maryland
health services
cost review commission

Performance Measurement Workgroup

September 20, 2023

HSCRC Quality Team

Meeting Agenda

- Welcome and introductions, webinar housekeeping
- IPPS FY 2024 Final Rule Summary
- 2023-2024 PMWG Work Plan review
- Model updates re. Quality
  - Total Cost of Care (TCOC)
  - SIHIS
  - Next model Progression Plan
  - RY 2024 Revenue Adjustments
- Quality-Based Reimbursement (QBR) RY 2026 policy discussion
  - 30 day mortality
  - HCAHPS improvement
  - ED wait times
- HSCRC digital measures update
- Update on CY 2023 Monitoring Reports

Inpatient Prospective Payment System FY 2024 Final Rule

CMS IPPS Final Rule FFY 2024 Emerging Priorities

Hospital Value-Based Purchasing Program:

- FY 2026 - New measures
  - Adopting the Severe Sepsis and Septic Shock: Management Bundle measure in the Safety Domain
  - Adding health equity adjustment to hospitals' VBP Total Performance Scores (TPS) based on proportion dual eligible population hospital treats
- FY 2027- HCAHPS survey updates:
  - Three new web-first modes of survey implementation
  - Removal of the survey's prohibition on proxy respondents
  - Extension of the data collection period from 42 to 49 days
  - Limiting the number of supplemental survey items to 12
  - Requiring the official Spanish translation for Spanish language-preferring patients, and
  - Removing two administration methods not used

Hospital Inpatient Quality Reporting Program (IQR) :

- Adding new measures measure for FY 2027
  - Hospital Harm- Pressure Injury electronic clinical quality measure (eCQM)
  - Hospital Harm – Acute Kidney Injury eCQM
  - Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) eCQM

CMS IPPS Final Rule FFY 2024 Emerging Priorities

- **Removal of three measures under IQR:**
  - Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation measure beginning with the CY 2024 reporting period/FY 2026 payment determination.
  - Medicare Spending Per Beneficiary (MSPB) Hospital measure beginning with the CY 2026 reporting period/FY 2028 payment determination.
  - Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty measure beginning with the April 1, 2025, through March 31, 2028, reporting period/FY 2030 payment determination
- **Modifications to three current measures under Hospital IQR:**
  - Include Medicare Advantage admissions:
    - Hybrid Hospital-Wide All-Cause Risk Standardized Mortality measure (FY 2027 payment determination)
    - Hybrid Hospital-Wide All-Cause Readmission measure (FY 2027 payment determination).

Recap: CMS VBP Health Equity Adjustment (HEA)

- Beginning with the FY 2026 program year, CMS is modifying the existing VBP scoring methodology to reward excellent care in underserved populations.
- Rewards Hospitals Based on Total Performance and the Proportion of Their Patients Who Are Dually Eligible for Medicare and Medicaid
- The HEA bonus points are designed to award higher points for hospitals that (1) serve greater percentages of underserved populations and (2) have higher quality performance.
- The HEA bonus point calculation is purposefully designed to not reward poor quality

HSCRC's Approach to Advancing Health Equity in Quality Policies

- Maintain Improvement Incentives in Quality Policies until Full Maturation
  - Risk adjustments for underserved/disadvantaged populations in quality metrics can result in excusing worse quality outcomes for patients impacted more by social determinants.
  - HSCRC purposefully maintains improvement incentives (better of attainment/improvement) so that all hospitals are incentivized to improve, regardless of the population served
  - HSCRC additionally moves quality metrics to attainment only (e.g., MHAC) once the program is mature (and an optimal attainment level is known/expected) so that inequities in quality outcomes are not enshrined through payment policies
- Directly Incentivize Reductions in Disparities
  - Direct incentive for hospitals are used to reduce their within-hospital disparities
  - The ability to receive reward depends only on improvement within the hospital in original measure
  - Incentives are purposefully designed to not penalize hospitals that have a greater proportion of patients with high adversity

2023-2024 PMWG Work Plan Review: (See separate Work Plan document for more detail)

RY 2026 Policy Decisions

1. Quality-Based Reimbursement (QBR) Program
    - Addition of Sep 1 Measure to Safety domain
    - Transition from inpatient mortality to all-cause, all-payer 30-day mortality
    - HCAHPS improvement: Supplemental questions
    - Add disparity in Medicare Timely Follow-Up
    - Add ED wait time/Turnaround measure
    - Evaluate revenue at-risk under program given addition of measures

1. Maryland Hospital Acquired Conditions (MHAC) Program
    - Payment PPCs
    - Bayesian Smoothing
    - Calculation of performance standards
    - Small hospital concerns
    - Revenue at-risk

RY 2026 Policy Decisions, continued

3. Readmission Reduction Incentive Program (RRIP)
    - Improvement target
    - Attainment target
    - Revisits/Observation
    - Excess Days in Acute Care measure
    - Within hospital disparities measure and incentive

3. Population Health: IP diabetes screening recommendation
    - Discussion on options for payment policy
    - Evaluate options for removing those already screened and opt outs from denominator

3. Emergency Department/Multi-Visit Patient policy recommendation
    - Finalize measure
    - How to incorporate into existing or new PAU policy

Commission Draft and Final Policy Review and Vote

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

TCOC Model, SIHIS, Next model Progression Plan Updates

TCOC Model Year 4 Performance – Exceeded Most Targets

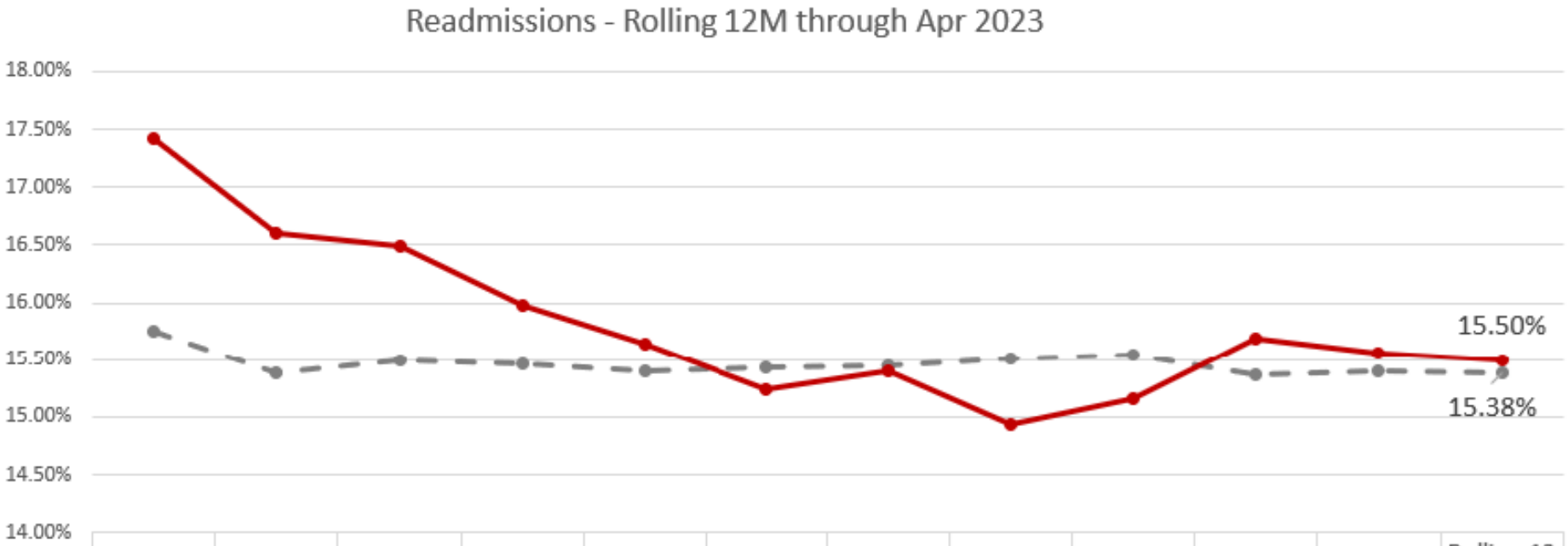
Performance Measures	2022 Targets	2022 Results	Met
Annual Medicare TCOC Savings	$267M in annual Maryland Medicare TCOC per Beneficiary of savings for MY4 (2022)	$269 million	✓
TCOC Guardrail Test	Cannot exceed growth in National Medicare TCOC per beneficiary by more than 1% per year and cannot exceed the National Medicare TCOC per beneficiary by any amount for 2+ consecutive years	0.9 percentage points above the National growth rate in 2022 and 0.6 percentage points above in 2021	*
All-Payer Revenue Limit	All-payer growth ≤ 3.58% per capita	2.72% per capita ($1.41 billion below the maximum revenue amount)	✓
Improvement in All-Payer Potentially Preventable Conditions	Improve upon the CY 2018 PPC rates for 14 Potentially Preventable Conditions (PPCs) that comprise Maryland's Hospital Acquired Condition program (MHAC)	0.2 percentage point reduction in the All-Payer PPC rate compared to CY 2018	✓
Readmissions Reductions for Medicare	Maryland's aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate at regulated hospitals ≤ the National Readmission Rate for Medicare FFS beneficiaries	15.56% (above the national rate of 15.40%)	**
Hospital Population Based Payment	≥ 95% of all Regulated Revenue for Maryland residents paid according to a Population-Based Payment methodology	98% of Regulated Revenues are under Maryland's 'Rate Setting System'	✓

*CMS did not ask the State to take additional corrective action in part because, in December 2022, HSCRC took steps to reduce 2023 growth, which should allow the State to meet their 2023 TCOC Guardrail requirement, and because Maryland's 2022 growth was partly based on CMS OACT estimates of growth that were significantly larger than actual growth.

**HSCRC staff believe the unadjusted readmission rate has increased due to increases in patient acuity in Maryland's hospitals, relative to the nation, an expected effect of GBRs. CMMI has agreed to consider to a risk-adjusted measure but also requested that the State conduct activities related to readmission improvements.

TCOC Model Performance: Medicare Readmission Test

Unadjusted, 30-day, all-cause readmissions



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

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TCOC Model Performance: CCW Regression Results

On a risk adjusted basis Maryland has **statistically significantly** (CI less than 1) lower odds of readmission than the nation in 2020, 2021 and 2022

