Rate Year 2020 Quality Programs

June 19, 2018

Covered in this Presentation

- Introduction
  - Maryland All-Payer Model
  - Performance Based Payment Programs Overview
- Rate Year 2020 Approved Program Updates:
  - MHAC Program
  - QBR Program
  - RRIP Program
- RY 2019 PAU Savings
- RY 2020 (Expected) Maximum Guardrail under Maryland Hospital Performance-Based Programs
- CRISP Reports to Track Hospital Progress
- HSCRC Resources
- Q and A

Webinar Housekeeping

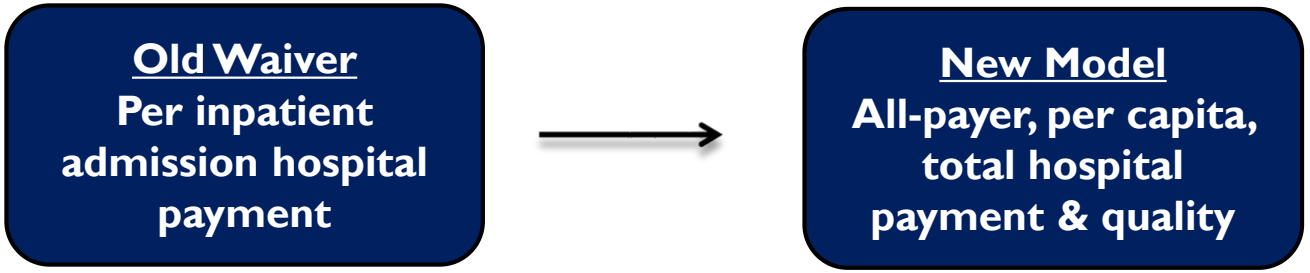
HSCRC
Health Services Cost Review Commission

Maryland All-Payer Model Overview

HSCRC
Health Services Cost Review Commission

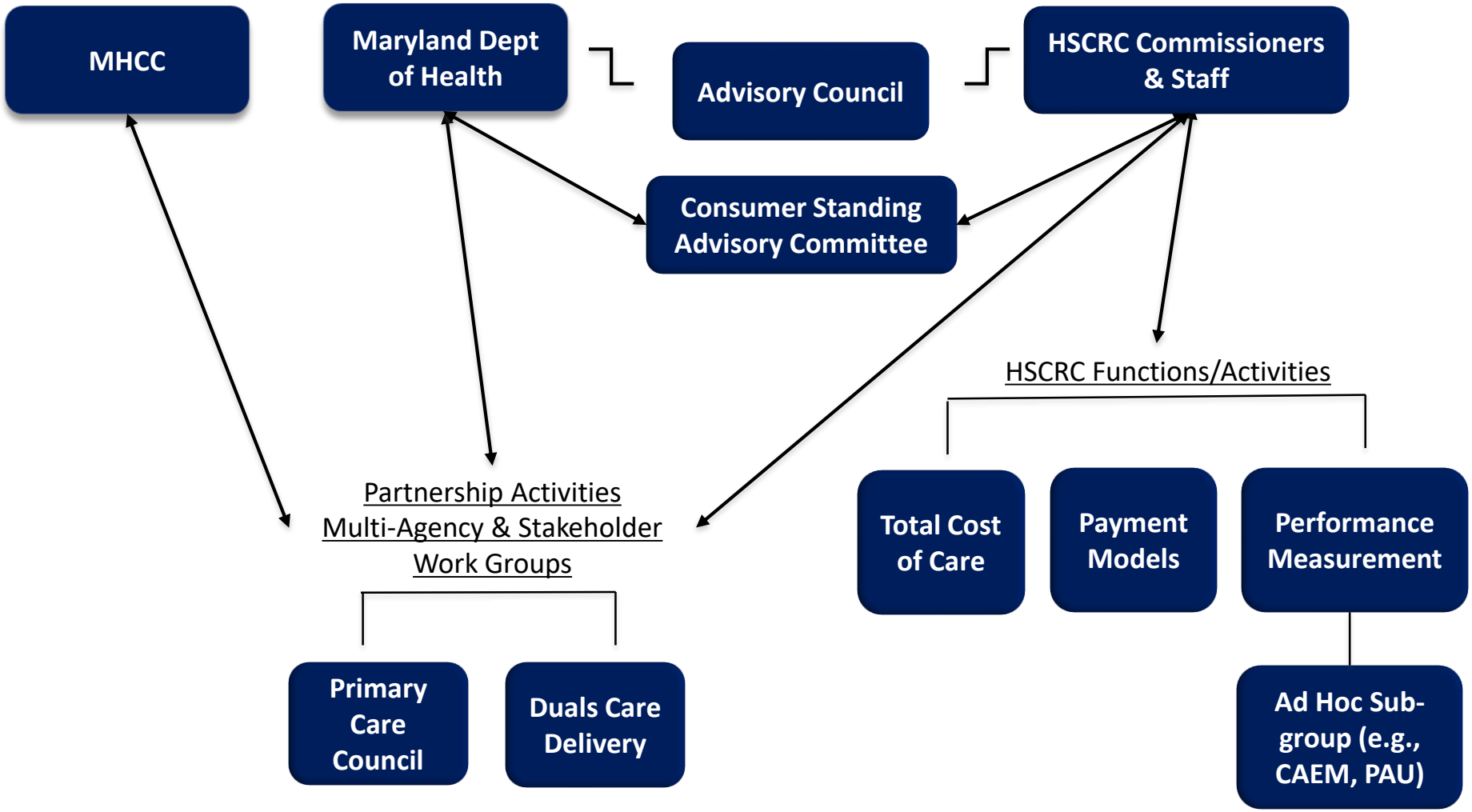
Unique New Model: Maryland's All-Payer Model

- Maryland is implementing an All-Payer Model for hospital payment
  - Approved by Center for Medicare & Medicaid Services (CMS) effective January 1, 2014 for 5 years
  - Modernizes Maryland's Medicare waiver and unique all-payer hospital rate system



- Key provisions of the new Model:
  - Hospital per capita revenue growth ceiling of 3.58% per year, with savings of at least $330 million to Medicare over 5 years
  - Patient and population centered-measures to promote care improvement
  - Payment transformation to global and population based for hospital services
  - Proposal covering all health spending, to include at least Medicare patients, presented at the end of Year 3 for 2019 and beyond

Stakeholder Input Structure



HSCRC
Health Services Cost Review Commission

HSCRC Performance-based Payment Programs Overview

HSCRC Performance Measurement Workgroup

- Comprises **broad stakeholder group** of hospital, payer, quality measurement, e-health quality, academic, consumer, and government agency experts and representatives
- Meets **monthly** with in-person and virtual participation
  - **Meetings are public** and materials are publicly available
- Reviews and recommends **annual updates** to the performance-based payment programs
- Considers and recommends **strategic direction** for the overall performance measurement system
  - Focus on **high-need patients** and **chronic condition** management
  - Build **care coordination** performance measures
  - Broaden focus to **patient-centered population health**
  - Align to the extent possible with **CMS Star Rating approach**
  - Incorporate **new measures** as available, such as Emergency Department, Outpatient, measures etc.

Guiding Principles For HSCRC 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
- Consider all settings of care

Performance Based Payment Programs: Maryland and CMS National

Maryland

- Quality Based Reimburse-ment (QBR)
- Potentially Avoidable Utilization (PAU) Savings
- Readmission Reduction Incentive Program (RRIP)
- Maryland Hospital Acquired Conditions (MHAC)

CMS National

- Value Based Purchasing
- Hospital Readmissions Reduction Program
- Hospital Acquired Condition Reduction

RY 2020 Quality Program Timelines

Rate Year (Maryland Fiscal Year)	Q3-16	Q4-16	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20	Q3-20	Q4-20
Calendar Year	Q1-16	Q2-16	Q3-16	Q4-16	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20
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)									
QBR	Hospital Compare Base Period*														Rate Year Impacted by QBR Results			
								Hospital Compare Performance Period*										
			Maryland Mortality Base Period															
									QBR Maryland Mortality Performance Period									
RRIP Incentive	RRIP Base Period (Proposed)														Rate Year Impacted by RRIP			
									RRIP Performance Period (Proposed)									
PAU Savings									PAU Savings Performance Period						Rate Year Impacted by PAU Savings			

HSCRC
Health Services Cost Review Commission

Rate Year (RY) 2020 Quality Program Updates

RY 2020 Maryland Hospital Acquired Conditions (MHAC) Program

MHAC Program

- Uses Potentially Preventable Complication (PPCs) measures developed by 3M Health Information Systems.
- PPCs are post-admission (in-hospital) complications that may result from hospital care and treatment, rather underlying disease progression
  - Examples: Accidental puncture/laceration during an invasive procedure or hospital acquired pneumonia
- 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.

Rate Year 2020

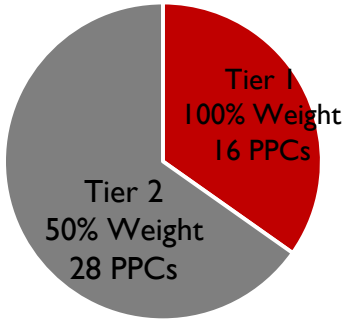
- Base Period = FY 2017 (July 2016-June 2017)
  - Used for normative values for case-mix adjustment
- Performance Period = CY2018
- 3M APR-DRG and PPC Grouper Version 35

MHAC Methodology

Overview of MHAC Methodology

Potentially Preventable Complication Measures

RY 2020: Restrict to diagnosis and PPC pairings where >80% of complications occurred in base.



Global Exclusions:

- Palliative care
- Discharges >6 PPCs
- Apr-DRG SOI cells with less than 30 at-risk discharges

Hospital PPC Exclusions:

- <10 at-risk discharges
- <1 expected PPC

Case-Mix Adjustment and Standardized Scores

PPC scores (0-10 points) calculated using observed to expected ratios.

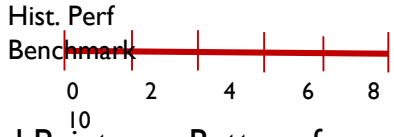
Expected calculated by applying statewide average PPC rates by APR-DRG-SOI to hospitals case-mix (i.e., indirect standardization).

Threshold: State Median (O/E=1)

Benchmark: Top performing hospitals w/ 25% discharges

Attainment Points:

Improvement Points:



Final Points are Better of Improvement or Attainment

Hospital MHAC Score & Revenue Adjustments

Hospital MHAC Score is Sum of Earned Points / Possible Points with Tier Weights Applied

Scores Range from 0-100%, with revenue neutral zone 45-55%

Max Penalty 2% & Reward +1%

Abbreviated Preset Scale	MHAC Score	Financial Adjustment
Max Penalty	**0%**	**-2.00%**
	10%	-1.56%
	20%	-1.11%
	30%	-0.67%
	40%	-0.22%
Penalty/Reward Cut Point (Range)	**45-55%**	**0.00%**
	60%	0.11%
	70%	0.33%
	80%	0.56%
	90%	0.78%
Max Reward	**100%**	**1.00%**

Performance Metric

- Hospital performance is measured using the Observed (O) / Expected (E) ratio for each PPC.
- Lower number = Better performance
- Expected number of PPCs for each hospital are calculated using the base period statewide PPC rates by APR-DRG and severity of illness (SOI).
  - See Appendix B of RY2020 MHAC Memo for details on how to calculate expected numbers

Normative values for calculating expected numbers are included in MHAC Excel workbook.

Adjustments to PPC Measurement

- Adjustments are done to improve measurement fairness and stability.
- Exclusions:
  - Palliative care cases
  - Cases with more than 6 PPCs
  - For each hospital, PPCs will be excluded if during the base period:
    - The number of cases at-risk is less than 10
    - The number of expected cases is less than 1

List of hospital specific excluded PPCs is included in MHAC Excel workbook.

