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## Performance Measurement Workgroup

November 16, 2022

HSCRC Quality Team

## PMWG Members

Carrie	Adams	Meritus	Stephen	Michaels	MedStar Southern Maryland Hospital Center
Ryan	Anderson	MedStar - MD Primary Care Program	Lily	Mitchell	CareFirst
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.	Tricia	Roddy	Maryland Department of Health
Tim	Chizmar	MIEMSS	Farzaneh L.	Sabi	Kaiser Mid-Atlantic Permanente Medical Group
Linda	Costa	University of Maryland School of Nursing	Nitza	Santiago	Lifebridge Health
Ted	Delbridge	MIEMSS	Jodi	Segal	Johns Hopkins University
Lori	Doyle	Community Behavioral Health Association of Maryland	Madeleine "Maddy"	Shea	Health Management Associates
Laura	Goodman	MD Medicaid	Brian	Sims	Maryland Hospital Association
Toby	Gordon	Johns Hopkins Carey Business School	Mike	Sokolow	University of Maryland Medical Systems
Theresa	Lee	Maryland Health Care Commission	Geetika "Geeta"	Sood	Johns Hopkins University School of Medicine, Division of Infectious Diseases.
Staci	Lofton	Maryland Health Care C	April	Taylor	Johns Hopkins Health System
Patsy	Mcneil	Adventist Health	Bruce	VanDerver	Maryland Physicians Care

# Meeting Agenda

- Final Maryland Hospital Acquired Conditions (MHAC) RY 2025 policy discussion
  - Modeling of revenue adjustments
- Draft Readmission Reduction Incentive Program (RRIP) RY 2025 policy discussion
- Hospital Population Health Accountability Policy discussion
- Potentially Avoidable Emergency Department Visits
- Health Equity

## Timeline of Deliverables (See PMWG Workplan document)

Month	Commission Meetings	CMMI	HSCRC/Other
October 2022	Draft QBR		
November	Final QBR Draft MHAC Hospital Population Health Policy Discussion		RY2023 Revenue Adjustments
December	Final MHAC PAU Measurement Report on Avoidable ED	Annual report including Year 3 SIHIS Update	
January 2023	Draft RRIP		
February	Final RRIP		
March/April			Internal TCOC Model Expansion Recommendations
May	Draft PAU Savings RY 2024 report (in Draft Update Factor Policy)		RY 2024 Revenue Adjustments
June	Final PAU Savings RY 2024 report (in Final Update Factor Policy)	Exemption Request	

# Maryland Hospital Acquired Conditions (MHAC) RY 2025 Final Policy

## MHAC RY 2025 Updates for Consideration

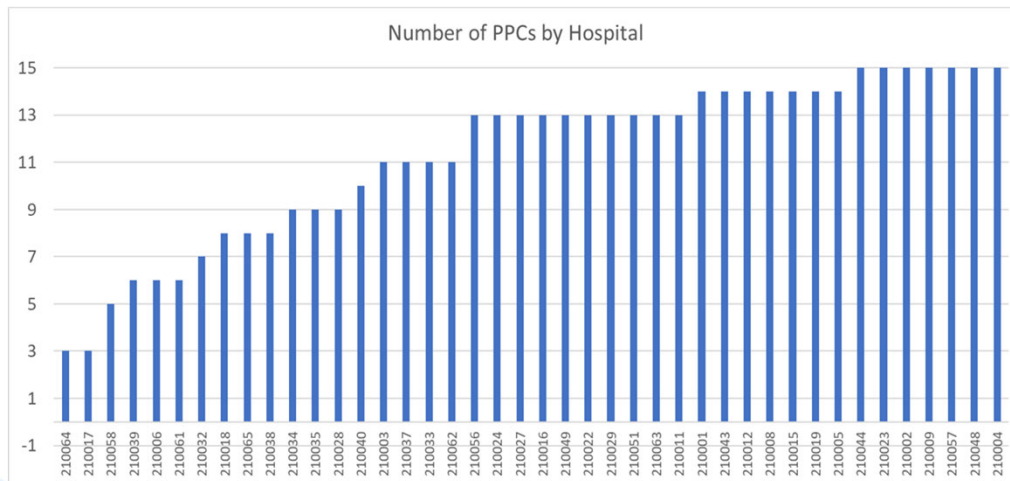
- Staff proposes minimal changes for RY 2025:
  - Add PPC 47 Encephalopathy to payment PPCs
  - Update Grouper Version: APR-DRG and PPC Version 40
  - Include palliative care and COVID patients for select PPCs as determined by 3M clinical logic
  - Use post-COVID time period for performance standards (July 2020-June 2022)
  - **Update small hospital criteria\***
  - Use most recent cost weights available
  - **Potentially adjust prospective payment scale\***

\*Staff will review modeling at November PMWG and include final small hospital criteria and prospective adjustment scale in final policy

# Small Hospital Criteria

- Use 2 years of performance data for small hospitals (i.e., CY 2022 and CY 2023)
  - 14 Payment PPCs:
    - Less than 20,000 at-risk discharges and/or 20 expected PPCs across all payment PPCs
  - 15 Payment PPCs (i.e., addition of PPC 47 Encephalopathy):
    - Increase proportionally
    - Less than 21,500 at-risk discharges and/or 22 expected PPCs

Small Hospitals	
210006	UM-Harford
210017	Garrett
210058	UMROI
210061	Atlantic General
210064	Levindale



Also hospital criteria for inclusion of each payment PPC (FY21 and FY22):

- > 2 expected
- > 20 at-risk

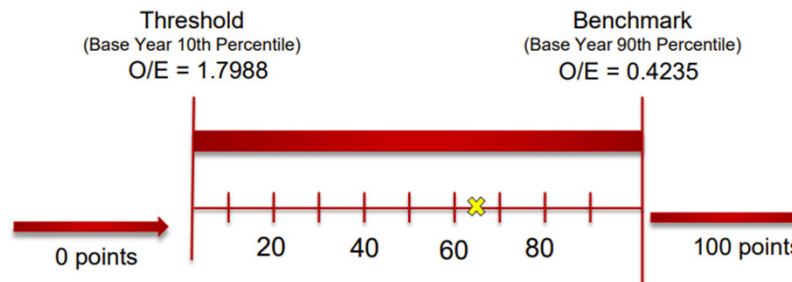
Note: Calvert qualifies for 6 PPCs, same as UM Harford and Atlantic General, but not as small hospital

# Performance Standards for Modeling

PPC	PPC Description	Threshold	Benchmark
3	Acute Pulmonary Edema and Respiratory Failure without	1.8333	0.3651
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1.6098	0.368
7	Pulmonary Embolism	1.9264	0.3406
9	Shock	1.9406	0.3702
16	Venous Thrombosis	1.723	0.0935
28	In-Hospital Trauma and Fractures	1.6768	0.4428
35	Septicemia & Severe Infections	1.5957	0.5546
37	Post-Operative Infection & Deep Wound Disruption Without	2.2327	0.175
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage	1.8755	0.3403
42	Accidental Puncture/Laceration During Invasive Procedure	1.2917	0.4245
47	Encephalopathy	1.8574	0.2446
49	Iatrogenic Pneumothrax	1.7027	0.3889
60	Major Puerperal Infection and Other Major Obstetric Complications	1.8998	0
61	Other Complications of Obstetrical Surgical & Perineal Wounds	2.1342	0.2995
67	Combined Pneumonia (PPC 5 and 6)	1.5275	0.3129

PPC 9 Shock – Attainment Score

Example graphic uses older benchmark and threshold



O/E of 1.1111 would be halfway between benchmark and threshold and would get score of 50. Since 0.90 is better than 1.1111, they get higher score of 65/100 points.

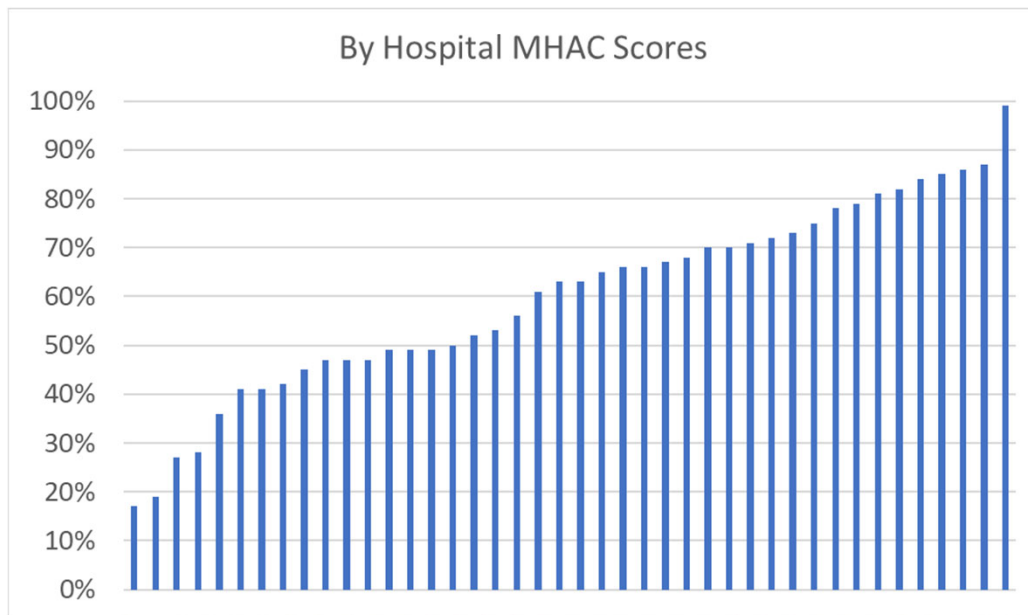
Hospital = 0.90  
Calculates to an attainment score of 65



