maryland
health services
cost review commission

619th Meeting of the Health Services Cost Review Commission

April 10, 2024

(The Commission will begin in public session at 12:00 pm for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00pm)

CLOSED SESSION
12:00pm

1. Discussion on Planning for Model Progression - Authority General Provisions Article, §3-103 and §3-104
2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on March 13, 2024

Informational

2. Presentation from the Camden Coalition

Specific Matters

3. Docket Status – Cases Closed

   2644A Johns Hopkins Health System

4. Docket Status – Cases Open

   2630R UM Shore Medical Center at Easton
   2645A Johns Hopkins Health System

Subjects of General Applicability

5. Development Plan: Nurse Support Program II (NSP II) Program Renewal
6. Report from the Executive Director
   a. Model Monitoring
   b. Legislative Update
7. Confidential Data Request: Solventum

8. Final Recommendation: Readmission Reduction Incentive Program (RRIP) - RY 2026
9. ED Policy Development and Implementation - EDDIE Update
10. Hearing and Meeting Schedule

MINUTES OF THE
618th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
March 13, 2024

Chairman Joshua Sharfstein called the public meeting to order at 12:04 a.m. In addition to Chairman Sharfstein, in attendance were Commissioners Joseph Antos, PhD, James Elliott, M.D., Adam Kane, Ricardo Johnson, and Maulik Joshi. Commissioner Nicki McCann, J.D attended virtually. Upon motion made by Commissioner Kane and seconded by Commissioner Elliott, the Commissioners voted unanimously to go into Closed Session. The Public Meeting reconvened at 1:00 p.m.

REPORT OF MARCH 13, 2024, CLOSED SESSION

Paul Katz, Analyst, External Affairs and Policy, summarized the items discussed at the March 13, 2024, Closed Session.

ITEM 1
PRESENTATION FROM ADVANCED RESEARCH PROJECTS AGENCY FOR HEALTH

Dr. Darshak Sanghavi, Program Manager, Advanced Research Projects Agency for Health (ARPH-H) presented an update on the Healthcare Rewards to Achieve Improve Outcomes program (HEROES) (see "HEROES Program Deep Dive" available on the HSCRC website).

Under the HEROES program, public health entities and collaborators will have the opportunity to improve the health status of their communities for specific patient populations as the program evaluates a new payment model that incentivizes community-based interventions to improve health outcomes across a fixed geography. These solutions will investigate a new regionally focused outcomes-based financing approach for the healthcare industry, which rewards only positive health outcomes and reduces the health care burden on patients, providers, and the economy.

Healthcare Outcomes included the following areas:

- Maternal Health: Reduction in rate of intrapartum and postpartum severe obstetric complications.
- Heart Attack and Stroke Risk: Reduction in aggregate 10-year risk of heart attack and stroke for people aged 40-70 years.
- Opioid Overdose: Reduction in the number of emergency medical service calls for opioid overdoses.

- Alcohol-Related Health Harms: Reduction in the number of emergency medical services calls for alcohol-related emergencies.

To accelerate the program's long-term sustainability, HEROES will invite employers, philanthropic groups, or insurance providers to partner with ARPA-H and purchase outcomes in the different regions that they serve. Over time, HEROES hopes that this novel incentive structure will eventually become self-sustaining and capable of surviving even after the program ends.

HEROES calls for letters of interest from potential health accelerators, corporations, investors, health insurers, and philanthropists invested in addressing one of the four health challenges mentioned above. Teams with diverse backgrounds and capabilities will be important for fulfilling the program's goals, and HEROES encourages applications from interested parties with many different specialties or areas of expertise.

HEROES creates incentives as follows:

- Picks Targets- Health Accelerator selects an outcome and target geographic area.
- Identify Outcome Buyers- Health Accelerator secures promise of future payment for successful health outcomes from ARPA-H, and Outcome Buyers (i.e. employers, health plans)
- Rise Funds- Health Accelerator raises money to be used in prevention-oriented care to fund new technologies and operations.
- Help People- Health Accelerator deploys innovative evidence based on technologies at scale to improve healthcare outcomes in specific geographic areas.
- Get Rewarded- If outcome is achieved, ARPA-H and Outcome Buyers reward Health Accelerator

ITEM II
REVIEW OF THE MINUTES FROM THE FRBRUARY 14, 2024, PUBLIC MEETING, AND CLOSED SESSION

Chairman Sharfstein requested the following updated language to the February 14, 2024, Public Meeting minutes.

UMROI Recommendation

Dr. Pollack assured Commissioners that UMMS is fully committed to maintaining access to the services that will be deregulated, as it is integral to UMMS strategic plan for Neurology.

Multi-Visit Patients (MVPs) Policy Recommendation

Commissioners voted on an amended recommendation:

1. Continue monitoring exiting performance data on MVPs.
2. Require hospitals to provide information on MVP interventions with the Commission to track outcomes associated with those interventions.
3. Develop reporting to assess health disparities related to MVPs.

4. Staff will return at a later date to discuss outcomes associated with the registered interventions and to discuss next steps for policy related to MVPs.

The Commission voted unanimously to approve the amended minutes of the February 14, 2024, Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM III
CLOSED CASES

2642N – University of Maryland Medical Center
2643N- Brook Lane Hospital

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ITEM IV
OPEN CASES

2630R - University of Maryland Shore Medical Center at Easton – Full Rate Application- No Commission action is required at this time.
2644A- Johns Hopkins Health System – ARM- OptumHealth Care Solutions, Inc- Solid Organ and Bone Marrow transplants- Approved for One Year.

ITEM V
REPORT FROM THE EXECUTIVE DIRECTOR

Staff Update

Jon Kromm, Executive Director, introduced Towanda Tombs, and Tare Suriel as new members of the Staff. Ms. Tombs will be a Human Resource Analyst**,** Operations, and Ms. Suriel will be the Senior Analyst, Economics and Data Analytics.

AHEAD Model Update

Dr. Kromm presented an update of the Staff's progress on the Notice of Funding Opportunity (NOFO) for the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model.

Dr. Kromm noted that Staff is close to submitting the NOFO to the Centers for Medicare & Medicaid Services (CMS). The NOFO response is focused on the capacity and capabilities of the HSCRC to meet the goals of the AHEAD Model.

Staff's response to CMS is due by Monday, March 18th.

Change Healthcare Update

Dr. Kromm presented an update on the Change Healthcare cyberattack.

Dr. Kromm noted that the state efforts are intended to ensure that providers and payers who are impacted by the cyberattacks get the support needed to make sure that their operations are stabilized.

Model Monitoring

Deon Joyce, Chief of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 11 months ending November 2023. The data showed that Maryland's Medicare Hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce stated that Medicare Nonhospital spending per-capita was unfavorable when compared to the nation. Ms. Joyce noted that Medicare TCOC spending per-capita was unfavorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail position is 2.38% below the nation through November, and that Maryland Medicare hospital and non-hospital growth through November shows a savings of $253,191,000.

Legislative Update

Megan Renfrew, Deputy Director, Policy and Consumer Protection, the Legislative Update (see "Legislative Update" available on the HSCRC website).

Ms. Renfrew noted that Staff is monitoring the following bills:

- SB 694/ HB 887- Maryland Department of Health – Health Commissions and Maryland Insurance Administration – Study
- HB 1333- Maryland Commission on Health Equity- Membership and Statewide Health Equity Plan
- HB 784 – Task Force on Reducing Emergency Department Wait Times
- HB 1143 – Emergency Medical Services – Maryland Emergency Department Wait Time Reduction Commission and Standardized Protocols - Establishment
- SB 784/ HB 935- Comprehensive Community Safety Funding Act
- HB 1439 – Public Health – Funding for Trauma Centers and Services
- SB 1006 – Medical Debt Collection – Sale of Patient Debt
- HB 328 – Hospitals – Financial Assistance Policies – Revisions
- SB 1103/ HB 1149- Hospitals and Related Institutions – Outpatient Facility Fees
- SB 360/ HB 350 – Budget Bill (Fiscal Year 2025)

ITEM VI
CONFIDENTIAL DATA REQUEST, THE INJURY OUTCOME DATA EVALUATION SYSTEM PROJECT

Oscar Ibarra, Associate Director, Information Management and Program Administration, presented Staff's final recommendation for the Injury Outcome Data Evaluation System Project (see "Confidential Data Request: The Injury Outcome Data Evaluation System Project").

The University of Maryland School of Medicine (UMSOM), and the National Study Center (NSC) for Trauma and EMS, is requesting access to the HSCRC Inpatient and Outpatient Hospital Data, which

includes limited confidential information ("the Data") for the Injury Outcome Data Evaluation System (IODES).

The IODES project is designed to make data related to injury available for analysis. The Data will be used for analysis of injuries to persons treated at Maryland hospitals. To fulfill a key component of the IODES effort, the Data will be linked (where possible) to police crash reports, EMS run sheets, and other datasets as required for further analysis. The NSC has been working with the Maryland Department of Transportation, Maryland Highway Safety Office, and other partners on the Crash Outcome Data Evaluation Systems project for more than a decade.

Investigators received approval from the Maryland Department of Health IRB on February 7, 2024, and the MDH Strategic Data Initiative office on January 12, 2024. The Data will not be used to identify individual hospitals or patients. This project is designed as an umbrella project, with no end date, that will continue to address individual approved projects and tasks to improve the public health of Marylanders with injuries. However, the Project Principal Investigator will notify the HSCRC if the project were terminated, and at that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

Staff recommendation is as follows:

1. HSCRC staff recommends that the request by UMSOM for the Data for Calendar Years 2021 through 2026 be approved.
2. This access of data will include limited confidential information for subjects meeting the criteria for the research.

Commissioner voted unanimously in favor of Staff's recommendation.

ITEM VII
FINAL RECOMMENDATION ON TRADITIONAL MEDICARE PERFORMANCE ADJUSTMENT

Ms. Christa Speicher, Deputy Director, Payment Reform, presented the Staff's final recommendation on the adjustment to the Medicare Performance Adjustment (see "Medicare Performance Adjustment Calendar Year 2024- Final Recommendation" available on the HSCRC website).

The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to:

1. Attribute 95 percent of all Maryland Medicare beneficiaries to some Maryland hospital;
2. Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and
3. Determine a payment adjustment based on the difference between the hospital's actual attributed TCOC and the benchmark.

This MPA recommendation fulfills the requirements to determine an MPA policy for CY 2024 and makes incremental improvements to the current policy and to the related MPA Framework.

The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care.

Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments represent a discount on the amount paid by CMS and not on the amount charged by the hospital. Accordingly, this policy does not change the Global Budget Revenue (GBR) or any other rate-setting policy that the HSCRC employs and – uniquely – is applied only on a Medicare basis.

This policy does not affect the rates paid by payers. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service areas.

This policy holds hospitals accountable for cost and quality of Medicare beneficiaries in the hospital's service area. Focusing resources to improve total cost of care provides the opportunity to focus the hospital on addressing community health needs, which can lower total cost of care.

This final recommendation is identical to the recommendation staff shared with the Commission in December 2023 but reflects the removal of the Care Transformation Initiative (CTI) buyout provisions as this was not approved by CMS.

The Staff's final recommendation is as follows:

- The removal of the CTI buyout provision
- Increase maximum revenue at risk under the traditional MPA to 2%
- Add Population Health Measure with weight of 4% of bonus/penalty
- Cap downside risk of a hospital under the CTI program to 2.5% of total Medicare payments

Laura Russell, Director of Healthcare Payment, Maryland Hospital Association (MHA), was supportive of the Staff's recommendation. However, MHA and the Maryland hospitals are disappointed that CMS did not approve the CTI buyout provision.

Commissioners voted unanimously in favor of the Staff's recommendation.

ITEM VIII
UPDATE FACTOR MODEL REVIEW

Mr. Jerry Schmith, Director, Revenue and Regulation Compliance, presented a review of the Update Review Model review process (see "Update Factor Model Review" available on the HSCRC website).

Staff updates hospitals' rates and approved revenues on July 1st for inflation as well as settling all adjustments from the prior year. The annual update factor is intended to provide hospitals with reasonable

changes to rates in order to maintain operational readiness while seeking to contain the growth of hospital costs in the State. The Update Factor aims to be fair and reasonable for hospitals and payers.

The Update Factor is developed in conjunction with the Payment Model Workgroup. The workgroup consists of nine hospitals and other stakeholders.

In considering the system-wide update factor, Staff sought to achieve balance among the following objectives:

1. Provide reasonable increases to the hospital's GBR so that they provide quality of care for the population they serve.
2. Meet the requirements of the Total Cost of Care agreements with the Center for Medicare and Medicaid Initiatives (CMMI).
3. Provide hospitals with the necessary resources to keep pace with changes in inflation and demographic changes.
4. Ensure that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the TCOC Model.
5. Incorporate quality performance programs.

Staff will have a draft recommendation on the FY25 Update Factor at the May Public meeting and a final recommendation at the June Public meeting.

ITEM IX
ED POLICY DEVELOPMENT and IMPLEMENTATION

Emergency Department Dramatic Improvement Effort (EDDIE) Update
ED Best Practices Incentive Policy Development Plan

Alyson Shuster, Deputy Director, Quality Methodologies, and Damaria Smith, Fellow, Quality Initiatives presented, the monthly update on the Emergency Department Dramatic Improvement Performance for February (see "Emergency Department Dramatic Improvement Effort" available on the HSCRC website).

Ms. Smith stated that Staff received February data from all the hospitals. The results of the data show the following:

- Emergency Department (ED) Median wait times in February shows that Inpatient wait times are longer when compared to Outpatient wait times. Behavioral health wait times are longer than non-behavioral health wait times.
- Fluctuation in February wait times when compared to June 2023 could be impacted due to seasonality.

Ms. Smith stated that the turnaround time data shows substantial movement of hospitals across all categories for February 2024, with eight hospitals improving in performance and one hospital declining in performance.

Ms. Smith stated that the Quality Based Reimbursement (QBR) ED-1 Subgroup and method of collecting data were discussed. The workgroup believes the best option to collect data is as follows:

- Take advantage of existing data collection methods and edit check processes.
- Add date and time stamps and other needed variables to monthly HSCRC case-mix data.
- HSCRC calculates measures for all hospitals.
- Additional time stamps can be collected (e.g. start of observation).
- Can stratify or risk adjust ED length of stay (LOS) data.

ED Best Practices Incentive Policy Development

Objective:

- Develop a series of process, structural, and/or outcome measures that will address systematically longer ED LOS in the State.
- Will incentivize hospital best practices, alignment with Emergency Department Dramatic Improvement Effort (EDDIE), and value-based arrangements with non-hospital providers that will improve hospital throughput and by extension ED LOS.

Description:

- Subgroup will advise on the development of 3-5 measures that will constitute a 1% revenue at risk program for CY 2025 performance.
- Workgroup will need to include those who are familiar with quality measurement, emergency department/hospital operations, non-hospital operations/policy (including home health, behavioral health, and skilled nursing facilities), and pay-for-performance/value-based payments.
- Will convene starting in March/April and should complete the task within 4-5 monthly subgroups.
- Monthly updates on progress will be provided to Commissioners as part of EDDIE presentations.

Next Steps

- Continue monthly EDDIE data collection from hospitals and the Maryland Institute for Emergency Medical Services .
    - Discuss next steps for MHA quality improvement initiative.
    - Invite hospital or other speakers.
- QBR ED Length of Stay measure.
    - Finalize QBR ED LOS Data subgroup.
    - Convene QBR ED LOS Measure and Incentive subgroup
- Finalize work plan for additional subgroup on Best Practices (1 percent idea)
    - Consult with experts in and outside of Maryland on types of best practices to consider
    - Recruit participants

- Establish meeting agendas and dates

ITEM X
POLICY DEVELOPMENT AND WORKGROUP UPDATES

Community Benefits Reporting Workgroup

Ms. Renfrew provided an update on the Community Benefits Workgroup (see "Hospital Community Benefits Reporting Instructions Workgroup" available on the HSCRC website").

The purpose of the Community Benefit Workgroup is to review several reporting instructions in regards to completing the hospitals' Community Benefit report.

The workgroup focuses on providing recommendations on changing the reporting instructions related to how hospitals are reporting indirect cost ratios associated with their community benefits activities and how they're reporting the percentage of their community benefits spending that is associated with their community health needs assessment activities.

Workgroup timeline is as follows:

- March: Recruit Members
- April: 1st Workgroup Meeting
- May: 2nd and 3rd Workgroup Meeting
- June: Final Workgroup Comments on Edits to Reporting Instructions
- July 1: Final Reporting Instructions Released

Out Of State & Deregulation Volume Policy Development

Allan Pack, Director, Population Based Methodologies, provided an update on the new Volume Subgroup (see "Volume Subgroup Overview" available on the HSCRC website)

The HSCRC adjusts global budgets for anticipated changes in demographic/volume shifts in the market. The Commission implements the following volume adjustments:

- Demographic Adjustment- Annual age adjusted population funding for in-state use rate growth
- Marketshift- Semiannual adjustments for regulated market shifts (zero sum)
- Out of State- Annual adjustments for material changes to out of state volumes
- Deregulation- As needed reductions for observed shifts to unregulated settings
- Complexity and Innovation- Prospective funding to Academic Medical Centers for growth in unique quaternary services
- Cost of Drugs Sold (CDS)-A- Funding for changes in volume for select drugs

The purpose of the Volume Subgroup is as follows.

- Volume subgroup will provide input to Payment Models Workgroup
- Will provide input for a formal policy on out-of-state and deregulation volume adjustments.

    - The established policy will allow for routine adjustments.
    - Will create greater transparency and predictability in the system.

- The workgroup will evaluate methodologies that have been used for adjustments related to out-of-state and deregulated volumes. Considerations include:

    - Data sources and granularity of analysis
    - Materiality thresholds
    - Time periods for assessment and potential one-time adjustments
    - Implementation schedule
    - Interaction with other policies (e.g., Episode Quality Improvement Program (EQIP), total volume policies)

- The workgroup will also advise on the development of a comprehensive volume scorecard that accounts for 5 volume policies.

    - Current scorecard is strictly an assessment of Marketshift and Demographic Adjustment funding for growth in in-state volumes (excluding Potentially Avoidable Utilization (PAU), high-cost drugs, innovation, and chronic cases).
    - Future scorecards will incorporate adjustments for out-of-state volumes, deregulation, and PAU as well as adjustments related to Efficiency policies.
    - Future scorecards will not incorporate CDS-A and Complexity and Innovation, as those policies are stand-alone.

- A comprehensive scorecard will allow staff to better assess questions about whether these policies are working as intended. These tools include Rate Corridors, Marketshift, Deregulation, and Efficiency assessments.

Workgroup timeline is as follows:

- Staff Prep work- Out-of-State and Deregulation tool.
- March 18th- 1st Workgroup Meeting
- April 25th- 2nd Workgroup Meeting
- Additional Staff work
- May TBD- 3rd Workgroup Meeting
- Payment Model Workgroup Meeting TBD
- Draft Recommendation- June 14th
- Final Recommendation- September 11th

Commissioner McCann stated that it is important to look at licensed bed capacity of all hospitals. Since the implementation of the GBR, she understands that some hospitals have had their licensed beds reduced by 37%. Commissioner McCann suspects that hospitals GBRs are not seeing the same kind of reduction.

Commissioner McCann also stated that the Commission must make sure we are aligning capacity with the needs of the community.

ITEM XI
HEARING AND MEETING SCHEDULE

April 10, 2024,	Times to be determined- 4160 Patterson Ave HSCRC Conference Room
May 8, 2024,	Times to be determined- 4160 Patterson Ave. HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:22 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

March 13, 2023

Chairman Sharfstein stated reasons for Commissioners to move into administrative session. Regarding TCOC Model Monitoring agenda item, Chairman Sharfstein stated that monitoring the TCOC Model and its contractual requirements is sensitive in nature and necessary for administering the Model successfully without the potential for disrupting the regular functions of the rate setting system. Total Cost of Care data is not complete until the performance year is over. Regarding the FY 2024 Hospital Unaudited Financial Performance agenda item, Chairman Sharfstein stated that information is based on unaudited data and not the official measure of hospital financial performance. Hospital financial performance is a critical factor in the Commission's ability to meet the tests of the Model. When looking at hospital financial performance from the vantage point of unaudited data, we cannot be certain that accurate conclusions can be drawn.

Upon motion made in public session, Chairman Sharfstein called for adjournment into administrative session

The Administrative Session was called to order by motion at 12:04 p.m.

In addition to Chairman Sharfstein, in attendance were Commissioners Antos, Elliott, Johnson, Joshi, and Kane.

Attending virtually was Commissioner McCann.

In attendance representing Staff were Jon Kromm, Jerry Schmith, Allan Pack, William Henderson, Claudine Williams, Alyson Schuster, Cait Cooksey, Megan Renfrew, Erin Schurmann, Christa Speicher, Bob Gallion, and Paul Katz.

Also attending were Assistant Attorneys General Stan Lustman and Ari Elbaum, Commission Counsel.

Item One

William Henderson, Director, Medical Economics & Data Analytics, updated the Commission and the Commission discussed Maryland Medicare Fee-For-Service TCOC versus the nation.

Item Two

Mr. Henderson briefly updated the Commission on the hospitals' unaudited financial performance through January 2024.

The Administrative Session was adjourned at 12:34 p.m.

The Camden Coalition

Approaches to Strengthening Ecosystems of Care

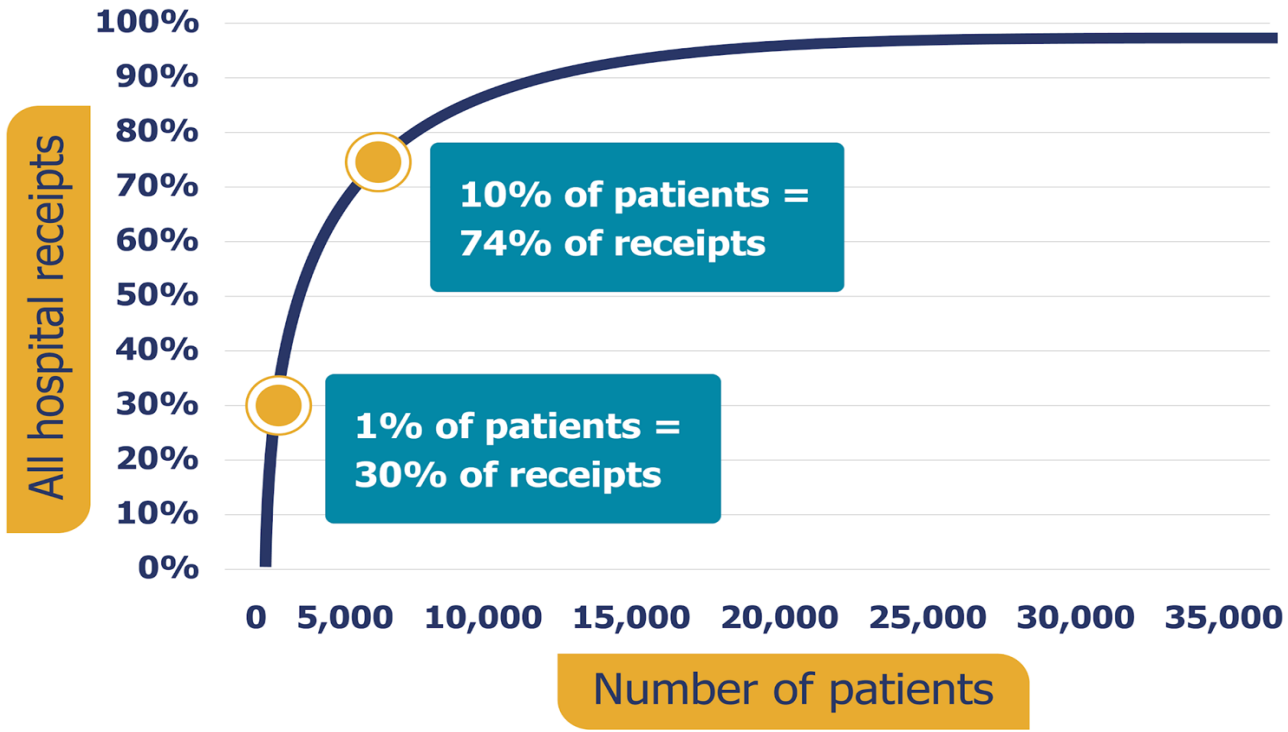
Maryland Health Services Cost Review Commission

April 10, 2024

Camden Coalition

Where we started

We started in Camden City focused on care management for people with complex health and social needs



- Camden Core Model launched in 2007
- Health Information Exchange launched 2010
- RCT with JPAL — data collection 2014-2017

What we learned

Success is possible, but some populations face barriers to engagement

JAN 2020

First RCT analysis found **null effect on readmissions** within a highly diverse study population

JUNE 2023

AJMC

"Dosage" of care management intervention matters.

SEP 2023

JN

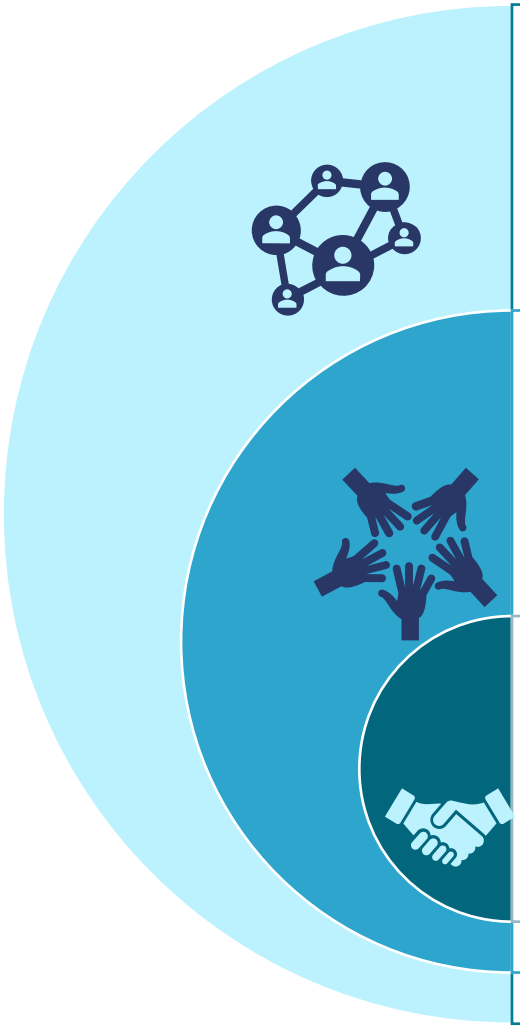
Reduced readmissions among sub-populations with higher engagement. Barriers to engagement: housing instability, SUD, recent arrest history.

DEC 2023

HA Health Affairs

New analysis: **Increased connection to outpatient care, DME**, across full study population.

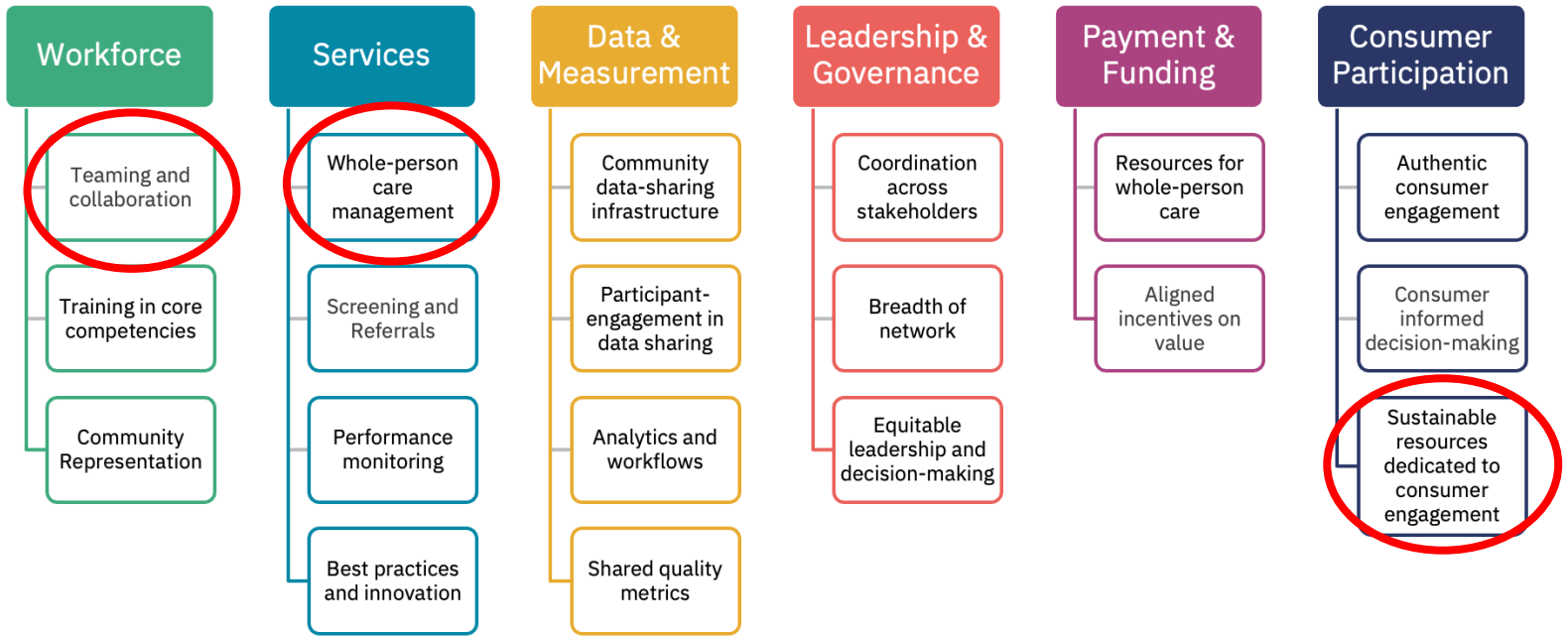
Working on multiple levels to create ecosystems of care



Building a field	• National Center for Complex Health and Social Needs • Online learning center • Complex Care Certificate
Systems-level	• Regional Health Hub • Health Information Exchange • Transitions-of-care pilots
High-touch, patient-facing	• Housing First • Medical-Legal Partnership

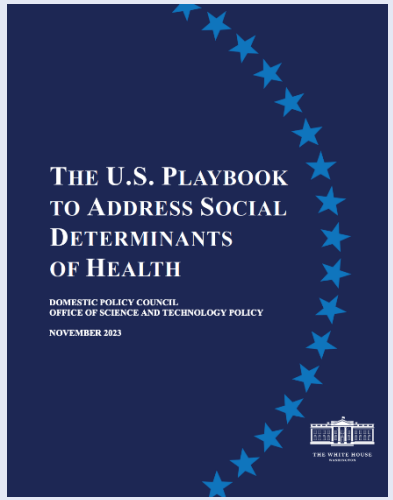
Strengthening Camden's ecosystem of care

Our ecosystem assessment tool:



Example projects: Pledge to Connect and Medical Legal Partnership

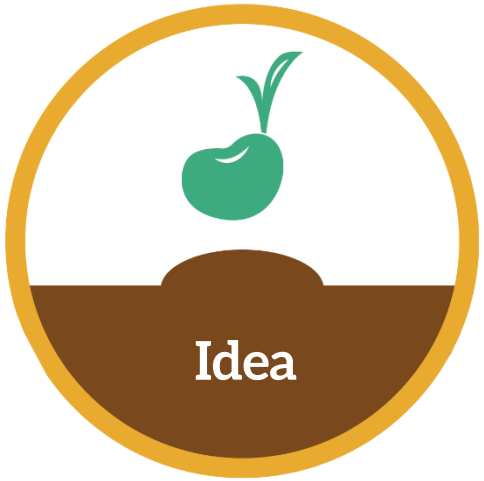
Federal focus on "backbone organizations"



NJ Regional Health Hub model cited as example of "innovation in action"

Pledge to Connect: Novel ED -> CCBHC workflow

Embedding CCBHC case managers in the ED to connect pts with mental health needs to outpatient BH care



