



maryland
health services
cost review commission

Performance Measurement Workgroup

September 18, 2024

HSCRC Quality Team

Meeting Agenda

- Welcome and introductions, webinar housekeeping
- IPPS FY 2024 Final Rule Summary
- Work plan review for RY 2027
- TCOC Model Performance and AHEAD Overview
- QBR RY 2027 Policy Discussion

Workgroup Learning Agreements

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

REMINDER: These
workgroup
meetings are
recorded.

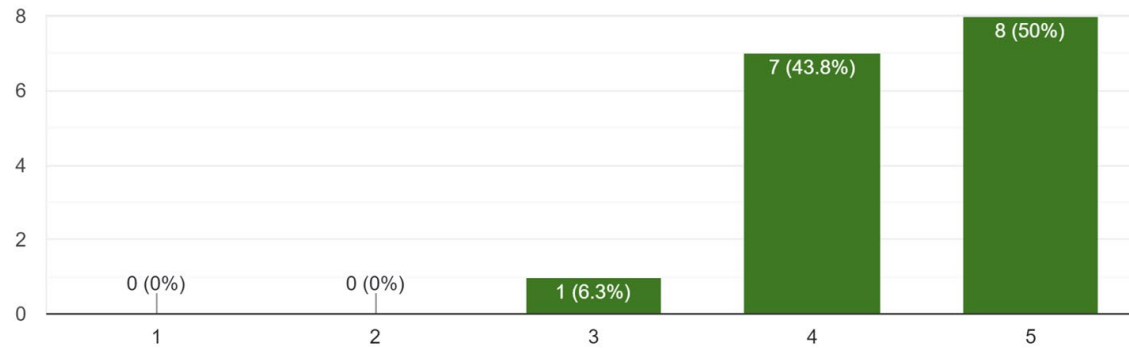
PMWG Invited (i) and Confirmed (c)Members

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

Performance Measurement Work Group 2023-2024 Members Survey Results- N=15

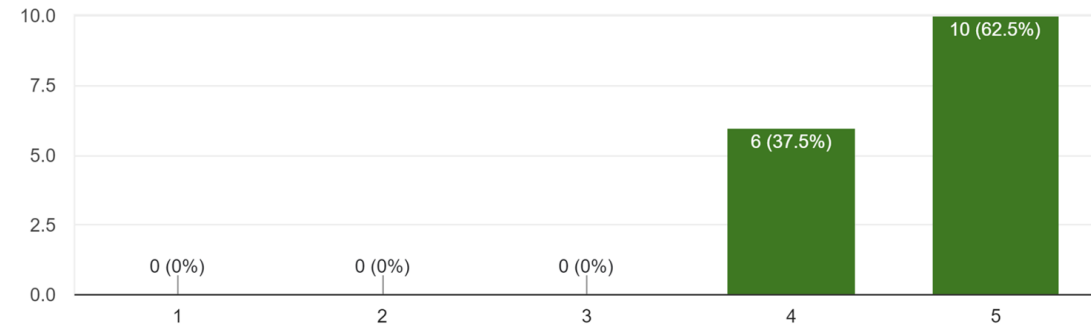
Overall, how satisfied were you with participating as a member on the work group?

16 responses



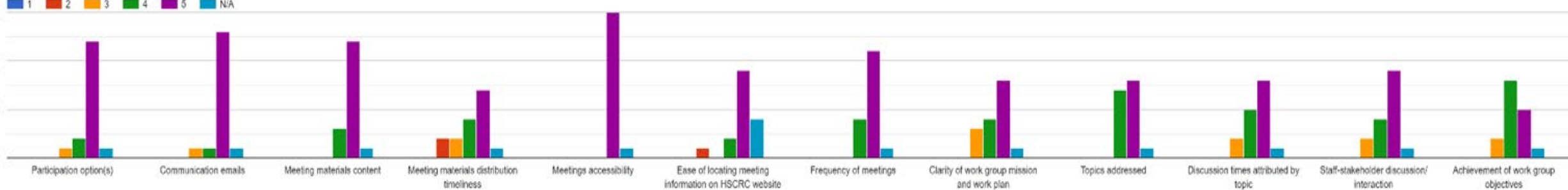
How relevant and helpful did you believe the work undertaken by the work group was for you in your professional role?

16 responses



How satisfied were you with the following aspects of the work group?

Legend: 1 (Blue), 2 (Red), 3 (Orange), 4 (Green), 5 (Purple), N/A (Cyan)



Inpatient Prospective Payment System FY 2025 Final Rule

CMS IPPS Final Rule FY 2025 and Emerging Priorities

The Hospital Inpatient Quality Reporting (IQR) Program plans to update its measures by adding seven new ones, removing five existing ones, and modifying one. CMS is also proposing new measures across various categories, including electronic, claim-based, structural, and healthcare-associated infections.

- Hospital Harm – Falls with Injury eCQM, with inclusion in the eCQM measure set beginning with the CY 2026 reporting period/FY 2028 payment determination.
- Hospital Harm – Postoperative Respiratory Failure eCQM, with inclusion in the eCQM measure set beginning with the CY 2026 reporting period/FY 2028 payment determination.
- Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) claims-based measure beginning with the July 1, 2023 – June 30, 2025 reporting period, which impacts the FY 2027 payment determination.
- Patient Safety Structural Measure beginning with the CY 2025 reporting period/FY 2027 payment determination.
- Age Friendly Hospital structural measure beginning with the CY 2025 reporting period/FY 2027 payment determination.
- Catheter-Associated Urinary Tract Infection Standardized Infection Ratio Stratified for Oncology Locations measure beginning with the CY 2026 reporting period/FY 2028 payment determination.
- Central Line-Associated Bloodstream Infection Standardized Infection Ratio Stratified for Oncology Locations measure beginning with the CY 2026 reporting period/FY 2028 payment determination.

CMS is proposing to modify the following measures:

- Global Malnutrition Composite Score eCQM beginning with the CY 2026 reporting period/FY 2028 payment determination. This modification adds patients ages 18 to 64 to the current cohort of patients 65 years or older.

CMS IPPS Final Rule FY 2025 and Emerging Priorities

- Beginning with the CY 2025 reporting period and FY 2027 payment determination, 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.
 - **Hospital Value-Based Purchasing (VBP) Program**
 - Modify scoring in the Person and Community Engagement Domain to only score on the six unchanged dimensions of the survey
 - Adopt Person and Community Engagement Domain measure updates beginning with FY 2030 program, the year after updates have been publicly reported for one year in the Hospital IQR Program
 - Modify HCAHPS Survey measure scoring in the Person and Community Engagement Domain beginning with the FY 2030 program year
- CMS is incrementally increasing the electronic clinical quality measures (eCQMs) requirements from six mandatory eCQMs (by 2024) to eight (by 2026), then to nine (by 2027), and finally to 11 (by 2028). Although a more aggressive schedule had been proposed, CMS ultimately decided on an extended timeframe. The new required eCQMs are all around Hospital Harm (Patient Safety).
- CMS proposes removing four condition-specific payment measures—AMI, HF, PN, and THA/TKA—starting with the FY 2026 payment determination, which covers performance periods ending in March 2024 (THA/TKA) and June 2024 (AMI, HF, PN). The removal is due to the availability of the more broadly applicable Medicare Spending Per Beneficiary-Hospital (MSPB Hospital) measure, which is part of the Hospital VBP Program.

CMS IPPS Final Rule FY 2025 and Emerging Priorities

Health Equity – is an overarching goal that includes many proposed changes, including:

- o To change the severity designation of seven ICD-10 diagnosis codes that describe inadequate housing and housing instability from non-complication or comorbidity to complication or comorbidity, which is aligned with higher average resource costs of cases with these diagnosis codes.
- o For VBP Program and PPS-Exempt Cancer Hospital Quality Reporting Program, proposing to move up the start date to publicly display performance on the Hospital Commitment to Health Equity measure to January 2026.
- o Proposing to use the CMS Innovation Center’s Strategy Refresh definition for identifying safety net hospitals within Transforming Episode Accountability Model (TEAM).
- o Proposing a rural hospital to be defined as an IPPS hospital that is in a rural area; is in a rural census tract; is reclassified as a rural hospital; or is designated as a rural referral center.

2024-2025 PMWG Work Plan Review:
(See separate Work Plan document for more detail)

RX 2027 Policies: Main Decisions

1. Quality-Based Reimbursement (QBR) Program
 - HCAHPS improvement framework
 - ED LOS Updates
 - Monitoring Digital Measures
2. Maryland Hospital Acquired Conditions (MHAC) Program
 - Payment PPCs
 - Small Hospital Concerns
 - Monitoring Digital Measures
3. Readmissions Reduction Incentive Program (RRIP)
 - Impact of ED revisits and use of observation status
 - Disparities modeling including observation stays
4. Population Health
 - Review IP diabetes screening pilot to inform potential policy recommendation
5. Emergency Department/Multi-Visit Patient Policy
 - Finalize measure as within MD or within system counts
 - Discuss how to incorporate into existing or new PAU policy
6. ED-Hospital Throughput Best Practices
 - Finalize best practices
 - Develop data collection
 - Develop methodology for scaling revenue adjustments

Commission Draft and Final Policy Review and Vote

Core Quality Policies									
Policy	October	November	December	January	February	March	April	May	June
QBR	Draft		Final						
RRIP			Draft		Final				
MHAC					Draft		Final		
ED Best Practices		Draft		Final					
Population Health and Potentially Avoidable Utilization Policies									
Policy	October	November	December	January	February	March	April	May	June
IP Diabetes Screening		Draft		Final					
PAU ED-MVP	Draft		Final						
MPA			?	?					
Update Factor PAU Adjustment							Draft		Final

TCOC Model Performance and AHEAD Overview

TCOC Model Years 1-5 Performance

Performance Measures	Annual Targets	2019	2020	2021	2022	2023
Annual Medicare TCOC Savings	\$120M (2019), \$156M (2020), \$222M (2021), \$267M (2022), and \$300M (2023) in annual Maryland Medicare TCOC per Beneficiary of savings	✓	✓	✓	✓	✓
TCOC Guardrail Test	Cannot exceed growth in National Medicare TCOC per beneficiary by more than 1% per year and cannot exceed the National Medicare TCOC per beneficiary by any amount for 2+ consecutive years	✓	✓	✓	*	✓
All-Payer Revenue Limit	All-payer growth ≤ 3.58% per capita	✓	✓	✓	✓	✓
Improvement in All-Payer Potentially Preventable Conditions	Improve upon the CY 2018 PPC rates for 14 Potentially Preventable Conditions (PPCs) that comprise Maryland's Hospital Acquired Condition program (MHAC)	✓	✓	✓	✓	✓
Readmissions Reductions for Medicare	Maryland's Hospital Wide Readmission rate for Medicare FFS beneficiaries at regulated hospitals ≤ the National Readmission Rate for Medicare FFS beneficiaries**	✓	✓	**	**	✓
Hospital Population Based Payment	≥ 95% of all Regulated Revenue for Maryland residents paid according to a Population-Based Payment methodology	✓	✓	✓	✓	✓

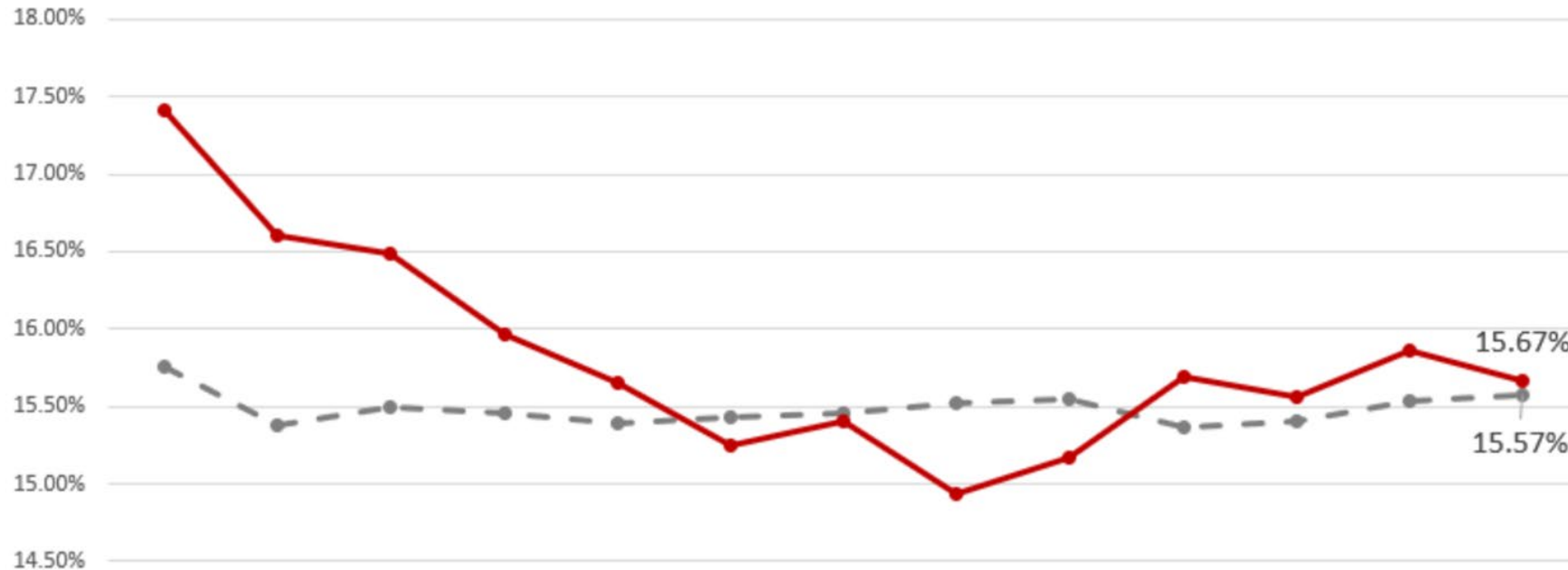
*0.9 percentage points above the National growth rate in 2022 and 0.6 percentage points above in 2021. CMS did not ask the State to take additional corrective action in part because, in December 2022, HSCRC took steps to reduce 2023 growth (should allow the State to meet their 2023 TCOC Guardrail requirement), and because Maryland's 2022 growth was partly based on CMS OACT estimates of growth that were significantly larger than actual growth.

**HSCRC staff believe the unadjusted readmission rate has increased due to increases in patient acuity in Maryland's hospitals, relative to the nation, an expected effect of GBRs. CMMI agreed to change to a risk-adjusted measure, which was implemented starting in CY2023.

TCOC Model Performance: Medicare Readmission Test

Unadjusted, 30-day, all-cause readmissions

Readmissions - Through April 2024

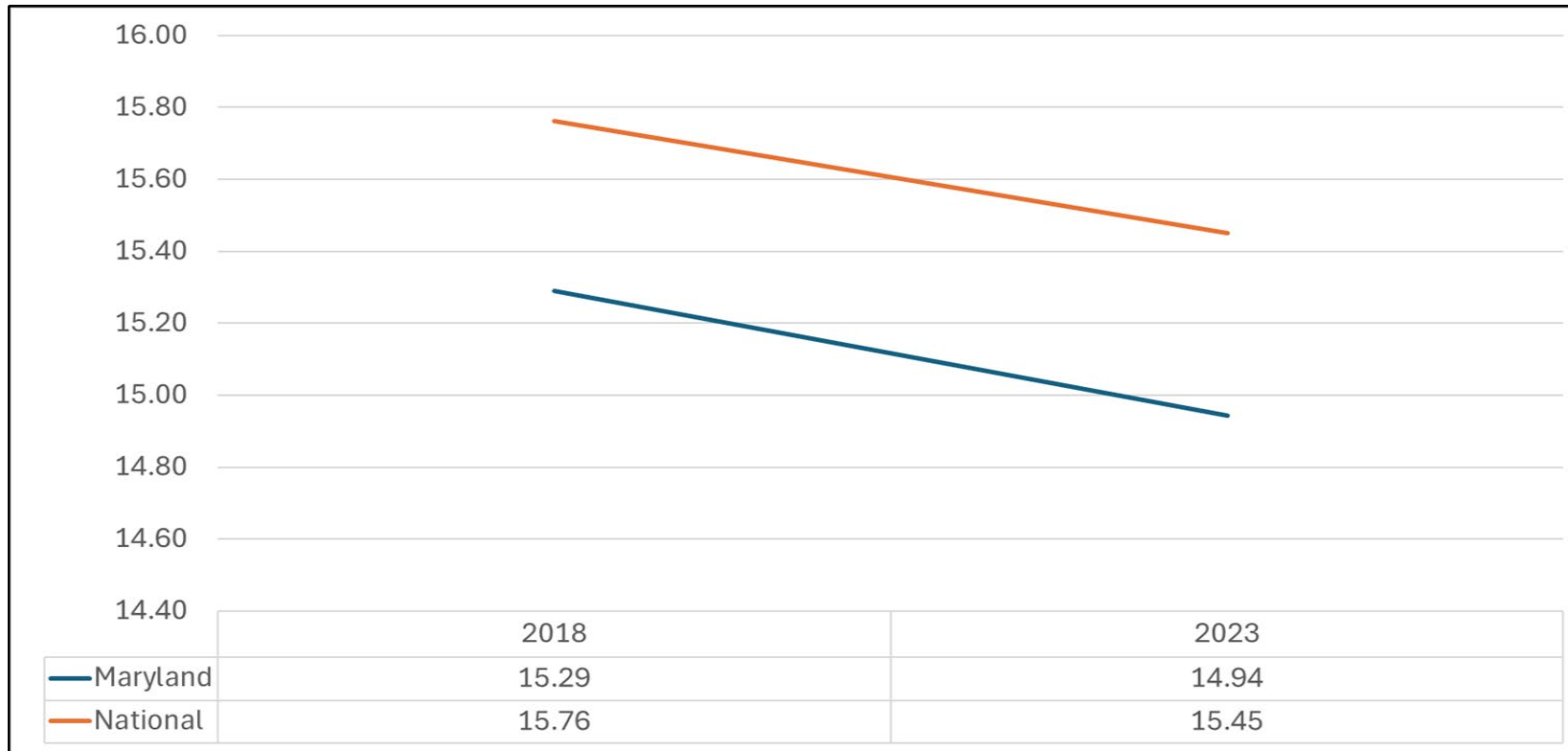


	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
—●— National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%	15.54%	15.57%
—●— Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%	15.86%	15.67%

