maryland
health services
cost review commission

FY 2026 Quarter 3 Data Forum

March 13, 2026
@10:00 AM

Join Zoom Meeting:
https://us06web.zoom.us/j/4107642605?pwd=MmVwREVMbFFYUzlCeWpJcFFZYWF5UT09&omn=85973965350

For Meeting ID and Passcode please contact Curtis Wills: curtis.wills@maryland.gov

Why, When, Where

- WHY?
  - Open and ongoing communication between HSCRC & industry
  - Forum to ask questions about submitted hospital data (case mix and financial)
  - Sharing of best practices
- WHEN?
  - 10:00 am
- WHERE?
  - via Webinar (link is posted on our website 2 months before the next meeting)

FY 2026 Dates
June 12, 2026

Agenda

- Quality Update (Princess)
- ED LOS Update (Princess)
- Audit & Integrity Update (Wayne)
- Financial Data Update (Nancy)
- Reminders (Curtis)
  - Points of Contact
  - CDS-A Report
  - Data Forum Survey
  - FY 2025 Annual Filing Reporting Update
- Patient Level Denial Reporting (Nancy)
- Data Processing Update (Maria Manavalan, hMetrix/Burton Policy)
- Case Mix Audit Update (Brenda Watson, Commence)
- Upcoming Workgroups and Next Meeting (Curtis)

Quality Update

AHEAD Updates and Transition Timelines

- Maryland entered the AHEAD Model beginning 1/1/2026.
- CMS will set **Medicare FFS global budgets** starting in 2028.
  - Performance Year 1 (2026) and PY2 (2027) will be a transition period where the State will continue to set all-payer Hospital Global Budgets.
  - In order to smooth the transition, the State will be able to re-direct a portion of the total Medicare global budget amount between PY3 (2028) and PY5 (2030).
- The State will continue to set **non-Medicare FFS state hospital global budgets (state HGB)** with quality adjustments.
- Savings target of $460M in additional **Medicare FFS savings** must be achieved in PY1 (2026) – PY7 (2032), with no additional savings expected in the final three PYs (through 2035).

HSCRC Policy Calendar & CY 2026 PMWG Priorities

RY 2028 Quality Core Policies									
Policy	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**
QBR		Draft		Final					
MHAC			Draft		Final				
RRIP				Draft		Final			
ED Best Practices	Draft		Final						

Grouper Transition: MHAC, RRIP, QBR for **CY 2026**

Rate Year	RY2028
***Solventum APR/PPC Version**	43 *(Updated from version 42 to incorporate annual Solventum updates)*
Timeline	**Base Year:** • **MHAC** (including PSI90)**:** FY 2024 & 2025 • **IP and 30-Day Mortality:** FY 2025 • **RRIP:** CYs 2022 and CY 2023 • **THA/TKA:** Q2 CY 2018- Q1 CY 2021 • **NHSN, HCAHPS, SEP-1:** CY 2024 **Performance Year:** • **HCAHPS, NHSN, SEP-1:** Q4 CY 2025 - Q3 CY 2025 • **THA/TKA:** Q2 CY 2023 – Q1 CY 2026 • **All Other Measures:** CY 2026 (CY 2025-2026 for PPCs for small hospitals)**
Implementation Date	RY 2026 policies began Jan 1, 2026 in most cases. Look for base and performance period reports on the CRS Portal coming in April.

*The Solventum™ All Patient Refined DRG (APR DRG) Software and Solventum™ Potentially Preventable Complications (PPC) Software are proprietary products of Solventum Health Information Systems.
**Staff still analyzing use of two years in performance period data for small hospitals for PSI-90

Alignment Prioritization and Phases

- **QBR-HVBP:** HSCRC staff has prioritized CY2026 alignment given lack of evidence that higher HCAHPS weight leads to improvement, program complexity, and number of MD-specific measures.
- **MHAC-HACRP:** Given revenue adjustment methodology includes scaled adjustments with rewards, staff propose maintaining program in RY 2028 with possible addition of PSI if removed from QBR. Alignment with HACRP or non-Medicare FFS policy development for RY 2029 will consider continued use of PPCs instead of NHSN and PSI, as well as opportunities to use eCQMs.
- **RRIP-HRRP:** Staff propose future RRIP policy should align with statewide all-payer readmissions goals under AHEAD vs. HRRP direct alignment; current policy includes improvement goal through CY2026 that could be used for RY 2028 and during CY 2026 focus could be on development of new all-payer measure that aligns with statewide goal for RY 2029. Once developed, penalty only program and weighting of HRRP at 3 percent could be considered.

Final RY 2028 QBR Policy

1. Update Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.
2. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and set the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 32 percent.
3. Retrospectively evaluate the preset cut-point using more recent data to calculate national average score for RY 2027 and RY 2028.
4. Based on concurrent analysis of national hospital performance, adjust the RY26 QBR cut-point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.
5. Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures; add a bonus incentive of $150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.

Note: Removed Medicare TFU, Medicare TFU Disparities, HCAHPS Linear Measures and PSI-90; added Sep-1 Bundle and THA/TKA

For RY 2028, Commission Approved Continuing QBR Incentive Program for Complete and Timely Digital Measures Reporting

- **The state contracts with CRISP/Medisolv for digital measure data reporting and recommends accelerated reporting compared to CMS requirements and all-payer hybrid data elements:**
  - HSCRC eCQM reporting period is on a calendar year basis with reporting required after first six months and then quarterly
  - HSCRC Hybrid Hospital Wide Readmission and Mortality measures Core Clinical Data Elements (CCDE) reporting is all-payer (age 18 yrs+) for July-June annual period and reporting required after first six months and then quarterly
- **Majority of hospitals are on track to earn the reward for RY 2027**

CMS Hospital eCQM Digital Measures Reporting Requirements CYs 2026-2028

CY 2026 (RY 2028): Maryland is aligning with CMS

Five selected by CMS and three self-selected CMS-mandated eCQMs:

- Safe Use of Opioids—Concurrent Prescribing: (CMS506)
- Cesarean Birth: (PC-02)
- Severe Obstetric Complications: (PC-07)
- Hospital Harm—Severe Hyperglycemia:newly required
- Hospital Harm—Severe Hypoglycemia: newly required

CY 2027

Six selected by CMS and three self-selected CMS-mandated eCQMs:

- Safe Use of Opioids—Concurrent Prescribing
- Cesarean Birth (PC-02)
- Severe Obstetric Complications (PC-07)
- Hospital Harm—Severe Hyperglycemia
- Hospital Harm—Severe Hypoglycemia
- Hospital Harm—Opioid-Related Adverse Events: newly required measure.
- *Emergency Care Access and Timeliness (HOQR)*: new voluntary

CY 2028

Eight selected by CMS and three self-selected CMS-mandated eCQMs:

- Safe Use of Opioids—Concurrent Prescribing
- Cesarean Birth (PC-02)
- Severe Obstetric Complications (PC-07)
- Hospital Harm—Severe Hyperglycemia
- Hospital Harm—Severe Hypoglycemia
- Hospital Harm—Opioid-Related Adverse Events
- Hospital Harm—Pressure Injury: new measure
- Hospital Harm—Acute Kidney Injury: new measure
- *Emergency Care Access and Timeliness (HOQR)*: newly required

Important considerations

- Non-compliance penalty: Failure to meet these requirements puts hospitals at risk of a one-fourth reduction in their annual payment update.
- Zero-denominator reporting: Hospitals that do not provide obstetric services but participate in the Hospital IQR program must submit a zero-denominator declaration for the Cesarean Birth (ePC-02) and Severe Obstetric Complications (ePC-07) measures each quarter.
- Validation scoring: Beginning with data from the 2025 reporting period (impacting the FY 2028 payment determination); CMS will score eCQM validation based on data accuracy.

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HSCRC Digital Measures Reporting Requirements CY 2026: Electronic Clinical Quality Measures (eCQMs) and Digital Hybrid Measures

Title	Short Name	CMS eCQM ID	2024	2025	2026	HSCRC*	CMS
Anticoagulation Therapy for Atrial Fibrillation/Flutter	STK-3	CMS71v13	X	X	X (v15)	Self-Selected	Self-Selected
Antithrombotic Therapy By End of Hospital Day 2	STK-5	CMS72v12	X	X	X (v14)	Self-Selected	Self-Selected
Cesarean Birth	PC-02	CMS334v5	X	X	X (v7)	Required	Required
Discharged on Antithrombotic Therapy	STK-2	CMS104v12	X	X	X (v14)	Self-Selected	Self-Selected
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Facility IQR)	IP-ExRad	CMS1074v2		X	X (v3)	Self-Selected	Self-Selected
Global Malnutrition Composite Score	GMCS	CMS986v2	X	X	X (v5)	Self-Selected	Self-Selected
Hospital Harm - Acute Kidney Injury	HH-AKI	CMS832v2		X	X (v3)	Self-Selected	Self-Selected
Hospital Harm - Opioid-Related Adverse Events	HH-ORAE	CMS819v2	X	X	X (v4)	Self-Selected	Self-Selected
Hospital Harm - Pressure Injury	HH-PI	CMS826v2		X	X (v3)	Self-Selected	Self-Selected
Hospital Harm - Severe Hyperglycemia	HH-Hyper	CMS871v3	X	X	X (v5)	Required	New Required
Hospital Harm - Severe Hypoglycemia	HH-Hypo	CMS816v3	X	X	X (v5)	Required	New Required

***For CY 2026 HSCRC will require 3 self-selected measures, consistent with CMS requirements**

HSCRC Digital Measures Reporting Requirements CY 2026: eCQMs and Digital Hybrid Measures

Title	Short Name	CMS ID	2024	2025	2026	HSCRC*	CMS
ICU Venous Thromboembolism Prophylaxis	VTE-2	CMS190v12	X	X	X (v14)	Self-Selected	Self-Selected
Safe Use of Opioids - Concurrent Prescribing	Safe use of opioids	CMS506v6	X	X	X (v8)	Required	Required
Severe Obstetric Complications	PC-07	CMS1028v2	X	X	X (v4)	Required	Required
Venous Thromboembolism Prophylaxis	VTE-1	CMS108v12	X	X	X (v14)	Self-Selected	Self-Selected
Hospital Harm - Postoperative Respiratory Failure	HH-RF	CMS1218v2			X	Self-Selected	Self-Selected
Hospital Harm - Falls with Injury	HH-FI	CMS1017v2			X	Self-Selected	Self-Selected
Core Clinical Data Elements for the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data	Hybrid HWR	CMS529v6	X	X	X	Required age 18+	Required age 65+
Core Clinical Data Elements for the Hybrid Hospital-Wide All-Condition All-Procedure Risk-Standardized Mortality Measure	Hybrid HWM	CMS844v6	X	X	X	Required age 18+	Required age 65+
Emergency Care Access and Timeliness (HOQR)		CMS1244v1				Require 2027?	Required 2028

***For CY 2026 HSCRC will require 3 self-selected measures, consistent with CMS requirements**

Final RY 2028 MHAC Policy

1. Use Potentially Preventable Complication (PPC) composite and all-payer AHRQ Patient Safety Indicator 90 to assess hospital acquired complications.
2. Assess PPC performance using more than one year of data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs).
3. Assess hospital performance based on statewide attainment standards.
4. Set revenue at-risk at a maximum penalty at 2 percent and maximum reward at 2 percent using the average Maryland hospital score as the cut point for start of rewards.
5. Going forward, consider other candidate measures/measure sets that may be important for assessing hospital avoidable, harmful complications and appropriate for use in the program under a non-Medicare FFS quality program.