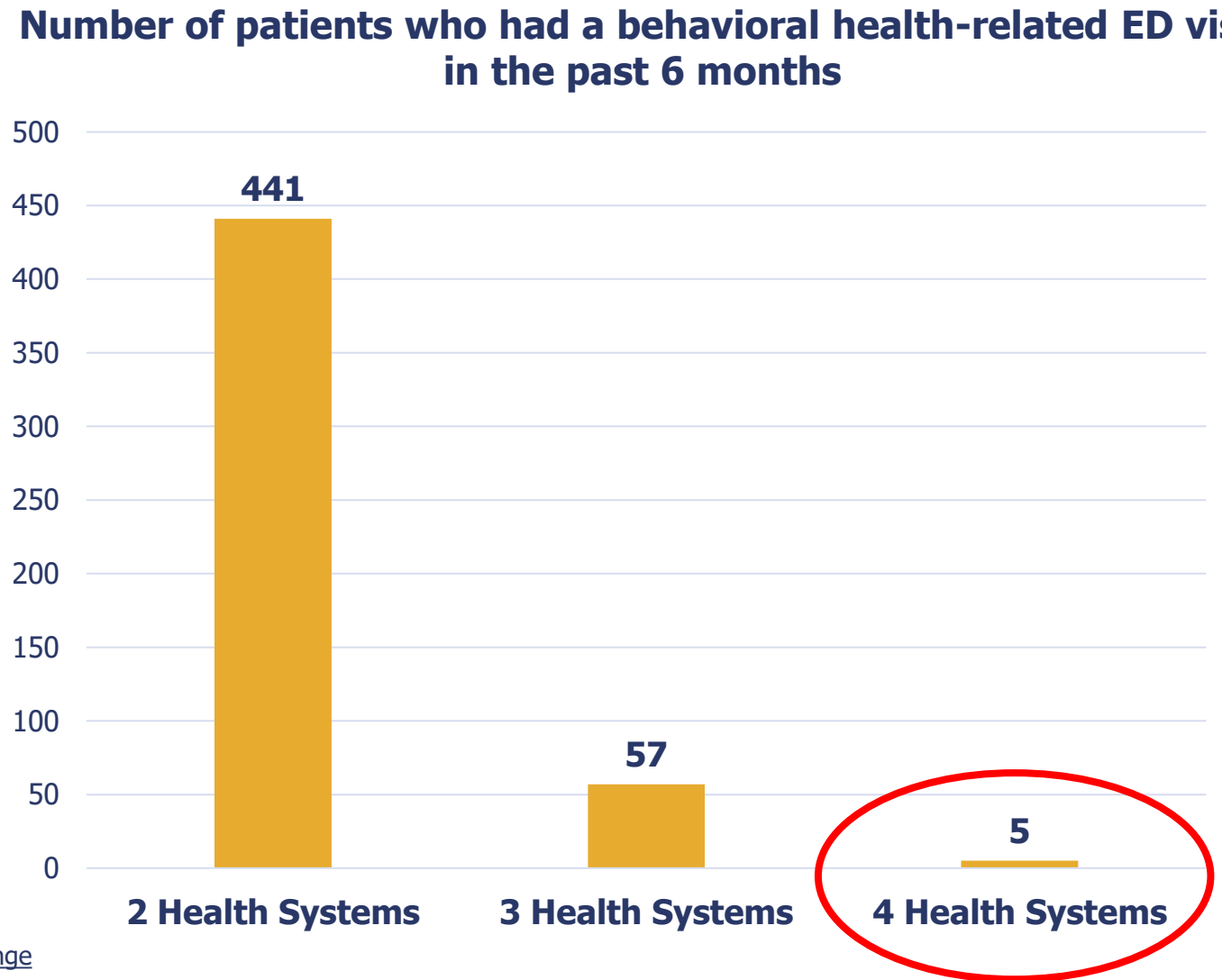
Created protocols, PDSA cycles. Connected outcome metrics to NJ Medicaid pay for performance program

In 2022, began to scale the pilot to 4 health systems & initiate regional triage and case conferencing

NJ Health New Jersey Department of Health · Oaks Integrated Care · Cooper University Health Care · ACENDA Integrated Health · Virtua Health · Jefferson Health · inspira Health Network

Regional case conferencing

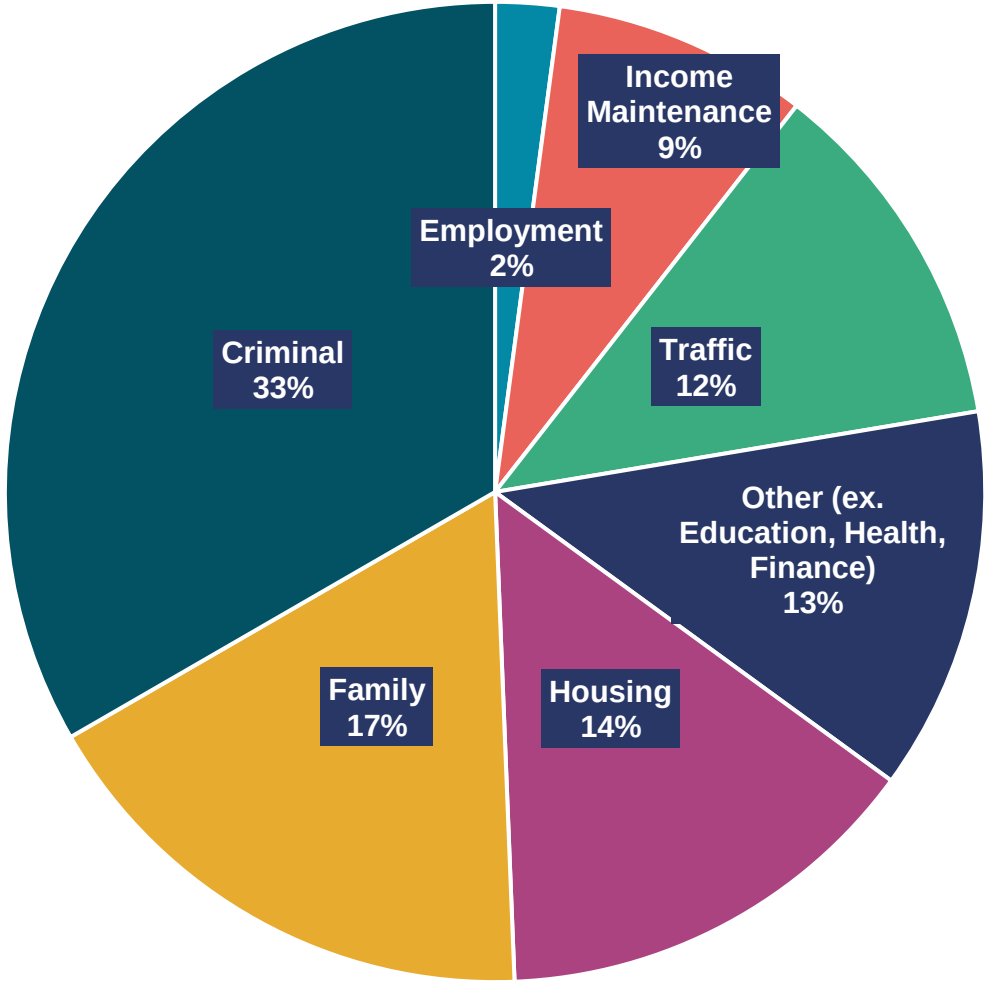
- Convenings for multi-system partners
- Integration of BH data into our HIE
- Regional triage pilot



Data compiled through the Camden Coalition Health Information Exchange

Medical Legal Partnership

- Attorneys are **embedded within health care settings** to reach some of the most vulnerable patients who typically do not have easy access to the legal system.
- MLP takes on **high-stakes issues** that present barriers to recovery and wellness
- In 2023, **our legal team took on 219 cases**, the majority of which came from the Cooper Addiction Medicine clinic.



Thank you

Camden Coalition

Cases Closed

The closed cases from last month are listed in the agenda

maryland
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Open Cases Overview

April 10 , 2024

Open Cases

- 2630R: UM Shore Medical Center at Easton - Full Rate Application - **No action required at this time**
- 2645A: Johns Hopkins Health System - ARM - Accarent Health- *Bariatric surgery, Oncology Surgical procedures, anal rectal surgery, spine surgery, thyroid parathyroid, join replacements, neurosurgery procedures, VAD procedures, pancreas surgery, cardiovascular services, musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, eating disorders, Cochlear implants, gallbladder surgery, CAR-T, ankle repairs, hernia and nephrectomy* **- Under Review by Staff**

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Nurse Support Program II

Program Renewal Development Plan

FY 2026 - FY 2030

Erin Schurmann, HSCRC
Laura Schenk, MHEC
Kimberly Ford, MHEC

Nurse Support Program I & II

Nurse Support Program I (NSP I)

- A non-competitive hospital grant to fund projects addressing needs related to nurse recruitment and retention.
- Focused on sustaining the number of bedside RNs through educational opportunities, improved working environments, and retention initiatives.
- Provides approximately $18M in annual funding (0.1% of gross patient revenue).
- Approved as a permanent program in 2022.

Nurse Support Program II (NSP II)

- Aimed at increasing the number of nurses in Maryland and strengthening nursing education programs by expanding capacity and increasing faculty at Maryland institutions.
- Initiated to increase the nursing and nursing faculty workforce with an emphasis on diversity.
- Provides approximately $18M in annual funding (0.1% of gross patient revenue).
- Five-year program renewal cycle.

Both Programs are funded by the HSCRC.

NSP I is not competitive and is administered by the HSCRC.

NSP II is competitive and is administered by the Maryland Higher Education Commission (MHEC).

Policy Charge: Program Renewal

- NSP II is beginning the program renewal process.
- The current program cycle concludes at the end of FY 2025.
- NSP II is reviewed for renewed funding by HSCRC every five years.
- NSP II has completed three program renewal cycles (20 years of funding), with the next renewal due by June 30, 2025.
- An end-cycle progress report is shared within the program renewal request.

Guiding Principles

- Fostering innovation and excellence in nursing education
- Achieving goals set forth in National Academy of Medicine's *Future of Nursing*
- Promoting diversity in faculty and student bodies
- Facilitating stability and sustainability in planning and investment
- Aligning and collaborating with NSP I to ensure a well-prepared new nursing workforce with direct pathways to hospital employment

Considerations as part of program renewal

Request for permanent funding: Continue NSP II as an ongoing program with permanent funding that does not require renewal, with the requirement for NSP II to provide annual reports on funded activities and accomplishments. Permanent funding is important for sustainability of funding for multi-year competitive grants and faculty-focused initiatives. Permanent funding would align NSP II with NSP I's permanent funding status and allow both programs to effectively work in tandem.

***Future of Nursing* Goals:** The foundational goal for NSP II is to increase educational capacity and strengthen nurse educators for an adequate supply of well-prepared nurses for Maryland hospitals and health systems. NSP II initiatives have and will continue to be informed by progress toward achieving national goals set forth by the *Future of Nursing 2020-2030* report from the National Academy of Medicine (formerly called the Institute of Medicine).

Diversity: In alignment with the NSP II statute's guideline provisions, the program tracks, analyzes, and prioritizes grant initiatives that promote the recruitment and retention of underrepresented groups of nursing. With the next program renewal, NSP II will work with stakeholders to find additional opportunities to meet this goal.

NSP I/II Alignment Opportunities

NSP I and II will continue to work closely together to find solutions to mutual priorities to meet the needs of schools of nursing and hospitals in Maryland. Nursing workforce needs are considered in the development of NSP II program goals and initiatives through NSP I representation in advisory groups, the competitive grant review process, and the establishment of program goals.

- **Building student pathways/pipelines to nursing:** With the next program renewal, NSP I and II will collaborate to develop nursing student pathways to fill nursing vacancies in understaffed specialty units. Behavioral health nursing has been identified as a potential initial focus area.
- **Strengthening Evidence-Based Practice (EBP) of new graduate nurses:** NSP I has identified a gap in nurse graduate readiness to practice the foundations of EBP. With the next program renewal, NSP I and II will work with stakeholders at the schools of nursing to identify grant-funded opportunities to establish a standard for embedding EBP in all pre-licensure curriculums.
- **Promoting Competency-Based Education (CBE):** CBE is focused on the learner's achievement of desired outcomes or competencies. CBE promotes quality education that is student-centered and benefits diverse learners. Nursing accrediting bodies encourage the use of CBE to ensure that all nursing graduates are practice ready. This requires a shift in focus for many nursing programs, resulting in the need for major curriculum revisions. Stakeholders from schools of nursing and nurse residency programs in MD have identified a gap in the use of CBE and the competencies of nursing graduates. To address these gaps, NSP I and II will partner with stakeholders to establish statewide initiatives that promote CBE.

Stakeholder engagement approach

NSP II will regularly engage with various stakeholders to assist with completing a comprehensive program renewal and end-cycle progress report. Examples of stakeholder engagement activities include:

1. **NSP I/II Advisory Group:** Meets tri-annually to discuss current issues affecting the nursing workforce. Membership includes select leadership from Schools of Nursing, Hospitals, NSP I, MD Hospital Association, MD Nurse Residency Collaborative, MD Nurse Workforce Center, etc. Meeting dates, times, and agendas are public and posted to the NSP website.
2. **NSP II Program Renewal Committee:** Private meetings to be held monthly leading up to the program renewal and includes select leadership from Schools of Nursing and representation from NSP I. The committee is primarily tasked with coordinating a plan and analyzing program data for the combined program renewal and end-cycle progress report.
3. **MD Deans/Directors:** Meets every other month to discuss issues affecting Schools of Nursing and membership includes leadership from all MD schools of nursing. NSP II is invited to attend all meetings and has the ability to engage in group discussions.
4. **MD Nurse Workforce Center:** Advisory Committee meets quarterly to discuss the goals/initiatives of this NSP II-funded statewide initiative. NSP II is a member of the Advisory committee and regularly collaborates with this group to conduct data analysis relevant to program renewal.

Other stakeholder feedback opportunities may include soliciting feedback from key stakeholders via an emailed survey and attending and/or presenting at statewide meetings to gather input about key problems affecting stakeholders.

Data

Various program, state and national data will be used to inform NSP II's program renewal, including:

- **Grant outcomes data:** data is collected from annual reports from NSP II grantees regarding the achievement of measurable outcomes related to NSP II goals (additional RN graduates).
- **Mandatory Data Tables from NSP II grantees:** data is collected from annual reports from schools of nursing regarding students, faculty, and program outcomes.
- **Faculty-focused initiatives data:** data is collected from faculty nomination forms and annual reports regarding faculty diversity, credentials, and achievement of competencies.
- **NSP I data:** data is obtained from NSP I annual reports regarding nurse vacancy rates, nurse residency data, etc.

Other relevant national & statewide data sources may include:

- **Bureau of Labor Statistics:** location quotient, cost of living, employment, wages, etc.
- **National Council State Boards of Nursing**: NCLEX-RN pass rates, National Nursing Workforce Study
- **American Association Colleges of Nursing:** faculty vacancies, new graduate employment
- **National League for Nursing:** nurse educator certifications
- **Professional Nursing Journals**: workforce projections & trends

Timeline

Program renewal process begins in FY 2024:

- **April 2024:** present program renewal plan to HSCRC
- **November 2024:** draft recommendations for program renewal
- **December 2024:** formal public comments solicited
- **January 2024:** final recommendations and Commissioner vote

Existing funding ends: June 30, 2025

After approval, renewed funding would begin: July 1, 2025

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Update on Medicare FFS Data & Analysis

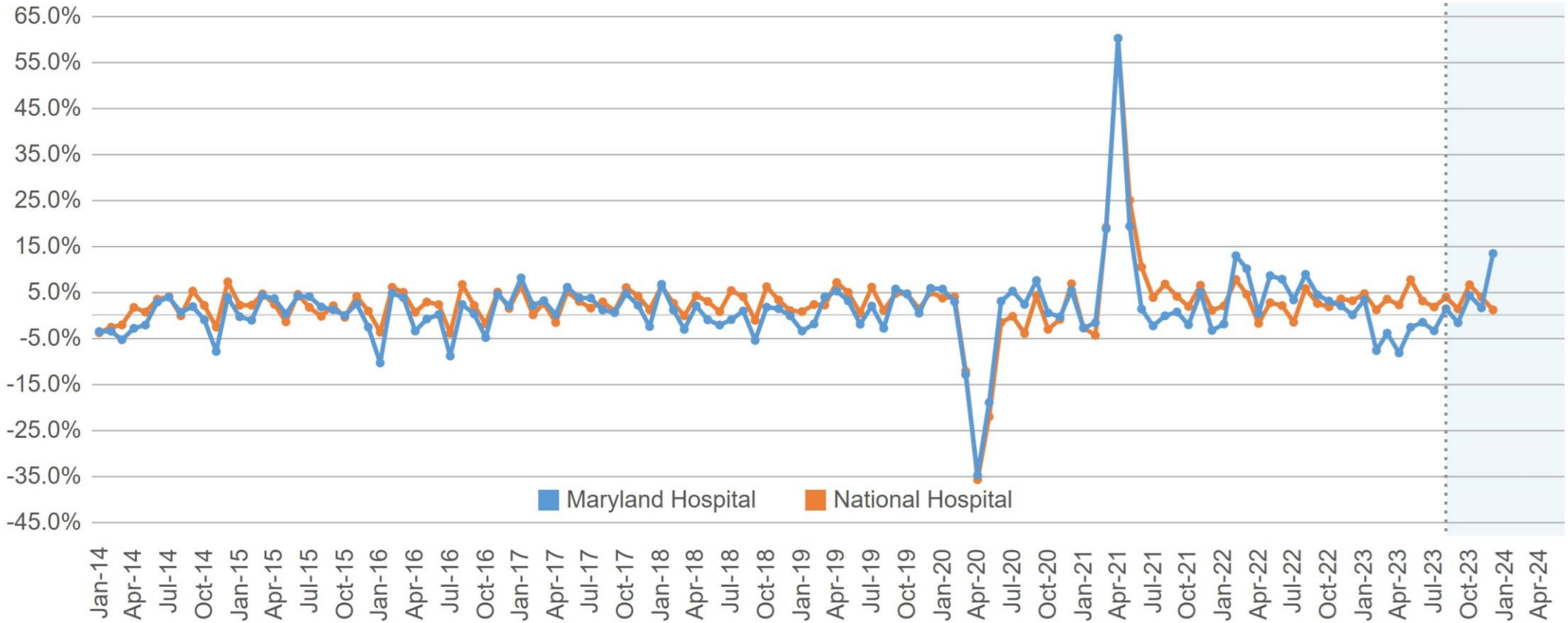
April 2024 Update

Data through December 2023, Claims paid through February 2024

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Hospital Spending per Capita

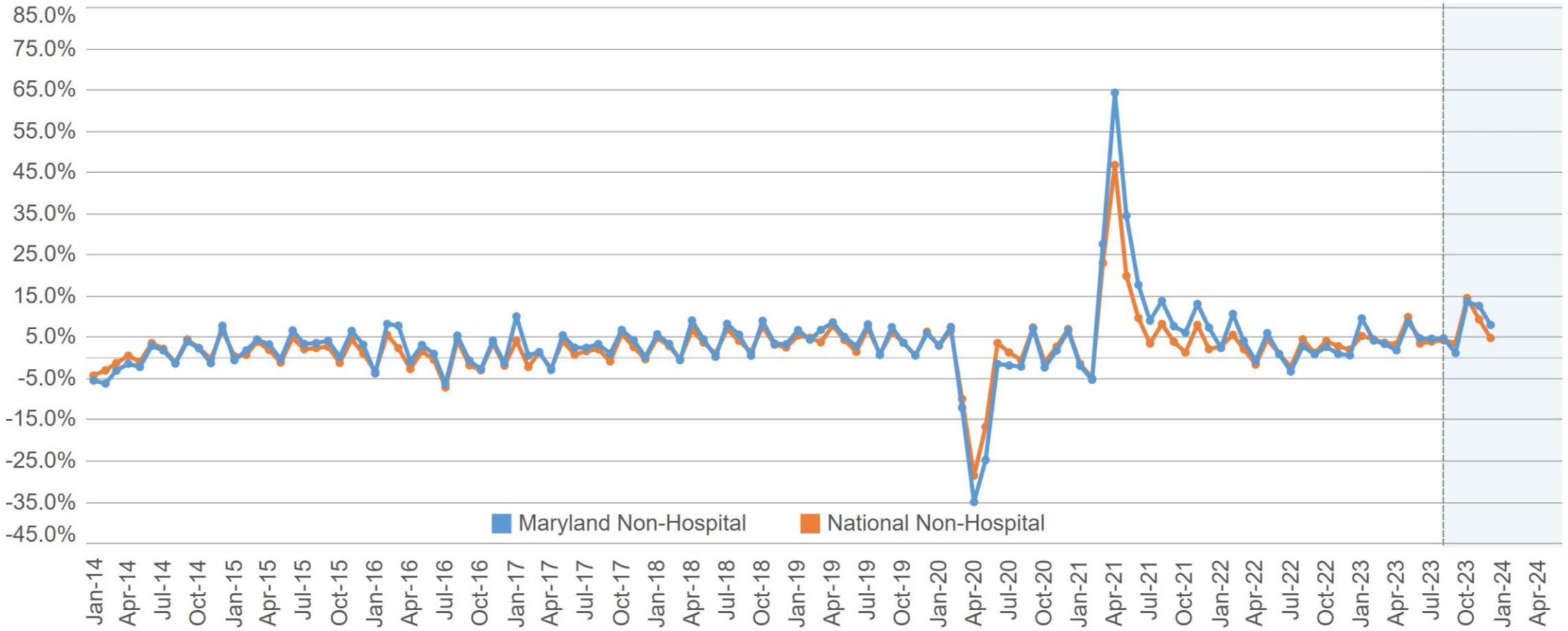
Actual Growth Trend (CY month vs. Prior CY month)



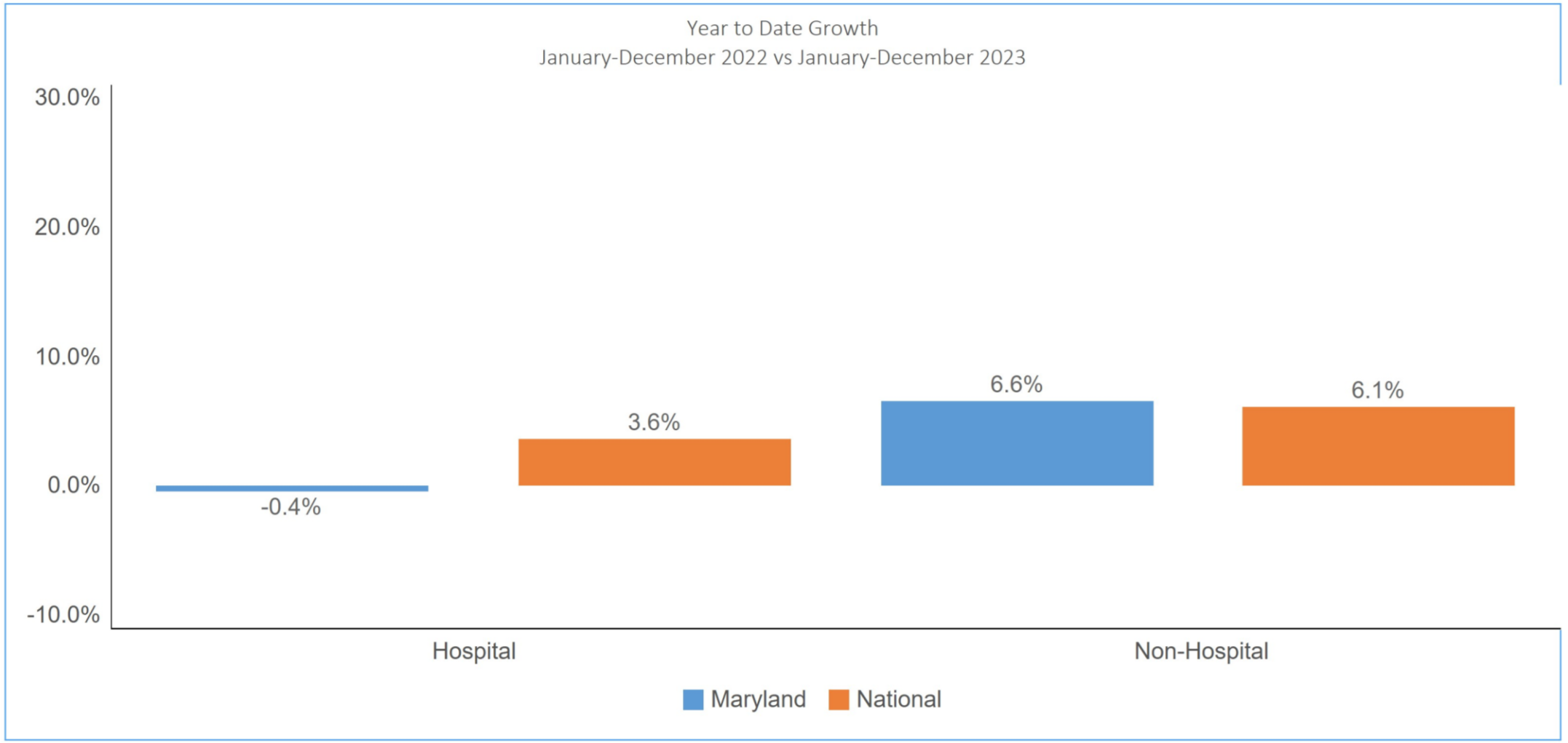
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)

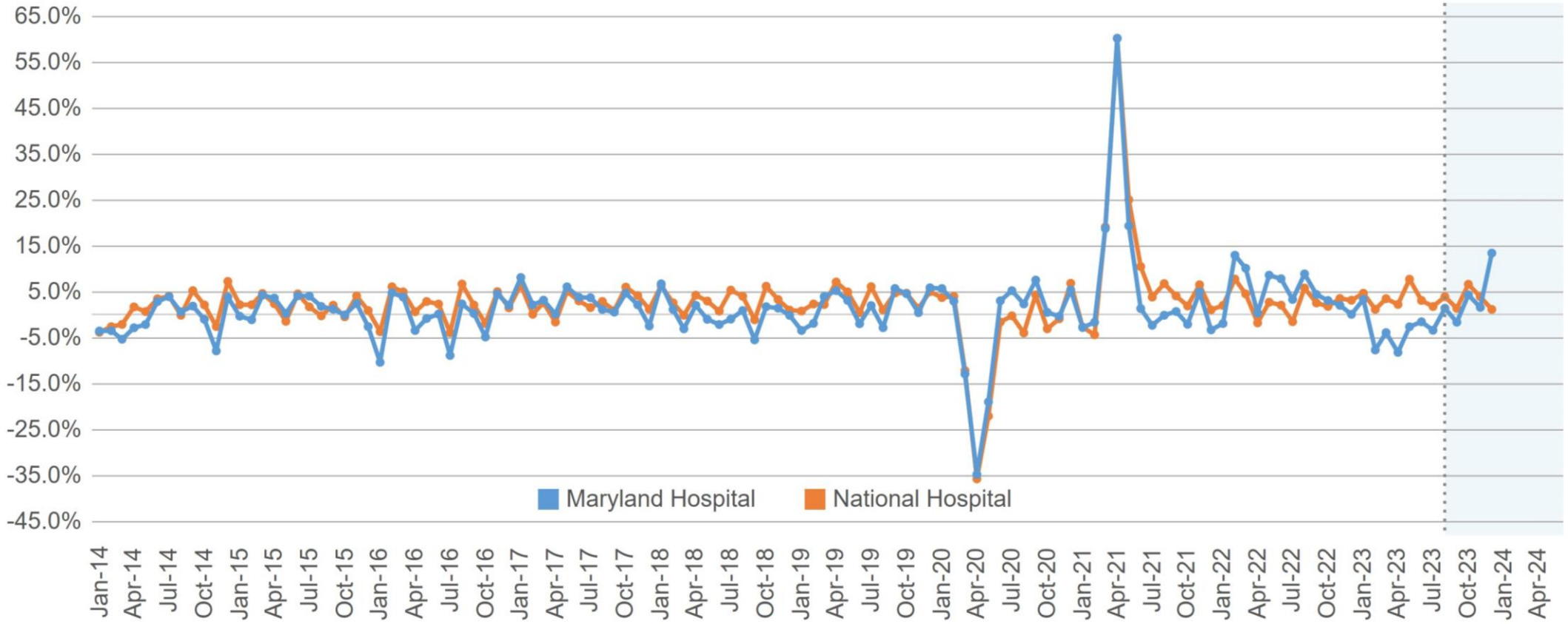


Medicare Hospital and Non-Hospital Payments per Capita



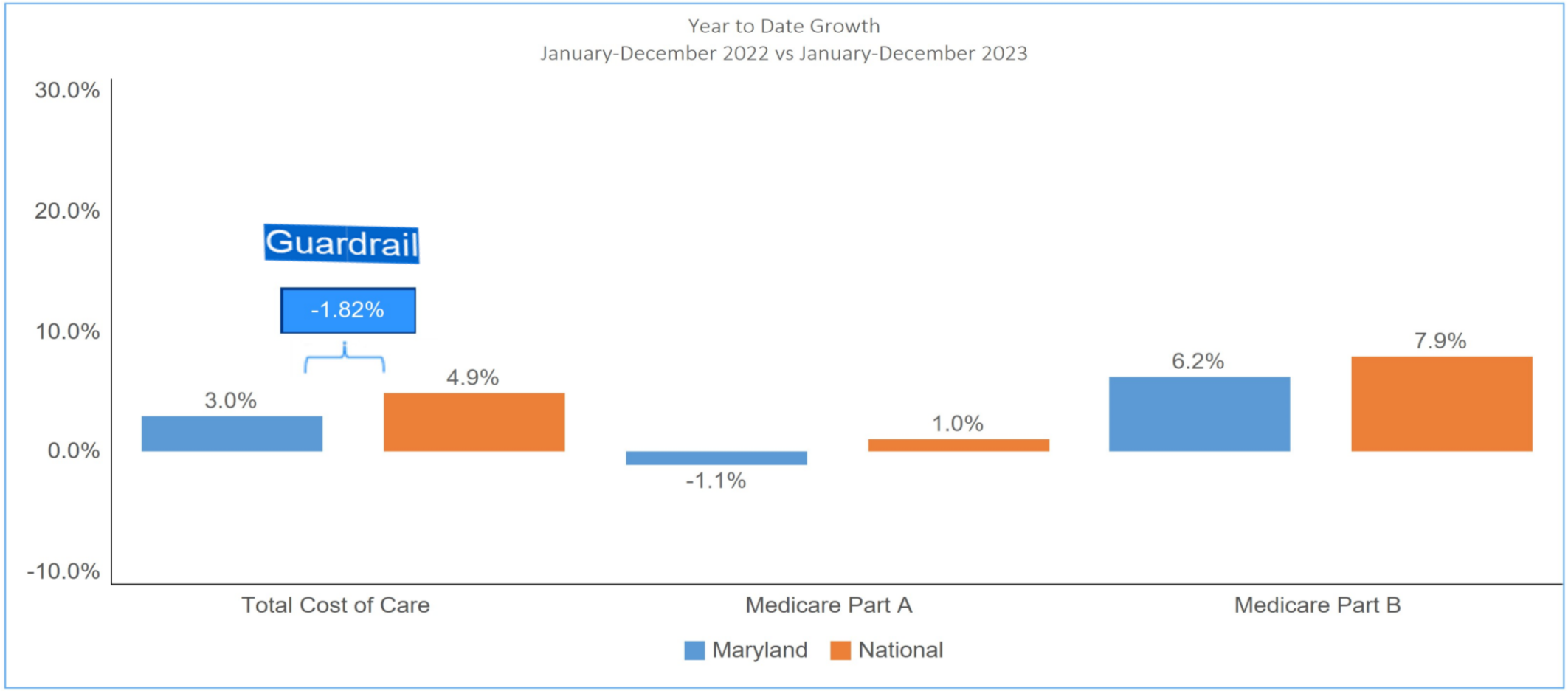
Medicare Total Cost of Care Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)



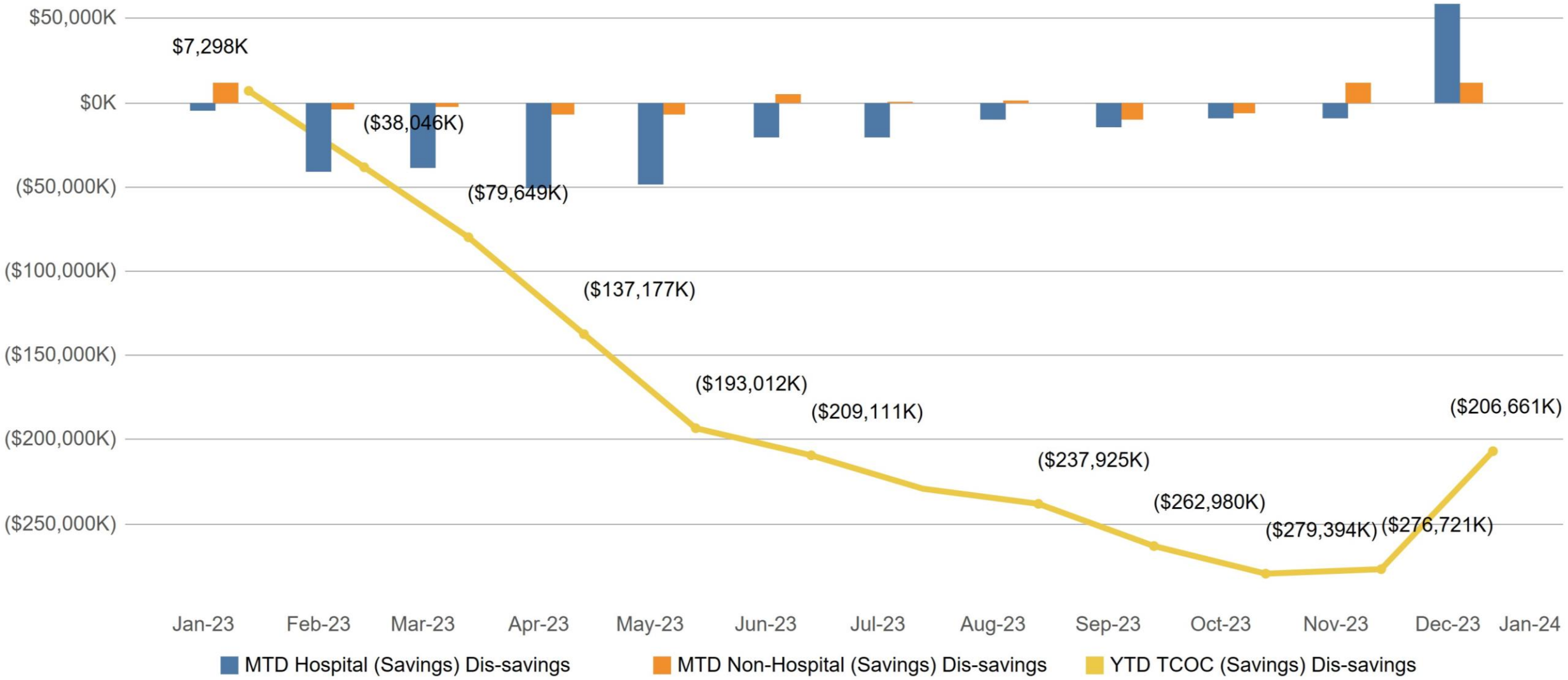
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through December 2023



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Legislative Update

HSCRC April 2024 Commission Meeting

April 10, 2024

2024 Maryland Legislative Session – Snapshot

The 446th session of the Maryland General Assembly ended on April 8 at midnight.

