Performance Measurement Work Group Meeting

December 20, 2023

HSCRC Quality Team

PMWG Members

Carrie	Adams	Meritus	Sharon	Neeley	Maryland Department of Health Medicaid
Ryan	Anderson	MedStar - MD Primary Care Program	Christine	Nguyen	Families USA
Kelly	Arthur	Qlarant QIO	Jonathan	Patrick	MedStar Health
Ed	Beranek	Johns Hopkins Health System	Elinor	Petrocelli	Mercy Medical Center
Barbara	Brocato	Barbara Marx Brocato & Associates	Mindy	Pierce	Primary Care Coalition of Montgomery County
Zahid	Butt	Medisolv Inc.	Farzaneh	Sabi	Kaiser Mid-Atlantic Permanente Medical Group
Tim	Chizmar	MIEMSS	Nitza	Santiago	Lifebridge Health
Linda	Costa	University of Maryland School of Nursing	Dale	Schumacher	MedChi, Maryland State Medical Society
Ted	Delbridge	MIEMSS	Jodi	Segal	Johns Hopkins University
Lori	Doyle	Community Behavioral Health Association of Maryland	Madeleine "Maddy"	Shea	Health Management Associates
Toby	Gordon	Johns Hopkins Carey Business School	Brian	Sims	Maryland Hospital Association
Theressa	Lee	Maryland Health Care Commission	Mike	Sokolow	University of Maryland Medical Systems
Angela	Maule	Garrett Regional Medical Center	Geetika "Geeta"	Sood	JHU SOM,Division of Infectious Diseases.
Patsy	Mcneil	Adventist Health	April	Taylor	Johns Hopkins Health System
Stephen	Michaels	MedStar Southern Maryland Hospital	Bruce	VanDerver	Maryland Physicians Care
Lily	Mitchell	CareFirst	Jamie	White	Frederick Health

Agenda

- RY26 QBR Update
    - Final recommendations
    - Next steps on ED length of stay
- MHAC RY 2026 draft recommendation
    - PPC Trends
    - Performance Standards and Scoring
    - Bayesian Smoothing
- MPA Population Health Adjustment: Pivot to PQIs
- Readmission Reduction Incentive Program

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RY 2026 Policy Decisions

1. Maryland Hospital Acquired Conditions (MHAC) Program
   - Payment PPCs
   - Bayesian Smoothing
   - Calculation of performance standards
   - Small hospital concerns
   - Revenue at-risk
2. Readmission Reduction Incentive Program (RRIP)
   - Improvement target
   - Attainment target
   - Revisits/Observation
   - Excess Days in Acute Care measure
   - Within hospital disparities measure and incentive

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RY 2026 Policy Decisions, continued

3. Emergency Department/Multi-Visit Patient policy recommendation
    - Finalize measure
    - How to incorporate into existing or new PAU policy
    - How to incorporate measure into existing methodologies (e.g., Marketshift)

4. Population Health: AHRQ Prevention Quality Indicators

5. Population Health: IP diabetes screening pilot

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RY26 Quality Based Reimbursement

QBR RY 2026 Final Recommendations

1. Modify Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 60 percent (+10%), Safety (NHSN measures) - 30 percent (-5%), Clinical Care - 10 percent (-5%).
   a. Within the PCE domain:
      i. Increase domain weight to 60 percent to accommodate new measures.
      ii. Decrease the weight on HCAHPS top-box; maintain weight on consistency linear measures.
      iii. Continue to include Medicare and Medicaid Timely Follow-Up (TFU) rates and add TFU Disparity Gap measure weighted at 10 percent.
      iv. Add an ED wait time measure weighted at 10 percent.
   b. Within the Safety domain:
      i. Reduce overall domain weight from 35 to 30 percent to be closer to the CMS VBP program weight of 25 percent.
   c. Within the Clinical Care domain:
      i. Remove THA-TKA measure and reduce domain weight by 5 percent.
      ii. Continue to include the inpatient mortality measure in the program.
      iii. Add the all-payer, all-cause 30-Day Mortality measure.
      iv. Split the domain weight between the two mortality measures.

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Models of Domain and Measure Weight Options

RY2026 Proposed Weighting (2% total at-risk)	Model 1: Current Policy w/o THA-TKA	Model 2: Draft Recommendation w/o THA-TKA	Model 3: Modified Staff Recommendation	Model 4: No Weight Changes w/o THA-TKA or ED LOS
PCE Domain	**50.0%**	**60%**	**60%**	**50%**
HCAHPS TopBox (8)	25.0%	25.0%	20%	25.0%
HCAHPS Consistency	10.0%	10.0%	10%	10.0%
HCAHPS Linear (4)	10.0%	5.0%	10%	10.0%
ED Wait Times	0.0%	10.0%	10%	0.0%
TFU Medicare	2.5%	3.3%	3.3%	1.7%
TFU Medicare Disparity Gap	0.0%	3.3%	3.3%	1.7%
TFU Medicaid	2.5%	3.3%	3.3%	1.7%
Clinical Care Domain	**15%**	**15%**	**10%**	**15%**
IP Mortality	15.0%	7.5%	5%	7.5%
30-Day Mortality	0.0%	7.5%	5%	7.5%
THA/TKA	0.0%	0.0%	0%	0%
Safety Domain	**35%**	**25%**	**30%**	**35%**
CAUTI	5.8%	4.2%	5%	5.8%
C. Diff	5.8%	4.2%	5%	5.8%
SSI (2)	5.8%	4.2%	5%	5.8%
CLABSI	5.8%	4.2%	5%	5.8%
MRSA	5.8%	4.2%	5%	5.8%
PSI 90 (10)	5.8%	4.2%	5%	5.8%

Modified Staff Recommendation:

- Maintains HCAHPS Linear/reduces HCAHPS top box

- Reduces Safety by 5 percent

- Places 10 percent on ED LOS (statewide $22.5 M)
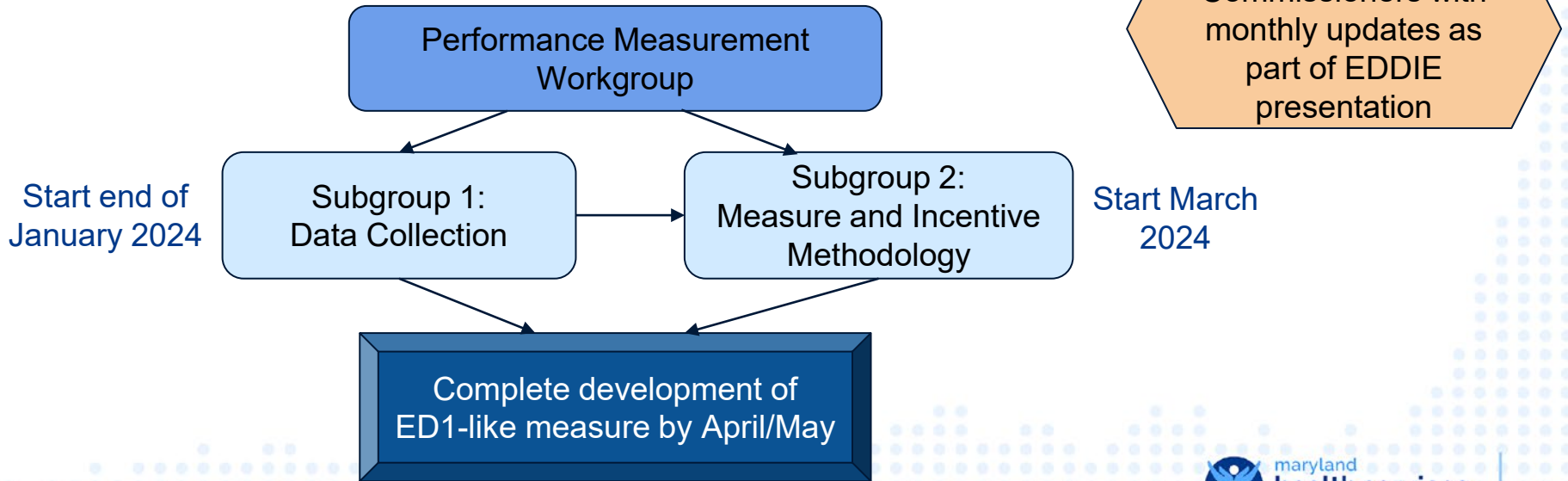
- Maintains mortality at 10 percent

