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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

1. 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. Report from the Executive Director
    a. CY 2023 TCOC Model Official Performance

b. Model Monitoring and Discussion of Projected CY 2024 Savings

5. Final Recommendation: Confidential Data Request

6. Final Recommendation: Adoption of previously proposed amendments to Community Benefits Reporting Regulation, COMAR 10.37.01.03.M.

7. Draft Recommendation: ARPA-H BCORE Outcome Buyer Recommendation

8. Draft Recommendation: Out-of-State, Deregulation, and Repatriation Volume Policies

9. Draft Recommendation: Quality-Based Reimbursement (QBR) Policy

10. Emergency Department Wait Time Activities Update

    a. HSCRC Staff Update
    b. Presentation: Adventist White Oak Emergency Department Improvement Efforts

11. Set Aside Follow-Up

12. Hearing and Meeting Schedule

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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.

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Application for an Alternative Method of Rate Determination

University of Maryland Medical Center

October 9, 2024

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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.

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

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 methodology[3] 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. All-Payer Quality Improvement Reductions in Potentially Preventable Conditions under the Maryland Hospital Acquired Condition Program (Section 8.d.1-3)

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 Revenue[5] for Maryland residents into Population-Based Payment[6]. 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.

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

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

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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.

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Final Recommendation

Revised Community Benefits Reporting Regulation

COMAR 10.37.01.03.M.

October 2024

P: 410.764.2605 ● 4160 Patterson Avenue | Baltimore, MD 21215 ● hscrc.maryland.gov

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).

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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

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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

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
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, Baltimore Comprehensive Overdose Response to End the Epidemic (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.

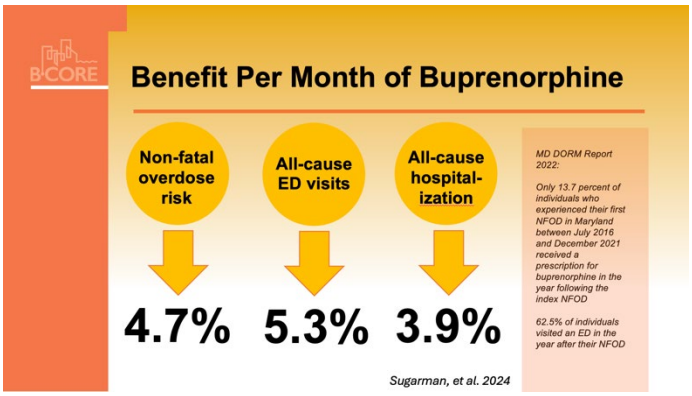
Overview of the Program

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 non-fatal 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.

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maryland
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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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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.
      i. 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.[1] 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 factor[3] 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 in-state 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	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)

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.

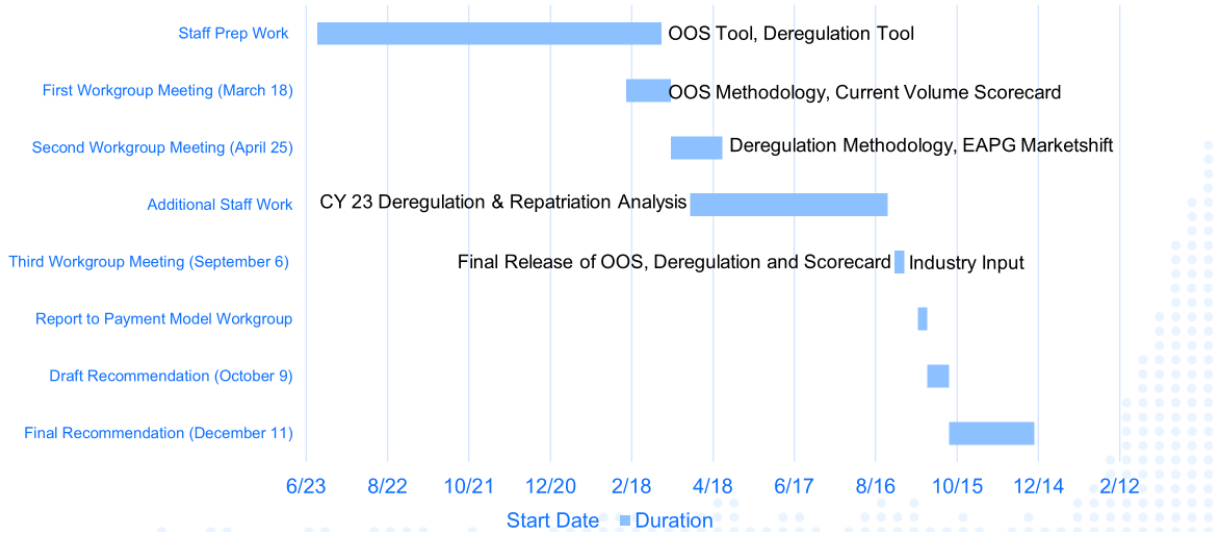
The purpose of this recommendation is to officially establish methodologies for making these volume adjustments, thereby reducing any potential arbitrary and capricious treatment that might result from not having methodologies first vetted by external stakeholders and then reviewed and approved by HSCRC 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.

Table 2: 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 2020[5] that have since been suspended, as well as an update to the Demographic Adjustment policy in 2023[6] 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

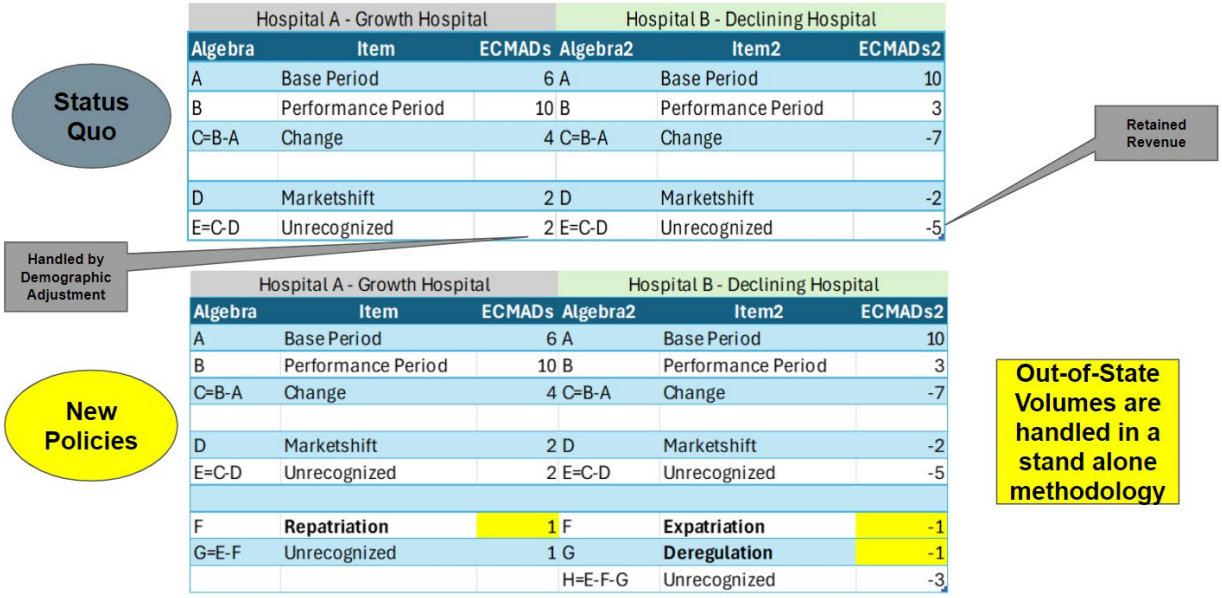
[4] Over the course of Volume Workgroup engagement, staff performed requested analyses related to the appropriateness of Commission approved variable cost factors as well as reviews of overlap with Ambulatory Surgical Center fee schedules.

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

[6] https://hscrc.maryland.gov/Documents/Strong%20als%20Folder/AUUR%20-%20Unit%20Rates%20and%20GBR/FY%202024/RY24%20Amended%20Final%20UF%20Recommendation%20061420 23%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:

Table 3: New Volume Policies Overview Example



Hospital A - Growth Hospital			Hospital B - Declining Hospital		
Algebra	Item	ECMADs	Algebra2	Item2	ECMADs2
A	Base Period	6	A	Base Period	10
B	Performance Period	10	B	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

Hospital A - Growth Hospital			Hospital B - Declining Hospital		
Algebra	Item	ECMADs	Algebra2	Item2	ECMADs2
A	Base Period	6	A	Base Period	10
B	Performance Period	10	B	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
			H=E-F-G	Unrecognized	-3

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 Centers[7] (only applicable to the following service lines: Major Surgery, Minor Surgery, and Cardiovascular)

Greater details of the proposed methodology are summarized below:

[7] https://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

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

*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:

1. 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=∑A(Maryland)	C=∑A(Border States)	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	I = CY 2022 + CY 2023 Unrecognized ECMADS	J = Minimim of H or I if Positive, Maximum if Negative	K= 2023 or 2019 Average Charge	L=J X K X 50%
Western Maryland	49.72	42.92	-0.69	0.69	115.84%	0.80	70%	1.13	3.38	1.13	$19,015	$10,787
Meritus	3.15	42.92	-0.69	0.69	7.34%	0.05	100%	0.05	(0.32)	-	$16,096	$0
Frederick	1.13	42.92	-0.69	0.69	2.63%	0.02	100%	0.02	-	-	$17,147	$0
Calvert	0.6	42.92	-0.69	0.69	1.40%	0.01	100%	0.01	-	-	$15,554	$0
UMMS- UMMC	-0.37	42.92	-0.69	0.69	-0.86%	(0.01)	30%	(0.02)	-	-	$26,039	$0
GBMC	-0.47	42.92	-0.69	0.69	-1.10%	(0.01)	100%	(0.01)	(0.08)	(0.01)	$17,946	-$68
JHH- Howard County	-0.48	42.92	-0.69	0.69	-1.12%	(0.01)	100%	(0.01)	-	-	$13,596	$0
Lifebridge- Northwest	-0.5	42.92	-0.69	0.69	-1.16%	(0.01)	100%	(0.01)	-	-	$16,523	$0
UMMS- Charles	-0.56	42.92	-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)	-	-	$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	-1.51	42.92	-0.69	0.69	-3.52%	(0.02)	100%	(0.02)	-	-	$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)	-	-	-	$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	-	-	-	$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 base[9] 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.

With the exception of utilizing experience data, the out-of-state methodology is pretty straight forward, as it is a volume variable methodology[11] that is only implemented when there is a material change.[12] The specifics of the methodology are as follows:

1. Out-of-state Revenue Increase = Current Hospital Rate X (Performance Year Volume - Base Year Volume) X 50 percent Variable Cost Factor
2. 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:

1. 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.[13] 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 for MD resident			
Repatriation	Approach B	X	
Expatriation	Approach A	X	
Change to Rendering Location State for Out of State residents			
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 methodologies[14], 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]

Hospital	Cardiovascular	CT/MRI/PET	Major Surgery	Minor Surgery	Oncology Related Services	Radiology	Total	Total with Materiality 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	-$144	-$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	-$82	-$1,312	-$9
ATLANTIC GENERAL	$0	-$56	-$58	-$446	-$307	-$421	-$1,288	-$274
HOLY CROSS	-$51	-$195	-$35	-$713	$0	-$172	-$1,166	-$123
NORTHWEST	-$1	-$30	-$52	-$146	-$466	-$448	-$1,141	-$1,141
Ascension Saint Agnes Hospital	-$301	$0	-$278	-$227	-$232	-$77	-$1,115	-$10
SHADY GROVE	-$70	-$896	-$22	-$1	$0	-$67	-$1,054	-$703
CALVERT	-$56	$0	-$121	-$155	$0	-$614	-$946	-$297
UM-Charles Regional	-$59	-$23	-$73	-$669	-$15	-$49	-$888	-$34
JH Bayview	-$120	-$80	-$104	-$523	$0	-$37	-$864	-$864
MERCY	-$9	-$93	-$82	-$197	$0	-$472	-$853	$0
CARROLL	-$21	-$3	-$358	-$402	$0	-$22	-$806	-$806
UMMC MIDTOWN	-$1	-$62	-$60	-$393	-$9	-$250	-$773	-$773
UM-Upper Chesapeake	-$125	-$218	-$212	-$155	$0	-$41	-$751	-$335
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	$0	-$56	-$115	-$459	-$6	-$635	$0
Adventist White Oak	-$5	-$270	-$21	-$47	$0	-$249	-$591	-$608
UM-Easton	-$6	-$41	-$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	-$86	-$5	-$19	-$5	$0	-$196	-$310	-$310
HOWARD COUNTY	-$13	-$2	-$77	-$126	$0	-$28	-$246	$0
Grace Medical center	$0	-$128	$0	$0	$0	-$108	-$237	-$323
MedStar Southern MD	-$105	-$11	$0	-$10	$0	-$71	-$197	-$4
HC-GERMANTOWN	-$5	-$19	-$85	-$28	-$1	-$1	-$138	-$1
UM-Chestertown	$0	$0	$0	-$130	$0	-$5	-$136	-$136
MedStar Montgomery	-$9	-$53	-$29	-$2	$0	-$37	-$129	-$106
FT. WASHINGTON	$0	$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/Expatriation with Materiality Thresholds
MedStar- Southern MD	$2,003,143	$2,584,312
JHH- Suburban	$1,231,427	$796,658
UMMS- BWMC	$1,042,118	$802,351
Saint Agnes	$800,568	$69,830
Calvert	$568,005	$626,486
MedStar- Union Mem	$732,156	$264,371
Trinity - Holy Cross Germantown	$644,512	$515,597
JHH- Johns Hopkins	-$512,259	$329,728
UMMS- St. Joe	$436,738	$387,783
MedStar- Montgomery	$353,702	$181,618
UMMS- Midtown	$353,997	$172,878
Mercy	$334,196	$188,599
Adventist-Ft. Washington	$319,769	$303,468
Luminis- Anne Arundel	$1,195,994	$1,538,505
MedStar- Franklin Square	$73,856	$386,225
JHH- Bayview	$137,054	-$35,957
UMMS- Chestertown	-$81,513	-$81,513
Tidal- McCready	-$68,431	-$3,142
UMMS- Capital Region	-$24,639	-$95,277
MedStar- St. Mary's	-$111,081	$9,626
MedStar- Good Sam	-$109,206	-$65,086
Lifebridge- Levindale	-$193,342	$136,451
JHH- Howard County	-$193,911	-$32,792
MedStar- Harbor	-$202,183	-$76,993
Lifebridge- Grace	-$244,216	-$106,489
Lifebridge- Northwest	-$206,732	-$282,755
Adventist- White Oak	-$225,528	-$468,169
Garrett	-$333,959	-$107,563
UMMS- Easton	-$404,124	-$404,042
ChristianaCare, Union	-$480,977	-$488,558
Frederick	-$573,660	-$298,516
Lifebridge- Carroll	-$762,716	-$762,716
Luminis- Doctors	-$927,158	-$915,759
Atlantic General	-$138,889	-$65,273
Tidal- Peninsula	-$655,294	$11,828
UMMS-Upper Chesapeake	-$1,114,711	-$70,759
UMMS- Harford	-$1,323,453	-$992,333
GBMC	-$1,244,030	$83,295
Lifebridge- Sinai	-$1,723,591	-$1,780,935
Western Maryland	-$3,144,793	-$1,320,072
Trinity - Holy Cross	-$2,943,102	-$218,897
UMMS- UMMC	-$3,608,282	-$3,539,955
Adventist- Shady Grove	-$4,546,224	-$3,058,101
Total	-$15,870,771	-$5,882,041