- NEW RY 2020:
  - Restrict P4P program to the diagnosis-complication pairings where at least 80% of complications occurred during the base period
  - Increase the number of at-risk cases required per APR-DRG SOI statewide from 2 to 31
    - These changes were to address concerns regarding "zero norms"

Example 80% Restriction

- APR-DRG-PPC Groupings: Each combination of APR-DRG (328 in total) and clinically eligible PPC included in payment program (44 PPC/PPC combos in total).

APR-DRG	PPC	Sorted by Observed Counts (highest to lowest)	% of Total Observed PPCs	Cumulative Percent
720	14	45	23%	23%
181	39	36	18%	41%
540	59	25	13%	53%
194	14	22	11%	64%
720	1	21	11%	75%
230	42	11	6%	80%
230	9	11	6%	86%
540	60	9	5%	90%
560	59	9	5%	95%
166	8	6	3%	98%
190	52	3	2%	99%
201	6	2	1%	100%
Observed PPCs across all groupings		200		

RY 2020 PPCs

- Total 41 individual PPCs and three PPC combos included in payment program
  - 9 PPCs included in Three Combo PPCs
    - New combo for RY 2020: Infection Combo (PPC 34 Moderate Infections, 54 Infections due to Central Venous Catheters, 66 Catheter Associated Urinary Tract Infection)
  - Hospitals scored on up to 44 PPC/PPC combos
- Seven PPCs (2, 15, 20, 29, 33, 36, 21) with lower reliability moved to a monitoring-only status and will not be scored for payment purposes.

The MHAC Excel workbook contains data on individual PPCs and PPC combos. Monitoring reports for all clinically valid PPCs are under development.

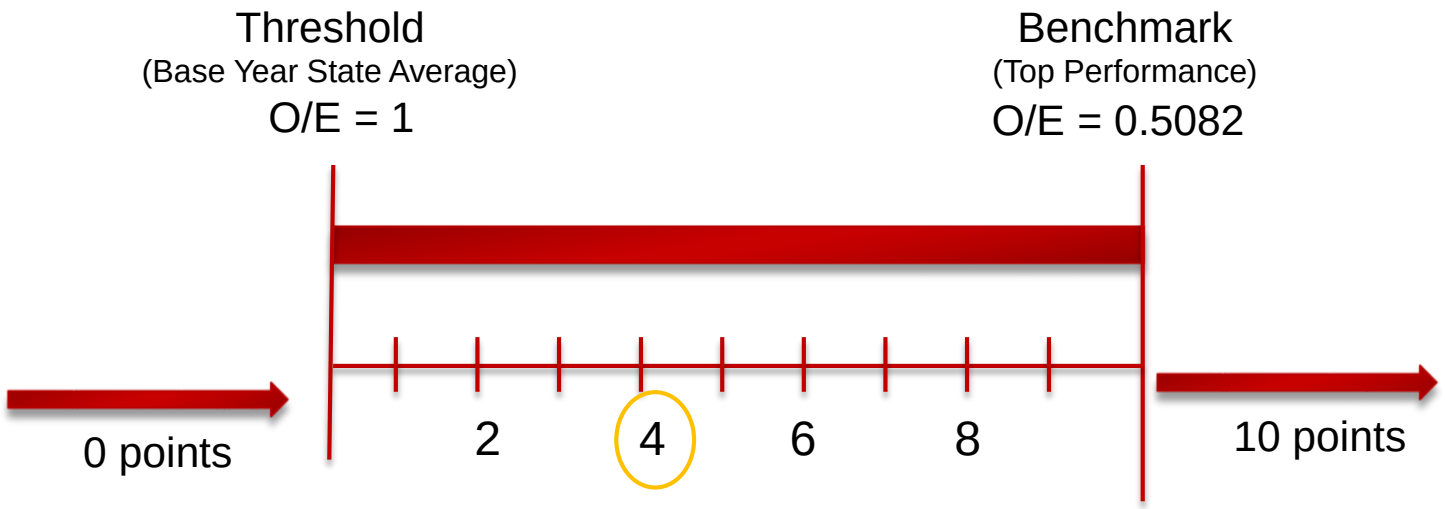
PPC Scoring: Benchmarks and Thresholds

- A threshold and benchmark value for each PPC/PPC combo is calculated based upon the base period data
  - Used to convert O/E ratio for each measure to a score
  - Threshold = weighted mean of all O/E ratios (O/E =1)
  - Benchmark = weighted mean of the O/E ratios for top performing hospitals that account for a minimum 25% of statewide discharges
- For serious reportable events, the threshold and benchmark are 0 (PPC 30, 31, 32, 45, and 46).

Thresholds and Benchmarks are included in MHAC Excel workbook.

MHAC Score: Attainment Score

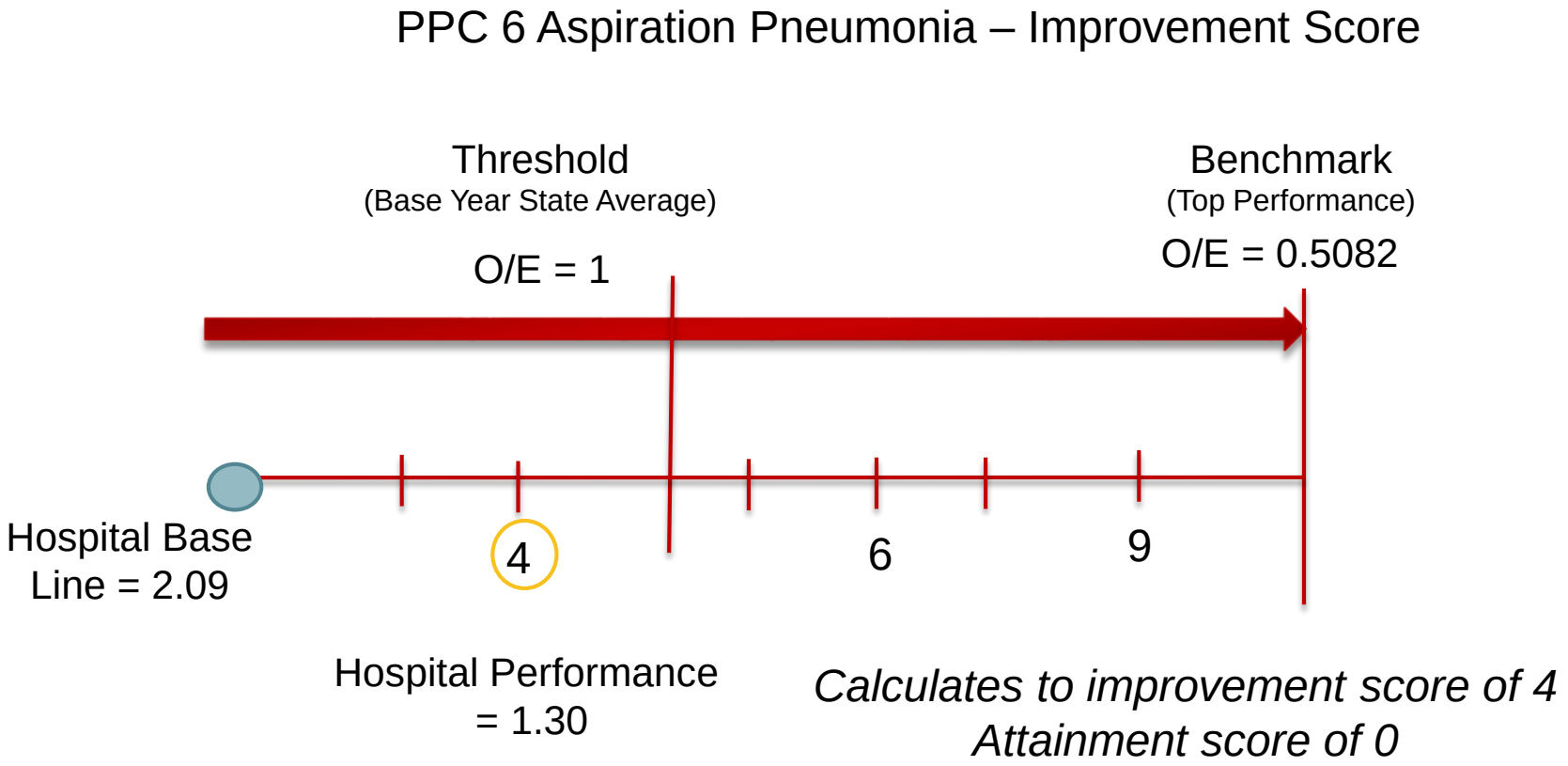
PPC 6 Aspiration Pneumonia – Attainment Score



Hospital = 0.82

Calculates to an attainment score of 4

MHAC Score: Better of Attainment or Improvement



HSCRC
Health Services Cost Review Commission

PPC Tiers

- PPCs are in tiers that are weighted differently to put more emphasis on the "target" PPCs.
- Two 'tiers' of MHACs/PPCs
  - Tier 1 – Target list– High volume, high cost, and opportunity for improvement and national focus
  - Tier 2 – All other PPCs, including those with very low volume, affecting low number of hospitals, Obstetric-related PPCs

Tier	Weighting	# of PPCs/Combos
1	100%	16
2	50%	28

Calculation of Overall MHAC Score

- The final score is calculated across all PPCs included for each hospital
  - Scores range from 0 to 1 (or 0% to 100%)
  - Scores are then used to calculate revenue adjustments

The MHAC Excel workbook provides PPC specific points and Hospital MHAC Scores.

MHAC Revenue Adjustments

- No statewide improvement goal
- Revenue adjustment scale ranges from 0% to 100%, with hold harmless zone between 45% and 55%.
- Maximum penalty is 2% and maximum reward is 1% of inpatient revenue.

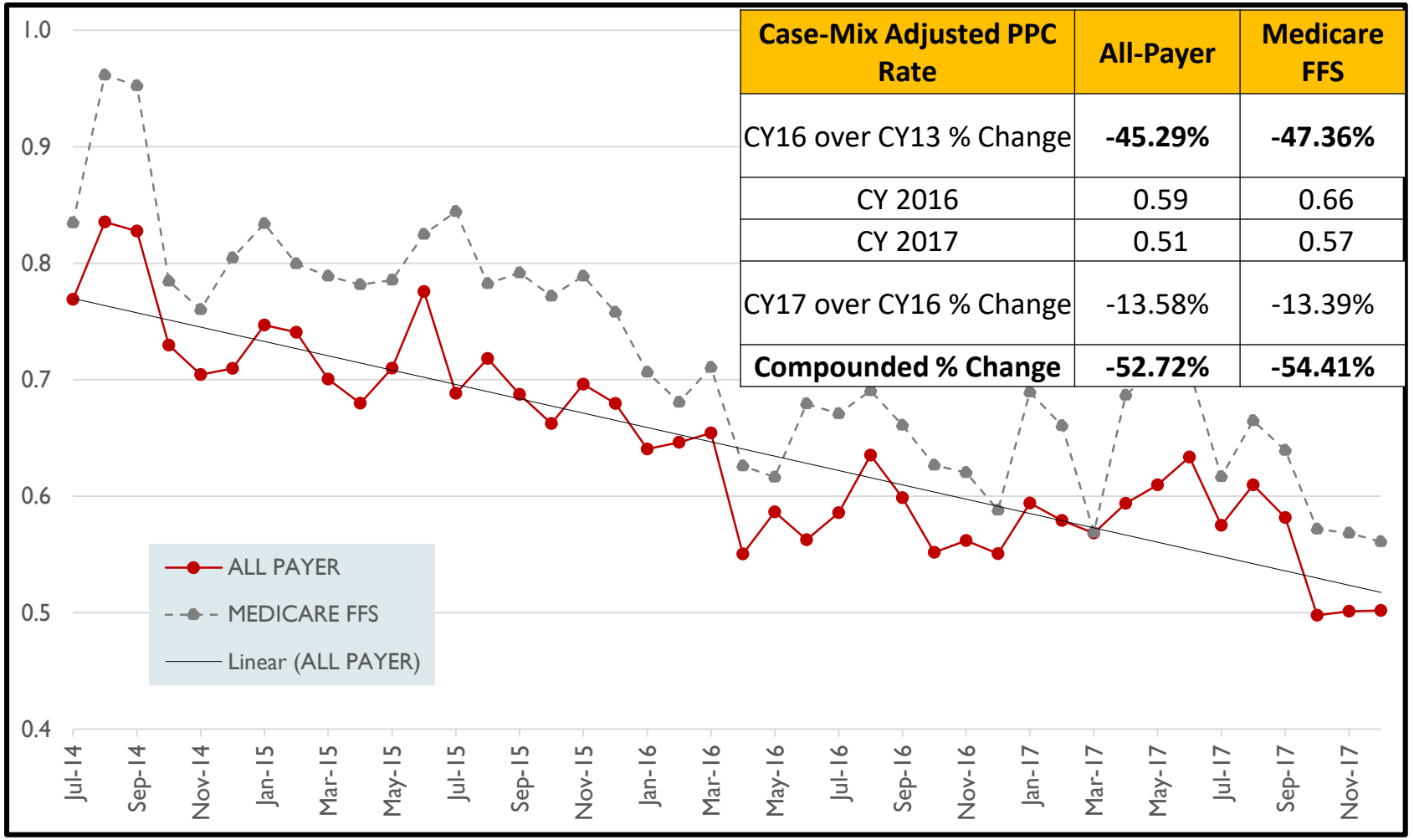
Final MHAC Score	Revenue Adjustment
0%	**-2.00%**
5%	-1.78%
10%	-1.56%
15%	-1.33%
20%	-1.11%
25%	-0.89%
30%	-0.67%
35%	-0.44%
40%	-0.22%
45%	0.00%
50%	0.00%
55%	0.00%
60%	0.11%
65%	0.22%
70%	0.33%
75%	0.44%
80%	0.56%
85%	0.67%
90%	0.78%
95%	0.89%
100%	**1.00%**

