Maryland
Hospital Association

May 25, 2016

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

On behalf of the 64 hospital and health system members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the *Draft Recommendations for the Readmissions Reduction Incentive Program for Rate Year 2018*, the *Draft Recommendations for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018,* and the *Draft Recommendations for the Potentially Avoidable Utilization Savings Policy for Rate Year 2017*. On the whole, we support the HSCRC staff recommendations related to readmissions and the amounts of revenue at risk for specific quality programs; however, we disagree with the staff recommendation on Potentially Avoidable Utilization (PAU) savings and the resulting quality-based payment program adjustment to the update.

MHA's position: the net quality-based payment program adjustment should be reduced from -0.61 percent to -0.16 percent by lowering the expected shared savings offset for Potentially Avoidable Utilization. This would reduce to 0.80 percent HSCRC staff's recommendation of a 1.25 percent reduction in hospital revenues.

- The recommendation to reduce hospital revenue by 1.25 percent according to hospitals' individual percentages of readmissions and admissions for certain chronic conditions, or Prevention Quality Indicators (PQIs), uses an Agency for Healthcare Research and Quality (AHRQ) metric in a way it was not intended. The metric was created not for hospitalized patients, but to measure prevention opportunities in the broader population. It has not been applied as a payment incentive anywhere else in the nation. In fact, a report of an AHRQ Clinical Expert Review Board on expanding the use of PQIs for pay for performance notes that "(p)anelists showed comparatively less support for using these indicators in pay for performance applications." They noted the need for careful risk adjustment and that "higher stakes use" may encourage adverse effects of implementation.

- In our April 4 comment letter (attached), we expressed concerns about, among other things, using the AHRQ measure to require an 11.4 percent reduction in readmissions and PQIs combined in one year. That steep of a reduction is, simply, unattainable, and if an incentive is unattainable it no longer acts as an incentive. It is instead just an arbitrary cut.

- The attempt to justify setting a goal of an 11.4 percent reduction in readmissions and PQIs using a 2012 Institute of Medicine report that suggests 27 percent of health care spending was for unnecessary services, compares apples to oranges. Unnecessary care can occur for many reasons: unnecessary screening exams, duplicative tests, invasive procedures near the end of life, lack of patient understanding of treatment options, defensive medicine and more. The opportunity to reduce this care and the interventions, if available, are varied and require patient and provider behavior change over the long term. Those efforts do not necessarily directly help a Maryland hospital meet a specific PQI reduction of more than 11 percent in one year.

- HSCRC staff's recommendation to reduce hospital revenue by 1.25 percent comes against a backdrop of a proposed global budget increase of just 1.1 percent for all hospitals, already far below inflation. Our recommendation of removing the PQI component and lowering that reduction to 0.80 percent to adjust only for readmissions – an adjustment we agree with – is still an increase over last year's reduction of 0.60 percent.

Aggregate Revenue at Risk
We support the staff recommendations on the remaining amounts at risk for the individual quality programs: Quality Based Reimbursement, Maryland Hospital Acquired Conditions, Readmissions, and the Maximum Penalty Guardrail of 3.5 percent of total revenue.

It is critical to note that, for fiscal year 2017, Maryland's potential all-payer revenue at risk is more than 11 percent – far higher than the nation's Medicare revenue at risk of 6 percent. The amount of actual adjustments or "realized risk" by Maryland's hospitals is also significant – projected at more than 4 percent of all-payer revenue. Therefore, there is plenty of room for HSCRC to make the minor adjustment for potentially avoidable utilization that we are recommending.

Readmissions
We support HSCRC staff's recommendations on fiscal year 2017 and 2018 readmissions results. We appreciate and commend HSCRC staff's diligence in developing a well-balanced readmissions policy that includes the concept of attainment – something that has not been achieved elsewhere. The policy does have opportunities for future refinement, in particular regarding the risk model that would recognize characteristics such as social and demographic predictors of readmission, as well as refinements to the out-of-state adjustment. The policy currently adjusts in-state risk-adjusted all-payer readmissions by the percentage of unadjusted Medicare readmissions that occur out of state. We are still working to understand the Medicare data, and may find that there is a better way to account for the all-payer readmissions that occur out of state.

The hospital field's strong performance on all of the Medicare demonstration metrics indicates that the current performance incentives are working. There are already incentives to reduce PQIs inherent in the global budget, and the Maryland amount of revenue at risk is greater than the nation, no matter which way it is measured. Experimenting with new, untried pay for performance metrics now would shift important focus away from the metrics that are actually generating valuable results for our state, its hospitals, and the communities and people we all serve.

