maryland
health services
cost review commission

Performance Measurement Workgroup

April 16, 2025

HSCRC Quality Team

Meeting Agenda

- Revised PMWG work plan review
- MHAC Updates--approved
- RRIP Updates-- approved
- Disparity Gap Updates
- QBR Updates
  - ED LOS QBR measure review
- Digital measure update and review

Workgroup Learning Agreements

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

REMINDER: These workgroup meetings are recorded.

PMWG Members

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

PMWG Revised Work Plan
(See separate work plan document)

PMWG April - June Meetings

High level goals of the April-June Meetings:

- Address issues identified in RY27 and develop list of RY28 priorities
- Review of Quality Performance and Resources to track performance
- Longer term strategic planning discussions, including AHEAD updates
- ED Commission and Best Practices updates and planning
- HCAHPS Learning Collaborative Updates
- **Topics subject to change based on available analyses**

Month/Meeting(s)	Goals/Deliverables
April 2025	
Commission Meeting 4/9/25	1. MHAC RY 2027, final policy 2. RRIP RY 2027, final policy
PMWG Meeting 4/16/25	1. Revised PMWG workplan review 2. MHAC Updates & Priorities a. RY27 implementation b. AMC concerns c. RY28 Priorities List 3. RRIP Updates & Priorities a. Next steps on transfers b. RY28 Priorities List c. Readmission Disparity Gap Update 4. QBR Updates & Priorities a. ED LOS RY25 QBR measure; RY26 next steps b. RY28 Priorities List 5. Digital measure update and review
May 2025	
Commission Meeting 5/14/25	1. Update factor discussion, including PAU
PMWG Meeting 5/21/25	1. Overview of Maryland Quality Performance and Resources a. Contractual outcomes for CY24 b. Avoidable Admissions (PQI) Trends c. Quality Financial Impact Dashboard review 2. Complications/MHAC Discussion a. PPC Measures b. Other measures 3. Disparity Gap Updates 4. HCAHPS Learning Collaborative Update 5. AHEAD Readmission Measure Update 6. RY2028 Priority List
June 2025	
Commission Meeting 6/11/25	1. Update Factor discussion, including PAU
PMWG Meeting 6/18/25	1. Overview of Maryland Quality Performance a. Current performance on key quality program outcomes b. Sepsis dashboard c. Outpatient quality measures 2. Disparity Gap Updates 3. ED Commission and Best Practices Update 4. Quality Strategic Plan Discussion a. RY2028 Priority List 5. Other items TBD

MHAC Updates

RY 2027 Final Approved Recommendations for MHAC

1. Use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
    a. Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
    b. Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
    c. Engage hospitals on specific PPC increases to understand trends and discuss potential quality concerns.
2. Assess performance using more than one year of data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs). The performance period for small hospitals will be CYs 2024 and 2025.
3. Assess hospital performance based on statewide attainment standards.
4. Score hospital performance on a PPC composite that includes all payment PPCs weighted by hospital specific expected volume and Solventum (3M) cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent:
    a. Use a continuous linear scale that ranges from 0 to 100 percent without a hold harmless zone.
    b. Establish the cut point for penalties and rewards as the average hospital MHAC score as determined through prospective modeling.
    c. Retrospectively assess the average hospital MHAC scores and propose to the Commissioners that the cutpoint be modified if the actual average score is more than +/- 10 percent different from the prospectively modeled average MHAC score.
6. Going forward, consider other candidate measures/measure sets that may be important for assessing hospital avoidable, harmful complications and appropriate for use in the program, e.g., digitally specified measures.

Expected Weighting Influence on PPC Scores: UMMS example

UMMS Example: Change in Scores with Improvement on each PPC				100% reduction		50% reduction		25% reduction	
PPC Typ	Original Observed PPCS	Expected	Cost Weight	Score Improvement if all Observed PPCs Reduced (Current Methodology)	Score Improvement if all Observed PPCs Reduced (Composite Methodolog	Score Improvement if all Observed PPCs Reduced (Current Methodology)2	Score Improvement if all Observed PPCs Reduced (Composite Methodology)3	Score Improvement if all Observed PPCs Reduced (Current Methodology)3	Score Improvement if all Observed PPCs Reduced (Composite Methodology)4
3	18	31.030	0.2945	0.24%	2.00%	0.24%	1.00%	0.20%	1.00%
4	11	17.325	1.1326	2.04%	5.00%	1.41%	3.00%	0.71%	1.00%
7	12	13.251	1.2328	4.69%	6.00%	3.16%	3.00%	1.62%	1.00%
9	28	29.446	1.1956	3.39%	13.00%	2.32%	7.00%	1.16%	3.00%
16	3	6.559	1.4819	1.74%	2.00%	1.74%	1.00%	0.82%	1.00%
28	10	13.101	0.4574	1.08%	2.00%	0.92%	1.00%	0.54%	1.00%
35	19	22.861	1.2705	3.08%	10.00%	2.81%	5.00%	1.41%	3.00%
37	32	26.217	1.5593	8.20%	20.00%	6.15%	10.00%	3.02%	5.00%
41	5	5.044	1.0451	3.04%	2.00%	1.95%	1.00%	0.65%	0.00%
42	12	9.185	1.5203	7.15%	7.00%	3.89%	4.00%	2.00%	2.00%
47	2	20.066	0.8107	0.00%	1.00%	0.00%	0.00%	0.00%	0.00%
49	3	5.609	0.425	0.26%	0.00%	0.26%	0.00%	0.26%	0.00%
60	1	1.245	0.7306	1.72%	0.00%	1.72%	0.00%	1.72%	0.00%
61	1	2.351	0.1389	0.18%	0.00%	0.18%	0.00%	0.18%	0.00%
67	27	33.244	1.1553	3.28%	13.00%	2.16%	6.00%	1.12%	3.00%

