maryland
health services
cost review commission

RY 2026 Quality Policies Webinar

Overview of Hospital Quality Programs

June 12, 2024

Agenda

- Introduction and Background
- Rate Year 2026 Approved Program Updates
  - MHAC
  - QBR
  - RRIP/Disparity Gap
  - PAU Savings
  - Maximum Guardrail
- Digital Measures Reporting
- CY 2024 Monitoring Reports
- Emergency Department Initiatives
- CRISP Reporting Services
- Resources
- Q&A

HSCRC Quality and Population Health Staff Members

Allan Pack- Principal Deputy Director of Center for Population Based Methodologies

Quality

- Alyson Schuster- Deputy Director
- Dianne Feeney- Associate Director
- Tina Simmons- Associate Director
- Princess Collins- Chief
- Damaria Smith- Fellow

Population Health

- Geoff Dougherty- Deputy Director
- Oseizame Emasealu- Chief
- Jason Mazique- Chief

*Prudence Akindo- Chief of Financial Methodologies

Introduction and Background

HSCRC - Who We Are

The Maryland Health Services Cost Review Commission (HSCRC) is an independent state agency responsible for regulating the quality and cost of hospital services to ensure all Marylanders have access to high value healthcare.

HSCRC's vision is to enhance the quality of health care and patient experience, improve population health and health outcomes, and reduce the total cost of care for Marylanders.

The HSCRC establishes rates for all hospital services and helps develop the State's innovative efforts to transform the delivery system and achieve goals under the Maryland Health Model.

Maryland's Unique Healthcare System: Overview

Maryland Health Model

All-Payer Hospital Rate Setting System

- The HSCRC has set hospital rates, on an all-payer basis, since the 1970s
- The system can be adjusted to achieve CMS agreement targets and other statewide priorities

Commission Policies

CMS-MD Agreement

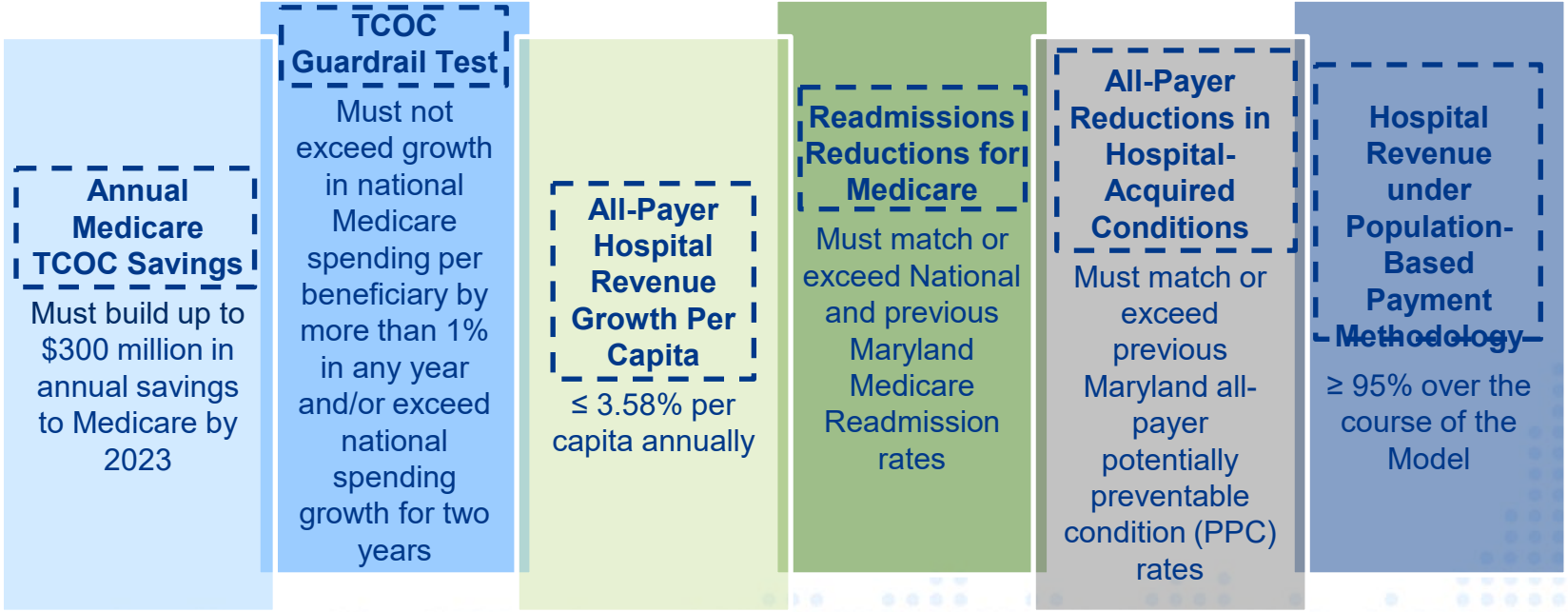
- A commitment between the State and Federal Government to use global budgets for hospitals, reform the health care and delivery system, and improve population health.
  - All-Payer Model (2014-2018)
  - Total Cost of Care Model (2019-2028)

Transitioning from the All-Payer Model to the Total Cost of Care Model

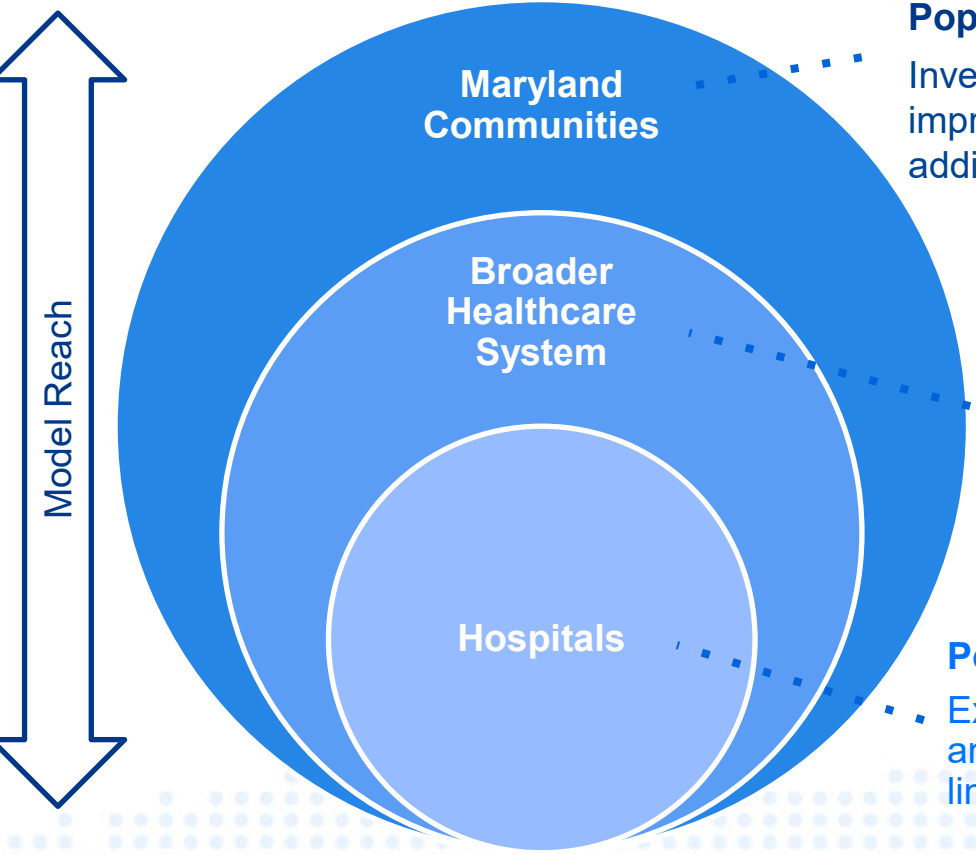
All-Payer Model (2014-2018): **Hospital Focus**	Total Cost of Care Model (2019-2028): **Health System Focus**
Focus on:	Focus on:
Hospital savings	**Total Cost of Care** savings
Hospital quality	Hospital quality and **population health**
Hospital alignment	**System-wide provider** alignment, including opportunities for **primary care** and other **non-hospital providers**

Total Cost of Care (TCOC) Model Targets

The TCOC Model requires the State of Maryland to meet the following targets:



TCOC Model Components



Population Health and Health Equity

Investment in initiatives that aim to make statewide improvements in the areas of diabetes, opioid addiction, and maternal and child health.

Payment and Delivery System Reform

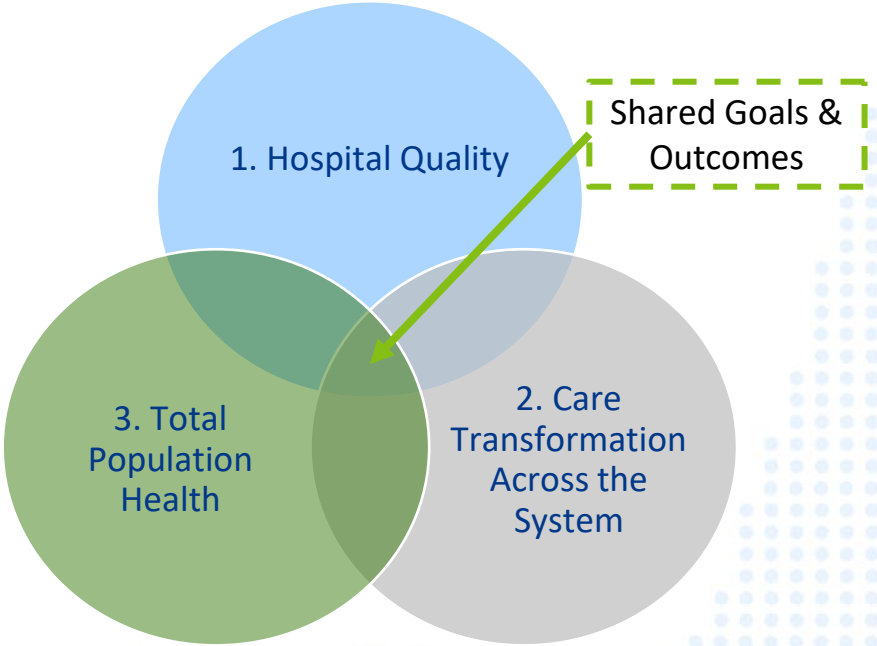
Incentivization of care transformation and partnerships across settings of care by expanding opportunities for non-hospital provider participation in value-based programs

Population-Based Revenue

Expanded hospital quality requirements, incentives, and responsibility to control total costs through limited revenue-at-risk

Statewide Integrated Health Improvement Strategy (SIHIS)

- SIHIS is designed to engage State agencies and private-sector partners to collaborate and invest in improving health, address disparities, and reduce costs for Marylanders.
- CMMI approved the SIHIS goals in March 2021.
- More information on SIHIS can be found on the HSCRC website. https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx



Global Budgets: Impacts on Quality

- Global budgets are strong incentives for efficiency or value
- Quality improvement activities can be well aligned with a GBR system that allows hospitals to retain savings from reduced complications, avoidable utilization, etc.
- It is imperative to measure quality under global budgets to prevent efficiency gains that could result in poor patient outcomes.

Overview of Pay-for-Performance Programs

Hospital Quality Adjustments

The following are HSCRC's four main quality payment incentive programs:

Maryland Hospital Acquired Conditions (MHAC) Program

Encourages hospitals to reduce infections and complications acquired during a hospital stay

Quality Reimbursement Program (QBR)

Focuses on patient experience, patient safety, and clinical quality outcomes

Readmissions Reduction Incentive Program (RRIP)

Encourages hospitals to reduce readmissions within 30 days of discharge

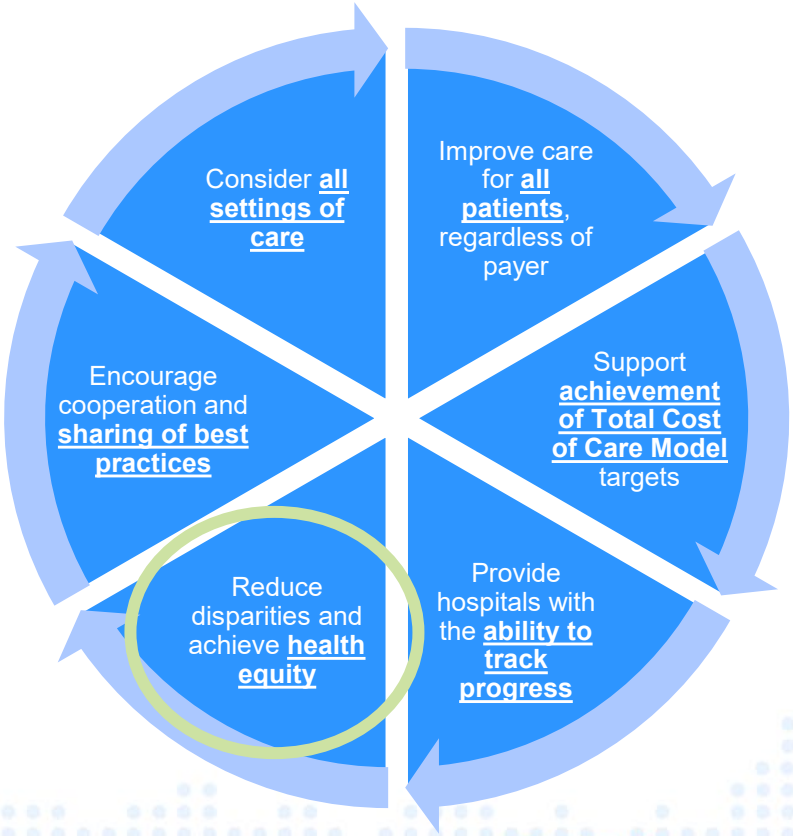
Potentially Avoidable Utilization (PAU)

Focuses on improving patient care and health through reducing potentially avoidable utilization

HSCRC's quality programs are similar to federal Medicare pay-for-performance programs, but are, wherever possible, All-Payer (instead of Medicare-only) and tailored to address MD's unique quality improvement strategies

HSCRC Quality Program Guiding Principles

- The mission of the HSCRC Quality Program is to create all-payer financial incentives for Maryland hospitals to provide efficient, high quality patient care, and to support delivery system improvements across the State.
- The program includes health equity in its guiding principles



HSCRC Performance Measurement Workgroup

- Broad stakeholder group of hospital, payer, quality measurement, academic, consumer, and government agency experts and representatives
- Meets monthly in-person and virtually (3rd Wednesday at 9:30am) from around September through May
  - Meetings are public, email hscrc.quality@maryland.gov to be added to listserv
- Reviews and recommends annual updates to the performance-based payment programs
- Considers and recommends strategic direction for the overall performance measurement system
  - Align to the extent possible with National measures and strategies
  - Incorporate new measures as available such as emergency department and outpatient measures
  - Broaden focus to patient-centered population health
  - Focus on high-need patients and chronic condition management
  - Build care coordination performance measures

RY 2026 Quality Programs

RY 2026 Quality Program Timelines

HSCRC RY 2026 Performance Based Payment Program Measurement, Performance, and Impact Periods

Rate Year (Maryland Fiscal Year)	Q3-21	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23	Q3-23	Q4-23	Q1-24	Q2-24	Q3-24	Q4-24	Q1-25	Q2-25	Q3-25	Q4-25	Q1-26	Q2-26	Q3-26	Q4-26
Calendar Year	Q1-21	Q2-21	Q3-21	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23	Q3-23	Q4-23	Q1-24	Q2-24	Q3-24	Q4-24	Q1-25	Q2-25	Q3-25	Q4-25	Q1-26	Q2-26
Maryland Hospital Acquired Conditons Program (MHAC)	Base Period:MHAC												Performance Period: MHAC (CY Q1-23 to Q4-24 for small hospitals)						Rate Year Impacted by MHAC Results			
Quality Based Reimbursement Program (QBR)					Base Period: Hospital Compare (HCAHPS measures, All NHSN Measures)							Performance Period: Hospital Compare (HCAHPS measures, All NHSN Measures)							Rate Year Impacted by QBR Results			
							Base Period: QBR IP and 30-day Mortality, PSI-90, Timely Follow-up Chronic Conditions (Medicare, Medicaid and w/in Hospital Disparity Reduction)						Performance Peirod: QBR IP and 30-day Mortality, PSI-90, Follow-up Chronic Conditions (Medicare, Medicaid and w/in Hospital Disparity Reduction)									
									Base Period: Emergency Department Length of Stay (Admitted Patients)				Performance Period: Emergency Department Length of Stay (Admitted Patients)									
Readmisison Reduction Incentive Program (RRIP)- 30-day Readmissions					Base Period: RRIP 30-day Readmissions								Performance Period: RRIP 30-day Readmissions						Rate Year Impacted by RRIP 30-Day Readmission Results			
RRIP Within-Hospital Disparity Gap Improvement*	*Base period used to establish within-hospital RRIP disparity improvement target is 2018-2021																		Rate Year Impacted by RRIP Disparity Gap Improvement Results			
	*Performance period is 2018-2024																					
PAU Savings													PAU Savings Performance Period						Rate Year Impacted by PAU Savings Results			

RY 2026 Maryland Hospital Acquired Condition (MHAC) Program

Maryland Hospital Acquired Conditions (MHAC) Program

Purpose

To improve patient care and hospital decision-making by adjusting GBR based on 15 identified potentially preventable complications (PPCs), **complications acquired during a hospital stay** that were not present on admission

- PPCs can lead to **poor patient outcomes, including longer hospital stays, permanent harm**, and **death**, and **increased costs**.
- **Examples of PPCs** include an accidental laceration during a procedure, improper administration of medication, hospital-acquired pneumonia

How it Works: Revenue-at-Risk

The program puts **2 percent** of inpatient hospital revenue at risk (maximum penalty/reward)

Federal Alignment

The MHAC Program is **similar to the federal Medicare HAC Reduction Program (HACRP)** but is all-payer, uses a Maryland-specific list of PPC measures, and does not relatively rank hospitals in assigning financial rewards and penalties.

RY 2026 Data Details

- "Base" Period: July 2021-June 2023 (i.e., FYs 22 and 23)
  - Used for calculation of the threshold and benchmark (i.e., performance standards) and the normative values for case-mix adjustment
  - Used to determine hospital specific PPC exclusions
  - Used to determine small hospitals
- Performance Period: CY 2024
  - Smaller hospitals use two years for performance period (CY23 &24)
- 3M APR-DRG and PPC Grouper Version 41

MHAC Methodology

Overview of MHAC Methodology

Potentially Preventable Complication Measures

List of 15 clinically significant PPC included in payment program.

3-Acute Pulmonary Edema and Respiratory Failure w/o Ventilation	4-Acute Pulmonary Edema and Resp Failure w/ Vent	7-Pulmonary Embolism
9-Shock	16-Venous Thrombosis	28-In-Hospital Trauma /Fractures
35-Septicemia & Severe Infections	37-Post-Operative Infection without Procedure	41-Post-Operative Hemor/ Hematoma w/Procedure or I&D
42-Accidental Puncture/ Laceration w/Invasive Procedure	47-Encephalopathy	49-Iatrogenic Pneumothorax
60-Major Puerperal Infection and Other Major OB Complications	61-Other Complications of OB Wounds	67-Pneumonia Combo (with and without Aspiration)

Global Exclusions:

- Palliative care
- Discharges >6 PPCs
- APR-DRG SOI cells with less than 31 at-risk discharges

Hospital PPC Exclusions:

- <20 at-risk discharges
- <2 expected PPCs

Case-Mix Adjustment and Standardized Scores

Performance Measure: CY 2024 Observed to Expected PPC Ratio.*

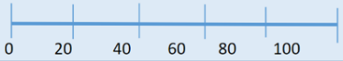
Expected calculated by applying statewide average PPC rates by diagnosis and severity of illness level to hospitals' patient mix (i.e., indirect standardization)

Attainment only score (0-100 points) calculated by comparing hospital performance to a statewide threshold and benchmark.

