STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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504th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
January 8, 2014

EXECUTIVE SESSION
12:00 p.m.

1. **Waiver and Personnel Update**
2. **Future Meeting Dates**
3. **Budget and Legislative Update**

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

1. **Review of the Minutes from the Executive Session and Public Meeting on December 4, 2013**

2. **Executive Director's Report**

3. **Update on Activities of the Advisory Council on All-Payer Hospital System Modernization**

4. **Docket Status – Cases Closed**

   2234N – Peninsula Regional Medical Center
   2235A – Johns Hopkins Health System
   2236A – Johns Hopkins Health System
   2237A – Johns Hopkins Health System

5. **Docket Status – Cases Open**

   2238A – Johns Hopkins Health System
   2239A – Johns Hopkins Health System
   2240A – Johns Hopkins Health System

6. **Draft Recommendations for Transitional Rate Setting Policies to Govern the Implementation of the Proposed All-Payer Model Effective January 1, 2014**

7. **Final Recommendations for Updating the Quality Based Reimbursement and Maryland Hospital Acquired Conditions Programs from FY 2016**

8. **Hearing and Meeting Schedule**

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

AS OF DECEMBER 17, 2013

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
2238A	Johns Hopkins Health System	11/25/2013	N/A	N/A	ARM	DNP	OPEN
2239A	Johns Hopkins Health System	11/25/2013	N/A	N/A	ARM	DNP	OPEN
2240A	Johns Hopkins Health System	11/25/2013	N/A	N/A	ARM	DNP	OPEN

NONE

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2013**
SYSTEM	*	**FOLIO:**	**2048**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2238A**

Staff Recommendation

January 8, 2014

I. INTRODUCTION

Johns Hopkins Health System (System) filed an application with the HSCRC on November 25, 2013 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular and orthopedic services with PepsiCo, Inc. for a period of one year beginning January 1, 2014.

II. OVE RVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular and orthopedic services for a one year period commencing January 1, 2014. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2013**
SYSTEM	*	**FOLIO:**	**2049**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2239A**

Staff Recommendation

January 8, 2014

I. INTRODUCTION

Johns Hopkins Health System (the “System”) filed an application with the HSCRC on November 25, 2014 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a global rate arrangement for joint replacement and cardiovascular services with Health Design Plus, Inc. for clients other than those of Pacific Business Group on Health for a period of one year beginning January 1, 2014.

II. OVE RVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The format utilized to calculate the case rates, i.e., historical data for like cases, has been utilized as the basis for other successful joint replacement and cardiovascular arrangements in which the Hospitals are currently participating. Staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement and cardiovascular services for a one year period commencing January 1, 2014. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2013**
SYSTEM	*	**FOLIO:**	**2050**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2240A**

Staff Recommendation

January 8, 2014

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on November 25, 2014 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a global rate arrangement for joint replacement services with Health Design Plus, Inc. for Pacific Business Group on Health clients for a period of one year beginning January 1, 2014.

II. OVE RVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The format utilized to calculate the case rates, i.e., historical data for like cases, has been

utilized as the basis for other successful joint replacement arrangements in which the Hospitals are currently participating. Staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement services for a one year period commencing January 1, 2014. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Final Recommendation for Updating the Quality Based Reimbursement and Maryland Hospital Acquired Conditions Programs for FY 2016

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

January 8, 2014

This document contains the final staff recommendations for updating the Quality Based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHAC) Programs for FY 2016 for consideration at the January 8, 2014 Public Commission Meeting.

Final Recommendation for Updating the Quality Based Reimbursement (QBR) and Maryland Hospital Acquired Condition (MHAC) Programs

A. Introduction

The HSCRC quality-based scaling methodologies and magnitudes "at risk" are important policy tools for providing strong incentives for hospitals to improve their quality performance over time.

Current HSCRC policy calls for the revenue neutral scaling of hospitals in allocating rewards and penalties based on performance on the HCSRC's Quality-based Reimbursement ("QBR") and Maryland Hospital Acquired Conditions ("MHAC") initiatives. The term "scaling" refers to the differential allocation of a pre-determined portion of base regulated hospital revenue based on assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year; scaling amounts applied for quality performance are applied on a "one-time" basis (and not considered permanent revenue).