This year the commission tracked and monitored 346 bills impacting access, equity, quality, consumer protection, public health, behavioral health, hospitals, providers, insurance, workforce, prescription drugs, procurement, information technology, and state employees.

We took formal positions on 13 bills and offered amendments on numerous bills that potentially impacted HSCRC priorities.

Bills HSCRC Tracked and Took Positions On

- **HB 1143 - Emergency Department Wait Time Reduction Commission –** supported with written and oral testimony and offered amendments that were adopted (Effective Date: July 1, 2024. Period of 3 years.)

- **HB 328** - **Financial Assistance Policies –** supported with written and oral testimony (Effective Date: October 1, 2024)

- **SB 1006** - **Sale of Patient Debt –** provided Letter of Information and offered technical amendments that were adopted (takes effect on the date enacted and expires on December 31, 2026)

- **SB 694 (HB 887) - Health Commissions and MIA –** supported with written and oral testimony, offered amendment that was adopted (Effective Date: October 1, 2024)

Bills HSCRC Tracked and Took Positions On (continued)

- **HB 728 (SB 705) - Access to Care Act** – supported with written and oral testimony (Effective Date: October 1, 2024)
- **HB 1333 - Commission on Health Equity** – supported with written and oral testimony, offered amendment (Effective Date: October 1, 2024)
- **SB 1103 (HB 1149) - Outpatient Facility Fees** – supported the study portion of the bill with written testimony and offered amendments to the study that were adopted (Effective Date: July 1, 2024)
- **HB 84 (SB 332) - Sepsis Protocol** – provided Letter of Information (Effective Date: October 1, 2024)

Trauma Funding: Bills HSCRC Monitored and Offered Amendments on Reporting Requirements

- **SB 784 (HB 935) - Comprehensive Community Safety Funding Act** (Effective date: July 1, 2025)
- **SB 1092 - Vehicle Registration – EMS Surcharge** (Effective date: July 1, 2024)
- **SB 360 (HB 350) - Budget Bill (Fiscal Year 2025)** (FY July 1, 2024-June 30, 2025)
- **SB 362 (HB 352) - Budget Reconciliation and Financing Act of 2024** (Effective Date: June 1, 2024)

Commissions and Workgroups that the HSCRC is Directed to Staff, Convene, or Support

- **ED Wait Time Reduction Commission** – Co-chaired and staffed by HSCRC, will report annually (2025-2027) to the Legislature on recommendations related to the development and implementation of the policies and programs to reduce ED wait times.
- **Outpatient Facility Fees** –
  - HSCRC shall convene a workgroup of interested parties to study and make recommendations including:
    - whether notices should be expanded to all outpatient services;
    - the nature, drivers, magnitude, and impact of costs underlying facility fees;
    - alternative billing mechanisms and their interaction with TCOC model obligations and public and private payers;
    - and the effectiveness of the current notice provided to consumers.
  - HSCRC will submit a preliminary report to the legislature on or before December 1, 2024 and a final report on or before December 1, 2025.

Commissions and Workgroups (continued)

- **Maryland Commission on Health Equity (MCHE) –** The Secretary of Health and the Executive Director of HSCRC will co-chair the MCHE. The AHEAD Model requires both the State and hospitals to create health equity plans and specifies membership and duties of the entity that develops the State Health Equity Plan. This bill modifies the existing Health Equity Commission to allow it to play a key role in AHEAD governance, including the development of the required State Health Equity Plan.

- **Health Commissions and MIA Study –** MDH will hire an independent consultant to seek input from MDH, HSCRC, MHCC, MCHRC, and MIA in conducting a study of these entities for overlap of duties, alignment, and efficiencies. HSCRC will provide any requested information to the consultant.

Legislative Trauma Funding Reports

- MHCC and HSCRC shall report annually to the General Assembly on the distribution of the Maryland Trauma Physician Services Fund and hospital costs for trauma centers.

- In February, the Commission to Study Trauma Center Funding submitted findings and recommendations to the Legislature. The Legislature is requesting the HSCRC, in consultation with MHCC, to submit a report evaluating findings and recommendations from the Commission to Study Trauma Center Funding in Maryland.

Reports (from Joint Chairmen's Report)

- **Evaluation of MD Primary Care Program (MDPCP) and Update on Outcome Based Credits (OBCs)** – An independent evaluation of MDPCP, outlining cost savings from reducing unnecessary utilization or hospitalization for participating patients and the amount that OBCs have discounted costs and other population health goals. HSCRC should also provide an update on the timing of federal approval for the two remaining OBCs and results related to diabetes prevention.
  - Note: HSCRC will report on OBCs and some topics related to MDPCP, if those topics are not covered by MDH's independent evaluation.
- **Recruitment and Retention of Anesthesiologists in Maryland** – MDH, MHCC, and HSCRC, in coordination with the MD Society of Anesthesiologists, are asked to study barriers in the recruitment and retention of anesthesiologists, and submit a joint report that outlines findings.
- **Reimbursement for Maternal Fetal Medicine** – MDH, in consultation with MHCC and HSCRC, are asked to study Medicaid reimbursement rates for services provided by maternal fetal medicine specialists. MHCC and HSCRC will provide data to MDH that is necessary to complete the study. MDH will submit a report that outlines the findings resulting from the study.

Miscellaneous Interim Projects

- Pending passage of HB 328 (Financial Assistance Policies), regulations and documentation will need to be updated to reflect changes to service area restrictions and asset tests.

- Pending passage of SB 1006 (Sale of Patient Debt), HSCRC will need to provide additional guidance to hospitals.

Questions?

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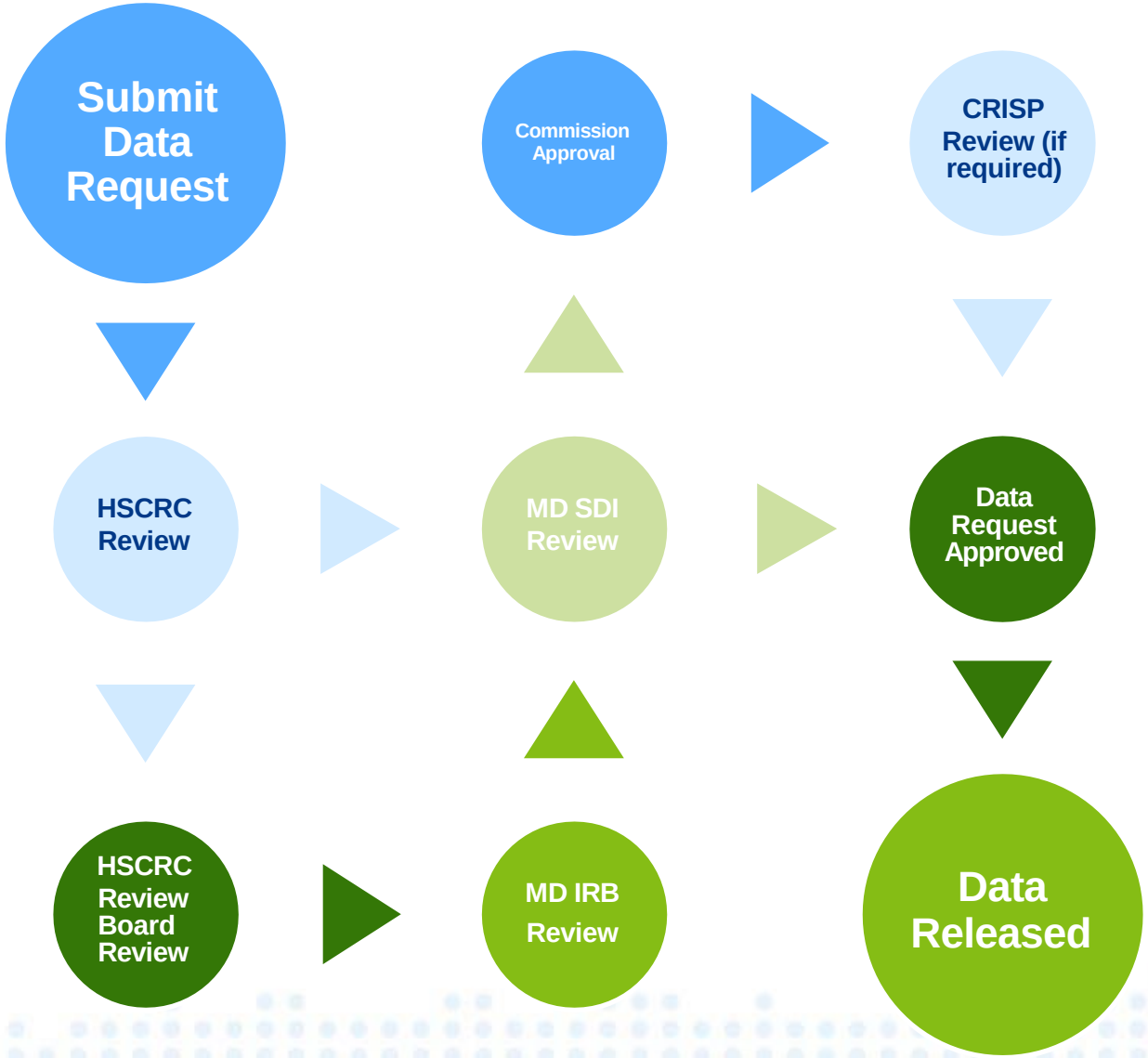
Confidential Data Request: Solventum

April 10, 2024

Data Request Process and Timelines: Patient-level Datasets



Processing Times

- Public Use Files – 90 days
- Confidential Data Files – 120 days

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Final Staff Recommendation for a Request to Access HSCRC Confidential Patient Level Data from Solventum.

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

April 10, 2024

This is a final recommendation for Commission consideration at the April 10, 2024, Public Commission Meeting.

SUMMARY STATEMENT

Solventum (previously known as 3M Health Information Systems), is requesting access to the Health Services Cost Review Commission (HSCRC) Confidential Inpatient and Outpatient Hospital Data ("the Data"), to assist with the parallel evaluation of Ambulatory Potentially Preventable Complications (AM-PPC) being performed by the HSCRC, as well as with the facilitation of questions and research surrounding outpatient and inpatient focused classification and normative statistics.

OBJECTIVE

The AM-PPC grouper identifies potentially preventable complications that occur following an elective ambulatory procedure, similar to the current inpatient complications grouper used in the Maryland Hospital Acquired Conditions program. The HSCRC is currently evaluating the AM-PPC grouper to support the HSCRC's overall quality objectives for the state of Maryland.

Solventum staff will assist HSCRC in evaluating the AM PPC grouper by:

1. Grouping HSCRC data to identifying complications within a procedure window for population health;
2. Supporting HSCRC with reviewing the AM-PPC results;
3. Provide technical assistance on ways to analyze and use the grouped data and compare with inpatient grouper results.

Solventum received approval from the Maryland Department of Health (MDH) Institutional Review Board (IRB) on February 14, 2024, and the MDH Strategic Data Initiative (SDI) office on March 1, 2024. The Data will not be used to identify individual hospitals or patients. The Data will be retained by Solventum until project completion or by December 31, 2025. At that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee is composed of representatives from the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements listed below and to make recommendations for approval to the HSCRC at its monthly public meeting.

1. The proposed study or research is in the public interest;
2. The study or research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
5. The organization has adequate data security procedures in place to ensure protection of patient confidentiality.

The Review Committee unanimously agreed to recommend that Solventum be given access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by Solventum for the Data for Calendar Year 2021 through 2023 be approved.

2. This access will include limited confidential information for subjects meeting the criteria for the research.

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Rate Year 2026 Final Policy for the Readmission Reduction Incentive Program

April 10, 2024

Stakeholder Input/Concerns: Improvement and Attainment Targets/ Revenue Adjustment Scaling

UMMS
1. Concerns about moving from 2018 to 2022 as the base year for measuring improvement since there have been significant improvements prior to 2023 performance and this “results in a dramatic one-time shift in revenue”. 2. Concerned that the readmission rate needed to reach the 2 percent improvement reward is much higher than the threshold. 3. Recommend attainment threshold be lowered from 65th to 50th percentile.
Staff Response
1. Staff believes that the change in the baseline year is appropriate since hospitals have earned rewards from 2018 for 5 years and it reduces the concerns about COVID impacting the readmission rate. The GBR also continues to reward hospitals for lowered readmission rates that occurred prior to 2022. 2. A modified slope reduced the readmission improvement for the maximum reward making it easier to receive the full 2 percent reward, it also reduced the readmission increases needed to receive the maximum 2 percent penalty. Staff will use this new slope when creating the 2-year improvement revenue adjustment since it’s not significantly different than the previous slope. 3. Staff continues to recommend the top 65th percentile as benchmark because, based on our benchmarking analyses, reducing it to the top 50th percentile would not incentivize better performance than our benchmarking peers. Also when applying the improvement target to the base period rate, the result is very close to the attainment threshold set at the 65th percentile of statewide performance.

Stakeholder Input/Concerns: Excess Days in Acute Care (EDAC) Measure

UMMS	MHA
Supports the monitoring of the EDAC measure but recommends an in-depth analysis before consideration for the payment policy in future years, citing peer reviewed literature revealing that a substantial number of top-performing hospitals would have shifted to lower-performing groups if EDAC was used	Expressed support for exploring other measure for post-discharge events
Staff Response	
Staff agrees additional monitoring is appropriate for EDAC as well as for the readmission rate with observation included. Staff believes that differences in performance may reflect important variation that should be explored in terms of hospital rankings under the readmission and EDAC measures,	

Stakeholder Input/Concerns: Readmission Within-Hospital Disparity Gap Measure

UMMS	UMMS and MHA	MHA
1. Threshold to start to earn rewards is too high	2. Measure methodology and how hospitals with a preponderance of low or high PAI patients perform and overall how sensitive the measure is to change 3. Attainment should be considered	4. Interested in working with HSCRC staff to develop the necessary form for hospitals to identify and detail activities aimed at reducing readmission disparities.
Staff Response		
1. Staff supports maintaining the threshold of 50 percent reduction in disparities since it aligns with SIHIS, the incentive is reward only, and the overall RRIP policy and the GBR itself rewards overall improvements and should be considered in conjunction with the disparity gap rewards. 2. Staff would like to explore attainment with hospitals but is concerned about setting a disparity gap greater than zero as the goal, i.e. how does staff reasonably determine a optimal level of disparity in outcomes. 3. While initial modeling indicates that the methodology does not disadvantage hospitals with different populations, staff is continuing to analyze the data and develop simulations to show hospitals the sensitivity of the measure to improvements. We are planning an upcoming webinar so that hospitals can better understand the measure so that they can focus on the interventions needed to impact disparities. 4. Added requirement for submission of interventions to promote equity. Staff appreciates MHA's willingness to assist with developing reporting of disparity interventions and will engage with them over the coming months so that hospitals can provide the HSCRC with additional information on interventions.		

Final RY 2026 RRIP Recommendations

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target- Set statewide 4-year improvement target for 5 percent from 2022 base period through 2026.
3. Attainment Target- Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. To be eligible for disparity gap reward, hospitals must not have an increase in overall readmission rate and must submit details on interventions aimed at reducing disparities.
6. Monitor ED and observation revisits by adjusting readmission measure and through all-payer EDAC measure. Collaborate with stakeholders to explore the causes and consequences of greater observation stay use in MD compared to the Nation.

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Final Recommendation for the Readmission Reduction Incentive Program for Rate Year 2026

April 10, 2024

This document contains the staff final recommendations for the

RY 2026 Readmission Reduction Incentive Program.

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Table of Contents

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List of Abbreviations

ADI	Area Deprivation Index
AMA	Against Medical Advice
APR-DRG	All-patient refined diagnosis-related group
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
CRISP	Chesapeake Regional Information System for Our Patients
CY	Calendar year
eCQM	Electronic Clinical Quality Measure
EDAC	Excess Days in Acute Care
FFS	Fee-for-service
HCC	Hierarchical Condition Category
HRRP	Hospital Readmissions Reduction Program
HSCRC	Health Services Cost Review Commission
HWR	Hospital-Wide Readmission Measure
MCDB	Medical Claims Database
MPR	Mathematica Policy Research
MSA	Metropolitan Statistical Area
NQF	National Quality Forum
PAI	Patient Adversity Index
PMWG	Performance Measurement Workgroup
PQI	Prevention Quality Indicators
RRIP	Readmissions Reduction Incentive Program
RY	Rate Year
SIHIS	Statewide Integrated Healthcare Improvement Strategy
SOI	Severity of illness
TCOC	Total Cost of Care
YTD	Year-to-date

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Key Methodology Concepts and Definitions

Diagnosis-Related Group (DRG): A system to classify hospital cases into categories that are similar in clinical characteristics and in expected resource use. DRGs are based on a patient's primary diagnosis and the presence of other conditions.

All Patients Refined Diagnosis Related Groups (APR-DRG): Specific type of DRG assigned using 3M software that groups all diagnosis and procedure codes into one of 328 All-Patient Refined-Diagnosis Related Groups.

Severity of Illness (SOI): 4-level classification of minor, moderate, major, and extreme that can be used with APR-DRGs to assess the acuity of a discharge.

APR-DRG SOI: Combination of diagnosis-related groups with severity of illness levels, such that each admission can be classified into an APR-DRG SOI "cell" along with other admissions that have the same diagnosis-related group and severity of illness level.

Observed/Expected Ratio: Readmission rates are calculated by dividing the observed number of readmissions by the expected number of readmissions. Expected readmissions are determined through case-mix adjustment.

Case-Mix Adjustment: Statewide rate for readmissions (i.e., normative value or "norm") is calculated for each diagnosis and severity level. These statewide norms are applied to each hospital's case-mix to determine the expected number of readmissions, a process known as indirect standardization.

Prevention Quality Indicator (PQI): a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Area Deprivation Index (ADI): A measure of neighborhood deprivation that is based on the American Community Survey and includes factors for the theoretical domains of income, education, employment, and housing quality.

Patient Adversity Index (PAI): HSCRC-developed composite measure of social risk incorporating information on patient race, Medicaid status, and the Area Deprivation Index.

Excess Days in Acute Care (EDAC): Capture excess days that a hospital's patients spent in acute care within 30 days after discharge. The measures incorporate the full range of post-discharge use of care (emergency department visits, observation stays, and unplanned readmissions).

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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 Readmission Reduction Incentive Program (RRIP), are intended to 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 RRIP policy is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time. It also provides incentive to reduce disparities in readmissions.	The RRIP policy currently holds up to 2 percent of hospital revenue at-risk for performance relative to predetermined attainment or improvement goals on readmissions occurring within 30-days of discharge, applicable to all payers and all conditions and causes. The hospitals can also earn up to a 0.5 percent reward for reductions in within hospital disparities.	This policy affects a hospital's overall GBR and so affects the rates paid by payers at that particular hospital. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	Currently, the RRIP policy measures within-hospital disparities in readmission rates, using an HSCRC-generated Patient Adversity Index (PAI), and provides rewards for hospitals that meet specified disparity gap reduction goals. The broader RRIP policy continues to reward or penalize hospitals on the better of improvement and attainment, which incentivizes hospitals to improve poor clinical outcomes that may be correlated with health disparities. It is important that persistent health disparities are not made permanent.

Recommendations

These are the final recommendation for the Maryland Rate Year (RY) 2026 Readmission Reduction Incentives Program (RRIP):

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target - Set statewide 4-year improvement target of 5 percent from 2022 base period through 2026.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. To be eligible for disparity gap reward, hospitals must not have an increase in overall readmission rate and must submit details on interventions aimed at reducing disparities. Scale rewards:
    a. beginning at 0.25 percent of IP revenue for hospitals on pace for 50 percent reduction in disparity gap measure over 8 years, and;
    b. capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
6. Monitor emergency department and observation revisits by adjusting readmission measure and through all-payer Excess Days in Acute Care measure. Consider future inclusion of revisits in the case-mix adjusted readmission measure or inclusion of EDAC in the RRIP program. Collaborate with stakeholders to explore the causes and consequences of greater observation stay use in Maryland compared to the Nation.

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 in 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 Readmissions Reduction Incentive Program (RRIP) is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve patient care and value over time that targets unplanned readmissions. While some hospital readmissions are unavoidable, other hospital readmissions within 30 days result from ineffective initial treatment, poor discharge planning, or inadequate post-acute care and result in poor patient outcomes and financially straining healthcare institutions.[1] The RRIP currently holds up to 2 percent of inpatient hospital revenue at-risk in penalties and rewards based on achievement of improvement or attainment targets in 30-day case-mix adjusted readmission rates. Furthermore,the RRIP also provides the opportunity to earn an additional 0.5 percent of inpatient revenue for hospitals with reductions in within-hospital readmission disparities (with requirement that the overall readmission rate does

[1] Rammohan R, Joy M, Magam S, et al. (May 15, 2023) The Path to Sustainable Healthcare: Implementing Care Transition Teams to Mitigate Hospital Readmissions and Improve Patient Outcomes. Cureus 15(5): e39022. doi:10.7759/cureus.39022

not increase). These two incentives should be considered in combination when assessing policy and evaluating performance.

For RRIP, as well as the other State hospital quality programs, updates are vetted with stakeholders and approved by the Commission to ensure the programs remain aggressive and progressive with results that meet or surpass those of the national CMS analogous programs (from which Maryland must receive annual exemptions). For purposes of the RY 2026 RRIP Final Policy, staff vetted the updated proposed recommendations in January and February with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Additionally, with the onset of the Total Cost of Care Model Agreement, each program was overhauled to ensure they support the goals of the Model. For the RRIP policy, the overhaul was completed during 2019, which entailed an extensive stakeholder engagement effort. The major accomplishments of the RRIP redesign were modifications to the inclusion and exclusion criteria for the readmission measure, development of a 5-year (2018-2023) improvement target, adjustment of the attainment target, and the addition of an incentive to reduce within hospital disparities in readmissions. See Appendix I for additional information on the Readmission Redesign Subgroup activities.

This final policy establishes a new four-year improvement target (CY2022 to CY2026), assesses the current attainment target, discusses the issue of revisits to the emergency department/observation following an inpatient admission, and continues the incentive for reductions in within-hospital disparities. The final policy does not make any changes to the current case-mix adjustment readmission measure, and includes minimal updates to the disparity gap measurement. Given the multi-year nature of this policy, staff may extend this policy for multiple years unless changes are warranted.

Background

Brief History of RRIP program

Maryland made incremental progress each year throughout the All-Payer Model (2014-2018), ultimately achieving the Model goal for the Maryland Medicare FFS readmission rate to be at or below the unadjusted national Medicare readmission rate by the end of Calendar Year (CY) 2018. Maryland had historically performed poorly compared to the nation on readmissions; it ranked 50th among all states in a study examining Medicare data from 2003-2004.[2] In order to meet the All-Payer Model requirements, the Commission approved the inaugural RRIP program in April 2014 to further bolster the incentives to reduce unnecessary readmissions beyond the incentives already inherent in the global budget system.

As recommended by the Performance Measurement Work Group (PMWG), the RRIP is more comprehensive than its federal counterpart, the Medicare Hospital Readmission Reduction Program (HRRP), as it is an all-cause, all-condition measure that includes all eligible discharges regardless of payer.[3] Furthermore, it assesses both improvement and attainment and provides an incentive to focus on disparities.

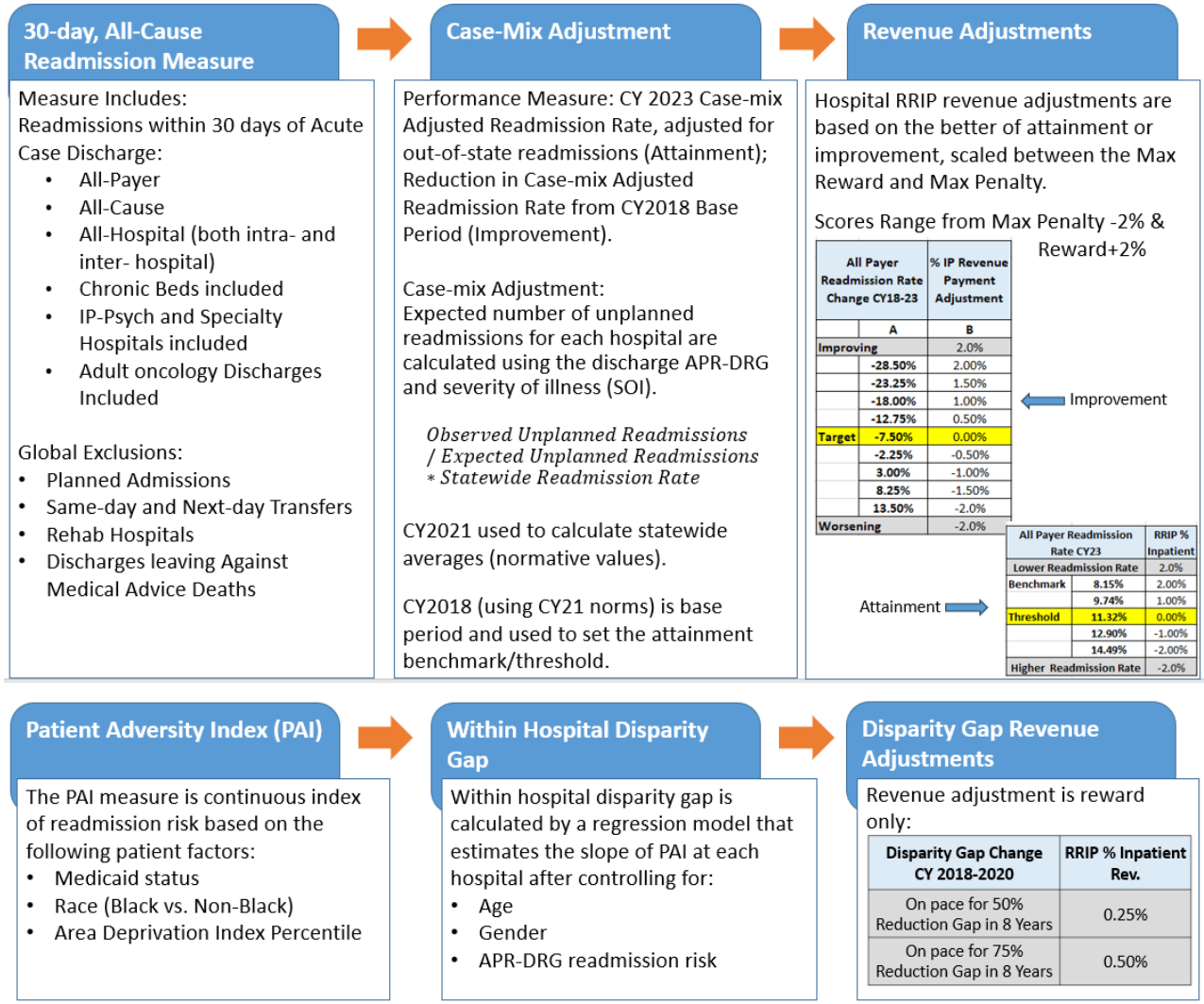
RRIP Methodology

Figure 1 provides an overview of the current RRIP methodology (also see Appendix I) that converts hospital performance to payment adjustments. In Maryland, the RRIP methodology evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges (pediatric oncology, patients who leave against medical advice, rare diagnosis groups) from consideration, due to data issues and clinical concerns. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR-DRG) severity of illness (SOI), and the policy determines a hospital's score and revenue adjustment by the better of

[2] Jencks, S. F. et al., "Hospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* Vol. 360, No. 14: 1418-1428, 2009.
[3] For more information on the HRRP, please see: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program

improvement or attainment.[4] The disparity gap methodology is separate and provides hospitals with the opportunity to earn rewards (no penalties) based on improvement.

Figure 1. RRIP Methodology RY25



[4] See Appendix I for details of on the current RRIP methodology.

Assessment

For RY 2026, the main policy decisions are to develop a new improvement target, since the original TCOC model goal was set through CY 2023, and assess the attainment standards with updated benchmarking. In order to set a new improvement goal, this section assesses readmissions performance and provides improvement scenarios for consideration. For attainment, updated benchmarking was evaluated for Medicare FFS and Commercial populations; as described below, staff is not proposing to change the attainment target from the 65th percentile. While there are no proposed changes to the readmission measure, staff is recommending that additional analytics be conducted over the coming year to assess hospital revisits to the emergency department and/or observation, which staff believes will complement some of the other workstreams the Commission currently is engaging in to improve emergency room length of stay. Finally, staff provides performance on the disparity gap measure and recommends to continue this targeted focus on high adversity patients.

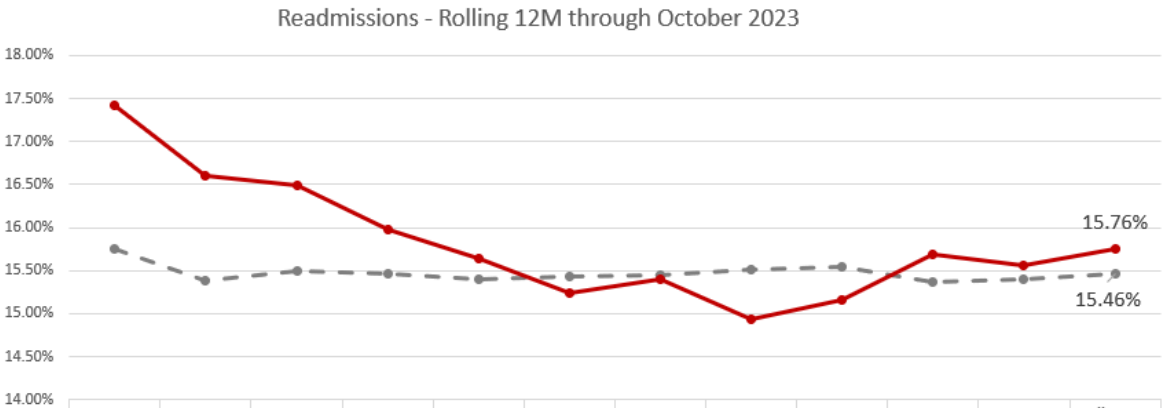
Current Statewide Year To Date Performance

Readmission performance is assessed in several ways. First, we present data on the unadjusted, all-cause Medicare Readmission Rate (the "Waiver Test"), which shows that Maryland currently has a slightly higher unadjusted readmission rate than the nation. Second, we present the all-payer, case mix adjusted readmission results used for the RRIP.

Medicare FFS performance

At the end of 2018, Maryland had an unadjusted FFS Medicare readmission rate of 15.40 percent, which was below the national rate of 15.45 percent. This is the measure that CMMI used to assess Maryland's successful performance on readmissions under the All-payer Model. Under the TCOC model, Maryland is required to maintain a Medicare FFS readmission rate that is below the nation. However, since CY 2021, Maryland's FFS Medicare unadjusted readmission rate has hovered slightly above that of the nation. The most recent readmission data, in Figure 2, show Maryland's readmission rate at 15.76 percent with the nation at 15.46 percent. However, as discussed in Appendix II, staff and CMMI have agreed to move to a risk-adjusted readmission measure that takes into account the case-mix differences between Maryland and the Nation. Overall, when taking case-mix into account, Maryland Medicare FFS patients have a lower readmission rate than National beneficiaries.

Figure 2. Maryland and National Medicare FFS Unadjusted Readmission Rates

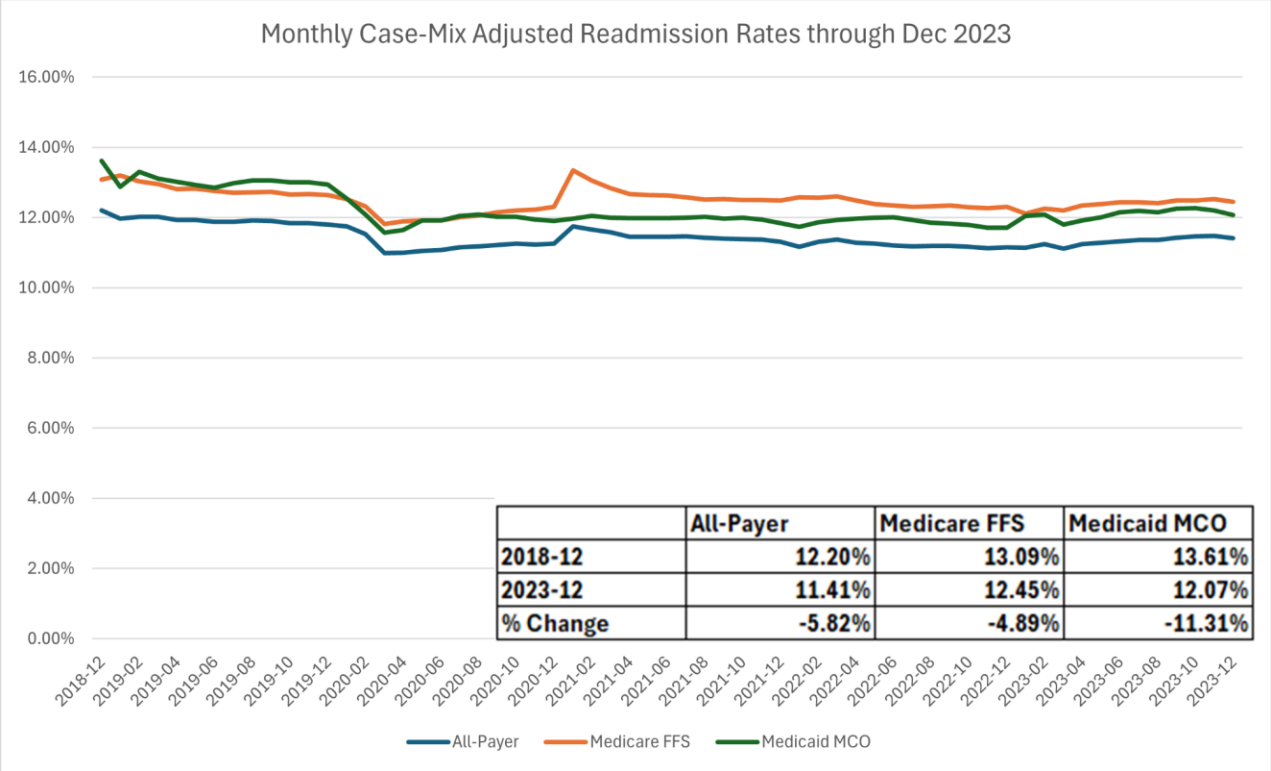


	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	Rolling 12 Months CY 2023
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%	15.46%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%	15.76%

All-Payer Readmission Performance

Maryland has also performed well statewide over time on RRIP performance standards as shown in Figure 3, with All-payer, Medicare FFS, and Medicaid MCO readmission reductions of 5.82 percent, 4.89 percent and 11.31 percent from 2018 respectively. The all-payer reduction is in line with the 5-year improvement goal, which was set as part of the RRIP redesign, of a 7.5 percent improvement from CY2018 through CY2023.

