maryland
health services
cost review commission

Performance Measurement Workgroup

September 16, 2020

HSCRC Quality Team

Meeting Agenda

1. CMS Interim Final Rule Update: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

2. Total Cost of Care (TCOC) Model update and SIHIS goals:
   a) Follow-up measure
   b) PQI improvement goal
   c) Disparities

3. Quality Based Reimbursement (QBR) Program RY 2023

4. Maryland Hospital Acquired Conditions (MHAC) Program RY 2023

5. Other topics and public comment

Interim Final Rule Addressing COVID-19

Quality Updates and Implications

Interim Final Rule: Response to the COVID-19 Public Health Emergency

- CMS will not use CY Q1 or CY Q2 of 2020 quality data even if submitted
- CMS is still reserving the right to suspend application of revenue adjustments for all programs at a future date in 2021; changes will be communicated through memos ahead of IPPS rules.
- We do not know at this time if Maryland has flexibility in suspending our programs and we have to make those decisions prior to CMS making their decisions.
- CMS modified the SNF VBP program performance period to use earlier time periods and then the July-September 2020 to ensure one full year of data
  - Six months data is probably inadequate.
  - Provides an option for duplicating use of 2019 data in combination with last six months of 2020.

RY 2022 Data Concerns and Revenue Adjustment Options

COVID Data Concerns	Options
Only 6 months of data for CY 2020: 1. Is 6-months data reliable? 2. What about seasonality?	• Use 6-months data, adjust base as needed for seasonality concerns • Merge 2019 and 2020 data together to create 12 month performance period • Use 2019 data or revenue adjustments
Clinical concerns over inclusion of COVID patients (e.g., assignment of respiratory failure as an in-hospital complication)	• Remove COVID patients from some or all measures of quality
Case-mix adjustment concerns: 1. Inclusion of COVID patients when not in normative values 2. Impacts on other DRG/SOI of COVID PHE	• Remove COVID patients from some or all measures of quality • Use 2019 data or revenue adjustments

Statewide Integrated Healthcare Improvement Strategy (SIHIS)

Quality Improvement Goals Discussion

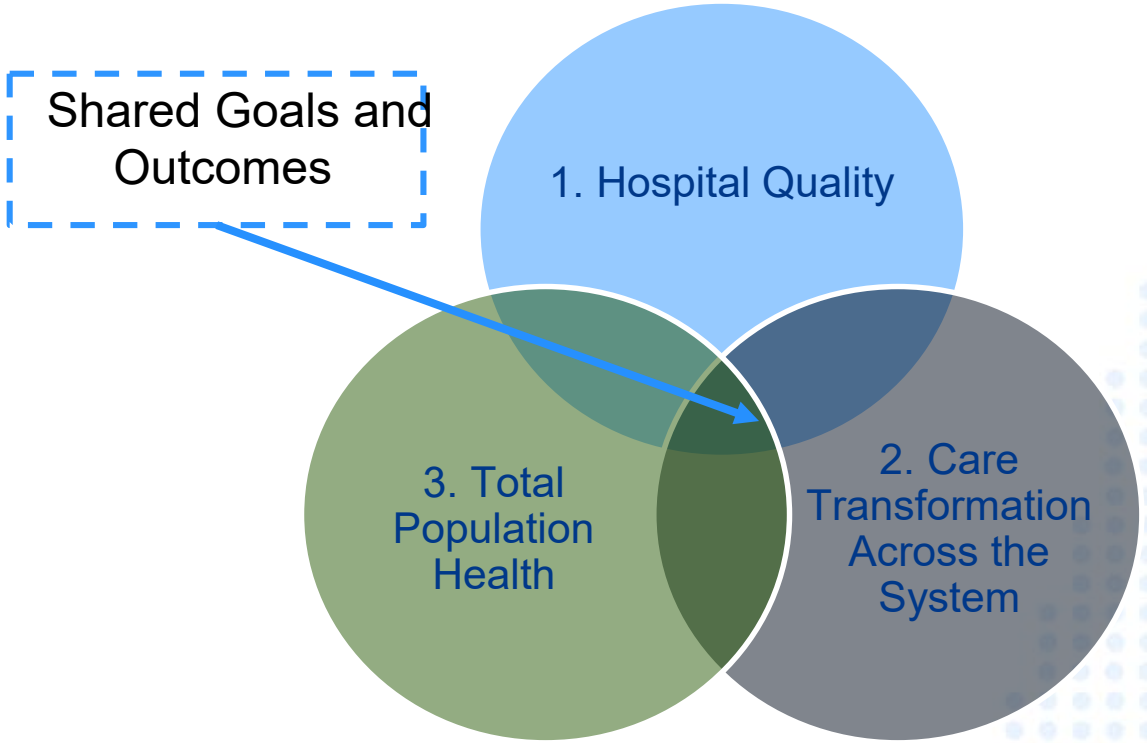
Background

- In December 2019, Maryland & CMS signed a Memorandum of Understanding (MOU) agreeing to establish a Statewide Integrated Health Improvement Strategy.
- This initiative is designed to engage more state agencies and private-sector partners than ever before to collaborate and invest in improving health, addressing disparities, and reducing costs for Marylanders.
- The MOU requires the State to propose goals, measures, milestone and targets in three domains by the end of 2020.
- CMMI insists that for the Maryland TCOC Model to be made permanent, the State must:
  - Sustain and improve high quality care under the hospital finance model
  - Achieve annual cost saving targets
  - Set targets/milestones and achieve progress on the Statewide Integrated Health Improvement Strategy

Domains of Maryland's Statewide Integrated Health Improvement Strategy

Stakeholder Engagement

- Domain 1
  - PQI/Disparities: HSCRC's Performance Measurement Work Group
- Domain 2
  - Follow-up: HSCRC's Performance Measurement Work Group
  - CTIs: HSCRC's Total Cost of Care Work Group
- Domain 3
  - Diabetes: Maryland Department of Health (MDH)
  - Opioids: Maryland Opioid Operational Command Center (OOCC)



Setting Targets

- The State must set targets and demonstrate progress in the 3 domains
- CMMI will start to review data through 2021, which will serve as a criteria for making the Model permanent
  - Although outcomes are preferred to show success, they are less likely to be obtained in 2021 data
  - Each goal/measure should have a baseline, measurement approach, 2021 milestone, a 2023 interim target, and a 2026 target

1. Hospital Quality	**Goal:**				
	Baseline	Measure(s)	2021 Milestone	2023 Interim Target	2026 Final Target
2. Care Transformation Across the System	**Goal:**				
	Baseline	Measure(s)	2021 Milestone	2023 Interim Target	2026 Final Target
3. Total Population Health a) Diabetes	**Goal:**				
	Baseline	Measure(s)	2021 Milestone	2023 Interim Target	2026 Final Target
Total Population Health – b) Opioids	**Goal:**				
	Baseline	Measure(s)	2021 Milestone	2023 Interim Target	2026 Final Target

Deliverables

- Timeline
  - July – October– Goals, Baseline, Milestones, Targets, & Measures developed
  - November 11th – Presentation to Commissioners on Goals and Targets
  - October – December 1st – Drafting of Proposal
  - (TBD) December 9th – Presentation of Final Proposal to Commissioners
  - December 31st – SIHIS Proposal is due to CMS

Performance Measurement Workgroup

Proposed SIHIS Measures

Hospital Quality

- Goal: Reduce Avoidable Admissions and Readmissions
  - Measures:
    - Avoidable Admissions (PQI-90)
    - Disparities in Within Hospital Readmissions

