



Performance Measurement Work Group Meeting

2/19/2020

Agenda

1. Welcome and introductions
2. Potentially Avoidable Utilization (PAU)
3. Readmissions Reduction Incentive Program (RRIP)
4. Quality Based Reimbursement (QBR) Subgroup Overview
5. Qlarant QIN Scope of Work Overview

Potentially Avoidable Utilization (PAU) Program

PAU Measurement Report

- ▶ Staff presented a RY21 and RY22 PAU Measurement Report to the Commission in February.
- ▶ Measurement Report Goals:
 - ▶ Provide progress report on efforts to modernize PAU
 - ▶ Per Capita PQIs
 - ▶ PDIs
 - ▶ PAU subgroup
 - ▶ Low value care exploration
 - ▶ Align PAU Savings program timeline with other quality program timelines (performance measurement determined earlier in performance year)
 - ▶ Request Commissioner feedback on strategic direction

Review IP/OBS consideration

▶ Concern

- ▶ Last month, PMWG members were concerned that it was confusing to show the inpatient expected values of PQIs and inpatient + Obs > 24hrs observed values of PQIs

▶ Solution

- ▶ HSCRC to display both inpatient rate and inpatient rate with observation stays greater than 24 hours.
- ▶ Data type filters will be added to the Tableau Avoidable Admissions Report

RY2021 Adjustment

- ▶ Will bring hospital-specific methodology/modeling to March meeting
- ▶ Percent Reduction
 - ▶ Plan on using the inflation-based calculation developed last year to calculate the PAU Savings amount in the spring
- ▶ **New:** Exclude dollars associated with categorical exclusions to align with Innovation policy

Avoidable ED

Overall impetus for discussion

- ▶ All Payer Model focused on reducing avoidable inpatient utilization and appropriately moving services down the continuum of care. In the Total Cost of Care Model, staff need to consider avoidable utilization in other settings.
- ▶ Multiple programs/policies related to the TCOC model reference avoidable ED, but may use different definitions
- ▶ Interest in selecting one definition to be used as the default definition through analyses and reporting

Why Avoidable ED

- ▶ Research shows it can be impacted
- ▶ MDPCP investments in PCPs - should have reduced avoidable ED utilization
- ▶ Hospitals have impacted avoidable ED rates, but those reductions are shared in market shift
- ▶ Mentioned in our RTI report

Avoidable ED - Goals for today's meeting

- ▶ Introduce Avoidable ED concept
 - ▶ Opportunities and challenges
 - ▶ Timeline
- ▶ Introduce Avoidable ED definitions
 - ▶ NYU/Billings Algorithm
 - ▶ Adaptations of PQI definition
 - ▶ All Payer Model Evaluation definition
 - ▶ MedPAC/RTI definition
 - ▶ 3M PPV
- ▶ Review Preliminary results

Avoidable ED

- ▶ **What is avoidable ED? Can be split into two buckets:**
 - ▶ Preventive - ED care needed but could have been prevented with community and primary care
 - ▶ Care pathways- alternative setting of care
 - ▶ Also preventive
 - ▶ Treatment required within 12 hours, but could be treated by primary care or other outpatient providers
 - ▶ Non-emergent

Avoidable ED Opportunities / Challenges

- ▶ **Regulatory Challenges**
 - ▶ Care settings with EMS
 - ▶ EMTALA
- ▶ **Other Challenges**
 - ▶ Insurance Coverage
 - ▶ Physician supply

Timeline

- ▶ **CY2020 Q1 (Current): ED measure selection and initial testing**
- ▶ CY2020 Q2: Discuss attribution approaches and develop risk adjustment if applicable
- ▶ CY2020 Q3-Q4: Build summary reporting and incorporate selected ED measures into data
- ▶ CY2021 Q1: RY2023 PAU measurement report, potentially recommending avoidable ED measure inclusion in RY2023 PAU measurement (CY2021 Performance Period).

