maryland
health services
cost review commission

Performance Measurement Workgroup

December 18, 2024

HSCRC Quality Team

Meeting Agenda

- RY 2027 Final QBR Policy
  - QBR ED LOS measure
- Readmissions Update:
  - RY 2027 RRIP Policy: Extension from RY 2026
  - Observation Inclusion
- RY 2027 Draft MHAC Policy
- Population Health
  - Maryland Inpatient Diabetes Screening Pilot Program

Workgroup Learning Agreements

- **Be Present** – Make a conscious effort to know who is in the room, become an active listener. Refrain from multitasking and checking emails during meetings.
- **Call Each Other In As We Call Each Other Out** – When challenging ideas or perspectives give feedback respectfully. When being challenged - listen, acknowledge the issue, and respond respectfully.
- **Recognize the Difference of Intent vs Impact** – Be accountable for our words and actions.
- **Create Space for Multiple Truths** – Seek understanding of differences in opinion and respect diverse perspectives.
- **Notice Power Dynamics** – Be aware of how you may unconsciously be using your power and privilege.
- **Center Learning and Growth** – At times, the work will be uncomfortable and challenging. Mistakes and misunderstanding will occur as we work towards a common solution. We are here to learn and grow from each other both individually and collectively.

REMINDER: These workgroup meetings are recorded.

PMWG Members

Carrie	Adams	Meritus
Andrew	Anderson	Johns Hopkins Bloomberg
Ryan	Anderson	MedStar - MD Primary Care Program
Kelly	Arthur	Qlarant QIO
Ed	Beranek	Johns Hopkins Health System
Barbara	Brocato	Barbara Marx Brocato & Associates
Zahid	Butt	Medisolv Inc.
Tim	Chizmar	MIEMSS
Linda	Costa	University of Maryland School of Nursing
Ted	Delbridge	MIEMSS (c)
Toby	Gordon	Johns Hopkins Carey Business School
Shannon	Hall	Community Behavioral Health Association of MD
Theressa	Lee	Maryland Health Care Commission
Stacy	Lofton	Families USA
Angela	Maule	Garrett Regional Medical Center
Patsy	Mcneil	Adventist Health
Stephen	Michaels	MedStar Southern Maryland Hospital
Lily	Mitchell	CareFirst
Sharon	Neeley	Maryland Department of Health Medicaid
Christine	Nguyen	Families USA
Jonathan	Patrick	MedStar Health
Elinor	Petrocelli	Mercy Medical Center
Mindy	Pierce	Primary Care Coalition of Montgomery County
Nitza	Santiago	Lifebridge Health
Dale	Schumacher	MedChi, Maryland State Medical Society
Madeleine "Maddy"	Shea	Health Management Associates
Brian	Sims	Maryland Hospital Association
Mike	Sokolow	University of Maryland Medical Systems
Geetika "Geeta"	Sood	JHU SOM,Division of Infectious Diseases.
April	Taylor	Johns Hopkins Health System
Bruce	VanDerver	Maryland Physicians Care
Jamie	White	Frederick Health

Final RY 2027 QBR Recommendations and Next Steps

QBR RY 2026 Final Recommendations

1. Maintain Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 60 percent, Safety (NHSN measures) - 30 percent , Clinical Care - 10 percent.
    a. Within the PCE domain, weight the measures as follows:
        i. HCAHPS Top Box: 33.33 Percent
        ii. HCAHPS Consistency: 16.67 percent
        iii. HCAHPS Linear: 16.67 percent
        iv. Timely Follow-Up for Medicare: 5.56 percent
        v. Timely Follow-Up for Medicaid: 5.56 percent
        vi. Disparities in Timely Follow-Up for Medicare: 5.56 percent
        vii. Emergency Department Length of Stay: 16.67 percent
    b. Within the Safety domain, weight each of the measures equally (i.e., 30 percent divided by number of measures).
    c. Within the Clinical Care domain, weight the inpatient and 30-day mortality measure equally.

QBR RY 2026 Final Recommendations

2. With regard to monitoring reports to track hospital performance:
    a. Consider the feasibility of developing a Timely Follow-Up for Behavioral Health measure.
    b. Disseminate Sepsis Dashboard.
    c. Develop tools to monitor HCAHPS performance by patient and hospital characteristics.
3. Implement an HCAHPS learning collaborative with hospitals.
4. Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures; add a bonus incentive of $150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.
5. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and maintain the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 41 percent.
    a. Retrospectively evaluate 41 percent cut point using more recent data to calculate national average score for RY 2026 and RY 2027.
    b. Based on concurrent analysis of national hospital performance, adjust the RY25 QBR cut point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.

Next Steps

- RY 2027 QBR Memo for Hospitals
- Upcoming Analytics:
  - Finalize QBR ED LOS measure for RY 2026/RY 2027 for improvement
  - Develop risk-adjusted ED LOS measure for attainment
  - Finalize Timely Follow-Up measure updates
  - Run Base Year Measures under updated APR-DRG Grouper (v42) and assess performance standards for Maryland Specific measures
  - RY 2027 QBR calculation sheet
  - RY 2027 QBR base period workbook

ED LOS Measure Update

QBR ED LOS Measure Updates

- Ad-hoc submissions:
  - CY 2023 + Q1 CY 2024: Submitted in September and reviewed by hMetrix; hospitals with low match rates with case-mix or other anomalies are resubmitting.
  - Q2 & Q3 CY 2024: Submission window is now open until 1/17/25.
  - Q4 CY 2024 forward: Date and time stamps will be submitted as part of Case-Mix submissions.
- Additional analytics on hold pending resubmissions

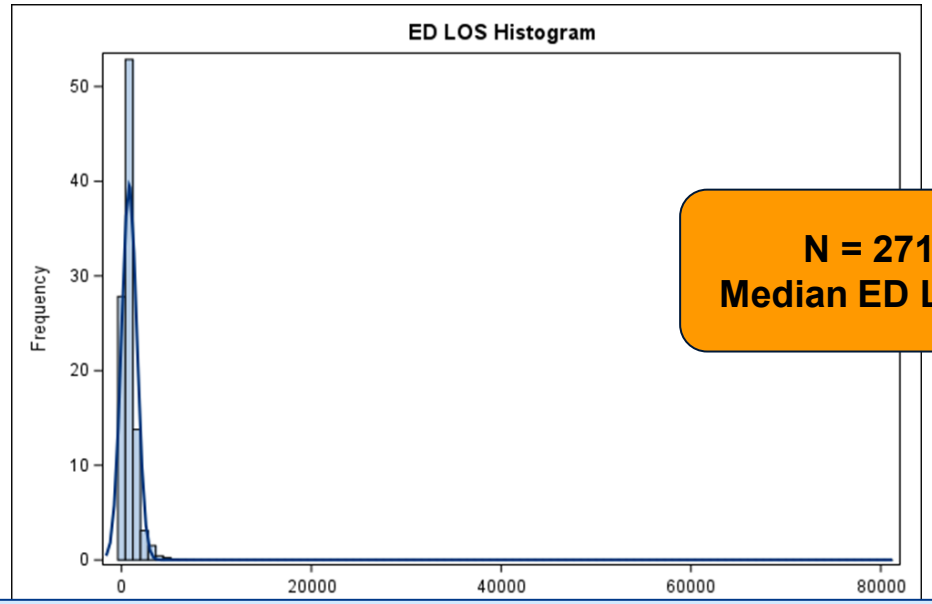
RY 26 P4P ED LOS Metric

ED1b: Median length of stay for non-psychiatric patients admitted to the hospital.

