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Performance Measurement Work Group Meeting

February 21, 2024

HSCRC Quality Team

PMWG Members

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

Workgroup Ground Rules

- **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.

Agenda

- Emergency Department Incentives Update
- MPA PQI Adjustment
- Readmission Reduction Incentive Program Final Recommendation

RY 2026 Policy Decisions

1. Readmission Reduction Incentive Program (RRIP)
    - Improvement target
    - Attainment target
    - Revisits/Observation
    - Excess Days in Acute Care measure
    - Within hospital disparities measure and incentive
2. Population Health: AHRQ Prevention Quality Indicators
    - AHRQ PQI MPA Adjustment

Emergency Department Subgroup Updates

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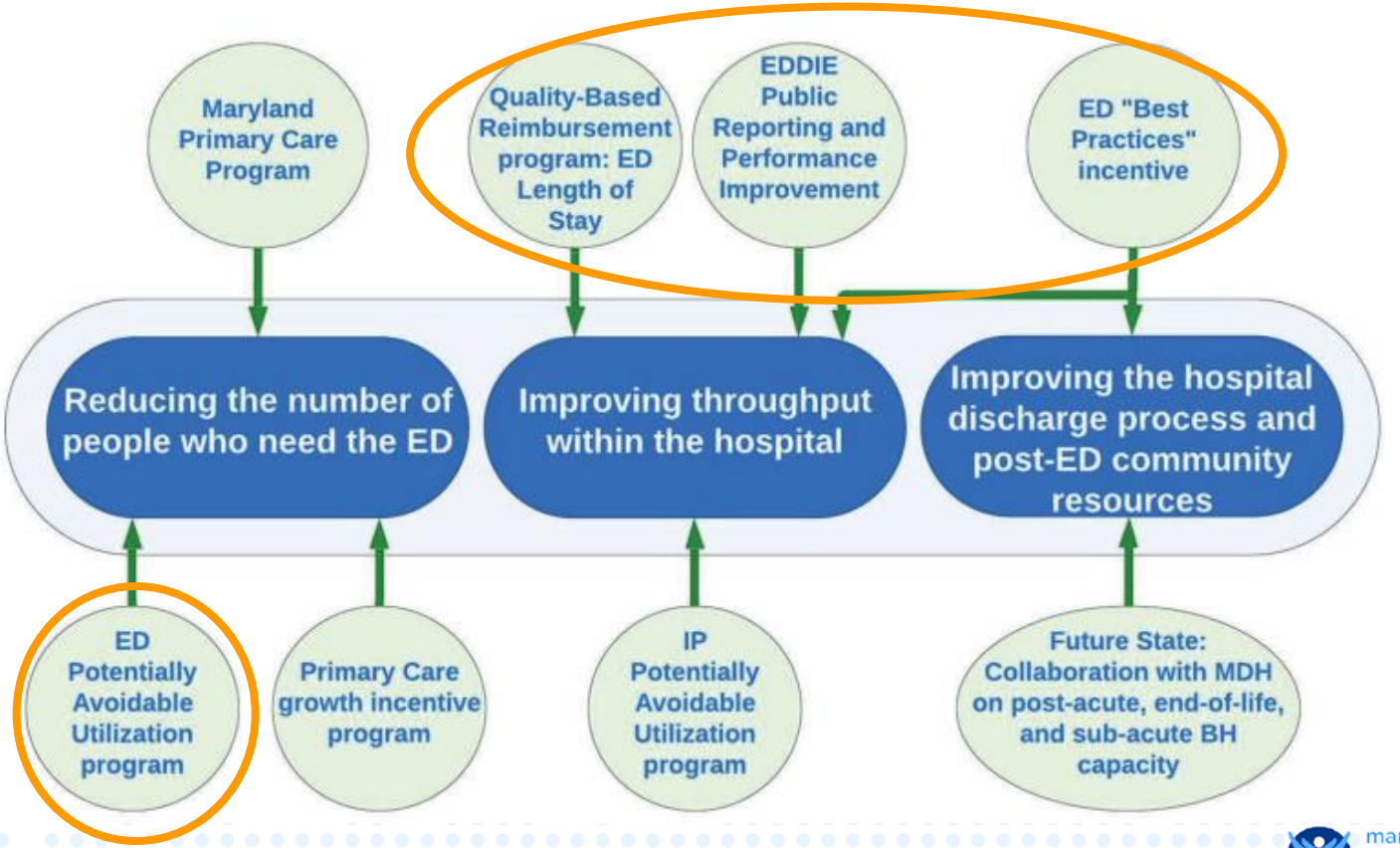
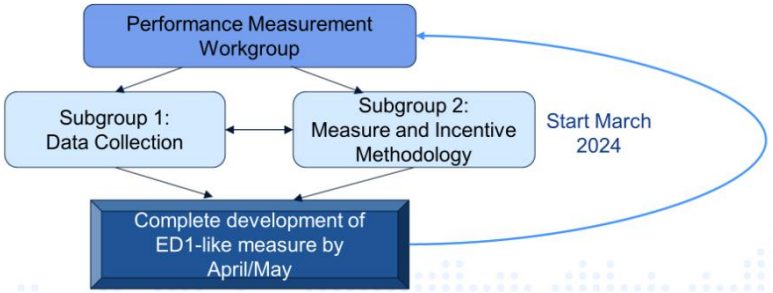
Incentives for Improving ED Length of Stay



Staff Accomplishments

QBR ED-1 Measure

- Finalized membership and meeting schedule for subgroups
- Convened 1st subgroup on 2/1
- Survey was distributed to capture commonalities how ED arrival to departure times for those admitted into an inpatient bed is calculated



Developed draft work plan for best practices subgroup (see next slide)

Presented on ED length of stay at Maryland's Health Finance and Management Association meeting

Finalized ED PAU MVP policy for Commission consideration

Reviewing legislation to address ED LOS concerns

Maryland Health Services Cost Review Commission: ED 1 LOS Subgroup Meeting February 2, 2024

- 12 separate stakeholder groups represented
- All of the health systems reported that wait times are a hospital throughput issue
  - Identified not enough inpatient beds available for patients to end ED care and begin inpatient care
  - Identified this is also influenced by staffing issues (RN shortage)
  - Identified a media (news) issue secondary to an insufficient understanding that patients may not be waiting for ED care in the waiting room, but rather are waiting for an inpatient bed, or possibly admission to a skilled nursing facility (SNF).
  - Believe wait times are also skewed if a patient is being discharged to a location other than home (homeless, discharge to SNF, etc.).
- Definition of Observation status does not align across health systems
  - Most Health Systems define “Observation” using Medicare guidelines for reimbursement.
  - Health systems reported their SOP’s do not define “Observation”; insurance companies define this.
  - Some health systems reported “Observation” is defined by a physician’s order (order status).
- Most health systems start the “observation level of care” in the ED secondary to inpatient throughput issues.

