COUNCIL ON CLINICAL & QUALITY ISSUES

Maryland
Hospital Association

August 10, 2021
Join Zoom Meeting

Maryland
Hospital Association

COUNCIL ON CLINICAL & QUALITY ISSUES

Tuesday, Aug. 10, 2021, 9:30 – 11:30 a.m.

Join Zoom Meeting

AGENDA

9:30 a.m.	Welcome to New Members and Consideration of June 8 Meeting Minutes ***(Tab 1)***	Mitchell Schwartz, M.D., Chair
9:40	Meeting Objectives	Traci La Valle, Senior Vice President, Quality & Health Improvement
9:45	Future of the Maryland Model ***(Tab 2)*** • KPIs	Katie Eckert, Vice President Strategic Analytics
	• Care Transformation Stories and Community Health Interventions	Traci LaValle
10:30	Direct-Entry Midwives' Scope of Practice ***(Tab 3)***	Traci La Valle Invited Guests Harold Fox, M.D., and Monica Buescher, M.D., MHA representatives on DEM Advisory Committee to Maryland Board of Nursing
11:05	Informational Report: Quality Based Reimbursement ***(Tab 4)***	Brian Sims, Director, Quality & Health Improvement
11:15	Mandatory COVID Vaccination: Open Forum	Nicole Stallings, Chief External Affairs Officer, SVP Government Affairs & Policy
11:27	Next Steps	Traci La Valle
11:30	Adjourn	

Maryland Hospital Association

COUNCIL ON CLINICAL & QUALITY ISSUES

Membership Roster
Fiscal Year 2022

Mitchell Schwartz, M.D., Chair
Chief Medical Officer & President of Luminis Health Clinical Enterprise
Anne Arundel Medical Center
Annapolis

Carrie Adams, Pharm.D
Vice President & Chief Quality/ Transformation Officer
Meritus Health, Hagerstown

Mohammed Shafeeq Ahmed, M.D.*
Interim President & CMO
Howard County General Hospital
Columbia

John Chessare, M.D.
President & CEO
Greater Baltimore Medical Center
Baltimore

Angela Cooper*
Director, Quality & Population Health
Mercy Medical Center
Baltimore

Gail Cunningham, M.D.
Vice President, Medical Affairs & Chief Medical Officer
University of Maryland St. Joseph Medical Center, Towson

Griffin Davis, M.D.
Senior Vice President & Chief Medical Officer
Adventist HealthCare Fort Washington Medical Center, Oxon Hill

Jonathan D'Souza, M.D.*
Chief Medical Officer
Ascension Saint Agnes
Baltimore

Terry Fairbanks, M.D.
Vice President, Quality and Safety
MedStar Health
Columbia

Kathryn Fiddler, DNP
Vice President, Population Health
TidalHealth
Salisbury

Michelle A. Gourdine, M.D.
Interim Chief Medical Officer & Senior Vice President, Population Health & Primary Care
University of Maryland Medical System
Baltimore

Pamela Johnson, M.D.*
Vice President, Care Transformation
The Johns Hopkins Health System
Baltimore

Heather Kirby
Vice President, Integrated Care Delivery
Frederick Health
Frederick

Stuart Levine, M.D.
President, MedStar Franklin Square Medical Center
Senior Vice President, MedStar Health
Baltimore

Stephen Michaels, M.D.
Chief Operating Officer & Chief Medical Officer
MedStar St. Mary's Hospital
Leonardtown

Brent Reitz
President, Post-Acute Care Services
Adventist HealthCare Rehabilitation
Rockville

Nitza Santiago
Assistant Vice President, Quality
& Patient Safety
Sinai Hospital of Baltimore
Baltimore

Rahul Shah, M.D.
Vice President, Chief Quality & Safety
Officer
Children's National Health System
Washington, D.C.

Mary Sparks*
Acting Chief of the Office of Patient Safety
& Clinical Quality
NIH Clinical Center, Bethesda

*Denotes new members

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COUNCIL ON CLINICAL & QUALITY ISSUES
MEETING DATES

2021

October 12

December 7

All meetings will take place from 9:30 to 11:30 a.m.

Advance notice of all meetings and materials will be provided.

Please mark your calendars accordingly.

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COUNCIL ON CLINICAL & QUALITY ISSUES

Tuesday, June 8, 2021, 9:30-11:30 a.m.
MINUTES

ATTENDANCE

Members	***Present***	***Absent***
Mitchell Schwartz, M.D., Chair	X	
Carrie Adams	X	
John Chessare, M.D.		X
Gail Cunningham, M.D.	X	
Griffin Davis, M.D.	X	
Renee Demski		X
Patricia Ercolano	X	
Terry Fairbanks, M.D.	X	
Kathryn Fiddler, DNP	X	
Michelle Gourdine, M.D.	X	
Heather Kirby	X	
Stuart Levine, M.D.	X	
Stephen Michaels, M.D.	X	
Yancy Phillips, M.D.	X	
Brent Reitz	X	
Wilma Rowe, M.D.	X	
Nitza Santiago	X	
Rahul Shah, M.D.	X	

Guests
Blair Eig, Maryland Patient Safety Center; Kim McBride, Holy Cross Health; Aneena Patel, Johns Hopkins Medicine

Attending MHA Staff
Bob Atlas, Brian Burkhalter, Erin Dorrien, Ahmed Elsayed-Ahmed, Amy Goodwin, Traci La Valle, Brett McCone, Brian Sims, Amanda Thomas, Vidhya Tirumalaraju

CALL TO ORDER AND APPROVAL OF MINUTES

Chair Mitchell Schwartz called the meeting to order at 9:31 a.m. The minutes of the April 13 Council meeting were reviewed and approved.

