0.35%	-\$5,379,554	-0.47%	-\$7,223,972
210010	DORCHESTER	-0.01%	-\$2,052	-0.17%	-\$34,880	-0.15%	-\$30,776
210011	ST. AGNES	-0.75%	-\$1,869,191	-0.85%	-\$2,118,417	-0.89%	-\$2,218,107
210012	SINAI	-0.92%	-\$4,082,545	-0.97%	-\$4,304,422	-0.98%	-\$4,348,798
210013	BON SECOURS	2.00%	\$0	2.00%	\$0	2.00%	\$0
210015	FRANKLIN SQUARE	-0.21%	-\$648,591	-0.30%	-\$926,558	-0.34%	-\$1,050,099
210016	WASHINGTON ADVENTIST	0.11%	\$197,724	-0.06%	-\$107,849	-0.10%	-\$179,749
210017	GARRETT COUNTY	0.39%	\$89,753	0.35%	\$80,548	0.38%	\$87,452
210018	MONTGOMERY GENERAL	-0.29%	-\$245,746	-0.50%	-\$423,700	-0.40%	-\$338,960
210019	PENINSULA REGIONAL	-0.75%	-\$1,948,514	-0.54%	-\$1,402,930	-0.45%	-\$1,169,108
210022	SUBURBAN	-0.93%	-\$2,023,698	-0.83%	-\$1,806,096	-0.70%	-\$1,523,214
210023	ANNE ARUNDEL	-0.73%	-\$2,333,756	-0.57%	-\$1,822,248	-0.56%	-\$1,790,278
210024	UNION MEMORIAL	0.01%	\$25,856	-0.11%	-\$284,415	-0.16%	-\$413,694
210027	WESTERN MARYLAND	-0.76%	-\$1,334,559	-0.81%	-\$1,422,359	-0.69%	-\$1,211,639
210028	ST. MARY	0.43%	\$341,012	0.31%	\$245,846	0.36%	\$285,498
210029	HOPKINS BAYVIEW MED CTR	-0.60%	-\$2,327,675	-0.53%	-\$2,056,113	-0.51%	-\$1,978,524
210030	CHESTERTOWN	2.00%	\$0	2.00%	\$0	2.00%	\$0
210032	UNION HOSPITAL OF CECIL	-0.76%	-\$517,840	-0.91%	-\$620,045	-0.94%	-\$640,486
210033	CARROLL COUNTY	0.24%	\$357,121	0.06%	\$89,280	0.06%	\$89,280
210034	HARBOR	-0.82%	-\$1,001,948	-0.87%	-\$1,063,043	-0.90%	-\$1,099,699
210035	CHARLES REGIONAL	-0.22%	-\$178,395	-0.19%	-\$154,068	-0.21%	-\$170,286
210037	EASTON	0.09%	\$98,534	0.22%	\$240,862	0.24%	\$262,759
210038	UMMC MIDTOWN	-0.15%	-\$161,556	-0.16%	-\$172,326	-0.20%	-\$215,408
210039	CALVERT	0.08%	\$56,795	-0.18%	-\$127,788	-0.15%	-\$106,490
210040	NORTHWEST	-0.42%	-\$590,308	-0.48%	-\$674,638	-0.52%	-\$730,858
210043	BALTIMORE WASHINGTON	-0.02%	-\$53,283	-0.04%	-\$106,566	-0.03%	-\$79,925
210044	G. B. M. C.	-0.63%	-\$1,557,352	-0.69%	-\$1,705,671	-0.68%	-\$1,680,952
210048	HOWARD COUNTY	-0.44%	-\$818,895	-0.55%	-\$1,023,618	-0.48%	-\$893,340
210049	UPPER CHESAPEAKE HEALTH	-0.52%	-\$817,806	-0.60%	-\$943,622	-0.52%	-\$817,806
210051	DOCTORS COMMUNITY	0.04%	\$59,532	-0.14%	-\$208,362	-0.17%	-\$253,011
210055	LAUREL REGIONAL		\$0		\$0		\$0
210056	GOOD SAMARITAN	-0.52%	-\$838,436	-0.61%	-\$983,550	-0.66%	-\$1,064,169
210057	SHADY GROVE	-0.94%	-\$2,674,350	-1.03%	-\$2,930,405	-0.92%	-\$2,617,449
210060	FT. WASHINGTON	-1.20%	-\$260,360	-1.20%	-\$260,360	-1.23%	-\$266,869
210061	ATLANTIC GENERAL	0.09%	\$36,571	0.16%	\$65,015	0.10%	\$40,634
210062	SOUTHERN MARYLAND	-0.45%	-\$788,377	-0.64%	-\$1,121,247	-0.67%	-\$1,173,806
210063	UM ST. JOSEPH	0.30%	\$754,639	0.47%	\$1,182,268	0.49%	\$1,232,577
210065	HC-GERMANTOWN	0.13%	\$91,968	-0.12%	-\$84,893	-0.17%	-\$120,266
	<b>Statewide Total</b>		<b>-\$48,681,640</b>		<b>-\$52,506,794</b>		<b>-\$53,698,992</b>







Maryland  
Hospital Association

November 19, 2020

Dr. Alyson Schuster  
Deputy Director, Quality Methodologies  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Dr. Schuster:

On behalf of the Maryland Hospital Association's 61 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) *Draft Recommendations for the Quality-Based Reimbursement Program for Rate Year 2023*. We appreciate the collaborative process to engage with staff and offer input to shape the policy in the best interest of high-quality care for all Marylanders, particularly during the coronavirus public health emergency.

We support the recommendations, which are similar to existing policy. As HSCRC staff agrees, fair and equitable performance measurement is dependent upon adequately adjusting program methodology as needed due to COVID-19. We look forward to partnering in these efforts and urge staff to evaluate measurement throughout this pandemic.

The Centers for Medicare & Medicaid Services (CMS) will use Maryland's performance on the Statewide Integrated Health Improvement Strategy (SIHIS) to evaluate the future of the Total Cost of Care Model (the Model). Where appropriate, SIHIS measures should be included in payment policy to bolster performance and provide resources to hospitals. It is reasonable to include timely follow-up after acute exacerbations of chronic conditions to the Person and Community Engagement domain. This measure aligns with areas identified for improvement through evaluation of the Model. It is essential that hospitals have the tools in place to monitor progress on this measure in real-time. We urge staff to work with the field and partners, such as CRISP, to develop tools and resources to ensure success on this measure.

We support adding the Patient Safety Indicator (PSI) 90 measure to the Safety Domain, as this measure was previously included in the QBR program—eliminating issues of new, untested measures. Maryland's QBR program is generally modeled after the National Hospital Value-Based Purchasing (VBP) program, yet we think it is important to remember the distinct differences that drive performance for hospitals in the rest of the nation relative to Maryland. However, alignment between the two programs is necessary for comparisons.

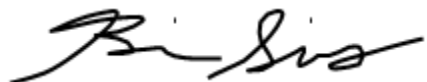
We support the low-volume, high-complexity exclusion for the Total Hip/Knee Arthroplasty measure. Originally intended for academic hospitals, members requested this exclusion extend to

Alyson Schuster  
November 19, 2020  
Page 2

community hospitals. Therefore, we implore staff to change the exclusion to be based solely on sample size and case-mix index.

We look forward to the very important work of convening the QBR Redesign Work Group in the coming year and continuing to work with HSCRC staff on modifications to this program.

Sincerely,



Brian Sims, Director, Quality & Health Improvement

cc: Adam Kane, Esq. Chairman

Joseph Antos, Ph.D., Vice Chairman

Victoria W. Bayless

Stacia Cohen, RN, MBA

John M. Colmers

James N. Elliott, M.D.

