Performance Measurement Work Group Meeting

11/20/2018

HSCRC
Health Services Cost Review Commission

Guiding Principles For Performance-Based Payment Programs

- Program must improve care for **all patients**, regardless of payer
- Program incentives should support achievement of **all payer total cost of care model targets**
  - Promote health equity while minimizing unintended consequences
- Program should **prioritize** high volume, high cost, opportunity for improvement and areas of national focus
- **Predetermined** performance targets and financial impact
- Hospital ability to **track progress**
- Encourage **cooperation** and sharing of best practices
- Consider **all settings of care**

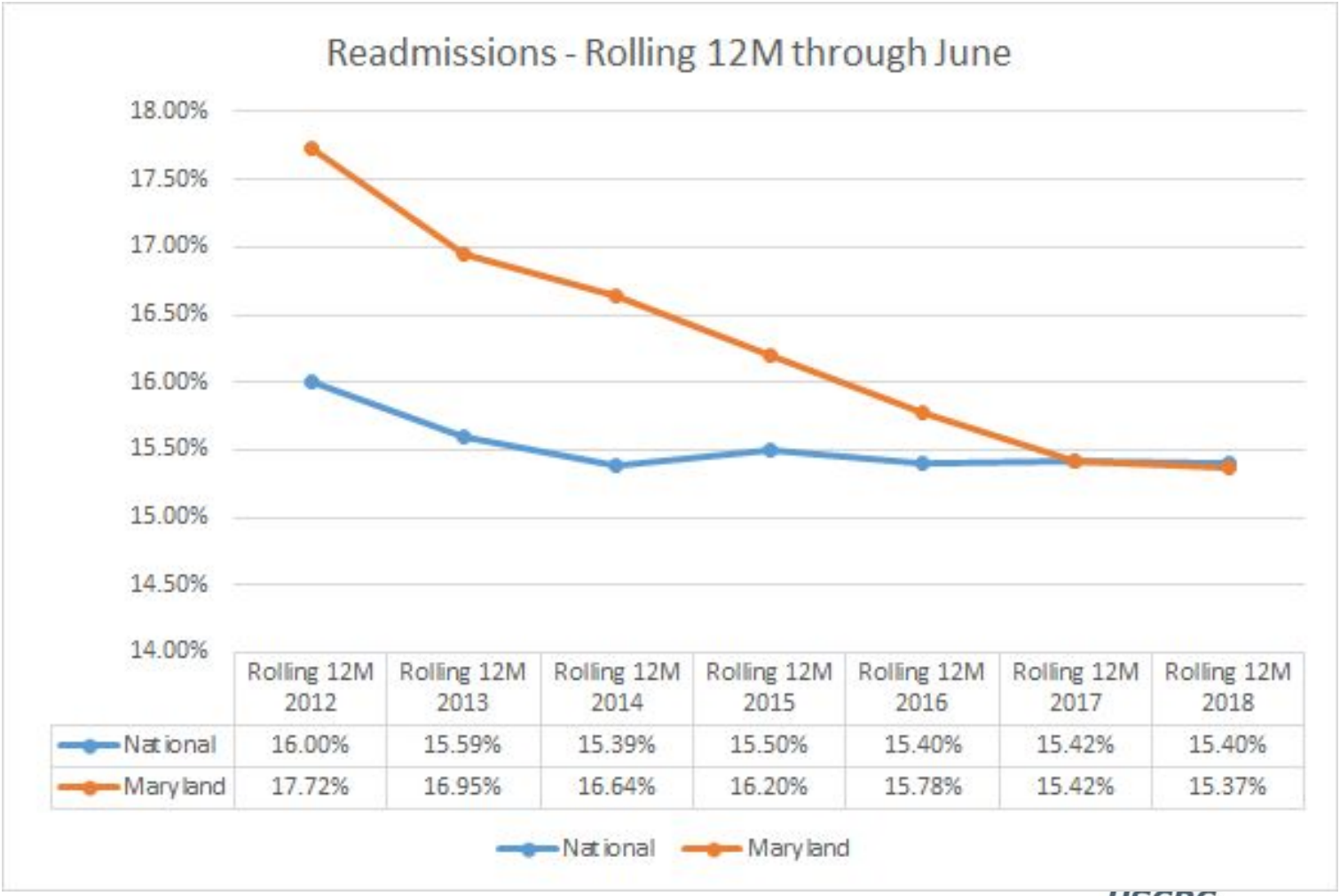
Agenda

- 1. Welcome and Introductions
- 2. RY 2021 RRIP Policy
- 3. RY 2021 MHAC Policy
- 4. RY 2021 QBR Final Policy
- 5. FY 2020 PAU-Follow Up/ Next Steps

Welcome and Introductions

RY 2021 RRIP Policy

Update on Trends from Latest CMMI Data



	Rolling 12M 2012	Rolling 12M 2013	Rolling 12M 2014	Rolling 12M 2015	Rolling 12M 2016	Rolling 12M 2017	Rolling 12M 2018
National	16.00%	15.59%	15.39%	15.50%	15.40%	15.42%	15.40%
Maryland	17.72%	16.95%	16.64%	16.20%	15.78%	15.42%	15.37%

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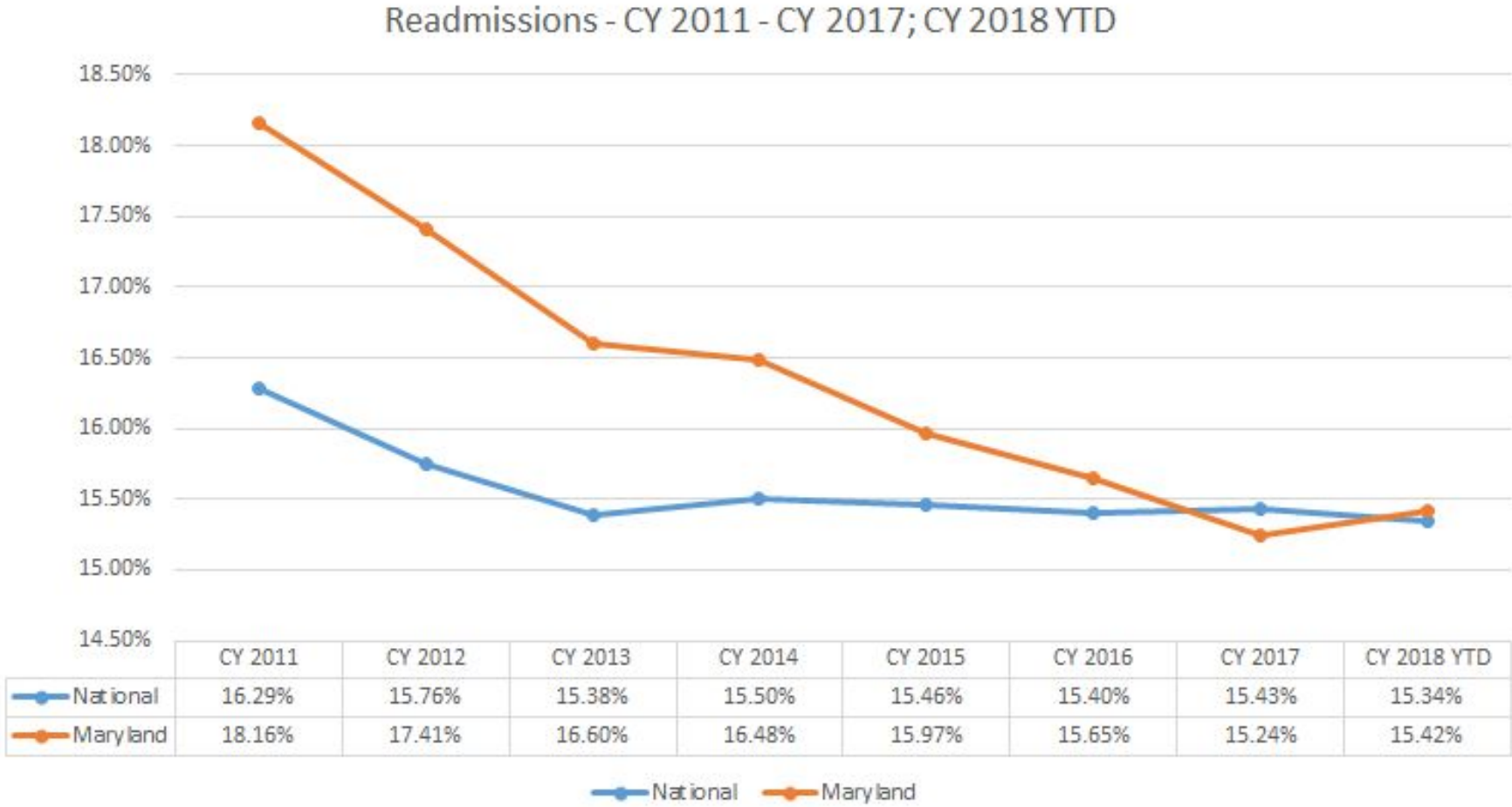