- Some stakeholders raised the issue that weighting by expected PPCs does not appear to influence MHAC scores materially
  - Evidenced by comparing score after a change of one PPC for each PPC type
- To better assess influence of weighting expected PPCs, staff reviewed the change in scores if the reduction in each PPC type changed by the same percentage

Example PPC 37: If UMMS had 100% reduction and all other performance remained the same, the composite score would increase by 20 percentage points and the old method the score would increase by 8.20 percentage points.

Example PPC 37: If UMMS had 25% reduction and all other performance remained the same, the composite score would increase by 5 percentage points and the old method the score would increase by 3.02 percentage points.

RY 2027 Policy Implementation: Next Steps

- Hospital webinar: Recorded webinar on new composite methodology is on MHAC webpage
- MHAC Reporting:
  - Base year data anticipated on CRS portal in June
    - Normative values; Benchmark and thresholds; Excluded PPCs; Small Hospital Determination; Calculation Sheet; v42 cost weights
  - Performance year data anticipated on CRS portal in June
    - 2025 Year to date performance (2 years for small hospitals)
- Cutpoint for Revenue Adjustment Scale (TBD)
  - Staff will update the modeling of CY24 performance with v42 cost weights, QA results, and then will calculate the hospital average score to use as the prospectively determined cutpoint for the revenue adjustment scale
  - Approved policy indicates if the actual average differs by +/- 10 percent, staff will propose a retrospective change to the cut point to the commission
  - Average of statewide scores could be included in monthly reports for monitoring throughout the performance year

RY 2026 MHAC Revenue Adjustment Updates

- RY 2026 Updates:
  - Based on hospital input, Solventum made clinical updates to PPC 42 Accidental Puncture or Laceration in v42.
  - Staff are rerunning RY26 MHAC performance under v42. Hospitals will receive the higher score for PPC 42 under v41 vs v42.
  - Updated cost weights were also used (v41 0.4972, v42 1.5203).
  - Final data/revenue adjustments anticipated by 4/25/2025

Next Steps on MHAC Concerns

Academic Medicare Center (AMC) Concerns:

To assess specific concerns related to the unique procedures and higher severity patients served by AMCs and how performance is benchmarked, including:

- Evaluation of AMC contribution to normative values and adequacy of risk-adjustment
- Assessment of setting of benchmark and thresholds
- Identification of procedures unique to AMCs and occurrence of complications
- Consideration of national benchmarks for AMCs

PPC Concerns:

- Criteria for selecting concerns under composite methodology
- Increases in Monitoring PPCs
- Assessment of Payment PPCs
- Use of measures not in National program

National Comparisons:

- Under PPC v.42, Solventum national norms use CY 2020 and CY 2021
- HACRP- How hospitals in Maryland perform if they were under HACRP

Payment PPC Selection Criteria

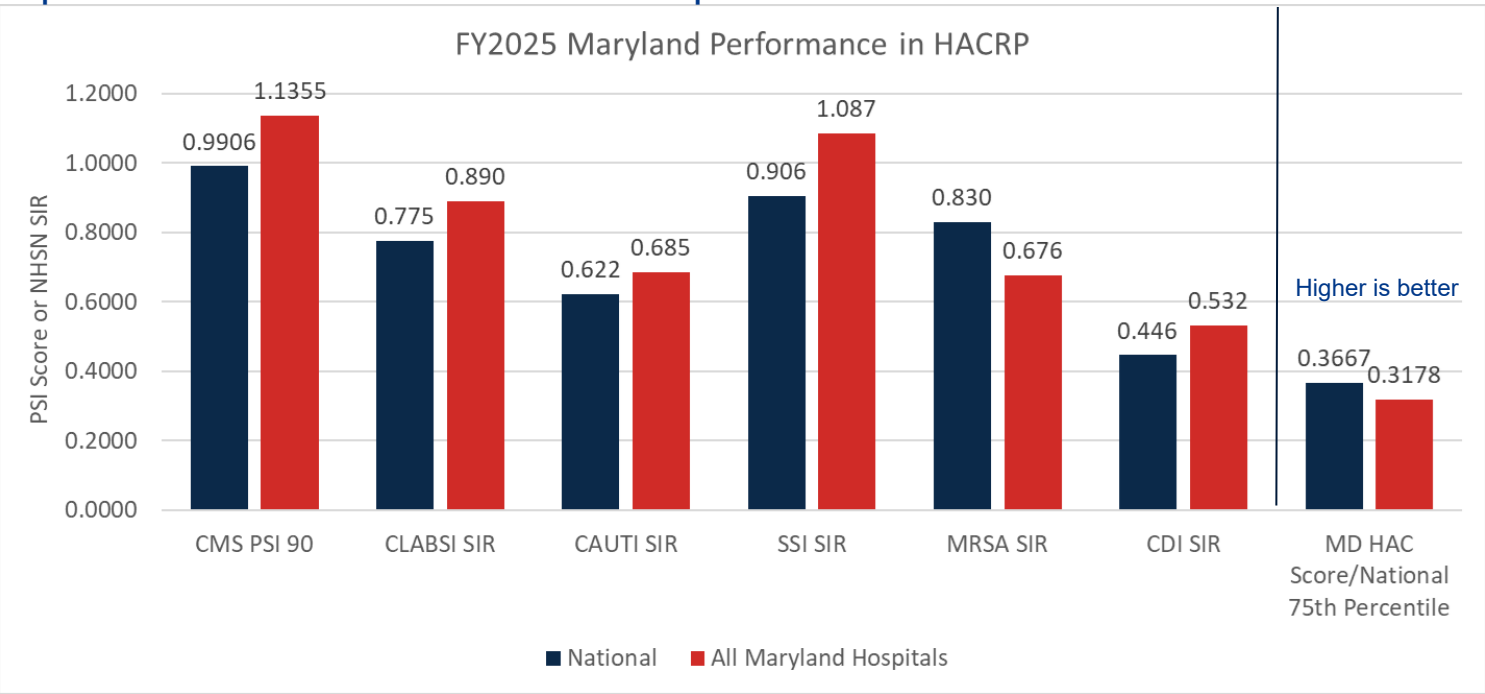
- PPC Data Analysis/Statistics
  - **High rates: Rate per 1,000 generally 0.5 or above**
  - **High Volume: Volume of observed events 100 or above (over two years)**
  - Significant variation across hospitals
  - At least half of the hospitals are eligible for the PPC

