Maryland
Hospital Association

November 16, 2023

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

Dear Dr. Schuster:

We appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) *Draft Recommendations for the Quality-Based Reimbursement (QBR) Program for Rate Year (RY) 2026.* We appreciate the opportunity to collaborate with staff and others around the state to shape the policy in the best interest of high-quality care for all Marylanders.

We have significant concerns with several of the staff recommendations and outline those below. Additionally, while we understand staff's commitment to following a strict process for transparent public discussion and a comment period, we believe the expansive nature of the policy recommendations and the proposed inclusion of a new and untested measure raises concern for the risk of unintended consequences and a lack of time to diligently process the proposals.

## PERSON AND COMMUNITY ENGAGEMENT (PCE) DOMAIN

### Domain Weighting

We oppose the increased weighting of the PCE domain from 50% to 60% to accommodate new measures. Without guiding principles for improvement, increased weighting in the PCE domain furthers the long-standing view that the QBR program has become increasingly punitive. Additionally, increasing the number of measures in the domain dilutes the value of each measure and hospitals' ability to narrow focus on quality improvement. We recommend removing existing measures if new measures must be added. We currently have not identified specific measures for removal, as we have not had the time to process this with members. Similarly, we oppose reducing the weight of four linear Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) measures from 20% to 10% to accommodate new measures. Linear measures were included to bolster top-box HCAHPS improvement. The proposal to halve the weight will reduce the value of this approach. We agree with staff that further assessment is needed over the next one-to-two years to determine whether the linear measures help improve top-box scores.

**Timely Follow-Up Disparity Gap**

We support the inclusion of the Timely Follow-Up for Medicare Disparity Gap measure. Ensuring that we meet our Statewide Integrated Health Improvement Strategy goals and targets is critical for the success of our Model and meeting the Centers for Medicare and Medicaid Services' (CMS) expectations. However, we strongly urge this measure to be initially implemented as a reward-only policy. This would offer an opportunity to evaluate the metrics and incentives and make any policy revisions or enhancements. Like the readmissions disparity component—also reward-only and created using the patient adversity index—we anticipate a reward-only approach will successfully drive desired results.

**Emergency Department Length of Stay**

We support the inclusion of an emergency department (ED) wait time measure in QBR as a reward-only policy. We recognize the necessity of addressing the issue of ED wait times and hospital throughput, which is why we are currently engaged in several comprehensive statewide efforts to address this issue systemically. We expect these efforts will offer insights into longer-term solutions, which may or may not relate to a payment policy measure in QBR. Staff has indicated that more time is needed to develop specific measure options to include in a payment policy, thus we strongly oppose hospitals being at risk for financial penalties related to untested and currently undeveloped approaches. Further, a reward-only policy allows hospitals who have made investments in ED LOS improvement to be recognized if those investments have begun to drive improvement. Conversely, hospitals that are still developing successful approaches for addressing ED LOS and hospital throughput issues, should not be subject to financial penalties as this severely compromises the resources necessary to invest in these and other critical improvement efforts. Typically, the HSCRC has agreed to monitor measures for up to a year prior to implementation in a payment policy, allowing time for evaluation, refinements, and analysis. Additionally, we recommend staff adopt the OP-18 measure, as it is a validated CMS measure, and there is national data available for benchmarking. Staff acknowledged a preference for the ED-1 EDDIE measure. However, the concern with this measure is that the data is unaudited and is significantly more challenging to improve year-over-year. Assuming the measure selected for the RY26 policy would be supplanted by the ED-2 electronic clinical quality measure in the future, measures that OP-18, should be considered for this “interim” period.

## SAFETY DOMAIN

MHA opposes the recommendation to reduce the overall domain weight from 35% to 25%. We suggest maintaining the current weighting to avoid jeopardizing hospitals' performance given that Maryland's trajectory is improving relative to the nation. Furthermore, reduced weighting does not correspondingly reduce hospitals' burden of focusing on an increased number of measures.

**CLINICAL CARE DOMAIN**

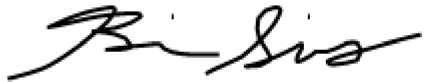
We support the recommendation to add the all-payer, all-cause 30-Day Mortality measure and split the domain weight between the inpatient and 30-day measure. Phasing in the measure is reasonable, and as a guiding principle of the HSCRC Hospital Quality Program, aligning with CMS' Value-Based Purchasing Program where feasible is appropriate.

**RY2024 CUT POINT**

We appreciate HSCRC staff's plans to retrospectively adjust the RY 2024 QBR reward/penalty threshold, or cut-point, to reflect national performance, which has significantly declined since the original cut-point (41%) was created. We recommend staff consider a cut point that uses a multi-year average that weights the most recent national performance (23%) higher than federal fiscal year 2021 performance (35%), as this is a more appropriate comparison for Maryland hospital performance for the RY24 performance period. Using a geometric mean, we suggest a cut point for RY24 of 28%.

We look forward to continuing to work with the Commission on this and future policies.

Sincerely,



Brian Sims
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