Risk Adjustment Variables

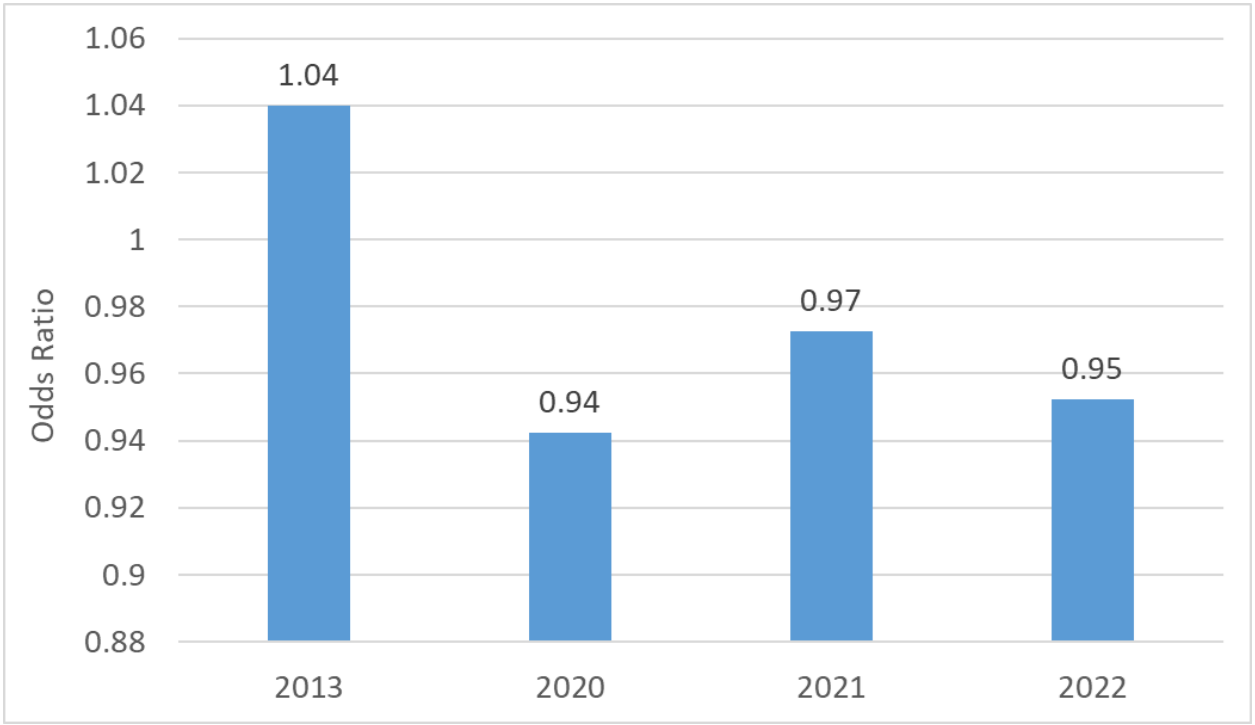
Age

Sex

Major Diagnostic Category

Elixhauser Comorbidity Index

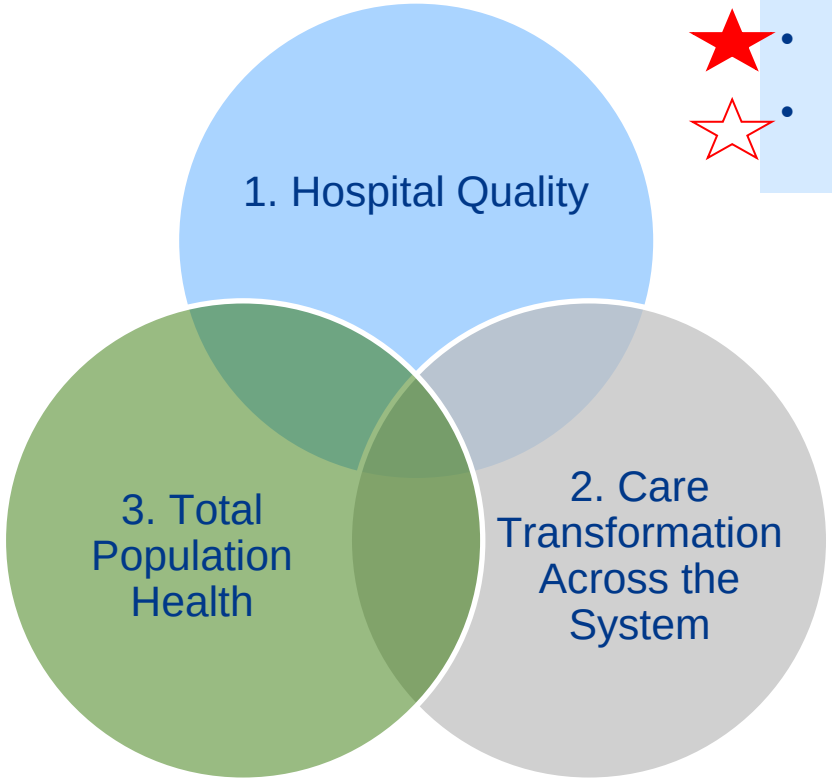
COVID-19 (post-2020 models)



As Maryland continues to trend lower than the nation on a risk adjusted basis, the HSCRC believes the current unadjusted test is not indicative of actual performance and will continue to advocate for moving to a risk adjusted test.

Statewide Integrated Healthcare Improvement Strategy (SIHIS): Goals Across Three Domains

Total Cost of Care Model (2019-2028)



Hospital Quality

- ★ Reduce avoidable admissions (ambulatory sensitive conditions)
- ☆ Improve Readmission Rates by Reducing Within-Hospital Disparities

Care Transformation Goals

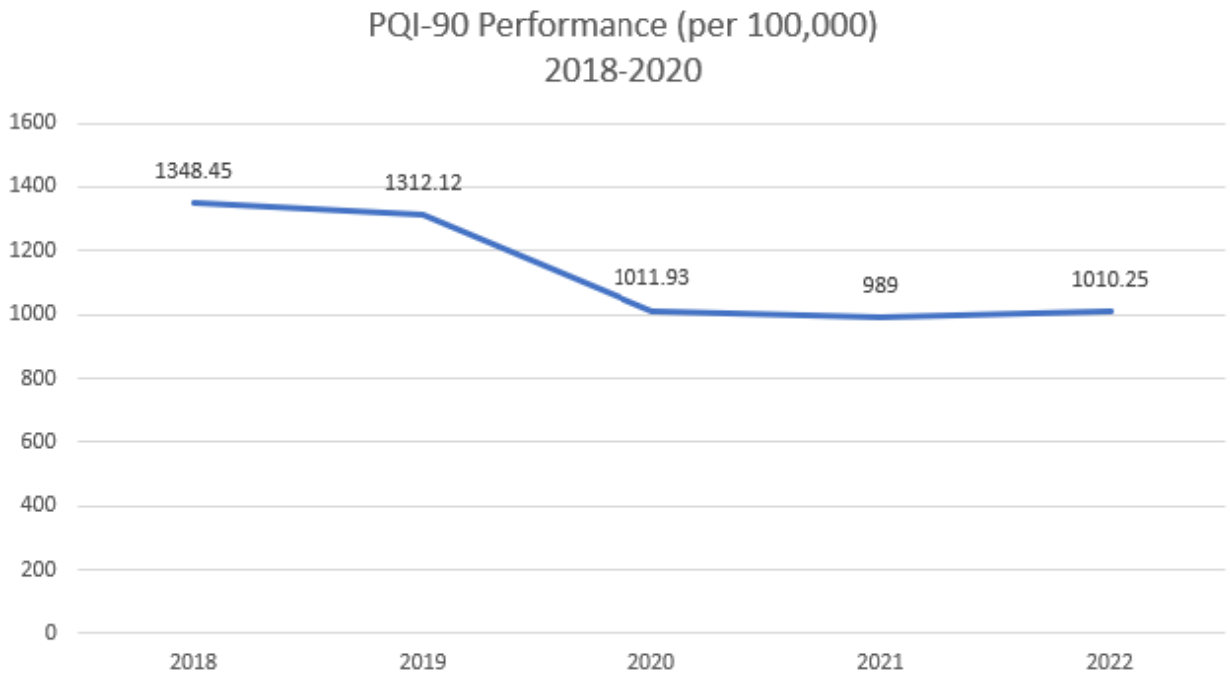
- Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models*
- ★ Improve care coordination for patients with chronic conditions

Total Population Health Goals

- Priority Area 1 (Diabetes): Reduce the mean BMI for adult Maryland residents
- Priority Area 2 (Opioids): Improve overdose mortality
- Priority Area 3 (Maternal and Child Health Priority Area):
  - Reduce severe maternal morbidity rate
  - Decrease pediatric asthma-related emergency department visit rates for ages 2-17

*Value-based models including the Care Redesign Program, Care Transformation Initiatives, and qualifying successor models.

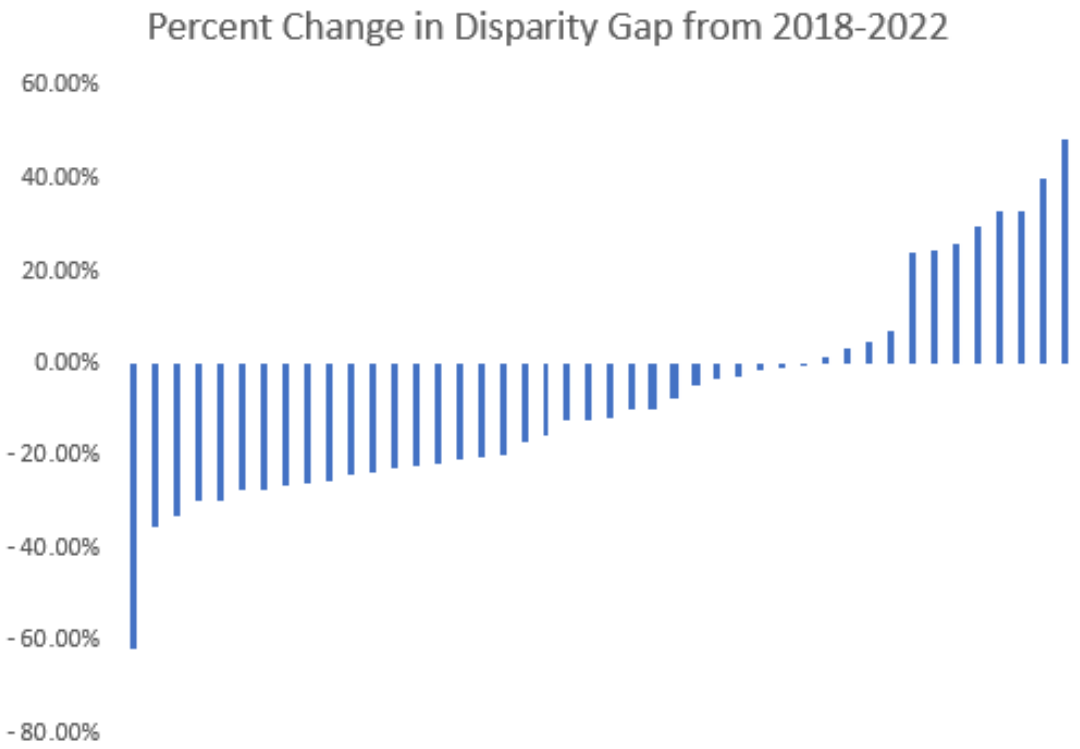
SIHIS: Reduce Avoidable Admissions



PQIs through June 2023	2018 Baseline	Rolling 12 Months	2023 State Target	Difference from State Target
Admits/100k	1,348	1,076	1,146	-6.10%
Total Count of PQIs	61,996	51,170	52,697	-2.90%

- Much of the improvement in 2020 and 2021 is likely due to COVID
- A rebound in avoidable admissions is occurring as previously predicted
- On target to meet 2023 goal of reducing avoidable admissions by 15%

SIHIS: Reducing Within-Hospital Disparities



% Change through May 2022	On Track for 50% Reduction by 2026	Achieved 50% Reduction in Rolling 12 Months	2026 Target	Difference from Target
% of Hospitals	2.27%	2.27%	50%	47.73%
Number of Hospitals	1	1	22	21

SIHIS: Improve Care Coordination for Patients with Chronic 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%

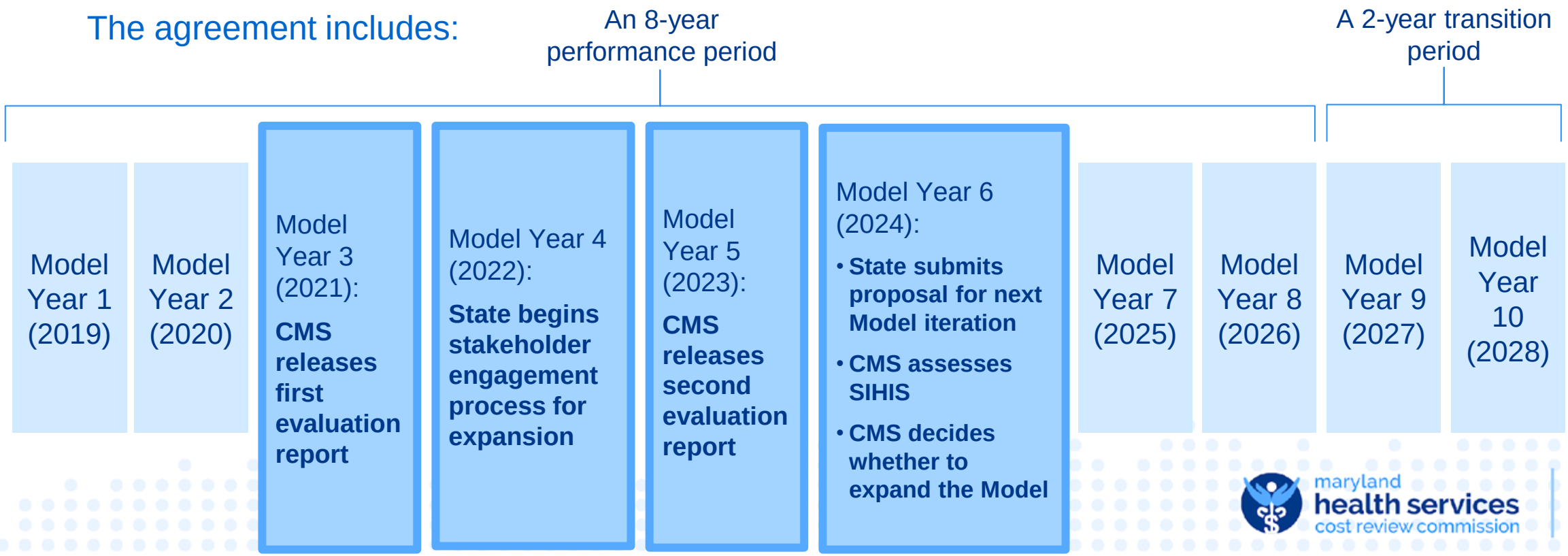
- State and Nation saw a drop in TFU rates in CY2020, likely due to disruptions caused by COVID
- There was recovery in CY 2021, but State did not meet Year 3 milestone (72.38%)
- CY 2023 through May performance is 71.72%, CY 2023 goal is 73.42%
- Despite the State decreasing and the Nation increasing TFU rates from CY 2018, the State performed ~4.95% better than the Nation in CY 2022

TCOC Model: Moving Forward

The Maryland Total Cost of Care Model State Agreement states:

> "Under this Model, CMS and the State will test whether statewide healthcare delivery transformation, in conjunction with Population-Based Payments, improves population health and care outcomes for individuals, while controlling the growth of Medicare Total Cost of Care."

The agreement includes:



TCOC Model: What is Expansion?

"Expansion" means that **all or some portion of the TCOC Model could be extended long term,** without the need to renegotiate agreements with CMMI.

§1115A(c) of the Social Security Act requires the following to happen to expand a Model:

- CMMI must determine that expansion is expected to—
  - **reduce spending** without reducing the quality of care; or
  - **improve the quality of patient care** without increasing spending;
- CMS's Chief Actuary must certify that expansion would **reduce** (or would not result in any increase in) **net Medicare spending**

A **positive independent evaluation** is necessary for, but does not guarantee, TCOC Model expansion.