Sam Malhotra

Katie Wunderlich, Executive Director



November 19, 2020

Adam Kane  
Chairman  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Chairman:

On behalf of both the Johns Hopkins Health System (JHHS) and the University of Maryland Medical System (UMMS), we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC's) *Draft Recommendations for the Quality Based Reimbursement (QBR) Program for Rate Year 2023*. We thank HSCRC commissioners and staff for the collaborative approach that fosters ongoing engagement.

Our healthcare systems strongly support a continued focus on clinical quality improvement and patient safety that directly affects our patient populations and aligns with the daily efforts of our frontline staff providing clinical care. Through regular collaboration, we continue to be successful in engaging clinical expertise to lead system-wide service improvements, resulting in improved coordination of care and improved patient safety. Our efforts remain strong and steady through an ever-changing healthcare environment related to the pandemic. While we make every effort to consistently drive practices we know improve care and patient safety, our ability to focus and sustain previous improvements is difficult while we are currently fighting, with all available resources, to manage the SARS-CoV-2 virus.

This challenge is compounded by the recent increase in our employee SARS-CoV-2 positivity rates. Across our two health systems, we have seen our November employee positivity rates more than double from those of September, growing from a 7-day average as low as 6% to an average of 13% to 15%. These percentages equate to a loss, on average, of 125 employees per week, per health system. As resources are limited and diverted to sustaining the safest environment for both patients and staff, we do have concerns that the expected pace of improvement in these quality metrics will not be consistent with those previously demonstrated.

JHHS and UMMS generally support the staff recommendations for the RY2023 QBR Program, but we request consideration of our concerns within specific metrics.

### **The Impact of SARS-CoV-2 (COVID-19) on PSI-90 and Mortality**

While engagement in improving coordination of care and patient safety continues, the healthcare environment and delivery of care has seen significant shifts as the COVID-19 pandemic has affected all aspects of the delivery model from resource allocation, initial and ongoing assessment of patient condition and risk, family engagement, and clinical management. In addition, there is no evidence to indicate the pandemic's disruption will conclude before the end of 2021.

Nationally, there has been a documented increase in healthcare associated infections with several studies outlining the impact of resource diversion on expected outcomes. These infection prevention experts reference the fact that the full impact of the COVID-19 pandemic on health systems and traditional health associated complications remains to be determined.

The most current release of the AHRQ Quality Indicator (QI) software, v2020, does not include any consideration for COVID-19 ICD CM/PCS codes, nor any assessment on expected and/or exclusions. Our health systems’ case mix has shifted during COVID-19, with reductions in elective surgeries. This shift will decrease the number of surgical discharges and change the risk profile of the reference population underpinning the QI risk-adjustment methodologies.

AHRQ acknowledges that hospital volumes of discharges is likely to decrease in 2020, as short-stay elective surgeries are cancelled or delayed, and longer-stay emergency or medical discharges become more prevalent. These changes impact the reliability of individual and composite indicators, which are primarily driven by volume.

The ICD-10 code used to identify COVID patients in footnote 16 of the Draft Recommendations for Updating the QBR Program for RY2023 (CY2021) is U07.1. U07.1 was made available on April 1, 2020, but COVID was present in Maryland hospitals prior to that date. The published coding guidelines in March 2020 directed hospitals to use use ICD-10 code B97.29 for COVID positive patients.

**Recommendations:** We recommend that HSCRC evaluate the impact of COVID-19 on PSI-90. We also recommend that COVID-19 positive cases be excluded from the RY2023 (CY2021) PSI-90 program until a time when hospitals have the opportunity to understand how AHRQ will risk adjust for COVID-19 positive cases.

While we concur with the HSCRC Staff recommendation to exclude the COVID-19 patients from inpatient mortality measure if any CY2020 data is used, we would request the same consideration for FY2023 (CY2021). We also recommend that HSCRC expand footnote 16 to include patients with B97.29 for March 2020 discharges.

**Improvements to PSI 90**

We acknowledge that PSI measures include some complications that are similar to the PPCs in the MHAC program. The concern is that a hospital may be penalized twice for essentially the same measure (PPC or PSI) on the same patient.

Here are some examples of this overlap:

Measure	PSI Inclusion	PPC Inclusion
Iatrogenic Pneumothorax	IA secondary diagnosis for cases surgical/medical discharge 18 years and older code J95811 <ul style="list-style-type: none"> <li>AHRQ exclusions for pleural effusions POA, intrathoracic and cardiac procedures</li> </ul>	The following secondary diagnosis is coded but not present on admission J95811 <ul style="list-style-type: none"> <li>PPC excludes POA scoliosis, intrathoracic, esophageal and chest trauma</li> </ul>
Peri-operative hemorrhage and hematoma	Cases involving treatment of the perioperative hemorrhage and hematoma <ul style="list-style-type: none"> <li>Excludes coagulopathies</li> </ul>	Post procedure and intraoperative hemorrhage and hematoma procedure identified by APRDRG <ul style="list-style-type: none"> <li>Excludes coagulopathies</li> </ul>

We support the current risk-adjustment model developed by AHRQ, but there is a concern with low volume consequences. Due to the Bayesian smoothing in the PSI-90 composite, this can create a

scenario where a small hospital may have zero numerator complication events with a non-zero PSI-90 composite. Historically in the QBR Program, there was a small hospital exclusion for hospitals with zero events during a 12-month period, or not meeting minimum denominator cases.

**Recommendations:** We recommend removing those PSI measures that are similar in the MHAC program and monitor them only.

We also recommend maintaining the current AHRQ risk-adjustment model, but adding an exclusion for small hospitals, similar to the MHAC program. An approach, where hospitals are either excluded or have a 2-year measurement period, would address this statistical concern.

### **Person and Community Engagement (PCE) Domain**

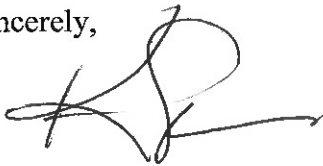
Adding the measure Timely Follow-up After Acute Exacerbations of Chronic Conditions is dependent on the ability to identify the patients and tracking of those patients. A significant percentage of patients ( $\geq 50\%$ ) may not be able to be identified or tracked if they're outside the respective facility or outside of the health care network.

**Recommendation:** We recommend delaying the implementation of this measure until the HSCRC staff has worked with CRISP to leverage health information exchange tools for the hospitals to track patient follow-up. This step would also provide hospitals the opportunity to validate the reliability of the measure.

In summary, we are very appreciative of the opportunity to collaborate in the continual improvement of the QBR Program. JHHS and UMMS remain fully committed to improving and maintaining high quality patient care and value over time.

We look forward to ongoing collaboration related to quality improvement.

Sincerely,



Kevin W. Sowers, MSN, RN, FAAN  
President, Johns Hopkins Health System  
Executive Vice President, Johns Hopkins Medicine



Mohan Suntha, MD, MBA  
President & Chief Executive Officer  
University of Maryland Medical System

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

Sam Malhotra  
Alyson Schuster, Deputy Director, Quality Methodologies  
Dianne Feeney, Assoc. Director, Quality Initiatives  
Allan Pack, Dir., Population-Based Methodologies

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November 23, 2020

Mr. Adam Kane  
Chairman  
Health Services Cost Review Commission

Dear Chairman Kane,

On behalf of Luminis Health, thank you for the opportunity to provide comments on the Quality-Based Reimbursement (QBR) RY2023 policy. Given the COVID-19 crisis, we support the Staff's decision to keep the policy largely unchanged in RY2023. We look forward to discussing new methodologies, metrics, and targets in the upcoming QBR Redesign Workgroup.