# Score Modeling

Base: July 2020-June 2022; Performance: CY 2021

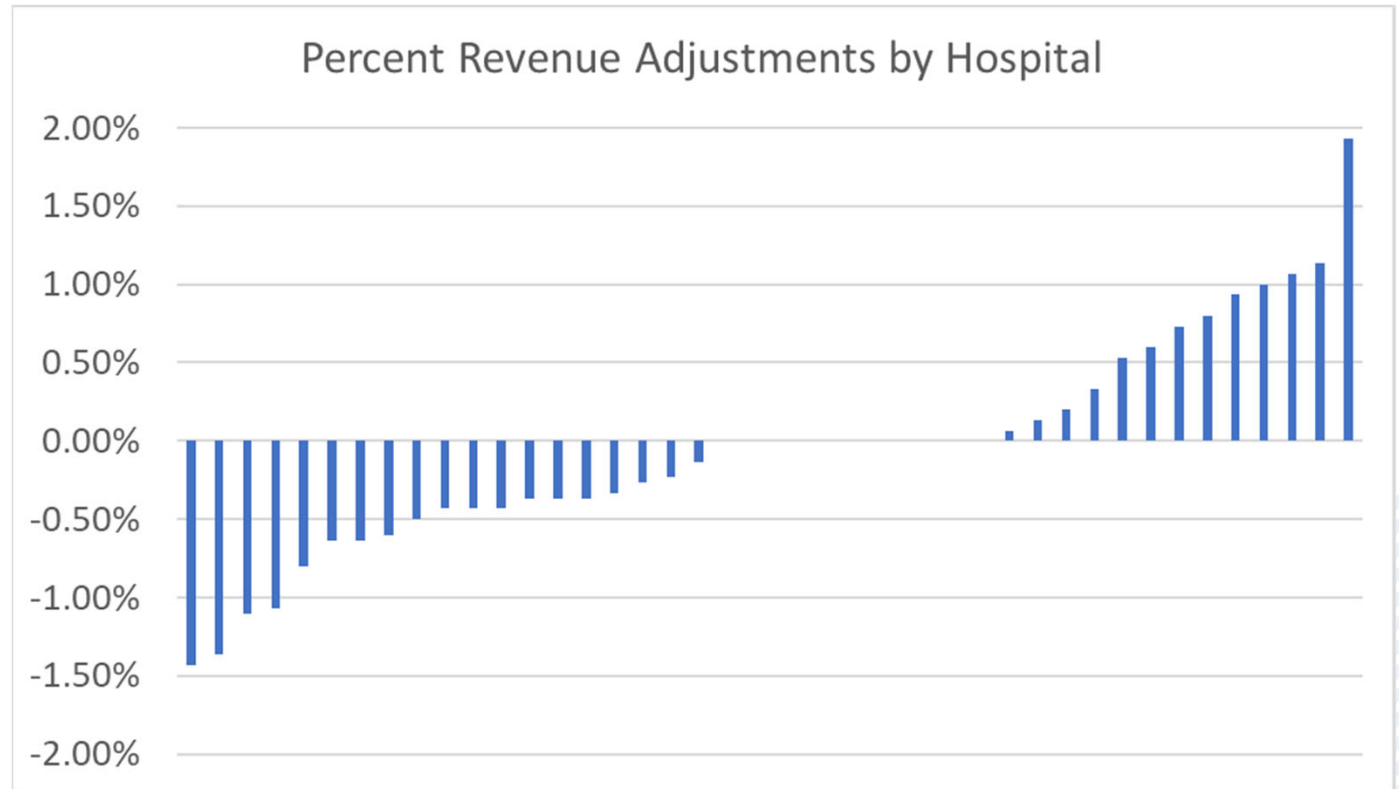
Interpret with caution



Score Statistics	
Average	60%
Median	63%
25th Percentile	47%
75th Percentile	74%
Highest	99%
Lowest	17%

# Revenue Adjustment Modeling

Final MHAC Score	% Revenue Adjustment
0%	-2.00%
5%	-1.83%
10%	-1.67%
15%	-1.50%
20%	-1.33%
25%	-1.17%
30%	-1.00%
35%	-0.83%
40%	-0.67%
45%	-0.50%
50%	-0.33%
55%	-0.17%
60%	0.00%
65%	0.00%
70%	0.00%
75%	0.33%
80%	0.67%
85%	1.00%
90%	1.33%
95%	1.67%
100%	2.00%
<b>Penalty Cut-point</b>	<b>60%</b>
<b>Reward Cut-point</b>	<b>70%</b>



## MHAC RY 2025 Final Recommendations

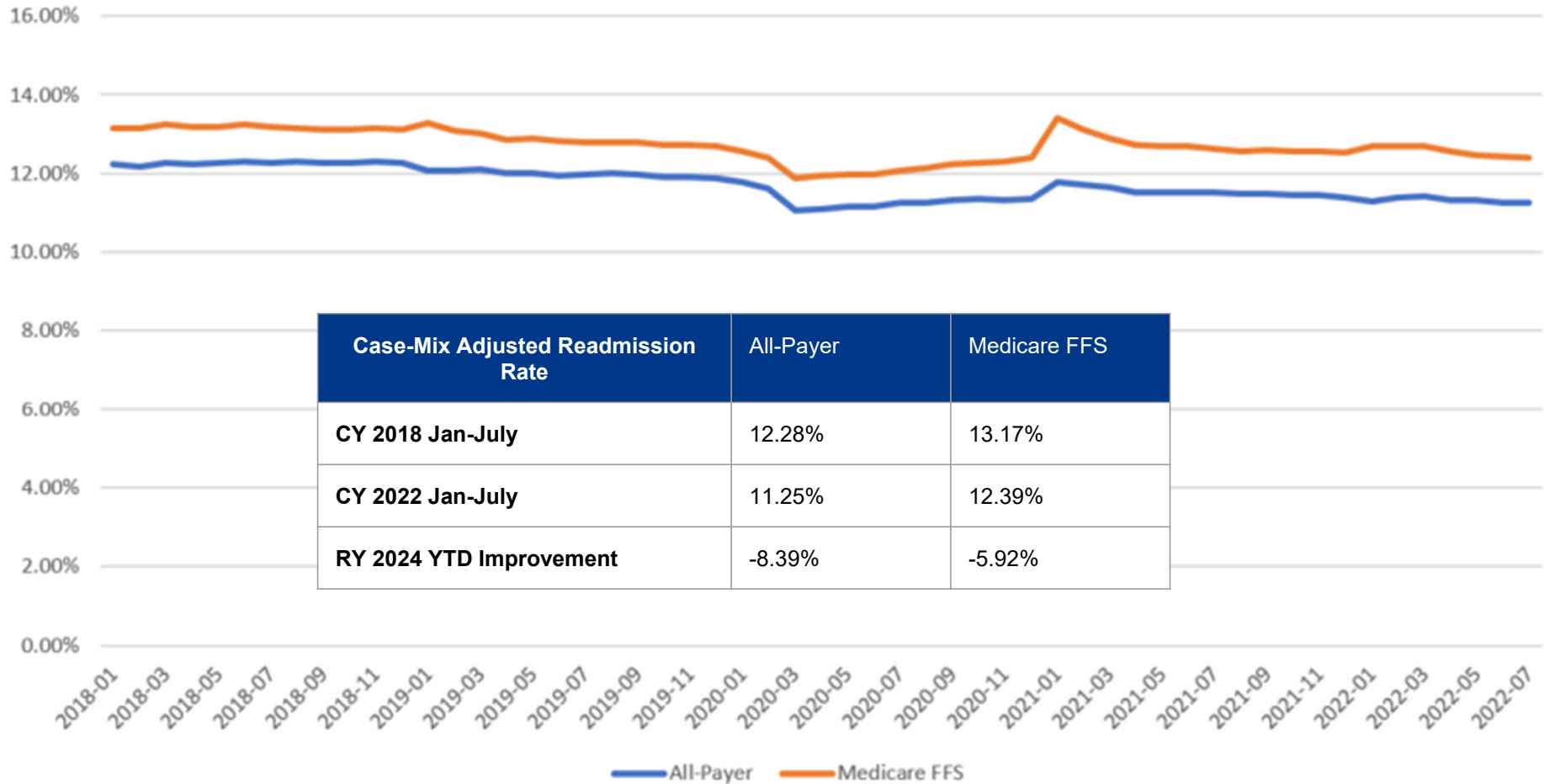
- Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
  - Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
  - Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
  - Engage hospitals as needed/appropriate on specific PPC increases to understand trends and discuss potential quality concerns.
- 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.
- Continue to assess hospital performance on attainment only.
- Continue to weigh the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
- 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 60 and 70 percent.

# Readmission Reduction Incentive Program (RRIP) RY 2025 Final Policy

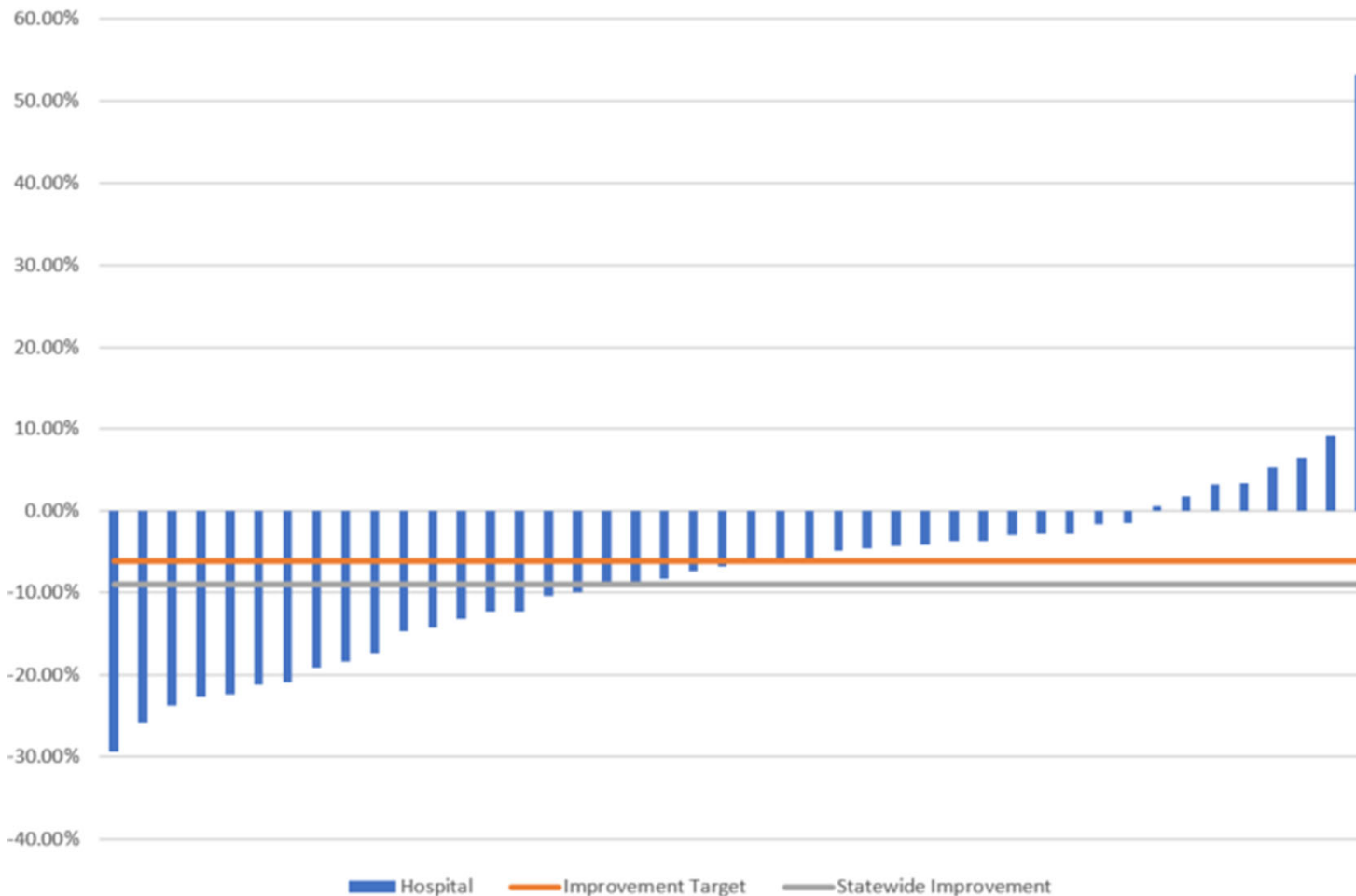
## Final RY 2023 & 2024 RRIP Recommendations

1. Maintain the 30-day, all-cause readmission measure.
2. **Improvement Target** - Maintain the RY 2022 statewide 5-year improvement target of -7.5 percent from 2018
3. **Attainment Target** - Maintain the attainment target whereby hospitals at or better than the 65th percentile statewide performance receive scaled rewards for low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in **within-hospital readmission disparities**. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years, capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
6. Continue development of an all-payer **Excess Days in Acute Care** measure in order to account for readmission, emergency department, and observation revisits post-discharge.
7. Adjust the RRIP pay-for-performance program methodology as needed due to **COVID-19 Public Health Emergency** and report to Commissioners.