Care Transformation

- Goal: Improve care coordination for patients with chronic conditions
  - Measure:
    - Timely Follow-up After Acute Exacerbations of Chronic Conditions

Care Transformation Goal #1:

Timely Follow-up After Acute Exacerbations of Chronic Conditions

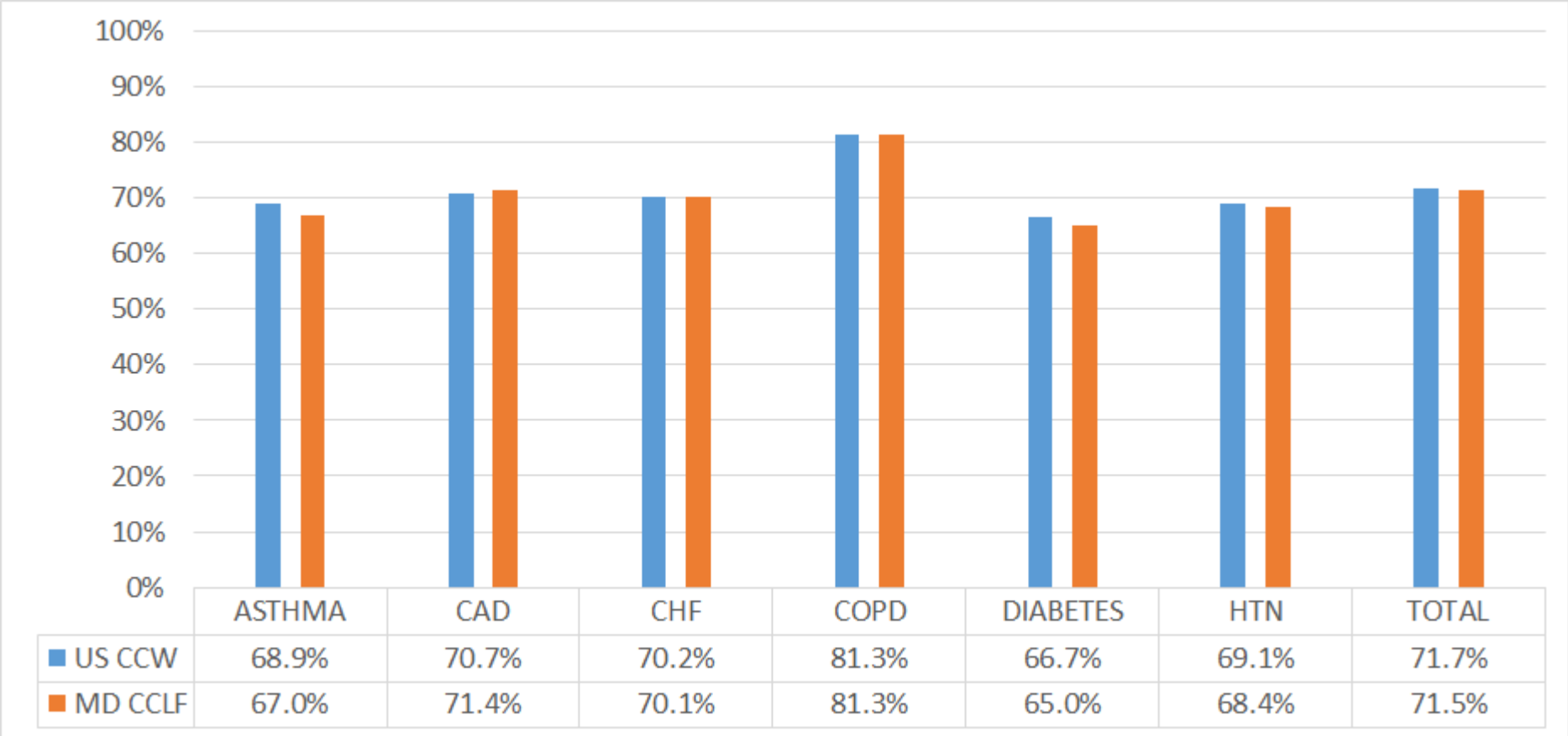
- NQF endorsed health plan measure that looks at percentage of ED, observation stays, and inpatient admissions for one of the following six conditions, where a follow-up was received within time frame recommended by clinical practice:
  - Hypertension (7 days)
  - Asthma (14 days)
  - Heart Failure (14 days)
  - CAD (14 days)
  - COPD (30 days)
  - Diabetes (30 days)
- Important link between hospitals and primary care; chronic conditions overlaps with many of the PQIs; expect that TCOC model evaluation will examine follow-up

Clarification on Measure Specifications & Updates

- HSCRC clarified how readmissions greater than two days after the index admission were handling in measure specifications
  - The measure stewards (IMPAQ) confirmed that the index admission is included in the denominator of the measure because the logic model is that appropriate follow-up would lead to lower readmissions
- Currently this measure is undergoing an annual NQF review but measure stewards have confirmed no changes have been made or anticipated to the current measure specifications

Maryland vs. National Performance by Condition

Maryland performs around the national average, but given TCOC model CMS expects Maryland to perform demonstrably better than the nation



	ASTHMA	CAD	CHF	COPD	DIABETES	HTN	TOTAL
US CCW	68.9%	70.7%	70.2%	81.3%	66.7%	69.1%	71.7%
MD CCLF	67.0%	71.4%	70.1%	81.3%	65.0%	68.4%	71.5%

