MHDO Maine Health Data Organization
Information | Insight | Improvement

Maine Quality Forum
MEASURING TO IMPROVE

Health Care Expenditures and Health Care Quality in Maine: Baseline Report

Submitted by:

Karynlee Harrington
Executive Director
MHDO & MQF
State of Maine
Karynlee.harrington@maine.gov

Table of Contents

Overview

Public Law 2021, Chapter 459 (LD 120), *An Act To Lower Health Care Costs through the Establishment of the Office of Affordable Health Care*, created the Office of Affordable Health Care. The Office of Affordable Health Care is established as an independent executive agency for the purpose of analyzing health care costs in the State of Maine in accordance with the duties described in §3122(3), which includes the following: at a minimum, the office shall use data available from the Maine Health Data Organization (MHDO), established pursuant to Title 22, chapter 1683, and the Maine Quality Forum (MQF), established in Title 24-A, section 6951.

At the request of the Governor's Office, the MHDO produced a set of health care expenditure reports to serve as a baseline to begin to inform the discussion on health care costs in Maine. These reports are largely informed by the *Recommended Standard Analytic Reports: Phase 1* of *A Data Use Strategy for State Action to Address Health Care Cost Growth Report (Peterson-Milbank*); a few data points are informed by the Massachusetts Health Policy Commission. Additionally, the MQF provided baseline information specific to the status of reporting and measuring the quality of health care in the state of Maine and nationally.

Under contract with the Maine Health Data Organization, Human Services Research Institute (HSRI), provided MHDO technical support in the preparation of the interactive tableau report; and under contract with the Maine Quality Forum the University of Southern Maine, Muskie School of Public Service, Cutler Institute, provided MQF support in the drafting of the section of the report dedicated to health care quality in Maine.

Health Care Expenditures Report: Highlights

The Health Care Expenditures in Maine Report is constructed as an interactive Tableau report that provides access to a multitude of selection criteria displaying thousands of data points. MHDO produced this baseline report in a way that can be easily refreshed and, if requested, used to expand into additional reports in the future, such as payer-level and provider-level analyses. **The interactive Tableau dashboard can be accessed here: MHDO – Health Care Expenditures (maine.gov)**

The baseline payment totals reported in the interactive dashboard represent strictly **claim-based payment data** that payers submit to the Maine Health Data Organization per the requirements in Rule 90-590, Chapter 243, *Uniform Reporting System for Health Care Claims Data Sets.* More information about the All-Payer Claims Database (APCD), including how many members are represented as part of this analysis, is found on the MHDO website: MHDO Available Data (maine.gov). Given the data source and methodology used for this baseline report, it is important to note the following:

a. At the time of producing this baseline report, **non-claims-**based payments **were not available**, that is payments that are for something other than a fee-for-service claim. These non-claims-based payments include, but are not limited to, Capitation Payments, Care Management/Care Coordination/Population Health Payments, Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments, Global Budget Payments, Patient-centered Medical Home Payments, Pay-for-performance Payments, Pay-for-reporting Payments, Primary Care and Behavioral Health Integration Payments, Prospective Case Rate Payments, Prospective Episode-based Payments, Provider Salary Payments, Retrospective/Prospective Incentive Payments, Risk-based Payments, Shared-risk Recoupments, Shared-savings Distributions. Other non-claims-based payments that were not available for inclusion in the report are pharmacy rebate amounts.
b. Payments for MaineCare **include** services that are traditionally not covered by Commercial or Medicare insurance, including Long Term Services and Support (LTSS). LTSS services include: Adult Family Care Services, Consumer Directed Attendant Services, Home and Community-Based Services (HCBS) for Adults with Brain Injury, Home and Community Benefits (HCBS) for the Elderly and Adults with Disabilities, Home and Community Based Services (HCBS) for Adults with Other Related Conditions, Home and Community Benefits (HCBS) for Members with Intellectual Disabilities or Autism Spectrum Disorder, Day Health Services, Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder, Home Health Services, ICF-MR Services, Nursing Facility Services, Private Duty Nursing and Personal Care Services, Private Non-Medical Institution Services (PNMI), and Rehabilitative Services.

The majority of MaineCare payments for LTSS services are expected to be represented in the service category breakdowns as 'Institutional: Other' and 'Professional.'

c. The claim-based payments in this baseline report are calculated without any adjustments; they are not adjusted for inflation in healthcare costs, and not adjusted to control for differences in age, gender, or illness burden between groups.

Below are highlights of the baseline claims-based payments analysis; more information on the definition of payments and the measures developed for this report is included in Appendix A, Methodological Notes. Most of

our highlights are focused on the dashboard tab labeled "Overall," which is one of six interactive displays of the data, referred to as report “pages.” To further understand what is driving the changes observed in the overall payments, users can explore the detailed breakdowns available in the report, by drilling down on geography (based on the location of residence of the insurance enrollees), demographic groups, and by groups of individuals with selected chronic conditions, such as diabetes, Alzheimer’s disease, hypertension, cancer.

- **Total payments** for **commercial** plans have increased every year, except in 2020, (Overall page, Payment Amounts display) with the largest year-over-year (YOY) increase of 10.8% occurring from 2020 to 2021 (Overall page, Year-Over-Year Percent Change display). Some of this increase may be compensating for the decrease observed for the period 2019 to 2020, likely attributable to the decrease in the use of medical services during the initial peak of the COVID-19 pandemic.
- **Total payments** have been increasing annually every year from 2018 through 2021 for **MaineCare** and **Medicare Advantage** plans, across all service types combined (Overall page, Payment Amounts display), but **per capita payments** have decreased when comparing 2017 to 2021 – MaineCare went from $13,451 to $11,992 and Medicare Advantage went from $14,749 to $13,060. The observed MaineCare trend aligns with a national trend of enrollment growth due to continuous coverage requirements associated with the COVID-19 Public Health Emergency: members who would have normally been disenrolled due to loss of eligibility have maintained coverage (Per Capita Payments denominator). These members tend to have lower healthcare utilization (Per Capita Payments numerator).
- For **Medicare**, **total payments** and **per capita payments** have varied (Overall page, Payment Amounts display and the Year-Over-Year Percent Change display).
- Of the 30 **Chronic Conditions**, the **total payments** for individuals with Depression, Bipolar, or other Depressive Mood Disorders were the highest among the other chronic conditions for those with **MaineCare** coverage, while total payments for individuals with Hypertension were highest among the other chronic conditions for those with **Commercial, Medicare or Medicare Advantage** coverage, for each year included in this analysis (Chronic Conditions page, Payment Amounts display).
- The top **25 costliest drugs** are all brand name drugs, with a total cost of $757,322,271 — with **Medicare Advantage** paying over half of those costs at $401,992,957. For the **top 25 costliest generic drugs**, the cost is $44,823,272, with **Medicare Advantage** paying over half at $28,581,421 (Rx Drug Spending page, top 25 Costliest Drugs display).
- In 2021, for **all payers combined**, total payments made **by service category** were ranked from highest amounts to lowest as follows: Professional (26.4%), Pharmacy (24.5%), Hospital Outpatient — institutional portion only (19.7%), other institutional services (17.5%), Hospital Inpatient — institutional portion only (16.0%). For **commercial** insurance, the largest percentage of payments were for Hospital Outpatient services — institutional portion only (29.4%); for **MaineCare**, the largest percentage was for Professional (40.0%); for **Medicare**, the largest percentage was for Pharmacy (23.0%); and for **Medicare Advantage**, the largest percentage was for Pharmacy (26.5%). As noted above, payments for MaineCare in this baseline report are reflective of services that are traditionally not covered by commercial or Medicare insurance.

Snapshots of Interactive Tableau Reports

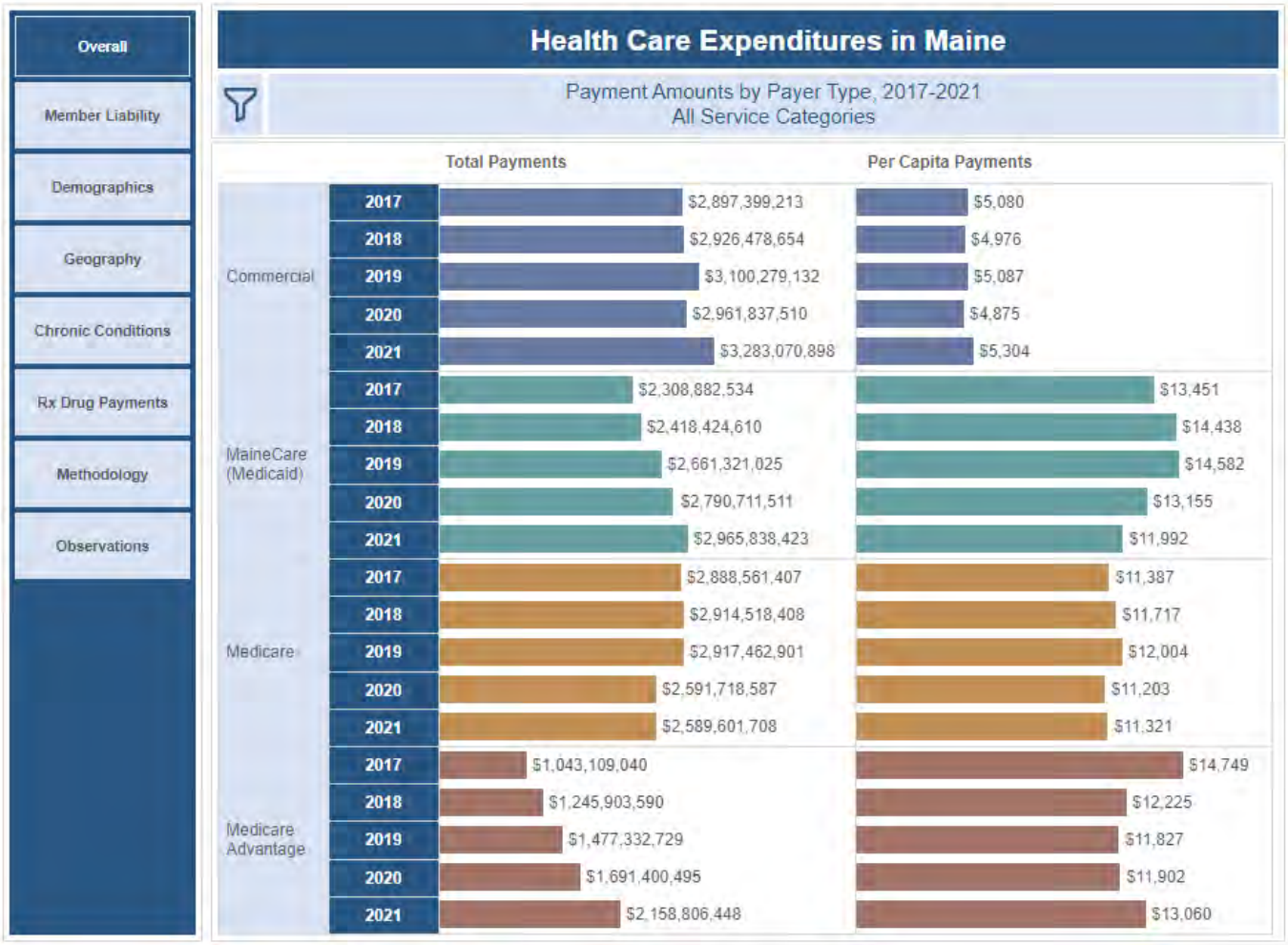
The following section displays static images (snapshots) from the interactive Tableau report. To browse the full content of the report, including all available drop-down menu options that are available, go directly on the webpage: [MHDO – Health Care Expenditures (maine.gov).]

How to Use the Interactive Report

1. Use the navigation tabs on the left to select a page to view — except for the last two, all have payer type and service category breakdowns:
    - **Overall** – payment types displayed by payer type and service category
    - **Member Liability** – total payments and member liability by payer type and service category
    - **Demographics** – summary statistics by age group, gender
    - **Geography** – summary statistics by Maine county, market rating area, public health district
    - **Chronic Conditions** – summary statistics for groups of individuals diagnosed with selected chronic conditions
    - **RX Drug Spending** – top 25 prescription drug costs and utilization in Maine at retail at mail order pharmacies
    - **Methodology** – details on the methodology used to develop this report
    - **Observations** – notes about specific statistics displayed in the report

2. Click on the Filter button ( ) to expand a set of criteria — such as payer type, measure, service category, and year — and use the drop downs to automatically adjust the information displayed on the respective report page.

1. Annual Total Payments and Per Capita Payments, by Payer Type

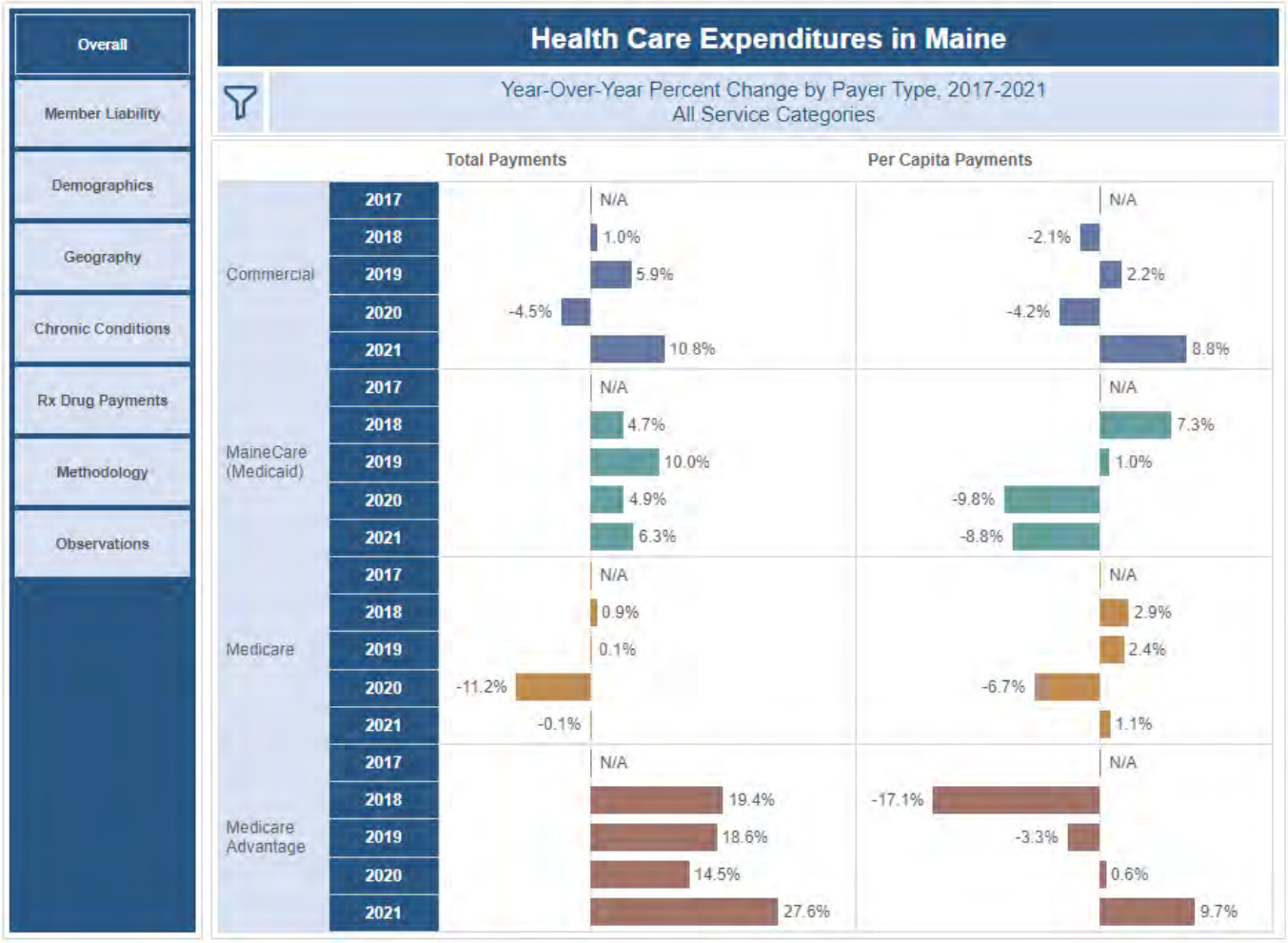


Data Source: MHDO All Payer Claims Data

Summary: Total allowed amounts and per capita allowed amounts from medical and pharmacy claims, disaggregated by major payer types: Commercial, Medicaid, Medicare Advantage, Medicare Fee-For-Service.