- Additional Considerations
  - Clinical significance
  - Potential influence of coding practices/changes
  - Opportunity for improvement/actionability
  - PSI overlap
  - All-payer

If using composite methodology, staff plan to revisit monitoring PPCs with lower rates and volumes.

FY 2025 HACRP MD Performance

MD performs worse on all measures except MRSA; State as a whole performs better than national 75th percentile.



	FY25 HACRP	RY25 MHAC
State Net Total	**-$63,317,885**	**$39,070,817**
Penalty	-$63,317,885	-$8,879,421
% Inpatient	-0.54%	-0.08%
Reward	$0	$47,950,238
% Inpatient	0.00%	0.41%
Revenue Adjustments	15/42 = 36% penalty	9/42= 21% penalty 25/42 = 54% rewards

Note: Staff estimated all-payer revenue adjustments using HACRP results from CMMI (apples to apples comparison). CMS would apply adjustments to Medicare FFS revenue only, so this is higher than what it would be if in the HACRP program.

While staff still believe the MHAC program is superior to the HACRP program because of its comprehensiveness (e.g, inclusion of major obstetric complications), prospective standards, and upside risk, staff believe it is important to understand how Maryland would fare in the national program.

For the FY 2025 HAC Reduction Program, the CMS PSI 90 measure uses a performance period of July 1, 2021, through June 30, 2023. The CDC NHSN HAI measures (CLABSI, CAUTI, SSI, MRSA, and CDI) have a performance period of January 1, 2022, through December 31, 2023.

RY2025 MHAC is based on CY 2023 performance using Solventum Potentially Preventable Complications.

MHAC RY 2028 and Beyond: Priorities List

Bolded = Highest priorities for RY28

- Continue to assess Composite Methodology
  - **AMC Analyses:** Benchmarks/norms, identification of specific procedures of AMC concern
  - **Composite evaluation** and modifications if warranted
- Complications Strategic Plan Discussion
  - **Payment PPC selection criteria**
  - **Monitored PPCs:** Update validity and reliability analysis, and PPC selection criteria
  - **Updated PPCs for payment and monitoring:** PPC trends
  - Overlap of MHAC and QBR Safety Domain & Revenue At Risk
  - Revenue at-risk on complications
  - National comparisons
  - Consideration of digital measures: Work with stakeholders on adoption plan for additional measures including digital quality measures (e.g., hyper/hypo glycemia, maternal complications)
  - Complications in outpatient hospital setting
- PMWG members thoughts and questions for future improvements to the MHAC program; (*contact staff with questions or ideas*)

RY 2027 Readmission Reduction Incentive Program

Final Approved RY 27 RRIP Recommendations

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

RY 2027 Policy Implementation: Next Steps

- Rerun RY 2026 with blended base period (anticipated 4/25)
  - Re-calculate attainment standards
- Run RY 2027 with blended base period for readmission rates and norms
  - Calculate attainment standards
- Provide RY 27 RRIP reports via CRS Portal (anticipated 5/9)
  - Normative values
  - Blended base period performance
  - 2025 YTD Performance
  - Improvement and Attainment Targets and Scaling

RRIP RY2028 and Beyond: Priorities List

- Better understand the issue of transfers
  - Assess Medicare CCW transfer definition and concerns
  - Use the Medicaid and APCD data to understand the impact of transfers outside Medicare FFS
  - Are border hospitals being unfairly penalized for OOS transfers that are transferred back to a MD hospital?
- Assess the disparity gap methodology
  - See next section
- Decide how to handle observation and ED revisits
- Assess preventability and revisit shrinking denominator concern
- Alignment with AHEAD readmission measure and State goal

Disparity Gap Updates

The RRIP Disparities Component

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

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

Rewards are scaled:

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

Overview of PAI and Disparity Gap Mechanisms

Patient Adversity Index (PAI)

PAI is formulated using a regression analysis that determines the statewide association between the following factors and readmissions:

