Performance Measurement Work Group Meeting

9/18/2018

HSCRC
Health Services Cost Review Commission

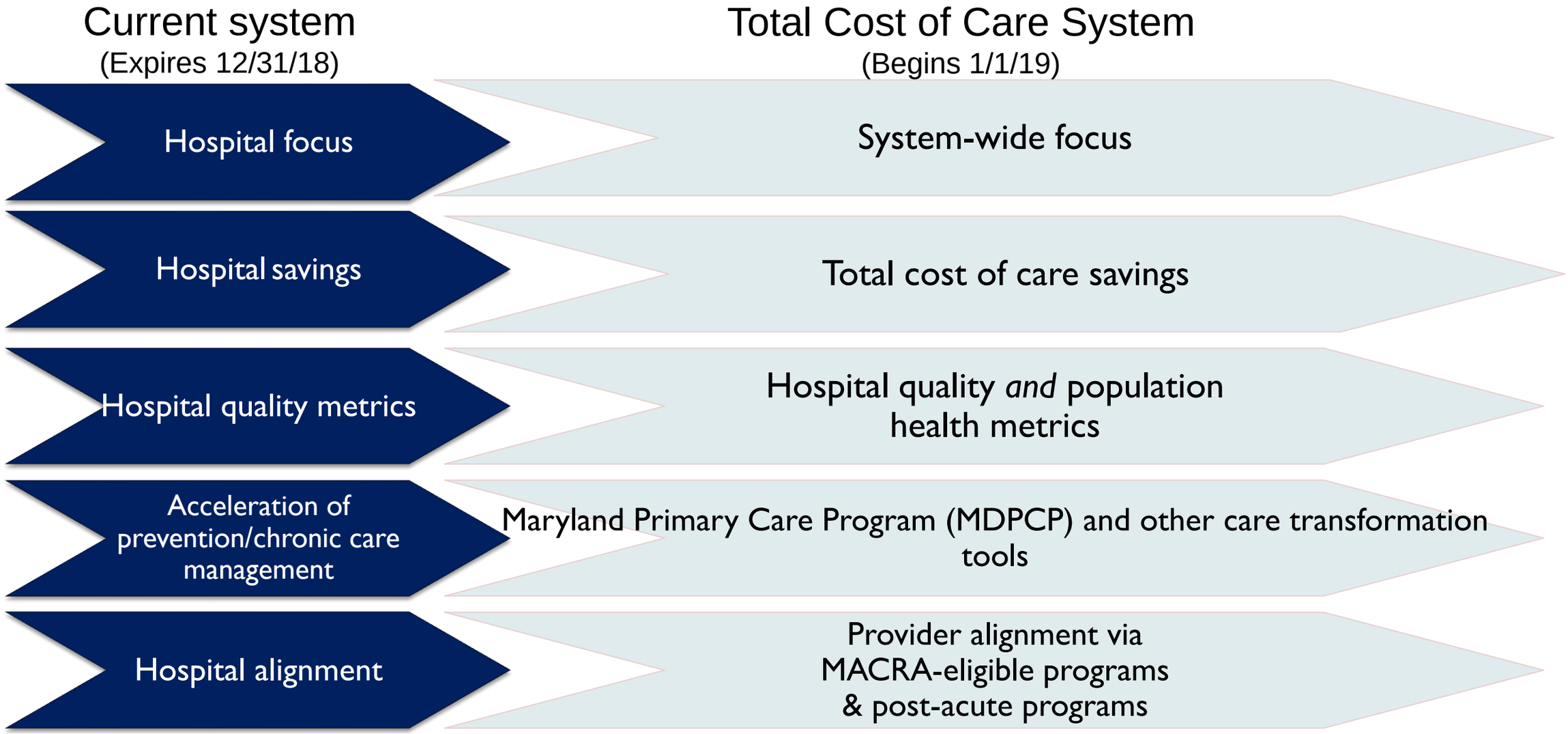
Agenda

- 1. Welcome and Introductions
- 2. TCOC Model Overview
- 3. Federal Rule-Overview and Implications
- 4. Work Plan and Quality Strategy under TCOC Model
  - A. Maryland Hospital Acquired Conditions Program (**MHAC**)
  - B. Potentially Avoidable Utilization (**PAU**)
  - C. Quality Based Reimbursement Program (**QBR**)
  - D. Readmissions Reduction Incentive Program (**RRIP**)
- 5. Public Comment

Welcome and Introductions

TCOC Model Overview

The Change


Current system
(Expires 12/31/18)
Total Cost of Care System
(Begins 1/1/19)
Hospital focus
System-wide focus
Hospital savings
Total cost of care savings
Hospital quality metrics
Hospital quality *and* population health metrics
Acceleration of prevention/chronic care management
Maryland Primary Care Program (MDPCP) and other care transformation tools
Hospital alignment
Provider alignment via MACRA-eligible programs & post-acute programs

Total Cost of Care (TCOC) Model Overview

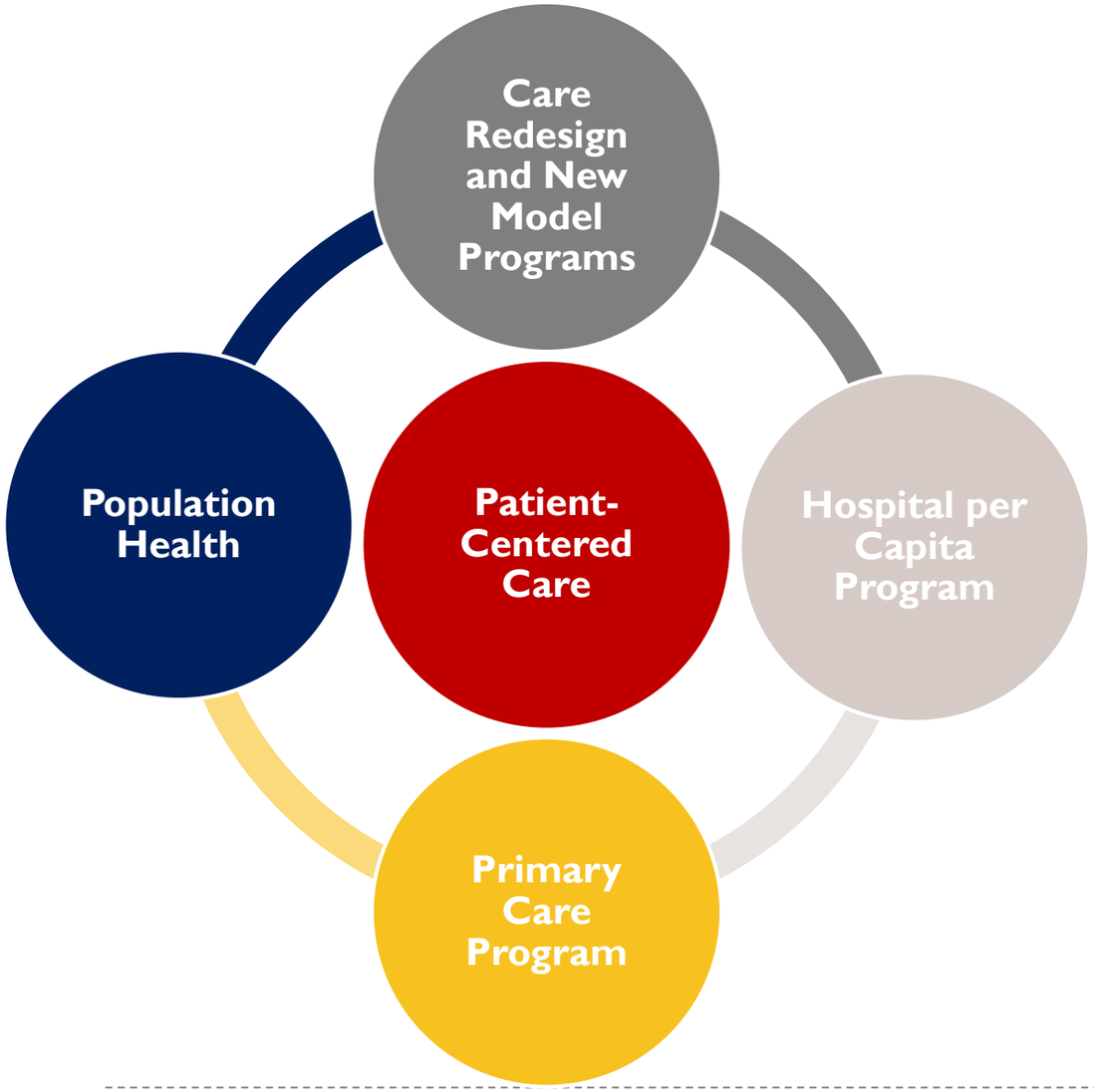
- New Contract will be a 10-year agreement (2019-2028) between MD and CMS
  - Five years (2019-2023) to build up to required Medicare savings and five years (2024-2028) to maintain Medicare savings and quality improvements
- Total Cost of Care (TCOC) Medicare Savings building to $300 million annually by 2023
- Continue to limit growth in all-payer hospital revenue per capita at 3.58% annually
- Designed to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes and constrain the growth of costs
  - Aligns hospitals, physicians, long term care, skilled nursing facilities and other health care providers
  - Focuses on managing and preventing chronic and complex conditions
  - Enhances primary care delivery
- Expand value based payment programs to include population health outcomes via outcomes based credits

Annual Medicare TCOC Savings Targets

Annual Medicare TCOC Savings Targets (relative to 2013 base)		
2019	PY 1:	$120 million
2020	PY 2:	$156 million
2021	PY 3:	$222 million
2022	PY 4:	$267 million
2023	PY 5:	$300 million

- By the end of 2023, achieve $300 million in annual savings to Medicare Parts A and B (~4%), through slower TCOC spending growth per beneficiary
  - In 2017, annual TCOC savings to Medicare were $138 million
  - Beyond 2017, the improvement necessary is $162 million, or approximately 1% of total hospital revenues
- No cumulative liability or credit
  - Missed performance does not need to be paid back
  - The State has to catch up to the next savings target

Total Cost of Care Model Components



- Expands **Care Redesign Programs** to enable private sector led programs supported by State flexibility; opportunity for **New Model Program** development in the future.
  - 'MACRA-tize' the model and expand incentives for hospitals to work with others
- Continues **Hospital per Capita Budgets**, while expanding incentives to control total costs
  - Expand responsibility for total costs through gradual revenue at risk under **Medicare Performance Adjustment**
- Initiates the **Maryland Primary Care Program** to enhance chronic care and health management
- Develops **Population Health** improvement programs for chronic conditions, opioid deaths and senior health quality of life

Aim High

- Population health improvement
- Improved outcomes
- Lower disease burden
- Lower costs of care

Purpose: HSCRC staff and stakeholders need to develop far-reaching, broad improvement goals and targets to align Maryland's community health and provider systems for success under the TCOC Model.

