maryland
health services
cost review commission

Performance Measurement Workgroup

November 20, 2024

HSCRC Quality Team

Meeting Agenda

- RY 2027 Final QBR Policy
- ED Best Practices Update
- RY 2027 Draft RRIP Policy
- RY 2027 Draft MHAC Policy
- AHEAD Model 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.

PMWG Members

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

QBR RY 2027 Draft Policy Updates

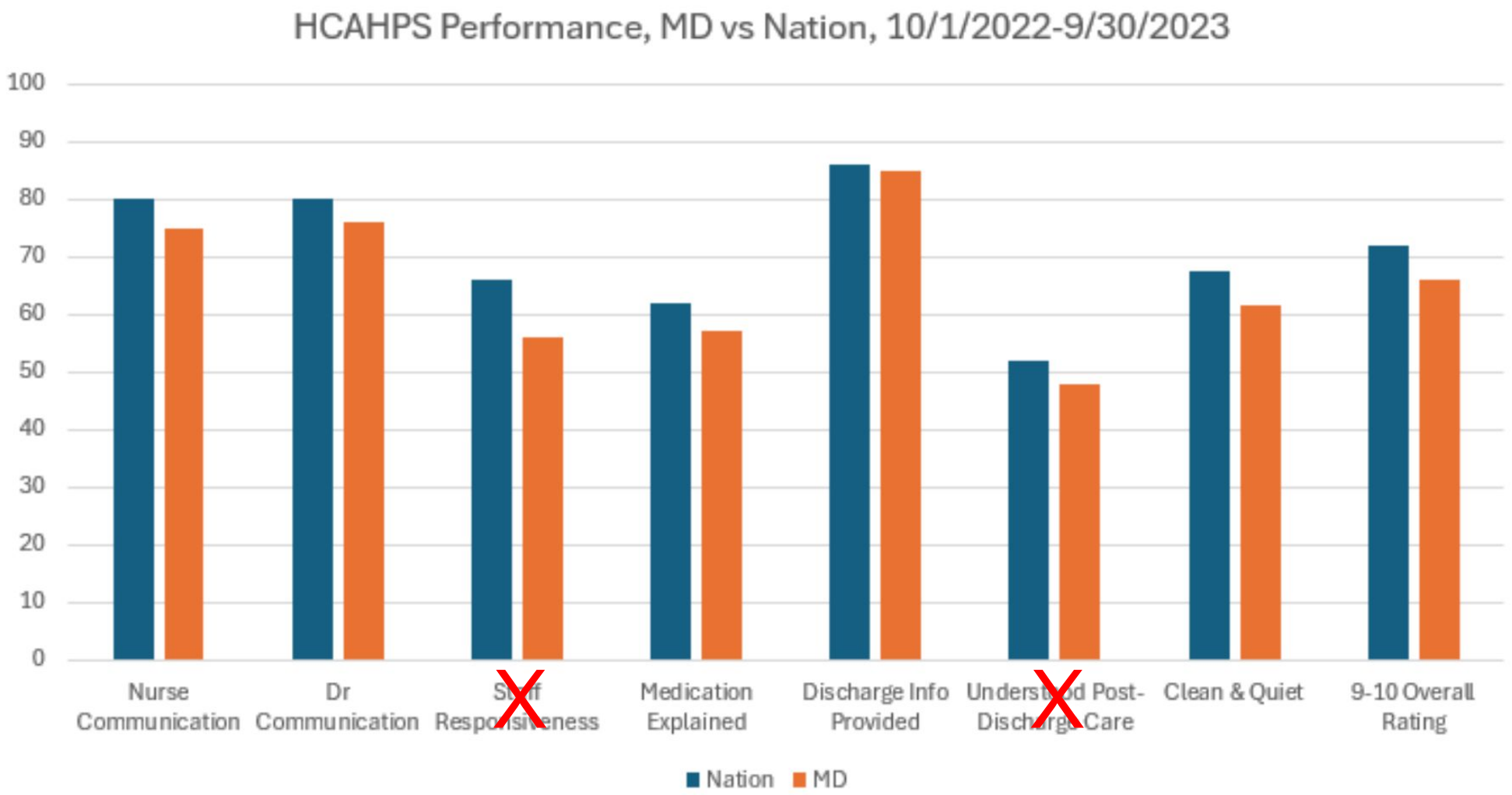
HCAHPS Linear Measure Updates

Updated HCAHPS Survey CYs 2025 through 2027

- There is a decrease from eight to six HCAHPS sub-domains in the Person and Community Engagement VBP domain:
  - Communication with nurses
  - Communication with doctors
  - Communication about medicine
  - Hospital cleanliness and quietness
  - Discharge information
  - Overall hospital rating

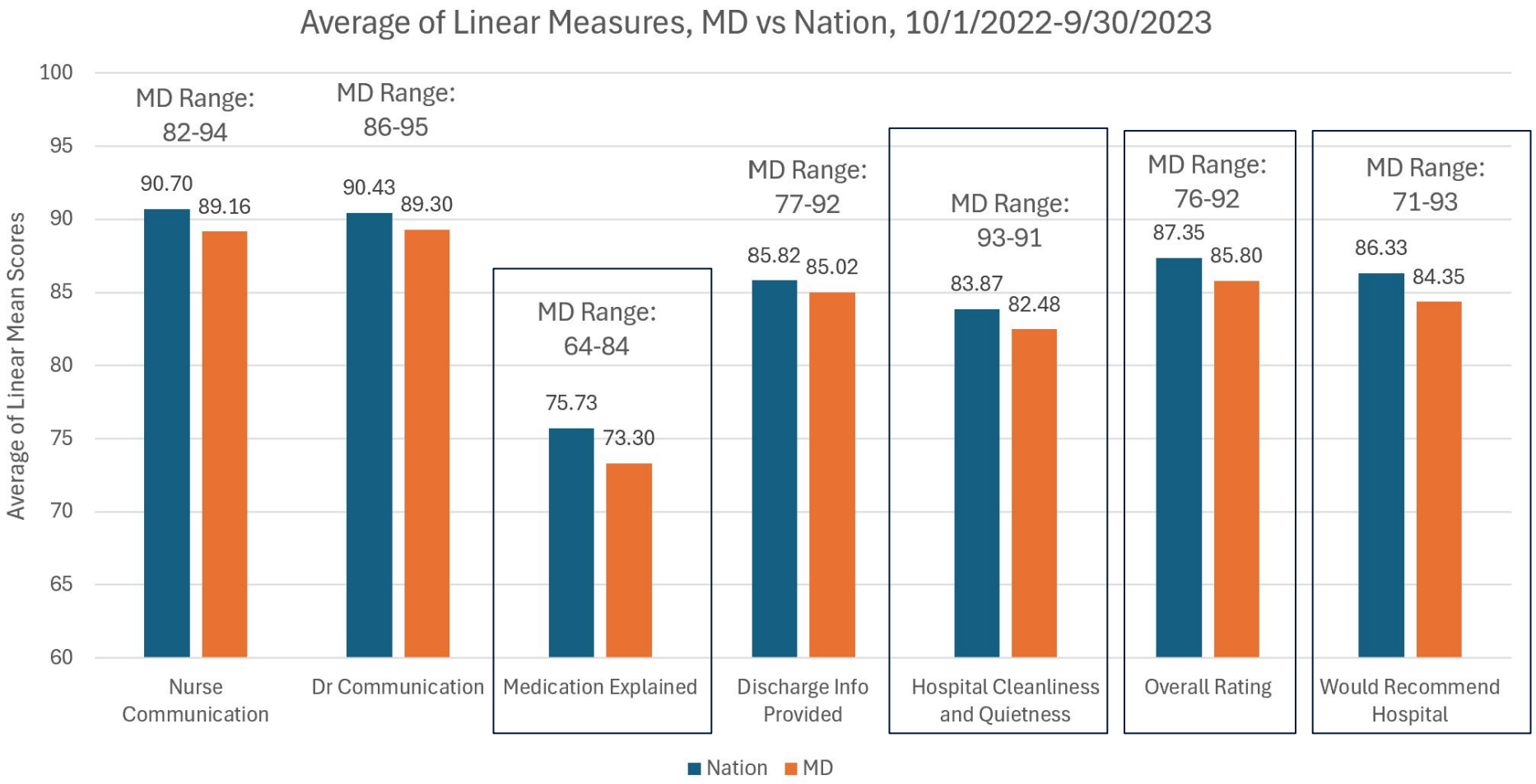
- CMS is updating two HCAHPS sub-domains and will re-adopte them into the PCE VBP domain in CY 2028
  - Composite care transition
  - Responsiveness of hospital staff
  - The two HCAHPS domains are included in the linear measures
    - Staff recommends Overall Rating and Medication Explained

HCAHPS Most Recent Available Performance



X: Removed from HCAHPS

Most Recent Available HCAHPS Linear Performance



Currently include Dr and Nurse Communication linear scores in QBR.

Options for RY27: Medication explained, Cleanliness, Quietness, Overall Rating, Would Recommend

Linear Measures for RY 2027

- Staff modeled scores with Communication about Medications and Overall Rating
  - MD performs the worst on Communication about Medications and this domain sees the largest variation in hospital performance signaling room for improvement
  - Picked overall rating since it is more general measure
  - Assessed correlations between linear HCAHPS measures and ED LOS (OP18b), timely follow up (Medicare and Medicaid), mortality (inpatient and 30-day), readmissions, and complications (PSI-90)
    - Correlation coefficients indicate very weak, weak, and a few moderate correlations (green)

Linear Measures	OP18b	TFU Medicare	TFU Medicaid	30-day Medicare Mortality	IP mortality	Readmissions RRIP	PSI90
Communication about medicines	0.01	0.31	0.32	0.24	0.19	-0.01	-0.10
Overall hospital rating	-0.03	0.45	0.30	0.22	0.13	0.01	-0.12
Recommend hospital	0.01	0.44	0.22	0.25	0.11	0.09	-0.14
Cleanliness	-0.03	0.24	0.20	0.17	-0.04	-0.29	-0.22
Quietness	0.30	0.26	0.11	0.23	0.08	0.00	-0.06
Discharge information	-0.27	0.35	0.42	0.03	0.14	0.02	-0.21
Doctor communication	-0.08	0.30	0.18	0.32	0.20	-0.15	0.03
Nurse communication	-0.20	0.54	0.46	0.19	0.19	-0.07	-0.16

RY 2027 Linear Measure Discussion?

- Given correlations did not provide strong evidence for picking measure, which measures do you think we should pick?