The reward and penalty allocations for the quality programs are computed on a "revenue neutral" basis for the system as a whole. This means that the net increases in rates for better performing hospitals are funded entirely by net decreases in rates for poorer performing hospitals. For State FY 2015 rates, as approved by the Commission, the HSCRC will scale a maximum penalty of 0.5% of base approved hospital inpatient revenue for the QBR program (which was the same level as FYs 2010 through 2014), and 3% for the MHAC program (which includes 2% for performance and 1% for improvement); this is a total of 3.5% of hospital base revenue related to quality.

Staff recommends updating the scaling magnitudes and methodologies to translate scores into rate updates for the QBR and MHACs initiatives to be applied to FY 2016 rates for each hospital.

B. Background

1. Centers for Medicare & Medicaid Services (CMS) Value Based Purchasing (VBP) and Hospital Acquired Conditions (HAC) Programs

The Patient Protection and Affordable Care Act of 2010 requires CMS to fund the aggregate Hospital VBP incentive payments by reducing the base operating diagnosis-related group (DRG) payment amounts that determine the Medicare payment for each hospital inpatient discharge. The law set the reduction at one percent in FY 2013, rising to 2 percent by FY 2017.

For the federal FY 2015 (October 1 to September 30) Hospital VBP program, CMS measures include four domains of hospital performance: clinical process of care; patient experience of care (HCAHPS survey measure); outcomes; and efficiency/Medicare spending per beneficiary. Results are weighted by CMS as listed below.

Figure 1. CMS VBP Domain Weights, FY 2015

	Clinical/Process	Patient Experience	Outcome	Efficiency/Medicare spending/beneficiary
FFY 2015	20%	30%	30%	20%

CMS has indicated its future emphasis will increasingly lean toward outcomes in the VBP program. Staff notes that for the CMS VBP program for FY 2015, CMS added additional outcome measures, including the Agency for Healthcare Research and Quality ("AHRQ") Patient Safety Indicator ("PSI") 90 Composite measure and the Centers for Disease Control National Health Safety Network ("CDC-NHSN") Central Line Associated Blood Stream Infection (CLABSI) measure.

The federal HAC program began in FFY 2012 when CMS disallowed an increase in DRG payment for cases with added complications in 14 narrowly defined categories. Beginning in FFY 2015, CMS established a second HAC program, which reduces payments of hospitals with scores in the top quartile for the performance period on their rate of Hospital Acquired Conditions as compared to the national average. In FY 2015, the maximum reduction is 1 percent for all DRGs. HSCRC staff also notes that CMS is using the PSI 90 Composite and the CDC CLABSI and Catheter-Associated Urinary Tract Infection ("CAUTI") measures for its HAC program, with PSI 90 and CLABSI also added to the VBP program, as noted above.

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

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

The QBR program uses the CMS/Joint Commission core process measures—e.g., aspirin upon arrival for the patient diagnosed with heart attack—, eight "patient experience of care" or Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") measures, and a mortality domain newly adopted for rate year 2015 performance which includes all-cause inpatient mortality using the 3M Risk of Mortality classifications; the weighting for each domain is illustrated below.

Figure 2. Maryland QBR Domain Weights, FY 2015

	Clinical/Process	Patient Experience	Outcome
State FY 2015	40%	50%	10%

The QBR and MHAC Programs in Maryland together are consistent in design and intent with the CMS VBP program, and target performance on a robust set of process of care/effectiveness measures, patient safety measures, preventable complication rates, mortality rates, and patient experience of care measures. The programmatic elements of both the QBR and MHAC programs together comprise "VBP-like" measures that overlap the two programs.

