

624th Meeting of the Health Services Cost Review Commission

October 9, 2024

(The Commission will begin in public session at 11:30 am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00pm)

CLOSED SESSION 11:30 am

Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING 1:00 pm

1. Review of Minutes from the Public and Closed Meetings on September 11, 2024

Specific Matters

There will be no specific matters discussed during this meeting. For the purpose of public notice, here is the docket status.

Docket Status - Cases Closed

2655A Johns Hopkins Health System 2656A Johns Hopkins Health System 2657A Johns Hopkins Health System

Docket Status - Cases Open

2658A Johns Hopkins Health System

2659A University of Maryland Medical Center

Subjects of General Applicability

- 2. Status Update: Nurse Support Program II Renewal (External Presenters)
- 3. External Presenters & Discussion: Maryland's Maternal Health Strategy and Role of HSCRC Support through the MCH Improvement Fund
- 4. Emergency Department Wait Time Activities Update
 - HSCRC Staff Update

- b. Presentation: Adventist White Oak Emergency Department Improvement Efforts
- 5. Report from the Executive Director
 - a. CY 2023 TCOC Model Official Performance
 - b. Model Monitoring and Discussion of Projected CY 2024 Savings

Specific Matters

- 6. Final Recommendation: Confidential Data Request
- 7. Draft Recommendation: ARPA-H BCORE Outcome Buyer Recommendation

Subjects of General Applicability

- 8. Final Recommendation: Adoption of previously proposed amendments to Community Benefits Reporting Regulation, COMAR 10.37.01.03.M.
- 9. Draft Recommendation: Out-of-State, Deregulation, and Repatriation Volume Policies
- 10. Draft Recommendation: Quality-Based Reimbursement (QBR) Policy
- 11. Set Aside Follow-Up
- 12. Hearing and Meeting Schedule



MINUTES OF THE 623rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION September 11, 2024

Chairman Joshua Sharfstein called the public meeting to order at 11:35 a.m. In addition to Chairman Sharfstein, in attendance were Commissioners James Elliott, M.D., Ricardo Johnson, Maulik Joshi, DrPH., Adam Kane, J.D., Nicki McCann, J.D., and Farzaneh Sabi, M.D. Upon motion made by Commissioner Johnson and seconded by Commissioner Elliott, the Commissioners voted unanimously to go into Closed Session. The Public Meeting reconvened at 1:13 p.m.

Chairman Sharfstein asked for a moment of silence before the meeting to commemorate those we lost during September 11, 2001.

REPORT OF SEPTEMBER 11, 2024, CLOSED SESSION

Mr. William Hoff, Chief of Audit and Integrity, summarized the items discussed at the September 11, 2024, Closed Session.

ITEM I REVIEW OF THE MINUTES FROM THE JULY 10, 2024, PUBLIC MEETING AND CLOSED SESSION

Upon Motion made by Commissioner Kane and seconded by Commissioner Joshi, the Commission voted unanimously to approve the minutes of the July 10, 2024, Public Meeting and Closed Session and to unseal the Closed Session minutes.

<u>ITEM II</u> GREEN & HEALTHY HOMES INITIATIVE

Ms. Ruth Ann Norton, President and Chief Executive Officer and Mr. Michael McKnight, Senior Vice President of National Programs presented an update on the Green & Healthy Homes Initiative (GHHI) (see "Green & Healthy Homes Initiative" available on the HSCRC website).

GHHI is dedicated to addressing the social determinants of health and the advancement of racial and health equity through the creation of healthy, safe, and energy efficient homes. By delivering a standard of excellence in its work, GHHI aims to eradicate the negative health impacts of unhealthy housing and unjust policies for children, seniors, and families to ensure better health, economic and social outcomes in historically disinvested communities with an emphasis on communities of color.

Mr. McKnight listed GHHI accomplishments:

Joshua Sharfstein, MD Chairman

James N. Elliott, MD Vice-Chairman

Ricardo R. Johnson

Maulik Joshi, DrPH

Adam Kane, Esq

Nicki McCann, JD

Farzaneh Sabi, MD

Jonathan Kromm, PhD Executive Director

William Henderson

Director

Medical Economics & Data Analytics

Allan Pack

Director

Population-Based Methodologies

Gerard J. Schmith

Director

Revenue & Regulation Compliance

Claudine Williams

Director

Healthcare Data Management & Integrity

- \$650 million raised and +45 pieces of legislation passed to support health and equity in housing.
- Architect of the most health protective lead laws in the nation, leading to a 99% reduction in lead poisoning in Maryland. Policies have been replicated around the country.
- Leading healthy housing convener at the local (over 75 partnering jurisdictions), state and national levels.
- Field leader in alignment of housing with other sectors such as healthcare, energy, and education.
- National leader in innovative financing models for healthy homes including designing the first Pay for Success model with Medicaid paying for outcomes.
- Leading healthy homes programs contracted by Medicaid MCOs and ACOs. Supports other contracted programs by demonstration of Medicaid and Hospital Community Benefits investments.

He noted as the result of decades of discrimination, low-income communities, communities of color, and Indigenous communities are significantly more likely to suffer sickness and death from high levels of air pollution, contaminated drinking water, proximity to toxic waste sites, and other legacy pollution. GHHI work is centered on effective service delivery, policy change and developing sustainable funding mechanisms to support the creation of healthy, safe and energy efficient homes. In addition to its direct service programs, GHHI's work includes technical assistance and capacity building for the field; training, economic analysis and policy and standards development; and sustainable funding for the creation of healthy, safe and energy efficient homes for low-income communities.

Ms. Norton provided example of projects with healthcare providers they are associated with, including WellPoint Medicaid MCO, Penn Medicine Lancaster General Hospital, and Blue Cross NC.

ITEM III CLOSED CASES

No action is necessary on this agenda item.

ITEM IV OPEN CASES

No action is necessary on this agenda item.

ITEM V HCAHPS PRESENTATION

Dr. Alyson Shuster, Deputy Director, Quality Methodologies introduced Mr. Jonathan Sachs who was hired as a Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) performance improvement consultant (see "HCAHPS Presentation" available on the HSCRC website). He is assisting the Commission Staff with the analysis of patient experience data and identifying opportunities for improvement and to provide a framework for monitoring HCAHPS scores for the Maryland hospitals.

Mr. Jonathan Sachs, MBA, FACHE, PCC presented and update on the HCAHPS survey. This survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there was no national standard for collecting and publicly reporting information about patient experience of care that allowed valid comparisons to be made across hospitals locally, regionally, and nationally.

The HCAHPS survey has three broad goals. First, the survey is designed to produce data about patients' perspectives of care that allow objective and meaningful comparisons of hospitals on topics that are important to consumers. Second, public reporting of the survey results creates new incentives for hospitals to improve quality of care. Third, public reporting serves to enhance accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment.

The survey asks discharged patients 29 questions about their recent hospital stay. The survey contains 19 core questions about critical aspects of patients' hospital experiences. They include communication with nurses and doctors, the responsiveness of hospital staff, the cleanliness and quietness of the hospital environment, communication about medicines, discharge information, overall rating of hospital, and would they recommend the hospital.

Maryland hospitals are doing relatively well in discharge information, with 85% of patients reporting that they did receive information prior to discharge, which is only 1% below the national average of 86%. There is ample opportunity for improvement in all other measures, with the greatest potential in responsiveness and cleanliness, each 9 points below the national average, as well as medication communication and overall rating, which are 6 points below the national average.

Mr. Sachs stated he is working with MHA representatives and the HSCRC Staff to compile and share best practices to help Maryland hospital improve their HCAHPS scores by analyzing data, sharing best practices and quality improvement initiatives using the plan-do-study-act (PDSA) cycles.

Chairman Sharfstein asked what is needed to improve the HCAHPS scores.

Mr. Sachs noted that being able to analyze the data and the resources to implement best practices and quality improvement listed in Press Ganey will help improve Maryland's scores.

Chairman Sharfstein also asked Dr. Schuster about the incentive that is being added in the quality measures for the HCAHPS scores – specifically, will it include processes that will drive

outcome that ultimately will get better scores. He noted that Maryland is ranked 46% in the nation on the HCAHP survey results.

Dr. Schuster stated Staff is eager to get the work started on sharing best practices for the Emergency Department, which also impact patients' experiences.

Dr. Kromm added that it is a two-way learning collaborative, Staff needs to know why the HCAHPS best practices are not being implemented or are not working in Maryland. Staff needs to get the data to learn more about the process. Staff is looking forward to hospital engagement to assist advancing the policy for improvement.

<u>ITEM VI</u> REPORT FROM THE EXECUTIVE DIRECTOR

AHEAD Model Update

Dr. Kromm informed the Commission that the state is actively engaged in negotiations with CMMI on the agreement for the AHEAD model. Stakeholders have engaged with the Total Cost of Care workgroup and with the Healthcare Transformation Advisory Committee (HTAC). Two meetings were set up in the month of September to discuss the different elements of the model.

No action is necessary on this agenda item.

Advancing Innovation in Maryland (AIM) Contest

Ms. Marla Oros, RN, MS, FAAN, Founder and Chief Executive Officer for the Mosaic Group provided an update on the AIM contest (see "Advancing Innovation in Maryland Contest" available on the HSCRC website).

Advancing Innovation in Maryland contest is a public-private partnership involving the Maryland Department of Health (MDH), the HSCRC, and local foundations. The goal is to surface ideas to support Maryland's unique health care model, which incentivizes better health, prevention of complications, and more efficient care. The contest will award cash prizes to individuals and organizations with ideas to promote improved population health and reduce the overall health care costs for the state. AIM is seeking ideas in three categories, all with the dual goal of improving health outcomes and promoting affordability:

- **Innovative Interventions**: Ideas for interventions that a hospital can implement, by itself or in coordination with community partners.
- Innovative Collective Action: Ideas for programs or platforms that require collective implementation by all hospitals within a region or statewide, by themselves, or in coordination with community partners.
- **Innovative Payment Approaches**: Ideas for payment innovations that the Health Services Cost Review Commission can implement.

In addition to the cash prizes, winning ideas will be presented to the Health Secretary and the Health Services Cost Review Commission for consideration. More information about the AIM contest, including a call for ideas, will be released in the coming weeks.

Vice Chairman Elliott asked how the information about AIM is being disseminated.

Ms. Oros stated that her organization has a communication plan and is utilizing social media, the press and MDH, and many other partners to help disseminate the information about AIM.

No action is necessary on this agenda item.

Model Monitoring

Ms. Deon Joyce, Chief of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 4-month ending May 2024. The data showed that Maryland's Medicare Hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce stated that Medicare Nonhospital spending per-capita was favorable when compared to the nation. Ms. Joyce noted that Medicare TCOC spending per-capita was favorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail is negative -1.48% below the nation through May, and that Maryland Medicare hospital and non-hospital growth through May shows a savings of (\$56,261).

Emergency Department (ED) Initiatives Update

Dr. Alyson Schuster, Deputy Director, Quality Methodologies, and Ms. Tina Simmons, Associate Director for Quality Methodologies, presented and updated the Commission on the Emergency Department Initiatives. (see "Emergency Department Initiatives Updates" available on the HSCRC website).

Purpose: To address factors throughout the health care system that contribute to increased ED wait times

Specific Focus:

Develop strategies and initiatives to recommend to state and local agencies, hospitals, and health care providers for reducing emergency department wait times, including initiatives that:

- Ensure that patients are being seen in the most appropriate setting to reduce unnecessary use of ED.
- Improve Hospital efficiency by increasing ED and Inpatient throughput.
- Improve post discharge resources to facilitate timely ED and inpatient discharges.
- Identify and recommend improvement for the collection and submission of data that is necessary to monitor and reduce ED wait times.
- Facilitate the sharing of best practices for reducing ED wait time.

Annual Legislative Reports will be due on 11/01/2025 and 11/01/2026.

The new members of the ED Wait-Time Commission have been appointed and will focus on looking at statewide interventions as well as hospital interventions. The statewide interventions will be driven by collaboration on behavioral health, post-acute, access to primary care, as well as on-going analysis of capacity concerns across the system. The hospital specific focus is being looked at as pre and post hospital opportunities that are within the hospital span of control. For example, hospital efficiency impacts throughput and capacity as well as integration of population healthcare and primary care integration. So, while the ED Commission will direct state level intervention and may advise on hospital level interventions, the HSCRC will still approve all hospital performance and payment policy.

Dr. Schuster presented the ED Best Practices Incentive Policy Development.

Objective:

- Develop process or structural measures that will address systematically longer ED length of stay (LOS) in the State.
- Incentivize hospital best practices, as well as alignment with EDDIE and the ED Wait Time Reduction Commission.

Description:

- Subgroup will advise on the development of 3-5 measures that will constitute a +/- 1% revenue at risk program for CY 2025 performance.
- Repurposing QBR ED Subgroup 2 to assist with this development, as well as other experts.
- Next Meeting: 9/27/2024 10 am noon
- Incentive measures improvement from CY 2023 to CY 2024
- Measure: Percent change in the median time from ED arrival to physical departure from the ED for patients admitted to the hospital

- Population: All non-psychiatric ED patients who are admitted to inpatient bed and discharged from hospital during reporting period
- Scoring: Use attainment calculation for percent change to convert improvement into a 0-to-10-point score
- Data: Ad hoc data submissions of time stamps to merge in with case-mix data
- Statewide Goal: TBD by ED Wait Time Reduction Commission

Dr. Schuster stated the deadline to submit patient level data was extended to 9/13. HSCRC staff and hMetrix are following up with hospitals with low match rates between the ad hoc ED LOS data file and case mix data. The reasons for lack of matches include: the difference in admission dates, patients who came to ED but left without being seen do not have case mix data, duplicates and truncated Medical Record Numbers (MRNs). Staff will process data by the end of September.

Commissioner McCann noted that it will be worth revisiting the timeline since the measuring process began in January.

Dr. Schuster responded that this will be one of the tasks of the ED wait time Commission understands how Maryland is performing compared to the nation and to set hospital specific goals for improvement.

No action is necessary on this agenda item.

Hospital Refund Reimbursement Project Update

Mr. Zachary Starr, Intern, Policy and Government Affairs and Ms. Megan Renfrew, Deputy Director, Policy and Consumer Protection, presented Hospital Refund Reimbursement Project Update (see "Hospital Refund Reimbursement Project Update" available on the HSCRC website).

Mr. Starr updated the Commission on the Hospital Free Care Reimbursement Law Implementation. He stated Staff coordinated with MDH, Maryland Department of Human Services (DHS), the Office of the Comptroller, the Health Education and Advocacy Unit (HEAU), the Maryland State Department of Education (MSDE), and the Maryland Hospital Association (MHA) to develop a process that:

- 1. Identifies hospital patients who paid more than \$25 for hospitals services provided in 2017-2021 and who qualified for free care, using data from hospitals, the Comptroller, SNAP, Maryland's energy assistance program, and WIC.
- 2. Provides reimbursement from the hospital to the identified patients.

- 3. Uses a "safe address" to contact the patient if available; and
- 4. Ensures that the state agencies share and disclose relevant information to the hospitals in compliance with state and federal law and to the minimum extent necessary to carry out the required process.

Legislators will schedule a meeting with stakeholders in the upcoming months to discuss possible 2025 legislation and anticipates that a bill will be introduced in 2025 by one of the key legislators to solve the sunset issue. Based on this expectation, Staff will continue to work with stakeholders this fall to prepare for implementation in the spring. The goal is to have contractual documents ready for signature by hospitals and state agencies as soon as the expected legislation becomes law. Based on this timeline, refunds will likely start going out to eligible patients in the second half of 2025.

Chairman Sharfstein asked when the Hospital Free Care Reimbursement Law is scheduled for sunset.

Ms. Renfrew advised that the law was scheduled to sunset in July of 2025; however, she is anticipating new legislation to change the sunset date with modifications to streamline the process.

Commissioner McCann acknowledged that a great deal of Staff and Hospitals resources have been expended developing this law; however, no one knows the number of individuals who will qualify for a refund. Additionally, she believes a retrospective look-back to provide refunds offers very little return in comparison to the resources that have been invested in trying to implement this law.

No action is necessary on this agenda item.

Set-Aside Update

Dr. Kromm presented the Set-Aside update. He stated that the intention of the Set-Aside is to use these funds for unforeseen events that occur at hospitals experiencing financial hardship, regardless of efficiency (e.g., cyberattacks).

- Criteria for evaluation
- Weighting of evaluation criteria
- Evaluation responsibility

Ms. Caitlin Cooksey, Deputy Director, Hospital Rate Regulation stated that for rate year 2025, the Commission approved \$30M for the Set-Aside to be used for unforeseen events that occur at hospitals with a financial hardship. Below is the process overview.

Scoring Rubric: Technical Evaluation

- A. Financial Hardship Technical Evaluation
 - Unforeseen and/or Preventable Ranking
 - *Is the request being made due to poor decision making/investments?*
- B. Relative Efficiency Technical Evaluation
 - Population Health Ranking
 - Does the proposed intervention improve the health of the population?
 - Methodology Disadvantage Ranking
 - How material is the adverse impact from a methodology?

Scoring Rubric: Need Evaluation & Oversight

- A. Financial Assessment (e.g., 33 points)
 - FY24 Total Margin (Regulated + Unregulated)
 - Variance to Statewide Average
 - FY24 Regulated Margin
 - Variance to Statewide
 - Days Cash
 - Variance to Statewide
- B. Improvement Opportunities (e.g., 33 points)
 - Cost per ECMAD
 - Variance from Statewide Average
 - Overhead Cost per ECMAD
 - Variance from Statewide Average
 - Margin from Unregulated System Operation
 - Variance from Statewide Average
 - PAU
 - Variance from Statewide Average
- C. Oversight & Accountability (e.g., 33 points)
 - Controls to mitigate financial position
 - How will hospital management find sustainable reduction in cost to offset funding priorities?
 - Pledge/management commitment
 - Should funding be conditional on a pledge to not repeat funding request or reduce other administrative cost for the next 2 years?

Ms. Cooksey concluded by asking for guidance on how the Set-Aside funding will be allocated. The comment period is open through 9/25/2024, and Staff will follow up during the October meeting.

Chairman Sharfstein clarified that once the Set-Aside policy is approved by the Commission, it will be up to staff to implement the funding as per the policy.

Staff will provide the Commissioners the comments of the stakeholders upon receipt and in advance of the next Commission meeting.

No action is necessary on this agenda item.

Fall Preview

Dr. Kromm presented the schedules for the Fall 2024 Meeting Preview. (see "Fall Preview" available on the HSCRC website).

No action is necessary on this agenda item.

ITEM VII ACCOUNTING & BUDGET MANUAL UPDATE

Wayne Nelms, Assistant Chief, Audit & Integrity, presented an update on the modernization of the HSCRC Accounting and Budget Manual (see "Update to the Accounting and Budget Manual" available on the HSCRC website).

The current version of the Accounting and Budget Manual was created in the late 1970s. In July 2023, Staff engaged I3 Healthcare Consulting to assist with an Annual Filing Modernization (AFM) initiative. The goal of this project is to obtain additional information about the operational costs at hospitals and to improve Staff oversight over compliance. The project also seeks to streamline the documentation and collection of this information. During Phase I, Staff removed outdated contents and revised the Manual.

Staff Recommendation:

- That the Commission approve the revisions of Phase I to the Accounting & Budget Manual. These revisions are to remove outdated contents and are part of the Annual Filing Modernization initiative.
- 2. That the updated revisions of Phase I of the Accounting & Budget Manual be effective in accordance with a subsequent Maryland Register notice of adoption.

Commissioner Johnson moved to approve the staff recommendation, and it was seconded by Commissioner Joshi. The motion passed unanimously in favor of the Staff's recommendation.

ITEM VIII HEARING AND MEETING SCHEDULE

October 9, 2024, Time to be determined-4160 Patterson Ave. HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:50 p.m.

Closed Session Minutes of the Health Services Cost Review Commission

September 11, 2024

Chairman Sharfstein stated reasons for Commissioners to move into administrative session pursuant to 3-103, and 3-104 and of the Authority General Provisions Articles for the purposes of discussing the administration of the Model and providing an update on hospital rate requests.

Upon motion made in public session, Chairman Sharfstein called for adjournment into closed session:

The Administrative Session was called to order by motion at 11:35 a.m.

In addition to Chairman Sharfstein, in attendance were Commissioners Elliott, Kane, Johnson, Joshi, McCann and Sabi.

In attendance representing Staff were Jon Kromm, Claudine Williams, Allen Pack, Alyson Schuster, Cait Cooksey, Bob Gallion, Megan Renfrew and William Hoff.

Joining by Zoom: William Henderson and Deb Rivkin

Also attending were Assistant Attorney General Stan Lustman and Ari Elbaum, Commission Counsel.

Item One

Jon Kromm, Executive Director, updated the Commission on the process related to rate request letters submitted by hospitals. Dr. Kromm also updated the Commission's on the AHEAD model and its current status.

Item Two

William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, updated the Commission, and the Commission discussed the FY24 Hospital Unaudited Financial Performance.

The Closed Session was adjourned at 1:05 p.m.

Cases Closed

The closed cases from last month are listed in the agenda



Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

October 9, 2024



IN RE: THE APPLICATION FOR AN * BEFORE THE MARYLAND HEALTH

ALTERNATIVE METHOD OF RATE * SERVICES COST REVIEW

DETERMINATION * COMMISSION

JOHNS HOPKINS HEALTH * DOCKET: 2024

SYSTEM * FOLIO: 2468

BALTIMORE, MARYLAND * PROCEEDING: 2658A

I. INTRODUCTION

On August 29, 2024, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a revised global price arrangement with Blue Cross and Blue Shield Association Blue Distinction Centers for Transplants (BDCT) for solid organ and bone marrow transplant services. The Hospitals request that the Commission approve the arrangement for one year beginning October 1, 2024.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the new global rates for solid organ transplants was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in



payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services with Blue Cross Blue Shield Association Blue Distinction Centers for Transplants for the period beginning October 1, 2024. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.



Application for an Alternative Method of Rate Determination

University of Maryland Medical Center

October 9, 2024



IN RE: THE APPLICATION FOR AN * BEFORE THE MARYLAND HEALTH

ALTERNATIVE METHOD OF RATE * SERVICES COST REVIEW

DETERMINATION * COMMISSION

UNIVERSITY OF MARYLAND * DOCKET: 2024

MEDICAL CENTER * FOLIO: 2469

BALTIMORE, MARYLAND * PROCEEDING: 2659A

I. INTRODUCTION

On August 29, 2024, University of Maryland Medical Center ("Hospital") filed a renewal application for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital is requesting approval to continue to participate in a revised global price arrangement with Blue Cross and Blue Shield Association Blue Distinction Centers for Transplants (BDCT) for solid organ and bone marrow transplant services. The Hospital requests that the Commission approve the arrangement for one year beginning October 1, 2024.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University of Maryland Faculty Physicians, Inc. (FPI), which is a subsidiary of the University of Maryland Medical System. FPI will continue to manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to FPI for all contracted and covered services. FPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between FPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.



V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospital can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and bone marrow transplant services with Blue Cross Blue Shield Association Blue Distinction Centers for Transplants for the period beginning October 1, 2024. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.



Nurse Support Program II

Update on Program Renewal and Performance Report

NSP II Timeline Update

NSP II funding is used to support nursing education initiatives at Maryland Schools of Nursing, aiming to increase educational capacity to meet the needs of the Maryland nursing workforce and improve the delivery and quality of care in all healthcare settings.

- December 2024: Draft Recommendation on Program Renewal and Progress Report
 - Progress Report: Progress Report and Program Outcomes (FY 2021 FY 2025 Activities)
 - Program Renewal: Draft Recommendation on Program Renewal
- January 2025: Solicit formal public comments.
- February 2025: Final Recommendation Commissioner vote
- Existing funding ends: June 30, 2025
- If approved, renewed funding would begin: July 1, 2025

Looking Back – Progress Report Preview

- NSP II funded programs are required to align with one of the seven listed NSP II initiatives (left column) and report on outcomes specific to initiative goals.
- The progress report will include general metrics for all initiatives:
 - Total amount (\$) of funding awarded
 - Distribution of awards to underrepresented groups of nursing
 - Geographic distribution of awards
- The progress report will include narrative and qualitative data on the initiatives and metrics shown below.

NSP II Initiative	Specific Outcome Metrics
Increase Nursing Pre-Licensure Enrollments and Graduates	# of additional nursing pre-licensure graduates
Advance the Education of Students and RNs to BSN, MSN, & Doctoral Level	# of additional nursing higher degrees completed
Increase the Number of Doctoral-Prepared Nursing Faculty	# of additional nursing faculty at Doctoral level
Build Collaborations between Education and Practice	# of academic-practice collaborations (& additional metrics specific to grant initiative)
Increase Capacity Statewide	# of statewide resources developed (& additional metrics specific to grant initiative)
Increase Cohen Scholars as Future Faculty and Clinical Educators	# of Cohen Scholars; # of additional nurse educators produced
Statewide faculty-focused initiatives to recruit & retain nurse faculty	Nurse faculty retention rates; # of nurse educator doctoral grants awarded, # of Certified Nurse Educator certifications; # of nurse faculty recognition awards

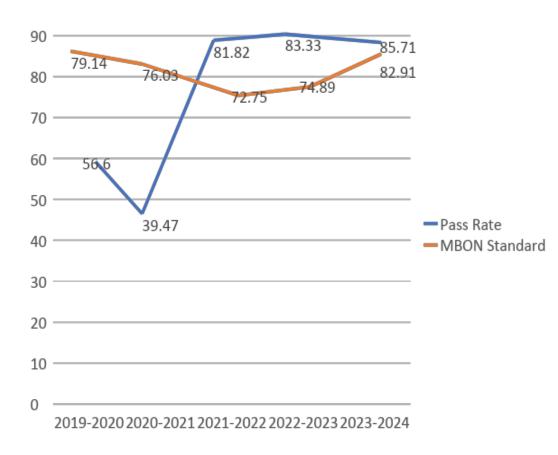
NSP-II Grants at JHU

- 35 grants including:
 - New nursing program development
 - pre-licensure nursing education, doctoral education (nurse anesthesia), post-master's nursing education (psychiatric mental health NP)
 - Nurse educator preparation, preceptor education/training, faculty development
 - Resilience training for nurses, faculty, students
- Current highlighted NSP-II grant
 - Supporting Nursing Advanced Practice Transitions (SNAPT)
 - Goal to increase the number of primary care NPs in MD
 - Have placed 22 primary care NPs since 2021 (currently 18 applicants for the 5th cohort starting in Jan 2025)
 - All fellows have remained in practices in which they were initially placed
 - Expanding to include acute care NPs and acute care settings



Bowie State University & NSP II

NCLEX-RN Pass-Rates



Key NSP II Grants:

- New Nursing Faculty Fellowship (NNFF)
 - 11 recipients
 - Improved faculty retention rate 91%
- Certified Nurse Educators (CNE)
 - Increased # of CNEs from 0 to 11 in 3-year period

Conceptual Framework

NSP II Initiatives

Education (Schools of Nursing)

Nursing Care Delivery Workforce Healthcare Improvements

- Increase nursing pre-licensure enrollments and graduates
- Advance the education of students and RNs to BSN, MSN, & doctoral level
- Increase the number of doctoralprepared nursing faculty
- Build collaborations between education and practice
- Increase educational capacity statewide
- Increase Cohen Scholars as future faculty and clinical educators
- Faculty-focused initiatives to recruit & retain nurse faculty
- New: Prioritize education that advances practice in community health settings / advances population health

- Expanded enrollments, pathways, and/or programs through partnership
- Strong foundations in nursing basics
- New curricula address future needs in equity-centered healthcare system
- Assist under-resourced nursing schools in fulfilling regulatory requirements
- Aligned clinical training opportunities to drive competency-based care
- Recruitment of diverse student bodies & faculty

- Increase the number of highly qualified faculty & nurses to meet workforce demands.
- Increase collaborations between education and practice.
- Recruit well-trained nurses to address vacancies and gaps in care across all care settings.
- Support advanced nursing education to enhance care quality of care.

- Transformation of care delivery across all settings (acute, primary, community)
- Total cost of care
- Quality improvements (e.g. lower readmission rates)
- Population health and health equity improvements
- Culturally competent care delivery to meet community needs
- Expansion of preventative care practice
- Chronic disease reduction



Questions for Commissioners

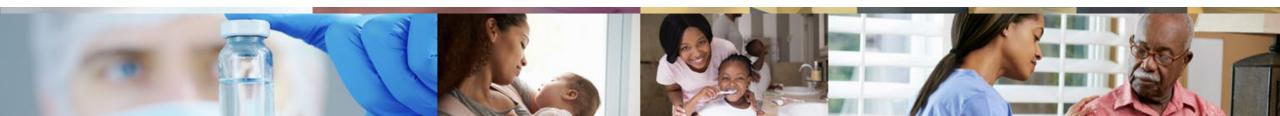
- While NSP II grants have already funded programs to advance nursing in primary care and community health settings, staff will recommend adding a dedicated initiative to prioritize building population health and community-based practice. Do Commissioners believe this intentional focus is taking the program in the right direction?
- In recent years, staff have worked to foster collaboration between hospitals and schools and aim to enhance this under the renewed program by promoting direct pathways to practice and aligning NSP I (hospital-focused) and NSP II (education-focused) initiatives. Are there additional ways to encourage collaboration between providers and schools to build a well-trained nursing workforce that meets Maryland's needs?
- What additional information about nursing education in Maryland, beyond the previously listed outcome metrics, would help Commissioners understand the role of higher education in advancing the nursing workforce?





Improving Maternal Health in Maryland Presentation to the Health Services Cost Review Commission

October 9, 2024



Our current state - Maternal Health



women died from pregnancy

or its complications in Maryland, 2014-2018. Nearly 83% of cases were preventable.



2000 severe complications during labor and delivery

were reported between Oct. 2022 and Oct. 2023, leading to "significant short- or long-term health consequences.

28 states

have banned or highly restricted access to abortion.

Maryland is the southernmost state on the east coast with policies protecting abortion and reproductive rights.

Black non-Hispanic women were

2.8x

more likely to die from pregnancy related complications than White non-Hispanic women from 2016-2018.

Out-of-state patients contributed to a



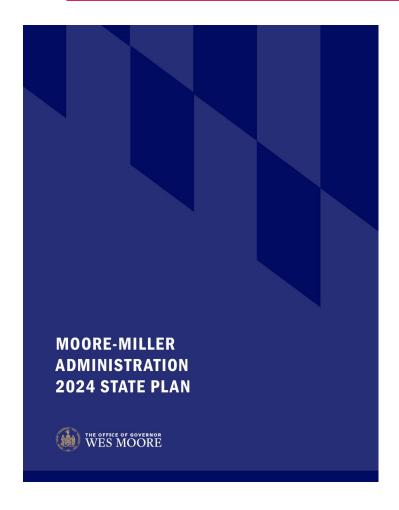
increase in abortions provided in Maryland between April 2022 and June 2023.

Nearly 75%

of Maryland counties have no abortion clinics and almost a **third of Maryland women** live in those counties.



Maternal Health Prioritized in Maryland



Moore-Miller Administration 2024 State Plan

- Goal 8: Ensuring world-class health systems for all Marylanders
 Objective: 8.1: Improve eligibility and access to quality care, particularly focusing on maternal and infant health, behavioral health, and support for veterans and older adult populations

2024 State Health Improvement Plan (SHIP): Building a Healthier Maryland

- **Priority 3: Women's Health**
 - **Goal 1:** Improve maternal health outcomes through improved maternal care before, during and after pregnancy
 - Goal 2: Increase breast and cervical cancer prevention, screening and care



Vision for Women's Health in Maryland

Ensure all women can achieve and maintain their highest level of physical, mental, and emotional well-being, and have the agency to make choices regarding their bodies and reproductive and sexual health.



NOTE: This work uses the term *women*. We recognize and respect that people including pregnant, birthing, postpartum, and parenting people have a range of gender identities, and do not always identify with *women*.



Women's Health Action Plan

Equity, Choice, and Access in Maryland

KEY GOALS

Protect reproductive rights and expand access to reproductive health services, including abortion care.

- Improve access to comprehensive high-quality somatic services through the life course.
- Advance birth equity, with a focus on Black maternal and infant health, through the perinatal continuum.
- Increase place-based and community-centered approaches to promote health and prevent diseases.

- Support behavioral health needs across the life course.
- 6 Ex

Expand, support and diversify the perinatal workforce.

Visit: health.maryland.gov/womens-action-plan



Progress to Date:



Advance birth equity, with a focus on Black maternal and infant health, through the perinatal continuum.

Coverage Expansion

- o 12-Month Postpartum Expansion: Expanded postpartum coverage from 60 days to 12 months for those eligible for Medicaid due to pregnancy (eff. April 1, 2022)
- Healthy Babies Equity Act: Comprehensive care for pregnant individuals who are Medicaid-eligible but for their immigration status (eff. July 1, 2023)
 - More than 13,700 participants enrolled to date

Postpartum Expansion Positive Impact

Early research by the Hilltop Institute found that extended postpartum coverage was associated with positive impact in Medicaid-insured birthing parents.

- Those with extended coverage were 25 percent more likely to have a primary care appointment in the postpartum period
- Those without extended coverage were two times more likely to experience an avoidable postpartum hospitalization

Citation: Goetschius, L.G., Middleton, A., & Idala, D. (2023, October 26). The effect of extended postpartum care on health care utilization and outcomes. Baltimore, MD: The Hilltop Institute, UMBC.



Progress to Date:

Advance birth equity, with a focus on Black maternal and infant health, through the perinatal continuum.

Prenatal Support Services

- Expansion of CenteringPregnancy, group-based Prenatal Care through start-up grant funds and enhanced Medicaid Reimbursement (HSCRC-funded Population Health Improvement Fund)
 - Grant funds to 9 of 11 possible sites over in FY 22-24; Grant funds still available for 2 additional sites
 - Enhanced Medicaid Reimbursement since 1/1/2023 with over 575 participants*
- Doulas to provide support through pregnancy, birth and postpartum (HSCRC-funded Population Health Improvement Fund)
 - Effective 2/21/2022 and over 100 Medicaid Participants*
- MOM Program: Expanded statewide case management for pregnant people with opioid misuse and or Opioid Use Disorder (HSCRC-funded Population Health Improvement Fund)
 - > 85 participants, effective 7/1/2021**



^{*}Number of Medicaid participants between program start date and 5/3/2024.

^{**}Initially launched as a small pilot program. Has been available statewide since 1/1/2023.

MOM Case Management Participant Experiences

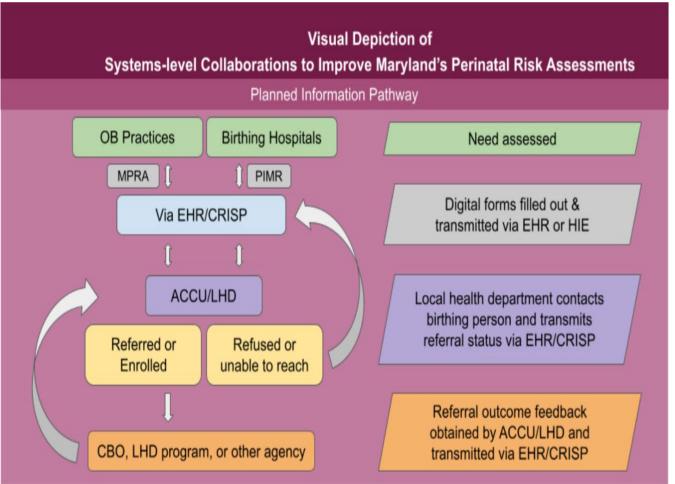
"[My case manager] also made sure not only to give me contact information, but really took the time to explain other programs and resources available to me. She is so personable and kind and really took the time to get to know me as a person and listened to my fears as a first time mother (also having a history of opioid addiction) and helped me navigate through this very stressful process.

After I had the baby, I actually looked forward to [my case manager's] call every month because I knew I could ask her questions and she would have an educated but not judgemental answer for me...and if there were things she didn't have the answer to, she took the time to find out or get me the help I needed. I have never felt more connected with a healthcare professional that I trust as much as [my case manager] from the MOM program." - MOM participant, April 2024

"Addiction can be such an isolating thing, but having just one person who cares can make all the difference in the world." - MOM participant, May 2024

Progress to Date:

Advance birth equity, with a focus on Black maternal and infant health, through the perinatal continuum.



- Enhancing linkages to community-based resources through digitization of Prenatal Risk Assessment and the Postpartum Infant Maternal Referral Form
- Increase the number of referrals and provide support for health-related social needs across the perinatal continuum.
- Digitize existing referral forms and partner with MCOs, CRISP, Local Health Departments, CRISP.
- FY 2025 focus is on the Eastern Shore (Cecil, Kent, Queen Anne's, Caroline, Talbot, Dorchester, Wicomico, Somerset, Worcester) and Prince George's County



Progress to Date:



Advance birth equity, with a focus on Black maternal and infant health, through the perinatal continuum.



Resources Initiatives PBAC About Us Bulletins

Making Maryland a Safer Place to Have a Baby

https://www.mdpqc.org/



Perinatal Health Equity Ideation Sessions

Imagining and Collaborating in the State of Maryland



- Target the leading cause of pregnancy-related deaths and SMM through the implementation of the Obstetric Hemorrhage Safety Bundle in the PQC initiative (HRSA AIM grant)
- MDH has partnered with Bloom Collective to provide training and technical assistance for birthing hospitals to incorporate reproductive justice, holistic care, and what it means to center Black birthing people in quality improvement work.



Progress to Date:



Advance birth equity, with a focus on Black maternal and infant health, through the perinatal continuum.

- Accelerate communitybased solutions and new funding partnerships with State of Birth Equity Funders Alliance
- Target the leading cause of postpartum readmissionscomplications of pregnancy induced hypertension through the HHS Postpartum Collaborative





Progress to Date



Increase place-based and community-centered approaches to promote health and prevent diseases.

Expansion of Perinatal Home Visiting

- HRSA MIECHV Home Visiting Program expanded from 10 jurisdictions to 17 jurisdictions in SFY25
- O Expansion to 4 sites through the Population Health Improvement Funds to serve an additional 110 individuals
- Medicaid Reimbursement to Healthy Families
 America and Nurse Family Partnership Models
- > 640 participants in Home Visiting Program reimbursed through Medicaid (effective 1/13/2022). (HSCRC-funded Population Health Improvement Fund)

Healthy Families America Home Visiting Sites in Maryland



https://www.healthyfamiliesamerica.org/map/



Progress to Date



Increase place-based and community-centered approaches to promote health and prevent diseases.

- Expansion of HealthySteps
 - Offers Child development screenings and resources
 - Since 1/1/2023, there have been more than 1,480 participants (HSCRC-funded Population Health Improvement Fund)



https://www.healthysteps.org/who-we-are/





Progress to Date for Goals 1 & 3



Protect reproductive rights and expand access to reproductive health services, including abortion care.

- Launched partnership with Upstream USA to expand access to on-demand contraceptive care. Currently across 4 health center sites with more than 45,000 women reproductive age covered
- Developed first-in-nation Abortion Care Clinical Training Program with an inaugural cohort starting Fall
 2024
- Funding to ensure every county has at least 1 Title X/Maryland Family Planning clinic by mid FY25



Support behavioral health needs across the life course.

- Launching Perinatal Mental Health Training Hub for in FY 2025 to increase more perinatal practitioners certified in Postpartum Support International (PSI)
- MACS for MOMs Provides training and support to providers across the state. In FY 2024, 160 unique providers served by the Tele-ECHO Clinics; plan to double number of providers in program for FY 2025.



Progress to Date for Goals 4 & 6



Improve access to comprehensive high-quality somatic services through the life course.

- Expand SBHC footprint by supporting 3 organizations in FY 2025 to start new SBHC
- Start a Community-clinical linkage project focused on Black women in partnership with MDH's Breast and Cervical Cancer Program.



Expand, support and diversify the perinatal workforce.

- Support Doula workforce participation as Medicaid-enrolled providers and provide technical assistance.
- Train CHWs on a MCH-specific curriculum that will be launched in FY 2025 that provides basics on what is preconception health, stages of pregnancy, and behavioral health in pregnancy.



Summary

- Women's, maternal, and reproductive health remain key priorities for Maryland Department of Health
- Partnering amongst Public Health Services, Medicaid, and Community partners key to collaboration and building sustainability
- Upcoming work will focus on enhanced data translation, deepening partnership with local health departments and communities, and ongoing health equity promotion.



Thank you

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Emergency Department Initiatives Update

October Commission Meeting

Today's Presentation

- Update on Best Practices Incentive Policy
- Presentation from Adventist White Oak
- EDDIE Updates (in Appendix)



ED-Hospital Best Practices Policy Development Update

Commission leadership directive: Identify 3-5 best practice measures that will constitute a +/- 1% revenue at risk program for CY 2025 performance.

Policy Goal:

- Develop structural or process measures that will address systematically longer ED length of stay (LOS) in the State.
- Promote adoption of hospital best practices by providing GBR financial incentives.
- Align hospital initiatives with the goals of the ED Wait Time Reduction Commission.

Subgroup Purpose:

- Develop a set of hospital best practices and scoring criteria to improve overall hospital throughput and reduce ED length of stay
- 2. Advise on revenue at-risk and scaled financial incentives
- 3. Provide input on data collection and auditing



Real Opportunity for Paradigm Shift

ED Commission State Initiatives

Primary Care

Hospital Initiatives

Post-Acute Care



Reducing the number of people who need the ED

Improving throughput within the hospital

Improving the hospital discharge process and post-ED community resources



Access

Structure + Process = Outcomes

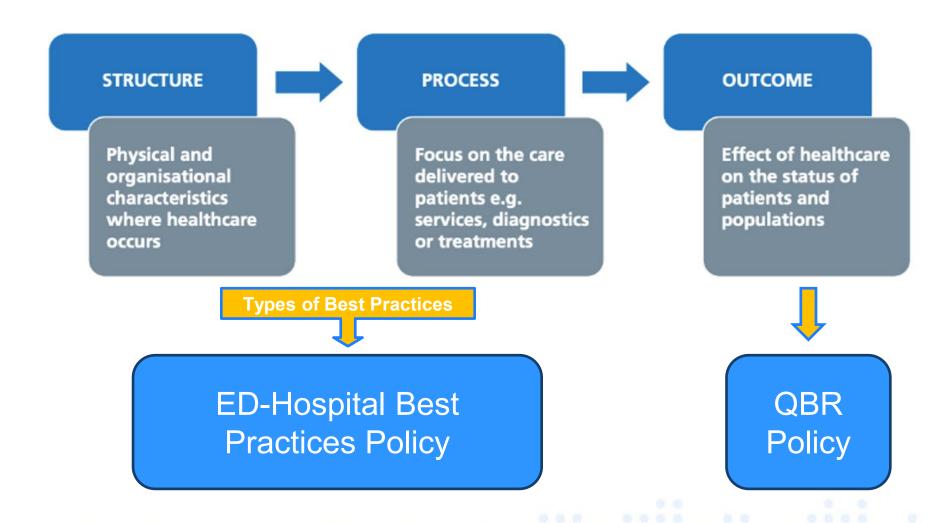
Capacity

Behavioral Health

Population Health

Health Equity

The Donabedian Model for Quality of Care



ED-Hospital Best Practices

- Subgroup 2 Members submitted Best Practice recommendations prior to 9/27 meeting
- 9/27 Meeting
 - O Discussed a model with a drop-down menu of measures, each hospital selects a certain number
 - Recommendation list reviewed
 - O Discussed the need for clear definitions, parameters and targets
- Subgroup 2 Members were asked to send their "Top Recommendations" from the complete list by 10/4
- Top Recommendation List compiled and shared with Subgroup for further discussion
 - 5 top recommendations were selected by the majority of the 8 system respondents, an additional 5 recommendations were selected by multiple system respondents
 - HSCRC and Hospital Members attended AHRQ Webinar on ED Boarding on 10/8
- Next meeting on 10/11
 - Discuss Suggested Interventions discussed in AHRQ Webinar
 - Discuss "Top Recommendations" and select final measures to move forward
 - Begin further defining measures, parameters
 - Revenue at Risk Discussion, "ramp up" model



Examples of Best Practices In Review

1. Implement/Optimize Bed Capacity Alert Process

2. Implement/Optimize Interdisciplinary Rounds

3. Patient Flow/Performance Improvement Throughput Council with Leadership Accountability

4. Standardized Daily or Shift Huddles



Appendix



September Data 2024 Reporting

Monthly, public reporting of three measures:

- ED1-like measure: ED arrival to inpatient admission time for all admitted patients
- OP18-like measure: ED arrival to discharge time for patients who are not admitted
- EMS turnaround time (from MIEMSS): Time from arrival at ED to transfer of patient care from EMS to the hospital

Data received for 44 out of 44 hospitals

- These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month)
- These data are being collected for hospital quality improvement and have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital
- Data may be updated over time if issues are identified or specifications change

Graphs:

- Rolling median (June 2023-Latest Month) and change from June 2023/first month provided
- Latest month grouped by CMS ED volume category (Volume data is from CMS Care Compare or imputed by hospital
 volume categories were recently updated on CMS Care Compare.)
- · Graphs have not been QAed by hospitals due to fast turnaround time

ED Length of Stay and EMS Turnaround Data

- Monthly, unaudited data on ED length of stay for September 2024 was received from 44 out of 44 hospitals (IP and OP data).
- There was a decrease for ED1a, ED1b, and an increase for ED1c in Median Wait Times in September compared to August.
 - September Average Median Wait Time:

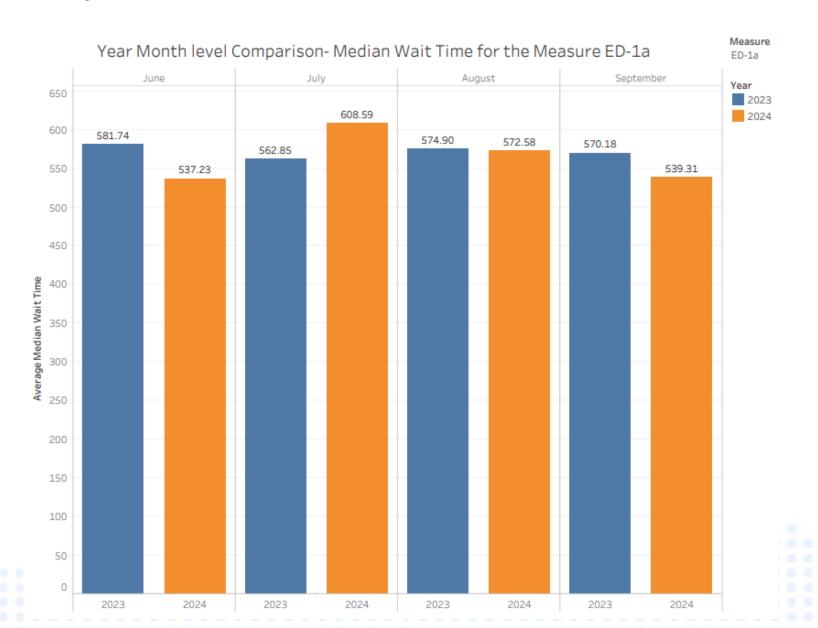
ED1a: 539.3 minutes ED1b: 535.6 minutes

minutes

- These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month) and the data have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital.
- EMS turnaround time data shows notable net movement of hospitals across categories for September 2024, with six hospitals improving in performance and two hospitals declining in performance

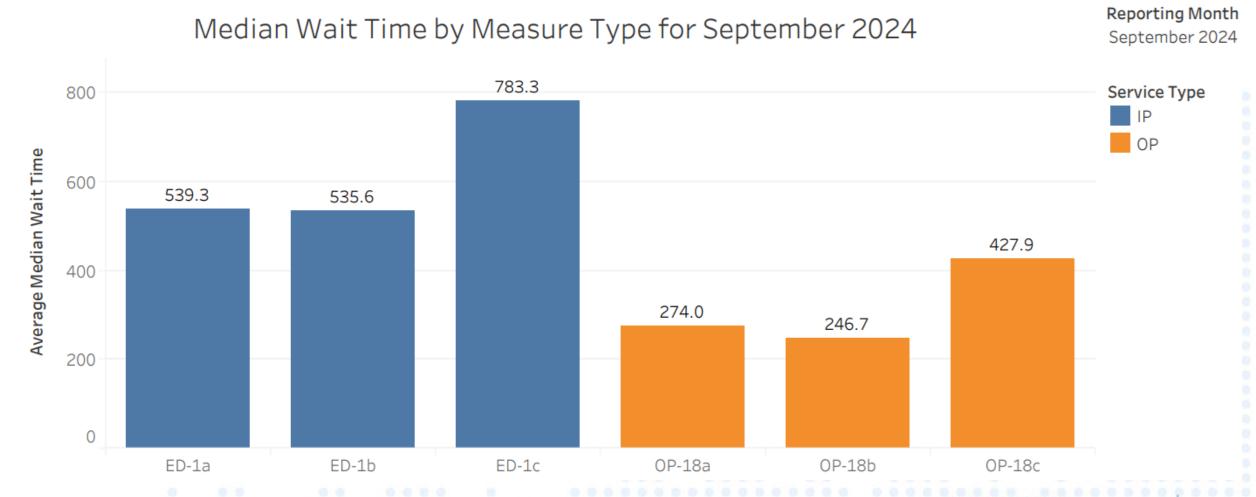
ED1c: 783.3

Monthly Results 2023 vs. 2024



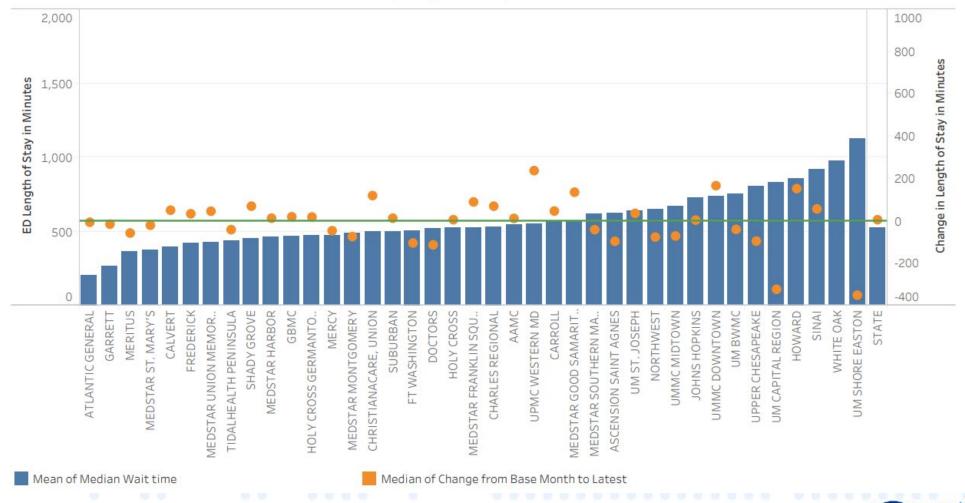


ED Median Wait Time

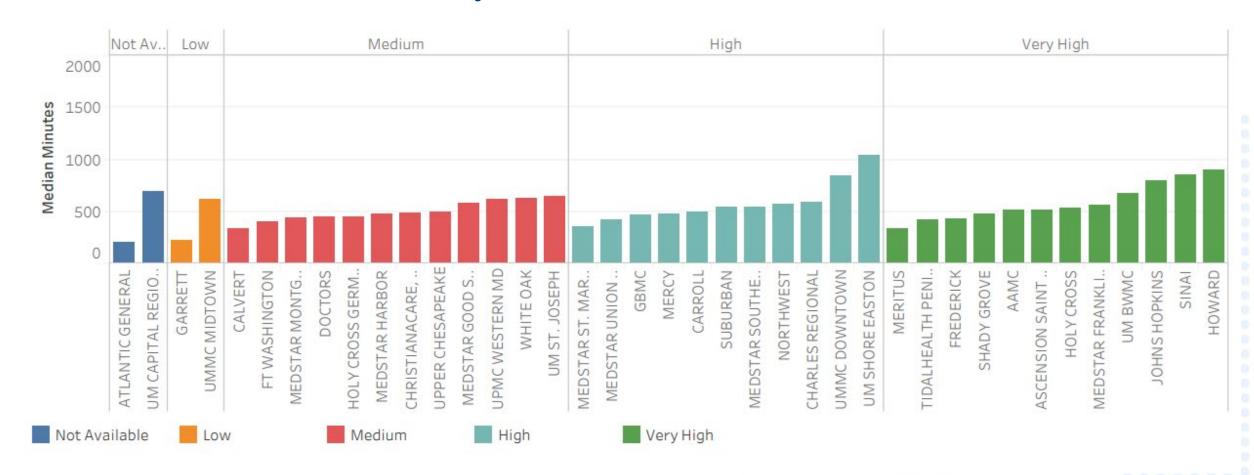


ED 1a: ED Arrival to Inpatient Admission

Average Median Wait Time by Hospital Reporting Month: September 2024

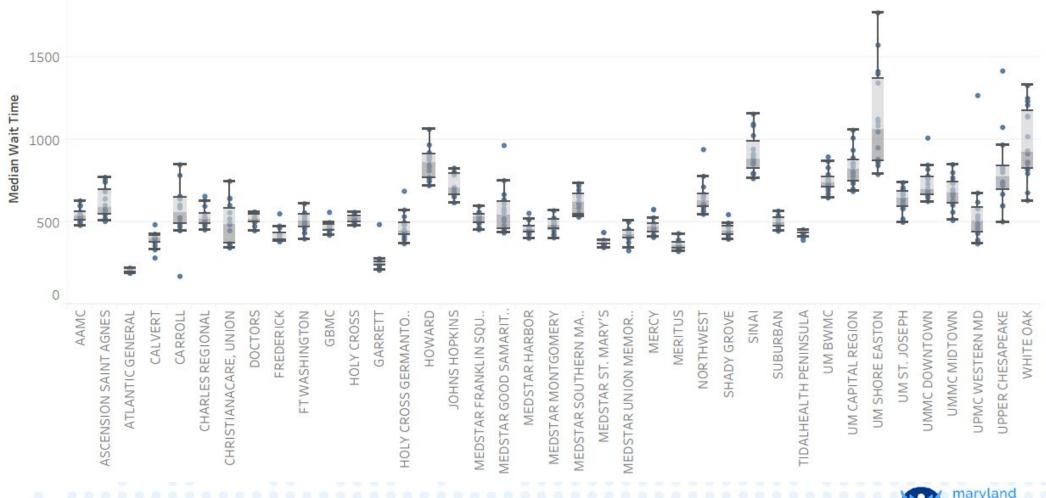


ED 1a: ED Arrival to Inpatient Admission Time Latest Month Median By Volume--Latest Month



ED 1a: ED Arrival to Inpatient Admission

Median Wait Time Distribution for ED-1a



ED 1a: ED Arrival to Inpatient Admission

Heat Graph: Colors are relative to June/first month reported.