Proposed BIGs Timeline

August 2018

- BIG Charge and Vision development
- Candidate Measures Brainstorming

Fall 2018

- Stakeholder and Expert Development
- Commissioner Executive Session
- Staff Development

Winter/Spring 2019

- Policy development where applicable
- Policy Implementation where applicable

Staff is planning to develop a quality strategic plan to align quality programs with the TCOC model

Discussion: Staff brainstormed the following three priory areas to shape the quality strategy moving forward

01

Redesign Quality Programs to Support TCOC Model

Consider how to evolve quality programs to expand to additional care settings, focus on preventative and population health, and address health equity.

02

Incentivize Patient-centered Care and Strengthen Communities

Consider incorporating new measures, like patient reported outcome measures, and build on collaboration mechanisms like regional partnerships to strengthen community.

03

Align and Partner with Others to Improve Quality and Enable Success

Work with State and other partners to align quality programs, reducing burden for hospitals and harmonizing quality signals to industry. Orchestrate quality improvement and technical assistance directed at state priority areas.

In future meetings, we will validate these priority areas and brainstorm key questions to answer in the quality strategic plan.

Federal Rule Overview and Implications

MARYLAND

Rule Changes and Implications

Changes	Implications
VBP- Removing 1 measure from QBR: PC-01 - FY2021 Increased weight on clinical care domain	We will need to remove from QBR
HRRP - codifying definitions of dual eligible patients	Continue to monitor national policy discussion on adjustment factors
HACRP- Adopt new scoring methodology that removes the domains and assigns equal weights	Does this impact refurbished RY 2021 MHAC program?
HACRP- Establishing administrative policies to collect, validate, and publically report NHSN HAI quality measure data	N/A

Rule Changes and Implications Continued

Changes	Implications
IQR-De-duplicating 21 measures	Ensure data is available for Maryland Quality Programs
IQR-ED wait time measures: • ED-1b removal in CY 2019 for reporting • ED-2b removal in CY 2020 chart abstracted reporting, retained as voluntary eCQM measure	QBR program: Remove ED-1b for RY2021 Consider options for retaining ED-2b after RY2022
VBP - Safety domain retained for CY 2019, but signaled may be removed in subsequent years	Consider options for QBR and/or MHAC changes for the Safety Domain measures, and track subsequent IPPS final rule updates
PSI-90 - Measure retained in HAC; not used in VBP.	Consider how we will adopt an all-payer version of the measure

For more information: https://www.qualityreportingcenter.com/wp-content/uploads/2018/09/Inpatient_FY2019_IPPSFinalRule_Slides_vFINAL5081.pdf

Work Plan and Quality Strategy Under TCOC Model

Performance Based Payment Programs: Maryland and CMS National

Maryland

- Quality Based Reimburse-ment (QBR)
- Potentially Avoidable Utilization (PAU) Savings
- Readmission Reduction Incentive Program (RRIP)
- Maryland Hospital Acquired Conditions (MHAC)

CMS National

- Value Based Purchasing
- Hospital Readmissions Reduction Program
- Hospital Acquired Condition Reduction

Timeline for Performance Measurement Work Group and Commission Recommendations

Performance Measurement Work Group:

- Meets 3rd Wednesday of each month
- Composed of hospitals, consumers, physicians, payers, other state agencies
- Tentative schedule for Draft and Final Recommendations:

Program	Draft Recommendation	Final Recommendation
QBR	November 2018	December 2018
RRIP	December 2018	January 2019
MHAC	January 2019	February 2019
PAU	May 2019	Jun 2019

Guiding Principles For Performance-Based Payment Programs

- Program must improve care for **all patients**, regardless of payer
- Program incentives should support achievement of **all payer model targets**
- Program should **prioritize** high volume, high cost, opportunity for improvement and areas of national focus
- **Predetermined** performance targets and financial impact
- Hospital ability to **track progress**
- Encourage **cooperation** and sharing of best practices
- Consider **all settings of care**

MHAC

RY 2021 MHAC Program Redesign

- Under TCOC model, MD is redesigning our performance based payment program(s) for hospital acquired conditions.

- Since January, HSCRC has had 8 meetings with the Clinical Adverse Events Measure (CAEM) sub-group
  - Staffed with assistance from contractor, Dr. Zahid Butt
  - sub-group made up of clinical and measurement experts from across MD

- sub-group's primary goal was to vet complication measures and how performance should be evaluated.

- The main groups of measures considered were:
  - National Healthcare Safety Network infections measures
  - Potentially Preventable Complications
  - Patient Safety Index measures*

***Consideration of PSI measures will be deferred for CY19 performance period because all-payer risk adjusted PSI software is not available under ICD-10; once available the PPCs and PSIs will need to evaluated.**

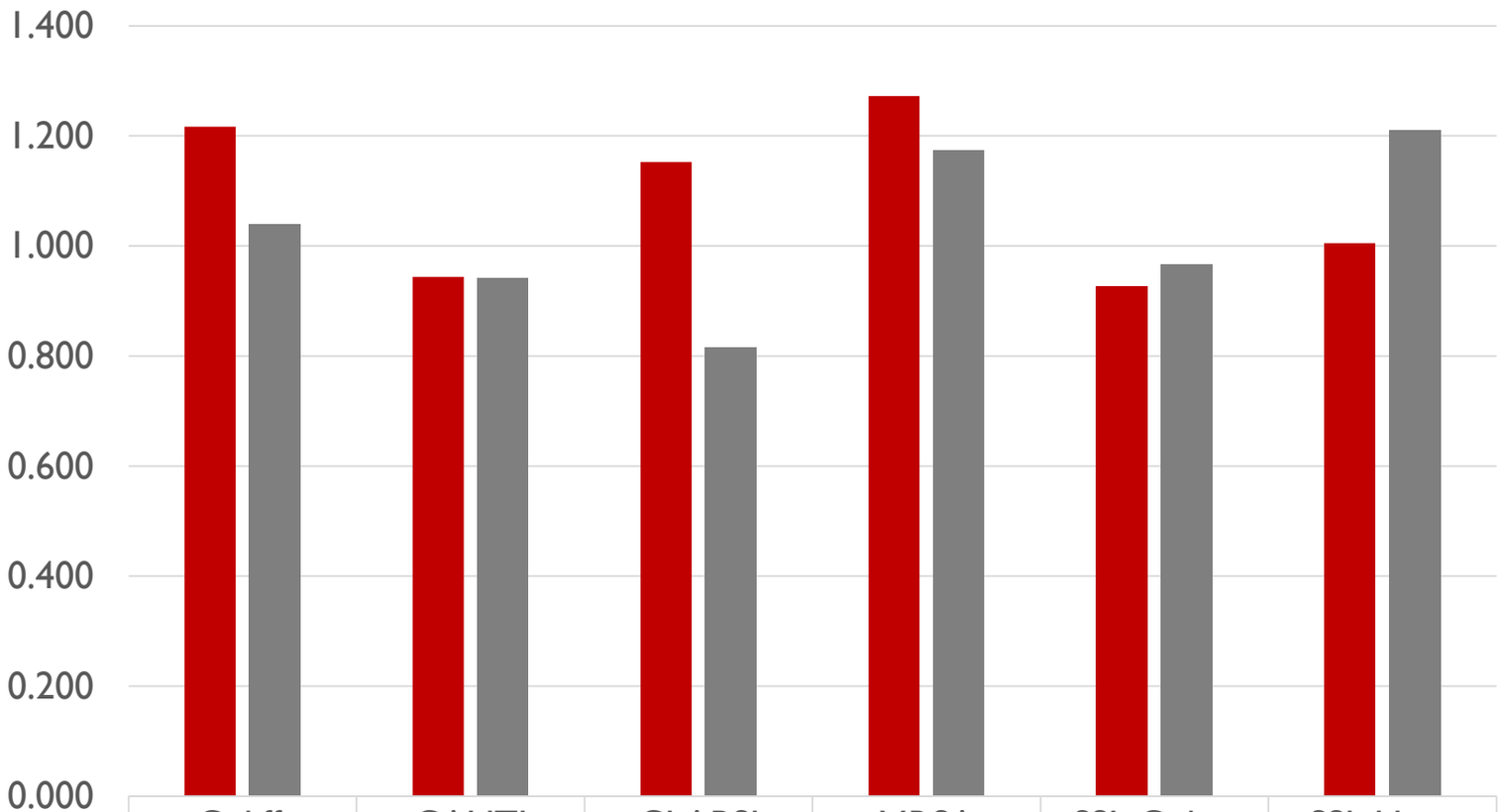
NHSN:
Program Inclusion and At-Risk

National Health Safety Network Measures

- NHSN Standardized Infection Ratios (SIR)
  - C. diff.
  - CAUTI
  - CLABSI
  - MRSA
  - SSI: Colon
  - SSI: Hysterectomy