Additional Exclusions for RY 2026:

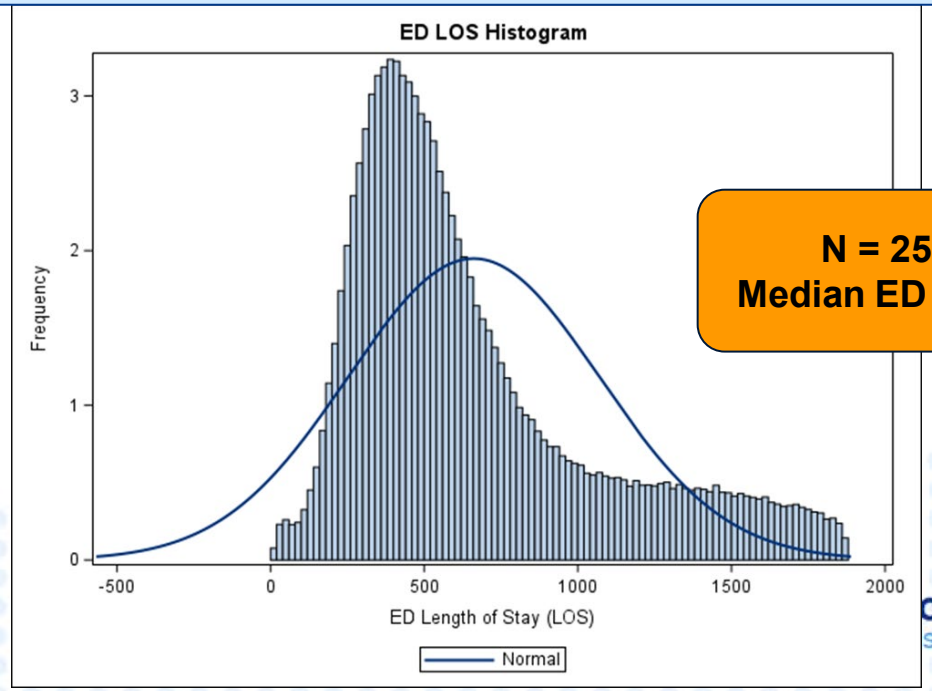
- Shock Trauma
- Obstetric Care
- Pediatrics
- Rehabilitation/Chronic

Discussion last month was on how to identify cases with social concerns. **Staff propose to remove statistical outliers as way to address difficult cases rather than specific types of patients.** Can be revisited for future years.



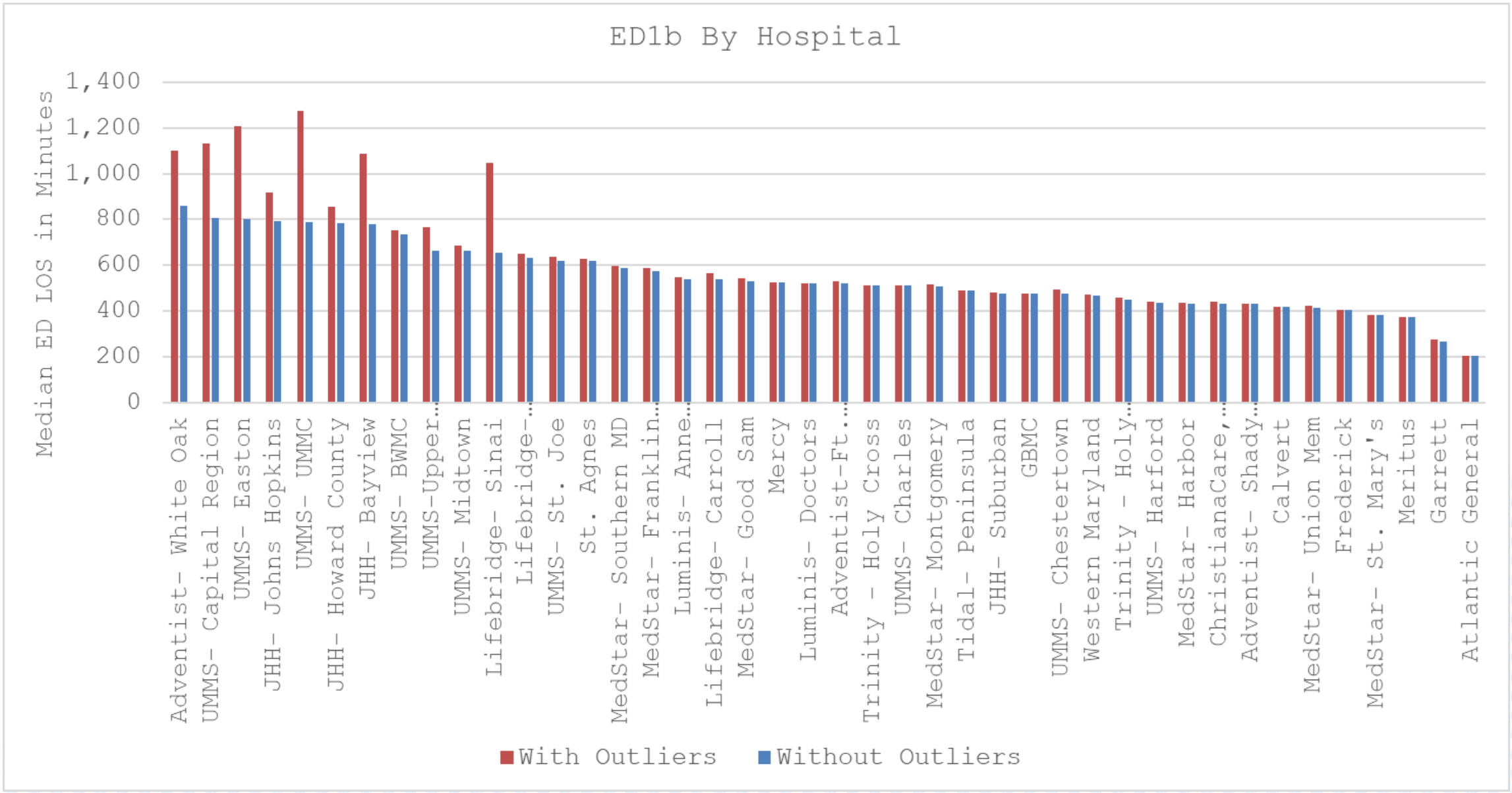
N = 271,395
Median ED LOS: 563

Outliers: Identified cases statewide that are greater than 1.5 * interquartile range (N = 18,343)



N = 253,052
Median ED LOS: 534

ED LOS with and without Outliers by Hospital



Outlier Impact: Specific Hospital Examples (see Handout)

Adventist White Oak
Outliers: 1,376 (20% removed)
ED LOS w/o Outliers: 859 minutes (-242 minutes)

Meritus
Outliers: 2 (0.02% removed)
ED LOS w/o Outliers: 374 minutes (no change)

UMMS Capital Region
Outliers: 1,531 (26.6% removed)
ED LOS w/o Outliers: 806 minutes (-326 minutes)

Anne Arundel
Outliers: 295 (2.3% removed)
ED LOS w/o Outliers: 539 minutes (-7 minutes)

Johns Hopkins
Outliers: 1,862 (13.2% removed)
ED LOS w/o Outliers: 791 minutes (-126 minutes)

Medstar Southern MD
Outliers: 161 (2.3% removed)
ED LOS w/o Outliers: 588 minutes (-10 minutes)