[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)

HospitalName	OOS Revenue Increase @ 50%	Materiality Thresholds: 1% growth, 3% Decline OR 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

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.[17] 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)

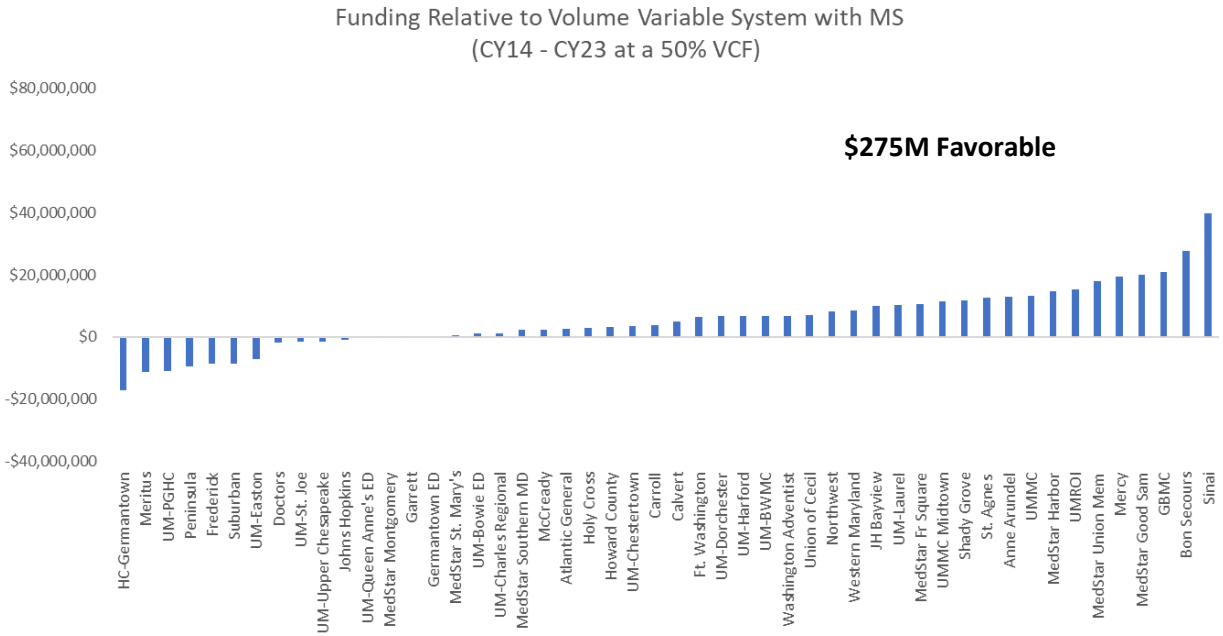


Table 10b: Volume Scorecard (with Market Shift and Demographic Adjustments)

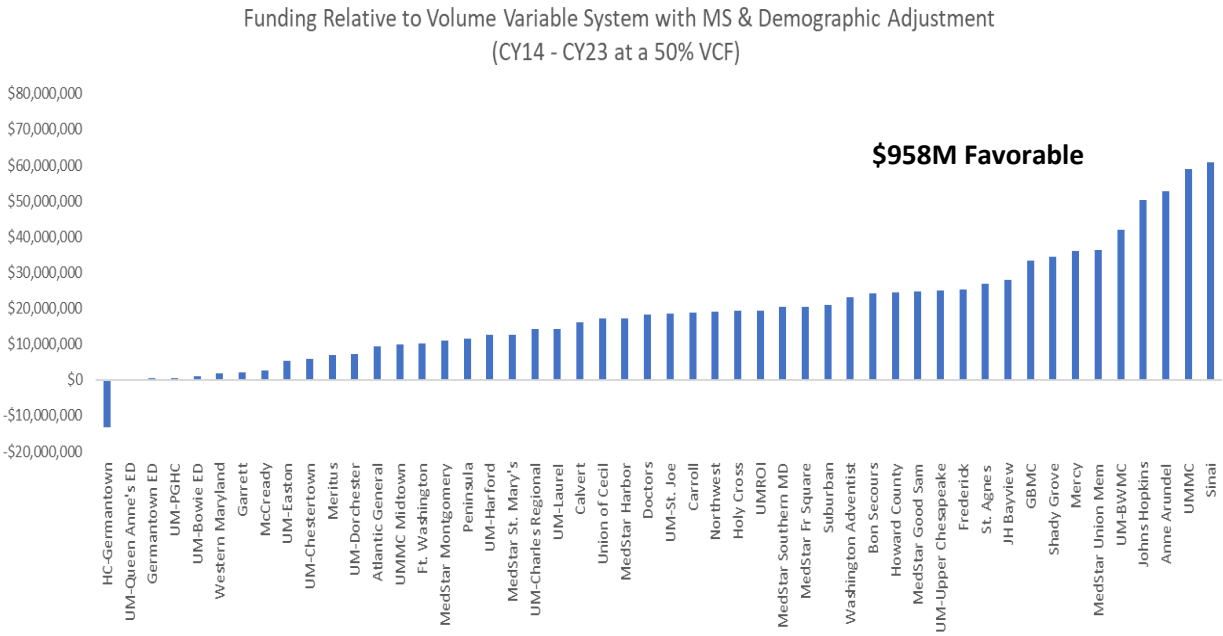


Table 10c: Volume Scorecard (with Market Shift and Demographic Adjustments & Out-of-State and Potentially Avoidable Utilization Adjustments)

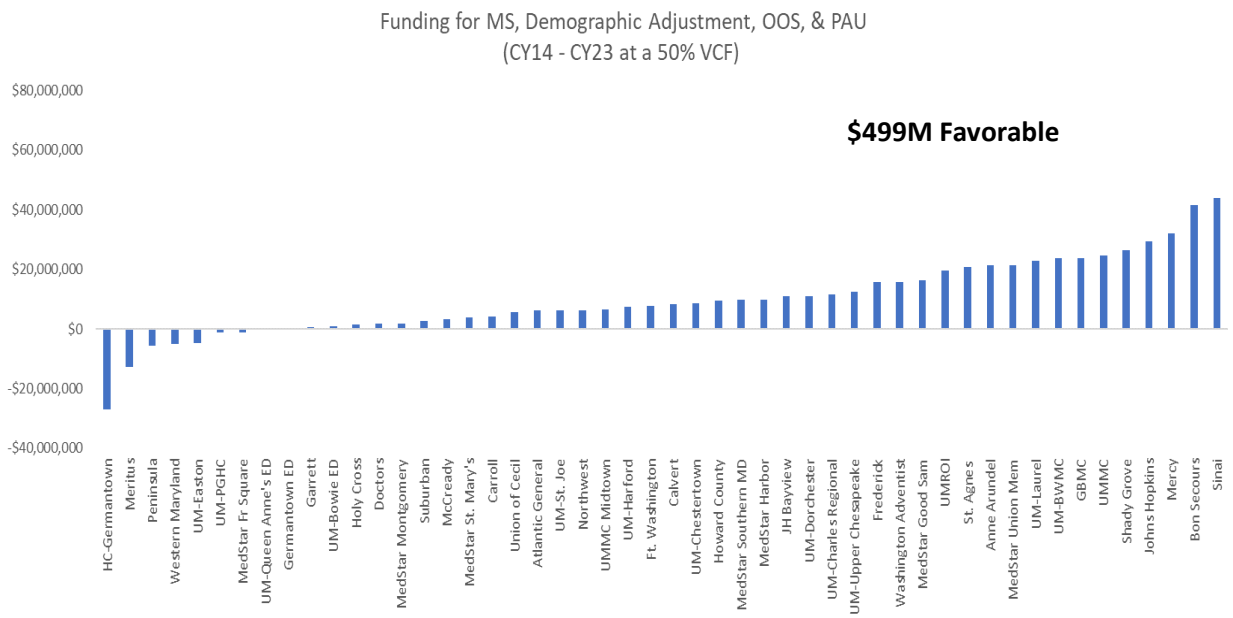
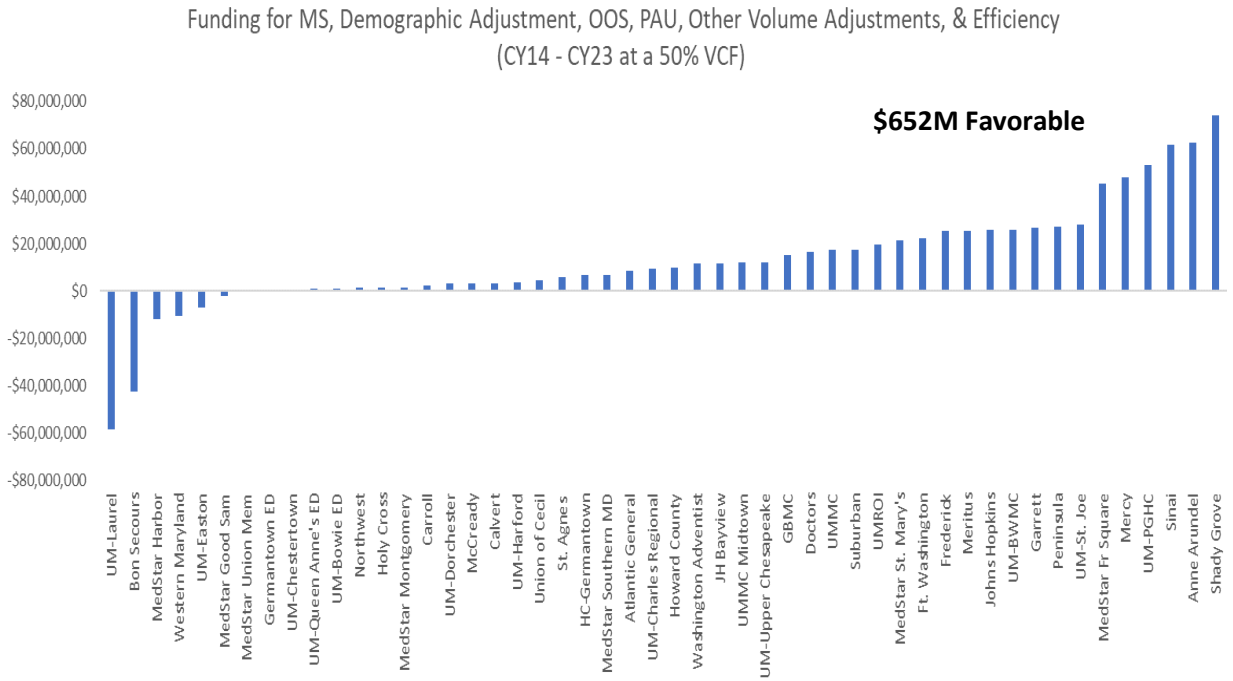


Table 10d: Volume Scorecard (with Market Shift and Demographic Adjustments, Out-of-State and Potentially Avoidable Utilization Adjustments, & Other Volume and Efficiency Adjustments)



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.[18] 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.
        i. 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 age-adjusted 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