Data Source: Chronic Conditions Warehouse (CCW)

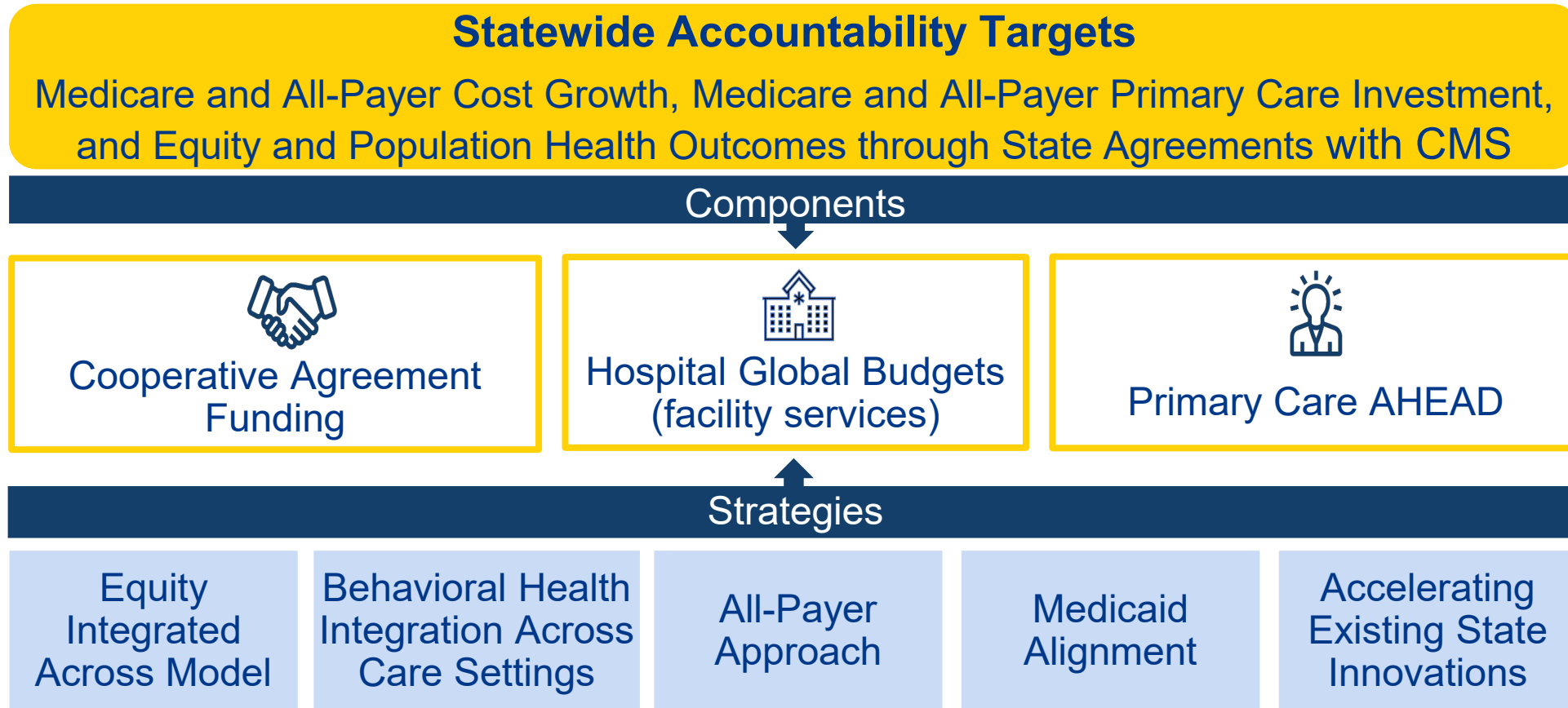
TCOC Model Performance: Risk-Adjusted HWR Measure

Starting with CY 2023 performance, CMMI agreed to use the risk-adjusted hospital wide readmission (HWR) measure modified to include Medicare FFS benes who are under the age of 65 and a few other adjustments.



CMMI has shown interest in further modifying this measure to include observation revisits along with inpatient readmissions beginning in CY 2025. Will discuss whether RRIP should also modify readmission measure to include observation.

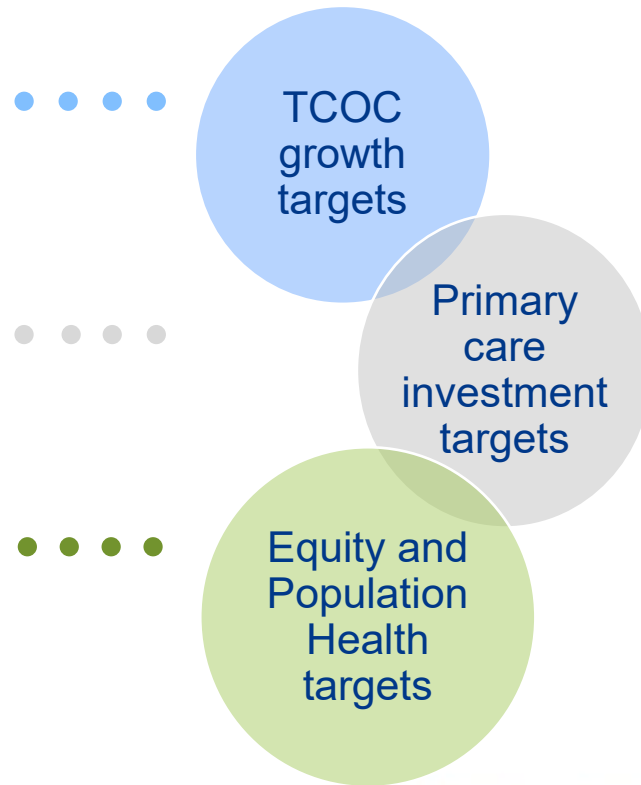
States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model



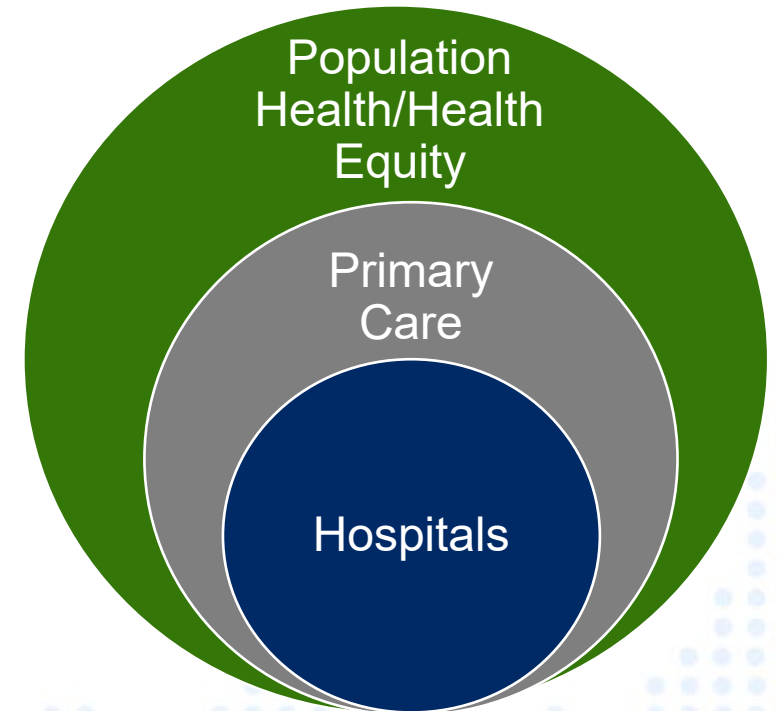
AHEAD Builds on the TCOC Model

The States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model is a state total cost of care (TCOC) model designed to:

- curb growth in healthcare cost spending;
- improve population health; and
- advance health equity by reducing disparities in health outcomes.



Similar to the Maryland Total Cost of Care (TCOC) Model, AHEAD focuses on three overlapping domains to achieve its goals.



AHEAD Statewide Accountability Targets

The AHEAD Model requires participants to meet **statewide targets in three areas**, which will be negotiated during the pre-implementation period and formalized in the State Agreement.

TCOC growth

- Includes **all-payer** and **Medicare FFS** targets
- CMS may **adjust Medicare FFS hospital global budgets** or require a **corrective action plan** and/or **adjust Enhanced Primary Care Payments** if the state does not meet

Primary care investment

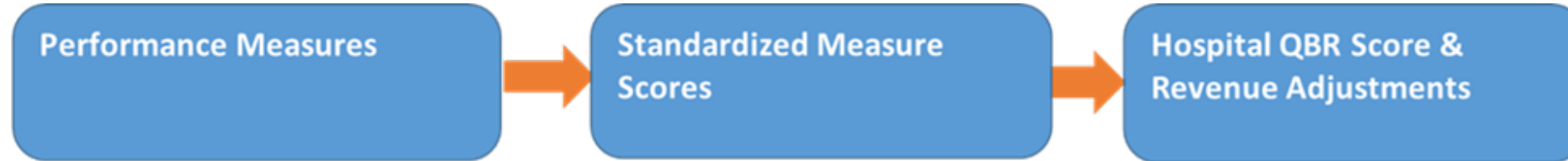
- Includes **all-payer** and **Medicare FFS** targets
- Includes **annual** improvement targets and a **final** primary care investment target
- CMS will set a standard definition of primary care for Medicare FFS measurement, but State may use **existing definition** of primary care for all-payer measurement

Equity and Population Health

- Includes **statewide and primary care measures**, as well as **hospital quality programs**, each with a **health equity focus**.
- The Model will use reliable population health measures in the areas of (1) **Prevention and Wellness**, (2) **Population Health** (including **chronic conditions**), (3) **Behavioral Health**, and (4) **Health Care Quality and Utilization**

QBR RY 2026 Discussion Topics

QBR RY 2026 Program



Domain and Measures:

Person and Community Engagement—
 -8 HCAHPS categories;
 -Timely Follow Up (TFU) Medicare and Medicaid & TFU Disparity Gap*
 -ED LOS, admitted patients*

Safety— 6 Measures:
 -5 CDC NHSN HAI Categories;
 -AHRQ PSI 90 All-payer

Clinical Care—
 --Mortality Inpatient, 30-day All-payer*

■ Person and Community Engagement
 ■ Clinical Care
 ■ Safety

***New in RY 2026**

Individual Measures are Converted to 0-10 Points:

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

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

Final Points are Better of Improvement or Attainment

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

Scale Ranges from 0-80%

Max Penalty 2% & Reward +2%

(ALL HOSPITALS HAVE OPPORTUNITY TO EARN REWARD)

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

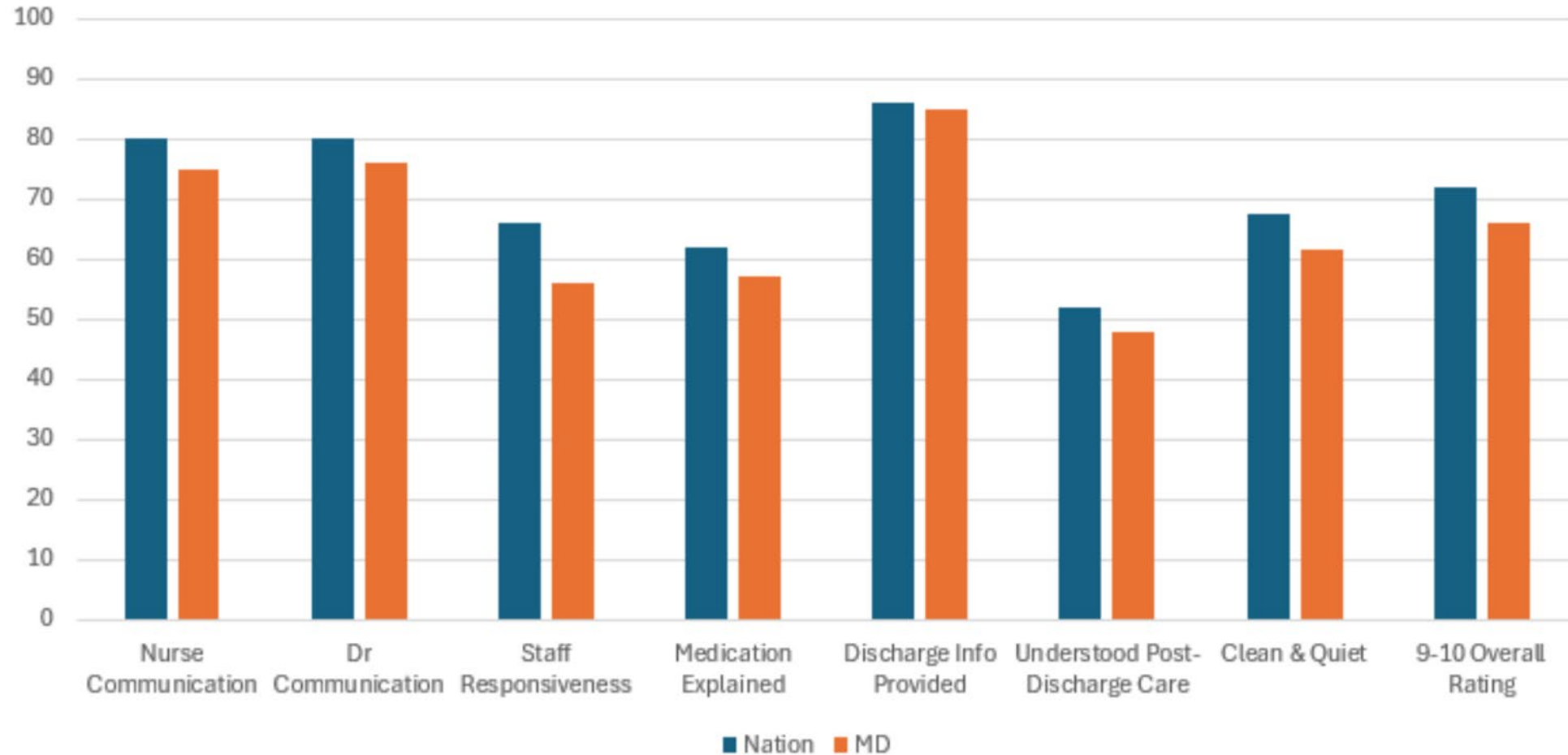
QBR RY 2027 Make Minimal, if any, Changes from RY 2026

- HCAHPS improvement framework
 - Maryland continues to lag compared to the Nation
 - HSCRC will support a co-led HCAHPS Learning Collaborative
- ED LOS measure updates
 - Staff will vet performance standards, propose to develop and monitor risk-adjusted ED LOS attainment measure, and revenue adjustment options for this measure for RY 2027
- Monitoring Digital Measures
 - Staff presents measure results by hospital and statewide
 - Staff does not propose any changes from CY 2024 to the measures for the CY 2025 reporting period

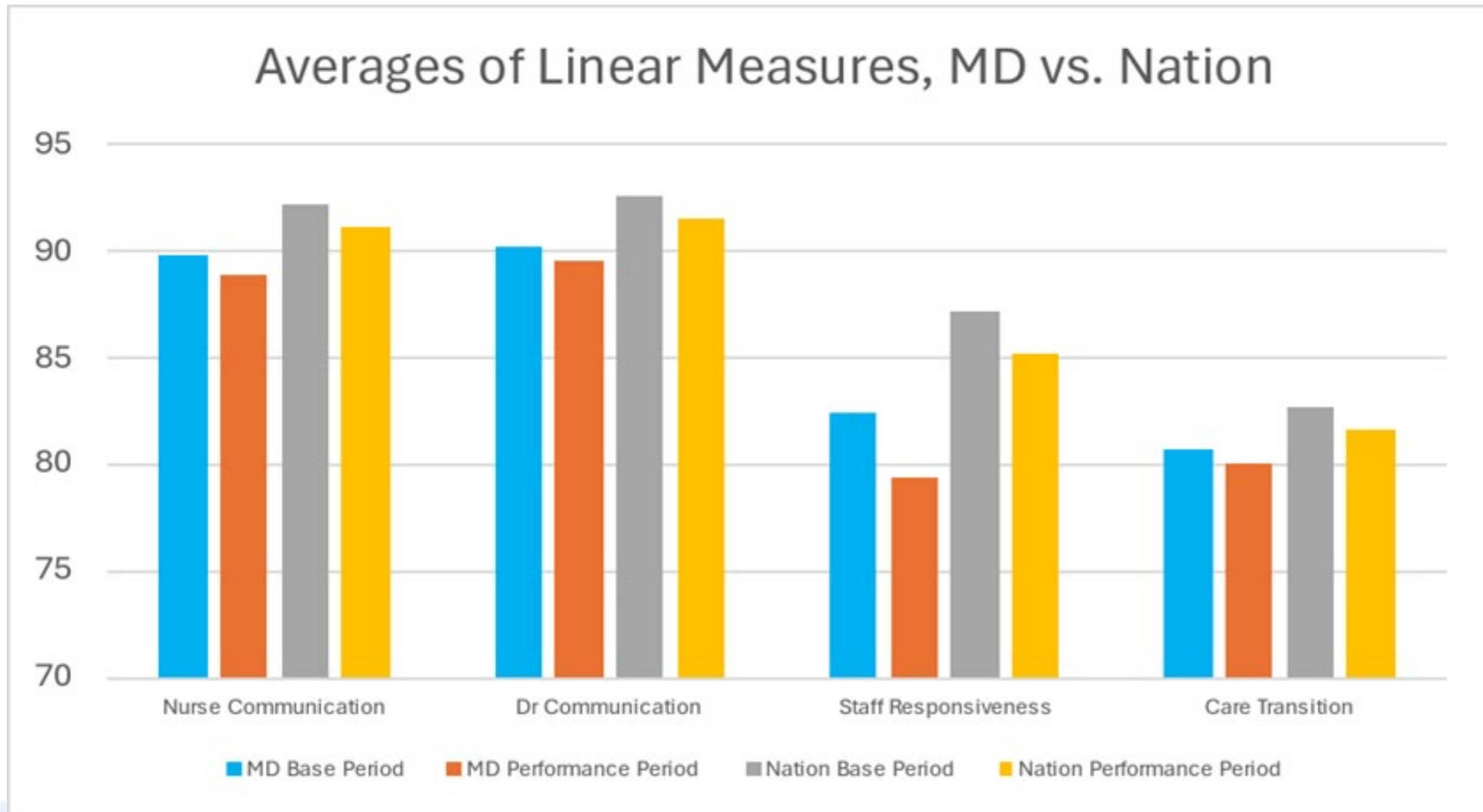
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

HCAHPS Most Recent Available Performance

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



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



MHCC Analyzed 30,653 Patient Surveys Collected Between July 2022 and June 2023 Revealing Disparities in Responses

- White respondents are more highly represented than Black or other respondent categories relative to their proportion in Maryland's population from the 2020 Census.^[1]
 - 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 94% 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 Maternity comprising 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

^[1] Percents by race rounded up to full digit values.

