Performance Measurement Work Group Meeting

03/21/2018

HSCRC
Health Services Cost Review Commission

Agenda

- RY 2019 PAU
- TCOC Model – Measurement Strategy Discussion
  - Critical Action List
  - Clinical Adverse Event Measures Work Group – Update
- RY 2020 QBR Status Update

PAU Savings Policy Discussion

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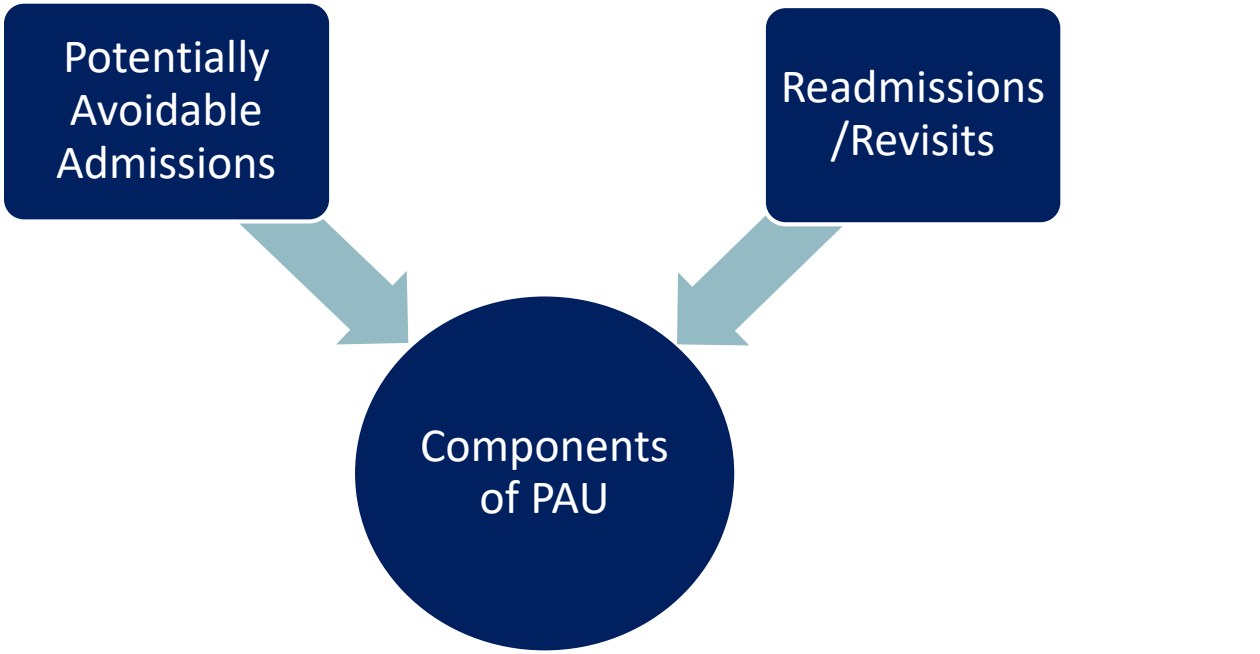
PAU Discussion

PAU: Purpose and Measure

Definition: "Hospital care that is unplanned and can be prevented through improved care coordination, effective primary care and improved population health."