The MHAC program currently uses a large subset of the 65 Potentially Preventable Complications developed by 3M Health Information Systems, which computes actual versus expected rates of complications adjusted for each patient by the All Patient Refined Diagnosis Related Group ("APR DRG"), and severity of illness ("SOI") category. The attainment scale measures the proportion of each hospital's inpatient revenue from excess PPCs compared to the benchmarks. For FY 15, the Commission approved targeting improvement in the following measures for scaling 1% of inpatient revenue, bringing the "at risk" revenue to 3% for the MHAC program. The 5 measures targeted under the improvement methodology are PPC5 – Pneumonia and Other Lung Infections, PPC6 – Aspiration Pneumonia, PPC16 – Venous Thrombosis, PPC24 – Renal Failure without Dialysis, and PPC35 – Septicemia and Severe

Infections. Each year, staff will re-evaluate the PPCs used for the improvement scale based on improvement rates, prevalence, cost, and policy considerations and input from MHAC/QBR work group.

The overall risk adjusted hospital-acquired potentially preventable complication (PPC) rates have declined from the first quarter of state fiscal year 2011 to the present by 34.6%. For FY 2015, the expected performance benchmark is calculated using a value of 15% below the statewide average performance for each PPC used in the MHAC program, as approved by the Commission last year.

Appendix II lists the measures used for the QBR and MHAC programs for FY 2015.

3. *Value Based Purchasing Exemption Provisions*

Pursuant to 1886(o)(1)(C)(iv) of the Social Security Act, "the Secretary may exempt such hospitals from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection." VBP exemptions have been requested and granted for FYs 2013 and 2014. A VBP exemption request for FY 2015, which includes a report of Maryland's health outcomes and cost savings for the MHAC and QBR programs and a support letter from Secretary Sharfstein, was submitted to HHS Secretary Sebelius on November 15, 2013.

C. Assessment

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

Staff examined measures proposed for the CMS VBP and HAC programs and those in the potential pool for the QBR program and in the MHAC program for 2015 and 2016 and notes that Maryland lags behind in adopting measures.

Staff has convened three work group meetings last two months and has deliberated the addition of both the AHRQ PSI 90 measure and of the CMS CLABSI measure to the QBR program for FY 2016, again, both of which were already added to the CMS VBP program as of FY 2015. Staff believes there was broad agreement in the most recent work group meeting convened to add these measures for FY 2016, as well as to weight the measure domains as illustrated below, particularly in light of lacking an efficiency domain, and the need to continue to focus on HCAHPS and to further focus on outcomes. Figure 3 details the CMS VBP domain weights compared with the Maryland domain weights for FY 2016.

Figure 3. CMS VBP and Maryland QBR Domain Weights, FY 2016

FY 2016	Clinical/ Process	Patient Experience	Outcome	Efficiency
CMS VBP	10%	25%	40%	25%
Maryland QBR	30%	40%	30%	N/A

In addition to the added measures, the group agreed to align the list of process of care measures, threshold and benchmark values, and time lag periods with those used by CMS.[1] This will allow HSCRC to use the data submitted directly to CMS and to align our performance scores precisely, which to date have been slightly different from CMS'. Because CMS has a 9 month lag in the performance period in the data they release and because they use four rolling quarters to update hospitals' performance scores, the group agreed to move the performance period back by one quarter for FY 2015 and use October 1, 2012 to September 30, 2013, and use this same performance period going forward. This results in counting CY 2012 quarter 4 for performance in both FY 2014 and FY 2015. HSCRC agreed to re-calculate QBR scores using the original performance period of CY 2013 when the data becomes available and to make any adjustments if the difference in scores are significant in FY 2016.. This recalculation will occur only for CY2013 measurement year as the timelines will be aligned with the proposed schedule in FY2016.

Appendix III details the baseline and performance periods for both the QBR and MHAC programs for 2014 through 2017.

To determine the potential impact of increasing the amount of revenue at risk for the QBR program, and in order to have an "at risk" magnitude consistent with the CMS VBP program, staff conducted modeling using the most recent results for FY 2014 to consider altering the magnitude of scaling to 1% of total inpatient revenue. The results in Appendix IV reveal that a total of $8,430,202 is redistributed under the revenue neutral scaling methodology. There was broad agreement at the last work group meeting to increase the revenue "at risk" to 1% for FY 2016.

