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# Performance Measurement Workgroup

August 19, 2026

HSCRC Quality Team

# Meeting Agenda

- AHEAD Quality Transition & RY 2029 Policy Discussion
- Statewide and Hospital Population Health Accountability Plan updates
- RY2029 Quality Based Reimbursement
- Clinical Adverse Events Measure Update
- ED & Hospital Throughput Best Practices Update

# Workgroup Learning Agreements

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

**REMINDER: These workgroup meetings are recorded.**

# AHEAD Quality Transition & RY 2029 Policy Discussion

# AHEAD Updates and Hospital Global Budgets Transition Timelines

- Maryland entered the AHEAD Model in 2026.
- CMS will set **Medicare FFS global budgets** starting in 2028.
  - Performance Year 1 (2026) and PY2 (2027) will be a transition period where the State will continue to set all-payer Hospital Global Budgets.
  - In order to smooth the transition, the State will be able to re-direct a portion of the total Medicare global budget amount between PY3 (2028) and PY5 (2030).
  - Based on stakeholder discussions, CMMI will formally transition to the CMS hospital quality programs in CY 2030 using CMS FY 2030 quality results; CY 2028 and CY 2029 adjustments will be made to the Medicare FFS HGBs based on the State All-Payer Quality programs for RY 2028 and RY 2029.
- The State will continue to set Maryland HGBs (other than Medicare FFS).
  - The Maryland HGBs will continue to be adjusted for all-payer quality to ensure global budget efficiencies do not result in quality of care concerns, as was done under the previous models

# Updated CMS Transition Timeline

| Transition Timeline | | | Performance Year 1 | | Performance Year 2 | | Performance Year 3 | | Performance Year 4 | | Performance Year 5 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| CY ---> | Policy | 2025 | 2026 | | 2027 | | 2028 | | 2029 | | 2030 |
| RY 2027 | MHAC, RRIP, QBR, PAU | Performance Period (varies by measure) | | All-Payer Revenue Adjustments | | | | | | | |
| RY 2028 | | | Performance Period (varies by measure) | | | To Be Determined^ | | | | | |
| RY 2029 | | | | | Performance Period (varies by measure) | | | TBD Non-Medicare FFS HGBs^ | | | |
| | | | | | | | | Medicare FFS HGBs | | | |
| RY 2030 | | | | | | | Performance Period (varies by measure) | | | TBD Non-Medicare FFS HGBs^ | |
| FY 2030 | HVBP | | | | | | HVBP PCE & Safety Domains* | | | | Medicare Revenue Adjustments** |
| | | | | HVBP Mortality Measures & THA-TKA Complications | | | | | | | |
| | HRRP | | | | Medicare Condition Specific Readmissions | | | | | | |
| | HACRP | | | CMS PSI-90 | | | | | | | |
| | | | | | NHSN HAI | | | | | | |

*Efficiency domain is also on this timeframe. CMMI has indicated MD hospitals may not be measured on efficiency but this needs to be confirmed.

**CMS revenue adjustments for quality programs are implemented on FFY October-September timeframe. AHEAD revenue adjustments implemented on CY; awaiting final decision on whether the timeframe will be moved back one quarter or if multiple years will be averaged.

^Need to work with rate setting, CMMI, and stakeholders to figure out timeframe for RY vs. CY revenue adjustments

# FY 2029 Quality Program Policy Timelines

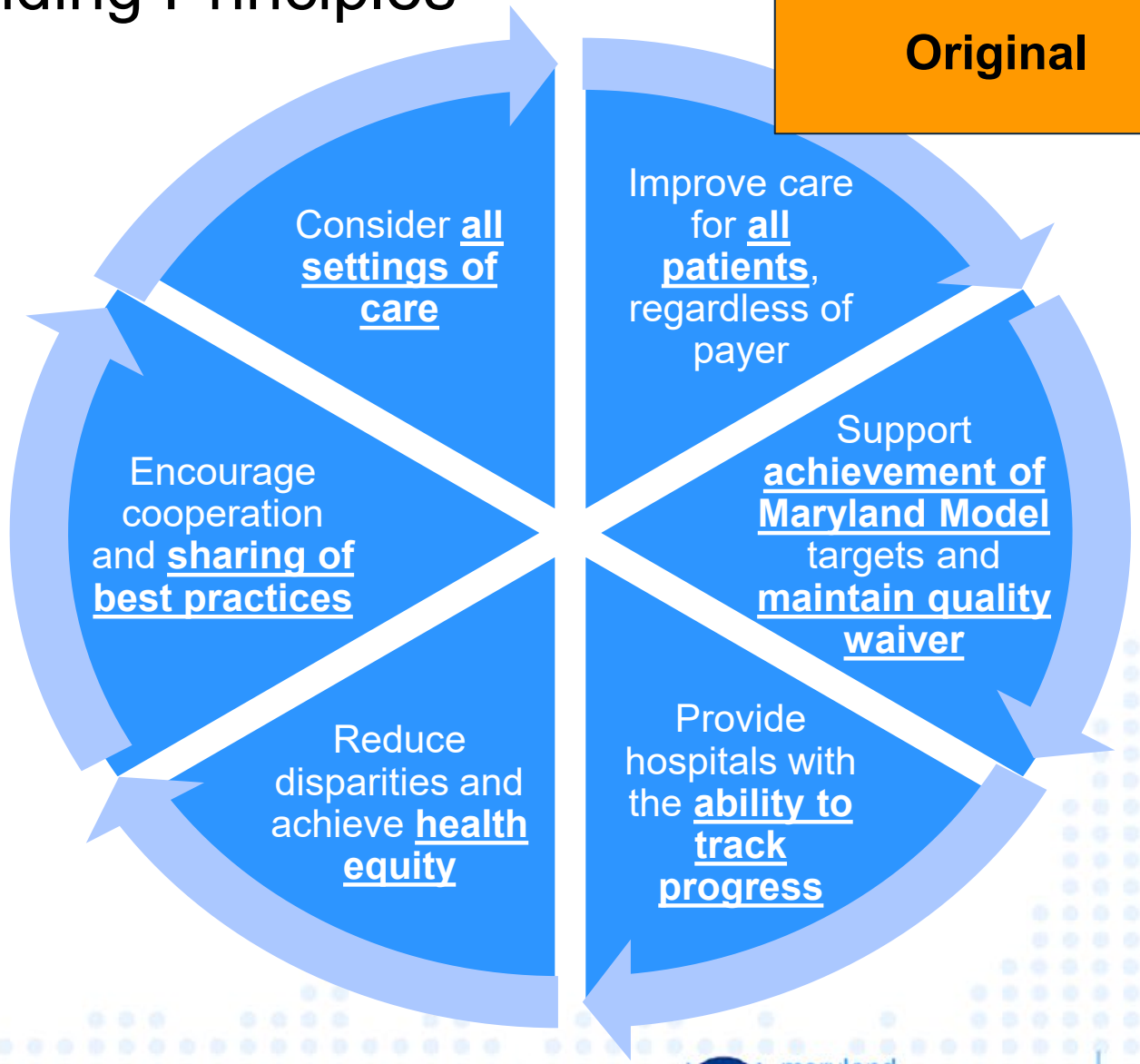
| Tentative Commission Meeting Timelines | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **September** | **October** | **November** | **December** | **January** | **February** | **March** | **April** | **May** | **June** |
| **QBR** | **RY 2029 Quality Overview** | **Draft** | | **Final** | | | | | | |
| **MHAC** | | | **Draft** | | **Final** | | | | | |
| **RRIP** | | | | **Draft** | | **Final** | | | | |
| **ED Best Practices**** | | | **Draft** | | **Final** | For stakeholder discussion: Transition from Monitoring Policy to Learning Collaborative | | | | |
| **PAU*** | | | | | | | | | **Draft** | **Final** |