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018 YTD
National	16.29%	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.34%
Maryland	18.16%	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.42%

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RY 2021 RRIP Considerations

- Readmission Measure:
  - Staff recommendation: Calculate readmissions for acute care hospitals with readmissions to specialty hospitals
- Improvement target:
  - Staff recommendation: Continue to set improvement target as projection of national medicare rate plus cushion
- Attainment target:
  - Reward hospitals with relatively low readmission rates
  - Consider expanding the definition of 'relatively low' to reward more hospitals, commensurate with improvement relative to the nation

Flowchart of Predicting Improvement Target

Step 1

- **Project CY 2019 National Medicare rates [15.33%]**

Step 2

- **Add a cushion to Medicare projections [15.23%; 15.13%; 15.03%]**

Step 3

- **Convert MD Medicare (projected) rate to All-Payer Case-mix Adjusted Rate [11.50%; 11.42%; 11.35%; 11.27%]**

Step 4

- **Calculate 2016-2019 Improvement Target (RY 2021) [[-1.91%; -2.55%; -3.19%; -3.83]**

HSCRC expects to have more recent data to improve predictions for final policy.

Step 1-2: Improvement Target and Forecasting

Model	AAC	MRAC	12MMA	24MMA	PROC	ARIMA	STL
CY 2019	15.41%	15.39%	15.37%	15.39%	15.07%	15.36%	15.31%

	Average of Predictive Models	With additional 0.1% Cushion	With additional 0.2% Cushion	With additional 0.3% Cushion
Medicare FFS Projection	15.33%	15.23%	**15.13%**	15.03%
All-Payer Case-mix Adjusted Rate*	11.50%	11.42%	11.35%	11.27%

*Using calculated All-Payer to Medicare FFS ratio of 75.0%

Step 3: Conversion to All-Payer Target

- Once MD Medicare reduction target is determined, need to calculate corresponding All-Payer reduction
- Last year, tested multiple methods and ended up using the ratio of the MD Medicare numbers from CMMI and the all-payer case-mix adjusted readmission rate:
  - Average of ratios for 2012-2018 is 75.0%
  - The all-payer case-mix readmission rates will include specialty hospitals

Projected CY 2019 National Medicare FFS	15.33%	15.23%	15.13%	15.03%
Corresponding All-Payer Case-mix Adjusted Rate*	11.50%	11.42%	11.35%	11.27%
CY 2016-2019 All-Payer Improvement	-1.91%	-2.55%	**-3.19%**	-3.83%

Attainment Target

- Adjust attainment target by ranking hospitals by Case-mix Adjusted Readmissions (further adjusted for out-of-state readmissions)
- Decrease calculated readmission rate to further incent improvement
  - 18-month improvement (Current 2018YTD Jun extended to projected CY2019)
- Establish benchmark and threshold based on percentiles of top performers
  - Consider expanding distance between threshold and benchmark

RY 2021 Proposed Revenue Adjustment Scales (Better of Attainment or Improvement)

