



maryland
health services
cost review commission

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

December 11, 2024

This document contains the staff final recommendations for updating the Quality-Based Reimbursement Program for RY 2027.

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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
HWR/HWM	Hospital Wide Readmission/Hospital Wide Mortality
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.

FINAL RECOMMENDATIONS

This document puts forth the RY 2027 Quality-Based Reimbursement (QBR) final policy recommendations for consideration. The policy has few changes compared to the RY 2026 approved recommendations. Staff has vetted 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.

Final 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; add a bonus incentive of \$150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.
 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 from 41% to 32% based on National performance. For purposes of finalizing the RY 2027 QBR Policy recommendations, staff vetted the policy recommendations 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 final 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	<ul style="list-style-type: none"> 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 Focus linear HCAHPS weight on the three communication domains (doctor, nurse, and medication) 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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. Update to latest clinical logic Explore behavioral health data sources and ways to monitor follow up following a hospitalization for behavioral health 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Continue monitoring hospital performance on the Sepsis Dashboard measures and consider adjustments to payment measures if performance declines
CDC National Health Safety Network	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> • Eight HCAHPS categories (RY 2026) • Six HCAHPS categories (RY 2027), top box score and consistency, 4 categories for linear scores ; • TFU (Medicare, Medicaid, disparities improvement); • ED LOS 	25 percent Six HCAHPS measures top box score and consistency
Safety	30 percent Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	25 percent Six measures: Five CDC NHSN HAI measure categories; Sep 1 Bundle measure
Efficiency	n.a.	25 percent One measure: Medicare spending per beneficiary

The QBR Program assesses hospital performance by comparing each measure to National or State performance standards. For all measures, except the ED LOS measure³, the performance standards range from the 50th percentile of hospital performance (threshold) to the mean of the top decile (benchmark). Each measure is assigned a score of zero to ten points, then the points are summed and divided by the total number of available points, and weighted by the domain weight. A total score of 0 percent means that performance on all measures is below the performance threshold and has not improved, whereas a total score of 100 percent means performance on all measures is at or better than

³ The ED LOS performance standards are 0-10 percent and 0-5 percent for those above and below the statewide average, respectively.

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.

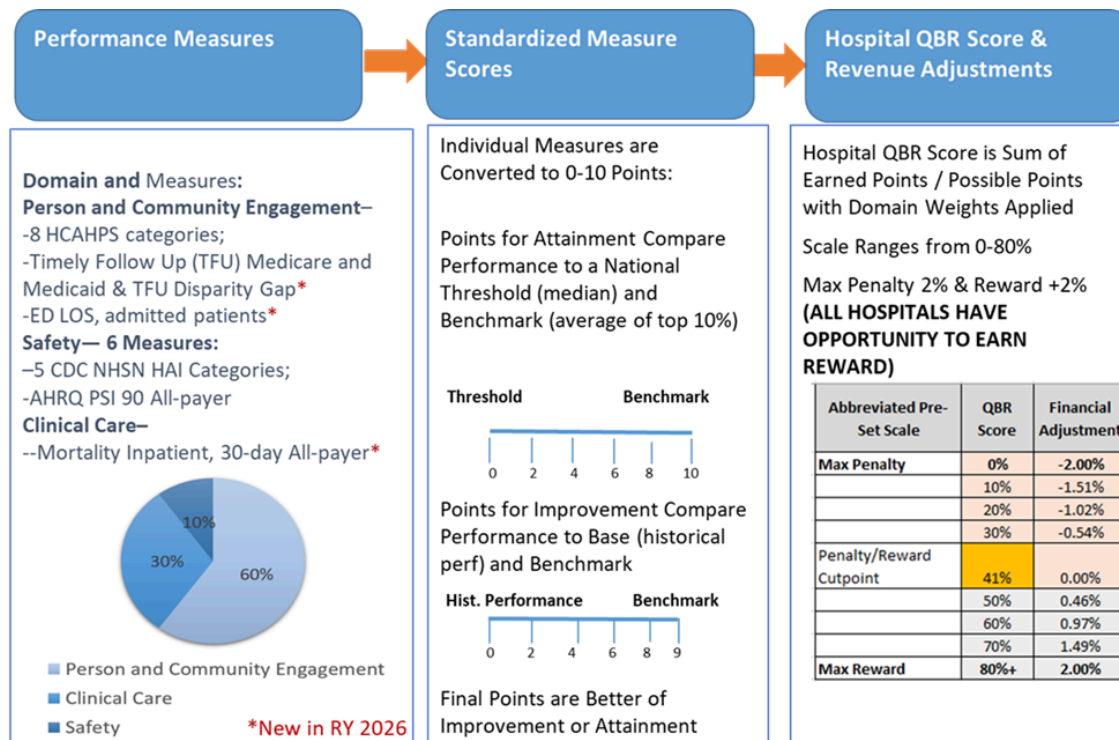
Historically, Maryland hospitals have low scores on the QBR program in part due to HCAHPS performance. In order to ensure Maryland hospitals are not rewarded for subpar performance, the preset revenue adjustment scale for the entire QBR program ranges from 0 to 80 percent, regardless of the score of 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 final policy provides recommended measure and domain weights, as well as modeling of QBR scores with the recommended changes.

Person and Community Engagement Domain

The Person and Community Engagement domain currently measures performance using the HCAHPS patient survey, three measures of timely follow-up (TFU) after discharge for an acute exacerbation of a chronic condition (one measure for Medicare fee-for-service (FFS), one measure for Medicaid

beneficiaries, and one measure on within-hospital disparity gap reduction for Medicare FFS beneficiaries). In addition, an ED LOS measure for patients admitted to the hospital (non-psychiatric) was added to the program in RY 2026. This domain currently accounts for 60 percent of the overall QBR score.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

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

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

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 add Communication about Medicine and have only three linear measures starting in RY 2027 weighted at 10 percent of the QBR program (thus three measures weighted

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

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

at same percent as previous rate years). The modeling included in this policy, reflects this proposal to focus the linear measures on the three communication domains. As staff noted in previous years' QBR policies, we will assess if adding the linear measures helps improve top-box scores over the next few years. If top box scores do not improve, staff will recommend reducing the weight or removing the linear measures in future rate years.

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

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

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

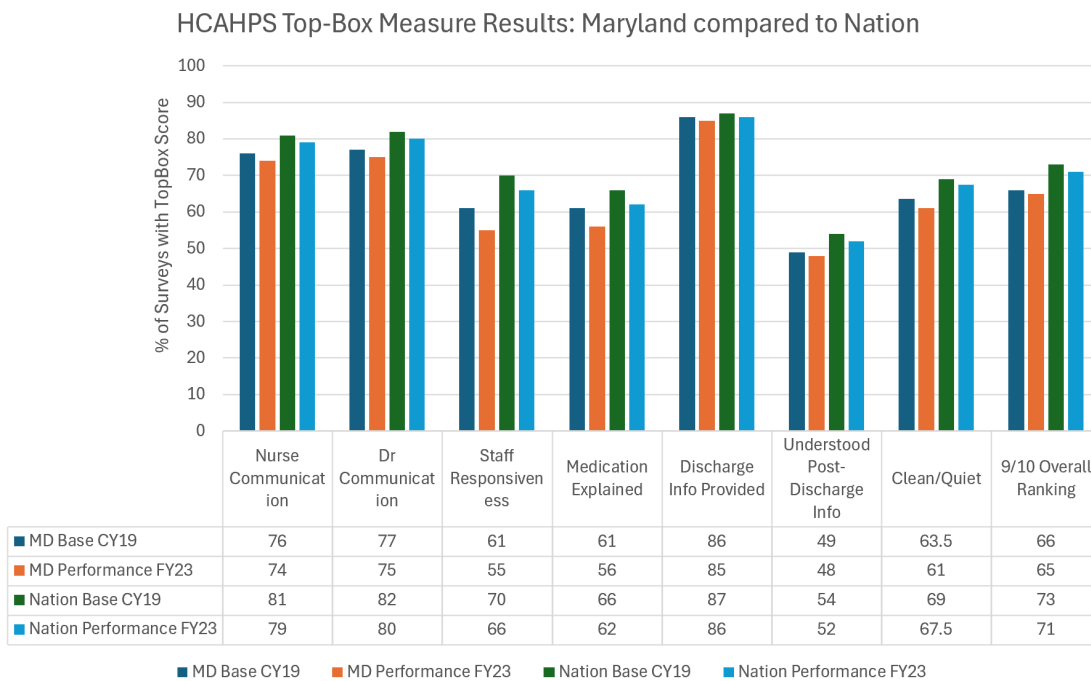
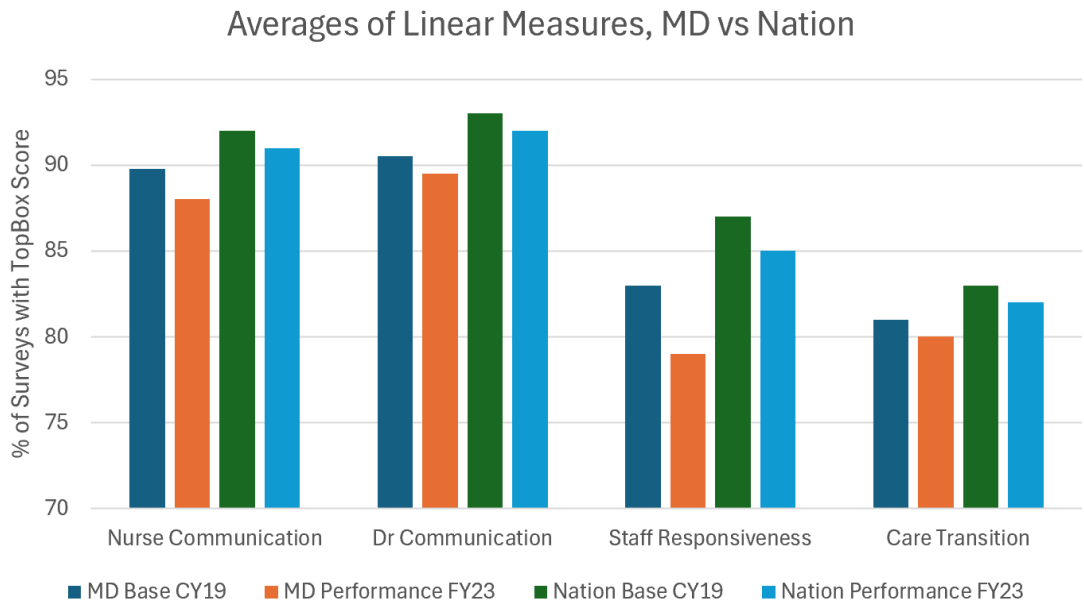


