maryland
health services
cost review commission

613th Meeting of the Health Services Cost Review Commission
November 8, 2023

(The Commission will begin in public session at 11:30 am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00pm)

CLOSED SESSION
11:30 am

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

Informational

1. Meritus Behavioral Health Crisis Center and Urgent Care Center Presentation

Subjects of General Applicability

2. Review of Minutes from the Public and Closed Meetings on October 11, 2023
3. Final Adoption of Proposed Regulation - Accounting and Budget Manual: COMAR 10.37.01.02
4. Recommendation on Adjustment to MPA Savings Component
5. Draft Recommendation on Quality-Based Reimbursement Program for RY 2026
6. Policy Update and Discussion
    a. Model Monitoring
    b. Emergency Department Dramatic Improvement Effort (EDDIE) Update

Specific Matters

7. Docket Status – Cases Closed

    2632A University of Maryland Medical Center
    2633A University of Maryland Medical Center
    2634A University of Maryland Medical Center
    2635A John Hopkins Health System

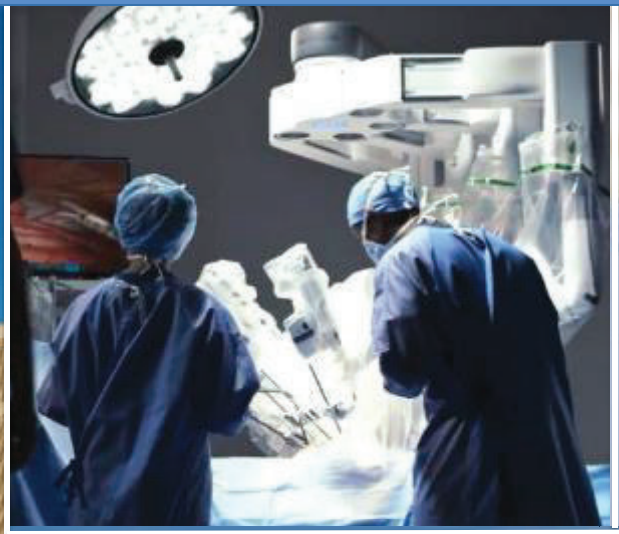
2636N Adventist Shady Grove Medical Center
2600A University of Maryland Medical Center - Request for Extension

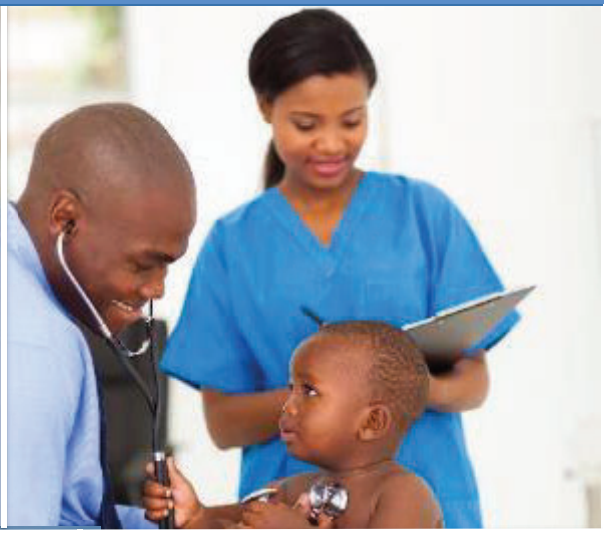
8. Docket Status – Cases Open

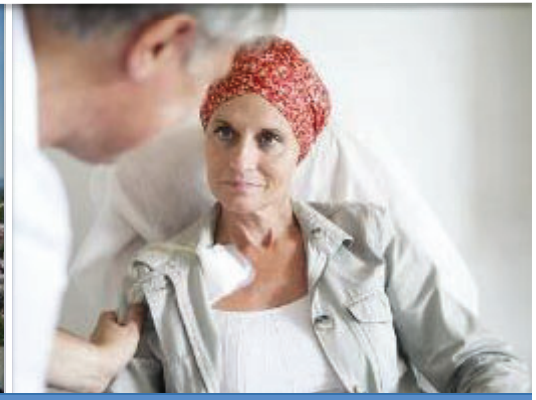
2631N Tidal Health Peninsula
2627A John Hopkins Health System
2628A John Hopkins Health System
2629A John Hopkins Health System
2637A John Hopkins Health System
2638A John Hopkins Health System
2639A John Hopkins Health System

9. Hearing and Meeting Schedule

Meritus Health



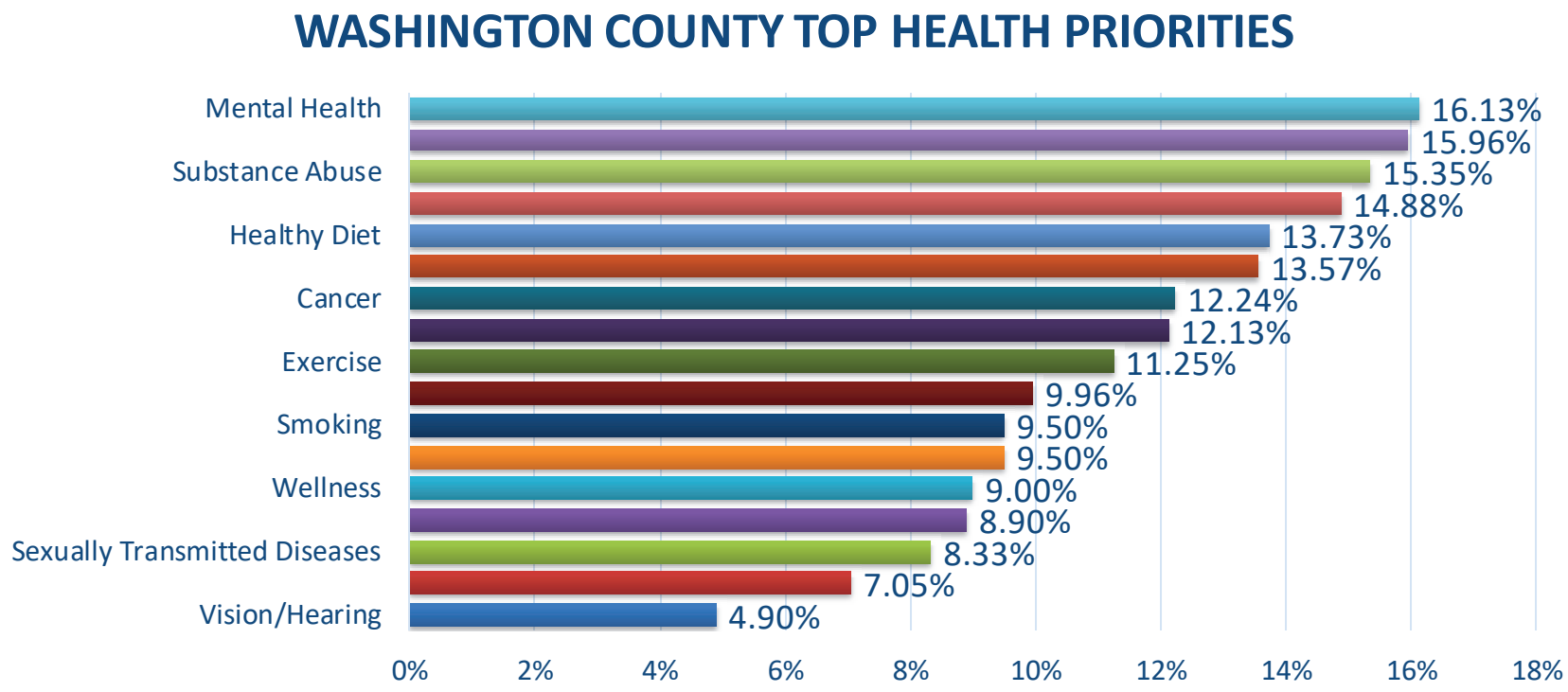




Crisis Center and Mental Health Urgent Care

November 8, 2023

The Problem



- Increased rates of **suicide** and **drug overdose fatalities**
- 20th out of 24 in Maryland for health outcomes

Meritus Health

The Crisis Center Pilot

- Began 3 bed pilot in 2022
- Co-located in our mental health inpatient unit
- Had to overcome patients' stigma with transferring to the unit
- Extremely successful outcomes

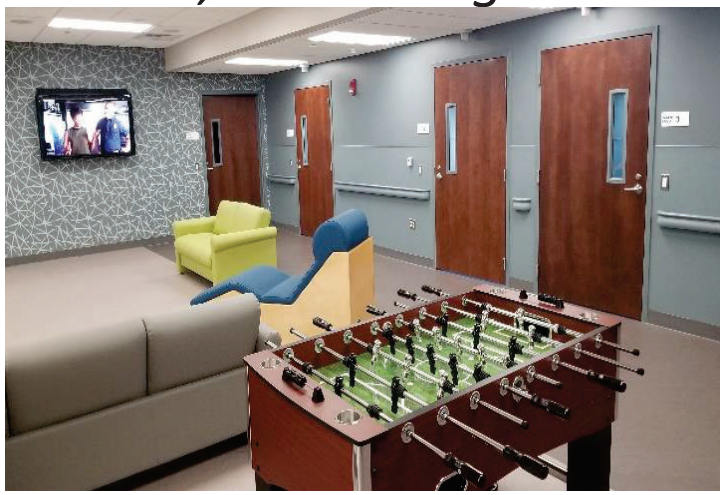
<u>Outcomes from our pilot</u>

- ~300 Patients in 3-bed pilot
- 75% successfully transitioned to long term treatment
- 22% readmission rate in 30 days
- 27% readmission rate in 90 days

Meritus Health

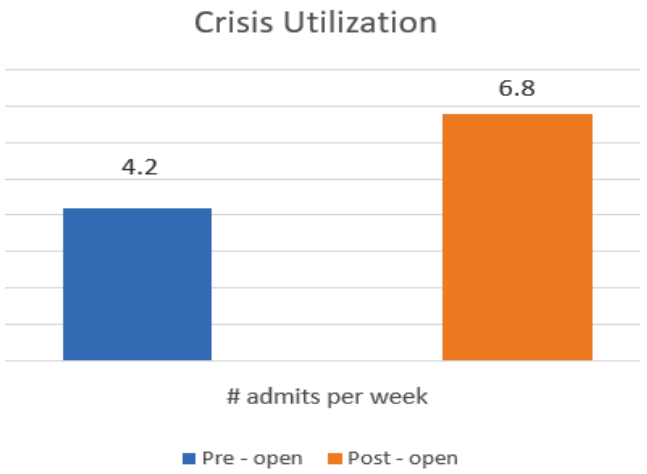
The Crisis Center – Beyond the Pilot

Crisis stabilization center *means a home-like environment to address substance crisis situations with a multidisciplinary team providing basic supportive care, medical assessment, and linkage to treatment for recovery*



Core Principles

- Available 24/7/365 with "no wrong door" policy
- Immediate crisis intervention
- Home-like environment
- Trauma-Informed Care
- Zero Suicide risk assessment
- Safety/Security
- Staff with multidisciplinary care team;
  Physician, CRNP, LCSW-C, Peer support
- Partner with community
- 6 beds



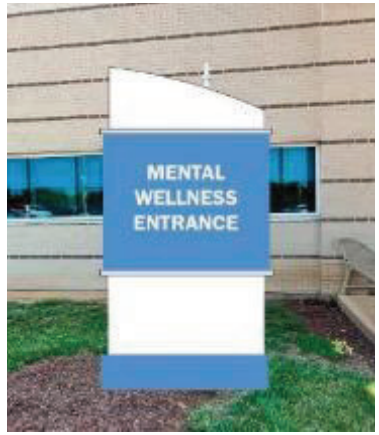
Mental Health Urgent Care

In partnership with Brook Lane

BROOK LANE
Hope · Healing · Recovery

- Everyone ages 6+
- Direct Admitting to Meritus or Brook Lane for adults and peds
- Comfortable environment with group therapy and activities
- Prioritizing stabilization and transition to a long-term treatment relationship
- Started September 2023

As soon as we opened, 20+ patients per week began using the service



Connection to the Maryland Model

- The GBR model allowed for re-envisioning use of hospital space and allowed for the creation of new, much needed, services in the community.
- These new services help divert patients away from the emergency room to a more appropriate care setting, which will help reduce potentially avoidable utilization.
  - Total cost of care savings will be generated by treating patients in the most appropriate care setting.
- The innovation component of the model allows hospitals and health systems to pursue the care patients need for both medical AND non medical services.

Meritus Health

Implications

- This endeavor is repurposing GBR dollars at the onset to hopefully gain hospital utilization savings and improve ICC efficiency.

- Coordination with all payers.

- Coordination across community partners through joint ventures and other collaboration efforts allow for expanded access to mental health services. Focus on improving access to care, **including non medical services**, is an investment in reducing total cost of care.

Meritus Health

MINUTES OF THE 612th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION October 11, 2023

Chairman Adam Kane called the public meeting to order at 11:07 a.m. In addition to Chairman Kane, in attendance were Commissioners Joseph Antos, PhD, James Elliott, M.D., Ricardo Johnson, Maulik Joshi, Nickki McCann, and Dr. Josh Sharfstein. Upon motion made by Commissioner Joshi and seconded by Commissioner Elliot, The Commissioners voted unanimously to go into Closed Session. The Public Meeting reconvened at 1:16 p.m.

STAFF UPDATE

Jon Kromm, Executive Director introduced Deborah Rivkin as a new member of the staff. Ms. Rivkin position will be Director, Government Affairs.

REPORT OF OCTOBER 11, 2023, CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the items discussed at of the October 11, 2023, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE SEPTEMBER 13 , 2023, PUBLIC MEETING, AND CLOSED SESSION

The Commission voted unanimously to approve the minutes of the September 13, 2023, Public Meeting and Closed Session.

ITEM II
CLOSED CASES
N/A

ITEM III
OPEN CASES

2636N- SHADY GROVE MEDICAL CENTER

On August 31, 2023, Shady Grove Medical Center ("SGMC" or "the Hospital") submitted a partial rate application requesting a rebundled rate for Radiation Therapy (RAT) services.

The purpose of this rate application is to establish a rebundled rate for inpatients who need radiation therapy services. SGMC will no longer provide this service at the Hospital. Inpatients requiring RAT services will be transported for treatment to Shady Grove Adventist Aquilino Cancer Center, an unregulated facility. Charge for services provided to inpatients can only be billed by the Hospital.

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. Based on the information received, Shady Grove requested a RAT service rate of $8.82 per RVU, while the statewide median rate for RAT service is $14.29 per RVU.

Staff Recommendation is as follows:

1. That the RAT rate of $8.82 per patient days be approved effective October 1, 2023;
2. That the RAT rate center is not rate realigned because it is a rebundled rate; and
3. A reduction be made to the FY24 GBR based on the deregulation activity.

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

2600A- UNIVERSITY OF MARYLAND MEDICAL CENTER

Staff recommended approval of a 60-day extension for the University of Maryland Medical Center alternative rate arrangement determination with OptumHealth Care Solutions Inc.

The Commissioners unanimously approved the Staff's request.

ITEM IV
COMMUNITY BENEFITS- FY 2022 ACTIVITIES

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Ms. Megan Renfrew, Associate Director, External Affairs, and Ms. Laura Spicer, Director, Hilltop Institute, presented an overview FY 2022 Maryland Community Benefit Report (CBR) (see "Maryland Hospital Community Benefit Report: FY 2022" available on the HSCRC website).

In summary, FY 2022 CBRs were submitted for all 51 Maryland hospitals, showing nearly $2.06 billion in community benefit expenditures, slightly higher than in FY 2021. The distribution of expenditures across community benefit categories remained like prior years, with mission driven services accounting for most expenditures. Overall, expenditures as a percentage of operating expenses slightly decreased from 10.7% in FY 2021 to 10.6% in FY 2022. After accounting for rate support, expenditures as a percentage of operating expenses decreased from 6.6% to 6.2% (partially driven by accounting for additional types of rates support this year). Staff appreciates hospital efforts to meet the new reporting requirement for itemizing Community Health Need Assessment (CHNA) related community benefit expenditures.

The narrative portion of the CBR provides the HSCRC with richer details on hospital community benefit and CHNA activities beyond what is included in the financial report. Encouraging findings of the review include a senior-level commitment to community benefit activities and community engagement. For

example, most hospitals employed a population health director, and most reported that these staff members were involved in selecting the community health needs to target and in developing community benefit initiatives. Most hospitals employ staff dedicated to community benefits, and most report having initiatives targeting the Statewide Integrated Health Improvement Strategy goals.

Commissioner Sharfstein asked if hospitals' service areas in the CBRs are the same as the Primary Service Areas defined in hospital GBR agreements.

Ms. Renfrew confirmed that there was a significant overlap between the two sources, but they are not required to be identical.

Commissioner Joshi noted that several CHNAs are more than three years old.

Staff explained that this is likely due to timing Hospitals whose CHNAs are more than three years old in the CBR have likely completed a new CHNA.

Commissioner Joshi pointed out that there was a considerable variation in indirect cost ratios and asked if there were any policies that should be enacted to address this issue.

Ms. Renfrew explained that Staff intends to improve reporting instructions on this issue and is working with hospitals to ensure that the variations are understood.

Commissioner McCann noted that many hospitals claim zip codes in and around Baltimore city. This highlights the need to discuss how resources are aligned and allocated across the state, particularly considering that Baltimore city has some of the worst health outcomes even though most hospitals claim these zip codes in their CBRs.

ITEM V
POLICY UPDATE AND DISCUSSION

Model Monitoring

Ms. Deon Joyce Chief of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 6 months ending June 2023. Maryland's Medicare Hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce noted that Medicare Nonhospital spending per-capita was unfavorable when compared to the nation. Ms. Joyce noted that Medicare Total Cost of Care (TCOC) spending per-capita was favorable when compared to the nation. Ms. Joyce noted that the Medicare TCOC guardrail position is 2.91% below the nation through June. Ms. Joyce noted that Maryland Medicare hospital and non-hospital growth through June shows a savings of $171,125,000.

ED Wait Times Update

Alyson Shuster, Deputy Director, Quality Methodologies, and Geoff Dougherty, Deputy Director, Population-Based Methodologies, Analytics, and Modeling presented an update on strategies to address

Emergency Department performance (see "Emergency Department Dramatic Improvement Effort" available on the HSCRC website).

At the June Public Meeting, Staff stated that the state legislature requested that Staff and MHA convene a workgroup to identify solutions to improve hospital Emergency Department (ED) performance.

Maryland has underperformed on ED measures since before the start of the All-Payor model.

The workgroup task will address:

- ED challenges due to significant lack of statewide Emergency Medical Services units.
- Developing payment policies for ED wait times and avoidable ED for CY 24
- Identifying short-term policies that could spur rapid city improvement.

To help improve the ED performance the workgroup developed the Emergency Department Dramatic Improvement Effort (EDDIE) project.

Staff implemented the EDDIE project in August.

EDDIE is a short-term reporting project that will be used for conversation and input. The components to be addressed are as follows:

The first component of EDDIE is a rapid cycle Quality Initiative (QI) that will be led by MHA. MHA has hired a contractor to lead 4 hospital group discussions on how to address ED length of stay.

All hospitals submitted an initial aim statement to MHA as part of the rapid-cycle QI initiative.

- Submitting initial aim statements represents an important first step.
- The intent for the EDDIE Project is to engage in a multi-cycle improvement process to bring Maryland ED length of stay (i.e., wait times) towards the national average within an agreed upon time frame.
- Ongoing monthly progress updates will be critical for executing the intended multi-cycle improvement process.

When reviewing these aim statements, Staff determines if the statements were specific, measurable, achievable, realistic, and timely. Staff believes that the hospitals may need to clarify their aim statements so that they are specific enough to be monitored.

The staff has determined that the next step is to decide on statewide long-term goals and a timeframe for achievement. They will also monitor progress on QI sprints to ensure achievement of long-term goals.

The second component of EDDIE is the monthly, public reporting of three measures:

- ED1 Inpatient arrival to admission time

- OP18 Outpatient ED arrival to discharge time.
- EMS turnaround time (data from Maryland Institute for Emergency Systems)

Staff received September reports from all hospitals (except Garrett Memorial). Some hospitals have resubmitted previous months reports as they work through the process of providing the metrics shortly after the end of the month.

Garrett Memorial submitted alternative metrics but is working to report requested metrics.

EDDIE results are as follows:

- ED1a- ED Arrival to Inpatient Admission Time
- OP18a- ED Arrival to Discharge Time
- EMS Turnaround Time

EDDIE's August results reports the following:

- ED1a- ED Arrival to Inpatient Admission Time

Data results show no dramatic movement from arrival to Inpatient admission. Staff was not surprised with the results considering that EDDIE is a new program. Staff believes that results will improve over the next several months.

- OP18a- ED Arrival to Discharge Time

Again, data results show no dramatic movement from arrival to discharge time. Staff is not surprised with results considering that EDDIE is a new program. Staff feel that results will improve over the next several months.

- EMS Turnaround Time (ambulance to hospital)

    - 44 Hospitals turnaround time is under 35 minutes.
    - 7 Hospitals turnaround time is greater than 60 minutes.

Dr Shuster stated that the next steps are as follows:

- Provide Commissioners with draft recommendation for inclusion of ED related measures in RY26 (CY24) Quality Based Reimbursement.
- Continue monthly data collection from hospitals and MIEMSS.
    - Address reporting questions and concerns with hospitals.
    - Present results at monthly Commission meeting.
    - Add visualizations suggested by Commissioners and other stakeholders.
- Collect and present progress on hospital improvement goals from MHA at the monthly Commission meeting.

- Collaborate with MHA on legislative request and EDDIE quality improvement initiative.

Commissioner McCann asked when the General Assembly Task Force (GATF) was going to conclude its work and when will we expect to see the outcome of that work.

Dr. Dougherty stated that he believes that the deadline is January for this report.

Commissioner McCann stated that she would be reluctant to approve any program without seeing the outcome of the GATF report. She stated that until we understand the root cause why ED wait times in Maryland are so different from the rest of the nation, that no QBR measures will have an impact.

EQIP and CTI Performance Update

William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, Gene Ransom, Chief Executive Officer, MedChi, and Jessica Heslop, Program Manager, CRISP, presented an update on the Episode Quality Improvement and Care Transformation Initiative programs (see " The Episode Quality Improvement Program and Care Transformation Initiatives" available on the HSCRC website)

The Episode Quality Improvement Program (EQIP) is a voluntary program engaging non-hospital practitioners and suppliers in care transformation and value-based payment through an episode-based approach.

By providing incentive payments based on financial and quality performance, EQIP aims to:

- Increase practitioners' accountability for improving quality of care and reduce healthcare spending, by eliminating low-value care, shifting care to lower-cost settings, increasing care coordination, and fostering quality improvement.
- Encourage physicians interested in continuously transforming care to align with value-based payment policies and Maryland hospital Global Budget Revenues.
- Shift to physician-focused, value-based care reimbursement to create environments that stimulate development and deployment of evidence-based knowledge.
- Increase the likelihood of better health at lower cost through patient education and ongoing communication throughout the clinical episode.

EQIP uses the Prometheus Episode Grouper and episodes that are created by Maryland physicians. This approach has allowed Maryland Physicians to define their own value-based payment models. EQIP works directly with physicians and allows them to earn a portion of the savings they create through better care management. EQIP helps to align physicians with the hospitals and the TCOC Model. By succeeding in EQIP, physicians will help the state meet its savings target and reduce potentially avoidable hospitalizations.

EQIP year 1 results are as follows:

- EQIP saved $20 million in total cost of care in 2021. Overall, EQIP episodes accounted for ~$400 million in costs so the savings rate was approximately 5%.

    - Savings were only counted if the entity exceeded a 3% minimum savings rate, which was created to ensure that savings and payouts from EQIP would be statistically significant.
    - 19 EQIP entities earned savings out of a total of 50. However, most of the smaller practices had difficulty earning savings.

- Based on the savings, we expect to pay out $13 million in incentive payments to physicians (i.e., 60% of the total earned savings).

- The amount of savings earned by the practices was partially determined by the number of episodes the practice had.

    - On average the top quintile in terms of volume saved about $1 mil. The lower quintiles had very little impact.
    - Similarly, the average percent savings per episode was correlated with the number of episodes.
    - Note there is substantial variation within the lower quartiles. For instance, Q5 varies from +29% to -22% episode savings.

    - This could be because larger practices had more resources to use in the program.
    - It could also be because the statistical noise from the small sample size has washed out the signal from the program.

EQIP overall assessments and next steps are as follows:

- HSCRC is conducting a post-episode monitoring analysis, to be completed prior to payment.
- CRISP Learning Collaborative has commissioned a formal evaluation study, they expect to release it in the next 3-6 months.
- CRISP/MedChi to host Learning Collaborative highlighting practices earning incentive payments.
- The Year 1 results are favorable and exceeded our expectations.

    - The program savings exceeds that from CMMI's bundled payment programs and other programs nationally.
    - While the dollar value of the savings is small in the context of MD TCOC, EQIP could have a substantial impact on the savings test if the savings rate can be maintained as the program grows.

- Years 2 and 3 will substantially expand the program.

    - Staff had added new episodes. 25 new episodes in Year 2 and 5 new episodes in Year 3.
    - The number of participants is also increasing substantially. We expect to have around 4 thousand participants in Year 3, about 2 times the size of the program in Year 1.

- Support for smaller practices

    - In Year 3 MedChi assisted smaller practices in grouping together into single entities
    - In Year 4+, we are considering providing practices with some practice transformation support.

        1. Currently, EQIP has been very low touch with practices, meaning limited engagement between HSCRC / CRISP staff and the practices.
        2. This has ensured that the administrative burden of the program on participants remains small. However, it is clear that small practices may not have the resources to identify and deploy interventions that will lead to their success.
        3. Practice transformation support could help raise the smaller practices to the level of success of the best performing practices.

Care Transformation Initiatives (CTIs) focus on identifying hospital investments that provide a return on investment through beneficiary-level TCOC reductions. CTIs enable hospitals to define their own populations reflective of their current work and incentivize the development of new efforts to transform care in Maryland.

The CTI program allows hospitals to define their own populations to focus on. It provides all hospitals with 'first dollar' savings, and distributes savings in a net neutral manner, so that hospitals that do not participate (or do not make a successful effort) in care transformation are penalized.

CTI are grouped into "thematic areas" which share a common attribution methodology and parameters that hospitals can use to select their population. These "thematic areas" are as follows:

- Care Transitions- Interventions focusing on transitional care management.

- Palliative Care- Interventions to manage and direct the care of chronic pain patients.

- Primary Care (Episodic or Panel-Based)- Interventions to improve primary care services.

- Community-Based Care (PAC Touch or Geographic)- Interventions targeting the broader health community.

- Emergency Care- Interventions to improve access to clinical and social services for users of the emergency department.

Each CTI has a target price that is based on the TCOC of the beneficiaries attributed to the CTI in the baseline period.

- Baseline period costs are updated for inflation and risk adjusted.

- This compares hospitals to their own historical performance. Hence, this is an improvement only program.
- Baseline periods can be set back as far as FY17 to try and recognize early adopters.

Hospitals earn savings if their performance period costs are less than the target price.

- Hospitals earn 100% of the savings they achieve that exceed a Minimum Savings Rate. This ensures that all payments are made for savings that are statistically significant.
- All shared savings payments are offset on a statewide basis. Hospitals that are less successful in the CTI will pay for the savings of those hospitals that were successful in the CTI.
- This ensures that Medicare continues to benefit from care transformation and that hospitals not engaged in successful care transformation pay their fair share of meeting the statewide savings target.

Year 1 CTI results are as follows:

- All hospitals participated in the CTI program and nearly 25% of the State's Medicare population was attributed to a hospital's clinical care transformation program.

- Overall, the CTI program accounted for nearly $130 mil. of the State's overall run rate.

    - The range of savings varied from -3% to +7% of the hospital's Medicare FFS revenue.
    - The CTI program redistributed about $56 mil. in revenues. This is the amount that is moved from one hospital to another.
    - If a hospital earns its share of the Statewide savings, then its shared savings is equal to its share of the statewide offset.

Mr. Henderson stated that the next steps are as follows:

- Staff will continue analyzing the CTI to try and identify what is driving success.

    - Some additional discussion in CTI evaluation reports sponsored by CRISP Learning Collaborative.
    - Most of the drivers of success are likely to be operational drivers, that we cannot identify through claims analysis.
    - We plan to work with CRISP and MHA to try and create some lessons learned that could be exported to other hospitals.
    - We will continue to analyze the CTI definitions, including NPI composition, and report to the CT Steering Committee.

- Staff is asking for industry comments on revisions by October 11, 2023. Revisions will be incorporated, as needed, in the upcoming MPA proposal. Planned adjustments:

    - Cap downside risk

- Request to restore CTI buy out in MPA policy.

COMMISSION UPDATE

Chairman Kane announced that Dr. Sharfstein will be the new Chairman starting with the November Public Meeting. Chirman Kane will stay on the Commission as a Commissioner.

ITEM VI
HEARING AND MEETING SCHEDULE

November 8, 2023, Times to be determined- 4160 Patterson Ave
HSCRC Conference Room
December 13, 2023, Times to be determined- 4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:31 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

October 11, 2023

Upon motion made in public session, Chairman Kane called for adjournment into closed session to discuss the following items:

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

3. Update on Commission Response to the COVID-19 Pandemic – Authority General Provisions Article, §3-103 and §3-104

4. Consultation with Legal Counsel-Authority General Provisions Article, Section §3-305

The Closed Session was called to order by motion at 11:07 a.m.

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

In attendance representing Staff were Jon Kromm, Jerry Schmith, Allan Pack, William Henderson, Claudine Williams, Deb Rivkin, Geoff Dougherty, Alyson Schuster, Megan Renfrew, Erin Schurmann, Cait Cooksey, Bob Gallion, and Dennis Phelps.

Also attending were:
Eric Lindemann, Commission Consultant, Sule Gerovich, Senior Fellow-Mathematica, and Ari Elbaum Commission Counsel.

Executive Director Kromm introduced Kim Rivkin, a new member of the Staff leadership team.

Item One

Ms. Gerovich summarized, and the Commissioners and staff discussed the history and context of the All-payer and TCOC Models.

Item Two

Allan Pack and William Henderson, Staff Directors, updated the Commission and the Commission discussed TCOC Model priorities and opportunities.

Item Three

Mr. Lindemann updated the Commission and the Commission discussed Maryland Medicare Fee-For-Service TCOC versus the nation.

Item Four

William Henderson, Director, Medical Economics & Data Analytics, briefly updated the Commission on the hospitals' unaudited financial performance through August 2023.

Item Five

Commission Counsel updated the Commission on legal matters.

The Closed Session was adjourned at 1:12 p.m.

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Final Adoption of Proposed Regulation - Accounting and Budget Manual

Title 10
MARYLAND DEPARTMENT OF HEALTH
Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION
10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

- Notice of Final Action
  - On November 8, 2023, the Health Services Cost Review Commission adopted amendments to the Regulation .02 under COMAR 10.37.01 “Uniform Accounting and Reporting System for Related Institutions”. This action, which was proposed for adoption in 50.1 Md. R.7 (August 25, 2023) has been adopted as proposed. The comment period closed on September 25, 2023, with no comments received.

- Recommendation
  - That the commission approves the Final Adoption of the Proposed Regulation effective December 11, 2023.

Title 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§19-207 and 19-215, Annotated Code of Maryland

Notice of Final Action

[22-162-P-I]

On November 8, 2023, the Health Services Cost Review Commission adopted amendments to Regulation **.02** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions.** This action, which was proposed for adoption in 50:17 Md. R. 772-773 (August 25, 2023), has been adopted as proposed.

Expected Effective Date: December 11, 2023

Recommendation on Adjustment to MPA Savings Component

Staff recommend that the Commission should reverse the entire $64 Million MPA-SC reduction implemented earlier in 2023 as follows:

1. Execute an offsetting adjustment in December of 2023 such that the net reductions to hospitals in CY2023 are only $50 Million resulting in a $14 M revenue increase for hospitals. The adjustment should be distributed on the same basis as the original reductions.
2. Redirect the remaining $50 Million to be used in two primary care-related care transformation efforts as follows:
   a) $31 Million to contribute to the accelerated start-up of a Maryland Primary Care (MDPCP) aligned program focused on Medicaid.
   b) $19 Million to establish a value-based program focused on creating funding for primary care providers entering previously underserved markets.

The provisions of this recommendation are contingent on CMMI approval of the reversal of the $64 Million MPA-SC for CY2023 and should such approval not be received none of this recommendation will be implemented.

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Final Recommendation On Adjusting the MPA Savings Component for Calendar Year 2023

November 8, 2023

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Table of Contents

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Background

In December 2019 the Commission approved the Medicare Performance Adjustment Framework (the Framework) as part of implementing the Medicare Performance Adjustment (MPA) described in the Total Cost of Care Model State Agreement (TCOC Model Agreement). Under the Framework the Commission could implement reductions to hospital Medicare reimbursements in order to achieve the Medicare savings target established in the TCOC Model Agreement. Such reductions were known as using the MPA Savings Component (MPA-SC).

In December 2022, concerned about the level of savings being achieved, the Commission approved the use of $64[1] Million in MPA-SC reductions to ensure the State did not miss the Calendar Year 2023 (CY2023) Medicare savings target. The reduction was implemented only for CY2023 and sunsets at the end of the year.

In addition to Commission approval, all adjustments to the MPA are reviewed and approved by the Center for Medicare and Medicaid Innovation (CMMI). The $64 M reduction described above was approved by CMMI in early 2023.

Recommendation

Staff recommend that the Commission should reverse the entire $64 Million MPA-SC reduction implemented earlier in 2023 as follows:

1. Execute an offsetting adjustment in December of 2023 such that the net reductions to hospitals in CY2023 are only $50 Million resulting in a $14 M revenue increase for hospitals. The adjustment should be distributed on the same basis as the original reductions.
2. Redirect the remaining $50 Million to be used in two primary care-related care transformation efforts as follows:
    a. $31 Million to contribute to the accelerated start-up of a Maryland Primary Care (MDPCP) aligned program focused on Medicaid.
    b. $19 Million to establish a value-based program focused on creating funding for primary care providers entering previously underserved markets.

[1] Staff recommended $50 M but that amount was increased to $64 M in a Commissioner amendment as documented in the minutes of the December 2022 Commission meeting.

Staff believe the reversal is appropriate given the State's current stronger position on the Medicare savings test and because the reductions were (a) one-time in nature, (b) not applied on an all-payer basis and (c) specifically enacted to meet Medicare savings goals when those goals were thought to be at risk. Staff recommend redirecting $50 Million to fund care transformation programs rather than completely restoring hospital revenue because (a) CMMI continues to emphasize the importance of population health investments in the continuation of the model and (b) hospitals already received an offset to this lost revenue via a change in the Fiscal Year 2024 Medicaid Deficit Assessment.

Staff also note that the provisions of this recommendation are contingent on CMMI approval of the reversal of the $64 Million MPA-SC for CY2023 and should such approval not be received none of this recommendation will be implemented.

CY2023 Medicare Savings Target Position

In the materials for the November 8, 2023 Commission meeting Staff will present that the State is 2.74% below the guardrail target in the TCOC Model Agreement and has accumulated $188 Million of incremental Medicare savings through July 2023. Combining the year-to-date savings with the $269 M of savings reported for 2022, results in a run rate of $457 M or $157 M above the $300 M target set in the TCOC Model Agreement. Staff anticipated greater saving in the first half of the year and expects lower incremental savings in the second half of the year but still expects to end the year with excess savings. Therefore, Staff are comfortable that reversing the $64M one-time MPA-SC will not impact the State's ability to pass the 2023 guardrail or savings test.

Proposed Programs

MDPCP-Aligned Medicaid Program

The Maryland Primary Care Program (MDPCP) is a voluntary program that supports participating primary care practices by providing funding and support for the delivery of "advanced primary care" services to their patients. Advanced primary care refers to the patient-centered medical home model where primary care physicians act as the quarterback of a patient's care. MDPCP, which began in 2019, is a component of the TCOC Model Agreement and is operated by the Maryland Department of Health (MDH).

Practices enrolled in MDPCP are expected to provide advanced features to all patients of the practice, but the additional funding provided currently is exclusive to Medicare Fee-for-service enrollees (although CareFirst BlueCross BlueShield has an aligned program). For some time, it has been a shared goal of CMMI and the State to expand funding to apply to Medicaid enrollees. The August 2022 MOU required Maryland to prioritize the development and implementation of a MD PCP Medicaid alignment policy, and It is anticipated that this will be a requirement of future agreements between the State and CMMI.

The State is currently working to arrange the funding to support MDPCP for Medicaid enrollees. But in the near term, to allow the program to commence, Staff recommends that $31 Million be set aside from the reversal of the MPA-SC to be used to provide funding for the initial expansion.

Primary Care Expansion Program

MDPCP focuses primarily on enhancing the quality of currently available primary care. However, this approach does not address areas of the State that do not currently have an adequate supply of primary care. For example, 20% of residents of Prince George's county live in a primary care Health Professional Shortage Area (HPSA), as designated by the US Department of Health and Human Services.

Therefore, Staff recommends directing the remaining $19 Million of MPA-SC reversals to fund a program to provide additional reimbursement to primary care practices who create new capacity in HPSA-designated primary care shortage areas. The following sections outline the program concept. Staff intend to complete a request for information to gather input from the industry and continue to work with CMMI and MDH on the program design so the information below is intended as a guide to the concept rather than final program design.

Program Framework

The program will be operated under the Episode Quality Improvement Program (EQIP). EQIP is the Commission's physician-focused value-based program. While the primary care program will not be episodic, the EQIP infrastructure does not depend on an episodic program. Using the EQIP infrastructure to implement this program allows Staff to leverage processes for implementation, reporting and payment that have already been established with CMMI, CRISP and MedChi, the Maryland State Medical Society. EQIP also provides a path for review with CMMI as it is governed under a template established under the Care Redesign Program track defined in the TCOC Model Agreement.

Delivery Model

The design and services of the proposed primary care capacity will be based on best practices from around the country for advanced primary care in underserved areas. The model will include a focus on common preventable conditions, such as hypertension, and will include community health workers hired from the communities served. The model will have expectations for use of health information technology and for data sharing with CRISP and the MDH

Payment Model

Participating practices will be required to align with or participate in the State's value-based payment programs for Medicaid and private insurers such as MDPCP. For Medicare, the HSCRC will provide value-

based payments based on total cost of care savings to the Medicare population, similar to the structure of EQIP payments in Maryland today.

Start-Up Costs

It is anticipated that the participating practices will incur significant start-up costs in identifying clinicians, purchasing systems, and building practices. The pilot program funds will go to support these start- up costs.

Outcomes

A comprehensive evaluation framework for the program will be established. Clinic level outcomes will include:

- Expansion of primary care capacity
- Quality metrics, similar to those used by MDPCP, with a focus on equity
- Patient satisfaction
- Total cost of care for attributed patients.

Population outcomes for the geographic focus areas will include:

- Use of primary care
- Utilization metrics, with a focus on equity: Potentially avoidable emergency department visits, low intensity emergency department visits, potentially avoidable hospitalizations
- Total cost of care

Timeline

Staff are targeting an enrollment process beginning in the Spring of 2024 with the program effective January 1, 2025. However, the final timeline will be revised as needed as the program is refined.

