Performance Measurement Workgroup

October 21, 2020

HSCRC Quality Team

Meeting Agenda

1. Maryland exemption from CMS Quality Programs, feedback from CMS

2. Total Cost of Care (TCOC) Model update and SIHIS goals
   PMWG Endorsement

3. Quality Based Reimbursement (QBR) Program RY 2023

4. Maryland Hospital Acquired Conditions (MHAC) Program RY 2023

5. Other topics and public comment

Exemption from CMS FY 2021 Quality Programs; Feedback from CMS

RY 2021 VBP Exemption Granted, Concerns Raised

- CMS "used their discretion" to grant the State of Maryland's exemption on the basis of expected QBR performance improvement, favorable performance improvement under MHAC, and consistent performance under RRIP that has exceeded national outcomes.
- For Quality Based Reimbursement (QBR):
  - Maryland's performance continues to lag behind the nation under the person and community engagement and safety measure domains.
  - CMS supports program redesign for implementation in RY 2024 using a focused subgroup.
  - In the interim, the State must integrate high level work plan to address CMS' concerns related to QBR and other program performance into the annual monitoring report (due December 2020), including
    - redesign subgroup objectives,
    - outline of the actionable strategies required to accomplish each objective, and
    - an associated project milestone timeline.

CMS Feedback on QBR Re-Design Subbroup

- CMS requests a comprehensive report detailing QBR redesign subgroup findings and formalized plans to improve quality performance (due June 2021).
  - Report and subsequent QBR policy changes will be heavily considered in evaluating the State's national hospital quality and P4P programs exemption request for FFY 2022.
  - CMS supports HSCRC's plans to consider ED Wait Time measure options as part of the QBR redesign during CY 2021 with potential re-adoption of measures; The State has had a longstanding issue with extended ED wait times compared to the nation.
  - CMS encourages the State to hold hospitals accountable for high quality obstetric care. The State may consider integrating maternal and child health clinical topic areas into the QBR program redesign to improve the patient care experience in Maryland hospitals.

PAU and MPA Feedback from CMS

- Potentially Avoidable Utilization (PAU) Savings:
  - CMS supports expanding the definition of avoidable utilization to include ED and additional categories of unplanned admissions or other types of unnecessary utilization,
  - With the PQI per-capita shift, CMS expects the State to set a concrete per capita PQI reduction target under SIHIS by December 31, 2020.
- Medicare Performance Adjustment (MPA):
  - CMS supports the State's initiative to transition to a pure geographic method of attribution as it simplifies the algorithm and provides predictability when assessing Total Cost of Care performance.
  - CMS believes the State should consider increasing the amount of revenue at risk under the MPA to progressively incentivize care coordination and alignment across providers.
  - It is critical that revenue at risk under the MPA continue to increase to account for expenditure growth beyond hospital walls.

maryland
health services
cost review commission

CMS Feedback on Quality Programs' Mid-/Long-Term Strategy

- HSCRC Quality Strategic Plan:
  - CMS supports the HSCRC's approach to evaluate the efficacy of Maryland's hospital quality programs through ensuring key clinical topic areas, such as obstetric care and maternal/child health, are adequately addressed by current measures.
  - CMS supports State efforts to:
    - Achieve greater health equity through reducing disparities,
    - Assess how complications can be measured outside the inpatient setting,
    - Determine if expanding the quality adjustment under the MPA would continue to improve hospital pay-for-performance programs with the broader population health strategies of the model.
  - Ultimately, CMS expects the State to progressively align hospital pay-for-performance programs with the broader population health strategies of the model.
  - CMS recognizes that the COVID-19 pandemic has caused quality program delays, data concerns, and other unforeseen model challenges that need to be addressed.
  - CMS remains committed to our partnership with the State and supports efforts to collaboratively work through these challenges on an ongoing basis.

maryland
health services
cost review commission

Statewide Integrated Healthcare Improvement Strategy (SIHIS)

Quality Improvement Goals Discussion

Summary for PMWG Endorsement

Domain 1: Hospital Quality Domain				
Goal: Reduce Avoidable Admissions and Readmissions*				
Measure	2018 Baseline	2021 Year 3 Milestone	2023 Year 5 Interim Target	2026 Year 8 Final Target
AHRQ Risk-Adjusted PQIs	1335 admits per 100,000**	8 percent improvement	15 percent improvement	25 percent improvement
Readmission Disparity Gap	TBD	Establish and monitor a measurement methodology and payment incentive for reducing within hospital readmission disparities and set a 2023 and 2026 target	TBD	TBD
Domain 2: Care Transformation Domain				
Goal: Improve care coordination for patients with chronic conditions				
Measure	2018 Baseline	2021 Year 3 Milestone	2023 Year 5 Interim Target	2026 Year 8 Final Target
Timely Follow-up After Acute Exacerbations of Chronic Conditions^ (NQF# 3455)	71.59%	72.85% 1.76 percent improvement	73.70% 2.95 percent improvement	75.00% 4.76 percent improvement or 0.50 percent better than the national rate
		Alternate ➡ 72.43% 1.17 percent improvement	73.28% 2.35 percent improvement	

*Maryland will pursue expanding the definition of avoidable inpatient stays to the emergency department and may set targets for reductions in avoid ED visits in the future.