Figure 5. Linear Measure, Maryland Compared to the Nation, CY 2019 vs 7/1/22-6/30/23



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

HCAHPS Improvement Framework

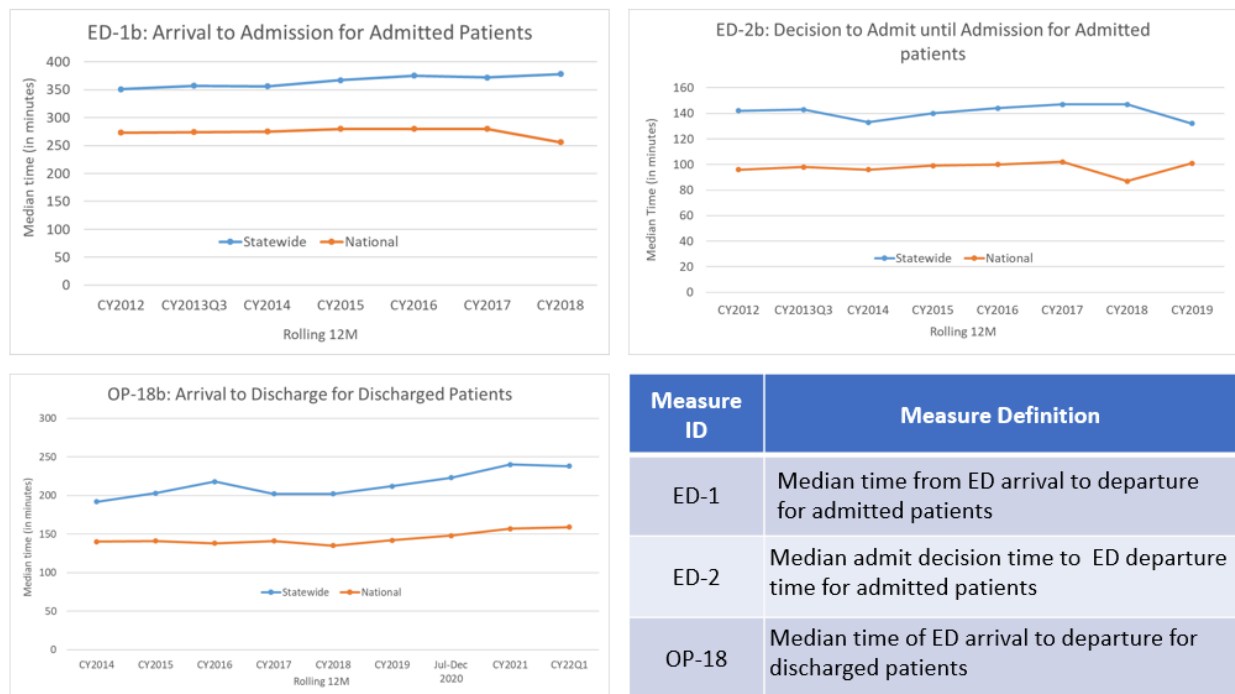
One important area CMS has identified in feedback to the Commission is the need for targeting improvement in HCAHPS in the Person and Community Engagement domain. CMS has recommended that the State consider implementing a Statewide HCAHPS performance improvement initiative that leverages input from providers, industry experts, and other stakeholders to develop future improvement goals. Further, CMS noted they are looking for the State to further develop these strategies and commit to creating a framework for setting HCAHPS performance improvement goals for future performance years. To improve HCAHPS performance as a state, the HSCRC is co-leading a Patient Experience Learning Collaborative with the Maryland Hospital Association (MHA). As outlined in Appendix D the goal of the learning collaborative is to compile best practices to help Maryland hospitals improve patient experience and attain higher HCAHPS scores. The learning collaborative will accomplish this task by analyzing patient-level HCAHPS data, learning best practices from national organizations that consult hospital providers on improving patient experience, and through quality improvement initiatives using Plan, Do,

Act Study (PDSA) cycles. HSCRC has brought on an HCAHPS expert with hospital executive leadership experience as Chief Patient Experience Officer to lead the HCAHPS improvement framework implementation. Based on Maryland’s overall lagged HCAHPS performance and MHCC’s analysis, it is of great import to focus on disparities in HCAHPS results; staff will examine disparities, for example, in the response rates and the maternity service line responses for HCAHPS, as well as other related process and outcome measures.

Emergency Department Length of Stay

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

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

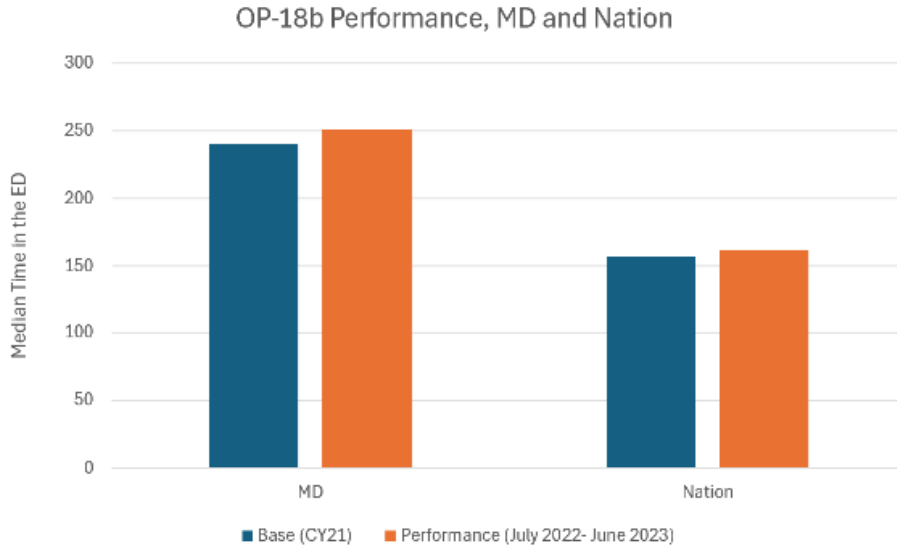


As illustrated in Figure 7 below, based on the most current data available, the OP-18b wait time for discharged patients has increased slightly for both Maryland and the Nation from the base to the

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.

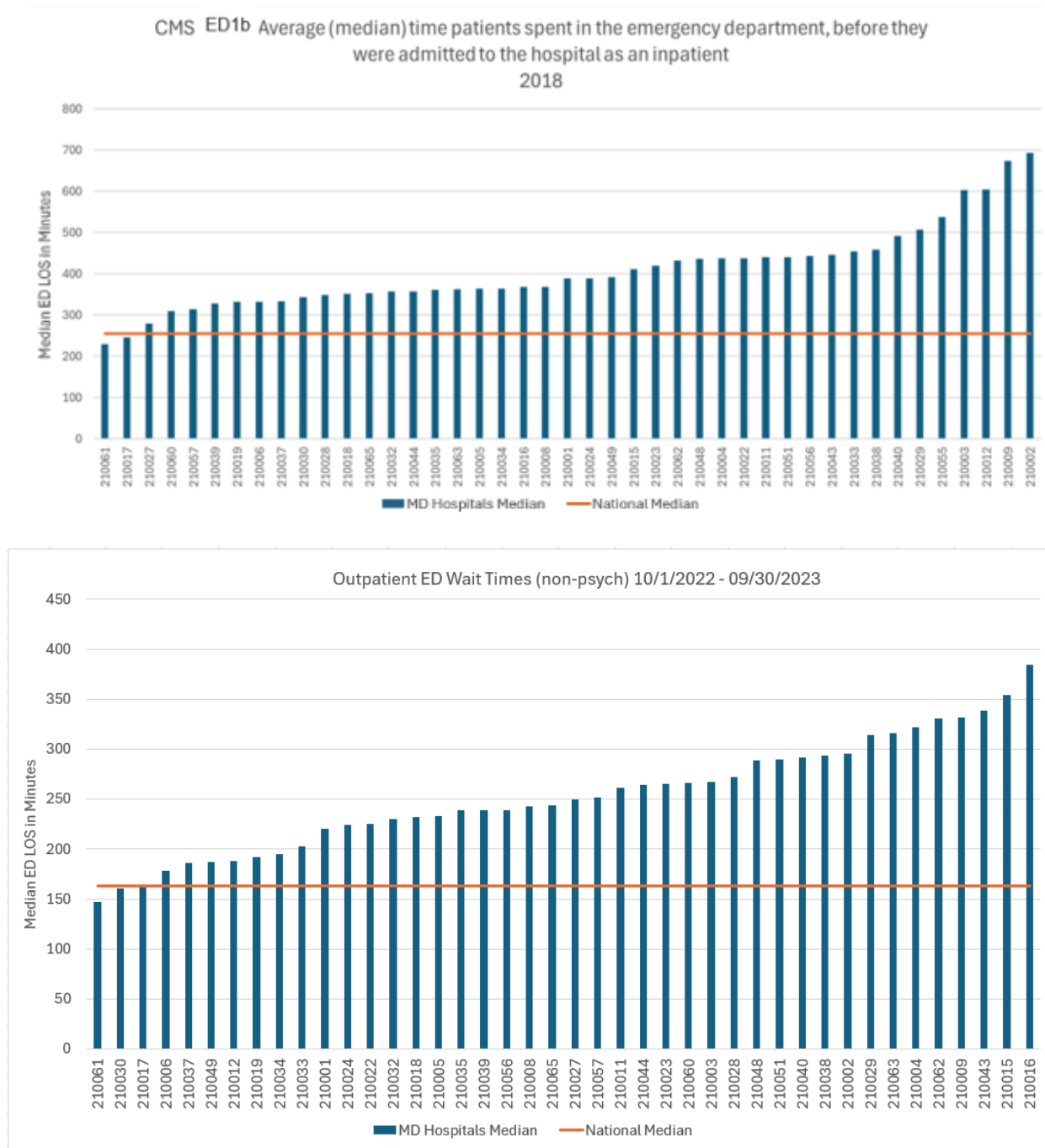
performance year, and Maryland wait times continue to be significantly above those of the Nation for both the base and performance years.