- Medicaid Status
- Race (Black vs. Non-Black)
- Area Deprivation Index Percentile

Coefficients from the regression are used to calculated PAI for each discharge

PAI Scores for each discharge are available by hospital-level on CRISP

Disparity Gap

Within-hospital disparity gap is calculated by a second statistical model that incorporates PAI

The multilevel regression estimates the slope of PAI at each hospital after controlling for:

- Age
- Gender
- APR-DRG readmission risk
- Hospital Mean PAI

The Yearly Disparity Gap is equal to Risk-Adjusted Readmissions Rate (PAI = 1) – Risk-Adjusted Readmissions Rate (PAI = 0)

Disparity Gap Revenue Adjustment

Revenue adjustments are currently reward only

Scaled to begin at 0.25% of IP Revenue and capped at 0.5% of IP Revenue

Disparity Gap Change	RRIP % Inpatient Rev.
50% Reduction in Gap in 8 Years (-29.29% CY 2023)	0.25%
75% Reduction in Gap in 8 Years (-50% CY 2023)	0.50%

The Connection between Risk Factors and Readmission Rates

Race, Medicaid Status, Area Deprivation Index

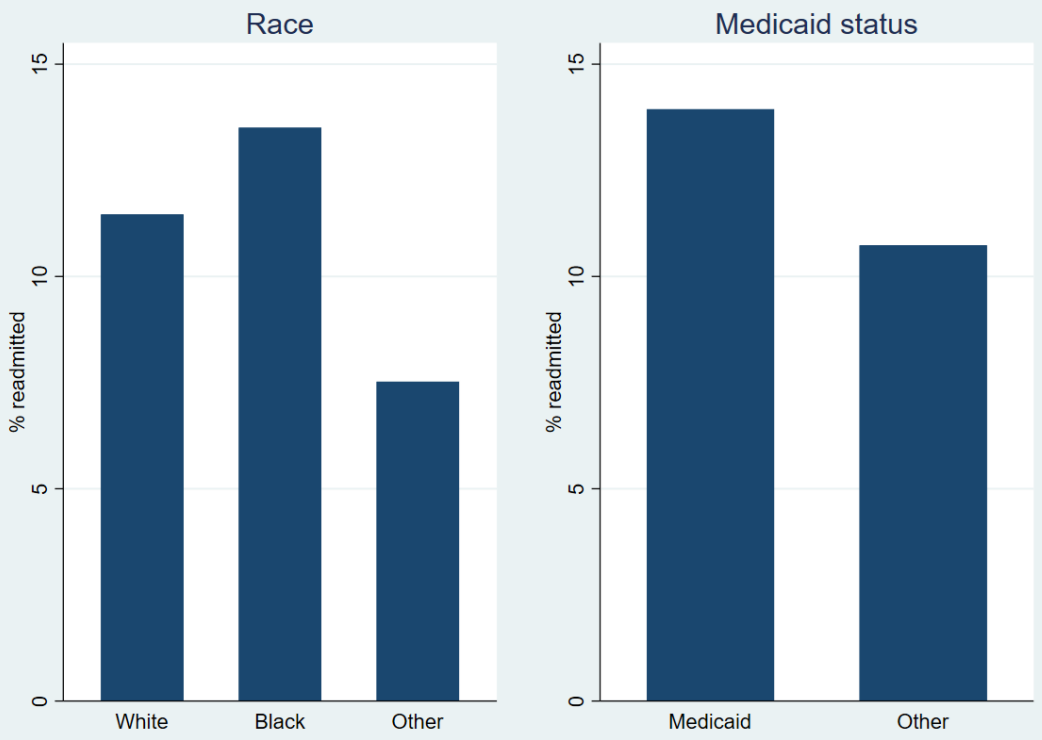
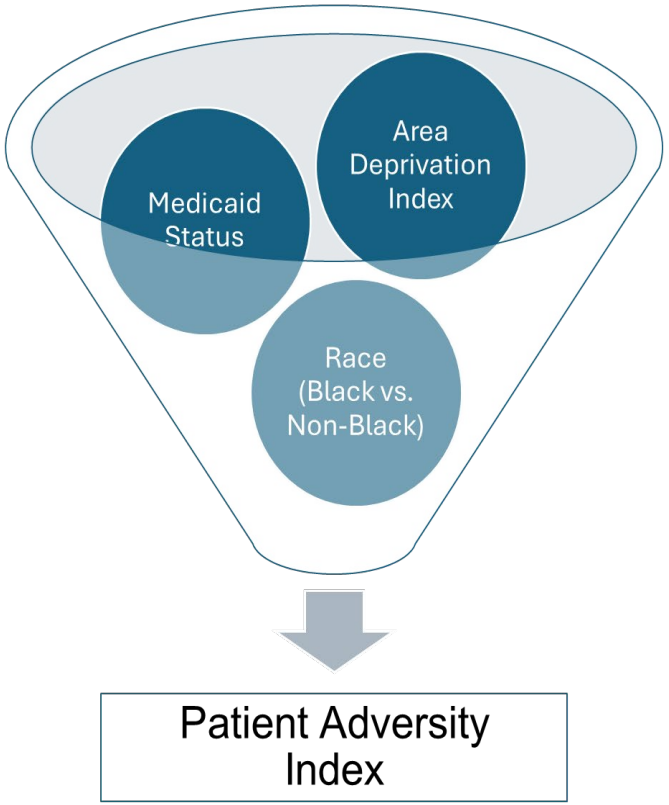


