



maryland
health services
cost review commission

Performance Measurement Workgroup

October 19, 2022

HSCRC Quality Team

PMWG Members

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Lori	Doyle	Community Behavioral Health Association of Maryland
Laura	Goodman	MD Medicaid
Toby	Gordon	Johns Hopkins Carey Business School
Shyloe	Jones	Families USA
Theresa	Lee	Maryland Health Care Commission
Skelly	Wingate	Kaiser Foundation

Patsy	Mcneil	Adventist Health
Stephen	Michaels	MedStar Southern Maryland Hospital Center
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Madeleine "Maddy"	Shea	Health Management Associates
Brian	Sims	Maryland Hospital Association
Mike	Sokolow	University of Maryland Medical Systems
Geetika "Geeta"	Sood	Johns Hopkins University School of Medicine, Division of Infectious Diseases.
April	Taylor	Johns Hopkins Health System
Bruce	VanDerver	Maryland Physicians Care
Skelly	Wingate	Kaiser Foundation

Meeting Agenda

- QBR RY 2025 FINAL recommendation discussion
 - CY 2023 eCQM/hybrid measure adoption
- Hospital Population Health Accountability Policy discussion
- Maryland Hospital Acquired Conditions (MHAC) RY 2025 policy discussion
 - PPC trends
 - MHAC methodology
 - Draft recommendations

Timeline of Deliverables (See PMWG Workplan document)

Month	Commission Meetings	CMMI	HSCRC/Other
October 2022	Draft QBR		
November	Final QBR Draft MHAC Draft Hospital Population Health Policy		RY2023 Revenue Adjustments
December	Final MHAC Draft RRIP Final Hospital Population Health Policy Draft PAU Measurement Policy	Annual report including Year 3 SIHIS Update	
January 2023	Final RRIP Final PAU Measurement Policy		
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	

QBR Final Recommendation

RY 2025 QBR Draft Recommendations (slide 1 of 2)

1. Continue Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 50 percent, Safety (NHSN measures) - 35 percent, Clinical Care - 15 percent.
 - a. Within the PCE domain, continue to include four linear HCAHPS measures weighted at 10% of QBR score; remove associated revenue at risk from top box.
 - b. Within the PCE domain, add the Timely Follow-Up measure for Medicaid.
2. Develop the following monitoring reports for measures that will be considered for adoption after RY 2025:
 - a. 30-day all-payer, all-cause mortality (claims based)
 - b. Timely Follow-Up for Behavioral Health
 - c. Disparity gaps for Timely Follow-Up
3. Implement the HCAHPS improvement framework with key stakeholders.

RY 2025 QBR Draft Recommendations (slide 2 of 2)

4. Continue collaboration with CRISP on infrastructure to collect hospital electronic clinical quality measures and core clinical data elements; For CY 2023 require submission of:
 - a. ED-2 eCQM for monitoring; consider for re-adoption after RY 2025 (in CY 2024)
 - b. Safe Opioid Use eCQM for monitoring
 - c. Four additional eCQM measures aligned with the SIHIS goals and hospital improvement priorities
 - d. Clinical data elements for 30-day mortality and readmission hybrid measures beginning July 2023
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 cutpoint using more recent data to calculate national average score

Proposed RY 2025 QBR Policy Overview

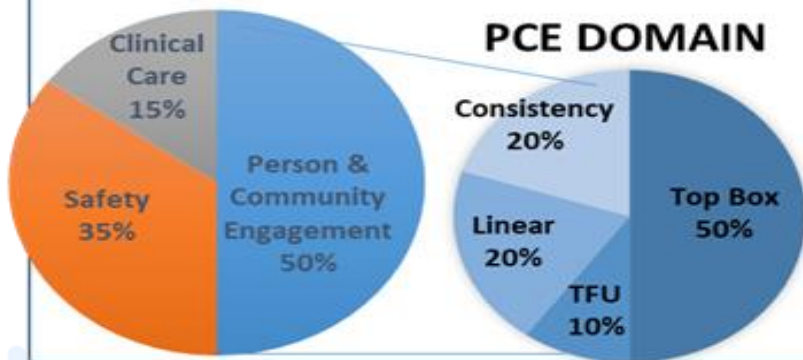
Performance measures

Measures by domain:

Person and Community Engagement (PCE)- follow-up after chronic conditions exacerbation measure (TFU) Medicare, **PROPOSED NEW add TFU Medicaid**; 8 HCAHPS categories top box, 4 HCAHPS categories linear score.

Safety- (6 measures: 5 CDC NHSN HAI categories; all-payer PSI 90 measure)

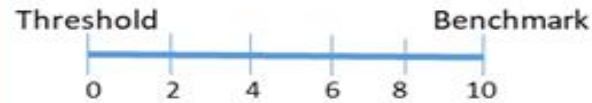
Clinical Care- (inpatient mortality, THA/TKA complications)



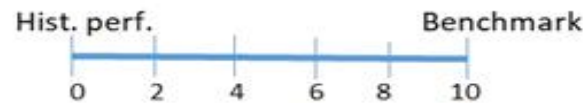
Standardized measure scores

Individual measures are converted to 0–10 points:

Points for attainment are based on performance versus a national threshold (median) and benchmark (top 5%)



Points for improvement are based on performance versus base (historical perf.) and benchmark



Final score is the better of the two scores (improvement or attainment)

Hospital QBR score and revenue adjustments

Hospital QBR score is the sum of earned points / possible points with domain weights applied

Scale of 0–80%

Max penalty -2% & reward +2%

Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	0%	-2.00%
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	41%	0.00%
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	80%+	2.00%

Integrating **Medicaid** Timely Follow Up Measure into the QBR Methodology

- Current Policy: Medicare TFU 10% of PCE Domain
- Proposed Policy: Medicare and Medicaid each 5% of PCE Domain
- Significant differences between Medicare and Medicaid rates with Medicaid rate ~20% lower than Medicare year over year
- 50% lower odds of follow up for black population; Commissioner suggestion to address this disparity more directly in the QBR policy
- 0.67 correlation between Medicare and Medicaid rates in CY 2021
- PMWG input needed:
 - Are proposed weighting updates significant enough of an incentive?
 - Other thoughts?

CY 2023 Required Digital Measure Data Submission

- Maryland will require submission of a minimum of six eCQM measures for four quarters in CY 2023:
 - Continue submission of ED-2 and Safe Opioid measures.
 - Hyper- and Hypo-glycemia eCQMs for monitoring, potential public reporting by MHCC:
 - Safety events are priority for CMS; could be considered in the future for MHAC or QBR
 - These events “are associated with a range of harms, including increased in-hospital mortality, infection rates, and hospital length of stay” (NQF documentation of developer rationale)
 - Impact all hospitals
 - NQF Endorsed, measure steward is CMS
 - Obstetric morbidity and c-section rates eCQMs for monitoring, potential for public reporting by MHCC:
 - CMS focus (required starting in CY 2024) and related SIHIS priority
 - Currently tracking statewide, unadjusted rate; SMM is a risk-adjusted measure
 - Impacts the birthing hospitals
 - Hospitals not eligible for the PC measures must choose two optional measures
- Beginning July 2023, hospitals must submit clinical data elements used for risk adjustment of the 30-day mortality and readmission measures.