Red = higher wait time Green = lower wait time Change from Base
-620

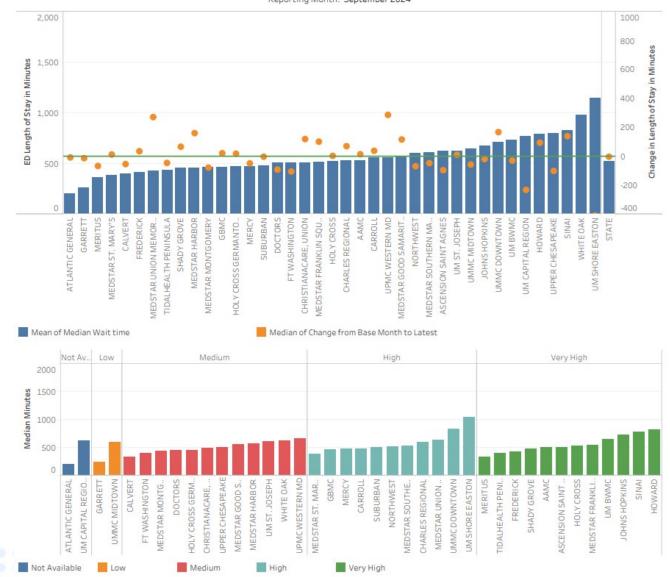
Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
AAMC	493	532	540	534	563	601	629	597	530	544	501	480	550	521	512	504
ASCENSION SAINT AGN	601	564	545	574	641	576	755	772	684	694	742			524	518	504
ATLANTIC GENERAL	210	218	221	212	195	189	216		190	191	199	199	200	210		203
CALVERT	282	383	411	425	405	409	484	426	408	402	375	389	423	395	356	332
CARROLL	447	527	481	640	602	470	654	848	656	649	783	519	171	493	586	493
CHARLES REGIONAL	527	486	497	453	492	455	508	656	631	551	475	514	548	526	514	596
CHRISTIANACARE, UNI	369	351	370	343	360	448	641	601	645	557		520	483		496	488
DOCTORS	561	514	537	503	559	529	555	559	513	512	500	500	522	509	474	447
REDERICK	392	388	382	395	416	432	464	550	476	381	386	402	395	391	397	425
FT WASHINGTON	503	434	488	493	550	539	611	460	476	556	524	435	536	553	510	398
SARRETT			244		246	244	277	254	231	237	207	485	223	257	232	228
GBMC	439	467	456	475	482	420	476	559	497	474	454	457	428	425	483	458
HOLY CROSS	524	481	540	513	547	518	546	559	496	524		496	498	501	526	529
HOLY CROSS GERMANT	435	393	428	369	483	414	573	687	499	437		533	401	483	441	453
HOWARD	748	770	765	834	968	921	902	889	721	845	811	747	915	1,062	877	900
IH BAYVIEW	945	1,007	1,153	968	1,135	1,276	1,229	1,277	1,315	1,001	1,110	862	522	1,110		
OHNS HOPKINS	794	680	652	697	704	708	661	804	786	710	663	666	617	790	827	797
MEDSTAR FRANKLIN SQ	463	467	493	492	532	509	560	596	539	512	537	532	454	532	554	552
MEDSTAR GOOD SAMA	441	479	522	456	559	506	667	965	752	637	442	434	450	610	581	576
MEDSTAR HARBOR	458	553	474	518	513	402	441	457	436	437	432	434	451	466	424	470
MEDSTAR MONTGOME	518	461	486	495	525	497	505	569	518	480	471	419	405	427	469	443
MEDSTAR SOUTHERN	585	544	539	530	542	554	660	733	695	673	719	622	624	651	606	543
MEDSTAR ST. MARY'S	380	351	362	354	362	382	436	437	363	372	390	367	382	345	367	359
MEDSTAR UNION MEM	375	456	412	326	407	400	504	500	439	410	446	347	425	455	441	420
MERCY	526	577	575	407	450	423	466	492	461	476	463	470	417	419	458	479
MERITUS	393	370	354	386	379	345	368	430	370	354	354	335	338	322	324	335
NORTHWEST	645	778	669	566	602	608	661	940	713	593	668	584	651	608	547	568
SHADY GROVE	408	427	446	435	545	494	428	437	403	470	396	419	469	468	472	477
SINAI	796	796	877	861	764	856	791	1,155	1,085	942	904	887	1,025	914	1,095	852
SUBURBAN	527	462	467	480	537	469	499	521	497	445	475	567	485	490	510	539
TIDALHEALTH PENINSU		453	448	447	432	430	445	450	438	406	424	390	434	441	440	411
JM BWMC	711	740	691	708	717	647	756	895	758	731	725	743	830	868	789	670
JM CAPITAL REGION	1,010	853	858	751	890	734	835	1,057	936	838	736	778	701	806	793	686
IM SHORE EASTON	1,399		1,344	1,414	1,109	789	1,574	1,770	1,084	1,124	843	868		881	861	1,04
JM ST. JOSEPH	604	600	641	667	687	499	621	739	580	585	672	663	701	709	519	639
JMMC DOWNTOWN	680	625	648	688	658	650	670	768	687	758	731	780	705	1,010	819	846
JMMC MIDTOWN	685	849	800	658	768	560	698	677	748	669	631	516	510	734	602	613
JPMC WESTERN MD	383	430	438	481	522	523	489	676	580	392	368	539	461	1,268	582	620
JPPER CHESAPEAKE	598	669	599	834	801	968	1,075	1,417	721	741	834	822	811	744	738	502
WHITE OAK	1,251	865	1,143	855	1,328	1,210		825	677	1,233	1,138	932	914	817	1,018	631

JH Bayview did submit data but not in time for inclusion

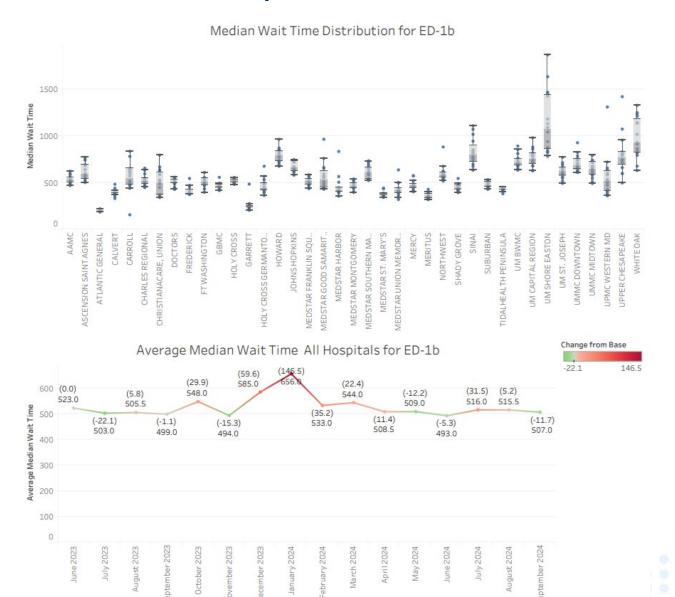


ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric

Average Median Wait Time by Hospital Reporting Month: September 2024



ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric

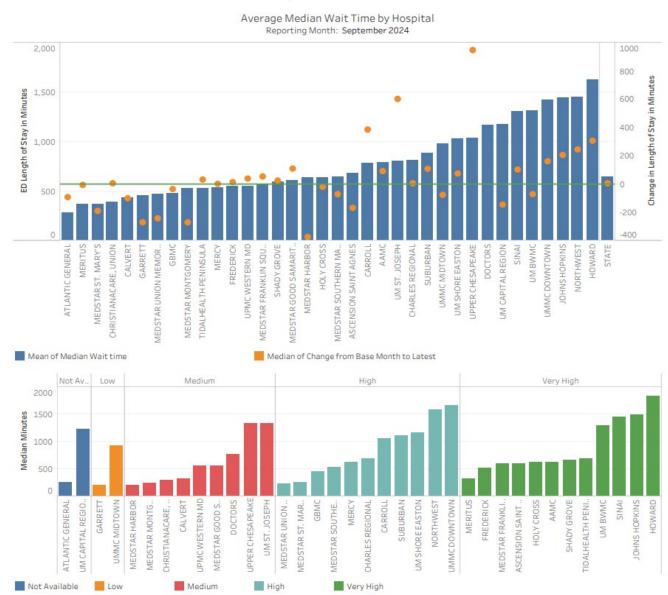


ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric

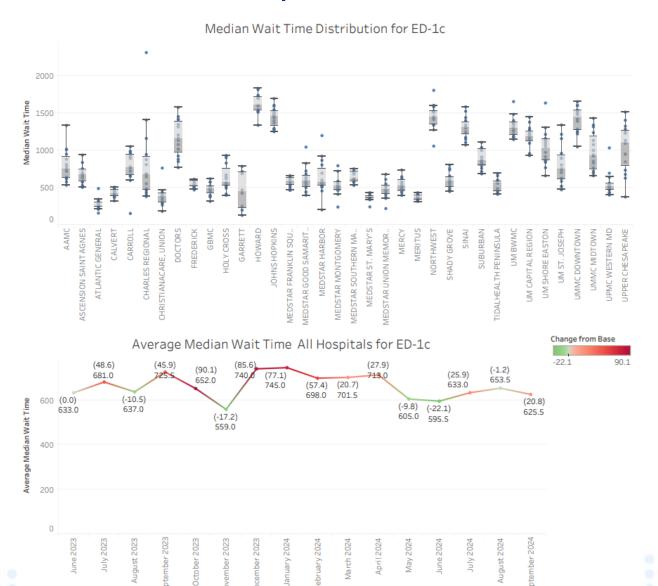
Average Median Wait Time All Hospitals for ED-1b

easure														Char	ge from Base	
D-1b														-668		
				September		November	December		February							Septemb
Hospital Name	June 2023	July 2023	August 2023	2023	October 2023	2023	2023	January 2024	2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	2024
AAMC	488	527	536	529	565	597	623	591	528	539	495	471	528	508	486	
ASCENSION SAINT AGN	599	563	541	573	641	576	755	772	683	694	741			525	515	
ATLANTIC GENERAL	209	203	222	212	195	189	216		190	190	199	199	199	210		
ALVERT		386	403	420	390	408	484	443	404	395	369	391	407	392	353	
ARROLL	441	520	470	623	603	158	653	837	648	648	782	500	480	487	574	
HARLES REGIONAL	526	484	499	449	489	456	507	656	634	551	474	516	544	526	516	
HRISTIANACARE, UNI	372	351	370	343	356	450	640	627	669	588		530	493		510	
OCTORS	541	503	525	499	559	523	547	543	510	509	489	491	429	493	453	
REDERICK	388	376	378	391	410	427	458	546	472	375	379	397	390	381	394	
TWASHINGTON	503	434	488	493	550	539	611	469	476	556	524	435	536	553	510	
SARRETT			244		246	244	277	255	227	236	206	486	223	256	246	
BMC	438	467	455	475	481	417	476	558	496	475	454	455	429	427	480	
IOLY CROSS	524	482	540	513	544	518	546	557	495	524		496	499	500	523	
OLY CROSS GERMANT	435	396	427	365	487	414	568	677	498	436		533	398	488	441	
OWARD	722	734	729	776	871	839	836	785	676	785	741	699	855	964	813	
H BAYVIEW	895	951	1,107	885	1,097	1,250	1,179	1,270	1,307	973	1,059	815	1,117	1,085		
OHNS HOPKINS	746	631	613	650	672	652	617	744	732	667	623	626	581	722	734	
MEDSTAR FRANKLIN SQ	445	471	492	484	516	471	570	585	538	492	522	512	437	516	547	
MEDSTAR GOOD SAMA	440	474	512	449	556	494	654	965	761	664	442	430	450	594	571	
MEDSTAR HARBOR	407	506	424	835	391	357	399	447	416	432	415	406	436	445	415	
MEDSTAR MONTGOME	520	459	478	477	525	438	490	540	495	454	448	404	398	402	460	
MEDSTAR SOUTHERN	584	542	536	525	540	533	654	735	691	668	720	622	604	652	616	
MEDSTAR ST. MARY'S	368	350	362	356	362	385	436	443	361	366	390	369	385	344	367	
MEDSTAR UNION MEM	367	442	397	321	398	389	498	503	434	413	425	342	410	435	419	
MERCY	523	576	574	404	450	421	464	490	461	476	462	469	416	417	458	
MERITUS	404	371	357	386	377	341	368	430	364	352	347	334	339	320	322	
ORTHWEST	595	676	613	558	575	561	600	883	624	549	609	551	600	559	518	
HADY GROVE	408	424	446	434	546	493	427	437	397	468	395	419	465	468	472	
INAI	638	636	759	699	675	765	737	1,110	945	852	814	819	1,018	834	1,072	
UBURBAN	510	441	445	457	516	455	485	506	474	429	456	534	457	472	493	
IDALHEALTH PENINSU		452	446	447	429	430	447	448	437	405	423	383	429	440	434	
M BWMC	684	704	681	683	699	635	740	893	747	721	698	734	813	855	764	
M CAPITAL REGION	859	752	781	714	809	683	793	981	882	821	679	721	632	740	730	
M SHORE EASTON	1,452	941	1,468	1,428		784	1,634		1,089	1000000	823	832	878	875	843	
M ST. JOSEPH	598	562	641	656	100000000000000000000000000000000000000	494	607	7.002.00	583	100700000	669	650	715	694	517	
MMC DOWNTOWN	658	610	625	669		622	651		662		707	758	697	928	787	
MMC MIDTOWN	647	792	735	614		547	676		726		617	509	493	716	581	
PMC WESTERN MD	373	417	411	473		503	430	The second second	520		360	585	536	1.310	641	

ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



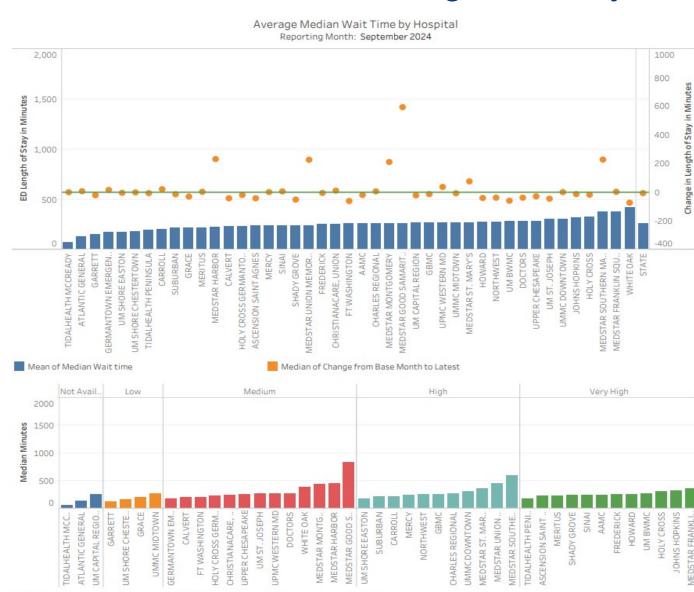
ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric

Average Median Wait Time All Hospitals for ED-1c

Meas	Change fr	om Base	
ED-1	-644		1,629

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
AAMC	535	883	719	643	1,335	951	1,009	1,017	757	790	629	578	812	618	740	627
ASCENSION SAINT AGN	755	939	631	691	652	531	682	745	698	574	839			505	666	587
ATLANTIC GENERAL		345	160	262	286	490	255			254		242	210	322		253
CALVERT	425	379	457	471	508	427	501	369	449	458	393	389	490	427	410	325
CARROLL	665	667	764	893	598	156	724	988	989	717	924	906	652	781	963	1,051
CHARLES REGIONAL	682	678	487	810	1,407	406	1,161	647	466	2,311	946	436	555	877	383	688
CHRISTIANACARE, UNI	290	184	268		424	422	764	431	463	388	331	375	355		405	296
DOCTORS	1,414	1,316	1,167	1,019	1,418	1,453	1,347	1,208	1,134	850	1,079	881	1,575	1,015	925	770
FREDERICK	506	517	540	514	613	534	586	609	613	557	514	586	471	606	501	520
GARRETT							470	717	428	786	131	691			252	200
GBMC	480	387	479	476	508	526	498	621	578	471	398	573	376	318	509	445
HOLY CROSS	642	416	518	568	903	559	532	933	831	400		526	495	671	920	623
HOLY CROSS GERMANT	410	320	643	400	412	458	1,208	919	643	818		215	584	447	697	
HOWARD	1,524	1,512	1,338	1,597	1,699	1,602	1,701	1,815	1,728	1,519	1,603	1,547	1,598	1,740	1,545	1,831
JH BAYVIEW	1,309	1,205	1,440	1,376	1,383	1,394	1,475	1,316	1,348	1,147	1,294	1,115	1,431	1,214		
JOHNS HOPKINS	1,281	1,294	1,284	1,510	1,458	1,470	1,453	1,606	1,694	1,396	1,368	1,436	1,251	1,546	1,592	1,487
MEDSTAR FRANKLIN SQ	532	465	500	532	627	662	469	642	542	583	589	627	531	577	641	586
MEDSTAR GOOD SAMA	446	502	590	549	608	522	827	1,045	725	577	401	588	441	637	684	556
MEDSTAR HARBOR	577	868	923	1,199	806	520	695	531	603	458	540	572	562	561	508	204
MEDSTAR MONTGOME	512	472	498	532	531	722	550	795	588	568	579	465	413	468	488	242
MEDSTAR SOUTHERN	609	575	586	573	601	714	683	717	754	722	713	622	710	617	532	538
MEDSTAR ST. MARY'S	434	356	356	339	359	374	415	379	376	430	396	353	351	374	364	244
MEDSTAR UNION MEM	464	681	473	358	475	431	612	470	530	407	553	371	480	518	525	222
MERCY	622	648	738	490	458	531	518	556	398	456	577	492	464	435	544	624
MERITUS	329	344	317	385	423	395	363	434	397	362	413	340	337	348	374	323
NORTHWEST	1,337	1,510	1,454	1,058	1,435	1,275	1,347	1,523	1,805	1,343	1,604	1,413	1,518	1,450	1,529	1,582
SHADY GROVE	633	805	526	760	450	573	592	497	739	594	589	552	607	471	466	658
SINAI	1,337	1,336	1,108	1,400	1,248	1,151	1,299	1,248	1,584	1,309	1,525	1,308	1,073	1,310	1,174	1,440
SUBURBAN	1,000	849	875	865	1,029	718	868	760	912	686	1,040	1,025	804	830	795	1,108
TIDALHEALTH PENINSU		659	490	441	473	415	415	567	440	596	465	605	581	565	562	691
UM BWMC	1,359	1,400	1,349	1,654	1,216	1,176	1,146	1,271	1,255	1,183	1,360	1,483	1,310	1,191	1,378	1,288
UM CAPITAL REGION	1,379	1,445	1,189	1,169	1,299	1,191	1,147	1,272	1,146	931	959	950	1,212	1,096	1,155	1,234
UM SHORE EASTON	1,085	974	769	1,304	875	842	917	1,121	661	878	1,215	1,052	857	1,635	1,125	1,160
UM ST. JOSEPH	739	1,159	627	899	1,216	520	756	473	516	961	806	702	626	893	586	1,341
UMMC DOWNTOWN	1,491	1,410	1,419	1,222	1,510	1,519	1,541	1,249	1,599	1,253	1,286	1,605	1,047	1,482	1,390	1,653
UMMC MIDTOWN	1,001	1,341	1,431	1,078	1,317	664	1,238	698	767	830	855	661	721	1,134	941	925
UPMC WESTERN MD	513	520	508	510	525	484	560	640	695	437	428	539	403	1,034	468	552
UPPER CHESAPEAKE	377		679	1,513	948	1,283	1,096	848		953	1,404		1,243	629	735	1,325
WHITE OAK			2,701													

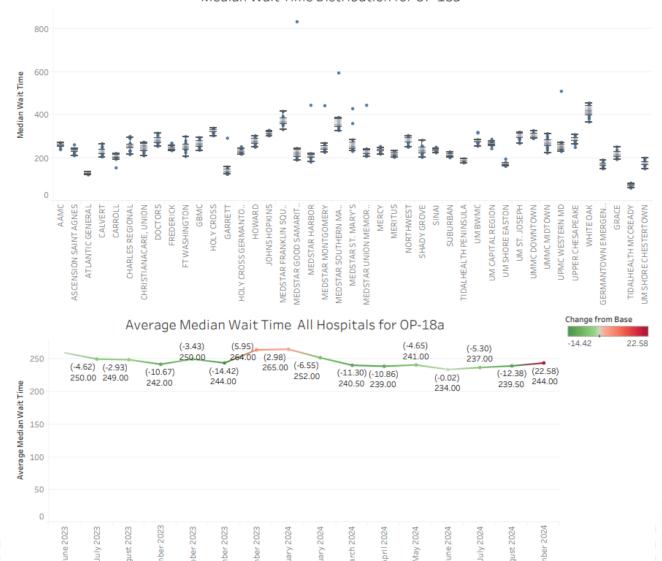
OP18a: ED Arrival to Discharge Time by Month





OP18a: ED Arrival to Discharge Time by Month

Median Wait Time Distribution for OP-18a



OP18a: ED Arrival to Discharge Time by Month

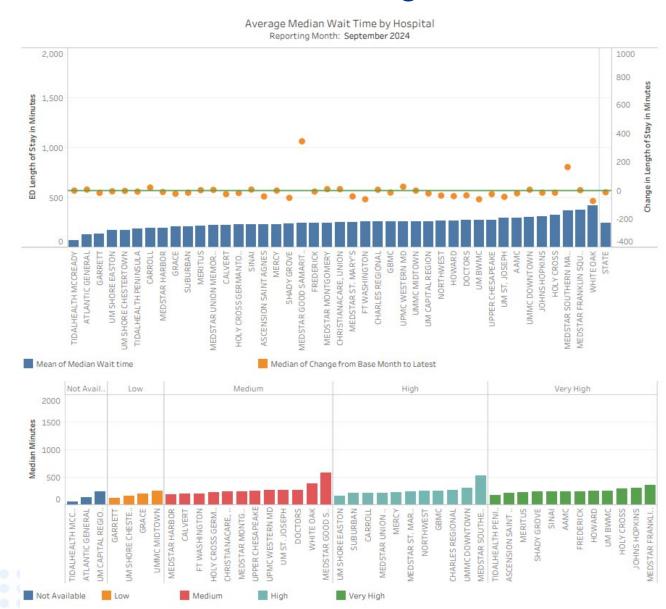
Average Median Wait Time All Hospitals for OP-18a

 Measure
 Change from Base

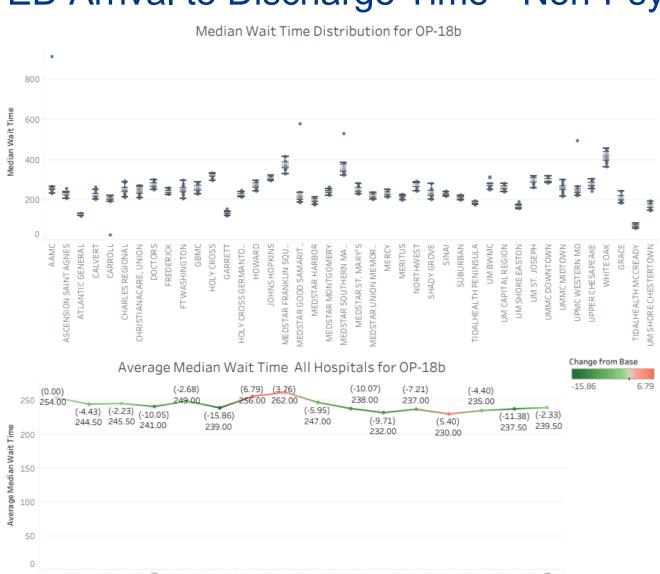
 0P-18a
 59

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
AAMC	258.0	255.0	260.0	254.0	266.0	263.0	271.0	268.0	256.0	258.0	253.0	241.0	255.0	258.0	241.0	239.0
ASCENSION SAINT AGN	261.0	238.0	236.0	243.0	220.0	226.0	239.0	238.0	232.0	227.0	233.0			237.0	211.0	219.0
ATLANTIC GENERAL	124.0	127.0	131.0	133.0	128.0	123.0	134.0		125.0	122.0	128.0	132.0	126.0	129.0		131.0
CALVERT	247.0	229.0	240.0	233.0	253.0	235.0	266.0	218.0	215.0	216.0	220.0	227.0	211.0	218.0	220.0	205.0
CARROLL	194.0	203.0	201.0	201.0	221.0	154.0	212.0	209.0	211.0	209.0	210.0	203.0	203.0	213.0	213.0	215.0
CHARLES REGIONAL	254.0	253.0	232.0	216.0	230.0	234.0	258.0	261.0	252.0	258.0	253.0	267.0	300.0	291.0	292.0	260.0
CHRISTIANACARE, UNI	229.0	234.0	222.0	211.0	211.0	234.0	271.0	265.0	272.0	258.0	260.0	266.0	273.0		258.0	240.0
DOCTORS	311.0	288.0	280.0	265.0	281.0	285.0	315.0	302.0	290.0	254.0	270.0	288.0	270.0	272.0	267.0	273.0
FREDERICK		249.0	248.0	236.0	240.0	244.0	265.0	269.0	256.0	234.0	240.0	237.0	241.0	236.0	249.0	244.0
FT WASHINGTON	268.0	238.0	262.0	247.0	260.0	259.0	299.0	280.0	266.0	259.0	250.0	240.0	224.0	237.0	235.0	207.0
GARRETT			145.0		150.0	147.0	158.0	134.0	132.0	138.0	124.0	292.0	135.0	132.0	130.0	124.0
GBMC	267.0	257.0	261.0	273.0	279.0	266.0	287.0	276.0	294.0	294.0	266.0	247.0	236.0	241.0	248.0	254.0
GERMANTOWN EMERG	162.0	156.0	159.0	150.0	167.0				190.0	175.0	178.0	165.0	171.0	161.0	173.0	178.0
GRACE	236.0	251.0	226.0	221.0	228.0	206.0	233.0	227.0	209.0	215.0	212.0	222.0	193.0	195.0	205.0	206.0
HOLY CROSS	320.0	304.0	335.0	333.0	327.0	314.0	329.0	337.0	324.0	315.0		322.0	338.0	320.0	322.0	303.0
HOLY CROSS GERMANT	242.0	227.0	252.0	233.0	235.0	228.0	245.0	234.0	226.0	227.0		222.0	220.0	217.0	229.0	223.0
HOWARD	290.0	290.0	303.0	252.0	275.0	263.0	296.0	280.0	271.0	269.0	280.0	278.0	282.0	283.0	260.0	250.0
JH BAYVIEW	312.0	312.0	308.0	281.0	283.0	262.0	264.0		276.0	297.0	313.0	286.0	607.0	304.0	12200000	107.00
JOHNS HOPKINS	328.0	319.0	318.0	309.0	312.0	303.0	305.0	313.0	311.0	309.0	319.0	315.0	327.0	311.0	319.0	315.0
MEDSTAR FRANKLIN SQ.,	357.0	373.0	382.0	365.0	374.0	385.0	416.0		332.0	350.0	355.0	365.0	367.0	393.0	372.0	360.0
MEDSTAR GOOD SAMA	239.0	237.0	244.0	228.0	239.0	207.0	239.0		215.0	210.0	201.0	190.0	196.0	203.0	222.0	833.0
MEDSTAR HARBOR	213.0	213.0	211.0	202.0	214.0	181.0	196.0		184.0	202.0	203.0	210.0	210.0	220.0	210.0	445.0
MEDSTAR MONTGOME	232.0	226.0	247.0	238.0	259.0	246.0	262.0		249.0	244.0	229.0	249.0	247.0	246.0	240.0	443.0
MEDSTAR SOUTHERN	367.0	344.0	331.0	328.0	340.0	329.0	388.0	381.0	358.0	360.0	374.0	348.0	345.0	348.0	382.0	595.0
MEDSTAR ST. MARY'S	284.0	269.0	272.0	251.0	254.0	249.0	265.0	265.0	252.0	233.0	247.0	232.0	429.0	231.0	238.0	360.0
MEDSTAR UNION MEM	218.0	227.0	230.0	221.0	241.0	219.0	241.0		229.0	217.0	236.0	210.0	207.0	220.0	215.0	445.0
MERCY	232.0	241.0	231.0	219.0	218.0	222.0	233.0		236.0	237.0	225.0	253.0	234.0	233.0	239.0	233.0
MERITUS	225.0	207.0	207.0	221.0	211.0	203.0	225.0		221.0	218.0	221.0	219.0	219.0	213.0	221.0	228.0
NORTHWEST	288.0	291.0	304.0	279.0	291.0	290.0	299.0		271.0	273.0	277.0	272.0	271.0	258.0	252.0	250.0
SHADY GROVE	282.0	256.0	252.0	242.0	247.0	246.0	238.0	217.0	203.0	206.0	228.0	234.0	222.0	217.0	234.0	231.0
SINAI	232.0	240.0	250.0	232.0	233.0	233.0	243.0		229.0	232.0	227.0	231.0	224.0	231.0	226.0	238.0
SUBURBAN	227.0	216.0	227.0	217.0	219.0	210.0	209.0		213.0	206.0	208.0	217.0	201.0	209.0	208.0	213.0
TIDALHEALTH MCCREA	227.0	210.0	62.0	73.0	83.0	67.0	75.0		74.0	70.0	69.0	74.0	73.0	60.0	72.0	62.0
TIDALHEALTH PENINSU	9	184.0	190.0	196.0	195.0	191.0	192.0		190.0	182.0	182.0	177.0	185.0	183.0	191.0	178.0
UM BWMC	316.0	319.0	285.0	282.0	277.0	280.0	278.0	272.0	269.0	276.0	278.0	280.0	267.0	282.0	255.0	257.0
UM CAPITAL REGION	265.0	277.0	271.0	265.0	269.0	260.0	287.0		262.0	259.0	258.0	269.0	265.0	256.0	263.0	243.0
UM SHORE CHESTERTO	169.0	175.0	164.0	180.0	193.0	150.0	189.0		180.0	164.0	168.0	174.0	164.0	176.0	163.0	168.0
UM SHORE EASTON	178.0	165.0	172.0	174.0	163.0	161.0	178.0		164.0	173.0	164.0	174.0	167.0	174.0	178.0	174.0
UM ST. JOSEPH	313.0	305.0	313.0	319.0	319.0	291.0	318.0		295.0	287.0	284.0	296.0	293.0	291.0	269.0	268.0
UMMC DOWNTOWN	310.0	312.0	306.0	299.0	292.0	291.0	304.0		327.0	298.0	303.0	296.0	293.0	301.0	290.0	311.0
		294.0		279.0							247.0	260.0	291.0	267.0	249.0	259.0
UMMC MIDTOWN	266.0		277.0		270.0	237.0	301.0		284.0	270.0				20000000		
UPMC WESTERN MD	233.0	236.0	248.0	250.0	272.0	260.0	259.0		256.0	250.0	238.0	240.0	230.0	510.0	258.0	270.0
UPPER CHESAPEAKE	278.0	280.0	278.0	270.0	280.0	282.0	308.0		294.0	277.0	287.0	297.0	288.0	263.0	280.0	249.0
WHITE OAK	455.0	404.0	420.0	397.0	452.0	402.0	426.0	445.0	439.0	397.0	386.0	444.0	430.0	425.0	367.0	382.0

OP18b: ED Arrival to Discharge Time - Non-Psychiatric



OP18b: ED Arrival to Discharge Time - Non-Psychiatric



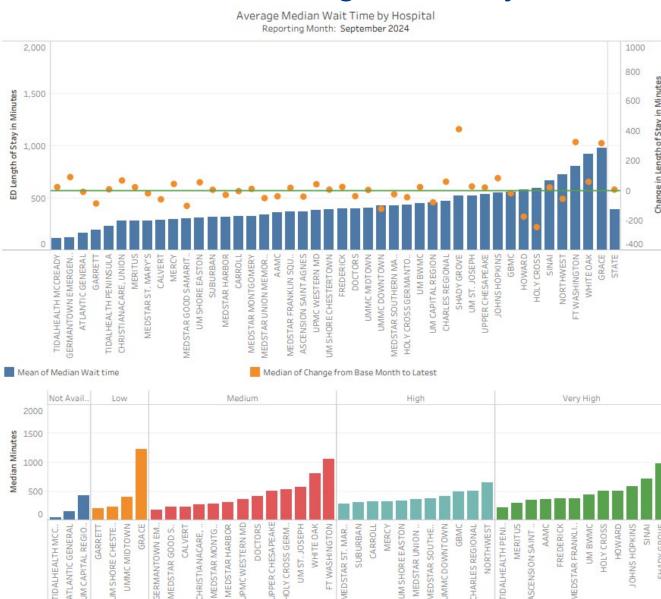
OP18b: ED Arrival to Discharge Time - Non-Psychiatric

Average Median Wait Time All Hospitals for OP-18b

Measure OP-18b

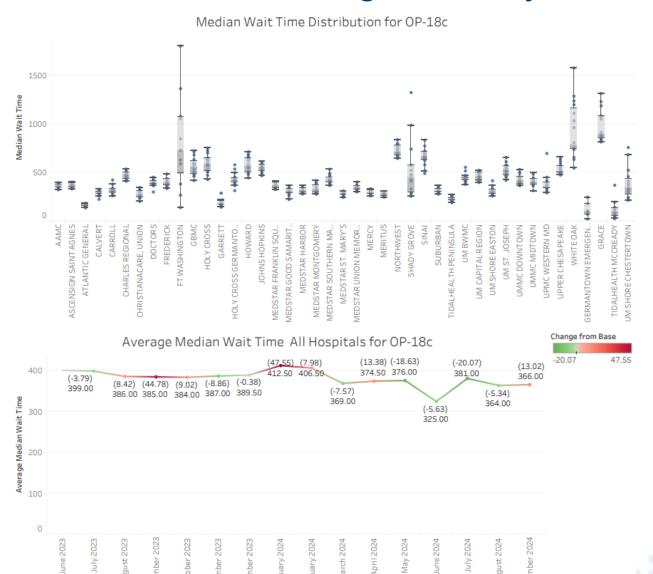
Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
AAMC	254.0	251.0	257.0	248.0	256.0	260.0	268.0	266.0	254.0	259.0	251.0	237.0	914.0	254.0	234.0	235.0
ASCENSION SAINT AGN	258.0	235.0	232.0	241.0	216.0	225.0	225.0	234.0	228.0	224.0	230.0			235.0	208.0	217.0
ATLANTIC GENERAL	123.0	126.0	130.0	132.0	127.0	122.0	134.0		124.0	121.0	127.0	132.0	125.0	128.0		130.0
CALVERT		229.0	237.0	231.0	251.0	233.0	265.0	216.0	212.0	212.0	218.0	224.0	209.0	216.0	218.0	204.0
CARROLL	193.0	201.0	200.0	201.0	220.0	27.0	210.0	207.0	209.0	207.0	209.0	202.0	202.0	212.0	213.0	214.0
CHARLES REGIONAL	250.0	247.0	230.0	213.0	226.0	232.0	255.0	259.0	247.0	253.0	250.0	264.0	295.0	287.0	287.0	256.0
CHRISTIANACARE, UNI	230.0	234.0	222.0	211.0	211.0	234.0	272.0	265.0	272.0	257.0	260.0	265.0	272.0		257.0	240.0
DOCTORS	302.0	272.0	274.0	260.0	285.0	280.0	301.0	291.0	280.0	251.0	263.0	280.0	264.0	266.0	258.0	268.0
FREDERICK		246.0	245.0	232.0	235.0	239.0	256.0	261.0	251.0	229.0	234.0	233.0	235.0	229.0	244.0	239.0
FT WASHINGTON	268.0	238.0	261.0	247.0	260.0	259.0	299.0	280.0	265.0	259.0	250.0	240.0	224.0	237.0	235.0	207.0
GARRETT		100000	138.0		145.0	144.0	156.0	133.0	132.0	137.0	123.0	134.0	134.0	130.0	131.0	122.0
GBMC	262.0	248.0	255.0	265.0	273.0	259.0	282.0	269.0	287.0	286.0	257.0	240.0	230.0	235.0	243.0	248.0
GERMANTOWN EMERG	162.0	156.0	159.0	150.0	167.0				190.0	175.0	178.0	165.0	171.0	161.0	173.0	
GRACE	220.0	243.0	218.0	209.0	212.0	199.0	223.0	215.0	200.0	203.0	197.0	210.0	185.0	185.0	197.0	198.0
HOLY CROSS	315.0	298.0	330.0	328.0	324.0	309.0	326.0	334.0	322.0	313.0		320.0	333.0	318.0	321.0	300.0
HOLY CROSS GERMANT	237.0	224.0		232.0		225.0	242.0		223.0	226.0		220.0	219.0	215.0		220.0
HOWARD	284.0	287.0		247.0		259.0	289.0	275.0	264.0	265.0	275.0	273.0	277.0	276.0		245.0
JH BAYVIEW	290.0	290.0		268.0		252.0	250.0		259.0	286.0	306.0	281.0	289.0	288.0	10000000	70700
JOHNS HOPKINS	320.0	312.0		299.0		297.0	298.0		304.0	302.0	313.0	305.0	318.0	300.0		305.0
MEDSTAR FRANKLIN SQ	357.0	373.0		369.0		387.0	417.0		331.0	349.0	354.0	363.0	367.0	393.0		360.0
MEDSTAR GOOD SAMA	234.0	231.0		225.0		202.0	237.0	238.0	210.0	208.0	198.0	188.0	190.0	200.0		580.0
MEDSTAR HARBOR	204.0	204.0		190.0		176.0	189.0		178.0	193.0	198.0	201.0	206.0	213.0		194.0
MEDSTAR MONTGOME	230.0	224.0		233.0		243.0	258.0		246.0	240.0	228.0	246.0	244.0	244.0		240.0
MEDSTAR SOUTHERN	366.0	342.0		324.0		325.0	384.0		356.0	359.0	372.0	343.0	343.0	346.0		531.0
MEDSTAR ST. MARY'S	283.0	268.0		250.0		247.0	263.0		250.0	231.0	245.0	231.0	242.0	231.0		242.0
MEDSTAR UNION MEM	211.0	221.0		218.0		215.0	237.0		225.0	212.0	230.0	205.0	203.0	214.0		216.0
MERCY	230.0	238.0		217.0		219.0	233.0		233.0	236.0	222.0	251.0	233.0	231.0		230.0
MERITUS	223.0	205.0		219.0		200.0	224.0		220.0	216.0	219.0	215.0	216.0	212.0		226.0
NORTHWEST	280.0	282.0		270.0		283.0	293.0		263.0	266.0	270.0	266.0	267.0	253.0		245.0
SHADY GROVE	282.0	256.0		241.0		245.0	238.0		203.0	206.0	227.0	234.0	222.0	217.0		231.0
SINAI	226.0	236.0		226.0		230.0	240.0		225.0	228.0	223.0	226.0	219.0	225.0		233.0
SUBURBAN	226.0	214.0		214.0		207.0	207.0		211.0	204.0	205.0	215.0	200.0	207.0		211.0
TIDALHEALTH MCCREA	220.0	214.0	62.0	73.0		66.0	75.0		73.0	70.0	68.0	74.0	72.0	60.0		62.0
TIDALHEALTH PENINSU	- 1	184.0		195.0		190.0	191.0		190.0	181.0	182.0	176.0	184.0	182.0		177.0
UM BWMC	312.0	315.0		279.0		277.0	274.0		264.0	273.0	274.0	277.0	263.0	278.0		251.0
UM CAPITAL REGION	261.0	273.0		260.0		256.0	283.0		259.0	253.0	254.0	267.0	263.0	253.0		241.0
						147.0										
UM SHORE CHESTERTO	166.0	171.0		176.0		15 (6.0)	185.0		177.0	161.0	167.0	167.0	162.0	170.0		164.0
UM SHORE EASTON	176.0	162.0		171.0		159.0	175.0		161.0	169.0	162.0	169.0	164.0	170.0		171.0
UM ST. JOSEPH	308.0	296.0		314.0		289.0	317.0		290.0	281.0	279.0	293.0	291.0	286.0		264.0
UMMC DOWNTOWN	301.0	306.0		293.0		290.0	299.0		319.0	294.0	297.0	292.0	285.0	294.0		307.0
UMMC MIDTOWN	254.0	276.0		265.0		231.0	289.0		271.0	263.0	243.0	251.0	218.0	262.0	-	254.0
UPMC WESTERN MD	229.0	232.0		244.0		249.0	251.0		247.0	244.0	227.0	234.0	222.0	496.0		256.0
UPPER CHESAPEAKE	269.0	275.0		265.0		276.0	304.0		285.0	269.0	279.0	290.0	283.0	257.0		244.0
WHITE OAK	455.0	403.0	419.0	395.0	452.0	402.0	426.0	444.0	438.0	396.0	386.0	443.0	429.0	425.0	366.0	382.0

OP18c: ED Arrival to Discharge Time by Month





OP18c: ED Arrival to Discharge Time by Month



OP18c: ED Arrival to Discharge Time by Volume Psychiatric ED Visits

Average Median Wait Time All Hospitals for OP-18c

Measure	Change from Base
OP-18c	-590 1,072

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
AAMC	394	383	353	385	393	372	363	349	344	330	322	331		360	353	356
ASCENSION SAINT AGN	379	342	389	330	371	384	387	391	402	365	373			346	360	339
ATLANTIC GENERAL	164	179	175	151	156	136	158		171	149	159	139	185	167		156
CALVERT		282	302	302	318	270	328	283	301	307	292	288	256	266	289	224
CARROLL	322	423	323	260	296	339	325	329	286	320	381	330	299	260	271	319
CHARLES REGIONAL	444	433	419	453	476	487	475	414	521	410	502	488	472	446	536	504
CHRISTIANACARE, UNI	202	236	238	260	253	250	237	341	306	316	324	345	287		308	270
DOCTORS	451	363	389	393	380	397	404	447	411	389	397	432	386	380	299	414
FREDERICK		343	335	376	426	395	435	484	433	396	435	373	350	382	401	368
FT WASHINGTON	729	847	1,078		120000			1,801	629	381		590	267	139	1,363	1,055
GARRETT		7.00	288		288	167	154	144	166	169	167	188	193	217	145	202
GBMC	506	681	587	631	534	714	592	586	576	723	482	417	463	498	462	488
GERMANTOWN EMERG	87	69							246	105		18				178
GRACE	912	845	1,083	1,313	1,187	909	859	837	833	1,050	814	872	1.074	877	876	1,230
HOLY CROSS	751	609	726	701	586	642	524	577	569	633	024	427	651	504	469	507
HOLY CROSS GERMANT	579	496	386	364	426	434	383	406	415	454		429	313	411	420	535
HOWARD	687	445	503	550	571	496	549	714	644	479	582	667	623	647	504	513
JH BAYVIEW	659	678	714	598	635			593		574	583	417	492	562	304	213
						684	630		601						670	580
JOHNS HOPKINS	496	488	583	595	564	540	612	598	508	550	466	546	557	520	572	
MEDSTAR FRANKLIN SQ	353	365	337	324	328	370	405	406	398	366	364	403	342	398	333	372
MEDSTAR GOOD SAMA	324	333	292	314	364	285	337	351	315	273	298	259	280	291	305	222
MEDSTAR HARBOR	333	336	322	346		279	316	330	297	310	282	338	289	296	284	305
MEDSTAR MONTGOME	276	320	302	345	386	309	392	416	322	396	313	282	319	290	292	288
MEDSTAR SOUTHERN	390	426	422	399	467	432	479	491	398	412	429	534	388	370	436	366
MEDSTAR ST. MARY'S	302	293	310	271	289	295	297	290	293	269	275	244	276	259	281	284
MEDSTAR UNION MEM	401	332	307	325	359	299	359	346	342	303	371	359	320	357	346	351
MERCY	276	302	287	274	289	275	269	324	326	258	333	319	285	307	271	321
MERITUS	269	251	246	262	266	301	284	293	256	283	300	291	305	254	302	292
NORTHWEST	700	776	698	767	677	669	713	739	680	776	795	661	837	797	648	645
SHADY GROVE	574	294	741		466	411	288	330	478	288	574	255	522	423	265	986
SINAI	692	672	648	717	622	518	698	659	833	773	722	634	579	657	490	714
SUBURBAN	300	322	359	299	362	300	291	308	295	277	346	305	279	325	334	306
TIDALHEALTH MCCREA			24	52	140	369	74	133	74	37	195	121	113	103	84	48
TIDALHEALTH PENINSU		202	225	254	189	270	227	208	197	226	226	237	232	221	259	211
UM BWMC	413	469	377	446	420	446	553	443	440	434	397	404	516	442	451	437
UM CAPITAL REGION	508	473	488	522	406	491	514	465	397	497	455	425	436	407	411	430
UM SHORE CHESTERTO	214	313	411	329	382	293	363	411	459	324	239	757	244	523	683	221
UM SHORE EASTON	276	265	330	314	275	258	307	366	274	307	304	296	311	301	415	332
UM ST. JOSEPH	537	656	548	611	576	451	469	479	420	471	461	508	559	575	511	565
UMMC DOWNTOWN	531	419	448	500	416	365	443	450	455	363	391	376	399	491	374	409
UMMC MIDTOWN	398	440	420	483	379	390	426	492	444	416	376	398	313	361	364	403
UPMC WESTERN MD	309	415	289	398	337	399	353	349	451	372	338	367	325	696	351	352
UPPER CHESAPEAKE	473	556	526	495	482	585	657	634	611	525	538	498	495	494	505	494
WHITE OAK	748	655	545	1.198	963	634	737	1.237	1.032	1.109	1.286	750	1.575	746	746	807
WHITE UAK	/48	655	545	1,198	963	634	/3/	1,23/	1,032	1,109	1,286	750	1,5/5	746	/46	807



EMS Turnaround Times: September Performance

- 25 hospitals reported the 90th percentile of turnaround time was <=35 minutes
- 23 hospitals reported the 90th percentile of turnaround time was 35-60 minutes
- 3 hospitals reported the 90th percentile of turnaround time was over 60 minutes
- Hospitals with improving performance
 - (Average to high performing): Anne Arundel Medical Center, Bowie Health Center, Carroll Hospital Center
 - (Low performing to average): Charles Regional, St. Agnes Hospital, White Oak Medical Center
- Hospitals with declining performance
 - (High performing to average): Suburban Hospital
 - (Average to low performing): St. Agnes Hospital, Northwest Hospital

EMS Turnaround Times: September 2024 Performance

90th Percentile: 0-35 Minutes

Anne Arundel Medical Center+

Atlantic General Hospital

Bowie Health Center +

Cambridge Free-Standing ED

Carroll Hospital Center +

Chestertown

Frederick Health Hospital

Garrett Regional Medical Center

Germantown Emergency Center

Holy Cross Germantown Hospital

Holy Cross Hospital

Johns Hopkins Hospital PEDIATRIC

McCready Health Pavilion

Meritus Medical Center

Montgomery Medical Center

Peninsula Regional

Queenstown Emergency Center

R Adams Cowley Shock Trauma Center

Shady Grove Medical Center

St. Mary's Hospital

Union Memorial Hospital

Upper Chesapeake Health Aberdeen

Walter Reed National Military Medical Center

Western Maryland

>35 Minutes

Baltimore Washington Medical Center

CalvertHealth Medical Center

Charles Regional +

Doctors Community Medical Center

Easton

Fort Washington Medical Center

Franklin Square

Good Samaritan Hospital

Grace Medical Center

Greater Baltimore Medical Center

Harbor Hospital

Howard County Medical Center

Johns Hopkins Bayview

Johns Hopkins Hospital ADULT

Laurel Medical Center

Mercy Medical Center

Midtown

Sinai Hospital

St. Agnes Hospital +

St. Joseph Medical Center

Suburban Hospital -

Union Hospital

University of Maryland Medical Center

Upper Chesapeake Medical Center

White Oak Medical Center +

>60 Minutes

Capital Region Medical Center

Northwest Hospital -

Southern Maryland Hospital



White Oak Medical Center ED Throughput Improvement

10/09/2024

Ogech



White Oak Medical Center

Presenters

- Dr. Jim Rost Chief Medical Officer, White Oak Medical Center
- Kevin Cargill, CPA Chief Financial Officer, White Oak and Fort Washington Medical Centers
- Dr. Mary Kim VP, Adventist HealthCare Primary Care and Population Health
- ➤ **Katie Eckert, CPA** VP, Adventist HealthCare Reimbursement, Strategic Analytics & Operational Excellence



WOMC Overview Governmental Payer Mix **59%**

Census Capacity 100%+

ED Diversion (% of time) >70%

Longest ED Wait Time Rank (Becker's)

#8 in US

ED Visits per year

(ranked 25th in the state)

Volume from Prince George's County

~50%

IP Adults Admissions Entered through the ED

~85% (ranked 16th highest in the state)

HSCRC MPA TCOC Ranking* (CY 2024)

#1 in MD

Leap Frog Safety Grade A

Lowest ED Use Rate per Capita – Medicare FFS

Top 7% in US

(on par with Kodiak, Alaska)



WOMC ED Optimization Initiatives



Emergency Department LOS

Full Capacity Protocol

Post Discharge Area

Emergency Department Vertical Care Unit



Hospital LOS

Hospital Throughput Committee

SNF Authorization Process Redesign

New Complex Care Navigator

Accountability for Completion % of Care

Navigation Admission Assessments

EDDIE Project Statistics

Problem:

Highest ED wait time in the state

> 1100 minutes in CY23



Effort:

Over 3 years of focused ED throughput work



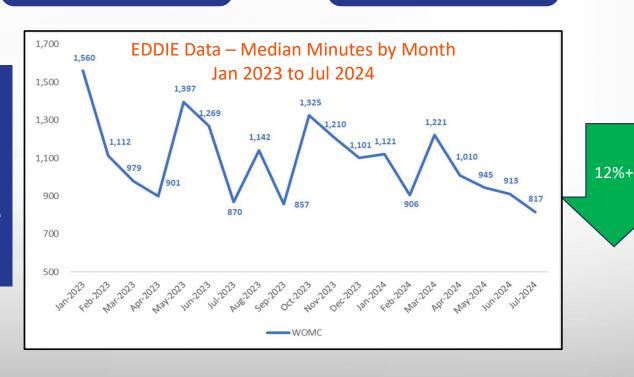
Results:

More than 12% decrease in ED LOS since CY23

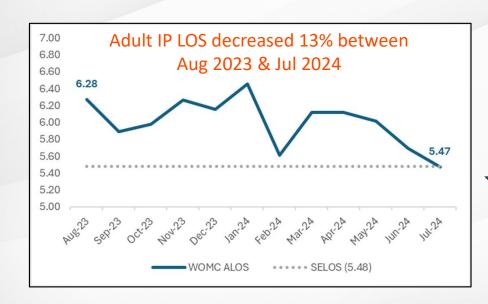
EDDIE Goal

By March 31, 2024, the Hospitalist Medicine, Nursing, and Care Navigation leadership teams will redesign the patient discharge process to promptly identify next day discharges and increase discharges by 11AM from 11% to 15%.





