Maryland
Hospital Association

January 5, 2015

Dianne Feeney
Associate Director, Quality Initiatives
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland

Dear Ms. Feeney:

On behalf of the 64 hospital and health system members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the proposed changes to the *Draft Recommendation for Updating the Hospital Readmission Reduction Incentive Program for FY 2017*.

Crafting a payment policy recommendation is difficult at a time when significant questions remain about the difference between Maryland's readmissions rate and the national rate in both the calendar year 2013 base period and in the calendar year 2014 performance period. We support the Health Services Cost Review Commission (HSCRC) staff's intention to postpone setting the readmissions target until calendar year 2013 base year data is validated, likely by March, and we appreciate the recent decision to postpone until February a final readmission payment policy recommendation to allow time for additional analysis. However, we believe that a decision on a final readmission payment policy should be postponed beyond February to allow time to complete the necessary analyses.

Our primary concern is that a revised readmissions payment policy must not slow the good work underway at Maryland's hospitals to address the root causes of hospital readmissions. In this comment letter, we will outline what we know about readmission rates, and Maryland's rates in particular; what we don't yet know about the drivers of readmissions and the opportunities to improve; and, we will propose a way to develop a payment policy with incentives that reward hospitals for providing the best care for patients and supports hospitals' focus on areas where there is the most opportunity and need to improve. Our recommendation is that we postpone final approval of a fiscal year 2017 readmissions payment policy until we've been able to answer these important questions.

What We Know about Readmission Rates

Maryland's historic readmissions rate is higher than the nation. From June 2009 through June 2012, the most recent period available on Medicare readmission rates at the Medicare website Hospital Compare, readmission rates for heart failure, pneumonia, and heart attack across Maryland's hospitals in the aggregate were among the highest in the nation. In that same period, Maryland's mortality rates for the same conditions were the second lowest in the nation. This finding is consistent with what has been reported in the literature.[1]

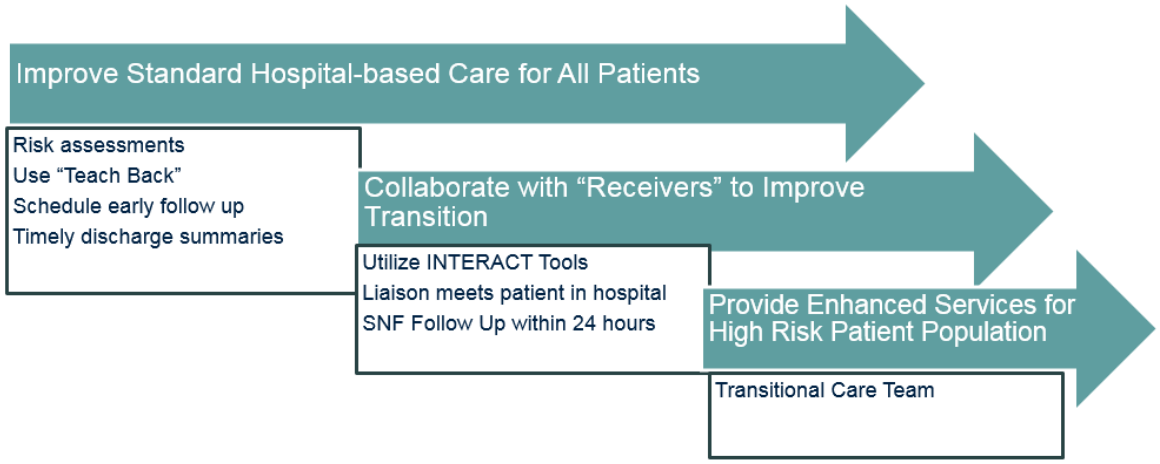
[1] Divergent trends in survival and readmission following a hospitalization for heart failure in the Veterans Affairs health care system 2002 to 2006. Journal of the American College of Cardiology (7/2010); In a study of hospitals within the Veteran Affairs health care system, reported that at the patient level, mortality after an admission for HF declined from 2002 to 2006 while readmission increased.

Are All Readmissions Bad Readmissions? New England Journal of Medicine (7/2010); A higher occurrence of readmissions after index admissions for heart failure was associated with lower risk-adjusted 30-day mortality. Our

Maryland's readmission rate has been improving faster than the nation. We also know from Medicare data published by Delmarva, the Quality Improvement Organization at the time, that Maryland's all-cause readmission rate improved by 10 percent from October 2010 through September 2013. From January 2011 to December 2013, Maryland's 30-day Medicare readmission rate for people admitted with heart attack, heart failure, diabetes, chronic kidney disease, chronic obstructive pulmonary disease, and pneumonia improved faster than the nation.

