

**DRAFT RECOMMENDATION REGARDING UPDATING THE QUALITY-BASED  
REIMBURSEMENT INITIATIVE FOR FY 2012**

Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215  
(410) 764-2605  
Fax (410) 358-6217

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This document is a draft staff recommendation to the Commission at the June 1, 2011 public meeting.

## 1. Background

The Maryland Health Services Cost Review Commission, at its June 4, 2008 meeting, approved the staff recommendation titled, "Final Staff Recommendations regarding the HSCRC's Quality-Based Reimbursement (QBR) Project - based on deliberations of the Initiation Work Group (IWG)." The QBR Initiative's development and implementation are based upon the deliberations and analysis performed by the HSCRC staff, the Initiation Work Group (IWG), the Evaluation Work Group (EWG), and Commission consultants over the past several years. The IWG completed its work in June 2008 and the EWG was then established to: provide a system for developing new measures, retiring old measures, and recommending other adjustments to the data and scoring; ensure that the QBR Initiative was meeting its established goals; and to support and increase the rationale for linking hospital performance to payment.

## 2. QBR Initiative Initial Year Implementation

For the first year of the QBR Initiative, the approved recommendations included using data for 19 process measures in four care domains including heart attack, heart failure, pneumonia and surgical care. For these measures, the additional approved recommendations included:

- incorporating new definitions for these core measures as they become available from CMS and the Joint Commission;
- weighting the scores for each process measure equally;
- establishing one index for the process measures for purposes of scoring, anticipating that reporting will be on performance for each domain separately;
- utilizing the Opportunity Model for scoring purposes, whereby a hospital receives credit for each time the measure is performed, and the hospital's available points will be 10 times the number of quality measures;
- utilizing calendar year 2007 as the Base Period and calendar year 2008 as the Measurement Period, establishing the scale for calibrating performance based on the prior year's experience so that thresholds and benchmarks are known in advance;
- counting (for purposes of scoring) the "higher of" either Attainment or Improvement points on each process measure for each hospital - on a 10 point scale for each measure;
- establishing the threshold for Attainment at the 50th percentile, the benchmark at 95th percentile for the non-topped off measures, and for topped off measures, 65 percent and 90 percent respectively;
- applying rewards and incentive payments maintaining revenue neutrality in FY 2010 as part of the FY 2010 Update Factor for individual hospitals;
- determining the amount of funding "at-risk" based on further deliberations and recommendations of the Payment Work Group comprising HSCRC staff and the hospital and payer industries, and based on approval of the Commission;
- scaling reward and incentive payments on a continuous basis for hospitals reporting on a minimum of 5 measures;
- utilizing an exchange rate function (cubed-root functional form) for translating scoring into rewards/incentives without high or low restrictions on eligibility or rewards/incentives achieved;

- establishing a rule to adjust for “down and up” year to year performance on any individual process measure, establishing the base-line for improvement as that hospital’s best previous score on that measure;
- establishing a mechanism where the Commission can obtain necessary data directly from hospitals through its own vendor arrangement based on work with the Maryland Health Care Commission in implementing a contract with a data vendor to collect quality data for both MHCC’s quality performance guide and the HSCRC QBR Initiative;
- moving over time toward use of complete data and away from sampling;
- assuring public accountability by providing accessibility to data given necessary restrictions on confidentiality;
- carefully planning and managing the public release of quality-related scoring information; and,
- investigating the feasibility in future years of incorporating additional funding (“new money”) into the system if Maryland as a state can achieve certain benchmarks vs. the performance of hospitals nationally on the selected performance measures.

Hospital rate adjustments were made for FY 2010 within the parameters of the recommendations specified above. The amount of funding “at risk” for the first year was 0.5 percent consistent with the deliberations and approved recommendations of staff and the Payment Work Group, however, the distribution of payment differential was quite narrow at 0.16 percent as the cube root exchange function was used to translate performance into rewards and penalties. The hospital quality data vendor has been procured by MHCC, and began collecting patient-level quality data in the first quarter of CY 2009. The EWG met regularly to deliberate: measure additions, changes, and deletions; changes to the benchmark and threshold values for topped off measures; and the use of a blended Appropriateness and Opportunity Model for the process measures in order to raise the bar of performance and better distinguish hospital performance in light of the increasing number of topped off measures. The EWG concluded its work in May 2009 with the Commission’s approval of the updated QBR recommendations for FY 2011.