All Payer Readmission Rate Change CY16-CY19		RRIP % Inpatient Revenue Payment Adjustment
	A	B
Improving Readmission Rate		1.0%
	-13.70%	1.00%
	-8.45%	0.50%
Target	-3.20%	0.00%
	2.05%	-0.50%
	7.30%	-1.00%
	12.55%	-1.50%
	17.80%	-2.0%
Worsening Readmission Rate		-2.0%

All Payer Readmission Rate CY19		RRIP % Inpatient Revenue Payment Adjustment
	A	B
Lower Absolute Readmission Rate		1.0%
Benchmark	8.44%	1.00%
	9.57%	0.50%
Threshold	10.69%	0.00%
	11.82%	-0.50%
	12.94%	-1.00%
	14.07%	-1.50%
	15.19%	-2.0%
Higher Absolute Readmission Rate		-2.0%

Proposals for 2019 Sub-Group

- Staff will convene readmission subgroup in early 2019 to consider issues, such as:
  - Attainment vs Improvement
  - Socio-demographic risk-adjustment for attainment only program
  - Shrinking denominator issue and per capita approaches
  - By payer data sources for benchmarks
  - Observation stays
- Those interested in participating in subgroup should email hscrc.quality@maryland. gov and provide brief bio and reason for interest

RY 2021 MHAC Policy

RY 2021 MHAC Program Decisions

- Narrowed down, targeted measure list
- Cost-weights
- Attainment-only
- **Expanded Scoring Methodology**
- **Revenue At-Risk and Adjustment Scale**

Measure Selection

- For payment program, proposing 14 PPCs with higher rates, variation, and clinical support
- No national comparison, but 3M is developing national norms under v36 that should be available in early 2019
- In future years, staff will assess AHRQ Patient Safety indicators or other new measures that have national comparability

- **See handout for PPC list with descriptive statistics**

3M Cost-Based Weights: Proxy for Harm

- The cost estimates are the relative incremental cost increase for each PPC, which can be a proxy for the harm of the PPC within the hospital stay.
- 3M plans to update cost weights under v36/ICD-10 logic in month and staff will evaluate changes to make decision on whether to update.