- SIRs (observed/predicted) adjust for various facility and/or patient-level factors that contribute to HAI risk within each facility.
  - Nationally used measures that allow comparison to standardized benchmark
  - **Unit location code**; medical school affiliation; other risk adjustment variables may be inconsistently defined or documented

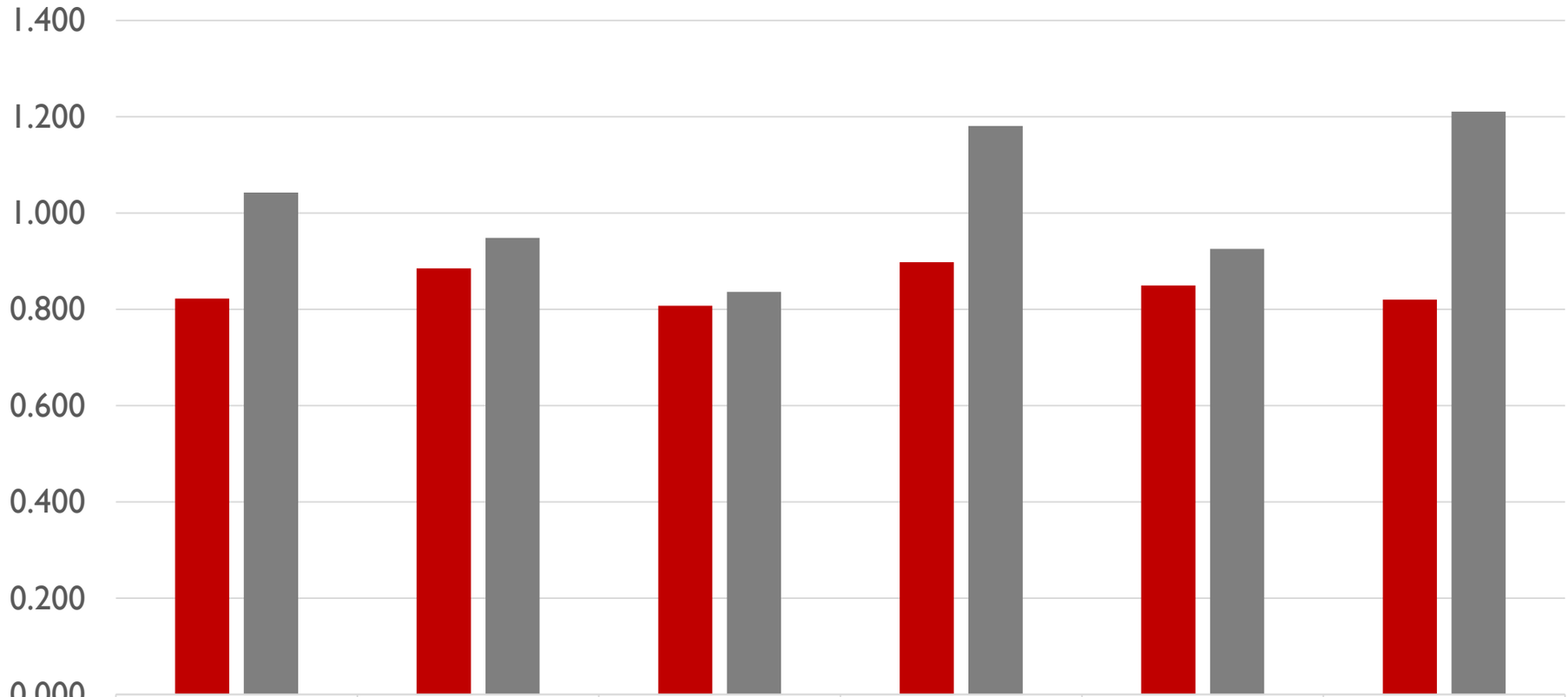
RY 2019 QBR: NHSN Statewide Improvement



	C.diff.	CAUTI	CLABSI	MRSA	SSI: Colon	SSI: Hyst.
Base	1.217	0.944	1.152	1.273	0.926	1.005
Perf	1.039	0.942	0.815	1.174	0.967	1.211

RY 2019 Base = CY 2015; Performance = October 2016 - September 2017

Comparison of National and Maryland NHSN Average SIR Performance



	C. Diff	CAUTI	CLABSI	MRSA	SSI-Colon	SSI-Hyst
National	0.822	0.885	0.808	0.898	0.850	0.820
Maryland	1.043	0.948	0.836	1.181	0.926	1.211

Based on Hospital Compare from October 2016 - September 2017
Results differ from RY19 Performance period because all MD hospitals with SIR are included

Revenue At-Risk Discussion

- Should NHSN measures in both QBR and revised MHAC program?
  - General consensus was that having same SIR included in two programs would be difficult because the results on scoring and revenue adjustments may differ
  - However, nationally NHSN is in both CMS VBP and HACRP

- Does Maryland need to increase revenue at-risk for NHSN to spur improvements?
  - No agreement

NHSN Measures		VBP/QBR	HACRP/MHAC	Total
National		25% of 2%	Approx. 83% of 1%	
	% at-risk	0.50%	0.83%	1.33%
MD		35% of 2%	?	
	% at-risk	0.70%		0.70%

Summary of sub-group Discussion NHSN

- Maryland must improve performance on NHSN measures relative to the nation
  - Lack of agreement on increasing revenue at-risk to drive improvement
- Agreement that NHSN safety domain should remain in QBR to align with VBP
- Concerns regarding the use of NHSN measures in both the QBR and MHAC programs under different methodologies
  - Note: Nationally NHSN measures are included in both VBP and HACRP

PPC Selection Recommendations by Clinical Adverse Events Measures (CAEM) sub-group for PMWG

PPC Selection Criteria and Considerations Recommended by CAEM

- Payment program should align with quality improvement initiatives for provider engagement
- Narrowed down PPC list to those with higher rates and variation
- PPC Data Analysis/Statistics
  - Rate generally 0.5 or above
  - Volume of observed events 100 or above
  - Significant variation across hospitals
  - At least half of the hospitals are eligible for the PPC
- Additional Considerations
  - PSI overlap
  - Clinically significant
  - Opportunity for improvement
  - All-payer
- See excel with all PPCs and rationale for inclusion/exclusion

CAEM Proposed Payment Program PPC List

PPC NUMBER	PPC Description	Eligible Hospitals	Observed PPCs	At Risk Discharges	Obs/At-Risk*1,000	3M v33 PPC Marginal Cost Weight
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	46	1,238	696,950	1.78	0.7958
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	47	848	698,946	1.21	2.7409
7	Pulmonary Embolism	44	407	824,106	0.49	1.3671
9	Shock	46	984	833,605	1.18	1.5133
16	Venous Thrombosis	44	297	822,712	0.36	1.4346
28	In-Hospital Trauma and Fractures	38	110	827,456	0.13	0.3353
35	Septicemia & Severe Infections	47	801	289,205	2.77	1.3722
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	39	319	128,674	2.48	1.2701
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	44	1,067	306,410	3.48	0.5881
41	Post-Operative Hemorrhage & Hematoma withHemorrhage Control Procedure or I&D Proc	32	167	241,162	0.69	1.0951
42	Accidental Puncture/Laceration During Invasive Procedure	43	440	897,351	0.49	0.4466
49	Iatrogenic Pneumothrax	40	154	829,953	0.19	0.6090
60	Major Puerperal Infection and Other Major Obstetric Complications	27	123	125,667	0.98	0.1729
61	Other Complications of Obstetrical Surgical & Perineal Wounds	25	100	122,183	0.82	0.1172
67	Pneumonia Combo	47	1,282	713,219	1.80	1.3002

Descriptive statistics use CY2016 and CY2017 data grouped under v35

Rate >1.0 per 1,000 At-risk discharges	Rate >0.5 per 1,000 At-risk discharges

Robust Monitoring Plan

- Several PPCs were not selected for the payment program, did not meet rate or observed volume criteria but constitute important clinical areas where the events are preventable.
- As endorsed by CAEM, HSCRC will work to publish PPC reports that include all PPCs.
- For monitored PPCs, data reports will be provided to hospitals, and results will be reviewed by the HSCRC staff at regular intervals.

