



maryland  
**health services**  
cost review commission

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# Performance Measurement Workgroup

February 19, 2025

HSCRC Quality Team

# Meeting Agenda

- ED Wait Times:
  - ED Wait Time Commission Update
  - RY 2027 ED-Hospital Throughput Best Practices Policy Update
- RY 2027 Draft RRIP Recommendations
- RY 2027 MHAC Discussion

# Workgroup Learning Agreements

- **Be Present** – Make a conscious effort to know who is in the room, become an active listener. Refrain from multitasking and checking emails during meetings.
- **Call Each Other In As We Call Each Other Out** – When challenging ideas or perspectives give feedback respectfully. When being challenged - listen, acknowledge the issue, and respond respectfully.
- **Recognize the Difference of Intent vs Impact** – Be accountable for our words and actions.
- **Create Space for Multiple Truths** – Seek understanding of differences in opinion and respect diverse perspectives.
- **Notice Power Dynamics** – Be aware of how you may unconsciously be using your power and privilege.
- **Center Learning and Growth** – At times, the work will be uncomfortable and challenging. Mistakes and misunderstanding will occur as we work towards a common solution. We are here to learn and grow from each other both individually and collectively.

**REMINDER:** These  
workgroup  
meetings are  
recorded.

# PMWG Members

Carrie	Adams	Meritus	Stephen	Michaels	MedStar Southern Maryland Hospital
Andrew	Anderson	Johns Hopkins Bloomberg	Lily	Mitchell	CareFirst
Ryan	Anderson	MedStar - MD Primary Care Program	Sharon	Neeley	Maryland Department of Health Medicaid
Kelly	Arthur	Qlarant QIO	Christine	Nguyen	Families USA
Ed	Beranek	Johns Hopkins Health System	Jonathan	Patrick	MedStar Health
Barbara	Brocato	Barbara Marx Brocato & Associates	Elinor	Petrocelli	Mercy Medical Center
Zahid	Butt	Medisolv Inc.	Mindy	Pierce	Primary Care Coalition of Montgomery County
Tim	Chizmar	MIEMSS	Nitza	Santiago	Lifebridge Health
Linda	Costa	University of Maryland School of Nursing	Dale	Schumacher	MedChi, Maryland State Medical Society
Ted	Delbridge	MIEMSS (c)	Madeleine "Maddy"	Shea	Health Management Associates
Toby	Gordon	Johns Hopkins Carey Business School	Brian	Sims	Maryland Hospital Association
Shannon	Hall	Community Behavioral Health Association of MD	Mike	Sokolow	University of Maryland Medical Systems
Theressa	Lee	Maryland Health Care Commission	Geetika "Geeta"	Sood	JHU SOM, Division of Infectious Diseases.
Stacy	Lofton	Families USA	April	Taylor	Johns Hopkins Health System
Angela	Maule	Garrett Regional Medical Center	Bruce	VanDerver	Maryland Physicians Care
Patsy	Mcneil	Adventist Health	Jamie	White	Frederick Health

# ED Wait Time Reduction Commission Updates



# ED Wait Time Reduction Commission:

Collaborate on behavioral health, post-acute, primary care, and other areas of opportunity.

