All Payer Hospital System Modernization
Performance Measurement Workgroup Meeting

Meeting Agenda

September 19, 2014, 9 AM
HSCRC
4160 Patterson Ave
Baltimore, MD 21215
410-764-2605

9:00 AM Introductions, overview of meeting schedule and topic areas

9:15 AM Draft QBR Policy presented to the Commission on September 10, and request for comments through 9/22

10:00 AM MHAC Policy- General discussion:

- Guiding principles
- Program recent results
- FY2017 updates

10:45 AM Readmission Reduction Policy- General discussion:

- Guiding principles
- Program recent results
- FY2017 potential updates

11:30 PM Adjourn

HSCRC Performance Measurement Work Group

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Theressa Lee
Chief of Hospital Quality and Performance
Maryland Health Care Commission

HSCRC Performance Measurement Workgroup

Proposed Work Plan – Phase 2

Updated 7/23/14

Meeting Date	Meeting Goals
Commission Meeting Date: September 10, 2014 (Draft QBR FY2017 Policy)	
September 19, 2014 9:00 – 11:30 Room 100	1. Overview of Meeting Schedule/Agendas 2. Draft QBR Policy -(Draft policy shared w/workgroup for comment in August) 3. MHAC: General discussion of FY2017 Updates 4. Readmission : General discussion of FY2017 Updates
Commission Meeting Date: October 15, 2014 (Final QBR FY2017 Policy)	
October 17, 2014 9:00 – 11:30 Room 100	1. MHAC: Progress report 2. POA Audits/Possible presentation 3. Readmission : Socio Economic Adjustments
November 5, 2014 9:00 – 11:30 Room 100	1. MHAC: Draft MHAC policy (including benchmarks and targets) 2. Readmissions : MD vs. National trend modeling
Commission Meeting Date: November 12, 2014 (Draft MHAC FY2017 Policy)	
November 21, 2014 9:00 – 11:30 Room 100	1. Readmission: Draft FY 2017 policy review 2. MHAC: Final FY 2017 policy review
Commission Meeting Date: December 10, 2014 (Final MHAC FY2017 Policy; Draft Readmission FY2017 Policy)	
December 19,2014 (tentative) 9:00 – 11:30 Room 100	1. Readmission: Final FY 2017 readmission policy review 2. Potentially Avoidable Utilization Measurement 3. Patient Centered Performance Measurement Strategy 4. Other Topics – TBD
January 6, 2015 9:00 – 11:30 Room 100	1. Potentially Avoidable Utilization Measurement 2. Topics TBD based on future work group plans
Commission Meeting Date: Jan 14, 2014 (Final Readmission FY2017 Policy)	

Note: This is a preliminary work plan. It is possible that meetings or conference calls could be added or that some materials may be reviewed via email.

Draft Recommendation for Updating the Quality Based Reimbursement Program for FY 2017

Health Services Cost Review Commission
4160 Patterson Avenue Baltimore, MD 21215
(410) 764-2605

September 10, 2014

This document contains the draft staff recommendations for updating the Quality Based Reimbursement (QBR) Program for FY 2017 for consideration at the September 10, 2014 Public Commission Meeting. Public comments should be sent to Dianne Feeney at the above address or by e-mail at Dianne.Feeney@Maryland.gov. For full consideration, comments must be received by September 22, 2014.

A. Introduction

The HSCRC quality-based measurement initiatives, including the scaling methodologies and magnitudes of revenue "at risk" for these programs, are important policy tools for providing strong incentives for hospitals to improve their quality performance over time. For HCSRC's Quality-based Reimbursement ("QBR") Program, current Commission policy calls for measurement of hospital performance scores across clinical process of care, outcome and patient experience of care domains, and revenue neutral scaling of hospitals in allocating rewards and penalties based on performance.

"Scaling" for QBR refers to the differential allocation of a pre-determined portion of base regulated hospital inpatient revenue based on assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year; these scaled amounts are applied on a "one-time" basis (and not considered permanent revenue), and are computed on a "revenue neutral" basis for the system so that the net increases in rates for better performing hospitals are funded entirely by net decreases in rates for poorer performing hospitals.

For the QBR program for State FY 2016 rates, as approved by the Commission, the HSCRC will weight the clinical outcomes domain more heavily than the previous year, and scale a maximum penalty of 1% of approved base hospital inpatient revenue.

Staff recommends adjusting the weights of the measurement domains so that outcome domains account for a greater proportion of the hospital's overall performance scores going forward, as well as updating the amount of total hospital revenue at risk for scaling for the QBR program.

B. Background

1. Centers for Medicare & Medicaid Services (CMS) Value Based Purchasing (VBP) Program

The Patient Protection and Affordable Care Act of 2010 requires CMS to fund the aggregate Hospital VBP incentive payments by reducing the base operating diagnosis-related group (DRG) payment amounts that determine the Medicare payment for each hospital inpatient discharge. The law set the reduction at one percent in FY 2013, rising incrementally to 2 percent by FY 2017.

CMS implemented the VBP program with hospital payment adjustments beginning in October 2013. For the federal FY 2016 (October 1, 2015 to September 30, 2016) Hospital VBP program, CMS measures include four domains of hospital performance: clinical process of care; patient experience of care (HCAHPS survey measure); outcomes; and efficiency/Medicare spending per beneficiary. Results are weighted by CMS as listed below, with 1.75% of Medicare hospital payments "at risk" for 2016.

Figure 1. CMS VBP Domain Weights, FY 2016

	Clinical/Process	Patient Experience	Outcome	Efficiency/Medicare spending/beneficiary
FFY 2016	10%	25%	40%	25%

CMS indicated its future emphasis will increasingly lean toward outcomes in the VBP program. In addition, staff notes that for the CMS VBP program for FY 2016, CMS added additional outcome measures, including the Agency for Healthcare Research and Quality ("AHRQ") Patient Safety Indicator ("PSI") 90 Composite measure and the Centers for Disease Control National Health Safety Network ("CDC-NHSN") Central Line Associated Blood Stream Infection (CLABSI) and Catheter Associated Urinary Tract Infection (CAUTI) measure.

2. *QBR Measures, Domain Weighting and Magnitude at Risk to Date*

HSCRC implemented the first hospital payment adjustments for QBR program performance in July 2009. For rate year 2016 (July 1, 2015-June 30, 2016), the QBR program scales 1% of revenue at risk and uses the CMS/Joint Commission core process measures—e.g., aspirin upon arrival for the patient diagnosed with heart attack—, "patient experience of care" or Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") measures, and three outcome measures, which include AHRQ PSI 90, the CDC-NHSC CLABSI measure, and all-cause inpatient mortality using the 3M Risk of Mortality classifications. The weighting for each domain compared with the CMS VBP Program are illustrated below in Figure 2.