Hospital Throughput Committee Key Metrics







Goal of 15% Met



IP Lab Resulting Time

All 8 metrics between 95-100%



EVS Room Turn/Clean Time

99.8% toward achieving goal



Imaging Turnaround Time

4 of 6 Metrics between 95-100%



13%

ED KPIs Monitored for Improvement

ED Door to Provider
Assignment Time
18% ↓

ED Decision to Admit to Bed Assignment

50% ↓

Time

ED Discharge Order to Discharge Time

Avg ~ 18 minutes

% Left Without Being Seen 40% ↓

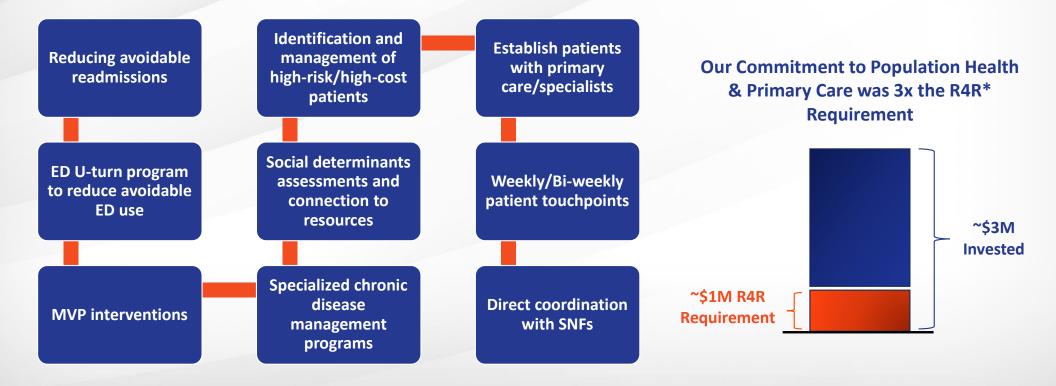
ED Arrival to ED Discharge LOS

Avg ~ 350 - 400 minutes

% of Patients Left Against Medical Advice Avg ~ 0.5%



"Care Navigation" focus on preventing PAUs, optimizing discharge coordination with external providers and coordinating care in the community



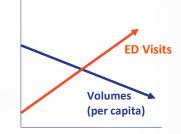


ED Throughput Opportunity Analysis



ED visits are up but per-capita volumes are down and ranks best in the Nation on par with Kodiak, Alaska.

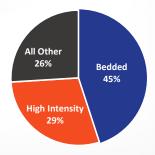
- 7% increase in ED Visits since 2022 but <u>decreased</u> 6% on a per capita basis
- Ranks as one of the lowest in the State and Nation for attributed Medicare beneficiaries





Need for bedded care and high acuity/intensive OP care is driving ED volumes:

- 73% of ED minutes driven by need for acute bedded care and OP-high intensity care
- Of this, 84% is for high acuity care (urgent, emergency or life threatening)





Waiting for an acute bed is top driver of ED minutes:

• ED minutes for bedded patients is $\underline{2-3x}$ the ED LOS for OP ED and driving ~60%+ of extra minutes.



New tower capacity downsized by 16% in 2013 by prior State leadership



By recommendation of prior HSCRC leadership, new tower project was downsized by 28 beds or 16% despite Maryland Department of Planning estimates at the time.



WOMC consistently operates its med/surg beds at 100% physical occupancy.

(Capacity: CY2023 93%, CY2022 102%)



White Oak is licensed for 16% more beds than physical/staffed capacity.

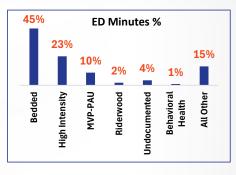
% Growth Med/Surg & Observation Census FY2017-FY2023						
Montgomery County						
	Growth %					
Washington Adventist/White Oak	132%					
JHH- Suburban	26%					
Adventist- Shady Grove	5%					
MedStar Montgomery	4%					
Holy Cross	4%					
Source: HSCRC Experience Reports						

ED Throughput Opportunity Analysis Continued



Avoidable ED utilization and other volume drivers are small:

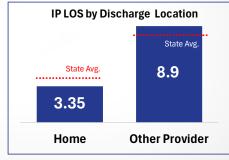
• MVP-PAU patients who don't need an acute care bed make up <u>less than 10%</u> of ED minutes





Excess IP LOS is concentrated for patients discharged to other providers:

- Nearly <u>2/3</u> are discharged home and LOS is <u>11% below</u> State average
- LOS for the 1/3 patients discharged to another provider is 3x the LOS discharged to home





WOMC struggles with excess LOS to SNFs in the region

• Driven by authorization delays & low managed care reimbursement capping available SNF beds



LOS Opportunity concentrated with SNF placements and Managed Care

Average LOS by Discharge Location & Payer

Above/(Below) State

Discharge to:	Medicare FFS	Medicare HMO	MD Medicaid HMO	MD Medicaid FFS	Commercial/ All Other	Self Pay	All Payer
SNF	7%	7%	51%	(4%)	(2%)	-	7%
Home Health	(12%)	6%	(15%)	(22%)	(17%)	(29%)	(10%)
Rehab	4%	(25%)	(29%)	(2%)	(9%)	-	(9%)
Home	(7%)	7%	(24%)	(22%)	2%	(17%)	(11%)







Continuous improvement through White Oak **Hospital Operations Throughput Committee**



Implement recommendations of independent consultant

Next Steps

Complete 8th Floor to add IP capacity (30 beds)

HSCRC Ask

Provide funding for implementation

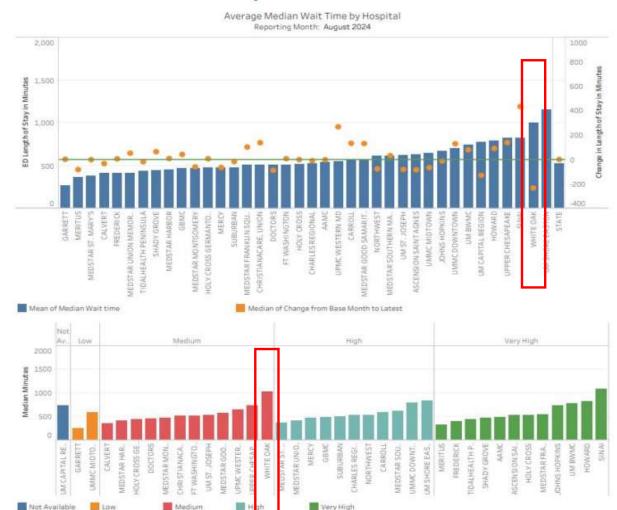


Partnership with State to address SNF and Managed Care post acute capacity

Appendix



ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric





EDDIE Update at September Commission Meeting

OP18b: ED Arrival to Discharge Time - Non-Psychiatric





WOMC Excellence and Honors

- Pathway to Excellence Designation® by the American Nurses Credentialing Center
- "A" Hospital Safety Group from The Leapfrog Group (Fall 2023 & Spring 2024)
- 3-Star Rating from The Society of Thoracic Surgeons
- Blue Cross Blue Shield Blue Distinction for Maternity Care
- Designation by CMS as a Birthing-Friendly Hospital
- 3-Star Hospital Rating from CMS
- American Heart Association/American Stroke Association's 2024 Get With the Guidelines-Stroke GOLD PLUS quality achievement award with Target: Stroke Elite Honor Roll and Target: Type 2 Diabetes Honor Roll recognitions
- American Heart Association/American Stroke Association's 2024 Get With The Guidelines—Coronary Artery Disease NSTEMI Gold with Target: Type 2 Diabetes recognition



Adventist HealthCare, Inc.

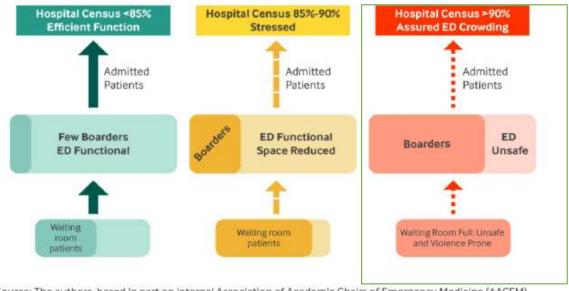
- A mission driven organization that provides health care to more than 1 million residents in Maryland and the District of Columbia
- An integrated health care delivery system providing a full continuum of care through an integrated team of physicians and care centers that include:
 - Three acute care hospitals
 - A rehabilitation hospital
 - Behavioral health services.
 - Two cancer centers
 - · Primary care and specialty physicians
 - Free standing emergency center
 - Imaging and outpatient centers
 - Extensive home health services
 - · Top-ranked cardiac surgery program





Impact of Boarding Admitted Patients on Emergency Department Function

When census is <85%, hospitals typically can function efficiently (green). Hospitals become stressed as census increases beyond 85% and admissions from the ED begin to accumulate from prolonged boarding (yellow) filling the ED to capacity. Most hospitals cannot overcome inefficiencies when hospital census is above 90% (red). The ED becomes overwhelmed and backed up, filling the waiting room and delaying care for those patients leading to increased risk of patient harm.



Source: The authors, based in part on internal Association of Academic Chairs of Emergency Medicine (AACEM) members' data, and informed by Forster AJ, Stiell I, Wells G, Lee AJ, van Walraven C. The effect of hospital occupancy on emergency department length of stay and patient disposition, Acad Emerg Med. 2003;10(2):127-133. https://onlinelibrary.wiley.com/doi/epdf/10.1197/aemj.10.2.127.



CY 2022

On ED diversion **70%** of the time, only able to accept 4% of Montgomery Count ambulances vs. 12% at Takoma Park



CY 2023

Increased ED diversion by +7 percentage points from 70% in CY22 to 77% in CY23. Still only able to accept 5% of Montgomery Count ambulances

17 ED holds (boarders) per day, 60 instances of 25+ patients holding



ED Holds

Reduced ED Holds by -65% down to 6 ED holds (boarders) as of midnight census in CY2023, 47 instances of 25+ patients holding during the day

9.75 hours



Hours From Bed Assignment to an Inpatient Bed

Reduced average hours from bed assignment to an inpatient bed by -19%, down to **7.93** hours in 2023

15 hours due to this med/surg bed capacity shortfall



ED Wait Time

Average ED wait time increase +20% since CY22 to 18 hours (15 hours in 2022) due to increased volumes.

Admissions increased +4.5% in 2023 vs. 2022 but patient days decreased -2.7%. IP LOS improved +6%, ED visits increased +2%.



WOMC Hospital Throughput Committee (HTC)

White Oak Medical Center's Throughput Committee, established in March 2021, is an interdisciplinary team dedicated to optimizing patient flow from admission to discharge. Meeting monthly, the committee focuses on reducing delays, enhancing care quality, shortening wait times, and expanding the hospital's capacity.

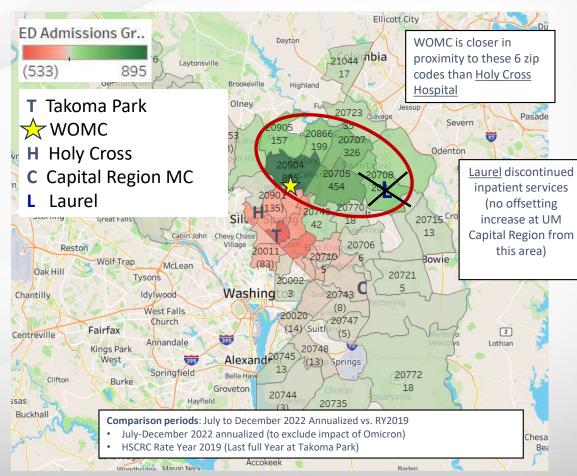
Key Functions

- 1. Performance Indicators: Develop and track key performance indicators (KPIs) for patient throughput
- **2. Monitoring Patient Flow:** Analyze patient flow data to identify and address bottlenecks in admissions, diagnostics, surgery, and discharge processes.
- **3.** Process Improvement: Implement strategies to streamline operations, such as revising bed management policies, enhancing interdepartmental communication, and optimizing scheduling.

The committee includes representatives from nursing, administration, emergency services, surgery, and case management

ED Admissions from Laurel have more than tripled WOMC market share

- Shift of Laurel patients driving increased ED volumes: 8.5% increase in ECMADs admitted through the ED resulting in an incremental ADC of 31 (as compared to the last full year on the Takoma Park campus)
- ED Admissions are <u>not a use-rate-per-capita</u> increase:
 - Result of shift in care patterns and ambulance traffic from 6-zip code Laurel region
 - CY2022 ED admissions per 1,000 were 5% below CY2018 levels from 6-zip code Laurel region
 - Equates to 10,000 fewer ED visits (37% reduction) and 2,700 fewer ED admissions (55% reduction) between Holy Cross Hospital and UM Capital Region Health



Maryland Medicare Beneficiary Enrollment Trends – 2019 vs. 2023

			Beneficiary Population % by	2019 v 2023 Beneficiary	Weighted Impact on Statewide 8%
County	CY2019	CY 2023	County 2023	Growth Rate	Population Growth
Montgomery	166,612	184,482	16%	11%	21%
Prince George's	131,717	143,972	13%	9%	14%
Anne Arundel	94,823	103,415	9%	9%	10%
Baltimore	160,648	168,810	15%	5%	9%
Howard	47,796	54,111	5%	13%	8%
Frederick	42,080	48,439	4%	15%	8%
Harford	47,825	52,873	5%	11%	6%
Charles	23,687	26,939	2%	14%	4%
Carroll	32,968	35,718	3%	8%	3%
St. Mary's	16,597	18,569	2%	12%	2%
Calvert	15,969	17,788	2%	11%	2%
Queen Anne's	10,256	11,949	1%	17%	2%
Cecil	19,152	20,846	2%	9%	2%
Washington	31,204	32,988	3%	6%	2%
Worcester	14,898	16,311	1%	9%	2%
Wicomico	19,800	21,298	2%	8%	2%
Talbot	11,270	11,904	1%	6%	1%
Dorchester	8,098	8,692	1%	7%	1%
Garrett	7,169	7,619	1%	6%	1%
Caroline	6,583	7,040	1%	7%	1%
Kent	5,608	6,100	1%	9%	1%
Somerset	5,138	5,385	0%	5%	0%
Allegany	16,989	16,952	2%	0%	0%
Baltimore City	100,064	100,274	9%	0%	0%
Total	1,036,951	1,122,474	100%	8%	



TCOC Model Year 5 Performance – Met/Exceeded All Targets

Performance Measures	2023 Targets	2023 Results	Met
Annual Medicare TCOC Savings	\$300M in annual Maryland Medicare TCOC per Beneficiary of savings for MY5 (2023)	\$509.1 million	√
TCOC Guardrail Test	Cannot exceed growth in National Medicare TCOC per beneficiary by more than 1% per year and cannot exceed the National Medicare TCOC per beneficiary by any amount for 2+ consecutive years	1.9 percentage points below the National growth rate in 2023	✓
All-Payer Revenue Limit	All-payer growth ≤ 3.58% per capita	2.70% per capita \$1.71 billion below the maximum revenue amount(√
Improvement in All- Payer Potentially Preventable Conditions	Improve upon the CY 2018 PPC rates for 14 Potentially Preventable Conditions (PPCs) that comprise Maryland's Hospital Acquired Condition program (MHAC)	0.36 percentage point reduction in the All-Payer PPC rate compared to CY 2018	✓
Readmissions Reductions for Medicare	Maryland's risk-adjusted Hospital Wide Readmission rate for Medicare FFS beneficiaries at regulated hospitals ≤ the National Readmission Rate for Medicare FFS beneficiaries*	0.97 (below the national rate of 1.00)	√
Hospital Population Based Payment	≥ 95% of all Regulated Revenue for Maryland residents paid according to a Population-Based Payment methodology	97.9% of Hospital Regulated Revenue is under Global Budgets	✓

^{*} Starting with 2023, Maryland is accountable for readmissions on a risk-adjusted basis. Prior to 2023, the State was held accountable for readmissions based on the Medicare 30-day unadjusted all-cause, all-site readmission rate at regulated hospitals. CMS agreed to change this measure due to increases in patient acuity in Maryland's hospitals (relative to the nation), which is an expected effect of GBRs.





August 08, 2024

Jon Kromm Executive Director, HSCRC 4160 Patterson Avenue Baltimore, Maryland 21215

Re: Maryland's Performance on the Total Cost of Care Requirements, CY 2023

Dear Dr. Kromm:

Centers for Medicare & Medicaid Services (CMS) has reviewed the State's performance on the annual requirements specified in sections 6 and 8 of the Maryland Total Cost of Care (TCOC) Model (the Model) State Agreement (the Agreement) and determined that the State has met all six annual requirements for calendar year (CY) 2023 (Model Year 5): the All-Payer Revenue Limit performance requirement, the Annual Medicare Savings requirement, the TCOC Guardrail requirement, the Readmissions Reductions for Medicare Requirement, the All-Payer Quality Improvement Reductions in Potentially Preventable Conditions performance requirement, and the Hospital Revenue Population-Based Payment performance.

In response to the state of Maryland's 2022 Diabetes Outcomes Based Credit memo, CMS agrees that the BMI outcome measure may be substituted for performance on the 2022 diabetes outcomes-based credit.

Maryland's Performance on the Annual Requirements specified in the Model Agreement

1. Annual Medicare Savings (Section 6.c).1

The State is required to produce annual savings in the Maryland Medicare TCOC per Beneficiary of \$300 million for CY 2023. In accordance with the Methodology defined in Section 6.b and Appendix C of the State Agreement, CMS has calculated the annual Medicare TCOC savings per Maryland Medicare Beneficiary to be \$509.1 million for CY 2023, inclusive of an effective Medicare Part B expenditure reduction via a Maryland Primary Care Program (MDPCP) Care Management Fee (CMF) non-claims based payment (NCBP) offset resulting from performance on the CY 2022 diabetes outcomes-based credit. CMS verifies Maryland has met this requirement of the Model for CY 2023.

CMS received and reviewed the state of Maryland's 2022 Diabetes Outcomes Based Credit memo, dated March 6, 2024, requesting that, due to changes in the Behavioral Risk Factor Surveillance System (BRFSS) survey, the diabetes outcomes-based credit.² be granted for 2022 on the basis of the complementary Body

¹ Additional Non-Claims Based Payments were identified and included in the calculation of the Annual Medicare Savings Requirement in accordance with section 2.b.ii of the MD TCOC State Agreement.

² The test prevalence metric derives from the Behavioral Risk Factor Surveillance System (BRFSS) survey from the Centers for Disease Control (CDC) and compares prevalence in the current year to a 2017 baseline as agreed by CMS and the State using self-report question 'PDIABTST' in the 2017 survey form. However, the survey form language was subsequently changed from 'PDIABTST' to a new version 'PDIABTS1' which is reflected in the 2022 response data.

Mass Index (BMI) measure per consensus methodology³ agreed upon between CMS and the State. After consulting with subject matter experts from the CDC, CMS concurs with the State's assessment that this change in survey question language renders it infeasible to compare diabetes testing prevalence in 2022 to that in 2017. As a result, CMS agrees that the BMI outcome measure may be substituted for performance on the CY 2022 diabetes outcomes-based credit, yielding a credit amount of \$4,726,091 against MDPCP CMF NCBP Medicare Part B expenditure for CY 2023.

2. TCOC Guardrail (Section 6.e)

The State must not exceed the National Medicare TCOC per beneficiary spending growth by more than one percent for any given Model Year and must not exceed the National Medicare TCOC per beneficiary spending growth by any amount for two or more consecutive Model Years. The State's TCOC per beneficiary growth rate was 0.9 percentage points above the National growth rate in CY 2022 and was 1.9 percentage points below the National growth rate in CY 2023. CMS verifies Maryland has met this requirement of the Model for CY 2023.

3. All-Payer Revenue Limit (Section 6.f)

Maryland's all-payer regulated gross patient service revenue must be less than or equal to the maximum revenue that Regulated Maryland Hospitals may earn in that Model Year from All Payers. In accordance with the Methodology defined in Appendix B.II of the State Agreement, CMS has calculated the State's all-payer regulated gross patient service revenue for CY 2023 to be \$1.43 billion below the maximum revenue amount; therefore, CMS verifies Maryland has met this requirement of the Model or CY 2023.

4. <u>All-Payer Quality Improvement Reductions in Potentially Preventable Conditions under the Maryland Hospital Acquired Condition Program (Section 8.d.1-3)</u>

The State must maintain improvements seen under the All-Payer Model by not exceeding the CY 2018 PPC rates for 14 Potentially Preventable Conditions (PPCs) that comprise Maryland's Hospital Acquired Condition Program in a given Model Year. The HSCRC reported that All-Payer PPC performance for CY 2023 yielded a 0.36 percentage point reduction in the All-Payer PPC rate compared with CY 2018. Based on the State's report, CMS considers this requirement of the Model met for CY 2023.

5. Readmissions Reductions for Medicare (Section 8.d. 1-3)

The State must maintain the improvements achieved under the All-Payer Model on the aggregate CMS Medicare Hybrid Hospital Wide Readmissions (HWR) risk-adjusted measure.⁴ for Medicare FFS beneficiaries such that regulated Maryland Hospitals have achieved equal to or less than the National Readmission Rate for Medicare FFS beneficiaries at the end of CY 2023. This represents an adjusted methodology compared to CY 2022 when the State was held accountable for readmissions under the 30-day unadjusted all-cause, all-site hospital readmission rate. Moving forward into CY 2024 and beyond, the State will continue to be held accountable for readmissions on the basis of hybrid HWR, accounting for risk adjustment of the beneficiary population compared to the National. CMS has reviewed the

³ The "Maryland Diabetes Incidence Outcome-Based Credit Methodology", which was agreed upon January 17, 2019, and updated May 2, 2019, and dictates that "the State will evaluate performance under the complementary outcome during a given year of the intervention period if the diabetes outcome estimation indicates no improvement in Maryland, but diabetes test prevalence in Maryland in that year increases by more than two points over the 2017 value" (p.47).

⁴ https://www.cms.gov/files/document/hybrid-hospital-wide-readmission-measure-electronic-health-record-extracted-risk-factors.pdf-0

State's calculation and concludes that the State's CY 2023 Standardized Readmission Rate of 0.9671 is below the National CY 2023 Standardized Readmission Rate of 1.00; therefore, CMS verifies Maryland has met this requirement of the Model for CY 2023.

6. Hospital Revenue Population Based Payment (Section 8.a.)

The State is required to facilitate the movement of Regulated Revenue⁵ for Maryland residents into Population-Based Payment⁶. Section 8.a.ii requires that at least 95 percent of all Regulated Revenue for Maryland residents is paid according to a Population-Based Payment methodology. CMS has determined that all Regulated Revenues under Maryland's 'Rate Setting System' meet the definition of Population-Based Payment. The HSCRC has reported 97.90 percent of Regulated Revenues for CY 2023 meet this standard. Based on the State's report, CMS considers this requirement of the Model met for CY 2023.

In summary, CMS has determined that the State has met or exceeded the annual requirements of the Model across all six requirements for the fifth year of the Model. CMS appreciates the State's commitment to and continued success in achieving the annual performance requirements of the Model and looks forward to our continued partnership.

Sincerely,

Amanda Johnson
Acting Director
State and Population Health Group
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services

⁵ The full subset of revenue charged by Regulated Maryland Hospitals for which the State has the legal authority to set payment rates.

⁶ Population-Based Payment is defined to mean hospital payment that either (1) is directly population-based, such as prospectively tying hospitals' reimbursement to the projected utilization of services by a specific population or subpopulation of Maryland residents, or (2) establishes a fixed budget for Regulated Maryland Hospitals for services projected to be furnished.



September 6, 2024

Jon Kromm Executive Director, HSCRC 4160 Patterson Avenue Baltimore, Maryland 21215

Re: Update to Maryland's All-Payer Regulated Gross Patient Service Revenue, CY 2023

Dear Dr. Kromm:

On August 9, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a letter to HSCRC (subject: "Maryland's Performance on the Total Cost of Care Requirements, CY 2023") affirming that the State has met all six annual requirements specified in sections 6 and 8 of the Maryland Total Cost of Care Model (the Model) State Agreement (the Agreement) for calendar year (CY) 2023 (Model Year 5). This memo serves to notify HSCRC that the calculation of the State's all-payer regulated gross patient service revenue for CY 2023, estimated at \$1.43 billion below the All-Payer Revenue Limit in the aforementioned letter, has been revised to an increased savings estimate of \$1.71 billion below the maximum revenue amount. With this revised all-payer revenue growth and savings estimate, Maryland continues to meet the All-Payer Revenue Limit requirement specified in section 6 of the Agreement.

This update was made in accordance with the Methodology defined in Appendix B.II of the Agreement and incorporates new findings from the Maryland Department of Planning in conjunction with the 2020 census revising the Maryland population estimate for 2020 by an increase of about 2%, as noted in an HSCRC memo on April 3, 2024 (subject: "Report of the All-Payer Revenue Limit for Model Year 5 of the TCOC Model State Agreement").

In summary, CMS has determined that the State has met or exceeded the annual requirements of the Model across all six requirements for the fifth year of the Model and has revised the estimate of the State's all-payer regulated gross patient service revenue for CY 2023 to be \$1.71 billion below the maximum revenue amount.

Sincerely,

Amanda Johnson
Acting Director
State and Population Health Group
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services



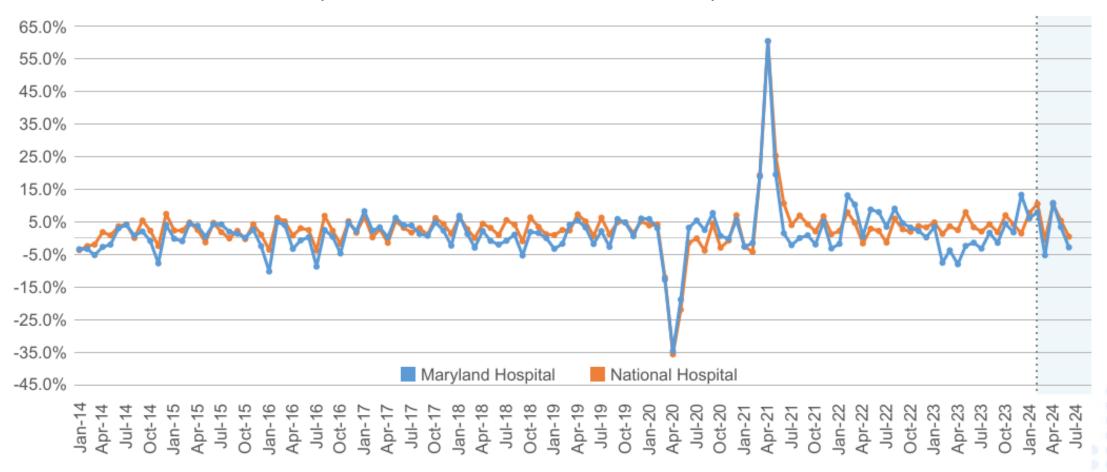
Update on Medicare FFS Data & Analysis October 2024 Update

Data through June 2024, Claims paid through August 2024

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

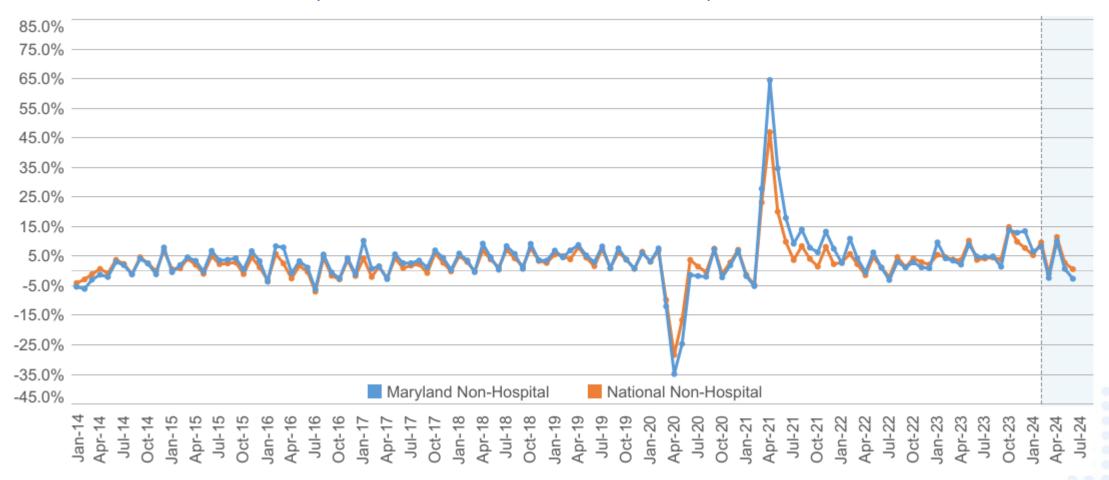
Medicare Hospital Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)

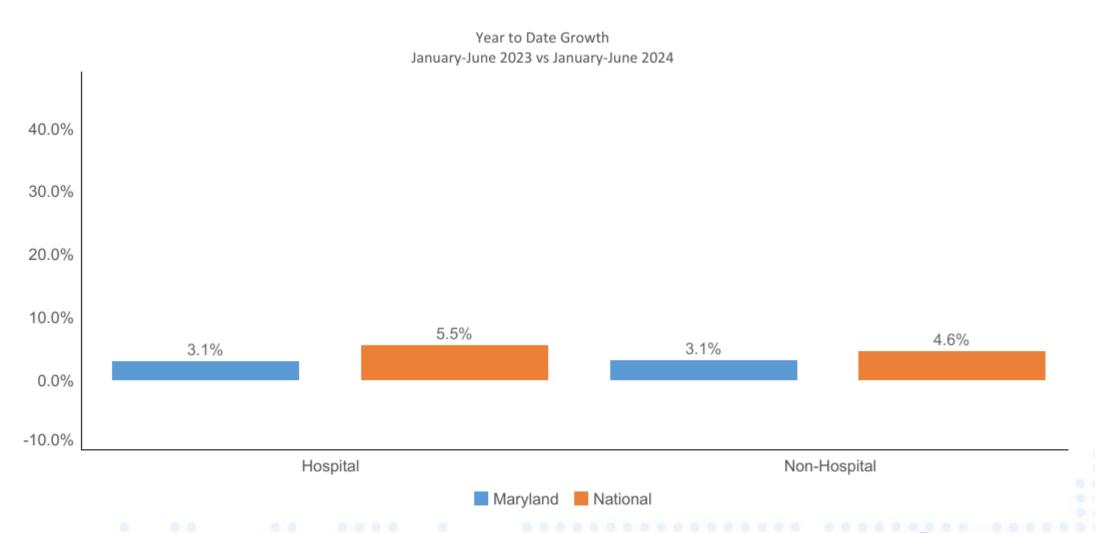


Medicare Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)

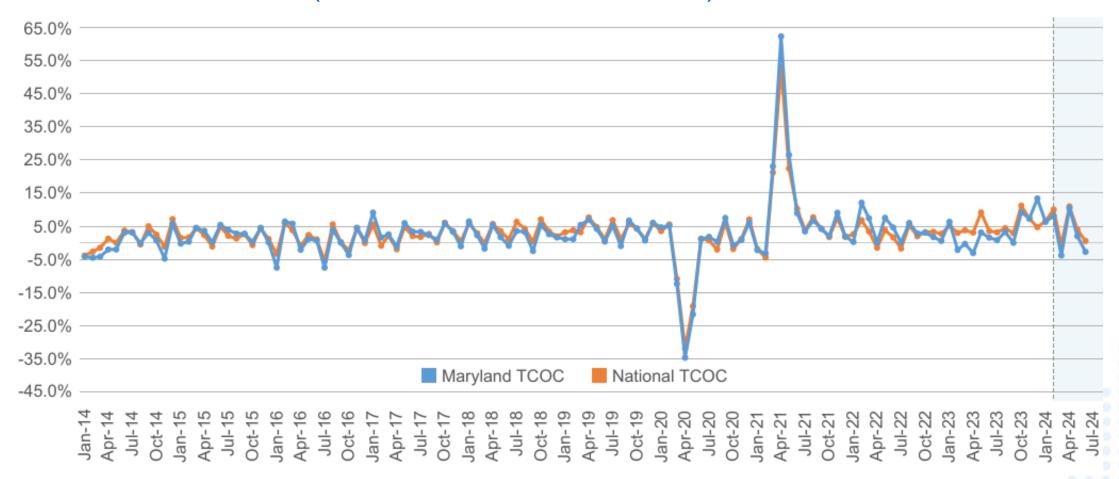


Medicare Hospital and Non-Hospital Payments per Capita

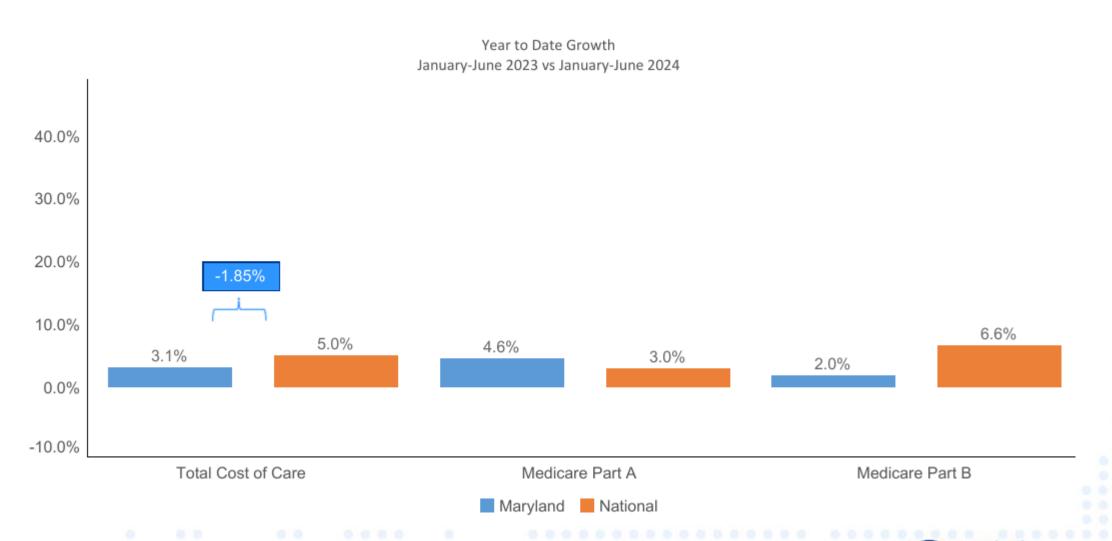


Medicare Total Cost of Care Spending per Capita

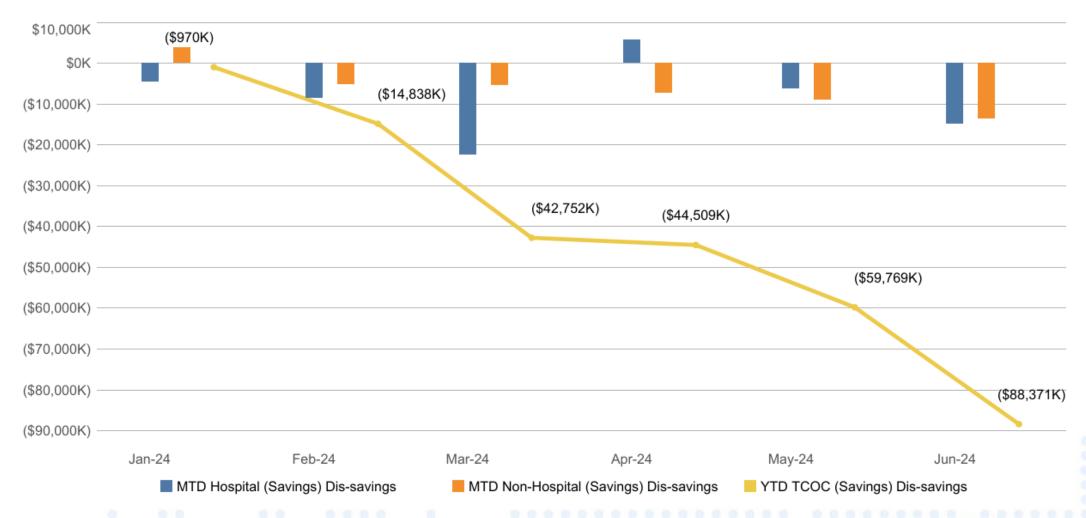
Actual Growth Trend (CY month vs. Prior CY month)



Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth CYTD through June 2024





Final Staff Recommendation

HSCRC Confidential Patient Level Data Request from

Johns Hopkins University Bloomberg School of Public Health for
the AIDS Linked to the Intravenous Experience (ALIVE) Study.

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, MD 21215

This is a final recommendation for Commission consideration at the October 9, 2024, Public Commission Meeting.



Johns Hopkins University, Bloomberg School of Public Health, requests access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient) and Hospital Outpatient Data Sets (Outpatient) collected by the Health Services Cost Review Commission (HSCRC) to obtain information on clinical encounters, procedures, diagnoses, outcomes, and healthcare costs of participants in the AIDS Linked to the Intravenous Experience (ALIVE) Study. This ongoing observational cohort study focuses on adults from the Baltimore area with a history of injection drug use.

Background

The objective of this study is to ascertain clinical encounters, procedures, diagnoses, outcomes, and healthcare costs of participants in the AIDS Linked to the Intravenous Experience (ALIVE) Study, an ongoing observational cohort study of the health of adults from the Baltimore area who have a history of injection drug use. All ALIVE participants provided informed consent, allowing the investigators access to their medical records (including claims covered under 42 CFR Part 2). The Investigators are using HSCRC data to study health outcomes and healthcare utilization in this population, particularly, the characterization of the incidence and risk factors for blood borne infections, the natural history of injection drug use, the natural and treated course of HIV infection, and the impact of coinfection and comorbidities in the setting of HIV.

The information obtained from the study will provide important public health insights by providing clinical outcomes for risk predictions, conducting cost-benefit analysis, and guiding public health and clinical interventions. Johns Hopkins University Bloomberg School of Public Health received approval from the Maryland Department of Health (MDH) Institutional Review Board (IRB) on January 18, 2024, and the MDH Strategic Data Initiative (SDI) office on July 8, 2024. The Data will be retained by JHU for the duration of the project. Once the project is completed, the Data will be destroyed, and a certification of Destruction will be submitted to the HSCRC.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee included representatives from the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements listed below and to assist HSCRC staff in making recommendations for approval to the Commission at its monthly public meeting:

- 1. The proposed study or research is in the public interest;
- 2. The study or research design is sound from a technical perspective;
- 3. The organization is credible;
- 4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
- 5. The organization has adequate data security procedures in place to ensure protection of patient confidentiality.

The Review Committee voted unanimously to give Johns Hopkins University, Bloomberg School of Public Health, access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.



STAFF RECOMMENDATION

- 1. HSCRC staff recommends that the request by Johns Hopkins University Bloomberg School of Public Health for the Data for Calendar Year 2014-2024 be approved.
- 2. This access will include limited confidential information for subjects meeting the criteria for the research.

BCORE Program Introduction

- Proposal for HSCRC to become "outcomes buyer" for BCORE participation in ARAPA-H HEROES program
- BCORE representatives in attendance to describe ARPA-H program and BCORE capabilities.
- BCORE to submit application to ARPA-H in early November
- BCORE has received funding commitment from Baltimore City
- Staff looking for input on draft recommendation to support including a letter of intent from HSCRC to BCORE for the application





APRA-H HEROES Opportunity

ARPA-H: \$15M funding



For grantees:

- \$2M guaranteed
- \$13M at risk, pay for performance

\$30M funding match



Grantees asked to engage additional "outcome buyers" to pay for performance

\$10M committed by the City of Baltimore

HEROES Performance Metric

 10% reduction in EMS encounters for fatal and nonfatal OD compared to the national average



A Broad Coalition is Ready to Help

A multidisciplinary collaborative leveraging broad expertise and established operational infrastructure will implement a comprehensive scope of services — building upon the foundation of overdose response in BALTIMORE

We will implement evidence-based interventions including medication for opioid use disorder (MOUD), with innovation focused on service delivery models and connection across the health system

We will establish an integrated system of harm reduction, treatment, prevention, and crisis response We will aim to be accessible to all in need, but target those at highest risk of overdose and high-need neighborhoods



KEY CONTRIBUTORS

University of Maryland, Baltimore
University of Maryland, Baltimore County
Johns Hopkins Medicine

University of Maryland Medical System

Baltimore City Fire Department

Maryland Institute for Emergency Medical Services Systems

MedStar Health

Charm City Care Connection

Behavioral Health System Baltimore

Baltimore City Health Department

Baltimore VA Medical Center

People Encouraging People

Ascension St. Agnes Mobile Health Clinic

Health Care for the Homeless

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Eric Weintraub, MD

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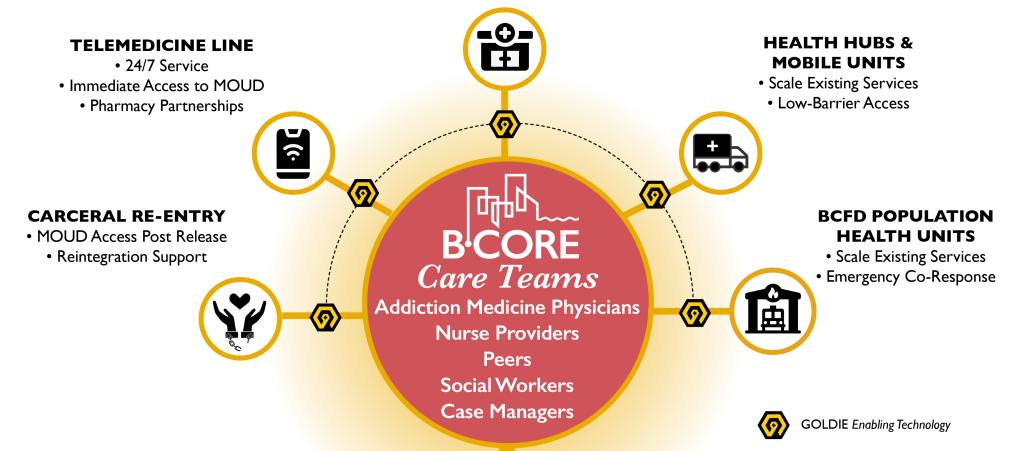
Lucy Wilson, MD, ScM

Professor & Graduate Program Director Senior Advisor to the University for Public Health and Pandemic Response Department of Emergency and Disaster Health Systems University of Maryland, Baltimore County



EMERGENCY DEPARTMENTS

- Bias Reduction
- Standardized Protocols



INTEGRATION WITH OTHER CARE AND SERVICE PROVIDERS

Primary Care Physicians • Mental Health Services • Social Services • Employment Services



Goldie: A Patient Management Tool

Goldie is built to engage patients with opioid use disorder and facilitate the work of multidisciplinary care teams, including in non-traditional care settings.



CORE BENEFITS

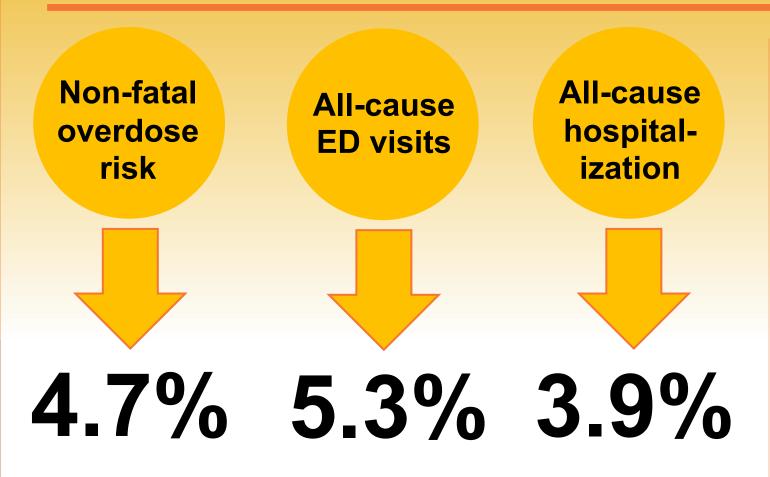
Engage more patients in treatment and recovery

Easier and more complete reporting and analytics

Performance benchmarking to identify and adopt best practices



Benefits of Monthly Buprenorphine



MD DORM Report 2022:

Only 13.7 percent of individuals who experienced their first NFOD in Maryland between July 2016 and December 2021 received a prescription for buprenorphine in the year following the index NFOD

62.5% of individuals visited an ED in the year after their NFOD



BCORE's Daily Reach

Emergency Department:

10 patients post NFOD

BCFD Population Health:

7 patients post NFOD

Mobile Health:

• 4 patients per mobile unit Telemedicine Line:

16 patients





Recommendation

- HSCRC agrees to become an "outcomes buyer" and makes payments to BCORE based on an agreed upon outcome measure.
 - Contingent upon acceptance of BCORE's application by ARPA-H
 - Measure will be based on healthcare spending by Baltimore City residents directly or indirectly related to an ED visit with an opioid-related diagnosis. Staff to work with BCORE to finalize measurement.
 - Payment set at 30% of valued savings.
 - Payment capped at \$15 M over 3 years (likely starting in FY2026)
- Final recommendation scheduled for December. Public comment due by October 23, 2024.



Baltimore Comprehensive Overdose Response to End the Epidemic **Outcome Buyer**

Draft Recommendation

October 9, 2024

This is a draft recommendation for consideration by the Commission. Public comments must be received by October 23, 2024, to william.henderson@maryland.gov



Table of Contents

List of Abbreviations	1
Policy Overview	2
Summary of the Recommendation	2
Background	3
ARPA-H HEROES	3
BCORE	3
Alignment with HSCRC goals	3
Funding Approach	4
Staff Recommendation	4
Appendix A: Description of BCORE	5
About BCORE	5
Overview of the Program	5
Innovation, Team Composition, and Mitigating Technical Risk	6
References	7



List of Abbreviations

AHEAD States Advancing All-Payer Health Equity Approaches and Development model

BCORE Baltimore Comprehensive Overdose Response to End the Epidemic

CMS Centers for Medicare & Medicaid Services

ARPA-H Advanced Research Projects Agency for Health

HEROES Health Care Rewards to Achieve Outcomes

HSCRC Health Services Cost Review Commission



Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consum	Effect on Health Equity
			ers	
To fund an innovative, comprehensive approach to opioid treatment in Baltimore City while leveraging available Federal funding.	Commit to providing funding based on outcomes achieved so BCORE, a partnership focused on opioid treatment, can participate in a Federally funded health care program that focuses on improving health.	Hospitals benefit from reduced emergency department and inpatient utilization through improved community treatment of opioid use disorder.	Payers and consumers benefit from improved health outcomes and reduced costs for those with opioid use disorder.	BCORE's focus on opioid use disorder in Baltimore City is consistent with a strategy that prioritizes reducing health disparities.

Summary of the Recommendation

Staff recommend the Health Services Cost Review Commission (HSCRC) commit to providing up to \$15 million of funding over 3 years as an outcome buyer for the Baltimore Comprehensive Overdose Response to End the Epidemic (BCORE) in support of BCORE's application under the Advanced Research Projects Agency for Health's (ARPA-H) Health Care Rewards to Achieve Outcomes (HEROES) program. The provision of any funding by the HSCRC is contingent upon BCORE being selected for participation in the HEROES program.

Assuming BCORE is selected, the initiative will invest in evidence-based interventions including medication for opioid use disorder, targeted naloxone distribution, and community-based peer recovery specialists with a focus on decreasing opioid overdose mortality in Baltimore City. As part of the HEROES program BCORE, the "Health Accelerator" is required to identify "Outcome Buyers" who will agree to provide additional funding based on BCORE's success in addressing their targeted issue and an agreed upon outcome metric. Payments are proposed to be set at 30% of the value measured. If this recommendation is adopted the HSCRC will be committed to acting as an outcome buyer for the program.

BCORE and the HSCRC have preliminarily agreed on a metric centered on reducing costs directly and indirectly related to emergency room visits for opioid use disorder for residents of Baltimore City. HSCRC Staff will continue to work with BCORE to refine the outcome metric and will periodically report to the Commission with updates.



Background

BCORE is applying to participate in ARPA-H's HEROES program. The application is due in November 2024.

ARPA-H HEROES

ARPA-H HEROES is a three-year program that aims to demonstrate that novel outcome-based incentives can dramatically improve health outcomes by accomplishing the following three goals: 1) improve healthcare in large, geographically defined populations through implementation of novel technologies and strategies; 2) track changes in quantifiable outcomes metrics in near real-time; and 3) develop economic incentives that reward improvements via a sustainable, scalable economic model. Leveraging a conceptual framework of outcomes-based financing, the HEROES program will provide payments to organizations based on activities that aim to improve health outcomes. These incentives, or outcome payments, will depend on HEROES program Performers achieving transparent and measurable pre-determined outcomes that will have major impacts on health.

BCORE

BCORE is a unique collection of clinical experts, community program leaders, EMS personnel, data scientists, and public health specialists who will leverage broad expertise and existing operational infrastructure to implement a comprehensive interconnected scope of services in Baltimore City focused on decreasing opioid overdose mortality.

A description provided by BCORE of their activities, goals and evidence base is attached as Appendix A to this recommendation.

Alignment with HSCRC goals

Reducing overdose mortality is one of the goals under the population health programs of the Total Cost of Care Model. Further, the State anticipates opioid use disorder and overdose mortality will continue to be a priority area under Centers for Medicare & Medicaid Services' (CMS) States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model which is anticipated to be the next phase of the Total Cost of Care Model. The focus on Baltimore City and on opioid use disorder is consistent with the AHEAD model's prioritization of reducing disparities in health outcomes.

BCORE's focus on treating patients in the community to avert future acute crises that are costly both in personal and dollar terms is also consistent with the general goals of the HSCRC's global budget model which seeks to move dollars from reactive, expensive acute care and into prevention.



Based on these factors Staff believe the BCORE program is highly aligned with the HSCRC's goals and serves the interests of payers and providers by bringing specialized resources to bear on a critical issue.

Funding Approach

Under the HEROES program the Outcome Buyer (HSCRC) and the Health Accelerator (BCORE) must agree on an outcome measure which is used to evaluate progress and set funding. HSCRC is proposing to fund the program at 30% of the measured outcome.

Based on preliminary discussions HSCRC Staff and BCORE have agreed to use the cost of emergency department (ED) visits and subsequent care for opioid use disorder in Baltimore City as the outcome measure. Staff and BCORE will continue to work together to refine that measure and will share periodic updates with the Commission.

Initial data shows that Baltimore City residents had approximately 12,500 relevant visits in 2023 with a total direct cost of ~\$100 million. A methodology for identifying follow-up costs is still being developed but any definition will add considerably to this amount. BCORE hopes to reduce ED costs by about 10% and related inpatient costs by about 2%, this level of achievement would generate approximately \$6.0 M of savings and an HSCRC funding liability of \$1.8 M (30%) on the direct visit costs. However, these estimates are still being refined, once follow-on costs are included these potential savings will increase.

Staff recommend capping payments under this program at \$15 million over 3 years in order to provide some cost certainty to the HSCRC. Payments will be made using a method established by Staff. Staff anticipate that any payments will commence during Fiscal Year 2026 and go through Fiscal Year 2028.

Staff Recommendation

Staff recommend the Health Services Cost Review Commission (HSCRC) commit to providing up to \$15 million of funding over 3 years as an outcome buyer for the Baltimore Comprehensive Overdose Response to End the Epidemic (BCORE) in support of BCORE's application under the Advanced Research Projects Agency for Health's (ARPA-H) Health Care Rewards to Achieve Outcomes (HEROES) program. Staff anticipate any funding due will be paid from FY2026 to FY2028. The provision of any funding by the HSCRC is contingent upon BCORE being selected for participation in the HEROES program.



Appendix A: Description of BCORE

About BCORE

The city-wide, multi-disciplinary collaborative, <u>Baltimore Comprehensive Overdose Response to End the Epidemic (BCORE)</u> is a unique collection of clinical experts, community program leaders, EMS personnel, data scientists, and public health specialists who will leverage broad expertise and existing operational infrastructure to implement a comprehensive interconnected scope of services in Baltimore City focused on decreasing opioid overdose mortality.