## Improve Access

Maryland Primary Care Program

Expand Behavioral Health Framework

SNF/Post-Acute

## Implement Hospital Payment Programs to Improve Clinical Care

MD Hospital Quality Policies

ED "Best Practices" Incentive

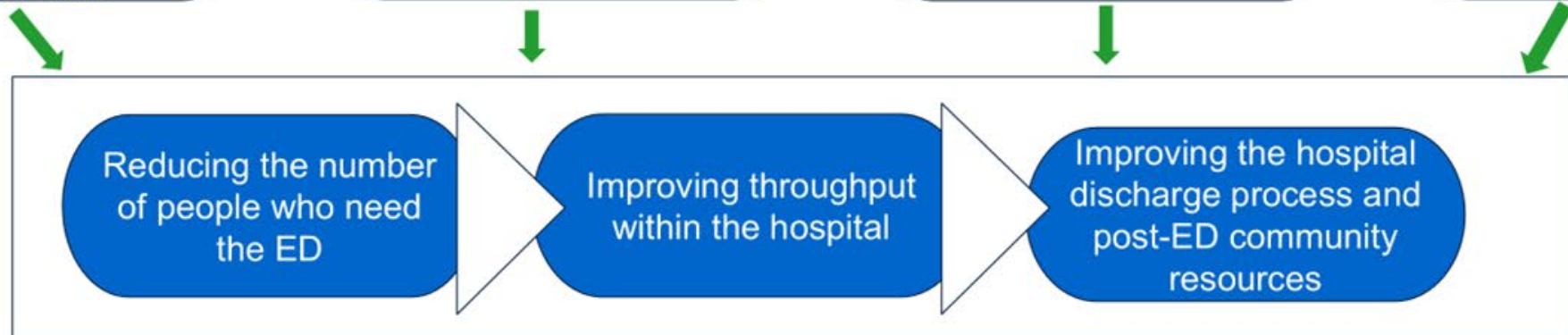
## Increase Transparency

MHCC Public Quality Reporting

ED Dramatic Improvement Effort

## Reduce Avoidable Utilization

Programs to optimize high value care and reduce avoidable utilization

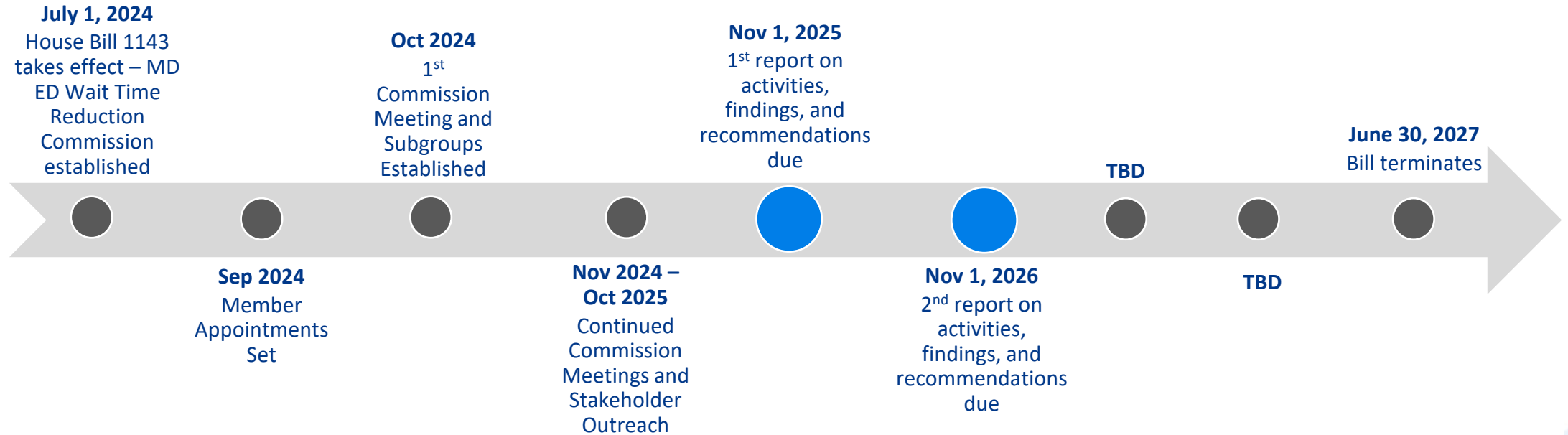


Increasing Transparency

Workforce Issues



# Commission Timeline



- HSCRC maintains ongoing collaboration with the Maryland Department of Health, hospital representatives, state agencies, and industry stakeholders while communicating about upcoming meeting dates, agendas, and priorities.
- HSCRC has implemented monthly meetings with the Maryland Hospital Association leadership to discuss ongoing priorities including the ED Wait Time Reduction Commission.
- All Emergency Department Wait Time Reduction Commission and subgroup materials are available on the HSCRC webpage: <https://hscrc.maryland.gov/Pages/ED-WTR-Commission.aspx>

# Initial Key Priorities Identified by ED Wait Time Reduction Commission

- **Key Priority Identified: Hospital Throughput & ED Boarding**
- Staff are focusing on the following key drivers impacting hospital throughput & ED boarding:
  - **Optimize capacity across the continuum of care (ambulatory, acute, post-acute, and community resources)**
  - **Care transitions within the hospital that impact length of stay (best practice subgroup focused on these efforts)**
  - **Care transitions to post-acute levels of care, inclusive of skilled nursing, palliative care, and home health**



# ED Wait Time Reduction Commission Subcommittees

## Access to Non-Hospital Care

- Integrate and optimize best practices and data analytics for advanced primary care, specialty care, home health, post-acute care, and ancillary services in an effort to reduce avoidable ED and hospital utilization and improve care transition workflows throughout the continuum of care.
- Meetings every six to eight weeks.

