



**All Payer Hospital System Modernization  
Performance Measurement Work Group**

**October 28, 2015**

**9:30 am to 12:00 pm**

**Health Services Cost Review Commission, Conference Room 100**

**4160 Patterson Avenue, Baltimore, MD 21215**

**Meeting Agenda**

- I. Welcome and Introductions
  
- II. Review of Performance Measurement Work Plan  
***Dianne Feeney, HSCRC***
  
- III. Program Updates
  - a. Quality Based Reimbursement Program
  - b. Maryland Hospital Acquired Conditions Program
  - c. Readmission Reduction Incentive Program***Alyson Schuster, Sule Gerovich, Dianne Feeney, HSCRC***
  
- IV. Efficiency Measurement  
***Sule Calikoglu, HSCRC***
  
- V. Future Strategic Direction for Performance Measurement  
***Dianne Feeney, HSCRC***
  
- VI. ICD 10 Transition Issues  
***Dianne Feeney, HSCRC***



## **HSCRC Performance Measurement Work Group**

(as of 10/22/15)

**Thelma Baker**

Chief Operating Officer  
VHQC

**Ed Beranek**

Director of Regulatory Compliance  
Johns Hopkins Health System

**Zahid Butt, MD, FACG**

CEO  
Medisolv Inc.

**Daniel Cochran**

Vice President, CFO  
Shady Grove Adventist Hospital

**Linda Costa, Ph.D., RN, NEA-BC**

Assistant Professor, OSAH  
University of Maryland School of Nursing

**Steve Daviss, MD, DFAPA**

President  
FUSE Health Strategies

**Justin Deibel**

Senior Vice President, CFO  
Mercy Medical Center

**Barbara Epke**

Vice President  
LifeBridge Health

**Patricia Ercolano**

Vice President, Quality Management  
University of Maryland Medical Systems

**John Hamper**

Director, Provider Reimbursement, Analytics & Compliance  
CareFirst

**Theresa Lee**

Director, Center for Quality Measurement and Reporting  
Maryland Health Care Commission

**Traci LaValle**

Vice President, Financial Policy & Advocacy  
Maryland Hospital Association

**Robert Murray**

Consultant  
CareFirst

**Chad Perman**

Director, Health Systems Transformation  
Maryland Department of Health and Mental Hygiene

**Jeff Richardson, MBA, LCSW-C**

Executive Director  
Mosaic Community Services

**Tricia Roddy**

Director, Office of Planning  
Maryland Department of Health and Mental Hygiene

**Farzaneh L. Sabi, MD**

Kaiser Mid-Atlantic Permanente Medical Group

**Joseph Territo, MD**

Associate Medical Director for Quality  
Kaiser Mid-Atlantic Permanente Medical Group

**Anthony Tucker, Ph.D.**

Planning and Policy Analysis  
Office of Personnel Management

**Benjamin Turner**

Program Manager  
Primary Care Coalition of Montgomery County

**Albert Wu, MD, Ph.D.**

Director, Center for Health Services and Outcomes Research  
Johns Hopkins Bloomberg School of Public Health

### **HSCRC STAFF**

**Dianne Feeney**

Associate Director, Quality Initiative

**Sule Gerovich, Ph.D.**

Director, Center for Population-Based Methodologies

**Alyson Schuster, Ph.D.**

Associate Director, Performance Measurement

## HSCRC Performance Measurement Workgroup

### Draft Work Plan

*Updated 10/1/15*

Month/Meeting (s)	Goals/Deliverables
<b>SEPTEMBER</b>	No meetings
Commission Meeting September 9, 2015	<ul style="list-style-type: none"> <li>• Draft FY 2018 QBR Recommendation</li> </ul>
<b>OCTOBER</b>	
Commission Meeting October 14, 2015	<ul style="list-style-type: none"> <li>• Final FY 2018 QBR Recommendation</li> </ul>
Readmission Subgroup October 21, 2015	<ul style="list-style-type: none"> <li>• Socio-Economic Demographic Risk adjustment</li> </ul>
Performance Measurement Work Group October 28, 2015	<ul style="list-style-type: none"> <li>• Work Plan</li> <li>• Review of YTD Performance Results</li> <li>• Performance measurement strategic plan discussion- patient centered measures, efficiency measures</li> </ul>
<b>NOVEMBER</b>	
Commission Meeting November 18, 2015	<ul style="list-style-type: none"> <li>• Performance Strategic Plan Discussion</li> </ul>
Readmission Subgroup	<ul style="list-style-type: none"> <li>• Risk Adjustment</li> </ul>
Performance Measurement Work Group November 20, 2015	<ul style="list-style-type: none"> <li>• Discuss draft readmission updates for FY 2018</li> <li>• Discuss draft MHAC updates FY 2018</li> <li>• Discuss potential PAU measure updates</li> <li>• Aggregate at Risk</li> </ul>
Payment Models Work Group	<ul style="list-style-type: none"> <li>• Discuss Aggregate At Risk FY2018</li> </ul>
<b>DECEMBER</b>	
Commission Meeting December 9, 2015	<ul style="list-style-type: none"> <li>• Draft recommendation on readmission updates for FY 2018</li> <li>• Draft recommendation for MHAC updates for FY 2018</li> <li>• Draft Revenue at risk FY 2018</li> </ul>
Performance Measurement Work Group December 16, 2015	<ul style="list-style-type: none"> <li>- Finalize Recommendations</li> </ul>
<b>JANUARY</b>	
Commission Meeting January 13, 2016	<ul style="list-style-type: none"> <li>• Final recommendation on readmission updates for FY 2018</li> <li>• Final recommendation for MHAC updates for FY 2018</li> <li>• Final Revenue at risk FY 2018</li> </ul>
Performance Measurement Work Group January 20, 2016	
<b>FEBRUARY</b>	
Commission Meeting February 10, 2016	