HCAHPS Next Steps

- Commence work on the HCAHPS Best Practices improvement collaborative
- Collaborate with MHCC on data collection and ongoing analysis
- Continue analysis of supplemental questions, patient qualitative comments
- Discuss options, timing for adding supplemental questions statewide to HCAHPS survey, if appropriate

HSCRC Learning Collaborative to Target HCAHPS Improvement

- See Jonathan Sach's HCAHPS Commission presentation in Appendix

Emergency Department Policy Updates:

ED Wait Time Reduction Commission
ED - Hospital Throughput Best Practices
QBR Data Collection and Performance Standards Update

Today's Presentation

- Emergency Department Wait Time Reduction Commission
- Best Practices Incentive Policy
- ED QBR Performance Standards and Data Collection Update
- EDDIE Updates (in Appendix)

Establishment of Maryland ED Wait Time Reduction Commission

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

Annual Reports due Nov 2025 and Nov 2026

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

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

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

Commission Appointed Members

Chairs:

Secretary of Health –**Laura Herrera Scott, MD, MPH**

Executive Director of HSCRC–**Jon Kromm, PhD**

Appointed Members:

- Executive Director of MIEMSS–**Ted Delbridge, MD**
- Executive Director of MHCC–**Wynee Hawk, RN, JD**
- 1 Individ. with operation leadership experience in an ED (physician)–**Dan Morhaim, MD**
- 1 Individ. with operation leadership experience in an ED (physician)–**Neel Vibhakar, MD**
- 1 Individ with operations leadership experience in an ED (non-physician or APP)– **Barbara Maliszewski, RN**
- 1 representative from local EMS–**Danielle Knatz**
- 1 representative from a Managed Care Plan –**Amanda Bauer, DO**
- 1 representative of Advanced Primary Care Practice–**Mary Kim, MD**
- 1 representative from MHA–**Andrew Nicklas, JD**
- 1 representative from a patient advocacy organization–**Toby Gordon, ScD**
- 1 representative of a behavioral health provider–**Jonathan Davis, LPC**



ED Wait Time Reduction Commission:

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

Improve Access

Maryland Primary Care Program

Expand Behavioral Health Framework

SNF/Post-Acute

Hospital Payment Programs to Improve Clinical Care

MD Hospital Quality Policies

ED "Best Practices" incentive

Increase Transparency

MHCC Public Quality Reporting

ED Dramatic Improvement Effort

Reduction in Avoidable Utilization

Programs to optimize high value care and reduce avoidable utilization

Reducing the number of people who need the ED

Improving throughput within the hospital

Improving the hospital discharge process and post-ED community resources



ED Best Practice Incentive Update

ED Best Practices Incentive Policy Development

Draft Policy November 2024
Final Policy January 2025

Objective:

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

Description:

- Subgroup will advise on the development of 3-5 measures that will constitute a +/- 1% revenue at risk program for CY 2025 performance.
- Repurposing QBR ED Subgroup 2 to assist with this development, as well as other experts.
- Next Meeting: 9/27/2024 10 am - noon

ED LOS Improvement Initiatives

Literature Review Overview

ED Inputs
GP-led walk-in centers / Co-located GP
Extended GP opening hours
Choice of ED
Social interventions including; education campaigns, financial disincentives, redirection
Posting wait times
Patients make ED appointments
Forecast spikes in census, manage resources, and balance elective admissions.

ED Output
Active bed management
Leadership program/Support
Implementation of nationally mandated, timed patient disposition targets
ED staff direct admit rights
Admitting team priorities ED admissions
Alternative admission policies (i.e., admitting MD to see patient on the floor vs. ED)
Increased inpatient beds and staff
Inpatient Admissions Unit within ED
Move ED patients to other holding areas
Provide a discharge lounge
Early inpatient discharge planning

ED Throughput	
Split ESI 3 on presentation	Nurse initiated protocols (aka clinical practice pathways)
Earlier physician assessment, including physician-led/supported triage	Earlier inpatient consultation
Fast-track / flexible care area	Increased ED bed numbers
Rapid Medical Evaluation Team	Increased ED staff
Shorter turnaround-times for laboratory tests & point of care tests	Medical scribes
Shift tests and procedures to outpatient when possible; cancel tests not necessary	Maximize use of EHR functionality
ED nurse flow coordinator	Apply LEAN methodology to identify bottlenecks
Bedside registration/ registration kiosks	Straight-back process brings a patient to bed when open, skip triage
Patient communication, education, and follow up	

ED LOS Improvement Initiatives - Commonalities

- **Admission Unit** - Cleveland Clinic opened an 8-bed inpatient Admissions Unit within the ED, reducing LOS by 30 minutes.
- **Rapid Medical Evaluation (RME) Team** - Oregon Health & Science Univ. Created RME team for peak hours to evaluate and treat lower acuity patients, initial results showed a 35% reduction in similar patients' LOS.
- **Providers in triage** – shown improved patient flow, satisfaction, decreased LOS, LWBS, and mortality within 7 days.
- **Apply LEAN methodology** - One ED identified the following areas of improvement that shortened LOS by 1.5 hours: match **staffing with volume** and **implement fast-track** for low acuity patients.
- **Clinical Practice Pathways** – one study showed orders initiated by nurses have been associated with 16% reduction of in-room ED care.
- **Rapid registration** – saves an average of 30 minutes LOS.

ED LOS Improvement Initiatives - Discussion

- **Which improvement initiatives have your organization implemented?**
- **Which were successful? Or did not meet expectations/goals?**
- **Were there notable lessons learned that you can share?**
- **Are there initiatives that your organization has not tried? Is there a reason?**

ED Best Practices: Stakeholder Feedback Requested and Welcomed

- ED Subgroup 2 members will submit Best Practice suggestions by 9/20
- Suggestions will be compiled and shared with the ED Subgroup 2 by 9/25
- Suggestions will be discussed on 9/27 during the ED Subgroup 2 meeting
- Recommendations for incentive scaling will also be discussed (i.e. do we work up to +/-1% rather than start at +/-1% in CY 2025)
- Please feel free to share any recommendations for ED Best Practices for consideration at the 9/27 meeting

QBR ED Performance Standards and Data Collection Update

QBR ED LOS Data Collection Update

- Deadline to submit patient level data was extended to 9/13
- HSCRC staff and hMetrix have been following up with hospitals with low match rates between the adhoc ED LOS data file and case mix data. Reasons for lack of matches includes:
 - Difference in admission dates - moving forward we will adjust naming of matching variables
 - **Patients who came to ED but Left without Being Seen do not have case mix data**
 - Duplicates
 - Truncated MRNs
- Staff should have processed data by end of September; if errors are found hospitals may need to re-submit earlier quarters when the data is submitted in December.

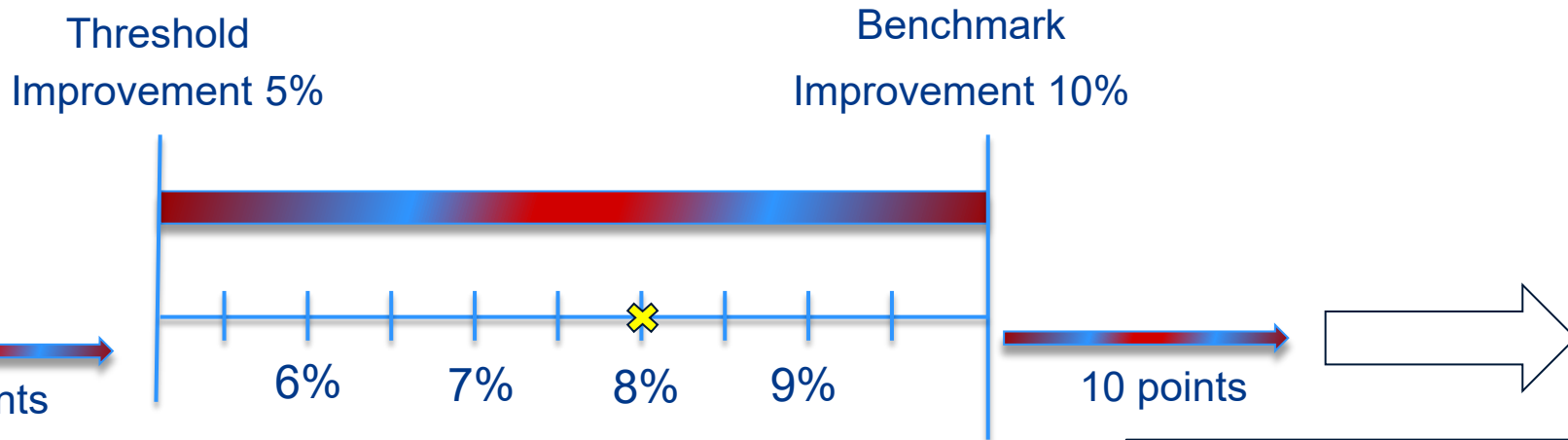
QBR ED LOS Incentive CY 2024

- 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

QBR Performance Standards

Performance Standard Options:

- Option 1:** Set 5% threshold and 10% benchmark for all hospitals (example below)
- Option 2:** Tier threshold and benchmark based on CY 2023 performance (best 1/3rd of hospitals: 0-5%; middle 1/3rd: 5-10%; lowest 1/3rd: 10-15%)



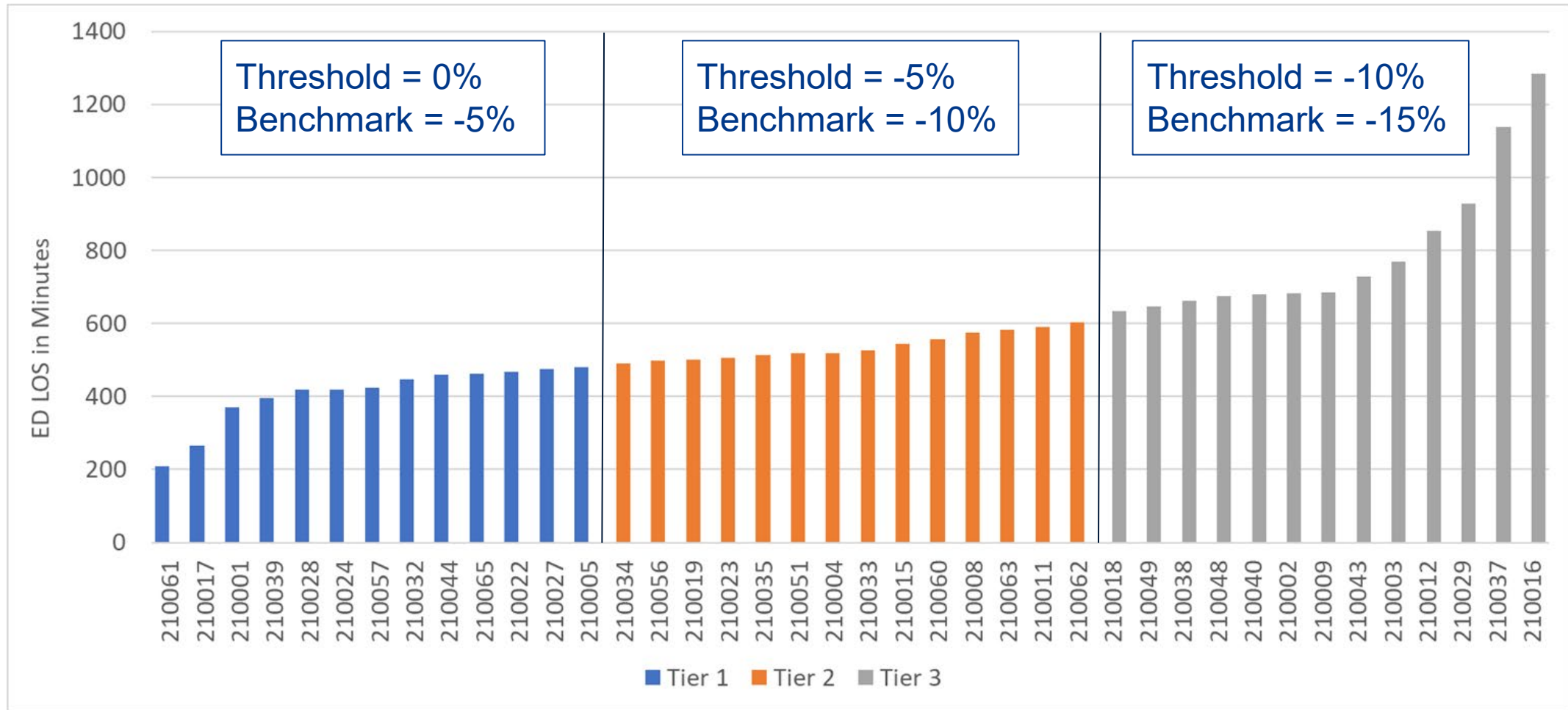
Hospital Improvement = 8.0%
Calculates to a score of 6 out of 10

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%

Tiered Performance Standards



Statewide Revenue Adjustment Modeling

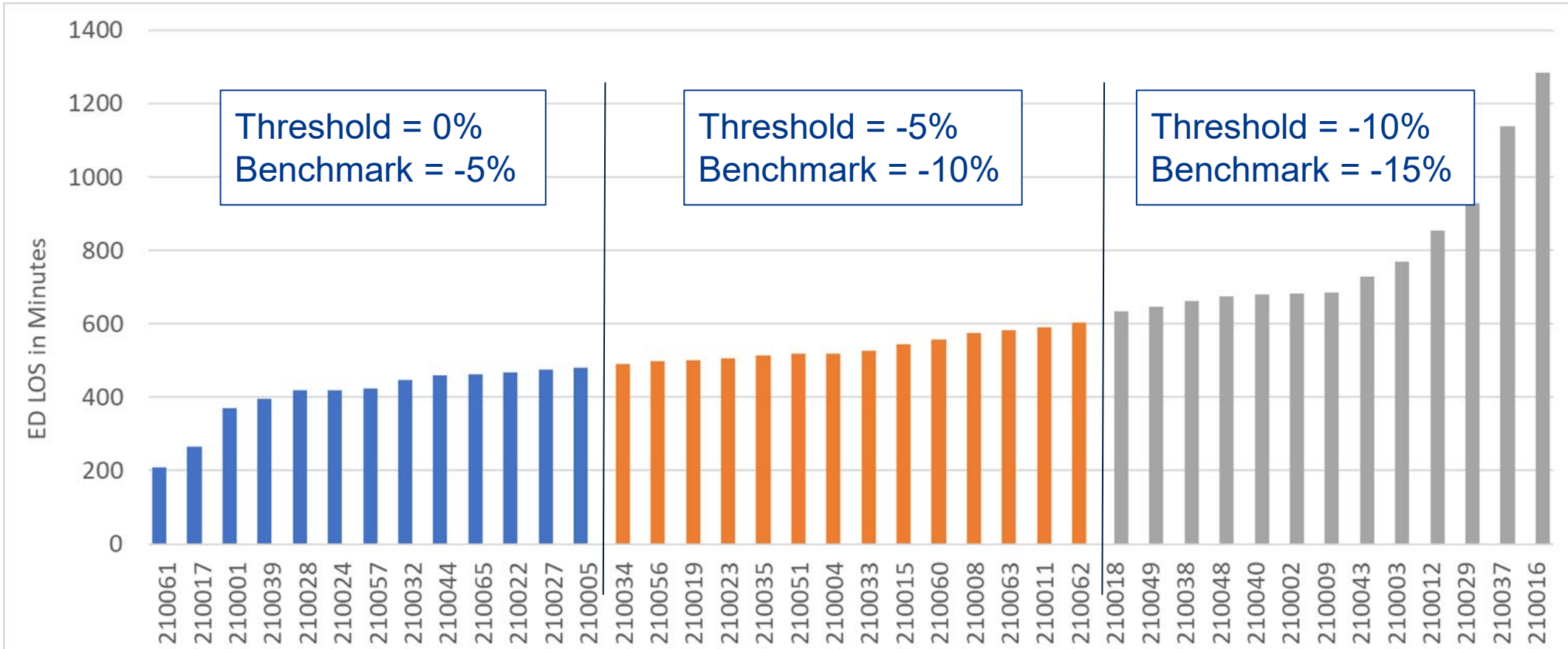
#	Model	Threshold/Benchmark	Hospital Performance	Statewide Revenue Adjustments		
				Net	Penalty	Rewards
1	QBR without ED LOS	NA	NA	-79,998,636	-80,756,911	758,275
2a	QBR with ED LOS	All hospitals -5% and -10%	0%	-90,050,122	-90,493,387	443,265
2b	QBR with ED LOS	All hospitals -5% and -10%	-7.50%	-62,659,360	-63,570,366	911,006
2c	QBR with ED LOS	All hospitals -5% and -10%	-10%	-35,425,725	-37,638,191	2,212,466
3a	QBR with ED LOS	Tiered improvement target	0%	-88,947,242	-89,451,977	504,735
3b	QBR with ED LOS	Tiered improvement target	-7.50%	-71,600,470	-73,261,524	1,661,054
3c	QBR with ED LOS	Tiered improvement target	-10%	-61,090,152	-63,302,618	2,212,466
3d	QBR with ED LOS	Tiered improvement target	EDDIE 2024 YTD	-80,999,304	-82,414,987	1,415,683

