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Performance Measurement Work Group Meeting

January 17, 2024

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

- Emergency Department Incentives Update
- MHAC RY 2026 Final Recommendation
- Readmission Reduction Incentive Program
- Multi-Visit Patients: Final Recommendation

RY 2026 Policy Decisions

1. MHAC RY 2026 draft recommendation
    - PPC Trends
    - Performance Standards and Scoring
    - Bayesian Smoothing
2. Readmission Reduction Incentive Program (RRIP)
    - Improvement target
    - Attainment target
    - Revisits/Observation
    - Excess Days in Acute Care measure
    - Within hospital disparities measure and incentive
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

Emergency Department Subgroup Updates

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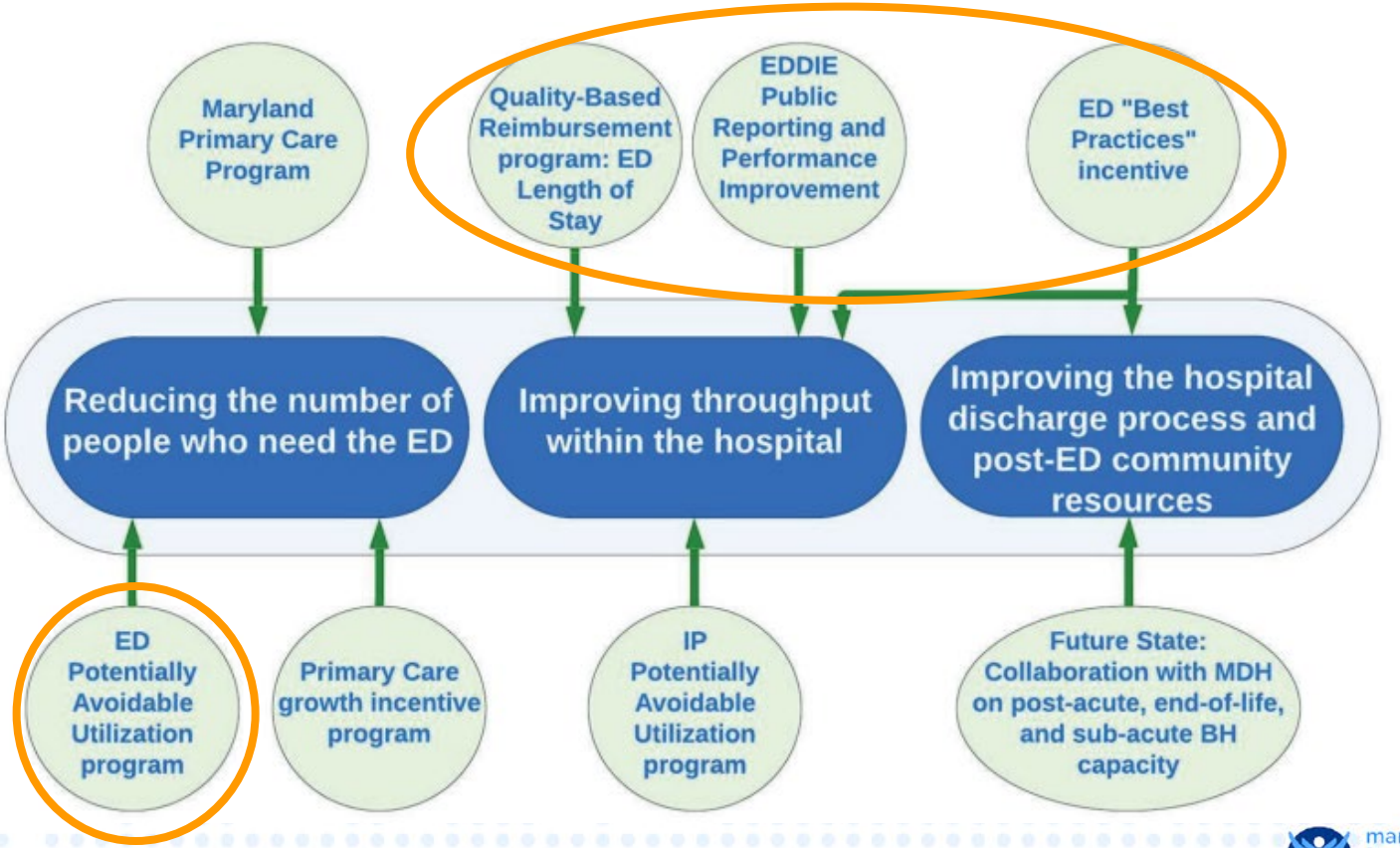
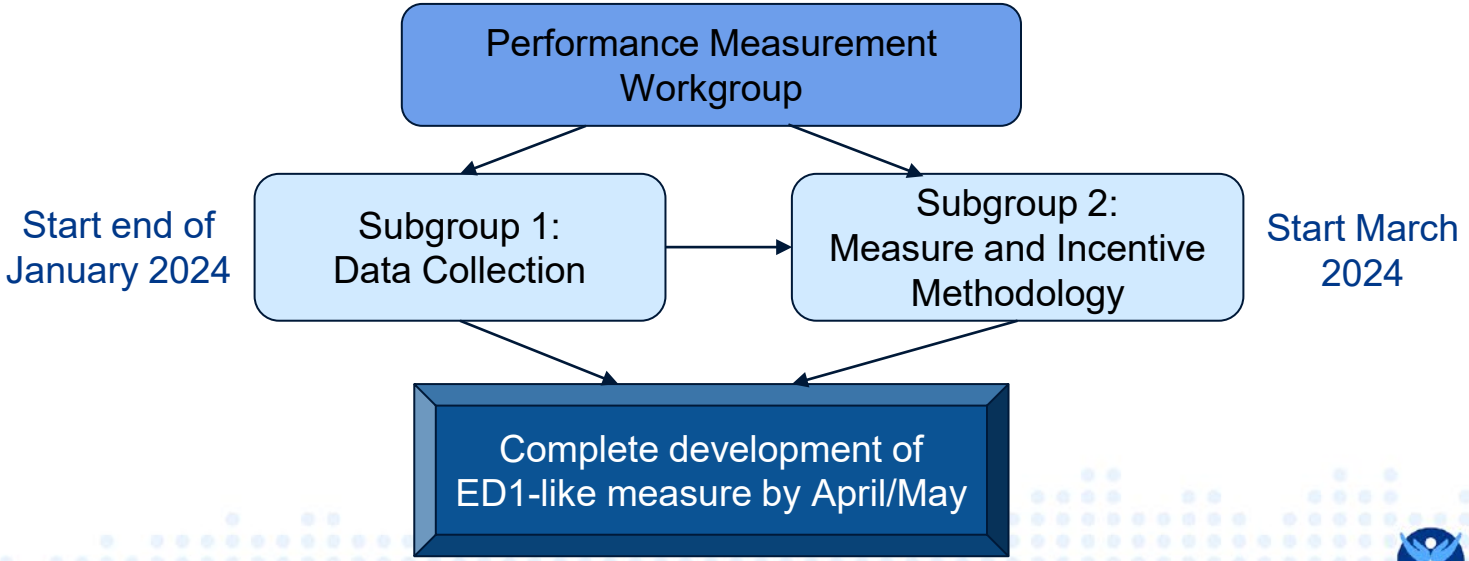
Incentives for Improving ED Length of Stay