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Draft RY 2026 Quality Based Reimbursement DRAFT Policy

November 8, 2023

HSCRC Quality Team

QBR RY 2026 Policy Decisions

Addition of New Measures:

- Sepsis Bundle Measure (Sep-1)
- Timely Follow Up - Medicare disparity
- ED Length of Stay Measure
- Mortality – 30-day all-cause, all-payer

HCAHPS improvement– Collection of supplemental question(s)

Revenue Adjustment Methodology

- Revenue Adjustment Scale Cutpoint
- Revenue At-Risk for QBR
- Weighting of Measures in QBR

Performance Measurement Workgroup

Develops recommendations on measures and pay-for-performance methods, which are reliable, informative, and practical, for assessing hospital quality and population health.

- Clinical experts (cardiology, effectiveness research, emergency, epidemiology, gastrointestinal, hospitalist, infectious disease, OBGYN, orthopedic surgery, preventive medicine, primary care, public health)
- Clinical quality measurement experts (physician, nurse, quality measurement, QIO, digital measures)
- Nursing leadership (hospital leadership, academia, nursing sensitive measures)
- Consumer advocacy/ representatives (Families USA, community behavioral health)
- Hospital operations leadership (fiscal, quality, population health, CEO)
- Payer representatives (Medicaid managed care, Medicaid, commercial)
- Public policy (state policy makers, academic health policy and business)
- Health equity experts
- Diverse hospital representatives (MHA, academic, teaching, community, urban, rural)
- Diverse provider settings (hospital, primary care, specialty care, OBGYN care, community behavioral health)

PMWG Members

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

Addition of New Measures

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SEP-1 (The Severe Sepsis and Septic Shock Management Bundle)

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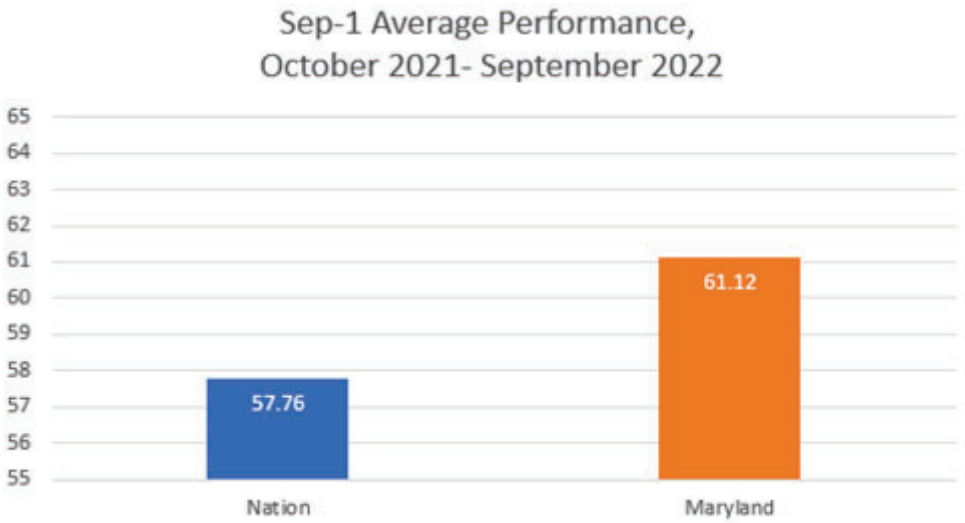
Sep-1 Sepsis and Septic Shock Bundle, Maryland Performs Better



Maryland Hospital Change from CY19 to 10/21-9/22	
	• 4 hospitals improved >50% • 6 hospitals improved 20%- 50% • 15 hospitals improved 1%- 20%
	• 10 hospitals declined 1%- 20% • 6 hospitals declined 20%-50%

- CMS adding to FY 2026 VBP; 2018 public reporting on Care Compare
- Reduces mortality
- "one fits all" therapeutic approach lacks sufficient evidence for diverse group of patients

PMWG discussion–

- Infectious Disease input, measure too broad; sepsis definition needs updates
- Maryland inpatient all-condition mortality measure includes sepsis
- QBR includes postop. sepsis as part of PSI 90 in Safety domain; Sepsis PPC

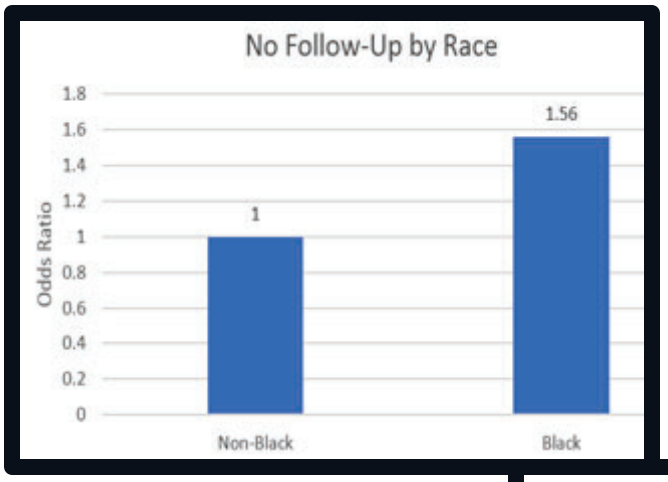
Disparities in Medicare Timely Follow-Up

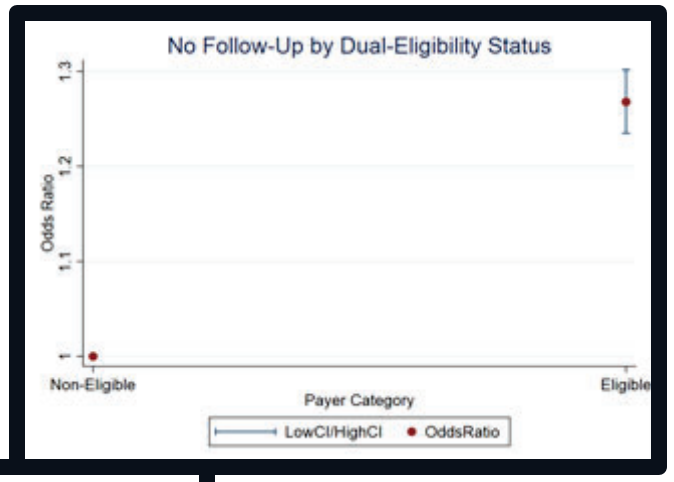
Timely Follow-up After Acute Exacerbations of Chronic Conditions

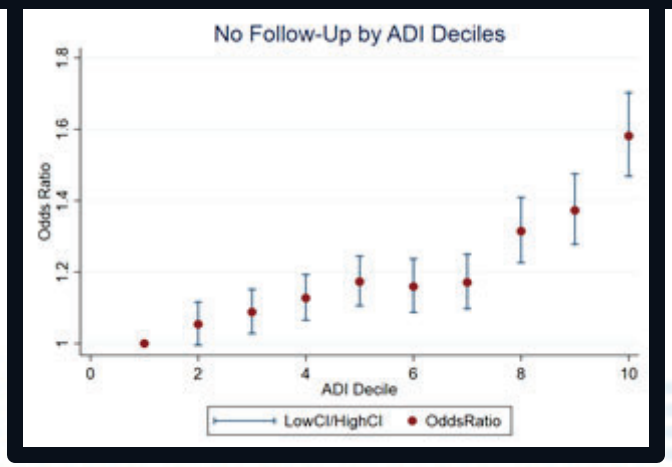
Included in SIHIS Care Transformation Domain

- NQF endorsed health plan measure that looks at percentage of ED, observation stays, and inpatient admissions for one of the following six conditions, where a follow-up was received within time frame recommended by clinical practice:
  - Hypertension (7 days)
  - Asthma (14 days)
  - Heart Failure (14 days)
  - CAD (14 days)
  - COPD (30 days)
  - Diabetes (30 days)
- Important link between hospitals and primary care, overlap with PQIs
- RY 2025- Measure included in QBR program in the Person and Community Engagement domain, weighted at 5% of the program
  - (2.5% Medicaid, 2.5% Medicare)

Disparities in Medicare TFU by PAI components Reveals Disparities for







Based on these results, HSCRC staff has been working over the last year to adapt the readmission disparity gap methodology to TFU for Medicare.

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SIHIS Domain 2: Goal #2, Targets vs Performance

Goal: Improve care coordination for patients with chronic conditions		
Measure	**GOALS: Timely Follow-up**	**Statewide Performance**
2018 Baseline	70.85%	
2021 Year 3 Milestone	72.38% 2.16 percent improvement	70.07% 1.10 percent reduction
2023 Year 5 Milestone	73.42% 3.62 percent improvement	72.08%, YTD through June 1.74 percent improvement
2026 Year 8 Final Target	75% or .50% better than national rate 5.86 percent improvement	

HSCRC was required to submit memo to CMMI on CY21 missed goal.

Memo emphasized that focus on reducing disparities in TFU would allow MD to meet future goal of 75 percent.

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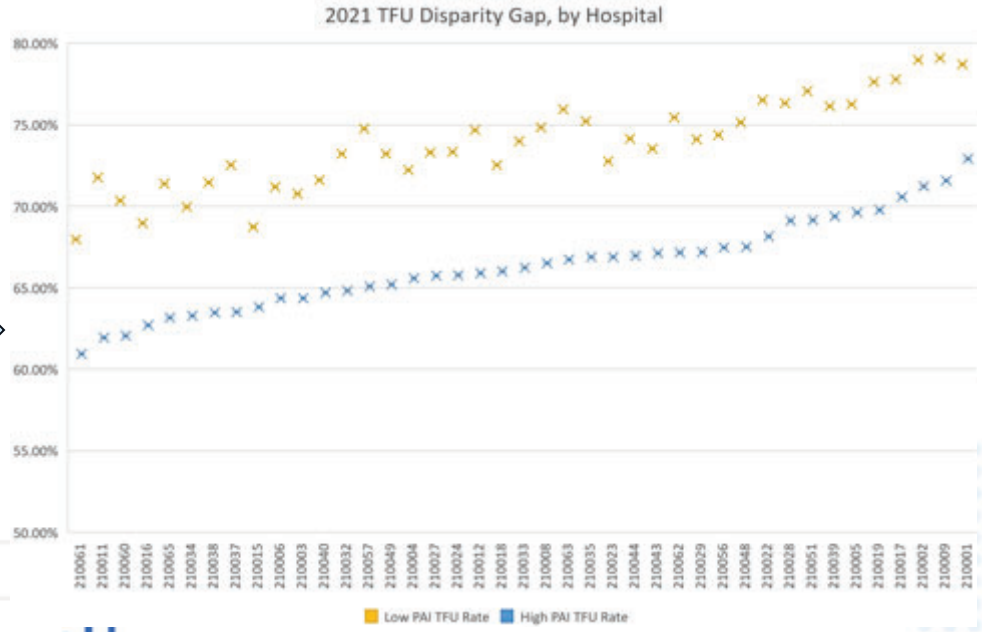
Key Components of TFU Disparity Gap Methodology

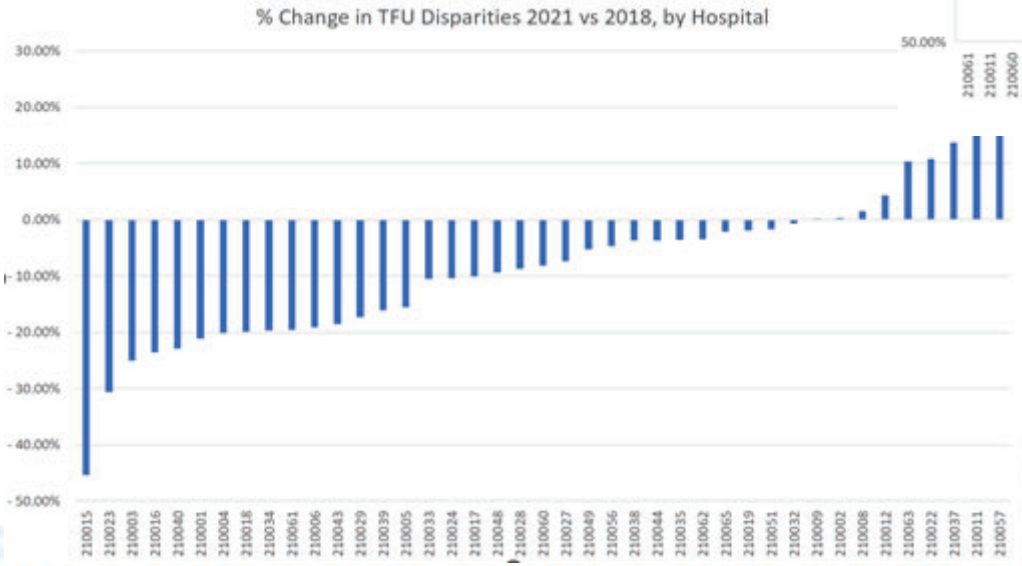
Methodology Modeled after Readmission Disparity Gap

- Medicare only (in future years staff plan to add Medicaid)
- Measure patient-level social exposures
  - Patient Adversity Index (PAI) = race, Medicaid coverage, ADI
- Estimate association between social exposures and likelihood of TFU at hospital level for baseline (2018)
- Estimate the association for each performance year
- Difference between performance year and baseline is disparity gap improvement
- No risk adjustment because TFU is a process measure

2021 TFU Disparity Gap and Percent Change,by Hospital

Disparity Gap Descriptive Statistics:
Min: 4.91%
Max: 9.84%
Median: 7.55%





Percent Change Descriptive Statistics:
Min: 18.91%
Max: -45.38%
Median: -8.13%

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Emergency Department Length of Stay Measures

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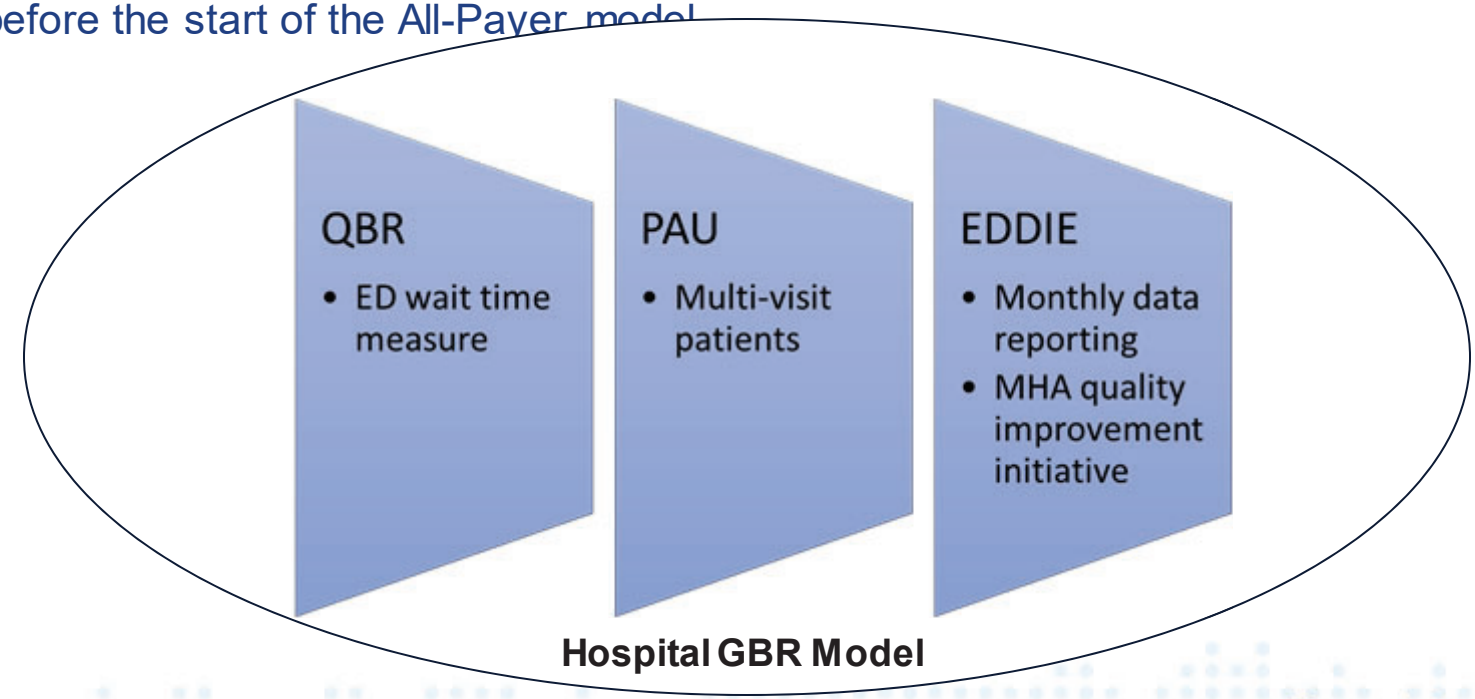
HSCRC Policies and Initiatives to Address ED Length of Stay*

ED length of stay in Maryland has been consistently higher than the nation since before the start of the All-Payer model



*In addition to HSCRC policies and initiatives, other activities like legislative task force are underway

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ED Length of Stay Measure Options

Appendix Slide has Pros and Cons of ED measures

Option 1: Delay implementation of an ED length of stay measure for admitted patients for one year so that staff can finalize measure development and selection.

Option 2: Approve inclusion of an existing ED measure for CY 2024. The options for existing measures would be OP-18 from Care Compare, which measures length of stay for non-admitted patients, or the EMS turnaround time measure.

Option 3: Approve inclusion of ED-1 like measure in RY 2026 QBR program, which will be finalized during CY 2024 and will not require additional Commission approval.

30-Day Mortality

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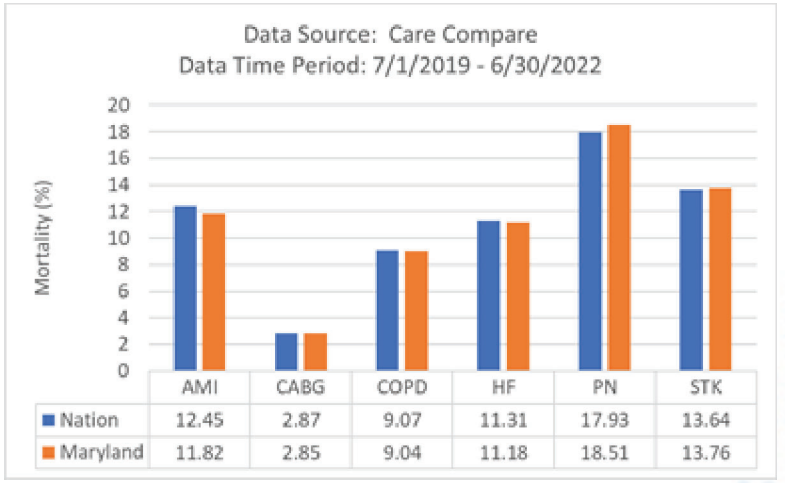
Transition from IP to 30-Day Mortality

- CMS VBP program assesses 30-day condition specific mortality; Maryland performs similar to the nation on CMS 30-day mortality measures
- CMS has also developed a hybrid all-cause 30-day mortality measure
- HSCRC worked with Mathematica to adapt CMS measures and develop an all-payer, all-cause 30-day mortality measure
- Appendix slides show measure exclusions (e.g., hospice patients, transfers, non-MD residents) and calculation steps



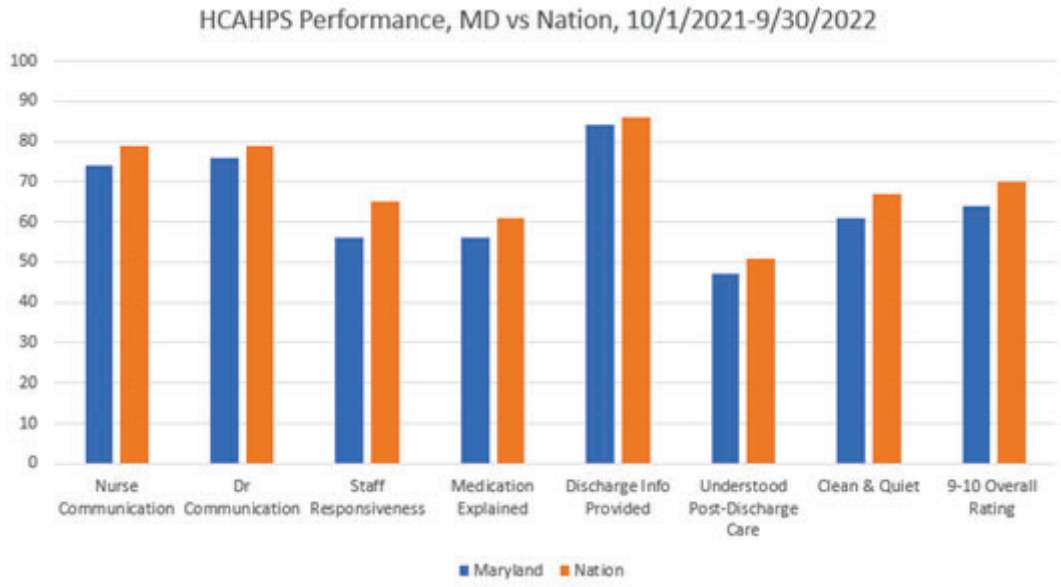
	AMI	CABG	COPD	HF	PN	STK
Nation	12.45	2.87	9.07	11.31	17.93	13.64
Maryland	11.82	2.85	9.04	11.18	18.51	13.76

Summary of New Measures

Measure	RY26 Staff Recommendation
Sepsis Bundle	Do not include for RY26. Continue to incentivize high quality sepsis care using mortality, PSI, PPCs in MHAC. Develop Sepsis Dashboard for ongoing monitoring.
Timely FU Disparity Gap	Include for RY26.
ED Length of Stay	See staff options for commissioner consideration.
30-day, all-payer, all-cause Mortality	Phase into QBR program by splitting mortality weight between inpatient and 30-day for RY26.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

HCAHPS Most Recent Available Performance, Maryland Under-Performs the Nation



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Strong Evidence on the Positive Impact of Hourly Rounding to Improve HCAHPS Scores

- In 2013 a study of 108 Press Ganey Inpatient clients asked whether a staff member visited hourly during their stay with 120,164 patients providing a yes/no response:
  - Patients who reported experiencing hourly rounding reported higher evaluations of care in all areas across both Press Ganey measures and HCAHPS measures; differences were statistically significant. http://www.theinstituteforinnovation.org/sites/default/files/public/resources/inspiring-innovation-stories_patient-report-of-hourly-rounding_final.pdf
- There is a growing body of literature about the impact of rounding: http://www.theinstituteforinnovation.org/sites/default/files/public/resources/Hourly-Rounds_Apr2018.pdf
- Advent Health System notes the following about hourly rounding:
  - The MOST IMPORTANT strategy, hardest to hardwire
  - Not the same as going into a room once an hour
  - MUST be done with intentionality around the following four patient needs:
    - PAIN- effort to control pain safely
    - POTTY- ensure safe toileting
    - POSITION- Reposition for comfort and skin protection
    - PERIPHERY- Room tidy, items in reach
  - RNs responsible for ensuring that Purposeful Hourly Rounding is occurring.

https://www.adventhealth.com/sites/default/files/assets/AHCentralFloridaNorth_PatientExperiencePresentation.pdf

HSCRC Next Steps to Target HCAHPS Improvement

- Continue analysis of supplemental questions, specifically rounding
- Discuss options, timing for adding supplemental questions statewide to HCAHPS survey
- Collaborate with MHCC on data collection and ongoing analysis of HCAHPS patient level data, with particular emphasis on disparities

QBR Revenue Adjustment Methodology

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QBR Cutpoint

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Revenue Adjustment Scale Cutpoint

- To account for COVID, RY24 and RY25 policies recommend to reassess reward/penalty cutpoint.
- Cutpoint is established by estimating how national hospitals would perform in QBR program across multiple years and averaging the average scores.
- RY26 Final recommendation will provide staff recommendations for the following RYs:

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

RY2024: Current cutpoint of 41% results in all but one hospital being penalized for a total $98M in penalties. Preliminary analyses indicate large drop in national scores.

RY2025: Will need to reassess next year with more recent data.

RY2026: Staff recommend to maintain current scale and again retrospectively evaluate

QBR Revenue-at-Risk and Measure Weighting Discussion

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Revenue At-Risk and Measure Weights

Addition of New Measures to QBR reduces measure weights

- To maintain salience of QBR incentive across multiple domains and measures, staff discussed adjusting revenue at-risk across QBR and MHAC programs:
  - Option 1: Continue to weight QBR at 2% with additional measures
  - Option 2: Move QBR safety domain to MHAC, maintain both QBR and MHAC at 2%
  - Option 3: Increase QBR 3%, Decrease MHAC 1%
- Stakeholders were hesitant to change revenue at-risk across quality programs without larger discussion.
- Thus, staff are **not proposing changes to total revenue at-risk** for QBR. However, staff is **proposing measure weighting changes** within QBR to ensure measure salience.

RY2026 Proposed Domain and Measure Weighting

RY2026 Proposed Weighting (2% total at-risk)	Domain Weight	QBR Program Weight	IP Revenue at Risk (%)	Revenue at Risk ($) for Hospital w/$250k IP Revenue
PCE Domain		60%	1.20%	$3,000,000
HCAHPS TopBox (8)	41.67%	25.00%	0.50%	$1,250,000
HCAHPS Consistency	16.67%	10.00%	0.20%	$500,000
HCAHPS Linear (4)	8.33%	5.00%	0.10%	$250,000
ED Wait Times	16.67%	10.00%	0.20%	$500,000
TFU Medicare	5.56%	3.33%	0.07%	$166,667
TFU Medicare Disparity Gap	5.56%	3.33%	0.07%	$166,667
TFU Medicaid	5.56%	3.33%	0.07%	$166,667
Clinical Care Domain		15%	0.30%	$750,000
IP Mortality	33.33%	5.000%	0.10%	$250,000
30-Day Mortality	33.33%	5.000%	0.10%	$250,000
THA/TKA	33.33%	5.000%	0.10%	$250,000
Safety Domain		25%	0.50%	$1,250,000
CAUTI	16.6667%	4.17%	0.08%	$208,333
C. Diff	16.6667%	4.17%	0.08%	$208,333
SSI (2)	16.6667%	4.17%	0.08%	$208,333
CLABSI	16.6667%	4.17%	0.08%	$208,333
MRSA	16.6667%	4.17%	0.08%	$208,333
PSI 90 (10)	16.6667%	4.17%	0.08%	$208,333

Lowers Weight

Maintains same potential $ on HCAHPS top box and consistency

Adds ED LOS and TFU Disparity w/ reassigned Safety Domain and linear measure weight

Splits Weight

Lower Weight to match CMS VBP

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RY 2026 Proposed QBR Program

Performance Measures

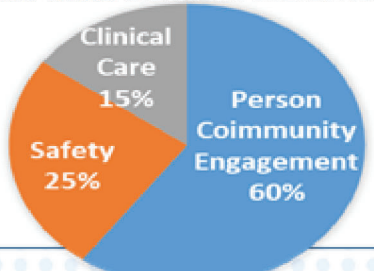
Measures by Domain:

Person and Community Engagement–
PROPOSED 11 Measures:
-8 HCAHPS categories;
-TFU Medicare and Medicaid and
PROPOSED disparity gap;
-PROPOSED ED LOS

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

Clinical Care–
--Mortality inpatient, PROPOSED 30-day;
--THA/TKA Complication

PROPOSED DOMAIN WEIGHTS

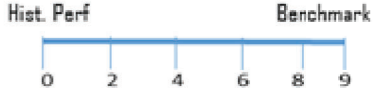


Standardized Measure Scores

Individual Measures are Converted to 0-10 Points:

Points for Attainment Compare Performance to a National Threshold (median) and Benchmark (top 5%)

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



Final Points are Better of Improvement or Attainment

Hospital QBR Score & Revenue Adjustments

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

Scale Ranges from 0-80%

Max Penalty 2% & Reward +2%

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

RY 2026 Draft Recommendations for QBR Program

1. Modify Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 60 percent (+10%), Safety (NHSN measures) - 25 percent (-10%), Clinical Care - 15 percent (no change).
    a. Within the PCE domain:
        i. Increase domain weight to 60 percent to accommodate new measures but do not increase the weight on HCAHPS top-box and consistency scores.
        ii. Continue to include four linear HCAHPS measures but reduce overall weight by half to accommodate new measures.
        iii. Continue to include Medicare and Medicaid Timely Follow-Up (TFU) rates and add TFU Disparity Gap measure.
        iv. Add an ED wait time measure.
    b. Within the Safety domain:
        i. Reduce overall domain weight from 35 to 25 percent to match CMS VBP program.
    c. Within the Clinical Care domain:
        i. Continue to include the inpatient mortality measure in the program.
        ii. Add the all-payer, all-cause 30-Day Mortality measure.
        iii. Split the weight on mortality between the two mortality measures.

RY 2026 Draft Recommendations for QBR Program

2. Develop the following monitoring reports to track hospital performance::
    a. Timely Follow-Up for Behavioral Health
    b. Sepsis Dashboard: Sepsis mortality, Sep-1 measure–Early Management Bundle, Severe Sepsis/Septic Shock
3. Continue implementing the HCAHPS improvement framework with key stakeholders.
    a. Explore statewide adoption of added question(s) to the survey linked to best practice with evidence that implementation improves HCAHPS scores.
    b. Address emergency department length of stay/hospital throughput issues as strategy to improve HCAHPS
4. Continue collaboration with CRISP and other partners on infrastructure to collect hospital electronic clinical quality measures and core clinical data elements for hybrid measures;
5. Maintain the pre-set scale (0-80 percent with cut-point at 41 percent) and continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) for the QBR program.
    a. Retrospectively evaluate 41 percent cut point using more recent data to calculate national average score for RY25 and RY26
    b. Based on more analyses on the impact of pre-COVID performance standards on national hospital performance, adjust the RY24 QBR cut point to be [to be determined in final policy, see discussion under revenue adjustment section]

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QBR Background- ED Measures

- Inpatient ED wait times (ED1b and ED2b) were added to QBR program in RY 2020 (CY 2018 performance)
  - Improvement only
  - Benchmark was national median by ED volume category
  - Included in Person and Community Engagement domain as two measures
  - Protection for hospitals that did worse on QBR despite earning 1 improvement point for ED length of stay (i.e., if hospitals QBR score was lower despite 1 improvement point, the higher score without ED measures was used)
  - In RY2020, 53% of hospital measures had an improvement, 2% remained the same, and 45% declined
  - In RY2021, 62% of hospitals measures had an improvement, 4% remained the same, and 33% declined
- Starting in CY 2022, Maryland hospitals were required to submit the electronic clinical quality measure for ED2
  - CMS then discontinued the ED2 eCQM starting in CY 2024, however HSCRC staff are in discussions with CMS about maintenance of this measure.

Measure Availability

ED Wait Time Measures	2012	2013	2014-2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Frequency	Source
ED 1: Arrival to IP Admission													Quarterly, rolling 12 months	CMS Care Compare
ED 2: Decision to admit until Admission													Quarterly, rolling 12 months	CMS Care Compare
OP 18 a,b,c: Arrival to Discharge													Quarterly, rolling 12 months	CMS Care Compare
ED 2: eCQM Version (MD only)											?	?	6 months/Quarterly	CRISP-Medisolv
EDDIE ED1-like: Arrival to IP Admission										June		?	Monthly	Hospital send to HSCRC
EDDIE OP 18-like: Arrival to Discharge										June		?	Monthly	Hospital send to HSCRC
EDDIE: EMS Turnaround Time										June		?	Monthly	MIEMSS
Available														
Available for RY2026 QBR														

QBR Measure Options

ED Measures	Pros	Cons
OP-18: Arrival to Discharge	• 80 percent of ED visits • Validated CMS measure • Available on Care Compare • National data available for benchmarking	• Data is delayed (9 months) • Concern on not focusing on IP throughput issues as directly
ED 2: eCQM Version (MD only)	• Validated CMS measure (historically) • State has infrastructure to collect • CY22 and CY23 historical data available for measuring improvement	• Requires special assistance from CMS to maintain and from EHR vendors to implement • Exclusion of patients with >1 hr observation • Concerns on lack of order to admit for some patients admitted • May not be available for CY 2024
EDDIE ED1-like: Arrival to IP Admission	• Full time from arrival to IP admission • Timely monthly reporting • Focus on IP • All ED admissions (not sampled)	• Similar measure to CMS but unaudited data • Concerns over observation cases being treated the same across hospitals or being excluded • Only about 20 percent of patients are admitted
EDDIE OP 18-like: Arrival to Discharge	• Timely monthly reporting • All ED admissions (not sampled) • 80 percent of ED visits	• Similar measure to CMS but unaudited data • Concerns over observation cases being treated the same across hospitals or being excluded • Concern on not focusing on IP throughput issues as directly
EDDIE: EMS Turnaround Time	• Easy measure to collect • Improvement will benefit patient, hospital, and EMS	• Concern on data collection consistency • Only addresses length of stay for those arriving by ambulance

Maryland All-Payer 30-day All Cause All Payer Mortality Measure

- Used CMS 30-Day Hospital-Wide Mortality Measure as a guide to develop
- Uses Maryland Vital Statistics death data merged with inpatient records

Step 1.

Cases Excluded from Sample	
Transferred in from another acute care facility	Inconsistent vital status
Enrolled in hospice 12M before, during index admission, 30-days after (Medicare/Medicaid)	Left against medical advice
Metastatic cancer	Crush, spinal, brain, or burn injury
Limited ability for survival (uses ICD-10 codes)	Non-Maryland resident

Step 2 Assign to Service Line:

MATERNITY	**NON-SURGICAL**	Neurology	**SURGICAL**	
	Cancer	Orthopedic	Cancer	
	Cardiac	Pulmonary	Cardiothoracic surgery	
	Gastrointestinal	Renal	Neurosurgery	
	Infectious Disease	Other Conditions	Orthopedic surgery	Other

Maryland All-Payer 30-day All Cause All Payer Mortality Measure

Step 3. Estimate risk-adjusted regression models:

- **Adjust for age, APR-DRG category and Risk of Mortality (ROM)**
  - Outcome: 0/1 indicator for whether patient died within 30-days of index admission date
  - Use APR-DRG categories and ROM values present on index stay
  - Adjust for age and quadratic of age
- **Estimate models within each service line**
  - Allows for association between risk adjustment variables and outcome to vary by type of case
- **All models estimated using logistic regression**

Step 4: Produce hospital-level rates:

- **For each hospital, calculate the expected number of 30-day deaths**
  - Within each service-line, calculate sum of predicted (expected) 30-day deaths for the hospital
  - These are the number of 30-days that are expected for that service line, given the hospital's mix of patients
- **Calculate service line-specific observed to expected (O/E) ratios**
  - By hospital, calculate ratio of observed number of 30-day deaths to expected number of 30-day deaths for each service line
- **Create aggregate O/E ratios for each hospital**
  - Calculate weighted average of O/E ratios across service lines
  - Hospital-specific weights = proportion of overall case volume represented by a service line
- **Multiply hospital's aggregate O/E ratio by state average 30-day mortality rate**
  - Risk-standardized mortality rate (RSMR)

Mortality Updates: Hospice

- In HSCRC measure, confirmed hospice is identified by:
  - Type of daily service = hospice
  - Discharge disposition = home hospice or hospice
  - Claims data for any hospice claim within 30 days (*currently Medicare only but plan to extend to Medicaid*)
- Medicare condition-specific claims based 30-day mortality measures exclude hospice differently than hybrid Hospital Wide Mortality measure. Hybrid is all-cause so more analogous to our all-payer, all-cause measure. Hybrid measure excludes:
  - Those enrolled in hospice at time of, or 12 months prior to index admission, or enrolled within 2 days of admission, or with principle dx of cancer and enrolled in hospice at anytime during admit

HCAHPS Supplemental Questions Survey Results

- Data collected August 2023
- 38 hospital responses
  - 32 hospitals collect supplemental questions for all patients
    - range of 1-23 questions
  - 6 hospitals do not collect supplemental questions
- 3 hospitals include questions targeting subgroups beyond Medical, Surgical, Maternity-
  - ED
  - Stroke
  - ICU
- 16 hospitals segment results by Medical, Surgical, Maternity, discreet unit, and less so on race, gender, ethnicity, ED admits, rounding
- Follow up with 3 hospitals/systems (Adventist, Atlantic, Garrett County) reveal affirmative responses about staff rounding are correlated with higher overall HCAHPS scores

QBR Cutpoint Comparison

RY2024

	41% cutpoint	31% cutpoint
# of hospitals penalized	40	33
# of hospitals rewarded	1	8
$ revenue penalties	$ (97,990,365.00)	$ (64,250,481.00)
% revenue penalties	-0.87%	-0.57%
$ revenue rewards	$ 91,892.00	$ 4,712,071.00
% revenue rewards	0.0008%	0.042%
Net Adjustments	$ (97,898,473.00)	$ (59,538,410.00)

- Need to also propose/refine RY25 and RY26 cutpoint
- Final policy for RY 2026 will include modeling of proposed QBR changes. Given increase in non-National measures, need to think about best ways to estimate National scores (i.e., add in Maryland average or median score for national hospitals?)

maryland
health services
cost review commission

Draft Quality-Based Reimbursement Program for Rate Year 2026

November 8, 2023

This document contains the staff draft recommendations for updating the Quality-Based Reimbursement Program for RY 2026. Comment letters on this draft recommendation are due by COB Wednesday, November 15, 2024 and may be submitted to hscrc.quality@maryland,gov.

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Table of Contents

List of Abbreviations

APR DRG	All Patient Refined Diagnosis Related Group
CDC	Centers for Disease Control & Prevention
CAUTI	Catheter-associated urinary tract infection
CCDE	Core Clinical Data Elements (for digital hybrid measures)
CDIF	Clostridium Difficile Infection
CLABSI	Central Line-Associated Bloodstream Infection
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-Related Group
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
ED-1 Measure	Emergency Department Arrival to Departure for Admitted Patients
ED-2 Measure	Time of Order to Admit until Time of Admission for ED Patients
EDDIE	Emergency Department Dramatic Improvement Effort
FFY	Federal Fiscal Year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commission
LOS	Length of Stay
MIEMSS	Maryland Institute for Emergency Medical Services Systems
MRSA	Methicillin-Resistant Staphylococcus Aureus
NHSN	National Health Safety Network
PQI	Prevention Quality Indicators
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year (Coincides with State Fiscal Year (SFY) July-Jun; signifies the timeframe in which the rewards and/or penalties would be assessed)
SIR	Standardized Infection Ratio
SSI	Surgical Site Infection
TFU	Timely Follow Up after Acute Exacerbation of a Chronic Condition
THA/TKA	Total Hip and Knee Arthroplasty Risk Standardized Complication Rate
VBP	Value-Based Purchasing

POLICY OVERVIEW

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/ Consumers	Effect on Health Equity
The quality programs operated by the Health Services Cost Review Commission, including the Quality-Based Reimbursement (QBR) program, are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.	The QBR program is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value within a global budget framework.	The QBR policy currently holds 2 percent of hospital inpatient revenue at-risk for Person and Community Engagement, Safety, and Clinical Care outcomes.	This policy ensures that the quality of care provided to consumers is reflected in the rate structure of a hospital's overall global budget. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	Quality programs that reward hospitals for the better of attainment or improvement (QBR and RRIP) better allow the policies to target improvements in hospitals that serve a high proportion of under-resourced patients. The Health Equity Workgroup (HEW) analyzed the Medicare Timely Follow-Up (TFU) measure and found disparities by race, dual-status, and Area Deprivation, and thus is proposing an addition of a disparity gap improvement metric for TFU. Going forward, HSCRC staff will continue to analyze disparities and propose incentives for reducing them in the program.