Figure 3. Statewide Improvement in Case-Mix Adjusted Readmission Rates by Payer, 2018 through 2023 (Preliminary)



	All-Payer	Medicare FFS	Medicaid MCO
2018-12	12.20%	13.09%	13.61%
2023-12	11.41%	12.45%	12.07%
% Change	-5.82%	-4.89%	-11.31%

Most hospitals continue to perform well under the RY 2025 RRIP program, which is based on CY 2023 performance (current results are YTD through preliminary December). As illustrated in Figure 4 below, 14 hospitals are on target to reach the improvement goal of 7.5 percent, and as shown in Figure 5, 13 hospitals are on target to have a readmission rate below the attainment threshold of 11.32 percent. Hospitals performing well on both improvement and attainment will receive the better revenue adjustment (i.e., the higher reward or lower penalty). Overall there are 20 unique hospitals on track to receive a scaled reward for CY 2023 performance.

Figure 4. By-Hospital Change in All-Payer Case Mix Adjusted Readmission Rates, 2018-YTD 2023

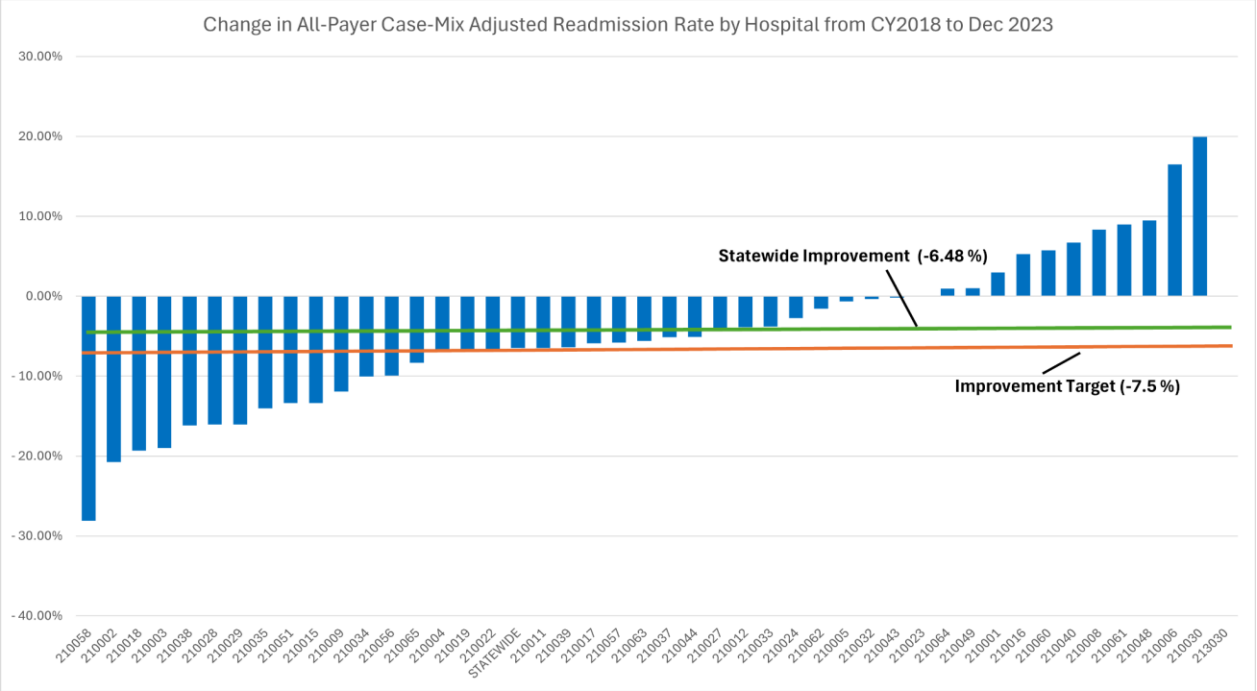
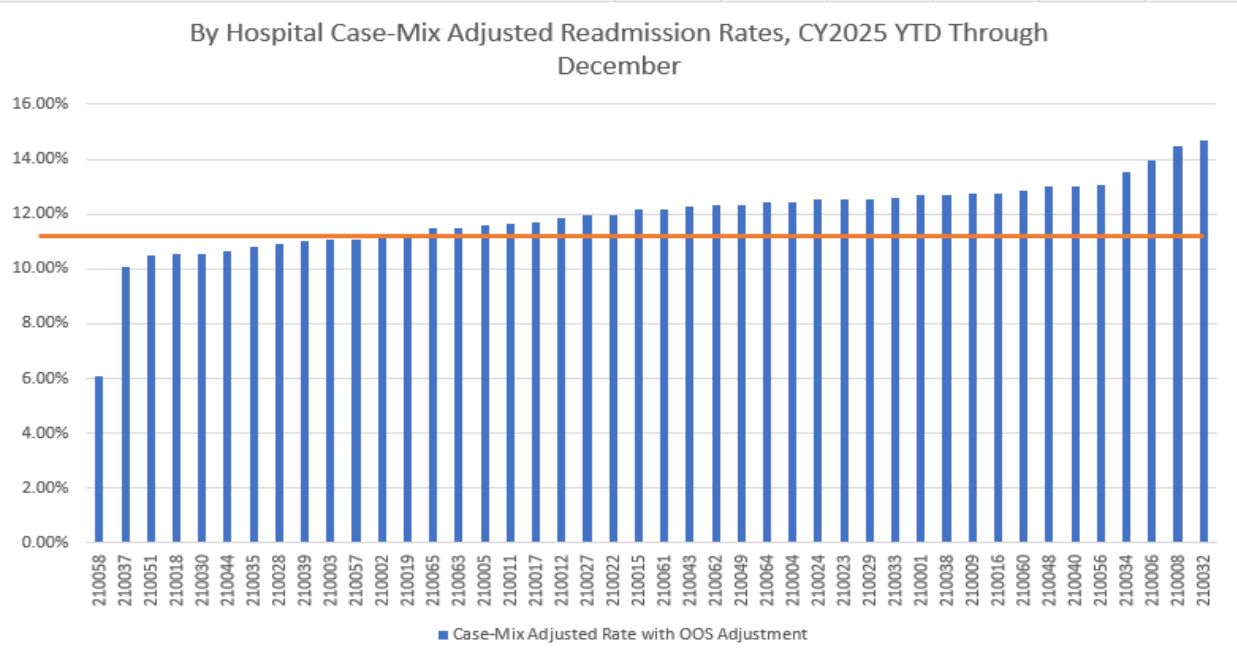


Figure 5. By-Hospital Change Case Mix Adjusted Readmission Rates, YTD 2023



Updating the Performance Targets Under the TCOC Model

Improvement

Maryland hospitals achieved the contractual test for Medicare readmissions to be at or below the nation by 2018. Analyses conducted as part of the RRIP redesign suggested that further improvements of 7.5 percent could be achieved. This policy repeats the analyses conducted in 2019 to determine a reasonable improvement goal for earning rewards, and whether additional improvement should be expected over the last few years of the TCOC model.

Staff believes that further reductions in readmissions are possible, but recommends a more modest improvement target from CY 2022 through CY2026 in recognition of the sustained and substantial improvement under the All-Payer Model and the first five years under the TCOC Model. As the literature does not provide an optimal all-payer readmission rate, staff has generated a range of potential improvement scenarios. Figure 5 reflects the modeling revealing a range of readmission rate reductions of approximately 2 to 9 percent from existing CY 2022 levels.

Figure 6. Improvement Target Estimates

Estimating Method	Percent Improvement from CY2022 (11.15%)	Resulting Readmission Rate (2026)*
1 Actual Compounded Improvement, 2018-2022	-8.61%	10.19%
2 Actual Improvement 2021-2022, Annualized to Four Years	-5.54%	10.53%
3 All Hospitals to 2022 Median	-4.1%	10.69%
4a Medicare Benchmarking - Peer County/MSA to 75th Percentile**	-4.75% to -5.45%	10.58%

4b Commercial Benchmarking - Peer County/MSA to 75th Percentile**	-2.22% to -9.15%	10.52%
5 Reduction in Readmission-PQIs	-2.39%	10.88%

* Assuming a constant CY 2022 readmission rate of 11.15 percent (under RY 2025 logic with specialty hospitals included)

For the first estimating method (Row 1), staff analyzed the improvement achieved under the first four years of the TCOC model and assumed that similar improvements could be repeated during the last four years under the TCOC Model. This ~9 percent reduction represents the higher end of the improvement estimates. The second method (Row 2) uses the (slightly slower) improvement achieved between 2021 and 2022 and annualizes this one-year improvement to four years, resulting in a slightly less aggressive improvement target of ~5.5 percent.

The third and fourth estimating methods derive targets by assuming that hospitals currently performing worse than the statewide median or other peer geographies could improve to these rates. The third method (Row 3) calculates the statewide improvement if all hospitals are reduced to the CY 2022 median readmission rate. This method provides a lower improvement goal than the trending analysis. The fourth estimating method (Row 4a and 4b) uses national benchmarks of like geographies to generate improvement targets for Maryland hospitals to reduce to the 75th percentile of similar geographies by payer. Based on 2022 data, Maryland Medicare FFS readmission rates would need to improve by 4.75 percent to reach the Peer county 75th best percentile, or 5.75 percent to ensure that all Maryland counties were at or below the 75th percentile.[5] While for Commercial population, the CY 2022 readmission rate would need to improve by 2.22 percent to reach the Peer county 75th best percentile, or 9.15 percent to ensure that all Maryland counties were at or below the 75th percentile.

The fifth method estimates what the readmission rate would be if a certain percent of readmissions that are also PQIs (i.e., avoidable admissions for conditions such as diabetes,

[5] The second scenario is lower as there are Maryland counties already better than the 75th percentile.

COPD, and hypertension) are prevented. In this analysis we used the SIHIS PQI improvement goal, and reduced readmissions that were also PQIs by this goal and recalculated statewide rate. We also considered how reductions in readmission disparities might impact overall improvement, but would have needed to assess reductions for each factor (medicaid status, race, ADI) independently, which would be difficult to interpret and would not account for differing populations of interest across hospitals.

These scenarios identify a range of potential targets but do not determine a specific, optimal readmission rate. Staff and stakeholders agree generally with the range of potential improvement targets and support the generation of a four-year target rather than annual targets. Stakeholders also continue to support including both improvement and attainment in building a revenue adjustment. Based on the above modeling, as well as stakeholder input, staff has decreased the improvement target in this final policy from 5.5 percent to 5.0 percent (2022 to 2026). Staff reserves the right to revisit and revise this target should it prove too aggressive or too lenient such that the state creates unintended consequences or risks not meeting the continued goal of remaining at or below that national Medicare rate.

Attainment

Prior to the RRIP Redesign for the TCOC model, the HSCRC has used the 75th percentile of best performers as the threshold to begin receiving rewards for attainment. In RY 2021, this was amended to the 65th percentile to allow hospitals in the top-third of Maryland performance to earn financial rewards for attainment, which acknowledged that Maryland (historically a poor performer on readmissions) had accomplished substantial improvement during the All-Payer Model. Staff analyzed the current policy of the 65th percentile and compared this to the improvement targets suggested by the Peer Group national benchmarking analysis and the various opportunity analyses. To do this, staff calculated the statewide CY 2022 casemix-adjusted rate inclusive of a 5% improvement target and compared this statewide rate to the 65th percentile of hospital performance in CY 2022. Staff determined that the 65th percentile of current performance is quite close to the targeted statewide readmission rate. Thus, as discussed more in the stakeholder

feedback section, staff supports maintaining the attainment threshold (start of rewards) at the 65th percentile of hospital performance since it aligns with the start of rewards for improvement.

Revisits to Emergency Department and Observation Stays

Improvement in readmission rates under the model should result in better patient experience. However, the current readmission measures only count a readmission if the patient returns to the hospital and is admitted into an inpatient bed. Thus, revisits to the emergency department or for an observation stay after an initial inpatient admission are not considered. This potentially has an impact on hospital throughput and ED boarding as anecdotally hospital ED staff have said that they are doing more testing and diagnostics in the ED, which previously may have been done during the inpatient admission, to determine whether an admission is really necessary. While this might be appropriate clinically, if these revisits represent quality of care or care coordination concerns, these are not being identified for payment incentives at this time (only exception is PAU includes observation stays >=24 hours as inpatient stays). When HSCRC staff looked at this previously for just observation stays, we found that while readmission rates increased when observation stays were included, the correlation between the readmission rates with and without observation stays was 0.986 in 2018. This analysis, and the fact that the national program does not include observation stays, led the staff at that time to recommend that the RRIP readmission measure remain an inpatient only measure. However, staff recommended in the draft policy, and seeks Commissioner input/support, to repeat these analyses over the coming year with both ED and observation stays included, to assess the extent of revisits, types of revisits, and differential impacts of revisits on readmission performance by hospital (e.g., does the rank order of hospitals change with inclusion of revisits). While PMWG members have told us that revisits may reflect quality of care or other concerns such as medication access, they do not think that shorter observation stays necessarily reflect quality concerns and do remain concerned about lack of benchmarking for a broader measure. Finally, staff has discussed with CMMI and other stakeholders their interest in understanding the causes and consequences of higher use of observation in Maryland compared to the nation. CMMI has proposed adding observation stays to the Medicare readmission measure used for comparing Maryland and the Nation. However, staff believes additional analytics and clinical input is needed to assess this change and whether

shorter observation stays should be excluded. Staff will continue to collaborate with CMMI on this issue and has updated the recommendation on monitoring of revisits to reflect that CMMI has identified higher use of observation stays as a topic of interest.

Excess Days in Acute Care (EDAC)

As discussed above, stakeholders remain concerned about emergency department and observation revisits, especially given the global budget incentives to reduce avoidable[6] admissions. Another approach for addressing this issue would be to adopt the Excess Days in Acute Care measure into payment. The EDAC measure captures the number of days that a patient spends in the hospital within 30 days of discharge, and includes emergency department and observation stays by assigning ED visits a half-day length of stay and assigning observation hours rounded up to half-day units.[7] Staff has worked with our methodological contractor to adapt the Medicare Excess Days in Acute Care (EDAC) condition-specific measures to an all-cause, all-payer measure for potential program adoption in future years. This work was completed and monitoring reports for this measure are posted on the CRISP portal on a monthly basis for hospital monitoring and input. Over the coming year as staff assesses revisits, the EDAC measure may be one option for consideration rather than adapting the actual readmission measure. However, the EDAC measure has been criticized by some PMWG members because of the time element associated with the readmission. Specifically, the concern is that longer readmissions (which would represent worse performance) may indicate a less preventable readmission. While staff will consider this concern, it could also be countered that a longer readmission represents a more serious quality of care issue from the initial admission. Staff should collaborate with CMMI on observation stays as they decide if and how to factor in revisits as a quality of care concern.

Digital Measures/Electronic Clinical Quality Measure (eCQM)

Under the Inpatient Quality Reporting program, CMS transitioned from the claims-based 30-day Hospital Wide Readmission (HWR) measure to the digital Hybrid HWR measure with the July, 1

[6] Updated 4/5/2024 from “to avoid admissions” to say “reduce avoidable admissions”.
[7] Additional information on the EDAC measures and methodology can be found here: https://www.qualitynet.org/inpatient/measures/edac/methodology

2023-June 30, 2024 mandatory reporting of the hybrid measure for Medicare patients for FFY 2026 payment year. The HWR 30-day readmission hybrid measure merges electronic health record data elements with a set of 13 Core Clinical Data Elements (CCDE) consisting of six vital signs and seven laboratory test results; hospitals must map these 13 CCDE to the patient electronic health record (EHR). The claims and CCDE data are then merged and used to calculate measure results. For the initial mandatory year beginning July 1, 2023, HSCRC also requires hospitals to submit the hybrid HWR measure data to the State for Medicare patients. Additionally, staff has formally communicated to hospitals the State's intent to expand the measure to all-payers aged 18 and above beginning with July 1, 2024 discharges. To prepare for this update, CRISP and Medisolv (CRISP digital measure subcontractor) have indicated they are updating the data collection infrastructure and will be ready to receive data on the expanded measure with the first submission scheduled to begin in January 2025. However, in a digital measures stakeholder subgroup staff convened in August 2023, and in subsequent communication with staff, hospital and EHR vendor representatives significant concerns have been raised about the feasibility of expanding the measure beyond Medicare patients. Among the specific concerns from hospitals are, in some cases, their EHR vendors are telling them there are additional costs and significant effort to set up and implement the expanded measure; in other cases, hospitals are noting their EHR vendor is telling them they are unable to do the work to expand and implement the measure. HSCRC staff will continue to investigate the issues voiced by hospitals and identify strategies to progress on expansion of the Hybrid measure, and will also consider options for augmenting the RRIP all-payer measure with EHR data elements in the future.

Reducing Disparities in Readmissions

Racial and socioeconomic differences in readmission rates are well documented[8,9] and have been a source of significant concern among healthcare providers and regulators for years. In Maryland, the 2018 readmission rate for blacks was 2.6 percentage points higher than for whites, and the

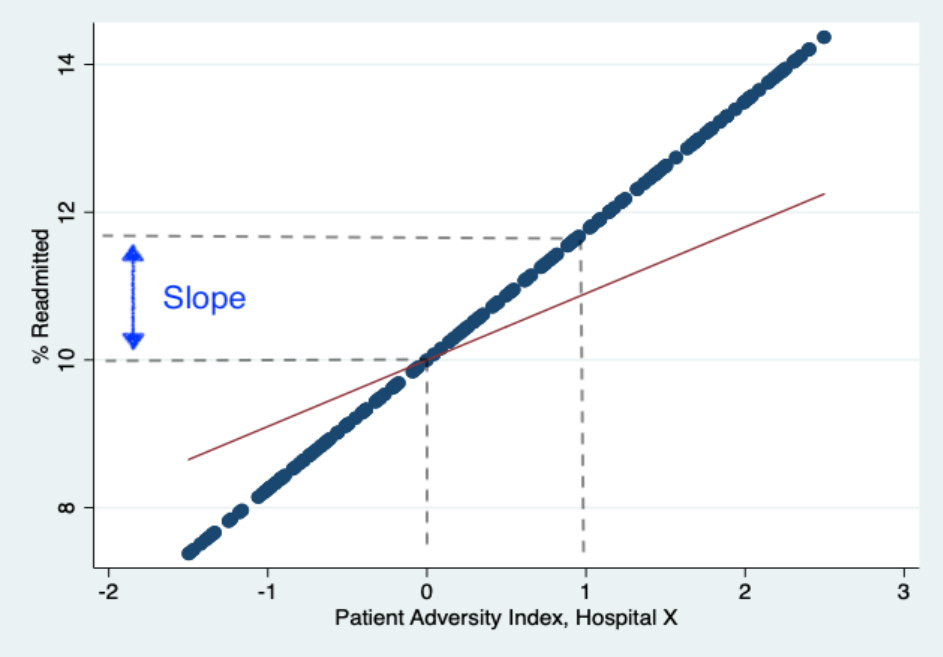
[8] Tsai TC, Orav EJ, Joynt KE. Disparities in surgical 30-day readmission rates for Medicare beneficiaries by race and site of care. *Ann Surg*. 2014;259(6):1086–1090. doi:10.1097/SLA.0000000000000326;
[9] Calvillo–King, Linda, et al. "Impact of social factors on risk of readmission or mortality in pneumonia and heart failure: systematic review." *Journal of general internal medicine* 28.2 (2013): 269-282.

rate for Medicaid enrollees was 3.4 points higher than for other patients. A 2019 Annals of Internal Medicine paper co-authored by HSCRC staff[10] reported a 1.6 percent higher readmission rate for patients living in neighborhoods with increased deprivation. Maryland hospitals, as well as CMS and the Maryland Hospital Association, identify reduction in disparities as a key priority over the near term. Thus, staff developed and the Commission approved adding a within-hospital disparity gap improvement goal to the RRIP in RY2021.

Specifically, the RRIP within hospital disparity methodology assesses patient-level socioeconomic exposure using the Patient Adversity Index (PAI), a continuous measure that reflects exposure to poverty, structural racism, and neighborhood deprivation. As shown in Figure 6, the relationship between PAI and readmissions is then assessed for each hospital for the base and performance period, and improvements in the slope of the line or in the difference in readmission rates at two points on the line (e.g., PAI = 1 vs PAI = 0) are compared for the base and performance period to calculate improvement. Hospitals that improve on the within hospital disparity gap and do not decline on overall readmissions, are eligible for a scaled reward up to 0.50 percent of inpatient revenue. Additional information on the development of the within-hospital disparity metric can be found in the RY 2021 RRIP policy.

Figure 6. Hypothetical Example of Relationship between PAI and Readmission Rates

[10] Jencks, Stephen F., et al. "Safety-Net hospitals, neighborhood disadvantage, and readmissions under Maryland's all-payer program: an observational study." Annals of internal medicine 171.2 (2019): 91-98.



The RRIP disparity gap improvement goal was set through the end of the TCOC model (CY2026) and aligns with one of the goals in the Statewide Integrated Health Improvement Strategy (SIHIS). The SIHIS goal is to have half of eligible hospitals achieve a 50 percent reduction in readmission disparities. CY 2022 data shows that 32 hospitals saw a reduction in their within-hospital disparities in readmissions, ranging from a 0.18% reduction to a 61.54% reduction. Through the RY2024 RRIP-Disparity Gap Program (CY 2022 performance), scaled rewards were provided to 11 of these hospitals for reducing their disparities in readmissions by the required minimum of 22.89 percent while simultaneously not increasing their overall readmission rate; the range of revenue adjustments was 0.26 percent to 0.5 percent for a statewide total of about $7.8 million in rewards. To meet the CY 2023 SIHIS Target, the State needs at least 22 hospitals to reduce their within-hospital disparities in readmissions by 25 percent. The State remains committed to ensuring hospitals are advancing health equity by continuing to financially incentivize reductions in disparities through the RRIP policy and other policies. The ability to set hospital payment incentives specifically for advancing health equity is an important hallmark of the TCOC Model and exemptions from national quality programs. In the RY 2026 Quality Based Reimbursement program, this disparity gap methodology was adapted to the Timely Follow-Up post hospitalization

measure, and the Commission approved financial incentives for reductions in disparities in follow up for Medicare patients.

Post-COVID there have been some updates to the disparity gap methodology for readmissions. First, HSCRC staff updated the measure to use post-COVID CY 2021 norms that are applied to both the historical CY 2018 data, as well as to the performance periods. However, in doing this, staff decided that in order to fully measure improvement, all of the regression model coefficients used for risk-adjustment such as diagnosis-severity of illness, age, and sex (not just the PAI coefficient) should be “locked in" or not recalculated for each time period. This technical change ensures any improvement over time is fully captured, rather than only capturing improvement above the state average improvement (which would make the SIHIS goal challenging/impossible). Staff is working to lock model coefficients from the CY 2021 base period to be applied to the performance period, but initial analyses show this has only a minor impact on results. These updates to the RRIP-Disparity Gap methodology, however, are important for stakeholder engagement.

For RY 2026, the RRIP disparity gap draft recommendation uses the previously calculated improvement targets pushed forward to CY 2024 performance. Staff continue to work with hospitals to help them understand this methodology and are planning to conduct a learning session on the methodology in April. This learning session will review the methodology and model scenarios to show how certain interventions that focus on high adversity patients to reduce readmissions impacts the measure. Finally, as recommended through Commissioner input, staff have added a requirement that hospitals must submit a report detailing the interventions they are engaged in to promote health equity and reduce disparities in readmissions. This new requirement for RY2026 will need to be met for hospitals to qualify for a disparity reduction reward. Details on how hospitals will report their interventions will be developed and communicated by staff over the coming months.

Revenue Adjustment Modeling

For this final policy, staff modeled hospital performance and revenue adjustments as if the policy were applied from the 2022 base year to the 2023 performance year (this focused just on the

RRIP improvement and attainment portion of the program and not disparity reward). This was done by calculating the one-year improvement target (1st year -1.28% of 4-year 5% target) and by updating the attainment target to what it would have been if it were set at the 65th percentile of CY 2022 performance. The revenue adjustment scales for improvement and attainment were created as if the RY 2026 policy were in place for CY 2023 performance. Based on the combined revenue adjustments for the better of improvement or attainment, Figure 7 shows that 31 hospitals would be penalized for a total of $49 million and 13 hospitals would be rewarded for a total of $10 million. The modeling results are more punitive than the actual RY 2025 policy since hospitals may have met and maintained improvement in earlier years (i.e., the improvement from 2018 to 2023 vs 2022 to 2023) and since this policy was not actually in place during 2023 (i.e., hospital may have pushed for additional improvements if the policy had been in place). Preliminary revenue adjustments for RY25 were net positive, with 24 hospitals projected to be penalized for a total of $26 million and 20 hospitals projected to be rewarded for a total of $45 million.

Figure 7. Modeling of CY2022- CY2023 Readmissions Performance

Statewide Revenue Adjustment Modeling	Better of Attainment/Improvement Case-Mix Adjusted Readmission Rate	
	$	%
Net	-$38,665,347	-0.34%
Penalties	-$49,059,832	-0.43%
Rewards	$10,394,485	0.09%
# Hospitals Penalized	31	70.45%
# Hospitals Rewarded	13	29.55%

Stakeholder Feedback and Staff Responses

Comment letters on the draft policy were received from University of Maryland Medical Systems (UMMS) and the Maryland Hospital Association (MHA). Stakeholder feedback was also provided to staff through the PMWG. Specific input provided and staff responses are outlined below.

Comments on RRIP Improvement and Attainment Targets/Revenue Adjustment Scaling

Both UMMS and MHA were supportive of the 5 percent improvement target over 4-years and maintaining attainment in the program. UMMS did express concerns about moving from 2018 to 2022 as the base year for measuring improvement since there have already been significant improvements prior to 2023 performance, and this "results in a dramatic one-time shift in revenue". Furthermore, they believe both the improvement benchmark and attainment threshold should be less aggressive since Maryland is achieving the CMMI readmissions test on a risk-adjusted basis. Specifically, they are concerned that the readmission rate needed to reach the 2 percent improvement reward is much higher than the threshold and suggested instead that the top decile of hospital performance using the HSCRC modeling would be more appropriate. In the modeling, this would move the 2 percent reward from requiring about a 21 percent improvement to only requiring a 10 percent improvement. They also would like the attainment threshold lowered from the 65th to the 50th percentile.

STAFF RESPONSE

Staff believes that the change in the baseline year is appropriate since hospitals have earned rewards for improvement from 2018 for 5-years and it reduces the concerns about COVID impacting the readmission rate. In response to UMMS' request to modify the linear scale for the improvement target, staff applied a modified slope for the linear revenue adjustment scale for both the hypothetical modeling and RY24 results. While this new slope reduced the readmission improvement for the maximum reward making it easier to receive the full 2 percent reward, it also reduced the readmission increases needed to receive the maximum 2 percent penalty. However the change for RY25 preliminary results is more positive than negative, and given that the revised slope is not significantly different, staff will use this new slope when creating the 2-year

improvement revenue adjustment scale. However, if hospitals have concerns about this change, we can review for RY27 and even potentially consider non-linear revenue adjustment scale.

Figure 8. RY25 (estimated) Revenue Adjustments with and without New Improvement Slope

Statewide Revenue Adjustment Modeling	Better of Attainment/Improvement Case-Mix Adjusted Readmission Rate	
	RY25 estimated $	RY25 estimated w/new improvement slope $
Net	$19,039,736	$26,292,211
Penalties	-$26,387,674	-$28,135,198
Rewards	$45,427,410	$54,427,409
# Hospitals Penalized	24	24
# Hospitals Rewarded	20	20

In response to the request to update the performance standards for attainment, staff continues to recommend the top 35th percentile as the benchmark because, based on our benchmarking analyses, reducing it to the top 50th percentile would not incentivize better performance than our benchmarking peer groups. Also, when applying the RY26 improvement target (-1.28%) to the CY 2022 readmission rate (11.34%), the result is 11.19% which is very close to the attainment threshold (11.22%) which is set at the 65th percentile.

Excess Days in Acute Care Measure (EDAC)

UMMS supports the monitoring of the EDAC measure but recommends an in-depth analysis before consideration for the payment policy in future years, citing peer reviewed literature revealing that a substantial number of hospitals in the top-performing group would have shifted to lower-performing groups if EDAC was used.

STAFF RESPONSE

Staff agrees additional monitoring is appropriate for EDAC, as well as for the readmission rate with observation included. We appreciate hospitals continuing to review the all-payer EDAC results to better understand the patients who are returning to the ED and observation, or having long stay readmissions. In terms of hospital rankings under the readmission and EDAC measures, staff believes differences in performance may reflect important variation that should be explored. If both measures are highly correlated it may not make sense to include the EDAC measure in payment. In MHAs letter they also expressed support for exploring other measures for post-discharge events (i.e., ED or Observation revisits).

Readmission Within Hospital Disparity Gap Measure

Overall, MHA, UMMS, and other stakeholders are supportive of the inclusion of a disparity measure in the RRIP policy. The main feedback is that the threshold to start to earn rewards is too high (i.e., 50 percent reduction in disparity) and that attainment should be considered. Furthermore, there are concerns about the measure methodology and how hospitals with a preponderance of low or high PAI patients perform and overall how sensitive the measure is to change. Hospitals and interested parties have requested additional modeling and data components, such as regression coefficients, in order to better understand the program. Given the variability in year-to-year performance in PAI, UMMS would like to investigate this model further before providing additional comment. Last, MHA noted their interest in working with HSCRC staff to develop the necessary form for hospitals to identify and detail activities aimed at reducing readmission disparities.

STAFF RESPONSE

Staff is encouraged by the overall support for the RRIP disparity gap measure. We also recognize the need to provide hospitals with additional modeling to better understand the measure and whether certain hospitals are disadvantaged in the measurement based on their population (i.e., hospitals with a high proportion of high PAI patients needing to reduce

readmissions more to impact gap measure). Thus, staff has been meeting with hospitals who have specific concerns, to understand their questions, and have scheduled an April webinar to provide responses to these concerns. While initial modeling indicates that the methodology does not disadvantage hospitals with different populations, staff is continuing to analyze the data and develop simulations to show hospitals the sensitivity of the measure to improvements. This will help hospitals understand the level of investments needed to impact the measure. If through this process, staff does identify concerns with the methodology, we will work to quantify the issue and explore how to fix the concern. However, because the current methodology risk-adjusts for the type of patients at each hospital and reliability adjusts the results, staff recognizes the modeling is complicated and not easy to understand, but also believe that this complexity is needed to address the concerns raised by hospitals. We look forward to the upcoming webinar so that hospitals can better understand the measure so that they can focus on the interventions needed to impact disparities. Staff appreciates MHA's willingness to assist with developing reporting of disparity interventions and will engage with them over the coming months so that hospitals can provide the HSCRC with additional information on interventions.

In terms of the disparity gap threshold of a 50 percent reduction in disparities needed to begin receiving a reward, staff supports maintaining this high standard since it aligns with SIHIS, the incentive is reward only, and the overall RRIP policy rewards overall improvements and should be considered in conjunction with the disparity gap rewards. Finally, staff would like to explore attainment with hospitals but is concerned about setting a disparity gap of greater than zero as the goal (i.e., difficult to say what if any gap is "acceptable" to earn a reward).

Recommendations

These are the final recommendation for the Maryland Rate Year (RY) 2026 Readmission Reduction Incentives Program (RRIP):

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target - Set statewide 4-year improvement target of 5 percent from 2022 base period through 2026.

3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. To be eligible for disparity gap reward, hospitals must not have an increase in overall readmission rate and must submit details on interventions aimed at reducing disparities. Scale rewards:
    a. beginning at 0.25 percent of IP revenue for hospitals on pace for 50 percent reduction in disparity gap measure over 8 years, and;
    b. capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
6. Monitor emergency department and observation revisits by adjusting readmission measure and through all-payer Excess Days in Acute Care measure. Consider future inclusion of revisits in the case-mix adjusted readmission measure or inclusion of EDAC in the RRIP program. Collaborate with stakeholders to explore the causes and consequences of greater observation stay use in Maryland compared to the Nation.

