Quality-Related Payment Policies
HSCRC Waiver Implementation
February 28, 2014
Presentation Overview

• Quality-Based Reimbursement

• Readmissions

• Potentially Avoidable Utilization

• Maryland Hospital Acquired Conditions
Quality-Based Reimbursement
Quality-Based Reimbursement

- MHA supported January 2014 Quality-Based Reimbursement (QBR) final recommendations that updated existing policy to ensure the program meets or exceeds the national Medicare policy on Value-Based Purchasing

- 1.0 percent of inpatient revenue will be “at risk” based on performance and applied to 2016 rates

- Recommendations:
  - Publish any changes to methodology details for CY 2014 performance (e.g., transfer-in logic for mortality measure)
  - Reconvene HSCRC’s QBR work group in July to discuss revisions for CY 2015
    - Mortality (use of age cohort; transfers-in to include only acute care; adjust for one-day stays)
    - Weighting of domains
Readmissions
Readmissions

• Waiver Target: Maryland must be at or below the national average Medicare readmission rate by the end of the five year demonstration period

• Maryland must “close the gap” that exists in CY 2013 between Maryland and the nation by one-fifth of the difference each year

<table>
<thead>
<tr>
<th></th>
<th>National Medicare</th>
<th>Maryland Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Admissions</td>
<td>RA</td>
</tr>
<tr>
<td>FY 2010</td>
<td>11,043,196</td>
<td>2,049,473</td>
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<tr>
<td>FY 2011</td>
<td>11,129,694</td>
<td>2,070,250</td>
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<td>FY 2012</td>
<td>10,857,862</td>
<td>1,991,886</td>
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<tr>
<td>FY 2013</td>
<td>10,458,098</td>
<td>1,847,036</td>
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<tr>
<td>CY 2013</td>
<td>1,779,878</td>
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</table>
# Readmissions

## Closing the Gap

- Maryland RA rate – National RA Rate = 1.55 percentage points
- $1.55/5 = 0.31$ percentage points per year

<table>
<thead>
<tr>
<th>Year</th>
<th>National readmission rate</th>
<th>Maryland readmission rate</th>
<th>Maryland percent change prior yr</th>
<th>Pct point difference</th>
<th>Percent difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2013</td>
<td>17.66%</td>
<td>19.21%</td>
<td>-1.61%</td>
<td>1.55%</td>
<td>8.76%</td>
</tr>
<tr>
<td>FY 2014</td>
<td>17.66%</td>
<td>18.90%</td>
<td>-1.64%</td>
<td>1.24%</td>
<td>7.01%</td>
</tr>
<tr>
<td>FY 2015</td>
<td>17.66%</td>
<td>18.59%</td>
<td>-1.67%</td>
<td>0.93%</td>
<td>5.26%</td>
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<tr>
<td>FY 2016</td>
<td>17.66%</td>
<td>18.28%</td>
<td>-1.69%</td>
<td>0.62%</td>
<td>3.51%</td>
</tr>
<tr>
<td>FY 2017</td>
<td>17.66%</td>
<td>17.97%</td>
<td>-1.72%</td>
<td>0.31%</td>
<td>1.75%</td>
</tr>
<tr>
<td>FY 2018</td>
<td>17.66%</td>
<td>17.66%</td>
<td>-1.72%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>
Beyond closing the gap, Maryland will need to keep pace with the national readmission rate improvement

- It is unclear how much improvement can be expected nationally
  - Medicare readmission payment policies continue to penalize for readmissions above “expected”
  - National readmission payment policy has been in place since October 2012
  - When will national readmission rates stop declining?
  - As hospitals reduce avoidable admissions and move utilization to lower acuity settings, the inpatient severity of illness is likely to increase and readmission increases are likely to follow

- Set statewide quality improvement targets annually
Comparing hospitals’ readmission rates to one another or to a benchmark standard results in erroneous conclusions.