Note: Added PSI-90 at 1/6th of performance

Clinical Adverse Event Measures Subgroup

- Technical subgroup to evaluate complication and mortality measures for Maryland GBRs (i.e., the GBRs for commercial, medicaid, etc.)
- The group will consider measure validity and reliability, as well as data sources, cost and reporting burden, Medicare alignment, and areas of opportunity specific to Maryland
- Develop create criteria for inclusion of measures in a non-Medicare quality program
- Staff reviewing volunteers and will contact additional experts as needed to ensure group has appropriate quality and safety measurement expertise.
- Anticipated start date April 2026, updates presented at monthly PMWG and final recommendations at August/September PMWG

Final RY 2028 RRIP Recommendations

1. Maintain the all-payer, 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 with a blended base period of CY 2022 and CY 2023.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
    a. Adjust case-mix readmission rate by OOS Utilization Adjustment to account for OOS readmissions and transfers, retrospectively for RY 2027 and for RY 2028 and beyond
4. Maintain scaled rewards and penalties of up to 2 percent of inpatient revenue.
5. Monitor reductions in within-hospital readmission disparities and provide quarterly updates on by-hospital performance at Commission Meetings.
6. Assess opportunities for AHEAD alignment of readmission measure, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

Note: Removed RRIP Disparity Gap incentive

CY 2026 RRIP Priorities

During CY 2026 Staff will:

1. Work with MPR to adapt all-payer NCQA PCR measure specifications using case-mix data instead of claims
   a. Currently working to match Medicare and case-mix data to identify discrepancies in results
   b. May adapt RRIP measure to match elements of NCQA PCR measure (e.g., inclusion of observation)
2. Determine whether HWR and HRRP could be adapted for non-Medicare
3. Work with CMMI and industry to understand interactions between the different readmission incentives in AHEAD
4. Determine goals for Maryland GBR policy (i.e., improvement or attainment goal) and revenue adjustment methodology

Staff will use PMWG as stakeholder group to vet the RRIP policy development

ED LOS Updates

Important Updates related to QBR ED LOS

- CY 2025 Preliminary data through December was released in February, CY 2025 Final data will be available in April.
- For RY 2027 & RY 2028 QBR ED LOS measure, staff will maintain improvement goal that focuses on not declining in performance (i.e., 0 to -5% and 0 to -10% based on median in base) and provide those with rates below national average the full points.
- After in-depth review and discussion with numerous stakeholder groups, staff recommend that we do not implement a risk-adjustment methodology for RY 2027 and RY2028.
- Staff and stakeholders will evaluate potential transition to ECAT digital measures to replace the current ED LOS measure in subsequent years.
- ED LOS Dashboard is in development, the draft is currently being reviewed internally. The goal is to release V1 in April/May.

Audit and Integrity Update

Technical Workgroup - Labor & Delivery

- In November, staff began hosting technical workgroup meetings focusing on potential changes to the Relative Value Units (RVUs) for the Labor & Delivery Rate Center
  - Participants include hospital clinicians, statewide payors, consultants, and HSCRC staff.
- The goal of this workgroup is to update the RVUs in the Appendix D of the Accounting & Budget Manual.
  - *These adjustments are intended to be revenue neutral* ensuring no net increase or decrease in overall revenue for the rate center.

- **Action Required:**

  Please share this information with staff at your hospital. Any clinicians or reimbursement staff interested in participating should send their email contact information to me at **wayne.nelms2@maryland.gov**.

Updated Regulations for Hospital Financial Assistance

- **New Regulations:** The HSCRC promulgated updated regulations governing hospital financial assistance and medical debt, effective December 11, 2025.
- **Eligibility:** These provisions require that financial assistance be accessible to all eligible low-income patients residing in Maryland, regardless of citizenship status.
- **Updated Forms:** Staff has revised the Uniform Financial Assistance Application, which is now available on the Commission's website for your use.

*All hospitals must submit their updated financial assistance policy on or before **April 30, 2026**.*

- **Submission Email:** hscrc.financialassistance@maryland.gov
- **Inquiries:** If you have any questions, please contact Steven Crocker at Steven.Crocker1@maryland.gov.

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Financial Data Update

Updates to Monthly Experience Data

- As a result of select volume realignment due to Kaiser Permanente (KP) patient shifts, staff developed a supplemental schedule to submit along with the monthly experience data.
  - The new schedule will provide volume and revenue data by rate center for patients where KP is the **Primary and Secondary Health Plan Payer**.
- Hospitals will also report volume and revenue data by rate center for patients where Medicaid (FFS or MCO) is the **primary payer** in preparation for the AHEAD model.
- Hospitals will also reconcile Kaiser and Medicaid charges separately in the Reconciliation Reports

Updates to Monthly Experience Data

Kaiser Permanente (KP) Variables

Variable Name	Description	Variable Name	Description
Code	Rate Center Code	KP_Total_In_State_Vol_Out	Total KP In-State OP Volume
KP_Vol_In	Total KP IP Volume	KP_Total_Out_State_Vol_Out	Total KP Out-of-State OP Volume
KP_Vol_Out	Total KP OP Volume	KP_Total_In_State_Rev_In	Total KP In-State IP Revenue
KP_Rev_In	Total KP IP Revenue	KP_Total_Out_State_Rev_In	Total KP Out-of-State IP Revenue
KP_Rev_Out	Total KP OP Revenue	KP_Total_In_State_Rev_Out	Total KP In-State OP Revenue
KP_Total_In_State_Vol_In	Total KP In-State IP Volume	KP_Total_Out_State_Rev_Out	Total KP Out-of-State OP Revenue
KP_Total_Out_State_Vol_In	Total KP Out-of-State IP Volume		

Updates to Monthly Experience Data

Medicaid Variables

Variable Name	Description	Variable Name	Description
Mcaid_Vol_In	Total Medicaid IP Volume	Mcaid_Out_Vol_In	Total Medicaid Out-of-state IP Volume
Mcaid_Vol_Out	Total Medicaid OP Volume	Mcaid_Out_Vol_Out	Total Medicaid Out-of-state OP Volume
Mcaid_Rev_In	Total Medicaid IP Revenue	Mcaid_In_Rev_In	Total Medicaid In-state IP Revenue
Mcaid_Rev_Out	Total Medicaid OP Revenue	Mcaid_In_Rev_Out	Total Medicaid In-state OP Revenue
Mcaid_In_Vol_In	Total Medicaid In-state IP Volume	Mcaid_Out_Rev_In	Total Medicaid Out-of-state IP Revenue
Mcaid_In_Vol_Out	Total Medicaid In-state OP Volume	Mcaid_Out_Rev_Out	Total Medicaid Out-of-state OP Revenue

Updates to Quarterly Reconciliation Reporting

Quarterly Reconciliation Form for Time Period:

Please reconcile so that Financial/Abstract differences for each category are no more than 2% for the

Submission Schedule

Completed Reconciliation Form submitted to HSCRC by **Email Reconciliation Form to: HSCRC.reconciliation@Maryland.gov**

Hospital Name: <Hospital Name>

	Original Quarter				Revised for Quarter			
Category	**Financial (1)**	**Case Mix (1)**	**$ Diff**	**% Diff**	**Financial (2)**	**Case Mix (2)**	**$ Diff**	**% Diff**
Total Charges (All Primary Expected Payer Charges)			0.00	#DIV/0!			0.00	#DIV/0!
Maryland Charges (All Primary Expected Payer Charges and where zip code= MD zip code or invalid zip			0.00	#DIV/0!			0.00	#DIV/0!
Non-Maryland Charges (All Primary Expected Payer Charges and where zip code= Border state zip code			0.00	#DIV/0!			0.00	#DIV/0!
Breakdown by Payer Type (Not mutually exclusive; payers may be reflected in multiple								
Medicare FFS Charges (Primary Expected Payer = Medicare FFS (01))			0.00	#DIV/0!			0.00	#DIV/0!
Medicare HMO Charges (Primary Expected Payer = HMO (15))			0.00	#DIV/0!			0.00	#DIV/0!
Medicaid Charges (Primary Expected Payer = Medicaid FFS (02) or HMO (14))			0.00	#DIV/0!			0.00	#DIV/0!
Kaiser Permanente Total Charges (All Primary Expected Payer Charges)			0.00	#DIV/0!			0.00	#DIV/0!
Kaiser Permanente Maryland Charges (All Primary Expected Payer Charges and where zip code= MD zip			0.00	#DIV/0!			0.00	#DIV/0!
Kaiser Permanente Non-Maryland Charges (All Primary Expected Payer Charges and where zip code=			0.00	#DIV/0!			0.00	#DIV/0!

Detailed explanation as to why variance reported in column (M) exceeds 2%:_____

Please note:

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Experience Data and Reconciliation Report Timeline

Jan 21, 2026
Testing begins for new variables in DAVE.