- **PMWG Discussion (note all subsequent modeling applies these weights)**

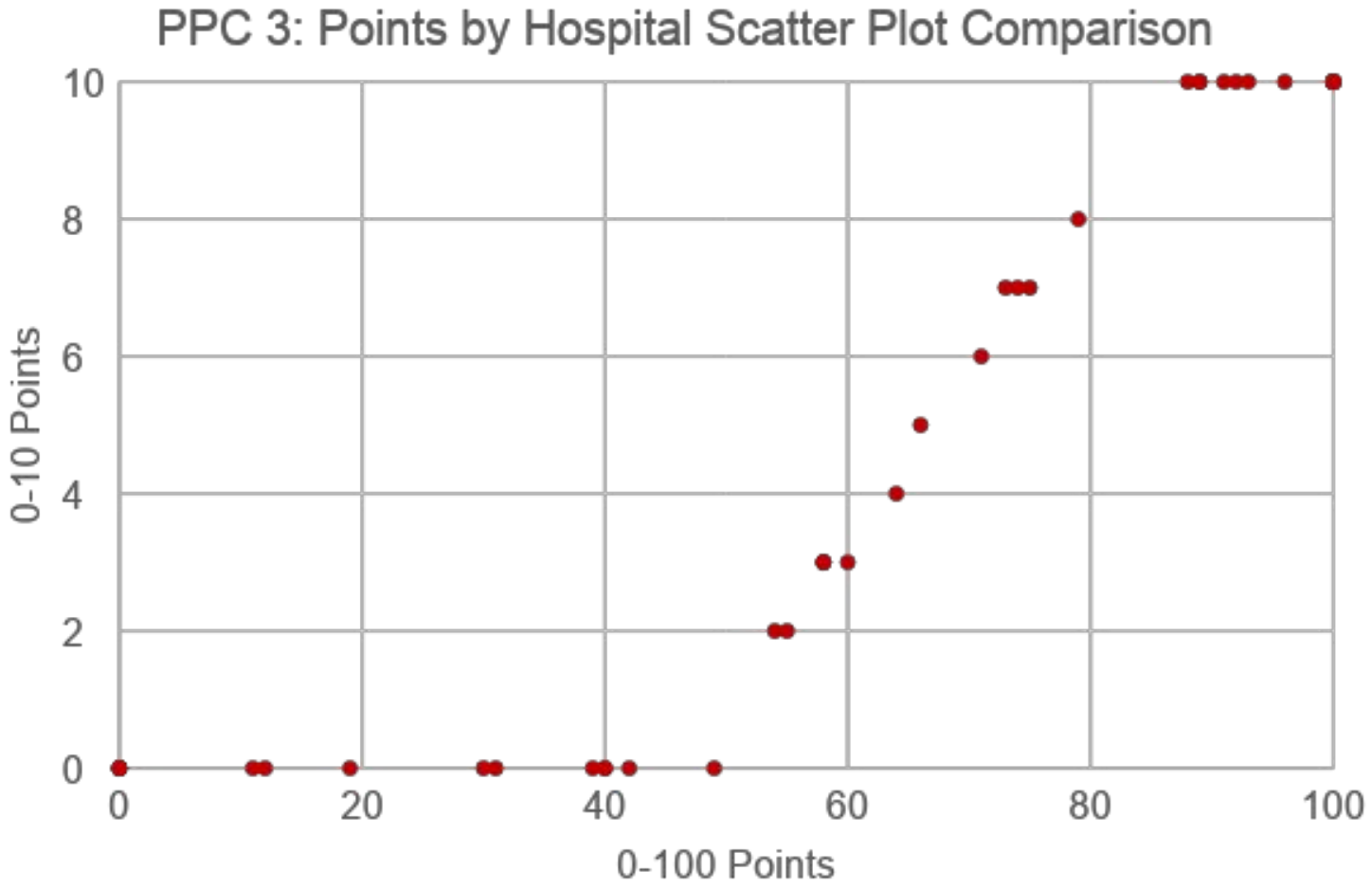
Hypothetical Example with Three PPCs: Weights Applied to Scores								
	PPC	**Attainment Points**	**Denominator**	**Unweighted Score**	**Weight**	**Weighted Attainment Points**	**Weighted Denominator**	**Weighted Score**
Hospital A **Worse on Higher Weight**	PPC X	10	10		0.5	5	5	
	PPC Y	5	10		1	5	10	
	PPC Z	3	10		2	6	20	
		18	30	60%		16	35	46%
Hospital B **Worse on Lower Weight**	PPC X	3	10		0.5	1.5	5	
	PPC Y	5	10		1	5	10	
	PPC Z	10	10		2	20	20	
		18	30	60%		26.5	35	76%

Attainment Only and Expanded Scoring Methodology

- Rationale:
  - Consistent with National HACRP program
  - Maryland has been rewarding improvement for last 5+ years and at this point should expect hospital attainment

- Considerations:
  - Measure annual performance to allow for change in performance to be recognized more quickly
  - Prospective program requires performance standards and PPCs to be determined using historical data
  - Use wider range of performance standards and more granular points under attainment only approach
    - **Current:** Scoring methodology assigns 0-10 points based on performance compared to the median (threshold) and top performers accounting for 25% of discharges (benchmark)
    - **Expanded:** Modify scoring methodology to assign 0-100 points based on 10th percentile threshold and 90th percentile benchmark; the 10th and 90th percentile cutoffs are open to PMWG discussion.