**This all-payer baseline rate for MD residents was run using HSCRC case-mix data (IP + Obs >23 hrs) under PQI v2020. The baseline rate will be updated with new PQI versions to ensure measure accounts for new codes and changes in clinical logic overtime.

^Medicare Only based on CCLF data. Maryland will pursue adding and setting goals for additional payers (e.g., Medicaid) and expanding the condi evaluated (e.g., follow-up after mental health hospitalization).

Quality Based Reimbursement (QBR) Program

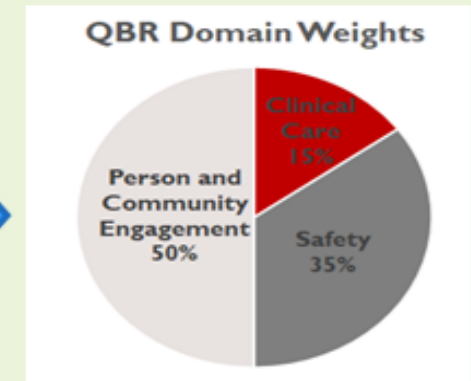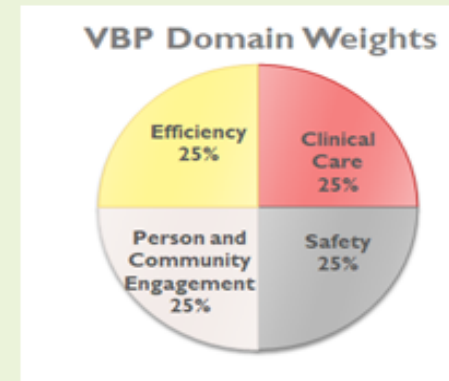# Quality Based Reimbursement (QBR) Program: Overview

Purpose: Incentivize quality improvement across three patient-centered quality measurement domains:

1. **Person and Community Engagement (HCAHPS)** - 8 survey-based measures
2. **Clinical Care** - in-patient mortality rate + hip/knee replacement complication rate
3. **Safety** - 6 measures of in-patient Safety (National Healthcare Safety Network (NHSN) Healthcare Associated Infections).

The QBR program uses similar measures to the federal Medicare Value-Based Purchasing (VBP) program

Because Maryland's program is separate from the national program, it can use data from all payers and can adjust domain weights to focus on MD-specific improvements.

VBP Domain Weights

- Efficiency 25%
- Clinical Care 25%
- Person and Community Engagement 25%
- Safety 25%

QBR Domain Weights

- Clinical Care 15%
- Person and Community Engagement 50%
- Safety 35%

RY 2023 Proposed QBR Vs. VBP Measures

	Maryland QBR Domain Weights and Measures	CMS VBP Domain Weights and Measures
Clinical Care	15 percent -2 measures: all cause inpatient Mortality; THA/TKA complications measure ; **Proposed for monitoring: new 30-day all-payer mortality measure.**	25 percent -5 measures: 4 condition-specific 30- Day Mortality measures; THA/TKA complications measure
Person and Community Engagement	50 percent- 9 measures: 8 HCAHPS measures; **Proposed new measure(s): follow up after discharge**	25 percent- 8 HCAHPS measures
Safety	35 percent -6 measures: 5 CDC NHSN HAI measures; **Proposed new measure(s): PSI 90**	25 percent 6 measures: 5 CDC NHSN HAI measures; **New: PSI 90**
Efficiency	N/A	25 percent-Medicare Spending Per Beneficiary measure

CMS FY 2023 VBP Minimum Hospital Case Numbers for Measures*
** Indicates QBR Current or Potential Measure

FY 2023 VBP Program Previously Adopted Minimum Case Number Requirements	
Measure Short Name	**Minimum Number of Cases**
Person and Community Engagement Domain	
HCAHPS	100 completed HCAHPS surveys.**
Clinical Outcomes Domain	
MORT-30-AMI	Hospitals must report a minimum number of 25 cases.
MORT-30-HF	Hospitals must report a minimum number of 25 cases.
MORT-30-PN (updated cohort)	Hospitals must report a minimum number of25 cases.
MORT-30-COPD	Hospitals must report a minimum number of 25 cases.
MORT-30-CABG	Hospitals must report a minimum number of 25 cases.
COMP-HIP-KNEE	*Hospitals must report a minimum number of 25 cases.**
Safety Domain	
CAUTI	1.000 predicted infections as calculated by the CDC.**
CLABSI	1.000 predicted infections as calculated by the CDC.**
Colon & Abdominal Hyster SSI	1.000 predicted infections as calculated by the CDC.**
MRSA Bacteremia	1.000 predicted infections as calculated by the CDC.**
CDI	1.000 predicted infections as calculated by the CDC.**
CMS PSI90	three eligible cases on any one underlying indicator.**
Efficiency and Cost Reduction Domain	
MSPB	Hospitals must report a minimum number of 25 cases.

