



Performance Measurement Work Group Meeting

9/20/2017

Welcome and New Members

Overview and Work Plan

Stakeholder Input Process

Review the policy decisions under consideration and solicit feedback from Commissioners and stakeholders on policy priorities for RY 2020 and Enhanced All-Payer Model.

- ▶ 9/13/2017 – Provide context to Commissioners for upcoming policy decisions in Quality programs
- ▶ **9/29/2017** – Written feedback from stakeholders is due to hscrc.quality@maryland.gov
- ▶ 10/11/2017 – Summarize stakeholder input at Commission meeting and allow stakeholders to present public testimony

Commissioner Input: Commissioner feedback will help staff set the workplan for Performance Measurement Work Group and HSCRC Contractors

Stakeholder Input: Stakeholders may submit letters to the Commission by Sept. 29, 2017, and may sign up to give public testimony at Oct Commission Meeting.

Current Performance-Based Payment Programs

Programs must be: comparable to Federal programs, have aggressive and progressive annual targets, meet annual potential and realized at risk targets, and meet contractually obligated targets, if specified, by end of 2018:

- Reduce Medicare readmissions to at or below the national average
- Reduce Potentially Preventable Complications by 30%.

Maryland

Potentially Avoidable Utilization (PAU) Savings

Quality Based Reimbursement (QBR)

Readmission Reduction Incentive Program (RRIP)

Maryland Hospital Acquired Conditions (MHAC)

CMS

Value Based Purchasing

Hospital Readmissions Reduction Program

Hospital Acquired Condition Reduction



Timeline for Performance Measurement Work Group and Commission Recommendations

Performance Measurement Work Group:

- ▶ Meets 3rd Wednesday of each month
- ▶ Composed of hospitals, consumers, physicians, payers, other state agencies
- ▶ Tentative schedule for Draft and Final Recommendations:

Program	Draft Recommendation	Final Recommendation
QBR	November 2017	December 2017
MHAC	December 2017	January 2018
RRIP	January 2018	February 2018
PAU	April 2018	May 2018

Summary of Policy Discussions for HSCRC Quality Programs

	RY 2020	Enhanced Model
Overall	<ul style="list-style-type: none"> - Meet goals of current model - Refine quality programs only when necessary 	<ul style="list-style-type: none"> -Establish goals in conjunction with stakeholders given that goals are not prescribed in the term sheet -Align measures across quality programs and ensure programs are comparable to federal programs.
QBR	<ul style="list-style-type: none"> - Consider adding ED wait times to QBR program - Discuss continued lack of HCAHPS improvement 	<ul style="list-style-type: none"> -Remodel based on direction of MHAC program
RRIP	<ul style="list-style-type: none"> - Develop an appropriate, aggressive, and progressive annual target 	<ul style="list-style-type: none"> - Develop a new appropriate,aggressive and progressive 5 year model target - Consider implementing readmission measure for freestanding psych hospitals -Consider socioeconomic risk-adjustment
PAU	<ul style="list-style-type: none"> -Modify risk-adjustment/protection -Consider extending to 90-day readmissions 	<ul style="list-style-type: none"> - Consider phasing out PAU Protection - Consider further expanding PAU categories/definition
Population Health	<ul style="list-style-type: none"> - Develop the methodology for evaluating population health that might be used as a credit to the Enhanced Model's Total Cost of Care test. 	<ul style="list-style-type: none"> -Develop plan for incorporating population health measures into value-based hospital payments.
MHAC	<ul style="list-style-type: none"> -Move certain PPCs to monitoring-only status 	<ul style="list-style-type: none"> - Consider different measurements of complications (PPCs vs HACRP) with of one three staff options
Service Line	<ul style="list-style-type: none"> -Consider developing and testing a service line approach 	<ul style="list-style-type: none"> -Consider utilizing based on Commissioner feedback and remodeling of other quality programs

General Principles for Quality Direction

RY 2020: Meet Goals of Current Model; Refine Quality Programs *Only When Necessary*

- ▶ **Update annual targets** to ensure the State meets Quality goals and ensure continuous quality improvement
- ▶ **Maintain** current quality programs through CY 2018 (RY 2020) to meet model tests
- ▶ Consider **Performance Measurement Work Group Feedback** and **HSCRC staff capacity** in modifying quality programs

RY 2021 and Beyond: Develop Measures and Goals of Quality Programs for the Enhanced Model

- ▶ Currently no specific quality targets but Commission must set annual performance targets that are “**aggressive and progressive**”
- ▶ Ensure **measure alignment** among all HSCRC programs and other initiatives
- ▶ Develop programs/goals with revenue at risk **comparable to Federal programs**
- ▶ Consider need to improve Maryland hospital rankings relative to national hospitals
- ▶ Develop population health improvement goals and incorporate aligned measures into quality programs
- ▶ Consider **staff bandwidth**, and ensure adequate time to include feedback from Stakeholders (HSCRC workgroups) in preparing for the Enhanced Model

The Enhanced Model terms provide the Commission greater latitude to determine goals for programs, select and revise measures, and remove measures with limited value.



Program Updates

QBR; MHAC; RRIP

Guiding Principles For Performance-Based Payment Programs

- ▶ Program must improve care for **all patients**, regardless of payer
- ▶ Program incentives should support achievement of **all payer model targets**
- ▶ Program should **prioritize** high volume, high cost, opportunity for improvement and areas of national focus
- ▶ **Predetermined** performance targets and financial impact
- ▶ Hospital ability to **track progress**
- ▶ Encourage **cooperation** and sharing of best practices

QBR

R.Y. 2018 Preliminary Scores; R.Y. 2019 Measure Updates;
R.Y. 2020 Proposed Updates and Considerations

What is the QBR Program?

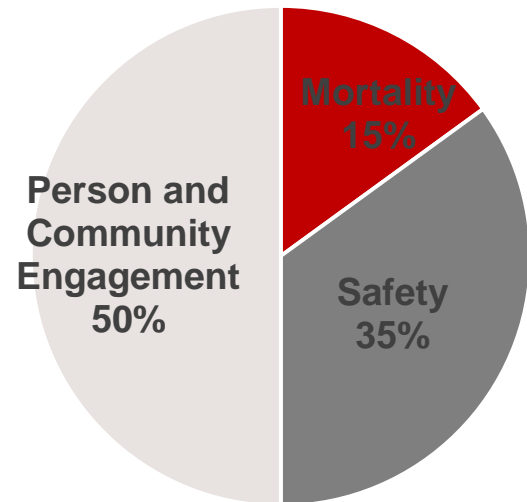
QBR Consists of 3 Domains:

- ▶ **Person and Community Engagement (HCAHPS)** - 8 measures;
- ▶ **Mortality** - 1 measure of in-patient mortality;*
- ▶ **Safety** - 6 measures of in-patient Safety (infections, early elective delivery)

