Maryland
Hospital Association

February 24, 2017

Alyson Schuster, Ph.D.
Associate Director, Performance Measurement
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Schuster:

On behalf of the 64 hospital and health system members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the February *Draft Recommendation for the Maryland Hospital-Acquired Conditions Program for Rate Year 2019.*

Maryland's hospitals have reduced the rates of preventable complications by over 45 percent in the first three years of the All-Payer Demonstration, with double digit reductions each year. In contrast, hospitals have reduced the number of cases that are counted as Prevention Quality Indicators (PQIs) by about four percent over the past three years, with over three-quarters of that reduction occurring between 2015 and 2016. The challenge now is to continue providing the right care, at the right time, in the right setting by expanding hospitals' efforts to work outside their four walls with physicians and other providers. To do that, we believe it is time to reduce the emphasis on Maryland Hospital-Acquired Conditions (MHACs) and focus our resources on alignment with physicians and others outside the hospital.

We support the staff's recommendation to eliminate the statewide improvement target and move to a single payment scale that includes a zone in which no payment adjustments are made. Because the expected values, the average, and the best practice performance standards are updated each year, there remains in the policy a strong incentive for each hospital to keep up with the prior year's statewide improvement just to maintain its prior year score. In addition, the points in the payment scale where penalties and rewards begin generate additional incentives. To reduce the emphasis on this program and provide hospitals the flexibility to build alignment with physicians and others, it is important to maintain a hold harmless zone.

We strongly oppose the recommendation to measure complications for individuals who have elected palliative care. Adding these cases to the measurement of MHACs sends the wrong message to clinicians because people who elect palliative care choose a multi-disciplinary approach focused on relieving the pain, symptoms and stresses of serious illness. These goals may be at cross purposes with interventions to prevent complications. For example, a decision to insert a urinary catheter risks infection but can relieve the dying patient of excess moisture and fouling of pressure ulcers; frequent turning can cause the patient distress and pain in a vain attempt to prevent inevitable pressure sores retaining a central line to provide pain relief also

risks infection; and administering high doses of narcotics for pain relief can cause hypotension or ileus, which could be counted as an MHAC.

The draft recommendation notes a concern about coding cases as palliative care for the sole purpose of eliminating from MHAC those with complications. If there is a concern about the coding of palliative care cases, the commission should strengthen its current audit procedures.

Palliative care improves the patient and family experience, as well as quality of life. It also reduces emergency department use, admissions, and days in intensive care, all of which align with the goals of the All-Payer Demonstration. Expanded use of palliative care should be encouraged and expected, but the recommendation to measure complications in those receiving palliative care is at odds with these goals.

We appreciate the commission's consideration of our comments and we are happy to discuss our concerns at any time.

Sincerely,

Traci La Valle
Vice President

cc: Nelson J. Sabatini, Chairman
Herbert S. Wong, Ph.D., Vice Chairman
Joseph Antos, Ph.D.
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