CY 2023 Digital Measure Submission to HSCRC

<u>Title</u>	<u>Short Name</u>	<u>CMS eCQM ID</u>	<u>NQF Number</u>	<u>Meaningful Measure</u>	<u>Notes</u>
Anticoagulation Therapy for Atrial Fibrillation/Flutter	STK-3	CMS71v12	N/A	Preventive Care	HSCRC Optional
Antithrombotic Therapy By End of Hospital Day 2	STK-5	CMS72v11	N/A	Preventive Care	HSCRC Optional
Cesarean Birth	PC-02	CMS334v4	N/A	Safety	HSCRC Required
Discharged on Antithrombotic Therapy	STK-2	CMS104v11	N/A	Preventive Care	HSCRC Optional
Discharged on Statin Medication	STK-6	CMS105v11	N/A	Preventive Care	HSCRC Optional
Exclusive Breast Milk Feeding	PC-05	CMS9v11	0480e	Care Personalized, Aligned with Patient's Goals	HSCRC Optional
Hospital Harm - Severe Hyperglycemia	HH-02	CMS871v2	3533e	Preventable Healthcare Harm	HSCRC Required

CY 2023 Digital Measure Submission to HSCRC

<u>Title</u>	<u>Short Name</u>	<u>CMS eCQM ID</u>	<u>NQF Number</u>	<u>Meaningful Measure</u>	<u>Notes</u>
Hospital Harm - Severe Hypoglycemia	HH-01	CMS816v2	3503e	Preventable Healthcare Harm	HSCRC Required
Intensive Care Unit Venous Thromboembolism Prophylaxis	VTE-2	CMS190v11	N/A	Preventive Care	HSCRC Optional
Median Admit Decision Time to ED Departure Time for Admitted Patients	ED-2	CMS111v11	N/A	Admission and Readmissions to Hospitals	HSCRC Required
Safe Use of Opioids - Concurrent Prescribing	N/A	CMS506v5	3316e	Prevention and Treatment of Opioid and Substance Use Disorders	HSCRC Required
Severe Obstetric Complications	PC-07	CMS1028v1	N/A	Safety (Measure Risk adjusted)	HSCRC Required
Venous Thromboembolism Prophylaxis	VTE-1	CMS108v11	N/A	Preventive Care	HSCRC Optional

eCQM CY 2022 Reporting Status, CY 2023 Reporting Timeline

- For CY 2022 required data submission- HSCRC received 7 ECE requests for the January-June 2022 data related to delay of timing of submission with all facilities indicating they will submit Q1, Q2 and Q3 data by Q3 submission close date of 12/30/2022
- CY 2023 data submission windows:

CY 2023 Performance Period Submission Windows for eCQMs

Q1- 2023 data	Open:	07/15/2023	Close:	10/02/2023
Q2- 2023 data	Open:	07/15/2023	Close:	10/02/2023
Q3- 2023 data	Open:	10/15/2023	Close:	12/30/2023
Q4- 2023 data	Open:	01/15/2024	Close:	04/01/2024

CY 2023 Performance Period Submission Windows for Hybrid Clinical Data Elements

Q3- 2023 data	Open:	01/15/2024	Close:	04/01/2024
Q4- 2023 data	Open:	01/15/2024	Close:	04/01/2024

Hospital Population Health Accountability Policy Discussion



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Population Health Measurement

October Meeting

Anwasha Majumder, MHS

Chief, Population Health

Geoff Dougherty, PhD, MPH

Deputy Director, Population Health

10/19/2022



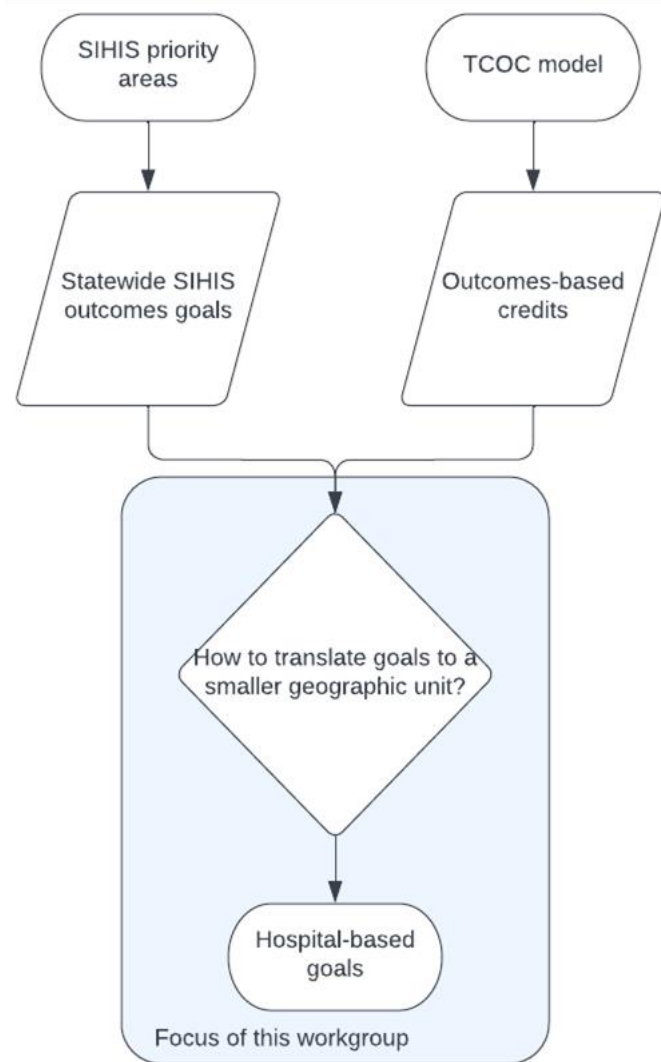
Mission of this Work

Population Health Measurement and Evaluation Workgroup

Goal: To discuss, explore, and identify a methodological approach to measure hospital-level improvements in population health and take measurement of SIHIS population health goals down to the hospital-level.

Schedule: Had three meetings over the summer focused specifically on diabetes, and will take lessons learned from development of this measure forward to 2023 when we develop population health measures for the other two SIHIS population health areas.

Our Workgroup Goal



Taking statewide population health goals to the hospital level to accelerate progress

Workgroup Members

- **Sean Allen**, DrPH, MPH- JHSPH
- **Kesha Baptiste-Roberts**, PhD, MPH- Morgan State University School of Community Health & Policy
- **Mark Bicket**, MD, PhD- University of Michigan School of Public Health
- **Carlos Castillo-Salgado**, MD, MPH, DrPH- JHSPH
- **Shelly Choo**, MD, MPH- MDH Director for the Bureau of Maternal and Child Health
- **Annice Cody**- President, Holy Cross Health Network
- **Laura Goodman**- Deputy Director, Medicaid Office of Innovation, Research and Development
- **Michelle Gourdine**, MD- SVP Population Health and Primary Care @ UMMS
- **Nilesh Kalyanaraman**, MD- Health Officer at Anne Arundel County Department of Health
- **Hadi Kharazzi**, MD, PhD, MHI- JHSPH
- **Taneisha Laume**, MHA- CRISP
- **Traci La Valle**, MPH- MHA
- **Nisa Marisa Maruthur**, MD, MHS- Johns Hopkins School of Medicine
- **Lily Mitchell**, MSN- CareFirst BlueCross BlueShield
- **Kashif M. Munir**, MD- University of Maryland School of Medicine
- **Kristi Pier**, MHS, MCHES- MDH Director for the Center for Chronic Disease Prevention and Control
- **Josh Sharfstein**, MD- JHSPH

Proposed Measure

Diabetes in Maryland

- Over 44% of Maryland residents – about 2.1 million residents – are either prediabetic or have diabetes
- Approximately a third of those who have Type 2 diabetes are unaware that they have it
- Medical expenses for people with diabetes are two to three times higher than people without diabetes, and Maryland is projected to spend \$11.1 billion in diabetes related care by 2025
- Early diagnosis can reduce expensive and disabling complications

HbA1c in the Emergency Department

- Assessing percentage of patients who receive an HbA1c test in the ED
- Can catch people with poorly controlled diabetes AND those who are unaware of their diagnosis AND people with pre-diabetes (can be referred into DPP)
- Data source: Casemix data
- Numerator: number of people screened for elevated HbA1c at a hospital's emergency department in a calendar year
- Denominator: adult population 35+ seen at a hospital's emergency department in a calendar year
- Data are available monthly, so almost real time feedback

HbA1c in the Emergency Department, cont'd

- Measure was selected to be responsive to stakeholders
 - Concerns over attribution to hospitals and the ability of hospitals to affect change outside of their walls
 - This measure is directly attributable to hospitals and responsive to hospital interventions
- Intent is to go beyond testing, to create connections to care
 - Incentive will encourage hospitals to work within their care coordination mechanisms to create systems that work for them
 - Strongly encourage referrals to primary care, DPPs, and DSMT
- Could work with CRISP to ensure that people who present to the ED multiple times a year are not being tested every time
 - Recommendations are for people to be tested once every three years
- Measure could eventually layer in a disparities focus
 - Could look at race, Medicaid status, and neighborhood deprivation as is done for RRIP disparities

Proof of Concept

Has This Been Done Elsewhere?