Attainment Points

Threshold
Avg 0-20th percentile

Benchmark
Avg 80th -100th percentile



July 2021-Jun 23 used to calculate statewide averages (norms) and thresholds, benchmarks.

***Small hospitals will be assessed on CYs 23 & 24**

Hospital MHAC Score & Revenue Adjustments

Hospital MHAC Score is Sum of Earned Points / Possible Points with PPC Cost Weights Applied.

Scores Range from 0-100%
Revenue neutral zone 60-70%

Max Penalty -2% & Reward +2%

MHAC Score	Revenue Adjustment
0%	-2.00%
10%	-1.67%
20%	-1.33%
30%	-1.00%
40%	-0.67%
50%	-0.33%
60% to 70% Hold Harmless	0.00%
80%	0.67%
90%	1.33%
100%	2.00%

Performance Metric

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

Normative values for calculating expected numbers are included in the MHAC Summary reports on the CRS portal

Adjustments to PPC Measurement

- Adjustments are made to improve measurement fairness and stability; whenever possible, these adjustments are done prospectively
- For each hospital, discharges will be excluded if:
  - The discharge has > 6 PPCs* (i.e., catastrophic cases)
  - The discharge is in an APR-DRG SOI group with less than 31 statewide discharges
- For each hospital, PPCs will be excluded if <u>during the base period</u>:
  - The number of discharges at-risk is less than 20
  - The number of expected cases is less than 2
- Two years of performance data (CY 23 & 24) are used for small hospitals
  (i.e., hospitals with less than 21,500 at-risk discharges and/or 22 expected PPCs across all payment program PPCs)

The list of excluded PPCs for each hospital is included in the MHAC Summary workbook on the CRS portal

*payment and monitoring PPCs

RY 2026 Payment PPCs

Data on each payment PPC is included in the MHAC Summary Report on the CRS Portal.

PPC Number	PPC Description
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation
7	Pulmonary Embolism
9	Shock
16	Venous Thrombosis
28	In-Hospital Trauma and Fractures
35	Septicemia & Severe Infections
37	Post-Operative Infection & Deep Wound Disruption without Procedure

PPC Number	PPC Description
41	Post-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D
42	Accidental Puncture/Laceration During Invasive Procedure
47	Encephalopathy
49	Iatrogenic Pneumothorax
60	Major Puerperal Infection and Other Major Obstetric Complications
61	Other Complications of Obstetrical Surgical & Perineal Wounds
67	Pneumonia Combo (with and without Aspiration)

PPC Updates and Feedback

Login procedure for PPC documentation:

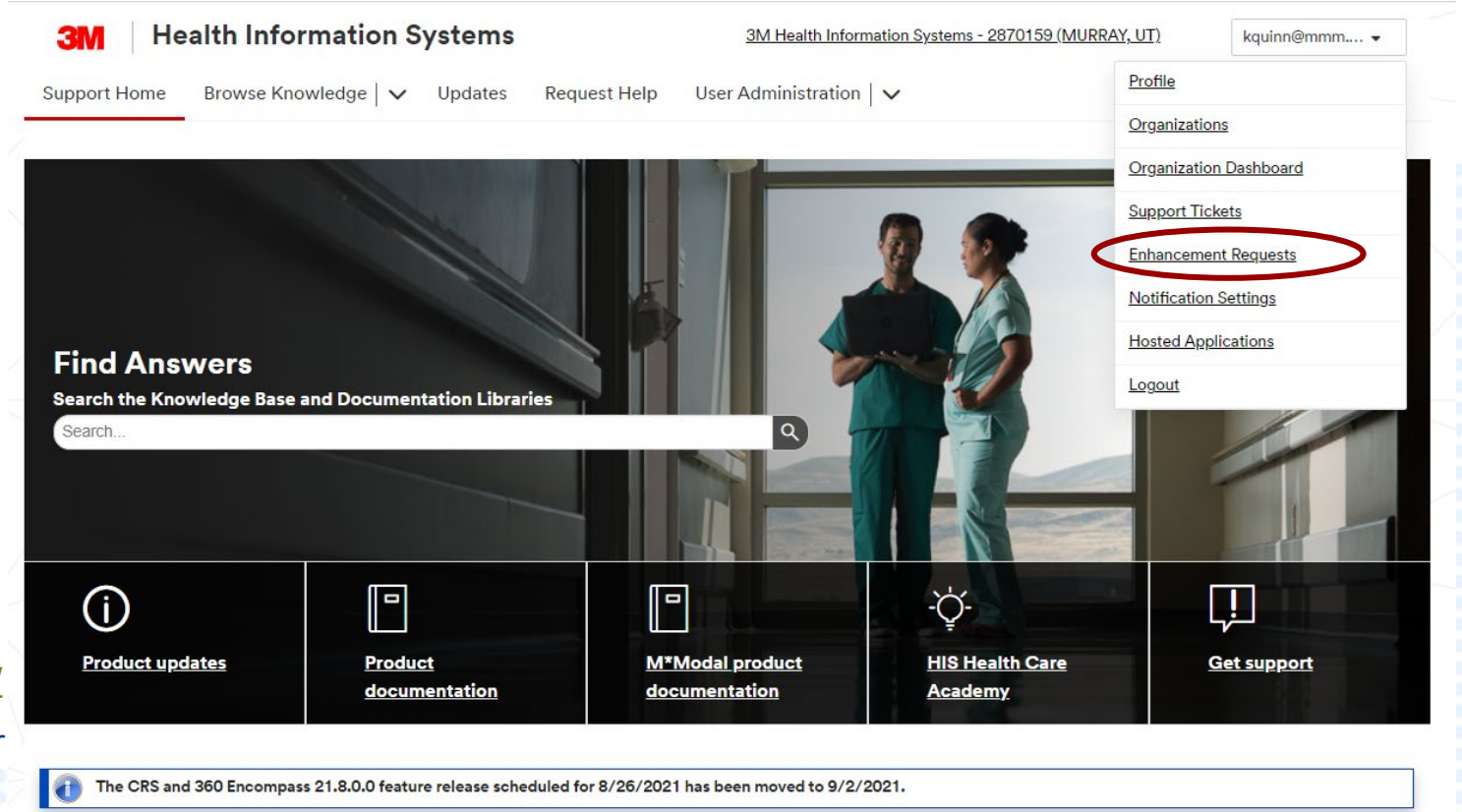
3M™ Web Portal - Login

For first use, at registration page, use the old username of "MDHosp" as your authorization code, complete the fields with your personal information to register

New PPC feedback submission procedure on 3M HIS support site:

https://support.3mhis.com/

Establish an account; after logging in, click on your login id in the upper right corner and click on



PPC Scoring: Benchmarks and Thresholds

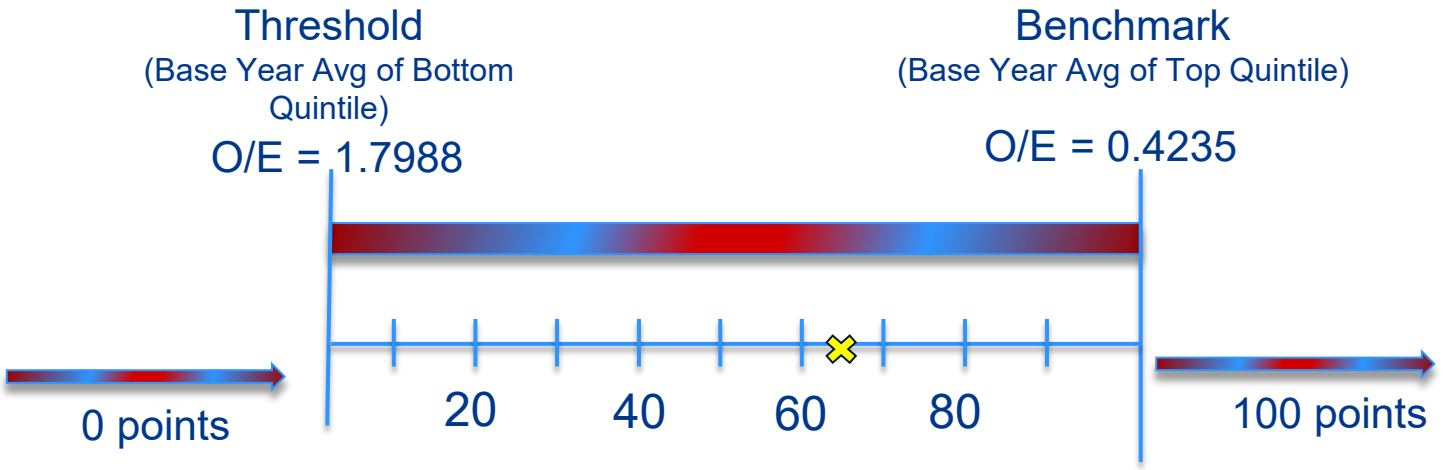
- RY 2026 uses FY2022 and FY2023 to determine performance standards for each PPC
- A threshold and benchmark value for each PPC/PPC combo are calculated based upon the base period data
  - Used to convert O/E ratio for each PPC to points (0-100)
  - Threshold = Average of bottom 20th percentile*
  - Benchmark = Average of top 20th percentile*
- Reports provide performance results for all PPCs

Thresholds and Benchmarks for each payment PPC are included in the MHAC Summary Report on the CRS Portal.

*New in RY 2026

MHAC Score: Attainment Score Example

PPC 9 Shock – Attainment Score



Hospital O/E ratio = 0.90

Calculates to an attainment score of 65

3M Cost-Based Weights: Proxy for Harm

The cost estimates are the relative incremental cost increase for each PPC, which can be a proxy for the harm and cost of the PPC within the hospital stay.

Hypothetical Example with Three PPCs: Weights Applied to Scores								
	PPC	Attainment Points	Denominator	Unweighted Score	Weight	Weighted Attainment Points	Weighted Denominator	Weighted Score
Hospital A Worse on Higher Weighted PPCs	PPC X	10	10		0.5	5	5	
	PPC Y	5	10		1	5	10	
	PPC Z	3	10		2	6	20	
		18	30	60%		16	35	46%
Hospital B Worse on Lower Weighted PPCs	PPC X	3	10		0.5	1.5	5	
	PPC Y	5	10		1	5	10	
	PPC Z	10	10		2	20	20	
		18	30	60%		26.5	35	76%

Version 41 PPC Cost Weights are included in the MHAC Summary Report on the CRS Portal.

RY 2026 Payment PPCs Cost Weights

PPC Number	PPC Description	3M v41 PPC Cost Weight
37	Post-Operative Infection & Deep Wound Disruption without Procedure	1.6222
16	Venous Thrombosis	1.4963
35	Septicemia & Severe Infections	1.2943
7	Pulmonary Embolism	1.2437
9	Shock	1.2107
67	Pneumonia Combo (with and without Aspiration)	1.1741
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1.1585
41	Post-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D	1.0429

PPC Number	PPC Description	3M v41 PPC Cost Weight
47	Encephalopathy	0.8396
60	Major Puerperal Infection and Other Major Obstetric Complications	0.7592
42	Accidental Puncture/Laceration During Invasive Procedure	0.4972
28	In-Hospital Trauma and Fractures	0.4538
49	Iatrogenic Pneumothorax	0.4424
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	0.3086
61	Other Complications of Obstetrical Surgical & Perineal Wounds	0.1525

Note: PPC 67's cost weight is determined using a weighted average of PPC 5&6

Score & Revenue Adjustment Scale

- The final MHAC score is calculated across all payment PPCs included for each hospital.
  - Sum numerator and denominator points (after applying cost weights) to get percent score
- Scores and revenue adjustment scale range from 0% to 100%; scale has hold harmless zone between 60% and 70%.
  - Hold harmless zone determined from average/median score modeling
- Maximum penalty and reward is 2% of inpatient revenue.

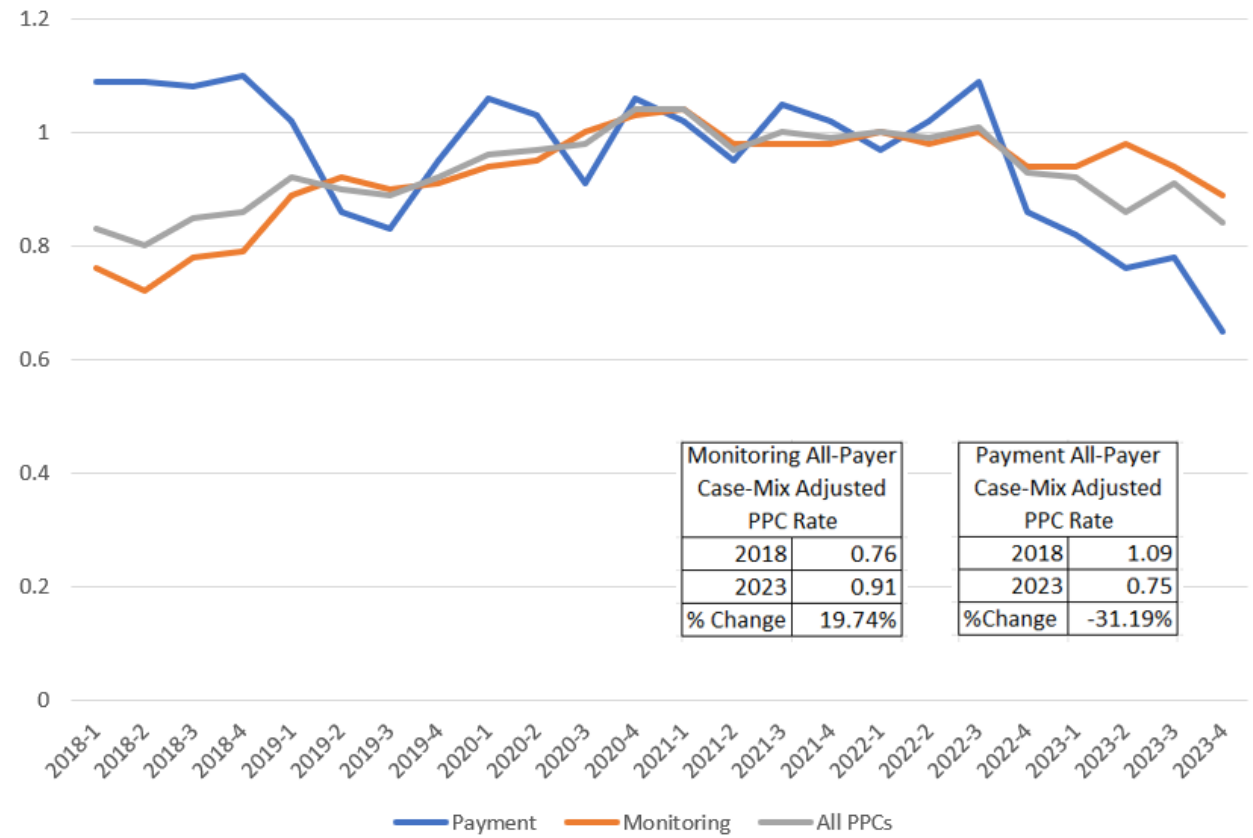
The MHAC Summary report on the CRS portal provides PPC specific points, Hospital MHAC Scores, calculation sheet, and revenue adjustment scale.

Final MHAC Score	Revenue Adjustment
0%	**-2.00%**
5%	-1.83%
10%	-1.67%
15%	-1.50%
20%	-1.33%
25%	-1.17%
30%	-1.00%
35%	-0.83%
40%	-0.67%
45%	-0.50%
50%	-0.33%
55%	-0.17%
60%	0.00%
65%	0.00%
70%	0.00%
75%	0.33%
80%	0.67%
85%	1.00%
90%	1.33%
95%	1.67%
100%	**2.00%**
Penalty Cut-point	**60%**
Reward Cut-point	**70%**

RY 2026 Measurement Methodology Recap

- Evaluate hospital performance on PPCs
  - 15 included in payment program, others in monitoring for potential inclusion in future years
- Assess hospital performance on attainment from 0-100% with a revenue hold harmless zone between 60-70%
- Weight PPCs in payment program by 3M cost weights as a proxy for patient harm
- Maximum reward and penalty at 2%

All-Payer Case-Mix Adjusted PPC Rate by Quarter



Monitoring All-Payer Case-Mix Adjusted PPC Rate	
2018	0.76
2023	0.91
% Change	19.74%

Payment All-Payer Case-Mix Adjusted PPC Rate	
2018	1.09
2023	0.75
%Change	-31.19%

Hospitals are exceeding the TCOC model goal to not backslide on PPC reductions gained under the All-Payer model.

Note: Based on V40 final data through December 2023

QBR Methodology

Quality Based Reimbursement (QBR) Program

Purpose

To incentivize quality improvement across three patient-centered quality measurement domains:

1. **Person and Community Engagement (HCAHPS)** - 8 survey-based measures + 4 linear measures + ED LOS + timely follow-up (tfu) + tfu disparity gap*
2. **Clinical Care** - inpatient mortality + 30-day mortality*
3. **Safety** - 6 measures of in-patient safety: 5 National Healthcare Safety Network (NHSN) Healthcare Associated Infections + Patient Safety Index (PSI-90)

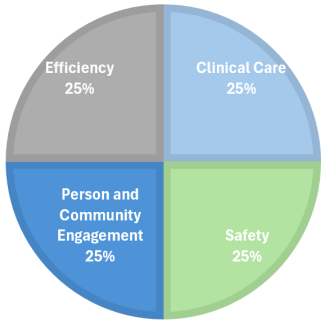
How it Works: Revenue-at-Risk

The Program puts **2 percent** of inpatient hospital revenue at risk (maximum penalty/reward)

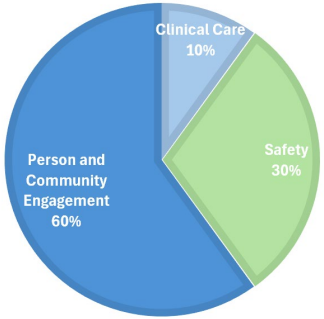
Federal Alignment

The QBR program uses **similar measures to the federal Medicare Value-Based Purchasing (VBP) program** but has an all-payer focus and can adjust domain weights to focus on MD-specific improvements.

VBP DOMAIN WEIGHTS



QBR DOMAIN WEIGHTS*



*New/Revised in RY2026

Overview of QBR Methodology

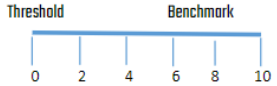
Performance Measures → **Standardized Measure Scores** → **Hospital QBR Score & Revenue Adjustments**

Domain and Measures:
Person and Community Engagement–
-8 HCAHPS categories;
-Timely Follow Up (TFU) Medicare and Medicaid & TFU Disparity Gap*
-ED LOS, admitted patients*
Safety— 6 Measures:
–5 CDC NHSN HAI Categories;
-AHRQ PSI 90 All-payer
Clinical Care–
--Mortality Inpatient, 30-day All-payer*

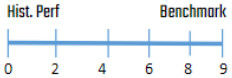
*New in RY 2026

Individual Measures are Converted to 0-10 Points:

Points for Attainment Compare Performance to a National Threshold (median) and Benchmark (average of top 10%)



Points for Improvement Compare Performance to Base (historical perf) and Benchmark



Final Points are Better of Improvement or Attainment

Hospital QBR Score is Sum of Earned Points / Possible Points with Domain Weights Applied

Scale Ranges from 0-80%

Max Penalty 2% & Reward +2%
(ALL HOSPITALS HAVE OPPORTUNITY TO EARN REWARD)

Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	**0%**	**-2.00%**
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	**41%**	**0.00%**
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	**80%+**	**2.00%**

QBR Methodology: Measure Inclusion Rules and Data Sources

- **Hospitals must have at least 100 HCAHPS survey responses** to be included in the QBR program.
- For hospitals with measures that have **no base period data, attainment only scores** will be used to evaluate performance.
- Domain weighting is adjusted based on data availability (i.e., if no safety score, PCE domain weighted at 85% and Clinical Care domain weighted at 15%)

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

Measure Inclusion Rules and Data Sources

DOMAIN	Clinical Care	Person and Community Engagement*	Safety
Inclusion Criteria	IP Mortality: - **No minimum threshold** for hospitals - Statewide: **20 cases for APR-DRG cell** to be included	- At least **100 HCAHPS surveys** during performance period	- At least **three measures** needed to calculate hospital score - Each NHSN measure requires at least **one predicted infection** during the applicable period
Data Source	IP Mortality: HSCRC Case-Mix Data 30-Day Mortality: HSCRC Case-Mix Data & VSA & CCLF & MD Medicaid Claims	HCAHPS surveys reported to CMS Hospital Compare TFU: CCLF, MD Medicaid Claims TFU Disparity Gap: CCLF & HSCRC Case-Mix ED LOS for admitted patients pending ad hoc data submission	CDC- NHSN data reported to CMS Hospital Compare PSI-90: HSCRC Case-Mix

RY 2026 Maryland IP Mortality Measure

- Maryland measures **inpatient** mortality, risk-adjusted for:
  - 3M risk of mortality (ROM)
  - Sex, age, and age-squared
  - Transfers from another acute hospital within MD
  - Palliative Care status
  - Confirmed COVID-19 flag
- Measure inclusion/exclusion criteria provided in calculation sheet and user guide.
  - Subset of APR-DRGs which account for 80% of all mortalities.
  - Specific high mortality APR-DRGs and very low mortality APR-DRGs are removed.
- All-Payer
- Hospitals evaluated using **risk-adjusted survival rate**

Case- and Hospital-level reports provided on CRS portal monthly.