Table 2. Readmission Risk at Different Percentiles of ADI and Safety-Net Index*

Percentile	Marginal Effect† of Safety-Net Index (95% CI)	Marginal Effect† of ADI (95% CI)
10th	0.116 (0.105-0.127)	0.125 (0.118-0.132)
25th	0.121 (0.113-0.129)	0.128 (0.121-0.134)
50th	0.131 (0.126-0.135)	0.132 (0.127-0.138)
75th	0.141 (0.132-0.150)	0.137 (0.133-0.142)
90th	0.148 (0.134-0.161)	0.141 (0.136-0.145)

Jencks, S. F., Schuster, A., Dougherty, G. B., Gerovich, S., Brock, J. E., & Kind, A. J. (2019). Safety-Net Hospitals, Neighborhood Disadvantage, and Readmissions Under Maryland's All-Payer Program: An Observational Study. *Annals of internal medicine*, *171*(2), 91-98.

Calculating the Patient Adversity Index (PAI)



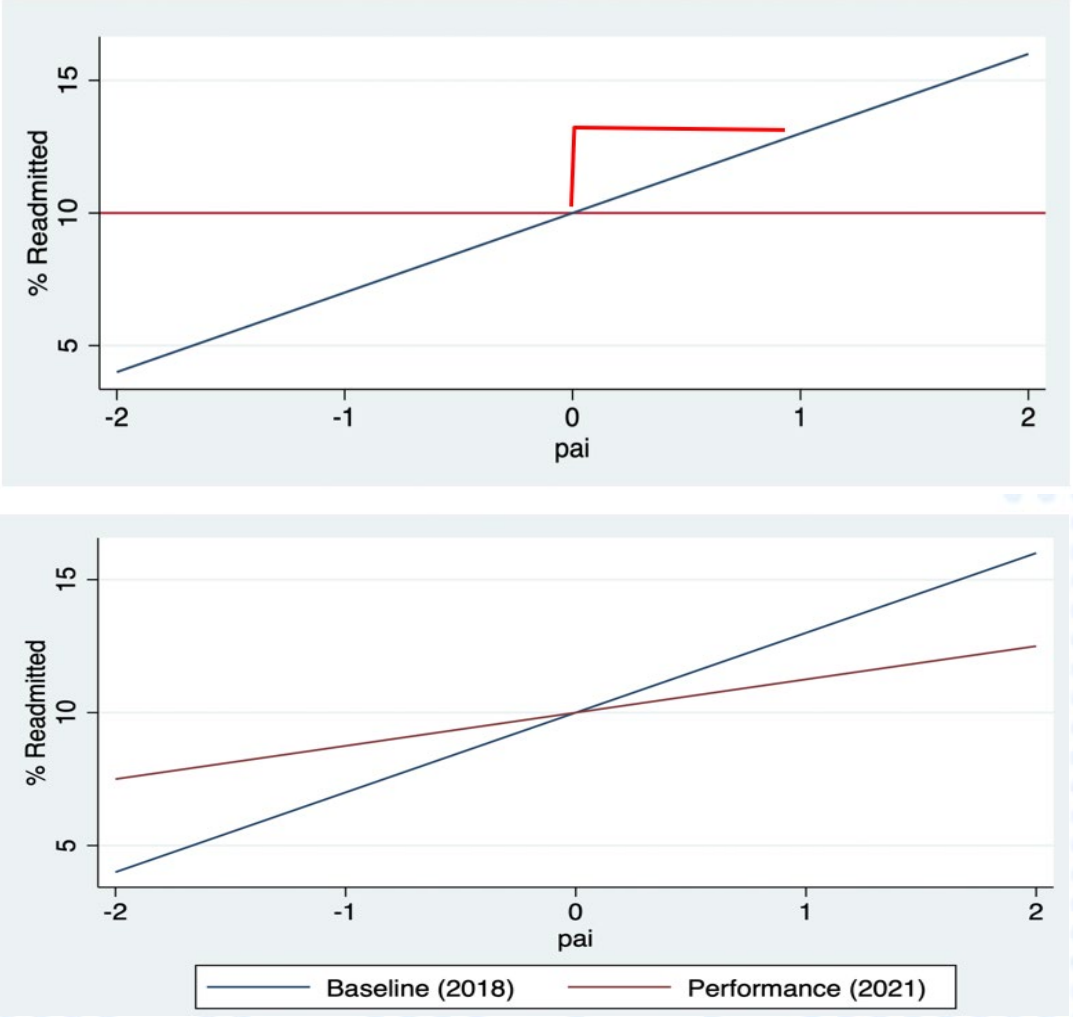
- The Patient Adversity Index is based on a multivariate regression model that estimates the association of readmission with ADI, Medicaid, Black race
- Larger value = Higher adversity
- PAI Score is then normalized so that statewide mean is 0. Each 1-point change in the scale represents a change of one standard deviation.