For the MHAC program, the QBR MHAC work group convened on December 13, 2013 to discuss modifications to the current MHAC program. Representing the industry, the MHA presented issues of concern they have with the current MHAC scaling approach used to translate performance into payment of rewards and penalties, and outlined generally the areas where changes to the policy should be considered—see Appendix V. Of note, the MHA presentation highlighted the concerns that:

- the MHAC reduction goals should be more directly aligned with the new waiver targets;
- there is little hospital-level predictability of revenue rewards and penalties with the current approach where hospital performance is scaled relative to other hospitals' performance after the performance period is ended; and,
- the scaling approach also promotes competition rather than collaboration and sharing of best practices to reduce MHACs.

The MHA strongly advised the Commission to consider a revised MHAC approach that could be finalized in part way into the measurement period of CY 2014 but applied retroactively starting January 1, 2014. The revised approach would set individual targets for hospitals and for each PPC, allowing hospitals to earn back part or all of the revenue set aside for the program based on levels of performance.

[1] HSCRC has used core measures data submitted to MHCC and applied state-based benchmarks and thresholds to calculate hospitals' QBR scores up to the period used for State FY 2015 performance.

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

- Modify the benchmark for the FY 2016 to one that constitutes a more linear relationship between performance and scaling.
- Make minimal adjustments to the measure list used based on the updated regression results.
- Add measures to the "improvement" PPC list by considering as candidate measures:
  - PPCs that overlap with the new CMS HAC program Domain 1, specifically those that comprise the AHRQ PPC 90 Composite measure; and,
  - PPCs recommended by MHA that are high cost, high volume, have opportunity to improve and align directly with the new waiver targets.
- Establishing a minimum threshold number of total PPC cases for including hospitals in the improvement scale.

As updating the measures does not require Commission approval, HSCRC will continue to work with stakeholders to receive input on recommended MHAC measure updates.

A memo summarizing the changes in the QBR and MHAC methodologies with the required benchmark data will be sent to the hospitals in January.

In order to enhance our ability to meet the targets proposed in the CMMI All-payer model demonstration application, the Commission will be conducting a series of work groups to discuss pertinent issues and potential changes to current Commission policy. A Performance Measurement and Improvement Work Group will be convened in early 2014 to consider issues relating to the Commission quality initiatives such as redesigning the incentives and shifting from revenue neutral scaling to establishing targets that allow hospitals to earn up to the full designated amounts if they meet the targets. While it is likely that any changes would apply to FY 17 payment policy, it is possible that the recommendations in this report for FY 16 could be altered after taking into account the timing and implications of the data available for the base and performance periods for payment adjustment. The work group will also be developing readmission and efficiency policies and a timeline and process for implementation under the new model. The readmission policy will be effective by July 1, 2014, and the efficiency standard at a future designated date.

D. Recommendations

For QBR and MHAC scaling, staff provides the following recommendations:

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

Appendix I. CMS VBP and HAC Measures for FY 2015

Process of Care Measures
AMI–7a ..... Fibrinolytic Therapy Received Within 30 Min- utes of Hospital Arrival.
AMI–8a ..... Primary PCI Received Within 90 Minutes of Hospital Arrival.
PN–3b ..... Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Re- ceived in Hospital.
PN–6 ..... Initial Antibiotic Selection for CAP inImmunocompetent Patient.
SCIP–Card–2 .... Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta- Blocker During the Perioperative Period.
SCIP–Inf–1 ..... Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.
SCIP–Inf–2 ..... Prophylactic Antibiotic Selection for Surgical Patients.
SCIP–Inf–3 ..... Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time.
SCIP–Inf–4 ..... Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose.
SCIP–Inf–9 ..... Urinary Catheter Removed on Postoperative Day 1 or Postoperative Day 2.
SCIP–VTE–2……. Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxes Within 24 Hours Prior to Surgery to 24 Hours After Surgery.
MORT–30–AMI, MORT–30–HF , MORT–30–PN
PSI–90
CDC NHSN- CLABSI

HCAHPS Survey Dimension
Communication with Nurses .....
Communication with Doctors .....
Responsiveness of Hospital Staff .....
Pain Management .....
Communication about Medicines .....
Hospital Cleanliness & Quietness .....
Discharge Information .....
Overall Rating of Hospital .....