- Multiple pilot studies in hospitals for HbA1c testing in EDs
 - Harvard: enrolled patients without diabetes for point-of-care HbA1c testing
 - For patients with a positive test, scheduled a free follow-up 1-6 weeks later (38% returned)
 - 76 (29%) of patients tested in the ED had an elevated HbA1c, of those who connected to care afterwards, ~40% had diabetes and ~40% had pre-diabetes

Ginde, Adit A., et al. "Point-of-care glucose and hemoglobin A1c in emergency department patients without known diabetes: implications for opportunistic screening." *Academic Emergency Medicine* 15.12 (2008): 1241-1247.

Long Island Jewish program

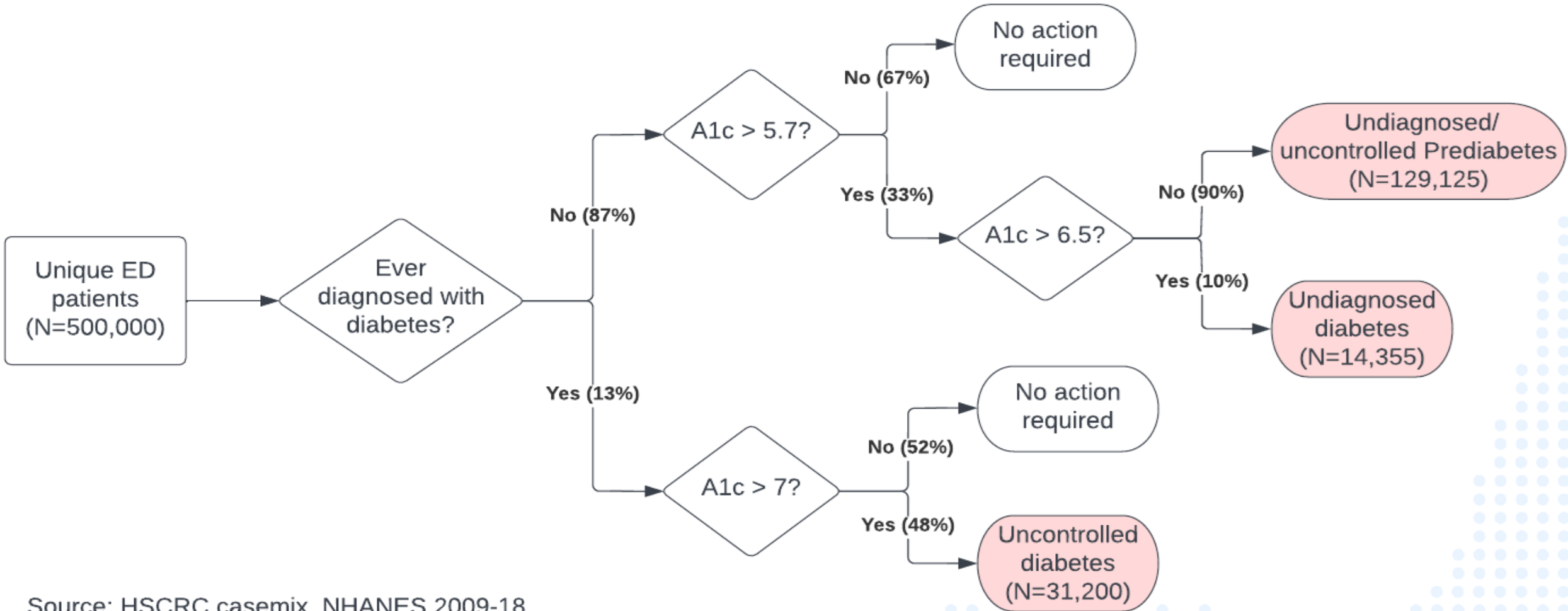
- All patients in ED observation unit receive A1c test
- 7% had $A1c \geq 9$
 - Of those, 81% were previously diagnosed with diabetes
 - 19% were undiagnosed prior to ED visit
- Those with high A1c were referred for endocrine consult
- 73.6% received endocrine consult during obs stay

Schulman-Rosenbaum, Rifka C., et al. "Use of Endocrine Consultation for Hemoglobin A1C $\geq 9.0\%$ as a Standardized Practice in an Emergency Department Observation Unit." *Endocrine Practice* 27.11 (2021): 1133-1138.

Precedent of HIV testing in EDs

- In 2006, the CDC recommended routine, opt-out screening for HIV in all acute care settings including EDs
 - Prior to this, testing was targeted at high-risk individuals and came with significant amounts of counseling
- EDs were specifically emphasized because they see heavy use by groups who have no other contact with health care, including the underserved and uninsured
- Uptake has not been universal, same issues of staffing in EDs and connection to care after a positive test

Expected diagnostic yields



Source: HSCRC casemix, NHANES 2009-18

Costs

- One higher-end estimate¹ of a POC test is \$170/20 cartridges
 - \$8.50 per test
 - \$8.50 * 500k ED patients = \$4.25M for 1 test/ED patient annually
 - This comes out to \$24/diabetes outcome (red bubbles in previous diagram)
- If hospitals choose to incorporate this into standard lab blood panels or bulk buy POC tests, cost would be substantially lower
- Still trying to confirm with CareFirst and Medicaid if they would cover the cost of these tests

Schulman-Rosenbaum, Rifka C., et al. "Use of Endocrine Consultation for Hemoglobin A1C≥ 9.0% as a Standardized Practice in an Emergency Department Observation Unit." *Endocrine Practice* 27.11 (2021): 1133-1138.



Other Potential Measures

Evaluation Criteria

- Data available at the sub-state level
- Numerator readily attributed to hospitals, not just state level
- Data updated at least annually/available with minimal lag
- Community measure (not constrained within a hospital's walls)
- Focused on primary or secondary prevention
 - Reduction of incidence
 - Screening at-risk population

Population Based Screening for Diabetes & DPP Enrollment

- Population Based Screening for Diabetes
 - Assessing annual per capita screening for diabetes onset within a hospital's geographic attribution area (MPA) using data from LabCorp
 - Almost real time data updates
 - Data acquisition and completion issues
- DPP enrollment
 - A proven method for delaying onset of diabetes
 - Many hospitals already reporting this because of SIHIS and regional partnership grants (Medicare/Medicaid FFS)
 - Issues with billing and unfairness between hospitals who received regional partnership grants and those who didn't

Assessing Diabetes Measures From Other Programs

- Regional partnership grants
 - Diabetes-related metrics: DPP, DSMT
 - Could be adapted to our population health focus? Yes
- MDPCP
 - Diabetes-related metrics: HEDIS assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:
 - Hemoglobin A1c (HbA1c) testing
 - HbA1c poor control (>9.0%)
 - HbA1c control (<8.0%)
 - Eye exam (retinal) performed
 - Medical attention for nephropathy
 - BP control (<140/90 mm Hg)
 - Could be adapted to our population health focus? No, mostly tertiary prevention
- Diabetes Quality Task Force
 - Diabetes-related metrics: Diabetes incidence, Percent of adults with obesity
 - Could be adapted to our population health focus? Yes, but data granularity issues



Next Steps

Questions Still to Answer

- This measure evolved out of a similar measure suggested by the workgroup, but the workgroup hasn't had a chance to weigh in on this particular measure yet
- Questions about ED throughput, if this is better suited to primary care settings
- Outstanding issues:
 - How to avoid overtesting
 - Most likely going into policy as monitoring for CY2023, will determine pay-for-performance incentives later
 - Who covers the costs of the test
 - Point of care vs lab for testing

Maryland Hospital Acquired Conditions (MHAC) RY 2025 policy discussion

Proposed RY 2025 MHAC Policy Overview

Not proposing significant changes for RY 2025

Potentially Preventable Complication Measures

List of 14 clinically significant PPC included in payment program.

Acute Pulmonary Edema & Respiratory Failure w/o Ventilation	Post-Operative Infection & Deep Wound Disruption Without Procedure
Acute Pulmonary Edema & Respiratory Failure w/ Ventilation	Post-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D Proc
Pulmonary Embolism	Accidental Puncture/Laceration During Invasive Procedure
Shock	Iatrogenic Pneumothorax
Venous Thrombosis	Major Puerperal Infection & Other Major Obstetric Complications
In-Hospital Trauma & Fractures	Other Complications of Obstetrical Surgical & Perineal Wounds
Septicemia & Severe Infections	Pneumonia Combo

Global Exclusions:

- Palliative care
- Discharges >6 PPCs
- APR-DRG SOI cells with less than 25 at-risk discharges

Hospital PPC Exclusions:

- <20 at-risk discharges
- <2 expected PPCs

Case-Mix Adjustment and Standardized Scores

Performance Measure: CY 2023* Observed to Expected PPC Ratio.