QBR is MD-specific answer to federal Value-Based Purchasing Program

* Mortality is hybrid measure in RY 2019

QBR Domain Weights



Up to 2% Reward or Penalty under QBR

Preset scale of 0-80 with cut point of 45

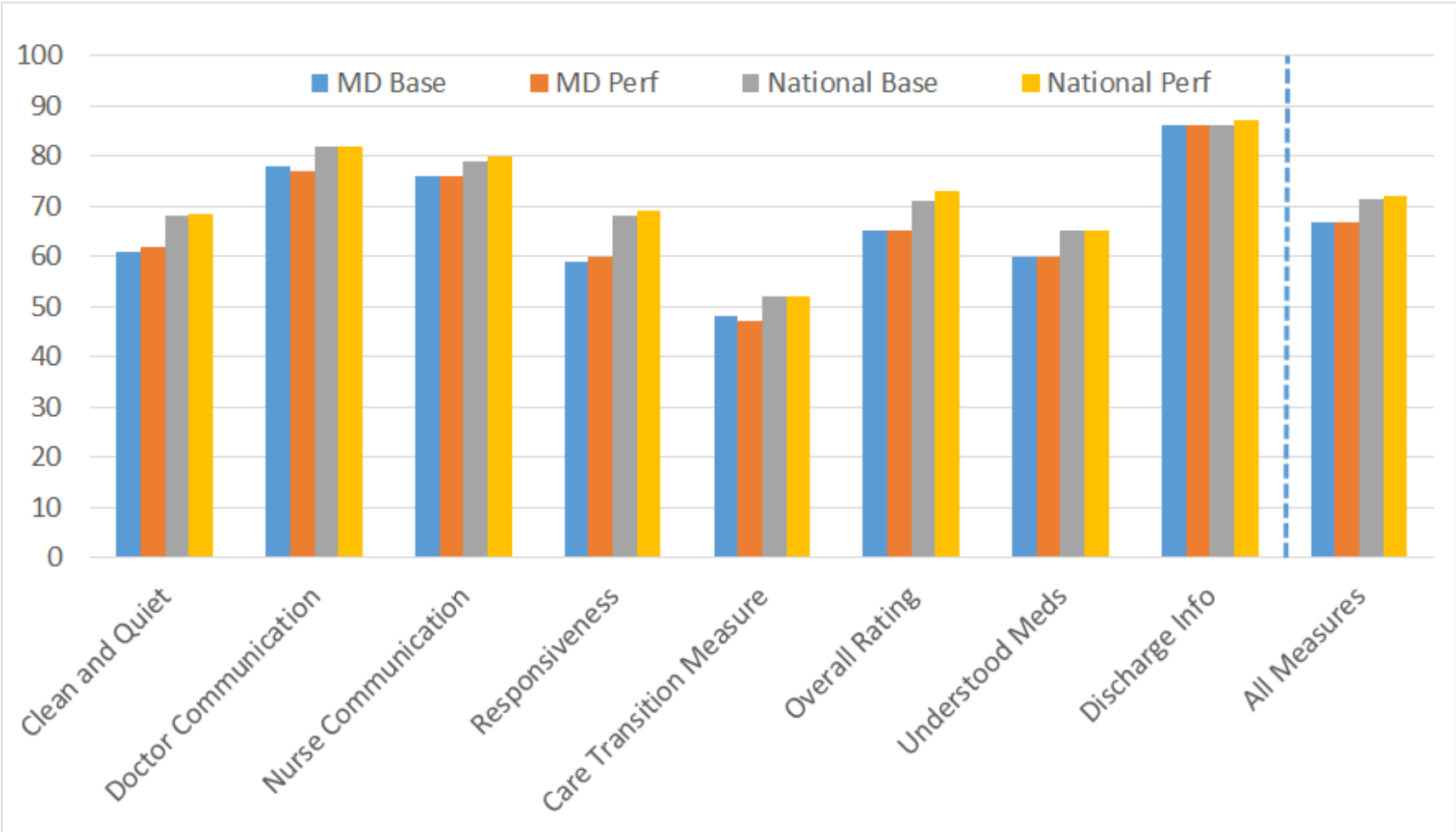


RY 2018 QBR Preliminary Scores

- ▶ Please see **Handout**.
 - ▶ Data is missing for Johns Hopkins Hospital.
- ▶ Process – Review Scores and return any questions/considerations to hscrc.quality@maryland.gov no later than **Monday, October 2, 2017**.
- ▶ Performance Adjustments will be placed in rates in January 2018.

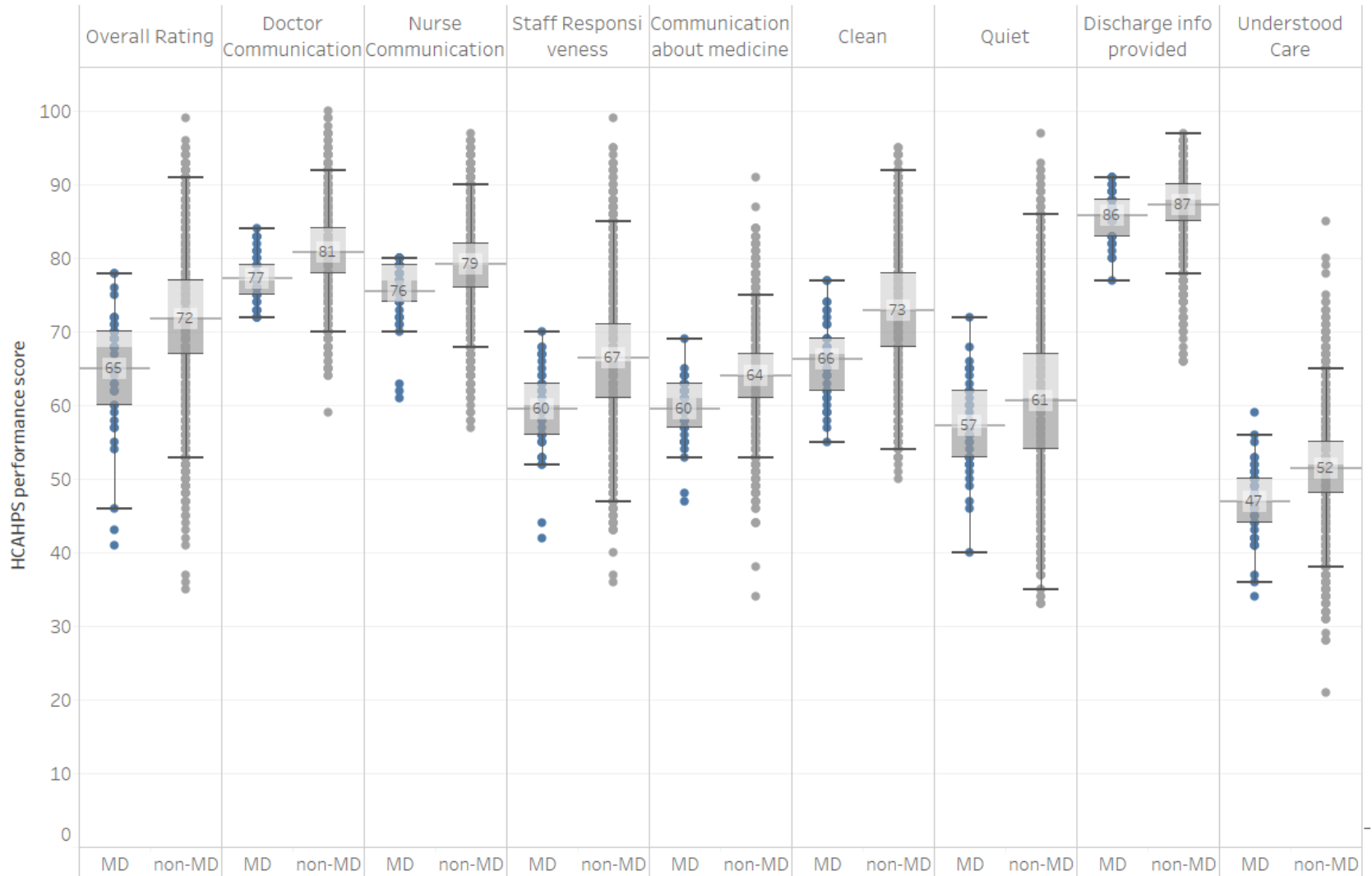
RY 2018: MD HCAHPS Compared to Nation

Time period CY 2014 (Base) 10/2015 to 9/2016 (Performance)