*PAU is included in update factor policy; PMWG will need to discuss future PAU adjustment including potential alignment with AHEAD PAU measures (e.g., effectiveness adjustment)
**Based on PMWG/ED Subgroup and September Commission discussion: If transitioning to learning collaborative then draft and final policy may not be required

# HSCRC Quality Program Guiding Principles

**Original**

The mission of the HSCRC Quality Programs is to create all-payer financial incentives for Maryland hospitals to provide efficient, high quality patient care, and to support delivery system improvements across the State.



# RY29 QUALITY POLICIES GUIDING PRINCIPLES

August 17, 2026

Maryland
Hospital Association

# EMERGING PRINCIPLES FOR HSCRC QUALITY POLICIES

**GOAL OF HSCRC QUALITY POLICIES**

HSCRC'S quality policies must support hospitals in achieving success and optimizing performance in federal quality programs and position Maryland as a national leader in the AHEAD model

**PRINCIPLES**

- Provide adequate lead time to support successful transition and implementation
- Align with federal quality programs to reduce administrative burden, promote consistency, and focus hospital resources on patient care and improvement efforts
- Limit downside financial risk to enable investment in efforts to preserve access to care and drive quality improvement
- Focus incentives on encouraging the transition of care to lower-cost settings where appropriate
- Account for broader policy, market, and other factors that influence performance, including patient acuity, social risks, behavioral health access, and payer-driven utilization of observation stays

# EMERGING STANDARD FOR HSCRC HAVING DIFFERENT QUALITY MEASURES

## REQUIREMENTS FOR CONTINUATION OR ADOPTION OF NON-ALIGNED MEASURES

To support hospital success in CMS quality programs and the AHEAD Model, a non-aligned measure must advance a compelling State quality objective that is not addressed by a CMS quality program measure and be narrowly tailored to achieve the objective

## SPECIFIC REQUIREMENTS

- **Evidence-Based and Clinically Meaningful Outcomes –** measure must address demonstrated performance gap and be supported by evidence that it improves patient outcomes, safety, and care delivery and access, rather than incentivizing documentation, coding optimization, or process compliance alone
- **Administrative Simplicity –** measure must leverage existing data sources, prioritize electronic reporting, and minimize unnecessary reporting requirements and operational burden
- **Validation and Testing –** measure must be subject to monitoring and validation periods before being tied to financial incentives or penalties to assess feasibility, reliability, and unintended consequences
- **Ongoing Evaluation –** measure must be periodically reassessed and retired when it no longer demonstrates value, effectiveness, or addresses an ongoing need
- **Transparency and Stakeholder Engagement –** selection or continuation of measure must allow a standardized and transparent process with stakeholder input

# Transition Core Principles

- Initially, the HSCRC approach will pursue incremental changes to HSCRC-managed policies. More substantive alterations will be pursued in the near term only where: 1) incremental change is not viable; or 2) there is consensus among hospitals, payers and the State that substantive change is necessary.
- HSCRC will align with CMMI policies where: 1) they are appropriate for populations under HSCRC hospital global budgets; 2) they align with the State's vision and goals for the health care system, as well as HSCRC's legislative mandate; and 3) the administrative cost of the transition to the CMMI approach is merited given the policy outcomes.
- As a result, the goal of the current workplan is to generate a 'Minimum Viable Product' for the bridge period and not a perfect end state. In the meantime, HSCRC will accumulate a list of ideas to incubate as the transition period progresses.

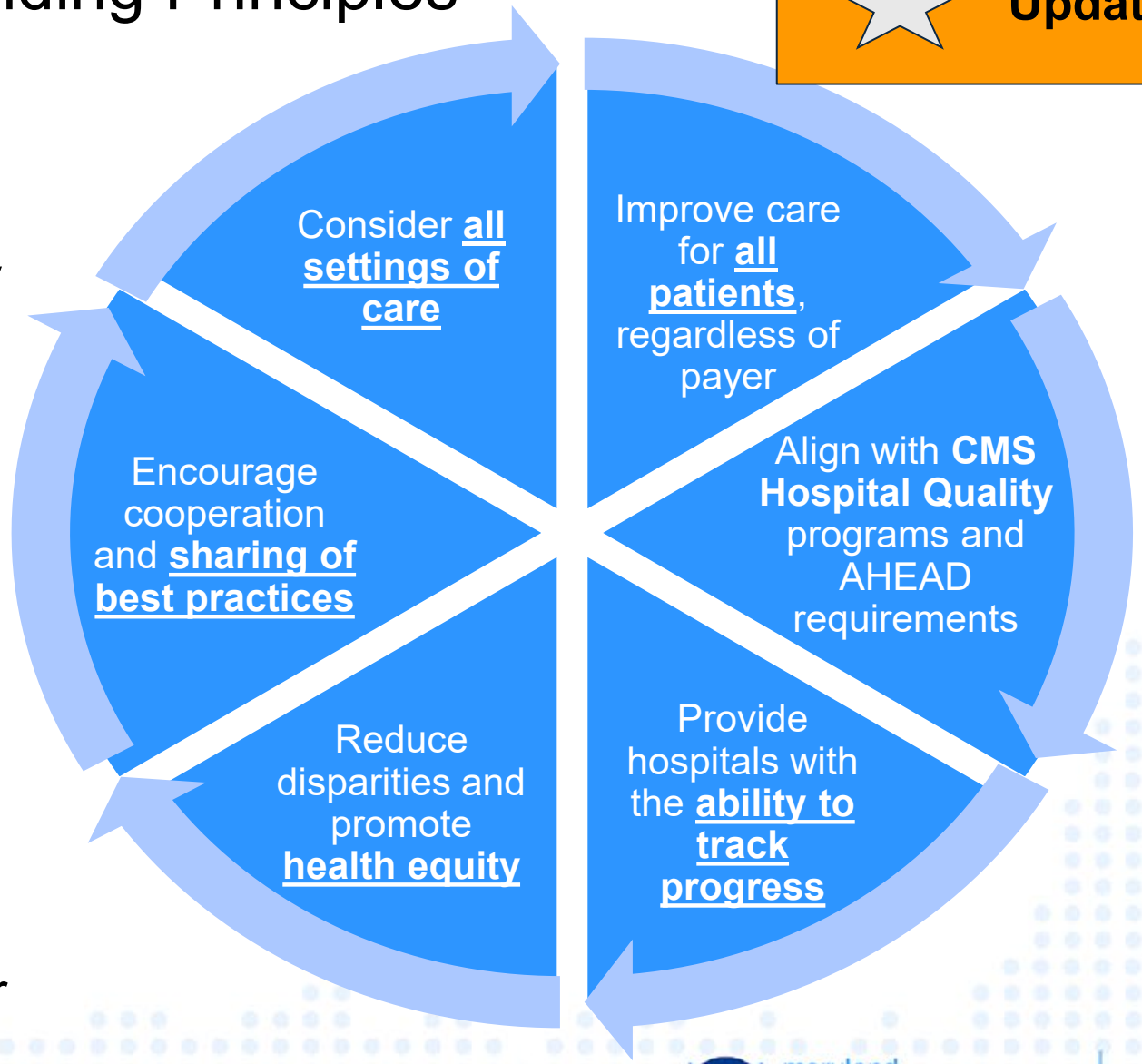
# HSCRC Quality Program Guiding Principles