Figure 2. Maryland QBR Compared with CMS VBP Domain Weights, FY 2016

FY 2016	Clinical/ Process	Patient Experience	Outcome	Efficiency
CMS VBP	10%	25%	40%	25%
Maryland QBR	30%	40%	30%	N/A

Staff convened several meetings of the QBR Update Workgroup in October and November of 2013 and the Performance Measurement Workgroup, which began meeting in January 2014, where there was agreement to add measures to be consistent with the VBP Program where feasible, and to align the list of process of care measures, threshold and benchmark values, and time lag periods with those used by CMS, [1] allowing HSCRC to use the data submitted directly to CMS. This alignment must include the measures used, data sources and magnitude of revenue "at risk" for the program. Maryland has not, to date, developed and implemented an efficiency measure as part of the QBR program. As part of the implementation of New All-Payer Model; there was agreement among Workgroup members and staff that a new efficiency measure is needed to incorporate population-based outcomes.

3. *Value Based Purchasing Exemption Provisions*

Pursuant to 1886(o)(1)(C)(iv) of the Social Security Act, "the Secretary may exempt such hospitals from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection." VBP exemptions have been requested and granted for FYs 2013, 2014 and 2015.

[1] HSCRC has used core measures data submitted to MHCC and applied state-based benchmarks and thresholds to calculate hospitals' QBR scores up to the period used for State FY 2015 performance.

The CMS FY 2015 Inpatient Prospective Payment final rule states that, in order to implement the Maryland All-Payer Model, CMS has waived certain provisions of the [Social Security] Act, and the corresponding implementing regulations, as set forth in the agreement between CMS and Maryland and subject to Maryland's compliance with the terms of the agreement. The final rule continues that, in other words, although the exemption from the Hospital VBP Program no longer applies, Maryland hospitals will not be participating in the Hospital VBP Program because section 1886(o) of the Act and its implementing regulations have been waived for purposes of the model, subject to the terms of the agreement

The section of Maryland All-Payer Model Agreement between CMS and the State addressing the VBP program is excerpted below.

> **…4. Medicare Payment Waivers.** Under the Model, CMS will waive the requirements of the following provisions of the Act as applied solely to Regulated Maryland Hospitals:
>
> > **…e. Medicare Hospital Value Based Purchasing.** Section 1886(o) of the Act, and implementing regulations at 42 CFR 412.160 - 412.167, only insofar as the State submits an annual report to the Secretary that provides satisfactory evidence that a similar program in the State for Regulated Maryland Hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under 1886(o) of the Act….

Staff will work out requirements and timelines with CMS for submitting an annual report on comparable programs to the VBP program in the State.

C. Assessment

Staff analyzed changes in performance on the QBR and VBP measures used for FY 2015 performance for Maryland versus the US for October 2012 through September 2013 compared with the immediately prior 12 month period. Figure 3 below lists each of the measures used for the VBP and QBR programs. The data indicate that Maryland improved at a slightly higher rate and/or performed slightly better for all but one of the process of care measures. Maryland also performed significantly better than the US on the CLABSI measure for both time periods and also improved. For HCAHPS, Maryland declined slightly in performance for almost half (4 out of 10) of the measures, and performed below the US on all measures with the exception of "Patient given information about recovery at home" where Maryland improved significantly and now performs the same as the US.

Figure 3. QBR Measures Change for Maryland Versus US

	CLINICAL OUTCOME Mortality						
		MD Base Period	MD Most Current Performance		US Base Period	US Most Current Performance	
		Q308-Q211	Q309-Q212	Difference	Q308-Q211	Q309-Q212	Difference
	Combined CHF, AMI, Pneumonia 30 day mortality	11.56	11.38	-0.18	12.34	12.31	-0.03
	CLINICAL PROCESS						
		Maryland Base Period	MD Performance Period		US Base Period	US Performance Period	
		Oct 11-Sep12	Oct12-Sep13	Difference	Oct11-Sep12	Oct12-Sep13	Difference
AMI 8a	Primary PCI within 90 minutes	89.96	94.68	4.72	95.22	96.25	1.03
HF 1	Discharge instructions	92.94	94.28	1.34	92.59	93.9	1.31
IMM 1	Pneumococcal vaccination*	91.59	94	2.41	88.28	92	3.72
Imm 2	Influenza vaccination*	90.19	94	3.81	84.16	90	5.84
PN 3b	Blood culture before first antibiotic	96.53	97.03	0.5	96.93	97.4	0.47
PN 6	Initial antibiotic selection	95.82	97.29	1.47	94.63	95.19	0.56
SCIP INF 1	Antibiotic givin within 1 hour	97.79	97.7	-0.09	97.96	98.3	0.34
SCIP INF 4	Cardiac surgery patients with controlled 6am postop serum glucose	94.23	96.51	2.28	95.88	96.47	0.59
SCIP INF 9	Urinary catheter removed postop day 1 or 2	93.69	97.74	4.05	94.98	96.84	1.86
Clinical Process	***Average Total Score***	93.64	95.91	2.28	93.40	95.15	1.75
	PATIENT EXPERIENCE (HCAHPS)						
HCAHPS	Doctors always communicated well	77.51	78	0.49	81.34	82	0.66
HCAHPS	Nurses always communicated well	74.84	75	0.16	78.18	79	0.82
HCAHPS	Patients always received help as soon as they wanted	59.19	58	-1.19	66.63	68	1.37
HCAHPS	Staff explained about medication	59.02	58	-1.02	63.47	64	0.53
HCAHPS	Pain was always controlled	67.67	67	-0.67	70.63	71	0.37
HCAHPS	Patient room always kept quiet	56.05	57	0.95	60.35	65	4.65
HCAHPS	Patient room always kept clean	65.21	64	-1.21	72.78	73	0.22
HCAHPS	Patient given information about recovery at home	82.93	85	2.07	84.21	85	0.79
HCAHPS	Patient would definitely recommend hospital to friends and family	66.88	67	0.12	70.76	71	0.24
HCAHPS	***Average Total Score***	***67.70***	***67.67***	***-0.03***	***72.04***	***73.11***	***1.07***
	SAFETY**						
		MD Base Period	MD Most current performance	Difference	US Base Peroid	US Most current performance	Difference
	CLABSI	0.55	0.53	-0.02	1	1	N/A
	CAUTI	1.59	1.78	0.19	1	1	N/A
	MRSA	N/A	1.83	N/A	N/A	1	N/A
	C-diff	N/A	1.16	N/A	N/A	1	N/A
	SSI Colon	N/A	0.95	N/A	N/A	1	N/A
	SSI Hysterectomy	N/A	1.51	N/A	N/A	1	N/A
	PSI 90	Data Unavailable			Data Unavailable		
*Data collection periods for Immunization measures differ than those for other measures.							
**For the Safety measures are ratios where a decrease indicates improvement. An average score for the saferty domain was not calculated due to incomplete data.							

Staff examined measures finalized for the CMS VBP Program for FY 2017 in the 2015 CMS Inpatient Prospective Payment System (IPPS) Final Rule and those in the potential pool for the QBR program for 2017. Figure 4 below details the measures by domain and the available published performance standards for each measure, and indicates the measures that will be included in the VBP and QBR programs.