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



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

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



Based on these results, staff believes all hospitals in Maryland have an opportunity to improve. Furthermore, there has been increased public scrutiny on Maryland’s poor performance in ED Wait times, as evidenced by the several initiatives that have been underway over the last couple years to promote understanding Maryland’s ED length of stay and promote improvement (e.g., MHA Legislative Taskforce, EDDIE). In the 2024 Maryland General Assembly Session, a new ED Wait Time Reduction Commission

was established. The ED Commission is co-chaired by the HSCRC Executive Director and staffed by the HSCRC. The ED Commission will work on hospital and wider access issues to improve hospital throughput and will develop a State goal for improvement in ED wait times. The QBR ED LOS measure is one of the HSCRC levers to assist with this effort and will build off of the goals set by the Commission. Appendix E provides additional information on ED initiatives and the ED Commission.

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

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 performance standards for RY 2027/CY 2025 performance will be determined in conjunction with the ED Wait Time Reduction Commission by March/April 2025 and be reported to the HSCRC Commission.

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 using the measure that 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

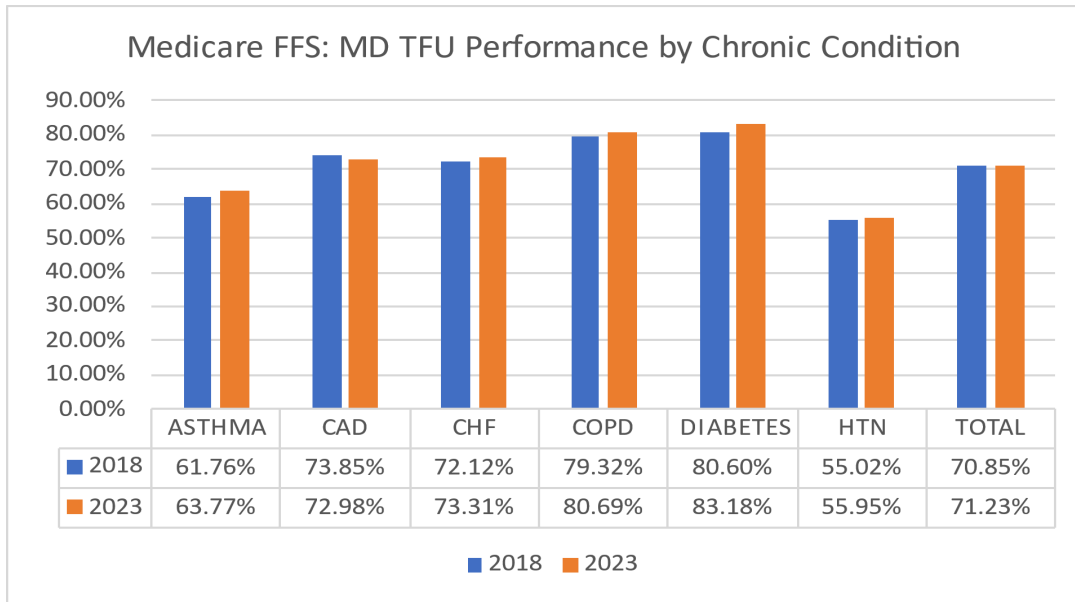
The Medicare TFU measure is also included in the Care Transition SIHIS domain with the goal of achieving a 75 percent follow-up rate by the end of 2026.⁹ Figure 9 shows Maryland's performance over time for each chronic condition and all conditions combined within the Medicare population. For all conditions,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

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. The HSCRC staff will update the TFU measure with the latest clinical logic for RY 2027 although the results presented here are still under the old logic.

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

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



While some stakeholders have raised concerns around the follow-up times by condition, it is important to note that Maryland and the Nation are being measured on the same timeframes and the expectation is not 100 percent follow-up. Furthermore, as discussed above, the HSCRC staff will update the TFU measure to account for the change in clinical timeframes. 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.

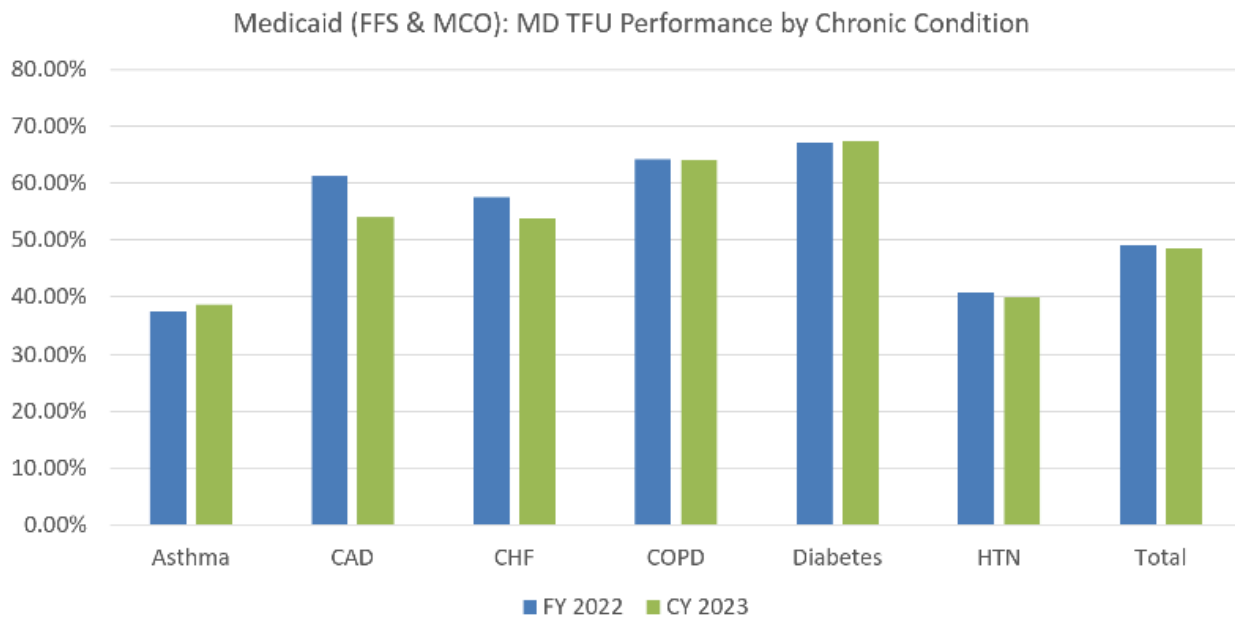
Figure 10. Medicare-only: Timely Follow-Up across All Conditions

TFU Rates	CY2018	CY2019	CY2020	CY2021	CY2022	CY2023
Maryland	70.85%	71.45%	67.90%	70.07%	70.59%	71.23%
US	66.82%	69.00%	64.75%	67.68%	67.26%	68.35%

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.

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.