If the Model is not expanded, CMMI could decide to **test a new model or return Maryland to the national prospective payment system.**

AHEAD Model

- The Center for Medicare and Medicaid Innovation (CMMI) has announced a new multi-state innovation Model, the States Advancing All-Payer Health Equity Approaches and Development Model ("AHEAD Model").
  - The AHEAD Model will "test state accountability for constraining overall growth in health care expenditures while increasing investment in primary care and improving population health and health equity." The Model will use hospital global budgets and advanced primary care, elements of the current Marland TCOC Model.
- Maryland is in the process of developing a plan for the future of the Maryland Model.
  - MDH and HSCRC will work with stakeholders throughout the State to ensure that many viewpoints contribute to the State's decisions about the future of the Maryland TCOC Model.
  - The stakeholder process will begin later this fall.
- Maryland looks forward to the release of more details on AHEAD Model. Further details will allow us to evaluate whether this new CMMI Model can be an option that will further and elevate Maryland's work to improve healthcare quality, control cost growth, improve health, and advance health equity for Marylanders.

QBR RY 2026 Discussion Topics

30-Day Mortality

30-Day Mortality: Overview of Measure Specifications and Development Process

September 20, 2023

Overview

- **Goal: develop a 30-day all cause, all payer mortality measure**
  - Capture deaths that occur within 30 days of hospital admission, regardless of where death occurs
- **Use CMS 30-Day Hospital-Wide Mortality Measure as a guide**
  - Currently under development, and not used publicly yet
  - Make necessary adjustments to estimate model on Maryland all-payer data
- **Use Maryland Vital Statistics death data merged with Maryland inpatient records**
  - CY 2018 and CY 2019 data were used for measure development and testing

Step 1: Apply inclusion/exclusion criteria

Cases Excluded from Sample	
Transferred in from another acute care facility	Inconsistent vital status (e.g. death date precedes admission date)
Enrolled in hospice during index admission	Left against medical advice
Metastatic cancer	Crush, spinal, brain, or burn injury
Limited ability for survival (based on ICD-10 codes)	Non-Maryland resident (Vital Statistics data not reliable for non-Maryland residents)

- For patients with multiple admissions that qualify for measure inclusion, randomly select one admission for inclusion in sample

Step 2: Assign stays to a service line

- **First, identify maternity stays and assign them to maternity service line**
  - APR-DRG = 540 or 560
- **Next, among non-maternity stays, determine if a major surgical procedure was performed**
  - If yes, then assign stay to the "surgical" cohort; if no, then assign to the "non-surgical" cohort
- **Last, assign stays to a service line within non-surgical and surgical cohorts**
  - Non-surgical cohort: assignment based on principle diagnosis
  - Surgical cohort: assignment based on principle procedure

Analytic Sample

Maternity Cases

Non-Maternity Cases

Non-surgical service lines		Surgical service lines
Cancer	Orthopedics	Cancer
Cardiac	Pulmonary	Cardiothoracic
Gastrointestinal	Renal	General
Infectious disease	Other conditions	Neurosurgery
Neurology		Orthopedic
		Other

Mathematica

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 the 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)

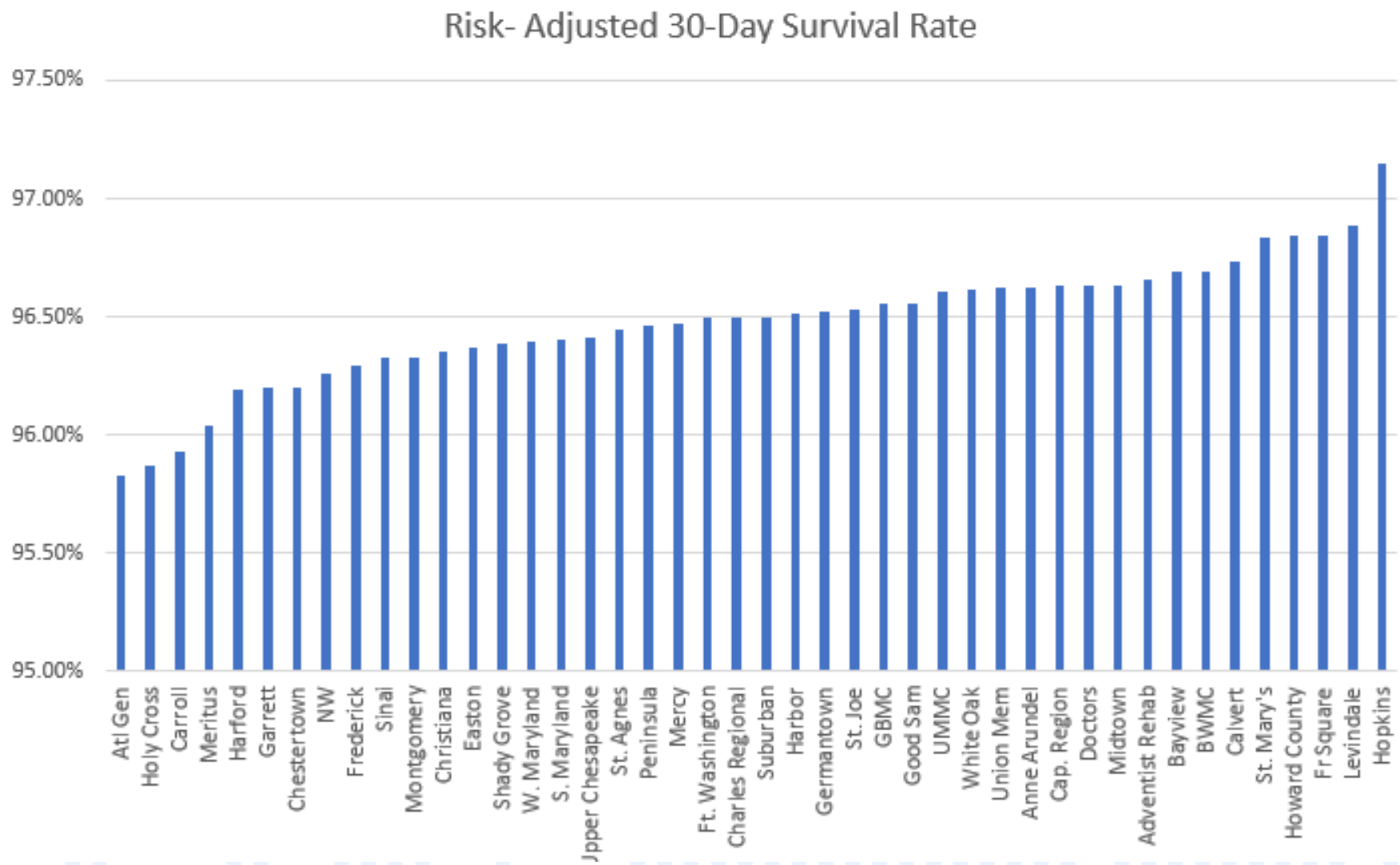
Overview of measure development process

- **Use CMS 30-day all-cause mortality measure as guide, but make changes to best reflect an all-payer population**
  - Carve out maternity cases as separate service line for monitoring
  - Use APR-DRGs and Risk of Mortality as primary risk adjusters to mimic inpatient mortality measure

- **Make adaptions based on hospital inpatient data**
  - Limit to in-state residents only, as Vital Statistics death data is less reliable for out of state patients
  - Merge in hospice utilization data from Medicare FFS claims, since indicators on inpatient records may not fully capture hospice utilization

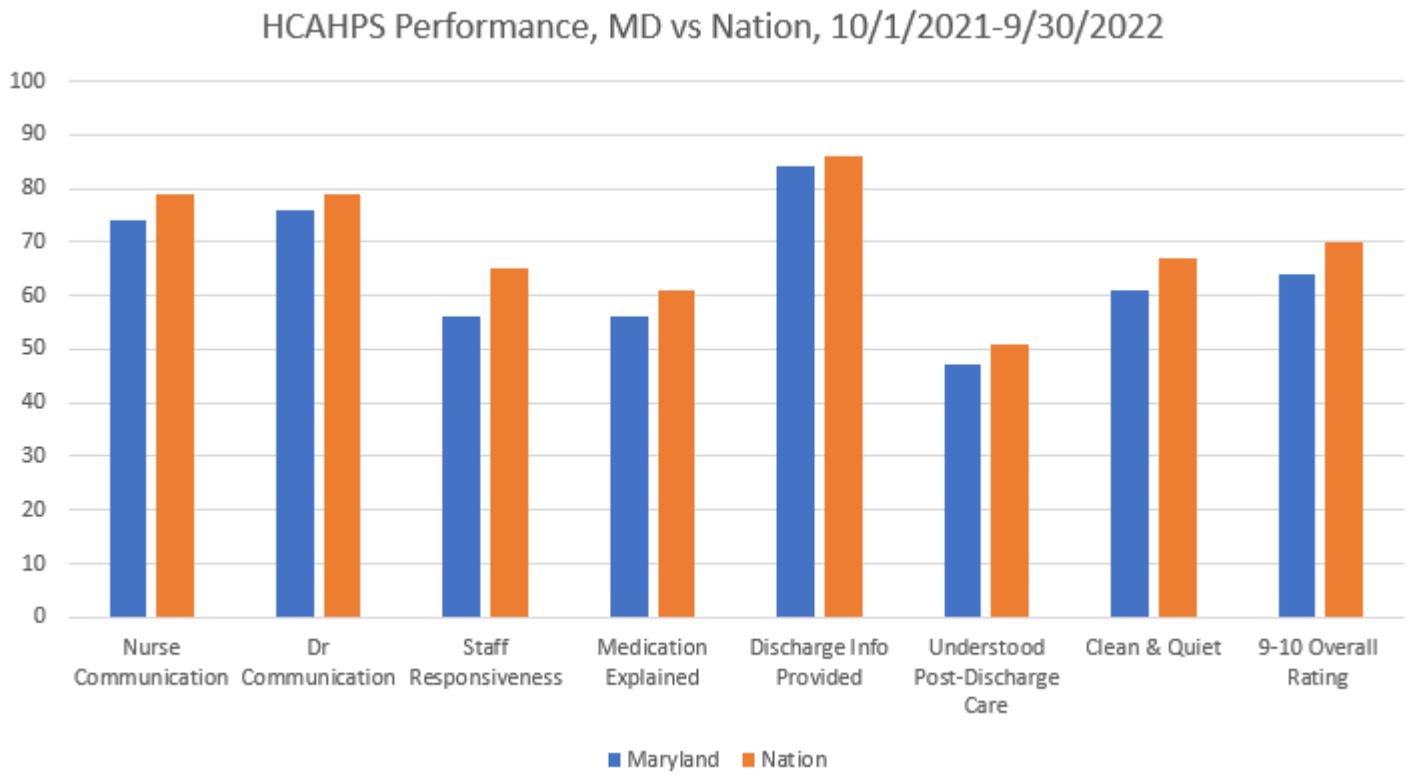
- **Assess statistical performance of model**
  - Calculate convergent and predictive validity
  - Calculate reliability (i.e. signal-to-noise test)

30-Day Mortality Performance, CY2023 YTD through July



Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

HCAHPS Most Recent Available Performance



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

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

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

Emergency Department Throughput

Emergency Department Dramatic Improvement Effort (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 with two components:

EDDIE: Improved ED Experience for Patients

Quality Improvement

- Rapid cycle QI initiatives to meet hospital set goals related to ED wait times
- Learning collaborative
- Convened by MHA

Commission Reporting

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

MHA Quality Improvement Initiative: Example of Hospital Goals

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.

Commission requests that hospitals submit short term, specific, and measurable goals related to ED throughput to MHA for reporting at October Commission meeting

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.

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.