Figure 4. Measures and Performance Standards for the FY 2017 CMS Hospital VBP Program Compared with Maryland QBR Program

Measure ID (Applicable Programs)	Description	Achievement Threshold	Benchmark
Safety Measures			
CAUTI (VBP and New QBR)	Catheter-Associated Urinary Tract Infection	0.845	0.000
CLABS (VBP and QBR)	Central Line-Associated Blood Stream Infection	0.457	0.000
C. *difficile* (New VBP and QBR TBD- MD data collection began in July 2013.)	*Clostridium difficile* Infection	0.750	0.000
MRSA Bacteremia (New VBP and QBR TBD- MD data collection began in July 2013)	Methicillin-Resistant *Staphylococcus aureus* Bacteremia	0.799	0.000
PSI-90 (VBP and QBR)	Complication/patient safety for selected indicators (composite)	0.577321* (*VBP MEDICARE ONLY;QBR All-PAYER THRESHOLD TBD)	0.397051* (*VBP MEDICARE ONLY;QBR All-PAYER BENCHMARK TBD)
SSI (VBP and New QBR)	Surgical Site Infection • Colon • Abdominal Hysterectomy	• 0.751 • 0.698	• 0.000 • 0.000
Clinical Care – Outcomes Measures			
MORT-30-AMI (VBP ONLY)	Acute Myocardial Infarction (AMI) 30-day mortality rate	0.851458	0.871669
MORT-30-HF (VBP ONLY)	Heart Failure (HF) 30-day mortality rate	0.881794	0.903985
MORT-30-PN (VBP ONLY)	Pneumonia (PN) 30-day mortality rate	0.882986	0.908124
Mortality (QBR ONLY)	All-cause inpatient using 3M risk of mortality	TBD	TBD
Clinical Care – Process Measures			
AMI-7a (VBP and QBR)	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0.954545	1.000000
IMM-2 (VBP and QBR)	Influenza Immunization	0.951607	0.997739

Measure ID (Applicable Programs)	Description	Achievement Threshold	Benchmark
PC-01 (New VBP and QBR TBD- MD data collection began in January 2014)	Elective Delivery Prior to 39 Completed Weeks Gestation	0.031250	0.000000
Efficiency and Cost Reduction Measure			
MSPB-1 (VBP ONLY)	Medicare Spending per Beneficiary	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period

Patient and Caregiver-Centered Experience of Care/Care Coordination Domain			
HCAHPS Survey Dimension (VBP and QBR)	Floor (percent)	Achievement Threshold (percent)	Benchmark (percent)
Communication with Nurses	58.14	78.19	86.61
Communication with Doctors	63.58	80.51	88.80
Responsiveness of Hospital Staff	37.29	65.05	80.01
Pain Management	49.53	70.28	78.33
Communication about Medicines	41.42	62.88	73.36
Hospital Cleanliness & Quietness	44.32	65.30	79.39
Discharge Information	64.09	85.91	91.23
Overall Rating of Hospital	35.99	70.02	84.60

Staff is proposing updated measure domain weights based on the VBP measures domain weights published in the CMS IPPS Final Rule, Maryland's need to improve on the HCAHPS measures, and the measures and domains available for adoption in the QBR rate year FY 2017; Figure 4 below illustrates the VBP final domain weights and the QBR proposed domain weights.

Staff circulated the draft recommendation via email to the members of the Performance Measurement Workgroup as in person meetings were not feasible due to summer schedules. The draft recommendation will be discussed at the September 19 in person meeting and issues raised in the discussions will be incorporated into the final recommendation.

Figure 4. Final Measure Domain Weights for the Hospital VBP Program and Proposed Domain Weights for the QBR Program FY 2017

	Clinical	Patient Experience	Safety	Efficiency
	• Outcomes (Mortality) • Process			

CMS VBP	• 25 percent • 5 percent	25%	20%	25%
Proposed Maryland QBR	• 15 percent • 5 percent	45%	35%	N/A

Staff notes again that the established revenue "at risk" magnitude for the CMS VBP Program is set at 2% for 2017. To determine the potential impact of increasing the amount of revenue at risk for the QBR program to 1.5% versus 2%, staff used the most recent scaling results (October 1, 2012 to September 30, 2013 performance period) that apply to hospitals for rate year FY 2015 for modeling purposes. The results, to be considered for altering the magnitude of revenue to be scaled for rate year FY 2017, detailed in Appendix I, reveal that a total range of $7.7M to $10.3M is redistributed under the revenue neutral scaling methodology.

A memo summarizing the updates to the QBR methodology with the required benchmark data will be sent to the hospitals after final Commission approval of the QBR program updates for FY 2017.

D. Recommendations

For the QBR program, staff provides the following recommendation:

1. Allocate 2% of hospital approved inpatient revenue for QBR relative performance in FY 2017.
2. Adjust measurement domain weights to include 5% for process, 15% for outcomes (mortality), 35% for safety, and 45% patient experience of care.

Appendix I. QBR Continuous Linear Scaling- Modeling Maximum Penalty of 1.5% Versus 2% of Hospital Inpatient Revenue Using Data Results for RY 2015