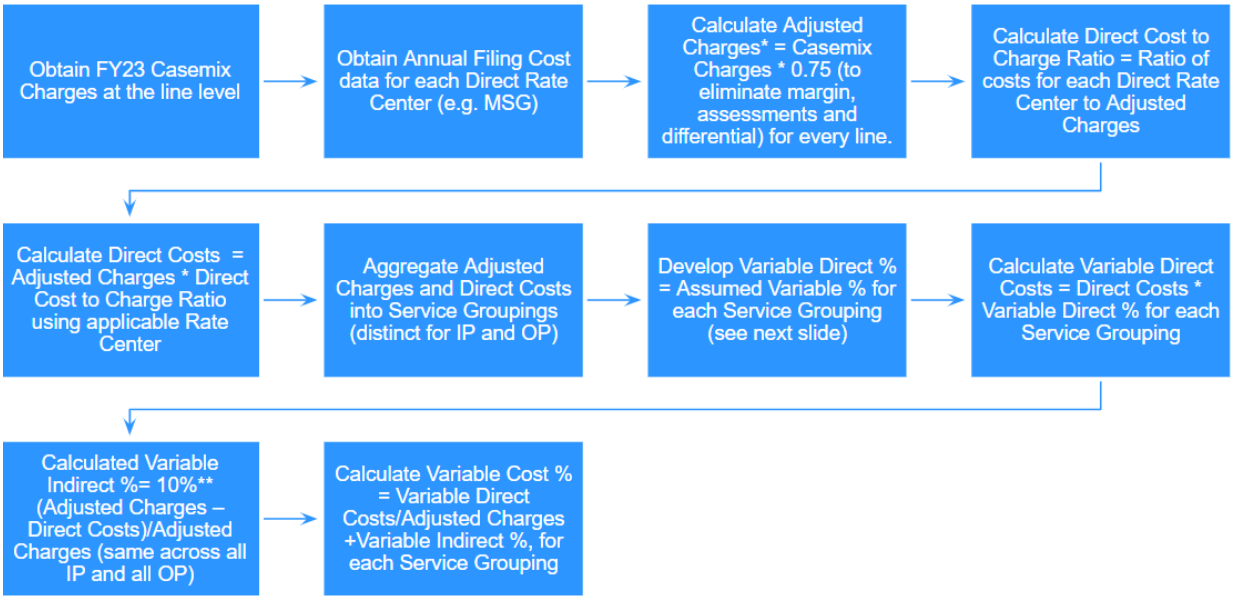
Actual Unrecognized ECAMDS for Frederick Hospital, Major Surgery in Prince George's (0.953)

HOSPITALNAME	Frederick
PROD_CAT	Major Surgery
zipcode	Prince Georges

	A	B	C=B-A	D	Calculated Proof E=C/SUM(C:C)	Calculated Proof F=CXSUM(D:D)
Row Labels	Sum of ecmadCY1922	Sum of hospshift	Unrecog ecmads	Allocated Unrecog ecmads	Share of EAPG/Unrecognized	Normalized 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 GYNECOLOGICAL PROCEDURES	(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 PROCEDURES	(0.68)	(0.24)	(0.442)	(0.428)	45%	(0.428)
29:::LEVEL II SPINE PROCEDURES	(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	$9,234
B	Direct Costs ($M)	$377	$677	$1,196	$507	$62	$2,507	$311	$5,637
C	Variable Direct %	50.0%	20.0%	100.0%	50.0%	50.0%	90.0%	80.0%	
D=B*C	Variable Direct Costs ($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. Therapy	Radiol.	Therapy	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%**

maryland
health services
cost review commission

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

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:

1. 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
v. 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 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.
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.

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.[1] 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 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, 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		
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	**60 percent** ● 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 measure[3], 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

[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.

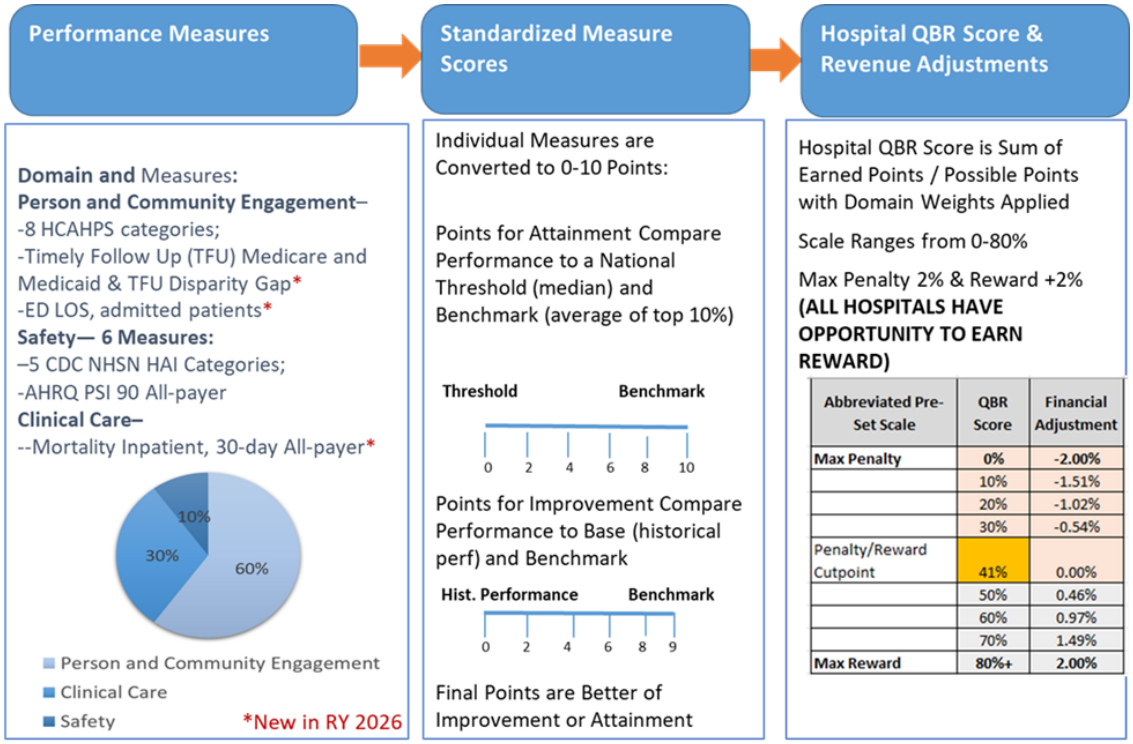
As a recap, the method for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019. It involves:

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.

5. 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 consistency[5]; 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.

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[4]Beginning 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.

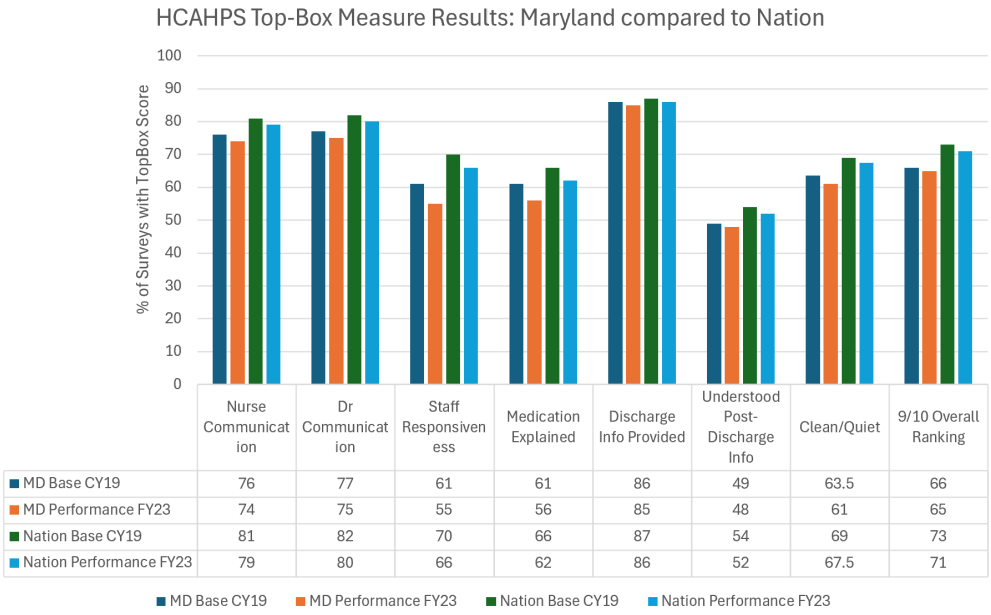
[5] For more information on the national VBP Program's performance standards, please see https://qualitynet.cms.gov/inpatient/hvbp/performance.

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 sub-measures, 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:

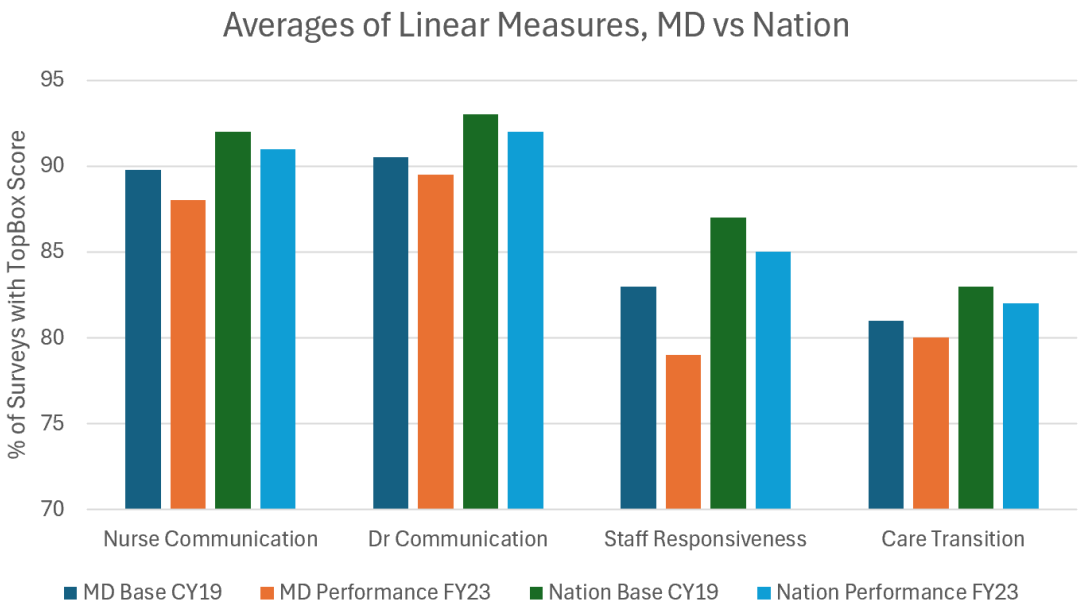
- Both the Nation and Maryland declined slightly from the base to the performance periods on top box and linear scores for all of the HCAHPS categories.
- For both top box and linear scores, Maryland lags behind the Nation in the base and the performance periods.
- For "Discharge Information Provided",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



	Nurse Communication	Dr Communication	Staff Responsiveness	Medication Explained	Discharge Info Provided	Understood Post-Discharge Info	Clean/Quiet	9/10 Overall Ranking
MD Base CY19	76	77	61	61	86	49	63.5	66
MD Performance FY23	74	75	55	56	85	48	61	65
Nation Base CY19	81	82	70	66	87	54	69	73
Nation Performance FY23	79	80	66	62	86	52	67.5	71

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

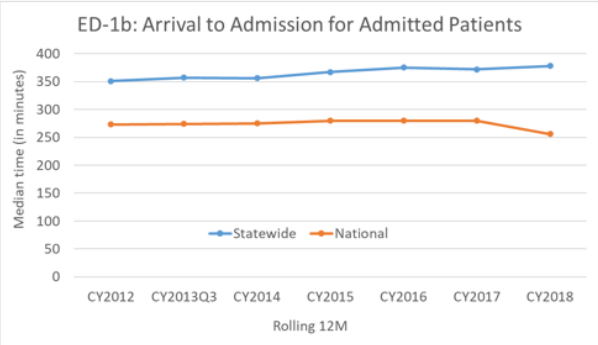
One important area CMS has identified in feedback to the Commission is the need for targeting improvement in HCAHPS in the Person and Community Engagement domain. CMS has recommended that the State consider implementing a Statewide HCAHPS performance improvement initiative that leverages input from providers, 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.

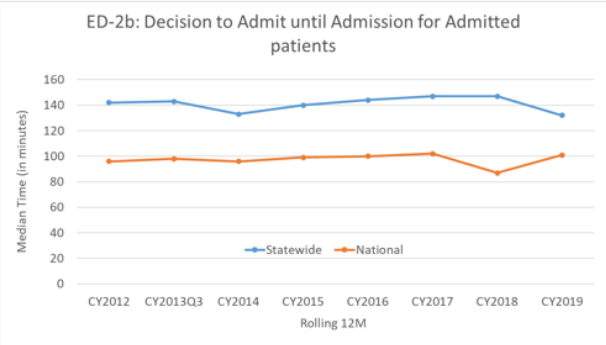
Emergency Department Length of Stay

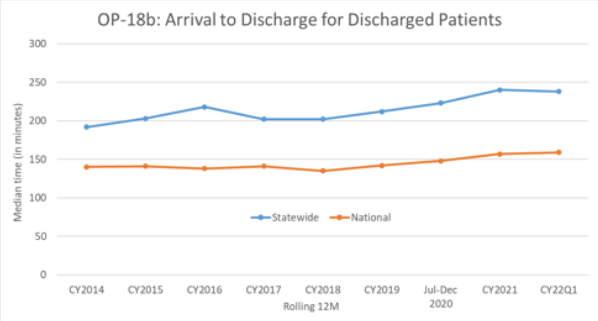
ED length of stay (LOS)--i.e., wait times–has been a significant concern in Maryland, predating Maryland's adoption of hospital global budgets instituted in 2014,[6] with multiple underlying causes and potential negative impacts (e.g., poorer patient experience, quality, care outcomes). Thus, the Commission 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.