- Potential options:
  - **Higher weight on remaining two linear measures (Doctor and Nurse Communication), or add one or two additional measures:**
    - **Communication about medicines**
    - Overall rating
    - Would Recommend
    - Cleanliness/Quietness

ED Length of Stay Measure

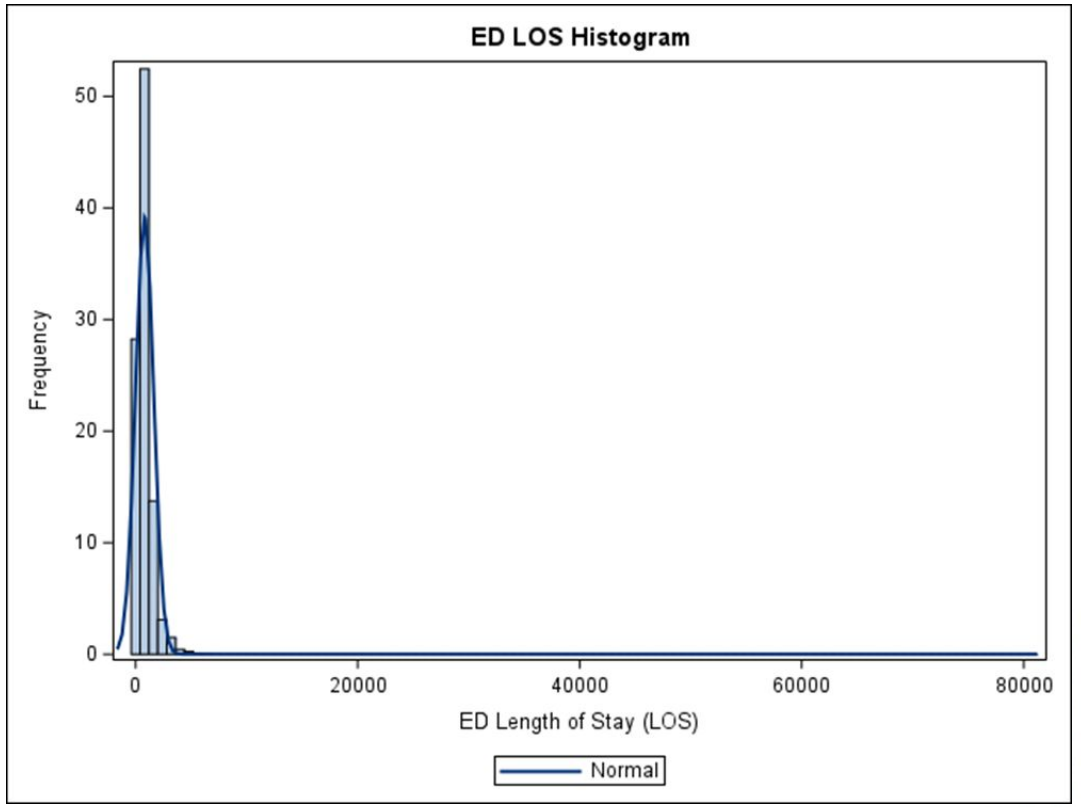
QBR ED LOS Measure

- Hospitals submitted ad-hoc patient level ED LOS data (dates and time stamps) that was merge with IP case-mix
- Subsequent slides provide preliminary calculations for CY2023 for non-psychiatric patients who were admitted to the hospital
  - Used TJC diagnosis code list to identify psychiatric patients

CY 2023	N
Total IP Admissions	526,396
Total IP Admissions with ED Rate Center Charge	309,262
Minus Psychiatric Admissions	286,725
Missing or Invalid Date/Time	5,275
ED LOS Measure Sample	281,450

CY 2023 ED LOS Descriptive Statistics

CY 2023 ED LOS for Non-Psychiatric Inpatient Admits In Minutes					
Number	Mean	Standard Deviation	Minimum	Maximum	Median
281,450	797.5	800.1	1	81149	556

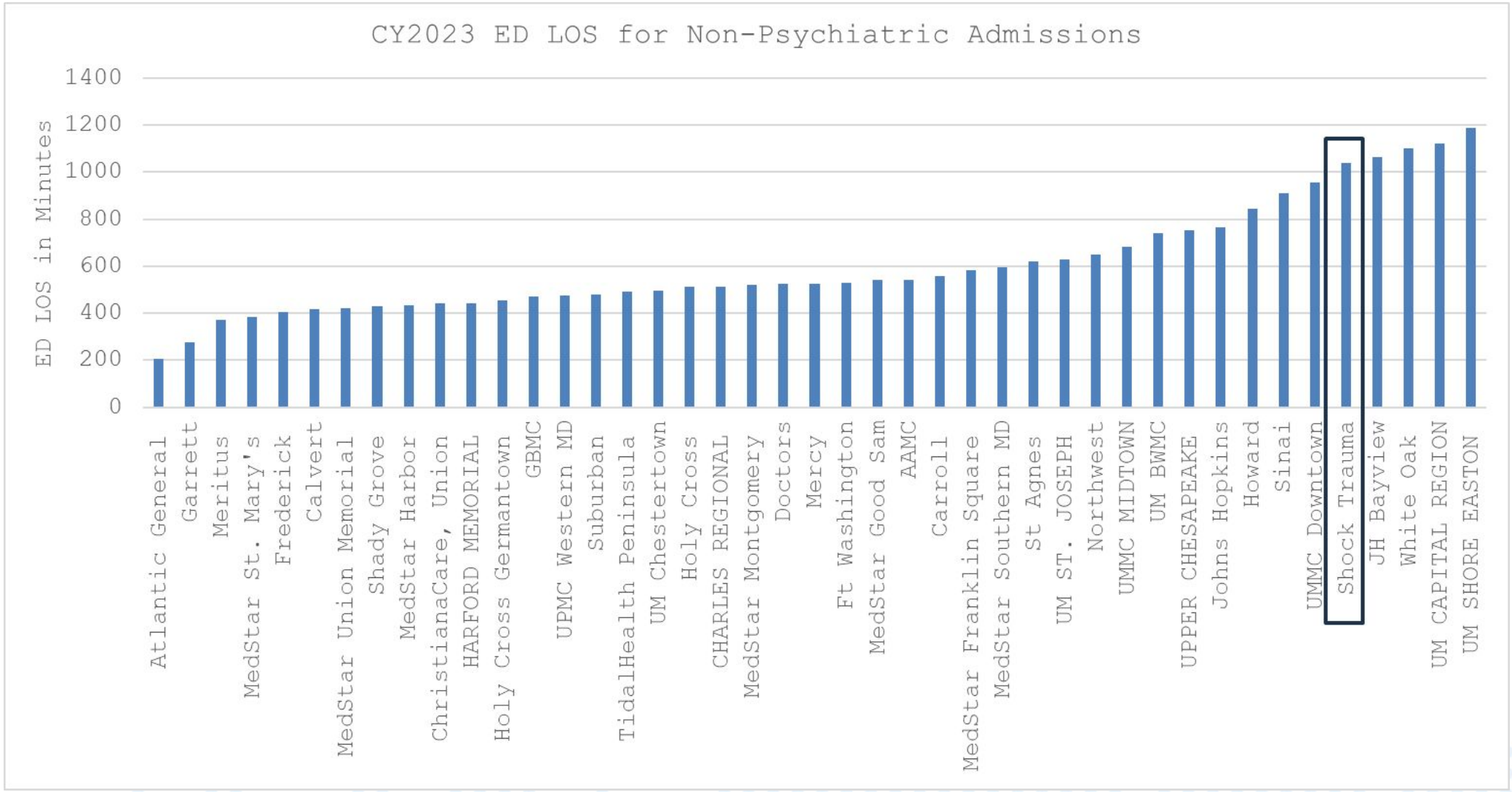


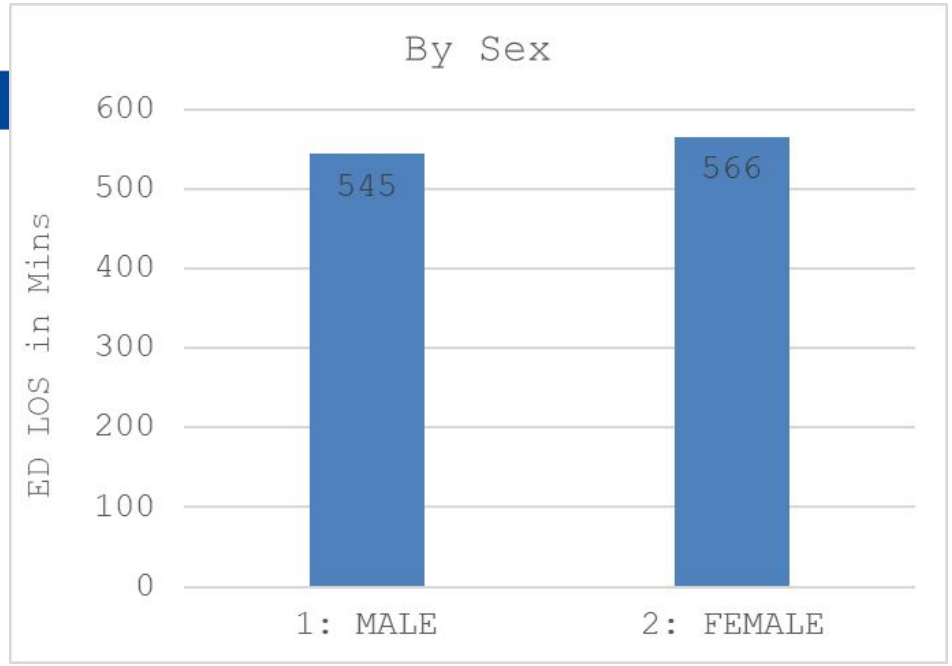
What additional exclusions do you think we should apply for payment measure?