Overview of the Program

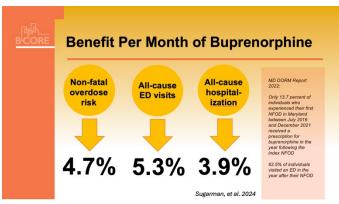
BCORE will invest in evidence-based interventions including medication for opioid use disorder (MOUD), targeted naloxone distribution, and community-based peer recovery specialists (PRS). These resources will be coupled with innovative service delivery models and new linkages across the system of care. Specifically, BCORE will provide access to a spectrum of services including evidence-based treatments, harm reduction, tailored crisis response, and support for social determinants of health (SDoH). The lifesaving services proposed in this intervention, while accessible to all, will be targeted to those in neighborhoods and settings with the highest overdose rates. Major components of the BCORE proposal are centered around the evidence-based recommendations of the National Institute of Health's (NIH) Opioid-Overdose Reduction Continuum of Care Approach (ORCCA),¹ and will be developed and implemented to build on the strengths and fill the gaps of the Baltimore ecosystem.

BCORE's solution components include:

- Expanded MOUD access to at-risk populations (e.g., OUD hotspots, justice-involved individuals, multi-visit emergency department patients)
- Community Connection Teams that will provide intensive personalized support
- Strategically located Health Hubs, in partnership with community-based organizations, that will anchor multifaceted treatment and harm reduction services in high-needs neighborhoods
- Tailored crisis response, in partnership with the Baltimore City Fire Department, that facilitates connection to services
- Bolstered support for existing programs addressing social determinants of health (SDoH)
- A unified community health-enabling software platform and technology infrastructure enabling (i) precision medicine and (ii) and care connections across the health care and social service continuums



A major focus of BCORE's work will be a systematic expansion of access points to increase engagement and retention in MOUD, which has been demonstrated to reduce overdose deaths by up to 80%.^{2,3} Recent analyses have shown that only 40% of Marylanders who would benefit from MOUD accessed treatment,⁴ and only 14% of individuals experiencing a non-fatal overdose received a buprenorphine prescription. In a



recent Maryland study, Sugarman and colleagues demonstrated the positive effect of buprenorphine on OUD; with each additional month of buprenorphine treatment after a nonfatal overdose the risk of subsequent overdose, all-case ED visits, and all-cause hospitalizations was reduced by 4.7%, 5.3% and 3.9%, respectively.⁵ Additionally, health care costs decreased with each subsequent

month of MOUD adherence.

The potential benefit of MOUD expansion can only be fully realized if implemented within a system of integrated services tailored to address structural barriers including stigma, racism, transportation, and housing that disproportionately prevent people who use drugs from starting and continuing care.⁶⁻¹⁰ Peer recovery specialists (PRSs) and Programs of Assertive Community Treatment (PACT) models can enhance linkage and increase retention in care, decrease relapse, improve relationships with treatment providers, and provide social support to individuals outside of typical office-based settings and foster longitudinal relationships.¹¹⁻¹³

Anchored geographically in neighborhoods with high rates of overdose, BCORE will invest in multidisciplinary Community Connection Teams that will utilize real time data and a public-facing referral line to respond to engage clients. Integrating PACT team models with existing PRS teams, Community Connection Teams will use evidence-based, trauma-informed approaches to facilitate long term relationships in support of whole-person wellness. Community Connection Teams will partner with emergency services and hospitals to provide targeted, intensive follow-up after a non-fatal overdose. Community Connection Teams will engage clients in housing case management, insurance enrollment, and vital document retrieval. Lastly, Community Connection Teams will provide overdose education and naloxone distribution throughout the community.

Innovation, Team Composition, and Mitigating Technical Risk

The success of the B-CORE solution relies on several new, publicly accessible innovations, including the development of a city-wide MOUD telemedicine line, CCTs, integrated Health Hubs, and technical software/data solutions that connect the existing health system with these new publicly available health



resources. The approach is designed to serve the entire population through using a 'no wrong door' approach, where access can occur across the health system and community-based networks. The team comprises experts from the UMMS, UMB, JHU, UMBC, city and state government, and various nonprofit organizations, and was carefully developed to balance the need for comprehensive expertise with operational simplicity. Technical risk will be mitigated through rigorous testing and phased implementation. Use cases will focus on post non-fatal overdose response and MOUD care linkage, especially among high interest groups (e.g. older adults, people with high ED and hospital utilization). Data types including patient trajectories and system performance metrics will be developed to ensure effective monitoring and intervention.

References

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Hospital Community Benefit Reporting: Recommendation to Adopt Changes to Regulations

October 9, 2024

Promulgating Regulations- Key Steps

- Staff engage stakeholders (workgroup) Changes were reviewed in the Community Benefits Reporting Workgroup.
- Staff present proposed regulations to Commission July 10, 2024.
- The Commission votes to send the proposed regulations to Maryland Register for public comment
 July 10, 2024.
- Public comment period begins when the regulations are published (30 days) August 23, 2024
- Staff consider public comments and revise regulations if needed No public comments received.
- If substantive changes are made to the regulation, staff propose updated regulations, repeating the steps above *Not applicable*.
- Staff present final regulations to the Commission for adoption.
- Commissioners vote to adopt the final regulations.
- Notice of Final Action sent to Maryland Register; regulations are effective 10 days after publication.

Edits to COMAR 10.37.01.03

- M. Annual Nonprofit Hospital Community Benefit Report.
- (1) Beginning on December 15, 2009, each nonprofit hospital shall submit the Annual Nonprofit Hospital Community Benefit Report to the Commission by [December 15 of every calendar year] the date prescribed by the Commission in the format prescribed by the Commission.
- (2) Hospitals shall complete the report on the basis of actual data covering the reporting period of the previous July 1 through June 30 *or other time period as specified by the Commission*.
- (3) The Commission shall provide instructions for completing the report [in its "Accounting and Budget Manual for Fiscal and Operating Management"] on its public website.

Questions?

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Final Recommendation Revised Community Benefits Reporting Regulation

COMAR 10.37.01.03.M.

October 2024



Purpose: These amendments to existing regulations will provide the Commission with the flexibility for determining the appropriate due dates for hospitals to submit their annual reports on community benefit activities and will simplify access to the submission instructions for these reports. These amendments were published as proposed regulations in the Maryland Register on August 23, 2024. HSCRC did not receive any public comments during the public comment period, which closed on September 23, 2024. Commissioners will be asked to vote on adopting these amendments to the regulation as final during the Commission meeting on October 9, 2024.

Title 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§19-207, 19-215, and 19-303, Annotated Code of Maryland

Notice of Proposed Action

.03 Reporting Requirements; Hospitals.

- A L. (text unchanged).
- M. Annual Nonprofit Hospital Community Benefit Report.
- (1) Beginning on December 15, 2009, each nonprofit hospital shall submit the Annual Nonprofit Hospital Community Benefit Report to the Commission by [December 15 of every calendar year] *the date prescribed by the Commission* in the format prescribed by the Commission.
- (2) Hospitals shall complete the report on the basis of actual data covering the reporting period of the previous July 1 through June 30 or other time period as specified by the Commission.
- (3) The Commission shall provide instructions for completing the report [in its "Accounting and Budget Manual for Fiscal and Operating Management"] *on its public website*.
 - N U. (text unchanged).



Draft Recommendation for Deregulation, Repatriation, and Out-of-State Volume Policies

October 9 2024

Agenda

- Volume Policy Overview and Workgroup Timeline
- Methodology Overview
 - Deregulation
 - Repatriation
 - Out-of-State
- Implementation Considerations
- Volume Scorecard
- Draft Recommendations



Global Budget Volume Policy Background

- The HSCRC adjusts global budgets for anticipated changes in demographics/volume patterns and observed shifts in the market
- To that end, the Commission implements the following volume adjustments:

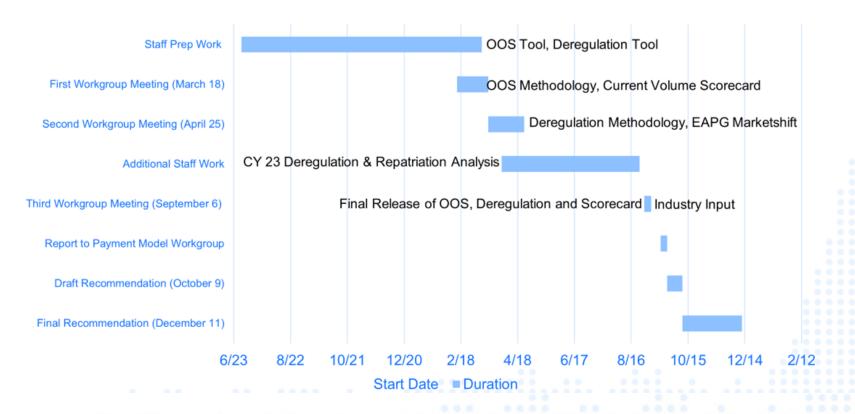
Volume Adjustment	Approved Policy	Stand Alone	Purpose	Comment
Demographic Adjustment	X		Annual age adjusted population funding for in-state use rate growth	
Marketshift	X		Semi-annual adjustments for regulated market shifts (zero sum)	
Out-of-State			Annual adjustments for material changes to out-of-state volumes	Due to WG will use ECMADS
Deregulation			As needed reductions for observed shifts to unregulated settings	Delayed due to WG concerns
Repatriation			As needed adjustments for cross state border hospital shifts	New methodology requested by WG
Complexity and Innovation	X	X	Prospective funding to Academic Medical Centers for growth in unique quaternary services	
CDS-A	X	X	Funding for changes in volume for select drugs (only volume variable methodology)	

Once the last remaining policies are established (with the Volume Scorecard), staff will reconsider with Commissioners any necessary modifications to volume policies.

• Ex: New service lines independent of population growth

maryland
health services*

Revised Timeline for CY 2024 Volume Workgroup



Due to data delays as well as requests for Repatriation and VCF Analyses, staff extended the timeline



New Volume Policies Overview Example

Status Quo

Hospital A - Growth Hospital			Hospital B - Declining Hospital				
Algebra	ltem	ECMADs	Algebra2	ltem2	ECMADs2		
Α	Base Period	6	Α	Base Period	10		
В	Performance Period	10	В	Performance Period	3		
C=B-A	Change	4	C=B-A	Change	-7		
D	Marketshift	2	D	Marketshift	-2		
E=C-D	Unrecognized	2	E=C-D	Unrecognized	-5		

Retained Revenue

Handled by Demographic Adjustment

New Policies

	Н	ospital A - Growth Hospit	al	Hospital B - Declining Hospital			
	Algebra	Item	ECMADs	Algebra2	Item2	ECMADs2	
	Α	Base Period	6	Α	Base Period	10	
	В	Performance Period	10	В	Performance Period	3	
	C=B-A	Change	4	C=B-A	Change	-7	
)							
/	D	Marketshift	2	D	Marketshift	-2	
	E=C-D	Unrecognized	2	E=C-D	Unrecognized	-5	
	F	Repatriation	1	F	Expatriation	-1	
	G=E-F	Unrecognized	1	G	Deregulation	-1	
	0 0 0 0	00000000000	00000	H=E-F-G	Unrecognized	-3	

Out-of-State
Volumes are
handled in a
stand alone
methodology



Deregulation Methodology



What is Deregulation?

Deregulation is the movement of a hospital service from a HSCRC regulated space to an unregulated space (most often outpatient services but also chronic and rehab).

- A service is presumed to be regulated if the building is on the campus of a hospital
- Criteria outlined in COMAR are considered for determination of unregulated services, which need to be approved by the Commission

Service movement can be initiated by three main actors: 1) payers, 2) the hospital itself, 3) and physician practices

- 1. Payer Initiative Example: A payer steers members to endoscopies at an Ambulatory Surgery Center.
- 2. Hospital Example: The hospital makes the decision to shift radiation therapy services to an unregulated setting.
- Physician Practices Example: A community physician makes the decision to no longer perform hand surgeries at the hospital. In this instance, the physicians made the decision outside of the hospital's control.



Deregulation Methodology

- Deregulation is similar to the Commission's Market Shift policy.
- Evaluation of deregulation is complicated by:
 - The different service offerings that occur between regulated and unregulated facilities
 - The incompleteness/availability of data
- For these reasons, staff have created a methodology that:
 - 1. Utilizes Medicare TCOC data to determine shifts across all settings of care
 - 2. Utilizes 3M's Enhanced Ambulatory Patient Groups (EAPGs) for outpatient services, in lieu of 3M's aggregated service lines to better identify at a more granular level potential deregulation (e.g., pacemaker replacement and/or echocardiography versus "Cardiovascular" service line)
 - 3. Incorporates total trend in EAPGs to remove use rate decline across all settings, which is not indicative of deregulation
 - 4. Extrapolates to all-payer using hospital casemix data
 - 5. Cross references against the Market Shift methodology to ensure there are effectively no duplicative volume adjustments.
 - Removes from consideration all EAPG cases that have a dominant procedure code that map to CMS Ambulatory Surgical Center Exclusion List



Repatriation Methodology



What is Repatriation?

- Repatriation is the cross border movement of Maryland residents from out-of-state hospital facilities to Maryland regulated facilities
 - Only accounts for hospital services; no evaluation along the continuum of care
 - The TCOC Model savings improve under repatriation because funding is reduced at a 100% variable cost factor outside of the State and in Maryland is increased at most at a 50% variable cost factor
 - Ex: Outpatient surgery from Wilmington, DE into Cecil county
- Expatriation is cross border movement of Maryland residents from Maryland regulated hospital facilities to out-of-state hospital facilities
 - Only accounts for hospital services; no evaluation along the continuum of care
 - The TCOC Model savings degrade under expatriation because funding is increased at a 100% variable cost factor outside of the State and in Maryland is decreased at a 50% variable cost factor
 - Ex: Inpatient Surgery & Cardiology into D.C.



Repatriation Methodology

- Repatriation is similar to the Commission's Market Shift policy.
- Evaluation of repatriation is complicated by:
 - The incompleteness/availability of data
 - Random variation that occurs by assessing volume change among hospitals not located in contiguous states (or Districts)
 - Market shifts that are occurring within border states versus shifts that are occurring across state lines.
- For these reasons, staff have created a methodology that:
 - Utilizes Medicare TCOC data to determine shifts across state lines by determining the aggregate change for Maryland and non-Maryland facilities in a given geographic area and service line (excludes non contiguous states)
 - 2. Utilizes 3M's inpatient and outpatient service lines because both settings are susceptible to repatriation, and there is no need for more granular analysis since acute care facilities (in-state and out-of-state) have similar service offerings.
 - 3. Extrapolates to all-payer using hospital casemix data
 - 4. Cross references against the Market Shift methodology to ensure there are effectively no duplicative volume adjustments.

Out-of-State Methodology



Out-of-State Volume Background

- Per the GBR contract, the Commission can adjust a hospital's global budget revenue "If this percentage [out-of-state volume] changes materially during the term of this Agreement..." Section X, Global Budget Revenue Agreement
 - To date, staff have adjudicated a few out-of-state adjustments because a) the volume change has been material and b) the volume change represented a material share of the hospital's global budget
- Unlike typical volume methodologies, staff have elected to use reported experience data in lieu of ECMADS from abstract data because the longitudinal assessments have base years under:
 - Different Groupers
 - Different Casemix Methodologies
 - Different Diagnosis and Procedure Code Versions (e.g., ICD-9 to ICD-10)

Most hospitals have a base year of 2014



Out-of-State Volume Methodology

- Baseline for hospital evaluation is:
 - 2014 if hospital has not had an adjustment for out-of-state
 - Rate year subsequent to 2014 that was used to adjudicate out-of-state adjustment
 - Rate year subsequent to 2014 that was used to adjudicate full rate application
- Performance year for evaluation is last completed fiscal year
- All volume changes are measured at a 50% variable cost factor
 - OOS Revenue Increase @ 50% VCF = Current Rate X (Performance Year Volume Base Year Volume)
 - Conversion factors are accounted for in volume assessment, e.g. clinic RVU conversion
- Notable Exclusions
 - CDS rate center
 - MSS rate center
 - Material volume declines

Concern about volume unit of cost and overlap with CDS-A

 Workgroup successfully argued for using ECMADS in future assessments so that all volume change from RY 2023 are assessed with acuity adjusted cases, inclusive of all rate centers

Implementation Considerations



Accuracy of Volume Evaluation and Potential for Temporal Volume Change

Three principal concerns were raised during the Volume Workgroup.

1. Reliance on Medicare TCOC data and the small and potentially temporal nature of the associated volume changes.

Not all hospitals have the same efficiency and retained revenue levels, and thus there should be some consideration of varying cost structures and profitability when implementing adjustments.
 In certain cases the reduction of services through deregulation, expatriation,

 In certain cases the reduction of services through deregulation, expatriation, and/or out-of-state movement may not be driven by a hospital and/or may happen rather suddenly

For these reasons, staff proposed the following implementation approaches:

- Implement Deregulation and Expatriation at the next available rate issuance on a one-time basis, negative Out-of-State adjustments on a permanent basis.
- Hospitals can provide additional information to contest an HSCRC finding, but will have the burden of proof, and HSCRC staff will be final arbiters of this decision.
- If one-time adjustments are made and the same finding is made the following year, the adjustment will be made permanent.
- All adjustments will be subject to a materiality threshold.



Materiality Thresholds

- Utility of Materiality Thresholds
 - Ensures that adjustments are only made when the variation is significant, similar to Minimum Savings Rate (MSR) in EQIP program
 - Creates alignment with various policies that incentivize actions like deregulation (GBR's, MPA, EQIP),
 - Future maturity of the Model may depend on moving to greater capitation risk, especially for rural hospitals
 - Aligns with principle of creating revenue predictability through global budgets
- Utility of Asymmetrical Materiality Thresholds & Integrated Efficiency
 - Growing repatriated and out-of-state volumes is good for the Model
 - Helps reduce outlier cost status

Policy	Policy Materiality perm		Implement permanently upon initial adjustment	
Deregulation				
Decreases GBR	Approach A	X		
Change to Rendering Location State for MD resident				
Repatriation	Approach B	X		
Expatriation	Approach A	X		
Change to Rendering	Location State	e for Out of State resident	ts	
Into State	Approach B		X	
Out of State	Approach A		X	
Mataulalitus Ammuanah A				

Materiality Approach A is:

- The hospital is in the worst quartile of the most recently published Integrated Efficiency policy OR
- 2. The adjustment exceeds 3 percent of the hospital's GBR OR
- 3. The adjustment exceeds 3 percent of the associated service line revenue

Materiality Approach B is

- 1. The adjustment exceeds 1 percent of the hospital's GBR OR
- . The adjustment exceeds 1 percent of the associated service line revenue



Volume Scorecard



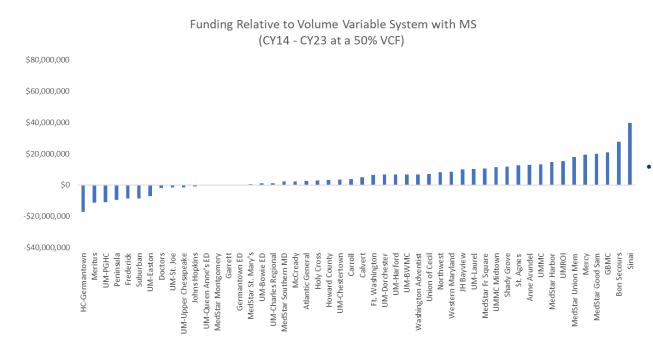
Scorecard Background

- The HSCRC is no longer a price regulator and thus the market no longer allocates funding in an unimpeded fashion
- With Global Budgets, the Commission must interpret the invisible hand of the market through several volume policies
- To ensure that the volume policies are working well, it is incumbent on the HSCRC to verify that the policies in aggregate are adequately covering the costs of new volumes
- Staff calculated an expected volume funding that would have occurred if all volume change was adjusted through a volume variable or fee-for-service methodology ("Counterfactual FFS Funding)," versus all revenue adjustments that actually occurred in the All-Payer and TCOC Models ("Observed Funding.")
- Staff do not believe this scorecard should be used as a methodology, as the Model is no longer volume based.
- Staff do believe this scorecard is an important analytical tool that the HSCRC can use for future evaluations, thereby improving the Commission's selection of what population based methodology to potentially modify.





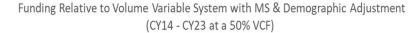
Volume Efficacy: Marketshift Funding Only

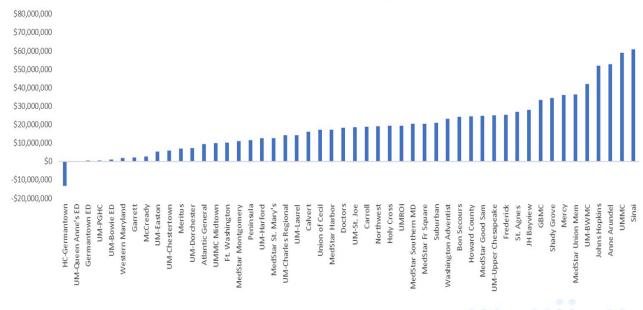


- Updates through CY 2023 still demonstrate that through the Marketshift alone very few hospitals are not funded for volume at at least a 50% variable cost factor
 - CY22 \$467M favorable
 - CY23 \$275M favorable
 - Analysis that only uses Marketshift and/or excludes Demographic Adjustment funding is flawed
 - Marketshift is not intended to capture all volume growth by design
 - Demographic Adjustment funds use rate growth over and above what is considered a "shift"



Volume Efficacy: Current Scorecard

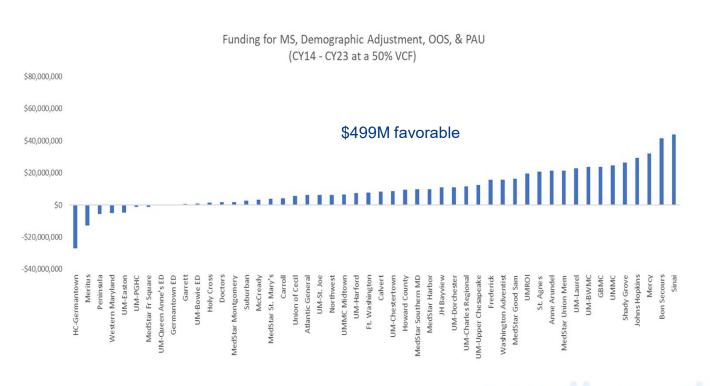




- Staff continue to demonstrate that most hospitals are funded at least a 50% VCF for in-state volume changes
 - CY22 \$1.10B favorable
 - CY23 \$958M favorable
- Scorecards on next few slides will layer in
 - Out-of-state
 - PAU
 - Miscellaneous Volume Adjustments
 - Efficiency



Volume Efficacy: Current Scorecard with OOS & PAU

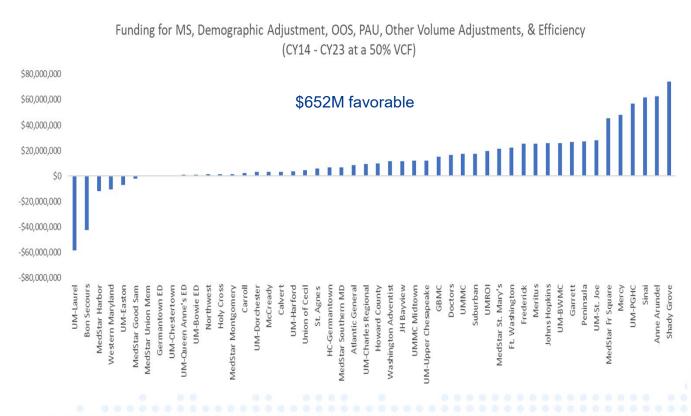


Inclusion of OOS volume adjustments generally increases favorable funding

- Statewide Increase \$139M
- Inclusion of PAU generally decreases favorable funding
 - Statewide Decrease \$597M



Volume Efficacy: Current Scorecard with OOS, PAU and Misc.



- Miscellaneous adjustments fall into three categories
 - Deregulation
 - Other Volume (e.g., payer initiated shifts)
 - Efficiency
- Summary findings
 - Population-based volume policies are having their intended effect; there is no need for modifications at this time
 - Any perceived funding misallocation is being handled through PAU, Integrated Efficiency, and the Full Rate Application



Draft Recommendations

Establish a Deregulation policy based on the methodology outlined herein that will result in negative revenue adjustments to hospitals' global budgets.

Establish a Repatriation policy based on the methodology outlined herein that will result in positive (repatriation)

and negative (expatriation) revenue adjustments to hospitals' global budgets.
Establish an Out-of-State policy based on the methodology outlined herein that will result in positive and negative revenue adjustments to hospitals' global budgets.

Implement Deregulation, and Expatriation, the next available rate issuance on a one-time basis, negative Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:

The hospital is in the worst quartile of the most recently published Integrated Efficiency policy OR

The adjustment exceeds 3 percent of the hospital's GBR OR

The adjustment exceeds 3 percent of the associated service line revenue

All Planned Deregulations should still be reported to the Commission in conformance with the GBR agreement and adjusted accordingly.

If deregulation methodology indicates a potential deregulation that varies from planned deregulation

by more than 10 percent, staff may consider revising the deregulation adjustment

Implement Repatriation at the next available rate issuance on a one-time basis, positive Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:

The adjustment exceeds 1 percent of the hospital's GBR OR

The adjustment exceeds 1 percent of the associated service line revenue

Implement Deregulation, and Repatriation/Expatriation adjustments on a permanent basis one year following the initial one-time revenue adjustment to allow for potential backfilling and/or dissipation. Hospitals can provide additional information to contest the volume finding, but will have the burden of proof, and HSCRC staff will be final arbiters of this decision.

Recognize the staff's approach to evaluating the over/under funding of volume in Commission's volume policies



Appendix



Appendix 1: Deregulation Methodology Example

		Example (AAMC; SPINE INJECTIONS	
Step Methodology Description	Algebra	AND OTHER RELATED PROCEDURES)	Comments
Array at an EAPG level the base year ECMAD count for			
1 regulated Medicare FFS services	Α	101 ECMADS	Staff utilized 2019 base period
			Staff utilized 2023 performance period in line
Array at an EAPG level the performance year ECMAD			with volume subgroup recommendation to not
2 count for regulated Medicare FFS services	В	56 ECMADS	use 2022 due to ongoing COVID confounding
At an EAPG level evaluate year over year ECMAD %			
3 growth in Medicare FFS regulated services	C=B/A-1	-45%	
At an EAPG level evaluate year over year ECMAD %			
growth in Medicare FFS regulated & unregulated service	s		
4 (similar to Step 3)	D	-2%	
Subtract the regulated year over year % change from the			
regulated & unregulated year over year percentage			
change. Exceptions: If the hospital year over year %			
change is greater than 0, value is listed as 0. If the total			Step ensures that general use rate decline as
year over year % change is greater than 0, it is not			opposed to movement of services down the
5 subtracted from the year over year % change	E=D-C	43%	continuum of care are not scored
Determine potential deregulated ECMADS for Medicare			If step 5 is negative (total use rate decline is
FFS by multiplying the base year ECMAD volume count			greater than hospital use rate decline), there is
6 by the variance calculated under Step 5	F=AxE	43	no potential deregulation
Array the share of evaluated EAPG attributable to			
7 Medicare FFS from base year	G	38%	Derived from hospital casemix data
Determine potential deregulated ECMADS for all-payer			
by dividing potential deregulated ECMADS for Medicare			
8 FFS by EAPG Medicare FFS Share	H=F/G	115	
			Requires creating EAPG marketshift analysis
			from regular service line marketshift by prorating
			quantifiable shifts and unrecognized ECMADS to
9 Array unrecognized ECMADS from EAPG markets hift *	<u> </u>	94	individual EAPGs
Determine all-payer ECMADS eligible for deregulation by	′		Ensures that deregulation does not remove
calculating the lesser of unrecognized ECMADS &			more volume than actual use rate decline not
10 potential deregulated ECMADS for all-payer	J=Lesser of H & I	94	recognized by Market Shift methodology
Array performance year average charge per ECMAD for			
relevant service line (base year if not available plus			
11 inflation)	K	\$14,057	
Determine all-payer \$ amount eligible for deregulation b	У		
multiplying relevant service line average charge by all-			
payer ECMADS eligible for deregulation and a 50%	1 1	¢cc0 070	
12 variable cost factor	L=J x K x 50%	\$662,276	
Identify and itemize dollars associated with EAPG's			Per recommendation from workers are staff
under Step 12 that have a Dominant Procedure Code			Per recommendation from workgroup, staff
which cannot be performed in an Ambulatory Surgical			identified and removed all EAPG cases where the dominant procedure code was listed on
Center (only performed for services that map to Major			·
Surgery, Min or Surgery, and Cardiovascular Service	M	0	Addendum EE Surgical Procedures to be Excluded from Payment in ASCs
13 Lines)	M	U	Excluded from Payment in ASCS

Does not include Materiality Thresholds



Appendix 2: EAPG Marketshift Example

Actual Unrecognized ECAMDS for Frederick

Hospital, Major Surgery in Prince George's (0.953)

			•	_	-	•	•	•
HOSPITA	LNAM	E					Frederick	.T
PROD_C	AT						Major Surgery	J.
zipcode							Prince Georges	-T

zipcode	Prince Georges 🛪	'			Calculated	l Pro of
	Α	В	C=B-A	D	E=C/SUM(C:C)	F=CXSUM(D:D)
	Sum of	Sum of	Unrecog	Allocated		Normalized
Row Labels	.▼ ecmadCY1922	hospshift	ecmads	Unre cog ecmads	Share of EAPG/Unrecognized	Unrecognized ECMADS
115:::DEEP LYMPH STRUCTURE PRO CEDURES	(0.62)	(0.38)	(0.242)	(0.234)	25%	(0.234)
172:::LEVEL III KIDNEY AND URETERAL PROCEDURES	(0.94)	(0.94)	-	-	0%	-
208:::LEVEL II OTHER UTERINE AND ADNEXA GYNECOLOGICAL PROCEDURE	S (0.59)	(0.29)	(0.302)	(0.292)	31%	(0.292)
26:::LEVEL I KNEE AND LOWER LEG PROCEDURES	(0.52)	(0.52)	-	-	0%	-
28:::LEVEL I SPINE PRO CEDURES	(0.68)	(0.24)	(0.442)	(0.428)	45%	(0.428)
29:::LEVEL II SPINE PRO CEDURES	(1.52)	(1.52)	-	-	0%	-
64:::LEVEL I LOWER AIRWAY ENDOSCOPY	0.33	0.33	-	-	0%	
Grand Total	(4.54)	(3.55)	(0.985)	(0.953)	100%	(0.953)



Appendix 3: Repatriation Methodology Example

Repatriation Example (Cardiology, Allegany County)

Hospital	ECMAD Change	MD Net Change	Non-Maryland Net Change	Eligible for MS	Proportion of Shift	Medicare FFS MS	Medicare FFS %	Allpayer MS	Unrecognized ECMADS	Repatriation (Expatriation)	Average Charge	Repatriation (Expatriation) Adjustment
Algebra>>>	A=CY23 ECMADS - CY 2019 ECMADS	B=ΣA(Maryland)		D= Minimum of Absolute Value for B & C	E=A/(B or C)	F=KXD	G = 2019 or 2023 Med FFS % or 1	H=F/G		J = Minimim of H or I if Positive, Maximum if : Negative		L=J X K X 50%
Western Maryland	49.72		-0.69	0.69	115.84%	0.80	70%	1.13	3.38	1.13	\$19,015	\$10,787
Meritus	3.15		-0.69	0.69	7.34%	0.05	100%	0.05	(0.32)	1.13	\$16,096	\$10,787
Frederick	1.13		-0.69	0.69	2.63%	0.03	100%	0.03	(0.32)		\$17,147	\$0
Calvert	0.6		-0.69	0.69	1.40%	0.02	100%	0.02			\$15,554	\$0
UMMS-UMMC	-0.37		-0.69	0.69	-0.86%	(0.01)	30%	(0.02)			\$26,039	\$0
GBMC	-0.47	- Acceptance	-0.69	0.69	-1.10%	(0.01)	100%	(0.01)	(0.08)	(0.01)	\$17,946	-\$68
JHH- Howard County	-0.48		-0.69	0.69	-1.12%	(0.01)	100%	(0.01)	10.007	(0.02)	\$13,596	\$0
Lifebridge- Northwest	-0.5		-0.69	0.69	-1.16%	(0.01)	100%	(0.01)			\$16,523	\$0
UMMS- Charles	-0.56		-0.69	0.69	-1.30%	(0.01)	100%	(0.01)			\$15,504	\$0
MedStar- Southern MD	-0.76	42.92	-0.69	0.69	-1.77%	(0.01)	100%	(0.01)	(0.11)	(0.01)	\$17,611	-\$108
JHH- Bayview	-0.87	42.92	-0.69	0.69	-2.03%	(0.01)	100%	(0.01)			\$23,417	\$0
Trinity - Holy Cross Germantown	-1.35	42.92	-0.69	0.69	-3.15%	(0.02)	100%	(0.02)	- 2	120	\$12,419	\$0
Saint Agnes	-1.46		-0.69	0.69	-3.40%	(0.02)	100%	(0.02)			\$24,802	\$0
MedStar- Harbor	-1.51	42.92	-0.69	0.69	-3.52%	(0.02)	100%	(0.02)	- 14		\$18,234	\$0
Garrett	-1.53	42.92	-0.69	0.69	-3.56%	(0.02)	82%	(0.03)			\$20,097	\$0
JHH- Johns Hopkins	-1.82	42.92	-0.69	0.69	-4.24%	(0.03)	9%	(0.33)	(0.38)	(0.33)	\$31,537	-\$5,177
wv	6.16	42.92	-0.69	0.69	-892.75%	(6.16)	100%	(6.16)			-	\$0
PA	5.42	42.92	-0.69	0.69	-785.51%	(5.42)	100%	(5.42)				\$0
DE	1.86	42.92	-0.69	0.69	-269.57%	(1.86)	100%	(1.86)	-	74	20	\$0
DC	-3.72	42.92	-0.69	0.69	539.13%	3.72	100%	3.72				\$0
VA	-10.41	42.92	-0.69	0.69	1508.70%	10.41	100%	10.41	-	74	20	\$0



Appendix 4: Additional Details on Volume Scorecard Background

FAQ's	Staff Responses
What do you mean by expected versus observed?	Observed adjustments are changes in revenue recorded in hospitals' rate file. Expected adjustments are what a hospital would have received at a 50% VCF if volumes were funded under a fee-for-service methodology
What are unrecognized ECMADS?	Unrecognized ECMADS are volume that grew or declined but were not shifted in the marketshift methodology
How are unrecognized dollars value calculated?	Unrecognized ECMADS X the base year average charge per case X 50% VCF X an inflation factor
Why don't the CY 2022 Demographic Adjustments tie to the rate file?	Staff attempted to allocate the census catch up portion of the RY 2024 DA in the CY 2022 evaluation. Moving forward the entire RY 2024 DA will be in the CY 2023 evaluation.
What revenue adjustments are used in the volume scorecard?	Marketshift adjustments and Demographic Adjustments for the existing scorecard. The scorecard today will also layer in the PAU Shared Savings Adjustments and out-of-state adjustments as well as additional miscellaneous volume adjustments (e.g., Kaiser realignment) and adjustments related to efficiency

- Notes about updated scorecard

 - Expected out-of-state revenue adjustments do not have any exclusions for PAU Expected PAU adjustments include unrecognized marketshift values and marketshift values New PAU Shared Savings Approach is reflected in CY23 assessment Marketshift values are final values

 - Hospital specific adjustments have been reviewed by external consultants and only exclude the following:
 - Capital Adjustments
 - Oncology Drug Adjustments
 Quaternary Care Adjustments
 - Capital Adjustments



Appendix 5: Methodology Results

Deregulation

					Oncology			Total with
0.51		OT MADURET		M: 0	Related			Materiality
Hospital	Cardiovascular				Services	Radiology	Total	Thresholds
ANNE ARUNDEL	-\$68		-\$4,558 -\$635	-\$1,346	-\$698	-\$111	-\$6,788	-\$7
GBMC JOHNS HOPKINS	-\$1 \$0	-\$51 -\$161	-\$635 -\$448	-\$512 -\$3,005	-\$3,475 \$0	-\$359 - \$41	-\$5,033	-\$97
JUHNS HUPKINS UMMC	\$0 -\$94		-\$448 -\$705		\$0	-\$41 -\$166	-\$3,655	-\$2,89
				-\$1,393			-\$2,898	
UM-St. Joe SINAI	-\$735 -\$56		-\$842 -\$870	-\$618 -\$821	-\$110	-\$516 -\$454	-\$2,881	-\$2,88
Frederick	-\$36 -\$15		-\$1,141	-\$021 -\$744	-\$479	-\$454	-\$2,865 - \$2,09 5	-\$2,86 -\$6
	-\$13				\$0			
MedStar Good Sam Peninsula	-\$108		-\$1 -\$325	-\$1,924 -\$53	-\$27	-\$43 -\$638	-\$1,995	-\$14 -\$6
					-\$473		-\$1,741	
MERITUS	-\$35		-\$56	-\$1,628	\$0	\$0	-\$1,720	-\$5 -\$1
UM-BWMC	\$0		-\$507	-\$850	-\$196	-\$46	-\$1,664	-\$i
Doctors	-\$166		-\$459	-\$456	-\$178	-\$206	-\$1,467	
Western Maryland	-\$235		-\$397	-\$313	-\$33	-\$82	-\$1,312	-40
ATLANTIC GENERAL	\$0		-\$58	-\$446	-\$307	-\$421	-\$1,288	-\$2
HOLYCROSS	-\$51	-\$195	-\$35	-\$713	\$0	-\$172	-\$1,166	-\$1:
NORTHWEST	-\$1	-\$30	-\$52	-\$146	-\$466	-\$448	-\$1,141	-\$1,1
Ascension Saint Agnes Hospital	-\$301	\$0	-\$278	-\$227	-\$232	-\$77	-\$1,115	
SHADY GROVE	-\$70		-\$22	-\$1	\$0	-\$67	-\$1,054	-\$70
CALVERT	-\$56		-\$121	-\$155	\$0	-\$614	-\$946	-\$29
UM-Charles Regional	-\$59		-\$73	-\$669	-\$15	-\$49	-\$888	-\$-
JH Bayview	-\$120	-\$80	-\$104	-\$523	\$0	-\$37	-\$864	-\$8
MERCY	-\$9		-\$82	-\$197	\$0	-\$472	-\$853	
CARROLL	-\$21		-\$358	-\$402	\$0	-\$22	-\$806	-\$8
UMMC MIDTOWN	-\$1		-\$60	-\$393	-\$9	-\$250	-\$773	-\$7
UM-Upper Chesapeake	-\$125		-\$212	-\$155	\$0	-\$41	-\$751	-\$3:
MedStar Union Mem	-\$246		-\$22	-\$35	\$0	-\$436	-\$745	-\$:
MedStar St. Mary's	-\$38		-\$177	-\$203	-\$160	-\$161	-\$738	4
MedStar Fr Square	\$0		-\$56	-\$115	-\$459	-\$6	-\$635	
Adventist White Oak	-\$5		-\$21	-\$47	\$0	-\$249	-\$591	-\$6
UM-Easton	-\$6		-\$129	-\$32	\$0	-\$340	-\$549	-\$5
SUBURBAN	-\$13		-\$115	-\$173	\$0	-\$116	-\$435	-\$:
UM-Harford	\$0		-\$189	-\$54	\$0	-\$116	-\$425	-4
ChristianaCare, Union	\$0		-\$124	-\$15	-\$5	-\$178	-\$405	-\$4
MedStar Harbor	-\$35		-\$270	-\$11	\$0	-\$69	-\$402	-4
Garrett	-\$7		-\$13	-\$280	\$0	-\$36	-\$337	4
UM-Capital Region Medical Center	-\$86		-\$19	-\$5	\$0	-\$196	-\$310	-\$3:
HOWARD COUNTY	-\$13		-\$77	-\$126	\$0	-\$28	-\$246	
Grace Medical center	\$0		\$0	\$0	\$0	-\$108	-\$237	-\$3
MedStar Southern MD	-\$105		\$0	-\$10	\$0	-\$71	-\$197	- 4
HC-GERMANTOWN	-\$5		-\$85		-\$1	-\$1	-\$138	-4
UM-Chestertown	\$0		\$0	-\$130	\$0	-\$5	-\$136	-\$13
MedStar Montgomery	-\$9		-\$29	-\$2	\$0	-\$37	-\$129	-\$10
FT. WASHINGTON	\$0	*-	-\$28	-\$10	\$0	-\$59	-\$96	-\$1
Mccready	\$0	\$0	\$0	-\$1	\$0	\$0	-\$1	
Total	-\$2,897	-\$3,874	-\$13,750	-\$18,965	-\$7,321	-\$7,701	-\$54,509	-\$18,02
IVIAL	-42,097	-93,074	-913,730	-\$10,363	-91,021	-\$1,101	-404,009	-\$10,0

Repatriation

Hospital	Repatria	tion/Expatriation	ation Mate	striation/Expatri with riality sholds
MedStar- Southern MD	\$	2,003,143		2,584,312
Luminis- Anne Arundel	\$	1,195,994		1,538,505
UMMS- BWMC	\$	1,042,118		802,351
JHH- Suburban	\$	1,231,427	_	796,658
Calvert	\$		\$	626,486
Trinity - Holy Cross Germantown	\$	644,512	_	515,597
UMMS- St. Joe	\$	436,738		387,783
MedStar- Franklin Square	\$	73,856	\$	386,225
IHH- Johns Hopkins	\$	(512,259)		329,728
Adventist-Ft. Washington	\$	319.769	\$	303,468
MedStar- Union Mem	\$	732,156		264,371
Mercy	\$	334,196		188,599
	\$	353,702		
MedStar- Montgomery				181,618
UMMS- Midtown	\$	353,997	\$	172,878
Lifebridge- Levindale	\$	(193,342)	_	136,451
JHH- Bayview	\$	137,054		120,394
UMMS- Charles	\$	13,347	_	88,720
GBMC	\$	(1,244,030)		83,295
Saint Agnes	\$	800,568	_	69,830
Meritus	\$	154, 136		54,297
UMMS- UMROI	\$		\$	44,379
Tidal- Peninsula	\$	(655,294)		11,828
MedStar- St. Mary's	\$	(111,081)	\$	9,626
Tidal- McCready	\$	(68,431)		(3,142
UMMS- Capital Region	\$	(24,639)	\$	(24,639
JHH- Howard County	\$	(193,911)	\$	(32,792
MedStar- Good Sam	\$	(109,206)	\$	(65,086
Atlantic General	\$	(138,889)	\$	(65,273
UMMS-Upper Chesapeake	\$	(1,114,711)	\$	(70,759
MedStar- Harbor	\$	(202, 183)	\$	(76,993
UMMS- Chestertown	\$	(81,513)	\$	(81,513
Lifebridge- Grace	\$	(244,216)	\$	(106,489
Garrett	\$	(333,959)	\$	(107,563
Lifebridge- Northwest	\$	(206,732)	\$	(206,732
Trinity - Holy Cross	\$	(2,943,102)	\$	(218,897
Frederick	\$	(573,660)	\$	(298,516
UMMS- Easton	\$	(404, 124)	\$	(404,124
Adventist- White Oak	\$	(225,528)		(468,169
ChristianaCare, Union	\$	(480,977)		(480,977
Lifebridge- Carroll	\$	(762,716)		(762,716
Luminis- Doctors	\$	(927, 158)		(915,759
UMMS- Harford	\$	(1,323,453)		(992,333
Western Maryland	\$	(3,144,793)		(1,320,072
Lifebridge- Sinai	\$	(1,723,591)	_	(1,723,591
Adventist- Shady Grove	\$	(4,546,224)		(3,058,101
UMMS- UMMC	\$	(3,608,282)		(3,608,282
OFFICE OFFICE	Ψ	(15,682,898)		(5,395,117

Out-of-State

		Materiality Thresholds: 1% growth, 3% Decline OR
HospitalName	OOS Revenue Increase @ 50%	Integrated Efficiency
ChristianaCare, Union	\$2,642,943	\$934,768
Suburban	\$2,436,391	\$0
MedStar Montgomery	\$1,352,522	\$0
Anne Arundel	\$1,204,766	\$0
Peninsula	\$474,859	\$0
Northwest	\$343,157	\$0
UMROI	-\$355,415	-\$355,415
UM-Chestertown	-\$422,391	-\$422,391
Shock Trauma	-\$433,419	\$0
Ft. Washington	-\$456,469	\$0
MedStar Franklin Square	-\$488,951	\$0
UM-Charles Regional	-\$510,257	\$0
MedStar Harbor	-\$522,913	\$0
Grace Medical Center	-\$562,990	\$0
UM-Harford	-\$597,587	\$0
Garrett	-\$606,328	\$0
UM-BWMC	-\$722,384	\$0
Doctors	-\$882,268	\$0
Holy Cross	-\$923,236	\$0
MedStar Union Memorial	-\$1,237,563	\$0
St. Agnes	-\$1,402,526	\$0
UM-Upper Chesapeake	-\$1,488,932	\$0
Shady Grove	-\$1,612,735	\$0
Carroll	-\$1,900,591	-\$1,900,591
Sinai	-\$2,496,323	-\$2,496,323
MedStar Good Sam	-\$2,629,575	\$0
UM-Laurel FMF	-\$3,226,947	-\$2,345,398
UM-St. Joe	-\$3,278,295	-\$3,278,295
Frederick	-\$3,614,904	\$0
GBMC	-\$3,644,367	\$0
Mercy	-\$5,406,642	\$0
JH Bayview	-\$6,222,775	-\$6,222,775
Adventist White Oak	-\$6,669,239	\$0
Western Maryland	-\$8,226,074	-\$616,389
UM-Capital Region	-\$10.162.905	-\$10,162,905
UMMC	-\$12,358,036	-\$12,358,036
Johns Hopkins	-\$65,682,740	-\$567,814
Journal Hopkins	\$05,082,740	\$307,814
Total	-\$139,761,961	-\$39,699,940





Draft Recommendation for Deregulation, Repatriation, and Out-of-State Volume Policies

October 9, 2024

This document contains staff draft recommendations for Deregulation, Repatriation, and Out-of-State Volume Policies. Comments are due by COB Wednesday Oct 30, 2024and may be submitted to allani.pack@maryland.gov

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Table of Contents

Recommendations	2
Introduction	3
Background & Methodology Overview	6
Workgroup Engagement & Impetus for New Policies	6
Deregulation	7
Repatriation/Expatriation	9
Implementation	12
Accuracy of Volume Evaluation and Potential for Temporal Volume Change	12
Results	15
Deregulation	15
Repatriation	16
Remaining Limitations	17
Out-of-State	17
Appendix 1. Key Methodology Concepts and Definitions	23
Appendix 2. EAPG Market Shift Example	24
Appendix 3, 50 Percent Variable Cost Factor Analyses	25

Recommendations

Staff recommend the following:

- 1. Establish a Deregulation policy based on the methodology outlined herein that will result in negative revenue adjustments to hospitals' global budgets.
- 2. Establish a Repatriation policy based on the methodology outlined herein that will result in positive (repatriation) and negative (expatriation) revenue adjustments to hospitals' global budgets. The terms, "repatriation" and "expatriation," refer to volumes related to Maryland residents moving into and out of state and are described in full below.
- 3. Establish an Out-of-State policy based on the methodology outlined herein that will result in positive and negative revenue adjustments to hospitals' global budgets.
- 4. Implement Deregulation and Expatriation adjustments at the next available rate issuance on a one-time basis and negative Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:
 - a. The hospital is in the worst quartile of the most recently published Integrated Efficiency policy OR
 - b. The adjustment exceeds 3 percent of the hospital's GBR OR

- c. The adjustment exceeds 3 percent of the associated service line revenue
- d. All Planned Deregulations should still be reported to the Commission in conformance with the GBR agreement and adjusted accordingly.
 - If deregulation methodology indicates a potential deregulation that varies from planned deregulation by more than 10 percent, staff may consider revising the deregulation adjustment
- 5. Implement Repatriation at the next available rate issuance on a one-time basis, positive Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:
 - a. The adjustment exceeds 1 percent of the hospital's GBR OR
 - b. The adjustment exceeds 1 percent of the associated service line revenue
- 6. Implement Deregulation, and Repatriation/Expatriation adjustments on a permanent basis one year following the initial revenue adjustment to allow for potential backfilling and/or dissipation. Hospitals can provide additional information to contest the volume finding but will have the burden of proof and HSCRC staff will be the final arbiters of this decision.
- 7. Recognize the staff's approach to evaluating the over/under funding of volume in Commission's volume policies

Introduction

The State of Maryland has led an effort to transform its health care delivery system to a population-based system that increases the emphasis on patient-centered care, improves population health, and lowers health care costs. To achieve these goals, the State of Maryland worked closely with hospitals, payers, other providers, consumers and the Centers for Medicare & Medicaid Services to develop the Maryland All-Payer Model, which was implemented in 2014, and later the Total Cost of Care Model, which was implemented in 2019. The Models moved away from a volume-based payment system that limited the growth in inpatient charge-per-case to a system that limits the growth in total hospital spending per capita and increasingly focused on outcomes: readmissions, in-hospital complications, potentially avoidable utilization, total cost of care, and patient satisfaction, among others.

Fundamental to the Models was the Global Budget Revenue (GBR) methodology, which was piloted by ten rural hospitals in 2010 and aimed to provide stability to hospitals by establishing annual prospective budgets and allowing for charges to fluctuate in line with reasonable changes in volume. However, while hospital budgets were fixed during a given fiscal year, thereby incentivizing hospitals not to grow volumes unnecessarily and providing a high level of predictability, the Commission had to develop strategies to modify budgets in future years based on changes in population, the aging of the population, changes in market selection, and

¹ The HSCRC allows hospitals to adjust charges for individual rate centers (e.g., room and board) to fluctuate within a 5 percent corridor. HSCRC reviews hospital requests to adjust prices beyond a 5 percent corridor.

new health care innovation cost drivers, the latter of which has been directly addressed by the Commission's two stand-alone volume methodologies, the CDS-A and Complexity and Innovation policies.

To achieve the twin goals of funding population related utilization changes and realigning budgets for market shifts, the HSCRC developed two core volume funding methodologies: the Demographic Adjustment and Market Shift Adjustment. The Demographic Adjustment methodology provides funding for age-adjusted growth/decline at the zip code or county level in order to anticipate changes in utilization based on demographic changes.²

The HSCRC staff also developed a Market Shift Adjustment methodology that evaluates hospitals' growth/decline for each defined service line and geography to determine the degree to which patients moved from one hospital to another in the most recent calendar year in comparison to the prior year. The Market Shift moves money in the following year at a 50 percent variable cost factor³ when volumes are moved up at one hospital and down at another in the same service line and geography.

Taken together, the Demographic Adjustment and Market Shift policies ensure a competitive hospital market where money follows the patient but only such that statewide volume on net does not grow for anything other than population growth and various forms of healthcare innovation. Both of these methodologies resulted in adequate volume funding statewide while maintaining the Models' status as population-based but have not addressed less common shifts in market share that occur due to deregulation, repatriation/expatriation (for Maryland residents), and changes in out-of-state service delivery. See Table 1 below for an overview of Commission policies that are either currently approved or seeking approval by way of this recommendation; additionally, please note that staff has categorized policies as either "Stand Alone," meaning they do not require additional policies to account for volume change or not Stand Alone because they work in concert with other volume policies to appropriately address volume change

² The Demographic Adjustment is capped by Maryland Department of Planning estimates of statewide population growth to align with the per capita nature of the Model tests, i.e., the contractual tests are not age-adjusted.

³ A 50 percent variable cost factor is the industry standard for determining the percent of charges necessary to cover all marginal or variable costs associated with providing one additional service and is the standard by which the Commission will evaluate its volume methodologies.

Table 1: Volume Policy Overview

Volume Adjustment	Approved Policy	Stand Alone	Purpose
Demographic Adjustment	X		Annual age adjusted population funding for instate use rate growth
Marketshift	X		Semi-annual adjustments for regulated market shifts (zero sum)
Out-of-State		X	Annual adjustments for material changes to out- of-state volumes
Deregulation			As needed reductions for observed shifts to unregulated settings
Repatriation			As needed adjustments for cross state border hospital shifts
Complexity and Innovation	Х	X	Prospective funding to Academic Medical Centers for growth in unique quaternary services
CDS-A	Х	X	Funding for changes in volume for select drugs (only volume variable methodology)

While the Commission does not currently have policies that outline the methodologies for Deregulation, Repatriation, and Out-of-State volume changes, staff have made, over the course of the All-Payer and Total Cost of Care Models, adjustments to hospitals' global budgets for these changes in volume, in keeping with language in hospital's global budget contracts.

