maryland
health services
cost review commission

Performance Measurement Workgroup

February 15, 2023

HSCRC Quality Team

PMWG Members

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Workgroup Ground Rules

- Be prepared: please read materials before the meeting
- Be brief
- Share the floor: please monitor your contributions to make sure others have an opportunity to engage in the discussion
- No interruptions (except for the time-keeper)
- Stay on topic
- Questions are welcome
- Respect deadlines for written comments

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	Annual report including Year 3 SIHIS Update	
January 2023	RRIP Policy Extension PAU Measurement Report on Avoidable ED Hospital Population Health Policy Discussion		
February			
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	

Meeting Agenda

- Potentially Avoidable Emergency Department Utilization
- RY 2024 Quality Policy Update
- Quality and Population Health: Model Progression Plan
  - Hospital Quality Programs
  - Health Equity
  - Statewide Population Health
  - Hospital accountability for Population Health

RY 2024 Quality Policy Update

Retrospective Updates

- Hospitals notified staff that PPC24 was being excluded from >6 PPC global exclusion
  - For each hospital, discharges are removed if discharge has more than 6 PPCs (i.e., a catastrophic case, for which complications are probably not preventable).
- HSCRC implemented PPC24 inclusion with RY24 Sept Final data
- Staff received pushback due to mid-year measure update

Question: Should we allow for retrospective changes or should all changes be realized at the beginning of a performance year?

- Revenue Scaling Adjustments
- COVID-19 adjustments
- Technical issues
- Etc.

Potentially avoidable emergency department utilization

Pivot to frequent fliers

- Stakeholders suggested focusing on frequent ED visitors
- Easier to intervene on patients with pre-existing relationship with a hospital
- Addresses low-acuity visits and those preventable with better primary care
- Several studies have focused on programs that reduce ED utilization by intervening on frequent visitors
- Interventions include case management, improving primary care access
- Case management may reduce ED use

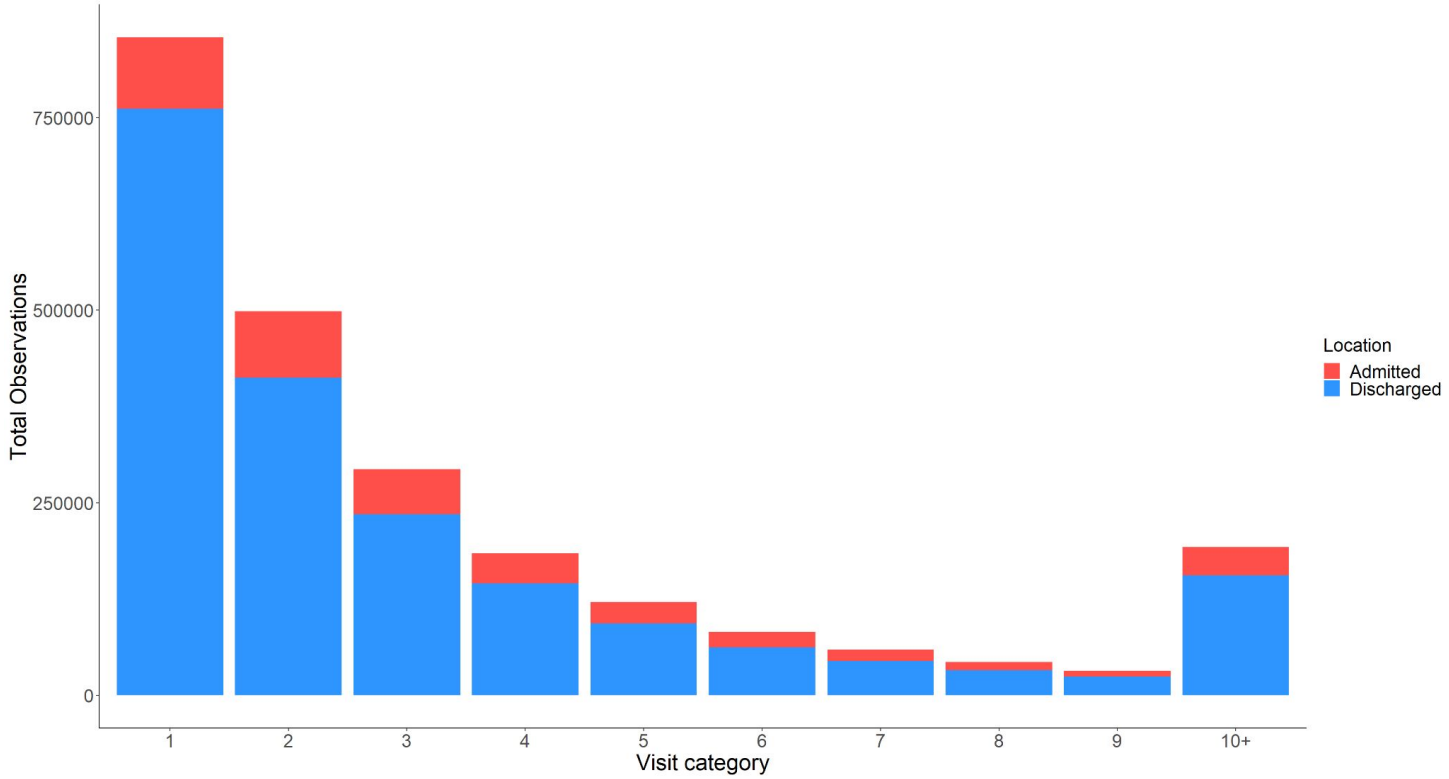
- Althaus et al. 2010. Effectiveness of interventions targeting frequent users of emergency departments: A systematic review. Annals of Emergency Medicine. Vol 58. pg 41-52
- Tsai et al. 2018. Reducing high-users visits to the emergency department by a primary care intervention for the uninsured:A retrospective study. Inquiry. Vol 55.
- Soril et al. 2015. Reducing frequent visits to the emergency department: A systematic review of interventions. PLoS One. 10(4)

Assessing opportunity related to frequent fliers

Staff sought to understand volume and cost related to frequent fliers, as well as overlap with PAU, payer and demographic patterns, and variability across hospitals

- Analyzed OP/IP across several years to understand frequent flier patterns.
- Results are based primarily on CY 2019 OP casemix data. This year was chosen because COVID could skew the 20/21 data.
- We categorized individuals with 4+ visits in a year as a “frequent flier”