Highest Penalties

Lowest Penalties

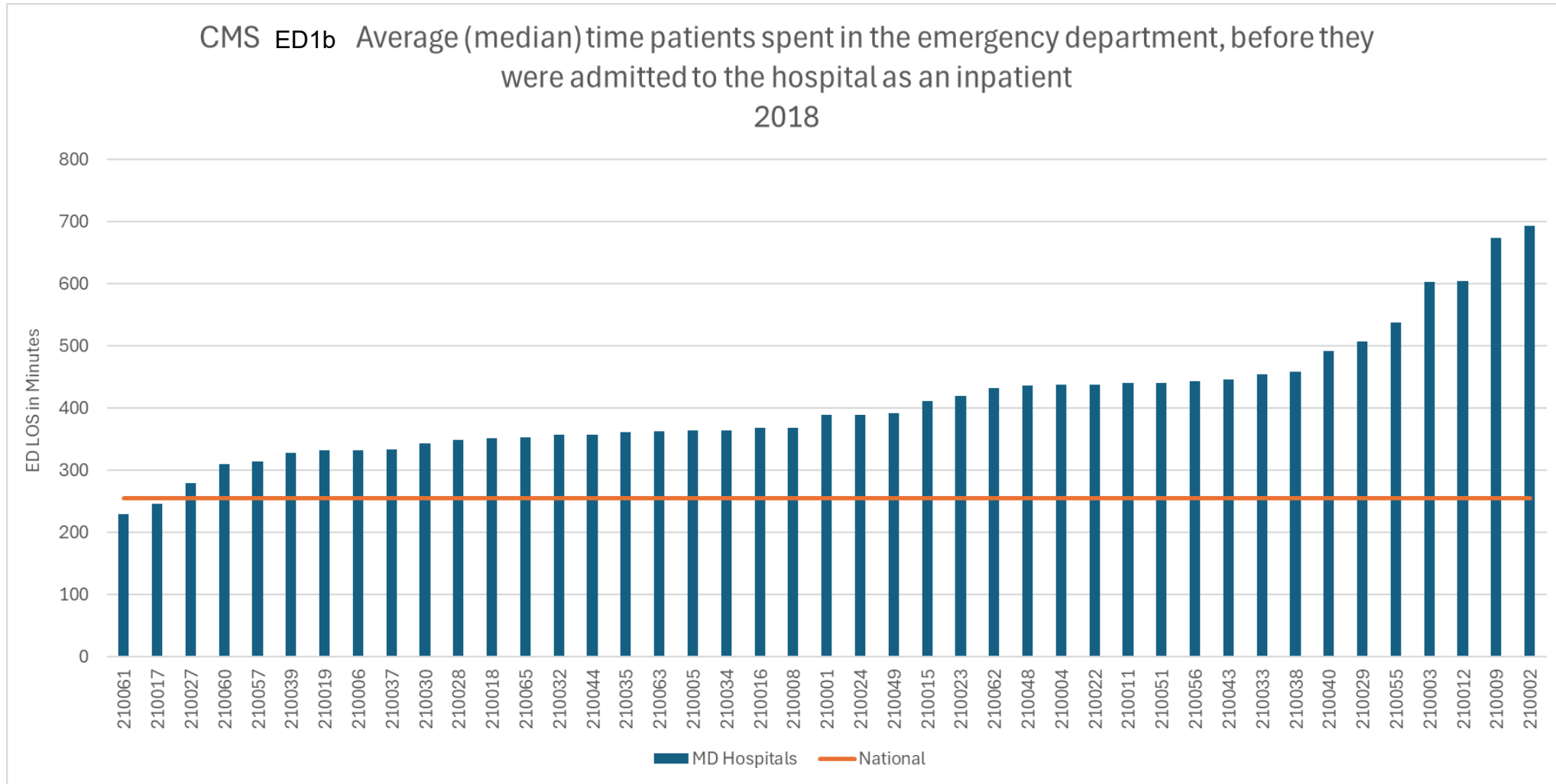
- Regardless of performance standards, the red and green boxes show the worse and best case scenario
- High “up-side”
- Reduces weight on HCAHPS top box scores

Tiered Performance Standards



Unit ID	ED LOS in Minutes	Net change in \$ with EDDIE proxy vs. No ED	June 23 - June 24 Rolling 12 month improvement
210061	200	\$104,344	-3.37%
210017	270	\$79,129	-6.06%
210001	370	\$189,153	-2.16%
210039	390	-\$205,250	3.53%
210028	410	\$422,442	-9.33%
210024	410	\$765,717	-3.81%
210057	420	-\$128,418	10.64%
210032	440	-\$108,678	5.58%
210044	450	-\$203,916	2.18%
210065	460	\$127,060	-1.73%
210022	460	-\$249,947	0.85%
210027	470	-\$76,092	-0.21%
210005	480	\$1,074,354	-14.35%
210034	490	\$517,700	-14.05%
210056	490	-\$95,749	6.24%
210019	490	-\$185,085	-4.19%
210023	490	-\$424,056	6.93%
210035	500	-\$59,016	0.39%
210051	500	\$688,044	-19.88%
210004	500	-\$158,965	-0.19%
210033	510	-\$78,684	12.36%
210015	520	\$575,274	-7.54%
210060	530	\$22,150	-5.73%
210008	540	\$867,077	-19.48%
210063	550	-\$336,309	5.15%
210011	550	-\$140,066	5.58%
210062	560	-\$19,647	-1.66%
210018	620	\$390,751	-26.44%
210049	630	-\$100,562	25.46%
210038	640	-\$165,437	-6.50%
210048	650	-\$149,850	13.19%
210040	650	\$220,109	-12.06%
210002	650	-\$1,277,508	-1.03%
210009	650	-\$2,724,345	-4.66%
210043	680	-\$261,168	-1.51%
210003	730	-\$253,804	-4.55%
210012	820	-\$154,616	-8.09%
210029	880	-\$364,138	12.18%
210037	1080	-\$47,973	-1.32%
210016	1250	\$925,307	-17.74%

Maryland vs. National Comparison: Older Data



Next Steps

- Review revenue adjustment modeling with Subgroup
- Propose performance standards to Commissioners in October for CY 2024
- RY 2027:
 - Propose updated performance standards for improvement
 - Recommend development of a risk-adjusted ED LOS measure for attainment monitoring
 - Maintain ED LOS of weight of 10 percent of QBR
- Use ad-hoc data to calculate CY 2023 base period ED LOS
 - Identify and data concerns
 - Calculate median and means, and tier hospitals (TBD) for non-psych patients
 - Analyze ED LOS by various characteristics

State Digital Measures Update

CMS is Driving Development and Use of Digital Quality Measures to Replace Claims-Based and Chart Abstracted Measures

PAPER TO DIGITAL REPORTING JOURNEY



Paper Quality Measures

Data from claims, manual chart abstractions and patient experience surveys.

- No digital standards
- Manual Specifications
- Custom programming for computations

Electronic Clinical Quality Measures (eCQMs)

Data primarily from electronic health records (EHRs)

- Quality Data Model (QDM)
- HQMF Specifications
- Clinical Quality Language
- Reports QRDA I and QRDA III

Digital Quality Measures (dQMs)

Data from EHRs, registries, HIEs, claims, patient experience surveys, etc.

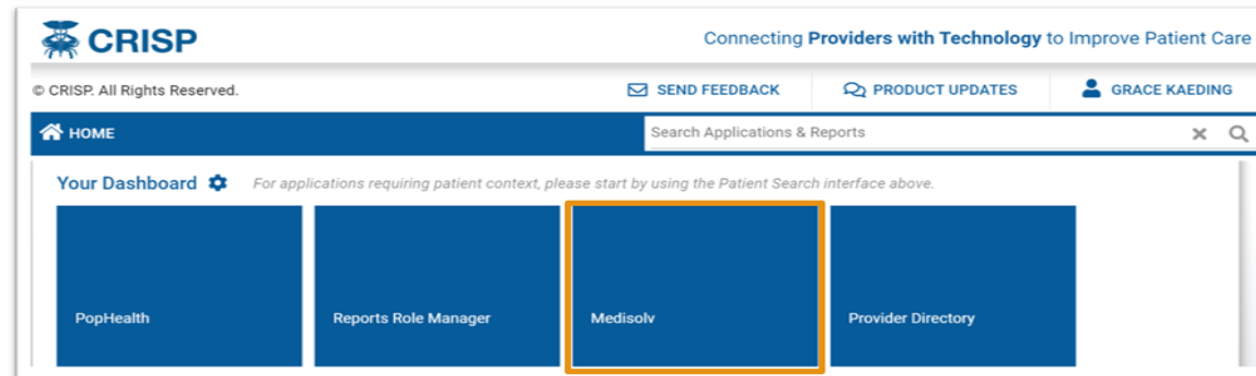
- FHIR QiCore/USCDI+QM Models
- Clinical Quality Language
- Measure Reports

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- Maryland Statewide Digital Measure Reporting Infrastructure: **Important** to Achieving Maryland's Quality Goals
 - In June 2022, Maryland became the first state in the country to successfully begin receiving STATEWIDE eCQM data from Maryland hospitals and subsequently HWR HWM Hybrid measures

HSCRC is Working with Partners CRISP and Medisolv (Subcontractor to CRISP) to Implement Digital Measures Reporting

- Hospitals are required to submit quality performance data on a quarterly basis through the Medisolv Submission Portal (MSP). Hospitals also have access to preliminary submission data through the Encor-E application and finalized submitted data in the Platform application. MSP, Encor-E and Platform can all be accessed through CRISP's HIE Portal (portal.crisphealth.org) in the 'Medisolv' card.
- If you cannot access HIE Portal, please contact support@crisphealth.org



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CMS eCQM Reporting CY 2025-CY 2027

Reporting Period/ Payment Determination	Total Number of eCQMs Reported	eCQMs Required to be Reported
CY 2024/FY 2026 and CY 2025/FY 2027	6	Three self-selected eCQMs; <i>and</i> Safe Use of Opioids - Concurrent Prescribing eCQM; <i>and</i> Cesarean Birth eCQM; <i>and</i> Severe Obstetric Complications eCQM
CY 2026/FY 2028	8	Three self-selected eCQMs; <i>and</i> Safe Use of Opioids - Concurrent Prescribing eCQM; <i>and</i> Cesarean Birth eCQM; <i>and</i> Severe Obstetric Complications eCQM; <i>and</i> Hospital Harm - Severe Hyperglycemia eCQM; <i>and</i> Hospital Harm - Severe Hypoglycemia eCQM
CY 2027/FY 2029	9	Three self-selected eCQMs; <i>and</i> Safe Use of Opioids - Concurrent Prescribing eCQM; <i>and</i> Cesarean Birth eCQM; <i>and</i> Severe Obstetric Complications eCQM; <i>and</i> Hospital Harm - Severe Hyperglycemia eCQM; <i>and</i> Hospital Harm - Severe Hypoglycemia eCQM; <i>and</i> Hospital Harm - Opioid-Related Adverse Events eCQM

HSCRC CY 2025 Reporting Requirements for eCQM Measures Unchanged from CY 2024; hospitals must also Select Two Optional Measures

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

*Verify active CBE endorsement on the CMS certified consensus-based entity's [PQM website](#)

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

Maryland All-Payer Reporting is Expanded to Hospital Wide Readmission (HWR) and Hospital Wide Mortality Hybrid Measures

- HSCRC requires hospitals to submit CCDE for the HWR and HWM hybrid measures **on patients from all payers > 17 years of age** using HSCRC specifications starting July 1, 2024;
 - For the first 6 months of the performance period (July-December 2024), reporting begins in January 2025, and then quarterly thereafter for the January-June 2025 time period
 - For additional technical information regarding the Hybrid Measures CCDE submission requirements, HSCRC, CRISP and Medisolv conducted and recorded a webinar on February 6, 2024, that is posted to the [CRISP eCQM webpage](#) (click on “Webinar” in the top bar of the page).
- **CCDE Data Completeness**
 - Consistent with the CMS requirements:
 - At least 95 percent of encounters must have all seven (7) linking variables documented and included in the QRDA files; these include first name, last name, DOB, street address, city, state, zip code;
 - At least 90 percent of encounters must have all required labs results within specification logic timing requirements and included in the QRDA files; and
 - At least 90 percent of encounters must have all required vital signs documented within specification logic timing requirements and included in the QRDA files.
 - **The Commission will reevaluate data completeness standards as all-payer CCDE is received and analyzed**

Proposed eCQM and Hybrid Measures Submission Timelines

eCQM CY 2025 Performance Period Submission Windows*

	Q1 2025 data	Open:	7/15/2025	
Close:	9/30/2025			
	Q2 2025 data	Open:	7/15/2025	Close: 9/30/2025
	Q3 2025 data	Open:	10/15/2025	Close: 12/30/2025
CMS Timeline:	Q4 2025 data	Open:	1/15/2026	Close: 3/31/2026

Hybrid Measures CCDE July 1, 2024 -June 30, 2025, Performance Submission Windows*

	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
CMS Timeline:	Q2 2025 data	Open:	7/15/2025	Close: 9/30/2025

***Note: for CY 2023-2024 reporting, HSCRC granted Exceptional Circumstances Exemption requests for submission timeline adjustments more aligned with CMS requirements**

Digital Measures Reporting Going Forward

- For hospitals unable to comply with the data submission requirements (including the timelines) for reasons beyond their control, they must submit an Extraordinary Circumstance Exception (ECE) request in accordance with the [Maryland Hospital Extraordinary Circumstances Exception \(ECE\) Policy](#) for HSCRC consideration. [1]
- If a hospital is found non-compliant with reporting requirements, they may be subject to corrective action, including one-time Global Budget Revenue adjustments and/or penalties under the performance-based payment programs.[2]
- Although the Commission has been flexible with granting ECE requests in the initial reporting periods, going forward, reporting compliance will be more strictly evaluated and enforced.

[1] Maryland 'uses CMS' guidance on ECE consideration. Per [CMS guidance](#), "Such circumstances may include, but are not limited to, natural disasters (such as a hurricane or flood) or systemic problems with CMS' data collection systems that directly affected the ability of facilities to submit data."

[2] Pursuant to regulation, COMAR 10.37.01.03R, which states that any "required report submitted to the Commission which is substantially incomplete or inaccurate may not be considered timely filed", HSCRC considers inaccurate or incomplete quality or case mix data not to be timely filed. Further, under this regulation, any hospital that does not file a report due under HSCRC law or regulation is liable for a fine of up to \$1,000 for each day the filing of the report is delayed.

- HSCRC will Continue to investigate measure options/limitations
- HSCRC will work with stakeholders to determine needed modifications/resources for "all-payer" measures/implementation
- HSCRC will work with auditing contractor or MHCC to design and implement eCQM measure auditing, public reporting

For detailed information and updates: [CRISP HSCRC Digital Measures Webpage](#)

RY 2025 Performance and Revenue Adjustments*

RY 2025 Quality Revenue Adjustments Summary

- MHAC
 - 26 hospitals received rewards; 8 performed in the hold harmless zone; 9 received penalties
 - State Net Total: ~\$39k
- RRIP
 - 20 hospitals rewarded; 24 hospitals penalized
 - State Net Total: ~\$14k
- RRIP-Disparity Gap
 - 20 hospitals saw a reduction in their disparities in readmissions; 2 received rewards
 - Total Rewards: ~1.8k
- QBR with 41% cutpoint
 - 36 hospitals to receive a penalty; 5 hospitals to receive a reward
 - State Net Total: ~(\$64k)



THANK YOU!

Next Meeting: Wednesday, October 18, 2024



Appendix



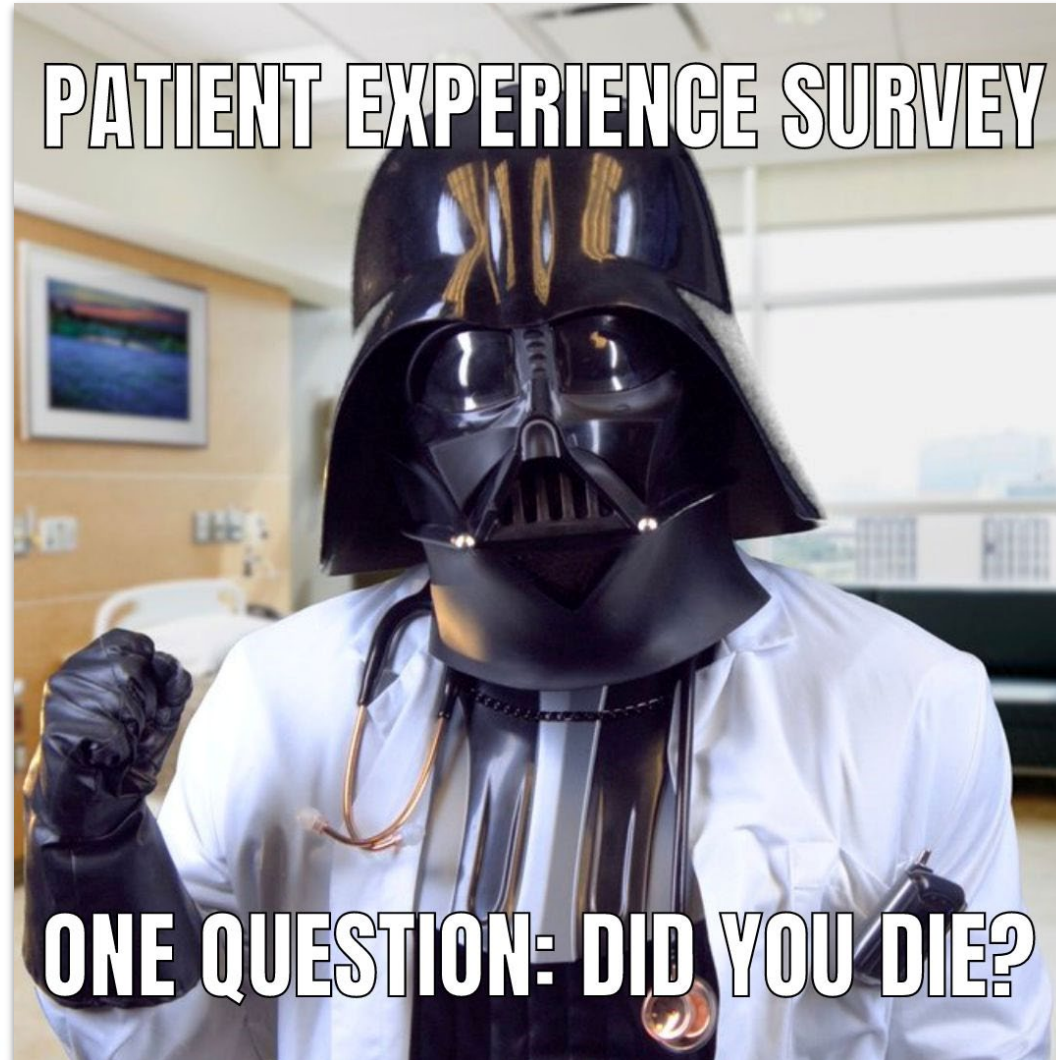
maryland
health services
cost review commission