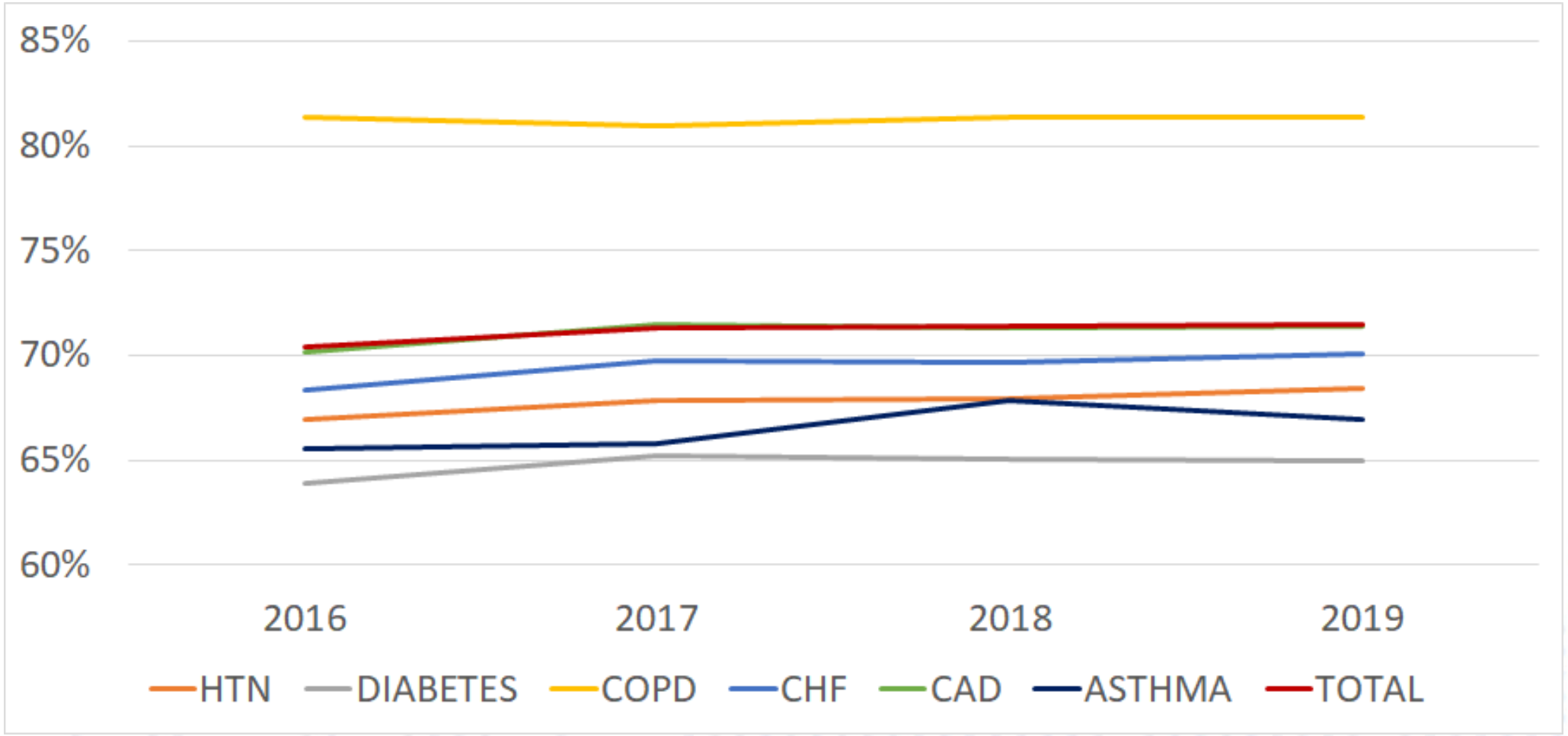
Approaches to Target Setting

1. Trends-based Approach
   a. Calculate annualized change from 2016 to 2019 across all conditions
   b. Target for a future year is annualized change compounded by the number of years in the performance period (i.e., 3, 5, and 8)

2. Performance-based Approach
   a. Calculated improvement needed to have all hospitals perform at 2019 national rate (i.e., hospitals performing below national average improve to national average and those above stay the same)
   b. Calculated improvement needed to have all hospitals perform at 2019 national rate plus half the annualized 2016-2019 improvement for those near or above national average

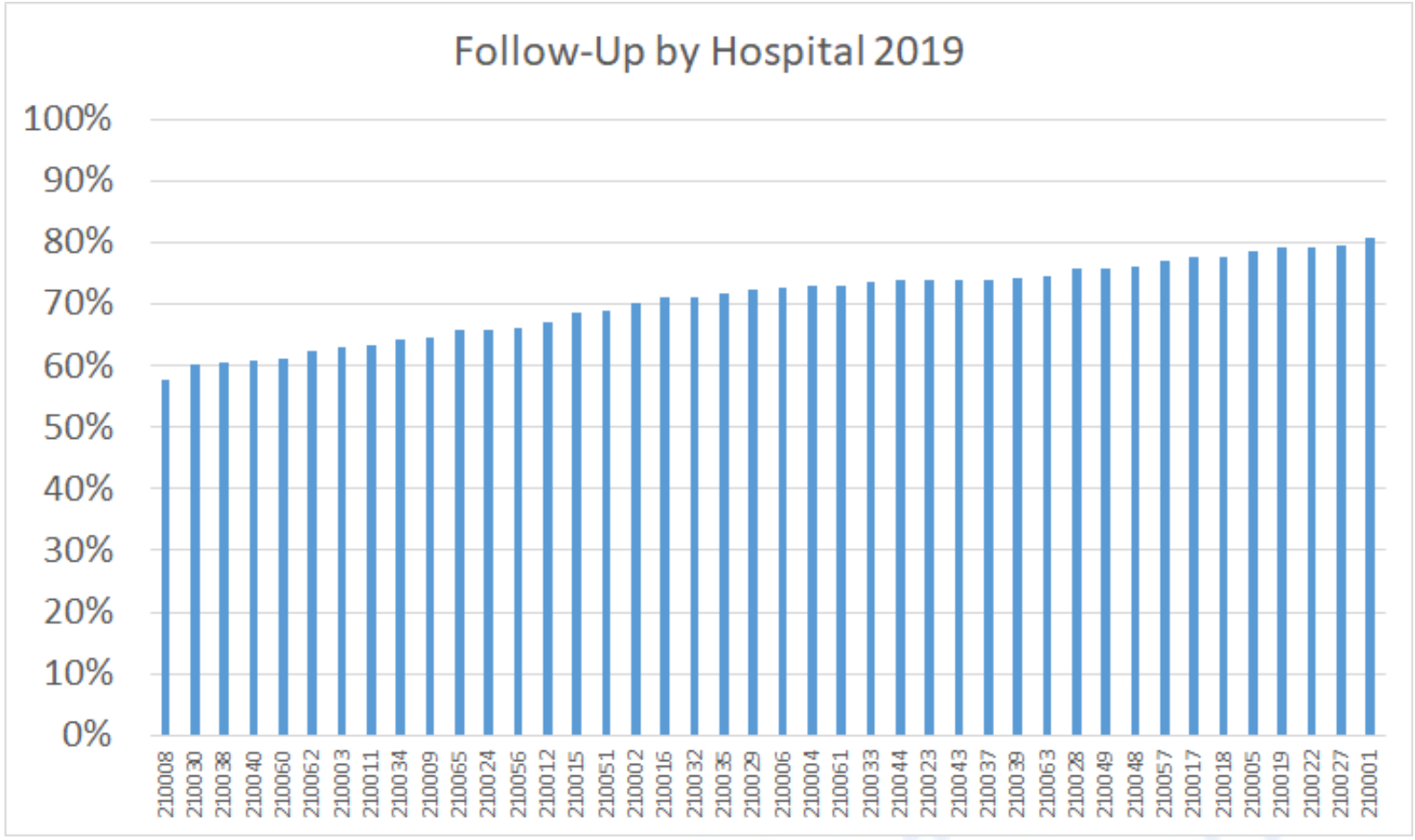
Maryland Performance on Follow-up 2016-2019

2016-2019 Change = 1.5% (compounded annual improvement 0.50%)



