



Performance Measurement Work Group Meeting

05/16/2018

HSCRC

Health Services Cost
Review Commission

Agenda

- ▶ **Potentially Avoidable Utilization (PAU)**
 - ▶ PAU in RY 2019
 - ▶ PAU in Future Years
- ▶ **Clinical Adverse Event Measures Work Group – Update**
- ▶ **RY 2020 QBR Status Update**
- ▶ **Summer 2018 – Strategic Priorities**



Ry2019 Draft Potentially Avoidable
Utilization (PAU) Savings

**COMMENT LETTERS DUE THURSDAY
MAY 17, 2018.**

RY2019 Draft PAU Savings

- ▶ Set the value of the PAU savings amount between 1.65 and 1.85 percent of total permanent revenue in the state, which is between a 0.20 and 0.40 percent net reduction compared to RY2018.
 - ▶ Final PAU Savings Adjustment has not been determined.
- ▶ Continue to cap the PAU savings reduction at the statewide average reduction for hospitals with higher socio-economic burden
 - ▶ Solicit input on phasing out or adjusting in subsequent years
- ▶ Evaluate expansion of PAU to incorporate additional categories of potentially avoidable admissions and potentially low-value care



RY 2019 Draft PAU Savings Statewide Calculation

Likely range of RY19 PAU Savings Adjustment is between 1.65% and 1.85%, so staff has modeled at 1.75%

Statewide Results		Value		
RY 2018 Total Approved Permanent Revenue	A	\$16.3 billion		
Total RY18 PAU %	B	11.00%		
Total RY18 PAU \$	C=A*B	\$1.8 billion		
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Statewide Total Calculations		Total	Last year	Net
RY 2018 Revenue Adjustment %	D	-1.75%	-1.45%	-0.30%
RY 2018 Revenue Adjustment \$	E=A*D	-\$285 million	-\$228 million	-\$56 million
RY 2018 PAU Revenue Reduction %	F= E/C	-15.9%		



Hospital adjustments

- ▶ The hospital's percent of PAU revenue is calculated using the hospital CY17 PAU \$ (B) divided by the hospital's CY17 \$ (C)
- ▶ The hospital's percent of PAU revenue (D) is applied to the hospital's permanent revenue (A) to estimate the PAU dollars in the following year (E)
- ▶ The estimated PAU dollars in the following year (E) are multiplied by the % required PAU reduction (F)

		Simple example	Hospital A (total revenue)
Ry18 Permanent revenue	A	\$100	\$187 million
Hosp CY17 PAU \$	B	\$10	\$30 million
Hosp CY17 Total \$	C	\$100	\$197 million
Hosp CY17 PAU %	$D=B/C$	10%	15.4%
Estimated PAU Dollars	$E=D*A$	\$10	\$28.8 million
RY18 PAU Revenue Reduction %	F	-15.9%	-15.9%
Pre protection adjustment (\$)	$G=E*F$	-\$1.59	-\$4.6 million

Denominator impact: Hospital Example

- ▶ Discussion of whether the denominator should be based on total revenue or only on inpatient and observation stays > 23 hrs revenue (IP/obs) given that only IP/obs is currently eligible for PAU
- ▶ Analysis shows no impact of revenue denominator on the Savings Adjustment before protections.

		Simple example (tot rev)	Simple example (IP/obs)	Hospital A (total revenue)	Hospital A (IP/obs revenue)
Ry18 Permanent revenue	A	\$100	\$50	\$187 million	\$119 million
Hosp CY17 PAU \$	B	\$10	\$10	\$30 million	\$30 million
Hosp CY17 Total \$	C	\$100	\$50	\$197 million	\$125 million
Hosp CY17 PAU %	D=B/C	10%	20%	15.4%	24.3%
Estimated PAU dollars	E=D*A	\$10	\$10	\$28.8 million	\$28.8 million
RY18 PAU Revenue Reduction %	F	-15.9%	-15.9%	-15.9%	-15.9%
Pre protection adjustment (\$)	G=E*F	-\$1.59	-\$1.59	-\$4.6 million	-\$4.6 million