RY 2020 Measurement Methodology Recap

- RY 2020 MHAC scoring methodology has not changed significantly.
- Changes include:
  - Restrict P4P program to the diagnosis-complication pairings where at least 80% of complications occurred during the base period
  - Increase the number of at-risk cases required per APR-DRG SOI statewide from 2 to 31
  - Removal of PPC 21
  - New Infection related combination (PPCs 34, 54, 66)

Monthly Case-Mix Adjusted PPC Rates

Case-Mix Adjusted PPC Rate	All-Payer	Medicare FFS
CY16 over CY13 % Change	**-45.29%**	**-47.36%**
CY 2016	0.59	0.66
CY 2017	0.51	0.57
CY17 over CY16 % Change	-13.58%	-13.39%
Compounded % Change	**-52.72%**	**-54.41%**



Note: Line graph based on v32 prior to October 2015; and v34 October 2015 to December 2017; all data are final, but are subject to validation.

Complications under the Enhanced Model (RY2021/CY 2019 Performance)

- No specific reduction goal expected in CMS contract but must maintain performance that is comparable to the nation and suitable for an all-payer quality program.

- Concerns with current MHAC program:
  - No national comparison for PPC measures; poor hospital performance on national HAC measures
  - Large number of complications in payment program
  - Method for case-mix adjustment, especially for low volume events
  - Based on claims data that is subject to documentation and coding improvements

- HSCRC has convened a sub-group of clinical experts to overhaul complications program under the Enhanced Model:
  - Clinical Adverse Events Measures (CAEM) subgroup
  - Currently evaluating NHSN measures, Patient Safety Index, and 3M PPCs:
    - Volume and variation
    - Clinical validity
    - Statistical reliability and validity
    - Risk-adjustment
    - Scoring options

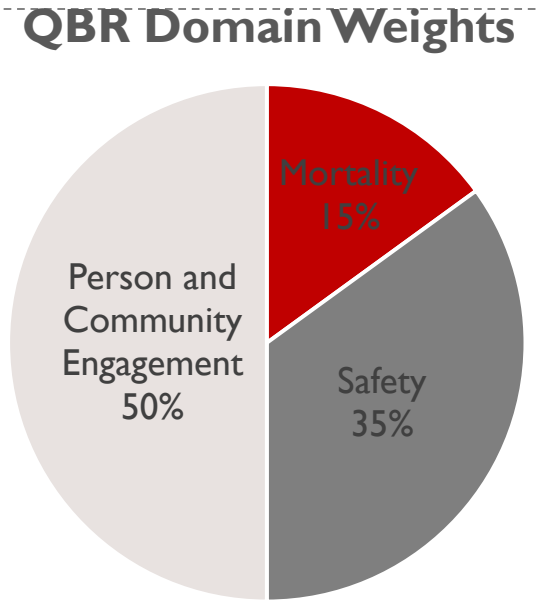
Rate Year (RY) 2020 Quality Based Reimbursement (QBR) Program

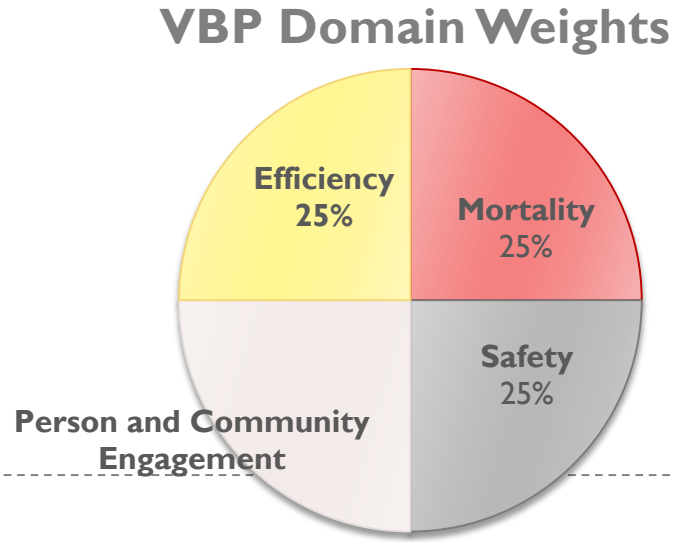
HSCRC
Health Services Cost Review Commission

Quality Based Reimbursement: Domains and Measures

RY 2020 QBR Consists of 3 Domains:

- **Person and Community Engagement (HCAHPS) -** 8 measures + 2 ED wait times measures *(NEW RY 2020)*;
- **Mortality -** 1 measure of in-patient mortality;
- **Safety -** 6 measures of in-patient Safety (infections, early elective delivery).





QBR RY 2020 Overview

MEASURES

- **Person and Community Engagement (PCE)**
  - **HCAHPS**
  - **NEW:** ED Wait Times Measures (ED-1b, ED-2b, stratified by ED volume)
- **Clinical care: Mortality** (Inpatient all-cause)
  - **NEW:** Include Palliative Care (PC) as a risk adjustment for both attainment and improvement (this is an update from last year's hybrid mortality measure which PC **excluded** for attainment and **included** PC for improvement)
  - **SUSPENSION Continued for QBR**: THA/TKA Complications measure (data suppressed for some hospitals)*
- **Safety:**
  - Central-Line Blood Stream Infections
  - Catheter-Related Urinary Tract Infections
  - Surgical Site Infections: Colon and Hysterectomy
  - MRSA,
  - c.Diff,
  - PC-01
  - **SUSPENDED for QBR:** AHRQ Patient Safety Indicator-90 (pending risk-adjustment)

* For VBP FFY 2020, Baseline is July 1, 2010 - June 30, 2013 and is Performance: January 1, 2015 - June 30, 2018

QBR RY 2020 Program Base and Performance Timelines

Rate Year (Maryland Fiscal Year)	Q3-16	Q4-16	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20	Q3-20	Q4-20
Calendar Year	Q1-16	Q2-16	Q3-16	Q4-16	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20
QBR	Hospital Compare Base Period*														Rate Year Impacted by QBR Results			
								Hospital Compare Performance Period*										
			Maryland Mortality Base Period															
									QBR Maryland Mortality Performance Period									

*Hospital Compare measures include the following: All HCAHPS measures, ED-1b, ED-2b; All NHSN Measures, PC-01.

QBR Methodology: Measure Inclusion Rules and Data Sources

- HSCRC will use the **data submitted to CMS for the Inpatient Quality Reporting** program for calculating hospital performance scores for all measures with exception of PSI-90 (currently suspended) and the mortality measure, which are calculated using HSCRC case-mix data.
- When possible, **CMS rules for minimum measure requirements** are used for scoring a domain and for readjusting domain weighting if a domain is missing. **Hospitals must be eligible for scores in 2 of the 3 domains** to be included in the program.
- For hospitals with measures that have **no base period data, attainment only scores** will be used to measure performance on those measures.
- For hospitals that have measures with data missing for the base and performance periods, hospitals will receive scores of zero for these measures.

- **It is imperative that hospitals review the data in the Hospital Compare Preview Reports as soon as it is available from CMS.**

QBR Methodology: Measure Inclusion Rules and Data Sources

DOMAIN	Clinical Care- Mortality	Person and Community Engagement	Safety
Minimum Numbers for Inclusion	- **No minimum threshold** for Hospitals - Statewide: **20 cases for APR-DRG cell** to be included	- At least **100 surveys** for applicable period	- At least **three measures** needed to calculate hospital score - Each NHSN measure requires at least **one predicted infection** during the applicable period
Data Source	HSCRC **Case-Mix Data**	**HCAHPS surveys** reported to CMS Hospital Compare	**CDC- NHSN data** reported to CMS Hospital Compare

QBR Scoring: Points Given for Better of Attainment or Improvement

Hospitals are given points based upon the higher of attainment/achievement or improvement

Attainment

- compares hospital's rate to a threshold and benchmark.
- if a hospital's score is equal to or greater than the benchmark, the hospital will receive 10 points for achievement.
- if a hospital's score is equal to or greater than the achievement threshold (but below the benchmark), the hospital will receive a score of 1–9 based on a linear scale established for the achievement range.

Improvement

- compares hospital's rate to the base year (the highest rate in the previous year for opportunity and HCAHPS performance scores)
- if a hospital's score on the measure during the performance period is greater than its baseline period score but below the benchmark (within the improvement range), the hospital will receive a score of 0–9 based on the linear scale that defines the improvement range.

Maryland Mortality Measure

- Maryland measures **inpatient** mortality, risk-adjusted for:
  - 3M risk of mortality (ROM)
  - Sex and age
  - Transfers from another acute hospital within MD
- Measure inclusion/exclusion criteria provided in calculation sheet.
  - Subset of APR-DRGs account for 80% of all mortalities.
  - Specific high mortality APR-DRGs and very low mortality APR-DRGs are removed.
- RY 2020 approved recommendation requires inclusion of palliative care discharges in the mortality measure
  - Addresses concern regarding improvement being driven partially by increases in palliative care
  - Inclusion of palliative care status as risk-adjustment variable ensures hospitals with higher palliative care are not unduly penalized

New ED Wait Time Measures

Measure ID	Measure Title
ED-1b	Median time from emergency department arrival to emergency department departure for admitted emergency department patients
ED-2b	Admit decision time to emergency department departure time for admitted patient

- Protections include:
  - Setting benchmark at national median stratified by ED volume
  - Hospitals that improve by at least 1 point will receive the better of their QBR scores, with or without the ED wait times included

Performance on ED Wait Time Measures

Volume Category	# Annual Visits	# MD Hospitals	ED-1b			ED-2b		
			Nation	MD	% MD Hospitals Above National Median	Nation	MD	% MD Hospitals Above National Median
LOW	0-19,999 visits	3	214	291	33.3%	58	84	33.3%
MEDIUM	20,000-39,999 visits	9	258	428	88.9%	89	168	88.9%
HIGH	40,000-59,999 visits	16	296	365	93.8%	119	150	81.3%
VERY HIGH	60,000+ visits	17	334	438	88.2%	136	186	70.6%

Maryland Performance Relative to National Performance

- Despite Maryland strategically increasing the weight for the Person and Community Engagement domain, Maryland still performs in aggregate in the lowest decile nationally
  - Little to no improvement since CY 2014

- Maryland performs comparable to the nation on the three VBP 30-day condition specific mortality measures
  - In addition, in RY 2018, Maryland improved in its all-payer, all-condition inpatient mortality measure, but the inclusion of palliative care reduces this improvement by approximately 50%.