Updated

The mission of the HSCRC Quality Programs is to ensure Maryland hospitals provide efficient, high quality patient care, and to support delivery system and population health improvements across the State.

Areas not specifically covered:

- Lead time for transitions
- Limit downside risk
- Account for factors outside hospitals control
- *Requirements for non-aligned measures:* Evidence based, clinically meaningful, administrative simplicity, validation, testing, re-evaluation, transparency and stakeholder engagement



# Non-Aligned Measures

Currently Used in Payment

- Solventum Potentially Preventable Complications
- Medicaid Timely Follow-Up
- Emergency Department Length of Stay for Admitted Patients (non-psychiatric admits)
- All-Payer, All-Condition 30 Day Readmissions
- Avoidable Admissions as measured by AHRQ Prevention Quality Indicators

Monitored or Under Consideration

- **Inpatient Length of Stay**
- Emergency Department Length of Stay for discharged patients, psychiatric, etc
- Excess Days in Acute Care (EDAC)
- Readmission Disparities
- Medicare Timely Follow-Up and Timely Follow-Up Disparities
- Multi-Visit Patients
- Diabetes screening
- **Electronic Clinical Quality Measures including maternal measures**
- **Hybrid Mortality and Readmissions**

# Items for Commission Discussion

- Options for RY 2029 MHAC policy (i.e., whether to discontinue PPC measures)
- Continued inclusion and weighting of non-aligned measures in RY 2029 QBR (i.e., ED LOS, Medicaid TFU, all-payer mortality)
- Future inclusion of IP LOS as payment measure in Quality Program portfolio (QBR, RRIP)
- Transition from Best Practice Policy to Learning Collaborative
- Alignment of readmission measure for RRIP and program goals
- Revenue at-risk and upside vs. downside incentives

# Statewide and Hospital Population Health Accountability Plan updates

# Statewide Population Health Accountability Plan (PHAP) Update

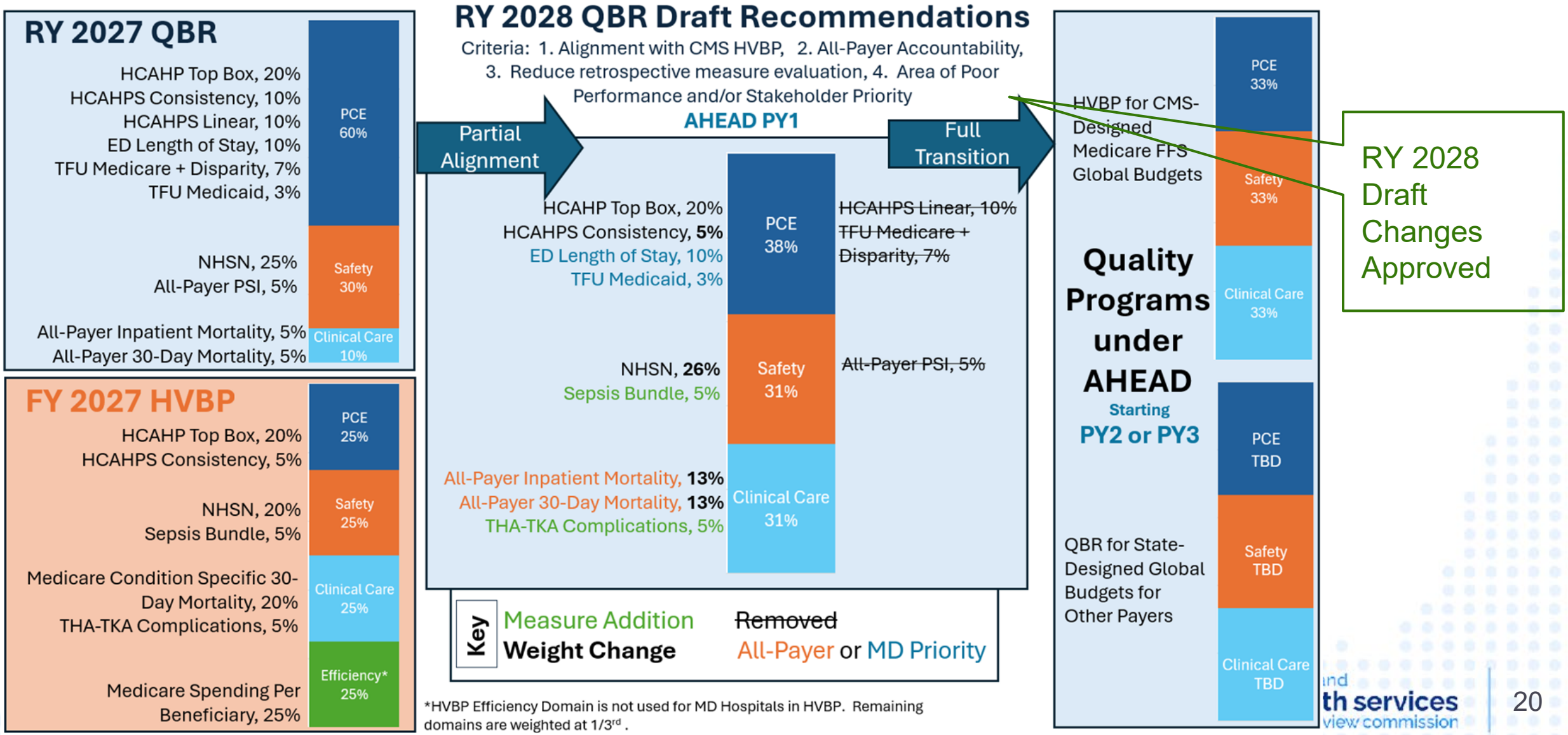
- On June 10th, 2026, CMMI provided the State with a memo that:
  - Approved the State PHAP targets for the:
    - Plan All-Cause Readmission (PCR-AD) measure
    - CDC's Health Related Quality of Life (HRQOL) - General Health Status (Good or Better Health) measure
    - BRFSS Survey Food Insecurity measure
  - Recommended updated State PHAP targets for the:
    - Timely Follow-Up After Hospitalization for Mental Illness (FUH-AD) measure - (*accepted by State*)
    - Colorectal Cancer Screening measure
    - HbA1c Diabetes Control measure
- The State responded to the recommended targets of the Colorectal Cancer Screening and the HbA1c measures with revised targets (see appendix)
- The State is currently awaiting a response from CMMI on the revised targets

