New All-Payer Model for Maryland
Performance Measurement Workgroup Meeting
02/06/2014

Overview
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HSCRC
Health Services Cost Review Commission

Maryland and National Healthcare Quality Strategies Articulate Broad Aims and Priorities

- Better Care: Improve the overall quality of care by making healthcare more patient-centered, reliable, accessible, and safe.
- Healthy People, Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- Affordable Care: Reduce the cost of quality healthcare for individuals, families, employers, and government.

Maryland's Programs and Priorities are Aligned with National Quality Strategy's Six Priorities

NATIONAL PRIORITES

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family is engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

MARYLAND PROGRAMS/ PRIORITIES

- Rewards for reducing complications
- Rewards for reducing inpatient admissions/re-admissions
- Rewards for improving clinical care delivery
- Rewards for improving patient experience
- Consider rewards for reducing avoidable utilization through better care
- Engage patients and families in the process
- Incent innovation in local care delivery improvements
- Focus on identifying and treating high needs patients

National Quality Strategy Vision and Mission

Vision

The vision of the CMS Quality Strategy is to optimize health outcomes by improving clinical quality and transforming the health system.

Mission

The CMS Quality Program will serve as a trusted partner with steadfast focus on improving outcomes, beneficiary experience of care, and population health, and reducing healthcare costs through improvement. To maintain this focus, we will:

- Lead quality measurement alignment, prioritization, and implementation and the development of new innovative measures
- Guide quality improvement across the nation and foster learning networks that generate results
- Reward value over volume of care
- Develop and implement innovative delivery system and payment models to improve care and lower costs
- Collaborate across CMS, HHS, and with external stakeholders
- Listen to the voices of beneficiaries and patients as well as those who provide healthcare
- Foster an environment that will create the capacity for providers to improve quality through use of locally generated data and local innovations in care delivery
- Be a model of effective business operations, customer support, and innovative information systems that excel in making meaningful information available
- Develop individuals, create high-functioning teams, foster pride and joy in work at all levels, continuously learn, and strive to improve

National Quality Strategy Values

- **Beneficiaries and Patients Come First** – We put first the best interest of the people we serve.
- **Public Service** – We take pride in our unique and privileged role in the healthcare of the nation.
- **Integrity** – We hold ourselves to the highest standards of honesty and ethical behavior.
- **Accountability** – We earn trust by being responsible for the outcomes of our actions.
- **Teamwork** – We foster unconditional teamwork and regard every employee in CMS as available and willing to help others.
- **External Collaboration** – We strive to work in full cooperation with the private sector.
- **Innovation** – We encourage finding and testing new ideas in all that CMS does.
- **Excellence** – We are committed to strengthening our organizational culture of striving for excellence in our products and services as well as in how we do business.
- **Respect** – We treat all our stakeholders and one another with the utmost respect and professionalism.

Maryland Quality-Based Payment Initiatives

QBR
(Quality Based Reimbursement)

- Clinical Process of Care Measures
- Patient Experience of Care (HCAHPS)
- Mortality, Outcomes

MHAC
(Maryland Hospital-Acquired Conditions)

- 65 Potentially Preventable Complications

ARR
(Admission-Readmission Revenue)

- Admission-Readmission episode bundles
- 30-Day All Cause Readmissions

Maryland Performance Initiatives Linked with Payment

- Revenue neutral adjustment of revenues based on attainment and improvement of PPCs
- The Quality Based Reimbursement (QBR) program was implemented in 2008 with performance linked with hospital rates for FY 2010; this is 3 years in advance of the start of the CMS VBP program.
- The Maryland Hospital Acquired Conditions (MHAC)program was implemented in 2009 with hospital rates adjusted based on performance in FY 2011.
- The Admission Readmission Revenue (ARR) voluntary program measures 30 day all cause readmissions and constructs rates using bundled episodes and began FY 2012

QBR Measures and Domains- FY 2016

Clinical Process of Care	
MEASURE ID	DESCRIPTION
AMI-7a	Fibrinolytic therapy received within 30 minutes of hospital arrival
PN-6	Initial antibiotic selection for CAP in immunocompetent patient
SCIP-Inf-2	Prophylactic antibiotic selection for surgical patients
SCIP-Inf-3	Prophylactic antibiotics discontinued within 24 hours after surgery end time
SCIP-Inf-9	Urinary catheter removed on postoperative day 1 or postoperative day 2
SCIP-Card-2	Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period
SCIP-VTE-2	Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery
NEW! IMM-2	Influenza immunization

Outcome Measures
Inpatient All Cause Mortality
Complication/Patient Safety for Selected Indicators
Central Line Associated Blood Stream Infection

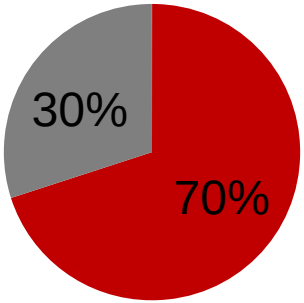
Patient Experience of Care
HCAHPS SURVEY DIMENSION
Communication with nurses
Communication with doctors
Responsiveness of hospital staff
Pain management
Communication about medicines
Hospital cleanliness and quietness
Discharge information
Overall rating of hospital