Drop-down menu includes: Measure (Payment Amounts; Year-Over-Year Percent Change); and Service Category (All; Institutional, Hospital Inpatient; Institutional, Hospital Outpatient; Institutional, Other; Professional; Pharmacy).

2. Year-Over-Year Percent Change Trend in Total Payments and Per Capita Payments, by Payer Type, 2017-2021

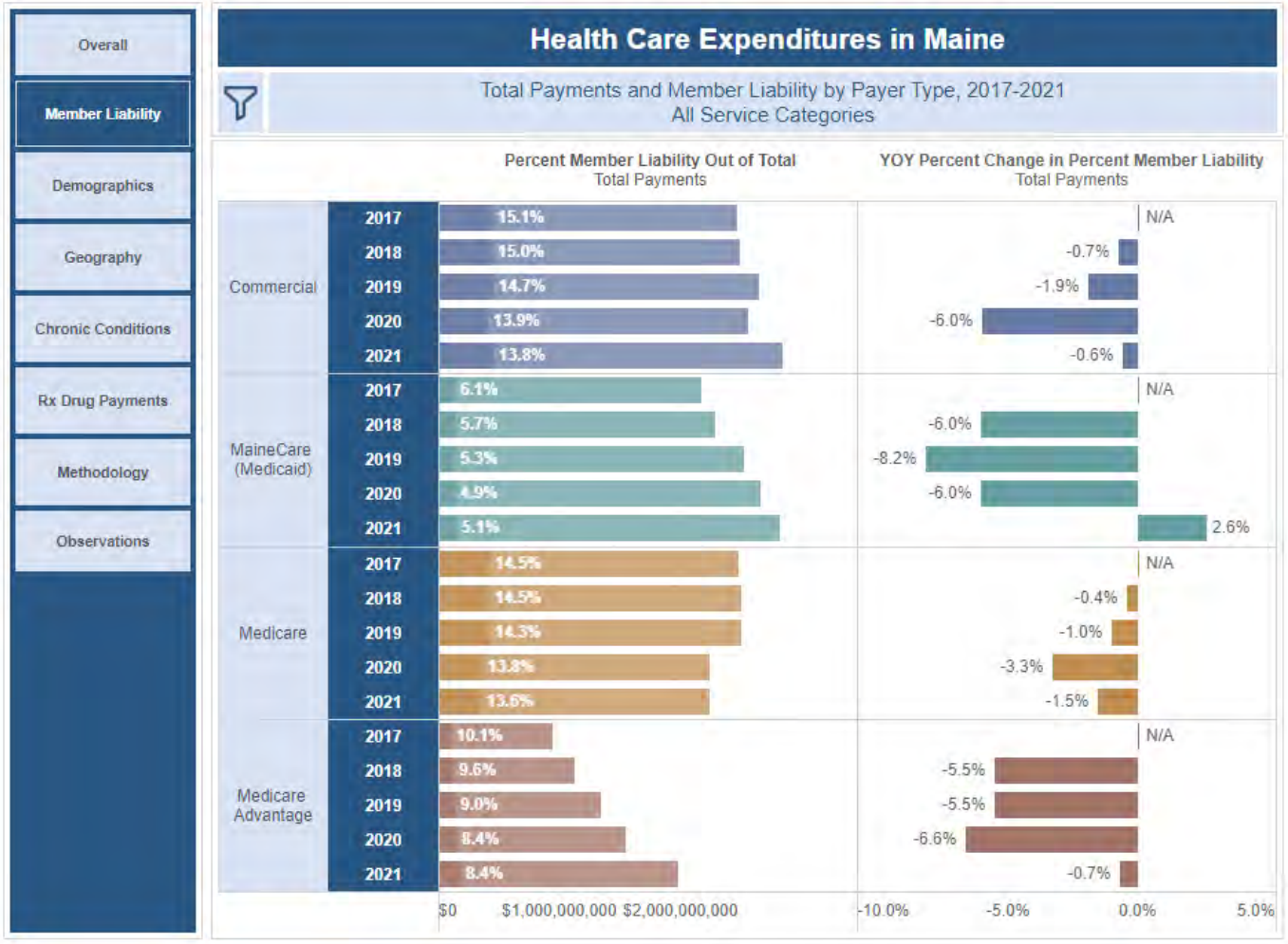


Data Source: MHDO All Payer Claims Data

Summary: Trend analysis of percent change in total allowed amounts and per capita allowed amounts from medical and pharmacy claims, disaggregated by major payer types: Commercial, Medicaid, Medicare Advantage, Medicare Fee-For-Service.

Drop-down menu includes: Measure (Payment Amounts; Year-Over-Year Percent Change); and Service Category (All; Institutional, Hospital Inpatient; Institutional, Hospital Outpatient; Institutional, Other; Professional; Pharmacy).

3. Annual Member Liability Payments Compared to Overall Payments, for Total Payments and Per Capita Payments, by Payer Type, 2017-2021

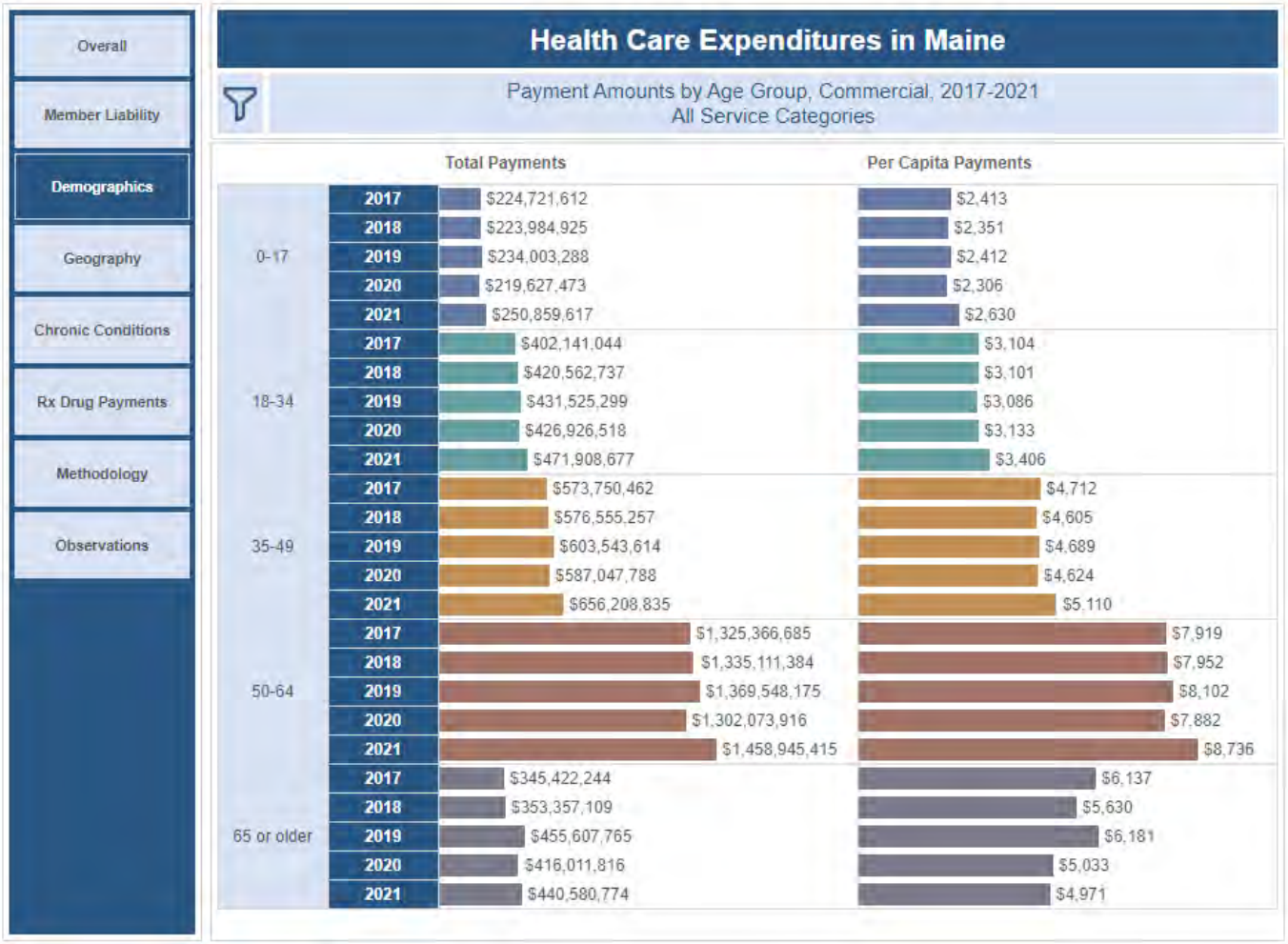


Data Source: MHDO All Payer Claims Data

Summary: Total payment amount compared to member liability payments, from medical and pharmacy claims, disaggregated by major payer types: Commercial, Medicaid, Medicare Advantage, Medicare Fee-For-Service.

Drop-down menu includes: Measure (Total Payments; Per Capita Payments); and Service Category (All; Institutional, Hospital Inpatient; Institutional, Hospital Outpatient; Institutional, Other; Professional; Pharmacy).

Annual Total Payments and Per Capita Payments, by Demographic Variables

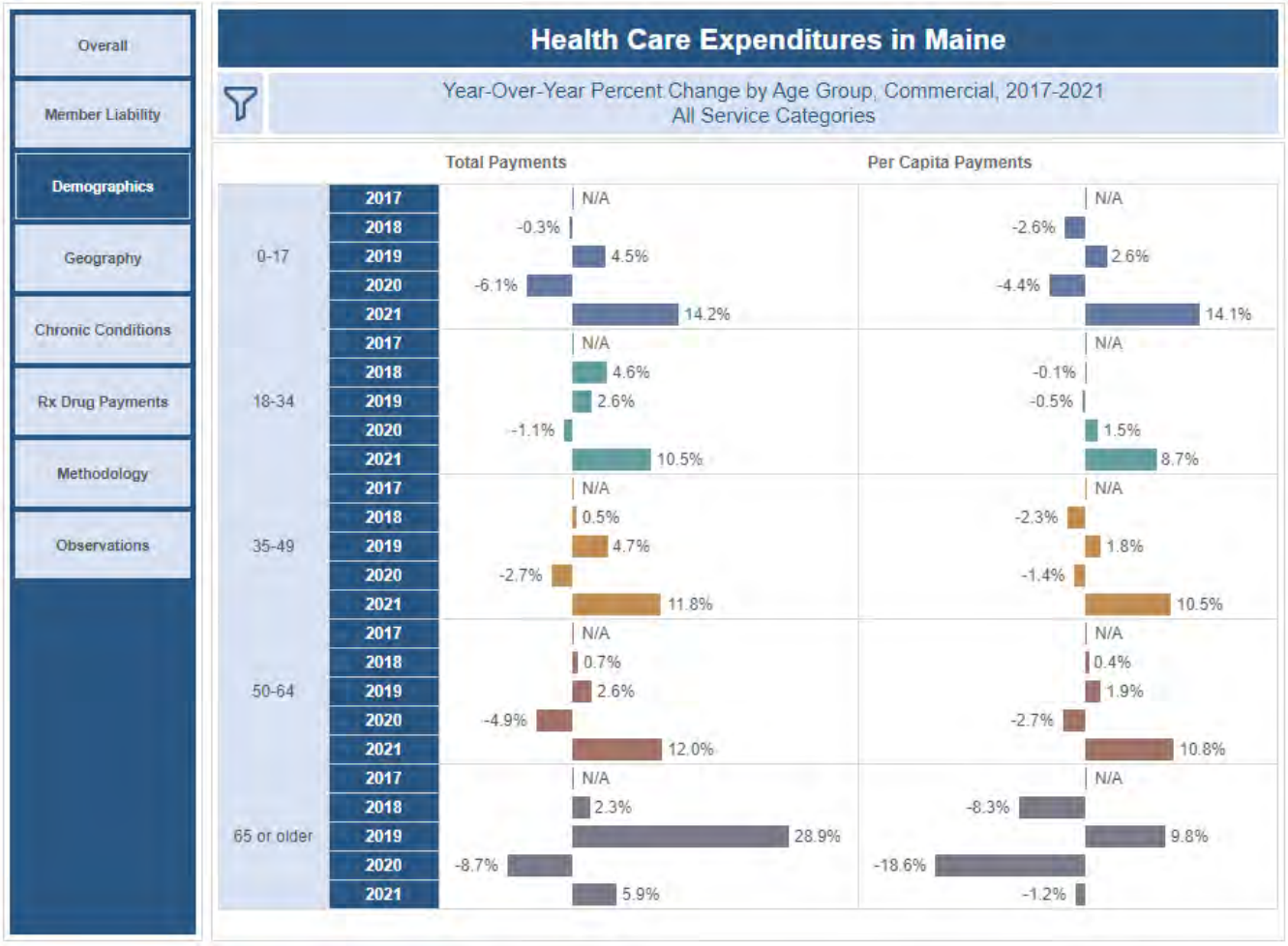


Data Source: MHDO All Payer Claims Data

Summary: Total payment amounts, and per capita payment amounts from medical and pharmacy claims.

