Maryland
Hospital Association

November 22, 2019

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

Dear Ms. Feeney:

On behalf of the Maryland Hospital Association's 61 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC's) *Draft Recommendations for updating the Quality-Based Reimbursement Program for Rate Year 2022.* We appreciate the collaborative process to engage with staff and offer input to shape the policy in the best interest of high-quality care for all Marylanders.

We agree with staff's recommendations, which have remained largely unchanged from the current version of the policy, though we look forward to working with HSCRC staff in the coming year to explore opportunities to revise the policy. As we consider options for a readoption of an emergency department (ED) wait time measure, we want to ensure it accurately focuses on improvements in ED care delivery related to appropriate use. Attached are slides showing drivers and trends in Maryland ED visits. Overall visits have decreased, particularly among low and medium complexity patients. For all payers, the number of ED visits for behavioral health conditions continues to rise, while non-behavioral health related ED visits and admissions decline.

We appreciate the commission's consideration of our feedback. We look forward to continuing to work with the commission to modify the QBR program. Should you have any questions, please call me at 410-540-5087.

Sincerely,

Traci La Valle

Traci La Valle
Senior Vice President, Quality & Health Improvement

cc: Nelson J. Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James N. Elliott, M.D.
Adam Kane
Alyson Schuster, Ph.D., Deputy Director

Enclosure

MARYLAND'S HOSPITALS
FUNCTION DIFFERENTLY TODAY

Screen for behavioral health conditions, social determinants, and abuse

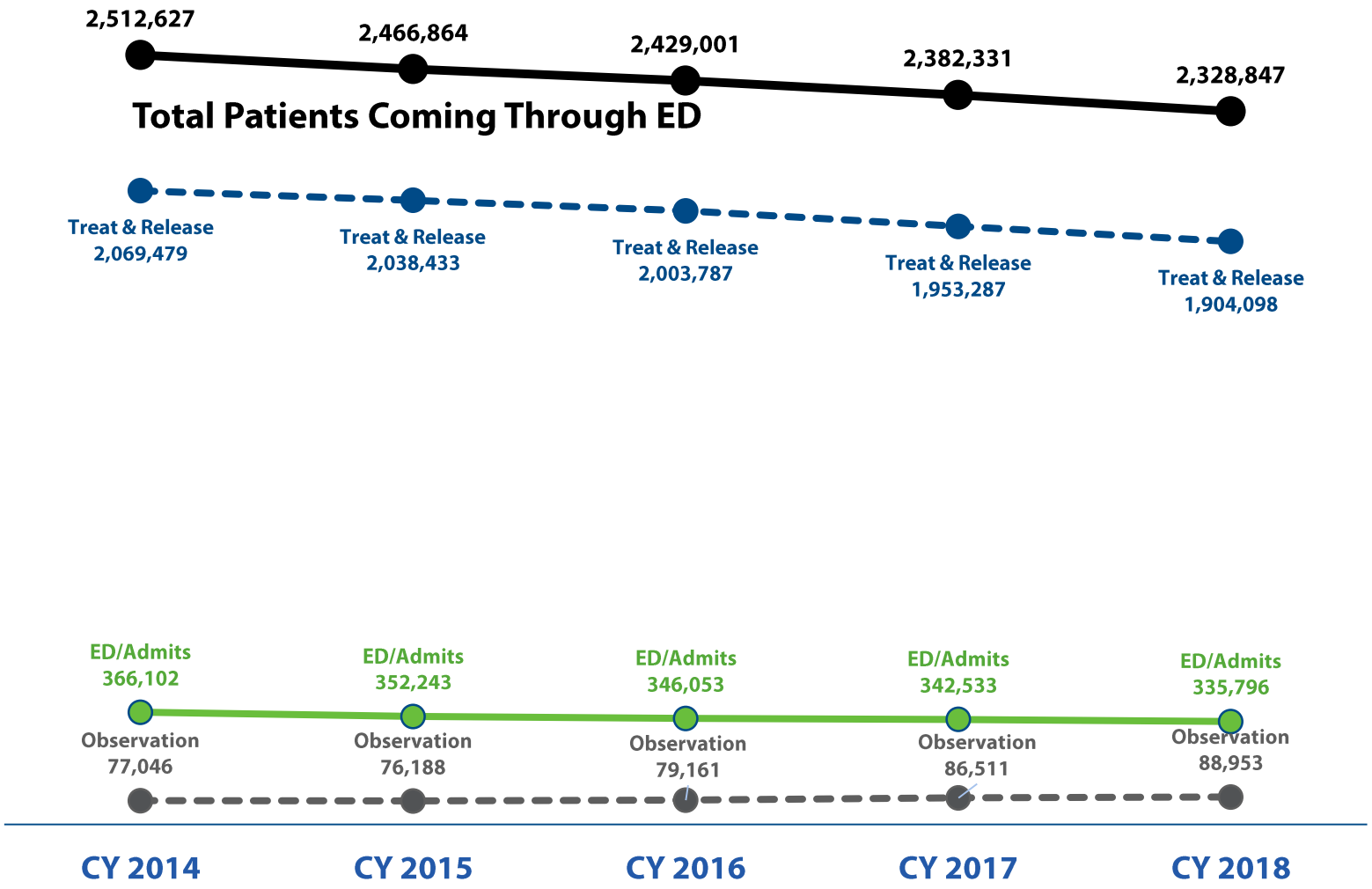
Administer more test and labs in emergency departments to determine which patients do not need to be admitted