Next Steps

- Await final data for CY 2023
- Assess outliers vs. clinical/social exclusions
- Finalize RY 2026 measure
- Address RY 2027 Priorities:
  - Improvement target
  - Risk-adjusted ED LOS/Attainment target

Readmission Reduction Incentive Program
RY 2027 Policy Discussion

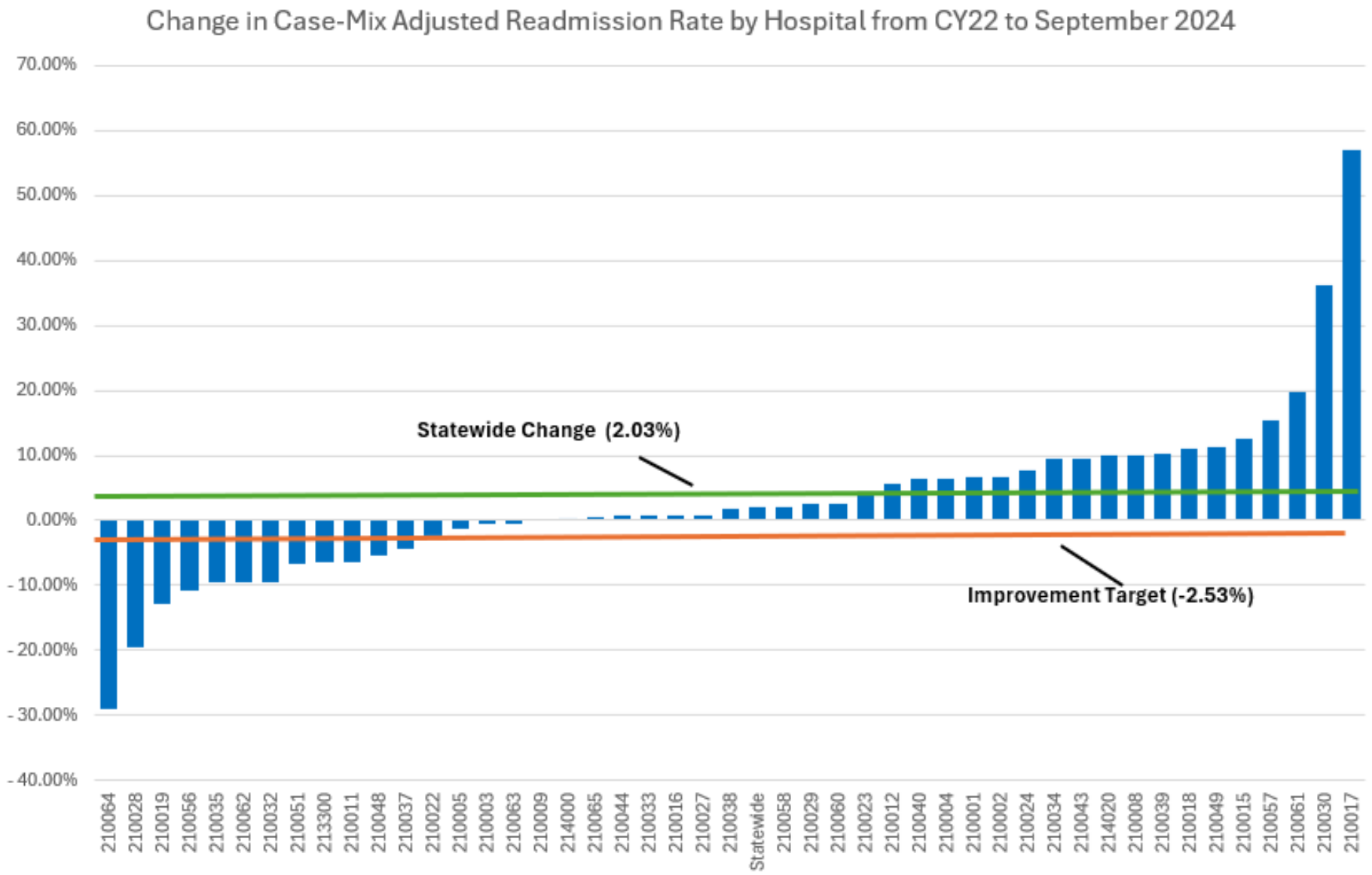
RY 2027 RRIP Proposal

- Extend RY 2026 Policy Recommendations:
  - Maintain the 30-day, all-cause readmission measure.
  - Improvement Target - Set statewide 4-year improvement target of 5 percent from 2022 base period through 2026.
  - Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
  - Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
  - Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. To be eligible for disparity gap reward, hospitals must not have an increase in overall readmission rate and must submit details on interventions aimed at reducing disparities.
  - Monitor emergency department and observation revisits by adjusting readmission measure and through all-payer Excess Days in Acute Care measure. Consider future inclusion of revisits in the case-mix adjusted readmission measure or inclusion of EDAC in the RRIP program. Collaborate with stakeholders to explore the causes and consequences of greater observation stay use in Maryland compared to the Nation.
- Include report to Commission to address AHEAD and stakeholder input

RY 2027 RRIP Report

- Report to Commission the following:
  - Recent RRIP performance
  - AHEAD requirements for readmissions
  - Discussion on observation inclusion
  - Stakeholder concerns with current policy:
    - Fixed base year for assessing improvement
    - Time period used to measure improvement (1 year vs. 2 years)
    - Out of state transfers

