HSCRC Commission Meeting
3/12/2014

Staff Draft Recommendation for Modifying the Maryland Hospital Acquired Conditions Program

Presentation Contents

- Background Overview and Guiding Principles
- Proposed Measurement Methodology Modifications
- Translating Performance into Payment
- Next Steps

Overview and Guiding Principles

Current MHAC Policy Overview Approved by Commission in January 2014

- Implemented in 2009 with performance-based payment adjustments effective in FY 2011
- Use of 3M Proprietary Software: Potentially Preventable Complications (PPC)
- Attainment
  - 2% maximum penalty, revenue neural
  - Based on (~50 out of 65 PPCs based on statistically significant costs and clinical considerations)
  - (Observed PPCs- Expected PPCs (Adjusted for Case mix and based on state-benchmark) * Cost of PPC)/Total Revenue at Risk
- Improvement
  - 1% maximum penalty, revenue neutral
  - Subset of high cost, high prevalence PPCs
  - Observed/Expected ratio aggregated

Guiding Principles for Meeting All-Payer Model Goals for MHAC Program

- Need to achieve the new All-payer model goal: 30% reduction in all 65 PPCs (applies to all payers)
  - CY 2013 base period
  - Measurement period began January 1, 2014
  - 30% Cumulative reduction by 2018
- Breadth and impact of the program must meet or exceed Medicare national program
  - Measures
  - Revenue at risk
- Program must improve care for all patients, regardless of payer
- Program should prioritize high volume, high cost, opportunity for improvement and areas of national focus

Additional Guiding Principles- Staff in Agreement with MHA Proposal

- Predetermined performance targets and financial impact
- Encourage cooperation and sharing of best practices
- Hold harmless for lack of improvement if attainment is highly favorable
- Hospital Ability to track progress

Proposed Measurement Methodology Modifications

Components of Redesign- Staff in Agreement with MHA Proposal

- Measurement Methodology
  - All 65 PPCs
  - Weighting select PPCs for focus
  - Design and calculation of “MHAC Score”
  - Establish thresholds and benchmarks
  - Better of attainment or improvement score

Prioritize a Targeted PPC List- Staff in Agreement with MHA Proposal

- Three 'tiers' of MHACs/PPCs
  - Tier A – Target list of 20 PPCs – highest weight
  - Tier B – PPCs not on target list, but have high percentage attributed to Medicare patients (60%) and affect majority of hospitals (> 43)
  - Tier C – All other PPCs, including those with very low volume, affecting low number of hospitals, Obstetric-related PPCs
- Each tier can be weighted differently to put more emphasis on the target PPCs

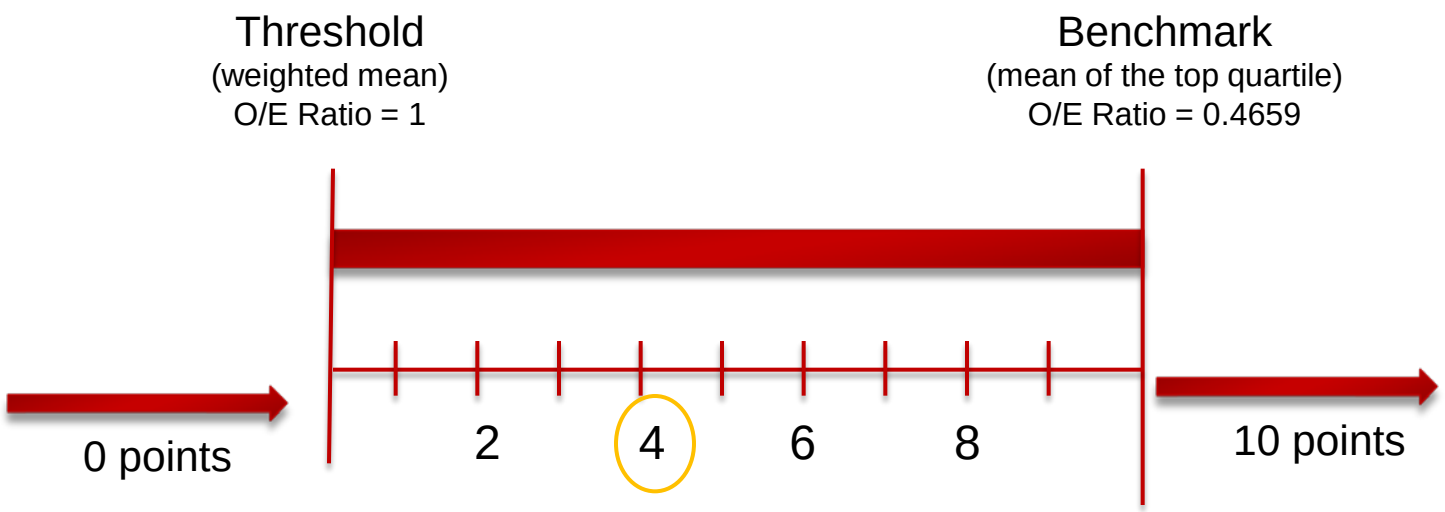
	Weighting	PPCs	FY12 Actual PPCs	FY13 Actual PPCs
Tier A	50%	20	23,102	17,451
Tier B	30%	9	5,166	4,074
Tier C	20%	36	12,259	10,452
	100%	65	40,527	31,977

PPC SCORE and Measurement- Staff in Agreement with MHA Proposal

- PPC Ratio is defined as Observed (O)/Expected (E) value for each measure
- The threshold value is the minimum performance level at which a hospital will be assigned points and is defined as weighted mean of all O/E ratios (O/E =1)
- The benchmark value is the performance level at which a full ten points would be assigned for a PPC and is defined as weighted mean of top quartile O/E ratio
- HSCRC Proposal: For PPCs that are never events, the benchmark will be set at 0.