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



Next Steps

- Hold 1st meeting for ED1-like measure workgroup (Subgroup 1)
- Convene subgroup to develop ED best practices incentive
  - Will address root causes of ED LOS and incentivize best practices
  - Will create alignment with EDDIE project
  - Will be developed for a draft policy in Spring Commission meeting

Maryland Hospital Acquired Conditions

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RY 2026 Final Recommendations for MHAC Program

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 on specific PPC increases as indicated/appropriate 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 CYs 2023 and 2024.

RY 2026 Final Recommendations for MHAC Program

3. Continue to assess hospital performance on attainment only, with adjustment to performance standards for increased stability.
4. Continue to weight 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 60 and 70 percent.
6. Future Considerations: 1. Assess options for streamlining (or simplifying) the quality programs overall, or for the hospital acquired complication measures that are currently included in both the QBR Safety Domain and the MHAC program. 2. Assess digitally specified quality measures such as electronic Clinical Quality Measures (eCQMs) for future inclusion in quality programs.

PPC 67 Low Volume Exclusion Criteria

- PPC 67 is the Pneumonia Combo of PPC 5 Pneumonia and Other Lung Infections and PPC 6 Aspiration Pneumonia
  - If a case can be assigned both PPCs based on documented codes not POA, a hierarchical PPC exclusion is applied and only PPC 6 Aspiration Pneumonia would be assigned so they ARE in effect mutually exclusive.
- Currently, PPC 67's low volume criteria is assessed at the combination level (i.e., not at the individual PPC level)
  - Thus some hospitals are held accountable for PPC 5 or PPC 6 even though they do not meet the minimum criteria for one or both of these PPCs individually
  - Statewide norms for some APR-DRG-SOI groups do not have minimum at individual PPC level, but are included if combination has minimum
- Should PPC 67's low volume criteria be based on the individual PPCs or on the combination?

ED PAU

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Draft Recommendations for Establishing the Emergency Department Potentially Avoidable Utilization Program for Rate Year 2026 - Stakeholder Comments

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Stakeholder Comment Letters

- Received from:
    a. Maryland Hospital Association (MHA)
    b. Johns Hopkins Health System (JHHS)
    c. MedStar Health
    d. Meritus Health
- MedStar and JHHS support the overall policy and recommended modifications.
- MHA opposed the policy but supports a voluntary program with infrastructure funding that incentivizes meaningful regional partnerships and sustainable health care programs.
- Meritus Health expressed concern that the program could result into the unintended consequence of incentivizing hospitals to reduce access to care for the most vulnerable patients.

Stakeholder Concern: Policy Scope

- The recommendation is singularly focused on hospitals without any intention to engage payers, state and local governments. (JHHS)
- The policy should be more intentionally focused on a single disease that truly represents avoidable care. (JHHS)
- The ED PAU program alone will not address the other factors external to the hospital which have been proven to be the drivers of high MVPs (MHA).
- The policy will unfairly hold hospitals accountable for systematic issues outside of their control. (MHA)

Staff Response: The HSCRC's mandate is to regulate hospitals. Hospitals/health systems can engage other actors in the health sector to improve performance on the MVP measure. There are numerous examples in the peer-reviewed literature of hospital-based programs that have been successful in addressing MVPs, so failing to incentivize hospitals to implement such programs would be a missed opportunity.