# Hospital Population Health Accountability Plan (PHAP) Update

- In July 2026, the State received a verbal overview of the vision for the Hospital PHAP
  - Included potential but *not final* timeline for template release and submission deadlines
- While we await the official hospital HAP template, we know:
  - The six PHAP measures have been established (even if the final statewide targets for two of the measures are still under discussion)
  - MCHE is required to ensure alignment of the hospital PHAP with the State PHAP
- Thus, it is recommended that hospitals begin collaboration with the local health departments for local action planning if they haven't already
  - To build forward-looking joint strategies designed to improve on the six PHAP measures
  - This can help ensure that interventions are feasible, measurable, and beneficial to the community and have the highest and best chance of improving population health outcomes and reducing total cost of care
  - For hospitals that are updating their CHNAs, this also presents an opportunity to engage LHDs early and align PHAP planning with broader community health priorities

# QBR RY 2029

# Quality Based Reimbursement Alignment with CMS Under AHEAD



# QBR RY 2029: Continue to Align Using Established Criteria: Consider Clinical Adverse Events Measures (CAEM) Input

**CAEM discussed need to align safety and mortality measurement with CMS programs and need for State all-payer measurement under Maryland Hospital Global Budgets (HGB)**

- **Mortality Measures**
  - CAEM discussed not adopting condition specific measures until Medicare HGB and retaining IP and 30-day All-payer measures during transition and under State HGB
- **THA and TKA Complications and Sepsis Bundle**
  - For THA TKA Complications, CAEM discussed concerns re. movement to OP settings but supported retaining the measure for alignment with HVBP (not unanimous)
  - Although not a perfect measure, supported Sepsis Bundle measure for alignment (not unanimous)
- **Incubator measures for future adoption proposed to CAEM**
  - Adult Community Onset Sepsis 30-day mortality measure
  - CDC Hospital Onset Bacteremia (HOB) measure
  - Hospital Wide Mortality (HWM) hybrid measure

# QBR RY 2029 Issues for Discussion

**Measures**

| | |
|---|---|
| ➔ Retain for HVBP Alignment:<br>● THA TKA Complications<br>● Sepsis Bundle | ➔ Retain for State-Driven priorities<br>● IP and 30-day All-Payer Mortality<br>● Medicaid Timely Follow Up<br>● ED Length of Stay (LOS) |

**Domain Weights- Current Weights**

- Person and Community Engagement- 38% (HCAHPS and Medicaid TFU and ED LOS)
- Clinical Care 31%- (IP and 30-day All-payer mortality, THA TKA Complications)
- Safety 31%- (CDC HAI measures, Sepsis Bundle)

**Revenue at Risk- Currently 2%**

- With additional State measures, should revenue at risk increase (w/ lowering complications rev at risk)

**Timing for incubator measures**

- State currently working with contractor to develop 30-day HWM risk adjustment using CCDE
- CMS Emergency Care Access and Timeliness (ECAT) eCQM
  - OPPS 2026 Final Rule (November 2025): voluntary reporting January 1, 2027 (2029 payment) and mandatory reporting January 1, 2028 (2030 payment)
  - In IPPS 2027 Proposed Rule (April 2026) and Final Rule (August 2026), CMS put out request for information on adapting this measure for the inpatient setting.

# QBR RY 2029 RY Policy Draft Next Steps

## September PMWG Meeting

- **Analytics for PMWG review**
- **Modeling**
  - Revenue at risk
  - Inclusion/exclusion of measures
  - Hold harmless zone
- **Staff will determine if ready to bring draft recommendations**

# Clinical Adverse Event Measures Subgroup Update

# CAEM Goals

1. Recommend ***complications (MHAC), safety (QBR), and mortality (QBR)*** measures for:
    a. RY2029 (CY2027) Maryland Hospital Acquired Conditions program and Quality-Based Reimbursement, and
    b. Incubator that can be considered in future years, including:
        i. Measures that are not yet ready for payment that are either under consideration by CMS or measures that are important for MD under an all-payer quality program such as maternal health measures.
2. Recommend criteria for measure selection that can be used in future years and any payment considerations for PMWG
    a. For example:  Maintain rewards in RY2029 if program includes measures beyond CMS portfolio.

# Complications Program

**CAEM Subgroup Work to be completed**

- Determine whether to recommend retention of PPCs with all-payer PSIs
- Determine whether to recommend adopting CDC HAI measures
- Review sepsis mortality case capture in current 30-day mortality measure using AHRQ definition to identify sepsis cases (ICD10 codes) and make any related recommendations
- Make recommendations regarding incubator measures

**PMWG RY 2029 Considerations**

- Evaluate CAEM subgroup recommendations
- Revenue at risk changes?
- With measure updates, any changes for the reward-penalty methodology?

# RY 2028 MHAC Modeling Scenarios

## Background

- RY 2028 MHAC policy added the all-payer PSI 90 composite to the existing PPC measures to align closer with the AHEAD model.
- Staff is considering further alignment with the CMS Hospital-Acquired Condition Reduction Program (HACRP), while retaining flexibility for Maryland-specific priorities.

## Purpose of proposed analysis

- Model alternative MHAC approaches to understand the effects of changing:
  - Measures included
  - Performance standards (retrospective versus concurrent)
  - Revenue adjustment methodology (current MHAC +/- 2 percent continuous scaling approach versus CMS's HACRP 1 percent for worst-performing quartile approach)
- Assess how these alternatives affect hospital MHAC scores, reward/penalty status, and statewide revenue adjustments.

**Key takeaway: Proposed analysis are intended to help understand tradeoffs between greater CMS alignment and Maryland-specific program design.**

# Proposed MHAC Analysis Scenarios

Scenarios vary three policy levers: measures, performance standards, and revenue adjustment methodology.

| Scenario | Measures | Performance standards | Revenue adjustment | Note |
|---|---|---|---|---|
| 1A | PPC + PSI 90 | Retrospective | MHAC +/- 2% scaling | **Current HSCRC** |
| 1B | PPC + PSI 90 | Concurrent | MHAC +/- 2% scaling | |
| 2A | PPC + PSI 90 | Retrospective | HACRP WPQ 1% | |
| 2B | PPC + PSI 90 | Concurrent | HACRP WPQ 1% | |
| 3A | PSI 90 only | Retrospective | MHAC +/- 2% scaling | |
| 3B | PSI 90 only | Concurrent | MHAC +/- 2% scaling | |
| 3C | PSI 90 only | Concurrent | HACRP WPQ 1% | |
| 4A | PPC + PSI 90 + HAIs | Retrospective | HACRP WPQ 1% | |
| 4B | PPC + PSI 90 + HAIs | Retrospective | HACRP WPQ 1% | |
| 5A | PSI 90 + HAIs | Retrospective | MHAC +/- 2% scaling | |
| 5B | PSI 90 + HAIs | Retrospective | HACRP WPQ 1% | |
| 5C | PSI 90 + HAIs | Concurrent | HACRP WPQ 1% | **Closest to HACRP** |

*HACRP = Hospital-Acquired Condition Reduction Program; WPQ = worst-performing quartile.*

# Proposed Analysis Outputs

## Hospital-level impacts

- Goal: Show how each policy option affects individual hospitals.
  - Compare each hospital's Total MHAC Score and revenue adjustment across scenarios.
  - Identify whether each hospital receives a penalty, reward, or no adjustment.