RY 2026 Maryland 30-Day Mortality Measure*

- 30-day, all-payer, all-condition, all-cause mortality
  - Capture deaths that occurs within 30 days of a hospital admission, regardless of where death occurs
- Use MD Vital Statistics death data merged with MD IP Casemix records and Medicaid claims
- Measure is based on CMS condition specific mortality and the Maryland IP mortality measure

Case- and Hospital-level reports provided on CRS portal monthly.

*New in RY 2026

Step 1: Apply inclusion/exclusion criteria

Cases Excluded from Sample	
Transferred in from another acute care facility	Inconsistent vital status (e.g. death date precedes admission date)
Enrolled in hospice during index admission (or within 30 days for Medicare and Medicaid)*	Left against medical advice
Metastatic cancer	Crush, spinal, brain, or burn injury
Limited ability for survival (based on ICD-10 codes)	Non-Maryland resident (Vital Statistics data not reliable for non-Maryland residents)

- For patients with multiple admissions that qualify for measure inclusion, randomly select one admission for inclusion in sample

*hospice is identified by:

- Type of daily service = hospice
- Discharge disposition = home hospice or hospice
- Claims data for any hospice claim within 30 days (*Medicare & Medicaid only)*

Step 2: Assign stays to a service line

- **First, identify maternity stays and assign them to maternity service line**
  - APR-DRG = 540 or 560
- **Next, among non-maternity stays, determine if a major surgical procedure was performed**
  - If yes, then assign stay to the "surgical" cohort; if no, then assign to the "non-surgical" cohort
- **Last, assign stays to a service line within non-surgical and surgical cohorts**
  - Non-surgical cohort: assignment based on principle diagnosis
  - Surgical cohort: assignment based on principle procedure

Analytic Sample

Maternity Cases

Non-Maternity Cases

Non-surgical service lines		Surgical service lines
Cancer	Orthopedics	Cancer
Cardiac	Pulmonary	Cardiothoracic
Gastrointestinal	Renal	General
Infectious disease	Other conditions	Neurosurgery
		Orthopedic
Neurology		Other

Step 3: Estimate risk-adjusted regression models

- **Adjust for age, APR-DRG category and Risk of Mortality (ROM)**
  - Outcome: 0/1 indicator for whether patient died within 30-days of index admission date
  - Use APR-DRG categories and ROM values present on the index stay
  - Adjust for age and quadratic of age

- **Estimate models within each service line**
  - Allows for association between risk adjustment variables and outcome to vary by type of case

- **All models estimated using logistic regression**

Step 4: Produce hospital-level rates

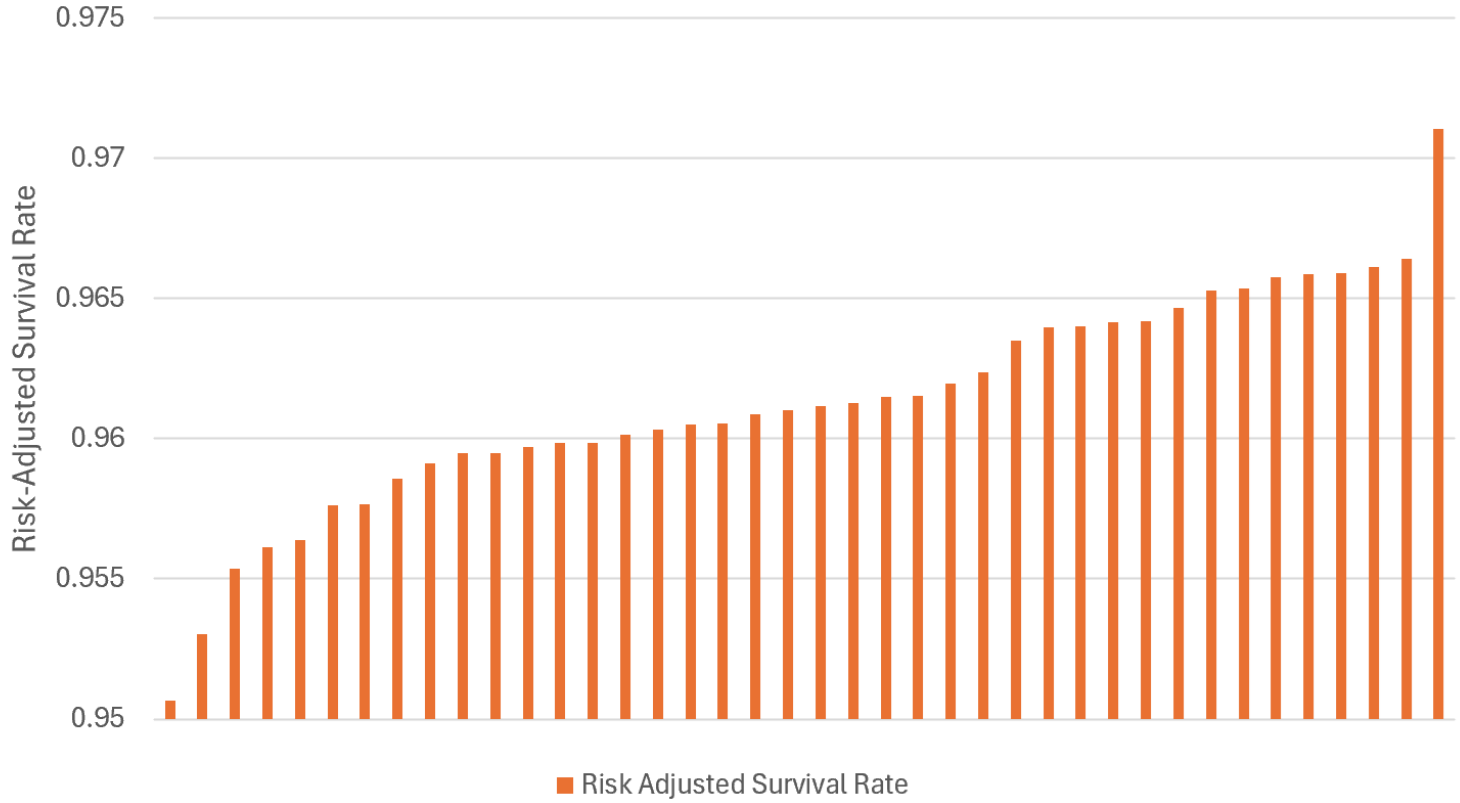
- **For each hospital, calculate the expected number of 30-day deaths**
  - Within each service-line, calculate sum of predicted (expected) 30-day deaths for the hospital
  - These are the number of 30-days that are expected for that service line, given the hospital's mix of patients

- **Calculate service line-specific observed to expected (O/E) ratios**
  - By hospital, calculate ratio of observed number of 30-day deaths to expected number of 30-day deaths for each service line

- **Create aggregate O/E ratios for each hospital**
  - Calculate weighted average of O/E ratios across service lines
  - Hospital-specific weights = proportion of overall case volume represented by a service line

- **Multiply hospital's aggregate O/E ratio by state average 30-day mortality rate**
  - Risk-standardized mortality rate (RSMR)

by Hospital 30-Day Mortality (Survival) Rate, FY 2023 (Base)



RY 2026 Timely Follow-up After Acute Exacerbations of Chronic Conditions

- NQF endorsed health plan measure that looks at percentage of ED, observation stays, and inpatient admissions for one of the following six conditions, where a follow-up was received within time frame recommended by clinical practice:
  - Hypertension (7 days)
  - Asthma (14 days)
  - Heart Failure (14 days)
  - CAD (14 days)
  - COPD (30 days)
  - Diabetes (30 days)

Summary and Case-Level reports are posted to the CRS portal monthly.

- 10% of QBR Program (⅓ for Medicaid, ⅓ for Medicare, ⅓ for Medicare Disparities*)

*New in RY 2026

Performance Metric- TFU Disparity Gap Improvement

Disparity gap: reflection of how TFU risk within a hospital changes for patients with varying levels of PAI

- Estimates the change in TFU rates per one-unit change in PAI at each hospital
- Adjustments made based on:
  - Mean PAI value at the hospital (to avoid penalizing hospitals that serve higher proportions of high PAI/highly disadvantaged patients being admitted)

Hospital payments are based on the **percent change of the disparity gap** between the base period and performance period (2018-2024).

TFU Disparity Gap: Time Periods, Coefficients, Etc

Base Period: Disparity Gap CY 2018

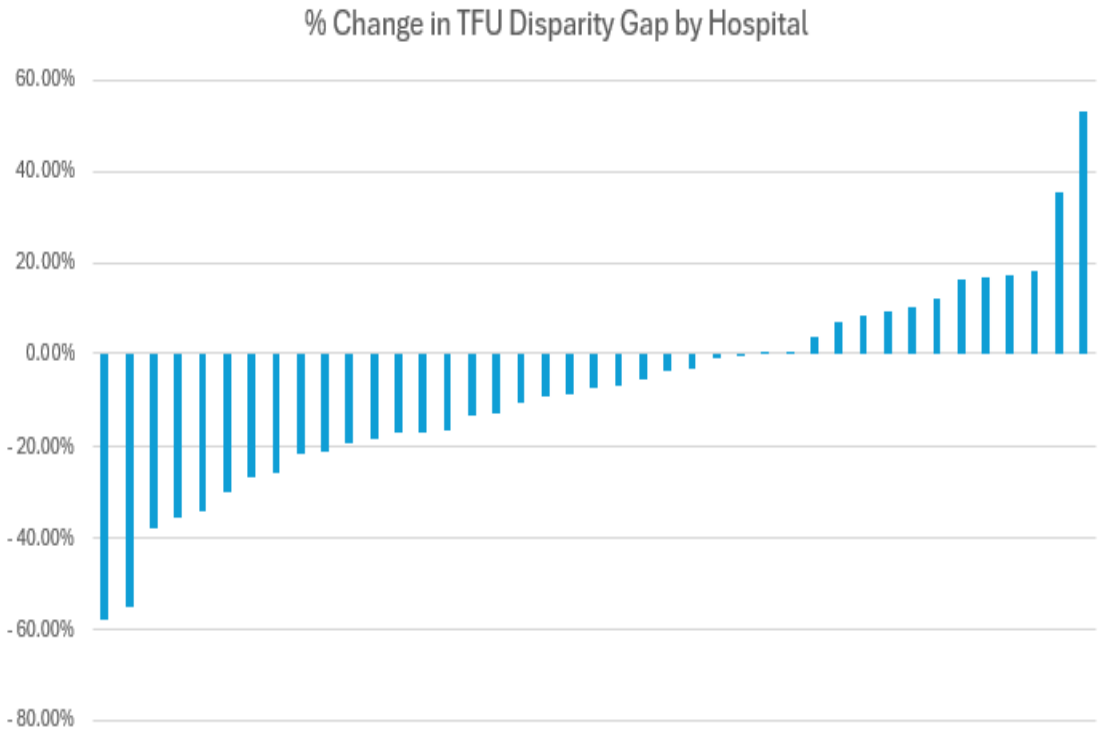
Performance Period: Disparity Gap CY 2024

Model Coefficients: CY 2021

APR-DRG Version: v41

ADI Version: 2020

CY2018-CY2023 Modeling Results



Note: PAI score is specific to the outcome. (ie. a patient may have different PAI scores for TFU vs RRIP)

ED1 LOS Measure Development Update

Measure Name:	HSCRC ED1 Length of Stay (LOS) measure
Description	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department or observation
Population	All ED patients who are admitted to Inpatient bed and discharged from hospital during reporting period
Exclusions	Patients who are discharged from ED or OBS to community/transfers, Deaths (in OP-18)

Data Subgroup Conclusion:

- ED LOS data will be collected by using monthly HSCRC case-mix data,in addition to adding date and time stamps and other needed variables
  - ED Arrival Date
  - ED Arrival Time
  - ED Departure Date
  - ED Departure Time

Methodology and Incentive Subgroup Update:

- Which strata is appropriate for payment only
- Risk adjustment considerations
- Improvement only vs. Improvement and Attainment considerations

Required Data Elements for ED LOS

Data Elements	Description	Rationale	Inpatient/Outpatient
Medicare Provider #	Hospital Medicare ID	Required for matching	Both Datasets
Medical Record Number	Patient's medical record number assigned by hospital		
Patient Account Number	Patient admission number		
From Date of Service	First day of patient encounter or visit		
Thru Date of Service	Date of patient discharge		
ED Arrival Date	Date patient arrived at ED (i.e., sign-in, pre-registration)	New Variables for ED1/OP18	Both Datasets
ED Arrival Time	Time patient arrived at ED (HHMM in military time)		
ED Departure Date	Date patient departed ED (i.e., physically left the ED)		
ED Departure Time	Time patient departed ED (HHMM in military time)		
Additional Variables			
Observation Status Start Date	EHR timestamp for when patient enters observation status; could be in or outside of the ED	To be able to examine impact of observation status on ED length of stay/boarding	Both Datasets
Observation Status Start Time	EHR timestamp for when patient enters observation status; could be in or outside of the ED		
Observation Status End Date	EHR timestamp for when patient leaves observation status; could be in or outside of the ED	To be able to examine impact of observation status on ED length of stay/boarding	Both Datasets
Observation Status End Time	EHR timestamp for when patient leaves observation status; could be in or outside of the ED		
IP Unit Arrival Date	Date patient arrived at IP unit	To be able to ensure we have data on total wait time if needed	Inpatient Only
IP Unit Arrival Time	Time patient arrived IP unit ED (i.e., physical arrive at unit)		

Required Data Elements for ED LOS

Tasks	Key Dates
Finalize ED-1 LOS & OP-18 Measure specifications and algorithm	May 2024
1st Ad hoc submission window opens: Submit CY23 & Jan-Mar 2024 (15 months data)	July 2024 (Submission window 7/16/24-8/1/24)
Release summary level statewide report on ED-1 and OP-18 median length of stay	September/October 2024
2nd Ad hoc submission window opens: Submit Apr-Sept 2024 (6 months data)	December 2024 (Submission window 12/16/24-12/30/24)
Starting in Jan 2025 regular case-mix submissions will include ED-1 LOS and OP-18 variables	From January 1, 2025
Final data submission (Oct-Dec 24) will use regular case-mix DSR that includes ED-1 LOS & OP-18 variables	March 2025
Release summary level statewide report on ED-1 & OP-18 median length of stay	April/May 2025
Final RY26 QBR Revenue Adjustments (ED-1 LOS Only)	January 2026 (preliminary July 2025)

Between 1st and 2nd ad-hoc submissions, check data quality:

1. Data error checks
2. Match ad hoc data with Case-Mix data; provide match rate.
3. Revise DSR, if needed
4. Request statewide or hospital specific resubmissions

RY 2026 All-Payer Patient Safety Index

PSI-90 is composite measure of 10 AHRQ-specified PSIs of in-hospital complications and adverse events following surgeries, procedures, and childbirth:

- PSI 03 Pressure Ulcer
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall with Hip Fracture Rate
- PSI 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

Case- and Hospital-level reports are posted to the CRS portal monthly.

QBR Scoring: Better of Attainment or Improvement

Attainment

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

Improvement

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

Overall Score & Revenue Adjustment Scale

1. Assess performance on each measure in the domain
2. Standardize measure scores relative to performance standards
3. Calculate the total points a hospital earned divided by the total possible points for each domain
4. Finalize the total hospital QBR score (0 to 100 percent) by weighting the domains based on the overall percentage placed on each domain
5. Convert the total hospital QBR score into a revenue adjustment using the preset scale

Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	**0%**	**-2.00%**
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	41%	0.00%
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	**80%+**	**2.00%**

RY 2026 Measurement Methodology Recap

- Measures are converted to 0-10 points using performance standards
- Final score is the better of attainment or improvement
- QBR Score: Sum of earned points/possible points with domain weights
- Preset Scale of 0-80%, with 41% cutpoint
- Max penalty and reward at 2%

- PCE Domain (60%)
  - HCAHPS top-box and consistency
  - HCAHPS linear
  - TFU- Medicare FFS
  - TFU- Medicaid
  - TFU Medicare Disparity Gap*
  - ED LOS for admitted patients*
- Safety Domain (30%)
  - PSI-90
  - 6 NHSN HAI measures
- Clinical Care Domain (10%)
  - IP Mortality
  - 30-Day Mortality*

*New in RY 2026

RRIP Methodology

Readmissions Reduction Incentive Program (RRIP)

Purpose

To incentivize hospitals to reduce avoidable readmissions by linking payment to (1) improvements in readmissions rates, and (2) attainment of relatively low readmission rates.

- **What is a readmission?** A readmission occurs when a patient is discharged from a hospital and is subsequently re-admitted to any hospital within 30 days of the discharge.
- **Why focus on readmissions?** Preventable hospitals readmissions may result from complications from previous hospitalizations or inadequate care coordination following discharge and can lead to substandard care quality for patients and unnecessary costs.

How it Works: Revenue-at-Risk

The program puts **2 percent** of inpatient hospital revenue at risk (maximum penalty/reward) + 0.5 percent max disparity gap reward

Federal Alignment

The RRIP is **similar to the Medicare Hospital Readmissions Reduction Program (HRRP)**, but has an all-payer focus.

RRIP Methodology Overview

30-day, All-Cause Readmission Measure

Measure Includes:
Readmissions within 30 days of Acute Case Discharge:

- All-Payer
- All-Cause
- All-Hospital (both intra- and inter- hospital)
- Chronic Beds
- IP-Psych and Specialty Hospitals
- Adult Oncology Discharges

Global Exclusions:

- Planned Admissions
- Same-day and Next-day Transfers
- Rehab Hospitals
- Discharges leaving Against Medical Advice
- Deaths
- Pediatric Oncology Discharges

Case-Mix Adjustment

Performance Measure: CY 2024 Case-mix Adjusted Readmission Rate, adjusted for out-of-state readmissions (Attainment); Reduction in Case-mix Adjusted Readmission Rate from Base Period (Improvement)

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

$$\frac{\textit{Observed Unplanned Readmissions}}{\textit{Expected Unplanned Readmissions}} * \textit{Statewide Readmission Rate}$$

CY2022 used to calculate statewide averages (normative values), as well as attainment benchmark/threshold

Revenue Adjustments

Hospital RRIP revenue adjustments are based on the better of attainment or improvement, scaled between the Max Reward and Max Penalty.