CMS HAC MEASURES Implemented Since FY 2012

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

CMS HAC Measures Implemented FY 2015

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

Appendix II: QBR and MHAC Measures, FY 2015

QBR Measures

DOMAIN	MEASURE
AMI	AMI-8a - Primary PCI Received Within 90 Minutes of Hospital Arrival
CAC	CAC-3-Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver
HF	HF-1 Discharge instructions
IMM	IMM-1a Pneumococcal vaccination
IMM	IMM-2 Influenza vaccination
PN	PN-3b Blood culture before first antibiotic – Pneumonia
PN	PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
SCIP	SCIP INF 1- Antibiotic given within 1 hour prior to surgical incision
SCIP	SCIP INF 4- Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose
SCIP	SCIP INF 9- Urinary catheter removed on Postoperative Day 1 or Postoperative Day 2

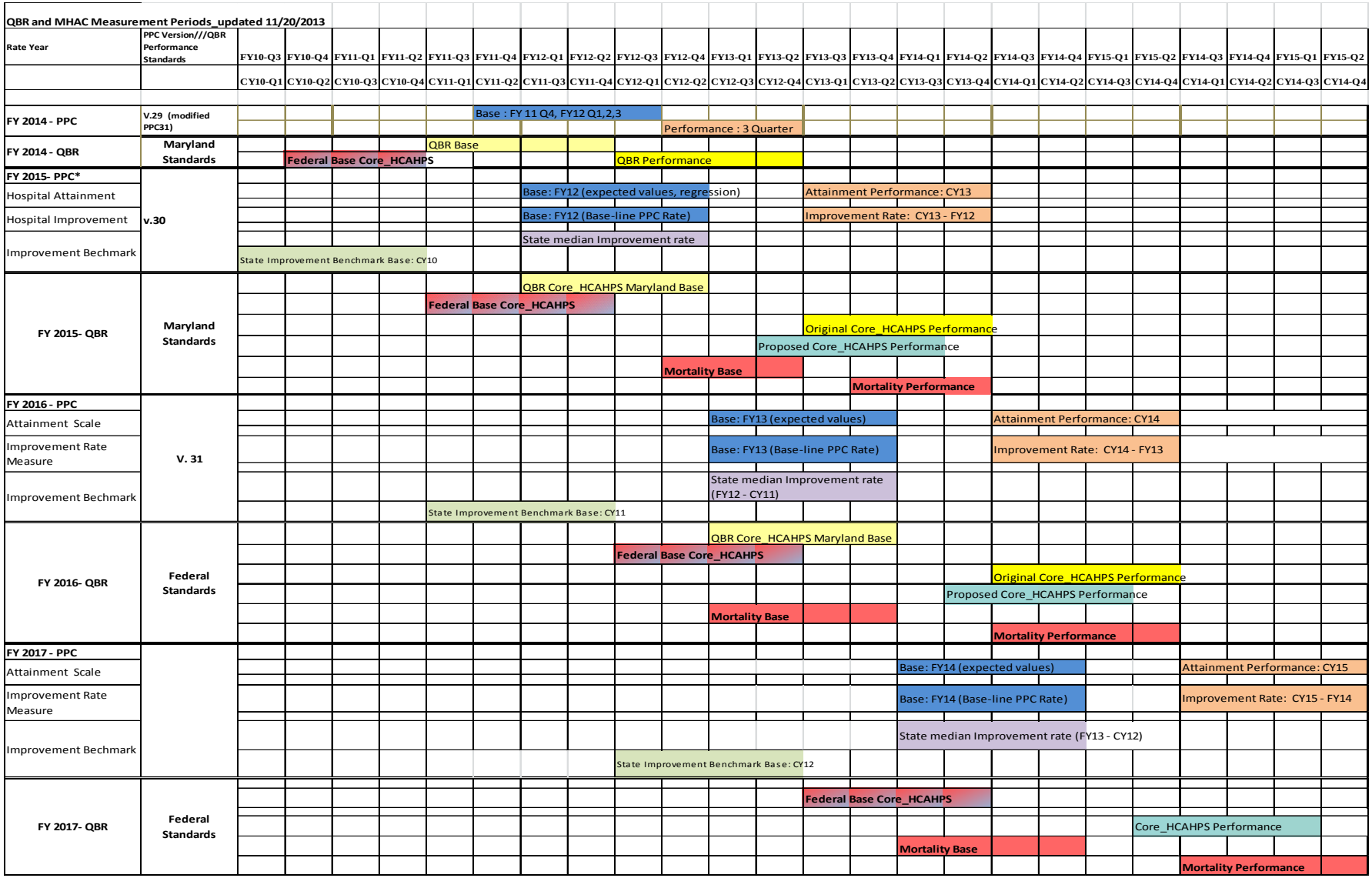
Domain	MEASURE
HCAHPS	Cleanliness and Quiteness of Hospital Envir
HCAHPS	Communication About Medicines (Q16-Q17)
HCAHPS	Communication With Doctors (Q5-Q7)
HCAHPS	Communication With Nurses (Q1-Q3)
HCAHPS	Discharge Information (Q19-Q20)
HCAHPS	Overall Rating of this Hospital
HCAHPS	Pain Management (Q13-Q14)
HCAHPS	Responsiveness of Hospital Staff (Q4,Q11)