HOSPID	HOSPITAL NAME	INPATIENT REVENUE	QBR FINAL POINTS	SCALING BASIS 1.5%	SCALING BASIS 2%	REVENUE IMPACT OF SCALING 1.5%	REVENUE IMPACT OF SCALING 2%	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING 1.5%	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING 2%	REVENUE NEUTRAL ADJUSTED GROSS REVENUE 1.5%	REVENUE NEUTRAL ADJUSTED GROSS REVENUE 2%	REVENUE NEUTRAL ADJUSTED PERCENT 1.5%	REVENUE NEUTRAL ADJUSTED PERCENT 2%
A	B	C	D	E	F	G	H	I	J	K	L	M	N
210062	Southern Maryland Hospital Center	$ 159,227,525	0.050	-1.500%	-2.000%	-$2,388,413	-$3,184,551	-$2,388,413	-$3,184,551	$156,839,112	$156,042,975	-1.500%	-2.000%
210003	Prince Georges Hospital Center	$ 172,920,161	0.110	-1.253%	-1.671%	-$2,167,170	-$2,889,561	-$2,167,170	-$2,889,561	$170,752,991	$170,030,601	-1.253%	-1.671%
210048	Howard County General Hospital	$ 163,303,899	0.230	-0.760%	-1.013%	-$1,240,839	-$1,654,452	-$1,240,839	-$1,654,452	$162,063,061	$161,649,448	-0.760%	-1.013%
210013	Bon Secours Hospital	$ 76,305,158	0.251	-0.675%	-0.900%	-$514,792	-$686,390	-$514,792	-$686,390	$75,790,366	$75,618,769	-0.675%	-0.900%
210019	Peninsula Regional Medical Center	$ 228,027,801	0.269	-0.600%	-0.800%	-$1,367,997	-$1,823,995	-$1,367,997	-$1,823,995	$226,659,805	$226,203,806	-0.600%	-0.800%
210044	Greater Baltimore Medical Center	$ 196,617,898	0.279	-0.560%	-0.747%	-$1,101,266	-$1,468,354	-$1,101,266	-$1,468,354	$195,516,632	$195,149,544	-0.560%	-0.747%
210029	Johns Hopkins Bayview Medical Center	$ 347,704,294	0.285	-0.534%	-0.712%	-$1,855,601	-$2,474,135	-$1,855,601	-$2,474,135	$345,848,693	$345,230,159	-0.534%	-0.712%
210055	Laurel Regional Hospital	$ 75,611,683	0.294	-0.495%	-0.661%	-$374,653	-$499,537	-$374,653	-$499,537	$75,237,030	$75,112,146	-0.495%	-0.661%
210060	Fort Washington Medical Center	$ 17,342,569	0.295	-0.493%	-0.657%	-$85,421	-$113,895	-$85,421	-$113,895	$17,257,148	$17,228,674	-0.493%	-0.657%
210022	Suburban Hospital	$ 176,985,550	0.310	-0.431%	-0.574%	-$762,580	-$1,016,774	-$762,580	-$1,016,774	$176,222,969	$175,968,776	-0.431%	-0.574%
210001	Meritus Hospital	$ 182,862,924	0.310	-0.431%	-0.574%	-$787,904	-$1,050,539	-$787,904	-$1,050,539	$182,075,019	$181,812,385	-0.431%	-0.574%
210040	Northwest Hospital Center	$ 138,718,749	0.316	-0.407%	-0.543%	-$565,094	-$753,459	-$565,094	-$753,459	$138,153,654	$137,965,289	-0.407%	-0.543%
210057	Shady Grove Adventist Hospital	$ 223,152,951	0.320	-0.390%	-0.520%	-$869,741	-$1,159,655	-$869,741	-$1,159,655	$222,283,210	$221,993,296	-0.390%	-0.520%
210018	Montgomery General Hospital	$ 85,514,349	0.335	-0.328%	-0.437%	-$280,547	-$374,063	-$280,547	-$374,063	$85,233,802	$85,140,286	-0.328%	-0.437%
210011	St. Agnes Hospital	$ 233,289,323	0.335	-0.328%	-0.437%	-$765,354	-$1,020,472	-$765,354	-$1,020,472	$232,523,969	$232,268,851	-0.328%	-0.437%
210015	Franklin Square Hospital Center	$ 278,723,093	0.345	-0.287%	-0.383%	-$799,797	-$1,066,396	-$799,797	-$1,066,396	$277,923,296	$277,656,697	-0.287%	-0.383%
210037	Memorial Hospital at Easton	$ 92,515,251	0.364	-0.208%	-0.277%	-$192,111	-$256,149	-$192,111	-$256,149	$92,323,139	$92,259,102	-0.208%	-0.277%
210016	Washington Adventist Hospital	$ 157,754,799	0.367	-0.196%	-0.261%	-$308,512	-$411,350	-$308,512	-$411,350	$157,446,287	$157,343,450	-0.196%	-0.261%
210024	Union Memorial Hospital	$ 236,590,732	0.374	-0.166%	-0.221%	-$392,446	-$523,262	-$392,446	-$523,262	$236,198,286	$236,067,471	-0.166%	-0.221%
210033	Carroll Hospital Center	$ 134,838,320	0.380	-0.143%	-0.191%	-$192,858	-$257,144	-$192,858	-$257,144	$134,645,462	$134,581,176	-0.143%	-0.191%
210004	Holy Cross Hospital	$ 311,801,309	0.400	-0.061%	-0.081%	-$189,539	-$252,719	-$189,539	-$252,719	$311,611,770	$311,548,590	-0.061%	-0.081%
210056	Good Samaritan Hospital	$ 176,449,767	0.405	-0.040%	-0.054%	-$70,983	-$94,644	-$70,983	-$94,644	$176,378,785	$176,355,124	-0.040%	-0.054%
210061	Atlantic General Hospital	$ 37,698,304	0.426	0.048%	0.064%	$18,052	$24,069	$12,462	$16,616	$37,710,766	$37,714,920	0.033%	0.044%
210012	Sinai Hospital	$ 418,687,491	0.446	0.127%	0.169%	$529,804	$706,406	$365,751	$487,668	$419,053,243	$419,175,160	0.087%	0.116%
210038	Maryland General Hospital	$ 130,524,694	0.451	0.148%	0.197%	$192,860	$257,147	$133,141	$177,522	$130,657,835	$130,702,215	0.102%	0.136%
210035	Civista Medical Center	$ 74,476,146	0.455	0.165%	0.220%	$123,164	$164,218	$85,026	$113,368	$74,561,172	$74,589,514	0.114%	0.152%
210034	Harbor Hospital Center	$ 120,977,775	0.469	0.221%	0.295%	$267,581	$356,775	$184,725	$246,300	$121,162,500	$121,224,075	0.153%	0.204%
210032	Union of Cecil	$ 66,197,257	0.482	0.277%	0.369%	$183,360	$244,480	$126,583	$168,777	$66,323,840	$66,366,034	0.191%	0.255%
210002	University of Maryland Hospital	$ 842,774,096	0.484	0.284%	0.379%	$2,394,842	$3,193,122	$1,653,283	$2,204,377	$844,427,379	$844,978,473	0.196%	0.262%
210039	Calvert Memorial Hospital	$ 65,741,743	0.491	0.315%	0.420%	$207,196	$276,261	$143,038	$190,717	$65,884,781	$65,932,461	0.218%	0.290%
210049	Upper Chesapeake Medical Center	$ 145,284,971	0.495	0.330%	0.440%	$479,229	$638,972	$330,837	$441,116	$145,615,808	$145,726,087	0.228%	0.304%
210043	Baltimore Washington Medical Center	$ 217,712,318	0.495	0.330%	0.440%	$718,134	$957,512	$495,765	$661,020	$218,208,083	$218,373,338	0.228%	0.304%
210005	Frederick Memorial Hospital	$ 184,859,281	0.500	0.350%	0.467%	$647,774	$863,699	$447,192	$596,256	$185,306,473	$185,455,537	0.242%	0.323%
210030	Chester River Hospital Center	$ 28,699,194	0.539	0.509%	0.679%	$146,086	$194,781	$100,851	$134,467	$28,800,045	$28,833,662	0.351%	0.469%
210051	Doctors Community Hospital	$ 132,902,820	0.540	0.515%	0.687%	$684,311	$912,415	$472,416	$629,887	$133,375,236	$133,532,708	0.355%	0.474%
210010	Dorchester General Hospital	$ 24,515,059	0.552	0.563%	0.751%	$137,989	$183,986	$95,261	$127,015	$24,610,320	$24,642,073	0.389%	0.518%
210027	Western MD Regional Medical Center	$ 179,984,650	0.589	0.718%	0.957%	$1,291,486	$1,721,982	$891,580	$1,188,773	$180,876,229	$181,173,423	0.495%	0.660%
210008	Mercy Medical Center	$ 227,476,677	0.609	0.799%	1.065%	$1,816,689	$2,422,252	$1,254,154	$1,672,206	$228,730,831	$229,148,882	0.551%	0.735%
210017	Garrett County Memorial Hospital	$ 18,267,389	0.611	0.806%	1.074%	$147,177	$196,236	$101,604	$135,472	$18,368,993	$18,402,861	0.556%	0.742%
210023	Anne Arundel Medical Center	$ 302,553,244	0.615	0.823%	1.098%	$2,490,917	$3,321,222	$1,719,608	$2,292,811	$304,272,852	$304,846,055	0.568%	0.758%
210006	Harford Memorial Hospital	$ 45,941,091	0.632	0.894%	1.192%	$410,619	$547,492	$283,472	$377,962	$46,224,563	$46,319,053	0.617%	0.823%
210009	Johns Hopkins Hospital	$ 1,260,991,141	0.634	0.900%	1.200%	$11,344,725	$15,126,300	$7,831,850	$10,442,466	$1,268,822,991	$1,271,433,607	0.621%	0.828%
210028	St. Mary's Hospital	$ 67,824,688	0.698	1.164%	1.552%	$789,483	$1,052,644	$545,021	$726,694	$68,369,709	$68,551,383	0.804%	1.071%
	Statewide Total	**$8,460,348,137**				**$7,747,859**	**$10,330,478**	**$ (0.0)**	**$ (0.0)**	**$ 8,460,348,137**	**$ 8,460,348,137**	**-0.1%**	**-0.1%**