Hospital Protections

- ▶ RY2019 recommendation: Cap the PAU savings reduction at the statewide average reduction for hospitals with higher socio-economic burden*
- ▶ Protections Step 1: Hospitals eligible for protections receive either their calculated adjustment % or the statewide average of -1.75% (whichever is lower)
- ▶ Protections Step 2: add in additional PAU revenue reductions to account for protected revenue

▶ *defined as hospitals in the top quartile of % inpatient + obs >23 hrs equivalent case-mix adjusted discharges (ECMADs) from Medicaid/Self-Pay over total inpatient + obs >23 hrs ECMADs

Impact of denominator on hospital protections

- ▶ A different denominator does not impact the Savings adjustment before protections, but does impact protected hospitals and the subsequent redistribution of revenue adjustment.
- ▶ The statewide average of PAU revenue using IP/obs rev is 18.3%, compared to 11% under total revenue.
 - ▶ This does not matter pre-protection, as the PAU rate is multiplied by the respective revenue
 - ▶ This does matter for the protection since protected hospitals are capped based on the statewide average
- ▶ The difference between a protected hospital's calculated reduction and the statewide average reduction determines how much benefit the hospital receives from the protection.
- ▶ See differences in Step I adjustment in the Comparison Workbook.



Denominator for RY 2019 PAU Savings

- ▶ Staff analyzed concern regarding denominator as Total Revenue or IP/OBS Revenue
- ▶ After conducting analysis, there is no impact of denominator in pre-protected PAU Savings adjustments.
 - ▶ Impact post-protection is minimal when distributed across hospitals.
- ▶ HSCRC staff believes that RY 2019 PAU Savings Policy should continue to use Total Revenue.
 - ▶ Focusing on total revenue aligns with the goals of the GBR
 - ▶ Per Implementation Plan Handout, will further review Protections in future years.
 - ▶ Additionally, planned expansion of PAU measure may alleviate concern with current IP/OBS focus of PAU measure.



Future Potentially Avoidable Utilization (PAU)

Hospital Protections Discussion

- ▶ Rationale: Hospitals serving populations with lower socio-economic status may need additional resources to reduce PAU %
 - ▶ PAU Savings does not include improvement, which may offer more of an opportunity for hospitals serving high need patients
 - ▶ Protections limits this potential annual disadvantage
- ▶ Concern: does this provide less incentive for reducing PAU among hospitals with lower socio-economic status?
 - ▶ In future years, should protection be adjusted based on improvement?
 - ▶ In future years, should protection be phased out?

*defined as hospitals in the top quartile of % inpatient + obs >23 hrs equivalent case-

- ▶ mix adjusted discharges (ECMADs) from Medicaid/Self-Pay over total inpatient + obs >23 hrs ECMADs

Potential PAU Timelines

RY2021 PAU

- ▶ Solicit input on broad areas of PAU and hospital-defined PAU (March-April)
- ▶ Develop workplan for RY2021 PAU and/or for incorporating hospital-defined PAU (April)
- ▶ Perform analyses and solicit continual input on RY2021 specific measures and their feasibility **through informal subgroup** (Spring-Fall)
- ▶ Begin reporting on potential RY2021 PAU measures (Fall-Winter)
- ▶ Performance period for RY2021 PAU (CY 2019)

RY2019 PAU Savings Policy

- ▶ Draft RY19 PAU Savings Policy (May 2018)
 - ▶ **COMMENTS DUE MAY 17**
- ▶ Final RY19 PAU Savings Policy (June 2018)



Informal PAU Subgroup

- ▶ To meet ambitious goals, HSCRC plans to hold a few meetings over the summer with interested parties on PAU measures and hospital-defined PAU.
- ▶ Discussion will focus on measures, domains, and feasibility to report back to WG
- ▶ Please email Quality inbox or let laura.mandel@Maryland.gov know if you or other colleagues are interested in participating.



Broad Areas of PAU discussion

- ▶ **Considerations:**
 - ▶ **Capture larger amount** of potentially avoidable utilization
 - ▶ Be more **comprehensive** across hospital service lines
 - ▶ Be **aligned** with current and future hospital interventions
 - ▶ Grounded in literature
- ▶ What sorts of domains should the PAU expansion cover?