CAEM sub-group PPC Scoring Recommendations for PMWG

Sub-Group Recommendations to PMWG for Measuring PPC Performance

- Measure **annual attainment-only** performance with expanded scoring approach
- **Weight PPC**s in payment program based on "harm" as defined by 3M relative cost weights
- Use **indirect standardization** using APR-DRG & SOI based on **1-year normative values**
- **Monitor PPCs on all patients** for both "payment" and "monitoring only" PPCs
- Continue to **evaluate PPCs and other complication measures** (e.g., PSI) throughout TCOC model

Attainment Only and Expanded Scoring Methodology

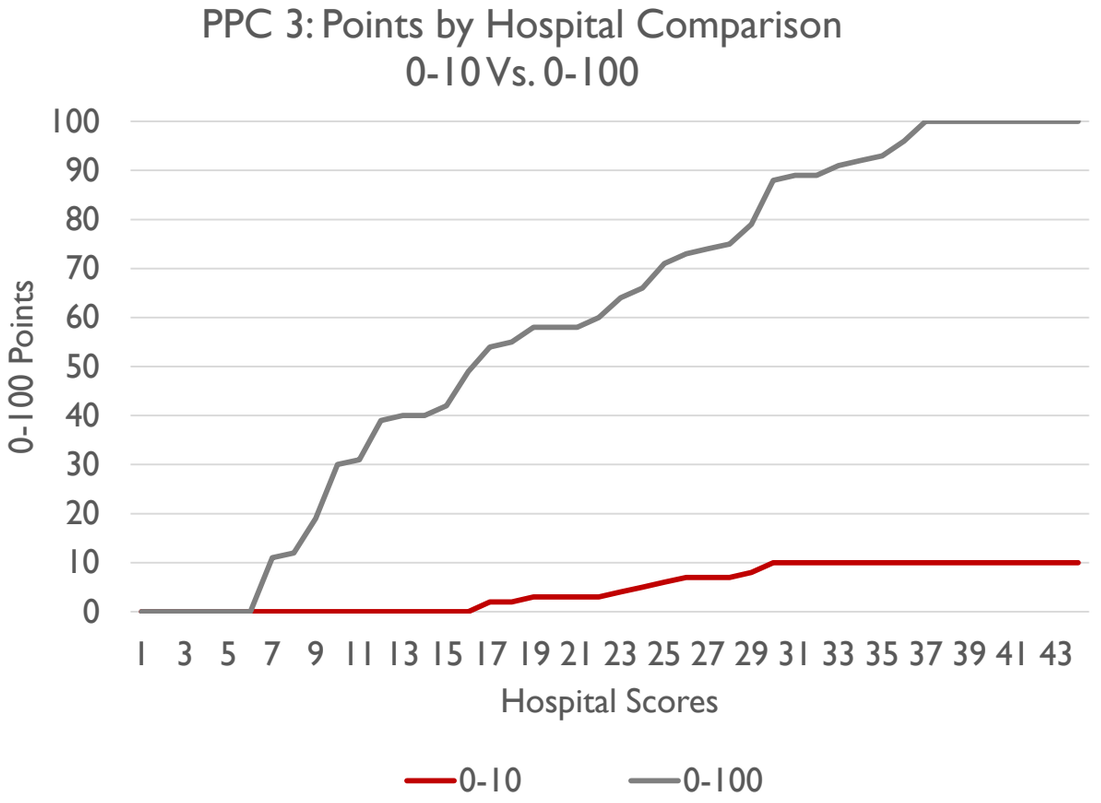
- Rationale:
  - Consistent with National HACRP program
  - Maryland has been rewarding improvement for last 5+ years and at this point should expect hospital attainment

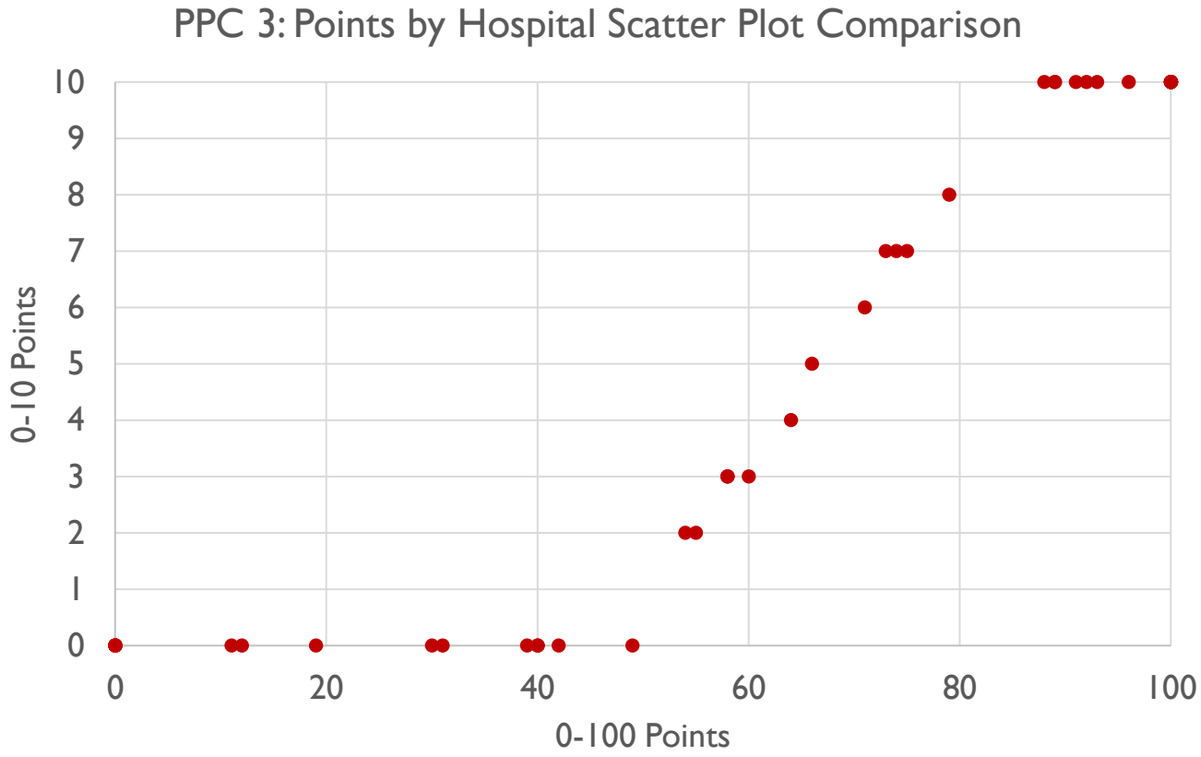
- Considerations:
  - Measure annual performance to allow for improvements to be recognized more quickly
  - Use wider range of performance standards and more granular points under attainment only approach
    - **Current:** Scoring methodology assigns 0-10 points based on performance compared to the median (threshold) and top performers accounting for 25% of discharges (benchmark)
    - **Expanded:** Modify scoring methodology to assign 0-100 points based on 10th percentile threshold and 90th percentile benchmark; the 10th and 90th percentile cutoffs are open to PMWG discussion.

Thresholds and Benchmarks

		Current 0-10 Points		Expanded Scale 0-100 Points	
PPC Number	**PPC Description**	**Threshold Median**	**Benchmark Top performing 25% discharges**	**Threshold 10th percentile**	**Benchmark 90th Percentile**
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	1	0.5659	1.6406	0.3483
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1	0.4691	1.6835	0.2530
7	Pulmonary Embolism	1	0.4724	1.9392	0.4070
9	Shock	1	0.4696	1.7393	0.2069
16	Venous Thrombosis	1	0.1658	2.1356	0.0000
28	In-Hospital Trauma and Fractures	1	0.2151	2.6935	0.0000
35	Septicemia & Severe Infections	1	0.4578	1.8121	0.2603
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	1	0.3684	1.5768	0.0000
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	1	0.5271	1.7103	0.4010
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	1	0.2930	1.9154	0.0000
42	Accidental Puncture/Laceration During Invasive Procedure	1	0.4195	1.8772	0.4281
49	Iatrogenic Pneumothrax	1	0.1077	2.0963	0.0000
60	Major Puerperal Infection and Other Major Obstetric Complications	1	0.5005	1.9099	0.2944
61	Other Complications of Obstetrical Surgical & Perineal Wounds	1	0.1710	1.7274	0.0000
67	Combined Pneumonia (PPC 5 and 6)	1	0.4822	1.8745	0.3419

Example of Current Versus Expanded Scoring: PPC 3





3M Cost-Based Weights: Proxy for Harm

- PPCs weighted based upon cost variation correlated with the individual PPC provides an option for combining the PPCs using a consistent weighting approach.
- The cost measurement provides an estimate of the incremental cost of the average PPC over the cost of the typical case at admission.
- Cost estimates are converted into relative weights on a similar scale to those of other admissions to provide context.
- 3M anticipates issuing updated cost weights under v36/ICD-10 logic in its October 2018 grouper release

- Alternative would be to equally weight each PPC measure

Application of Weights

- Apply weights to the points scored

Hypothetical Example with Three PPCs								
	PPC	**Attainment Points**	**Denominator**	**Unweighted Score**	**Weight**	**Weighted Attainment Points**	**Weighted Denominator**	**Weighted Score**
Hospital A **Worse on Higher Weight**	PPC X	10	10		0.5	5	5	
	PPC Y	5	10		1	5	10	
	PPC Z	3	10		2	6	20	
		18	30	60%		16	35	46%
Hospital B **Worse on Lower Weight**	PPC X	3	10		0.5	1.5	5	
	PPC Y	5	10		1	5	10	
	PPC Z	10	10		2	20	20	
		18	30	60%		26.5	35	76%

Hospital PPC Performance Scores by Model

- See excel
  - Overall descriptive analysis of 4 scoring models
    - Unweighted 0-10 point scores by hospital
    - Weighted 0-10 point scores by hospital
    - Unweighted 0-100 point scores by hospital
    - Weighted 0-100 point scores by hospital

- Overall descriptive statistics by model

	Current Threshold/Benchmark 0-10 Points UNWEIGHTED	Current Threshold/Benchmark 0-10 Points WEIGHTED	Expanded Threshold/Benchmark 0-100 Points UNWEIGHTED	Expanded Threshold/Benchmark 0-100 Points WEIGHTED
25th percentile	30%	31%	52%	51%
50th percentile	40%	45%	59%	60%
75th percentile	53%	58%	67%	71%
average	43%	44%	59%	60%
min	7%	5%	15%	14%
max	88%	83%	91%	86%
St. Dev	16%	18%	13%	14%

Differences in scores may indicate need for higher cut point in the revenue adjustment scale if using 0-100 scoring with threshold at 10th and benchmark at 90th percentiles.