MEETING OBJECTIVES

Traci La Valle, MHA senior vice president Quality & Health Improvement, outlined the meeting objectives:

- Obtain the Council's views on the challenges hospitals face moving patients through their emergency departments and discuss opportunities for improvement
- Understand hospitals' mechanisms for influencing quality and performance in ambulatory practices

EMERGENCY DEPARTMENT THROUGHPUT AND WAIT TIMES

Outcome

Council members discussed the Quality-Based Reimbursement (QBR) program being considered for revision, including emergency department (ED) wait times and patient satisfaction or Hospital Consumer Assessment of Healthcare. Providers and Systems (HCAHPS). They generally supported exploring ED wait time measures, citing the clinical significance and correlation with patient satisfaction. However, widespread support for inclusion of an ED wait time measure in payment policy was unclear. Council members said prefunding HCAHPS improvement was not a meaningful enough incentive to improve performance.

Main Points of Discussion

- Positive correlation between ED wait times and patient satisfaction is important when considering incentives to improve HCAHPS
- Components added to the person and community engagement domain of the QBR policy reduce the weight of HCAHPS
- Hospitals and health systems invest in efforts to improve flow in their ED
- ED throughput, as a reflection of overall hospital efficiency, requires a whole hospital effort to improve
- Prefunding HCAHPS improvement is unlikely to drive improvement, and members expressed concern about policies that require the Health Services Cost Review Commission (HSCRC) to recover funds from hospitals if hospitals and staff disagree on performance expectations
- Successful efforts to improve HCAHPS should center on investments in systemic and cultural change—not individual initiatives

MHA Next Steps

- MHA to continue to poll members to assess support for an ED wait time measure in payment policy
- MHA to work with HSCRC to answer questions about prefunding HCAHPS improvement

FUTURE OF THE MARYLAND MODEL: AMBULATORY QUALITY

Outcome

Several members shared their strategies to manage and incentivize quality in ambulatory and other nonhospital settings.

Main Points of Discussion

- Leaders selected existing quality and safety measures tied to hospitals' priorities. Some report measures to boards or an accountable community of providers.
- Some link performance to incentive pay, and others find inherent incentives to be enough (e.g., reporting providers' performance at meetings with colleagues or improving patient flow and leaving work earlier)

MHA Next Steps

- MHA to keep the Council informed of developments with the Maryland Primary Care Program

ADJOURNMENT

There being no further business, the council adjourned at 10:29 a.m.

THESE MINUTES HAVE BEEN APPROVED BY THE COUNCIL ON CLINICAL & QUALITY ISSUES

Maryland Hospital Association

Council on Clinical & Quality Issues

August 10, 2021

Topic	**Future of the Maryland Model**
Objective	To share an early look at key Model indicators and get consensus on the most promising opportunities for continued improvement
Discussion Questions	1. What are the best opportunities to reduce non-hospital spending and improve outcomes? 2. Which care transformation programs would be feasible to expand over the next 12-18 months?

Setting the Stage for Model Extension

MHA is fully engaged with the state to secure the future of Maryland's Total Cost of Care Model (Model). MHA is partnering with, and advocating to, the Health Services Cost Review Commission (HSCRC) and the Maryland Department of Health. Both agencies jointly represent the state to the federal sponsor of the Model, the Center for Medicare & Medicaid Innovation (CMMI).

CMMI is due to decide whether to extend the Model by the end of 2024. Crucial events occur between now and then. Principally, an independent evaluation is underway, with findings to be reported in late 2023, and negotiation of new savings targets to take effect for 2023. MHA is working closely with HSCRC to pursue a favorable evaluation.

Key Performance Indicators

CMMI's contractor, Mathematica Policy Research (Mathematica), is tasked with describing how the Model affects cost, utilization, quality, provider experience, beneficiary experience, and population health. Mathematica must also determine what features are associated with positive outcomes and what strategies best address unmet social needs. Ultimately, Mathematica will evaluate statewide health care system effectiveness to justify higher hospital payments from Medicare.

To better understand strengths and weaknesses, MHA analyzed key indicators of cost, utilization, and quality. Initial findings are attached. At the meeting, MHA staff will discuss the findings and ask Council members how to continue to reduce total cost of care, particularly in the non-hospital setting.

Care Transformation Programs and Community Health Interventions

To describe how Maryland hospitals are transforming care and lowering costs, MHA worked with a small group of hospital care transformation leads to refine descriptions of hospitals' efforts into concise messages. Seven categories were created to represent the common care transformation strategies hospitals use to meet medical and social needs of vulnerable, high-

risk and rising-risk patients. MHA also summarized the hospital field's efforts to meet the social needs of their communities. The transformation programs and community health interventions are attached for your reference. We will not discuss them in detail at the meeting. The aim is to create succinct messages that describe the field's work and represent hospitals' most important efforts.