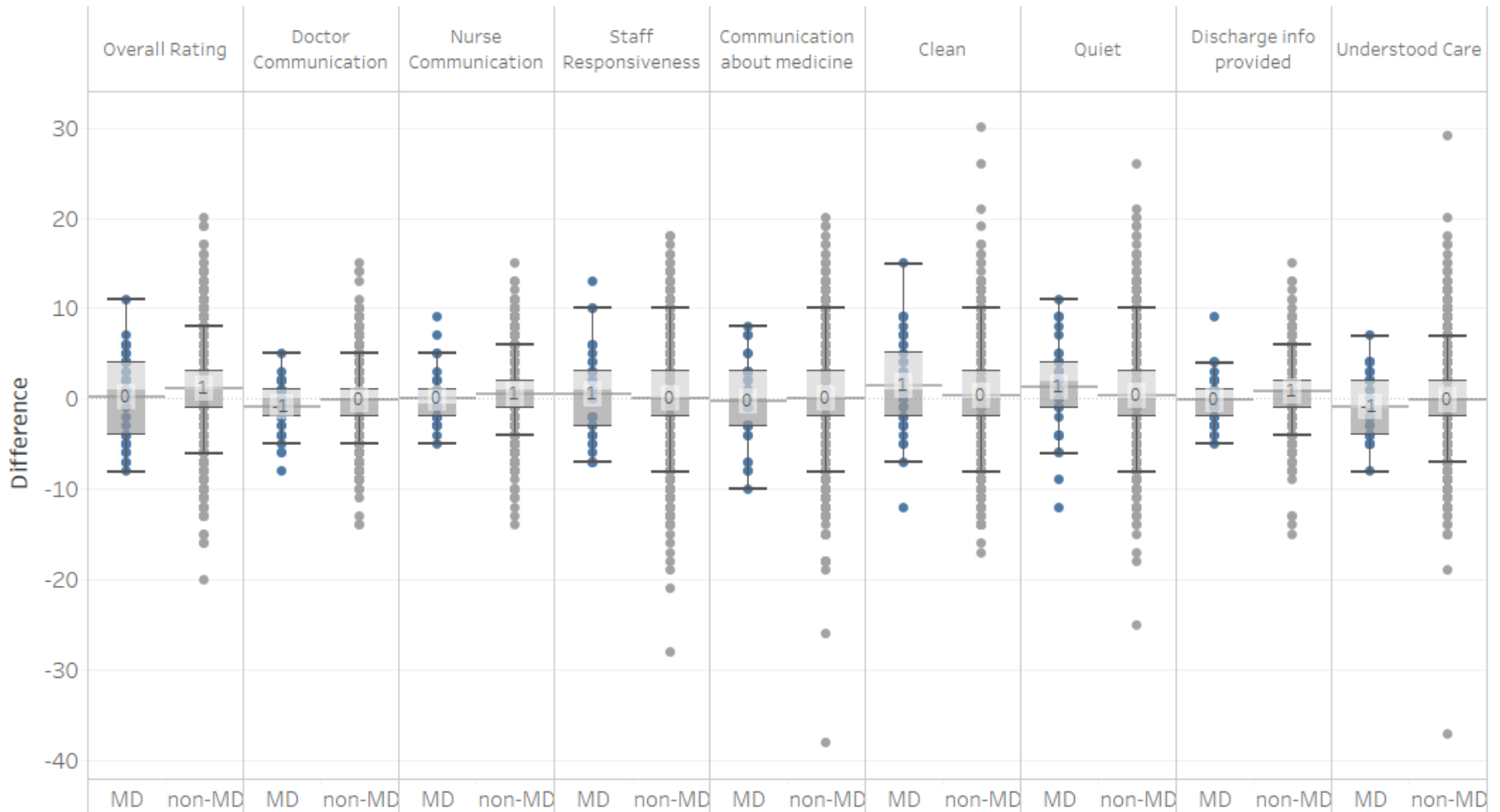
HCAHPS Performance

HCAHPS top box results



HCAHPS Improvement

HCAHPS difference between base and performance



RY 2018 Safety – Statewide Performance

Measure	Base	Performance	Difference
CLABSI	0.492	0.67	+0.182
CAUTI	0.681	0.70	+0.019
SSI-Colon	1.088	0.97	-0.118
SSI-Hysterectomy	1.203	0.75	-0.453
MRSA	1.269	1.18	-0.089
C.Diff	1.18	0.96	-0.220

RY 2019 Safety – Statewide Performance in Base Period (CY 2015)

- ▶ Note that these measures have been re-based.
- ▶ Data for CLABSI and CAUTI are not currently available.

Measure	Maryland	National
SSI-Colon	1.068	1
SSI-Hysterectomy	0.943	1
MRSA	1.303	1
C.Diff.	1.133	1

Final RY 2019 QBR Policy and Updates

- ▶ Maintain RY 2018 domain weights: 50% for Patient Experience/Care Transition, 35% for Safety, and 15% for Clinical Care.
- ▶ Move to a modified full score distribution ranging from 0-80%, and linearly scale penalties and rewards at 45% cut point.
- ▶ Maintain 2% maximum penalty and increase the maximum reward to 2% as the achieving rewards will be based on full score distribution.
- ▶ Re-based NHSN Measures CLABSI, CAUTI SIRs are currently inaccurate for base period (CY 2015).
 - ▶ Additionally, some C.Diff. SIRs are inaccurate for Q3-2016.
 - ▶ HSCRC will distribute corrected data when it becomes available.

RX 2020 Proposed Timeline

Rate Year (Maryland Fiscal Year)	FY16-Q3	FY16-Q4	FY17-Q1	FY17-Q2	FY17-Q3	FY17-Q4	FY18-Q1	FY18-Q2	FY18-Q3	FY18-Q4	FY19-Q1	FY19-Q2	FY19-Q3	FY19-Q4	FY20-Q1	FY20-Q2	FY20-Q3	FY20-Q4		
Calendar Year	CY16-Q1	CY16-Q2	CY16-Q3	CY16-Q4	CY17-Q1	CY17-Q2	CY17-Q3	CY17-Q4	CY18-Q1	CY18-Q2	CY18-Q3	CY18-Q4	CY19-Q1	CY19-Q2	CY19-Q3	CY19-Q4	CY20-Q1	CY20-Q2		
Quality Programs that Impact Rate Year 2020																				
QBR	Hospital Compare Base Period* (Proposed)																	Rate Year Impacted by QBR Results (Missing are THA/TKA, ED Wait Times)		
								Hospital Compare Performance Period* (Proposed)												
			Maryland Mortality Base Period (Proposed)																	
									QBR Maryland Mortality Performance Period (Proposed)											



RY 2020 Proposed Updates and Considerations

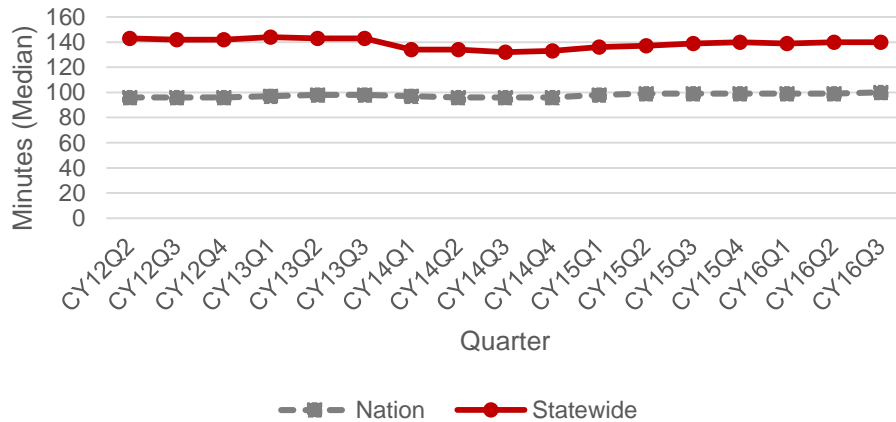
- ▶ ED Wait Times Measures?
- ▶ Single MD Mortality measure with Palliative Care included (Improvement and Attainment)

Additional development work in 2017-2018:

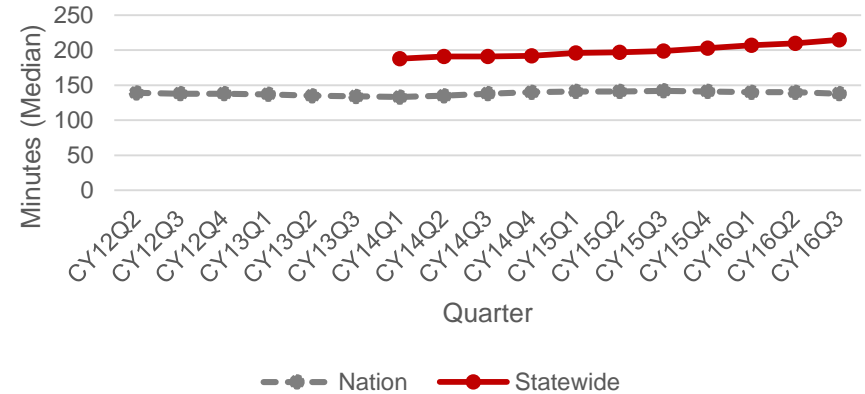
- ▶ 30-day Mortality measure for potential inclusion in RY 2021
- ▶ Measurement of Complications under Enhanced Model may impact QBR program beginning in RY 2021