- **High readmission rates associated with:**
  - Limited relationships and coordination with community partners
  - More challenging social and economic circumstances
  - Limited access to primary and specialty care
  - Patients with higher prevalence of chronic conditions and more severe illnesses
  - Lower use of “observation”

- **Low readmission rates associated with:**
  - Better care transitions
  - Careful discharge and follow up planning
  - Location near a state border
  - Readmissions to other hospitals
  - Higher use of “observation”
  - Lower severity of illness
  - Patient population with fewer social needs and more resources
Readmissions—Hospital Specific Goals

- Experts do not yet agree on how to adjust for risk of readmission—severity of illness, age, payer mix, socioeconomic status affect rates
- Interventions must target specific needs of the patient population—the same strategy does not work for all
- Data availability can limit the choice of readmissions metric
  - Readmissions to other Maryland hospitals (addressed with a unique Maryland ID)
  - Readmissions that occur outside the state (requires patient-level data from the payer; e.g., Medicare, commercial plan)
  - Without this information, only intra-hospital readmission rates can be calculated
Readmissions—Hospital Specific Goals

- Hospitals need access to timely and complete data to monitor payment metrics
  - CRISP readmission data is a valuable tool for quality improvement interventions. The data source is from hospital registration systems.
  - It does not, and cannot match exactly a payment policy since payment is determined by a patient’s status at discharge, not at time of registration.
  - In the future, it could be possible for CRISP to receive monthly case-mix data, apply the unique ID, calculate an inter-hospital readmission metric and provide that information to all hospitals by the end of the following month.
Readmissions: MHA Recommendations

- Global budgets provide a strong incentive to reduce readmissions—no additional incentive is needed, especially in the first year

- Continue work to develop a readmissions payment policy if Maryland’s progress on readmissions is not sufficient

- Establish a payment policy before the start of the performance period
Readmissions: MHA Recommendations

- When a payment policy is established, the metric should match the waiver metric as closely as possible
  - Medicare only
  - Inter-hospital—only if data available
  - Consider stratifying hospitals in lieu of risk adjustment
  - Make sure psychiatric and rehabilitation admissions are out

- Address concerns about influence of “observation” and out-of-state or inter-hospital readmissions by monitoring inter-hospital readmissions and an “observation” metric
Potentially Avoidable Utilization
Potentially Avoidable Utilization

- Assess potentially avoidable utilization opportunities using AHRQ Prevention Quality Indicators (PQIs)

- AHRQ recommends measuring PQIs at the population level as an indication of where to focus resources

- AHRQ does not recommend using PQIs at the hospital level, or for payment

- The health status of the hospital’s community and its access to primary care drive the PQI rate
FY 16 MHAC Methodology Redesign
HSCRC Performance Measurement
Work Group
February 20, 2014
Maryland Hospital Acquired Conditions

- Background: Reason to change, guiding principles, timing
- Measurement Methodology
- Payment Methodology
- Remaining Issues to Address
Background
Why Change Existing Policy?

- Use of 3M Proprietary Software: Potentially Preventable Complications (PPC)

- Waiver Goal: 30% reduction in all 65 PPCs

- Target list of 20 PPCs—high volume, high cost, opportunity for improvement and areas of national focus

- Revenue at risk commensurate with CMS policies
Guiding Principles

- Meet CMS waiver test and goals on an annual and long-term basis
  - Focus on areas of greatest opportunity
  - Match payment metric to policy goal
- Predetermined performance targets and financial impact
- Encourage cooperation and sharing of best practices
- Do not penalize a lack of improvement if attainment is highly favorable
- Ability to track progress
Implementation Timing

Waiver Goal for Complication Reduction
• CY 2013 base period
• Measurement period began January 2014
• 30% cumulative reduction by 2018

Maryland Hospital Acquired Conditions Policy
• FY 2013 base period
• CY 2014 first measurement period
Measurement Methodology
Components of Redesign

- **Measurement Methodology**
  - All 65 PPCs vs current 50 PPCs
  - Selecting PPCs for focus
  - Design and calculation of “MHAC Score”
  - Thresholds and benchmarks
  - Better of **attainment** or **improvement** score

- **Payment Methodology**
  - Translating score to payment impact
Ideally, measure would be similar to Waiver Goal metric

<table>
<thead>
<tr>
<th></th>
<th>Definition</th>
<th>Risk Adj</th>
<th>Vol Adj</th>
</tr>
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<tbody>
<tr>
<td>Total # MHACs</td>
<td># Actual MHACs</td>
<td>N</td>
<td>N</td>
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<tr>
<td>Unadjusted MHAC Rate</td>
<td># Actual ÷ At Risk Cases</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>O/E Ratio</td>
<td># Actual ÷ # Expected</td>
<td>Y</td>
<td>Y</td>
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</tbody>
</table>

