Overview of Maryland’s Quality Programs and Performance Based Payment Methodologies

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Presentation Overview

- Introduction
- Overview of Quality Programs FY18
- HSCRC Current Priorities/Future Direction
- Maryland Quality Approach Compared to National Medicare
- MHA Quality Strategy and Rate Year 2018 Priorities
Maryland Hospitals are Exempt from CMS Quality Programs

- All-payer demonstration agreement provides exemptions from CMS Hospital Acquired Conditions policy and CMS readmissions policies provided that Maryland meets annual performance targets.
- Maryland programs must meet or exceed the CMS percent of revenue at-risk for quality programs.
- Exemption from CMS Value Based Purchasing (VBP) program requires annual exemption request and performance evaluation.
- Failure to meet quality tests does not result in loss of waiver, but may lead to loss of exemption from national quality programs.
Introduction

- Maryland’s hospital quality initiatives are part of overall efforts in the State to achieve the three-part aim of better care for individuals, better health for populations, and reduced costs for all patients.

- Since 2008, Maryland has steadily expanded the magnitude and scope of its quality payment reform initiatives to ensure they remain consistent in design and intent with Medicare’s quality programs.

- In addition, the HSCRC has implemented several payment strategies designed to reduce utilization and readmissions, and improve the efficiency and effectiveness of hospital care in the State.

- The HSCRC performance-based payment methodologies, magnitudes “at risk”, and global payment arrangements are important policy tools for to promote hospital quality improvement.
Quality Targets Under New Model

• The new waiver contract requires that the breadth and impact of Maryland’s quality programs must meet or exceed Medicare’s quality programs in terms of measures and aggregate revenue at-risk.

• The new waiver contract also sets specific targets for complications, readmissions, and overall cost-savings:
  – 30% reduction in hospital-acquired conditions across 65 PPCs
  – Reduction in Medicare readmissions rate to at or below national rates
  – $330M in Medicare savings under the national Medicare trend
Maryland Quality-Based Payment Programs

QBR (Quality Based Reimbursement)
- Clinical Process of Care Measures
- Patient Experience of Care (HCAHPS)
- Mortality
- Safety

MHAC (Maryland Hospital-Acquired Conditions)
- Based on 3M Potentially Preventable Complications

Readmissions Reduction Incentive Program
30-day, all-cause, all hospital readmissions
Quality Programs for FY 2018 Rates

• QBR (2% penalty, 1% reward)
  – Changes in domain weighting with emphasis on HCAHPS
  – Relative scaling eliminated in FY17
  – FY18 payment scale still under development (estimated February/March)

• MHAC (FY18: TBD; FY17: 3% penalty, 1% reward)
  – CY2016 performance compared to FY2015 base period
  – 6% minimum statewide improvement target

• FY17 Readmissions (2% penalty, 1% reward)
  – Scaled penalties of up to 2% and rewards of up to 1%
  – 9.3% minimum reduction comparing CY2013 to CY2015
  – FY18 readmissions policy still under development
FY 2018 QBR Domains and Measures

- **Patient Experience/Care Coordination:**
  - HCAHPS + 3-item Care Transitions Measure

- **Clinical care**
  - Mortality

- **Safety:**
  - Central-Line Blood Stream Infections
  - Catheter-Related Urinary Tract Infections
  - Surgical Site Infections: Colon and Hysterectomy
  - **NEW:** MRSA, c.Diff, PC-01
  - **SUSPENDED:** Patient Safety Index-90
Patient Experience: MD vs. National

CY2014 Maryland and National HCAHPS Scores

- Maryland
- National
FY 2018 MHAC Program Update

• Commission approved using keeping FY17 methodology for FY18 payment program
  – Staff believe the current approach balances hospital-specific incentives with state goals, sets continuous specific quality improvement goals, and focuses the payment adjustments on best and worst performers.

• Modification of PPCs included in program and tiers
  – Change to two tiers (weighted at 100% and 50%)
  – Move 5 PPCs with lower reliability to monitoring only status
  – Create three additional combination PPCs for scoring purposes
  – Benchmark Update – Top 25th best Performance by Patient Population

• Memo to hospitals on updates in early February
Monthly Case-Mix Adjusted PPC Rates

- Based on final data through September 2015.
- Excludes PPC24.

<table>
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<th>New Waiver Start Date</th>
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Note: Based on final data through September 2015. Excludes PPC24.