Maryland Health Services Cost Review Commission:
ED 1 LOS Subgroup Meeting February 2, 2024

- Most health systems have the capacity to start “admitted inpatient level of care” orders in the ED secondary to inpatient throughput issues
  - No health system identified a specific time when admission orders are initiated
  - Two health systems reported having access to “as needed” RN support if observation or “admitted but holding” patients numbers reached 10-15 patients.
- Majority of the health systems have an EHR that captures the ED1 time stamp data elements for Arrival date and time as well as Departure date and time
  - Some systems reported having a hybrid health record (EHR and hard copy) requiring manual data extraction
  - Data definitions of arrival and departure times differ by health system
    - EMS transfer of care may or may not be captured in EHR
    - Cerner EHR allows a clinician to “park” the EHR letting them update/complete a patient entry into the EHR
    - Patient may be discharged or transferred to Observation or inpatient status.
    - The record is updated later, which means the time stamp in the EHR has a time later than when the patient was actually transferred or discharged
    - Medstar’s Quality Improvement initiative reported a decrease in ED wait times after EHR was updated with accurate time

ED Best Practices Incentive Policy Development

Draft Work Plan Goals for Discussion/Feedback

Objective:

- Develop a series of process, structural, and/or outcome measures that will address systematically longer ED length of stay (LOS) in the State.
- Will incentivize hospital best practices, alignment with EDDIE, and value based arrangements with non-hospital providers that will improve hospital throughput and by extension ED LOS.

Description:

- Subgroup will advise on the development of 3-5 measures that will constitute a 1% revenue at risk program for CY 2025 performance.
- Workgroup will need to include those who are familiar with quality measurement, emergency department/hospital operations, non-hospital operations/policy (including home health, behavioral health, and skilled nursing facilities), and pay-for-performance/value-based payments.
- Will convene starting in March/April and should complete the task within 4-5 monthly subgroups.
- Monthly updates on progress will be provided to Commissioners as part of EDDIE presentations.

MPA Adjustment- AHRQ PQIs

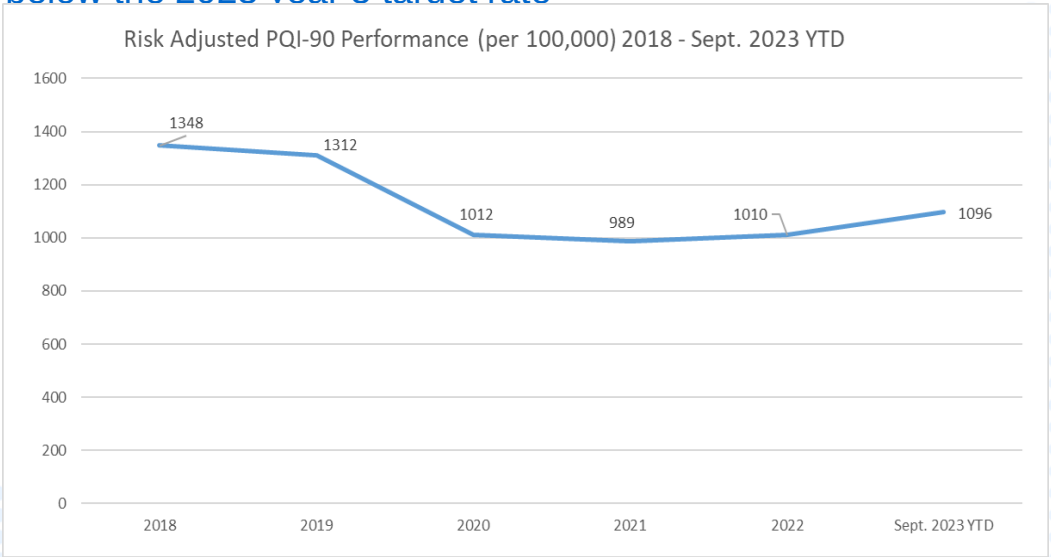
Introduction

- HSCRC staff are required to propose a population health measure as part of the Medicare Performance Adjustment
  - Given the additional development work required of the inpatient diabetes screening measure, staff proposed an alternative existing population health measure
  - Proposal is to use the AHRQ Prevention Quality Indicators
    - The AHRQ PQIs are population based indicators that identify hospitalizations that might have been avoided through access to high-quality outpatient care, thus providing insights into the quality of health services in a community
    - There are ten individual PQI measures that are included in the overall PQI composite measure (PQI-90), which is risk-adjusted based on age and sex. (See appendix A listing the 10 PQI measures)
      - These ten measures are also grouped into three other specific composites for
        - Acute composite(PQI 91)
        - Chronic composite (PQI 92)
        - Diabetic-related admissions composite (PQI 93) - can also be included in the chronic composite

AHRQ PQI Performance under SIHIS

- To support Maryland's success under SIHIS, Maryland hospitals are held financially accountable under the TCOC Model for all-payer PQI admissions
  - As of September 2023, Maryland has experienced a 19% percent decrease across all PQIs from the 2018 baseline
    - Current admission rate is 1,096 per 100,000 residents
    - Current PQI rate is -4.4 percent below the 2023 year 5 target rate

Goal: Reduce Avoidable Admissions	
Measure	AHRQ Risk-Adjusted PQIs
2018 Baseline	1,348 admits per 100,000
2021 Year 3 Milestone	8 percent improvement
2023 Year 5 Target	15 percent improvement
2026 Year 8 Final Target	25 Percent improvement



Proposed MPA-PQI Methodology

In line with statewide SIHIS PQI Improvement targets, staff has modeled hospital-specific PQI targets on the Better of Improvement versus Attainment

- Improvement Targets
  - Evaluating all hospitals on the annual statewide improvement targets used in setting the the SIHIS goal

Improvement	2023	2024	2025	2026
Threshold	-3%	-7%	-10%	-13%
Benchmark	-13%	-13%	-13%	-13%
Symetrical Benchmark	6%	-1%	-7%	-13%

- Attainment Targets
  - Staff modeled different approaches and settled on an attainment goal that aligns itself with the expectations under the Improvement targets (actual rates may change with updates to PQI logic; not applicable to improvement targets)
    - Reward Threshold (Reward Startpoint) = 2022 Median PLUS annual Improvement Targets
    - Reward Benchmark (Reward Endpoint) = Expected 2026 Median PLUS the same annual rate of change in the threshold calculation
  - Penalties are determined by maintaining same range of performance in reward targets
    - Penalty Threshold (Penalty Startpoint) = 2022 Median PLUS annual Improvement Targets
    - Penalty Benchmark (Penalty Endpoint) = Apply difference between Reward Threshold and Benchmark to Penalty Threshold (thus same range is maintained)
  - Aligns with improvement targets and maintains symmetry throughout multi-year performance assessment