August 2023 Reporting

Monthly, public reporting of three measures:

- ED1 Inpatient arrival to admission time
- OP18 Outpatient ED arrival to discharge time
- EMS turnaround time (data from MIEMSS)

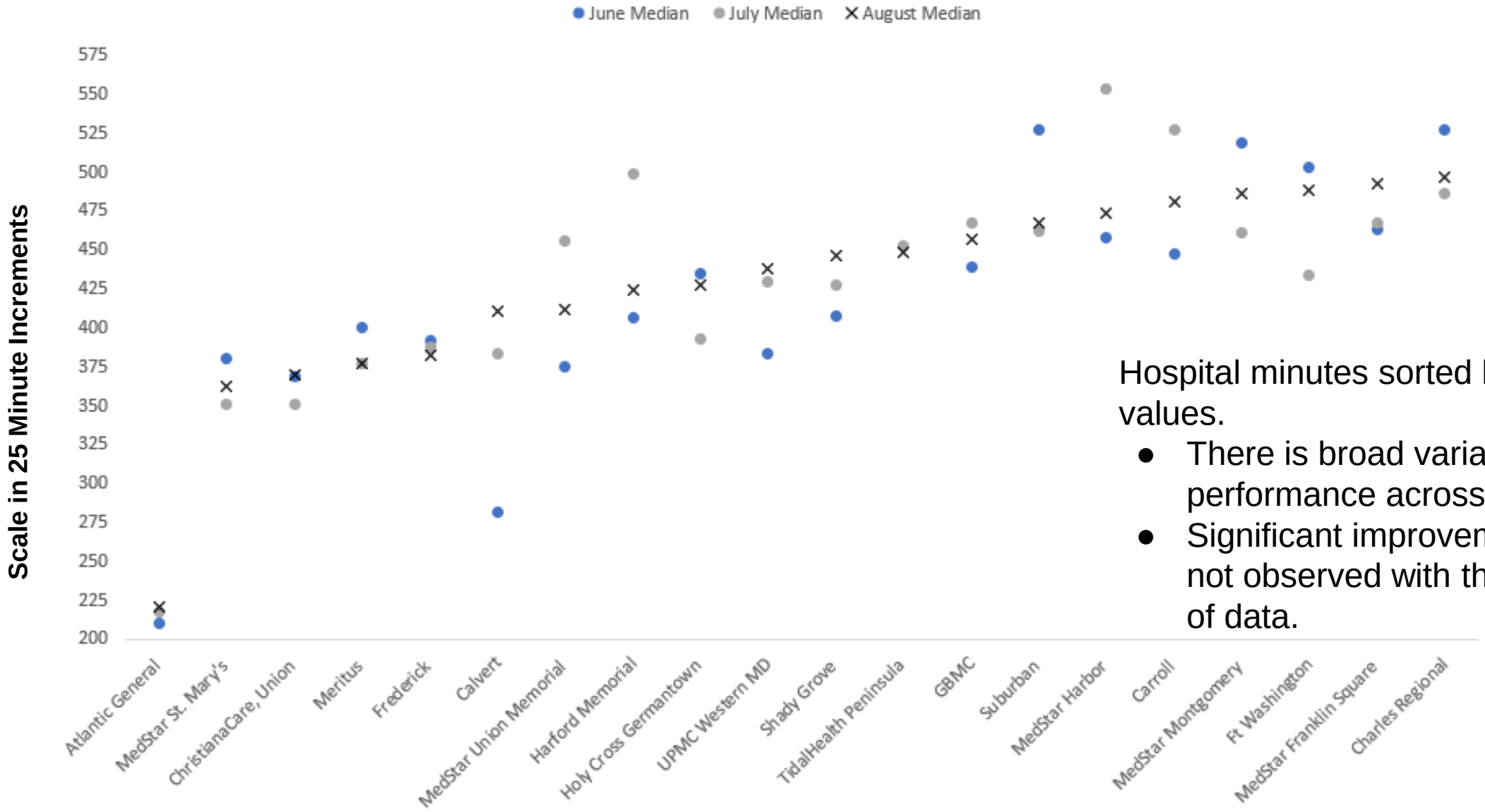
Reports received for all hospitals in August

- This data may be preliminary and some hospitals have resubmitted previous months as they work through the process of providing the metrics shortly after end of the month
- Garrett reported alternative metrics but is actively working to report requested metrics

Graphs for ED1a and OP18a

- Months of June, July, August
- Month of August grouped by CMS ED volume category (volume data is from CMS Care Compare)

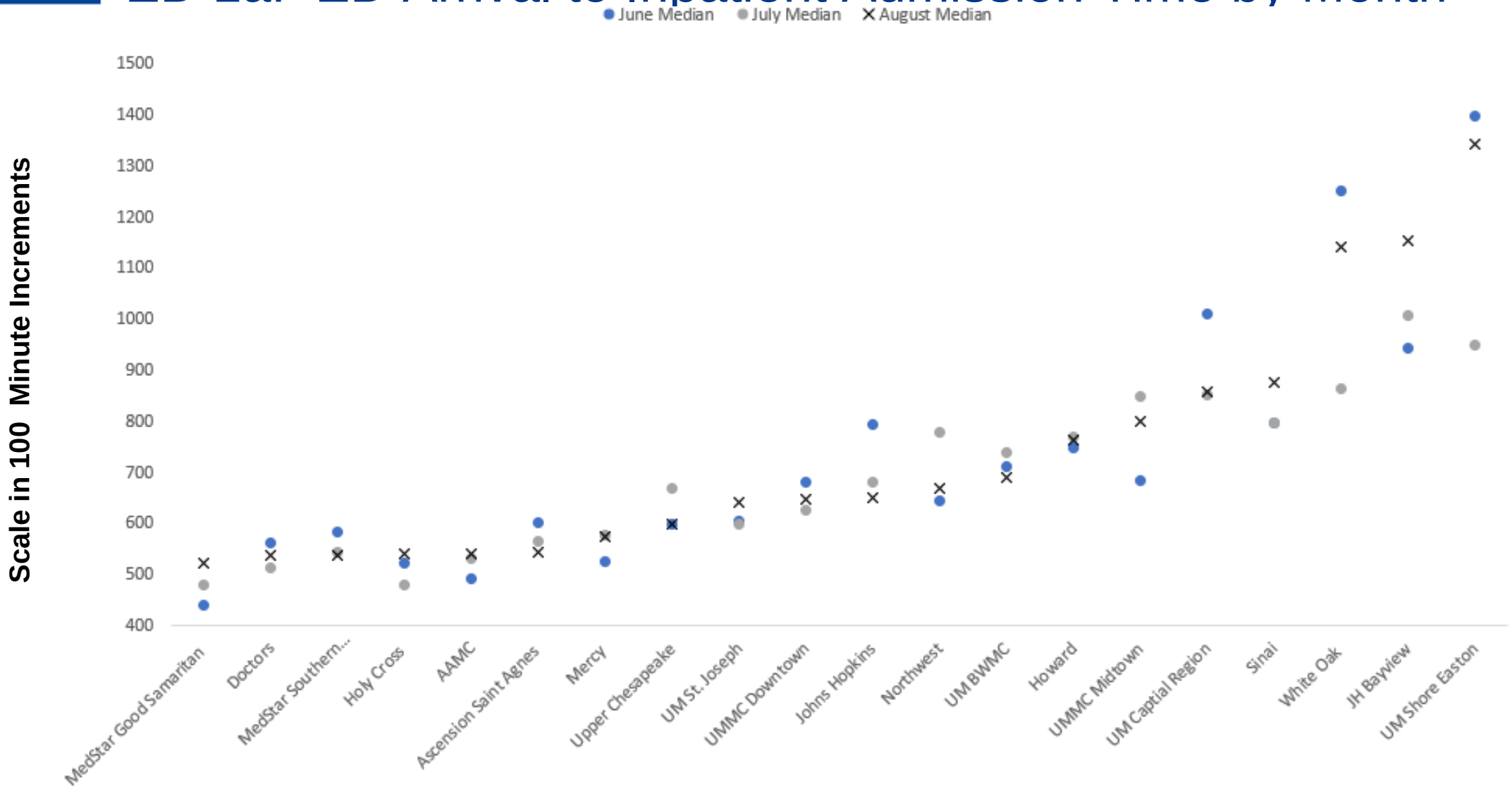
ED 1a: ED Arrival to Inpatient Admission Time by Month



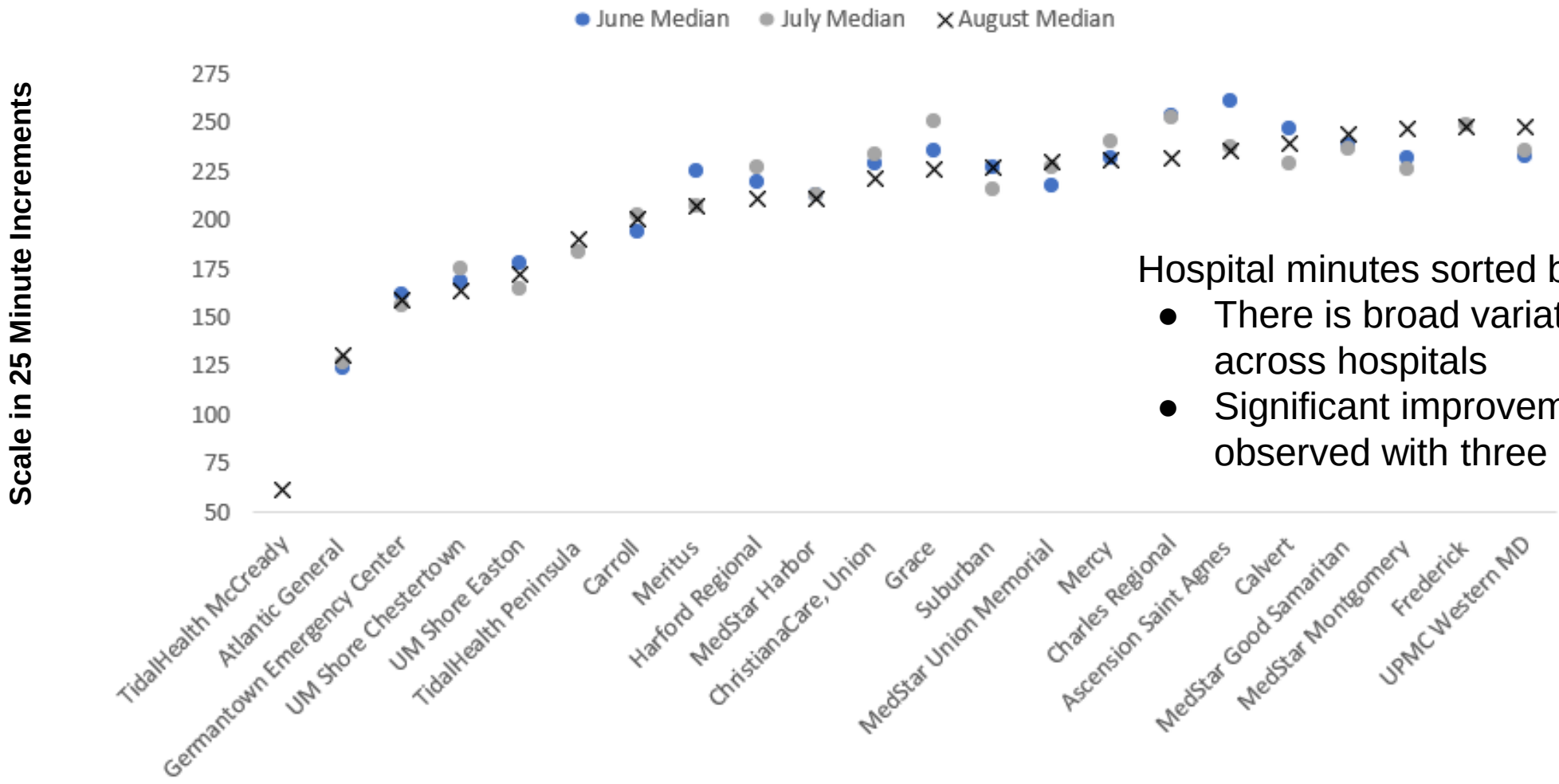
Hospital minutes sorted by August values.

- There is broad variation in performance across hospitals
- Significant improvement trends not observed with three months of data.

