HSCRC Payment Models Workgroup Meeting 3/13/2014

Maryland Hospital Acquired Conditions Program and Readmissions Improvement Strategy

HSCRC
Health Services Cost Review Commission

Presentation Contents

- Maryland Hospital Acquired Conditions Program
- Readmission Reduction Incentive Program
  - Background Overview and Guiding Principles
  - Proposed Measurement Methodology Modifications
  - Translating Performance into Payment
  - Next Steps

MHAC 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
  - Five high cost- high prevalent 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- HSCRC 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- HSCRC 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

MHAC Score Design Options- HSCRC in Agreement with MHA Proposal

Measure definition new Model Goal metric

	Definition	Risk Adj	Vol Adj
Total # MHACs	# Actual MHACs	N	N
Unadjusted MHAC Rate	# Actual ÷ At Risk Cases	N	Y
O/E Ratio	# Actual ÷ # Expected	Y	Y

Observed to Expected Ratio
Lower numbers are more favorable

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

- 20 PPCs
- High volume, high cost, and opportunity for improvement and national focus
- Heavier weight than non-target PPCs

Since target PPCs are those with high cost and high volume statewide, reducing these will contribute more to the overall model goal.

MHAC/PPC Tiers- HSCRC in Agreement with MHA Proposal for Most Part

- 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.

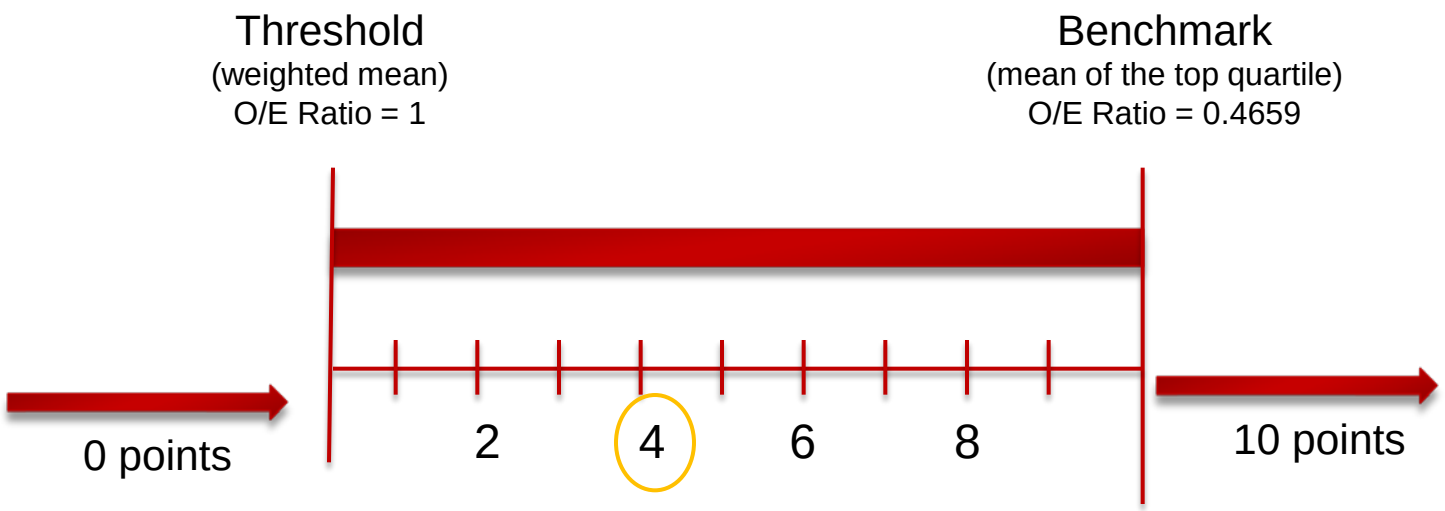
	Weighting	PPCs	FY12 Actual PPCs	FY13 Actual PPCs
Tier A	50%	20	23,102	17,451
Tier B	30%	9	5,166	4,074
Tier C	20%	36	12,259	10,452
	100%	65	40,527	31,977

Defining Thresholds and Benchmarks- HSCRC in Agreement with MHA Proposal

- The PPC measure would be 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

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- Hospital level

- PPC total cases with < 1
- PPCs < 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%

Determining Statewide PPC Reduction Target- 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%

Tiered and Fixed Scaling Approach

- 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 2% for the highest performing hospital if enough revenue is collected from worse performing hospitals.
- Scaling is based on a predetermined points based on base year scores.