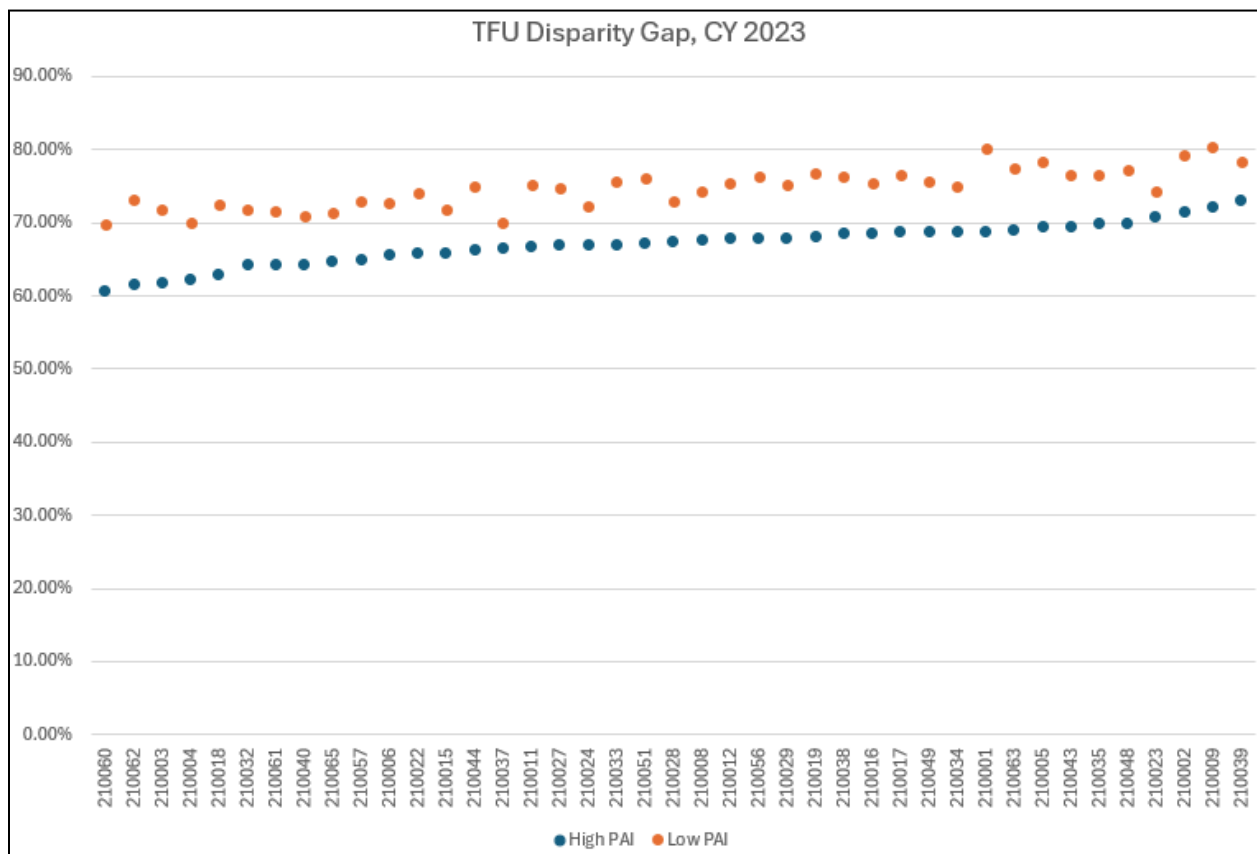
Disparities in Timely Follow-Up

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.

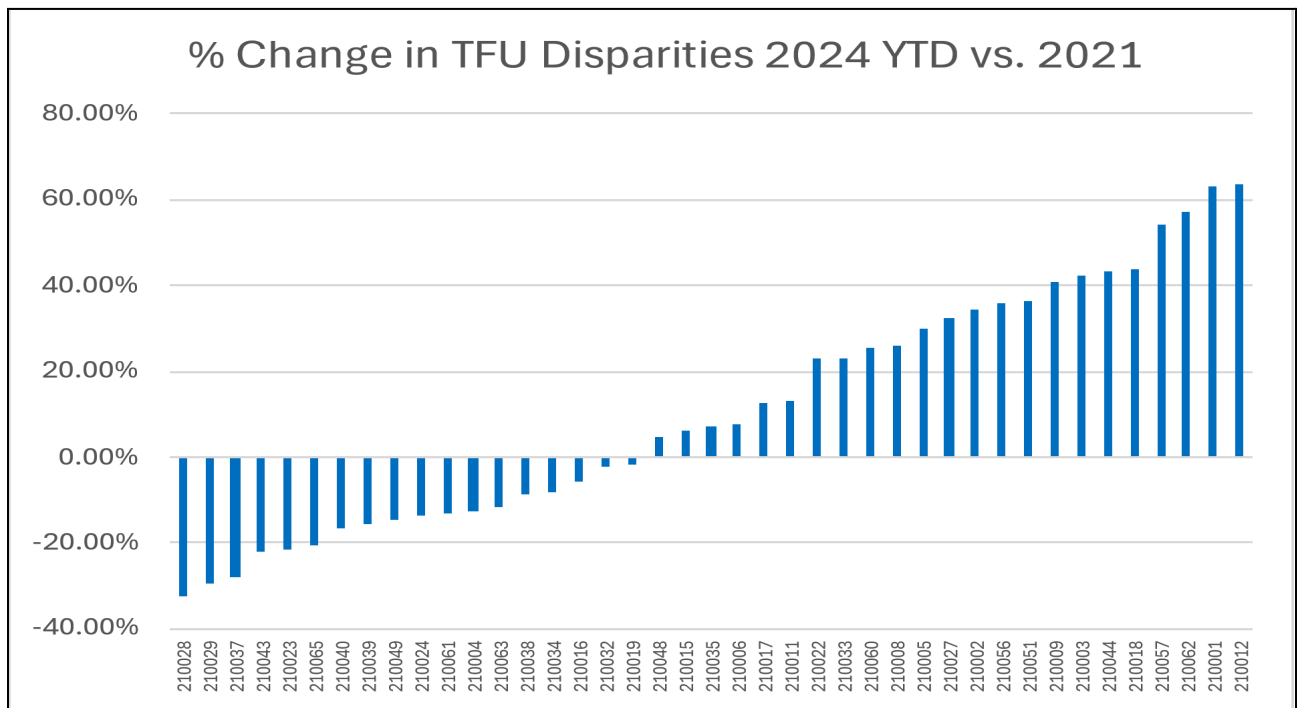
Figure 12. By Hospital TFU Disparity Gap, CY 2023



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

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

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 CDC's 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

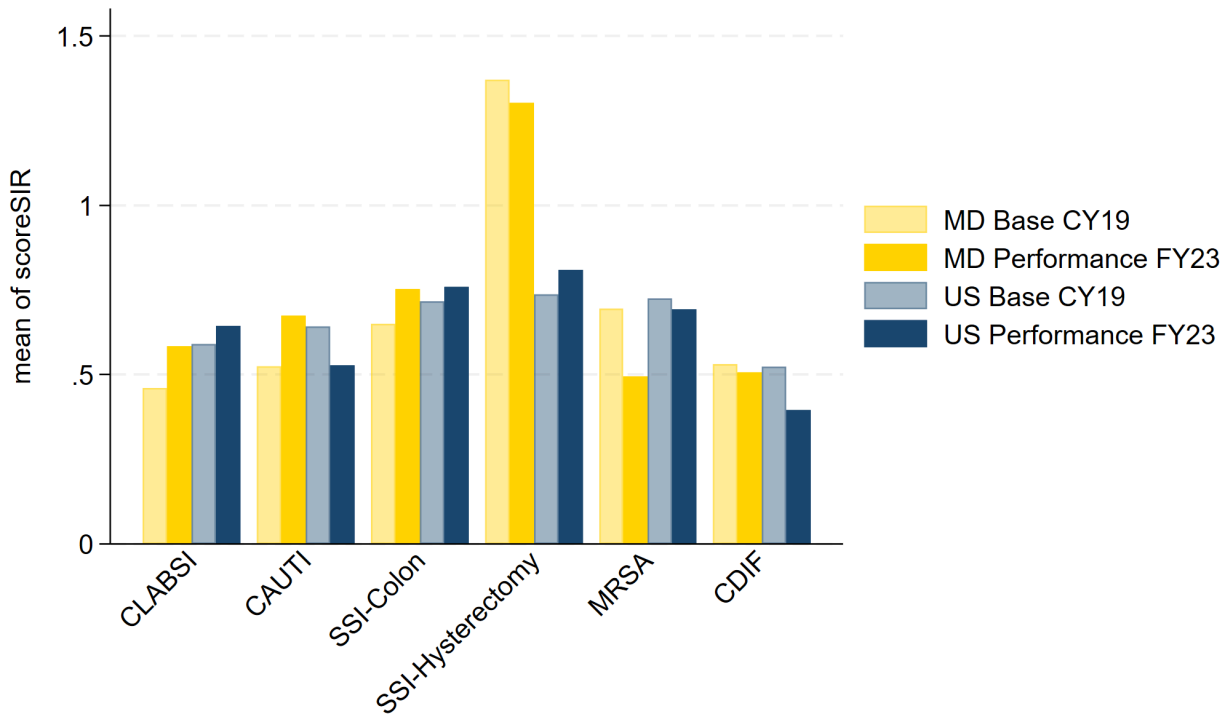
CMS Care Compare has updated the Healthcare Associated Infection Standardized Infection Ratio (SIR) data tables for the Nation and by state through June 2023. Figure 14 below shows how Maryland performs relative to the Nation, and how performance has changed over time for both Maryland and the Nation. 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 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

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

- ▶ 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.