## Statewide impacts

- Goal: Compare the overall financial impact for each scenario across Maryland.
  - Summarize the number of hospitals penalized, rewarded, or receiving no adjustment.
  - Compare total penalty and reward dollars, percent of inpatient revenue, and net statewide revenue adjustment.

**Key takeaway: Our goal is to show how each scenario changes hospital results, statewide financial impacts, and outcomes relative to the current HSCRC policy.**

# RY 2028 MHAC Analysis Considerations

## Available data

- Analyses will use the data available for each measure; measurement periods may vary across measures.

## Two-year periods

- Where needed, available annual measure results will be combined to approximate two-year measurement periods.

## Modeling approach

- Some data periods and calculation methods will differ from the official MHAC and CMS HACRP methodologies based due to data availability and statistical feasibility.
    - For example, applying the HACRP winsorized z-score methodology using only Maryland hospitals may be challenging given the relatively small number of hospitals and limited eligibility for some measures.

**Key takeaway: These adaptations reflect available data and are intended to support comparison of the policy options rather than replicate official CMS HACRP results.**

*HACRP = Hospital-Acquired Condition Reduction Program.*

# ED Wait Time Reduction Commission Update

# Key Drivers & Rationale

## Access to Post Acute Care

Strong anecdotal evidence provided from hospitals across the state, supported by analyses and HSCRC's ED-Hospital Modeling work demonstrating care transition delays to post-acute care and interventions to improve hospital-SNF coordination impact IP & ED LOS, ED-Hospital throughput, and ED Boarding.

## Capacity Alignment

Accurately identifying and analyzing hospital and post-acute bed capacity and occupancy was key priority identified and included in the Interim Legislative report. HB1563 has further prioritized. Ensuring capacity across the state through a combination of decreasing patient days, evaluating physical capacity, and exploring alternate capacity options is critical.

## Denial & Authorization Delays

Both qualitative and quantitative data shared in multiple workgroups, including the Multi-Agency working group and MHCC Post Acute Workgroup, have identified denials and authorization delays as a contributor to discharge delays leading to ED boarding and increased ED wait times. Internal data tracked by hospitals also supports denials as a key driver of ED Boarding.

## ED and IP Throughput Best Practices & Care Transitions

The care transition and best practice opportunities listed below have been identified by the hospital industry and/or multiple agencies throughout the past 18 months. Care Transitions was identified as a priority in the HB1563 legislation. We highlighted many of these opportunities in our Interim Legislative report.

# Key Drivers & Areas for Recommendations to Address ED LOS Updated

## Access to Post Acute Care

**Note: Will integrate MHCC Post Acute Workgroup Output**

- **Strengthen and expand participation in value based payment programs for post-acute providers**
  ***Key Stakeholders involved:*** *MHCC, HSCRC, Medicaid, Commercial Payers, Post-Acute Providers, MIEMSS, Legislature*
  ***Primary Recommendation***

- **Complete hospital and post-acute bed allocation/capacity analysis (aligned with HB1563)**
  ***Key Stakeholders involved****: MHCC, HSCRC, MDH, Acute & Post Acute Care Facilities, MIEMSS, Legislature*
  ***Prmary Recommendation***

- **Recommend stakeholders prioritize care transformation initiatives that impact ED and IP LOS**
  ***Key Stakeholders involved:*** HSCRC, MHCC, MIEMSS, Medicaid, Commercial Payers, Acute and Post-Acute Facilities, Legislature
  ***Primary Recommendation***

- **Recommend policymakers consider addressing reimbursement models, capacity gaps, regulations for authorization and acceptance, et.**
  ***Key Stakeholders involved****: MHCC, HSCRC, MDH, Acute and Post Acute Care Facilities, Medicaid, Legislature*
  ***Primary Recommendation***

## Authorization Delays & Denials

- **Review of prior authorization (PA) laws from across the nation and align with the AMA Advocacy Resource Center Document Recommendations to streamline and standardize prior authorization (PA) process.**
  **Key Stakeholder:** Adverse Decisions Workgroup
  **Primary Recommendation**

## Capacity Alignment

- **Assess Regional Needs for Inpatient & Post-Acute Capacity using hospital and post-acute bed allocation/capacity analysis conducted as part of HB1563**
  ***Key Stakeholders:*** *HSCRC, MHCC, MIEMSS, MDH, Acute & Post-Acute Facilities, Legislature*
  ***Primary Recommendation***
- **Multi-stakeholder collaboration on service line coordination across the state**
  ***Key Stakeholders:*** *HSCRC, Acute Care Facilities*
  ***Secondary Recommendation***
- **Explore alternate capacity options (Hospital at Home, Expanded Home Health, Bridge Clinics)**
  ***Key Stakeholders:*** *HSCRC, Hospitals, Legislature*
  ***Primary Recommendation but timeline is contingent on addressing statute limitations***
- **Monitor IP LOS (note: policy approved by HSCRC) and partner with hospitals to understand IP LOS drivers and best practices**
  ***Key Stakeholders:*** *HSCRC,Acute Care Facilities*
  ***Secondary Recommendation***
- **Evaluate staffing metrics as directed by regulatory agencies and recent Safe Staffing Act (SB411, HB624)**
  ***Key Stakeholders:*** *Acute Care Facilities, Legislature*
  ***Secondary Recommendation*** *(Low correlation to ED LOS impact & already implemented)*

## ED-Hospital Throughput & Care Transition Best Practices

- **Collaboration on resource allocation and support for Long Stay Patients and guardianship cases**
  ***Key Stakeholders:*** *HSCRC, MDH, Hospitals, Post-Acute Providers, Legislature*
  ***Primary Recommendation***

- **Expand community partnerships and investments in primary care, behavioral health including pediatrics, and to address social determinants of health**
  ***Key Stakeholders:*** *HSCRC, MDH, Hospitals, Post-Acute Providers, Legislature*
  ***Primary Recommendation***

- **Evaluate opportunity to integrate Psychiatric Bed Registry to improve care transitions**
  ***Key Stakeholders:*** *HSCRC, MDH, Hospitals, Post-Acute Providers, Legislature*
  ***Primary Recommendation***

- **Strengthen and expand Palliative Care and Hospice services**
  ***Key Stakeholders:*** *HSCRC, MDH, Hospitals, Post-Acute Providers, Medicaid, Legislature*
  ***Primary Recommendation***

- **Expansion of HSCRC Hospital Best Practice Policy**
  ***Key Stakeholders:*** *HSCRC, MDH, Hospitals, Post-Acute Providers, Legislature*
  ***Secondary Recommendation***

# ED-Hospital Throughput Best Practices Update

# Best Practice Policy

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# RY 2028 ED Best Practices Policy

The Best Practices policy is centered around a set of six Hospital Best Practices that are designed to improve the emergency department (ED) and hospital throughput and reduce ED length of stay (LOS). Each best practice includes three levels (tiers) with measures showing how well and how fully it's being implemented. Year 1 (RY2027/CY2025) was a partial year, and Year 2 (RY 2028/CY2026) is focused on starting implementation, developing reports, and collecting and analyzing data; no points will be assigned to these tiers.