We appreciate the commission's consideration of our comments.

Sincerely,

Traci La Valle
Vice President

cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director
Dianne Feeney, Associate Director, Quality Initiatives

Enclosures

Maryland
Hospital Association

April 4, 2016

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 Readmissions Reduction Incentive Program for Rate Year 2018* and the *Draft Recommendation for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018*. The draft recommendations raise three important policy concerns: the need for individual hospital consideration when there is no performance standard for readmissions; the lack of justification for expanding a penalty-only performance metric (shared savings) and to include an ill-conceived idea of measuring Prevention Quality Indicators and sepsis cases at the hospital level; and the amount of revenue at risk under quality-related programs. It is important that these policies be considered in the context of a second year of very favorable performance on the financial and quality metrics specified in the all-payer demonstration agreement. The hospital field has demonstrated that it can deliver on the demonstration targets ahead of the pace outlined in the agreement. In submitting our comments, we urge you to keep in mind the Health Services Cost Review Commission (HSCRC) Advisory Council's early advice to implement the agreement using broad targets and incentives and to avoid excessive regulation, thus allowing hospitals the flexibility to meet those targets.

Fiscal Year 2018 Policy (Calendar 2016 Performance)

HSCRC staff and the hospital field have made considerable progress in understanding readmissions rates over the last year. Most notably, we finally have a method to calculate Medicare readmissions that we believe fairly compares Maryland's unadjusted readmissions rates to the nation. We have also made progress on measuring social and demographic factors that affect readmissions rates and in quantifying the impact of other factors in a risk-adjusted model. However, we do not yet have a model that everyone agrees should be used to set a target readmissions rate for each hospital.

In calendar year 2015, it became clear that hospitals with lower starting readmissions rates were less likely to reduce readmissions and may even experience increases. We also saw a pattern that readmissions rates move up or down in tandem with admissions. Just as we do not fully understand the complex interplay of factors driving hospital readmissions rates, we are not yet

able to fully account for the factors driving overall utilization in each market, such as changes in physician and payer referral patterns.

Last year, HSCRC's readmissions policy included a provision that any hospital that believed the readmissions reduction policy was penalizing them inappropriately could bring additional information to HSCRC to more fully explain their individual circumstances. To date, a number of hospitals have met with HSCRC, but none has received penalty relief. HSCRC staff does not yet appear to have a mechanism to determine when a hospital is a good performer, even on an individual basis.

We recommend that HSCRC continue to work with the hospital field to come to agreement on a mechanism to determine a hospital-specific readmissions target so that the readmissions policy can recognize both attainment and improvement. Hospitals that have attained lower readmissions rates should not be penalized, particularly when those rates are well below state and national averages.

Penalty Relief Fiscal Year 2017 (Calendar 2015 Performance)

MHA has been advocating for a mechanism to recognize hospitals that have low readmissions rates and those that have significantly improved. Our recommended modification to fiscal 2017 policy accomplishes that by lowering the statewide target and mitigating penalties for hospitals whose rates are among the lowest third of the state in both the base year and the performance year. The options proposed by HSCRC do one or the other, but not both. The options to recognize Medicare improvement or all-payer improvement tend to help hospitals that have experienced larger reductions in readmissions generally. The option to lower the improvement target for hospitals with base rates below statewide average is a step in the right direction, but still leaves subject to penalties too many hospitals with low readmissions rates. Appendix 1 shows the MHA proposal, and our projection of the hospital-specific and statewide impact of all three proposals.

HSCRC staff stated in their recommendation that they disagree with lowering the statewide reduction target. However, at the time the 9.3 percent target was set, there was significant uncertainty around what an appropriate target would be. Maryland did not yet have the base year readmissions rates for the state and the nation, so we did not know how much difference Maryland's hospitals needed to make up, nor whether our year one performance was on track to meet the Medicare demonstration target. Now, with better data, we know that the 7.1 percent all-payer reduction through November 2015 has Maryland comfortably meeting the statewide Medicare readmissions target as specified in the demonstration agreement. Clearly, the 9.3 percent target was too aggressive.