## Monthly Case-Mix Adjusted Readmission Rates



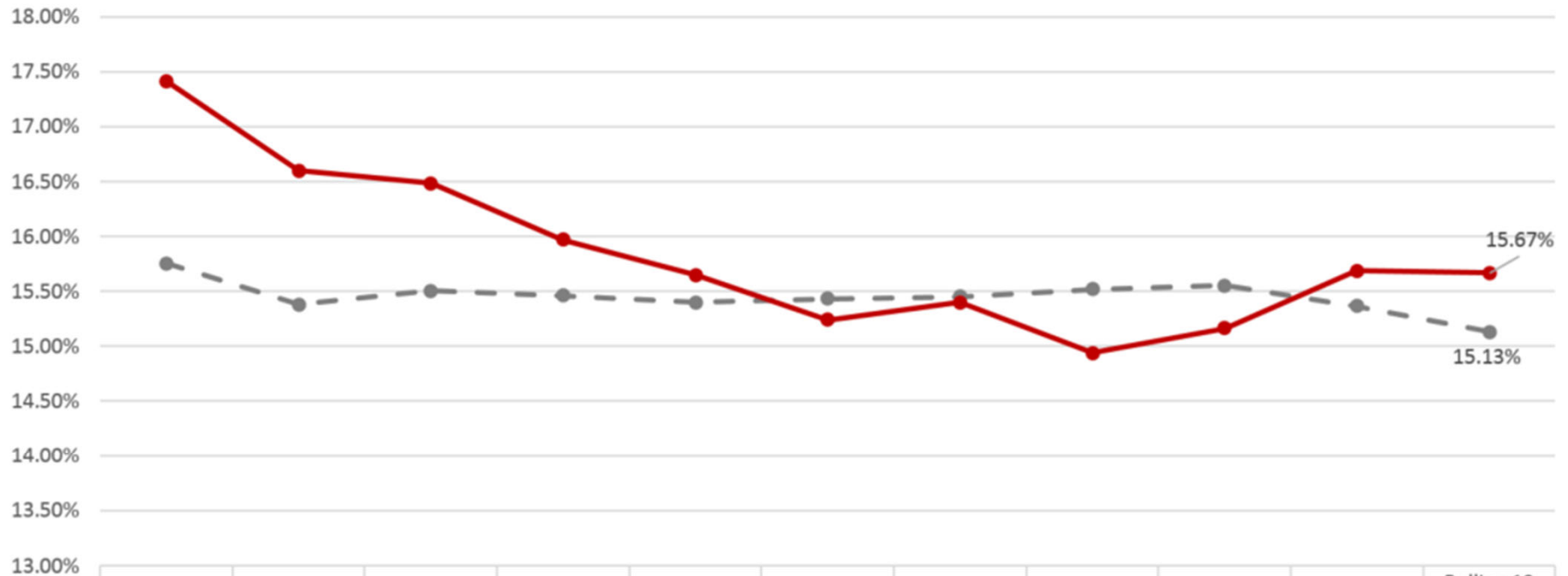
Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital from 2018 to July 2022



- **18** hospitals are on track to achieve the **improvement and attainment goals**
- **4** hospitals are on track to only achieve the **improvement goal (-6.05%)**
- **10** hospitals are on track to only achieve the **attainment goal (-11.59%)**
- **12** hospitals are **not on track** to achieve either of the readmission goals

# Medicare FFS Readmissions from CMMI

Readmissions - Rolling 12M through June 2022

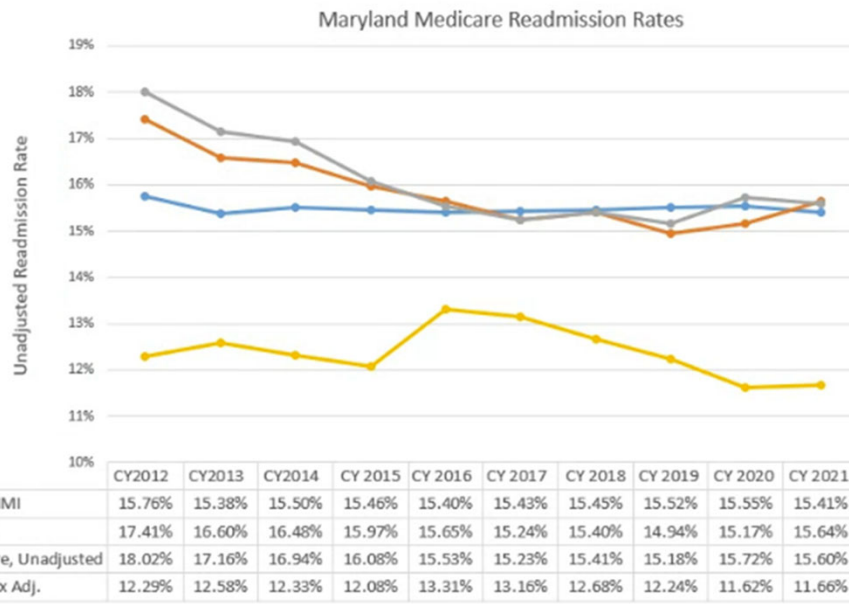


	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	Rolling 12 month CY 22
—●— National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.13%
—●— Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.67%



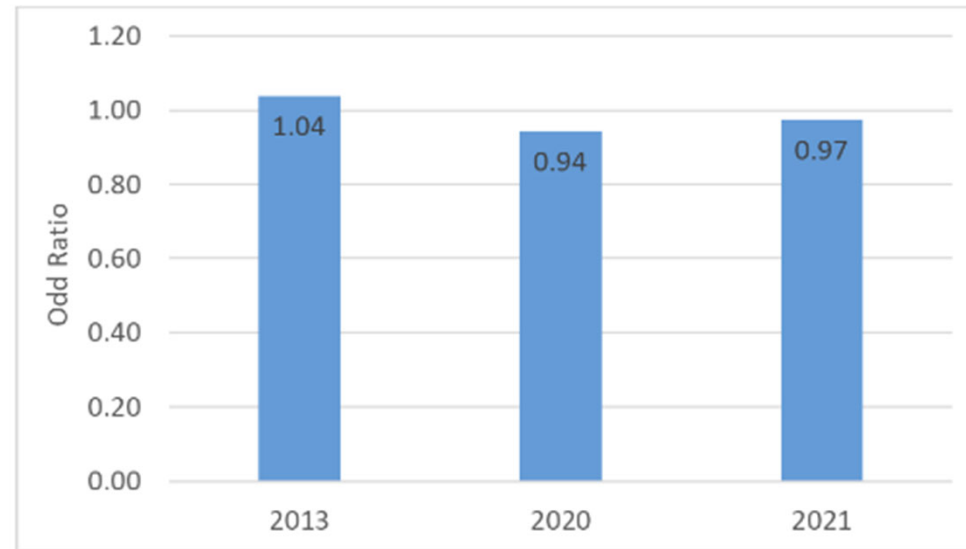
# CY 2021 CMS Readmissions Test

MD performs better with risk-adjustment



Preliminary analyses for CY 2022 indicate MD is still performing well on a risk adjusted basis.

Odds Ratio for Risk-Adjusted Readmission Rates for Maryland vs. Nation



Controlling for age, sex, COVID-19 status (for 2020 and 2021 models), Major Diagnostic Category (MDC) and the Elixhauser Comorbidity Index.

## RRIP Policy Discussion Items

- Readmission improvement target
  - Continue with 7.5% improvement goal from 2018, or
  - Adjust base to post-COVID and set new target?
- Readmission attainment target
  - Update time period for calculating attainment standards?
- Adjustments to readmission measure or case-mix adjustment?
  - Staff are not proposing any updates but are soliciting feedback from stakeholders
- Disparity gap methodology and target updates

## RRIP Redesign: Improvement Target

Based on these estimates, Commission approved a 7.5% improvement target

Figure 7. Improvement Target Estimates

Estimating Method	Percent Improvement	Resulting Readmission Rate (2023)*
1 Actual Compounded Improvement, 2013-2018	-14.94%	9.73%
2 Actual Improvement 2016-2018, Annualized to 5 Years	-11.48%	10.13%
3 All Hospitals to 2018 Median	-6.5%	10.70%
4 Benchmarking - Peer County/MSA to 75th Percentile	-4.63% to -6.20%	10.73% to 10.91%
5 Reduction in Readmission-PQIs	-9.36%	10.19%
6 Reduction in Disparities	-4.2%	10.96%

\* Assuming a constant CY 2018 readmission rate of 11.44 percent (under RY 2021 logic with specialty hospitals included)

# Medicare Benchmarking

	Unadjusted Rates	2021 Readmissions Rate		
		Maryland	Nation	Peer County BM <sup>1</sup>
Performance	Overall (Per CMMI)	<b>15.68%</b>	<b>15.37%</b>	
	<i>MD % Above (Below) National</i>	2.02%		
	HSCRC Calculated (CCW)	<b>15.46%</b>	<b>15.26%</b>	<b>15.50%</b>
	<i>MD % Above (Below) Benchmark</i>	1.34%		
	Benchmark 25th Percentile (CCW)	<b>15.46%</b>		<b>14.53%</b>
	<i>MD % Above (Below) Benchmark</i>	6.37%		
Opportunity	Benchmark if all MD counties were at or below <b>benchmark average</b>	<b>15.46%</b>		<b>15.06%</b>
	<i>MD improvement opportunity</i>	2.57%		
	Benchmark if all MD counties were at or below <b>benchmark 25<sup>th</sup> percentile</b>	<b>15.46%</b>		<b>14.39%</b>
	<i>MD improvement opportunity</i>	<b>6.90%</b>		

1. Benchmark reflects the straight average of each county's peer counties blended to a state average based on MD admits or beneficiaries