RECAP: Sub-Group Recommendations to PMWG for Measuring PPC Performance

- Measure **annual attainment-only** performance with expanded scoring approach
- **Weight PPC**s in payment program based on "harm" as defined by 3M relative cost weights
- Use **indirect standardization** using APR-DRG & SOI based on **1-year normative values**
- **Monitor PPCs on all patients** for both "payment" and "monitoring only" PPCs
- Continue to **evaluate PPCs and other complication measures** (e.g., PSI) throughout TCOC model

Additional Scoring Considerations for PMWG

List of Additional Considerations for PMWG

- "Zero-Norm" concern and clinical alignment
- Performance metric O/E vs. Excess PPC rate per discharge
- Revenue At Risk for PPCs
- Adjustment Scale

Zero-Norm Concerns and Clinical Alignment

- Goals:
  - Payment program should not provide rewards or penalties for random variation
  - Payment program should align with quality improvement initiatives for provider engagement

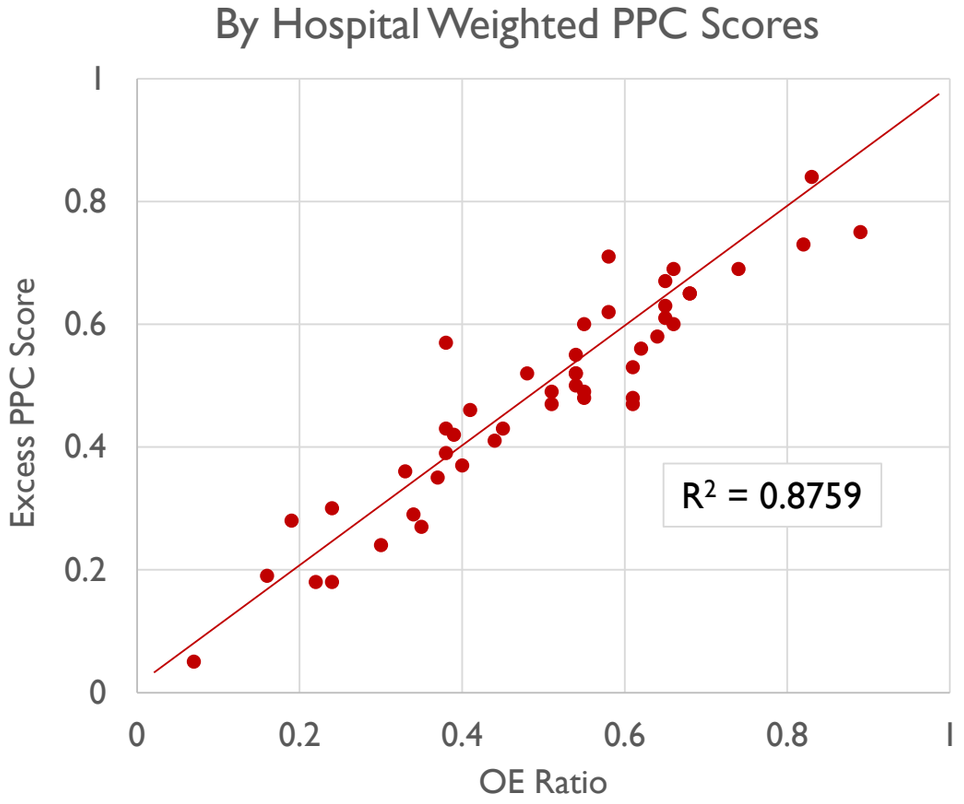
- Approaches:
  - Narrowed down PPC list to those remaining PPCs with higher rates and variation
  - Measure performance on the APR-DRG-PPC combos where at least 80% of complications occur
  - Raise minimum at-risk number to focus on larger patient populations

Percent Zero Norms of Proposed PPCs

PPC	PPC Description	Count Zero Norm	Count >0 Norm	Percent Zero
PPC 3	**Acute Pulmonary Edema and Respiratory Failure without Ventilation**	427	228	65.19%
PPC 4	**Acute Pulmonary Edema and Respiratory Failure with Ventilation**	473	182	72.21%
PPC 7	**Pulmonary Embolism**	598	114	83.99%
PPC 9	**Shock**	544	187	74.42%
PPC 16	**Venous Thrombosis**	606	106	85.11%
PPC 28	**In-Hospital Trauma and Fractures**	684	29	95.93%
PPC 35	**Septicemia & Severe Infections**	359	178	66.85%
PPC 37	**Post-Operative Infection & Deep Wound Disruption Without Procedure**	157	69	69.47%
PPC 40	**Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc**	292	181	61.73%
PPC 41	**Post-Operative Hemorrhage & Hematoma withHemorrhage Control Procedure or I&D Proc**	226	59	79.30%
PPC 42	**Accidental Puncture/Laceration During Invasive Procedure**	642	103	86.17%
PPC 49	**Iatrogenic Pneumothrax**	646	39	94.31%
PPC 60	**Major Puerperal Infection and Other Major Obstetric Complications**	1	12	7.69%
PPC 61	**Other Complications of Obstetrical Surgical & Perineal Wounds**	7	6	53.85%
PPC 67	**Pneumonia Combo**	383	262	59.38%
TOTAL		6045	1755	77.50%

Based on modeling using CY 2016 under v35

Performance Metric:
Excess PPC Rates (O-E / At-Risk) vs. O:E Ratio



- Less difference between approaches than anticipated
- Larger hospitals benefit most from excess PPC rate measurement
- Nationally NHSN measures use O/E ratio approach
- **For RY 2021, staff are not convinced that the performance metric should change**

Revenue At-Risk and Adjustment Scale

- RY 2020 MHAC Program = 2% max penalty and 1% max reward
- Revenue adjustment linear scale ranges from 0 to 100 percent with a hold harmless zone between 45 and 55 percent
- What changes should be considered for RY 2021?
  - Revenue at-risk for PPCs?
  - Other considerations: Should PMWG consider non-linear scaling to lower rewards/penalties around average performance and focus larger adjustments on extreme performers?

Potentially Avoidable Utilization (PAU)

PAU Sub-group

- HSCRC convened a PAU sub-group to consider modernization and expansion of PAU
  - Participation from hospitals, consumers, physicians, payers, including members of PMWG
- Met in August and September, scheduled for another meeting at the end of September.
- Goal to provide input on improved PAU measure for RY2021

Focusing on three buckets of work

- Incorporating low value care measures
- Refining existing measures of PQIs and readmissions
- Adding additional measures of avoidable utilization

Low Value Care Measures

Measure Selection and Preliminary Results

- Initial goal was to test low value care measures in the HSCRC case-mix dataset to capture all payer data
- Measure selection
  - Overall, 36 measures were suggested by Mathematica or others.
  - Mathematica aimed to test 2-3 measures in the time span allotted.
  - Measures selected by staff based on sub-group ratings, easily available specifications, and potential for significant variation/cost.

Preliminary results (under going refinements/validation):

Measure	MD rate compared to national benchmarks	$ Statewide over 2016 and 2017
Arthroscopic knee surgery among patients with osteoarthritis	Unexpectedly low	$4 million
Screening for carotid artery stenosis in asymptomatic adults	Unexpectedly low	$15 million
Head imaging for uncomplicated headache	Unexpectedly high	$13 million

Sub-group Initial Feedback

- Sub-group is meeting at the end of September to provide additional feedback

Initial Feedback—Staff will bring final feedback to October PMWG

- Strong concerns about measuring low value care in hospital data
  - Many measures rely on non-hospital data to determine value
  - Many low value procedures can be outside of the hospital
- Low value care measures tested may be too narrow and the dollar value when scaled is not worth the effort of implementation
  - Consider other revenue adjustment methods for low value care
- Explore providing broad utilization measures to hospitals for monitoring
- Some interest in developing a set of indicator measures

Refining Existing Readmissions and Avoidable Admissions

Updates on Per Capita Approach

- Sub-group is considering how we can move to a per capita approach for PQIs/readmissions
  - Some of the issues include hospital impactability, fairness, alignment with other parts of the model, and data availability.

- Two general types of approaches under discussion:
  - **Geographic approach**: Hospitals accountable for **full** population and **all** PAU from patients residing in their communities, regardless of receiving hospital.
  - **Direct Touch approach**: Hospitals accountable for received PAUs from patients residing in their communities.

- We will report back at the next PMWG meeting with additional details and the sub-group's preliminary recommendation

New Potential Avoidable Admissions Measures

Additional Measures under discussion

- Increase comprehensiveness of PAU measure to reflect populations with important health improvement initiatives
- Modeling new types of measures
  - Adding avoidable pediatric admissions based on AHRQ pediatric quality indicators (PDIs)
  - Adding low birthweight PQIs
  - Removing the transfer exclusion from PQIs to enable measurement of PQIs from nursing homes
- Future conversations will explore other types of admissions specific to pediatric or nursing home populations

Next Steps

- Sub-group to make final recommendations on low value care measurement approach, per capita approach, and new avoidable admission measures.
- Staff will present at the next PMWG meeting
- Staff to update Commission over next few months on sub-group and workgroup recommendations

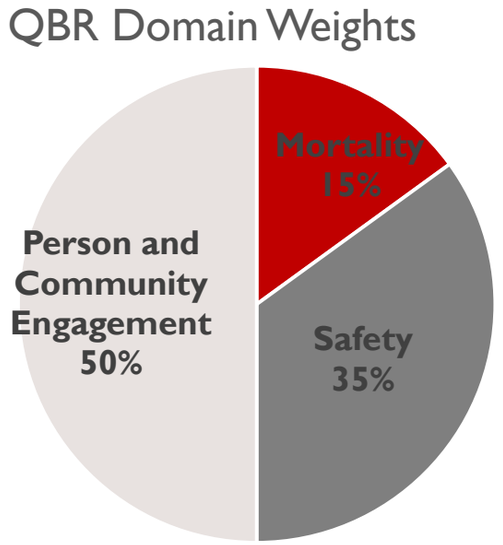
QBR

What is the QBR Program?