Potential Avoidable ED definitions

- ▶ Asked MPR to do an environmental scan of definitions
 - Found three-four potential types of definitions
- ▶ New York University (NYU) ED visit algorithm
- ▶ Adaptations of PQI
 - ▶ All Payer Model avoidable visits
 - ▶ RTI/MedPAC avoidable visits
- ▶ 3M Potentially Preventable Emergency Room Visits (PPV)

NYU / Billings Algorithm

- ▶ Claims-based measure for assessing the probability that an ED visit with a given discharge diagnosis falls into one of the four categories:
 - ▶ (1) a non-emergency;
 - ▶ (2) an emergency treatable in primary care setting;
 - ▶ (3) an emergency not treatable in primary care setting but preventable or avoidable; and
 - ▶ (4) an emergency not preventable or avoidable.

Non-emergent: Record indicated that immediate medical care was not required within 12 hours;	Emergent- ED care Needed- Preventable.Avoidable: •ED care was required, but was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness
Emergent/Primary Care Treatable: treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting.	Emergent- ED Care Needed- not preventable/avoidable: ED care was required and ambulatory care treatment could not have prevented the condition

NYU/Billings Algorithm continued

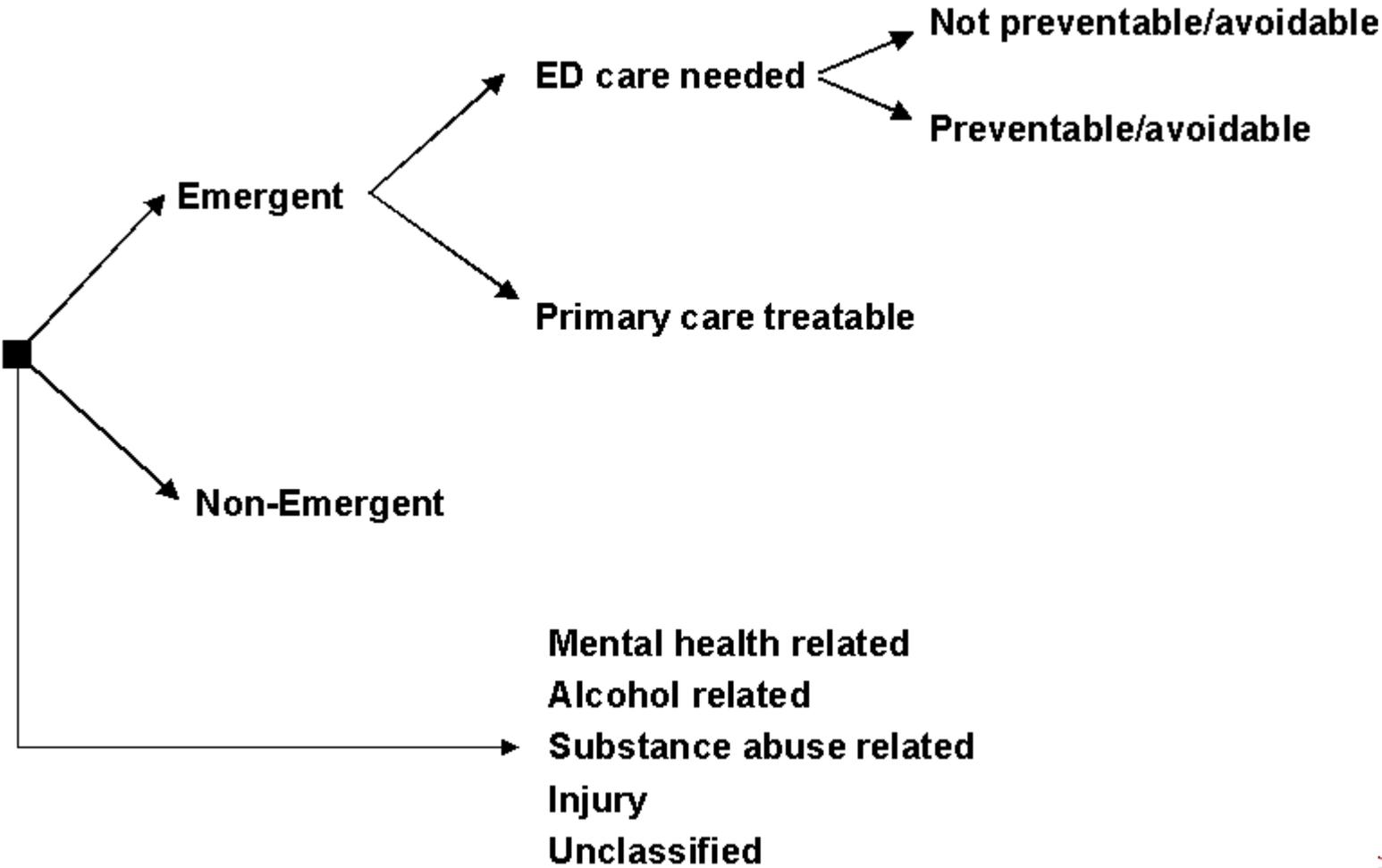
▶ Probabilities

- ▶ Probabilities developed in the 1990s by NYU researchers
- ▶ Based on study of clinical information from 6,000 ED records in six Bronx, New York hospitals
- ▶ Estimated probabilities can then be aggregated to the population level
- ▶ No measure steward that updates each year

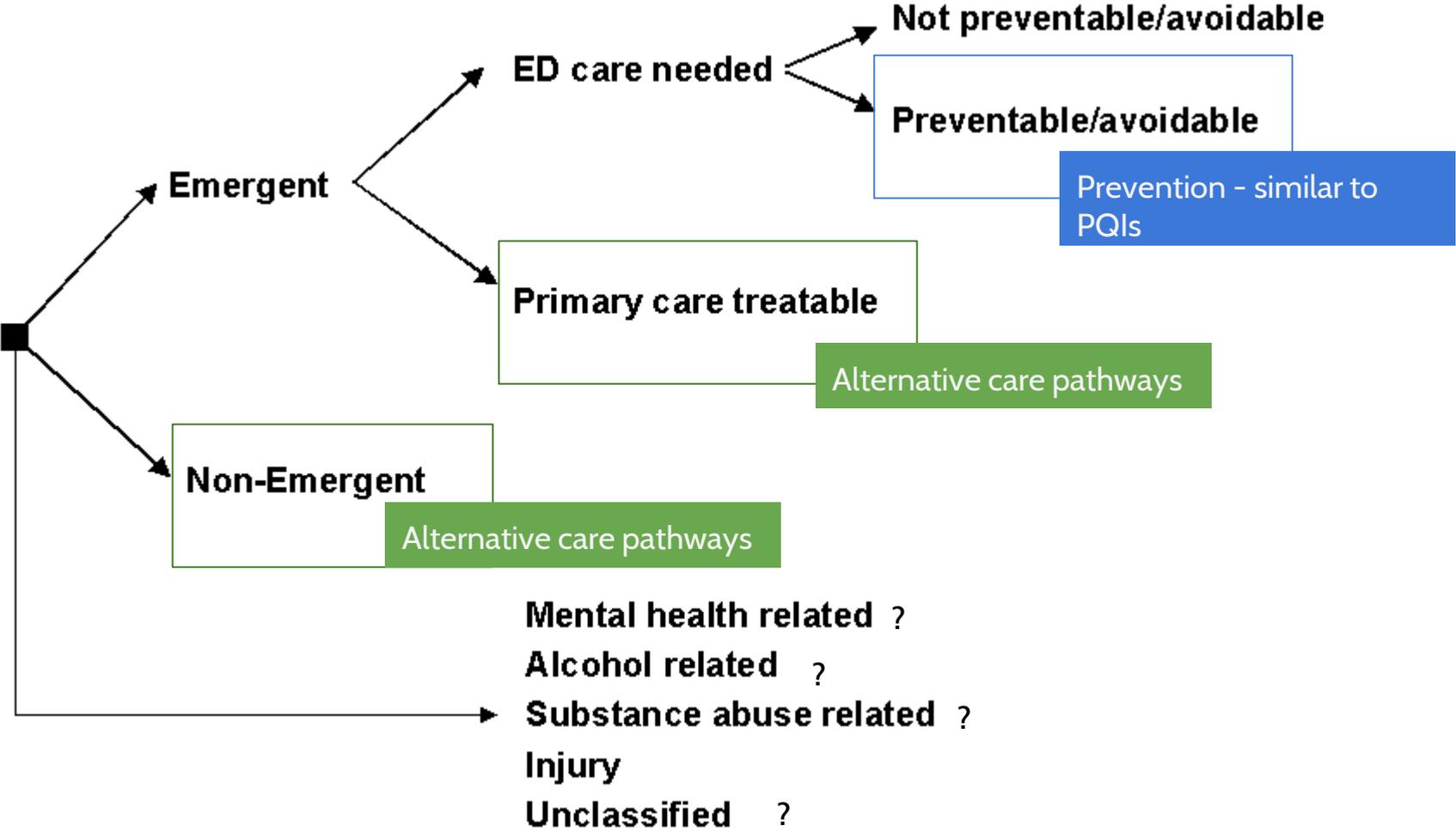
▶ The NYU algorithm has been widely used in academic research, state programs, and numerous local and industry-led quality initiatives.