READMISSIONS

Background

- Maryland's readmission rates are high compared to the nation.
- The CMMI all-payer model demonstration contract, which began on January 1, 2014, has established readmission reduction targets that require Maryland hospitals to be equal or below rates of Medicare readmissions by 2018.
- Staff has convened three meetings of the Performance Measurement Workgroup to vet a proposed methodology

Maryland Performs Poorly on Broad and DRG Specific Measures of Medicare Readmissions

- Colorado Foundation for Medical Care data on Medicare readmissions in CY 2012: Maryland continues to perform poorly and has one of the highest readmission rates of all states.
- Quarterly trend data from the Delmarva Foundation through September 2013 on Medicare readmissions: reveal that Maryland's readmission rate is substantially higher than the national average.
- Four Maryland hospitals were ranked in the worst 100 hospitals in the nation for each of the three indicators.
- For pneumonia readmissions, one-fifth of Maryland hospitals (n=9) were ranked among the worst 200 hospitals in the nation for excess readmissions.

CMMI All-payer Model Demonstration Contract Requires Maryland to Meet an Annual Readmission Reduction Target

- According to the (CMMI) all-payer model demonstration contract, “If in a given Performance Year Regulated Maryland Hospitals, in aggregate, fail to outperform the national Readmissions Rate change by an amount equal to or greater than the cumulative difference between the Regulated Maryland Hospital and national Readmission Rates in the base period divided by five, CMS shall follow the corrective action and/or termination provisions of the Waiver of Section 1886(q) as set forth in Section 4.c and in Section 14.”

Guiding Principles

- Measurement used for performance linked with payment must include all patients regardless of payer
- Measurement must be fair to hospitals
- First year target must be established to reasonably support the overall goal of equal or less than the National Medicare readmission rate by CY 2018
- Measure used should be consistent with the CMS Measure of Readmissions (also used by Partnership for Patients Program)

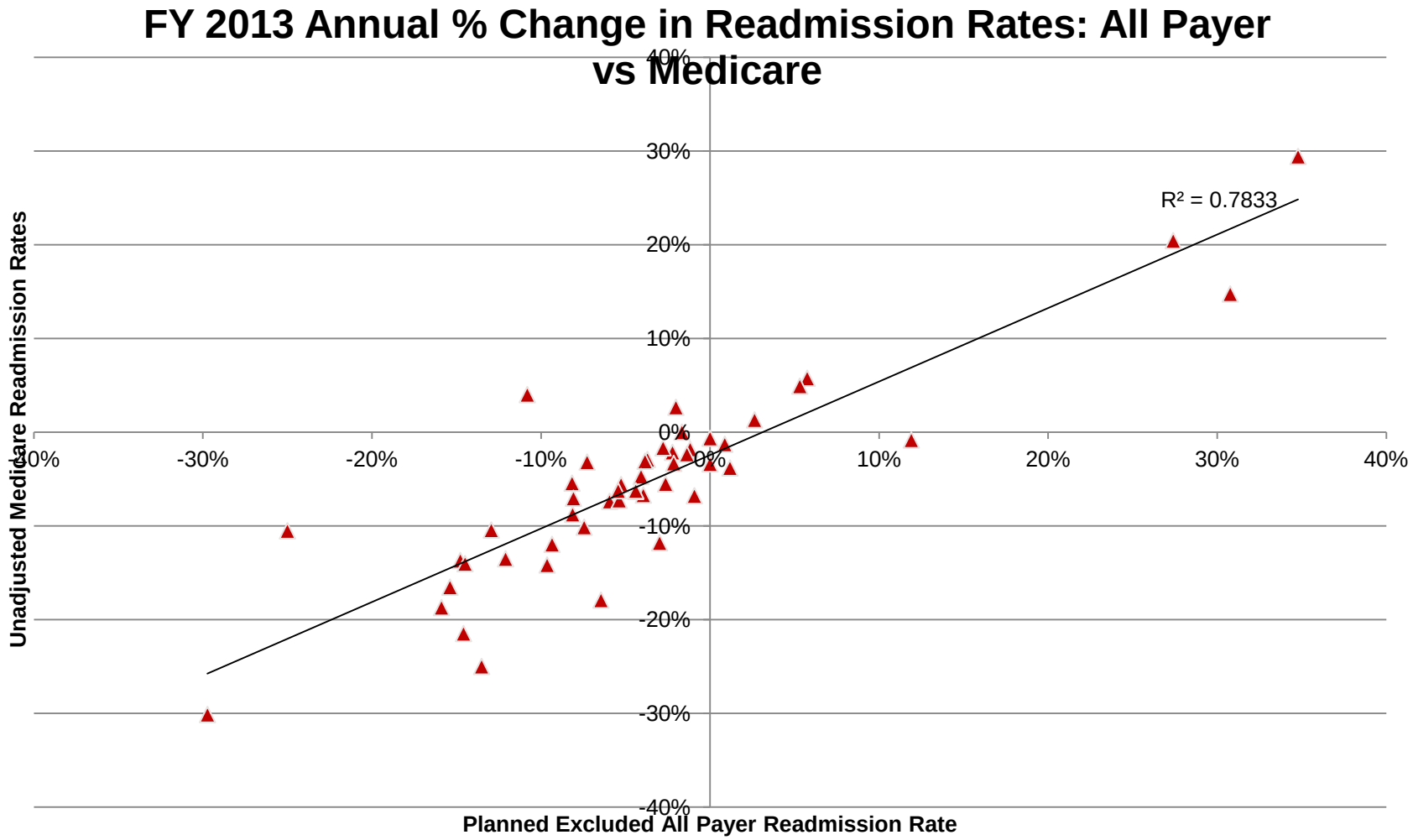
State Readmission Target- 6.8% Reduction