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QBR RY 2026 Final Recommendations

2. Develop the following monitoring reports to track hospital performance::
    i.   Timely Follow-Up for Behavioral Health
    ii. Sepsis Dashboard: Sepsis mortality, Sep-1 measure–Early Management Bundle, Severe
3. Continue implementing the HCAHPS improvement framework with key stakeholders.
    a. Explore statewide adoption of added question(s) to the survey linked to best practice with evidence that implementation improves HCAHPS scores.
    b. Address emergency department length of stay/hospital throughput issues as strategy to improve HCAHPS
4. Continue collaboration with CRISP and other partners on infrastructure to collect hospital electronic clinical quality measures and core clinical data elements for hybrid measures;
5. Maintain the pre-set scale (0-80 percent with cut-point at 41 percent) and continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) for the QBR program.
    a. Retrospectively evaluate 41 percent cut point using more recent data to calculate national average score for RY25 and RY26
    b. Based on more analyses on the impact of pre-COVID performance standards on national hospital performance, adjust the RY24 QBR cut point to 0.32.

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ED LOS Measure Development Plan

Objective:

1. Develop mechanism to collect ED length of stay for patients admitted to the hospital
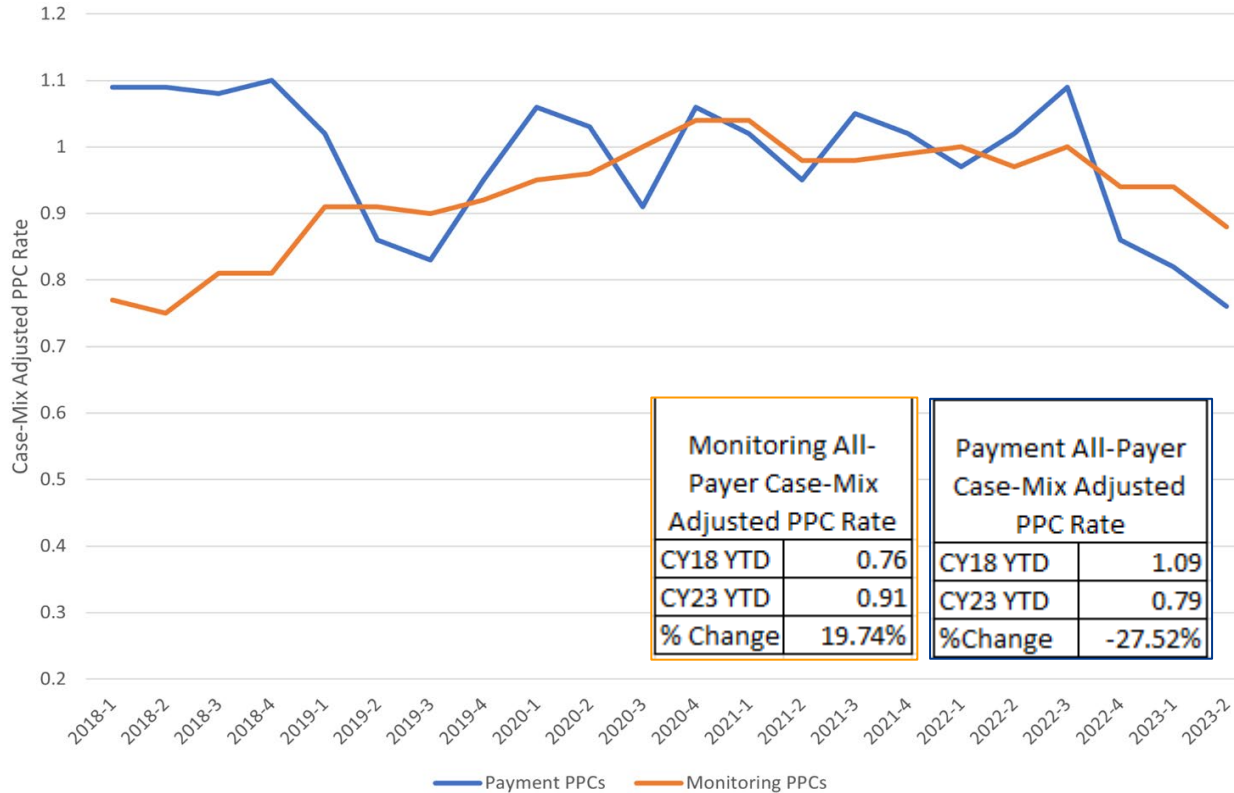2. Develop ED LOS measure and incentive methodology for RY 2026 QBR

Performance Measurement Workgroup

Start end of January 2024

Subgroup 1: Data Collection

Subgroup 2: Measure and Incentive Methodology

Start March 2024

Provide Commissioners with monthly updates as part of EDDIE presentation

Complete development of ED1-like measure by April/May

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Next Steps

- Finalize RY24 revenue adjustments with new cut point for 1/1/24 implementation

- Send memo to hospitals with RY26 policy updates

- Run baseline reports and performance standards for HSCRC generated measures; pull base period Care Compare measures

- Develop RY26 calculation sheet

- Solicit volunteers for ED1-like measure workgroups

- Explore development of additional ED incentive program (1 percent)
  - Will address root causes of ED LOS
  - Will create alignment with EDDIE project
  - Will be developed for a draft policy in Spring Commission meeting

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Maryland Hospital Acquired Conditions

PPC Performance, CY2023 YTD through June

All-Payer Case-Mix Adjusted PPC Rate by Quarter

Monitoring All-Payer Case-Mix Adjusted PPC Rate	
CY18 YTD	0.76
CY23 YTD	0.91
% Change	19.74%

Payment All-Payer Case-Mix Adjusted PPC Rate	
CY18 YTD	1.09
CY23 YTD	0.79
%Change	-27.52%