Performance Metric- Readmissions Disparity Gap Improvement

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

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

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



Disparity Gap Revenue Adjustments Results Over Time

	CY 2021 Performance	CY 2022 Performance	CY 2023 Performance
# of Hospitals with Improvement	17	32	22
# of Hospitals Rewarded	9	11	2
Statewide Total Reward ($)	~$10M	~$7.8M	~$1.8M

Concerns

- Results raise concerns that an increasing number of hospitals are not able to meet improvement targets and receive disparity gap rewards

Potential Hypotheses

- Hospitals not improving
  - Possibly due to lack of resources needed to address issues, early progress resulting in harder subsequent improvements, limitations in addressing non-hospital based social needs, among other factors
- Methodology Concerns
  - Shrinkage effects of model are limiting improvement
  - Inherent issues with statistical modeling

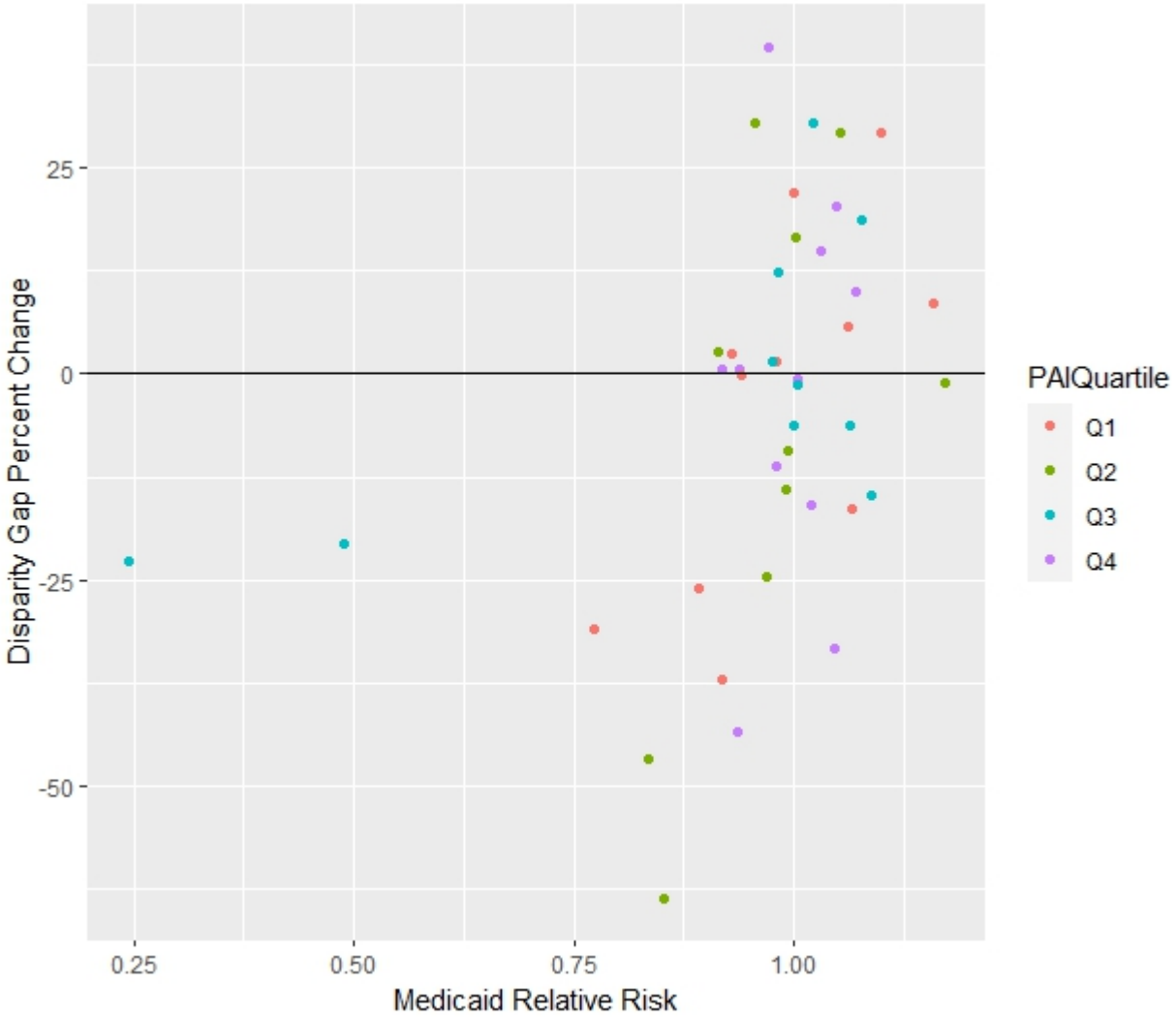
Initial Analyses

What is the influence of the individual PAI components (Medicaid, Race, ADI) on disparity gap improvement between CY2024 and CY2018?

Are hospitals that are showing relatively greater improvements in certain targeted populations (i.e., Medicaid, Black, and/or High-ADI) compared to their non-targeted counterparts (non-Medicaid, Black, and/or Low ADI) seeing commensurate improvements in the disparity gap?

Measurement: Comparing % Change in Risk-Adjusted Readmissions Rate for the six disparity gap component-groups (Medicaid, Non-Medicaid, Black, Non-Black, High ADI, Low ADI) between CY2024 and CY2018. Relative risks were then calculated using the non-targeted populations (i.e., Non-Medicaid, Non-Black, and Low ADI) as the respective referent groups. Relative risks were then plotted against % Change in Overall Disparity Gap between CY2024 and CY2018.

Is Improvement Correlated with Changes in Individual PAI Components?