- ▶ Pennsylvania Rural Health Model quantifying opportunity
- ▶ The New York State Department of Health dashboards

NYU/Billings Algorithm categories



NYU/Billings Algorithm categories



Adapted PQI (All Payer Model Eval)

- ▶ Potentially avoidable ED visits measure used in the Evaluation of the Maryland All-Payer Model published by CMS (Susan Haber et al, 2019)
- ▶ Included only four ACSC conditions (chronic COPD or asthma, bacterial pneumonia, uncontrolled diabetes, and heart failure).

MedPAC / RTI Avoidable Visits

- ▶ Developed by RTI and considered by the Medicare Payment Advisory Commission (Feng, et al. 2019).
 - ▶ builds on PQIs and HEDIS measures for Hospitalization for Potentially Preventable Complications (HPC).
- ▶ **Include:**
 - ▶ diabetes, chronic obstructive pulmonary disease (COPD), asthma, hypertension, heart failure, bacterial pneumonia, urinary tract infection, cellulitis, pressure ulcers, upper respiratory infection/otitis/rhinitis, influenza (without pneumonia), and nonspecific back pain.
- ▶ RTI AV measure classifies visits to binary categories, assuming that any ED visit is either potentially avoidable or not based on the diagnosis or procedure code.

3M PPV Measure

- ▶ 3M Potentially Preventable Emergency Room Visits (PPV) measure identifies ED visits for conditions that could otherwise be treated in a nonemergency setting.
- ▶ **Proprietary**
- ▶ Assigns each ED visit to a 3M Enhanced Ambulatory Patient Group (EAPG) based on claim procedure codes
 - ▶ potentially preventable if the assigned EAPG is one of the ambulatory sensitive conditions defined by the algorithm
- ▶ Follows a similar logic as the RTI AV measure, but enables users to measure specific types of potentially avoidable ED visits.
 - ▶ Several states—such as New York, Florida, and Minnesota—are using the 3M PPV software to monitor ED visits for their all-payer and/or Medicaid populations.



Conditions captured

	APM evaluation	RTI/MedP AC AV measure	Billings
Diabetes	M	A	M
COPD or asthma	A	A	M
Hypertension		A	M
Heart Failure	A	A	S
Bacterial Pneumonia	A	A	M
UTI		A	A
Cellulitis		A	M
Pressure Ulcers		A	Unclassified
Upper respiratory infection/otitis/rhinitis		A	M
Influenza (without pneumonia)		A	S
Non specific back pain		A	S
Mental health/substance use			
Injury subsequent encounters			M
Cutaneous abscess			A
Gastroenteritis			A
Pain in throat and chest			S
Other			S