- On the Safety domain NHSN infection measures, Maryland mean performance is worse than the national mean on four of six measures (4/16-3/17).

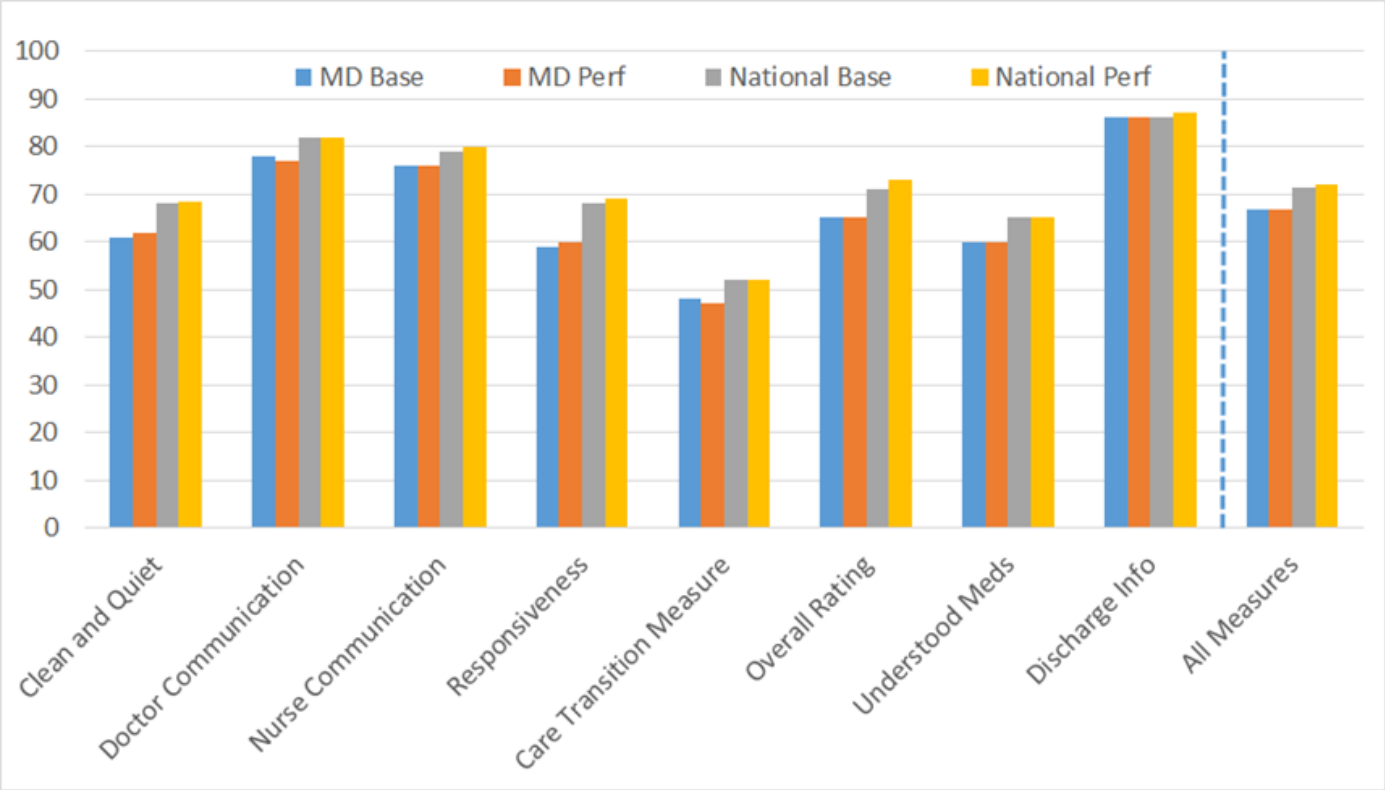
- Maryland performs poorly on Emergency Department Wait Time measures at all ED volume levels
  - Approximately 80% of hospitals are worse than the national median

Maryland NHSN Measures Statewide Results 4/1/16-3/31/17

MEASURE	Mean Maryland	Mean National	Hospital Count Maryland	Hospital Count National
C. diff.	1.049	0.864	45	3,069
CAUTI	1.077	0.905	39	2,290
CLABSI	1.035	0.859	40	2,016
MRSA	1.265	0.938	36	1,690
SSI: Colon	0.874	0.863	35	1,887
SSI: Hyster	0.835	0.800	10	768

RY 2018: MD HCAHPS Compared to Nation

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



HSCRC
Health Services Cost Review Commission

QBR Methodology: Scaling Rewards and Penalties

A **preset scale** (established using full range of QBR potential scores) is used to determine hospital rewards and penalties; hospitals that score below the **target of 0.45** will receive a penalty; and those that score above will receive a reward.

Maximum rewards are increased to 2.00%.

	Final QBR Score	Below/Above State Quality Target
Scores less than or equal to	0.00	-2.00%
	0.15	-1.33%
	0.30	-0.67%
	0.40	-0.22%
Penalty/Reward cut-point	0.45	0.00%
	0.50	0.29%
	0.55	0.57%
	0.60	0.86%
	0.70	1.43%
Scores greater than or equal to	0.80	2.00%
Penalty/Reward cut-point:		**0.45**

QBR RY 2020 Approved Updates **Recap**

Measure Changes

- **New-** ED Wait Times (ED 1b and ED 2b) included in Patient and Community Engagement domain.
- **Modified** - Mortality measure includes PC risk adjustment for attainment and improvement (last year PC **excluded** for attainment; **included** for improvement)
- **Monitoring/Suspended** –
  - PSI-90; THA/TKA Complications;

Measure Domain Weighting – remains at RY 2019 levels: 50% for PCE/HCAHPS, 35% for Safety, and 15% for Clinical Care.

QBR Scaling and Revenue at-risk

- **Preset scale** to 0.00 - 0.80, with cut point at 0.45. Hospitals who score lower than 0.45 will receive a penalty, hospitals who score greater than 0.45 will receive a reward.
- Performance expectations are better aligned with National performance benchmarks.

Future Considerations

- Maryland's Programs must keep pace with, and establish bold improvement goals relative to, the nation.
- CMS IPPS Proposed Rule FY 2019 Proposes to Remove measures from IQR and De-Duplicate10 measures from VBP:
  - Remove all seven healthcare Safety domain measures (HAI, PSI and PC-01) measures from the Safety domain, as they are already in the HAC Reduction Program.
  - Remove three condition-specific payment measures from the Efficiency and Cost Reduction domain already in the Hospital IQR Program (while retaining the Medicare Spending per Beneficiary-Hospital measure);
  - Revise the program's domain weighting beginning with the FY 2021 program year by increasing the weight of the Clinical Care domain in calculating hospitals' total performance scores (reweights mortalities and the THA/TKA complications domain to 50%)
  - Proposed changes to ED measures
    - ED-1b- Remove as of CY 2019 reporting period/FY 2021 payment determination;
    - Chart-abstracted version of ED-2b- Remove as of CY 2020 reporting period/FY 2022 payment determination (but retain as eCQM option).

RY 2020 Readmission Reduction Incentive Program (RRIP)

Readmission Reduction Incentive Program

- Payment program supports the waiver goal of reducing inpatient Medicare readmissions to national level, but applied to all-payers.

- The RRIP was approved in 2014 and began to impact hospital revenue starting in RY 2016.

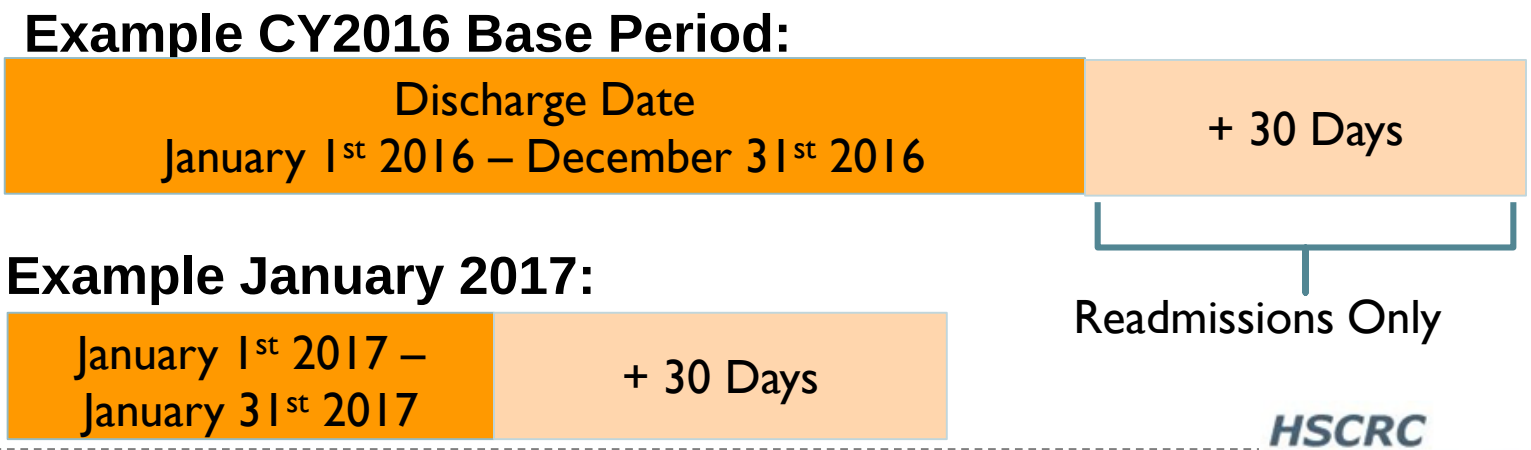
Performance Metric

- Case-Mix Adjusted Inpatient Readmission Rate
  - 30-Day
  - All-Payer
  - All-Cause
  - All-Hospital (both intra- and inter- hospital)
  - Chronic Beds included
- Exclusions:
  - Same-day and next-day transfers
  - Rehabilitation Hospitals
  - Oncology discharges
  - Planned readmissions – Logic updated in March 2018
    - (CMS Planned Admission Version 4 + all deliveries + all rehab discharges)
  - Deaths

Data Sources and Timeframe

- Inpatient abstract/case mix data with CRISP Unique Identifier (EID).
- Base period is CY 2016 and Performance period is CY 2018, run using version 35 of the APR grouper (ICD-10 compatible).
- RY20 Improvement will be compounded with final RY18 improvement to produce Compounded Cumulative Improvement Rate.

Measurement Timeframe:



HSCRC
Health Services Cost Review Commission

Case-Mix Adjustment

- Hospital performance is measured using the Observed (O) unplanned readmissions / Expected (E) unplanned readmission ratio and multiplying by the statewide base period readmission rate.

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

Measuring the Better of Attainment or Improvement

- The RRIP continues to measure the better of attainment or improvement due to concerns that hospitals with low readmission rates may have less opportunity for improvement.

- RRIP adjustments are scaled, with maximum penalties up to 2% of inpatient revenue and maximum rewards up to 1% of inpatient revenue.