Mar 2, 2026
January 2026 report due (current standard format)

Mar 30, 2026
Submission of January & February 2026 data including the **new** KP and Medicaid variables

Jun 8, 2026
Submission of FY 2026 Q3 **Reconciliation Reports,** including the new KP and Medicaid variables

Submission Note: *January and February Experience data must be submitted as* ***separate files*** *using the new template which is now available on the HSCRC website. Please ensure each file uses the corresponding report date to indicate the specific month of submission for the submission window between March 2 and March 30, 2026.*

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Reminders

HSCRC Points of Contact for Case Mix and Financial Data

Case Mix Data

Curtis Wills
Phone: (410) 764-2594
Email: curtis.wills@maryland.gov

Hannah Thurner
Phone: (410) 764-3371
Email: hannah.thurner@maryland.gov

Financial Data

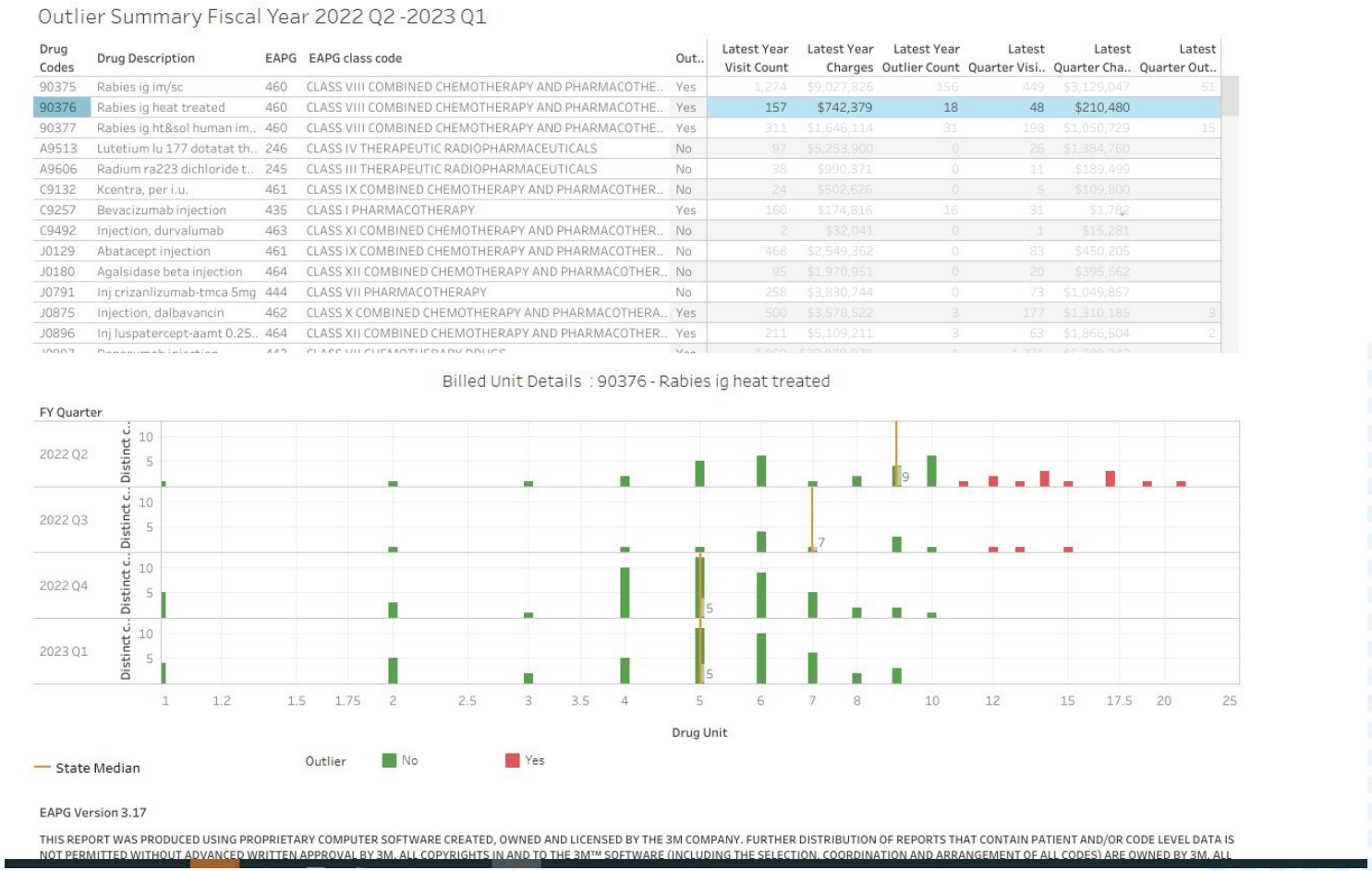
Andrea Strong
Phone: (410) 764-2571
Email: andrea.strong@maryland.gov

Marcella Guccione
Phone: (410) 764-5594
Email: marcella.guccione@maryland.gov

Nancy Chiles Shaffer
Phone: (410) 764-2566
Email: nancy.shaffer@maryland.gov

Reminder: CDS-A Reports on CRISP Portal

- Provides hospitals with **high-cost drug utilization for outlier dosage units** based on 3rd Monthly case mix data
- Information should used to correct errors prior to submission of Quarterly case mix data.
- Hospitals can see which drugs' units are outliers compared to the State average



Outlier Summary Fiscal Year 2022 Q2 -2023 Q1

Drug Codes	Drug Description	EAPG	EAPG class code	Out..	Latest Year Visit Count	Latest Year Charges	Latest Year Outlier Count	Latest Quarter Visi..	Latest Quarter Cha..	Latest Quarter Out..
90375	Rabies ig im/sc	460	CLASS VIII COMBINED CHEMOTHERAPY AND PHARMACOTHE..	Yes	1,274	$9,027,826	156	449	$3,129,047	51
90376	Rabies ig heat treated	460	CLASS VIII COMBINED CHEMOTHERAPY AND PHARMACOTHE..	Yes	157	$742,379	18	48	$210,480	
90377	Rabies ig ht&sol human im..	460	CLASS VIII COMBINED CHEMOTHERAPY AND PHARMACOTHE..	Yes	311	$1,646,114	31	198	$1,050,729	15
A9513	Lutetium lu 177 dotatat th..	246	CLASS IV THERAPEUTIC RADIOPHARMACEUTICALS	No	97	$5,253,900	0	26	$1,384,760	
A9606	Radium ra223 dichloride t..	245	CLASS III THERAPEUTIC RADIOPHARMACEUTICALS	No	38	$990,371	0	11	$189,499	
C9132	Kcentra, per i.u.	461	CLASS IX COMBINED CHEMOTHERAPY AND PHARMACOTHER..	No	24	$502,626	0	5	$109,800	
C9257	Bevacizumab injection	435	CLASS I PHARMACOTHERAPY	Yes	160	$174,816	16	31	$1,782	
C9492	Injection, durvalumab	463	CLASS XI COMBINED CHEMOTHERAPY AND PHARMACOTHER..	No	2	$32,041	0	1	$15,281	
J0129	Abatacept injection	461	CLASS IX COMBINED CHEMOTHERAPY AND PHARMACOTHER..	No	468	$2,549,362	0	83	$450,205	
J0180	Agalsidase beta injection	464	CLASS XII COMBINED CHEMOTHERAPY AND PHARMACOTHER..	No	95	$1,970,951	0	20	$395,562	
J0791	Inj crizanlizumab-tmca 5mg	444	CLASS VII PHARMACOTHERAPY	No	258	$3,830,744	0	73	$1,049,857	
J0875	Injection, dalbavancin	462	CLASS X COMBINED CHEMOTHERAPY AND PHARMACOTHERA..	Yes	500	$3,578,522	3	177	$1,310,185	3
J0896	Inj luspatercept-aamt 0.25..	464	CLASS XII COMBINED CHEMOTHERAPY AND PHARMACOTHER..	Yes	211	$5,109,211	3	63	$1,866,504	2

Billed Unit Details : 90376 - Rabies ig heat treated

EAPG Version 3.17

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Reminder: CDS-A Reports on CRISP Portal

- CDS-A Audits starts with what is reported in the case mix data. If the case mix data has errors, the CDS-A data for the following year will have errors.
- Hospitals are subject to fines if the case mix data used for CDS-A audits the following year contains errors.
- For access to the CRISP portal, contact your CRS Portal Point of Contact or support@crisphealth.org

Reminder: Please Complete the Data Forum Survey!

- Opportunity to provide feedback on
  - Meeting logistics (meeting notice, registration, ease of participation)
  - Topics covered during the prior meeting
  - Topics for discussion for future meetings
- After this Data Forum, participants will receive a link to a survey via Survey Monkey
- Questions about the survey: contact hscrcteam@hmetrix.com

Reminder: FY25 Annual Filing Submission (eF2)

Hospital trainings on eF2

- Meeting materials and training recordings have been posted: https://hscrc.maryland.gov/Pages/Subgroup-annual-filing-modernization.aspx

Clinician Cost Schedule (Schedule CCS)

- For FY 2025, Schedule CCS must be submitting using the excel template sent to hospitals on September 2, 2025
- For hospitals with a **December 31 year end**, Schedule CCS is due on **June 15, 2026**
  - Email completed schedules to: hscrc.annual@maryland.gov

Contact Information

- For any questions related to the Annual Filing or Schedule CCS

Email: hscrc.annual@maryland.gov

Patient-level Denial Reporting Update

HSCRC Workgroup Staff

Claudine Williams Principal Deputy Director Healthcare Data Management and Integrity	**Nancy Chiles Shaffer** Associate Director Healthcare Data Management and Integrity
Marcella Guccione Data Analyst Healthcare Data Management and Integrity	**Curtis Wills** Assistant Chief Healthcare Data Management and Integrity
Irene Cheng Senior Programmer Analyst Medical Economics and Data Analytics	**Prudence Akindo** Chief, Financial Methodologies Quality and Population-Based Methodologies

Workgroup Hospital Representatives

Hospitals and Systems	
Adventist HealthCare	Ascension St. Agnes Hospital
Atlantic General Hospital	Brooklane Hospital
Calvert Memorial Hospital	ChristianaCare Union Hospital
Frederick Health Hospital	Greater Baltimore Medical Center
Holy Cross Health	Johns Hopkins Hospital
LifeBridge Health	Luminis Health
WVU Garrett Regional Medical Center	MedStar Health
Mercy Medical Center	Meritus Hospital
TidalHealth Peninsula Regional Medical Center	UPMC Western Maryland
Maryland Hospital Association	