## Data Subcommittee

- Identify different data sources across healthcare platforms to include ambulatory, acute care, post-acute care, and third-party data. Will support the strategic data-driven priorities of the ED Wait Time Reduction Commission
- Meetings every six to eight weeks

## ED Hospital Throughput Best Practices

- Develop a set of hospital best practices and scoring criteria to improve overall hospital throughput and reduce ED length of stay, advise on revenue at-risk and scaled financial incentives, and provide input on data collection and auditing.
- Meetings every four weeks.

## Hospital Capacity, Operations & Staffing

- Subgroup will convene in April 2025.
- Planned focus of the subgroup is to assess access and capacity across the State, collaborate with commercial payers, Medicare, and Medicaid, and optimize workforce development opportunities.
- Meetings every four to six weeks.

# Subcommittee Updates

- **Access to Non-Hospital Care**
  - Top priorities identified are care transitions to post-acute (discharge barriers to post-acute and post-acute capacity) and advanced care planning
  - Consider engagement with experts in the space for focused discussions on post-acute care transitions and capacity opportunities.
  - Next meeting is March 6th.
- **ED Hospital “Throughput” Best Practices**
  - Best Practices Policy Draft presented to HSCRC Commission on Jan 8th.
  - Comment period through Feb 19th. Final policy will be presented at March 12th HSCRC Commission Meeting
  - Next meeting is Feb 27th to review final policy proposal
- **Data Subcommittee**
  - Focus is on priority data analyses to support the overall ED WTR Commission priorities
  - 1<sup>st</sup> meeting held February 5th
  - Next meeting is March 4th
- **Hospital, Capacity, Operations & Staffing**
  - Plans to convene April 2025



# ED Best Practices Update

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# DRAFT RECOMMENDATIONS FOR RY 2027 (CY 2025 PERFORMANCE PERIOD)

Final Policy  
March 2025

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
  - For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
  - Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026.
3. We propose that subsequent rate years will have 0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

# Final Six Best Practices Selected

Each hospital will select 2 interventions from the 6 interventions below:

- Interdisciplinary Rounds
- Bed capacity Alert Process
- Standard Daily/Shift Huddles
- Expedited Care Bucket (inclusive of expediting team, rapid medical evaluation team, rapid medical evaluation unit and patient observation management)
- Patient Flow Throughput PI Council
- Establishing Clinical Pathways

# Next Steps

- Best practice small workgroups will submit final measures & tiers by Feb 21st
- Best Practice subgroup will review final measures and tiers on Feb 27th
- Final policy submitted Feb 28th and will be presented at the March 12th HSCRC Commission Meeting