New All-Payer Model for Maryland
Performance Measurement Workgroup Meeting

9/19/2014

Rate Year 2017 Draft Quality Based Reimbursement Recommendation

HSCRC
Health Services Cost Review Commission

Presentation Contents

- Program Overview and Guiding Principles
- Brief Summary of Current Methodology and Results for 2014 YTD
- Rate Year 2017 Potential Updates
- Next Steps

Quality Based Reimbursement (QBR) Program

- Maryland was an early adopter and aspires to be a leader in hospital performance reporting and payment reform
- The QBR program, implemented in 2010, is analogous to the CMS Value Based Purchasing program, implemented in 2013.
- Revenue at risk:
  - For the QBR program it was initially 0.5% and is now 1% of approved inpatient revenue (applies to FY 2016 hospital rates)
  - For the VBP program it was initially 1% of base DRG revenue and is now 1.75% (applies to FY 2016 hospital rates); increasing to 2% for FY 2017.
- Under Maryland's previous waiver, Maryland was required to seek, and did receive, exemptions from the VBP program by demonstrating cost and quality outcomes equal to or better than the VBP program

Guiding Principles

- Measurement used for performance linked with payment must include all patients regardless of payer.
- Measurement must be fair to hospitals and allow the ability to track progress.
- Measures and targets(benchmarks and thresholds) used should be consistent with those used by the CMS VBP program to the extent possible.
- Emphasis on outcomes should increase going forward.
- The new Model contract requires participation in all Inpatient and Outpatient Quality Reporting requirements, and reporting to CMMI to maintain exemption from the VBP program.

Maryland QBR Compared with US Measure Weighting FY 2016

	Clinical/ Process	Patient Experience	Outcome (For QBR: Mortality, CLABSI, PSI 90)	Efficiency
CMS VBP	10%	25%	40%	25%
Maryland QBR	30%	40%	30%	N/A

Maryland QBR Most Currently Available Performance Results Compared with US

	CLINICAL OUTCOME Mortality (Outcome)						
		MD Base Period	MD Most Current Performance		US Base Period	US Most Current Performance	
		Q308-Q211	Q309-Q212	Difference	Q308-Q211	Q309-Q212	Difference
	Combined CHF, AMI, Pneumonia 30 day mortality	11.56	11.38	-0.18	12.34	12.31	-0.03
	CLINICAL PROCESS						
		Maryland Base Period	MD Performance Period		US Base Period	US Performance Period	
		Oct 11-Sep12	Oct12-Sep13	Difference	Oct11-Sep12	Oct12-Sep13	Difference
AMI 8a	Primary PCI within 90 minutes	89.96	94.68	4.72	95.22	96.25	1.03
HF 1	Discharge instructions	92.94	94.28	1.34	92.59	93.9	1.31
IMM 1	Pneumococcal vaccination*	91.59	94	2.41	88.28	92	3.72
Imm 2	Influenza vaccination*	90.19	94	3.81	84.16	90	5.84
PN 3b	Blood culture before first antibiotic	96.53	97.03	0.5	96.93	97.4	0.47
PN 6	Initial antibiotic selection	95.82	97.29	1.47	94.63	95.19	0.56
SCIP INF 1	Antibiotic givin within 1 hour	97.79	97.7	-0.09	97.96	98.3	0.34
SCIP INF 4	Cardiac surgery patients with controlled 6am postop serum glucose	94.23	96.51	2.28	95.88	96.47	0.59
SCIP INF 9	Urinary catheter removed postop day 1 or 2	93.69	97.74	4.05	94.98	96.84	1.86
Clinical Process	***Average Total Score***	93.64	95.91	2.28	93.40	95.15	1.75

Maryland QBR Most Currently Available Performance Results Compared with US

	PATIENT EXPERIENCE (HCAHPS)						
HCAHPS	Doctors always communicated well	77.51	78	0.49	81.34	82	0.66
HCAHPS	Nurses always communicated well	74.84	75	0.16	78.18	79	0.82
HCAHPS	Patients always received help as soon as they wanted	59.19	58	-1.19	66.63	68	1.37
HCAHPS	Staff explained about medication	59.02	58	-1.02	63.47	64	0.53
HCAHPS	Pain was always controlled	67.67	67	-0.67	70.63	71	0.37
HCAHPS	Patient room always kept quiet	56.05	57	0.95	60.35	65	4.65
HCAHPS	Patient room always kept clean	65.21	64	-1.21	72.78	73	0.22
HCAHPS	Patient given information about recovery at home	82.93	85	2.07	84.21	85	0.79
HCAHPS	Patient would definitely recommend hospital to friends and family	66.88	67	0.12	70.76	71	0.24
HCAHPS	***Average Total Score***	***67.70***	***67.67***	***-0.03***	***72.04***	***73.11***	***1.07***
	SAFETY** (Outcome)						
		MD Base Period	MD Most current performance	Difference	US Base Peroid	US Most current performance	Difference
	CLABSI	0.55	0.53	-0.02	1	1	N/A
	CAUTI	1.59	1.78	0.19	1	1	N/A
	MRSA	N/A	1.83	N/A	N/A	1	N/A
	C-diff	N/A	1.16	N/A	N/A	1	N/A
	SSI Colon	N/A	0.95	N/A	N/A	1	N/A
	SSI Hysterectomy	N/A	1.51	N/A	N/A	1	N/A
	PSI 90	Data Unavailable			Data Unavailable		

*Data collection periods for Immunization measures differ than those for other measures.

**For the Safety measures are ratios where a decrease indicates improvement. An average score for the saferty domain was not calculated due to incomplete data.