	National Medicare					Maryland Medicare					
	Admissions	Readmissions	% Readmissions	Percentage Point Change	Percent Change in Rate of Readmits	Admissions	Readmissions	% Readmissions	Percentage Point Change	Percent Change in Rate of Readmits	MD- US Difference
FY2010	11,043,196	2,049,473	18.56%			253,320	54,019	21.32%			14.9%
FY2011	11,129,694	2,070,250	18.60%	0.04%	0.22%	248,731	52,032	20.92%	-0.40%	-1.88%	12.5%
FY2012	10,857,862	1,991,886	18.35%	-0.25%	-1.34%	241,681	49,100	20.32%	-0.60%	-2.87%	10.7%
FY2013	10,458,098	1,847,036	17.66%	-0.69%	-3.76%	235,532	45,244	19.21%	-1.11%	-5.46%	8.8%
FY 2014			16.78%	-0.88%	-5.00%			17.91%	-1.30%	-6.76%	6.8%
CY 2014			**16.34%**	**-1.32%**	**-7.50%**			**17.26%**	**-1.95%**	**-10.13%**	**5.7%**

Key Proposed Methodology Components

- **Readmission definition**- Total readmissions/total admissions to any acute hospital
- **Broad patient inclusion-** For greater impact and potential for reaching the target the measure should include all payers and any acute hospital readmission in the state.
- **Adjustments needed for hospital performance measures–** To enhance fairness of the methodology, planned admissions (using the CMS Algorithm V 2.1) and deliveries should be excluded from readmission counts. Basic risk adjustment to be performed using APR-DRG SOIs.
- **Positive incentive**- For hospitals that reach or exceed the goal, they have the opportunity to earn the incentive.
- **Performance measurement consistent across hospitals**- A Uniform achievement benchmark for all hospitals will be established for the first year, and performance will be measured cumulatively for future years.
- **Monitor for unintended consequences**- Observation and ED visits within 30 Days of an inpatient stay will be monitored; possible adjustments may be made if observation cases within 30 days increase faster than the overall observations.