Stakeholder Concern: Latest ED wait time data

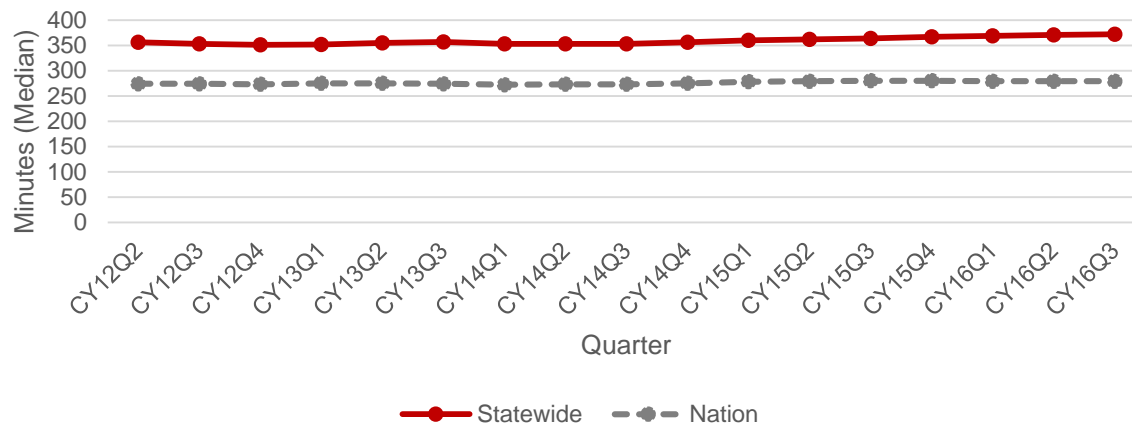
ED-2b: Admit Decision until Admission



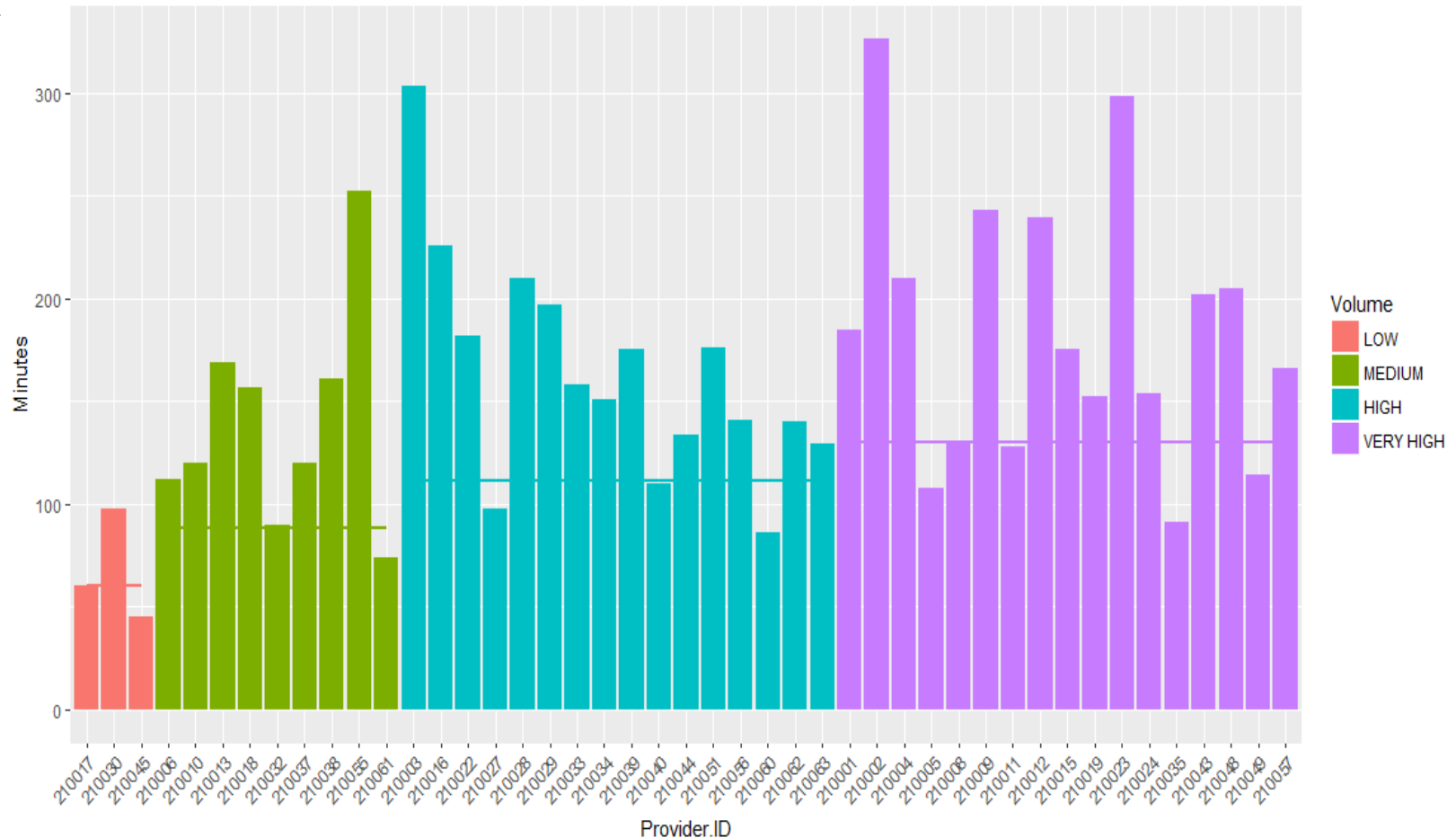
OP-18b: Arrival to Discharge for Discharged Patients



ED-1b: Arrival to Admission for Admitted Patients



ED-2b: Admit Decision Time to ED Departure Time for Admitted Patients Maryland Hospital Performance (Q415-Q316)



Solid line=national CY 2014 median minutes

Lower minutes are better

ED Wait Times - Key Policy Questions

Key Questions:

- 1) What are we trying to accomplish? What are we trying to measure?
- 2) Should MD prioritize improving ED wait times, as compared to the Nation?
- 3) Do hospitals require a payment policy to improve ED wait times?

Key Considerations if Commission decides to include ED wait times in payment policy:

- 1) What measures should be used?
- 2) What domain should ED wait times be included with? Patient experience? Safety?
- 3) What should the benchmark (highest performance) be for evaluating MD hospitals?
- 4) To what extent should ED wait times influence the overall QBR score?



Next Steps

- ▶ **Additional Modeling of ED Wait Times Measures**
 - ▶ Consider ED-1b, ED-2b measures – potential inclusion in HCAHPS domain
- ▶ **HSCRC plans to have QBR Draft in November**

MHAC

What is the Maryland Hospital Acquired Condition (MHAC) Program?

- ▶ Uses list of 65 Potentially Preventable Complications (PPCs) developed by 3M.
- ▶ PPCs are post-admission (in-hospital) complications that may result from hospital care and treatment, rather than underlying disease progression.
 - ▶ Examples: Accidental puncture/laceration during an invasive procedure or hospital acquired pneumonia
- ▶ Goal for first model was to reduce complications by 30%. To date, the State has exceeded this goal by reducing complications by over 45%.
- ▶ Relies on Present on Admission (POA) Indicators.
- ▶ Links hospital payment to hospital performance by comparing the observed number of PPCs to the expected number of PPCs.
- ▶ Measure hospital performance as the better of attainment or improvement to determine payment adjustments.
 - ▶ Max Penalty in RY2019 is 2% and Max Reward is 1%.

Final RY 2019 MHAC Policy

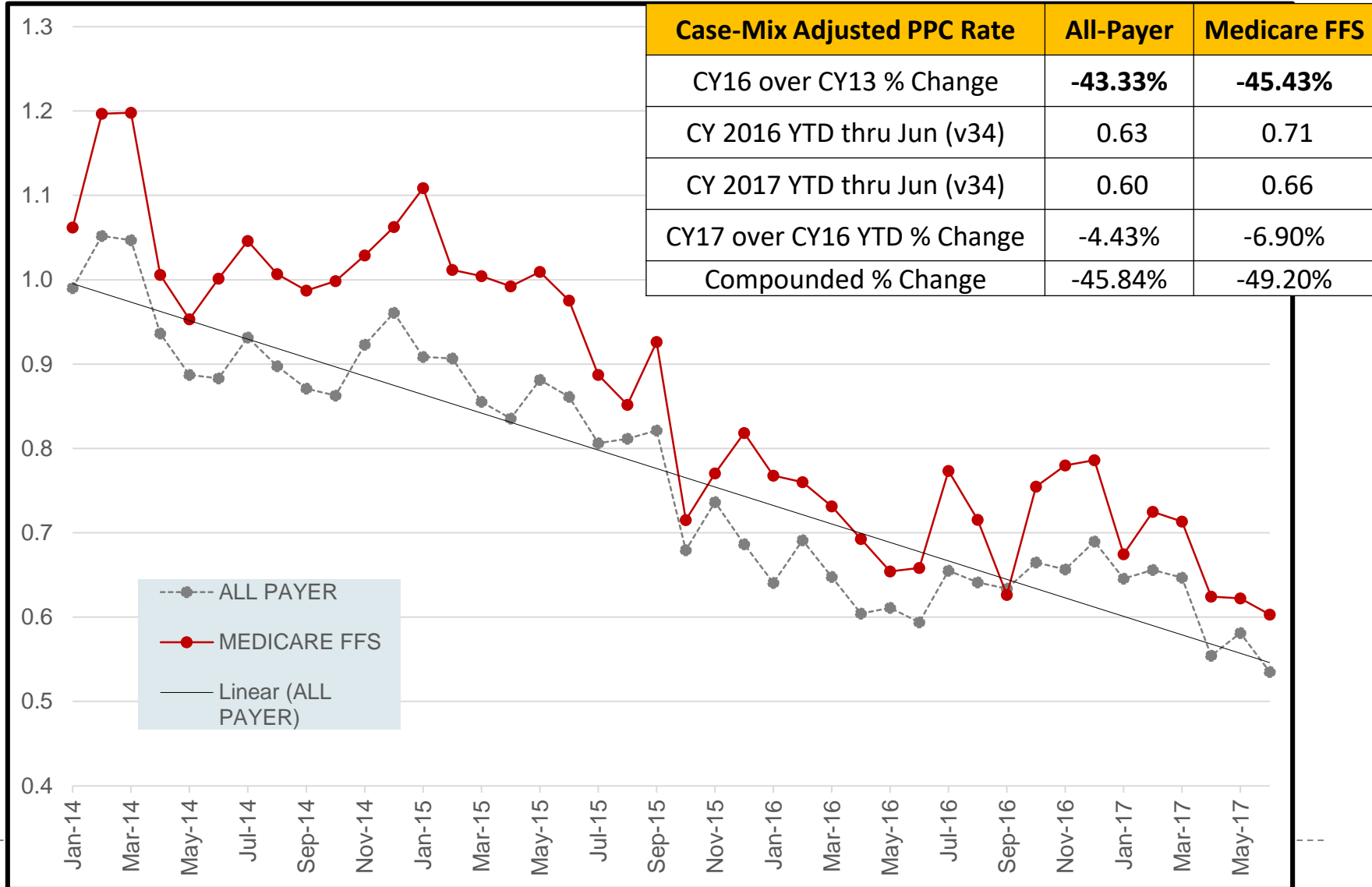
- ▶ Continue to exclude palliative care discharges in program for RY 2019, and perform a special hospital audit on palliative care coding.
- ▶ Modify scaling methodology to be a single payment scale, ranging from 0% to 100%, with a revenue neutral zone between 45% and 55%.
- ▶ Set the maximum penalty at 2% and the maximum reward at 1%.