Domain	Measure
MORTALITY	**3M Risk of Mortality**

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

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

Appendix III. MHAC and QBR Base and Performance Periods, FY 2014-2017



Appendix IV

QBR Continuous Linear Scaling of Maximum Penalty of 0.50% vs. 1.00% of Hospital Inpatient CPC Revenue with Revenue Neutrality Adjustment - For Rate Year FY 2014

HOSPID	HOSPITAL NAME	GROSS INPATIENT CPC/CPE REVENUE	QBR FINAL SCORE	SCALING BASIS 0N 0.50%	SCALING BASIS 0N 1.00%	REVENUE IMPACT OF SCALING 0.50%	REVENUE IMPACT OF SCALING 1.00%	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING 0.50%	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING 1.00%	REVENUE NEUTRAL ADJUSTED GROSS REVENUE 0.50%	REVENUE NEUTRAL ADJUSTED GROSS REVENUE 1.00%	REVENUE NEUTRAL ADJUSTED PERCENT 0.50%	REVENUE NEUTRAL ADJUSTED PERCENT 1.00%
A	B	C	D	E	F	G	H	I	J	K	L	M	N
210003	Prince Georges Hospital Center	$163,205,248	0.2972	-0.500%	-1.000%	-$816,026	-$1,632,052	-$816,026	-$1,632,052	$162,389,221	$161,573,195	-0.500%	-1.000%
210043	Baltimore Washington Medical Center	$184,662,660	0.4688	-0.216%	-0.433%	-$399,417	-$798,834	-$399,417	-$798,834	$184,263,243	$183,863,826	-0.216%	-0.433%
210012	Sinai Hospital	$362,977,920	0.4811	-0.196%	-0.392%	-$711,291	-$1,422,583	-$711,291	-$1,422,583	$362,266,629	$361,555,337	-0.196%	-0.392%
210051	Doctors Community Hospital	$119,486,136	0.4867	-0.187%	-0.373%	-$223,082	-$446,165	-$223,082	-$446,165	$119,263,054	$119,039,971	-0.187%	-0.373%
210062	Southern Maryland Hospital Center	$145,134,232	0.4923	-0.177%	-0.355%	-$257,531	-$515,061	-$257,531	-$515,061	$144,876,701	$144,619,171	-0.177%	-0.355%
210061	Atlantic General Hospital	$33,780,340	0.4938	-0.175%	-0.350%	-$59,103	-$118,206	-$59,103	-$118,206	$33,721,237	$33,662,134	-0.175%	-0.350%
210022	Suburban Hospital	$151,177,296	0.5002	-0.164%	-0.329%	-$248,508	-$497,017	-$248,508	-$497,017	$150,928,788	$150,680,279	-0.164%	-0.329%
210015	Franklin Square Hospital Center	$241,738,193	0.5108	-0.147%	-0.294%	-$355,010	-$710,020	-$355,010	-$710,020	$241,383,183	$241,028,173	-0.147%	-0.294%
210055	Laurel Regional Hospital	$53,359,459	0.514	-0.142%	-0.283%	-$75,539	-$151,078	-$75,539	-$151,078	$53,283,920	$53,208,381	-0.142%	-0.283%
210040	Northwest Hospital Center	$121,348,486	0.5191	-0.133%	-0.266%	-$161,557	-$323,114	-$161,557	-$323,114	$121,186,929	$121,025,372	-0.133%	-0.266%
210024	Union Memorial Hospital	$215,726,275	0.5248	-0.124%	-0.247%	-$266,878	-$533,755	-$266,878	-$533,755	$215,459,397	$215,192,520	-0.124%	-0.247%
210013	Bon Secours Hospital	$70,685,898	0.5345	-0.108%	-0.215%	-$76,111	-$152,221	-$76,111	-$152,221	$70,609,787	$70,533,677	-0.108%	-0.215%
210035	Civista Medical Center	$60,770,370	0.5438	-0.092%	-0.185%	-$56,090	-$112,180	-$56,090	-$112,180	$60,714,280	$60,658,190	-0.092%	-0.185%