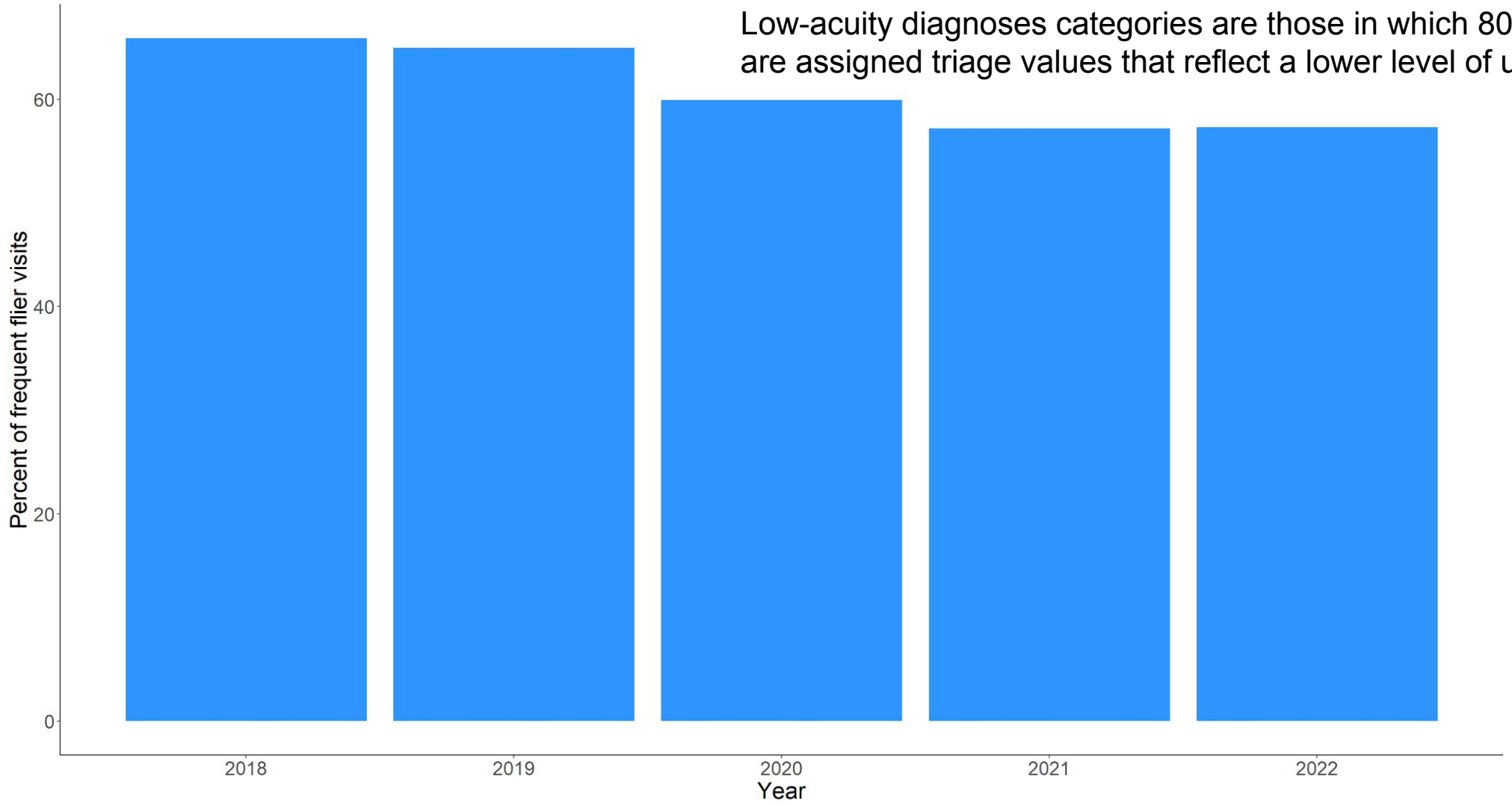
Frequent fliers accounted for 30% of all ED visits in 2019



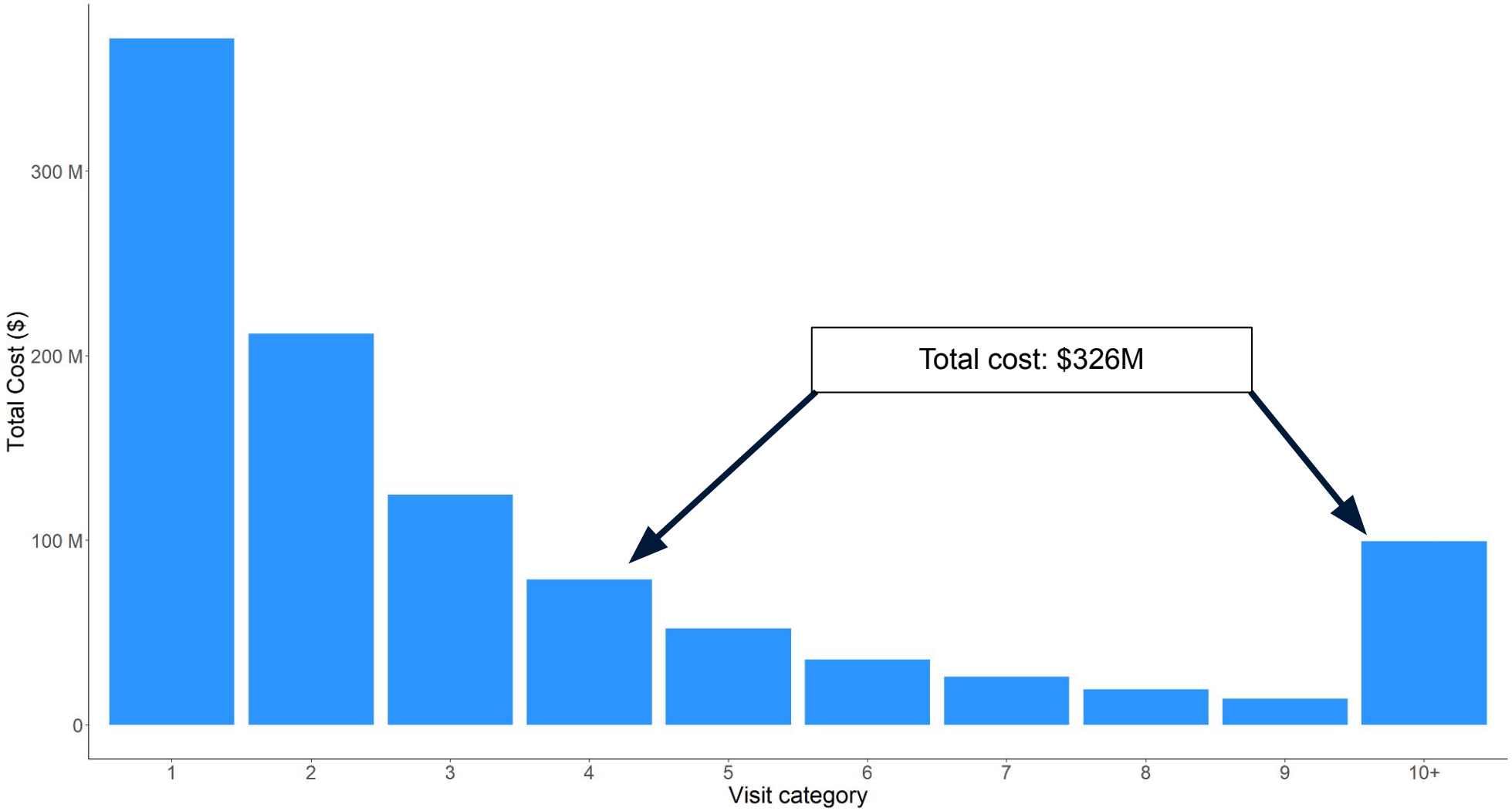
- Bulk of frequent flier visits are discharged from ED
- Indicates lower-acuity problems are common in frequent flier population
- Limited overlap with PAU

