Performance Measurement Work Group Meeting

03/21/2018
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
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.”

Components of PAU:

- Potentially Avoidable Admissions
- Readmissions / Revisits

HSCRC Calculates Percent of Revenue Attributable to PAU
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.

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

Total Hospital Inpatient and Outpatient Discharges and Revenue

All Inpatient Stays and Observation stays >= 24 hrs

Is the revenue associated with a 30 day all cause readmission?

- Yes
  - Readmissions
  - PAU revenue

- No
  - Other Revenue

Is the revenue associated with a PQI admission?

- Yes
  - PQI PAU revenue

- No
  - Not PAU revenue
PAU Revenue %

\[
\text{PAU Revenue} = \text{Readmissions PAU revenue} + \text{PQI PAU revenue}
\]

\[
\text{Total Hospital Inpatient and Outpatient Revenue} = \text{PAU Revenue %}
\]
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%:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>PAU %</th>
<th>PAU Savings Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>10%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Hospital B</td>
<td>20%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Hospital C</td>
<td>5%</td>
<td>-0.5%</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Statewide Results</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>RY 2017 Total Approved Permanent Revenue</td>
<td>$15.8 billion</td>
</tr>
<tr>
<td>Total RY18 PAU %</td>
<td>10.86%</td>
</tr>
<tr>
<td>Total RY18 PAU $</td>
<td>$1.7 billion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statewide Total Calculations</th>
<th>Total</th>
<th>Previous year</th>
<th>Net</th>
</tr>
</thead>
<tbody>
<tr>
<td>RY 2018 Revenue Adjustment %</td>
<td>-1.45%</td>
<td>-1.25%</td>
<td>-0.20%</td>
</tr>
<tr>
<td>RY 2018 Revenue Adjustment $</td>
<td>-$228.4 million</td>
<td>-$194.4 million</td>
<td>-$34.0 million</td>
</tr>
</tbody>
</table>
Hospital Scaling

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

<table>
<thead>
<tr>
<th>Rate Year</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>RY2018</td>
<td>CY2016</td>
</tr>
<tr>
<td>RY2019</td>
<td>CY2017</td>
</tr>
<tr>
<td>RY2020</td>
<td>CY2018</td>
</tr>
<tr>
<td>RY2021</td>
<td>CY2019</td>
</tr>
<tr>
<td>RY2022</td>
<td>CY2020</td>
</tr>
</tbody>
</table>

- 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

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*“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.

<table>
<thead>
<tr>
<th>Hospital supported intervention examples</th>
<th>Potential type of measure</th>
</tr>
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<tbody>
<tr>
<td>Physicians rounding in skilled nursing facilities</td>
<td>Avoidable admissions from nursing homes</td>
</tr>
<tr>
<td>90 day care coordination after admission</td>
<td>90 day readmissions</td>
</tr>
<tr>
<td>ED care management, chronic condition clinics</td>
<td>Condition-specific ED revisits (asthma, diabetes, etc.)</td>
</tr>
<tr>
<td>Fall prevention/ seniors at home programs</td>
<td>Fall-related ED or hospitalizations</td>
</tr>
<tr>
<td>Prenatal community care</td>
<td>Low birthweight PQI</td>
</tr>
<tr>
<td>Green and Healthy home initiatives</td>
<td>Pediatric PQIs</td>
</tr>
<tr>
<td>Physician education around low-value tests</td>
<td>Choosing Wisely measures</td>
</tr>
</tbody>
</table>
Enhance comprehensiveness of PAU across hospital service lines

- **Currently eligible for PAU:**
  - Readmissions
    - Readmissions: Most IP and OBS $\geq 24$ hours cases
    - All ages
  - PQIs
    - IP and OBS $\geq 24$ 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 $\geq 24$ 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
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
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 18\(^{th}\), 2018 at 9:30 AM**
Contact Information

Email: HSCRC.performance@Maryland.gov