Rate Year	Performance Year	Improvement Target	Attainment Benchmark
RY 2017	CY 2015	9.30%	12.09%
RY 2018	CY 2016	9.50%	11.85%
RY 2019	CY 2017	14.10%	10.83%
RY 2020	CY 2018	14.30%	10.70%

Improvement Scaling

- Improvement compares CY18 case-mix adjusted inpatient readmission rates to CY16 case-mix adjusted inpatient readmission rates, and compounds this improvement with RY 2018 CY13-CY16 improvement.
- Improvement Target for CY18 = 14.3% cumulative decrease
- Adjustments range from 1% reward to 2% penalty, scaled for performance.

All Payer Readmission Rate Change CY13-CY18		RRIP % Inpatient Revenue Payment Adjustment
	A	B
Improving Readmission Rate		1.0%
	-24.80%	1.00%
	-19.55%	0.50%
Target	-14.30%	0.00%
	-9.05%	-0.50%
	-3.80%	-1.00%
	1.45%	-1.50%
	6.70%	-2.0%
Worsening Readmission Rate		-2.0%

Attainment Scaling

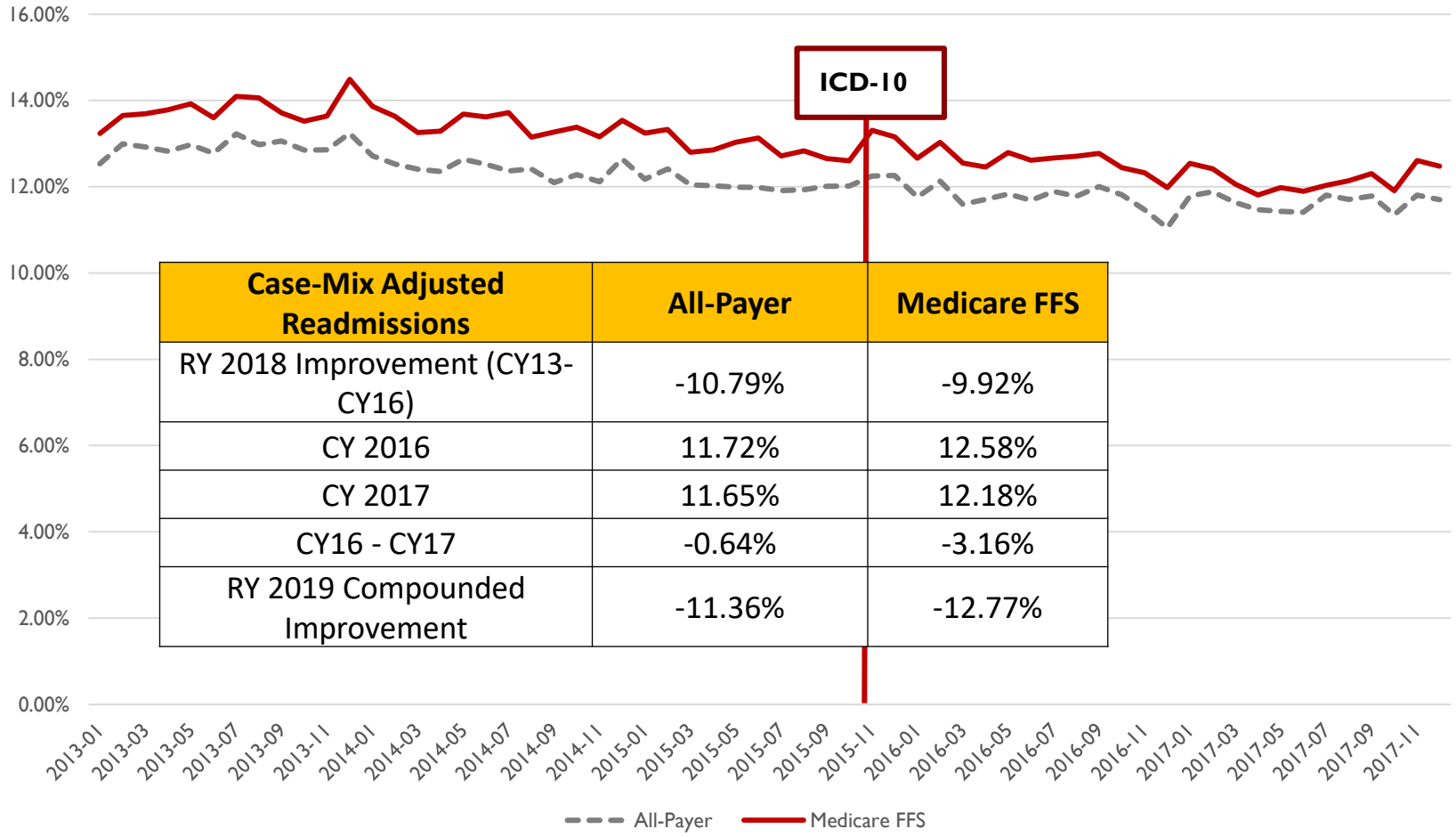
- Attainment scaling compares CY18 case-mix adjusted inpatient readmission rates to a state benchmark.
  - Adjust attainment scores to account for readmissions occurring at non-Maryland hospitals.
- Attainment Benchmark for CY18= 10.70%
- Adjustments range from 1% reward to 2% penalty, scaled for performance.

All Payer Readmission Rate CY18		RRIP % Inpatient Revenue Payment Adjustment
	A	B
Lower Absolute Readmission Rate		1.0%
Benchmark	10.20%	1.00%
	10.45%	0.50%
Threshold	10.70%	0.00%
	10.95%	-0.50%
	11.20%	-1.00%
	11.45%	-1.50%
	11.70%	-2.0%
Higher Absolute Readmission Rate		-2.0%

RY 2020 RRIP Methodology **Recap**

- Readmissions **measure** is same as RY 2019 measure.
  - Now with updated Planned Admission logic – from March 2018.
- Readmissions **targets** updated:
  - RY 2018 improvement compounded with RY 2020 improvement for **Compounded Cumulative Improvement Rate**
  - New **Targets** and **Scaling** to meet Medicare Waiver Test
    - **Improvement** – **14.30%** Improvement; max 1% reward at 24.80% improvement
    - **Attainment** – **10.70%** Attainment target; max 1% reward at 10.20% rate

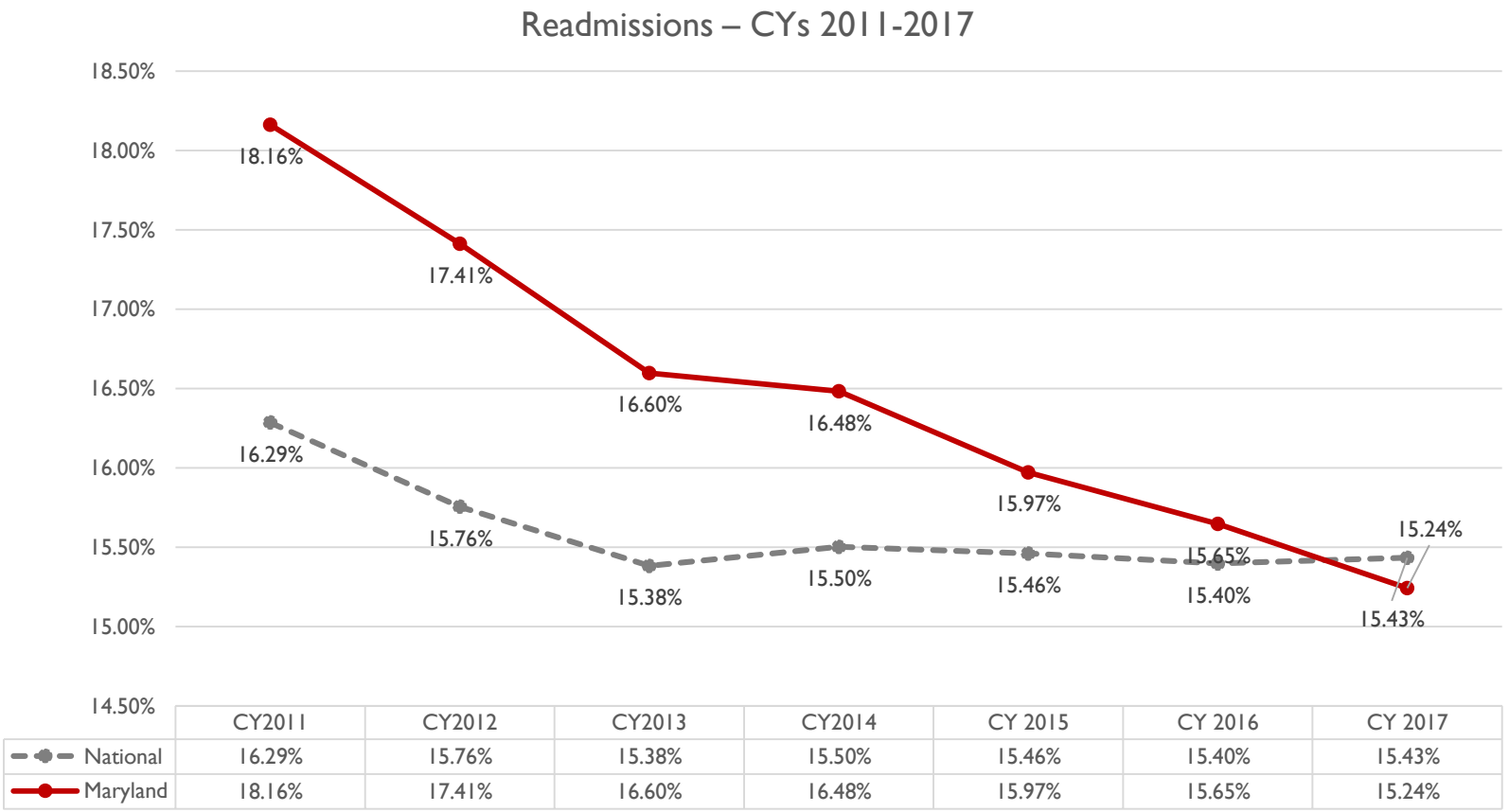
Monthly Case-Mix Adjusted Readmission Rates



Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
RY 2018 Improvement (CY13-CY16)	-10.79%	-9.92%
CY 2016	11.72%	12.58%
CY 2017	11.65%	12.18%
CY16 - CY17	-0.64%	-3.16%
RY 2019 Compounded Improvement	-11.36%	-12.77%

Note: Based on final data for Jan 2012 – Dec 2017; Preliminary data Jan 2018. Statewide improvement to-date in RY 2019 is compounded with RY 2018 improvement.

Medicare Readmissions – Rolling 12 Months Trend



	CY2011	CY2012	CY2013	CY2014	CY 2015	CY 2016	CY 2017
National	16.29%	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%
Maryland	18.16%	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%

NOTE: These data represent the final re-stated data from CMS for CY 2017. Based on these numbers, Maryland has achieved the required 2017 reduction in readmissions.