Maryland QBR Measures for FY 2017 Compared with US

Measure ID (Applicable Programs)	Description
	Safety Measures
CAUTI **(VBP and New QBR)**	Catheter-Associated Urinary Tract Infection
CLABS **(VBP and QBR)**	Central Line-Associated Blood Stream Infection
C. *difficile* **(New VBP and QBR TBD- MD data collection began in July 2013.)**	*Clostridium difficile* Infection
MRSA Bacteremia **(New VBP and QBR TBD- MD data collection began in July 2013)**	Methicillin-Resistant *Staphylococcus aureus* Bacteremia
PSI-90 **(VBP and QBR)**	Complication/patient safety for selected indicators (composite)
SSI **(VBP and New QBR)**	Surgical Site Infection • Colon • Abdominal Hysterectomy

	Clinical Care – Outcomes Measures
MORT-30-AMI **(VBP ONLY)**	Acute Myocardial Infarction (AMI) 30-day mortality rate
MORT-30-HF **(VBP ONLY)**	Heart Failure (HF) 30-day mortality rate
MORT-30-PN **(VBP ONLY)**	Pneumonia (PN) 30-day mortality rate
Mortality **(QBR ONLY)**	All-cause inpatient using 3M risk of mortality
	Clinical Care – Process Measures
AMI-7a **(VBP and QBR)**	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
IMM-2 **(VBP and QBR)**	Influenza Immunization
PC-01 **(New VBP and QBR TBD- MD data collection began in January 2014)**	Elective Delivery Prior to 39 Completed Weeks Gestation

Maryland QBR Measures for FY 2017 Compared with US

Patient Experience

HCAHPS Survey Dimension (VBP and QBR)
Communication with Nurses
Communication with Doctors
Responsiveness of Hospital Staff
Pain Management
Communication about Medicines
Hospital Cleanliness & Quietness
Discharge Information
Overall Rating of Hospital

Efficiency and Cost Reduction Measure	
MSPB-1 (VBP ONLY)	Medicare Spending per Beneficiary

Rate Year 2017
Base and Performance Periods

HSCRC Quality Program Measurement, Performance and Impact Periods 09/15/2014

Rate Year (Maryland Fiscal Year)		FY13-Q2	FY13-Q3	FY13-Q4	FY14-Q1	FY14-Q2	FY14-Q3	FY14-Q4	FY15-Q1	FY15-Q2	FY15-Q3	FY15-Q4	FY16-Q1	FY16-Q2	FY16-Q3	FY16-Q4	FY17-Q1	FY17-Q2	FY17-Q3	FY17-Q4
Calendar Year		CY12-Q4	CY13-Q1	CY13-Q2	CY13-Q3	CY13-Q4	CY14-Q1	CY14-Q2	CY14-Q3	CY14-Q4	CY15-Q1	CY15-Q2	CY15-Q3	CY15-Q4	CY16-Q1	CY16-Q2	CY16-Q3	CY16-Q4	CY17-Q1	CY17-Q2
Quality Programs that Impact Rate Year 2017																				
MHAC	PPC Grouper V. 32				MHAC Base Period						MHAC Performance						Rate Year Impacted by MHAC Results			
QBR	Federal Standards		Maryland QBR Core and HCAHPS SAFETY Base Period														Rate Year Impacted by QBR Results			
			Federal Base Core_HCAHPS																	
										QBR Core and HCAHPS Safety Performance Period										
					Maryland Mortality, PSI Base Period															
											Maryland Mortality, PSI Performance Period									
Readmission Reduction Incentive					Readmission Reduction Base Period												Rate Year Impacted by Readmission Reduction Results			
											Readmission Reduction Performance Period									

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Measure Domain Weighting Recommended for FY 2017

	Clinical • Outcomes (Mortality) • Process	Patient Experience	Safety	Efficiency
CMS VBP	• 25 percent • 5 percent	25%	20%	25%
Proposed Maryland QBR	• 15 percent • 5 percent	45%	35%	N/A

Revenue at Risk of 2% Recommended for QBR FY 2017

- The established revenue "at risk" magnitude for the CMS VBP Program is set at 2% for 2017.
- Staff modeled 1.5% versus 2%, of revenue at risk using the most recent scaling results (October 1, 2012 to September 30, 2013 performance period) that apply to hospitals for rate year FY 2015
- The results reveal that a total range of $7.7M to $10.3M is redistributed under the revenue neutral scaling methodology.

Discussion

New All-Payer Model for Maryland
Performance Measurement Workgroup Meeting

9/19/2014

Draft MHAC Rate Year 2017 Program Potential Updates

Presentation Contents

- Program Overview and Guiding Principles
- Brief Summary of Current Methodology and Results for 2014 YTD
- Rate Year 2017 Potential Updates
- Next Steps

MHAC Program

- Uses list of 65 Potentially Preventable Complications (PPCs) developed by 3M.
- PPCs are defined as harmful events (accidental laceration during a procedure) or negative outcomes (hospital acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of underlying disease.
- 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.