# Draft RY 2027 Readmission Reduction Incentive Program Discussion

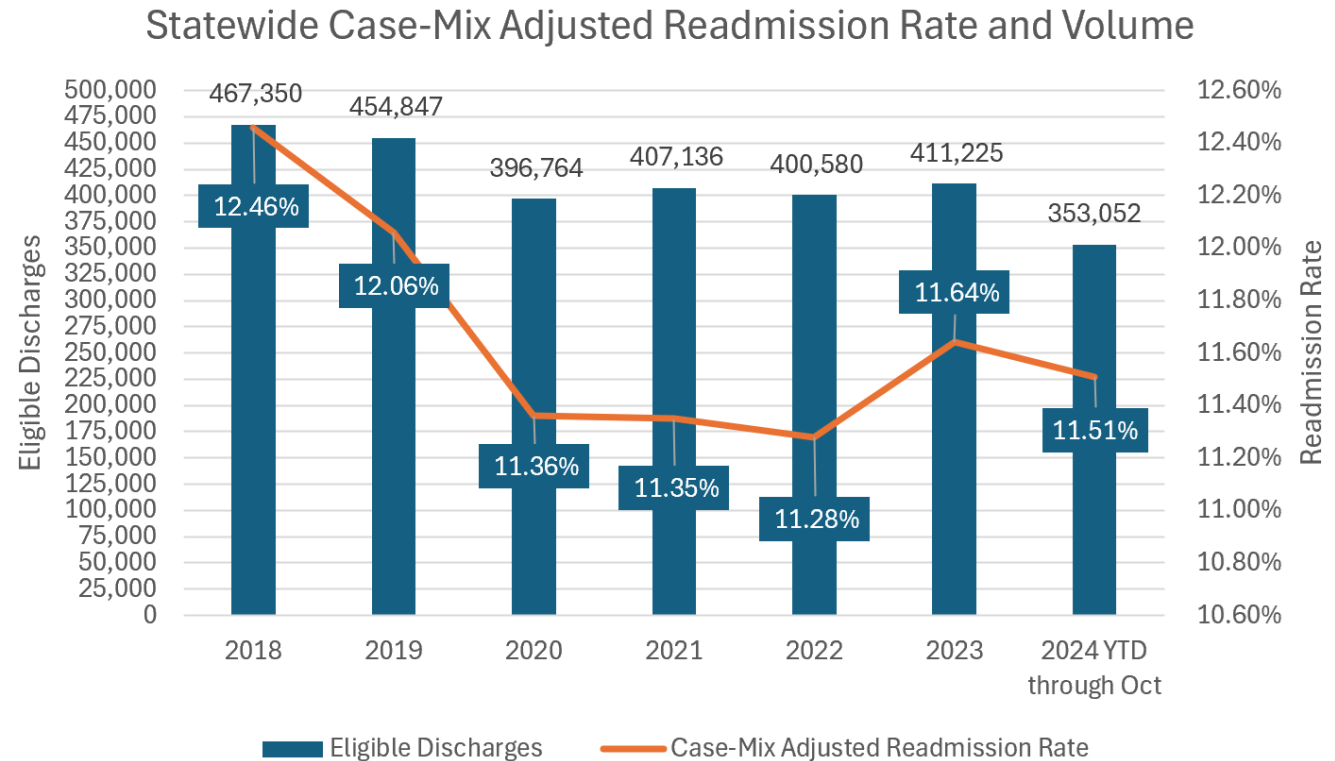
# RRIP Update

- The RY 2027 draft policy addresses the following:
  - Updated base period for assessing improvement (i.e., 2022 & 2023)
- Starting in RY 2028, the RRIP policy will align with statewide readmission goal under AHEAD. Specifically the measure definition and improvement targets are being developed for AHEAD between now and July 2025.
- Other items to address in future policies:
  - Observation Revisits
  - Out of State transfers and returns