Clinical PPC Concerns

- Inclusion of Sepsis PPC for all hospitals
  - Impact of Sepsis PPC
- PPC 42: Accidental Puncture or Laceration
  - Dural tears- for Grouper v41, 3M will remove diagnosis G9612 Meningeal adhesions (cerebral) (spinal)
  - Adhesions- 3M investigating clinical concerns and will address in v42
- PPC 07- Pulmonary Embolism
  - Add codes below to DVT exclusion list in v41

RY25 Suggestions:
- Retrospective changes only for clinical issues vetted by 3M or administrative errors
- For PPC 42 and 07, staff propose to use v41 grouper results that have some fixed

RY26 Suggestions:
- Include sepsis for all hospitals?
- Repeat fix for PPC 42 by using v42 grouper results at end of the year

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PPC Report Analysis

- Utilized the O/E ratio and Obs/At Risk to understand the progress of the PPC's and determine if any needed to be moved into the opposite program.
- There were concerns with a few monitoring PPC's due to their increase in O/E ratio over time; however, the PPCs with increases had clinical validity concerns raised during MHAC redesign.
  - PPC 8: Other Pulmonary Complications
  - PPC 15: Peripheral Vascular Complications except Venous Thrombosis
  - PPC 53: Infection, Inflammation and Clotting Complication of Peripheral Vascular and Infusions
- **Based on the findings, overall HSCRC will not be moving any monitoring PPC's into the payment program for RY 2026.** We will continue to monitor the MHAC summary report for findings in the future.

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PPC Trends Over Time

Monitoring PPC 8: **Other Pulmonary Complications** Progress 2018-2022

Monitoring PPC 15: **Peripheral Vascular Complications except Venous Thrombosis** Progress 2018-2022

Monitoring PPC 53: **Infection, Inflammation and Clotting Complications of Peripheral Vascular Catheters and Infusions** Progress 2018-2022
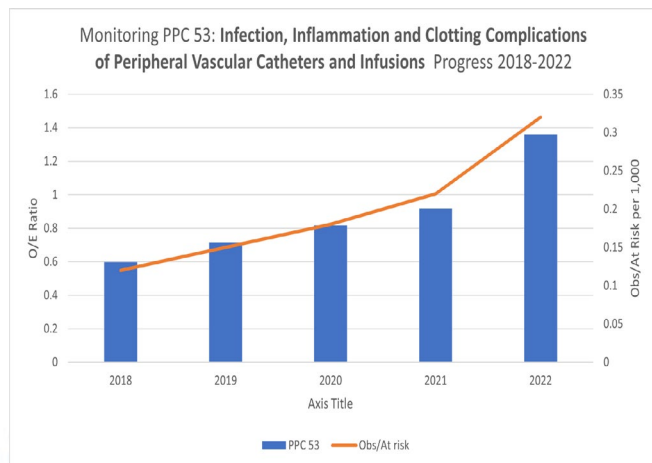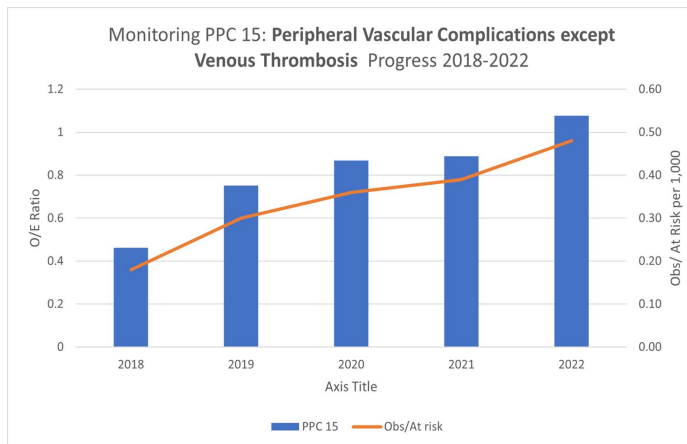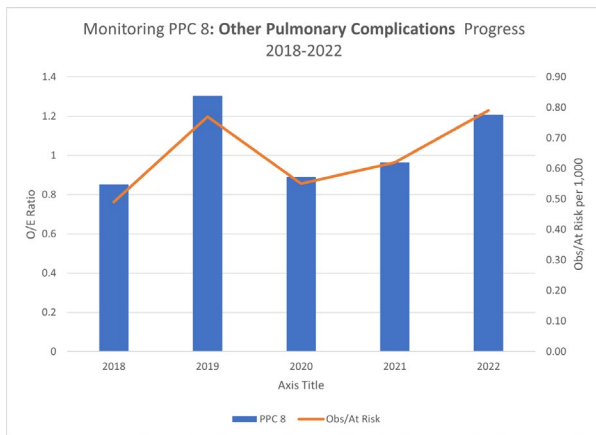
Observed Counts CY 2022:
- PPC 8: 154
- PPC 15:140
- PPC 53: 91

Other MHAC Recommendation Changes

- Consider how benchmarks and thresholds are calculated to increase stability of the performance standards:
  - Current: Threshold = Rate at the 10th percentile   Benchmark = 90th percentile
  - Options explored:
    - Take mean of top and bottom decile or quintile of hospital rates
    - Explore + / - 2 standard deviations from the mean
- Establish MHAC revenue adjustment scale
- Determine if Bayesian Smoothing should be considered to improve measurement reliability--future years?

Performance Standards by Calculation Method

Base CY21 and CY22		Current Method			Potential Method	
		P90	P10		Avg P80	Avg P20
PPC Number	PPC Description	Threshold	Benchmark		Threshold	Benchmark
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	1.4652	0.4577		1.8063	0.3641
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1.8435	0.2207		1.7991	0.2203
7	Pulmonary Embolism	1.7835	0.3125		1.6457	0.2709
9	Shock	2.0077	0.3751		1.9209	0.345
16	Venous Thrombosis	1.5923	0.0964		1.7412	0.131
28	In-Hospital Trauma and Fractures	1.828	0.1732		2.1401	0.2135
35	Septicemia & Severe Infections	1.547	0.464		1.8284	0.4323
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	1.9892	0.3349		1.9412	0.3196
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	2.1739	0		2.0487	0.045
42	Accidental Puncture/Laceration During Invasive Procedure	1.4578	0.2903		1.4101	0.2817
47	Encephalopathy	1.8575	0.2666		1.9884	0.2432
49	Iatrogenic Pneumothrax	1.8755	0.3216		2.0387	0.263
⭐ 60	Major Puerperal Infection and Other Major Obstetric Complications	1.8307	0		1.7426	0.1491
61	Other Complications of Obstetrical Surgical & Perineal Wounds	2.1728	0		2.0577	0.1402
67	Combined Pneumonia (PPC 5 and 6)	1.4636	0.2822		1.5771	0.2608