Of outpatient visits by frequent fliers, 62% are for low-acuity principal diagnoses

Low-acuity diagnoses categories are those in which 80% of visits are assigned triage values that reflect a lower level of urgency



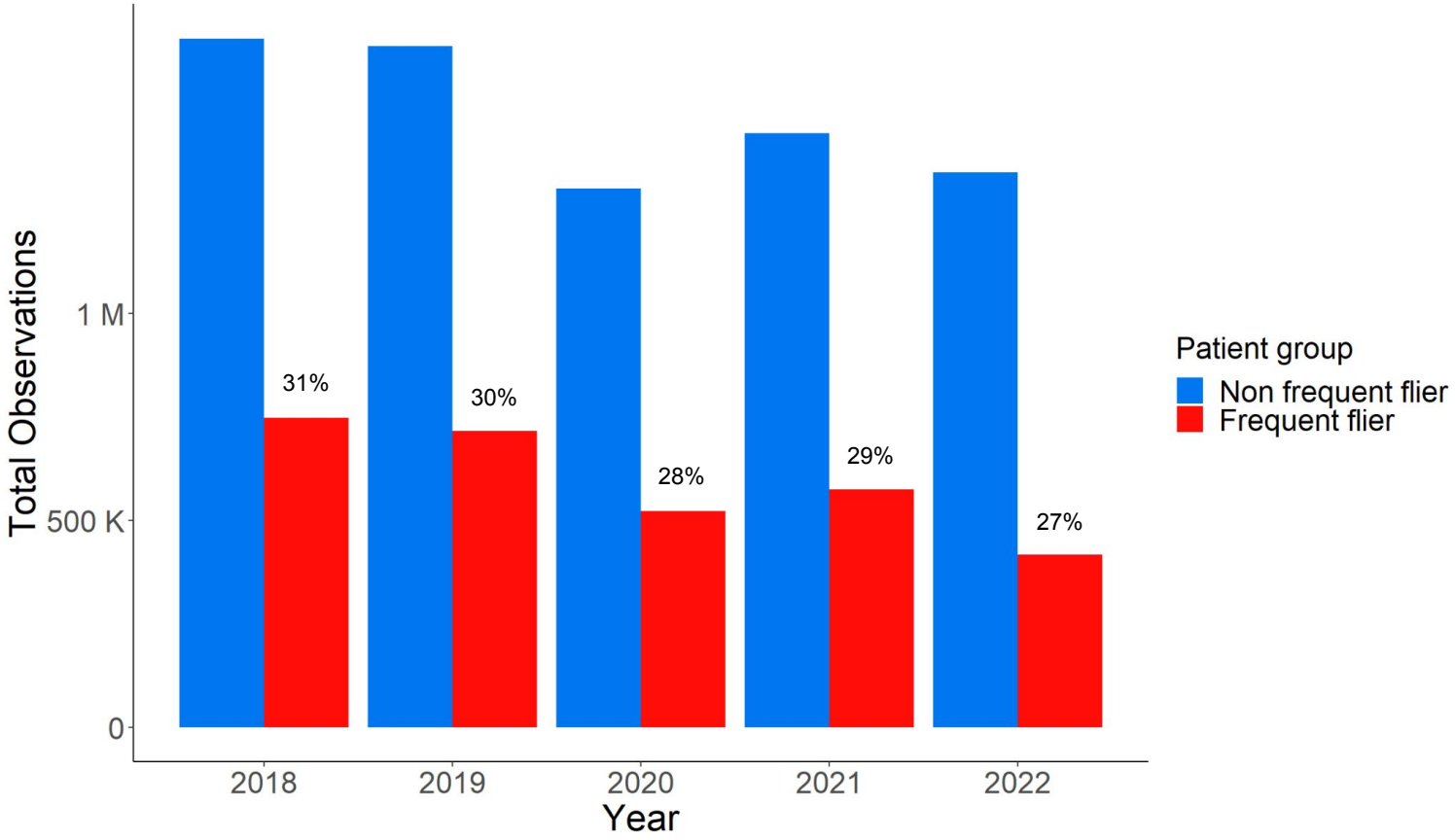
Frequent fliers accounted for 32% of discharged ED costs in 2019



Characteristics of Frequent Flier Visits in 2019

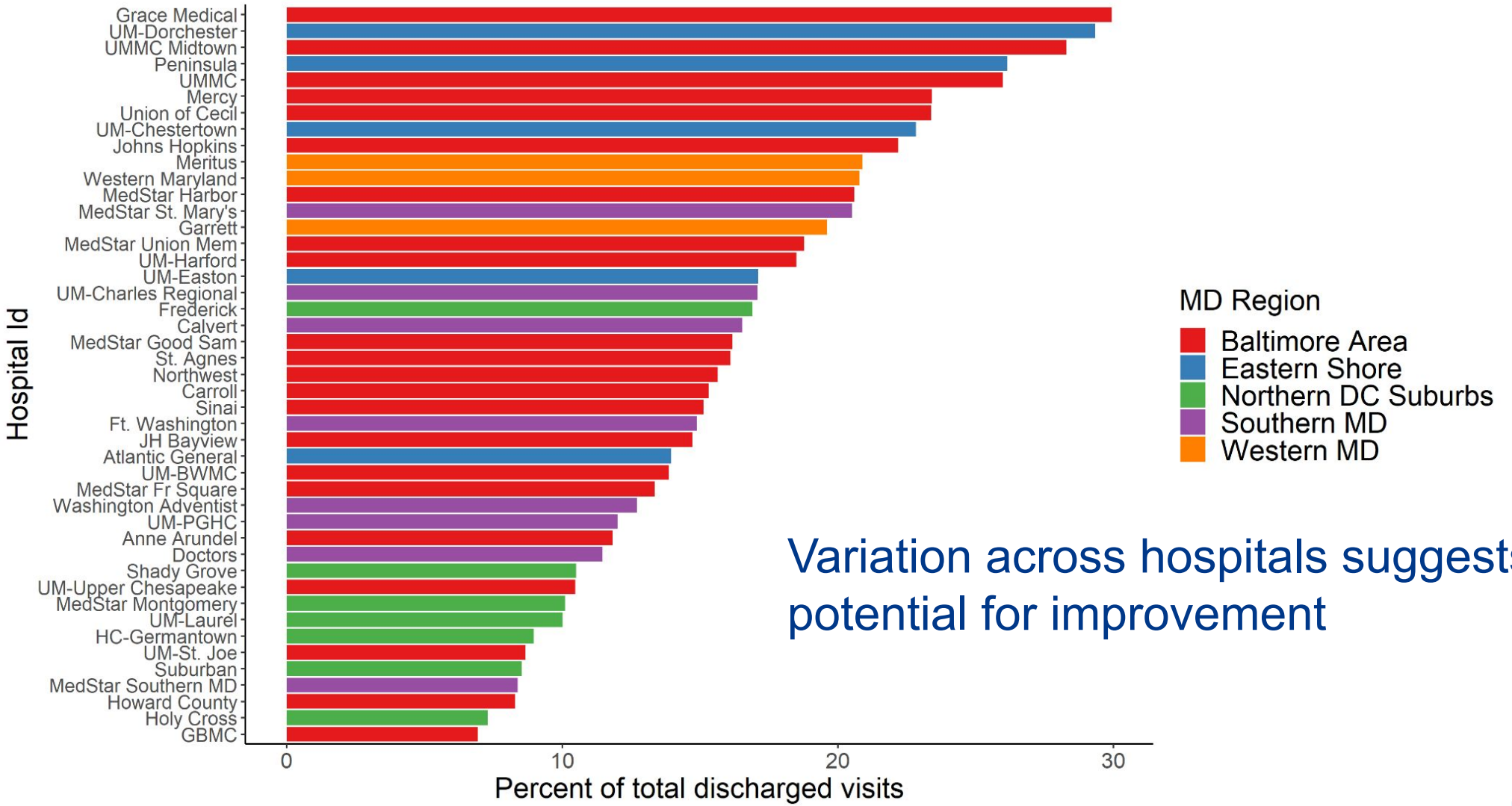
- 40% are covered by Medicaid
- 37% involve patients in the top quartile of Area Deprivation Index
- 41% involve Black patients
- 1% involve homeless patients
- 38% (of admitted visits) are also flagged as PQI's