*Published in the CMS IPPS FY 2021 Final Rule.

maryland
health services
cost review commission

QBR RY 2023 Draft Recommendations

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.
2. Implement the following **measure updates**:
   a. Add an academic small sample and complexity exclusion for the hip/knee complication measure.
   b. Add follow-up after discharge measure to the PCE Domain.
   c. Add PSI 90 measure to the Safety domain
3. 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.
4. Convene a QBR Redesign Work Group in the first half of CY 2021 that targets the CMS concerns and implements identified strategic priorities for quality.

maryland
health services
cost review commission

RY 2023 Quality-Based Reimbursement Program Targeted Potential Update Areas

- Update measure specifications
- Need to Address COVID-19 impacts; base time period and comparability for PSI and mortality
- Addition of all-payer Patient Safety Index (PSI) 90 measure to the Safety domain
- Consider addition of SIHIS measure for follow up after discharge
- Discuss transition from inpatient mortality to 30-day mortality measure
- VBP RY 2021 exemption: CMMI Concerns
- Other stakeholder concerns?

maryland
health services
cost review commission

THA-TKA Measure

Academic Small Sample and Complexity Exclusion

- Measure is for elective hip and knee surgeries
- Requires 25 cases to be evaluated in the measure
- Johns Hopkins currently does not meet minimum criteria; UMMS had 29 cases but several were miscoded and should have been excluded
  - In order to recognize that UMMS should have been excluded in the base and likely will be excluded in the performance period, staff propose to prospectively exclude them through an academic small sample and complexity exclusion
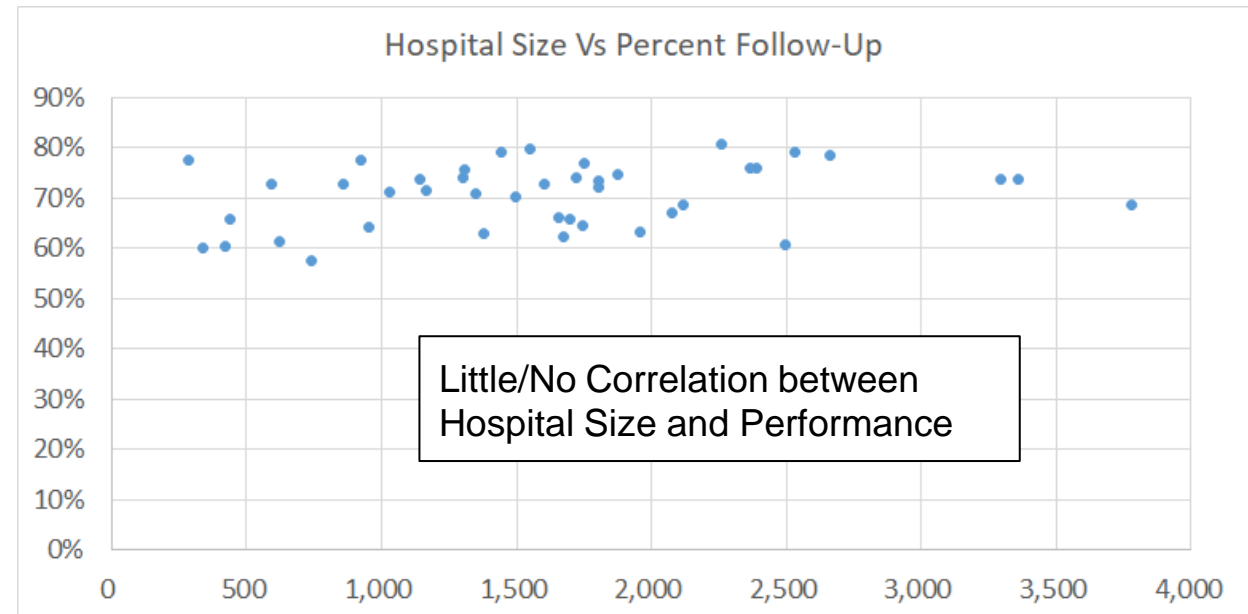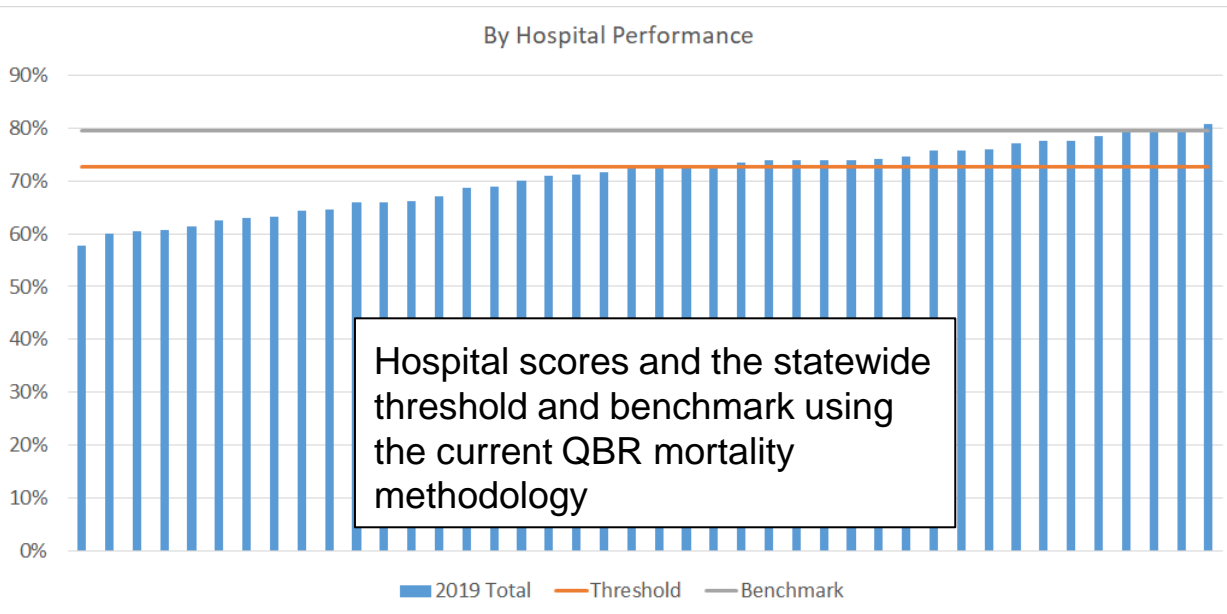
Follow up After Discharge Measure(s)