1. Ma Z.B., Khatri, R.P., Buehler, G., Boutwell, A., Tseng, K. (2023). Transforming Care Delivery and Outcomes for Multivisit Patients. NEJM 4(7))
2. Althaus F., Paroz S., Hugli O., Ghali W.A., Daeppen J., Peytremann-Bridevaux I., Bodenmann P. (2011). Effectiveness of Interventions targeting frequent users of Emergency Departments: a systematic review. Ann Emerg Med. Jul;58(1):41-52.e42

Stakeholder Concern: Ceiling Effect

- When financial incentives for reducing PAU are applied, it will be difficult to keep making incremental progress as PAU percentages decline.
- Similarly, hospitals with high percentages of PAU will be provided more opportunity to achieve financial reward than hospitals who have already achieved low levels of ED PAU (MedStar).
- The policy rewards all volume reduction and views all ED volume as addressable even though there is ED MVP utilization that is appropriate and medically necessary (JHHS and Meritus).

Staff Response: Staff acknowledge that even the best-performing EDs will have some MVPs. It appears that there is significant room for improvement before this becomes an issue. Staff will monitor policy results. Development of an attainment policy component could occur at that point. Attainment incentives would also provide benefits to hospitals that have already invested in addressing the MVP issue.

Stakeholder Concern: Unintended Consequences

- The policy recommendation incentivizes a reduction in care options for marginalized groups (MHA and Meritus).
- Within the current model, hospitals that reduce or entirely eliminate services are rewarded, while hospitals that provide medically necessary care – or take on volume that was shed by other hospitals, are penalized (JHHS).

Staff Response: The intent of the policy is to incentivize hospitals to develop more effective care pathways for MVPs and by extension for marginalized groups. Staff will develop and monitor access to care metrics to ensure the policy has the intended effect. The Market Shift policy ensures that appropriate financial accommodation is made when shifts in patient volume occur across facilities.

Stakeholder Suggestions

- The focus in the ED should be on improving ED wait times and throughput. (Meritus Health)
  - The MVP policy is one component of the State's response to the ED performance issue. While improving ED throughput and securing additional inpatient resources for ED patients are important, reducing the number of patients visiting the ED remains a key part of the solution.
- Hospital analyses have shown that some MVPs travel farther to seek care at specific hospitals, while others do not have the option to seek care elsewhere. (JHHS)
  - The policy accounts for this by assigning MVP status based on visits to all hospitals in the state.
- Instead of MVP, HSCRC should create a voluntary program with infrastructure funding that incentivizes meaningful regional partnerships and sustainable programs to address the needs of patients. (MHA)
  - A voluntary program will be insufficient to address the current magnitude of the ED performance challenge in the state, and is not responsive to the Commission's original request to staff.

Additional Stakeholder Suggestions

- In order to maximize the effectiveness of the ED PAU Policy, CRISP data will need to be made available in an easy to understand and user-friendly report so hospitals can track MVPs across hospitals in Maryland (MedStar).
    - HSCRC will work with CRISP and hospitals on this.
- Commitment from HSCRC staff that this policy is not intended to include downside financial risk (MedStar)
    - Per HSCRC policy, staff do not make commitments on the future structure of financial programs. If significant improvement is observed under the reward-only approach, there would be little justification for changing the policy.

Staff Recommendation

1. Implement a Rate Year 2026 pay-for-performance policy incentivizing reduction in ED visits by multi-visit patients (MVP) on a reward-only and improvement-only basis
2. Set Calendar Year 2023 as the base year.
3. Establish the threshold for performance reward at 5% improvement.
4. Reward hospitals for improvement as follows:
    a. Calendar Year 2024 improvement of 5-20%: 0.125% of total revenue
    b. Calendar Year 2024 improvement of >20%: 0.25% of total revenue
5. Evaluate reporting to assess health disparities and other unintended consequences, and make policy modifications as necessary
6. Explore development of attainment policy component
7. Facilitate discussions with CRISP and other stakeholders regarding data requirements

Readmissions

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Figure 1. Overview Rate Year 2022 RRIP Methodology

30-day, All-Cause Readmission Measure

Measure Includes:
Readmissions within 30 days of Acute Case Discharge:

- All-Payer
- All-Cause
- All-Hospital (both intra- and inter- hospital)
- Chronic Beds included
- IP-Psych and Specialty Hospitals included
- Oncology Discharges Included (New in RY 2022)

Global Exclusions:

- Planned Admissions
- Same-day and Next-day Transfers
- Rehab Hospitals
- Discharges leaving Against Medical Advice (New in RY 2022)
- Deaths

Case-Mix Adjustment

Performance Measure: CY 2020* Case-mix Adjusted Readmission Rate, adjusted for out-of-state readmissions (Attainment); Reduction in Case-mix Adjusted Readmission Rate from Base Period (Improvement)

Case-mix Adjustment:
Expected number of unplanned readmissions for each hospital are calculated using the discharge APR-DRG and severity of illness (SOI).

*Observed Unplanned Readmissions / Expected Unplanned Readmissions * Statewide Readmission Rate*

CY2018 used to calculate statewide averages (normative values), as well as attainment benchmark/threshold

*TBD in response to the COVID-19 Public Health Emergency

Revenue Adjustments

Hospital RRIP revenue adjustments are based on the better of attainment or improvement, scaled between the Max Reward and Max Penalty.