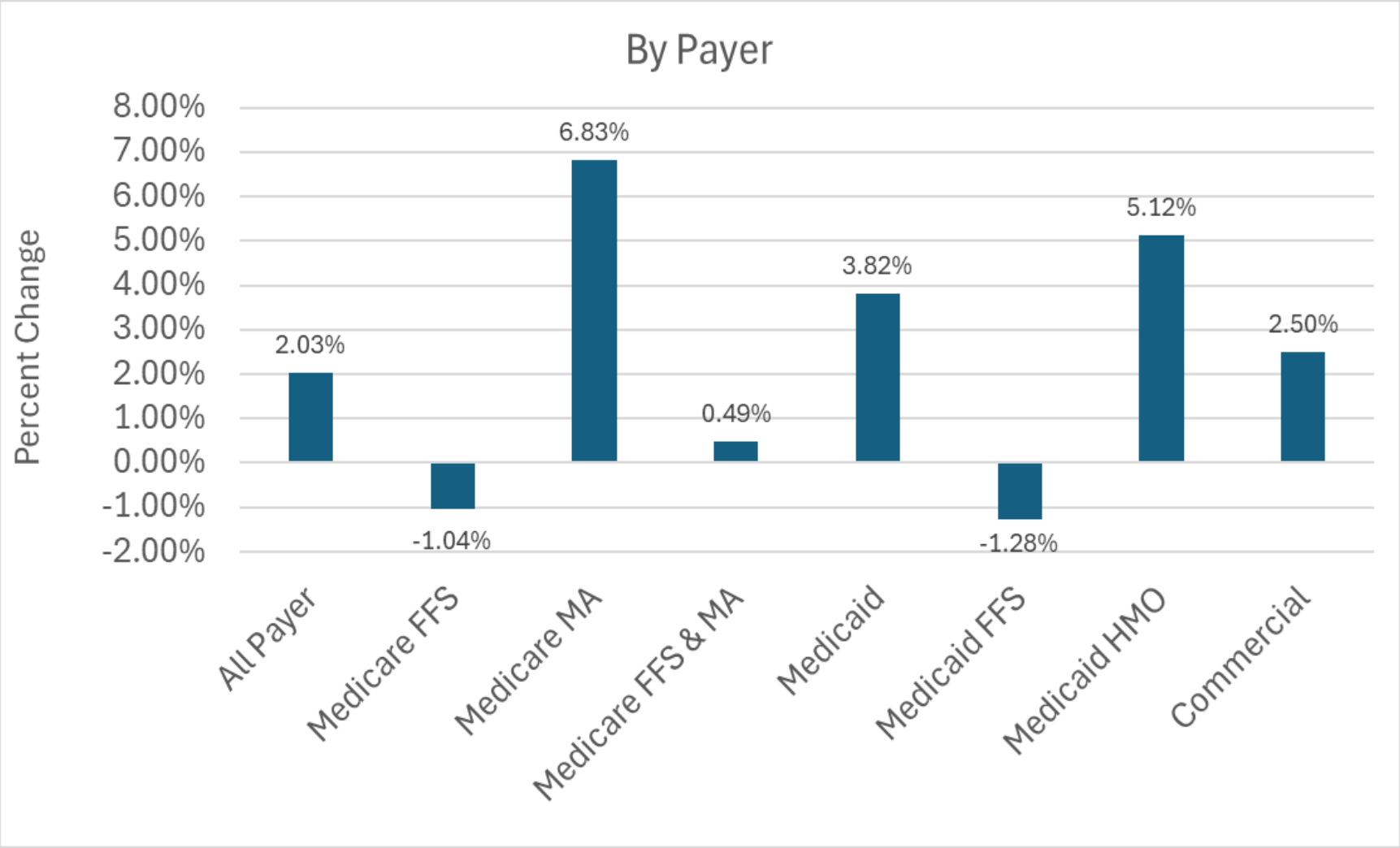
RY 2026 RRIP Performance

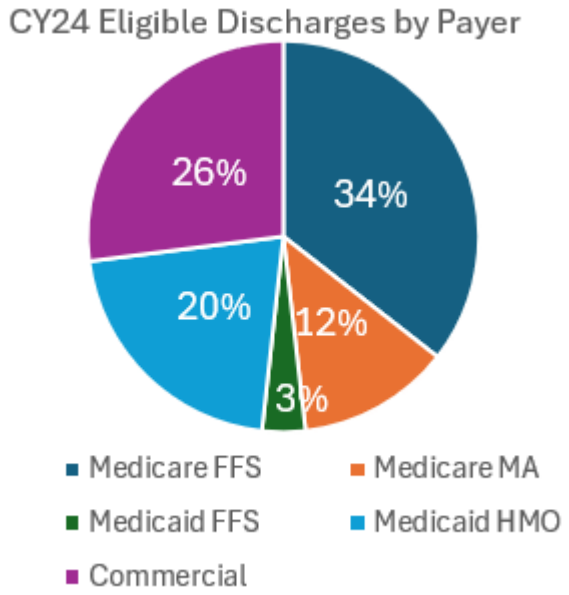


Staff performed analyses to understand drivers of the increased statewide readmit rate

Case-Mix Readmission Rates

CY 2022 YTD compared to CY 2024 YTD through September





CY 2024 YTD By Service Line

Shows the O/E ratio and volume of various services lines statewide.

Example: Urology readmissions are 20% higher than expected

Sorted

Index APR ServiceLine	Eligible Discharges	Total Number of Read..	Percent Readmissions	Intra Readmissions	Intra Readmit Rate	Inter Readmissions	Inter Readmit Rate	Readmission Ratio (O/E)
Grand Total	308,690	36,687	11.88%	24,015	7.78%	12,672	4.11%	1.023
Urology	951	122	12.83%	88	9.25%	34	3.58%	1.203
OB/GYN	47,746	777	1.63%	649	1.36%	128	0.27%	1.124
Ventilator Support	641	121	18.88%	42	6.55%	79	12.32%	1.118
Injuries/complic. of prior ca..	1,444	210	14.54%	154	10.66%	56	3.88%	1.116
Orthopedic Surgery	14,656	1,314	8.97%	850	5.80%	464	3.17%	1.108
Cardiothoracic Surgery	3,325	368	11.07%	225	6.77%	143	4.30%	1.090
Oncology	5,390	1,008	18.70%	708	13.14%	300	5.57%	1.088
Transplant Surgery	440	138	31.36%	135	30.68%	< 11		1.087
Neurological Surgery	3,935	333	8.46%	225	5.72%	108	2.74%	1.083
Hematology	4,715	1,085	23.01%	768	16.29%	317	6.72%	1.066
Vascular Surgery	2,728	480	17.60%	342	12.54%	138	5.06%	1.061
Psychiatry	20,803	3,032	14.57%	1,243	5.98%	1,789	8.60%	1.033
Gastroenterology	24,162	3,705	15.33%	2,557	10.58%	1,148	4.75%	1.028
Neurology	16,882	1,852	10.97%	1,082	6.41%	770	4.56%	1.022
General Medicine	39,657	5,815	14.66%	3,796	9.57%	2,019	5.09%	1.022
Cardiology	24,847	4,024	16.20%	2,594	10.44%	1,430	5.76%	1.011
Trauma	1,938	162	8.36%	76	3.92%	86	4.44%	1.001
Thoracic Surgery	1,409	93	6.60%	72	5.11%	21	1.49%	1.000
Gynecological Surg	1,462	68	4.65%	56	3.83%	12	0.82%	1.000
Pulmonary	27,075	4,063	15.01%	2,815	10.40%	1,248	4.61%	0.999
Infectious Disease	30,825	4,427	14.36%	3,057	9.92%	1,370	4.44%	0.994
General Surgery	19,753	2,345	11.87%	1,701	8.61%	644	3.26%	0.993
Urological Surgery	1,376	185	13.44%	124	9.01%	61	4.43%	0.991
Ophthalmology	417	32	7.67%	22	5.28%	< 11		0.973
Endocrinology Surgery	2,169	80	3.69%	65	3.00%	15	0.69%	0.967
ENT Surgery	933	60	6.43%	41	4.39%	19	2.04%	0.956
Invasive Cardiology	7,478	681	9.11%	466	6.23%	215	2.88%	0.948
Spinal Surgery	1,393	97	6.96%	58	4.16%	39	2.80%	0.902

Analysis of Readmission Rates Including Observation Stays

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Analysis of unadjusted readmission rates including observation stays

Maryland has a relatively high rate of observation stays

- Currently, Maryland hospitals' readmissions rates are based on inpatient stays only and are not impacted by observation stays

- The HSCRC is examining how Maryland hospitals' readmissions rates would be affected by including observations stays in the following ways:

  Scenario 1) Only inpatient stays can be index admissions and readmissions

  Scenario 2) Observation stays can be readmissions (but not index admissions)

  Scenario 3) Observation stays can be both index admissions and readmissions

  Scenario 4) Scenario 3 with two-way norms for inpatient and observation stays

Risk Adjusted Readmission Rates Including Observation Stays

			A	B	C= B/A	D	E= B/D	F = E*Unadj. Base Rate	G =(F(23) - F(19)) / F(19)
Index/ Readmit	**Case Mix Adjustment**	**Year**	**Total Number of Inpatient Discharges**	**Total Number of Readmissions**	**Percent Readmissions**	**Total Number of Expected Readmissions**	**Readmission Ratio**	**Case-Mix Adjusted Readmission Rate**	**% Change (Base to Performance)**
IP/IP	All IP	Base (19)	454,839	51,065	11.23%	48,910	1.044	11.73%	NA
IP/IP	All IP	Performance (23)	411,275	48,688	11.84%	48,042	1.013	11.39%	-2.90%
IP/ IP+OBS	IP+OBS	Base (19)	453,443	60,499	13.34%	58,525	1.034	13.83%	NA
IP/ IP+OBS	IP+OBS	Performance (23)	409,887	57,792	14.10%	56,878	1.016	13.60%	-1.66%
IP+OBS/ IP+OBS	IP+OBS	Base (19)	597,007	76,985	12.90%	73,538	1.047	13.45%	NA
IP+OBS/ IP+OBS	IP+OBS	Performance (23)	549,881	73,593	13.38%	73,085	1.007	12.94%	-3.79%
IP+OBS/ IP+OBS	IP+OBS (2-Way Norm)	Base (19)	596,914	76,968	12.89%	73,682	1.045	13.42%	NA
IP+OBS/ IP+OBS	IP+OBS (2-Way Norm)	Performance (23)	549,699	73,556	13.38%	73,013	1.007	12.94%	-3.58%

All analyses use normative values calculated from CY 2021 data
The Readmission Ratio is multiplied by the model specific base rate; for model comparison it is thus recommended to assess the Readmission Ratio to understand differences across models.