## HSCRC Performance Measurement Workgroup

### Draft Work Plan

*Updated 10/1/15*

Month/Meeting (s)	Goals/Deliverables
Performance Measurement Work Group February 17, 2016	<ul style="list-style-type: none"> <li>• Strategic Plan FY19</li> <li>• PAU Update for FY16 Rates</li> </ul>
<b>MARCH</b>	
Commission Meeting March 9, 2016	<ul style="list-style-type: none"> <li>• Performance Measurement strategic plan report</li> </ul>
Performance Measurement Work Group March 16, 2016	
3M PPC clinical review subgroup	<ul style="list-style-type: none"> <li>• 3M PPC clinical review</li> </ul>
<b>APRIL</b>	
Commission Meeting April 13, 2016	
Performance Measurement Work Group April 20, 2016	<ul style="list-style-type: none"> <li>• ICD-10 Review</li> </ul>
<b>MAY</b>	
Commission Meeting May 11, 2016	<ul style="list-style-type: none"> <li>• Updated PAU Measures</li> </ul>
Performance Measurement Work Group May 18, 2016	
<b>JUNE</b>	
Commission Meeting June 8, 2016	
3M PPC clinical review subgroup	<ul style="list-style-type: none"> <li>• Discuss clinical input and 3M response; determine next steps</li> </ul>
Performance Measurement Workgroup June 15, 2016	<ul style="list-style-type: none"> <li>• Discuss FY2019 Quality Program Updates</li> </ul>
<b>JULY</b>	
Commission Meeting July 13, 2016	<ul style="list-style-type: none"> <li>• Update on FY2019 Quality Updates</li> </ul>
Performance Measurement Workgroup July 20, 2016	



# Performance Measurement Workgroup

10/28/2015

# Guiding Principles For Performance-Based Payment Programs

---

- ▶ Program must improve care for all patients, regardless of payer (Stake holder buy-in)
- ▶ Program incentives should support achievement of all payer model targets
- ▶ Program should prioritize high volume, high cost, opportunity for improvement and areas of national focus (Stake holder buy-in)
- ▶ Predetermined performance targets and financial impact (transparency, sustainability)
- ▶ Hospital ability to track progress (transparency, and infrastructure)
- ▶ Encourage cooperation and sharing of best practices

# Maryland Quality Based Reimbursement Program

## Recent Results

---

- ▶ Changes in performance on the QBR (and VBP) measures used for FY 2016 performance for Maryland versus the United States (October 2013 through September 2014) reveal that Maryland is:
  - ▶ Similar to the nation on the clinical process of care measures
  - ▶ Better than the nation on the 30-day condition-specific mortality measures.
  - ▶ Better than the nation on the CLABSI measure;
  - ▶ Worse than the nation for CAUTI and SSI infection measures- we are aligning with Medicare
  - ▶ With exception of the “Discharge Information”, lagged behind on HCAHPS measures.
  - ▶ Improving from the base period on inpatient all cause mortality rates
- ▶ Final QBR payment scaling for FY 2016 rate year is provided in Appendix II.

# Maryland Quality Based Reimbursement Program Commission Approved Changes for Rate Year 2018

- ▶ Continue to allocate 2 percent of hospital-approved inpatient revenue for QBR performance in FY 2018 to be finalized by the Aggregate Revenue “at risk” recommendation.
- ▶ Adjust measurement domain weights to include: 50 percent for Patient Experience/Care Transition, 35 percent for Safety, and 15 percent for Clinical Care.

	Clinical Care	Patient experience of Care/ Care Coordination	Safety	Efficiency
QBR FY 2017	15% (1 measure- mortality) 5% (clinical process measures)	45% (8 measures- HCAHPS)	35% (3 infection measures, PSI)	Potentially Avoidable Utilization (PAU)
Final QBR FY 2018	15% (1 measure- mortality)	50% (9 measures- HCAHPS + CTM)	35% (7 measures- Infection, PSI, PC -01)	PAU
CMS VBP FY 2018	25% (3 measures- condition specific mortality)	25% (9 measures- HCAHPS + CTM)	25% (7 measures- Infection, PSI, PC -01)	25%