### **3. Approved Changes to the QBR Initiative Beginning FY 2011**

*New Process Measures-* New measures were added consistent with MHCC’s timeframe for adding these measures to the Hospital Performance Evaluation Guide:

- AMI 8- Percutaneous Coronary Intervention Timing for AMI patients- base CY 2008, measurement CY 2009, and rate year FY 2011
- SCIP VTE 1- Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered - base CY 2009, measurement CY 2010, and rate year FY 2012
- SCIP VTE 2 - Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Given 24 hours prior and after surgery-base CY 2009, measurement CY 2010, and rate year FY 2012

- SCIP CARD-2 Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period – base CY 2009, measurement CY 2010, and rate year FY 2012
- SCIP Inf – 4- Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose - base CY 2009, measurement CY 2010, and rate year FY 2012
- SCIP Inf 6- Surgery Patients with Appropriate Hair Removal - base CY 2009, measurement CY 2010, and rate year FY 2012
- Children’s Asthma Care Asthma Measures (CAC-1-3)- base CY 2009, measurement CY 2010, and rate year FY 2012); these measure include:
  - CAC 1-Relievers for Inpatient Asthma Systemic
  - CAC 2- Corticosteroids for Inpatient Asthma
  - CAC 3- Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver

***Blended Opportunity and Appropriateness Scores***-To mitigate the effects of topped off measures better distinguishing hospital performance, and to raise the performance bar, a hybrid of the Opportunity and Appropriateness model was used where hospital scores are based 25% on Opportunity and 75% on Appropriateness for base CY 2008, measurement CY 2009, and rate year FY 2011.

***Topped off Measures Benchmarks*** – Based on analysis of the data in early 2009, the benchmark for topped off measures was changed from 0.9 percent to 0.95 percent to mitigate effects of topped off measures and better distinguish performance.

***Maryland Hospital Performance Changes on Measures used for FY 2010 and FY 2011*** – For FY 2011 we have 17 measures, compared to 19 measures the previous year. Two measures excluded for this year were:

- AMI-6 Beta Blocker prescribed at arrival (Retired)
- PN3a Blood cultures performed within 24 hours prior to or 24 hours after hospital arrival (No longer required by CMS or MHCC)

Staff compared the average percentage of patients who received each process measure and observed some improvement between 2008 and 2009 CY performance periods as follows:

- 14 measures improved with an average of 1.08 percentage point increase
- 2 measures worsened by less than one percentage point.
- 1 measure- influenza- changed the collection period.

Appendix A contains a list of the 17 measures and their changes from CY 2008 to 2009.

***Patient Experience of Care*** – Based upon the results of analysis of patient experience of care measures data (Hospital Consumer Assessment of Healthcare Providers and Systems – “HCAHPS”) relative to other domains of quality measures, and upon

proposed modeling of incorporating the patient experience domain in the QBR formula, the Commission approved allowing the option of including this domain for base CY 2009, measurement CY 2010, and rate year FY 2012.

#### **4. Centers for Medicare & Medicaid Services Value Based Purchasing (VBP) Program**

The Patient Protection and Affordable Care Act of 2010 requires CMS to fund the aggregate Hospital VBP incentive payments by reducing the base operating diagnosis-related group (DRG) payment amounts that determine the Medicare payment for each hospital inpatient discharge. The law sets the reduction at 1 percent in FY 2013, rising to 2 percent by FY 2017. CMS issued its VBP final rule in April 2011, the details of which are summarized below.