Recap of Activities Since July 8th Meeting

- Met with technical subgroup 5 times:
  - **October 17, 2025**
  - **November 13, 2025**
  - **December 12, 2025**
  - **December 19, 2025**
  - **February 5, 2026**
- Came to consensus on:
  - **Initial vs Final Denials**
  - **Denial Reasons Categories**
  - **Proposed Template**
  - **Timeline for Historical Data and Routine Submissions**

Subgroup Hospital Representatives

Janice Napieralski Jean Marx	TidalHealth
MaryAnn Kanis Kalin Robert Greenwald	MedStar Health
Sydney Winter Alexis Rivers	University of Maryland Health System
Bill Rew	LifeBridge Health
Annalise Franco	Adventist HealthCare

Proposed Patient Level Data - Revised

- Metadata tab
  1. Reporting Quarter
  2. Hospital ID
  3. Hospital Name (auto populated)
- Denial Data tab
  1. Patient Account Number
  2. Service Date *(Discharge or From date as reported in case mix)*
  3. Total Charges *(as reported in case mix)*
  4. Amount Paid by the Primary Insurance
  5. Amount Denied by Primary Insurance
  6. Primary Payer Responsible for Denial (Financial Class)
  7. Primary Health Plan Payer Responsible for Denial
  8. Type of Service (IP,OP,ED)
  9. Insurance Reason for Denial

Insurance Reason For Denial Categories

Authorization (or No Pre-Authorization): A claim that is denied due to not obtaining pre authorization prior to the admission or the OP service. Including Maryland Medicaid Technical Denials.

Not Medically Necessary: A claim that is denied due to the admission or service not being covered by the patient's insurance plan due to Medical Necessity.

Non-Covered: A claim that is denied due to the admission or service not being covered by the patient's insurance plan that is not related to Medical Necessity.

Untimely Filing: A claim that was not submitted within the permitted time frame (initial and late charge claims).

Observation: A claim in which the charged observation time is more than the amount allowed by the payer.

Audit: A claim that contains services that were not performed or the record notes do not support the service. Does not include claims that are in appeal status.

Insurance Reason For Denial Categories, cont.

Administrative: A claim that contain services that were performed but the hospital leadership decides not to bill (insurance or patient) and is adjusted/written off.

Physician/Provider Credentialing: Provider not credentialed to perform the service.

Template and Example - Revised

Hospital ID	Reporting Qtr.	Provider Name
111111	FY25Q2	Auto populated Hospital Name

Metadata Example

	A	B	C	D	E	F	G	H	I
	Reporting Template								
	Patient Account Number	Service Date	Total Charges from Case Mix	Amount paid by primary insurance	Amount Denied by Primary insurance	Primary Payer Code that Denied the claims	Expected Primary HP Payer Code	Type of Service (IP,OP,ED)	Insurance Reason for Denial
	111111111111111000	2/3/2025	700	200	500	05	102	IP	1
	222222222222222000	1/7/2025	1000	800	200	05	101	OP	4

Insurance Reason for Denial Categories	
1	**Authorization (or No Pre-Authorization):** A claim that is denied due to not obtaining preauthorization prior to the admission or the OP service. Including Maryland Medicaid Technical Denials.
2	**Not Medically Necessary:** A claim that is denied due to the admission or service not being covered by the patients insurance plan due to Medical Necessity.
3	**Non-Covered:** A claim that is denied due to the admission or service not being covered by the patients insurance plan that is not related to Medical Necessity.
4	**Untimely Filing:** A claim that was not submitted within the permitted timeframe (initial and late charge claims)
5	**Observation:** A claim in which the charged observation time is more than the amount allowed by the payer.
6	**Audit:** A claim that contains services that were not performed or the record notes does not support the service. Does not include claims that are in appeal status.
7	**Administrative:** A claim that contain services that were performed but the hospital leadership decides not to bill (insurance or patient) and is adjusted/written off.
8	**Physician/Provider Credentialing:** Provider not credentialed to perform the service.

Expected Primary Payer Codes from the HSCRC DSR Guidelines	
01	Medicare FFS
02	MD Medicaid FFS and Pending MD Medicaid
05	Commercial Insurance
06	Other Governmental Programs
07	Workmen's Compensation
10	Other Governmental Programs (i.e. Tricare - Military Insurance)
14	MD Medicaid MCO
15	Medicare MA (Medicare Advantage)
18	International Insurance
19	Behavioral Health Plan
77	Not Applicable

Expected	**Primary Health Plan Payer Code from the HSCRC DSR Guidelines**
098	Health Plan Payers Not Specified Below
099	Unknown
100	Not Applicable - Does Not Require Health Plan Payer
101	Aetna Health Plans
102	CareFirst BlueCross BlueShield
103	Cigna
104	Generic TPA/Commercial Plans
105	Generic Commercial Employee Health Plans
106	Humana
107	Kaiser Permanente
108	United Healthcare
109	Wellpoint (Formerly Amerigroup Community Care)
110	Jai Medical Systems
111	Maryland Physicians Care
112	Medstar Family Choice
113	Priority Partners
115	Johns Hopkins Advantage Md
116	Provider Partners Health Plan (New)
	Optum Maryland (Md Medicaid)
118	*Discontinued For Discharges On Or After 1/1/2025*
119	Magellan
120	Cigna Behavioral Health
121	ComPsych
122	Manage Health Network
123	Optum Behavioral Health (Commercial)
124	Beacon Health Options
125	Johns Hopkins Employee Health Plans
126	University Of Md Employee Health Plans
127	Medstar Employee Health Plans
128	Horizons Medicare Direct
129	Out Of State (Non-Maryland) Medicaid Payers
130	Carelon Behavioral Health (MD Medicaid)

Proposed Timeline for Historical and Ongoing Data Submissions

Due Date	**7/30/2026**	**10/30/2026**		**1/29/2027**		
Denial File	Summary	Summary	Patient-Level	Summary	Patient-Level	Patient-Level
Reporting Period	FY 26 Q4	FY27 Q1	FY26 Q4	FY27 Q2	FY27 Q1	FY27 Q2
Location	HSCRC Email	DAVE	DAVE	DAVE	DAVE	DAVE
Naming Convention	N/A	HOSPID_FY27Q1_SUMDENIAL.xlsx	HOSPID_FY26Q4_DENIAL.xlsx	HOSPID_FY27Q2_SUMDENIAL.xlsx	HOSPID_FY27Q1_DENIAL.xlsx	HOSPID_FY27Q2_DENIAL.xlsx
Final Denial Date	During FY26 Q4	During FY27 Q1	During FY25 and FY26	During FY27 Q2	During FY27 Q1	During FY27 Q2

- From FY 2027 onwards, all denial files will be submitted through DAVE
- Adherence to the mandatory naming conventions below is required
  - Summary data: HOSPID_FYyyQq_SUMDENIAL.xlsx
  - Patient-level data: HOSPID_FYyyQq_DENIAL.xlsx
- Patient-level reporting will be done in parallel with the existing quarterly Denial Reporting.
- Hospitals may submit a summary file along with FY 2026 Q4 patient-level data covering all denial dates in FY 2025 and FY 2026 with file name- HOSPID_FY26Q4_SUMDENIAL.xls

Submission Process

1. Delivery & File Naming
   - **Location:** Upload files directly to the designated DAVE submission folder.
   - **Frequency:** Submit one file per hospital, per quarter.
   - **Standard Naming Convention:** HOSPID_FYyyQq_DENIAL.xlsx.
     - *Example: 210001_FY25Q1_DENIAL.xlsx.*
2. Data Reconciliation Logic
   - To ensure data integrity, denial records will be reconciled with Case Mix data using the following keys:
     - Hospital ID
     - Patient Account Number
     - Service Date

   Note: The reported Service Date must fall between the **Admission/From Date** and **±1 day** of the **Discharge/Thru Date**.
3. Error Reporting
   - While HSCRC plans to implement automated error reports in the future, there is currently no error threshold for these submissions.

Data Processing Update

Points of Contact- hMetrix / Burton Policy

Shivani Bhatt (Primary PoC)

Phone: (484) 228-1453

Email: shivani@hmetrix.com

Mary Pohl (Hospital Support)

Phone: (410) 274-3926

Email: marypohl@burtonpolicy.com

Team Email: hscrcteam@hmetrix.com

Submission Instructions

- Submitting Production Files
  - Submit data files to the appropriate subfolder after selecting "Production File Submission".
- Production Subfolder Guide:
  - **adhoc**: For files intended for direct submission to HSCRC, bypassing hMetrix processing.
    - Notify the HSCRC staff and hMetrix after uploading the file
  - **submission:** For Case Mix, UCC, supplemental, and other hMetrix-processed ad hoc submissions (e.g., integrity files, ED LOS Adhoc) destined for HSCRC.
    - Production error reports for these submissions can be found under Tasks tab in DAVE(https://hscrcdave1.hmetrix.com)
    - **All files other than the Case Mix files require a naming convention**
- Testing Submissions (Case Mix & UCC)
  - For testing, select "Test/Sandbox File Submission".
  - Submit **Case Mix, Financial, and UCC** test data to the test directory.
  - Test environment error reports are available under “Review Test Error Reports” Tab.

Automated File Rejection Notifications

- hMetrix has automated the file rejection notification process to enhance turnaround times.
- Hospitals will now receive automated alerts from HSCRCTeam@hmetrix.com.
- Common Causes for Rejection:
  - **Naming Conventions:** Utilization of an incorrect file naming format.
  - **Submission Channel:** Transmitting files to DAVE instead of the designated HSCRC email address.
  - **Data Integrity:** Inclusion of empty lines within data or the absence of contiguous months.
  - **Metadata Errors:** Discrepancies between the report date specified in the filename and the internal metadata.
- The current automation efforts are focused on addressing naming conventions and submission channel errors.
- The system is scheduled for expansion in future updates to encompass all rejection categories.