Drop-down menu includes: Payer Type (Commercial, Medicare, etc.); Measure (Payment Amounts; Year-Over-Year Percent Change); Demographic (Age Group; Gender); and Service Category (All; Institutional, Hospital Inpatient; Institutional, Hospital Outpatient; Institutional, Other; Professional; Pharmacy).

4. Year-Over-Year Percent Change Trend in Total Payments and Per Capita Payments, by Demographic Variables, 2017-2021

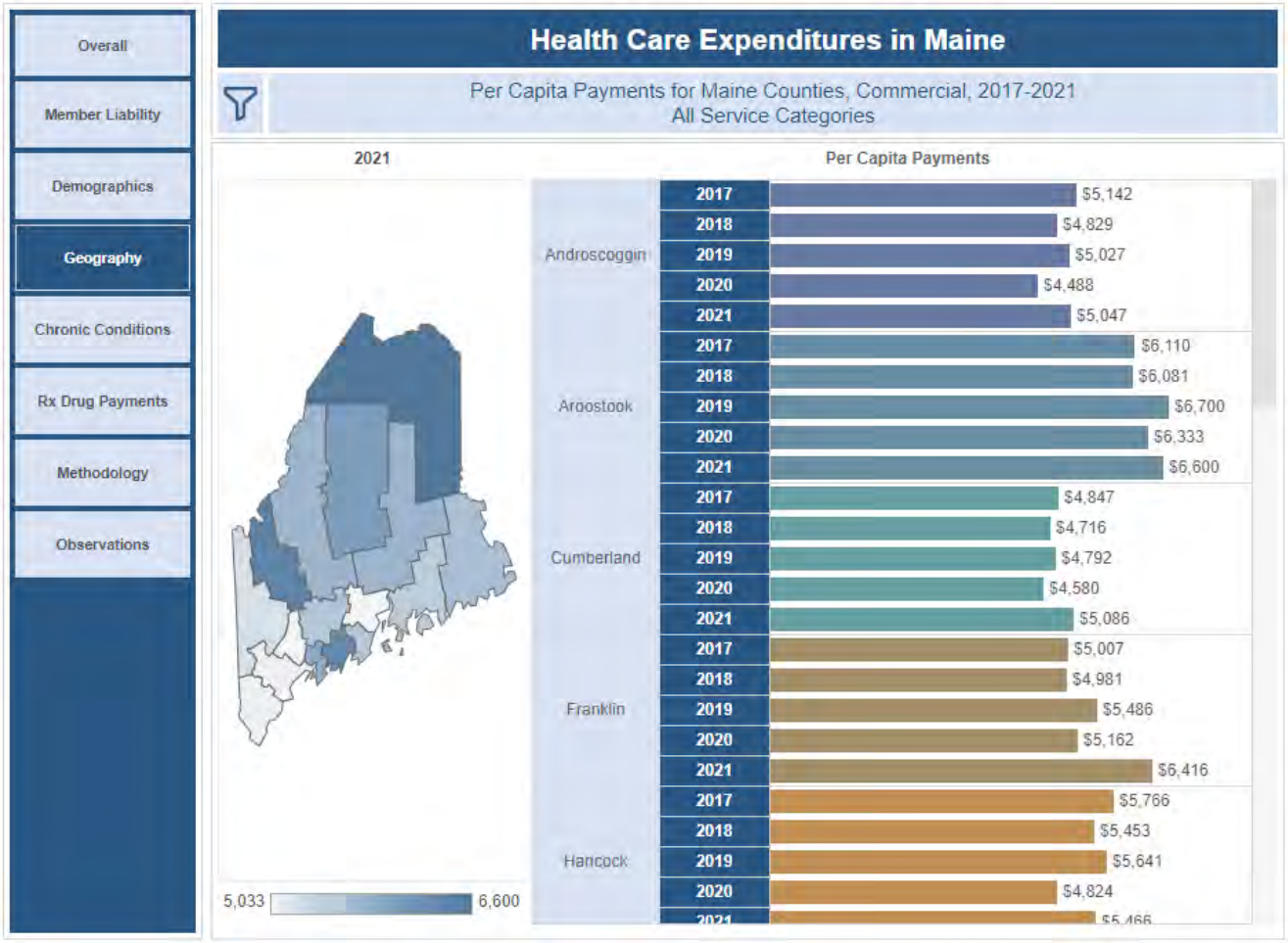


Data Source: MHDO All Payer Claims Data

Summary: Total payment amounts, and per capita payment amounts from medical and pharmacy claims.

Drop-down menu includes: Payer Type (Commercial, Medicare, etc.); Measure (Payment Amounts; Year-Over-Year Percent Change); Demographic (Age Group; Gender); and Service Category (All; Institutional, Hospital Inpatient; Institutional, Hospital Outpatient; Institutional, Other; Professional; Pharmacy).

5. Annual Total Payments and Per Capita Payments, by Geography

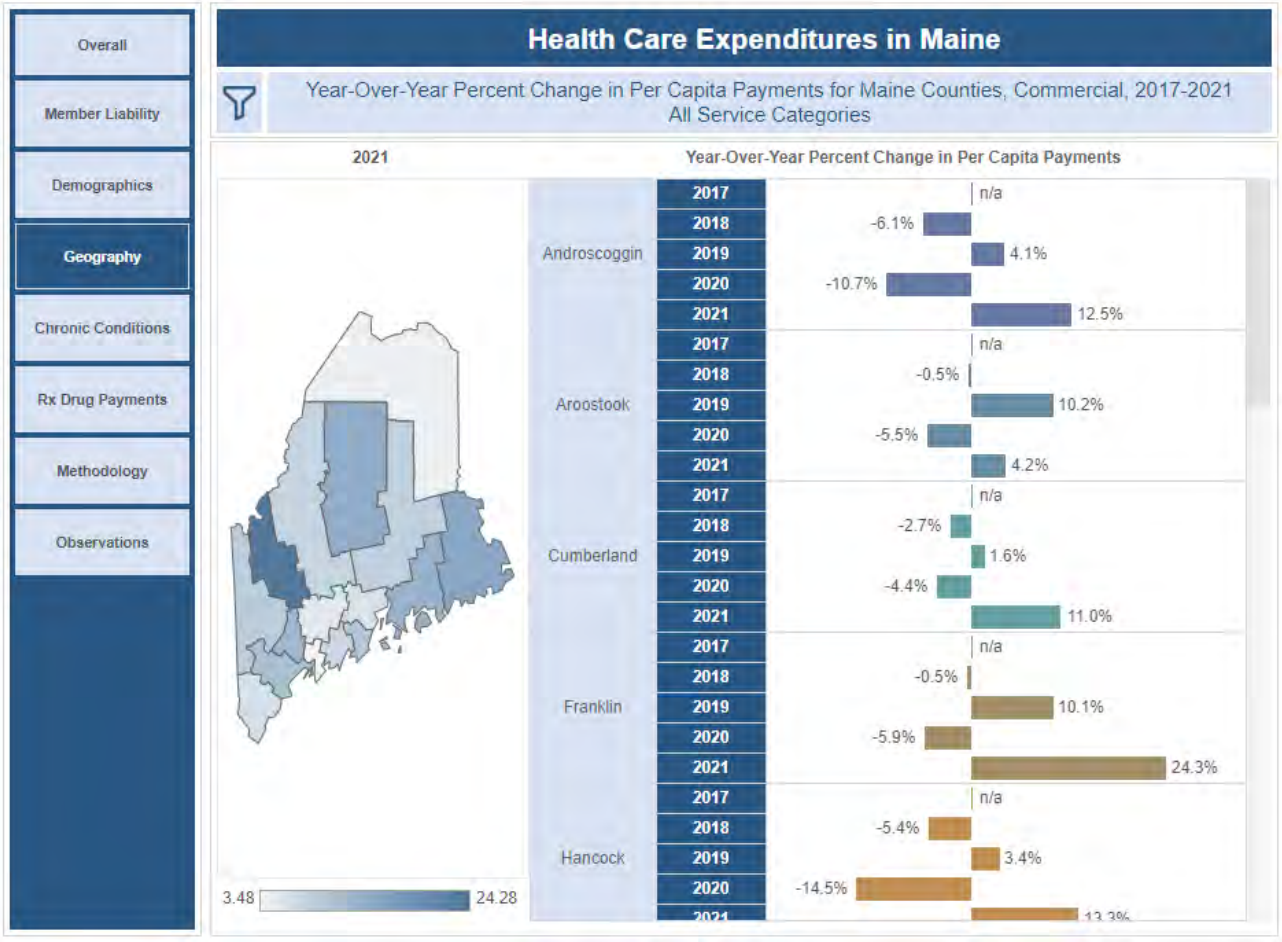


Data Source: MHDO All Payer Claims Data

Summary: Total payments and per capita payments from medical and pharmacy claims, by county, Local Public Health Districts, Market Rating Areas. Geographies listed represent the location of residence of the insurance enrollees. Please note that, while the snapshot above shows just the first five counties in alphabetical order, the complete output with the full list of Maine counties can be viewed in the interactive Tableau dashboard. Also note that, while the title for this display refers to both "Total Payments" and "Per Capita Payments," only a single measure at a time can be displayed in the interactive report (as seen in the snapshot above); dashboard viewers can use the drop-down menu to select one or the other measure.

Drop-down menu includes: Payer Type (Commercial, Medicare, etc.); Measure (Total Payments; Year-Over-Year Percent Change in Total Payments; Per Capita Payments; Year-Over-Year Percent Change in Per Capita Payments); Geography (Maine Counties; Maine Market Rating Areas; Maine Public Health Districts); and Service Category (All; Institutional, Hospital Inpatient; Institutional, Hospital Outpatient; Institutional, Other; Professional; Pharmacy); and Year.

6. Year-Over-Year Percent Change Trend in Total Payments and Per Capita Payments, by Geography, 2017-2021



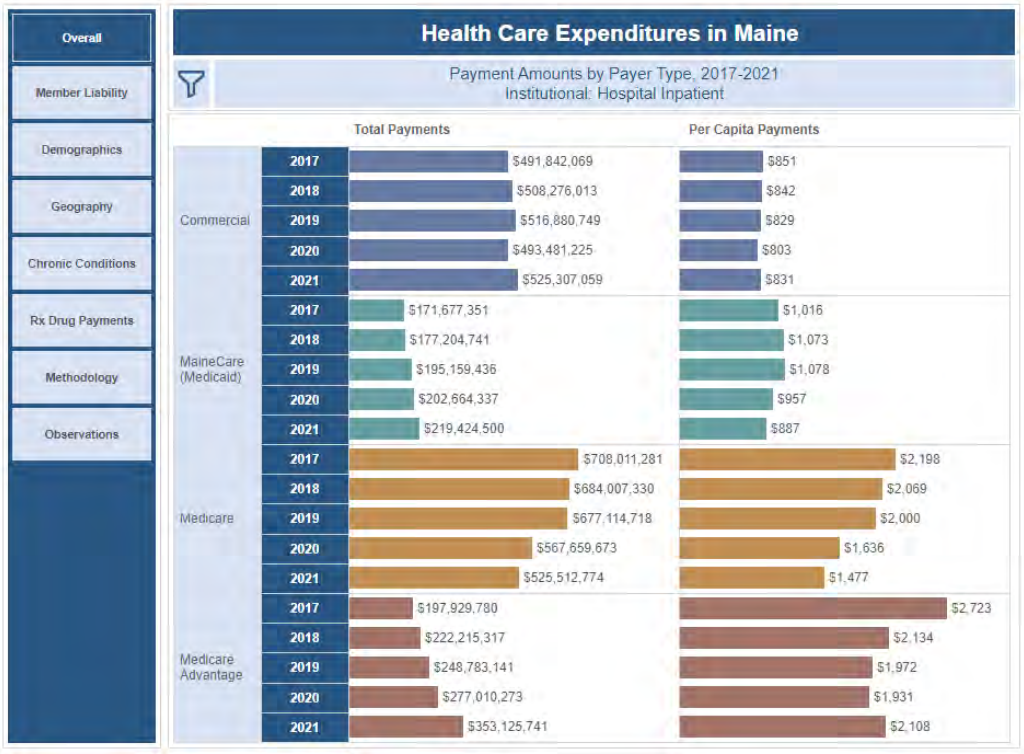
Data Source: MHDO All Payer Claims Data

Summary: Total payments and per capita payments from medical and pharmacy claims, by county, Local Public Health Districts, Market Rating Areas. Geographies listed represent the location of residence of the insurance enrollees. Please note that, while the snapshot above shows just the first five counties in alphabetical order, the complete output with the full list of Maine counties can be viewed in the interactive Tableau dashboard. Also note that, while the title for this display refers to both "Total Payments" and "Per Capita Payments," only a single measure at a time can be displayed in the interactive report (as seen in the snapshot above); dashboard viewers can use the drop-down menu to select one or the other measure.

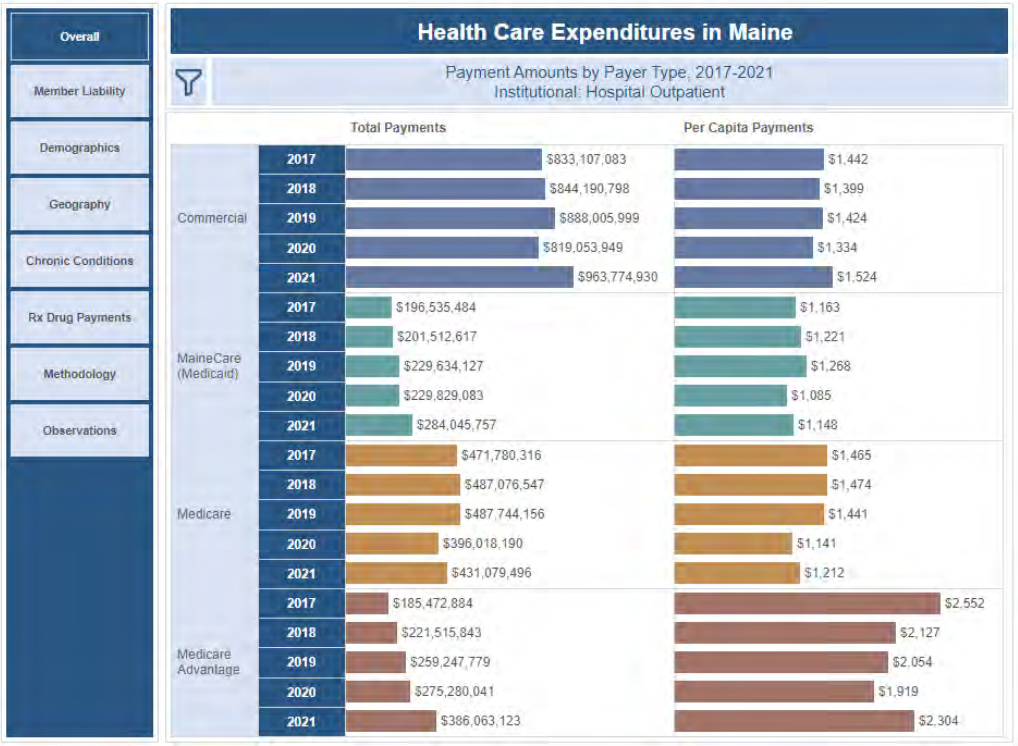
Drop-down menu includes: Payer Type (Commercial, Medicare, etc.); Measure (Total Payments; Year-Over-Year Percent Change in Total Payments; Per Capita Payments; Year-Over-Year Percent Change in Per Capita Payments); Geography (Maine Counties; Maine Market Rating Areas; Maine Public Health Districts); and Service Category (All; Institutional, Hospital Inpatient; Institutional, Hospital Outpatient; Institutional, Other; Professional; Pharmacy); and Year.