**Hospital VBP Measures-** For the federal FY 2013 (which begins on October 1, 2012) Hospital VBP program, CMS will measure hospital performance using two domains: the clinical process of care domain, which is comprised of 12 clinical process of care measures, decreased from 17 in the proposed rule, and the patient experience of care domain, which is comprised of the HCAHPS survey measure. The FY 2013 measures are in Appendix B. CMS will add the following measures in the Hospital VBP program for the FY 2014 payment determination: three mortality outcome measures, eight Hospital Acquired Condition (HAC) measures, and two Agency for Healthcare Research and Quality (AHRQ) composite measures. These measures are also specified in Appendix B.

**Performance Period-** CMS has established a base period that runs from July 1, 2009 through March 1, 2010, and a performance period that runs from July 1, 2011 through March 31, 2012, for the FY 2013 Hospital VBP payment determination. CMS anticipates that in future program years, if it becomes feasible, it may propose to use a full year as the performance period.

**Scoring Methods-** CMS will score each hospital based on achievement and improvement ranges for each applicable measure. A hospital's score on each measure will be the higher of an achievement score in the performance period or an improvement score, which is determined by comparing the hospital's score in the performance period with its score during a baseline period.

For scoring on achievement, hospitals will be measured based on how much *their* current performance differs from *all other hospitals'* baseline period performance. Points will then be awarded based on the hospital's performance compared to the threshold and benchmark scores for all hospitals. Points will only be awarded for achievement if the hospital's performance during the performance period exceeds a minimum rate called the "threshold," which is defined by CMS as the 50th percentile of hospital scores during the baseline period.

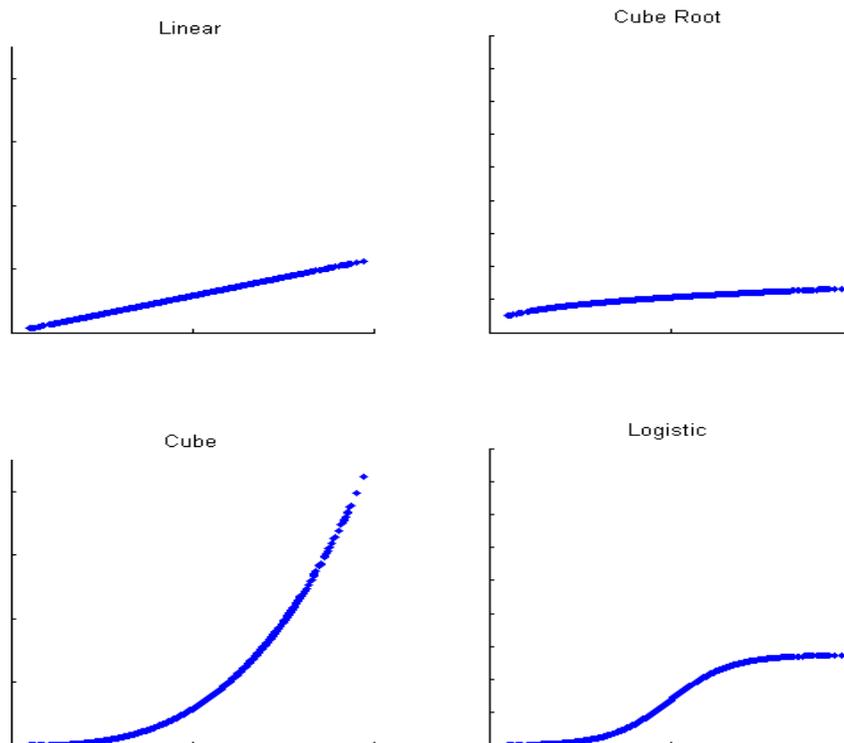
For scoring on improvement, hospitals will be assessed based on how much their *current performance* changes from their own *baseline period performance*. Points will then be awarded based on how much distance they cover between that baseline and the benchmark score. Points will only be awarded for improvement if the hospital's performance improved from their performance during the baseline period.

Finally, CMS will calculate a Total Performance Score (TPS) for each hospital by combining the greater of its achievement or improvement points on each measure to determine a score for each domain, multiplying each domain score by the proposed domain weight and adding the weighted scores together. In FY 2013, the clinical process of care domain will be weighted at 70 percent and the patient experience of care domain will be weighted at 30 percent.