Observed to expected ratio
Lower numbers are more favorable
Target PPC List

- 20 PPCs
- High volume, high cost, and opportunity for improvement and national focus
- Heavier weight than non-target PPCs

Since target PPCs are those with high cost and high volume statewide, reducing these will contribute more to the overall waiver goal.
## Target PPC List: Top 10 by Volume * Cost

<table>
<thead>
<tr>
<th>PPC</th>
<th>ALL PAYER PPC Description</th>
<th>PPCs Expected</th>
<th>PPCs Actual</th>
<th>PPC Weighted Impact</th>
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<tbody>
<tr>
<td>PPC 4</td>
<td>Acute Pulmonary Edema and Respiratory Failure with Ventilation</td>
<td>1,069.72</td>
<td>1,209</td>
<td>$39,634,647</td>
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<tr>
<td>PPC 65</td>
<td>Urinary Tract Infection without Catheter</td>
<td>2,388.77</td>
<td>2,048</td>
<td>$29,313,024</td>
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<tr>
<td>PPC 14</td>
<td>Ventricular Fibrillation/Cardiac Arrest</td>
<td>1,250.11</td>
<td>1,375</td>
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<td>PPC 24</td>
<td>Renal Failure without Dialysis</td>
<td>3,660.69</td>
<td>3,355</td>
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<td>PPC 5</td>
<td>Pneumonia &amp; Other Lung Infections</td>
<td>1,288.80</td>
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<td>PPC 3</td>
<td>Acute Pulmonary Edema and Respiratory Failure without Ventilation</td>
<td>2,326.32</td>
<td>2,209</td>
<td>$21,665,872</td>
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<td>PPC 9</td>
<td>Shock</td>
<td>1,141.40</td>
<td>1,063</td>
<td>$20,538,223</td>
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<td>PPC 35</td>
<td>Septicemia &amp; Severe Infections</td>
<td>1,052.88</td>
<td>1,060</td>
<td>$19,984,180</td>
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<tr>
<td>PPC 21</td>
<td>Clostridium Difficile Colitis</td>
<td>1,028.00</td>
<td>1,030</td>
<td>$17,934,360</td>
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<tr>
<td>PPC 40</td>
<td>Post-Operative Hemorrhage &amp; Hematoma without Hemorrhage Control Proc</td>
<td>1,515.83</td>
<td>1,512</td>
<td>$14,846,328</td>
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</table>