Scores Range from
Max Penalty -2% & Reward +1%

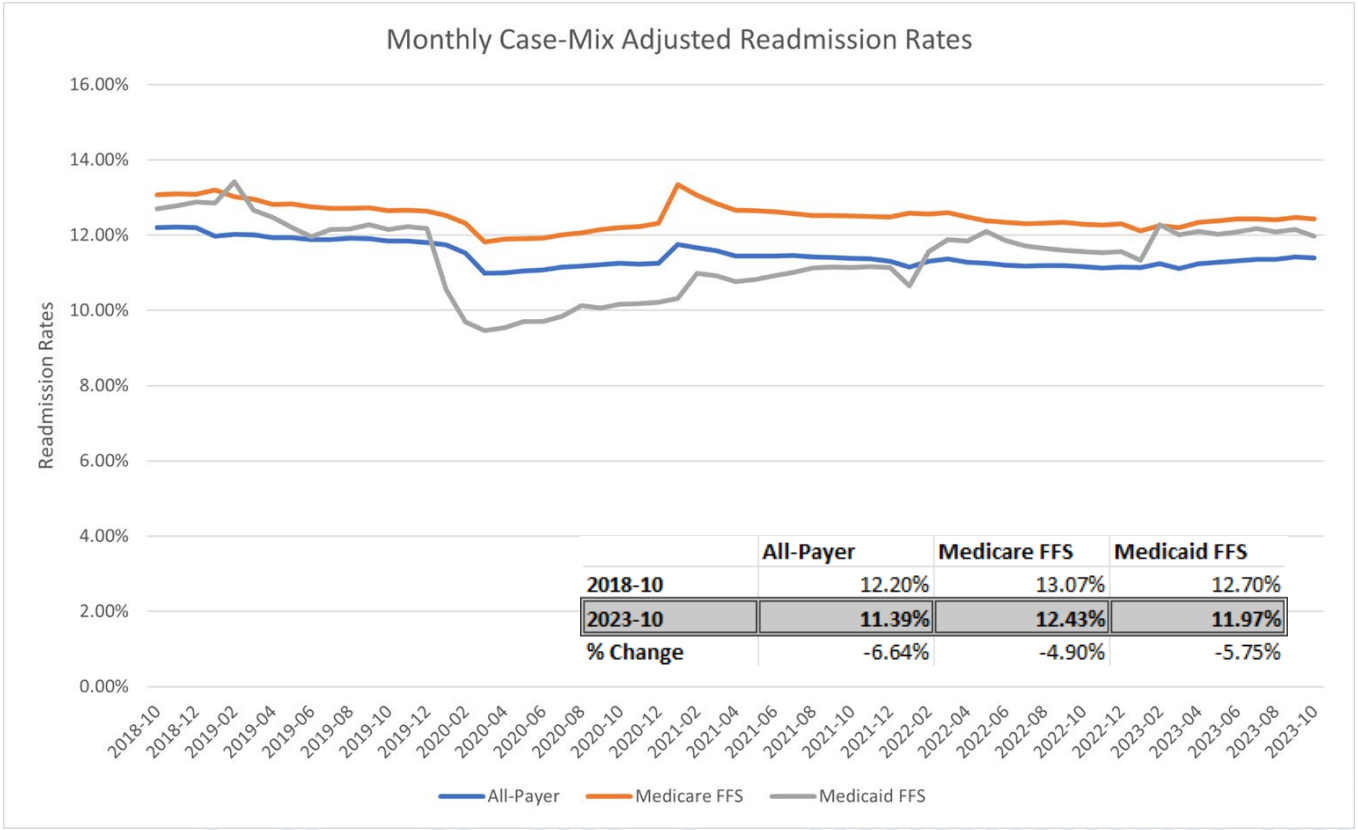
All Payer Readmission Rate Change CY 2018-2020		RRIP % Inpatient Rev.	All Payer Readmission Rate CY20		RRIP % IP Rev.
Improving Rate		1.0%	Lower Rate		1.0%
	-13.57%	1.00%	Benchmark	8.74%	1.00%
	-8.32%	0.50%		10.02%	0.50%
Target	-3.07%	0.00%	Threshold	11.30%	0.00%
	2.18%	-0.50%		12.59%	-0.50%
	7.43%	-1.00%		13.87%	-1.00%
	12.68%	-1.50%		15.15%	-1.50%
	17.93%	-2.0%		16.43%	-2.0%
Worsening Rate		-2.0%	Higher Rate		-2.0%

Draft Readmissions Reduction Incentive Program

RY 2026 Discussion Items:

- Improvement target
- Attainment target
- Impact of Revisits/Observation
- Excess Days in Acute Care measure
- Within hospital disparities measure and incentive

Improvement in Case-Mix Adjusted Readmission Rates



	All-Payer	Medicare FFS	Medicaid FFS
2018-10	12.20%	13.07%	12.70%
2023-10	**11.39%**	**12.43%**	**11.97%**
% Change	-6.64%	-4.90%	-5.75%