7. Annual Total Payments and Per Capita Payments, by Service Category, 2017-2021

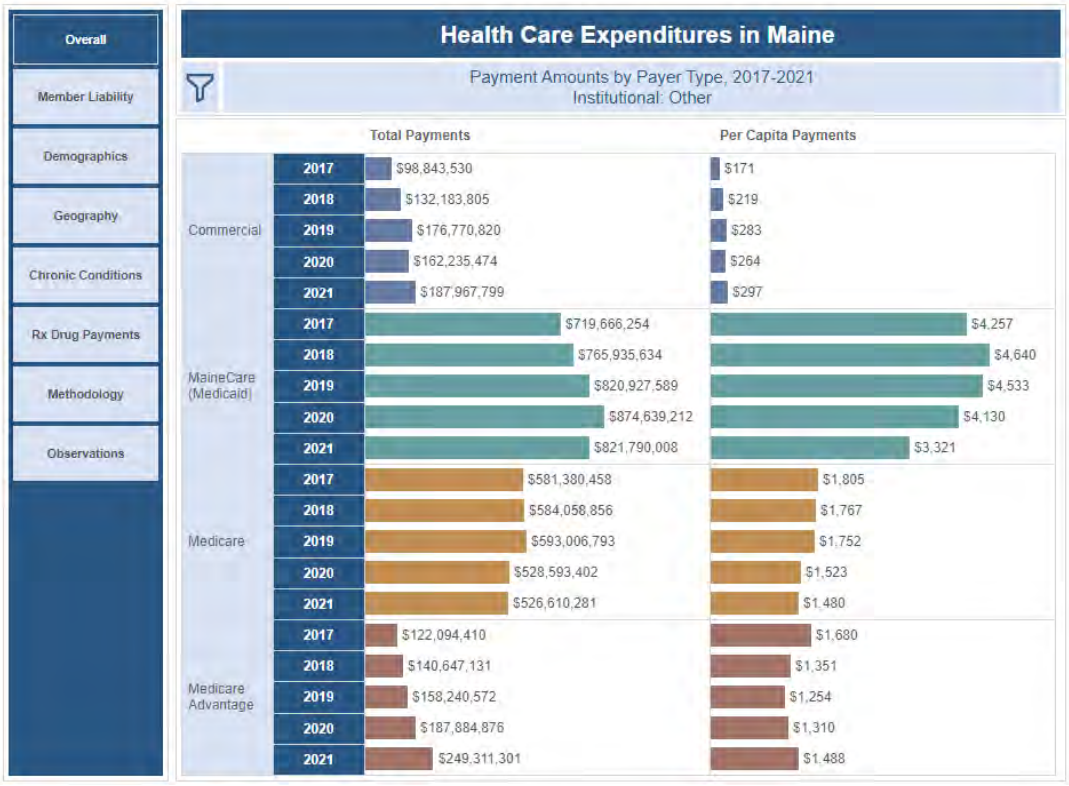
a. Institutional: Hospital Inpatient



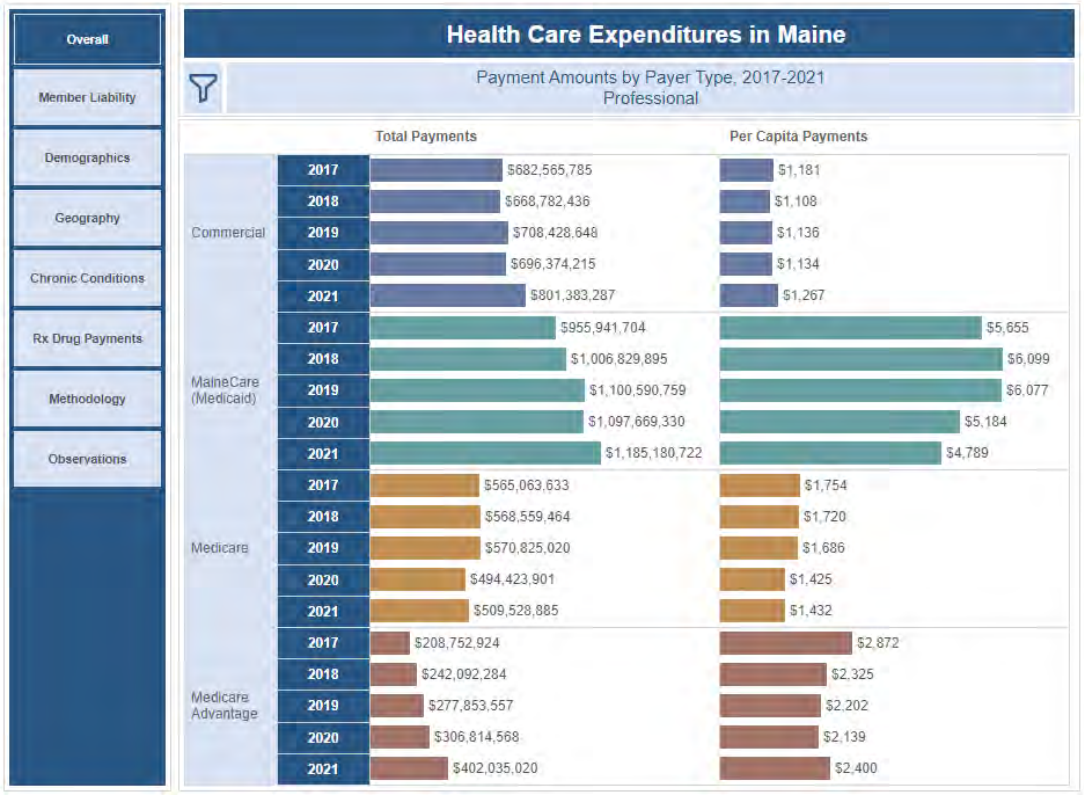
b. Institutional: Hospital Outpatient



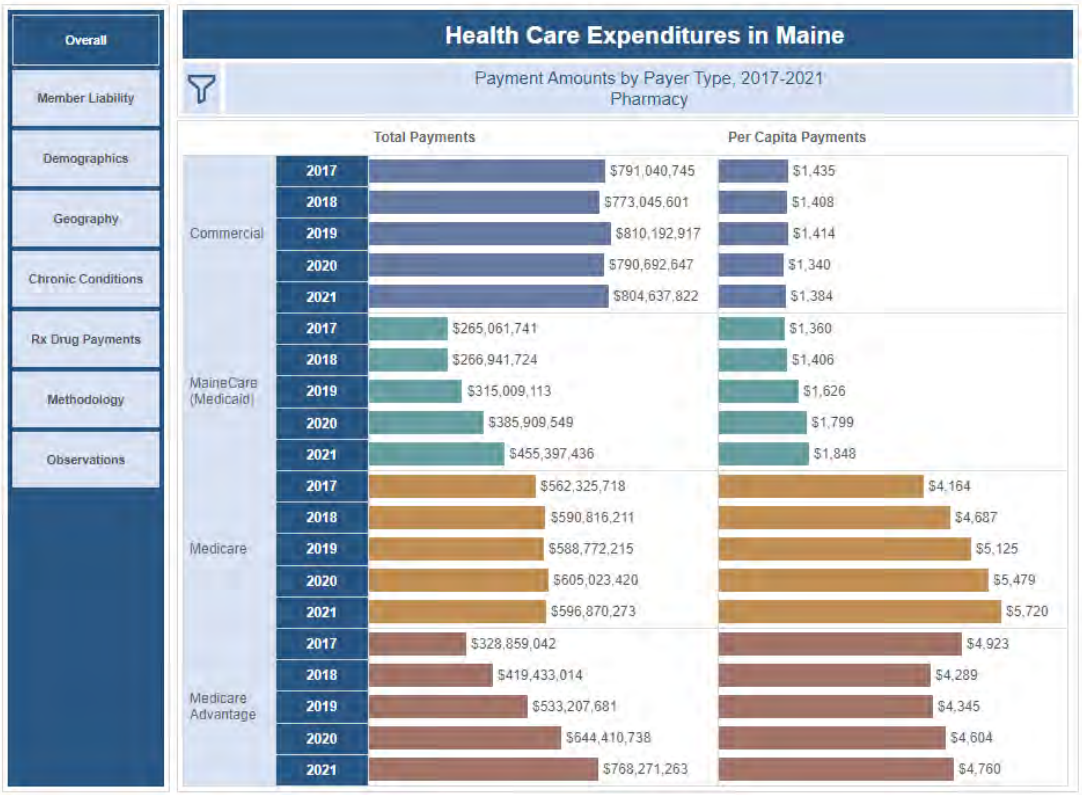
c. Institutional: Other



d. Professional



e. Pharmacy



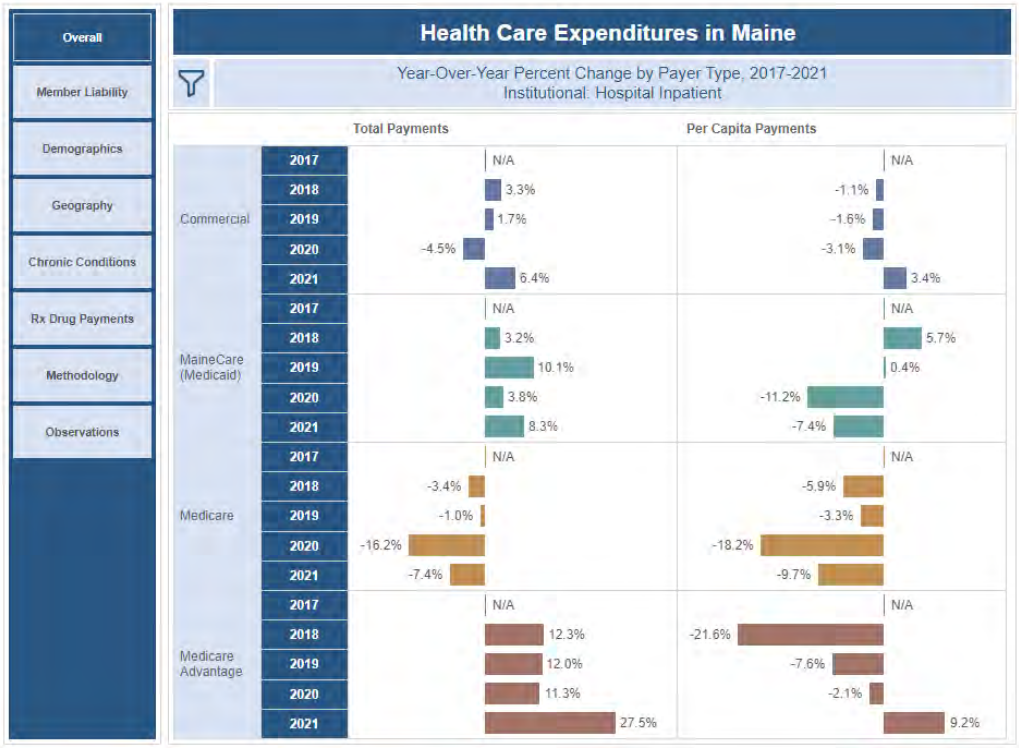
Data Source: MHDO All Payer Claims Data

Summary: Total payments and per capita payments for medical and pharmacy claims.

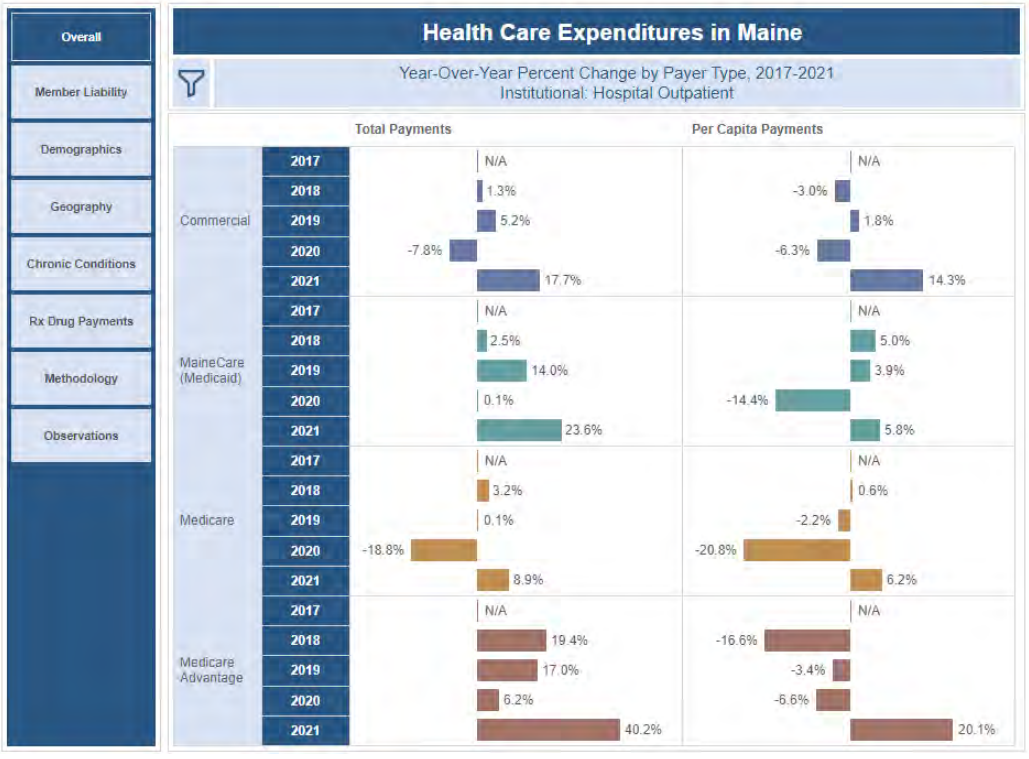
Drop-down menu includes: Measure (Payment Amounts; Year-Over-Year Percent Change); and Service Category (All; Institutional, Hospital Inpatient; Institutional, Hospital Outpatient; Institutional, Other; Professional; Pharmacy).