# RX2018 QBR Update Considerations

---

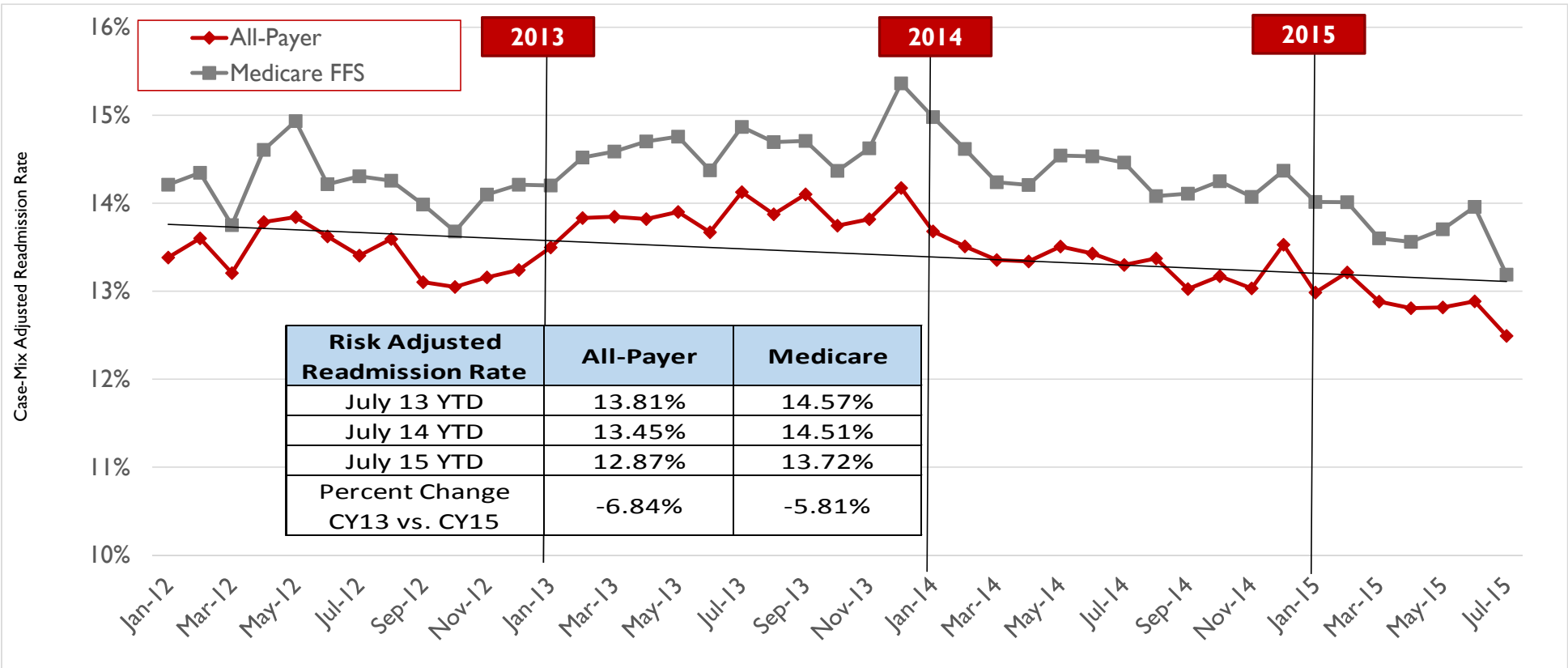
- ▶ Finalize percent of revenue at risk
- ▶ Finalize preset scale for rewards and penalties