Coordinate care with ambulatory and post-acute partners to ensure patients do not unnecessarily return

Are home for hard-to-place patients

On front-lines of behavioral health and opioid epidemic

VOLUME OF TOTAL ED VISITS HAS DECREASED

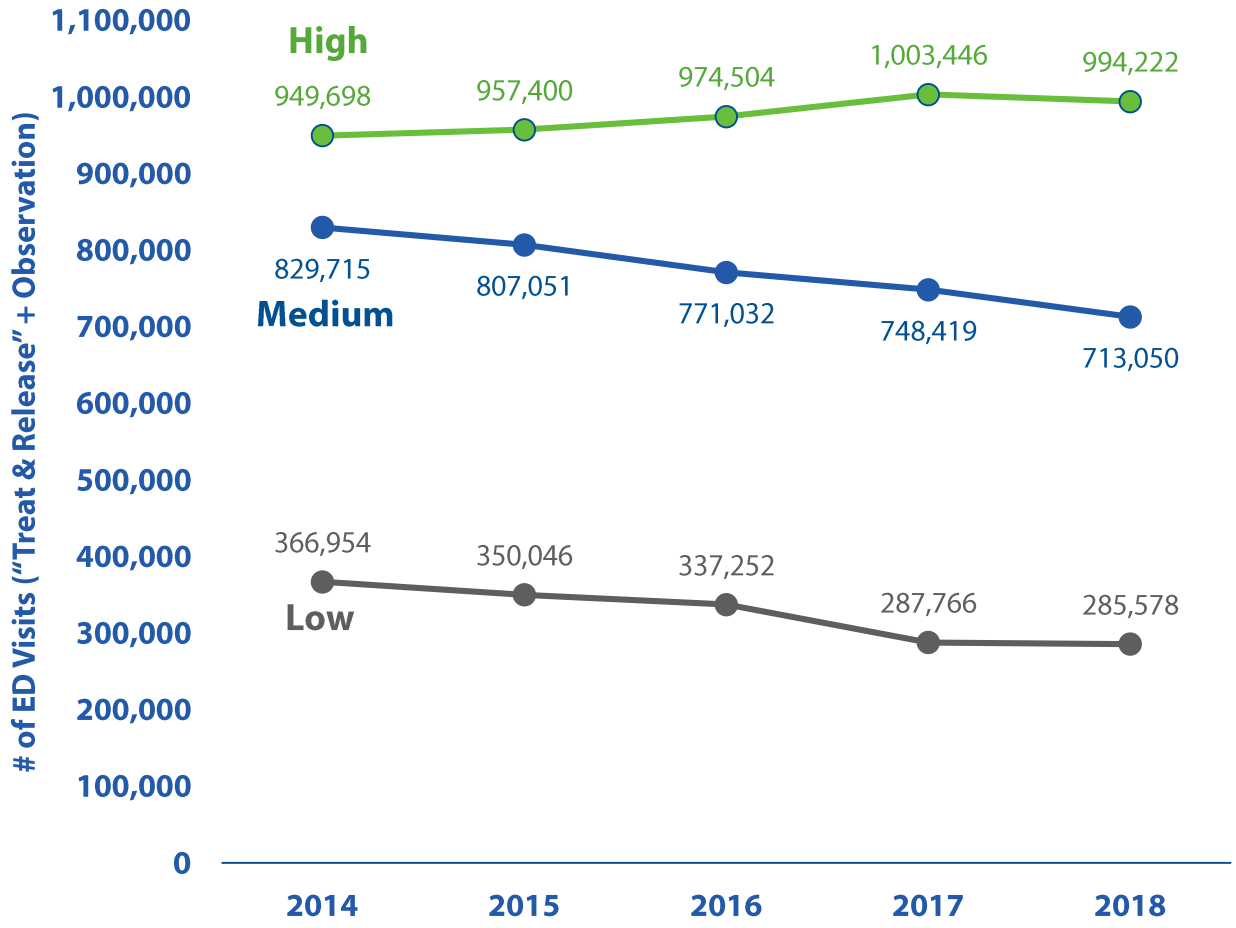


All ED Visits have decreased from 2014-2018 while Observation stays have increased