Maryland's hospitals have significantly increased the focus and amount of resources dedicated to reducing readmissions this year, in response to the new waiver's requirements and incentives. While some of the nation's hospitals have significantly reduced readmissions for targeted, high risk populations, very few have reduced their hospital-wide readmissions rate in the way Maryland's hospitals have. There is substantial difference between designing an intervention to reduce readmissions in a relatively small, well-defined target population, such as a pilot for congestive heart failure patients and designing a strategy to reduce overall hospital readmissions. Maryland's hospitals are using a robust portfolio of strategies to address this challenge.

Sample Portfolio Strategy:



While every hospital is investing in evidence-based interventions that are tailored to their local communities, still more work can be done. The investments are significant, involve numerous partners and require time and actionable data to realize their full potential. Examples of hospital strategies are included as links in Appendix 1.

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findings suggest that readmissions could be "adversely" affected by a competing risk of death — a patient who dies during the index episode of care can never be readmitted. Hence, if a hospital has a lower mortality rate, then a greater proportion of its discharged patients are eligible for readmission. As such, to some extent, a higher readmission rate may be a consequence of successful care. Furthermore, planned readmissions for procedures or surgery may represent appropriate care that decreases the risk of death, but this is not accounted for in Hospital Compare.

Looking forward, looking back: assessing variations in hospital resource use and outcomes for elderly patients with heart failure. Circulation: Cardiovascular Quality and Outcomes (10/2009); This study examines the association between mortality and resource use at the hospital level, when all Medicare beneficiaries hospitalized for heart failure are examined. Findings: California teaching hospitals that used more resources caring for patients hospitalized for heart failure had lower mortality rates.

What We Don't Know about Readmission Rates

We do not yet know the magnitude of the difference in Maryland's readmissions rate compared to the nation, for the calendar year 2013 base period or for any part of the calendar year 2014 measurement period. Data sources put the gap between 1.55 to 2.56 percentage points. The Delmarva Foundation for Medical Care as the Medicare Quality Improvement Organization produced quarterly utilization reports using Medicare data as required under the Centers for Medicare & Medicaid Services (CMS) contract Scope of Work. Based on data released in their June 6, 2014 report, Maryland's 30-day all cause annual readmission rate for calendar year 2013 was 18.96 percent compared to the nation's rate of 17.41 percent; a difference of less than 9 percent or 1.55 percentage points. However, recent comparisons HSCRC staff shared at a Performance Measurement Work Group meeting based on calendar year 2013 data received from the Center for Medicare and Medicaid Innovation (CMMI) indicate Maryland readmission rates were at 20.65 percent in Maryland compared to 18.09 percent nationally--a base year gap just over 14 percent or 2.56 percentage points. Between the two data sources, the discrepancy in the Maryland to national base year gap is more than 5 percent. More recent data from CMMI indicates that the base year gap is closer to the Delmarva data than the data shared with the Performance Measurement Work Group. The recent CMMI data indicates the base year gap is 11.53 percent or 1.94 percentage points. Looking at the recent CMMI data on the performance year, Maryland is continuing to reduce readmission rates faster than the nation and is close to or may have outpaced the national rate of improvement by one-fifth of the base year gap, thereby possibly meeting the calendar year 2014 readmissions waiver target.

We do not yet know how much of the gap between Maryland and national rates is due to errors or differences in measurement method. The difference between Maryland and national readmissions rates may be due, at least in part, to the inclusion of a larger proportion of high-risk individuals in the data set. Most concerning is that the state does not yet have sufficient data to verify base year readmission rates, nor 2014 performance year results. Further, it is not clear whether the data provided by the CMMI has appropriately handled Maryland's psychiatric units within acute care hospitals that are paid under the Maryland hospital payment system, but would not be paid under the Inpatient Prospective Payment System (IPPS) were they located outside of Maryland. Because the national data includes only hospitals paid under IPPS but not those cases receiving psychiatric care and associated with the claims paid under the Medicare Inpatient Psychiatric Prospective Payment System, we believe there is a higher proportion of people with behavioral health conditions in Maryland's readmission data, and the presence of a behavioral health condition significantly increases the risk of readmission.