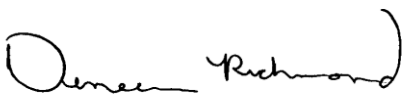
We appreciate the need to measure timely follow-ups after acute exacerbations of chronic conditions and promote alignment with the Statewide Integrated Health Improvement Strategy (SIHIS). However, we are concerned about the ability to track this data on a timely basis. We ask the Commission to delay incorporating this measure until hospitals are able to see their baseline data and establish mechanisms for tracking performance timely.

Thank you again for the opportunity to provide comments. We look forward to future collaboration.

Sincerely,



Sherry B. Perkins, PhD, RN, FAAN  
President, Luminis Health, Anne Arundel Medical Center



Deneen Richmond, MHA, RN  
Acting President, Luminis Health, Doctors Community Medical Center



maryland  
**health services**  
cost review commission

# Draft Recommendation for the Readmission Reduction Incentive Program for Rate Year 2023

December 9, 2020

This document contains the draft staff recommendations for the Readmission Reduction Incentive Program. Please submit any comment letters to HSCRC Quality ([hscrc.quality@maryland.gov](mailto:hscrc.quality@maryland.gov)) no later than December 18, 2020.

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## List of Abbreviations

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

## Key Methodology Concepts and Definitions

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

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

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

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

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

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

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

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

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

## Policy Overview

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

## Recommendations

The RRIP policy was redesigned in Rate Year (RY) 2022 to modernize the program for the Total Cost of Care Model. This RY 2023 final recommendation, in general, maintains the measure updates and methodology determinations that were developed and approved for RY 2022.<sup>1</sup>

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

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the RY 2022 approved statewide 5-year improvement target of -7.5 percent from 2018 base period.

<sup>1</sup> See the [RY 2022 policy](#) for detailed discussion of the RRIP redesign, rationale for decisions, and approved recommendations

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

## Introduction

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

The Readmissions Reduction Incentive Program (RRIP) is one of several pay-for-performance initiatives that provide incentives for hospitals to improve patient care and value over time. The RRIP currently holds up to 2 percent of inpatient hospital revenue at-risk in penalties and up to 1 percent at-risk in rewards based on improvement and attainment in case-mix adjusted readmission rates. In addition, the RRIP is the first quality policy to provide incentives for reducing disparities by rewarding hospitals up to 0.5% of inpatient hospital revenue for reducing within-hospital disparities in readmissions.

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

## Background

### Brief History of RRIP program

Maryland made incremental progress each year throughout the All-Payer Model (2014-2018), ultimately achieving the Model goal for the Maryland Medicare FFS readmission rate to be at or below the unadjusted national Medicare readmission rate by the end of Calendar Year (CY) 2018. Maryland had historically performed poorly compared to the nation on readmissions; it ranked 50th among all states in a study examining Medicare data from 2003-2004.<sup>2</sup> In order to meet the All-Payer Model requirements, the Commission approved the RRIP program in April 2014 to further bolster the incentives to reduce unnecessary readmissions.

As recommended by the Performance Measurement Workgroup, the RRIP is more comprehensive than its federal counterpart, the Medicare Hospital Readmission Reduction Program (HRRP), as it is an all-cause measure that includes all patients and all payers.<sup>3</sup>

In Maryland, the RRIP methodology evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges (such as planned readmissions) from consideration, due to data issues and clinical concerns. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR-DRG) severity of illness (SOI), and the policy determines a hospital's score and revenue adjustment by the better of improvement or attainment, with scaled rewards of up to 1 percent of inpatient revenue and scaled penalties of up to 2 percent.<sup>4</sup>

### RRIP Redesign

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

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<sup>2</sup> Jencks, S. F. et al., "Hospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* Vol. 360, No. 14: 1418-1428, 2009.

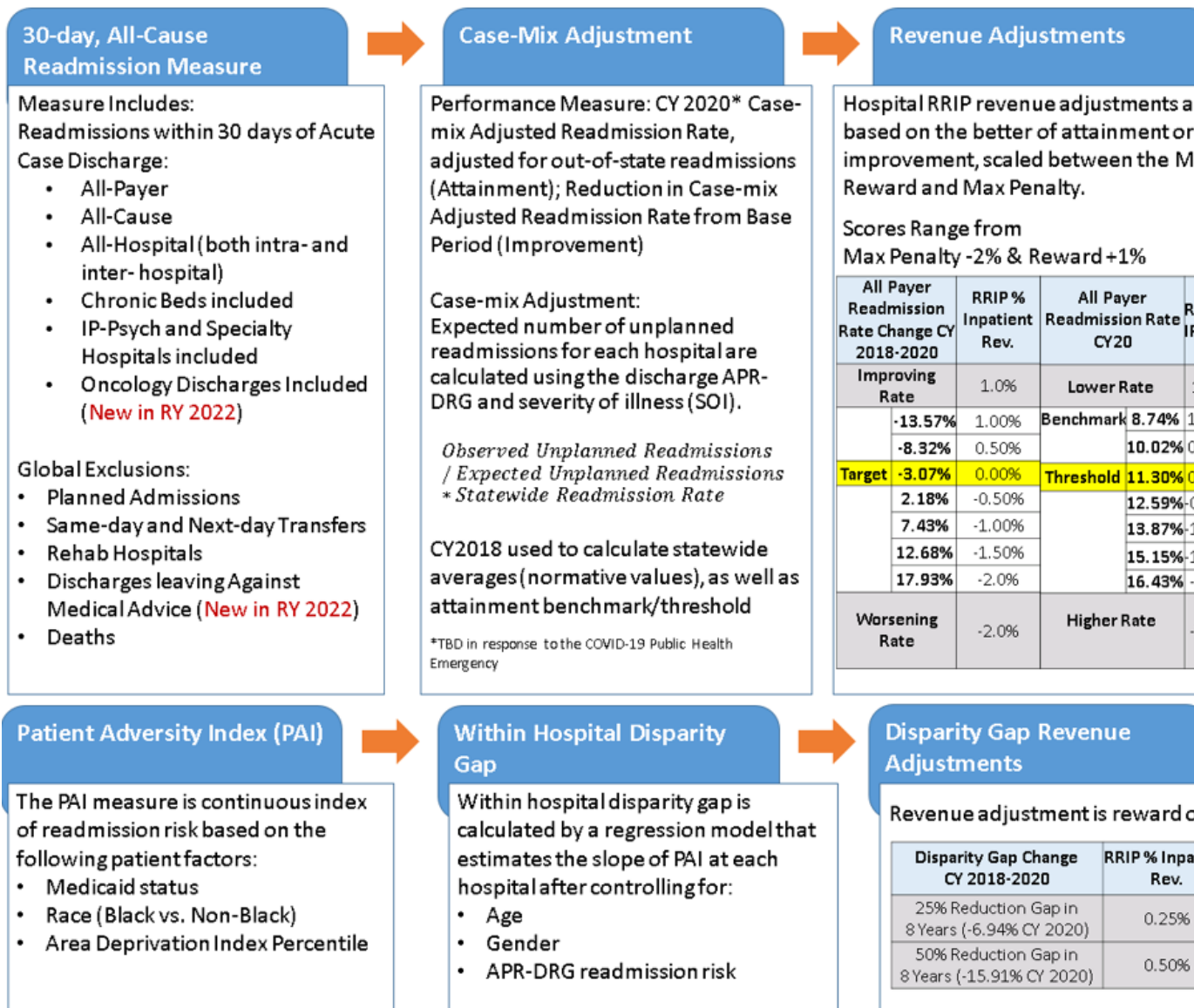
<sup>3</sup> For more information on the HRRP, please see: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program>. Maryland remains exempted from the federal HRRP.