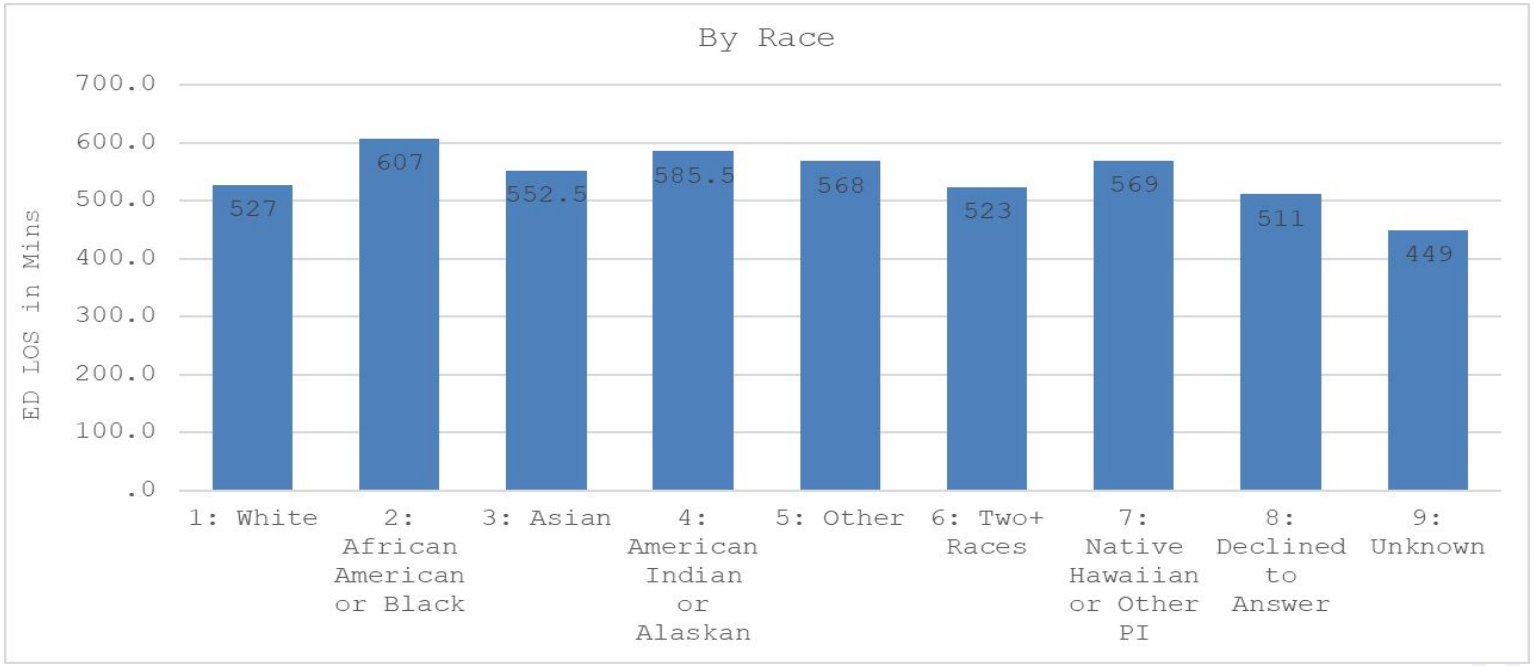
Some potentials include:

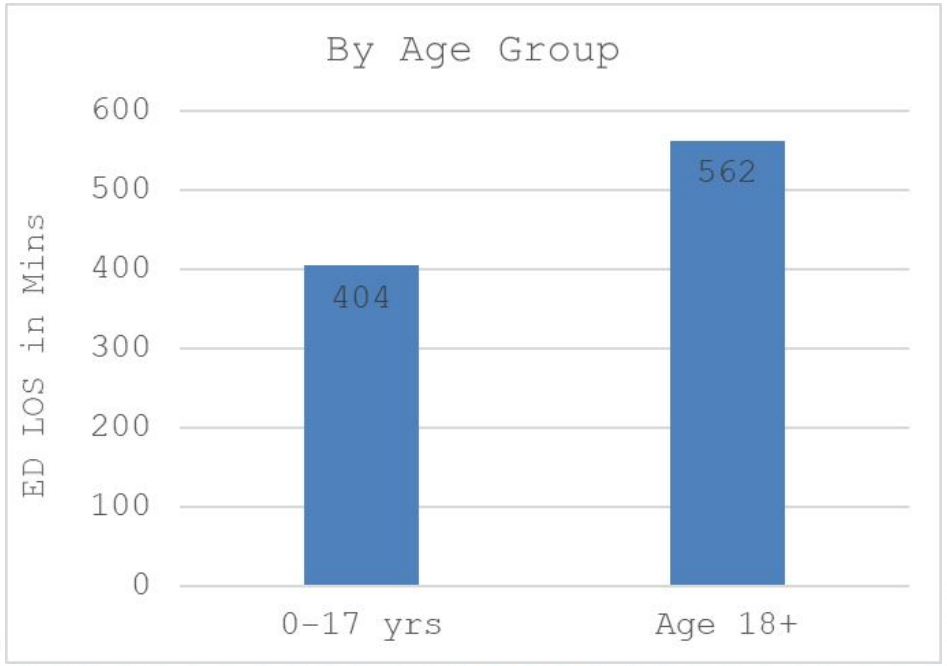
- Shock Trauma
- Obstetric Care
- Pediatrics
- Statistical Outliers