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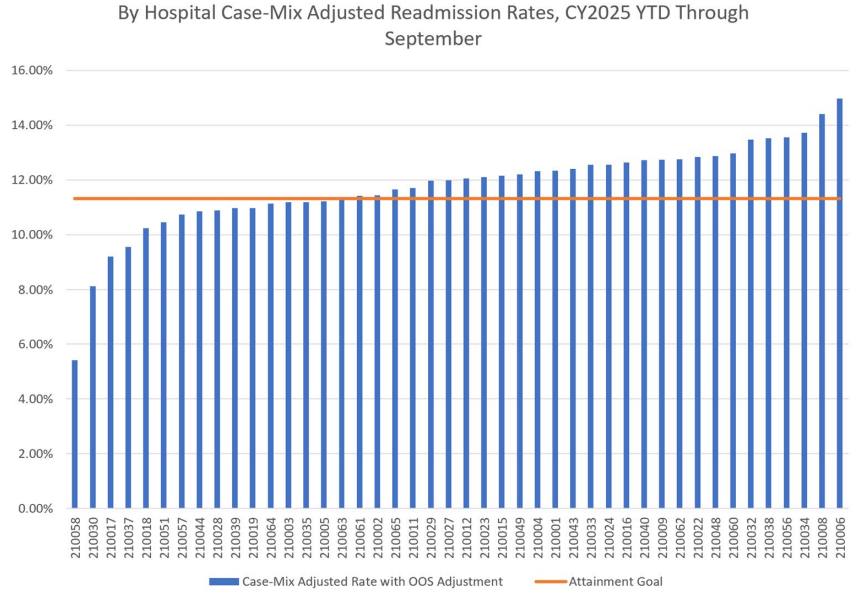
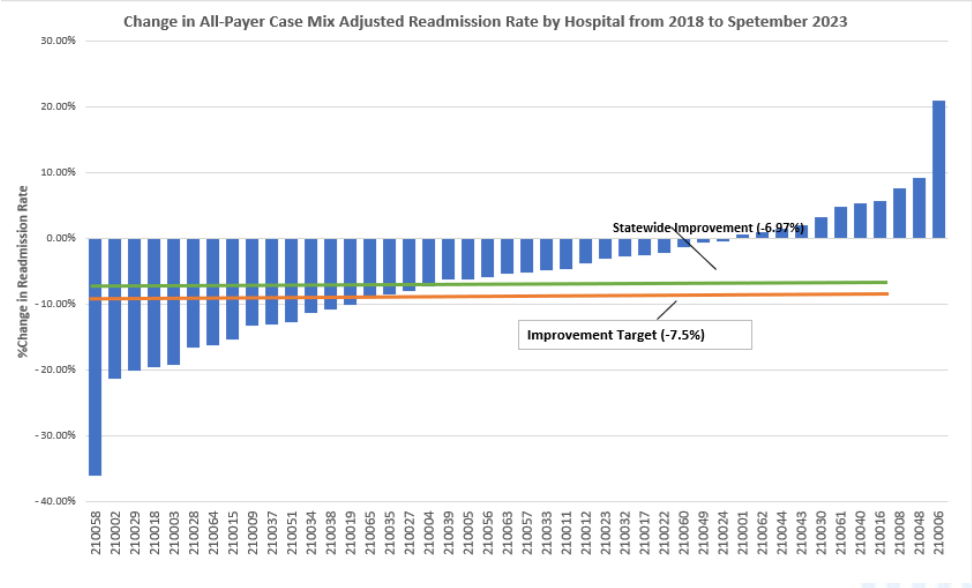
RY2025 YTD By Hospital Case-Mix Adjusted Readmission Rates