ED 1a: ED Arrival to Inpatient Admission Time by Month



OP18a: ED Arrival to Discharge Time by Month



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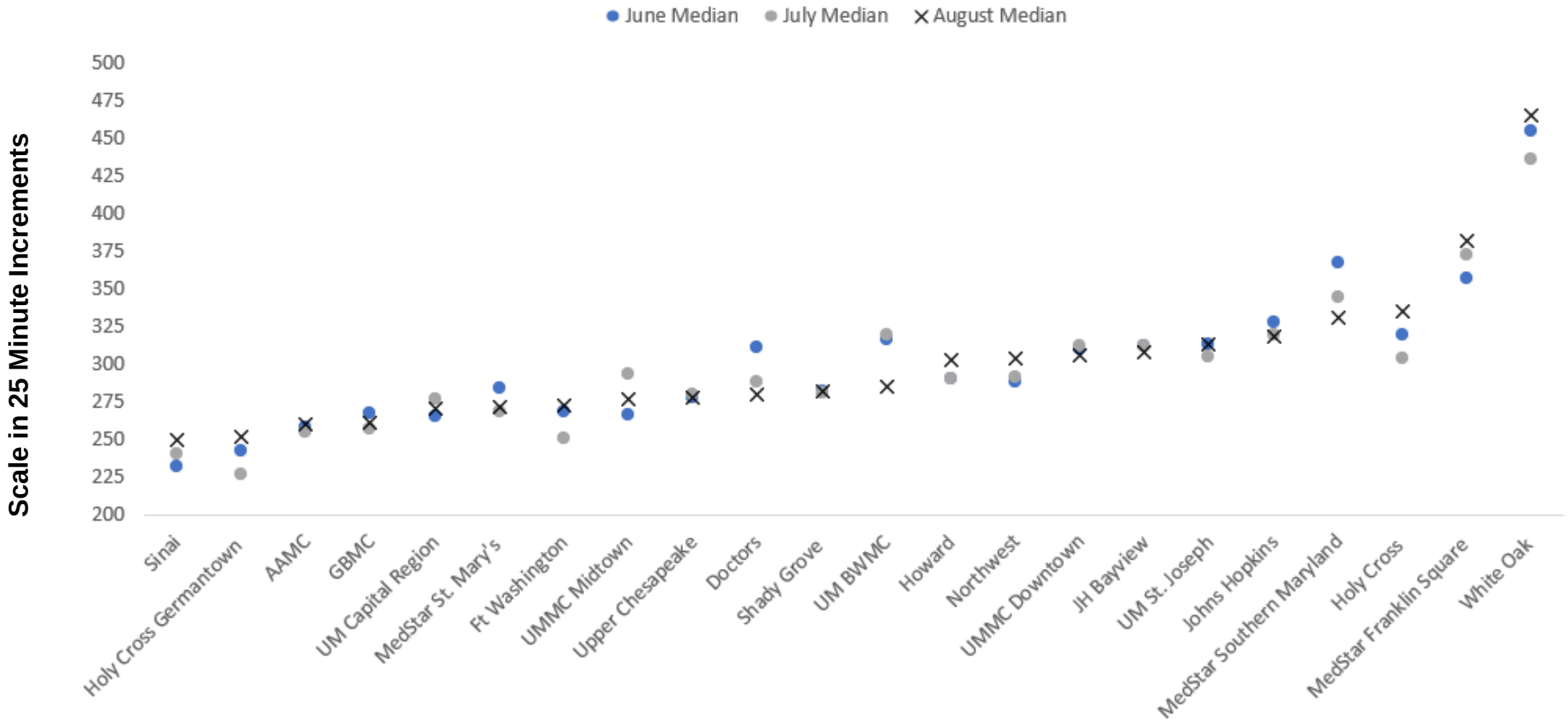
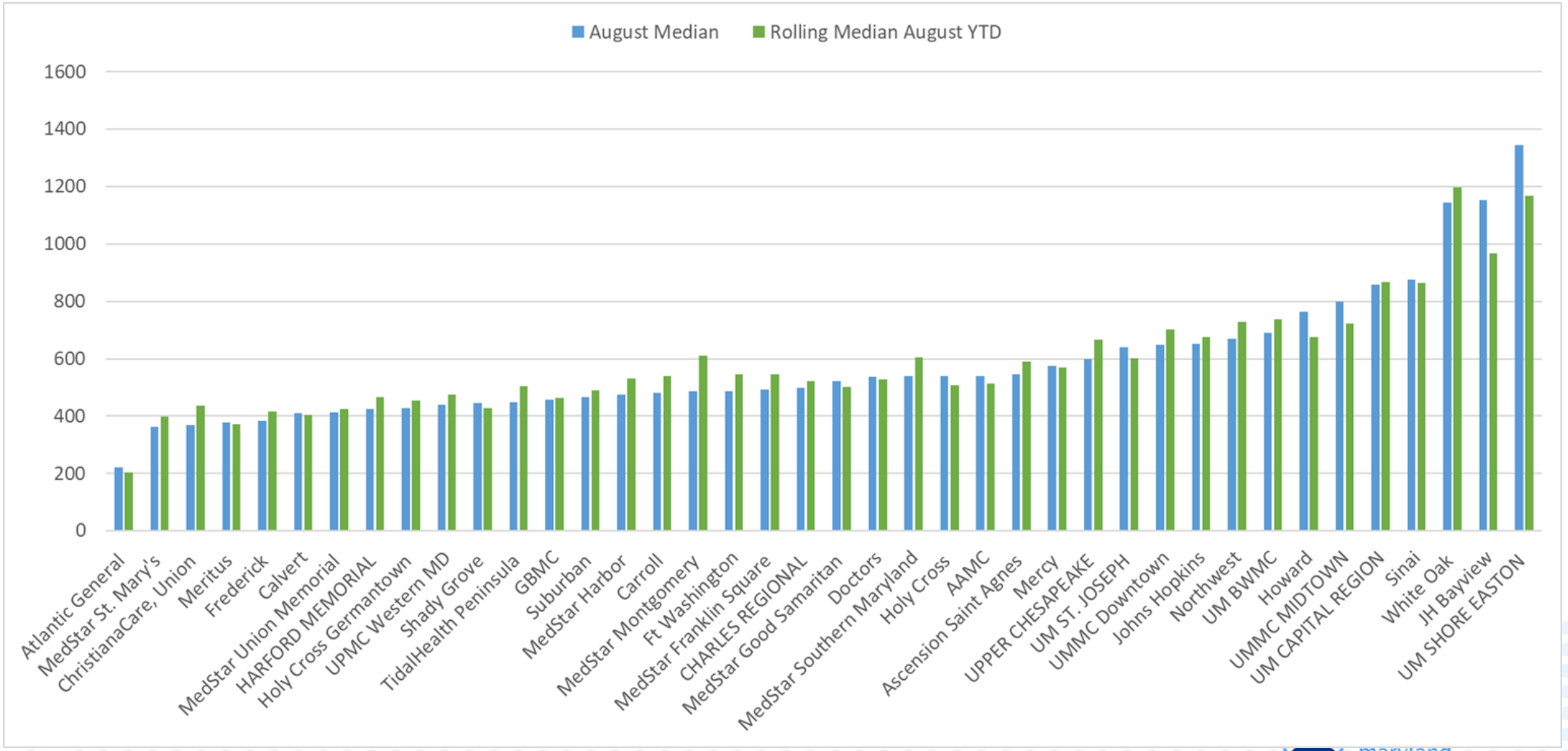
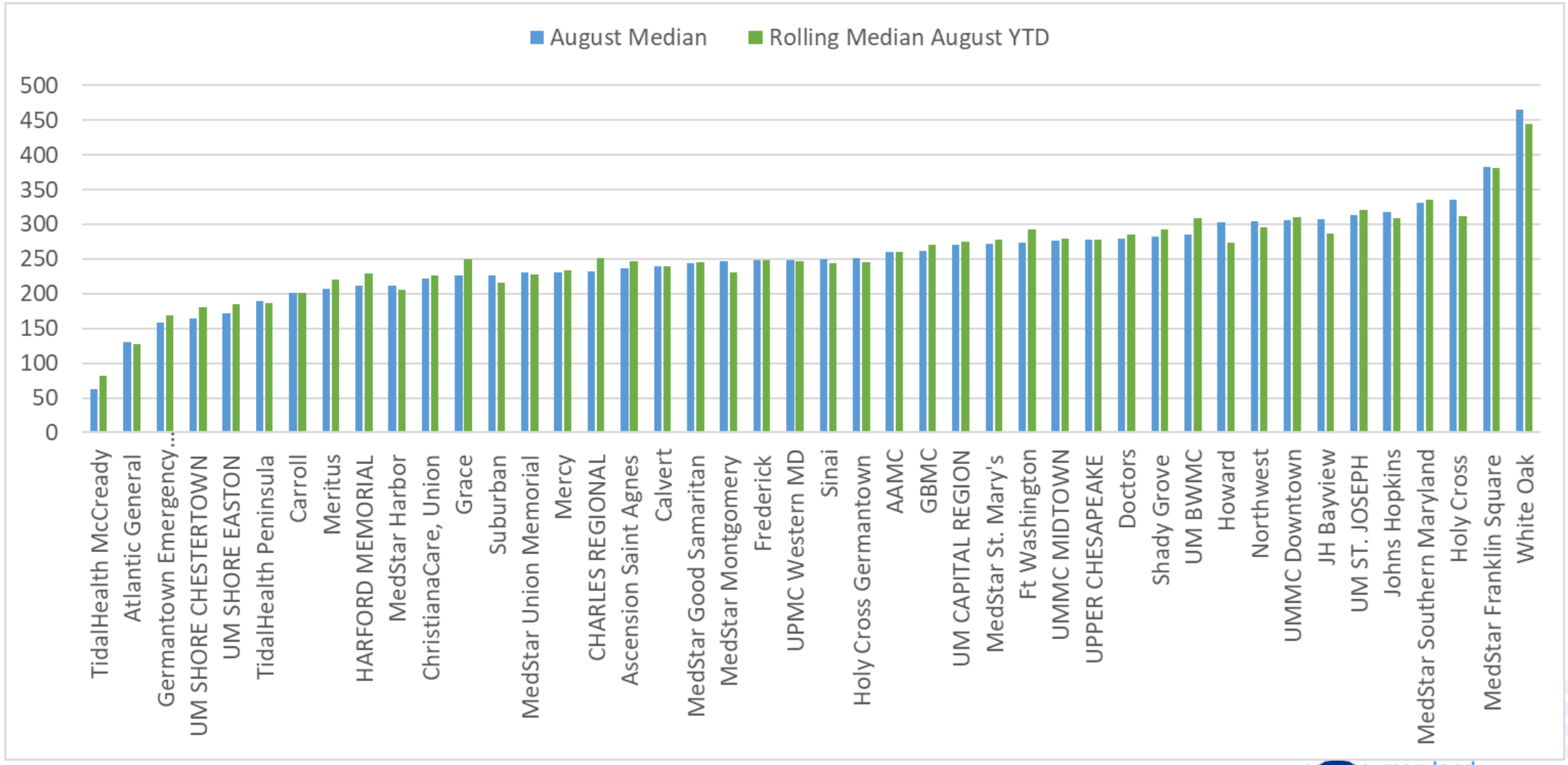


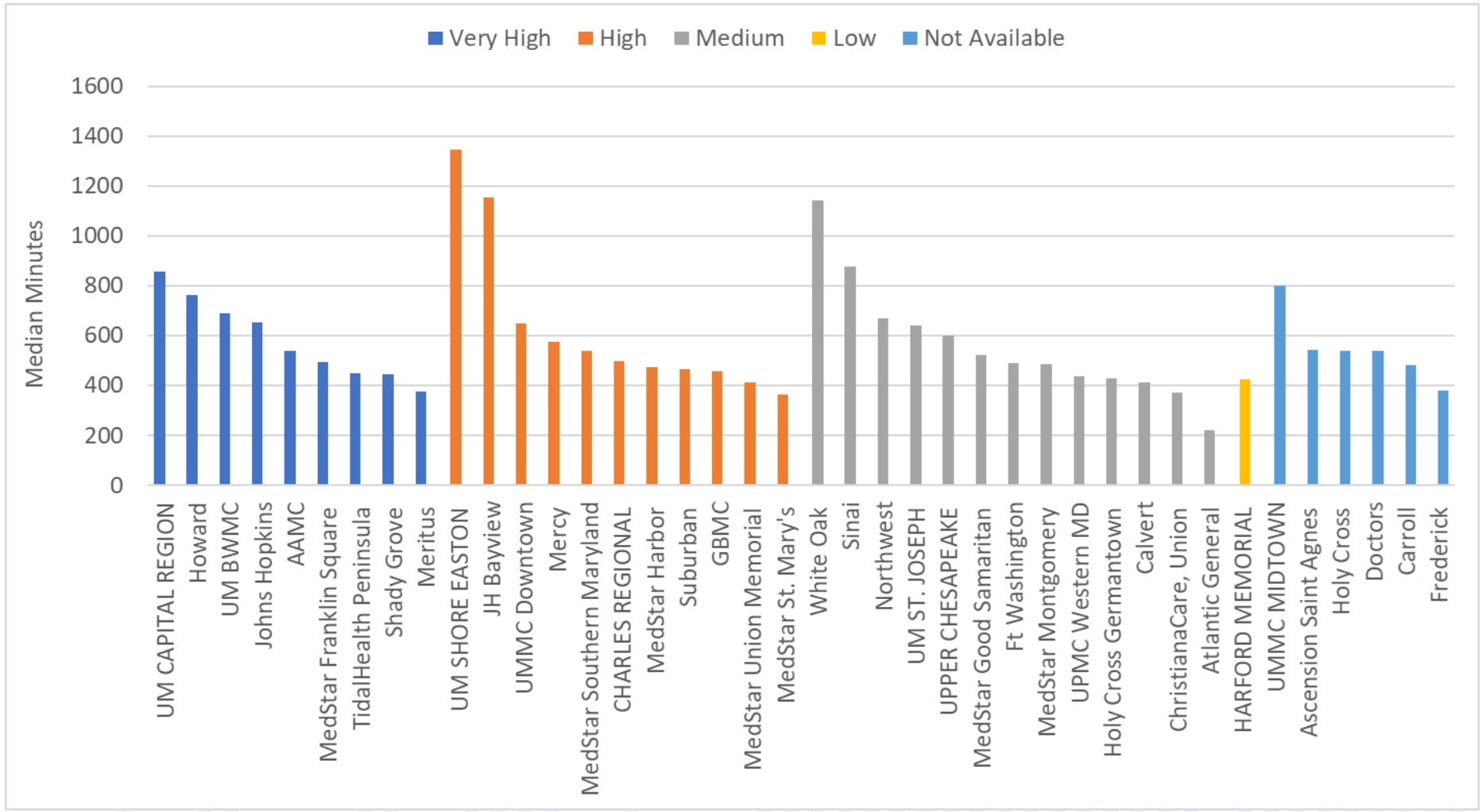
ED 1a: ED Arrival to Inpatient Admission Time - Monthly and Rolling 12-Months