RY 2019 MHAC Updates

- ▶ **3M will re-issue v.34 in October 2017**
 - ▶ Includes updates to clinical logic requested by hospitals
 - ▶ Suspension of 3 PPCs (39, 62, Combination 69)
 - ▶ Changes to 3 PPCs
 - PPC 31 – 3M will add a new pressure ulcer exclusion group for LOS >4 days
 - PPC 40 – Exclusion group will be updated, as well as exclusion of PPC 20 cases
 - PPC 66 – Exclusion group will be expanded
 - ▶ Norms, base period, and performance period to-date will all be re-run at this time

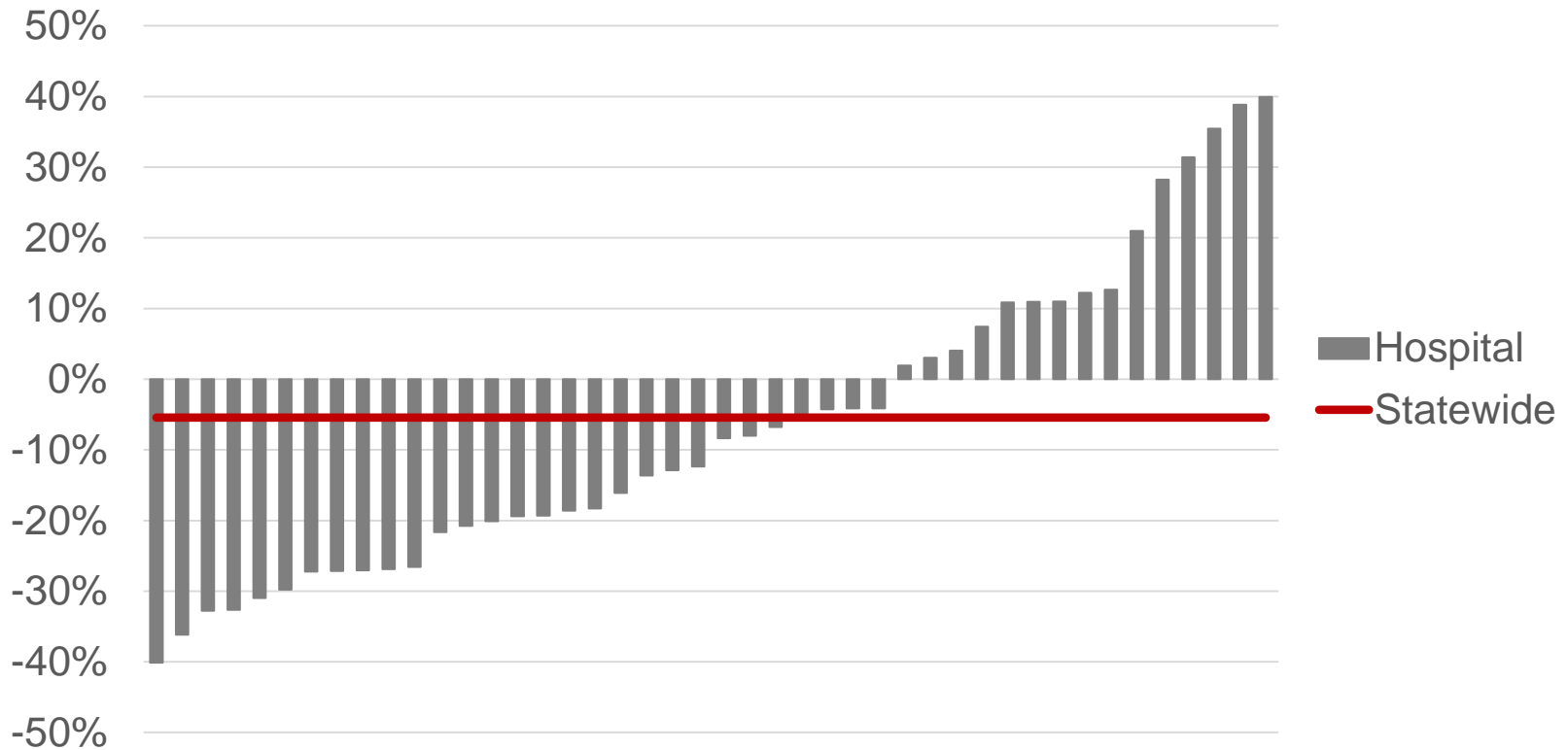
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- ▶ More information on measure changes is detailed in QBR Memo 07-13-17

MHAC Performance



Current RY 2019 MHAC Performance By-Hospital

% Change - Jan-Jun 2016 and 2017



RY 2020 Proposed Updates

- ▶ HSCRC proposes to shift to version 35 of the APR-DRG and PPC Grouper
 - ▶ MHA plans to disseminate information regarding v35 with 3M
 - ▶ 3M has agreed to implement additional clinical logic changes in v35
- ▶ Base = FY 2017; Performance = CY 2018

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Quality Programs that Impact Rate Year 2020																			
MHAC: Better of Attainment or Improvement			MHAC Base Period (Proposed)															Rate Year Impacted by MHAC Results	
									MHAC Better of Attainment or Improvement Performance (Proposed)										

- ▶ No PPC or tier changes; no changes to current exclusions
 - ▶ Update normative values and benchmarks using current methodology



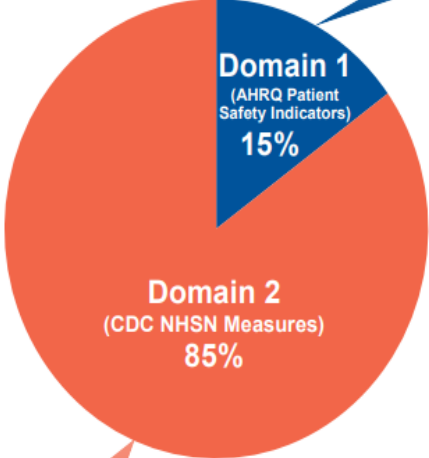
Complications under the Enhanced Model

Does Industry Want CMS HAC Methodology or Measures?

Methodology:

- ▶ No comparison to base period
- ▶ Time period of measurement and length of performance period differ
- ▶ Z-scores result in continuous scores
- ▶ NHSN measure scores are averaged
- ▶ Hospitals ranked and lowest performing 25% are penalized full 1%

**FY 2019 HAC Reduction Program
Domain Weighting and Measures**
(Payment adjustment effective for discharges from October 1, 2018 –September 30, 2019)



DOMAIN 1	
	Performance Period
	October 1, 2015 – June 30, 2017
AHRQ* Modified PSI 90 Measure**	Winsorized Z-Score
PSI 03 Pressure ulcer rate	
PSI 06 Iatrogenic pneumothorax rate	
PSI 08 In-hospital fall with hip fracture rate	
PSI 09 Perioperative hemorrhage or hematoma rate	
PSI 10 Postoperative acute kidney injury requiring dialysis rate	
PSI 11 Postoperative respiratory failure rate	
PSI 12 Perioperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT)	
PSI 13 Postoperative sepsis rate	
PSI 14 Postoperative wound dehiscence rate	
PSI 15 Unrecognized abdominopelvic accidental puncture/laceration rate	

*The Agency for Healthcare Research and Quality
** Modified PSI 90: Patient Safety and Adverse Events Composite. The weighting is based not only on volume of each, but also on harms associated with events.

DOMAIN 2	
	Performance Period
	January 1, 2016 – December 31, 2017
CDC NHSN* Measures	Average of Winsorized Z-Score of each measure
CLABSI SIR rate	
CAUTI SIR rate	
SSI Colon† Abdominal Hysterectomy†	
MRSA Bacteremia	
CDI	

*Centers for Disease Control and Prevention National Healthcare Safety Network

†There will be one SSI measure score that will be a weighted average based on predicted infections for both procedures.