HSCRC Calculates Percent of Revenue Attributable to PAU

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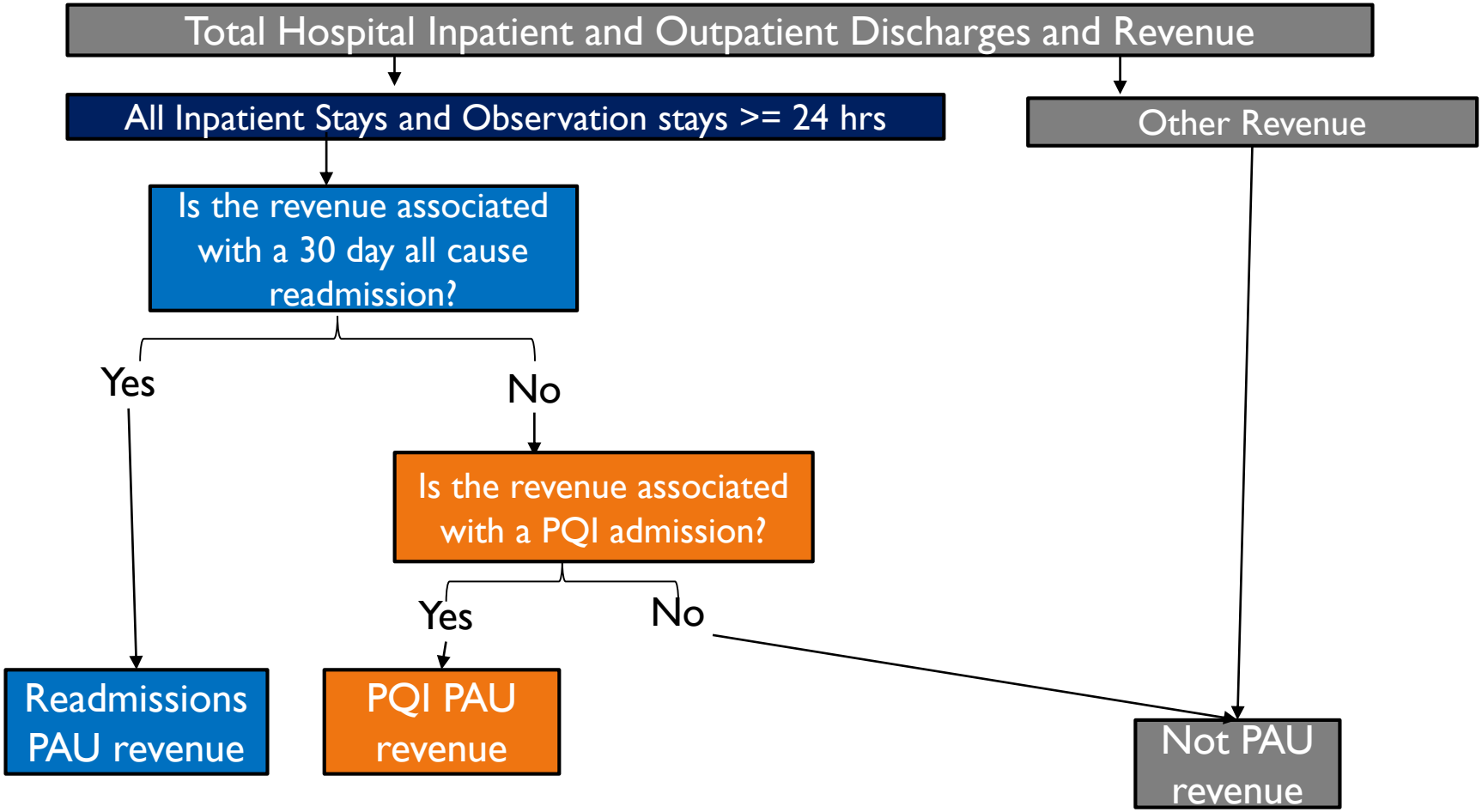
Current PAU measure

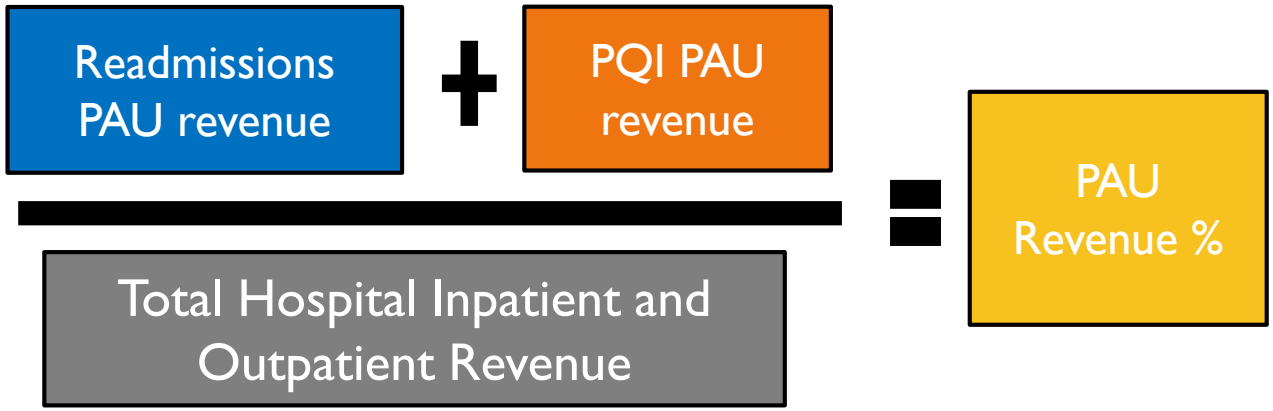
- Revenue from Readmissions
  - 30 day readmissions (inpatient and observation stays > 23 hours) at the receiving hospital
  - Includes readmission clinical logic, such as excluding planned admissions
- Revenue from AHRQ Preventable Quality Indicators (PQIs)
  - Hospitalizations from ambulatory-care sensitive conditions that may be preventable through effective primary care and care coordination.