MHA will amplify hospitals' care transformation and community health accomplishments through strategic communication targeting top officials in the Maryland Department of Health, HSCRC, and beyond. The intent is to make these stories better known and to gain advocates for Maryland hospitals and the Model to clearly show value and influence both state and federal officials involved in decisions about the future of the Model. Our goal is to use available resources to drive conversations highlighting hospital's success for the September 2023 evaluation.

In addition to promoting the good work the hospital field is already doing, we may need to boost action in communities by expanding existing efforts or catalyzing new partnerships. Council members are asked to consider in which areas it may be feasible for your hospital to expand activity within the next 12-18 months.

Prepared by:
Traci La Valle, Senior Vice President, Quality & Health Improvement
Katie Eckert, Vice President, Strategic Analytics

Attachments:
- Key Performance Indicators – to be reviewed at meeting
- Care Transformation Programs and Community Health Interventions – for reference

FUTURE OF THE MARYLAND MODEL

Council on Clinical & Quality Issues

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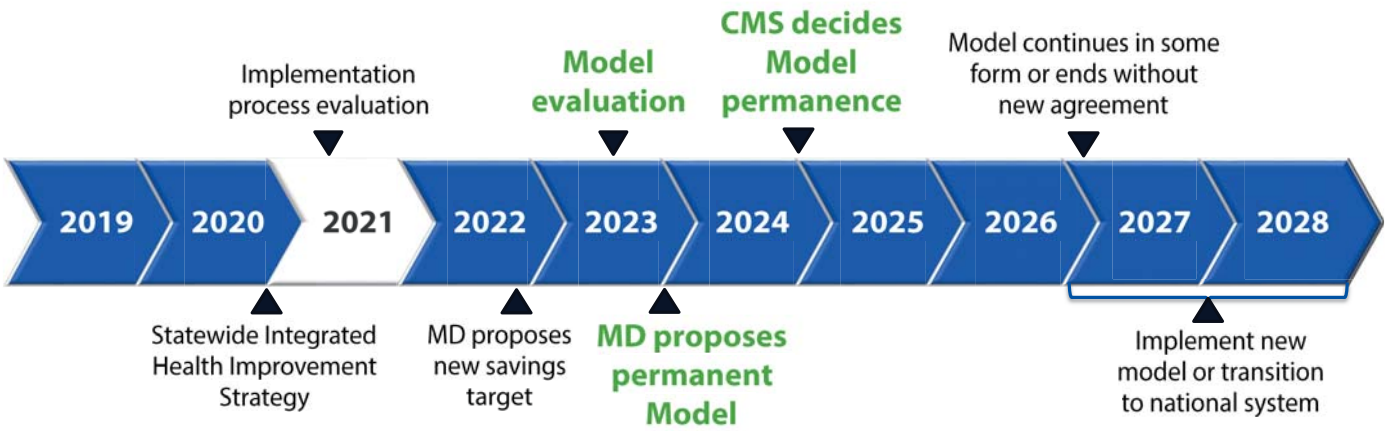
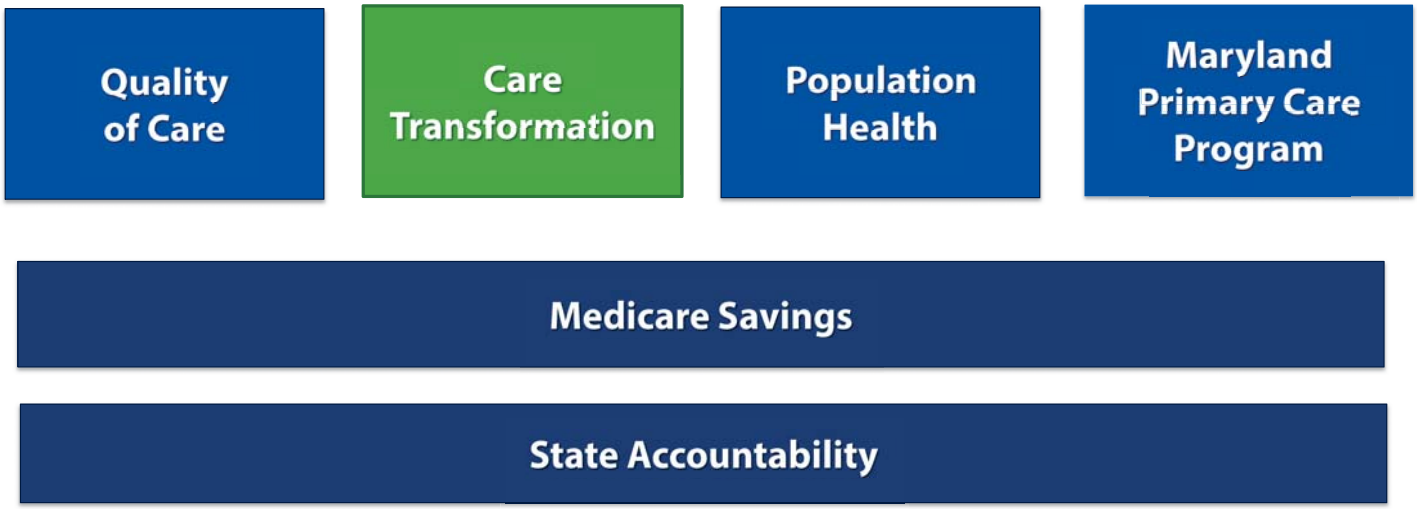
TOTAL COST OF CARE MODEL TIMELINE



CMMI EVALUATION COMPONENTS



SIHIS DOMAINS AND GOALS

Statewide Integrated Health Improvement Strategy

Hospital Quality	Care Transformation	Population Health
• Avoidable admissions • Readmission disparities	• Follow-up after discharge for patients with chronic conditions • Participation in models having downside risk	• Diabetes • Opioid-use disorder • Asthma in children and severe maternal morbidity

EVALUATING MARYLAND MODEL PERFORMANCE

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EVALUATING MODEL PERFORMANCE

CMMI Purpose:

"Test whether the Model is effective in improving quality of care and patient health outcomes in the state while reducing Medicare costs."