- **Total Patients Coming Through ED ↓7.3%**
- **Treat & Release ↓8.0%**
- **ED Admissions ↓8.3%**
- **Observation Stays ↑15.5%**

Source: MHA Analysis of HSCRC's hospital data (also referred to as the Revisit Files), calendar years 2014 through 2018
- ED "Treat & Release" patients that were discharged from the ED, died, or left against medical advice and does not include observation stays or inpatient admissions

ED VISITS ARE BECOMING MORE COMPLEX



LOW - Level I and II (CPT 99281 & 99282)

Example Interventions:

- Wound rechecks
- Suture removal
- Application of ace wrap or sling
- Assessment of visual acuity

MEDIUM - Level III (CPT 99283)

Example Interventions:

- Foley/In & Out catheterizations
- C-Spine precautions
- Mental health – anxious, simple treatment
- Routine psychiatric medical clearance; limited social worker intervention

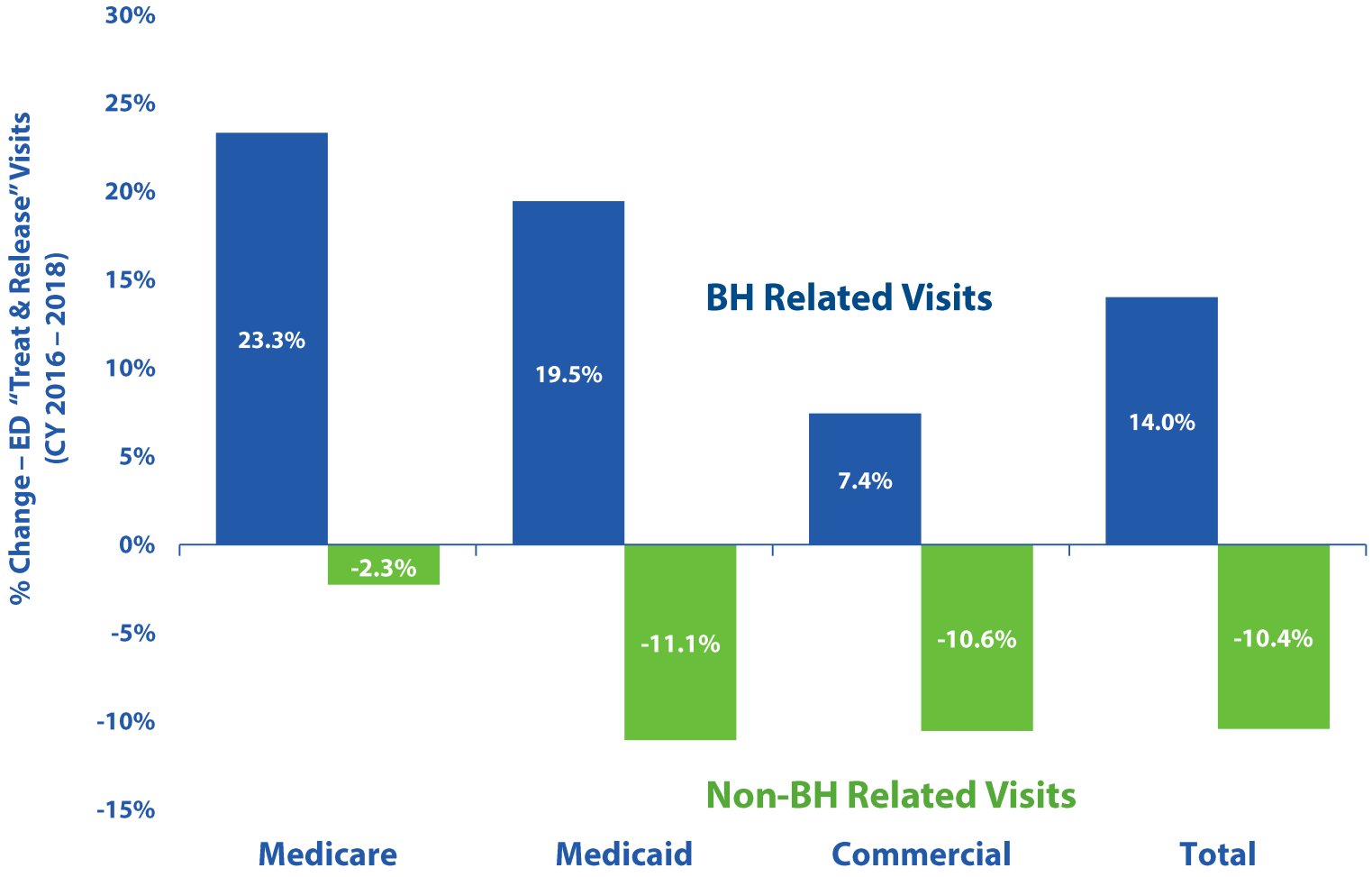
HIGH - Level IV and V (CPT 99284 & 99285)