RECOMMENDATIONS

This document puts forth the RY 2026 Quality-Based Reimbursement (QBR) draft policy recommendations. Staff has and will continue vetting these recommendations with the Performance Measurement Workgroup (PMWG) and also greatly benefits from feedback provided by Commissioners and other stakeholders on draft recommendations and longer-term priorities.

Draft Recommendations for RY 2026 QBR Program:

1. Modify Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 60 percent (+10%), Safety (NHSN measures) - 25 percent (-10%), Clinical Care - 15 percent (no change).
    a. Within the PCE domain:
        i. Increase domain weight to 60 percent to accommodate new measures but do not increase the weight on HCAHPS top-box and consistency scores.
        ii. Continue to include four linear HCAHPS measures but reduce overall weight by half to accommodate new measures.
        iii. Continue to include Medicare and Medicaid Timely Follow-Up (TFU) rates and add TFU Disparity Gap measure.
        iv. Add an ED wait time measure.

b. Within the Safety domain:
    i. Reduce overall domain weight from 35 to 25 percent to match CMS VBP program.
c. Within the Clinical Care domain:
    i. Continue to include the inpatient mortality measure in the program.
    ii. Add the all-payer, all-cause 30-Day Mortality measure.
    iii. Split the weight on mortality between the two mortality measures.

2. Develop the following monitoring reports to track hospital performance::
    a. Timely Follow-Up for Behavioral Health
    b. Sepsis Dashboard: Sepsis mortality, Sep-1 measure–Early Management Bundle, Severe Sepsis/Septic Shock
3. Continue implementing the HCAHPS improvement framework with key stakeholders.
    a. Explore statewide adoption of added question(s) to the survey linked to best practice with evidence that implementation improves HCAHPS scores.
    b. Address emergency department length of stay/hospital throughput issues as strategy to improve HCAHPS
4. Continue collaboration with CRISP and other partners on infrastructure to collect hospital electronic clinical quality measures and core clinical data elements for hybrid measures;
5. Maintain the pre-set scale (0-80 percent with cut-point at 41 percent) and continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) for the QBR program.
    a. Retrospectively evaluate 41 percent cut point using more recent data to calculate national average score for RY25 and RY26
    b. Based on more analyses on the impact of pre-COVID performance standards on national hospital performance, adjust the RY24 QBR cut point to be [to be determined in final policy, see discussion under revenue adjustment section]

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 Quality-Based Reimbursement (QBR) program is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time. The program currently holds 2 percent of hospital revenue at-risk for performance by hospitals on patient experience, clinical care, and safety. Based on RY 2024 preliminary QBR performance results, with the exception of one hospital, all hospitals are receiving a penalty under the program. HSCRC staff is retrospectively evaluating the reward/penalty scale for the performance period to determine if an adjustment is needed based on impacts of COVID on the Nation and Maryland. For purposes of the RY 2026 QBR draft Policy, staff vetted the updated draft policy with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Under the TCOC Model, Maryland must request exemptions each year from CMS hospital pay-for-performance programs, e.g., the Value Based Purchasing (VBP) program for which QBR is the state analog. CMS assesses and grants these exemptions based on a report showing that Maryland's results continue to meet or surpass those of the nation. However, in the CMS response to HSCRC's FY 2023 VBP exemption request, they once again noted Maryland's lagging performance in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Person and Community Engagement (PCE) domain compared to national standards; they also highlighted the need to implement a strategic plan outlining our approach for HCAHPS improvement and the need for continued improvement in population health and health equity. HSCRC has submitted our exemption request for FY

2024 with responses to the issues raised by CMS in last year's exemption approval; staff is awaiting CMS' response.

Additionally, with the onset of the TCOC Model Agreement, each program was overhauled to ensure they support the goals of the Model. For the QBR policy, the overhaul was completed during 2021, which entailed an extensive stakeholder engagement effort to address CMS and other stakeholders' concerns.[1] This policy includes updates on the QBR redesign and additional recommended changes to strengthen the incentives and focus the program on specific areas of concern for Maryland. Figure 1 provides QBR updates by domain and measure for RY 2026 and future program years.

Figure 1. QBR Updates

Domain/ Measure	RY 2026	Future program years
Person and Community Engagement domain		
HCAHPS	• Continue to weight HCAHPS top box scores more heavily than the CMS VBP program; begin phasing out HCAHPS linear scores by lowering weight. • Use HCAHPS patient level data from the Maryland Health Care Commission (MHCC) for additional analytics, including on disparities, and hospital improvement • Plan for statewide adoption of added question(s) to the survey linked to best practice with evidence that implementation improves HCAHPS scores	• Continue to use HCAHPS patient-level data from the MHCC for additional analytics, including on disparities, and hospital improvement. • Continue working with stakeholders to facilitate more sharing of best practices • Adopt additional question(s) in the payment program after CY 2024.
Emergency department (ED) wait times	• Collect ED wait time measures and promote performance improvement through the EDDIE project • Potentially adopt an ED wait time/length of stay measure in the PCE domain given its correlation with patient experience	• Continue to evaluate ED length of stay measures, including eCQMs, and use of the QBR program to incentivize improvement • Collaborate with CMS on ED boarding measures
Follow-up measure	• Continue to include the TFU measure for Medicaid, which was added in the RY 2025 program • Implement a TFU disparity measure to reduce disparities and support achievement of the SIHIS goal for Timely Follow-up • Explore behavioral health data sources and ways to monitor follow up following a hospitalization for behavioral health	• Evaluate the ongoing TFU rates for Medicare, as well as the disparity gap measure, to ensure SIHIS goal is met • Monitor impact on TFU for Medicaid • Consider adding a measure that includes / behavioral health to the QBR Program in RY 2026
Safety domain		
CDC National Health Safety Network	• In light of the work group's findings that demonstrate that Maryland is on par with national performance, maintain alignment with the national VBP Program; focus on improvement on current measures	• Continue to analyze Maryland trends compared to national performance. • Explore working with CDC to add more innovative and less burdensome "digital" measures.

[1] See the RY 2024 QBR policy for additional information on the findings from the QBR Redesign.

Domain/ Measure	RY 2026	Future program years
Clinical Care domain		
30-day mortality	• Maintain IP mortality measure but also phase in the 30-day all-cause, all-payer measure (i.e., include both measures)	• Evaluate weight on mortality in program • Monitor the Medicare a hybrid measure using the digital measures infrastructure • Plan for implementation of an all-payer hybrid measure using the digital measures infrastructure
Total hip arthroplasty/total knee arthroplasty	• Continue to explore expansion of the current inpatient total hip arthroplasty/total knee arthroplasty measure to all-payers and/or to outpatient cases	• Continue to develop outpatient quality of care strategy using THA/TKA as exemplar • Explore opportunities for Patient Reported Outcome Measures (PROMs)

BACKGROUND

Overview of the QBR Program

The QBR Program, implemented in 2010, includes potential scaled penalties or rewards of up to 2 percent of inpatient revenue. The QBR program assesses hospital performance against national standards for measures included in the CMS VBP program and Maryland-specific standards for other measures unique to our all-payer system. Figure 2 compares RY 2025 QBR measures and domain weights to those used in the VBP Program.

Figure 2. RY 2025 QBR measures and domain weights compared Proposed RY 2026 measures and domain weights, and to the CMS VBP Program

Domain	Maryland RY 2025 QBR domain weights and measures	Maryland Proposed RY 2026 QBR domain weights and measures	CMS VBP domain weights and measures
Clinical Care	**15 percent** Two measures: All-cause inpatient mortality; THA/TKA complications	**15 percent (no change)** Three measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality, THA/TKA complications	**25 percent** Five measures: Four condition-specific mortality measures; THA/TKA complications
Person and Community Engagement	**50 percent** Nine measures: Eight HCAHPS categories top box score and consistency, and four categories linear score; TFU Medicare, Medicaid.	**60 percent (+10%)** 11 measures: Eight HCAHPS categories top box score and consistency, and four categories linear score; TFU Medicare, Medicaid, disparities improvement; ED LOS.	**25 percent** Eight HCAHPS measures top box score.

Domain	Maryland RY 2025 QBR domain weights and measures	Maryland Proposed RY 2026 QBR domain weights and measures	CMS VBP domain weights and measures
Safety	**35 percent** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**25 percent (-10%)** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**25 percent** Five measures: CDC NHSN HAI measures
Efficiency	n.a.	n.a.	**25 percent** One measure: Medicare spending per beneficiary

For the FY 2025 QBR program, with the selected measures from above, the QBR Program assesses hospital performance based on the national or state threshold (50th percentile of hospital performance) and benchmark (mean of the top decile). Each measure is assigned a score of zero to ten points, then the points are summed and divided by the total number of available points, and weighted by the domain weight. Thus, a total score of 0 percent means that performance on all measures is below the performance threshold and has not improved, whereas a total score of 100 percent means performance on all measures is at or better than the mean of the top decile (about the 95th percentile). This scoring method is the same as that used for the national VBP Program. But unlike the VBP Program, which ranks all hospitals relative to one another and assesses rewards and penalties to hospitals in a revenue neutral manner retrospectively based on the distribution of final scores, the QBR Program uses a preset scale to determine each hospital's revenue adjustment and is not necessarily revenue neutral. This gives Maryland hospitals predictability and an incentive to work together to achieve high quality of care, instead of competing with one another for better rank.

Historically, Maryland hospitals have low scores on the QBR program in part due to HCAHPS performance. In order to ensure Maryland hospitals are not rewarded for subpar performance, the preset revenue adjustment scale ranges from 0 to 80 percent, regardless of the score of the highest-performing hospital in the state (i.e. the scale is not relative to Maryland performance so that poor performance compared to the Nation is not rewarded). The cut-point at which a hospital earns rewards or receives a penalty has been based on an analysis of the national VBP Program scores. For RY 2024 and RY 2025, federal fiscal years 2016–2021 were used to calculate the average national score using Maryland QBR domain weights (without the Efficiency domain). This resulted in a cut-point around 41 percent (range of scores was from 38.5 to 42.7). However, due to the COVID PHE the RY 2024 and RY 2025 policies both indicate that the cut point will be reassessed retrospectively with more recent national data. While this is inconsistent with the guiding principle to provide hospitals with a way to monitor revenue adjustments

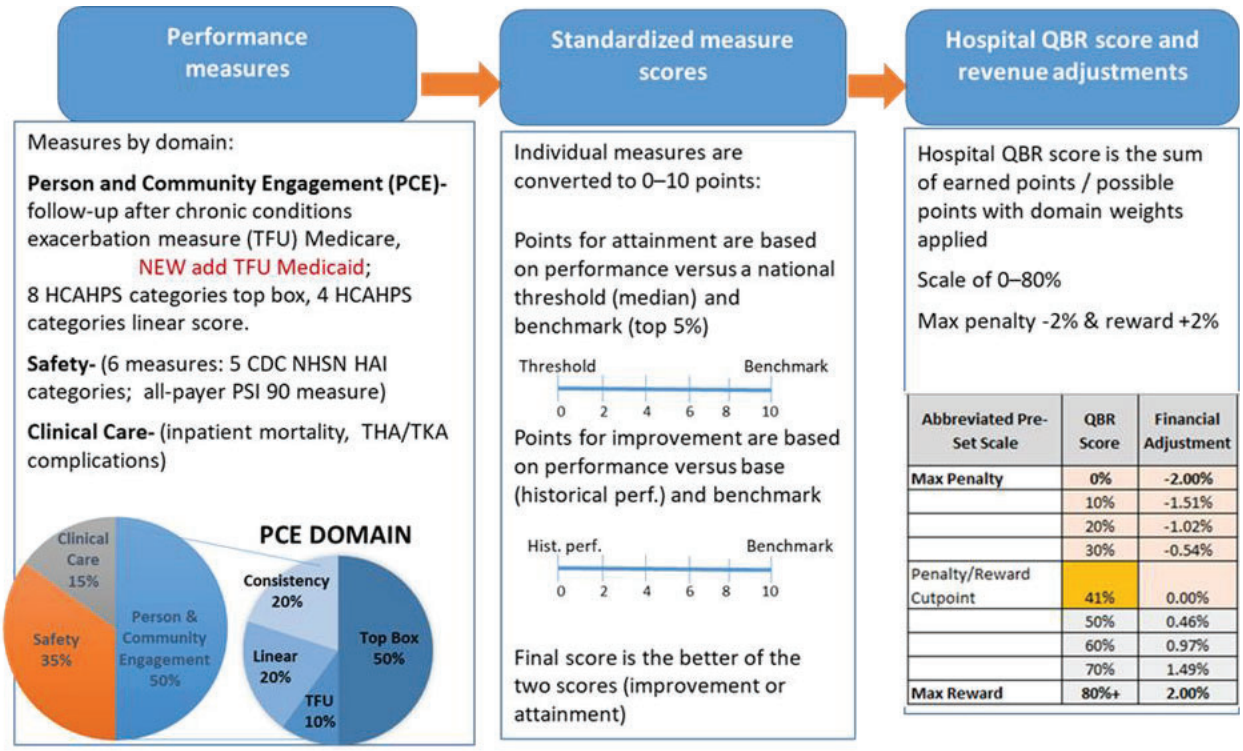
during the performance year, it protects Maryland hospitals from excessive penalties due to changes in performance post-COVID compared to national hospitals. The RY 2026 policy will also provide recommendations for the RY 2024 final cut point based on more recent analyses, however, for RY 2026 the staff will continue to use the 41 percent cut point but agree to reassess this cut point with more recent data in the future. Given performance standards are now post-COVID, staff believes scores may be higher in RY 2026 than in RYs 2024 or RY 2025.

As a recap, the method for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019. It involves:

1. Assessing performance on each measure in the domain.
2. Standardizing measure scores relative to performance standards.
3. Calculating the total points a hospital earned divided by the total possible points for each domain.
4. Finalizing the total hospital QBR score (0 to 100 percent) by weighting the domains, based on the overall percentage or importance the HSCRC placed on each domain.
5. Converting the total hospital QBR scores into revenue adjustments using the preset scale (range of 0 to 80 percent).

This method is shown in Figure 3.

Figure 3. RY 2025 QBR Policy Methodology Overview



Appendix A contains more background and technical details about the QBR and VBP Programs. Appendix B contains the by-hospital QBR results for RY 2024 with the 41 percent cut point and the final policy will propose the revised cut point. Preliminary results show that 40 hospitals will be penalized and only one hospital will receive a reward; statewide net penalties amount to almost $98 million across the 40 hospitals that would be penalized while the one hospital earning a reward would receive about $92 thousand.

Assessment

The purpose of this section is to present an assessment, using the most current data available, of Maryland's performance on measures used in the QBR program, compared to the Nation when national data is available. In addition, staff is proposing to add several new measures to the QBR program and to modify the measure and domain weights. The rationale for new measures is discussed in each section and the domain and measure weights are discussed at the end. Finally, this draft policy provides an overview of the financial modeling that will be included in the final policy with options for Commissioner consideration.

Person and Community Engagement Domain

The Person and Community Engagement domain currently measures performance using the HCAHPS patient survey and two measures of timely follow-up (TFU) after discharge for an acute exacerbation of a chronic condition (one measure for Medicare fee-for-service (FFS) and one measure for Medicaid beneficiaries). This domain currently accounts for 50 percent of the overall QBR score; however, staff is recommending the weight for this domain be increased to 60 percent to account for the addition of two proposed measures. The proposed measures, with rationale for inclusion, are a TFU disparity gap metric and a measure of emergency department length of stay (i.e., wait times).

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

The HCAHPS survey is a standardized, publicly reported survey that measures patient's perceptions of their hospital experience. In keeping with the national VBP Program, the QBR Program scores hospitals using top box scores (e.g., the percent of respondents who indicate the highest performance category) to calculate improvement and attainment points (0-10), and counts the points for whichever is highest, across the following HCAHPS domains: (1) communication with nurses, (2) communication with doctors, (3) responsiveness of hospital staff, (4) communication about medicine, (5) hospital cleanliness and quietness, (6) discharge information, (7) a composite care transition measure, and (8) overall hospital rating. The QBR Program also scores hospitals separately on consistency[2]; a range of 0-21 consistency points are awarded by comparing a hospital's HCAHPS survey lowest performing measure rates during the performance period to all hospitals' HCAHPS survey measure rates from a baseline period. In RY 2024, HCAHPS linear scores were added as 20% of the PCE domain (i.e., 10 percent of overall QBR score) for the following domains: the nurse communication, doctor communication, responsiveness of staff, and care transition. The addition of the linear measures is designed to further incent focus on HCAHPS by providing credit for improvements along the continuum and not just improvements in top box scores.

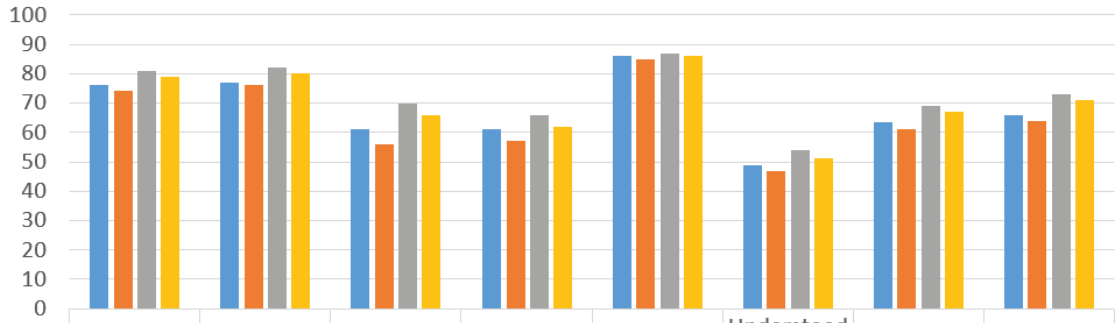
While the HSCRC staff recommends continuing the linear measures for RY 2026, the weight of these measures should be lowered to accommodate additional measures (TFU disparity and ED length of stay). Furthermore, staff will assess if adding the linear measures helps improve top-box scores over the next 1-2 years. If top box scores do not improve, the staff will recommend removing the linear measures in future rate years.

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

Updated data on HCAHPS performance through 6/30/22 from CMS Care Compare reveal the following, as illustrated in Figures 4 and 5 below: provide top box and linear performance respectively of the HCAHPS measure results for Maryland compared to the Nation, revealing that:

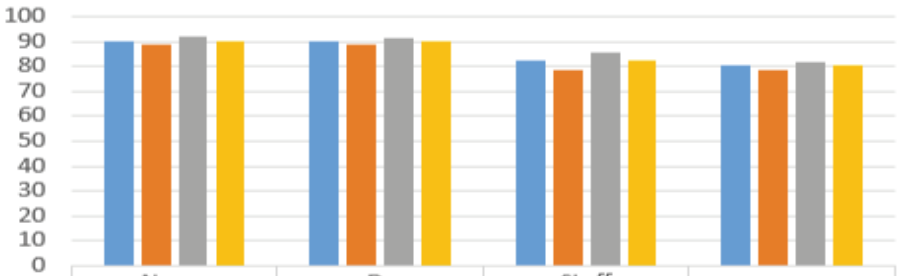
- Maryland continues to lag behind the Nation.
- Both the Nation and Maryland declined slightly from the base to the performance periods for all of the HCAHPS categories.
- For " Discharge Information Provided", Maryland and the Nation performed most similarly.

Figure 4. Top Box HCAHPS Results: Maryland Compared to the Nation , CY 2019 vs 7/1/21-6/30/22



	Nurse Communication	Dr Communication	Staff Responsiveness	Medication Explained	Discharge Info Provided	Understood Post-Discharge Care	Clean & Quiet	9/10 Overall Rating
MD Base	76	77	61	61	86	49	63.5	66
MD Performance	74	76	56	57	85	47	61	64
Nation Base	81	82	70	66	87	54	69	73
Nation Performance	79	80	66	62	86	51	67	71

Figure 5. Linear Measure, Maryland Compared to the Nation, CY 2019 vs 7/1/21-6/30/22



	Nurse Communication	Dr Communication	Staff Responsiveness	Care Transition
MD Base	90	90	82	80
MD Performance	89	89	79	79
National Base	92	92	86	82
National Performance	90	90	82	80

In addition to the CMS data, MHCC has analyzed patient-level HCAHPS data submitted by hospitals for the 2021 Q3 to 2022 Q2 time period and found the following:

- 33,134 surveys were included in the data set
- White respondents are more highly represented than black or other respondent categories relative to their proportion in Maryland's population from the 2020 Census.
- When collapsing "would recommend" categories into two, "No" = Definitely No/Probably No - 2,263 (7%), and "Yes" = Definitely Yes/Probably Yes - 30,871 (93%):
    - Maryland responses are similar to those of the Nation.
    - More black respondents than expected indicated the "No" category.
- For the responses by service line in Maryland, there were 4,760 surveys within the Maternity service line comprising 15% of the total with the following results:
    - Black respondents are relatively more highly represented in the Maternity service line compared with the Medical and Surgical service lines.
        - For "would recommend", there were significantly more "No" reported by black patients than expected.
        - For the Overall Rating, there were significantly more "6 or lower" reported by black patients than expected

For additional details on the MHCC analysis see the HCAHPS Improvement Framework in Appendix C.

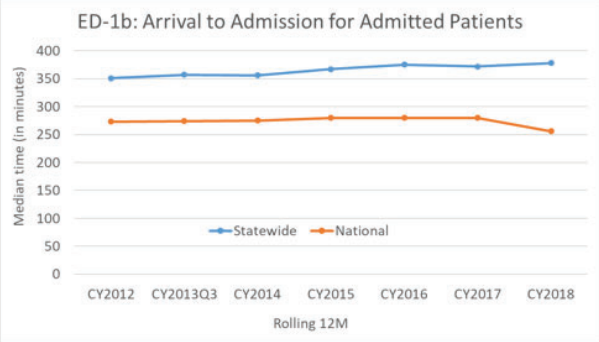
HCAHPS Improvement Framework

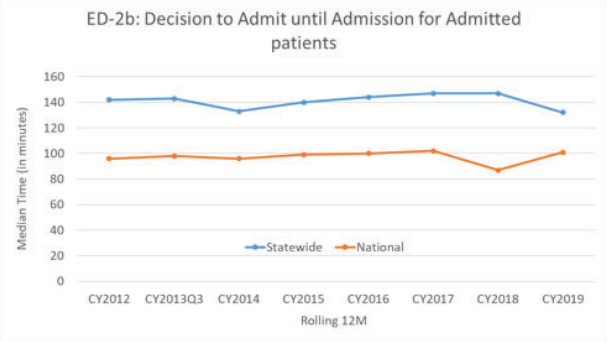
One important area CMS has identified in feedback to the Commission is the need for targeting improvement in HCAHPS in the Person and Community Engagement domain. CMS has recommended that the State consider implementing a State-wide HCAHPS performance improvement initiative that leverages input from providers, industry experts, and other stakeholders to develop future improvement goals. Further, CMS noted they are looking for the State to further develop these strategies and commit to creating a framework for setting HCAHPS performance improvement goals for future performance years. Key components of the HCAHPS improvement framework include administrative leadership accountability, data analysis and data sharing (including disparities in findings), and hospital adoption and sharing of best practices, detailed in Appendix C. Based on Maryland's overall lagged HCAHPS performance MHCC's analysis, it will be important to focus on disparities in HCAHPS results; in particular, staff will examine disparities, for example, in the maternity service line for HCAHPS and other related process and outcome measures. Given the correlation between patient experience and ED length of stay, the framework also discusses the Emergency Department Dramatic Improvement Effort (EDDIE) among the best practices.

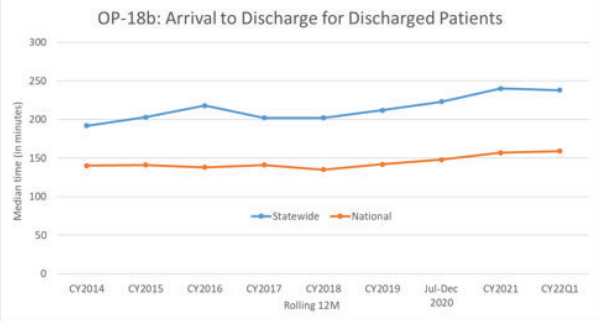
Emergency Department Length of Stay

ED length of stay (LOS)--i.e., wait times–has been a significant concern in Maryland, predating Maryland's adoption of hospital global budgets instituted in 2014,[3] with multiple underlying causes and potential negative impacts (e.g., poorer patient experience, quality, care outcomes). Publicly available data on CMS Care Compare reveals Maryland's poor performance compared to the Nation on both inpatient and outpatient ED measures (i.e., higher wait times for both those admitted to the inpatient hospital and those discharged home), as shown in Figure 6.

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







Measure ID	Measure Definition
ED-1	Median time from ED arrival to departure for admitted patients
ED-2	Median admit decision time to ED departure time for admitted patients
OP-18	Median time of ED arrival to departure for discharged patients

Concerns about unfavorable ED throughput data have been shared by many Maryland stakeholders, including the HSCRC, the MHCC, payers, consumers, emergency department and other physicians, hospitals, the Maryland Institute of Emergency Medical Services Systems, and the Maryland General Assembly, with ten legislatively mandated reports on the topic issued between 1994 and 2022. Historically, the HSCRC has taken several steps to address emergency department length of stay concerns as listed in Appendix D. However, in the past few years, the COVID public health emergency and its effects on inflation and labor have had particularly significant negative impacts on hospitals and

[3] Under alternative payment models, such as hospital global budgets or other hospital capitated models, some stakeholders have voiced concerns that there may be an incentive to reduce resources that lead to ED throughput issues.

other care settings that patients may use after receiving hospital care (e.g., nursing homes), further exacerbating pressures on emergency departments.

Currently there are several initiatives implemented or under consideration to address this ongoing patient safety and experience concern. The use of an ED LOS measure in the QBR payment program is one policy under consideration to leverage incentives for hospital performance improvement and underscore the regulatory importance of the issue for patient care. The QBR incentive should be a mutually reinforcing part of a holistic strategy to address ED LOS and hospital throughput issues. In general, ED staff supports including inpatient wait time measures to address the issue of ED boarding and hospital throughput. Furthermore, an expert commentary on ED boarding and the global budget system discussed the inclusion of QBR payment incentive previously and added recommended re-adoption of this measure:

> "Although the first effort at including an ED boarding metric in HSCRC's QBR program was short-lived, the inclusion of such a metric should be reconsidered. Several possible explanations exist for the lack of improvement in ED boarding despite previous inclusion of the ED-2b metric in Maryland's QBR program. Most simply, shifting hospital operations and workflow is a difficult process that requires time. Second, given public notice of CMS's proposed rule change, hospital executives had a diminished incentive to react to a quality metric that they perceived as transient. Lastly, the financial penalties tied to excessive ED-2b times may have simply been too small to matter. The solution to all these potential issues may be similar. A meaningful financial incentive tied to ED boarding metrics that is implemented on a long-term basis is highly likely to encourage hospital innovation to optimize patient access to emergency services".[4]

Below we discuss the history of ED LOS measures in QBR, provide an overview of the other initiatives to address ED LOS and hospital throughput, and provide recommendations to readopt an ED wait time measure in QBR to complement the other ED initiatives designed to improve quality of patient care.

History of ED Wait Times in QBR

The HSCRC staff proposed and implemented for two years inclusion of ED LOS measures in the QBR program. In RY 2020 (CY 2018 measurement period), the QBR Program introduced the use of the two CMS inpatient ED wait time measures (chart abstracted measures: ED-1 and ED-2) as part of the QBR Person and Community Engagement (PCE) domain because of the correlation between ED wait times and HCAHPS performance (also in the PCE domain and on which the state also performs poorly). CMS retired ED-1 after CY 2018 and ED-2 after CY 2019 necessitating both measures' removal from the QBR

[4] Stryckman, B., Kuhn, D., Gingold, D., Fischer, K., Gatz, J.D., Schenkel, S., Browne, B. Balancing Efficiency and Access: Discouraging Emergency Department Boarding in a Global Budget System, Western Journal of Emergency Medicine, Volume 22, No. 5: September 2021.

program after only two years. Overall, ED LOS improved (i.e., ED LOS time went down) for more than half the hospitals

More recently, staff collaborated with CRISP and their contractor to collect an electronic Clinical Quality measure (eCQM) of ED-2 for CYs 2022 and 2023 but this measure has been subsequently retired by CMS as well. CMMI has considered maintaining this measure, but it has not yet made a formal decision and it is too late into the CY to implement for CY2024. While staff is still exploring whether the eCQM could be maintained in the future, this will not be feasible to implement in CY 2024. Furthermore, initial analyses of the ED2 eCQM found that there are a significant number of hospitalizations (>50,000 statewide) that are dropped from the measure due to an exclusion for stays where the patient spends more than one hour in observation care. Currently HSCRC staff is in discussions with CMMI about this measure and ED boarding measures in general and hope that in the future the eCQM infrastructure can be used to collect ED length of stay. In the meantime, staff is also exploring other ways to collect this data including adding additional time stamps to the monthly case-mix data and/or use of EDDIE measures submitted to the HSCRC directly by hospitals and MIEMSS.

To decide on the direction for CY2024, the Commission will need to consider the ED length of stay measurement options outlined below, as well as other initiatives underway to address this issue in CY 2024.

Additional Initiatives: Emergency Department Dramatic Improvement Effort (EDDIE)

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

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

To support this work, MHA has begun convening hospitals to set aim statements and provide on-going learning sessions to share best practices and design rapid cycle tests of change. The HSCRC and MIEMSS are supporting this work by collecting and publicly reporting hospital ED wait times at monthly Commission meetings. The intent is that Commission monitoring of timely ED performance data will bring on-going attention to this issue through public reporting, provide an opportunity for the Commission to recognize and learn from high performers, and to track the hospitals performance improvement efforts relative to their aim statements.

Additional Initiatives: ED Potentially Avoidable Utilization

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

Additional Initiatives: Legislative Workgroup

As alluded to earlier, in early 2023, the Maryland General Assembly passed legislation establishing the Task Force on Reducing Emergency Department Wait Times to study best practices for reducing emergency department wait times; and requiring the Task Force to report its findings and recommendations to the Governor and the General Assembly by January 1, 2024. In response, MHA, with co-chair Dr. Ted Ted Delbridge, executive director of Maryland Institute for Emergency Medical Services Systems (MIEMSS), are leading a multi-stakeholder work group, the Hospital Throughput Work Group, aimed at making recommendations to improve the patient journey in Maryland.

Members include hospital representatives, legislators, the HSCRC, the MHCC, the state Department of Health, patient advocates and emergency department and behavioral health providers. The Task Force is charged with making legislative, regulatory and/or policy recommendations in a report due to Maryland General Assembly committees by Jan. 1, 2024. The HSCRC staff is an active participant in the Task Force and believe that inclusion of an ED length of stay measure in QBR will be consistent with any policy recommendations designed to improve ED length of stay and hospital throughput (i.e., a payment incentive should bolster performance improvement and not hinder other policy recommendations).

Appendix D provides a picture of these various initiatives and how they can be mutually reinforcing.

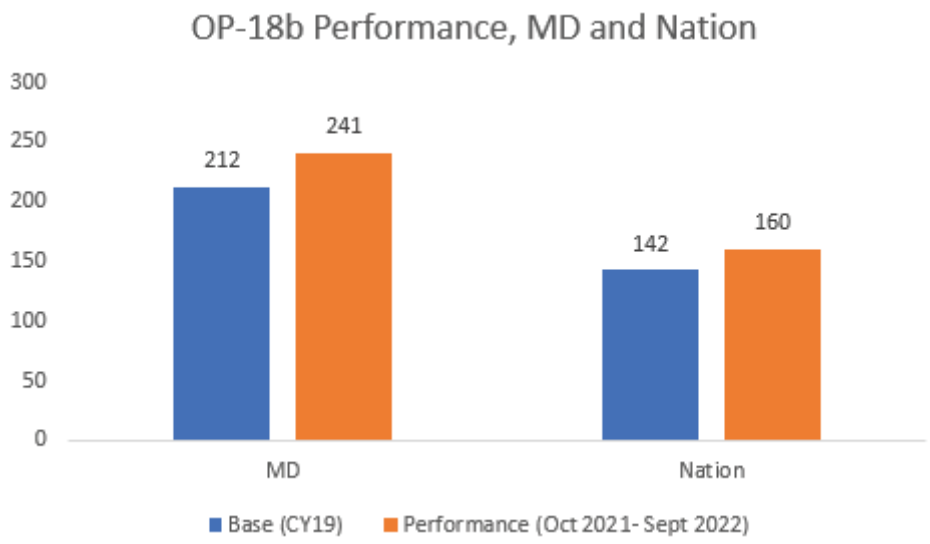
RY 2026 QBR Options for ED Length of Stay

Given the measurement concerns and ongoing activities, this draft policy provides three options for Commission consideration in regard to recommendations for RY2026.

Option 1: Delay implementation of an ED length of stay measure for admitted patients for one year so that staff can finalize measure development and selection either through addition of timestamps to case mix data, by improving and auditing ED1 submissions through EDDIE, or refinement of an ED measure through the eCQM collection process. Adoption of any new data elements in case mix would require some lead time (at least 6 months) for hospitals to adjust their data submission processes to accommodate the change.

Option 2: Approve inclusion of an existing ED measure for CY 2024. The options for existing measures would be OP-18 from Care Compare, which measures length of stay for non-admitted patients, or the EMS turnaround time measure. Figure 7 compares the base to the performance period used for modeling inclusion of ED length of stay. It shows the Nation and Maryland have both seen increases in their wait times; however, Maryland performs worse than the Nation and saw a larger increase in wait times. While ED length of stay for non-admitted patients has historically been correlated with ED length of stay for admitted patients and accounts for around 80 percent of all ED visits, some stakeholders have expressed that the hospital throughput issue for admitted patients is what really needs to be addressed to improve ED length of stay for all patients. Furthermore, OP-18 from Care Compare is not reported until about 9 months after the end of the performance period and is based on a sample of patients discharged from the ED. As for the EMS turnaround time, some stakeholders have raised concerns about the consistency and accuracy of this measure across jurisdictions. While staff believes this measure is accurate enough for use, it focuses on a narrow set of patients who are arriving at the hospital via ambulance.

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



Option 3: Approve inclusion of ED-1 like measure in RY 2026 QBR program, which will be finalized during CY 2024 and will not require additional Commission approval. The measure would use case mix data, the EDDIE submission process, and/or eCQM infrastructure. While not customary, staff would contend that the hospitals are familiar with the measures and submitting the data already on the candidate measure options and do not need to know the *exact* measure(s) to be selected beyond understanding they will be held accountable for the length of stay for the majority of, or for all patients admitted to the hospital. Since hospitals should be working on performance improvement in CY 2024, inclusion of an ED length of stay measure should reinforce and provide financial rewards to support the performance improvement initiatives. As stated above in Option 1, adoption of any new data elements in case mix would require some lead time (at least 6 months) for hospitals to adjust their data submission collection processes to accommodate the change but could be retrospectively reported for previous years if the data elements existed in the EHR.

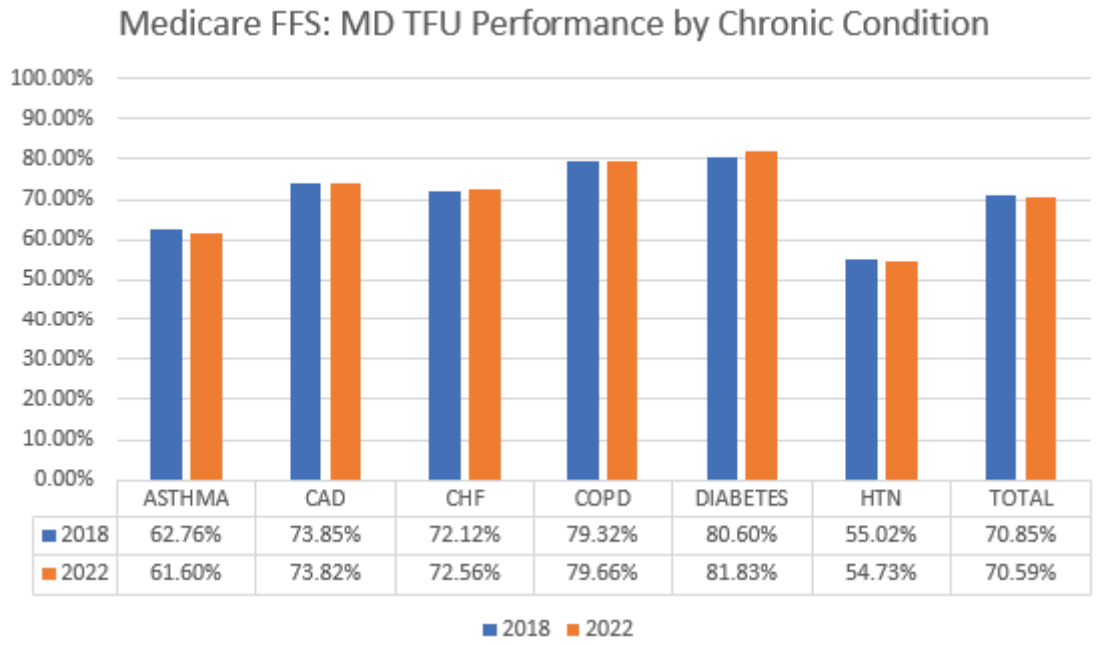
Timely Follow-Up After Discharge

On March 17, 2021, CMS approved Maryland's proposed SIHIS, which included a National Quality Forum-endorsed health plan measure of timely follow-up (TFU) after an acute exacerbation of a chronic condition in the Care Transition domain. The SIHIS goal is to achieve a 75 percent TFU rate for Medicare FFS beneficiaries across the six specified conditions and respective time frames. To hold hospitals accountable for meeting this goal, the HSCRC introduced this measure for Medicare beneficiaries into the RY 2023 QBR Program within the Person and Community Engagement domain and recommends continuing it in the RY2026 QBR program. The measure assesses the percentage of ED visits, observation stays, and inpatient admissions for one of six conditions in which a follow-up was received within the time frame recommended by clinical practice:

- Hypertension (follow-up within seven days)
- Asthma (follow-up within 14 days)
- Heart failure (follow-up within 14 days)
- Coronary artery disease (follow-up within 14 days)
- Chronic obstructive pulmonary disease (follow-up within 30 days)
- Diabetes (follow-up within 30 days)

Figure 8 shows Maryland's performance over time for each chronic condition and all conditions combined within the Medicare population. For all conditions, there was a slight drop in Medicare rates from in 2018 to 2022 (70.85% to 70.59%); however, there was a slight increase seen from 2021 to 2022 (70.07% to 70.59%). The largest drop in follow-up from 2018 to 2022 was for Asthma (-0.26%) and HTN (-0.53%). For CAD, CHF, diabetes, and hypertension there were slight increases in timely follow-up.

Figure 8. Medicare FFS: Maryland Timely Follow-Up by Condition



	ASTHMA	CAD	CHF	COPD	DIABETES	HTN	TOTAL
2018	62.76%	73.85%	72.12%	79.32%	80.60%	55.02%	70.85%
2022	61.60%	73.82%	72.56%	79.66%	81.83%	54.73%	70.59%

Note: Maryland numbers are claims-based and built on the Claim and Claim Line Feed with a four-month runout. CAD = coronary artery disease, CCW = Chronic Conditions Data Warehouse; CHF = coronary heart failure; COPD = chronic obstructive pulmonary disease; HTN = hypertension.

While some stakeholders have raised concerns around the follow-up times by condition, it is important to note that Maryland and the Nation are being measured on the same timeframes and the expectation is not 100 percent follow-up. Figure 9 shows the annual performance on the total TFU measure for Maryland and the Nation (national data is based on the Chronic Condition Warehouse 5 percent sample).