Frequent flier volume fell during the pandemic



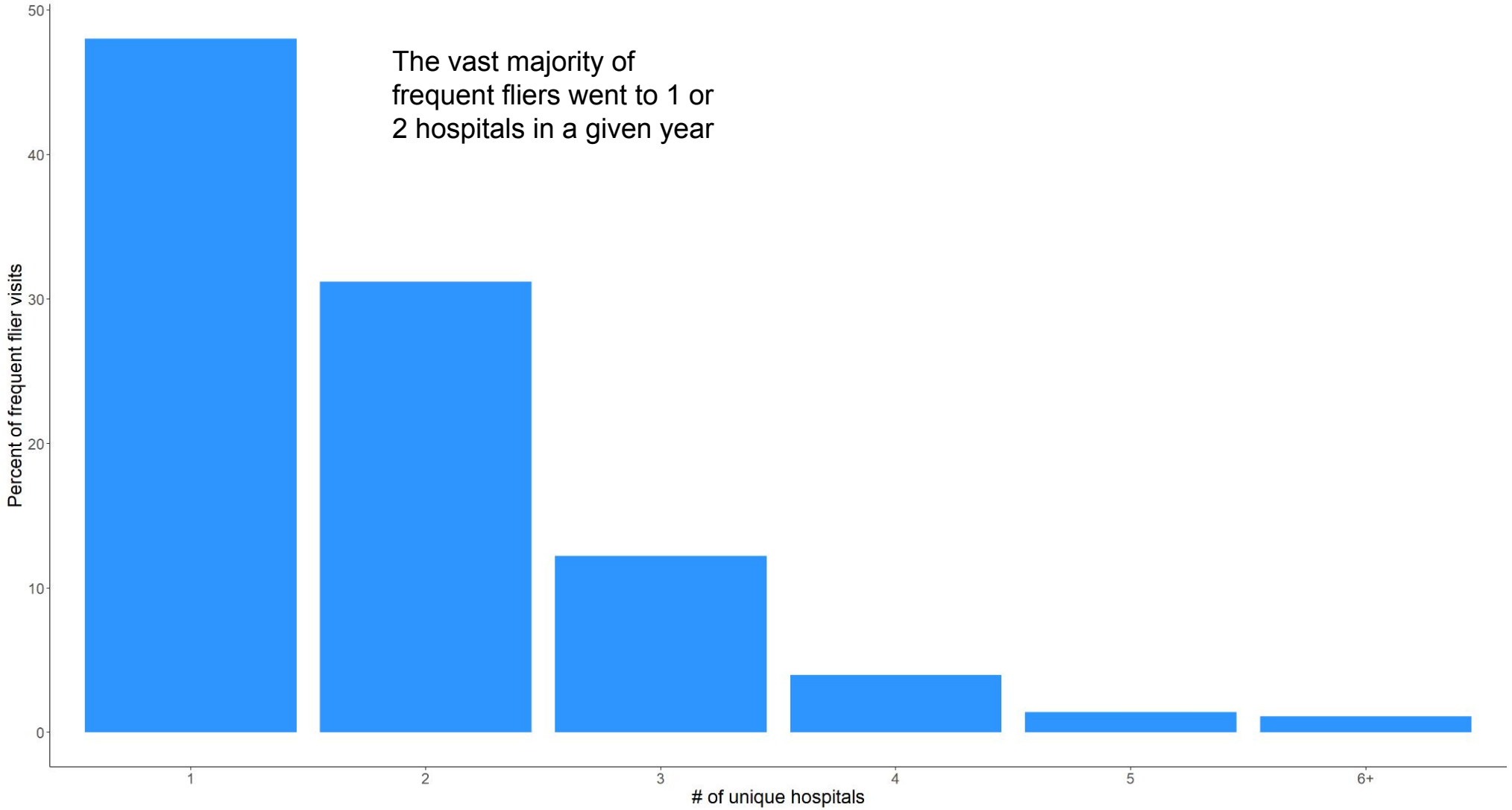
- We believe volume is high enough to create incentives around frequent flier volume