Expected calculated by applying statewide average PPC rates by diagnosis and severity of illness level to hospitals' patient mix (i.e., indirect standardization)

Attainment only score (0-100 points) calculated by comparing hospital performance to a statewide threshold and benchmark.

Attainment Points

Threshold 10th Percentile Benchmark 90th Percentile

0 20 40 60 80 100

FY21 & FY22 used to calculate statewide averages (norms) and thresholds, benchmarks.

*Small hospitals will be assessed on CYs 22 & 23

Hospital MHAC Score & Revenue Adjustments

Hospital MHAC Score is Sum of Earned Points / Possible Points with PPC Cost Weights Applied.

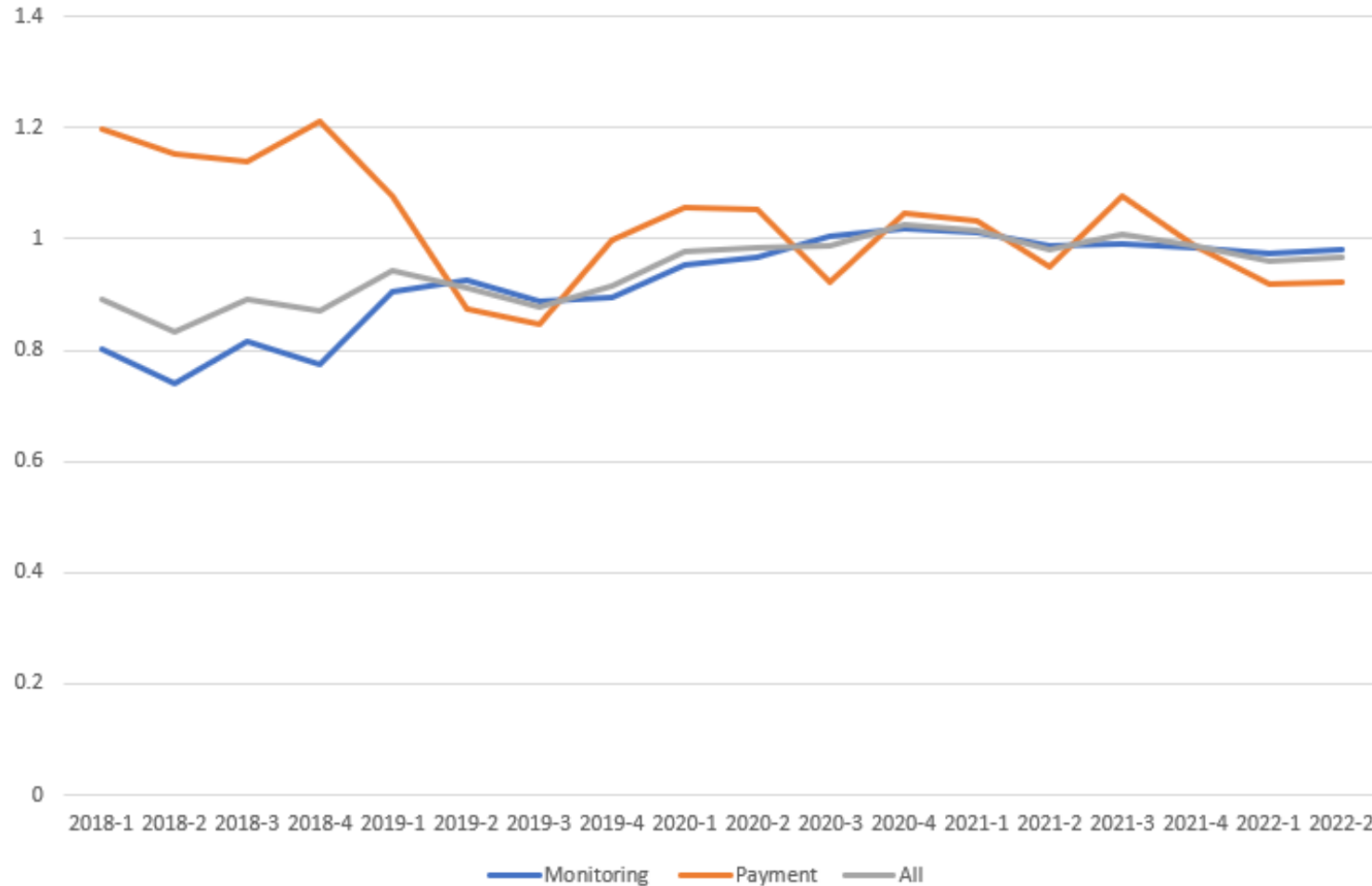
Scores Range from 0-100%
Revenue neutral zone 60-70%**

Max Penalty -2% & Reward +2%

MHAC Score	Revenue Adjustment
0%	-2.00%
10%	-1.67%
20%	-1.33%
30%	-1.00%
40%	-0.67%
50%	-0.33%
60% to 70% Hold Harmless	0.00%
80%	0.67%
90%	1.33%
100%	2.00%