QBR Consists of 3 Domains:

- **Person and Community Engagement (HCAHPS) -** 8 measures;
  - + 2 ED Wait Time Measures
- **Mortality -** 1 measure of in-patient mortality;
- **Safety -** 6 measures of in-patient Safety (infections, early elective delivery)

QBR is MD-specific answer to federal Value-Based Purchasing Program



Up to 2% Reward or Penalty under QBR

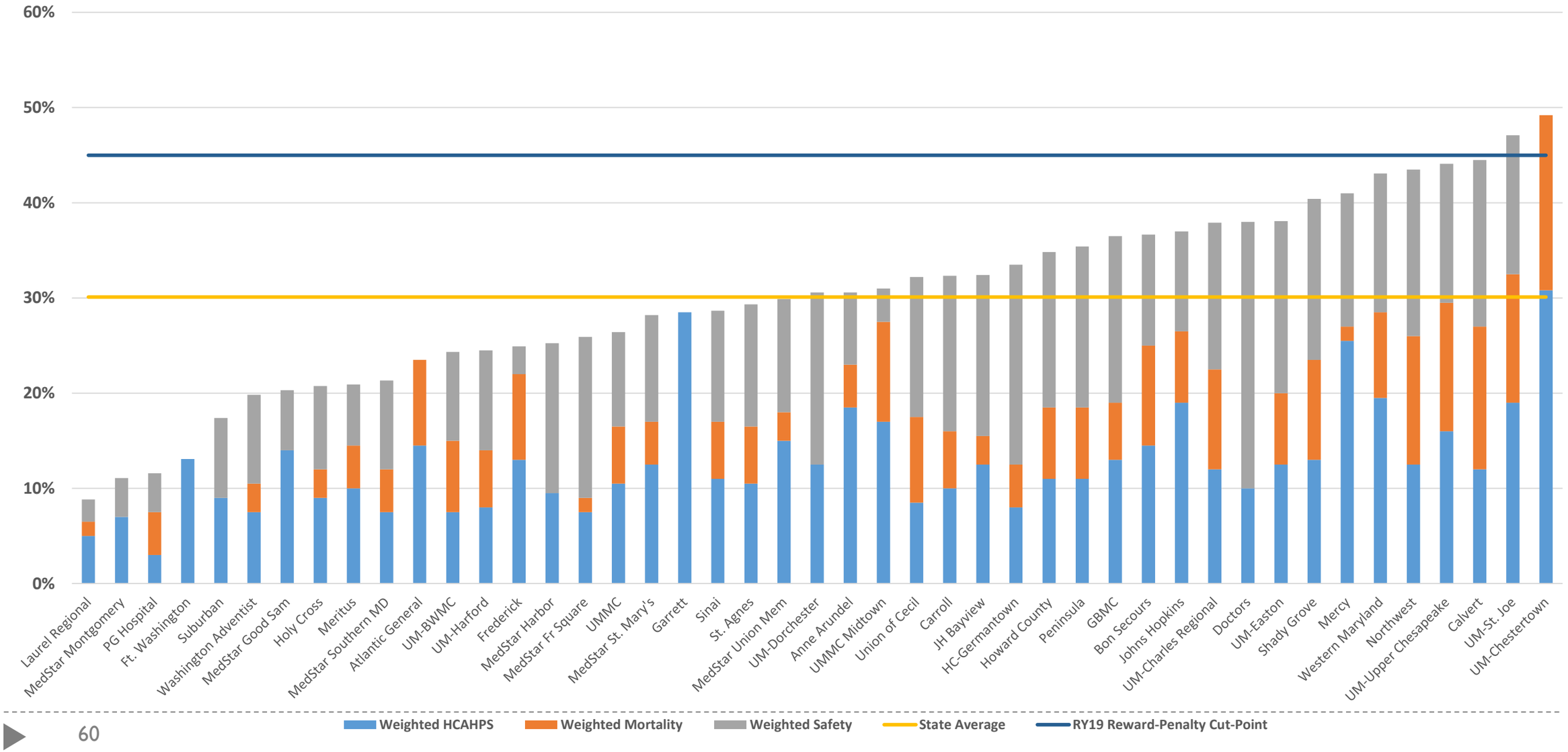
Preset scale of 0-80 with cut point of 45

DIANNE's UPDATED SLIDE: RY 2021 Proposed Timeline

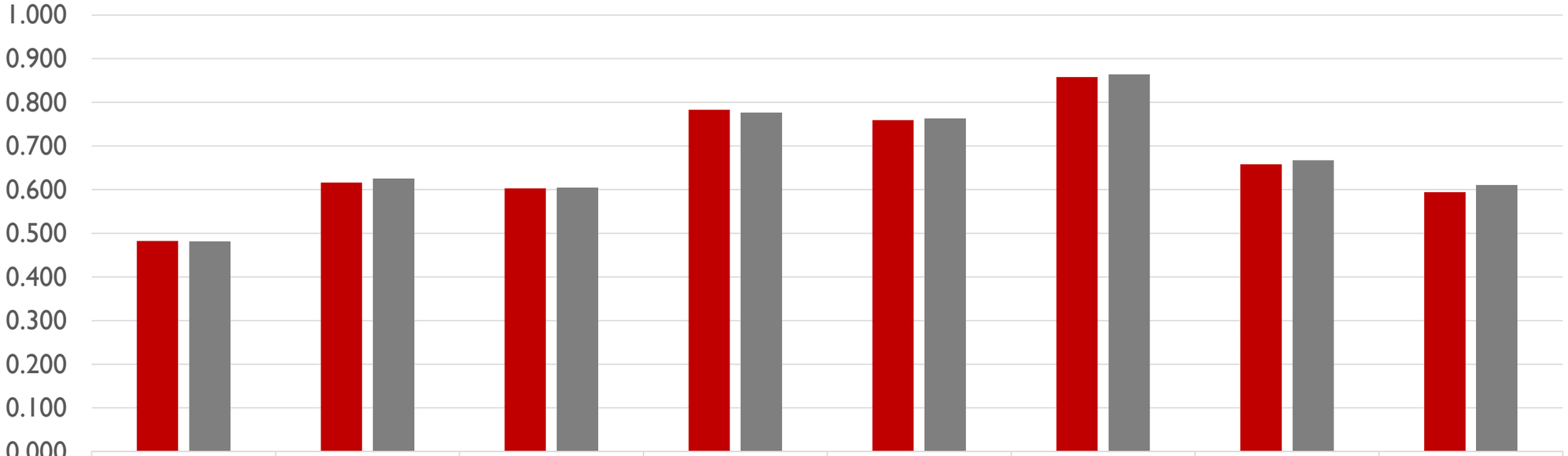
Rate Year (Maryland Fiscal Year)	Q3-16	Q4-16	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20	Q3-20	Q4-20	Q1-21	Q2-21	Q3-21	Q4-21
Calendar Year	Q1-16	Q2-16	Q3-16	Q4-16	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20	Q3-20	Q4-20	Q1-21	Q2-21
Rate Year 2021																						
QBR					Hospital Compare Base Period (HCAHPS measures, ED-1b, ED-2b; All NHSN Measures, PC-01)														Rate Year Impacted by QBR Results			
												Hospital Compare Performance Period (HCAHPS measures, ED-2b) NOTE: ED 1-b, PC-1 removed.									
							QBR Maryland Mortality Base Period															
													QBR Maryland Mortality Performance Period								
			POTENTIAL NEW MEASURES: Hospital Compare 30 Day Mortality AMI, HF, COPD Performance Period*																			
							POTENTIAL NEW MEASURE: Hospital Compare 30 Day Mortality Pneumonia Performance Period*															
		POTENTIAL NEW MEASURE: Hospital Compare THA/TKA Performance Period**																				

*Hospital Compare 30 day mortality Base period: July 1, 2011- June 30, 2014 for AMI, HF, COPD; July 1, 2012-June 30, 2015 for pneumonia
**Hospital Compare THA /TKA Complications Base Period April 1, 2011-March 31, 2014

Current Progress: RY 2019 QBR Scores by-Domain (Final)



RY 2019 Maryland HCAHPS Improvement



	Care Transitions	Clean/Quiet	Comm. Meds	Comm. Doctors	Comm. Nurses	Discharge Info	Overall Rating	Responsive
Base	0.482	0.616	0.603	0.783	0.759	0.858	0.658	0.593
Perf	0.482	0.625	0.603	0.777	0.763	0.864	0.668	0.610

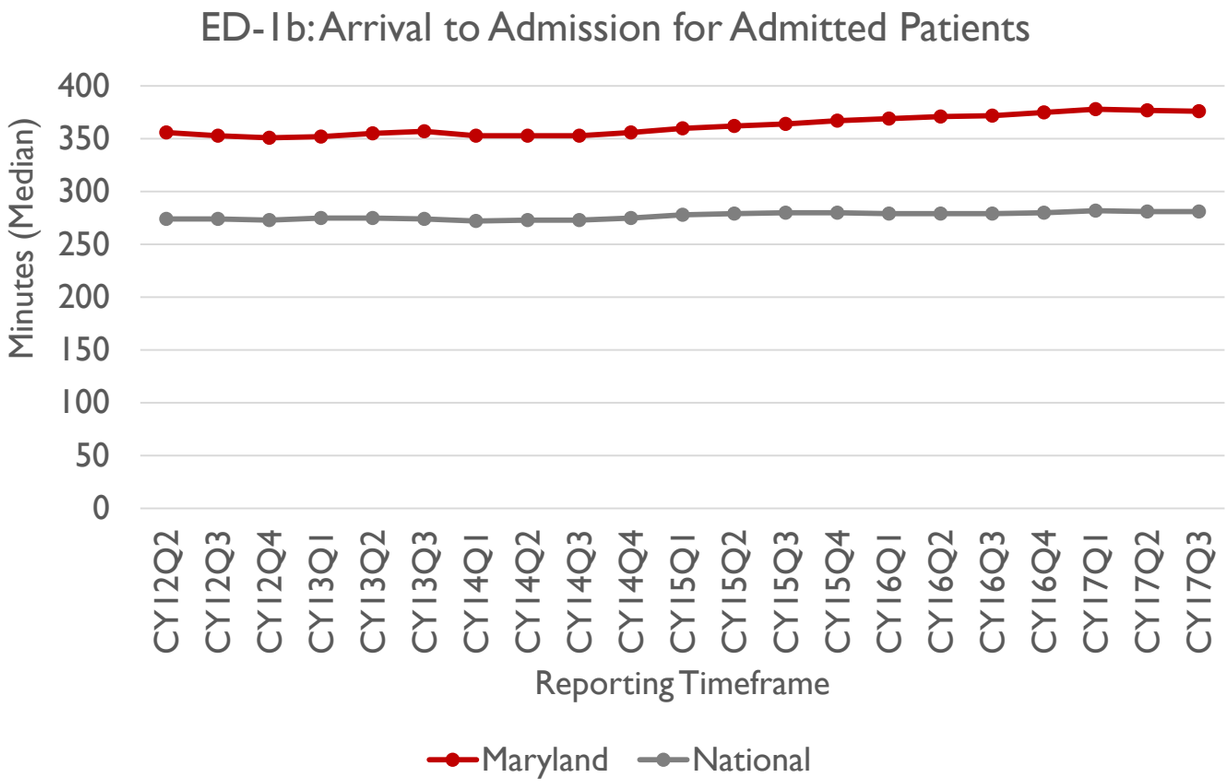
RY 2019 Base = CY 2015; Performance = October 2016 - September 2017