By Hospital Follow-up

Range of hospital performance from around 58 to 81 percent

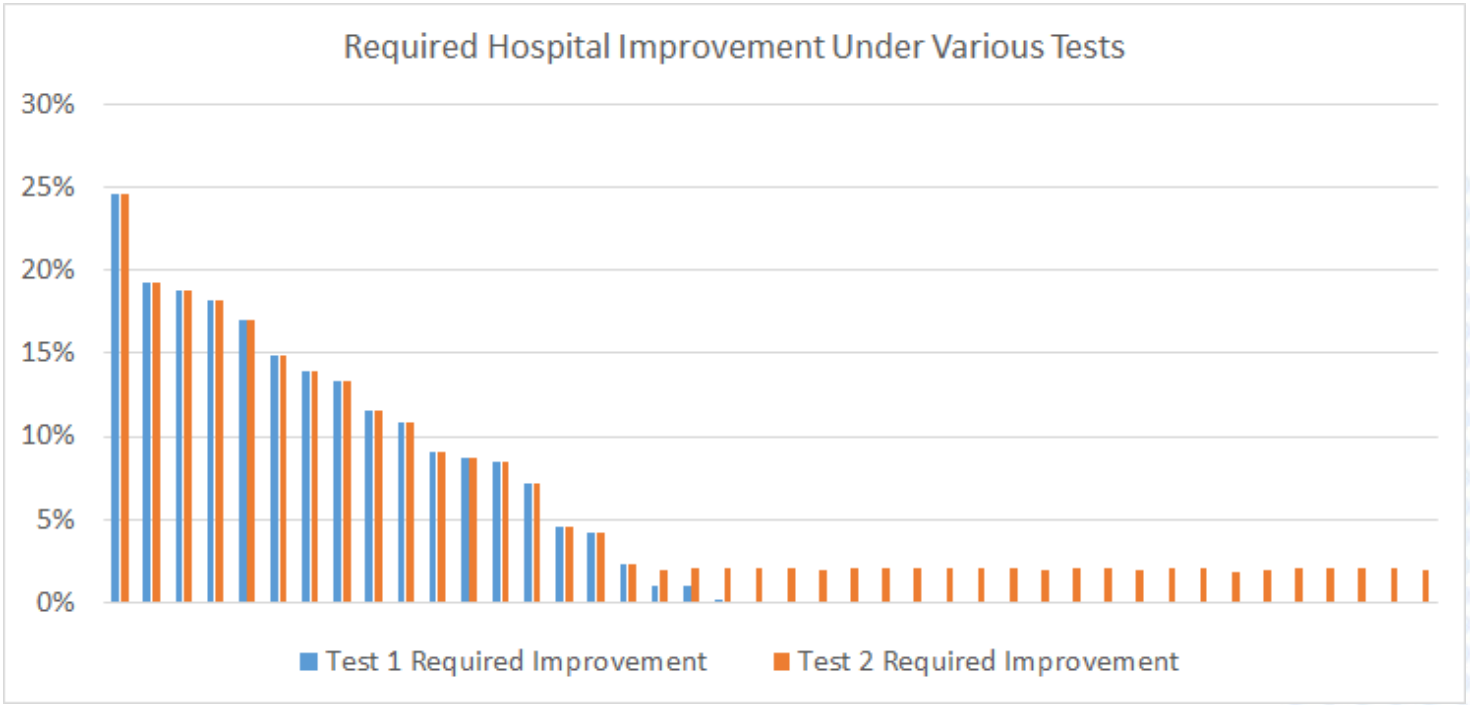


Two Performance Based Approaches

Difference is that Test 2 requires improvement from all hospitals

1. Calculated improvement needed to have all hospitals perform at 2019 national rate (i.e., hospitals performing below national average improve to national average and those above stay the same)

2. Calculated improvement needed to have all hospitals perform at 2019 national rate plus half the annualized 2016-2019 improvement for those near or above national average



SIHIS Follow-Up Targets

All Roads Lead to 75 Percent Attainment Target

- Staff propose the 8 year target should be to achieve the better of a 75 percent follow-up rate or the 2025/2026 national average
  - Year 3 and 5 goals are annualized change needed to achieve ~ 75 percent in 8 years

Proposed SIHIS Targets	2018	Year 3 (2021)		Year 5 (2023)		Year 8 (2026)	
	Rate	Rate	Percent Improvement	Rate	Percent Improvement	Rate	Percent Improvement
Trend Target	71.59%	72.66%	1.50%	73.39%	2.51%	74.49%	4.04%
Performance Target 1: All Improve to National Average	71.59%	72.51%	1.28%	73.13%	2.15%	74.07%	3.46%
Performance Target 2: All Improvement to National Average + Half Annualized Improvement	71.59%	72.84%	1.75%	73.69%	2.94%	74.98%	4.74%
Proposed Target	**71.59%**	**72.85%**	**1.76%**	**73.70%**	**2.95%**	**75.00%**	**4.76%**

Next Steps/Future Considerations

- Finalize Medicare Targets based on PMWG feedback
- HSCRC exploring feasibility of adding Medicaid MCO data and HEDIS measure for follow-up after mental health hospitalization
  - SIHIS proposal will mention these additional areas
- Inclusion of incentives on hospital and PCP for improvements in follow-up

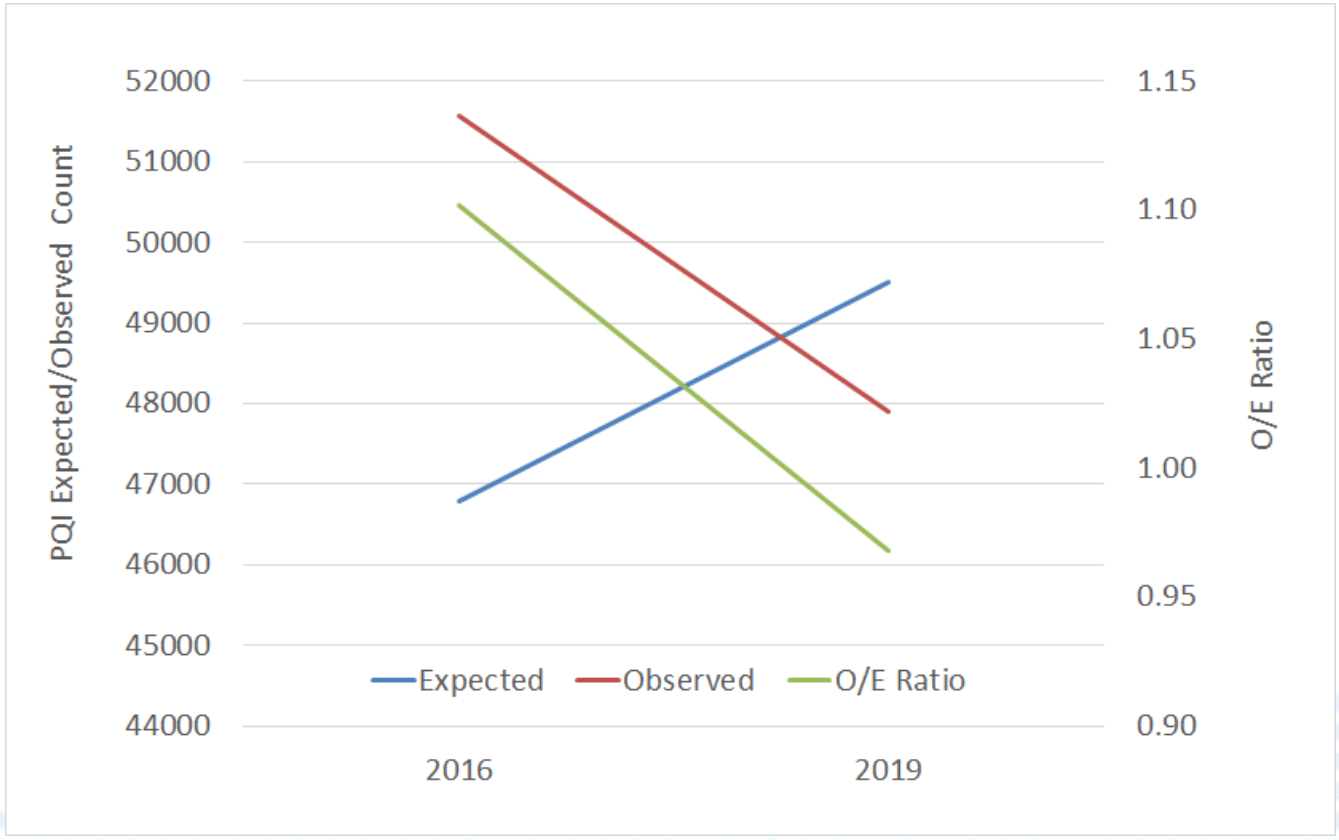
Hospital Quality Goal #1: Avoidable Admissions