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

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

Maryland Changes in Statewide Standardized 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 categories; 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 developed¹⁴ and 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

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

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)

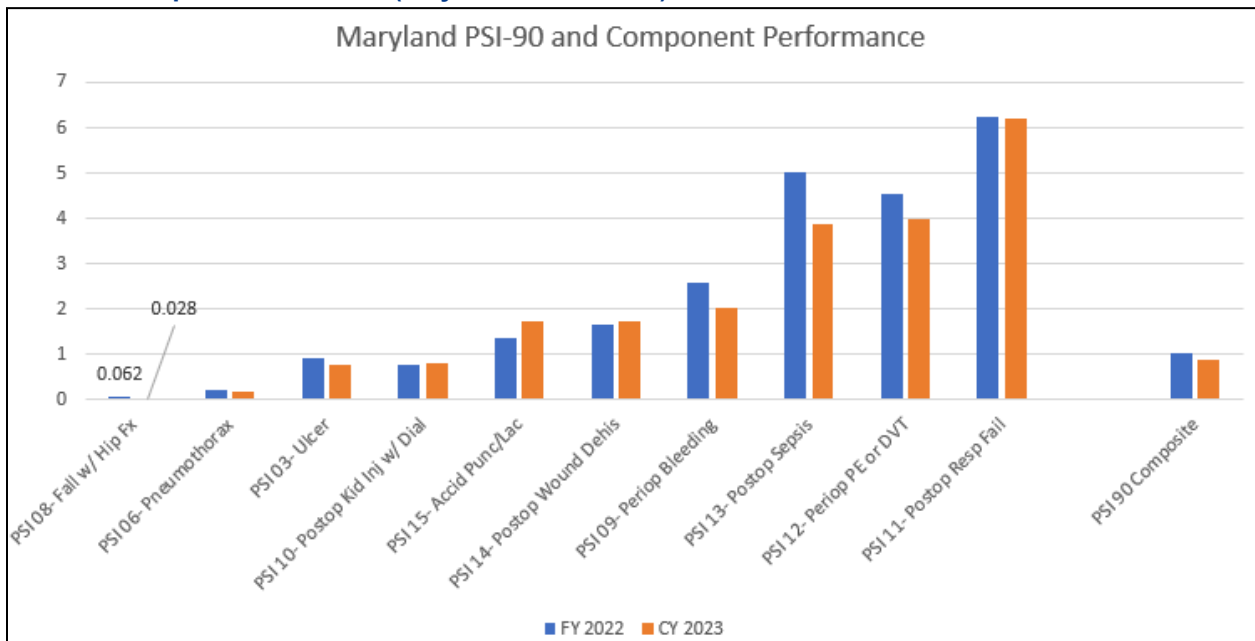
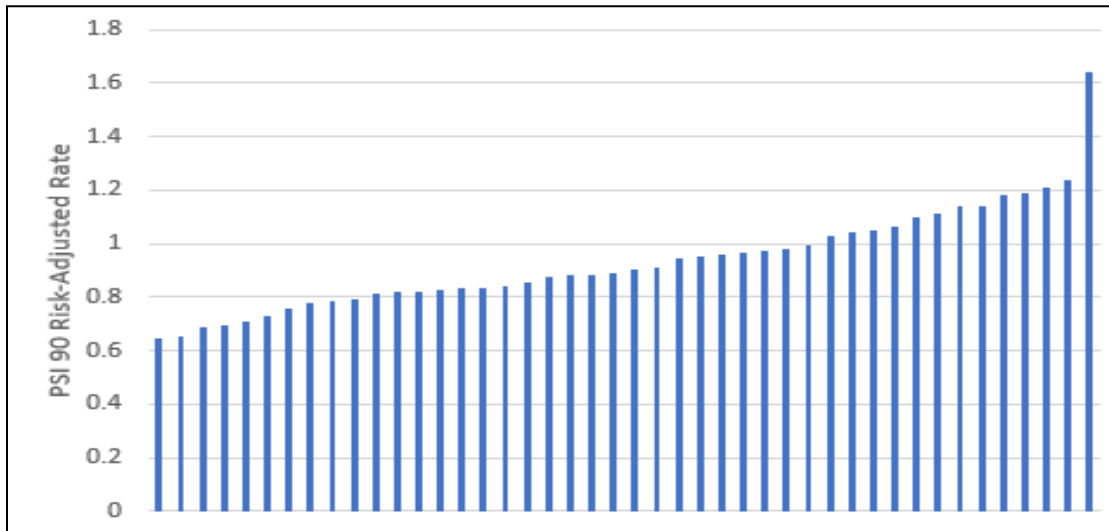


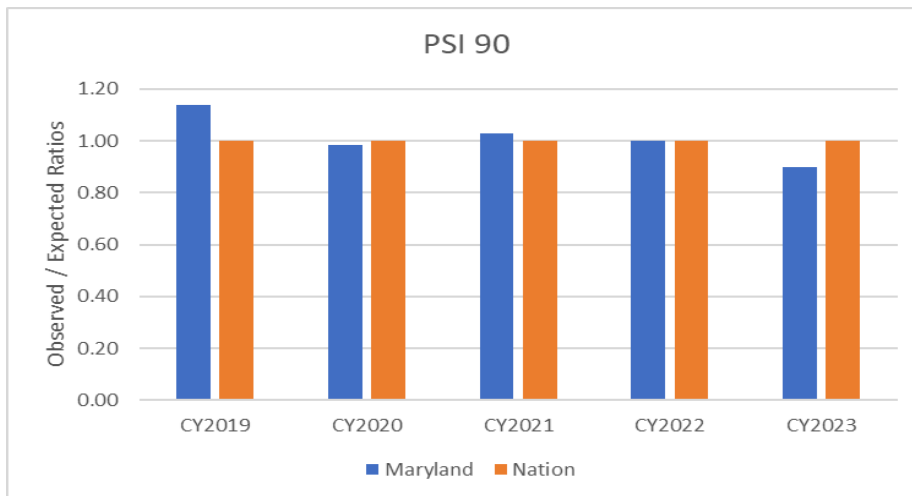
Figure 17 below illustrates the hospital-level performance on the all-payer PSI-90 composite measure for CY 2023; consistent with last year, the variation in performance by hospital suggests there may be opportunity for improvement on this measure.

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



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

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



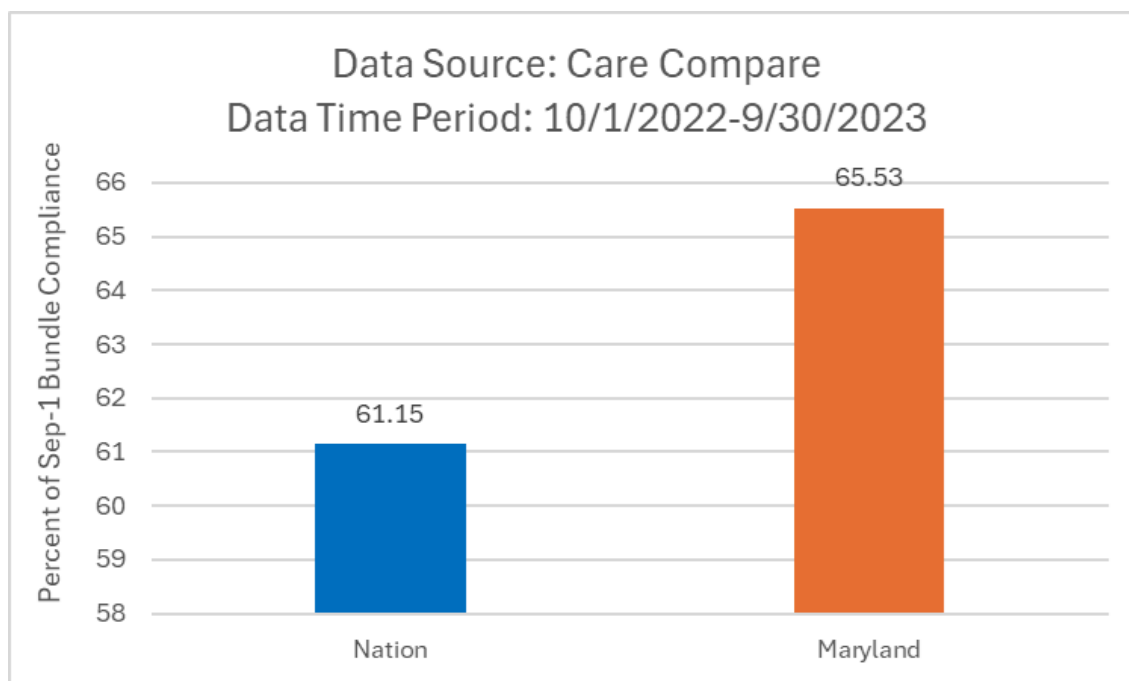
¹⁵ Levindale Hospital performs the worst on the PSI-90 measure; their results are driven by poor performance on pressure ulcers. Given they have a longer length of stay than most acute care hospitals, they need to focus on quality improvement for pressure ulcers.