8. Year-Over-Year Percent Change Trend in Total Payments and Per Capita Payments, by Service Category, 2017-2021

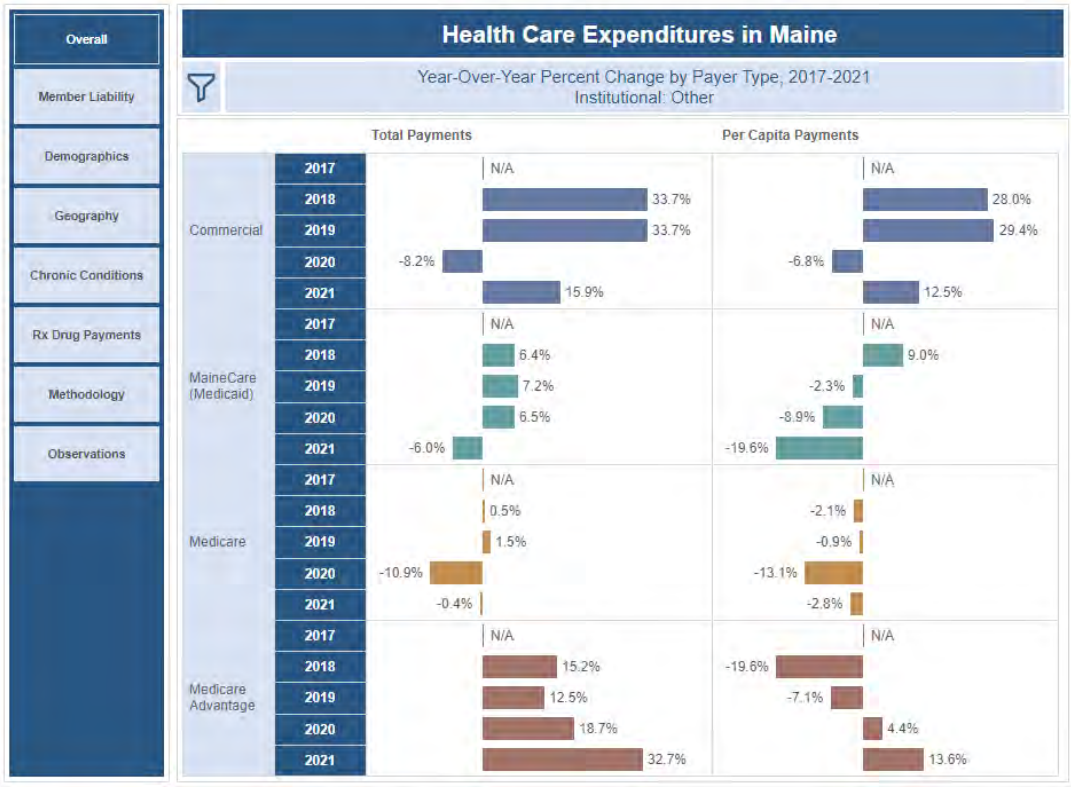
a. Institutional: Hospital Inpatient



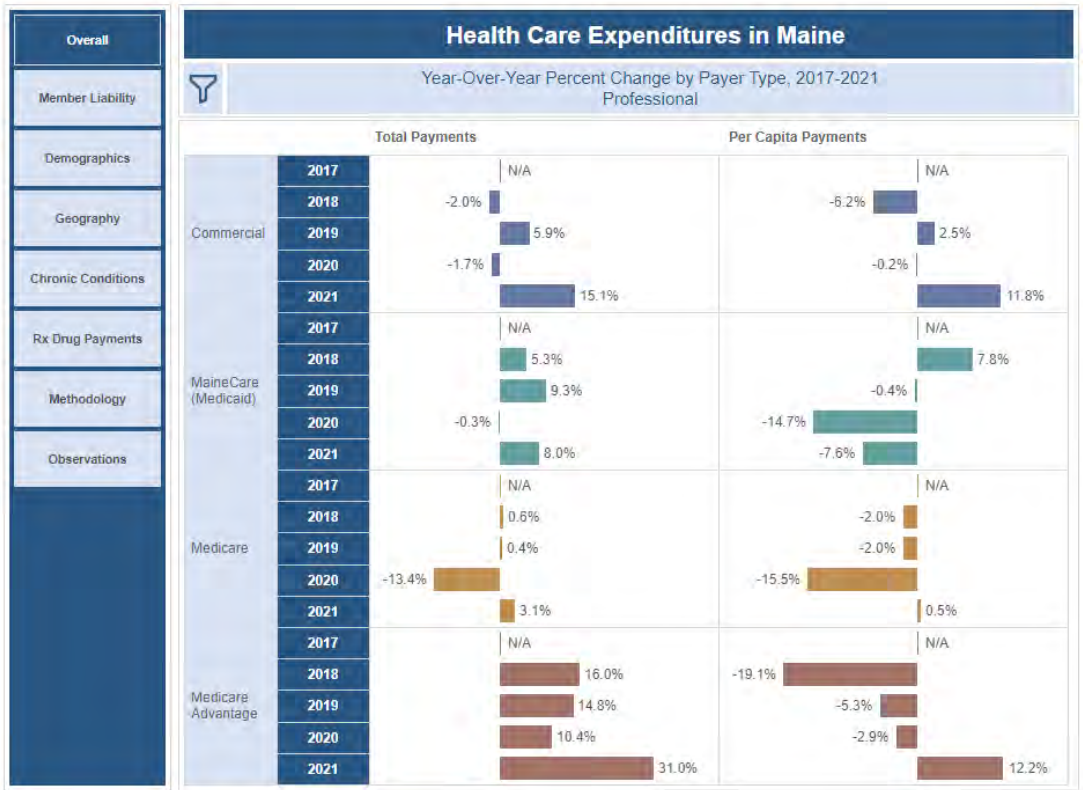
b. Institutional: Hospital Outpatient



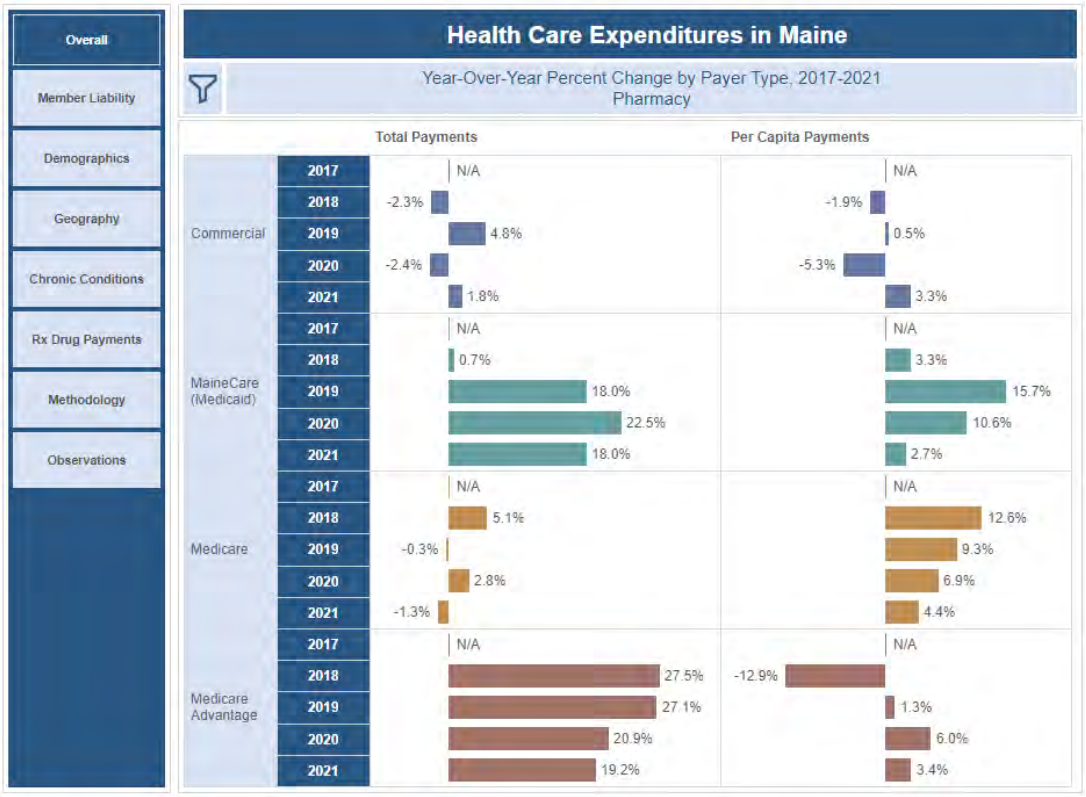
c. Institutional: Other



d. Professional



e. Pharmacy

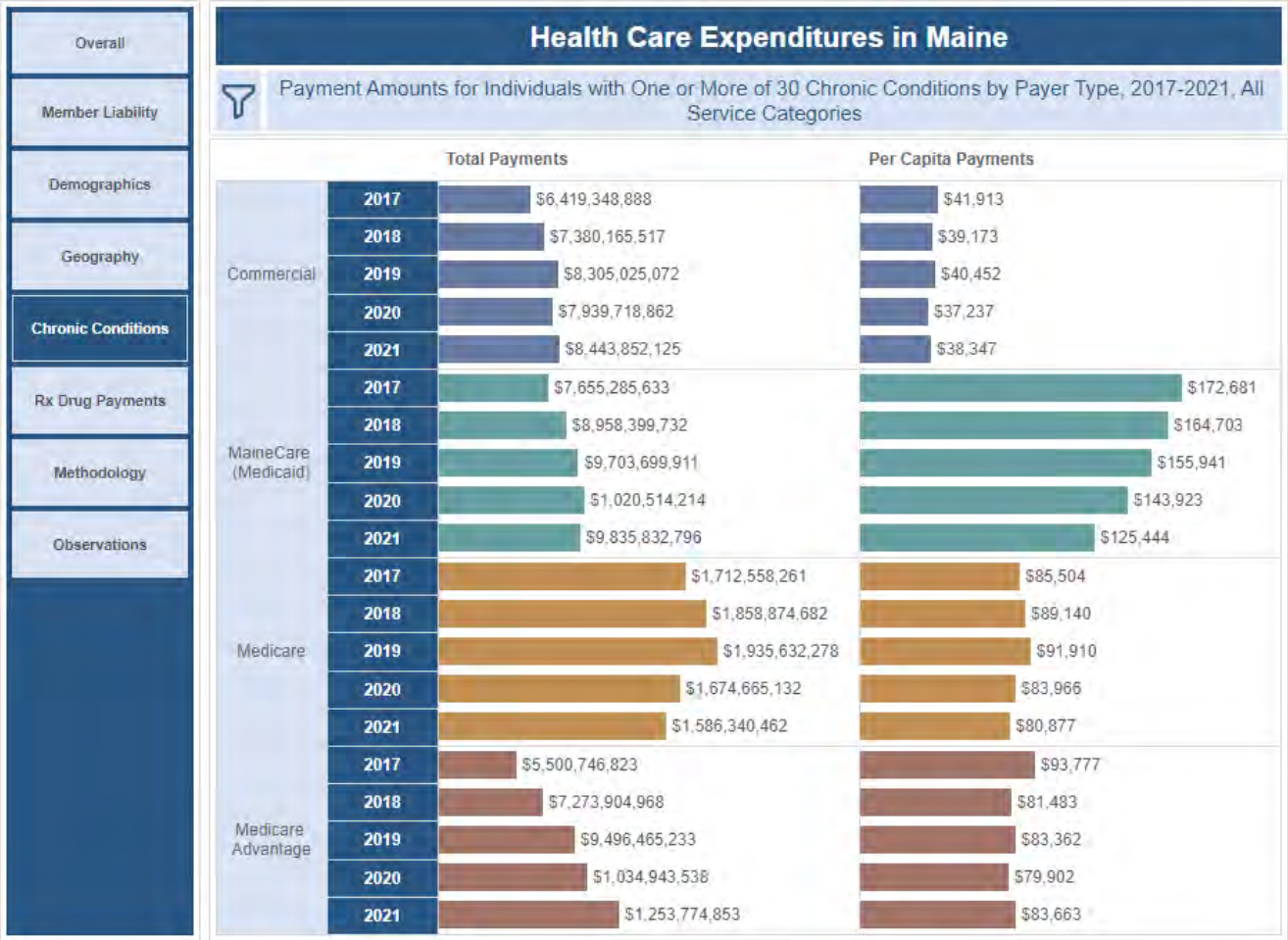


Data Source: MHDO All Payer Claims Data

Summary: Year-over-year percent change in total payments and per capita payments for medical and pharmacy claims.

Drop-down menu includes: Measure (Payment Amounts; Year-Over-Year Percent Change); and Service Category (All; Institutional, Hospital Inpatient; Institutional, Hospital Outpatient; Institutional, Other; Professional; Pharmacy).