- Work group on Pay for Performance Methodology started in 2005, implemented in FY 2009
- Measurement Domains for FY 2016 Rate Adjustments
  - **Clinical Care Process Measures (30%)**: heart attack, heart failure, pneumonia, surgical care improvement program
  - **Patient Experience of Care (40%)** – Patient Surveys about satisfaction and communication
  - **Outcomes (30%)–** Mortality, Central Line Blood Stream Infections, Patient Safety Indicators

QBR MEASURES AND DOMAINS

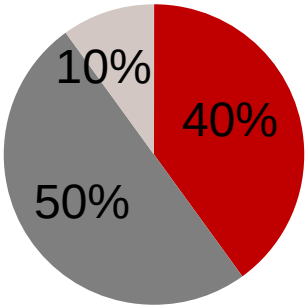
FY 2014

0.5% at risk



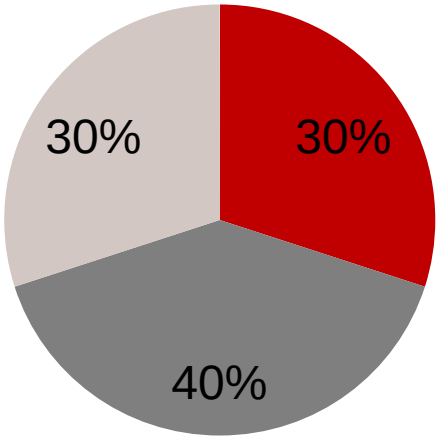
FY 2015

0.5% at risk



FY 2016

1% at risk



Clinical

Patient Experience

Outcome

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Maryland Hospital Acquired Conditions Initiative

- Implemented in July 2009
- Relies on Present on Admission Indicators (POA) for secondary diagnosis
- PPCs are defined as harmful events (accidental laceration during a procedure) or negative outcomes (hospital acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease
- Revenue neutral adjustment of revenues based on attainment and improvement of PPCs

MHAC Components

Attainment Scale

- Includes ~50 PPCs selected based on clinical and data quality
- Score is based on case-mix adjusted PPC rates weighted by the estimated resource use
- Revenue neutral scaling
- Rewards are given if a hospital performs better than 65 percent.
- Maximum reduction is 2 % of total inpatient revenue

Improvement Scale

- Includes 5 PPCs that are high cost, high prevalence and high priority
- Measures percent change from a base year for each hospital
- Revenue neutral scaling
- Rewards are given if a hospitals improves more than 11 %, which is the current median improvement in the base year.
- Maximum reduction is 1 % of total inpatient revenue

Highest Total Cost PPCs (Improvement list is highlighted)

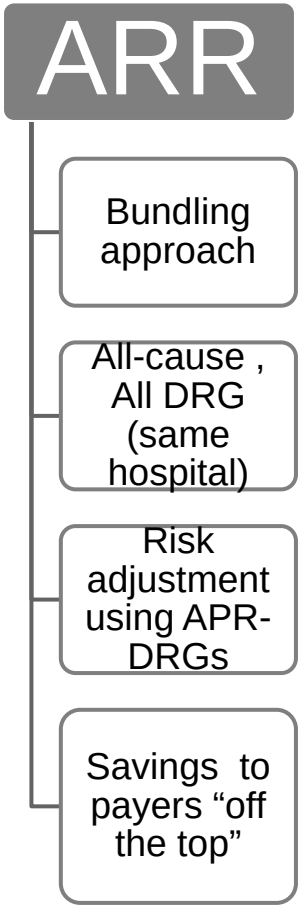
PPC Number and Name		Cost per Case	Number of Hospitals with PPC	Total PPC Count	Expected	Change from FY2011	Total Cost	Total Case Rank	Cost per Case Rank	Total Cost Rank
PPC4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	$32,143	44	1380	1443	-4.4%	$44,357,340.00	8	5	1
PPC65	Urinary Tract Infection without Catheter	$14,549	46	2721	3365	-19.1%	$39,587,829.00	3	26	2
PPC24	Renal Failure without Dialysis	$8,304	46	4534	5052	-10.2%	$37,648,833.80	1	40	3
PPC5	Pneumonia & Other Lung Infections	$19,788	46	1607	1884	-14.7%	$31,799,316.00	5	11	4
PPC14	Ventricular Fibrillation/Cardiac Arrest	$19,093	45	1552	1576	-1.5%	$29,632,336.00	6	12	5
PPC35	Septicemia & Severe Infections	$21,766	45	1314	1663	-21.0%	$28,600,524.00	9	9	6
PPC3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	$9,256	45	2892	3456	-16.3%	$26,766,958.00	2	35	7
PPC9	Shock	$18,126	44	1397	1464	-4.6%	$25,322,022.00	7	16	8
PPC40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	$8,851	44	1851	1993	-7.1%	$16,382,795.08	4	37	9
PPC6	Aspiration Pneumonia	$15,661	45	1016	1108	-8.3%	$15,911,576.00	11	21	10
PPC16	Venous Thrombosis	$17,301	44	916	1041	-12.0%	$15,847,716.00	13	17	11
PPC1	Stroke & Intracranial Hemorrhage	$14,597	44	748	836	-10.5%	$10,918,556.00	18	25	12