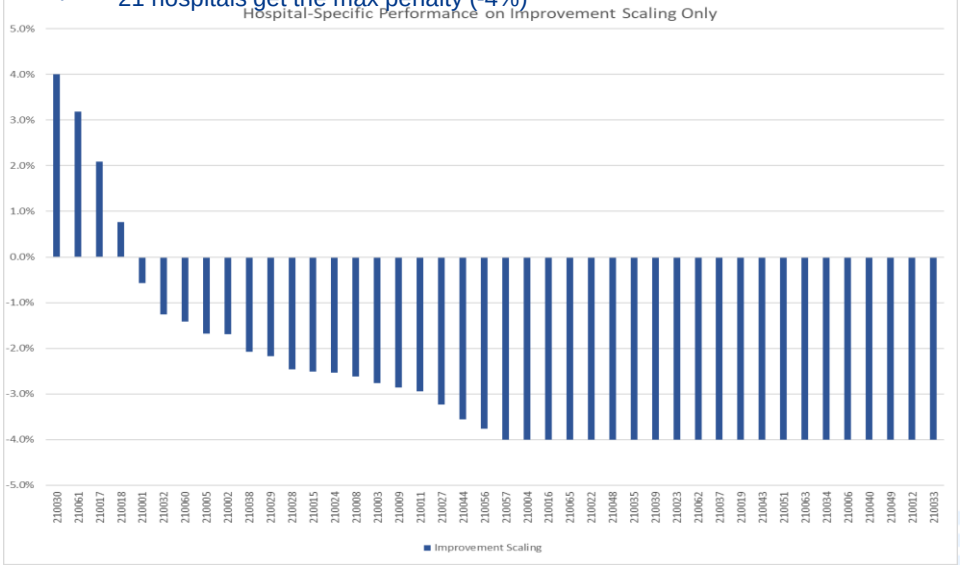
Attainment	2023	2024	2025	2026
Threshold (Improved Median)	10.07	9.72	9.38	9.06
Benchmark (Same Exp as Median)	9.06	8.75	8.45	8.16
Poor Performance Benchmark (Same Exp as Median)	11.08	10.69	10.32	9.97
Reward Range	1.01	0.97	0.94	0.91
Penalty Range	1.01	0.97	0.94	0.91

Hospital-Specific Performance - Improvement Only v. Attainment Only

- Based on the improvement and attainment targets on the previous slide

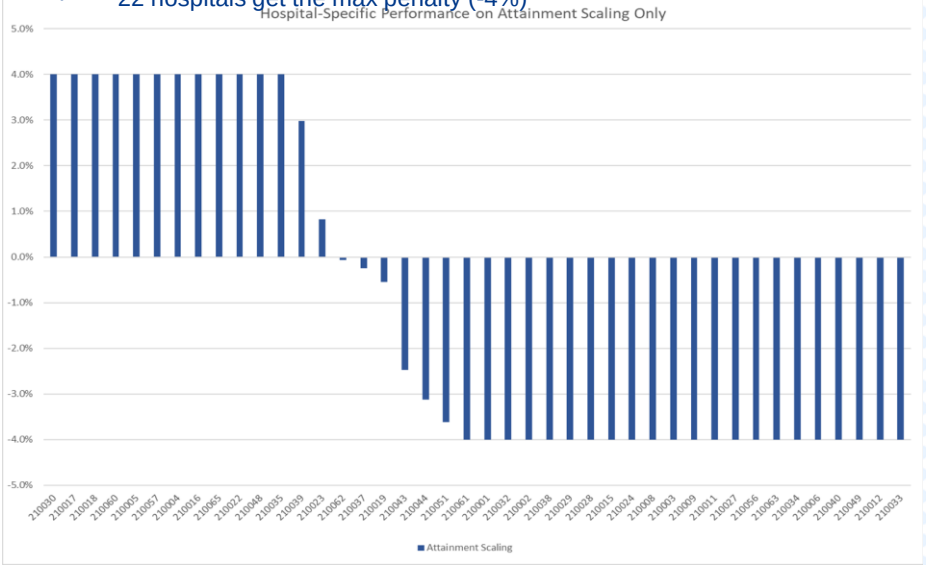
Scaling on Improvement ONLY

- 1 hospital gets the max reward (+4%)
- 21 hospitals get the max penalty (-4%)



Scaling on Attainment ONLY

- 12 hospitals get the max reward (+4%)
- 22 hospitals get the max penalty (-4%)



Hospital-Specific Performance - Scaling on the better of Improvement or Attainment

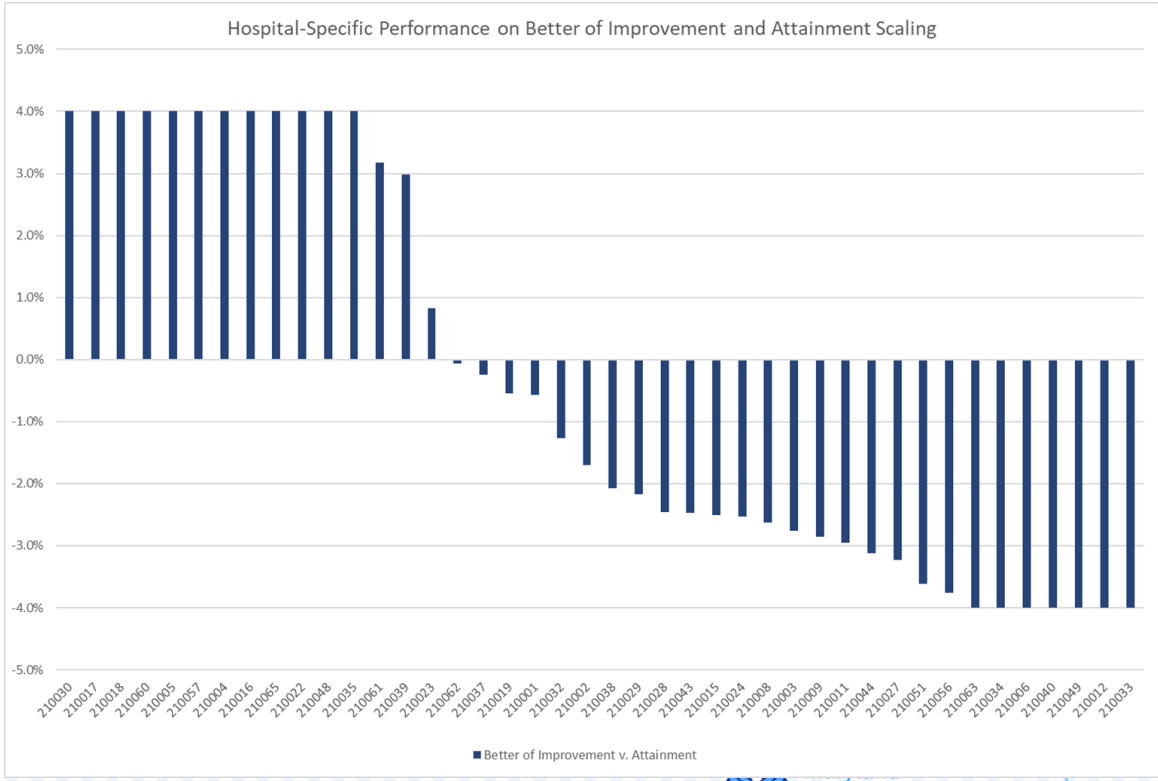
Under the Improvement or Attainment scaling approach;