## Hospital Requirements for RY2028 (CY2026)

- Hospitals will continue the two Best Practices implemented and reported on in Year 2 with a focus on hardwiring and expanding implementation.
- Hospitals must notify HSCRC in writing if they wish to change Best Practice selections from Year 1.

## Key Dates and Requirements

**December 15, 2026: Final Deadline**

- Missing this deadline will result in a 0.1% penalty on inpatient revenue in January 2027
- Extraordinary events (e.g., cyberattacks, disasters) will be handled under the exception policy.

## Ongoing Work

- The subgroup will work to update the reporting templates
- The subgroup will focus on analysis of the reports and sharing of best practices.
- They'll also study how the practices affect LOS and make future recommendations about tying performance to payment.

# CY25 & CY26 ED-Hospital Throughput Best Practices

- Interdisciplinary Rounds & Discharge Planning
- Standard Daily Shift Huddles
- Bed Capacity Alerts
- Clinical Pathways and Observation Management
- Expedited Care Bucket
- Patient Flow throughput Council

# CY 2025 ED-Hospital Throughput Best Practice Hospital Selections

### Standardized Daily/Shift Huddles
20 hospitals implemented
**10 had ED LOS improvement**

### Patient Flow Throughput Performance Council
19 hospitals implemented
**9 had ED LOS improvement**

### Expedited Care Intervention
16 hospitals implemented
**9 had ED LOS improvement**

### Interdisciplinary Rounds & Discharge Planning
13 hospitals implemented
**8 had ED LOS improvement**

### Bed Capacity Alert System
10 hospitals implemented
**7 had ED LOS improvement**

### Clinical Pathways & Observation Mgmt
4 hospitals implemented
**3 had ED LOS improvement**

- Not reflected is improvement in other metrics (IP LOS, ED Boarding, LWBS, etc.).
- In Year 2, the subgroup will discuss the feasibility of tracking secondary metrics via the Best Practices Report or ED LOS Dashboard.

# RY2029/CY 2027 Best Practice Policy Considerations

**CY 2027 Policy Calendar Target:** Draft Recommendations scheduled for **November 2026**. Final Recommendations scheduled for **January 2027**.

OPTION 01

## Transition to Pay for Performance

Transition from monitoring and pay-for-reporting to direct **pay for performance** models.

OPTION 02

## Maintain Monitoring Policy

Continue monitoring and pay-for-reporting frameworks **similar to CY25 and CY26** regulations.

OPTION 03

## Development of Learning Collaborative

**Sunset Best Practices as a policy** and develop a learning collaborative as a forum for continuing to share best practices and DATA .

Partner with front-line representatives to better understand ED & IP LOS key drivers to be addressed with Collaborative.

⚠ **Calendar Note:**
Staff will provide an overall strategic update on quality policies at September Commission meeting. This will include discussion on future of Best Practice Policy and QBR ED LOS payment incentives based on stakeholder discussions. If Option 03 is chosen, draft and final recommendations may not be needed.

Staff supports this option and can use the HCAHPS Learning Collaborative as a model for the collaborative. Propose that initially HSCRC staff will meet with hospitals to better understand key drivers and opportunities and to gather input for development of collaborative.

# ED-Hospital Best Practices Subgroup Questions and Feedback Discussion

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# Metric Consideration: Questions Sent to Subgroup for Feedback

In reviewing our Best Practice reporting, some hospitals reported “secondary” metrics, including Left Without Being Seen (LWBS) and ED Boarding Time. Other additional metrics were reported, but for this discussion, we would like to focus on LWBS and ED Boarding Time.

Questions for the group:

- From your perspective, would there be value in collecting additional metrics across all hospitals not already required by CMS or able to be calculated with HSCRC case mix data? In discussion it seems that most facilities are already tracking these metrics internally.
- What would be the administrative burden of submitting LWBS or ED boarding metrics?
- Would reporting these metrics necessitate EMR changes or do the timestamps already exist on the hospital side?
- LWBS and ED Boarding Time are part of the CMS ECAT measure (details on next slide). The ECAT measure reporting is mandatory in CY 2028 and optional in CY 2027 for CMS. Should the State make CY 2027 reporting mandatory in CY 2027 as has been done with other voluntary electronic clinical quality measures? This could establish an earlier base year for potential transition from our current ED LOS payment measure to ECAT in CY 2028?

# Feedback Received From:

- MedStar
- Calvert
- Federick
- Adventist
- Luminis
- UMMS
- JHHS
- HSCRC

# How can we make reporting more robust in Year 2 (CY 2026) without increasing hospital burden?

Are there secondary metrics that we could correlate to changes in ED LOS?

## Feedback for Robust & Simple Reporting

- **Progress Goals:** Add percent improvement or attainment goals to each best practice to show progress over time.
- **Tool Simplification:** Re-visit survey tool and simplify fields to brief definitions, goals/targets, and actual results.
- **Minimize Narrative:** Remove narrative requirements (impact, rationale, success, barriers) to reduce hospital reporting friction.

## Secondary Metrics for Capacity Monitoring

Establish monitoring first to determine benchmarking targets before incorporating metrics into the payment model:

1. **LWBS** (Left Without Being Seen)
2. **ED Boarding > 4 Hours**
3. **Door to Triage**
4. **Door to Provider**
5. **EMS Turnaround Time (provided by MIEMSS)**
6. **IP LOS (HSCRC to pull from casemix data)**

# What is the administrative burden of submitting LWBS or ED boarding metrics?

Would reporting these metrics necessitate EMR changes or do timestamps already exist on the hospital side?

## LWBS Metrics (Left Without Being Seen)

- **Easy to Report:** All responses indicate that LWBS is currently tracked and would be relatively easy to report without additional administrative burden.
- **No EMR Modifications:** Timestamps already exist on the hospital side, meaning no major system or workflow changes are required.

## ED Boarding Metrics

- **Definition Challenges:** Although currently tracked without immediate burden, standardizing definitions across all hospitals is critical to avoid a heavier EMR alignment lift.
- **Measurement Analysis:** An analysis of how each hospital measures ED Boarding is necessary to ensure statewide standards capture meaningful capacity data.
- **ECAT Alignment:** Several responses suggest waiting for ECAT metrics to be finalized and utilizing that standard definition for ED boarding.