Most similar to current method

Run under 3M PPC Grouper V40 (i.e., RY25 version) and will be updated to v41.
⭐ PPC is dropped in V41 due to no hospitals qualifying for PPC
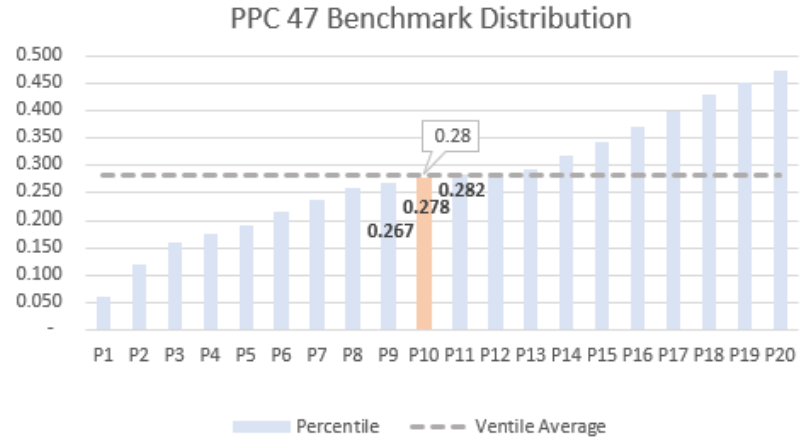
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PPC Variation in Performance

- To understand if there's a need to move to an average approach, staff wanted to understand the variation around the cut points for rewards and penalties
   - Large variation would warrant moving to an average approach

	Best Performers							PPC 47		Worst Performers				

Percentile

Best Performers: P6 P7 P8 P9 P10

PPC 47

Worst Performers: P90 P91 P92 P93 P94

O/E Ratio

Best Performers: 0.21 0.24 0.26 0.27 0.28

Worst Performers: 1.83 1.86 1.88 1.91 1.94

Note: Staff calculations vary from SAS calculations due to rounding differences between SAS and Excel

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EX: PPC 47 Variation in Performance

PPC 47 Benchmark Distribution


PPC 47 Threshold Distribution

- 10th percentile for benchmark determination appears reasonable
    - Delta between 9th, 10th, and 11th percentile is limited
    - Range between 1st percentile and 20th percentile is limited (~0.4)
    - Average of best ventile is similar to 10th percentile
- 90th percentile for threshold determination appears less reasonable
    - Delta between 89th, 90th, and 91st percentile is more significant
    - Range between 81st percentile and 100th percentile is substantial (~1.5)
    - Average of worst ventile is less similar to 90th percentile

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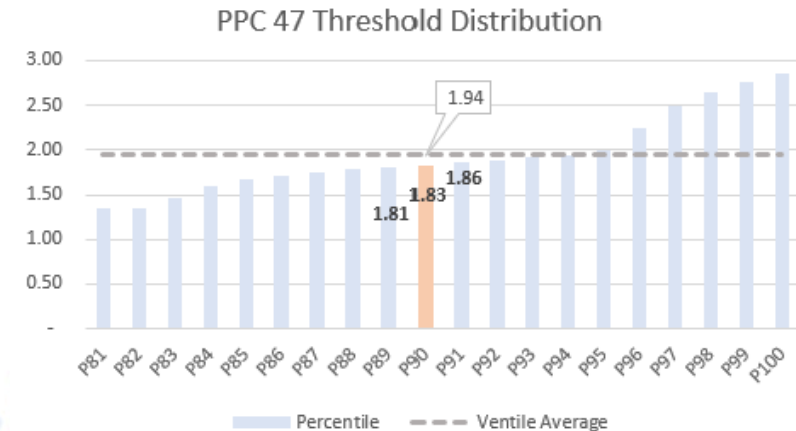
MHAC Scores: Current vs. Potential Performance Standards

Hospital Scores: Current vs Potential Method
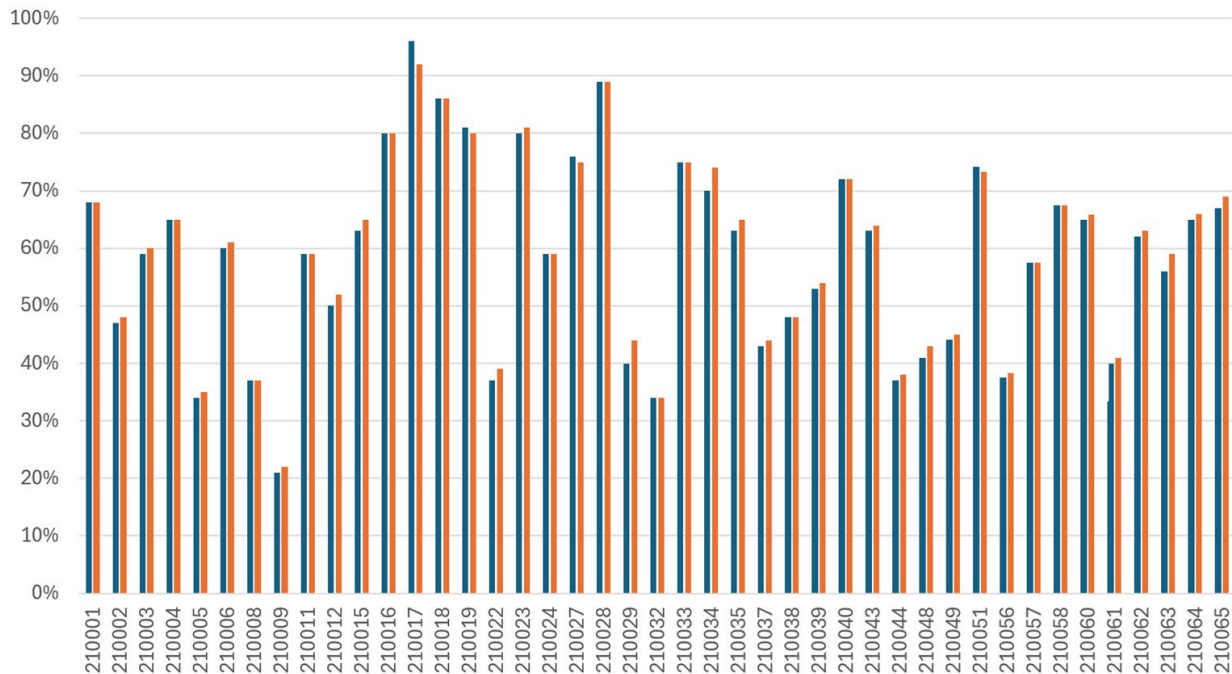
Performance Comparison (Potential vs Current)	# of Hospitals	Average Change to Score
Worse	4	-2%
No Change	14	--
Better	25	2%

Methods are very similar in terms of results.
Should we modify the method for setting performance standards?

Examples:
Hospital A goes from 83% to 85% the revenue adjustment increases by 0.13%
Hospital B goes from 43% to 45% the revenue adjustment decreases by 0.07%

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Bayesian Smoothing

Bayesian Smoothing

/ **Adjusts hospitals scores based on reliability of PPC measure at given hospital**

/ **For a given PPC, the reliability of the PPC tends to increase as the number of at-risk discharges increases**

/ **The reliability for PPC i for hospital j can be calculated as follows:**

○ $$\frac{Variance\ between\ hospital_i}{Variance\ between\ hospital_i + Variance\ within\ hospital_{ij}}$$

○ This is referred to as the signal to noise ratio

/ **Alternative methods exist for calculating reliability**

Bayesian Smoothing for MHAC Scoring

⟋ **The equation below illustrates how hospital j's smoothed rate for PPC measure i is based on the hospital's risk-adjusted rate (RAR), the statewide RAR, and PPC measure i's reliability for hospital j:**

$$Smoothed\ rate_{ij} = (Hospital\ RAR_{ij} \times Reliability_{ij}) + (Statewide\ RAR_i \times (1 - Reliability_{ij}))$$

- o The hospital's smoothed rate equals the hospital's RAR when the reliability is 1 for the measure at the hospital.
- o The hospitals' smoothed rate equals the state RAR when the reliability is 0 for the measure at the given hospital
- Similar to AHRQ's PSI 90 reliability adjustment used to calculate CMS PSI 90 results for CMS payment programs (e.g., HAC Reduction Program).