Next Steps

- Finalize RRIP report and policy extension for January Commission meeting
- Continue to analyze the data to understand drivers of the current increases
  - Reach out to hospitals with the highest increases in readmissions to better understand their challenges
- Develop statewide AHEAD readmissions target
- Assess stakeholder concerns for RY 2028 RRIP policy

MHAC RY 2027 Draft Discussion

RY 2027 MHAC Topics for Discussion

- Payment PPCs
- Small Hospital Concerns
- Number of Hospital per PPC Category
- Monitoring Digital Measures

Policy Options	Considerations
Exclude small hospitals based on volume	●How to define small hospital? ●How to ensure small hospitals are accountable for complications ●Small hospitals are included in HACRP but less likely to receive penalty due to measure smoothing
Exclude hospitals that qualify for less than a specific number of PPCs	●Uncertainty for small hospitals that may or may not be included (assessed each year) ●Only measured on small number of PPCs for whole score
Use two years of data for small hospitals (current policy)	●PPCs count for small hospitals for longer time
Reliability adjust PPCs like CMS PSI 90 (e.g., Bayesian smoothing)	●Bayesian smoothing is more difficult to understand and replicate ●Impact on Benchmarks and Thresholds ●Small hospitals more likely to be impacted since their rates will be moved towards state average
Create a weighted composite of PPCs	●Composite has significantly higher reliability than individual PPCs ●How to weight PPCs in composite (3M harm, volume (at risk discharges), expected PPCs, or PPC reliability) ●Could lower or remove criteria for sufficient data because 1) ranking against other Maryland hospitals only once composite calculated - no longer ranking on each individual PPC and 2) Volume weights mean that PPCs with relatively few at risk discharges would have a relatively small impact on hospital's composite score. ●Expect more stability for smaller hospitals because more data used ●Hospitals can look at data by PPC feeding into composite score

Initial Plan to Address Small hospital Concerns

- Examine PPC measure reliability and MHAC composite reliability updated from the January 2022 analysis
- Mathematica will do the following:
  - Test the MHAC composite methodology
    - The resulting weights of PPCs that factor into each hospital's MHAC score
    - Degree to which addresses small hospital concerns
  - Compare the MHAC composite methodology to the current MHAC methodology and the Bayesian smoothing methodology overall and for small hospitals compared with non-small hospitals on:
    - PPC and MHAC composite reliability
    - MHAC performance
    - PPCs factoring into each hospital's MHAC score
    - Degree to which hospital concerns addressed
  - Evaluate PPC and MHAC composite reliability overall and for each hospital by number of at-risk discharges when using 1-year performance period versus 2-year performance period for all hospitals.
    - Empirically evaluate which small hospital at-risk discharge threshold should be used for using two years of performance data to achieve sufficient MHAC composite reliability (composite methodology) or PPC reliability (current MHAC methodology)
  - Determine which Maryland hospitals have a Total HAC Score (are included in the HAC Reduction Program) and which measure(s) factor into their Total HAC Score

Maryland Inpatient Diabetes Screening Pilot Program

Introduction

- CMMI required staff to develop one or more measures to enhance hospital accountability for population health progress
- After a series of subgroup meetings in CY22, staff recommended monitoring diabetes screening for ED patients
- JHHS/MedStar/UMMS recommended focusing measure on inpatients due to concerns about ED throughput and follow-up
- Staff proposed IP screening policy in CY23
- Commission suggested running a pilot to evaluate effectiveness
- Based on success of pilot program, staff recommends implementation of payment policy
- Policy recommendations are unchanged from CY23

Pilot Structure

Pilot Parameters & Participating Institutions

- The primary aim of the pilot was to gauge the effectiveness of an automatic screening protocol to detect prediabetes, undiagnosed diabetes, and uncontrolled diabetes among inpatients meeting ADA screening guidelines
- The secondary aims: understand operational details, obstacles, and bottlenecks associated with inpatient screening for diabetes
- The pilot lasted from July 1, 2024 to November 1, 2024
  - Total duration period: **123 Days**
- Participating Institutions included:
  - Garrett Regional Medical Center
  - MedStar Southern Maryland Hospital
  - MedStar Franklin Square Hospital

Patient Eligibility and Intervention

Patient Eligibility

The eligibility criteria for this Pilot followed a recommended protocol established by the American Diabetes Association (ADA) for screening:

Patients 35 years of age or above without a history of Type 2 Diabetes that are missing a HbA1c result from within the past three years prior to admission as indicated by their Electronic Medical Record (EMR)

or

Patients 35 years of age or above with a history of Type 2 Diabetes that are missing a HbA1c result from within three months prior to admission as indicated by their Electronic Medical Record (EMR)

Intervention

The intervention for this pilot study includes ***a standing lab order for inpatient HbA1c testing*** that automates the process of screening eligibility.