## All Hospitals to 2021 Case-Mix Adjusted Median

CY 2021: 11.36%  
 CY 2021 Median: 11.21%  
 All Hospitals above at the 2021 Median: 10.51%  
 Improvement: -7.53%

## Statewide Improvement Trends

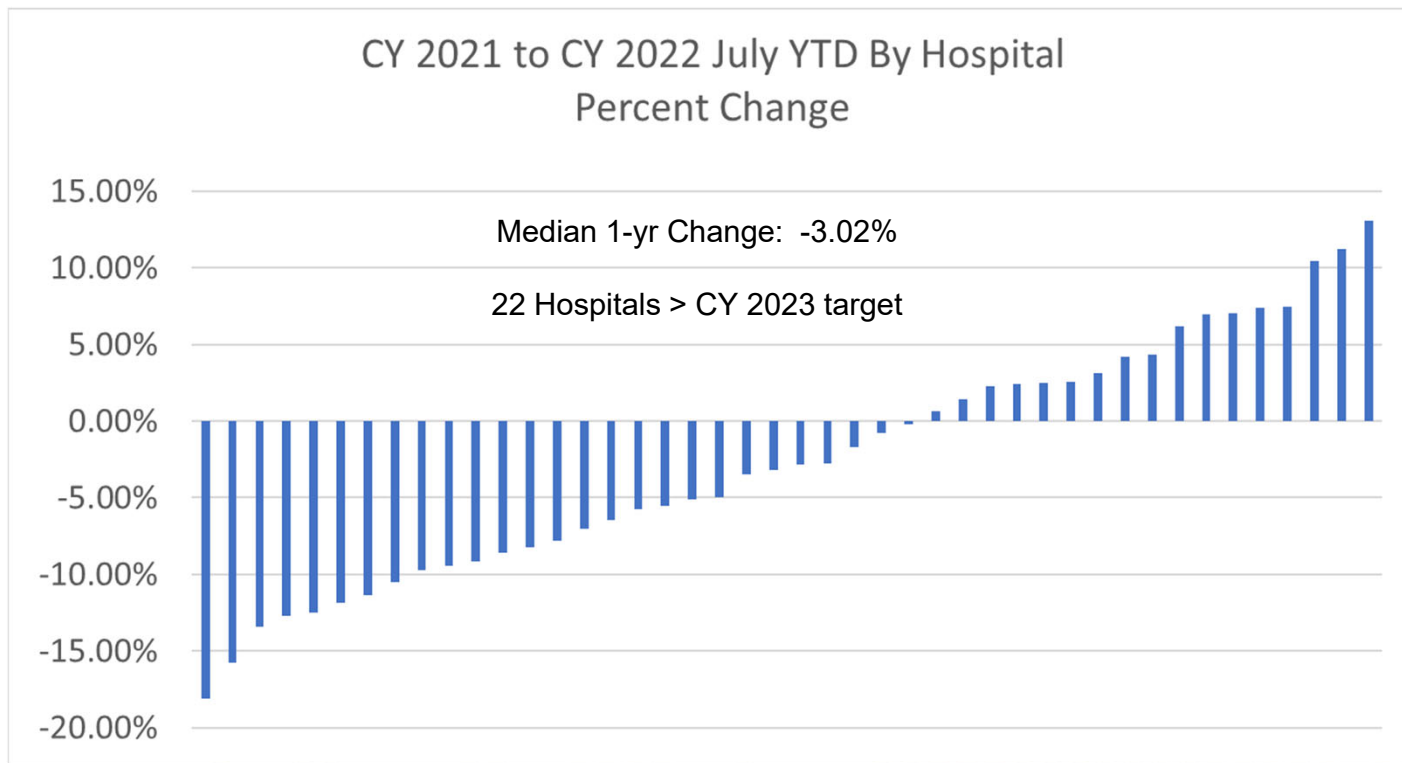
CY 2018 - CY 2019: -3.03%  
 CY 2019 - CY 2020: -4.65%  
 CY 2020 - CY 2021: +0.33%

## RY 2025 Improvement Target?

Current Policy  
 CY 2018 - CY 2023: -7.5%  
 New 5-Year Target CY 2021 - CY 2026?

# RX 2025 Modeling: Improvement Target

Despite slight statewide increase, majority of hospitals showing CY 2022 YTD improvement



**Improvement by Year**  
New 7.5% Improvement Target

- CY 2022: -1.55%
- CY 2023: -3.07%**
- CY 2024: -4.57%
- CY 2025: -6.05%
- CY 2026: -7.50%

**Case-Mix Adjusted Statewide Rate**

- CY 2021: 11.36%
- CY 2026: 10.51%

## RY 2025 Modeling: Attainment Target

Calculate 35th percentile with Out of State factor + improvement from CY 2021

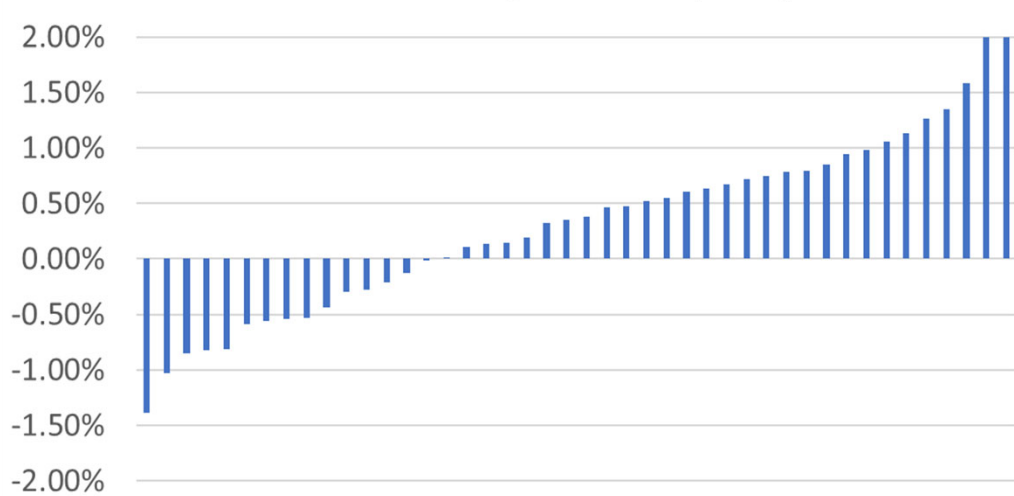
- The 35th percentile without the OOS factor is 10.52%
  - Consistent with the CY 2026 case mix adjusted rate with 7.5% improvement of 10.51%
- Estimated attainment targets and scaling for modeling:

All Payer Readmission Rate CY22		RRIP % Inpatient Revenue Payment
Lower Absolute Readmission Rate		2.0%
Benchmark	8.47%	2.00%
	9.85%	1.00%
<b>Threshold</b>	<b>11.23%</b>	<b>0.00%</b>
	12.61%	-1.00%
	13.99%	-2.00%
Higher Absolute Readmission Rate		-2.0%

# R.Y. 2025 Modeling: Revenue Adjustments

Preliminary modeling based on 5- year 7.5% improvement target  
(1.55% 1 year target)

Percent Revenue Adjustment by Hospital



Statewide Revenue Adjustment Modeling	Better of Improvement or Attainment	
	\$	%
Net	\$ 34,362,524.00	0.32%
Penalties	\$ (13,376,503.00)	-0.12%
Rewards	\$ 47,739,027.00	0.44%
# Hospitals Penalized	14	
# Hospitals Rewarded	29	

## Excess Days in Acute Care (EDAC) Update

CRISP is programming all-payer, all-cause reports based on MPR code for monitoring in RY2025

**Background:** CMS has 3 condition-specific measures of **Excess Days of Acute Care (EDAC)**: AMI, Heart Failure, and Pneumonia

- EDAC defined as: sum of **Readmissions** (length of stay of readmissions); **Observation Stays**; and **Emergency Department Visits**
- Conceptually this will provide a **more comprehensive/nuanced view of post-discharge hospital utilization** than binary readmission (yes/no)
- Excess days are sum of:
  - LOS for IP Readmission
  - Sum of Observation Stay hours, rounded to half-days
  - ED visit = 0.5 days (half day)

EDAC measure offers two advantages over a dichotomous readmission measure: 1) it accounts for more forms of post-discharge care, and 2) it accounts for the intensity of post-discharge care, including length of stay for any readmissions.

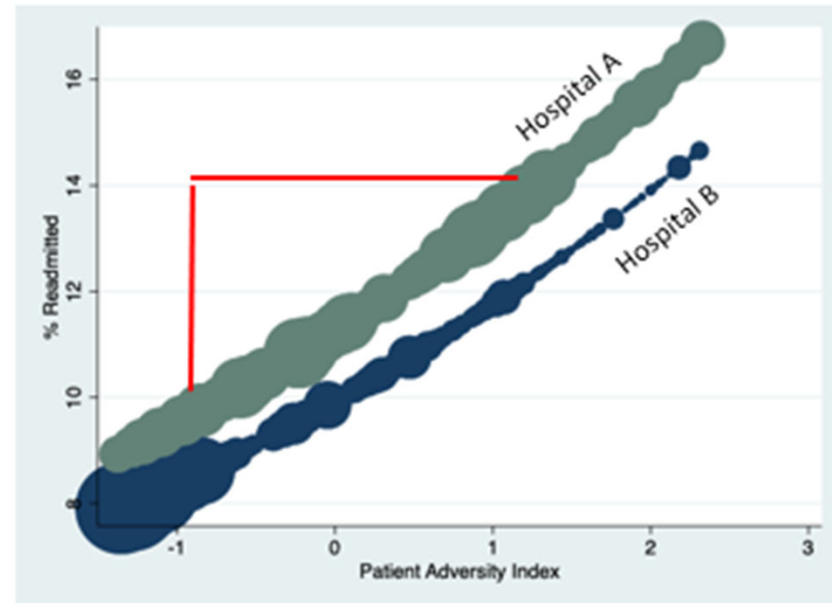
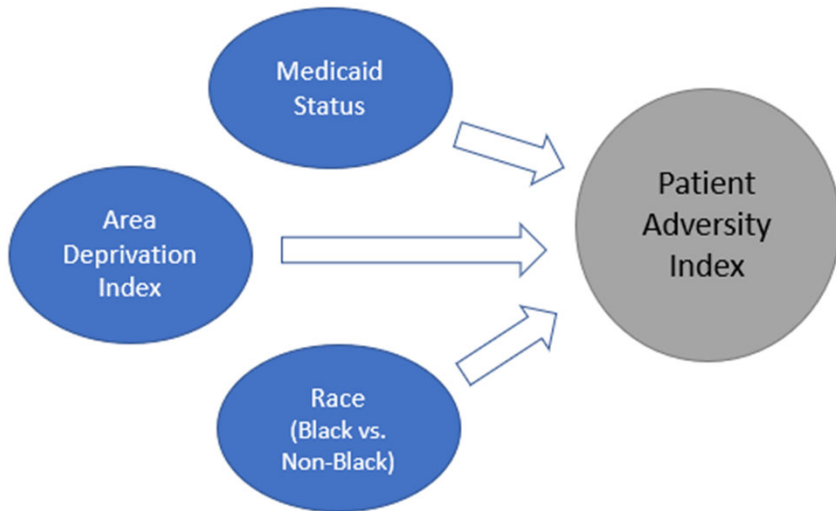
Appendix contains data through 2019 indicating MD performs worse than the nation on condition specific EDAC