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

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

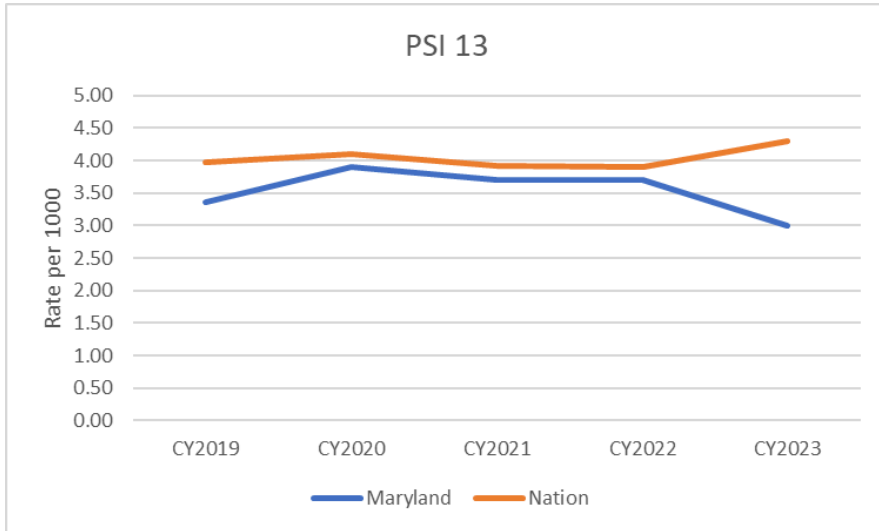
Figure 19. Maryland vs. the Nation, Sep-1 Early Management Bundle Measure



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

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



Maryland Hospital-Level Sepsis Dashboard

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

Clinical Care Domain

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

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

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

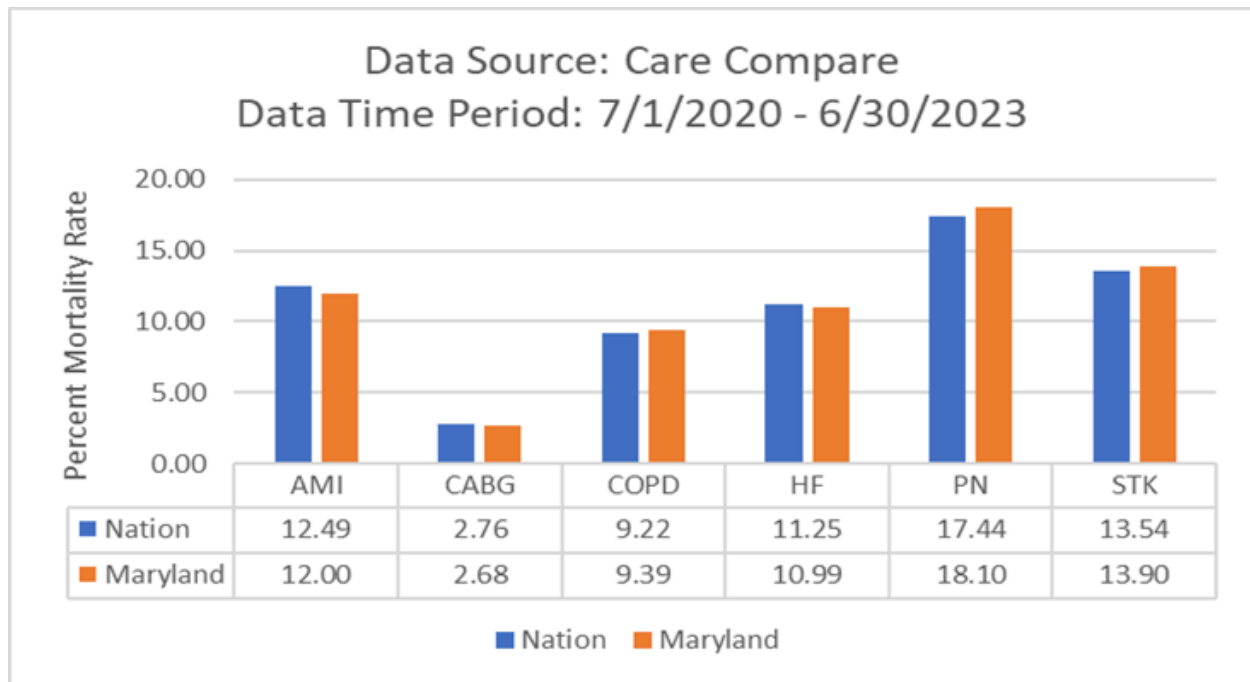
outcome measure. The data through March 2023, shows Maryland hospital performance is on par with the Nation for the THA/TKA measure.

Mortality

CMS 30-Day Condition-Specific Mortality Measures

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

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

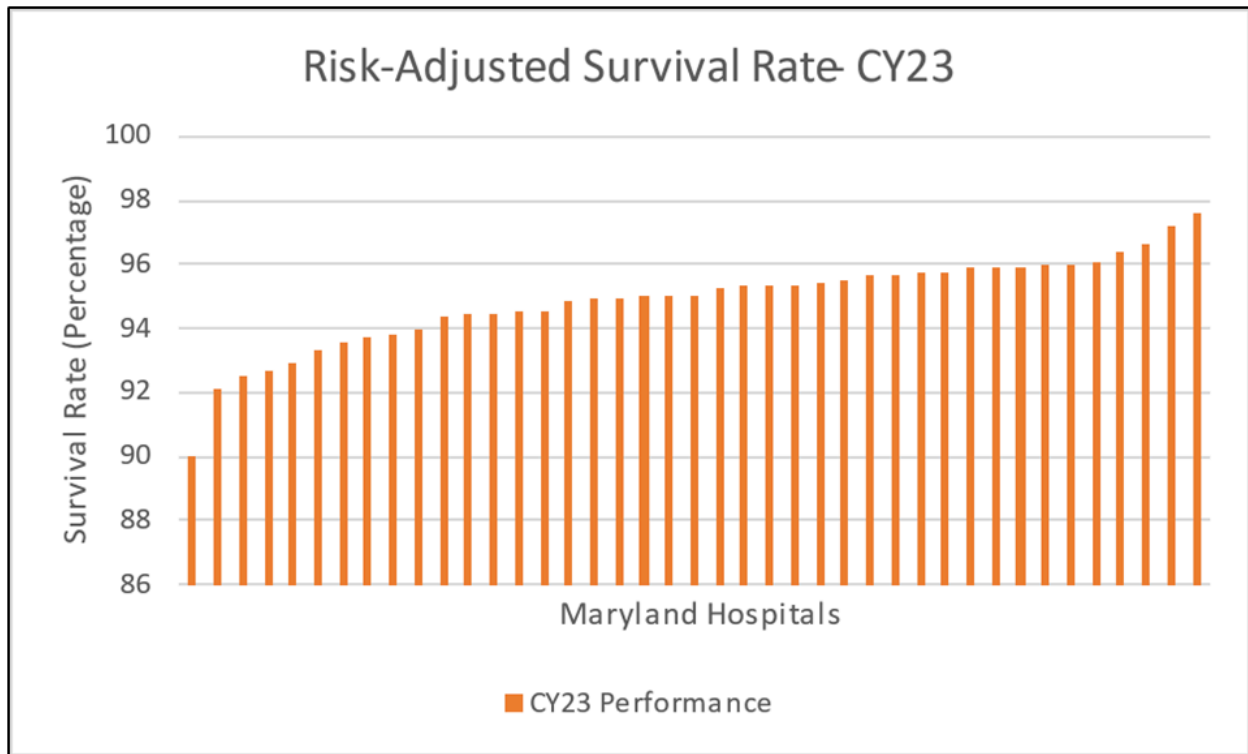


QBR Inpatient, All-payer, All-condition Mortality measure

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

model to better account for COVIDs impact on mortality. As illustrated in Figure 22 below, CY2023, all hospitals perform above 90 percent.¹⁸

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).

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

implementation of the updates, and hospitals have in CYs 2023 and 2024 submitted [Exceptional Circumstances Exemption \(ECE\)](#) requests for timeline extensions which have been granted on a case by case basis by the Commission. Staff has, therefore, updated its final recommendation to provide a positive incentive aligned with hospitals’ estimated additional costs to meet Maryland’s expedited timeline for data submission beginning in CY 2025; however, staff will also allow data submission in accordance with the CMS annual submission deadlines provided that hospitals notify the Commission in a timely manner (See Stakeholder Input and Staff Response section below). Figure 24 below illustrates the Maryland and CMS CY 2025 digital measure 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, staff has begun working with Medisolv and CRISP 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 2024- 2026 Digital Measures Reporting Requirements

Reporting Periods	CMS Measures	Maryland Measures
2024-2026	CYs 2024 and 2025 Three self-selected eCQMs; Three required eCQMs -Safe Use of Opioids -Cesarean Birth -Severe Obstetric Complications July 25-June 26 Core Clinical Data Elements for two hybrid measures for Medicare -30-day mortality -30-day readmissions	CYs 2024 and 2025 Two self-selected eCQMs Required eCQMs- -Safe Opioids -hypoglycemia -hyperglycemia -Cesarean Birth -Severe Obstetric complications July 2025-June 2026 Core Clinical data elements for two hybrid measure for all-payers July-June -30-day mortality -30-day readmissions

In addition to the eCQM reporting requirements, Maryland is also utilizing 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. Furthermore, the linear measure weight will now be applied to only three domains (doctor, nurse, and medication communication).

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.

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. Furthermore, as discussed in the Stakeholder Feedback section, staff will work to provide a cut

point assessment with six months of national data (i.e., earlier in the year provide an estimate of change in cut point for hospitals).

RY2027 Revenue Adjustment Scale

For this policy, staff believe 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.

RY 2027 Modeling

Beginning in CY 2025, the VBP program is removing the domains Staff Responsiveness and Understood Post-Discharge Care from HCAHPS pending updates to these measures for future years. To understand how the removal of these domains impact MD hospitals' performance, staff have modeled RY 2027 scores using the most recent available data. In Figure 26 below, statewide descriptive statistics are provided using the 41 percent and 32 percent cut point. This modeling removes the HCAHPS domains Staff Responsiveness and Understood Post-Discharge care from TopBox, Linear, and Consistency measures and adds Communication about Medicines to the linear measures. The modeling also uses the RY2026 ED performance standards, which will be updated when final performance standards are established. Thus these are estimates based on historical data but indicate that the changes in the HCAHPS measures do not significantly change the overall QBR scores. Finally, these estimates do not include the proposed incentive of \$150,000 per hospital for hospitals that comply with the State's expedited digital quality measures reporting submission timeline, totalling a potential maximum of \$6M statewide (see Stakeholder Input and Staff Responses section below).