Preliminary Results

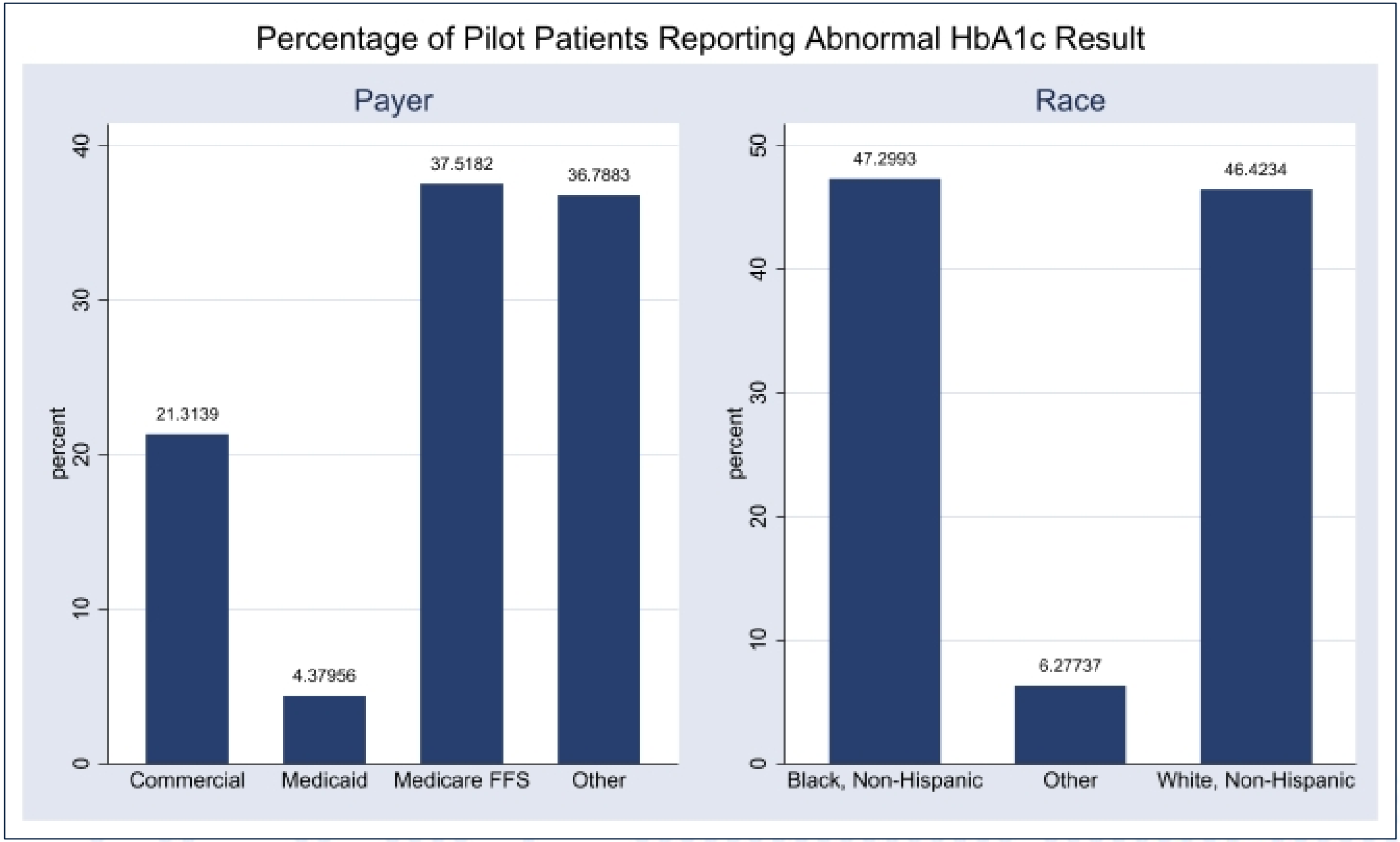
Descriptive Statistics (July - October)

Number of Admitted Patients: 7,392 Patients

Number and Percentage of Patients Eligible to be Screened (>= 35 Years of Age): 4,528 Patients (63.96%)

Total Tests Delivered: 3,367 Tests

Percentage of Eligible Inpatients Receiving Pilot HbA1c Tests: 84.5%


Percentage of Pilot Patients Reporting Abnormal HbA1c Result
Payer
percent
0
10
20
30
40
21.3139
4.37956
37.5182
36.7883
Commercial
Medicaid
Medicare FFS
Other
Race
percent
0
10
20
30
40
50
47.2993
6.27737
46.4234
Black, Non-Hispanic
Other
White, Non-Hispanic

Number Needed to Screen (NNS)

Test efficacy can measured by calculating the number of subjects screened to yield one positive test result, otherwise known as the Number Needed to Screen (NNS)

Similar public health interventions have yielded NNS values ranging from **670** (Opportunistic HIV Screening) to **1,100** (Pap Smear for Cervical Cancer)

Number Needed to Screen (NNS) by Diagnostic Category

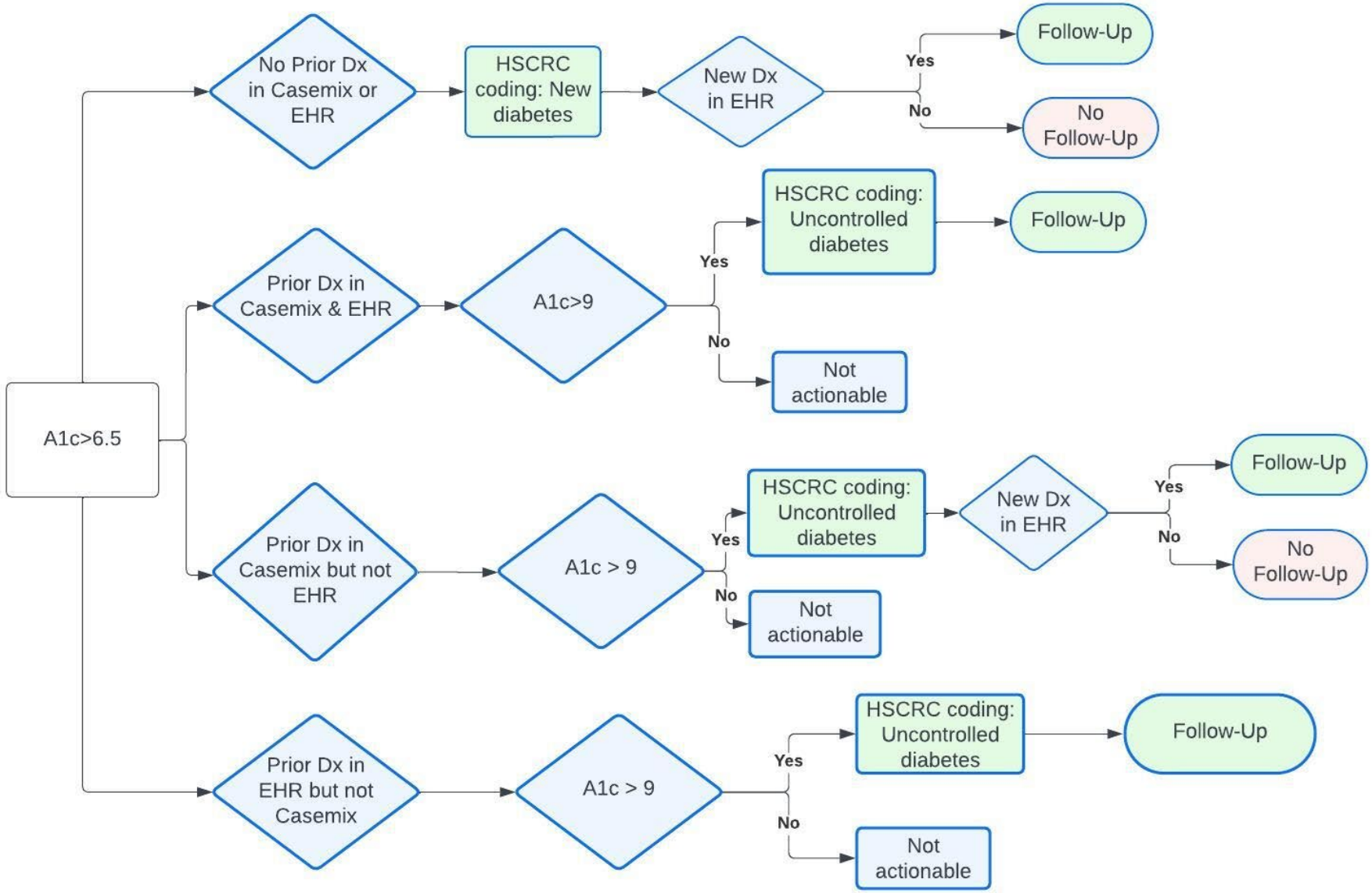
- Out-of-range HbA1c Level for Eligible Inpatients
  - Based on the appropriate glycemic level for those without history of T2DM (HbA1c >= 5.7%) and for those with a history of T2DM (HbA1c >= 9.0%)
  - NNS: 5.83
- Prediabetes (HbA1c >= 5.7% for Eligible Inpatients)
  - NNS: 5.03
- Undiagnosed Diabetes (HbA1c >= 6.5% for Eligible Inpatients)
  - NNS: 75.3
- Uncontrolled Diabetes (HbA1c >= 9.0% for Eligible Inpatients)
  - NNS: 7.95