Follow-Up Measure Discussion

- First question is should HSCRC include follow-up measure in hospital pay for performance programs:
  - Need incentives to achieve SIHIS goal?
  - Is QBR right program for inclusion?

- Subsequent questions if we include:
  - Total chronic condition follow-up vs. individual measures chronic conditions?
  - What domain and weight?
  - Small hospital exclusion?
  - Base and performance periods?
  - How to establish benchmark and threshold?
  - Does preset revenue adjustment scale need to be updated?
  - How do we support hospitals with CRISP tools to track follow-up?

Follow-Up Measure* Analysis CY 2019 Medicare Only CCLF

*NQF endorsed health plan measure that looks at percentage of ED, observation stays, and inpatient admissions for one of the following six conditions, where a follow-up was received within time frame recommended by clinical practice: Hypertension (7 days), Asthma (14 days), Heart Failure (14 days), CAD (14 days), COPD (30 days), Diabetes (30 days)

By Hospital Performance

Hospital scores and the statewide threshold and benchmark using the current QBR mortality methodology

■ 2019 Total — Threshold — Benchmark

Hospital Size Vs Percent Follow-Up

Little/No Correlation between Hospital Size and Performance

Note: Statewide benchmark (79.6 %) and threshold (72.6%) values relative to the proposed SIHIS target for CY 2021 of 72.85% or 72.43%

19

Question	Staff Proposal for Draft QBR
Include Follow-Up in QBR	Yes, to align with SIHIS goal
Total chronic condition follow-up vs. individual measures chronic conditions?	Total measure to align with SIHIS and ensure larger sample sizes
What domain and weight?	Patient experience, equally weighted with each HCAHPS measure
Small hospital exclusion?	Not needed
Base and performance periods?	CY 2019 Base, CY 2021 Performance
How to establish benchmark and threshold?	Use same scoring methodology as for other QBR measures
Does preset revenue adjustment scale need to be updated?	Conduct modeling for impact
How do we support hospitals with CRISP tools to track follow-up?	HSCRC is in discussion with CRISP on existing tools for tracking whether patient has had follow-up

All-Payer PSI-90 into QBR

PSI 90 Component Measures with Weights

- PSI 90 combines the smoothed (empirical Bayes shrinkage) indirectly standardized morbidity (observed/expected) ratios from selected PSIs
- Component PSIs are weighted based on volume and harm calculations for each PSI

Composite Weights for PSI 90 v2019

(V2020 was released in July 2020 and HSCRC will use the latest version for RY 2023 QBR Program)

INDICATOR	HARM WEIGHT	VOLUME WEIGHT	COMPONENT WEIGHT
PSI 3 Pressure Ulcer	0.0860	0.3080	0.1373
PSI 6 Iatrogenic Pneumothorax	0.1381	0.0538	0.0385
PSI 8 In Hospital Fall With Hip Fracture	0.1440	0.0172	0.0128
PSI 9 Periop Hemorrhage or Hematoma	0.0570	0.1598	0.0472
PSI 10 Postop Acute Kidney Injury Requiring Dialysis	0.3584	0.0280	0.0520
PSI 11 Postoperative Respiratory Failure	0.2219	0.1821	0.2094
PSI 12 Periop PE or DVT	0.1557	0.2543	0.2052
PSI 13 Postoperative Sepsis Rate	0.3102	0.1550	0.2491
PSI 14 Postoperative Wound Dehiscence Rate	0.1441	0.0138	0.0103
PSI 15 Unrecognized Abdominopelvic Accidental Puncture or Laceration	0.1474	0.0500	0.0382

PSI modeling

- RY2021 QBR re-modeled to include PSI-90
  - FY2018 Base Period, used to determine statewide threshold and benchmark
  - CY2019 Performance Period
  - PSI-90 composite measure falls under Safety Domain, for a total of six possible measures weighted at 35 percent of total QBR score
- 28 hospitals decreased QBR score (average -2.2%), 12 increased QBR score (average 1.5%), 2 hospitals remained the same
- Staff proposes to include PSI in the QBR program again, in compliance with federal VBP