**Incentive Payment Calculations-** CMS indicates in the Final Rule that the exchange function is the means to translate a hospital's total performance score into the percentage of the value-based incentive payment earned by the hospital, and that the selection of the exact form and slope of the exchange function is of critical importance to how the incentive payments reward performance and encourage hospitals to improve the quality of care they provide.

CMS considered four mathematical exchange function options: straight line (linear); concave curve (cube root function); convex curve (cube function); and S shape (logistic function) as illustrated in Figure 1 below.

**Figure 1: Mathematical Exchanged Function Options Considered by CMS**



For each of the above exchange function option, CMS evaluated:

- how each option would distribute the value-based incentive payments among hospitals;
- the potential differences between the value-based incentive payment amounts for hospitals that perform poorly and hospitals that perform very well;
- the different marginal incentives created by the different exchange function shapes; and,
- the relative importance of having the exchange function be as simple and straightforward as possible.

The linear function moves more aggressively to higher levels for higher performing hospitals than the cube root function, but not as aggressively as the logistic and cube functions. Due to the fact that the cube root function distributes lower payment amounts to higher performing hospitals, the cube root function creates the narrowest distribution of incentive payments across hospitals. The linear is next, followed by the logistic, and then the cube function, which creates the widest distribution. In the case of the linear shape, the marginal incentive does not vary for higher or lower performing hospitals; the slope of the linear function is constant, so any hospital with a Total Performance Score that is 0.1 higher than another hospital would receive incrementally the same increase.

When all of the above factors were taken together, CMS determined that the linear exchange function ensures that all hospitals have strong incentives to continually improve the quality of care they provide to their patients. CMS may revisit the issue of the most appropriate exchange function in future rulemaking as they gain more experience under the Hospital VBP program. CMS will notify each hospital of the *estimated* amount of its value-based incentive payment for FY 2013 through its QualityNet account at least 60 days prior to Oct. 1, 2012. CMS will notify each hospital of the *exact* amount of its value-based incentive payment on Nov. 1, 2012

***Maryland VBP Exemption-*** Inpatient acute care hospitals located in the State of Maryland are not currently paid under the IPPS in accordance with a special waiver provided by section 1814(b)(3) of the Act. Despite this waiver, Maryland hospitals continue to meet the definition of a “subsection (d) hospital” under section 1886(d)(1)(B) of the Affordable Care Act and are, therefore, not exempt from the CMS VBP program. While Maryland hospitals are not subject to the payment reduction under the CMS Hospital Inpatient Quality Reporting (IQR) program, all or nearly all of them submit data to Hospital Compare on a voluntary basis. Therefore, CMS does not believe that requiring Maryland hospitals to participate in the Hospital VBP program would create

an additional or duplicative burden, and therefore the Hospital VBP program will apply to acute care hospitals in Maryland. While the collection and submission of quality data for both the VBP and QBR programs does not constitute additional burden for the data collection and submission, participation in both programs would constitute payment changes, up or down, linked with each program.

The Health and Human Services Secretary may exercise discretion pursuant to 1886(o)(1)(C)(iv), which states that “the Secretary may exempt such hospitals from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.” As a precursor to future rulemaking on this topic, CMS provides further guidance indicating that:

- The report should be received prior to the Secretary’s consideration of whether to exercise discretion.
- A State shall submit, in writing and electronically, a report pursuant to section 1886(o)(1)(C)(iv) in a timeframe such that allows CMS-3239-F 126 it to be received no later than October 1, 2011, which is the beginning of the fiscal year prior to the beginning of FY 2013.
- The report should be as specific as possible in describing the quality (and other) measures included and in describing the results achieved over an applicable time period, noting that for the initial report the applicable time period would likely be before and after implementation of the State program.