Bayesian Smoothing Example

PPC	Reliability for Hospital A	PPC RAR for Hospital A	Statewide Mean RAR	Smoothed PPC rate for Hospital A
3	0.954	1.009	1.403	1.027
4	0.151	1.028	1.593	1.508

Note: This table contains hypothetical data

PPC 3 Reliability for Hospital A = 0.954

Hospital RAR   Hospital smoothed rate   Statewide RAR

PPC 4 Reliability for Hospital A = 0.151

Hospital RAR   Hospital smoothed rate   Statewide RAR

MHAC scores using smoothed rates

/ *For each PPC, calculate the smoothed threshold for the given PPC as the 90th percentile of hospital smoothed rates for the given PPC*

/ *For each PPC, calculate the smoothed benchmark for the given PPC as the 10th percentile of hospital smoothed rates for the given PPC*

/ *Calculate each hospital's smoothed total points for each PPC based on the smoothed benchmark and smoothed threshold*
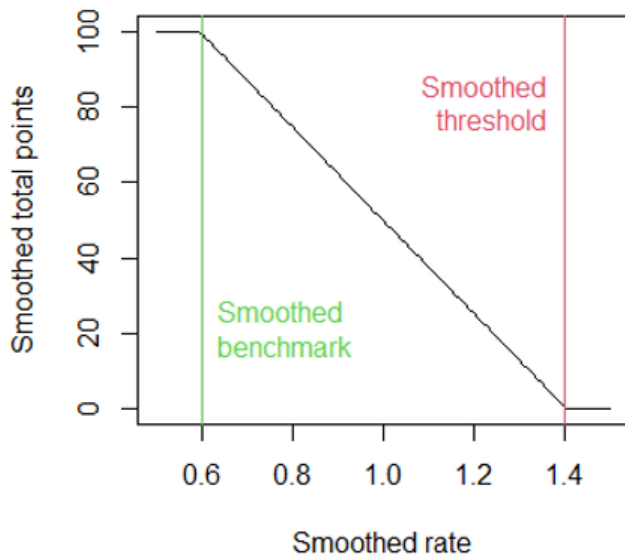
Implementing reliability adjustment

/ **Option 1 - Adjust PPC rates by indirect standardization (current approach) and estimate signal variance to perform reliability adjustment**

/ **Option 2 – Use regression to risk adjust PPCs and reliability adjusted hospital effect**

/ **Option 3 – Fully Bayesian estimation procedure**

/ **We have tested options 1 and 2**

- Using FY 2022 performance year
- Small hospitals performance includes FY 2021 and FY 2022

Comparison of Hospital MHAC Scores: Option 1 vs Current Method
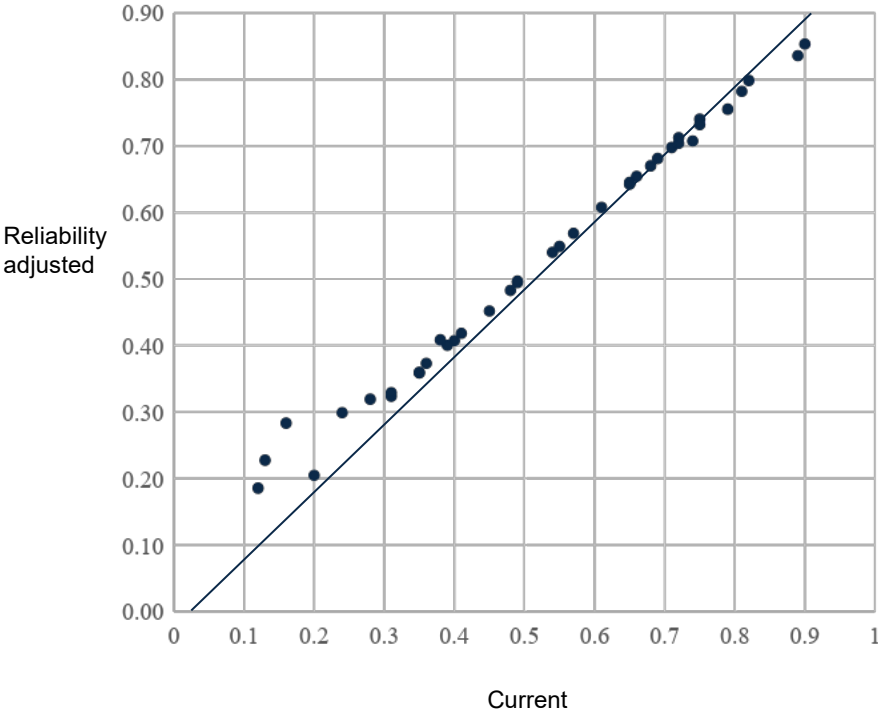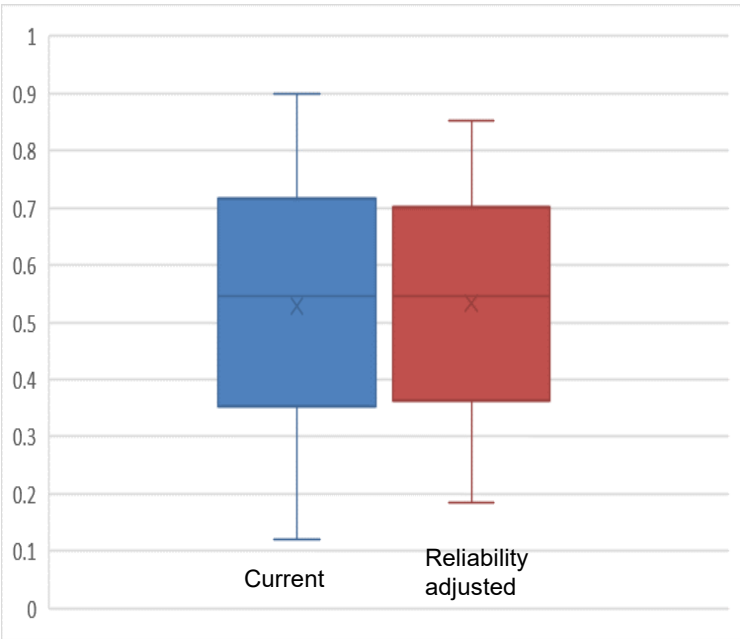
Comparison of reliability estimates

PPC Number	Option 1	Option 2a	Option 2b
3	0.59	0.61	0.63
4	0.41	0.36	0.40
7	0.35	0.41	0.54
9	0.63	0.68	0.69
16	0.30	0.46	0.56
28	0.96	0.19	0.37
35	0.70	0.62	0.64
37	0.48	0.29	0.31
41	0.08	0.10	0.05
42	0.50	0.59	0.61
47	0.60	0.63	0.61
49	0.23	0.18	0.32
60	0.00	0.20	0.75
61	0.16	0.28	0.36
67	0.71	0.72	0.71

For average sized hospital. Option 2a – Regression with random hospital intercepts; Option 2b – Regression with random hospital intercepts and dispersion

Next steps

/ **Score option 2 and compare**

/ **Test extended performance periods**

/ **Robustness and sensitivity tests: different base and performance periods, excluding certain indicators or hospitals**

/ **Consider option 3**

HSCRC staff propose to monitoring smoothing for RY 2026

Draft RY2026 MHAC Recommendations

1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.

    a. Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.

    b. Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.

    c. Engage hospitals as needed/appropriate on specific PPC increases to understand trends and discuss potential quality concerns.