RY 2023 QBR Revenue Adjustment Scale

Pending decision and modeling of follow-up measure

- Staff does not support lower cut point for rewards due to CMS concern regarding MD performance
- New VBP data not yet available for modeling national average score; may be released prior to final policy
- Addition of PSI has small impact on scores and thus does not necessitate change in scale
- Staff will model inclusion of follow-up depending on stakeholder feedback on its inclusion
- Draft policy will most likely propose the same revenue adjustment scale as RY 2022

maryland
health services
cost review commission

Mortality Measurement: Potential Future Transition from Inpatient to 30-Day Mortality Measure

Monitor for RY 2023

30-Day Mortality: Presentation of Analytic Findings

October 21, 2020

Overview

- **Goal: develop a 30-day all cause, all payer mortality measure**
  - Capture deaths that occur within 30 days of hospital admission, regardless of where death occurs

- **Use CMS 30-Day Hospital-Wide Mortality Measure as a guide**
  - Currently under development, and not used publicly yet
  - Make necessary adjustments to estimate model on Maryland all-payer data

- **Use Maryland Vital Statistics death data merged with Maryland inpatient records**
  - CY 2018 and CY 2019 data

- **Today's agenda:**
  - Present overview of analytic results
  - Facilitate group discussion and feedback to inform additional testing

Mathematica

Step 1: Apply inclusion/exclusion criteria

- Exclude APR-DRGs that do not contribute to the top 80 percent of 30-day deaths (similar exclusion applied to QBR inpatient measure)
- Apply exclusion criteria

Cases Excluded from Sample	
Transferred in from another acute care facility	Inconsistent vital status (e.g. death date precedes admission date)
Enrolled in hospice during index admission	Left against medical advice
Metastatic cancer	Crush, spinal, brain, or burn injury
Limited ability for survival (based on ICD-10 codes)	Non-Maryland resident (Vital Statistics data not reliable for non-Maryland residents)

- For patients with multiple admissions that qualify for measure inclusion, randomly select one admission for inclusion in sample

Mathematica

Distribution of stays by exclusion criteria (CY 2018)

Initial Sample	Dropped Cases	Resulting Sample
524,373		
Drop APR-DRGs that contribute to less than 80 percent of 30-day deaths	**318,346**	**206,027**
Exclusion Criteria	**40,098**	**165,929**
Transferred in from another facility	*5,020*	
Age > 95	*2,565*	
Hospice enrollment at time of admission	*1,042*	
Metastatic cancer	*16,723*	
Limited ability to affect survival	*282*	
Inconsistent vital status	*3*	
AMA	*3,514*	
Crush, spinal, brain, or burn injury	*1,622*	
Non-Maryland resident	*12,480*	
Random Case Exclusion for patients with more than one discharge	**43,478**	**122,451**
Additional Dropped Cases	**2,910**	**119,541**
Final Sample for Model		**119,541**

Step 2: Assign stays to a service line

- **First, determine if a major surgical procedure was performed**
  - If yes, then assign stay to the "surgical" cohort
  - If no, then assign stay to the "non-surgical" cohort

- **Second, assign stays to a service line within surgical and non-surgical cohorts**
  - Non-surgical cohort: assignment based on principle diagnosis
  - Surgical cohort: assignment based on principle procedure

Non-surgical service lines	
Cancer	Orthopedics
Cardiac	Pulmonary
Gastrointestinal	Renal
Infectious disease	Other conditions
Neurology	

Surgical service lines
Cancer
Cardiothoracic
General
Neurosurgery
Orthopedic

Mathematica

Distribution of stays by service line (CY 2018)

Non-Surgical	# of Stays	# of Deaths	MD All-Payer Unadjusted Mortality Rate	CMS Unadjusted Mortality Rate*
Cancer	573	68	11.87%	14.60%
Cardiac	15,010	664	4.42%	6.50%
Gastrointestinal	10,067	336	3.34%	4.90%
Infectious Disease	25,242	2,815	11.15%	13.00%
Neurology	12,031	873	7.26%	8.00%
Orthopedics	239	11	4.60%	4.90%
Pulmonary	21,021	1,380	6.56%	9.50%
Renal	17,351	900	5.19%	8.80%
Other Conditions	12,269	645	5.26%	5.60%
Subtotal	**113,803**	**7,692**	**6.76%**	**8.28%**

Surgical	# of Stays	# of Deaths	Unadjusted Mortality Rate	CMS Unadjusted Mortality Rate
Cancer	52	0	0.00%	2.30%
Cardiothoracic	447	81	18.12%	6.40%
General	1,095	126	11.51%	6.60%
Neurosurgery	898	84	9.35%	3.00%
Orthopedic	3,246	107	3.30%	1.50%
Subtotal	**5,738**	**398**	**6.94%**	**3.10%**
GRAND TOTAL	**119,541**	**8,090**	**6.77%**	**6.87%**

Mathematica

*CMS numbers taken from 2019 QualityNet Conference presentation by Yale/CORE

Overview of statistical properties of 30-day mortality measure

Measure Assessment: Three Categories of Criteria

Feasibility Criteria

Evidence that data needed for measurement is available

➡ Not a focus of today's presentation, but we expect measure to pass this step

Validity Criteria

Evidence that the measure is measuring what it is supposed to measure

➡ Multiple steps/checks, but today's presentation will focus on **convergent validity** and **predictive validity**