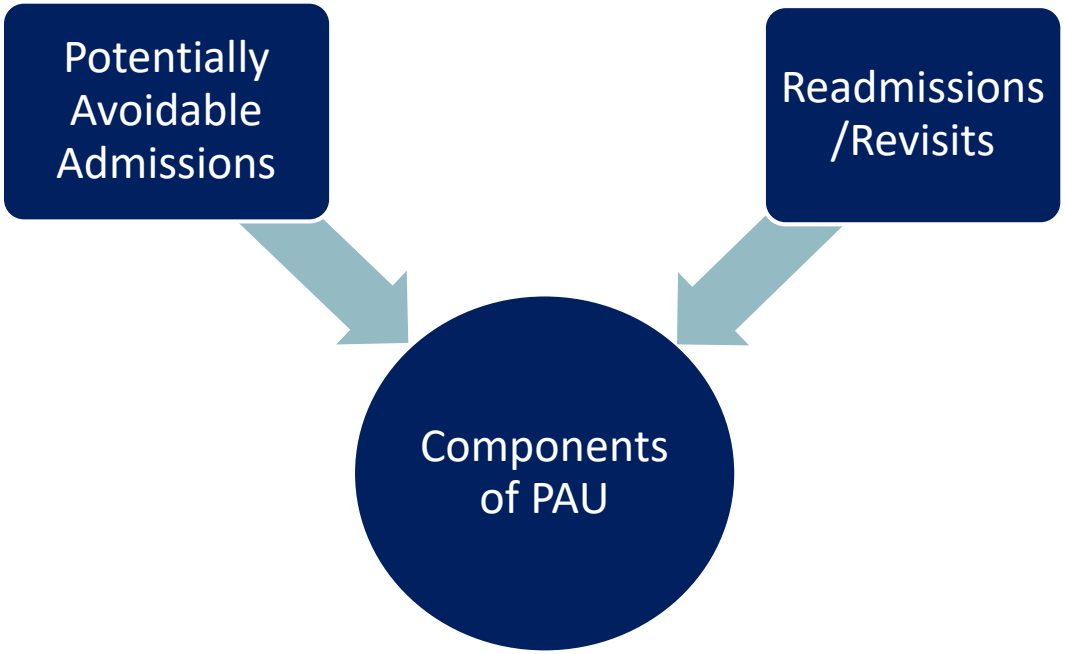
Upcoming Readmissions Considerations

- Readmission Rates under New Model?
- Expanded Attainment Scaling? (currently 25th to 10th percentiles)
- By-Payer Readmission Benchmarks?
- Diminishing Denominator of Eligible Discharges?

RY 2019 Potentially Avoidable Utilization (PAU) Savings Policy

Potentially Avoidable Utilization (PAU)

Definition: "Hospital care that is unplanned and can be prevented through improved care coordination, effective primary care and improved population health."



HSCRC Calculates Percent of Revenue Attributable to PAU

60

RY 2019 PAU Savings Revenue Reduction

- Measurement updates: Updated to PQI version 7.01
- Increase the net PAU reduction by 0.30%, which is a cumulative PAU reduction of 1.75%, compared to the 1.45% reduction in RY2018.
- Cap the PAU Savings reduction for hospitals with higher socioeconomic burden at the statewide average reduction; however, solicit input on phasing out or adjusting for subsequent years.
- Evaluate expansion and refinement of the PAU measure to incorporate additional categories of potentially avoidable admissions and potentially low-value care.

RY 2020 Maximum Guardrail under Maryland Hospital Performance-Based Programs

Final Recommendation for RY 2020

RY 2020 Quality Program Revenue Adjustments	Max Penalty	Max Reward
MHAC	-2.0%	1.0%
RRIP	-2.0%	1.0%
QBR	-2.0%	2.0%

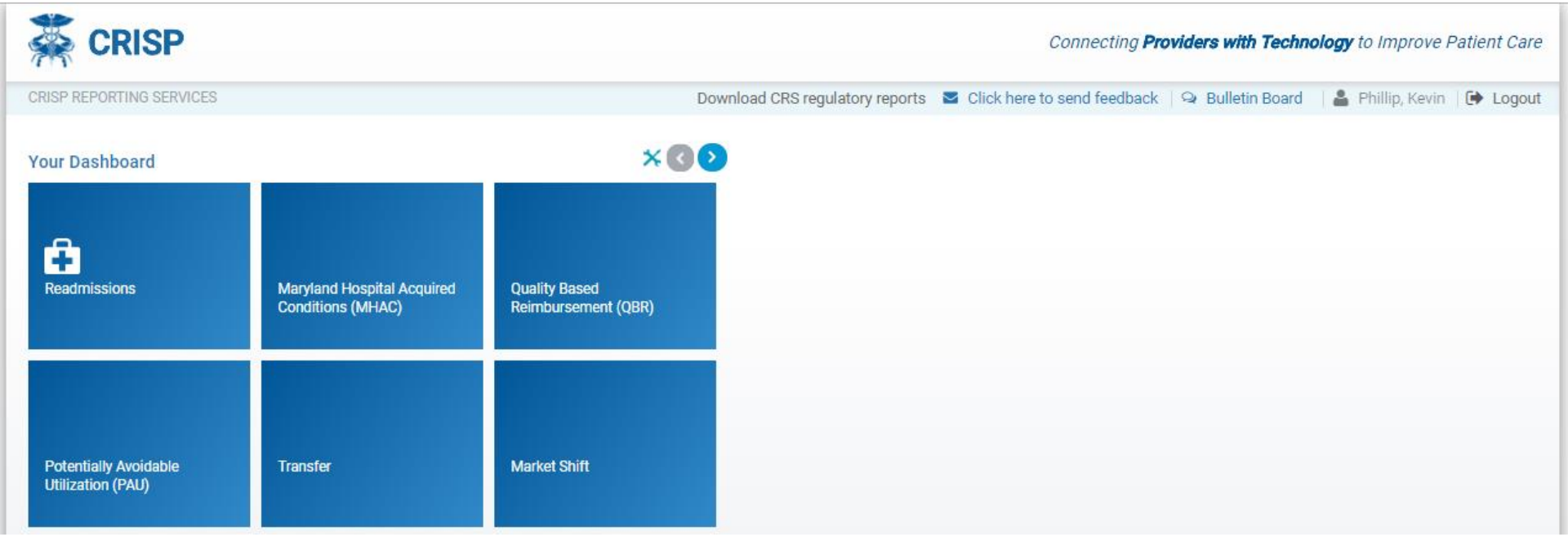
- Proposed: Continue to set the maximum penalty guardrail at 3.5 percent of total hospital revenue.
- The quality adjustments are applied to inpatient revenue centers, similar to the approach used by CMS.

CRISP Monitoring Reports for Hospitals and Other Resources

Monitoring Reports

- HSCRC summary level reports and case level data files are distributed through a secure site called the CRISP Reporting Services Portal – "CRS Portal" https://reports.crisphealth.org
- The following quality summary reports and case level files are currently posted on the CRS Portal:
  - QBR Mortality (quarterly preliminary and final)
  - MHAC Workbook (monthly preliminary/quarterly final)
  - RRIP Workbook (monthly)
  - PAU Report (monthly—1st report will be released 6/22/18)

CRISP Reporting Services Portal

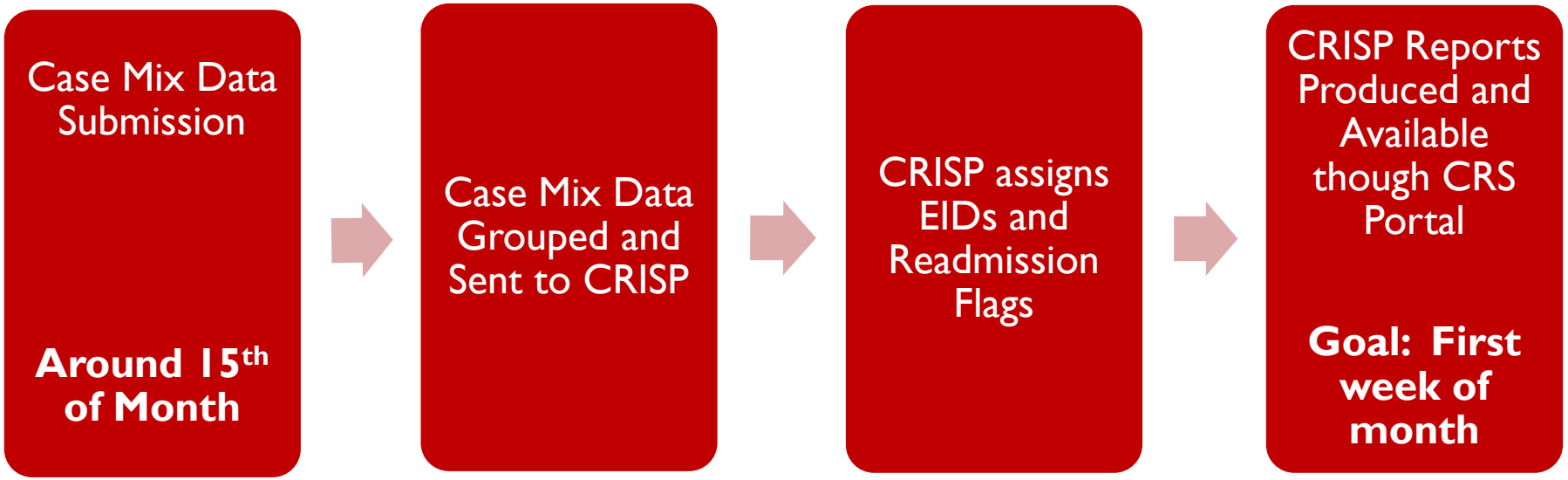


HSCRC
Health Services Cost Review Commission

Reporting Timeline

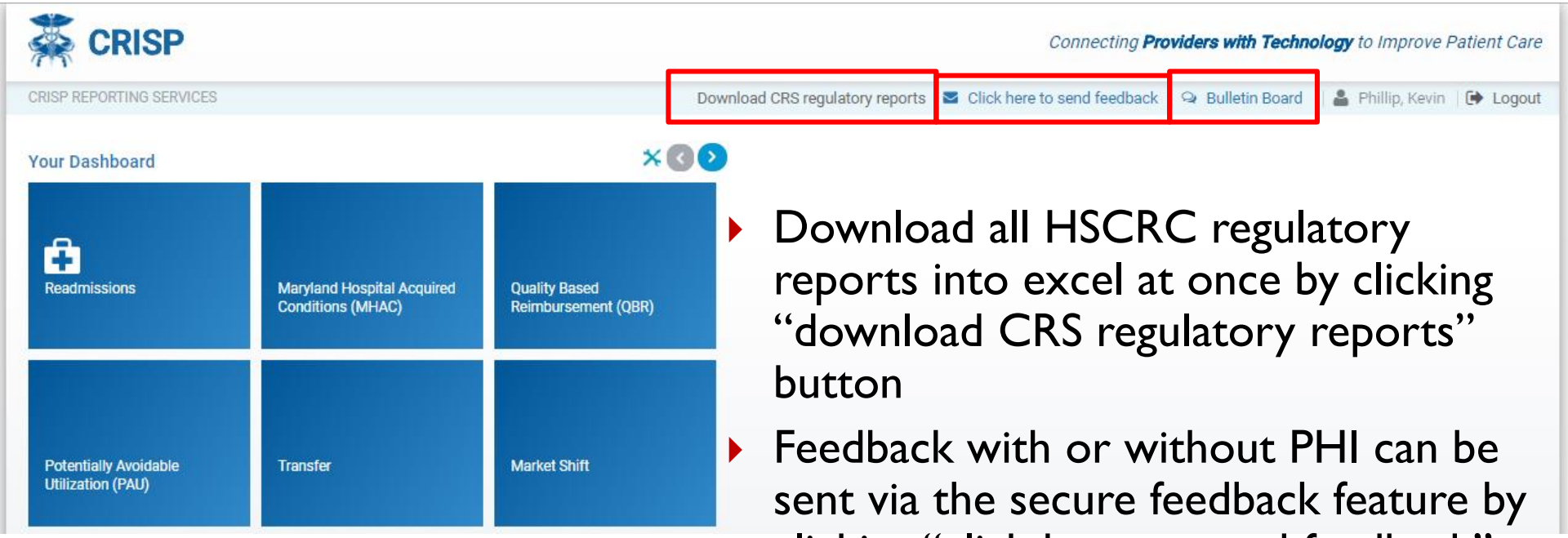
- Timeline is dependent on timely data submission
- Per HSCRC policy, incomplete preliminary data may be processed, however final data will not be processed until all hospitals submit