<table>
<thead>
<tr>
<th>Risk Adjusted PPC Rate</th>
<th>All-Payer</th>
<th>Medicare FFS</th>
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<tbody>
<tr>
<td>CY13 Sept. YTD</td>
<td>1.15</td>
<td>1.37</td>
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<tr>
<td>CY14 Sept. YTD</td>
<td>0.85</td>
<td>0.96</td>
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<tr>
<td>CY15 Sept. YTD</td>
<td>0.76</td>
<td>0.88</td>
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<tr>
<td>CY13 - CY15 YTD Percent Change</td>
<td>-33.91%</td>
<td>-35.77%</td>
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Change in All-Payer Risk-Adjusted PPC Rates YTD by Hospital

Notes:
Based on final data for July 2013 – September 2015.
Excludes McCready Hospital due to small sample size and PPC 24.
FY 2018 Readmission Reduction Incentive Program
CMMI readmission measure specification refinements reduced the difference between Maryland and National readmission rates to 7.9% in CY2013

- **Refinements include**
  - Requiring 30 day enrollment period after hospitalization
  - Excluding special-licensed beds from Maryland rates similar to the national rate
  - Refining transfer logic
1/3 of the hospitals are meeting the reduction target, 1/4 have increases in their readmission rates (YTD August)
Monthly Case-Mix Adjusted Readmission Rates

New Waiver Start Date

<table>
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<th>Case-Mix Adjusted Readmission Rate</th>
<th>All-Payer</th>
<th>Medicare FFS</th>
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<tr>
<td>CY13 Oct. YTD</td>
<td>13.84%</td>
<td>14.57%</td>
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<tr>
<td>CY14 Oct. YTD</td>
<td>13.40%</td>
<td>14.43%</td>
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<tr>
<td>CY15 Oct. YTD</td>
<td>12.84%</td>
<td>13.65%</td>
</tr>
<tr>
<td>CY13 - CY15 YTD Percent Change</td>
<td>-7.24%</td>
<td>-6.35%</td>
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**Definition:** “Hospital care that is unplanned and can be prevented through improved care coordination, effective primary care and improved population health.”

**Components of PAU**

- Potentially Avoidable Admissions
- Readmissions/Revisits
- Hospital Acquired Conditions

HSCRC Calculates Percent of Revenue Attributable to PAU
Prevention Quality Indicators

- Admissions for conditions for which good outpatient care could potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.
  - Examples: Diabetes long-term complications, bacterial pneumonia, heart failure, hypertension

- Reducing PQI admissions is critical for success in meeting Medicare financial targets.

- HSCRC staff inclined to increase the importance of PQIs in pay for performance programs (possibly adding shared savings requirements for FY18).
Future Direction: Patient Centered Outcomes

• Measures specific to certain patient population
  – Cancer, Orthopedic Surgery, Colonoscopy, Deliveries etc.

• Composite measures with different domains (e.g., STAR Rating)
  – Episode cost, quality outcomes, satisfaction, efficiency

• Population based
  – Population health, provider alignment, cost per capita
  – Electronic Medical Records- clinical outcomes (Diabetes, hypertension control, etc.)

• Development of consumer dashboard
Future Direction:
GBR Investments/Care Coordination

• HSCRC staff will be developing better performance measurement strategy for GBR investment reports, and implementation grants to track outcomes and progress in care management programs.

• Key Outcome Measures:
  – Total hospital/health care cost per capita, readmission, PAU

• Key Process Measures:
  – Use of encounter notification alerts, completion of health risk assessments, established longitudinal care plan

• Key Cost/Savings Measures:
  – Return on investment
Maryland P4P Risk Compared to the Nation

- All-payer demonstration contract language
  
  *The state must ensure that the aggregate percentage of regulated revenue at risk for quality programs...is equal to or greater than the aggregate...at risk under national Medicare quality programs.*

- Compares the Maryland all-payer percent of inpatient revenue to the national Medicare inpatient revenue

- Includes readmissions reduction policy and readmissions shared savings; complications; QBR/VBP; and for Maryland, PAU in the demographic adjustment

- Federal regulators interpret this language to require 3 separate ways of evaluating amount at risk
  
  - Percent at risk for all programs, including readmissions, complications, and QBR/VBP is equivalent. Currently at 6 percent.
  
  - “Realized risk” or the percent of inpatient revenue actually awarded or penalized is equivalent to the nation. In this measure, it’s the absolute value of the risk, so a 1 percent reward and a 1 percent penalty add up to 2 percent. As of FY 2017, Maryland estimated to be 0.23 percent above nation.
  
  - Cumulative percent at risk beginning with FY 2014. As of FY 2017, Maryland risk 2.72 percent above national
Maryland Quality Approach Compared to National

- Maryland sets performance expectations tied to specific, pre-determined payment consequences. National quality programs do not attempt to define performance targets, instead they penalize the lowest quartile of hospitals, regardless of score.