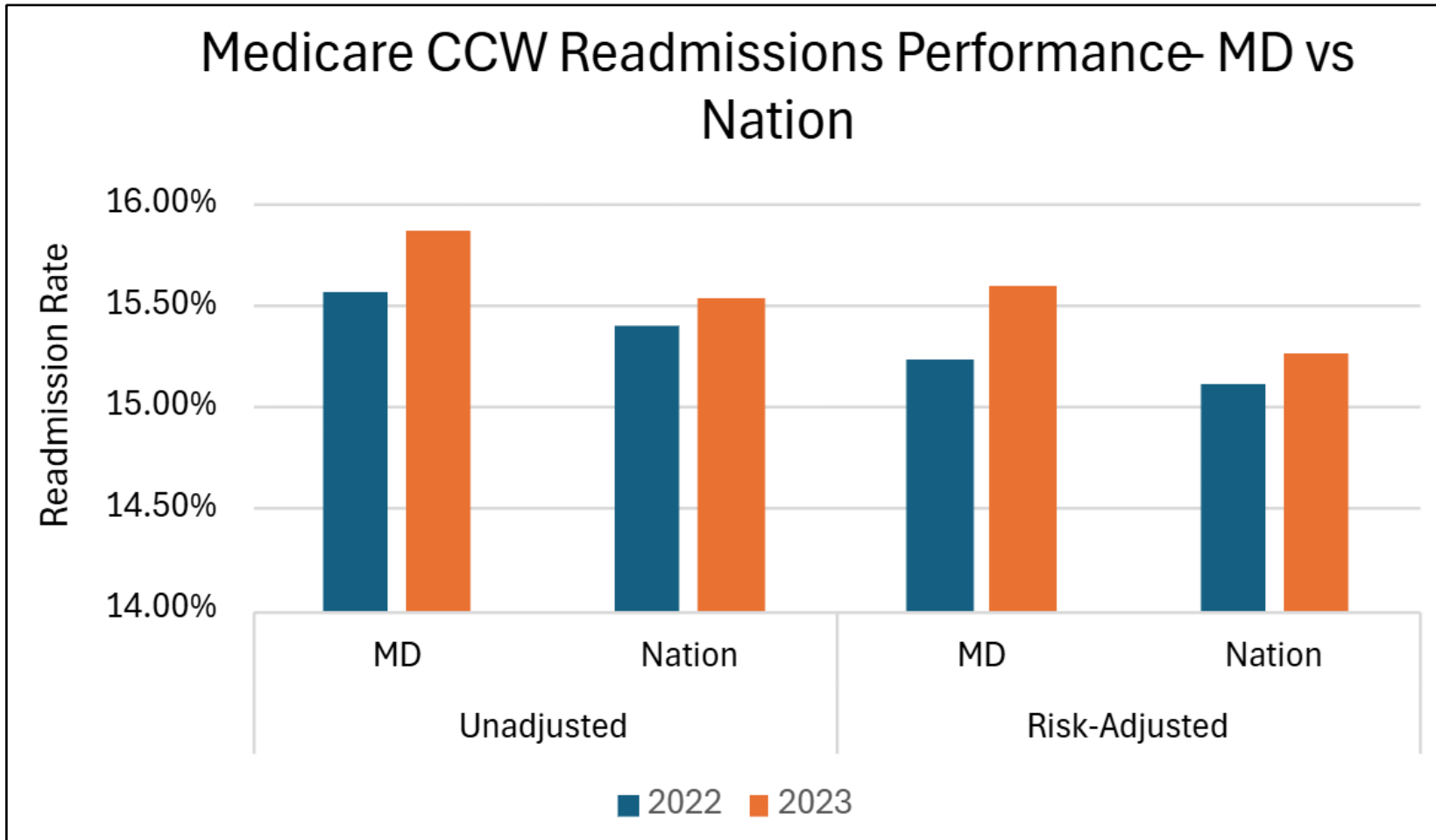


# Statewide Case-Mix Adjusted Readmission Rate, CY 2018-2024 YTD

Due to the historically low volume and low readmission rate in CY 2022, staff agree that we should re-evaluate CY 2022 base



# Readmissions Performance, MD vs the Nation



Staff believes that blending CY 2022 and CY 2023 takes into account the degradation in readmission rates that occurred in CY 2023 without excusing the worsening rates and poor performance compared to the Nation retrospectively

## Improvement and Attainment Target

- Due to the degradation in readmission rates from CY 2022 to CY 2023, blending the two base periods would require a larger improvement target to reach the peer benchmarks
- Staff is not recommending an increase in the improvement target due to the State's favorable performance compared to the Nation on a unadjusted basis in CY 2024.
- Staff is not recommending a change to the attainment target as the 65th percentile of performance in the base year

# RRIP Statewide Revenue Adjustments, CY 2022 vs Blended Base

RY 2026 YTD Revenue Adjustments	<u>CY 2022 Base Period</u> Attainment Target: 11.02% Improvement Target: -2.53%	<u>CY2022/2023 Blended Base Period</u> Attainment Target: 11.31% Improvement Target: -2.53%
Statewide Net Adjustments (\$), (%)	~ -\$56M, -0.47%	~ -\$34M, -0.30%
Statewide Penalties (\$), (%)	~ -74M, -0.63%	~ -\$53M, -0.45%
Statewide Rewards (\$), (%)	~ \$18M, 0.15%	~ 18M, 0.15%

RY 2027 Estimated Revenue Adjustments	<u>CY 2022 Base Period</u> Attainment Target: 10.88% Improvement Target: -3.78%	<u>CY2022/2023 Blended Base Period</u> Attainment Target: 11.31% Improvement Target: -3.78%
Statewide Net Adjustments (\$), (%)	~ -\$66M, -0.56%	~ -\$49M, -0.41%
Statewide Penalties (\$), (%)	~ -\$82M, -0.70%	~ -\$64M, -0.54%
Statewide Rewards (\$), (%)	~ 16M, 0.14%	~ \$15M, 0.12%

# Draft Recommendations

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 with a blended base period of CY 2022 and CY 2023
3. Retroactively apply a blended base period of CY 2022 and CY 2023 to the RY 2026 policy
4. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
5. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
6. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards:
  - beginning at 0.25 percent of IP revenue for hospitals on pace for 50 percent reduction in disparity gap measure over 8 years, and;
  - capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
7. Monitor emergency department and observation revisits by adjusting readmission measure and through all-payer Excess Days in Acute Care measure. Consider future inclusion of revisits of EDAC in the RRIP program.

\*Comment letters due EOD, March 12 to [hscrc.quality@maryland.gov](mailto:hscrc.quality@maryland.gov)\*

# Draft RY 2027 MHAC Recommendations Discussion

# MHAC Analysis



# MHAC Analysis Overview

- / PPC Composite Options**
- / Results by Methodology**





# Differences Across MHAC Methodologies

Aspect	Current Methodology	PPC Composite Option 1	PPC Composite Option 2	PPC Composite Option 3
PPC Exclusion Criteria	Exclude PPC measures with <2 expected PPCs or <20 at risk discharges		Exclude PPCs with 0 at-risk discharges	
PPC Measure “Volume” Weights	PPC measures not weighted by volume	PPC measures with greater expected PPCs at hospital receive a larger weight	PPC measures with more at-risk discharges at hospital receive larger weight	PPC measures with more observed PPCs across Maryland hospitals receive a larger weight
PPC Measure 3M Cost Weights	PPC measures are weighted by 3M Cost Weights	In calculation of PPC composite O/E ratio, PPC measures are weighted by 3M Cost Weights		
Benchmarks and Thresholds	For each of the 15 payment PPCs, calculate a benchmark and threshold	Calculate a benchmark and threshold for the PPC Composite		