<table>
<thead>
<tr>
<th>PPC</th>
<th>MEDICARE PPC Description</th>
<th>PPCs Expected</th>
<th>PPCs Actual</th>
<th>PPC Weighted Impact</th>
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<td>PPC 4</td>
<td>Acute Pulmonary Edema and Respiratory Failure with Ventilation</td>
<td>605.40</td>
<td>788</td>
<td>$25,833,004</td>
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<tr>
<td>PPC 14</td>
<td>Ventricular Fibrillation/Cardiac Arrest</td>
<td>788.81</td>
<td>989</td>
<td>$19,981,756</td>
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<tr>
<td>PPC 65</td>
<td>Urinary Tract Infection without Catheter</td>
<td>1,314.70</td>
<td>1,356</td>
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<tr>
<td>PPC 24</td>
<td>Renal Failure without Dialysis</td>
<td>1,994.09</td>
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<td>PPC 5</td>
<td>Pneumonia &amp; Other Lung Infections</td>
<td>699.79</td>
<td>757</td>
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<td>PPC 9</td>
<td>Shock</td>
<td>657.09</td>
<td>728</td>
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<tr>
<td>PPC 21</td>
<td>Clostridium Difficile Colitis</td>
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<tr>
<td>PPC 35</td>
<td>Septicemia &amp; Severe Infections</td>
<td>600.34</td>
<td>657</td>
<td>$12,386,421</td>
</tr>
<tr>
<td>PPC 6</td>
<td>Aspiration Pneumonia</td>
<td>496.70</td>
<td>607</td>
<td>$10,093,196</td>
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<tr>
<td></td>
<td>Target PPC List: Proposed List</td>
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<tr>
<td>3</td>
<td>Respiratory Failure without Ventilation</td>
<td>CMS HAC (PSI 90)</td>
<td>Top Volume * Cost</td>
<td>Other (Pair, Opportunity, etc)</td>
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<tr>
<td>4</td>
<td>Respiratory Failure with Ventilation</td>
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<td>x</td>
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<tr>
<td>5</td>
<td>Pneumonia &amp; Other Lung Infections</td>
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<tr>
<td>6</td>
<td>Aspiration Pneumonia</td>
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<td>x</td>
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<td>7</td>
<td>Pulmonary Embolism</td>
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<tr>
<td>9</td>
<td>Shock</td>
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<td>x</td>
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<td>14</td>
<td>Cardiac Arrest</td>
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<td>16</td>
<td>Venous Thrombosis</td>
<td></td>
<td>x</td>
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</tr>
<tr>
<td>24</td>
<td>Renal Failure without Dialysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>In-Hospital Trauma and Fractures</td>
<td></td>
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<tr>
<td>31</td>
<td>Decubitus Ulcer</td>
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<tr>
<td>35</td>
<td>Septicemia &amp; Severe Infections</td>
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<tr>
<td>37</td>
<td>Post-Operative Infection &amp; Deep Wound Disruption Without Procedure</td>
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<tr>
<td>38</td>
<td>Post-Operative Wound Infection &amp; Deep Wound Disruption with Procedure</td>
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<td>40</td>
<td>Post-operative Hemorrhage and Hematoma</td>
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<td>42</td>
<td>Accidental Puncture/Laceration During Invasive Procedure</td>
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<td>49</td>
<td>Iatrogenic Pneumothrax</td>
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<tr>
<td>54</td>
<td>Infections due to Central Venous Catheters</td>
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<tr>
<td>65</td>
<td>Urinary Tract Infection</td>
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</tr>
<tr>
<td>66</td>
<td>Catheter-Related Urinary Tract Infection</td>
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</tr>
</tbody>
</table>
MHAC/PPC Tiers

- Two or three ‘tiers’ of MHACs/PPCs
  - Tier A – Target list of 20 PPCs – highest weight
  - Tier B – PPCs not on target list, but have high percentage attributed to Medicare patients (> 60%) and affect majority of hospitals (> 43)
  - Tier C – All other PPCs, including those with very low volume, affecting low number of hospitals, obstetric-related PPCs