<sup>4</sup> See Appendix I for details of the current RRIP methodology.

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

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

Figure 1. Overview Rate Year 2022 RRIP Methodology



## Assessment

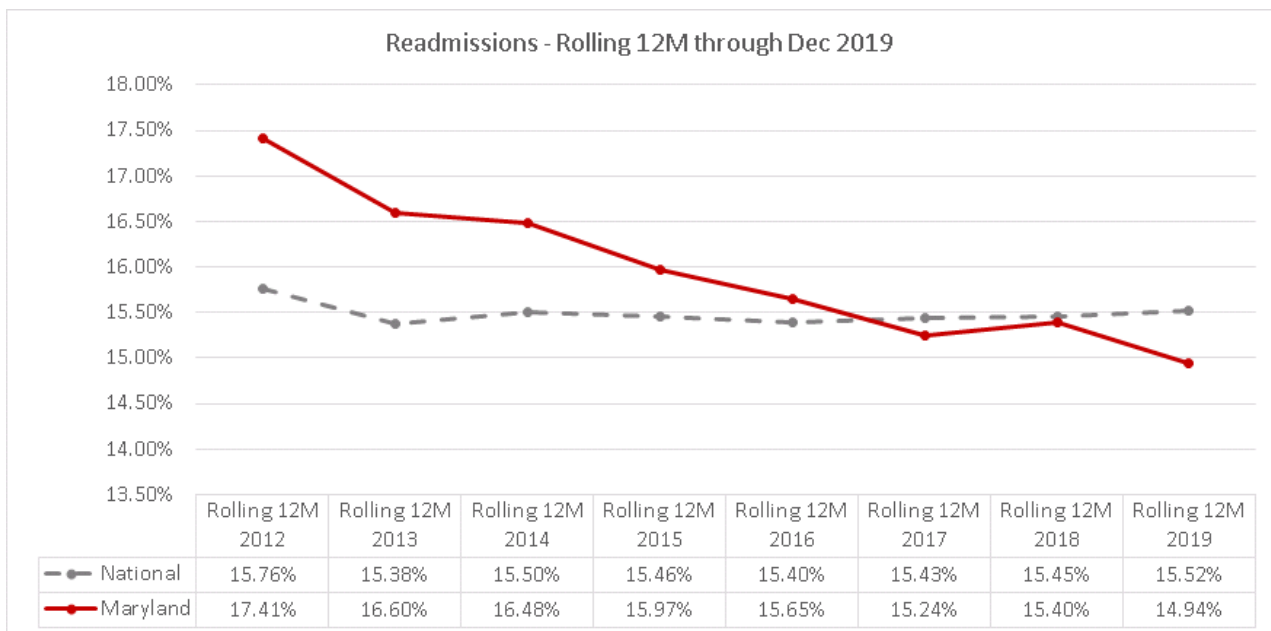
In general, stakeholders support the staff's recommendation to not make major changes to the RY 2023 RRIP program. This section of the report provides an overview of the data and issues discussed by the PMWG, including analysis of CY 2019 statewide readmission rates, estimated hospital scores, and revenue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



## Statewide Readmissions Performance

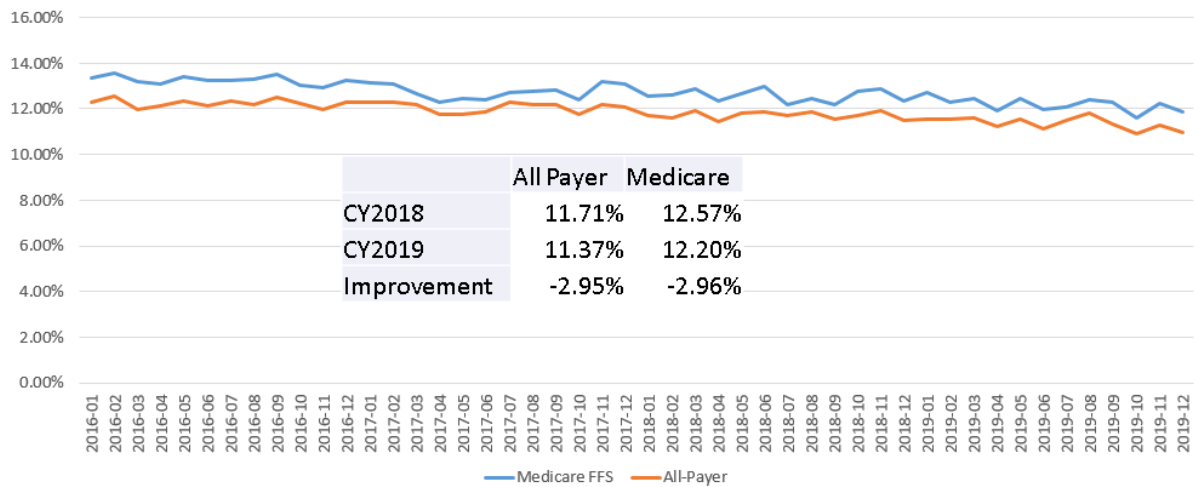
In CY 2019, Maryland improved upon its All-Payer Model achievement of being at or below the National Medicare FFS Rate. In CY 2018 at the conclusion of the All-Payer Model, Maryland had an unadjusted Medicare readmission rate of 15.40%, compared to the national rate of 15.45%. Through CY 2019, Maryland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

**Figure 2. TCOC Model “Waiver Test” - Maryland and National Unadjusted Readmission Rates**



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

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



Given these favorable trends in readmission rates and given the challenges with assessing CY 2020 case-mix data during the COVID-19 Public Health Emergency (more below), staff is not recommending large changes to the RY 2023 RRIP policy, including maintaining the improvement and attainment methodologies for a planned CY 2021 performance period. The incremental improvement rate is assessed to be -4.57 percent, see Figure 4 below, while the attainment target benchmark and threshold will be calculated off of most recent actionable case-mix data, adjusted for the proposed improvement (presently, CY 2019 under v37.1 of the APR-DRG grouper, yielding an attainment threshold of 10.96 percent and attainment benchmark of 8.16 percent). Based on the 2018 to 2019 readmission performance, there are 20 hospitals who have already exceeded the 4.57 percent improvement target such that if they maintain their 2019 readmission rates in 2021 they should receive an improvement reward.<sup>5</sup>

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

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

<sup>5</sup> Based on this preliminary attainment target one additional hospital would receive an attainment reward despite not meeting the improvement target.