Preliminary Data Processing Timeline



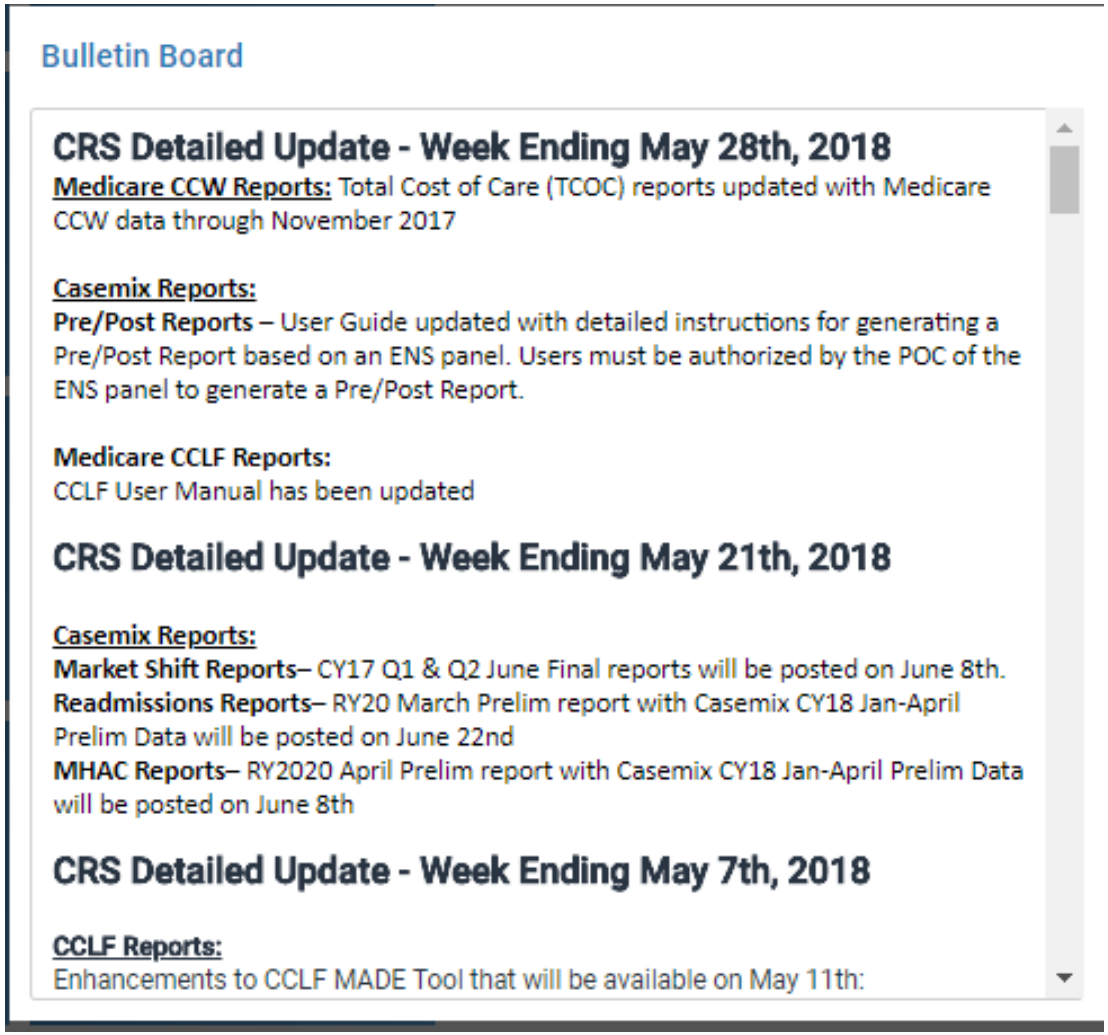
HSCRC
Health Services Cost Review Commission

CRISP Reporting Services Portal

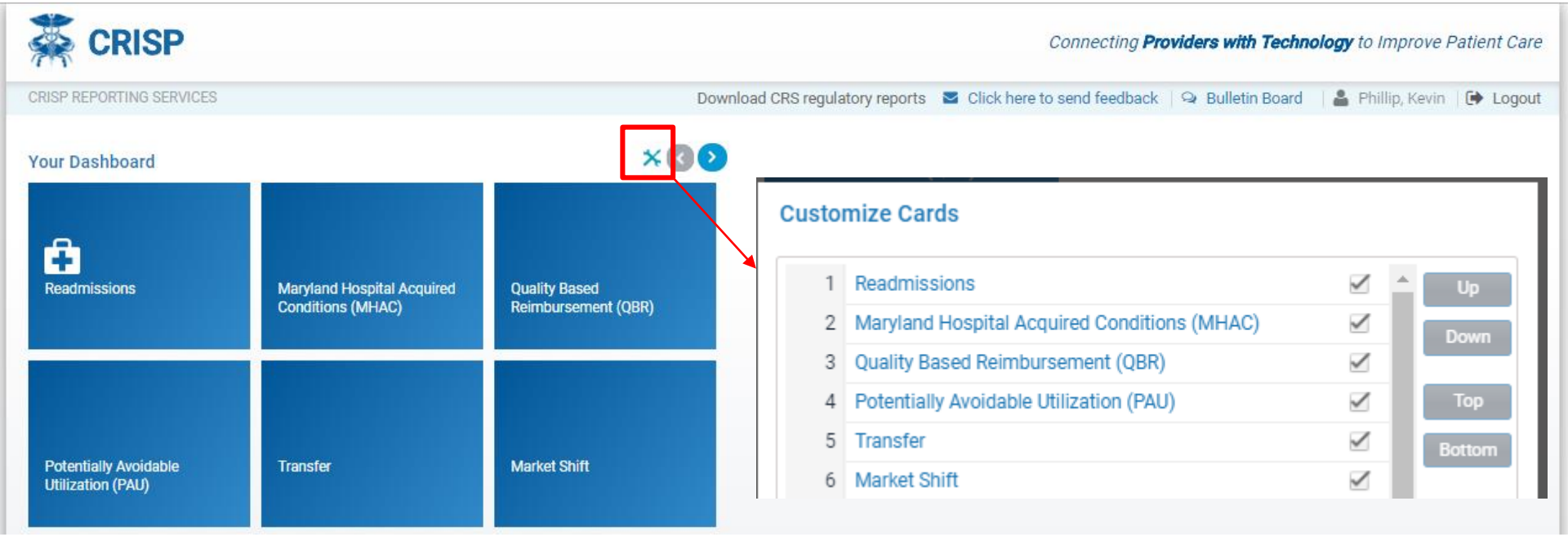


- Download all HSCRC regulatory reports into excel at once by clicking "download CRS regulatory reports" button
- Feedback with or without PHI can be sent via the secure feedback feature by clicking "click here to send feedback"
- Updates outside of the CRISP release date can be found weekly by clicking the "Bulletin Board"