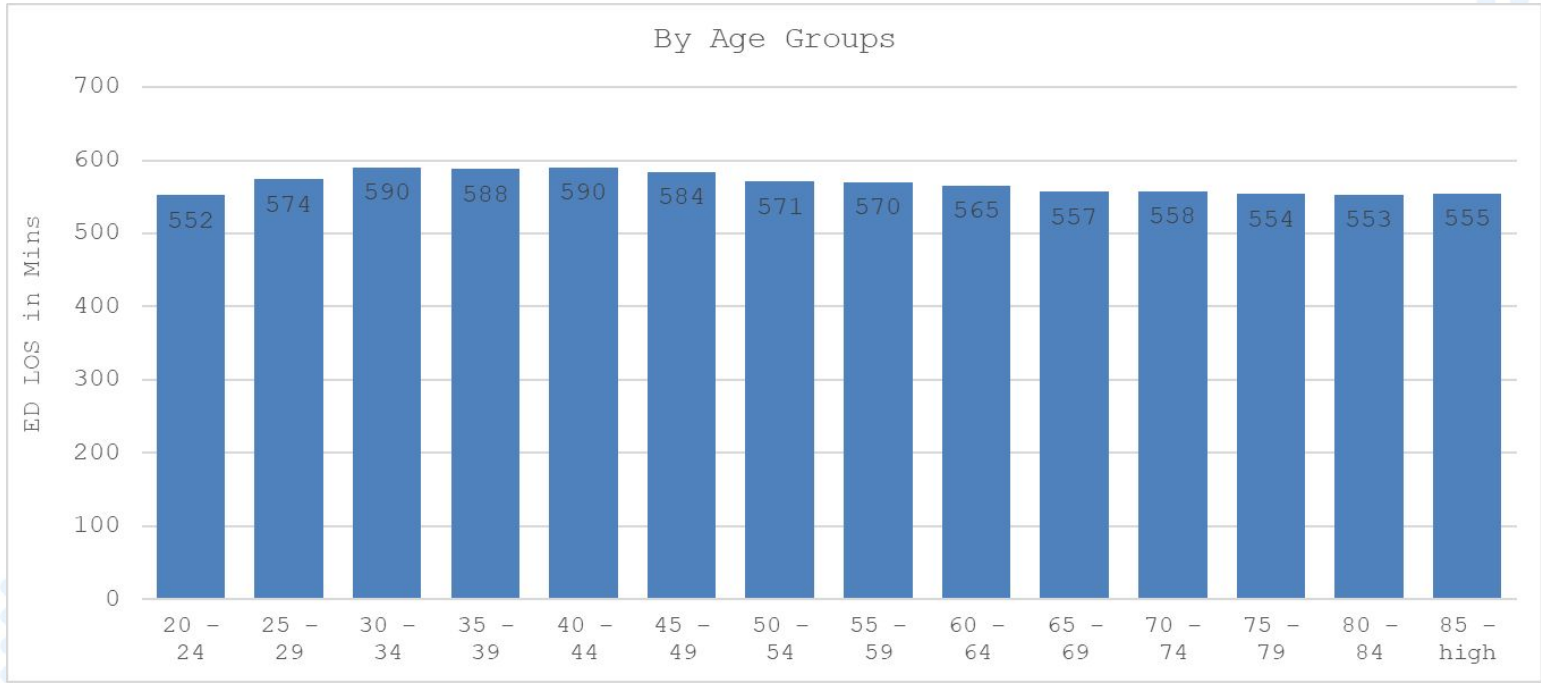
ED LOS by Hospital

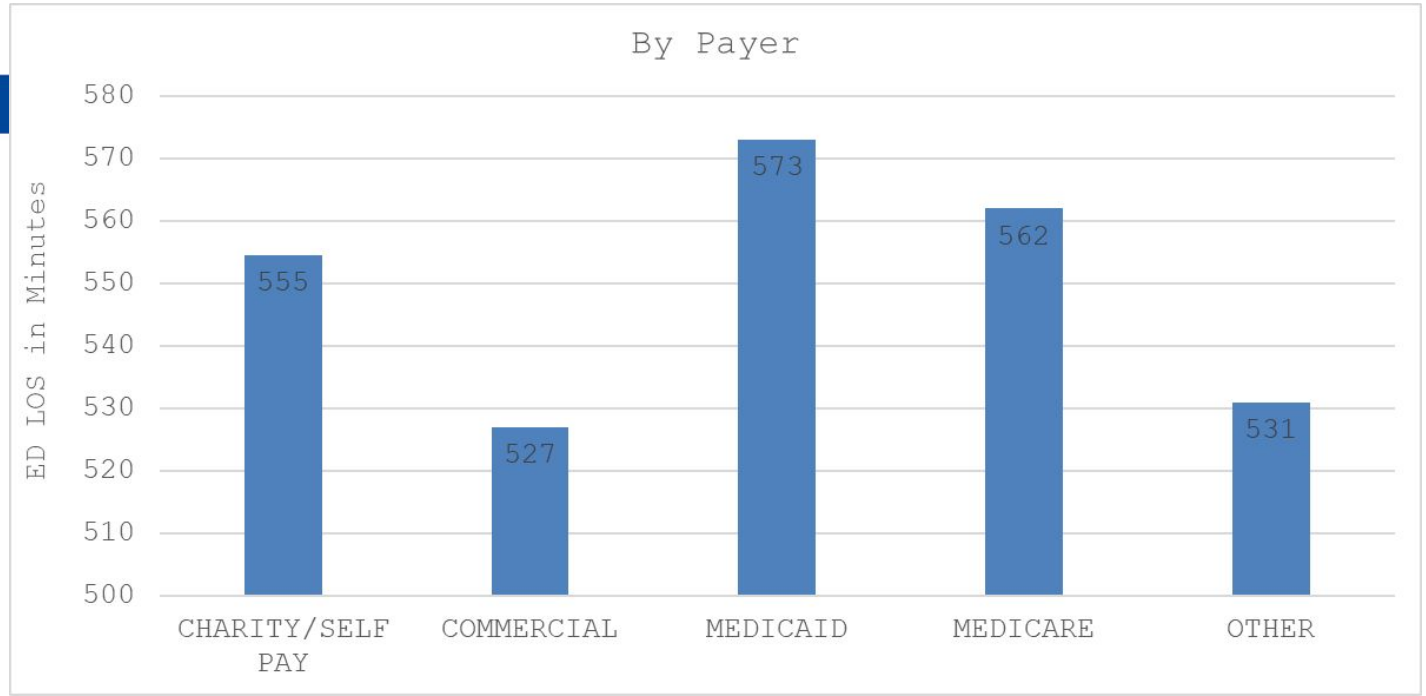


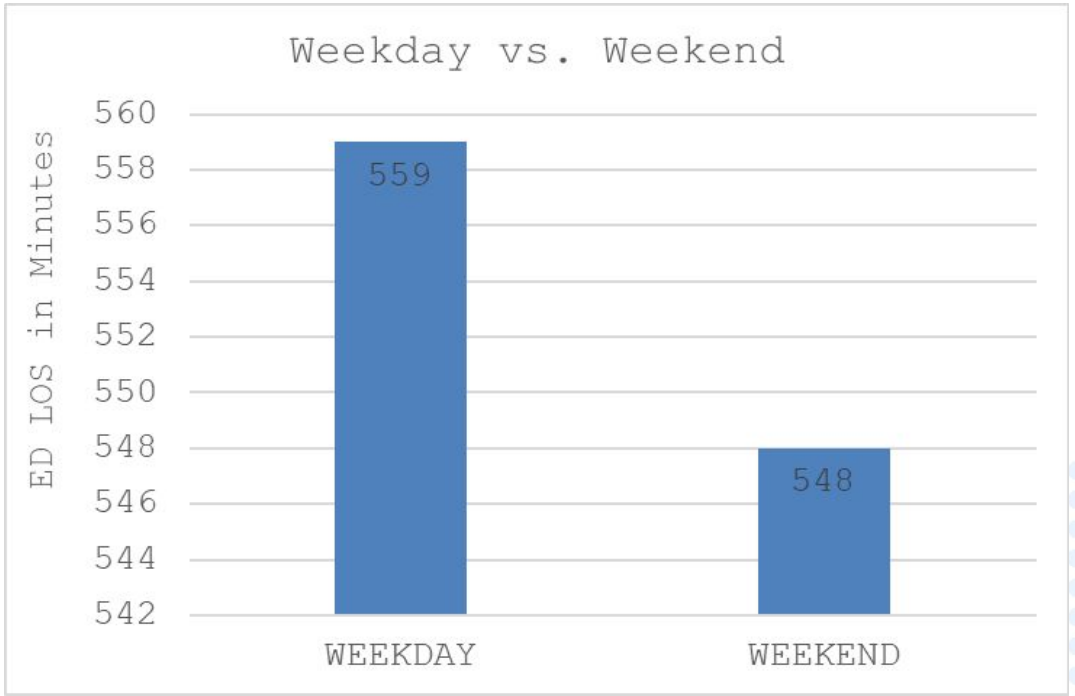

By Sex
ED LOS in Mins
600
500
400
300
200
100
0
545
566
1: MALE
2: FEMALE

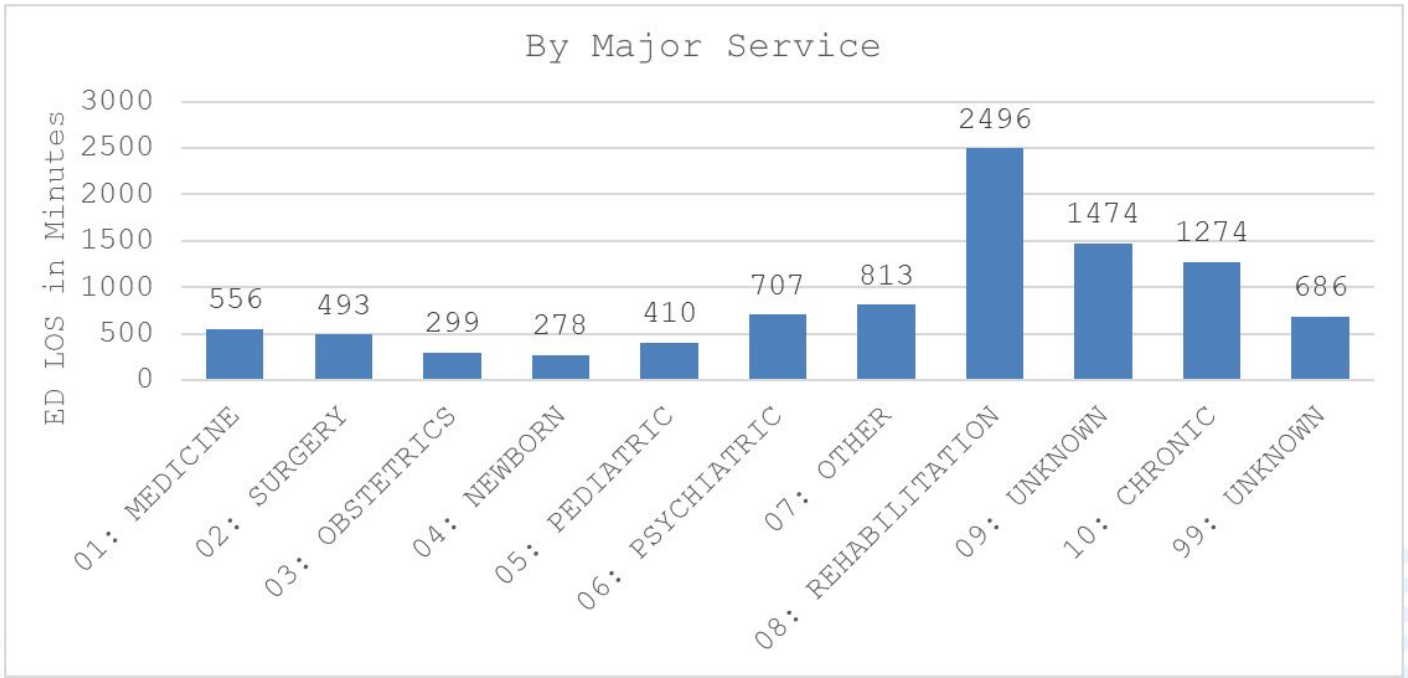

By Race
ED LOS in Mins
700.0
600.0
500.0
400.0
300.0
200.0
100.0
.0
527
607
552.5
585.5
568
523
569
511
449
1: White
2: African American or Black
3: Asian
4: American Indian or Alaskan
5: Other
6: Two+ Races
7: Native Hawaiian or Other PI
8: Declined to Answer
9: Unknown

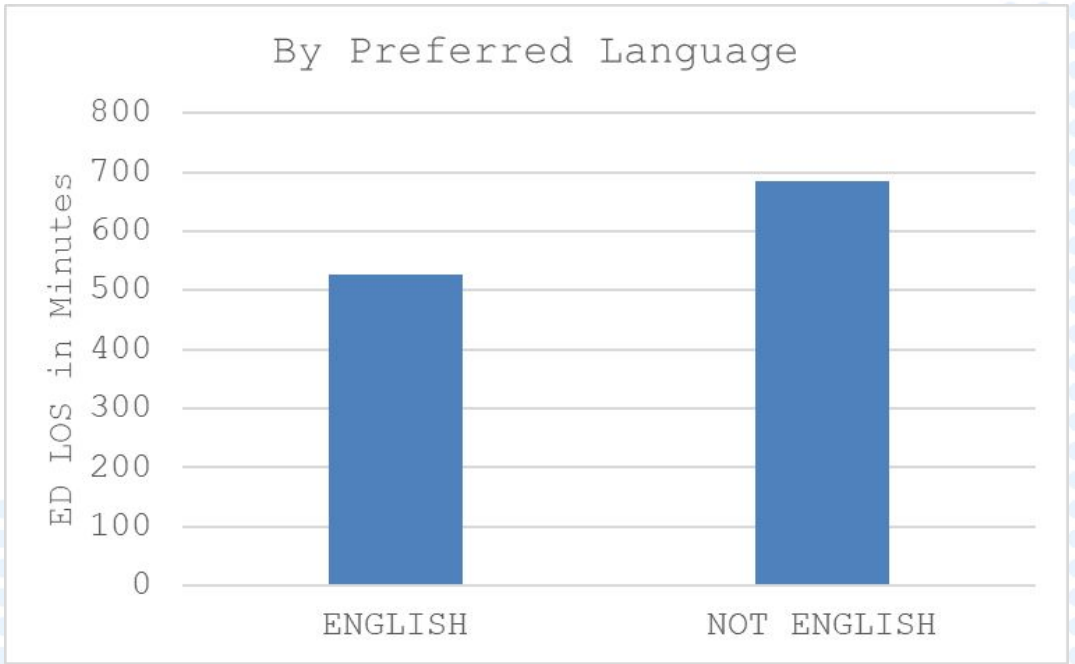

By Age Group
ED LOS in Mins
600
500
400
300
200
100
0
404
562
0-17 yrs
Age 18+


By Age Groups
ED LOS in Mins
700
600
500
400
300
200
100
0
552
574
590
588
590
584
571
570
565
557
558
554
553
555
20 - 24
25 - 29
30 - 34
35 - 39
40 - 44
45 - 49
50 - 54
55 - 59
60 - 64
65 - 69
70 - 74
75 - 79
80 - 84
85 - high