## COVID-19 Program Considerations

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

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

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

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

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

COVID Data Concerns	Options
Only 6 months of data for CY 2020: <ol style="list-style-type: none"> <li>1. Is July-December data reliable?</li> <li>2. What about seasonality?</li> </ol>	<ul style="list-style-type: none"> <li>• Use 6-months data, adjust base as needed for seasonality concerns</li> <li>• Merge 2019 and 2020 data together to create a 12 month performance period</li> <li>• Use 2019 data or revenue adjustments</li> </ul>
Clinical concerns over inclusion of COVID patients	<ul style="list-style-type: none"> <li>• Remove COVID patients from CY 2020 Eligible Discharges or Readmissions</li> </ul>
Case-mix adjustment, performance standard and revenue adjustment scale concerns: <ol style="list-style-type: none"> <li>1. Inclusion of COVID patients when not in normative values</li> <li>2. Impacts on other DRG/SOI of COVID PHE</li> </ol>	<ul style="list-style-type: none"> <li>• Remove COVID patients from CY 2020 evaluation</li> <li>• Develop concurrent norms and performance standards for comparison and possible use</li> <li>• Use 2019 data or revenue adjustments</li> <li>• Modify revenue adjustment scale to recognize COVID related concerns</li> </ul>

At this stage, staff believes the most appropriate approach for the RRIP policy is to exclude the COVID-19 patients<sup>6</sup> if any CY 2020 data is used. Over the coming months, staff will work to assess any case-mix adjustment and performance standard issues due to the absence of COVID-19 patients in the base period and normative values, and to finalize the performance period. Staff will provide updates to the Commission in February, at the earliest, on the final decisions for any adjustments to all RY 2022 quality policies.

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

## **Within-Hospital Disparities in Readmissions**

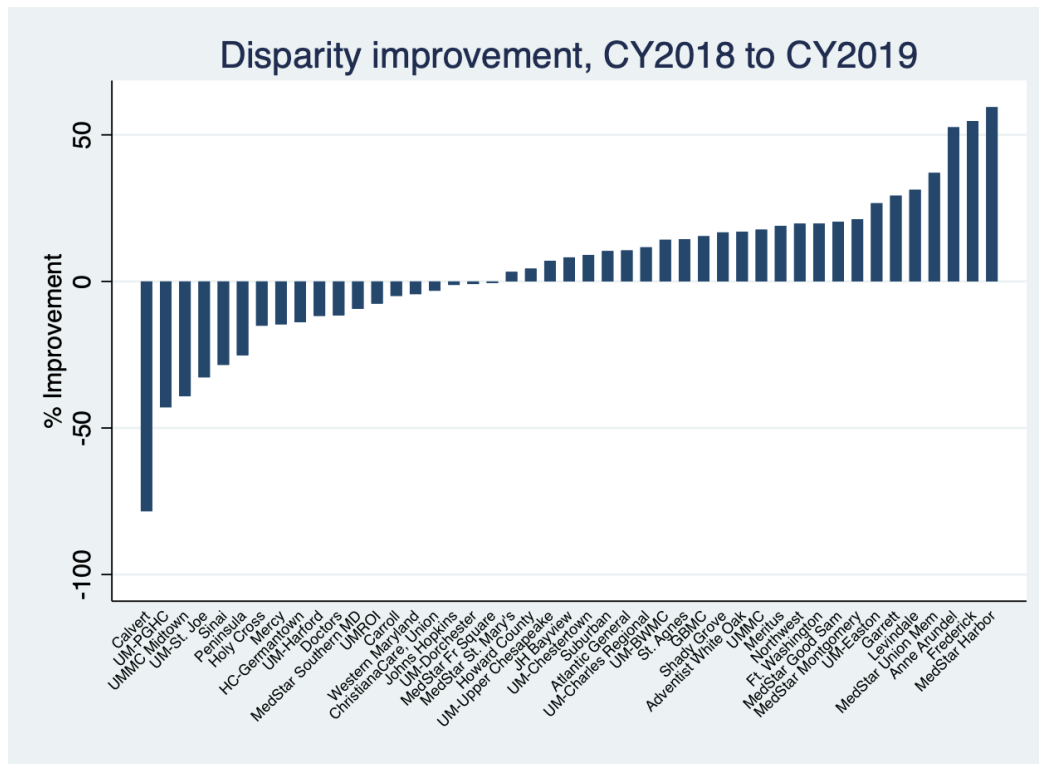
In March 2020 the Commission approved rewards for hospitals reducing socioeconomic disparities in readmission rates between CY2018 and CY2020.<sup>7</sup> Evaluation of performance for CY2019 showed 26 of 45 hospitals improved on the disparity measure (Figure 6).

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<sup>6</sup> COVID-19 cases are defined as those coded with the ICD10 code U07.1

<sup>7</sup> Details on the methodology for calculating within hospital disparities can be found in the [RY 2022 RRIP policy](#)

Figure 6: CY2019 Disparity Improvement



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

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

Because of this methodology change, Staff recommends updating the reward structure to provide rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap

measure over 8 years ( $\geq 15.91$  percent reduction in disparity gap measure 2018 to 2021), and 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years ( $\geq 29.29$  percent reduction in disparity gap measure 2018 to 2021).<sup>8</sup> Under this approach, six hospitals are currently on track to receive the lower reward, and 13 on track to receive the higher one. Staff also tends to evaluate approaches to scaling rewards between the lower and higher points.

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

## Hospital Score and Revenue Adjustment Modeling

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

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

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<sup>8</sup> Five hospitals have already improved by greater than 29.29 percent CY 2018 to CY 2019

Figure 7: Modeling of 2018-2019 Readmissions Performance

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

## Additional Future Considerations

It remains important that the HSCRC continue to compare Maryland readmission rates against national readmission rates to evaluate relative Maryland performance. Staff is presently working with CMMI to better understand the federal Hospital-wide Readmission (HWR) measure, which is publicly posted on CMS Hospital Compare once a year. It may be advantageous to better understand the federal HWR measure, as it includes a risk-adjustment; the “Waiver Test” readmission rate for Maryland is presently an unadjusted readmission rate, which may present future challenges as Maryland reduces unnecessary utilization and simultaneously increases the case-mix index of remaining eligible discharges. Additionally, a Hybrid HWR Measure was adopted by CMS in 2018 as a voluntary measure under the Hospital Inpatient Quality Reporting Program. The Hybrid HWR Measure differs from the [claims-based HWR measure](#), as it merges electronic health record (EHR) data elements with claims data to calculate the risk-standardized readmission rate.<sup>9</sup> Staff will consider potential use(s) of the HWR/HWR Hybrid measure in the future.

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

## Recommendations

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the RY 2022 approved statewide 5-year improvement target of -7.5 percent from 2018 base period.

<sup>9</sup> For additional information, see: <https://qualitynet.cms.gov/inpatient/measures/hybrid>

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



# Appendix I. Readmission Measure Specifications and Revenue Adjustment Methodology

## 1) Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra- and inter-hospital) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and planned admissions.<sup>10</sup> Unique patient identifiers from CRISP are used to be able to track patients across hospitals for readmissions.

The measure is similar to the readmission rate that is calculated by CMMI to track Maryland performance versus the nation, with some exceptions. The most notable exceptions are that the HSCRC measure includes psychiatric patients in acute care hospitals, and readmissions that occur at specialty hospitals. In comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, an additional adjustment is made to account for differences in case-mix. See below for details on the readmission calculation for the RRIP program.

## 2) Inclusions and Exclusions in Readmission Measurement

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 4.0. The HSCRC has also added all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs, rather than principal diagnosis.<sup>11</sup> Planned admissions are counted as eligible discharges in the denominator, because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.<sup>12</sup>
- **New in RY 2022:** Remove DRG oncology exclusion but continue to exclude bone marrow transplants and liquid tumor patients by making these discharges not eligible to have an unplanned readmission or count as an unplanned readmission.<sup>13</sup>
- **New in RY 2022:** Exclude patients with a discharge disposition of Left Against Medical Advice (PAT\_DISP = 71, 72, or 73 through FY 2018; 07 FY 2019 onward)
- Rehabilitation cases as identified by APR-860 (which are coded under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after

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<sup>10</sup> Planned admissions defined under [CMS Planned Admission Logic version 4 – updated March 2018].