# Readmission Reduction Incentive Program

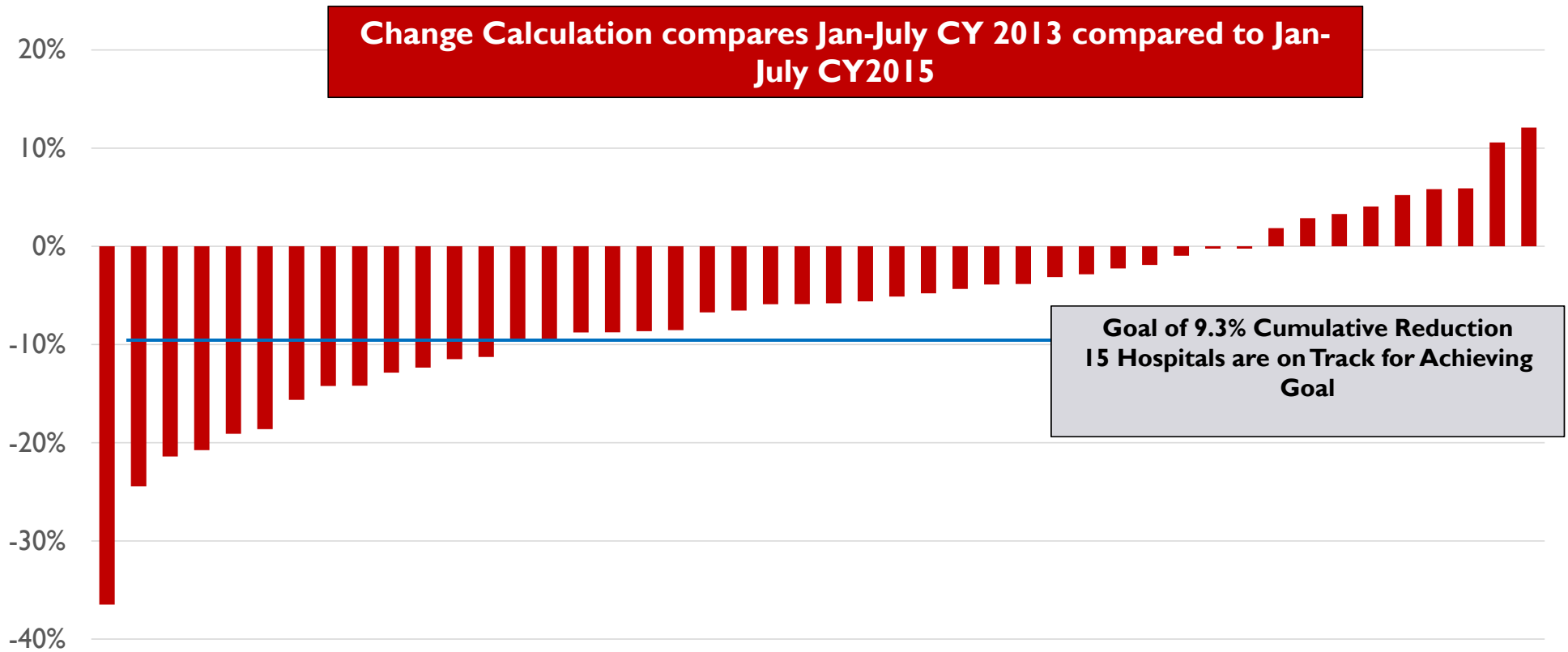
---

- ▶ Incentive program designed to support the waiver goal of reducing Medicare readmissions, but applied to all-payers.
- ▶ Case-Mix Adjusted 30-Day, All-Hospital, All Cause Readmission Rate
- ▶ **RY 2017:** 9.3% minimum improvement target (CY 2013 compared to CY2015), scaled penalties up to 2% and rewards up to 1%.
- ▶ Planned admissions, newborns, same-day transfers, deaths, and rehab discharges are excluded.
- ▶ Continue to assess the impact of observation stays, admission reductions, SES/D and all payer and Medicare readmission trends and make adjustments to the rewards or penalties if necessary.

# Monthly Risk-Adjusted Readmission Rates



# Change in All-Payer Risk-Adjusted Readmission Rates by Hospital



8 Note: Based on final data for January 2012 – June 2015, and preliminary data through August 2015.

## RX2018 RRIP Update Considerations

---

- ▶ Potential measure updates (e.g., planned admissions, transfer logic)
- ▶ Incorporating attainment levels to the program
- ▶ Medicare vs. Non-Medicare readmission rates
- ▶ Incorporation of Socio-economic and other factors to the program
- ▶ Statewide and hospital-specific target
- ▶ Payment adjustment structure and amounts (Scaling)

## MHAC Overview

---

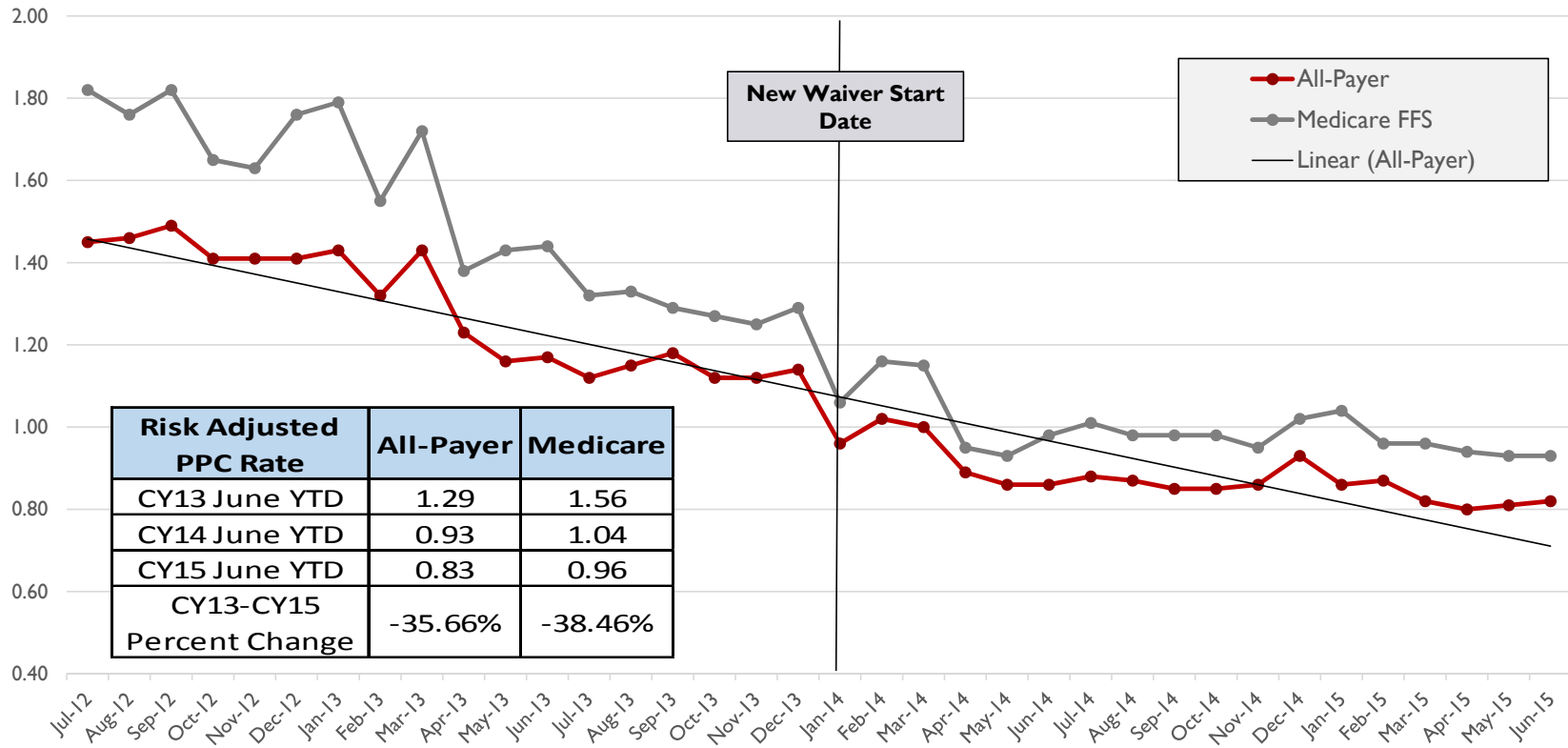
- ▶ Uses Potentially Preventable Complications (PPCs) tool developed by 3M.
- ▶ PPCs are defined as harmful events (accidental laceration during a procedure) or negative outcomes (hospital acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease.
- ▶ Links hospital payment to hospital performance by comparing the observed number of PPCs to the expected number of PPCs.