9. Annual Total Payments and Per Capita Payment Amounts, by Chronic Condition, 2017-2021

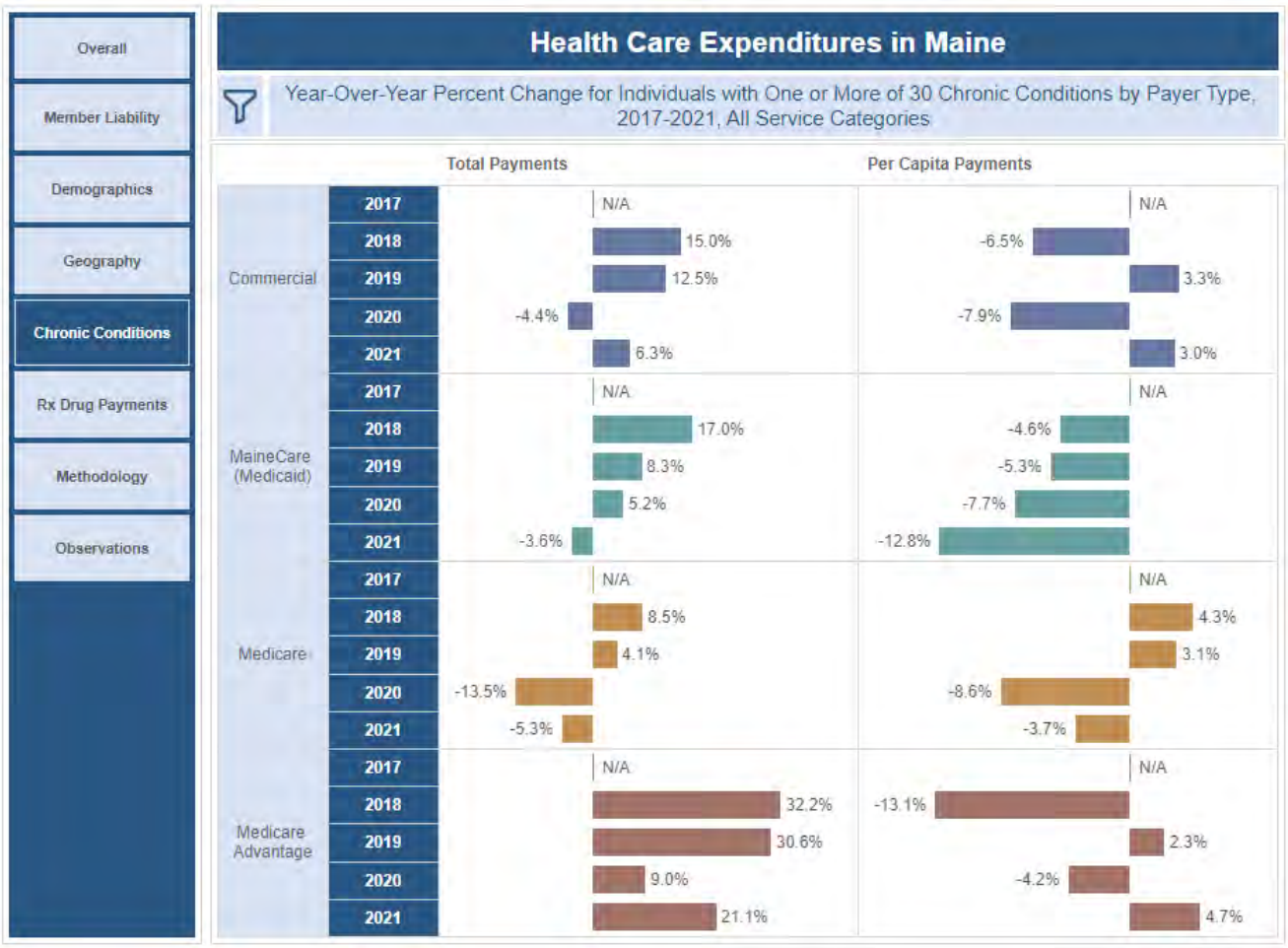


Data Source: MHDO All Payer Claims Data

Summary: Total payment and per capita payments from medical and pharmacy claims

Drop-down menu includes: Measure (Payment Amounts; Year-Over-Year Percent Change); 30 Chronic Conditions (full list in Methodology section); and Service Category (All; Institutional, Hospital Inpatient; Institutional, Hospital Outpatient; Institutional, Other; Professional; Pharmacy).

10.Year-Over-Year Percent Change Trend in Total Payments and Per Capita Payments, by Chronic Condition, 2017-2021



Data Source: MHDO All Payer Claims Data

Summary: Total payment and per capita payments from medical and pharmacy claims

Drop-down menu includes: Measure (Payment Amounts; Year-Over-Year Percent Change); 30 Chronic Conditions (full list in Methodology section); and Service Category (All; Institutional, Hospital Inpatient; Institutional, Hospital Outpatient; Institutional, Other; Professional; Pharmacy).

11. State Fiscal Year Total Payments for 25 Costliest Drugs, 25 Most Frequently Prescribed Drugs, and 25 Drugs with the Highest Year-Over-Year Cost Increases, by Payer Type and Brand/Generic Drug Category

Health Care Expenditures in Maine

Top 25 Costliest Drugs for Brand Name or Generic Drugs, All Payers
(June 1, 2020 to June 30, 2021)

Rank	NDC	Drug Name	Drug Class(es)	Number of Prescriptions	Number of Prescription Users	Cost	Cost Per Prescription
1	00074055402	Humira Pen	Disease-modifying Ant..	16,530	2,342	$126,672,881	$7,663
2	00003089421	Eliquis	Antithrombotic Agents	96,248	23,998	$93,381,950	$970
3	57894006103	Stelara	Disease-modifying Ant..	3,492	739	$87,499,616	$25,057
4	51167033101	Trikafta	Cystic Fibrosis Trans..	1,453	173	$37,685,222	$25,936
5	58406003204	Enbrel Sureclick	Disease-modifying Ant..	5,206	820	$35,977,557	$6,911
6	00002143480	Trulicity	Antidiabetic Agents	23,174	5,759	$32,689,868	$1,411
7	12496120803	Suboxone	Analgesics and Antipy..	134,543	8,476	$27,157,275	$202
8	00088221905	Lantus Solostar	Antidiabetic Agents	40,045	10,061	$25,242,289	$630
9	00002143380	Trulicity	Antidiabetic Agents	18,505	5,356	$23,224,635	$1,255
10	61958250101	Biktarvy	Antivirals	5,166	685	$20,492,678	$3,967
11	00074433902	Humira Pen	Disease-modifying Ant..	2,560	395	$20,.22,379	$7,821
12	50458057930	Xarelto	Antithrombotic Agents	17,279	4,886	$18,495,143	$1,070
13	00597015230	Jardiance	Antidiabetic Agents	17,320	5,416	$17,661,415	$1,020
14	00186037020	Symbicort	Adrenals; Anti-inflam..	31,102	8,509	$17,141,393	$551
15	00003089321	Eliquis	Antithrombotic Agents	20,695	4,935	$17,056,667	$824
16	00078063941	Cosentyx Sensoready Pen	Disease-modifying Ant..	2,356	369	$17,.14,890	$7,222
17	00173088710	Trelegy Ellipta	Anticholinergic Agents..	17,151	4,059	$17,011,934	$992
18	00597015330	Jardiance	Antidiabetic Agents	15,293	4,261	$16,598,151	$1,085
19	00169633910	Novolog Flexpen	Antidiabetic Agents	14,100	4,080	$16,585,155	$1,176
20	00169643810	Levemir Flextouch	Antidiabetic Agents	17,038	4,089	$16,216,992	$952
21	57962042028	Imbruvica	Not Available	1,031	120	$16,137,409	$15,652
22	00169406013	Victoza	Antidiabetic Agents	9,262	2,278	$15,189,422	$1,640
23	00597007541	Spiriva Handihaler	Anticholinergic Agents..	19,030	4,847	$14,225,828	$748
24	55513013760	Otezla	Disease-modifying Ant..	2,822	5..6	$13,974,701	$4,952
25	00024591401	Dupixent	Skin and Mucous Me..	3,853	521	$13,966,821	$3,625
			Top 25 Overall	535,254	107,680	$757,322,271	$1,415
			State Total	**348,204,900**	**22,814,950**	**$69,061,117,100**	**$198**

Data Source: MHDO All Payer Claims Data

Summary: Total allowed amounts for 25 Costliest Drugs, 25 Most Frequently Prescribed Drugs, and 25 Drugs with the Highest Year-Over-Year Cost Increases from pharmacy claims.

Drop-down menu includes: Payer Type (All Payers, Commercial, Medicare, etc.); Measure (Top 25 Costliest Drugs, Top 25 Most Frequently Prescribed Drugs, Top 25 Drugs with Highest Year-Over-Year Cost Increases); Drug Type (Brand Name or Generic; Brand Name; Generic).

Overview of Health Care Quality Measurement in Maine

This section of the report provides information on the health care quality data that is currently available nationally and in Maine; and information on the Maine Quality Forum's (MQF) legislative mandate and activities for collecting, measuring, and publicly reporting health care quality data in the state in collaboration with the Maine Health Data Organization.

Association between Health Care Quality and Costs

Pursuing safe and high-quality care is one of the Institute of Health Improvement's (IHI) Triple Aim for optimizing health for individuals and hospitals.[1] Patient experience of care including both quality of care and satisfaction, along with population health and cost of care are all important factors to consider in trying to design a high functioning health system.

While consumers and purchasers often may assume higher prices are associated with better quality, there is emerging consensus in the research literature that healthcare pricing and the quality of care are largely unrelated and can be negatively associated depending on how each is measured.[2] [3]Some studies have found high-priced hospitals performed worse in areas of measured quality such as readmissions rates, patient-safety indicators and post-surgical complications, including deaths.[4] Other analyses of U.S. hospitals charge-to-cost ratio and CMS's total hospital quality performance and subdomains found that higher prices were significantly and negatively associated with total performance scores, patient experience, and efficiency measures, and only marginally significantly positively associated with clinical care domains.[5] This and other research has informed guidance by the federal government and other national quality organizations that support public reporting and transparency efforts, to strongly recommend quality information be reported along with costs in order for consumers to factor both in choosing the best value option for them.[6,7,8,9,10]

---

[1] https://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

[2] Hussey PS, Wertheimer S, Mehrotra A. The association between health care quality and cost: a systematic review. Ann Intern Med. 2013 Jan 1;158(1):27-34.

[3] Health Care Cost Institute, The Price-Quality Paradox in Healthcare, Data Brief #3, April 2016. https://healthcostinstitute.org/hcci-research/the-price-quality-paradox-in-health-care

[4] White C., Reschovsky J.D., Bond A.M. Understanding differences between high-and low-price hospitals: Implications for efforts to rein in costs. *Health Aff.* 2014;33:324–331.

[5] Beauvais B, Gilson G, Schwab S, Jaccaud B, Pearce T, Holmes T. Overpriced? Are Hospital Prices Associated with the Quality of Care? Healthcare (Basel). 2020 May 17; 8(2):135. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7349401/

[6] https://www.ahrq.gov/talkingquality/explain/share-info/offer-info.html

[7] General Accounting Office, Health Care Transparency: Actions Needed to Improve Cost and Quality Information to Consumers, October 2014 downloaded from https://www.gao.gov/assets/gao-15-11.pdf

[8] Emanuel EJ, Diana A. Considering the Future of Price Transparency Initiatives—Information Alone Is Not Sufficient. *JAMA Netw Open.* 2021;4(12) downloaded from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787076

[9] Federal Register, Executive Order 13877 of June 24, 2019 Improving Price and Quality Transparency in American Healthcare To Put Patients First downloaded from https://www.govinfo.gov/content/pkg/FR-2019-06-27/pdf/2019-13945.pdf

[10] Andrew M. Ryan, Ph.D. Christopher P. Tompkins, Ph.D, Efficiency and Value in Healthcare: Linking Cost and Quality Measures. A paper commissioned by the National Quality Forum, November 14, 2014

Maine Quality Forum

The Maine Quality Forum (MQF), established in 2003, is responsible for monitoring and improving the quality of health care in the state as defined in 24-A Chapter 87 Section 6951. Many years ago, MQF adopted the Institute of Medicine's (IOM) quality framework[11] which includes the following six aims:

- **Safe**: Avoiding harm to patients from the care that is intended to help them.
- **Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse respectively)
- **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Adopting a quality framework like the IOMs has helped guide decisions and the selection of which health care quality indicators to publicly report in Maine.

Another critical factor in the MQF's approach for collecting and reporting quality measures is whether the measure has been endorsed nationally and if the data is available publicly. Existing quality data and measures address some areas more extensively than others and the level at which they are collected and or available also can vary (e.g., facility-level versus individual provider-level). Most of the existing measures are specific to hospital entities and address effectiveness and safety, a smaller number examine timeliness and patient-centeredness, and very few assess the efficiency or equity of health care.

National Quality Data Sources

Maine providers participate in several national efforts that collect and report quality and patient safety data by providers both public (Centers for Medicaid and Medicare Services) and private voluntary (e.g., The Leapfrog Group).

The following is a brief description of these data sources and the data that is reported. While public data sources allow download of their data for state-level reporting, private, voluntary efforts restrict public release of provider-specific data without express permission from the provider.

Medicare Care Compare (previously Hospital Compare, Physician Compare)

The Centers for Medicare & Medicaid Services' (CMS) Care Compare website https://www.medicare.gov/care-compare/ provides consumers with information on how well hospitals and other facilities deliver care to Medicare patients and encourages health care facilities to make continued improvements in care quality. Care Compare reports information on more than 150 quality measures for health care providers nationwide and allows consumers to compare hospital performance across many conditions.

[11] https://www.ahrq.gov/talkingquality/measures/six-domains.html

The data displayed on Care Compare are submitted by hospitals and other facilities in fulfillment of the reporting requirements of Medicare's respective quality reporting programs based on administrative claims, electronic medical records, and/or patient survey data (i.e., Hospital CAHPS). Care Compare currently reports 34 hospital-based quality measures that have been endorsed by the National Quality Forum (see Appendix B for list of these measures). The number of Maine hospitals reporting can vary by measure depending on minimum sample size requirements but are largely available for all Maine Medicare Prospective payment system hospitals and some Critical Access Hospitals.

Care Compare also publicly reports performance information for doctors, clinicians, groups, and Accountable Care Organizations (ACOs) on doctors and clinicians profile pages and in the Provider Data Catalog (PDC). For those participating in the Merit-Based Incentive Payment System (MIPS) quality program, CMS publicly reports 65 clinician MIPS quality measures as star ratings on Care Compare profile pages and includes 133 clinician MIPS quality measures in the PDC. While data is reported, most measures for providers are reported at the group or ACO level.

For more information and details on quality measures by these clinical groups see:

- https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/care-compare-dac-initiative
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Care-Compare-DAC-Initiative/Frequently-Asked-Questions

Agency for Health Care Research and Quality (AHRQ)

MHDO releases its hospital inpatient and outpatient discharge data to the Agency for Health care Research and Quality's Health Care Utilization Project (HCUP). HCUP brings together the data collection efforts of State data organizations, hospital associations, private data organizations, and the Federal government to create a national information resource of encounter-level health care data. HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988. These databases enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to health care programs, and outcomes of treatments at the national, State, and local market levels.

State-level reports are also available and show how states compare with the national average and relative to prior reporting periods on specific measures. For example, Maine providers reporting in HCUP, performed above the national average in the baseline year on care coordination, person-centered care, healthy living, and effectiveness of care measures, and are similar to the national average on other measures.

For more information on HCUP go here:

- https://www.hcup-us.ahrq.gov/overview.jsp
  https://datatools.ahrq.gov/nhqdr?tab=nhqdrstsn&type=tab

Health Care Effectiveness and Data and Information Set (HEDIS)

HEDIS consists of quality measures created by the National Committee for Quality Assurance (NCQA). This data is tracked from year to year to measure health plan performance and provides information about the patient populations served. The data collected is intended to identify opportunities for improvement and to:

- Monitor the health of the general population
- Evaluate patient treatment outcomes and procedures
- Provide an external performance measurement

Most health plans measure their quality and performance with HEDIS, one of the most widely used health care performance measurement tools.

The number of HEDIS measures vary from year to year as new measures are added and some are retired. Measures cover aspects of health care including preventative care, such as screenings and immunizations, management of physical and mental health conditions, access and availability of care, patient experience, health care utilization, and resource use. The scores on measures can assist health care plans to understand the quality of care provided to their members in the most common chronic and acute illness populations.