Updates on Target Setting

- Previous analyses kept the population data constant across years
  - Tested using population estimates to vary denominator (or predicted PQIs) to set improvement trends
  - Population estimates resulted in increases in expected PQIs primarily due to aging of the population (i.e. older cohorts are more likely to experience avoidable admissions)
    - Using a dynamic population denominator also suggests that since 2016 reductions in risk-adjusted PQI rates has been larger in scale, i.e., the State reduced PQI's despite an increasing expected number of PQI's due to the aging of population

Expected and Observed PQI Changes Overtime

As expected PQI's increase and there is simultaneously decreases in observed PQI's, overall improvement in the O/E ratio (and risk-adjusted PQI rate) is greater than the reduction suggested by just looking at changes in the numerator



	Percent Change 2016-2019
Expected	1.9%
Observed	-2.4%
O/E Ratio	-4.2%

Diabetes PQIs and Eastern Shore Removed

Comparison of Numerator Only and Population Adjusted Improvement Trends

	Expected	Observed	O/E	2018 to 2021 O/E Change
2018 Actuals	48635.4	48993	1.007	
2021 Projected Numerator Only	48635.4	45500.49	0.936	-7.1%
2021 Projected Population Adjusted	51446.3	45500.49	0.884	-12.2%

Discussion Points on Approaches:

1. Population numbers are estimates that are restated overtime and generally 1-2 years lagged from numerator counts
2. Modeling of population adjusted improvement targets assumes historical changes continue
3. If there are significant population changes (#, aging), not adjusting for this could advantage or disadvantage state
4. If the State selects Numerator Only Approach, CMMI and Model evaluators may cite that goal was met, in large part, due to aging of the population

Target Options

Requires Decision on Population Adjusted vs. Numerator Only Targets

Targets with Diabetes and Eastern Shore Removed	3 Years CY 2021	5 Years CY 2023	8 Years CY 2026
Trend goal based on CY 2016-CY2019 improvement (Numerator Only)	-7.1%	-11.6%	-17.9%
Trend goal based on CY 2016-CY2019 improvement (Population Adjusted)	-12.2%	-19.5%	-29.3%
Trend goal based on CY 2018-CY2019 improvement (Numerator Only)	-6.5%	-10.6%	-16.5%
Trend goal based on CY 2018-CY2019 improvement (Population Adjusted)	-11.3%	-18.2%	-27.5%
Performance-based goal of moving median to top quartile	-8.1%	-13.2%	-20.2%
HSCRC Staff Proposal:			
Trend goal based on CY 18-CY19 improvement (Population Adjusted)—Minus 1 Yr improvement due to COVID	**7.7%**	**14.8%**	**24.5%**

Quality Based Reimbursement (QBR) Program

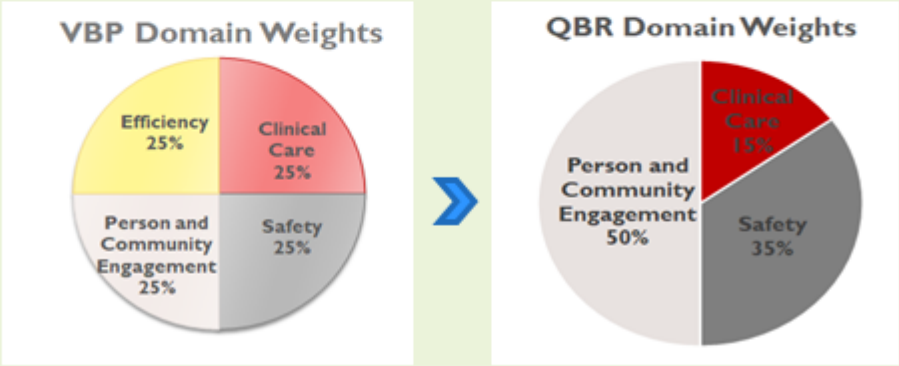
Quality Based Reimbursement (QBR) Program: Overview

Purpose: Incentivize quality improvement across three patient-centered quality measurement domains:

1. **Person and Community Engagement (HCAHPS)** - 8 survey-based measures
2. **Clinical Care** - in-patient mortality rate + hip/knee replacement complication rate
3. **Safety** - 6 measures of in-patient Safety (National Healthcare Safety Network (NHSN) Healthcare Associated Infections).

The QBR program uses similar measures to the federal Medicare Value-Based Purchasing (VBP) program

Because Maryland's program is separate from the national program, it can use data from all payers and can adjust domain weights to focus on MD-specific improvements.



RY 2023 Quality-Based Reimbursement Program

- QBR redesign delayed: consider convening redesign subgroup in CY 2021 which will impact FY 2024.
- RY 2023 considerations:
  - Addition of all-payer Patient Safety Index (PSI) 90 measure to the safety domain
  - Discuss transition from inpatient mortality to 30-day mortality measure
  - Consider addition of SIHIS measure for follow up after discharge
  - COVID-19 impacts; base time period and comparability for PSI and mortality
  - Other stakeholder concerns?

All-Payer PSI-90 into QBR

Agency for Healthcare Research and Quality (AHRQ)Patient Safety Indicators (PSIs)

- PSIs focus on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth
- AHRQ Patient Safety Indicators were developed* and released in 2003 to help assess the quality and safety of care for adults in the hospital
- PSI uses:
  - Assess, monitor, track, and improve the safety of inpatient care
  - Comparative public reporting, trending, and pay-for-performance initiatives
  - Identify potentially avoidable complications that result from a patient's exposure to the health care system
  - Detect potential safety problems that occur during a patient's hospital stay

*AHRQ contracted with the University of California, San Francisco, Stanford University Evidence-based Practice Center, and the University of California Davis for development. For additional Information: https://www.qualityindicators.ahrq.gov/Modules/psi_resources.aspx

PSI Indicators

- PSI 02 - Death rate in low-mortality diagnosis related groups (DRGs)
- **PSI 03 - Pressure ulcer rate***
- PSI 04 - Death rate among surgical inpatients with serious treatable conditions
- PSI 05 - Retained surgical item or unretrieved device fragment count
- **PSI 06 - Iatrogenic pneumothorax rate***
- PSI 07 - Central venous catheter-related blood stream infection rate
- **PSI 08 - Postoperative hip fracture rate***
- **PSI 09 - Perioperative hemorrhage or hematoma rate***
- **PSI 10 - Postoperative physiologic and metabolic derangement rate***
- **PSI 11 - Postoperative respiratory failure rate***
- **PSI 12 - Perioperative pulmonary embolism or deep vein thrombosis rate***
- **PSI 13 - Postoperative sepsis rate***
- **PSI 14 - Postoperative wound dehiscence rate***
- **PSI 15 - Accidental puncture or laceration rate***
- PSI 16 - Transfusion reaction count
- PSI 17 - Birth trauma rate – injury to neonate
- PSI 18 - Obstetric trauma rate – vaginal delivery with instrument
- PSI 19 - Obstetric trauma rate-vaginal delivery without instrument
- **PSI 90 – Composite Measure: Patient Safety for Selected Indicators***

***Composite measure and PSIs comprising it are bolded.**

V2020 was released in July 2020 and HSCRC will use the latest version for RY 2023 QBR Program

Calculating Individual PSI Rates: Empirical Methods

Observed rate
The number of hospitalizations with each PSI divided by the number of hospitalizations for patients at risk for the event.

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Expected rate
Rate of adverse events expected if this hospital provided the average level of care observed in the reference population, but provided it to the patients with the locally observed distribution of characteristics (i.e., average performance from the reference population applied to locally observed mix of patients with their local risk profiles).