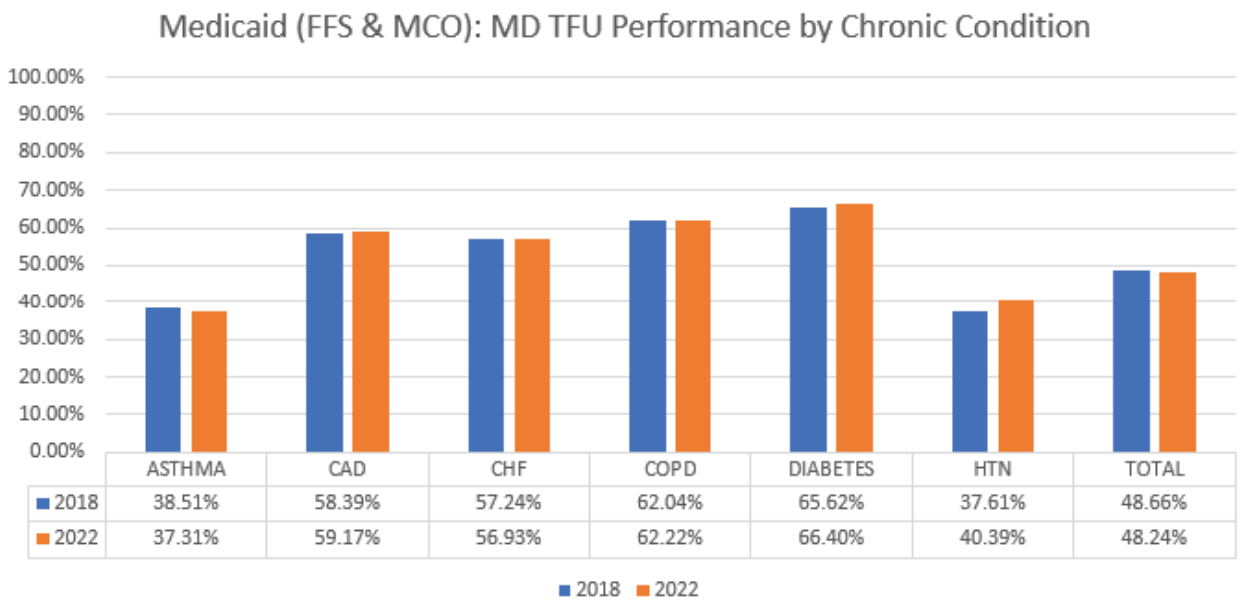
Comparing 2018 to 2022, the Nation has seen a 0.66% increase and Maryland has seen a 0.37% decrease in timely follow-up rates; however, Maryland still performs about 4.5% better than the Nation in 2022. Also, the Nation saw a decrease in timely follow-up rates comparing 2021 to 2022, while Maryland saw improvement.

Figure 9. Medicare-only: Timely Follow-Up across All Conditions

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

As part of the SIHIS proposal, it was noted that staff would explore expanding the timely follow-up rates for chronic conditions to other payers and adding follow-up after a hospitalization for behavioral health. In Calendar Year 2022, staff worked with CRISP and Maryland Medicaid to provide hospitals monthly Medicaid Timely Follow-Up reports on the CRS portal. In RY 2025, the HSCRC introduced the Medicaid Timely Follow-Up measure into the QBR program within the Person and Community Engagement domain and recommend continuing it in the RY2026 QBR program weighted the same as the Medicare measure but assessed separately. Figure 10 shows Maryland's performance over time for each chronic condition and all conditions combined for Medicaid patients.

Figure 10. Maryland Medicaid Timely Follow-Up by Condition



	ASTHMA	CAD	CHF	COPD	DIABETES	HTN	TOTAL
2018	38.51%	58.39%	57.24%	62.04%	65.62%	37.61%	48.66%
2022	37.31%	59.17%	56.93%	62.22%	66.40%	40.39%	48.24%

Staff is continuing to work to understand the Medicare and Medicaid behavioral health data to create a Timely Follow-Up monitoring report for Behavioral Health.

Disparities in Timely Follow-Up

In the Summer of CY 2022, staff convened a Health Equity Workgroup which stratified Maryland's quality measures by social demographic factors to glean disparities. For the QBR program, staff stratified the Timely Follow-Up measure by race, dual-eligibility status, and Area Deprivation Index (ADI). Results of this stratification analysis are below in Figures 11, 12, and 13, but overall the analysis found disparities on all three factors. For example, Figure 11 indicates that Blacks have a 58 percent higher odds of not receiving follow-up compared to Whites. Similar trends were seen where duals and those with higher area deprivation had a higher odds of not receiving follow-up (Figures 12 and 13).

Figure 11. Odds Ratio of No Follow-Up by Race

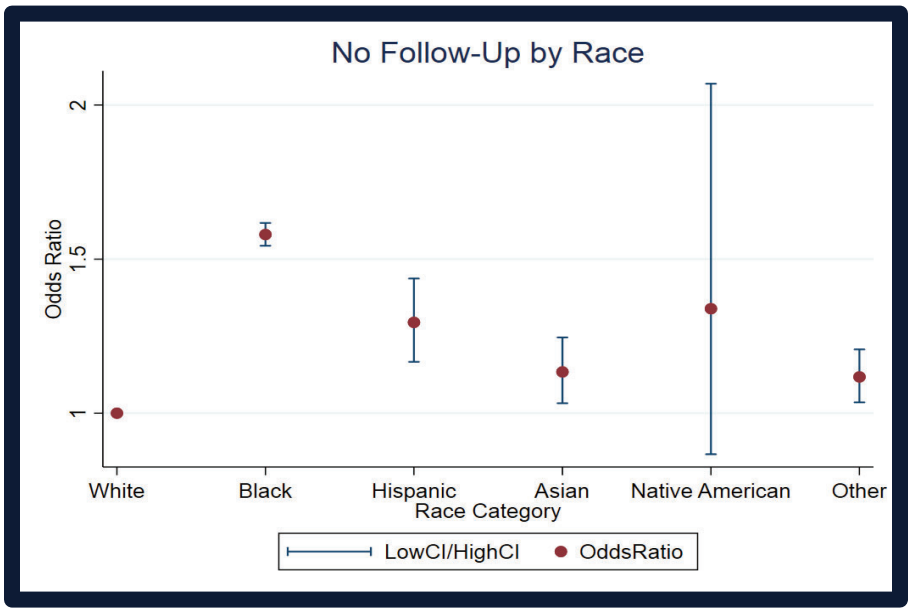


Figure 12. Odds Ratio of No Follow-Up by ADI Decile

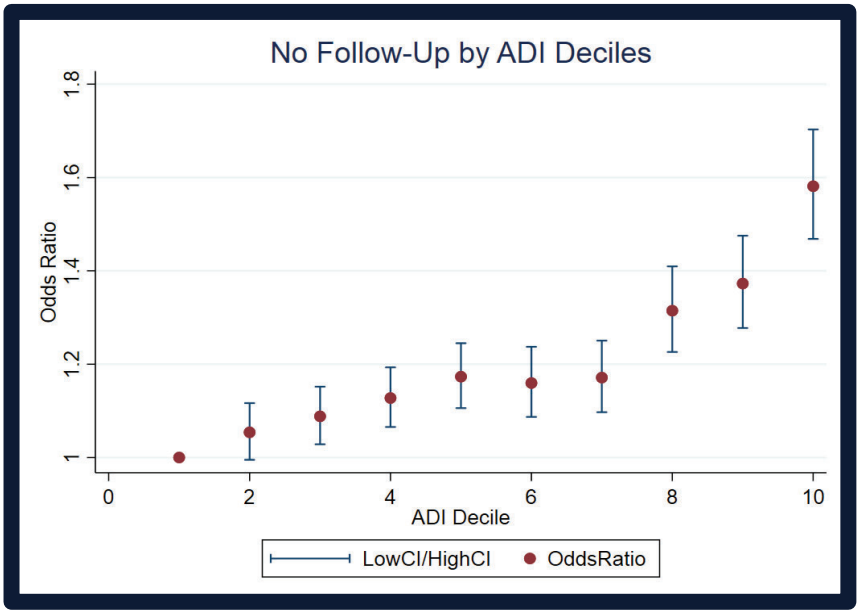
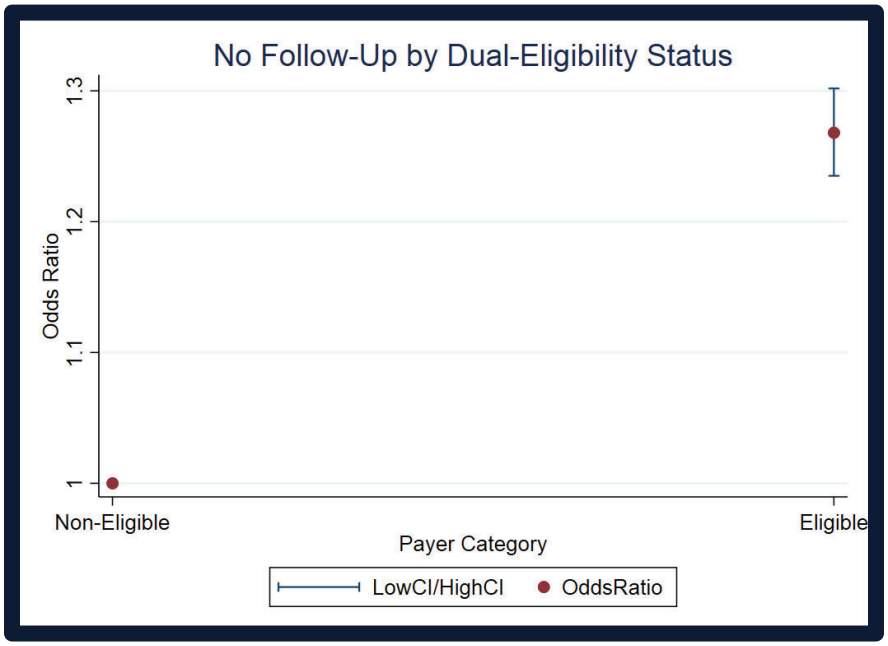


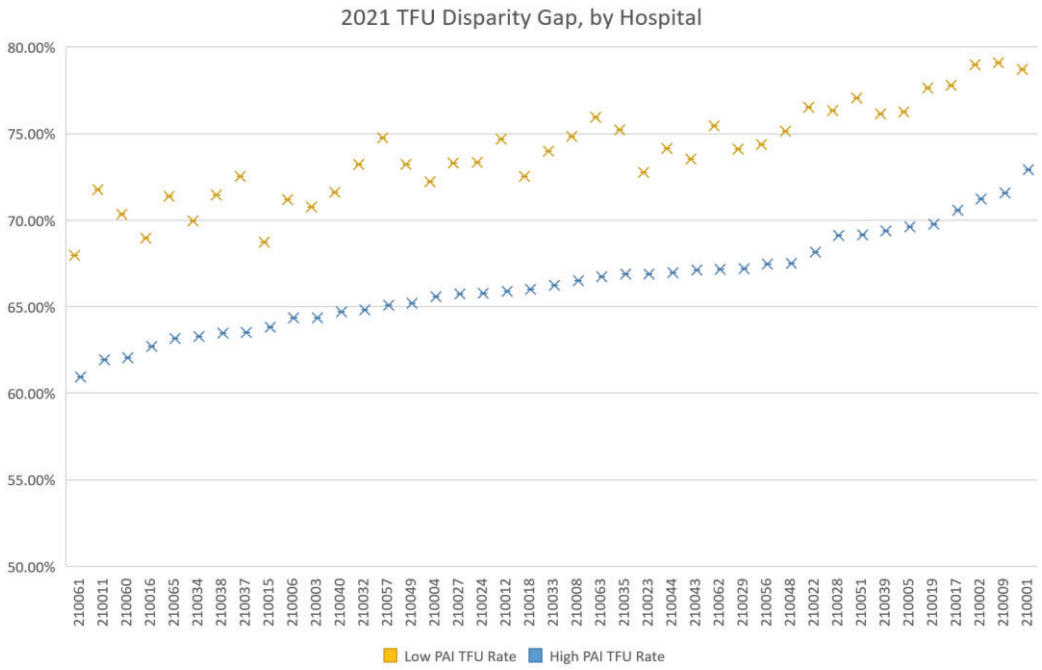
Figure 13. Odds Ratio of No Follow-Up by Dual-Eligibility Status



Given that the state did not meet the 2021 Year 3 Milestone SIHIS Target and the overwhelming evidence of disparities in this measure, HSCRC staff has developed a timely-follow up disparity gap metric that is similar to the readmissions disparity gap measure. The timely follow-up disparity gap metric takes the patient-level social exposures of race, dual eligibility status, and ADI and estimates the association between these social exposures and the likelihood of receiving a follow-up in the recommended timeframe. Based on this analysis, a TFU Patient Adversity Index score (TFU PAI) is assigned to each patient and hospitals are then assessed on the TFU rate for low and high PAI patients (i.e., the within-hospital disparity gap is the difference between these rates). The performance metric for RY 2026 would be the change in the TFU disparity gap from 2018 to 2024. Staff modeled the TFU disparity gap improvement using CY 2018 to CY 2021 and proposes to use this data to set the standards for improvement in the disparity gap for RY 2026.

Figure 14 shows the TFU disparity gaps by hospital in CY 2021. The median gap between low and high PAI patients is 7.55% percent, with a range of 4.91%-9.84% percent indicating all hospitals have a gap and there is some variation across hospitals.

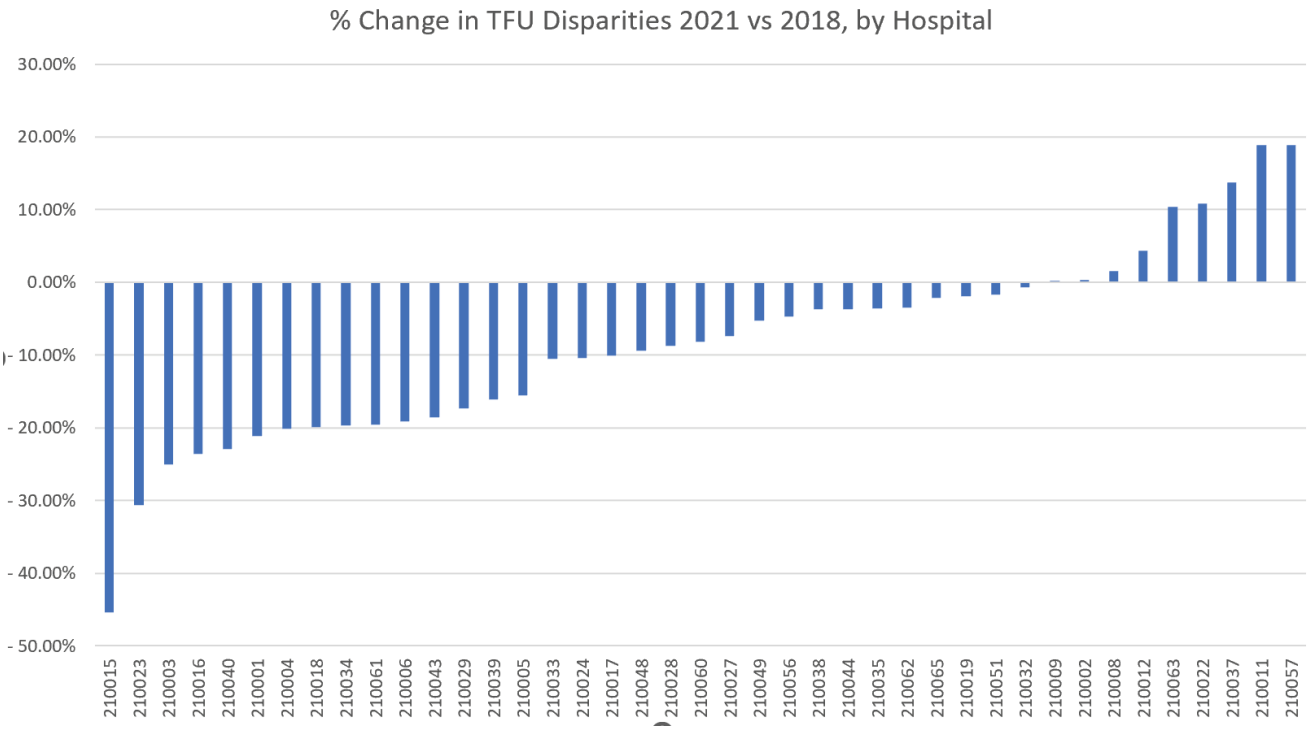
Figure 14. By Hospital TFU Disparity Gap, CY 2021



As illustrated in Figure 15 below, most (32) hospitals saw progress in the reduction of disparities in timely follow-up in 2021 compared to 2018. Nine hospitals saw increases in their disparities with two hospitals seeing almost 20% increases. To incentivize hospitals to improve on the disparities experienced by their patients, HSCRC is proposing to add this measure to the QBR program, specifically in the PCE domain. This differs from our readmission disparity gap policy where there is a stand-alone incentive on disparity reductions; however, staff proposed this approach for simplicity since QBR already has multiple measures (unlike RRIP that only had one). Staff is also recommending increasing the weight of the PCE domain to accommodate the TFU disparity measure and the ED length of stay measure (see section below on measure and domain weighting). Because the overall goal is improvement and the performance metric is percent change over time, this measure will be assessed using the attainment methodology (i.e., we will not be measuring whether there was improvement on the change in the disparity gap). However, as stated above, staff proposes to use the change in the TFU disparity gap from 2018 to 2021, to prospectively set the attainment standards. Based on this approach, the threshold to begin receiving rewards will be a 30% reduction and the benchmark to earn full rewards at a 50% reduction[5]. The threshold and benchmark were calculated as the median percent and average for the top 10th percentile of performers respectively, on the change in disparities from CY 2018 to CY 2021.

[5] The performance standards were rounded for ease of reporting.

Figure 15. By Hospital Improvements in TFU Disparity Gap, 2018 vs 2021



Safety Domain

The QBR Safety domain contains five measures from six CDC NHSN HAI categories and the AHRQ Patient Safety Index Composite (PSI-90).[6] This domain has been weighted at 35 percent of the total QBR score; however, for RY 2026 staff is proposing to lower the weight to 25 percent (this is the weight in the CMS VBP program). For the FY 2026 VBP program, CMS is adding the Sepsis and Septic Shock Management Bundle (SEP-1), a measure that has been publicly reported on Care Compare since July 2018. However, as discussed below, staff is proposing to not adopt this measure in the QBR program based on stakeholder input, inclusion of sepsis mortality in QBR, and Maryland performance on sepsis. Another difference between the VBP and QBR safety domain is that QBR has maintained the use of the AHRQ PSI measure rather than moving this measure to a standalone complications program, i.e., the MHAC program. While the Safety Domain will remain in the QBR program for RY 2026, this change may be reconsidered for future years.

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

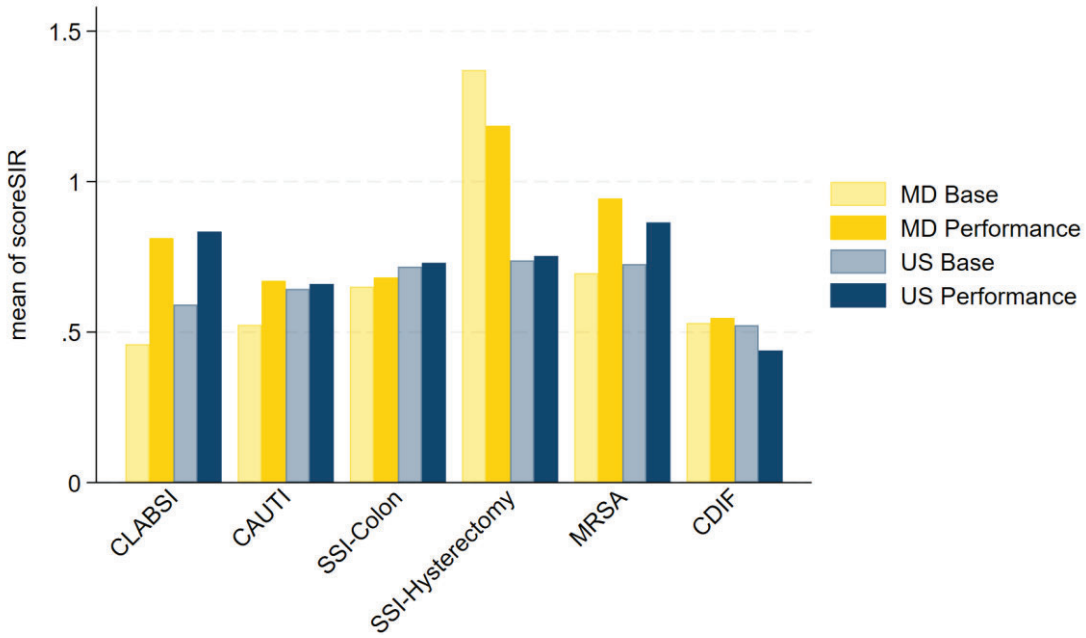
CDC NHSN HAI Measures

The CDCs National Healthcare Safety Network (NHSN) tracks healthcare-associated infections such as central-line associated bloodstream infections and catheter-associated urinary tract infections. Both Maryland and the Nation have seen increases in HAIs during CY 2020 and CY 2021 largely related to the COVID 19 pandemic, as was discussed in previous policies, and supported by peer reviewed research.[7]

CMS Care Compare has updated the Healthcare Associated Infection Standardized Infection Ratio (SIR) data tables for the Nation and by state through September 2022. Figure 16 below shows how Maryland performs relative to the nation, and how performance has changed over time for both Maryland and the nation. For the most recent time period, Maryland's performance is similar to that of the Nation on CLABSI and CAUTI, worse (higher SIRs) on SSI-hysterectomy, MRSA and CDIF, and slightly better on SSI-Colon. Nationally the SIRs got worse from the base period for CLABSI and MRSA, remained similar for CAUTI, SSI-Colon, SSI-hysterectomy, and improved for CDIF. In Maryland, the SIRs got worse from the base period for CLABSI, CAUTI, and MRSA, remained similar for SSI-Colon and CDIF, and improved for SSI-hysterectomy. Despite this performance, staff is recommending reducing the weight of the Safety domain and thus each of the NHSN measures. See RY2023 QBR policy for additional discussion of NHSN surveillance bias concerns and assessment of Maryland performance.

[7] Lastinger, L., Alvarez, C., Kofman, A., Konnor, R., Kuhar, D., Nkwata, A., . . . Dudeck, M. (2022). Continued increases in the incidence of healthcare-associated infection (HAI) during the second year of the coronavirus disease 2019 (COVID-19) pandemic. *Infection Control & Hospital Epidemiology,* 1-5. doi:10.1017/ice.2022.116

Figure 16. NHSN SIR Values for CY19 compared to Q4 CY21-Q3 CY22, Maryland versus the nation.



Patient Safety Index (PSI-90)

The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators were developed[8] and released in 2003 to help assess the quality and safety of care for adults in the hospital. PSI-90 focuses on a subset of ten AHRQ-specified PSIs of in-hospital complications and adverse events following surgeries, procedures, and childbirth. The PMWG noted previously that CMS removed the PSI-90 measure from the VBP program in FY 2024 but retained the measure in the Hospital Acquired Conditions Reduction Program. Since Maryland does not have PSI-90 in the MHAC program, staff has recommended retaining the measure in the QBR program.

As illustrated in Figure 17 below, for CY 2022 compared with FY 2021 (July 2020-June 2021), Maryland's statewide performance is as follows:

- On the overall PSI 90 composite measure, the State has improved.
- The State has **improved** with lower rates in 2022 on the following PSIs:

[8] AHRQ contracted with the University of California, San Francisco, Stanford University Evidence-based Practice Center, and the University of California Davis for development. For additional Information: https://www.qualityindicators.ahrq.gov/Modules/psi_resources.aspx

- 09 Perioperative Hemorrhage or Hematoma Rate and 14 Postoperative Wound Dehiscence Rate
- 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate.
- 11 Postoperative Respiratory Failure Rate
- 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- 13 Postoperative Sepsis Rate
- 14 Postoperative Wound Dehiscence Rate

- The State has **neither improved or worsened** on the following PSIs:
  - 06 Iatrogenic Pneumothorax Rate
  - 08 In-Hospital Fall With Hip Fracture Rate .
- The State has **worsened** with higher rates on the following PSIs:
  - 03 Pressure Ulcer Rate (slight increase)
  - 15 Abdominopelvic Accidental Puncture or Laceration Rate

Figure 17. Maryland Statewide All-Payer Performance on PSI-90 and Component Indicators, CY 2022 Compared to FY 2021 (July 2020-June 2021)

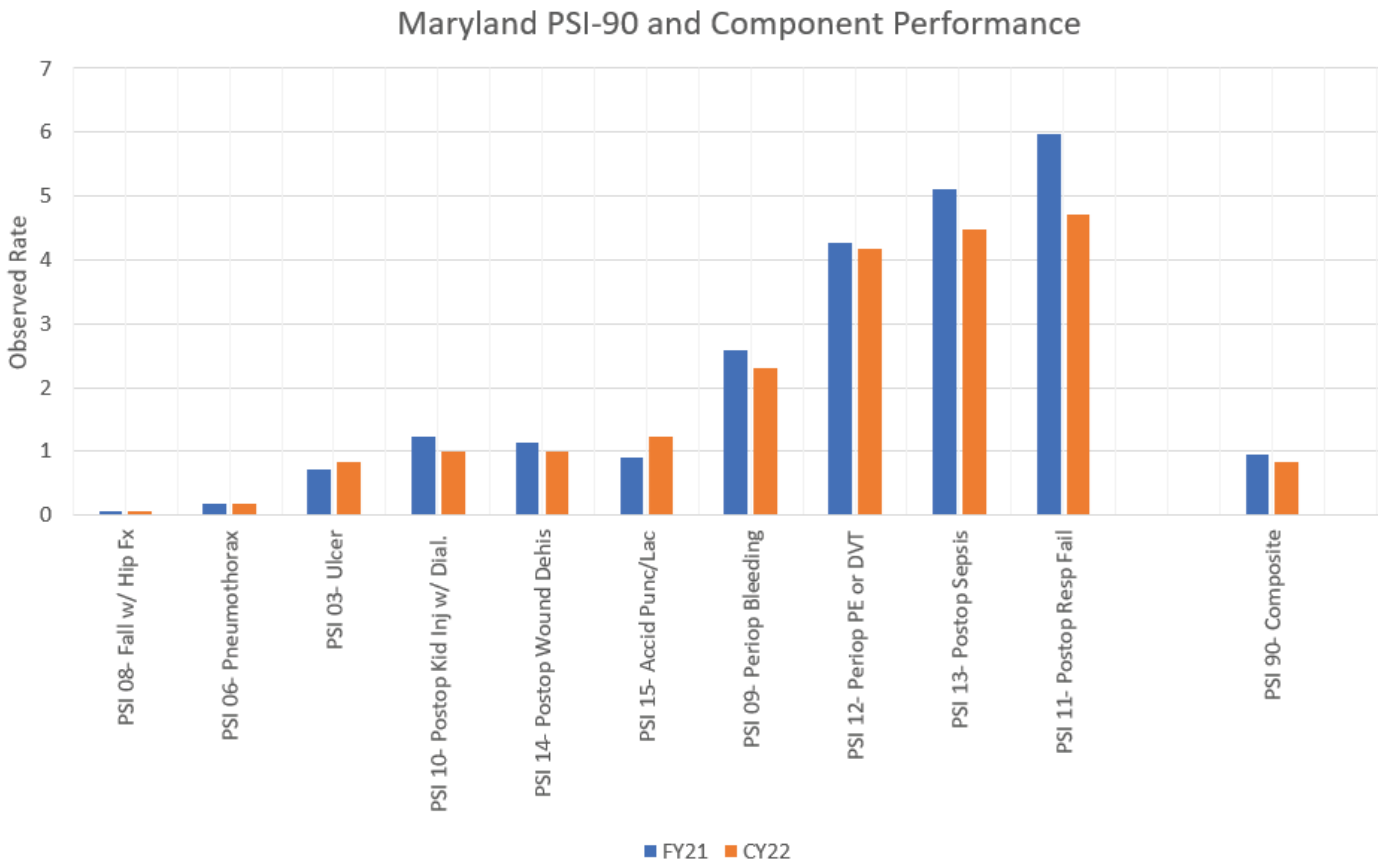
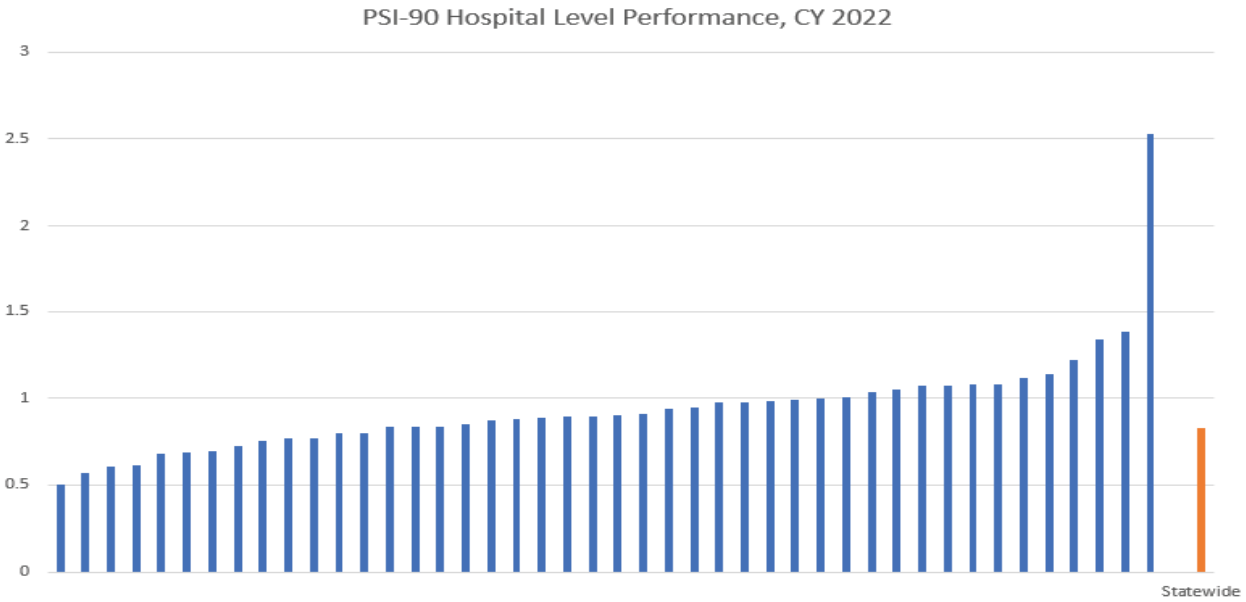


Figure 18 below illustrates the hospital-level performance on the all-payer PSI-90 composite measure for CY 2022; consistent with last year, the variation in performance by hospital suggests there may be opportunity for improvement on this measure.

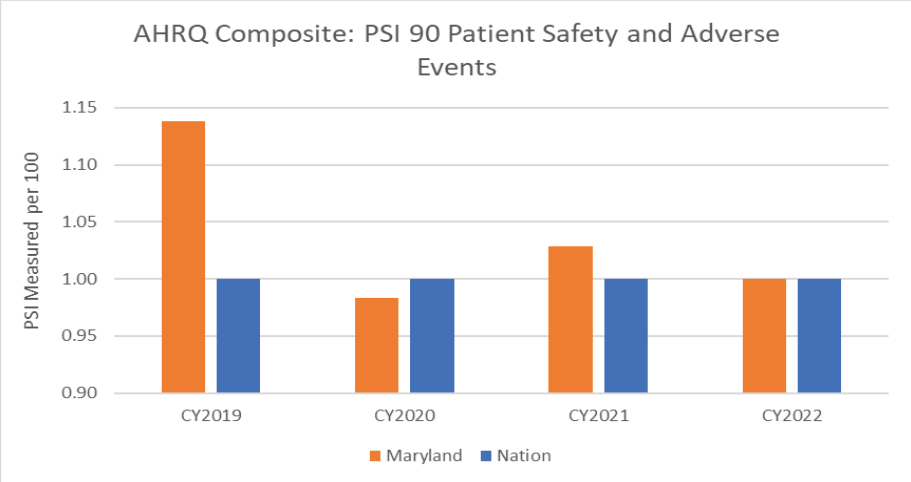
Figure 18. PSI-90 Hospital-Level Performance, CY 2022[9]



The Agency for Research and Quality publishes all-payer risk-adjusted PSI 90 data by state and for the Nation using the hospital Healthcare Cost and Utilization Project (HCUP) data; as Figure 19 below, Maryland performs on par with the Nation based on the most currently available CY 2022 data.

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

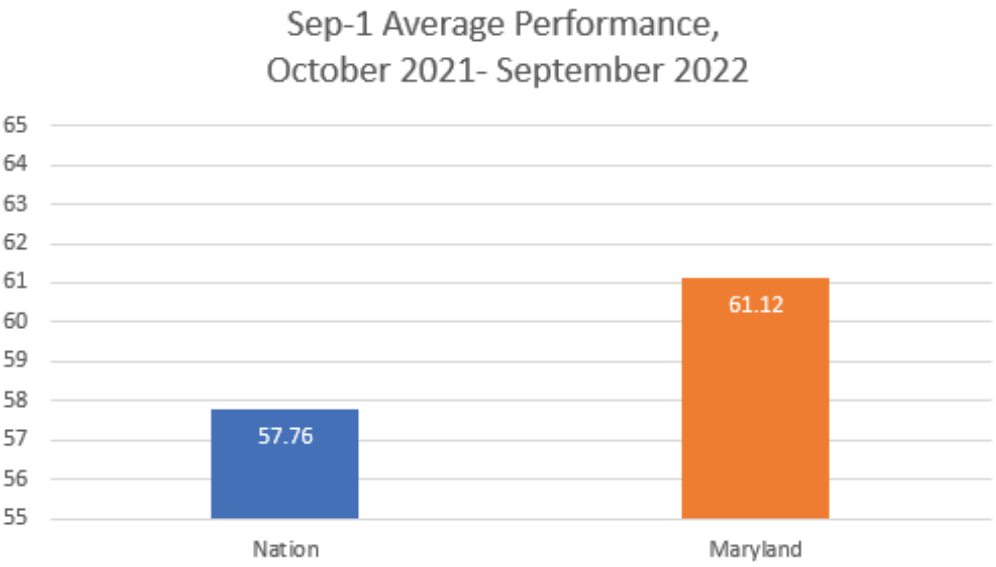
Figure 19. Maryland vs. National Performance on PSI 90 Composite Measure, CY 19-CY 22[10]



New VBP Measure: Sep-1 measure–Early Management Bundle, Severe Sepsis/Septic Shock

As noted previously, Medicare is adopting the Sep-1 measure into the VBP program in FY 2026. As illustrated in Figure 20 below, Maryland performs favorably on the Sep-1 measure compared to the nation.

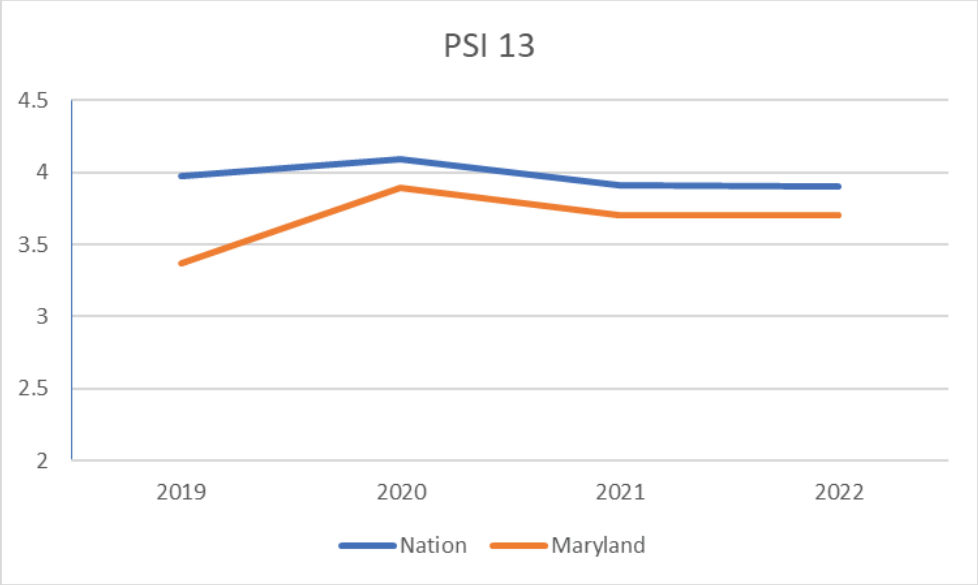
Figure 20. Maryland vs. the Nation, Sep-1 Early Management Bundle Measure



[10] Data provided by MHCC used for the Maryland Hospital Performance Guide published on the MHCC website.

There are opposing views on the SEP-1 measure adoption for payment. On one hand, some providers have voiced concerns that it mandates an inflexible "one size fits all" therapeutic approach for sepsis that lacks a sufficient level of evidence for the highly diverse group of patients it is directed at.[11] On the other hand, because of its emphasis on timing, an opposing perspective is that the SEP-1 measure is lifesaving and long supported by the Sepsis Alliance.[12] In contrast with the CMS VBP program, the QBR program has retained the PSI 90 composite measure in the Safety domain with PSI 13 Postoperative Sepsis included as one of the 10 measures in the PSI 90 composite. On PSI 13, Maryland has improved from FY 2021 to CY 2022 as noted in the PSI 90 section above; as shown in Figure 21 below, Maryland has performed consistently favorably compared to the Nation from CY 2019-2022.

Figure 21. PSI 13 Postoperative Sepsis, Maryland vs. the Nation 2019-2022



The PMWG stakeholders discussed the Sep-1 bundle measure and also voiced concerns about its universal applicability and efficacy for all patients identified with sepsis in the hospital based on the definitions used in the measure. Stakeholders also noted that unlike nationally, Maryland's inpatient mortality measure applies to all causes and all conditions, including sepsis, which likely has an impact on sepsis performance. Given the concerns about the sepsis bundle process measure and Maryland's

[11] Wang J, Strich JR, Applefeld WN, Sun J, Cui X, Natanson C, Eichacker PQ. Driving blind: instituting SEP-1 without high quality outcomes data. J Thorac Dis. 2020 Feb;12(Suppl 1):S22-S36. doi: 10.21037/jtd.2019.12.100. Erratum in: J Thorac Dis. 2021 Jun;13(6):3932-3933. PMID: 32148923; PMCID: PMC7024755.

[12] Sepsis Alliance: Found at: https://www.sepsis.org/news/sep-1-update-inclusion-in-hospital-value-based-purchasing-program-is-a-victory-for-patients/; last accessed, 10/10/2023.

favorable performance on sepsis-related outcome measures, staff is proposing to not adopt the Sepsis bundle measure at this time. However, staff supports the development of a sepsis dashboard, which includes the Sep-1 process measure along with other outcome measures such as postoperative sepsis complications and mortality, for continued monitoring of sepsis performance in Maryland. If performance deteriorates or concerns with the sepsis bundle measure are addressed, staff will reconsider its inclusion in QBR for future years.

Clinical Care Domain

This domain, weighted at 15 percent of the QBR score, currently includes:

- Inpatient, all-payer, all-condition mortality measure
- Inpatient Medicare Total Hip Arthroplasty-Total Knee Arthroplasty (THA/TKA) Complications measure. This is also used by the CMS VBP program.