Frequent flier visit percentage in 2019 by hospital



Variation across hospitals suggests potential for improvement

Over 45% of frequent fliers went to the same Emergency Room



Next steps

1. Further explore measure definition based on Commission, stakeholder feedback
2. Begin monitoring

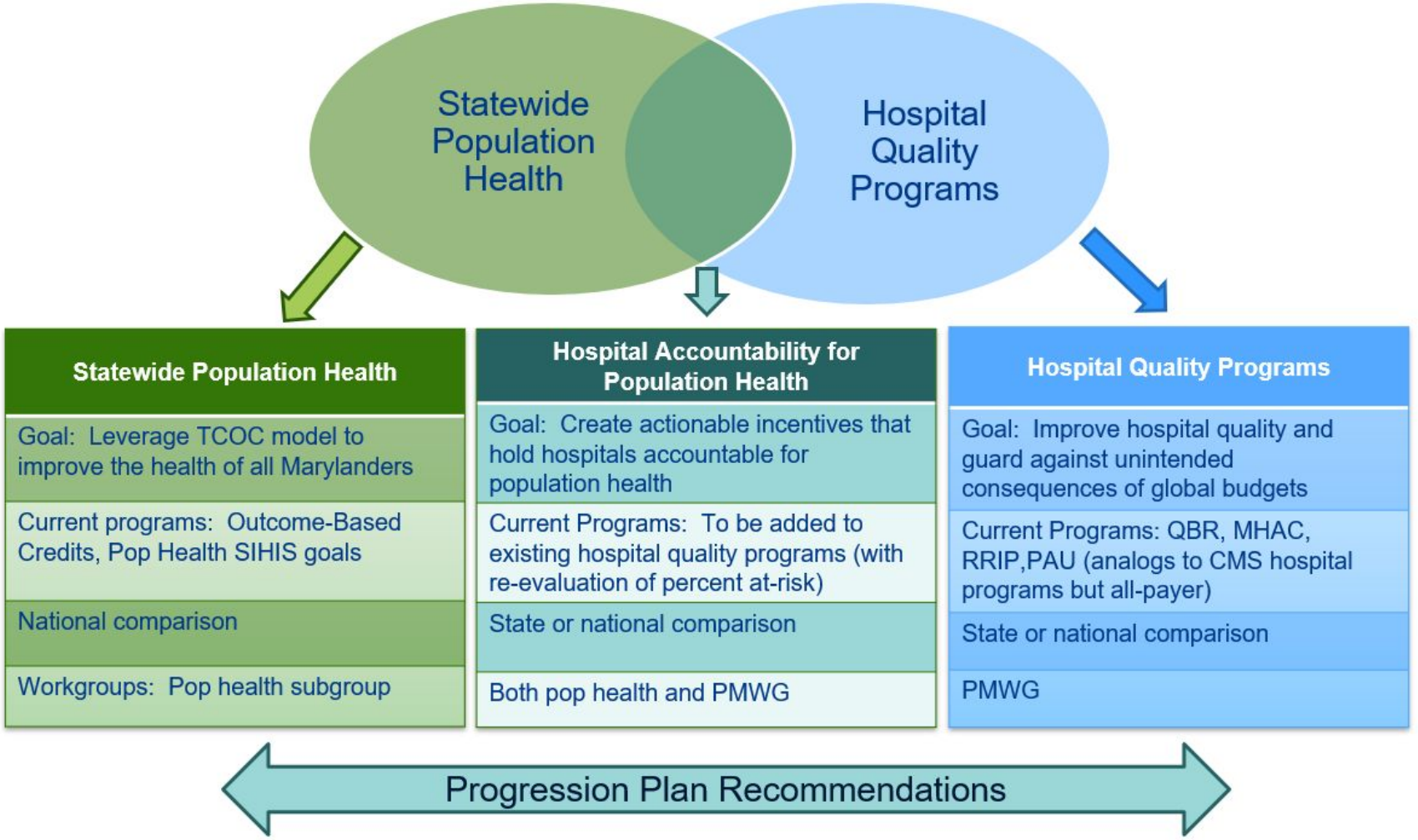
Hospital Quality and Population Health Progression Plan Strategy Development

Future Model Planning: Hospital Quality and Population Health

Task: April report for HSCRC leadership outlining strategic plan for future model

- Convene workgroup members to discuss model evolution and outline 3-5 year plan for future of Quality programs
  - Population health metrics
  - Digital measures: electronic Clinical Quality measures (eCQMs)/hybrid measures
  - Additional disparity metrics
  - Expansion of hospital focus, e.g., patient-reported outcome measures, climate change
  - Consider providers and other care settings
  - Revise policy approach (e.g., service lines, unified policy per MedPAC Hospital Value Incentive Program (HVIP))

Intersection of Hospital Quality and Population Health



Today's Discussion:

1. Hospital Quality Programs
2. Health Equity
3. Statewide Population Health
4. Hospital accountability for Population Health

Stakeholder Input

- Received 4 submissions
  - Feedback types: measure suggestions, technical adjustments, guiding principles, policy

- Feedback still expected from several stakeholders; input still welcome.
  - Any subject area not covered in today's meeting will be discussed at next month's meeting.

- Despite potentially impacting performance measurement, input on MPA attribution methodology and market shift/deregulation concerns are not dealt with by quality team
  - Concerns about MPA attribution can be brought up with TCOC workgroup
  - Concerns about MS/dereg can be brought up at payment models

Progression Plan: Hospital Quality

Stakeholder Input: Quality Programs

- Programs overall
  - Flexible P4P programs that are based on a hospital's profile/service-mix
  - Incentivize same measures as the nation
  - Target Medicaid population

- Program specific
  - Blended or rolling RRIP baseline, e.g., use average of 3 yrs
  - Incorporate PAU into core quality programs with a rewards/savings approach
  - Transition MHAC program to be similar to HACRP to reduce administrative complexity
  - Consider more clinically appropriate timeframe for TFU measure

MedPAC Population-based Measures and Hospital Quality incentives

- Principles for measuring quality: patient oriented, encourage coordination,promote system change.
- Use a small set of outcomes, patient experience, and value measures across different populations, e.g., Medicare Advantage (MA) plans, accountable care organizations (ACOs), and fee-for-service (FFS) in defined market areas, specified hospitals, groups of clinicians, and other providers.
- Score risk-adjusted, population-based measure results against absolute performance thresholds, then use peer grouping to determine payment adjustments
  - Potentially preventable admissions and home and community days (formerly known as “healthy days at home”).
  - New hospital quality incentive program that combines measures of hospital outcomes, patient experience, and Medicare spending per beneficiary.
    a. there are too many overlapping programs,creating unneeded complexity
    b. “all-condition” measures are more appropriate to measure the performance of hospitals;
    c. the existing programs include process measures and measures not consistently reported
    d. some of the programs score hospitals using “tournament models” (providers are scored relative to one another) rather than on clear, absolute, and prospectively set performance targets.

Hospital Value Incentive Program

Redesigning Medicare's hospital quality payment programs

Implement New Structure for Medicare's hospital quality payment programs

- Eliminate the Inpatient Quality Reporting Program
- Replace existing CMS pay for performance programs with a single quality payment program for hospitals that merging the HRRP, HACRP, and VBP Programs

Measuring and paying for quality under the HVIP

- Include five CMS-administered measure domains: mortality, readmissions, Medicare spending per beneficiary (MSPB), patient experience, and hospital-acquired infections.
- Reward or penalize a hospital based on its individual performance relative to a prospectively set system of targets.
- Distribute rewards based on a continuous scale of points, ensuring hospitals with similar performance receive similar financial rewards (i.e., minimizing payment "cliffs"). The continuous scale stretches over the entire distribution of performance, giving even top-performing hospitals an incentive to continue to improve.
- Report unadjusted performance to provide beneficiaries with accurate information to use when making care decisions, and *then* account for social risk factors by adjusting hospital rewards.
- Assign hospitals to peer groups based on their share of Medicare patients who were fully dual-eligible beneficiaries;under this approach, hospitals serving the greatest shares of fully dual-eligible patients incur the same level of payment adjustment on average as those serving the lowest shares.

Reference: https://www.medpac.gov/the-hospital-value-incentive-program-measuring-and-rewarding-meaningful-hospital-quality/

Aligning Quality Measures across CMS — The Universal Foundation

Reference: https://www.nejm.org/doi/pdf/10.1056/NEJMp2215539?articleTools=true

- Part of CMS's efforts to implement the vision outlined in our National Quality Strategy
- Fundamental to achieving several of the agency's quality and value-based care goals.
- Intended to focus providers' attention on measures that are:
  - Meaningful for the health of broad segments of the population;
  - Reduce provider burden by streamlining and aligning measures;
  - Advance equity by tracking disparities in care among and within populations;
  - Aid the transition from manual reporting of quality measures to seamless, automatic digital reporting; and
  - Permit comparisons among various quality and value-based care programs, to better understand what drives quality improvement and what does not.
- Ultimately, the Universal Foundation will eventually include selected measures for assessing quality along a person's care journey — from infancy to adulthood — and for important care events, such as pregnancy and end-of-life care.