# Readmission Disparity Gap

Updating base period to CY 2021; will provide update at December PMWG

## Patient Adversity Index (PAI)



## RY 2025 Draft Recommendations

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the RY 2022 statewide 5-year improvement target of X.X percent from 20XX
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile statewide performance receive scaled rewards for low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities.
  - a. Scale rewards beginning at 0.25 percent of IP revenue for hospitals with 50 percent reduction in disparity gap measure, capped at 0.50 percent of IP revenue for hospitals with 75 percent or larger reduction in disparity gap measure.
6. Monitor an all-payer Excess Days in Acute Care measure and consider for payment in future years

# Hospital Population Health Accountability Policy Discussion



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## ED Diabetes Screening

**Geoff Dougherty, PhD, MPH**  
Deputy Director, Population Health

## Background

- CMMI requested staff to develop programs that provide hospital accountability for population health goals
- First area of focus: Type 2 diabetes
- Measure(s) will be monitoring only in CY23, payment in CY24
- Staff convened a workgroup composed of population health measurement and clinical experts to discuss options
- Considered broader accountability measures, including disease incidence, county-level diabetes screening and DPP as options
  - Stakeholders voiced concerns over data quality and attribution
- In light of stakeholder concerns, staff explored screening options that were not susceptible to attribution criticisms

## Proposed measure: Diabetes screening in ED

- Derived from American Diabetes Association screening guidelines
  - Healthy adults over 35 should be tested every 3 years, diabetics every 3 months
- <5% of ED patients currently receive A1c test
- 1.5M ED visits/year in the population targeted for regular diabetes screening
  - 500k are unique patients
- Cost: \$10/per test equates to ~\$15M annually
- Those visiting ED are less likely to have access to primary care, more likely to be in populations affected by health disparities
  - More likely to have diabetes than general population
  - Less likely to be screened for diabetes than general population
- Will position MD as the first state to incentivize ED screening, will create value out of potentially avoidable ED visits, and will lead to additional referrals to DPP and other interventions

## Key discussion points for today

- Measure spec
- Simulation results
- Decision support tool
- How to capture monitoring and performance data
- Commission feedback
- Next steps

## Measure specification

- Denominator: Patients  $\geq 35$  presenting to ED
  - Includes admitted, obs, discharged patients
  - Exclusions
    - Patient left (AMA/transfer from ED)
    - Documented patient refusal
    - Patient died prior to discharge
    - Documented as clinically inappropriate
      - Hospice, tested yesterday, etc
      - Expected to be  $< 1\%$  of visits

### Numerator:

- Received test during encounter that started in ED



## Simulation methodology

- 100k patients, each assigned:
  - History of diabetes/prediabetes, drawn from random distribution matching NHANES
  - Previous A1c value drawn from NHANES mean/sd for appropriate diagnostic group
- Patients visit ED randomly based on MD casemix visit frequencies
  - Patients receive A1c test in ED according to testing rules
  - Test “result” is a new draw from NHANES A1c distribution
  - Patient diabetes status updated according to new A1c values

## Model assumptions & outputs

- Assumptions
  - MD diabetes dynamics are similar to national
    - No MD-specific NHANES data
  - 3-year time horizon
- Outputs
  - # visits, # tested, # with new or uncontrolled prediabetes/diabetes
  - Reduction in prevalence of undiagnosed/uncontrolled diabetes under multiple testing approaches
  - Number needed to test to identify one positive under multiple approaches

## Model Results

Who's tested	Output: NNT (undiagnosed diabetes)	Output: NNT (uncontrolled diabetes)	Outcome: % reduction undiagnosed diabetes
>34 years old	15.3	1.75	83%
>34 and meets ADA guideline	14.6	1.66	79%

- Marginal improvement in number needed to treat yields a worse population health outcome
  - Test savings will likely not eclipse savings from better managing 4% of the diabetic population

## Reporting

- Add A1c value, A1c status to casemix spec
  - Status: Excluded (AMA/dead/etc), Referred for high A1c, not referred
  - HSCRC/hospitals have control of process/data
  - Minimal timeframe for development
  - Limited flexibility in data structure
- Develop EQCM/EHR export spec
  - Uncertain timeline/cost
  - Possibly more flexibility

## Decision support tool

- CRISP flags patients meeting denominator criteria for clinical team
  - Last test >3 years ago for those w/o prediabetes/diabetes
  - Last test >3 months ago for those w/ prediabetes/diabetes
- Hospital uses data to determine who is tested
  - Review data on CRISP site
  - Integrate w/ EHR
  - Develop programmatic lab orders
- Tool development and EHR integration costs likely exceed savings from reduced testing over three years
  - Save for later?

## Commission feedback

- Generally supportive
- Should we focus on primary care instead of ED?
  - Measure focus is hospital accountability
  - We don't regulate primary care
  - Many patients in ED don't see PCP regularly and thus are not tested
- Should only those with high glucose get A1c?
  - Could reduce # of A1c tests
  - >65% of ED patients not tested for glucose (NHAMCS)
  - Two-step process + wait for labs could have throughput implications

## Next steps

- Finalize/socialize measure spec
- Revisit with commissioners
- Implement data collection for monitoring
- Monitor and report
- Develop payment component



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## Potentially Avoidable Emergency Department Utilization

Performance measurement work group

**Adam Pittman**

Chief, Population Health

**Geoff Dougherty**

Deputy Director, Population Health

11/16/2022



# Defining Avoidable Emergency Department Utilization

Avoidable Emergency Department utilization consists of services provided in the emergency department that could have either been prevented with intervention, or triaged to a more appropriate level of care.

- Primary care treatable conditions are a focal point of many avoidable ED usage studies.
- Other common subgroups to focus on include:
  - Low acuity or low urgency visits
  - Visits without the need for specialized ED services
  - Non-admission ED visits

## Public Health Problem - Avoidable ED Utilization

Avoidable Emergency Department Utilization presents public health problems on both the quality and the cost fronts.

- **Cost:** increases patient and payer costs, drains resources, inflates total cost of care.
- **Quality:** avoidable use contributes to crowding, long wait times, and resource shortages. Further, EDs are not able to perform continuity of care functions that primary care can.

## Recap of work until this point

**Reminder:** The timeline and priority of this policy is decided by the Commissioners

In CY2021, a PAU-ED subgroup met, and decided to collect Triage information

- Starting in CY22, all hospitals were required to submit ED triage information to the HSCRC

In CY2022, the HSCRC analyzed the submitted hospital triage information and used this data to drive policy recommendations

- We will present these analyses and policies today

## ED Triage data

Hospitals were required to collect triage information starting in 2022

- Used to evaluate and identify Reason for Visit (RFV) categories with potentially avoidable utilization
- Some hospital systems also provided retrospective triage data for ED visits in 2021
- Not feasible for all hospitals

Collected a total of **2.4M** ED observations with triage information, some missingness still exists

Percentage of missing triage values

Year	Q1	Q2	Q3	Q4	Total
2021	10%	14%	11%	29%	16%
2022	5%	14%	4%	NA	7%

## Triage values

Examined different levels of triage status across hospitals and ICD-10 codes

Decided to use visits with a 3, 4, or 5 status as “potentially avoidable” or “non-urgent”

ESI Level 1	Patient requires immediate life-saving intervention
ESI Level 2	Patient is in a high-risk situation, is disoriented, in severe pain, or vitals are in danger zone
ESI Level 3	If multiple resources are required to stabilize the patient, but vitals are not in danger zone
ESI Level 4	If one resource is required to stabilize the patient
ESI Level 5	If patient does not require any resources to be stabilized

## Analyzing this data

Checked rating scales across the hospital systems by analyzing their most common ICD-10 codes at each triage level

- All hospitals appear to use a similar scoring system
  - Scales ranges from 1-5; 1 is consistently the highest acuity
  - Still a question of standardization across hospitals, e.g. is a 3 the same in two different facilities

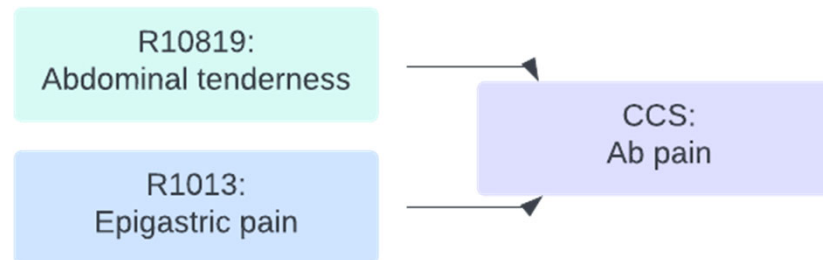
Tested various levels of Reason for Visits (RFV) grouping for analysis (ICD-10, CCS, CCSR)

- Tried to balance encompassing enough information with granularity of coding
- Used CCS as main grouping
- Reason for Visit reflects chief complaint, not diagnosis