Scores Range from Max Penalty -2% & Reward+2%

All Payer Readmission Rate Change CY22-24		% IP Revenue Payment Adjustment
	A	B
Improving		2.00%
	-19.79%	2.00%
	-11.16%	1.00%
Target	-2.53%	0.00%
	6.10%	-1.00%
	14.73%	-2.00%
Worsening		-2.00%

Improvement

Attainment

All Payer Readmission Rate CY24		RRIP % Inpatient Revenue
Lower Readmission Rate		2.0%
Benchmark	9.17%	2.00%
	10.09%	1.00%
Threshold	11.02%	0.00%
	11.95%	-1.00%
	12.87%	-2.00%
Higher Readmission Rate		-2.0%

Performance Metric

- Case-Mix Adjusted Inpatient Readmission Rate
  - 30-Day readmissions
  - All-Cause, All-Payer
  - All-Hospital (both intra- and inter- hospital)
  - Chronic beds and readmissions to specialty hospitals included
- Exclusions:
  - Same-day and next-day transfers
  - Rehabilitation Hospitals
  - Pediatric Oncology discharges
  - Planned readmissions – CMS Planned Readmission Logic (v4 2022), rehab and OB deliveries
  - Deaths, Left AMA
- Risk-Adjustment
  - APR-DRG & SOI

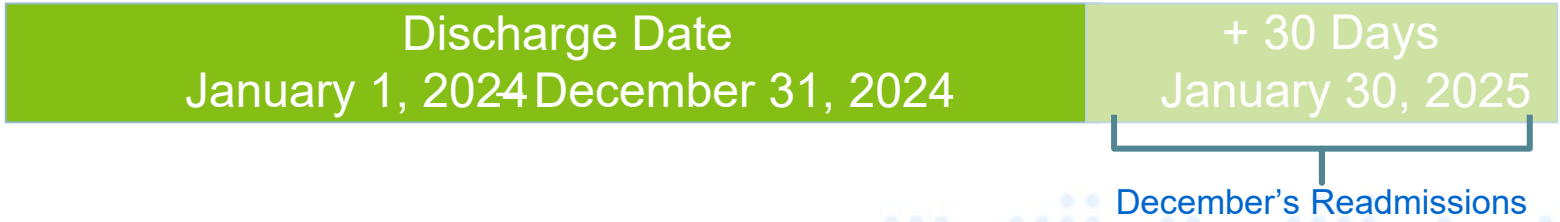
Summary and case-level* reports are posted to the CRS portal monthly.

*Patients who opt-out of CRISP data-sharing and/or experience SUD are excluded from patient-level reports

Data Sources and Timeframe

- Inpatient abstract/case mix data with CRISP Unique Identifier (EID).
  - Base period: CY 2022
  - Performance period: CY 2024
  - v41 of the APR grouper
- Data on out of state readmissions is obtained from Medicare and used to adjust the all-payer readmission rate
- Looks 30-days after the performance period

Example CY 2024



Case-Mix Adjustment

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

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

Measuring the Better of Attainment or Improvement

- RRIP continues to measure the better of attainment or improvement due to concerns that hospitals with low readmission rates may have less opportunity for improvement.
- RRIP adjustments are scaled, with maximum penalties up to 2% of inpatient revenue and maximum rewards up to 2% of inpatient revenue.

Rate Year	Performance Year	Improvement Target (from CY 2022)	Attainment Reward Threshold
RY 2026	CY 2024	-2.53%	11.02%

Attainment threshold is 65th percentile of readmission rate in 2022, further adjusted for out-of-state readmissions with improvement target

Improvement Scaling

- Improvement compares CY24 case-mix adjusted inpatient readmission rates to CY22 case-mix adjusted inpatient readmission rates
- Improvement Target for CY23 = 2.53% cumulative decrease
- Adjustments range from 2% reward to 2% penalty, scaled for performance

All Payer Readmission Rate Change CY18-23		% IP Revenue Payment Adjustment
	A	B
Improving		2.00%
	-19.79%	2.00%
	-11.16%	1.00%
Target	-2.53%	0.00%
	6.10%	-1.00%
	14.73%	-2.00%
Worsening		-2.00%

Attainment Scaling

- Attainment scaling compares CY24 case-mix adjusted inpatient readmission rates to a state threshold (65th percentile of 2022 readmission rates)
  - Attainment scores adjusted to account for readmissions occurring at non-Maryland hospitals (OOS adjustment)
- Attainment Threshold for CY24= 11.02%
- Adjustments range from 2% reward to 2% penalty, scaled for performance

All Payer Readmission	RRIP % Inpatient Revenue
LOWER	2.0%
9.17%	2.0%
9.35%	1.80%
9.54%	1.60%
9.72%	1.40%
9.91%	1.20%
10.09%	1.00%
10.28%	0.80%
10.46%	0.60%
10.65%	0.40%
10.83%	0.20%
11.02%	0.00%
11.20%	-0.20%
11.39%	-0.40%
11.57%	-0.60%
11.76%	-0.80%
11.95%	-1.00%
12.13%	-1.20%
12.32%	-1.40%
12.50%	-1.60%
12.69%	-1.80%
12.87%	-2.00%
HIGHER	-2.00%

RY 2026 Measurement Methodology Recap

- Performance Metric: Case-mix adjusted readmission rates
- Case-mix adjustment:
  - Observed Unplanned Readmissions / Expected Unplanned Readmissions * Statewide Readmission Rate
- Readmissions targets: Better of improvement or attainment
  - Improvement – 2.53% Improvement target; max 2% reward at -19.79% improvement
  - Attainment – 11.02% Attainment target; max 2% reward at 9.17% rate

RRIP-Disparity Gap Methodology

The RRIP's Disparities Component

The Readmissions Reduction Incentive Program includes a **within-hospital disparities readmissions measure,** making it the **only statewide program in the nation** with an **incentive for reducing disparities in all-payer readmission rates.**

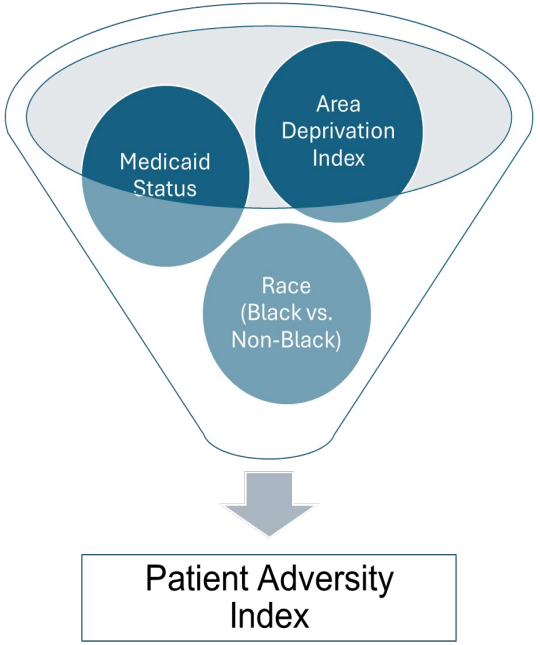
HSCRC rewards hospitals with reductions in year-over-year overall readmission rate disparities related to race and socioeconomic status, with the goal of a 50% reduction in disparities over 8 years.

Rewards are scaled

- Rewards are based on performance in 2018
- Rewards begin at 0.25% IP revenue for hospitals on track for 50% reduction in the disparity gap measure over 8 years.
- Rewards are capped at 0.50% of IP revenue for hospitals on pace for a 75% or larger reduction in the disparity gap measure over 8 years

Patient Adversity Index (PAI) Measurement

- HSCRC-developed claims-based measure
- Calculated for each discharge based on social factors:
  - Medicaid status (Yes or No)
  - Race (Black or Non-Black)
  - Area Deprivation Index (ADI), measure of neighborhood disadvantage
- Social factors weighted to reflect the strength of its association with readmissions
- Larger value = Higher adversity
- PAI value is normalized so that statewide mean is 0. Each 1-point change in the scale represents a change of one standard deviation.

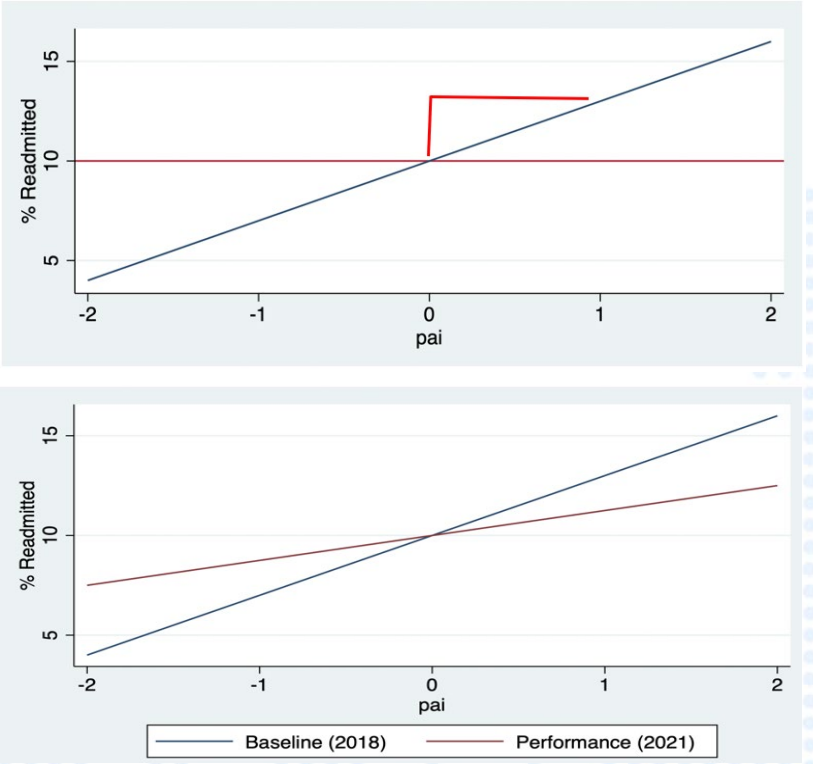


Performance Metric- Readmissions Disparity Gap Improvement

Disparity gap: reflection of how readmission risk within a hospital changes for patients with varying levels of PAI

- Estimates the change in readmission rates per one-unit change in PAI at each hospital
- Adjustments made based on:
  - Age
  - APR-DRG
  - Gender
  - Mean PAI value at the hospital (to avoid penalizing hospitals that serve higher proportions of high PAI/highly disadvantaged patients)

Hospital payments are based on the percent change of the disparity gap between the base period (2018-2021) and performance period (2018-2024).



RY 2026 Readmissions Disparity Gap Scaling

- Assesses improvement only
- Model Goal: At least 50% of hospitals reduce their disparities in readmissions by 50% by RY2029
- CY 2024 performance trajectory standards:
  - -35.16% threshold to begin rewards
  - -57.96% for full reward
- RY 2026: Reward-only
- Rewards scaled from 0.25 percent up to 0.50 percent of IP revenue
- To be eligible for the disparity gap reward, hospitals must submit their interventions that are aimed at reducing disparities in readmissions*

Summary and case-level* reports are posted to the CRS portal monthly.

*case level PAI components are included in RRIP case level reports

*New in RY 2026

RY 2026 RRIP Disparity Gap Measurement Methodology Recap

- Performance metric:
  - % change in disparity gap comparing CY 2018 (Baseline) to CY 2024
- Begin receiving rewards at **35.16% reduction** in readmission disparities compared to CY 2018

FY 2025 Potentially Avoidable Utilization (PAU) Savings Policy

Potentially Avoidable Utilization (PAU) Savings Program

Purpose

- To encourage hospitals **to focus on improved care coordination and enhanced community-based care** by holding hospitals accountable for potentially avoidable utilization
- Designed to encourage hospitals to look at **upstream, community-based factors** that influence utilization

How it Works

"Potentially avoidable utilization" is defined as hospital care that is unplanned and may be prevented through improved care quality, care coordination, or effective community-based care

Methodology

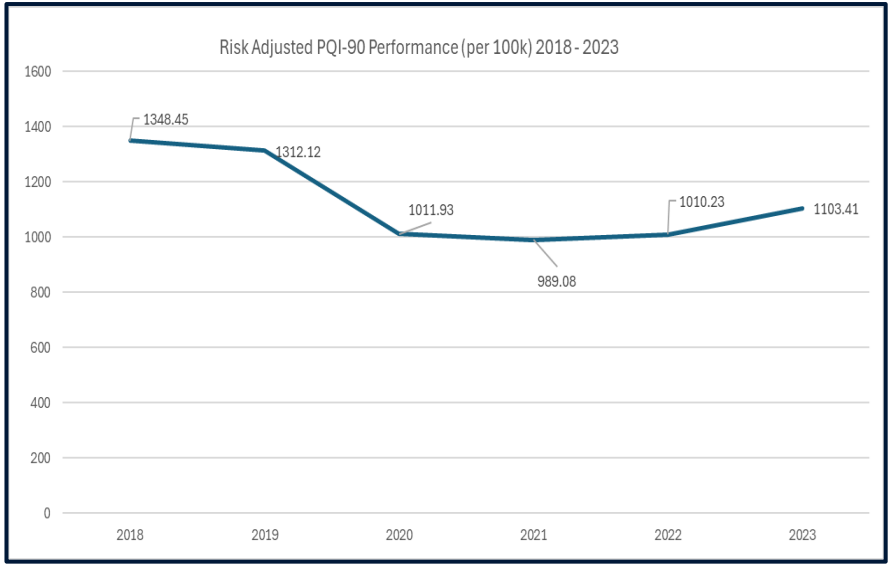
The HSCRC examines the following measures in its PAU calculations:

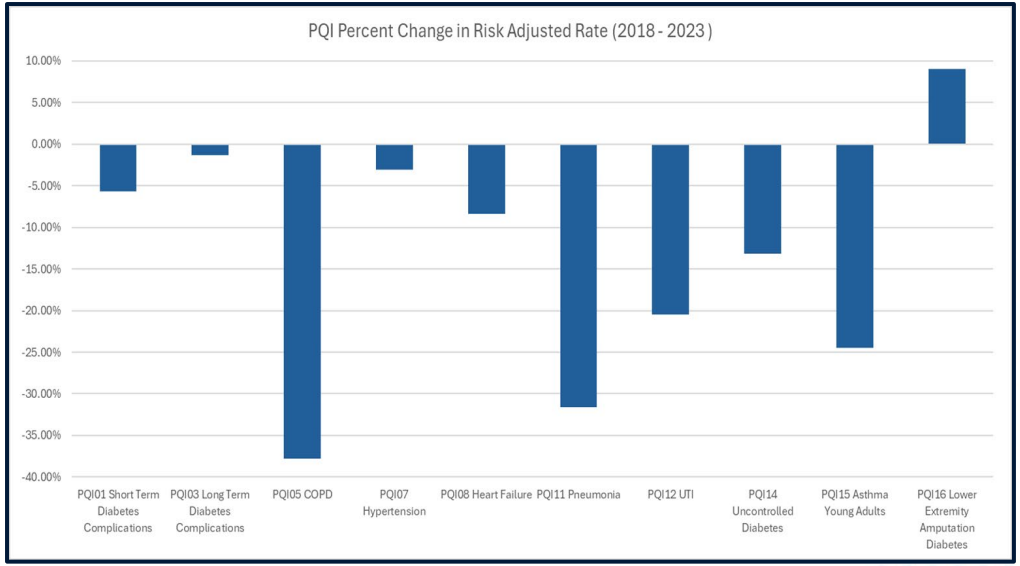
- **30-day readmissions (uses similar logic as RRIP)** – All Hospital All Cause 30-Day Readmissions with adjustment for planned admissions
- **Avoidable admissions** – Ambulatory-care sensitive conditions identified with AHRQ Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs) (e.g. admissions for diabetes complications, admissions for urinary tract infections)

RY2025 PAU Measures

Per Capita Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs)
•**Measure definition:** AHRQ Prevention Quality Indicators, which measure adult (18+) ambulatory care sensitive conditions. AHRQ Pediatric Quality Indicators focuses on preventable hospitalizations among pediatric patients •**Data source:** Inpatient and observation stays >= 24 hours
Revenue from PAU Readmissions
•**Measure definition:** 30-day unplanned readmissions measured at the sending hospital •**Data Source:** Inpatient and observation stays >= 24 hours

Prevention Quality Indicator (PQI) Performance (2018 - 2023)





- As of December 2023, Maryland has experienced an 18% decrease across all PQIs from its 2018 baseline rate of 1348 admits per 100k residents
  - The current PQI rate is -3.7% below the 2023 year 5 target rate under SIHIS

Potential changes to the RY2025 PAU Shared Savings Policy (Pending Commission Approval)

- The PAU Program was originally a statewide reduction necessary to achieve required savings in the Model and to recoup the ~$200M built into rates for “infrastructure” investments (e.g., care management)
  - Annual reductions were originally not formulaic
  - Advancement in RY2020 tied annual reductions to inflation and population growth
  - To date, the Commission has removed ~$600M through the Shared Savings Program.

- Staff believe the PAU program should continue as a policy to recognize differential margin opportunities in the Model, but staff are concerned that using PAU to generate additional savings could compromise access

- In light of Commissioner feedback, staff have amended the proposed revision to the PAU Share Savings policy, so that rewards for hospitals are capped at 0%.
  - Effectively discontinues system savings aspect of the policy while not providing upside to hospitals that may not have improved PAU performance under the Model.

Hospitals	Current Policy	Staff Proposal (PAU Reduction - Statewide PAU Reduction)
RY2023 Statewide Reduction	-0.38%	-0.02%
Hospital with ~Average PAU performance	-0.38%	0.00%
Hospital with Above Average PAU Performance (Garrett)	-0.18%	0.00%
Hospital with Below Average PAU Performance (UM Hartford)	-0.53%	-15%

Potential changes to the RY2025 PAU Shared Savings Policy (Pending Commission Approval) Continued

- Potential Access Issues from PAU & Requirements
  - While staff think this change to the PAU policy is an important step forward, we are also concerned about potential reduced focus on avoidable admissions. Thus, we are recommending the following:
    - An analysis to be funded out of hospital rates of activities of current interventions to reduce PAU
    - Establishment of a single point of executive accountability for the PAU reduction strategy
    - Hospitals would need to submit a plan for Commission approval to reduce PAU or maintain low rates of PAU
    - Agreement to engage in future analyses of PAU performance
- Staff appreciates the hospital support to amend the PAU policy and to review PAU performance over the course of the Model. If approved by the Commission, staff will utilize a portion of the set aside ($500k-$1M) to contract a vendor to begin analyses of PAU performance before the start of next calendar year.

RY 2026 Maximum Guardrail under Maryland Hospital Performance-Based Programs

Maximum Guardrail for RY 2026

RY 2026 Quality Program Revenue Adjustments	Max Penalty	Max Reward
MHAC	-2.0%	2.0%
RRIP	-2.0%	2.0%
QBR	-2.0%	2.0%

- Percent of ***Maryland Medicare revenue at-risk for quality (6%)*** multiplied by the percent of ***Maryland revenue attributable to inpatient services***
- RY 2026 Guardrail: 6% x 58%* = 3.48%
- The quality adjustments are applied to inpatient revenue centers, similar to the approach used by CMS.
- RRIP-Disparity Gap is not included to encourage focus on and express the importance of advancing health equity

*CY2023 % IP Services

Digital Measures Reporting Requirements

Detailed reporting and submission information may be found on the CRISP website

Maryland Statewide Digital Measure Reporting Infrastructure: Important to Achieving Maryland's Quality Goals

- Maryland began reporting of quality measures prior to the CMS Hospital Compare reporting
- In June 2022, Maryland became the first state in the country to successfully begin receiving eCQM data statewide from Maryland hospitals
- The CMS Digital Quality Measurement Strategic Roadmap issued in March 2022 put forth a timeline of seven years to achieving a fully digital quality measurement enterprise
- Maryland is targeting quality improvement priorities using digital measures
- See the CRISP eCQM website for more information and HSCRC memos on the main HSCRC Quality page

- Potentially add measure(s) to RY 2027 payment programs

Maryland Statewide Digital Measures Reporting CY 2024: Electronic Clinical Quality Measures (eCQM)

- Maryland's programs are all-payer and goal digital measures reporting to reflect all payer population
- HSCRC will require submission of QRDA I files for the eCQM's listed below.