2. Use more than one year of performance data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs). The performance period for small hospitals will be CY 2022 and 2023.

3. Continue to assess hospital performance on attainment only.

4. Continue to weigh the PPCs in the payment program by 3M cost weights as a proxy for patient harm.

5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between XX and XX percent. **TBD**

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Population Health Measure

Pivot to PQIs for 2024

- Staff will seek to pilot inpatient diabetes screening program with interested hospitals/systems
- Those interested in participating in pilot should email:
  - jason.mazique@maryland.gov
  - geoff.dougherty@maryland.gov
- Commission is still required to include hospital population health measure in MPA payment policy for CY24
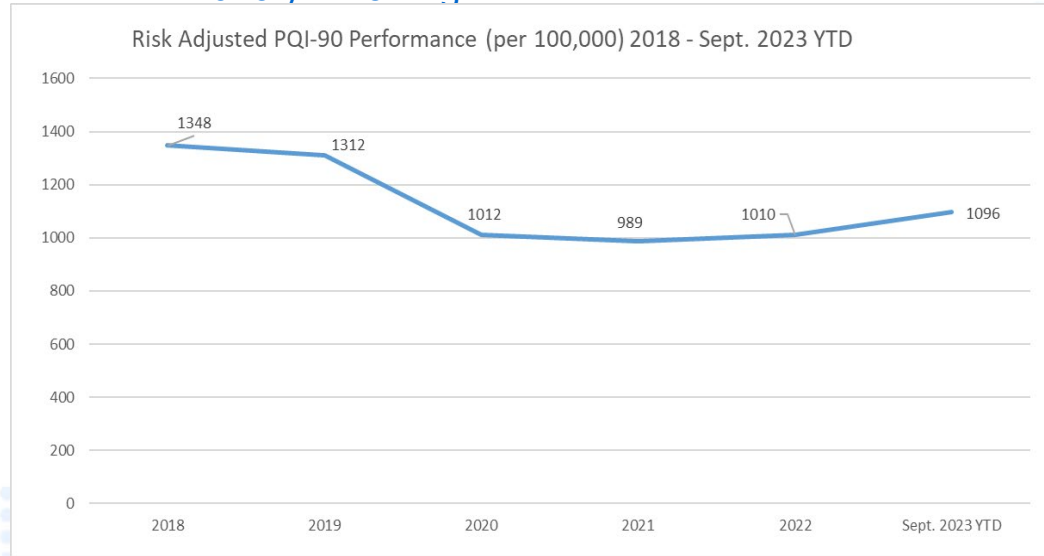- Will use Prevention Quality Indicators to meet this requirement for CY24

Introduction

- HSCRC staff are required to propose a population health measure as part of the Medicare Performance Adjustment

  - Given the additional development work required of the inpatient diabetes screening measure, staff proposed an alternative existing population health measure

  - Proposal is to use the AHRQ Prevention Quality Indicators

    - The AHRQ PQIs are population based indicators that identify hospitalizations that might have been avoided through access to high-quality outpatient care, thus providing insights into the quality of health services in a community

    - There are ten individual PQI measures that are included in the overall PQI composite measure (PQI-90), which is risk-adjusted based on age and sex. (See appendix A listing the 10 PQI measures)

      - These ten measures are also grouped into three other specific composites for

        - Acute composite(PQI 91)

        - Chronic composite (PQI 92)

        - Diabetic-related admissions composite (PQI 93) - can also be included in the chronic composite

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AHRQ PQI Performance under SIHIS

- To support Maryland's success under SIHIS, Maryland hospitals are held financially accountable under the TCOC Model for all-payer PQI admissions
  - As of September 2023, Maryland has experienced a 19% percent decrease across all PQIs from the 2018 baseline
    - Current admission rate is 1,096 per 100,000 residents
    - Current PQI rate is -4.4 percent below the 2023 year 5 target rate

Goal: Reduce Avoidable Admissions	
Measure	AHRQ Risk-Adjusted PQIs
2018 Baseline	1,348 admits per 100,000
2021 Year 3 Milestone	8 percent improvement
2023 Year 5 Target	15 percent improvement
2026 Year 8 Final Target	25 Percent improvement

Risk Adjusted PQI-90 Performance (per 100,000) 2018 - Sept. 2023 YTD

Year	Value
2018	1348
2019	1312
2020	1012
2021	989
2022	1010
Sept. 2023 YTD	1096

Proposed MPA-PQI Methodology

In line with statewide SIHIS PQI Improvement targets, staff has modeled hospital-specific PQI targets on the Better of Improvement versus Attainment

Improvement Targets
- Evaluating all hospitals on the annual statewide improvement targets used in setting the the SIHIS goal

Improvement	2023	2024	2025	2026
Threshold	-3%	-7%	-10%	-13%
Benchmark	-13%	-13%	-13%	-13%
Symetrical Benchmark	6%	-1%	-7%	-13%

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Proposed MPA-PQI Methodology, cont.

Attainment Targets: Staff modeled different approaches and settled on an attainment goal that aligns itself with the expectations under the Improvement targets (actual rates may change with updates to PQI logic; not applicable to improvement targets)

- Reward Targets
  - Reward Threshold (Reward Startpoint) = 2022 Median PLUS annual Improvement Targets
  - Reward Benchmark (Reward Endpoint) = Expected 2026 Median PLUS the same annual rate of change in the threshold calculation
- Penalties are determined by maintaining same range of performance in reward targets
  - Penalty Threshold (Penalty Startpoint) = 2022 Median PLUS annual Improvement Targets
  - Penalty Benchmark (Penalty Endpoint) = Apply difference between Reward Threshold and Benchmark to Penalty Threshold (thus same range is maintained)
- Aligns with improvement targets and maintains symmetry throughout multi-year performance assessment

| Attainment	2023	2024	2025	2026
Threshold (Improved Median)	10.07	9.72	9.38	9.06
Benchmark (Same Exp as Median)	9.06	8.75	8.45	8.16
Poor Performance Benchmark (Same Exp as Median)	11.08	10.69	10.32	9.97
Reward Range	1.01	0.97	0.94	0.91
Penalty Range	1.01	0.97	0.94	0.91