Alignment with example hospital interventions

Hospitals are implementing programs around population health and care coordination that may not be captured in current measurement of PAU

Hospital supported intervention examples	Potential type of measure
Physicians rounding in skilled nursing facilities	Avoidable admissions from nursing homes
90 day care coordination after admission	90 day readmissions
ED care management, chronic condition clinics	Condition-specific ED revisits (asthma, diabetes, etc.)
Fall prevention/ seniors at home programs	Fall-related ED or hospitalizations
Prenatal community care	Low birthweight PQI
Green and Healthy home initiatives	Pediatric PQIs



Potentially low value care

- ▶ **Low value care is defined as medical care in which potential harms outweigh potential benefits**
 - ▶ Harms can include inappropriate treatment, false positives, clinical risks, and unnecessary consumer cost.
 - ▶ Example: cardiac imaging for individuals with low risk of cardiac disease
- ▶ **Who determines what is low value?**
 - ▶ Individual level: patients and doctors should determine whether services are appropriate and valuable in each particular circumstance
 - ▶ System level: High rates of low value care at certain hospitals may indicate unnecessary or harmful care for patients.
- ▶ **Measures under consideration should be supported by clinical recommendations, consumer advocacy groups, and research.**
- ▶ **Ongoing stakeholder input on these measures is crucial as we consider the inclusion of low value care measures in PAU**



Additional Considerations for specific PAU Measures and use

- ▶ **Measure details and availability**
 - ▶ Link to revenue?
 - ▶ Available on an All-Payer basis
 - ▶ Measurable/reportable in HSCRC case mix data?
- ▶ **Current use of PAU**
 - ▶ PAU Savings Program
 - ▶ Market Shift
 - ▶ Demographic Adjustment
 - ▶ Consideration in Rate Reviews
- ▶ **Should all the programs using PAU use the same definition or could there be different definitions?**
 - ▶ For example, market shift needs to be based on revenue, but the scaling for PAU Savings does not necessarily need to be based on revenue



Hospital-defined PAU concept

- ▶ Commissioner white paper suggestion that hospitals should have the opportunity to propose programs designed to reduce unnecessary care.
 - ▶ Proposals grounded in literature, data, physician leadership, etc.
 - ▶ Hospitals would submit specific details of planned programs and expected reductions.
 - ▶ Hospitals with approved proposals could be exempt from the standard PAU policy.
- ▶ RY2019 PAU Policy will discuss future directions for the PAU program, including the suggestion around hospital-defined PAU
 - ▶ Stakeholders are encouraged to submit responses through comment letters for May Commission or oral testimony at June Commission



Hospital-defined PAU Discussion

- ▶ Is there interest in hospital-defined measurement of PAU?

- ▶ How should/could hospital-defined PAU be used?
 - ▶ PAU Savings:
 - ▶ Given that PAU Savings Policy relatively ranks hospitals, how could PAU Program be redesigned to allow hospitals to opt out of standard?
 - ▶ How would hospitals opting out be evaluated?
 - ▶ Market Shift
 - ▶ Rate Reviews:
 - ▶ Should hospitals be able to propose approaches to reduce self defined PAU for the purposes of future year rate reviews?



Complications in TCOC Model – Update

Complications Sub-Group – Deliverables Update (RY 2021; CY 2019)

- ▶ **Develop a *Measure Evaluation Framework***
 - ▶ *Identify high priority clinical areas*
 - ▶ *Develop criteria for formal measure selection process.*
- ▶ **Create a Preliminary *MHAC Measures Under Consideration* (MHAC MUC) list from the existing inventory of available measures, including:**
 - ▶ *Current MHAC patient safety measures;*
 - ▶ *Current QBR patient safety measures; and/or*
 - ▶ *Other measures that meet criteria*
- ▶ **Conduct *in-depth analysis* on MUC measures, to include:**
 - ▶ Reporting Requirements and Measure Definitions (including limitations)
 - ▶ Data Availability
 - ▶ Current Trends; by-Hospital distribution
- ▶ **Develop *consensus recommendation* on performance measures in the MHAC program regarding payment commitments under the TCOC Waiver**



