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 Aggregate Revenue Amount at Risk under Maryland Hospital Quality Programs for FY 2017*.

The 8.86 percent of all-payer revenue that the Health Services Cost Review Commission (HSCRC) is proposing to place at risk for quality-related programs is far above the amount at risk in the rest of the nation. This change would subject Maryland's hospitals to an extraordinarily large risk at a time when they are already assuming exceptional risk under global budgets.

For performance year 2015, which impacts fiscal year 2017 rates, the HSCRC staff's proposal to place 8.86 percent of inpatient revenue at risk, without counting any of the utilization at risk under global budgets, compares to less than 6 percent of Medicare inpatient revenue, or about 2 percent of all-payer inpatient revenue, at risk nationally, assuming 40 percent of the nation's payer mix is Medicare. Figure 1 shows the significantly greater financial risk to a $200 million Maryland hospital under the December HSCRC proposal to the same hospital in another state.

Figure 1

The % at Risk Between MD and the Nation is Dissimilar When the Dollar Value is Considered

- For Maryland, penalties affect all inpatient revenue under global budgets
- For hospitals in the rest of the nation, penalties only affect *Medicare* inpatient revenue

Example Maryland Hospital with $200M in Revenue*		
$120M in Inpatient Revenue		
	2017	
Program	**% at Risk**	**Dollar Value**
MHAC	4.00%	$4.8M
Readmissions	2.86%	$3.4M
QBR	2.00%	$2.4M
Total Without PAU	**8.86%**	**$10.6M**

Example National Hospital With $200M in Annual Revenue*		
$120M in Inpatient Revenue **$48M** (40% of Inpatient Revenue) from Medicare **$29M** (~60% of Medicare inpatient Revenue) from base DRG *Readmission penalties apply to full Medicare payment		
	2017	
Program	**% at Risk**	**Dollar Value**
HAC	1.00%	$0.29M
Readmissions*	3.00%	$1.44M
VBP	2.00%	$0.58M
Total	**6.00%**	**$2.31M**

When the dollar value of potential penalties is considered against total annual revenue, the Maryland hospital in this example would have $10.6 million or 8.8 percent of revenue at risk versus $2.31 million or 1.9 percent of revenue at risk for the hospital located elsewhere in the nation

*Revenues are hypothetical and roughly based on known proportions of inpatient revenue, Medicare inpatient revenue and base MS-DRG revenue relative to total hospital revenue

The HSCRC staff recommendation seeks to justify this greater financial risk in two ways:

- The Center for Medicare and Medicaid Innovation (CMMI) requires Maryland to reallocate revenue based on quality performance on a similar scale with the nation; and

- By contract, Maryland's aggregate amounts at risk for quality-related programs must be on par with the nation over a cumulative period that extends beyond the years in which the new waiver demonstration would be in place. The cumulative period would begin with a performance period in 2012, which corresponds to fiscal year 2014, and presumably extend through the calendar year 2018 performance period which would apply to fiscal year 2020 payment adjustments.

We strongly disagree. Neither assertion is supported by the language or the spirit of the agreement between the state of Maryland and CMMI and, as mentioned earlier, this interpretation places an unduly large amount of revenue at risk for Maryland's hospitals. Attempting to shoehorn Maryland's demonstration into the confines of the national payment system with this overly aggressive policy is out of step with the Advisory Council's recommendations that hospital budgets and related policies be set to include incentives for hospitals to manage patients, and allow hospitals flexibility to achieve targets without heavy regulatory intervention. Furthermore, failure to achieve quality programs' risk amounts commensurate with national risk amounts is not one of the events that trigger a consequence within the waiver agreement.

To uphold the good faith and cooperation required for a successful demonstration, we strongly believe that input from the hospital field is required when interpreting the language of the waiver demonstration contract. It is important to reconcile the revenue at risk assumptions for quality programs with CMMI and the hospital field before any decisions are made by Commissioners about the fiscal year 2017 quality program at risk amounts.

In addition, Maryland hospitals' utilization risk under global budgets needs to be accounted for in the same way that the national "efficiency measure" used in the Value-Based Purchasing Program counts towards the sum of the aggregate amount at risk. A fair accounting of the avoidable utilization risk in global budgets is not only appropriate, it helps lower the risk on the other measures in Quality-Based Reimbursement, which are not directly tied to the readmissions and complications metrics under the waiver agreement. It also mitigates concerns with the metric itself, as mentioned in our September 22 comment letter on Quality-Based Reimbursement program recommendations. We also recommend shifting a portion of the revenue at risk from Maryland Hospital Acquired Conditions to readmissions, to reflect Maryland's performance on hospital acquired conditions over the past year and the less clear performance on readmissions relative to our target.

Thank you for the opportunity to participate in this process and to comment on this recommendation. If you have any questions, please contact me.

Sincerely,

Michael B. Robbins
Senior Vice President