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 Calikoğlu, 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)

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Director, Center for Population-Based Methodologies

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Associate Director, Performance Measurement
<table>
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<tr>
<th>Month/Meeting (s)</th>
<th>Goals/Deliverables</th>
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<tr>
<td><strong>SEPTEMBER</strong></td>
<td>No meetings</td>
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<td>Commission Meeting  September 9, 2015</td>
<td>- Draft FY 2018 QBR Recommendation</td>
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<td><strong>OCTOBER</strong></td>
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<tr>
<td>Commission Meeting  October 14, 2015</td>
<td>- Final FY 2018 QBR Recommendation</td>
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<td>Readmission Subgroup  October 21, 2015</td>
<td>- Socio-Economic Demographic Risk adjustment</td>
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| Performance Measurement Work Group  October 28, 2015 | - Work Plan  
- Review of YTD Performance Results  
- Performance measurement strategic plan discussion- patient centered measures, efficiency measures |
| **NOVEMBER**     |                    |
| Commission Meeting  November 18, 2015 | - Performance Strategic Plan Discussion |
| Readmission Subgroup | - Risk Adjustment        |
| Performance Measurement Work Group  November 20, 2015 | - Discuss draft readmission updates for FY 2018  
- Discuss draft MHAC updates FY 2018  
- Discuss potential PAU measure updates  
- Aggregate at Risk |
| Payment Models Work Group | - Discuss Aggregate At Risk FY2018 |
| **DECEMBER**     |                    |
| Commission Meeting  December 9, 2015 | - Draft recommendation on readmission updates for FY 2018  
- Draft recommendation for MHAC updates for FY 2018  
- Draft Revenue at risk FY 2018 |
| Performance Measurement Work Group  December 16, 2015 | - Finalize Recommendations |
| **JANUARY**      |                    |
| Commission Meeting  January 13, 2016 | - Final recommendation on readmission updates for FY 2018  
- Final recommendation for MHAC updates for FY 2018  
- Final Revenue at risk FY 2018 |
<p>| <strong>FEBRUARY</strong>     |                    |
| Commission Meeting  February 10, 2016 | |</p>
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| **Performance Measurement Work Group**  
February 17, 2016 | • Strategic Plan FY19  
• PAU Update for FY16 Rates |
| **MARCH**  
Commission Meeting  
March 9, 2016 | • Performance Measurement strategic plan report |
| Performance Measurement Work Group  
March 16, 2016 |  
3M PPC clinical review subgroup | • 3M PPC clinical review |
| **APRIL**  
Commission Meeting  
April 13, 2016 |  
Performance Measurement Work Group  
April 20, 2016 | • ICD-10 Review |
| **MAY**  
Commission Meeting  
May 11, 2016 |  
Performance Measurement Work Group  
May 18, 2016 | • Updated PAU Measures |
| **JUNE**  
Commission Meeting  
June 8, 2016 |  
3M PPC clinical review subgroup | • Discuss clinical input and 3M response; determine next steps |
| Performance Measurement Workgroup  
June 15, 2016 | • Discuss FY2019 Quality Program Updates |
| **JULY**  
Commission Meeting  
July 13, 2016 |  
Performance Measurement Workgroup  
July 20, 2016 | • Update on FY2019 Quality Updates |
Performance Measurement Workgroup

10/28/2015
Guiding Principles For Performance-Based Payment Programs

- Program must improve care for all patients, regardless of payer (Stakeholder 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 (Stakeholder 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.

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<tr>
<th></th>
<th>Clinical Care</th>
<th>Patient experience of Care/ Care Coordination</th>
<th>Safety</th>
<th>Efficiency</th>
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<tr>
<td><strong>QBR FY 2017</strong></td>
<td>15% (1 measure- mortality)</td>
<td>45% (8 measures- HCAHPS)</td>
<td>35% (3 infection measures, PSI)</td>
<td>Potentially Avoidable Utilization (PAU)</td>
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<td><strong>Final QBR FY 2018</strong></td>
<td>15% (1 measure- mortality)</td>
<td>50% (9 measures- HCAHPS + CTM)</td>
<td>35% (7 measures-Infection, PSI, PC-01)</td>
<td>PAU</td>
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<tr>
<td><strong>CMS VBP FY 2018</strong></td>
<td>25% (3 measures condition specific mortality)</td>
<td>25% (9 measures- HCAHPS + CTM)</td>
<td>25% (7 measures-Infection, PSI, PC-01)</td>
<td>25%</td>
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RY2018 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

Note: Based on final data for January 2012 – June 2015, and preliminary data through August 2015.
Change in All-Payer Risk-Adjusted Readmission Rates by Hospital

Note: Based on final data for January 2012 – June 2015, and preliminary data through August 2015.
RY2018 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:
Excludes McGready Hospital due to small sample size and includes PPC 24.
RY2018 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

Cost per Capita

Cost Per Case
Efficiency Measure Time & Space

- Hospitalization /Cost per case
- Episode/Bundled Cost
- Per capita Total Cost
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
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)
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
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