Complications Sub-Group: Anticipated Timeline for Phase I (Subject to Updates)

▶ *Mar 27, 2018*

- ▶ *Reviewed CMS HAC measures*
- ▶ *Discussed measure selection process and criteria*
- ▶ *Discussed candidate measures inventory*

▶ *Apr 24, 2018*

- ▶ *Continue discussion of candidate measures/review specification sources*
- ▶ *Review 3M Potentially Preventable Complication (PPC) measures/methodology*
- ▶ *Review Leapfrog Safety Grade methodology*

▶ **May 22, 2018**

- ▶ PSI measures- methodology discussion
- ▶ CDC NHSN measures- Maryland/National analysis review and discussion
- ▶ PPC measures- volume and variation analysis review and discussion

▶ **Jun 28, 2018**

- ▶ PSI measures- review of counts by hospital
- ▶ Continue measure selection process
- ▶ Discuss scoring and scaling issues

▶ **July-August Date TBD**

- ▶ Review draft measure set with data sources, timelines, risk adjustment, scoring and scaling
- ▶ Define gaps in measurement

▶ **September- Date TBD**

- ▶ Deliverable: Measure recommendations for RY 2021
- ▶ Include identified gaps in recommendation

▶ **October- Date TBD**

- ▶ Deliverable: Final measure recommendations for RY 2021; including acknowledgment of measure gaps



QBR Status Update – ED Wait Times – Additional Adjustment

RY 2020 ED Wait Time Measures

- ▶ Two ED Wait Time measures in RY 2020 QBR Program
 - ▶ Under **Person and Community Engagement** Domain
 - ▶ Weighted at ~4% each of total QBR score (max potential revenue adjustment per measure is ~0.08%)
- ▶ **ED-1b**: Median time (in minutes) patients spent in the ED, before they were admitted to the hospital as an inpatient. A lower number of minutes is better
- ▶ **ED-2b**: Median time (in minutes) patients spent in the ED, after the doctor decided to admit them as an inpatient before leaving the ED for their inpatient room. A lower number of minutes is better



Risk adjustment and mean wait time difference: Maryland and National Average

Risk-Adjustment	Regression Description	ED_1b	ED_2b
None	Unadjusted average wait time difference US and MD	120	63
Volume Only	Average wait time difference adjusted for volume	86	37
Full Model	Average wait time difference adjusted for all factors	74	28