QBR and MHAC Base and Performance Periods

Readmissions:Episode-Based Payment

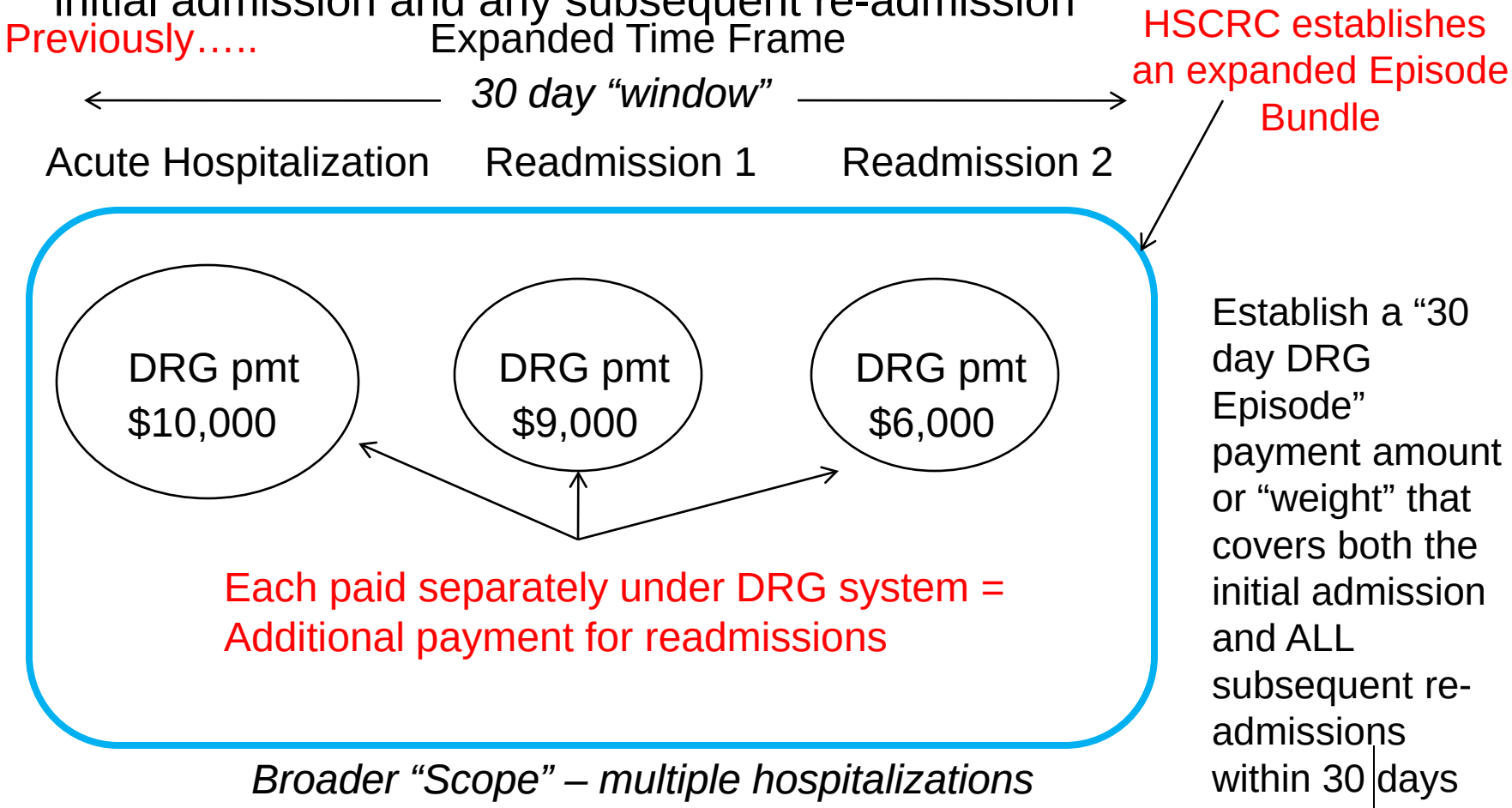
Admission-Readmission Program (ARR)

- All-Cause 30-Day Readmissions and Admissions
- All Payer
- Most Hospitals other than TPR
- Implemented in FY2012



Episode Development

- Maryland establish an episode-based payment that covers both the initial admission and any subsequent re-admission



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Readmission Shared-Savings

- FY 2014 Rate Adjustment to achieve 0.3% savings from inpatient revenues
- Based on Case-mix Risk-Adjusted 30-Day Readmission Rates
- FY 2015: Planned readmissions are excluded
- Possible Changes for FY 2016
  - Incorporation of across hospital readmissions
  - Changing the measurement methodology to align with CMS

Consistent with the National Agenda, Maryland Must Define High Value Healthcare

Characteristics of Low cost and high Quality….

Safe, Efficient and Effective care….

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Maryland Performance Measurement Near Term Focus

Meeting/Exceeding the Payment System Modernization Targets!