Next Steps

- Finalize measurement and incentive approach
- Model hospital-specific financial adjustments in the MPA against the proposed improvement vs attainment targets
- Final discussion at January PMWG
- Incorporate into MPA final policy in February

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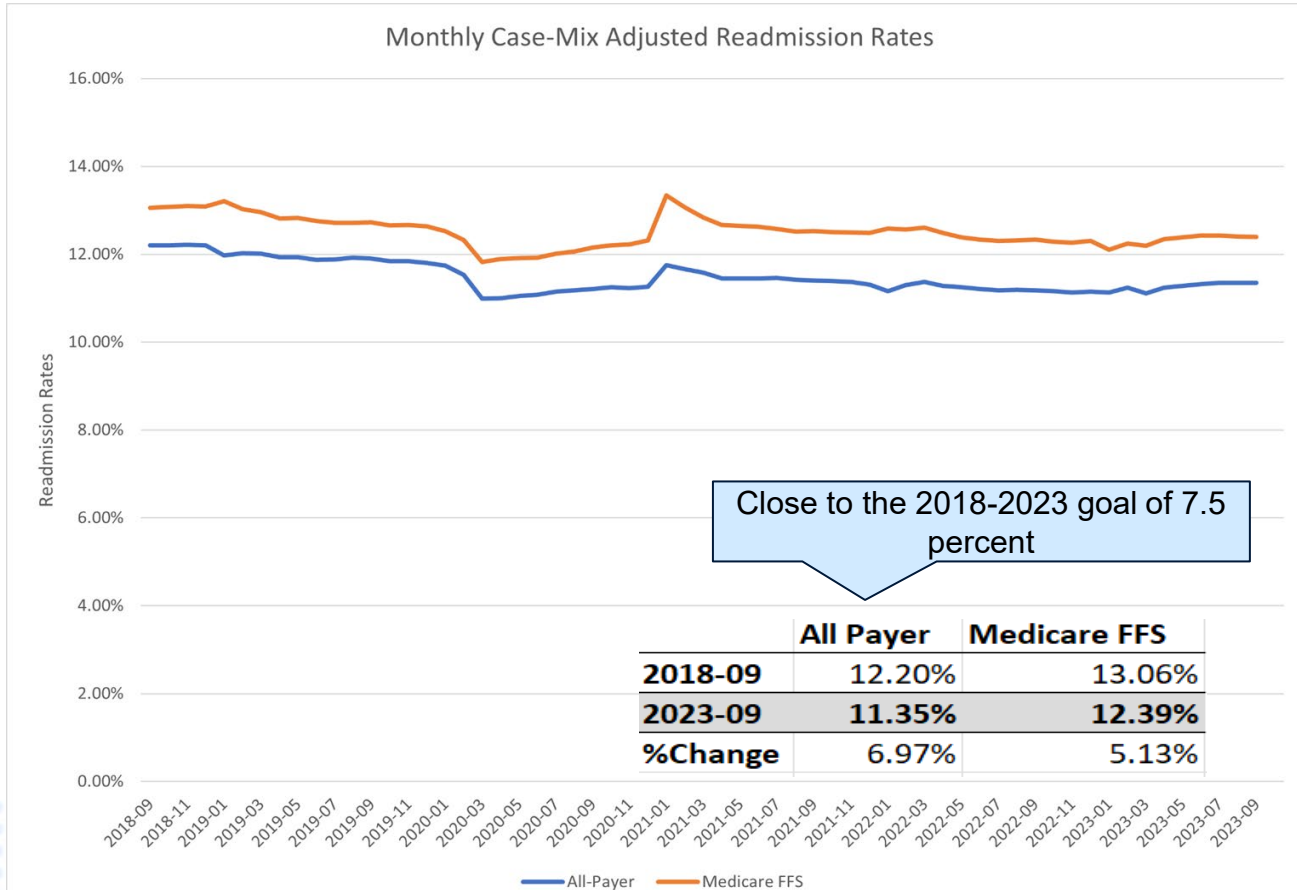# Readmissions

Unadjusted Readmission Rates, MD vs Nation

> CMMI has agreed to move to a risk-adjusted measure, but will still monitor unadjusted test. CMMI is currently adapting HWR measure for Maryland.

Readmissions - Rolling 12M through July 2023
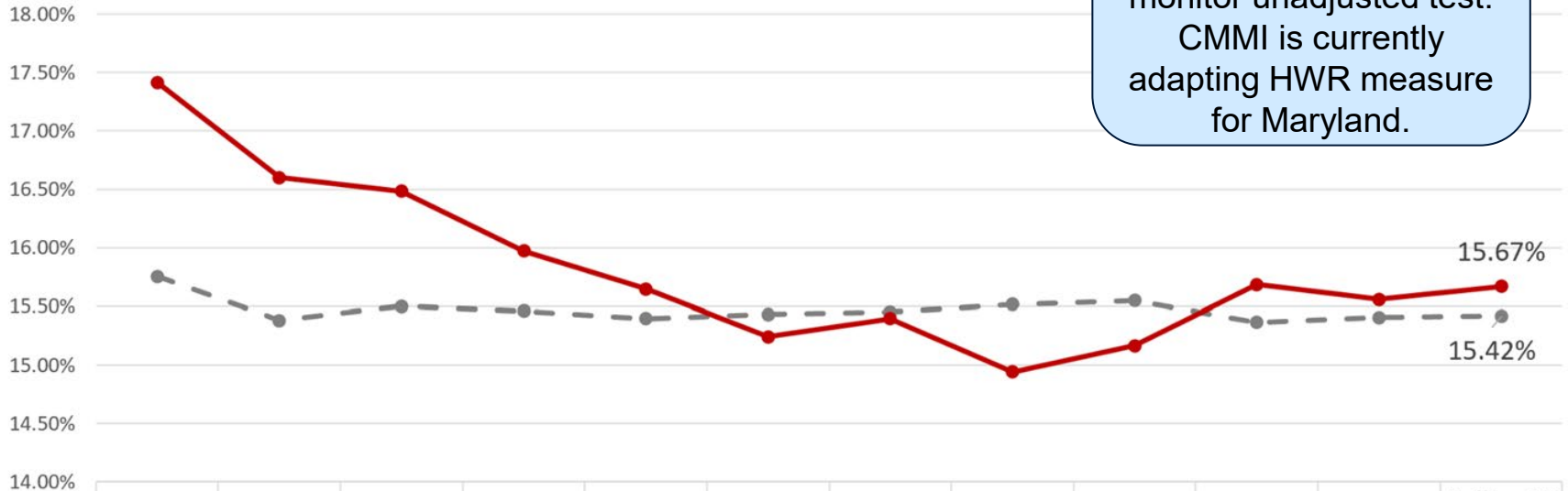
15.67%

15.42%

|	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	Rolling 12 Months CY 2023
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%	15.42%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%	15.67%

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Improvement in Case-Mix Adjusted Readmission Rates, All-Payers vs Medicare FFS