× **Reference Population Rate** =

Risk-adjusted rate
Rate of adverse events for this hospital compare to the rate we would expect to see if it provided the average level of care observed in the reference population, to the patients with the locally observed distribution of characteristics

→

Smoothed rate
A weighted average of the reference population rate and the risk-adjusted hospital rate.

Large hospital: Smoothed rate will be very close to the risk-adjusted rate

Small hospital: Smoothed rate will be closer to the reference population rate

The smoothed rate is calculated with a shrinkage estimator that, in practice, brings rates toward the reference population mean.

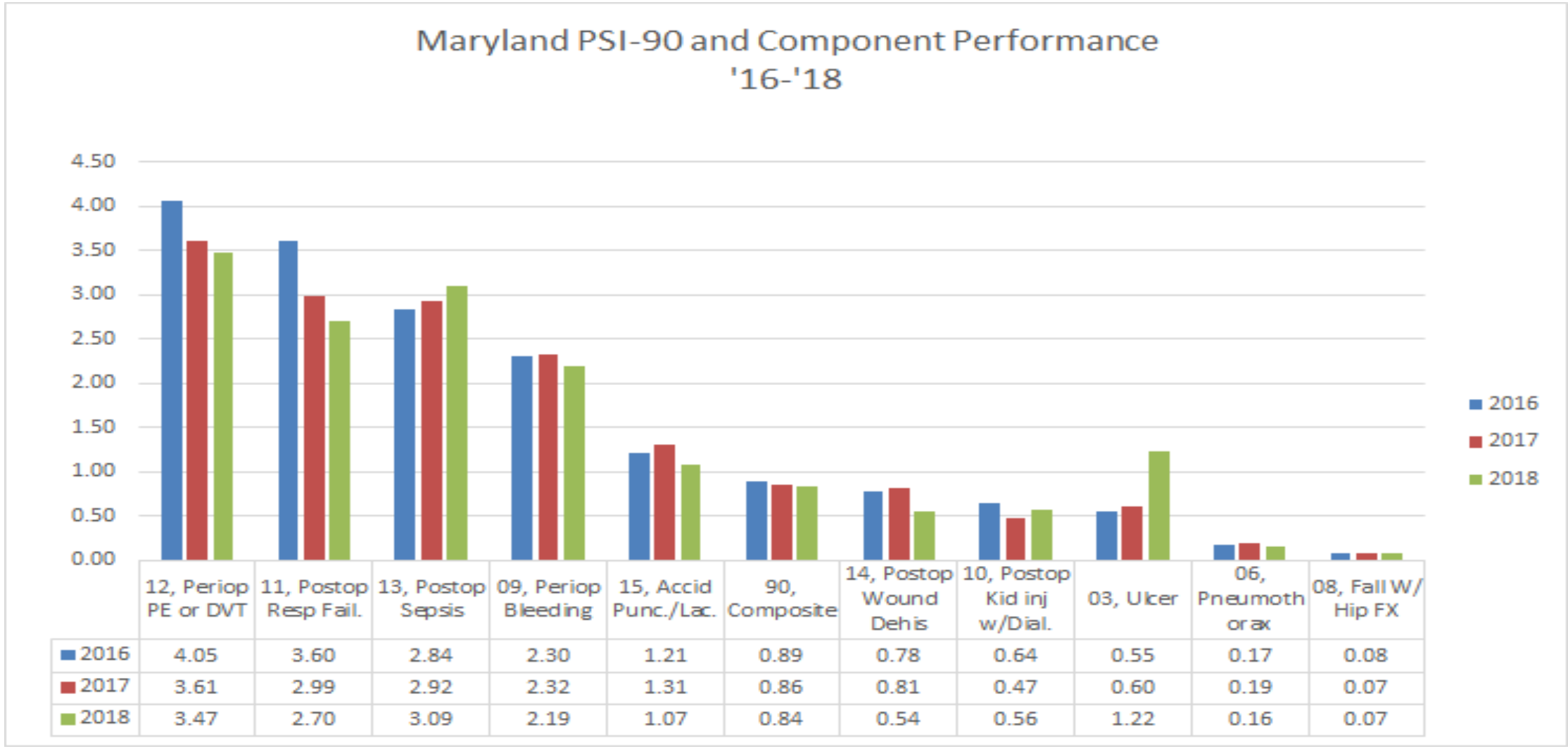
Additional factors in Calculating PSI 90

- PSI 90 combines the smoothed (empirical Bayes shrinkage) indirectly standardized morbidity (observed/expected) ratios from selected PSIs
- Component PSIs are weighted based on volume and harm calculations for each PSI

  - **Composite Weights for PSI 90 v2019**

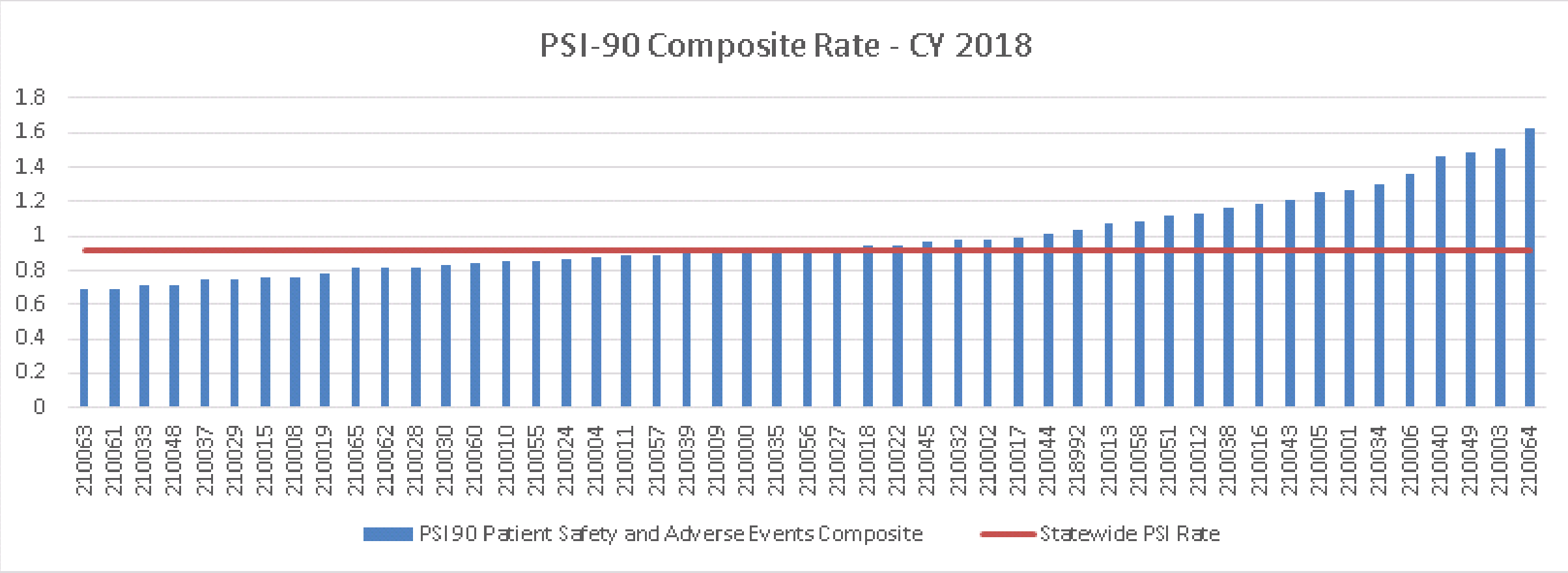
INDICATOR	HARM WEIGHT	VOLUME WEIGHT	COMPONENT WEIGHT
PSI 3 Pressure Ulcer	0.0860	0.3080	0.1373
PSI 6 Iatrogenic Pneumothorax	0.1381	0.0538	0.0385
PSI 8 In Hospital Fall With Hip Fracture	0.1440	0.0172	0.0128
PSI 9 Periop Hemorrhage or Hematoma	0.0570	0.1598	0.0472
PSI 10 Postop Acute Kidney Injury Requiring Dialysis	0.3584	0.0280	0.0520
PSI 11 Postoperative Respiratory Failure	0.2219	0.1821	0.2094
PSI 12 Periop PE or DVT	0.1557	0.2543	0.2052
PSI 13 Postoperative Sepsis Rate	0.3102	0.1550	0.2491
PSI 14 Postoperative Wound Dehiscence Rate	0.1441	0.0138	0.0103
PSI 15 Unrecognized Abdominopelvic Accidental Puncture or Laceration	0.1474	0.0500	0.0382

