Maryland
Hospital Association

January 3, 2017

Dianne Feeney
Associate Director, Quality Initiatives
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

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 December *Draft Recommendations for Updating the Quality Based Reimbursement Program for Rate Year 2018 and 2019.*

Fiscal Year 2017 Background

With the fiscal 2017 Quality-Based Reimbursement (QBR) policy, a fundamental change was made to the payment scale to create more predictable payment adjustments that hospitals can monitor throughout the performance year. The changes, supported by the hospital field, eliminated a payment scale that required penalties to fund rewards in a revenue-neutral manner and replaced it with a non-revenue neutral scaling using pre-set adjustments based on specific performance targets. The discussions around the fiscal 2017 outcomes brought to light questions about statewide performance expectations.

Recommendations

MHA offers two suggestions to better align QBR policy and methodology with HSCRC expectations:

1. The QBR payment scale is set in advance so clinicians can understand performance goals. However, while the HSCRC approves the weights to be applied to each measure and the maximum amount of rewards and penalties, it has not set explicit performance targets and does not approve how hospitals' performance will be arrayed within those reward and penalty boundaries. For example, the "break point" – the point chosen within the distribution of Maryland's hospitals that defines where rewards end and penalties begin – is a critically important decision and more strongly influences the outcome than does the decision about where the maximum rewards and penalties are set. **The HSCRC should expand its discussion and the commission should explicitly approve additional elements of the QBR policy, to include setting a break point that determines the penalty and reward zones in advance**.

2. Of greater importance, as noted at the October commission meeting, is a big picture question: what are we trying to achieve? Performing at the highest levels is desirable, but,

as in all incentive-based programs, the objective is to apply an incentive that yields a specific result. What are the goals for each measure? What level of improvement in each of the metrics do the HSCRC and the Centers for Medicare & Medicaid Services (CMS) consider meaningful? What do the evidence and research show about how quickly any particular measure can be improved, about the mix of providers and interventions needed to achieve that change, or about the time needed to achieve the desired change? These questions are critical for commission discussion and consideration, both in setting targets for improvement and in informing the staff's development of current and future goals and methods. **The HSCRC should expand its discussion of QBR policy to include these broader questions and discuss performance expectations**.

Fiscal Year 2018 Background

The fiscal 2018 performance period ended September 30 for some metrics and December 31 for others. Statewide performance results will not be available for at least another six months, although hospitals are able to track their individual performance with less lag.

Recommendation

Since the performance period has ended, there is little value in setting a performance target for fiscal 2018. **Instead, we recommend basing the payment scale on the actual fiscal 2018 scores, similar to the way in which HSCRC staff recommended revising the fiscal 2017 payment scale**. The payment scale could be tied to actual scores in the following manner:

> *The highest score would be "anchored" to the maximum reward, in this case 1 percent of inpatient revenue. The lowest score would be anchored to the maximum penalty, previously set at 2 percent of inpatient revenue. A third anchor would be set at the "break point" or the score above which a hospital receives a reward and below which a hospital is penalized. The break point would be set at the average score. Payment adjustments would be linearly proportional between the average and highest score and likewise, proportional between the average and lowest score.*

Under this scenario, roughly half the hospitals would receive a reward and half penalized, but the positive and negative adjustments would not need to balance to zero. This change should occur after the performance period ended, but before hospitals' fiscal 2018 budgets are set because it reduces the risk of having statewide performance and payment adjustments fall out of line with expectations.

Fiscal Year 2019 Background

Several options have been considered for the fiscal 2019 payment scale:

1. *Returning to a relative scale*
   This option is undesirable because the payment adjustments are not known until all hospitals' final performance scores are calculated. The lag in publicly available data means that the payment adjustment is uncertain until a few months after the start of the fiscal year

in which the adjustment applies, making it difficult for hospitals to budget for the payment adjustment.

2. *Pre-set scale based on Maryland performance in a current or prior period*
While we support this approach for fiscal 2018 only, improvements are needed for 2019 and future years. Simply setting the payment scale on the most recent year's performance does not account for volatility in overall scores as measures are added to the program. This approach risks another misalignment of actual payment adjustments and performance expectations.

3. *National scale based on possible points (range from 0 - 1, with a break point set at 0.5.*)
This option is also undesirable. Under CMS' Value-Based Payment program, hospitals can score anywhere between 0 and 1.0 total points. However, the program adjusts for relative ranking, effectively grading on a curve. Using the 0-1 range and 0.5 as the break point would create a significantly higher performance standard in Maryland than the nation. To earn a score of 0.5, a hospital would need to perform at the national level or improve at the national improvement rate for each metric. Actual national average scores over the last several years range from 0.36-0.41.

Recommendation

MHA proposes setting the payment scale using three anchor points: a top score tied to the maximum reward, a low score tied to the maximum penalty and the average score tied to the break point. Between the break point and the maximum reward and between the break point and the maximum penalty, payment adjustments would be proportionally scaled. Because hospitals above the break point receive positive adjustments and hospitals scoring below the break point are penalized, deciding where to set the three anchor points would make an explicit statement about performance expectations.

To address the difficulty in predicting a "good score," as metrics are added to or removed from the program each year, HSCRC should create a zone in the mid-range where no payment adjustment is made. This would create a "buffer zone" to protect against volatility in outcomes that results from changing metrics and is therefore beyond anyone's ability to predict. The no-adjustment zone would be set at a quarter of the standard deviation, centered on either side of an average score. Although a buffer zone raises concerns because of the idea that all hospitals should have a performance incentive, a small buffer zone would not detract from overall performance incentives.