Source: CMS RFP for Evaluation of the Maryland Total Cost of Care Model dated 4/5/2019

KEY PERFORMANCE INDICATORS (KPI)

Healthcare System KPI Categories

Spending

- Spending per Capita (Hospital)
- Spending per Beneficiary (Medicare)

Utilization

- Admissions & Length of Stay
- Emergency Room
- OP/Ambulatory Visits (by modality and site of care)
- Severity & Intensity (CMI, HCC Scores)

Quality & Outcomes

- Avoidable Utilization (readmissions, PQIs, avoidable ED)
- Quality (HAIs, HCAHPS, SIHIS)
- CMS Star Ratings & other national health scorecards

Definitions

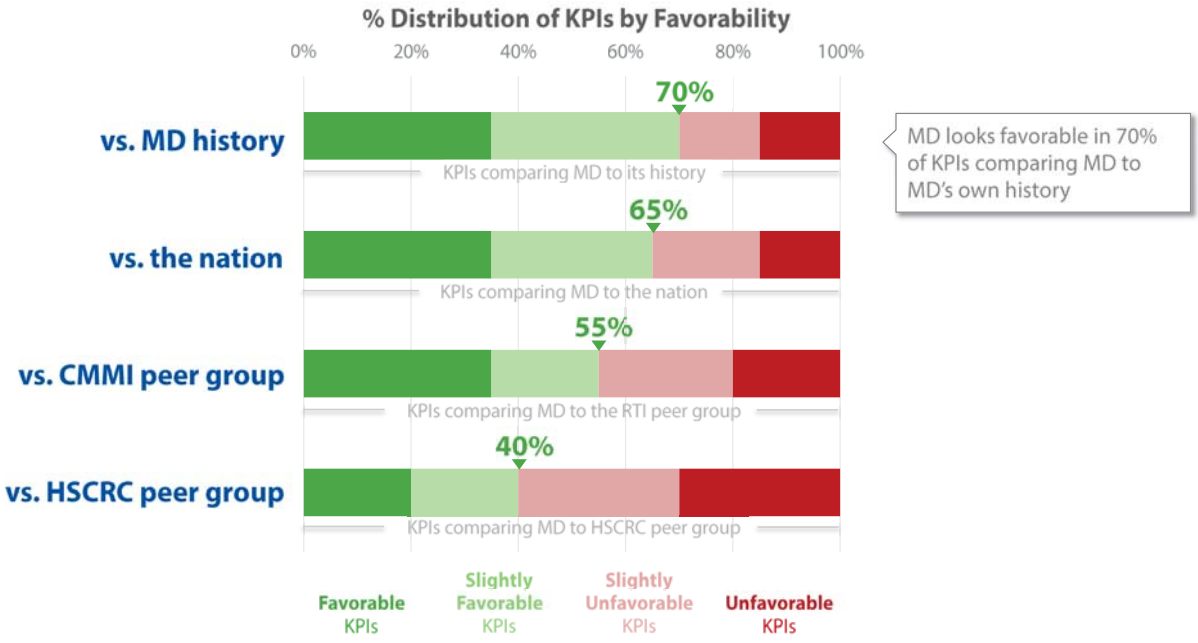
CMI	Case Mix Index
HCC	Hierarchical Condition Category
PQI	Prevention Quality Indicators
HAI	Healthcare-Associated Infection
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
SIHIS	Statewide Integrated Health Improvement Strategy

ALTERNATIVE BENCHMARKS

Comparison Groups

1. Maryland's own history
2. The nation
3. CMMI peer group
   - 2019 RTI peer group
   - 2020-2021 Mathematica (TBD)
4. HSCRC peer group

DIFFERENT BENCHMARKS → DIFFERENT RESULTS



DIFFERENT BENCHMARKS → DIFFERENT RESULTS

MD KPI Favorability

by KPI category, by comparison group

	Spending	Utilization	Quality & Outcomes
vs. MD's own history			
vs. the Nation			
vs. CMMI peer group			
vs. HSCRC peer group			

INPATIENT MEDICARE PERFORMANCE

Medicare IP Utilization Metrics

favorability by comparison group

	Admissions	Length of Stay	Severity & Intensity
vs. MD's own history			
vs. the Nation			
vs. CMMI peer group			
vs. HSCRC peer group			

Medicare IP Quality Metrics

favorability by comparison group

Readmissions	PQIs

NEXT STEPS

- Recommend HSCRC evaluate peer group
- Analytics:
  - Drill down and stratify
  - Focus in on length of stay
- Create statewide KPI dashboard to inform strategic decision making