- Staff evaluated YoY change in disparity performance vs. RRIP performance for Medicaid patients, Black patients and those in high ADI areas.
- We found weak correlation between disparity performance and readmission changes for individual PAI components
- This could indicate that hospitals have mixed results – e.g., those reducing risk for Medicaid patients may have increasing readmissions for Black patients
- Staff will continue to investigate this issue

RY2028 Readmission Disparity Gap and Beyond: Priorities List

- Assess PAI and Disparity Gap methodology to understand performance results
  - Investigate whether hospitals that are showing relatively greater improvements in certain targeted populations (e.g., Medicaid) compared to different targeted populations (e.g., Black) are seeing imbalanced improvements in the disparity gap
  - Impact of risk-adjustment model and reliability adjustments
  - Applies to Timely Follow-up for Medicare as well
- Provide hospitals with modeling that more clearly shows the impact of changes in readmissions on the disparity gap
- Re-evaluate the base period and time period for coefficients
- Re-assess the improvement targets and scaling
- Improve disparity gap report to be more user-friendly
- Align with AHEAD priorities

QBR Measure Review

RY 2025 ED LOS Measure Update

- Hospital Review and Validation Process
  - CY2023 Median ED LOS by hospital report and corresponding patient level files will be sent out to hospitals by end of next week (4/25)
  - Hospitals will have two week review period; May 1st Best Practices Meeting will review results and discuss measure specifications
- RY2026 Decisions
  - Measure changes
  - Improvement goal

QBR RY2028 and Beyond: Priorities List

- **Evaluate ED LOS measures and goals**
- **Address HCAHPS Learning Collaborative recommendations**
    - Consider adoption of additional question(s) linked with best practices with evidence of improving HCAHPS performance in the payment program after CY 2024
- **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**
- **Timely Follow Up- consider feasibility, based on data availability, of adding a measure that includes behavioral health patients.**
- Mortality- Examine correlations between IP and 30 day measures; develop all-payer hybrid mortality risk adjustment.
- Outpatient measures-
    - Continue to develop outpatient quality of care strategy using THA/TKA as exemplar
    - Explore opportunities for Patient Reported Outcome Measures (PROMs)
    - Consider available CMS OP measure options

Digital Measures Updates

HSCRC Digital Measures Reporting Requirements 2025: Electronic Clinical Quality Measures (eCQMs)

Title	Short Name	CMS eCQM ID	CBE* #	2024	2025	HSCRC
Anticoagulation Therapy for Atrial Fibrillation/Flutter	STK-3	CMS71v13	N/A	X	X	Self-Selected
Antithrombotic Therapy By End of Hospital Day 2	STK-5	CMS72v12	N/A	X	X	Self-Selected
Cesarean Birth	PC-02	CMS334v5	0471e	X	X	Required
Discharged on Antithrombotic Therapy	STK-2	CMS104v12	N/A	X	X	Self-Selected
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Facility IQR)	IP-ExRad	CMS1074v2	3663e		X	Self-Selected
Global Malnutrition Composite Score	GMCS	CMS986v2	3592e	X	X	Self-Selected
Hospital Harm - Acute Kidney Injury	HH-AKI	CMS832v2	3713e		X	Self-Selected
Hospital Harm - Opioid-Related Adverse Events	HH-ORAE	CMS819v2	3501e	X	X	Self-Selected
Hospital Harm - Pressure Injury	HH-PI	CMS826v2	3498e		X	Self-Selected
Hospital Harm - Severe Hyperglycemia	HH-Hyper	CMS871v3	3533e	X	X	Required
Hospital Harm - Severe Hypoglycemia	HH-Hypo	CMS816v3	3503e	X	X	Required
ICU Venous Thromboembolism Prophylaxis	VTE-2	CMS190v12	N/A	X	X	Self-Selected
Safe Use of Opioids - Concurrent Prescribing	Safe use of opioids	CMS506v6	3316e	X	X	Required
Severe Obstetric Complications	PC-07	CMS1028v2	N/A	X	X	Required
Venous Thromboembolism Prophylaxis	VTE-1	CMS108v12	N/A	X	X	Self-Selected

Digital Hybrid Measure Reporting Requirements: Core Clinical Data Elements for Hospital Wide Mortality and Readmission Measures

Hospitals must submit CCDE measures for **all payer hospitalizations for patients aged 18 and older** for July 1, 2024 to June 30, 2025 reporting period; hospitals must submit an ECE request for HSCRC consideration if they are unable to comply with the reporting requirement. Hospitals must notify HSCRC of their reporting timeline (option i Quarterly or ii Annual as outlined below).

