



Performance Measurement Work Group Meeting

1/15/2020

Agenda

1. Welcome and introductions
2. Readmissions Reduction Incentive Program (RRIP)
3. Potentially Avoidable Utilization (PAU)
4. Statewide Integrated Health Improvement Strategy (SIHIS) - Stakeholder Suggestions/HSCRC Update
5. Maryland Hospital Acquired Conditions (MHAC) Program

RRIP

RY 2022 RRIP Draft Recommendations

1. Readmission measure changes:
 - a. Include oncology with cancer-specific clinical adjustments
 - b. Exclude patients discharged AMA from denominator
2. Readmission Improvement Target: -7.5% over five years (-3.07% by end of 2020)
3. Readmission Attainment Target: Maintain current 65 percent attainment threshold for earning rewards based on updated benchmarking
4. Creation and Evaluation of Disparity Metric (Reward-Only)
5. Develop all-payer EDAC to assess ED and OBS revisits

Outstanding Issues

- ▶ Oncology validation
- ▶ Evaluate out-of-state ratio via other payers (Commercial and Medicaid)

Disparity Measure - Options for Discussion

Status Update

- ▶ MPR validation work is largely complete
- ▶ Seeking feedback from Office of Minority Health and Health Disparities, other stakeholders
- ▶ Today's discussion
 - ▶ Policy evaluation
 - ▶ Final policy recommendation

Policy Evaluation

- ▶ Introduction of disparity incentive in payment program is innovative and would make Maryland the first state in the nation to pilot such an approach:
 - ▶ If we only monitor, we cannot gauge the impact of payment incentives
 - ▶ Thus staff recommends implementing in RY 2022 as a reward only program
- ▶ Based on experience with disparity gap metric in payment program, in future years staff may recommend:
 - ▶ Changes to PAI or gap estimation methods
 - ▶ Modification to financial incentives