Reliability Criteria

Evidence that the measure consistently produces the same result, versus measure results being a product of statistical noise

➡ Implemented a **signal-to-noise test** for the 30-day measure

Mathematica
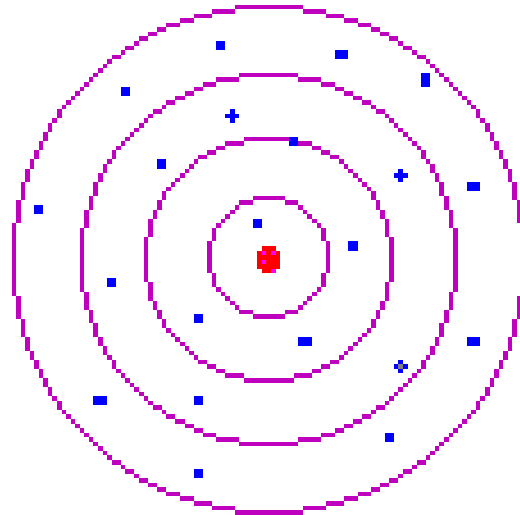
Validity and Reliability Analyses

- **Convergent validity: correlate 30-day measure results with other existing measures of quality**
  - CMS overall star rating
  - CMS diagnosis and procedure-specific 30-day mortality results (July 2015 – June 2018 results)
  - HSCRC Inpatient mortality results from QBR (FY19 Base results; Q32018 – Q22019)
  - Use rank correlations when comparing mortality measure results

- **Predictive validity: correlate 30-day measure results from 2018 with results from 2019**

- **Reliability analysis: calculate signal-to-noise test**
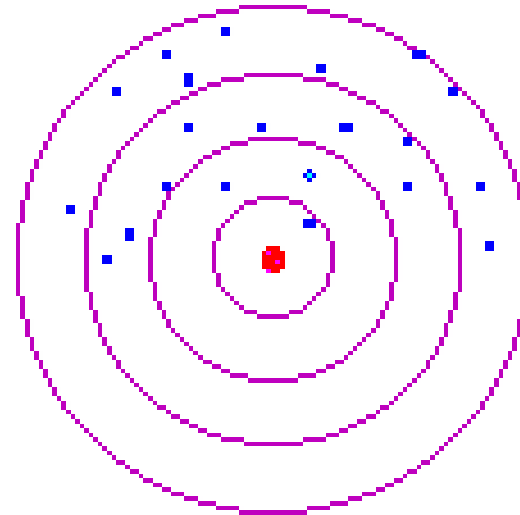 - Calculated for overall measure reliability, and by hospital
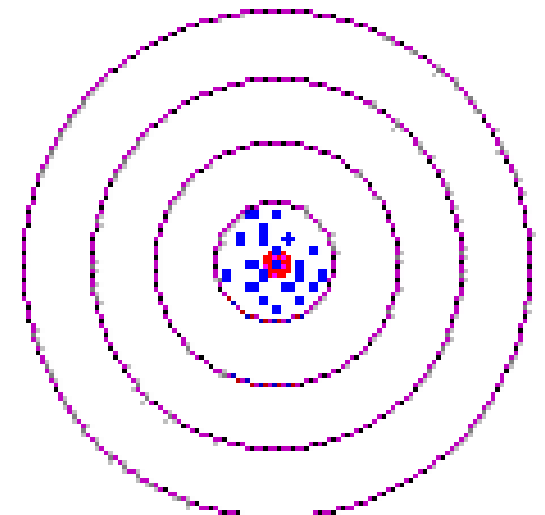
Mathematica