***Minimum Number of Measures and Case Counts for Inclusion in VBP- CMS***

commissioned Brandeis researchers to check the reliability of the total performance score for hospitals with only 4 measures. The approach used was to randomly select 4, 6, 10, or 14 measures and compare the reliabilities determined using these different sets of measures per hospitals. The research found that using 4 randomly selected measures per hospital did not greatly reduce between-hospital reliability (particularly in terms of rank ordering) from what would have been determined using 10 or 14 measures. The whisker plots and reliability scores demonstrated a clear difference in the distribution of scores for hospitals reporting 4 or more measures compared with those reporting fewer than 4 measures.

Examining hospitals with at least 10 cases for each clinical process measure, the analysis compared the reliability of clinical process measure scores for hospitals according to the number of such measures reported. Whisker plots and reliability scores revealed comparable levels of variation in the process scores for hospitals reporting even a

small number of measures as long as the minimum of 10 cases per clinical process measure was met. Based on this analysis, CMS has established the minimum number of cases required for each measure under the proposed Three Domain Performance Scoring Model at 10, which will allow CMS to include more hospitals in the Hospital VBP program.

The reliability of HCAHPS scores was determined through statistical analyses conducted by RAND, the statistical consultant for HCAHPS. RAND's analysis indicates that HCAHPS data does not achieve adequate reliability with a sample of less than 100 completed surveys to ensure that true hospital performance rather than random "noise" is measured. RAND's analysis indicates that HCAHPS data are significantly below 85 percent reliability levels across all HCAHPS dimensions with a sample of less than 100 completed surveys.

Based on the above analysis, in summary, CMS requires the following for inclusion of measures and cases in the VBP performance score calculations:

- Minimum number of cases per measure is 10.
- Minimum number of measures with 10 cases is 4.
- Minimum number of HCAHPS surveys is 100.

## **5. QBR Expansion Work**

HSCRC staff began, in March of this year, convening a QBR Expansion Work Group comprising hospital quality, case mix and program operations staff, MHA staff and other stakeholders to analyze the CMS proposed and final VBP rule and requirements, to determine the updates and expansions that should be made in order to meet or exceed the patient health and cost outcomes of the CMS VBP Program and to deliberate and finalize the recommendations for updating the QBR program for FY 2012 rate adjustments. Based on discussion at the meetings, HSCRC staff is in the process of coordinating follow up discussions on the use of the linear exchange function, the magnitude of dollars at risk for rewards and penalties and the use of the blended Opportunity/Appropriateness models.

In the course of the meetings, it was also noted that the Maryland Hospital Acquired Conditions (MHAC) and QBR programs must be proposed together to CMS as meeting or exceeding Medicare's VBP program, and that the QBR Expansion Work Group was specifically focused on updating the QBR program.

The next meeting of the Work Group is planned for Wednesday, 6/15/11.

## **DRAFT RECOMMENDATIONS TO UPDATE AND EXPAND THE QBR INITIATIVE BEGINNING WITH FY 2012 RATE ADJUSTMENTS**

Based on the analysis conducted, the CMS VBP developments and the deliberations of the QBR Expansion Work Group, staff recommend the Commission approve the following draft recommendations:

- Continue to use the 17 process measures used for FY 2011 payment adjustments (see Appendix A) and the additional measures approved for inclusion in the FY 2012 rate adjustment calculations (see Section 3).
- To mitigate the effects of topped off measures, better distinguishing hospital performance, and to raise the performance bar, continue to use a hybrid of the Opportunity and Appropriateness model where hospital scores are based 50 percent on Opportunity and 50 percent on Appropriateness for base CY 2009, measurement CY 2010, and rate year FY 2012.
- Topped off Measures Benchmarks – Continue to use 95 percent as the topped off benchmark to mitigate effects of topped off measures and better distinguish performance, and further add a truncated coefficient of variation of less than 0.1 to the topped off definition.
- Apportion 70 percent of the hospital scores to process measure performance, and 30 percent to HCAHPS performance.
- Continue to use the CMS minimum case number of 10 for process measures, and adopt the minimum case number of 100 for HCAHPS surveys for inclusion of the measures in the scoring.
- In light of the blended Opportunity/ Appropriateness model, keep the minimum number of 5 process measures reported for inclusion of the hospital in the QBR program.
- Keep the topped off measures in the scoring calculation in light of the blended Appropriateness/Opportunity model recommendation.
- Use the Linear Exchange Function for translating the scores into payment adjustments, consistent with the CMS approach.
- Use the magnitude at risk determined by the Payment Work Group and approved by the Commission in a separate recommendation.
- Prepare and submit to the US HHS Secretary, a VBP program exemption request letter by October 1, 2011.