Staff Proposal

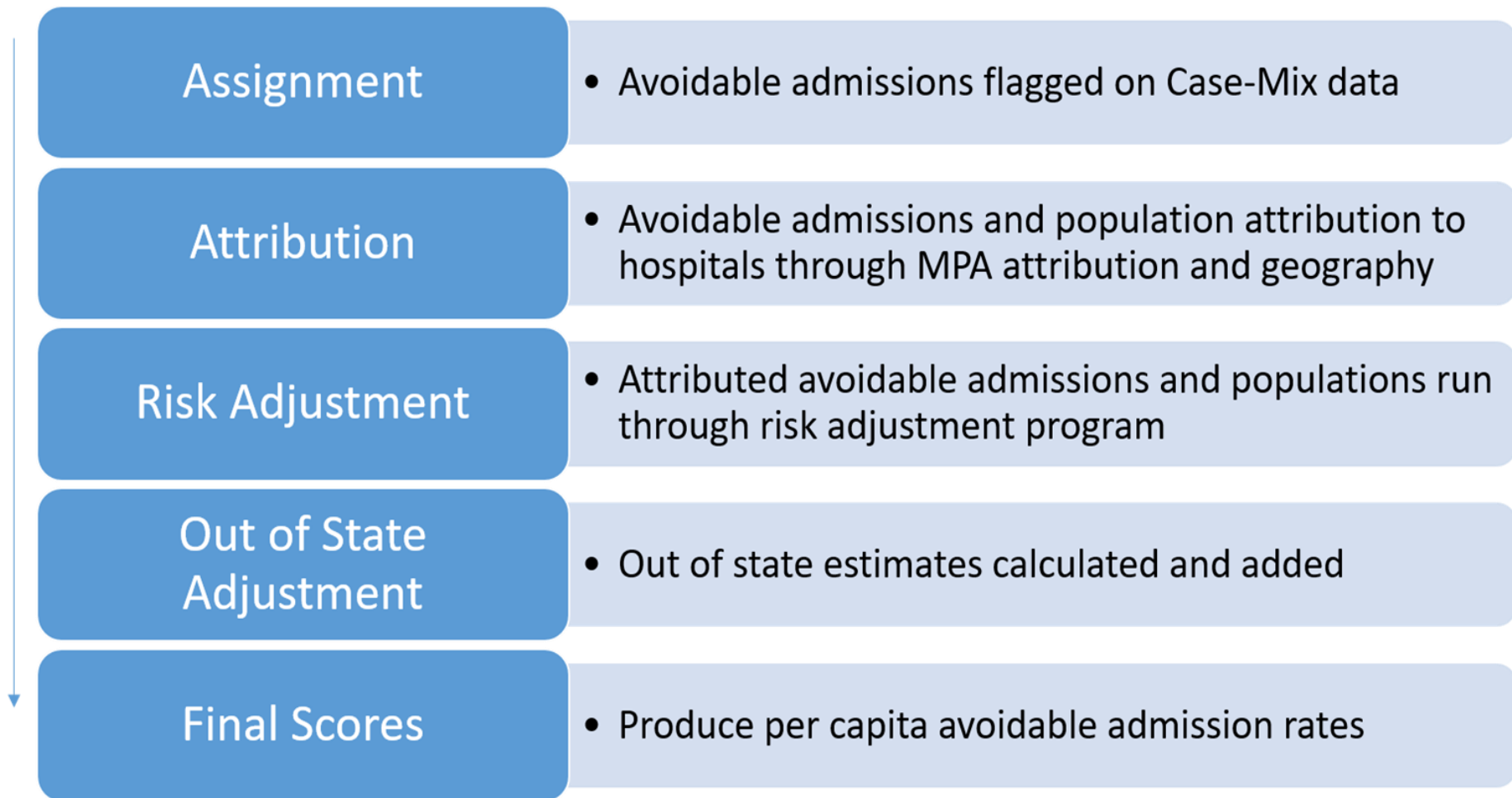
- ▶ Restrict disparity reward eligibility to hospitals with reduction in overall readmission rate
- ▶ **RY 2022:** Base Year 2018 Performance Year 2020
- ▶ Preliminary goal, pending SIHIS development, is a 50% reduction in disparity over 8 year TCOC Model
- ▶ Proposed RY 2022 reward of:
 - ▶ 0.25% of IP revenue for hospitals on pace for 25% reduction in 8 years, $\geq 6.94\%$ reduction in disparity gap
 - ▶ 0.50% of IP revenue for hospitals on pace for 50% reduction in 8 years, $\geq 15.91\%$ reduction in disparity gap

Hospital Reporting

- ▶ Staff will develop quarterly disparity performance analytics for distribution to hospitals in the near future
- ▶ Report components
 - ▶ Descriptives on hospital patient population
 - ▶ % black, % Medicaid, mean ADI
 - ▶ Estimated disparity gap (rolling four quarters) in comparison to hospital's base year
 - ▶ Estimated disparity gap (rolling four quarters) in comparison to other hospitals
 - ▶ Estimated readmission rate by PAI components

Potentially Avoidable Utilization (PAU) Program

PAU Savings Avoidable Admissions Performance Flowchart



Risk Adjustment

- ▶ AHRQ Risk Adjustment program for PQIs and PDIs adapted to be used to produce hospital-level risk adjusted results
- ▶ Age and gender coefficients based on 2016 national data*
- ▶ Results in expected avoidable admissions based on population attributed to a hospital
 - ▶ Calculate observed and expected ratios multiplied by statewide rate to estimate per capita risk adjusted rates

*National data and norms are based on IP data. Maryland PAU Savings Programs use IP+Obs>23 hrs, but analysis shows that using IP norms for IP+Obs>23 hrs does not change hospital results compared to each other



Out of State Adjustment

- ▶ Need to include estimates of out of state admissions for Maryland residents
- ▶ Plan to use actual out of state PQIs/PDIs from payers when available
 - ▶ Anticipating receiving Medicare FFS out of state PQIs this month
 - ▶ Working with Medicaid
- ▶ In the interim, using estimates as placeholders
 - ▶ Based on principal diagnosis estimates from Medicare data, extrapolated to PQI estimates and non-Medicare data

Readmissions

- ▶ Estimated cost of readmissions from your hospital
- ▶ Calculated as the total number of sending readmissions multiplied by the average cost of an intrahospital readmission (to and from same hospital)
- ▶ **NEW:** Exclude categorical exclusions and Ventilator Support charges from calculating the average cost of an intrahospital readmission.