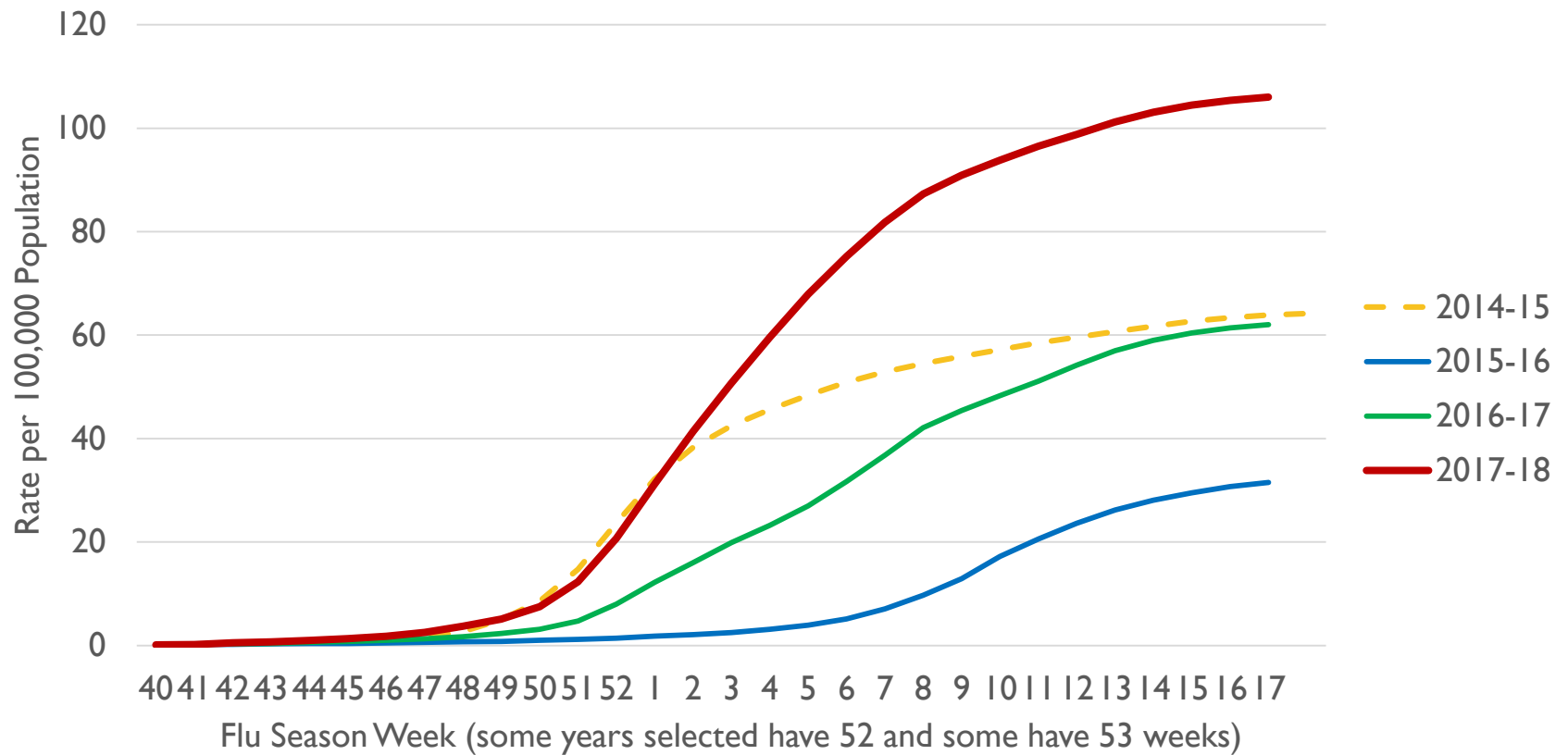
QBR – ED Wait Times – Additional Adjustment?

- ▶ Per final (approved) RY 2020 QBR policy, commissioners recommended that staff and industry explore additional risk adjustment beyond ED volume by June 2018
- ▶ Additional factors were considered in univariate and multivariate analysis, presented at last month's PMWG
 - ▶ While factors such as occupancy and DSH were statistically significant in multivariate models, the explanatory value of these additional variables was minimal when compared to volume.
 - ▶ While additional risk-adjustment is important for measuring attainment, it would be complex to implement.
 - ▶ When measuring improvement, additional risk-adjustment is less critical.