- All Maryland programs include penalties and rewards with the possibility that all hospitals achieving performance expectations can receive payment rewards. In Maryland, quality programs are designed to improve performance at all hospitals; not explicitly for the purpose of cost savings.

- Nationally, only the VBP program provides rewards; national HAC and readmissions programs are penalty-only and count penalties as “cost savings” to the system.

- Maryland performance targets are clear, predictable, and prospective.
MHA Quality-Related Policy Strategy

• Focus on the complications that really make a difference in health care outcomes, health care costs and people’s lives
• Continue to measure all-payer readmissions and track Medicare readmissions rates
• Structure payment policies to support good performance on those metric
• Build on progress in reducing complications and readmissions, where it is appropriate and beneficial to patient outcomes
• As hospitals’ expand focus to alignment with external partners, consider how that alignment should be reflected in quality measurement and policy
MHA Quality Priorities for FY 2018  
(CY 2016 Measurement)

Readmissions Policies

• **HSCRC Payment Policy vs All-Payer Demonstration Test**
  • Demonstration test is Medicare un-adjusted readmissions compared to nation, based on claims data

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<th>CY 2013</th>
<th>Jan-Aug 2015</th>
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<tbody>
<tr>
<td>Maryland</td>
<td>16.31%</td>
<td>15.98%</td>
</tr>
<tr>
<td>US</td>
<td>15.38%</td>
<td>15.37%</td>
</tr>
<tr>
<td>Gap</td>
<td>8.0%</td>
<td>3.9%</td>
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- HSCRC payment policy is all-payer risk-adjusted, includes in-state readmissions only. Jan-Aug 2015 rate = 12.85%

- Important to recognize Maryland’s collective status on Medicare readmissions relative to nation— all-payer demonstration test
MHA Quality Priorities for FY 2018 (CY 2016 Measurement)

Readmission payment policies

- Recognize attainment and improvement—what is a “good” readmission rate for your hospital?
- Important to consider other factors in evaluating actual readmissions rate
  - Consider: social and demographic characteristics of neighborhood, i.e., health literacy, availability of social support, etc.; presence of a behavioral health or substance abuse diagnosis; patient’s age; and additional co-morbidities in addition to case-mix and severity of illness
  - Coordinate with HSCRC socio-demographic sub-group and other work HSCRC is doing to enhance risk adjustment in readmissions policy
  - Maintain incentive to address health disparities
Readmission payment policies

- Barriers include data limitations, especially on the social factors that influence readmissions, such as support at home, health literacy, family income.
- There are no nationally accepted risk-adjustment models that consider medical conditions and the wide variety of other factors that influence readmissions.
- Understand where there are opportunities to improve and when other areas may present greater opportunity, e.g., PQI, population health.
- For payment policy, hospitals must be able to monitor status with monthly data.
- An alternative approach is to develop a risk modeling tool that could be deployed for care management.
MHA Quality Priorities for FY 2018 (CY 2016 Measurement)

• Complications
  • Maryland hospitals have met the 30% MHAC reduction target
  • Focus on PPCs with greatest clinical opportunity to improve patient outcomes and cost savings
  • Clinicians identified about 15 conditions where there are evidence based guidelines for prevention or other opportunities for clinical improvement
  • Continue to work with hospitals and 3M on MHAC definitions
Speaker Biographies

• **Alyson Schuster, PhD, MPH, MBA** is the Associate Director of Performance Measurement at the Health Services Cost Review Commission. In this role, Alyson oversees hospital quality-based payment initiatives designed to improve hospital quality and reduce costs. Prior to joining the HSCRC, she managed a team of analysts responsible for implementing and evaluating care management interventions at a managed care organization. Alyson has a doctorate in health services research from Johns Hopkins Bloomberg School of Public Health.

• **Traci La Valle** is Vice President, Rate Setting, at the Maryland Hospital Association where she advocates for Maryland's hospitals, health systems, communities, and patients primarily before state regulatory bodies. In her role, she works to ensure fair and reasonable hospital payment policies that provide appropriate incentives to improve quality and reduce avoidable costs. In her twelve years at MHA, she has held progressively responsible roles covering a range of issues that affect Maryland hospitals’ finances. Most recently, she worked with hospital representatives and state regulators to restructure the incentives to reduce hospital complications and is currently revising policies related to readmission measurement and related payment incentives. Traci has a Master of Public Health and a Certificate in Health Finance and Management from Johns Hopkins School of Public Health, and a Bachelor of Science in Physical Therapy from Temple University.