Preliminary Adult and Pediatric Universal Foundation Measures.*	
Domain	**Identification Number and Name**
Adult	
Wellness and prevention	139: Colorectal cancer screening 93: Breast cancer screening 26: Adult immunization status
Chronic conditions	167: Controlling high blood pressure 204: Hemoglobin A1c poor control (>9%)
Behavioral health	672: Screening for depression and follow-up plan 394: Initiation and engagement of substance use disorder treatment
Seamless care coordination	561 or 44: Plan all-cause readmissions or all-cause hospital readmissions
Person-centered care	158 (varies by program): Consumer Assessment of Healthcare Providers and Systems overall rating measures
Equity	Identification number undetermined: Screening for social drivers of health

Pediatric	
Wellness and prevention	761 and 123: Well-child visits (well-child visits in the first 30 months of life; child and adolescent well-care visits) 124 and 363: Immunization (childhood immunization status; immunizations for adolescents) 760: Weight assessment and counseling for nutrition and physical activity for children and adolescents 897: Oral evaluation, dental services
Chronic conditions	80: Asthma medication ratio (reflects appropriate medication management of asthma)
Behavioral health	672: Screening for depression and follow-up plan 268: Follow-up after hospitalization for mental illness 264: Follow-up after emergency department visit for substance use 743: Use of first-line psychosocial care for children and adolescents on antipsychotics 271: Follow-up care for children prescribed attention deficit–hyperactivity disorder medication
Person-centered care	158 (varies by program): Consumer Assessment of Healthcare Providers and Systems overall rating measures

CMMI Areas of Focus

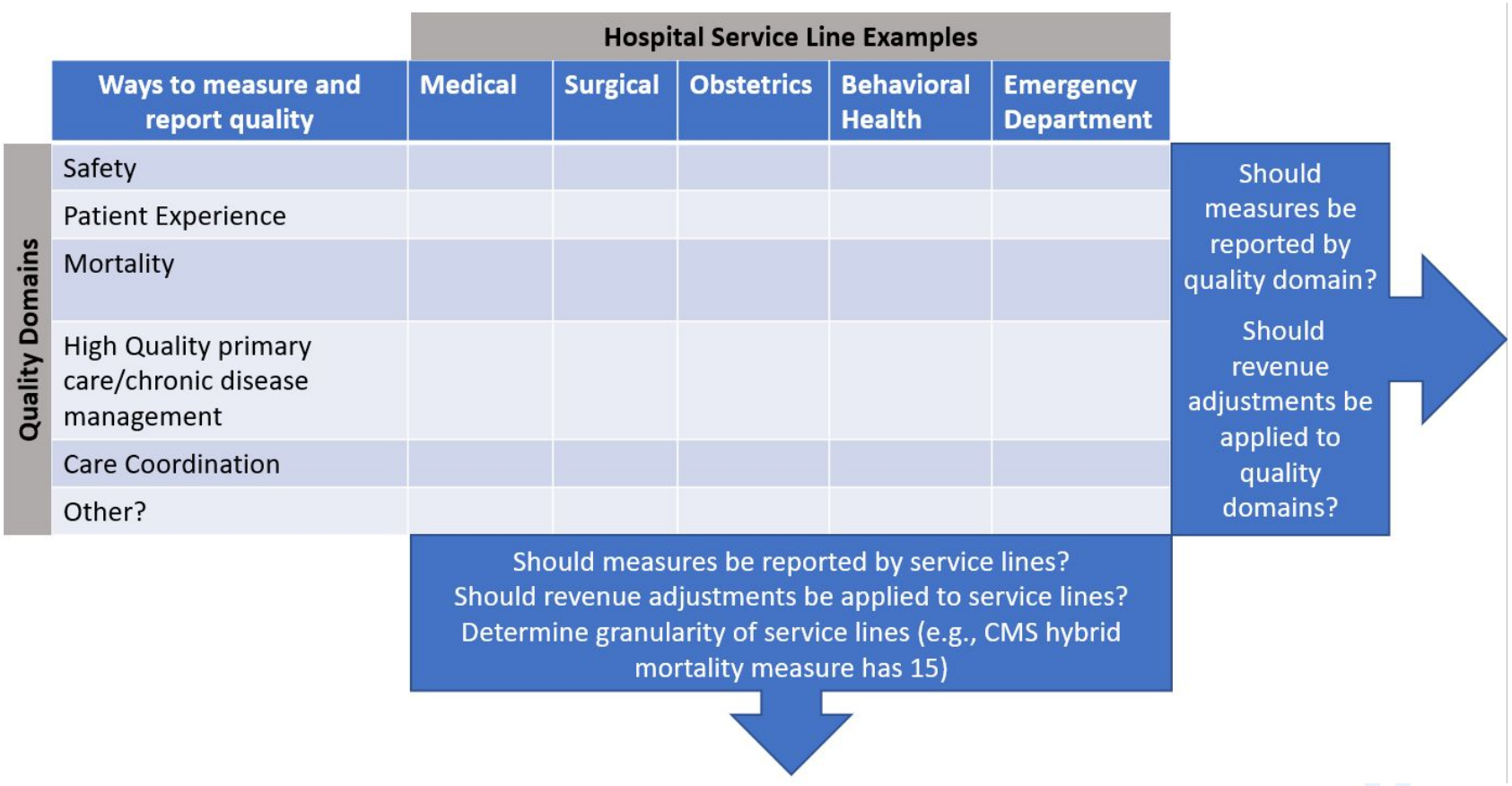
Feedback on Quality Programs in TCOC Model:

- Concerns of patient experience
- Advance Health equity
- Foster best practices
- All-Payer/Multi-payer alignment
- Readmissions
- ED concerns
- Population health accountability

Hospital Quality Program Updates (MedPAC, Universal Foundation, CMMI, HSCRC)

RY23/CY21 and Prior	RY24/CY 22	RY 25/CY 23	RY 26/CY 24	RY27/CY25	RY 28/CY26	New TCOC Model
-Use absolute performance standards**	-Develop 30-day all condition mortality measure***	-Engage stakeholders in digital measures WG****	-Develop new targets for RRIP*	-Assess safety measure portfolio (PPCs, PSI, NHSN)	-Model and develop monitoring reports for streamlined quality program	**Implement Enhanced Hospital Quality Program/s**
-Use prospective targets**	-Begin state collection of digital measures/ eCQMs***	-Add perinatal eCQMs****	-Include ED wait times in payment policy*	-Evaluate QBR domains and measures	-Reassess revenue at-risk across quality programs	
-Use all-condition measures**		-Collaborate with MHA and on HCAHPS improvement***	-Consider adding perinatal or other eCQMs in payment policy*	-Assess risk-adjustment across programs		
-Distribute rewards based on a continuous scale of points**		-Implement TFU Medicaid***	-Develop infrastructure for PROMs*			
		-Implement 30 day mortality, TFU Beh Hlth, EDAC Monitoring Reports****				
		-Consider plan for all-payer patient reported outcome measures (PROMs)*				
		-Develop progression plan recommendations*				
		Consider options for streamlining Hospital quality programs*** Imbed payment incentives for Equity in Hospital Quality Programs***				