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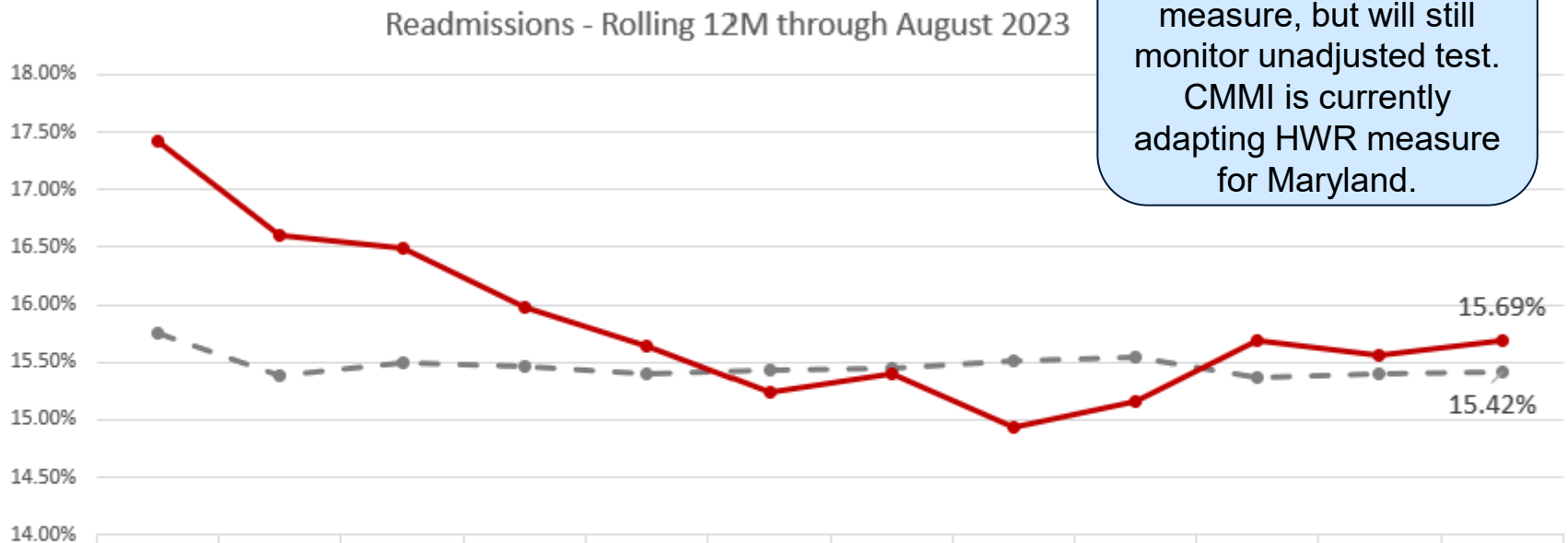
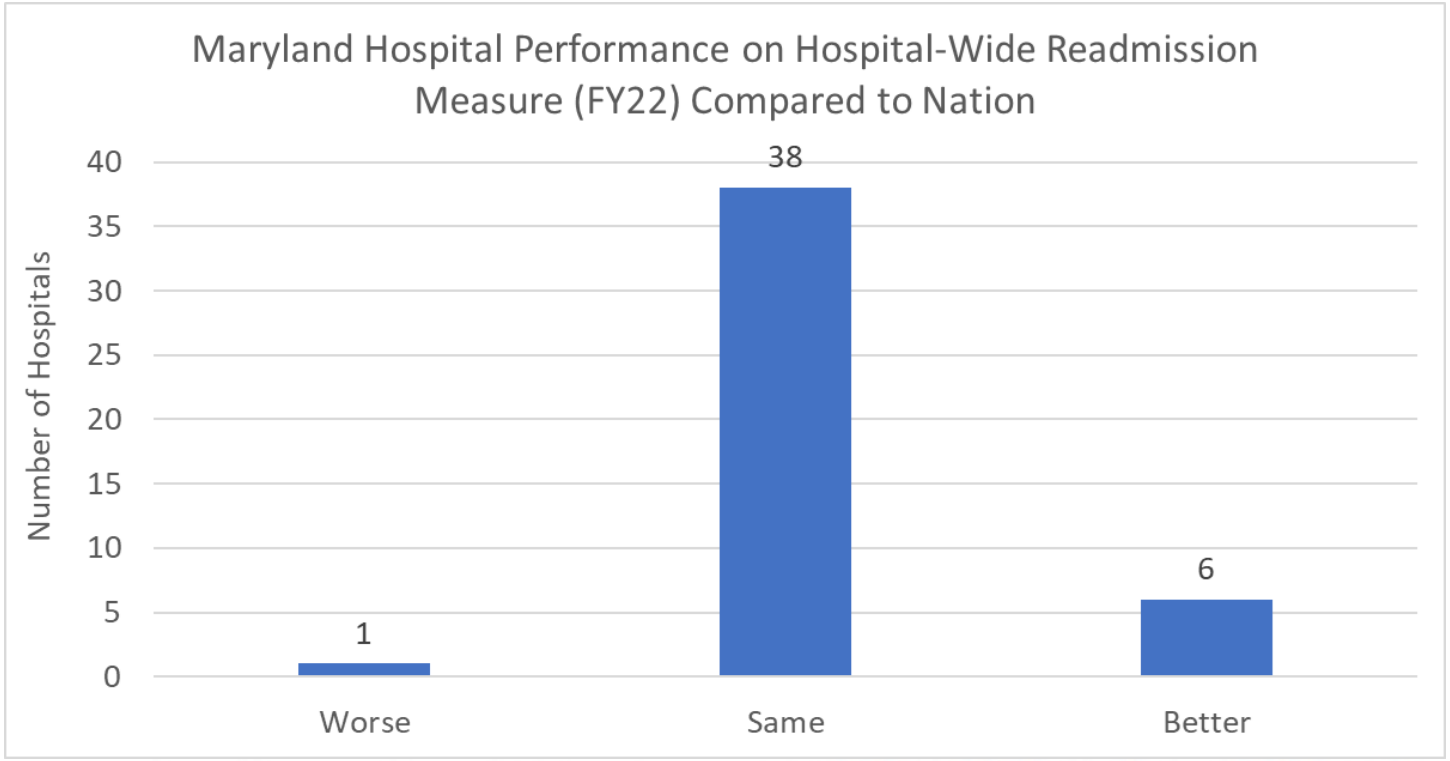
Unadjusted Readmission Rates, MD vs Nation

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



	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%	15.69%

Medicare Risk-Adjusted Hospital-Wide Readmission Measure



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General Improvement Target Considerations

- RRIP Redesign set 5 year improvement goal (2018-2023) of 7.5 percent
  - Should policy still provide incentives for improvement? If so, over what time period (e.g., 2023-2026)?
  - SDOH adjustment is less critical with improvement incentives
  - Case-mix adjustment using statewide normative values acknowledge changes in case-mix index over time
  - Uncertainty in acceptable readmission rate is cushioned with opportunity to earn credit for improvement
  - An acceptable readmission rate will always be non-zero, some readmissions are unavoidable and hospitals should not be unduly pressured to reach zero readmission rate
    - Should trend in improvement be lower than during last 5 years?