Leapfrog Hospital Safety Grades

Leapfrog Hospital Safety Grades reports on over 30 national performance measures from the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Hospital Survey, and information from other supplemental data sources. Together, these performance measures produce a single letter grade representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors while in the hospital. As of Spring 2022, 16 of 33 Maine hospitals had composite overall grades reported on Leapfrog. Leapfrog does not currently support measures or grades for critical access hospitals.

Maine hospitals that report in Leapfrog generally perform higher than average nationally. For example, for 2022 Maine ranked 11th nationally for percentage of hospitals receiving an A grade (43.9% of reporting Maine hospitals).

For more information on The Leapfrog Group visit:

- https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/state-rankings
- https://www.hospitalsafetygrade.org/search?findBy=state&zip_code=&city=&state_prov=ME&hospital=https://www.leapfroggroup.org/ratings-reports

State Data Source for Defining and Colleting Health Care Quality Measures

Rule 90-590, Chapter 270 - Uniform Reporting System for Health Care Quality Data Sets

The Maine Quality Forum and the Maine Health Data Organization collaborate with stakeholders including the Maine-CDC on the maintenance and updates to the quality reporting requirements in Rule Chapter 270, *Uniform Reporting System for Health Care Quality Data Sets.* Chapter 270 defines health care quality data sets and the provisions for filing these data sets to the Maine Health Data Organization.

Chapter 270 requires hospitals to report on six health care associated infection measures, including central line catheter-associated blood stream infection rates, catheter-associated urinary tract infection rates and surgical site infection rates for knee and hip replacements (effective 7/1/23); and nursing sensitive indicators, which currently include pressure ulcers, and patient falls. In addition, nursing facilities will begin reporting their *Clostridium difficile* Lab ID Events effective July 1, 2023.

Public Reporting of Quality Measures in Maine

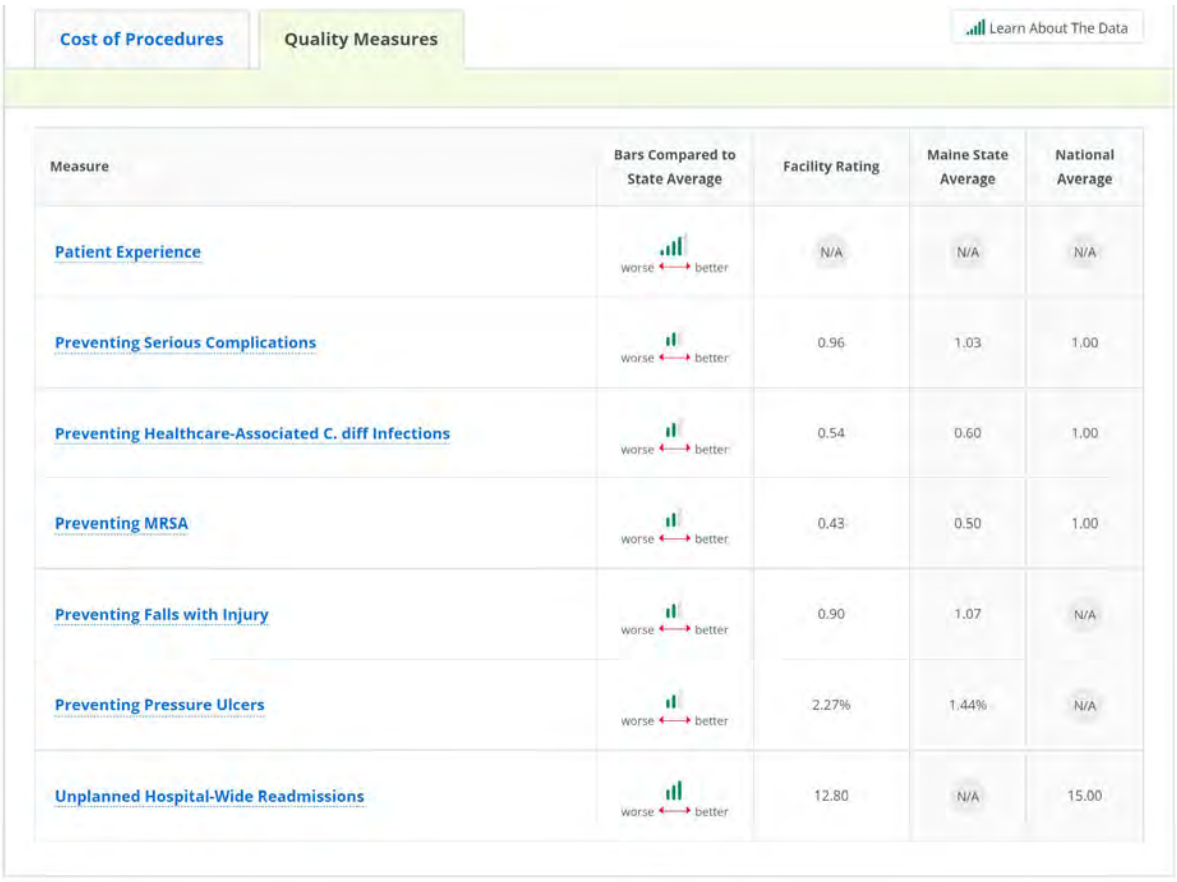
CompareMaine

MHDO and MQF are required by statute to promote the transparency of health care costs and quality on a public website. In October 2015, CompareMaine.org was launched. CompareMaine reports the average payments by procedure for over 250 healthcare procedures, by health care facilities across the state, by the top five commercial payors in the State of Maine. The procedures reported on CompareMaine are some of the more common procedures in the MHDO claims data; and where there is usually variation in the average payments made by payors to facilities. (Note: In April of 2009, the MQF and the Advisory Council on Health Systems Development, released a report titled, *All-Payer Analysis of Variation in Healthcare in Maine.* Essentially the report identifies variation in healthcare spending in Maine using the MHDO's all-payor claims data, to identify the drivers of cost, and to allow for an informed discussion of strategies to reduce variation and costs overall. The report can be found here: https://mhdo.maine.gov/_externalReports/HDAS_MQF_Report_Final050609.pdf

MQF's primary mechanism for publicly reporting hospital-specific quality measures is on the MHDO's website CompareMaine. The quality data on CompareMaine comes from existing publicly available data r either through the state (90-590 Chapter 270 data) or through national sources (i.e., CMS Care Compare). Two important criteria used in the in the selection of the quality measures to include on CompareMaine are whether the measure is endorsed by the National Quality Forum or required by a federal agency for public reporting; and is there a national benchmark available so performance can be compared to a national standard.

To identify measures that meet these criteria, MQF created a measures inventory tool of measures endorsed by the National Quality Forum. The measures are organized by setting, measure steward, data source, and whether the measure is publicly reported and by what entity (e.g., Hospital Compare, etc.).

Below is a screen shot of the quality data specific to hospitals that is available on CompareMaine.



Cost of Procedures | Quality Measures | Learn About The Data

Measure	Bars Compared to State Average	Facility Rating	Maine State Average	National Average
Patient Experience	worse ⟷ better	N/A	N/A	N/A
Preventing Serious Complications	worse ⟷ better	0.96	1.03	1.00
Preventing Healthcare-Associated C. diff Infections	worse ⟷ better	0.54	0.60	1.00
Preventing MRSA	worse ⟷ better	0.43	0.50	1.00
Preventing Falls with Injury	worse ⟷ better	0.90	1.07	N/A
Preventing Pressure Ulcers	worse ⟷ better	2.27%	1.44%	N/A
Unplanned Hospital-Wide Readmissions	worse ⟷ better	12.80	N/A	15.00

Both the cost and quality data reported on CompareMaine are updated annually based on most recent data available. In fact, in December 2022, version 11.0 of CompareMaine was launched https://www.comparemaine.org/

MQF is in the process of expanding the number of quality measures to report on CompareMaine for future versions to represent a broader distribution of measures that fall within the six IOM domains. Additionally, MQF is exploring the feasibility of calculating and reporting HEDIS measures for non-hospital settings using MHDO's All Payer Claims and Hospital Discharge Data.

Other MQF Annual Reports and Information

In addition to quality measures included on CompareMaine, MQF is required by statute to produce an annual report for the legislature on Health care Associated Infections that analyzes how hospitals are performing by peer group and assesses statewide trends in reducing health care associated infections.[12]

Limitations of Quality Data Available Publicly

Key lessons learned from MQF's environmental scan and review of existing measures include:

- Most quality measures calculated and publicly reported are for hospitals and are payer-specific (i.e., Medicare only).
- Few endorsed quality measures are procedure-specific

[12] https://mhdo.maine.gov/_mqfdocs/2018%20HAI%20Annual%20Report%20FINAL.pdf

- Because of the expense and complexity of developing procedure specific quality measures, NQF has only endorsed a few (e.g., hip replacement, CT scans)
- Most publicly available measures are process measures, which in general, are measures regarding the steps providers take (or don't take) during a patient encounter and/or while providing care. Process measures are intended to encourage providers to do things such as screen for a condition or risk-factor, take time to go over a surgical safety checklist, provide discharge instructions, etc.
- Fewer measures are outcome related, meaning, measures that reflect the impact of the health care service or intervention on the health status of patients. For example: the percentage of patients who died because of surgery (surgical mortality rates).
- Individual Provider-level quality measures are largely not available.

Other Analyses: Milliman Low Value Care Calculator, APCD Analyses

In 2018, the Maine Quality Forum was asked by Milliman and VBID to participate in a study with four other states specific to identifying and quantifying low-value care (LVC) using the Milliman MedInsight Health Calculator, a proprietary, algorithm-based software program designed to quantify LVC use and spending by differentiating whether the use of a specific medical service was clinically necessary, likely low-value, or low-value. Milliman consulted with experts nationally on the including the United States Preventive Services Task Force (USPSTF) and the Choosing Wisely campaign, on the definition of low value care.

The data source used in each state was their All-Payer Claims Data. VBID/Milliman used the claims data to quantify the utilization and spending on 47 specific low-value services over a three-year period. by payer type and broken down into plan payment and beneficiary out-of-pocket spending. Low value care services were identified based on sources such as the United States Preventive Services Task Force (USPSTF) and the Choosing Wisely® campaign.

Maine's Top 10 highest volume low value procedures included Annual Resting EKGs, Antibiotics for Acute Upper Respiratory and Ear Infections, Opiates in Acute Disabling Low Back Pain, Routine General Health Checks (for Asymptomatic Adults), Preoperative Baseline Laboratory Studies, 25-OH-Vitamin D Deficiency, PSA Imaging Tests for Eye Disease, Cervical Cancer Screening in Women, Cough and Cold Medicines in Children.

A copy of VBIDs report can be found here: https://vbidhealth.com/docs/APCD-LVC-Final.pdf

Appendix A: Methodological Notes

Data Source

The data in the interactive Tableau reports is based on the MHDO All Payer Claims data, which is created based on the data submissions defined in 90-590 CMR Chapter 243, *Uniform Reporting System for Health Care Claims Data Sets*. The data period represents January 2017 through December 2021 for Commercial, MaineCare (Medicaid), Medicare Advantage and Medicare data. MHDO claims data goes through over 300 data quality validations designed to ensure high data quality.

More information about the APCD, including how many members are represented as part of this analysis, is found on the MHDO website: MHDO Available Data (maine.gov). The MHDO APCD contains 100% of MaineCare and Medicaid members and approximately 70% of the commercially insured members, including several of the largest self-insured ERISA plans who are voluntarily submitting data to the MHDO. Also, prospective interim payments paid to Critical Access Hospitals (CAH) and Institutions for Mental Disease (IMD) on behalf of MaineCare members (where MaineCare is the primary payer) are not included in the APCD. Beginning with Q4 of 2022 MaineCare will begin to submit payments to MHDO for CAH's and IMD's.

At the time of producing this baseline report, **non-claims**-based payments **were not available**, that is payments that are for something other than a fee-for-service claim. These non-claims-based payments include, but are not limited to, Capitation Payments, Care Management/Care Coordination/Population Health Payments, Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments, Global Budget Payments, Patient-centered Medical Home Payments, Pay-for-performance Payments, Pay-for-reporting Payments, Primary Care and Behavioral Health Integration Payments, Prospective Case Rate Payments, Prospective Episode-based Payments, Provider Salary Payments, Retrospective/Prospective Incentive Payments, Risk-based Payments, Shared-risk Recoupments, Shared-savings Distributions. Other non-claims-based payments that were not available for inclusion in the report are pharmacy rebate amounts. MHDO recently started collecting non-claims-based payments per the requirements defined in 90-590 Chapter 247, *Uniform Reporting System for Non-Claims Based Payments.* Future reporting may consider the inclusion of these non-claims-based payments in health care spending totals.

Payments for MaineCare include services that are traditionally not covered by Commercial or Medicare insurance, including Long Term Services and Support (LTSS). The list below are the specific sections of the MaineCare Benefits Manual that are considered LTSS:

- Section 2 - Adult Family Care Services,
- Section 12 - Consumer Directed Attendant Services,
- Section 18 - Home and Community-Based Services (HCBS) for Adults with Brain Injury,
- Section 19 - Home and Community Benefits (HCBS) for the Elderly and Adults with Disabilities,
- Section 20 - Home and Community Based Services (HCBS) for Adults with Other Related Conditions,
- Section 21 - Home and Community Benefits (HCBS) for Members with Intellectual Disabilities or Autism Spectrum Disorder,
- Section 26 - Day Health Services,

- Section 29 - Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder,
- Section 40 - Home Health Services,
- Section 50 - ICF-MR Services,
- Section 67 - Nursing Facility Services,
- Section 96 - Private Duty Nursing and Personal Care Services,
- Section 97 - Private Non-Medical Institution Services (PNMI) Appendix C and F,
- Section 102 - Rehabilitative Services.

The majority of MaineCare payments for LTSS services are expected to be represented in the service category breakdowns as 'Institutional: Other' and 'Professional.'

The claim-based payments in this baseline report are calculated without any adjustments; they are not adjusted for inflation in healthcare costs, and not adjusted to control for differences in age, gender or illness burden between groups.

Report Measures

This report displays the following measures:

Total Payments

Represents the total dollars spent on medical and pharmacy services as calculated from allowed amounts from medical and pharmacy claims submitted to MHDO by health insurance plans. Allowed dollar amounts include the amount paid by insurance company, federal or state payer, plus any out-of-pocket amount paid by the insured person, specifically the sum of copay, coinsurance, and deductible amounts. This calculation excludes amounts submitted on dental claims.

Year-Over-Year Percent Change in Total Payments

Represents the percent change in total payment amount, comparing the reporting year to the previous year. This is not calculated for 2017 (first calendar year included in this analysis).

Per Capita Payments

Represents a calculation of the average allowed amount paid per person in a year. It is calculated by dividing the total allowed amounts from medical and pharmacy services by the total number of insured-years. The total dollars spent on medical and pharmacy services are based on insurance claims submitted to MHDO by health insurance plans. Insured years are calculated by summing the months of insurance eligibility for all people with at least one month of eligibility in the reporting period, then dividing the result by 12.