## FY2014 Audits

---

- ▶ 9 Hospitals Audited for ICD coding accuracy and POA quality
- ▶ Independent auditor reviews 230 cases (115 coding audit, 115 POA quality)
- ▶ Specific cases selected POA quality review (e.g., cases at-risk but not having one of the PPCs with largest reduction, cases that changed from having a PPC to not having PPC in final data)
- ▶ 8 out of 9 hospitals met 95% target for POA accuracy across POA quality and coding accuracy. POA quality audits identified higher rate of POA issues (5 hospitals with POA issues around 5-7%), however not systematically assigning POA of Y in cases with issues
- ▶ Hospitals and POA quality criteria updated for FY 2015 audits

# Monthly Risk-Adjusted PPC Rates

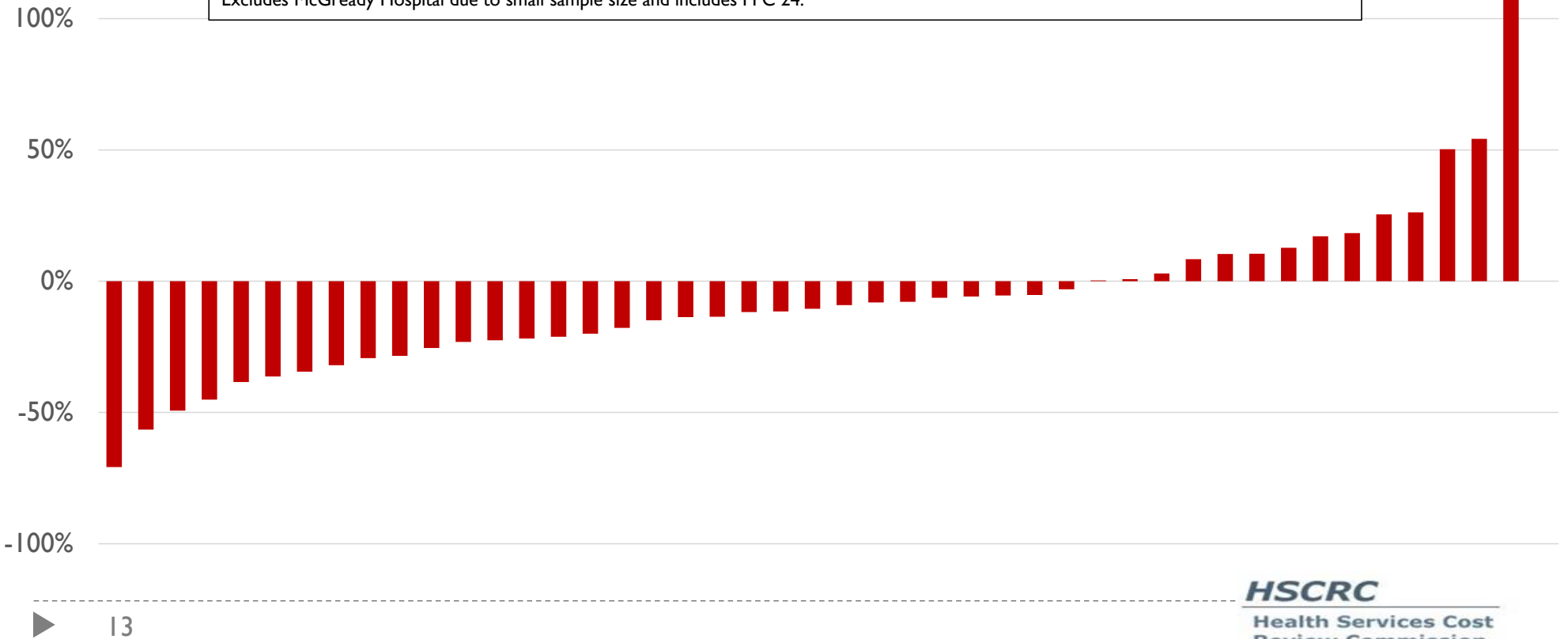


Note: Reported as of 9/30/2015, based on final data through June 2015. Includes PPC24.



# Change in All-Payer Risk-Adjusted PPC Rates YTD by Hospital

Notes:  
 Based on final data for January 2014 – June 2015.  
 Percent change is comparing Jan. – June. of CY2014 YTD to Jan. – June. of CY2015.  
 Excludes McGready Hospital due to small sample size and includes PPC 24.