More on Validity and Reliability Analyses

Reliable
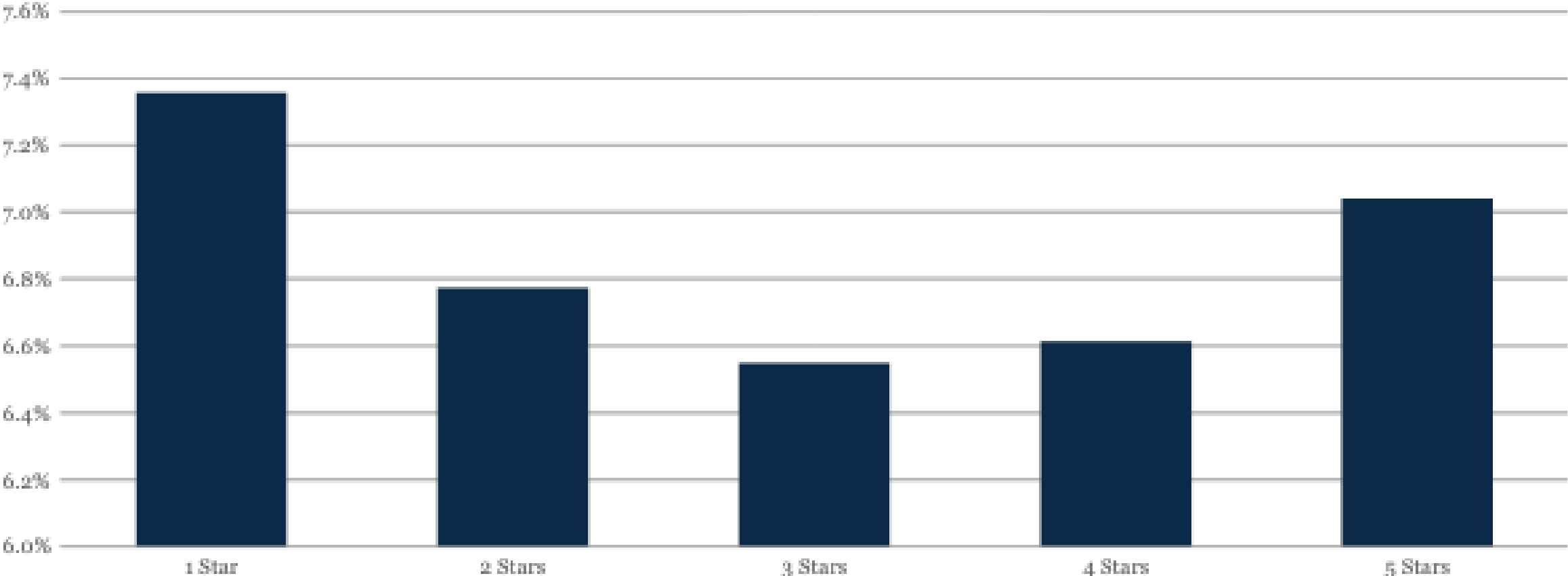Not Valid

Valid
Not Reliable

Neither Reliable
Nor Valid

Both Reliable
And Valid

Mathematica

Convergent validity: comparison to CMS Star Ratings
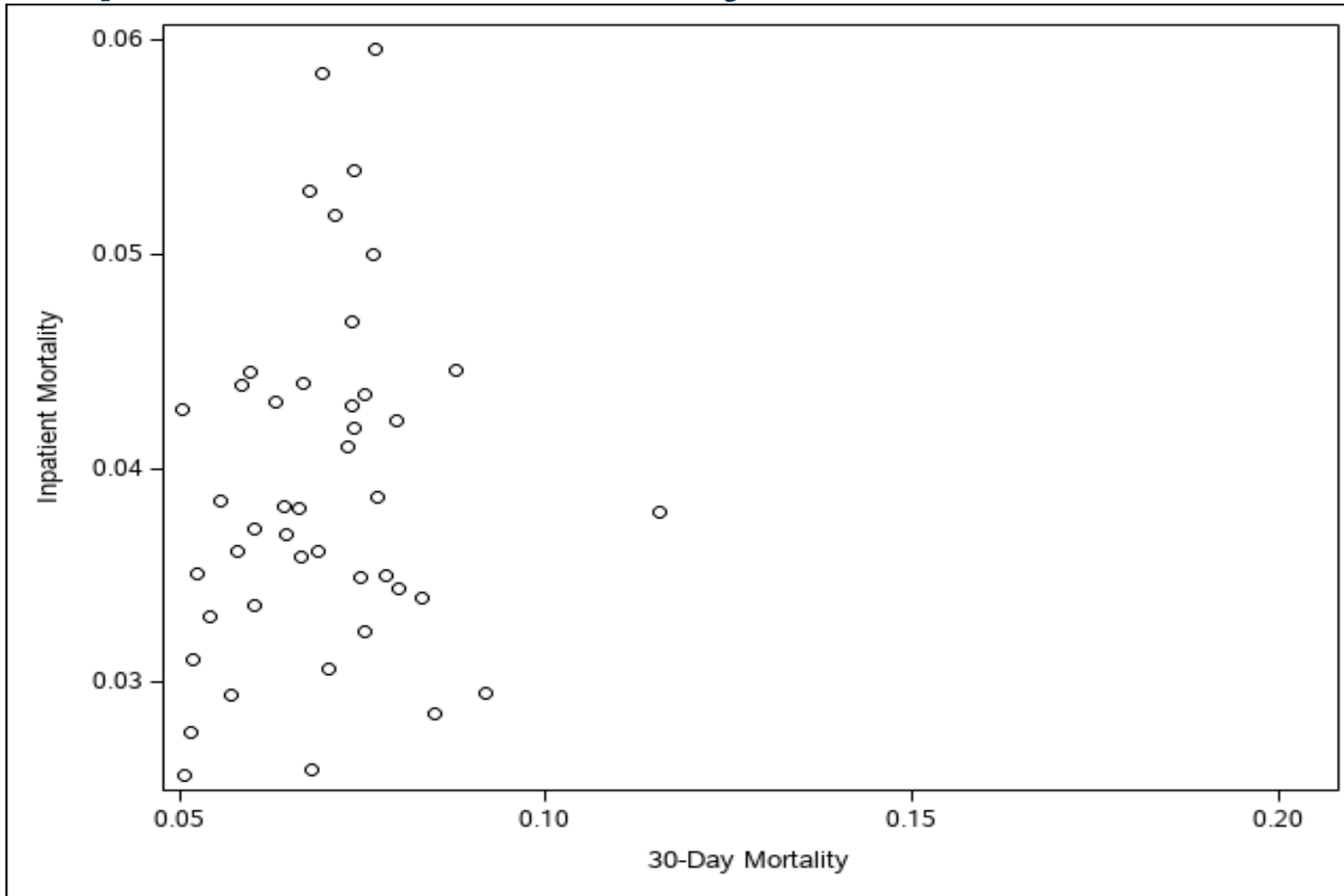