Improving Patient Experience in Maryland

Jonathan Sachs, MBA, FACHE, PCC

September 11, 2024

Perceptions of Patient Experience



Outline

1. Context: What is Patient Experience?
2. HCAHPS 101 with Upcoming Changes
3. New Ways to Understand Patient Preferences
4. Maryland Hospitals Can Improve HCAHPS Scores
5. MHA Learning Collaborative
6. Concluding Thoughts
7. Q&A

About Me - Professional

- Patient experience consultant with the HSCRC
- Chief Executive Officer for a Patient Experience Tech Startup
- Chief Experience Officer, Robert Wood Johnson University Hospital
- Vice President of Experience Transformation, Adventist HealthCare
- Executive Director of Urgent Care Operations, Adventist HealthCare
- Director of Public Policy, Adventist HealthCare
- Intern, US House Energy and Commerce Committee during the ACA
- MBA and BA, University of Maryland, College Park
- Fellow, American College of HealthCare Executives
- Certificate, Health Care Innovation, Stanford University

About Me - Personal

- Sister with Development Disabilities
- Son to both parents who have had invasive neurosurgery
- Family and friend to patients
- Advocate for patients
- Husband
- Father of two boys
- Proud resident of Baltimore County
- Proud to have been raised in Montgomery County

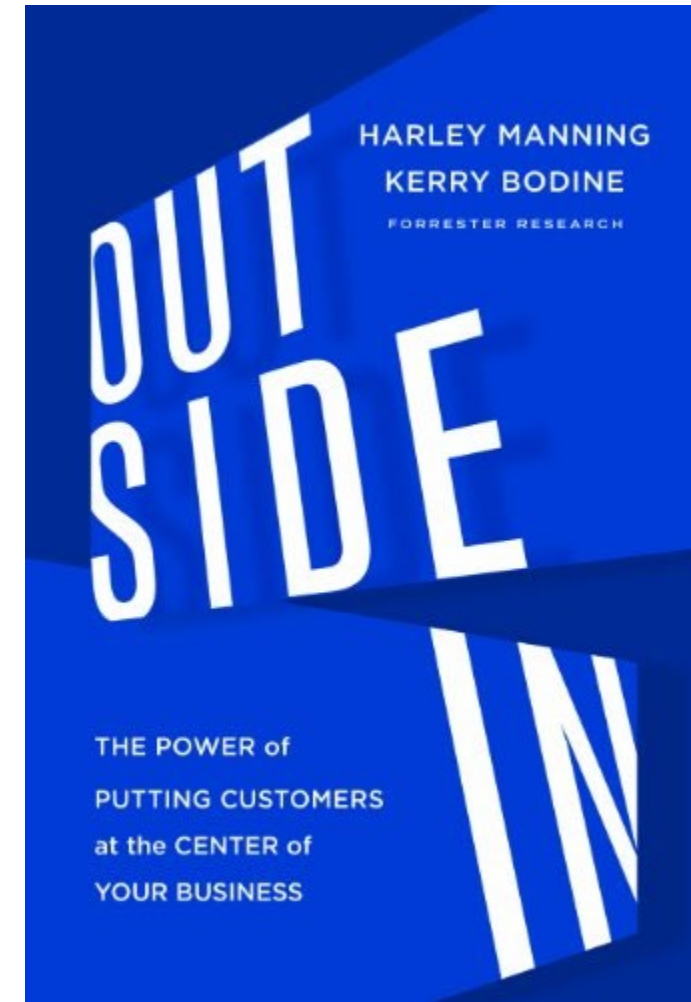
Setting the Context: What is Patient Experience

Outside In or Inside Out?

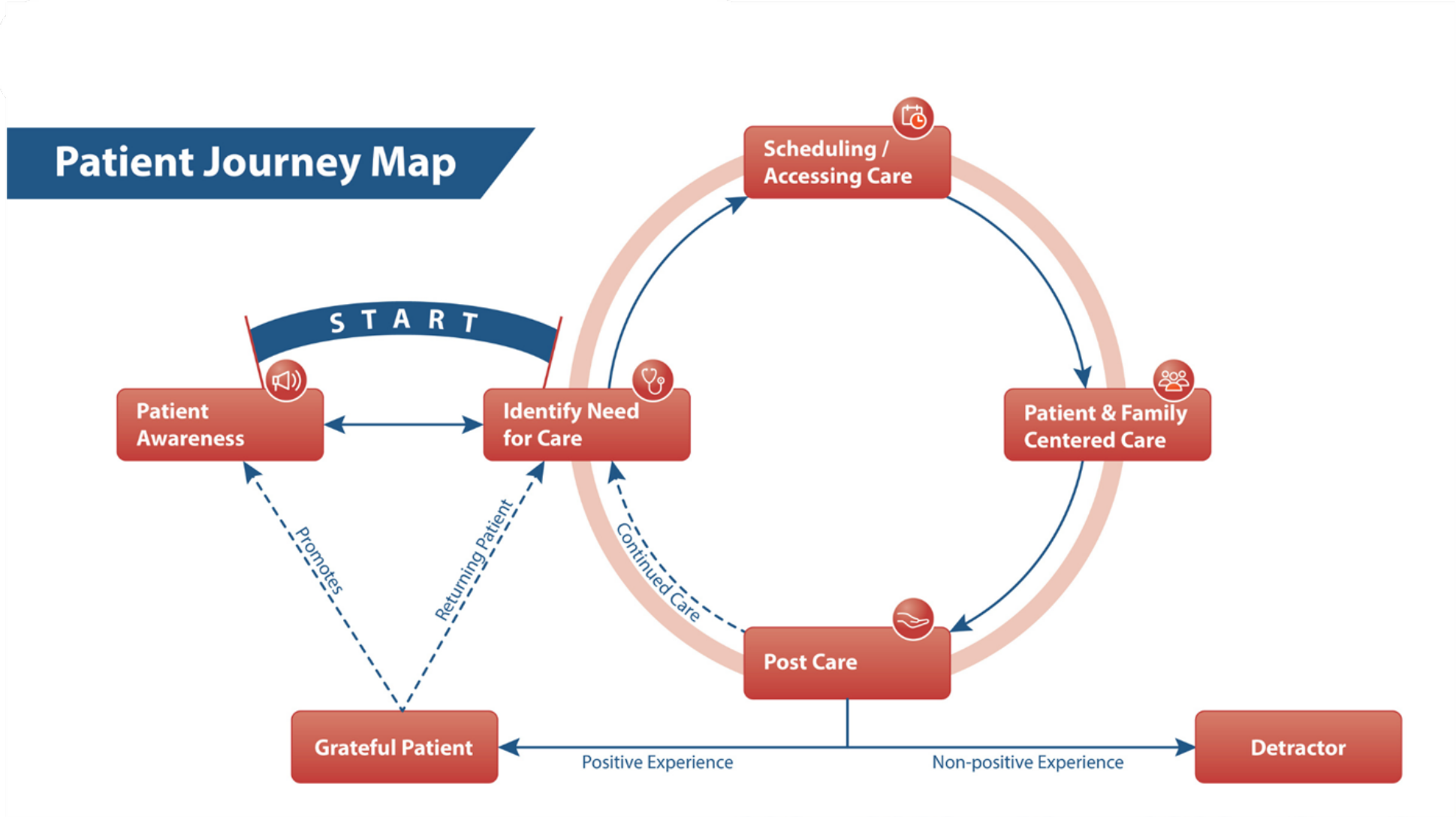


Outside In or Inside Out?

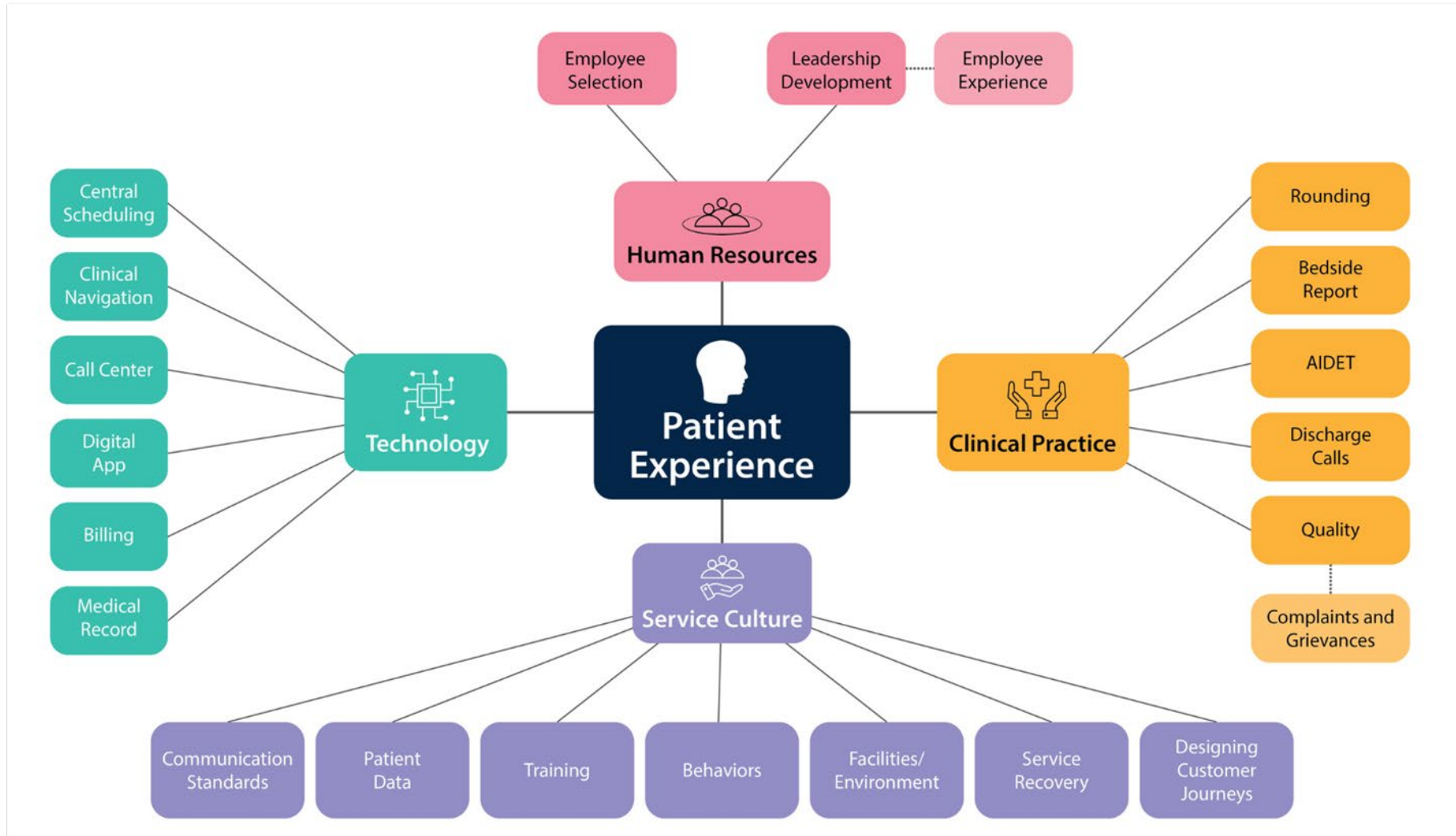
- Patient experience is how patients perceive their interactions with receiving care.
- Outside-In: Bringing the perspective of the patient to every decision we make.



Understanding the Patient Journey



What Must Come Together To Deliver A Positive Patient Exp?





HCAHPS 101

HCAHPS Goals

1. The survey is designed to produce comparable data on patients' perspectives of care that allows objective and meaningful comparisons among hospitals on topics that are important to consumers.
2. Public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care.
3. Public reporting serves to enhance public accountability in health care by increasing transparency.

How HCAHPS is Used

The screenshot shows the Medicare.gov website interface. At the top left is the Medicare.gov logo. To the right are navigation menus for 'Basics', 'Health & Drug Plans', and 'Providers & Services'. Further right are 'Chat' and 'Log in' buttons. The main content area features a large heading 'Find & compare providers near you.' and a photograph of a woman with short blonde hair wearing a blue and white striped shirt, holding a smartphone. Below the heading is a link: 'Not sure what type of provider you need? Learn more about the types of providers.' At the bottom, there are two cards: 'Welcome' with a binoculars icon and 'Doctors & clinicians' with a doctor icon. A larger card titled 'Find hospitals near me' contains the text: 'Find and compare information about the quality of care at over 4,000 Medicare-certified hospitals, including over 130 Veterans Administration (VA) medical centers and over 50 military hospitals, across the country.' A vertical 'Feedback' button is on the right side of the main content area.

Medicare.gov

Basics ▾ Health & Drug Plans ▾ Providers & Services ▾

Chat Log in

Find & compare providers near you.

Not sure what type of provider you need?
[Learn more about the types of providers.](#)

Welcome

Doctors & clinicians

Find hospitals near me

Find and compare information about the quality of care at over 4,000 Medicare-certified hospitals, including over 130 Veterans Administration (VA) medical centers and over 50 military hospitals, across the country.

Feedback

How HCAHPS is Used

1. **Northwest Hospital Center** 

3.4 mi **ACUTE CARE HOSPITALS**
5401 Old Court Road
Randallstown, MD 21133
(410) 521-2200

Overall star rating



Patient survey rating



[Compare](#) 

2. **Sinai Hospital of Baltimore** 

3.4 mi 
ACUTE CARE HOSPITALS
2401 West Belvedere Avenue
Baltimore, MD 21215
(410) 601-5131

Overall star rating



Patient survey rating



[Compare](#) 

How HCAHPS is Used

LEAPFROG
HOSPITAL
SAFETY GR**A**DE



maryland
health services
cost review commission

HCAHPS and Other Quality Measures



Relationship Between Patient-Reported Hospital Experience and 30-Day Mortality and Readmission Rates for Acute Myocardial Infarction, Heart Failure, and Pneumonia

Ning Dong, MD, MS¹, Jonathan D. Eisenberg, MD², Kumar Dharmarajan, MD, MBA^{3,4,5}, Erica S. Spatz, MD, MHS^{3,4}, and Nihar R. Desai, MD, MPH^{3,4}

Correlation Between Patient Experience and Outcome Measures

The HCAHPS overall satisfaction measures were inversely correlated with readmission rates for all three conditions assessed ($r = -0.22$ to -0.31 , $p < 0.001$) (Table 1). The overall satisfaction measures were also inversely associated with mortality rates for AMI and PNA ($r = -0.10$ to -0.20 , $p < 0.001$).

Maryland's Ranking – Overall Rating

46th

Source: hcahponline.org - 2023 Summary of HCAHPS Survey Results

Maryland's Ranking – Overall Rating

Top 5:

1. IA
2. KS
3. NE
4. SD
5. MN

Bottom 5:

49. NY
50. NJ
51. DC
52. PR
53. VI

Source: hcahponline.org - 2023 Summary of HCAHPS Survey Results

What HCAHPS Measures

- 22 Questions, followed by 7 demographic questions
- Typical scale:
 - Never - Usually - Sometimes - Always
- Domains:
 - Overall Rating
 - Communication with Nurses
 - Communication with Doctors
 - Responsiveness of Hospital Staff
 - Hospital Environment
 - Communication about Medicines
 - Communication about Pain***
 - Discharge Information
 - Care Transitions

***Omitted from QBR/VBP

What HCAHPS Measures

Domains	Questions
Doctor Communication	During this hospital stay, how often did doctors treat you with courtesy and respect?
	During this hospital stay, how often did doctors listen carefully to you?
	During this hospital stay, how often did doctors explain things in a way you could understand?
Responsiveness of Hospital Staff	During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
	During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
	How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?

- 1 Never
- 2 Sometimes
- 3 Usually
- 4 Always

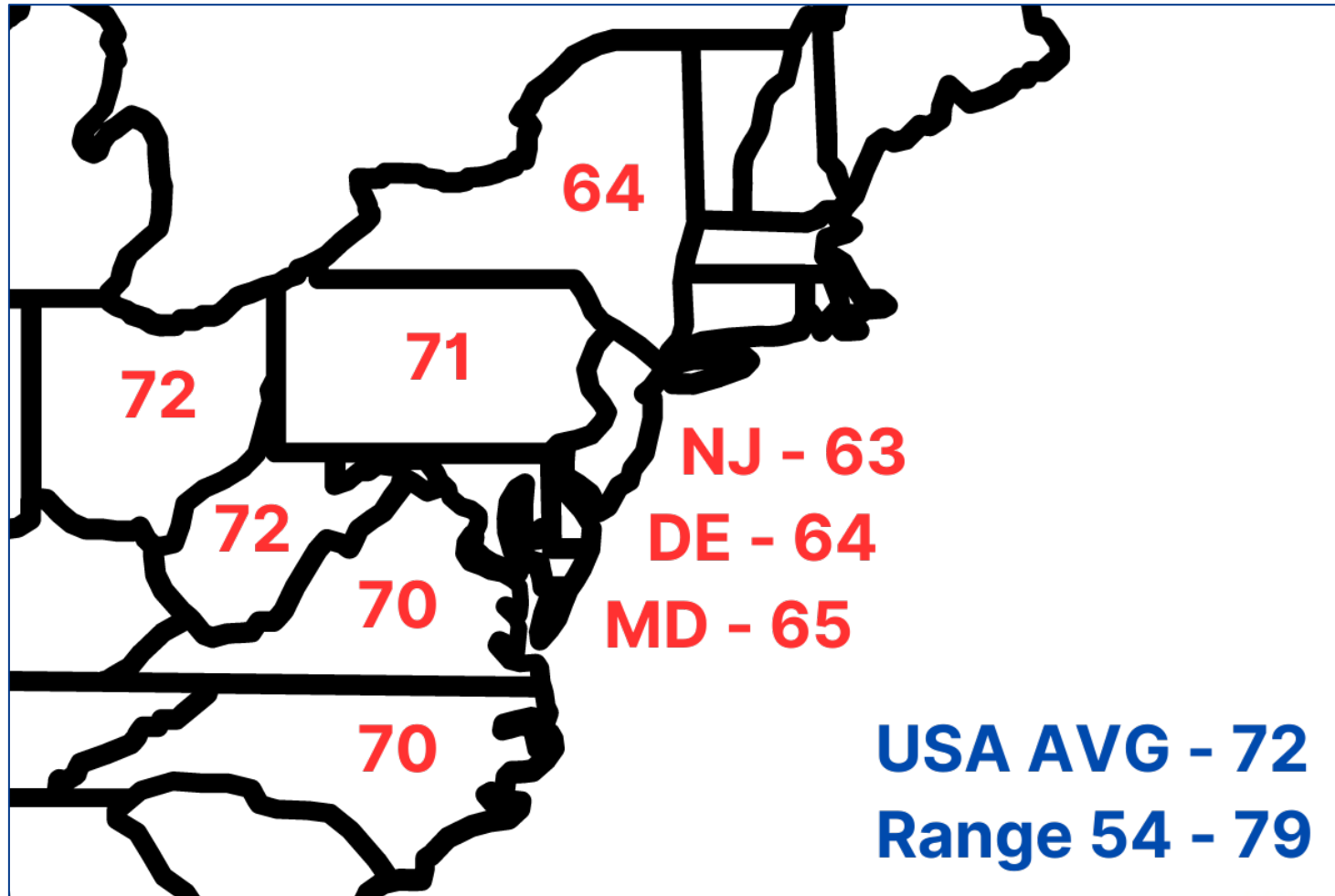
OVERALL RATING OF HOSPITAL

Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

18. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?