# RX2018 MHAC Update Considerations

---

- ▶ Statistical Validity and Reliability Analysis
- ▶ Evaluation of tier groups
- ▶ Statewide target
- ▶ Maximum at risk determination
- ▶ Monitoring of ICD-10 Impact

# Potentially Avoidable Utilization Measure

---

- ▶ **Expanding the definition to other areas (9 Months)**
  - ▶ Nursing home admissions
  - ▶ High risk patient utilization
  - ▶ Sepsis admissions
  - ▶ Avoidable Emergency Department Visits
- ▶ **Risk adjusted measure of PAUs (18 months)**



# Maryland Health Services Cost Review Commission

## Efficiency/Cost Measures

Performance Measurement Work Group Meeting  
10/28/2015



## Possible uses of Efficiency/Cost measures

---

- ▶ Provide comparative information for decision making
  - ▶ by businesses about health plan purchasing
  - ▶ by consumers about health plan/provider choice
  - ▶ by health plans about provider contracting
  - ▶ by managers about resource allocation
- ▶ Monitoring and planning
- ▶ Pay-for-performance
- ▶ Public reporting

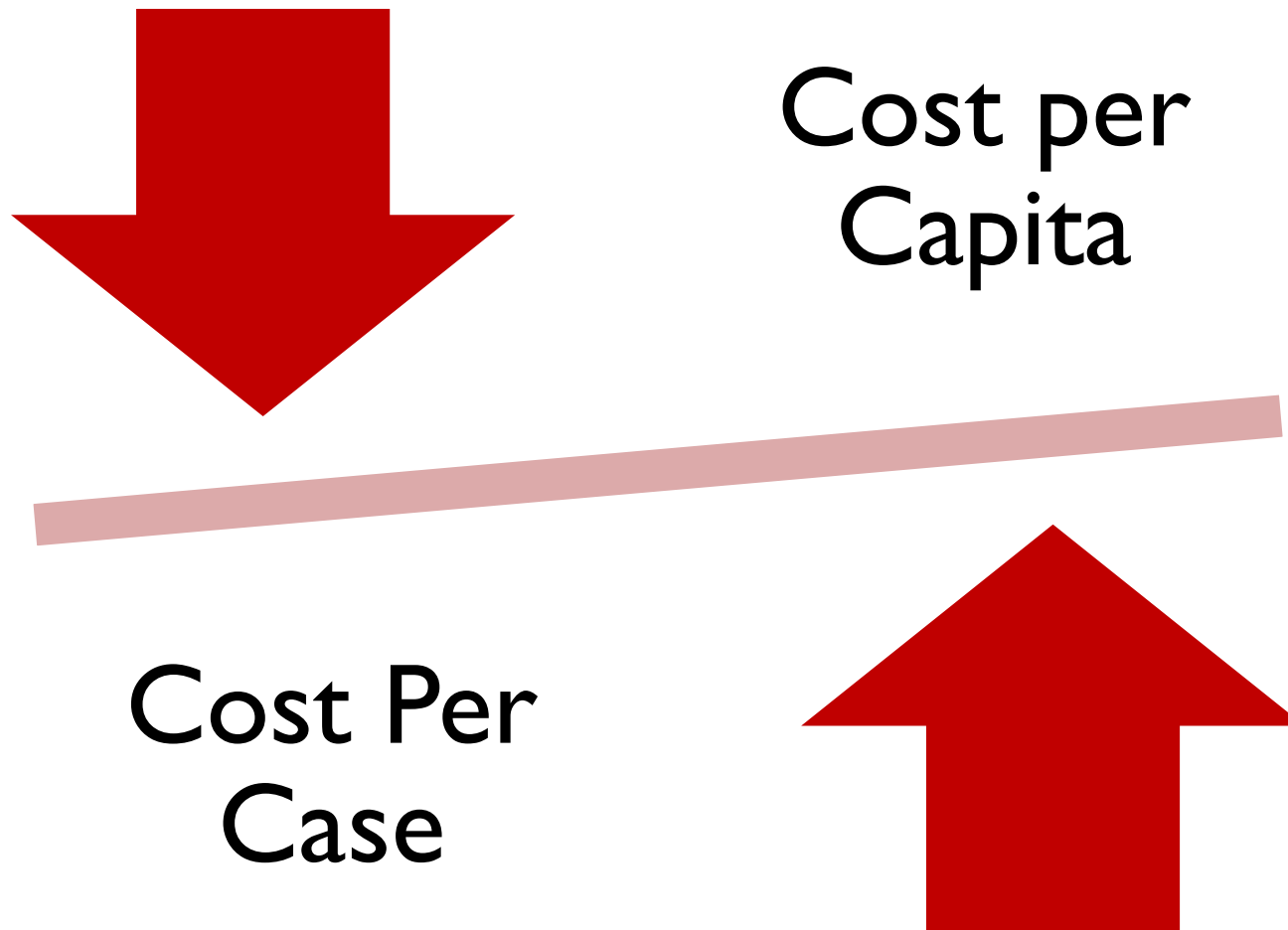
# HSCRC Efficiency Measure Uses

---

- ▶ Full & Partial Rate Applications
- ▶ Certificate of Need Reviews
- ▶ Performance measurement (CMS Value-Based Purchasing)