Naming convention for Experience, FSA, and FSB data

January 1, 2026

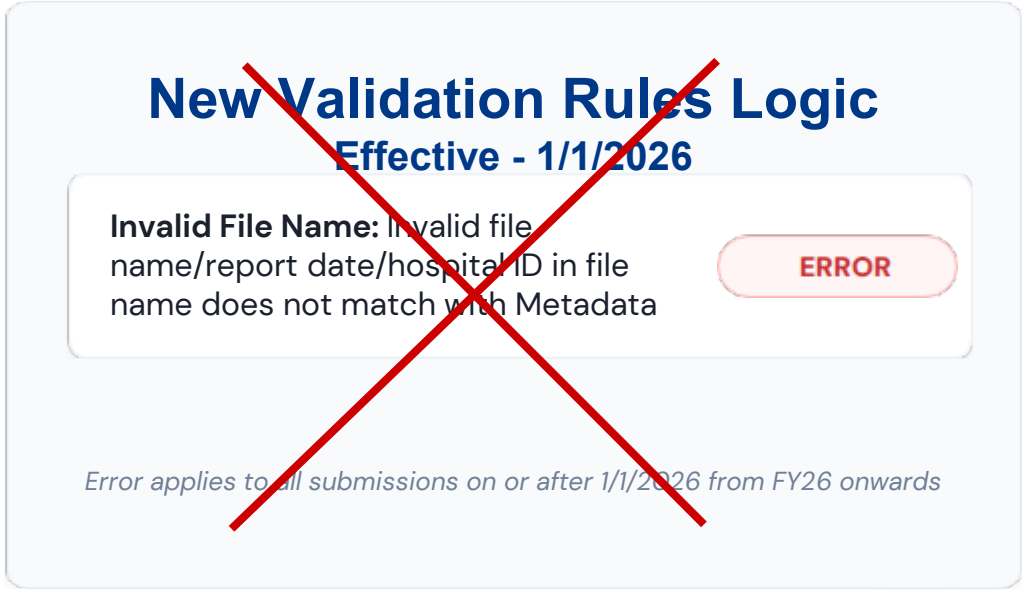
If the file name does not adhere to the recommended naming convention, or if the hospital ID or Report date in the file name is inconsistent with the Metadata tab, an error will be flagged.

March 12, 2026

Files will be rejected if the file name does not match the recommended naming convention, or if the hospital ID or Report date in the file name does not match the Metadata tab.

Naming Conventions

- Experience data: `[HospitalID]_Experience_[ReportDate].xlsx` OR `[HospitalID]_EXP_[ReportDate].xlsx`
- FSA data: `[HospitalID]_FSA_[ReportDate].xlsx`
- FSB data: `[HospitalID]_FSB_[ReportDate].xlsx`



maryland health services cost review commission

2-Factor Authentication

- **DAVE Platform Security Enhancement:** hMetrix is enhancing the DAVE platform login process to ensure the highest level of data protection and align with modern cybersecurity standards.
- **Current State:** User access is currently secured solely through username and password credentials.
- **New Security Layer:** 2-Factor Authentication (2FA) will be implemented to validate logins via email or SMS.
- **Implementation Timeline:**
  - Q2 2026: Issuance of a formal memorandum detailing specific implementation procedures.
  - Q3 2026: Full deployment of 2FA across the DAVE platform.

Reminders

- Rate Center Trend Monitoring Report
  - hMetrix added Rate Center Trend Monitoring Report to case Mix error report to help hospitals identify unusual Rate Center Charges and enable timely resolution of potential issues during submission from FY25 Q1 report
  - Thank you for all the feedback
- Financial Reconciliation Form
  - Download from DAVE 2 days after the Quarterly case-mix submission deadline
- EHR Survey Overdue Reminder
  - Use the DAVE “EHR Survey” tab to update EHR system information every 6 months
- DAVE User Management
  - Reach out to the hMetrix Team to add new users or modify access
  - A worksheet for each hospital/hospital system is maintained by hMetrix
  - Update and return the user workbook to modify access
- Change in Hospital Connection Option
  - hMetrix can now support both connection for hospital submission using SFTP and DAVE.
  - Reach out to hMetrix Team to change the choice of Hospital Connection method

Case Mix Audit Update

Case Mix Reminders

- July 1, 2024 variables
  - Emergency department arrival date and time
  - Emergency department departure date and time
  - Observation date and time
  - Inpatient arrival date and time

Emergency Department Duration

	Inpatient Cases						Outpatient Cases					
ED Departure Times	Hospital 1	Hospital 2	Hospital 3	Hospital 4	Hospital 5	Average	Hospital 1	Hospital 2	Hospital 3	Hospital 4	Hospital 5	Average
Departure within 2 hours	0%	4%	5%	0%	34%	**8%**	12%	5%	32%	13%	5%	**13%**
Departure 2 to 4 hours	3%	3%	5%	5%	3%	**4%**	25%	19%	24%	30%	33%	**26%**
Departure 4 to 6 hours	11%	9%	18%	18%	8%	**13%**	26%	28%	8%	15%	15%	**19%**
Departure 6 to 12 hours	47%	32%	48%	57%	28%	**43%**	25%	30%	8%	36%	28%	**27%**
Departure greater than 12 hours	39%	51%	22%	20%	27%	**32%**	12%	19%	27%	6%	20%	**15%**
Median ED Duration (Hours)	9.7	12.4	8.1	8.4	11.9	**9.8**	5.0	5.7	3.2	4.8	5.6	**5.1**
Mean ED Duration (Hours)	12.2	16.5	10.4	10.0	16.8	**13.1**	6.6	9.2	10.5	6.0	8.9	**8.0**
Observation Stays	19%	47%	36%	12%	23%	**27%**	35%	35%	19%	31%	35%	**32%**

National Provider Identifier Accuracy

	Attending Physician NPI						
Category	Hospital 1	Hospital 2	Hospital 3	Hospital 4	Hospital 5	Hospital 6	Average
Inpatient	95	99	100	79	100	100	96
Outpatient	100	100	100	99	100	53	92

	Operating Physician NPI						
Category	Hospital 1	Hospital 2	Hospital 3	Hospital 4	Hospital 5	Hospital 6	Average
Inpatient	99	97	100	91	100	100	98
Outpatient	100	100	99	100	100	-	100

Upcoming Standing Workgroup Meetings

AHEAD Model All-Payer TCOC Target Technical Advisory Committee Meeting

- **Objectives:** Implement statewide AHEAD Model accountability targets for all-payer cost growth and primary care investment, supported by a public advisory council formed by HSCRC, MHCC, and MIA.
- **Membership:** Open to the public
- **Next Meeting:** April 10, 2026
- **For more information:** https://hscrc.maryland.gov/Pages/ahead-model.aspx

Technical Workgroup for Insurance Denials

- **Objectives:** To define the essential data points and reporting elements for a standardized template to analyze denial trends across hospitals, and develop timeline for patient level data submissions by FY2027
- **Membership:** Open to all hospitals
- **Next Meeting:** TBD
- For more information please contact curtis.wills@maryland.gov

Payment Models Workgroup

- **Objective:** Develops recommendations for the HSCRC on the structure of payment models. This group focuses on balancing the approach to updates, addressing key topics such as Balanced Updates, Guardrails for Model Performance, Market Share, and Initial and Future Models.
- **Next Meeting:** April 1, 2026
- **For more information:** https://hscrc.maryland.gov/Pages/hscrc-workgroup-payment-models.aspx

Performance Measurement Workgroup

- **Objective:** Responsible for evaluating measurement methodologies and recommending optimal approaches to the HSCRC. The goal is to identify measures that are reliable, informative, and practical for assessing hospital quality and safety.
- **Subgroups to the Performance Measurement Workgroups**
  - Readmissions Subgroup to the PMWG
  - Quality Based Reimbursement (QBR) Program Redesign Subgroup to the PMWG
  - Emergency Department Length of Stay Measure Subgroup to the PMWG
- **Next Meeting:** For the meeting schedule and location, please contact: hscrc.performance@maryland.gov
- **For more information:** https://hscrc.maryland.gov/Pages/hscrc-workgroup-performance-measurement.aspx

Total Cost of Care Workgroup

- **Objective:** Provide technical feedback to HSCRC on the methodologies and calculations that underpin care transformation and total cost of care management activities.
- **Membership:** The HSCRC has appointed a diverse group of experts to serve on the Total Cost of Care workgroup. A comprehensive list of members can be accessed [here].
- **Next Meeting: March 25, 2026**
- **For more information:** https://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx

Volume Technical Subgroup

- **Objective:** Advise the Payment Models Workgroup on formalizing volume adjustment policies and developing a comprehensive volume scorecard.
- **Membership:** Includes HSCRC staff, policy analysts, and stakeholders with expertise in volume trends, data analysis, and payment methodologies.
- **Next Meeting:** TBD
- **For more information:** https://hscrc.maryland.gov/Pages/Volume-subgroup.aspx

Next Meeting

Notes and slides will be posted to the HSCRC website:

https://hscrc.maryland.gov/Pages/hsp_info1.aspx

Next Meeting
FY 2026 Q4
June 12, 2026

Join Zoom Meeting
https://us06web.zoom.us/j/4107642605?pwd=MmVwREVMbFFYUzlCeWpJcFFZYWF5UT09&omn=85973965350

For Meeting ID and Passcode please contact Curtis Wills: curtis.wills@maryland.gov

Appendix 1: Financial Reminders

Reminder: Datasets Submitted to DAVE Submission Folder for hMetrix Processing

Type of File	Frequency	Naming Convention
Case Mix IP, OP, PS	Monthly & Quarterly	*NA*
UCC	Quarterly	HospID_FYyyQy_UCC
Financial Experience Data	Monthly	HospID_EXP_MMDDYYYY
Financial FSA Data	Monthly	HospID_FSA_MMDDYYYY
Financial FSB Data	Quarterly	HospID_FSB_MMDDYYYY
Intern Resident Survey	Annual	HospID_GME_FYyy
Hospice	Quarterly	HospID_HOSPICE_FYyyQx
Outpatient Cosmetic Surgery	Quarterly	HospID_OPCOSM_FYyyQx
Integrity and Audit files	As Required	HospID_INTEGRITY_*
Audited Financial Statement PDF report	Annual	FYyy_Audited_Financial_HospitalSystemName
6/12 month Financial Projection*	Biannual	*NA*
9/12 month Financial Attestation *	Biannual	*NA*