  - eOPI-1: Safe Use of Opioids-Concurrent prescribing (MHCC will begin public reporting in July 2024 on the hospital guide)
  - PC-02: Cesarean Birth*
  - PC-07: Severe Obstetric Complications (risk adjusted)*
  - HH-01: Hospital Harm- Severe Hypoglycemia
  - HH-02: Hospital Harm- Severe Hyperglycemia
  - Two additional optional measures of hospitals' choosing

*Hospitals not eligible for the PC measures must choose two additional alternate measures for reporting

CY 2024 Digital Measure Submission to HSCRC

Title	Short Name	CMS eCQM ID	NQF Number	HSCRC	Specifications
Anticoagulation Therapy for Atrial Fibrillation/Flutter	STK-3	CMS71v13	Not Applicable	Optional	CMS71v13.zip
Antithrombotic Therapy By End of Hospital Day 2	STK-5	CMS72v12	Not Applicable	Optional	CMS72v12.zip
Cesarean Birth	PC-02	CMS334v5	0471e	Required	CMS334v5.zip
Discharged on Antithrombotic Therapy	STK-2	CMS104v12	Not Applicable	Optional	CMS104v12.zip
Global Malnutrition Composite Score	GMCS	CMS986v2	3592e	Optional	CMS986v2.zip
Hospital Harm - Opioid-Related Adverse Events	HH-ORAE	CMS819v2	3501e	Optional	CMS819v2.zip

CY 2024 Digital Measure Submission to HSCRC

Title	Short Name	CMS eCQM ID	NQF Number	HSCRC	Specifications
Hospital Harm - Severe Hyperglycemia	HH-Hyper	CMS871v3	3533e	Required	CMS871v3.zip
Hospital Harm - Severe Hypoglycemia	HH-Hypo	CMS816v3	3503e	Required	CMS816v3.zip
Intensive Care Unit Venous Thromboembolism Prophylaxis	VTE-2	CMS190v12	Not Applicable	Optional	CMS190v12.zip
Safe Use of Opioids - Concurrent Prescribing	N/A	CMS506v6	3316e	Required	CMS506v6.zip
Severe Obstetric Complications*	PC-07	CMS1028v2	Not Applicable	Required	CMS1028v2.zip
Venous Thromboembolism Prophylaxis	VTE-1	CMS108v12	Not Applicable	Optional	CMS108v12.zip

*This is a risk adjusted measure. Risk Adjustment Methodology Report: Severe Obstetric Complications Methodology Report

Appendix A Source: https://ecqi.healthit.gov/eh-cah?qt-tabs_eh=1&globalyearfilter=2024&global_measure_group=3716

Quality Update: eCQM Reporting Timeline

- CY 2023 Performance Period Submission Windows for eCQMs

Q3 2023:	Open: 10/15/2023	Close: 12/30/2023
Q4 2023:	Open: 01/15/2024	Close: 04/01/2024

- CY 2024 Performance Period Submission Windows for **eCQMs**

Q1 2024:	Open:	7/15/2024	Close:	9/30/2024
Q2 2024:	Open:	7/15/2024	Close:	9/30/2024
Q3 2024 :	Open:	10/15/2024	Close:	12/30/2024
Q4 2024:	Open:	1/15/2025	Close:	3/31/2025

Hospitals may apply for an extraordinary circumstances exemption if warranted, including an extension if more time is needed. (See Quality page on HSCRC website)

Maryland Statewide Digital Measures Reporting 2023-2025: Hybrid Core Clinical Data Elements (CCDE)

1. HSCRC requires hospitals to submit the Core Clinical Data Elements (CCDE) for the Hospital Wide Readmission (HWR) and Hospital Wide Mortality (HWM) hybrid measures covering the performance period July 1, 2023 – June 30, 2024 from one of the following options:

   Option 1.a. Medicare only patients using the CMS HWR and HWM specifications for the performance period July 1, 2023-December 31, 2023 beginning in January 2024

   Option 1.b. Medicare only patients using the CMS HWR and HWM specifications for the performance period July 1 2023-June 30, 2024 beginning in July 2024 directly following the performance period.

   Option 2. *Voluntary Pilot for Reporting CCDE Data on Patient >age 17 from All Payers* using the HSCRC HWR and HWM specification from performance period July 1, 2023 – June 30, 2024 or a partial year submission for the performance period January 1 – June 30, 2024

1. HSCRC will require hospitals to submit CCDE for the HWR and HWM hybrid measures **on patients from all payers >17 yrs. of age** using HSCRC specifications starting July 1 2024.

HSCRC Hospital Wide Readmission and Hospital Wide Mortality CY 2024 Reporting Requirements

July 1, 2023-June 30, 2024 Performance Period Submission Windows for Hybrid Measures

CCDE

Q3 2023 data	Open: 1/15/2024	Close: 3/31/2024
Q4 2023 data	Open: 1/15/2024	Close: 3/31/2024
Q1 2024 data	Open: 4/15/2024	Close: 6/30/2024
Q2 2024 data	Open: 7/15/2024	Close: 9/30/2024

Alternate option: Submit all data for the period Open: 7/15/2024 Close: 9/30/2024

July 1, 2024 -June 30, 2025 Performance Period Submission Windows for Hybrid Measures

CCDE

Q3 2024 data	Open: 1/15/2025	Close: 3/31/2025
Q4 2024 data	Open: 1/15/2025	Close: 3/31/2025
Q1 2025 data	Open: 4/15/2025	Close: 6/30/2025
Q2 2025 data	Open: 7/15/2025	Close: 9/30/2025

CY 2024 Monitoring Reports

Monitoring Measures Update

- Excess Days in Acute Care (EDAC)- excess days that a hospital's patients spent in acute care within 30 days after discharge (ED visits, Obs stays, unplanned readmissions)
- IP Diabetes Screening
- ED MVP

Inpatient Diabetes Screening Pilot Background

- CMMI directed HSCRC to include one or more measures of hospital population health performance in the Medicare Performance Adjustment for CY24
- Commissioners asked staff to conduct a pilot of the screening program to better understand impact on hospital operations and effect on population health
- Inpatient Screening Pilot *to take place between July 1 - Oct 1 at MedStar Franklin Square, MedStar Southern Maryland, and Garrett Regional Hospitals*

Inpatient Diabetes Screening Pilot

Sampling Frame

Patients 35 years of age or above, with no prior history of Type 2 Diabetes Mellitus, without a prior HbA1c test result listed in the patient's Electronic Medical Record (EMR) from within the past three years prior to admission.

or

Patients 35 years of age or above, with a prior history of Type 2 Diabetes Mellitus, without a prior HbA1c test result listed in the patient's Electronic Medical Record (EMR) from within the past three months prior to admission.

Proposed Intervention

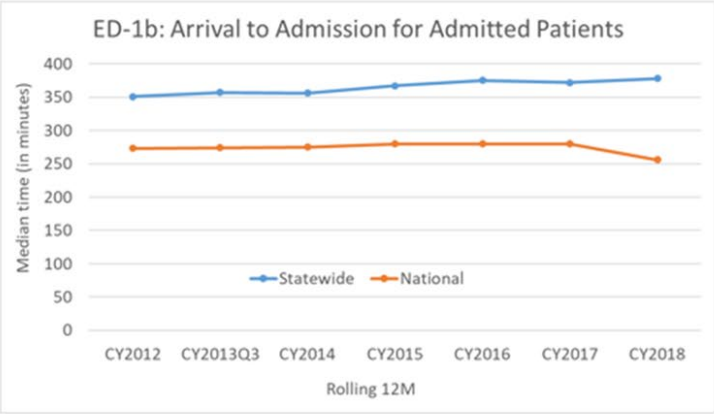
The intervention for this pilot study will include a standing lab order for inpatient HbA1c testing that automates the process of screening eligibility.

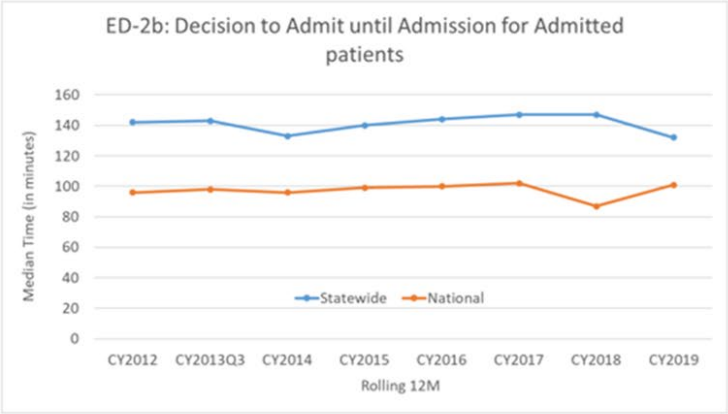
These pilot results will inform the future planning and implementation of an inpatient diabetes screening program within the State of Maryland.

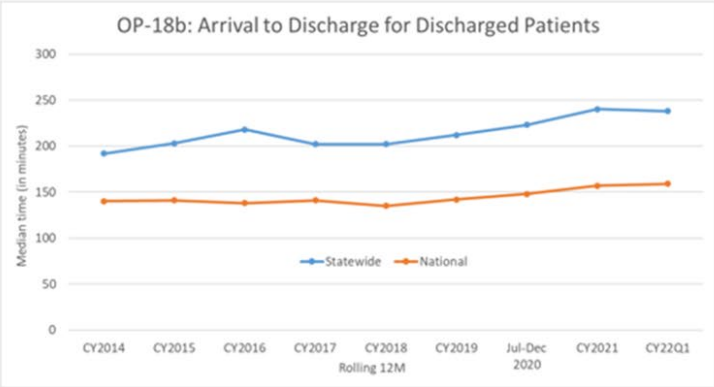
As demonstrated by quantitative and qualitative analyses, this program may be incorporated into future HSCRC policy as a requisite population health accountability measure for acute-care hospitals across Maryland.

Emergency Department Initiatives

CMS ED LOS Data: Maryland performs worse than nation

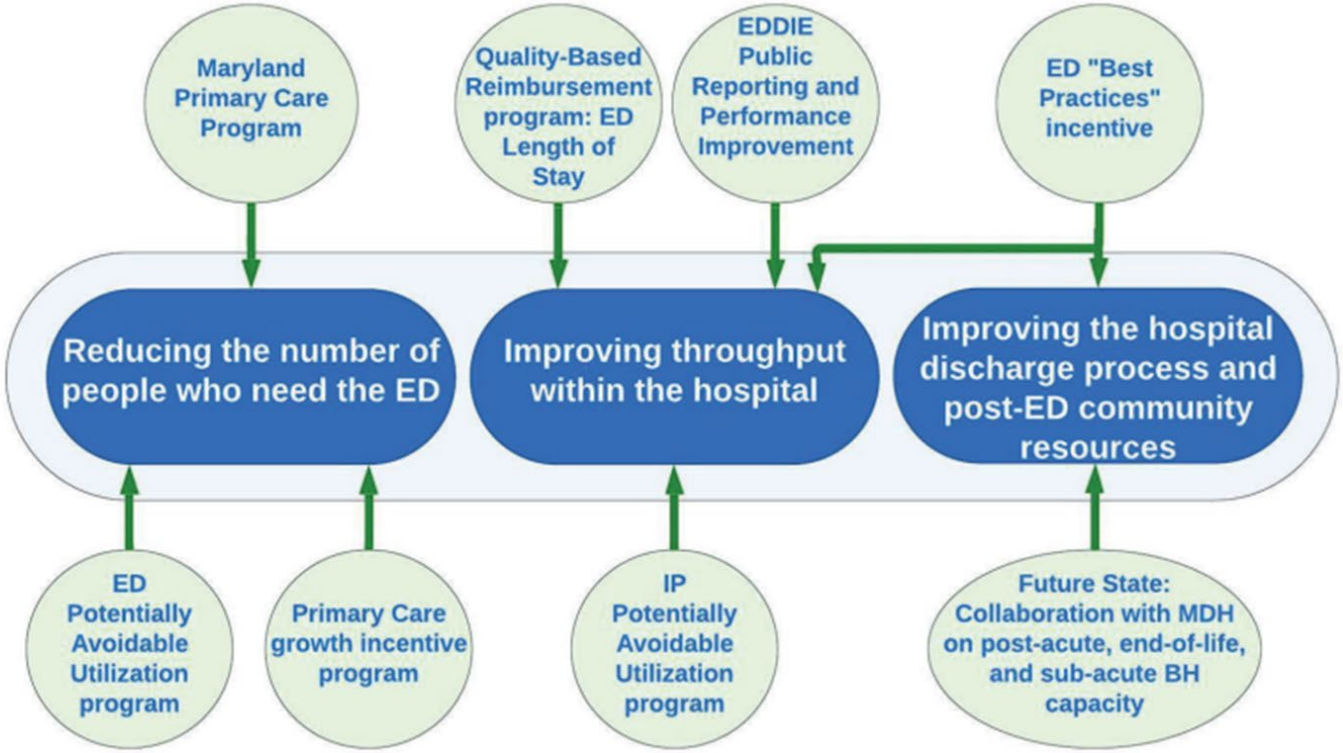






Measure ID	Measure Definition
ED-1	Median time from ED arrival to departure for admitted patients
ED-2	Median admit decision time to ED departure time for admitted patients
OP-18	Median time of ED arrival to departure for discharged patients

Interventions to Impact ED LOS



Avoidable ED Utilization Measure Update

- Measure focuses on reducing utilization by multi-visit patients (MVPs)
- Currently in monitoring status
- Staff will work with Commission to evaluate transition to payment
- Numerator: # of ED visits at by patients who have >= 4 visits at any hospital in calendar year
- Denominator: # of ED visits at a given hospital

Summary and case-level reports are posted to the CRS portal monthly.

EDDIE (Emergency Department Dramatic Improvement Effort)

- Monthly, public reporting of three measures:
  - ED1 Inpatient arrival to admission time
  - OP18 Outpatient ED arrival to discharge time
  - EMS turnaround time (data from MIEMSS)

- Hospital reporting:
  - Monthly reporting of ED1 and OP18 began June 2023
  - Data is used for public reporting at Commission meetings and other venues
  - Currently all hospitals in the state of Maryland are successfully reporting EDDIE submissions to the HSCRC. Hospitals who do not report are listed in public report

Rationale:

Commission is prioritizing immediate reporting of ED wait time data for public reporting, while developing payment incentives for CY 2024 such as the ED1 LOS measure.

Monthly, publicly reported of timely ED wait time should drive improvement.

CRISP Reporting

CRISP Reporting Services (CRS) Introduction

June 2024

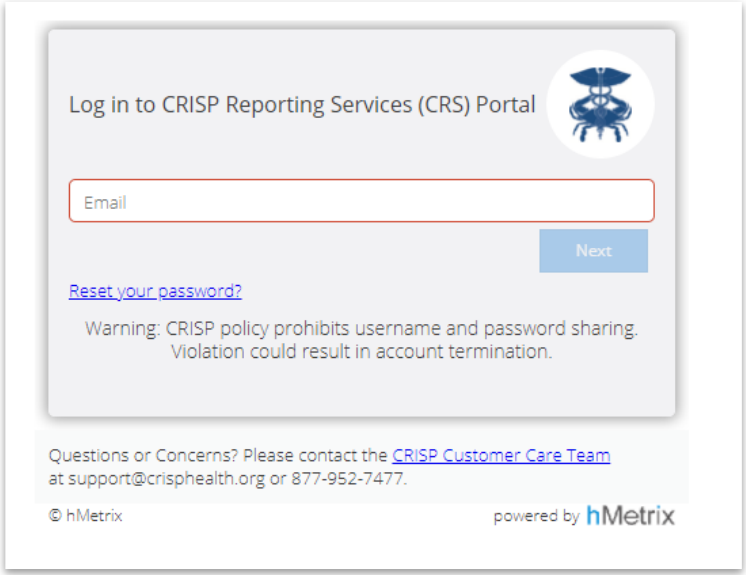
CRISP Reporting Services

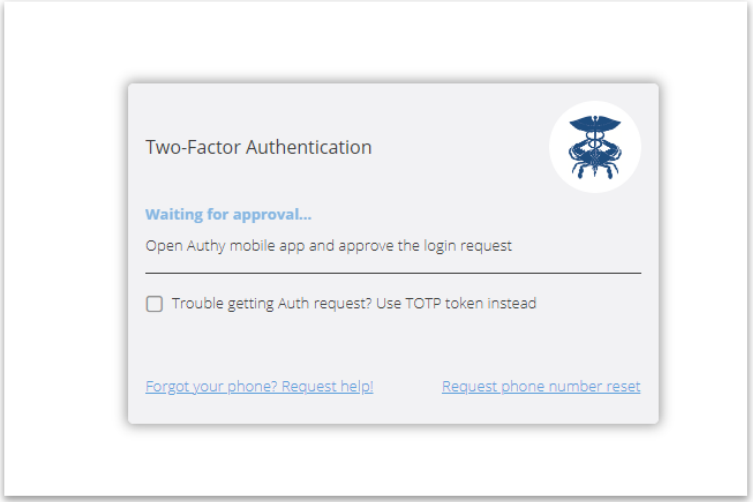
- CRS (reports.crisphealth.org) hosts reports for the HSCRC Quality Programs.
  - CRISP is working on transitioning organizations to access CRS via the CRISP Portal (portal.crisphealth.org).
- HSCRC Regulatory reports and SIHIS Directional Indicators are refreshed once per month (beginning and middle of the month, respectively)

CRS Login Page – reports.crisphealth.org

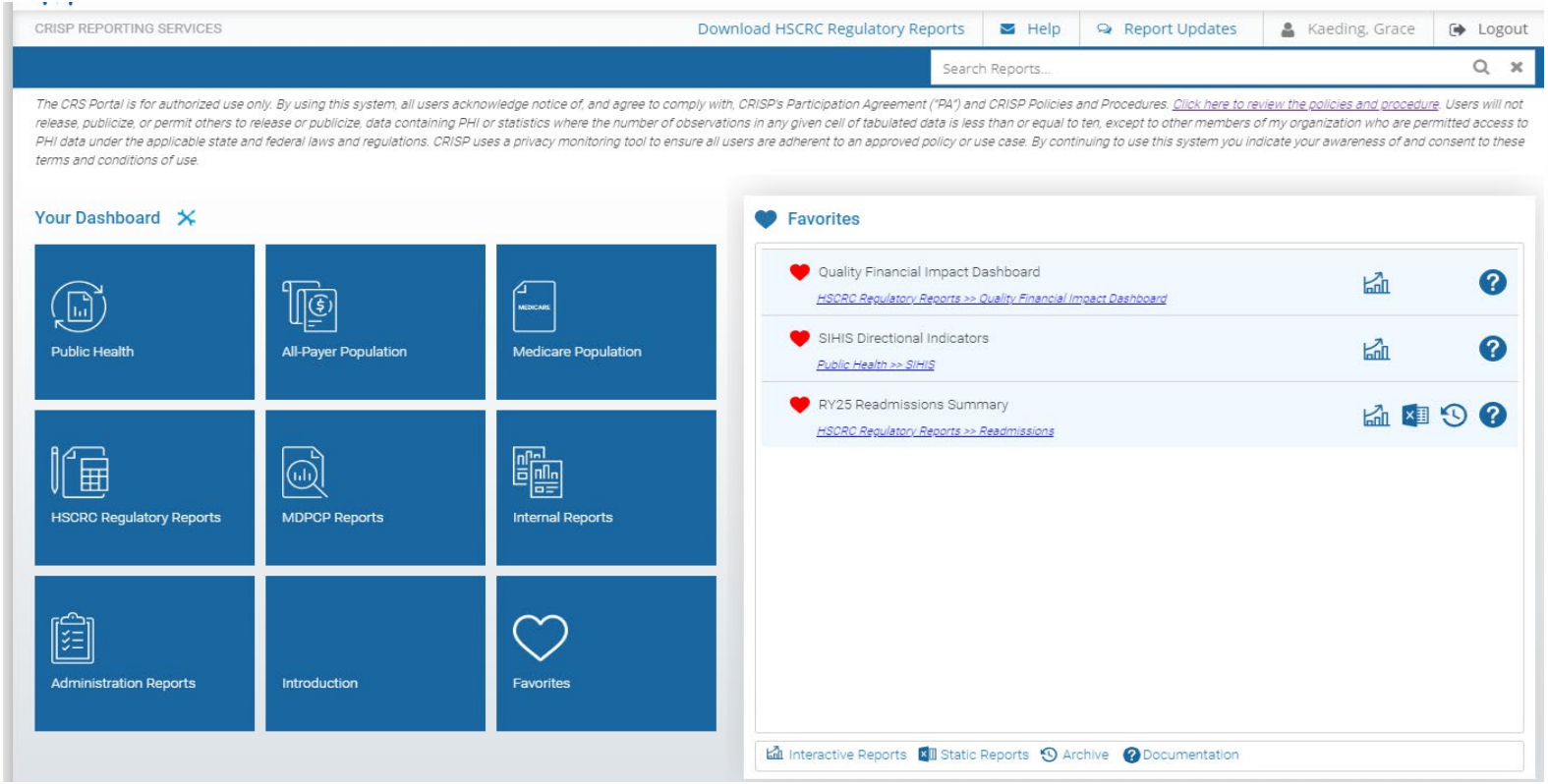
You can access CRS at reports.crisphealth.org with your User ID, password, and accepting the Authy two factor authentication notification.