CMS HAC Reduction (All Measures) & QBR (All Safety & Complications Measures)

CMS HAC Reduction	QBR
NHSN HAI1 CLABSI	NHSN HAI1 CLABSI
NHSN HAI2 CAUTI	NHSN HAI2 CAUTI
NHSN HAI3 SSI Hysterectomy	NHSN HAI3 SSI Hysterectomy
NHSN HAI4 SSI Colon	NHSN HAI4 SSI Colon
NHSN HAI5 MRSA	NHSN HAI5 MRSA
NHSN HAI6 CDI/F	NHSN HAI6 CDI/F
PSI-90 (discontinued in 2019) Replace with Patient Safety & Adverse Events Composite (2023)	PSI-90 (discontinued in 2019) Replace with Patient Safety & Adverse Events Composite (2020?)*
	INPATIENT ALL CAUSE MORTALITY

* Due to our own regulatory authority, we could introduce revised PSI-90 at an earlier date than federal government

Considerations of PPCs versus CMS HAC

Category	MHAC	CMS HAC
Coverage of complications	<ul style="list-style-type: none"> - Per previous audit, PPCs capture complications not flagged by HAC logic. - Although surgically biased, all but 6 PPCs apply to both medical and surgical cases. 	<ul style="list-style-type: none"> - Many PSI HACs include only surgical cases in the denominator. (see Measure Overlap)
Ability to refine clinical logic	<ul style="list-style-type: none"> - Hospitals have ability to refine PPC logic in direct collaboration with 3M 	<ul style="list-style-type: none"> - Hospitals limited in providing input except through public comment.
Measure overlap	<ul style="list-style-type: none"> - Overlap but not duplicative of QBR measures (reference MHCC cross-validation with NHSN) 	<ul style="list-style-type: none"> - Measures are already in QBR program and may identify fewer complications - Aligns with measures in the hospital star ratings
	<p>Ex: Sepsis PPC in MHAC program is medical and surgical, while sepsis PSI in the CMS programs is surgical only; among surgical patients, PSI identifies 50% fewer complications than PPCs</p>	
Applicability	<ul style="list-style-type: none"> - Limited to \$200 million exposure in a \$17 billion industry, thus quality improvements may not merit the investment 	<ul style="list-style-type: none"> - Nationally used - Measures targeted to Medicare patients
Service Line approach	<ul style="list-style-type: none"> -Wider range of complications that more easily lends itself to service line approach 	<ul style="list-style-type: none"> - NHSN measures (except SSI measures) cannot be done by service line - PSI could be done by service line. - Could consider additional PSI measures that are not part of PSI-90 composite



Options for Measuring Complications in Enhanced Model

1. **Keep MHAC Program, but narrow down use of PPCs to only those valued as most important by staff and industry.**
 - a. Could reduce PPCs from 49 currently used to 10-20 most important (66 possible PPCs in total)
 - b. Could consider moving some PPCs to monitoring only in RY 2020 prior to decision on MHAC program in Enhanced Model.

2. **Remove MHAC (Complications) Program altogether.**
 - a. Double the at-risk value of QBR program, given strong similarities to measures in HAC Reduction Program, OR:
 - b. Divide QBR into two programs – one for complications and clinical care, and one for patient experience (HCAHPS) – while ensuring that the aggregate at-risk for a new QBR(s) is equal to current QBR and MHAC

3. **Revise MHAC Program to use PSI measures (more than just those in composite) in lieu of PPCs or in combination with paired down PPCs**
 - a. Use current MHAC program's case-mix adjustment and scoring methodology



RRIP

What is the Readmissions Reduction Incentive Program (RRIP)?

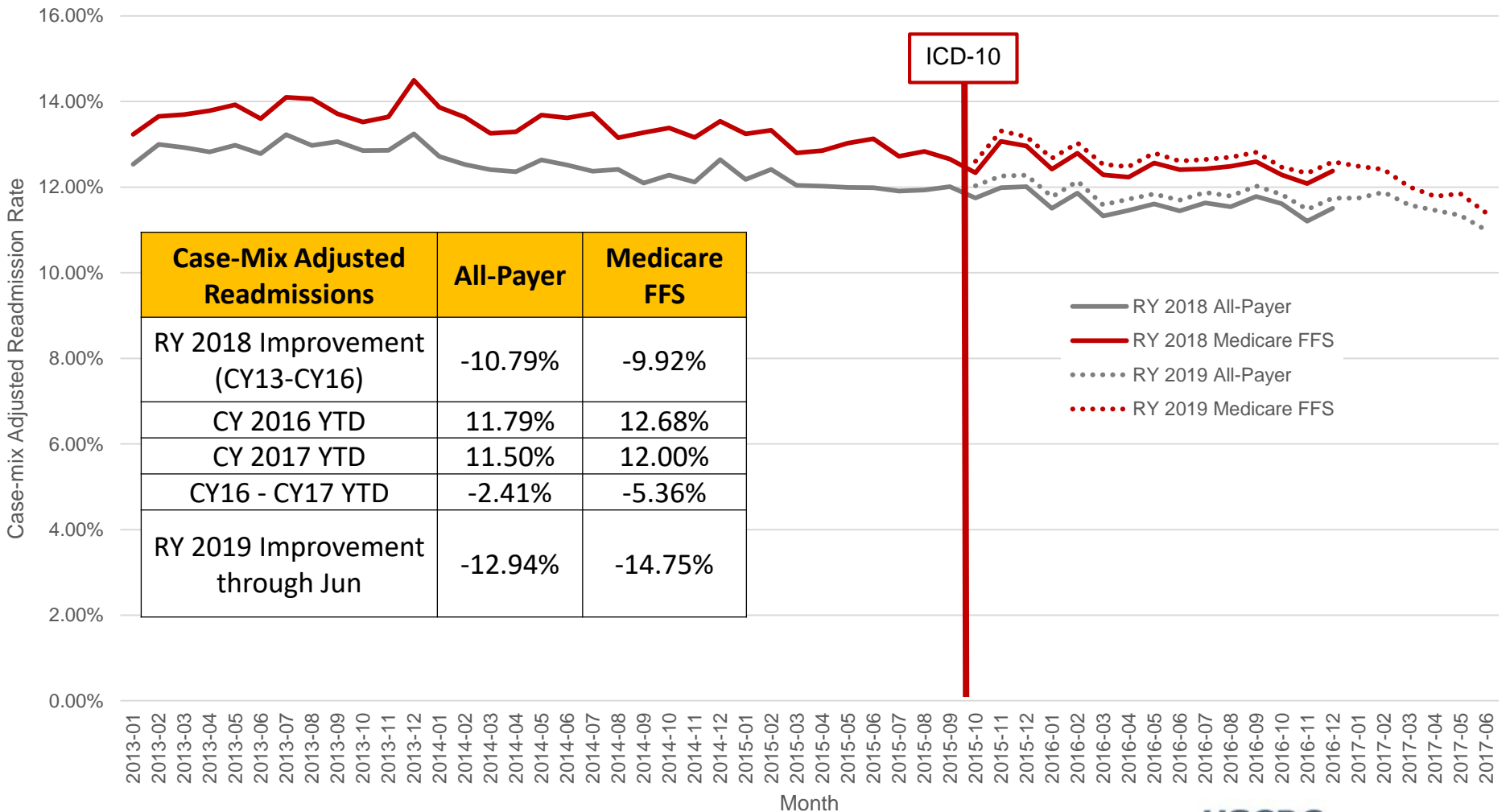
- ▶ **Measures readmissions** across hospitals in Maryland to incentivize readmission reductions for Medicare and All-Payers.
 - ▶ Adjusts All-Payer readmission rates for patient case-mix and severity of illness.
 - ▶ Excludes planned admissions from the program using CMS logic with Maryland-specific adjustments (i.e., all deliveries are considered planned).
 - ▶ Also excludes: transfers, rehabilitation hospitals, oncology, deaths.
- ▶ Measures **hospital performance on an All-Payer basis** as the better of attainment or improvement to determine payment adjustments
 - ▶ Adjusts attainment scores to account for readmissions occurring at non-Maryland hospitals.
 - ▶ Scales rewards and penalties for attainment based on relative performance to statewide attainment benchmark and for improvement based on relative performance to statewide minimum improvement target.
 - ▶ Sets Max Penalty in RY2019 at 2% and Max Reward at 1%.



Final RY 2019 RRIP Policy

- ▶ The RRIP policy should continue to be set for **all-payers**.
- ▶ Hospital performance should continue to be measured as the **better of attainment or improvement**.
- ▶ Due to ICD-10, RRIP should have a **one-year improvement target (CY 2017 over CY 2016)**, and will add this one-year improvement to the achieved improvement CY 2016 over CY 2013, to create a **modified cumulative improvement target**.
- ▶ The attainment benchmark should be set at **10.83 percent**.
- ▶ The reduction benchmark for CY 2017 readmissions should be **-3.75 percent** from CY 2016 readmission rates.
- ▶ Hospitals should be eligible for a **maximum reward of 1 percent**, or a **maximum penalty of 2 percent**, based on the better of their attainment or improvement scores.
- ▶ Staff will continue to work with CMS to **review readmission logic and data discrepancies**, and an update will be provided to the Commission if any substantive issues are found that warrant revisiting RY 2019 targets.