MARYLAND MODEL IMPLEMENTATION EVALUATION

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ATTRIBUTING CHANGE TO TCOC MODEL

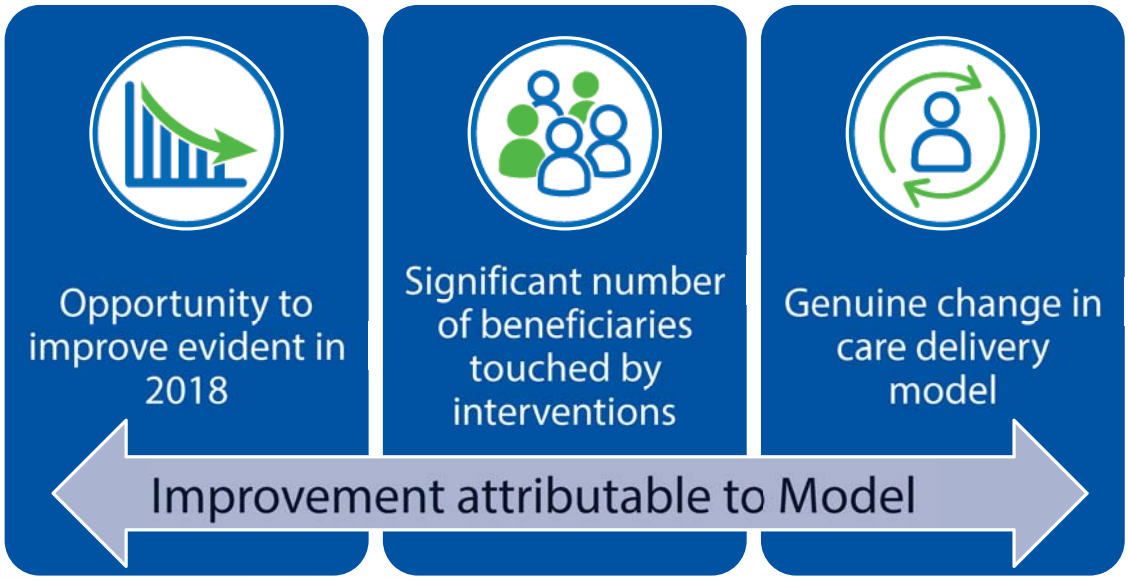

Table 2.1. Room for improvement was generally higher in 2013, before the MDAPM began, but still existed for many key outcomes in 2018 at the start of the MD TCOC Model

Domain	Outcome	Room for improvement (and Maryland rank among all 50 50 states)	
		In 2013 (before MDAPM began)	In 2018 (before MD TCOC began)
Spending	Total Part A and B spending	**Very high (1st)**	**Very high (1st)**
	Hospital spending	**Very high (1st)**	**Very high (2nd)**
	Non-hospital spending	Medium (11th)	**High (7th)**
Utilization	Hospital admissions (all-cause)	**High (7th)**	Medium (34th)
	Outpatient emergency department visits	Medium (39th)	**Low (41st)**
Quality	Potentially preventable hospital admissions	Medium (14th)	Medium (32nd)
	Unplanned 30-day hospital readmission rate	**Very High (2nd)**	Medium (23rd)
	Timely follow-up after acute exacerbations of chronic conditions	Medium (37th)[a]	Medium (31st)[a]
	Patient satisfaction with primary care	**Low (n.a.)[b]**	**Low (n.a.)[b]**
Population health	Diabetes prevalence, residents ages 45–74	Medium (36th)	Medium (30th)
	Obesity prevalence, ages 45–74	Medium (28th)	Medium (28th)
	BMI, ages 45-74	Medium (26th)	Medium (27th)

Source: Evaluation of the Maryland Total Cost of Care Model: Implementation Report. Mathematica, July 2021

MARYLAND PQI TRENDS

VS NATIONAL BENCHMARK

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MARYLAND PQI TRENDS

OVERALL, MD IS OUTPERFORMING THE NATIONAL BENCHMARK

PQI		National Benchmark	MD 2019	% Var.
PQI 1	Diabetes Short-term Complications Admission Rate	58.3	74.6	28%
PQI 3	Diabetes Long-term Complications Admission Rate	104.1	108.8	4%
PQI 5	COPD or Asthma in Older Adults Admission Rate	493.8	376.5	-24%
PQI 7	Hypertension Admission Rate	60.0	53.7	-11%
PQI 8	Heart Failure Admission Rate	413.0	371.4	-10%
PQI 11	Community Acquired Pneumonia Admission Rate	158.8	139.4	-12%
PQI 12	Urinary Tract Infection Admission Rate	141.3	109.7	-22%
PQI 14	Uncontrolled Diabetes Admission Rate	43.0	32.6	-24%
PQI 15	Asthma in Younger Adults Admission Rate	30.3	36.4	20%
PQI 16	Lower-Extremity Amputation among Patients w/ Diabetes Rate	29.3	30.7	5%
Composites				
PQI 90	Prevention Quality Overall Composite	1,306.3	1,152.6	-12%
PQI 91	Prevention Quality Acute Composite	300.1	249.1	-17%
PQI 92	Prevention Quality Chronic Composite	1,006.4	903.5	-10%
PQI 93	Prevention Quality Diabetes Composite	218.8	229.6	5%