Maryland Patient Safety Indicator (PSI) Performance



	12, Periop PE or DVT	11, Postop Resp Fail.	13, Postop Sepsis	09, Periop Bleeding	15, Accid Punc./Lac.	90, Composite	14, Postop Wound Dehis	10, Postop Kid inj w/Dial.	03, Ulcer	06, Pneumothorax	08, Fall W/ Hip FX
2016	4.05	3.60	2.84	2.30	1.21	0.89	0.78	0.64	0.55	0.17	0.08
2017	3.61	2.99	2.92	2.32	1.31	0.86	0.81	0.47	0.60	0.19	0.07
2018	3.47	2.70	3.09	2.19	1.07	0.84	0.54	0.56	1.22	0.16	0.07

PSI-90 CY 2018



PSI-90 in Pay for Performance

VBP

Maryland QBR

- Medicare-only
- Two-year time period
- Break in Reporting during ICD-9 to ICD-10 conversion(FY 19-22)
- Included in Safety Domain
- Benchmark/Threshold calculated from base period
- Scored on better of improvement or attainment

- All-Payer
- Base and Perf Pds
  - Confirmed one and two year results sufficiently correlated
- Statewide Benchmark and Threshold for Composite (similar to MD Mortality)
- Benchmark and Threshold calculated
- Scored on better of improvement and attainment

Discussion and Next Steps

- For the RY 2021 VBP Exemption Request, CMMI has noted the need to improve in the QBR program.
- CMS is adding the updated PSI 90 Patient Safety and Adverse Events Composite (Medicare) measure to VBP for FY 2023.
- Maryland must keep pace with the VBP program and use all-payer measures where possible.
- Next month modeling of QBR scores with PSI will be brought to the workgroup.

Consider Transition from Inpatient to 30-Day Mortality Measure

30-Day Mortality: Overview and Introduction to the Measure

Overview

- **Goal: develop a 30-day all cause, all payer mortality measure**
  - Capture deaths that occur within 30 days of hospital admission, regardless of where death occurs
- **Use CMS 30-Day Hospital-Wide Mortality Measure as a guide**
  - Currently under development, and not used publicly yet
  - Make necessary adjustments to estimate model on Maryland all-payer data
- **Use Maryland Vital Statistics death data merged with Maryland inpatient records**
  - CY 2018 and CY 2019 data
- **Today's agenda:**
  - Introduce measure structure
  - Discuss analytic next steps

Step 1: Apply inclusion/exclusion criteria

- Apply exclusions:

Cases Excluded from Sample	
Transferred in from another acute care facility	Inconsistent vital status (e.g. death date precedes admission date)
Enrolled in hospice during index admission	Left against medical advice
Metastatic cancer	Crush, spinal, brain, or burn injury
Limited ability for survival (based on ICD-10 codes)	Non-Maryland resident (Vital Statistics data not reliable for non-Maryland residents)

- For patients with multiple admissions that qualify for measure inclusion, randomly select one admission for inclusion in sample

Step 2: Assign stays to a service line

- **First, determine if a major surgical procedure was performed**
  - If yes, then assign stay to the "surgical" cohort
  - If no, then assign stay to the "non-surgical" cohort
- **Second, assign stays to a service line within surgical and non-surgical cohorts**
  - Non-surgical cohort: assignment based on principle diagnosis
  - Surgical cohort: assignment based on principle procedure

Non-surgical service lines	
Cancer	Orthopedics
Cardiac	Pulmonary
Gastrointestinal	Renal
Infectious disease	Other conditions
Neurology	

Surgical service lines
Cancer
Cardiothoracic
General
Neurosurgery
Orthopedic

Step 3: Estimate risk-adjustment models and produce hospital-level results

- **Risk-adjustment**
  - Primary risk factors are APR-DRG SOI indicators
  - Models also control for age, gender, and palliative care
- **Estimate a separate model for each service line within each cohort**
  - 14 different risk-adjusted models are estimated
  - Allows for differences in relationship between risk factors and risk of mortality across service lines
- **Produce hospital-level observed-to-expected ratios for each service line**
  - Ratio of actual 30-day deaths to predicted 30-day deaths for each hospital for each service line
- **Produce overall hospital-level observed-to-expected ratio**
  - Volume-weighted average of service line-specific O/E ratios

Status of analytic steps

- **Measure has been implemented using HSCRC data**
  - No major implementation hurdles
- **Currently assessing statistical properties of measure**
  - Predictive power
  - Validity
  - Reliability
- **On deck: comparing QBR score impacts from 30-day measure to inpatient measure**

Maryland Hospital Acquired Conditions (MHAC) Program

Maryland Hospital Acquired Conditions (MHAC) Program: Overview

Purpose: Improve patient care and hospital decision-making by adjusting GBR based on 14 identified potentially preventable complications (PPCs), complications acquired during a hospital stay that were not present on admission

Examples of PPCs: An accidental laceration during a procedure, hospital acquired venous thrombosis, hospital-acquired pneumonia

PPC Significance: These complications can lead to poor patient outcomes, including longer hospital stays, permanent harm, and death, and they also lead to increased costs.