# PPC Composite Option 1

- **Option 1:** Sum of hospital's observed PPCs divided by sum of expected PPCs across 15 payment PPCs, both numerator and denominator weighted by each PPC's 3M Cost Weight

$$PPC\ Composite_j = \frac{(\sum_{i=1}^{15} ObservedPPC_{ij} * 3M\ Cost\ Weight_i)}{(\sum_{i=1}^{15} ExpectedPPC_{ij} * 3M\ Cost\ Weight_i)}$$

- Does not explicitly weight PPC measures by volume, but PPC measures with higher expected PPCs receive more weight.
  - Expected PPCs increase as volume increases



# PPC Composite Option 2

- **Option 2:** Sum of hospital's observed-to-expected (O/E) ratio for each PPC, weighted by the PPC measure's 3M Cost Weight and hospital's volume of at-risk discharges for given PPC measure

$$PPC\ Composite_j = \sum_{i=1}^{15} \left( \frac{Observed\ PPCs_{ij}}{Expected\ PPCs_{ij}} \right) * \left( \frac{Volume_{ij} * 3M\ Cost\ Weight_i}{\sum_{i=1}^{15} Volume_{ij} * 3M\ Cost\ Weight_i} \right)$$

- Volume = at-risk discharges for PPC measure (i) for hospital (j)
- For each hospital, the sum of the Volume-3MCostWeights across the 15 PPC measures equals 1



# PPC Composite Option 3

- **Option 3:** Sum of hospital's O/E ratio for each PPC, weighted by the PPC measure's 3M Cost Weight and hospital's volume of at-risk discharges for given PPC measure

$$PPC\ Composite_j = \sum_{i=1}^{15} \left( \frac{Observed\ PPCs_{ij}}{Expected\ PPCs_{ij}} \right) * \left( \frac{Volume_i * 3MCostWeight_i}{\sum_{i=1}^{15} Volume_i * 3MCostWeight_i} \right)$$

- For each hospital, the sum of the Volume-3MCostWeights across the 15 PPC measures equals 1



# Content Validity

- The composite methodologies have high content validity because they generally evaluate 13 to 15 payment PPCs for all hospitals.
- Under the Current Methodology, content validity is high for the largest hospitals in Maryland but lower for other hospitals

Hospital Category	Number of Hospitals	Average Number of PPC Measures Evaluated using Current Methodology	Average Number of PPC Measures Evaluated using Composite Methodology
Small Hospitals	5	3.6	13.2
Medium Hospitals	13	10.5	14.2
Large Hospitals	24	13.7	15

*Notes:*

- 1) *Used FY 2021 and FY 2022 as the base period.*
- 2) *Does not include UM-Chestertown, which is completely excluded due to not having any payment PPC measures with at least 2 expected PPCs.*



# MHAC Results - Reliability

Average Hospital-Level Reliability (one-year performance period for all hospitals)

FY	Current Methodology	Composite Option 1	Composite Option 2	Composite Option 3
24	0.24*	0.61	0.48	0.54
23	0.38*	0.81	0.63	0.68
22	0.50*	0.81	0.70	0.76
21	0.42*	0.80	0.62	0.72
<b>Average</b>	<b>0.39*</b>	<b>0.76</b>	<b>0.61</b>	<b>0.68</b>

*\*For Current Methodology, calculated average reliability across payment PPCs with two or more expected PPCs during performance period*



# MHAC Results - Reliability

Average Hospital-Level Reliability (two-year performance period for all hospitals)

FYs	Current Methodology	Composite Option 1	Composite Option 2	Composite Option 3
23-24	0.33*	0.78	0.68	0.71
22-23	0.50*	0.86	0.76	0.80
21-22	0.54*	0.87	0.76	0.81
20-21	0.47*	0.85	0.71	0.77
<b>Average</b>	<b>0.46*</b>	<b>0.84</b>	<b>0.73</b>	<b>0.77</b>

*\*For Current Methodology, calculated average reliability across payment PPCs with two or more expected PPCs during performance period*



# MHAC Results - Reliability

Average Hospital-Level Reliability (three-year performance period for all hospitals)