**This scale may be adjusted retrospectively to consider COVID impacts.

PPC Trends

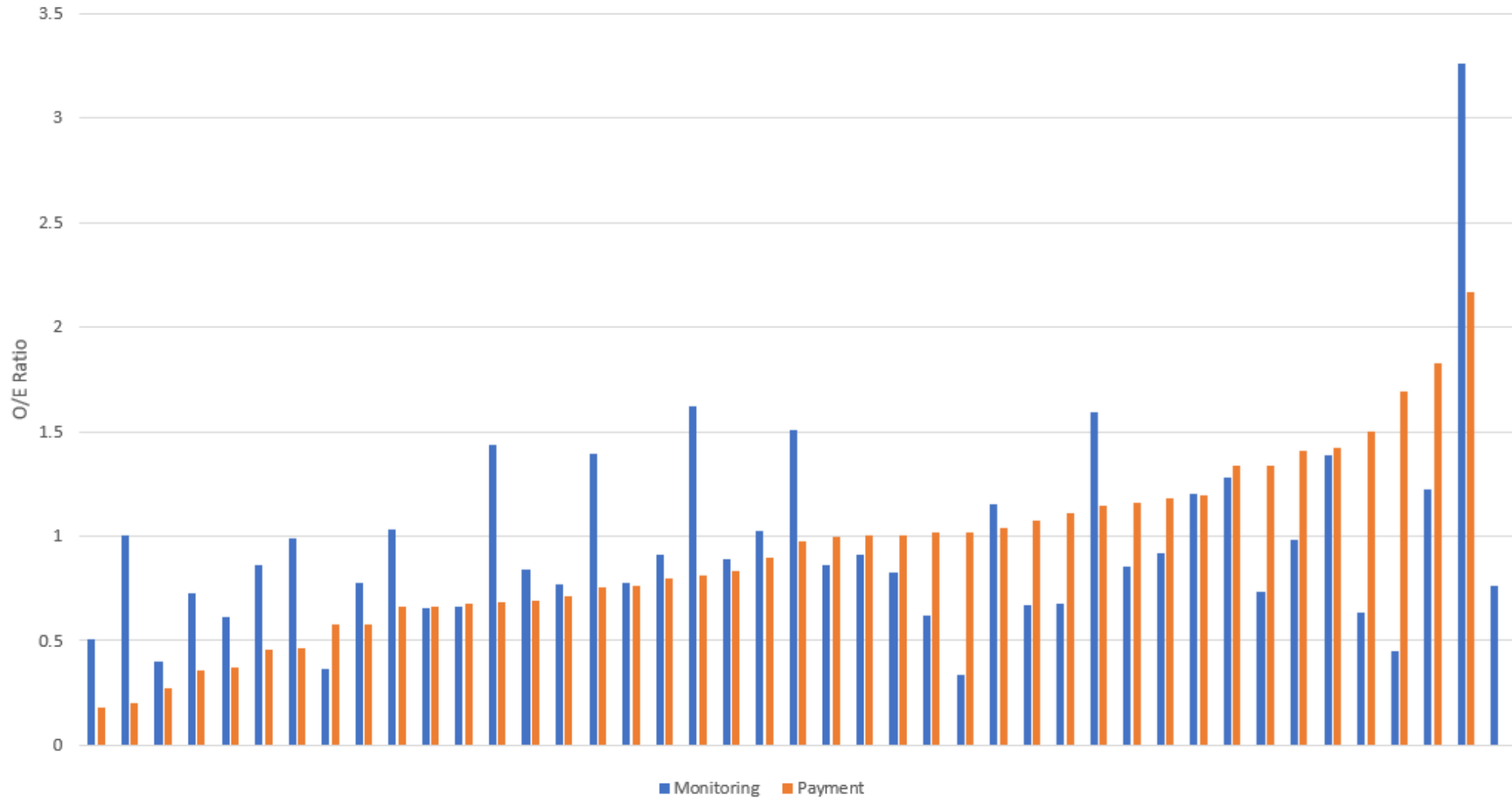


	2018-2022 % Change
All PPCs	11.49%
Monitoring PPCs	25.64%
Payment PPCs	-22.03%

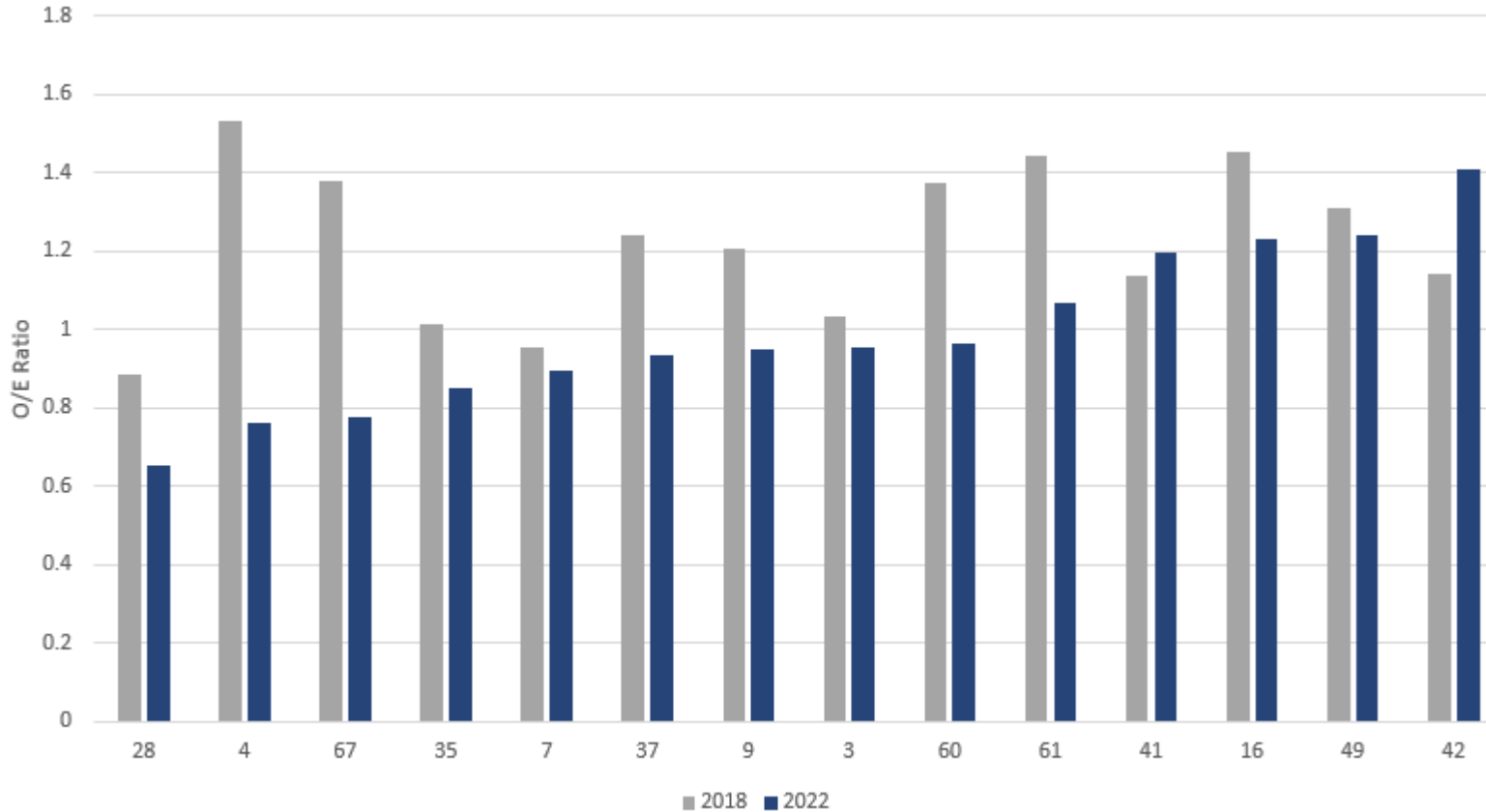
- 2 out of 14 payment PPCs have increased; both have O/E ratio >1
- 31 out of 39 monitoring PPCs have increased; 15 have O/E ratio >1

Monitoring vs Payment by Hospital, CY 2022 June YTD

Hospital Monitoring & Payment O/E Ratios



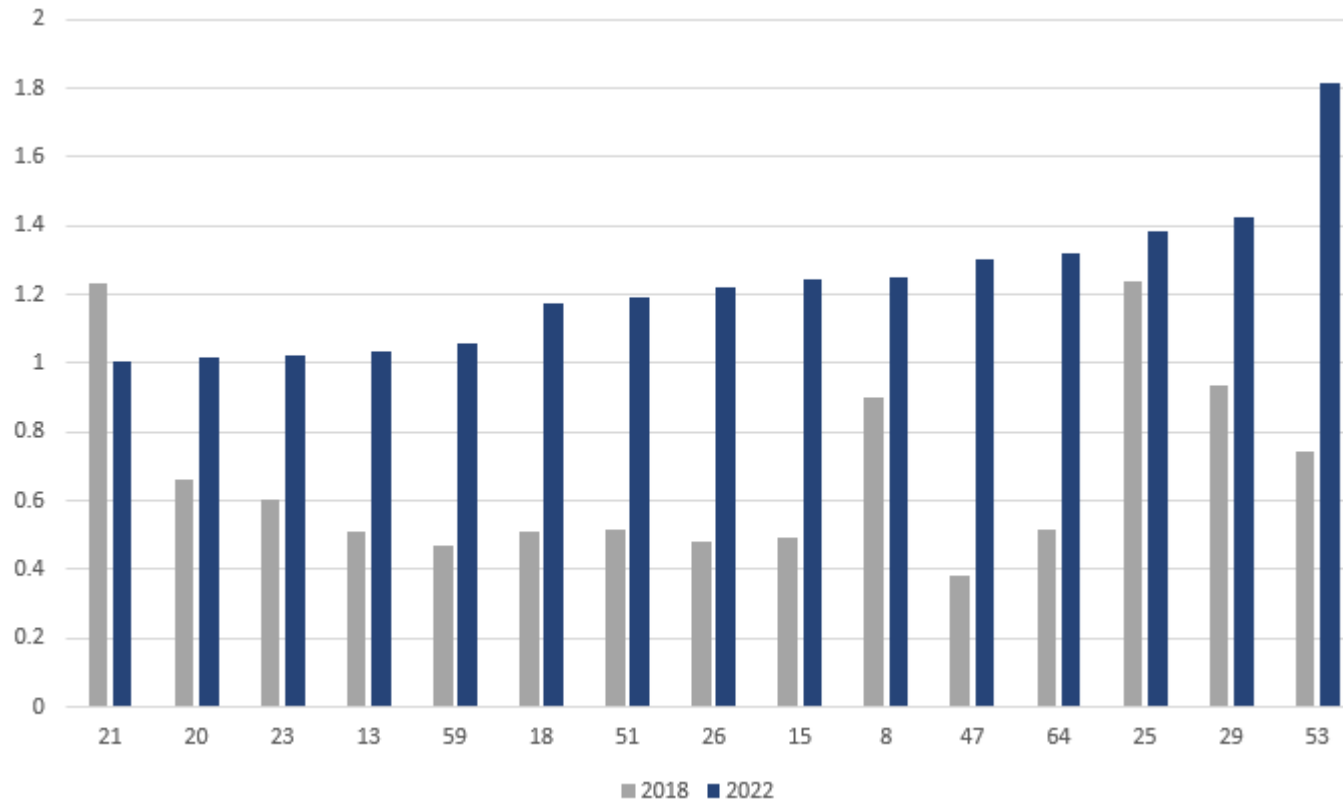
Payment PPCs O/E Ratio 2018 & 2022 June YTD