- Each tier can be weighted differently to put more emphasis on the target PPCs

<table>
<thead>
<tr>
<th>Weighting</th>
<th>PPCs</th>
<th>Total Points</th>
<th>FY12 Actual PPCs</th>
<th>FY13 Actual PPCs</th>
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<tbody>
<tr>
<td>Tier A</td>
<td>20</td>
<td>200</td>
<td>23,102</td>
<td>17,451</td>
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<tr>
<td>Tier B</td>
<td>9</td>
<td>54</td>
<td>5,166</td>
<td>4,074</td>
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<tr>
<td>Tier C</td>
<td>36</td>
<td>144</td>
<td>12,259</td>
<td>10,452</td>
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<tr>
<td>Total</td>
<td>65</td>
<td>398</td>
<td>40,527</td>
<td>31,977</td>
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<tr>
<td>Tier A</td>
<td>Tier C</td>
<td></td>
<td></td>
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<tr>
<td>--------</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operative Hemorrhage &amp; Hematoma without Hemorrhage Control Procedure or I&amp;D Proc</td>
<td>Remaining PPGs</td>
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<tr>
<td>8 Acute Pulmonary Edema and Respiratory Failure without Ventilation</td>
<td>3 Other Gastrointestinal Complications without Transfusion or Significant Bleeding</td>
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<tr>
<td>8 Acute Pulmonary Edema and Respiratory Failure with Ventilation</td>
<td>6 Acute Mental Health Changes</td>
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<tr>
<td>1 Pneumonia &amp; Other Lung Infections</td>
<td>10 Acute Postoperative Respiratory Failure with Tracheostomy</td>
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<tr>
<td>1 Aspiration Pneumonia</td>
<td>11 Decubitus Ulcer</td>
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</tr>
<tr>
<td>7 Pulmonary Embolism</td>
<td>12 Other Pneumonia</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6 Shock</td>
<td>13 Infection, Inflammation &amp; Clotting Complications of Peripheral Vascular Catheters &amp; Infusions</td>
<td></td>
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<tr>
<td>14 Ventricular Fibrillation/Cardiac Arrest</td>
<td>14 Major Complications of Obstetrical Surgical &amp; Perineal Procedures</td>
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<tr>
<td>15 Septicemia &amp; Severe Infections</td>
<td>15 Obstetrical Hemorrhage without Transfusion</td>
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<tr>
<td>16 In-Hospital Trauma and Fractures</td>
<td>15 Obstetrical Hemorrhage and Hematoma without Hemorrhage Control Procedure or I&amp;D Proc</td>
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<tr>
<td>36 Venous Thrombosis</td>
<td>16 Obstetrical Laceration &amp; Other Trauma Without Instrumentation</td>
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<td></td>
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<tr>
<td>12 Decubitus Ulcer</td>
<td>17 Obstetrical Complications of Obstetrical Surgical &amp; Perineal Procedures</td>
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<td>32 Post-Operative Infection</td>
<td>18 Obstetrical Uterine Rupture &amp; Other Trauma With Instrumentation</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3 Post-Operative Infection &amp; Deep Wound Disruption Without Procedure</td>
<td>18 Other Obstetrical Complications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Post-Operative Wound Infection &amp; Deep Wound Disruption With Procedure</td>
<td>19 Other Obstetrical Complications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Post-Operative Hemorrhage &amp; Hematoma without Hemorrhage Control Procedure or I&amp;D Proc</td>
<td>20 Other Obstetrical Complications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Accidental Hemorrhage &amp; Hematoma with Hemorrhage Control Procedure or I&amp;D Proc</td>
<td>21 Obstructive Sleep Apnea</td>
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<tr>
<td>12 Accidental Hemorrhage &amp; Hematoma without Hemorrhage Control Procedure or I&amp;D Proc</td>
<td>22 Other Surgical Complications</td>
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<tr>
<td>12 Other Medical Care</td>
<td>23 GU Complications</td>
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<tr>
<td>12 Other Medical Care</td>
<td>24 Other Vascular Complications</td>
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<td>25 Renal Failure</td>
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<td>12 Other Medical Care</td>
<td>26 Renal Failure without Dialysis</td>
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<tr>
<td>12 Other Medical Care</td>
<td>27 Other In-Hospital Adverse Events</td>
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<tr>
<td>12 Other Medical Care</td>
<td>28 Other Major Adverse Events</td>
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<td></td>
</tr>
<tr>
<td>12 Other Medical Care</td>
<td>29 Other Obstetrical Complications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Other Medical Care</td>
<td>30 Other Obstetrical Complications</td>
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<tr>
<td>12 Other Medical Care</td>
<td>31 Perioperative Obstetrical Complications</td>
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<tr>
<td>12 Other Medical Care</td>
<td>32 Post-Operative Infection &amp; Other Acute Events with Transfusion</td>
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<tr>
<td>12 Other Medical Care</td>
<td>33 Post-Operative Hemorrhage &amp; Hematoma with Hemorrhage Control Procedure or I&amp;D Proc</td>
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<tr>
<td>12 Other Medical Care</td>
<td>34 Major Gastrointestinal Complications with Transfusion or Significant Bleeding</td>
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<tr>
<td>12 Other Medical Care</td>
<td>35 Major Gastrointestinal Complications with Transfusion or Significant Bleeding</td>
<td></td>
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<tr>
<td>12 Other Medical Care</td>
<td>36 Major Gastrointestinal Complications with Transfusion or Significant Bleeding</td>
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</tbody>
</table>

Tier B:

- Selected as remaining PPGs with high Medicare percentage (>60%) and high number of Maryland hospitals (>43)
- 8 Other Pulmonary Complications
- 10 Congestive Heart Failure
- 11 Acute Myocardial Infarction
- 17 Major Gastrointestinal Complications without Transfusion or Significant Bleeding
- 23 Operative Hemorrhage & Other Acute Events with Transfusion
- 30 Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc
- 38 Other Complications of Medical Care

Tier C:

- Remaining PPGs
- 8 Other Pulmonary Complications
- 10 Congestive Heart Failure
- 11 Acute Myocardial Infarction
- 17 Major Gastrointestinal Complications without Transfusion or Significant Bleeding
- 23 Operative Hemorrhage & Other Acute Events with Transfusion
- 30 Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc
- 38 Other Complications of Medical Care
Measurement Methodology