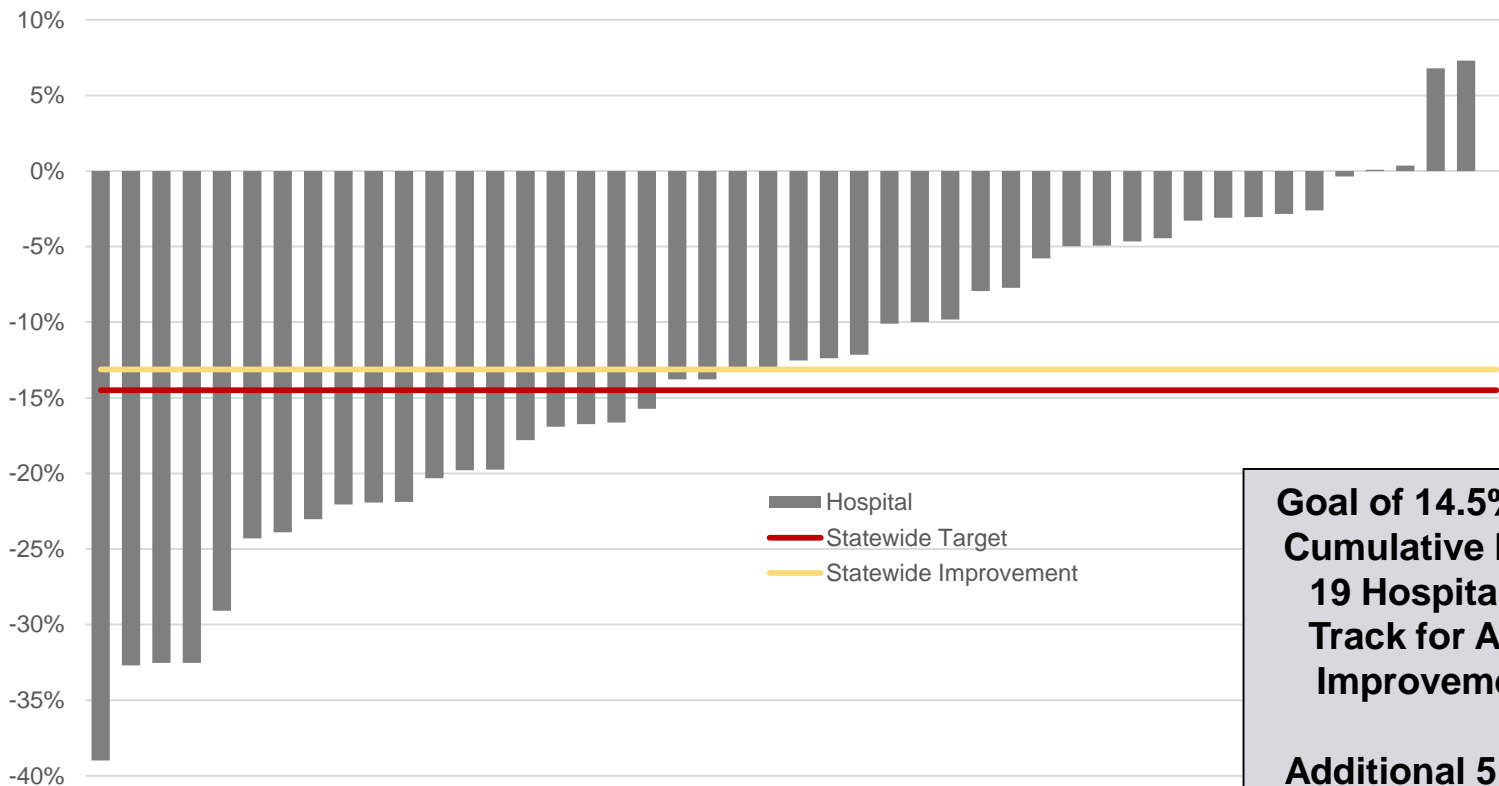
Monthly Case-Mix Adjusted Readmission Rates



41 **Note: Based on final data for January 2012 – March 2017; Preliminary Data for Apr-Jun 2017. Statewide improvement to-date is compounded with complete RY 2018 and RY 2019 YTD improvement.**

Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital

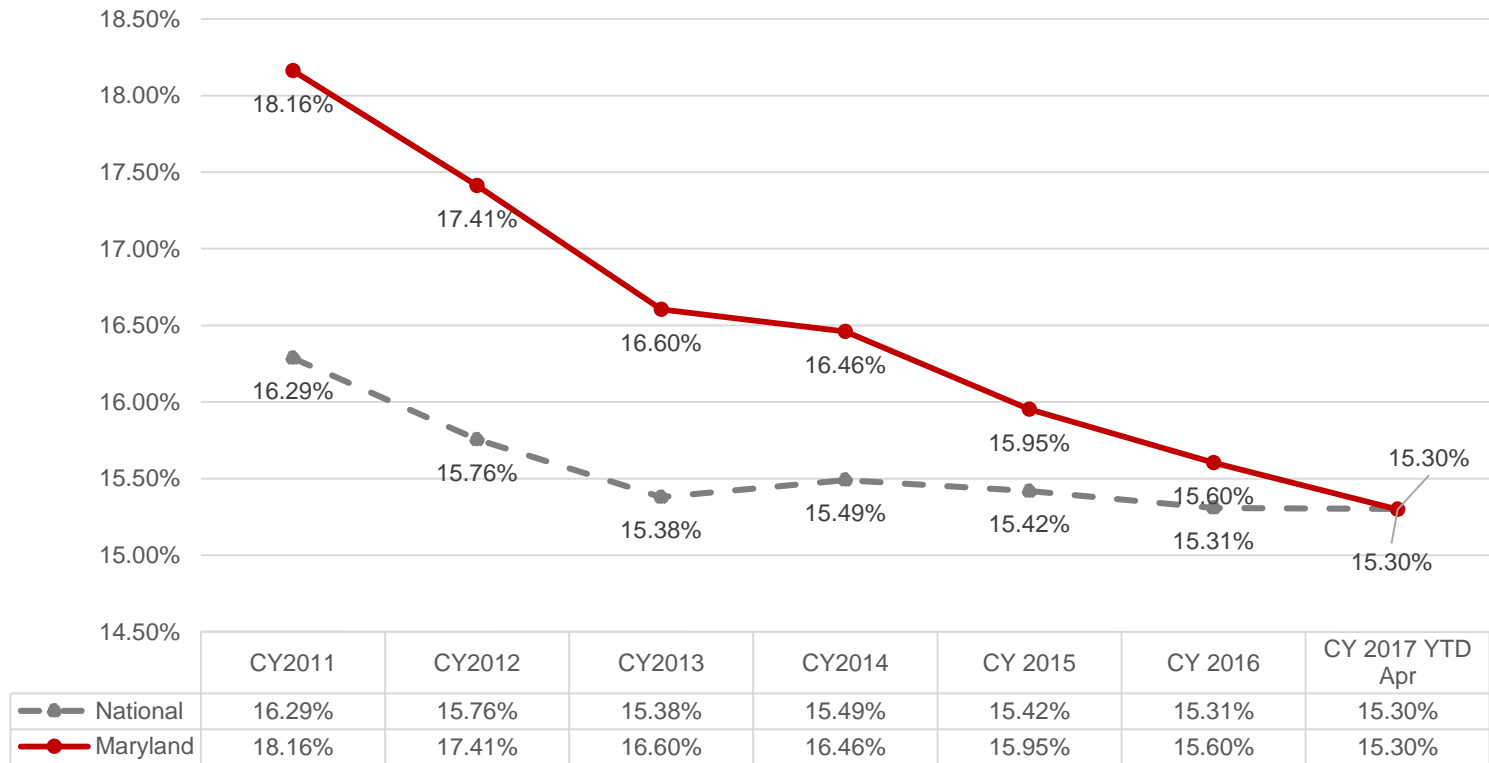
Cumulative change CY 2013 – CY 2016 + CY 2016 YTD to CY 2017 YTD through June



Goal of 14.5% Modified Cumulative Reduction
19 Hospitals are on Track for Achieving Improvement Goal

Additional 5 Hospitals on Track for Achieving Attainment Goal

Medicare Readmissions – Maryland Compared to Nation



Reliability of Readmissions Forecasting

- ▶ No methodology thus far can predict the national readmission rate with 100% accuracy.
- ▶ **Staff plans on recommending using a forecasting model that is more aggressive than the National average**
 - ▶ If MD performance is worse than National Average when goal is set, staff will propose a small “cushion” to ensure waiver test is met (e.g. 0.1%)
 - ▶ If MD performance is equal or better than National Average, staff will propose alternative benchmarks
- ▶ Current timeline of January DRAFT policy would utilize modeling data through August 2017
 - ▶ Is this sufficient?
 - ▶ Concerns over September 2017 data

R.Y. 2020 Proposed Updates

- ▶ Base period = CY 2016; Performance period = CY 2018
- ▶ Grouper version 35
- ▶ Compound R.Y. 2018 improvement to R.Y. 2020 improvement (CY 2018 over CY 2016)
- ▶ Continue R.Y. 2019 methodology in updating Attainment Target

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RRIP Incentive	RRIP Base Period (Proposed)														Rate Year Impacted by RRIP				
									RRIP Performance Period (Proposed)										