Follow-Up

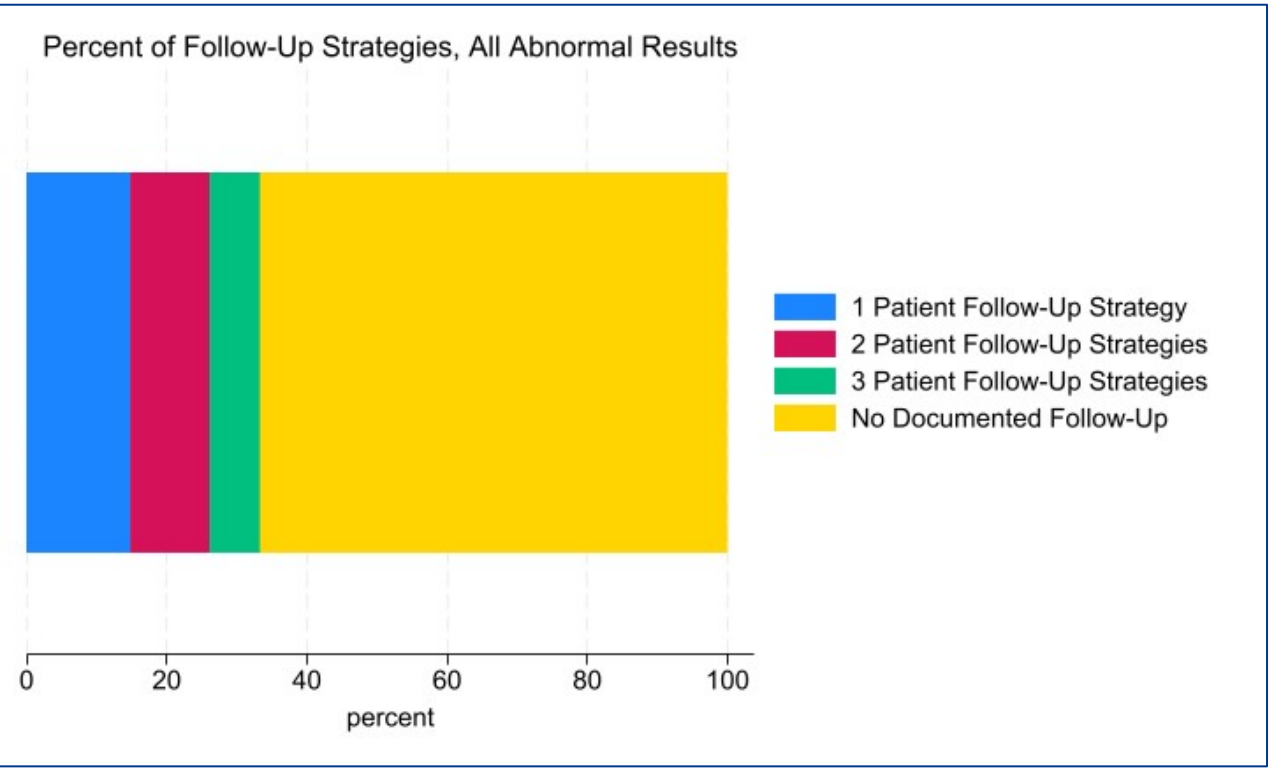
Patient Follow Up

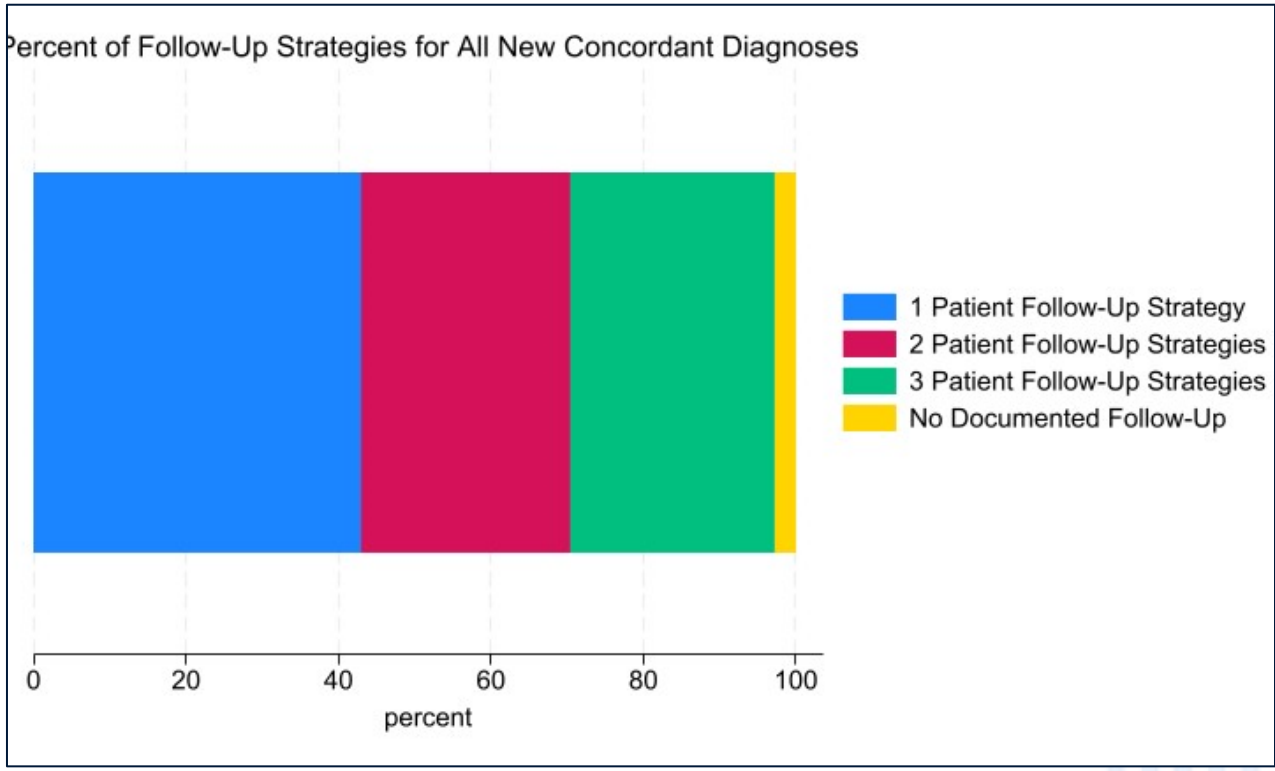
- The intent of the Pilot was for hospitals to follow up on abnormal HbA1c results that indicated either new prediabetes, type two diabetes, or uncontrolled existing diabetes
- Hospitals were asked to follow pre-existing clinical pathways for relevant Pilot diagnostic follow-up
- In some instances, challenges arose in accurately identifying and following these patients
  - Differences in diabetes history between HSCRC records and EHR
  - Absence of new EHR diagnosis triggering clinical pathway
- Pilot partners indicated that these challenges are straightforward to address with EHR solutions going forward

Patient Follow-Up



Comparison of Follow Up Results by Number of Strategies





Compared to follow-up for an abnormal test result (33.3%), 97.2% of patients with a concordant diagnosis in their chart received at least one form of follow-up