[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



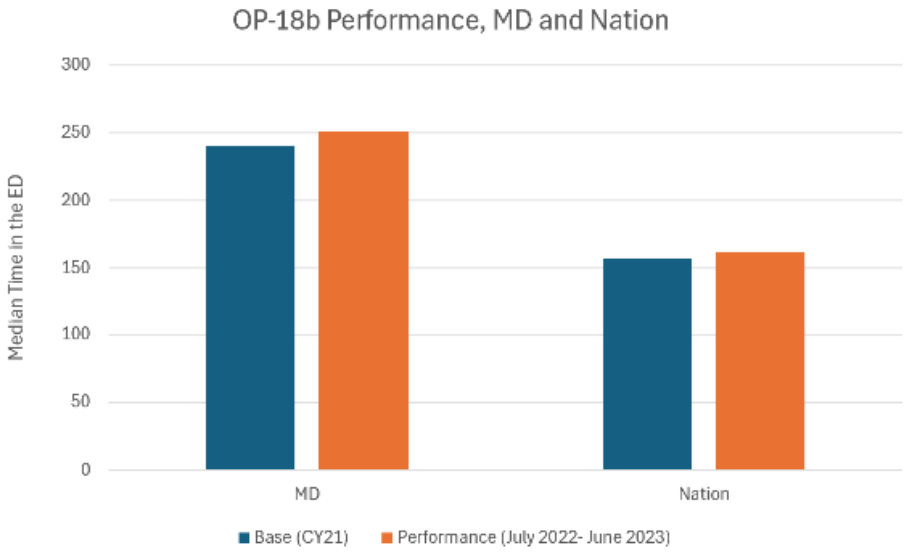




Measure ID	Measure Definition
ED-1	Median time from ED arrival to departure for admitted patients
ED-2	Median admit decision time to ED departure time for admitted patients
OP-18	Median time of ED arrival to departure for discharged patients

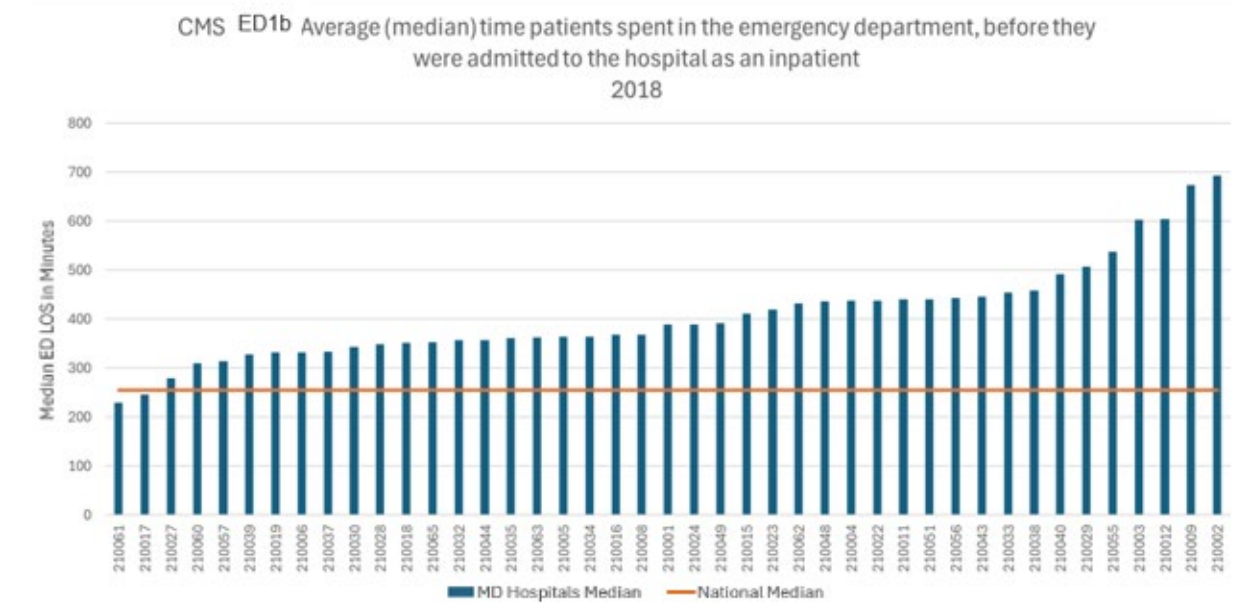
As illustrated in Figure 7 below, based on the most current data available, the OP-18b wait time for discharged patients has increased slightly for both Maryland and the Nation from the base to the performance year, and Maryland wait times continue to be significantly above those of the Nation for both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

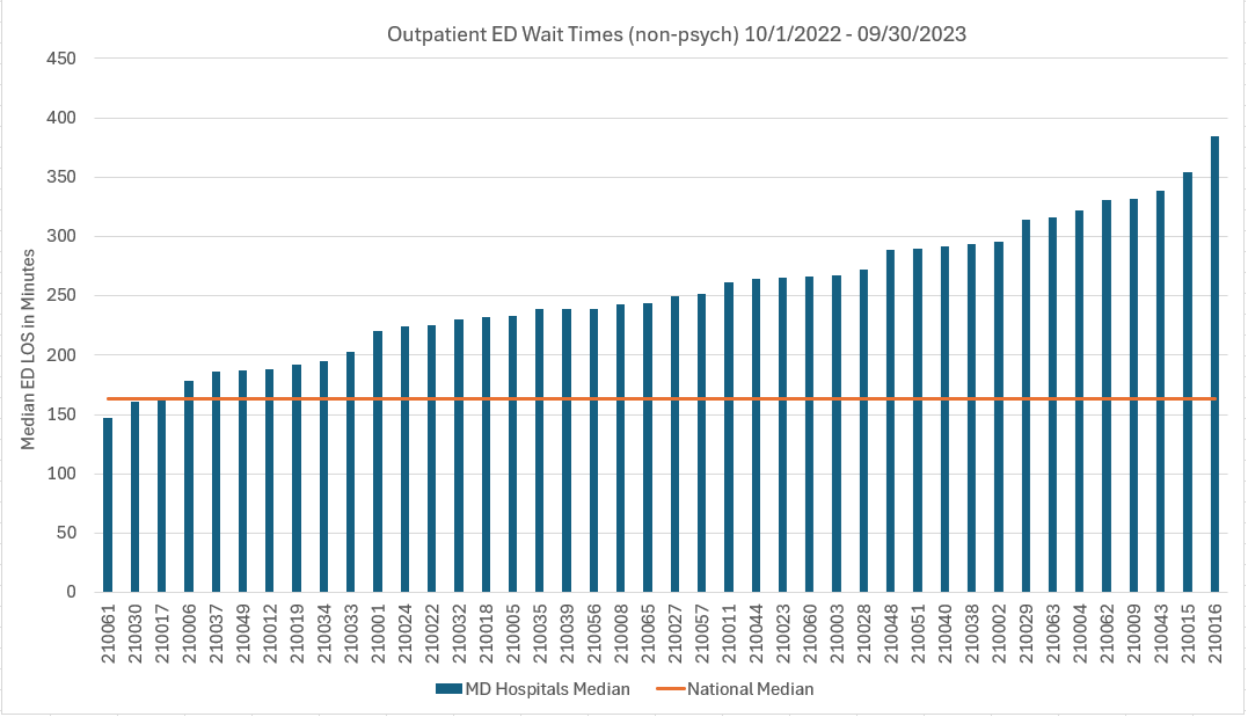
Figure 7. Maryland and National Performance on ED Wait Times for Discharged Patients



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). I n 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.[7] 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.[8] 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%)

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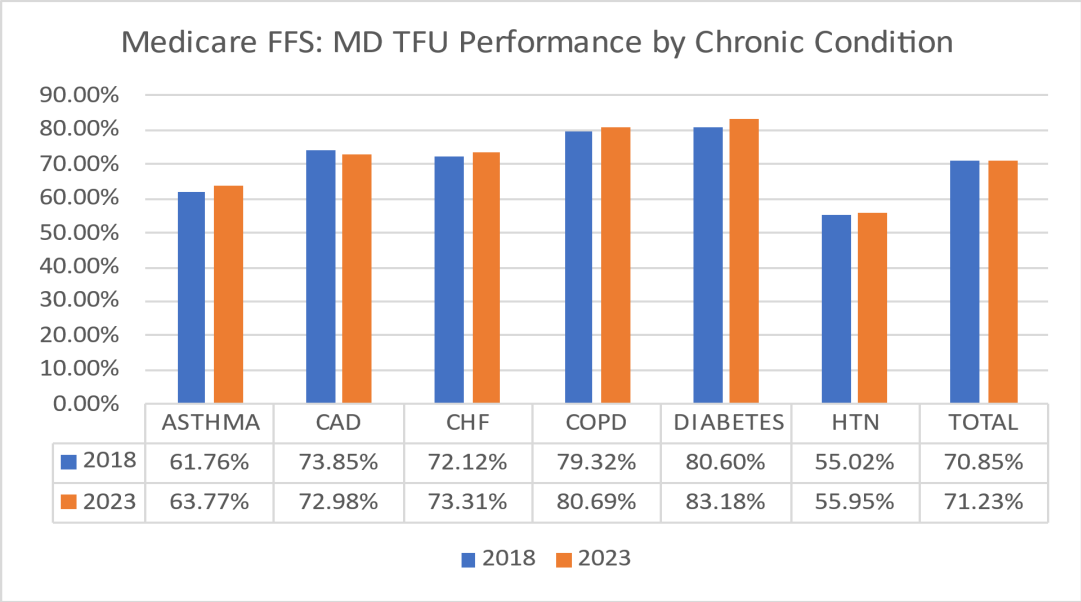
[7] The measure currently assesses the percentage of ED visits, observation stays, and inpatient admissions for one of six conditions in which a follow-up was received within the time frame recommended by clinical practice: Hypertension (follow-up within seven days), Asthma (follow-up within 14 days), 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.

[9] The 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 Condition[10]



	ASTHMA	CAD	CHF	COPD	DIABETES	HTN	TOTAL
2018	61.76%	73.85%	72.12%	79.32%	80.60%	55.02%	70.85%
2023	63.77%	72.98%	73.31%	80.69%	83.18%	55.95%	71.23%

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

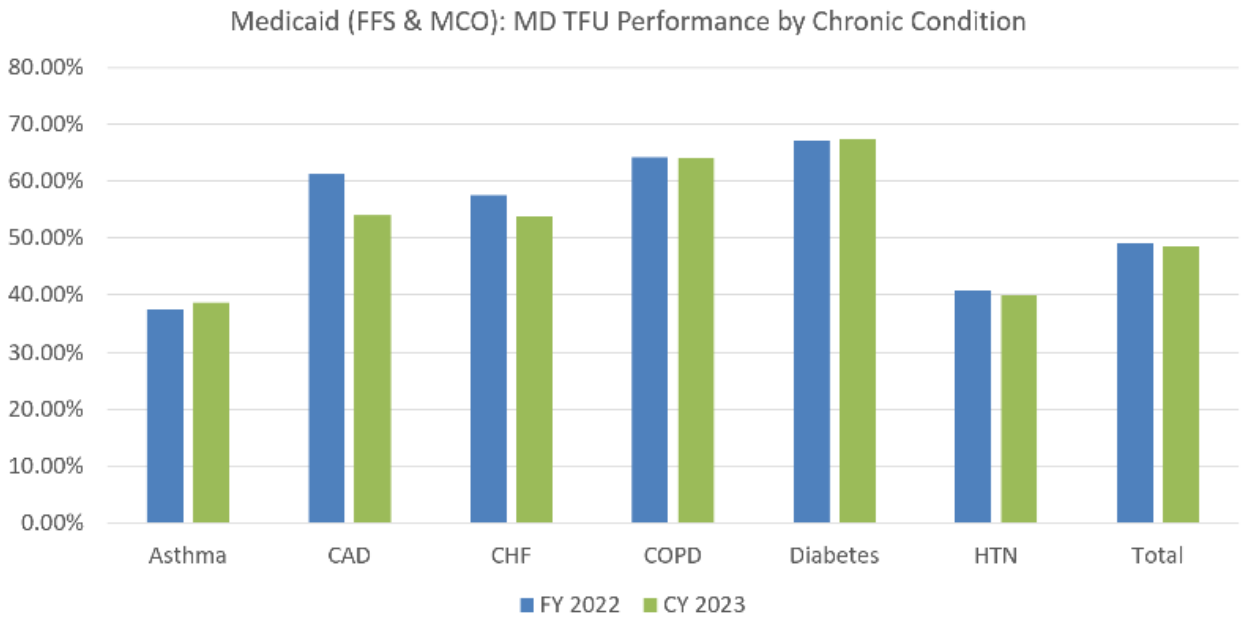
TFU Rates	CY2018	CY2019	CY2020	CY2021	CY2022	CY2023
Maryland	70.85%	71.45%	67.90%	70.07%	70.59%	71.23%

[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%

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.

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.