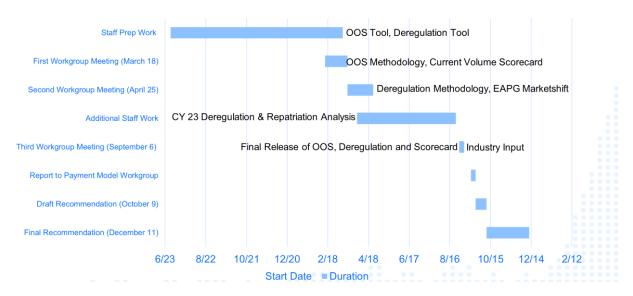
The purpose of this recommendation is to officially establish methodologies for making these volume adjustments, thereby reducing any potential arbitrary and capricious treatment that might result from not having methodologies first vetted by external stakeholders and then reviewed and approved by HSCRC Commissioners. Additionally, this recommendation will lay out for the first time a complete accounting of all volume adjustments that have occurred over the course of the All-Payer and Total Cost of Care Models, otherwise known as the "Volume Scorecard," and in so doing allow future policy makers to assess the need for potential revisions to Commission volume policies.

Background & Methodology Overview

Workgroup Engagement & Impetus for New Policies

Over the past year, staff have worked on developing new volume methodologies, which included extensive data validation, modeling, four stakeholder engagement meetings, and additional analyses in response to stakeholder feedback.⁴ See Table 2 below for an overview of the Volume Workgroup Work Plan.





This is first time staff have significantly reviewed volume policies since 2019 when it consolidated the geographies and service lines in the Market Shift, thereby reducing Market Shift cells (e.g., Cardiology services in Allegany County) from approximately 20,000 to 5,000, and markets with less than 10 discharges (an indicator of a potentially unstable cell size) from approximately 7,000 to 1,000. Staff additionally created new volume policies unique to the COVID -19 pandemic in 2020⁵ that have since been suspended, as well as an update to the Demographic Adjustment policy in 2023⁶ to account for the misestimate of population growth identified in the 2020 census.

Staff proposed and Commissioners agreed that in 2024 the Commission should revisit its volume policies to codify adjustments that were being made at the request of hospitals and

⁴ Over the course of Volume Workgroup engagement, staff performed requested analyses related to the appropriateness of Commission approved variable cost factors as well as reviews of overlap with Ambulatory Surgical Center fee schedules.

⁵ https://hscrc.maryland.gov/Documents/April%2030%202020%20Public%20Meeting%20Materials.pdf (Pages 6 - 15)

⁶https://hscrc.maryland.gov/Documents/Strong%20als%20Folder/AUUR%20-%20Unit%20Rates%20and%20GBR/FY%202024/RY24%20Amended%20Final%20UF%20Recommendation%200614 2023%20%20with%20comment%20letters%20(1).pdf (Page 11)

payers. Hospitals often requested revenue enhancements due to growth in out-of-state and repatriated volumes, and payers often requested that hospitals should have revenue write-downs for volume that shifted down the continuum of care from acute care settings to unregulated sub-acute settings, e.g., ambulatory surgical centers. In effect, both sets of stakeholders were requesting that the Commission reduce the extent of use rate growth (or decline) that was not recognized in the Market Shift methodology, otherwise known as Unrecognized Equivalent Casemix Adjusted Discharges (ECMADS). See Table 3 below that outlines how Unrecognized ECMADS are classified in the absence of Deregulation and Repatriation policies, and how they can be reclassified if these volumes policies are established, thereby reducing retained revenue and extending the utility of Demographic Adjustment funding:

Hospital A - Growth Hospital Hospital B - Declining Hospital Algebra Item ECMADs Algebra2 Item2 ECMADs2 Base Period 6 A Base Period 10 **Status** В Performance Period 10 B Performance Period 3 Retained Quo C=B-A Change 4 C=B-A Change D Marketshift 2 D Marketshift -2 2 E=C-D E=C-D Unrecognized Unrecognized -5 Hospital A - Growth Hospital Hospital B - Declining Hospital Item2 Algebra **ECMADs Algebra2** ECMADs2 Item Base Period Base Period 10 6 A В Performance Period 10 B Performance Period 3 Out-of-State C=B-A Change 4 C=B-A Change -7 **Volumes** are New handled in a **Policies** 2 D Marketshift D Marketshift -2 stand alone E=C-D Unrecognized 2 E=C-D Unrecognized -5 methodology Repatriation 1 F Expatriation G=E-F Unrecognized 1 G Deregulation H=E-F-G Unrecognized

Table 3: New Volume Policies Overview Example

Deregulation

Deregulation is the movement of a hospital service from an HSCRC regulated space to an unregulated space (most often outpatient services but also chronic and rehab). A service is presumed to be regulated if it is provided on the campus of a hospital. Criteria outlined in COMAR are considered for determination of whether a service is considered regulated or unregulated.

Deregulation can be initiated by three principal actors: 1) payers/patients, 2) the hospital itself, and 3) physician practices. Examples of deregulation include:

1. Payer Initiative Example: A payer makes the decision to no longer reimburse for certain procedures or therapies to be administered in a regulated hospital setting and move

- them to an Ambulatory Surgery Center. Examples of this type of shift include immunoglobulin therapies and endoscopies.
- 2. Hospital Example: The hospital makes the decision to shift radiation therapy services to an unregulated setting. Perhaps the most straightforward example because the hospital makes the decision to move services.
- 3. Physician Practices Example: A community physician makes the decision to no longer perform hand surgeries at the hospital. In this instance, the physicians made the decision outside of the hospital's control. A deregulation adjustment still needs to occur because the service is no longer being provided at the hospital.

Deregulation is similar to the Commission's Market Shift policy in that there is a shift in services from one facility to another; however, because the unregulated facility that is experiencing use rate growth is outside of the HSCRC regulatory scope (and thus data availability is limited), it is difficult to quantify precisely the extent of a deregulation. The evaluation of deregulation is further complicated by the different service offerings that occur between regulated and unregulated facilities as well as the incompleteness of data, as the Commission only reliably has access to Medicare total cost of care claims data and yet all-payers are susceptible to deregulation. For these reasons, staff have created a methodology that:

- 1. Utilizes Medicare data to determine shifts across all settings of care
- 2. Utilizes 3M's Enhanced Ambulatory Patient Groups (EAPGs) for outpatient services, in lieu of 3M's aggregated service lines to better identify at a more granular level potential deregulation (e.g., pacemaker replacement and/or echocardiography versus "Cardiovascular" service line)
- 3. Incorporates total trend in EAPGs to remove use rate decline across all settings, which is not indicative of deregulation
- 4. Extrapolates to all-payer using hospital casemix data
- 5. Cross references against the Market Shift methodology to ensure there are effectively no duplicative volume adjustments.
- 6. Removes from consideration all EAPG cases that have a dominant procedure code that maps to CMS Addendum EE -- Surgical Procedures to be Excluded from Payment in Ambulatory Surgical Centers⁷ (only applicable to the following service lines: Major Surgery, Minor Surgery, and Cardiovascular)

Greater details of the proposed methodology are summarized below:

⁷https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda

Table 4: Actual Example and Methodology Description of Deregulation

		Example (AAMC; SPINE INJECTIONS	
Step Methodology Description	Algebra	AND OTHER RELATED PROCEDURES)	Comments
Array at an EAPG level the base year ECMAD count for			
1 regulated Medicare FFS services	A	101 ECMADS	Staff utilized 2019 base period
			Staff utilized 2023 performance period in line
Array at an EAPG level the performance year ECMAD	_		with volume subgroup recommendation to not
2 count for regulated Medicare FFS services	В	56 ECMADS	use 2022 due to ongoing COVID confounding
At an EAPG level evaluate year over year ECMAD %	C=B/A-1	-45%	
3 growth in Medicare FFS regulated services At an EAPG level evaluate year over year ECMAD %	C=B/A-1	-45%	
growth in Medicare FFS regulated & unregulated services			
4 (similar to Step 3)	D	-2%	
Subtract the regulated year over year % change from the		-270	
regulated & unregulated year over year percentage			
change. Exceptions: If the hospital year over year %			
change is greater than 0, value is listed as 0. If the total			Step ensures that general use rate decline as
year over year % change is greater than 0, it is not			opposed to movement of services down the
5 subtracted from the year over year % change	E=D-C	43%	continuum of care are not scored
Determine potential deregulated ECMADS for Medicare			If step 5 is negative (total use rate decline is
FFS by multiplying the base year ECMAD volume count			greater than hospital use rate decline), there is
6 by the variance calculated under Step 5	F=AxE	43	no potential deregulation
Array the share of evaluated EAPG attributable to			
7 Medicare FFS from base year	G	38%	Derived from ho spital casemix data
Determine potential deregulated ECMADS for all-payer			
by dividing potential deregulated ECMADS for Medicare 8 FFS by EAPG Medicare FFS Share	H=F/G	115	
8 FFS by EAFG Medicale FFS Stiate	H=F/G	115	Requires creating EAPG marketshift analysis
			from regular service line marketshift by proratin
			quantifiable shifts and unrecognized ECMADS t
9 Array unrecognized ECMADS from EAPG markets hift *	1	94	individual EAPGs
Determine all-payer ECMADS eligible for deregulation by			Ensures that deregulation does not remove
calculating the lesser of unrecognized ECMADS &			more volume than actual use rate decline not
10 potential deregulated ECMADS for all-payer	J=Lesser of H & I	94	recognized by Market Shift methodology
Array performance year average charge per ECMAD for			
relevant service line (base year if not available plus			
11 inflation)	K	\$14,057	
Determine all-payer \$ amount eligible for deregulation by			
multiplying relevant service line average charge by all-			
payer ECMADS eligible for deregulation and a 50%			
12 variable cost factor	L=J x K x 50%	\$662,276	<u> </u>
Identify and itemize dollars associated with EAPG's			Daniel de la constant
under Step 12 that have a Dominant Procedure Code			Per recommendation from workgroup, staff
which cannot be performed in an Ambulatory Surgical			identified and removed all EAPG cases where
Center (only performed for services that map to Major			the dominant procedure code was listed on Addendum EE Surgical Procedures to be
Surgery, Minor Surgery, and Cardiovascular Service 13 Lines)	м	0	Excluded from Payment in ASCs
14 Determine final potential deregulation for Hospitals	N=L-M	\$662,276	Excluded Ironi Fayinent III ASCS
1- Determine iniat botential delegatation for Hospitals	IA-F-I-I	ψ002,270	

*EAPG Market Shift example can be found in Appendix 2

Repatriation/Expatriation

Repatriation is the cross-border movement of Maryland residents from out-of-state hospital facilities back to Maryland regulated facilities. Unlike deregulation, the assessment is localized to Maryland residents and does not account for any movement across the continuum of care; it only assesses patient movement from one acute care facility to another and in this case when that transpires across state lines. It is important to note that repatriation potentially improves access, patient satisfaction and clinical outcomes, because Marylanders do not have to travel out-of-state for care. Additionally, repatriation improves TCOC Model savings because funding is reduced at a 100 percent variable cost factor outside of the state, and in Maryland it is increased at a 50 percent variable cost factor, the imbalance of which may increase further if materiality thresholds that will be discussed below are included in the methodology. In effect,

the Commission should consider how to more directly incentivize repatriation, as it does represent "good volumes."

Expatriation, on the other hand, is cross border movement of Maryland residents from Maryland regulated hospital facilities to out-of-state hospital facilities. When expatriation occurs, there are TCOC Model dissavings, because funding is increased at a 100 percent variable cost factor outside of the state, and in Maryland it is decreased at a 50 percent variable cost factor. However, it should be noted that there are several mechanisms currently in place to mitigate potential expatriation, including GBR corridors that limit hospital delegated pricing authority to 5 percent, the Medicare Performance Adjustment (MPA) that assesses Medicare TCOC performance that penalizes hospitals for volume loss to border states (among other things), the Integrated Efficiency Policy that scales inflation for hospitals deemed relatively inefficient (potentially due to expatriation), and the TCOC Model savings targets that ensure that any significant dissavings from activities like expatriation are accounted for in the annual Update Factor policy.

Repatriation, like deregulation, is similar to the Commission's Market Shift policy in that there is a shift in services from one facility to another; however, again it is difficult to precisely quantify the extent of the shift because non-Maryland facilities are not subject to HSCRC regulations and as such the data is incomplete. Additionally, staff were concerned that: a) assessments of volume change among hospitals not located in contiguous states (or Districts) would be indicative of random variation versus genuine, permanent changes in market selection; and b) the current Market Shift methodology that evaluates all facilities separately would be confounded by market shifts that are occurring within border states versus shifts that are occurring across state lines. For those reasons, staff have created a methodology that:

- Utilizes Medicare data to determine shifts across state lines by determining the aggregate change for Maryland and non-Maryland facilities in a given geographic area and service line
- 2. Utilizes 3M's inpatient and outpatient service lines because both settings are susceptible to repatriation, and there is no need for more granular analysis since acute care facilities (in-state and out-of-state) have similar service offerings.
- 3. Extrapolates to all-payer using hospital casemix data
- 4. Cross references against the Market Shift methodology to ensure there are effectively no duplicative volume adjustments.

Greater details on the proposed methodology are outlined below in an actual example:

Table 5: Repatriation Example (Cardiology, Allegany County)

Hospital	ECMAD Change	MD Net Change	Non-Maryland Net Change	Eligible for MS	Proportion of Shift	Medicare FFS MS	Medicare FFS %	Allpayer MS	Unrecognized ECMADS	Repatriation (Expatriation)	Average Charge	Repatriation (Expatriation) Adjustment
Algebra>>>	A=CY23 ECMADS - CY 2019 ECMADS	B=ΣA(Maryland)		D= Minimum of Absolute Value for B & C		F=KXD	G = 2019 or 2023 Med FFS % or 1	H=F/G		J = Minimim of H or I if Positive, Maximum if : Negative		L=J X K X 50%
Western Maryland	49.7		-0.69	0.69		0.80	70%	1.13	3.38	1.13	\$19.015	\$10,787
Meritus	3.15	5 42.92	-0.69	0.69	7.34%	0.05	100%	0.05	(0.32)		\$16,096	\$0
Frederick	1.13	3 42.92	-0.69	0.69	2.63%	0.02	100%	0.02			\$17,147	\$0
Calvert	0.0	42.92	-0.69	0.69	1.40%	0.01	100%	0.01	-		\$15,554	\$0
UMMS-UMMC	-0.3	7 42.92	-0.69	0.69	-0.86%	(0.01)	30%	(0.02)	-		\$26,039	\$0
GBMC	-0.4	7 42.92	-0.69	0.69	-1.10%	(0.01)	100%	(0.01)	(0.08)	(0.01)	\$17,946	-\$68
JHH- Howard County	-0.4	3 42.92	-0.69	0.69	-1.12%	(0.01)	100%	(0.01)	-	-	\$13,596	\$0
Lifebridge- Northwest	-0.9	5 42.92	-0.69	0.69	-1.16%	(0.01)	100%	(0.01)			\$16,523	\$0
UMMS- Charles	-0.56	3 42.92	-0.69	0.69	-1.30%	(0.01)	100%	(0.01)			\$15,504	\$0
MedStar- Southern MD	-0.70	42.92	-0.69	0.69	-1.77%	(0.01)	100%	(0.01)	(0.11)	(0.01)	\$17,611	-\$108
JHH- Bayview	-0.8	7 42.92	-0.69	0.69	-2.03%	(0.01)	100%	(0.01)	-	-	\$23,417	\$0
Trinity - Holy Cross Germantown	-1.3	5 42.92	-0.69	0.69	-3.15%	(0.02)	100%	(0.02)			\$12,419	\$0
Saint Agnes	-1.46	42.92	-0.69	0.69	-3.40%	(0.02)	100%	(0.02)	-	-	\$24,802	\$0
MedStar- Harbor	-1.5	1 42.92	-0.69	0.69	-3.52%	(0.02)	100%	(0.02)			\$18,234	\$0
Garrett	-1.50	3 42.92	-0.69	0.69	-3.56%	(0.02)	82%	(0.03)	-		\$20,097	\$0
JHH- Johns Hopkins	-1.83	2 42.92	-0.69	0.69	-4.24%	(0.03)	9%	(0.33)	(0.38)	(0.33)	\$31,537	-\$5,177
WV	6.1	6 42.92	-0.69	0.69	-892.75%	(6.16)	100%	(6.16)	-		-	\$0
PA	5.42	2 42.92	-0.69	0.69	-785.51%	(5.42)	100%	(5.42)				\$0
DE	1.80	5 42.92	-0.69	0.69	-269.57%	(1.86)	100%	(1.86)	-	-	-	\$0 \$0
DC	-3.72	2 42.92	-0.69	0.69	539.13%	3.72	100%	3.72	-			\$0
VA	-10.4	1 42.92	-0.69	0.69	1508.70%	10.41	100%	10.41			-	\$0

Out-of-State

Out-of-state evaluations of volume are specific to patients that live outside of the state of Maryland, which is different from repatriation and expatriation volume assessments that are specific to Maryland residents. Per the GBR contract, the Commission can adjust a hospital's GBR "If this percentage [out-of-state volume] changes materially during the term of this Agreement..." - Section X, Global Budget Revenue Agreement.⁸ To date, staff have adjudicated a few out-of-state adjustments because: a) the volume change was material; and b) the volume change represented a material share of the hospital's global budget. Due to the increasing frequency of hospital requests to adjust for out-of-state volumes, staff believe it is necessary to establish a formal policy.

Unlike typical volume methodologies, staff elected to use reported experience data in lieu of ECMADS, e.g., patient days versus weighted APR-DRGs, when previously adjudicating out-of-state volume adjustments because these evaluations were longitudinal assessments with base⁹ and performance years under:

- Different Groupers
- Different Casemix Weighting Methodologies
- Different Diagnosis and Procedure Code Versions (e.g., ICD-9 to ICD-10)¹⁰

⁸ Hospital GBR Agreement, section X, page 13

⁹ Most hospitals have a base year of 2014 because that is when global budgets were established. A few hospitals have a more advanced base year because they were effectively rebased through a direct out-of-state adjustment or indirectly through a full rate application policy.

¹⁰ The transition from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures in the United States occurred on October 1, 2015. https://www.cms.gov/medicare/coding-billing/icd-10-codes#:~:text=Pages%20in%20this%20section&text=What's%20New?,who%20bill%20Medicare%20or%20Medicaid">https://www.cms.gov/medicare/coding-billing/icd-10-codes#:~:text=Pages%20in%20this%20section&text=What's%20New?,who%20bill%20Medicare%20or%20Medicaid">https://www.cms.gov/medicare/coding-billing/icd-10-codes#:~:text=Pages%20in%20this%20section&text=What's%20New?,who%20bill%20Medicare%20or%20Medicaid">https://www.cms.gov/medicare/coding-billing/icd-10-codes#:~:text=Pages%20in%20this%20section&text=What's%20New?,who%20bill%20Medicare%20or%20Medicaid">https://www.cms.gov/medicare/coding-billing/icd-10-codes#:~:text=Pages%20in%20this%20section&text=What's%20New?,who%20bill%20Medicare%20or%20Medicaid">https://www.cms.gov/medicare%20or%20Medicaid

With the exception of utilizing experience data, the out-of-state methodology is pretty straight forward, as it is a volume variable methodology¹¹ that is only implemented when there is a material change.¹² The specifics of the methodology are as follows:

- Out-of-state Revenue Increase = Current Hospital Rate X (Performance Year Volume -Base Year Volume) X 50 percent Variable Cost Factor
- Excluded from this analysis are drug and supply rate centers because of the unreliable unit of cost and because a significant portion of drug costs are covered by the Commission's stand-alone CDS-A policy
- 3. Conversion factors are accounted for in volume assessment, e.g., clinic RVU conversion

During the volume workgroup engagement, stakeholders understood the need for utilizing experience data, especially over the course of the ICD-9 to ICD-10 conversion but were nevertheless concerned about the permanent departure from using ECMADS in a volume assessment because: a) growth in out-of-state drugs and supplies would not be accounted for; and b) multiple volume statistics would over complicate the volume ecosystem. Staff concurred and furthermore agreed to the workgroup's suggestion to lock in out-of-state assessments from Rate Year 2014 to Rate Year 2023 using experience data, and then to advance to ECMAD assessments for Rate Year 2023 to future fiscal years. Moving forward, this will require a compounding calculation on the part of HSCRC staff between the two volume statistic periods but will ensure that no future volume adjustments will be made without utilizing ECMADS, the industry standard for assessing acuity adjusted volumes.

Implementation

In this section, staff explains implementation considerations that were discussed by the Volume Workgroup and reported out to the Payment Model Workgroup. In addition to the volume methodologies outlined in this recommendation, staff request that the comment letters also opine on the proposed implementation processes.

Accuracy of Volume Evaluation and Potential for Temporal Volume Change

Three principal concerns were raised by the Volume Workgroup. First, workgroup members raised the issue of methodology accuracy, given the reliance on Medicare total cost of care data and the small and potentially temporal nature of the associated volume changes. Second, members noted that not all hospitals have the same efficiency and retained revenue levels, and thus there should be some consideration of varying cost structures and profitability when implementing adjustments. Third, members noted that in certain cases the reduction of services through deregulation, expatriation, and/or out-of-state movement may not be driven by a hospital and/or may happen rather suddenly, e.g, a physician practice elects to quickly

¹¹ The Total Cost of Care contract requires that 95 percent of all in-state revenue be under a population-based methodology. Out-of-state volume is not subject to this requirement, which is why it can be evaluated through a volume variable methodology.

¹² Materiality will be discussed in the following *Implementation* section.

sever affiliation with a hospital and moves its referrals elsewhere. In this case the hospital may still like to replace the departing practice with a new physician group over the course of the next year which would make any adjustment temporary. This last point is particularly salient for deregulation, as Commission staff noted in the workgroup engagement that it would not advance a policy incentive to Commissioners that reverses deregulation and rewards movement up the continuum of care, given the goals of the TCOC Model.

For these reasons, staff proffered the following implementation approaches:

- Deregulation, Repatriation, and Out-of-State adjustments are to be implemented at the next available rate issuance on a one-time basis, thereby recognizing potentially temporal volume change
- 2. Hospitals can provide additional information to contest an HSCRC finding, but will have the burden of proof, and HSCRC staff will be final arbiters of this decision.
- 3. If one-time adjustments are made and the same finding is made the following year, the adjustment will be made permanent.
- 4. All adjustments will be subject to a materiality threshold.

Materiality Thresholds

Staff spent the majority of time with the workgroup debating what are appropriate materiality thresholds, which represent a tool the Commission has previously used to reduce the need for making out-of-state volume adjustments year after year, per the GBR contracts. While no consensus was reached, many members did appear to support the idea of not applying materiality thresholds for negative adjustments to inefficient hospitals, as identified by the Integrated Efficiency policy. Additionally, many members supported the idea of asymmetrical materiality thresholds, whereby hospitals would receive a negative adjustment only when a larger materiality was met - a commercial payer representative did not agree with this recommendation.

Staff concurred with the idea that inefficient hospitals should not get special protections from negative materiality thresholds, because these hospitals are already classified as outliers and allowing them to retain more revenue would worsen their position. Staff believe, however, that negative materiality thresholds are warranted for non-inefficient hospitals, because most of these volume changes are small and potentially temporal. Additionally, various policies incentivize actions like deregulation (GBR's, MPA, EQIP), and the future maturity of the Model may depend on moving to greater capitation risk, especially for rural hospitals; therefore, it is not desirable to be overly punitive towards these changes.

¹³ The Integrated Efficiency policy simultaneously evaluates hospitals relative ranking in hospital cost per case efficiency and total cost of care effectiveness, both for Medicare and Commercial beneficiaries. https://hscrc.maryland.gov/Pages/efficiency.aspx

The asymmetrical proposal was the most difficult proposal to evaluate because symmetry is methodologically desirable and more intuitive; however, upon further reflection, staff identified that all growth in out-of-state volumes is beneficial for the Model because Maryland is effectively exporting services, which when reimbursed at a 50 percent variable cost factor, lowers price per case and Maryland TCOC. Additionally, all repatriation is favorable for the Model because reimbursement at a 50 percent variable cost factor inside the state and divestment at a 100 percent variable cost factor outside the state lowers price per case and Maryland TCOC. Thus, applying a higher materiality threshold to desirable actions, albeit symmetrical, may disincentive hospitals from growing "good volumes."

In light of these considerations, staff propose the following recommendations:

Table 6: Recommendations for Materiality Threshold Implementation

Policy	Materiality Threshold	Implement one-time initially and permanently one year later (Recommendation 5)	Implement permanently upon initial adjustment				
Deregulation							
Decreases GBR	Approach A	X					
Change to Rendering	Location State	e for MD resident					
Repatriation	Approach B	X					
Expatriation	Approach A	X					
Change to Rendering	Location State	e for Out of State resident	ts				
Into State	Approach B		X				
Out of State	Approach A		X				
 Materiality Approach A is: 1. The hospital is in the worst quartile of the most recently published Integrated Efficiency policy OR 2. The adjustment exceeds 3 percent of the hospital's GBR OR 3. The adjustment exceeds 3 percent of the associated service line revenue Materiality Approach B is 1. The adjustment exceeds 1 percent of the hospital's GBR OR 2. The adjustment exceeds 1 percent of the associated service line revenue 							

Results

This section will outline the results of the proposed methodologies¹⁴, both with and without the materiality thresholds. For Deregulation and Repatriation the assessment is calendar year 2023 over 2019, per the workgroup recommendation. For out-of-state volume the assessment is rate year 2023 over rate year 2014 (except for hospitals that have been rebased since 2014).

Deregulation

Table 7: Deregulation 2019-2023 (\$ Thousands; with and without materiality thresholds)¹⁵

		CT/MRI/PE	Major	Minor	Oncology Related			Total with Materiality
Hospital	Cardiovascular	Т	Surgery	Surgery	Services	Radiology	Total	Thresholds
ANNE ARUNDEL	-\$68	-\$7	-\$4,558	-\$1,346	-\$698	-\$111	-\$6,788	-\$70
GBMC	-\$1	-\$51	-\$635	-\$512	-\$3,475	-\$359	-\$5,033	-\$970
JOHNS HOPKINS	\$0	-\$161	-\$448	-\$3,005	\$0	-\$41	-\$3,655	-\$1
UMMC	-\$94	-\$539	-\$705	-\$1,393	\$0	-\$166	-\$2,898	-\$2,898
UM-St. Joe	-\$735	-\$60	-\$842	-\$618	-\$110	-\$516	-\$2,881	-\$2,881
SINAI	-\$56	-\$186	-\$870	-\$821	-\$479	-\$454	-\$2,865	-\$2,865
Frederick	-\$15	-\$34	-\$1,141	-\$744	\$0	-\$161	-\$2,095	-\$69
MedStar Good Sam	\$0	\$0	-\$1	-\$1,924	-\$27	-\$43	-\$1,995	-\$144
Peninsula	-\$108		-\$325	-\$53	-\$473	-\$638	-\$1,741	-\$66
MERITUS	-\$35	\$0	-\$56	-\$1,628	\$0	\$0	-\$1,720	-\$94
UM-BWMC	\$0	-\$64	-\$507	-\$850	-\$196	-\$46	-\$1,664	-\$15
Doctors	-\$166	-\$1	-\$459	-\$456	-\$178	-\$206	-\$1,467	-\$63
Western Maryland	-\$235	-\$253	-\$397	-\$313	-\$33	-\$200 -\$82	-\$1,312	-\$0
ATLANTIC GENERAL	-φ <u>2</u> 33		-\$58	-\$446	-\$307	-\$421	-\$1,288	-\$274
HOLY CROSS	-\$51	-\$195	-\$35	-\$713	\$0	-\$172	-\$1,166	-\$123
NORTHWEST	-\$1		-\$52	-\$146	-\$466	-\$448	-\$1,141	-\$1,141
Ascension Saint Agnes Hospital		\$0	-\$278	-\$227	-\$232	-\$77	-\$1,115	-\$10
SHADY GROVE	-\$70	-\$896	-\$22	-φ227 -\$1	\$0	-\$67	-\$1,054	-\$703
CALVERT	-\$56	-\$690 \$0	-\$121	-\$155	\$0	-\$614	-\$1,054	-\$297
UM-Charles Regional	-\$59	-\$23	-\$121	-\$155	-\$15	-\$614	-\$888	-\$297 -\$34
JH Bayview	-\$120	-\$23	-\$104	-\$523	-915	-\$49	-\$864	-\$864
MERCY	-\$120	-\$80	-\$104	-\$523	\$0	-\$37 -\$472	-\$853	-\$802
CARROLL	-\$21	-\$3	-\$358	-\$197	\$0	-\$472	-\$806	-\$806
UMMCMIDTOWN	-\$21 -\$1			-\$402	-\$9	-\$250	-\$806	
	-\$1 -\$125	-\$62 -\$218	-\$60 -\$212	-\$393 - \$1 55	-\$9	-\$250 -\$41	-\$773 -\$751	-\$773 -\$335
UM-Upper Chesapeake								
MedStar Union Mem	-\$246	-\$6	-\$22	-\$35	\$0	-\$436	-\$745	-\$34
MedStar St. Mary's	-\$38	\$0	-\$177	-\$203	-\$160	-\$161	-\$738	-\$5
MedStar Fr Square	\$0		-\$56	-\$115	-\$459	-\$6	-\$635	\$0
Adventist White Oak	-\$5	-\$270	-\$21	-\$47	\$0	-\$249	-\$591	-\$608
UM-Easton	-\$6		-\$129	-\$32	\$0	-\$340	-\$549	-\$549
SUBURBAN	-\$13	-\$18	-\$115	-\$173	\$0	-\$116	-\$435	-\$17
UM-Harford	\$0	-\$67	-\$189	-\$54	\$0	-\$116	-\$425	-\$7
ChristianaCare, Union	\$0	-\$83	-\$124	-\$15	-\$5	-\$178	-\$405	-\$405
MedStar Harbor	-\$35	-\$16	-\$270	-\$11	\$0	-\$69	-\$402	-\$1
Garrett	-\$7	\$0	-\$13	-\$280	\$0	-\$36	-\$337	-\$1
UM-Capital Region Medical Cen		-\$5	-\$19	-\$5	\$0	-\$196	-\$310	-\$310
HOWARD COUNTY	-\$13	-\$2	-\$77	-\$126	\$0	-\$28	-\$246	\$0
Grace Medical center	\$0		\$0	\$0	\$0	-\$108	-\$237	-\$323
MedStar Southern MD	-\$105	-\$11	\$0	-\$10	\$0	-\$71	-\$197	-\$4
HC-GERMANTOWN	-\$5		-\$85	-\$28	-\$1	-\$1	-\$138	-\$1
UM-Chestertown	\$0	\$0	\$0	-\$130	\$0	-\$5	-\$136	-\$136
MedStar Montgomery	-\$9		-\$29	-\$2	\$0	-\$37	-\$129	-\$106
FT. WASHINGTON	\$0		-\$28	-\$10	\$0	-\$59	-\$96	-\$12
Mccready	\$0	\$0	\$0	-\$1	\$0	\$0	-\$1	\$0
Total	-\$2,897	-\$3,874	-\$13,750	-\$18,965	-\$7,321	-\$7,701	-\$54,509	-\$18,024

¹⁴ Please note that the modeling will differ slightly from what was provided to the Volume Workgroup because staff amended the materiality thresholds to reconcile to the threshold value versus the whole variance once the threshold is triggered.

¹⁵ Values are subject to change because the Rate Year 2025 Integrated Efficiency rankings have yet to be finalized due to data delays in Commercial TCOC data.

Repatriation

Table 7: Repatriation 2019-2023 (with and without materiality thresholds)¹⁶

Hospital	Repatriation/Expatriation	Repatriation/Expa triation with Materiality Thresholds
MedStar- Southern MD	\$2,003,143	\$2,584,31
JHH- Suburban	\$1,231,427	\$796,65
UMMS- BWMC	\$1,042,118	\$802,35
Saint Agnes Colvert	\$800,568	\$69,83
Calvert MedStar- Union Mem	\$568,005	\$626,48
	\$732,156	
Trinity - Holy Cross Germantown	\$644,512	\$515,59
JHH- Johns Hopkins	-\$512,259	\$329,72
UMMS- St. Joe	\$436,738	\$387,78
MedStar- Montgomery	\$353,702	\$181,61
UMMS- Midtown	\$353,997	\$172,87
Mercy	\$334,196	\$188,59
Adventist-Ft. Washington	\$319,769	\$303,46
Luminis- Anne Arundel	\$1,195,994	\$1,538,50
MedStar- Franklin Square	\$73,856	\$386,22
JHH- Bayview	\$137,054	-\$35,95
UMMS- Chestertown	-\$81,513	-\$81,51
Tidal- McCready	-\$68,431	-\$3,14
UMMS- Capital Region	-\$24,639	-\$95,27
MedStar- St. Mary's	-\$111,081	\$9,62
MedStar- Good Sam	-\$109,206	-\$65,08
Lifebridge- Levindale	-\$193,342	\$136,45
JHH- Howard County	-\$193,911	-\$32,79
MedStar- Harbor	-\$202,183	-\$76,99
Lifebridge- Grace	-\$244,216	-\$106,48
Lifebridge- Northwest	-\$206,732	-\$282,75
Adventist- White Oak	-\$225,528	-\$468,16
Garrett	-\$333,959	-\$107,56
UMMS- Easton	-\$404,124	-\$404,04
ChristianaCare, Union	-\$480,977	
Frederick	-\$573,660	-\$298,51
Lifebridge- Carroll	-\$762,716	-\$762,71
Luminis- Doctors	-\$927,158	-\$915,75
Atlantic General	-\$138,889	-\$65,27
Tidal- Peninsula	-\$655,294	\$11,82
UMMS-Upper Chesapeake	-\$1,114,711	-\$70,75
UMMS- Harford	-\$1,323,453	-\$992,33
GBMC	-\$1,244,030	\$83,29
Lifebridge- Sinai	-\$1,723,591	-\$1,780,93
Western Maryland	-\$3,144,793	-\$1,320,07
Trinity - Holy Cross	-\$2,943,102	-\$218,89
UMMS- UMMC	-\$3,608,282	-\$3,539,95
Adventist- Shady Grove	-\$4,546,224	-\$3,058,10
Total	-\$15,870,771	-\$5,882,04

¹⁶ See supra note 15

-

Remaining Limitations

Staff have ensured that volumes adjusted through the Deregulation and Repatriation methodologies do not duplicate what has already been shifted through the Market Shift policy. However, this cross-referencing step was done separately for each methodology. There is a scenario where deregulation adjustments and expatriation adjustments can simultaneously but independently cross reference the same service lines in the Market Shift policy, which could result in removing more volume from GBR's than actual declines that occurred. Staff believe this is a small but still important risk to consider, and as such will release additional modeling, prior to the final policy recommendation, that ensures the deregulation and expatriation methodologies are not duplicative.

Out-of-State

Table 9: OOS Volume Change through RY 2023 (removes potential adjustments under \$300k)

dine change thire	·	Materiality Thresholds: 1% growth, 3% Decline OR
HospitalName	OOS Revenue Increase @ 50%	Integrated Efficiency
ChristianaCare, Union	\$2,642,943	\$934,768
Suburban	\$2,436,391	\$0
MedStar Montgomery	\$1,352,522	\$0
Anne Arundel	\$1,204,766	\$0
Peninsula	\$474,859	\$0
Northwest	\$343,157	\$0
UMROI	-\$355,415	-\$355,415
UM-Chestertown	-\$422,391	-\$422,391
Shock Trauma	-\$433,419	\$0
Ft. Washington	-\$456,469	\$0
MedStar Franklin Square	-\$488,951	\$0
UM-Charles Regional	-\$510,257	\$0
MedStar Harbor	-\$522,913	\$0
Grace Medical Center	-\$562,990	\$0
UM-Harford	-\$597,587	\$0
Garrett	-\$606,328	\$0
UM-BWMC	-\$722,384	\$0
Doctors	-\$882,268	\$0
Holy Cross	-\$923,236	\$0
MedStar Union Memorial	-\$1,237,563	\$0
St. Agnes	-\$1,402,526	\$0
UM-Upper Chesapeake	-\$1,488,932	\$0
Shady Grove	-\$1,612,735	\$0
Carroll	-\$1,900,591	-\$1,900,591
Sinai	-\$2,496,323	-\$2,496,323
MedStar Good Sam	-\$2,629,575	\$0
UM-Laurel FMF	-\$3,226,947	-\$2,345,398
UM-St. Joe	-\$3,278,295	-\$3,278,295
Frederick	-\$3,614,904	\$0
GBMC	-\$3,644,367	\$0
Mercy	-\$5,406,642	\$0
JH Bayview	-\$6,222,775	-\$6,222,775
Adventist White Oak	-\$6,669,239	\$0
Western Maryland	-\$8,226,074	-\$616,389
UM-Capital Region	-\$10,162,905	-\$10,162,905
UMMC	-\$12,358,036	-\$12,358,036
Johns Hopkins	-\$65,682,740	-\$567,814
Total	-\$139,761,961	-\$39,699,940
	Q100,, 01,001	\$55,555,540

Future Considerations

The HSCRC is no longer strictly a price regulator. The Commission has direct oversight of price and volume under GBRs, and thus the market no longer allocates volume funding in an unimpeded fashion. With Global Budgets, the Commission must interpret the invisible hand of the market and distribute funding through several volume policies. To ensure that the volume policies are working well, it is incumbent on the HSCRC to verify that the policies in aggregate are adequately covering the costs of new volumes.

For several years, staff have demonstrated that the combination of the Demographic Adjustment and Market Shift policy revenue adjustments exceed total in-state volume changes. However, there was no accounting for additional adjustments related to irregular volume change (deregulation, repatriation, out-of-state, and miscellaneous), negative adjustments that occurred due to the Potentially Avoidable Utilization Shared Savings policy, and Efficiency adjustments that are heavily influenced by volume change.

As such, during the Volume Workgroup engagement, staff created a "Volume Scorecard" to assess the relationship of volume to funding during the All-Payer and Total Cost of Care Models. Specifically, staff calculated an expected volume funding that would have occurred each year if all volume change was adjusted through a volume variable or fee-for-service methodology (utilizing a 50 percent variable cost factor), otherwise known as "FFS Counterfactual Funding," versus all revenue adjustments that occurred, otherwise known as "Observed Funding." Staff purposefully used a 50 percent variable cost factor because the fixed costs are already covered by the global budgets and are adjusted each year for inflation through the Annual Update Factor. The evaluation builds off previous analyses of Market Shift and Demographic Adjustment policies and purposefully demonstrates how each revenue adjustment layers on top of each other to adequately fund volume at both the state and individual hospital level.

Staff do not believe this scorecard should be used as a methodology, for example to reconcile hospital revenue to FFS Counterfactual Funding, as the Model is no longer volume based, and a hospital that has failed to implement appropriate population health initiatives may have Observed Funding below FFS Counterfactual Funding in this approach. Staff do believe this scorecard is an important analytical tool that the HSCRC can use for future evaluations, thereby improving the Commission's selection of what population-based methodology to potentially modify. Below are the results of the Volume Scorecard for calendar year 2014 through 2023:

¹⁷ During the Volume workgroup engagement staff did extensive analyses, per workgroup member requests, to support the use of a 50 percent variable factor. Highlights of those analyses can be found in Appendix 3.

Table 10a: Volume Scorecard (with Market Shift Adjustments)

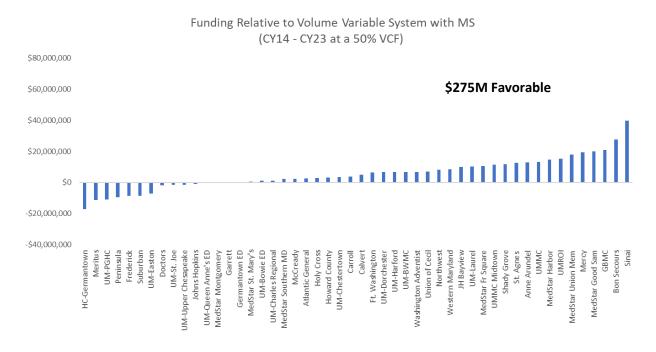


Table 10b: Volume Scorecard (with Market Shift and Demographic Adjustments)

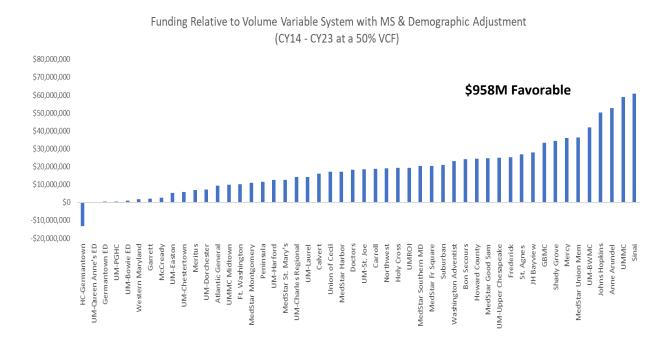


Table 10c: Volume Scorecard (with Market Shift and Demographic Adjustments & Out-of-State and Potentially Avoidable Utilization Adjustments)

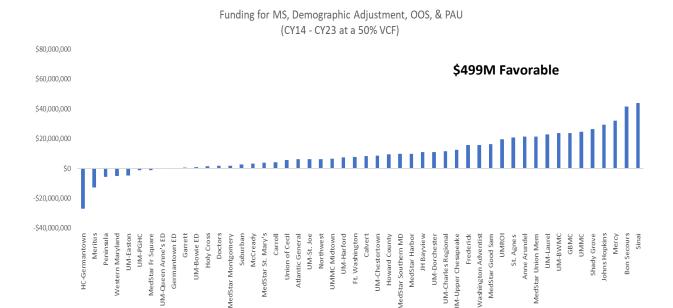
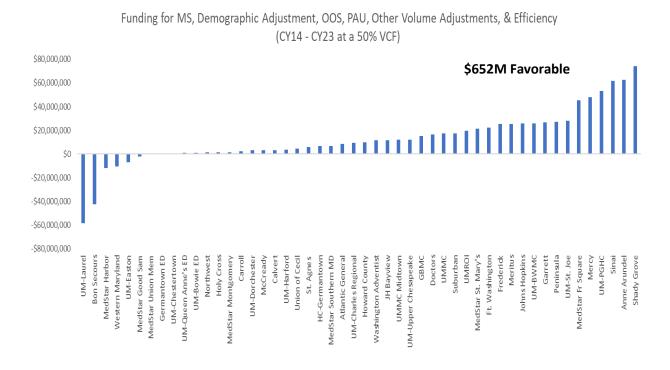


Table 10d: Volume Scorecard (with Market Shift and Demographic Adjustments, Out-of-State and Potentially Avoidable Utilization Adjustments, & Other Volume and Efficiency Adjustments)



As noted in Table 10a, there are thirteen hospitals through the Market Shift policy alone that have not been funded for all volume growth, which is by design, as the Market Shift was never

intended to fund all use rate growth. In table 10b, the addition of the Demographic Adjustment reduces this to only two hospitals not meeting this standard. In table 10c, when out-of-state and Potentially Avoidable Utilization (PAU) volumes and revenue adjustments are accounted for, there are eight hospitals that where FFS Counterfactual Funding is below Observed Funding, largely due to the nearly \$700 million that PAU Shared Savings Model removed from GBR's. It should be noted that this was also by design and that PAU Shared Savings Model is no longer a system savings mechanism. Finally, in table 10d when all relevant adjustments are accounted for, there are seven hospitals where FFS Counterfactual Funding is below Observed Funding, but of the seven, two are free-standing medical facility (FMF) conversions that should be evaluated along with their sister system hospitals as there are offsetting relationships (UM-Laurel with Cap Region and Grace with Sinai). Moreover, some deficit between FFS Counterfactual Funding and Observed Funding of a few hospitals for volume growth may be entirely warranted in the Model if select hospitals have been unsuccessful in reducing potentially avoidable utilization and/or if use rate growth is generally outpacing population growth.

The other side of this dynamic is that far more hospitals across all evaluations had high Observed Funding, relative to the FFS Counterfactual Funding, and several hospitals were by a significant amount. However, this is the central incentive of the Model to retain revenue as efforts are made to improve the health of the population and potentially avoidable utilization is averted. Nevertheless, over the past several years, the Commission has implemented three significant policies to reduce any perceived imbalance or misallocation in the system that may result because of the population based volume methodologies: a) PAU Shared Savings, which penalizes hospitals with above average levels of readmissions and avoidable admissions and has evolved to a redistribution policy; b) Integrated Efficiency, which scales inflation for relatively inefficient hospitals that have idle resources due to excessive retained revenue, among other things; and c) the Full Rate Application policy, that has provided over the past two years nearly \$150 million to hospitals that are relatively efficient, in large measure due to lower than average volume funding.

In summary, it appears that the population-based volume policies, as a whole, are having their intended effect in funding volume changes across the system and at this time there is no need to modify the underlying methodologies. Further, even if it showed all volumes were not funded it would not necessarily indicate a need to change policies as Maryland is not operating under a volume-based fee-for-service system; however, it could be a warning sign to gaps in the policy suite. For example, the Volume Scorecard could indicate that new service line offerings that were never provided to the population when global budgets were first established require an additional volume policy. Finally, staff cautions against any perceived funding misallocation that the Volume Scorecard might propound, as redistribution is being addressed

¹⁸ Staff has currently engaged a contractor to help develop methodologies for measuring access, across multiple care domains, that will help with future policies that aim to address unmet need.

each year, in parallel to the volume policies, through the formulaic methodologies of PAU, Integrated Efficiency, and the Full Rate Application policies.

Recommendations

- 1. Establish a Deregulation policy based on the methodology outlined herein that will result in negative revenue adjustments to hospitals' global budgets.
- 2. Establish a Repatriation policy based on the methodology outlined herein that will result in positive (repatriation) and negative (expatriation) revenue adjustments to hospitals' global budgets.
- 3. Establish an Out-of-State policy based on the methodology outlined herein that will result in positive and negative revenue adjustments to hospitals' global budgets.
- 4. Implement Deregulation, and Expatriation, the next available rate issuance on a one-time basis, negative Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:
 - a. The hospital is in the worst quartile of the most recently published Integrated Efficiency policy OR
 - b. The adjustment exceeds 3 percent of the hospital's GBR OR
 - c. The adjustment exceeds 3 percent of the associated service line revenue
 - d. All Planned Deregulations should still be reported to the Commission in conformance with the GBR agreement and adjusted accordingly.
 - If deregulation methodology indicates a potential deregulation that varies from planned deregulation by more than 10 percent, staff may consider revising the deregulation adjustment
- 5. Implement Repatriation at the next available rate issuance on a one-time basis, positive Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:
 - a. The adjustment exceeds 1 percent of the hospital's GBR OR
 - b. The adjustment exceeds 1 percent of the associated service line revenue
- 6. Implement Deregulation, and Repatriation/Expatriation adjustments on a permanent basis one year following the initial one-time revenue adjustment to allow for potential backfilling and/or dissipation. Hospitals can provide additional information to contest the volume finding, but will have the burden of proof, and HSCRC staff will be final arbiters of this decision.
- 7. Codify the staff's approach to evaluating the over/under funding of volume in Commission's volume policies

Appendix 1. Key Methodology Concepts and Definitions

- 1. All-Payer Refined Diagnosis Related Groups (APR-DRG) 3M's classification system that groups hospital inpatients according to their reason for admission, severity of illness and risk of mortality.
- 2. Enhanced Ambulatory Patient Groups (EAPGs) 3M's classification system that groups outpatient medical visits and procedures based on similar clinical characteristics, resource use and costs. 3M EAPGs are designed to reflect the resources used in an ambulatory visit and to calculate expected payments for outpatient services.
- 3. Equivalent Case Mix Adjusted Discharges (ECMADS) Often referred to as casemix, ECMADS are a volume statistic that account for acuity, as not all services require the same level of care and resources.
- 4. Markets Shift Policy (Market Shift) Provides the criteria to reallocate funding to account for shifts in cases between regulated hospitals, with the objective of ensuring that funding follows the patient and hospitals continue to have a competitive interest in serving patients. The MSA does not currently address all volume changes, only those the Commission can quantify as shifts between hospitals and only volumes the Commission deems appropriate.
- 5. Demographic Adjustment Policy (Demographic Adjustment) Provides funding for ageadjusted growth at the zip code or county level in order to anticipate changes in utilization based on demographic changes. The Demographic Adjustment is capped by Maryland Department of Planning estimates of statewide population growth to align with the per capita nature of the All-Payer/Total Cost of Care Model tests.
- 6. Unrecognized ECMADS Acuity adjusted volume that grew or declined but was not shifted in the Market Shift methodology.
- 7. Casemix Data –Confidential patient-level hospital administrative data on all inpatient admissions and outpatient visits.
- 8. Experience Data Monthly hospital unaudited revenue and volumes data by rate center used to monitor hospital charging compliance with approved rates.
- 9. Variable Cost Factor The percentage of charges required to reimburse a hospital for the variable costs (supplies, drugs, etc.) associated with increases in volume. The standard by which the industry and the Commission evaluates volume funding adequacy is 50 percent, as 50 percent of all service charges on average covers fixed costs and 50 percent covers variable costs. This value is not uniform by service line.

- 10. Service Lines Groupings of services into higher level categories that reflect similar clinical delivery. Service lines are utilized to determine market shifts in the Market Shift methodology and the proposed Deregulation and Repatriation Policies.
- 11. Volume Scorecard A comprehensive visualization tool that accounts for all volume policies. The Volume Scorecard assesses Market Shift, Demographic Adjustment, out-of-state volumes, deregulation, repatriation/expatriation and PAU, as well as adjustments related to efficiency policies. The scorecard will not include CDS-A and Complexity and Innovation, as those policies are standalone.
- 12. Chronic Condition Warehouse (CCW) Data Medicare and Medicaid beneficiary, claims, and assessment data linked by beneficiary across the continuum of care.

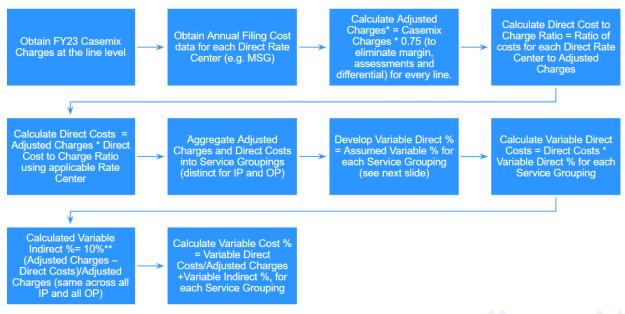
Appendix 2. EAPG Market Shift Example

Actual Unrecognized ECAMDS for Frederick

Hospital, Major Surgery in Prince George's		(0.953)					
HOSPITALNAME		Frederick J					
PROD_CAT		Major Surgery 🖫					
zipcode		Prince Georges 🛪				Calculated	Proof
		Α	В	C=B-A	D	E=C/SUM(C:C)	F=CXSUM(D:D)
		Sum of	Sum of	Unrecog	Allocated		Normalized
Row Labels	.T	ecmadCY1922	hospshift	ecmads	Unre cog ecmads	Share of EAPG/Unrecognized	Unrecognized ECMADS
115:::DEEP LYMPH STRUCTURE PROCEDURES		(0.62)	(0.38)	(0.242)	(0.234)	25%	(0.234)
172:::LEVEL III KIDNEY AND URETERAL PROCEDURES		(0.94)	(0.94)	-	-	0%	-
208:::LEVEL II OTHER UTERINE AND ADNEXA GYNE COLOGICAL PROCEDURE	S	(0.59)	(0.29)	(0.302)	(0.292)	31%	(0.292)
26:::LEVEL KNEE AND LOWER LEG PROCEDURES		(0.52)	(0.52)	-	-	0%	-
28:::LEVEL I SPINE PRO CEDURES		(0.68)	(0.24)	(0.442)	(0.428)	45%	(0.428)
29:::LEVEL II SPINE PRO CEDURES		(1.52)	(1.52)	-	-	0%	-
64:::LEVEL I LOWER AIRWAY ENDOSCOPY		0.33	0.33	-	-	0%	-
Grand Total		(4.54)	(3.55)	(0.985)	(0.953)	100%	(0.953)

Appendix 3. 50 Percent Variable Cost Factor Analyses

Evaluation Process



- * Adjusted Charges is conceptually = total costs since all non-cost items have been stripped out.
- ** Indirect variable ratio of 10% was obtained based on a review of which indirect cost centers were likely to flex with volume in the short term. As all costs are variable in the long term this value would move towards 100% with time, this approach can be used to derive estimates of variable % over the longer time windows.