<sup>11</sup> **Rehab DRGs:** 540, 541, 542, 560, and 860; **OB Deliveries and Associated DRGs:** 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.

<sup>12</sup> **Newborn APR-DRGs:** 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.

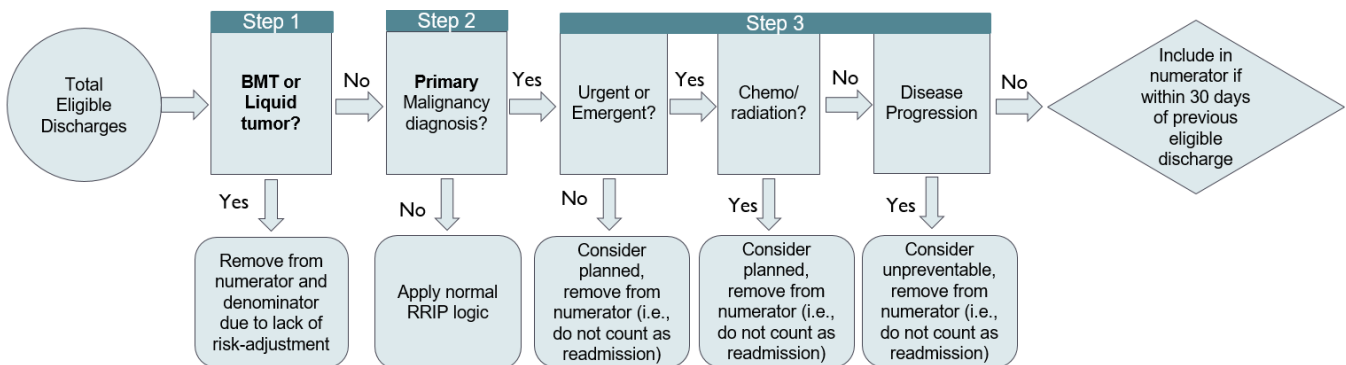
<sup>13</sup> **Bone Marrow Transplant:** Diagnosis code Z94.81 or CCS Procedure code 64; **Liquid Tumor:** Diagnosis codes C81.00-C96.0. See section below for additional details on the oncology logic.

readmission logic is run.

- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission, but can be a readmission for a previous admission.
- APR-DRG-SOI categories with less than two discharges statewide are removed.
- A hospitalization within 30 days of a hospital discharge where a patient dies is counted as a readmission; however, the readmission is removed from the denominator because the case is not eligible for a subsequent readmission.
- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same or next day as the admission date of the subsequent admission, are removed from the denominator. Thus, only one admission is counted in the denominator, and that is the admission to the transfer hospital (unless otherwise ineligible, i.e., died). It is the second discharge date from the admission to the transfer hospital that is used to calculate the 30-day readmission window.
- Beginning in RY 2019, HSCRC started discharges from chronic beds within acute care hospitals.
- In addition, the following data cleaning edits are applied:
  - Cases with null or missing CRISP unique patient identifiers (EIDs) are removed.
  - Duplicates are removed.
  - Negative interval days are removed.
 HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, hospitals are required to make sure 99.5 percent of inpatient discharges have a CRISP EID.

### Additional Details on Oncology Logic:

Flow Chart for Revised Oncology Logic



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

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

**Step 1:** Exclude discharges where patients have a bone marrow transplant procedure, bone marrow transplant related diagnosis code, or liquid tumor diagnosis. This logic varies from the NQF cancer hospital measure that risk-adjusts for bone marrow transplant and liquid tumors. HSCRC staff recommended removing these discharges (similar to current DRG exclusion) because the current indirect standardization approach did not allow for additional risk-adjustment but based on conversations with clinicians staff agreed these cases were significantly more complicated and at-risk for an unpreventable readmission.

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

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

- a) Nature of admission of urgent or emergent considered unplanned, all other nature of admission statuses are planned
- b) Any admission with primary diagnosis of chemotherapy or radiation is considered planned

- c) Any admission with primary diagnosis of metastatic cancer is not considered preventable, and thus gets excluded from being a readmission  
In step 3, admissions are deemed not eligible to be a readmission but they are eligible to have a subsequent unplanned readmission.

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

**Data Source:**

To calculate readmission rates for RRIP, inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) are used for the measurement period, with an additional 30 day runout. To calculate the case-mix adjusted readmission rate for CY 2018 base period and CY 2020 performance period, data from January 1 through December 31, plus 30 days in January of the next year are used. The base period data are used to calculate the normative values, which are used to determine a hospital's expected readmissions, as detailed below, as well as the estimated CY 2018 readmission rates.

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

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

**Calculation:**

$$\text{Case-Mix Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions)}}{\text{(Expected Readmissions)}} \quad * \text{ Statewide Base Year Readmission Rate}$$

**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.

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

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

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

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

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

**Expected Values:**

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

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

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

Let:

N = norm

P = Number of discharges with a readmission

D = Number of eligible discharges

i = An APR DRG category and a single SOI level

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

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

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

Consider the following example for a single diagnosis category.

#### Expected Value Computation Example – Individual APR-DRG

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

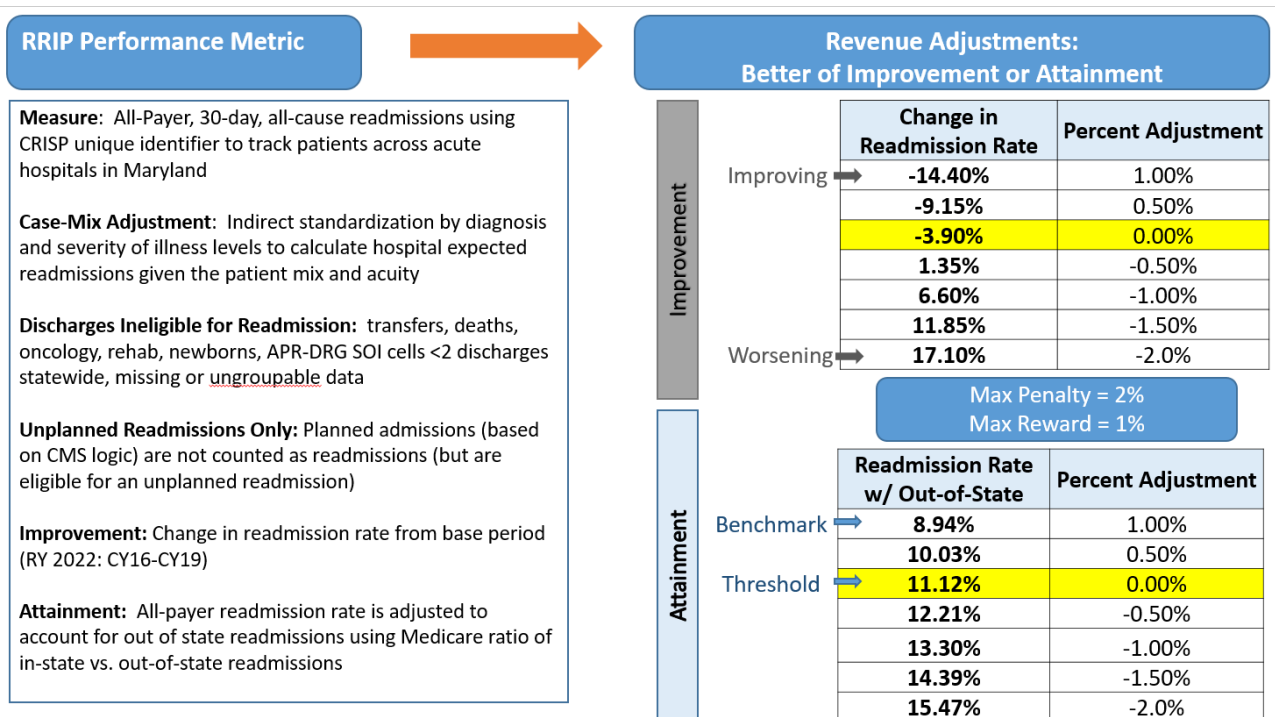
For the diagnosis category, the number of discharges with a readmission is 45, which is the sum of discharges with readmissions (column C). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of eligible discharges with a readmission (sum of column C) by the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

In this example, the expected number of readmissions for this diagnosis category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had 11.5 fewer actual discharges with readmissions than were expected for this diagnosis category. This difference can also be expressed as a percentage or the O/E ratio.