Expanding "Shared Savings"

The staff recommendation links fiscal year 2017 penalty relief to a proposed larger "shared savings" reduction, to generate additional savings for Medicare and all other payers. This is completely unnecessary from a financial incentive standpoint, and poorly conceived from a

performance measurement standpoint. The financial targets of the all-payer model would allow the commission to mitigate fiscal 2017 penalties without additional offsets. Maryland is already far ahead of the Medicare savings targets. The cumulative year two savings target is $49 million, but in year one alone more than $100 million in savings was generated. Likewise, there is plenty of cushion under the all-payer cap. In fiscal year 2015, commissioners approved a 2.35 percent per capita increase to global budgets. The per capita increase actually provided in global budgets was 1.85 percent, according to commission data. Likewise, in fiscal 2016, commissioners approved an increase of 2.61 percent per capita, and through January, hospital per capita revenue has increased only 1.52 percent. Across the two years combined, 5.02 percent per capita growth was approved, but only 3.47 percent per capita has been reflected in hospital rates.

From a performance measurement standpoint, adjusting hospital revenues by a modified version of the Agency for Healthcare Research and Quality Prevention Quality Indicator (PQI) admissions disregards the important fact that the measure is intended to evaluate the rate of preventable admissions in a *population*. The agency never intended for the admissions to be counted at the provider level without knowing the population at risk for a PQI admission. Without understanding the denominator, or the ability to quantify the number of people who were at risk for admission to a hospital, PQI performance cannot be compared across hospitals. Hospitals with a more surgical focus will have lower PQI rates, hospitals in areas where there is low population density and fewer physicians will have higher rates. The enclosed chart shows that PQI admissions per 1,000 population vary significantly by county. The concept, perhaps well intentioned, is that the hospital is responsible for the health of its community, so if fewer people are admitted for chronic conditions, it must mean that the community is healthier. It could also mean that primary care services are more available, or that patients went to another hospital.

The measurement issues related to sepsis are also significant, and should cause concern when being considered for inclusion in the proposed readmissions shared savings policy. There is national debate among physicians and infection preventionists about when a patient's clinical conditions should be labeled as sepsis. Over-identification can lead to overuse of antibiotics and proliferation of other complications, such as Claustridium Difficile. Patient Safety Organizations and the Centers for Medicare & Medicaid Services are focused on reducing sepsis mortality by identifying people who are in the early stage of sepsis and need antibiotics and hydration within three hours to reduce the risk of dying. Patient safety interventions such as these that rely on early detection may cause an initial increase in the number of sepsis cases, but should also be accompanied by reductions in sepsis mortality. Adding an incentive to reduce sepsis cases could be at odds with efforts to identify and reduce sepsis mortality. Septicemia and shock, which may be the result of the body's reaction to sepsis, are included in the Maryland Hospital-Acquired Conditions program, and sepsis mortality is included in HSCRC's Quality Based Reimbursement program.

The HSCRC staff recommendations on a fiscal year 2018 readmissions policy, fiscal year 2017 readmissions penalty mitigation, and in particular, the recommendation to tie penalty relief to an expansion of a penalty-only policy based on performance metrics that are not suited to hospital

level measurement and which seem to be hastily constructed, are overly punitive. The hospital field's strong performance on all of the Medicare demonstration metrics indicate that the current performance incentives are working well. There are already incentives to reduce PQIs inherent in the global budget, and the Maryland amount of revenue at risk is greater than the nation, no matter which way it is measured. Piling on additional metrics, additional penalties and additional risk would jeopardize and remove focus from the good work and good results hospitals are already delivering.

We appreciate the commission's consideration of our comments.

Sincerely,

Traci La Valle
Vice President

Enclosure

"Shared Savings" Reductions are Simply Revenue Reductions

- The net proposed shared savings adjustment of 0.65 percent would remove $98.4 million from hospital budgets
- It's been characterized as a savings mechanism that allows hospitals to retain 100 percent of the reduction beyond the savings benchmark. However, since costs are both fixed and variable, savings are generated and accrued at less than 100 percent.
- Assuming hospital costs are 50% variable, for the hospital field to break even on a $98.4 million reduction, the field must reduce volume equivalent to $198.6 million ($98.4 x 2)
- A hospital would not begin to keep any cost savings until PQIs and readmissions were reduced by over 11 percent

	CY 2015 Average Charge	Number cases to reduce to achieve $198.6 million savings	CY 2015 number of cases (including Observation)	**Percent reduction required for hospital to break even**
		(Savings target of $198.6 M / PQI avg chg $10,651)		(Cases to reduce / CY 15 number of cases)
PQI	$10,651	18,646	77,654	**-24.0%**
Readmissions	$15,277	13,001	83,412	**-15.6%**
Combined	$13,961	14,226	124,499	**-11.4%**