A = Avoidable, M = Mostly Avoidable, S = Somewhat Avoidable

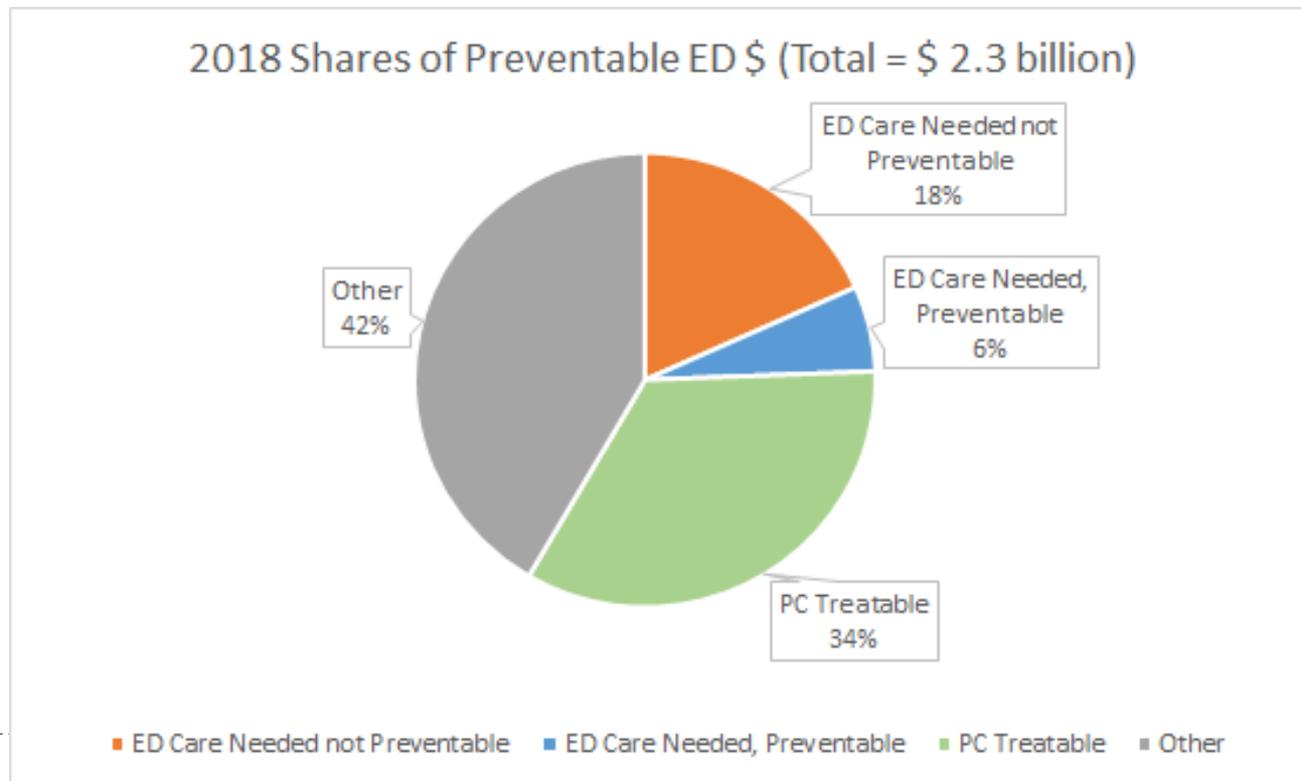
Applying analyses to data

All analyses are on HSCRC ED data that does not lead to an admission or an observation stay greater than or equal to 24 hours.

Preliminary Results

▶ See Spreadsheets

- ▶ CY 17 and CY18
- ▶ General ED counts and charges by paper
- ▶ Avoidable using original algorithm



RRIP

RY 2022 RRIP Draft Recommendations

1. Readmission measure changes:
 - a. Include oncology with cancer-specific clinical adjustments
 - b. Exclude patients discharged AMA from denominator
2. Readmission Improvement Target: -7.5% over five years (-3.07% by end of 2020)
3. Readmission Attainment Target: Maintain current 65 percent attainment threshold for earning rewards based on updated benchmarking
4. Implement payment incentives on disparity gap metric (Reward-Only)
5. Develop all-payer EDAC to assess ED and OBS revisits

Commissioner Feedback and Next Steps

▶ Commissioner Feedback -

- ▶ Clarify -7.5% Improvement Rate, i.e., 2018 = 11.44% -->2023 = 10.58% (or 0.86 percentage point reduction)

- ▶ Obtain Medicare Unadjusted Statewide Ranking

- ▶ 2013 and 2017 State rankings from prior QIOs

2012: MD #52 of 53 States/Territories in Readmission Rate;

2017: MD #29 of 53 States/Territories in Readmits per 1000;

2017: MD #1 in year-over-year improvement in Readmits per 1,000

▶ Next Steps

- ▶ Evaluate out-of-state ratios for Commercial and Medicaid
- ▶ Comment letters are due TODAY, Feb 19
- ▶ HSCRC will finalize policy and prepare base period data

Disparity Measure -

Commissioner Feedback and Next Steps

▶ Commissioner Feedback -

- ▶ Identify opportunities to collaborate with Medicaid managed care on disparity reduction
- ▶ Evaluate potential for unintended consequences
 - ▶ Will hospitals attempt to avoid high-PAI patients?
 - Statistical model takes into account hospital average PAI
 - Disparity incentive should be calibrated relative to the main RRIP incentives, such that overall improvement in readmissions is still primary driver of behavior

▶ Next Steps

- ▶ Interim reporting of demographic components within PAI (unweighted) will be added to detail-level readmission reports in March
- ▶ Staff working to develop additional reporting.