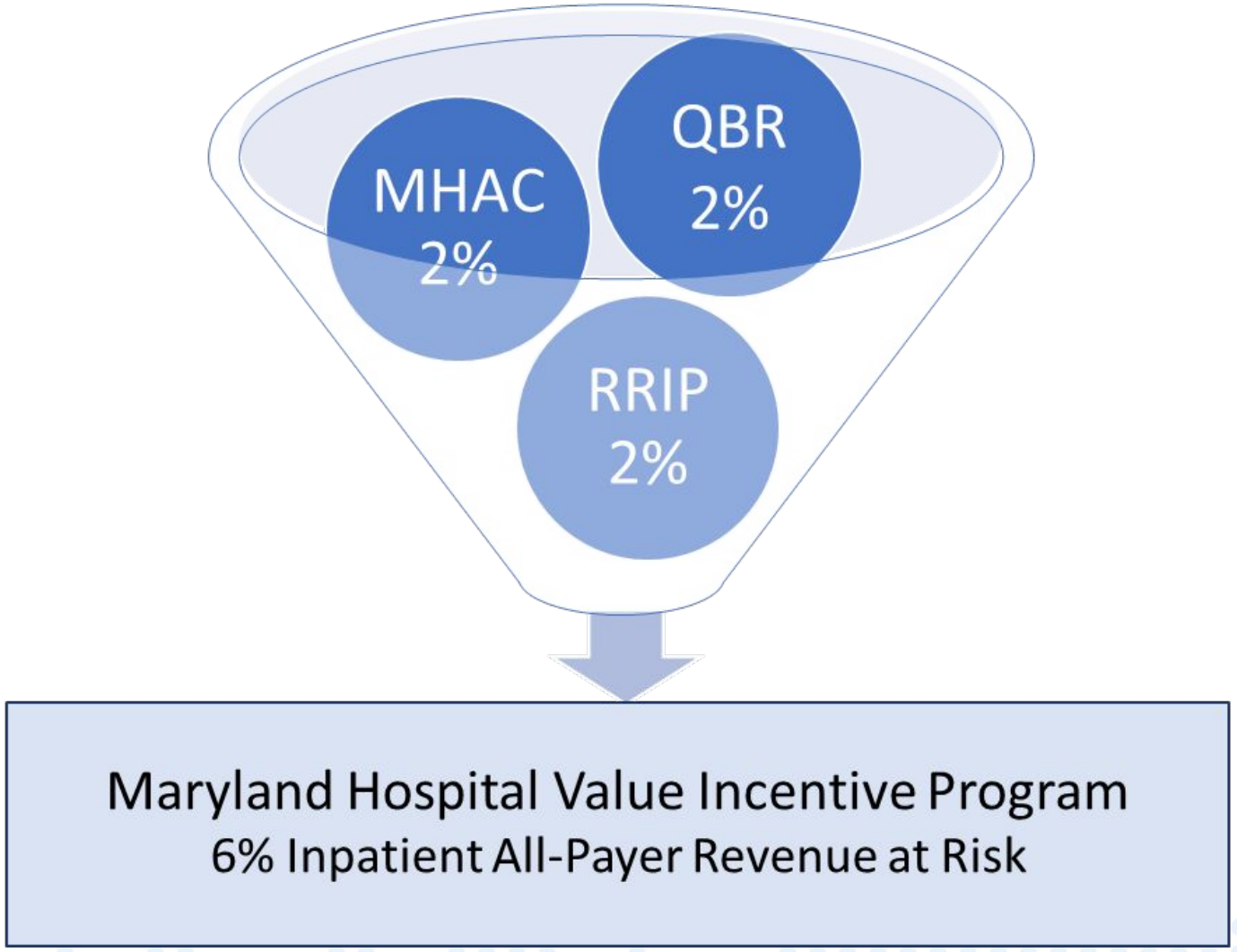
Quality Incentives:
Patient Centeredness through Service Line Approach



Additional questions:

- What is meaningful for clinicians? Patients?
- Improvement vs. attainment for payment?
- Report improvement?
- Roll service lines into hospital level metric
  - Risk adjustment at service line level?

Streamlined Programs and Revenue At-Risk



Additional Revenue At-Risk under:

- Potentially Avoidable Utilization Adjustment
- Readmission Disparity Gap reward
- Quality adjustment in MPA

Next Steps

- Meeting in March:
  - Review additional stakeholder input
  - Invite stakeholders to present on topics

- Meeting in April
  - Review draft progression plan recommendations and timeline

Progression Plan: Health Equity

Health Equity Survey

- In 2015, all MD hospitals signed #123 for Equity 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 was extended to December 15th, 2022
  - Any hospitals that have not submitted need to contact the HSCRC
- Survey Results in Appendix

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 ≤ 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 ≤ who were screened and screened positive for one or more of the social drivers

Requesting that hospitals submit this data to the State as well as CMS

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

Stakeholder Input: Health Equity

- Stratify all quality and population health measures by socio-demographic factors
- Focus on TFU, avoidable admissions, and IP mortality as opposed to lower volume outcomes such as PPCs
- Focus on OP settings
- Consider CMS Health Equity Structural Measures
- Prioritize structural and process measures initially which can be indicators of hospitals' readiness to achieve success on advanced health equity outcome metrics

Health Equity Measurement Timeline

<table>
<tr><th>RY23/CY21</th><th>RY25/CY23</th><th>RY26/CY24</th><th>RY27/CY25</th><th>RY28/CY26</th><th>Post- TCOC Model</th></tr>
<tr><td rowspan="2">RRIP Disparity Gap measure</td><td rowspan="2">Assess application of existing PAI measure on additional HE measures

Medicaid TFU in QBR Program

Workgroup to improve SDoH Data Collection and Documentation</td><td>TFU Disparity Measure in QBR Payment Program</td><td></td><td rowspan="2">Continuation of RRIP, TFU, and Avoidable Admissions Disparity Measures, and consider HCAHPS</td><td rowspan="2">Aggregated Health Equity Monitoring and Pay-for-Performance Program???</td></tr>
<tr><td colspan="2">Avoidable Admissions Disparity Measure in PAU Payment Program</td></tr>
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- Staff will modify the RRIP PAI methodology for the TFU and Avoidable Admissions measures
  - Which social factors are of interest, measure specific or same for all?
- These measures (RRIP, TFU, and Avoidable Admissions) are being prioritized due to their drastic disparities and their indication of issues with access to outpatient services

Potential Health Equity Recommendations

- Adopt an equity in all policies approach for hospital quality and population health accountability
  - Do we agree we must include health equity recommendation in progression plan?
- Collect additional data on socio-demographics/hospital process measures, stratify all quality and population health measures, and develop payment programs to address identified disparities.
  - Staff currently working to improve collection of SOGI data
  - Improvements need to be made with the collection of SDoH data