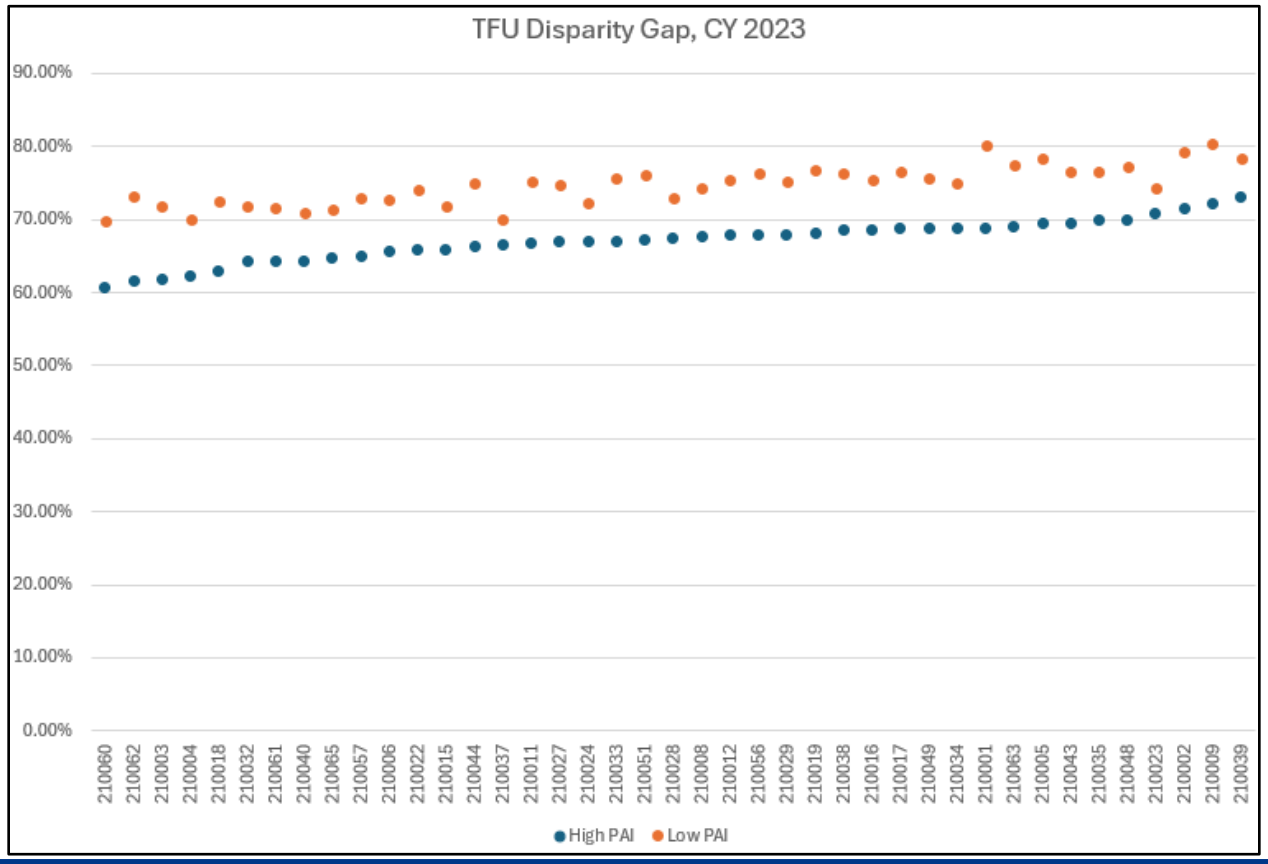
Disparities in Timely Follow-Up

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.

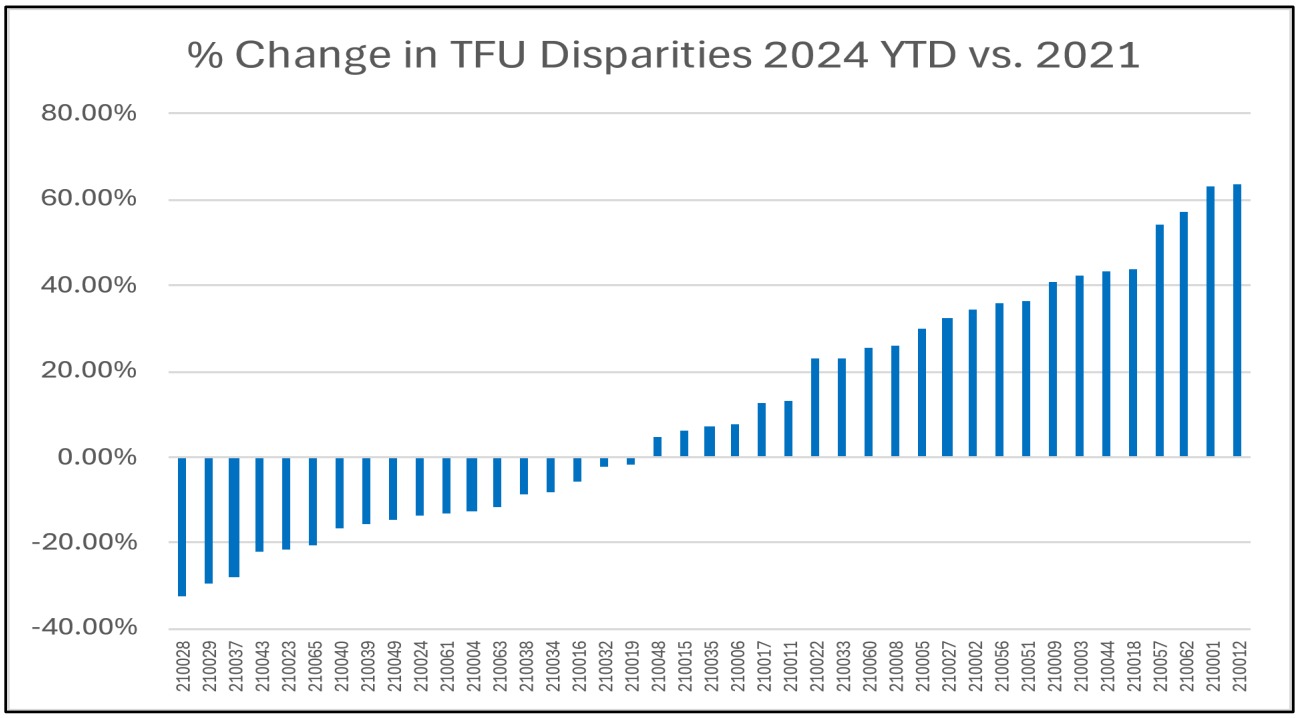
Figure 12 shows the TFU disparity gaps by hospital in CY 2023. The median gap between low and high PAI patients is 7.74 percent, with a range of 3.54-11.60 percent indicating all hospitals have a gap and there is variation across hospitals.

Figure 12. By Hospital TFU Disparity Gap, CY 2023



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).

Figure 13. By Hospital Improvements in TFU Disparity Gap, 2024 YTD vs 2021



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

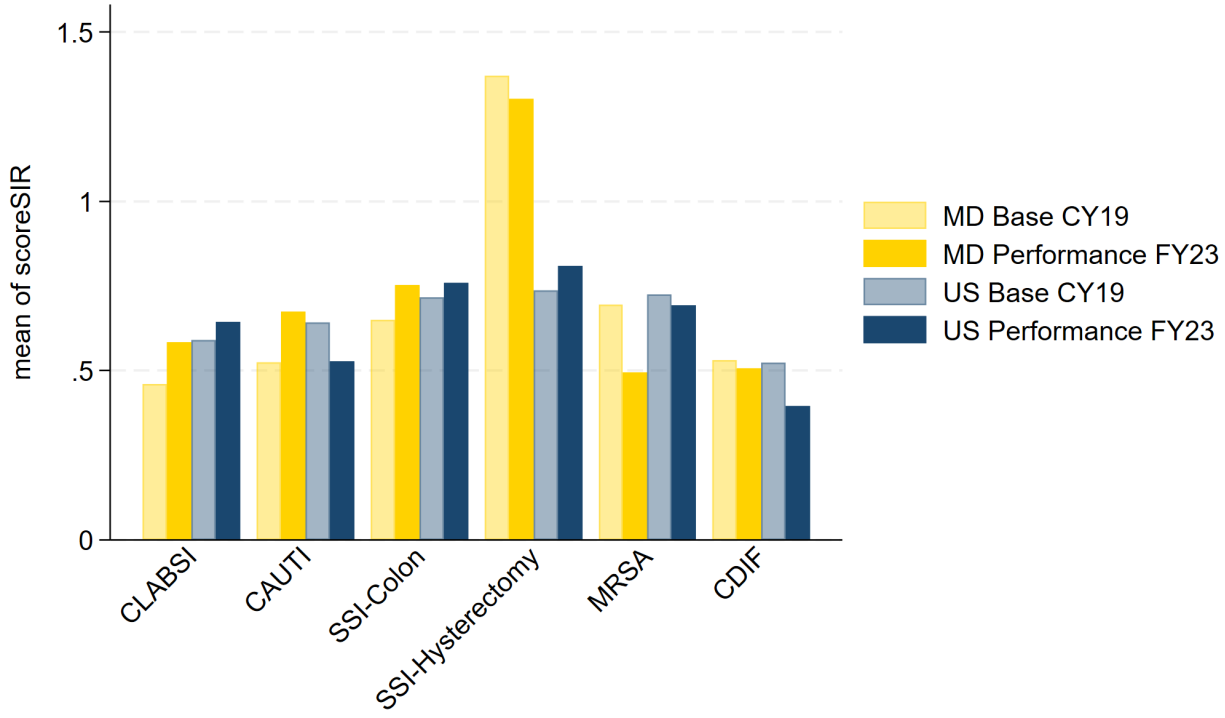
[11] For use in the QBR Program, as well as the VBP program, the SSI Hysterectomy and SSI Colon measures are combined.

[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 Change	Direction of Change Based on Statistical Significance*	p-value
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

[13]2022 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:
    - PSI 08- In Hospital Fall and Fracture
    - PSI 06- Iatrogenic Pneumothorax
    - PSI 03- Pressure Ulcer
    - PSI 09- Perioperative Hemorrhage or Hematoma
    - PSI 13- Postoperative Sepsis
    - 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:
    - PSI 10- Postoperative Acute Kidney Injury with Dialysis (slight increase)
    - PSI 14- Postoperative Wound Dehiscence (slight increase)
    - 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)

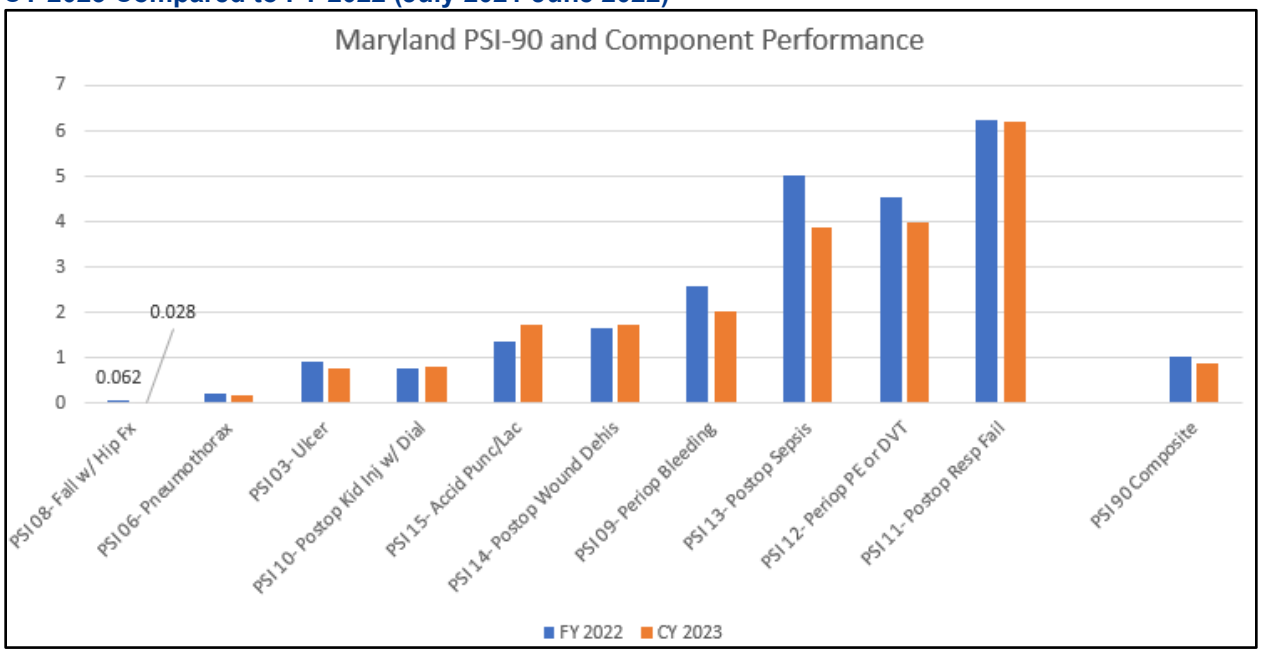
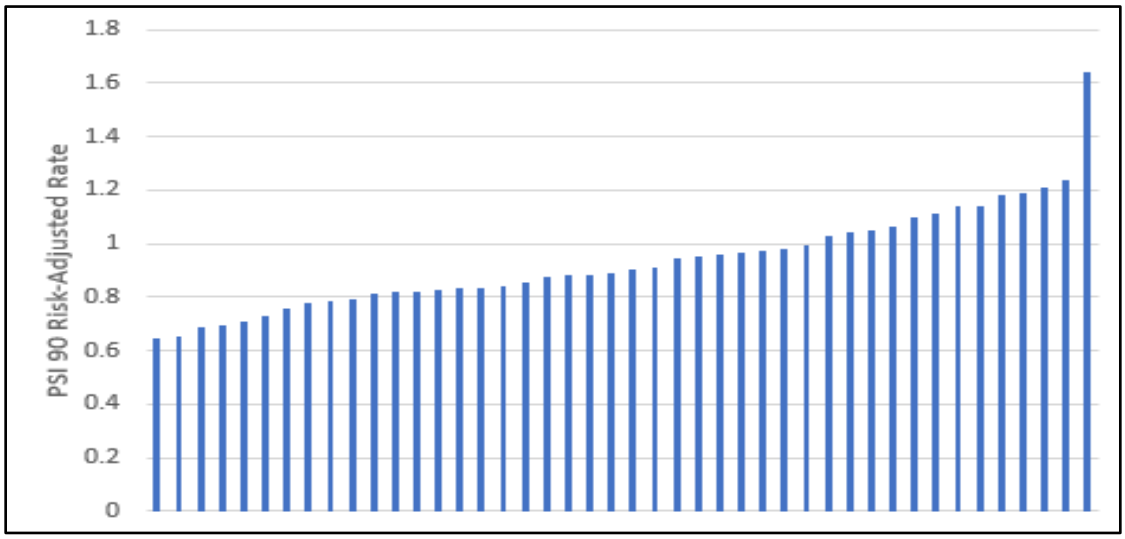


Figure 17 below illustrates the hospital-level performance on the all-payer PSI-90 composite measure for CY 2023; consistent with last year, the variation in performance by hospital suggests there may be opportunity for improvement on this measure.