*** Indicates that they are forms to be filled in DAVE**

Reminder: Reports Submitted to Delegated Mailboxes or HSCRC Website

Report Name	Frequency	Designated Mailbox / Website Portal
Debt Collection / Financial Assistance (DCFA)	Annually	hscrc.dcfa@maryland.gov
Credit and Collections Policy	Annually	hscrc.creditcollection@maryland.gov
Outpatient Service Survey	Annually	hscrc.opsurvey@maryland.gov
Special Audit Reports	Annually	hscrc.specialaudits@maryland.gov
Special Audit Report - By Report	Annually	hscrc.specialaudits@maryland.gov
IRS Form 990s	Annually	hscrc.form990@maryland.gov
Trustee Disclosure List of Trustees	Annually	https://www.doit.state.md.us/selectsurvey/TakeSurvey.aspx?SurveyID=l213l52#
Trustee Disclosure of Interest Statement	Annually	https://www.doit.state.md.us/selectsurvey/TakeSurvey.aspx?SurveyID=l213952#
Denials Reports	Quarterly	hscrc.denial-reports@maryland.gov
Reconciliation Reports	Quarterly	hscrc.reconciliation@maryland.gov

Reminder: Submitting Extensions for Financial and Supplemental Data

Process for submitted extensions for Financial and Supplemental Data that is **not submitted via DAVE:**

- Submitted in writing on hospital letterhead with **explanation** for extension and **noting each hospital and report** that will be delayed
- Made within a reasonable time, **before the due date**
- Addressed to the HSCRC Executive Director with copies to staff to ensure timely processing

Email Extension Requests to:

- Jon Kromm, Executive Director (jon.kromm@maryland.gov)
- Andrea Strong (andrea.strong@maryland.gov)
- Marcella Guccione (marcella.guccione@maryand.gov)
- Wayne Nelms (wayne.nelms2@maryland.gov)

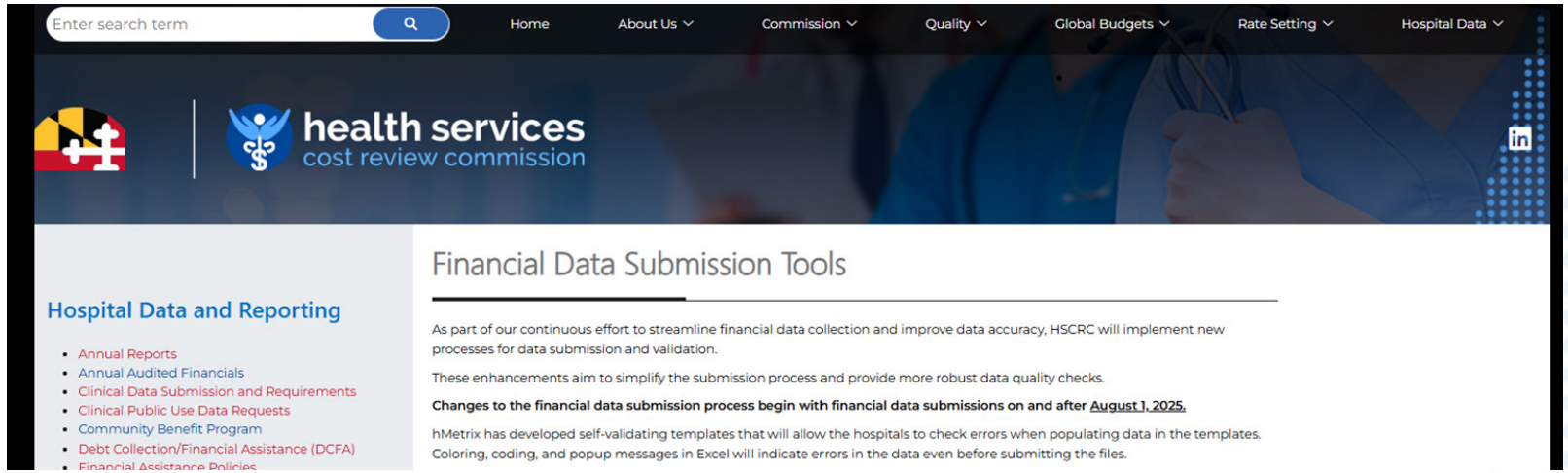
Submitting Extensions for Financial Data and Supplemental Data

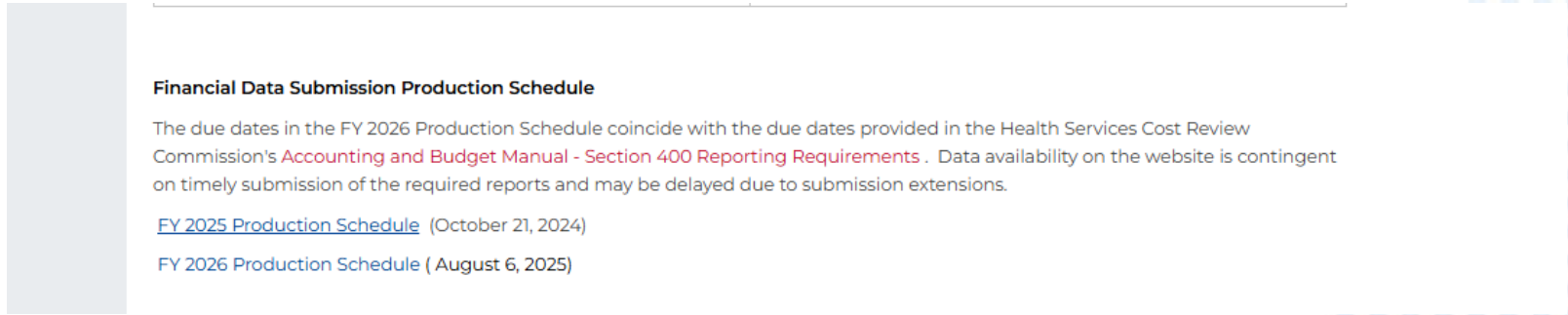
- Staff will review the extension request and respond (in writing) to the hospital indicating whether the request has been approved, and if the request is approved, the new due date (**typically 1 week**).
- **Submissions of late or significantly erroneous data** is subject to a fine and/or GBR adjustment of up to $1,000 per day.

Appendix 2a: Financial and Supplemental Data Production Schedule

Production Schedule for Financial and Supplemental Data Submissions

- Posted to the website on the Financial Data Submission Tools page: https://hscrc.maryland.gov/Pages/hsp_info2.aspx
- Financial Data availability on the website is contingent on timely submission of the required reports and are subject to change.





Appendix 2b: Process for Requesting Financial and Supplemental Data Extensions for Data **Not Submitted via DAVE**

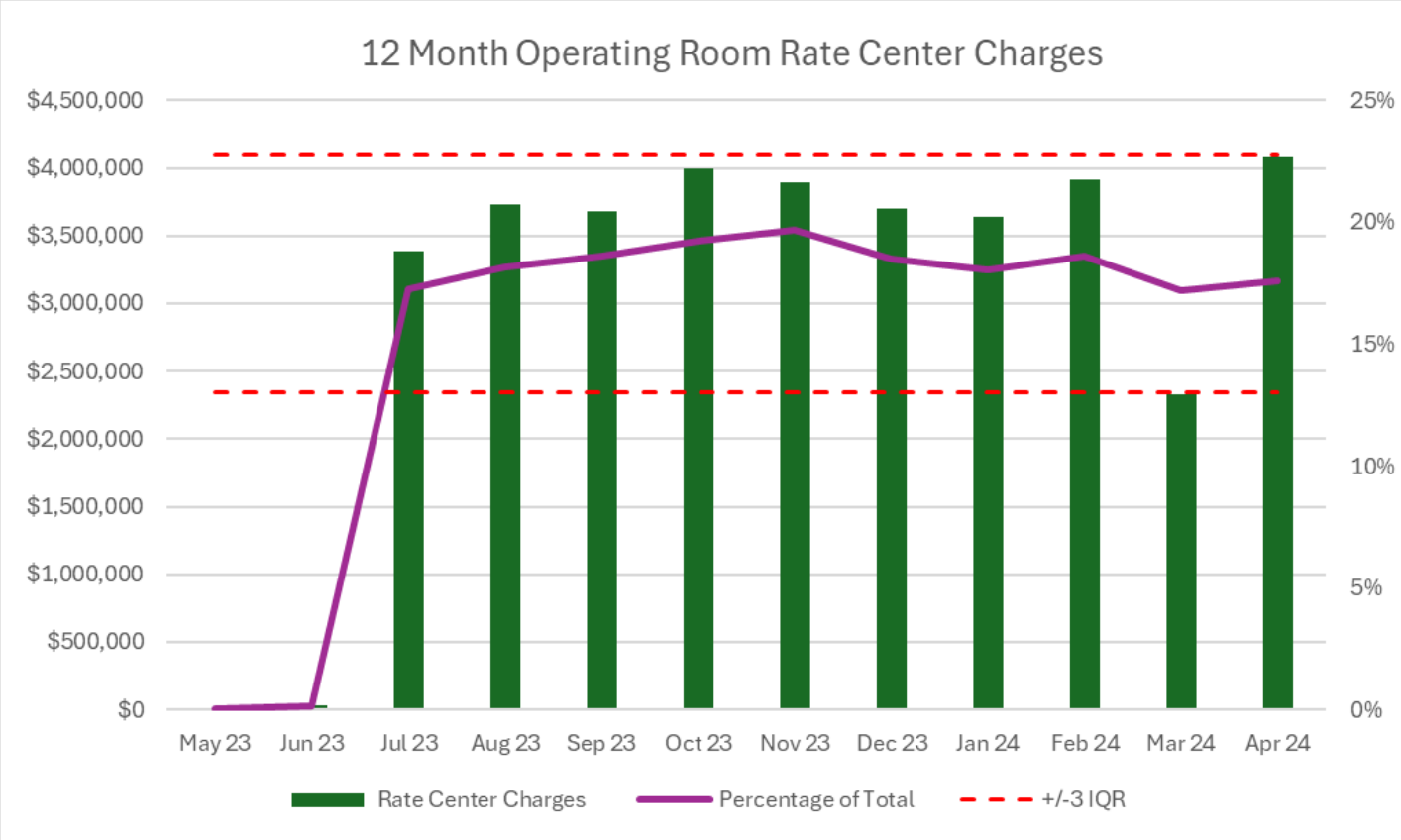
Appendix 3: Rate Center Trend Monitoring Report