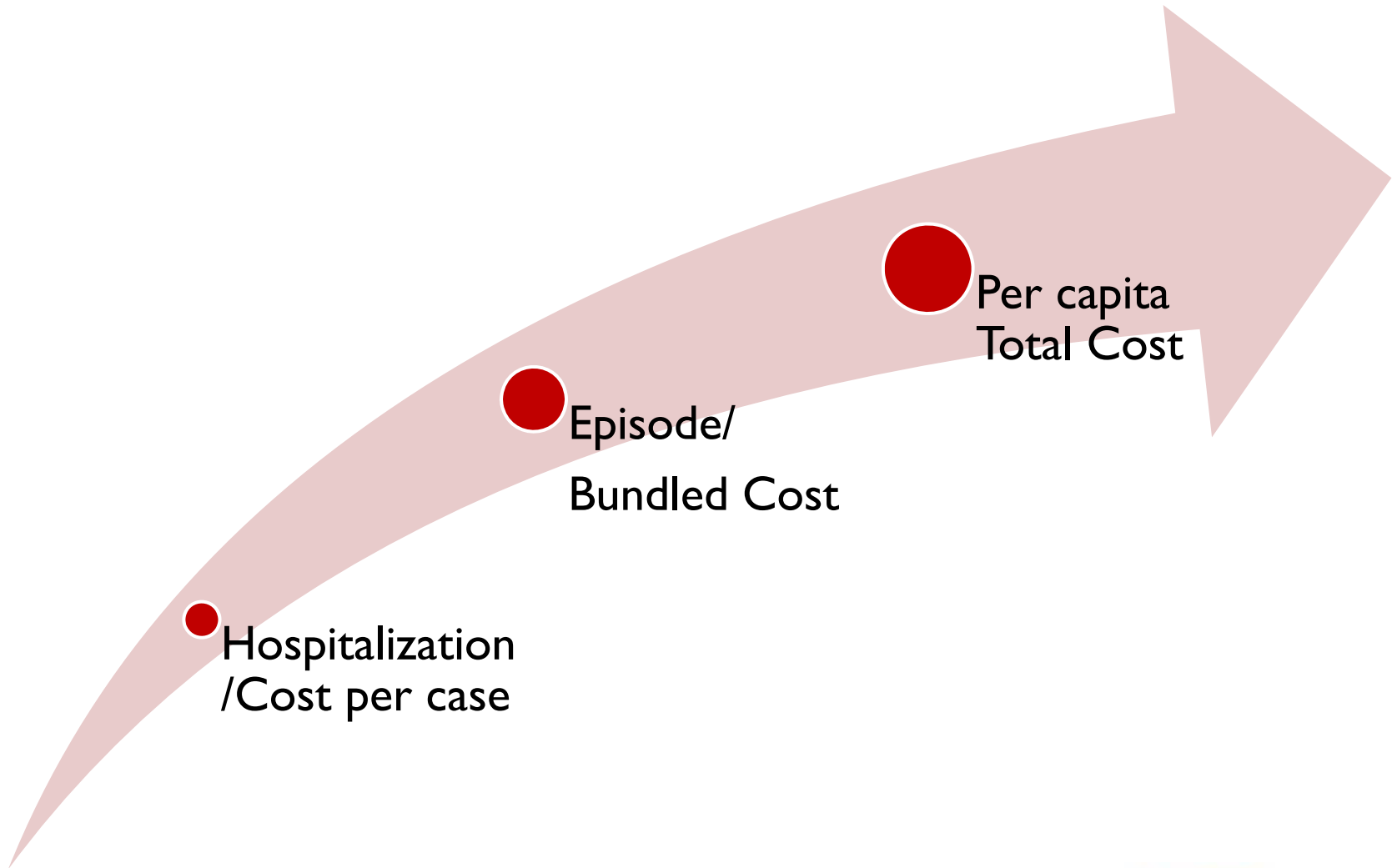
# Global Budgets Efficiency

---



# Efficiency Measure Time & Space

---





## Review of Selected Cost Measures

---

- ▶ Per Case: Reasonableness of Charges (ROC)
- ▶ Episode: Medicare Spending per Beneficiary (MSPB)
- ▶ Population: Total Cost of Care measures (PMPM)

---

# Reasonableness of Charges (ROC)

## HSCRC per case measure

## ROC Adjustment Factors

- ▶ To compare hospitals with their peer group standards, approved charges per case adjusted for the following:
  - ▶ **Uncompensated care (Mark-up)** – Commission approved markups over costs that reflect built into each hospital's rate structure.
  - ▶ **Direct Medical Education, Nurse Education, and Trauma (Direct Strips)** remove partial costs of resident salaries, nurse education costs and incremental costs of trauma services of hospitals with trauma centers
  - ▶ **Labor Market** – Adjustment for differing labor costs in various markets
  - ▶ **Case Mix** – Adjustment accounts for differences in average patient acuity across hospitals
  - ▶ **Indirect Medical Education**- Adjustment for inefficiencies and unmeasured patient acuity associated with teaching programs.
  - ▶ **Disproportionate Share** – Adjustment for differences in hospital costs for treating relatively high number of poor and elderly patients
  - ▶ **Capital** – Costs for a hospital are partially recognized

# Total Cost of Care PMPM

## Time Dimension

**Annual  
Quarterly  
Others**

## Cost Dimension

**Inpatient, Outpatient,  
Professional, Pharmacy,  
Ancillary Services,  
Home Health,  
Hospice,  
Skilled Nursing Facility,  
Durable Medical  
Carrier**



# Considerations

- ▶ **Measurement of Total Cost of Care**
  - ▶ Medicare Claims
  - ▶ Commercial Claims from Maryland Health Care Commission
  - ▶ Medicaid Claims
- ▶ **Risk Adjustment**
  - ▶ Demographics (Age, Sex, Social/economic factors)
  - ▶ Risk Adjustment Methodology
- ▶ **Denominator**
  - ▶ Virtual Patient Service Area
- ▶ **Out of State Utilization Adjustment**
- ▶ **Benchmarks**