RY2022 RRIP Redesign

Based on these estimates, the Commission approved a 5-year, 7.5 percent improvement target (5 years 2018-2023)

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)

Updated All-Payer Improvement Estimates

Need to determine number of years for improvement target, used 2026 here.

Estimating Method	Percent Improvement	Resulting Readm Rate (2026)
1. Annual 2018-2022 Improvement	-8.61%	10.19%
2. Annual 2021-2022 Improvement	-5.54%	10.53%
3. Readmission-PQI Reduction (50%)	TBD	
4. All hospitals to 2022 Median	-4.1%	10.69%
5. Reduction in Disparities	TBD	
6. Benchmarking - Peer County/MSA to 75th percentile (currently Medicare Only, will update with Commercial next month)	-4.75% to -5.45%	TBD

Attainment Target

- Hospitals are assessed also on attainment, and get better of the revenue adjustment
  - Hospitals at or better than the 65th percentile of performance receive scaled rewards
  - Readmission rates for attainment are adjusted for out of state readmissions using Medicare data as proxy
  - No adjustment for SDOH because improvement is also assessed
- For RY24,17 out of 44 (~39%) hospitals performed better under attainment
- Should attainment threshold be changed moving forward?

Analytic Plan and Discussion

Present next month

- Compare statewide and by hospital, unadjusted readmission rates with and without including ED revisits and/or observation stays (all)
  - Impact on hospital rankings
  - Impact on improvement rates
- Given concern about ED volume, should RRIP policy monitor or include in payment revisits?
  - Concerns on impact to ED of avoiding admission
  - Potentially way to game readmission rates
  - How would inclusion impact access?
  - Other concerns?

EDAC

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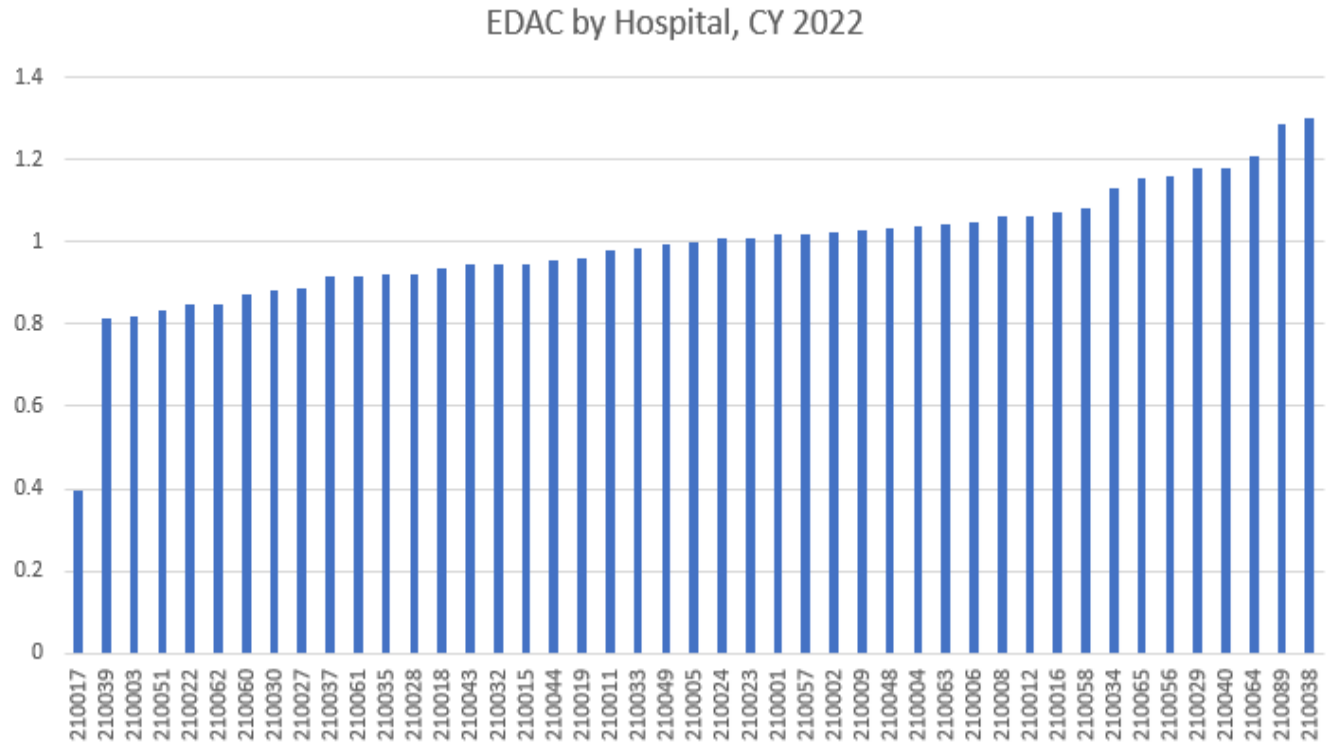
Excess Days in Acute Care (EDAC)

- 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
  - 2) it accounts for the intensity of post-discharge care.