- 0 0 Worst hospital possible
- 1 1
- 2 2
- 3 3
- 4 4
- 5 5
- 6 6
- 7 7
- 8 8
- 9 9
- 10 10 Best hospital possible

Maryland's Ranking – Overall Rating



Source: hcahpsonline.org - 2023 Summary of HCAHPS Survey Results

New Regulations from CMS

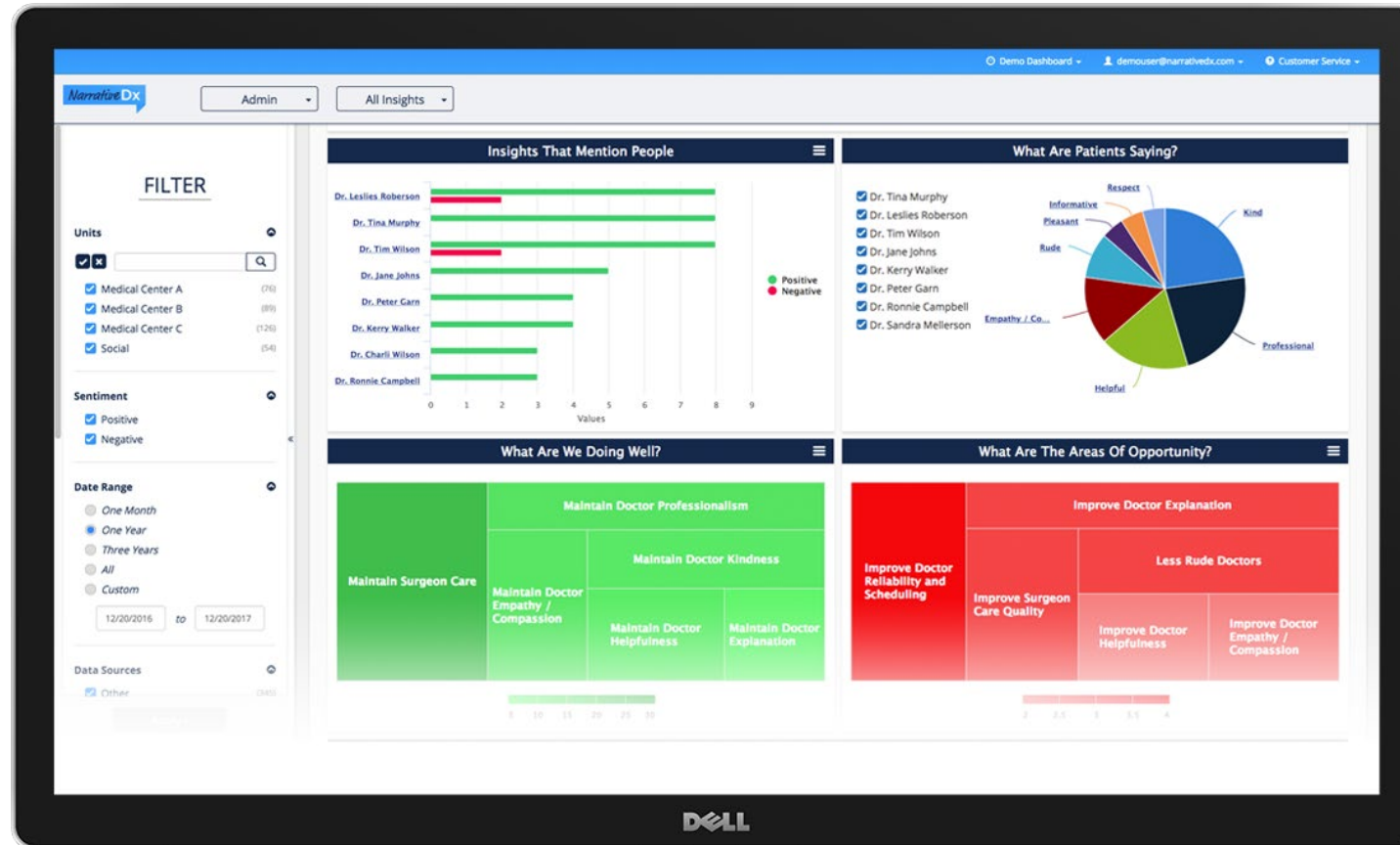
- “HCAHPS 2.0”
 - Coming January 1, 2025
- E-mail surveys
- Allow patient proxy
- Maximum 12 supplemental items
- Spanish language HCAHPS surveys to patients who note spanish language preference in the hospital

New Ways to Understand Patient Preferences

The Future of Patient Experience Measurement

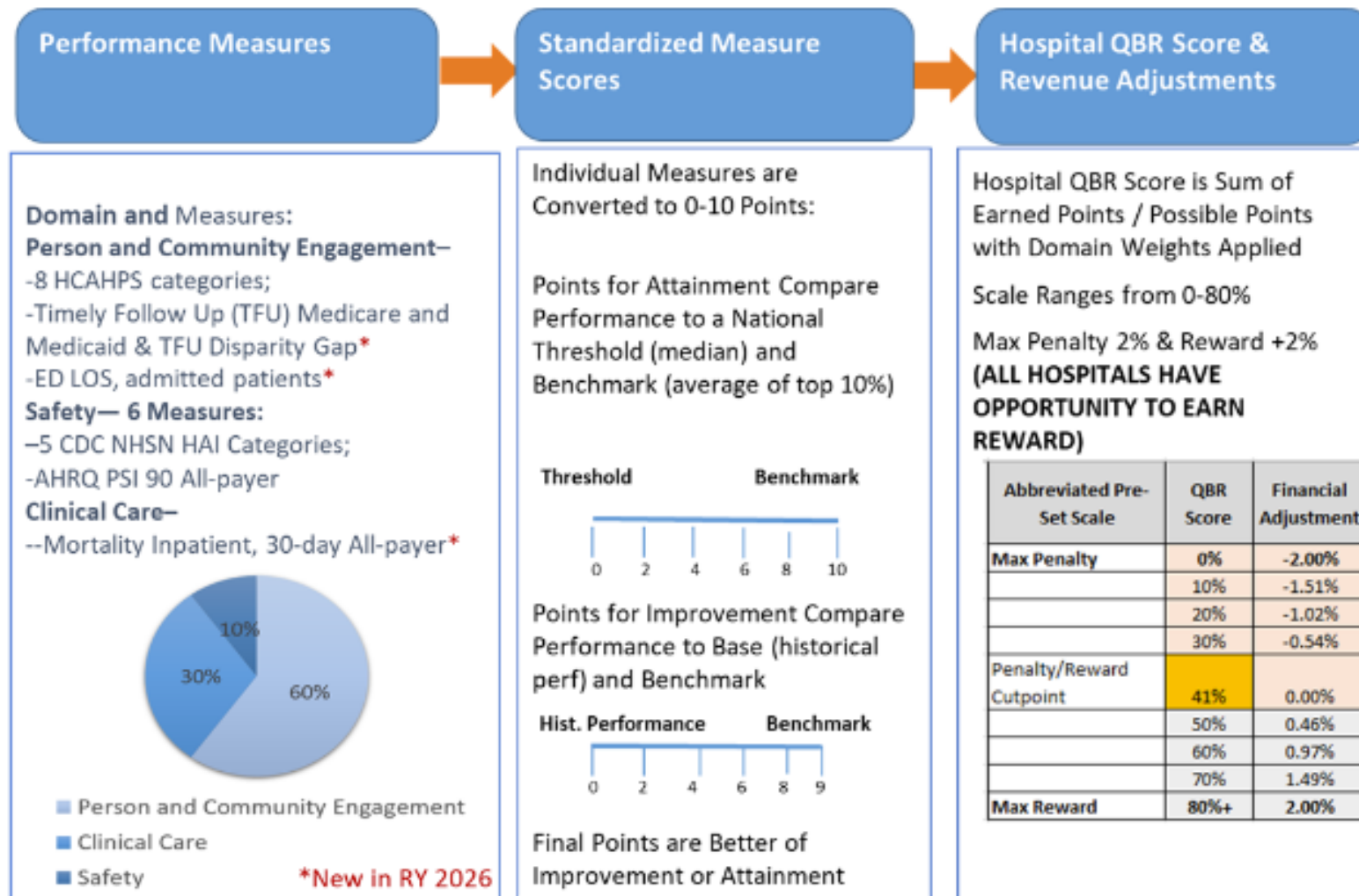


Using AI and NLP to Understand Patient Comments



Maryland Hospitals Can Improve HCAHPS Scores

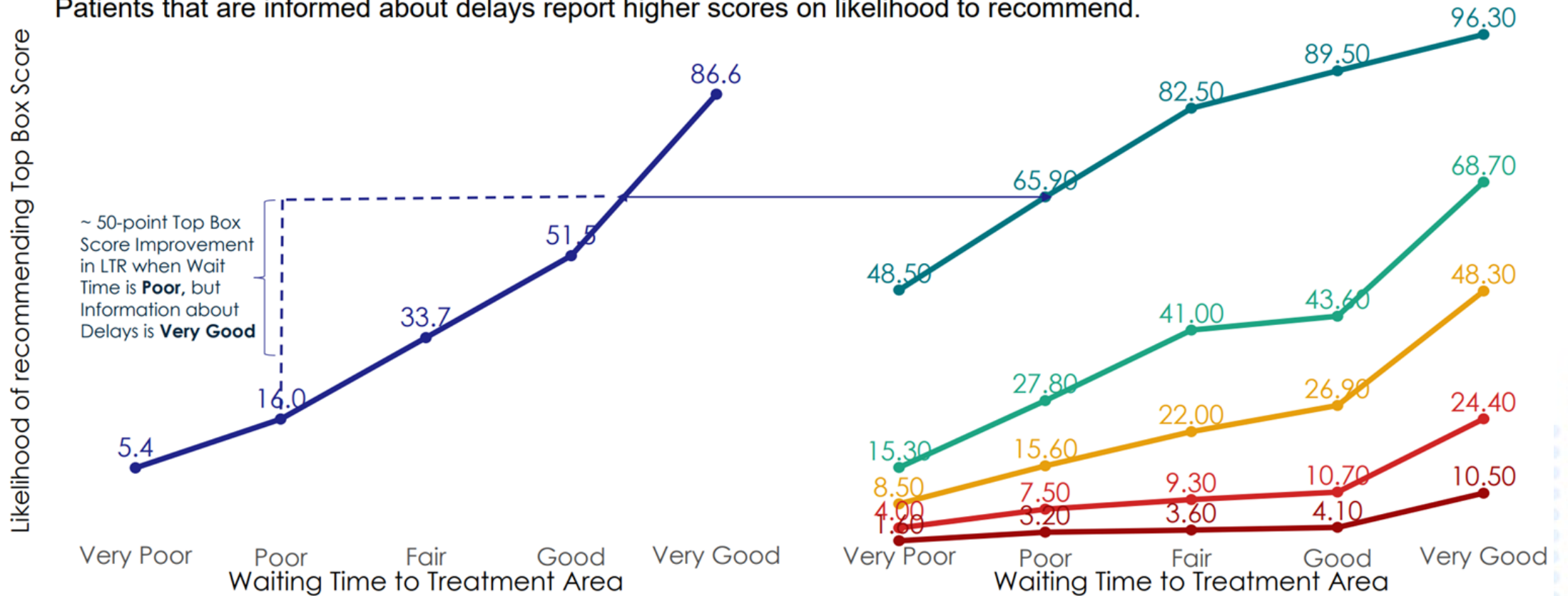
QBR Incentives for HCAHPS Performance



ED Wait Times

Impact of Perceptions of Wait Time/Informed about Delays on Emergency Department Likelihood to Recommend Scores

In 2023, Patients report higher scores related to likelihood to recommend with lower perceptions of wait times. Patients that are informed about delays report higher scores on likelihood to recommend.



~ 50-point Top Box Score Improvement in LTR when Wait Time is **Poor**, but Information about Delays is **Very Good**

Approx 3.4M survey responses for 2023 CY "All PG Database"

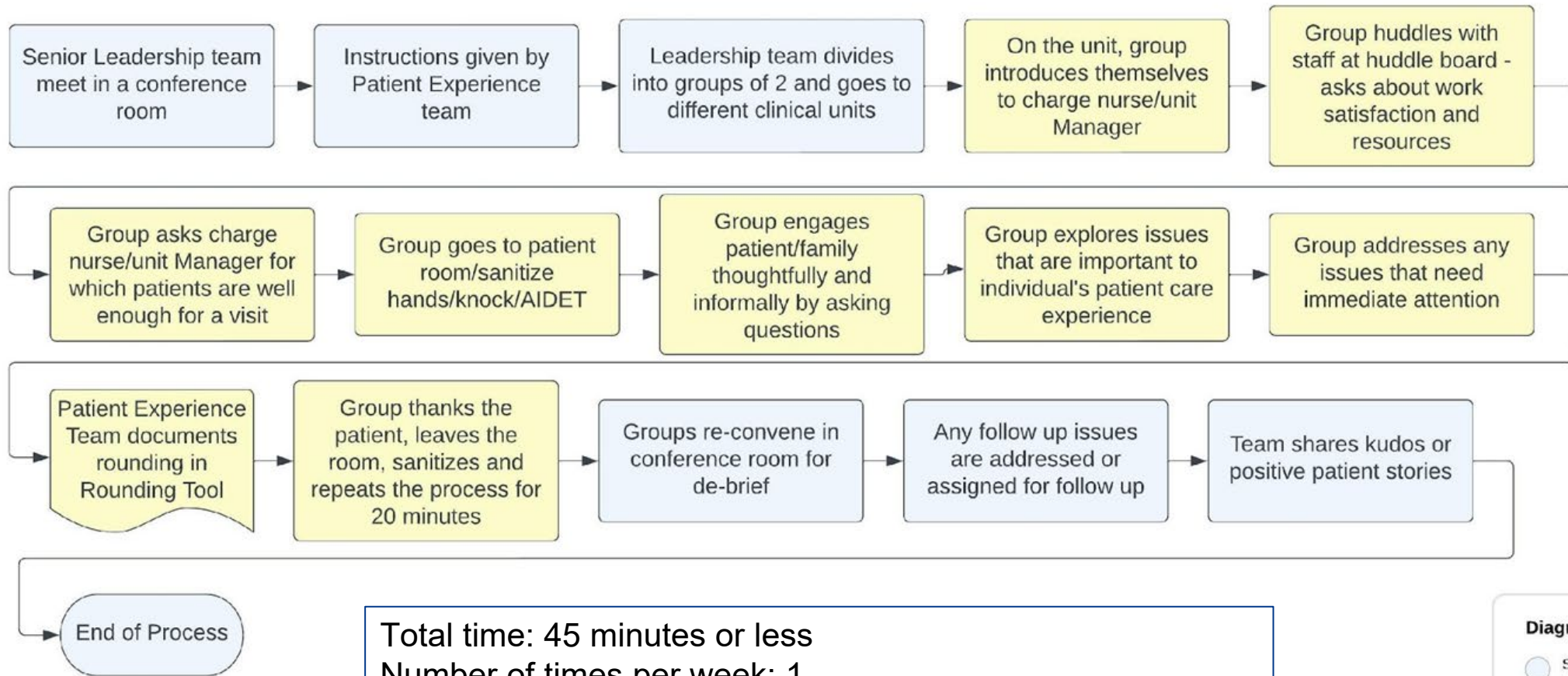


Informed about Delays ● Very Poor ● Poor ● Fair ● Good ● Very Good

Approx 1.6M survey responses for 2023 CY "All PG Database"

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Best Practice to Improve HCAHPS Fast



Total time: 45 minutes or less
 Number of times per week: 1
 Total number of patient clinical inpatient units (HCAHPS):
 -Adult: 34
 -Peds: 5
 -3 units/week = See patients in each unit about 4x per year



Best Practice to Improve HCAHPS Fast

Percentile Rank by Domain and Month

	Jan-23	Feb-23	Mar-23	Apr-23	2023 Year To Date
Overall Rating	18	41	45	76	39
<i>Overall Rating n-size</i>	330	325	351	166	1,172
Communication with Nurses	25	61	36	63	42
<i>Communication with Nurses n-size</i>	335	332	365	167	1,199
Communication with Doctors	21	42	35	63	36
<i>Communication with Doctors n-size</i>	335	332	363	167	1,197
Responsiveness of Hospital Staff	23	54	51	47	43
<i>Responsiveness of Hospital Staff n-size</i>	302	304	335	153	1,094

Data as of 5/11/2023

Learning Collaborative to Improve HCAHPS Scores

MHA Learning Collaborative

- **Who:**
 - Co-Lead with an MHA Representative
 - Hospital leaders responsible for HCHAPS Performance + National Survey Vendors
- **What:**
 - Compile and share best practices to help Maryland hospitals improve HCAHPS scores.
- **How:**
 - Analyze HCAHPS data
 - Sharing best practices, including from national experts
 - Quality improvement initiatives using PDSA cycles
- As a final work document, the learning collaborative will report findings to the HSCRC