Compared to the nation, Maryland's performance scores are more tightly clustered around the median, and a few points lower than the median. This suggests that moving the Maryland payment scale closer to national performance would move the Maryland performance curve to the right, indicating better statewide performance. The challenge in simply setting the Maryland scale with the break point a few points higher than the most recent Maryland average, or at the

most recent year's national median score, is that the national scores frequently move up or down by a few basis points, depending on which metrics are included.

The results of model of this alternative, using Maryland fiscal 2017 scores with a break point set at 0.36 (two basis points higher than the Maryland median and one point lower than the national median for 2017, are attached.

We appreciate the commission's consideration of our comments and the opportunity to continue working with the HSCRC.

Sincerely,

Traci La Valle
Vice President

Enclosure

cc: Nelson J. Sabatini, Chairman
Herbert S. Wong, Ph.D., Vice Chairman
Joseph Antos, Ph.D.
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FY 2019 Option

HOSPITAL NAME	FY 16 Permanent Inpatient Revenue	QBR FINAL POINTS	MHA Option	
			% Revenue Impact	$ Revenue Impact
Bon Secours Hospital	$ 74,789,724	0.07	-2.00%	-$1,495,794
Laurel Regional Hospital	$ 60,431,106	0.16	-1.33%	-$805,748
Maryland General Hospital	$ 126,399,313	0.20	-1.04%	-$1,310,808
Northwest Hospital Center	$ 114,214,371	0.22	-0.89%	-$1,015,239
Holy Cross Hospital	$ 316,970,825	0.23	-0.81%	-$2,582,725
Prince Georges Hospital Center	$ 220,306,426	0.24	-0.74%	-$1,631,899
Southern Maryland Hospital Center	$ 156,564,761	0.25	-0.67%	-$1,043,765
Washington Adventist Hospital	$ 155,199,154	0.25	-0.67%	-$1,034,661
Sinai Hospital	$ 415,350,729	0.31	-0.22%	-$923,002
Memorial Hospital at Easton	$ 101,975,577	0.31	-0.22%	-$226,612
Anne Arundel Medical Center	$ 291,882,683	0.31	-0.22%	-$648,628
Franklin Square Hospital Center	$ 274,203,013	0.31	-0.22%	-$609,340
Union Memorial Hospital	$ 238,195,335	0.31	-0.22%	-$529,323
St. Agnes Hospital	$ 232,266,274	0.32	-0.15%	-$344,098
Baltimore Washington Medical Center	$ 237,934,932	0.33	-0.07%	-$176,248
Western MD Regional Medical Center	$ 167,618,972	0.34	0.00%	$0
Harford Memorial Hospital	$ 45,713,956	0.35	0.00%	$0
Doctors Community Hospital	$ 132,614,778	0.35	0.00%	$0
Meritus Hospital	$ 190,659,648	0.36	0.00%	$0
Johns Hopkins Hospital	$ 1,244,297,900	0.36	0.00%	$0
Union of Cecil	$ 69,389,876	0.37	0.00%	$0
Johns Hopkins Bayview Medical Center	$ 343,229,718	0.38	0.00%	$0
Shady Grove Adventist Hospital	$ 220,608,397	0.38	0.00%	$0
Peninsula Regional Medical Center	$ 242,318,199	0.38	0.00%	$0
Upper Chesapeake Medical Center	$ 135,939,076	0.38	0.00%	$0
Chester River Hospital Center	$ 21,575,174	0.38	0.00%	$0
University of Maryland Hospital	$ 906,034,034	0.39	0.05%	$476,860
Atlantic General Hospital	$ 37,750,252	0.39	0.05%	$19,869
Garrett County Memorial Hospital	$ 19,149,148	0.40	0.11%	$20,157
Fort Washington Medical Center	$ 19,674,774	0.41	0.16%	$31,065
Mercy Medical Center	$ 214,208,592	0.41	0.16%	$338,224
Civista Medical Center	$ 67,052,911	0.42	0.21%	$141,164
Carroll Hospital Center	$ 136,267,434	0.43	0.26%	$358,599
Calvert Memorial Hospital	$ 62,336,014	0.43	0.26%	$164,042
UM ST. JOSEPH	$ 234,223,274	0.43	0.26%	$616,377
Dorchester General Hospital	$ 26,999,062	0.44	0.32%	$85,260
Montgomery General Hospital	$ 75,687,627	0.45	0.37%	$278,849
Harbor Hospital Center	$ 113,244,592	0.45	0.37%	$417,217
Frederick Memorial Hospital	$ 190,413,775	0.46	0.42%	$801,742
Suburban Hospital	$ 193,176,044	0.47	0.47%	$915,044
Greater Baltimore Medical Center	$ 207,515,795	0.49	0.58%	$1,201,407
Good Samaritan Hospital	$ 160,795,606	0.49	0.58%	$930,922
Howard County General Hospital	$ 165,683,744	0.57	1.00%	$1,656,837
St. Mary's Hospital	$ 69,169,248	0.72	1.00%	$691,692
FY17 Statewide Total	**$8,730,031,841**			**-$5,232,563**
		Total Penalties		-14,377,891
		% Inpatient Revenue		-0.16%
		Total rewards		9,145,329
		% Inpatient revenue		0.10%