Rate Center Trend Monitoring Report

- Objective
  - Help hospitals identify unusual Rate Center Charges
  - Enable timely resolution of potential issues during submission
- Reason
  - Several instances of delayed identification of incorrect Rate Center Charges
  - Resulted in an expensive and undesired reopening of a closed quarter for resubmission
- Timeline for implementation
  - FY25 Q1 Final (October 1, 2024) onward a monitoring tab has been added to the error report
  - Collect feedback via email in April 2025
  - FY25 Q4 refine identification of unusual Rate Center Charges
  - FY26 potential impact on error percentage

Total Charges & Rate Center Charges Outlier Identification

- Identify Significant Rate Center
  - The lookback period is 24 months
  - > 5% utilization for more than half of lookback period
- Outlier Identification
  - Total Visit and Charges
    - Current submission is outside +/- difference between 90th and 10th percentile
  - Rate Center Charges
    - Current submission is outside +/- 3 IQR
- Hospitals to review Outliers in
  - Current reported month



Monitoring Report Samples

- A new tab “Rate Center Summary” is added to the error report
  - Total visit count, total charges, total units, and all reported Rate center charges and units from the current and past 24 months are available for review
  - Outliers are flagged for the months reported in the file only
  - The outlier is determined by using the percent of charges or unit. The exception to this rule is if the hospital has at least one rate center that is >65% of total charges, the outlier is determined by using the value of reported charges or units.

Measure	Is Outlier?	202406	202405	202404	202403	202402-202308	202307
Total visit count	Yes	3,381	3,616	3,548	3,606	...	3,603
Total charges	No	$ 149,535,672	$ 168,731,364	$ 163,057,126	$ 162,261,622	...	$ 144,797,205
Total units	Yes	9,363,068	11,890,991	11,800,619	12,230,012	...	10,783,792
Rate Center for Neonatal ICU (NEO)- charge	NA	$ 2,538,767	$ 4,320,278	$ 4,272,632	$ 4,525,932	...	$ 2,946,247
% total charges for Rate Center for Neonatal ICU (NEO)	NA	1.70%	2.56%	2.62%	2.79%	...	2.03%
Rate Center for Drugs (CDS)- charge	NA	$ 11,057,032	$ 11,907,135	$ 11,334,764	$ 13,677,973	...	$ 10,392,932
% total charges for Rate Center for Drugs (CDS)	No	7.39%	7.06%	6.95%	8.43%	...	7.18%
Rate Center for Drugs (CDS)- units	NA	2,724,356	3,412,462	3,820,040	4,226,131	...	3,480,831
% total units for Rate Center for Drugs (CDS)	Yes	29.10%	30.70%	32.37%	34.56%	...	32.28%

Data Received | Errors for Data Received | Warnings for Data Received | Data Fields | Total Revenue | Revenue By UB Revenue Code | Rate Center Summary | Percent Er

Appendix 4: UCC Reporting

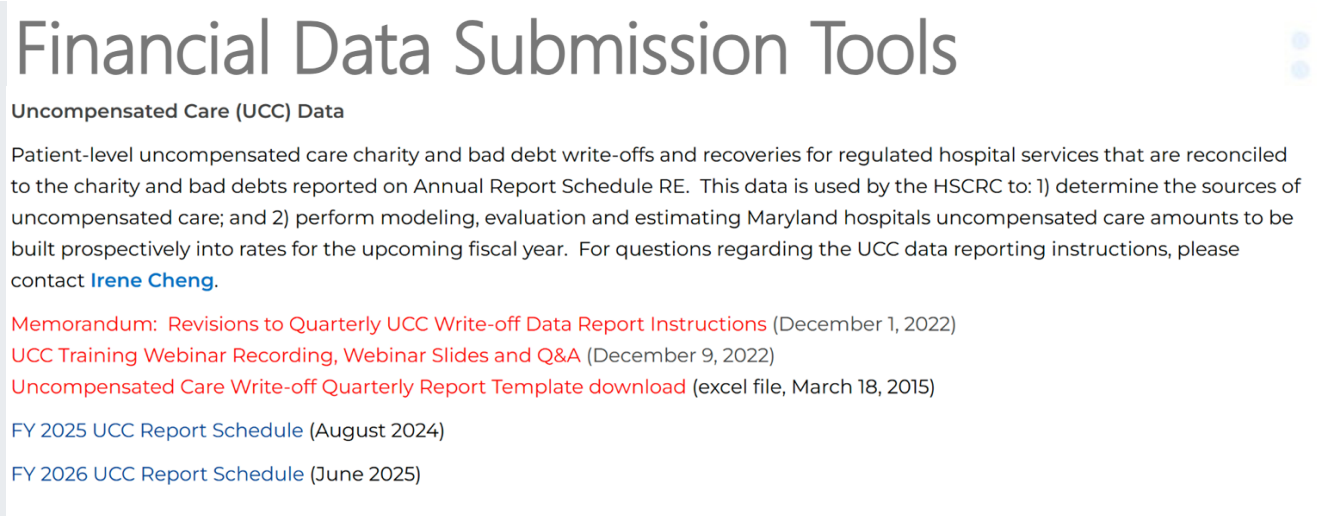
UCC Data Collection and Processing

- FY26Q2 Data Submission: 55 reports received, 1 pending
- FY26Q3 Data Submission: **Apr 16 – Jun 01, 2026**

FY26 UCC report submission schedule is posted on the HSCRC Financial Data Submission Tools web page.

Hospital Data and Reporting

- Annual Reports
- Annual Audited Financials
- Clinical Data Submission and Requirements
- Clinical Public Use Data Requests
- Community Benefit Program
- Debt Collection/Financial Assistance (DCFA)
- Financial Assistance Policies
- Financial Data
- Financial Data Submission Tools
- Hospital Credit and Collection Policies
- Hospital IRS 990 Forms
- Nurse Support Programs I & II
- Outpatient Services Survey Results
- Special Audit Exceptions



Financial Data Submission Tools

Uncompensated Care (UCC) Data

Patient-level uncompensated care charity and bad debt write-offs and recoveries for regulated hospital services that are reconciled to the charity and bad debts reported on Annual Report Schedule RE. This data is used by the HSCRC to: 1) determine the sources of uncompensated care; and 2) perform modeling, evaluation and estimating Maryland hospitals uncompensated care amounts to be built prospectively into rates for the upcoming fiscal year. For questions regarding the UCC data reporting instructions, please contact Irene Cheng.

Memorandum: Revisions to Quarterly UCC Write-off Data Report Instructions (December 1, 2022)
UCC Training Webinar Recording, Webinar Slides and Q&A (December 9, 2022)
Uncompensated Care Write-off Quarterly Report Template download (excel file, March 18, 2015)

FY 2025 UCC Report Schedule (August 2024)

FY 2026 UCC Report Schedule (June 2025)

UCC DSR and Edit Report Updates for FY 2026 Q2

- UCC Data Edit Summary:
  - 45 reports have < 1% error
  - 5 reports have 1 - 1.99% error
  - 4 reports have 2 - 2.99% error
  - 1 reports with > 3% error rate had data validated and was manually passed
  - 1 reports to be submitted

UCC Data: Notable Errors Observed in FY26Q2 Data Submission

Error	Notes	Percent of Records with Errors
Invalid or missing billed amount	This information might be unavailable for accounts that are old or transferred from another system	0.026% of write-off records from 14 report files
Missing service date	Date should not be left blank	< 0.01% of write-off records
Missing expected payer	Text (e.g., n/a, unknown) is not valid; use code 99 if unknown	< 0.01% of write-off records
UCC account with service date within the past 8 quarters not found in Case Mix tapes	This may happen if UCC write-off reported before discharge (**not an error but report timing differences**), old account reported with incorrect service date, non-regulated patient account that are not required to be reported, etc.	0.24% of write-off records (excluding psych hospitals)
Mismatched UCC service date outside of the range of one day prior to Case Mix admission/from date and discharge/through date by 1 day, 2 - 30 days or > 30 days	This may happen if either the service date reported for UCC record or the service date reported in case mix is incorrect	0.19% of write-off records.

Points of Contact: UCC Data

HSCRC	hMetrix
Irene Cheng Email: Irene.Cheng@maryland.gov	**DAVE Technical Support** Email: hscrcteam@hmetrix.com
For questions regarding: • Revised UCC reporting instructions • UCC data edit rules • UCC data quality • Request report submission extension before due date (via DAVE) • Request report data pass if error rate > 3% (via DAVE) • Request report submission window be reopened to submit past due report (via DAVE)	For questions regarding: • Access to edit reports and notification e-mail • Filling the requests via DAVE

Appendix 5: Financial Methodology Grouper Versions

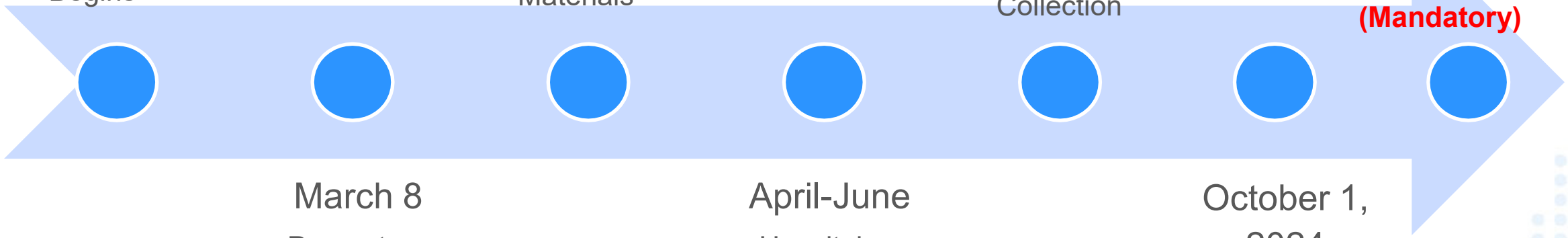
Grouper Transition: Case Mix Weights and Reports

Rate Year	RY 2027
Solventum APR/EAPG Version*	**IP Weights:** 41 **OP Weights:** 3.18
Data Period Used for Weight Development	**IP:** CY 2023 (12 Months) **OP:** CY 2023 and Q1 of CY 2024 (15 Months)
Weight Release Date	**Second Quarter CY 2025**
Policies Applicable To	CY 2025 12-Month Marketshift 2026 Demographic Report

*The Solventum™ All Patient Refined DRG (APR DRG) Software and Solventum™ Potentially Preventable Complications (PPC) Software are proprietary products of Solventum Health Information Systems.