Example: Current vs Expanded Scoring



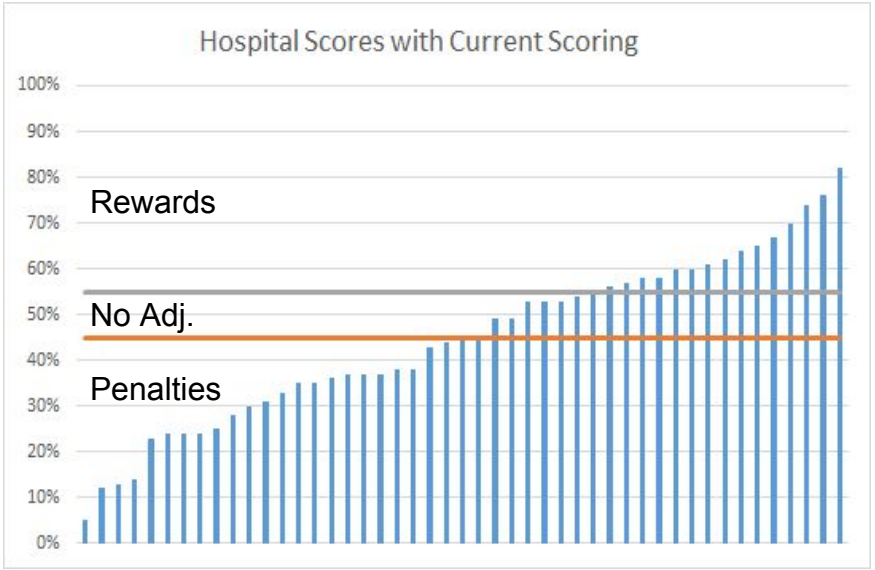
Hospital Scores

- Hospital scores with PPC weighting:
  1. Improvement and attainment with current scoring approach
  2. Attainment only with current scoring approach
  3. Attainment only with expanded scoring approach

Hospital Score Distribution	Current Threshold/Benchmark 0-10 Points with Att & Imp	Current Threshold/Benchmark 0-10 Points with Att Only	Expanded Threshold/Benchmark 0-100 Points
25th percentile	34%	31%	51%
50th percentile	49%	45%	60%
75th percentile	63%	58%	71%
average	50%	45%	60%
min	13%	5%	15%
max	82%	82%	85%

Under expanded scoring approach, the median hospital score is 15 percentage points higher