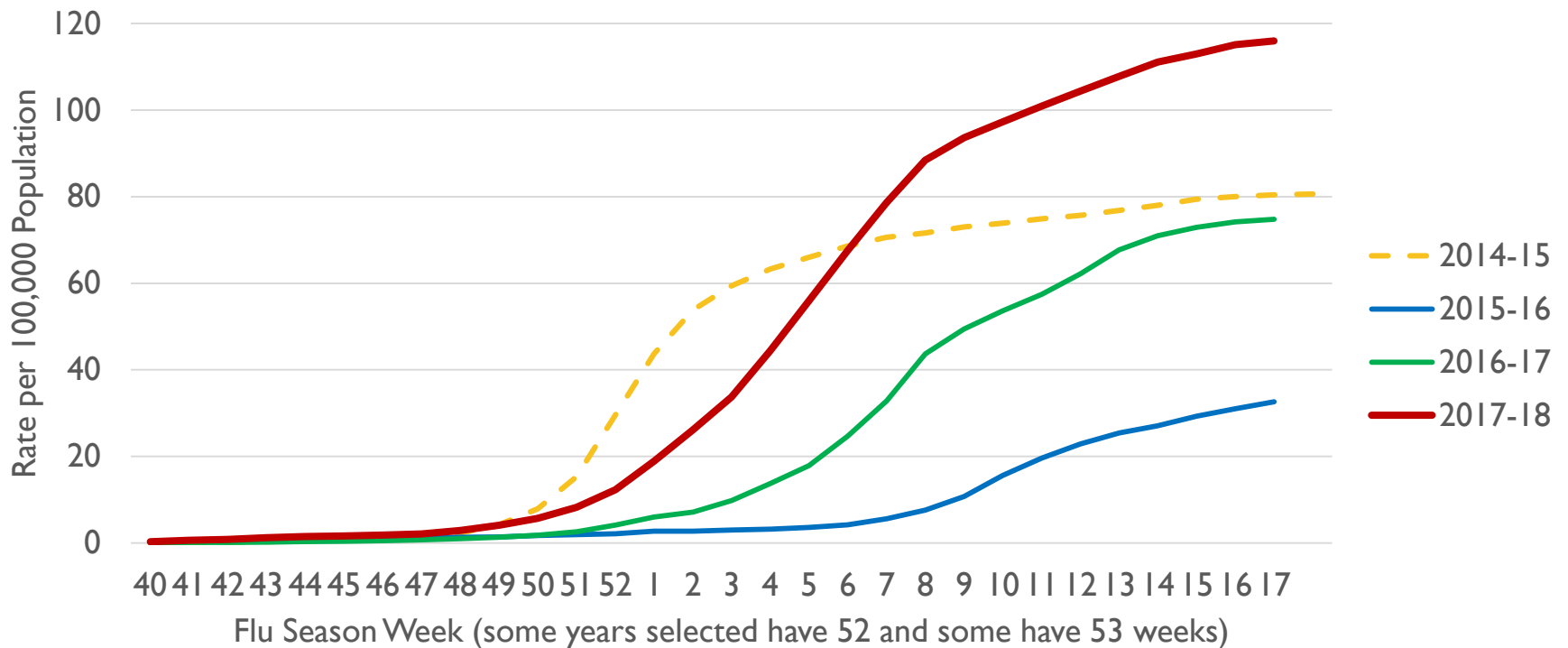
Flu-Related Hospitalizations: Entire Network

FluSurv-NET (CDC): Entire Network: Cumulative Rate of Lab-Confirmed
Influenza Hospitalizations
Preliminary as of 4/28/2018



Flu-Related Hospitalizations: Maryland

FluSurv-NET (CDC): Maryland: Cumulative Rate of Lab-Confirmed
Influenza Hospitalizations
Preliminary as of 4/28/2018



Flu Season and ED Wait Times

- ▶ Table shows for most volume groups, ED wait times are slightly less when lower IP admissions for flu.
- ▶ Across all volume categories, ED-1b had shorter wait times in 2015-2016 flu season (lowest) compared to 2014-2015 (highest); ED-2b had shorter ED wait times only for the medium and low volume hospitals.

Flu Season	MD	Entire Network	ED-1b				ED-2b			
	Cumulative flu admits/100k wk17	Cumulative flu admits/100k wk17	Very High	High	Medium	Low	Very High	High	Medium	Low
2014-2015	80.6	64.2	343	299	262	216	134	115	90	60
2015-2016	32.6	31.5	335	295	258	212	134	116	88	58
2016-2017	74.8	62	335	300	262	211	138	119	90	56
2017-2018	116	106	Data for this Flu Season Not Available Until around April 2019							

Sources: Flu data from <https://www.cdc.gov/flu/weekly/fluactivitysurv.htm> and ED Wait Time data from Hospital Compare



Flu: Next Steps

- ▶ HSCRC recognizes higher admission rates related to flu may impact ability to improve.
- ▶ HSCRC staff plans to propose to Commission that this should be examined when performance period is available; adjustments may be made as needed.
- ▶ One potential solution would be to assign improvement points relative to concurrent National median (benchmark).
 - ▶ See Handout
 - ▶ Please note that this adjustment would need to be made **retrospectively**.
 - ▶ Other ideas?