List of included PQIs (PQI version 6)
PQI 01 Diabetes Short-Term Complications
PQI 02 Perforated Appendix Admission
PQI 03 Diabetes Long-Term Complications Admission
PQI 05 COPD or Asthma in Older Adults Admission
PQI 07 Hypertension Admission
PQI 08 Heart Failure Admission
PQI 10 Dehydration Admission
PQI 11 Bacterial Pneumonia Admission
PQI 12 Urinary Tract Infection Admission
PQI 14 Uncontrolled Diabetes Admission
PQI 15 Asthma in Younger Adults Admission
PQI 16 Lower-Extremity Amputation among Patients with Diabetes

Current PAU Flowchart



PAU Revenue %


Readmissions PAU revenue
+
PQI PAU revenue
Total Hospital Inpatient and Outpatient Revenue
=
PAU Revenue %

Current use of PAU measure

- PAU Savings Program
  - Statewide PAU
  - Hospital-specific scaling of savings adjustment
- Market Shift
- Demographic Adjustment
- Consideration in Rate Reviews

PAU Savings Program

PAU Savings Program

- The Global Budget Revenue (GBR) system assumes that the state will be reducing potentially avoidable utilization as care delivery transformation is ongoing

- The PAU Savings Policy prospectively reduces hospital GBRs in anticipation of those reductions
  - All hospitals contribute to the statewide PAU savings, however, each hospital's reduction is proportional to their percent PAU revenue.

PAU Savings Program con't

- Hospital-specific reductions are scaled based on the percentage of PAU revenue received at the hospital in a prior year
  - i.e., hospitals with higher than average PAU revenue will have a higher reduction than the statewide average and hospitals with lower PAU will have a lower reduction
- Example: If the statewide PAU revenue % is 10% and the statewide % reduction is set at 1.0%:

	PAU %	PAU Savings Adjustment
Hospital A	10%	-1.0%
Hospital B	20%	-2.0%
Hospital C	5%	-0.5%

Summary of methodology approach

1. Determine statewide % reduction in PAU revenue
2. Calculate scaled revenue reductions for each hospital based on prior CY PAU revenue %
3. Apply protection for hospitals meeting certain criteria
4. Apply adjustments to total hospital revenue

Statewide % Reduction: RY 2018 Example

- Set the value of the PAU savings amount to 1.45 percent of total permanent revenue in the state, which is a 0.20 percent net reduction from RY 2017.

Statewide Results		**Value**
RY 2017 Total Approved Permanent Revenue	A	$15.8 billion
Total RY18 PAU %	B	10.86%
Total RY18 PAU $	C	$1.7 billion

Statewide Total Calculations		**Total**	**Previous year**	**Net**
RY 2018 Revenue Adjustment %	D	-1.45%	-1.25%	-0.20%
RY 2018 Revenue Adjustment $	E=A*D	-$228.4 million	-$194.4 million	-$34.0 million

Hospital Scaling

- Calculate scaled revenue reduction for each hospital based on CY PAU revenue %

Rate Year	Performance
RY2018	CY2016
RY2019	CY2017
RY2020	CY2018
RY2021	CY2019
RY2022	CY2020

- RY18 (CY16) PAU % was 10.86% of total revenue statewide, with hospital-specific values ranging from:
  - 5.25% to 19.71% of total revenue*

*Excluding UMROI (CY16 PAU % = 0.32%)

Hospital Protections: RY2018 Policy

- RY2018: Cap the PAU savings reduction at the statewide average reduction for hospitals with higher socio-economic burden
  - Higher socio-economic burden defined as hospitals in the top quartile of Medicaid/Self-Pay % of ECMADs
    - % of inpatient ECMADs from Medicaid/Self-Pay over total inpatient ECMADs (equivalent case-mix adjusted discharges).

- Revenue adjustments are calculated for hospitals meeting the criteria before and after protection.
- Hospitals are assessed on the smaller of the hospital-calculated or statewide average reduction

Hospital Protections con't

- Rationale
  - Hospitals serving populations with lower socio-economic status may need additional resources to reduce PAU %
  - Since PAU Savings program is attainment only and does not include improvement methodology, hospitals with higher PAU may be at a disadvantage
  - Policy attempts to limit this potential annual disadvantage while still incentivizing hospitals to reduce PAU % below the statewide level
  - However, does this provide less incentive for reducing PAU among hospitals with lower socio-economic status?

Hospital Revenue Adjustment

- Apply hospital-specific revenue adjustment to total hospital inpatient and outpatient revenue
  - Note: other quality programs are applied to inpatient revenue only
- Entered into update factor as one time adjustments and are not permanent.

PAU and PAU Savings moving forward

- RYs 2019 and 2020
  - No change to measure
  - Phase down of protection?
- RY 2021 and beyond
  - Expand measure to include new types of PAU?
  - Continue to link measure to total hospital revenue?