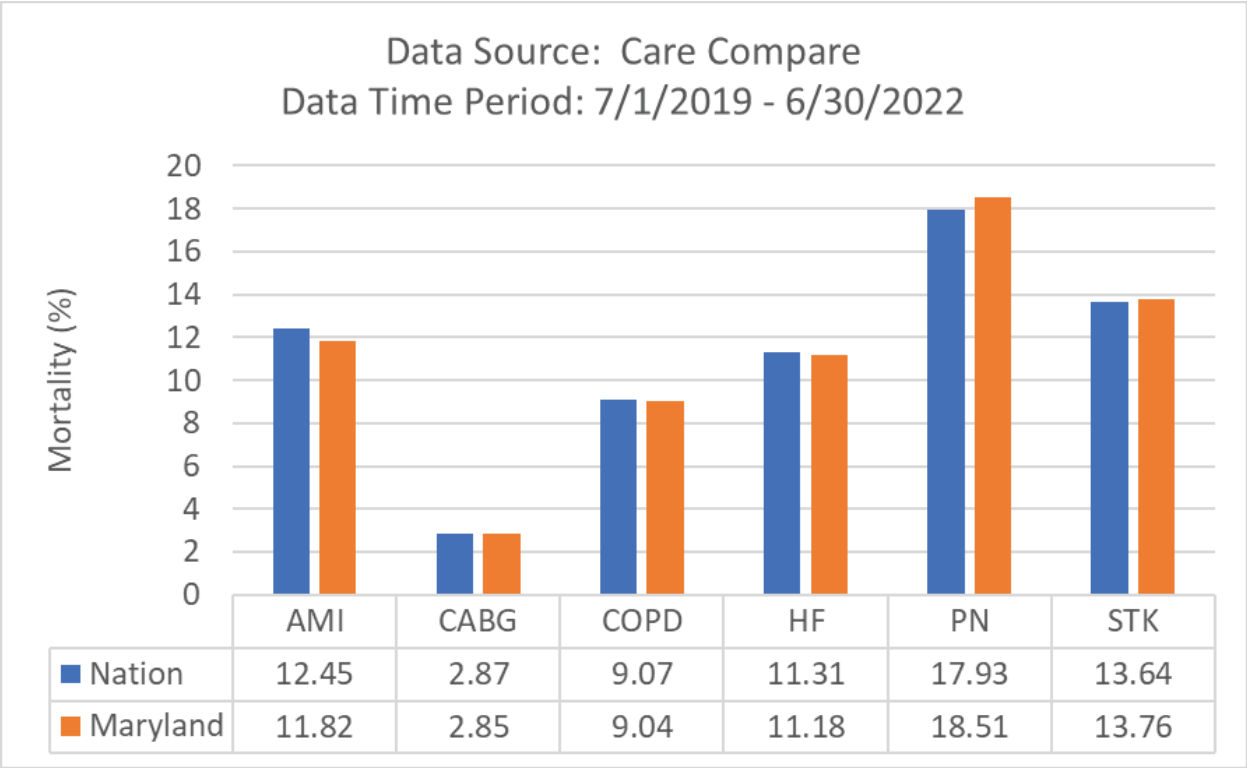
Of note, Maryland's QBR mortality measure currently differs from the CMS VBP Program that uses four condition-specific, 30-day mortality measures for Medicare beneficiaries. Medicare also monitors two additional 30-day mortality measures for Coronary Artery Bypass Graft (CABG) and Stroke (STK). The HSCRC has developed an all-payer, all-cause 30 day mortality measure and staff recommends adopting this measure into the QBR program for RY 2026.

Mortality

CMS 30-Day Condition-Specific Mortality Measures

Based on the most recently available data through June of 2022, Maryland performs on par or better than the Nation on five out of six of the condition specific mortality measures. Specifically, Maryland performs better than the Nation on AMI, CABG, COPD, HF, and STK but worse on pneumonia (Figure 22). It should be noted that this data was impacted by the COVID PHE and that the first 6 months of CY 2020 was excluded from the three-year measure (i.e., the measurement period was shorter than normal).

Figure 22. Maryland vs. National Hospital Performance on CMS Condition-Specific Mortality Measures

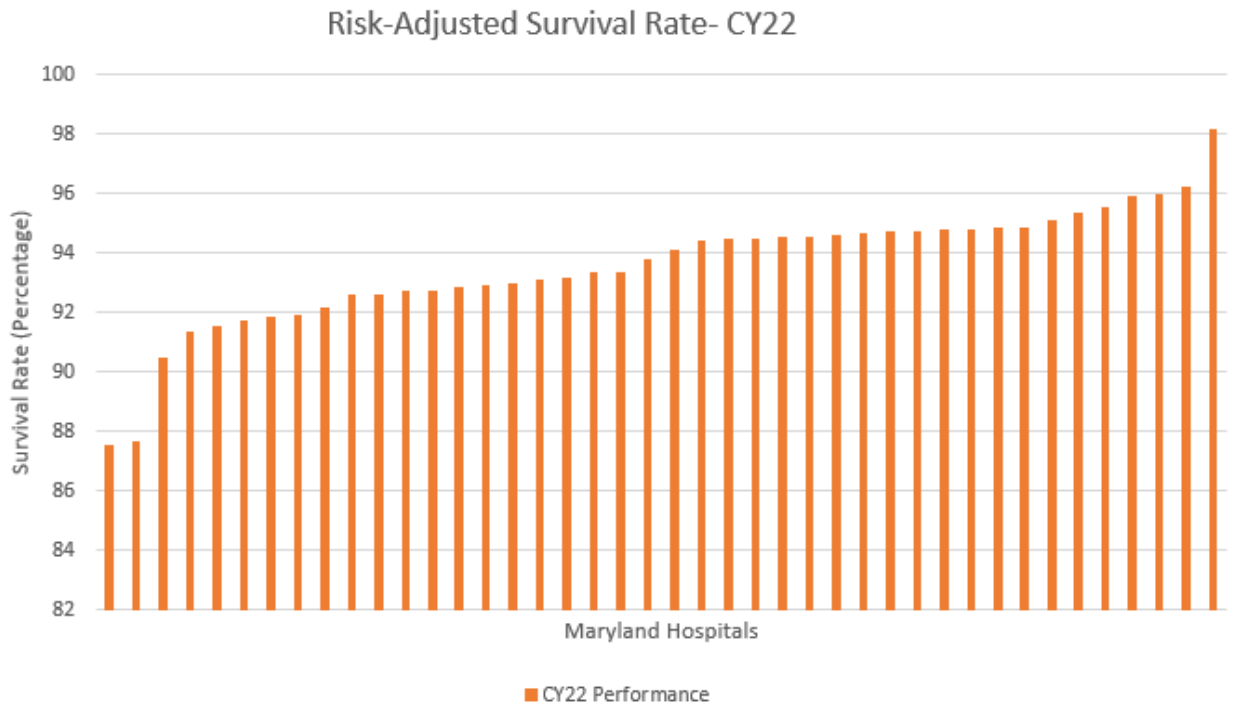


	AMI	CABG	COPD	HF	PN	STK
Nation	12.45	2.87	9.07	11.31	17.93	13.64
Maryland	11.82	2.85	9.04	11.18	18.51	13.76

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

For the QBR all-payer inpatient mortality measure, which assesses hospital services where 80 percent of the mortalities occur (80% DRG exclusion), statewide survival rate decreased during the COVID PHE from 94.86% in CY 2019 to 93.55% in the CY 2022 performance period. These mortality results were derived with a modified risk-adjustment model - COVID status during admission and percent of patients at the hospital with COVID to the CY 2021 were added regression to better account for COVIDs impact on mortality. As illustrated in Figure 23 below, there are two hospitals that appear to have lower survival rates, whereas most perform above 90 percent.

Figure 23. Maryland Hospital Performance, CY 2022 QBR Inpatient All Condition, All Payer Mortality Measure

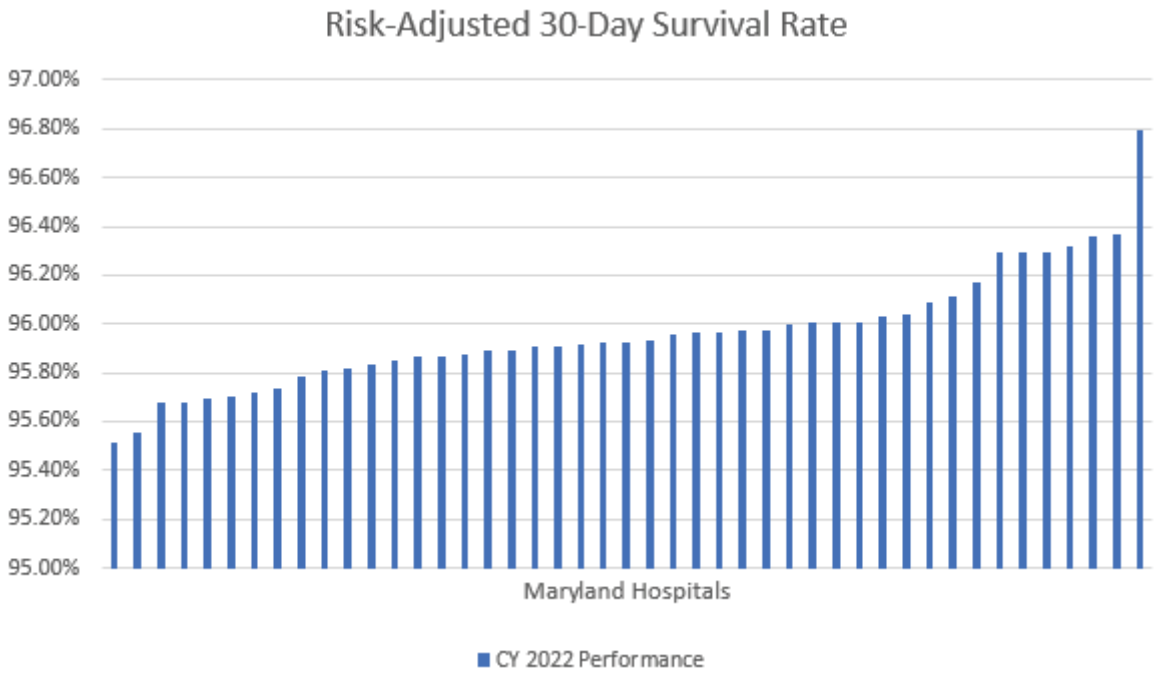


New 30-Day Inpatient, All-payer, All-condition Mortality Measure

HSCRC began reporting the 30-day, all-payer, all-condition, all-cause mortality measure to hospitals through the CRISP portal in CY 2023. The measure was developed by Mathematica based on the CMS 30-day all-payer, all-cause mortality measure and adapted for use of all-payer, APR DRG patient-level data. Staff believes that expansion to a 30-day measure in the payment program better captures and incentivizes the quality of care delivered by a hospital, expanding beyond the wall of the hospital. Staff is recommending the addition of the 30-day, all-payer, all-condition, all-cause mortality measure for the 2026 QBR program. In CY 2022, as shown in Figure 24 below, survival rates range from 95.2 percent to 96 percent. While staff believes that expansion to a 30-day measure will better capture the quality of care delivered by hospitals, this measure was not strongly correlated with the inpatient measure. Based on PMWG discussion in October, for RY 2026 staff agrees to split the mortality weight equally between the all-payer, all-cause, inpatient and 30-day mortality measures. In future years staff will further examine the correlation between inpatient and 30-day mortality and decide whether to fully move to the 30-day measure or maintain both measures if the inpatient measure is capturing different patients based on the 80 percent DRG selection. In the future staff may want to explore whether there is sufficient weight on mortality overall, given the significance of this outcome and because it is how we are assessing sepsis

performance (as opposed to adding Sepsis bundle measure). However, for RY 2026, staff is not proposing to make any changes to the Clinical Care Domain.

Figure 24. Maryland Hospital Performance, CY 2022 30-Day, All Cause All Condition, All Payer Mortality Measure

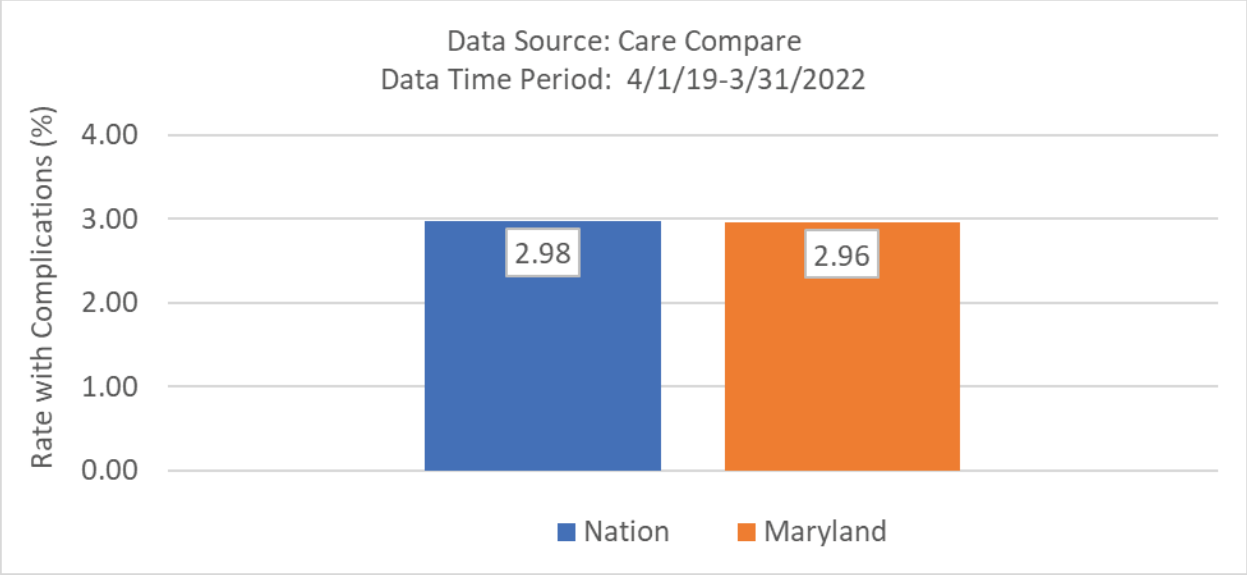


Last, as part of the digital measures initiative, staff plans to consider transitioning from the fully claims-based measure to the hybrid 30-day mortality measure (claims plus Core Clinical Data Elements) in the future. In order to do this on an all-payer basis, electronic health record (EHR) vendors will need to be able to adapt measures specifically for Maryland's all-payer measurement environment, a difficult undertaking according to hospitals and EHR vendors providing feedback to staff.

Hip and Knee Arthroplasty Complications

For the hip and knee complication rate measure based on the most recent data available on Care Compare, Figure 25 illustrates that, based on analysis of the weighted average rates for Maryland and the Nation, Maryland performed on par with the Nation.

Figure 25. Maryland THA/TKA Measure Performance Compared to the Nation, 4/1/19-3/31/2022



Since this measure currently includes only Medicare inpatients, stakeholders of the PMWG have voiced support for expanding this measure to the commercial population and for inpatient and outpatient settings when feasible. Commission staff has had discussions over the last few years with the PMWG and other stakeholders on strategies for inclusion of outpatient measures in the program; going forward, Commission staff will continue to work with the PMWG and other stakeholders on building a multiyear, multipronged, broad strategy in this area. Specifically, for a THA/TKA measure, staff and stakeholders have begun to explore approaches to adapting CMS's current claims-based inpatient THA/TKA measure to the all-payer population, and the feasibility, validity and reliability of specifying the eCQM version of the measure at the hospital level. Further in the future, staff and stakeholders should explore the feasibility of developing an infrastructure to collect and use a hospital-level patient-reported outcome performance measure (PRO-PM) for elective primary THA/TKA procedures. For additional specific details on the options for THA/TKA outpatient and all-payer measure adoption or adaptation, please see the Quality Based Reimbursement RY 2024 Policy.

Digital Measures Near-Term Reporting Requirements

In CY 2021 Maryland implemented a statewide infrastructure and required all acute hospitals to report to HSCRC electronic Clinical Quality Measures (eCQM) measures beginning in CY 2022, with planned expansion to other digital measures going forward. The reporting requirements are more aggressive than the national CMS requirements as Maryland believes early adoption and migration to the digital data and measures will constitute less burden for hospitals and provide greater opportunity for the state and hospitals to measure and improve quality. Figure 26 below illustrates the Maryland and CMS reporting

requirements for eCQMs. Staff notes that, in alignment with the State's goals to improve on maternal health and the SIHIS goal to reduce Severe Maternal Morbidity, the HSCRC required submission of the Severe Obstetric Complications measure beginning in CY 2022, a year ahead of CMS' requirement for hospitals to submit this eCQM; through data/information sharing, staff will continue collaboration with the Maryland's Dept of Health on this important population health improvement priority.

Figure 26. CMS-Maryland CY 2023-CY 2024 Anticipated eCQM Reporting Requirements

Reporting Period/ payment determination	CMS Measures	Maryland Measures
CY 2024/ FY 2026	Three self-selected eCQMs; Three required eCMQs -Safe Use of Opioids -Cesarean Birth -Severe Obstetric Complications Clinical data elements for two hybrid measures -30-day mortality -30-day readmissions	One-two self-selected eCQMs; Required eCQMs- -Safe Opioids -hypoglycemia -hyperglycemia -Cesarean Birth -Severe Obstetric complications Clinical data elements for two hybrid measures -30-day mortality -30-day readmissions

In addition to the eCQM reporting requirements, Maryland will also utilize the established infrastructure to collect 30-day Hospital Wide Readmission (HWR) and Hospital Wide Mortality (HWM) hybrid measures required as of July 1, 2023. The state notes that subsequent transition to and adoption of an all-payer hybrid HWM measure will allow for its use in the QBR program.

Domain and Measure Weighting

As discussed in the previous sections, the staff proposes to modify the domain and measure weights for RY 2026 to improve the saliency of new measures, e.g., ED Wait Times, Disparities in Timely Followup. The Performance Measurement Workgroup expressed reservations about revising QBR weighting prior to a larger assessment of all at-risk quality assessments; however, staff believes incremental adjustments are necessary to ensure ED wait times and other new measures yield performance improvement.

These weights are proposed for Commissioner and other stakeholder input. This is a recap of the proposed changes:

- Overall QBR Domains:

- Decrease Safety Domain by 10 percent to match its weight in CMS VBP program
- Increase PCE Domain by 10 percent and lower HCAHPS linear weight to accommodate addition of TFU disparity gap and ED wait time measure (i.e., do not change weight on HCAHPS top box or consistency)
- Within the Clinical Care domain, split the weight between 30-day, mortality and IP mortality

Figure 27 provides the proposed domain weights and then provides measure weights within each domain and estimated revenue adjustments for a hospital with $250M in inpatient revenue. Estimating revenue adjustments by measure helps assess the salience of the potential revenue adjustments for hospitals. For RY 2026 the proposed changes are to reduce the Safety Domain from 35 to 25 percent to match the CMS VBP program and to reduce the weight on the HCAHPS linear scores within the PCE Domain. This reduced weight is then split between the three TFU measures and the yet to be finalized/chosen ED LOS measure. Based on this proposal, the three TFU measures (Medicare, Medicaid, and the disparity gap) and the ED LOS measure will be worth 10 percent of the QBR score. For an average hospital with $250M in revenue, this means $500,000 would be at-risk for penalties or rewards for ED LOS and also for TFU. If the ED LOS measure is not adopted, the Commission can consider where the additional weight should be applied. Options could include not reducing the HCAHPS linear weight, increasing weight on TFU, or increasing weight on other measures such as mortality or the AHRQ PSI composite. In the future, staff believes it will be necessary to have a larger discussion on percent at-risk across quality programs. For example, staff believes that the weight on QBR will need to be increased if additional measures are added or more salient incentives are needed to motivate hospital improvement. This could be accomplished, as discussed by PMWG, by increasing the QBR percent at-risk to 3 percent and reducing the MHAC percent at-risk to 1 percent, or by moving the Safety Domain from the QBR program to the MHAC program. In conclusion, staff welcomes Commissioner input on weighting and salience of incentives for vetting with stakeholders, PMWG, and incorporated into the final policy.

Figure 27. RY 2026 Proposed Domain and Measure Weighting and Revenue Adjustments for Average Hospital

RY2026 Proposed Weighting (2% total at-risk)	Domain Weight	QBR Program Weight	IP Revenue at Risk (%)	Revenue at Risk ($) for Hospital w/$250k IP Revenue
PCE Domain		**60%**	**1.20%**	**$3,000,000**
HCAHPS TopBox (8)	41.67%	25.00%	0.50%	$1,250,000
HCAHPS Consistency	16.67%	10.00%	0.20%	$500,000
HCAHPS Linear (4)	8.33%	5.00%	0.10%	$250,000
ED Wait Times	16.67%	10.00%	0.20%	$500,000
TFU Medicare	5.56%	3.33%	0.07%	$166,667
TFU Medicare Disparity Gap	5.56%	3.33%	0.07%	$166,667
TFU Medicaid	5.56%	3.33%	0.07%	$166,667
Clinical Care Domain		**15%**	**0.30%**	**$750,000**
IP Mortality	33.33%	5.000%	0.10%	$250,000
30-Day Mortality	33.33%	5.000%	0.10%	$250,000
THA/TKA	33.33%	5.000%	0.10%	$250,000
Safety Domain		**25%**	**0.50%**	**$1,250,000**
CAUTI	16.6667%	4.17%	0.08%	$208,333
C. Diff	16.6667%	4.17%	0.08%	$208,333
SSI (2)	16.6667%	4.17%	0.08%	$208,333
CLABSI	16.6667%	4.17%	0.08%	$208,333
MRSA	16.6667%	4.17%	0.08%	$208,333
PSI 90 (10)	16.6667%	4.17%	0.08%	$208,333

Revenue Adjustment Methodology

The revenue adjustments for QBR are calculated using a preset scale so that hospitals can prospectively and concurrently track financial performance in quality programs. In addition to determining the range of the scale, the cut point for penalties and rewards needs to be set such that it does not reward the highest performing Maryland hospitals for performance that is subpar compared to the nation. However, establishing this cut point prospectively has become more difficult to do over the course of the COVID-19 PHE. As mentioned previously, quality of care declined over the COVID-PHE in Maryland and Nationally. Thus, both the RY 2024 and RY 2025 policies indicated that the cut point would be reassessed retrospectively with more recent national data. While this is inconsistent with the guiding principle to

provide hospitals with a way to monitor revenue adjustments during the performance year, it protects Maryland hospitals from excessive penalties due to changes in performance post-COVID compared to national hospitals. Below is a discussion of the more recent analyses and a proposed new cut point for RY2024, as well as updates and recommendations for RY2025 and RY2026.

RY2024 Final Cut Point Recommendation

The cut point at which a hospital earns rewards or receives a penalty has been based on an analysis of the national VBP Program scores. For RY 2024 and RY 2025, federal fiscal years 2016–2021 were used to calculate the average national score using Maryland QBR domain weights (without the Efficiency domain). This resulted in a cut-point around 41 percent (range of scores was from 38.5 to 42.7). To assess whether this cut point fairly assesses Maryland hospital performance relative to the nation, staff attempted to repeat this analysis with more recent data. While the exact analysis could not be conducted because there are no more recent VBP scores, the VBP measure data is available on Care Compare. For measures unique to Maryland (i.e., not available for national hospitals on Care Compare) the median Maryland points were used for all hospitals. This analysis was conducted for FY2022 and repeated for FY2021 (where we did have VBP scores to see how the results compared using this method to the method that reweighted domains). Currently staff is checking these analyses and attempting to run additional years, however initial analyses do confirm that nationally estimated scores are significantly lower post COVID. However, given these are all estimates staff believes a multi-year average is needed and do not support using FY2022 only. The final QBR policy will provide a revised cut point for Commissioner consideration and approval.

RY2025 Update

As with RY 2024, staff will reassess the current preset scale for RY 2025 as was indicated in the policy. Similar considerations will be examined as was done for RY2024; however, it should be noted that the performance standards for RY2025 are post-COVID and thus the base periods are reflective of worse patient experience and quality of care. This could increase improvement points for performance that returns to pre-pandemic levels. Providing rewards or lower penalties for returning to pre-pandemic performance may be questionable. Thus further discussion is needed amongst stakeholders once data is available to determine the best way to adjust the RY 2025 scaling.

RY2026 Revenue Adjustment Scale

For this policy, staff believes it is still important to have a preset method for taking scores and converting those scores to revenue adjustments on a prospective basis despite the concerns discussed above. Thus for RY 2026, staff proposes to maintain the 0-80 percent scale where rewards start for those who score greater than 41 percent. As was done for RY 2024 and will be done for RY 2025, staff will retrospectively assess the cut point with more recent data. However, unlike with RY2024, the staff

believes QBR scores may be on the rise since the performance standards are now set during the post-COVID time period. Thus, the cut point could decrease or increase with this retrospective assessment. As with RY2024, staff will not use a single year of data to determine the cut point. Thus staff proposes to maintain the current scale, but determine if the cut point needs to be amended once we have more recent complete data. If staff determines the cut point needs to be amended, we will report this to the Commission.

DRAFT RECOMMENDATIONS FOR RY 2026 QBR PROGRAM

6. Modify Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 60 percent (+10%), Safety (NHSN measures) - 25 percent (-10%), Clinical Care - 15 percent (no change).
    a. Within the PCE domain:
        i. Increase domain weight to 60 percent to accommodate new measures but do not increase the weight on HCAHPS top-box and consistency scores.
        ii. Continue to include four linear HCAHPS measures but reduce overall weight by half to accommodate new measures.
        iii. Continue to include Medicare and Medicaid Timely Follow-Up (TFU) rates and add TFU Disparity Gap measure.
        iv. Add an ED wait time measure.
    b. Within the Safety domain:
        i. Reduce overall domain weight from 35 to 25 percent to match CMS VBP program.
    c. Within the Clinical Care domain:
        i. Continue to include the inpatient mortality measure in the program.
        ii. Add the all-payer, all-cause 30-Day Mortality measure.
        iii. Split the weight on mortality between the two mortality measures.
7. Develop the following monitoring reports to track hospital performance::
    a. Timely Follow-Up for Behavioral Health
    b. Sepsis Dashboard: Sepsis mortality, Sep-1 measure–Early Management Bundle, Severe Sepsis/Septic Shock
8. Continue implementing the HCAHPS improvement framework with key stakeholders.
    a. Explore statewide adoption of added question(s) to the survey linked to best practice with evidence that implementation improves HCAHPS scores.
    b. Address emergency department length of stay/hospital throughput issues as strategy to improve HCAHPS
9. Continue collaboration with CRISP and other partners on infrastructure to collect hospital electronic clinical quality measures and core clinical data elements for hybrid measures;

10. Maintain the pre-set scale (0-80 percent with cut-point at 41 percent) and continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) for the QBR program.
    a. Retrospectively evaluate 41 percent cut point using more recent data to calculate national average score for RY25 and RY26
    b. Based on more analyses on the impact of pre-COVID performance standards on national hospital performance, adjust the RY24 QBR cut point to be [to be determined in final policy, see discussion under revenue adjustment section]

APPENDIX A: QBR PROGRAM BACKGROUND

Maryland's QBR Program, in place since July 2009, uses measures that are similar to those in the federal Medicare VBP Program, under which all other states have operated since October 2012. Similar to the VBP Program, the QBR Program currently measures performance in Clinical Care, Safety, and Person and Community Engagement domains, which comprise 15 percent, 35 percent, and 50 percent of a hospital's total QBR score, respectively. For the Safety and Person and Community Engagement domains, which constitute the largest share of a hospital's overall QBR score (85 percent), performance standards are the same as those established in the national VBP Program. The Clinical Care Domain, in contrast, uses a Maryland-specific mortality measure and benchmarks. In effect, Maryland's QBR Program, despite not having a prescribed national goal, reflects Maryland's rankings relative to the Nationby using national VBP benchmarks for the majority of the overall QBR score.

In addition to structuring two of the three domains of the QBR Program to correspond to the federal VBP Program, the HSCRC has increasingly emphasized performance relative to the Nation through benchmarking, domain weighting, and scaling decisions. For example, beginning in RY 2015, the QBR Program began using national benchmarks to assess performance for the Person and Community Engagement and Safety domains. Subsequently, the RY 2017 QBR policy increased the weighting of the Person and Community Engagement domain, which was measured by the national HCAHPS survey instrument to 50 percent. The weighting was increased to raise incentives for HCAHPS improvement, as Maryland has consistently lagged behind the Nation on these measures. In RY 2020, ED-1b and ED-2b wait time measures for admitted patients were added to this domain, with the domain weight remaining at 50 percent. In RY 2021, the domain weight remained constant, but the ED-1b measure was removed from the program. For RY 2022, ED-2b was removed from QBR because CMS no longer required submission of the measure for the Inpatient Quality Reporting Program.

The QBR domains and weights have remained constant from RY2023 to RY2025; modifications are proposed for RY 2026. Although the QBR Program has many similarities to the federal Medicare VBP Program, it does differ because Maryland's unique model agreements and autonomous position allow the state to be innovative and progressive. Figure 1 below illustrates the QBR RY2025 measurement domains and weights compared with what is proposed for RY 2026 and the National VBP program.

Figure 1. RY 2025 and Proposed RY 2026 QBR measures and domain weights compared with those used in the VBP Program

Domain	Maryland RY 2025 QBR domain weights and measures	Maryland Proposed RY 2026 QBR domain weights and measures	CMS VBP domain weights and measures
Clinical Care	**15 percent** Two measures: All-cause inpatient mortality; THA/TKA complications	**15 percent (no change)** Three measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality, THA/TKA complications	**25 percent** Five measures: Four condition-specific mortality measures; THA/TKA complications
Person and Community Engagement	**50 percent** Nine measures: Eight HCAHPS categories top box score and consistency, and four categories linear score; TFU Medicare, Medicaid.	**60 percent (+10%)** 11 measures: Eight HCAHPS categories top box score and consistency, and four categories linear score; TFU Medicare, Medicaid, disparities improvement; ED LOS.	**25 percent** Eight HCAHPS measures top box score.
Safety	**35 percent** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**25 percent (-10%)** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**25 percent** Five measures: CDC NHSN HAI measures
Efficiency	n.a.	n.a.	**25 percent** One measure: Medicare spending per beneficiary

Note: Details of CMS VBP measures can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019. It involves (1) assessing performance on each measure in the domain; (2) standardizing measure scores relative to performance standards; (3) calculating the total points a hospital earned divided by the total possible points for each domain; (4) finalizing the total hospital QBR score (0–100 percent) by weighting the domains based on the overall percentage or importance the HSCRC has placed on each domain; and (5) converting the total hospital QBR scores into revenue adjustments, using a preset scale ranging from 0 to 80 percent.

QBR program revenue at risk

The HSCRC sets aside a percentage of hospital inpatient revenue to be held "at risk" based on each hospital's QBR Program performance. Hospital performance scores are translated into rewards and penalties in a process called scaling.[13] Rewards (positive scaled amounts) or penalties (negative scaled

[13] Scaling refers to the differential allocation of a predetermined portion of base-regulated hospital inpatient revenue based on an assessment of hospital performance.

amounts) are then applied to each hospital's update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered permanent revenue. The HSCRC previously approved scaling a maximum reward of 2 percent and a penalty of 2 percent of the total approved base revenue for inpatients across all hospitals.

HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the CMS VBP Program, where feasible,[14] enabling the HSCRC to use data submitted directly to CMS. Maryland implemented an efficiency measure outside of the QBR Program, based on potentially avoidable utilization (PAU). The PAU savings adjustment to hospital rates is based on the costs of potentially avoidable admissions, as measured by the Agency for Healthcare Research and Quality's Prevention Quality Indicators and avoidable readmissions. HSCRC staff will continue to work with key stakeholders to develop updates to efficiency measure that incorporate population-based cost outcomes.

QBR score calculation

QBR scores are evaluated by comparing a hospital's performance rate to its base period rate, as well as to the threshold (which is the median, or 50th percentile, of all hospitals' performance during the baseline period) and the benchmark (which is the mean of the top decile, or roughly the 95th percentile, during the baseline period).

Attainment points: During the performance period, attainment points are awarded by comparing a hospital's rates with the threshold and the benchmark. With the exception of the Maryland mortality measure and ED wait time measures, the benchmarks and thresholds are the same as those used by CMS for the VBP Program measures.[15] For each measure, a hospital that has a rate at or above the benchmark receives 10 attainment points. A hospital that has a rate below the attainment threshold receives 0 attainment points. A hospital that has a rate at or above the attainment threshold and below the benchmark receives 1–9 attainment points.

Improvement points: Improvement points are awarded by comparing a hospital's rates during the performance period to the hospital's rates from the baseline period. A hospital that has a rate at or above the attainment benchmark receives 9 improvement points. A hospital that has a rate at or below the baseline period rate receives 0 improvement points. A hospital that has a rate between the baseline period rate and the attainment benchmark receives 0–9 improvement points.

[14] VBP measure specifications can be found at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

[15] One exception is the ED wait time measures. For these measures, attainment points are not calculated; instead, the full 10 points are awarded to hospitals at or below (more efficient) than the national medians for their respective volume categories in the performance period.

Consistency points: Consistency points are awarded only in the HCAHPS measure in the Experience of Care domain. The purpose of these points is to reward hospitals that have scores above the national 50th percentile in all eight HCAHPS dimensions. If they do, they receive the full 20 points. If they do not, the dimension for which the hospital received the lowest score is compared to the range between the national 0 percentile (floor) and the 50th percentile (threshold) and is awarded points proportionately.

Domain denominator adjustments: In certain instances, QBR measures will be excluded from the QBR Program for individual hospitals. Hospitals are exempt from measurement for any of the NHSN Safety measures for which there is less than one predicted case in the performance period. If a hospital is exempt from an NHSN measure, its Safety domain score denominator is reduced from 50 to 40 possible points. If it is exempt from two measures, the Safety domain score denominator would be 30 possible points. Hospitals must have at least two of five Safety measures to be included in the Safety domain.

Domain scores: The better of the attainment score and improvement score for each measure is used to determine the measure points for each measure. The measure points are then summed and divided by the total possible points in each domain and multiplied by 100.

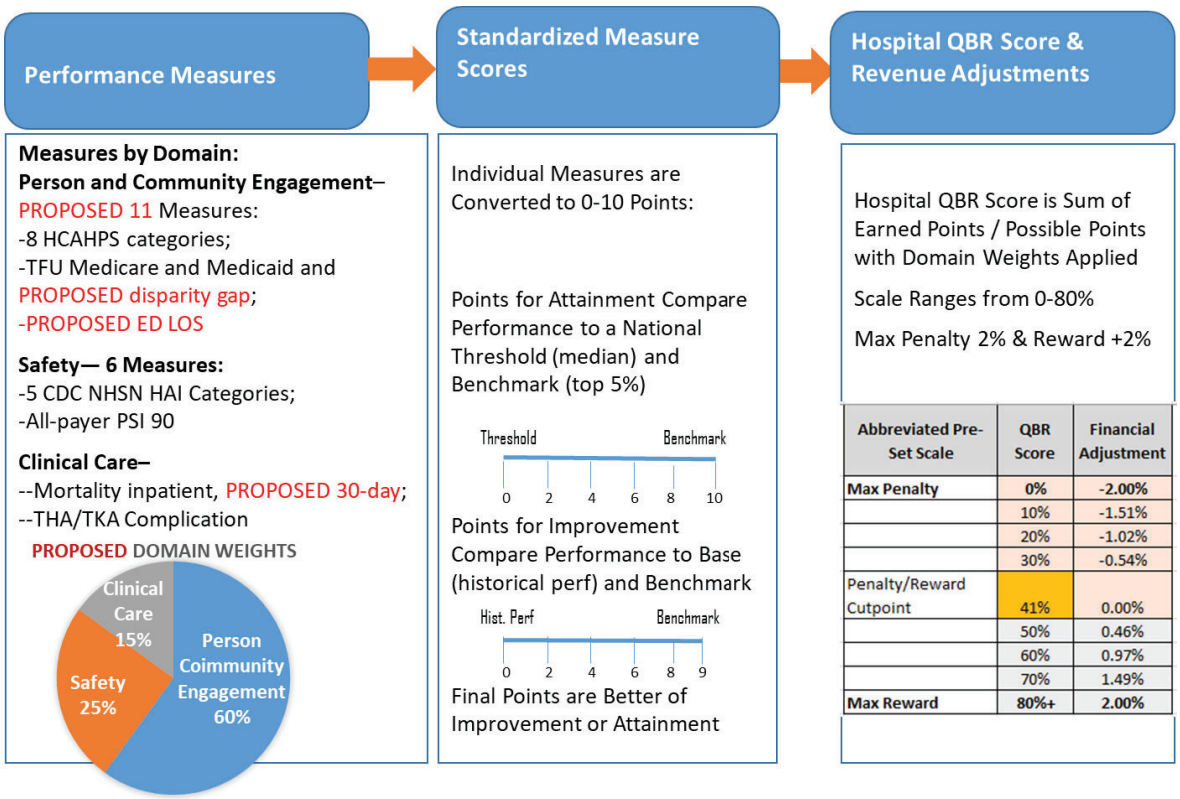
Total performance score*:* The total performance score is computed by multiplying the domain scores by their specified weights and then adding those totals together. The total performance score is then translated into a reward or penalty that is applied to hospital revenue.

RY 2023-RY 2026 Updates to the QBR Program

For RY 2023, the HSCRC did not make fundamental changes to the QBR Program's methodology but implemented the addition of the Follow-Up After Acute Exacerbation of Chronic Conditions measure and PSI-90 composite measures. The methodology remained unchanged from RY 2023-2025.

Figure 2 shows the steps for converting measure scores to standardized scores for each measure, and then to rewards and penalties based on total scores earned, reflecting the updates proposed for RY 2026.

Figure 2. Process for calculating RY 2026 QBR scores, and Proposed updates for RY 2026



PSI 90 measure (adopted beginning RY 2023)

Newly adopted in RY 2023, the Patient Safety Indicator composite measure was developed by the Agency for Healthcare Research and Quality in 2003.[16] CMS first adopted the composite measure in the VBP program in FFY 2015 and removed the measure in FY 2019-FY 2022 due to operational constraints from the International Classification of Diseases, Tenth Revision (ICD-10) transition. The HSCRC had used the ICD-9 version of this measure in the QBR program but applied it to Maryland's all-payer population. CMS adopted the updated NQF endorsed ICD-10 version of the measure (Medicare only) that is used beginning with the FY 2023 Hospital VBP program[17] , and also adopted by the QBR program (all-payer version) in RY 2023.

AHRQ's specified PSI uses include:

- Assess, monitor, track, and improve the safety of inpatient care

[16] Source: https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2020/TechSpecs/PSI%2090%20Patient%20Safety%20and%20Adverse%20Events%20Composite.pdf.

[17] For more information on the measure removal and adoption, reference the FY 2018 IPPS/LTCH PPS final rule (82 FR 38242-38244) and (82 FR 38251-38256).

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

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

- PSI 03 Pressure Ulcer Rate
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall With Hip Fracture Rate
- PSII 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

PSI 90 combines the smoothed (empirical Bayes shrinkage) indirectly standardized morbidity ratios (observed/expected ratios) from selected Patient Safety Indicators. The weights of the individual component indicators are based on two concepts: the volume of the adverse event and the harm associated with the adverse event. The volume weights were calculated based on the number of safety-related events for the component indicators in the all-payer reference population. The harm weights were calculated by multiplying empirical estimates of the probability of excess harms associated with each patient safety event by the corresponding utility weights (1–disutility). Disutility is the measure of the severity of the adverse events associated with each harm (for example, the outcome severity or the least-preferred states from the patient perspective).