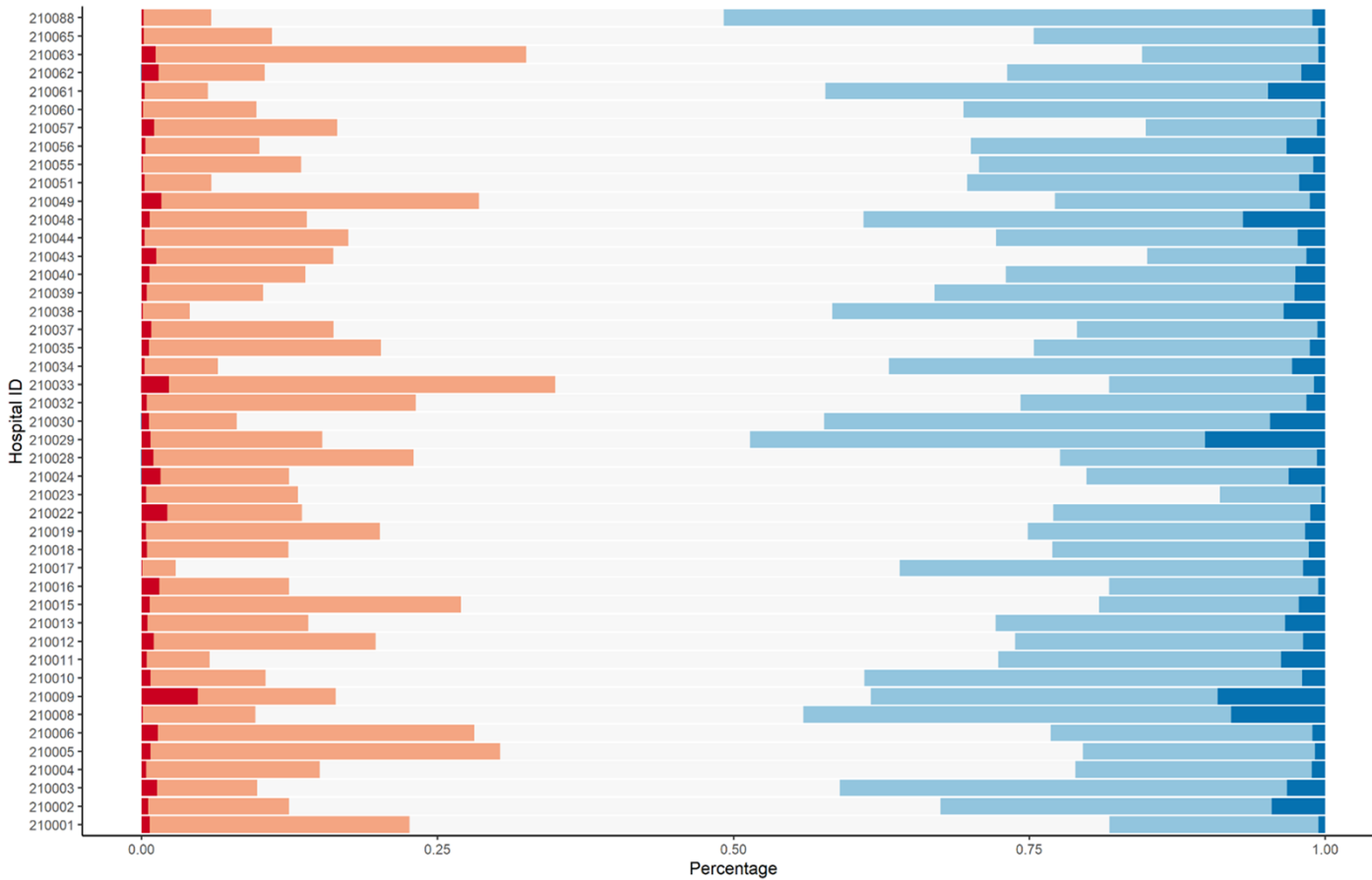
## CCS grouping

Decided to use **Clinical Classification Software (CCS)** from Agency of Healthcare Research and Quality (AHRQ)

- Tool for clustering patient diagnoses/complaints
- CCS provided the optimal combination of high level summary and granularity



# Distribution of triage values across hospitals

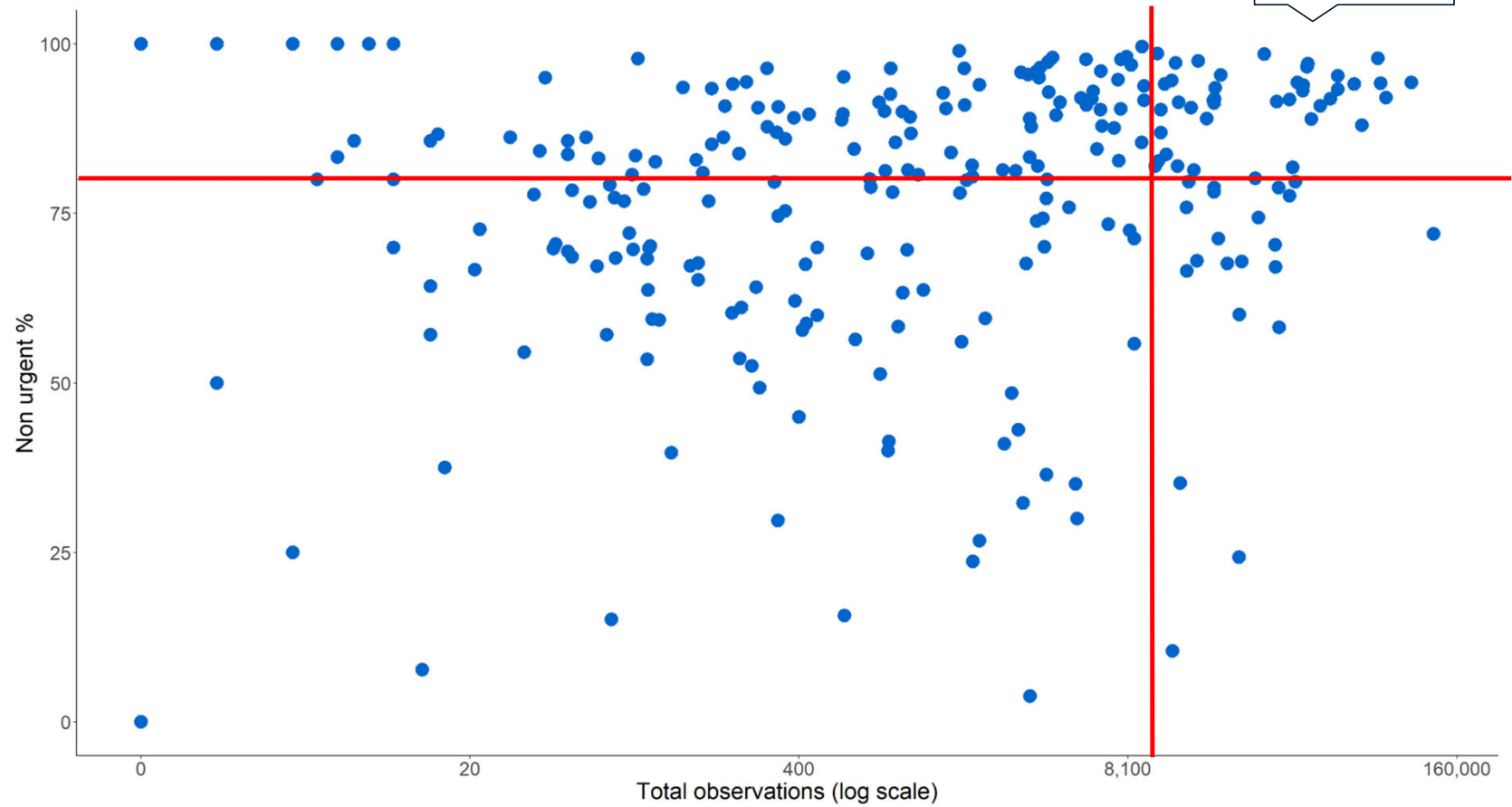


Triage Status	Percent
1	0.9
2	14.8
3	56.0
4	25.4
5	2.9

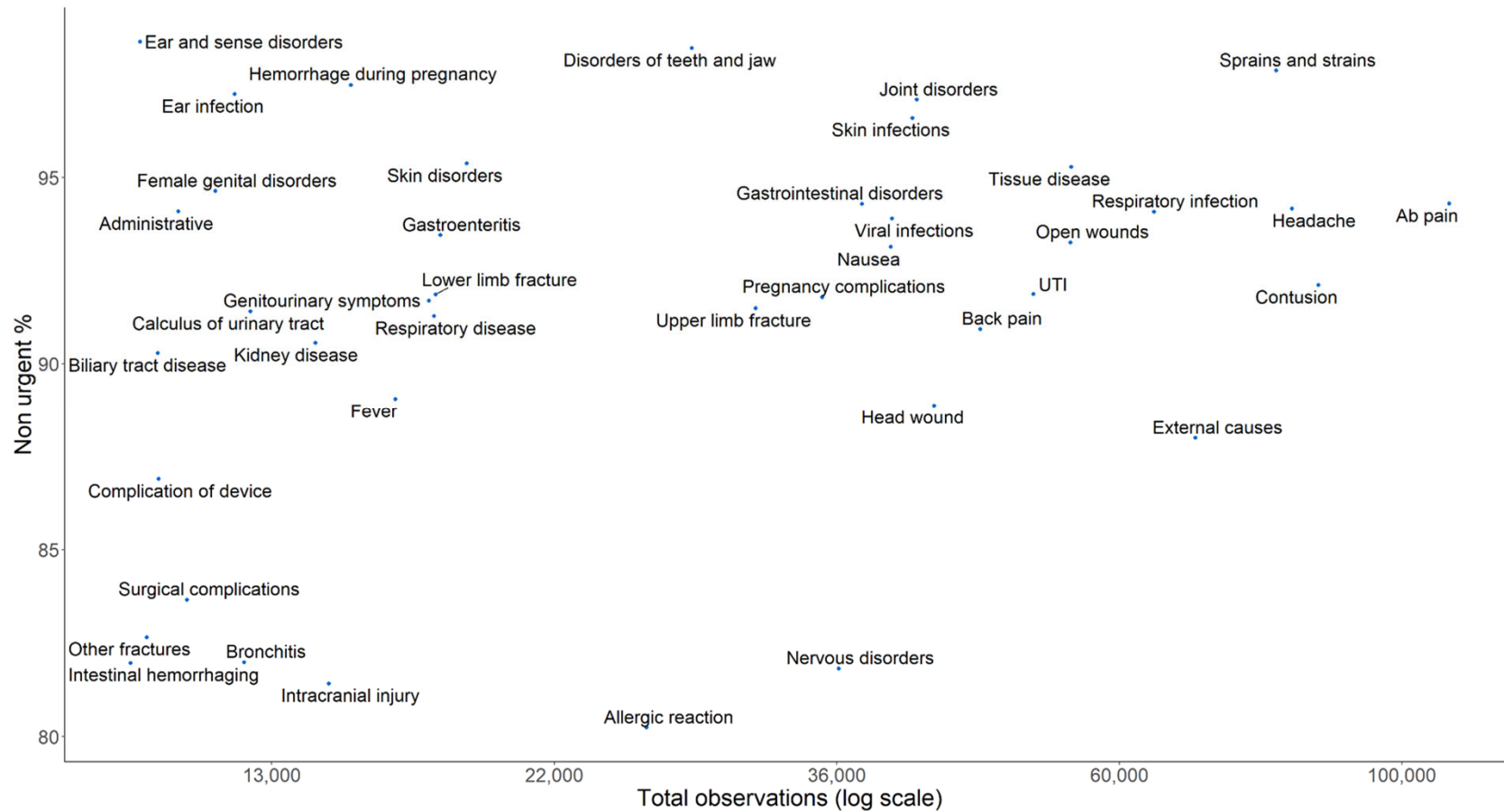


# CCS categories by volume and % non-urgent

Opportunity  
for New ED  
PAU  
Measure



# Selected chief complaints (RFV) from Opportunity Zone updated



## Additional analyses excluded from this presentation

- Time of day analysis (Day of week)
- By payer analysis
- Nursing home
- Behavioral health items
- Secondary diagnoses



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cost review commission

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## Policy options

## Policy option 1

### Full selection of low acuity reasons for visit (RFV)

- More than 80% low-acuity
- More than 10,000 in each chief complaint group

### Strengths

- Covers a wide range of chief complaints
- Potentially incentivizes more complete reduction in avoidable ED
- Provides maximum flexibility for hospitals to craft meaningful interventions