Attainment Only Hospital Scores with Revenue Adjustment Cutpoints



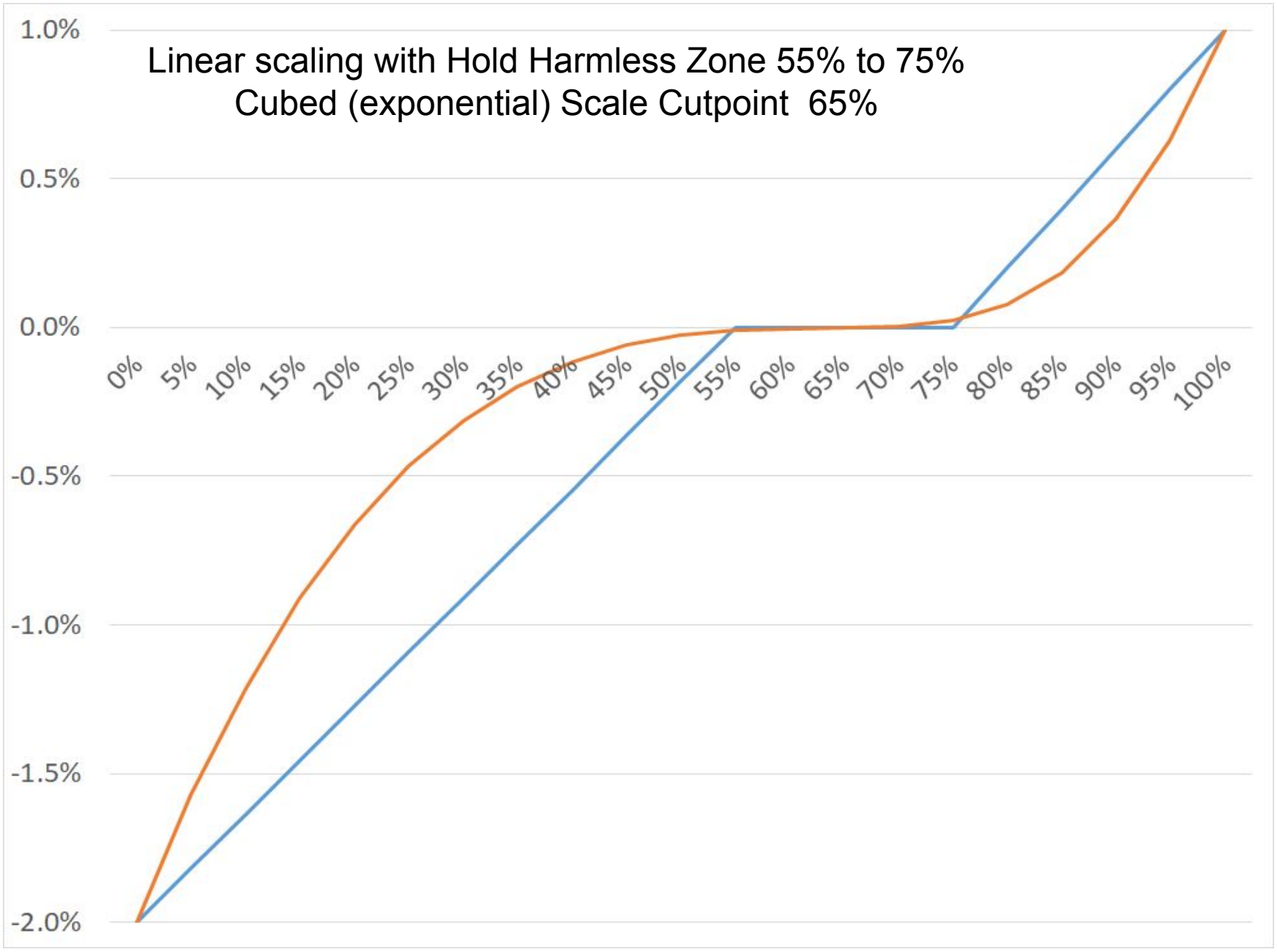
Penalty Cutpoint: 45%

Reward Cutpoint: 55%

Penalty Cutpoint: 55%

Reward Cutpoint: 75%

Expanded Scoring requires adjustments to revenue cutpoints; hold harmless zone raises concerns on incentives


Linear scaling with Hold Harmless Zone 55% to 75%
Cubed (exponential) Scale Cutpoint 65%
1.0%
0.5%
0.0%
-0.5%
-1.0%
-1.5%
-2.0%
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%
50%
55%
60%
65%
70%
75%
80%
85%
90%
95%
100%

Revenue Adjustment Descriptive Stats

Hospital Revenue Adjustments	Att & Improvement, current methodology	Att Only, current methodology	Att Only, expanded scoring with 55%-75% cutpoints	Att Only, expanded scoring with cubed scale
# Hospitals Penalized	20	23	16	26
# Hospitals No Adjustment	7	9	25	5
# Hospitals Rewarded	20	15	6	16
25th percentile	-0.49%	-0.62%	-0.15%	-0.02%
50th percentile	0.00%	0.00%	0.00%	0.00%
75th percentile	0.18%	0.07%	0.00%	0.00%
average	**-0.13%**	**-0.28%**	**-0.12%**	**-0.04%**
min	-1.42%	-1.78%	-1.45%	-0.91%
max	0.60%	0.60%	0.40%	0.19%

Max Penalty and Reward

- New RY2021: approximately 0.5 percent all-payer revenue at-risk under Medicare Performance Adjustment
  - Counts towards aggregate risk but is for Medicare only
  - Should all-payer revenue at-risk be reduced because of MPA? If so, what program should be reduced?
  - If max penalty reduced, should max reward be reduced?

MD All-Payer	Max Penalty %	Max Reward %
MHAC	2.0%	1.0%
RRIP	2.0%	1.0%
QBR	2.0%	2.0%

Next Steps?