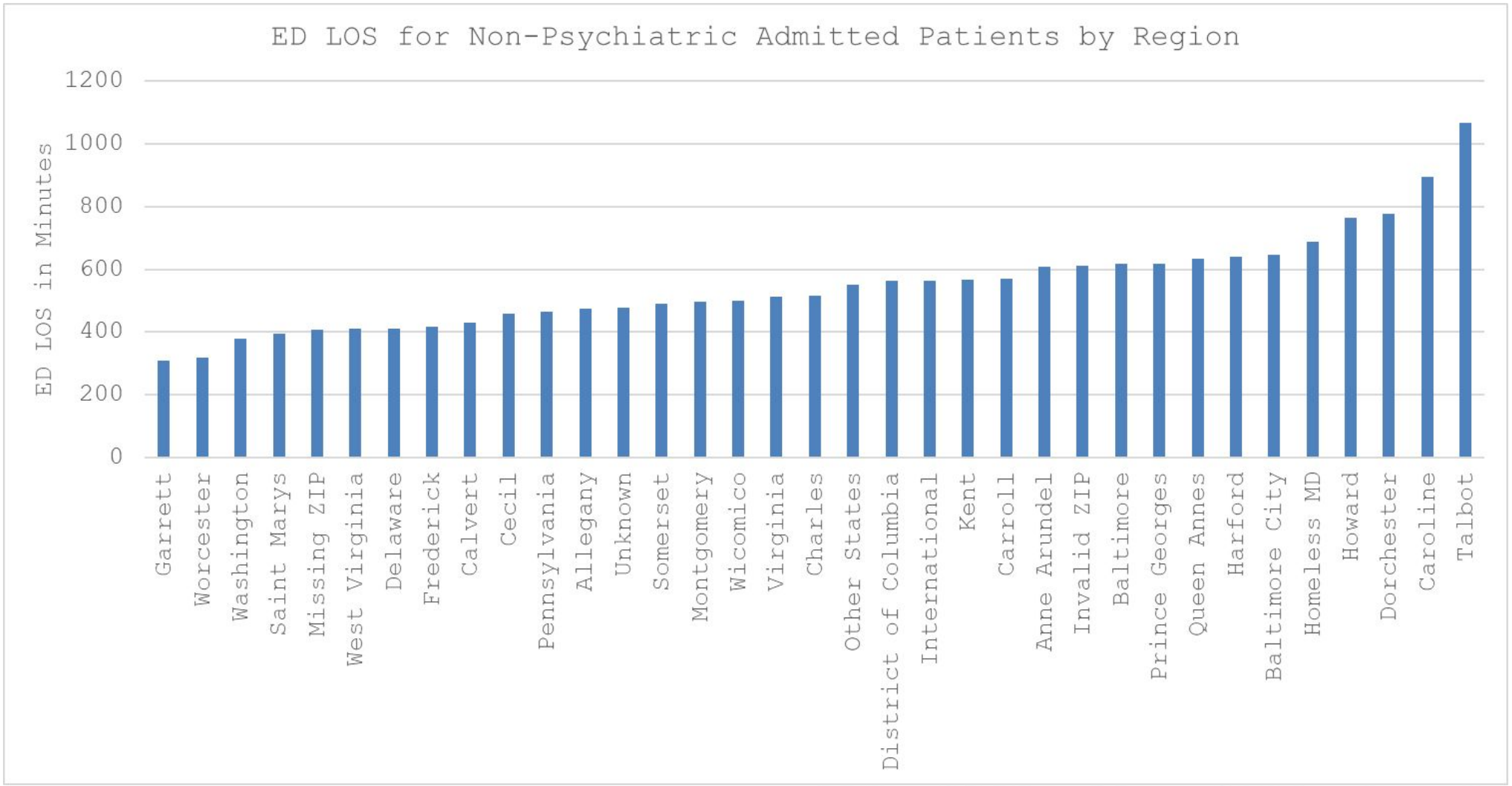

By Payer
ED LOS in Minutes
580
570
560
550
540
530
520
510
500
555
527
573
562
531
CHARITY/SELF PAY
COMMERCIAL
MEDICAID
MEDICARE
OTHER


Weekday vs. Weekend
ED LOS in Minutes
560
558
556
554
552
550
548
546
544
542
559
548
WEEKDAY
WEEKEND


By Major Service
ED LOS in Minutes
3000
2500
2000
1500
1000
500
0
556
493
299
278
410
707
813
2496
1474
1274
686
01: MEDICINE
02: SURGERY
03: OBSTETRICS
04: NEWBORN
05: PEDIATRIC
06: PSYCHIATRIC
07: OTHER
08: REHABILITATION
09: UNKNOWN
10: CHRONIC
99: UNKNOWN


By Preferred Language
ED LOS in Minutes
800
700
600
500
400
300
200
100
0
ENGLISH
NOT ENGLISH

ED LOS by Region



Discussion

Some potential exclusions or areas to further examine include:

- Shock Trauma
- Obstetric Care
- Pediatrics
- Statistical Outliers
- Rehab
- Chronic

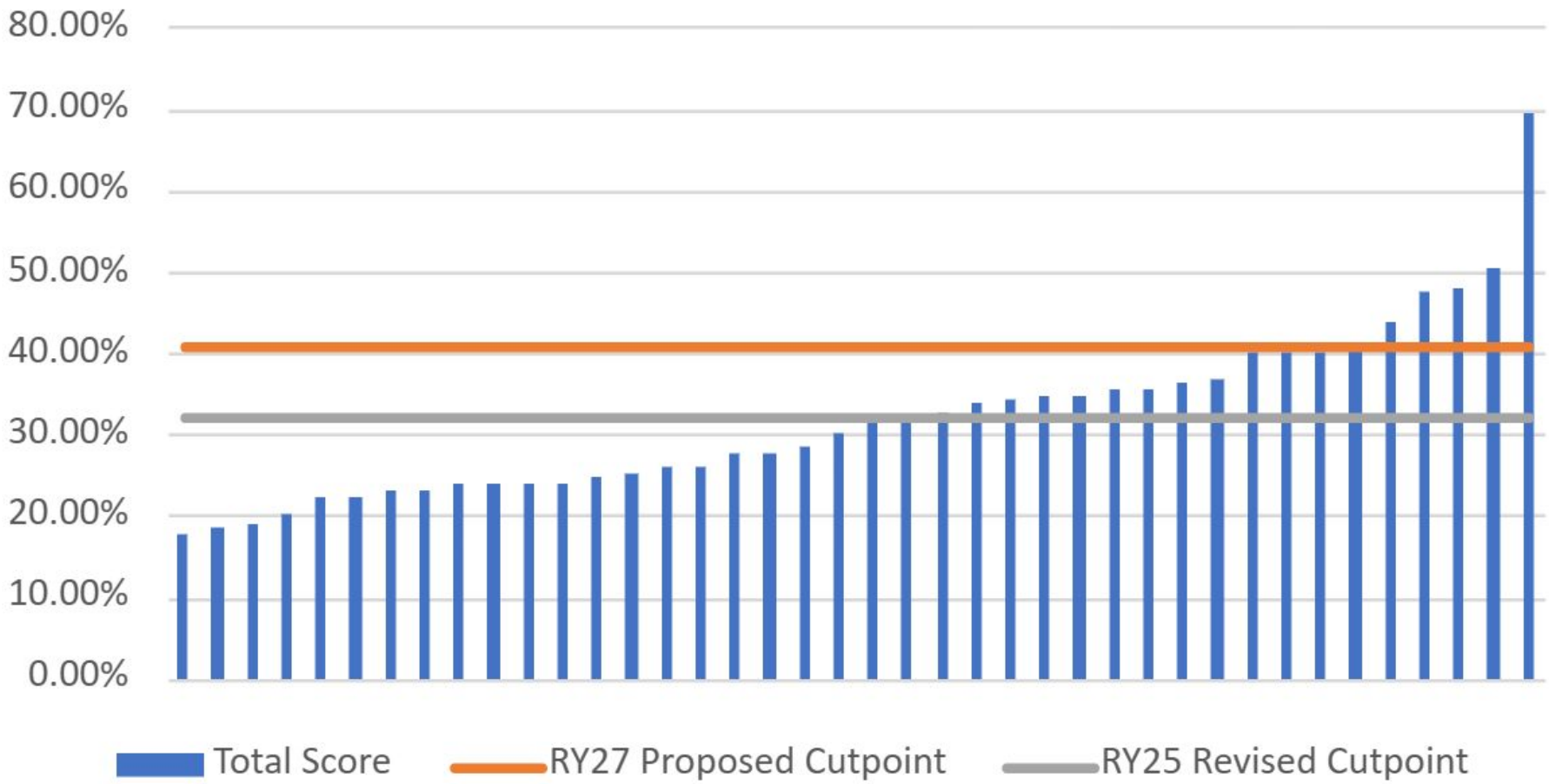
QBR Modeling

RY 2027 QBR Modeling

Statewide Descriptive Statistics	
Mean Score	31.90%
Median Score	30.83%
Interquartile Range	12.64%
Highest Score	69.55%
Lowest Score	17.67%
Statewide Net Estimated Revenue Adjustment ($), (%)	-$58,918,738, -0.53%
Statewide Net Estimated Penalties ($), (%)	-$69,560,231, -0.54%
Statewide Net Estimated Rewards ($), (%)	$1,641,493, 0.01%

- The above modeling includes the linear measures: Nurse Communication, Dr. Communication, Overall Hospital Rating, and Communication About Medicine; removes Staff Responsiveness and Understood Post-Discharge Care from TopBox, Consistency, and Linear

Modeled RY 2027 QBR Scores



Stakeholder Feedback to QBR Draft Recommendation

Feedback and Staff Responses

- ***Digital Quality Data Including Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE)***
  - MHA's letter: Reconsider the timeline to collect data for the development of electronic quality measure infrastructure as hospitals have significant concerns about additional hospital staff burden and cost created by misaligned submission timelines between HSCRC and CMS.

Staff Response: Staff appreciates the comments and is considering the feasibility of supporting a bonus incentive for hospitals that fully comply with the timeline.

- ***RY 2025 QBR Reward/ Penalty "Cut-Point"***
  - MHA's letter: Agree with retrospective adjustment for the RY 2025 QBR reward/penalty threshold ("cut-point") to 32%; they recommend permanently revising the cut-point downward going forward if trend continues.
  - Commissioner Joshi suggested analyzing the status of the reward/penalty cut point earlier in the year.

Staff Response: Staff agrees to 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.

QBR Recommendations

QBR RY 2027 Updated Draft Recommendations

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 Medicare Timely Follow-Up: 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).

QBR RY 2027 Updated Draft Recommendations

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; consider a bonus incentive for hospitals that fully comply with the reporting requirements.
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.

ED Best Practice Incentive Update

ED Best Practices Incentive Policy Development

Draft Policy December 2024
Final Policy February 2025
*Status update will be provided after Nov Commission meeting

Commission Leadership Directive:

Initial Directive: Identify 3-5 best practice measures that will constitute a +/- 1% revenue at risk program for CY 2025 performance.

Current Proposal: CY 2025 Monitor, No revenue at risk, accountability metric for implementation/reporting (this proposal is not yet approved by the HSCRC commission, will be discussed at 12/11 HSCRC Commission meeting

Policy Goal:

- Develop structural or process measures that will address systematically longer ED length of stay (LOS) in the State.
- Promote adoption of hospital best practices by providing GBR financial incentives.
- Align hospital initiatives with the goals of the ED Wait Time Reduction Commission.