- 3 Acute Pulmonary Edema and Resp Failure w/o Ventilation
- 4 Acute Pulmonary Edema, Resp Failure w/ventilation
- 7 Pulmonary Embolism
- 9 Shock
- 16 Venous Thrombosis
- 28 In-Hospital Trauma and Fractures
- 35 Septicemia & Severe Infections
- 37 Postoperative Infection & Deep Wound Disruption Without Procedure
- 41 Postoperative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D
- 42 Accidental Puncture/ Laceration During Invasive Procedure
- 49 Iatrogenic Pneumothorax
- 60 Major Puerperal Infection and Other Major Obstetric Complications
- 61 Other Complications of Obstetrical Surgical & Perineal Wounds
- 67 Pneumonia Combo (with and without aspiration)

- PPC 42 increase of 23.47% from 2018 to 2022
- PPC 41 increase of 5.02% from 2018 to 2022

Monitoring PPCs with O/E >1, CY 2018 & 2022 June YTD



- 8 Other Pulmonary Complications
- 13 Other Cardiac Complications
- 15 Peripheral Vascular Complications Except Venous Thrombosis
- 18 Major GI Complications w/ Transfusion or Sig. Bleeding
- 20 Other GI Complications w/o Transfusion or Sig. Bleeding
- 21 Clostridium Difficile Colitis
- 23 GU Complications Except UTI
- 25 Renal Failure with Dialysis
- 26 Diabetic Ketoacidosis & Coma
- 29 Poisonings Except from Anesthesia
- ★ 47 Encephalopathy
- 51 GI Ostomy Complications
- 53 Complications of Peripheral Vascular Catheters & Infusions
- 59 Medical & Anesthesia Obstetric Complications
- 64 Other In-Hospital Adverse Events

Monitoring PPC: Analysis of PPC 47

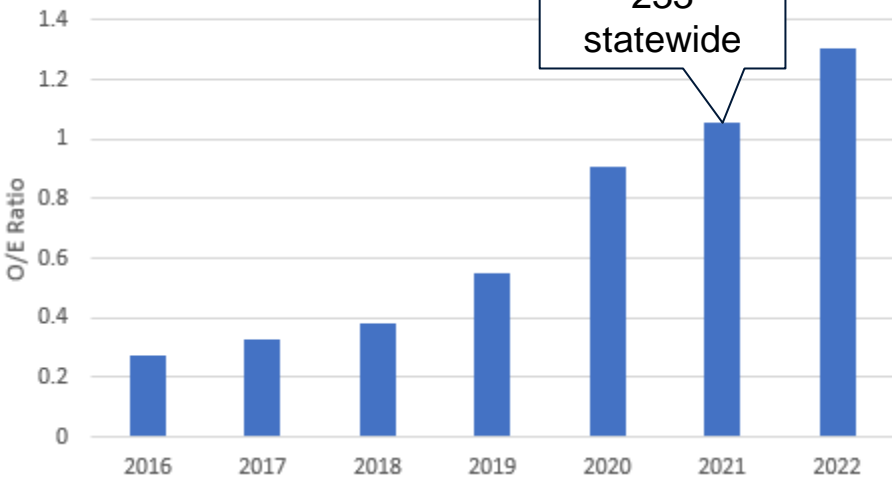
- Greater than 50% increase in O/E ratio comparing to 2018
 - 177.27% in 2021, 243.51% for 2022
- Clinical considerations
- Observed counts: 233 in 2021, 138 in 2022
- 3M v39 cost weight: 0.8728
- Percent of hospitals with O/E ratios less than .85 or greater than 1.15 (variation): 86.62 in 2021, 82.5% in 2022
- Rate per 1000 at risk: 1.12 in 2021, 1.43 in 2022
- Predictive validity: Adequate
- Reliability: Substantial
- 3M Group: Other Medical and Surgical Complications
- 3M Level: Major

PPC 47 Encephalopathy, CY 2022 June YTD

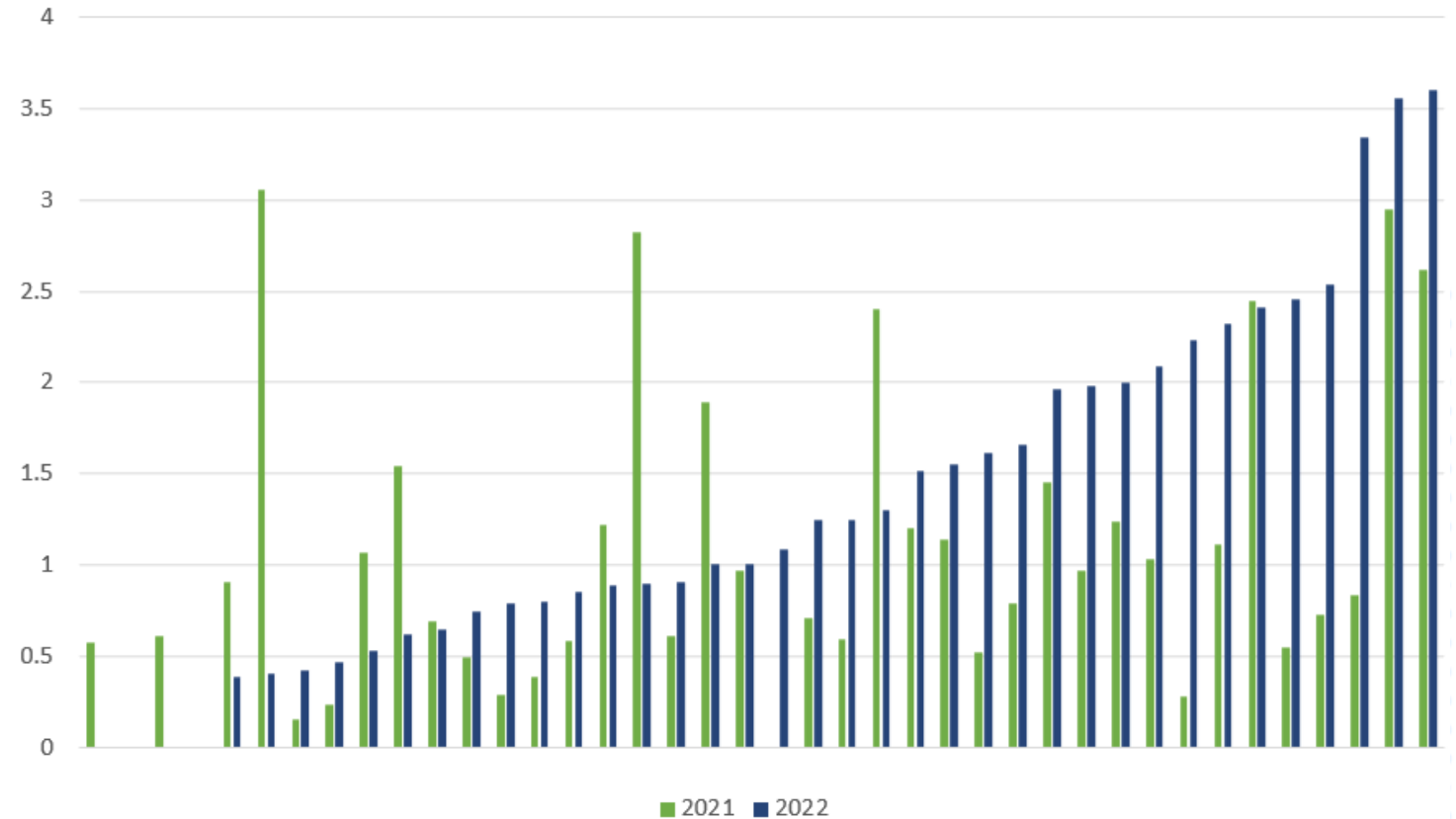
Encephalopathy: **an acute or subacute global, functional alteration of mental status due to systemic factors.** Acute encephalopathy may be further identified as toxic, metabolic, or toxic-metabolic.