# The ECAT measure reporting is mandatory in CY 2028 and optional in CY 2027 for CMS.

Should the State make CY 2027 reporting mandatory as has been done with other voluntary electronic clinical quality measures? Provides time to test metric and could be on the annual CMS reporting timeline.  Better ensures CY2028 reporting

## Financial & Budget Impact

- **FY27 Budget Finalized:** Budgeting is already approved to account only for currently required metrics.
- **Financial Burden:** Mandating CY27 reporting at the state level adds an unbudgeted financial burden on hospitals.
- **Vendor Infrastructure:** Additional infrastructure builds with third-party vendors would be required prematurely.

## Technical Readiness

- **Specs Not Finalized:** The CMS measure is still being finalized, and vendors have not released technical specifications.
- **Epic Compatibility:** Timestamps exist (arrival to room), but internal surge process revamps complicate integration.
- **No Manual Reporting:** Any manual reporting burden is strictly not supported by hospitals.

## Strategic Alignment

- **Uniform Transition:** Using Yale's ECAT measure for boarding is highly recommended to maintain uniformity.
- **Reduced Duplication:** Adopting the ECAT measure ultimately streamlines and reduces duplicative reporting.
- **Conditional Support:** Open to CY27 base year only if HSCRC requirements are minimal and automated.

# Measure Specifications

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# ECAT Measure Proposed for RY 2027 (voluntary) and RY 2028

The numerator is comprised of ED visits meeting the denominator criteria and where the patient experiences any of the following quality gaps in access:

1. The patient waited longer than 60 minutes (1 hour) after arrival to the ED to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination, or

2. The patient left the ED without being evaluated, or

3. The patient boarded (time from Decision to Admit order to ED departure for admitted patients) in the ED for longer than 240 minutes (4 hours), or

4. The patient had an ED length of stay (LOS) (time from ED arrival to ED departure as defined by the ED departure timestamp indicating when the patient physically left the ED) of longer than 480 minutes (8 hours).

ED encounters with ED observation stays are excluded from numerator criteria #3 (boarding) and #4 (ED LOS). To clarify, patients who have a 'decision to admit' after an ED observation stay remain excluded from numerator criteria #3 (boarded) calculations.

# ECAT Measures Specifications: LWBS & Emergency Department Boarding

| Measure: | Key Specifications |
|---|---|
| Left Without Being Seen (LWBS) | • Description: Percentage of ED patients who leave before being evaluated by a physician, APRN, or PA.<br>• Numerator: Patients who leave the ED without evaluation by a physician/APRN/PA.<br>• Denominator: All patients who present to the ED (i.e., sign in for emergency services).<br>• Definition: Patients evaluated by a resident/intern or institutionally credentialed provider under physician supervision are considered "seen." Advanced practice providers (e.g., NP, CRNA, CNS, CNM) also satisfy the evaluation requirement. |
| Emergency Department Boarding | • Description: Measures boarding of admitted patients who remain in the ED due to unavailable inpatient beds.<br>• Definition: Boarding is defined by CMS as holding admitted patients in the ED after admission because no inpatient bed is available.<br>• ECAT Population: All ED visits ending during the measurement period.<br>• Reporting: Included as one of the quality gaps within the ECAT (CMS1244v2) measure. |

Source: Emergency Care Access & Time

# Potential Inpatient ECAT Measure: FY 2027 IPPS Rule RFI

- CMS recognizes that this issue is not specific to one particular setting; a higher-level approach may instead be needed.
- If proposed for future rulemaking, CMS could consider adopting the existing outpatient measure into the hospital IQR or could make adjustments to tailor it more specifically for inpatient care, e.g., modifying specific numerator components or the overall denominator, may be at odds with system approach.
- Specific comments:
  - **Broad concern about expanding ECAT to inpatient programs:**Opposition/ significant concerns about about fairness, accountability, and the measure's readiness for inpatient use.
  - **Many drivers of ED boarding are outside hospital control:** Included bed availability, behavioral health and post-acute care capacity, prior authorization delays, workforce shortages, and community resources.
  - **Need for refinement of the measure:** Accounting for case mix, patient acuity, hospital type, rural vs. urban settings, socioeconomic factors, and social determinants of health; recognize alternative care models and clinically meaningful measures beyond simply time-based metrics.
  - **Unintended consequences:** ECAT could incentivize converting patients to observation status, avoiding direct admissions, premature discharge, patient diversion, and reduced time for thorough clinical assessment, potentially creating patient safety and care-quality concerns.
  - **Concerns about using ECAT in the Hospital VBP Program:** Commenters considered the measure inappropriate for value-based purchasing because hospitals could face financial consequences for factors beyond their control. Some recommended at least two years in Hospital IQR reporting before consideration for VBP.

# Left Without Being Seen OP 22 Measure Specifications

**Performance Measure Name:** Left Without Being Seen

**Measure ID #:** OP-22

**Measure Set:** Hospital Outpatient ED-Throughput

**Outpatient Setting:** Emergency Department

**Description:** Percent of patients who leave the Emergency Department (ED) without being evaluated by a physician/advanced practice nurse/physician's assistant (physician/APN/PA).

**Measure ascertains response to the following question(s):**

- What was the total number of patients who left without being evaluated by a physician/APN/PA? _____(numerator).
- What was the total number of patients who presented to the ED? _____(denominator).

**Definition for patients who presented to the ED:**

- Patients who presented to the ED are those that signed in to be evaluated for emergency services.

**Definition for Physician/APN/PA:**

- Patients who are seen by a resident or intern are to be considered as seen by a physician.
- An institutionally credentialed provider, acting under the direct supervision of a physician for healthcare services in the emergency department (e.g., an obstetric nurse providing assessment of an obstetric patient) are to be considered as seen by a physician.
- Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialties. Some common titles that represent the advanced practice nurse role are:
  - Nurse Practitioner (NP)
  - Certified Registered Nurse Anesthetist (CRNA)
  - Clinical Nurse Specialist (CNS)
  - Certified Nurse Midwife (CNM)