Rewards:

- 12 Hospitals will get the full +4% reward for reducing PQIs beyond the benchmark or having a PQI composite lower than the attainment benchmark
- 3 hospitals will receive a portion of the rewards for scoring better than the improvement and attainment thresholds

Penalties:

- 20 Hospitals will receive some penalties for performing below the threshold but above the poor performance benchmark on either improvement or attainment
- 7 hospitals will receive the max penalty (-4%) for performing worse than the poor performance benchmark on either improvement or attainment



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Readmissions Reduction Incentive Program
Final Recommendations

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RY2025 RRIP Methodology Overview

30-day, All-Cause Readmission Measure

Measure Includes:
Readmissions within 30 days of Acute Case Discharge:

- All-Payer
- All-Cause
- All-Hospital (both intra- and inter- hospital)
- Chronic Beds included
- IP-Psych and Specialty Hospitals included
- Adult oncology Discharges Included

Global Exclusions:

- Planned Admissions
- Same-day and Next-day Transfers
- Rehab Hospitals
- Discharges leaving Against Medical Advice Deaths

Case-Mix Adjustment

Performance Measure: CY 2023 Case-mix Adjusted Readmission Rate, adjusted for out-of-state readmissions (Attainment); Reduction in Case-mix Adjusted Readmission Rate from CY2018 Base Period (Improvement).

Case-mix Adjustment:
Expected number of unplanned readmissions for each hospital are calculated using the discharge APR-DRG and severity of illness (SOI).

*Observed Unplanned Readmissions / Expected Unplanned Readmissions * Statewide Readmission Rate*

CY2021 used to calculate statewide averages (normative values).

CY2018 (using CY21 norms) is base period and used to set the attainment benchmark/threshold.

Revenue Adjustments

Hospital RRIP revenue adjustments are based on the better of attainment or improvement, scaled between the Max Reward and Max Penalty.

Scores Range from Max Penalty -2% & Reward+2%

All Payer Readmission Rate Change CY18-23		% IP Revenue Payment Adjustment
	A	B
Improving		2.0%
	-28.50%	2.00%
	-23.25%	1.50%
	-18.00%	1.00%
	-12.75%	0.50%
Target	-7.50%	0.00%
	-2.25%	-0.50%
	3.00%	-1.00%
	8.25%	-1.50%
	13.50%	-2.0%
Worsening		-2.0%

Improvement

Attainment

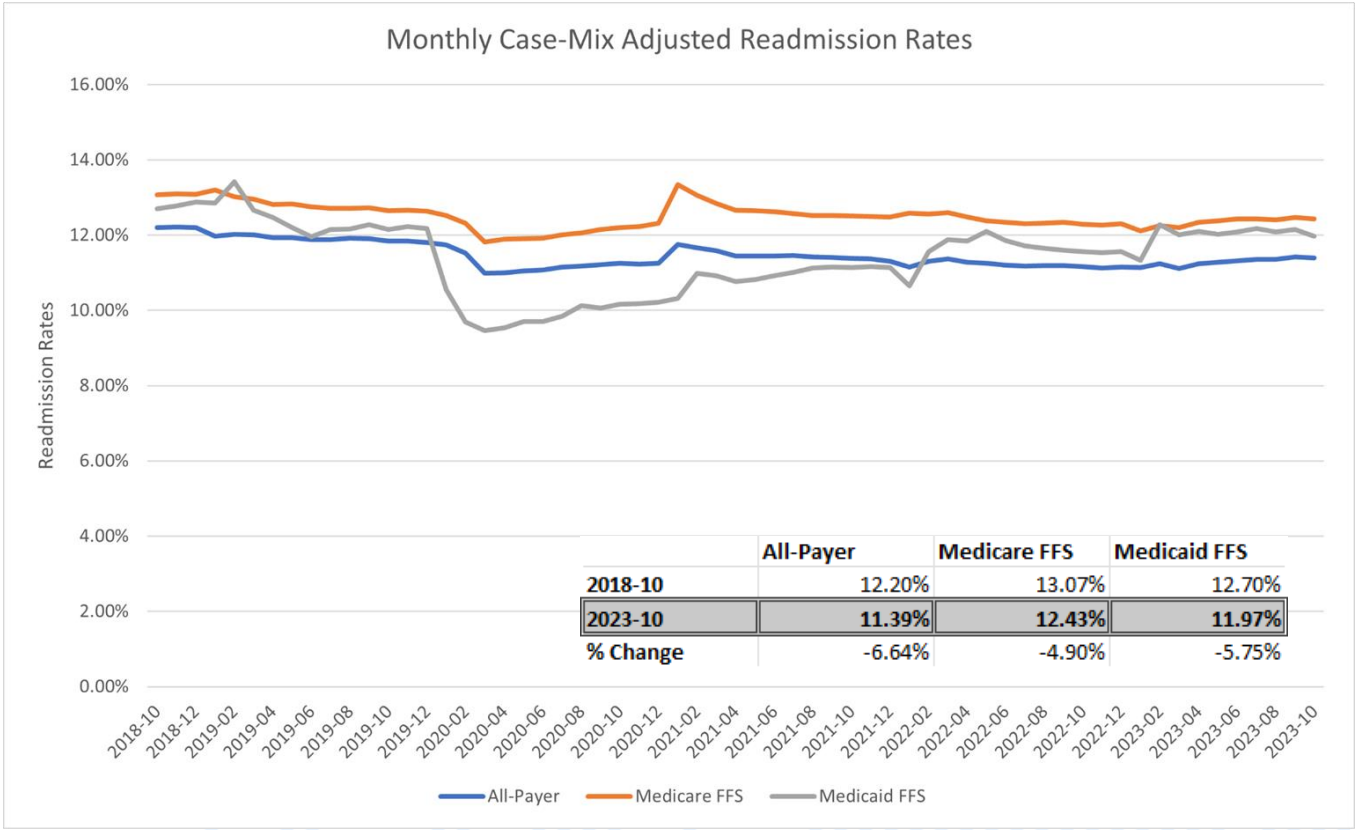
All Payer Readmission Rate CY23		RRIP % Inpatient
Lower Readmission Rate		2.0%
Benchmark	8.15%	2.00%
	9.74%	1.00%
Threshold	11.32%	0.00%
	12.90%	-1.00%
	14.49%	-2.00%
Higher Readmission Rate		-2.0%