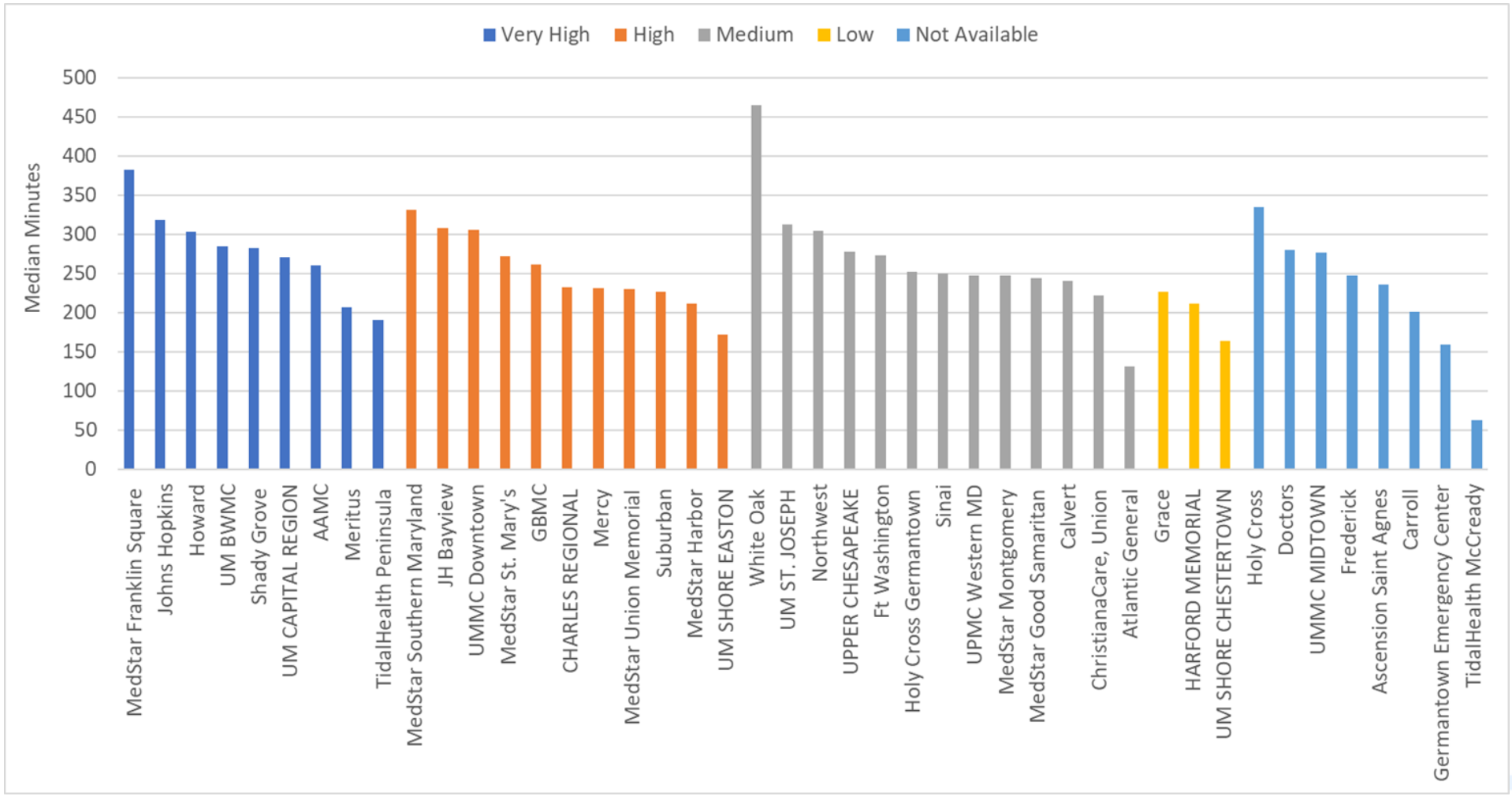
OP18a: ED Arrival to Discharge Time - Monthly and Rolling 12-Months



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



OP18a: ED Arrival to Discharge Time August Median By Volume



EMS Turnaround: Time (Minutes) at 90th Percentile

Facilities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
McCready Health Pavilion	6.8	6.8	12.5	8.8	6.5	7.1	5.8	4.7
Atlantic General Hospital	8.8	8.0	9.0	8.3	9.2	10.0	10.6	10.2
Western Maryland (UPMC)	14.0	14.0	13.0	15.0	15.0	15.0	13.2	11.9
Garrett Regional Medical Center (WVU)	14.0	12.9	15.0	12.6	13.3	13.7	12.8	12.7
Meritus Medical Center	16.9	16.6	14.7	15.8	16.2	16.7	15.0	16.9
Peninsula Regional (TidalHealth)	18.7	18.3	17.7	17.1	18.4	18.6	17.0	17.0
Walter Reed National Military Medical Center	26.8	26.8	17.3	21.1	32.0	17.2	24.0	17.4
Harford Memorial Hospital	24.3	21.2	28.0	25.6	21.5	22.0	21.0	18.2
Frederick Health Hospital	23.6	22.2	20.0	18.6	20.6	21.0	20.1	20.0
Cambridge Free-Standing ED (UMSRH)	31.0	24.0	17.5	25.6	21.0	22.5	19.0	20.4
Germantown Emergency Center (Adventist)	25.0	25.7	24.1	26.6	21.8	20.7	19.9	20.7
Union Hospital (ChristianaCare)	25.0	24.7	22.4	23.3	21.2	25.0	25.0	23.0

Source: MIEMSS

EMS Turnaround: 0-35 Minutes, continued

Facilities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
R Adams Cowley Shock Trauma Center	35.0	36.9	35.7	37.1	30.8	25.5	23.6	23.3
Kimbrough Ambulatory Care Center								23.4
Holy Cross Germantown Hospital	31.3	27.7	27.5	28.3	28.8	26.9	28.1	23.9
Johns Hopkins Hospital PEDIATRIC	29.1	30.8	34.0	32.1	31.0	25.4	31.4	24.0
Queenstown Emergency Center (UMSRH)	36.8	21.5	24.0	26.5	17.3	25.4	24.7	27.0
St. Mary's Hospital (MedStar)	35.6	33.6	30.0	28.0	31.7	35.2	33.0	28.4
Union Memorial Hospital (MedStar)	37.6	34.5	33.0	33.0	32.6	30.0	30.0	29.2
Montgomery Medical Center (MedStar)	36.0	34.1	35.1	29.8	31.7	32.2	32.5	31.0
Shady Grove Medical Center (Adventist)	40.9	34.5	33.7	33.8	32.0	37.5	35.1	32.3
Carroll Hospital Center (LifeBridge)	46.9	42.7	41.1	35.5	37.1	32.2	35.4	33.0
Grace Medical Center (LifeBridge)	54.0	44.0	41.8	41.6	33.0	36.6	37.0	34.6
Good Samaritan Hospital (MedStar)	51.8	42.5	37.7	35.6	38.7	33.1	34.4	34.8
St. Joseph Medical Center (UM)	54.3	40.0	33.3	31.6	34.7	36.0	36.8	34.9

EMS Turnaround: 35 to 60 minutes

Facilities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Greater Baltimore Medical Center	61.5	49.4	46.0	40.8	39.5	40.4	36.5	35.7
Franklin Square (MedStar)	50.5	42.5	38.3	33.8	36.3	34.7	35.3	37.8
Holy Cross Hospital	52.6	49.8	45.5	44.0	46.5	47.2	42.7	37.9
CalvertHealth Medical Center	38.1	35.7	32.7	37.4	33.6	35.9	40.3	39.6
Easton (UMSRH)	45.0	35.0	39.3	37.5	30.4	42.5	33.8	40.5
Johns Hopkins Bayview	55.5	50.5	43.3	45.0	41.1	42.5	43.6	40.6
Northwest Hospital (LifeBridge)	69.4	50.4	46.4	42.0	41.5	41.4	44.8	40.7
Upper Chesapeake Medical Center (UMUCH)	50.2	44.7	50.2	48.7	45.9	46.7	47.8	40.9
University of Maryland Medical Center	60.0	57.3	55.0	53.8	43.2	40.3	41.4	41.1
Sinai Hospital (LifeBridge)	55.0	47.8	47.1	47.3	44.7	43.1	43.2	43.0
Suburban Hospital (JHM)	44.2	43.0	41.8	38.6	36.9	50.8	43.1	43.6

EMS Turnaround: 35 to 60 minutes

Facilities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Mercy Medical Center	60.0	50.5	43.7	48.8	46.3	45.0	48.1	44.4
Chestertown (UMSRH)	38.6	46.1	41.2	36.7	36.8	38.4	46.6	44.4
Johns Hopkins Hospital ADULT	52.4	52.6	50.0	49.6	44.1	46.0	46.0	46.1
Charles Regional (UM)	93.5	64.7	54.3	51.6	81.7	85.4	64.5	47.9
Bowie Health Center (UMCRH)	68.8	64.7	68.5	60.9	50.3	72.2	51.4	48.6
Harbor Hospital (MedStar)	79.5	59.7	60.0	62.5	65.7	54.0	55.0	49.9
St. Agnes Hospital (Ascension)	66.8	60.3	60.3	58.4	54.8	53.3	47.7	52.5
Midtown (UM)	66.7	64.8	56.1	56.8	50.0	52.8	51.3	53.0
Laurel Medical Center (UMCRH)	85.0	82.5	73.0	62.3	62.9	70.7	68.4	59.8

EMS Turnaround: Greater than 60 minutes

Facilities	Jan	Feb	Mar	Apr	May	Jun
Anne Arundel Medical Center	78.3	67.4	80.4	74.6	78.7	70.8
Bowie Health Center (UM)	68.8	64.7	68.5	60.9	50.3	67.4
Capital Region Medical Center (U)	113.2	105.8	90.2	106.0	95.9	102.4
Charles Regional (UM)	93.5	64.7	54.3	52.0	81.7	85.6
Doctors Community Medical Center (Luminis)	94.3	90.5	74.9	82.5	92.4	91.3
Fort Washington Medical Center (Adventist)	124.3	120.4	96.2	91.6	90.5	83.9
Howard County General Hospital (JHM)	69.4	58.9	56.7	60.9	64.5	68.4
Laurel Medical Center (UM)	85.0	82.5	73.0	62.3	62.9	69.1
Southern Maryland Hospital (MedStar)	109.2	114.4	97.6	91.9	90.4	94.7

EMS Turnaround: Greater than 60 minutes

Facilities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Baltimore Washington Medical Center	81.5	63.7	68.9	74.1	67.1	61.4	65.9	61.6
Howard County General Hospital (JHM)	69.4	58.9	56.7	60.9	64.6	69.0	67.6	64.4
Anne Arundel Medical Center	78.3	67.4	80.4	74.6	78.7	71.0	70.5	68.0
Southern Maryland Hospital (MedStar)	109.2	114.4	97.6	91.9	90.4	95.0	91.4	73.3
Doctors Community Medical Center (Luminis)	94.3	90.4	74.9	82.5	92.4	91.6	85.2	81.5
White Oak Medical Center (Adventist)	63.4	51.0	52.6	52.3	54.4	57.6	64.6	87.7
Capital Region Medical Center (UMCRH)	113.2	105.8	90.2	106.0	95.8	101.5	100.8	92.9
Fort Washington Medical Center (Adventist)	124.3	120.4	96.2	91.6	90.5	84.8	79.0	97.2

ED 2 eCQM Measure

- ED 2 eCQM slated for discontinuation by CMS after CY 2023
  - CMS considering option for continued stewardship of the measure
- ED 2 eCQM measure specifications
  - No Decision to Admit documented - does not qualify for IPP
  - Decision to Admit documented after admission - does not qualify for IPP
  - Last ED Visit ended > 1 hour before the Inpatient Encounter- does not qualify

Analysis of case mix data to validate CY 2022 ED 2 eCQM measure

IP Visits admitted from ED based on ED Rate Centers	IP Visits admitted from ED based on ED Rate Centers with OBS > 1 hour excluded	Encounters for ED-2 in Medisolv Data
317443	223138	169232

- 24% difference in counts statewide after accounting for observation > 1 hour with large variation (5%-84%) across hospitals
- Next steps:
  - Determine measure ownership/stewardship after CY 2023
  - Design auditing approach for measure inclusive of measure specifications

Next Steps

- 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 **all** hospital improvement goals collected by MHA at October Commission meeting
  - Goals should be short term, specific, and measurable
- Collaborate with MHA on legislative request and EDDIE quality improvement initiative
- ED 2 eCQM- determine viability of this measure for ongoing use

State Digital Measures Update

Maryland Statewide Digital Measure Reporting Infrastructure: **Important** to Achieving Maryland's Quality Goals

- Maryland began reporting of quality measures prior to the CMS Hospital Compare reporting
- In June 2022, Maryland became the first state in the country to successfully begin receiving STATEWIDE eCQM data from Maryland hospitals
- The CMS Digital Quality Measurement Strategic Roadmap issued in March 2022 put forth a timeline of seven years to achieving a fully digital quality measurement enterprise ACROSS THE HEALTHCARE ECOSYSTEM
- Maryland targeted quality improvement using digital measures:
  - Maryland's programs are all-payer
  - ED wait times have been above the Nation for many years.
    - Infrastructure allows continue submission of ED-2, wait times for admitted patients.
  - Hyper- and Hypo-glycemia eCQMs for monitoring, potential public reporting by MHCC:
    - Safety events are priority for CMS; could be considered in the future for MHAC or QBR
    - These events "are associated with a range of harms, including increased in-hospital mortality, infection rates, and hospital length of stay" (NQF documentation of developer rationale)
    - Impact all hospitals
  - Obstetric morbidity and c-section rates eCQMs for monitoring, potential for public reporting by MHCC:
    - CMS focus (required starting in CY 2024) and related SIHIS priority
    - Currently tracking statewide, unadjusted rate; SMM is a risk-adjusted measure
    - Impacts the birthing hospitals
    - Hospitals not eligible for the PC measures must choose two optional measures
  - Maryland uses all-payer readmission and mortality measures.