If you do not have access to CRS, please reach out to support@crisphealth.org or the CRS Point of Contact for your organization

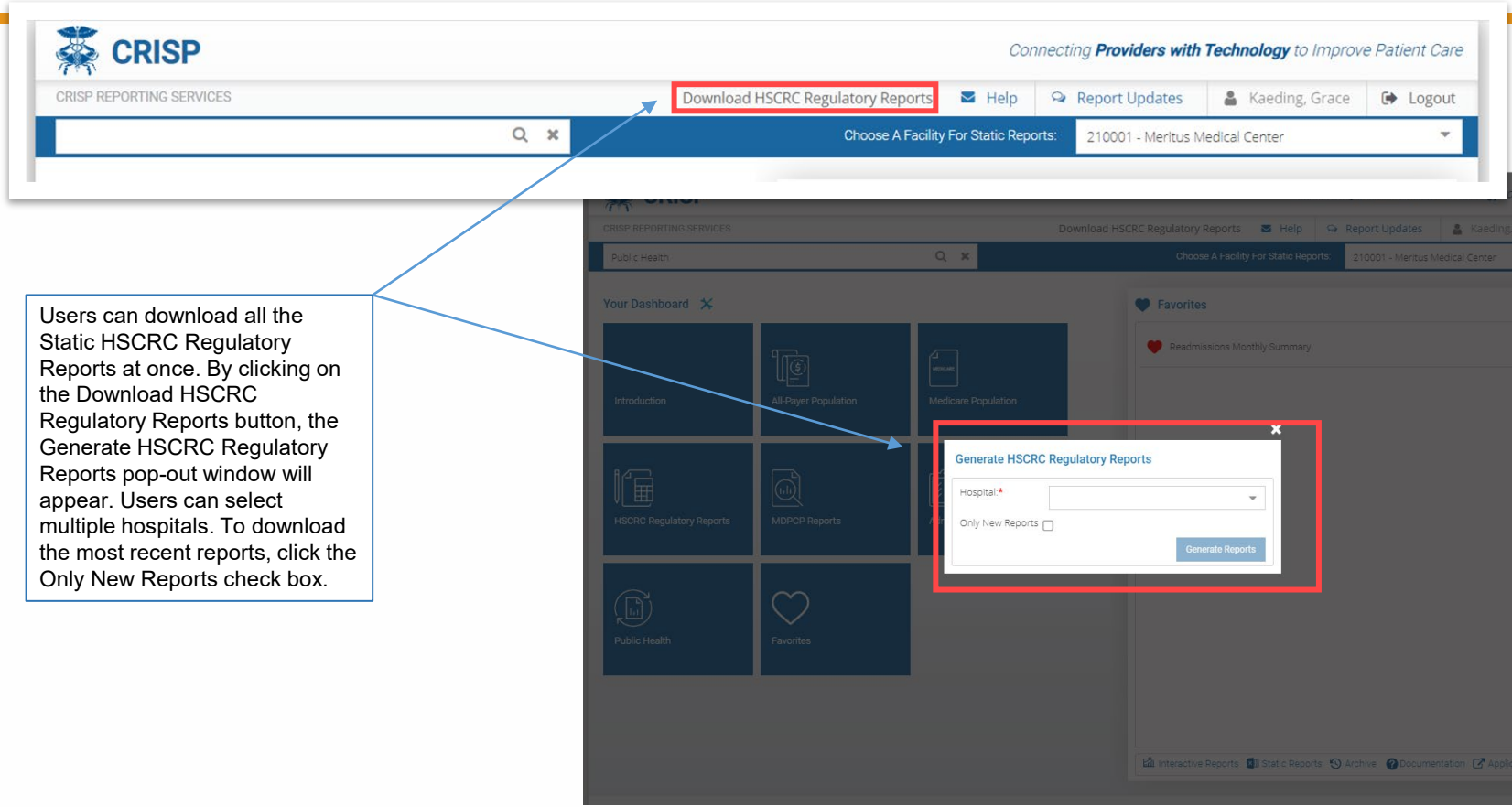




CRS Homepage

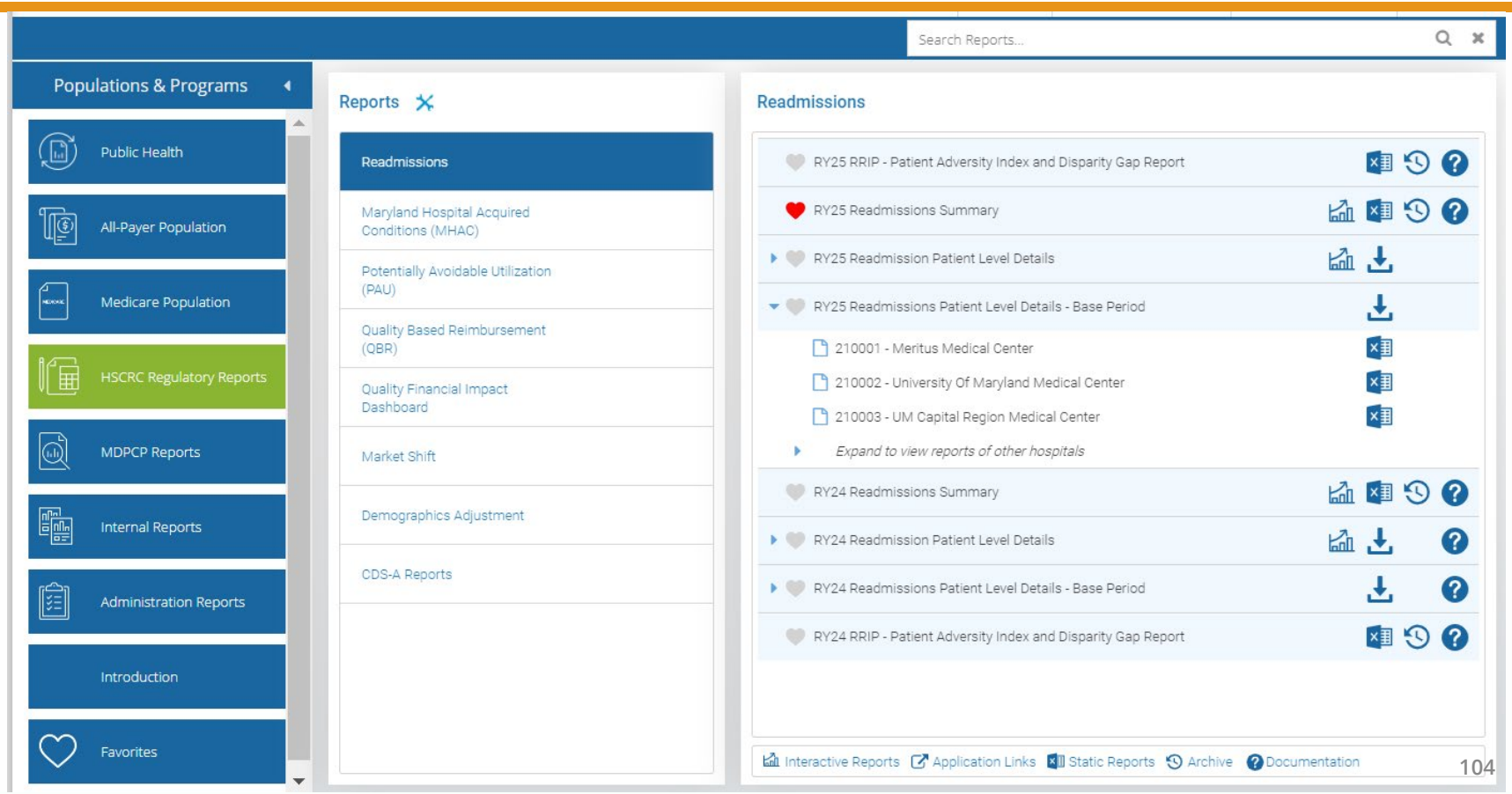


CRS Homepage



Users can download all the Static HSCRC Regulatory Reports at once. By clicking on the Download HSCRC Regulatory Reports button, the Generate HSCRC Regulatory Reports pop-out window will appear. Users can select multiple hospitals. To download the most recent reports, click the Only New Reports check box.

CRS HSCRC Regulatory Reports



Quality Policy Reports Available

RRIP

- Readmissions Static and Tableau Reports
- Patient Adversity Index and Disparity Gap Reports
- EDAC Monitoring Reports

QBR

- QBR Scoring and Calculation Sheet
- Timely Follow-Up Medicare, Medicaid, and Disparity Reports
- IP Mortality Reports
- 30-Day All-Cause Mortality

PAU

- Reference Reports
- Savings Reports
- ED Multi-Visit Patient Reports
- Avoidable Admissions Tableau

MHAC

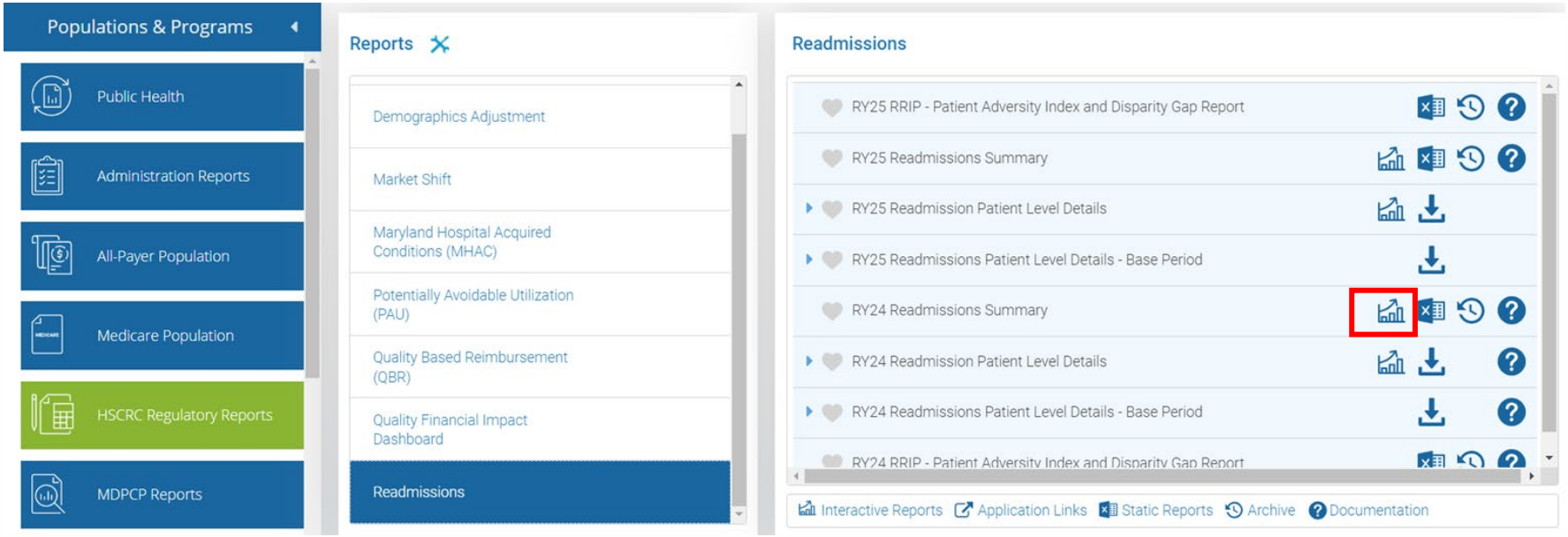
- MHAC Static Summary and Details Reports

Readmissions Tableau

Readmissions Tableau Overview

- The report allows users to filter and drilldown their hospital's readmission data.
- The following tabs are available
  - Landing Page
  - Improvement
  - Attainment
  - Trends & Locations
  - Unadjusted Hospital Readmission Trends
  - Case-mix Adjusted Readmission Trends
  - Service Line Readmission Analysis
  - Length of Discharge to Readmission (Requires PHI access)
  - Forecasting
  - Patient Level Details (Requires PHI access)
  - Documentation
  - Summary by Month

Readmissions Tableau



Filters

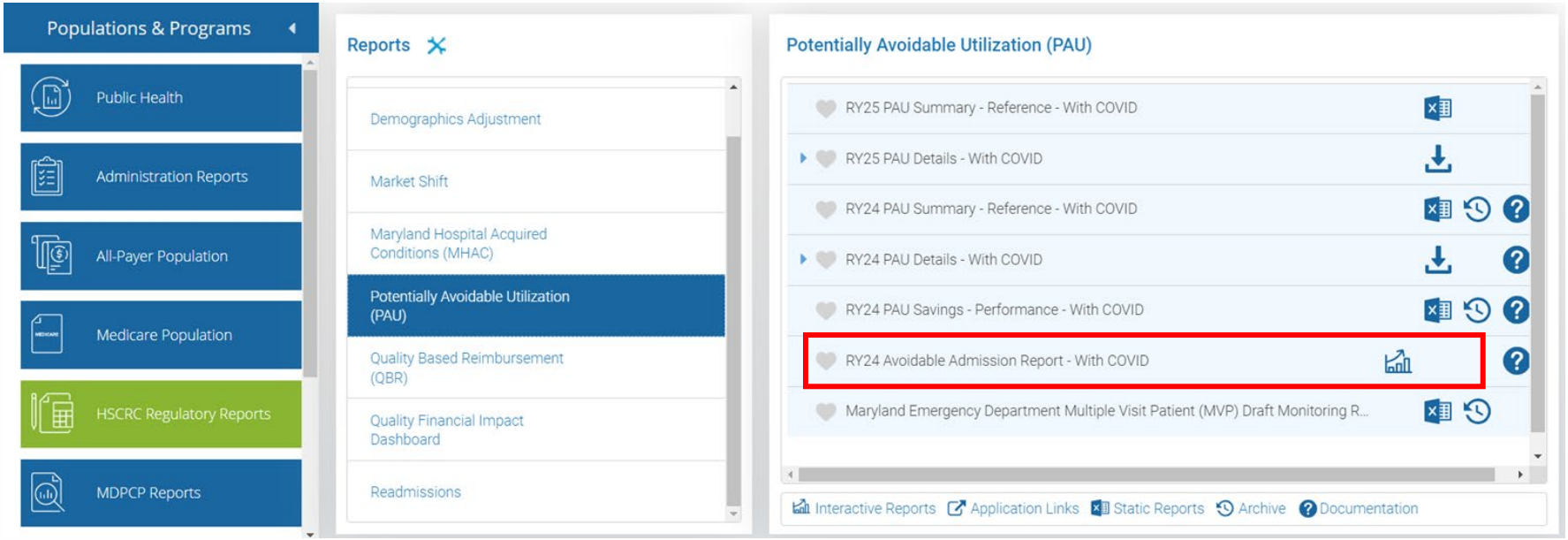
Filter	Description
Basic Period Structure	View either the complete base period (Based on CY2018 data) and/or matched YTD performance period.
Discharge Date	Select the year(s) of discharge.
Hospital Name	Filter on one or more hospitals
Index APR Service Line	Filter groups services into higher level categories, which is based on the index hospital.
Index APR Value	APR value from the index hospital.
Need Type	High Utilizer: 3+ bedded care visits (inpatient and observation stays over 24 hours) in the 12 months prior to their index visit Rising Needs: 2+ visits bedded care or ED in the 12 months before their index visit
Payer	Filter based on the type of payer (commercial, Medicare, Medicaid, and charity/self-pay)
Primary Diagnosis	Diagnosis at index visit
Race	Race reported by hospital at visit

Avoidable Admissions Tableau

Avoidable Admissions Report

- The Avoidable Admissions Report allows users to see per capita Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI) values.
- The report displays PQIs and PDIs that are assigned to hospitals based on geographic attribution.
- The following tabs are available:
  - Savings Performance
  - Summary by PQI
  - Summary by PDI
  - PQIs by Zip

Avoidable Admissions Report



Filters

Filter	Description
Year	Year in which the PQI occurred.
Hospital Name	Hospital to which the PQIs are attributed. This is not necessarily the hospital where the visit occurred.
Race	Race defined in case mix data at visit
Payer	Primary expected payer as listed in case mix data
Gender	Patient Gender
Age Group	Patient Age, distributed into available ACS census age groups.