Figure 26. Estimated QBR Scores

Statewide Descriptive Statistics		
	<u>RY27 Proposed Cutpoint: 41%</u>	<u>Revised RY25 Cutpoint: 32%</u>
Mean Score	31.77%	31.77%
Median Score	30.33%	30.33%
Interquartile Range	12.81%	12.81%
Lowest Score; Revenue Adjustment (\$)	17.67%	17.67%
Highest Score; Revenue Adjustment (\$)	69.31%	69.31%
Statewide Net Estimated Revenue Adjustment (\$); (%)	-\$61,019,392; -0.55%	-\$20,894,743; -0.19%
Statewide Net Estimated Penalties (\$); (%)	-\$62,627,302; -0.56%	-\$32,234,567; -0.29%
Statewide Net Estimated Rewards (\$); (%)	\$1,607,910; 0.01%	\$11,339,834; 0.10%

STAKEHOLDER INPUT AND STAFF RESPONSES

Staff have vetted this policy with the Performance Measurement workgroup. In addition, one comment letter was received from the Maryland Hospital Association (MHA) on the Draft RY 2027 QBR Policy on digital quality measures data submission requirements, and the QBR reward/penalty cut point. Additionally, Commissioner Joshi suggested analyzing the status of the reward/penalty cut point earlier in the year to signal whether an adjustment may be warranted.

Digital Quality Data Including Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE)

MHA strongly urged staff to reconsider the timeline to collect data for the development of electronic quality measure infrastructure, noting that hospitals have significant concerns about additional hospital staff burden and cost created by misaligned submission timelines between HSCRC requirements and the Centers for Medicare and Medicaid Services (CMS) requirements.

Staff Response: Staff appreciates the input regarding the expedited reporting timeline. Staff continues to support the position that more current digital data submission/availability strengthens hospitals' and the State's abilities to use the data for quality tracking and improvement that is more timely and actionable. Further, the early adoption of and migration to digital quality measures reporting in general will ultimately constitute less burden for hospitals and the State. Staff notes that CMS incentivizes fully compliant reporting under the Inpatient Quality Reporting program (which encompasses the measures in the pay-for-performance programs as well as measures that are monitored). Staff reached out to hospitals and systems for input on estimated

additional incremental costs to meet Maryland’s expedited reporting timeline and all-payer hybrid measure reporting requirements (including 1. Staff FTEs and salaries, 2. initial average up front costs that may be incurred after the initial years, 3. vendors, 4. IT-Related costs, and, 5. Other, e.g., training/education, etc.). The estimated additional costs ranged between \$100K and \$200K per year. Based on this input, staff has updated its final recommendation for consideration by the Commission to provide a positive incentive that is aligned with hospitals’ estimated additional costs of \$150,000 per hospital to meet Maryland’s expedited timeline for data submission, including Electronic Clinical Quality Measures and the Core Clinical Data Elements of the 30-Day all-payer Hospital Wide Readmission/Hospital Wide Mortality measures beginning in 2025 (see figure 27 below); however, staff will also allow data submission in accordance with the CMS annual submission deadlines provided that hospitals notify the Commission in a timely manner. Staff notes that the incentive for reporting should be sunsetted when the measures are adopted into pay-for-performance policies.

Figure 26. Digital Measures Expedited Data Submission Timeline

<i>eCOM CY 2025 Performance Period</i>		
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
Q4 2025 data	Open: 1/15/2026	Close: 3/31/2026
<i>Hybrid Measures 30-Day All-payer HWR/HWM CCDE-July 2025 -June 2026 Performance Period</i>		
Q3 2025 data	Open: 1/15/2026	Close: 3/31/2026
Q4 2025 data	Open: 1/15/2026	Close: 3/31/2026
Q1 2026 data	Open: 4/15/2026	Close: 6/30/2026
Q2 2026 data	Open: 7/15/2026	Close: 9/30/2026

RY 2025 QBR Reward/ Penalty “Cut-Point”

In MHA’s letter, they noted their appreciation for HSCRC staff’s plans to retrospectively adjust the RY 2025 QBR reward/penalty threshold (“cut-point”) to 32%, in line with national performance which has significantly declined since the original cut-point (41%) was created using national averages. In addition, MHA and Commissioner Joshi have asked to have staff project national performance earlier in the year to track Maryland performance in a more timely manner. Further, if recent national performance trends continue, they would recommend permanently revising the cut-point going forward.

Staff Response: Staff appreciates the comments regarding the RY 2025 cut point and, going forward will retrospectively analyze national vs Maryland performance under the QBR program domain weights earlier in the performance period using six months of performance data, and will continue to analyze whether changes are needed in the future.

FINAL RECOMMENDATIONS FOR RY 2027 QBR PROGRAM

Final 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; add a bonus incentive of \$150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.
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: <ul style="list-style-type: none"> • Eight HCAHPS categories top box score and consistency, and four categories linear score; • TFU Medicare, Medicaid, disparities improvement; • ED LOS0 	60 percent 8 measures: <ul style="list-style-type: none"> • 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 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

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.

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

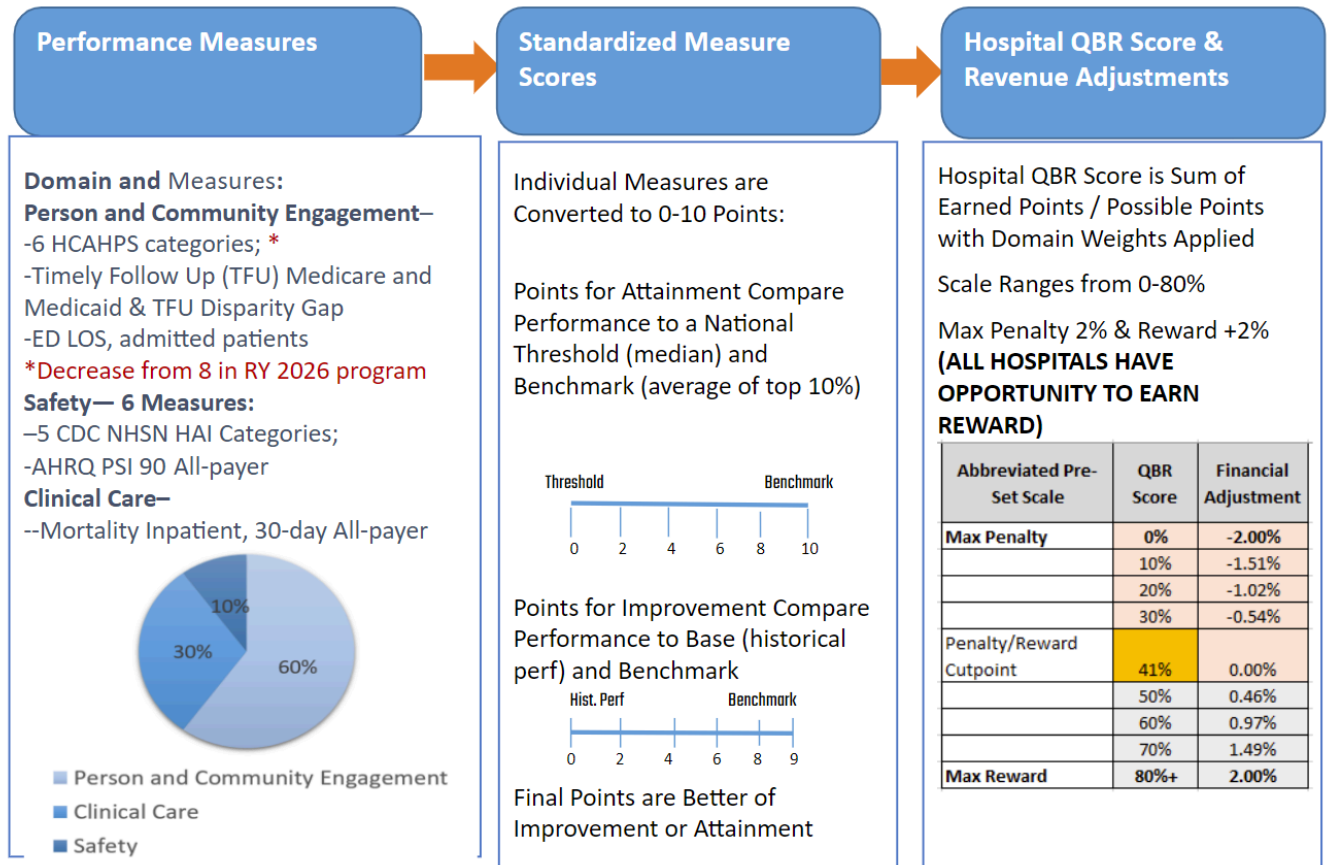


Figure A.3. below details the baseline and performance timelines for the measures in the QBR program for RY 2027.