Note: Monitoring Detail and Summary Level Reports are on CRS Portal

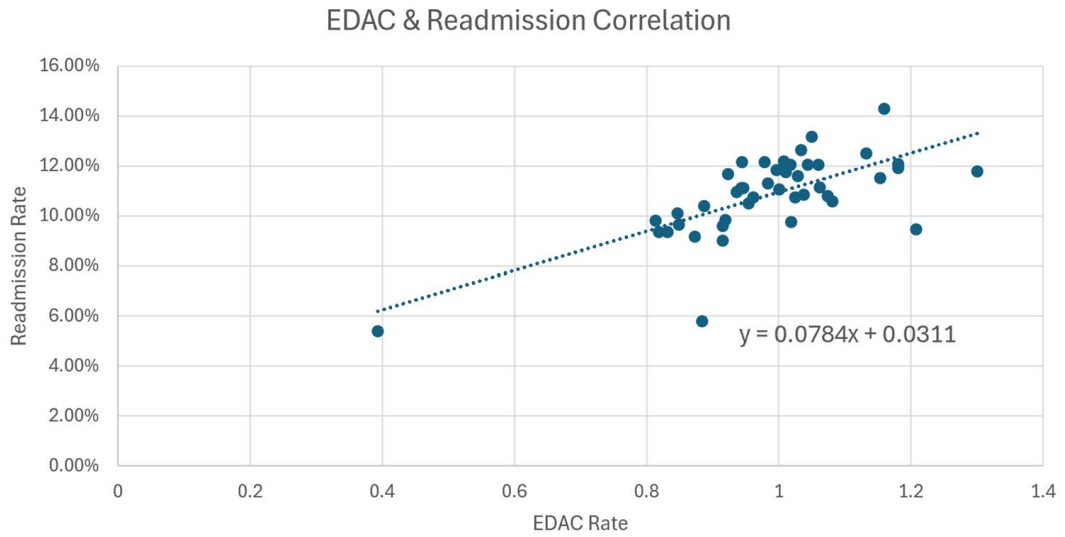
EDAC Performance



Performance Statistics (lower is better)	
Average	0.9923
Highest	1.3005
75th percentile	1.06014
Median	1.0008
25th percentile	0.9190
Lowest	0.3931

EDAC and Readmission Correlation, CY2022

- A moderate correlation (0.6865) between EDAC and readmissions suggests the two measures are mostly measuring the same thing



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Discussion

- EDAC is a way to look at revisits
- Concerns have been raised that long readmissions may be less preventable that shorter readmissions
- EDAC rates are low across all-payer, all-causes, with not a lot of variation

RRIP-Disparity Gap Updates

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Disparity Gap Reduction Goals: P4P Program

- In CY 2024, to begin receiving rewards, a hospital must reduce their readmission disparity gap by 35.16% when compared to 2018

Disparity Gap Improvement Scaling			
RY	2026	2027	2028
50% improvement (start of rewards)	-35.16%	-40.54%	-45.47%
75% improvement (full reward)	-57.96%	-64.64%	-70.27%

- RY 2024 RRIP-Disparity Gap Program (CY 2022 performance)
  - 11 hospitals rewarded
  - Range: (-29.74%, -61.54%)

Disparity Gap Reduction Goals: SIHIS

- In CY 2022, 32 hospitals saw a reduction in their within-hospital disparities in readmissions; range from -0.18% to -61.54%

- To meet the CY 2023 Target, the State needs at least 22 hospitals to reduce their within-hospital disparities in readmissions by at least 25%
  - In CY 2022, 12 hospitals saw a reduction in readmission disparities by ≥25%

Goal #2: Improve Readmission Rates by Reducing Within-Hospital Disparities	
Measure	Readmission disparity gap
2018 Baseline	Hospital-specific risk difference for readmissions across levels of Patient Adversity Index (PAI)
2021 Year 3 Milestone	Establish and monitor a measurement methodology and payment incentive for reducing within hospital readmission disparities and set a 2023 and 2026 target *Given current trends through August 2022, 10 Maryland hospitals are on track to meet the 2026 target.*
2023 Year 5 Target	Half of eligible hospitals achieving 25% improvement in disparity
2026 Year 8 Final Target	Half of eligible hospitals achieving 50% improvement in disparity

Locking PAI Coefficients

- RRIP- Disparity Gap uses two regression models
  1. Regression to calculate Patient Adversity Index (PAI)
  2. Regression to calculate disparity gap
- The 1st regression locks in PAI coefficients from 2018 and applies them to the performance period
- The 2nd regression locks in PAI coefficients and their interactions but other variables (APR-DRG-SOI, sex, age) in the regression have coefficients from the performance period (ie. they're always changing)
- Staff are working to **lock all coefficients from the base period** to apply to the performance period and will analyze whether the SIHIS goal and P4P improvement goal should be modified
  - Need to decide which year to lock in (2018 vs. Post-COVID)

Other Changes

- Method for identifying OOS Medicaid
  - Prior to FY22: Payer1=06 and Prin_HMO= 54
  - Post FY22: Payer1=06 and Non-Maryland Resident Status

RY2026 Draft RRIP Recommendations

Exact improvement and attainment targets may vary based on additional analyses and discussions with PMWG and other stakeholders

1. Maintain the 30-day, all-cause readmission measure.

2. Improvement Target - Set statewide 4-year improvement target of -5.0 percent from 2023 base period through 2026.

3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining 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. Monitor emergency department and observation revisits by adjusting readmission measure and through all-payer Excess Days in Acute Care measure. Consider future inclusion of revisits of EDAC in RRIP program.

Next Meeting: Wednesday, February 21, 2024

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