CARE TRANSFORMATION IN MARYLAND

Telling the Maryland Hospital Story

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ESTABLISHING A COMMON LANGUAGE

Purpose	Strategy
• Help hospitals amplify the message—care transformation efforts are more advanced and at larger scale throughout Maryland than other states • Tell stories to external stakeholders for widespread appreciation	• Analyze responses from initial information gathering to identify common themes and programs • Test terminology with hospital leads • Socialize common language to create uniformity in descriptions of care transformation to model evaluators

COMMON PROGRAMS AND ACTIVITIES

- Care Management Across Continuum
- Home-Based Care
- Mobile Integrated Health
- Post Acute Teams
- Community Care
- Community-Based Primary Care
- Emergency Department Alternatives/Avoidance

ALL CARE TRANSFORMATION PROGRAMS

- Mitigate barriers that patients experience in accessing care and managing their health by identifying and linking to, or providing community-based medical and social services
- Leverage multidisciplinary teams of clinical and non-clinical staff
- Intervene with specific high-risk/high-need populations
- Better manage chronic conditions, improve health, and reduce potentially avoidable inpatient and ED care
- Enhance primary care management with primary care in alternative settings, and support of patients' social and behavioral health needs
- Support with data analytic infrastructure, including care alerts, electronic notification service, risk scoring, and more
- Deliver programs regardless of payer

CARE MANAGEMENT ACROSS CONTINUUM

Longitudinal and transition-based care management delivered through hospital, post acute, and ambulatory encounters

Interventions

- Proactive identification and outreach to prevent illness, promote early detection
- Medication review and reconciliation
- Coordination and connection to PCP, specialty follow-up, therapy services
- Chronic disease self-management and coaching for patient and their support network. May augment with digital platforms.
- SDOH screening and connection to community resources
- Transportation
- Health risk assessments
- Behavioral health
- Substance use disorder support by peer or social worker
- Advance care planning

HOME-BASED PRIMARY CARE

Beyond typical services at discharge with home health. Often coupled with telehealth support and/or remote patient monitoring in the setting most appropriate for a patient, given medical necessity and/or access to care.

Interventions

- Medication review and reconciliation
- Coordination and connection to PCP and specialty follow-up
- Chronic disease self-management and coaching
- SDOH screening and connection to community resources
- PT, OT, speech therapies, medical and respiratory equipment, home infusion
- Personal level of care, such as nursing assistants
- Telehealth and remote patient monitoring
- Health risk assessments
- Advance care planning
- Behavioral health
- Substance use disorder support by peer or social worker

MOBILE INTEGRATED HEALTH

Multidisciplinary teams address the medical and psycho-social needs of the surrounding communities to support primary care and drive patients to primary care for routine source of care

Interventions

- Health risk assessments and screenings
- Home safety checks
- SDOH screening and connection to community resources
- Connections to primary care or other settings of care
- Care providers can include paramedics or others as part of mobile van clinics
- Advance care planning
- Chronic disease self-management and coaching
- Telehealth
- Behavioral health crisis response
- Substance use disorder support by peer or social worker
- Medication review and reconciliation

POST-ACUTE TEAMS

To avoid unnecessary hospital visits, embed clinicians and case management at skilled nursing facilities and home health to coordinate and manage high-risk/high-need patients. Services intended for seamless transition from the hospital, during the post-acute stay, and to home.

Interventions

- Hospital employed SNF and HHA liaisons
- Regular communication between hospital care team and nursing home, home health, and independent living facilities
- Clinical software to find problems early and avoid transfer to ED
- Shared data and analytics to drive post-acute facilities' performance
- Telehealth, incl. specialty evaluation on site
- Informed choice to patients and families on post-acute facilities inclusive of quality
- SDOH screening and link to community resources, including home health or CHW
- Health risk assessments
- Connection to PCP
- Advance care planning
- Medication review and reconciliation

COMMUNITY CARE TEAMS

Population health interventions in areas of concentrated need to expand access to care and mitigate impact of social needs on health

Interventions

- Boost community supply and connect people to resources such as fresh food, transportation, and more
- Health and housing; may be coupled with other services
- Violence prevention
- Access to dental care
- Health risk assessments and screenings
- Workforce development
- Community- based education and coaching for prevention and specific identified health needs
- SDOH screening and connection to community resources
- Can include telehealth for access to behavioral health and substance use treatment

COMMUNITY-BASED PRIMARY CARE

Networks of primary care sites focused on meeting the health and social needs of small panels of high-risk, high-need patients. The groups are a collaboration between hospitals, payors, and primary care practices.

Interventions

- Provider-led patient care teams
- Focus on special populations (e.g. geriatric Medicaid, homeless)
- Advance practice provider programs
- Telehealth
- SDOH screening and connection to community resources
- SDOH screening and connection to community resources
- Health risk assessments and screenings
- Behavioral health
- Substance use disorder support by peer or social worker
- Can include home-based primary care

ED TRIAGE, AVOIDANCE AND ALTERNATIVES

Teams intervene with low-acuity and high-utilization patients to identify individual needs and eliminate barriers to seeking medical care in urgent care, primary care, or other appropriate setting. Results in reduced utilization of ED visits and admissions.