Attainment Example- MHA Example

PPC 24 – Renal Failure



Hospital O/E = 0.7012

Calculates to an attainment score of 4

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Measurement Issues/Considerations

Previous Exclusions

- APR DRG Cells with < 2 total cases
- Palliative care cases
- Cases with >6 PPCs

New Proposed Exclusions- For Each Hospital:

- PPCs with total expected cases with less than 1
- PPCs with less than 10 at risk cases

Other Measurement Issues

- Define never events
- Refine PPC logic- ongoing discussion with 3M Over time,
- Re-define top performance over time—how high should the benchmark be set? How low can each PPC rate go?

Proposed Revenue at Risk: Must Meet or Exceed CMS Program Percentages for FY 2016

Program	Percent at Risk Medicare	Percent At Risk Maryland
VBP	FFY15 1.5% FFY16 1.75% FFY17 2% of Medicare Base DRG Payments	FFY15 0.5% FFY16 1.0%
Complications	FFY15 1% FFY16 1% FFY17 1% of Medicare Total DRG Payments	FFY15 3% FFY16 4%
Readmissions	FFY15 3% FFY16 3% FFY17 3% of Medicare Base DRG Payments	FFY15 0.3% (Shared Savings Program) FFY16 0.8% (Shared Savings and Readmission Improvement Incentive Program)
Total	FFY15 5.5% FFY16 5.75% FFY17 6%	FFY15 3.8% FFY16 5.8%

Staff Support Consideration of a Risk Tiering Option Where Magnitude at Risk Decreases with Better Statewide Performance

- Potential risk tiering options- to be further deliberated with Workgroup stakeholders. Example:
  - If statewide minimum annual goal of 6.89% (one fifth of the 5-year target) reduction is **not** met, maximum possible penalty of 4% applies and all hospitals receive a penalty.
  - If statewide minimum annual goal of 6.89% reduction is met but the CY2014 goal of 8.5% reduction is **not** met, maximum possible penalty is 3% and no penalties for highest performing hospital.
  - If full CY2014 goal of 8.5% is met, maximum possible penalty 1% with rewards up to ~~1%~~ 2% for the highest performing hospital if enough revenue is collected from worse performing hospitals.

PPC Reduction Trends 2010 to 2013

Potentially Preventable Complication (PPC) Rates in Maryland- State FY2010-FY2013										
	PPC RATES					Annual Change				
	FY10	FY11	FY12	FY13		FY11	FY12	FY13	Average Annual Change	Total FY10-FY13 Change
TOTAL NUMBER OF COMPLICATIONS	53,494	48,416	42,118	34,200		-9.5%	-13.0%	-18.8%	**-13.8%**	-36.1%
UNADJUSTED COMPLICATION RATE PER 1,000 AT RISK CASES	1.92	1.82	1.65	1.41		-5.2%	-9.3%	-14.5%	**-9.7%**	-26.6%
RISK ADJUSTED COMPLICATION RATE PER 1,000 AT RISK CASES	1.92	1.77	1.58	1.3		-7.8%	-10.7%	-17.7%	**-12.1%**	-32.3%

Staff Draft Recommendations for CY 2014 Performance Year that We Will Continue To Vet with Stakeholders

1. Measure hospital performance using Observed (O)/Expected (E) value for each PPC. Define the minimum threshold value to begin earning points as the weighted mean of all O/E ratios (O/E =1). Define the benchmark value where a full 10 points is earned as the weighted mean of top quartile O/E ratio. Establish appropriate exclusion rules to enhance measurement fairness and stability.

2. Set benchmark at zero for PPCs that are never events.

3. Prioritize PPCs that are high cost, high volume, have opportunity to improve, and are of national priority by tiering the PPCs in groups and weighting the groups in the final hospital score commensurate with the level of priority.

4. Establish tiered scaling based on state-wide MHAC performance and update annually based on the trends and CMMI contract goals.

5. Calculate rewards/penalties using preset positions on the scale based on the base year scores.

6. For CY 2014 performance year:

   a. Set minimum MHAC target at 6.89% improvement with a maximum revenue at risk of 4% B. of permanent inpatient revenue if this target is missed.

   b. Set CY 2014 target at 8.5% improvement with a maximum revenue at risk of ~~2%~~ 3% of permanent inpatient revenue if this target is missed.

   C. Set maximum revenue at risk at ~~1%~~ 2% of permanent inpatient revenue if CY 2014 target stated in 6.b. is met.