FYs	Current Methodology	Composite Option 1	Composite Option 2	Composite Option 3
22-24	0.48*	0.87	0.78	0.81
21-23	0.57*	0.91	0.81	0.84
20-22	0.61*	0.90	0.80	0.84
19-21	0.60*	0.89	0.77	0.83
<b>Average</b>	<b>0.57*</b>	<b>0.89</b>	<b>0.79</b>	<b>0.83</b>

*\*For Current Methodology, calculated average reliability across payment PPCs with two or more expected PPCs during performance period*





# MHAC Results – Reliability (Small Hospitals)

## Average Hospital-Level Reliability (small hospitals only)

Performance Period	FY	Current Methodology	Composite Option 1	Composite Option 2	Composite Option 3
One Year	24	0.13	0.28	0.14	0.18
Two Years	23-24	0.19	0.51	0.32	0.34
Three Years	22-24	0.32	0.66	0.43	0.41
One Year	23	0.20	0.46	0.26	0.29
Two Years	22-23	0.45	0.67	0.41	0.42
Three Years	21-23	0.41	0.73	0.46	0.45

*Notes:*

- 1) *For Current Methodology, calculated average reliability across payment PPCs with two or more expected PPCs during performance period*
- 2) *Excludes UM-Chestertown due to not having any payment PPC measures with at least 2 expected PPCs.*
- 3) *Under the current MHAC Program methodology, two years of performance data are used for small hospitals with less than 21,500 at-risk discharges or 22 expected PPCs across the 15 payment PPCs.*



# MHAC Composite Weighting Example

Illustration of differences in composite weighting

PPC Measure	At-risk discharges	Expected PPCs	Pct. of expected PPCs for hospital (Composite Option 1)	Pct. of at-risk discharges for hospital (Composite Option 2)	Pct. of expected PPCs statewide (Composite Option 3)	3M Cost Weight
4	11,525	7.3	6.5%	7.2%	6.3%	1.16
67	11,856	13.8	12.3%	7.4%	15.1%	1.17
28	20,270	5.4	2.4%	12.7%	4.8%	0.45
42	20,294	10.2	9.1%	12.7%	7.3%	0.50

- PPC measures with lower prevalence (i.e., relatively few expected PPCs given number of at-risk discharges) get more weight under Composite Option 2 than Composite Option 1, which could help explain why Composite Option 1 reliability is higher.
- PPC measures with few expected PPCs at a hospital can get a relatively large weight under Composite Option 3, which could explain why Composite Option 1 reliability is higher



# MHAC Results - Correlations

Correlations between at-risk discharges and differences between average O/E ratio under current methodology and Composite Value