- **In Quality-Based Reimbursement (QBR) methodology:**
  - Each measure receives separate points for attainment (compared to the state’s performance) and improvement (hospital performance year over year)
  - The higher of attainment or improvement points for each measure becomes the final points for that measure

- **Define *Threshold* and *Benchmark* for each measure (PPC)**
  - Threshold is minimum performance required to score points
    - median of all hospitals (50th percentile)
      - Mean performance is measured at the hospital level—including small hospitals with expected values less than 1
      - Assumes that case-mix adjusts adequately for all factors affecting a hospital’s performance
    - weighted mean of all O/E ratios (will equal O/E of 1)
      - Mean performance is measured at the case level
      - Inherently includes other factors that affect performance
      - Higher volume hospitals have more influence on PPCs mean
  - Benchmark is performance required to score maximum points
    - weighted mean of top quartile O/E ratio
Attainment Example

PPC 24 – Renal Failure

Threshold (statewide median)
O/E Ratio = 0.8705

Benchmark (mean of the top quartile)
O/E Ratio = 0.4659

Hospital O/E = 0.7012
_Calculates to an attainment score of 4_
Fiscal 2013 Base Period
PPC 9 Shock

Threshold 1.0000

Benchmark 0.5988

Top Quartile

Sum of O/E ratio for each Hospital ID. Color shows sum of FY13 IP Rev. The marks are labeled by sum of O/E ratio, sum of Actual PPCs and sum of Expected PPCs. Details are shown for PPC Name. The data is filtered on PPC, which keeps 9.

FY13 IP Rev
$4M $1,332M

Average of Top Decile 0.4215
Median 0.9040

All T and B exclude small hospitals
All T and B exclude small hospitals
Payment Methodology
Translating the Score to Payment Impact

- MHA proposes 3% revenue at risk on Medicare revenue
- Individual hospital payment impact depends on combination of statewide aggregate performance and individual hospital performance
- CMS waiver goal is 30 percent PPC reduction over five years, which will require sustained annual improvement of just under 7%

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<thead>
<tr>
<th></th>
<th>CY 14</th>
<th>CY 15</th>
<th>CY 16</th>
<th>CY 17</th>
<th>CY 18</th>
<th>5-Year Cumulative</th>
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</thead>
<tbody>
<tr>
<td>Penalty</td>
<td>6.89%</td>
<td>6.89%</td>
<td>6.89%</td>
<td>6.89%</td>
<td>6.89%</td>
<td>30.02%</td>
</tr>
</tbody>
</table>

- If annual goal is not met, maximum possible penalty applies
- If annual goal is met, maximum possible penalty is discounted to 1% of Medicare revenue with possibility of rewards for highest performing hospitals
Translating the Score to Payment Impact

Preset corridors of MHAC score (0-1) corresponding to payment impact

- **Statewide Target Met**: Targets and penalty scale “discounted” if statewide performance achieves policy target; max possible penalty = 1%

  - (1%)  (0.5%)  (0.25%)  no penalty  reward up to 0.5%

  
  0 – 0.2  0.21 – 0.4  0.41 – 0.6  0.61 – 0.8  >0.8

  *Reward up to 0.5%, as the penalty funding exists

- **Statewide CMS Target Not Met**: All hospitals penalized if CMS target not met; max possible penalty = 3%

  - (3%)  (2%)  (1%)  (0.5%)  (0.25%)

  
  0 – 0.2  0.21 – 0.4  0.41 – 0.6  0.61 – 0.8  >0.8
Methodology

- Address small hospitals
  - Hospitals with expected values < 1 score 0 or 10
  - Combine PPCs for an aggregate O/E, peer group, set minimum for expected value

- Ongoing discussion with 3M to refine PPC logic
  - Example...PPC 12 cardiac arrhythmia. This PPC occurs in 25% of open heart surgery cases. Pre-existing atrial fibrillation increases likelihood of arrhythmia after surgery. Request to 3M is adjust PPC logic.

- Define top performance—how high should the benchmark be set? How low can each PPC rate go? “Never” events—close to zero, but others are potentially preventable.
Quality-Related Payment Policies
HSCRC Waiver Implementation
February 28, 2014