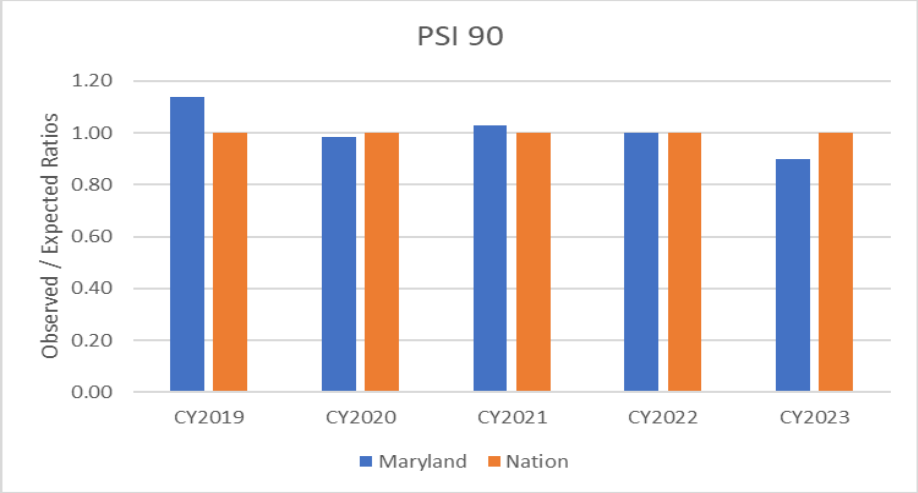
Figure 17. PSI-90 Hospital-Level Performance, CY 2023[15]



[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 23[16]



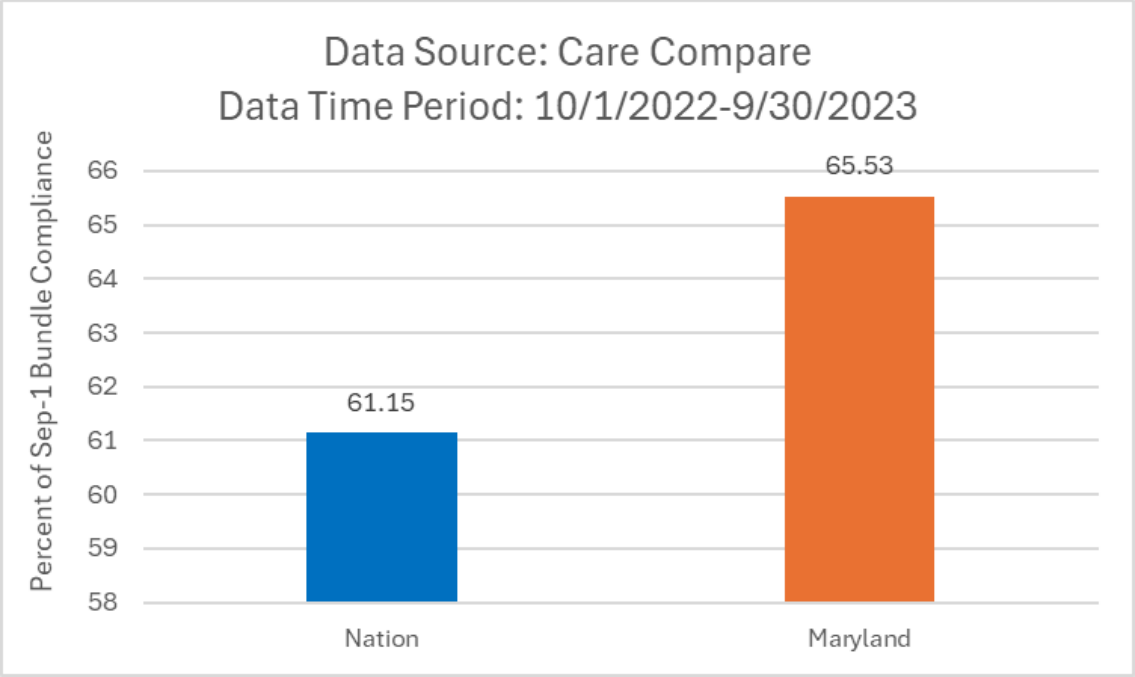
Sepsis Early Management Bundle (Sep-1)

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.

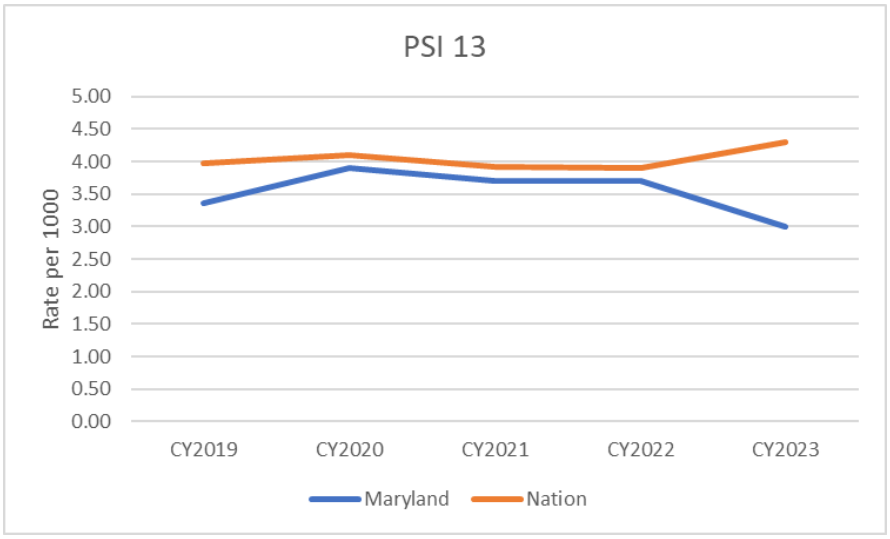
[17] See the RY 2026 QBR policy for additional information on the concerns with the Sep-1 measure.

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



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

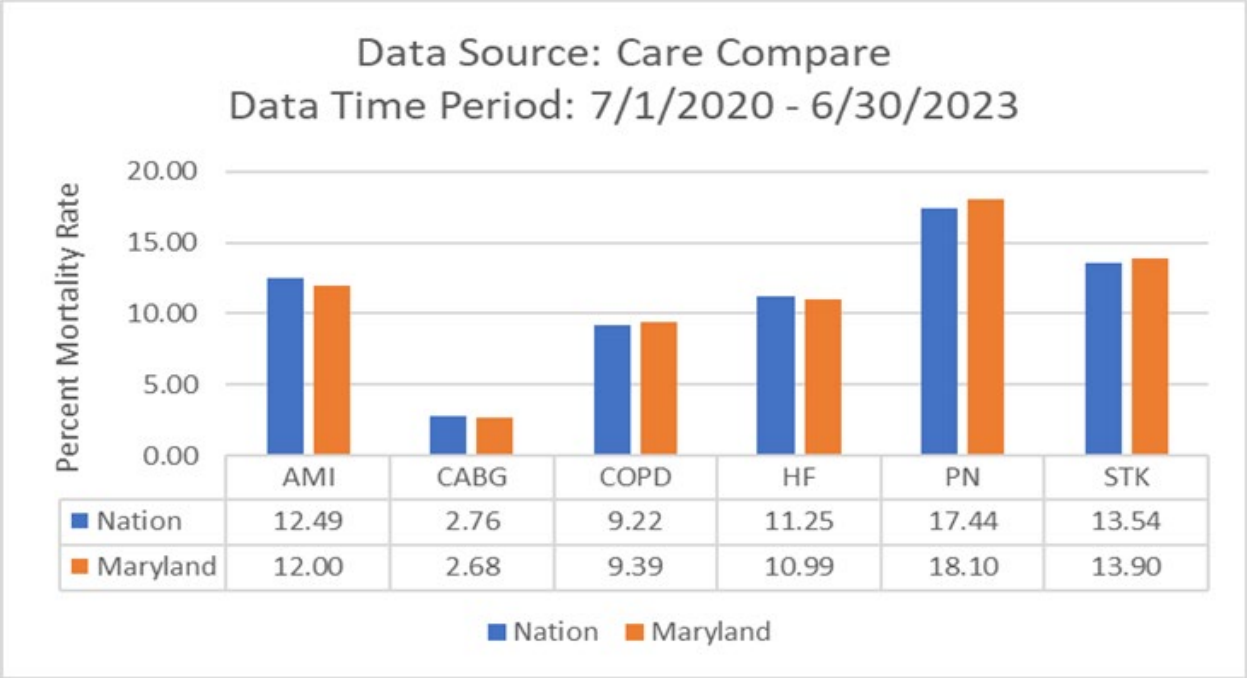
Of note, Maryland's QBR mortality measure currently differs from the CMS VBP Program that uses four condition-specific, 30-day mortality measures for Medicare beneficiaries. Medicare also monitors two additional 30-day mortality measures for Coronary Artery Bypass Graft (CABG) and Stroke (STK). In addition, 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

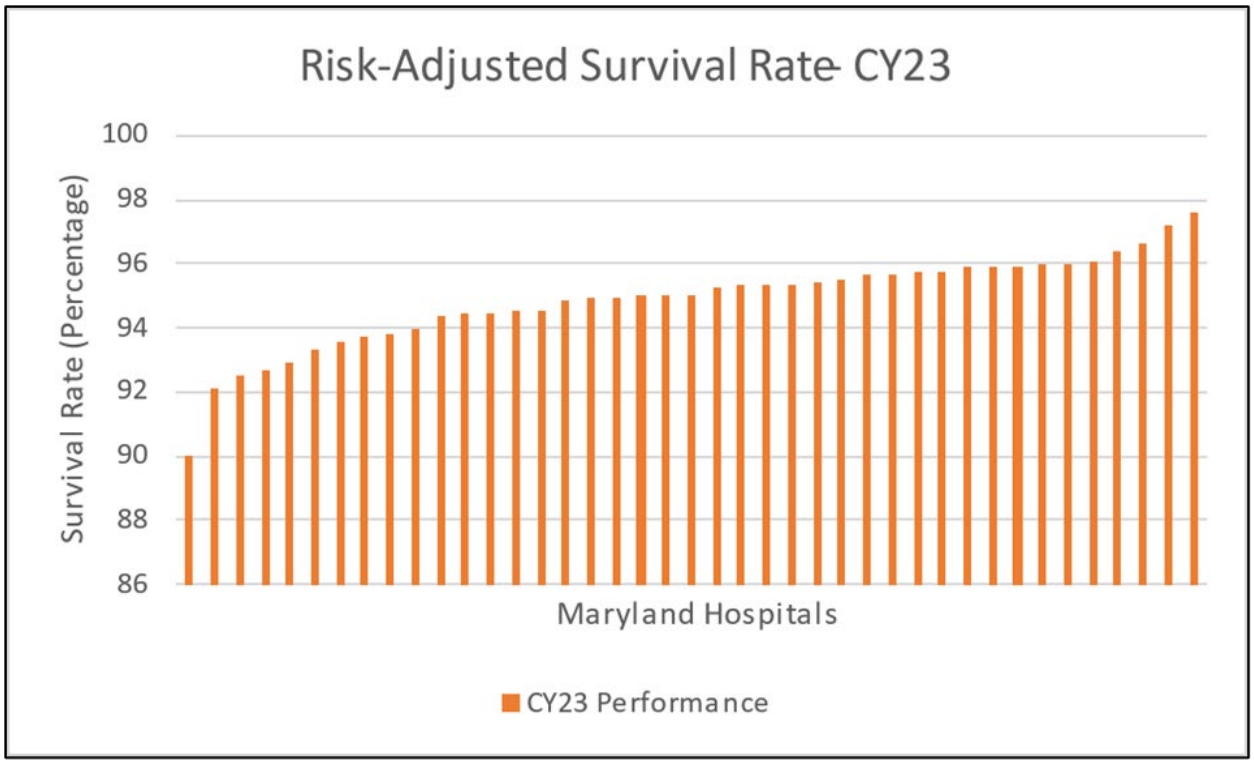


QBR Inpatient, All-payer, All-condition Mortality measure

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.