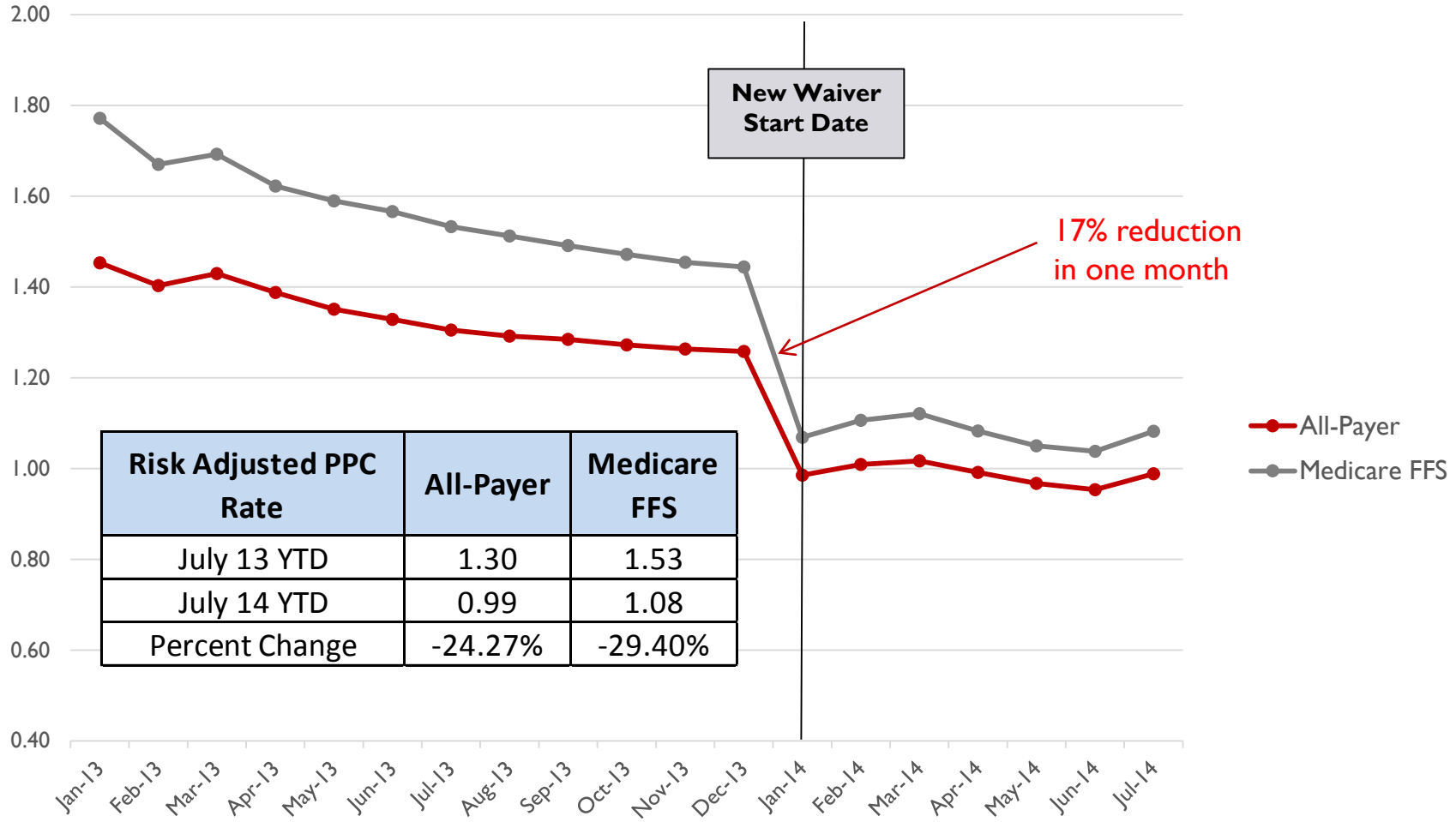
Guiding Principles

- **Achieve the new All-payer model goal of a 30% reduction in all 65 PPCs by the end of 2018.**
- Breadth and impact of the program must meet or exceed the Medicare national program in terms of measures and revenue at risk.
- Improve care for all patients, regardless of payer
- Prioritize PPCs that are high volume, high cost, have opportunity for improvement and are areas of national focus.
- Predetermined performance targets and financial impact
- Encourage cooperation and sharing of best practices
- Hold harmless for lack of improvement if attainment is highly favorable.
- Ability to track progress

MHAC Methodology

Dimension	MHAC Program RY2016
Performance Metric	Observed/Expected Ratio
Weights	Three tiers; high cost/high prevalence weighted more heavily (50% of total score)
Case Mix Adjustment	APR-DRG/Severity of Illness with limited case + small cell size exclusions (at risk<10, expected <1)
Attainment/ Improvement	Better of attainment or improvement
Performance Standards	• Threshold (0 Points): State average • Benchmark (Full Points): Ratio of cases from top 25% best hospitals • Serious Reportable Events:0
Scaling	• Point-based preset scaling, may not be revenue neutral • Statewide performance impacts the scaling results

Results: Risk-Adjusted PPC Rates YTD



Risk Adjusted PPC Rate	All-Payer	Medicare FFS
July 13 YTD	1.30	1.53
July 14 YTD	0.99	1.08
Percent Change	-24.27%	-29.40%

Note: Based on final data for January 2013 - June 2014 and preliminary data for July 2014.

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Improvements in All-Payer Risk-Adjusted PPC Rates YTD by Hospital

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Rate Year 2017
Base and Performance Periods

- Base Period = FY2014
- Performance Period = CY2015

RY2017 Update Considerations

- Basic Approach: Keep the changes to minimum necessary
- Statewide minimum improvement target
- Maximum at risk amounts
- Scaling methodology
  - Current policy would have preset scale based on FY2014 scores
- Other Potential changes
  - Tiering of PPCs/Serious Reportable Events
  - Case level and small hospital exclusions
  - 3M PPC Clinical Definitions
    - Version 32 changes
    - Submit any additional clinical recommendations/concerns

Discussion

New All-Payer Model for Maryland
Performance Measurement Workgroup Meeting

9/19/2014

Draft Rate Year 2017 Readmission Reduction Incentive Program Potential Updates

HSCRC
Health Services Cost Review Commission

Presentation Contents

- Program Overview and Guiding Principles
- Brief Summary of Current Methodology and Results for 2014 YTD
- Rate Year 2017 Potential Updates
- Next Steps

Readmission Reduction Incentive Program

- Maryland's readmission rates are high compared to the nation.
- The CMMI all-payer model demonstration contract established a readmission reduction target that requires Maryland Medicare rates to be equal or below National Medicare rates by 2018.
- For RY2015 any hospital who meets or exceeds a 6.76% readmission reduction target, will be eligible for up to a 0.5% provided that the update factor is favorable.