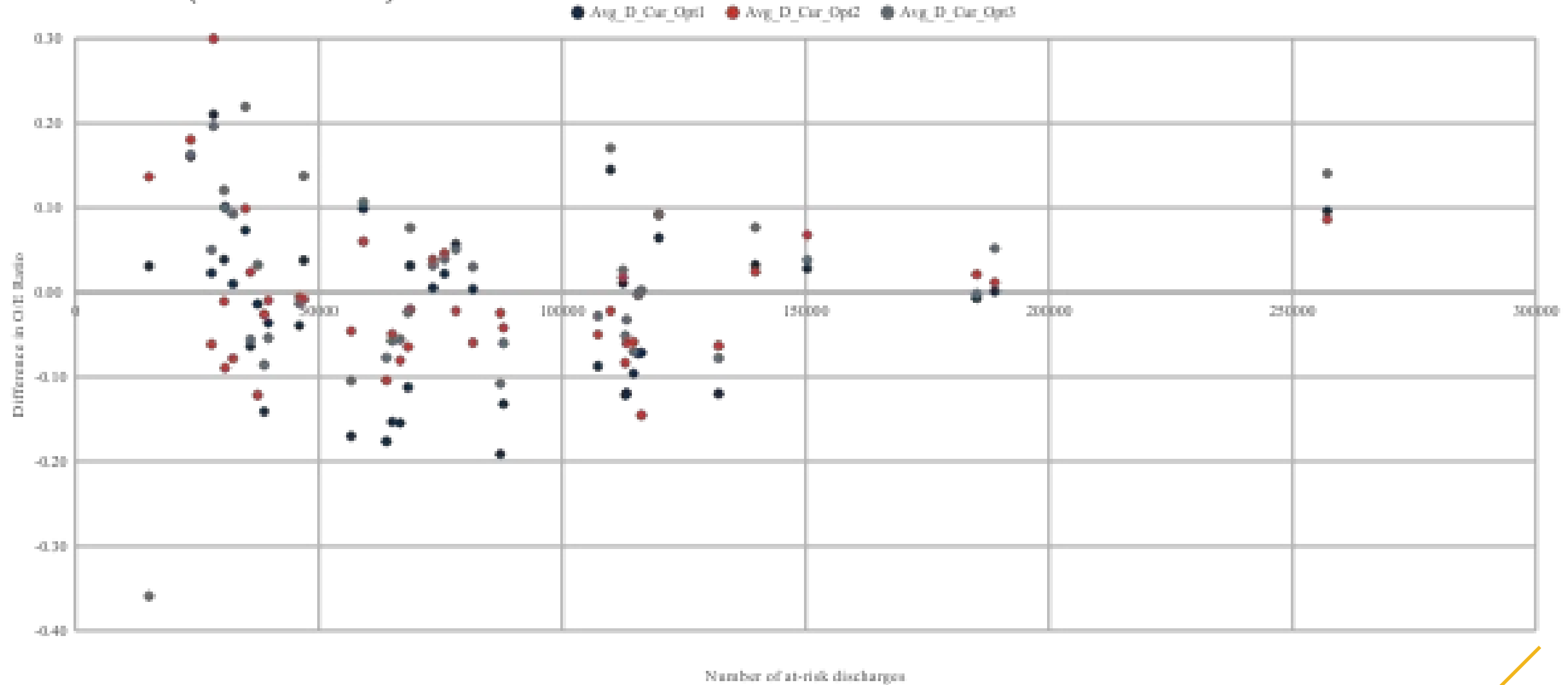
FY	Composite Option 1 and Current Methodology	Composite Option 2 and Current Methodology	Composite Option 3 and Current Methodology
2024	0.20	0.07	0.03
2023	0.09	-0.02	-0.05
2022	-0.05	-0.04	0.06
2021	-0.25	-0.17	-0.03
2020	-0.16	-0.05	0.00
2019	-0.09	0.09	0.07
<b>Average</b>	<b>-0.05</b>	<b>-0.02</b>	<b>0.01</b>

*Notes: Positive correlations indicate that as the number of at-risk discharges increases, hospital performance is worse under the composite methodology than under the current methodology*



# MHAC Results – Differences

Average Difference in O/E ratio between Current Methodology and PPC Composite Methodologies by number of at-risk discharges  
(FY 2019 - FY 2024)



*Note: The average standard deviation in hospitals' composite values is 0.36.*



# MHAC Results – Average Absolute Differences

Average Absolute Difference between Composite Value and Current Methodology Average O/E Ratio (FYs 19 – 24)

Composite Option 1 and Current Methodology	Composite Option 2 and Current Methodology	Composite Option 3 and Current Methodology
0.12	0.11	0.13

*Note: The average standard deviation in hospitals' composite values is 0.36.*



# MHAC Results - Correlations

Average Correlation between hospital at-risk discharges and O/E ratio or composite value (FYs 19 – 24)

	Current Methodology	Composite Option 1	Composite Option 2	Composite Option 3
FY24 at-risk discharges	0.10	0.10	0.09	0.12

*Note: Positive correlations indicate that as the number of at-risk discharges increases, hospital performance is (higher O/E ratio or composite value)*

*\*For Current Methodology, calculated average reliability across payment PPCs with two or more expected PPCs*



# MHAC Results – Correlations in Revenue Adjustments

Correlations between MHAC Revenue Adjustments between the current methodology and composite methodologies

FY	Composite Option 1 and Current Methodology	Composite Option 2 and Current Methodology	Composite Option 3 and Current Methodology
2024	0.82	0.80	0.82
2023	0.92	0.88	0.89
2022	0.88	0.85	0.85
2021	0.88	0.81	0.81
2020	0.91	0.85	0.89
2019	0.90	0.90	0.91
<b>Average</b>	<b>0.89</b>	<b>0.85</b>	<b>0.86</b>



# Appendix





# MHAC Results - Validity

Average correlation in composite values between (FYs 2019 - 2024)

No. of Years Apart	Composite Option 1	Composite Option 2	Composite Option 3
1	0.61	0.57	0.53
2	0.40	0.34	0.28
3	0.31	0.23	0.27
4	0.13	0.10	0.10
5	-0.08	-0.11	-0.07

*Note: Number of years apart indicates the number of years the FYs being compared are from each other. For example, FY 2024 and FY 2023 are one year apart and FY 2024 and FY 2019 are five years apart.*



# THANK YOU!

Next Meeting: March 19, 2025

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