Avoidable Admissions Report

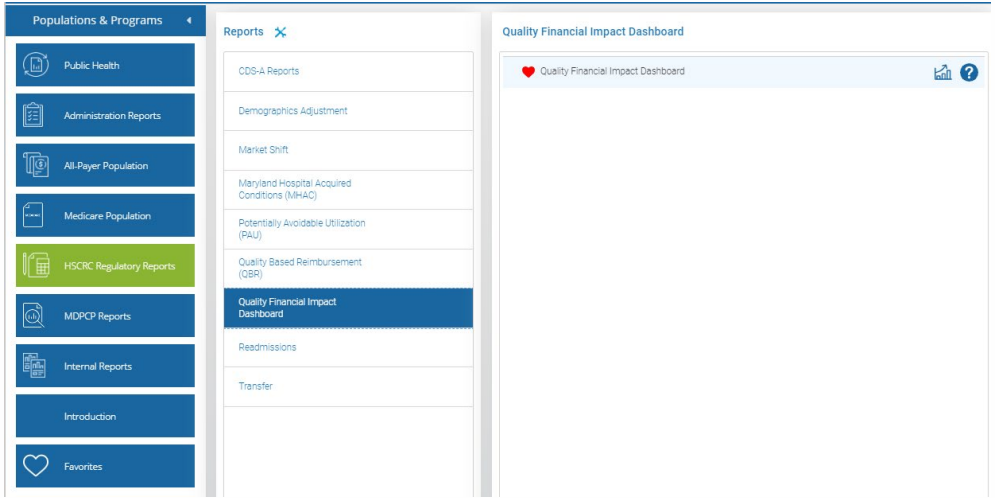
		Non-PQI/PDI Readmissions			PQIs			PDIs		
	Total Experienced Revenue (actual)	Non-PQI/PDI Readmissions (sending)	Non-PQI/PDI Readmission Revenue (estim..	Non-PQI/PDI Readmission Performance	PQI Attributed Population	Annualized Observed PQI Cases	PQI90 Risk Adjusted Rate	PDI Attributed Population	Annualized Observed PDI Cases	PDI90 Risk Adjusted Rat
Statewide	$20,548,856,496	54,790	$1,193,573,650	5.81%	4,731,575	55,712	11.81	920,010	700	0.7
	$472,490,321	1,860	$30,225,610	6.40%	122,659	2,040	15.70	23,540	30	1.2
	$2,160,701,910	2,525	$91,581,485	4.24%	71,745	1,483	23.14	11,913	34	2.8
	$410,389,528	968	$28,075,268	6.84%	101,362	1,378	14.91	20,677	2	0.1
	$578,946,746	1,958	$37,121,478	6.41%	202,434	1,692	8.53	40,484	16	0.3
	$415,246,120	1,730	$28,753,992	6.92%	214,811	1,746	8.29	45,265	28	0.6
	$115,566,911	675	$11,534,089	9.98%	34,566	529	15.07	6,548	1	0.1
	$666,378,362	1,122	$22,100,622	3.32%	86,646	1,769	23.20	14,541	38	2.5
	$3,006,600,541	4,570	$156,339,345	5.20%	102,522	1,965	22.78	16,671	42	2.5
	$514,181,587	1,537	$34,998,944	6.81%	90,468	1,243	12.68	17,019	24	1.4
	$959,586,781	1,827	$54,549,904	5.68%	112,021	2,114	17.87	21,340	34	1.6
	$670,779,223	2,466	$47,905,496	7.14%	107,182	1,923	17.99	19,762	22	1.1
	$351,085,472	1,119	$23,130,015	6.59%	197,578	1,368	8.87	38,195	8	0.2
	$90,287,182	129	$2,244,895	2.49%	18,877	205	8.79	2,606	3	0.9
	$217,189,598	811	$14,123,421	6.50%	91,959	648	6.22	19,474	13	0.6
	$574,388,930	1,760	$33,325,395	5.80%	122,523	1,377	10.59	21,877	20	0.9
	$416,084,129	1,492	$27,520,905	6.61%	189,135	1,089	4.93	39,966	7	0.1
	$731,826,865	2,303	$39,886,556	5.45%	288,936	3,034	9.80	56,731	30	0.5
	$498,023,977	1,253	$34,053,379	6.84%	79,850	1,531	20.54	12,720	25	1.9
	$387,310,016	1,119	$20,926,793	5.40%	63,385	1,125	15.56	9,133	2	0.2
	$229,145,424	689	$10,906,097	4.76%	90,852	1,182	13.61	19,871	6	0.3
	$805,427,349	1,709	$43,534,268	5.41%	85,821	1,770	22.73	16,287	28	1.7
	$52,843,103	48	$1,267,774	2.40%	23,256	188	6.52	3,379	2	0.4
	$196,955,157	540	$10,592,418	5.38%	75,422	1,207	15.67	15,431	1	0.0
	$279,058,075	1,149	$20,054,351	7.19%	131,242	1,729	12.10	25,898	20	0.7
	$218,983,119	906	$17,185,563	7.85%	35,020	681	22.68	7,668	20	2.5
	$185,108,419	522	$11,284,119	6.10%	122,914	1,109	9.80	27,070	0	0.0
	$293,645,543	793	$13,961,620	4.75%	91,459	987	8.43	17,149	8	0.4
	$276,842,327	593	$15,060,694	5.44%	18,647	451	26.19	2,892	12	3.9
	$178,117,522	553	$8,844,639	4.97%	74,070	764	9.91	15,934	8	0.4
	$307,479,451	1,380	$25,331,481	8.24%	63,590	992	15.70	12,357	17	1.3

Quality Financial Impact Dashboard (QFID)

Background on Quality Financial Impact Dashboard

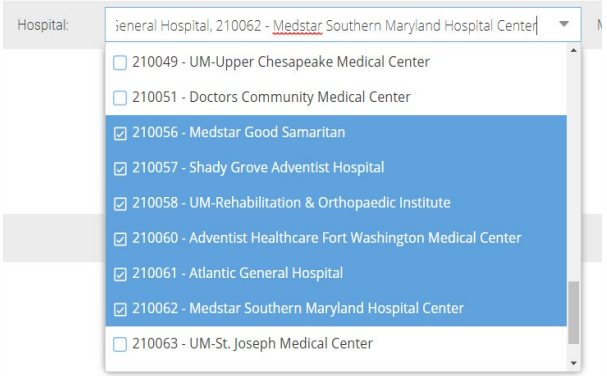
Purpose of the Dashboard:

- **To give executive leadership high-level insight on their year-to-date performance in the quality pay-for-performance programs as it relates to the overall budget in the Global Budget Revenue (GBR) model**



Report Features

The hospital filter at the top of the screen allows users to select which hospital(s) they want to view in the dashboard. Please select “Apply” after selecting the hospitals.

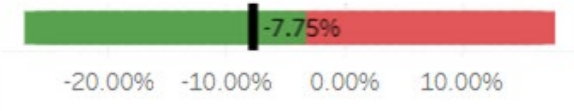


The green to red bar shows users how close or far they are from the reward/penalty cutpoint.

Red indicates performance that would receive a penalty

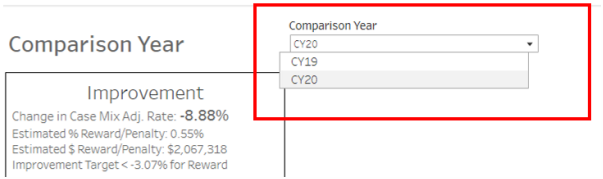
Blue (if applicable) represents a revenue-neutral “hold harmless zone”

Green represents performance receiving a reward

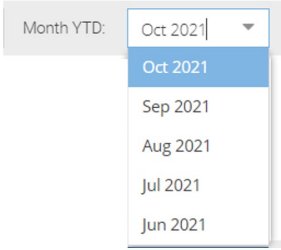


QFID Report Features

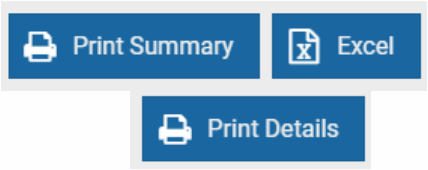
The comparison year on the left half of the screen allows users to change what year they are comparing against the current year. Please note that comparison years will use the current year's rate logic



The "Month YTD" filter allows users to change which data load they are using as the current performance period.



The Excel and Print features allows the users to export the report they are viewing.



QFID Caveats and Notes

- The revenue adjustments in this dashboard are estimates, based on a hospital's last approved global budget
  - These revenue adjustment estimates will be updated to exact totals for the current rate-year through the update factor process at the end of the fiscal year
  - The revenue percentages are also provided, and hospitals are welcome to apply these percentages against their current global budget projections
- Hospital rankings are calculated by sorting on "% Reward/Penalty" from highest percent reward
- Current performance and financial impact are calculated to reflect the performance to-date and resultant financial impact, and will be updated throughout the year as new data become available
- RY26 methodology will be updated in the report by August

QFID Tabs

QFID has a box for each of the most current rate years for each quality program. These boxes represent the financial impact for the respective program and rate year. To view a page, the user must click on the box for the tab they want to view

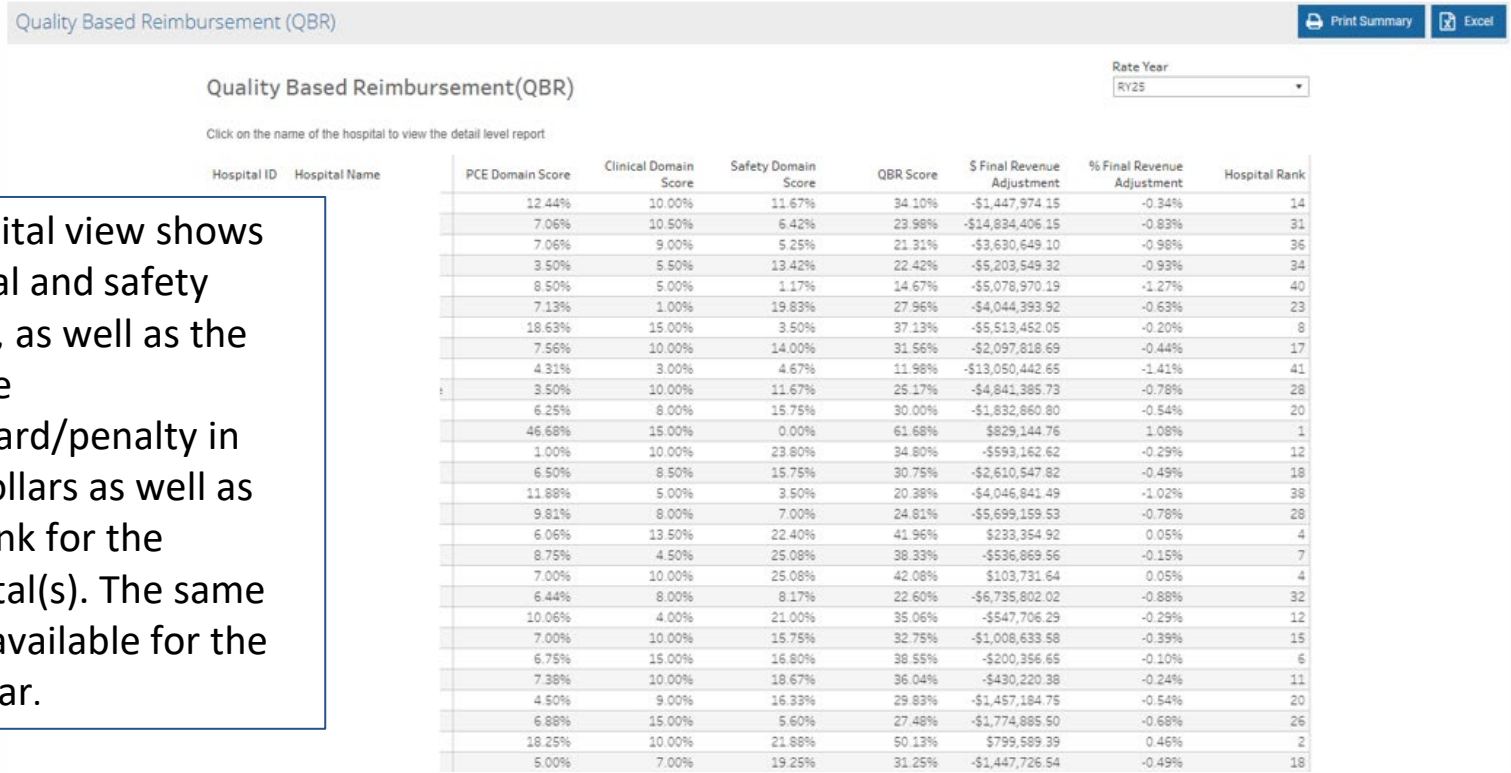
Summary View Total Tab

The Total page allows users to view the current and comparison years along with the % change for each of the quality programs and the total quality revenue adjustment.

Hospital ID	Hospital Name	RRIP			MHAC			QBR			Total Quality Revenue Adjustment			PAU		
		Current Year	Comparison Year	% Change	Current Year	Comparison Year	% Change	Current Year	Comparison Year	% Change	Current Year	Comparison Year	% Change	Current Year	Comparison Year	% Change
		-$2,079,856	-$1,474,283	-41.08%	$1,261,023	$315,256	300.00%	-$1,447,974	-$5,171,336	72.00%	-$2,266,808	-$6,330,364	64.19%	-$2,373,541	-$2,271,347	-4.50%
		$17,533,019	$20,930,641	-16.23%	$3,785,208	-$5,204,661	172.73%	-$14,834,406	-$18,324,855	19.05%	$6,483,821	-$2,598,875	349.49%	-$9,863,489	-$9,331,644	-5.70%
		$3,034,628	$4,379,668	-30.71%	$0	-$282,005	100.00%	-$3,630,649	-$5,082,909	28.57%	-$596,021	-$985,246	39.51%	-$2,127,838	-$1,965,672	-8.25%
		-$408,860	$1,874,136	-121.82%	$0	$0		-$5,203,549	-$7,394,517	29.63%	-$5,612,409	-$5,520,382	-1.67%	-$2,575,952	-$2,314,129	-11.31%
		-$535,572	-$15,421	-3372.98%	-$1,108,461	-$2,046,389	45.83%	-$5,078,970	-$3,906,900	-30.00%	-$6,723,003	-$5,968,710	-12.64%	-$1,932,316	-$1,905,977	-1.38%
		-$3,302,991	$391,216	-944.29%	-$361,282	-$1,661,897	78.26%	-$4,044,394	-$5,599,930	27.78%	-$7,708,666	-$6,870,611	-12.20%	-$3,211,284	-$2,930,802	-9.57%
		$6,484,131	$13,934,897	-53.47%	-$4,540,576	-$19,865,019	77.14%	-$5,513,452	-$8,270,178	33.33%	-$3,569,898	-$14,200,300	74.86%	-$16,864,558	-$16,850,732	-0.08%
		-$355,419	-$843,862	57.88%	$466,889	$0		-$2,097,819	-$4,195,637	50.00%	-$1,986,349	-$5,039,500	60.58%	-$2,573,300	-$2,438,965	-5.51%
		-$1,976,263	$1,224,948	-261.33%	$0	-$1,717,949	100.00%	-$13,050,443	-$10,800,366	-20.83%	-$15,026,706	-$11,293,367	-33.06%	-$5,100,776	-$4,398,075	-15.98%
e		$1,836,822	$4,661,697	-60.60%	$5,639,934	$0		-$4,841,386	-$8,169,838	40.74%	$2,635,371	-$3,508,142	175.12%	-$3,916,348	-$3,715,257	-5.41%
		-$2,017,643	$62,107	-3348.66%	$3,009,128	$2,407,303	25.00%	-$1,832,861	-$2,999,227	38.89%	-$841,375	-$529,817	-58.80%	-$1,615,653	-$1,535,891	-5.19%
		-$39,325	$510,511	-107.70%	-$59,560	$442,443	-113.46%	$829,145	$276,382	200.00%	$730,260	$1,229,335	-40.60%	-$196,765	-$175,632	-12.03%
		$957,967	$732,133	30.85%	$828,866	$1,480,118	-44.00%	-$593,163	-$2,570,371	76.92%	$1,193,670	-$358,120	433.32%	-$873,364	-$828,667	-5.39%
		$136,301	$376,832	-63.83%	$2,673,439	$2,262,140	18.18%	-$2,610,548	-$4,437,931	41.18%	$199,192	-$1,798,959	111.07%	-$2,439,727	-$2,306,774	-5.76%
		-$226,876	$2,587,253	-108.77%	-$833,158	-$1,287,607	35.29%	-$4,046,841	-$3,854,135	-5.00%	-$5,106,875	-$2,554,489	-99.92%	-$1,653,693	-$1,450,327	-14.02%
		-$2,784,440	-$1,547,019	-79.99%	$771,012	$3,598,055	-78.57%	-$5,699,160	-$8,904,937	36.00%	-$7,712,588	-$6,853,901	-12.53%	-$3,111,321	-$2,861,398	-8.73%
		-$1,305,456	-$344,888	-278.52%	-$94,533	-$189,066	50.00%	$233,355	-$700,065	133.33%	-$1,166,634	-$1,234,019	5.46%	-$3,116,534	-$2,694,376	-15.67%
		-$860,444	$494,531	-273.99%	$2,029,120	$2,029,120	0.00%	-$536,870	-$3,937,043	86.36%	$631,807	-$1,413,392	144.70%	-$1,853,205	-$1,675,314	-10.62%
		$1,056,325	-$463,072	328.11%	$1,113,415	$1,702,870	-34.62%	$103,732	-$414,927	125.00%	$2,273,472	$824,871	175.62%	-$943,292	-$919,907	-2.54%
		$4,939,969	$6,520,849	-24.24%	$303,448	-$1,517,239	120.00%	-$6,735,802	-$8,981,069	25.00%	-$1,492,385	-$3,977,459	62.48%	-$4,656,145	-$4,257,582	-9.36%
		$33,808	$140,472	-75.93%	$0	$0					$33,808	$140,472	-75.93%	-$122,422	-$103,031	-18.82%
		-$678,169	-$1,363,307	50.26%	-$754,705	-$754,705	0.00%	-$547,706	-$2,099,541	73.91%	-$1,980,580	-$4,217,553	53.04%	-$945,671	-$932,816	-1.38%
		-$590,522	$1,069,695	-155.20%	-$209,823	$1,888,408	-111.11%	-$1,008,634	-$1,765,109	42.86%	-$1,808,978	$1,192,994	-251.63%	-$1,422,080	-$1,323,109	-7.48%
		$256,588	$1,781,831	-85.60%	$2,157,086	$1,121,685	92.31%	-$200,357	-$1,402,497	85.71%	$2,213,317	$1,501,019	47.45%	-$1,509,521	-$1,394,651	-8.24%
		$618,271	$250,856	146.46%	$524,579	$0		-$430,220	-$1,548,793	72.22%	$712,629	-$1,297,937	154.90%	-$811,697	-$748,201	-8.49%
		$962,661	$1,298,539	-25.87%	$0	-$439,749	100.00%	-$1,457,185	-$3,576,726	59.26%	-$494,524	-$2,717,936	81.81%	-$1,004,801	-$936,599	-7.28%

Multiple Hospital View

The multi hospital view shows the PCE, Clinical and safety domain scores, as well as the total QBR score estimated reward/penalty in percent and dollars as well as the hospital rank for the selected hospital(s). The same measures are available for the comparison year.