- Discussion

- Analysis of 80% exclusion--impact on RY2020
- Review of updated 3M Cost Weights
- Scoring methodology--assess impact of small changes in observed PPCs
- Decision on revenue at-risk and adjustment scale

RY 2021 QBR Final Policy

Revenue Adjustment Follow Up

- **Concern**: 45% cut off may be too aggressive

- **Analysis**:

FFY 2016	FFY 2017	FFY 2018
42%	**40%**	**41%**

- **Recommendation:** Previous scale allowed for rewards irrespective of comparability to the nation. Staff's desire is to provide rewards for comparably good performance relative to the nation. Staff supports a 45% penalty/reward cutoff

Potentially Avoidable Utilization (PAU)

November PMWG

Takeaways from last meeting

- Last month PMWG reviewed direct and geographic per capita PQI approaches
  - Direct: Attribute PQIs to receiving hospital if patient is in hospital's PSAP
  - Geographic: Hospitals accountable for PQIs in their PSAP
- Takeaways from meeting
  - Interest in moving to a per capita approach
  - Preference for gradual approach
  - Concern that geographic approach dilutes responsibility, but may more fairly attribute across hospitals with different service lines
  - Support for pediatric measures
  - Interest in SNF measures, but concerns about per capita and risk-adjustment
- Given these tradeoffs, staff is assessing an provider /geography approach suggested by MHA

Provider/Geography Attribution Approach

- Stakeholder interest in using patient-provider-hospital relationships to help attribute PQIs
- Medicare Performance Adjustment (MPA) is the only HSCRC methodology currently linking patients to providers to hospitals
  - MPA attributes Medicare beneficiaries to primary care providers based on primary care use, and then links providers with hospitals based on existing relationships
- Could envision similar approaches for other payers, but do not currently have existing mechanisms/data

MPA 101
A scaled adjustment for each hospital based performance relative to a Medicare Total Cost of Care (TCOC) benchmark

Provider/Geography Attribution Approach (con't)

- Could use existing Medicare Performance Adjustment (MPA) attribution for the Medicare FFS beneficiaries and geographic attribution for all other payers
- Rationale
  - May help align hospital efforts across programs
    - Focus on the same population
  - Reduces overlapping responsibility
  - May be more actionable for hospitals
  - Keeps geographic approach for pediatric patients

Data/Logistical Concerns

• Different attribution for different payers
• Case-mix and CCLF data (MPA data source) may not tie together exactly
  ○ Different Maryland resident definitions, Part A/B, exclusions, etc.
• Reliant on MPA attribution
  ○ Any changes to MPA attribution would impact PAU
  ○ Revised MPA attribution likely not finalized until after January

Review of options

- Geographic
  - Attributes PQIs and population to one or more hospitals based on patient residence and hospital service areas, regardless of which hospital treated the PQI
- Direct
  - Attributes PQIs to hospital that treated the PQI, if the patient's residence is in the hospital's service area. Attributes population based on hospital service areas.
- Provider/Geography (aka MPA)
  - Attributes patients and corresponding PQIs to hospitals based on outside algorithm. Remaining PQIs attributed to hospitals based on geography

Staff assessment

	Geographic	Direct	Provider/Geography
Alignment with pop health/TCOC Model	Enhanced	Status quo	Enhanced
Additional Populations	✔	✖	✔
Fairness	✔	✖	✔
Risk Adjustment	✔	Potentially	Potentially
Comprehensiveness	✔	✖	Likely, may lose some Medicare A only or B only
Clarity	✔	✔	~
Engagement	Proactive	Reactive	Proactive
Data Availability	Aggregate	✔	Aggregate and through MPA reporting

Per Capita PQI Adjustments – spring work

- How should we look at border crossing?

- Risk adjustment
  - Stakeholders interest to take into account demographic differences across areas
  - AHRQ uses indirect standardization to risk-adjust PQIs by age groups and sex (National adjustment not yet available under ICD-10)
  - HSCRC staff will explore AHRQ risk-adjustment when national benchmarks are released, but geographic attribution is necessary
  - May require extra work/consideration if we do not use a geographic approach

Staff suggestion on readmissions

- Implement readmissions per capita on a direct approach using the sending hospital as the link and PSAP as the denominator.
  - Focuses PAU readmissions measure on discharge planning and follow-up within a hospital's community
  - Responsive to hospital and clinical concerns of sending vs. receiving hospital
  - Direct approach provides greater link to hospitals discharging patients compared to MPA
- Excludes readmissions that occur outside of the sending hospital's PSAP
  - Limited comprehensiveness may be an acceptable tradeoff, especially given all readmissions included in RRIP