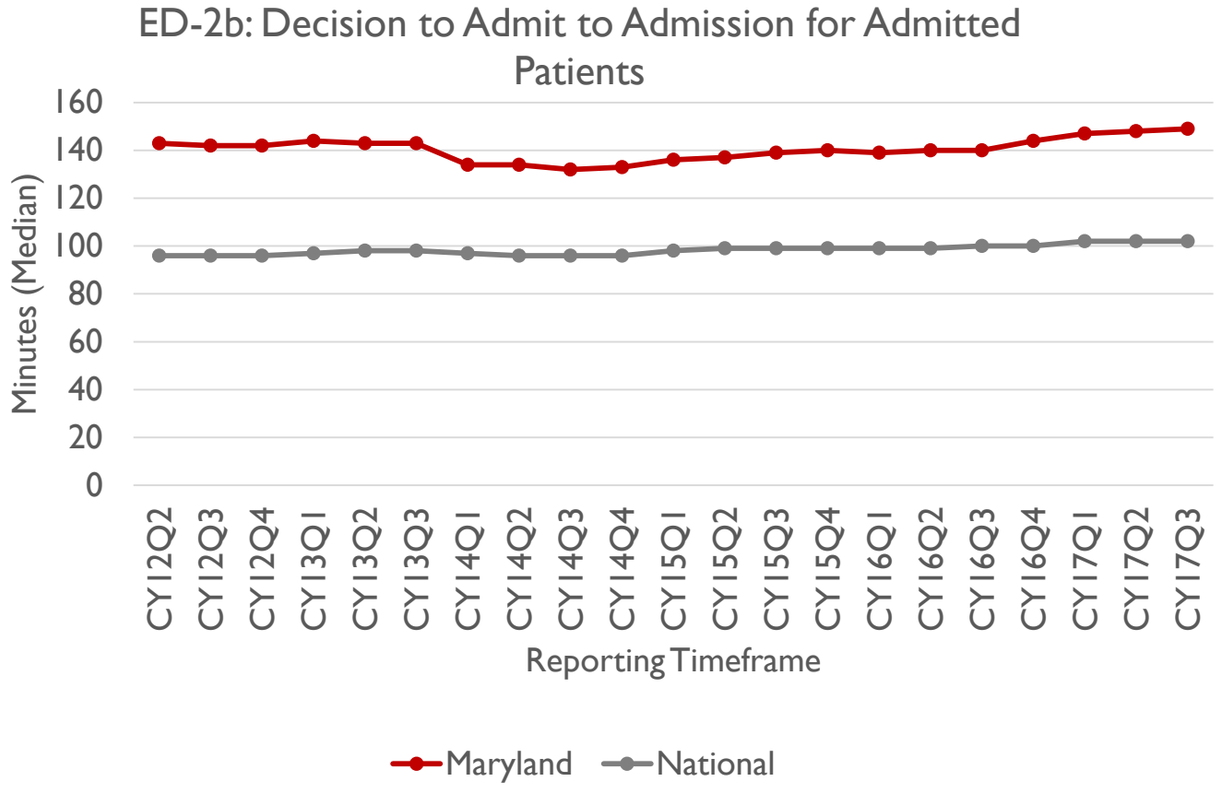
Update on RY 2020 QBR Mortality – Data Collection Change

- Starting with RY 2019 (July) case-mix data submissions, the source of admission and discharge disposition codes have changed and match the UB-04 codes
- Both of these variables are used in the calculation of the QBR mortality measure:
  - Source of admission is used to identify transfer-ins, which is a risk-adjustment variable
  - Discharge disposition is used to remove cases from the denominator

- Currently, the HSCRC plans to use the new codes for the July-December 2018 data and NOT rerun the RY2020 base of first 6 months of performance
  - Analysis shows little impact on hospital scores
- For RY2021, we will need to review the codes and make final decision on whether any adjustments are needed

Performance on ED Wait Time Measures: Update





Next Steps for RY 2021 QBR

- Implement THA/TKA measure for alignment with CMS VBP
- Discuss future inclusion of ED Wait Time Measures
- Review domain weights in regards to safety domain
- Decide on QBR max penalties and rewards and any implications for aggregate at-risk
- Potential Additional Measures (condition-specific mortality)

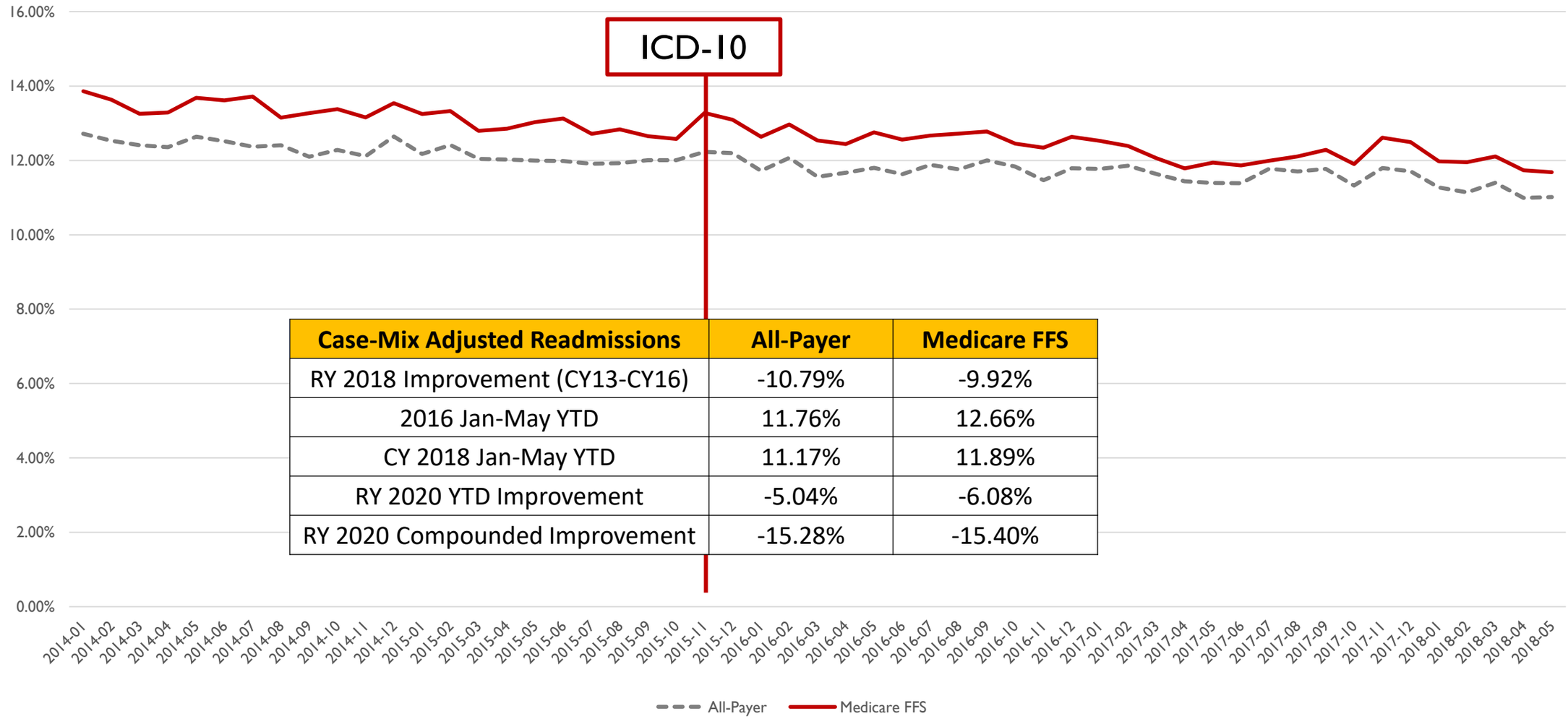
RRIP

MARYLAND

What is the Readmissions Reduction Incentive Program (RRIP)?