Considerations for Readmissions in Enhanced Model

- ▶ **How should HSCRC set a Readmissions Target Rate under Enhanced Model?**
 - ▶ Enhanced Model requires “**aggressive and progressive**” quality metrics
 - ▶ Would the State want to improve beyond the national median?
 - ▶ Possible options: **top national quartile** or select a **new comparison group**, perhaps similar peer states
- ▶ **Expand definition of Readmissions/Revisits:**
 - ▶ Consider expanding readmission window to 90 days
 - ▶ Consider including OBS and/or ED visits in readmission
 - ▶ Include readmissions to and from free-standing psychiatric facilities
- ▶ **Incorporate additional risk-adjustment?**

2017-2018 Future Topics

Readmission Window; Service Line Approach

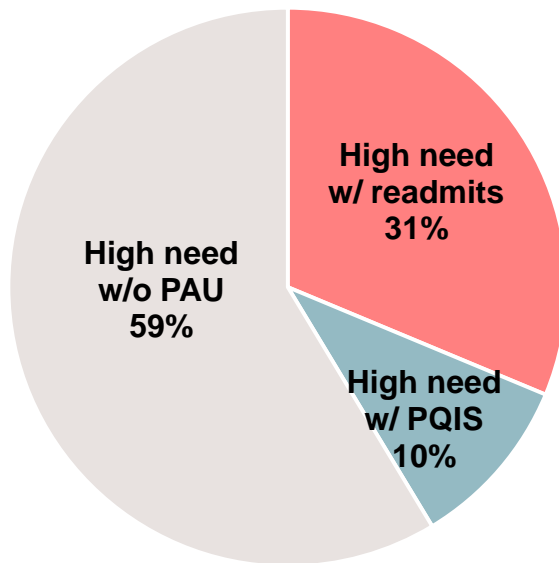
Readmission Window

- ▶ Current readmission window for both Potentially Avoidable Utilization (PAU) and RRIP is readmission within 30 days
- ▶ Expansion to 90 days captures a larger of percentage of utilization of high need patients that could be avoided through better care coordination
 - ▶ High needs patients defined as patients with 3+ bedded stays during the year

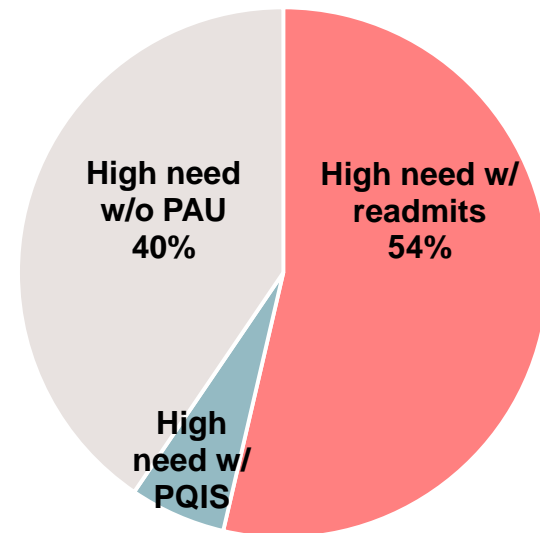
Proportion of High Need Patients

- ▶ Discharges of high need patients represent about 25% of all discharges in CY16.

Discharges of High Need Patients:
30 day Readmissions Window



Discharges of High Need Patients:
90 day Readmissions Window



PAU: Statewide analyses

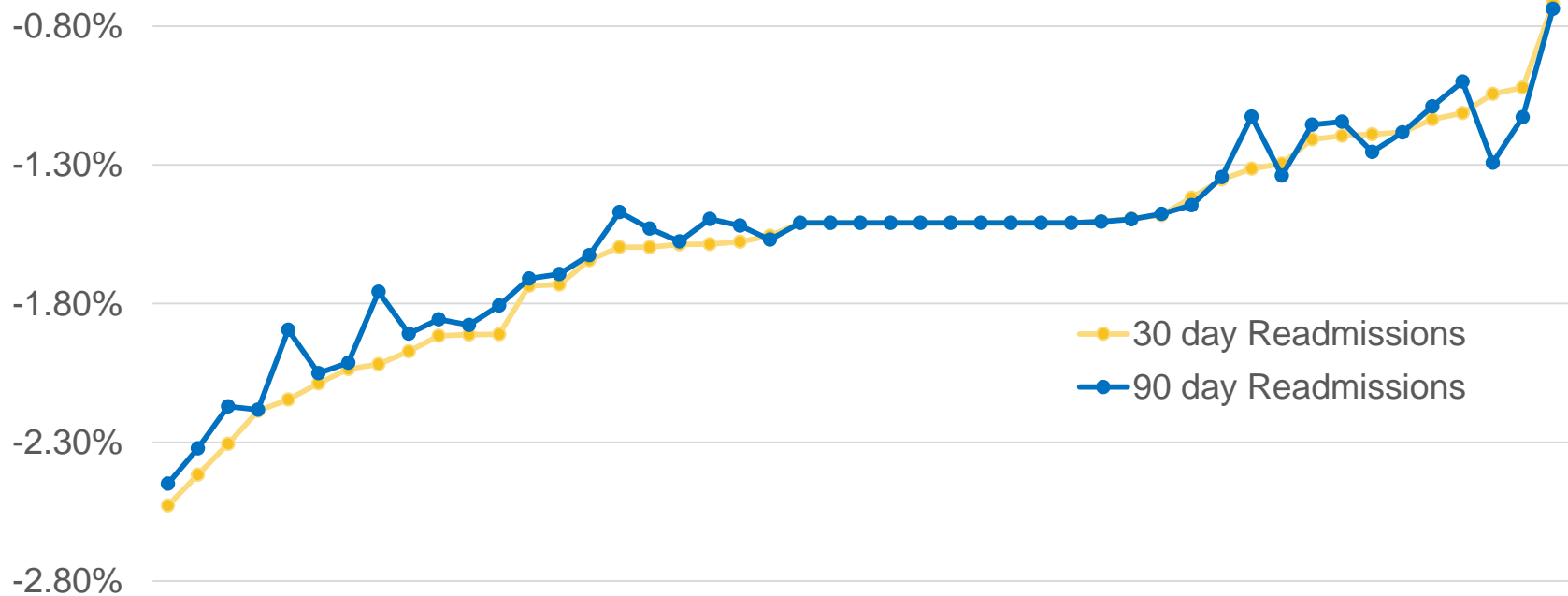
- ▶ Discharges of high need patients represent about 25% of all discharges in CY16.

CY 16, version 6	30 day	90 day
PAU (% of Total Revenue)	11.0%	15.3%
Discharges		
PAU discharges	137,918	183,674
Readmit discharges	73,404	131,067
Readmit % of Total PAU	53.2%	71.4%
Revenue (\$)		
PAU	\$1.8 billion	\$2.5 billion
Readmissions	\$1.1 billion	\$2 billion
Readmissions (% of PAU)	63%	78%

Impact on PAU Savings Policy

- ▶ Readmissions window extension does not affect statewide PAU Savings amount
- ▶ Would shift the relative adjustments among hospitals.

PAU Savings Adjustment % of Total Revenue



Next Steps: Additional Considerations

- ▶ Use of 90 day readmission window in other settings?
- ▶ All-Cause?
- ▶ Interaction with other HSCRC programs?
- ▶ Consistency between RRIP and PAU?

- ▶ Potential shift for RY 2019 PAU Savings Policy

Service Line Approach

Service Line Specific Approach

Bundling outcomes by service line (e.g., surgical, medical, OB) is an alternative approach that is more provider and patient-centric.

Benefits of Service Line Approach:

- ▶ Better measures performance among hospitals that provide similar services
- ▶ Can set benchmarks by service line, which addresses the issue of small hospitals driving benchmarks
- ▶ Focuses on differences that are of interest to patients
- ▶ May provide more actionable data for hospital quality improvement
- ▶ Could be applied to the claims-based measures from the MHAC, RRIP, and QBR programs, and some service line specific non-claims based measures (i.e., early elective delivery, NHSN surgical site infection measures)

Considerations for Development of Service Line Approach

Define service lines using the following key principles:

- ▶ **Scope.** Service lines should apply to a minimum threshold number of hospitals (determined based on discussions with HSCRC and stakeholders), so it is possible to produce most measures for most hospitals.
- ▶ **Transparency.** Service lines should be clearly defined so stakeholders can understand each service line and compare hospitals by service line.
- ▶ **Clinical coherence.** Service lines should form groups that reflect similar technical requirements or patient needs.
- ▶ **Coverage (case size).** Each measure and service line should have enough cases (stays, procedures, etc.) or hospitals to establish statistical reliability in assessing hospital performance.

Determine level of aggregation:

- ▶ Program scores specific to each service line (i.e., multiple scores for each program by service line for MHAC, RRIP, and QBR)
- ▶ Program-specific aggregate scores (i.e., one score per Quality program)
- ▶ Service line-specific aggregate scores across programs (i.e., one score per service line)
- ▶ Overall hospital score that aggregates across all measures and service lines.



Contact Information

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