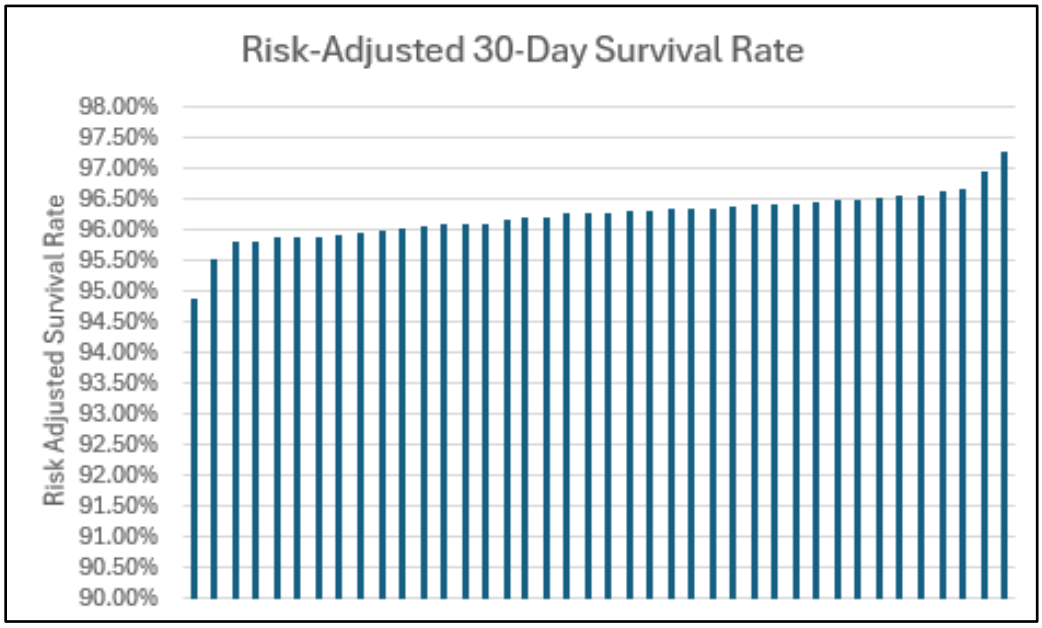
Figure 22. Maryland Hospital Performance, CY 2023 QBR Inpatient All Condition, All Payer Mortality Measure



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 eCQMs- -Safe 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		60%	1.20%
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		10%	0.20%
IP Mortality	50.00%	5.00%	0.10%
30-Day Mortality	50.00%	5.00%	0.10%
Safety Domain		30%	0.60%
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:

1. 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
        v. 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.
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.

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 Community Engagement	**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.

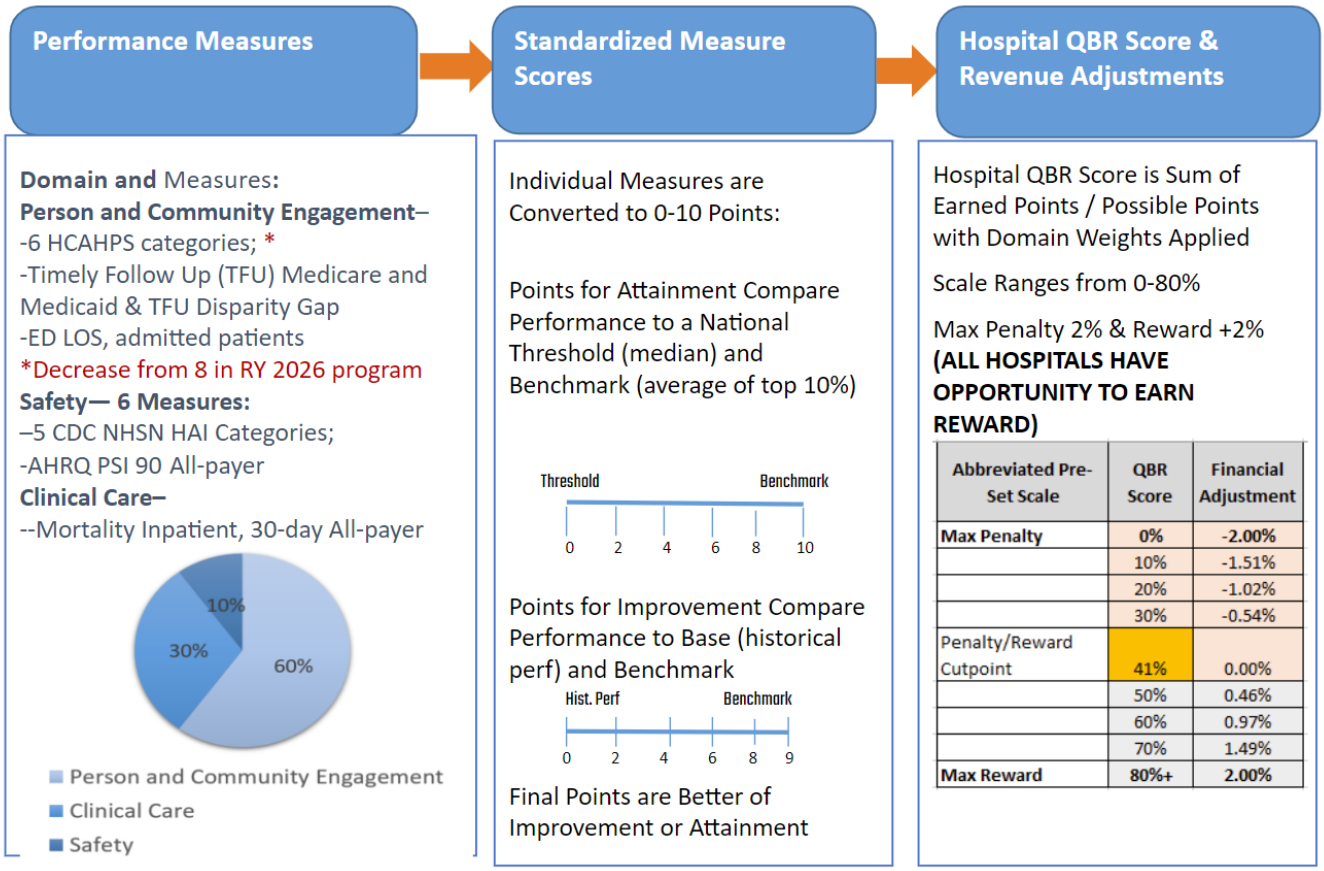
Total performance score*:* The total performance score is computed by multiplying the domain scores by their specified weights and then adding those totals together. The total performance score is then translated into a reward or penalty that is applied to hospital revenue.

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)..

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



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%

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 program[23] **,** 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 Iatrogenic 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%20Safety%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://impaqint.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://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions.

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:

1. Subsequent acute events that occur two days after the prior discharge but still during the follow-up 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:

1. 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

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]

[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

<table>
<tr><td>Rate Year (Maryland Fiscal Year)</td><td>Q3-22</td><td>Q4-22</td><td>Q1-23</td><td>Q2-23</td><td>Q3-23</td><td>Q4-23</td><td>Q1-24</td><td>Q2-24</td><td>Q3-24</td><td>Q4-24</td><td>Q1-25</td><td>Q2-25</td><td>Q3-25</td><td>Q4-25</td><td>Q1-26</td><td>Q2-26</td><td>Q3-26</td><td>Q4-26</td><td>Q1-27</td><td>Q2-27</td><td>Q3-27</td><td>Q4-27</td></tr>
<tr><td>Calendar Year</td><td>Q1-22</td><td>Q2-22</td><td>Q3-22</td><td>Q4-22</td><td>Q1-23</td><td>Q2-23</td><td>Q3-23</td><td>Q4-23</td><td>Q1-24</td><td>Q2-24</td><td>Q3-24</td><td>Q4-24</td><td>Q1-25</td><td>Q2-25</td><td>Q3-25</td><td>Q4-25</td><td>Q1-26</td><td>Q2-26</td><td>Q3-26</td><td>Q4-26</td><td>Q1-27</td><td>Q2-27</td></tr>
<tr><td rowspan="3">Quality Based Reimbursement Program (QBR)</td><td colspan="8">Base Period: Hospital Compare (HCAHPS measures, All NHSN Measures)</td><td colspan="6">Performance Period: Hospital Compare (HCAHPS measures, All NHSN Measures)</td><td colspan="6" rowspan="3">Rate Year Impacted by QBR Results</td></tr>
<tr><td colspan="6"></td><td colspan="6">Base Period: QBR IP and 30-day Mortality, PSI-90, Timely Follow-up Chronic Conditions (Medicare, Medicaid and w/in Hospital Disparity Reduction)</td><td colspan="6">Performance Peirod: QBR IP and 30-day Mortality, PSI-90, Follow-up Chronic Conditions (Medicare, Medicaid and w/in Hospital Disparity Reduction)</td></tr>
<tr><td colspan="8"></td><td colspan="6">Base Period: Emergency Department Length of Stay (Admitted Patients)</td><td colspan="6">Performance Period: Emergency Department Length of Stay (Admitted Patients)</td></tr>
</table>

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 Inpatient Revenue	RY 2025 FINAL Score	% Revenue Impact	$ Revenue Impact
210001	Meritus	$ 251,995,786	33.06%	0.04%	$100,798
210002	UMMS- UMMC	$ 1,473,072,120	24.60%	-0.46%	-$6,776,132
210003	UMMS- Capital Region	$ 309,492,831	29.79%	-0.14%	-$433,290
210004	Trinity - Holy Cross	$ 413,940,590	19.17%	-0.80%	-$3,311,525
210005	Frederick	$ 254,562,530	25.42%	-0.41%	-$1,043,706
210006	UMMS- Harford	$ 18,810,727	36.69%	0.20%	$37,621
210008	Mercy	$ 220,664,524	31.02%	-0.06%	-$132,399
210009	JHH- Johns Hopkins	$ 1,818,903,395	38.29%	0.26%	$4,729,149
210011	St. Agnes	$ 254,764,484	30.17%	-0.11%	-$280,241
210012	Lifebridge- Sinai	$ 519,012,883	11.75%	-1.27%	-$6,591,464
210015	MedStar- Franklin Square	$ 371,862,302	27.25%	-0.30%	-$1,115,587
210016	Adventist- White Oak	$ 242,890,872	27.85%	-0.26%	-$631,516
210017	Garrett	$ 28,988,189	65.15%	1.38%	$400,037
210018	MedStar- Montgomery	$ 96,052,028	37.60%	0.23%	$220,920
210019	Tidal- Peninsula	$ 350,375,491	27.67%	-0.27%	-$946,014
210022	JHH- Suburban	$ 249,484,035	17.46%	-0.91%	-$2,270,305
210023	Luminis- Anne Arundel	$ 367,930,454	25.83%	-0.39%	-$1,434,929
210024	MedStar- Union Mem	$ 267,917,283	38.60%	0.28%	$750,168
210027	Western Maryland	$ 183,379,829	38.88%	0.29%	$531,802
210028	MedStar- St. Mary's	$ 100,479,485	44.38%	0.52%	$522,493
210029	JHH- Bayview	$ 471,786,218	23.77%	-0.51%	-$2,406,110
210032	ChristianaCare, Union	$ 84,802,922	28.50%	-0.22%	-$186,566
210033	Lifebridge- Carroll	$ 162,844,959	35.42%	0.14%	$227,983
210034	MedStar- Harbor	$ 128,234,465	46.90%	0.62%	$795,054
210035	UMMS- Charles	$ 97,586,229	41.31%	0.39%	$380,586
210037	UMMS- Easton	$ 123,617,439	30.42%	-0.10%	-$123,617
210038	UMMS- Midtown	$ 140,418,656	33.15%	0.05%	$70,209
210039	Calvert	$ 80,925,064	56.94%	1.04%	$841,621
210040	Lifebridge- Northwest	$ 160,861,387	26.75%	-0.33%	-$530,843
210043	UMMS- BWMC	$ 325,584,009	32.15%	0.01%	$32,558
210044	GBMC	$ 263,774,655	28.25%	-0.23%	-$606,682
210048	JHH- Howard County	$ 220,287,562	27.50%	-0.28%	-$616,805
210049	UMMS-Upper Chesapeake	$ 236,862,562	29.75%	-0.14%	-$331,608
210051	Luminis- Doctors	$ 187,232,106	31.02%	-0.06%	-$112,339
210056	MedStar- Good Sam	$ 186,628,391	36.42%	0.18%	$335,931
210057	Adventist- Shady Grove	$ 333,973,100	26.08%	-0.37%	-$1,235,700
210060	Adventist-Ft. Washington	$ 37,782,970	18.39%	-0.85%	-$321,155
210061	Atlantic General	$ 47,434,007	39.33%	0.31%	$147,045
210062	MedStar- Southern MD	$ 210,921,411	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..
    - 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

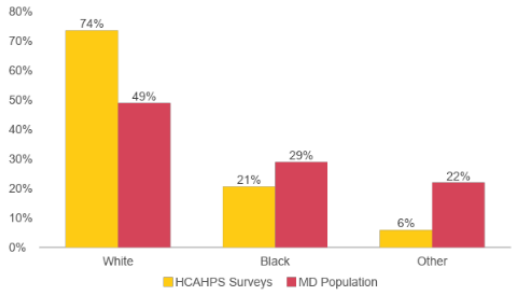
TITLE OF MEETING

NOVEMBER 2023

Background

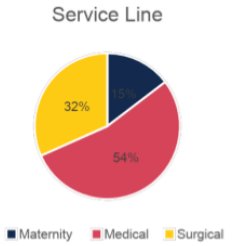
- MHCC began requiring detailed level HCAHPS data starting January 2022 (Q3 2021 discharges)
  - Joint memo with HSCRC
- Allows for more detailed analysis into race, ethnicity, service line, etc.
  - More timely
- More targeted approaches for quality improvement (e.g., patient populations, domains, etc.)