Review CY 2019 YTD Results

- ▶ Released CY 2019 YTD PAU Savings- Performance report on CRISP Portal
- ▶ See handout

RY2021 Adjustment

- ▶ Will bring hospital-specific methodology/modeling to February or March meeting
- ▶ Percent Reduction
 - ▶ Plan on using the inflation-based calculation developed last year to calculate the PAU Savings amount in the spring
- ▶ **New:** Exclude dollars associated with categorical exclusions to align with Innovation policy

PAU Measurement Report

- ▶ Staff intends to present a RY21 and RY22 PAU Measurement Report to the Commission in February.
- ▶ Measurement Report Goals:
 - ▶ Provide progress report on efforts to modernize PAU
 - ▶ Per Capita PQIs
 - ▶ PDIs
 - ▶ PAU subgroup
 - ▶ Low value care exploration
 - ▶ Align PAU Savings program timeline with other quality program timelines (performance measurement determined earlier in performance year)
 - ▶ Request Commissioner feedback on strategic direction

Avoidable ED

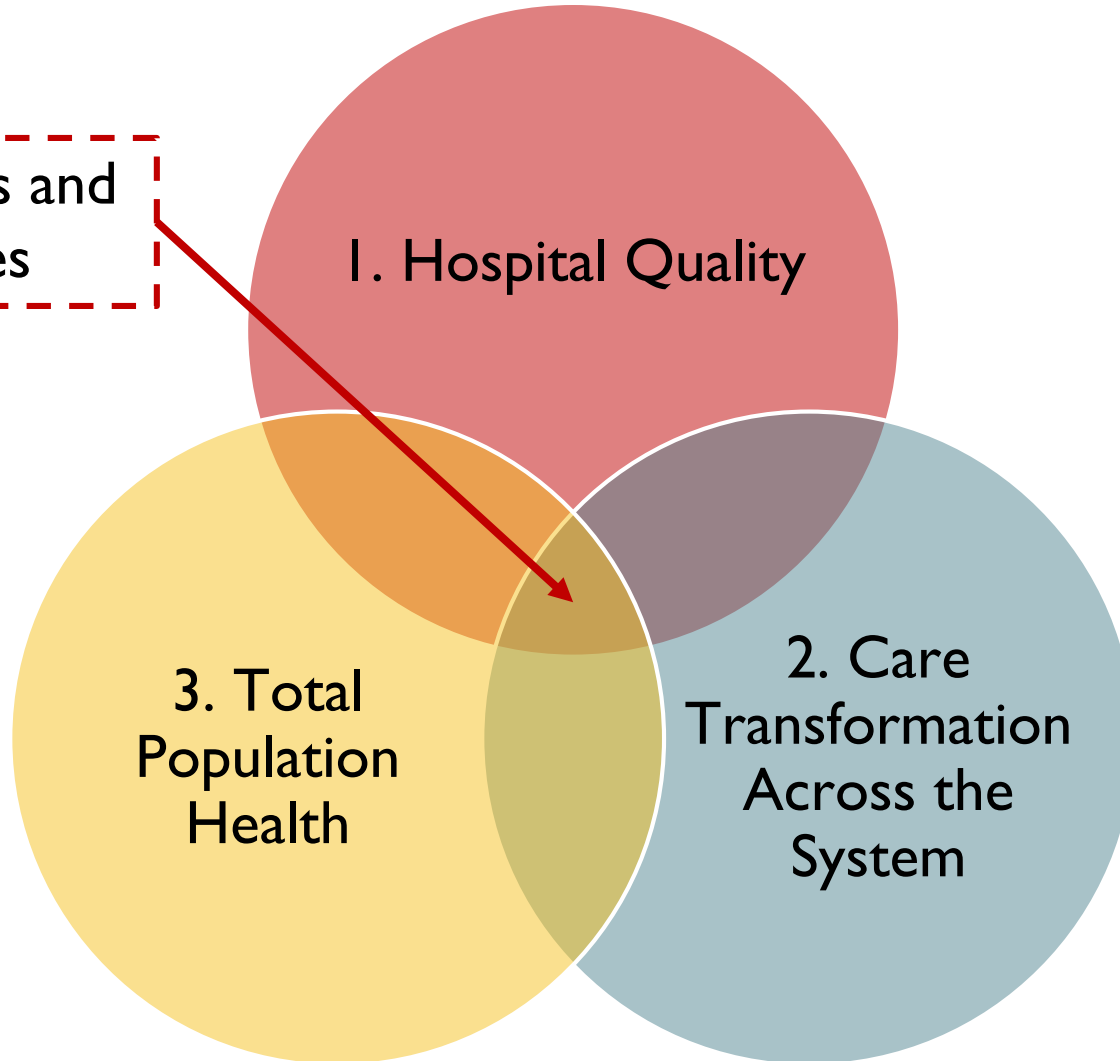
- ▶ Interest in Avoidable ED from payers, stakeholders, commissioners, consumers, MDPCP
- ▶ Questions PMWG can help with:
 - ▶ How to define “Avoidable” ED?
 - ▶ Mathematica doing lit review, present results in next few months
 - ▶ How to use Avoidable ED?
 - ▶ Weigh in on adjustments, risk adjustment
 - ▶ How/if to use in PAU