Draft Readmissions Reduction Incentive Program

RY 2026 Discussion Items:

- Improvement target
- Attainment target
- Impact of Revisits/Observation
- Excess Days in Acute Care measure
- Within hospital disparities measure and incentive

Improvement in Case-Mix Adjusted Readmission Rates



	All-Payer	Medicare FFS	Medicaid FFS
2018-10	12.20%	13.07%	12.70%
2023-10	**11.39%**	**12.43%**	**11.97%**
% Change	-6.64%	-4.90%	-5.75%

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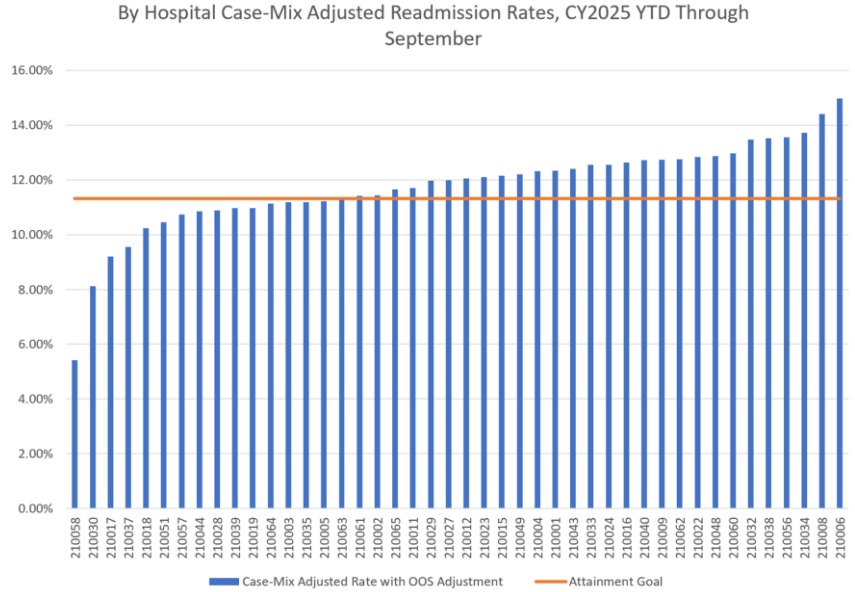
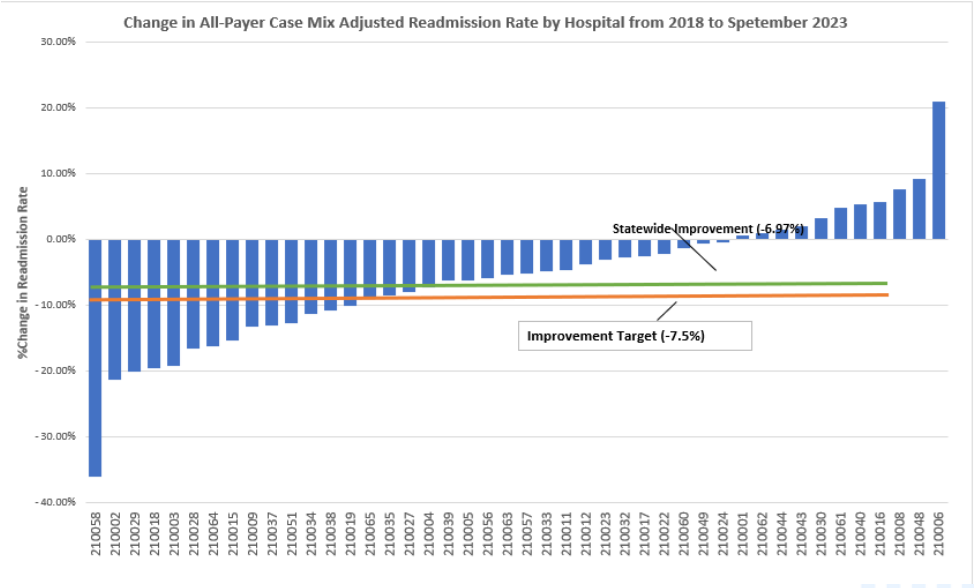
RY2025 YTD By Hospital Case-Mix Adjusted Readmission Rates