Monthly Case-Mix Adjusted Readmission Rates

Close to the 2018-2023 goal of 7.5 percent

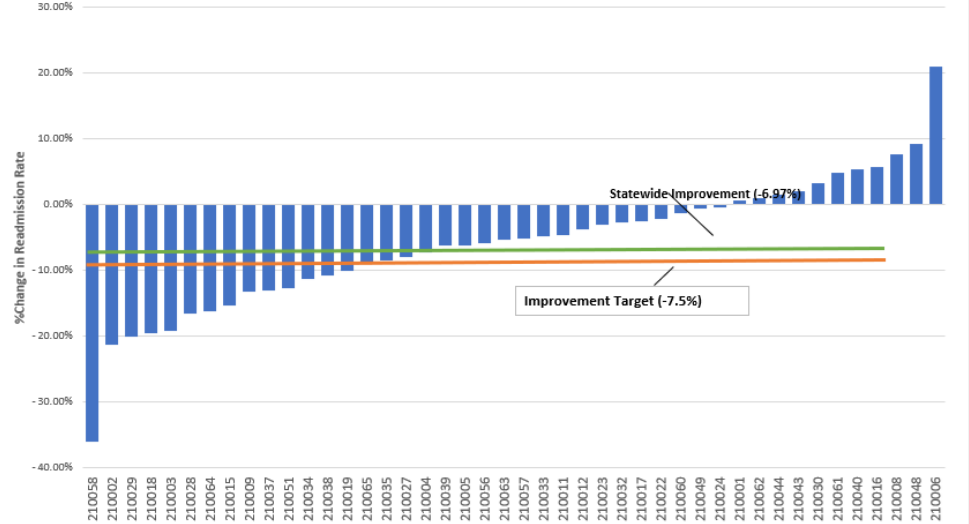|	**All Payer**	**Medicare FFS**
2018-09	12.20%	13.06%
2023-09	**11.35%**	**12.39%**
%Change	6.97%	5.13%

RY2025 YTD By Hospital Case-Mix Adjusted Readmission Rates

By Hospital Case-Mix Adjusted Readmission Rates, CY2025 YTD Through September
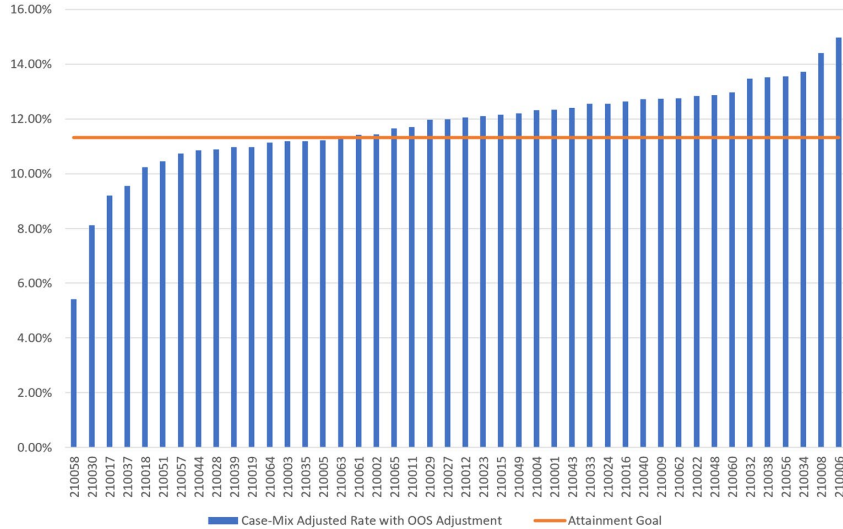
Change in All-Payer Case Mix Adjusted Readmission Rate by Hospital from 2018 to Spetember 2023

Readmissions Attainment and Improvement Targets

- RY 2022 RRIP established a 5-year improvement target (-7.5 percent) and attainment target (65th percentile of base period performance with OOS adjustment)

- Improvement and Attainment Target were established by looking at:

  - Trend analysis 2013-2018 and 2016-2018

  - State rate if all hospitals got to 2018 median

  - MEDA Center national benchmarking analysis:

    - Trended similar geographies (MD compared to nation and peer counties) benchmarking performance and improvement opportunities using commercial and medicare data

  - Reduction in Readmission-PQIs

  - Reduction in Disparities

Staff are working to replicate analyses to establish new targets for CY 2024-CY 2026 (3 year improvement)

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RY 2026 Readmission Incentive Reduction Program (RRIP)

Next Steps:

- Need to establish a new multi-year improvement target

- Need to evaluate the 65th percentile attainment target

- Measure Updates?

- Assess impact of revisits to the ED or observation on inpatient readmissions

- Evaluate whether to include in payment or continue to monitor Excess Days in Acute Care measure

- Evaluate within hospital disparities measure and incentive and establish annual improvement target

Draft RRIP scheduled for February Commission meeting

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Next Meeting: Wednesday, January 17, 2023

APPENDIX

AHRQ Prevention Quality Indicators (PQIs)

PQI 01	Prevention Quality Indicator 01 (PQI 01) Diabetes ShortTerm Complications Admission Rate
PQI 03	Prevention Quality Indicator 03 (PQI 03) Diabetes LongTerm Complications Admission Rate
PQI 05	Prevention Quality Indicator 05 (PQI 05) Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
PQI 07	Prevention Quality Indicator 07 (PQI 07) Hypertension Admission
PQI 08	Prevention Quality Indicator 08 (PQI 08) Heart Failure Admission Rate
PQI 11	Prevention Quality Indicator 11 (PQI 11) CommunityAcquired Pneumonia Admission Rate
PQI 12	Prevention Quality Indicator 12 (PQI 12) Urinary Tract Infection Admission Rate
PQI 14	Prevention Quality Indicator 14 (PQI 14) Uncontrolled Diabetes Admission Rate
PQI 15	Prevention Quality Indicator 15 (PQI 15) Asthma in Younger Adults Admission Rate
PQI 16	Prevention Quality Indicator 16 (PQI 16) Lower-Extremity Amputation Among Patients with Diabetes Rate
PQ1 90	Prevention Quality Indicator 90 (PQI 90) Prevention Quality Overall Composite
	All PQIs listed above
PQI 91	Prevention Quality Indicator 91 (PQI 91) Prevention Quality Acute Composite
	PQI 11 Community-Acquired Pneumonia Admission Rate
	PQI 12 Urinary Tract Infection Admission Rate
PQI 92	Prevention Quality Indicator 92 (PQI 92) Prevention Quality Chronic Composite
	PQI 01 Diabetes Short-Term Complications Admission Rate
	PQI 03 Diabetes Long-Term Complications Admission Rate
	PQI 05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
	PQI 07 Hypertension Admission Rate
	PQI 08 Heart Failure Admission Rate
	PQI 14 Uncontrolled Diabetes Admission Rate
	PQI 15 Asthma in Younger Adults Admission Rate
	PQI 16 Lower-Extremity Amputation among Patients with Diabetes Rate
PQI 93	Prevention Quality Indicator 93 (PQI 93) Prevention Quality Diabetes Composite
	PQI 01 Diabetes Short-Term Complications Admission Rate
	PQI 03 Diabetes Long-Term Complications Admission Rate
	PQI 14 Uncontrolled Diabetes Admission Rate
	PQI 16 Lower-Extremity Amputation among Patients with Diabetes Rate

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