### Limitations

- Difficult to communicate to patients
- Significant resources required
- May result in diminished focus
- May include clinically inappropriate cases

## Policy option 2

### Top 10-20 by total volume for low acuity RFV

- Select the top 10-20 low acuity RFV by total ED observations
  - ( $\geq 80\%$  low acuity)
  - Subset of policy 1

### Strengths

- Focused on high-volume items
- Potentially incentivizes more complete reduction in avoidable ED
- Provides opportunity for hospitals to craft meaningful interventions
- Favored by Carefirst

### Limitations

- Not all items may be addressable
- Could miss items that are readily intervened upon
- Difficult to communicate to patients

## Top 10-20 items by total volume

Rank	Item	Avoidable %
1.	Ab pain	94
2.	Superficial injury	92
3.	Headache	94
4.	Sprains and strains	98
5.	Other injuries (External causes)	88
6.	Upper respiratory infection	94
7.	Connective tissue disease	95
8.	Open wounds	93
9.	Urinary tract infection	92
10.	Back problems	91

Rank	Item	Avoidable %
11.	Open wound of head	89
12.	Joint disorders	97
13.	Skin issues	97
14.	Viral infection	94
15.	Nausea and vomiting	93
16.	Gastrointestinal disorders	94
17.	Nervous system disorders	82
18.	Pregnancy complications	92
19.	Fracture of upper limb	92
20.	Disorders of teeth and jaw	99

## Policy option 3

### By chief complaint themes

- Choose items that are relatively similar to one another from opportunity zone
  - Joint (Joint problems, joint disorders, spondylosis, strains and sprains)
    - ~8% total volume
  - Ear, nose, throat (Sense organ disorders, Teeth disorders, Eye infection, Eye disorders, ear infection)
    - ~3% of total volume

### Strengths

- May create more focused interventions
- Easily communicated to patients
- Favored by some clinicians in subgroup

### Limitations

- May not provide best return on investment
- Different items may require different interventions
- Potential for unanticipated consequences
- Limited flexibility for hospitals to innovate



## Discussion questions

1. Staff recommendation: Start with Option 3, potential expansion to Top 20
2. How do we limit unintended consequences?
3. How does this affect health equity?
4. How do we message this information to patients and hospitals?

<b>Policy 1</b>	All low acuity items
<b>Policy 2</b>	Top 10-20 by total volume
<b>Policy 3</b>	By theme

**Slide 57**

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1 @allani.pack@maryland.gov @adam.pittman@maryland.gov  
Geoff Dougherty -MDH-, 11/15/2022

## Next steps

1. Incorporate feedback from all interested parties
2. Present PAU-ED to Commission in December
3. Monitoring in CY23
4. Development of scaling/payment policy



# Health Equity

## FY23 IPPS Final Rule: Health Equity Measures

1. Hospital Commitment to Health Equity (CMS CY23)
  - a. Attestation structural measure of 5 domains of health equity:
    - i. Equity as strategic priority, data collection, data analysis, quality improvement, leadership engagement
2. Screening for Social Drivers of Health (CMS CY24)
  - a. Assesses the percent of patients 18 years  $\leq$  who are screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety
  - b. Can use a self-selected screening tool
3. Screen Positive Rate for Social Drivers of Health (CMS CY24)
  - a. Assesses the percent of patients 18 years  $\leq$  who were screened and screened positive for one or more of the social drivers

Requesting that hospitals submit this data to HSCRC as well as CMS

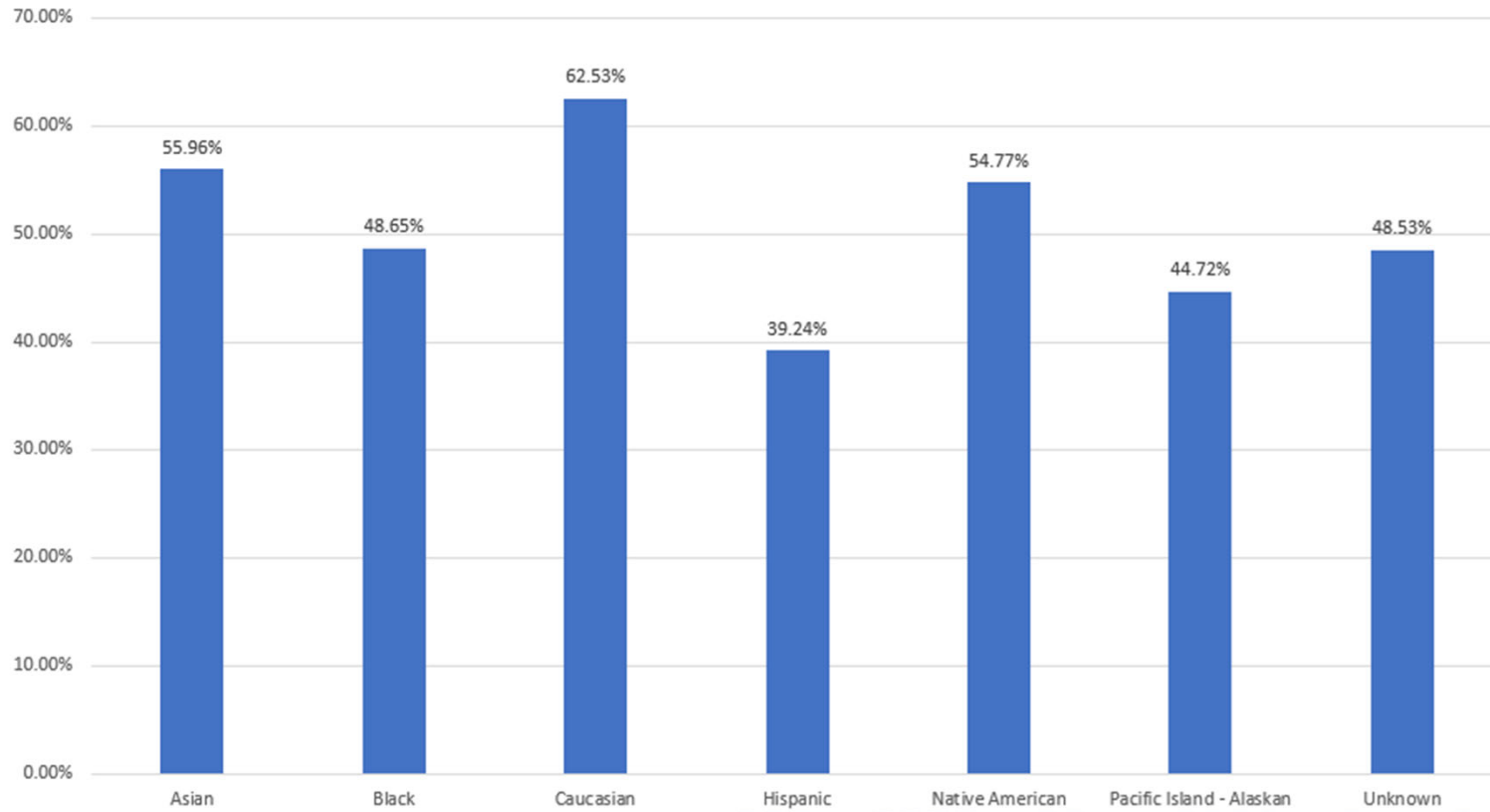
- During CY 2023 will further evaluate these requirements and develop reporting mechanism

## Health Equity Survey

- In 2015, all MD hospitals signed #123forEquity pledge
- On August 24th, HSCRC staff sent out a Health Equity Survey to better understand hospital efforts in regard to health equity
- This survey will be used as an environmental scan to gather information about the state of addressing health equity at each of the hospitals
  - Results will be aggregated and will NOT be used to penalize hospitals
- The deadline is being extended to December 15th, 2022