State Integrated Health Improvement Strategy (SIHIS)

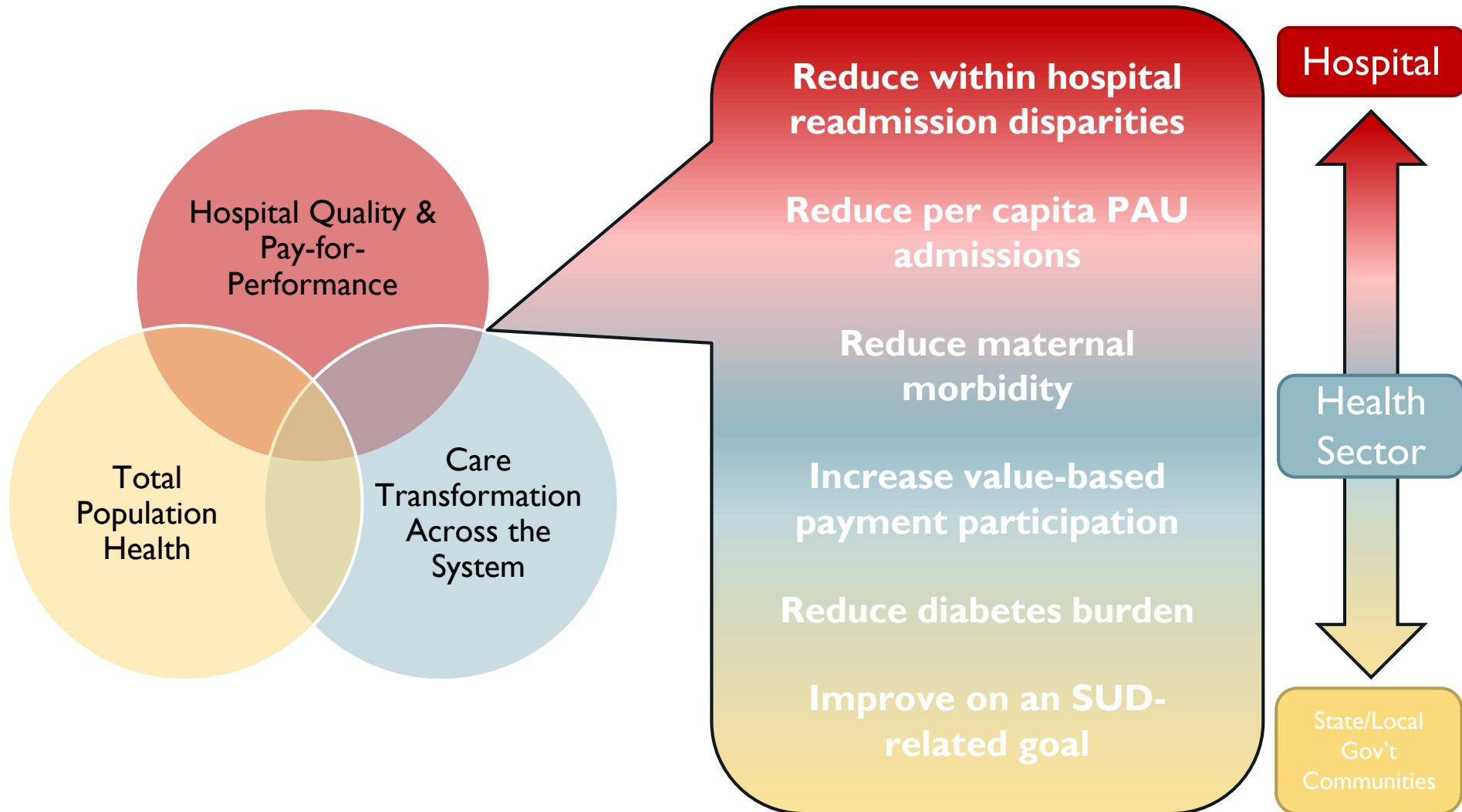
Maryland's Quality and Population Health Strategy