Results – Inpatient

Calculation	Service Grouping	Emerg.	Lab & Tests	MSS & CDS	OR	Other	R&B	Therapy	Total
A=Charges X .75	Adjusted Charges(\$M)	\$698	\$1,377	\$1,636	\$1,081	\$100	\$3,848	\$494	\$9,234
В	Direct Costs (\$M)	\$377	\$677	\$1,196	\$507	\$62	\$2,507	\$311	\$5,637
С	Variable Direct %	50.0%	20.0%	100.0%	50.0%	50.0%	90.0%	80.0%	
D=B*C	Variable Direct Costs (\$M)	\$189	\$135	\$1,196	\$253	\$31	\$2,257	\$249	\$4,310
E	Variable Indirect %	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%
F=D/A+E	Variable Cost %	30.9%	13.7%	77.0%	27.3%	35.2%	62.5%	54.3%	50.6%

Results – Outpatient (see formulas on IP Table)

Service Grouping	Emerg.	Lab & Tests	MSS & CDS	OR	Other	Clinic	Rad. Therap Y	Radiol.	Therap y	Total
Adjusted Charges(\$M)	\$687	\$526	\$1,767	\$1,255	\$16	\$370	\$202	\$714	\$95	\$5,632
Direct Costs (\$M)	\$444	\$271	\$1,235	\$556	\$6	\$252	\$81	\$317	\$51	\$3,214
Variable Direct %	50.0%	20.0%	100.0%	50.0%	50.0%	50.0%	20.0%	30.0%	80.0%	
Variable Direct Costs (\$M)	\$222	\$54	\$1,235	\$278	\$3	\$126	\$16	\$95	\$41	\$2,070
Variable Indirect %	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
Variable Cost %	36.7%	14.6%	74.2%	26.5%	23.9%	38.5%	12.4%	17.6%	47.3%	41.1%



RY 2027 Quality Based Reimbursement Draft Policy

October 9, 2024

HSCRC Quality Team

RY 2027 QBR Policy Updates

- RY 2027 Policy is largely unchanged from RY 2026
- HCAHPS:
 - Updated survey goes into effect January 2025: Responsiveness and composite care transitions domains temporarily removed from VBP/QBR
 - HCAHPS Learning Collaborative
- Timely Follow up measure updates
- ED LOS updates
- Digital Measures Update
- RY 2025 cut-point adjustment
- RY 2027 Recommendations



QBR RY 2026 Program

Performance Measures



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*

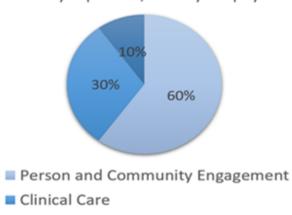
Safety— 6 Measures:

- -5 CDC NHSN HAI Categories;
- -AHRQ PSI 90 All-payer

Clinical Care-

Safety

--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%)



Benchmark



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

Hist. Performance

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%

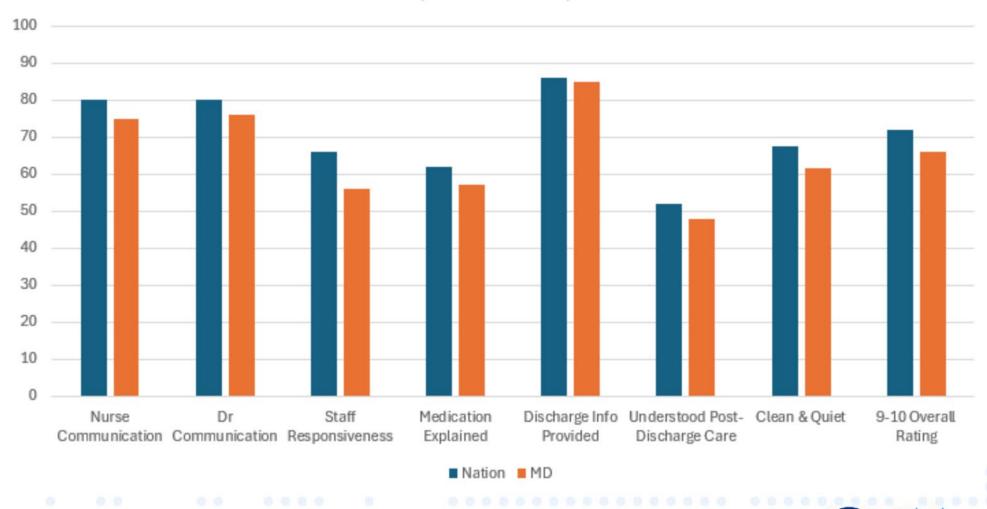
Max Penalty 2% & Reward +2% (ALL HOSPITALS HAVE OPPORTUNITY TO EARN REWARD)

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%

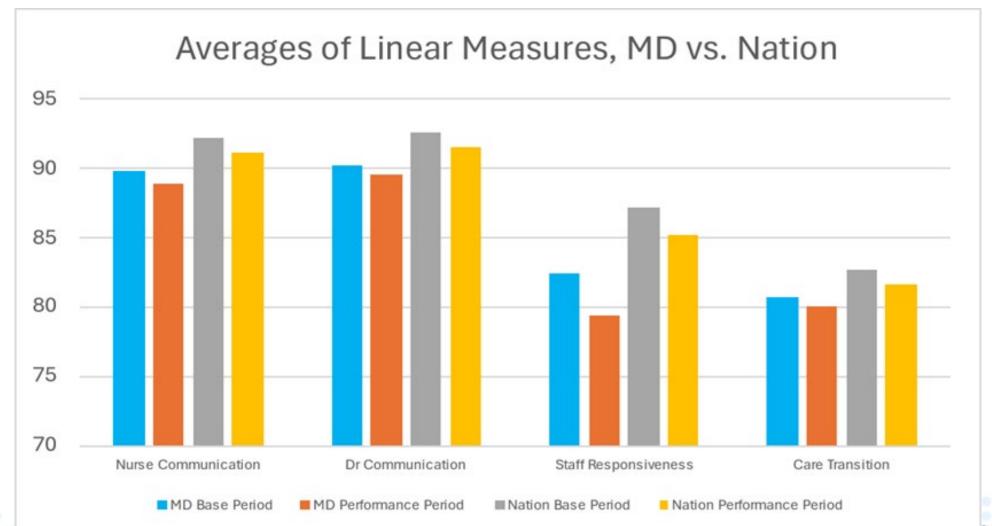
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

HCAHPS Most Recent Available Performance

HCAHPS Performance, MD vs Nation, 10/1/2022-9/30/2023



Linear Measure HCAHPS Results: Statewide Results Lag National Average, CY 2019 vs 7/1/22-6/30/23



Updated HCAHPS Survey CYs 2025 through 2027

• There is a decrease from eight to six HCAHPS sub-domains in the Person and Community Engagement

VBP domain:

- Communication with nurses
- Communication with doctors
- Communication about medicine
- Hospital cleanliness and quietness
- Discharge information
- Overall hospital rating
- CMS is updating two HCAHPS sub-domains and will be re-adopted into the PCE VBP domain in CY 2028
 - Composite care transition
 - Responsiveness of hospital staff
 - The two HCAHPS categories are included in the HCAHPS linear score measure and will need to be replaced; staff recommends including the overall hospital rating, and will vet linear measure inclusions with the PMWG.



HSCRC Learning Collaborative to Target HCAHPS Improvement

Goals: Compile best practices to improve patient experience; improve HCAHPS scores

Co-led by Jonathan Sachs (HSCRC consultant) and MHA

Stakeholders: Hospital HCAHPS and operations leaders, HSCRC Quality leadership team, national survey representatives

Staff tasks: Analyze HCAHPS data; Learn best practices from national organizations that consult to hospital providers; Quality improvement initiatives

Meetings: Monthly; HCAHPS knowledge level-setting, learning best practices from survey vendors and hospitals, and presenting data analysis results

Deliverable: Report of findings to the Commission

Jul-Aug 2024-Draft work plan presented to HSCRC

✓

Sept 2024-Present project to Commission Nov 2024 -Convene initial learning collaborative mtg; refine goals and objectives. Jan 2025-Convene learning collaborativ e for data review from the HSCRC/ MHCC

Mar 2025 Convene
learning
collaborative
to begin
process
improvement
initiatives

Sep-Oct 2025 – Share findings with HSCRC and work with Performance Measurement Workgroup to assess QBR incentives















Sep 2024 Begin data
analysis;
initial meetings
with MHA;
identify
collaborative cochair from hospital
leadership

Oct 2024 -Finalize work plan with MHA

Dec 2024 -Convene learning collaborative for data review with national survey vendors. Feb 2025 -Convene learning collaborative to share best practices. Apr-Sep 2025 - Convene sessions with learning collaborative to share findings initiatives, and draft final report.

Oct-Dec 2025 Update QBR HCAHPS policy recommendations as appropriate



QBR TFU Measure Updates for CY 2025



Timely Follow Up After an Acute Exacerbation of a Chronic Condition (TFU)- RY 2023-2026

The TFU measure assesses the percentage of ED visits, observation stays, and inpatient admissions for one of six chronic conditions in which a follow-up was received within the time frame recommended by clinical practice:

- Hypertension (follow-up within 7 days)
- Asthma (follow-up within 14 days)
- Congestive Heart failure (CHF)(follow-up within 14 days)
- Coronary artery disease (CAD)(follow-up within 14 days)
- Chronic obstructive pulmonary disease (COPD) (follow-up within 30 days)
- Diabetes (follow-up within 30 days)



TFU Measure Update: Spring of 2024 by the Partnership for Quality Measurement

"Qualifying" follow up visits that contribute to the numerator are now defined as those for which follow-up care was received <u>after the discharge date</u> (i.e., not same date as discharge) within the timeframe recommended by clinical practice guidelines, as detailed below:

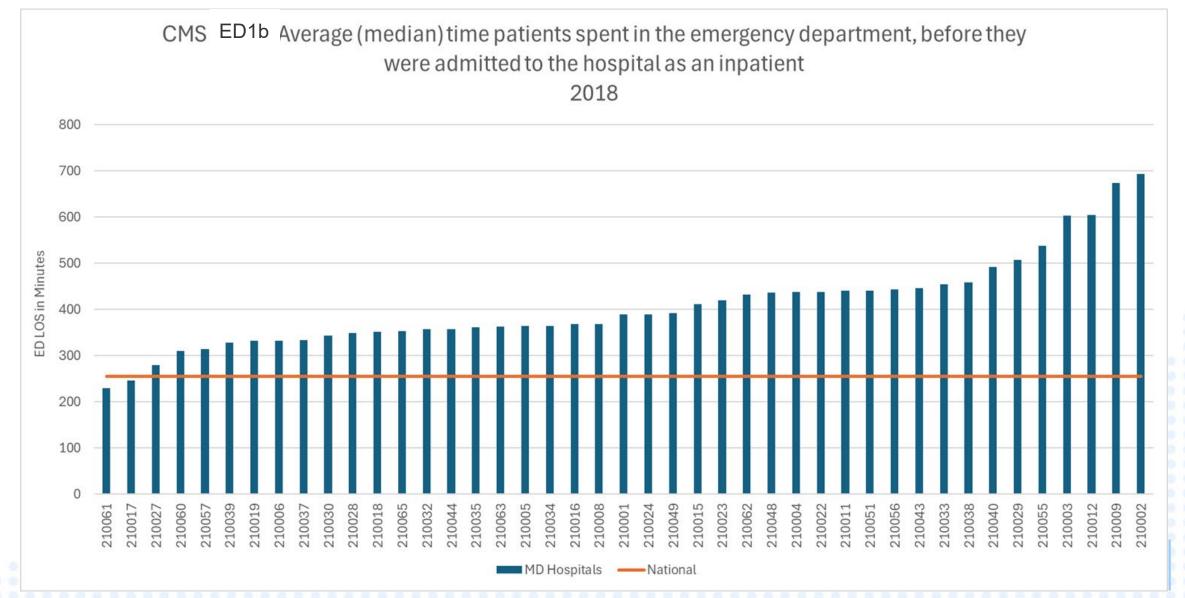
Chronic Condition	Original Follow-Up Days	Revised Follow-Up Days
Hypertension	7 days	14 days for high-acuity patients 30 days for medium-acuity patients
Asthma	14 days	14 days
Congestive Heart Failure	14 days	14 days
Coronary Artery Disease	14 days	7 days for high-acuity patients 6 weeks for low-acuity patients
Chronic Obstructive Pulmonary Disorder	30 days	30 days
Diabetes	30 days	14 days of the date of discharge for high-acuity patients

ED Length of Stay Measure

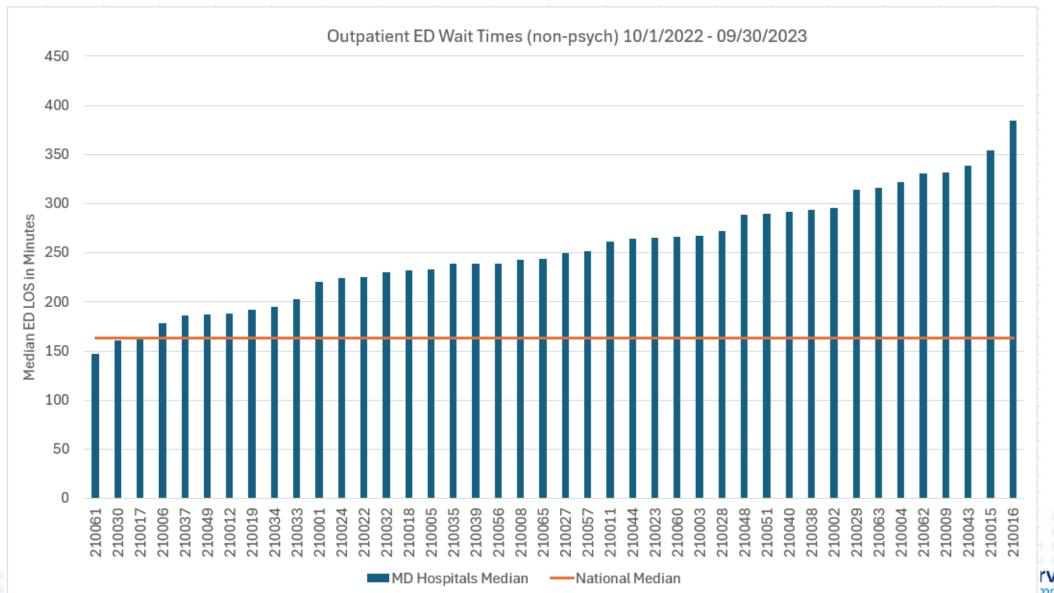
QBR Policy and ED LOS Measurement Development Timeline

- September/October/November 2023: Discussed at Performance Measurement Workgroup
- 11/8/2023 QBR Draft Policy: Proposed options for inclusion of ED LOS measure
 - Comment Letters: 11/1/2023 11/15/2023
- 12/13/2023 QBR Final Policy: Approved inclusion of ED LOS measure at 10 percent weight
- Commission discussion:
 - QBR ED LOS Measure Development plan was proposed on January 10, 2024 and reviewed on February 14, 2024
- ED LOS Development Subgroup Meetings:
 - ED Subgroup 1 (Data): February 2nd, 2024, March 1st, 2024, April 12th, 2024
 - ED LOS Data Submission Memo was sent via email to hospitals on May 20, 2024
 - ED LOS Data Submission Dates: Extended to September 13, 2024 (CY2023 and Jan-Mar 2024 data), December 16, 2024 (Apr-Sept 2024 data), March 2025 (Oct-Dec 2024 data)
 - ED Subgroup 2 (Incentive): April 26th, 2024, May 17th, 2024, June 21st, 2024, September 10, 2024,
 September 27, 2024
 - Meeting recordings and slides: <u>Subgroup ED LOS Measure (maryland.gov)</u>

Why include ED LOS in QBR?



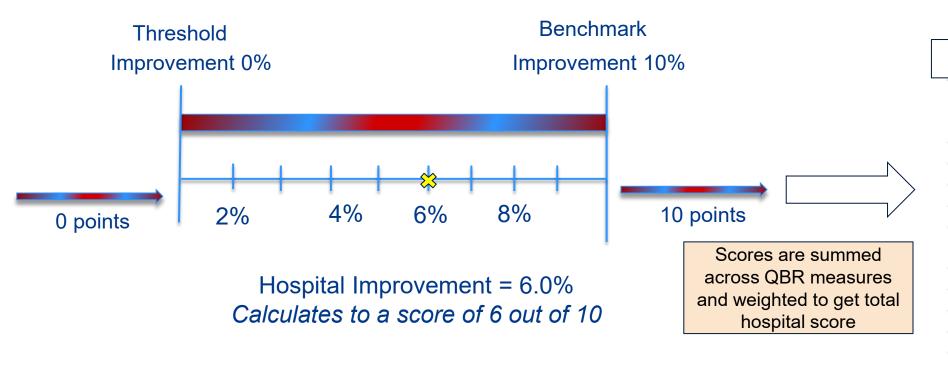
OP18b Outpatient ED LOS (more recent data)



QBR ED LOS Incentive CY 2024

- Incentive measures improvement from CY 2023 to CY 2024
- Measure: Percent change in the median time from ED arrival to physical departure from the ED for patients admitted to the hospital
- Population: All non-psychiatric ED patients who are admitted to Inpatient bed and discharged from hospital during reporting period
- Scoring: Use attainment calculation for percent change to convert improvement into a 0 to 10 point score (see next slide)
- Data: Ad hoc data submissions of time stamps to merge in with casemix data
- Performance standards: See Current Proposal slide

QBR Scoring Example



QBR Revenue Adjustment 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%



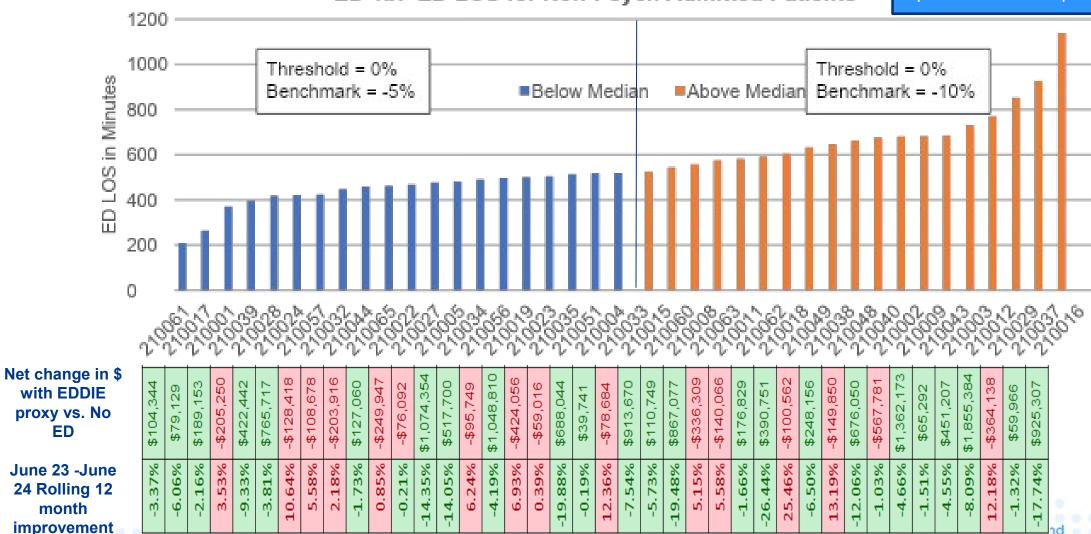
Current Proposal

ED

month

New! Hospitals beneath the 2018 ED1b National median of 256 minutes in performance period will not be penalized





CY25 Recommendations to Consider

- Staff is proposing the following for subgroup input:
 - Include ED1b in QBR PCE Domain at 10 percent of QBR (same weight)
 - Maintain improvement
 - Develop risk-adjusted ED LOS measure for attainment to be monitored or retrospectively adopted
 - Set improvement standards based on Statewide Improvement Goal established by ED
 Wait Time Reduction Commission
 - Base year: Cumulative improvement from 2023 vs. Year over Year improvement.
 - Tiers: Recommend if improvement only
 - Consider treating observation stays (23+ hrs?) as inpatient admissions
 - Other inclusion/exclusion criteria?

State Digital Measures Update

Goal: Drive Development and Use of Digital Quality Measures to Replace Claims-Based and Chart Abstracted Measures

- Reporting Requirements in CYs 2024 and 2025
 - Seven Electronic Clinical Quality Measures with
 - Hybrid Hospital Wide Readmissions and Hospital Wide Mortality measures for all payers beginning in July 2024
 - Submission timelines are quarterly
- Hospitals have voiced concern about stepped up timeline (CMS requires annual data submission after the performance year) related to EHR/vendor readiness
- The Commission has established an Exceptional Circumstances Exemption process for Maryland hospitals that also applies to delayed timelines
- Additional detail is included in the draft policy document

RY 2025 Revised Cut Point

RY 2025 QBR Cutpoint Discussion

Background:

- Current cut point is 41%, based on average national scores from FFY16-FFY21 using QBR weighting
- Due to changes in performance post-COVID, the cut point is retrospectively evaluated to try to ensure that MD hospitals are rewarded or penalized relative to national performance
- For RY 2025 the by-measure analysis has a national average score of ~31%
- To account for degradation in National and State performance, Staff recommends to lower cut point to 32 percent
 - Based on average performance of three post-covid years (FFY21-22, RY25)



QBR RY 2027 Draft Recommendations

- Maintain Domain Weighting as follows for determining hospitals' overall performance scores:
 Person and Community Engagement (PCE) 60 percent, Safety (NHSN measures) 30 percent,
 Clinical Care 10 percent.
 - a. Within the PCE domain, weight the measures as follows:

i. HCAHPS Top Box:	33.33 Percent
i. HCAHPS Top Box:	33.33 Perce

ii. HCAHPS Consistency: 16.67 percent

iii. HCAHPS Linear: 16.67 percent

iv. Timely Follow-Up for Medicare: 5.56 percent

v. Timely Follow-Up for Medicaid: 5.56 percent

vi. Disparities in Medicare Timely Follow-Up: 5.56 percent

vii. Emergency Department Length of Stay: 16.67 percent

- b. Within the Safety domain, weight each of the six measures equally (i.e., 30 percent divided by number of measures).
- c. Within the Clinical Care domain, weight the inpatient and 30-day mortality measure equally(i.e., 10 percent divided by two measures).

QBR RY 2027 Draft Recommendations

- 2. With regard to monitoring reports to track hospital performance:
 - a. Consider the feasibility of developing a Timely Follow-Up for Behavioral Health measure.
 - b. Disseminate Sepsis Dashboard.
 - c. Develop tools to monitor HCAHPS performance by patient and hospital characteristics.
- 3. Implement an HCAHPS learning collaborative with hospitals.
- 4. Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures.
- 5. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and maintain the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 41 percent.
 - a. Retrospectively evaluate 41 percent cut point using more recent data to calculate national average score for RY 2026 and RY 2027.
 - b. Based on concurrent analysis of national hospital performance, adjust the RY25 QBR cut point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.



Draft Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2027

October 9, 2024

This document contains the staff draft recommendations for updating the Quality-Based Reimbursement Program for RY 2027. Comments are due by COB 10/24/2024 and may be submitted to hscrc.quality@maryland.gov.

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Table of Contents

List of Abbreviations	3
Policy Overview	4
Draft Recommendations	4
Introduction	5
Background	9
Overview of the QBR Program	9
Assessment	11
Person and Community Engagement Domain	12
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)	12
HCAHPS Improvement Framework	14
Emergency Department Length of Stay	15
Timely Follow-Up After Discharge	19
Disparities in Timely Follow-Up	21
Safety Domain	24
CDC NHSN HAI Measures	24
Patient Safety Indicator Composite (PSI-90)	26
Sepsis Early Management Bundle (Sep-1)	29
Clinical Care Domain	31
Mortality	31
CMS 30-Day Condition-Specific Mortality Measures	31
QBR Inpatient, All-payer, All-condition Mortality measure	32
30-Day Inpatient, All-payer, All-condition Mortality Measure	33
Digital Measures Near-Term Reporting Requirements	34
Domain and Measure Weighting	36
Revenue Adjustment Methodology	37
Draft Recommendations for RY 2026 QBR Program	38
APPENDIX A: QBR PROGRAM BACKGROUND	1
APPENDIX B: RY 2025 QBR PERFORMANCE BY HOSPITAL	13
APPENDIX C: HCAHPS PATIENT LEVEL DISPARITY ANALYSIS	15
APPENDIX D: HCAHPS LEARNING COLLABORATIVE	20
APPENDIX E: HSCRC EFFORTS TO ADDRESS ED LENGTH OF STAY	22
APPENDIX F: ED LOS MEASURE DEVELOPMENT AND MODELING	27

LIST OF ABBREVIATIONS

AHEAD State's Advancing All-Payer Health Equity Approaches and Development

Model

APR DRG All Patient Refined Diagnosis Related Group
CDC Centers for Disease Control & Prevention
CAUTI Catheter-associated urinary tract infection

CCDE Core Clinical Data Elements (for digital hybrid measures)

CDIF Clostridium Difficile Infection

CLABSI Central Line-Associated Bloodstream Infection
CMS Centers for Medicare & Medicaid Services

DRG Diagnosis-Related Group

eCQM Electronic Clinical Quality Measure

ED Emergency Department

ED-1 Measure Emergency Department Arrival to Departure for Admitted Patients
ED-2 Measure Time of Order to Admit until Time of Admission for ED Patients

EDDIE Emergency Department Dramatic Improvement Effort

FFY Federal Fiscal Year

HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems

HSCRC Health Services Cost Review Commission

LOS Length of Stay

MIEMSS Maryland Institute for Emergency Medical Services Systems

MRSA Methicillin-Resistant Staphylococcus Aureus

NHSN National Health Safety Network
PQI Prevention Quality Indicators
QBR Quality-Based Reimbursement

RY Maryland HSCRC Rate Year (Coincides with State Fiscal Year (SFY) July-

Jun; signifies the timeframe in which the rewards and/or penalties would

be assessed)

SIR Standardized Infection Ratio

SSI Surgical Site Infection

TFU Timely Follow Up after Acute Exacerbation of a Chronic Condition
THA/TKA Total Hip and Knee Arthroplasty Risk Standardized Complication Rate

VBP Value-Based Purchasing

POLICY OVERVIEW

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/ Consumers	Effect on Health Equity
The quality programs operated by the Health Services Cost Review Commission, including the Quality-Based Reimbursement (QBR) program, are intended to promote quality improvement and ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.	The QBR program is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value within a global budget framework.	The QBR policy currently holds 2 percent of hospital inpatient revenue at-risk for Person and Community Engagement, Safety, and Clinical Care outcomes.	This policy ensures that the quality of care provided to consumers is reflected in the rate structure of a hospital's overall global budget. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	HSCRC Quality programs (QBR and Readmission Reduction Incentive Program)) give hospitals two scores, one for achievement and one for improvement; the final score is the higher of the two scores. Including improvement allows all hospitals the potential to earn rewards regardless of the types of patients served. In advance of the approval of the RY 2026 policy, staff worked with the Health Equity Workgroup (HEW) and found disparities in the Medicare Timely Follow-Up (TFU) measure by race, dual-status, and Area Deprivation, and thus adopted a within hospital disparity gap improvement metric for TFU. Going forward, HSCRC staff will continue to analyze disparities and propose incentives for reducing them in the program.

DRAFT RECOMMENDATIONS

This document puts forth the RY 2027 Quality-Based Reimbursement (QBR) draft policy recommendations for consideration. The policy has few changes compared to the RY 2026 approved recommendations. The main updates are changes to the HCAHPS measures, consistent with the CMS VBP program, and proposal for the ED LOS performance standards. Staff has and will continue vetting these recommendations with the Performance Measurement Workgroup (PMWG) and also greatly benefits from feedback provided by Commissioners and other stakeholders on draft recommendations and longer-term priorities that should be considered as Maryland transitions to the AHEAD model.

Draft Recommendations for RY 2027 QBR Program:

- Maintain Domain Weighting as follows for determining hospitals' overall performance scores:
 Person and Community Engagement (PCE) 60 percent, Safety (NHSN measures) 30 percent,
 Clinical Care 10 percent.
 - a. Within the PCE domain, weight the measures as follows:
 - i. HCAHPS Top Box:

33.33 Percent

ii. **HCAHPS** Consistency: 16.67 percent iii. **HCAHPS** Linear: 16.67 percent iv. Timely Follow-Up for Medicare: 5.56 percent Timely Follow-Up for Medicaid: 5.56 percent ٧. vi. Disparities in Timely Follow-Up for Medicare: 5.56 percent Emergency Department Length of Stay: vii. 16.67 percent

- b. Within the Safety domain, weight each of the measures equally (i.e., 30 percent divided by number of measures).
- c. Within the Clinical Care domain, weight the inpatient and 30-day mortality measure equally.
- 2. With regard to monitoring reports to track hospital performance:
 - a. Consider the feasibility of developing a Timely Follow-Up for Behavioral Health measure.
 - b. Disseminate Sepsis Dashboard.
 - c. Develop tools to monitor HCAHPS performance by patient and hospital characteristics.
- 3. Implement an HCAHPS learning collaborative with hospitals.
- Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures.
- 5. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and maintain the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 41 percent.
 - a. Retrospectively evaluate 41 percent cut point using more recent data to calculate national average score for RY 2026 and RY 2027.
 - b. Based on concurrent analysis of national hospital performance, adjust the RY25 QBR cut point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.

INTRODUCTION

Maryland hospitals are funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under the All-Payer Model agreement with the Centers for Medicare & Medicaid Services (CMS) beginning in 2014, and continuing under the current Total Cost of Care (TCOC) Model agreement, which took effect in 2019. Under the global budget system, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk under Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Commission's quality programs reward quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

The Quality-Based Reimbursement (QBR) program is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time. The program currently holds 2 percent of hospital revenue at-risk for performance by hospitals on patient experience, clinical care, and safety. In RY 2024, the net revenue adjustments statewide for QBR were -\$63,871,949. HSCRC staff has evaluated the reward/penalty scale for the performance period and determined that an adjustment is needed; staff is recommending to lower the cut point form 41% to 32% based on National performance. For purposes of the RY 2027 QBR draft Policy, staff vetted the updated draft policy with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Under the TCOC Model, Maryland must request a waiver each year from CMS hospital pay-for-performance programs, e.g., the Value Based Purchasing (VBP) program for which QBR is the State analog. CMS assesses and grants these waivers based on a report showing that Maryland's results continue to meet or surpass those of the Nation. Currently, CMMI is reviewing the RY 2025 waiver request and any feedback will be included in the final policy. However, based on the FY 2024 VBP waiver request, and as discussed further in the assessment section of this policy, CMS continues to note Maryland's lagging performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and also noted Maryland's relatively high rate of Hysterectomy Surgical Site Infections, and Maryland's need to focus on areas such as the Medicaid population, ED throughput, and non-hospital settings of care.

Additionally, with the onset of the TCOC Model Agreement, each program was overhauled to ensure they support the goals of the Model. For the QBR policy, the overhaul was completed during 2021, which entailed an extensive stakeholder engagement effort to address CMS and other stakeholders' concerns. Additional changes were also approved in the RY 2026 policy, such as reintroduction of an emergency department length of stay measure. This year's draft policy updates include changes to the HCAHPS measures consistent with changes to the National VBP program, and updates to the ED LOS performance standards. Figure 1 provides the RY 2027 QBR domain and measure updates, and related updates for future program years.

Figure 1. QBR Updates

Domain/ Measure	RY 2027	Future program years						
Person and Community Engagement domain								
HCAHPS	 Continue to weight HCAHPS top box scores more heavily than the CMS VBP program; evaluate efficacy of including HCAHPS linear scores Continue to use HCAHPS patient level data from the Maryland Health Care Commission (MHCC) for additional analytics, including on disparities, and hospital improvement Collaborate with hospitals, MHA and other stakeholders on learning collaborative to share best practices with evidence that implementation improves HCAHPS scores Modify scoring of HCAHPS Survey consistent with the CMS VBP program; beginning in CY 2025, CMS will not score the Responsive of Staff or Care Transition sub-measures.² 	 Continue to use HCAHPS patient-level data from the MHCC for additional analytics, including on disparities, and hospital improvement. Continue, through designated staff support, to work with stakeholders to facilitate sharing of best practices Consider adoption of additional question(s) linked with best practices with evidence of improving HCAHPS performance in the payment program after CY 2024. Modify scoring on the HCAHPS Survey measure for the RY 2028 through RY 2029 program years to only score on the six unchanged dimensions of the survey while updates to the survey are adopted and publicly reported in the Hospital IQR Program. 						

¹ See the RY 2024 QBR policy for additional information on the findings from the QBR Redesign.

² The <u>HCAHPS Survey will be updated</u> by adding three new sub-measures—"Care Coordination," "Restfulness of Hospital Environment," and "Information about Symptoms"—which will be publicly reported starting October 2026, with the intent to adopt the measures in the VBP Program in 2030. The updates also include removing the "Care Transition" sub-measure from Hospital Compare in January 2026 and revising the "Responsiveness of Hospital Staff" sub-measure by removing "Call Button" questions and adding a new "Get Help" question beginning January 2025.

Domain/ Measure	RY 2027	Future program years
Emergency department (ED) wait times	 Collect ED length of stay measures through HSCRC case-mix submissions Collaborate with the new ED Wait Time Reduction Commission to develop a statewide improvement goal Develop performance standards for RY 2027 that support statewide improvement goal Develop risk-adjusted attainment for ED LOS for monitoring or payment Develop separate policy on ED-Hospital Best Practices to incentivize structural and process measures to support improved hospital throughput 	 Continue to evaluate ED length of stay measures, and use of the QBR program to incentivize improvement Adopt risk-adjusted ED LOS measure for attainment into QBR Provide staff support to the State's ED Wait Time Reduction Commission Implement and continue to evaluate ED-Hospital Best Practice measures for monitoring and/or payment
Timely Follow-up measure	 Continue to include the TFU measure for Medicaid(added in the RY 2025) and the TFU within-hospital disparity measure beginning with Medicare (added in RY 2026) to reduce disparities and support achievement of the SIHIS goal for Timely Follow-up Explore behavioral health data sources and ways to monitor follow up following a hospitalization for behavioral health 	 Evaluate the ongoing TFU rates for Medicare and Medicaid as well as the within- hospital disparity gap measure, to ensure SIHIS goal is met Consider feasibility, based on data availability, of adding a measure that includes behavioral health patients
Safety domain		
SEP-1: Severe Sepsis and Septic Shock: Management Bundle	 Monitor hospital performance on the Sepsis Bundle measure and implement a hospital-level "Sepsis Dashboard" that includes inpatient and 30-day mortality, 30-day readmissions, and the Sepsis PPC and PSI measures 	 Continue monitoring hospital performance on the Sepsis Dashboard measures and consider adjustments to payment measures if performance declines
CDC National Health Safety Network	 In light of the work group's findings that demonstrate that Maryland is on par with national performance, continue the 30% domain weight to better align with the National VBP Program; focus on improvement on current measures 	 Continue to analyze Maryland trends compared to National performance. Explore working with CDC to add more innovative and less burdensome "digital" measures.
Clinical Care domain	1	
Mortality	 Maintain IP and 30-day all-cause, all-payer mortality measures weighted equally in the domain Begin implementation of data collection on an all-payer 30-day digital Hybrid Hospital Wide Mortality measure using the digital measures infrastructure 	 Monitor the Medicare and all-payer digital Hybrid Hospital Wide Mortality measures using the digital measures infrastructure in advance of planning for implementation of an all-payer hybrid measure.
Total hip arthroplasty/total knee arthroplasty (THA/TKA)	 Monitor THA/TKA measure performance removed from QBR in RY2026 Continue to explore options for expanding measurement of THA/TKA complications to all- payers and outpatient cases 	 Continue to develop outpatient quality of care strategy using THA/TKA as exemplar Explore opportunities for Patient Reported Outcome Measures (PROMs)

BACKGROUND

Overview of the QBR Program

The QBR Program, implemented in 2010, includes potential scaled penalties or rewards of up to 2 percent of inpatient revenue. The program assesses hospital performance against National standards for measures included in the CMS VBP program and Maryland-specific standards for other measures unique to our all-payer system. Figure 2 presents RY 2026 and proposed RY 2027 QBR measures and domain weights compared to those used in the VBP Program.

Figure 2. RY 2026 and Proposed RY 2027 QBR measures and Domain Weights Compared to the CMS VBP Program

Domain	Maryland RY 2026 and Proposed RY 2027 QBR domain weights and measures	CMS VBP domain weights and measures
Clinical Care	10 percent Two measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality	25 percent Five measures: Four condition- specific mortality measures; THA/TKA complications
Person and Community Engagement	 Eight HCAHPS categories (RY 2026) Six HCAHPS categories (RY 2027), top box score and consistency, 4 categories for linear scores; TFU (Medicare, Medicaid, disparities improvement); ED LOS 	25 percent Six HCAHPS measures top box score and consistency
Safety	30 percent Six measures: Five CDC NHSN hospital- acquired infection (HAI) measure categories; all-payer PSI 90	25 percent Six measures: Five CDC NHSN HAI measure categories; Sep 1 Bundle measure
Efficiency	n.a.	25 percent One measure: Medicare spending per beneficiary

The QBR Program assesses hospital performance by comparing each measure to National or State performance standards. For all measures, except the ED LOS measure³, the performance standards range from the 50th percentile of hospital performance (threshold) to the mean of the top decile (benchmark). Each measure is assigned a score of zero to ten points, then the points are summed and divided by the total number of available points, and weighted by the domain weight. A total score of 0 percent means that performance on all measures is below the performance threshold and has not

С

³ The ED LOS performance standards are still being finalized for CY 2024/RY 2026 performance.

improved, whereas a total score of 100 percent means performance on all measures is at or better than the mean of the top decile (about the 95th percentile). This scoring method is the same as that used for the national VBP Program. But unlike the VBP Program, which ranks all hospitals relative to one another and assesses rewards and penalties to hospitals in a revenue neutral manner retrospectively based on the distribution of final scores, the QBR Program uses a preset scale to determine each hospital's revenue adjustment and is not necessarily revenue neutral. This gives Maryland hospitals predictability and an incentive to work together to achieve high quality of care, instead of competing with one another for better rank.

Historically, Maryland hospitals have low scores on the QBR program in part due to HCAHPS performance. In order to ensure Maryland hospitals are not rewarded for subpar performance, the preset revenue adjustment scale for the entire QBR program ranges from 0 to 80 percent, regardless of the score of the highest-performing hospital in the state (i.e., the scale is not relative to Maryland performance so that poor performance compared to the Nation is not rewarded). The cut-point at which a hospital earns rewards or receives a penalty has been based on an analysis of the national VBP Program scores. For RY 2024 and RY 2025, federal fiscal years 2016-2021 were used to calculate the average national score using Maryland QBR domain weights (without the Efficiency domain). This resulted in a cut-point around 41 percent (range of scores was from 38.5 to 42.7). However, due to the COVID Public Health Emergency (PHE) the RY 2024 through RY 2026 policies indicated that the cut point would be reassessed retrospectively with more recent National data. While this is inconsistent with the guiding principle to provide hospitals with a way to monitor revenue adjustments during the performance year, it protects Maryland hospitals from excessive penalties due to changes in performance post-COVID compared to national hospitals. The RY 2026 approved policy lowered the RY24 QBR cut point to 32 percent based on more analyses on the impact of pre-COVID performance standards on National hospital performance. The RY 2027 policy also provides recommendations for the RY 2025 final cut point based on more recent analyses. Given performance standards are now post-COVID, staff believes scores may be higher beginning in RY 2026 than in RYs 2024 or RY 2025.

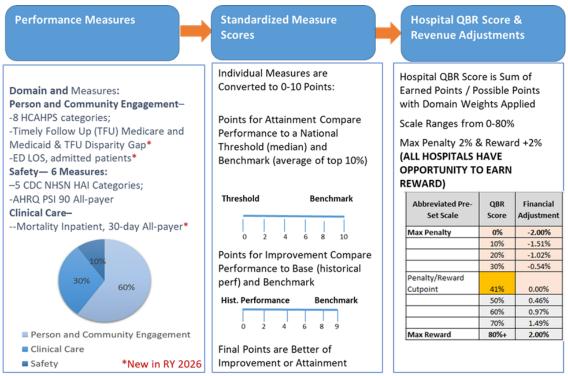
As a recap, the method for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019. It involves:

- 1. Assessing performance on each measure in the domain.
- 2. Standardizing measure scores relative to performance standards.
- 3. Calculating the total points a hospital earned divided by the total possible points for each domain.
- 4. Finalizing the total hospital QBR score (0 to 100 percent) by weighting the domains, based on the overall percentage or importance the HSCRC placed on each domain.

Converting the total hospital QBR scores into revenue adjustments using the preset revenue adjustment scale (range of 0 to 80 percent).

This method is shown in Figure 3.

Figure 3. RY 2026 QBR Policy Methodology Overview



Appendix A contains more background and technical details about the QBR Program. Appendix B contains the by-hospital QBR results for RY 2025 with the 41 percent cut point and a proposed revised cut point of 32 percent. With the 41 percent cut point, 36 hospitals would receive penalties totalling ~-\$66M and 5 hospitals would receive rewards totalling ~\$1.6M yielding a State net total of ~-\$64.4M. These statewide results are similar to those awarded prior to COVID. With the proposed revised 32 percent cut point, 24 hospitals would receive penalties totalling ~\$33M and 17 hospitals would receive rewards totalling ~\$11M yielding a State new total of ~\$22M.

Assessment

The purpose of this section is to present an assessment, using the most current data available, of Maryland's performance on measures used in the QBR program, compared to the Nation when national data is available. Finally, this draft policy provides recommended measure and domain weights; while the cut point for rewards and penalties is discussed, the modeling of scores will be included in the final policy.

Person and Community Engagement Domain

The Person and Community Engagement domain currently measures performance using the HCAHPS patient survey, three measures of timely follow-up (TFU) after discharge for an acute exacerbation of a chronic condition (one measure for Medicare fee-for-service (FFS), one measure for Medicaid beneficiaries, and one measure on within-hospital disparity gap reduction for Medicare FFS beneficiaries). In addition, an ED LOS measure for patients admitted to the hospital (non-psychiatric) was added to the program in RY 2026. This domain currently accounts for 60 percent of the overall QBR score.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

The HCAHPS survey is a standardized, publicly reported survey that measures patient's perceptions of their hospital experience. In keeping with the national VBP Program, the QBR Program scores hospitals using top box scores (e.g., the percent of respondents who indicate the highest performance category) to calculate improvement and attainment points (0-10), and counts the points for whichever is highest, across the following HCAHPS domains beginning in CY 2025 (RY 2027 policy performance period): (1) communication with nurses, (2) communication with doctors, (3) communication about medicine, (4) hospital cleanliness and quietness, (5) discharge information, and (6) overall hospital rating. Staff notes that the two HCAHPS sub measures that include the composite care transition measure and responsiveness of hospital staff measure are being updated by CMS beginning in CY 2025 and therefore cannot be included in the HCAHPS scoring for CYs 2025 through 2027 (VBP FFY 2027 through FFY 2029).⁴

The QBR Program also scores hospitals separately on HCAHPS consistency⁵; the lowest performing HCAHPS domain score is compared to the floor (worst performer in the Nation in the base) and the achievement threshold performance level. If the worst domain score is above the achievement threshold then all domains are above, and the full 20 points are earned. If the lowest domain score is above the floor but less than threshold, partial points of 1-19 are earned. If the lowest scoring domain score is less than or equal to the floor, zero consistency points are awarded.

⁴Beginning in CY 2025, the HCAHPS Survey will be updated by adding three new sub-measures—"Care Coordination," "Restfulness of Hospital Environment," and "Information about Symptoms"—which will be publicly reported starting October 2026. The updates also include removing the "Care Transition" sub-measure from Hospital Compare in January 2026 and revising the "Responsiveness of Hospital Staff" sub-measure by removing "Call Button" questions and adding a new "Get Help" question beginning January 2025.Because of these changes to the survey, VBP scoring on the HCAHPS Survey measure FY 2027 through FY 2029 program years will be modified to only score on the six unchanged dimensions of the survey while updates to the survey are adopted and publicly reported in the Hospital IQR Program.

⁵ For more information on the national VBP Program's performance standards, please see https://qualitynet.cms.gov/inpatient/hvbp/performance.

In RY 2024, HCAHPS linear scores were added as 20% of the PCE domain (i.e., 10 percent of overall QBR score) for the following domains: the nurse communication, doctor communication, responsiveness of staff, and care transition. The addition of the linear measures was designed to further incent focus on HCAHPS by providing credit for improvements along the continuum and not just improvements in top box scores. Based on stakeholder feedback from last year, HSCRC staff recommends continuing the linear measures for RY 2027 at the current weight. However, with the modifications to the HCAHPS survey beginning in CY 2025 that exclude the scores for Staff Responsiveness and Care Transition submeasures, staff proposes to replace these measures in the linear score performance calculations with Overall Hospital Rating, and to vet with the PMWG an alternate sub-measure for inclusion. Staff has included the communication about medicine for modeling scores as it is one domain where the State could improve. As staff noted in previous years' QBR policies, we will assess if adding the linear measures helps improve top-box scores over the next few years. If top box scores do not improve, staff will recommend reducing the weight or removing the linear measures in future rate years.

CMS Care Compare data on HCAHPS top box and linear performance through 6/30/23 reveal the following, as illustrated in Figures 4 and 5 below:

- Both the Nation and Maryland declined slightly from the base to the performance periods on top box and linear scores for all of the HCAHPS categories.
- For both top box and linear scores, Maryland lags behind the Nation in the base and the performance periods.
- For "Discharge Information Provided", Maryland and the Nation performed most similarly on top box scores.

Figure 4. Top Box HCAHPS Results: Maryland Compared to the Nation , CY 2019 vs 7/1/22-6/30/23

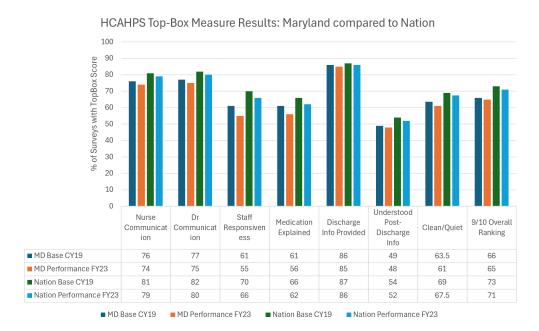
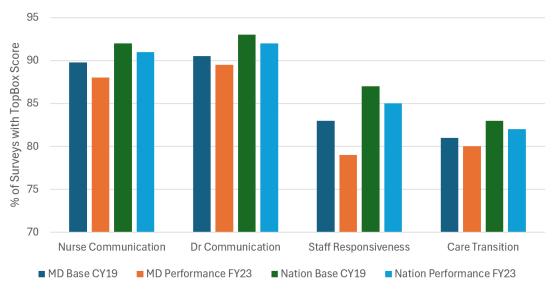


Figure 5. Linear Measure, Maryland Compared to the Nation, CY 2019 vs 7/1/22-6/30/23





Starting in CY 2022, MHCC began collecting patient level HCAHPS data from Maryland hospitals. This patient level data is critical for identifying opportunities within hospitals at a more granular level, including identification of disparities. See Appendix C for more information on the data collection and results indicating there are disparities by race in completion of the survey, with the black hospital population underrepresented and the white hospital population overrepresented compared to their proportion of the

total population, and the black population indicating an overall lower rating of care, particularly in the Maternity service line.

HCAHPS Improvement Framework

One important area CMS has identified in feedback to the Commission is the need for targeting improvement in HCAHPS in the Person and Community Engagement domain. CMS has recommended that the State consider implementing a Statewide HCAHPS performance improvement initiative that leverages input from providers, industry experts, and other stakeholders to develop future improvement goals. Further, CMS noted they are looking for the State to further develop these strategies and commit to creating a framework for setting HCAHPS performance improvement goals for future performance years. To improve HCAHPS performance as a state, the HSCRC is co-leading a Patient Experience Learning Collaborative with the Maryland Hospital Association (MHA). As outlined in Appendix D the goal of the learning collaborative is to compile best practices to help Maryland hospitals improve patient experience and attain higher HCAHPS scores. The learning collaborative will accomplish this task by analyzing patient-level HCAHPS data, learning best practices from national organizations that consult hospital providers on improving patient experience, and through quality improvement initiatives using Plan, Do, Act Study (PDSA) cycles. HSCRC has brought on an HCAHPS expert with hospital executive leadership experience as Chief Patient Experience Officer to lead the HCAHPS improvement framework implementation. Based on Maryland's overall lagged HCAHPS performance and MHCC's analysis, it is of great import to focus on disparities in HCAHPS results; staff will examine disparities, for example, in the response rates and the maternity service line responses for HCAHPS, as well as other related process and outcome measures.

Emergency Department Length of Stay

ED length of stay (LOS)--i.e., wait times—has been a significant concern in Maryland, predating Maryland's adoption of hospital global budgets instituted in 2014, ⁶ with multiple underlying causes and potential negative impacts (e.g., poorer patient experience, quality, care outcomes). Thus, the Commission approved the addition of an ED wait time or length of stay (LOS) measure in the RY 2026 QBR program. Previously published and available data on CMS Care Compare reveals Maryland's poor performance compared to the Nation on both inpatient and outpatient ED measures (i.e., higher wait times for both those admitted to the inpatient hospital and those discharged home), as shown in Figure 6.

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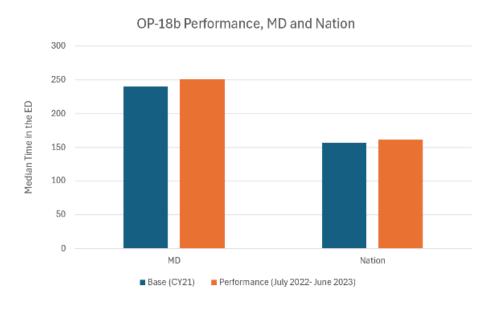
⁶ Under alternative payment models, such as hospital global budgets or other hospital capitated models, some stakeholders have voiced concerns that there may be an incentive to reduce resources that lead to ED-hospital throughput issues.

Figure 6. Emergency Department Performance on CMS ED Wait Time Measures



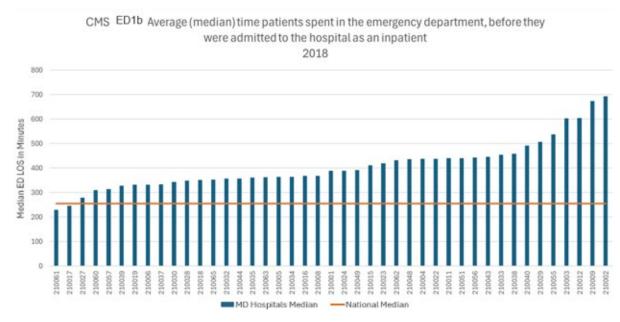
As illustrated in Figure 7 below, based on the most current data available, the OP-18b wait time for discharged patients has increased slightly for both Maryland and the Nation from the base to the performance year, and Maryland wait times continue to be significantly above those of the Nation for both the base and performance years.

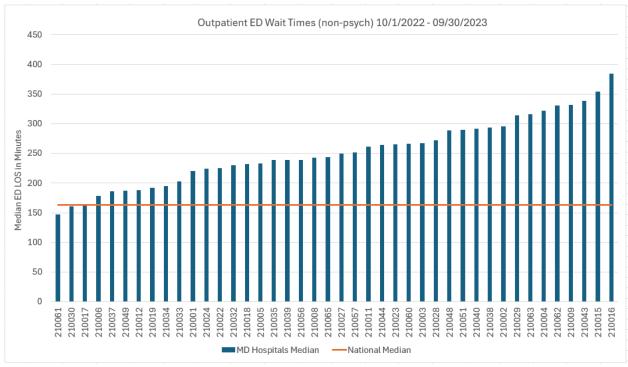
Figure 7. Maryland and National Performance on ED Wait Times for Discharged Patients



Furthermore, all but a couple of hospitals in Maryland perform worse than the national average. Figure 8, shows the ED length of stay for non-psychiatric patients who are admitted (ED1b) for 2018 (last year this was reported) and for those who are discharged home (OP-18b) using the most recently available data.

Figure 8. Maryland by Hospital and National Performance on ED Wait Times





Based on these results, staff believes all hospitals in Maryland have an opportunity to improve. Furthermore, there has been increased public scrutiny on Maryland's poor performance in ED Wait times, as evidenced by the several initiatives that have been underway over the last couple years to promote understanding Maryland's ED length of stay and promote improvement (e.g., MHA Legislative Taskforce, EDDIE). In the 2024 Maryland General Assembly Session, a new ED Wait Time Reduction Commission was established. The ED Commission is co-chaired by the HSCRC Executive Director and staffed by the HSCRC. The ED Commission will work on hospital and wider access issues to improve hospital throughput and will develop a State goal for improvement in ED wait times. The QBR ED LOS measure is one of the HSCRC levers to assist with this effort and will build off of the goals set by the Commission. Appendix E provides additional information on ED initiatives and the ED Commission.

For RY 2026, the QBR ED measure and performance standards were under development during the performance year through a stakeholder subgroup process. Recently, the hospitals have expressed concern that the ED LOS measure should have been monitored and not in payment for the CY 2024 performance period, since the exact measure and performance standards were unknown. Despite not knowing the exact measure or performance standards, hospitals were aware of the need to improve ED LOS since prior to the start of CY 2024. However, in recognition of the hospital's concerns, staff plans to recommend performance standards that give credit to hospitals for maintaining or improving the ED length of stay during CY 2024. This will be discussed as part of the ED update at the October Commission meeting, with the expectation that the decision on performance standards will be determined by the end of the month. Appendix F provides details on the development of the ED LOS measure and modeling estimates of the RY 2025 results with the ED LOS measure included, using the latest proposal on performance standards and estimates of hospital performance. Of note, the hospitals have just completed submitting the first round of historical data at a patient level for the calculation of the ED LOS based on data submission requirements that were provided to the industry in May 2024. Staff will be analyzing this data and will provide updates on the data collection process in the final RY2027 QBR policy.