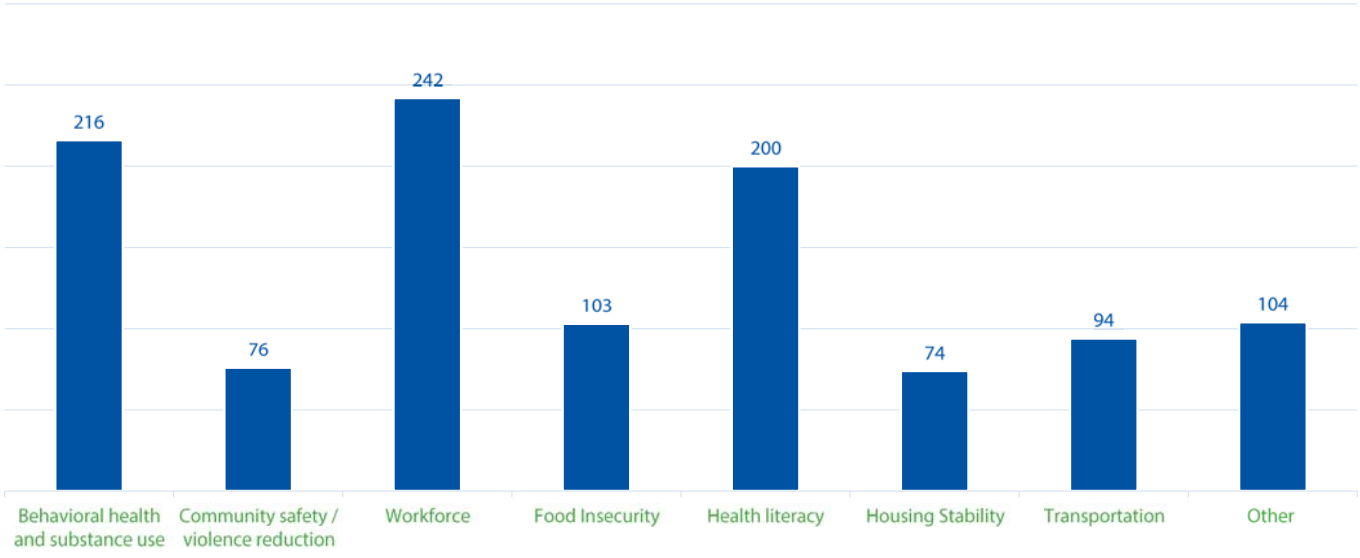
Interventions

- Technology-enabled triage before coming to ED or on arrival
- Telehealth consults
- Paramedic response
- SDOH screening and connection to community resources
- Home health visits
- Care alerts
- Care management in the ED
- Connect patients to primary care via other access points such as urgent care and clinics
- Chronic disease self-management
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Initiate Medication-Assisted Treatment (MAT) in ED

SOCIAL NEEDS

- Behavioral Health
- Community Safety/ Violence Prevention
- Workforce
- Food Insecurity
- Health Literacy
- Housing Stability
- Transportation
- Children and Families

TOTAL INTERVENTIONS BY MD HOSPITALS TO ADDRESS SOCIAL NEEDS



Maryland Hospital Association

Council on Clinical & Quality Issues

August 10, 2021

Topic	**Direct-Entry Midwives' Scope of Practice**
Objective	To receive guidance on MHA's advocacy strategy related to direct-entry midwives' scope of practice
Discussion Questions	1. Do your policies or practices related to midwives differ for certified nurse midwives and midwives without nursing credentials? 2. What additional information is important to share with policy makers?

The Direct-Entry Midwifery Advisory Committee (advisory committee) to the Maryland Board of Nursing (board) is considering whether to expand direct-entry midwives' (DEM) scope of practice. Last year, the advisory committee recommended the board allow DEMs to assist women who have previously had a cesarean section. The board did not agree, concluding there was insufficient information and documentation to support the recommendation.[1] In response, the advisory committee planned to review data to monitor the current outcomes of home births assisted by DEMs, presumably in hopes of a favorable decision in the future. It's not clear that any additional data has been made available to review.

Similarly, in last year's General Assembly session, a bill was introduced seeking an expansion to the DEMs' scope of practice. MHA, the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatrics, and the Maryland Section of the American College of Obstetricians and Gynecologists opposed the bill. The bill ultimately failed. We expect the advisory committee may again attempt to expand DEMs' scope of practice through a direct recommendation to the board and, if that fails, through legislation. MHA's current representative to the advisory committee, Dr. Harold Fox, who opposes expansion, and Dr. Monica Buescher, Dr. Fox's anticipated replacement on the advisory committee, have been invited to join us to discuss our approach and strategy.