Diverse Approaches for Statewide Integrated Health Improvement Strategy (SIHIS)

Shared Goals and
Outcomes

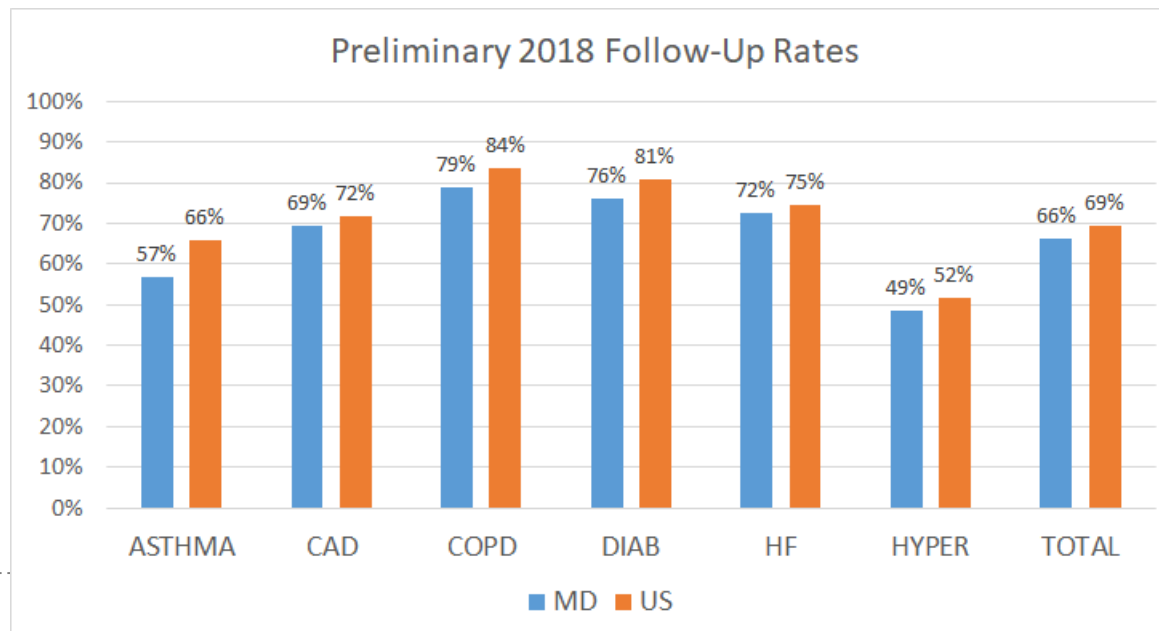


Potential Examples of Shared Outcomes and Goals



HSCRC Update: Per Capita Admits and Follow-up After Discharge

- Updated per capita admission data to include risk-adjustment but still working to trend Maryland data
- Preliminary results for follow-up after hospitalization
 - Confirming denominator exclusions and other measure adaptations
 - Requesting numerator and denominator to assess impact of changes in proportion of discharges with each chronic condition
 - Potential opportunity given preliminary data indicates Maryland performs worse than the nation



Suggested Measures/Topics from Stakeholders

- ▶ What other measures do stakeholders believe should be explored for hospital population health and care transformation across the system goals?
- ▶ Consumers provided suggestions for measures:
 - ▶ Readmissions
 - ▶ Avoidable hospitalizations and ED visits
 - ▶ Prenatal and postpartum care
 - ▶ Behavioral health: follow up after admission and routine health screenings (for diabetes, smoking cessation, etc.).
 - ▶ Diabetes care: Hemoglobin A1c control, admissions for complications
 - ▶ Costs and Resource use: PMPM cost and use Indices, AMI episode of care cost.

Maryland Hospital Acquired Conditions (MHAC) Program

Stakeholder Feedback

- ▶ Four comment letters received: MHA, Carefirst, Hopkins, Garrett
- ▶ Overall letters support the proposed RY 2022 policy except for the following:
 - ▶ Exclusion of small hospital (Garrett)
 - ▶ Resolved with modification
 - ▶ Continued concerns on indirect standardization (Hopkins)
 - ▶ Staff continues to support use of indirect standardization for simplicity and believes the MHAC redesign's focus on higher rate PPCs partially mitigates this issue; will continue to evaluate.
 - ▶ PPC logic and Appeals process (Hopkins)
 - ▶ Staff does not agree this is needed in rate based system
 - ▶ Hold harmless zone (Carefirst)
 - ▶ Staff continues to support hold harmless zone to avoid cliff effects between rewards and penalties and believes hospitals are incentivized to perform even better than hold harmless zone.

RY 2022 Final MHAC Recommendations

- ▶ Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital-acquired complications.
 - ▶ Maintain focused list of PPCs in payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
- ▶ Monitor all PPCs and provide reports for hospitals and other stakeholders.
 - ▶ Evaluate PPCs in “Monitoring” status that worsen and consider inclusion back into the MHAC program for RY 2023 or future policies.
- ▶ Use two years of performance data for small hospitals (i.e., less than 20,000 at-risk discharges and/or 20 expected PPCs). **Revised Recommendation**
- ▶ Continue to assess hospital performance on attainment only.
- ▶ Continue to weight the PPCs in 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.

Minimum Measure Exclusion

- ▶ **Recommend change for in final policy:**
 - ▶ Do not exclude smaller hospitals, instead use two years of performance data for payment program
 - ▶ Set exclusion not on number of PPC measure categories, but instead on number of at-risk discharges and expected PPCs
- ▶ **New Small Hospital Recommendation**
 - ▶ Criteria: Must have 20,000 at-risk discharges and/or 20 expected PPCs across all payment program measures
 - ▶ Propose using base period for determining whether two years will be used to maintain ability to prospectively track

Rationale

- ▶ No exclusions from the national HACRP program
- ▶ Concern that smaller hospitals under GBR deserve credit for low PPC rates
 - ▶ Some of the smaller hospitals with favorable MHAC scores have observed PPCs that are far less than the expected PPCs
- ▶ Observed numbers and O/E ratios for smaller hospitals in some cases exceed numbers or rate of slightly larger hospitals
 - ▶ Exclusion could ostensibly represent a reprieve to hospitals with higher patient complication rates
 - ▶ Sends message to patients who are served by these smaller hospitals

Who is Impacted? What is Impact?