- **Measures readmissions** across hospitals in Maryland to incentivize readmission reductions for Medicare and All-Payers.
  - Adjusts All-Payer readmission rates for patient case-mix and severity of illness.
  - Excludes planned admissions from the program using CMS logic with Maryland-specific adjustments (i.e., all deliveries are considered planned).
    - Also excludes: transfers, rehabilitation hospitals, oncology, deaths.
- Measures **hospital performance on an All-Payer basis** as the better of attainment or improvement to determine payment adjustments
  - Adjusts attainment scores to account for readmissions occurring at non-Maryland hospitals.
  - Scales rewards and penalties for attainment based on relative performance to statewide attainment benchmark and for improvement based on relative performance to statewide minimum improvement target.
  - Sets Max Penalty in RY2019 at 2% and Max Reward at 1%.

Monthly Case-Mix Adjusted Readmission Rates

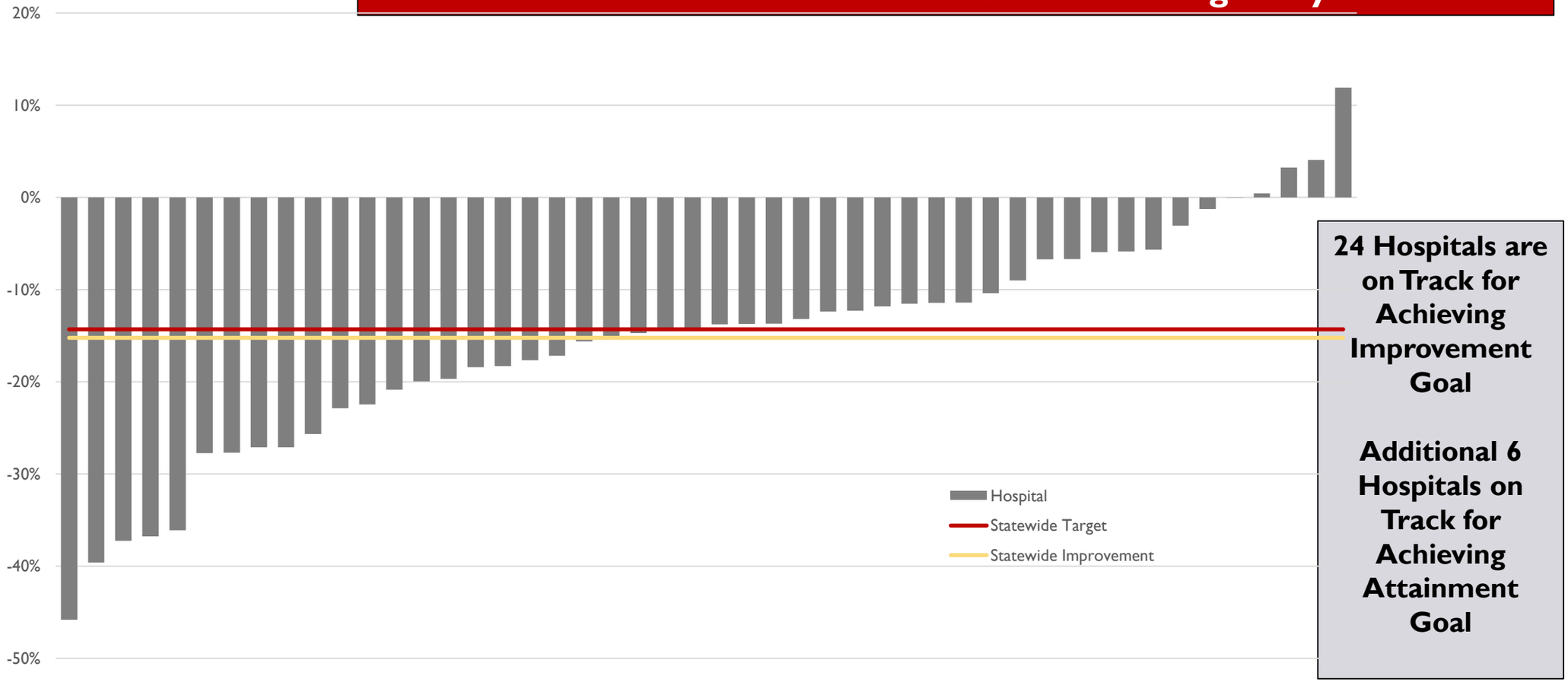


Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
RY 2018 Improvement (CY13-CY16)	-10.79%	-9.92%
2016 Jan-May YTD	11.76%	12.66%
CY 2018 Jan-May YTD	11.17%	11.89%
RY 2020 YTD Improvement	-5.04%	-6.08%
RY 2020 Compounded Improvement	-15.28%	-15.40%

Note: Based on final data for Jan 2013 – Mar 2018; Preliminary data through June 2018. Statewide improvement to-date in RY 2020 is compounded with RY 2018 improvement.

Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital

Cumulative change CY 2013 – CY 2016 (RY2018) Compounded with CY 2016 to CY 2018 YTD through May



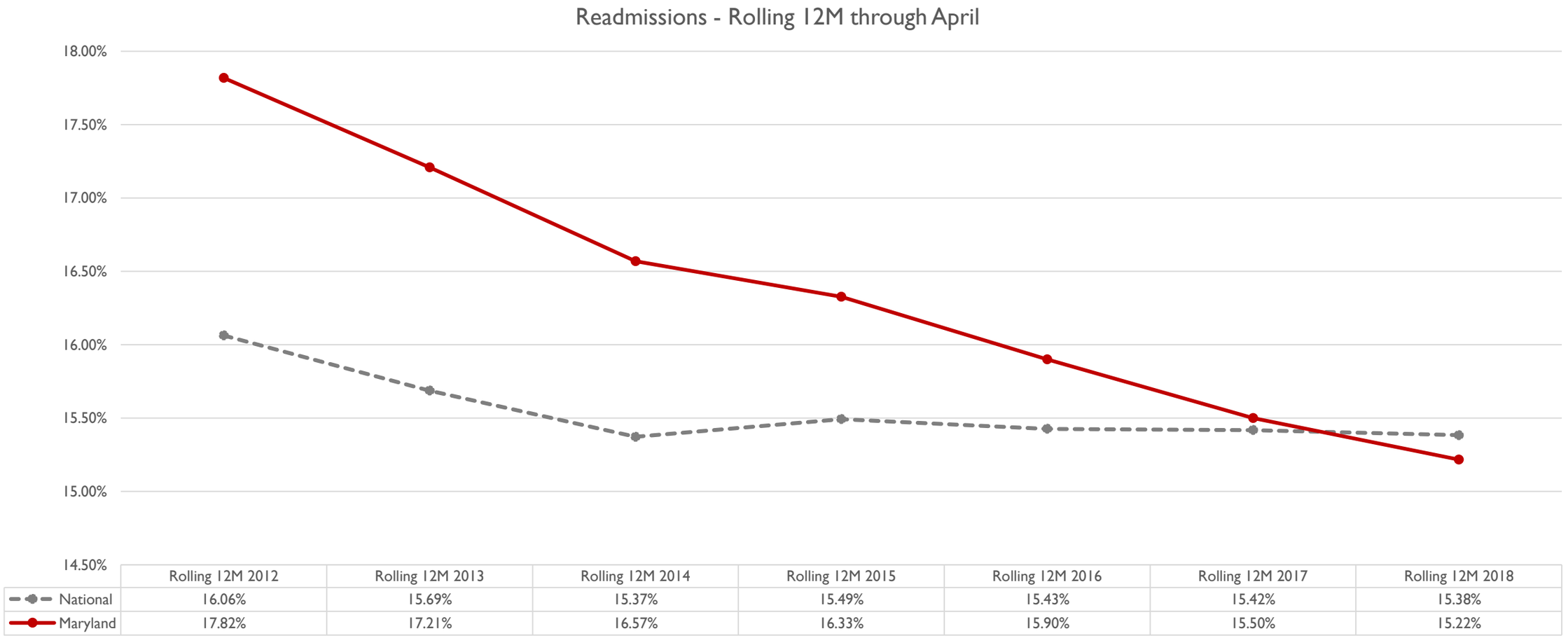
24 Hospitals are on Track for Achieving Improvement Goal

Additional 6 Hospitals on Track for Achieving Attainment Goal

Note: Based on Final data for Oct 2015 - Mar 2018; Prelim through Jun 2018.

HSCRC
Health Services Cost Review Commission

Medicare Readmissions – Rolling 12 Months Trend



	Rolling 12M 2012	Rolling 12M 2013	Rolling 12M 2014	Rolling 12M 2015	Rolling 12M 2016	Rolling 12M 2017	Rolling 12M 2018
National	16.06%	15.69%	15.37%	15.49%	15.43%	15.42%	15.38%
Maryland	17.82%	17.21%	16.57%	16.33%	15.90%	15.50%	15.22%

Data are currently available through April 2018.

RY 2021 Proposed Updates

- Base period – re-base to ICD-10 (CY 2016) or end of All-Payer Model (CY 2018)
  - Compound with previous improvement?
- Grouper version 36*
  - Available October 2016; testing still required
- Widen range between benchmark and threshold under Attainment target

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Quality Programs that Impact Rate Year 2021														
RRIP Incentive	RRIP Base Period (Proposed)										Rate Year Impacted by RRIP			
					RRIP Performance Period (Proposed)									

Additional Considerations for RY 2021 RRIP and Beyond

- RY 2021:
  - Improvement target to ensure MD remains below the Nation in 2019
  - Re-base for improvement target
  - Include Specialty Hospitals in RY 2021 Readmissions - implications
  - Review attainment target methodology

- Beyond:
  - Ongoing Literature Review:
    - Searched the literature for high performing health systems and became aware of innovative approaches utilized to reduce high readmission rates outside of Maryland
    - Examined successes and critiques of the federal HRRP
  - Re-visit Observation Stays >23 hours for potential inclusion
  - Per Capita Readmission or other per capita measures
  - Moving away from improvement to attainment-only readmissions

Contact Information

Email: HSCRC.performance@Maryland.gov

Next Meeting Date is **Wednesday October 17th**