The PSI 90 measure scores are converted to program scores, as described in the QBR Score Calculation section of this appendix.

Follow-Up After Acute Exacerbation for Chronic Conditions (adopted for RY 2023)

Newly proposed for RY 2023, this measure was developed by IMPAQ on behalf of CMS.[18] Technical details for calculating measure scores are provided below.

Measure full title: Timely Follow-Up After Acute Exacerbations of Chronic Conditions

Measure steward: IMPAQ International

Description of measure: The percentage of issuer-product-level acute events requiring an ED visit or hospitalization for one of the following six chronic conditions: hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes mellitus (Type I or Type II), where follow-up was received within the time frame recommended by clinical practice guidelines in a non-emergency outpatient setting.

Unit of analysis: Issuer-by-product

Numerator statement: The numerator is the sum of the issuer-product-level denominator events (ED visits, observation hospital stays, or inpatient hospital stays) for acute exacerbation of the following six conditions in which follow-up was received within the time frame recommended by clinical practice guidelines:

1. Hypertension: Within 7 days of the date of discharge
2. Asthma: Within 14 days of the date of discharge
3. HF: Within 14 days of the date of discharge
4. Coronary artery disease: Within 14 days of the date of discharge
5. Chronic obstructive pulmonary disease: Within 30 days of the date of discharge
6. Diabetes: Within 30 days of the date of discharge

Numerator details: This measure is defined at the issuer-by-product level, meaning that results are aggregated for each qualified insurance issuer and for each product. A product is defined as a discrete package of health insurance coverage benefits that issuers offer in the context of a particular network type, such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity. Issuers are broadly defined as health insurance providers who participate in the Federally Facilitated Marketplaces and health insurance contracts offered in the Medicare Advantage market.

[18] Source: https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions

Timely follow-up is defined as a claim for the same patient after the discharge date for the acute event that (1) is a non-emergency outpatient visit and (2) has a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code indicating a visit that constitutes appropriate follow-up, as defined by clinical guidelines and clinical coding experts. The follow-up visit may be an office or telehealth visit and takes place in certain chronic care or transitional care management settings. The visit must occur within the condition-specific time frame to be considered timely and for the conditions specified in the numerator. For a list of individual codes, please see the data dictionary.[19]

The time frames for a follow-up visit for each of the six chronic conditions are based on evidence-based clinical practice guidelines, as laid out in the evidence form.

Denominator statement: The denominator is the sum of the acute events—that is, the issuer-product-level acute exacerbations that require an ED visit, observation stay, or inpatient stay—for any of the six conditions listed above (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes).

Denominator details: Acute events are defined as either an ED visit, observation stay, or inpatient stay. If a patient is discharged and another claim begins for the same condition on the same day or the following day, the claims are considered to be part of one continuous acute event. In this case, the discharge date of the last claim is the beginning of the follow-up interval. The final claim of the acute event must be a discharge to community.

An acute event is assigned to [condition] if:

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

OR

2. The primary diagnosis is a related code for [condition] AND at least one additional diagnosis is a sufficient code for [condition].
    - If the event has two or more conditions with a related code as the primary diagnosis and a sufficient code in additional diagnosis positions, **assign the event to the condition with a sufficient code appearing in the "highest" (closest to the primary) diagnosis position**.

If the visits that make up an acute event are assigned different conditions, the event is assigned the condition that occurs last in the sequence. Following this methodology, only one condition is recorded in the denominator per acute event.

Denominator exclusions: The measure excludes events with:

[19] Please see https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions.

1. Subsequent acute events that occur two days after the prior discharge but still during the follow-up interval of the prior event for the same reason; to prevent double-counting, the denominator will include only the first acute event
2. Acute events after which the patient does not have continuous enrollment for 30 days in the same product
3. Acute events in which the discharge status of the last claim is not “to community” (“left against medical advice” is not a discharge to community)
4. Acute events for which the calendar year ends before the follow-up window ends (for example, acute asthma events ending less than 14 days before December 31)
5. Acute events in which the patient enters a skilled nursing facility, non-acute care, or hospice care during the follow-up interval

Measure scoring:

1. Denominator events are identified by hospitalization, observation, and ED events with appropriate codes (that is, codes identifying an acute exacerbation of one of the six included chronic conditions).
2. Exclusions are applied to the population from Step 1 to produce the eligible patient population (that is, the count of all qualifying events) for the measure.
3. For each qualifying event, the claims are examined to determine whether they include a subsequent code that satisfies the follow-up requirement for that event (for example, whether a diabetes event received follow-up within the appropriate time frame for diabetes, from an appropriate provider). Each event for which the follow-up requirement was satisfied is counted as one in the numerator. Each event for which the follow-up requirement was not satisfied is counted as zero in the numerator.
4. The percentage score is calculated as the numerator divided by the denominator.

Measure-scoring logic: Following the National Quality Forum’s guideline, we use **opportunity-based weighting** to calculate the follow-up measure. This means each condition is weighted by the sum of acute exacerbations that require either an ED visit or an observation or inpatient stay for all of the six conditions that occur, as reflected in the logic below.

[NUM(ASM) + NUM(CAD) + NUM(HF) + NUM (COPD) + NUM(DIAB) + NUM(HTN)] / [DENOM(ASM) + DENOM(CAD) + DENOM(HF) + DENOM (COPD) + DENOM(DIAB) + DENOM(HTN)]

Although the development team designed the measure to aggregate each condition score in the manner described above into a single overall score, programs may choose to also calculate individual scores for

each chronic condition when implementing the measure. Individual measure scores would be calculated by dividing the condition-specific numerator by the condition-specific denominator, as in the example for heart failure: NUM(HF) / DENOM(HF).

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

Digital Quality Measures Infrastructure: CMS Roadmap

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

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

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

Maryland, like CMS, believes that In the future, interoperability of EHR and other digital health data can fuel a revolution in healthcare delivery and advance Measure Calculation Tools to leverage data beyond just EHRs and across settings and providers. CMS has outlined a roadmap to transition from the current

environment to a learning health system powered by advanced analytics applied to all digital health data to optimize patient safety, outcomes, and experience.[20]

[20] Please see full details on CMS Digital Quality Measurement Strategic Roadmap: https://ecqi.healthit.gov/sites/default/files/CMSdQMStrategicRoadmap_032822.pdf, last accessed 8/9/2022.

QBR RY 2026 timeline: base and performance periods; financial impact

PROPOSED Quality Based Reimbursement (QBR) Program Rate Year 2026 Base and Performance Periods

Rate Year (Maryland Fiscal Year)	Q3-21	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23	Q3-23	Q4-23	Q1-24	Q2-24	Q3-24	Q4-24	Q1-25	Q2-25	Q3-25	Q4-25	Q1-26	Q2-26	Q3-26	Q4-26
Calendar Year	Q1-21	Q2-21	Q3-21	Q4-21	Q1-22	Q2-22	Q3-22	Q4-22	Q1-23	Q2-23	Q3-23	Q4-23	Q1-24	Q2-24	Q3-24	Q4-24	Q1-25	Q2-25	Q3-25	Q4-25	Q1-26	Q2-26
					Base Period: CMS Hospital Compare (HCAHPS , NHSN measures)																Rate Year Impacted by QBR Results	
												Performance Period: CMS Hospital Compare (HCAHPS, NHSN measures)									
							Base Period: QBR Maryland Mortality, PSI-90, TFU, ED LOS															
													Performance Period: Maryland Mortality, PSI-90, TFU, ED LOS								
		Hospital Compare THA/TKA Performance Period*																				

APPENDIX B: RY 2024 QBR PERFORMANCE BY HOSPITAL

HOSPID	HOSPITAL NAME	FY23 Estimated Permanent Inpatient Revenue*	RY 2024 Final	% Revenue Impact	$ Revenue Impact
210001	MERITUS	$ 236,441,777	15.73%	-1.23%	-$2,908,234
210002	UNIVERSITY OF MARYLAND	$ 1,419,452,964	20.10%	-1.02%	-$14,478,420
210003	PRINCE GEORGE	$ 282,004,743	12.71%	-1.38%	-$3,891,665
210004	HOLY CROSS	$ 397,412,083	14.17%	-1.31%	-$5,206,098
210005	FREDERICK MEMORIAL	$ 255,798,612	21.44%	-0.95%	-$2,430,087
210006	HARFORD	$ 68,386,364	31.44%	-0.47%	-$321,416
210008	MERCY	$ 216,769,130	23.33%	-0.86%	-$1,864,215
210009	JOHNS HOPKINS	$ 1,702,715,898	35.15%	-0.29%	-$4,937,876
210011	ST. AGNES	$ 233,444,507	23.08%	-0.87%	-$2,030,967
210012	SINAI	$ 515,384,553	16.67%	-1.19%	-$6,133,076
210015	FRANKLIN SQUARE	$ 338,396,055	14.17%	-1.31%	-$4,432,988
210016	WASHINGTON ADVENTIST	$ 225,684,639	22.73%	-0.89%	-$2,008,593
210017	GARRETT COUNTY	$ 25,525,538	47.98%	0.36%	$91,892
210018	MONTGOMERY GENERAL	$ 88,807,087	15.00%	-1.27%	-$1,127,850
210019	PENINSULA REGIONAL	$ 308,473,682	24.42%	-0.81%	-$2,498,637
210022	SUBURBAN	$ 227,224,802	20.79%	-0.99%	-$2,249,526
210023	ANNE ARUNDEL	$ 385,505,885	15.63%	-1.24%	-$4,780,273
210024	UNION MEMORIAL	$ 283,598,962	37.69%	-0.16%	-$453,758
210027	WESTERN MARYLAND	$ 190,230,034	19.17%	-1.06%	-$2,016,438
210028	ST. MARY	$ 98,242,476	36.75%	-0.21%	-$206,309
210029	HOPKINS BAYVIEW MED CTR	$ 455,171,792	17.08%	-1.17%	-$5,325,510
210032	UNION HOSPITAL OF CECIL	$ 90,564,569	18.40%	-1.10%	-$996,210
210033	CARROLL COUNTY	$ 157,367,331	26.83%	-0.69%	-$1,085,835
210034	HARBOR	$ 129,425,148	26.83%	-0.69%	-$893,034
210035	CHARLES REGIONAL	$ 98,358,514	23.31%	-0.86%	-$845,883
210037	EASTON	$ 119,931,603	14.25%	-1.30%	-$1,559,111
210038	UMMC MIDTOWN	$ 137,864,557	14.56%	-1.29%	-$1,778,453
210039	CALVERT	$ 82,099,977	37.63%	-0.16%	-$131,360
210040	NORTHWEST	$ 157,220,825	25.33%	-0.76%	-$1,194,878
210043	BALTIMORE WASHINGTON	$ 326,459,954	25.02%	-0.78%	-$2,546,388
210044	G.B.M.C.	$ 254,895,213	22.50%	-0.90%	-$2,294,057
210048	HOWARD COUNTY	$ 214,071,732	20.56%	-1.00%	-$2,140,717
210049	UPPER CHESAPEAKE HEALTH	$ 201,124,139	19.08%	-1.07%	-$2,152,028
210051	DOCTORS COMMUNITY	$ 176,421,777	30.50%	-0.51%	-$899,751
210056	GOOD SAMARITAN	$ 191,497,544	32.75%	-0.40%	-$765,990
210057	SHADY GROVE	$ 321,044,393	10.58%	-1.48%	-$4,751,457
210060	FT. WASHINGTON	$ 31,642,518	11.80%	-1.42%	-$449,324
210061	ATLANTIC GENERAL	$ 45,367,141	27.75%	-0.65%	-$294,886
210062	SOUTHERN MARYLAND	$ 196,475,930	22.58%	-0.90%	-$1,768,283
210063	UM ST. JOSEPH	$ 280,257,927	33.44%	-0.37%	-$1,036,954
210065	HC-GERMANTOWN	$ 79,412,195	12.50%	-1.39%	-$1,103,830
	Statewide Total	**$11,246,174,568**			**-$97,898,473**

APPENDIX C. HCAHPS IMPROVEMENT FRAMEWORK

Administrative Leadership Accountability:

Working with MHCC, HSCRC has identified key staff at each hospital accountable for HCAHPS survey administration, data analysis, and improvement. HSCRC has engaged these hospital contacts in activities established under the HCAHPS improvement framework, including sharing of data and best practices.

> ***Timeline Status:*** *HSCRC began communications with key HCAHPS hospital contacts early in 2023 and will continue to communicate on an ongoing basis with these contacts regarding options for improving best practices, results of data analysis, and potential new incentives or measures targeted at improving HCAHPS (e.g.,adding ED wait time measures back to the payment program).*

Data Analysis and Data Sharing:

HSCRC is working with MHCC on HCAHPS data analysis using the newly obtained patient level data. As discussed in this Appendix below, the analysis includes hospital performance by patient-specific demographic factors that may be contributing to hospital-specific trends or that indicate disparities in performance.

MHCC Patient Level HCAHPS Analysis Results

Starting in CY 2022, MHCC requires that Maryland hospitals submit patient level HCAHPS data to them directly. This investment in data investment was implemented by the state to address the ongoing HCAHPS performance concerns, with a focus on identifying disparities on HCAHPS ratings by patient demographics and service lines. MHCC has begun analyzing patient level data of 33,134 surveys collected from 2021 Q3 to 2022 Q2. The findings of their analysis are summarized in the MHCC slides presented at the PMWG March 2023 presentation:

- White respondents are more highly represented than black or other respondent categories relative to their proportion in Maryland's population from the 2020 Census.
- When collapsing "would recommend" categories into two, "No" = Definitely No/Probably No - 2,263 (7%), and "Yes" = Definitely Yes/Probably Yes - 30,871 (93%):
    - Maryland responses are similar to those of the Nation.
    - More black respondents than expected indicated the "No" category.
- When collapsing overall ratings into three categories: (1). 6 or lower, (2).7 or 8, and (3). 9 or 10:
    - Maryland responses are lower in the 9 or 10 category than the Nation.

    - There are relatively fewer white respondents and more black respondents in the 6 or lower category.
- For the responses by service line in Maryland, there were 4,760 surveys within the Maternity service line comprising 15% of the total, 17,475 surveys within Medical comprising 54% of the total, and 10,285 surveys within Surgical comprising 32% of the total. As illustrated in Figure 9 below:
    - Black respondents are relatively more highly represented in the Maternity service line compared with the Medical and Surgical service lines.
    - There are significant differences between black and non-black respondents for the Maternity service line:
        - For "would recommend", there were significantly more "No" reported by black patients than expected.
        - For the Overall Rating, there were significantly more "6 or lower" reported by black patients than expected.

Timeline Status: *HSCRC conducts ongoing analysis on HCAHPS top box and linear scores and will continue to do this work going forward using the patient level data in collaboration with MHCC. HCAHPS data submission began in Q3 CY 2021. MHCC has analyzed the initial year of patient-level HCAHPS data hospitals have submitted (CY 2021 Q3-CY 2022 Q2). These results have been shared with the hospitals and will be further discussed with stakeholders as future policies to advance health equity for patient experience are considered. Additionally, HSCRC is in the process of surveying hospitals on any additional questions beyond the standard they are asking patients based on best practices.*

Hospital Adoption and Sharing of Best Practices:

HSCRC has begun collaborations with representatives from the organizations listed below to explore options that have promise for disseminating best practices among hospitals.

Maryland Hospital Association- HSCRC believes that MHA is an important stakeholder for convening hospitals and facilitating sharing of best practices, similar to work they conducted in 2018 and 2019. Further, they have resources such as the Maryland Healthcare Education Institute (MHEI) subsidiary and the Maryland Patient Safety Center (MPSC) partnership that may be helpful in these efforts. In ongoing discussions with MHA, they have indicated their commitment to supporting hospitals' efforts to improve on HCAHPS.

Qlarant– Qlarant is the QIN-QIO working with Maryland hospitals on Person and Family Engagement (PFE), which should improve patient experience. In a Performance Measurement Workgroup presentation, Qlarant advised that hospitals can choose to participate in the Hospital Quality Improvement Contract and access support from American Institutes for Research[21] (AIR) to implement five learning modules:

- PFE 1: Preadmission Planning Checklist
- PFE 2: Discharge Planning Checklist
- PFE 3: Shift Change Huddles and bedside reporting
- PFE 4:Designated PFE Leader
- PFE 5: Person Family Advisory Committee (PFAC) or representatives on hospital committees

HSCRC believes that improvement in PFE has potential to improve HCAHPS scores. HSCRC will continue to consider options to encourage hospitals to participate in PFE training. The HSCRC also continues to discuss with Qlarant how to align hospital quality improvement efforts across the State. Qlarant participates in the PMWG meetings to help provide input on resources for hospital quality improvement. In the October 2023 PMWG meeting, AIR presented on the potential for engagement for patient and family advisors to improve HCAHPS.

Press Ganey– The HSCRC staff has reached out to Press Ganey, the largest HCAHPS survey vendor, to discuss Maryland performance and disparities in HCAHPS performance. In these discussions, representatives noted that hospital HCAHPS scores nationally show similar trends to those in Maryland with regard to lower minority response rates, lower scores during and post-COVID, and lower scores among black patients in the maternity service line. Additionally, in discussing best practices, Press Ganey emphasized the importance of HCAHPS performance and the CMS position on HCAHPS:

> "Patient experience surveys sometimes are mistaken for customer satisfaction surveys. Patient experience surveys focus on how patients experienced or perceived key aspects of their care, not how satisfied they were with their care. Patient experience surveys focus on asking patients whether or how often they experienced critical aspects of health care, including communication with their doctors, understanding their medication instructions, and the coordiNation of their healthcare needs. They do not focus on amenities."

[21]Person and Family Engagement Implementation Guides for Hospitals, found at: https://hqic-library.ipro.org/2021/12/20/person-and-family-engagement-implementation-guides-for-hospitals/

Additional materials shared by Press Ganey after these discussions supports providers' abilities to improve patient experience after adopting best practices.[22] Specifically, they have shown that when hospitals ask about receipt of a best practice and stratify results, those who report receiving the best practice have higher HCAHPS scores than those who do not report receiving the service within the same hospital. This highlights differential patient experience within hospitals that can be addressed through greater fidelity to best practices. The information shared by Press Ganey provides options for the Commission to require hospitals to add a limited number of key questions to their HCAHPS surveys that ask about best practices such as hourly rounding, and reporting the responses to the questions along with correlations with higher overall HCAHPS scores as part of the patient level data submitted to MHCC; such reporting should also be stratified by discreet patient population groups to help identify disparities.

> ***Timeline Status:*** *HSCRC will continue working through 2024 and beyond with Qlarant/AIR, Press Ganey, MHA, hospitals, and others to share best practices and strengthen incentives for hospitals to improve on HCAHPS; this will include encouraging hospitals to employ better patient and family engagement strategies, and recommending the statewide addition of HCAHPS questions that are based on best practices with evidence of HCAHPS improvement.*

***Hospital Emergency Department Dramatic Improvement Effort (EDDIE*)-** Staff notes previous analytic findings and literature reviews show evidence of linkage of extended ED lengths of stay with lower HCAHPS scores as well as patient safety concerns. To address these issues, staff has worked collaboratively with key stakeholders over the last several months to develop and implement the EDDIE project and complementary incentives for use in the QBR policy; these efforts are described more fully below. However staff has invested time and effort on these initiatives as we believe they will impact HCAHPS scores.

[22] Study showing the impact of hourly rounding on Press Ganey inpatient measures as well as HCAHPS measures: http://www.theinstituteforinnovation.org/sites/default/files/public/resources/inspiring-innovation-stories_patient-report-of-hourly-rounding_final.pdf
Bibliography about the impact of rounding:
http://www.theinstituteforinnovation.org/sites/default/files/public/resources/Hourly-Rounds_Apr2018.pdf
Publicly available training slide deck from Advent Health. Of note, slide 41 shows their bullseye charts that they used across their system to show the impact of rounding on HCAHPS measures.
https://www.adventhealth.com/sites/default/files/assets/AHCentralFloridaNorth_PatientExperiencePresentation.pdf

Maryland HCAHPS Exploratory Data

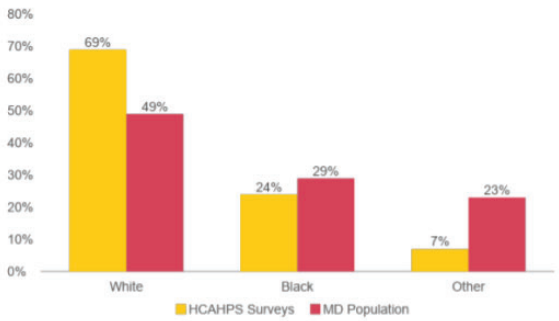
PERFORMANCE MEASUREMENT WORKGROUP MEETING

MARCH 2023

Background

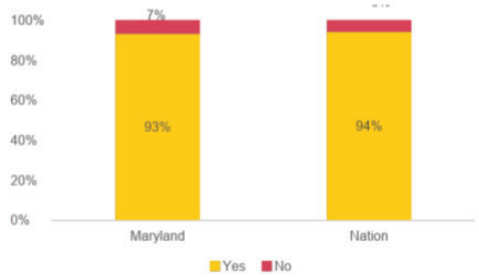
- MHCC began requiring detailed level HCAHPS data starting January 2022 (Q3 2021 discharges)
  - Joint memo with HSCRC
- Allows for more detailed analysis into race, ethnicity, service line, etc.
  - More timely
- More targeted approaches for quality improvement (e.g., populations, domains, etc)

- Q3 2021 – Q2 2022 (33,134 surveys)
- MD population data from 2020 Census



Would Recommend

- Collapsed Scores
- Denominator – 33,134
  - No = *Definitely No/Probably No - 2,263 (7%)*
  - Yes = *Definitely Yes/Probably Yes* - 30,871 (93%)



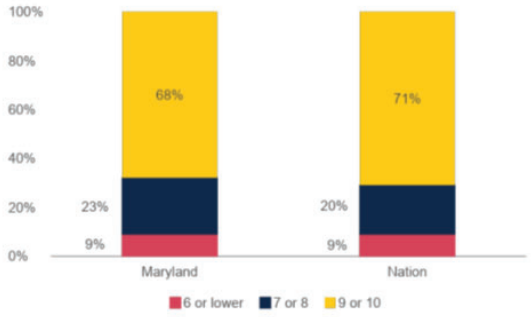
National data: Q2 2021-Q1 2022

- Chi-square test shows marginal differences in Recommendation (Yes/No) between races in MD data
  - More blacks report "No" than expected

	Yes (93%)	No (7%)
White	70%	67%
Black	24%	27%
Other	7%	7%

Overall Rating

- Collapsed Ratings 1-10
- Denominator – 33,134
  - 6 or lower – 3,121 (9%)
  - 7 or 8 – 7,458 (23%)
  - 9 or 10 – 22,555 (68%)



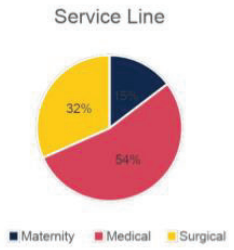
National data: Q2 2021-Q1 2022

- Chi-square test shows marginal differences in Overall Rating between races
  - Fewer white, more black in the 6 or lower category

	6 or lower (9%)	7 or 8 (23%)	9 or 10 (68%)
White	67%	70%	70%
Black	26%	23%	24%
Other	7%	7%	6%

Service Lines

- Denominator – 32,520
  - Maternity – 4,760 (15%)
  - Medical – 17,475 (54%)
  - Surgical – 10,285 (32%)



- Black & Other is higher in the maternity service line than medical and surgical

	Maternity (15%)	Medical (54%)	Surgical (32%)
White	56%	69%	75%
Black	31%	25%	20%
Other	14%	5%	5%

Maternity Service Line – Black Women

- Denominator – 4,760
  - Black – 1,456 (31%)
  - Other – 3,304 (69%)
- Significant differences between black and other races
  - Would Recommend – Significantly more "No" reported by black women than expected
  - Overall Rating – Significantly more "6 or lower" reported by black women than expected

Would Recommend		
	Yes (96%)	No (4%)
Black	30%	49%
Non-Black	70%	51%

Overall Rating			
	6 or lower (7%)	7 or 8 (24%)	9 or 10 (70%)
Black	47%	32%	28%
Non-Black	53%	68%	72%

APPENDIX D: HSCRC EFFORTS TO ADDRESS EMERGENCY DEPARTMENT LENGTH OF STAY

Figure 1. HSCRC Historic Efforts to Address Extended ED Lengths of Stay

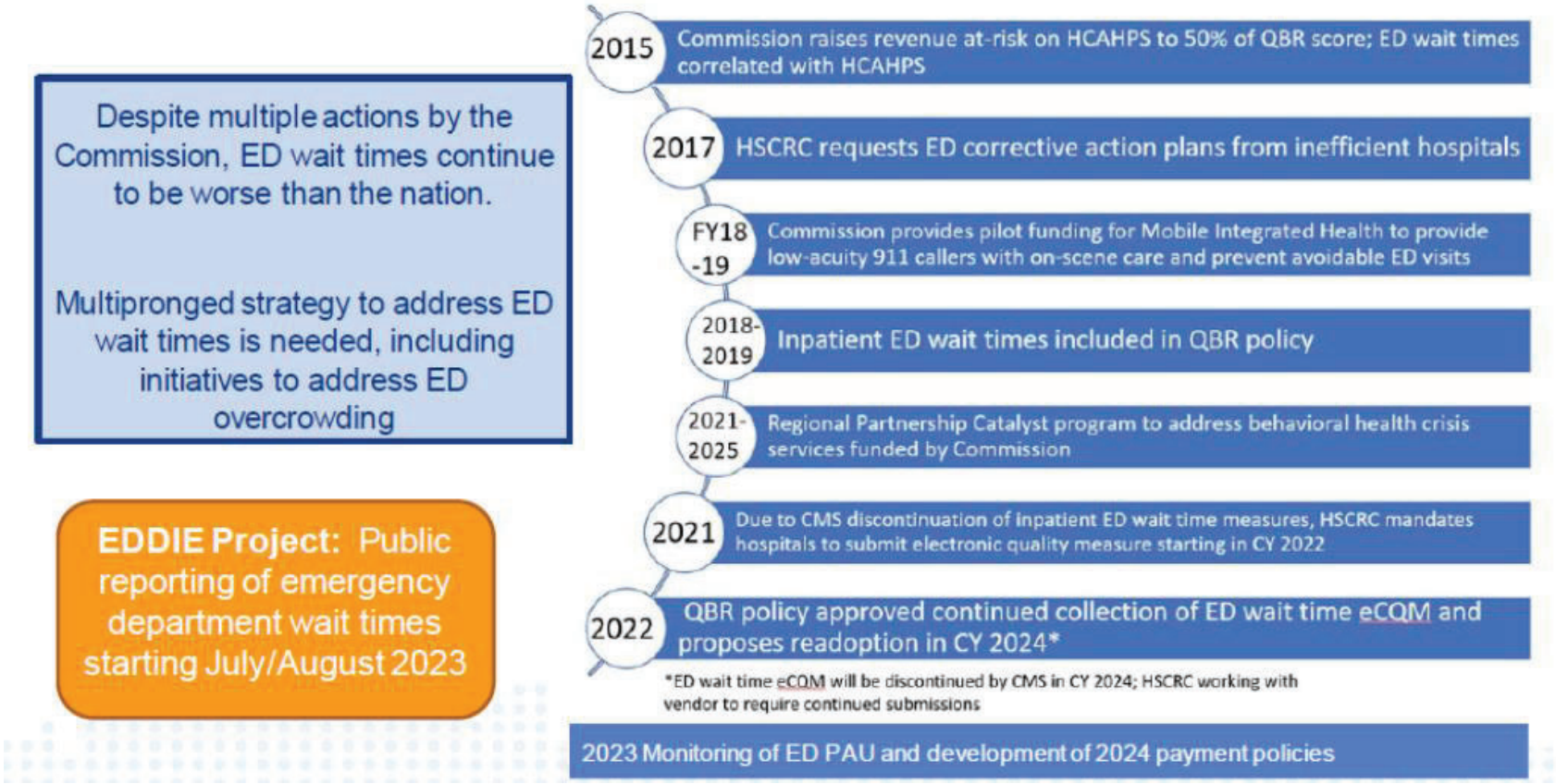
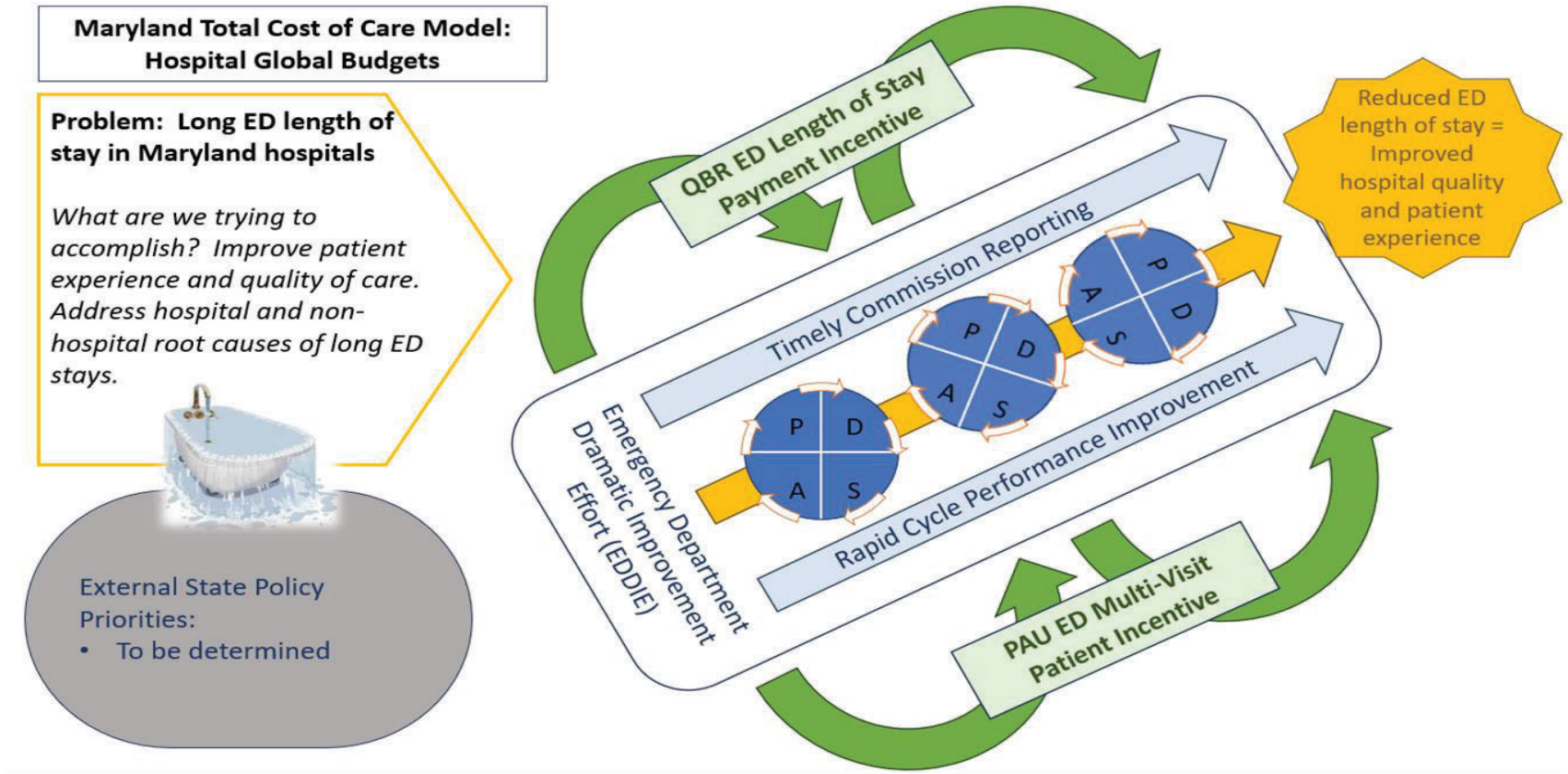


Figure 2. EDDIE Plan-Do-Study-Act Cycles and Pay-for-Performance Incentives



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Update on Medicare FFS Data & Analysis

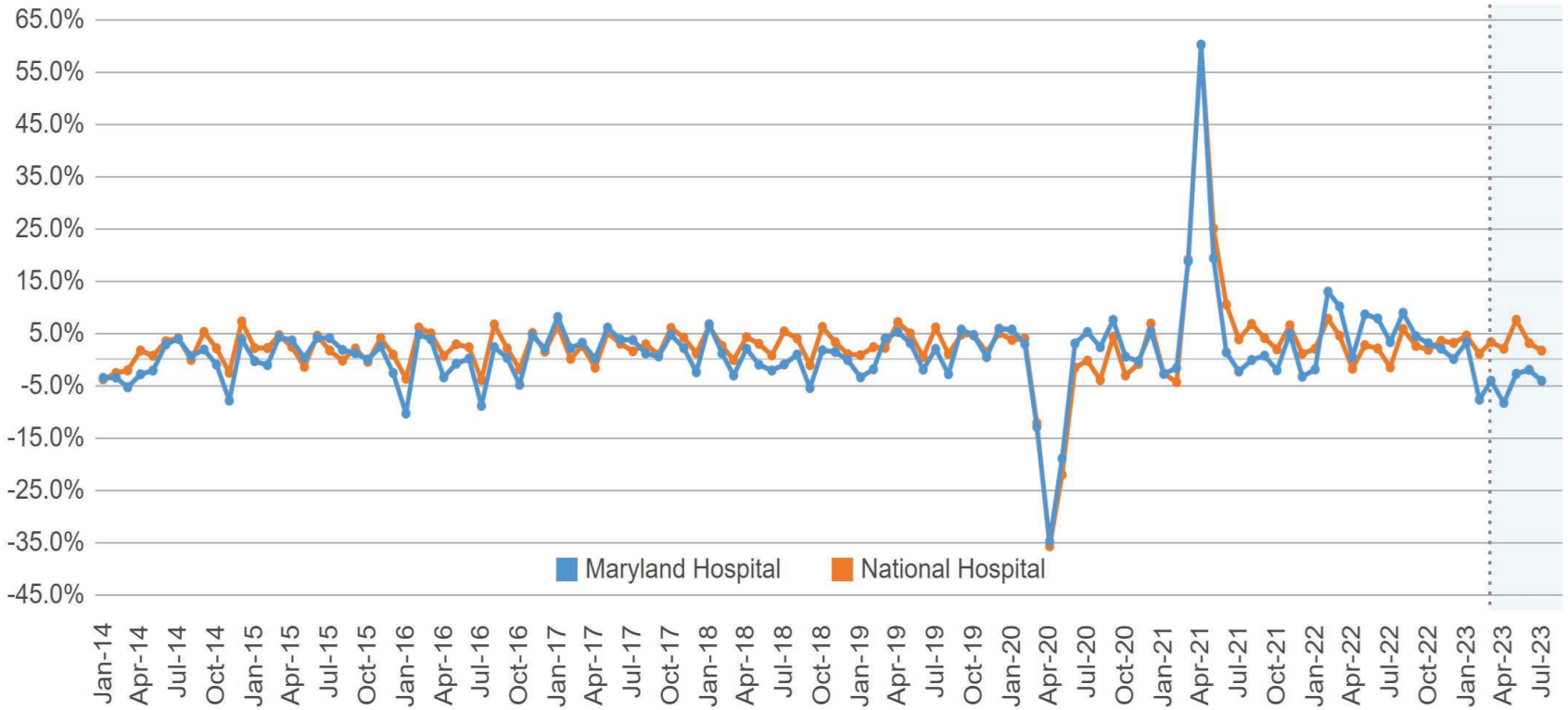
November 2023 Update

Data through July 2023, Claims paid through September 2023

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

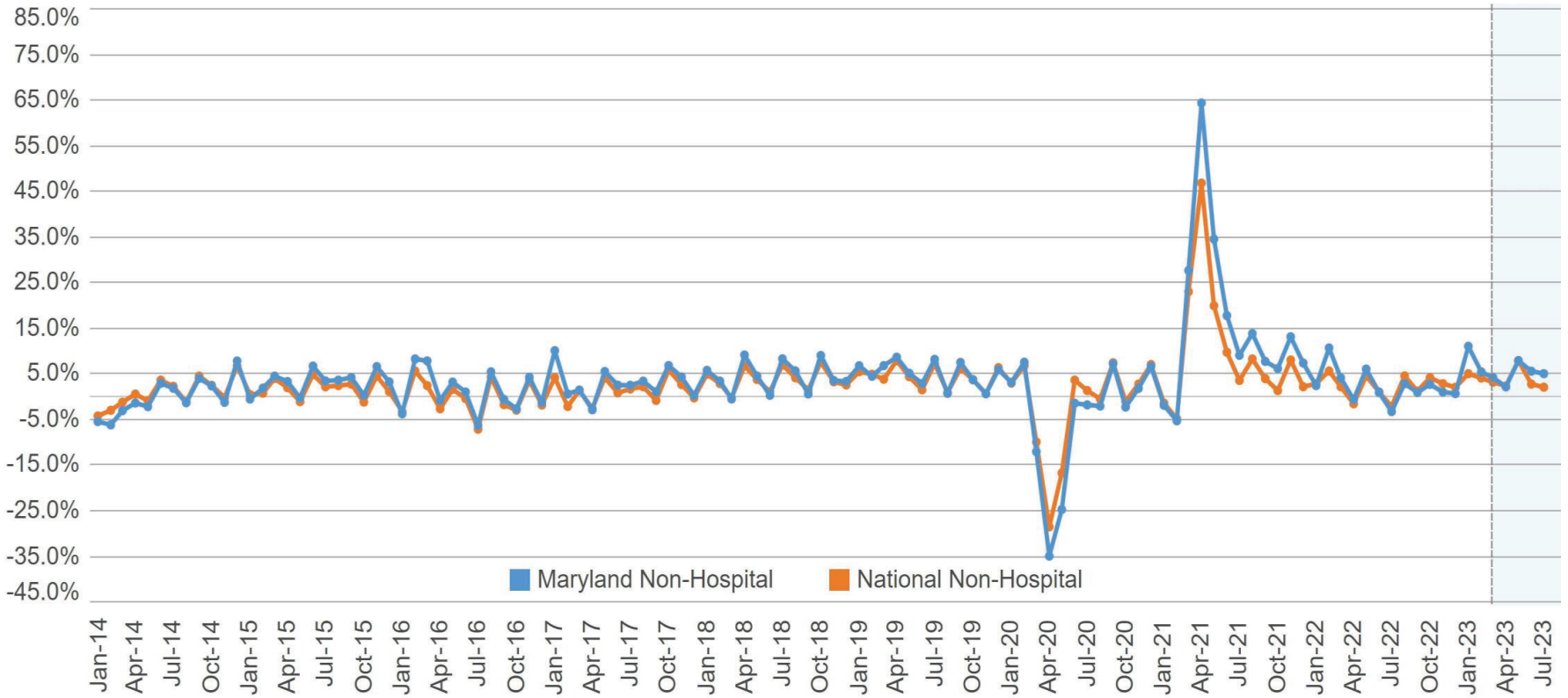
Actual Growth Trend (CY month vs. Prior CY month)