- Over 50% of patients received two or more forms of follow-up

Follow-Up Results by Type of Strategy

Categorization of Follow-Up Types for Patients reporting Abnormal HbA1c Results

	Summary
N	685
InpatientMedication	
No Documented Inpatient Medication Initiation or Change	566 (82.6%)
Received Inpatient Medication Initiation or Change	119 (17.4%)
InpatientDiseaseManagement	
No Documented Inpatient Education and Disease Management	582 (85.0%)
Received Inpatient Education and Disease Management	103 (15.0%)
OutpatientResolve	
No Documented Outpatient Resolve	504 (73.6%)
Received Outpatient Resolve	181 (26.4%)

Categorization of Follow-Up Types for Patients reporting New Formal Diagnoses

	Summary
N	179
InpatientMedication	
No Documented Inpatient Medication Initiation or Change	100 (55.9%)
Received Inpatient Medication Initiation or Change	79 (44.1%)
InpatientDiseaseManagement	
No Documented Inpatient Education and Disease Management	113 (63.1%)
Received Inpatient Education and Disease Management	66 (36.9%)
OutpatientResolve	
No Documented Outpatient Resolve	5 (2.8%)
Received Outpatient Resolve	174 (97.2%)

- The majority of those with concordant diagnoses following an abnormal test received outpatient resolve (97%), followed by inpatient medication initiation or change (44.1%) and/or inpatient disease management (36.9%)

Differential Outcomes in Follow-Up

- Insights from the Pilot demonstrated that when an appropriate diagnosis is able to be made, then patients are extremely likely to receive at least one form of follow-up
- Pilot hospitals noted that changing process so that abnormal lab triggers follow up would result in follow up for vast majority of patients

Average Length of Stay (ALOS)

Average Length of Stay

- Measured using propensity-score matching (PSM) technique
- Compared to an equivalent period in CY 2023, there was no indication that the Pilot contributed to increased average length of stay (ALOS) among Pilot hospitals.

2023: 5.64 Days
2024 (Pilot Period): 5.11 Days

Key Takeaways

- Nearly 85% of those eligible to be screened received a Pilot HbA1c test
- Low NNS for out-of-range blood glucose levels
  - Primarily driven by prediabetes among inpatient population
- Follow-up for concordant diagnoses following an abnormal HbA1c result is extremely high (>95%)
- The pilot had no measurable negative influence on average length of inpatient stay
- Pilot partners did not report any impact on clinical operations or physician burden and highlighted the positive impacts of the Pilot on patient care

Draft Policy Updates

Draft Recommendation for RY27 Policy & Outstanding Questions

- Staff recommends instituting a screening policy as proposed in CY23
- Establish the threshold for performance reward at 40% screening prevalence, and the benchmark at 70%. Reward hospitals for screening prevalence as follows:
  - CY25 screening rate of 40-55%: **0.1%** of inpatient revenue
  - CY25 screening rate of 56-70%: **0.2%** of inpatient revenue

Outstanding Policy Questions

- How should we determine which patients are eligible for testing?
  - Casemix/lab records may possess info on all previous A1c tests
  - Pilot found ~64% of patients in age range were screened, so may be able to ignore this
  - Could add variable to IP casemix indicating whether patient was excluded from denominator
- Should the policy incentivize follow-up/treatment?
  - May be able to identify OP follow up with Medicare data
  - Other types of follow up/other payers are uncertain
  - Perhaps develop followup ECQM/ad hoc submission for year 2 of policy?

HSCRC Monitoring & Follow-up

- Monitoring for unintended consequences
  - Elevated length of stay?
  - Availability of endocrinology appointments?
- Disparities
  - Is screening and follow-up equitable?

THANK YOU!

Next Meeting: January 15, 2025

Appendix

Appendix 1: Pilot Eligibility and Screening by Demographics

Pilot Demographics by Eligibility Status

	Eligible		
	No	Yes	Test
N	2,664 (36.0%)	4,728 (64.0%)	
AgeGroup			
35-49	408 (15.3%)	840 (17.8%)	0.011
50-64	740 (27.8%)	1,213 (25.7%)	
65+	1,516 (56.9%)	2,675 (56.6%)	
Sex			
Female	1,473 (55.3%)	2,525 (53.4%)	0.118
Male	1,191 (44.7%)	2,203 (46.6%)	
Race			
Black, Non-Hispanic	1,008 (37.8%)	1,983 (41.9%)	<0.001
Other	134 (5.0%)	270 (5.7%)	
White, Non-Hispanic	1,522 (57.1%)	2,475 (52.3%)	

Pilot Demographics by Screening Status for Eligble Patients

	Screened		
	No	Yes	Test
N	734 (15.5%)	3,994 (84.5%)	
AgeGroup			
35-49	210 (28.6%)	630 (15.8%)	<0.001
50-64	179 (24.4%)	1,034 (25.9%)	
65+	345 (47.0%)	2,330 (58.3%)	
Sex			
Female	433 (59.0%)	2,092 (52.4%)	<0.001
Male	301 (41.0%)	1,902 (47.6%)	
Race			
Black, Non-Hispanic	306 (41.7%)	1,677 (42.0%)	0.007
Other	60 (8.2%)	210 (5.3%)	
White, Non-Hispanic	368 (50.1%)	2,107 (52.8%)	

Appendix 2: Relative Risk (RR) for Prediabetes, Newly-Diagnosed Diabetes, and Uncontrolled Diabetes across Relevant Demographic Characteristics

Figure 1: Relative Risk Ratios for Newly-Diagnosed Prediabetics (HbA1c >= 5.7%) across Relevant Demographic Characteristics.

Relative Risk of New Prediabetic Diagnosis

	prediab	
AgeGroup		
50-64	1.741	**
	(0.274)	
65+	2.349	**
	(0.362)	
Sex		
Male	1.108	
	(0.096)	
Race		
Other	1.006	
	(0.190)	
White, Non-Hispanic	0.690	**
	(0.062)	
Payer		
Medicaid	0.865	
	(0.207)	
Medicare FFS	0.756	*
	(0.104)	
Other	0.797	
	(0.099)	
Intercept	0.151	**
	(0.024)	
Number of observations	2083	

** p<.01, * p<.05

Figure 2: Relative Risk Ratios for Newly-Diagnosed Diabetics (HbA1c >= 6.5%) across Relevant Demographic Characteristics.

Relative Risk of New T2DM Diagnosis

	diab	
AgeGroup		
50-64	2.185	
	(1.261)	
65+	0.750	
	(0.493)	
Sex		
Male	1.561	
	(0.593)	
Race		
Other	0.649	
	(0.668)	
White, Non-Hispanic	0.613	
	(0.237)	
Payer		
Medicare FFS	1.802	
	(0.967)	
Other	0.518	
	(0.282)	
Intercept	0.015	**
	(0.009)	
Number of observations	1618	

** p<.01, * p<.05

Figure 3: Relative Risk Ratios for Uncontrolled Diabetics (HbA1c >= 9.0%) across Relevant Demographic Characteristics.

Relative Risk of New Uncontrolled Diagnosis

	uncontrolled	
AgeGroup		
50-64	0.696	*
	(0.113)	
65+	0.356	**
	(0.064)	
Sex		
Male	1.322	*
	(0.166)	
Race		
Other	1.075	
	(0.258)	
White, Non-Hispanic	0.820	
	(0.107)	
Payer		
Medicaid	1.856	*
	(0.511)	
Medicare FFS	0.881	
	(0.175)	
Other	1.090	
	(0.187)	
Intercept	0.220	**
	(0.044)	
Number of observations	1814	

** p<.01, * p<.05