Earlier History

In 2015, the Maryland General Assembly passed a bill that opened a path to licensure for DEMs to assist women giving birth at home. When the legislation passed, MHA and other stakeholders agreed to certain restrictions to promote the safety of women who choose a home birth with a DEM. Since these certified professional midwives have different educational requirements than certified nurse midwives, it was important for appropriate parameters to be in place.[2] One of the

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[1] Maryland Board of Nursing. (November 25, 2020). "Report required by Health Occupations Article § 8-6C-12(c) (MSAR # 10523)"

[2] American College of Nurse Midwives. (October, 2017). "Comparison of Certified Nurse-Midwives, Certified Midwives, Certified Professional Midwives Clarifying the Distinctions Among Professional Midwifery Credentials in the U.S."

conditions was to limit the DEMs' scope of practice to not include vaginal births after a c-section, also known as VBACs. While it can be medically appropriate to perform VBACs for certain patients, the inherent additional risk in those deliveries dictates that they take place where emergency services are readily available, such as in a hospital.[3]

Prepared by:
Traci La Valle, Senior Vice President, Quality & Health Improvement

[3] The American College of Obstetricians and Gynecologists. (n.d.). "Vaginal Birth After Cesarean Delivery (VBAC): Frequently Asked Questions"

QBR REDESIGN REPORT TO CMMI - TOPICS

Domain	Measure	Topic	MHA Action/Position
Person & Community Engagement	HCAHPS	• **Add linear scoring** to incentivize improvements in top-box performance • Offer **voluntary up-front funding** to support activities to improve HCAHPS	• **Support** the addition of linear scoring for a focused set of measures and HSCRC's proposed 10% weight on this component • **Neutral** on voluntary pre-funding proposal. No hospital expressed interest
	Follow-up	• **Monitor timely follow-up** after discharge measure for **Medicaid MCO** patients; evaluate for inclusion in payment policy in future years • **Monitor timely follow-up** for **behavioral health** in RY2024	• **Support** monitoring timely follow-up for Medicaid patients. Oppose including in payment policy now. • **Support** monitoring of follow-up for behavioral health in RY2024
	ED Throughput	• **Develop** eCQM infrastructure and evaluate re-introduction of **ED wait times** measure beginning in RY 2024/25	• **Submitted comment letter** to CMS supporting removal of ED-2 measure from the IQR • **Oppose** inclusion of ED wait time measure in payment policy
Safety	NHSN	• **Continue** focus on current **safety measures** • **Explore** opportunities for less burdensome **"digital" measures** including opportunities with CDC	• **Support** continued focus on existing measures • **Monitor** national development of digital measures; technology and feasibility still conceptual
Clinical Care	Mortality	• **Continue** development of 30-day mortality measure	• **Support** continued evaluation of 30-day mortality measure
	THA-TKA	• **Explore expansion** of current IP measure to all payers as well as development of eCQM measure applicable to IP and OP adapted to hospitals	• Continue to evaluate as feasibility is explored

Maryland
Hospital Association

July 30, 2021

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

Dear Dr. Schuster:

On behalf of the Maryland Hospital Association's 60 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) Quality-Based Reimbursement (QBR) Redesign Subgroup's (subgroup) proposals.

HSCRC convened the subgroup in the spring to help ensure success under the Total Cost of Care Model. The subgroup discussed the domains of Maryland's QBR program, where Maryland underperforms relative to the nation, and where there are opportunities to improve hospital measurement and innovation. We support the subgroup's proposal to add linear measures to encourage top-box HCAHPS improvement. We do not support the proposed reintroduction of an emergency department (ED) wait time measure in payment policy.

Since HCAHPS was included in QBR's Person and Community Engagement (PCE) domain, Maryland hospitals have on average underperformed compared to hospitals in the National Value-Based Purchasing (VBP) program. Additionally, in rate year 2021, roughly two-thirds of hospitals were penalized under QBR. Considering PCE is weighted at 50% of QBR, HCAHPS performance drives the penalties or rewards earned by hospitals. We continue to urge HSCRC to reduce this weight to align with the national VBP program more closely and rebalance the emphasis on metrics that reflect improved quality and safety. HCAHPS improvement is best supported by sustainable and stable investment in resources and infrastructure. We appreciate the subgroup's recommendation to offer hospitals upfront funding to support HCAHPS improvement. However, funding for meaningful improvement must be sustainable, and the return on this funding needs to be evaluated for longer than one year. It is appropriate to offer this advance funding as a voluntary program.

We support the subgroup's proposal to offer hospitals the opportunity for reward for linear HCAHPS score improvement. This proposal reduces emphasis on top box HCAHPS scores and allows hospitals to gain credit for the full spectrum of HCAHPS improvement. We also support a focused approach to including linear scores—a subset of all eight HCAHPS measures. We look forward to working with staff to decide what measures should be included.

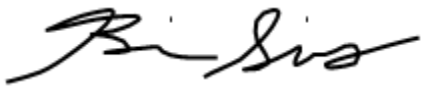
In Maryland, overall ED visits decreased, particularly among low and medium complexity patients. For all payers, ED visits for behavioral health conditions continue to rise, while non-

behavioral health ED visits and admissions decline. We recognize ED wait times are an important operational measure, yet there are too many external factors to control for in a payment policy.

Recognizing the importance to patient safety and shared responsibility for the Marylanders they care for, hospitals in recent years addressed wait times with hospital clinical leaders and ED physician leaders. Maryland hospitals aggressively reduced avoidable utilization and ensured patients receive the appropriate level of care in the right setting. EDs are at the center of this transformation. Increased screening and use of evidence-based practices to lower readmissions and unnecessary inpatient stays require hospitals to consider the needs of all units and overall operations. For these reasons, we do not support an ED wait time measure in payment policy.

We welcome the opportunity to participate in this collaborative and engaging process. We also appreciate staff's willingness to work with the field to modernize the QBR program to benefit of Marylanders and the patients we serve. Please reach out to me with any questions.

Sincerely,



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