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Appendix I. RRIP Readmission Measure and Revenue Adjustment Methodology

Introduction: RRIP Redesign Subgroup

As part of the ongoing evolution of the All-Payer Model's pay-for-performance programs to further bring them into alignment under the Total Cost of Care Model, HSCRC convened a work group to evaluate the Readmission Reduction Incentive Program (RRIP). The work group consisted of stakeholders, subject matter experts, and consumers, and met six times between February and September 2019. The work group focused on the following six topics, with the general conclusions summarized below:

1. Analysis of Case-mix Adjustment and trends in Eligible Discharges over time to address concern of limited room for additional improvement;
    - Case-mix adjustment acknowledges increased severity of illness over time
    - Standard Deviation analysis of Eligible Discharges suggests that further reduction in
    - readmission rates is possible
2. National Benchmarking of similar geographies using Medicare and Commercial data;
    - Maryland Medicare and Commercial readmission rates and readmissions per capita are on par with the nation
3. Updates to the existing All-Cause Readmission Measure;
    - Remove Eligible Discharges that left against medical advice (~7,500 discharges)
    - Include Oncology Discharges with more nuanced exclusion logic
    - Analyze out-of-state ratios for other payers as data become available
4. Statewide Improvement and Attainment Targets under the TCOC Model;
    - 7.5 percent Improvement over 5 years (2018-2023)
    - Ongoing evaluation of the attainment threshold at 65th percentile
5. Social Determinants of Health and Readmission Rates; and
    - Methodology developed to assess within-hospital readmission disparities
6. Alternative Measures of Readmissions
    - Further analysis of per capita readmissions as broader trend; not germane to the RRIP policy because focus of evaluation is clinical performance and care management post-discharge
    - Observation trends under the All-Payer Model to better understand performance given variations in hospital observation use; future development will focus on incorporation of Excess Days in Acute Care (EDAC) measure in lieu of including observations in RRIP policy
    - Electronic Clinical Quality Measure (eCQM) may be considered in future to improve risk adjustment

Methodology Steps

1) Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra- and inter-hospital) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and planned admissions.[11] Unique patient identifiers from CRISP are used to be able to track patients across hospitals for readmissions.

The measure is similar to the readmission rate that is calculated by CMMI to track Maryland performance versus the nation, with some exceptions. The most notable exceptions are that the HSCRC measure includes psychiatric patients in acute care hospitals, and readmissions that occur at specialty hospitals. In comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, an additional adjustment is made to account for differences in case-mix. See below for details on the readmission calculation for the RRIP program.

2) Inclusions and Exclusions in Readmission Measurement

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 4.0. The HSCRC has also added all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs, rather than principal diagnosis.[12] Planned admissions are counted as eligible discharges in the denominator, because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.[13]
- Exclude bone marrow transplants and liquid tumor patients by making these discharges not eligible to have an unplanned readmission or count as an unplanned readmission.[14]
- Exclude patients with a discharge disposition of Left Against Medical Advice (PAT_DISP = 71, 72, or 73 through FY 2018; 07 FY 2019 onward)
- Rehabilitation cases as identified by APR-860 (which are coded under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after readmission logic is run.
- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission, but can be a readmission for a previous admission.

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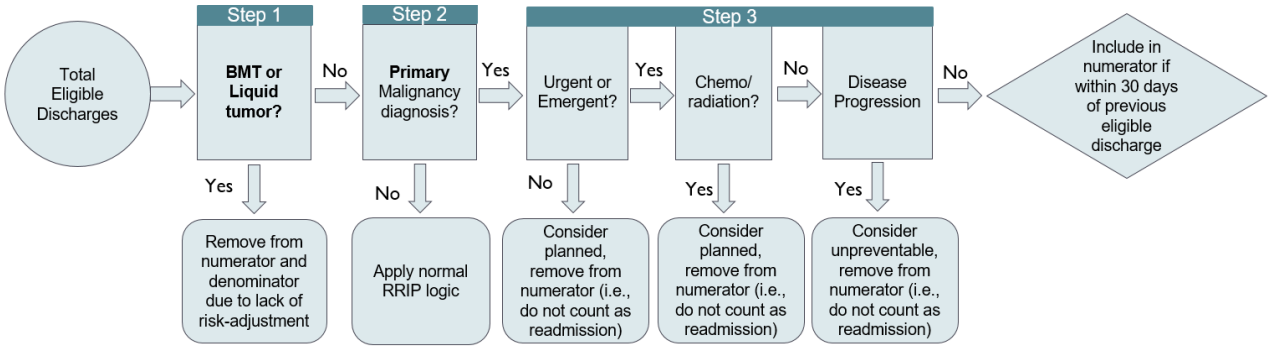
[11] Planned admissions defined under [CMS Planned Admission Logic version 4 – updated March 2018].
[12] **Rehab** DRGs: 540, 541, 542, 560, and 860; **OB Deliveries and Associated DRGs**: 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.
[13] **Newborn APR-DRGs:** 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.
[14] **Bone Marrow Transplant:** Diagnosis code Z94.81 or CCS Procedure code 64; **Liquid Tumor:** Diagnosis codes C81.00-C96.0. See section below for additional details on the oncology logic.

- APR-DRG-SOI categories with less than two discharges statewide are removed.
- A hospitalization within 30 days of a hospital discharge where a patient dies is counted as a readmission; however, the readmission is removed from the denominator because the case is not eligible for a subsequent readmission.
- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same or next day as the admission date of the subsequent admission, are removed from the denominator. Thus, only one admission is counted in the denominator, and that is the admission to the transfer hospital (unless otherwise ineligible, i.e., died). It is the second discharge date from the admission to the transfer hospital that is used to calculate the 30-day readmission window.
- Beginning in RY 2019, HSCRC started discharges from chronic beds within acute care hospitals.
- In addition, the following data cleaning edits are applied:
    - Cases with null or missing CRISP unique patient identifiers (EIDs) are removed.
    - Duplicates are removed.
    - Negative interval days are removed.

      HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, hospitals are required to make sure 99.5 percent of inpatient discharges have a CRISP EID.

Additional Details on Oncology Logic:

Flow Chart for Revised Oncology Logic



*Items that are **bolded** are adaptations from NQF measure

This updated logic replaces the RY 2021 measure logic that removes all oncology DRGs from the dataset, such that an admission with an oncology DRG cannot count as a readmission or be eligible to have a readmission.

Step 1: Exclude discharges where patients have a bone marrow transplant procedure, bone marrow transplant related diagnosis code, or liquid tumor diagnosis. This logic varies from the NQF cancer hospital measure that risk-adjusts for bone marrow transplant and liquid tumors. HSCRC staff recommended removing these discharges (similar to current DRG exclusion) because the current indirect standardization approach did not allow for additional risk-adjustment but based on conversations with clinicians staff agreed these cases were significantly more complicated and at-risk for an unpreventable readmission.

Step 2: Flag discharges with a primary malignancy diagnosis to apply cancer specific logic for determining readmissions. This varies from the NQF cancer hospital measure that flags patients with primary or secondary malignancy diagnosis being treated in a cancer specific hospital. Staff think we should only flag those with a primary diagnosis since in a general acute care hospital there may be differences in the types of patients with a secondary malignancy diagnosis. Further, we remove the bone marrow and liquid tumor discharges regardless of malignancy diagnosis, thus ensuring the most severe cases are removed. Last, our initial analyses did not show a large impact on overall hospital rates when primary vs primary and secondary malignancies were flagged. It should be noted however that the current modeling in this policy uses readmission rates where both primary and secondary are flagged.

Step 3: Flag planned admissions using additional criteria beyond the CMS planned admission logic:

a) Nature of admission of urgent or emergent considered unplanned, all other nature of admission statuses are planned
b) Any admission with primary diagnosis of chemotherapy or radiation is considered planned
c) Any admission with primary diagnosis of metastatic cancer is not considered preventable, and thus gets excluded from being a readmission

In step 3, admissions are deemed not eligible to be a readmission but they are eligible to have a subsequent unplanned readmission.

3) Details on the Calculation of Case-Mix Adjusted Readmission Rate

Data Source:

To calculate readmission rates for RRIP, inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) are used for the measurement period, with an additional 30 day runout. To calculate the case-mix adjusted readmission rate for CY 2022 base period and CY 2024 performance period, data from January 1 through December 31, plus 30 days in January of the next year are used. CY 2022 data are used to calculate the normative values, which are used to determine a hospital's expected readmissions, as detailed below, as well as the estimated CY 2022 readmission rates.

Please note that, the base year readmission rates are not "locked in", and may change if there are CRISP EID or other data updates. The HSCRC does not anticipate changing the base period data, and does not anticipate that any EID updates will change the base period data significantly; however, the HSCRC has decided the most up-to-date data should be used to measure improvement. For the performance period, the CRISP EIDs are updated throughout the year, and thus, month-to-month results may change based on changes in EIDs.

SOFTWARE: APR-DRG Version 41 for CY 2018-CY 2024.

Calculation:

$$\text{Case-Mix Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions)}}{\text{(Expected Readmissions)}} * \text{Statewide Base Year Readmission Rate}$$

Numerator: Number of observed hospital-specific unplanned readmissions.

Denominator: Number of expected hospital specific unplanned readmissions based upon discharge APR-DRG and Severity of Illness. See below for how to calculate expected readmissions, adjusted for APR-DRG SOI.

Risk Adjustment Calculation:

Calculate the Statewide Readmission Rate without Planned Readmissions.

- Statewide Readmission Rate = Total number of readmissions with exclusions removed / Total number of hospital discharges with exclusions removed.

For each hospital, enumerate the number of observed, unplanned readmissions.

For each hospital, calculate the number of expected unplanned readmissions at the APR-DRG SOI level (see Expected Values for description). For each hospital, cases are removed if the discharge APR-DRG and SOI cells have less than two total cases in the base period data.

Calculate at the hospital level the ratio of observed (O) readmissions over expected (E) readmissions. A ratio of > 1 means that there were more observed readmissions than expected, based upon a hospital's case-mix. A ratio of < 1 means that there were fewer observed readmissions than expected based upon a hospital's case-mix.

Multiply the O/E ratio by the base year statewide rate, which is used to get the case-mix adjusted readmission rate by hospital. Multiplying the O/E ratio by the base year state rate converts it into a readmission rate that can be compared to unadjusted rates and case-mix adjusted rates over time.

Expected Values:

The expected value of readmissions is the number of readmissions a hospital would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals,

given its mix of patients as defined by discharge APR-DRG category and SOI level. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being “eligible” for a readmission. All discharges will either have zero readmissions or will have one readmission. The readmission rate is the proportion or percentage of admissions that have a readmission.

The rates of readmissions in the normative database are calculated for each APR-DRG category and its SOI levels by dividing the observed number of readmissions by the total number of eligible discharges. The readmission norm for a single APR-DRG SOI level is calculated as follows:

Let:

N = norm
P = Number of discharges with a readmission
D = Number of eligible discharges
i = An APR DRG category and a single SOI level

$$N_i = \frac{P_i}{D_i}$$

For this example, the expected rate is displayed as readmissions per discharge to facilitate the calculations in the example. Most reports will display the expected rate as a rate per one thousand.

Once a set of norms has been calculated, the norms are applied to each hospital’s DRG and SOI distribution. In the example below, the computation presents expected readmission rates for a single diagnosis category and its four severity levels. This computation could be expanded to include multiple diagnosis categories, by simply expanding the summations.

Consider the following example for a single diagnosis category.

Expected Value Computation Example – Individual APR-DRG

A Severity of Illness Level	B Eligible Discharges	C Discharges with Readmission	D Readmissions per Discharge (C/B)	E Normative Readmissions per Discharge	F Expected # of Readmissions (A*E)
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
Total	**500**	**45**	**.09**		**56.5**

For the diagnosis category, the number of discharges with a readmission is 45, which is the sum of discharges with readmissions (column C). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of eligible discharges with a readmission (sum of column C) by the total number of discharges at risk for readmission (sum of column B), i.e., 0.09 = 45/500. From the normative population, the proportion of discharges with readmissions for each severity level for that diagnosis category is displayed in column E. The expected number of readmissions for each severity level shown in column F is calculated by multiplying the number of eligible discharges (column B) by the normative readmissions per discharge rate (column E) The total number of readmissions expected for this diagnosis category is the sum of the expected numbers of readmissions for the 4 severity levels.

In this example, the expected number of readmissions for this diagnosis category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had 11.5 fewer actual discharges with readmissions than were expected for this diagnosis category. This difference can also be expressed as a percentage or the O/E ratio.

4) Revenue Adjustment Methodology

The RRIP assesses improvement in readmission rates from base period, and attainment rates for the performance period with an adjustment for out-of-state readmissions. The policy then determines a hospital's revenue adjustment for improvement and attainment and takes the better of the two revenue adjustments, with scaled rewards of up to 2 percent of inpatient revenue and scaled penalties of up to 2 percent of inpatient revenue. The figure below provides a high level overview of the RY 2025 RRIP methodology for reference.

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30-day, All-Cause Readmission Measure

Measure Includes:
Readmissions within 30 days of Acute Case Discharge:

- All-Payer
- All-Cause
- All-Hospital (both intra- and inter- hospital)
- Chronic Beds included
- IP-Psych and Specialty Hospitals included
- Adult oncology Discharges Included

Global Exclusions:

- Planned Admissions
- Same-day and Next-day Transfers
- Rehab Hospitals
- Discharges leaving Against Medical Advice Deaths

Case-Mix Adjustment

Performance Measure: CY 2023 Case-mix Adjusted Readmission Rate, adjusted for out-of-state readmissions (Attainment); Reduction in Case-mix Adjusted Readmission Rate from CY2018 Base Period (Improvement).

Case-mix Adjustment:
Expected number of unplanned readmissions for each hospital are calculated using the discharge APR-DRG and severity of illness (SOI).

$$\frac{\textit{Observed Unplanned Readmissions}}{\textit{Expected Unplanned Readmissions}} * \textit{Statewide Readmission Rate}$$

CY2021 used to calculate statewide averages (normative values).

CY2018 (using CY21 norms) is base period and used to set the attainment benchmark/threshold.

Revenue Adjustments

Hospital RRIP revenue adjustments are based on the better of attainment or improvement, scaled between the Max Reward and Max Penalty.

Scores Range from Max Penalty -2% & Reward+2%

All Payer Readmission Rate Change CY18-23		% IP Revenue Payment Adjustment
	A	B
Improving		2.0%
	-28.50%	2.00%
	-23.25%	1.50%
	-18.00%	1.00%
	-12.75%	0.50%
Target	-7.50%	0.00%
	-2.25%	-0.50%
	3.00%	-1.00%
	8.25%	-1.50%
	13.50%	-2.0%
Worsening		-2.0%

Improvement

Attainment

All Payer Readmission Rate CY23		RRIP % Inpatient
Lower Readmission Rate		2.0%
Benchmark	8.15%	2.00%
	9.74%	1.00%
Threshold	11.32%	0.00%
	12.90%	-1.00%
	14.49%	-2.00%
Higher Readmission Rate		-2.0%

Patient Adversity Index (PAI)

The PAI measure is continuous index of readmission risk based on the following patient factors:

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

Within Hospital Disparity Gap

Within hospital disparity gap is calculated by a regression model that estimates the slope of PAI at each hospital after controlling for:

- Age
- Gender
- APR-DRG readmission risk

Disparity Gap Revenue Adjustments

Revenue adjustment is reward only:

Disparity Gap Change CY 2018-2020	RRIP % Inpatient Rev.
On pace for 50% Reduction Gap in 8 Years	0.25%
On pace for 75% Reduction Gap in 8 Years	0.50%

Appendix II. Analyses of Medicare Readmissions

Based on analyses, HSCRC staff believe that patients admitted in Maryland have gotten sicker since 2018 (i.e., higher rate of comorbidities) and that this increase in case mix acuity is greater in Maryland than the increase seen nationally. These analyses support what hospitals have reported anecdotally. To examine the change in patient case mix over time from 2018 through 2022, HSCRC staff first used the CCW data to estimate readmission risk in 2018. Then, the annual predicted readmission risk was calculated for CYs 2019 through 2022 by applying the 2018 coefficients for each comorbidity. Changes in the predicted readmission rates indicate that there are differences in the population at-risk for readmissions. Specifically, increases in the predicted readmission rate would indicate that the at-risk population was composed of patients with comorbidities or other risk factors with a higher risk of readmission. Decreases in the predicted readmission rate would indicate the at-risk population was composed of patients with lower risk for readmission than in 2018. Furthermore, differences between the predicted and actual readmission rates reflect how well Maryland performed relative to what was expected based on 2018. We specified two models: One adjusting for age groups, race, sex, dual eligibility status, and the 38 Elixhauser comorbidity flags, and another with just the Elixhauser comorbidity flags. While the results are similar, this report includes the simpler model that only contained the Elixhauser comorbidity flags so that it could focus on changes in health status over time. In addition, the analysis was run for all ages combined, and then for those under 65 versus those 65 and older; given the similarities in results, we have focused on the 65+ model since it is majority of the at-risk population for Medicare and this aligns with the national readmissions measures that restrict to those 65 and older.

The Figure 1 below shows the predicted readmission rate nationally and for Maryland increased by 2.95 and 4.74 percent respectively. The increase in the predicted readmission rate in Maryland indicates that the patients admitted to Maryland hospitals in 2022 were sicker than the patients admitted in 2018, and the increase in case mix index was higher in Maryland than it was nationally.

Figure 1. Predicted and Actual Maryland and National Readmissions

CCW Analysis		HSCRC Readmission Predictions for 65+ Yrs (CY Dec - Nov)				
Provider	Index Stay Year	Actual Admissions	Actual Readmissions	Predicted Readmission Rate	Actual Readmission Rate	Readmission Rate Difference
National	2018	6,866,364	976,561	14.22%	14.22%	0.00%
National	2019	6,786,204	967,802	14.40%	14.26%	-0.14%
National	2020	5,602,629	789,957	14.62%	14.10%	-0.52%
National	2021	5,354,330	758,226	14.62%	14.16%	-0.46%
National	2022	5,282,350	747,517	14.64%	14.15%	-0.49%
Change from 2018 to 2022				**2.95%**	**-0.49%**	
Maryland	2018	149,748	21,229	14.55%	14.18%	-0.38%
Maryland	2019	146,970	20,177	14.72%	13.73%	-0.99%
Maryland	2020	121,924	16,767	15.00%	13.75%	-1.25%
Maryland	2021	122,250	17,495	15.10%	14.31%	-0.79%
Maryland	2022	121,574	17,226	15.24%	14.17%	-1.07%
Change from 2018 to 2022				**4.74%**	**-0.07%**	
Prediction using 2018 national data as baseline						
Model is adjusted for 38 Elixhauser comorbidity flags (ICD-10 version)						

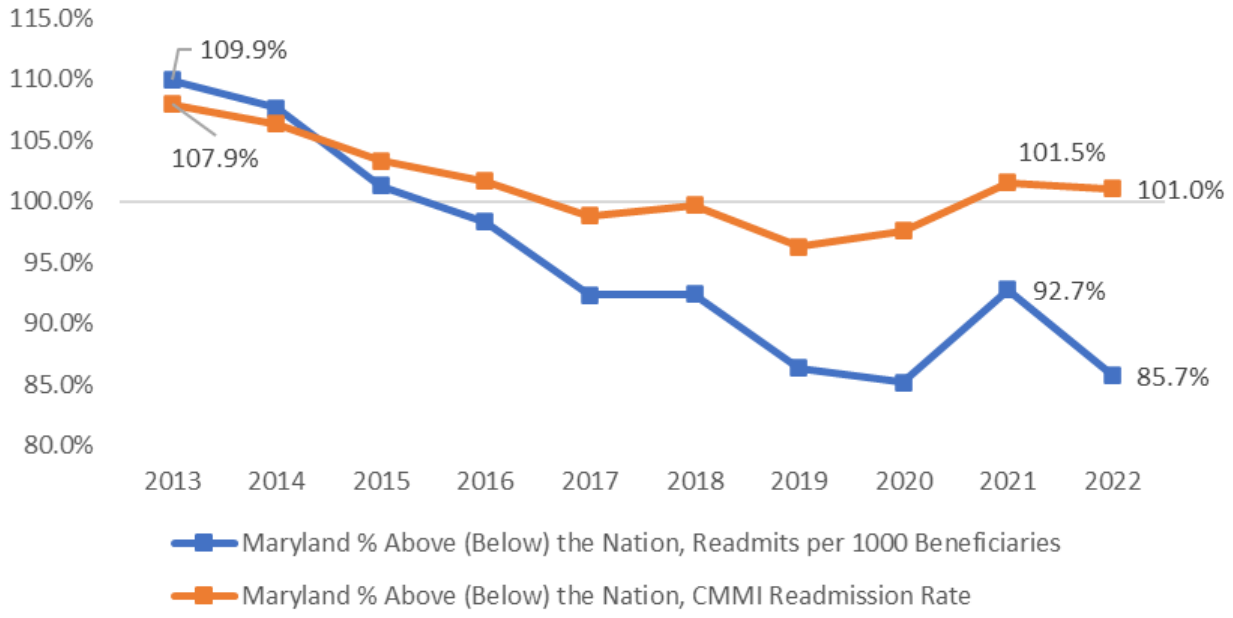
Figure 1 also shows the difference between the predicted and observed readmission rates. In CY 2022, Maryland had an actual readmission rate that was 1.07 percent lower than the predicted readmission rate, and this was more than twice as much as the gap between predicted and actual seen nationally (0.49 percent lower). Overall, staff contend that these analyses support the assertion that Maryland patients are sicker in 2022 than in 2018 and this increase in case mix severity is higher than what was seen nationally.

1) Per Capita Readmissions

Another approach to controlling for different admitting populations is to examine the number of readmissions per beneficiary rather than the readmission rate. This removes changes in the nature of the admitted population (the denominator in the traditional readmission rate) and focuses on just the number of readmissions across the entire population. Figure 2 compares Maryland's performance versus the Nation using readmissions per 1000 and the unadjusted CMMI readmission rate. Performance shows that in 2013 both the unadjusted and per capita readmission rates for Maryland were higher than the Nation by 7.9 percent and 9.9 percent, respectively. Starting in 2016 and 2017, the per capita and the unadjusted readmission rate dropped to below the national rate until 2021 where the unadjusted rate again is higher

than the Nation but the per capita rate is below the Nation. And while there was erosion in 2021 Maryland, in CY 2022 the per capita rate drops to 14.3 percent lower than the nation. This means that fewer Medicare beneficiaries are readmitted in Maryland than nationally and it aligns with the idea that those who are admitted in Maryland have a higher case mix acuity than the Nation and thus a higher unadjusted readmission rate.

Figure 2: Maryland's Performance Versus the Nation Under Unadjusted Readmission Rate and Readmissions per 1000[15]



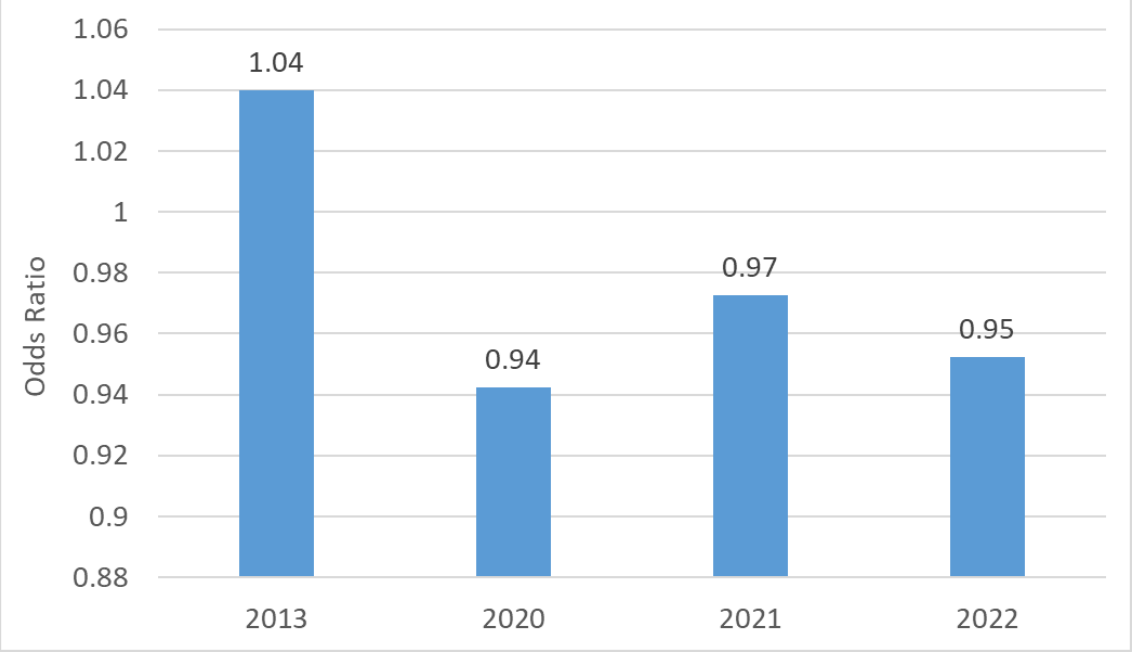
2) Risk-Adjusted Medicare Readmission Rates

As discussed in the previous exemption request and above, reductions in inpatient utilization and differential COVID impacts, have increased the case mix index for patients admitted to the hospital in Maryland compared to the nation. Thus the staff continue to advocate for a risk-adjusted readmission measure and appreciate the CMMI team's agreement to collaborate with Maryland to develop a risk-adjusted readmission measure for consideration. By moving to a risk-adjusted measure, Maryland's performance on readmissions can be more fully evaluated since differences in the admitted population are removed. Currently, HSCRC staff has run regression models for Medicare beneficiaries who were 65 and older using

[15] HSCRC calculation based on 100% Maryland and National Hospital Claim files received annually.

the CCW data for 2013, 2020, 2021, and 2022 controlling for age, sex, COVID-19 status (for post-2020 models), Major Diagnostic Category (MDC) and the Elixhauser Comorbidity Index[16]. The results of these models show that in 2021 and 2022, despite higher unadjusted readmissions, Maryland patients had statistically significantly lower odds of being readmitted (2021 OR 0.97, CI 0.956-0.989; 2022 OR 0.95, CI 0.936-0.969). Figure 3 shows the odds ratios for each year. For CY 2022, the odds ratio of 0.95 means that Maryland Medicare FFS patients had a 5 percent lower odds of being readmitted than national patients. We then tested removing the Elixhauser Comorbidity Index for CY 2020, CY 2021, and CY 2022; for CY 2020 the OR increased to 0.972 but Maryland still performed statistically better than the Nation (CI 0.952-0.993) but for CY 2021 and CY 2022 the OR increased and there no longer was a statistically significant difference between MD and the nation. We believe this shows that during CY 2021 and again in CY 2022, MD admissions had higher comorbidities than national admissions (or 2020 admissions), which accounts for the higher unadjusted readmission rate. Again the HSCRC staff appreciate the collaboration with CMMI on developing a risk-adjusted readmission rate for comparing Maryland to the nation.

Figure 3: Odds Ratio for Risk-Adjusted Readmission Rates for Maryland vs. Nation



[16] The Elixhauser Comorbidity Index has ICD-9 and ICD-10 versions with different comorbidity flags. Staff tested using the actual version that corresponded with the time period and using the comorbidity flags that were common across both versions. The results did not meaningfully differ, so the results presented here use the common flags.

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Appendix III. RRIP Modeling, CY23 YTD Readmission Rates, CY22 Norms

The modeling establishes the reward and penalty performance standards as outlined below. This represents a hypothetical analysis since hospitals were not under the policy. In general, actual results are more favorable than modeled results.

MaxReward	2.00%
MaxPenalty	-2.00%

ImpTarget	-1.28%
ImpMaxRewardScore	-22.28%
ImpMaxPenaltyScore	19.72%
AttTarget	11.22%
AttMaxRewardScore	9.14%
AttMaxPenaltyScore	15.19%