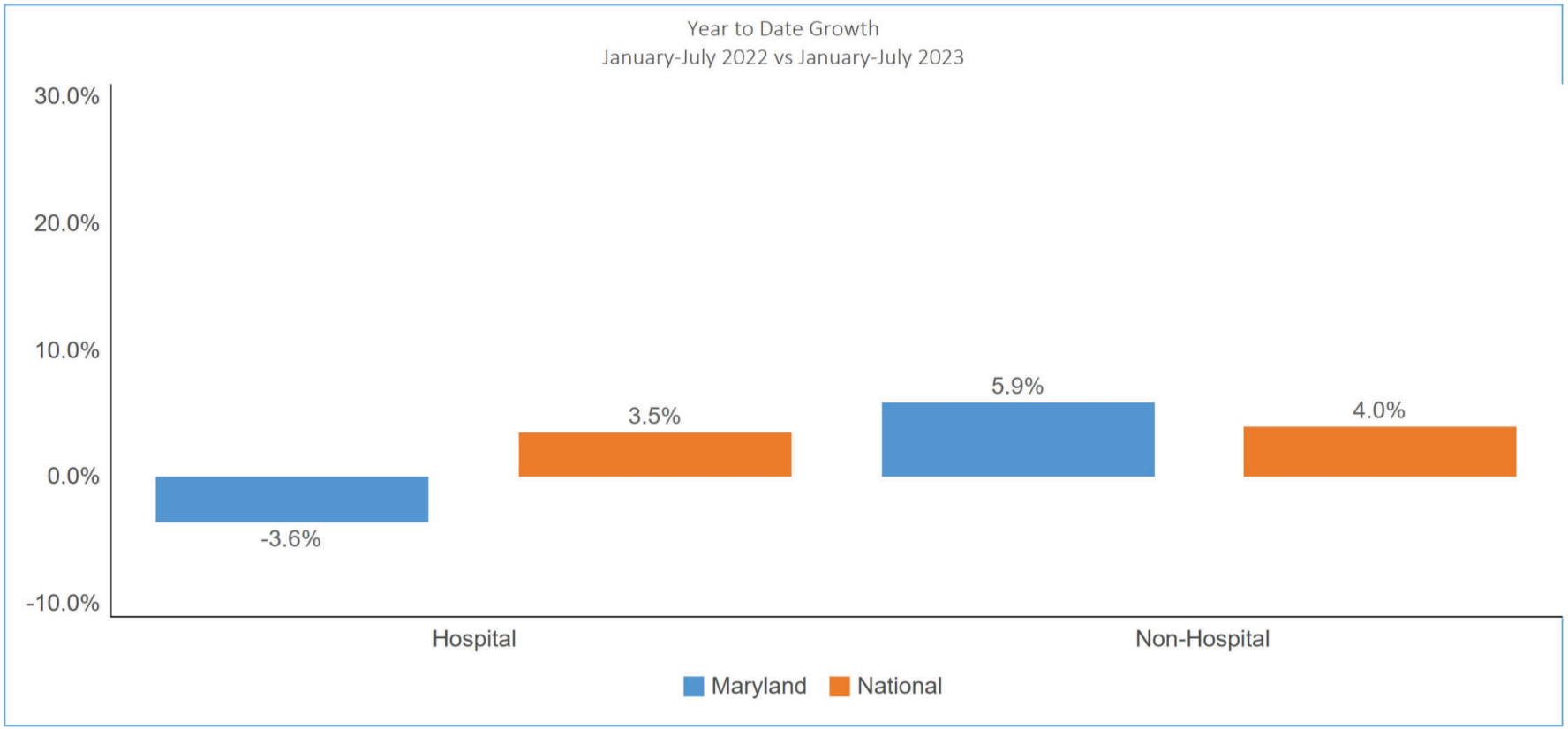
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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

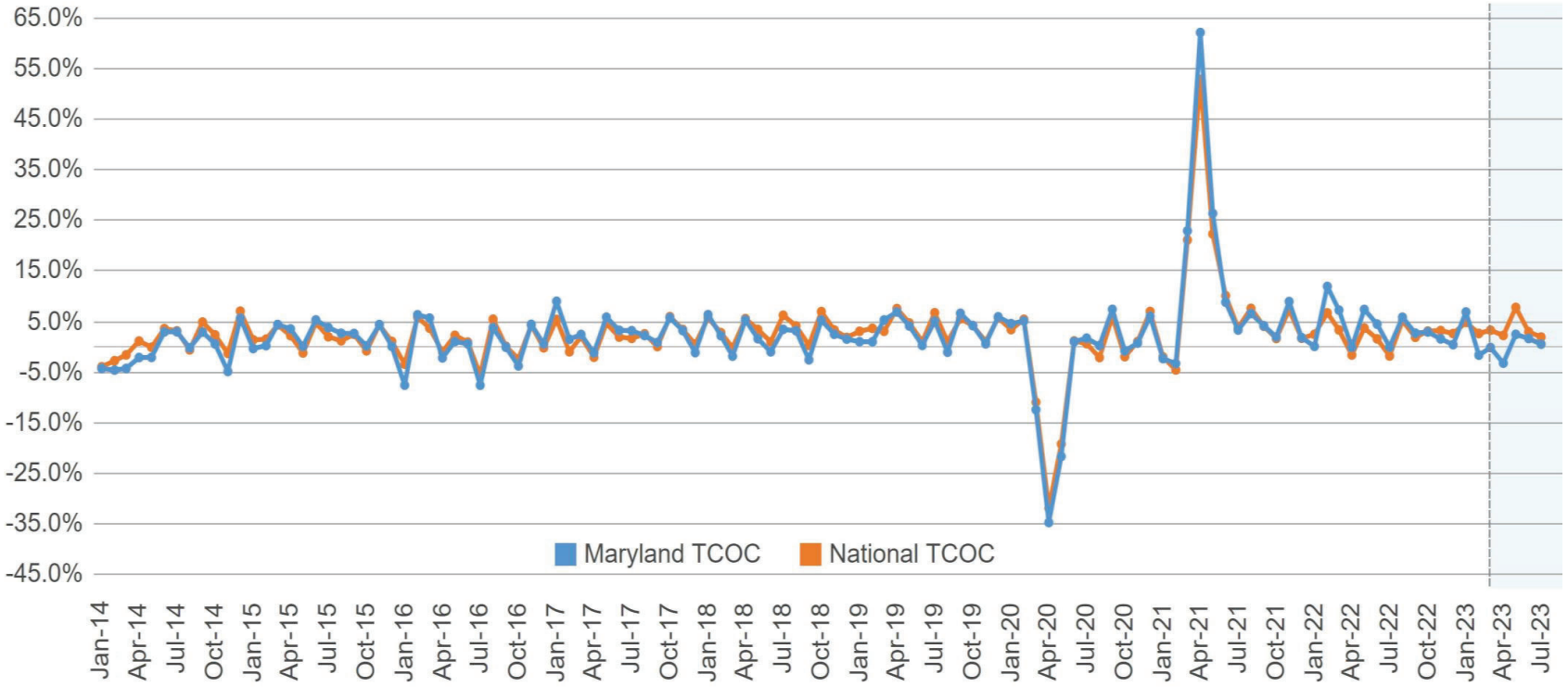


Medicare Hospital and Non-Hospital Payments per Capita



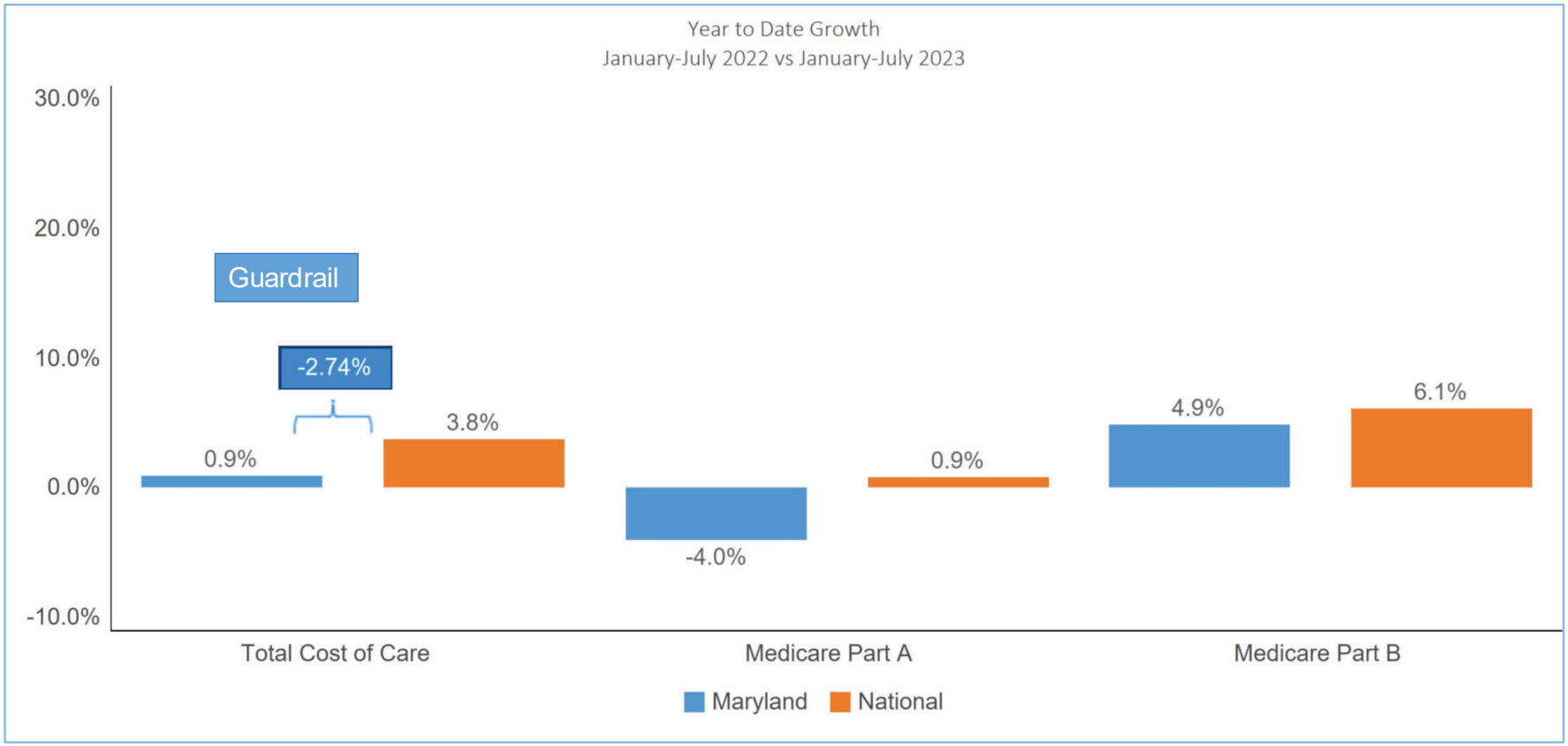
Medicare Total Cost of Care Spending per Capita

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



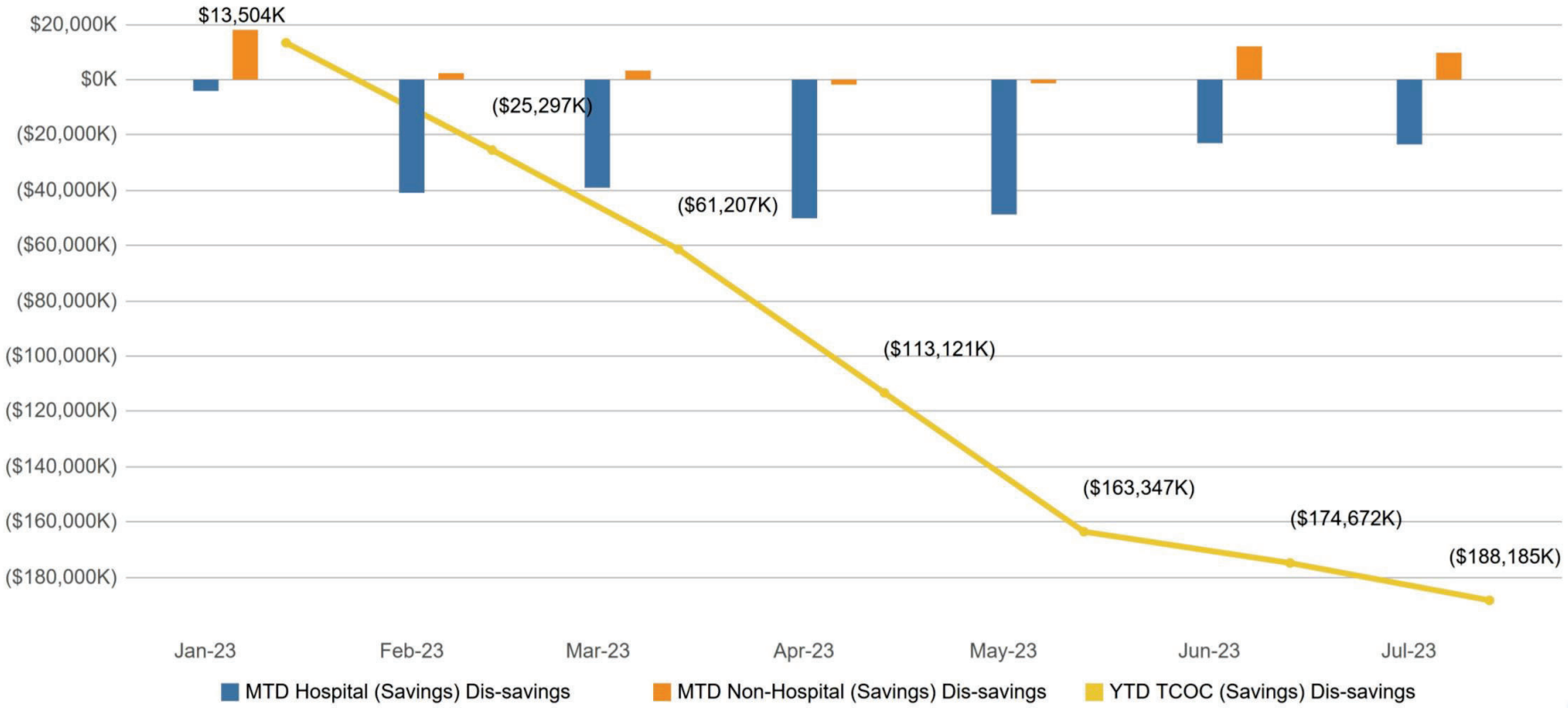
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through July 2023



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Emergency Department Dramatic Improvement Effort (EDDIE)

November Commission Meeting

Geoff Dougherty and Alyson Schuster

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

October Data 2023 Reporting

Additional Discussion on ED Length of Stay Measures is part of Draft Quality Based Reimbursement Policy being presented this month

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

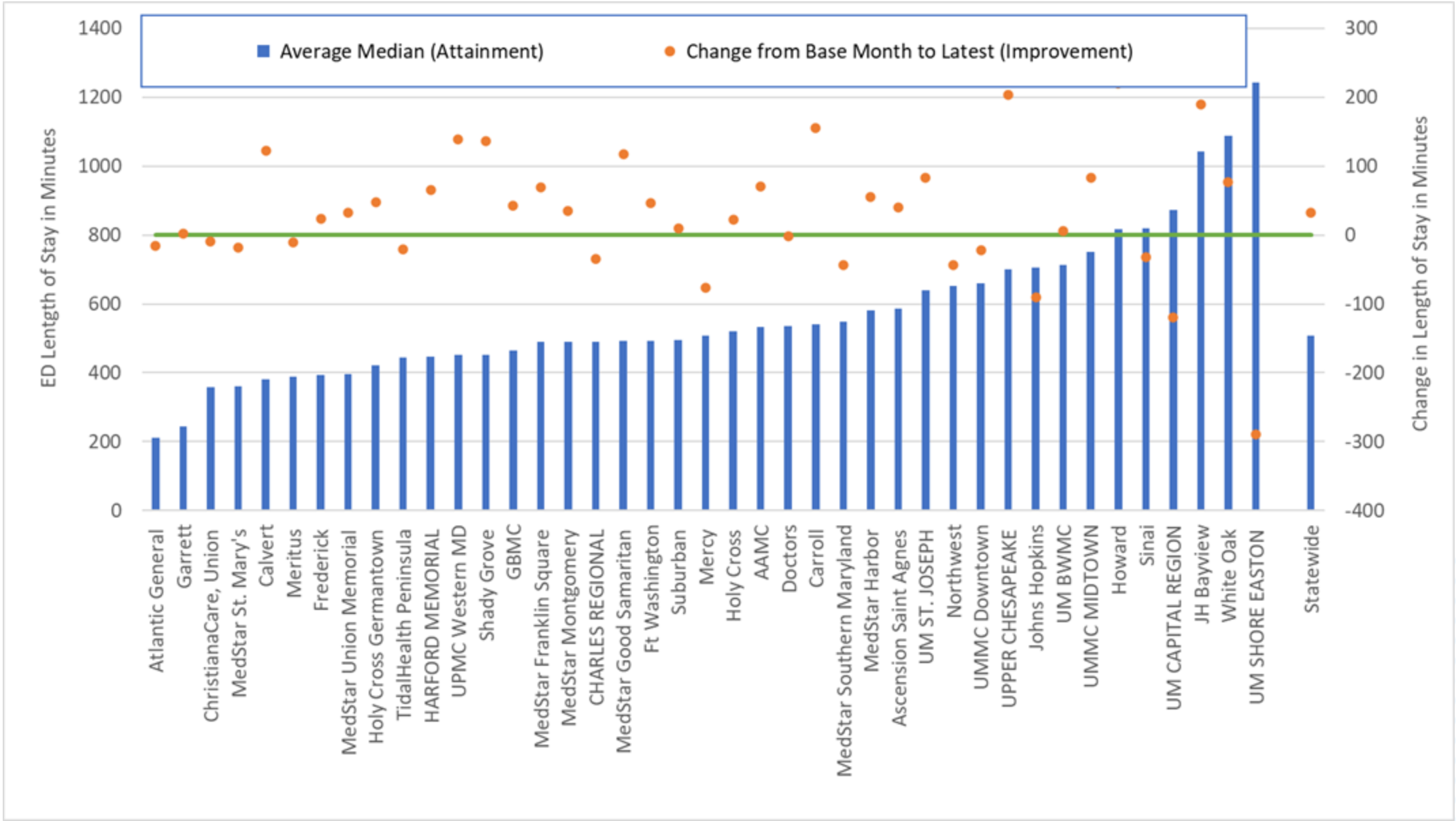
October data received for all hospitals

- 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

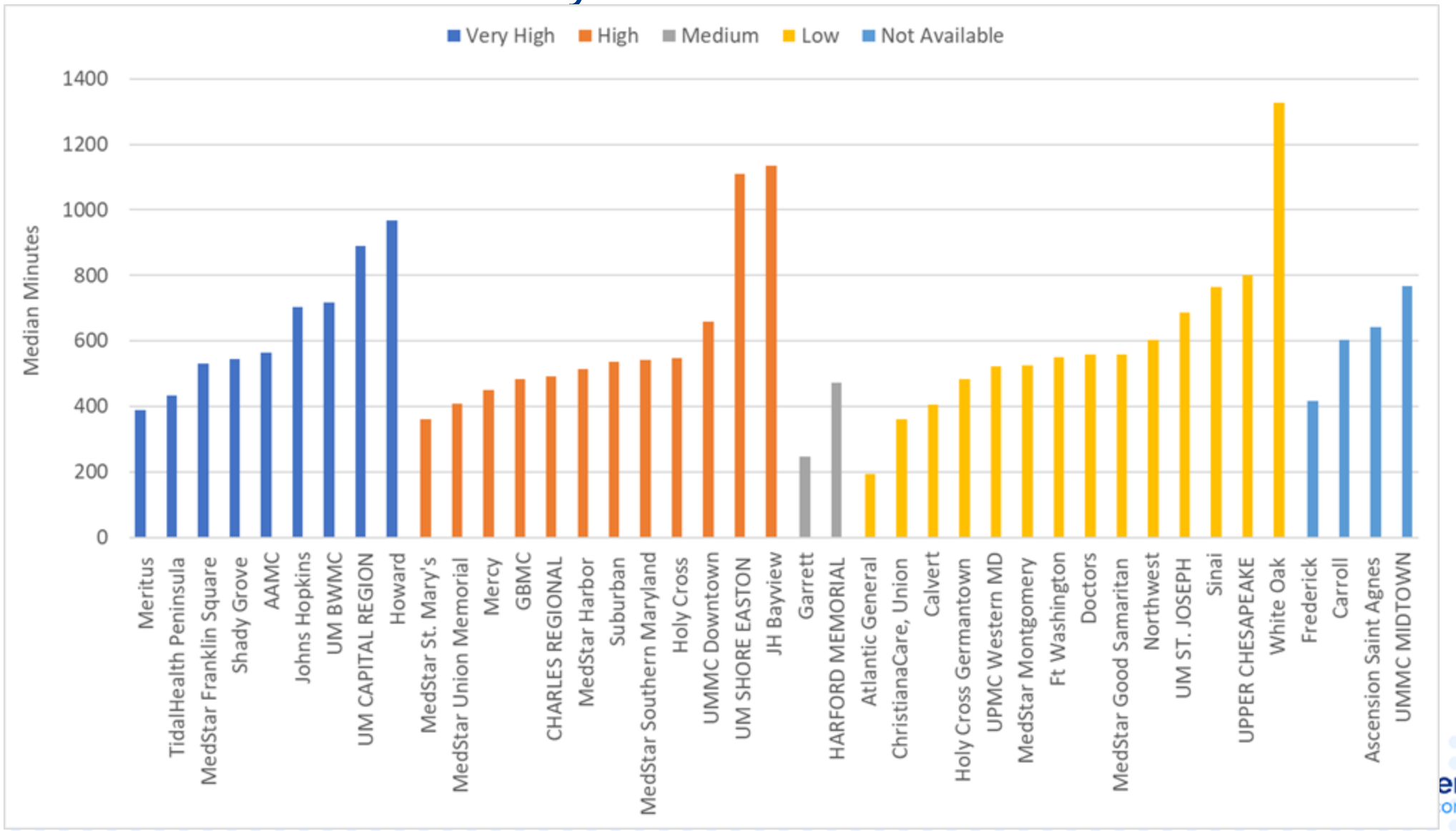
Graphs for ED1a,b,c and OP18a,b,c:

- 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; some inconsistencies have been identified)
- Graphs have not been QAed by hospitals due to fast turnaround time

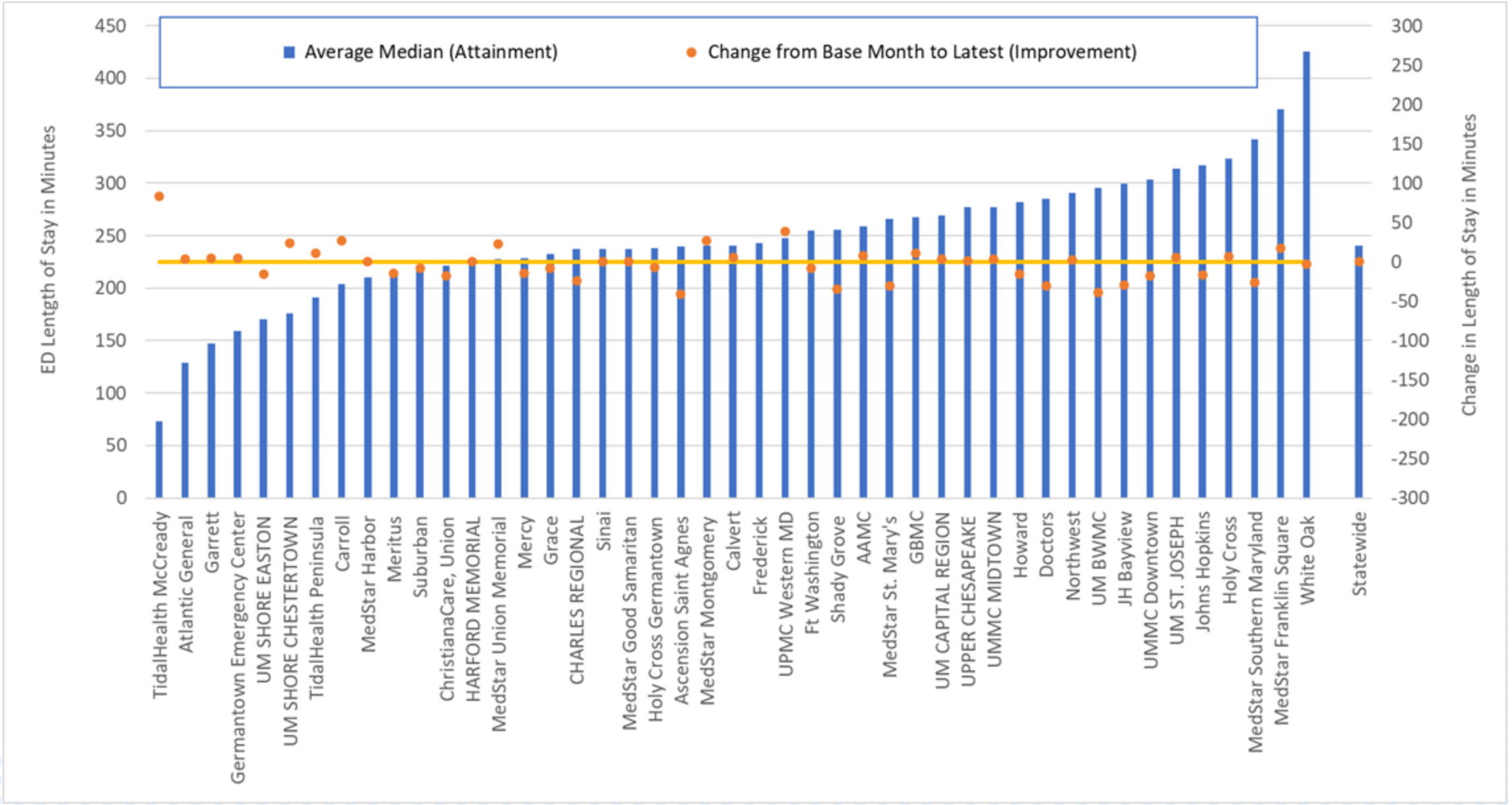
ED 1a: ED Arrival to Inpatient Admission



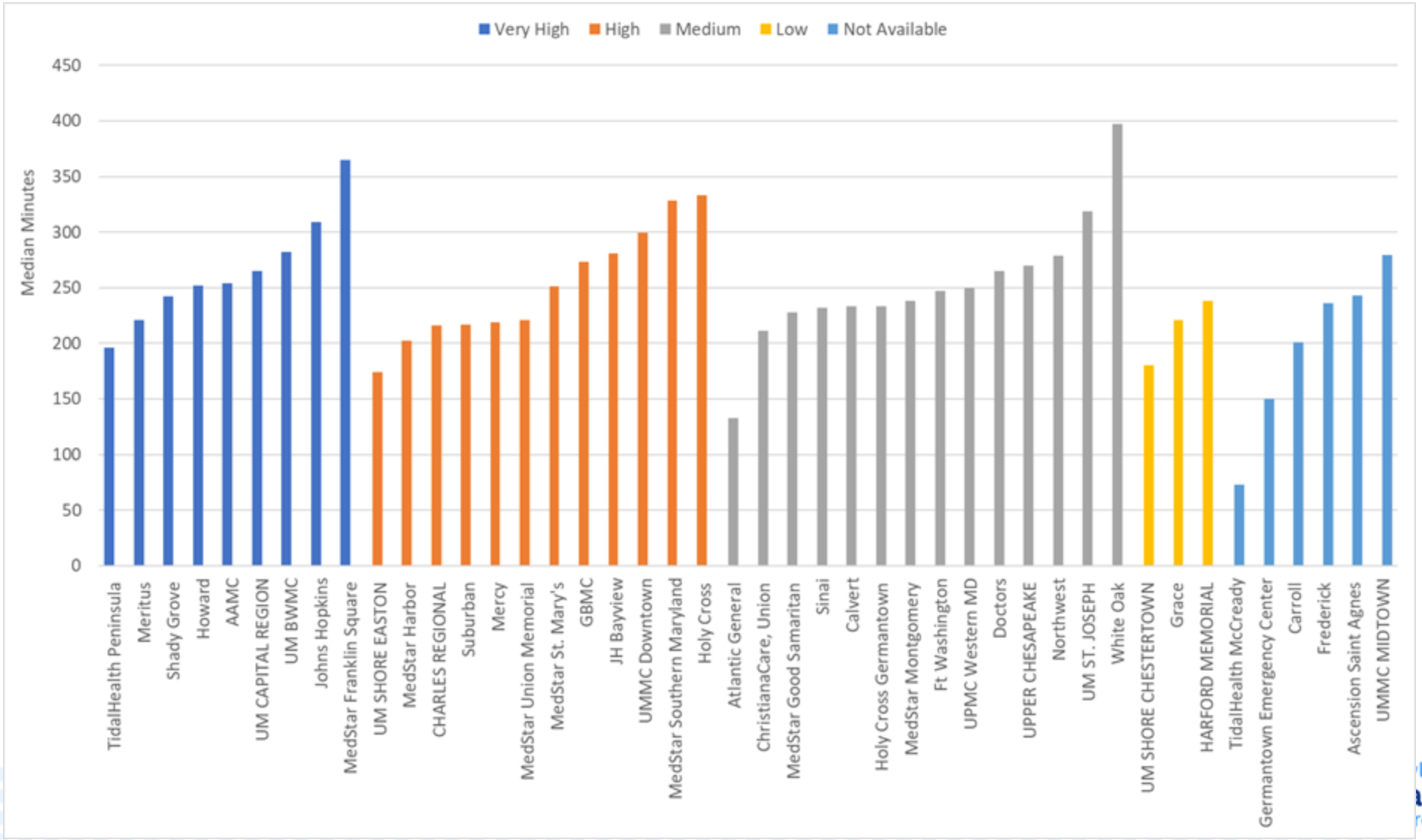
ED 1a: ED Arrival to Inpatient Admission Time Latest Month Median By Volume



OP18a: ED Arrival to Discharge Time by Month



OP18a: ED Arrival to Discharge Time Latest Month Median By Volume



EMS Turnaround Times: September Performance

90th Percentile: 0-35 Minutes

Atlantic General Hospital
CalvertHealth Medical Center
Cambridge Free-Standing ED
Easton+
Frederick Health Hospital
Garrett Regional Medical Center
Germantown Emergency Center
Greater Baltimore Medical Center+
Harford Memorial Hospital
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
Shady Grove Medical Center
St. Mary's Hospital
Union Hospital
Union Memorial Hospital
Western Maryland

>35 Minutes

Bowie Health Center
Carroll Hospital Center
Charles Regional
Chestertown
Franklin Square
Good Samaritan Hospital -
Grace Medical Center -
Harbor Hospital
Johns Hopkins Bayview
Johns Hopkins Hospital ADULT
Laurel Medical Center
Mercy Medical Center
Midtown
Northwest Hospital
Sinai Hospital
Southern Maryland Hospital
St. Agnes Hospital
St. Joseph Medical Center
Suburban Hospital
University of Maryland Medical Center
Upper Chesapeake Medical Center

>60 Minutes

Anne Arundel Medical Center
Baltimore Washington Medical Center
Capital Region Medical Center
Doctors Community Medical Center
Fort Washington Medical Center
Howard County General Hospital
White Oak Medical Center

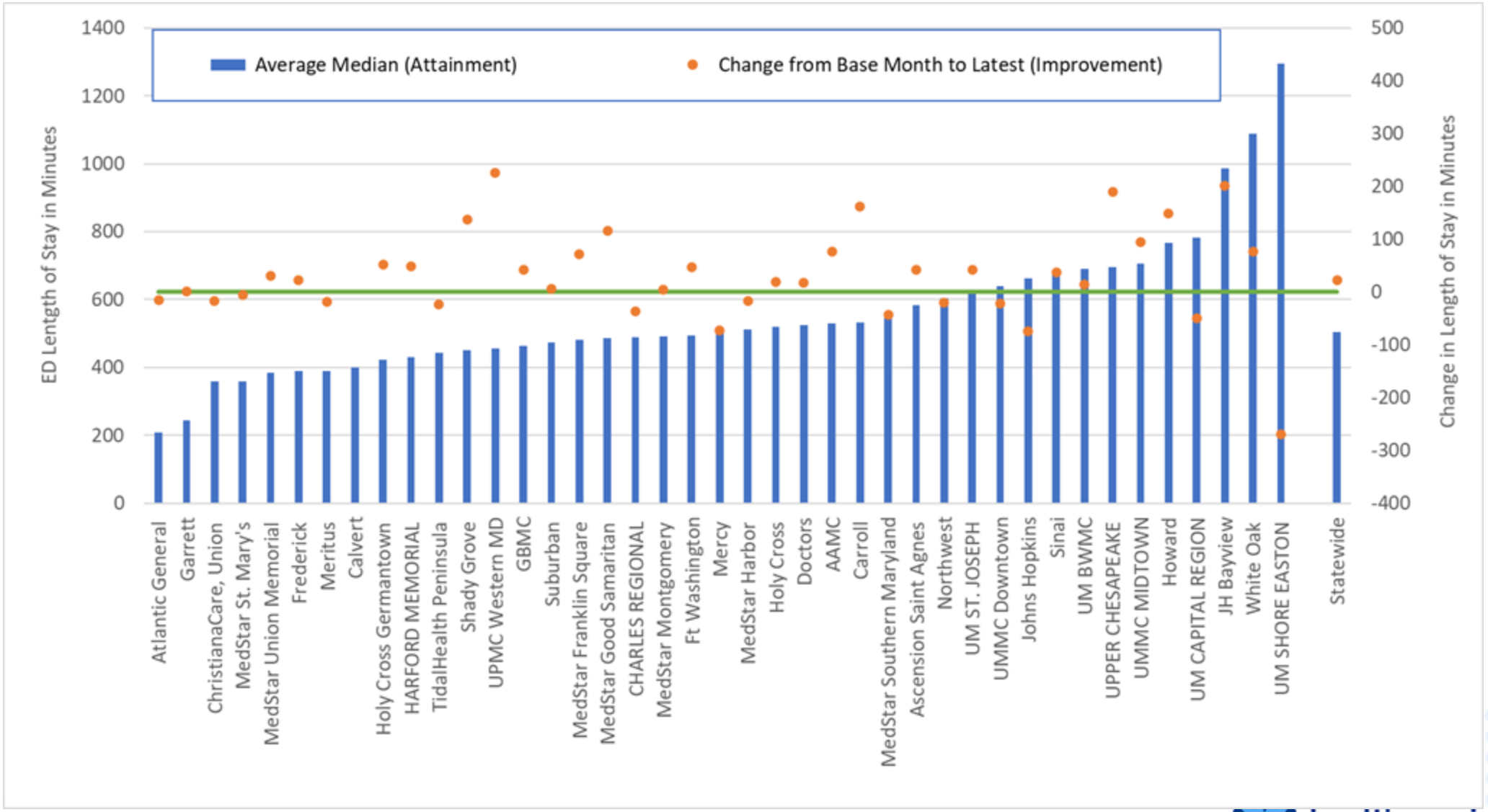
(+): Hospital improved by one or more categories; **(-)**: Hospital declined by one or more categories

Next Steps

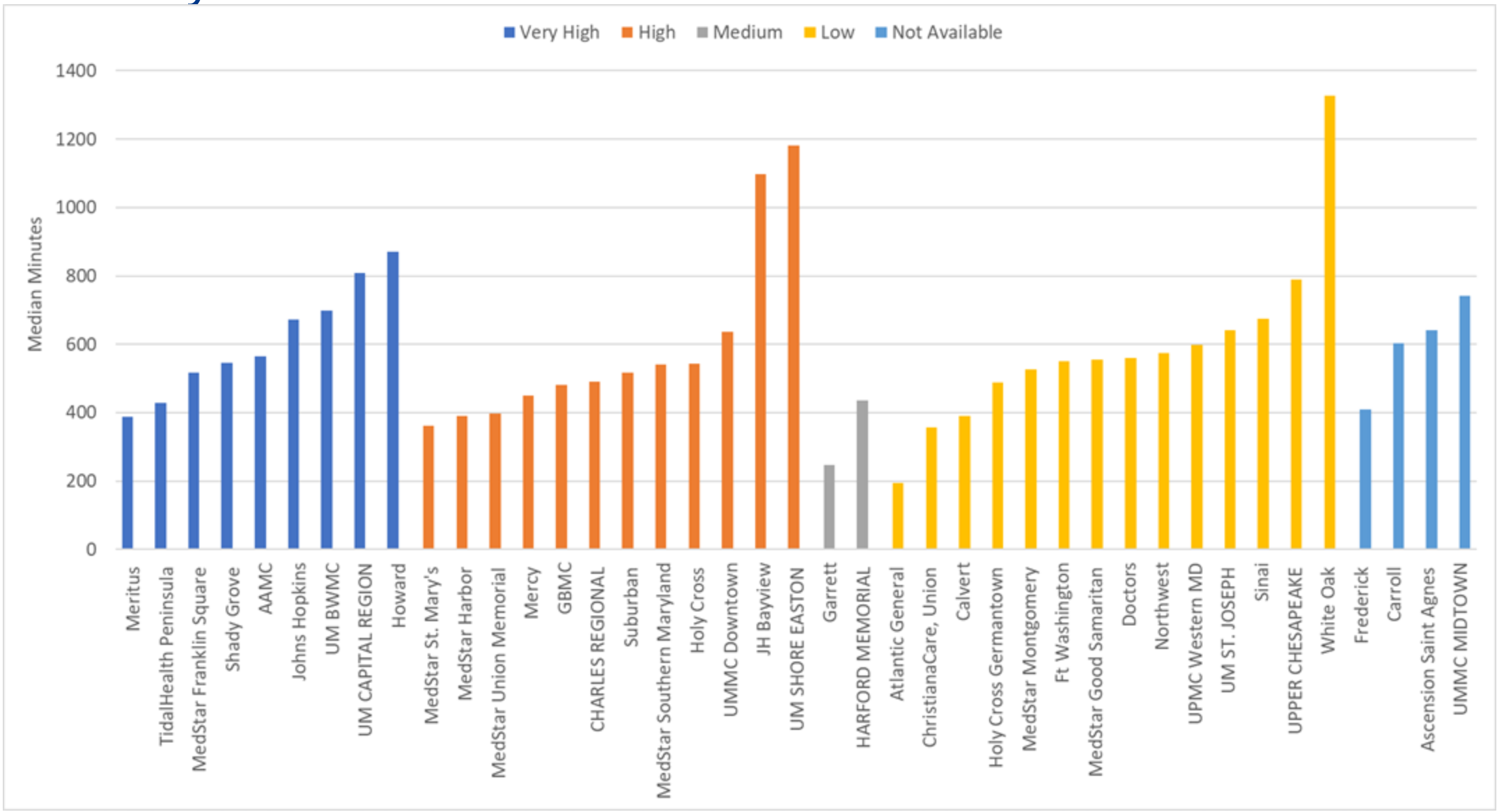
- Provide Commissioners with draft recommendation for inclusion of ED related measures in RY26 (CY24) Quality Based Reimbursement
- Continue monthly data collection from hospitals and MIEMSS
  - Address reporting questions and concerns with hospitals
  - Present results at monthly Commission meeting
  - Add visualizations suggested by Commissioners and other stakeholders
- Determine statewide long-term goals and timeframe for achievement
- Collect and present **progress on** hospital improvement goals from MHA at monthly Commission meeting--Under discussion with MHA
- Collaborate with MHA on legislative request and EDDIE quality improvement initiative