- ▶ Using the criteria proposed on previous slide, 5 hospitals would be scored using two years of performance data (for policy CY18 and CY19)
- ▶ Modeled impact on scores for these 5 hospitals:

HOSPITAL ID	HOSPITAL NAME	At-Risk (FY18 and FY19)	Observed (FY18 and FY19)	Expected (FY18 and FY19)	TOTAL NUMBER OF PPCs (max 14)	Scores with 1 Year Performance Data (FY19)	Scores with 2 Years Performance Data (FY18 and FY19)
210010	UM-Dorchester	6733	5	6.84	3	100%	86%
210064	Levindale	8709	31	11.86	4	0%	7%
210017	Garrett	10889	4	13.97	5	100%	95%
210060	Ft. Washington	11594	1	14.25	5	100%	100%
210013	Bon Secours	22139	43	17.75	5	3%	0%

Version 37 Performance Standards

PPC Number	PPC Description	Threshold	Benchmark
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	1.8882	0.3348
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1.4274	0.4933
7	Pulmonary Embolism	1.5660	0.3091
9	Shock	1.6965	0.3727
16	Venous Thrombosis	1.7715	0.1242
28	In-Hospital Trauma and Fractures	1.5749	0.4468
35	Septicemia & Severe Infections	1.5732	0.3891
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	1.9911	0.4162
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	2.4933	0.4362
42	Accidental Puncture/Laceration During Invasive Procedure	2.1677	0.3735
49	Iatrogenic Pneumothrax	1.6971	0.3351
60	Major Puerperal Infection and Other Major Obstetric Complications	1.6266	0
61	Other Complications of Obstetrical Surgical & Perineal Wounds	1.8975	0
67	Combined Pneumonia (PPC 5 and 6)	1.6422	0.3986

MHAC Modeling Updated

- ▶ **Model 1: RY 2022 Attainment Standards (FY18/19) and CY 19 YTD performance**
 - ▶ Time period for attainment standards overlaps performance period; may underestimate improvements/rewards and overestimate penalties
- ▶ **Model 2: RY 2021 Attainment Standards (FY17/18) and CY 19 YTD performance**

Statewide Revenue Adjustments <small>Updated Modeling all Under v37 PPC Grouper</small>	Model 1: RY2022 Modeling		Model 2: RY2021 YTD Results	
	\$	%	\$	%
Net	\$5,436,695	0.06%	\$20,961,586	0.22%
Penalties	-\$15,261,760	-0.16%	-\$9,000,698	-0.09%
Rewards	\$20,698,455	0.21%	\$29,962,284	0.31%
Median Score	63%		69%	
# Hospitals Penalized	19		14	
# Hospitals Revenue Neutral	10		11	
# Hospitals Rewarded	16		20	

- ▶ Calculated high correlation between 6 and 12 months performance data across multiple years, thus staff are less concerned regarding seasonality

RY 2022 Final MHAC Recommendations

- ▶ Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital-acquired complications.
 - ▶ Maintain focused list of PPCs in payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
- ▶ Monitor all PPCs and provide reports for hospitals and other stakeholders.
 - ▶ Evaluate PPCs in “Monitoring” status that worsen and consider inclusion back into the MHAC program for RY 2023 or future policies.
- ▶ Use two years of performance data for small hospitals (i.e., less than 20,000 at-risk discharges and/or 20 expected PPCs).
- ▶ Continue to assess hospital performance on attainment only.
- ▶ Continue to weight the PPCs in 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.

Next Work Group Meeting

Next PMWG meeting is scheduled for
Wednesday, February 19