Example Interventions:

- Cardiac monitoring
- Nebulizer treatments
- Administration of infusions or parenteral medications
- Coordination of hospital admission/transfer or change in living situation

Source: MHA Analysis of HSCRC's hospital data (also referred to as the Revisit Files), calendar years 2014 through 2018
- ED "Treat & Release" patients that were discharged from the ED, died, or left against medical advice and does not include observation stays or inpatient admissions
- ED Severity Levels – High (Level IV & V) , Medium (Level III), Low (Level I & II)

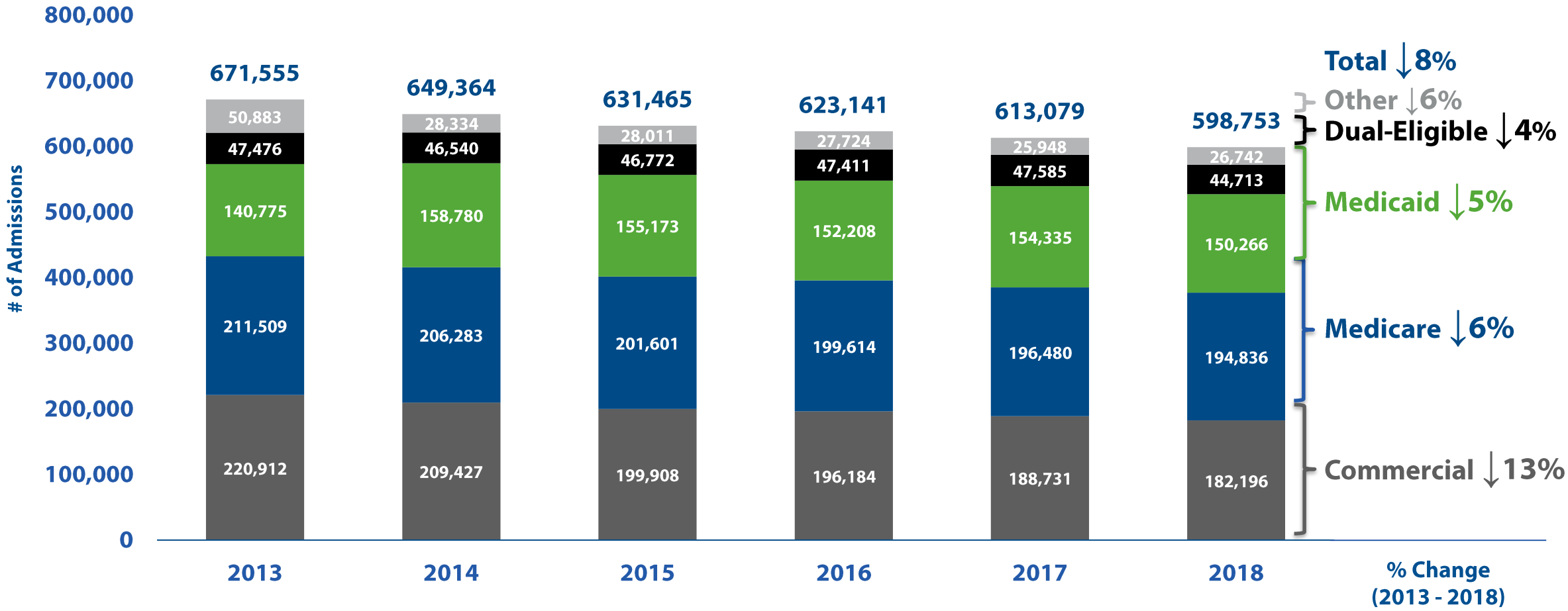
BEHAVIORAL HEALTH PATIENTS CONTINUE TO RISE IN MARYLAND'S EMERGENCY DEPARTMENTS



ED visits for behavioral health increased by **14%** from 2016-2018, while all other ED visits dropped by **10%**