Subgroup Purpose:

1. **Develop a set of hospital best practices and scoring criteria to improve overall hospital throughput and reduce ED length of stay**
2. Advise on revenue at-risk and scaled financial incentives
3. Provide input on data collection and auditing

Model Structure

- Models reviewed by the subgroup:
  - **Monitor only for CY25 with accountability measures in place related to implementation of best practices; transition to revenue at risk in CY26 after monitoring period

****this is the model selected by the subgroup to present in the draft policy, still requires HSCRC Commission approval.**

  - Revenue at risk/ penalty reward model tied directly to best practices tiers with x % revenue at risk; HSCRC Commission proposed 1% initially but we can counter propose a lower %
  - No incentive tied to best practices, BUT increase incentive/penalty for ED LOS outcome measure in QBR

*Note: If no significant improvement in ED LOS occurs in CY25, an increased weight in QBR would be anticipated separate from the best practices consideration.

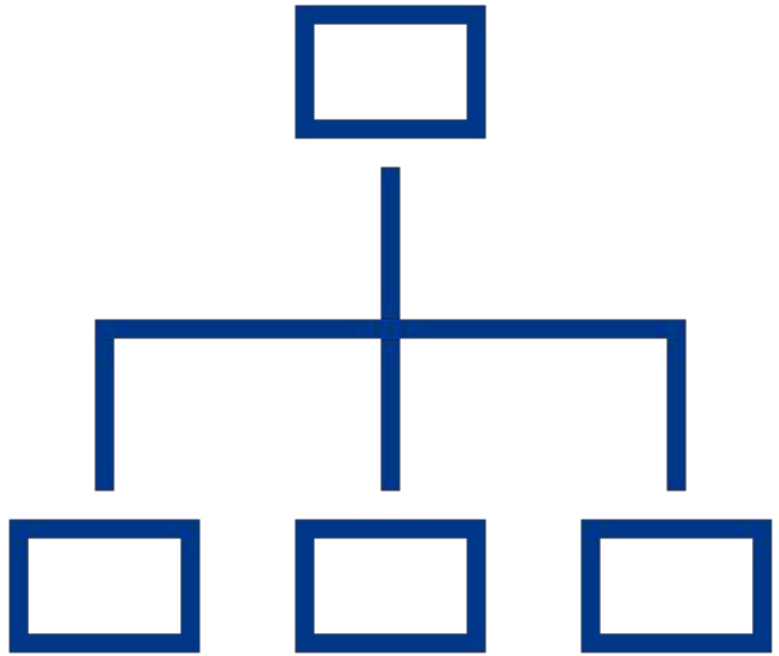
Final Six Best Practices Selected

Based on discussion with subgroup, we will recommend picking 3 interventions from a drop-down menu of 6 interventions.

- Patient flow throughput PI council
- Bed capacity Alert Process
- Interdisciplinary Rounds
- Standard Daily/Shift Huddles
- Establishing Clinical Pathways
- Expedited Care Bucket (inclusive of expediting team, rapid medical evaluation team, rapid medical evaluation unit and patient observation management)

Discussion of Tiers

- 3 Tiers, Tier 3 more heavily weighted
  - Example below:
  - Tier 1—1 point
  - Tier 2-up to 4 points
  - Tier 3—up to 10 points
- Specific KPIs with defined targets built into each tier
- Points assigned to tiers above are examples, please feel free to make recommendations for point allocation in each tier



Example of Tiers for Discussion

- Interdisciplinary Rounds

  - Tier 1—Documentation of Interdisciplinary rounds performed with a target of x%
  - Tier 2—Tier 1 requirement plus Documentation of discharge planning initiated Day 1
  - Tier 3—Tier 1 & 2 requirements and as clinically necessary:
    - PT eval ordered or initiated by x day/ time
    - specialist consult occurs within 24 hours of order
    - SDOH Screening Day 1, target x %
    - Positive SDOH screening has referral triggered within x timeframe
    - Prior auth initiated for post-acute placement by x day/time
    - Pharmacy IV to PO conversion accepted, target x%

  **these are suggestions for the purpose of discussion only; actual measures and tiers will be developed by the designated small group

Next Steps

- Continue development of measure definition, tiers, and targets
- Hospital collaboration groups identified to work on Best Practices 11/15
- ED Hospital Throughput Best Practice Subgroup check-in on 11/22
- ED Best Practice Throughput Subgroup meeting to review tier development on 12/3
- Draft policy released to public on 12/4 and presented to HSCRC Commission on 12/11
- Comment period and continued tier and measure development through mid-January
- Final policy presented to HSCRC Commission on 2/12

Readmission Reduction Incentive Program
RY 2027 Policy Discussion

RY 2027 RRIP Topics for Discussion

- Addition of observation revisits to the RRIP measure
  - CMMI questions on of observation in Maryland
  - Observation impact on readmission rates
    - Observation stays as readmissions only vs. index and readmissions
- Measurement of Improvement
  - Current improvement target uses CY 2022 as base for three years
  - Should we consider moving base year forward or using multiple years?
- Out of State transfers
  - MD Hospitals transferring cases outside state and then returning patient to MD hospital are flagged with readmission

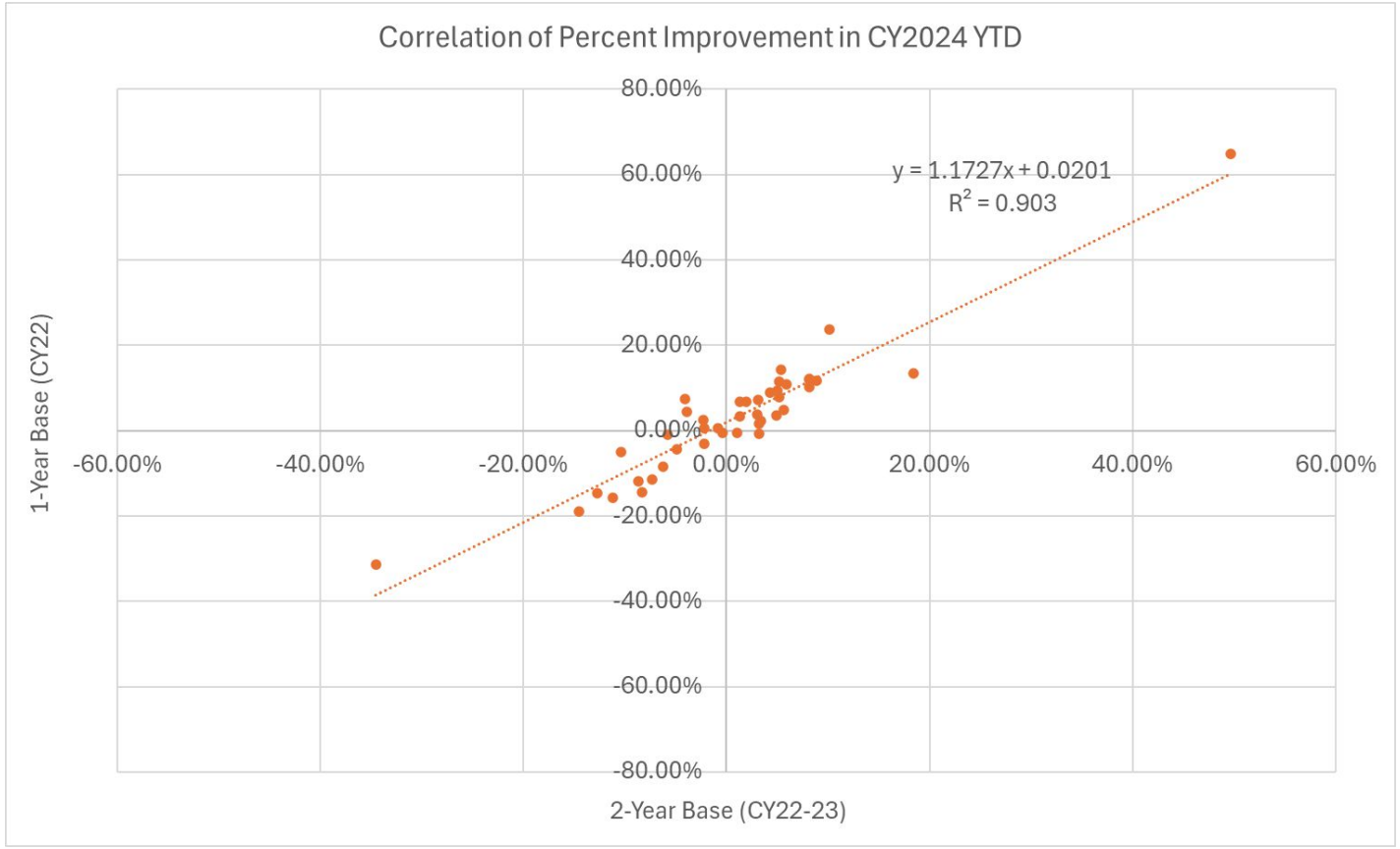
RY 2027 RRIP Options

Need to revisit timelines:

- Extend RY 2026 policy to RY 2027 with no changes
- Draft policy in January with observation data and modeling for readmissions (disparity modeling for final policy)

CMMI has stated that for CY 2025, observation cases will be considered as revisits for purposes of the readmission test in the TCOC Agreement

Modeling RY26 with 1- and 2-Year Base



Other consideration is moving forward the base year for improvement each year as is done with other programs.

Staff plan to assess this and interaction with attainment.