Policy Evaluation

- ▶ Introduction of disparity incentive in payment program is innovative and would make Maryland the first state in the nation to pilot such an approach:
 - ▶ If we only monitor, we cannot gauge the impact of payment incentives
 - ▶ Thus staff recommends implementing in RY 2022 as a reward only program
- ▶ Based on experience with disparity gap metric in payment program, in future years staff may recommend:
 - ▶ Changes to PAI or gap estimation methods
 - ▶ Modification to financial incentives

Staff Proposal

- ▶ Restrict disparity reward eligibility to hospitals with reduction in overall readmission rate
- ▶ **RY 2022:** Base Year 2018 Performance Year 2020
- ▶ Preliminary goal, pending SIHIS development, is a 50% reduction in disparity over 8 year TCOC Model
- ▶ Proposed RY 2022 reward of:
 - ▶ 0.25% of IP revenue for hospitals on pace for 25% reduction in 8 years, $\geq 6.94\%$ reduction in disparity gap
 - ▶ 0.50% of IP revenue for hospitals on pace for 50% reduction in 8 years, $\geq 15.91\%$ reduction in disparity gap

Hospital Reporting

- ▶ Staff will develop quarterly disparity performance analytics for distribution to hospitals in the near future
- ▶ Report components
 - ▶ Descriptives on hospital patient population
 - ▶ % black, % Medicaid, mean ADI
 - ▶ Estimated disparity gap (rolling four quarters) in comparison to hospital's base year
 - ▶ Estimated disparity gap (rolling four quarters) in comparison to other hospitals
 - ▶ Estimated readmission rate by PAI components

Quality Based Reimbursement (QBR) Subgroup

QBR Redesign Subgroup Purpose and Goals

- ▶ Consider options for overhauling the program to continue to meet or exceed the cost and quality outcomes of the national VBP program
- ▶ Ensure the state achieves the goals of the TCOC Model of better care with improved health outcomes, while slowing the growth of health spending
- ▶ Within the scope specified, the goals of the Subgroup will include reviewing and suggesting options for:
 - ▶ Updating measures in the QBR program
 - ▶ Updating the scoring and incentives
 - ▶ Measurement data sources

QBR Redesign Scope of Work

1. Consideration of options for targeting HCAHPS improvement
 - Revising incentives to improve performance
2. Consideration of ED wait time measurement issues
 - Consider options for data sources or data development such as eCQM ED-2b measure, or ADT feed
 - Measure alignment with incentives of Model
 - Need and options for potential additional risk adjustment
3. Exploration of complementary measures that align with State Integrated Health Improvement Strategy (SIHIS) & RTI Maryland Model evaluation report, e.g.:
 - Follow-up after discharge measure
 - Other care coordination elements that can reinforce use of Chesapeake Regional Information System for our Patients (CRISP) data



QBR Redesign Scope of Work, Continued.

4. Refinement of existing measures/domains
 - Mortality: Shift from current all-payer, all-condition inpatient measure to all-payer, all-condition 30-day mortality
 - Patient Safety Indicator Composite: Implement all-payer PSI composite
 - Total Hip/Total Knee complications (THA-TKA): Consider feasibility of implementing all-payer measure.
5. Consideration of “attainment only” scoring for various aspects of the program, i.e. mortality
6. Movement to outpatient hospital/ambulatory surgery, e.g.:
 - New measures such as return to hospital after colonoscopy or surgery at ambulatory surgery center
 - THA-TKA complications after outpatient hospital surgery
7. Consideration of alternative measurement topic or domain options for needed improvement areas in Maryland, e.g.:
 - Maternal health care
 - Incentives for improving disparities
 - Palliative Care



Qlarant (pronounced “Clarant”)
QIO Presentation

Enhance the Health of Your Community

Partner with the IPRO QIN-QIO

Health Services Review Commission Meeting
Performance Measurement Work Group
February 19, 2020