**Appendix A: Change in Measure Performance for CY 08 and CY 09 Applied to FY 10 and FY 11 Rates Respectively.**

<b>MEASURE</b>	<b>Measure Name</b>	<b>2008 Average</b>	<b>2009 Average</b>	<b>Change</b>
AMI-1	Aspirin at Arrival	96.1%	97.5%	1.31%
AMI-2	Aspirin prescribed at discharge	96.0%	95.4%	-0.65%
AMI-3	Angiotensin converting enzyme inhibitors (ACEI) or angiotensin receptor blockers (ARB) for left ventricular systolic dysfunction (LVSD)	92.4%	93.7%	1.34%
AMI-4	Adult smoking cessation advice/counseling	97.7%	98.8%	1.09%
AMI-5	Beta blocker prescribed at discharge	95.8%	94.9%	-0.88%
HF-1	Discharge instructions	83.5%	86.9%	3.45%
HF-2	Left ventricular systolic function (LVSF) assessment	94.9%	97.1%	2.14%
HF-3	ACEI or ARB for LVSD	91.5%	93.1%	1.56%
HF-4	Adult smoking cessation advice/counseling	96.6%	97.3%	0.61%
PN-2	Pneumococcal vaccination	84.2%	89.0%	4.86%
PN-3b	Blood culture before first antibiotic – Pneumonia	89.9%	91.6%	1.74%
PN-4	Adult smoking cessation advice/counseling	95.6%	95.9%	0.33%
PN-5c	Antibiotic within 6 hours	92.6%	93.7%	1.09%
PN-7	Influenza vaccination	78.6%	85.9%	7.26%
SCIP-INF-1	Antibiotic given within 1 hour prior to surgical incision	92.5%	94.7%	2.21%
SCIP-INF-2	Antibiotic selection	96.1%	96.9%	0.77%
SCIP-INF-3	Antibiotic discontinuance within appropriate time period postoperatively	88.6%	91.4%	2.74%

## Appendix B: CMS VBP Quality Measures

<b>Clinical Process of Care Measures for FY 2013 Adjustments</b>	
<i>Measure ID</i>	<b>Measure Description</b>
<b>Acute Myocardial Infarction</b>	
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival
<b>Heart Failure</b>	
HF-1	Discharge Instructions
<b>Pneumonia</b>	
PN-3b	Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient
<b>Healthcare-associated Infections</b>	
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
<b>Surgical Care Improvement</b>	
SCIP-Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery
<b>Patient Experience of Care Measures</b>	
HCAHPS	Hospital Consumer Assessment of Healthcare Providers & Systems Survey (HCAHPS) <ul style="list-style-type: none"> <li>· Communication with Nurses</li> <li>· Communication with Doctors</li> <li>· Responsiveness of Hospital Staff</li> <li>· Pain Management</li> <li>· Communication About Medicines</li> <li>· Cleanliness and Quietness of Hospital Environment</li> <li>· Discharge Information</li> <li>· Overall Rating of Hospital</li> </ul>

**MEASURES FINALIZED FOR THE FISCAL YEAR 2014 HVBP PROGRAM IN THE FINAL RULE:**

Mortality Measures:

- Mortality-30-AMI: Acute Myocardial Infarction (AMI) 30-day Mortality Rate
- Mortality-30-HF: Heart Failure (HF) 30-day Mortality Rate
- Mortality-30-PN: Pneumonia (PN) 30-Day Mortality Rate

Hospital Acquired Condition Measures:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Pressure Ulcer Stages III & IV
- Falls and Trauma
- Vascular Catheter-Associated Infections
- Catheter-Associated Urinary Tract Infection (UTI)
- Manifestations of Poor Glycemic Control

AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs), and Composite Measures:

- Complication/ patient safety for selected indicators (composite)
- Mortality for selected medical conditions (composite)



**NHQR Resources**

[State Resources for Taking Action](#)

**2010 State Snapshots Home**

**Getting Started**

[State Selection Map](#)

[What's New](#)

**State-Specific Information**

[State Dashboard](#)

[Overall Health Care Quality](#)

[Strongest and Weakest Measures](#)

[Types of Care](#)

[Settings of Care](#)

[Care by Clinical Area](#)

[Focus on Diabetes](#)

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[Focus on Payer](#)

[Focus on Variation Over Time](#)

[State Rankings for Selected Measures](#)

[Contextual Factors](#)

**Other Information**

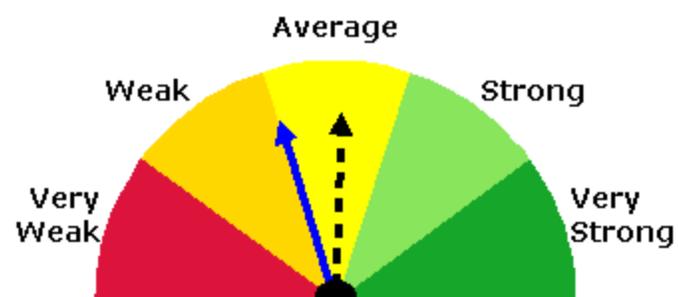
[All-State Data Tables for All Measures](#)

[Snapshot Print Version](#)

## Maryland

### Dashboard on Health Care Quality Compared to All States

#### Overall Health Care Quality



**Performance Meter:  
All Measures**

= Most Recent Data Year  
 = Baseline Year

(Baseline year may vary across measures)

The graphics on this page are summaries of measures reported in the National Healthcare Quality Report (NHQR) for Maryland. Above is a summary of over 100 measures in the NHQR reported at the State level, and below are graphics describing specific types of care, settings of care, and care in clinical areas. Select the graphics to find the underlying measures.

[How is State performance scored? \(select this link or Methods\)](#)

**Most Recent Data Year**

**Baseline Year**

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[Measuring Healthcare Quality](#)

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Compendium](#)

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**Types of Care**

Very Weak    Weak    Average    Strong    Very Strong

Preventive Measures



Acute Care Measures



Chronic Care Measures



**Settings of Care**

Home Health Care Measures



Hospital Care Measures



Nursing Home Care Measures



Ambulatory Care Measures



**Care by Clinical Area**

Cancer Measures



Diabetes Measures



Heart Disease Measures





Each graphic shows a State's balance of below average, average, and above average measures compared to all States reporting such data in the United States. The graphics have five categories: very weak, weak, average, strong, and very strong. This State's performance for the most recent data year is described by a solid arrow or solid triangle; a dashed arrow or hollow triangle describes the baseline year. A missing arrow or triangle means there were insufficient data to create the summary measure.

An arrow or triangle pointing to "Very weak" means all or nearly all included measures for a State are below average within a given data year. An arrow or triangle pointing to "Very strong" indicates that all or nearly all available measures for a State are above average within a given data year.

[How is State performance scored? \(select this link or Methods\)](#)

### Additional Resources for Understanding Quality in Maryland

The Agency for Healthcare Research and Quality's [Health Care Report Card Compendium](#) is a searchable database of health care report cards for comparing the quality of health plans, hospitals, medical groups, individual physicians, nursing homes, and other providers of care. The report cards demonstrate approaches to reporting data and are a resource for those interested in creating health care report cards.

[Search the Health Care Report Card Compendium.](#)

[AHRQ Health Care Innovations Exchange](#): A searchable database of successful and attempted health care innovations, quality tools, and learning and networking opportunities—a resource for those interested in developing and adopting innovations in health care delivery. [The Innovations Exchange includes information for Maryland.](#)



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Agency for Healthcare Research and Quality • 540 Gaither Road Rockville, MD 20850 • Telephone: (301) 427-1364