All Payer vs Medicare Readmission Trends



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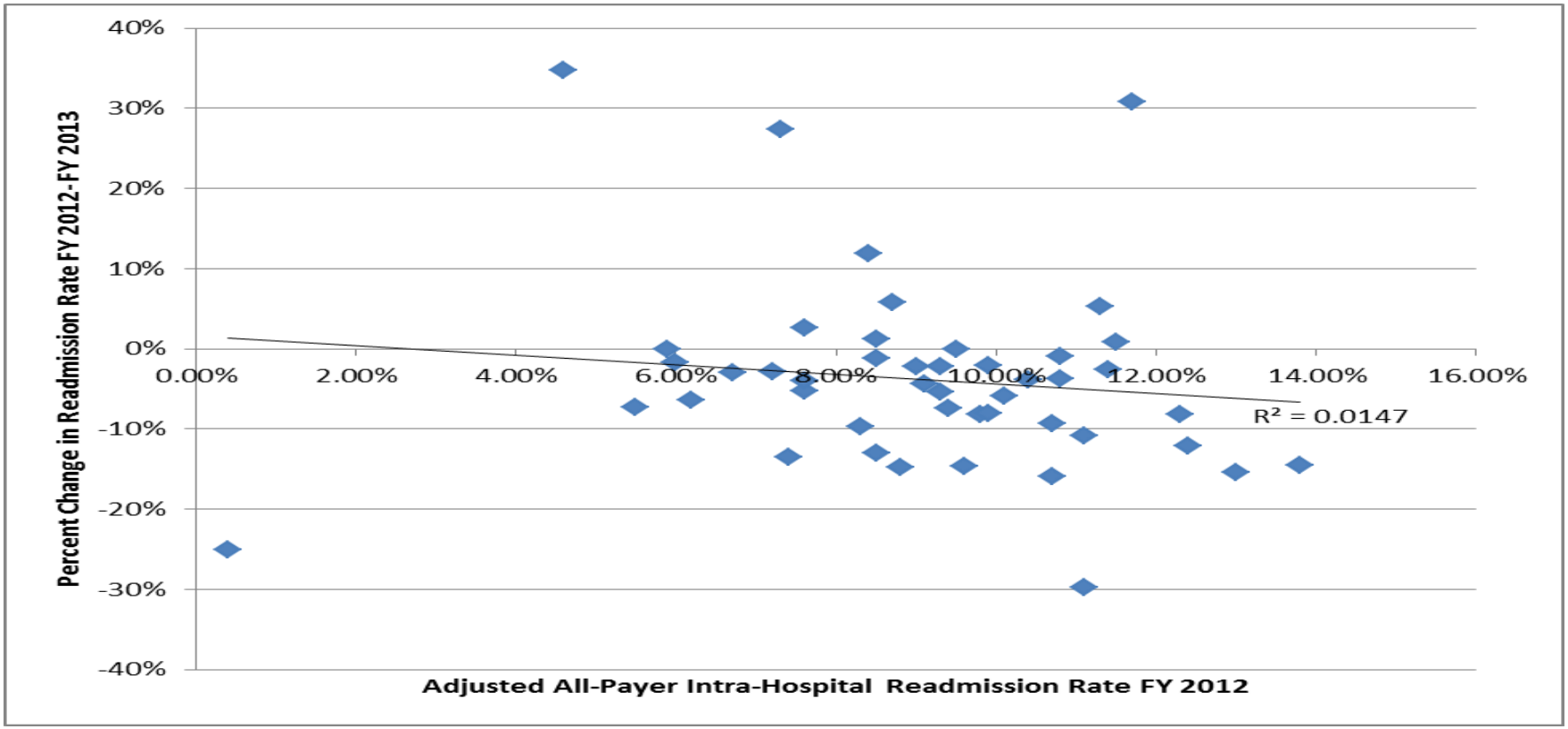
There is no Significant Impact of Base Year Readmission Rates on Readmission Reductions the Following Year



Given the debate whether socio-economic and demographic factors should be used in readmission risk adjustment and that arguments could be made to lower readmission targets for high readmission hospitals if they serve hard to reach populations, staff recommends using a uniform achievement benchmark for all hospitals.

Staff Draft Recommendations

- The Commission should implement a Readmissions Reduction Incentive Program.
- The CMS readmission measure definition specifications should be used with the Maryland adjustments to enhance the fairness of the measure.
- The annual target for the first year, CY 2014, should be a 6.76% readmission reduction with the percentage reevaluated annually.
- A positive incentive magnitude of 0.5% for hospitals that meet or exceed the 6.76% target the first year and achievements should be measured cumulatively for future years.

Ongoing Work

- Continue with CMMI to refine the readmission measure
  - Planned Admissions
  - Rehab-psych subunit
  - Risk adjustment
- Hospital specific measure
  - Risk adjustment
  - Subsequent target determination etc.