- Healthcentric
Advisors
- Qlarant

Meet Your Presenters



Bonnie Horvath, MHA, FACHE
Senior Director, Quality Improvement



Dr. Paula Neuman, Ed.D., PSYD., MSCP, HSPP
*Director of Behavioral Health / Neuropsychologist,
Clinical Psychopharmacologist*



Lisa Nanton, CPhT
Quality Improvement Consultant



Angela Diggs
*Project Manager,
Chronic Disease*



Janet Jones
Project Manager, Care Transitions



Charlotte Gjerloev, BSN, RN
Project Manager, Nursing Home Quality

The IPRO QIN-QIO – Who We Are



- Healthcentric Advisors
- Qlarant

The federally funded Medicare Quality Innovation Network – Quality Improvement Organization for 11 states and the District of Columbia

- Led by IPRO
- Joined by **Healthcentric Advisors** and **Qlarant**
- Offering enhanced resources and support to healthcare providers and the patients and residents they serve
- Promoting patient and family engagement in care
- Supporting implementation and strengthening of innovative, evidence-based, and data-driven methodologies to support improvements



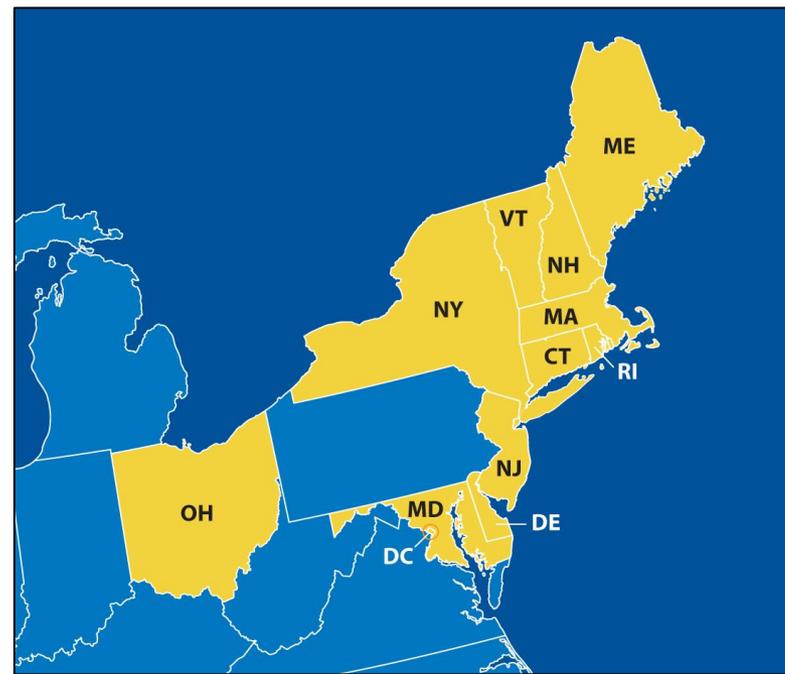
The IPRO QIN-QIO – Where We Are

The IPRO QIN-QIO Region

IPRO: New York, New Jersey, Ohio

Healthcentric Advisors: Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island

Qlarant: Maryland, Delaware, District of Columbia



Working to ensure high-quality, safe healthcare for 20% of the nation's Medicare beneficiaries



QIN-QIO vs. BFCC-QIO



- Healthcentric Advisors
- Qlarant

Quality Innovation Network – Quality Improvement Organizations (QIN-QIOs)

- Bring together healthcare providers, stakeholders, and Medicare beneficiaries to improve the quality of healthcare for targeted health conditions
- 12 regional CMS QIN-QIOs

Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs)

- Manage all beneficiary complaints, quality of care reviews, EMTALA violations, and reviews of hospital discharge or discontinuation-of-services appeals
- Two regional BFCC-QIOs (Livanta and KePro)

The Whole is Greater Than the Sum of its Parts

Learning & Action Network

- Invitation only spot light on success sharing, affinity groups and ECHO sprints with national subject matter experts
- Network and collaborate in peer-to-peer shared learning across states