Concluding Thoughts

Outline

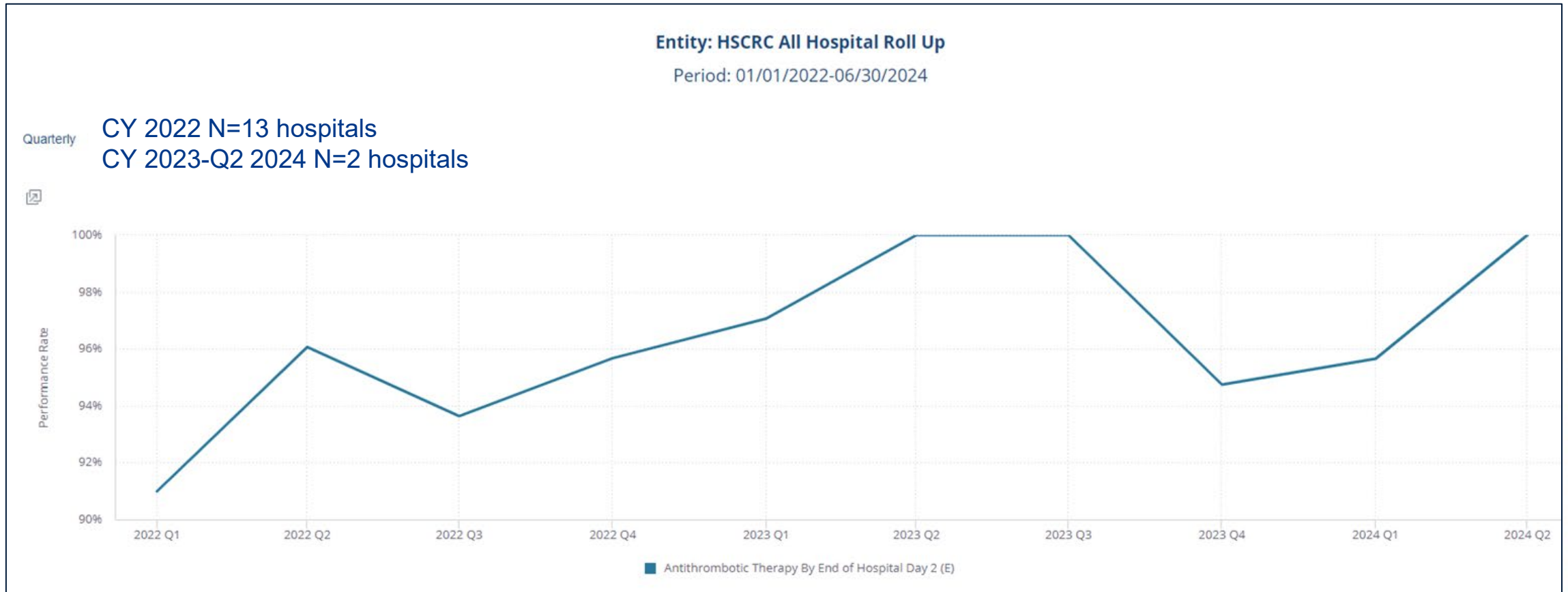
1. Context: What is Patient Experience?
2. HCAHPS 101 with Upcoming Changes
3. AI Can Help Us Understand the Patient Experience
4. Using Technology for Data Analysis
5. Maryland Hospitals Can and Must Improve HCAHPS Scores
6. MHA Learning Collaborative
7. Concluding Thoughts
8. Q&A

Patient Experience is Part of the Care Plan



Selected Digital Measures Trends

Antithrombotic Therapy by end of Hospital Day 2 Trend



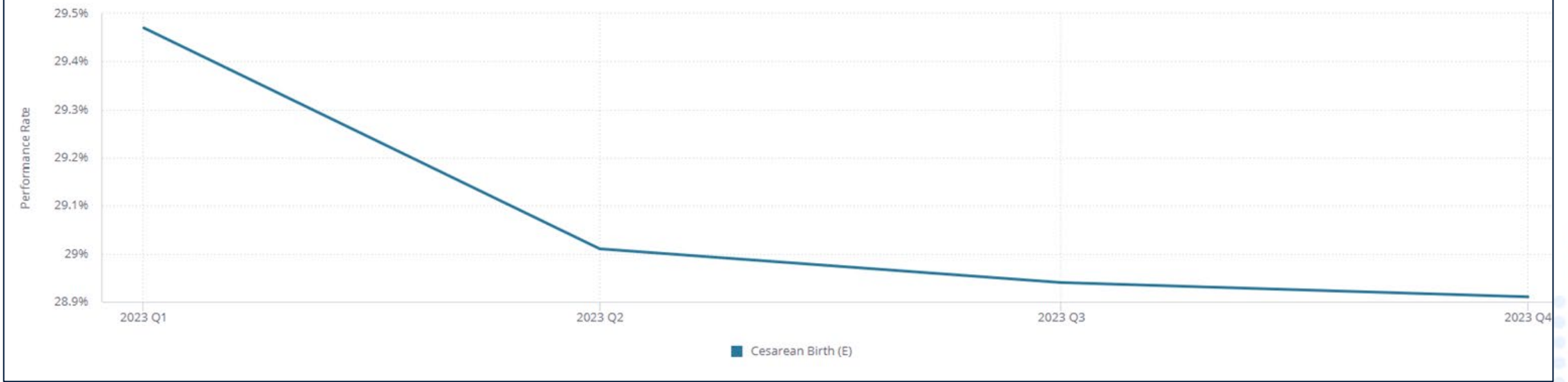
Cesarean Birth Trend

Entity: HSCRC All Hospital Roll Up

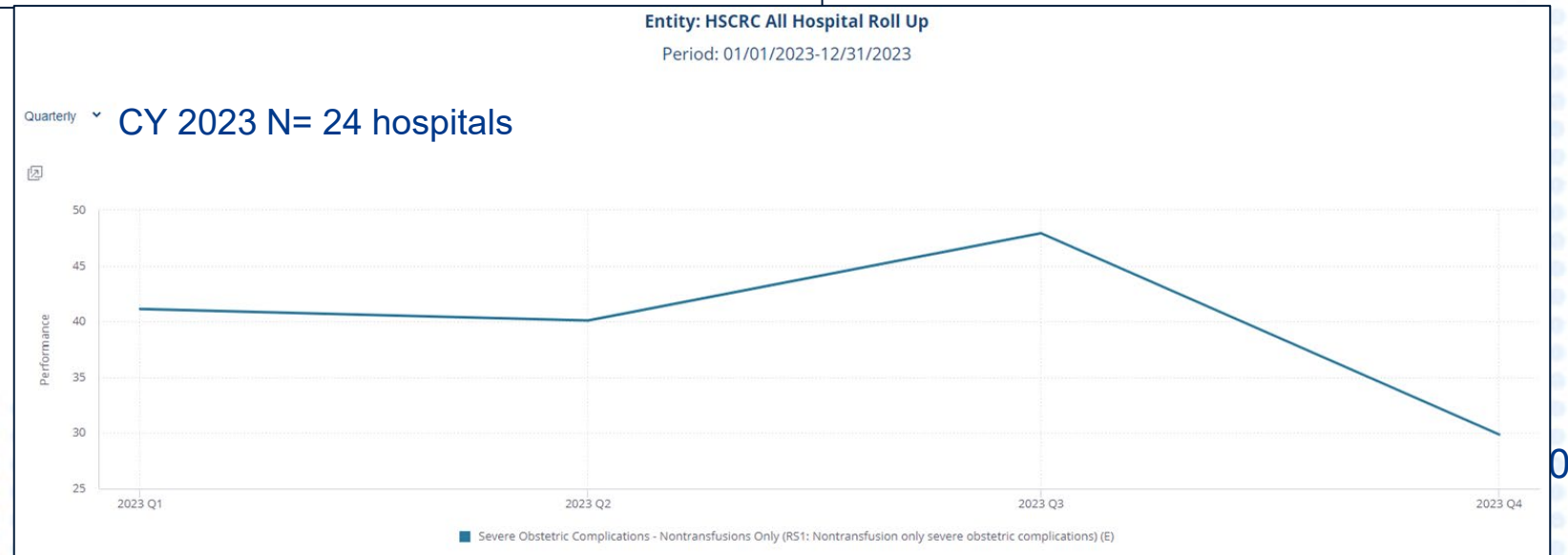
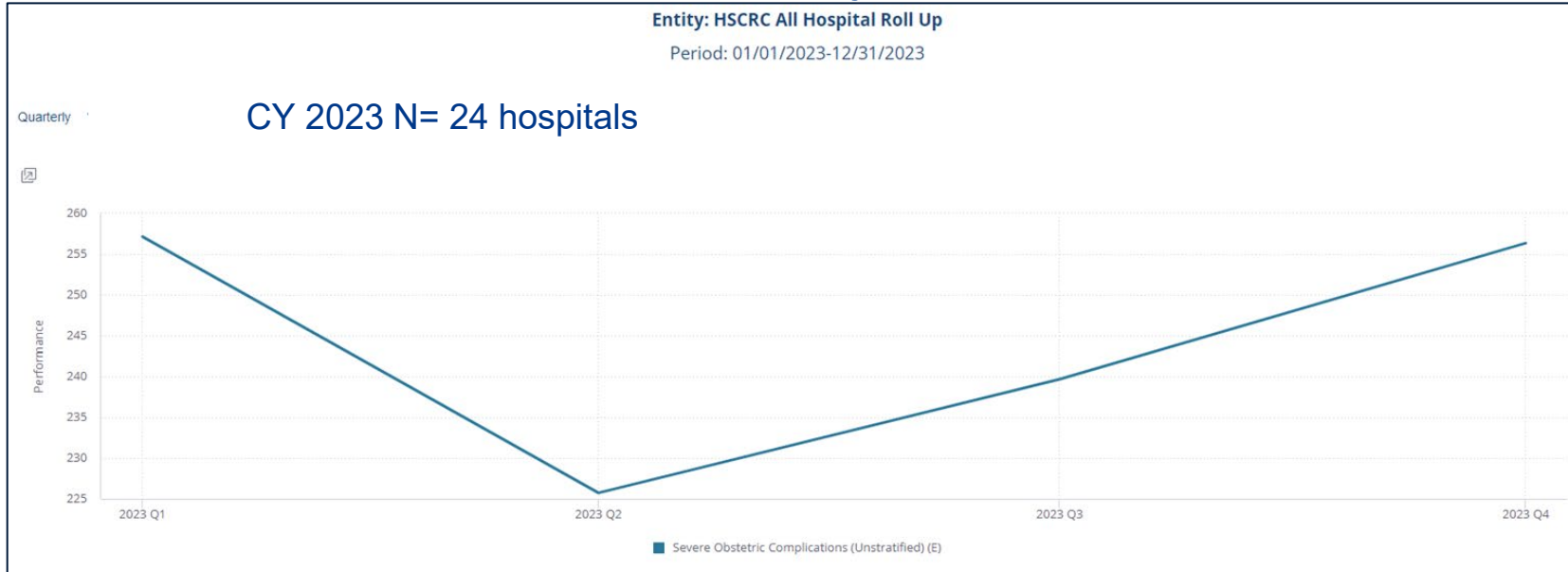
Period: 01/01/2022-12/31/2023

Quarterly

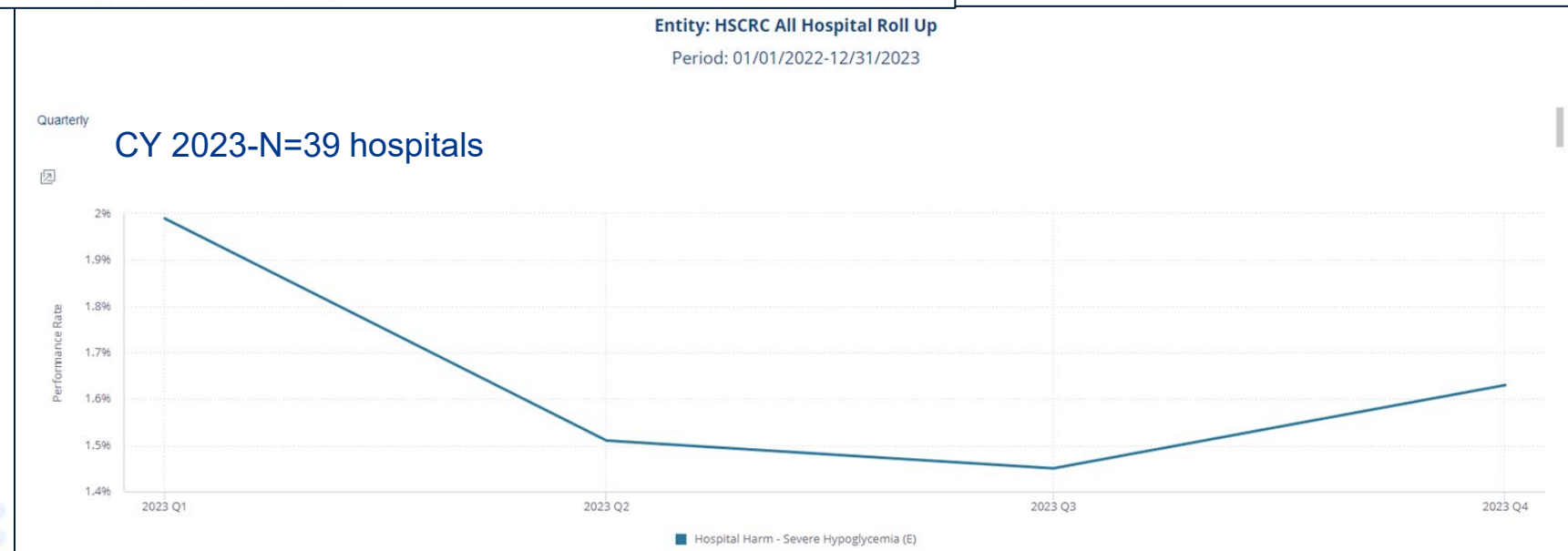
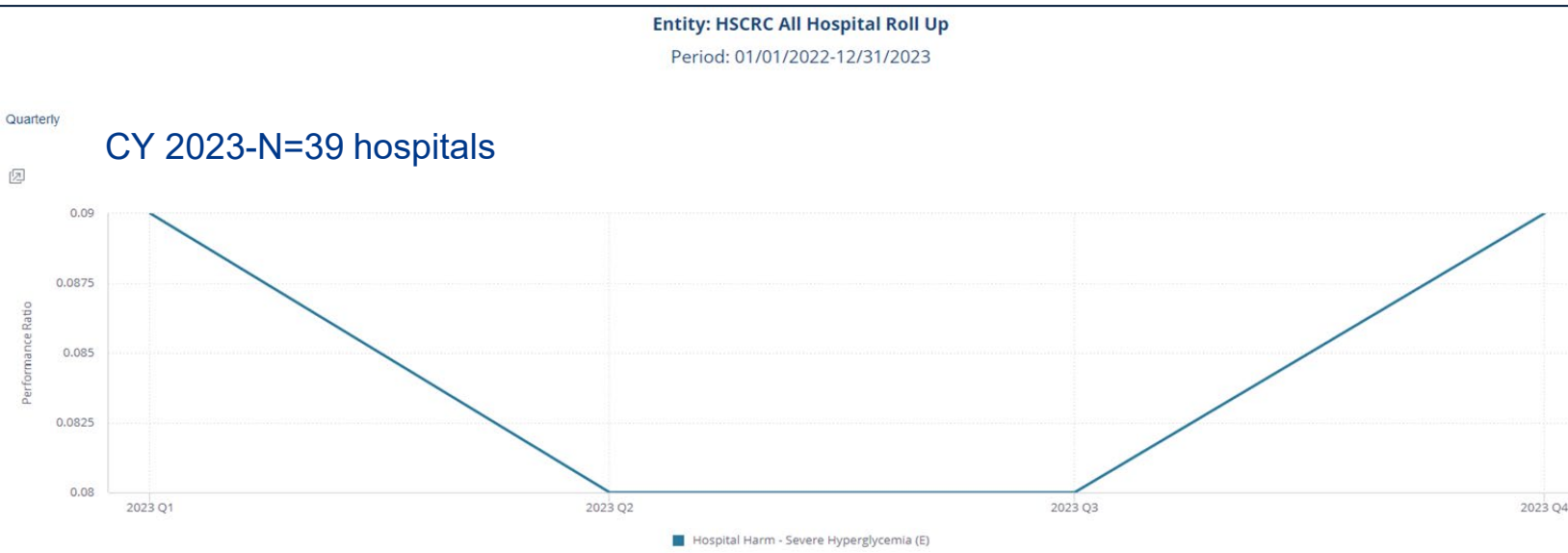
CY 2023 N=26 hospitals



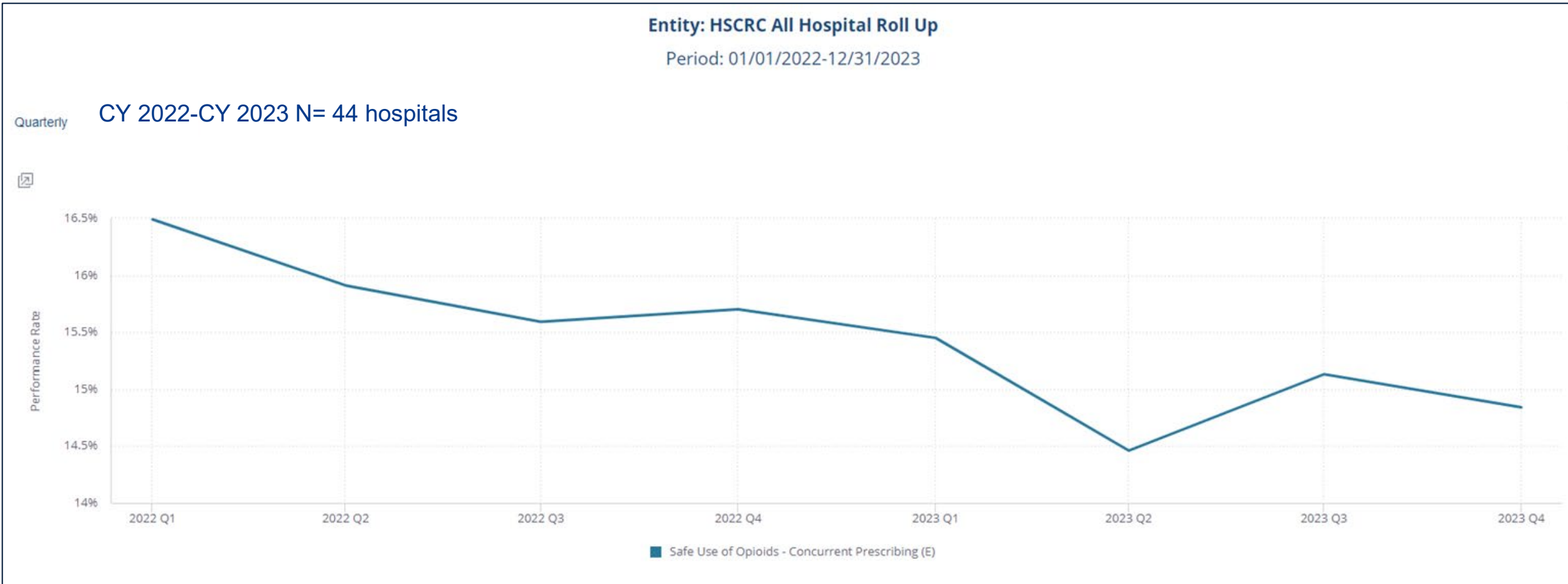
Unadjusted Severe Obstetric Complications Unstratified and Non-transfusions Only Trends