Bulletin Board

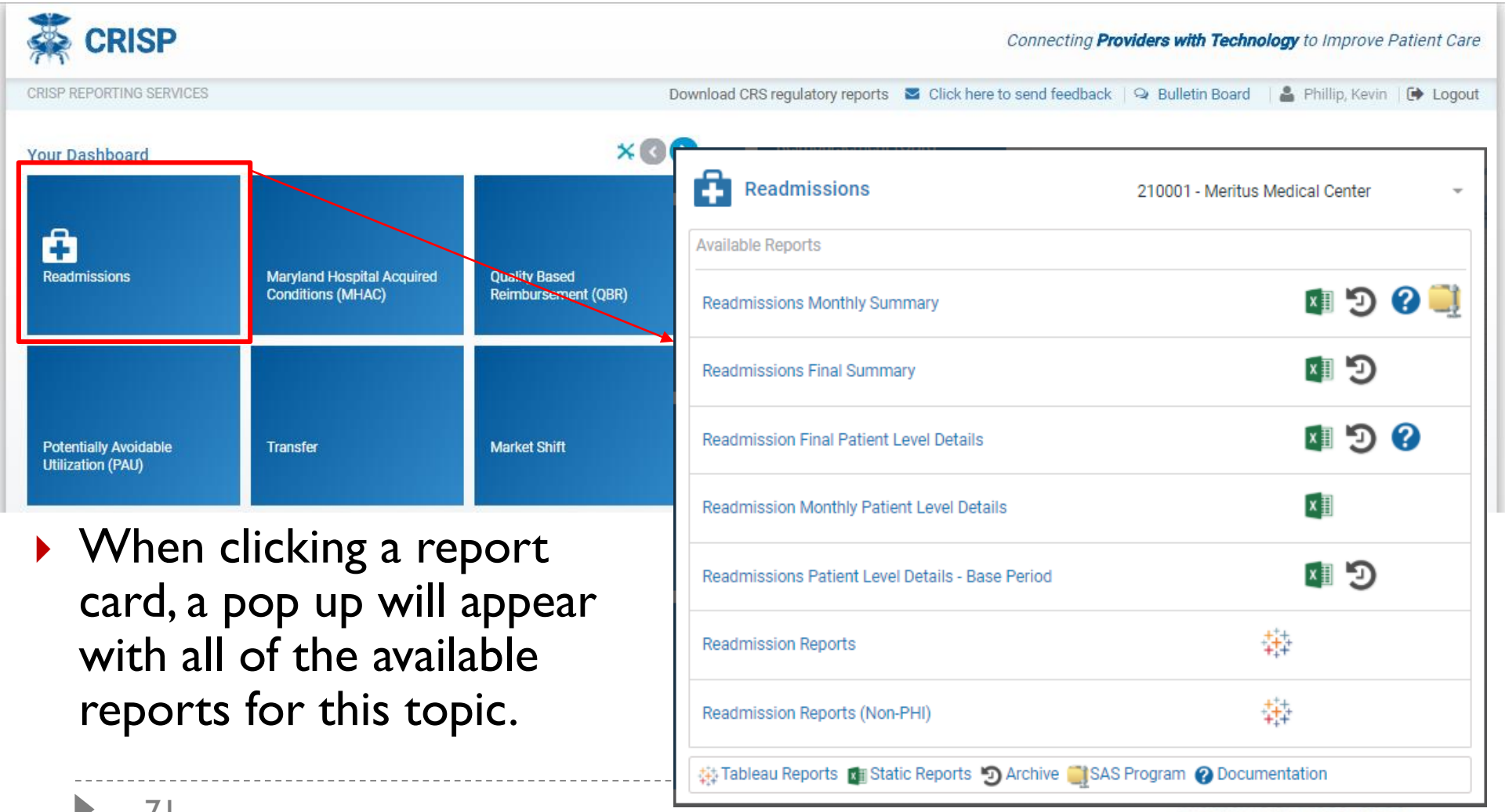


Customize Report Cards



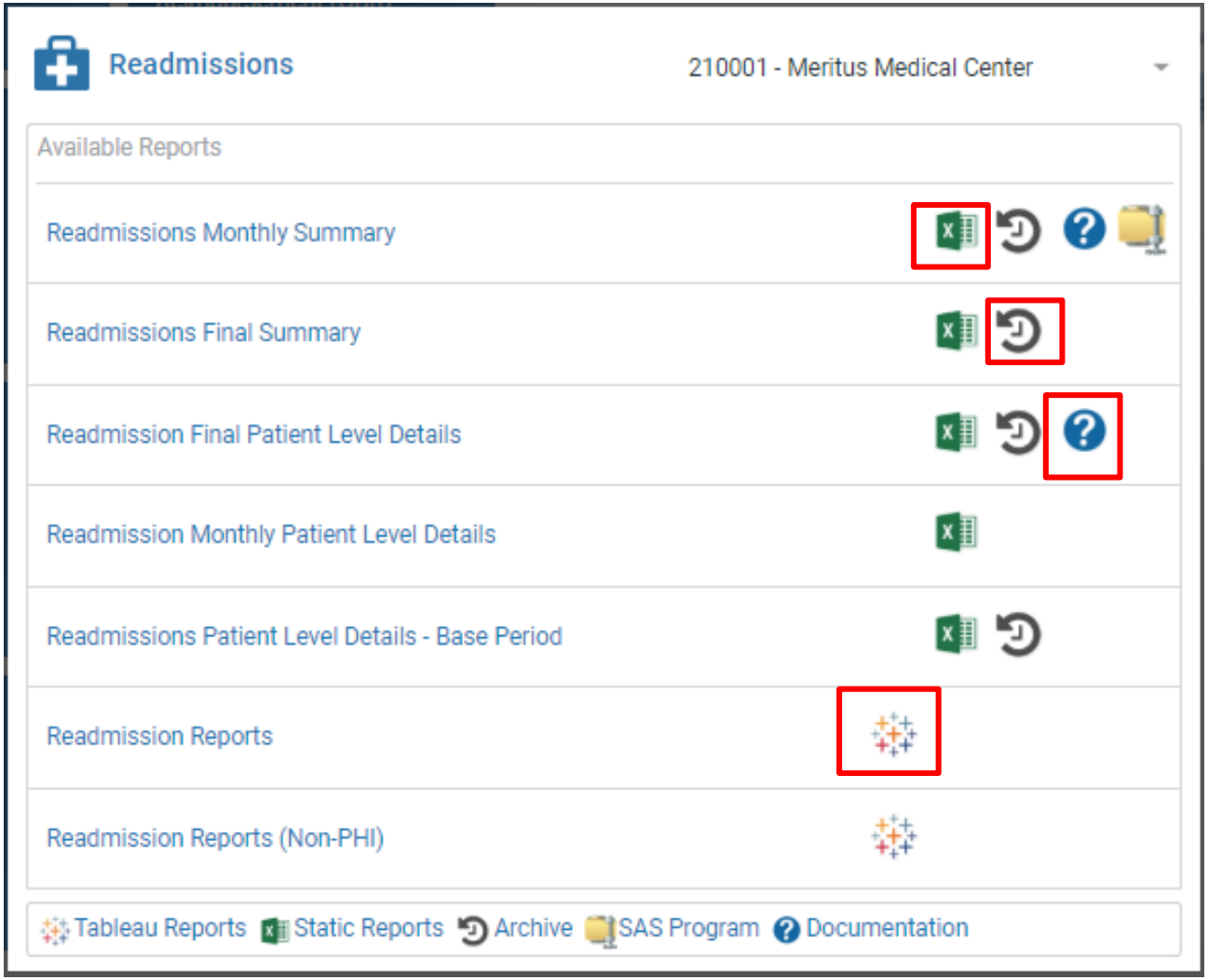
- Reports cards can be organized by clicking the wrench and spanner icon on the toolbar.

Report Cards



- When clicking a report card, a pop up will appear with all of the available reports for this topic.

Icons



HSCRC
Health Services Cost Review Commission

Reporting Archives

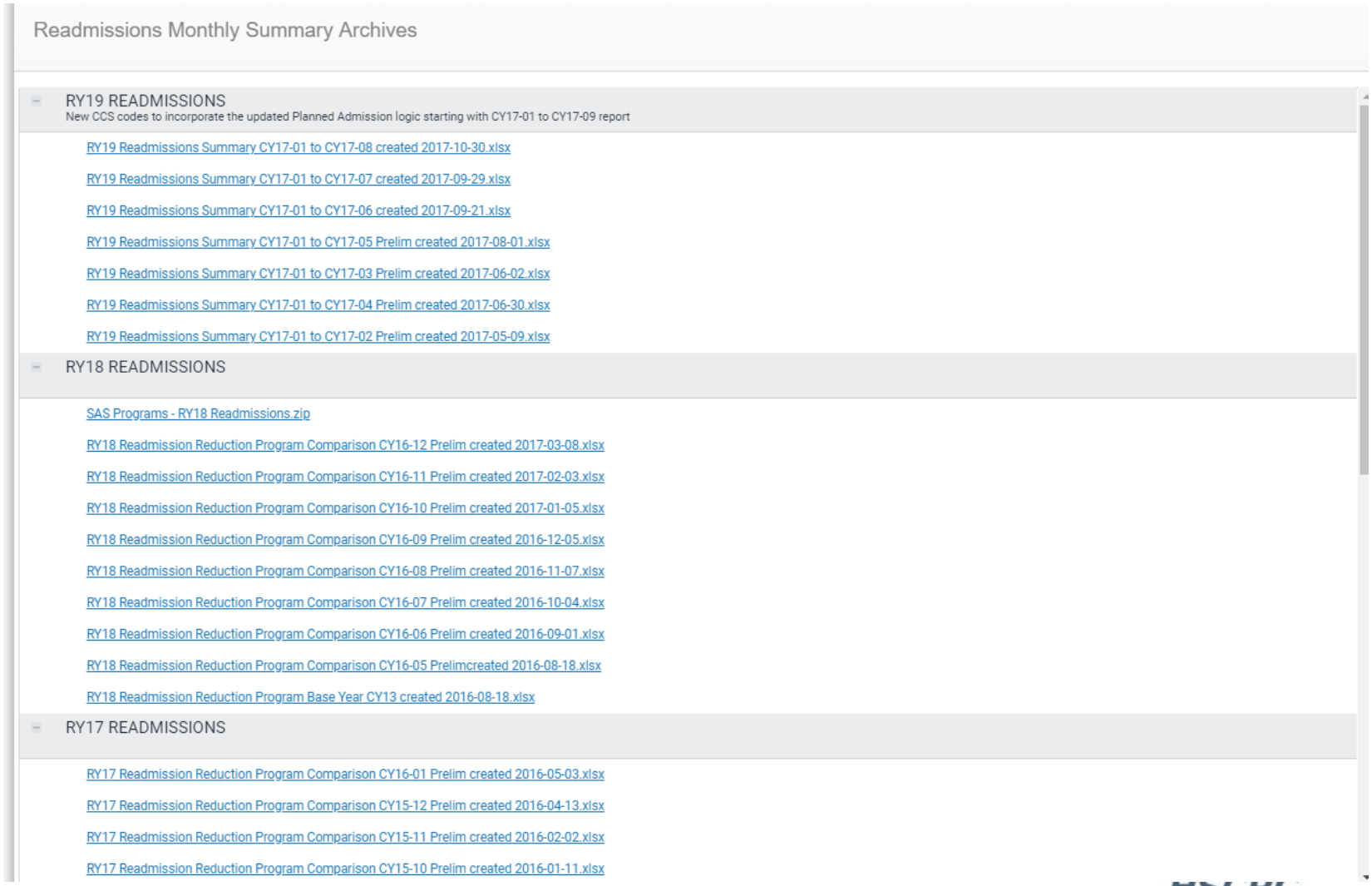
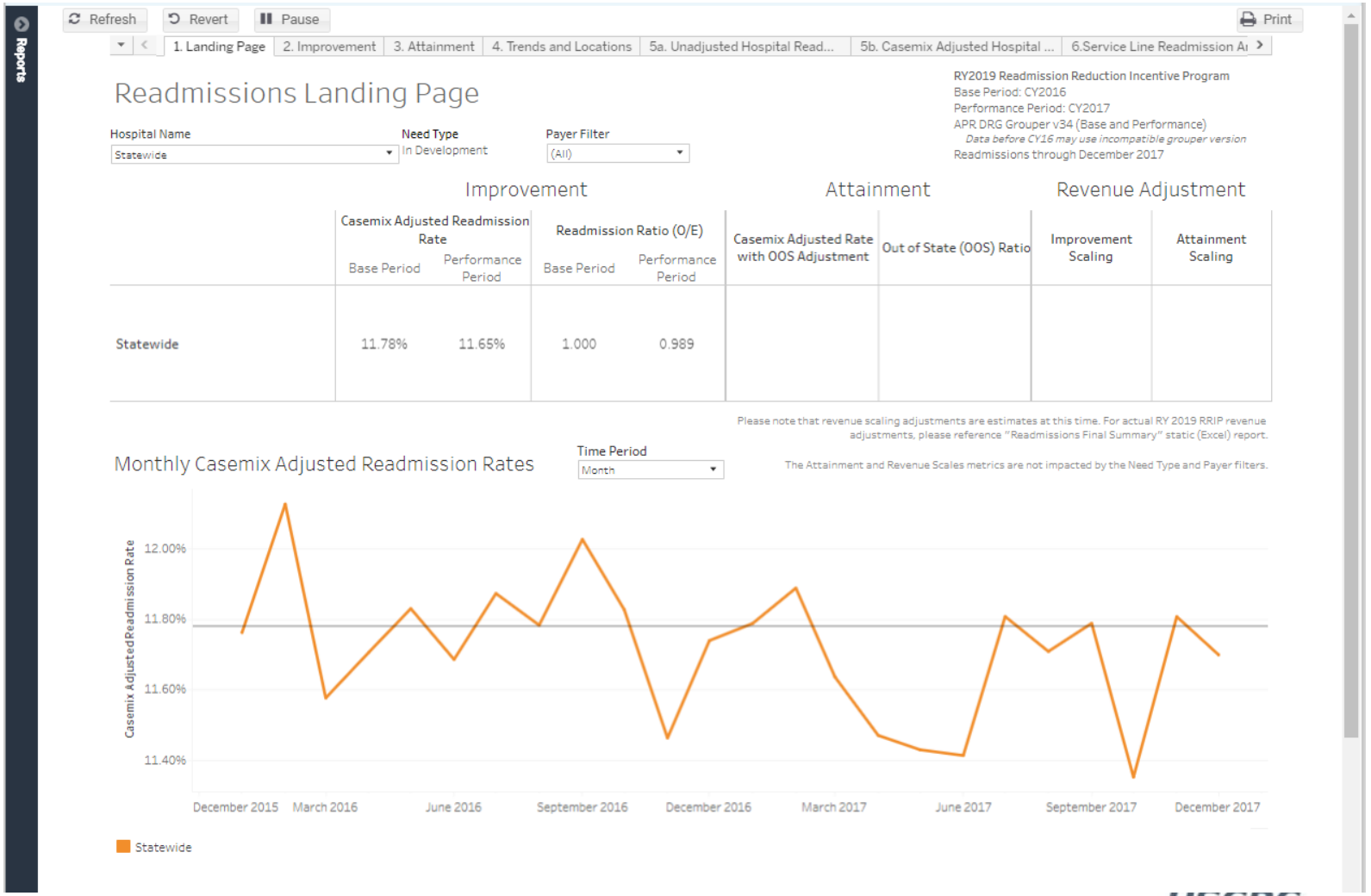


Tableau Report Example



HSCRC
Health Services Cost Review Commission

Accessing Reports

- Email your Organization's CRS Point of Contact (POC) to request access to portal:
  - Request should specify hospital and level of access (summary vs. case-level)
  - Access will be granted to all hospital reports (i.e., not program specific)
- CRS Point of Contact (CFO or designee) confirm and approve access requests for each organization
- Questions regarding content of static reports or report policy should be directed to the HSCRC quality email (hscrc.quality@maryland.gov)
- Questions regarding access issues or tableau reports should be directed to (support@crisphealth.org)

HSCRC Resources

- **HSCRC Website**
  - Please check the Quality Program pages for most recent policies, memos, calculation sheets, etc.
  - http://hscrc.maryland.gov/Pages/quality.aspx
- **HSCRC Contact List –**
  - Requests to receive HSCRC Quality announcements can be made to: hscrc.quality@maryland.gov
  - If you are not on the e-mail distribution list, please refer to our Quality Pages for most recent announcements.

Acknowledgments

- Thanks to the Performance Measurement Work Group members, CAEM subgroup, MHA, CRISP, hospital industry, consumers, and other stakeholders for their work on developing and vetting Maryland's performance-based payment methodologies.

Q & A

- Please type your Question into the Questions Bar or raise your hand to be unmuted.
- Additional or unanswered questions can be emailed to the HSCRC Quality mailbox: hscrc.quality@maryland.gov
- Thank you again for your participation!