In terms of the RY 2027 measure and performance standards, the staff propose the following:

- Maintain the ED1b measure in the QBR PCE domain and weight at 10 percent of the QBR program (same as RY 2026)
- Continue to assess hospital on improvement on ED1b
- Develop risk-adjusted ED LOS measure for attainment
- Monitor attainment and consider retrospectively adopting attainment in the policy
- Set improvement standards based on State improvement goal established by the ED Commission
- Including observation stays (23 hrs+) as inpatient admissions in the ED1b measure

While the staff are deferring the CY 2025 performance standards, hospitals should be aware that an improvement in ED LOS is expected during CY 2025. The final RY 2027 QBR policy will include additional details and potentially modeling of performance standard options.

Timely Follow-Up After Discharge

The HSCRC introduced this National Quality Forum-endorsed measure for Medicare beneficiaries into the RY 2023 QBR Program within the PCE domain, expanded the measure to Medicaid in RY 2025, and added a within-hospital disparity gap measure in RY 2026. The measure for RY 2026 assesses the percentage of ED visits, observation stays, and inpatient admissions for one of six conditions in which a follow-up was received within the time frame recommended by clinical practice. Staff recommends continuing these measures in the RY2027 QBR program and notes that the measure was updated in the spring of 2024 by the Partnership for Quality Measurement. Specifically, "qualifying" follow up visits that contribute to the numerator are those for which follow-up care was received after the discharge date within the timeframe recommended by clinical practice guidelines, as detailed below:

- Hypertension: Follow up within 14 days of the date of discharge for high-acuity patients or within 30 days for medium-acuity patients
- Asthma: Follow up within 14 days of the date of discharge
- Heart Failure: Follow up within 14 days of the date of discharge
- Coronary Artery Disease: Follow up within 7 days of the date of discharge for high-acuity patients or within 6 weeks for low-acuity patients (defined by ICD 10 codes)
- Chronic Obstructive Pulmonary Disease: Follow up within 30 days of the date of discharge
- Diabetes: Follow up within 14 days of the date of discharge for high-acuity patients

The Medicare TFU measure is also included in the Care Transition SIHIS domain with the goal of achieving a 75 percent follow-up rate by the end of 2026.⁹ Figure 9 shows Maryland's performance over time for each chronic condition and all conditions combined within the Medicare population. For all conditions, there was a slight increase in Medicare rates from in 2018 to 2023 (70.85% to 71.23%)

⁷ The measure currently assesses the percentage of ED visits, observation stays, and inpatient admissions for one of six conditions in which a follow-up was received within the time frame recommended by clinical practice: Hypertension (follow-up within seven days), Asthma (follow-up within 14 days), Heart failure (follow-up within 14 days), Coronary artery disease (follow-up within 14 days), Chronic obstructive pulmonary disease (follow-up within 30 days), Diabetes (follow-up within 30 days).

⁸ In the spring of 2024, the measure was reviewed and re-endorsed through Battelle's Partnership for Quality Measurement (PQM). As a designated Centers for Medicare & Medicaid Services (CMS) certified consensus-based entity, Battelle's PQM uses a consensus-based process involving a variety of experts - clinicians, patients, measure experts, and health information technology specialists - to ensure informed and thoughtful endorsement reviews of qualified measures. See the Battelle PQM website for more information about the measure.

⁹The SIHIS goal is to achieve a 75 percent TFU rate for Medicare FFS beneficiaries across the six specified conditions and respective time frames.

across all conditions; for asthma, CHF, COPD, diabetes, and hypertension there were increases in the rates of timely follow-up; however, for CAD there was a slight decrease in follow-up (-0.87%).

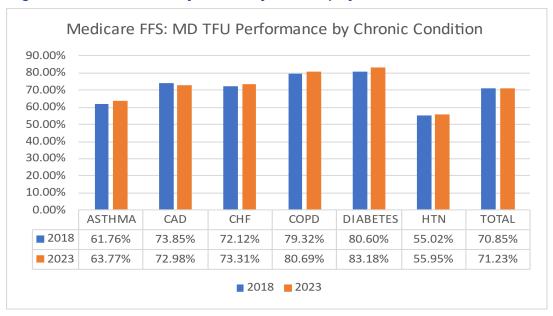


Figure 9. Medicare FFS: Maryland Timely Follow-Up by Condition¹⁰

While some stakeholders have raised concerns around the follow-up times by condition, it is important to note that Maryland and the Nation are being measured on the same timeframes and the expectation is not 100 percent follow-up. Figure 10 shows the annual performance on the total TFU measure for Maryland and the Nation (national data is based on the Chronic Condition Warehouse 5 percent sample). Comparing 2018 to 2023, the Nation has seen a 2.29 percent increase and Maryland has seen a 0.54 percent increase in timely follow-up rates; however, Maryland still performed about 4 percent better than the Nation in 2023.

Figure 10. Medicare-only: Timely Follow-Up across All Conditions

TFU Rates	CY2018	CY2019	CY2020	CY2021	CY2022	CY2023
Maryland	70.85%	71.45%	67.90%	70.07%	70.59%	71.23%

¹⁰ Maryland numbers are claims-based and built on the Claim and Claim Line Feed with a four-month runout. CAD = coronary artery disease, CCW = Chronic Conditions Data Warehouse; CHF = coronary heart failure; COPD = chronic obstructive pulmonary disease; HTN = hypertension.

US	66.82%	69.00%	64.75%	67.68%	67.26%	68.35%
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As part of the 2021 SIHIS proposal, staff said they would explore expanding the TFU rates for chronic conditions to other payers and adding follow-up after a hospitalization for behavioral health. In CY 2022, staff worked with CRISP and Maryland Medicaid to provide hospitals monthly Medicaid Timely Follow-Up reports on the CRS portal. In RY 2025, the HSCRC introduced the Medicaid TFU measure and recommends continuing it in the RY2027 QBR program weighted the same as the Medicare measure but assessed separately due to large differences in the rates. Figure 11 shows Maryland's performance over time for each chronic condition and all conditions combined for Medicaid patients.

Medicaid (FFS & MCO): MD TFU Performance by Chronic Condition 80.00% 70.00% 60.00% 50.00% 40.00% 30.00% 20.00% 10.00% 0.00% Asthma CAD CHF COPD Diabetes HTN Total ■ FY 2022 ■ CY 2023

Figure 11. Maryland Medicaid Timely Follow-Up by Condition

Staff is continuing to work to understand the Medicare and Medicaid behavioral health data to create a Timely Follow-Up monitoring report for Behavioral Health.

Disparities in Timely Follow-Up

In the Summer of CY 2022, staff convened a Health Equity Workgroup to review Maryland's quality measures stratified by social demographic factors to glean disparities. For the QBR program, staff stratified the Timely Follow-Up measure by race, dual-eligibility status, and Area Deprivation Index (ADI). Results of this stratification analysis found marked disparities on all three factors. Given that the State did

not meet the 2021 Year 3 Milestone SIHIS Target and the overwhelming evidence of disparities in this measure, HSCRC staff developed a timely-follow up disparity gap metric similar to the readmissions disparity gap measure that was added to the PCE domain in RY 2026. The timely follow-up disparity gap metric takes the patient-level social exposures of race, dual eligibility status, and ADI and estimates the association between these social exposures and the likelihood of receiving a follow-up in the recommended timeframe. Based on this analysis, a TFU Patient Adversity Index score (TFU PAI) is assigned to each patient and hospitals are then assessed on the TFU rate for low and high PAI patients (i.e., the within-hospital disparity gap is the difference between these rates). The performance metric for RY 2027 would be the change in the TFU disparity gap from 2018 to 2025. Staff modeled the TFU disparity gap improvement using CY 2018 to CY 2023 and proposes to use this data to set the standards for improvement in the disparity gap for RY 2027.

Figure 12 shows the TFU disparity gaps by hospital in CY 2023. The median gap between low and high PAI patients is 7.74 percent, with a range of 3.54-11.60 percent indicating all hospitals have a gap and there is variation across hospitals.

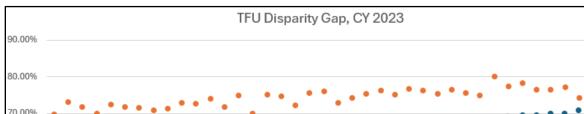


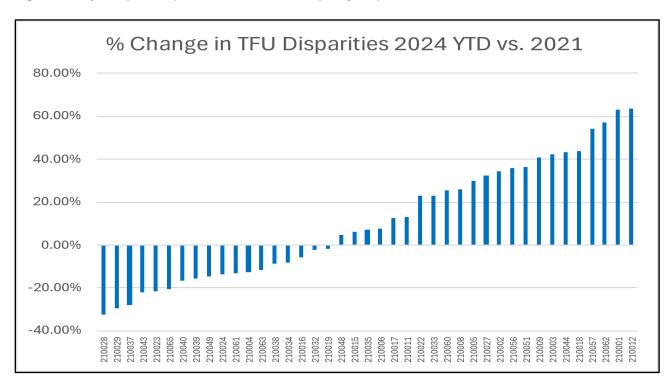
Figure 12. By Hospital TFU Disparity Gap, CY 2023

70.00% 60.00% 50.00% 40.00% 30.00% 20.00% 10.00% 0.00% 210028 210008 210005 210055 210029 210018 210010 210040 210007 210003 210003 210003 210003 210003 210003 210003 210003 210060 210002 210003 210004 210001 210061 210060 210067 210067 210067 21007 21 210011

● High PAI ● Low PAI

As illustrated in Figure 13 below, 18 hospitals have seen progress in the reduction of disparities in timely follow-up thus far in 2024 compared to 2021. However, 23 hospitals saw increases in their disparities with two hospitals seeing almost 60 percent increases. To continue incentivizing hospitals to improve on the disparities experienced by their patients, staff proposes to continue use of this measure in the QBR program in the PCE domain. Because the overall goal is improvement and the performance metric is the percent change over time, this measure is assessed using the attainment methodology (i.e., we do not measure whether there was improvement on the change in the disparity gap, instead we measure whether or not the improvement made meets and/or exceeds the set performance standards). However, as stated above, staff proposes to use the change in the TFU disparity gap from 2018 to 2023, to prospectively set the attainment standards. The threshold and benchmark are to be calculated as the median percent and average for the top 10th percentile of performers respectively, on the change in disparities from CY 2018 to CY 2025 (consistent with how VBP calculates other performance standards).





Safety Domain

The QBR Safety domain contains five measures from six CDC NHSN HAI categories and the AHRQ Patient Safety Index Composite (PSI-90).¹¹ This domain is weighted at 30 percent of the total QBR score. In the FY 2026 VBP program, CMS added the Sepsis and Septic Shock Management Bundle (SEP-1), a measure that has been publicly reported on Care Compare since July 2018. However, staff proposed not adopting this measure in the QBR program based on stakeholder input, inclusion of sepsis mortality in QBR, and Maryland performance on sepsis. Instead, the staff proposed and has been working to finalize a Sepsis Dashboard that would allow the State and hospitals to monitor performance on a comprehensive set of measures for sepsis patients (see below for more details). Another difference between the VBP and QBR safety domain is that QBR has maintained the use of the AHRQ PSI measure rather than moving this measure to a standalone complications program, i.e., the MHAC program. While the Safety Domain will remain in the QBR program for RY 2027, consolidation of the Safety domain with the MHAC program may be considered for future years.

CDC NHSN HAI Measures

The CDCs National Healthcare Safety Network (NHSN) tracks healthcare-associated infections such as central-line associated bloodstream infections and catheter-associated urinary tract infections. Both Maryland and the Nation have seen increases in HAIs during CY 2020 and CY 2021 largely related to the COVID 19 pandemic, as was discussed in previous policies, and supported by peer reviewed research.¹²

CMS Care Compare has updated the Healthcare Associated Infection Standardized Infection Ratio (SIR) data tables for the Nation and by state through June 2023. Figure 14 below shows how Maryland performs relative to the Nation, and how performance has changed over time for both Maryland and the Nation. For the most recent time period, Maryland's performance is similar to that of the Nation on SSI-Colon, worse (higher SIRs) on CAUTI, SSI-Hysterectomy, and C.Diff, and slightly better on CLABSI and MRSA. Nationally the SIRs got worse from the base period for CLABSI, SSI-Colon, and SSI-Hysterectomy, remained similar for MRSA, and improved for CAUTI and C.Diff. In Maryland, the SIRs got worse from the base period for CLABSI, CAUTI, SSI-Colon, remained similar for C.Diff, and improved for SSI-hysterectomy, MRSA. As noted previously, CMS has raised concern regarding Maryland's relatively high rate of Hysterectomy Surgical Site Infections; upon looking further into the data, staff notes State rates are impacted by relatively low numbers of events occurring at a small subset of hospitals that varied over time. For example, one hospital accounted for 30% of the SSI Hyst cases between 2018 and

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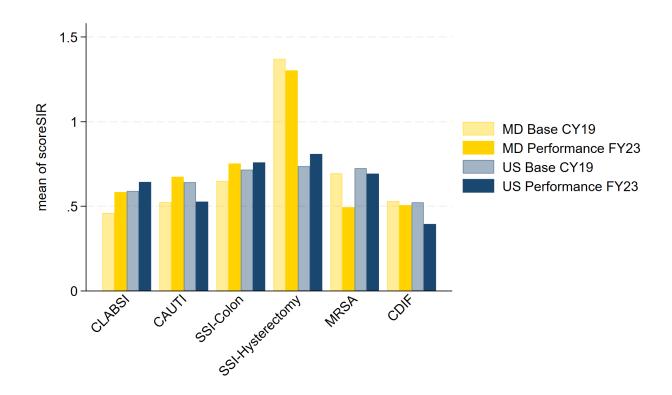
¹¹ For use in the QBR Program, as well as the VBP program, the SSI Hysterectomy and SSI Colon measures are combined.

¹² Lastinger, L., Alvarez, C., Kofman, A., Konnor, R., Kuhar, D., Nkwata, A., . . . Dudeck, M. (2022). Continued increases in the incidence of healthcare-associated infection (HAI) during the second year of the coronavirus disease 2019 (COVID-19) pandemic. Infection Control & Hospital Epidemiology, 1-5. doi:10.1017/ice.2022.116

2020.In reviewing the hospital's cases, they served a complex, high risk population including a large proportion of oncology patients that were not accounted for in the NHSN measure. Hospital interventions in partnership with the Maryland Dept of Health began in 2018 resulting in sustained low SIRs since 2021. Interventions included:

- ► Targeting Staff competency and education on vaginal and skin prep
- ▶ Pre-operative antiseptic cleansing by patient the night before and morning of surgery
- ▶ Updated antibiotic prophylaxis grid with follow up to providers for any fallouts
- ▶ Enhanced patient education regarding surgical site infection prevention
- ▶ Observations in the ER
- ► Hand hygiene observations in procedure areas
- ► ATP testing in the OR to ensure environmental cleanliness

Figure 14. NHSN SIR Values for CY19 compared to Q3 CY2022-Q2 CY2023, Maryland versus the Nation.



The CDC publishes an annual report that includes state specific performance on HAI measures that includes comparison of performance to the previous year as well as the statistical significance of the

change;¹³ Figure 15 below illustrates Maryland's change from CY 2021 to CY 2022 (the most current annual report published by CDC). The data reveal that Maryland's performance had statistically significant improvement (decrease) or unchanged performance on all HAI measure SIRs included in the QBR program.

Figure 15. CDC Healthcare-Associated Infections Progress Report, Maryland SIRs, CY 2022 Compared to CY 2021

Maryland Changes in Statewide Stantardized Infection Ratios (SIRs) Between 2021 and 2022 for NHSN Acute Care Hospitals.								
	2021 SIR 2022 SIR Percent Direction of Change p-value							
	Change Based on Statistical							
				Significance*				
CLABSI	1.023	0.946	-8%	No change	0.2369			
CAUTI	0.920	0.753	-18%	Decrease	0.0041			
MRSA	0.941	0.767	-18%	No change	0.0566			
CDI	0.645	0.57	-12%	Decrease	0.0056			
SSI Hyst	1.368	1.185	-13%	No change	0.5265			
SSI Colon	0.760	0.879	16%	No change	0.2512			

^{*}Percent SIR changes from 2021 to 2022 decreased for 5 of 6 categorie; the differences were statistically significant for 2 of the categories.

The RY 2026 QBR policy finalized a slight reduction in the weight of the Safety domain from 35 percent to 30 percent compared to the VBP Safety domain weighted at 25 percent; staff is recommending maintaining the 30 percent domain weight in the RY 2027 policy. While the NHSN measures are used in the National VBP program, there are some concerns that have been raised about surveillance bias of these measures. Furthermore, the CDC is currently developing and piloting digital measures that, when broadly implemented, will help to address the concerns related to surveillance bias and also constitute less burden than current manual chart abstracted data collection efforts. See RY2023 QBR policy for additional discussion of NHSN surveillance bias concerns and assessment of Maryland performance.

Patient Safety Indicator Composite (PSI-90)

The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators were developed 14 and

¹³2022 National and State Healthcare-Associated Infections Progress Report found at: https://www.cdc.gov/healthcare-associated-infections/php/data/progress-report.html?CDC_AAref_Val=https://www.cdc.gov/hai/data/portal/progress-report.html, last accessed 8/15/2024

¹⁴ AHRQ contracted with the University of California, San Francisco, Stanford University Evidence-based Practice Center, and the University of California Davis for development. For additional Information: https://www.qualityindicators.ahrq.gov/Modules/psi resources.aspx

released in 2003 to help assess the quality and safety of care for adults in the hospital. PSI-90 focuses on a subset of ten AHRQ-specified PSIs of in-hospital complications and adverse events following surgeries, procedures, and childbirth. The PMWG noted previously that CMS removed the PSI-90 measure from the VBP program in FFY 2024 but retained the measure in the Hospital Acquired Conditions Reduction Program. Since Maryland does not have PSI-90 in the MHAC program, staff has recommended retaining the measure in the QBR program.

Maryland's statewide performance compared to the Nation on the PSI 90 Composite measure and the individual measures within the Composite for FY 2022 and CY 2023 are summarized below and illustrated in Figures 16, 17 and 18.:

- On the overall PSI 90 composite measure, the State has improved.
- The State has improved with lower rates in CY 2023 compared to FY 2022 on the following PSIs:
 - o PSI 08- In Hospital Fall and Fracture
 - PSI 06- latrogenic Pneumothorax
 - o PSI 03- Pressure Ulcer
 - o PSI 09- Perioperative Hemorrhage or Hematoma
 - PSI 13- Postoperative Sepsis
 - o PSI 12- Perioperative Pulmonary Embolism or Deep Vein Thrombosis
 - PSI 11- Postoperative Respiratory Failure
- The State has worsened with higher rates on the following PSIs:
 - o PSI 10- Postoperative Acute Kidney Injury with Dialysis (slight increase)
 - PSI 14- Postoperative Wound Dehiscence (slight increase)
 - o PSI 15- Abdominopelvic Accidental Puncture or Laceration Rate



Figure 16. Maryland Statewide All-Payer Performance on PSI-90 and Component Indicators, CY 2023 Compared to FY 2022 (July 2021-June 2022)

Figure 17 below illustrates the hospital-level performance on the all-payer PSI-90 composite measure for CY 2023; consistent with last year, the variation in performance by hospital suggests there may be opportunity for improvement on this measure.

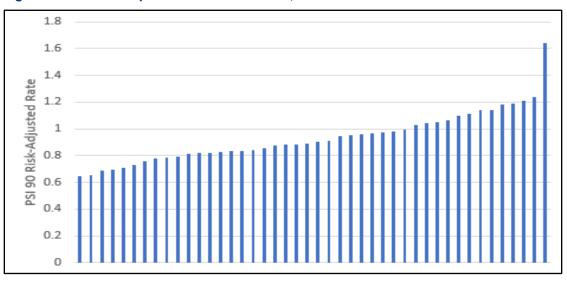


Figure 17. PSI-90 Hospital-Level Performance, CY 2023¹⁵

¹⁵ Levindale Hospital performs the worst on the PSI-90 measure; their results are driven by poor performance on pressure ulcers. Given they have a longer length of stay than most acute care hospitals, they need to focus on quality improvement for pressure ulcers.

The Agency for Research and Quality publishes all-payer risk-adjusted PSI 90 data by state and for the Nation using the hospital Healthcare Cost and Utilization Project (HCUP) data. Figure 18 below, indicates that Maryland has improved over time and performs better than the Nation based on the most currently available CY 2023 data.

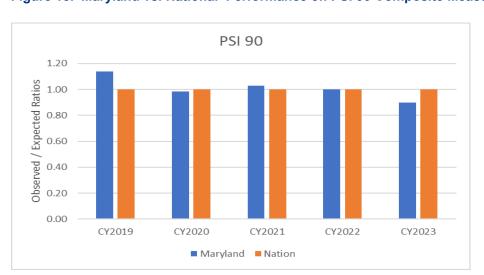


Figure 18. Maryland vs. National Performance on PSI 90 Composite Measure, CY 19-CY 23¹⁶

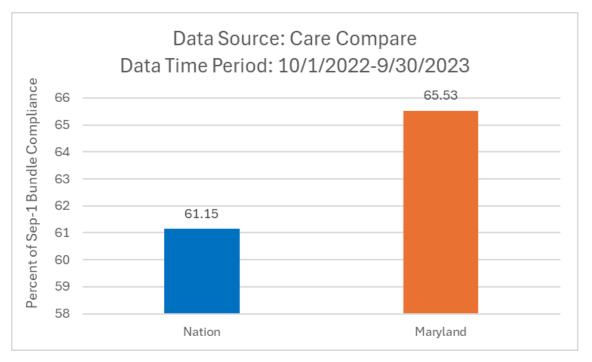
Sepsis Early Management Bundle (Sep-1)

Medicare adopted the Sep-1 measure into the VBP program in FY 2026. However, in the RY 2026 QBR policy, the Commission approved the staff and stakeholder recommendation to *not* adopt the Sep-1 measure. Specifically, there were opposing views on the SEP-1 measure adoption for payment and given Maryland performed well on the measure, and includes the sepsis PSI, PPC, and sepsis mortality in the Maryland in its quality programs, the determination was made that instead of adopting the measure the HSCRC staff would develop and disseminate a hospital Sepsis Dashboard (discussed below). Given Maryland continues to perform well compared to the Nation on Sep-1 and Sepsis PSI, as illustrated in Figure 19 and Figure 20 below, the HSCRC staff still do not recommend adopting this measure. ¹⁷

¹⁶ Data provided by MHCC used for the Maryland Hospital Performance Guide published on the MHCC website.

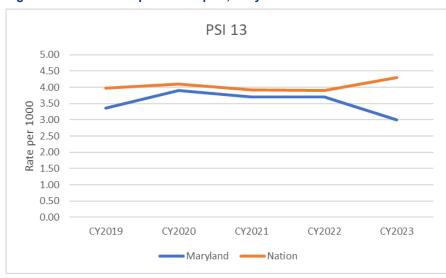
¹⁷ See the RY 2026 QBR policy for additional information on the concerns with the Sep-1 measure.

Figure 19. Maryland vs. the Nation, Sep-1 Early Management Bundle Measure



On PSI 13, Maryland has improved from FY 2021 to CY 2022 as noted in the PSI 90 section above; as shown in Figure 21 below, Maryland has performed consistently favorably compared to the Nation from CY 2019-2022.

Figure 20. PSI 13 Postoperative Sepsis, Maryland vs. the Nation 2019-2023



Maryland Hospital-Level Sepsis Dashboard

Staff supports the continued monitoring of performance compared to the Nation along with other existing outcome measures that include PSI 13 postoperative sepsis complications, PPC 35 Sepsis acquired in the hospital, inpatient and 30-day mortality, and 30-day readmissions in a Sepsis Dashboard currently under development that will be disseminated through CRS portal by the end of the year. If performance deteriorates or concerns with the sepsis bundle measure are addressed, staff will reconsider its inclusion in QBR for future years. Finally it should be noted that in July 2024, the FDA announced that there is a shortage of blood culture vials from one of the main suppliers, and CMS has stated this may impact sepsis care, which this monitoring report may help us to identify.

Clinical Care Domain

This domain, weighted at 10 percent of the QBR score, currently includes:

- Inpatient, all-payer, all-condition mortality measure
- 30-Day all-payer, all-condition mortality measure

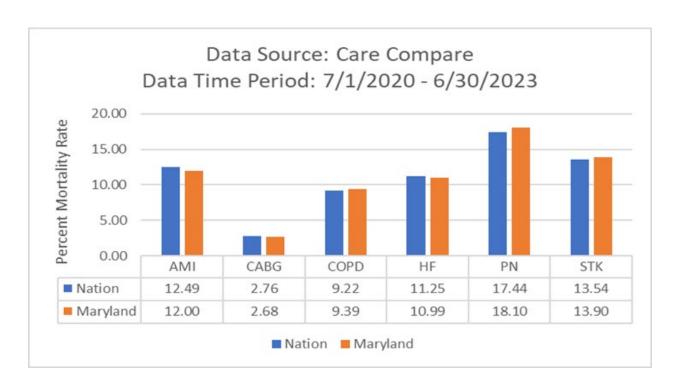
Of note, Maryland's QBR mortality measure currently differs from the CMS VBP Program that uses four condition-specific, 30-day mortality measures for Medicare beneficiaries. Medicare also monitors two additional 30-day mortality measures for Coronary Artery Bypass Graft (CABG) and Stroke (STK). In addition, the RY 2026 QBR policy removed the Inpatient Medicare Total Hip Arthroplasty-Total Knee Arthroplasty (THA/TKA) Complications measure with a proposal to monitor performance on the measure and consider alternative measures in the future such as the newly required THA-TKA patient reported outcome measure. The data through March 2023, shows Maryland hospital performance is on par with the Nation for the THA/TKA measure.

Mortality

CMS 30-Day Condition-Specific Mortality Measures

On the CMS 30-day condition-specific mortality measures used in the VBP program, based on the most recently available data through June of 2023, Maryland performs essentially on par with the Nation (Figure 21). Specifically, Maryland performs slightly better on 30-day mortality for AMI, CABG, and HF, and slightly worse on COPD, PN, and Stroke.

Figure 21. Maryland vs. National Hospital Performance on CMS Condition-Specific Mortality Measures



QBR Inpatient, All-payer, All-condition Mortality measure

For the QBR all-payer inpatient mortality measure, which assesses hospital services where 80 percent of the mortalities occur (80% DRG exclusion), the statewide survival rate decreased during the COVID PHE from 94.86 percent in CY 2019 to 93.55 percent in the CY 2022 performance period. In CY 2023, the statewide survival rate increased to 94.92 percent, on par with the pre-COVID PHE statewide survival rate in 2019. These mortality results were derived with a modified risk-adjustment model where COVID status during admission and percent of patients at the hospital with COVID were added to the regression model to better account for COVIDs impact on mortality. As illustrated in Figure 22 below, CY2023, all hospitals perform above 90 percent.¹⁸

¹⁸ The lowest performing hospital is Ft. Washington followed by Atlantic General.

Risk-Adjusted Survival Rate CY23

100

98

94

92

90

88

86

Maryland Hospitals

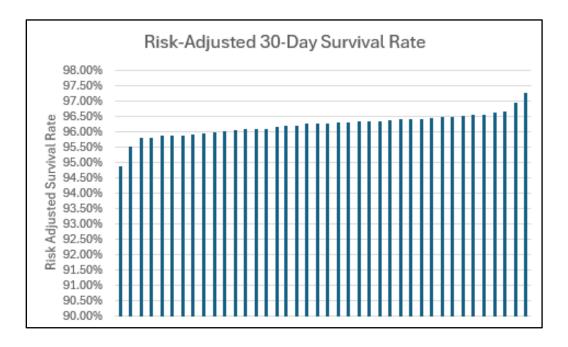
CY23 Performance

Figure 22. Maryland Hospital Performance, CY 2023 QBR Inpatient All Condition, All Payer Mortality Measure

30-Day Inpatient, All-payer, All-condition Mortality Measure

HSCRC began reporting the 30-day, all-payer, all-condition, all-cause mortality measure to hospitals through the CRISP portal in CY 2023 and the measure was adopted into the RY 2026 program. For the CY 2023 performance period, as shown in Figure 23 below, survival rates range from 95 percent to 97 percent. Staff continues to support inclusion of the 30-day measure along with the inpatient measure to better capture the quality of care delivered by hospitals, and notes that these measures are not strongly correlated with one another. Staff also supports continuing to split the domain weight of 10 percent equally between the all-payer, all-cause, inpatient and 30-day mortality measures. In future years staff will further examine the correlation between inpatient and 30-day mortality and decide whether to fully move to the 30-day measure or maintain both measures if the inpatient measure is capturing different patients based on the 80 percent DRG selection. In the future staff may want to explore whether there is sufficient weight on mortality overall, given the significance of this outcome and because it is how we are assessing sepsis performance (as opposed to adding Sepsis bundle measure).

Figure 23. Maryland Hospital Performance, CY 2023 30-Day, All Cause All Condition, All Payer Mortality Measure



Last, as part of the digital measures initiative, staff plans to consider transitioning from the fully claims-based mortality measure to the hybrid 30-day mortality measure (claims plus Core Clinical Data Elements) in the future. In order to do this on an all-payer basis, electronic health record (EHR) vendors will need to be able to adapt measures specifically for Maryland's all-payer measurement environment, a difficult undertaking according to hospitals and EHR vendors providing feedback to staff.

Digital Measures Near-Term Reporting Requirements

In CY 2021 Maryland implemented statewide infrastructure and required all acute hospitals to report to HSCRC electronic Clinical Quality Measures (eCQM) measures beginning in CY 2022, with planned expansion to other digital measures going forward. The reporting requirements are more aggressive than the National CMS requirements in terms of measures, and the expectation for quarterly data submissions as opposed to annual submissions required by CMS.

The State believes that more current digital data submission/availability strengthens hospitals' and the State's ability to use the data for quality tracking and improvement that is actionable. Further, the early adoption and migration to digital data and measures in general will ultimately constitute less burden for hospitals and the State. However, it is also important to note that some hospital stakeholders and Electronic Health Record (EHR) vendors have raised concerns regarding the quarterly data submissions related to EHR vendor system digital measure updates and hospitals' implementation of the updates, and

hospitals have submitted Exceptional Circumstances Exemption requests for timeline extensions which have been granted on a case by case basis by the Commission. The Commission will continue to consider and approve timeline extension requests up to the CMS annual submission deadlines. Figure 24 below illustrates the Maryland and CMS CY 2025 reporting requirements.

Staff notes that, in alignment with the State's goals to improve on maternal health and the SIHIS goal to reduce Severe Maternal Morbidity, the HSCRC required submission of the Severe Obstetric Complications measure beginning in CY 2022, a year ahead of CMS' requirement for hospitals to submit this eCQM; of note, beginning this year, Maryland will work with a contractor, Mathematica, to develop risk adjustment for this measure so it may be used to compare hospital performance in the future. Also, through data/information sharing, staff will continue to collaborate with Maryland's Department of Health on this important population health improvement priority.

Figure 24. CMS-Maryland CY 2024CY 2025 Anticipated eCQM Reporting Requirements

Reporting Period/ payment determination	CMS Measures	Maryland Measures
CY 2024-2025/ FY 2026-2027	Three self-selected eCQMs; Three required eCMQs -Safe Use of Opioids -Cesarean Birth -Severe Obstetric Complications Clinical data elements for two hybrid measures for Medicare -30-day mortality -30-day readmissions	Two self-selected eCQMs; Required eCQMsSafe Opioids -hypoglycemia -hyperglycemia -Cesarean Birth -Severe Obstetric complications Clinical data elements for two hybrid measures (for all-payers beginning in July 2024-June 2025) -30-day mortality -30-day readmissions

In addition to the eCQM reporting requirements, Maryland will also utilize the established infrastructure to collect 30-day Hospital Wide Readmission (HWR) and Hospital Wide Mortality (HWM) hybrid measures required as of July 1, 2023. The State notes that subsequent transition to and adoption of an all-payer hybrid HWM measure will allow for its use in the QBR program.

Domain and Measure Weighting

Staff proposes to maintain the domain and measure weights adopted for RY 2026 to support the saliency of more recently added measures, e.g., ED Wait Times, Disparities in Timely Followup for the second performance year, as illustrated in figure 25 below. However, as noted previously, the HCAHPS top box measures will now only include 6 domains instead of 8 domains, and staff do not propose adjusting the weight overall. Stakeholders should provide feedback on whether the HCAHPS top-box scores should be weighted lower and the weight shifted to other priorities such as ED LOS or Timely Follow-Up.

Figure 25. RY 2026 and Proposed RY 2027 Domain and Measure Weights

RY2026 QBR Weighting (2% total at-risk)	Domain Weight	QBR Program Weight	IP Revenue at Risk (%)
PCE Domain		<u>60%</u>	<u>1.20%</u>
HCAHPS TopBox (8)	33.33%	20.00%	0.40%
HCAHPS Consistency	16.67%	10.00%	0.20%
HCAHPS Linear (4)	16.67%	10.00%	0.20%
ED Wait Times	16.67%	10.00%	0.20%
TFU Medicare	5.56%	3.34%	0.07%
TFU Medicare Disparity Gap	5.56%	3.34%	0.07%
TFU Medicaid	5.56%	3.34%	0.07%
Clinical Care Domain		<u>10%</u>	<u>0.20%</u>
IP Mortality	50.00%	5.00%	0.10%
30-Day Mortality	50.00%	5.00%	0.10%
Safety Domain		<u>30%</u>	<u>0.60%</u>
CAUTI	16.67%	5.00%	0.10%
C. Diff	16.67%	5.00%	0.10%
SSI (2)	16.67%	5.00%	0.10%
CLABSI	16.67%	5.00%	0.10%
MRSA	16.67%	5.00%	0.10%
PSI 90 (10)	16.67%	5.00%	0.10%

Revenue Adjustment Methodology

The revenue adjustments for QBR are calculated using a preset scale so that hospitals can prospectively and concurrently track financial performance in quality programs. In addition to determining the range of the scale, the cut point for penalties and rewards needs to be set such that it does not reward the highest performing Maryland hospitals for performance that is subpar compared to the nation. However, establishing this cut point prospectively has become more difficult to do over the course of the COVID-19 PHE. As mentioned previously, quality of care declined over the COVID-PHE in Maryland and nationally. Thus, the RY 2024 through RY 2026 policies indicated that the cut point would be reassessed retrospectively with more recent national data. For RY 2025, as discussed below, staff are proposing that the cut point be revised from 41 percent to 32 percent based on a simulation of how hospitals outside of Maryland would have performed under QBR. While a retrospective revision is inconsistent with the guiding principle to provide hospitals with a way to monitor revenue adjustments during the performance year, it protects Maryland hospitals from excessive penalties due to changes in performance post-COVID compared to national hospitals. Below is a discussion of the more recent analyses and a proposed new cut point for RY 2025, as well as updates and recommendations for RY 2026 through RY 2027. The final policy will include additional modeling of QBR scores with the HCAHPS changes and ED LOS options.

RY2025 Update

As with RY 2024, staff reassessed the current preset scale for RY 2025 as was indicated in the policy. Based on an analysis that estimates how national hospitals would perform in the QBR program, staff are recommending to reduce the cutpoint to 32% from 41%. Staff estimated national hospitals' performance in the QBR program by applying QBR weighting to CMS/Care Compare measures and by using the average of MD hospitals' performance for MD-only measures. As noted previously, Appendix B documents how each hospital performs with the cut point of 41% and 32%. Statewide, revising the 41% cut point to 32% reduces penalties by about \$33M and increases rewards by about \$9M. While staff are recommending a reduction in the cut point to 32%, the definite cut point will not be determined until the final policy is passed by Commissioners.

RY2026 Update

As with RY 2024-2025, staff will reassess the current preset scale for RY 2026 as was indicated in the policy. Similar considerations will be examined as was done for RY 2024 and RY 2025; however, it should be noted that the performance standards for RY 2026 are post-COVID and thus the base periods are reflective of worse patient experience and quality of care. This could increase improvement points for performance that returns to pre-pandemic levels and lower attainment standards. Providing rewards or lower penalties for returning to pre-pandemic performance may be questionable. Thus, further discussion

is needed amongst stakeholders once data is available to determine the best way to adjust the RY 2026 scaling.

RY2027 Revenue Adjustment Scale

For this policy, staff believes it is still important to have a preset method for taking scores and converting those scores to revenue adjustments on a prospective basis despite the concerns discussed above. Thus, for RY 2027, staff proposes to maintain the 0-80 percent scale where rewards start for those who score greater than 41 percent. As was done for RY 2024 and RY 2025 and will be done for RY 2026, staff will retrospectively assess the cut point with more recent data. However, unlike earlier RYs, the staff believes QBR scores may be on the rise since the performance standards are now set during the post-COVID time period. Thus, the cut point could decrease or increase with this retrospective assessment. As with RY 2026, staff will not use a single year of data to determine the cut point. Thus, staff proposes to maintain the current scale, but determine if the cut point needs to be amended once we have more recent complete data. If staff determines the cut point needs to be amended, we will report this to the Commission.

DRAFT RECOMMENDATIONS FOR RY 2026 QBR PROGRAM

Draft Recommendations for RY 2027 QBR Program:

- Maintain Domain Weighting as follows for determining hospitals' overall performance scores:
 Person and Community Engagement (PCE) 60 percent, Safety (NHSN measures) 30 percent,
 Clinical Care 10 percent.
 - a. Within the PCE domain, weight the measures as follows:

i.	HCAHPS Top Box:	33.33 Percent
ii.	HCAHPS Consistency:	16.67 percent
iii.	HCAHPS Linear:	16.67 percent
iv.	Timely Follow-Up for Medicare:	5.56 percent
٧.	Timely Follow-Up for Medicaid:	5.56 percent
vi.	Disparities in Timely Follow-Up for Medicare:	5.56 percent
vii.	Emergency Department Length of Stay:	16.67 percent

- b. Within the Safety domain, weight each of the six measures equally (i.e., 30 percent divided by number of measures).
- c. Within the Clinical Care domain, weight the inpatient and 30-day mortality measure equally(i.e., 10 percent divided by two measures).
- 2. With regard to monitoring reports to track hospital performance:
 - a. Consider the feasibility of developing a Timely Follow-Up for Behavioral Health measure.

- b. Disseminate Sepsis Dashboard.
- c. Develop tools to monitor HCAHPS performance by patient and hospital characteristics.
- 3. Implement an HCAHPS learning collaborative with hospitals.
- Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures.
- 5. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and maintain the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 41 percent.
 - a. Retrospectively evaluate 41 percent cut point using more recent data to calculate national average score for RY 2026 and RY 2027.
 - b. Based on concurrent analysis of national hospital performance, adjust the RY25 QBR cut point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.

APPENDIX A: QBR PROGRAM BACKGROUND

Maryland's QBR Program, in place since July 2009, uses measures that are similar to those in the federal Medicare VBP Program, under which all other states have operated since October 2012. Similar to the VBP Program, the QBR Program currently measures performance in Clinical Care, Safety, and Person and Community Engagement domains, which comprise 15 percent, 35 percent, and 50 percent of a hospital's total QBR score, respectively. For the Safety and Person and Community Engagement domains, which constitute the largest share of a hospital's overall QBR score (85 percent), performance standards are the same as those established in the national VBP Program. The Clinical Care Domain, in contrast, uses a Maryland-specific mortality measure and benchmarks. In effect, Maryland's QBR Program, despite not having a prescribed national goal, reflects Maryland's rankings relative to the Nation by using national VBP benchmarks for the majority of the overall QBR score.

In addition to structuring two of the three domains of the QBR Program to correspond to the federal VBP Program, the HSCRC has increasingly emphasized performance relative to the Nation through benchmarking, domain weighting, and scaling decisions. For example, beginning in RY 2015, the QBR Program began using national benchmarks to assess performance for the Person and Community Engagement and Safety domains. Subsequently, the RY 2017 QBR policy increased the weighting of the Person and Community Engagement domain, which was measured by the national HCAHPS survey instrument to 50 percent. The weighting was increased to raise incentives for HCAHPS improvement, as Maryland has consistently lagged behind the Nation on these measures. In RY 2020, ED-1b and ED-2b wait time measures for admitted patients were added to this domain, with the domain weight remaining at 50 percent. In RY 2021, the domain weight remained constant, but the ED-1b measure was removed from the program. For RY 2022, ED-2b was removed from QBR because CMS no longer required submission of the measure for the Inpatient Quality Reporting Program.

The QBR domains and weights have remained constant from RY2023 to RY2025; modifications are proposed for RY 2026. Although the QBR Program has many similarities to the federal Medicare VBP Program, it does differ because Maryland's unique model agreements and autonomous position allow the state to be innovative and progressive. Figure A.1. below illustrates the QBR RY2025 measurement domains and weights compared with what is proposed for RY 2026 and the National VBP program.

Figure A.1. RY 2025 and Proposed RY 2026 QBR measures and domain weights compared with those used in the VBP Program

Domain	Maryland Proposed RY 2026 QBR domain weights and measures	Maryland Proposed RY 2027 QBR domain weights and measures	CMS VBP domain weights and measures
Clinical Care	10 percent (-5% from RY 2025) Two measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality,	10 percent Two measures: all-cause, all-condition inpatient mortality; all-cause, all- condition 30-day mortality,	25 percent Five measures: Four condition- specific mortality measures; THA/TKA complications
Person and Communi ty Engagem ent	 60 percent (+10% from RY 2025) 10 measures: Eight HCAHPS categories top box score and consistency, and four categories linear score; TFU Medicare, Medicaid, disparities improvement; ED LOS0 	 60 percent 8 measures: Six HCAHPS categories top box score and consistency, and four categories linear score; TFU Medicare, Medicaid, disparities improvement; ED LOS0 	25 percent Eight HCAHPS measures top box score.
Safety	30 percent (-5% from RY 2025) Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	30 percent (-5% from RY 2025) Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	25 percent Five measures: CDC NHSN HAI measures
Efficiency	n.a.	n.a.	25 percent One measure: Medicare spending per beneficiary

Note: Details of CMS VBP measures can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019. It involves (1) assessing performance on each measure in the domain; (2) standardizing measure scores relative to performance standards; (3) calculating the total points a hospital earned divided by the total possible points for each domain; (4) finalizing the total hospital QBR score (0–100 percent) by weighting the domains based on the overall percentage or

importance the HSCRC has placed on each domain; and (5) converting the total hospital QBR scores into revenue adjustments, using a preset scale ranging from 0 to 80 percent.

QBR program revenue at risk

The HSCRC sets aside a percentage of hospital inpatient revenue to be held "at risk" based on each hospital's QBR Program performance. Hospital performance scores are translated into rewards and penalties in a process called scaling. ¹⁹ Rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered permanent revenue. The HSCRC previously approved scaling a maximum reward of 2 percent and a penalty of 2 percent of the total approved base revenue for inpatients across all hospitals.

HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the CMS VBP Program, where feasible, ²⁰ enabling the HSCRC to use data submitted directly to CMS. Maryland implemented an efficiency measure outside of the QBR Program, based on potentially avoidable utilization (PAU). The PAU savings adjustment to hospital rates is based on the costs of potentially avoidable admissions, as measured by the Agency for Healthcare Research and Quality's Prevention Quality Indicators and avoidable readmissions. HSCRC staff will continue to work with key stakeholders to develop updates to efficiency measure that incorporate population-based cost outcomes.

QBR score calculation

QBR scores are evaluated by comparing a hospital's performance rate to its base period rate, as well as to the threshold (which is the median, or 50th percentile, of all hospitals' performance during the baseline period) and the benchmark (which is the mean of the top decile, or roughly the 95th percentile, during the baseline period).

Attainment points: During the performance period, attainment points are awarded by comparing a hospital's rates with the threshold and the benchmark. With the exception of the Maryland mortality measure and ED wait time measures, the benchmarks and thresholds are the same as those used by CMS for the VBP Program measures.²¹ For each measure, a hospital that has a rate at or above the benchmark receives 10 attainment points. A hospital that has a rate below the attainment threshold

¹⁹ Scaling refers to the differential allocation of a predetermined portion of base-regulated hospital inpatient revenue based on an assessment of hospital performance.

²⁰ VBP measure specifications can be found at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

²¹ One exception is the ED wait time measures. For these measures, attainment points are not calculated; instead, the full 10 points are awarded to hospitals at or below (more efficient) than the national medians for their respective volume categories in the performance period.

receives 0 attainment points. A hospital that has a rate at or above the attainment threshold and below the benchmark receives 1–9 attainment points.

Improvement points: Improvement points are awarded by comparing a hospital's rates during the performance period to the hospital's rates from the baseline period. A hospital that has a rate at or above the attainment benchmark receives 9 improvement points. A hospital that has a rate at or below the baseline period rate receives 0 improvement points. A hospital that has a rate between the baseline period rate and the attainment benchmark receives 0–9 improvement points.

Consistency points: Consistency points are awarded only in the HCAHPS measure in the Experience of Care domain. The purpose of these points is to reward hospitals that have scores above the national 50th percentile in all eight HCAHPS dimensions. If they do, they receive the full 20 points. If they do not, the dimension for which the hospital received the lowest score is compared to the range between the national 0 percentile (floor) and the 50th percentile (threshold) and is awarded points proportionately.

Domain denominator adjustments: In certain instances, QBR measures will be excluded from the QBR Program for individual hospitals. Hospitals are exempt from measurement for any of the NHSN Safety measures for which there is less than one predicted case in the performance period. If a hospital is exempt from an NHSN measure, its Safety domain score denominator is reduced from 50 to 40 possible points. If it is exempt from two measures, the Safety domain score denominator would be 30 possible points. Hospitals must have at least two of five Safety measures to be included in the Safety domain.

Domain scores: The better of the attainment score and improvement score for each measure is used to determine the measure points for each measure. The measure points are then summed and divided by the total possible points in each domain and multiplied by 100.

Total performance score: The total performance score is computed by multiplying the domain scores by their specified weights and then adding those totals together. The total performance score is then translated into a reward or penalty that is applied to hospital revenue.

RY 2023-RY 2027 Updates to the QBR Program

Since RY 2023, the HSCRC has not made fundamental changes to the QBR Program's methodology but implemented the addition of the Follow-Up After Acute Exacerbation of Chronic Conditions measure and PSI-90 composite measures. In RY 2025, Timely Follow Up (TFU) for Medicaid was added. In RY 2026, a measure of within-hospital TFU disparities reduction as well as the ED1-like measure was added and the domain weights were adjusted as follows: Patient and Community Engagement weight was updated to 60%, Safety weight updated to 30% and Clinical Care updated to 10%. Figure A.2. shows the steps for converting measure scores to standardized scores for each measure, and then to rewards and penalties based on total scores earned, reflecting the updates through RY 2026 (added the ED1

measure), and proposed for RY 2027 (no changes to domain weights from those of RY 2026, and decreasing number of HCAHPS sub-measures to six)..

Performance Measures Standardized Measure **Hospital QBR Score &** Scores **Revenue Adjustments** Hospital QBR Score is Sum of **Domain and Measures:** Individual Measures are Earned Points / Possible Points Person and Community Engagement-Converted to 0-10 Points: with Domain Weights Applied -6 HCAHPS categories; * -Timely Follow Up (TFU) Medicare and Scale Ranges from 0-80% Points for Attainment Compare Medicaid & TFU Disparity Gap Performance to a National Max Penalty 2% & Reward +2% -ED LOS, admitted patients Threshold (median) and (ALL HOSPITALS HAVE *Decrease from 8 in RY 2026 program Benchmark (average of top 10%) **OPPORTUNITY TO EARN** Safety— 6 Measures: **REWARD)** -5 CDC NHSN HAI Categories; -AHRQ PSI 90 All-payer Abbreviated Pre-QBR Financial Clinical Care-Set Scale Score Adjustment --Mortality Inpatient, 30-day All-payer **Max Penalty** 0% -2.00% 10% -1.51% -1.02% 20% Points for Improvement Compare 30% -0.54% Performance to Base (historical Penalty/Reward 30% 60% perf) and Benchmark Cutpoint 41% 0.00% 0.46% Hist. Perf Benchmark 50% 60% 0.97% 70% 1.49% Person and Community Engagement Max Reward 80%+ 2.00% Final Points are Better of ■ Clinical Care Improvement or Attainment Safety

Figure A.2. Proposed RY 2027 Process for Calculating QBR Scores

Figure A.3. below details the baseline and performance timelines for the measures in the QBR program for RY 2027.

PSI 90 measure (adopted beginning RY 2023)

Newly adopted in RY 2023, the Patient Safety Indicator composite measure was developed by the Agency for Healthcare Research and Quality in 2003. ²² CMS first adopted the composite measure in the VBP program in FFY 2015 and removed the measure in FY 2019-FY 2022 due to operational constraints from the International Classification of Diseases, Tenth Revision (ICD-10) transition. The HSCRC had used the ICD-9 version of this measure in the QBR program but applied it to Maryland's all-payer population. CMS adopted the updated NQF endorsed ICD-10 version of the measure (Medicare only) that is used beginning with the FY 2023 Hospital VBP program²³, and also adopted by the QBR program (all-payer version) in RY 2023.

AHRQ's specified PSI uses include:

- Assess, monitor, track, and improve the safety of inpatient care
- Comparative public reporting, trending, and pay-for-performance initiatives
- Identify potentially avoidable complications that result from a patient's exposure to the health care system
- Detect potential safety problems that occur during a patient's hospital stay

The discharge weighted average of the observed-to-expected ratios for the following subset of AHRQ's PSIs comprise the PSI-90 composite measure:

- PSI 03 Pressure Ulcer Rate
- PSI 06 latrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall With Hip Fracture Rate
- PSII 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

²² Source: https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2020/TechSpecs/PSI%2090%20Patient%20 Safety%20and%20Adverse%20Events%20Composite.pdf.

²³ For more information on the measure removal and adoption, reference the FY 2018 IPPS/LTCH PPS final rule (82 FR 38242-38244) and (82 FR 38251-38256).

- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

PSI 90 combines the smoothed (empirical Bayes shrinkage) indirectly standardized morbidity ratios (observed/expected ratios) from selected Patient Safety Indicators. The weights of the individual component indicators are based on two concepts: the volume of the adverse event and the harm associated with the adverse event. The volume weights were calculated based on the number of safety-related events for the component indicators in the all-payer reference population. The harm weights were calculated by multiplying empirical estimates of the probability of excess harms associated with each patient safety event by the corresponding utility weights (1–disutility). Disutility is the measure of the severity of the adverse events associated with each harm (for example, the outcome severity or the least-preferred states from the patient perspective).

The PSI 90 measure scores are converted to program scores, as described in the QBR Score Calculation section of this appendix.

Follow-Up After Acute Exacerbation for Chronic Conditions (adopted for RY 2023)

Newly proposed for RY 2023, this measure was developed by IMPAQ on behalf of CMS.²⁴ Technical details for calculating measure scores are provided below.

Measure full title: Timely Follow-Up After Acute Exacerbations of Chronic Conditions

Measure steward: IMPAQ International

Description of measure: The percentage of issuer-product-level acute events requiring an ED visit or hospitalization for one of the following six chronic conditions: hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes mellitus (Type I or Type II), where follow-up was received within the time frame recommended by clinical practice guidelines in a non-emergency outpatient setting.

Unit of analysis: Issuer-by-product

Numerator statement: The numerator is the sum of the issuer-product-level denominator events (ED visits, observation hospital stays, or inpatient hospital stays) for acute exacerbation of the following six conditions in which follow-up was received within the time frame recommended by clinical practice guidelines:

1. Hypertension: Within 7 days of the date of discharge

²⁴ Source: https://impagint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions

- 2. Asthma: Within 14 days of the date of discharge
- 3. HF: Within 14 days of the date of discharge
- 4. Coronary artery disease: Within 14 days of the date of discharge
- 5. Chronic obstructive pulmonary disease: Within 30 days of the date of discharge
- 6. Diabetes: Within 30 days of the date of discharge

Numerator details: This measure is defined at the issuer-by-product level, meaning that results are aggregated for each qualified insurance issuer and for each product. A product is defined as a discrete package of health insurance coverage benefits that issuers offer in the context of a particular network type, such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity. Issuers are broadly defined as health insurance providers who participate in the Federally Facilitated Marketplaces and health insurance contracts offered in the Medicare Advantage market.