Medisolv (CRISP Sub-Contractor) Role

- Technology
  - Medisolv Submission Portal
  - ENCOR eCQM Measure Calculation Engine. ONC certified to the 2015 Cures Act Edition
  - Medisolv Analytics and Reporting Platform
- Professional Services
  - Data Management
  - Data Analytics & Reporting support
  - Full Service eCQM Measure Development
  - National Regulatory Reporting support as needed

HSCRC Plan: 2023 eCQM & Hybrid Submission Timeline

2023 – Q1/Q2 07/15/2023 – 10/02/2023	2023 – Q3 10/15/2023 – 12/30/2023	2023 – Q4 01/15/2024 – 04/01/2024	2023 – Q3/Q4 All Payer Hybrid 01/15/2024 – 04/01/2024
CMS 111 (ED-2)	CMS 111 (ED-2)	CMS 111 (ED-2)	All Payer CCDE (Readmission)**
CMS 334 (PC-02)*	CMS 334 (PC-02)*	CMS 334 (PC-02)*	All Payer CCDE (Mortality)**
CMS 506 (OPI-1)	CMS 506 (OPI-1)	CMS 506 (OPI-1)	
CMS 816 (HH-01)	CMS 816 (HH-01)	CMS 816 (HH-01)	
CMS 871 (HH-02)	CMS 871 (HH-02)	CMS 871 (HH-02)	
CMS 1028 (PC-07)*	CMS 1028 (PC-07)*	CMS 1028 (PC-07)*	
*if not eligible two other approved eCQMs should be selected	*if not eligible two other approved eCQMs should be selected	*if not eligible two other approved eCQMs should be selected	**Not be confused with CMS 529 and CMS 844 these all-payer measures are specific to HSCRC and the measure package can be downloaded from www.crisphealth.org

CY 2023 Optional eCQM Measures

Title	Short Name	CMS eCQM ID	NQF Number	Meaningful Measure	Notes
Anticoagulation Therapy for Atrial Fibrillation/Flutter	STK-3	CMS71v12	N/A	Preventive Care	HSCRC Optional
Antithrombotic Therapy By End of Hospital Day 2	STK-5	CMS72v11	N/A	Preventive Care	HSCRC Optional
Discharged on Antithrombotic Therapy	STK-2	CMS104v11	N/A	Preventive Care	HSCRC Optional
Discharged on Statin Medication	STK-6	CMS105v11	N/A	Preventive Care	HSCRC Optional
Exclusive Breast Milk Feeding	PC-05	CMS9v11	0480e	Care Personalized, Aligned with Patient's Goals	HSCRC Optional
Intensive Care Unit Venous Thromboembolism Prophylaxis	VTE-2	CMS190v11	N/A	Preventive Care	HSCRC Optional
Venous Thromboembolism Prophylaxis	VTE-1	CMS108v11	N/A	Preventive Care	HSCRC Optional

*Source: Eligible Hospital / Critical Access Hospital eCQMs | eCQI Resource Center (healthit.gov)

Digital Measures Work Group Convened August 10, 2023

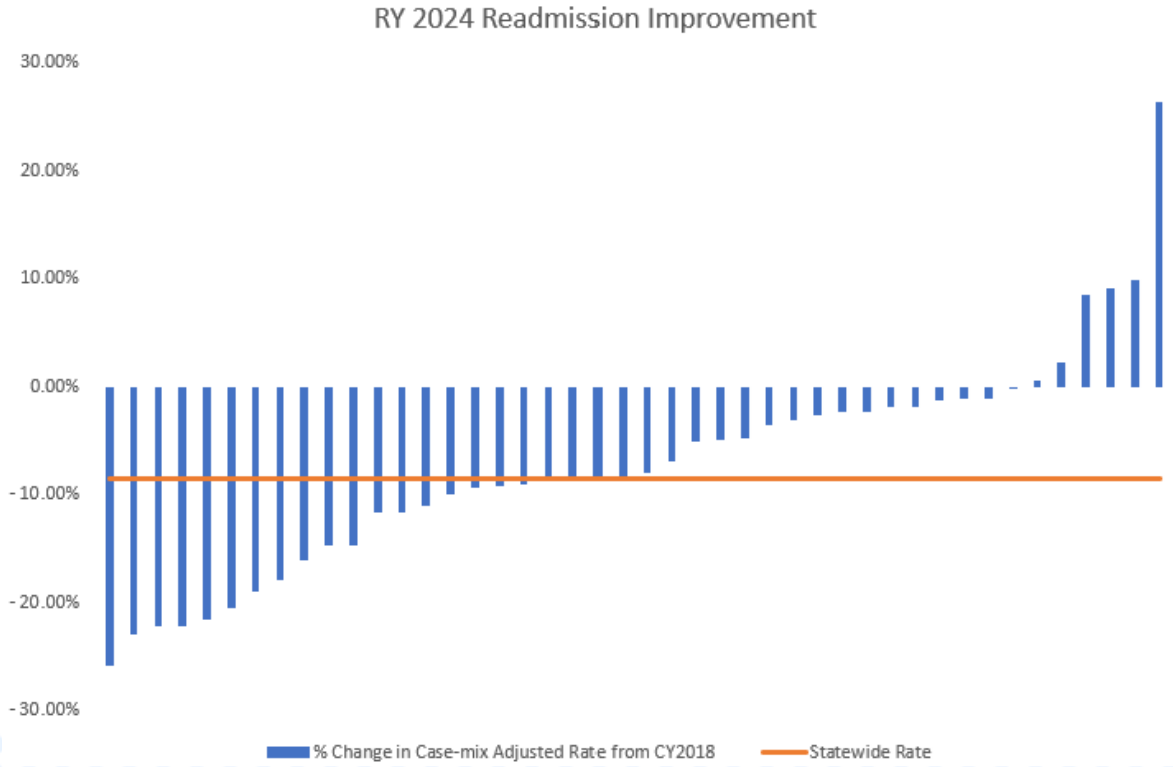
- Challenges/concerns raised:
  - HIT vendor updates not aligned with Maryland timeline for earlier submission
  - Measures not exactly aligned with CMS are “new measures”, require separate workflow implementation and testing steps
  - Measures not “owned” by CMS not supported
- Next steps
  - Continue to investigate measure options/limitations
  - Determine needed modifications/resources for “all-payer” measures/implementation plan
  - Work with MHCC to design and implement eCQM measure auditing, public reporting

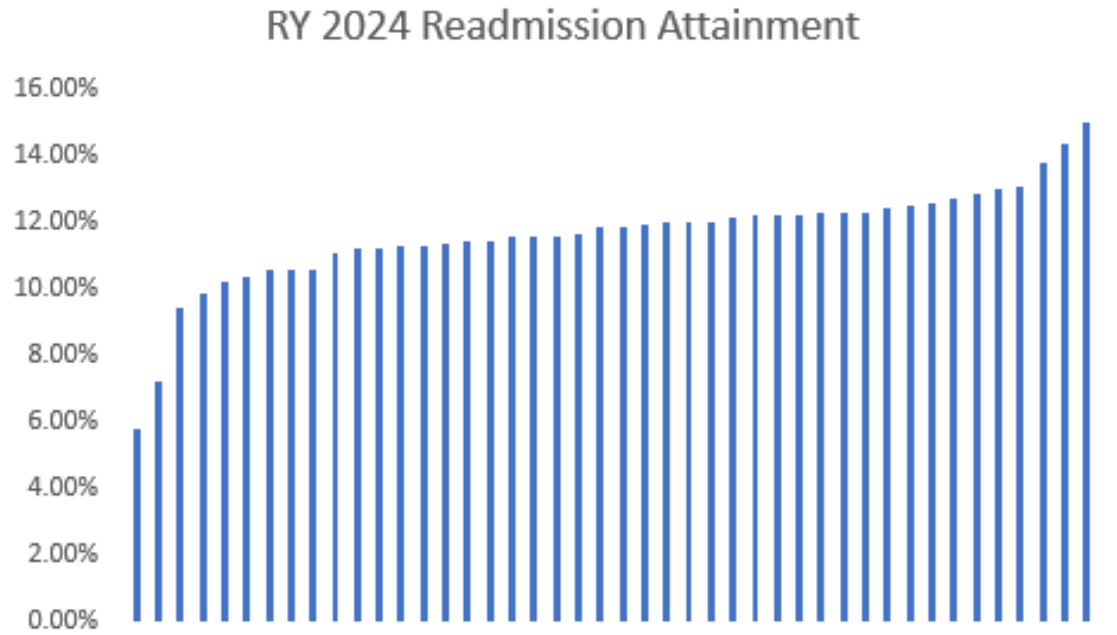
RY 2024 Performance and Revenue Adjustments*

RY 2024 RRIP Performance

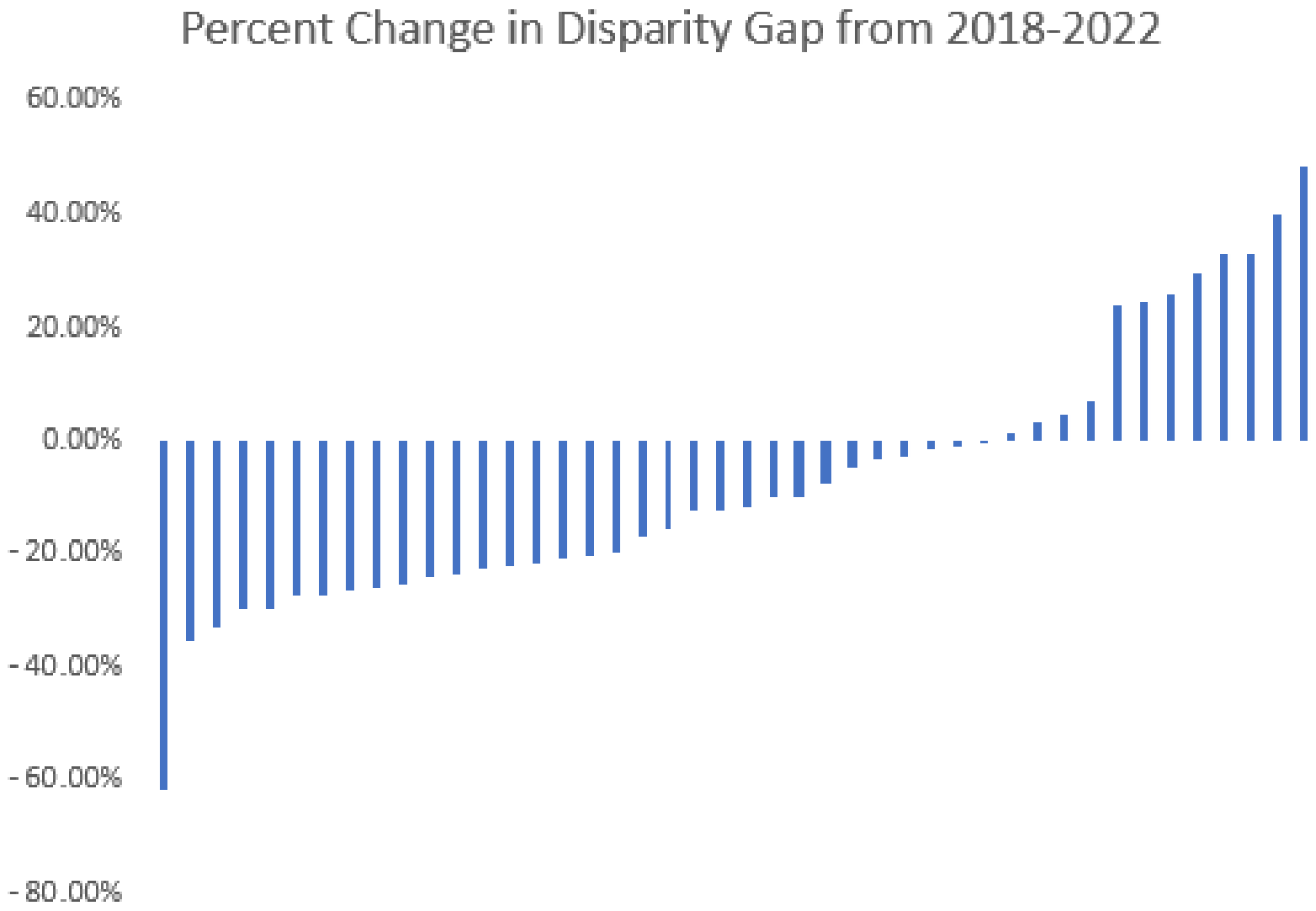
State Net Total	$56,176,033
Penalty	-$12,811,324
% Penalty	-0.11%
Reward	$68,987,357
% Reward	0.61%