Appendix

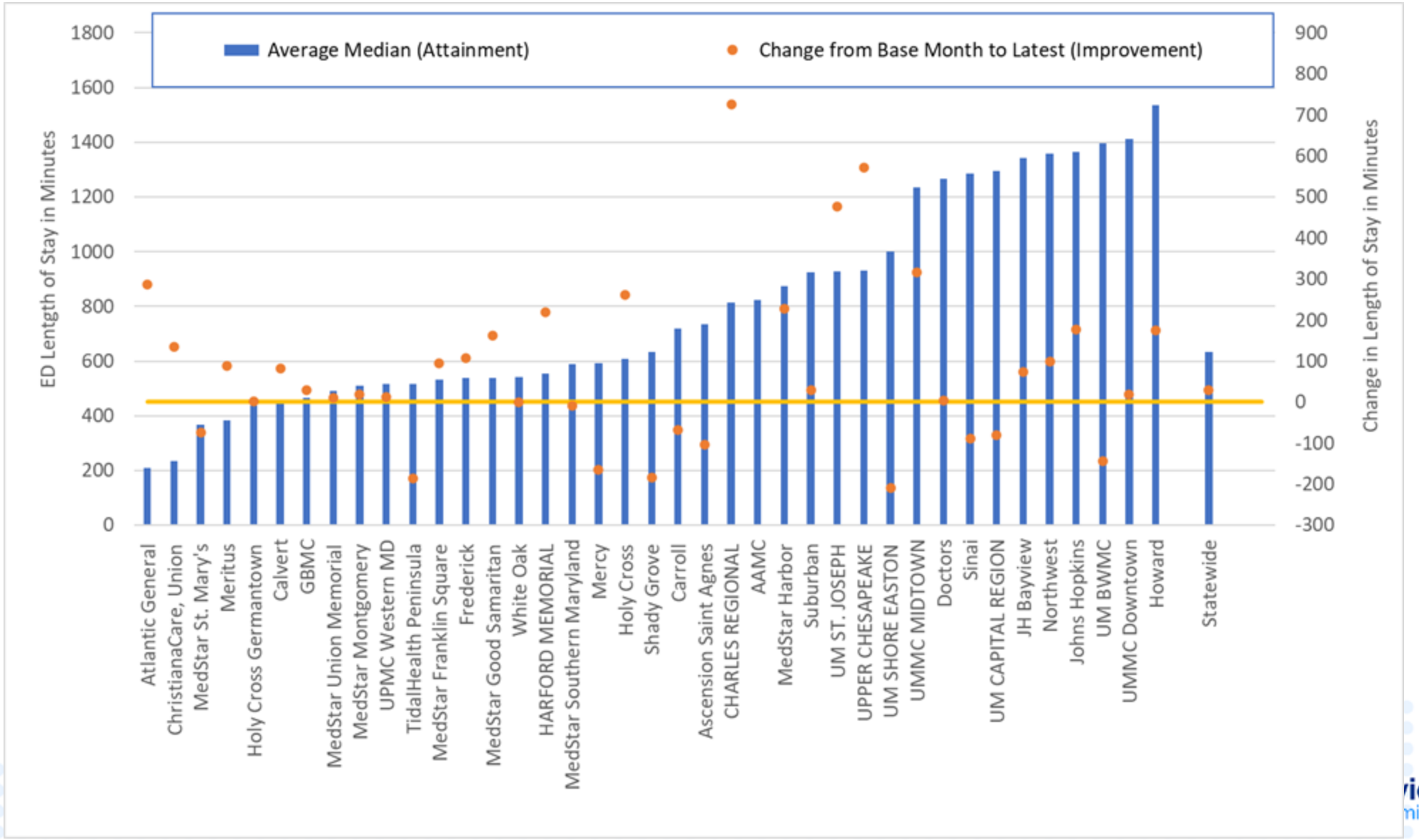
ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric



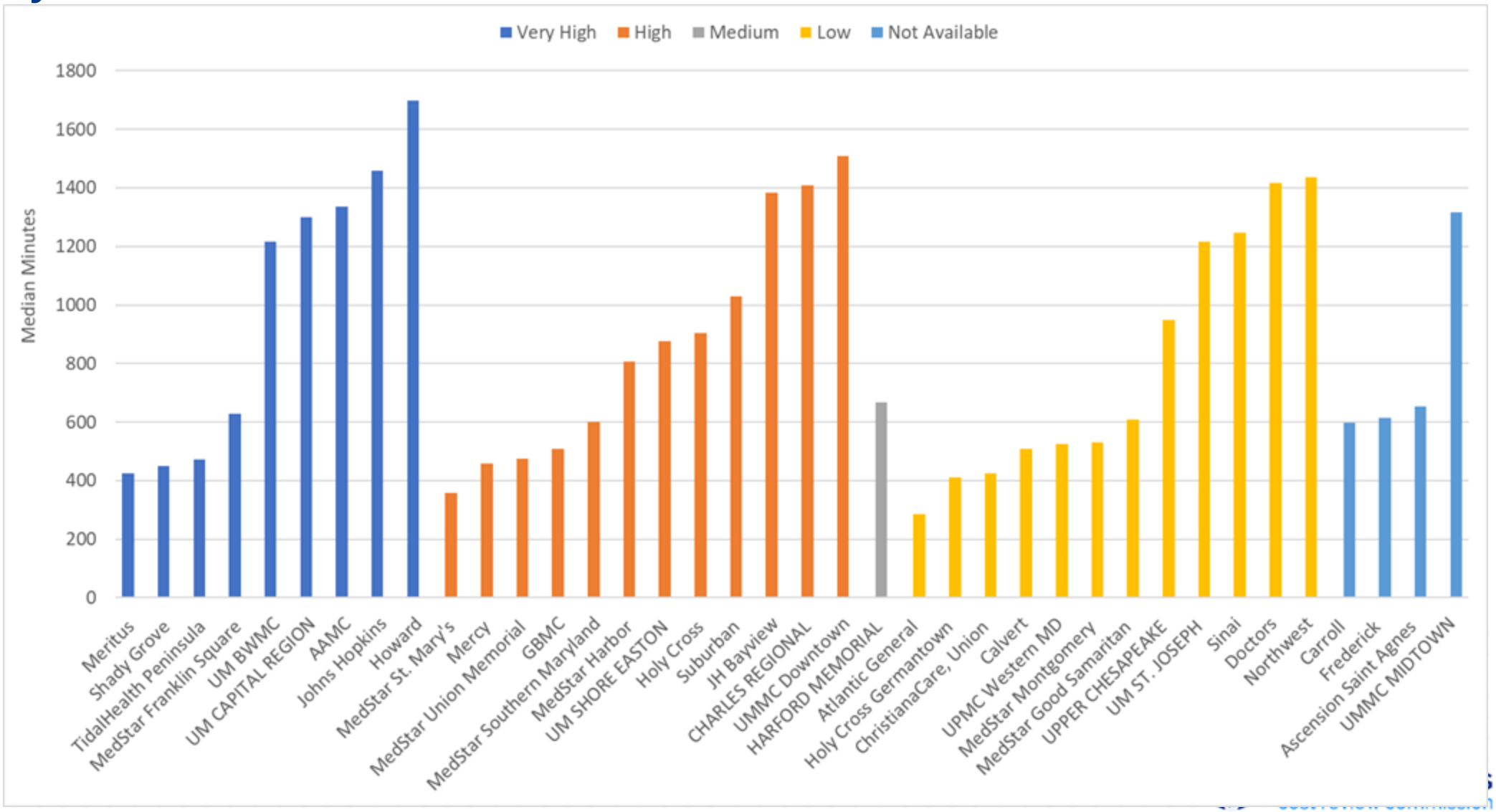
ED 1b: ED Arrival to Inpatient Admission Time by Volume Non-Psychiatric ED Visits



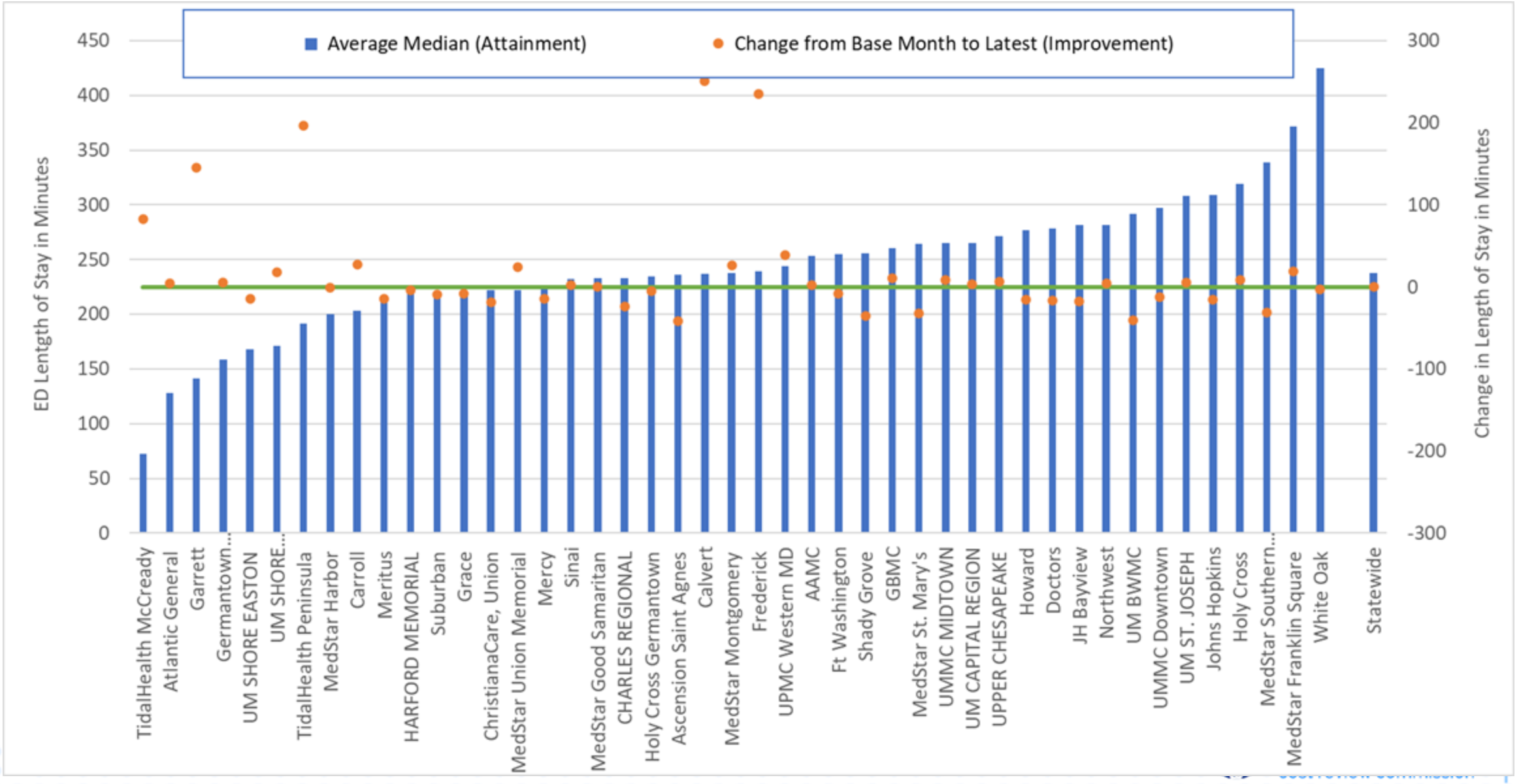
ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



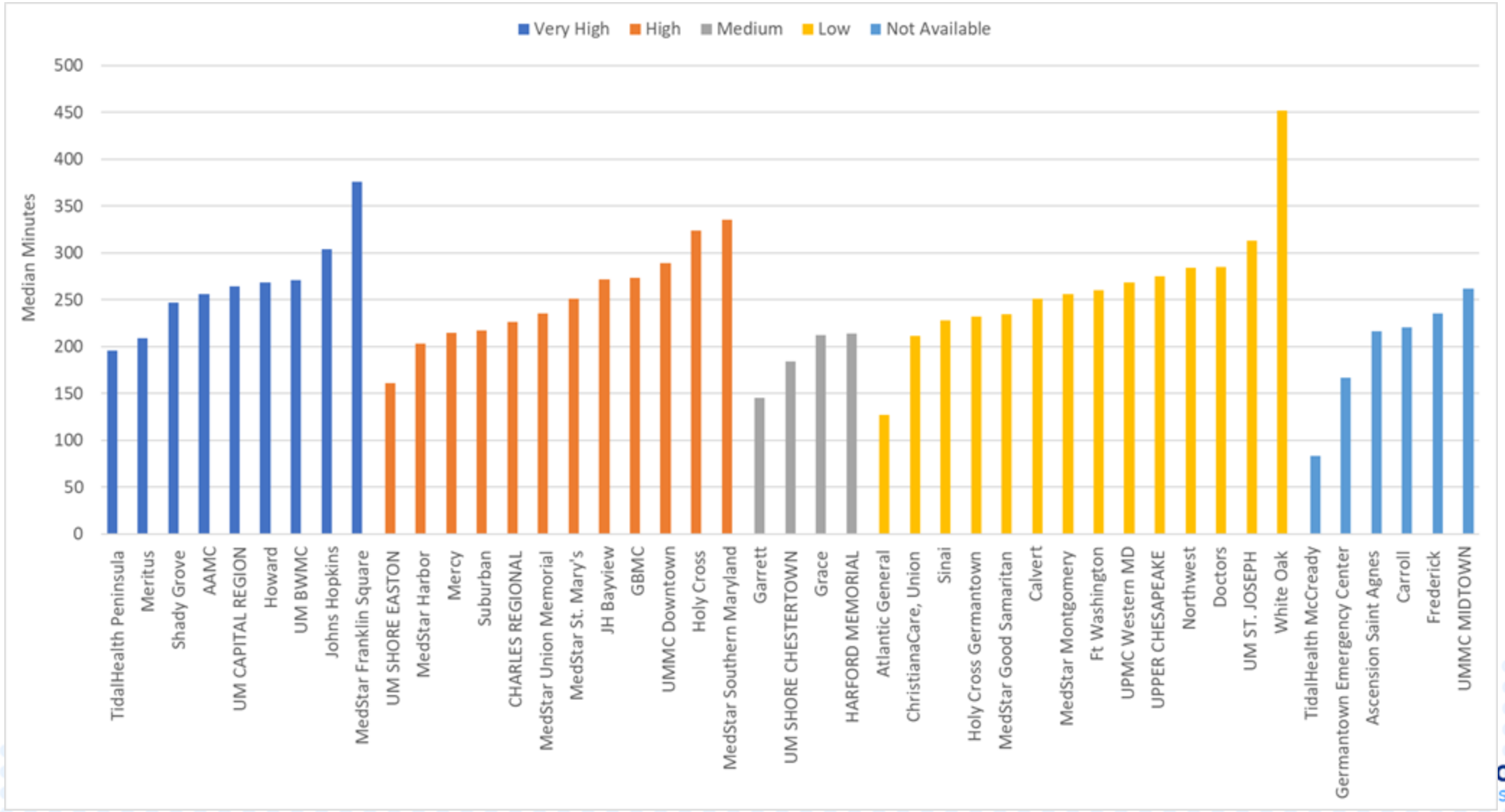
ED 1c: ED Arrival to Inpatient Admission Time by Volume Psychiatric ED Visits



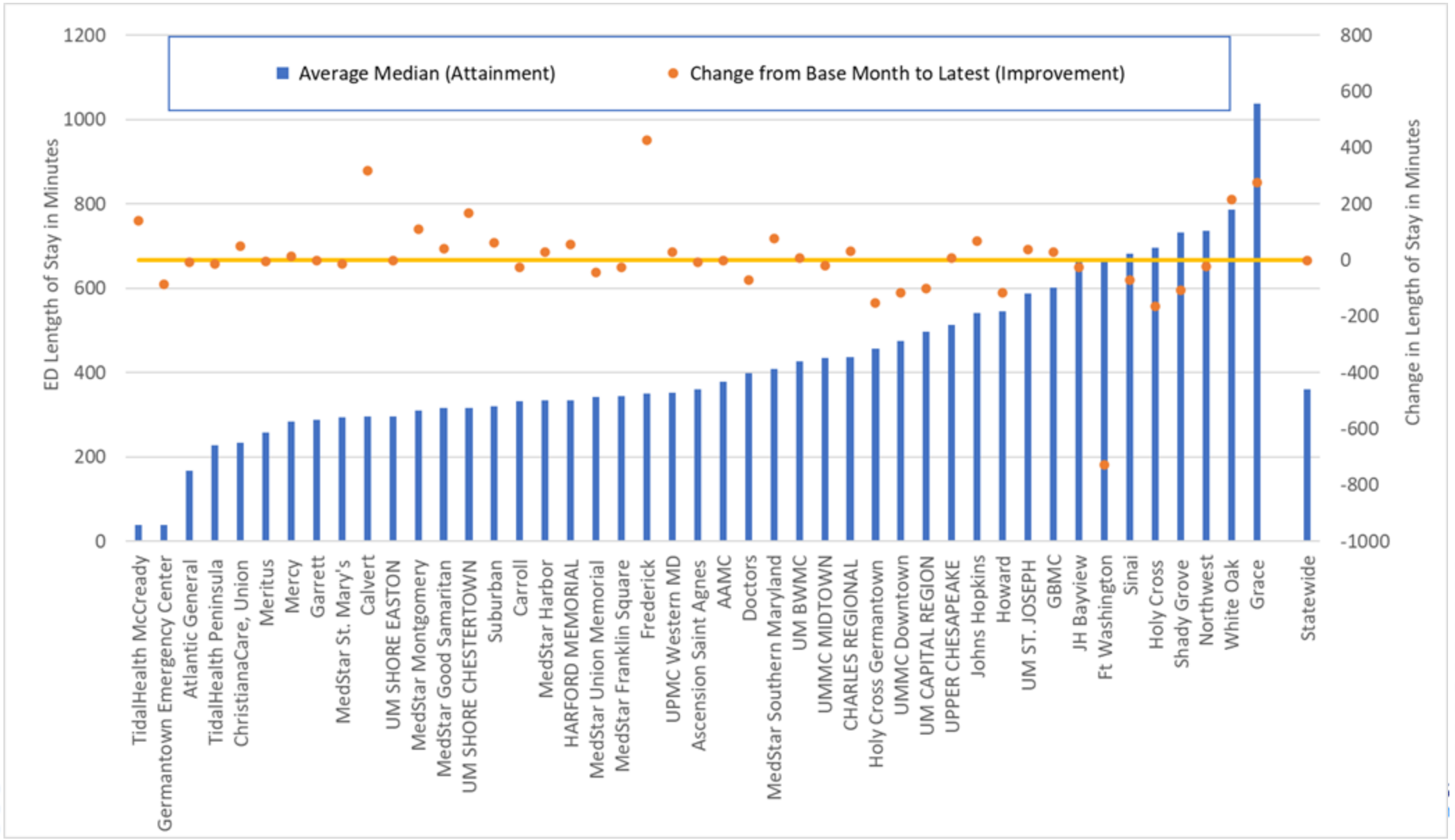
OP18b: ED Arrival to Discharge Time - Non-Psychiatric



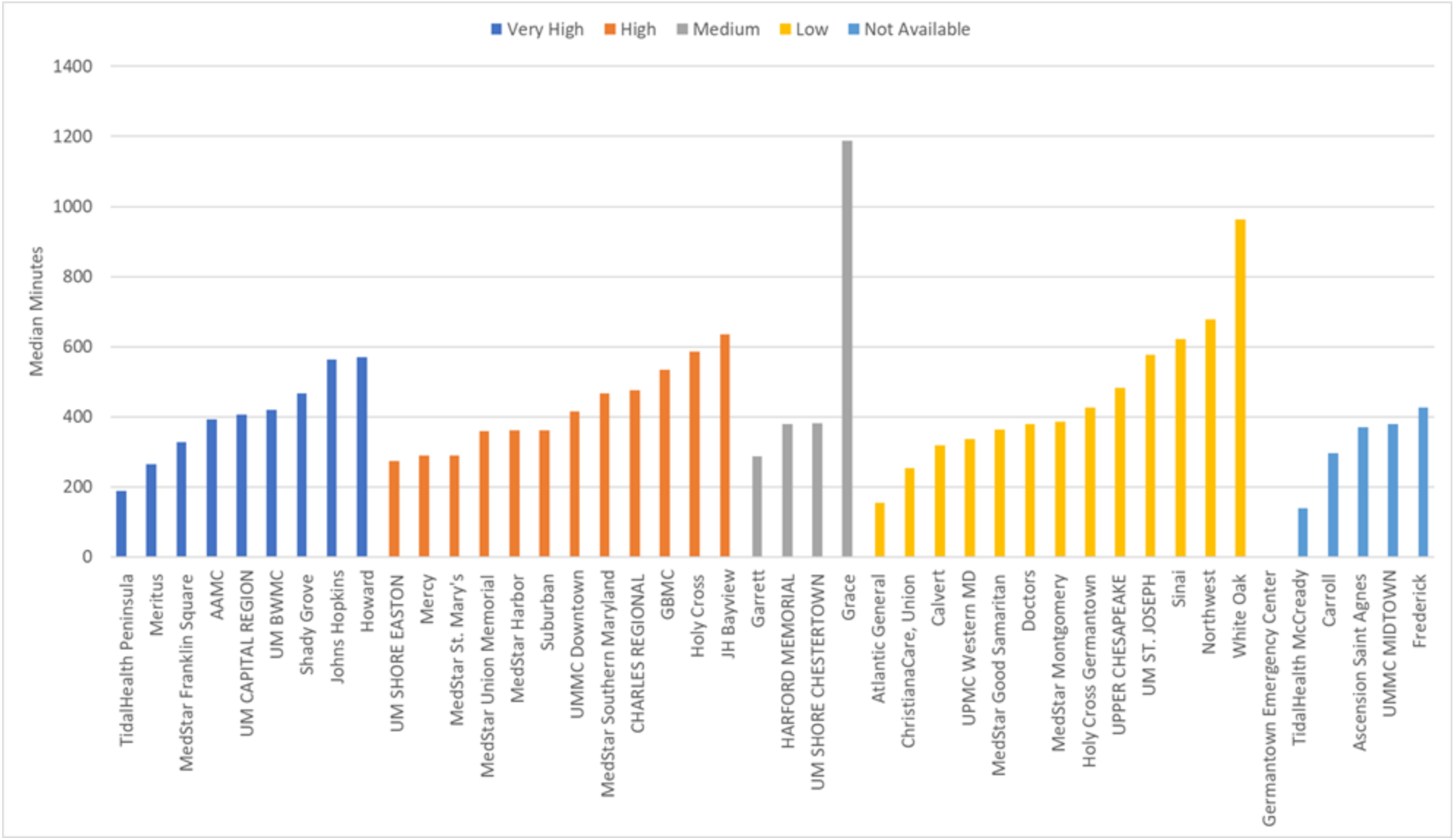
OP18b: ED Arrival to Discharge Time by Volume Non-Psychiatric ED Visits



OP18c: ED Arrival to Discharge Time by Month Psychiatric



OP18 c: ED Arrival to Discharge Time by Volume Psychiatric ED Visits



MHA Quality Improvement Initiative: Aim Statements

- All hospitals submitted an initial aim statement to MHA as part of the rapid-cycle QI initiative
  - Submitting initial aim statements represents an important first step
  - The intent for the EDDIE Project is to engage in a multi-cycle improvement process to bring Maryland ED length of stay (i.e., wait times) towards the national average within an agreed upon time frame
  - Ongoing monthly progress updates will be critical for executing the intended multi-cycle improvement process.
- When reviewing these aim statements, the HSCRC looked for the following elements:

HSCRC believes some hospitals may need to clarify their aim statements so that they are specific enough to be monitored

Hospital (listed in alphabetical order)	AIM statement
Adventist Fort Wash	By 1/1/24, Adventist Healthcare Ft Washington Medical Center will implement process improvements to decrease EMS turnaround times by 10%.
Adventist Shady Grove	Shady Grove Medical Center Emergency Department is committed to the reduction of LWOBS (left without being seen) by 50% by January 1, 2024. (The national benchmark threshold is 2% and we are currently at 1.31% for the month of September as compared to this time last year of up to 7.95 July 2022, 6.73 August 2022 and 5.80 September 2022) This reduction is in direct correlation with the re-implementation of Supertrack and RPA (results pending area).
Adventist White Oak	By March 31, 2024, the Hospitalist Medicine, Nursing, and Care Navigation leadership teams will redesign the patient discharge process to promptly identify next day discharges and increase discharges by 11A from 11% to 15%
Atlantic General	1) Achieve a LWBS (Left Without Being Seen) rate of 1% or less by 3/1/24. 2)Achieve a median length of stay of 120 minutes or less for ER patients being discharged to home by 3/1/24.
CalvertHealth	1) The CalvertHealth Nursing Division will Decrease admit to floor time from 73 minutes(July 2023) to 45 minutes by June 30, 2024. 2) The CalvertHealth Nursing Division will increase the percent of discharges by 2pm from 41% (July 2023) to 45% by June 2024.
Carroll Hospital	1) Carroll Hospital will utilize Standard Work to increase the percent of discharges by noon from 13% to 25% by July of 2024. 2) Carroll Hospital will utilize Standard Work to increase the percent of discharges by 3pm from 48% to 60% by July 2024. 3) Carroll Hospital will establish a process to track interval data points for patient flow and utilize Standard Work to achieve goal of “Patient in bed within 60 mins from start of room clean” by March of 2024
ChristianaCare	ChristianaCare, Union Hospital will reduce ED arrival to inpatient admission (ED-1a measure) from FY23 median of 422 minutes to median of 410 minutes for the timeframe July 1, 2023 to December 31, 2023.
Frederick Health	By June 30, the Length of Stay Committee, in collaboration with the Stroke Committee, will implement targeted strategies to achieve our expected LOS for stroke patients. (O/E = 1.0)
Garrett Regional	By March 1st, 2024 GRMC will decrease the total average turnaround time for Emergency Department visits by 20 minutes to increase the overall throughput in the Emergency Department.
GBMC	GBMC will decrease Ready to Move (RTM) to Off the Floor (OTF) from 61 minutes to a goal of 45 minutes by June 30, 2024.

Hospital	AIM statement
Grace	Sinai Hospital of Baltimore aims to create a more positive care experience for our patients by reducing length of stay, improving patient flow, and discharging patients safely and timely while maintaining the highest quality of healthcare available for our community throughout our current FY.
Holy Cross	1) By January 2, 2024, the ED Team will increase utilization of the Nurse Handoff tool and identify reasons for Delayed Transfers from the ED to the units to decrease ED median turnaround time from Admit Order to ED Depart by 10%. 2) By January 2, 2024, the Med-Surg Floors will standardize the Interdisciplinary Round Checklist to increase percentage of discharges by 4pm by 5%.
Holy Cross Germantown	1) By January 2, 2024, the ED Team will increase utilization of the Nurse Handoff tool and identify reasons for Delayed Transfers from the ED to the units to decrease ED median turnaround time from Admit
JH Bayview	Johns Hopkins Bayview Medical Center will reduce the time between when a patient is assigned to a unit/bed on selected services and the time the patient departs the Emergency Department by 10% by March 30, 2024.
JH Howard	Johns Hopkins Howard County Medical Center will reduce the time between when a patient is assigned to a unit/bed on selected services and the time the patient departs the Emergency Department by 10% by March 30, 2024.
JH Suburban	Johns Hopkins Suburban Hospital will reduce the time between when a patient is assigned to a unit/bed on selected services and the time the patient departs the Emergency Department by 10% by March 30, 2024.
JHH	Johns Hopkins Hospital will reduce the time between when a patient is assigned to a unit/bed on selected services and the time the patient departs the Emergency Department by 10% by March 30, 2024
Luminis AAMC	1) Luminis Health Anne Arundel Medical Center will reduce ED arrival to discharge home (OP-18a measure) from FY23 median of 258 minutes to median of 245 minutes for the timeframe July 1, 2023 to December 31, 2023 2) Luminis Health Anne Arundel Medical Center will reduce the average inpatient admission to SNF referral by 0.50 days from 6.36 days to 5.86 days by January 31st, 2024.
Luminis DCMC	1) Luminis Health Doctor's Community Medical Center will reduce ED arrival to discharge home (OP18a measure) from FY23 median of 289 minutes to median of 275 minutes for the timeframe July 1, 2023 to December 31, 2023. 2)Luminis Health Doctors Community Medical Center will reduce average inpatient admission to skilled nursing facility referral by 1.0 days from 8.04 days to 7.04 days by January 31, 2024.
Mercy	Mercy Medical Center will reduce overall ED arrival to ED departure time from median 277 minutes in FY23 to median 269 minutes for the timeframe July 1, 2023 to December 31, 2023.

Hospital	AIM statement
Meritus	Meritus Health will reduce ED arrival to discharge home from median 219 minutes in FY23 to 209 minutes (median) from July 1, 2023 to December 31, 2023.
MS Franklin Square	By December of 2023, we will reduce ED waiting room wait times for ESI level 3V, 4, and 5 patients by 10% through the full implementation of a recently piloted LPN-provider team-based model of care.
MS Good Sam	The inpatient/observation units will improve the utilization of the Discharge Hospitality Center (Discharge Lounge or DHC) by; 1) increasing the volume of patients sent to the DHC by 20% per week. 2) Improving the average DHC arrival time by 30 minutes by January 2024.
MS Harbor	Over the next six months, MHH will implement an early discharge stratification program, bedside medication delivery day prior to discharge, and optimization of patient throughput software to impact the reduction of ED1 by 25 minutes (5%) and OP18 by 10 minutes (3%) compared to FY23.
MS Montgomery	By December 2023, the Inpatient team will improve Hospitalist discharge efficiency by 40% and decrease inpatient LOS from 5.3 days to < 4.9 days. The decrease in average LOS will lead to more available beds for ED patients with admission orders and improve overall ED throughput.
MS Southern	By March 31, 2024, MSMHC will decrease the ED2B time by at least 10% compared to median FY23 by restructuring the admission and discharge process.
MS St. Mary's	1) Revise inpatient admission process to expedite bed assignment to improve ED-2B performance. Goal is to decrease ED-2B by 2.5% in FY24. 2) Implement Emergency Department Patient Throughput RN to improve OP-18 performance. Goal is to decrease OP-18 by 2.5% in FY24.
MS Union	The inpatient/observation units will improve the utilization of the Discharge Hospitality Center (Discharge Lounge or DHC) by; 1) increasing the volume of patients sent to the DHC by 20% per week. 2) Improving the average DHC arrival time by 30 minutes by January 2024.
Northwest	1) By end of FY24 the ED will reduce their LOS for admitted patients by 10%. Resulting in an average LOS for admitted patients of 630 minutes. 2) By end of FY24 NW Hospital will increase monthly offloading by 10% over baseline. Achieving goal of 80% of all EMS arrivals offloaded in 30 min or less. 3) By end of FY24 NW hospital will note a 4 % reduction in ALOS. Resulting in a 0.3 reduction from baseline of 6.8 days and a goal of 6.5.
Sinai	Sinai Hospital of Baltimore aims to create a more positive care experience for our patients by reducing length of stay, improving patient flow, and discharging patients safely and timely while maintaining the highest quality of healthcare available for our community throughout our current fiscal year.

Hospital	AIM statement
St Agnes	By March 31,2024 Ascension Saint Agnes med-surg/telemetry units will deploy an improved model of multidisciplinary rounds to increase the following day's discharges before noon to 35% from 25.7% and by June 30, 2024 decrease the percentage of observation stays exceeding 48 hours to 20.5% from 22%
Tidal Health	By January 31, 2024, the Emergency Department and inpatient units will collaborate to decrease the time from the admission order is placed to the time the patient is bedded on the admission unit by 30 minutes.
UM BWMC	By December 31st, the Patient Flow Council will further build out the Expediting Team to increase the number of Departure Lounge patients to 15/day.
UM Cap Region	The Throughput Change Council will implement the Expeditor Role by January 1, 2024 to improve inpatient med-surg discharges by noon by 25% by April 1, 2024.
UM Charles Regional	August 21st CRMC ED implemented a new split flow design triage process to improve “arrival to bed” time, by 15% over the next 60 days.
UM Medical Center	By November 1, 2023, to improve ED throughput and move discharges earlier in the day by 10% over FY23 baseline: Analyze ICU-acute bed ratio and staffing constraints, Analyze hospital system delays, Expand ED vertical 3s and tele-triage, Optimize hospitalist services embedded in ED, Collaborate with lab and radiology on turnaround times
UM Midtown	The Admissions Work Group and Discharge Efficiency Group will merge into Throughput Improvement Council beginning November 1st to achieve 3 of the ADT efficiency goals by end of FY24. ADT Efficiency Goals: ED Boarders < 120 minutes Increase DBN by 4% above FY23 ED Offload time <10% above target Admissions w/out orders 0% Admissions orders written within 60 minutes of decision to admit
UM Shore(Chestertown & Easton)	By January 3, 2024 UM Shore Regional will move discharge order median time written before 12 noon. The current median time for discharge orders written is 14:15. This will be accomplished by implementing our Triad Rounding (11/3/2023) on all units and Care Transition Rounds reorganization (by 11/15/2023) to focus on discharge needs.

Hospital	AIM statement
UM St Joes	1) By January 5th, the ED will create a trial vertical care space in the front end of the ED to decrease arrival to depart times for discharged patients by 10%. 2) By January 5th, SJMC will fully operationalize an AI Capacity Management tool to decrease Inpatient Admission wait time by 10%. 3) By December 15th, the ED will implement a Flow Coordinator Role to ensure 80% of patients are offloaded within 30 minutes of arrival by ambulance.
UM Upper Chesapeake (UC & Harford)	By June 30, 2024 Upper Chesapeake Health will: 1) reduce the LOS of Observation patients by 20% from 1.9 days to 1.52 days; and 2) reduce average total weekly patients boarding hours by 10% from 2143.2 to 1714.6.
UPMC Western MD	By May 31, 2024, UPMC Western Maryland's Emergency Department team will redesign its vertical care model to reduce Total ED Length of Stay for discharged patients excluding psychiatric patients (ED 18b) by 8% (reduction of 19.5 mins for a time of 224.5) over a median baseline of 244 minutes from Sep22-Aug23.

Next steps:

- Decide on statewide long-term goals and timeframe for achievement
- Monitor progress on incremental QI sprints to ensure achievement of long-term goals

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Open Cases Overview

November 8, 2023

Open Cases

- 2631N: Tidal Health Peninsula - Partial Rate Application for Adolescent Psych - December Recommendation
- 2627A: John Hopkins Health System -Under Armor, Inc - *Executive Health Services* **- Approved for one year**
- 2628A: John Hopkins Health System- Johns Hopkins Employer Health Programs/Uniformed Services Family Health Plan - *Spine and Bariatric Surgery* - **Approved for one year**
- 2629A: John Hopkins Health System- Quality Health Management - *Cardiovascular Surgery* - **Approved for one year**
- 2637A: John Hopkins Health System - Employer Direct Healthcare - *Cardiovascular services, Bariatric Surgery, Orthopedic Services (shoulder, hip, knee, and spine), Gallbladder, Thyroid/Parathyroid, Oncology Diagnosis, and Prostate services* - **Approved for one year**
- 2638A: John Hopkins Health System - Aetna Health, Inc. - *Solid Organ and Bone Marrow Transplants* - **Approved for one year**
- 2639A: John Hopkins Health System - Blue Cross Blue Shield Distinction - *Solid Organ and Bone Marrow Transplants* - **Approved for one year**

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
JOHNS HOPKINS HEALTH	*	**DOCKET: 2023**
SYSTEM	*	**FOLIO: 2437**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2627A**

Staff Recommendation

November 8, 2023

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on June 28, 2023, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital ("the Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement for Executive Health Services with Under Armor, Inc. for a period of one year beginning August 1, 2023.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION ANDASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC

maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this arrangement was positive for the last year. Staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Executive Health Services for a one-year period commencing August 1, 2023. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
JOHNS HOPKINS HEALTH	*	**DOCKET: 2022**
SYSTEM	*	**FOLIO: 2438**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2628A**

Staff Recommendation

November 8, 2023

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on June 28, 2023, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a revised global rate arrangement with the Priority Partners Managed Care Organization. Inc., the Johns Hopkins Employer Health Programs, Inc., and the Johns Hopkins Uniformed Services Family Health Plan for Spine and Bariatric surgery services. The System requests approval of the arrangement for a period of one year beginning August 1, 2023.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION ANDASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System

contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this arrangement for the last year has been favorable. The Hospitals have adjusted the prices in their current arrangement to eliminate the losses. Staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Bariatric and Spine Surgery Procedures for a one-year period commencing August 1, 2023. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
JOHNS HOPKINS HEALTH	*	**DOCKET: 2022**
SYSTEM	*	**FOLIO: 2439**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2629A**

Staff Recommendation

November 8, 2023

I. INTRODUCTION

On June 28, 2023, the Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") requesting approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular surgery with Quality Health Management. The Hospitals request that the Commission approve the arrangement for one year effective August 1, 2023.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the System hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payment, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that there was no activity under this arrangement for the prior year. However,

staff believes that the Hospitals can achieve a favorable outcome under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular surgery for one year beginning August 1, 2023. The Hospitals must file a renew application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document will formalize the understanding between the Commission and the Hospitals and will include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2023
SYSTEM	*	FOLIO:	2447
BALTIMORE, MARYLAND	*	PROCEEDING:	2637A

Staff Recommendation

November 8, 2023

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on October 5, 2023, on behalf of its regulated member Hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Inc., Suburban Hospital Inc., and Howard County General Hospital, Inc. (the "Hospitals") for approval to continue to participate in a global rate arrangement for Cardiovascular services, Bariatric Surgery, Orthopedic Services (shoulder, hip, knee, and spine), Gallbladder, Thyroid/Parathyroid, Oncology Diagnosis, and Prostate services with Employer Direct Healthcare. The System requests that the approval be for a period of one year beginning November 1, 2023.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving similar joint replacement services at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this arrangement for the last year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Cardiovascular services, Bariatric Surgery, Orthopedic Services (shoulder, hip, knee, and spine), Gallbladder, Thyroid/Parathyroid, Oncology Diagnosis, and Prostate services with Employer Direct for a one-year period commencing November 1, 2023. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2023**
SYSTEM	*	**FOLIO:**	**2448**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2638A**

Staff Recommendation

November 8, 2022

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on October 19, 2022, on behalf of its regulated member hospitals, Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center ("the Hospitals"), requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. The Hospitals request that the Commission approve the arrangement for one year beginning December 1, 2023.

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II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments calculated for cases that exceed a specific length of stay outlier threshold were similarly adjusted.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

The staff found that the experience under this arrangement for the last year was favorable.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one-year period beginning December 1, 2023. The Hospitals must file a renewal application annually for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2023
SYSTEM	*	FOLIO:	2449
BALTIMORE, MARYLAND	*	PROCEEDING:	2639A

Staff Recommendation

November 8, 2023

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on June 1, 2023 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center ("the Hospitals") for approval to continue to participate in a global rate arrangement for solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers. The Hospitals requests that the Commission approve the arrangement for one year effective July 1, 2023.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments calculated for cases that exceed a specific length of stay outlier threshold were similarly adjusted.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this arrangement has been favorable over the last year.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for solid organ and bone marrow transplant services for one year beginning July 1, 2023. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: November 8, 2023

RE: Hearing and Meeting Schedule

December 13, 2023 To be determined - GoTo Webinar

January 10, 2024 To be determined - GoTo Webinar

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.