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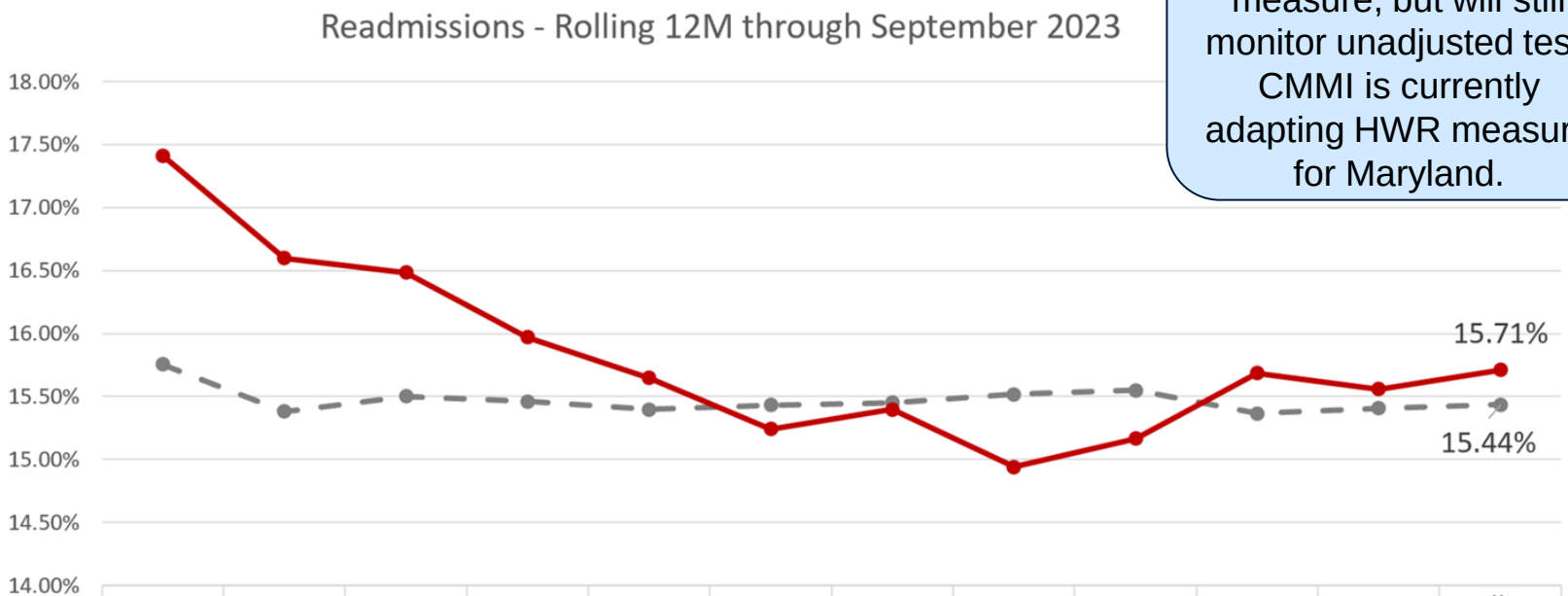
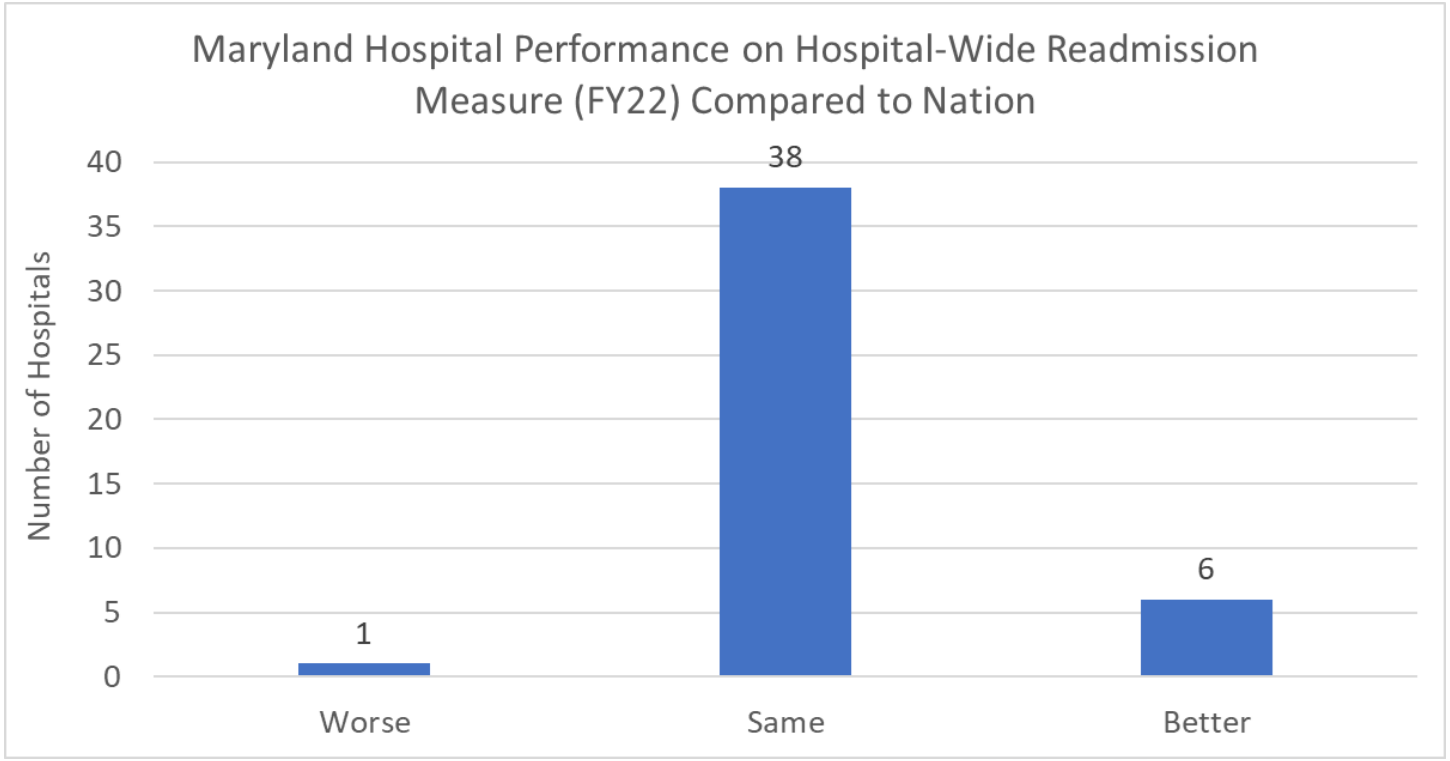
Unadjusted Readmission Rates, MD vs Nation

CMMI has agreed to move to a risk-adjusted measure, but will still monitor unadjusted test. CMMI is currently adapting HWR measure for Maryland.



	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	Rolling 12 Months CY 2023
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%	15.44%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%	15.71%

Medicare Risk-Adjusted Hospital-Wide Readmission Measure



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General Improvement Target Considerations

- RRIP Redesign set 5 year improvement goal (2018-2023) of 7.5 percent
  - Should policy still provide incentives for improvement? If so, over what time period (e.g., 2023-2026)?
  - SDOH adjustment is less critical with improvement incentives
  - Case-mix adjustment using statewide normative values acknowledge changes in case-mix index over time
  - Uncertainty in acceptable readmission rate is cushioned with opportunity to earn credit for improvement
  - An acceptable readmission rate will always be non-zero, some readmissions are unavoidable and hospitals should not be unduly pressured to reach zero readmission rate
    - Should trend in improvement be lower than during last 5 years?

Updated All-Payer Improvement Estimates

Propose to make final policy a more explicit multi-year policy through CY 2026

Estimating Method	Percent Improvement from CY 2022 (11.15%)	Resulting Readm Rate (in 2026)
1. Annual 2018-2022 Improvement	-8.61%	10.19%
2. Annual 2021-2022 Improvement	-5.54%	10.53%
3. All hospitals to 2022 Median	-4.1%	10.69%
4a. Medicare Benchmarking - Peer County/MSA to 75th Percentile**	-4.75% to -5.45%	TBD
4b. Commercial Benchmarking - Peer County/MSA to 75th Percentile**	-2.22% to -9.15%	TBD
5. Reduction in Readmission-PQIs	-2.39%	10.88%
6. Reduction in Disparities	TBD	TBD

RY 2026 Attainment Target

- Staff applied the proposed improvement rate (-5.5%) to the OOS adjusted statewide readmission rate
- The resulting readmission rate is very similar to the 65th percentile
- Staff recommend continuing to set the RRIP threshold at the 65th percentile

Monitoring Plan and Discussion: ED and Observation Revisits

CMMI is asking what we think about this for purposes of waiver test

- Compare statewide and by hospital, unadjusted readmission rates with and without including ED revisits and/or observation stays (all)
  - Impact on hospital rankings
  - Impact on improvement rates
- Given concern about ED volume, should RRIP policy monitor or include in payment revisits?
  - Concerns on impact to ED of avoiding admission
  - Potentially way to game readmission rates
  - How would inclusion impact access?
  - Other concerns?