By Year

Observed
233
statewide



By Hospital



Stratification for Disparities Analysis

- Outcome:
 - 14 Payment PPCs
- Methodology Details:
 - Only observations eligible for the program
 - Controlled for age, ADM_DRG, severity of illness, and sex
 - CY 2018 - CY 2021
 - Stratified by ADI, Race, and Payer
- Analysis Results (see appendix):
 - Statistically insignificant differences for race
 - Statistically significant differences between payer groupings
 - Statistically significant differences between ADI groupings

Prospective Revenue Adjustment Scale

Based on PPC discussion today, staff will model scores using for draft policy:

- FY2021 and FY2022 Base Period for Performance Standards using v39 (will update to v40 for actual RY25 program)
- FY2022 as Performance Period for modeling
- Will use average/median hospital scores to propose any changes to Hold Harmless Zone
 - Current RY2024 scores June YTD:
 - Average = 62 percent
 - Median = 62 percent

RY 2024 Prospective Revenue Adjustment Scale	
MHAC Score	Revenue Adjustment
0%	-2.00%
10%	-1.67%
20%	-1.33%
30%	-1.00%
40%	-0.67%
50%	-0.33%
60% to 70% Hold Harmless	0.00%
80%	0.67%
90%	1.33%
100%	2.00%

MHAC RY 2025 Draft 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 20,000 at-risk discharges and/or 20 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.



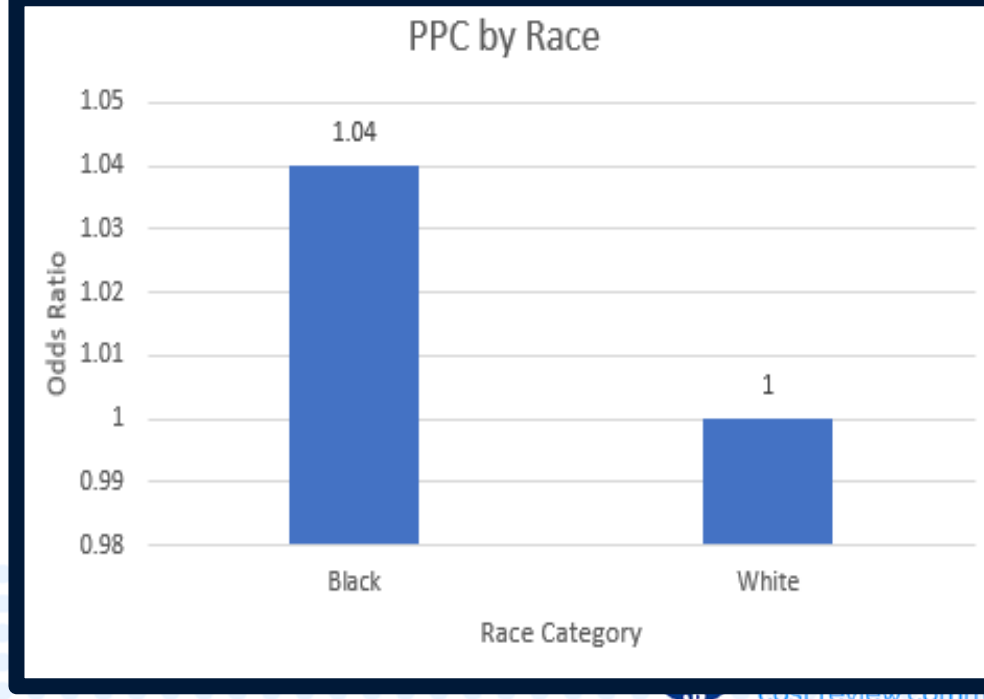
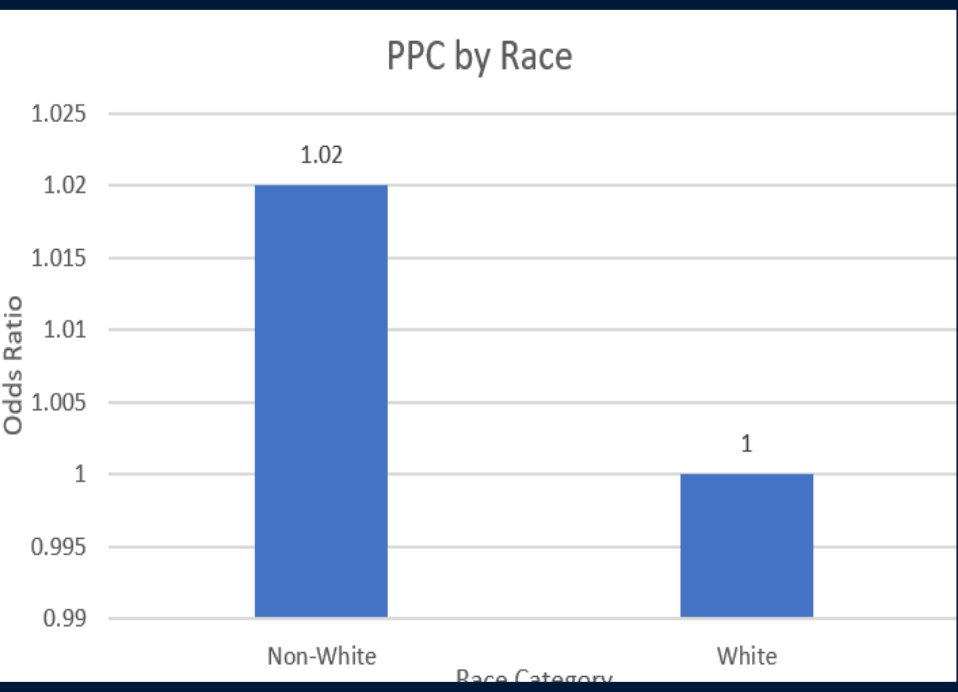
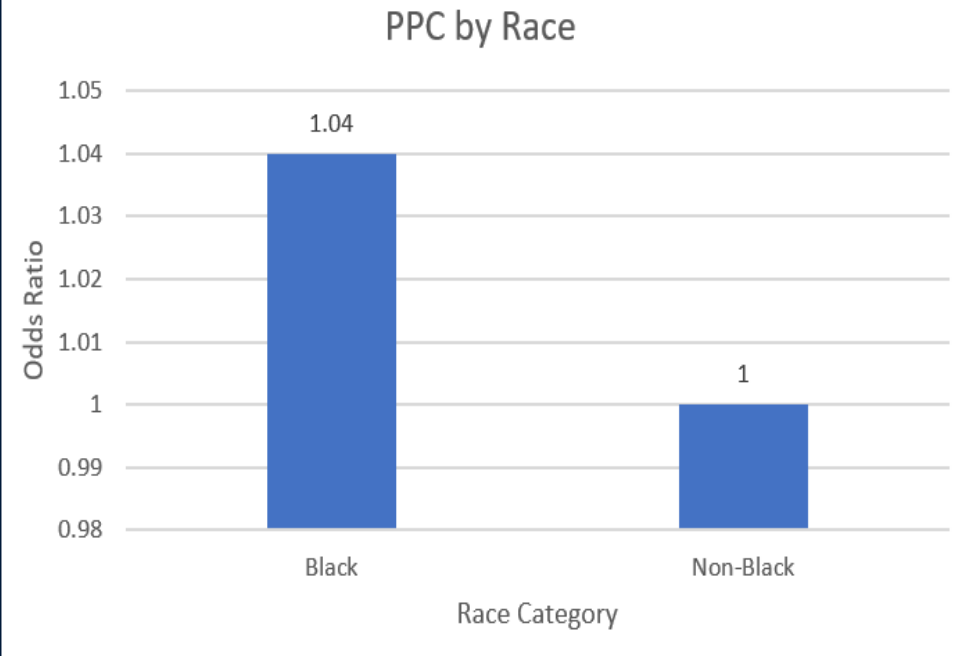
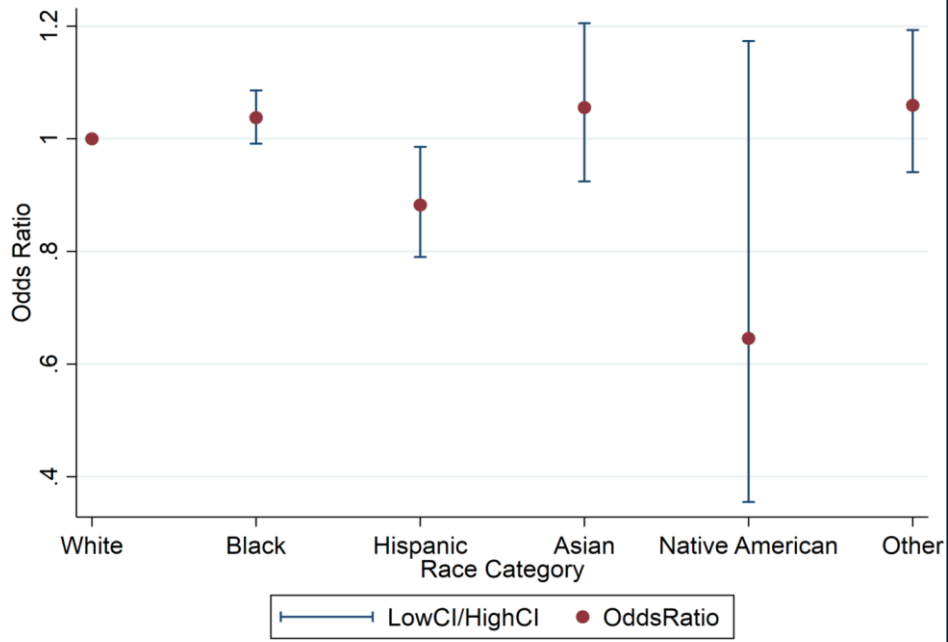
THANK YOU!