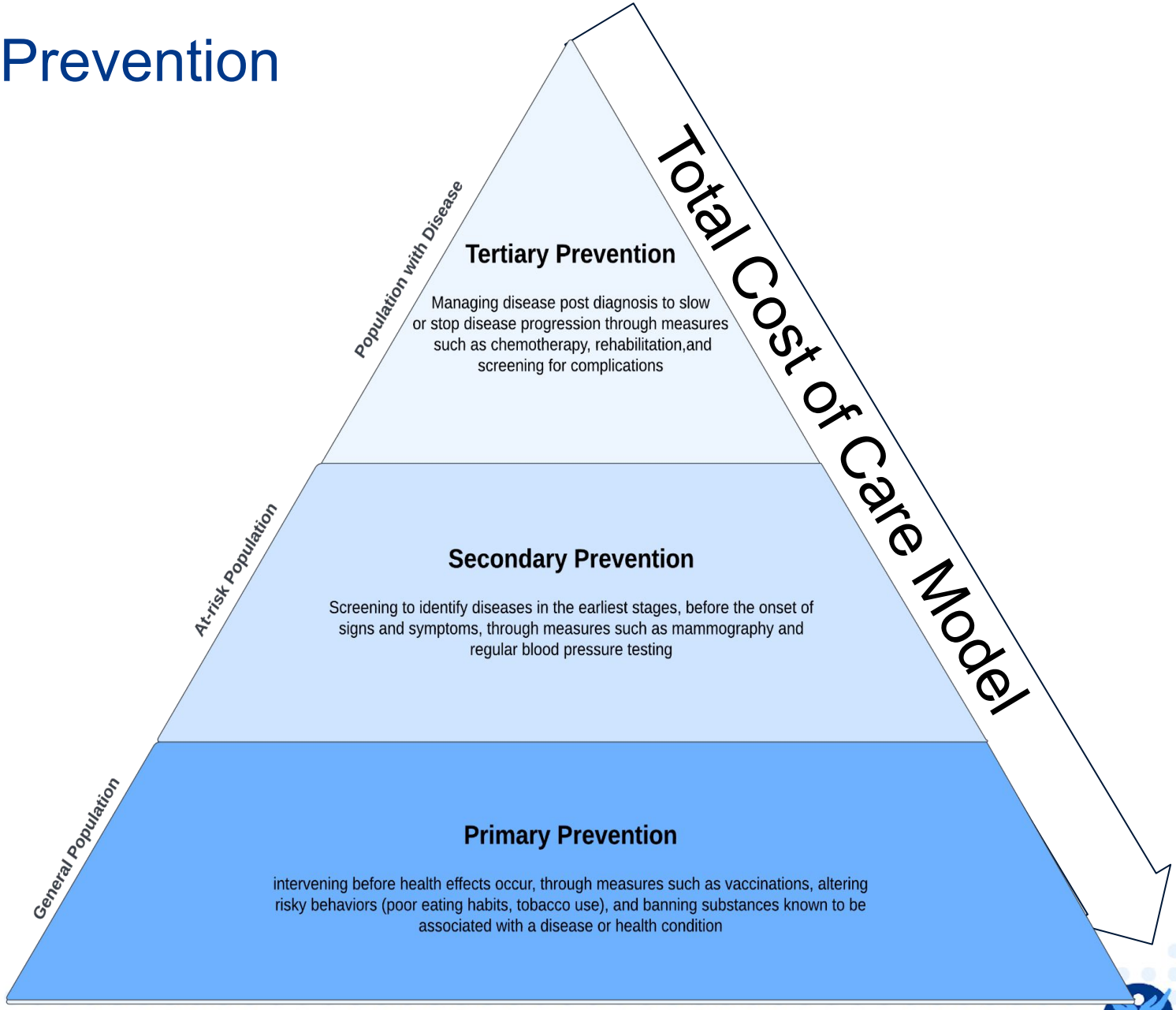
Progression Plan: Statewide Population Health

Statewide Population Health

- Statewide Integrated Health Improvement Strategy
  - What should this look like in the future?
    - Expansion?
    - More holistic, e.g., life expectancy?
  - Are there things the state should try to link with SIHIS success?
- Statewide population health should measure and consider impact on equity
- Outcomes Based Credits
  - Does PMWG recommend that HSCRC staff advocate for continuing and potentially expanding OBCs under future model?
  - Should OBC amount be more directly tied to hospital payments?

Progression Plan: Population Health

Levels of Prevention



https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf

Key Work Streams for Pop Health in Remaining Model Years

- Focus on hospital accountability for primary and secondary prevention
  - Necessary to drive further model performance
  - Health systems in other states are innovating very quickly in this area
  - Model credibility depends on MD keeping pace with industry leaders elsewhere
- Identify data sources for pop health work
  - Timely
  - Sub-state estimates
  - Visibility on incidence, prevalence and screening
  - Provide counterfactuals outside of Maryland
- Develop new measures for monitoring first, followed by payment
- Equity in all policies

Stakeholder Input: Population Health

- Limit patients attributed based on receipt of services (subset of community)
- Provide general guidance on the types of activities to provide
- Focus on pop health measures that are aligned across multiple payers/programs
- Consider Healthy Days at Home measure
- Consider avoidable admissions a hybrid measure of hospital quality and pop health
- Explore per capita readmissions measure
- Focus on healthcare workforce and outreach into communities

Population Health Progression Timeline

RY25/CY23	RY26/CY24	RY27/CY25	RY28/CY26
Evaluate A1c screening, avoidable ED measure performance Submit opioid and HTN outcome credit methodologies Update diabetes credit methodology to address added test volume, measurement challenges Evaluate need for EMS handoff incentive	Transition A1c, avoidable ED measures into payment policy Evaluate need for additional secondary prevention measures Identify data requirements for developing hospital accountability measures on primary prevention	Implement additional secondary prevention measures Bring enhanced pop health data online Develop & monitor primary prevention hospital accountability measures Evaluate need for pop health equity measures Consider stand-alone pop health payment policy	Move primary prevention hospital accountability measures into payment policy Evaluate state population health progress and update focus for SIHIS/outcome credits/hospital accountability based on disease burden estimates

THANK YOU!

Next Meeting: Wednesday, March 15th, 2023

Appendix

Acute Care Hospital Survey Results

- 10 responses received for 28 hospitals
- All acute care hospitals explicitly prioritize health equity in their missions and goals
- 23 hospitals have a particular definition for health equity
- 25 have a designated health equity individual/team
- 25 have specific goals for achieving health equity, but all have plans to further develop specific health equity goals
  - 4 hospitals have incentives tied to goals
- Analyzed outcomes data to understand the health disparities
  - 12 hospitals have analyzed for the surrounding community
  - 25 have analyzed for their patients
- 28 hospitals are committed to recruiting and supporting multilingual employees that are fluent in languages most spoken by patient population

Health Equity Survey Results cont'd

- All hospitals have training and education to support the workforce in culturally appropriate practices and policies
- 22 require implicit bias training for all staff members
- 28 have items related to HE in their CHNA implementation strategy; all plan to include health equity in CHNA in future
- 18 hospitals do not screen for SDoH during IP admissions; 21 don't during obs stays or ED visits
- 9 document SDoH indicators on EMR; 2 using z-codes; 1 doesn't document at all