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						Improvement Scaling			Attainment Scaling				Final Adjustment		
HOSPITAL ID	HOSPITAL NAME	RY 23 Permanent Inpatient Revenue**	CY 2022 Case Mix Adjusted Readmission Rate (RY 2026 Base)	CY 2023 YTD Case Mix Adjusted Readmission Rate (Modeling Performance)†	CY22-CY23 YTD% Change in Case Mix Adjusted Rate*	Target	% Revenue Adjustment	$ Revenue Adjustment	CY 2023 YTD Case Mix Adjusted Rate with Out-of-State Adjustment*	Target (top 35th %)	% Revenue Adjustment	$ Revenue Adjustment	$ Better of Attainment or Improvement	% Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment
210001	MERITUS	$236,441,777	12.04%	12.37%	2.74%	-1.28%	-0.38%	-$898,479	12.98%	11.22%	-0.88%	-$2,080,688	-$898,479	-0.38%	Imp
210002	UNIVERSITY OF MARYLAND	$1,419,452,964	11.07%	11.18%	0.99%	-1.28%	-0.22%	-$3,122,797	11.49%	11.22%	-0.13%	-$1,845,289	-$1,845,289	-0.13%	Att
210003	PRINCE GEORGE	$282,004,743	9.53%	9.49%	-0.42%	-1.28%	-0.08%	-$225,604	11.29%	11.22%	-0.03%	-$84,601	-$84,601	-0.03%	Att
210004	HOLY CROSS	$397,412,083	11.04%	11.59%	4.98%	-1.28%	-0.60%	-$2,384,472	12.76%	11.22%	-0.77%	-$3,060,073	-$2,384,472	-0.60%	Imp
210005	FREDERICK MEMORIAL	$255,798,612	11.25%	11.17%	-0.71%	-1.28%	-0.05%	-$127,899	11.79%	11.22%	-0.28%	-$716,236	-$127,899	-0.05%	Imp
210006	HARFORD	$68,386,364	13.21%	13.92%	5.37%	-1.28%	-0.63%	-$430,834	14.09%	11.22%	-1.44%	-$984,764	-$430,834	-0.63%	Imp
210008	MERCY	$216,769,130	12.40%	14.64%	18.06%	-1.28%	-1.84%	-$3,988,552	14.96%	11.22%	-1.88%	-$4,075,260	-$3,988,552	-1.84%	Imp
210009	JOHNS HOPKINS	$1,702,715,898	11.82%	12.19%	3.13%	-1.28%	-0.42%	-$7,151,407	13.07%	11.22%	-0.93%	-$15,835,258	-$7,151,407	-0.42%	Imp
210011	ST. AGNES	$233,444,507	12.35%	11.79%	-4.53%	-1.28%	0.31%	$723,678	11.86%	11.22%	-0.32%	-$747,022	$723,678	0.31%	Imp
210012	SINAI	$515,384,553	11.24%	11.93%	6.14%	-1.28%	-0.71%	-$3,659,230	12.06%	11.22%	-0.42%	-$2,164,615	-$2,164,615	-0.42%	Att
210015	FRANKLIN SQUARE	$338,396,055	11.21%	12.31%	9.81%	-1.28%	-1.06%	-$3,586,998	12.38%	11.22%	-0.58%	-$1,962,697	-$1,962,697	-0.58%	Att
210016	WASHINGTON ADVENTIST	$225,684,639	11.10%	11.91%	7.30%	-1.28%	-0.82%	-$1,850,614	13.13%	11.22%	-0.96%	-$2,166,573	-$1,850,614	-0.82%	Imp
210017	GARRETT COUNTY	$25,525,538	5.50%	7.01%	27.45%	-1.28%	-2.00%	-$510,511	11.90%	11.22%	-0.34%	-$86,787	-$86,787	-0.34%	Att
210018	MONTGOMERY GENERAL	$88,807,087	11.01%	10.02%	-8.99%	-1.28%	0.73%	$648,292	10.68%	11.22%	0.52%	$461,797	$648,292	0.73%	Imp
210019	PENINSULA REGIONAL	$308,473,682	10.90%	10.81%	-0.83%	-1.28%	-0.04%	-$123,389	11.53%	11.22%	-0.15%	-$462,711	-$123,389	-0.04%	Imp
210022	SUBURBAN	$227,224,802	10.32%	11.25%	9.01%	-1.28%	-0.98%	-$2,226,803	12.25%	11.22%	-0.52%	-$1,181,569	-$1,181,569	-0.52%	Att
210023	ANNE ARUNDEL	$385,505,885	11.95%	12.22%	2.26%	-1.28%	-0.34%	-$1,310,720	12.83%	11.22%	-0.81%	-$3,122,598	-$1,310,720	-0.34%	Imp
210024	UNION MEMORIAL	$283,598,962	12.53%	12.85%	2.55%	-1.28%	-0.37%	-$1,049,316	12.97%	11.22%	-0.88%	-$2,495,671	-$1,049,316	-0.37%	Imp
210027	WESTERN MARYLAND HEALTH SYSTEM	$190,230,034	10.44%	10.99%	5.27%	-1.28%	-0.62%	-$1,179,426	12.16%	11.22%	-0.47%	-$894,081	-$894,081	-0.47%	Att
210028	ST. MARY	$98,242,476	11.74%	10.10%	-13.97%	-1.28%	1.21%	$1,188,734	11.15%	11.22%	0.07%	$68,770	$1,188,734	1.21%	Imp
210029	HOPKINS BAYVIEW MED CTR	$455,171,792	12.27%	12.68%	3.34%	-1.28%	-0.44%	-$2,002,756	12.93%	11.22%	-0.86%	-$3,914,477	-$2,002,756	-0.44%	Imp
210030	CHESTERTOWN	$7,023,612	5.85%	9.31%	59.15%	-1.28%	-2.00%	-$140,472	10.74%	11.22%	0.46%	$32,309	$32,309	0.46%	Att
210032	UNION HOSPITAL OF CECIL COUNT	$90,564,569	12.24%	11.21%	-8.42%	-1.28%	0.68%	$615,839	14.99%	11.22%	-1.90%	-$1,720,727	$615,839	0.68%	Imp
210033	CARROLL COUNTY	$157,367,331	11.34%	12.07%	6.44%	-1.28%	-0.73%	-$1,148,782	12.78%	11.22%	-0.78%	-$1,227,465	-$1,148,782	-0.73%	Imp
210034	HARBOR	$129,425,148	12.67%	13.52%	6.71%	-1.28%	-0.76%	-$983,631	13.72%	11.22%	-1.26%	-$1,630,757	-$983,631	-0.76%	Imp
210035	CHARLES REGIONAL	$98,358,514	9.93%	9.42%	-5.14%	-1.28%	0.37%	$363,927	10.97%	11.22%	0.25%	$245,896	$363,927	0.37%	Imp
210037	EASTON	$119,931,603	9.06%	9.35%	3.20%	-1.28%	-0.43%	-$515,706	10.18%	11.22%	1.00%	$1,199,316	$1,199,316	1.00%	Att
210038	UMMC MIDTOWN	$137,864,557	11.89%	12.71%	6.90%	-1.28%	-0.78%	-$1,075,344	12.85%	11.22%	-0.82%	-$1,130,489	-$1,075,344	-0.78%	Imp
210039	CALVERT	$82,099,977	9.86%	10.25%	3.96%	-1.28%	-0.50%	-$410,500	11.18%	11.22%	0.04%	$32,840	$32,840	0.04%	Att
210040	NORTHWEST	$157,220,825	11.86%	12.97%	9.36%	-1.28%	-1.01%	-$1,587,930	13.11%	11.22%	-0.95%	-$1,493,598	-$1,493,598	-0.95%	Att
210043	BWMC	$326,459,954	11.20%	12.41%	10.80%	-1.28%	-1.15%	-$3,754,289	12.49%	11.22%	-0.64%	-$2,089,344	-$2,089,344	-0.64%	Att
210044	G.B.M.C.	$254,895,213	10.74%	10.70%	-0.37%	-1.28%	-0.09%	-$229,406	10.90%	11.22%	0.32%	$815,665	$815,665	0.32%	Att
210048	HOWARD COUNTY	$214,071,732	12.79%	12.96%	1.33%	-1.28%	-0.25%	-$535,179	13.24%	11.22%	-1.02%	-$2,183,532	-$535,179	-0.25%	Imp
210049	UPPER CHESAPEAKE HEALTH	$201,124,139	11.96%	12.44%	4.01%	-1.28%	-0.50%	-$1,005,621	12.67%	11.22%	-0.73%	-$1,468,206	-$1,005,621	-0.50%	Imp
210051	DOCTORS COMMUNITY	$176,421,777	9.61%	9.20%	-4.27%	-1.28%	0.28%	$493,981	10.78%	11.22%	0.43%	$758,614	$758,614	0.43%	Att
210056	GOOD SAMARITAN	$191,497,544	14.49%	13.44%	-7.25%	-1.28%	0.57%	$1,091,536	13.49%	11.22%	-1.14%	-$2,183,072	$1,091,536	0.57%	Imp
210057	SHADY GROVE	$321,044,393	9.74%	10.54%	8.21%	-1.28%	-0.90%	-$2,889,400	11.23%	11.22%	0.00%	$0	$0	0.00%	Att
210058	REHAB & ORTHO	$74,199,749	11.03%	6.24%	-43.43%	-1.28%	2.00%	$1,483,995	6.24%	11.22%	2.00%	$267,119	$1,483,995	2.00%	Imp
210060	FT. WASHINGTON	$31,642,518	9.27%	10.07%	8.63%	-1.28%	-0.94%	-$297,440	13.23%	11.22%	-1.01%	-$319,589	-$297,440	-0.94%	Imp
210061	ATLANTIC GENERAL	$45,367,141	9.68%	11.06%	14.26%	-1.28%	-1.48%	-$671,434	12.44%	11.22%	-0.61%	-$276,740	-$276,740	-0.61%	Att
210062	SOUTHERN MARYLAND	$196,475,930	9.81%	10.41%	6.12%	-1.28%	-0.70%	-$1,375,332	12.59%	11.22%	-0.69%	-$1,355,684	-$1,355,684	-0.69%	Att
210063	UM ST. JOSEPH	$280,257,927	12.24%	11.56%	-5.56%	-1.28%	0.41%	$1,149,058	11.77%	11.22%	-0.28%	-$784,722	$1,149,058	0.41%	Imp
210064	LEVINDALE	$66,200,891	9.92%	12.80%	29.03%	-1.28%	-2.00%	-$1,324,018	12.80%	11.22%	-0.79%	-$522,987	-$522,987	-0.79%	Att
210065	HOLY CROSS GERMANTOWN	$79,412,195	11.70%	11.68%	-0.17%	-1.28%	-0.11%	-$87,353	11.73%	11.22%	-0.26%	-$206,472	-$87,353	-0.11%	Imp
STATEWIDE		**$11,393,598,820**						**-$46,102,604**				**-$62,592,027**	**-$30,305,977**		
Penalty								-$53,861,644				-$66,474,353	-$40,409,780		
Reward								$7,759,040				$3,882,326	$10,103,803		

Percentages have been rounded for display. Final scaling values are rounded to two decimal places.
*2023 Jan-Dec Prelim data

Maryland
Hospital Association

March 13, 2024

Dr. Alyson Schuster
Deputy Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Schuster:

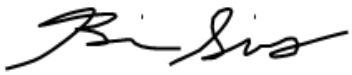
On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment in support of the Health Services Cost Review Commission's (HSCRC) Draft Recommendations for the Readmissions Reduction Incentive Program (RRIP) for Rate Year (RY) 2026.

We support the staff's proposal as it is largely unchanged from the previous policy. We appreciate the staff's recommendation to set a multi-year target effective through December 2026. We look forward to working with staff on future considerations for the RRIP, including exploring other measures for post-discharge events.

We applaud the inclusion of incentives in the RRIP for hospitals to improve within-hospital readmission disparities between patients with high social risk and those with low social risk. As we gain further insights into effective strategies across different populations with varying levels of social risk, it becomes imperative to evaluate how the current incentive and methodology can evolve to ensure equitable results statewide. We propose examining the inclusion of an attainment target in the policy. Additionally, we look forward to working closely with HSCRC staff to develop the necessary form for hospitals to identify and detail activities aimed at reducing readmission disparities.

We are committed to ongoing collaboration with staff on this and future policies.

Sincerely,



Brian Sims
Vice President, Quality & Equity

cc: Joshua Sharfstein, M.D., Chair
Joseph Antos, Ph.D., Vice Chair
James N. Elliott, M.D.
Ricardo. R. Johnson
Maulik Joshi, DrPH
Adam Kane, Esq.
Nicki McCann, JD
Jonathan Kromm, Ph.D., Executive Director

UNIVERSITY of MARYLAND MEDICAL SYSTEM

March 13, 2024

Alyson Schuster, PhD, MPH, MBA
Deputy Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Schuster:

I extend my gratitude on behalf of the University of Maryland Medical System (UMMS) for the chance to contribute our insights to the Health Services Cost Review Commission's (HSCRC) Draft Recommendations for the Readmission Reduction Incentive Program (RRIP) for Rate Year 2026.

We wish to express our views on specific aspects of the draft recommendations:

General Program Proposals

UMMS agrees with the following staff proposals for the RRIP program including:

- Maintaining both improvement and attainment targets to incentive hospitals.
- Setting a 5.0% improvement target over four years with a 2022 base period through 2026 performance to maintain program stability.
- Continuing use of APR-DRG Severity of Illness (SOI) for risk adjustment and use of Out of State Adjustment (OOS)
- Maintaining maximum rewards and penalties at 2 percent of inpatient revenue
- Providing additional payment incentive for reduction in within-hospital readmission disparities

Excess Days in Acute Care Measure (EDAC)

UMMS supports the monitoring of the EDAC measure. However, we recommend an in-depth analysis before consideration for payment policy in future years. In a review of the Annals of Internal Medicine publication supporting use of EDAC measure[1], Calderon states in the New England Journal of Medicine: Journal Watch[2]: "Results revealed that about 25% of hospitals would have had their penalty status changed if EDAC was used. A substantial number of hospitals in the current top-performing group would have shifted to lower-performing groups". We recommend further analysis to understand the relationship between readmission rates and EDAC given the major shifts in performance as stated in these publications.

[1] Wadhera, R. K., Joynt Maddox, K. E., Desai, N. R., Landon, B. E., Md, M. V., Gilstrap, L. G., Shen, C., & Yeh, R. W. (2021). Evaluation of Hospital Performance Using the Excess Days in Acute Care Measure in the Hospital Readmissions Reduction Program. Annals of internal medicine, 174(1), 86–92. https://doi.org/10.7326/M20-3486
[2] Calderon, A. J. (2020). Excess Days in Acute Care: A Better Measurement for Hospital Readmissions? New England journal of medicine: Journal watch.

Disparity Gap Measurement

UMMS supports the continuation of the disparity gap reduction metric within the RRIP program. This is an important metric for improving health equity in Maryland. However, we recommend alterations to the revenue scale. The staff proposal requires hospitals to be on pace for 50% reduction to begin to achieve rewards. Alternatively, we recommend a linear scale for revenue adjustment with incentive ranging a full 0.0% to 0.5%, starting at 5% reduction in disparity and a maximum reward set 50% reduction in disparity. We believe starting rewards at 5% reduction in disparity requires improvement that is more than normal variation in rates. Improvements in health equity require purposeful strategies and investments. In the 2023 performance report for data through November 2023 published in CRISP, there is only 1 hospital in the state meeting the Rate Year 2025 target with 31.64% reduction in disparity. However, there are 4 additional hospitals with >20% reduction, 4 hospitals with >10% reduction, and 3 hospitals with >5% reduction that are generating zero incentive. A hospital achieving a 20% reduction in disparity, for example, represents committed investment in improving health equity in Maryland, but is not incentivized in the proposed program. A linear scaling model aligns with incremental improvement, and adequately incentives hospitals with substantial advances.

In addition, UMMS requests an extension in comment period for overall Patient Adversity Index (PAI) methodology. Hospitals and interested parties have requested additional modelling and data components, such as regression coefficients, in order to better understand the program. Given the variability in year-to-year performance in PAI, we would like to investigate this model further before providing additional comment.

RRIP Scaling Model

Updating the baseline for improvement from 2018 to 2022 results in a dramatic one-time shift in revenue across the state for hospitals that achieve improvement goals through 2023 performance. While improvement opportunity across Maryland still exists, the state is currently meeting the expectations of CMMI for risk-adjusted readmission. For these reasons, we recommend updating the minimum and maximum range of the linear scale for the improvement model. In the modelling provided by HSCRC staff, the maximum reward is set at an additional 21% improvement above the 1.28% target. Since the state has improved substantially over the last five years, the amount of improvement expected going forward should be less. In the modelling of 2023 year-to-date performance compared to 2022, the mean of the top decile performance of improvement is 9.66%% - excluding the one hospital with less than 20 readmissions annually. It is consistent in other Maryland and national programs, such as Quality Based Reimbursement and Value Based Purchasing, to set maximum goals at top decile performance. Therefore, we recommend setting the maximum 2% reward at an additional 9.66% improvement versus the cut-point. In addition, we recommend the cut-point for attainment should be the 50th percentile and not the top 35th percentile due to the state performance in comparison to the nation in the risk-adjusted metric.

We appreciate the HSCRC's consideration of our recommendations. We look forward to continuing to work with the HSCRC to update the RRIP program.

Sincerely,

Andrew N. Pollak, MD
Senior Vice President and Chief Clinical Officer
University of Maryland Medical System

cc: Joshua Sharfstein, MD, Chairman
Adam Kane
Joseph Antos, PhD
James Elliott, MD
Maulik Joshi, DrPH
Ricardo R. Johnson
Nicki McCann, JD

maryland
health services
cost review commission

Emergency Department Dramatic Improvement Effort (EDDIE)

April Commission Meeting

Today's Presentation

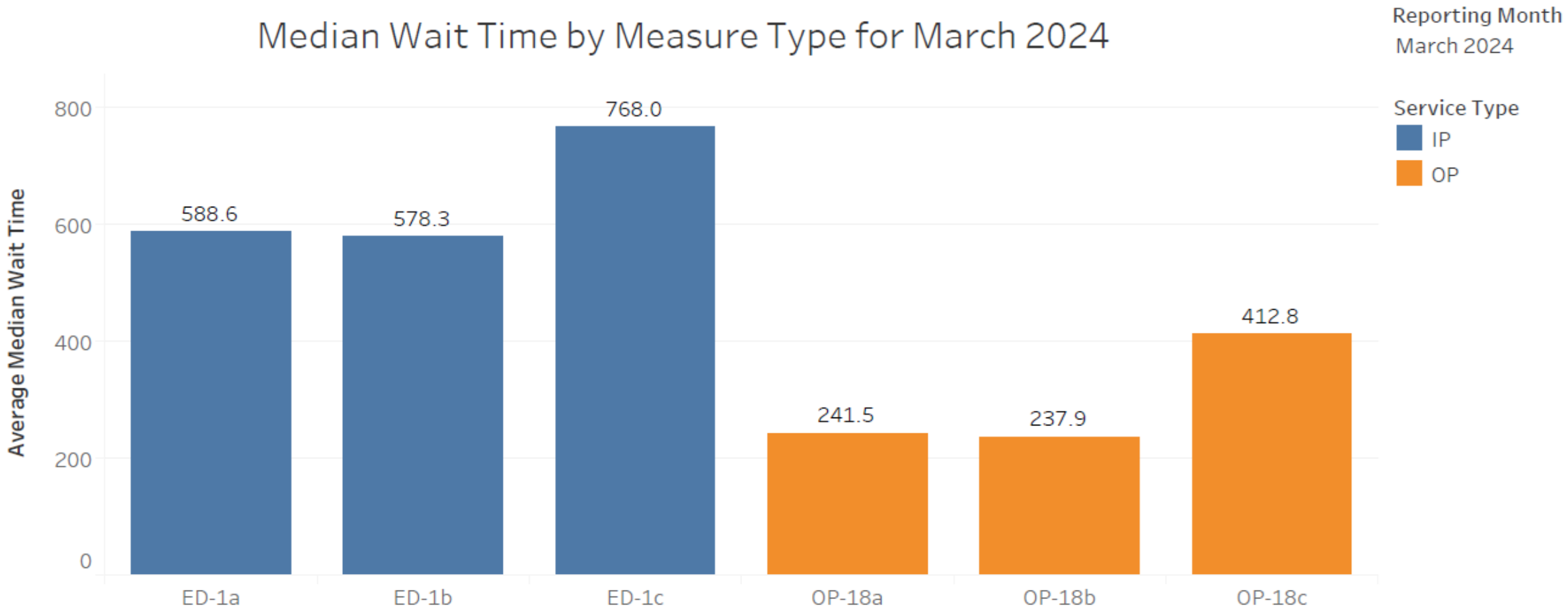
- EDDIE data update
- Subgroup 1: QBR Data Update
- Next Steps

ED Length of Stay and EMS Turnaround Data

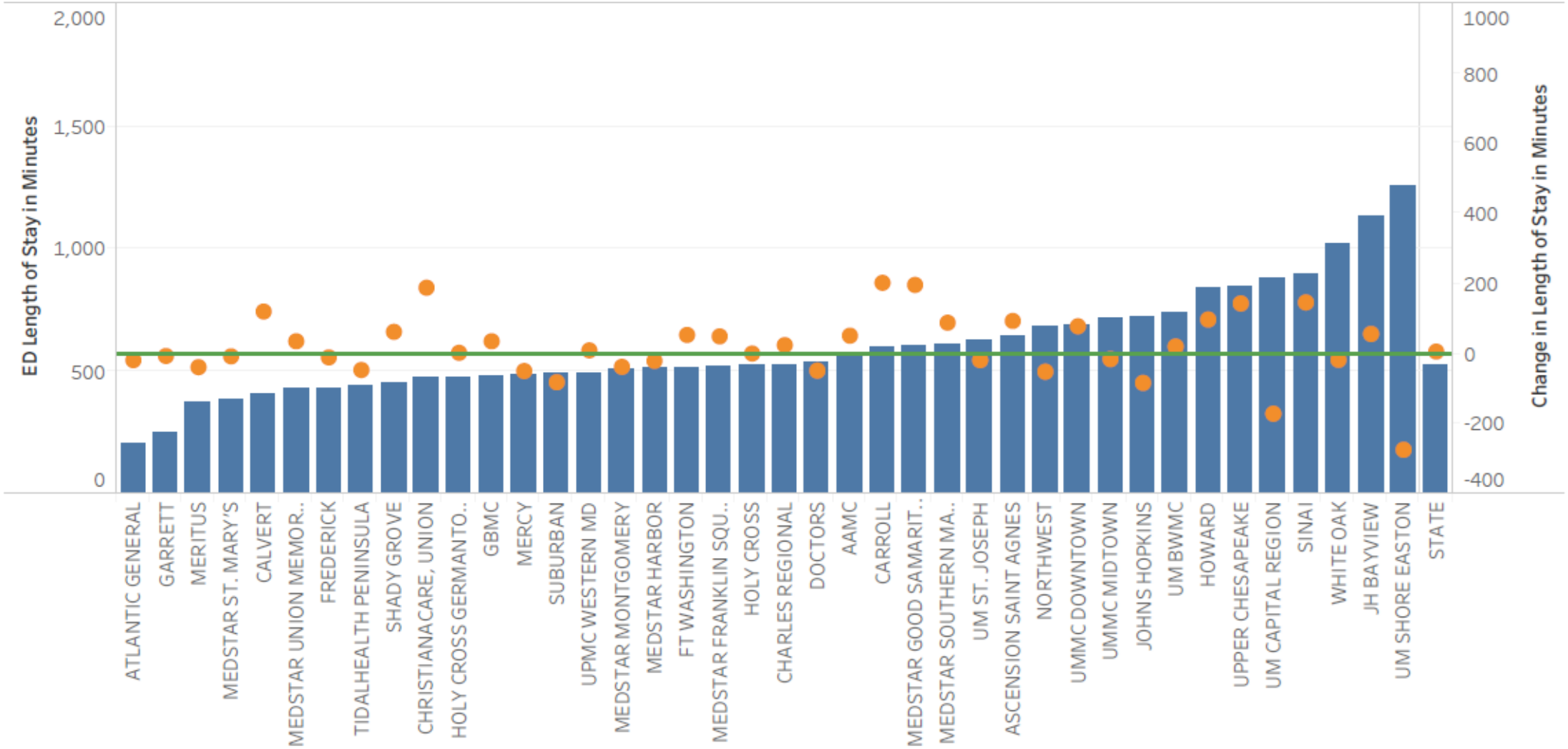
- Monthly, unaudited data on ED length of stay for March 2024 was received from all hospitals
  - These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month)
  - These data are being collected for hospital quality improvement and have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital
- EMS turnaround time data shows minimal movement of hospitals across categories for March 2024, with two hospitals improving in performance and none declining

See Appendix for graphs and data for all measures

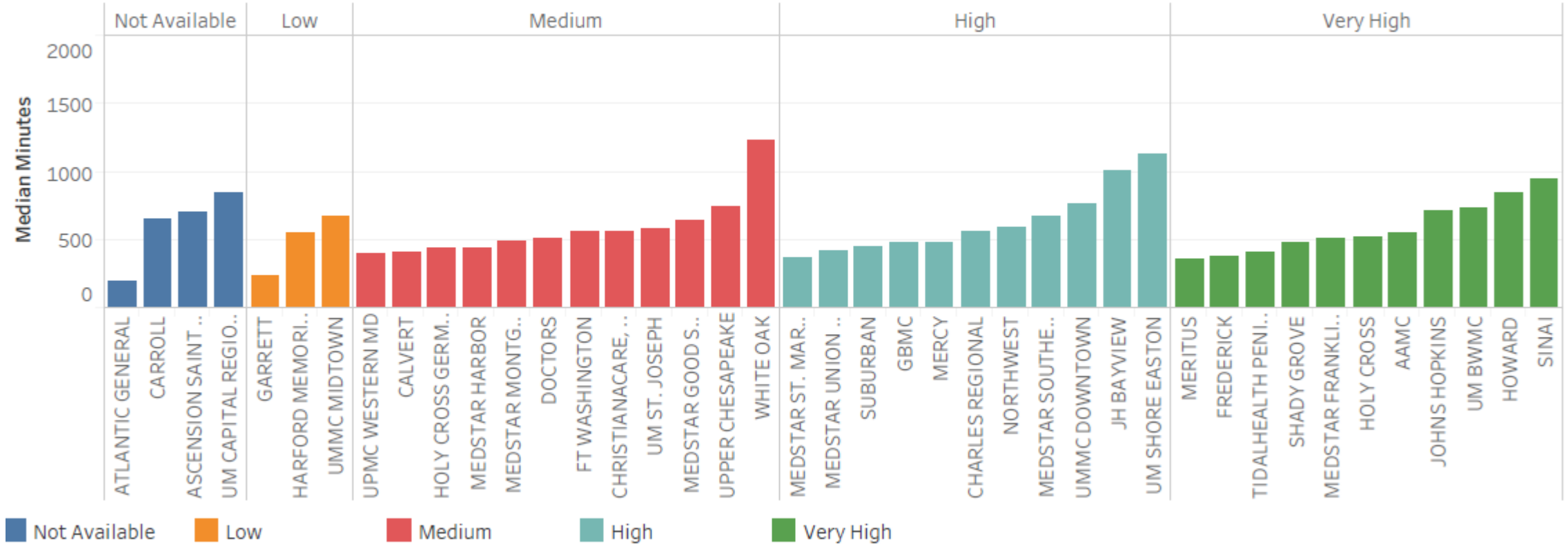
ED Median Wait Time



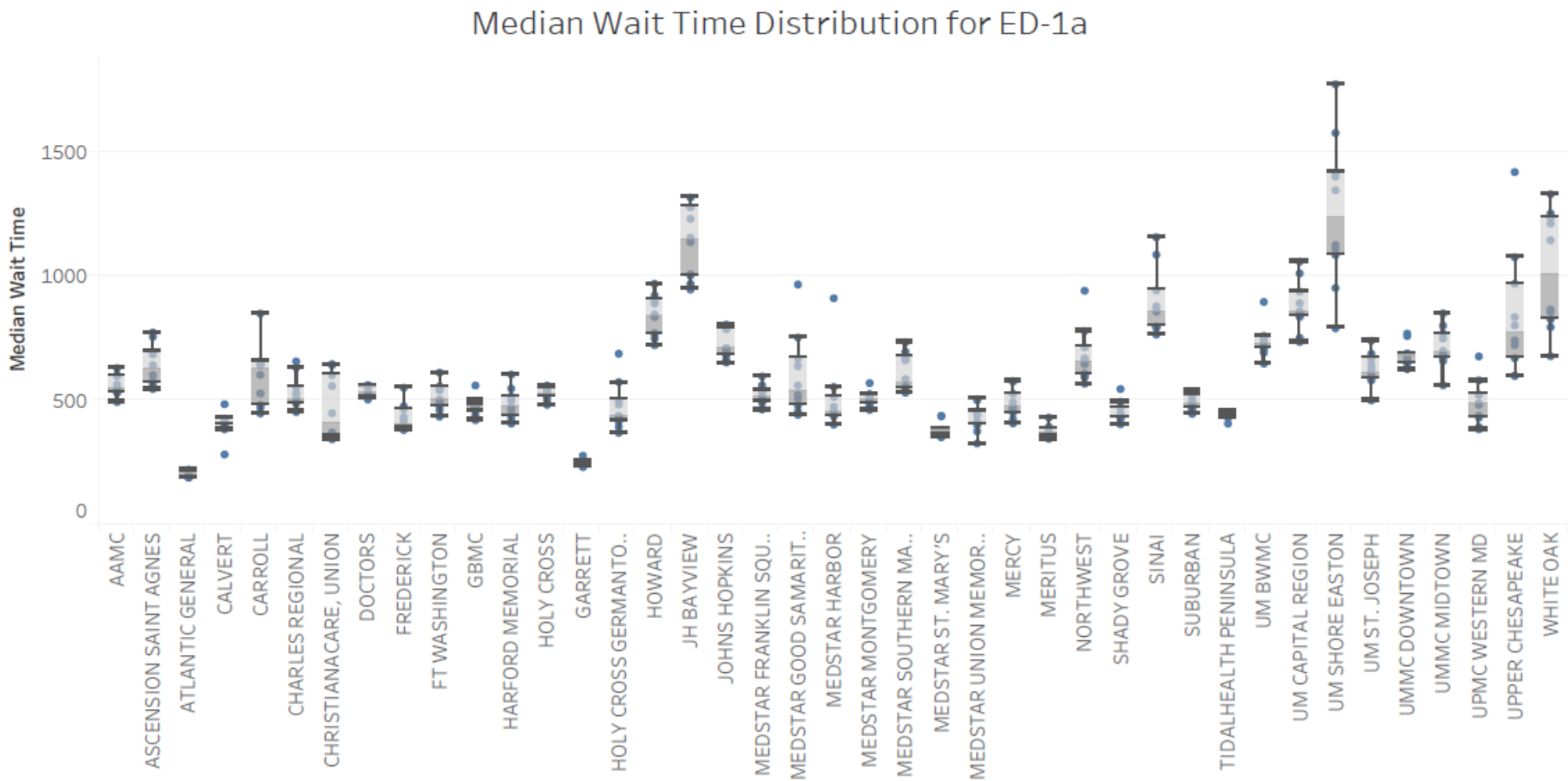
ED 1a: ED Arrival to Inpatient Admission



ED 1a: ED Arrival to Inpatient Admission Time
Latest Month Median By Volume--Latest Month



ED 1a: ED Arrival to Inpatient Admission



ED 1a: ED Arrival to Inpatient Admission

Heat Graph:
Colors are relative to June/first month reported.

Red = higher wait time
Green = lower wait time

Average Median Wait Time All Hospitals for ED-1a

Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024
AAMC	493	532	540	534	563	601	629	597	530	544
ASCENSION SAINT AG..	601	564	545	574	641	576	755	772	684	694
ATLANTIC GENERAL	210	218	221	212	195	189	216		190	191
CALVERT	282	383	411	425	405	409	484	426	408	402
CARROLL	447	527	481	640	602	470	654	848	656	649
CHARLES REGIONAL	527	486	497	453	492	455	508	656	631	551
CHRISTIANACARE, UN..	369	351	370	343	360	448	641	601	645	557
DOCTORS	561	514	537	503	559	529	555	559	513	512
FREDERICK	392	388	382	395	416	432	464	550	476	381
FT WASHINGTON	503	434	488	493	550	539	611	460	476	556
GARRETT			244		246	244	277	254	231	237
GBMC	439	467	456	475	482	420	476	559	497	474
HARFORD MEMORIAL	406	499	424	437	472	459	515	603	547	
HOLY CROSS	524	481	540	513	547	518	546	559	496	524
HOLY CROSS GERMAN..	435	393	428	369	483	414	573	687	499	437
HOWARD	748	770	765	834	968	921	902	889	721	845
JH BAYVIEW	945	1,007	1,153	968	1,135	1,276	1,229	1,277	1,315	1,001
JOHNS HOPKINS	794	680	652	697	704	708	661	804	786	710
MEDSTAR FRANKLIN S..	463	467	493	492	532	509	560	596	539	512
MEDSTAR GOOD SAM..	441	479	522	456	559	506	667	965	752	637
MEDSTAR HARBOR	458	553	474	910	513	402	441	457	436	437
MEDSTAR MONTGOM..	518	461	486	495	525	497	505	569	518	480
MEDSTAR SOUTHERN ..	585	544	539	530	542	554	660	733	695	673
MEDSTAR ST. MARY'S	380	351	362	354	362	382	436	437	363	372
MEDSTAR UNION ME..	375	456	412	326	407	400	504	500	439	410
MERCY	526	577	575	407	450	423	466	492	461	476
MERITUS	393	370	354	386	379	345	368	430	370	354
NORTHWEST	645	778	669	566	602	608	661	940	713	593
SHADY GROVE	408	427	446	435	545	494	428	437	403	470
SINAI	796	796	877	861	764	856	791	1,155	1,085	942
SUBURBAN	527	462	467	480	537	469	499	521	497	445
TIDALHEALTH PENINS..		453	448	447	432	430	445	450	438	406
UM BWMC	711	740	691	708	717	647	756	895	758	731
UM CAPITAL REGION	1,010	853	858	751	890	734	835	1,057	936	838
UM SHORE EASTON	1,399	951	1,344	1,414	1,109	789	1,574	1,770	1,084	1,124
UM ST. JOSEPH	604	600	641	667	687	499	621	739	580	585
UMMC DOWNTOWN	680	625	648	688	658	650	670	768	687	758
UMMC MIDTOWN	685	849	800	658	768	560	698	677	748	669
UPMC WESTERN MD	383	430	438	481	522	523	489	676	580	392
UPPER CHESAPEAKE	598	669	599	834	801	968	1,075	1,417	721	741
WHITE OAK	1,251	865	1,143	855	1,328	1,210	794	825	677	1,233

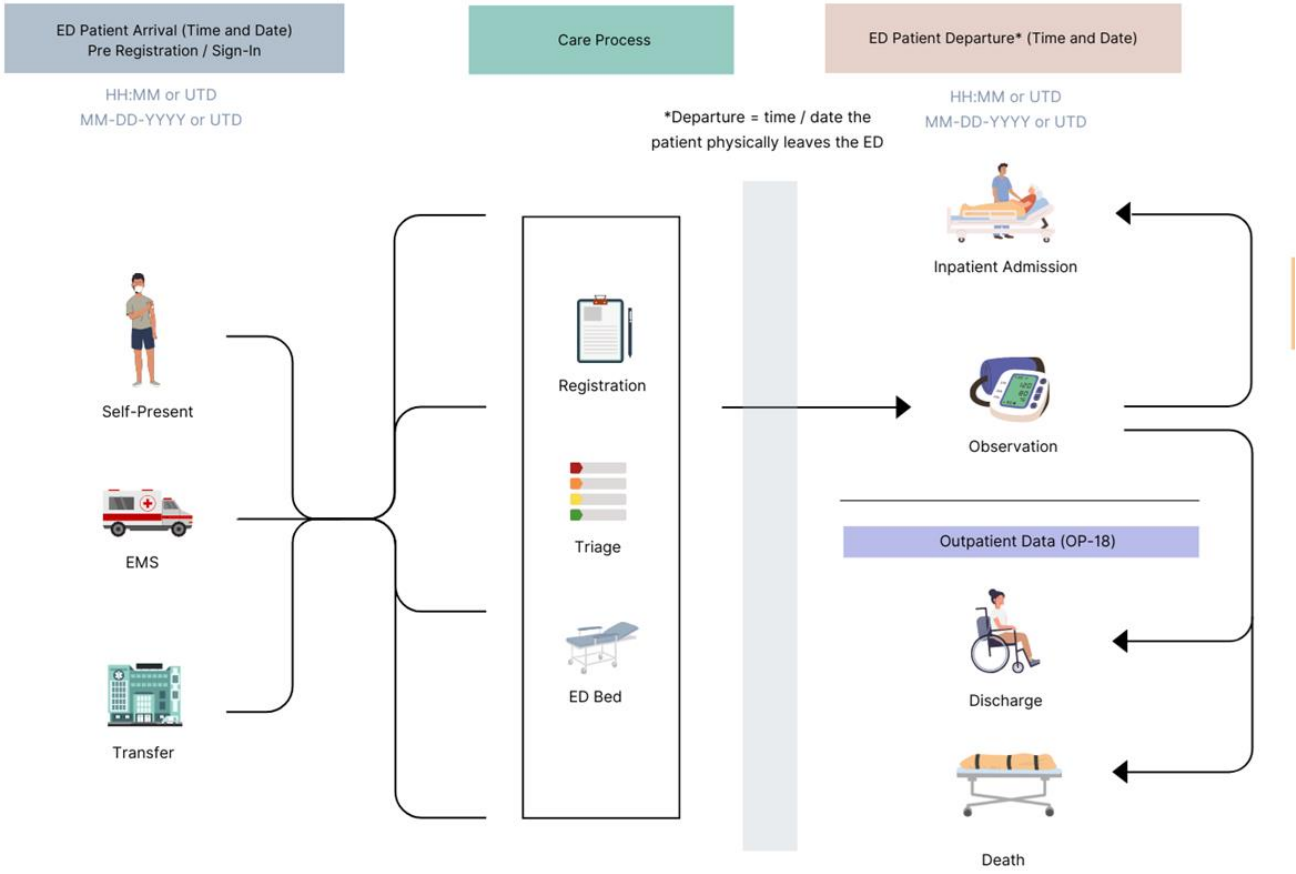
Measure
ED-1a

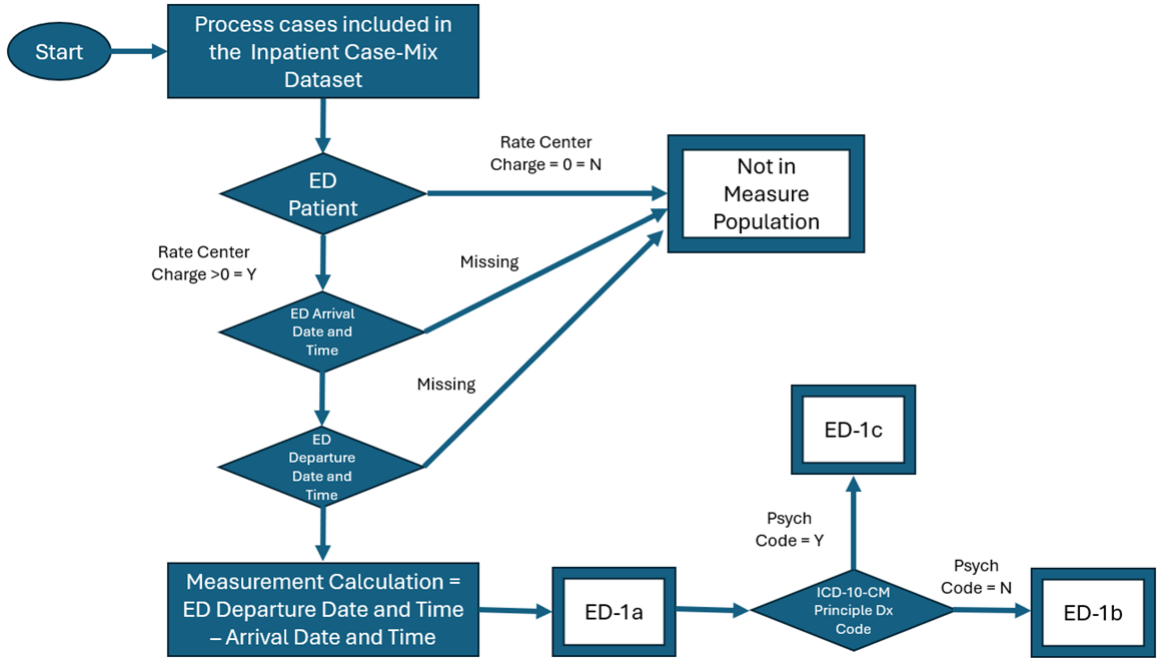
Change from Base
-610 819

QBR ED-1 Subgroups

Subgroup 1: ED1 Data

Final meeting is Friday, April 12; Subgroup 2 starts Friday, April 24th





Next Steps

- Continue monthly EDDIE data collection from hospitals and MIEMSS
- QBR ED Length of Stay measure
  - Finalize QBR ED LOS Data subgroup
  - Convene QBR ED LOS Measure and Incentive subgroup
- Finalize work plan for additional subgroup on Best Practices (1 percent idea)
  - Consult with experts in and outside of Ma[illegible] practices to consider
  - Recruit participants
  - Establish meeting agendas and dates