ED Wait Times Conclusion

- ▶ Staff are **not** proposing to remove ED wait time measures, and are not recommending to further adjust beyond volume at this time.
- ▶ Staff may recommend that Commissioners consider **retrospective** adjustment related to the flu once performance period data is available.



Summer 2018 – Strategic Priorities

Summer 2018 Priorities

▶ **CAEM**

- ▶ As previously mentioned, will work to develop list of measures and weighting/scaling approach to present to PMWG in Fall

▶ **PAU**

- ▶ Consider how to responsibly expand the PAU measure



Summer 2018 Priorities (Cont'd)

▶ **Readmissions**

- ▶ **Determine revised target for RY 2021 Medicare Improvement and all-payer conversion**
- ▶ Begin work in CY 2018 but major focus in CY 2019:
 - ▶ Acquire data to develop by-payer readmission benchmarks; consider comparison groups; revised out-of-state methodology
 - ▶ Review improvement versus attainment; assess risk-adjustment
 - ▶ Consider changes to readmission measure including observation, readmissions to/from Specialty Hospitals

▶ **QBR**

- ▶ Review domain weighting
 - ▶ Operationalize THA/TKA measure
 - ▶ Ongoing work on 30-day Mortality measure development
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Consider Proposed CMS Inpatient Quality Reporting (IQR) Changes and Impacts

- ▶ CMS proposes to adopt one additional factor to consider when evaluating measures for removal from the Hospital IQR Program measure set:
 - ▶ “The cost associated with a measure outweighs the benefit of its continued use in the program”
- ▶ CMS proposes to remove 18 previously adopted measures that are “topped out”, no longer relevant, or where burden of data collection outweighs the measure’s ability to contribute to improved quality of care.
 - ▶ Two measures that are considered “too costly” are:
 - ▶ ED-1b- Remove as of CY 2019 reporting period/FY 2021 payment determination;
 - ▶ Chart-abstracted version of ED-2b- Remove as of CY 2020 reporting period/FY 2022 payment determination (but retain as eCQM option).
- ▶ CMS proposes to de-duplicate 21 measures to simplify and streamline measures across programs; these measures will remain in one of the 4 hospital quality programs.



FFY 2019 IPPS/LTCH PPS Proposed Rule: Removal of Ten Measures from VBP

- ▶ CMS' changes based on goals of using a smaller set of more meaningful measures, focusing on patient-centered outcome measures, and taking into account opportunities to reduce paperwork and reporting burden on providers.
 - ▶ Remove (de-duplicate) 10 measures from VBP:
 - ▶ Remove all seven healthcare Safety domain measures (HAI, PSI and PC-01) measures from the Safety domain, as they are already in the HAC Reduction Program.
 - ▶ Remove three condition-specific payment measures from the Efficiency and Cost Reduction domain already in the Hospital IQR Program (while retaining the Medicare Spending per Beneficiary-Hospital measure);
 - ▶ Revise the program's domain weighting beginning with the FY 2021 program year by increasing the weight of the Clinical Care domain in calculating hospitals' total performance scores (reweights mortalities and the THA/TKA complications domain to 50%)
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FFY 2019 IPPS/LTCH PPS Proposed Rule: HACRP and HRRP Programs

- ▶ **Hospital Acquired Reduction Program (HACRP)**
 - ▶ Administrative updates to receive and assess accuracy for five Healthcare Associated Infection measures
 - ▶ Update measure weighting to simplify the methodology and address concerns raised by small hospitals.
 - ▶ Measures under HACRP would remain the same.
- ▶ **Hospital Readmission Reduction Program (HRRP)**
 - ▶ Updates to clarify definitions to implement 21st Century Cures Act requirements to assess eligible hospital readmission performance relative to hospitals with a similar proportion of dual-eligible (five equal peer groups)
 - ▶ Readmission Measure under the HRRP would remain the same.



Performance Measurement Work Group will **NOT** meet in June – please feel free to join us for our RY 2020 Quality Webinar on **Tuesday, June 19th, at 9:30 AM.**



Contact Information

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