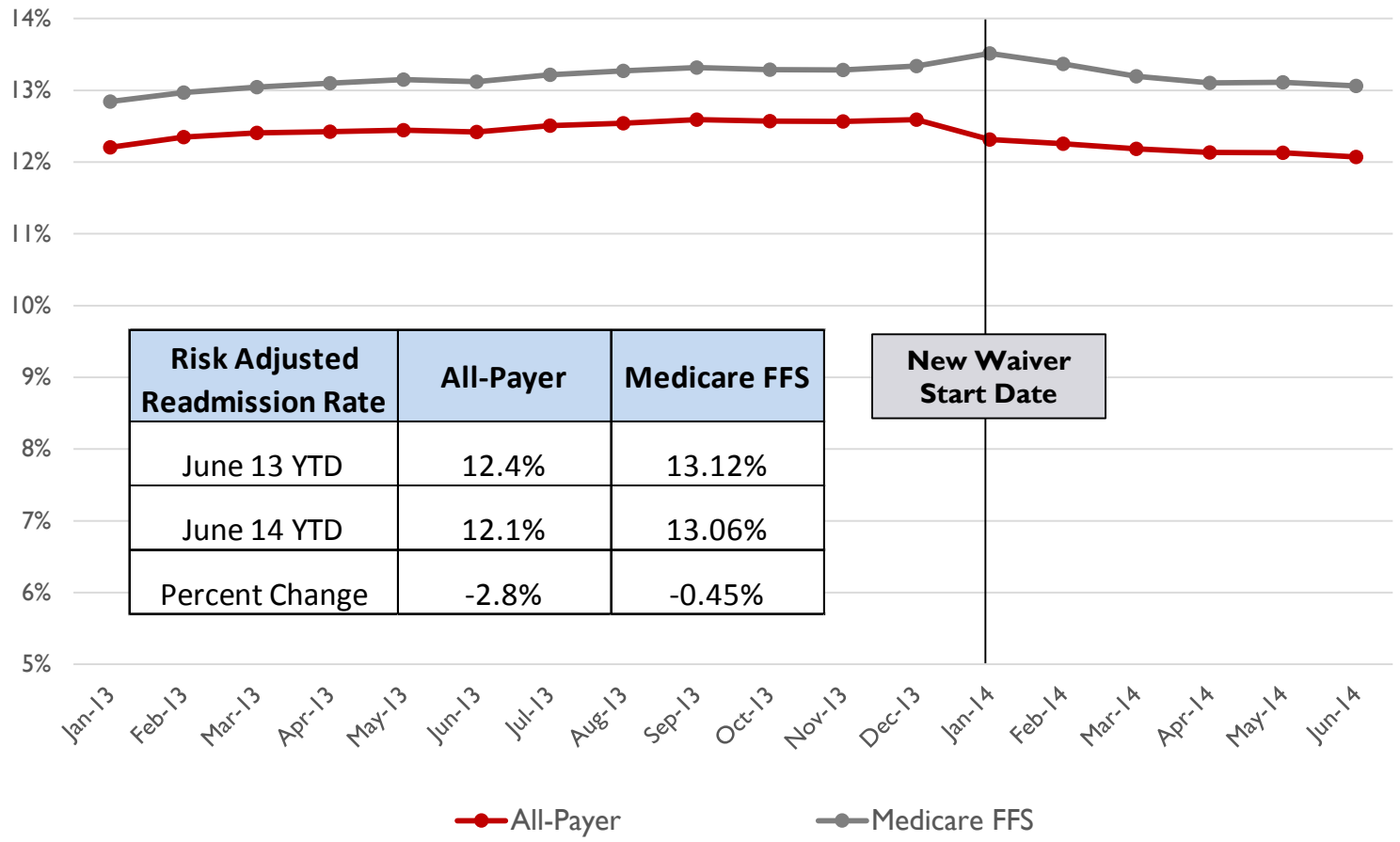
Guiding Principles

- Measurement used for performance linked with payment must include all patients regardless of payer.
- Measurement must be fair to hospitals.
- Annual targets must be established to reasonably support the overall goal of equal or less than the National Medicare readmission rate by CY 2018.
- Measure used should be consistent with the CMS Measure of Readmissions.
- Ability to track progress.

RY2015 Performance Metric

- Risk-Adjusted Readmission Rate
  - 30-Day
  - All-Payer
  - All-Cause
  - All-Hospital (both intra and inter hospital)
- Exclusions:
  - Planned readmissions (CMS Planned Admission + all deliveries)
  - Deaths
  - Same-day transfers
  - Rehabilitation Hospitals

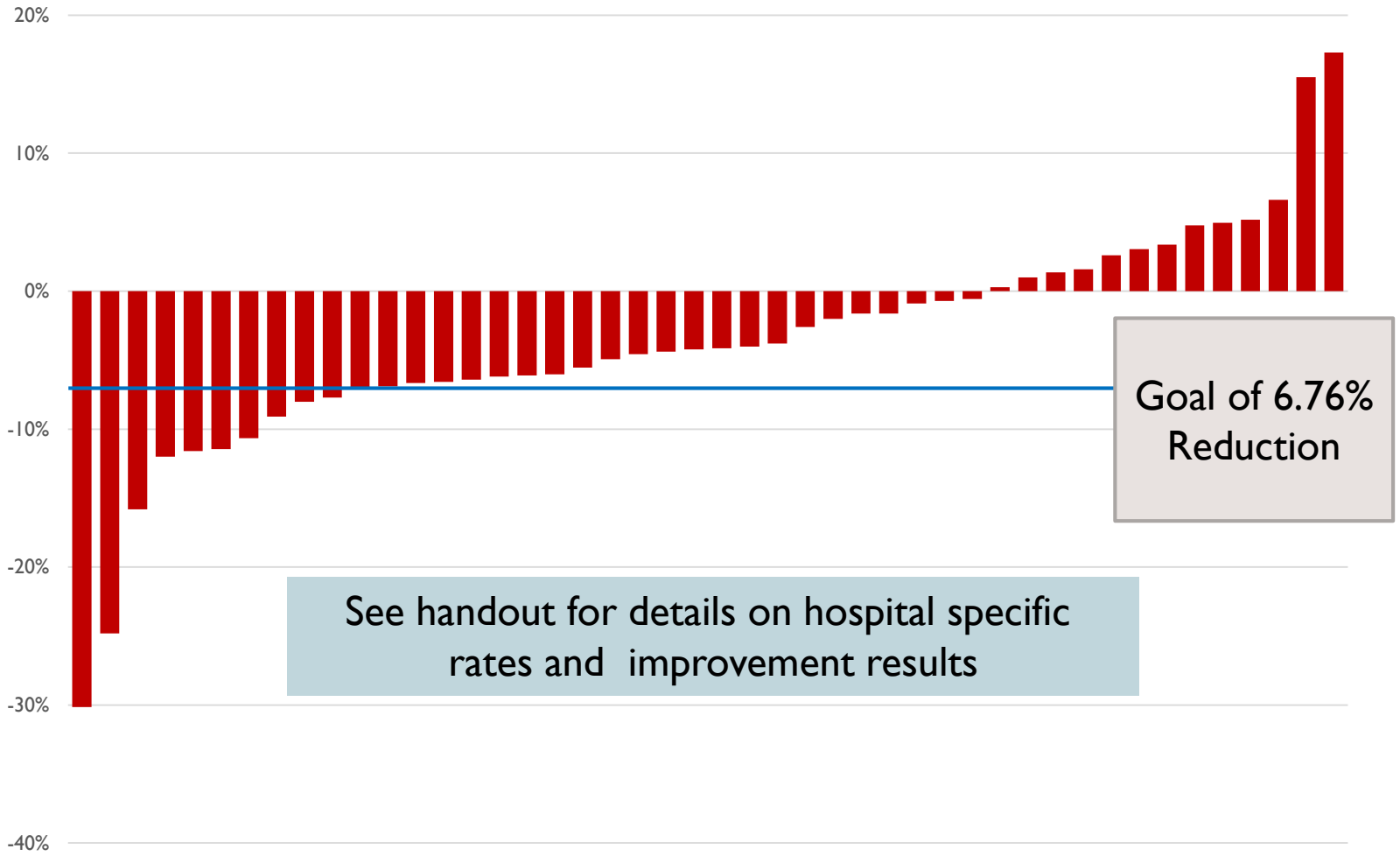
Results:
Risk-Adjusted Readmission Rates YTD



Risk Adjusted Readmission Rate	All-Payer	Medicare FFS
June 13 YTD	12.4%	13.12%
June 14 YTD	12.1%	13.06%
Percent Change	-2.8%	-0.45%

Note: Based on final data for January 2013 - June 2014 and preliminary data for July 2014.

Improvement in All-Payer Risk-Adjusted Readmission Rates YTD by Hospital



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Rate Year 2017
Base and Performance Periods

- Base Period = FY2014
- Performance Period = CY2015

RY2017 Update Considerations

- Statewide and hospital-specific target
- Payment incentive structure and amount
- Exclusions/Adjustments
  - CMS planned admission algorithm update
  - Exclusions: Multiple-births
- With proper adjustments, consider addition of attainment to the model
  - Out-of-State readmissions
  - Risk-adjustment beyond APR-DRG SOI

Discussion