Staff will provide update at May Commission meeting on Best Practices Subgroup Timeline

Appendix

EDDIE Overview

- Maryland has underperformed most other states on ED throughput measures since before the start of the All-Payer model
- EDDIE is a Commission-developed quality improvement initiative that began in June 2023 with two components:

EDDIE: Improved ED Experience for Patients

Quality Improvement

- Rapid cycle QI initiatives to meet hospital set goals related to ED throughput/length of stay
- Learning collaborative
- Convened by MHA

Commission Reporting

- Public reporting of monthly data for three measures
- Led by HSCRC and MIEMSS

March Data 2024 Reporting

Monthly, public reporting of three measures:

- ED1-like measure: ED arrival to inpatient admission time for all admitted patients
- OP18-like measure: ED arrival to discharge time for patients who are not admitted
- EMS turnaround time (from MIEMSS): Time from arrival at ED to transfer of patient care from EMS to the hospital

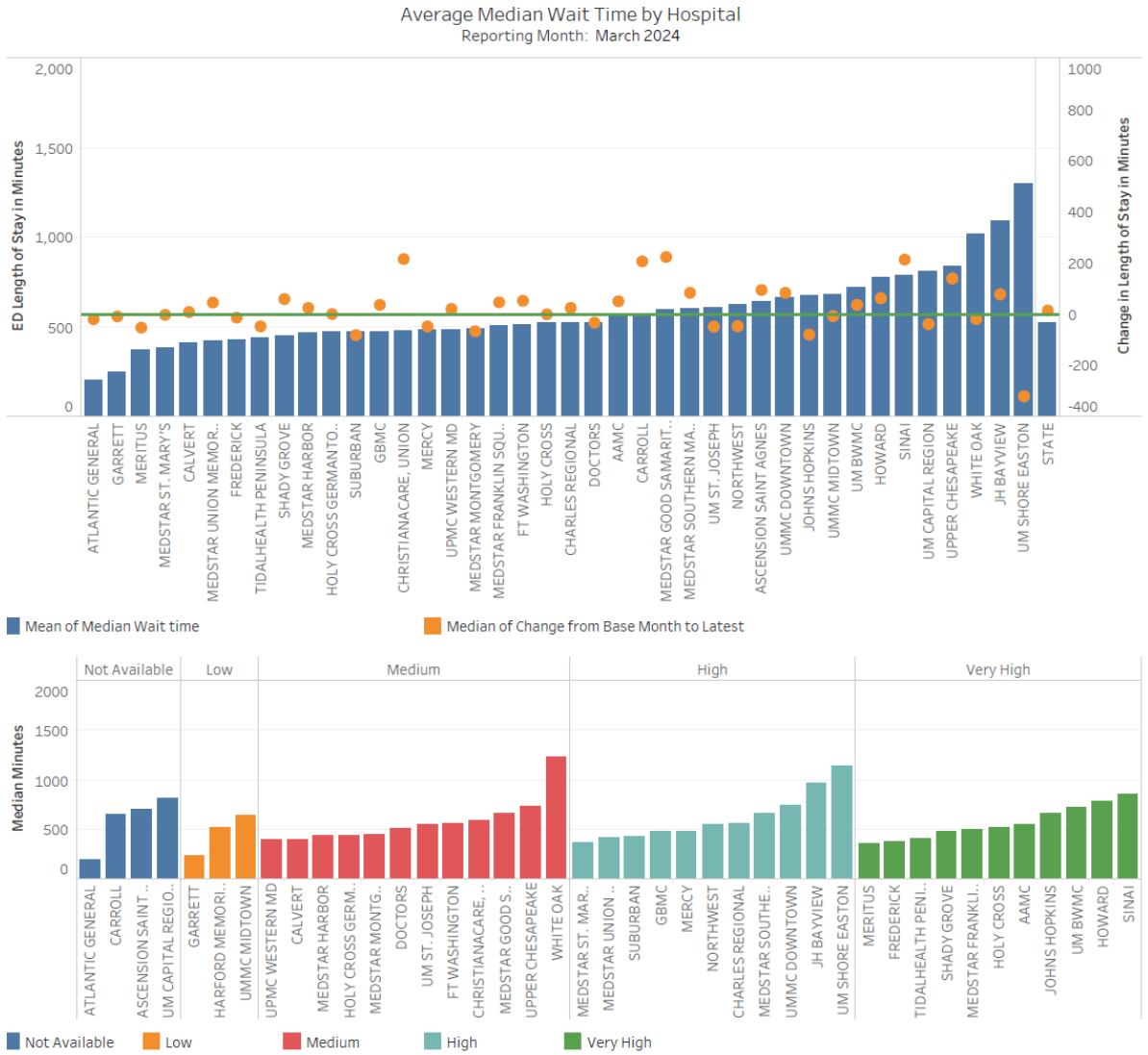
March data received for all hospitals

- These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month)
- These data are being collected for hospital quality improvement and have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital
- Data may be updated over time if issues are identified or specifications change

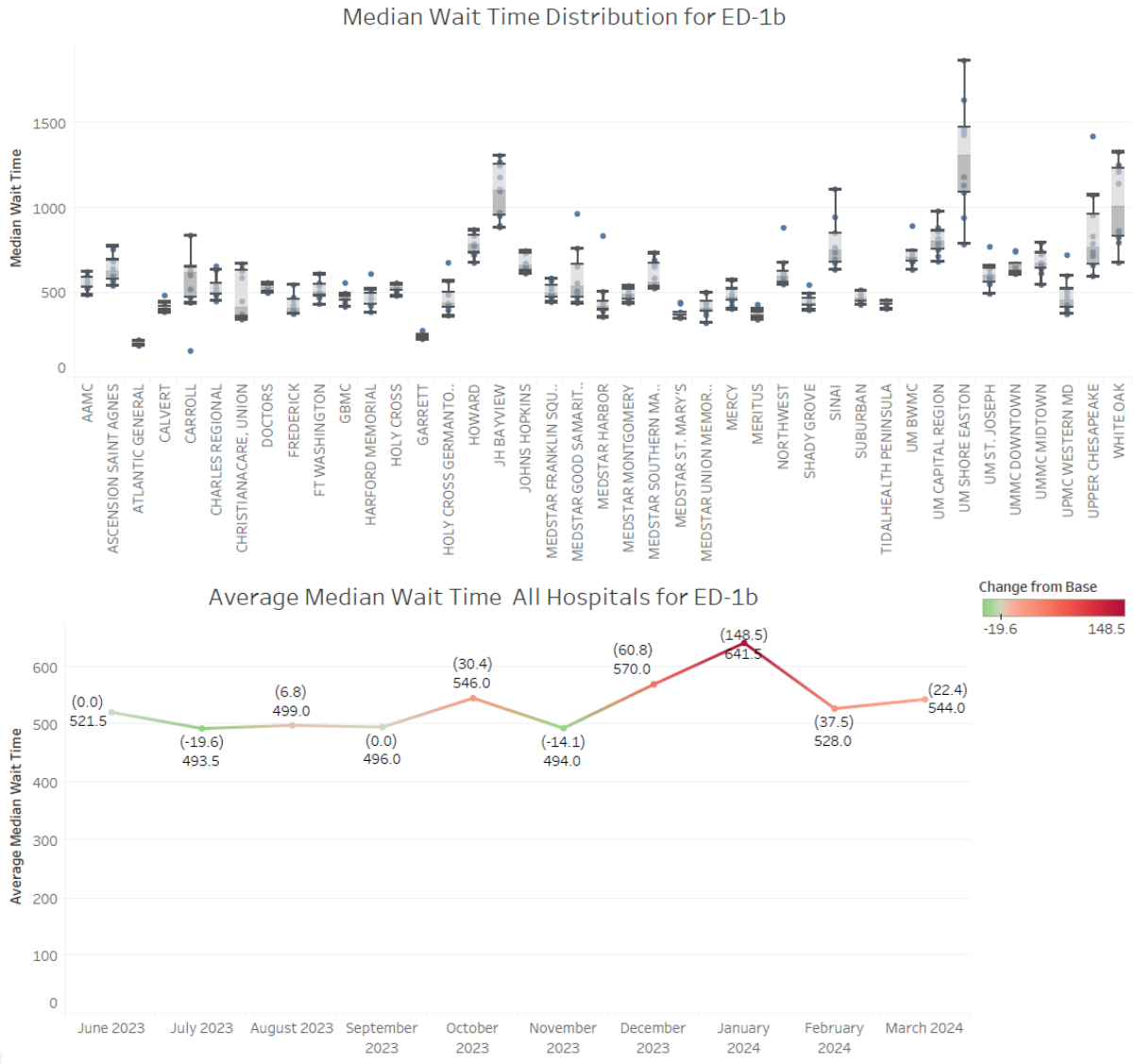
Graphs:

- Starting with February data, CRISP automated several new types of graphs/charts to illustrate EDDIE data using Tableau.
- Rolling median (June-Latest Month) and change from June/first month provided
- Latest month grouped by CMS ED volume category (Volume data is from CMS Care Compare or imputed by hospital, volume categories were recently updated on CMS Care Compare.)
- Graphs have not been QAed by hospitals due to fast turnaround time

ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric



ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric



ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric

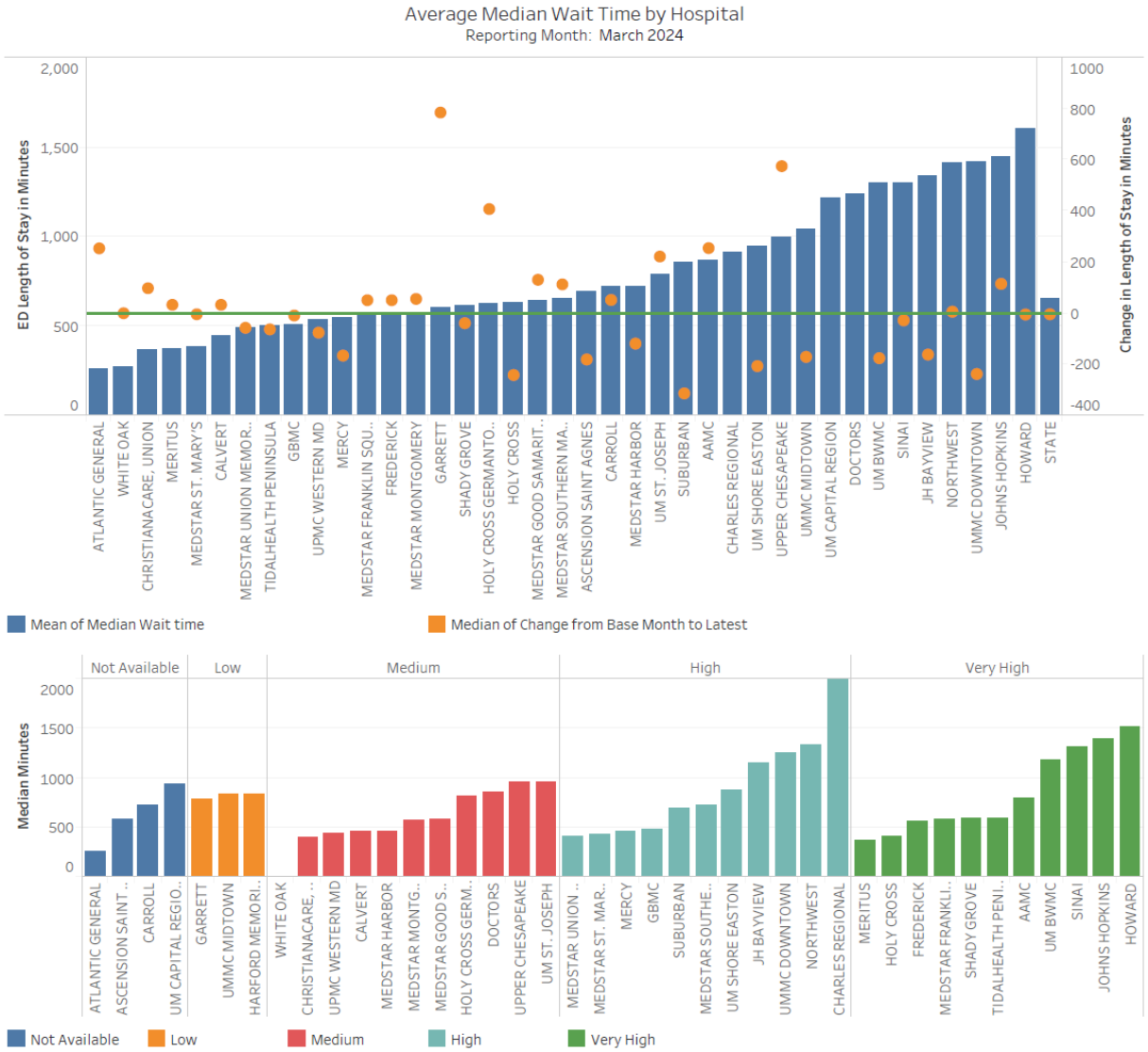
Average Median Wait Time All Hospitals for ED-1b

Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024
AAMC	488	527	536	529	565	597	623	591	528	539
ASCENSION SAINT AG..	599	563	541	573	641	576	755	772	683	694
ATLANTIC GENERAL	209	203	222	212	195	189	216		190	190
CALVERT		386	403	420	390	408	484	443	404	395
CARROLL	441	520	470	623	603	158	653	837	648	648
CHARLES REGIONAL	526	484	499	449	489	456	507	656	634	551
CHRISTIANACARE, UN..	372	351	370	343	356	450	640	627	669	588
DOCTORS	541	503	525	499	559	523	547	543	510	509
FREDERICK	388	376	378	391	410	427	458	546	472	375
FT WASHINGTON	503	434	488	493	550	539	611	469	476	556
GARRETT			244		246	244	277	255	227	236
GBMC	438	467	455	475	481	417	476	558	496	475
HARFORD MEMORIAL	386	466	432	429	435	421	496	611	517	
HOLY CROSS	524	482	540	513	544	518	546	557	495	524
HOLY CROSS GERMAN..	435	396	427	365	487	414	568	677	498	436
HOWARD	722	734	729	776	871	839	836	785	676	785
JH BAYVIEW	895	951	1,107	885	1,097	1,250	1,179	1,270	1,307	973
JOHNS HOPKINS	746	631	613	650	672	652	617	744	732	667
MEDSTAR FRANKLIN S..	445	471	492	484	516	471	570	585	538	492
MEDSTAR GOOD SAM..	440	474	512	449	556	494	654	965	761	664
MEDSTAR HARBOR	407	506	424	835	391	357	399	447	416	432
MEDSTAR MONTGOM..	520	459	478	477	525	438	490	540	495	454
MEDSTAR SOUTHERN ..	584	542	536	525	540	533	654	735	691	668
MEDSTAR ST. MARY'S	368	350	362	356	362	385	436	443	361	366
MEDSTAR UNION ME..	367	442	397	321	398	389	498	503	434	413
MERCY	523	576	574	404	450	421	464	490	461	476
MERITUS	404	371	357	386	377	341	368	430	364	352
NORTHWEST	595	676	613	558	575	561	600	883	624	549
SHADY GROVE	408	424	446	434	546	493	427	437	397	468
SINAI	638	636	759	699	675	765	737	1,110	945	852
SUBURBAN	510	441	445	457	516	455	485	506	474	429
TIDALHEALTH PENINS..		452	446	447	429	430	447	448	437	405
UM BWMC	684	704	681	683	699	635	740	893	747	721
UM CAPITAL REGION	859	752	781	714	809	683	793	981	882	821
UM SHORE EASTON	1,452	941	1,468	1,428	1,182	784	1,634	1,867	1,089	1,132
UM ST. JOSEPH	598	562	641	656	640	494	607	771	583	550
UMMC DOWNTOWN	658	610	625	669	636	622	651	747	662	742
UMMC MIDTOWN	647	792	735	614	742	547	676	664	726	640
UPMC WESTERN MD	373	417	411	473	599	503	430	722	520	394
UPPER CHESAPEAKE	599	662	598	831	789	956	1,074	1,421	717	739
WHITE OAK	1,251	865	1,142	855	1,328	1,212	795	825	677	1,233

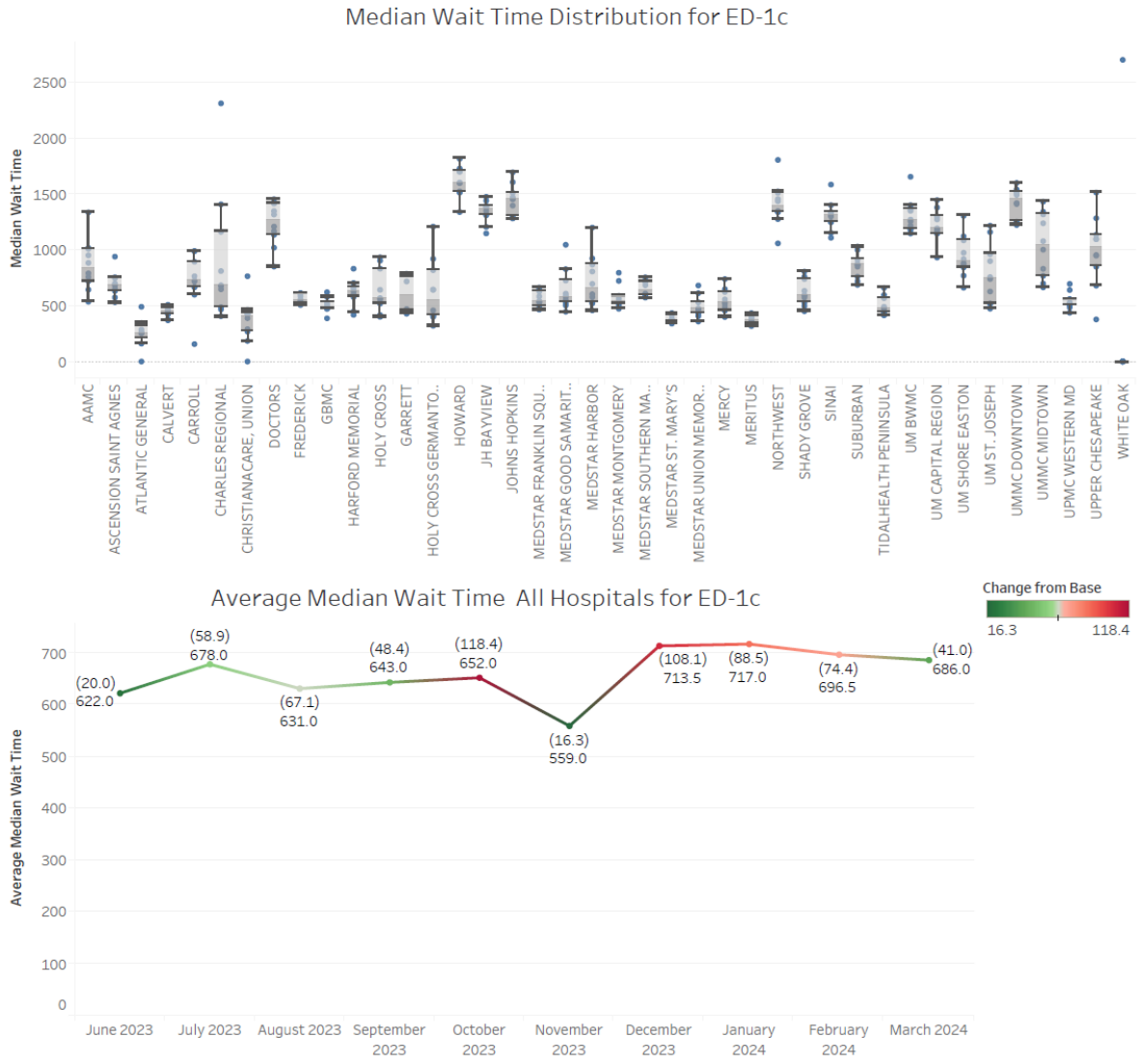
Measure
ED-1b

Change from Base
-668 822

ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric

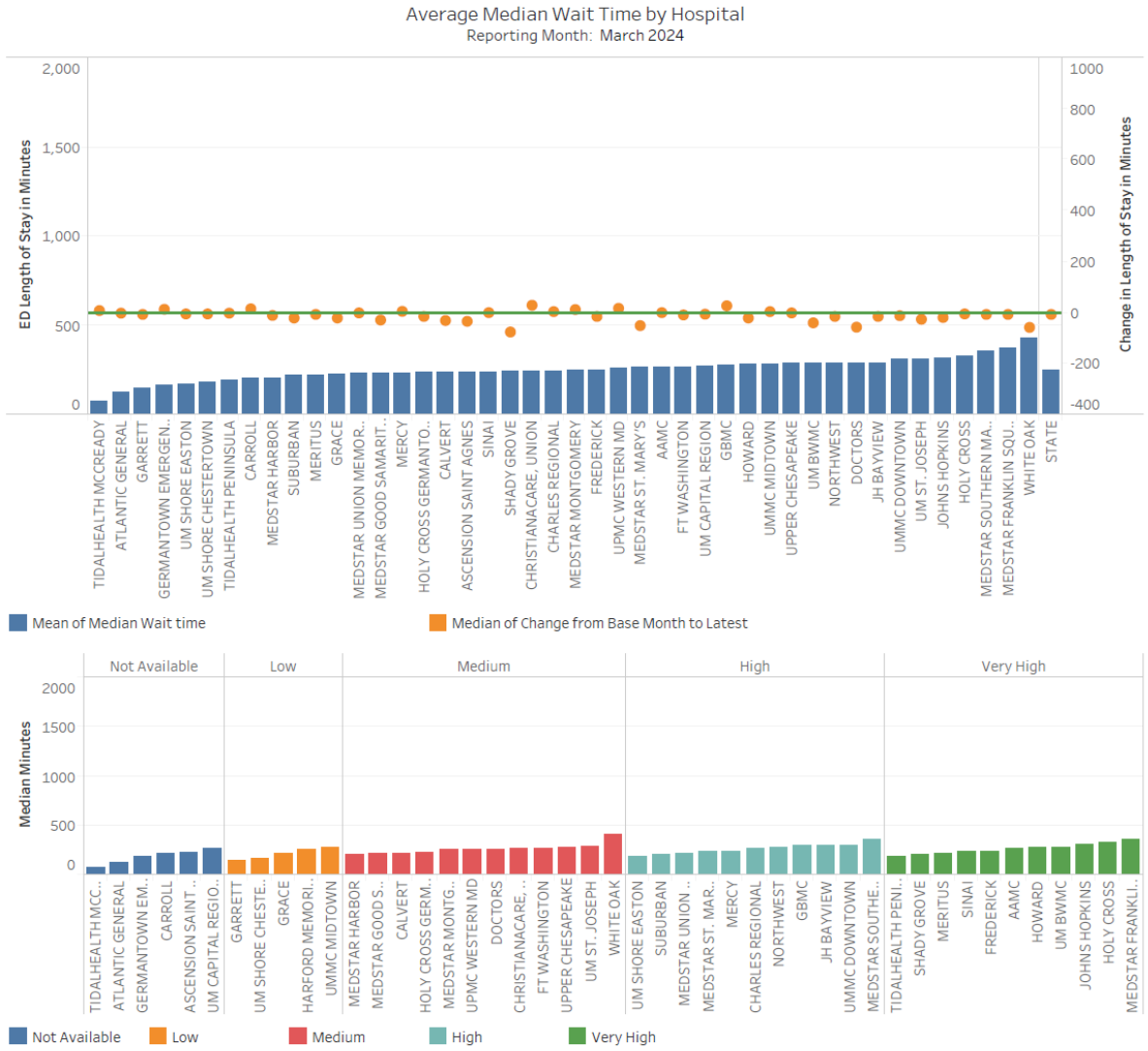
Average Median Wait Time All Hospitals for ED-1c

Measure
ED-1c

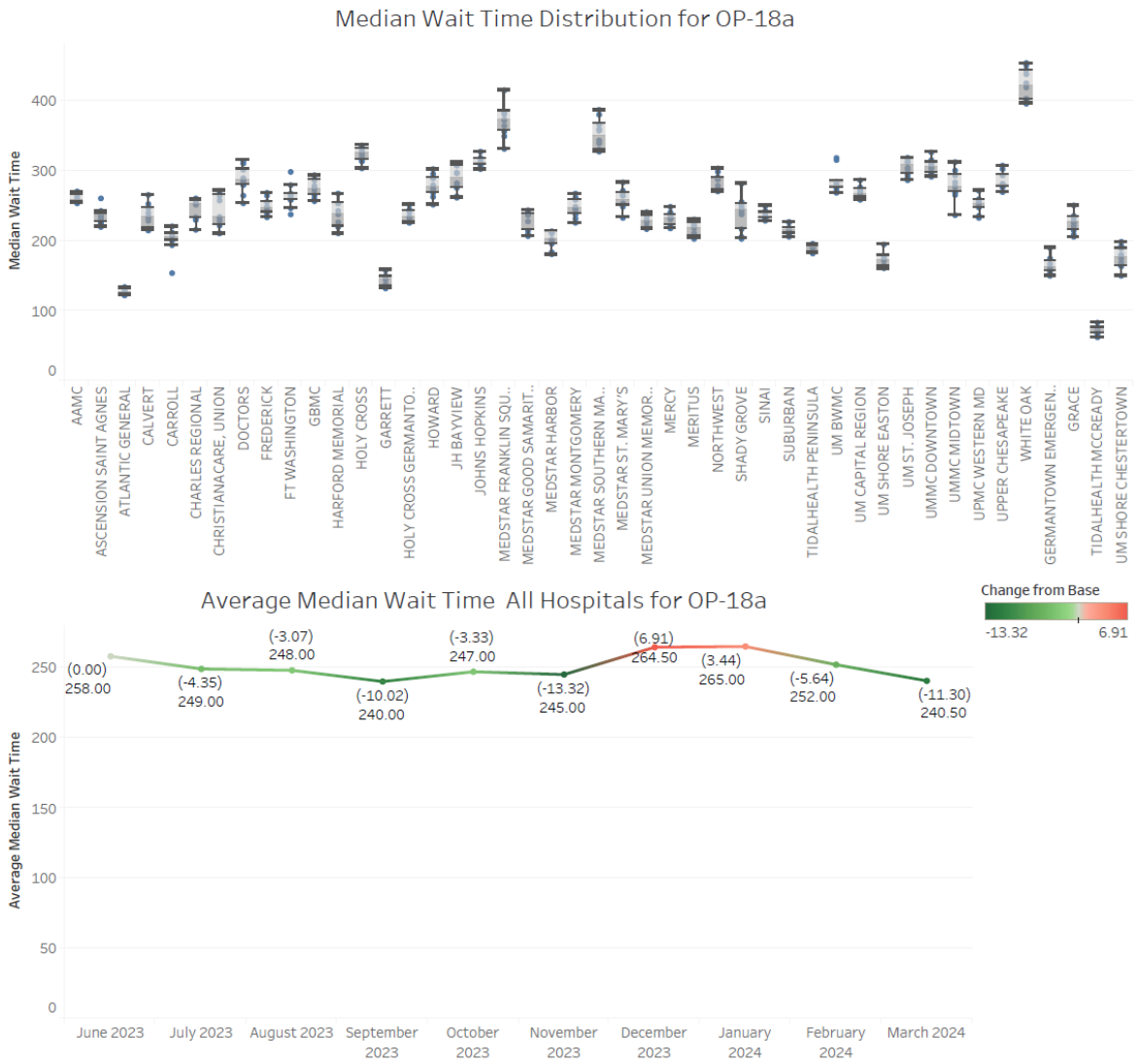
Change from Base
-564 2,701

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024
AAMC	535	883	719	643	1,335	951	1,009	1,017	757	790
ASCENSION SAINT AG..	755	939	631	691	652	531	682	745	698	574
ATLANTIC GENERAL		345	160	262	286	490	255		0	254
CALVERT	425	379	457	471	508	427	501	369	449	458
CARROLL	665	667	764	893	598	156	724	988	989	717
CHARLES REGIONAL	682	678	487	810	1,407	406	1,161	647	466	2,311
CHRISTIANACARE, UN..	290	184	268	0	424	422	764	431	463	388
DOCTORS	1,414	1,316	1,167	1,019	1,418	1,453	1,347	1,208	1,134	850
FREDERICK	506	517	540	514	613	534	586	609	613	557
GARRETT							470	717	428	786
GBMC	480	387	479	476	508	526	498	621	578	471
HARFORD MEMORIAL	448	601	418	630	667	654	703	577	831	
HOLY CROSS	642	416	518	568	903	559	532	933	831	400
HOLY CROSS GERMAN..	410	320	643	400	412	458	1,208	919	643	818
HOWARD	1,524	1,512	1,338	1,597	1,699	1,602	1,701	1,815	1,728	1,519
JH BAYVIEW	1,309	1,205	1,440	1,376	1,383	1,394	1,475	1,316	1,348	1,147
JOHNS HOPKINS	1,281	1,294	1,284	1,510	1,458	1,470	1,453	1,606	1,694	1,396
MEDSTAR FRANKLIN S..	532	465	500	532	627	662	469	642	542	583
MEDSTAR GOOD SAM..	446	502	590	549	608	522	827	1,045	725	577
MEDSTAR HARBOR	577	868	923	1,199	806	520	695	531	603	458
MEDSTAR MONTGOM..	512	472	498	532	531	722	550	795	588	568
MEDSTAR SOUTHERN ..	609	575	586	573	601	714	683	717	754	722
MEDSTAR ST. MARY'S	434	356	356	339	359	374	415	379	376	430
MEDSTAR UNION ME..	464	681	473	358	475	431	612	470	530	407
MERCY	622	648	738	490	458	531	518	556	398	456
MERITUS	329	344	317	385	423	395	363	434	397	362
NORTHWEST	1,337	1,510	1,454	1,058	1,435	1,275	1,347	1,523	1,805	1,343
SHADY GROVE	633	805	526	760	450	573	592	497	739	594
SINAI	1,337	1,336	1,108	1,400	1,248	1,151	1,299	1,248	1,584	1,309
SUBURBAN	1,000	849	875	865	1,029	718	868	760	912	686
TIDALHEALTH PENINS..		659	490	441	473	415	415	567	440	596
UM BWMC	1,359	1,400	1,349	1,654	1,216	1,176	1,146	1,271	1,255	1,183
UM CAPITAL REGION	1,379	1,445	1,189	1,169	1,299	1,191	1,147	1,272	1,146	931
UM SHORE EASTON	1,085	974	769	1,304	875	842	917	1,121	661	878
UM ST. JOSEPH	739	1,159	627	899	1,216	520	756	473	516	961
UMMC DOWNTOWN	1,491	1,410	1,419	1,222	1,510	1,519	1,541	1,249	1,599	1,253
UMMC MIDTOWN	1,001	1,341	1,431	1,078	1,317	664	1,238	698	767	830
UPMC WESTERN MD	513	520	508	510	525	484	560	640	695	437
UPPER CHESAPEAKE	377	1,135	679	1,513	948	1,283	1,096	848	1,096	953
WHITE OAK	0	0	2,701	0	0	0	0	0	0	0