Average All-Payer 30-Day Mortality Rate

Convergent validity: comparison to CMS 30-day mortality results

CMS 30-Day Mortality Rate for...	Correlation Statistic	p-value
AMI	0.36	0.03
CABG	-0.30	0.40
COPD	-0.07	0.65
Heart Failure	0.42	0.00
Pneumonia	0.30	0.04
Stroke	0.07	0.66

Mathematica

Convergent validity: comparison to HSCRC inpatient mortality results

- Low/moderate rank correlation between All-Payer 30-day Mortality results and QBR Inpatient Mortality results

- 2018 correlation = .18 and 2019 correlation = .36

Note: Vertical axis is QBR inpatient mortality results. Horizonal axis is All-Payer 30-Day Mortality results

Predictive validity results

- **CY 2018 and CY 2019 All-Payer 30-Day Mortality results are positively correlated**
  - Correlation coefficient = 0.70 with p-value <.01

Mathematica

Reliability results

- **Strong reliability for All-Payer 30-Day Mortality Measure**

- **Overall reliability = 0.85**

- **Variation in hospital-level reliability estimates**
  - Minimum = .05; Maximum = .95

- **79% of hospitals have reliability of at least 0.70**

- **Hospitals with lower reliability estimates have smaller case sizes**

Mathematica

Questions and discussion

Mathematica

Maryland Hospital Acquired Conditions (MHAC) Program

RY 2023 Draft Recommendations (Slide 1)

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. Monitor all PPCs and provide reports for hospitals and other stakeholders.
        i. Evaluate PPCs in "Monitoring" status that worsen and consider inclusion back into the MHAC program for RY 2024 or future policies.
2. 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 2021 plus the to be determined performance period for RY 2022 (i.e., January-June 2020 data will not be used).
3. Continue to assess hospital performance on attainment only.
4. Continue to weigh the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.

maryland
health services
cost review commission

RY 2023 Draft Recommendations (Slide 2)

61. Adjust the MHAC pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report to Commissioners as follows:
    a. For RY 2022 (CY 2020 performance period)
        i. Exclude COVID-19 positive cases from the program.
        ii. Exclude the data for January to June 2020 and evaluate the reliability and validity of the data for July-December 2020 to determine feasibility of its use for the RY 2022 payment adjustments.
    b. For RY 2023 (CY 2021 performance period)
        i. Update PPC Grouper to v38 and include COVID-19 positive cases consistent with the clinical updates to the grouper.
        ii. Retrospectively evaluate impact of inclusion of COVID-19 patients on case-mix adjustment.

Small Hospital Exclusion

Extended performance period not yet determined

- Based on CY18/CY19 data there are 8 hospitals (up from 5 in RY 2022) that meet criteria of less than 20,000 at-risk and/or 20 expected PPCs (under version 37)

HOSPITAL ID	HOSPITAL NAME	AT RISK	Expected PPCs	RY2022	New RY2023
210010	UM-Dorchester	1759	1.7464	Y	
210017	Garrett	6208	9.0034	Y	
210064	Levindale	6564	9.4115	Y	
210060	Ft. Washington	6988	8.9067	Y	
210061	Atlantic General	14863	18.5646		Y
210013	Grace Medical center	16150	12.1046	Y	
210058	UMROI	17188	23.775		Y
210006	UM-Harford	19974	16.9894		Y

cost review commission

Prospective Revenue Adjustment Scale

Given half the hospitals scored more than 73 percent, should cut point be raised?

- RY 2022 modeling had median of 60 percent, and said we would consider raising in the future
- If increased, shift or widen hold harmless zone?
  - Staff proposes for final policy to widen hold harmless zone to 60-75 percent (in RY 2021 this would move 7 out of 27 hospitals rewarded into hold harmless zone)

Additional RY 2021 Statistics:
- Score where O/E = 1 for all PPCs is 56%
- Score where O/E = hospital median is 80%
- Score where O/E = 0.75 is 74%

RY 2022 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%

Figure 6. RY 2021 Hospital Scores

RY 2021 Hospital Scores	CY 2019 Performance
Median	73%
Average	74%
Min	46%
Max	100%
25th Percentile	64%
75th Percentile	86%

PPC Assignment for COVID-19 Patients

RY 2022:
- Continue to use v37 and exclude COVID-19 positive patients from the program
- Exclude Jan-June 2020 data and evaluate reliability and validity of July-Dec data or other adjusted performance periods

RY 2023:
- Update to v38 that excludes 8 out 14 of the PPCs for COVID-19 patients and include COVID patients
- Will need to retrospectively evaluate inclusion of COVID-19 patients on case-mix adjustment
- Will need to determine the longer performance period for small hospitals

PPCs assigned to COVID-19 patients under v38:
- In-hospital trauma or fracture, post-operative infection and deep wound disruption without procedure, accidental puncture/laceration during invasive procedure, iatrogenic pneumothorax, obstetrical complications

maryland
health services
cost review commission

Other Thoughts or Questions?

Next PMWG Meeting: November 18, 9:30 AM-12:00 PM