#### 4) Revenue Adjustment Methodology

The RRIP assesses improvement in readmission rates from base period, and attainment rates for the performance period with an adjustment for out-of-state readmissions. The policy then determines a hospital's revenue adjustment for improvement and attainment and takes the better of the two revenue adjustments, with scaled rewards of up to 1 percent of inpatient revenue and scaled penalties of up to 2 percent of inpatient revenue. The figure below provides a high level overview of the RY 2021 RRIP methodology for reference. For RY 2022 RRIP methodology, please see figure 1 within the policy.

Overview Rate Year 2021 RRIP Methodology



## Appendix II. RRIP Revenue Adjustment Modeling

RY 20 RRIP for Modeling – CY 18 Base; CY 19 Perf				Imp	Attainment Scaling		Improve/Attain Final Adjustment			Disparity Gap				Combined Revenue Adjustment	
HOSP ID	HOSP NAME	RY 19 Estimated Permanent Inpatient Revenue	CY18-CY19 % Δ in CM Adj Rate	% Rev Adj For Imp - 1.55%	CY18 CM Adj Rate w OOS Adj	% Rev Adj 35 <sup>th</sup> % 10.7%	\$ Better of Att or Imp	RY20 Final % Rev Adj	Rev Adj Imp or Att	CY18-CY19 % Δ in Gap	Eli g?	% Rev Adj	\$ Rev Adj	% Rev Adj	\$ Rev Adj
210001	MERITUS	\$219,551,750	-6.24%	0.45%	11.06%	-0.12%	\$987,983	0.45%	Imp	-18.99%	Yes	0.5%	\$1,097,759	0.95%	\$2,085,742
210002	UMMC	\$1,203,673,856	-3.15%	0.15%	13.14%	-0.82%	\$1,805,511	0.15%	Imp	-17.68%	Yes	0.5%	\$6,018,369	0.65%	\$7,823,880
210003	UM-PG	\$282,929,188	-5.11%	0.34%	12.43%	-0.58%	\$961,959	0.34%	Imp	42.94%	Yes	0.0%	\$0	0.34%	\$961,959
210004	HOLY CROSS	\$355,608,692	-2.47%	0.09%	12.40%	-0.57%	\$320,048	0.09%	Imp	15.12%	Yes	0.0%	\$0	0.09%	\$320,048
210005	FREDERICK	\$232,665,827	-1.23%	-0.03%	10.96%	-0.09%	-\$69,800	-0.03%	Imp	-54.71%	Yes	0.5%	\$1,163,329	0.47%	\$1,093,529
210006	UM-HARFORD	\$54,181,186	0.00%	-0.15%	11.62%	-0.31%	-\$81,272	-0.15%	Imp	11.76%	No	0.0%	\$0	-0.15%	-\$81,272
210008	MERCY	\$226,492,002	-3.57%	0.19%	12.75%	-0.69%	\$430,335	0.19%	Imp	14.65%	Yes	0.0%	\$0	0.19%	\$430,335
210009	JHH	\$1,456,687,424	0.08%	-0.15%	13.67%	-0.99%	-\$2,185,031	-0.15%	Imp	1.20%	No	0.0%	\$0	-0.15%	-\$2,185,031
210010	UM-DORCHEST	\$22,653,845	-4.50%	0.28%	9.64%	0.36%	\$81,554	0.36%	Att	0.90%	Yes	0.0%	\$0	0.36%	\$81,554
210011	ST. AGNES	\$238,757,730	-4.94%	0.32%	11.61%	-0.30%	\$764,025	0.32%	Imp	-14.38%	Yes	0.5%	\$1,193,789	0.82%	\$1,957,814
210012	SINAI	\$399,817,673	-6.66%	0.49%	11.05%	-0.12%	\$1,959,107	0.49%	Imp	28.48%	Yes	0.0%	\$0	0.49%	\$1,959,107
210015	MS-FR SQ	\$306,898,504	-5.36%	0.36%	12.62%	-0.64%	\$1,104,835	0.36%	Imp	0.53%	Yes	0.0%	\$0	0.36%	\$1,104,835
210016	WASH ADV	\$164,197,283	-3.17%	0.15%	11.71%	-0.34%	\$246,296	0.15%	Imp	-16.96%	Yes	0.5%	\$820,986	0.65%	\$1,067,282
210017	GARRETT	\$23,714,400	-32.57%	1.00%	7.94%	0.92%	\$237,144	1.00%	Imp	-29.27%	Yes	0.5%	\$118,572	1.50%	\$355,716
210018	MS-MONTG	\$84,721,645	-13.13%	1.00%	10.91%	-0.07%	\$847,216	1.00%	Imp	-21.21%	Yes	0.5%	\$423,608	1.50%	\$1,270,824
210019	PRMC	\$249,228,264	-10.55%	0.86%	10.49%	0.07%	\$2,143,363	0.86%	Imp	25.22%	Yes	0.0%	\$0	0.86%	\$2,143,363
210022	SUBURBAN	\$208,954,270	-9.41%	0.75%	11.31%	-0.20%	\$1,567,157	0.75%	Imp	-10.38%	Yes	0.5%	\$1,044,771	1.25%	\$2,611,928