MHAC RY 2027 Draft Discussion

RY 2027 MHAC Topics for Discussion

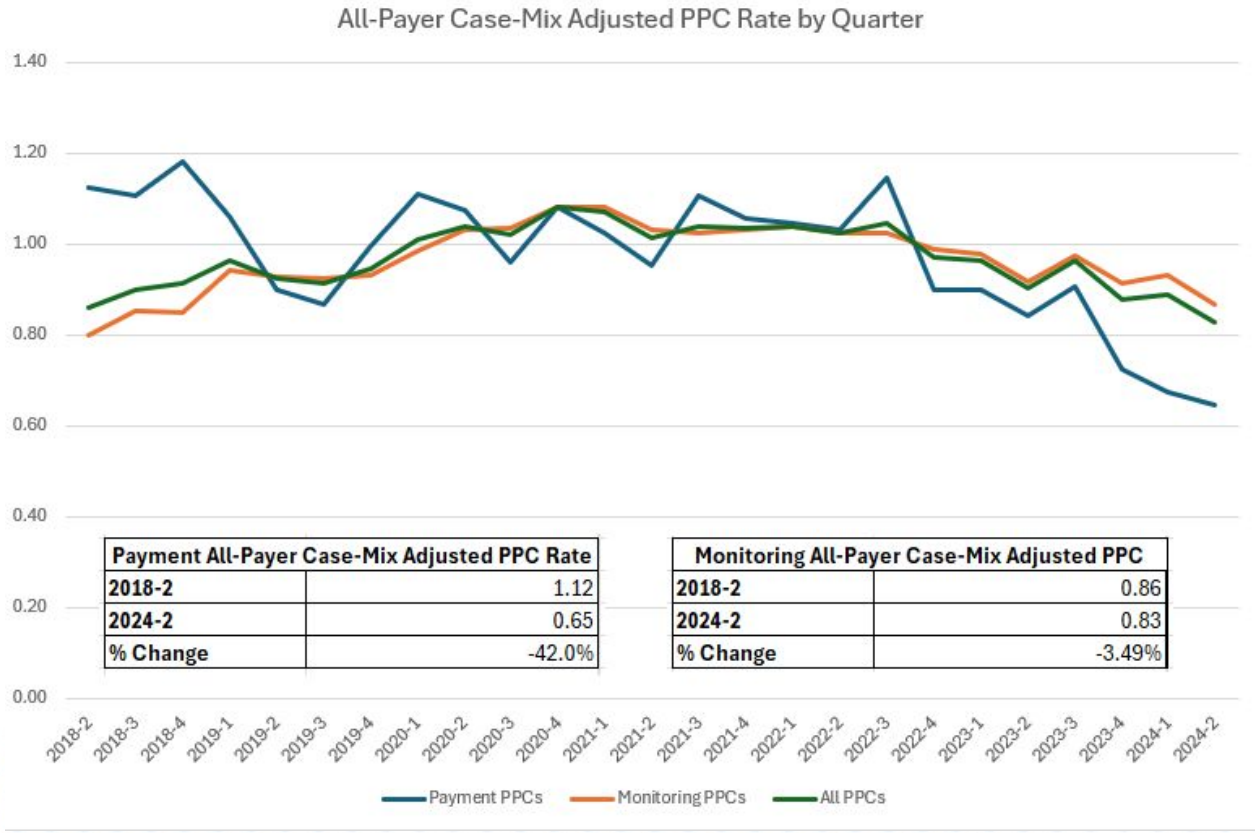
- **Payment PPCs**
- **Small Hospital Concerns**
- Number of Hospital per PPC Category
- Monitoring Digital Measures

There is Wide Variation in Performance on Payment PPCs

PPC Number	PPC Description	2023 O/E Ratio	2024 O/E Ratio	23/24 % Change	Below 0.85	Above 1.15
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	0.84	0.72	-14.23%	48.78%	19.51%
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	0.80	0.59	-26.98%	14.71%	70.59%
7	Pulmonary Embolism	0.97	0.79	-19.08%	52.63%	15.79%
9	Shock	0.89	0.86	-2.63%	42.50%	25.00%
16	Venous Thrombosis	0.60	0.50	-16.68%	36.67%	46.67%
28	In-Hospital Trauma and Fractures	0.96	0.78	-18.30%	10.81%	48.65%
35	Septicemia & Severe Infections	0.81	0.73	-9.89%	40.00%	25.00%
37	Post-Procedural Infection & Deep Wound Disruption without Procedure	1.07	0.75	-29.69%	31.25%	40.63%
41	Peri-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Procedure	0.82	0.57	-29.73%	40.91%	31.82%
42	Accidental Puncture/Laceration during Invasive Procedure	1.12	0.60	-46.09%	70.27%	8.11%
47	Encephalopathy	0.41	0.17	-58.55%	68.29%	14.63%
49	Iatrogenic Pneumothorax	0.95	0.54	-42.60%	27.27%	48.48%
60	Major Puerperal Infection and Other Major Obstetric Complications	0.52	0.67	27.74%	50.00%	50.00%
61	Other Complications of Obstetrical Surgical & Perineal Wounds	0.83	0.83	-0.60%	41.67%	33.33%
67	Combined Pneumonia (PPC 5 and 6)	0.77	0.87	13.51%	20.00%	42.50%

Monitoring PPC Analysis + PPC Update

- Applied the criteria such as Obs/At Risk, variation across hospitals, hospital eligibility, O/E ratio etc to understand PPC trends and determine if any monitoring PPCs need to be moved into the payment program
- **Based on the findings, Staff is not recommending moving any monitoring PPC's into the payment program for RY 2027.**

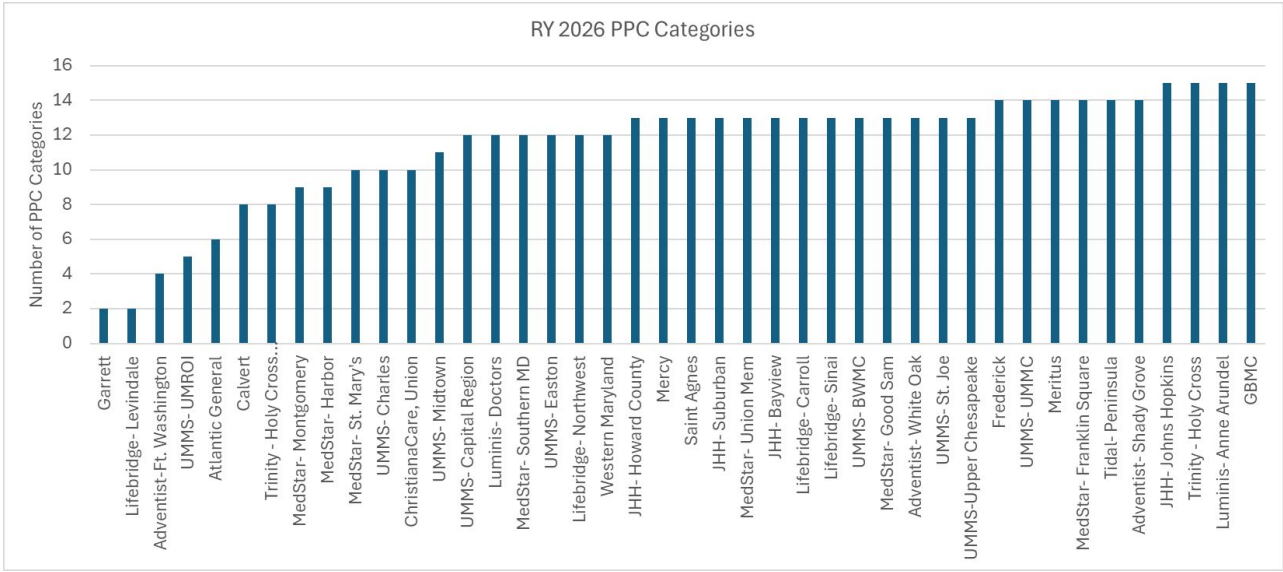


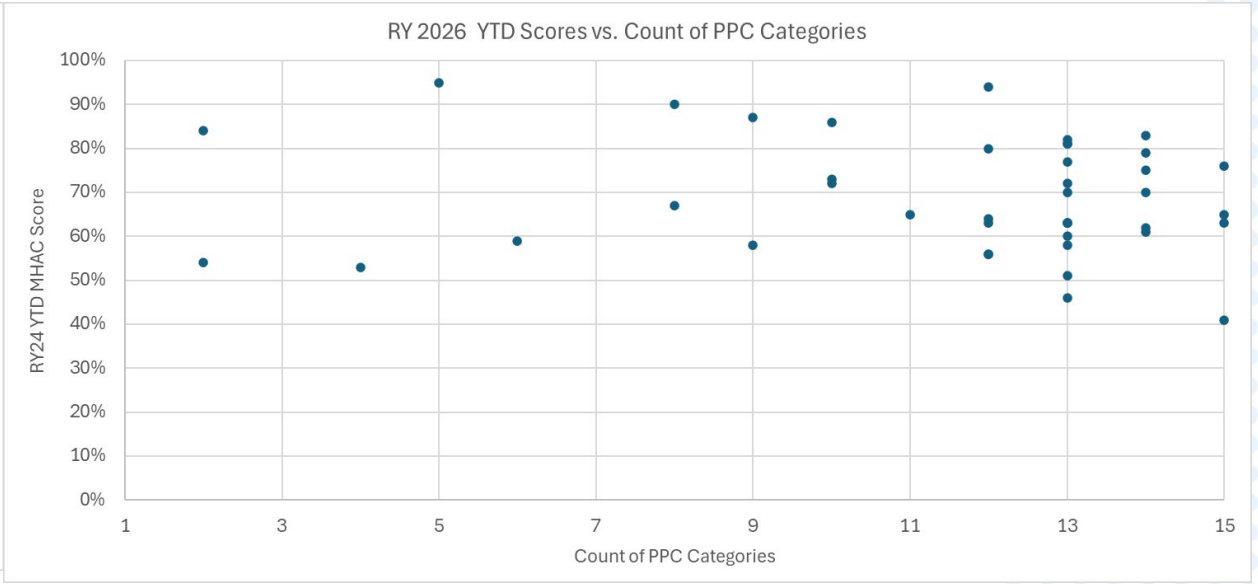
Payment All-Payer Case-Mix Adjusted PPC Rate	
2018-2	1.12
2024-2	0.65
% Change	-42.0%

Monitoring All-Payer Case-Mix Adjusted PPC	
2018-2	0.86
2024-2	0.83
% Change	-3.49%