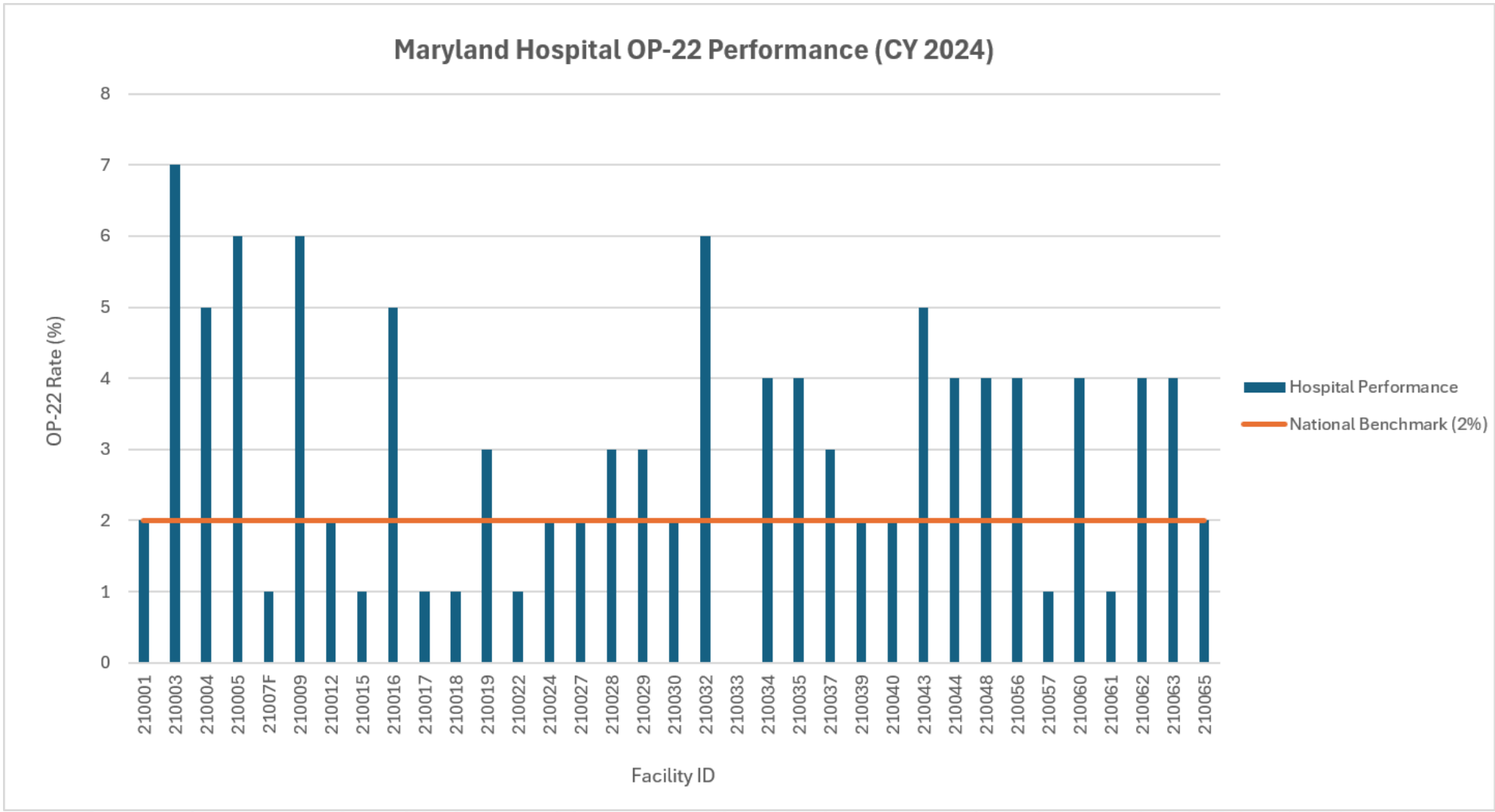
Source: Specifications Manual for encounters (pdf)

**For the ED Dashboard, we propose that we start with the historical data from Care Compare for LWBS then we can upgrade to one of the following options as available:**

1. **If the denominator cases are in casemix, evaluate if a flag can be added to indicate LWBS**
2. **Hospitals submit to HSCRC on a quarterly basis the file that they submit to CMS with the OP 22 data (minimize the data lag)**
3. **Transition to ECAT data when it is submitted**

**We can determine which option is best in 2027 if we agree it makes sense to start with Care Compare data initially**

# CY 2024 Maryland Hospital Performance: Left Without Being Seen (OP-22)




**Note: CY 2024 data is the latest available on CareCompare. Improvements noted by hospitals in CY 2025 are not yet reflected.**

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# THANK YOU!

## Next Meeting: September 16, 2026

# Appendix

# Hospital CCN Key

| Hospital ID | Hospital |
|---|---|
| 210001 | Meritus |
| 210002 | UMMS- UMMC |
| 210003 | UMMS- Capital Region |
| 210004 | Trinity - Holy Cross |
| 210005 | Frederick |
| 210008 | Mercy |
| 210009 | JHH- Johns Hopkins |
| 210011 | Saint Agnes |
| 210012 | Lifebridge- Sinai |
| 210015 | MedStar- Franklin Square |
| 210016 | Adventist- White Oak |
| 210017 | Garrett |
| 210018 | MedStar- Montgomery |
| 210019 | Tidal- Peninsula |
| 210022 | JHH- Suburban |
| 210023 | Luminis- Anne Arundel |
| 210024 | MedStar- Union Mem |
| 210027 | Western Maryland |
| 210028 | MedStar- St. Mary's |
| 210029 | JHH- Bayview |
| 210032 | ChristianaCare, Union |
| 210033 | Lifebridge- Carroll |
| 210034 | MedStar- Harbor |
| 210035 | UMMS- Charles |
| 210037 | UMMS- Easton |
| 210038 | UMMS- Midtown |
| 210039 | Calvert |
| 210040 | Lifebridge- Northwest |
| 210043 | UMMS- BWMC |
| 210044 | GBMC |
| 210048 | JHH- Howard County |
| 210049 | UMMS-Upper Chesapeake |
| 210051 | Luminis- Doctors |
| 210056 | MedStar- Good Sam |
| 210057 | Adventist- Shady Grove |
| 210060 | Adventist-Ft. Washington |
| 210061 | Atlantic General |
| 210062 | MedStar- Southern MD |
| 210063 | UMMS- St. Joe |
| 210065 | Trinity - Holy Cross Germantown |

# State PHAP Targets Update

| Domain | Measure | 2023 Baseline | State's *Original* Target for 2036 (PY10) | CMMI's Recommended Target for 2036 (PY10) | State's *Revised* Target for 2036 (PY10) |
|---|---|---|---|---|---|
| Population Health | CDC HRQOL -4 Healthy Days Core Module (Self-reported Health Status) | 16.5% with poor or fair health | 16.5% with poor or fair health | N/A | N/A |
| Prevention and Wellness | Colorectal Cancer Screening | 49.3% with screening | 54.6% with screening | 71.5% with screening | 59.8% with screening |
| Chronic Conditions | Hemoglobin A1c Control for Patients with Diabetes (>9.0%) | 67.8% with poor control | 60.3% with poor control | 15.7% with poor control | 60.3% with poor control for those without missing test results |
| Behavioral Health | Follow -up After Hospitalization for Mental Illness | 64.3% at 30 days; 38.0% at 7 days | 66.8% follow -up at 30 days; 40.5% at 7 days | 72.2% follow -up at 30 days; 51.5% at 7 days (accepted) | N/A |
| Utilization | Plan All -Cause Unplanned Readmission | O/E= 1.01 | O/E=0.98 | N/A | N/A |
| "Optional" | Food Insecurity | 16.4% food insecure | 15.0% food insecure | N/A | N/A |