Quality Based Reimbursement (QBR)

Print Summary | Excel

Quality Based Reimbursement(QBR)

Rate Year: RY25

Click on the name of the hospital to view the detail level report

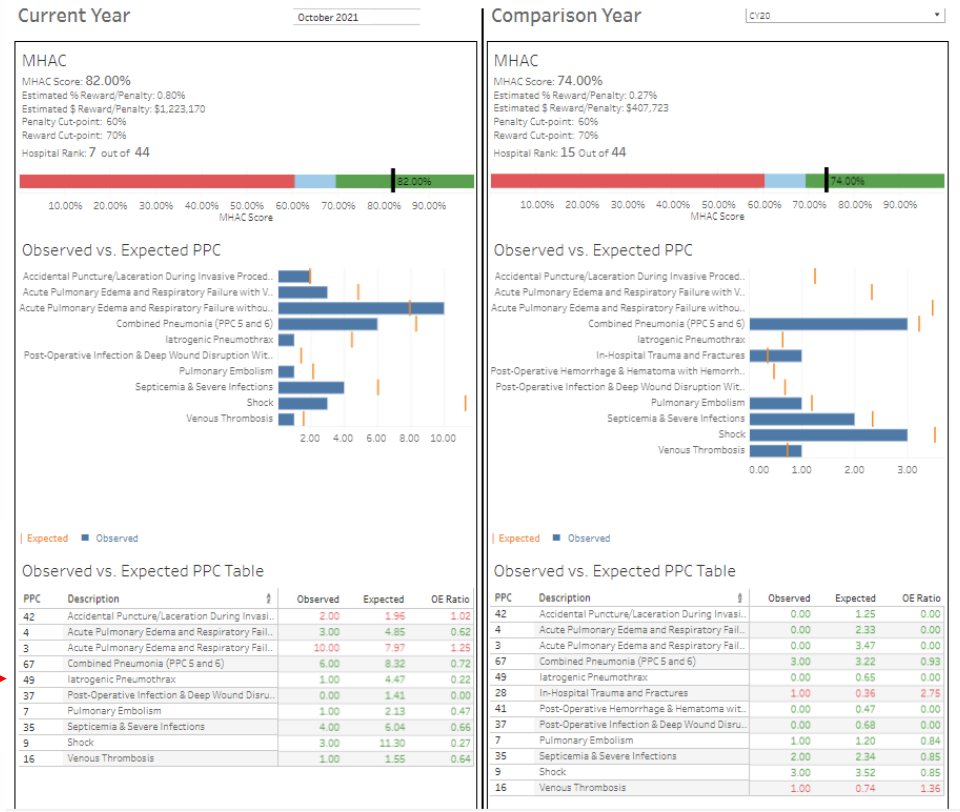
Hospital ID	Hospital Name	PCE Domain Score	Clinical Domain Score	Safety Domain Score	QBR Score	$ Final Revenue Adjustment	% Final Revenue Adjustment	Hospital Rank
		12.44%	10.00%	11.67%	34.10%	-$1,447,974.15	-0.34%	14
		7.06%	10.50%	6.42%	23.98%	-$14,834,406.15	-0.83%	31
		7.06%	9.00%	5.25%	21.31%	-$3,630,649.10	-0.98%	36
		3.50%	5.50%	13.42%	22.42%	-$5,203,549.32	-0.93%	34
		8.50%	5.00%	1.17%	14.67%	-$5,078,970.19	-1.27%	40
		7.13%	1.00%	19.83%	27.96%	-$4,044,393.92	-0.63%	23
		18.63%	15.00%	3.50%	37.13%	-$5,513,452.05	-0.20%	8
		7.56%	10.00%	14.00%	31.56%	-$2,097,818.69	-0.44%	17
		4.31%	3.00%	4.67%	11.98%	-$13,050,442.65	-1.41%	41
		3.50%	10.00%	11.67%	25.17%	-$4,841,385.73	-0.78%	28
		6.25%	8.00%	15.75%	30.00%	-$1,832,860.80	-0.54%	20
		46.68%	15.00%	0.00%	61.68%	$829,144.76	1.08%	1
		1.00%	10.00%	23.80%	34.80%	-$593,162.62	-0.29%	12
		6.50%	8.50%	15.75%	30.75%	-$2,610,547.82	-0.49%	18
		11.88%	5.00%	3.50%	20.38%	-$4,046,841.49	-1.02%	38
		9.81%	8.00%	7.00%	24.81%	-$5,699,159.53	-0.78%	28
		6.06%	13.50%	22.40%	41.96%	$233,354.92	0.05%	4
		8.75%	4.50%	25.08%	38.33%	-$536,869.56	-0.15%	7
		7.00%	10.00%	25.08%	42.08%	$103,731.64	0.05%	4
		6.44%	8.00%	8.17%	22.60%	-$6,735,802.02	-0.88%	32
		10.06%	4.00%	21.00%	35.06%	-$547,706.29	-0.29%	12
		7.00%	10.00%	15.75%	32.75%	-$1,008,633.58	-0.39%	15
		6.75%	15.00%	16.80%	38.55%	-$200,356.65	-0.10%	6
		7.38%	10.00%	18.67%	36.04%	-$430,220.38	-0.24%	11
		4.50%	9.00%	16.33%	29.83%	-$1,457,184.75	-0.54%	20
		6.88%	15.00%	5.60%	27.48%	-$1,774,885.50	-0.68%	26
		18.25%	10.00%	21.88%	50.13%	$799,589.39	0.46%	2
		5.00%	7.00%	19.25%	31.25%	-$1,447,726.54	-0.49%	18

Detail View MHAC Tab

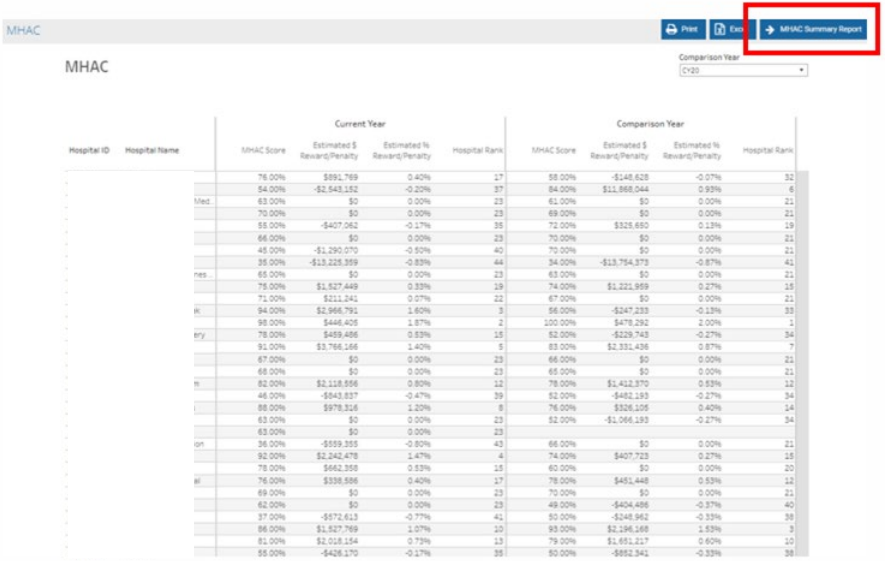
MHAC tab includes: MHAC score, estimated percent reward/penalty, estimated financial reward/penalty, hospital rank for MHAC, and tables for the observed versus expected PPC

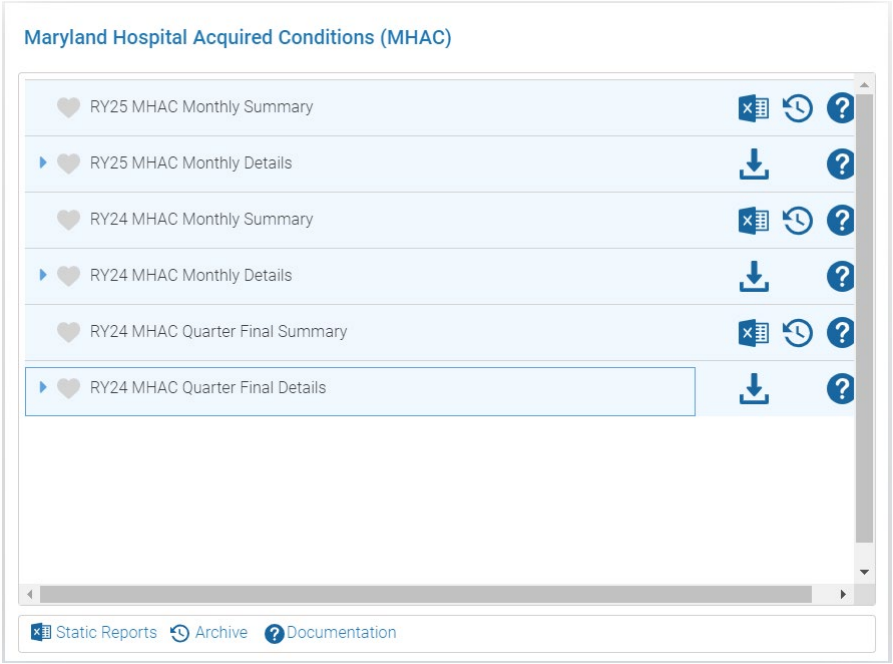
First table shows the PPCs the hospital is being held accountable. The blue bar is the observed PPC occurrence; the orange line is the expected

The second PPC tables the actual values for each PPC and the OE ratio. Red means the observed is higher than expected and green means the observed is lower than expected



MHAC Additional Reports

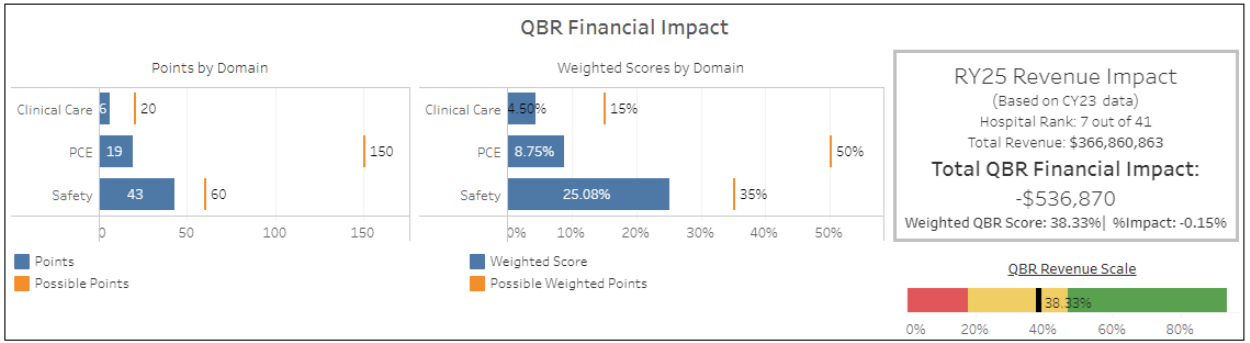




Clicking the “MHAC Summary Report” button at the top right on either the summary or details page will launch the full selection of reports supporting the MHAC Program.

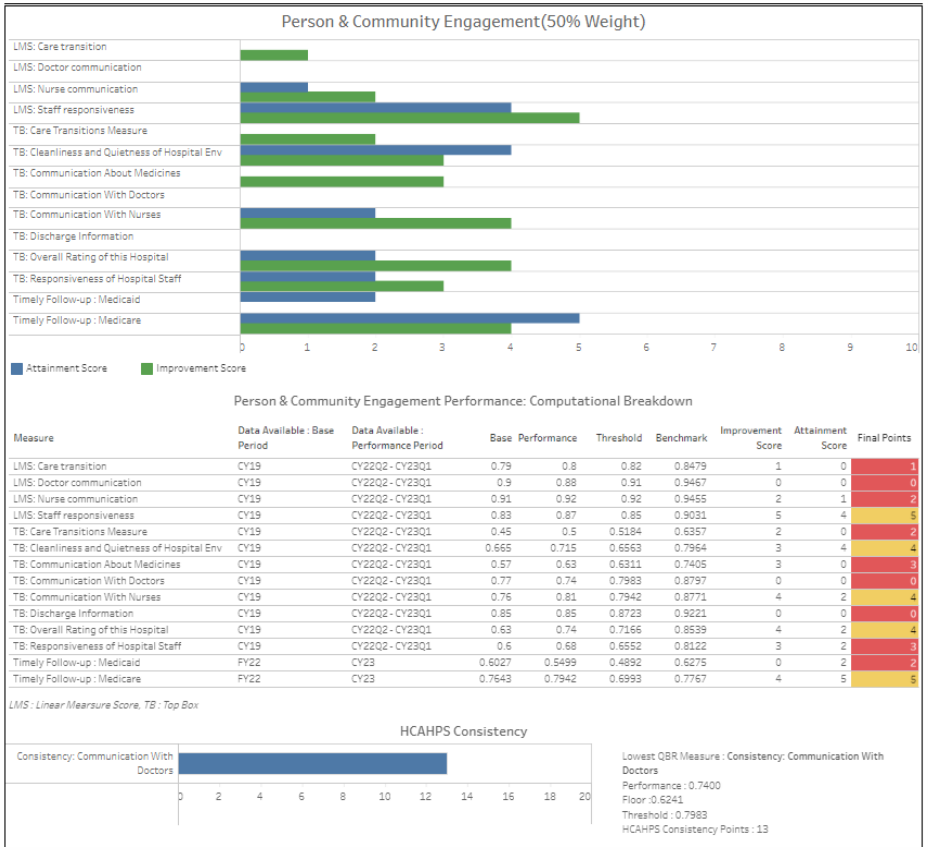
QBR in QFID

The top section of the QBR tab shows the possible points and achieved points by domain. The adjacent table is the weighted scores by domain. The last set shows the hospital rank, total revenue, QBR financial impact, weighted QBR score and percent impact.

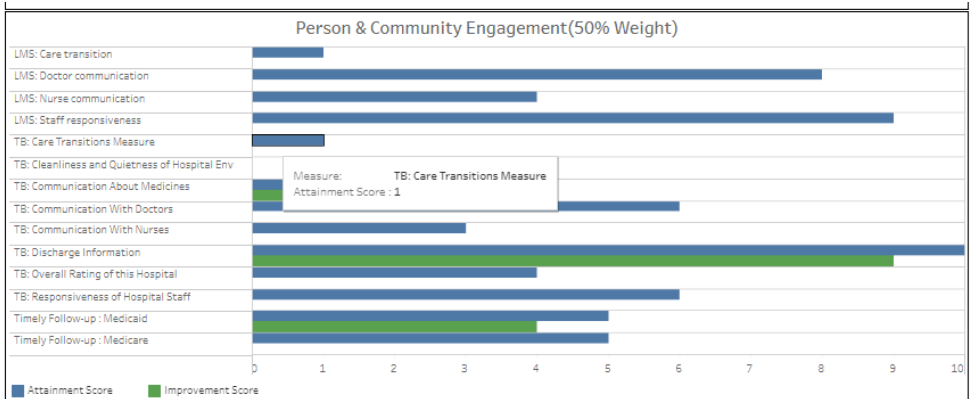


QBR in QFID

The person and community engagement section shows a visual for the attainment and improvement scores for each **care compare measure**. The second chart includes the measure, data about the base and performance period, threshold, benchmark, improvement, attainment and final points.



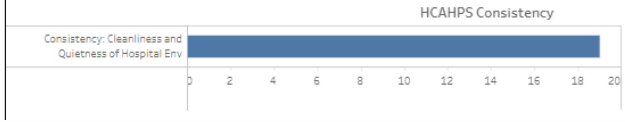
QBR in QFID



Person & Community Engagement Performance: Computational Breakdown

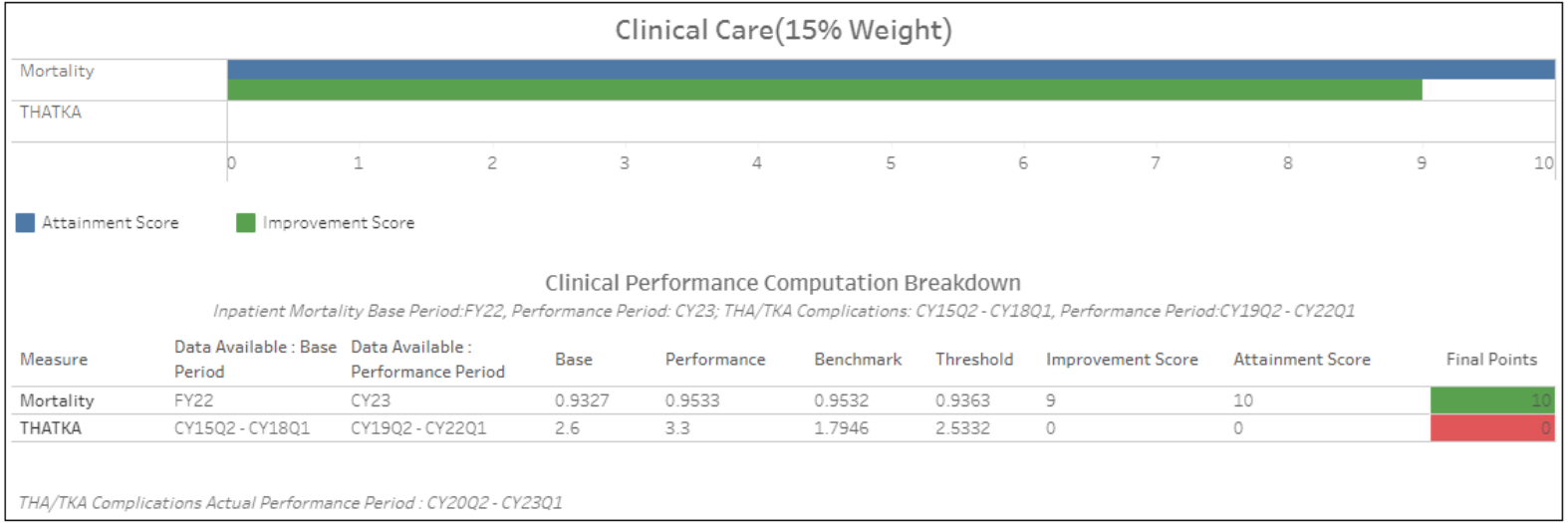
Measure	Data Available : Base Period	Data Available : Performance Period	Base	Performance	Threshold	Benchmark	Improvement Score	Attainment Score	Final Points
LMS: Care transition	CY19	CY22Q2 - CY23Q1	0.84	0.82	0.82	0.8479	0	1	1
LMS: Doctor communication	CY19	CY22Q2 - CY23Q1	0.95	0.94	0.91	0.9467	0	8	8
LMS: Nurse communication	CY19	CY22Q2 - CY23Q1	0.94	0.93	0.92	0.9455	0	4	4
LMS: Staff responsiveness	CY19	CY22Q2 - CY23Q1	0.91	0.9	0.85	0.9031	0	9	9
TB: Care Transitions Measure	CY19	CY22Q2 - CY23Q1	0.56	0.52	0.5184	0.6357	0	1	1
TB: Cleanliness and Quietness of Hospital Env	CY19	CY22Q2 - CY23Q1	0.725	0.655	0.6563	0.7964	0	0	0
TB: Communication About Medicines	CY19	CY22Q2 - CY23Q1	0.61	0.66	0.6311	0.7405	3	3	3
TB: Communication With Doctors	CY19	CY22Q2 - CY23Q1	0.87	0.85	0.7983	0.8797	0	6	6
TB: Communication With Nurses	CY19	CY22Q2 - CY23Q1	0.84	0.82	0.7942	0.8771	0	3	3
TB: Discharge Information	CY19	CY22Q2 - CY23Q1	0.89	0.94	0.8723	0.9221	9	10	10
TB: Overall Rating of this Hospital	CY19	CY22Q2 - CY23Q1	0.77	0.77	0.7166	0.8539	0	4	4
TB: Responsiveness of Hospital Staff	CY19	CY22Q2 - CY23Q1	0.8	0.75	0.6552	0.8122	0	6	6
Timely Follow-up : Medicaid	FY22	CY23	0.5929	0.717	0.4892	0.6275	4	5	5
Timely Follow-up : Medicare	FY22	CY23	0.7871	0.7802	0.6993	0.7767	0	5	5

LMS : Linear Mearsure Score, TB : Top Box



Lowest QBR Measure : **Consistency: Cleanliness and Quietness of Hospital Env**
Performance : 0.6550
Floor :0.4594
Threshold : 0.6563
HCAHPS Consistency Points : 19

Clinical Care



Clinical Performance Computation Breakdown

Inpatient Mortality Base Period:FY22, Performance Period: CY23; THA/TKA Complications: CY15Q2 - CY18Q1, Performance Period:CY19Q2 - CY22Q1

Measure	Data Available : Base Period	Data Available : Performance Period	Base	Performance	Benchmark	Threshold	Improvement Score	Attainment Score	Final Points
Mortality	FY22	CY23	0.9327	0.9533	0.9532	0.9363	9	10	10
THATKA	CY15Q2 - CY18Q1	CY19Q2 - CY22Q1	2.6	3.3	1.7946	2.5332	0	0	0

THA/TKA Complications Actual Performance Period : CY20Q2 - CY23Q1

The clinical care section shows a visual for the attainment and improvement scores for each **measure**. The second chart includes the measure, data about the base and performance period, threshold, benchmark, improvement, attainment and final points.

Support and Training

- For questions about the reports within CRS or suggestions for report enhancements contact report-support@crisphealth.org
- Detailed User Guides are available for all reports on the CRS website
- Webinars on select reports are on the CRISP Learning System website (crisphealth.org/learning-system/crs)

Accessing Reports

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

Non-HSCRC Quality Resources

- Why Not the Best?
- CMS Care Compare
- MHCC Health Care Quality Reports
- QualityNet
- LeapFrog Hospital Safety Grades
- US News & World Report - Hospital Rankings
- Commonwealth Fund Report

Acknowledgments

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

Q & A

- Please type your question(s) into the chat
- Additional or unanswered questions can be emailed to the HSCRC Quality mailbox: hscrc.quality@maryland.gov
- Thank you again for your participation!