- Rewards: 29 hospitals, 2 max reward for attainment
- Penalties: 15 hospitals





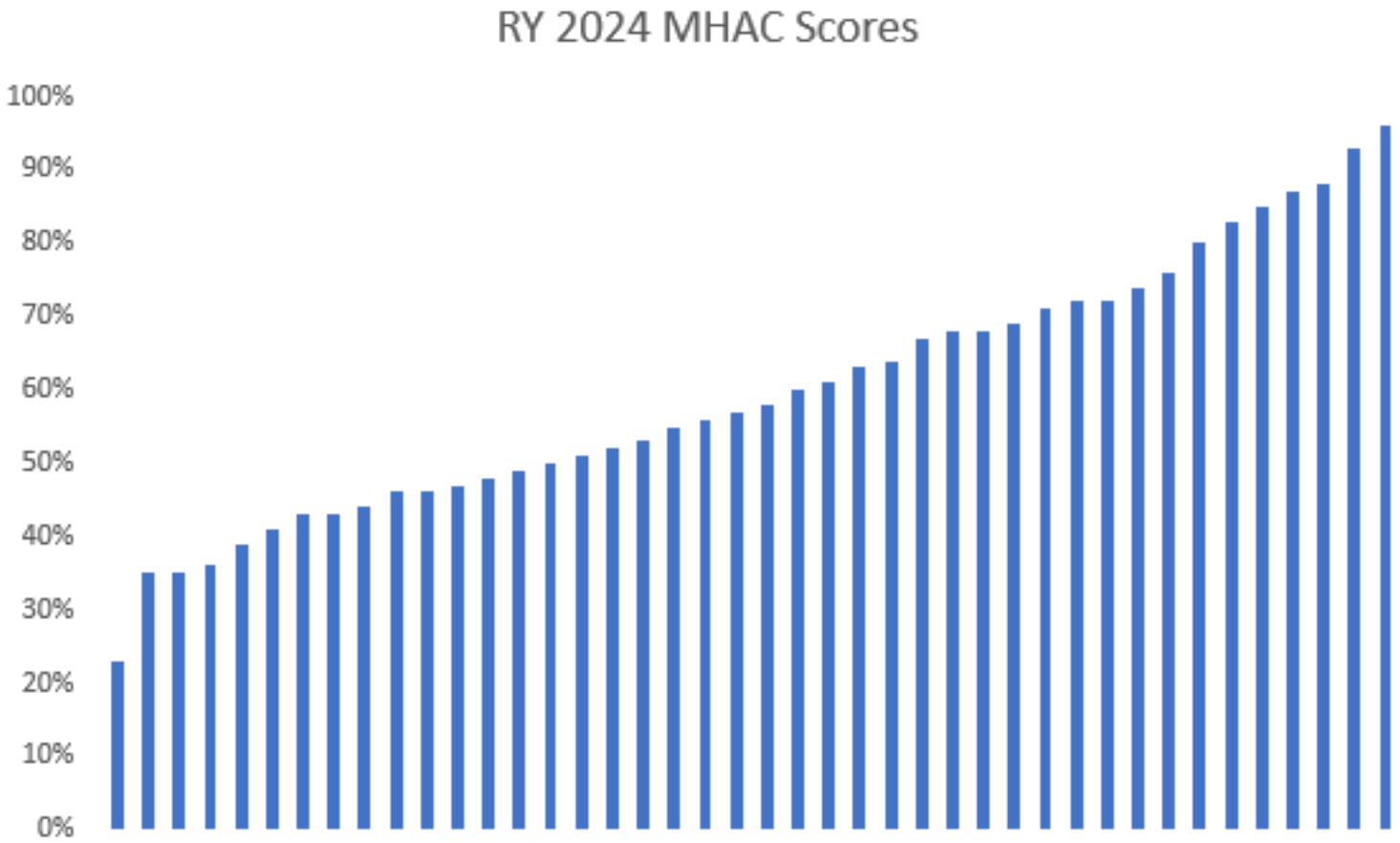
RY 2024 RRIP-Disparity Performance



State Net Total	$7,782,485
Reward	$7,782,485
% Reward	0.07%

- 32 hospitals saw a reduction in their disparity gap
- 11 hospitals received a reward for reducing their disparity gap by at least 22.89% and reducing their readmission rate

RY 2024 MHAC Performance

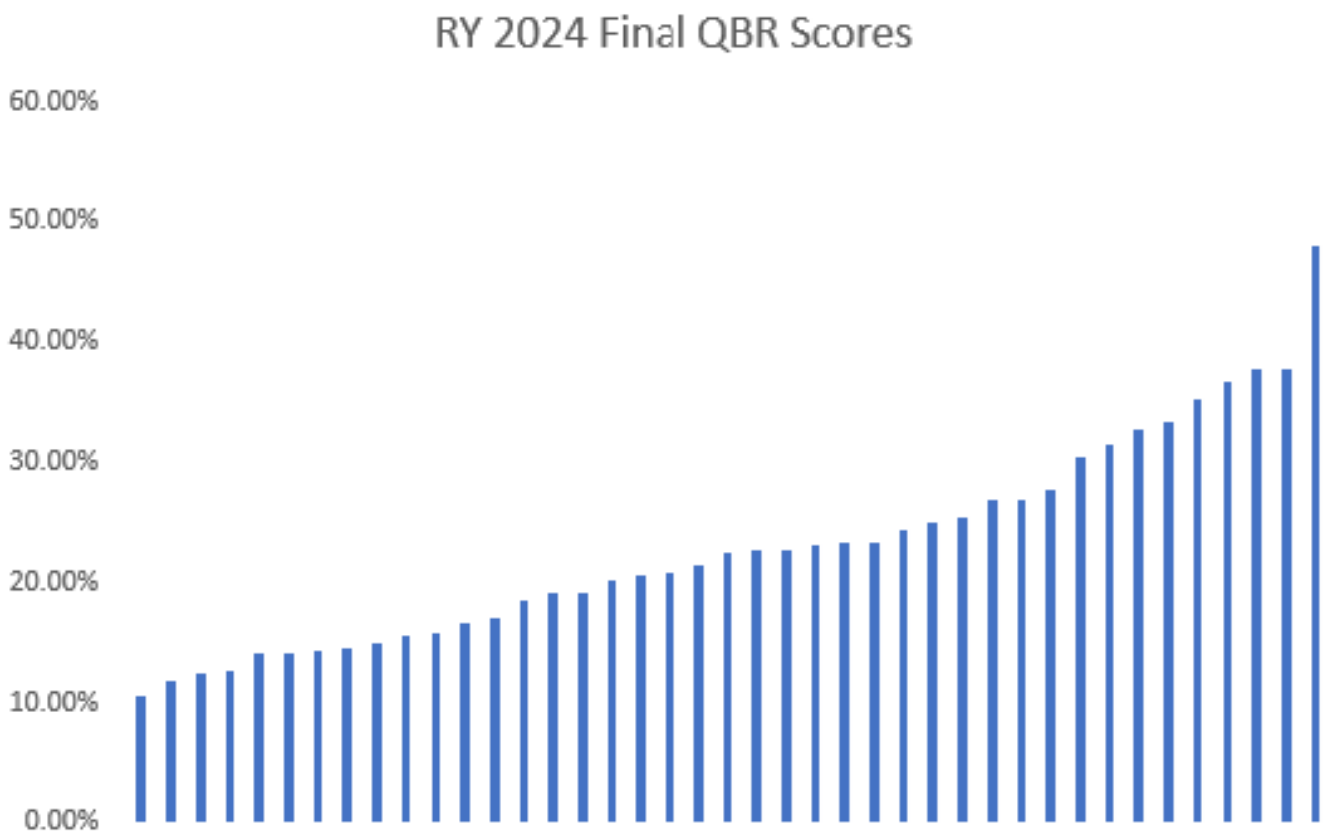


State Net Total	-$17,645,920
Penalty	-$39,388,242
% Inpatient	-0.35%
Reward	$21,742,322
% Inpatient	0.19%

- 15 hospitals received rewards
- 8 hospitals performed in the hold harmless zone
- 19 hospitals received penalties

Staff are evaluating the use of bayesian smoothing and analyzing alternative methods for calculating performance standards

RY 2024 QBR Performance



- 40 hospitals receive penalty
- 1 hospital receives reward (Garrett)
  - With 41% QBR cutpoint

State Net Total	-$97,898,473
Total Penalties	-97,990,365
% Inpatient Revenue	-0.87%
Total rewards	91,892
% Inpatient revenue	0.0008%

QBR Revenue Adjustment Scale

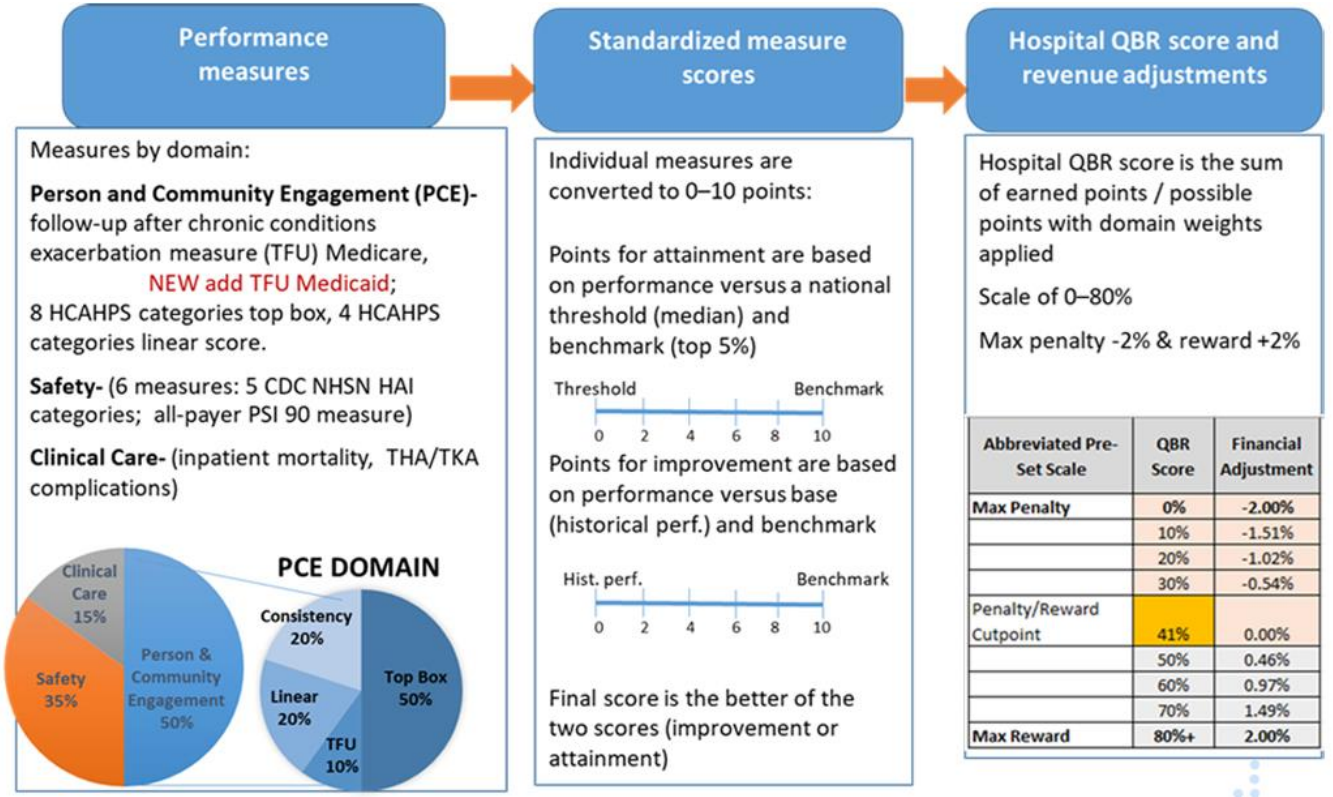
- Revenue adjustment scale ranges from 0-80 percent, with rewards starting at scores >41 percent
- Reward/penalty cut-point needs to ensure hospitals in Maryland are not rewarded for performance that is below the national average
- Cut-point estimated by weighting national scores by QBR weights and calculating national average
  - Previous data indicates that national average is as low as 30%
- **Staff are reviewing recent data to finalize cut-point for final RY2024 revenue adjustments**

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%

QBR Revenue At Risk- Discussion

- QBR holds 2% of a hospital's IP revenue-at-risk (r@r)
- Addition of TFU-Disparity Gap and Sepsis further reduces the r@r for each measure
- "Catch-all" program
- Ideas for addressing this r@r issue while continuing to align with VBP?
  - Increase program's r@r

RY 2025 QBR Program Methodology



Monitoring Reports

CY 2023 Monitoring Reports

- 30-Day All-Cause Mortality: Available, summary and pt level
- Excess Days in Acute Care (EDAC): Available, summary and pt level
- ED-PAU/ Multi-Visit Patients (MVP): Available, summary
- Inpatient Diabetes Screening: Available, summary
- TFU-Disparity Gap: Coming Soon

THANK YOU!

Next Meeting: Wednesday, October 18, 2023