It's also not clear to what extent Maryland's reduced admissions should be accounted for in a readmissions payment policy. There are many moving parts to the incentives in the new waiver. Maryland's hospitals have significantly reduced admissions and lowered costs for all payers. With this change, hospitals also recognize that the patients who remain in the hospital are sicker and often have more comorbidities. While reducing readmissions for this population is an imperative, data analysis needs to inform payment policies that are consistent with the goals of the waiver and enable an accurate assessment of performance. While patients are more complex, our hospitals have not wavered from their commitment to innovate beyond their four walls to address patient needs, as shown in the examples we highlight in the Appendix. As a field, we also recognize that focusing on all-payer readmissions, not just Medicare readmissions, is simply the right thing to do. As HSCRC analysis shows, all-payer readmissions is consistent with the trends in Medicare readmissions and solidly linked to waiver success – not only for the Medicare readmissions metric, but the limits on all-payer spending growth. Recognition that Maryland's hospitals could be lowering costs and improving quality, and just not meeting an arbitrary readmissions reduction goal (not informed by data), is concerning in light of the agreement hospitals

signed on to and the field's unwavering passion to get it right.

We do not know how to best structure readmissions performance incentives beyond those that exist in the global budget. The existing HSCRC readmissions payment policy adjusts expected readmissions rates for severity of illness and accounts for planned readmissions. However, because readmissions are also strongly associated with factors that we cannot yet measure well at the hospital level, such as health literacy, support at home, and the income and resources of the neighborhood in which a person lives, we don't know which Maryland hospitals have the most opportunity to reduce readmission rates and which are performing well relative to other hospitals with similar patient characteristics.[2]

Well-developed community partnerships, particularly those with primary care physicians, are critical to reducing readmissions. Brian Jack, MD, Professor and Vice Chair, Department of Family Medicine, Boston University School of Medicine, Boston Medical Center, and founder of Project RED said, "Safe readmission reduction can only happen if hospitals have well developed community-based partners, particularly primary care partners, willing and able to care for patients in the community. More effort to ensuring that this primary care safety net is available for patients is needed."[3] The concern with the proposed policy is that applying penalties--potentially large penalties--to hospitals because they did not improve at the uniform targeted rate is that the Commission could inadvertently harm a hospital's ability to provide services and interventions to the high-risk individuals who most need support. In federal Value-Based Purchasing, Hospital Acquired Conditions and in Maryland's comparable programs, it is broadly accepted that outcome measures should be adjusted for clinical severity and comorbidities, including conditions that are "present on admission," as these affect outcomes independent of the quality of care provided. Sociodemographic factors, like poverty, limited English proficiency, and homelessness, are also "present on admission." Unlike pre-existing medical conditions, these social factors are not directly affected by health care interventions, but will directly affect certain outcomes, such as 30-day

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[2] Neighborhood Socioeconomic Disadvantage and 30-Day Rehospitalization (Annals of Internal Medicine, 12/2014); *Living in a severely disadvantaged neighborhood predicts rehospitalization as powerfully as the presence of illnesses, such as peripheral vascular disease or chronic pulmonary disease, and more powerfully than being on Medicaid or having diabetes."*

Hospital Readmissions: Necessary Evil or Preventable Target for Quality Improvement (Annals of Surgery, 10/2014); *"High volume cancer centers have higher readmission rates….and may not be an appropriate marker for quality improvement."*

The Medicare Hospital Readmissions Reduction Program: Potential Unintended Consequences for Hospitals Serving Vulnerable Populations. (Health Services Research, 6/2014); *"Both dual eligible status and share of MC discharges have a positive effect on risk adjusted readmission rates."*

Socioeconomic status and readmissions: Evidence from an urban teaching hospital. (Health Affairs, 5/2014); *Patients living in high-poverty neighborhoods were 24 percent more likely than others to be readmitted, after demographic characteristics and clinical conditions were adjusted for."*

Variation in the Risk of Readmission Among Hospitals: The Relative Contribution of Patient, Hospital and Inpatient Provider Characteristics. (Journal of General Internal Medicine, 12/2013);*"Patient characteristics are the dominant contributor to the variation in risk of readmissions among hospitals…findings add to the accumulating evidence that hospitals may not be the appropriate sole target for placing accountability for excess readmissions."*

[3] *Readmission News* (August 2014)

readmissions. This concern is clearly reflected in the National Quality Forum's Expert Panel report on the need for sociodemographic adjustments for payment programs:

> *Just as quality measures for readmission aim to account for differences between patients in disease severity that affect repeat hospitalization, the Panel thought that factors related to social disadvantage … that affect risk for readmission should also be accounted for. … A measure of true performance accounts for the level of challenge posed by the patient to achieve an outcome, whether clinical or sociodemographic.*