Community Coalitions*

- Apply a collaborative approach to improve the overall health of community

Individual Providers

- Refine processes and improve outcomes with evidence-based tools/resources

* In applicable communities

Focus Areas Impact the Health of our Communities



Cross-Cutting Priority Areas



Health Information Technology



**Health Equity
Trauma-Informed Care**



Patient & Family Engagement

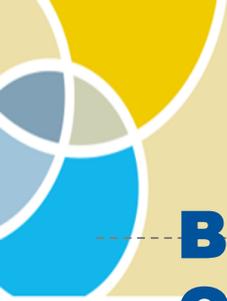


Rural Health

Technical Assistance From QI Experts



- Root cause analysis (RCA)
- Evidence-based and best practice intervention selection & implementation
- Rapid cycle improvement via Plan-Do-Study-Act (PDSA)
- Measurement strategy and data analytics
- Access to clinician, patient and care partner education resources, e.g., webinars, ECHO programs, learning and action networks, mobile apps, subject matter experts



Behavioral Health and Opioid Use

Use innovative, evidence-based and data driven methods to reduce opioid deaths and adverse drug events (ADEs) by

- Decreasing opioid prescribing for prescriptions ≥ 90 MME daily across hospitals, long-term care and outpatient facilities
- Reducing opioid utilization, where appropriate
- Assisting in implementation of pain management and opioid use best practices
- Increasing access to behavioral health services



Increase Patient Safety: Reduce All-Cause Harm



■ Healthcentric
Advisors
■ Qlarant

Use innovative, evidence-based and data driven methods to:

- Reduce ADEs due to high risk medications in community and long term care settings
- High risk medications include anticoagulants, diabetes medications, and opioids, or a medication class otherwise prioritized by the HHS National Action Plan for ADE Drug Event Prevention
- Reduce *Clostridioides difficile* infection in all settings by promoting the identification, prevention and treatment of *C. difficile* and the initiation/expansion of antibiotic stewardship

Chronic Disease Self-Management: A Public Health Issue

Diabetes	Chronic Kidney Disease	Cardiovascular Health
<<The Two Leading Causes of CKD are Diabetes and High Blood Pressure >>		
<ul style="list-style-type: none"> •26.9% of Medicare beneficiaries have diabetes; 32% of Medicare spending •People living with diabetes are twice as likely to develop heart disease or a stroke •It's the leading cause of kidney failure, lower limb amputations, and adult onset blindness 	<ul style="list-style-type: none"> • 30 million in the United States are affected (10% of the population) • 96% don't know they have it • Mortality rates for patients with CKD more than double those without CKD 	<ul style="list-style-type: none"> •Stroke is the leading cause of serious long-term disability in the United States •Each year over 1.5 million people suffer a heart attack or stroke •> 800,000 die from cardiovascular disease (CVD) each year

Sources: cdc.gov; kidney.org; millionhearts.hhs.gov; stroke.com

Improving Care Transitions: Reducing Readmissions

18% of Medicare patients discharged from the hospital have a readmission within 30 days, accounting for \$15 billion in healthcare spending



Source: Medicare Payment Advisory Commission. 2007. *Report to the Congress. Promoting Greater Efficiency in Medicare*

Improving Care Transitions: Reducing Readmissions

Under the Hospital Readmission Reduction Program (HRRP), CMS withholds up to 3% of reimbursement for hospitals with higher-than-expected number of 30-day readmissions for:

- Chronic lung disease
- Coronary artery bypass graft surgery
- Heart attacks
- Heart failure
- Hip and knee replacements
- Pneumonia

**2,599 hospitals
(82% of participants)
will receive reduced
reimbursement under the
Hospital Readmissions
Reduction Program
(HRRP) in FY 2019**

Improve Nursing Home Quality

**Nursing Home Quality Improvement (QI) Focus
using current best practices and person-centered approaches:**

- Decrease opioid prescribing
- Reduce adverse drug events (ADEs)
- Reduce hospitalizations for nursing home onset *C. difficile*
- Reduce healthcare-acquired infections
- Reduce emergency department visits & readmissions for short stay nursing home residents
- Improve the mean Total Quality Score for all nursing homes



Together We Can Make a Difference

We invite you to...

- **Join our team** to improve the quality of care across our network
- **Be part of the solution** for improving healthcare outcomes for 20% of the Medicare beneficiaries in the nation



Next Work Group Meeting

Next PMWG meeting is scheduled for
Wednesday, March 18