All per capita calculations in this report rely on the enhanced MHDO-assigned Person ID. The Person ID is uniquely assigned to individuals in the MHDO Data Warehouse regardless of submitters, payers, or contracts, and it spans multiple MHDO data sources (APCD, Hospital Encounter Data). The Person ID is populated in the APCD only for data submitted for years starting with 2017, because of improvements in the data collection and custom logic developed by MHDO for tracking individuals. The Person ID makes use of the full set of demographic information available to make a Person ID assignment.

Year-Over-Year Percent Change in Per Capita Payments

Represents the percent change in the per capita payment amount, comparing the reporting year to the previous year. This is not calculated for 2017 (first calendar year included in this analysis).

Member Liability Payments

Represents the out-of-pocket amount paid by the insured person on medical and pharmacy services, specifically the sum of copay, coinsurance, and deductible amounts, based on medical and pharmacy claims submitted to MHDO by health insurance plans. This calculation excludes amounts submitted on dental claims.

Year-Over-Year Percent Change in Member Liability Payments

Represents the percent change in member liability amount, comparing the reporting year to the previous year. This is not calculated for 2017 (first calendar year included in this analysis).

Per Capita Member Liability Payments

Represents a calculation of the average member liability amount per person in a year. It is calculated by dividing the member liability amounts from medical and pharmacy services by the total number of insured-years. The total dollars spent on medical and pharmacy services are based on insurance claims submitted to MHDO by health insurance plans. Insured years are calculated by summing the months of insurance eligibility for all people with at least one month of eligibility in the reporting period, then dividing the result by 12.

All per capita calculations in this report rely on the enhanced MHDO-assigned Person ID. The Person ID is uniquely assigned to individuals in the MHDO Data Warehouse regardless of submitters, payers, or contracts, and it spans multiple MHDO data sources (APCD, Hospital Encounter Data). The Person ID is populated in the APCD only for data submitted for years starting with 2017, as a result of improvements in the data collection and custom logic developed by MHDO for tracking individuals. The Person ID makes use of the full set of demographic information available to make a Person ID assignment.

Year-Over-Year Percent Change in Per Capita Member Liability Payments

Represents the percent change in the per capita member liability amount, comparing the reporting year to the previous year. This is not calculated for 2017 (first calendar year included in this analysis).

Prescription Drug Payments

This information is based on MHDO analyses for the publicly available report, *Prescription Drug Costs and Utilization in Maine at Retail and Mail Order Pharmacies* (available at https://mhdo.maine.gov/tableau/prescriptionReports.cshtml). The report displays the total allowed amounts for 25 Costliest Drugs, 25 Most Frequently Prescribed Drugs, and 25 Drugs with the Highest Year-Over-Year Cost Increases based on pharmacy claims submitted to MHDO by health insurance plans, disaggregated by major payer types: Commercial, Medicaid, Medicare Advantage, and by brand/generic drug category. Please note that these calculations are for state Fiscal Years rather than calendar years.

To comply with the CMS Cell Suppression Policy, we display “<11" for Number of Prescriptions and Number of Prescription Users. When Number of Prescriptions is <11, an asterisk (*) is displayed in the Cost per Prescription column.

Report Breakdowns

Reporting Year

Unless otherwise noted, this represents the calendar year (12 months of data, from January through December). It is based on the year of the date of service start on the claim, and on the eligibility year and eligibility month, for eligibility record-based statistics.

Payer Type

The report includes the major payer types: Commercial, Medicaid, Medicare Advantage, Medicare Fee-For-Service. The payer type 'Medicare' refers to Medicare Fee-For-Service coverage. The Medicare Advantage payer type includes a large proportion of Medicare Part D in the pharmacy category. All of these Part D claims are paid through a commercial plan and may not necessarily be part of a Medicare Advantage plan.

Service Category

Each of the report pages displays information by service category: hospital inpatient, hospital outpatient, other institutional services, professional, and pharmacy. Hospital inpatient and hospital outpatient categories represent information strictly from institutional claims (i.e., exclude the professional amounts paid for services occurring during inpatient stays or outpatient hospital visits). The 'Institutional: Other' category is comprised primarily of residential facility services, inpatient skilled nursing services, intermediate care and hospice care. The report also displays measures for 'All Service Categories' combined. This classification was developed primarily based on the Type of Bill values and the Place of Service values present on the claim.

Please note that the 'Institutional: Other' and 'Professional' service categories includes long-term care services for MaineCare (Medicaid), which are not covered by commercial or Medicare insurance. The respective services are covered under the following Long-Term Care Services (LTSS) policy sections:

- Section 2 - Adult Family Care Services,
- Section 12 - Consumer Directed Attendant Services,
- Section 18 - Home and Community-Based Services (HCBS) for Adults with Brain Injury,
- Section 19 - Home and Community Benefits (HCBS) for the Elderly and Adults with Disabilities,
- Section 20 - Home and Community Based Services (HCBS) for Adults with Other Related Conditions,
- Section 21 - Home and Community Benefits (HCBS) for Members with Intellectual Disabilities or Autism Spectrum Disorder,
- Section 26 - Day Health Services,
- Section 29 - Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder,
- Section 40 - Home Health Services,
- Section 50 - ICF-MR Services,
- Section 67 - Nursing Facility Services,
- Section 96 - Private Duty Nursing and Personal Care Services,
- Section 97 - Private Non-Medical Institution Services (PNMI) Appendix C and F,
- Section 102 - Rehabilitative Services.

Demographics

The following age groups are displayed in the report: 0 to 17, 18 to 34, 35 to 49, 50 to 64, and 65 or older. Age groups are based on age on December 31st of the reporting year.

Gender categories are based on the most recent member eligibility records available for the reporting year.

Geography

Geographic area breakdowns available in the report are Maine counties, Maine Public Health Districts, and Maine Market Rating Areas. They represent the location of residence for individuals (insurance enrollees) and are based on the most recent member eligibility records available for the reporting year.

Chronic Health Conditions

The chronic conditions assignment for the purposes of this analysis, developed at the person-year level, is based on the Centers for Medicare & Medicaid Services (CMS) Chronic Conditions methodology and selection of conditions (more details available at: https://www2.ccwdata.org/web/guest/condition-categories-chronic), using the most current available version—the 30 CCW Chronic Condition categories. The following conditions are included:

1. Acute Myocardial Infarction
2. Alzheimer's Disease
3. Anemia
4. Asthma
5. Atrial Fibrillation and Flutter
6. Benign Prostatic Hyperplasia
7. Cancer, Breast
8. Cancer, Colorectal
9. Cancer, Endometrial
10. Cancer, Lung
11. Cancer, Prostate
12. Cancer, Urologic (Kidney, Renal Pelvis, and Ureter)
13. Cataract
14. Chronic Kidney Disease
15. Chronic Obstructive Pulmonary Disease
16. Depression, Bipolar, or Other Depressive Mood Disorders
17. Diabetes
18. Glaucoma
19. Heart Failure and Non-Ischemic Heart Disease
20. Hip/Pelvic Fracture
21. Hyperlipidemia
22. Hypertension
23. Hypothyroidism
24. Ischemic Heart Disease
25. Non-Alzheimer's Dementia
26. Osteoporosis With or Without Pathological Fracture

27. Parkinson's Disease and Secondary Parkinsonism
28. Pneumonia, All-cause
29. Rheumatoid Arthritis/Osteoarthritis
30. Stroke/Transient Ischemic Attack

The Total Payments, Per Capita Payments and their respective year-over-year percent change values are calculated at the year level for subgroups of people that have been assigned one of these chronic conditions. Additionally, the report also displays these statistics for individuals that:

- Have one or more of the 30 chronic conditions,
- Have two or more of the 30 chronic conditions.

The reference period for determining the presence of these chronic conditions is either one or two calendar years, depending on the condition. In the latter case, the data points for the first year available in the report, 2017, are based on a single year rather than both 2016 and 2017, because claims are selected based on the APCD Person ID. As a result of improvements in the data collection and custom logic developed by MHDO for tracking individuals, the enhanced MHDO-assigned Person ID is populated in the APCD only for data submitted for years starting with 2017 and is unavailable for prior years.

Data Suppression

Values are suppressed if either the number of individuals or the number of claims used to calculate the respective value is below 11. For these reports, 0.6% of all rows have been suppressed.

Redaction of Substance Use Disorder (SUD) Claims

Payers submitting data to MHDO redact all SUD-related codes from their data submissions to MHDO as they feel is required under Federal Rule, 42 CFR Part 2.

Appendix B: CMS Health Care Quality Measure Inventory

Source: https://cmit.cms.gov/cmit/#/MeasureInventory

Measure Inventory Export (Exported 9/6/2022 13:51:34)						
Results: 34 | Query: None | Group By: Measure Variants | Filters: Hospital Compare,Active,Endorsed | Sort Order: None						
CMIT Ref. No	Measure Variant Title	Program	Measure Type	Reporting Status	CBE ID	CBE Endorsement Status
01641-C-HC	Hours of physical restraint use	Hospital Compare	Process	Active	0640	Endorsed
01930-C-HC	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Hospital Compare	Outcome	Active	1893	Endorsed
02264-C-HC	Hospital 30-day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery	Hospital Compare	Outcome	Active	2558	Endorsed
02277-C-HC	Hospital-Level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care for Pneumonia	Hospital Compare	Cost/Resource Use	Active	2579	Endorsed

Measure Inventory Export (Exported 9/6/2022 13:51:34)						
Results: 34 | Query: None | Group By: Measure Variants | Filters: Hospital Compare,Active,Endorsed | Sort Order: None						
CMIT Ref. No	Measure Variant Title	Program	Measure Type	Reporting Status	CBE ID	CBE Endorsement Status
02278-C-HC	Hospital-level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care for Heart Failure (HF)	Hospital Compare	Cost/Resource Use	Active	2436	Endorsed
02594-C-HC	Hospital-Level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Acute Myocardial Infarction (AMI)	Hospital Compare	Cost/Resource Use	Active	2431	Endorsed
02706-C-HC	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	Hospital Compare	Outcome	Active	2881	Endorsed
02751-C-HC	Medicare Spending Per Beneficiary (MSPB) - Hospital	Hospital Compare	Cost/Resource Use	Active	2158	Endorsed
02752-C-HC	Elective Delivery (Chart-abstracted)	Hospital Compare	Process	Active	0469	Endorsed
02754-C-HC	Hours of seclusion use	Hospital Compare	Process	Active	0641	Endorsed

Measure Inventory Export (Exported 9/6/2022 13:51:34)						
Results: 34 | Query: None | Group By: Measure Variants | Filters: Hospital Compare,Active,Endorsed | Sort Order: None						
CMIT Ref. No	Measure Variant Title	Program	Measure Type	Reporting Status	CBE ID	CBE Endorsement Status
02755-C-HC	American College of Surgeons - Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Hospital Compare	Outcome	Active	0753	Endorsed
02759-C-HC	Influenza Immunization	Hospital Compare	Process	Active	1659	Endorsed
02800-C-HC	30-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)	Hospital Compare	Outcome	Active	2860	Endorsed
02852-C-HC	Excess Days in Acute Care after Hospitalization for Pneumonia	Hospital Compare	Outcome	Active	2882	Endorsed
02929-C-HC	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	Hospital Compare	Outcome	Active	3490	Endorsed
00078-C-HC	Heart failure (HF) 30-day readmission rate	Hospital Compare	Outcome	Active	0330	Endorsed

Measure Inventory Export (Exported 9/6/2022 13:51:34)						
Results: 34 | Query: None | Group By: Measure Variants | Filters: Hospital Compare,Active,Endorsed | Sort Order: None						
CMIT Ref. No	Measure Variant Title	Program	Measure Type	Reporting Status	CBE ID	CBE Endorsement Status
00080-C-HC	Acute myocardial infarction (AMI) 30-day readmission rate	Hospital Compare	Outcome	Active	0505	Endorsed
00083-C-HC	Pneumonia (PN) 30-day readmission rate	Hospital Compare	Outcome	Active	0506	Endorsed
00086-C-HC	Hospital 30-day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization	Hospital Compare	Outcome	Active	0230	Endorsed
00089-C-HC	Hospital 30-day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization	Hospital Compare	Outcome	Active	0229	Endorsed
00092-C-HC	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	Hospital Compare	Outcome	Active	0468	Endorsed
00104-C-HC	CMS Recalibrated Patient Safety Indicator (PSI) 90 (CMS PSI 90)	Hospital Compare	Composite	Active	0531	Endorsed

Measure Inventory Export (Exported 9/6/2022 13:51:34)						
Results: 34 | Query: None | Group By: Measure Variants | Filters: Hospital Compare,Active,Endorsed | Sort Order: None						
CMIT Ref. No	Measure Variant Title	Program	Measure Type	Reporting Status	CBE ID	CBE Endorsement Status
00130-C-HC	Median Time to Transfer to Another Facility for Acute Coronary Intervention	Hospital Compare	Process	Active	0290	Endorsed
00831-C-HC	National Health care Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Hospital Compare	Outcome	Active	1717	Endorsed
00844-C-HC	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Hospital Compare	Outcome	Active	1550	Endorsed
00899-C-HC	Hospital-level 30 day, all-cause, risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Hospital Compare	Outcome	Active	1551	Endorsed

Measure Inventory Export (Exported 9/6/2022 13:51:34)						
Results: 34 | Query: None | Group By: Measure Variants | Filters: Hospital Compare,Active,Endorsed | Sort Order: None						
CMIT Ref. No	Measure Variant Title	Program	Measure Type	Reporting Status	CBE ID	CBE Endorsement Status
00907-C-HC	National Health care Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Hospital Compare	Outcome	Active	1716	Endorsed
00918-C-HC	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	Hospital Compare	Process	Active	0661	Endorsed
01061-C-HC	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Hospital Compare	Process	Active	0658	Endorsed
01364-C-HC	National Health care Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Hospital Compare	Outcome	Active	0138	Endorsed

Measure Inventory Export (Exported 9/6/2022 13:51:34)						
Results: 34 | Query: None | Group By: Measure Variants | Filters: Hospital Compare,Active,Endorsed | Sort Order: None						
CMIT Ref. No	Measure Variant Title	Program	Measure Type	Reporting Status	CBE ID	CBE Endorsement Status
01426-C-HC	Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary Artery Bypass Graft (CABG) Surgery	Hospital Compare	Outcome	Active	2515	Endorsed
01455-C-HC	Hospital-Level, 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Hospital Compare	Outcome	Active	1891	Endorsed
05537-C-HC	Patient Safety and Adverse Events Composite	Hospital Compare	Composite	Active	0531	Endorsed
05746-E-HC	Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Record Data	Hospital Compare	Outcome	Active	2879e	Endorsed