Potential Potentially avoidable utilization expansion goals

- Capture larger amount of potentially avoidable utilization
  - Research estimates that about 25-30% of total medical care spending is unnecessary or wasteful.*
  - Current PAU measure (% of total hospital revenue) is at about 11%
- Align PAU measures with current and future hospital interventions.
- Enhance comprehensiveness of PAU across hospital service lines

*"Reducing Waste in Health Care, " Health Affairs Health Policy Brief, December 13, 2012.DOI: 10.1377/hpb20121213.959735

Examples of hospital interventions to reduce clinically avoidable spending

Hospitals are implementing programs around population health and care coordination that 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
Physician education around low-value tests	Choosing Wisely measures

Enhance comprehensiveness of PAU across hospital service lines

- Currently eligible for PAU:
  - Readmissions
    - Readmissions: Most IP and OBS >=24 hours cases
    - All ages
  - PQIs
    - IP and OBS >= 24 hours generally on specific medical services lines only
    - 18+
- Other types of services or services lines are included in the total hospital revenue (denominator for the PAU measure) but are not currently eligible for PAU, such as:
  - Admissions on surgical services lines
  - Admissions for ages under 18
  - Any testing or imaging
  - Any outpatient revenue aside from OBS >=24 hours
- Depending on what measures are added to PAU, more of the total hospital revenue could be eligible for PAU

Continue hospital revenue as basis for PAU?

- Current PAU measure is revenue associated with readmissions and PQIs
- Could consider using utilization (ECMADs, discharges) instead of revenue
- Some measures may not be easily linked to revenue (for example, CMS publically available measures of overuse)
- Overtime consider moving towards using full population as the denominator instead of hospital population

Considerations for PAU Measures

- Measure details
  - Endorsed or recognized whenever possible
  - Grounded in literature or research
  - **Include more OP service lines?**
  - **Connect to existing hospital initiatives?**
  - **Link to revenue?**
  - **Hospital-defined PAU?**

- Measure availability
  - Available on an All-Payer basis
  - **Measurable/reportable in HSCRC case mix data?**

Considerations for PAU Use

- 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
  - How could hospital-defined PAU be used?

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 (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)
- Final RY19 PAU Savings Policy (June 2018)

TCOC Model – Measurement Strategy Discussion

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General Priorities Discussion

- Critical Action List to determine priorities under TCOC Model
  - **PLEASE SEE HANDOUT**

- HSCRC welcomes stakeholder feedback on these priorities/timelines.

Complications in TCOC Model – Update

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Complications Sub-Group: Goals and Scope of Work

- Establish Overarching **goals**:
  - Incentivize Maryland hospitals to provide the safest care to their patients
  - Meet or exceed TCOC waiver requirements for at-risk payments linked to Hospital Acquired Conditions and Adverse Events
  - Select high quality performance measures in high priority clinical areas, preferably aligned with CMS payment programs.
  - Other?
- Project **Scope**:
  - Acute Care Inpatient Facilities
  - Fully specified Hospital Acquired Conditions and Adverse Event performance measures currently in use or available for use with discharges in Performance Year 2019.

Complications Sub-Group: Anticipated Deliverables

- Phase I Deliverables (CY 2019 performance, RY 2021)
  - 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, potentially including:
    - Current MHAC patient safety measures;
    - Current QBR patient safety measures; and/or
    - Other measures that meet criteria
  - Develop consensus recommendation on performance measures in the MHAC program regarding payment commitments under the TCOC Waiver

- Phase II Recommendations (CY 2020 performance and beyond)
  - Identify important gaps, and potential future measures to address gaps (especially with eCQMs using EHR data).

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

- Mar 27, 2018
  - Review CMS HAC measures
  - Discuss measure selection process and criteria
  - Identify priority clinical areas for Maryland performance measures
  - Discuss candidate measures inventory
- Apr 24, 2018
  - Review 3M Potentially Preventable Complication (PPC) measures
  - Continue discussion of candidate measures
- May 22, 2018
  - Continue discussion of candidate measures
  - Measure selection from available measures
  - Identify gaps in measurement
- Jun 26, 2018
  - 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

QBR – ED Wait Times

- Per final (approved) RY 2020 QBR policy, commissioners recommended that staff and industry explore additional risk adjustment beyond ED volume. Factors under consideration:
  - Occupancy rates, urban/rural location, case-mix, behavioral health
  - Other thoughts on things we should consider?

- Next Steps
  - Mathematica to complete analysis and develop recommendation
  - MHA is also engaging stakeholders to develop recommendation
  - Plan to have draft recommendation for PMWG input at May meeting; updates in April will be provided as available.

Our next **Performance Measurement Work Group** Meeting is scheduled to take place **Wednesday, April 18th, 2018 at 9:30 AM**

Contact Information

Email: HSCRC.performance@Maryland.gov