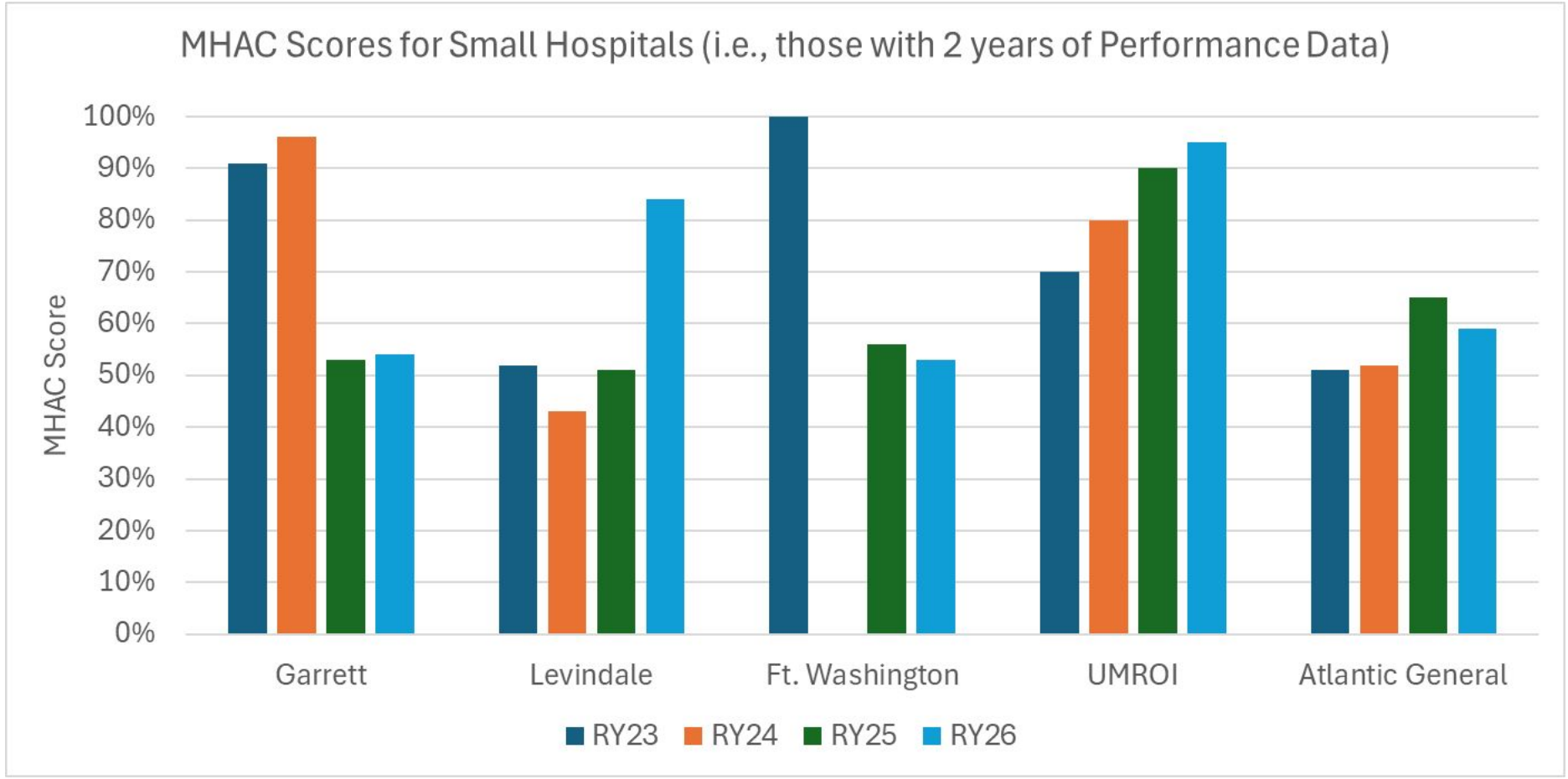
Small Hospital Concerns

- Small hospitals are defined as those with less than 21,500 at-risk or 22 expected PPCs across all 15 payment PPCs
  - These hospitals are assessed using two years of performance data.
    - Concern: Does not reflect improvement and penalizes past performance
- An additional inclusion rule for PPC categories: hospitals must have a minimum of 2 expected and 20 admissions at-risk for a PPC category to be measured for a hospital.





Small Hospital MHAC Scores Across Years



CMS Hospital Acquired Conditions Reduction Program (HAC RP)

Inclusion Criteria: Potential MHAC Application for Small Hospitals

- Minimum number of eligible discharges and meet the following criteria for CMS PSI 90 composite value:
  - One or more component PSI measures with at least 25 eligible discharges, and
  - Seven or more component PSI measures with at least three eligible discharges each
- For CDC NHSN measures:
  - Must have predicted number of infections per measure greater than one to calculate SIR.
  - May request an exemption from HAC RP under the following circumstances:
    - For CLABSI and CAUTI- No applicable locations for the measures (i.e., ICUs or adult or pediatric medical wards, surgical wards, or medical/surgical ward)
    - For SSI- Combined total of nine or fewer abdominal hysterectomies and specified colon surgeries in the prior CY.
    - No exemption requests for CDI or MRSA, but CDC will not calculate CDI SIR if community onset prevalence is > 2.6 for all quarters.
- After calculating Winsorized z-scores,CMS calculates Total HAC Scores using Equal Measure Weights with 100% weight assigned if one measure is scored, and 16.7% weight for each measure if all 6 measures are scored.

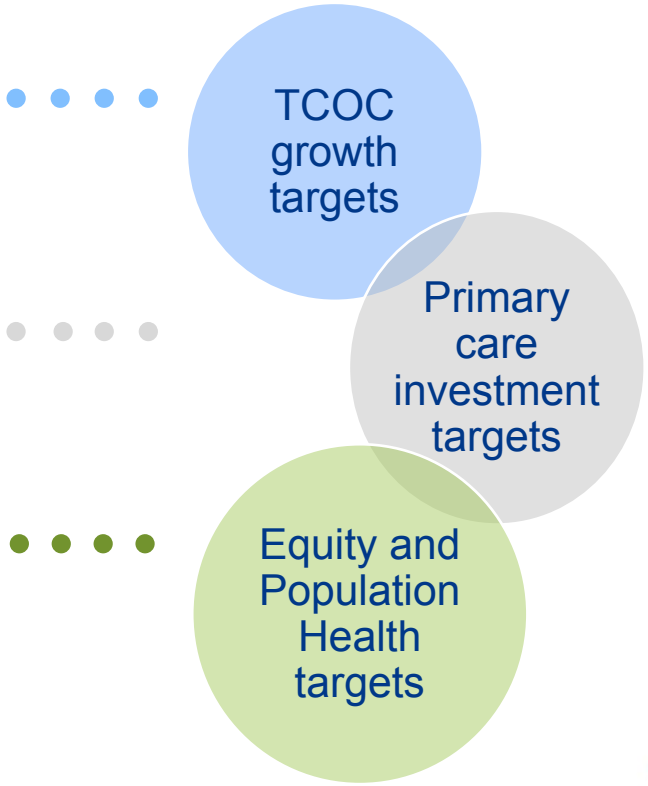
NOTE: Hospitals with HACRP scores in the worst quartile receive penalty of 1%

AHEAD Update

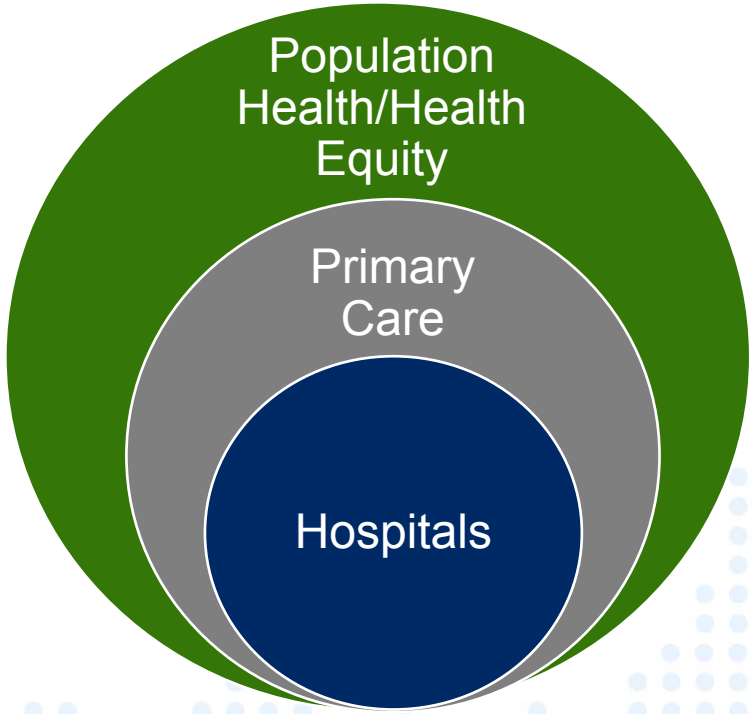
AHEAD Builds on the TCOC Model

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

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



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



TCOC Model and AHEAD

Feature	MD TCOC Model	AHEAD
Hospital Global Budgets	Maryland has a well developed all payer hospital global budget model.	Maryland can use the same methodology under AHEAD, subject to CMS approval.
Cost Growth Targets	Total cost of care Medicare savings target and all payer hospital spending target.	Total cost of care Medicare savings target, primary care investment targets, and all payer total cost of care spending targets (including Medicaid, MA, and commercial insurance).
Primary Care Program	Maryland has a well-developed Medicare primary care program.	A primary care program that is aligned between Medicare and Medicaid is required.
Quality	Maryland has a robust hospital quality program, including a measure on disparities. The MDPCP Program also has a quality program.	Similar hospital quality targets. For other providers/programs, Maryland will select quality measures from a list of measures provided by CMS.
Population Health & Equity	Maryland set population health targets related to diabetes, opioids, maternal morbidity, and childhood asthma.	States will select a set of population health measures from a menu of options provided by CMS. State must develop a health equity plan and equity targets.

AHEAD Quality, Equity and Population Health Measures

Statewide Quality and Equity Measures – Table 5&6 from the State Agreement

Domain- Core Set	Measure
Population Health	CDC HRQOL-4 Healthy Days Core Module
Prevention and Wellness - Pick at least 1	Colorectal Cancer Screening
	Breast Cancer Screening
Chronic Conditions- Pick at least 1	Controlling High Blood Pressure
	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
Behavioral Health- Pick at least 1	Use of Pharmacotherapy for Opioid Use Disorder
	Antidepressant Medication Management
	Follow-up After Hospitalization for Mental Illness
	Follow-up After ED Visit for Substance Use
Health Care Quality and Utilization	Plan All-Cause Unplanned Readmission

Domain-Optional	Measure *Pick One Optional Measure from this table
Maternal Health Outcomes- Pick least 1	Live Birth Weighing Less than 2500 grams
	Prenatal and Postpartum Care: Postpartum Care
Prevention Measures- Pick at least 1	Adult Immunization Status
	Prevalence of Obesity
	Medical Assistance with Smoking and Tobacco Use Cessation
	ED visits for Alcohol and Substance Use Disorders
Social Drivers of Health- Pick at least 1	Food Insecurity
	Housing Quality

In addition to Statewide Quality and Equity Targets from the menu above, the State shall, with CMS' approval, identify one or more measures that reflect the model's impact on population health, and set biannual interim and final performance targets for each selected measure (collectively, the "Statewide Population Health Targets").

AHEAD Model and PMWG and Subgroups

What we need from you…

1. Advise HSCRC on pay-for-performance incentives to improve hospital quality in Maryland
    a. Maryland's exemption from CMS quality programs is an opportunity for innovation and to address State-specific concerns
2. Evaluate potential statewide quality and equity targets for the following domains:
    a. Health Care Quality and Utilization
    b. Behavioral Health
3. Advise on the Hospital Health Equity Plans

THANK YOU!

Next Meeting: December 18, 2024

Appendix

RY 2027 Policies: Main Decisions

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

Commission Draft and Final Policy Review and Vote

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