Similar to the federal Medicare HAC program

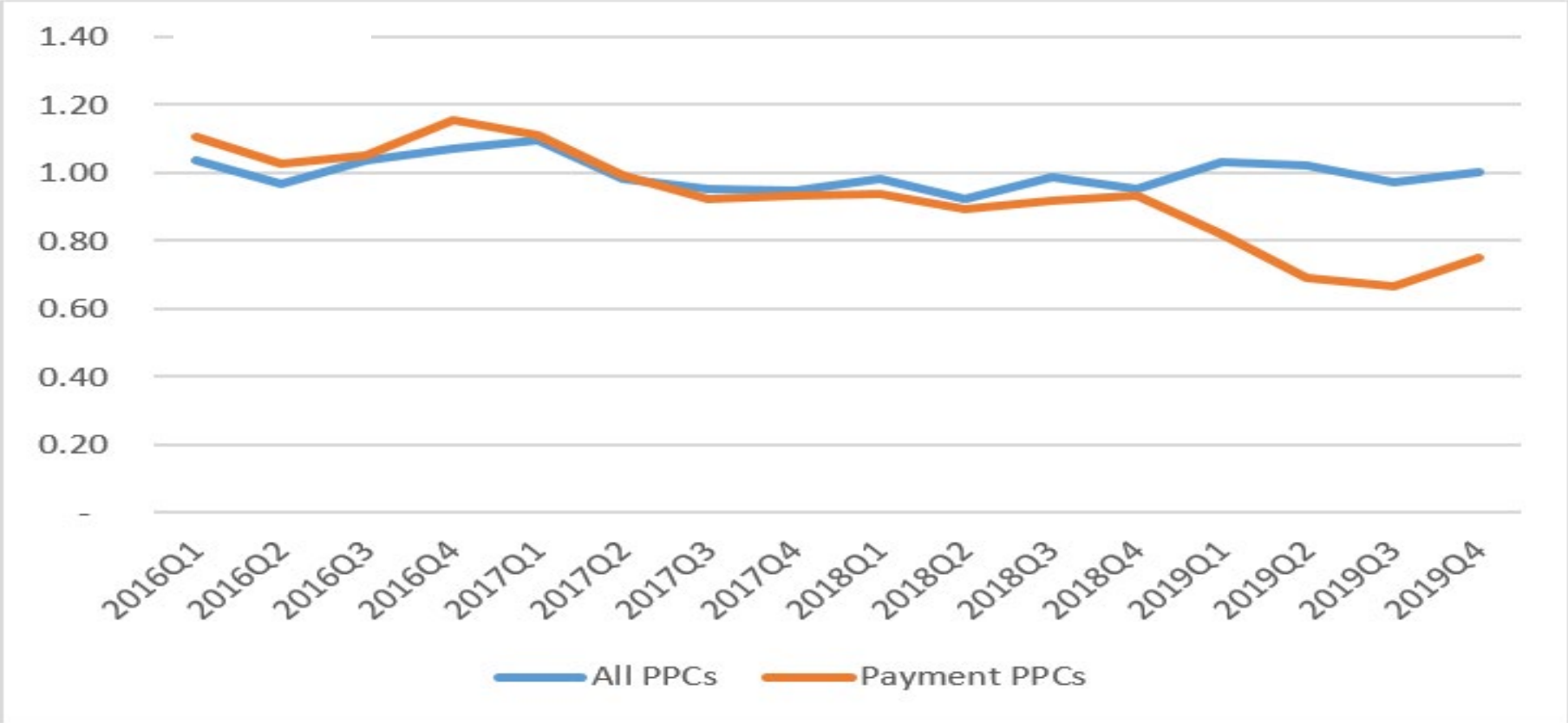
Maryland's program uses a different and targeted list of PPC measures, and does not relatively rank hospitals in assigning financial rewards and penalties.

RY 2023 Maryland Hospital Acquired Conditions Program

- Discussion Topics:
  - Review 2019 performance results, including performance on payment versus monitoring PPCs
  - Standard annual updates (grouper version, performance standards, normative values, cost weights)
  - COVID-19 impacts:
    - PPC clinical logic
    - Base time period and comparability
  - Other stakeholder concerns?

Performance Payment and Monitoring PPCs

Figure 10. Observed-to-Expected Ratios in Maryland, CY 2016 – CY 2019



Source: HSCRC Case-Mix Data

RY 2023 Methodology Updates

No changes are proposed to the methodology beyond standard annual updates

- Maintain the same 14 payment PPCs and assess for attainment only
- Base Period: CY 2018 and CY 2019
- Performance Period: CY 2021
- Use more than 1 year of data for small hospitals (TBD exact timeframe)
- Grouper Version: APR-DRG and PPC Version 38
- Most recent cost weights available will be used and updated if revised before June 2021

Performance Standards (run under v 37)

Staff recommend running performance standards on CY18 and CY19

Comparison of Performance Standards		RY 2022: FY18 & 19		Proposed RY 2023: CY18 & 19	
PPC Number	PPC Description	Threshold	Benchmark	Threshold	Benchmark
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	1.8882	0.3348	1.7457	0.5579
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1.4274	0.4933	1.6977	0.5965
7	Pulmonary Embolism	1.5660	0.3091	1.5511	0.3255
9	Shock	1.6965	0.3727	1.5214	0.4581
16	Venous Thrombosis	1.7715	0.1242	1.8832	0.1282
28	In-Hospital Trauma and Fractures	1.5749	0.4468	1.5914	0.3405
35	Septicemia & Severe Infections	1.5732	0.3891	1.7312	0.3462
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	1.9911	0.4162	1.6998	0.4648
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	2.4933	0.4362	1.5218	0.4649
42	Accidental Puncture/Laceration During Invasive Procedure	2.1677	0.3735	1.6087	0.2913
49	Iatrogenic Pneumothrax	1.6971	0.3351	1.7056	0.0000
60	Major Puerperal Infection and Other Major Obstetric Complications	1.6266	0	1.8030	0
61	Other Complications of Obstetrical Surgical & Perineal Wounds	1.8975	0	2.0182	0
67	Combined Pneumonia (PPC 5 and 6)	1.6422	0.3986	1.7795	0.3193

PPC Assignment for COVID-19 Patients

3M PPC Grouper v37.1

- PPC v37 assignment logic updated to incorporate the new COVID-19 dx code U071; assigned the U071 code where the predecessor code was assigned in PPC v37.
- Exclusion group 20 contains the COVID-19 dx code U071 so PPCs with this exclusion group would not be assigned the PPC if the COVID-19 dx code was POA.*
- **Policy Options (RY 2022):**
    - Keep in the COVID cases since 3M did apply aspects of exclusion where the similar mapped code was applied and therefore in the rate.
    - Keep in the COVID cases but exclude COVID cases for PPCs that have the cases removed in v38.
    - Remove the COVID cases altogether since they were not in the rate to begin with for v37/37.1

3M PPC Grouper v38

- 3M updating and expanding the use of the COVID-19 dx code U071 as an exclusion; created a new exclusion group and have applied it to a number of PPCs.
- Need to determine if Grouper v38 updates are sufficient for RY 2023

*Please see the summary of change document for PPC v37.1 on 3M support site for full details.

V38 COVID Exclusion Group for Payment PPCs

PPC #	PPC Description	Grouper V.38 COVID Status	PPC #	PPC Description	Grouper V38 COVID Status
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	Exclude	37	Post-Operative Infection & Deep Wound Disruption Without Procedure	Include
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	Exclude	41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	Exclude
7	Pulmonary Embolism	Exclude	42	Accidental Puncture/Laceration During Invasive Procedure	Include
9	Shock	Exclude	49	Iatrogenic Pneumothrax	Include
16	Venous Thrombosis	Exclude	60	Major Puerperal Infection and Other Major Obstetric Complications	Include
28	In-Hospital Trauma and Fractures	Include	61	Other Complications of Obstetrical Surgical & Perineal Wounds	Include
35	Septicemia & Severe Infections	Exclude	67	Combined Pneumonia (PPC 5 and 6)	Exclude

RY 2023 MHAC Draft Recommendations

1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
    a. Maintain focused list of PPCs in payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
    b. Monitor all PPCs and provide reports for hospitals and other stakeholders.
        i. a) Evaluate PPCs in “Monitoring” status that worsen and consider inclusion back into the MHAC program for RY 2024 or future policies.
2. Use two years of performance data for small hospitals (i.e., less than 20,000 at-risk discharges and/or 20 expected PPCs).
3. Continue to assess hospital performance on attainment only.
4. Continue to weight the PPCs in payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent
6. Adjust methodology as needed due to COVID-19 Public Health Emergency and report to Commissioners

Other Thoughts or Questions?

Next PMWG Meeting: October 21, 9:30 AM-12:00 PM