Hospital Harm- Severe Hyperglycemia and Hypoglycemia Trends



Safe Use of Opioids-Concurrent Prescribing Trend

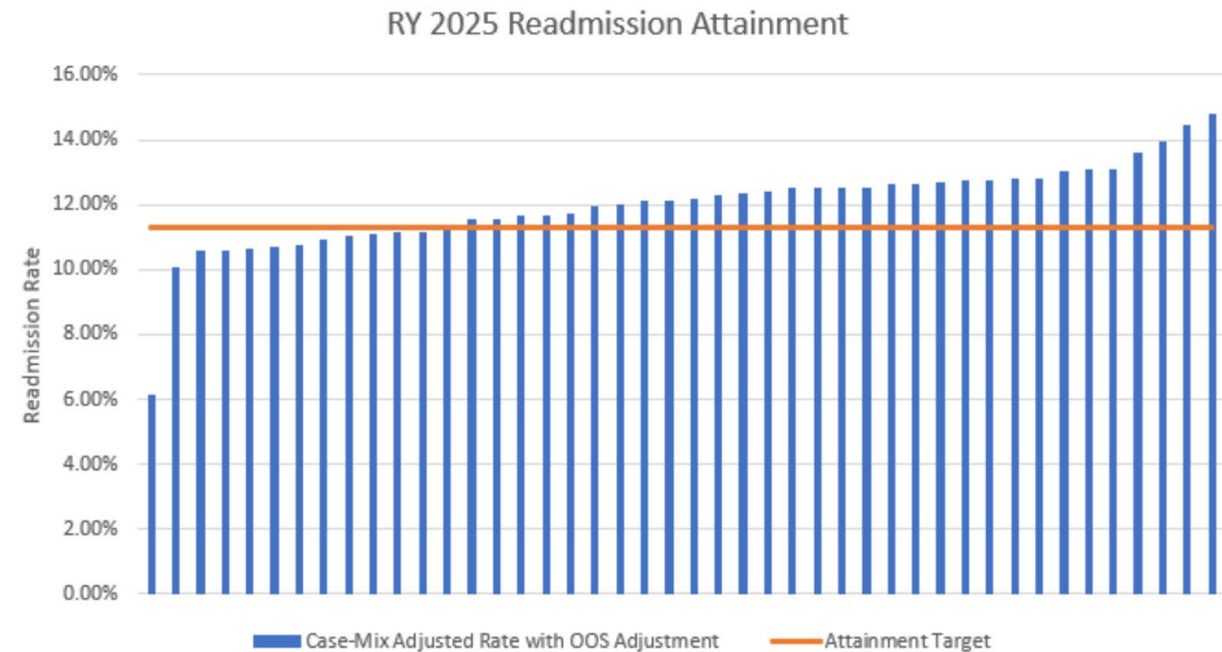
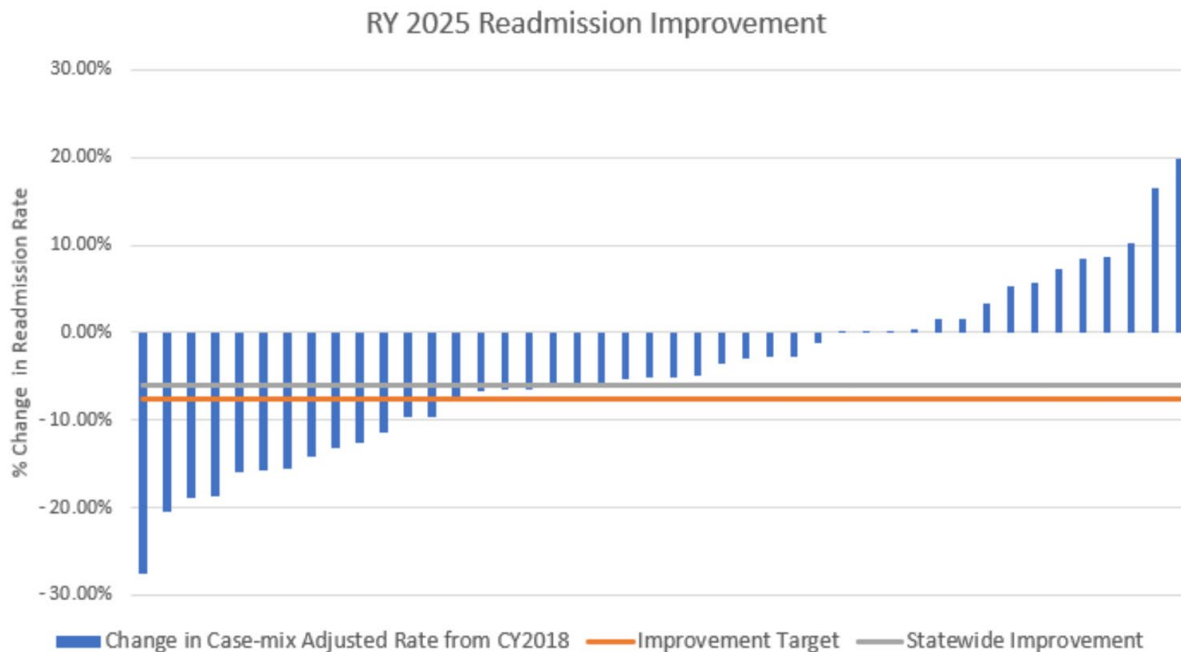


RY 2025 Performance and Revenue Adjustments*

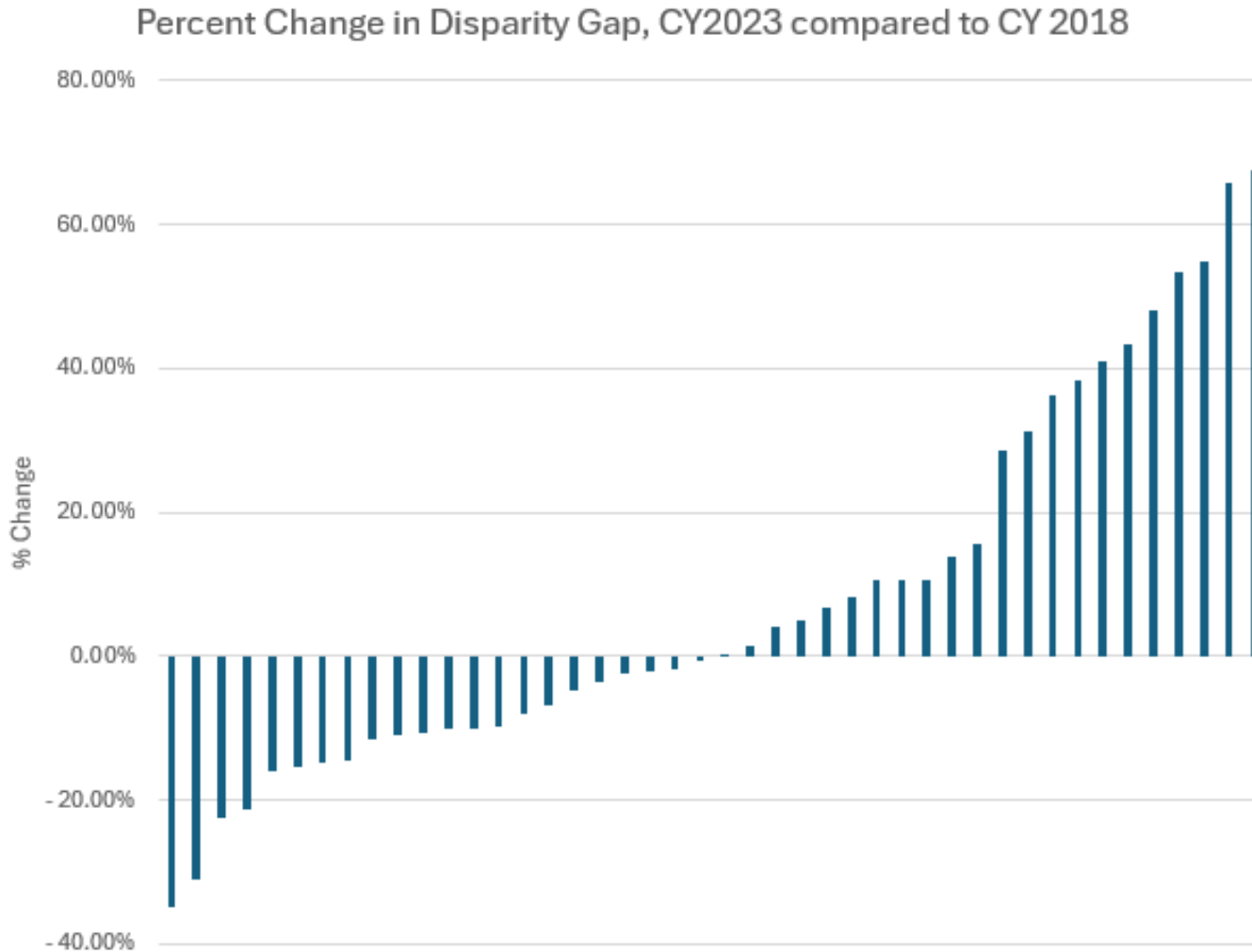
RY 2025 RRIP Performance

State Net Total	\$14,102,128
Penalty	-\$28,215,336
% IP Penalty	-0.24%
Reward	\$42,317,464
% IP Reward	0.36%

- Rewards: 20 hospitals; 7 for Attainment, 13 for Improvement
- Penalties: 24 hospitals



RY 2025 RRIP-Disparity Performance

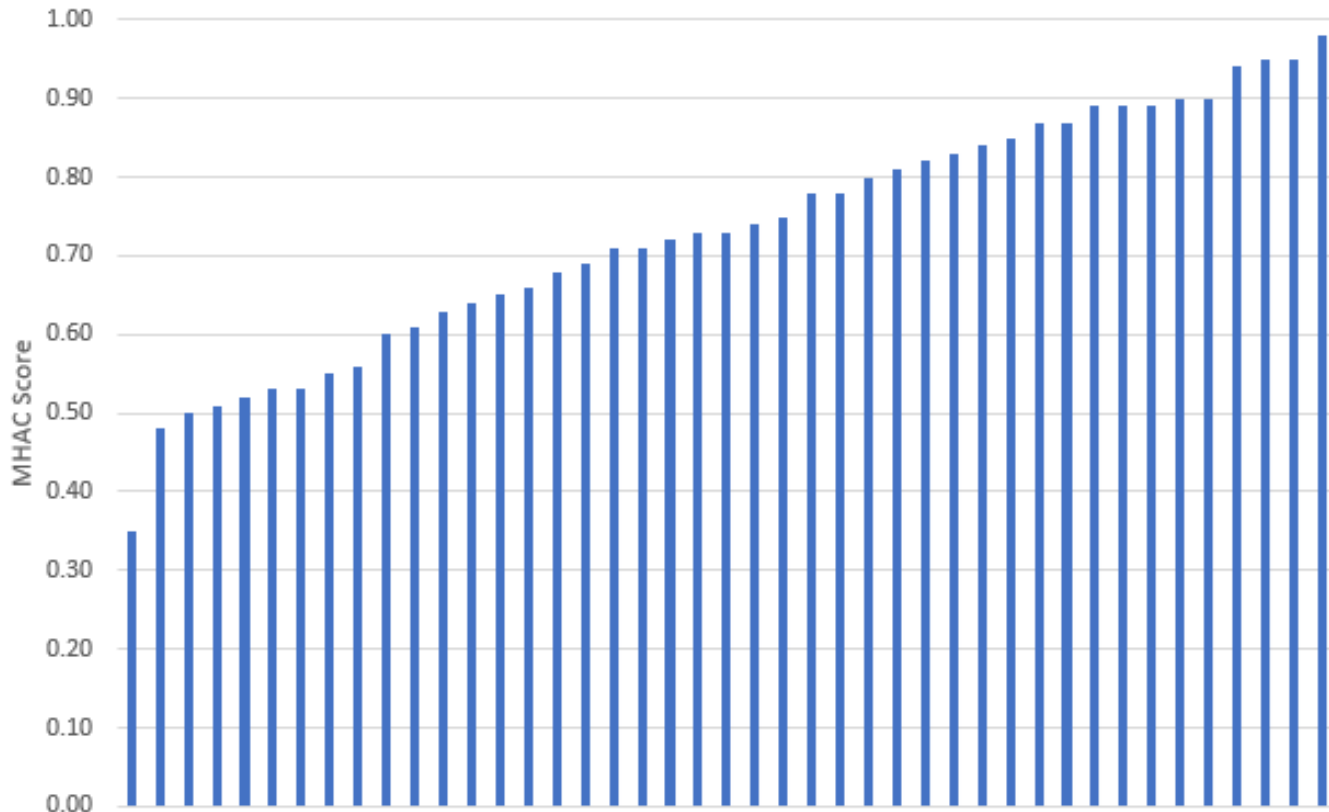


State Total Rewards	\$1,768,342
% IP Reward	0.015%

- 22 hospitals saw a reduction in their disparity gap in CY 2023 compared to CY 2018
- 2 hospitals received a reward for reducing their disparity gap by at least 29.29% and reducing their all-payer readmission rate

RY 2025 MHAC Performance

RY 2025 MHAC Scores

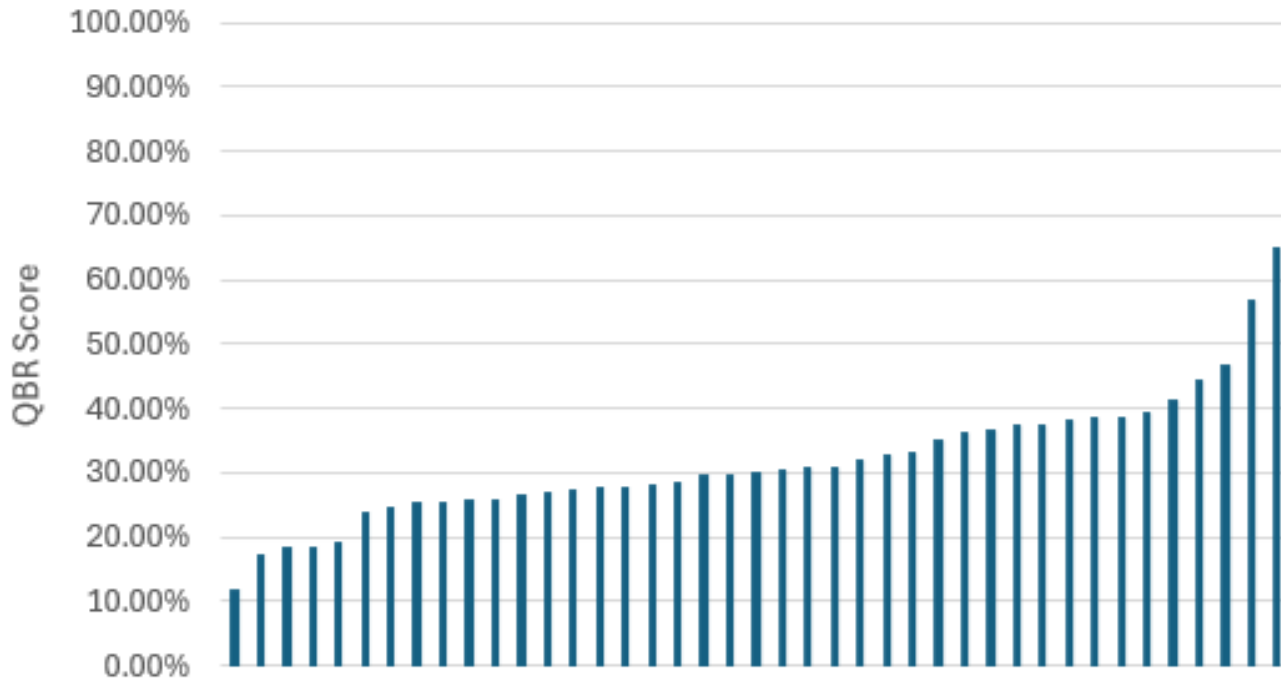


State Net Total	\$39,309,086
Penalty	-\$8,879,421
% IP Penalty	-0.08%
Reward	\$48,188,507
% IP Reward	0.41%

- 26 hospitals received rewards
- 8 hospitals performed in the hold harmless zone
- 9 hospitals received penalties

RY 2025 QBR Performance

RY 2025 QBR Scores



- With a 41% cutpoint
 - 36 hospitals receive penalty
 - 5 hospitals receive a reward

State Net Total	-\$64,389,900
Penalty	-\$65,987,875
% IP Penalty	-0.56%
Reward	\$1,598,075
% IP Reward	0.0137%

QBR Revenue Adjustment Scale

- Revenue adjustment scale ranges from 0-80 percent, with rewards starting at scores >41 percent
- Reward/penalty cut-point needs to ensure hospitals in Maryland are not rewarded for performance that is below the national average
- Cut-point estimated by weighting national scores by QBR weights and calculating national average
 - RY 2024 cutpoint was reduced from 41% to 32%
- **Staff are reviewing recent data to finalize cut-point for final RY2025 revenue adjustments**

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%

CY 2024 Monitoring Reports

- **Excess Days in Acute Care (EDAC):** Available, summary and pt level
- **ED-PAU/ Multi-Visit Patients (MVP):** Available, summary
- **Inpatient Diabetes Screening:** Available, summary