# Efficiency Measure Development Timelines

---

- ▶ **Per Case measure revisions (next 3 months)**
  - ▶ Disproportionate Share Adjustment (evaluate area deprivation index, and national estimates)
  - ▶ Indirect Medical Education Cost (evaluate national estimates)
  - ▶ Potentially Avoidable Utilization adjustments
- ▶ **Per Capita Hospital Cost (next 9 months)**
  - ▶ Data sources: Medicare claims, All-Payer Claims Database, HCUP, DC Hospital Discharge Database
  - ▶ Attribution :Virtual Patient Service Area
  - ▶ Risk Adjustment: Rate adjustments and patient level risk adjustment models (age, sex, HCC, ACG etc)
- ▶ **Per Capita Total Cost (next 18 months)**
  - ▶ Data sources: Medicare claims, All-Payer Database,
  - ▶ Attribution :Virtual Patient Service Area
  - ▶ Risk Adjustment: Rate adjustments and patient level risk adjustment models (age, sex, HCC, ACG etc)

# Performance Measurement Future Strategy Key Considerations

*As of October 21, 2015*

At its core, the All-payer Model in Maryland has the goal of achieving the “Triple Aim” of: (1) improving the patient experience, including quality and satisfaction; (2) improving health of populations; and (3) reducing the per capita cost of health care.

To achieve the Triple Aim, the incentive-based performance measurement system must evolve to one that is comprehensive/statewide, extends beyond the hospital walls to additional care/services categories and care settings, and supports true patient centered care. Key measurement areas identified through broad stakeholder input thus far that address all aspects of the Triple Aim are outlined below.

## **Improving the Patient Experience, including Quality and Satisfaction**

### *Quality of hospital care -*

- Current measures include, hospital acquired conditions (measured by 3M Potentially Avoidable Complications (PPCs), CDC National Health Safety Network infection measures, early elective delivery, AHRQ Patient Safety Indicator 90, and inpatient “all cause” mortality, all cause 30 day readmissions, and patient experience (measured by Hospital Consumer Assessment Surveys HCAPS)
- Mortality measure(s) need to extend to 30 days
- Measures of outpatient hospital care should be adopted (e.g., ED visit 7 days after a colonoscopy or outpatient procedure, Outpatient measures reported in Hospital Compare website)

### *Chronic care focus-*

- Chronically ill people often have multiple conditions
- Care coordination/ Medical homes/ should not be an afterthought and should be measured
- Provider notified of hospitalization is measured by CRISP
- Physician follow up after hospitalization requires out patient data
- 
- Care planning measures that indicate shared decision making are important (e.g., discussions about advanced directives, use of the Medical Order of Life Sustaining Treatment (MOLST))
- Consider outcome measures that are important for chronic conditions- e.g., functional status, patient reported outcomes, quality of life
- Medication management is critical to managing chronic conditions

### *Risk adjustment is important for measuring readmissions*

- A readmission attainment measure must include risk adjustment and measurement of out of state readmissions
- Adjustments may include such things as age, Area Deprivation Index (ADI)

# Performance Measurement Future Strategy Key Considerations

*As of October 21, 2015*

## Improving Health of Populations

- Current measures include Prevention Quality Indicators of hospitalizations for ambulatory sensitive conditions,
- Opiate prescribing was identified as of concern
- What other measures are most important for/indicative of population health? Infant mortality, other?

## Reducing Per Capita Cost of Health Care

- Current measures include cost of potentially avoidable utilization (PAUs, which include PQIs, PPCs, 30 day readmissions for inpatient stays and observation stays >23 hours
- Episode focused costs are appropriate and informative to consumers for specific conditions/procedures (e.g., hip and knee replacements)
- Total Cost of Care per capita measures must be developed
- For these cost measures, stakeholders indicated we need better cost data including all payer claims.

## Issues Potentially Impacting Measures for All Three Aims

- Consider comprehensive measure sets that address specific conditions that are common and substantial in cost- e.g., knee replacement, hip replacement
- Consider available measures (e.g., HEDIS, CAHPS, EHR measures)
- The evidence-based, chronic care model illustrates that there is a crucial connection between patient engagement and desirable patient outcomes. For example, engaged patients have better health outcomes and better health care experiences, and likely use fewer health care services and cost less.
- Patient engagement is critical, and must include multicultural engagement consumer; engagement surveys may be useful (e.g., patient confidence survey measure)
- A pilot of patient centered measures should be considered
- Choose relatively few meaningful, actionable measures; it is important to prioritize; what measures drive value and will consumers act upon?
- Attribution is difficult
- Investment in infrastructure is needed to link domains, e.g., cost and functional status
- Geographic boundaries are “artificial”
- Behavioral health primary or secondary have impact on performance
- Focus measurement on all payer
- Data quality and validation is important
- Leverage IT tools



## **Performance Measurement Future Strategy Key Considerations**

*As of October 21, 2015*

Facilitated discussion Questions

1. What should hospital pay for performance programs look like in 5 years?
2. What do the measurement strategy look like?
  - a. Is it specific to the domain, i.e., mortality, complications, readmission, etc.?
  - b. Is it specific to clinical areas: orthopedic surgery (mortality, complications, readmissions)
  - c. Is it a composite measure or separated by measurement domains?
3. How do we engage stakeholders in the discussions?

# Considerations for Specific MHACS

---

## Summary of PPC ICD-9/ICD-10 Replication

51

Clinical concepts translated directly or simply expanded in specificity

PPCs 1-37, 44-54, 63-66

13

Clinical definition remains valid for ongoing use though some coding concepts changed that could affect assignment rates. Suggest extra consideration in rate comparisons during the transition year.

PPCs 38-42, 55-62 (OB)

1

Clinical concepts not replicated in ICD-10 or combined with an existing concept.

PPC 43