i. Quarterly Timeline

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

ii. Annual Timeline

Q3, 2025 to Q2, 2026	Open 7/15/2025	Close: 9/30/2025

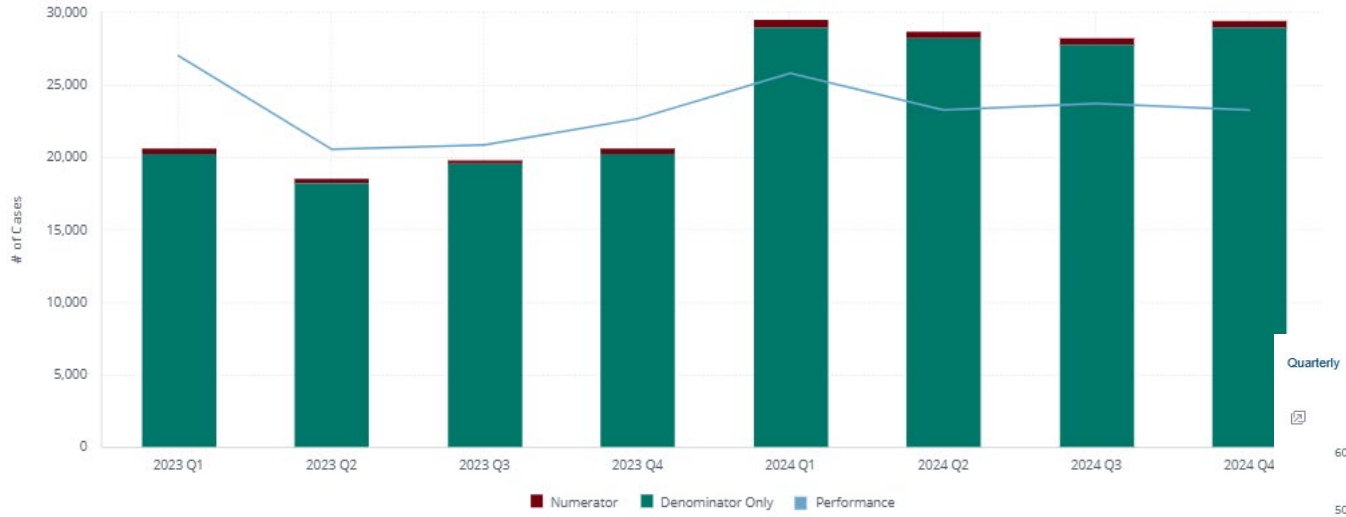
Hypoglycemia Measure Example 2023-2024 Quarterly Trends

Measure: Hospital Harm - Severe Hypoglycemia (E)

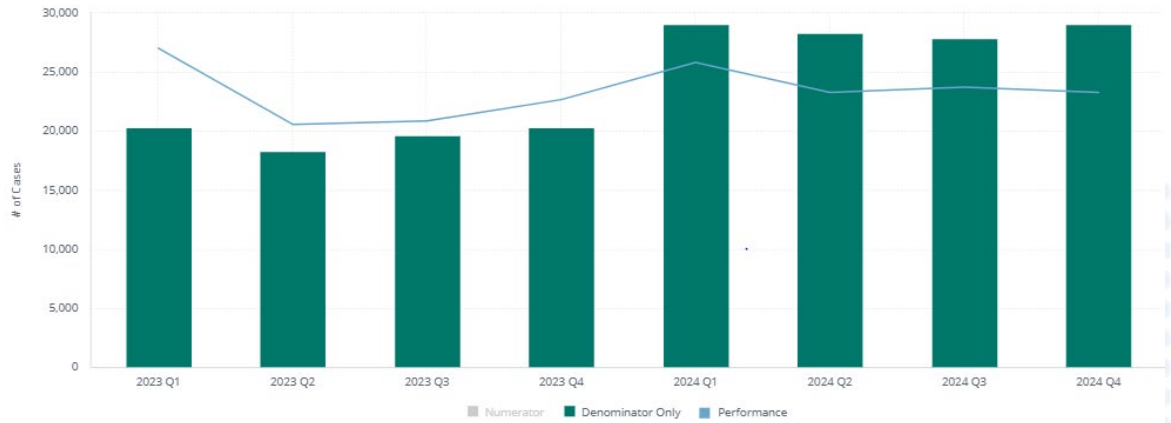
Entity: HSCRC All Hospital Roll Up

Period: 01/01/2023-12/31/2024

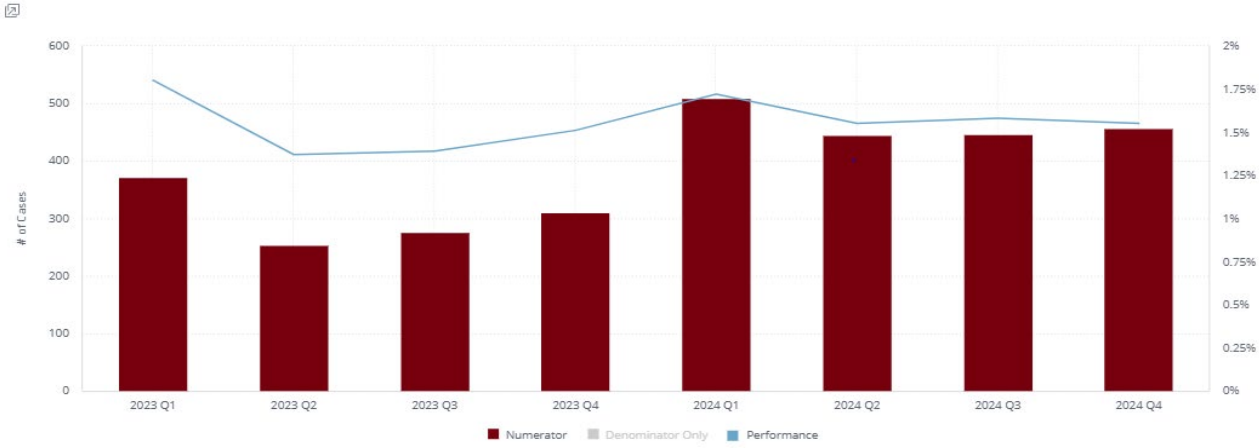
Quarterly Apply



Quarterly Apply



Quarterly Apply



THANK YOU!

Next Meeting: May 21, 2025