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



Service Lines

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

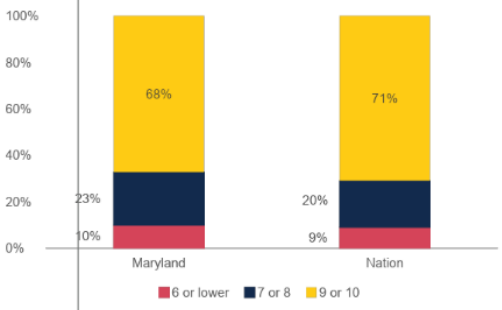


- Black & Other is higher in the maternity service line than medical and surgical

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

Overall Rating

- 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%)



National data: Q2 2021-Q1 2022

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

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%)

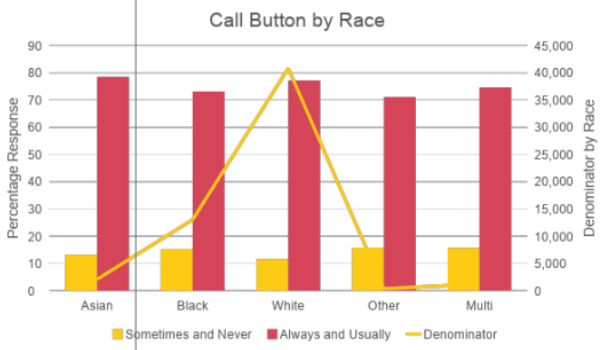
Would Recommend	Black 417	White 1,873	Other 386
No	34 8%	66 4%	16 4%
Yes	383 92%	1,807 96%	370 96%

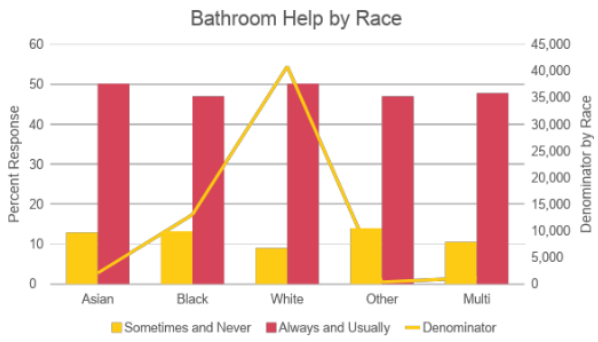
- Significant differences between black and othe races
  - Would Recommend – Significantly more "No" reported by black women than expected
  - Overall Rating – More "6 or lower" reported by black women than expected

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

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





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

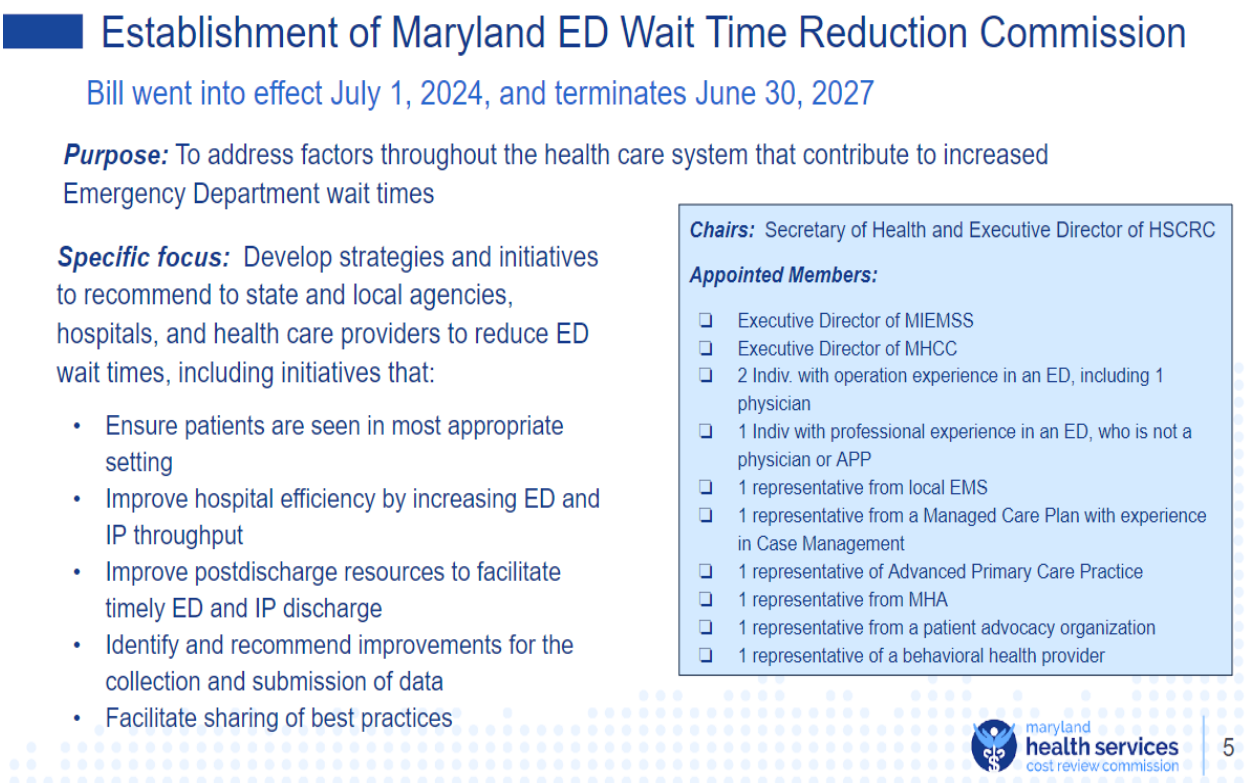
In early 2023, the Maryland General Assembly passed legislation establishing the Task Force on Reducing Emergency Department Wait Times to study best practices for reducing emergency department wait times; and requiring the Task Force to report its findings and recommendations to the Governor and the 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 multi-stakeholder 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

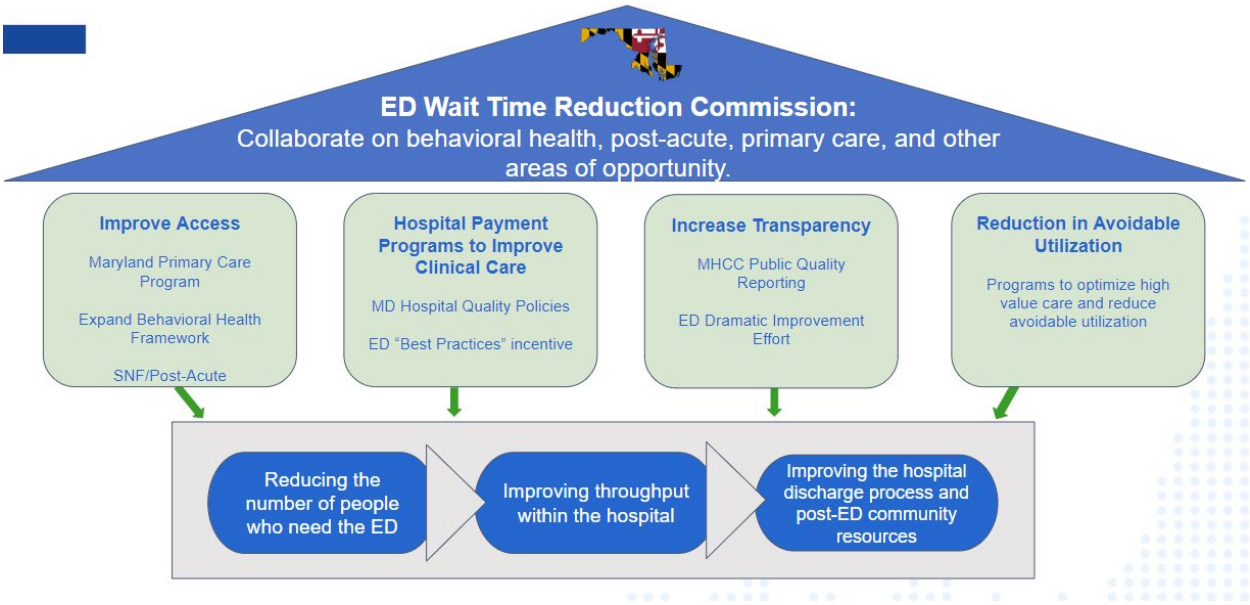
In the 2024 General Assembly session, legislation was passed establishing the ED Wait Times Reduction Commission, which went into effect on July 1, 2024. Figure E1 provides details on the ED Commission purpose, specific tasks, and what types of members will be on the ED Commission.

Figure E1. ED Wait Time Commission Description



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: Commission-Meetings (maryland.gov)
- 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: Subgroup ED LOS Measure (maryland.gov)

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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

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

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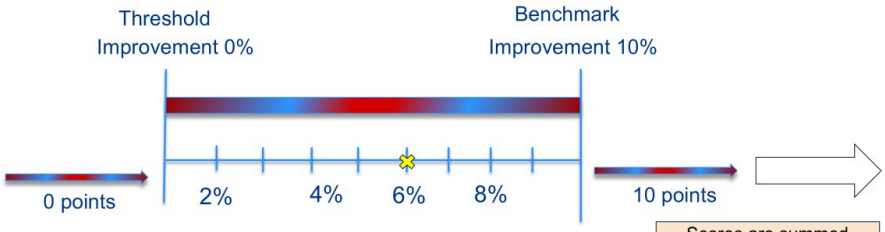
Ad-Hoc Data Submission Requirements (DSR)

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



Hospital Improvement = 6.0%
Calculates to a score of 6 out of 10

Scores are summed across QBR measures and weighted to get total hospital score

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%

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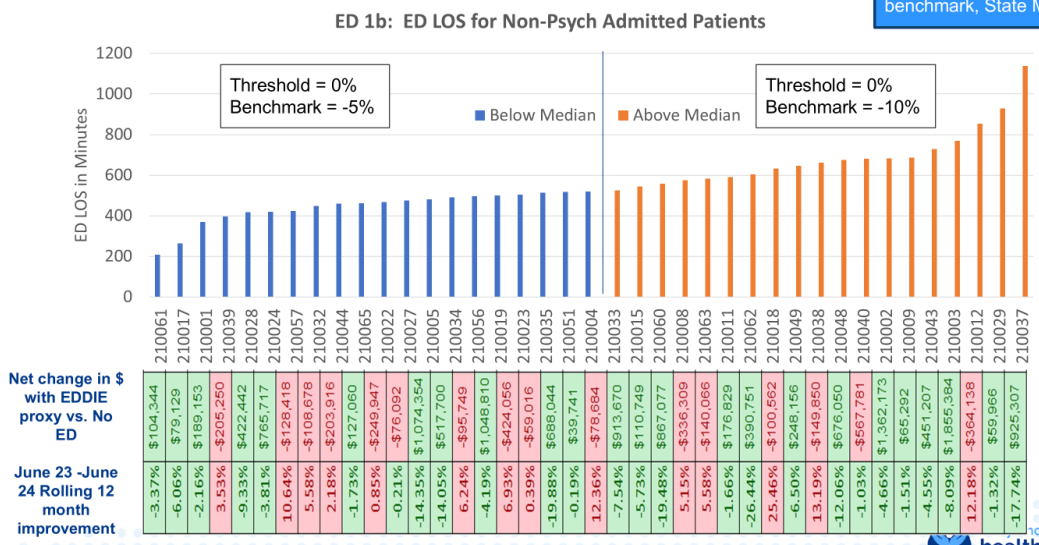
Current Proposal

Base State Median: 523

If all hospitals improve to benchmark, State Median: 491



	210061	210017	210001	210039	210028	210024	210057	210032	210044	210065	210022	210027	210005	210034	210056	210019	210023	210035	210051	210004	210033	210015	210060	210008	210063	210011	210062	210018	210049	210038	210048	210040	210002	210009	210043	210003	210012	210029	210037
Net change in $ with EDDIE proxy vs. No ED	$104,344	$79,129	$189,153	-$205,250	$422,442	$765,717	-$128,418	-$108,678	-$203,916	$127,060	-$249,947	-$76,092	$1,074,354	$517,700	-$95,749	$1,048,810	-$424,056	-$59,016	$688,044	$39,741	-$78,684	$913,670	$110,749	$867,077	-$336,309	-$140,066	$176,829	$390,751	-$100,562	$248,156	-$149,850	$676,050	-$567,781	$1,362,173	$65,292	$451,207	$1,855,384	-$364,138	$59,966	$925,307
June 23 -June 24 Rolling 12 month improvement	-3.37%	-6.06%	-2.16%	3.53%	-9.33%	-3.81%	10.64%	5.58%	2.18%	-1.73%	0.85%	-0.21%	-14.35%	-14.05%	6.24%	-4.19%	6.93%	0.39%	-19.88%	-0.19%	12.36%	-7.54%	-5.73%	-19.48%	5.15%	5.58%	-1.66%	-26.44%	25.46%	-6.50%	13.19%	-12.06%	-1.03%	-4.66%	-1.51%	-4.55%	-8.09%	12.18%	-1.32%	-17.74%

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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?

1. 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?

2. 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?

1. Should hospitals withhold executive bonuses as a prerequisite for set aside funding?

1. Should hospital management be required to outline sustainable reductions in cost to offset funding priorities as a prerequisite for set aside funding?

1. Should hospitals need to make a pledge to not ask for funding for a specific period of time following fund allocations?

Comments Received

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.

Comments Received

1. 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.

Comments Received

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 set-aside 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.

Comments Received

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.

Comments Received

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.

Comments Received

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.

Comments Received

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: Financial Need & Management Improvement Opportunities

- Financial Assessment (e.g., 50%)
  - FY24 Total Margin (Regulated + Unregulated)
    - Variance to Statewide Average
  - FY24 Regulated Margin
    - Variance to Statewide Average
  - Days Cash
    - Variance to Statewide Average

- Improvement Opportunities (e.g., 50%)
  - Cost per ECMAD
    - Variance from Statewide Average
  - Overhead Cost per ECMAD
    - Variance from Statewide Average
  - Margin from Unregulated System Operations
    - Variance from Statewide Average
  - PAU
    - Variance from Statewide Average

Each measure is weighted equally within each domain.

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
    i. Financial Need
    ii. Management Improvement Opportunities
d. Allocation Approach
    i. Allocated based on scoring rubric rank

maryland
health services
cost review commission

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.