Moving Forward

Maryland's hospitals are committed to improving care for all patients while they are inside the hospital walls and as they transition to home and to lower levels of care. Performing well on readmissions demonstrates our commitment to this important outcome, and helps us achieve the financial savings required under the waiver demonstration. We recommend that HSCRC staff and hospitals work together to answer the data and measurement questions, and to better understand the patient and hospital characteristics that may help to identify for targeted improvement efforts subpopulations with relatively high readmission rates. The results of the data validation and analysis should then inform the structure of incentives within a readmissions payment policy so that hospital payment adjustments are commensurate with successful levels of effort.

In addition to closely following the work on socio-demographic factors that the National Quality Forum and CMS are pursuing, we recommend an analysis that begins with the data that we can access. MHA recommends no change to the current readmissions payment policy until MHA and HSCRC have the opportunity to:

1. Analyze a combination of variables for their potential use to classify and assign Maryland's hospitals to peer groups. We believe an analysis that includes socio-economic and demographic indicators (by linking resident zip codes with data sets in the public domain such as census data on urbanicity, and poverty levels) will inform payment policies that have the right incentives and that recognizes the variations in hospitals' opportunity to improve.

   While we appreciate HSCRC's efforts to consider Medicaid status, we think the analysis was incomplete. Specifically, the analysis does not address whether having a higher percentage of Medicaid patients impacts a hospital's readmission rate. The analysis is simply focused on whether readmission rates at Maryland hospitals with a larger Medicaid population changed more (or less) over one year. That is a different question from whether those that care for more Medicaid patients tend to have higher readmissions rates. The HSCRC analysis is not sufficient for constructing a payment policy in a state where readmission rates have been steadily declining over the last several years.

2. Given Maryland's strong performance with mortality and the financial savings already realized, an analysis using the Charlson Comorbidity Index (CCI) could be informative. CCI is considered a gold standard as a risk adjustment variable and is commonly used to account for severity of illness and multiple chronic conditions (similar to APR-DRGs), and can also be used to estimate comorbidity-adjusted life expectancy.

3. While we understand and appreciate the need for safeguarding protected health information, transparency of CMMI readmission data is needed to appropriately compare Maryland with the nation. It would be helpful if MHA could review the SAS code used to pull the national readmissions data so that, when we have questions of what types of hospitals and cases are included, the detailed methodology contained in the SAS code can inform our validation process.

Considering the investments hospitals have made in their communities to reduce readmissions, the potential harm that would be done by imposing more financial risks, the uncertainties around the base year readmissions gap, uncertainties about Maryland's rate of improvement relative to the nation thus far in calendar year 2014, and the significant incentives under global budgets, we recommend the reward-only policy continue for a second year while we address the socio-demographic questions, the data validation issues, and the best path forward. Implementing a more aggressive penalty structure before validating our performance creates a ham-fisted corrective action plan that does not identify or target areas that need focus, and does it before knowing whether corrective action is even required. While we recognize the critical importance of payment polices supporting success under the waiver, changing this policy without adequate data, analysis, and a reasonable amount of time for hospitals to analyze and respond to the changes is not helpful to the state's overall success, nor to the collaborative nature that has allowed us to accomplish so much in such a short time.

We appreciate the Commission's consideration of our comments and look forward to continuing to work with HSCRC staff toward our shared goals.

Sincerely,

Traci La Valle

Traci La Valle
Vice President

Appendix 1

Examples of Hospital Strategies to Reduce Hospital Wide All Payer Readmissions

Frederick Memorial Hospital
http://www.hscrc.state.md.us/documents/md-maphs/wg-meet/cc/2014-12-12/3-Frederick-Memorial-Hospital.pdf

Johns Hopkins Health System
http://www.hscrc.state.md.us/documents/md-maphs/wg-meet/jt-mtg-2014-03-27/8-A-Deutschendorf-HSCRC-Presentation.pdf

Sinai Hospital
http://dhmh.maryland.gov/mchrc/Documents/Hospital%20Community%20Partnership%20Forums/HCAM%20Presentation.pdf

Additional resources and examples

http://www.modernhealthcare.com/article/20141206/MAGAZINE/312069983/global-budgets-pushing-maryland-hospitals-to-target-population-health

http://www.mhaonline.org/resources/video-resources/video-resources
http://www.mhaonline.org/quality/transitions-handle-with-care