Next Meeting: Wednesday, November 16, 2022

Appendix

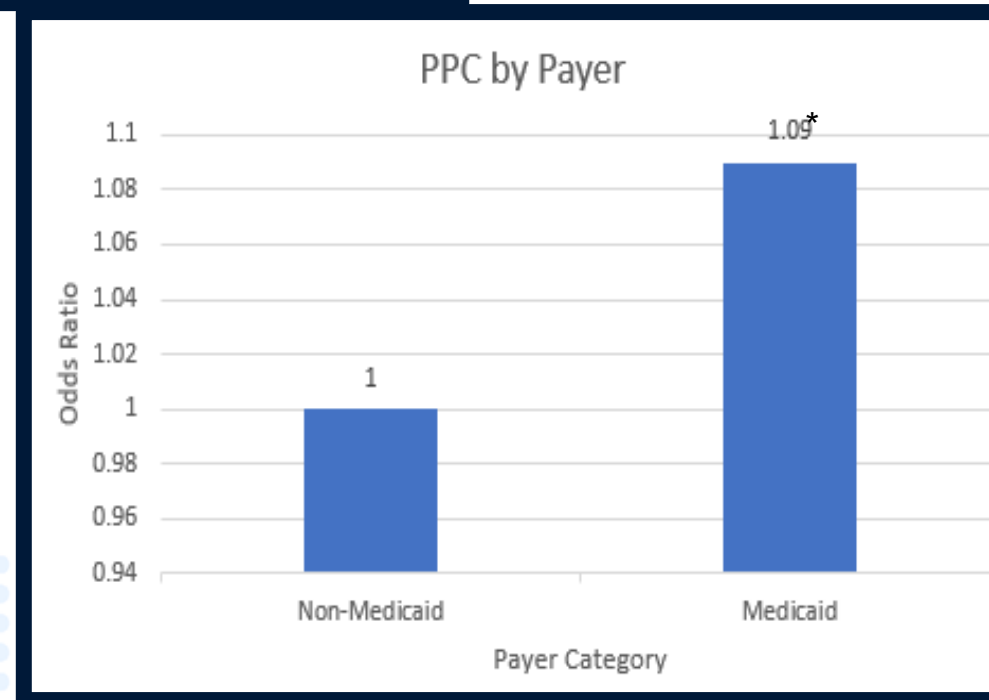
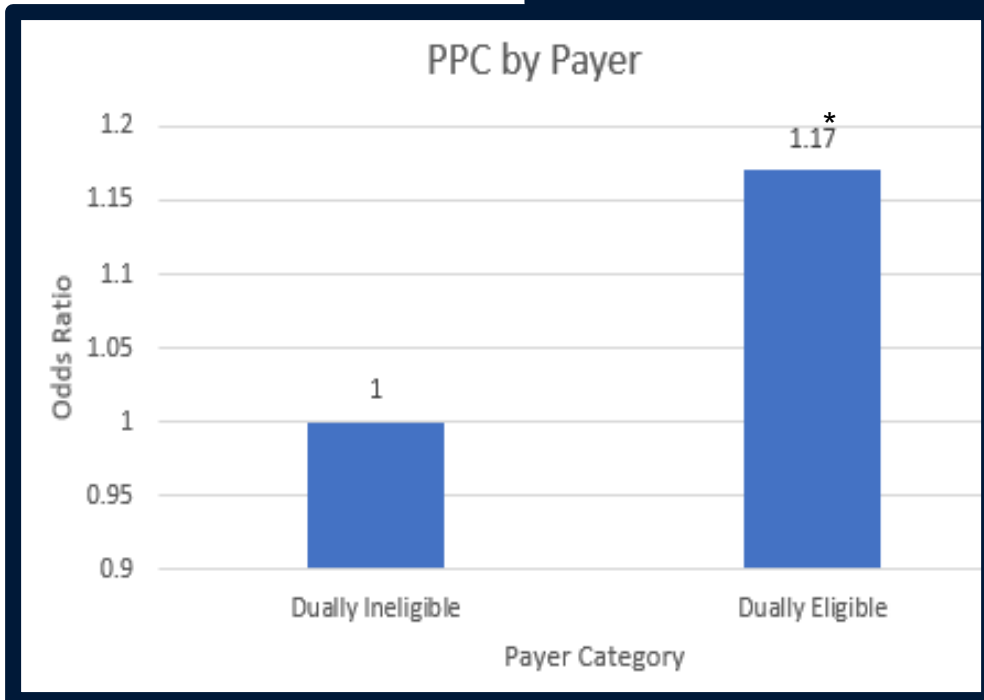
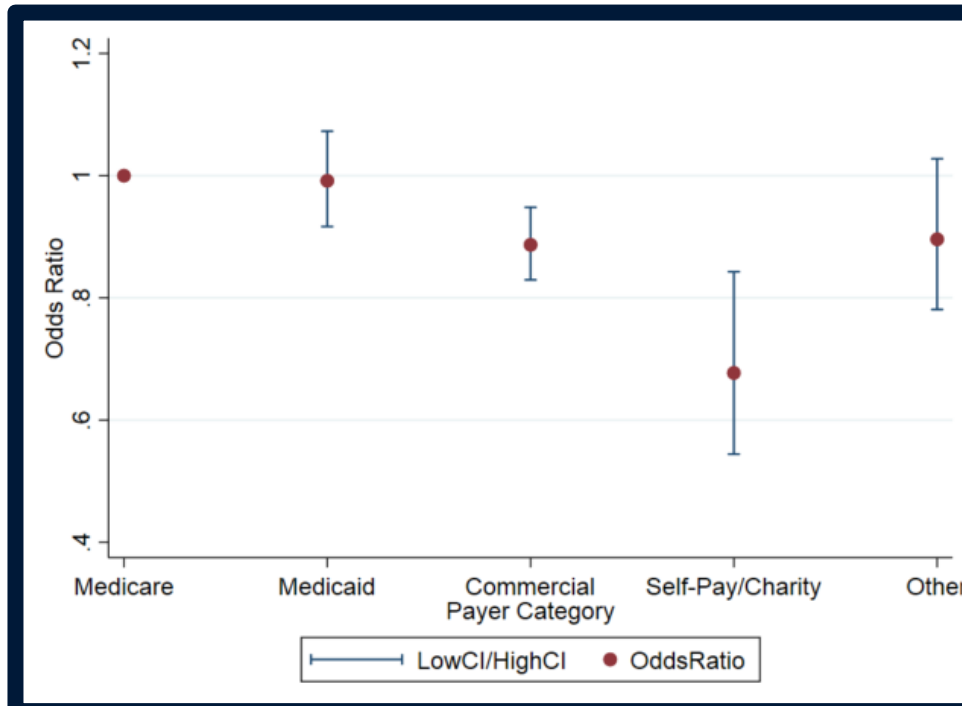
Potentially Preventable Complications

Race



Payer

* denotes statistical significance



Odds Ratio for ADI