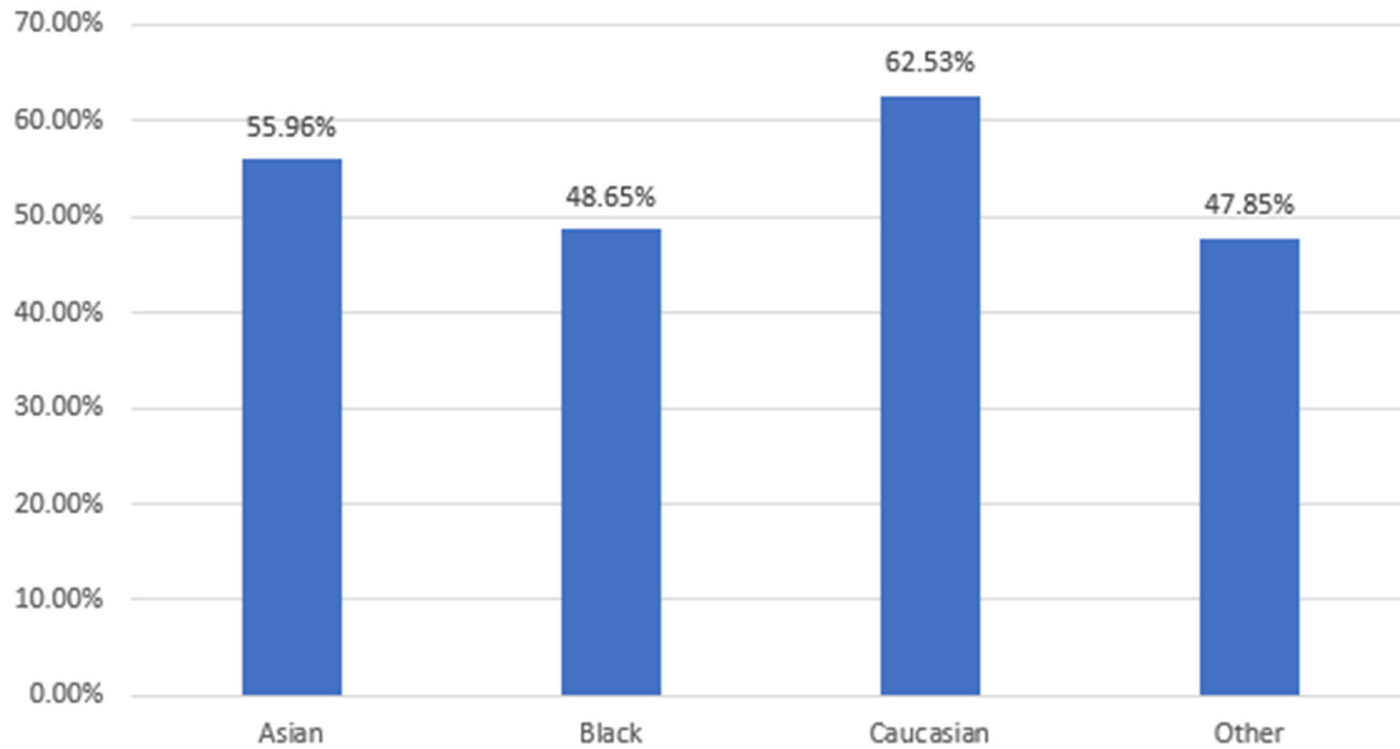
# Medicaid TFU Disparities by Race

TFU Rate by Race, CY2018-2021



## Medicaid TFU Disparities by Consolidated Race

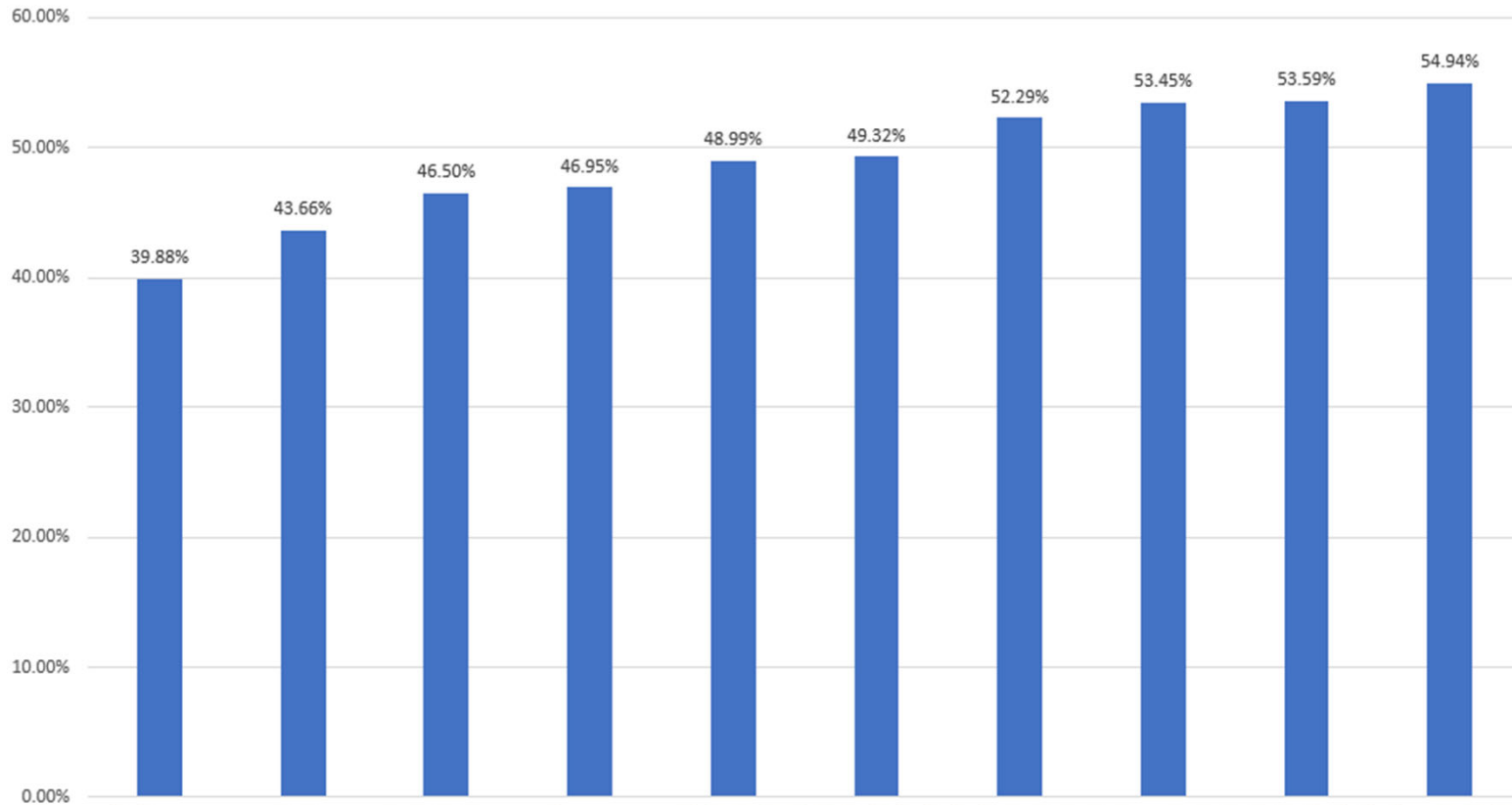
TFU Rate by Consolidated Race, CY2018-2021





# Medicaid TFU Disparities by MCO

TFU Rate by MCO, CY2018-2021





THANK YOU!

Next Meeting: Wednesday, December 21, 2022

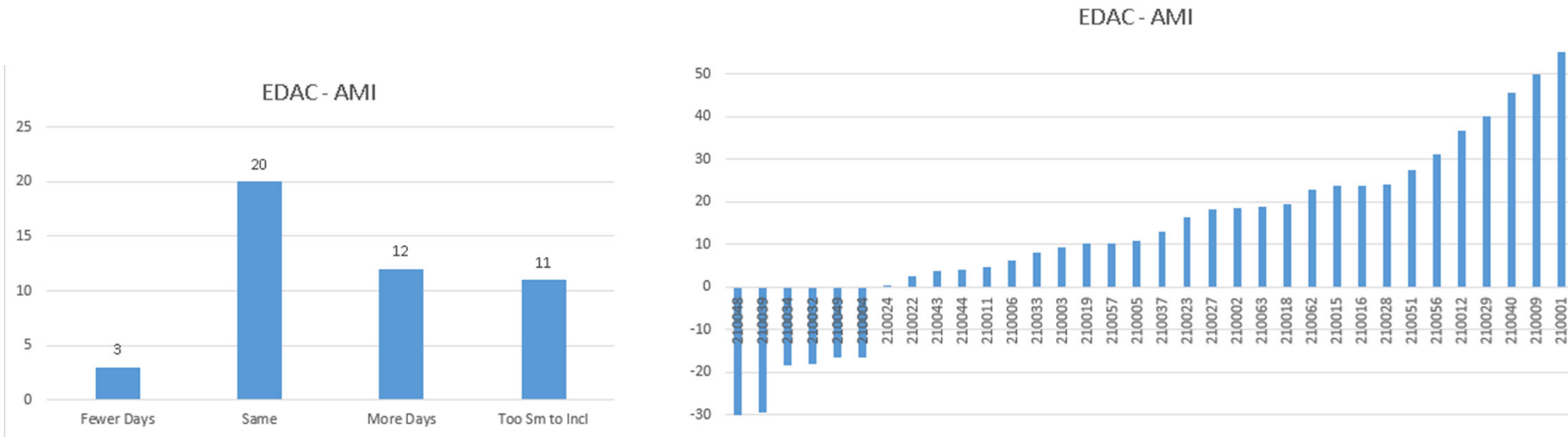
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# Appendix

# EDAC Results: Heart Attack (7/1/17-12/1/19)

National weighted average: 6.58 excess days per 100 discharges\*

Maryland weighted average: 8.68 excess days per 100 discharges\*

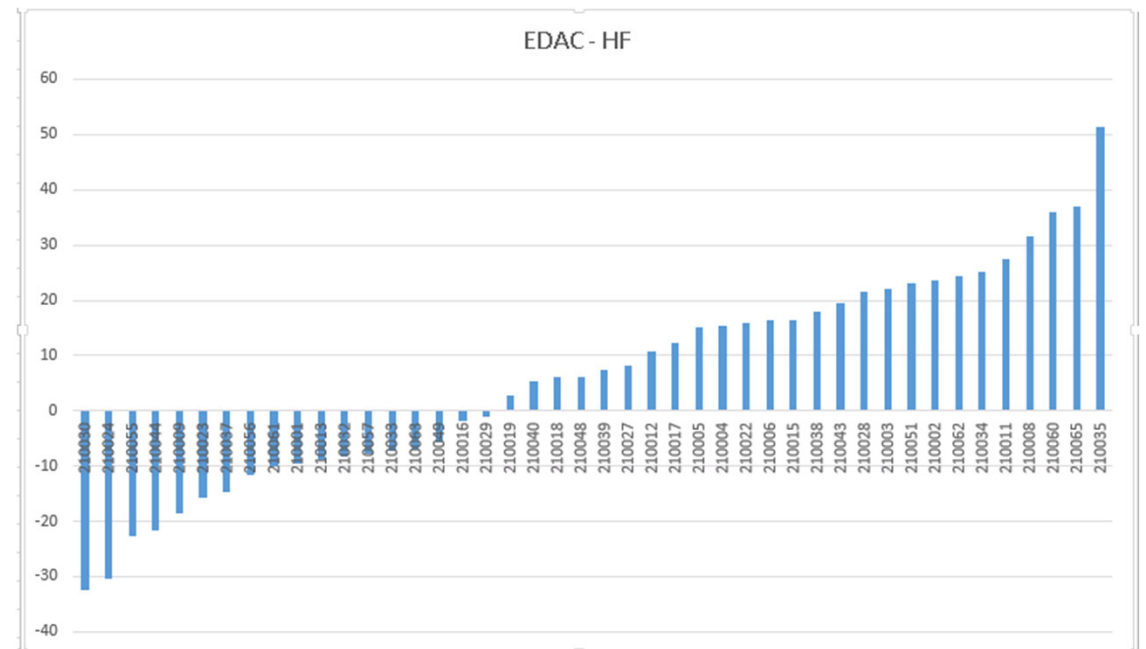
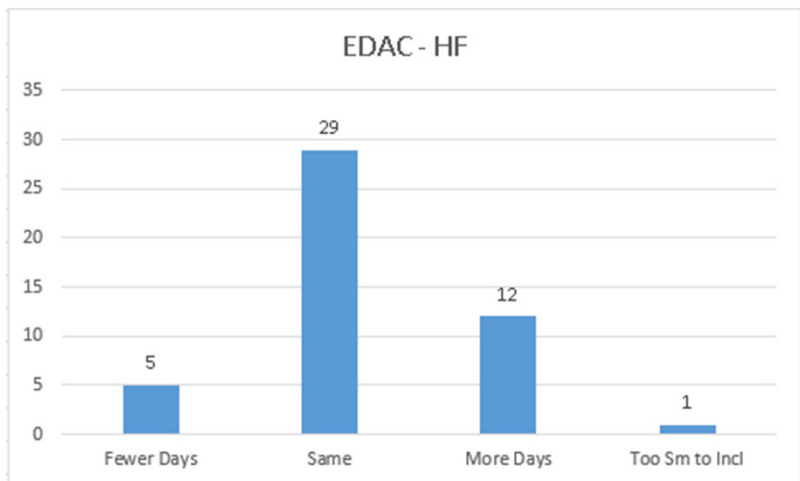


\* Weighted averages are calculated using Jul 2014 - Jun 2017 data

# EDAC Results: Heart Failure (7/1/17-12/1/19)

National weighted average: 10.17 excess days per 100 discharges\*

Maryland weighted average: 13.31 excess days per 100 discharges\*





# Medicaid TFU Disparities by Race by Condition