Timely follow-up is defined as a claim for the same patient after the discharge date for the acute event that (1) is a non-emergency outpatient visit and (2) has a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code indicating a visit that constitutes appropriate follow-up, as defined by clinical guidelines and clinical coding experts. The follow-up visit may be an office or telehealth visit and takes place in certain chronic care or transitional care management settings. The visit must occur within the condition-specific time frame to be considered timely and for the conditions specified in the numerator. For a list of individual codes, please see the data dictionary.²⁵

The time frames for a follow-up visit for each of the six chronic conditions are based on evidence-based clinical practice guidelines, as laid out in the evidence form.

Denominator statement: The denominator is the sum of the acute events—that is, the issuer-product-level acute exacerbations that require an ED visit, observation stay, or inpatient stay—for any of the six conditions listed above (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes).

Denominator details: Acute events are defined as either an ED visit, observation stay, or inpatient stay. If a patient is discharged and another claim begins for the same condition on the same day or the following day, the claims are considered to be part of one continuous acute event. In this case, the discharge date of the last claim is the beginning of the follow-up interval. The final claim of the acute event must be a discharge to community.

²⁵ Please see https://impaqin<u>t.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions.</u>

An acute event is assigned to [condition] if:

1. The primary diagnosis is a sufficient code for [condition].

OR

- 2. The primary diagnosis is a related code for [condition] AND at least one additional diagnosis is a sufficient code for [condition].
 - If the event has two or more conditions with a related code as the primary diagnosis and
 a sufficient code in additional diagnosis positions, assign the event to the condition
 with a sufficient code appearing in the "highest" (closest to the primary) diagnosis
 position.

If the visits that make up an acute event are assigned different conditions, the event is assigned the condition that occurs last in the sequence. Following this methodology, only one condition is recorded in the denominator per acute event.

Denominator exclusions: The measure excludes events with:

- Subsequent acute events that occur two days after the prior discharge but still during the followup interval of the prior event for the same reason; to prevent double-counting, the denominator will include only the first acute event
- 2. Acute events after which the patient does not have continuous enrollment for 30 days in the same product
- 3. Acute events in which the discharge status of the last claim is not "to community" ("left against medical advice" is not a discharge to community)
- 4. Acute events for which the calendar year ends before the follow-up window ends (for example, acute asthma events ending less than 14 days before December 31)
- 5. Acute events in which the patient enters a skilled nursing facility, non-acute care, or hospice care during the follow-up interval

Measure scoring:

- Denominator events are identified by hospitalization, observation, and ED events with appropriate codes (that is, codes identifying an acute exacerbation of one of the six included chronic conditions).
- 2. Exclusions are applied to the population from Step 1 to produce the eligible patient population (that is, the count of all qualifying events) for the measure.
- 3. For each qualifying event, the claims are examined to determine whether they include a subsequent code that satisfies the follow-up requirement for that event (for example, whether a

diabetes event received follow-up within the appropriate time frame for diabetes, from an appropriate provider). Each event for which the follow-up requirement was satisfied is counted as one in the numerator. Each event for which the follow-up requirement was not satisfied is counted as zero in the numerator.

4. The percentage score is calculated as the numerator divided by the denominator.

Measure-scoring logic: Following the National Quality Forum's guideline, we use **opportunity-based weighting** to calculate the follow-up measure. This means each condition is weighted by the sum of acute exacerbations that require either an ED visit or an observation or inpatient stay for all of the six conditions that occur, as reflected in the logic below.

[NUM(ASM) + NUM(CAD) + NUM(HF) + NUM (COPD) + NUM(DIAB) + NUM(HTN)] / [DENOM(ASM) + DENOM(CAD) + DENOM(HF) + DENOM (COPD) + DENOM(DIAB) + DENOM(HTN)]

Although the development team designed the measure to aggregate each condition score in the manner described above into a single overall score, programs may choose to also calculate individual scores for each chronic condition when implementing the measure. Individual measure scores would be calculated by dividing the condition-specific numerator by the condition-specific denominator, as in the example for heart failure: NUM(HF) / DENOM(HF).

The follow-up measure scores are converted to QBR scores, as described in the QBR Score Calculation section above.

Updated TFU Measurement Specifications CY 22025

Staff notes that the TFU measure specifications were updated in 2024 and were approved by the CMS-designated Partnership for Quality Measurement. The updated specifications will be adopted for the RY 2027 QBR program and include modifications in the follow up times for some conditions as illustrated below.

- 1. Hypertension: Follow up within 14 days of the date of discharge for high-acuity patients or within 30 days for medium-acuity patients
- 2. Asthma: Follow up within 14 days of the date of discharge
- 3. Heart Failure: Follow up within 14 days of the date of discharge
- 4. Coronary Artery Disease: Follow up within 7 days of the date of discharge for high-acuity patients or within 6 weeks for low-acuity patients
- 5. Chronic Obstructive Pulmonary Disease: Follow up within 30 days of the date of discharge
- 6. Diabetes: Follow up within 14 days of the date of discharge for high-acuity patients

Digital Quality Measures Infrastructure: CMS Roadmap

Maryland is an early adopter of digital measure reporting and has established beginning in CY 2022 statewide infrastructure and reporting requirements, initially for monitoring; Maryland envisions transitioning to the use of digital measures in the QBR program as well as other quality-based payment programs when digital measurement has had sufficient development and implementation is feasible.

Over the past decade, CMS has led efforts to advance the use of data from electronic health records (EHRs) to enhance and expand quality measurement. However, accessing clinical patient data from EHRs for the purpose of quality reporting remains relatively burdensome. Additionally, CMS's current approach to quality measurement does not easily incorporate emerging digital data sources such as patient-reported outcomes (PROs) and patient-generated health data (PGHD). There is a need to streamline the approach to data standardization, collection, exchange, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, quality improvement, and learning.

Advancements in the interoperability of healthcare data from EHRs create an opportunity to dramatically improve quality measurement systems and realize creation of a learning health system. In 2020, the Department of Health and Human Services (HHS) finalized interoperability requirements in CMS's Interoperability and Patient Access final rule and in the Office of the National Coordinator for Health Information and Technology's (ONC's) 21st Century Cures Act final rule. Driven by the Cures Act's goal of "complete access, exchange, and use of all electronically accessible health information," these changes will greatly expand the availability of standardized, readily accessible data for measurement. Most important, CMS's and ONC's interoperability rules and policies require specified healthcare providers and health plans to make a defined set of patient information available to authorized users (patients, other providers, other plans) with no special effort using Fast Healthcare Interoperability Resources (FHIR®) application programming interfaces (APIs). The scope of required patient data and standards that support them will evolve over time, starting with data specified in the United States Core Data for Interoperability (USCDI) Version 1, structured according to the Health Level Seven International (HL7®) FHIR US Core Implementation Guide (US Core IG).

Maryland, like CMS, believes that In the future, interoperability of EHR and other digital health data can fuel a revolution in healthcare delivery and advance Measure Calculation Tools to leverage data beyond just EHRs and across settings and providers. CMS has outlined a roadmap to transition from the current environment to a learning health system powered by advanced analytics applied to all digital health data to optimize patient safety, outcomes, and experience.²⁶

Please see full details on CMS Digital Quality Measurement Strategic Roadmap: https://ecqi.healthit.gov/sites/default/files/CMSdQMStrategicRoadmap_032822.pdf, last accessed 8/9/2022.

Figure A.3.QBR RY 2027 timeline: base and performance periods; financial impact

Calendar Year 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 Q1-27 Q2-27 Base Period: Hospital Compare (HCAHPS measures, All NHSN Measures) Performance Period: Hospital Compare (HCAHPS measures, All NHSN Measures) Rate Year Impacted by QBR Results Quality Based Reimbursement Program (QBR) Performance Period: QBR IP and 30-day Mortality, PSI-90, Timely Follow-up Chronic Conditions (Medicare, Medicaid and w/in Hospital Disparity Reduction) Base Period: Emergency Department Length of Stay Performance Period: QBR IP and 30-day Mortality, PSI-90, Follow-up Chronic Conditions (Medicare, Medicaid and w/in Hospital Disparity Reduction) Performance Period: Emergency Department Length of Stay	Rate Year (Maryland Fiscal Year)	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	Q1-27	Q2-27	Q3-27	Q4-27
Quality Based Reimbursement Program (QBR) Quality Based Reimbursement Program (QBR) Results Performance Period: Hospital Compare (HCAHPS measures, All NHSN Measures)	Calendar Year	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	Q1-27	Q2-27
Length of Stay (Admitted	Reimbursement					С	ompare easures	(HCAHI , All NHS sures) Base F day Mo Fo Coo Medic	PS SN Period: (ortality, ollow-up nditions aid and	PSI-90, p Chron s (Medic w/in Ho Reductio	Timely ic are, ospital on) e Period	:Emerge	Compa Al ency	Perfor and 30 Follow- (Medic Hospit	Measure Measure mance f O-day Mo -up Chro are, Meo al Dispa erforman	Peirod: (ortality, Fonic Condicaid arrity Red	QBRIP PSI-90, ditions and w/in uction) od:					icted by	QBR

APPENDIX B: RY 2025 QBR PERFORMANCE BY HOSPITAL

Cut Point = 41%

HOSPID	HOSPITAL NAME	FY24 Estimated Permanent Inpatient Revenue	RY 2025 FINAL Score	% Revenue Impact	\$ Revenue Impact
210001	Meritus	\$ 251,995,786	33.06%	-0.39%	-\$982,784
210002	UMMS- UMMC	\$ 1,473,072,120	24.60%	-0.80%	-\$11,784,577
210003	UMMS- Capital Region	\$ 309,492,831	29.79%	-0.55%	-\$1,702,211
210004	Trinity - Holy Cross	\$ 413,940,590	19.17%	-1.06%	-\$4,387,770
210005	Frederick	\$ 254,562,530	25.42%	-0.76%	-\$1,934,675
210006	UMMS- Harford	\$ 18,810,727	36.69%	-0.21%	-\$39,503
210008	Mercy	\$ 220,664,524	31.02%	-0.49%	-\$1,081,256
210009	JHH- Johns Hopkins	\$ 1,818,903,395	38.29%	-0.13%	-\$2,364,574
210011	St. Agnes	\$ 254,764,484	30.17%	-0.53%	-\$1,350,252
210012	Lifebridge- Sinai	\$ 519,012,883	11.75%	-1.43%	-\$7,421,884
210015	MedStar- Franklin Square	\$ 371,862,302	27.25%	-0.67%	-\$2,491,477
210016	Adventist- White Oak	\$ 242,890,872	27.85%	-0.64%	-\$1,554,502
210017	Garrett	\$ 28,988,189	65.15%	1.24%	\$359,454
210018	MedStar- Montgomery	\$ 96,052,028	37.60%	-0.17%	-\$163,288
210019	Tidal- Peninsula	\$ 350,375,491	27.67%	-0.65%	-\$2,277,441
210022	JHH- Suburban	\$ 249,484,035	17.46%	-1.15%	-\$2,869,066
210023	Luminis- Anne Arundel	\$ 367,930,454	25.83%	-0.74%	-\$2,722,685
210024	MedStar- Union Mem	\$ 267,917,283	38.60%	-0.12%	-\$321,501
210027	Western Maryland	\$ 183,379,829	38.88%	-0.10%	-\$183,380
210028	MedStar- St. Mary's	\$ 100,479,485	44.38%	0.17%	\$170,815
210029	JHH- Bayview	\$ 471,786,218	23.77%	-0.84%	-\$3,963,004
210032	ChristianaCare, Union	\$ 84,802,922	28.50%	-0.61%	-\$517,298
210033	Lifebridge- Carroll	\$ 162,844,959	35.42%	-0.27%	-\$439,681
210034	MedStar- Harbor	\$ 128,234,465	46.90%	0.30%	\$384,703
210035	UMMS- Charles	\$ 97,586,229	41.31%	0.02%	\$19,517
210037	UMMS- Easton	\$ 123,617,439	30.42%	-0.52%	-\$642,811
210038	UMMS- Midtown	\$ 140,418,656	33.15%	-0.38%	-\$533,591
210039	Calvert	\$ 80,925,064	56.94%	0.82%	\$663,586
210040	Lifebridge- Northwest	\$ 160,861,387	26.75%	-0.70%	-\$1,126,030
210043	UMMS- BWMC	\$ 325,584,009	32.15%	-0.43%	-\$1,400,011
210044	GBMC	\$ 263,774,655	28.25%	-0.62%	-\$1,635,403
210048	JHH- Howard County	\$ 220,287,562	27.50%	-0.66%	-\$1,453,898
210049	UMMS-Upper Chesapeake	\$ 236,862,562	29.75%	-0.55%	-\$1,302,744
210051	Luminis- Doctors	\$ 187,232,106	31.02%	-0.49%	-\$917,437
210056	MedStar- Good Sam	\$ 186,628,391	36.42%	-0.22%	-\$410,582
210057	Adventist- Shady Grove	\$ 333,973,100	26.08%	-0.73%	-\$2,438,004
210060	Adventist-Ft. Washington	\$ 37,782,970	18.39%	-1.10%	-\$415,613
210061	Atlantic General	\$ 47,434,007	39.33%	-0.08%	-\$37,947
210062	MedStar- Southern MD	\$ 210,921,411	25.58%	-0.75%	-\$1,581,911
210063	UMMS- St. Joe	\$ 292,568,045	37.42%	-0.17%	-\$497,366
210065	Trinity - Holy Cross Germantown	\$ 94,710,748	18.50%	-1.10%	-\$1,041,818
	Statewide Total	\$11,683,416,741			-\$64,389,900

Cut Point = 32%

HOSPID	HOSPITAL NAME	FY24 Estimated Permanent Inpatie Revenue	nt	RY 2025 FINAL Score	% Revenue Impact	\$ Revenue Impact
		A 054 005	700	· · · · · ·	2 2 4 2 4	A100 700
210001	Meritus	\$ 251,995,		33.06%	0.04%	\$100,798
210002	UMMS- UMMC	\$ 1,473,072,		24.60%	-0.46%	-\$6,776,132
210003	UMMS- Capital Region	\$ 309,492,		29.79%	-0.14%	-\$433,290
210004	Trinity - Holy Cross	\$ 413,940,		19.17%	-0.80%	-\$3,311,525
210005 210006	Frederick	\$ 254,562, \$ 18.810.		25.42%	-0.41% 0.20%	-\$1,043,706
210008	UMMS- Harford	' ' '		36.69%	-0.06%	\$37,621
210008	Mercy JHH- Johns Hopkins	<u> </u>		31.02%	0.26%	-\$132,399
210009		· , , ,		38.29%		\$4,729,149
210011	St. Agnes Lifebridge- Sinai	' ' '		30.17%	-0.11% -1.27%	-\$280,241
210012				11.75%	-0.30%	-\$6,591,464
210015	MedStar- Franklin Square	· , ,		27.25%		-\$1,115,587
	Adventist- White Oak Garrett	+		27.85%	-0.26%	-\$631,516
210017		+		65.15%	1.38%	\$400,037
210018 210019	MedStar- Montgomery	11		37.60%	0.23%	\$220,920
	Tidal- Peninsula	+,,		27.67%	-0.27%	-\$946,014
210022	JHH- Suburban	+		17.46%	-0.91%	-\$2,270,305
210023	Luminis- Anne Arundel	\$ 367,930,		25.83%	-0.39%	-\$1,434,929
210024	MedStar- Union Mem	\$ 267,917,		38.60%	0.28%	\$750,168
210027	Western Maryland	\$ 183,379,		38.88%	0.29%	\$531,802
210028	MedStar- St. Mary's	\$ 100,479,		44.38%	0.52%	\$522,493
210029	JHH- Bayview	\$ 471,786,		23.77%	-0.51%	-\$2,406,110
210032	ChristianaCare, Union	\$ 84,802,		28.50%	-0.22%	-\$186,566
210033	Lifebridge- Carroll	\$ 162,844,		35.42%	0.14%	\$227,983
210034	MedStar- Harbor	\$ 128,234,		46.90%	0.62%	\$795,054
210035	UMMS- Charles	\$ 97,586,		41.31%	0.39%	\$380,586
210037	UMMS- Easton	\$ 123,617,		30.42%	-0.10%	-\$123,617
210038	UMMS- Midtown	\$ 140,418,		33.15%	0.05%	\$70,209
210039	Calvert	\$ 80,925,		56.94%	1.04%	\$841,621
210040	Lifebridge- Northwest	\$ 160,861,		26.75%	-0.33%	-\$530,843
210043	UMMS- BWMC	\$ 325,584,		32.15%	0.01%	\$32,558
210044	GBMC	\$ 263,774,		28.25%	-0.23%	-\$606,682
210048	JHH- Howard County	\$ 220,287,		27.50%	-0.28%	-\$616,805
210049	UMMS-Upper Chesapeake	\$ 236,862,		29.75%	-0.14%	-\$331,608
210051	Luminis- Doctors	\$ 187,232,		31.02%	-0.06%	-\$112,339
210056	MedStar- Good Sam	\$ 186,628,		36.42%	0.18%	\$335,931
210057	Adventist- Shady Grove	\$ 333,973,		26.08%	-0.37%	-\$1,235,700
210060	Adventist-Ft. Washington	\$ 37,782,		18.39%	-0.85%	-\$321,155
210061	Atlantic General	\$ 47,434,		39.33%	0.31%	\$147,045
210062	MedStar- Southern MD	\$ 210,921,		25.58%	-0.40%	-\$843,686
210063	UMMS- St. Joe	\$ 292,568,	045	37.42%	0.23%	\$672,907
210065	Trinity - Holy Cross Germantown	\$ 94,710,	748	18.50%	-0.84%	-\$795,570
	Statewide Total	\$11,683,416	,741			-\$22,280,907

APPENDIX C: HCAHPS PATIENT LEVEL DISPARITY ANALYSIS

Maryland Health Care Commission Updated Patient-Level HCAHPS Analysis

Starting in CY 2022, MHCC requires that Maryland hospitals submit patient level HCAHPS data to them directly. This data collection investment was implemented by the State to address the ongoing HCAHPS performance concerns, with a focus that includes identifying disparities on HCAHPS ratings by patient demographics and service lines. MHCC analyzed the initial year of data and updated their analysis of surveys collected between July 2022 and June 2023. Findings were similar across both years. Highlights of the updated analysis are shown below.

- 30,653 surveys were included in the data set.
- White respondents are more highly represented than Black or other respondent categories relative to their proportion in Maryland's population from the 2020 Census.²⁷
 - White-Comprised 74% of all responses and 49% of the population
 - Black- Comprised 21% of all responses and 26% of the population
 - Other- Comprised 6% of all responses and 22% of the population
- When collapsing "would recommend" categories into two, "No" = Definitely No/Probably No 2,073 (7%), and "Yes" = Definitely Yes/Probably Yes 28,580 (93%):
 - Maryland responses are similar to those of the Nation of 6% and 9 respectively...
 - o More Black respondents than expected indicated the "No" category.
- When collapsing overall ratings into three categories: (1). 6 or lower, (2).7 or 8, and (3). 9 or 10:
 - Maryland responses are lower in the 9 or 10 category than the Nation.
 - There are relatively fewer White respondents and more Black respondents in the 6 or lower category.
- For the responses by service line in Maryland, there were 2,676 surveys within the
 Maternitycomprising 9% of the total, 17,217 surveys within Medical comprising 57% of the total, and 10,225 surveys within Surgical comprising 34%):
 - There are significant differences between Black and non-Black respondents for the Maternity service line:
 - For "would recommend", there were significantly more "No" reported by Black patients than expected.
 - For the Overall Rating, there were significantly more "6 or lower" reported by Black patients than expected

²⁷ Percents by race rounded up to full digit values.

For additional details on the MHCC analysis see below.

Figure C.1. HCAHPS by Race Response Results, 2022 Q3 to 2023 Q2

Across Service Lines-Would Recommend			Maternity Service Line-Would Recommend				
	Yes	No		Yes	No		
Black	92%	8%	Black	92%	8%		
White	94%	6%	White	96%	4%		
Other	93%	7%	Other	96%	4%		

Maternity Service Line-Overall Rating						
	6 or lower	7 or 8	9 or 10			
Black (n=417)	9%	26%	65%			
White (n=1,873)	5%	24%	70%			
Other (n=386)	6%	26%	69%			



Maryland HCAHPS Exploratory Data

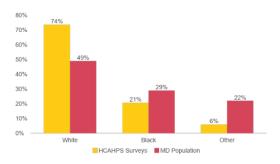
TITLE OF MEETING NOVEMBER 2023



Background

- MHCC began requiring detailed level HCAHPS data starting January 2022 (Q3 2021 discharges)
 - ▶ Joint memo with HSCRC
- Allows for more detailed analysis into race, ethnicity, service line, etc.
 - More timely
- More targeted approaches for quality improvement (e.g., patient populations, domains, etc.)

- Q3 2022 Q2 2023 (30,653 surveys)
- ▶ MD population data from 2020 Census



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Service Lines

- ► Denominator 32,520
 - ► Maternity 4,760 (15%)
 - Medical 17,475 (54%)
 - Surgical 10,285 (32%)

 Black & Other is higher in the maternity service line than medical and surgical

Service Line							
32% 54%							
■Maternity ■Medical ■Surgical							

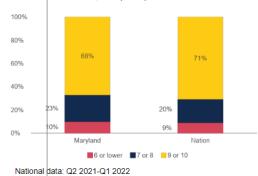
	Maternity (15%)	Medical (54%)	Surgical (32%)
White	56%	69%	75%
Black	31%	25%	20%
Other	14%	5%	5%

Overall Rating

* * * .1

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- ► Collapsed Ratings 1-10
- ▶ Denominator 30,653
 - ► 6 or lower 2,963 (10%)
 - ► 7 or 8 6,966 (23%)
 - ▶ 9 or 10 20,724 (68%)



- Chi-square test shows marginal differences in Overall Rating between races
 - Fewer white respondents, more black respondents in the 6 or lower category
 - ▶ White respondents: 2,108 versus 2,180 expected
 - Black respondents: 687 versus 610 expected

Overall Rating	Black	White	Other
	6,309	22,549	1,795
6 or lower	687	2,108	168
	11%	9%	9%
7 or 8	1,402	5,144	420
	22%	23%	23%
9 or 10	4,220	15,297	1,207
	67%	68%	67%

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Maternity Service Line - Black Women

- ► Time period: Q3 2022 Q2 2023 (30,653 surveys)
- Total Maternity Service Line Denominator 2,676
 - ► Black 417 (16%)
 - ► White 1,873 (70%)
 - ► Other 386 (14%)

Would		White	Other
Recommend		1,873	386
No	34	66	16
	8%	4%	4%
Yes	383	1,807	370
	92%	96%	96%

- Significant differences between black and othe races
 - Would Recommend Significantly more "No" reported by black women than expected
 - Overall Rating More "6 or lower" reported by black women than expected

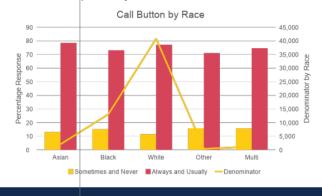
Overall Rating	Black	White	Other
	417	1,873	386
6 or lower	37	94	22
	9%	5%	6%
7 or 8	108	455	99
	26%	24%	26%
9 or 10	272	1,324	265
	65%	70%	69%

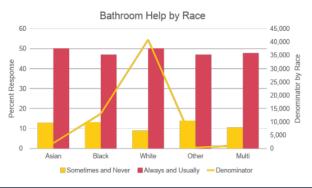
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Areas to Explore

- Areas related to communication are found to be sensitive to disparities (cite)
- ▶ Within the data set, the largest differences between Black and White respondents relate to Call Button Response and Bathroom Help, with a 4.01% and 3.17% difference between races, respectively





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APPENDIX D: HCAHPS LEARNING COLLABORATIVE

Overview

The HSCRC Patient Experience HCAHPS Consultant will co-lead a Patient Experience/HCAHPS Learning Collaborative with the MHA.

This learning collaborative will include hospital leaders responsible for HCAHPS performance and reporting, operations leads, members of the HSCRC Quality leadership team, and representatives from the national survey administrators. The Collaborative will meet on a monthly basis and will be supported by staff from the HSCRC, with assistance from MHA and MHA members as appropriate.

The goal of the learning collaborative is to compile best practices to help Maryland hospitals improve patient experience and attain higher HCAHPS scores. The learning collaborative will accomplish this task by analyzing HCAHPS data, learning best practices from national organizations that consult hospital providers on improving patient experience, and through quality improvement initiatives using PDSA cycles.

The learning collaborative meetings will include level-setting knowledge of HCAHPS and how the survey is evaluated, learning best practices from survey vendors and MHA member hospitals, and presenting the results of a state-wide data analysis by the HSCRC team.

As a final work document, the learning collaborative will report findings to the HSCRC.

Work Plan and Timeline

July/August 2024 - Draft work plan presented and discussed with HSCRC leadership

September 2024 - Begin data analysis, have initial meetings with MHA leadership, and identify a co-chair from hospital leadership for the learning collaborative. The co-chair should be a champion who can both command and engage teams across all hospitals and have proficiency in quality improvement. This person should have specific qualifications and experience in conducting large scale quality improvement and an enthusiasm for the importance of patient experience.

September 2024 - Present to a HSCRC Commission meeting on the value and nuances of patient experience and the HCAHPS survey. Introduce the learning collaborative and larger effort to improve Maryland's performance.

October 2024 - Agree upon a work plan for the learning collaborative with the MHA.

November 2024 - Convene learning collaborative for the first time. Define goals and objectives.

December 2024 - Convene learning collaborative for data review with national survey vendors.

January 2025 - Convene learning collaborative for data review from the HSCRC/MHCC.

February 2025 - Convene learning collaborative to share best practices.

March 2025 - Convene learning collaborative to begin process improvement initiatives.

April - September 2025 - Facilitative sessions with the learning collaborative to share findings on improvement initiatives and develop final report.

August/September 2025 – Share findings with HSCRC and work with Performance Measurement Workgroup to assess QBR incentives to support best practices.

Schedule updates at Commission meetings throughout this process and at the conclusion of the report.

APPENDIX E: HSCRC EFFORTS TO ADDRESS ED LENGTH OF STAY

Concerns about unfavorable ED throughput data have been shared by many Maryland stakeholders, including the HSCRC, the MHCC, payers, consumers, emergency department and other physicians, hospitals, the Maryland Institute of Emergency Medical Services Systems, and the Maryland General Assembly, with around a dozen legislatively mandated reports on the topic since 1994, including the Maryland General Assembly Hospital Throughput Work Group Final Report in March 2024.

Historically, the HSCRC has taken several steps to address emergency department length of stay concerns. However, in the past few years, the COVID public health emergency and its effects on inflation and labor have had particularly significant negative impacts on hospitals and other care settings that patients may use after receiving hospital care (e.g., nursing homes), further exacerbating pressures on emergency departments.

Previously, the HSCRC included ED LOS measures in the QBR program for two years. In RY 2020 (CY 2018 measurement period), the QBR Program introduced the use of the two CMS inpatient ED wait time measures (chart abstracted measures: ED-1 and ED-2) as part of the QBR Person and Community Engagement (PCE) domain because of the high correlation between ED wait times and HCAHPS performance (also in the PCE domain and on which the state also performs poorly). CMS retired ED-1 after CY 2018 and ED-2 after CY 2019 necessitating both measures' removal from the QBR program after only two years. Overall, ED LOS improved (i.e., ED LOS time went down) for more than half the hospitals when the measures were in QBR, although some of the improvements were minimal. With the retirement of the chart-abstracted ED LOS measures, the HSCRC continued to work to find a way to collect the data and include the results in QBR.

More recently, staff collaborated with CRISP and their contractor to collect the electronic Clinical Quality Measure (eCQM) ED-2 (Order of admission to admit time) for CYs 2022-2023. However, analyses of the ED-2 eCQM found that there are a significant number of hospitalizations (>50,000 statewide) that are dropped from the ED measure due to an exclusion for stays where the patient spends more than one hour in observation care. Furthermore, CMS discontinued this eCQM measure in CY 2024, rendering it not feasible for hospitals to continue to report the eCQM at this time for use in the QBR program.

To determine the direction for inclusion of an ED throughput measure in the RY 2026 QBR policy that would begin with CY2024 performance, the Commission considered several measurement options proposed by staff as well as other initiatives underway to address this issue going forward.

Ultimately, the Commission approved inclusion of ED 1-like measure in the RY 2026 QBR program to be finalized during CY 2024 and that would not require additional Commission approval. In working with ED Subgroup stakeholders in early 2024, staff selected a measure that mirrors the CMS ED1 measure, with

specifications aligned with those of The Joint Commission as much as possible; the initial measure collection and submission is through an ad hoc electronic data pull for all patients that will be submitted on an ongoing basis eventually through the existing HSCRC case mix data submission process; the initial ad hoc electronic data pull and submission includes data from CY 2023 to serve as the performance baseline period, and from January through March 2024. Hospitals will also provide an ad hoc submission in December that will correct any previously submitted data and provide data from April through September 2024; beginning with data from October 2024 going forward, the ED measure data elements will be included as part of the standard case mix submission process. The ED1 LOS measure captures the time of emergency department arrival to the time of physical departure from the emergency department for patients admitted to the facility. The population is all ED patients (pediatrics and adults) admitted to an inpatient (IP) bed and discharged from the hospital during the reporting period.

Additional Initiatives: Emergency Department Dramatic Improvement Effort (EDDIE)

In June of 2023, Commissioner Joshi convened HSCRC, MIEMSS, MHA, and MDH to propose the EDDIE project with the goal of reducing the time patients spent in the emergency department, and pushed the HSCRC staff and MHA to begin this project immediately (i.e., not wait until next policy year) given the importance of this issue. The EDDIE project focuses on short-term, rapid-cycle improvement in ED patient experience by collecting and publicly reporting on ED performance data, and fostering a quality improvement process to address those metrics.

Specifically, starting in July 2023, hospitals are submitting data on measures that mirror the CMS ED 1 and OP 18 CMS measures on a monthly basis in accordance with an excel reporting template along with a memo provided by HSCRC staff that contains reporting instructions and high level specifications. The HSCRC has requested that the measures submitted be stratified by behavioral health based on initial ICD codes. Additionally, the HSCRC has developed a reporting process by which MIEMSS provides monthly reporting on EMS turnaround times by hospital. This will provide hospital accountability for improving efficiency in handoffs by EMS personnel, which will in turn improve EMS unit availability and decrease response times.

The HSCRC and MIEMSS are supporting this work by collecting and publicly reporting hospital ED wait times at monthly Commission meetings. The intent is to provide a mechanism for Commission monitoring of timely ED performance data that brings on-going attention to this issue through public reporting, provides an opportunity for the Commission to recognize and learn from high performers, and to track the hospitals performance improvement efforts relative to their aim statements. Once hospitals have submitted CY 2023 and CY 2024 patient level data, the staff will ask the Commissioners whether EDDIE data submissions are still needed.

Additional Initiatives: ED Potentially Avoidable Utilization

In CY 2021, Commissioners asked staff to evaluate expansion of potentially avoidable utilization (PAU) to emergency department utilization. Staff recommendations initially focused on high volume and low acuity chief complaint encounters (e.g., ear pain, dental problems) based on analysis of 2.4M ED observations with triage ratings. With workgroup/stakeholder vetting, this project was re-focused on multi-visit patients in the ED with >3 ED visits (statewide) in a 12-month period. A hospital monitoring program with reporting through CRISP has been established in CY 2023, with plans to consider a payment policy for CY 2025. A draft ED PAU policy will be presented at the November 2024 commission meeting.

Additional Initiatives: Legislative Workgroup

In early 2023, the Maryland General Assembly passed legislation establishing the Task Force on Reducing Emergency Department Wait Times to study best practices for reducing emergency department wait times; and requiring the Task Force to report its findings and recommendations to the Governor and the General Assembly by January 1, 2024. In response, MHA, with co-chair Dr. Ted Ted Delbridge, executive director of Maryland Institute for Emergency Medical Services Systems (MIEMSS), led a multistakeholder work group, the Hospital Throughput Work Group, aimed at making recommendations to improve the patient journey in Maryland.

Members included hospital representatives, legislators, the HSCRC, the MHCC, the state Department of Health, patient advocates and emergency department and behavioral health providers. The Task Force was charged with making legislative, regulatory and/or policy recommendations in a report. The Maryland General Assembly Hospital Throughput Work Group Final Report was submitted in March 2024. The HSCRC staff were an active participant in the Task Force and believe that inclusion of an ED length of stay measure in QBR will be consistent with any policy recommendations designed to improve ED length of stay and hospital throughput (i.e., a payment incentive should bolster performance improvement and not hinder other policy recommendations).

New Commission: Maryland Emergency Department Wait Time Reduction Commission

In the 2024 General Assembly session, legislation was passed establishing the ED Wait Times Reduction Commission, which went into effect on July 1, 2024. Figure E1 provides details on the ED Commission purpose, specific tasks, and what types of members will be on the ED Commission.

Figure E1. ED Wait Time Commission Description

Establishment of Maryland ED Wait Time Reduction Commission

Bill went into effect July 1, 2024, and terminates June 30, 2027

Purpose: To address factors throughout the health care system that contribute to increased

Emergency Department wait times

Specific focus: Develop strategies and initiatives to recommend to state and local agencies, hospitals, and health care providers to reduce ED wait times, including initiatives that:

- Ensure patients are seen in most appropriate setting
- Improve hospital efficiency by increasing ED and IP throughput
- Improve postdischarge resources to facilitate timely ED and IP discharge
- Identify and recommend improvements for the collection and submission of data
- · Facilitate sharing of best practices

Chairs: Secretary of Health and Executive Director of HSCRC

Appointed Members:

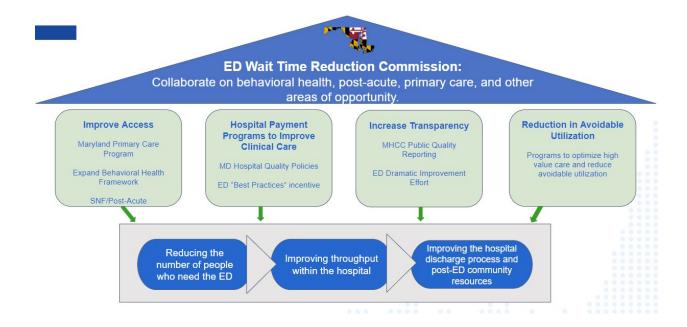
- ☐ Executive Director of MIEMSS
- □ Executive Director of MHCC
- 2 Indiv. with operation experience in an ED, including 1 physician
- 1 Indiv with professional experience in an ED, who is not a physician or APP
- ☐ 1 representative from local EMS
- ☐ 1 representative from a Managed Care Plan with experience in Case Management
- ☐ 1 representative of Advanced Primary Care Practice
- □ 1 representative from MHA
- ☐ 1 representative from a patient advocacy organization
- ☐ 1 representative of a behavioral health provider



5

The ED Commission's work aligns with many of the current HSCRC policies and those under development. These policies, shown in Figure E2, are designed to address ED and hospital throughput by reducing the number of people who need ED services, improving ED and hospital throughput, and improving the hospital discharge process and community resources. The ED Commission will address state-level opportunities related to access and community-based services that impact ED wait times, such as access to behavioral health, post-acute/SNF beds, and primary care. The ED Commission will also support hospital best practices to address ED wait times and throughput across Maryland hospitals. The ED Commission members have been appointed and the first meeting is scheduled for the end of October.

Figure E2. ED Wait Time Commission and Other Initiatives to Reduce ED Wait Times



APPENDIX F: ED LOS MEASURE DEVELOPMENT AND MODELING

The slides below outline the development of the ED LOS measure

QBR Policy Approval and ED LOS Measurement Development Timeline

- 11/8/2023 QBR Draft Policy: Proposed options for inclusion of ED LOS measure
- 12/13/2023 QBR Final Policy: Approved inclusion of ED LOS measure at 10 percent weight
- · Commission discussion:
 - QBR ED LOS Measure Development plan was proposed on January 10,2024
 - QBR ED LOS Measure Development Plan was reviewed on February 14, 2024
 - Commission meeting materials: <u>Commission-Meetings (maryland.gov)</u>
- Subgroup Meetings:
 - ED Subgroup 1 (Data): February 2nd, 2024, March 1st, 2024, April 12th, 2024
 - ED LOS Data Submission Memo was sent via email to hospitals on May 20, 2024
 - ED LOS Data Submission Dates: Extended to September 13, 2024 (CY2023 and Jan-Mar 2024 data), December 16, 2024 (Apr-Sept data), March 2025 (Oct-Dec data)
 - ED Subgroup 2 (Incentive): April 26th, 2024, May 17th, 2024, June 21st, 2024, September 10, 2024
 - Meeting recordings and slides: <u>Subgroup ED LOS Measure (maryland.gov)</u>



1

QBR ED LOS Incentive CY 2024

- Incentive measures improvement from CY 2023 to CY 2024
- Measure: Percent change in the median time from ED arrival to physical departure from the ED for patients admitted to the hospital
- Population: All non-psychiatric ED patients who are admitted to Inpatient bed and discharged from hospital during reporting period
- **Scoring:** Use attainment calculation for percent change to convert improvement into a 0 to 10 point score (see next slide)
- Data: Ad hoc data submissions of time stamps to merge in with case-mix data
- Statewide Goal: TBD by ED Wait Time Reduction Commission



15

Data Submission and Reporting Timeline

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

Should HSCRC try to collect CY2022 data?

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

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

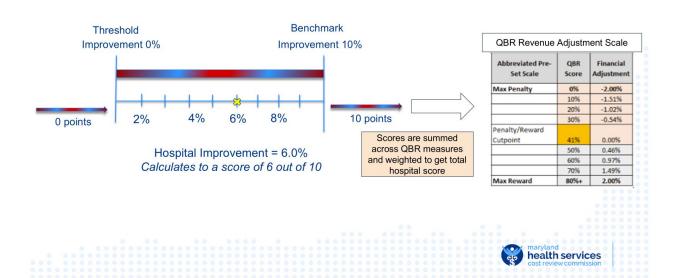


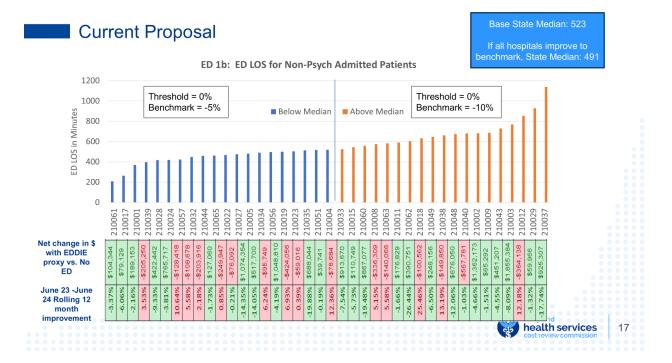
Ad-Hoc Data Submission Requirements (DSR)

Data Elements	Description	Rationale
Medicare Provider Number	Hospital Medicare ID	Required for matching
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 ED-1
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)	
Optional Variables		
Observation Status 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
Observation Status Time	EHR timestamp for when patient enters observation status; could be in or outside of the ED	
IP Unit Arrival Date	Date patient arrived at IP unit (HHMM in military time)	To be able to ensure we have data on total wait time if needed
IP Unit Arrival Time	Time patient arrived IP unit ED (i.e., physical arrive at unit)	

The next set of slides provide score modeling with the current proposal for performance standards.

QBR Scoring Example







Set Aside Discussion October 8, 2024

HSCRC Call for Comments

- 1. What constitutes a minimally viable technical proposal?
 - a. If hospitals reach the standard (i.e., they make it to step 3 of our process which evaluates need and oversight), should they automatically qualify for a portion of the set aside or should there be a minimum threshold in scoring?
- 2. Should some criteria be weighted more favorably in the overall evaluation?
 - a. For example, should hospital regulated margin be given more weight than total margin?
- 3. Are there any suggestions for how to allocate the funding?
 - a. For example, should funds be allocated based on evaluation score, margin and/or days cash on hand, total GBR, or a combination thereof?
- 4. Should hospitals withhold executive bonuses as a prerequisite for set aside funding?
- 5. Should hospital management be required to outline sustainable reductions in cost to offset funding priorities as a prerequisite for set aside funding?
- 6. Should hospitals need to make a pledge to not ask for funding for a specific period of time following fund allocations?



1. What constitutes a minimally viable technical proposal?

- All hospitals agree that the qualification for funding should focus on the unique financial circumstances of each hospital. MHA, Medstar, and Frederick Health emphasize the importance of assessing requests on individual merit, particularly when evaluating financial hardship.
- Hopkins and UMMS suggests that funding decisions should be need-based rather than strictly adhering
 to a predefined set of technical criteria. Luminis and Adventist support the idea of prioritizing or
 expanding the criteria for those meeting "Financial Hardship" over those meeting "Efficiency" standards,
 as efficient hospitals have other funding avenues available.

HSCRC Staff Response:

In light of the significant number of funding requests we've received, HSCRC staff are committed to ensuring that our evaluation process is both transparent and focused on addressing genuine need. Staff received feedback suggesting that technical proposals should be assessed based on their 'need' or 'merit.' While we agree that merit and need are important evaluative criteria, given the broad range of requests and varying circumstances of requesting hospitals, Staff recommend that a pass/fail for merit and need and a final scoring based on objective measures of financial hardship and management improvement opportunities is an reasonable approach.

1a. If hospitals reach the standard (i.e., they make it to step 3 of our process which evaluates need and oversight), should they automatically qualify for a portion of the set aside or should there be a minimum threshold in scoring?

Most hospitals argue against requiring a minimum scoring threshold if the hospital meets a standard
of financial hardship. Medstar suggests automatic qualification if funding requests are within
available set-aside limits, while Hopkins, Adventist, and Frederick Health, argue for flexibility and
prioritization based on need, rather than imposing a strict scoring requirement.

HSCRC Staff Response:

Staff agree that if the hospital meets a standard of financial hardship and minimum technical viability, they should automatically qualify to receive a portion of the funding. Staff created the four step review process to help define need in an objective and transparent manner.

- 2. Should some criteria be weighted more favorably in the overall evaluation? For example, should hospital regulated margin be given more weight than total margin?
- Most hospitals suggest that total margin should be given significant weight or even prioritized over regulated margin.
 They argue that total margin provides a more comprehensive view of financial health because it encompasses both
 hospital services and unregulated investments necessary to support health, such as physician services. John
 Hopkins also emphasizes the importance of considering the relationship between both the regulated and total
 margin, noting that evaluating both metrics is crucial in understanding financial hardship in cases where regulated
 operations are not fully covered by GBR or when non-regulated operations affect overall profitability.
- Medstar supports HSCRC staff weighing hospital regulated operating margins more heavily in their evaluation of setaside funding allocation.

HSCRC Staff Response:

While Staff understand the requested emphasis of total margin, given our authority over regulated hospital operations, Staff believe both total and margin statistics should be weighted equally. Secondly, Staff does not currently have a high degree of visibility related to the drivers related to unregulated losses. HSCRC Staff propose weighting all measures within the Financial Assessment domain equally in the first year of this evaluation. For future evaluations, staff will work with stakeholders through the Payment Model Workgroup to determine any potential modifications to the set-aside weighting method.



- 3. Are there any suggestions for how to allocate the funding? For example, should funds be allocated based on evaluation score, margin and/or days cash on hand, total GBR, or a combination thereof?
 - Most hospitals suggest that funding should be based on need and reflect true financial hardship. UMMS, Adventist, and MHA emphasize that the available excess savings should allow for full support of hospitals in financial distress.
 - Medstar suggests using a composite score based on both objective and subjective metrics, emphasizing financial performance as the key metric, especially for hospitals in hardship. They warn against using inconsistent metrics like days cash on hand or cash flow from hospital operations for funding decisions due to consistent reporting across the industry. Additionally, system level reporting may not reflect the financial hardship of individual member hospitals.
 - Hopkins and UMMS support allocating funds specifically for justified financial hardship. Frederick Health, Adventist, and MHA recommend increasing the funding pool if financial hardship exceeds the available set-aside. They also emphasize that allocation should not be simply prorated or distributed evenly but should reflect each hospital's unique needs.

HSCRC Staff Response:

Staff developed the scoring rubric to help define true need and define financial hardship. HSCRC staff appreciate MedStar acknowledging the rubric and composite scoring to define need. Financial scoring includes margin data, both total and regulated, as well as days cash on hand. Staff believe that days cash on hand is an important metric to consider in funding allocation as it provides valuable insight into a hospital's liquidity and ability to manage short-term financial challenges. This balanced approach will contribute to a more comprehensive understanding of each hospital's financial health and sustainability. Staff's current calculation to allocate the set-aside funding provides half based on financial performance ranking and the remaining half based on management improvement opportunity ranking.



4. Should hospitals withhold executive bonuses as a prerequisite for set aside funding?

- All hospitals oppose withholding executive bonuses as a prerequisite for funding. They argue that
 executive compensation is managed by hospital boards and is linked to meeting specific goals, such
 as quality and service, and are essential for hospital operations. Luminis further adds that executive
 compensation is already closely tied to key financial metrics, including those relevant to the financial
 hardship criteria.
- Medstar and MHA emphasize that executive bonuses are part of compensation packages necessary to attract and retain qualified leaders.

HSCRC Staff Response:

Historically, the Commission evaluates the reasonableness of cost. In this particular circumstance, Staff would be unable to determine the reasonableness of executive compensation.

- 5. Should hospital management be required to outline sustainable reductions in cost to offset funding priorities as a prerequisite for set aside funding?
- Hospitals generally agree that while outlining cost reduction measures is valuable, it should not be a strict prerequisite for
 receiving funding. Frederick Health, Adventist, Luminis and MHA note that cost-cutting alone cannot solve the financial
 distress that hospitals face, and many hospitals have already implemented cost-reduction measures.
- Medstar and MHA suggest that providing information on efficiency efforts could be beneficial, but requiring a one-to-one
 offset is not appropriate. Medstar further suggest that hospitals who are engaged in efforts to improve operational efficiency
 should be given additional consideration in the HSCRC Staff evaluation process.

HSCRC Staff Response:

Staff appreciate the insights shared by the hospitals regarding cost reductions. Moving forward, sustainable cost reduction measures will be an integral part of the application process for funding. This requirement will not only promote accountability but also encourage hospitals to adopt long-term strategies for financial stability. Staff believe that by including these measures in the application, we can better evaluate the overall health and sustainability of each institution while still recognizing the unique challenges they face. This balanced approach aims to support hospitals in their efforts to provide quality care while managing financial pressures.

- 6. Should hospitals need to make a pledge to not ask for funding for a specific period of time following fund allocations?
- All hospitals oppose requiring a pledge not to request additional funding after receiving allocations. They argue that such a requirement could endanger access to care if future financial needs arise. Medstar and Hopkins specifically emphasize the unpredictability of hospital funding needs and the importance of flexibility to request funding when needed.
- Frederick Health and MHA strongly argue that hospitals must be able to secure additional funding to cover costs, emphasizing
 that such a pledge is neither practical nor safe. However, while Frederick Health recommends fully allocating the requested
 funding, they also believe that, in the event of prorated funding, hospitals should still be allowed to seek the shortfall of
 funding.
- Luminis suggests that hospitals should refrain from seeking additional funding only if specific requests are fully funded.

HSCRC Staff Response:

There are several options available to hospitals that have a request related to their Global Budgets. 1) Request related to misapplication of a policy 2) Request related to a policy change and/or 3) Request that falls within the set aside framework. For any request that falls outside these three buckets, the administrative remedy is a full rate review. HSCRC Staff agree with several of the hospitals that if the allocated funding does not cover the amount of the full request, then they should be able to request further funding under the appropriate avenue, as outlined above, within the same fiscal year. In a future year, the hospital could make a request through the set aside, however; it should be noted in future evaluations of this process cost reduction measures will be integral in the evaluation of requests.



Other comments

- UMMS recommends that certain funding requests be considered for permanent solutions rather than only providing one-time funding.
 - HSCRC Response: Staff has been very clear from the beginning that hospitals that qualify under Integrated
 Efficiency will be provided permanent funding while hospitals that qualify under financial hardship will be
 provided one-time funding.
- MHA and Johns Hopkins seek greater transparency in the funding decision-making process, and advocate for a clear and objective evaluation criteria for fair resource allocation. MHA recommends that any criteria used be objectively verifiable and applicable, rather than subjective.
 - HSCRC Response: Staff have advanced a scoring rubric with clear and objective evaluation criteria in keeping with the commenters request.
- MHA further requests details regarding the process and timeline used to determine and distribute final awards, including the individuals who will ultimately make the funding decisions (HSCRC staff, HSCRC commissioners, appointed reviewers, etc.)
 - HSCRC Response: Commissioners have directed Staff to make final determinations on the set aside allocation. At the direction of Commissioners, Staff provided a public comment period and monthly updates in the public meeting to ensure transparency of the process.
- Adventist believes hospitals should be allowed to amend their applications if new criteria is added to the scoring
 process that was not included in the original application instructions.
 - HSCRC Response: Given the inherently objective nature of the scoring rubric, staff do not believe any hospitals need to re-submit information.

Comment Received: Eligibility Criteria

- Staff received criticism that the HSCRC's "arbitrary" criteria exclude hospitals like Luminis
 Health Doctor's Community Medical Center, which has below-average margins and operating
 losses relative to RY 2022.
- In light of this criticism, should the eligibility criteria be amended to allow for additional or new measures for hospitals experiencing hardship?
 - a. For example, should hospitals that are below the regulated statewide average margin and have a negative operating margin over RY 22, RY 23, and RY24, qualify? Should this criteria be broadened?

HSCRC Staff Response:

Staff's intention of requiring further deterioration in margin performance, in addition to poor performance in the most recent year, was to ensure that a) profitability concerns were not restricted to one year and b) that the hospital did not show signs of moving out of territory that would be considered "financial hardship." The statistic was not arbitrary. That said, staff do recognize that if a hospital had negative regulated and total margins, albeit with moderate improvement in recent years, that the hospital could be reasonably classified as an institution in financial hardship. For those reasons, staff ask Commissioners to consider amending the "gatekeeper criteria" such that hospitals with below average regulated margins and negative total margins over the past 3 years qualify for set aside consideration, regardless of the change in profitability over the preceding three years. Staff furthermore ask Commissioners if any additional criteria should be considered.

Overview

The intention of the set-aside is to use these funds for:

- Unforeseen events that occur at hospitals with a financial hardship, regardless of efficiency (e.g., cyberattacks)
- Enhancements for relatively efficient hospitals

Due to the volume of submissions & requested funding, staff would like Commissioners to weigh in on:

- Criteria for evaluation
- Weighting of evaluation criteria
- Evaluation responsibility

Process Overview



Scoring Rubric: Technical Evaluation

A) Financial Hardship Technical Evaluation

- Unforeseen and/or Preventable Ranking
 - Is the request being made due to poor decision making/investments?

A) Relative Efficiency Technical Evaluation

- Population Health Ranking
 - Does the proposed intervention improve the health of the population?
- Methodology Disadvantage Ranking
 - How material is the adverse impact from a methodology?

Scoring Rubric and Allocation

Financial Assessment (50%)

- FY24 Total Margin (Regulated + Unregulated)
- FY24 Regulated Margin
- Days Cash

Improvement Opportunities (50%)

- Cost per ECMAD
- Overhead Cost per ECMAD
- Margin from Unregulated System Operations
- Potentially Avoidable Utilization

Requirements for Funding

- Assessment of cost drivers
- Corrective Action plan approved by the Board for future financial sustainability
- Commitment to suspend variable executive compensation (TBD)
- Performance assessments are variance from statewide average.
- Measures are weighted equally within the domains.



Recommendation

Creation of a 4 part process for review of set aside submissions in RY25

- a. Gatekeeper Test
 - i. Pass/Fail after eligibility verification
 - ii. Subject to additional Commission review
- b. Technical Evaluation
 - i. Pass/Fail after review of technical narrative
- c. Scoring Rubric based on Hospital's rank compared to statewide metric & Allocation
 - i. Financial Need
 - ii. Management Improvement Opportunities
- d. Requirements for Funding
 - i. Cost Review Assessment
 - ii. Sustainability Plan & Board Approval of Sustainability Plan
 - iii. Executive Compensation commitment to suspend variable exec compensation?



TO:

HSCRC Commissioners

FROM:

HSCRC Staff

DATE:

October 9, 2024

RE:

Hearing and Meeting Schedule

November 13, 2024 In person at HSCRC office and Zoom webinar

December 11, 2024 In person at HSCRC office and Zoom webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.

Joshua Sharfstein, MD

Chairman

Joseph Antos, PhD Vice-Chairman

James N. Elliott, MD

Ricardo R. Johnson

Maulik Joshi, DrPH

Adam Kane, Esq

Nicki McCann, JD

Jonathan Kromm, PhD Executive Director

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Allan Pack

Director

Population-Based Methodologies

Gerard J. Schmith

Director

Revenue & Regulation Compliance

Claudine Williams

Director

Healthcare Data Management & Integrity