EDAC

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CMS EDAC Measure Summary

Purpose:

- The aim of this measure is to capture differences in days of acute care provided by hospitals to patients discharged alive after heart failure, heart attack, and pneumonia admission in the 30 days post-discharge
- Other aims for this measure:
  - Assess relative performance of hospitals
  - Align with any existing CMS AMI, HF, and PN quality measures

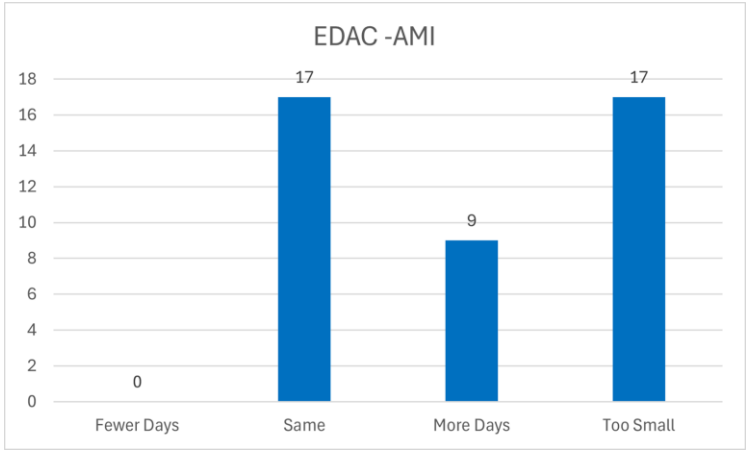
CMS EDAC Calculation:

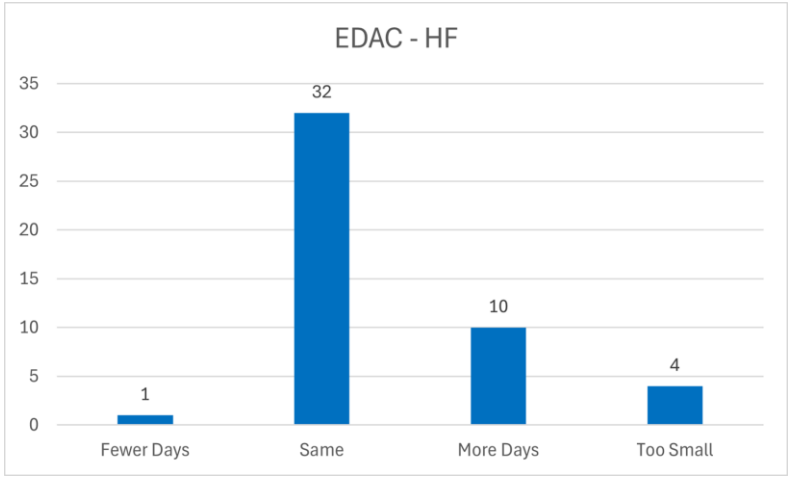
- Hospital EDAC = (Predicted Days- Expected Days) * 100 Discharges

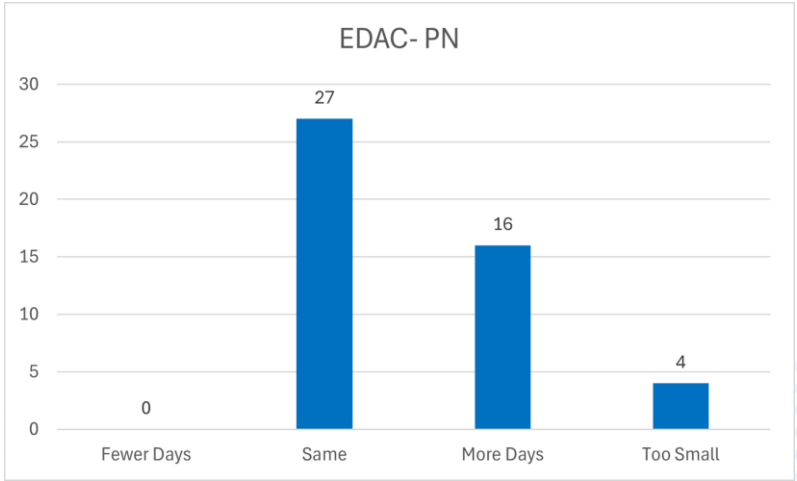
2023 Measure Updates:

- Updated ICD-10 code based specifications
- Applied a YNHHSC/CORE-modified v3.0 of the AHRQ Healthcare Cost and Utilization's (HCUP's) beta version 2019.1 CCS for ICD-10-CM/PCS to the planned readmission algorithm.

CMS EDAC Results: AMI, HF, and PN (7/1/19-6/30/22)







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HSCRC EDAC Measure Summary

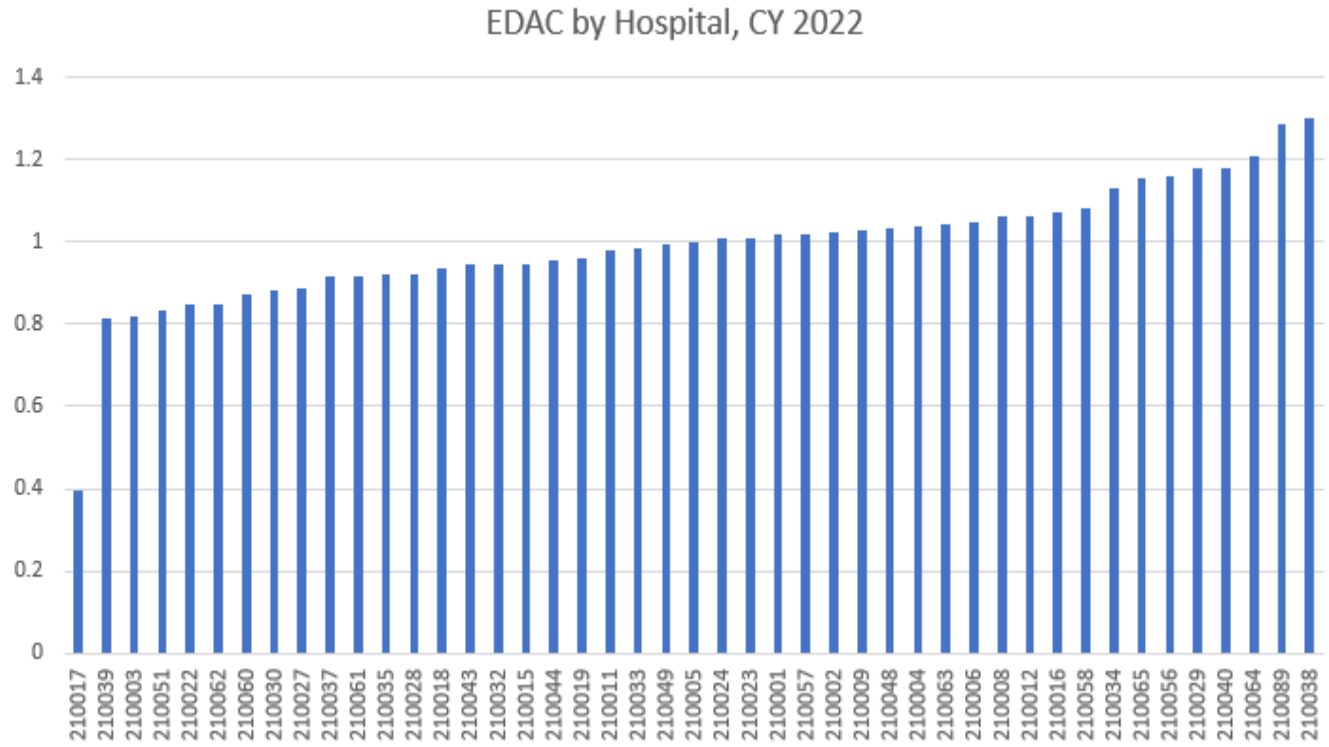
- For all patients/payers, EDAC defined as: sum of **Readmissions** (length of stay of readmissions); **Observation Stays**; and **Emergency Department Visits**
- Conceptually this will provide a **more comprehensive/nuanced view of post-discharge hospital utilization** than binary readmission (yes/no)
- Excess days are sum of:
  - LOS for IP Readmission
  - Sum of Observation Stay hours, rounded to half-days
  - ED visit = 0.5 days (half day)
- EDAC measure offers two advantages over a dichotomous readmission measure:

  1) it accounts for more forms of post-discharge care

  2) it accounts for the intensity of post-discharge care.

Note: Monitoring Detail and Summary Level Reports are on CRS Portal

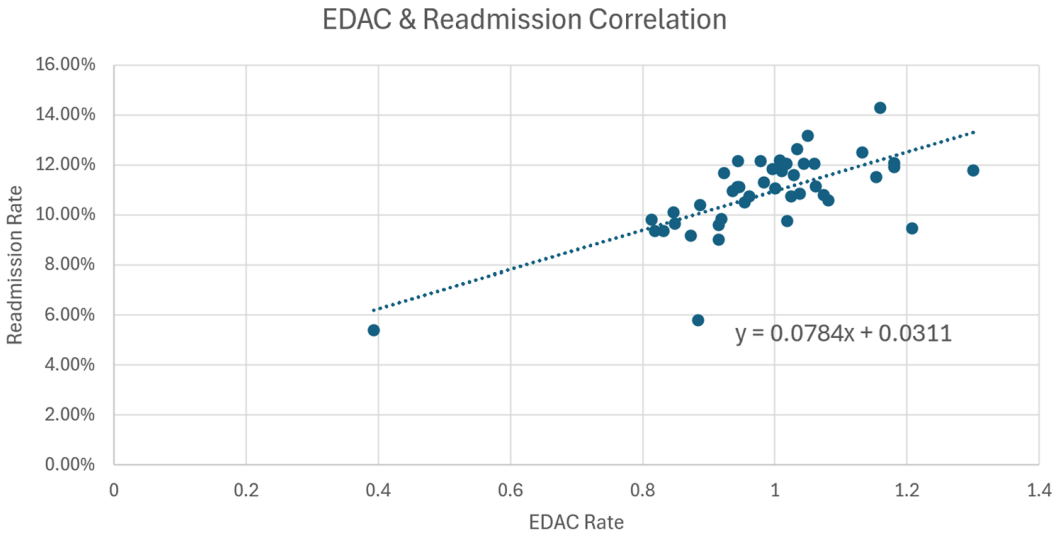
EDAC Performance



Performance Statistics (lower is better)	
Average	0.9923
Highest	1.3005
75th percentile	1.06014
Median	1.0008
25th percentile	0.9190
Lowest	0.3931

EDAC and Readmission Correlation, CY2022

- A moderate correlation (0.6865) between EDAC and readmissions suggests the two measures are mostly measuring the same thing



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Discussion

- EDAC is a way to look at revisits
- Concerns have been raised that long readmissions may be less preventable than shorter readmissions
- EDAC rates are low across all-payer, all-causes, with relatively low variation across hospitals

RRIP-Disparity Gap Updates

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Disparity Gap Reduction Goals: P4P Program

- In CY 2024, to begin receiving rewards, a hospital must reduce their readmission disparity gap by 35.16% when compared to 2018

Disparity Gap Improvement Scaling			
RY	2026	2027	2028
50% improvement (start of rewards)	-35.16%	-40.54%	-45.47%
75% improvement (full reward)	-57.96%	-64.64%	-70.27%

- RY 2024 RRIP-Disparity Gap Program (CY 2022 performance)
  - 11 hospitals rewarded
  - Range: (-29.74%, -61.54%)

NEW Disparity Gap Requirement

- To be eligible for the disparity gap reward hospitals must:
  - Submit a form identifying and explaining initiatives/programs aimed at reducing disparities in readmissions
  - This effort will allow the HSCRC to track the success of the initiatives with hopes of sharing best practices/successful initiatives
- Discussion:
  - What should be included on the form?
  - Reasonable deadline for CY24 performance?

RY2026 RRIP Draft Recommendations

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RY2026 Final-ish RRIP Recommendations

1. Maintain the 30-day, all-cause readmission measure.

2. Improvement Target - Set statewide 4-year improvement target of -5.0 percent from 2022 base period through 2026.

3. 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.

4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.

5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years, capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years. Hospitals must submit to HSCRC staff their efforts to reduce disparities in readmissions to be eligible for the disparity gap reward.

6. 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 of EDAC in RRIP program.

Work Group Process: General Overview and PMWG Near Term Next Steps

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Overview: HSCRC Workgroup Management Process, February 2024

Purpose & Staffing- Three standing workgroups: Payment Models, Performance Measurement, and Total Cost of Care; all workgroups need to have written charge; technical subgroups as needed to report back to standing workgroups;HSCRC staff-led; advisory to the Commission.

Communications- Dedicated webpage and email address; open to the public (request via email); staff to issue workgroup materials in advance of meetings; master calendar on HSCRC website.

Membership- Diversity in expertise, experience, background, geography, and race/ethnicity; Staff reviews membership annually; consider consumer engagement.

Meetings- Open to the public; announced in advance, materials and minutes or recordings posted on the website; may set aside time for public comment; accessibility; accessible with closed captioning, etc.

Performance Measurement Workgroup: Immediate Next Steps

- **Emergency Department -**
  - Two LOS subgroups: 1. Data Collection (commenced); 2. Measure and Incentive Methodology (March 2024).
  - Best practices subgroup
  - PMWG next steps: staff will summarize subgroup input and policy direction through March and April and email update to PMWG members
- **Other topics TBD-**
- Staff will potentially convene 1-2 PMWG meetings in April-May timeframe as needed to vet additional policy items
- Staff will survey PMWG members on their work group participation experience

Next Meetings:

Wednesday, March 20, 2024 (Tentative)

April 17, 2024 (Tentative)