Source: MHA Analysis of HSCRC's hospital data (also referred to as the Revisit Files), calendar years 2016, 2017, & 2018
- Diagnosis categories are based on MHA's application of the Agency for Healthcare Research and Quality's Clinical Classifications Software Refined, version 2019-1
- Behavioral health diagnosis identified as either primary or secondary conditions
- ED "Treat & Release" patients that were discharged from the ED, died, or left against medical advice and does not include observation stays or inpatient admissions

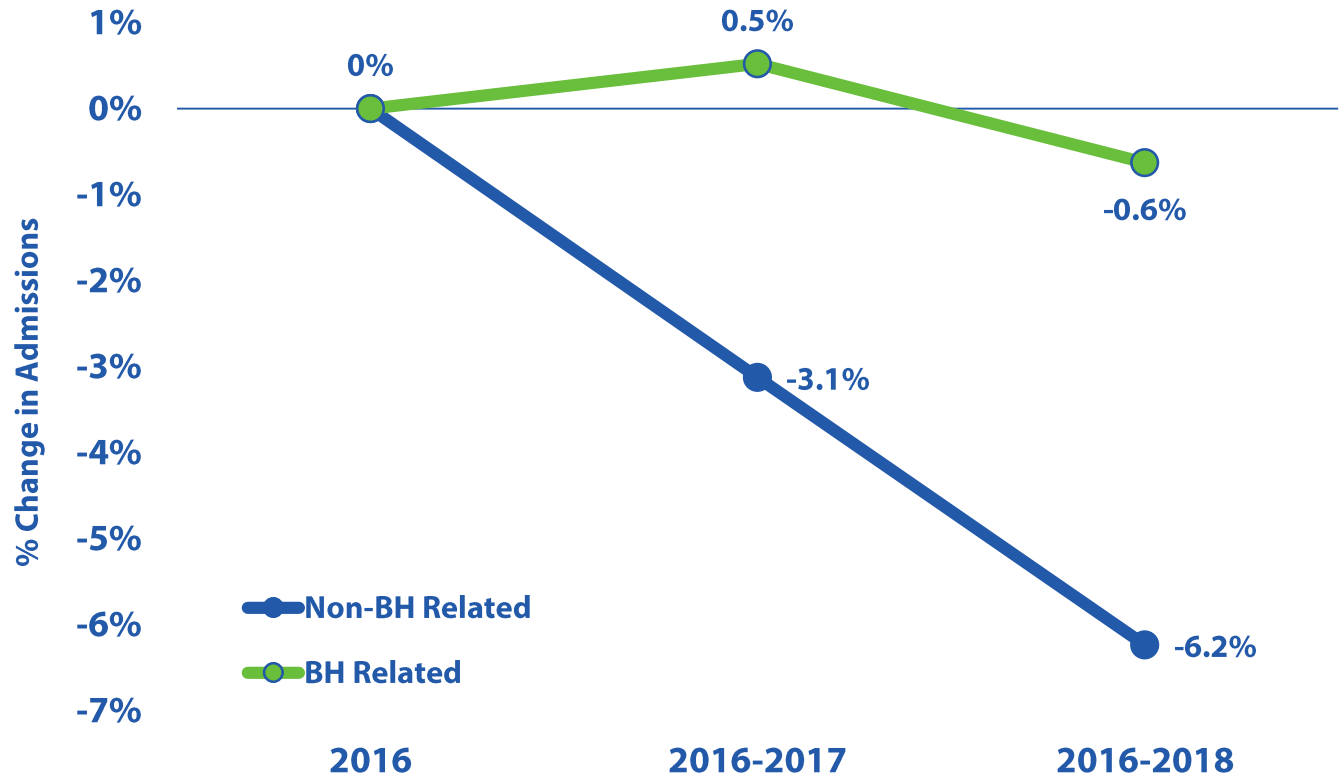
ADMISSIONS ARE DECREASING FOR ALL PAYERS



- **8%** decrease in inpatient admissions from 2014 to 2018
- Greatest decreases by payer includes Commercial **(13%)** & Medicare **(6%)**

Source: MHA Analysis of HSCRC's hospital data (also referred to as the Revisit Files), calendar years 2014 through 2018

ADMISSIONS FOR BEHAVIORAL HEALTH CONTINUE TO BE A CHALLENGE



Admissions for behavioral health remained steady in comparison to non-behavioral health related admissions from 2016-2018 with much of the increase attributed to Medicaid patients

Source: MHA Analysis of HSCRC's hospital data (also referred to as the Revisit Files), calendar years 2016, 2017, & 2018
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