RY 20 RRIP for Modeling – CY 18 Base; CY 19 Perf				Imp	Attainment Scaling		Improve/Attain Final Adjustment			Disparity Gap				Combined Revenue Adjustment	
HOSP ID	HOSP NAME	RY 19 Estimated Permanent Inpatient Revenue	CY18- CY19 % Δ in CM Adj Rate	% Rev Adj For Imp - 1.55%	CY18 CM Adj Rate w OOS Adj	% Rev Adj 35 <sup>th</sup> % 10.7%	\$ Better of Att or Imp	RY20 Final % Rev Adj	Rev Adj Imp or Att	CY18- CY19 % Δ in Gap	Eli g?	% Rev Adj	\$ Rev Adj	% Rev Adj	\$ Rev Adj
210023	AAMC	\$294,544,506	2.44%	-0.38%	12.15%	-0.49%	-\$1,119,269	-0.38%	Imp	-52.60%	No	0.0%	\$0	-0.38%	\$1,119,269
210024	MS-UNION	\$243,156,679	-3.35%	0.17%	11.99%	-0.43%	\$413,366	0.17%	Imp	-37.04%	Yes	0.5%	\$1,215,783	0.67%	\$1,629,149
210027	WESTERN MARYLAND	\$169,462,000	2.60%	-0.39%	12.65%	-0.65%	-\$660,902	-0.39%	Imp	4.34%	No	0.0%	\$0	-0.39%	-\$660,902
210028	MS-ST. MARY	\$79,141,046	-5.85%	0.41%	12.41%	-0.57%	\$324,478	0.41%	Imp	-3.28%	Yes	0.0%	\$0	0.41%	\$324,478
210029	JHBAYVIEW	\$366,607,627	-3.64%	0.20%	13.76%	-1.02%	\$733,215	0.20%	Imp	-8.22%	Yes	0.25%	\$916,519	0.45%	\$1,649,734
210030	UM- CHESTER	\$17,859,942	-7.44%	0.56%	7.80%	0.97%	\$173,241	0.97%	Att	-9.04%	Yes	0.5%	\$89,300	1.47%	\$262,541
210032	UNION OF CECIL	\$65,426,887	3.91%	-0.52%	13.34%	-0.88%	-\$340,220	-0.52%	Imp	3.19%	No	0.0%	\$0	-0.52%	-\$340,220
210033	CARROLL	\$140,291,849	3.14%	-0.45%	12.35%	-0.55%	-\$631,313	-0.45%	Imp	4.95%	No	0.0%	\$0	-0.45%	-\$631,313
210034	MS-HARBOR	\$110,392,040	-6.97%	0.52%	13.42%	-0.91%	\$574,039	0.52%	Imp	-59.46%	Yes	0.5%	\$551,960	1.02%	\$1,125,999
210035	UM-CHARL	\$76,930,098	-1.92%	0.04%	12.07%	-0.46%	\$30,772	0.04%	Imp	-11.66%	Yes	0.5%	\$384,650	0.54%	\$415,422
210037	UM-EASTON	\$103,481,053	-5.16%	0.34%	9.31%	0.47%	\$486,361	0.47%	Att	-26.70%	Yes	0.5%	\$517,405	0.97%	\$1,003,766
210038	UM-MID	\$111,141,002	-3.05%	0.14%	14.52%	-1.28%	\$155,597	0.14%	Imp	39.17%	Yes	0.0%	\$0	0.14%	\$155,597
210039	CALVERT	\$67,111,996	8.12%	-0.92%	12.26%	-0.52%	-\$348,982	-0.52%	Att	78.42%	No	0.0%	\$0	-0.52%	-\$348,982
210040	NORTHWES	\$138,719,920	-11.31%	0.93%	10.47%	0.08%	\$1,290,095	0.93%	Imp	-19.72%	Yes	0.5%	\$693,600	1.43%	\$1,983,695
210043	BWMC	\$250,217,336	-0.85%	-0.07%	11.79%	-0.37%	-\$175,152	-0.07%	Imp	-14.23%	Yes	0.5%	\$1,251,087	0.43%	\$1,075,935
210044	G.B.M.C.	\$237,787,317	1.13%	-0.25%	10.93%	-0.08%	-\$190,230	-0.08%	Att	-15.43%	No	0.0%	\$0	-0.08%	-\$190,230
210048	HOWARD	\$182,870,977	2.42%	-0.38%	11.62%	-0.31%	-\$566,900	-0.31%	Att	-4.38%	No	0.0%	\$0	-0.31%	-\$566,900
210049	UM-UCH	\$128,686,091	-0.17%	-0.13%	11.83%	-0.38%	-\$167,292	-0.13%	Imp	-7.06%	Yes	0.25%	\$321,715	0.12%	\$154,423
210051	DOCTORS	\$141,094,311	-9.17%	0.73%	10.88%	-0.06%	\$1,029,988	0.73%	Imp	11.59%	Yes	0.0%	\$0	0.73%	\$1,029,988

RY 20 RRIP for Modeling – CY 18 Base; CY 19 Perf				Imp	Attainment Scaling		Improve/Attain Final Adjustment			Disparity Gap				Combined Revenue Adjustment	
HOSP ID	HOSP NAME	RY 19 Estimated Permanent Inpatient Revenue	CY18-CY19 % Δ in CM Adj Rate	% Rev Adj For Imp - 1.55%	CY18 CM Adj Rate w OOS Adj	% Rev Adj 35 <sup>th</sup> % 10.7%	\$ Better of Att or Imp	RY20 Final % Rev Adj	Rev Adj Imp or Att	CY18-CY19 % Δ in Gap	Eli g?	% Rev Adj	\$ Rev Adj	% Rev Adj	\$ Rev Adj
210056	MS-GOOD SAMARITAN	\$146,901,579	-6.93%	0.51%	12.98%	-0.76%	\$749,198	0.51%	Imp	-20.37%	Yes	0.5%	\$734,508	1.01%	\$1,483,706
210057	SHADY GR	\$251,748,234	-8.49%	0.66%	10.09%	0.21%	\$1,661,538	0.66%	Imp	-16.74%	Yes	0.5%	\$1,258,741	1.16%	\$2,920,279
210058	UMROI	\$72,350,285	31.86%	-2.00%	11.30%	-0.20%	-\$23,152	-0.03%	Att	7.57%	No	0.00%	\$0	-0.03%	-\$23,152
210060	FT. WASH	\$19,890,383	11.19%	-1.21%	14.10%	-1.14%	-\$226,750	-1.14%	Att	-19.73%	No	0.00%	\$0	-1.14%	-\$226,750
210061	ATLANTIC GENERAL	\$36,931,910	-5.31%	0.36%	10.01%	0.23%	\$132,955	0.36%	Imp	-10.59%	Yes	0.50%	\$184,660	0.86%	\$317,615
210062	MS-SO MD	\$162,087,856	4.01%	-0.53%	13.02%	-0.78%	-\$859,066	-0.53%	Imp	9.33%	No	0.00%	\$0	-0.53%	-\$859,066
210063	UM ST. JOE	\$223,399,907	-0.44%	-0.11%	11.48%	-0.26%	-\$245,740	-0.11%	Imp	32.73%	Yes	0.00%	\$0	-0.11%	-\$245,740
210064	LEVINDALE	\$57,510,719	-8.68%	0.68%	10.00%	0.24%	\$391,073	0.68%	Imp	-31.28%	Yes	0.50%	\$287,554	1.18%	\$678,627
210065	HC GTOWN	\$59,062,315	-5.79%	0.40%	11.90%	-0.40%	\$236,249	0.40%	Imp	13.92%	Yes	0.00%	\$0	0.40%	\$236,249
<b>STATEWIDE</b>		<b>\$9,685,539,404</b>					<b>Net Reward/Penalty</b>	<b>\$13,947,627</b>					<b>\$20,288,666</b>		<b>\$34,236,293</b>
Penalty						Penalty	-\$7,891,071						\$0		-\$7,478,827
Reward						Reward	\$21,838,698						\$20,288,666		\$41,715,120

Values for PG hospital represent just PG Hospital  
Percentages have been rounded for display. Final scaling values are rounded to two decimal places.



**TO:** HSCRC Commissioners  
**FROM:** HSCRC Staff  
**DATE:** December 9, 2020  
**RE:** Hearing and Meeting Schedule

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January 13, 2021 To be determined - 4160 Patterson Avenue  
HSCRC/MHCC Conference Room

February 10, 2021 To be determined – 4160 Patterson Avenue  
HSCRC/MHCC Conference Room

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

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

**Adam Kane, Esq**  
Chairman

**Joseph Antos, PhD**  
Vice-Chairman

**Victoria W. Bayless**

**Stacia Cohen, RN, MBA**

**John M. Colmers**

**James N. Elliott, MD**

**Sam Malhotra**

.....  
**Katie Wunderlich**  
Executive Director

**Allan Pack**  
Director  
Population-Based Methodologies

**Tequila Terry**  
Director  
Payment Reform & Provider Alignment

**Gerard J. Schmith**  
Director  
Revenue & Regulation Compliance

**William Henderson**  
Director  
Medical Economics & Data Analytics