Maryland
Hospital Association

September 28, 2017

Allan Pack
Director, Population-Based Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Allan:

On behalf of the Maryland Hospital Association's 64 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's quality policy priorities, principles and direction. Developing population health metrics, aligning metrics with the national quality programs and creating a readmissions comparison group or benchmark should be top priorities for quality policy over the coming year.

As Maryland approaches performance year 2018, the fifth and final year of the current All-Payer demonstration, we urge commission staff to focus on the measures and policies that are needed to support the upcoming second phase of the model. Since this enhanced model will hold all hospitals individually accountable for population outcomes, equitable performance metrics and policies will bring even greater challenges than those we currently face. In addition, Maryland's performance will be compared to the measures that comprise national payment policies. As a result, we believe the measures used in Maryland's quality policies should align with the nation as closely as possible.

Quality Priorities
Over the next year, commission staff must expend significant resources to prepare for the implementation of the enhanced model. These activities should be prioritized:

- **Develop at least one population health metric.** Although a number of population health metrics are measured by Accountable Care Organizations, primary care practices, medical homes and health plans, no population health measures have been developed for individual hospital use. Identifying a data source and developing a method to assign populations to individual hospitals will be challenging.
- **Align with the national Hospital-Acquired Conditions (HAC) measures.** Maryland is on track to far exceed the 30 percent reduction in Potentially Preventable Conditions (PPCs) required in the current contract; since no other state uses the PPCs, there is no other group with which to compare Maryland's performance. The Maryland Hospital-Acquired Conditions (MHAC) have no national comparison, and moving away from them would allow hospitals to focus on metrics that they consider more meaningful and on the critical work of transforming

care delivery. Commission staff resources would also benefit by leveraging measures and performance standards administered by the Centers for Medicare & Medicaid Services.

- Identify an appropriate readmissions benchmark that considers best practices among hospitals and populations with characteristics similar to Maryland.

Hospital-Acquired Conditions
Transition from MHACs to a policy based on the national HAC measures for performance year 2019. Aligning Maryland's metrics with the national metrics will better position Maryland's hospitals to focus on the complications that national policy makers have determined are most important. In addition, reducing the sheer number of metrics (eliminating the 60+ Potentially Preventable Conditions) allows hospitals to redirect staff to the care delivery transformation activities that are so critical to the success of the model. Recognizing that this would be a significant change in hospital operations, adequate time to prepare for the transition will also be key.

Although the national HAC program is a penalty-only policy, the same metrics are used in the national Value-Based Purchasing (VBP) program that includes the possibility of both rewards and penalties. While leveraging the national VBP program could reduce complexity for hospitals and for commission staff, we need more time to work through the details of how the national program could be adapted to Maryland. We welcome continued dialogue on this issue.

Readmissions
As we anticipate reducing the statewide all-cause 30-day unadjusted Medicare readmissions rate below the national average by the end of the 2018 performance year, we will need to agree on the desired level of readmissions. Some level is appropriate to address serious or potentially life-threatening unanticipated changes in a person's health or new conditions that are unrelated to the initial admission. So far, there is no accepted method to determine the "right" level of readmissions, nor is there an accepted method to account for the social, demographic, and community factors that affect readmissions rates, particularly in an all-payer population. Over the coming year, we should work together to recommend an appropriate benchmark or comparison group of hospitals that provides a safe and achievable performance target.

We do not recommend changing the readmissions metric to include emergency department visits, observation stays or a 90-day window. The current readmissions metric is working well and the number of readmissions that occur after 30 days is small. It is most important to focus on the population health and measure alignment priorities.

Emergency Department Measures
We do not recommend adding emergency department wait time measures to the quality programs. These metrics are not an effective way to address concerns that have been raised about long wait times. Maryland's hospitals have been challenged by relatively long emergency department throughput times and the need to rely on diversions. Recognizing the importance to patient safety and shared responsibility for the Marylanders we touch, hospitals over the last year have been addressing the issue with our hospital clinical leaders and emergency department

physician leaders. Root cause analysis has identified a number of factors contributing to the problem, including: insufficient access to behavioral health treatment; Medicaid expansion and patterns of primary care delivery including non-emergent use of the emergency department; nursing shortages; and care transformation and redesign. Emergency departments are at the center of transformation. Increased screening and use of evidence-based practices to decrease readmissions and unnecessary inpatient stays require hospitals to rebalance the needs of all hospital units. Tracking the number of hours emergency departments are on diversion is a quicker way to show progress than wait times, which have a longer data lag. Yellow diversions have decreased more than 20 percent from second quarter 2017 compared to second quarter 2016.

Service Line
Evaluating performance along service lines may have advantages, such as addressing measurement biases. However, it would tax HSCRC staff resources that are needed to pursue the priorities identified earlier: population health metrics, alignment with national HAC measures and development of a readmissions benchmark. Using an existing model that would still allow Maryland's hospitals to be compared to a national cohort might be a more feasible approach.

Expansion of Potentially Avoidable Utilization
We do not recommend expanding the definition of Potentially Avoidable Utilization – a change that is not immediately needed to support the enhanced all-payer model. In the future, as we implement population health measures and expand hospitals' accountability for populations, it may be worthwhile to re-evaluate the way in which the Prevention Quality Indicators are implemented using hospital discharges as the denominator. The Agency for Healthcare Research and Quality developed the metric to measure how well an entity manages a population by providing necessary care in the ambulatory setting and avoiding hospitalizations. Experience with the Medicare Performance Adjustment and population health measures may provide insight into how to improve the way we use this measure.

We appreciate the commission's consideration of our feedback and the opportunity to continue working with commission staff on these issues. Should you have any questions, please call me at 410-540-5087.

Sincerely,

Traci La Valle

Traci La Valle, Vice President

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