210056	Good Samaritan Hospital	$172,932,011	0.5485	-0.085%	-0.169%	-$146,176	-$292,353	-$146,176	-$292,353	$172,785,835	$172,639,658	-0.085%	-0.169%
210032	Union of Cecil	$60,653,880	0.551	-0.080%	-0.161%	-$48,763	-$97,525	-$48,763	-$97,525	$60,605,117	$60,556,355	-0.080%	-0.161%
210011	St. Agnes Hospital	$209,768,089	0.5535	-0.076%	-0.153%	-$159,973	-$319,946	-$159,973	-$319,946	$209,608,116	$209,448,143	-0.076%	-0.153%
210048	Howard County General Hospital	$146,791,098	0.5673	-0.053%	-0.107%	-$78,454	-$156,909	-$78,454	-$156,909	$146,712,644	$146,634,189	-0.053%	-0.107%
210039	Calvert Memorial Hospital	$57,493,422	0.5756	-0.040%	-0.079%	-$22,839	-$45,677	-$22,839	-$45,677	$57,470,583	$57,447,745	-0.040%	-0.079%
210034	Harbor Hospital Center	$116,221,680	0.5793	-0.034%	-0.067%	-$39,058	-$78,117	-$39,058	-$78,117	$116,182,622	$116,143,563	-0.034%	-0.067%
210029	Johns Hopkins Bayview Medical Center	$248,923,504	0.5963	-0.006%	-0.011%	-$13,693	-$27,386	-$13,693	-$27,386	$248,909,811	$248,896,118	-0.006%	-0.011%
210002	University of Maryland Hospital	$783,335,558	0.6008	0.002%	0.004%	$15,188	$30,376	$11,838	$23,675	$783,347,396	$783,359,233	0.002%	0.003%
210030	Chester River Hospital Center	$26,318,692	0.6017	0.003%	0.007%	$902	$1,804	$703	$1,406	$26,319,395	$26,320,098	0.003%	0.005%
210060	Fort Washington Medical Center	$16,249,592	0.6082	0.014%	0.028%	$2,303	$4,606	$1,795	$3,590	$16,251,387	$16,253,182	0.011%	0.022%
210005	Frederick Memorial Hospital	$170,650,516	0.609	0.015%	0.031%	$26,444	$52,887	$20,611	$41,221	$170,671,127	$170,691,737	0.012%	0.024%
210018	Montgomery General Hospital	$79,741,456	0.6187	0.032%	0.063%	$25,145	$50,289	$19,598	$39,196	$79,761,054	$79,780,652	0.025%	0.049%
210019	Peninsula Regional Medical Center	$219,461,838	0.6188	0.032%	0.063%	$69,565	$139,130	$54,220	$108,440	$219,516,058	$219,570,278	0.025%	0.049%
210027	Western MD Regional Medical Center	$159,433,379	0.6241	0.040%	0.081%	$64,508	$129,015	$50,278	$100,556	$159,483,657	$159,533,935	0.032%	0.063%
210023	Anne Arundel Medical Center	$250,956,754	0.6255	0.043%	0.086%	$107,347	$214,694	$83,668	$167,336	$251,040,422	$251,124,090	0.033%	0.067%
210001	Meritus Hospital	$165,746,592	0.6308	0.052%	0.103%	$85,422	$170,843	$66,579	$133,158	$165,813,171	$165,879,750	0.040%	0.080%
210017	Garrett County Memorial Hospital	$17,951,439	0.6345	0.058%	0.115%	$10,350	$20,700	$8,067	$16,134	$17,959,506	$17,967,573	0.045%	0.090%
210049	Upper Chesapeake Medical Center	$115,418,544	0.6438	0.073%	0.146%	$84,291	$168,581	$65,697	$131,394	$115,484,241	$115,549,938	0.057%	0.114%
210044	Greater Baltimore Medical Center	$184,989,402	0.6457	0.076%	0.152%	$140,909	$281,819	$109,827	$219,654	$185,099,229	$185,209,056	0.059%	0.119%
210007	St. Joseph Medical Center	$180,611,979	0.6463	0.077%	0.154%	$139,367	$278,733	$108,624	$217,249	$180,720,603	$180,829,228	0.060%	0.120%