PSI 90 measure (adopted beginning RY 2023)

Newly adopted in RY 2023, the Patient Safety Indicator composite measure was developed by the Agency for Healthcare Research and Quality in 2003.²² CMS first adopted the composite measure in the VBP program in FFY 2015 and removed the measure in FY 2019-FY 2022 due to operational constraints from the International Classification of Diseases, Tenth Revision (ICD-10) transition. The HSCRC had used the ICD-9 version of this measure in the QBR program but applied it to Maryland's all-payer population. CMS adopted the updated NQF endorsed ICD-10 version of the measure (Medicare only) that is used beginning with the FY 2023 Hospital VBP program²³, and also adopted by the QBR program (all-payer version) in RY 2023.

AHRQ's specified PSI uses include:

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

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

- PSI 03 Pressure Ulcer Rate
- PSI 06 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
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration 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 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
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

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

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.

An acute event is assigned to [condition] if:

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

OR

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

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.

$$[\text{NUM}(\text{ASM}) + \text{NUM}(\text{CAD}) + \text{NUM}(\text{HF}) + \text{NUM}(\text{COPD}) + \text{NUM}(\text{DIAB}) + \text{NUM}(\text{HTN})] / [\text{DENOM}(\text{ASM}) + \text{DENOM}(\text{CAD}) + \text{DENOM}(\text{HF}) + \text{DENOM}(\text{COPD}) + \text{DENOM}(\text{DIAB}) + \text{DENOM}(\text{HTN})]$$

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: $\text{NUM}(\text{HF}) / \text{DENOM}(\text{HF})$.

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

Updated TFU Measurement Specifications CY 2025

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

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

Digital Quality Measures Infrastructure: CMS Roadmap

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

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

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

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

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

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

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 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

For additional details on the MHCC analysis see below.

²⁷ Percents by race rounded up to full digit values.

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

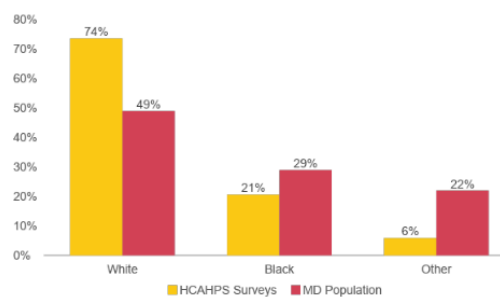
TITLE OF MEETING
NOVEMBER 2023



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.)

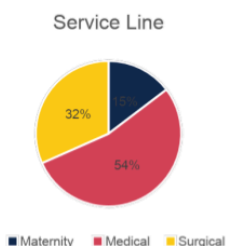
- ▶ Q3 2022 – Q2 2023 (30,653 surveys)
- ▶ MD population data from 2020 Census





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%

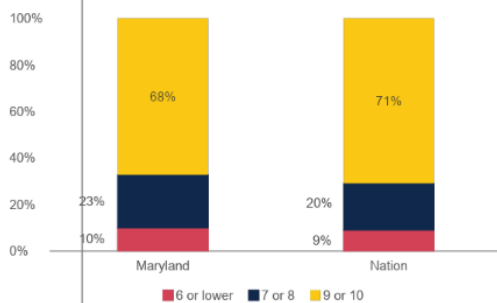
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Overall Rating

- 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%)
- 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



National data: Q2 2021-Q1 2022

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%

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Maternity Service Line – Black Women

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

Would 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 other 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%

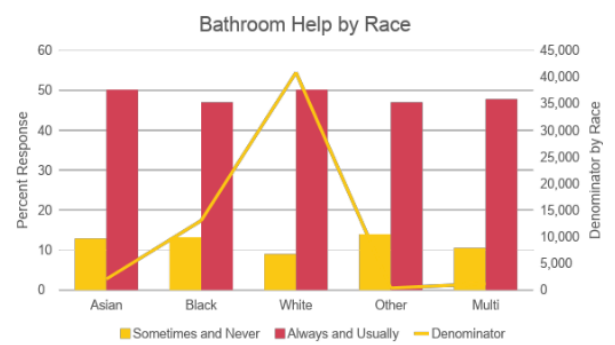
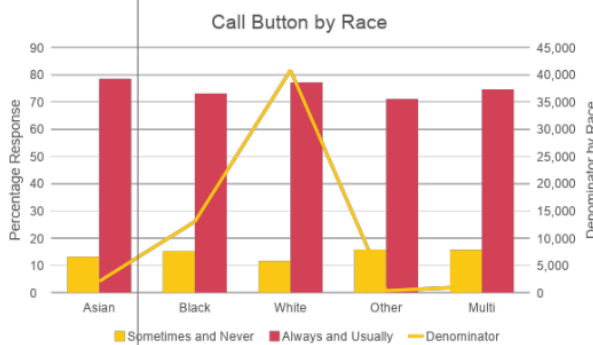
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Areas to Explore

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



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APPENDIX D: HCAHPS LEARNING COLLABORATIVE

Overview

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

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

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

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

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

Work Plan and Timeline

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

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

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

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

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

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

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

February 2025 - Convene learning collaborative to share best practices.

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

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

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

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

APPENDIX E: HSCRC EFFORTS TO ADDRESS ED LENGTH OF STAY

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

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

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

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

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

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

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

Additional Initiatives: Emergency Department Dramatic Improvement Effort (EDDIE)

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

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

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

Additional Initiatives: ED Potentially Avoidable Utilization

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

Additional Initiatives: Legislative Workgroup

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

Establishment of Maryland ED Wait Time Reduction Commission

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

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

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

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

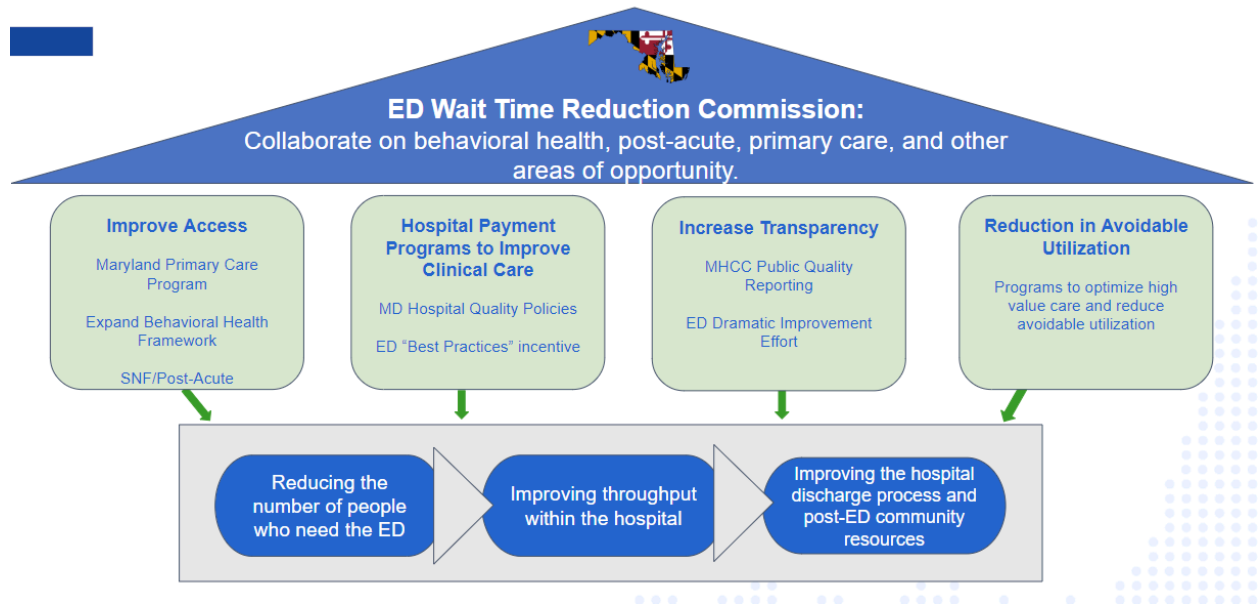
Chairs: Secretary of Health and Executive Director of HSCRC

Appointed Members:

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

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 \(maryland.gov\)](https://www.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 \(maryland.gov\)](https://www.maryland.gov)

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

Data Submission and Reporting Timeline

Should HSCRC try to collect CY2022 data?

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)

- 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

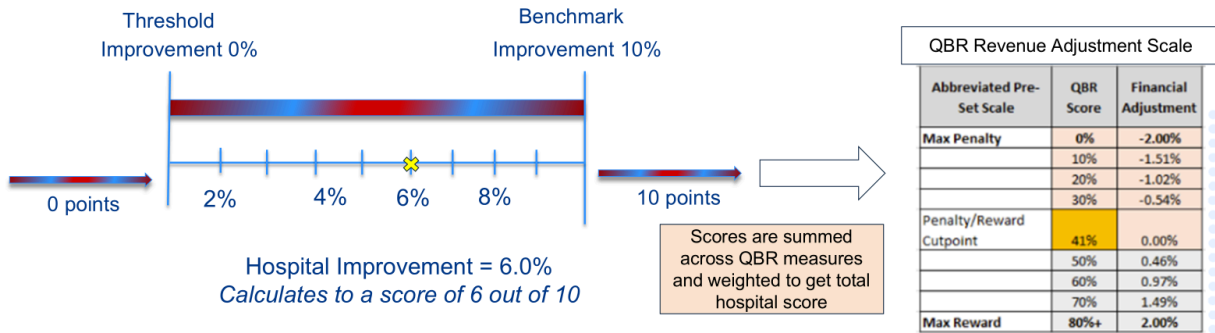


Ad-Hoc Data Submission Requirements (DSR)

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



Current Proposal

Base State Median: 523
If all hospitals improve to benchmark, State Median: 491