OP18a: ED Arrival to Discharge Time by Month



OP18a: ED Arrival to Discharge Time by Month



OP18a: ED Arrival to Discharge Time by Month

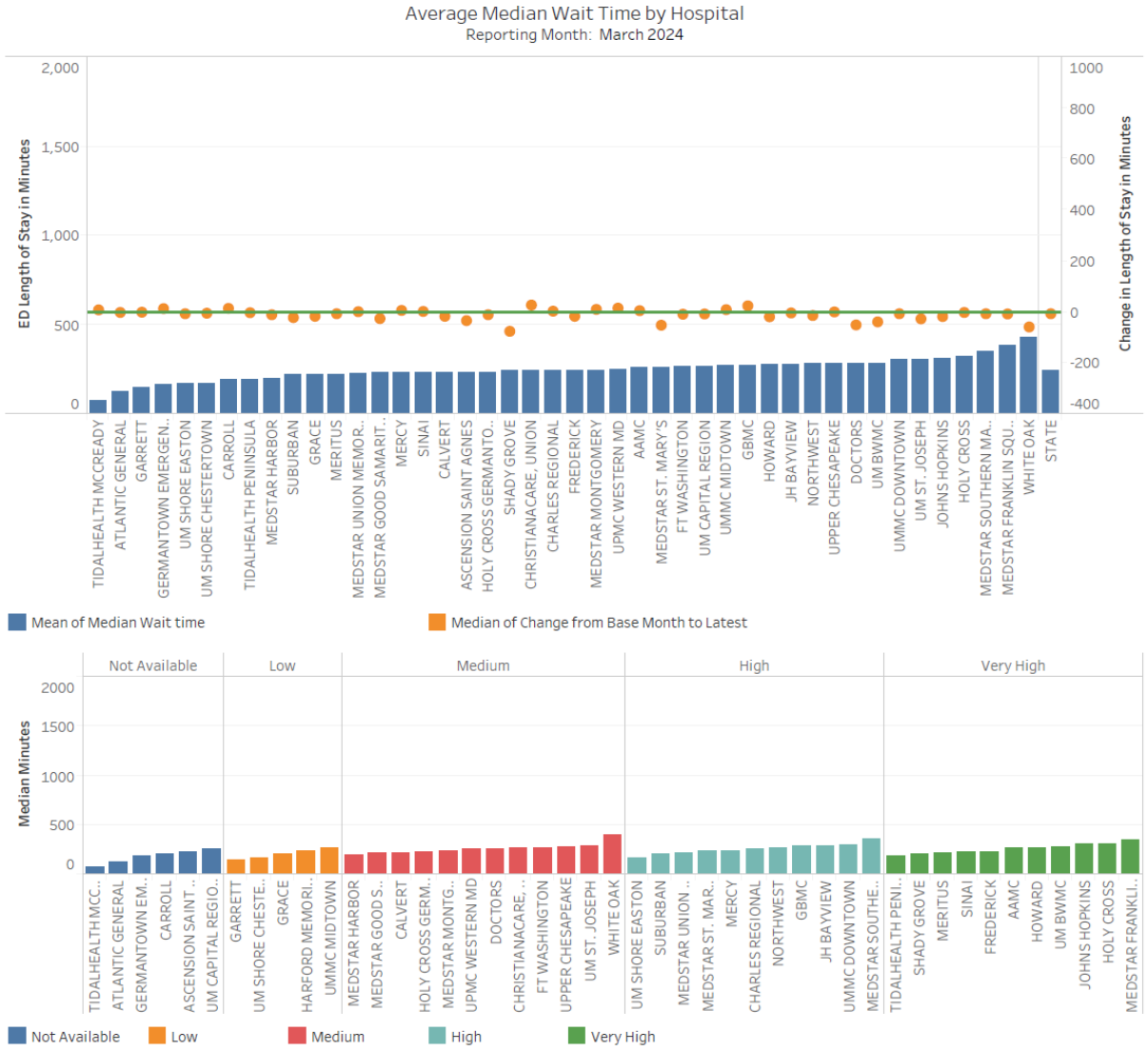
Average Median Wait Time All Hospitals for OP-18a

Measure
OP-18a

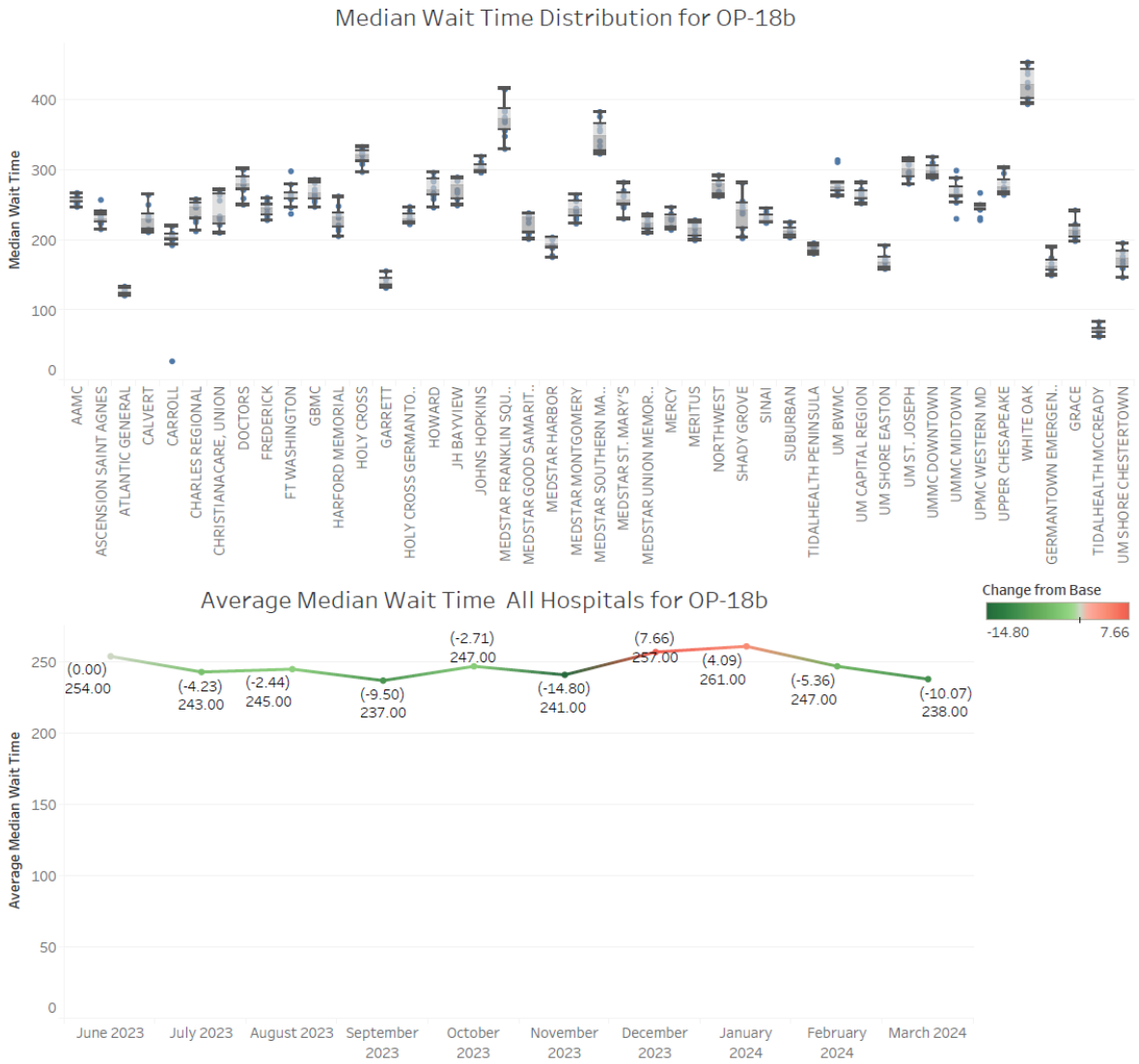
Change from Base
-79.0 59.0

Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024
AAMC	258.0	255.0	260.0	254.0	266.0	263.0	271.0	268.0	256.0	258.0
ASCENSION SAINT AG..	261.0	238.0	236.0	243.0	220.0	226.0	239.0	238.0	232.0	227.0
ATLANTIC GENERAL	124.0	127.0	131.0	133.0	128.0	123.0	134.0		125.0	122.0
CALVERT	247.0	229.0	240.0	233.0	253.0	235.0	266.0	218.0	215.0	216.0
CARROLL	194.0	203.0	201.0	201.0	221.0	154.0	212.0	209.0	211.0	209.0
CHARLES REGIONAL	254.0	253.0	232.0	216.0	230.0	234.0	258.0	261.0	252.0	258.0
CHRISTIANACARE, UN..	229.0	234.0	222.0	211.0	211.0	234.0	271.0	265.0	272.0	258.0
DOCTORS	311.0	288.0	280.0	265.0	281.0	285.0	315.0	302.0	290.0	254.0
FREDERICK		249.0	248.0	236.0	240.0	244.0	265.0	269.0	256.0	234.0
FT WASHINGTON	268.0	238.0	262.0	247.0	260.0	259.0	299.0	280.0	266.0	259.0
GARRETT			145.0		150.0	147.0	158.0	134.0	132.0	138.0
GBMC	267.0	257.0	261.0	273.0	279.0	266.0	287.0	276.0	294.0	294.0
GERMANTOWN EMER..	162.0	156.0	159.0	150.0	167.0				190.0	175.0
GRACE	236.0	251.0	226.0	221.0	228.0	206.0	233.0	227.0	209.0	215.0
HARFORD MEMORIAL	220.0	227.0	211.0	238.0	221.0	254.0	268.0	243.0	254.0	
HOLY CROSS	320.0	304.0	335.0	333.0	327.0	314.0	329.0	337.0	324.0	315.0
HOLY CROSS GERMAN..	242.0	227.0	252.0	233.0	235.0	228.0	245.0	234.0	226.0	227.0
HOWARD	290.0	290.0	303.0	252.0	275.0	263.0	296.0	280.0	271.0	269.0
JH BAYVIEW	312.0	312.0	308.0	281.0	283.0	262.0	264.0	298.0	276.0	297.0
JOHNS HOPKINS	328.0	319.0	318.0	309.0	312.0	303.0	305.0	313.0	311.0	309.0
MEDSTAR FRANKLIN S..	357.0	373.0	382.0	365.0	374.0	385.0	416.0	416.0	332.0	350.0
MEDSTAR GOOD SAM..	239.0	237.0	244.0	228.0	239.0	207.0	239.0	241.0	215.0	210.0
MEDSTAR HARBOR	213.0	213.0	211.0	202.0	214.0	181.0	196.0	200.0	184.0	202.0
MEDSTAR MONTGOM..	232.0	226.0	247.0	238.0	259.0	246.0	262.0	268.0	249.0	244.0
MEDSTAR SOUTHERN ..	367.0	344.0	331.0	328.0	340.0	329.0	388.0	381.0	358.0	360.0
MEDSTAR ST. MARY'S	284.0	269.0	272.0	251.0	254.0	249.0	265.0	265.0	252.0	233.0
MEDSTAR UNION ME..	218.0	227.0	230.0	221.0	241.0	219.0	241.0	235.0	229.0	217.0
MERCY	232.0	241.0	231.0	219.0	218.0	222.0	233.0	249.0	236.0	237.0
MERITUS	225.0	207.0	207.0	221.0	211.0	203.0	225.0	231.0	221.0	218.0
NORTHWEST	288.0	291.0	304.0	279.0	291.0	290.0	299.0	272.0	271.0	273.0
SHADY GROVE	282.0	256.0	252.0	242.0	247.0	246.0	238.0	217.0	203.0	206.0
SINAI	232.0	240.0	250.0	232.0	233.0	233.0	243.0	236.0	229.0	232.0
SUBURBAN	227.0	216.0	227.0	217.0	219.0	210.0	209.0	214.0	213.0	206.0
TIDALHEALTH MCCRE..			62.0	73.0	83.0	67.0	75.0	68.0	74.0	70.0
TIDALHEALTH PENINS..		184.0	190.0	196.0	195.0	191.0	192.0	184.0	190.0	182.0
UM BWMC	316.0	319.0	285.0	282.0	277.0	280.0	278.0	272.0	269.0	276.0
UM CAPITAL REGION	265.0	277.0	271.0	265.0	269.0	260.0	287.0	274.0	262.0	259.0
UM SHORE CHESTERT..	169.0	175.0	164.0	180.0	193.0	150.0	189.0	199.0	180.0	164.0
UM SHORE EASTON	178.0	165.0	172.0	174.0	163.0	161.0	178.0	195.0	164.0	173.0
UM ST. JOSEPH	313.0	305.0	313.0	319.0	319.0	291.0	318.0	302.0	295.0	287.0
UMMC DOWNTOWN	310.0	312.0	306.0	299.0	292.0	293.0	304.0	316.0	327.0	298.0
UMMC MIDTOWN	266.0	294.0	277.0	279.0	270.0	237.0	301.0	313.0	284.0	270.0
UPMC WESTERN MD	233.0	236.0	248.0	250.0	272.0	260.0	259.0	256.0	256.0	250.0
UPPER CHESAPEAKE	278.0	280.0	278.0	270.0	280.0	282.0	308.0	303.0	294.0	277.0
WHITE OAK	455.0	404.0	420.0	397.0	452.0	402.0	426.0	445.0	439.0	397.0

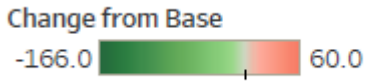
OP18b: ED Arrival to Discharge Time - Non-Psychiatric



OP18b: ED Arrival to Discharge Time - Non-Psychiatric



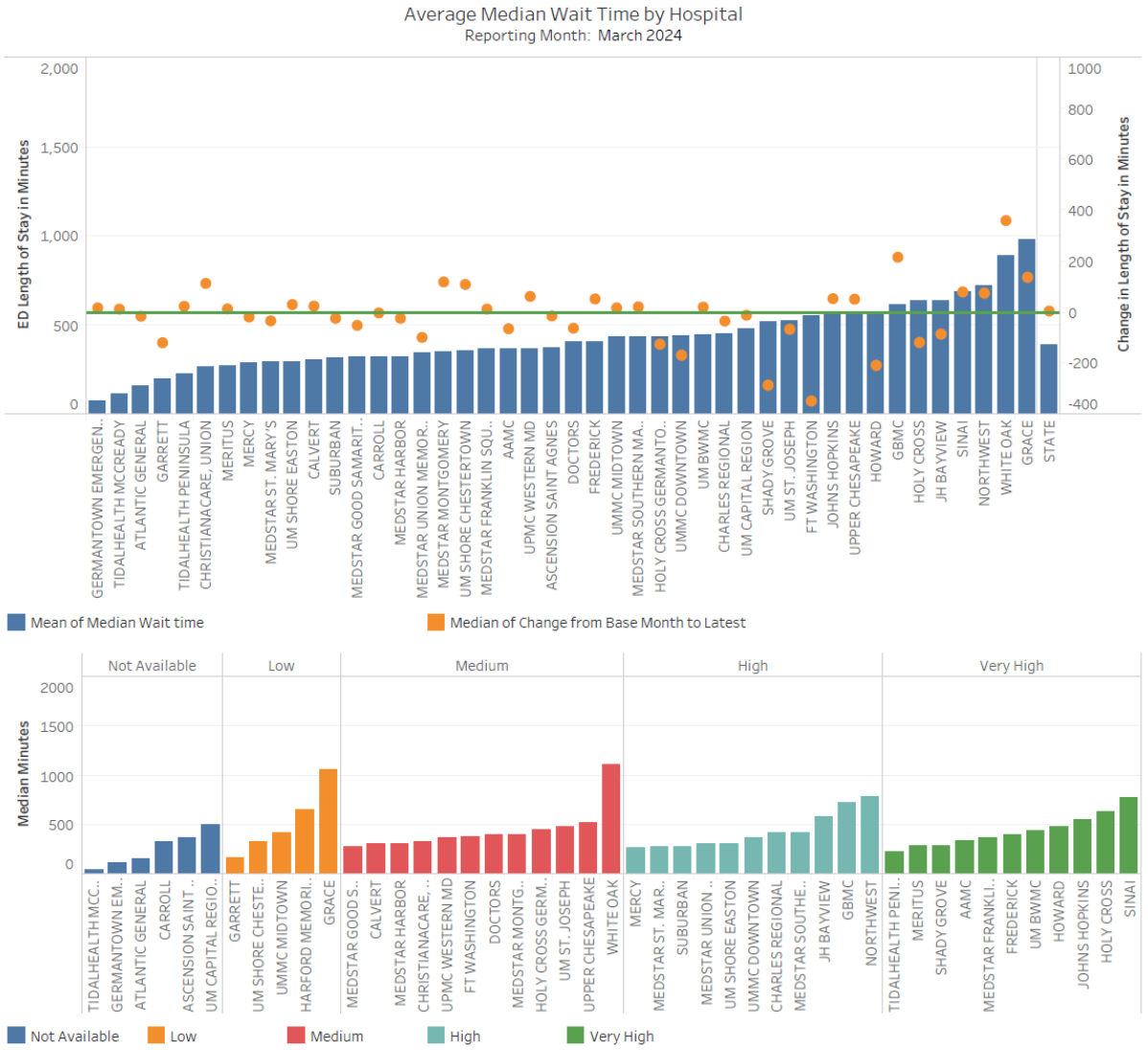
OP18b: ED Arrival to Discharge Time - Non-Psychiatric



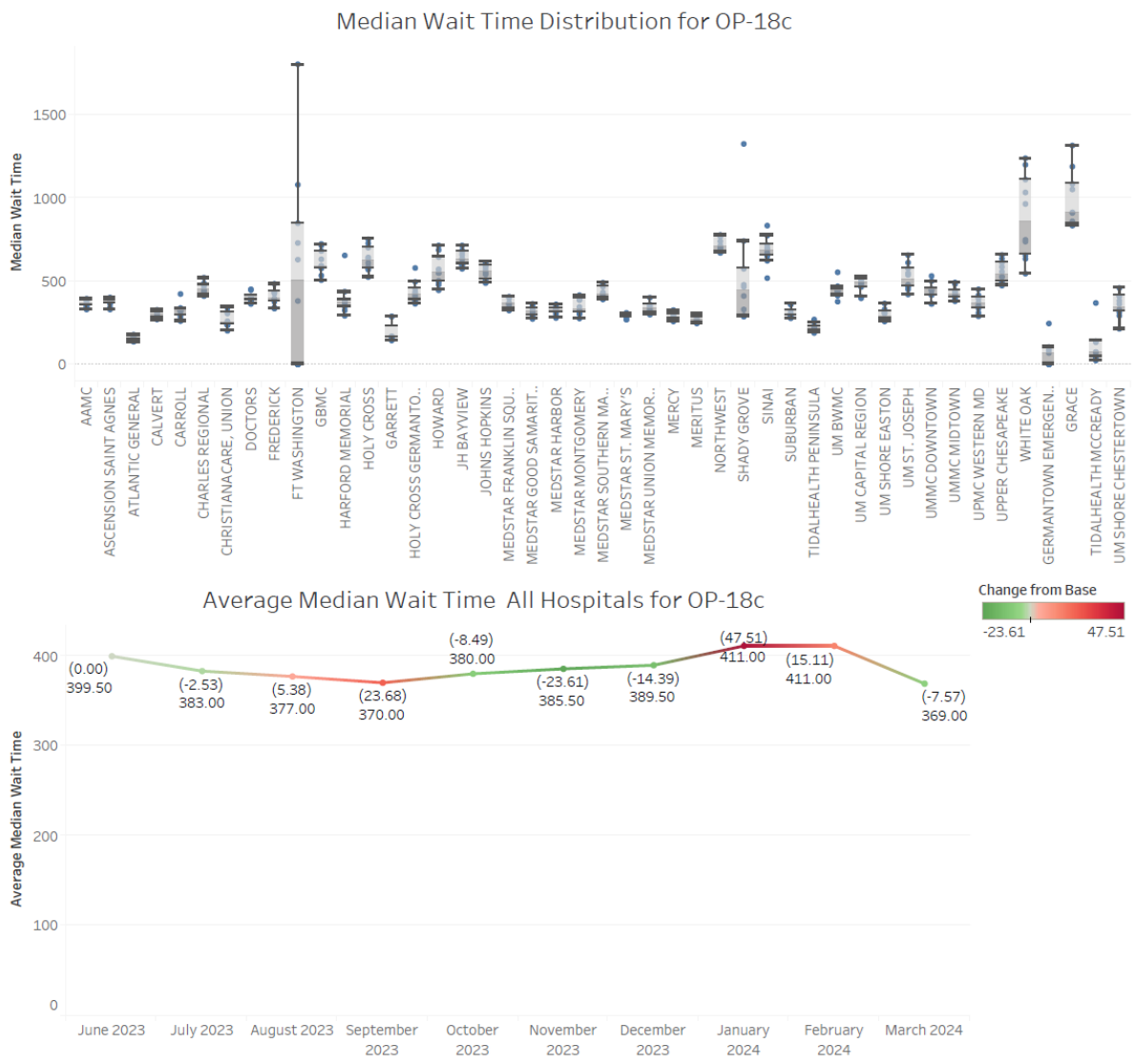
Average Median Wait Time All Hospitals for OP-18b

Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024
AAMC	254.0	251.0	257.0	248.0	256.0	260.0	268.0	266.0	254.0	259.0
ASCENSION SAINT AG..	258.0	235.0	232.0	241.0	216.0	225.0	225.0	234.0	228.0	224.0
ATLANTIC GENERAL	123.0	126.0	130.0	132.0	127.0	122.0	134.0		124.0	121.0
CALVERT		229.0	237.0	231.0	251.0	233.0	265.0	216.0	212.0	212.0
CARROLL	193.0	201.0	200.0	201.0	220.0	27.0	210.0	207.0	209.0	207.0
CHARLES REGIONAL	250.0	247.0	230.0	213.0	226.0	232.0	255.0	259.0	247.0	253.0
CHRISTIANACARE, UN..	230.0	234.0	222.0	211.0	211.0	234.0	272.0	265.0	272.0	257.0
DOCTORS	302.0	272.0	274.0	260.0	285.0	280.0	301.0	291.0	280.0	251.0
FREDERICK		246.0	245.0	232.0	235.0	239.0	256.0	261.0	251.0	229.0
FT WASHINGTON	268.0	238.0	261.0	247.0	260.0	259.0	299.0	280.0	265.0	259.0
GARRETT			138.0		145.0	144.0	156.0	133.0	132.0	137.0
GBMC	262.0	248.0	255.0	265.0	273.0	259.0	282.0	269.0	287.0	286.0
GERMANTOWN EMER..	162.0	156.0	159.0	150.0	167.0				190.0	175.0
GRACE	220.0	243.0	218.0	209.0	212.0	199.0	223.0	215.0	200.0	203.0
HARFORD MEMORIAL	218.0	222.0	206.0	232.0	214.0	249.0	263.0	236.0	239.0	
HOLY CROSS	315.0	298.0	330.0	328.0	324.0	309.0	326.0	334.0	322.0	313.0
HOLY CROSS GERMAN..	237.0	224.0	248.0	232.0	232.0	225.0	242.0	230.0	223.0	226.0
HOWARD	284.0	287.0	297.0	247.0	268.0	259.0	289.0	275.0	264.0	265.0
JH BAYVIEW	290.0	290.0	288.0	268.0	272.0	252.0	250.0	285.0	259.0	286.0
JOHNS HOPKINS	320.0	312.0	308.0	299.0	304.0	297.0	298.0	302.0	304.0	302.0
MEDSTAR FRANKLIN S..	357.0	373.0	384.0	369.0	376.0	387.0	417.0	416.0	331.0	349.0
MEDSTAR GOOD SAM..	234.0	231.0	239.0	225.0	234.0	202.0	237.0	238.0	210.0	208.0
MEDSTAR HARBOR	204.0	204.0	201.0	190.0	203.0	176.0	189.0	193.0	178.0	193.0
MEDSTAR MONTGOM..	230.0	224.0	245.0	233.0	256.0	243.0	258.0	265.0	246.0	240.0
MEDSTAR SOUTHERN ..	366.0	342.0	328.0	324.0	335.0	325.0	384.0	377.0	356.0	359.0
MEDSTAR ST. MARY'S	283.0	268.0	271.0	250.0	251.0	247.0	263.0	263.0	250.0	231.0
MEDSTAR UNION ME..	211.0	221.0	226.0	218.0	235.0	215.0	237.0	232.0	225.0	212.0
MERCY	230.0	238.0	229.0	217.0	215.0	219.0	233.0	247.0	233.0	236.0
MERITUS	223.0	205.0	205.0	219.0	209.0	200.0	224.0	229.0	220.0	216.0
NORTHWEST	280.0	282.0	293.0	270.0	284.0	283.0	293.0	266.0	263.0	266.0
SHADY GROVE	282.0	256.0	252.0	241.0	247.0	245.0	238.0	217.0	203.0	206.0
SINAI	226.0	236.0	245.0	226.0	228.0	230.0	240.0	232.0	225.0	228.0
SUBURBAN	226.0	214.0	224.0	214.0	217.0	207.0	207.0	211.0	211.0	204.0
TIDALHEALTH MCCRE..			62.0	73.0	83.0	66.0	75.0	67.0	73.0	70.0
TIDALHEALTH PENINS..		184.0	190.0	195.0	196.0	190.0	191.0	183.0	190.0	181.0
UM BWMC	312.0	315.0	282.0	279.0	271.0	277.0	274.0	269.0	264.0	273.0
UM CAPITAL REGION	261.0	273.0	267.0	260.0	264.0	256.0	283.0	270.0	259.0	253.0
UM SHORE CHESTERT..	166.0	171.0	160.0	176.0	184.0	147.0	185.0	196.0	177.0	161.0
UM SHORE EASTON	176.0	162.0	169.0	171.0	161.0	159.0	175.0	192.0	161.0	169.0
UM ST. JOSEPH	308.0	296.0	309.0	314.0	313.0	289.0	317.0	298.0	290.0	281.0
UMMC DOWNTOWN	301.0	306.0	298.0	293.0	289.0	290.0	299.0	311.0	319.0	294.0
UMMC MIDTOWN	254.0	276.0	267.0	265.0	262.0	231.0	289.0	300.0	271.0	263.0
UPMC WESTERN MD	229.0	232.0	246.0	244.0	268.0	249.0	251.0	249.0	247.0	244.0
UPPER CHESAPEAKE	269.0	275.0	272.0	265.0	275.0	276.0	304.0	296.0	285.0	269.0
WHITE OAK	455.0	403.0	419.0	395.0	452.0	402.0	426.0	444.0	438.0	396.0

OP18c: ED Arrival to Discharge Time by Month



OP18c: ED Arrival to Discharge Time by Month



OP18c: ED Arrival to Discharge Time by Volume Psychiatric ED Visits

Measure
OP-18c

Change from Base
-729 1,072

Average Median Wait Time All Hospitals for OP-18c

Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024
AAMC	394	383	353	385	393	372	363	349	344	330
ASCENSION SAINT AG..	379	342	389	330	371	384	387	391	402	365
ATLANTIC GENERAL	164	179	175	151	156	136	158		171	149
CALVERT		282	302	302	318	270	328	283	301	307
CARROLL	322	423	323	260	296	339	325	329	286	320
CHARLES REGIONAL	444	433	419	453	476	487	475	414	521	410
CHRISTIANACARE, UN..	202	236	238	260	253	250	237	341	306	316
DOCTORS	451	363	389	393	380	397	404	447	411	389
FREDERICK		343	335	376	426	395	435	484	433	396
FT WASHINGTON	729	847	1,078	0	0	0	0	1,801	629	381
GARRETT			288		288	167	154	144	166	169
GBMC	506	681	587	631	534	714	592	586	576	723
GERMANTOWN EMER..	87	69	0	0	0				246	105
GRACE	912	845	1,083	1,313	1,187	909	859	837	833	1,050
HARFORD MEMORIAL	325	375	292	347	380	387	437	371	654	
HOLY CROSS	751	609	726	701	586	642	524	577	569	633
HOLY CROSS GERMAN..	579	496	386	364	426	434	383	406	415	454
HOWARD	687	445	503	550	571	496	549	714	644	479
JH BAYVIEW	659	678	714	598	635	684	630	593	601	574
JOHNS HOPKINS	496	488	583	595	564	540	612	598	508	550
MEDSTAR FRANKLIN S..	353	365	337	324	328	370	405	406	398	366
MEDSTAR GOOD SAM..	324	333	292	314	364	285	337	351	315	273
MEDSTAR HARBOR	333	336	322	346	361	279	316	330	297	310
MEDSTAR MONTGOM..	276	320	302	345	386	309	392	416	322	396
MEDSTAR SOUTHERN ..	390	426	422	399	467	432	479	491	398	412
MEDSTAR ST. MARY'S	302	293	310	271	289	295	297	290	293	269
MEDSTAR UNION ME..	401	332	307	325	359	299	359	346	342	303
MERCY	276	302	287	274	289	275	269	324	326	258
MERITUS	269	251	246	262	266	301	284	293	256	283
NORTHWEST	700	776	698	767	677	669	713	739	680	776
SHADY GROVE	574	294	741	1,323	466	411	288	330	478	288
SINAI	692	672	648	717	622	518	698	659	833	773
SUBURBAN	300	322	359	299	362	300	291	308	295	277
TIDALHEALTH MCCRE..			24	52	140	369	74	133	74	37
TIDALHEALTH PENINS..		202	225	254	189	270	227	208	197	226
UM BWMC	413	469	377	446	420	446	553	443	440	434
UM CAPITAL REGION	508	473	488	522	406	491	514	465	397	497
UM SHORE CHESTERT..	214	313	411	329	382	293	363	411	459	324
UM SHORE EASTON	276	265	330	314	275	258	307	366	274	307
UM ST. JOSEPH	537	656	548	611	576	451	469	479	420	471
UMMC DOWNTOWN	531	419	448	500	416	365	443	450	455	363
UMMC MIDTOWN	398	440	420	483	379	390	426	492	444	416
UPMC WESTERN MD	309	415	289	398	337	399	353	349	451	372
UPPER CHESAPEAKE	473	556	526	495	482	585	657	634	611	525
WHITE OAK	748	655	545	1,198	963	634	737	1,237	1,032	1,109

EMS Turnaround Public Reporting Measure

- Currently, MIEMSS provides weekly data reflecting turnaround time at the 90th percentile by hospital
  - Provides visibility on delays that have most impact on system performance
  - Not all hospitals have elected to receive this data
- MIEMSS provides monthly reporting on 90th percentile turnaround times by hospital for use in HSCRC programs

EMS Turnaround Times: March Performance

- 23 hospitals reported the 90th percentile of turnaround time was <=35 minutes
  - Net increase of 2 Hospitals from last month
- 27 hospitals reported the 90th percentile of turnaround time was 35-60 minutes
  - Net increase of 3 Hospitals from last month
- 2 hospitals reported the 90th percentile of turnaround time was over 60 minutes
  - Net decrease of 5 Hospitals from last month
- Hospitals with improving performance
  - (Average to high performing): Cambridge Freestanding ED, Good Samaritan Hospital, Grace Medical Center
  - (Low performing to average): Doctors Community Medical Center, Fort Washington Medical Center, Howard County Medical Center, St. Agnes Hospital, White Oak Medical Center
- Hospitals with declining performance
  - (High performing to average): Shady Grove Medical Center
  - (Average to low performing) : N/A

EMS Turnaround Times: March 2024 Performance

90th Percentile: 0-35 Minutes

Atlantic General Hospital
CalvertHealth Medical Center+
Cambridge Free-Standing ED
Chestertown
Frederick Health Hospital
Garrett Regional Medical Center
Germantown Emergency Center
Good Samaritan Hospital
Grace Medical Center
Holy Cross Germantown Hospital
Holy Cross Hospital
Johns Hopkins Hospital PEDIATRIC
McCready Health Pavilion
Meritus Medical Center
Montgomery Medical Center
Peninsula Regional
Queenstown Emergency Center
R Adams Cowley Shock Trauma Center
Shady Grove Medical Center +
St. Mary's Hospital
Suburban Hospital +
Union Hospital
Union Memorial Hospital
Upper Chesapeake Health Aberdeen
Walter Reed National Military Medical Center
Western Maryland

>35 Minutes

Anne Arundel Medical Center
Baltimore Washington Medical Center
Bowie Health Center
Carroll Hospital Center
Charles Regional
Doctors Community Medical Center
Easton
Fort Washington Medical Center
Franklin Square
Greater Baltimore Medical Center
Harbor Hospital
Howard County Medical Center
Johns Hopkins Bayview
Johns Hopkins Hospital ADULT
Laurel Medical Center
Mercy Medical Center
Midtown
Northwest Hospital
Sinai Hospital
St. Agnes Hospital
St. Joseph Medical Center
University of Maryland Medical Center
Upper Chesapeake Medical Center
White Oak Medical Center

>60 Minutes

Capital Region Medical Center
Southern Maryland Hospital

(+): Hospital improved by one or more categories; **(-)**: Hospital declined by one or more categories

maryland
health services
cost review commission

TO:
HSCRC Commissioners

FROM:
HSCRC Staff

DATE:
April 10, 2024

RE:
Hearing and Meeting Schedule

May 8, 2024 To be determined - Zoom

June 14, 2024 To be determined - Zoom

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.