210016	Washington Adventist Hospital	$155,015,406	0.6517	0.086%	0.172%	$133,455	$266,910	$104,017	$208,033	$155,119,423	$155,223,439	0.067%	0.134%
210004	Holy Cross Hospital	$276,326,064	0.6532	0.089%	0.177%	$244,745	$489,491	$190,758	$381,516	$276,516,822	$276,707,580	0.069%	0.138%
210057	Shady Grove Adventist Hospital	$195,270,023	0.666	0.110%	0.219%	$214,276	$428,553	$167,010	$334,020	$195,437,033	$195,604,043	0.086%	0.171%
210008	Mercy Medical Center	$191,948,526	0.687	0.144%	0.289%	$277,274	$554,549	$216,112	$432,223	$192,164,638	$192,380,749	0.113%	0.225%
210037	Memorial Hospital at Easton	$82,689,144	0.6998	0.166%	0.331%	$136,945	$273,891	$106,737	$213,474	$82,795,881	$82,902,618	0.129%	0.258%
210038	Maryland General Hospital	$105,819,110	0.7008	0.167%	0.335%	$177,001	$354,003	$137,957	$275,915	$105,957,067	$106,095,025	0.130%	0.261%
210033	Carroll Hospital Center	$118,189,180	0.7018	0.169%	0.338%	$199,647	$399,293	$155,607	$311,215	$118,344,787	$118,500,395	0.132%	0.263%
210006	Harford Memorial Hospital	$42,495,040	0.739	0.230%	0.461%	$97,919	$195,837	$76,319	$152,638	$42,571,359	$42,647,678	0.180%	0.359%
210010	Dorchester General Hospital	$28,755,684	0.7679	0.278%	0.556%	$79,999	$159,999	$62,353	$124,705	$28,818,037	$28,880,389	0.217%	0.434%
210009	Johns Hopkins Hospital	$843,010,098	0.8032	0.337%	0.673%	$2,837,275	$5,674,550	$2,211,412	$4,422,825	$845,221,510	$847,432,923	0.262%	0.525%
210028	St. Mary's Hospital	$53,846,970	0.8667	0.442%	0.883%	$237,761	$475,521	$185,314	$370,628	$54,032,284	$54,217,598	0.344%	0.688%
	Statewide Total	$7,401,067,183				$1,192,936	$2,385,872	$0	$0	$7,401,067,183	$7,401,067,183		
		Average Score:	59.96%	**Total rewards**		5,408,037	10,816,073	0.779414	0.779414				
				Total Penalties		-4,215,101	-8,430,202						

Appendix V. MHA MHAC Policy Change Considerations

Maryland
Hospital Association

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DRAFT

MHAC Payment Policy Changes

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

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

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

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

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

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

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

George H. Bone, M.D.

Stephen F. Jencks, M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus, M.D.

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Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: December 20, 2013

RE: Hearing and Meeting Schedule

Public Session:

February 5, 2014 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room
March 12, 2014 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

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

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

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