Appendix 6: SOGI Data Collection Timeline

SOGI Data Collection Implementation Timeline (2024-2025)



February 1

- SOGI Training Contract Begins

March 8

- Present Proposed SOGI Variables at Data Forum

March-April

- Finalize SOGI Variables and Training Materials

April-June

- Hospital Staff Training

August 1
(FY25 Q1)

- Begin Testing Period for SOGI Data Collection

October 1, 2024
(FY25 Q2)

- SOGI Variables in Production **(Optional)**

October 1, 2025
(FY26 Q2)

- SOGI Variables in Production for discharges beginning 7/1 **(Mandatory)**

maryland health services cost review commission

Appendix 7: Quality Methodology Update

Grouper Transition: MHAC, RRIP, QBR for **CY 2025**

Rate Year	RY2027
***3M/Solventum APR/PPC Grouper Version**	42 *(Updated from version 41 to incorporate annual 3M updates)*
Timeline	**Base Year:** • **MHAC:** CY 2021 Q1 – CY 2022 Q4 • **RRIP:** Two-year base period of CY 2022 and CY 2023 • **QBR IP and 30-Day Mortality, PSI-90, TFU:** CY 2023 Q3 – CY 2024 Q2 (FY 2024) • **QBR HCAHPS, CDC NHSN measures:** CY 2023 **Performance Year:** • **QBR HCAHPS, CDC NHSN measures:** CY 2024 Q4- CY 2025 Q3 • **All Other Measures:** CY 2025 *(CY 2024-2025 for MHAC small hospitals)*
Implementation Date	RY 2027 policies begin Jan 1, 2025 in most cases. Look for base and performance period reports on the CRS Portal.

*The Solventum™ All Patient Refined DRG (APR DRG) Software and Solventum™ Potentially Preventable Complications (PPC) Software are proprietary products of Solventum Health Information Systems.

Potentially Preventable Complication Measures

List of 16 clinically significant PPC included in payment program.

3- Acute Pulmonary Edema & Respiratory Failure w/o Ventilation	4- Acute Pulmonary Edema & Respiratory Failure w/ Ventilation	5- Pneumonia & Other Lung Infections	6- Aspiration Pneumonia
7- Pulmonary Embolism	9- Shock	16- Venous Thrombosis	28- In-Hospital Trauma/ Fractures*
35- Septicemia & Severe Infections	37- Postoperative Infection w/o Procedure*	41- Postoperative Hemorrhage/Hematoma w/ Procedure or I&D*	42- Accidental Puncture/ Laceration w/ Invasive Procedure*
47- Encephalopathy	49- Iatrogenic Pneumothorax*	60- Major Puerperal Infection & Other Major OB Complications	61- Other Complications of OB Wounds

Exclusions:

- Palliative care (PC) most PPCs (exceptions- PC NOT excluded*)
- Discharges with >6 PPCs
- APR-DRG SOI cells <31 at-risk discharges in the base
- Hospital Specific: PPCs with 0 at-risk during performance

Case-Mix Adjustment and Standardized Scores

Performance Measure: CY 2025* PPC Composite Measure

Formula to calculate composite:

$$PPC\ Composite_j = \frac{\left(\sum_{i=1}^{16} ObservedPPC_{ij} * SolventumCostWeight_i\right)}{\left(\sum_{i=1}^{16} ExpectedPPC_{ij} * SolventumCostWeight_i\right)}$$

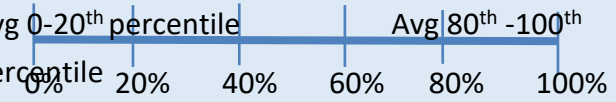
Solventum cost weights used as proxy for patient harm. Expected PPCs calculated by applying statewide average PPC rate by APR-DRG SOI cell (norms) from base to hospitals' patient mix in performance period

MHAC Score (0-100%) calculated by comparing hospital performance to a statewide threshold and benchmark.

MHAC Score

Threshold

Benchmark



July 22- June 24 used to calculate statewide averages (norms) and threshold/benchmark.

***Small hospitals will be assessed on CYs 24 & 25**

Hospital MHAC Score & Revenue Adjustments

Hospital MHAC Score (0-100%) is compared to a present revenue adjustment scale.

Cut point for rewards/penalties is average MHAC score based on historical modeling. This cut point will be reassessed and updated if the performance period average MHAC score varies by more than 10 percentage points.

Max Penalty -2% & Reward +2%

MHAC Score	Inpatient Revenue Adjustment
0%	-2.00%
10%	-1.76%
20%	-1.52%
30%	-1.29%
40%	-1.05%
50%	-0.81%
60%	-0.57%
70%	-0.33%
80%	-0.10%
84%	0.00%
90%	0.75%
100%	2.00%

RRIP- RY 2027

30-day, All-Cause Readmission Measure

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

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

Global Exclusions:

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

Case-Mix Adjustment

Performance Measure: CY 2025 Case-Mix Adjusted Rate Adjusted for Out-of-State Readmissions (Attainment); Reduction in Case-Mix Adjusted Readmission Rate from Base Period (Improvement)

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

Observed Unplanned Readmissions/ Expected Unplanned Readmissions * Statewide Readmission Rate

CY 2022/23 used to calculated statewide averages (normative values), as well as attainment benchmark/threshold

Revenue Adjustments

Hospital RRIP revenue adjustments are based on the better of attainment or improvement, scaled between the max reward (+2%) and max penalty (-2%) of IP revenue.

All Payer Readmission Rate CY25		RRIP % Inpatient Revenue
Lower Readmission Rate		2.00%
Benchmark	8.83%	2.00%
	10.04%	1.00%
Threshold	11.25%	0.00%
	12.46%	-1.00%
	13.67%	-2.00%
Higher Readmission Rate		-2.00%

Attainment Scale

All Payer Readmission Rate Change CY22/23-25		RRIP % IP Revenue Payment Adjustment
Improving		2.00%
Benchmark	-21.04%	2.00%
	-12.41%	1.00%
Target	-3.78%	0.00%
	4.85%	-1.00%
	13.48%	-2.00%
Worsening		-2.00%

Improvement Scale

Patient Adversity Index (PAI)

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

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

Within Hospital Disparity Gap

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

- Age
- Gender
- APR-DRG readmission risk

Disparity Gap Revenue Adjustments

Reward only, scaled from 0.25-0.50%:

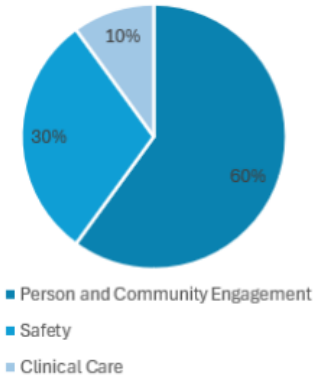
Disparity Gap Change CY 2018-2024	RRIP % Inpatient Rev.
On pace for 50% Reduction Gap in 8 Years	0.25%
On pace for 75% Reduction Gap in 8 Years	0.50%

RRIP Disparity Reduction RY 2027

Overview of QBR Methodology: Converting Performance to Reward and Penalty Scale

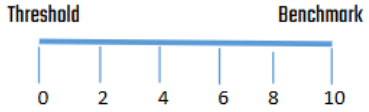
Performance Measures → **Standardized Measure Scores** → **Hospital QBR Score & Revenue Adjustments**

Domain and Measures:
Person and Community Engagement–
-HCAHPS: 6 top box measures, 3 linear measures, 1 consistency measure
-Timely Follow Up (TFU): Medicare, Medicaid & Disparity Gap
-ED Length of Stay, admitted patients
Safety— 6 Measures:
-5 CDC NHSN HAI Categories;
-AHRQ PSI 90 All-payer
Clinical Care–
-Mortality: Inpatient All-Payer, 30-day All-payer

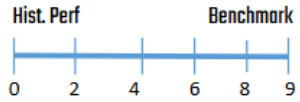


Individual Measures are Converted to 0-10 Points:

Points for Attainment Compare Performance to a National Threshold (median) and Benchmark (average of top 10%)



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



Final Points are Better of Improvement or Attainment

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

Scale Ranges from 0-80%

Max Penalty 2% & Reward +2% (All hospitals have an opportunity to earn a reward; not net neutral)

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%**

Cut point is reassessed retroactively; RY25 cut point was reduced to 32%

HSCRC Digital Measures Reporting Requirements 2025: Electronic Clinical Quality Measures (eCQMs)

Title	Short Name	CMS eCQM ID	CBE* #	2024	2025	HSCRC
Anticoagulation Therapy for Atrial Fibrillation/Flutter	STK-3	CMS71v13	N/A	X	X	Self-Selected
Antithrombotic Therapy By End of Hospital Day 2	STK-5	CMS72v12	N/A	X	X	Self-Selected
Cesarean Birth	PC-02	CMS334v5	0471e	X	X	Required
Discharged on Antithrombotic Therapy	STK-2	CMS104v12	N/A	X	X	Self-Selected
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Facility IQR)	IP-ExRad	CMS1074v2	3663e		X	Self-Selected
Global Malnutrition Composite Score	GMCS	CMS986v2	3592e	X	X	Self-Selected
Hospital Harm - Acute Kidney Injury	HH-AKI	CMS832v2	3713e		X	Self-Selected
Hospital Harm - Opioid-Related Adverse Events	HH-ORAE	CMS819v2	3501e	X	X	Self-Selected
Hospital Harm - Pressure Injury	HH-PI	CMS826v2	3498e		X	Self-Selected
Hospital Harm - Severe Hyperglycemia	HH-Hyper	CMS871v3	3533e	X	X	Required
Hospital Harm - Severe Hypoglycemia	HH-Hypo	CMS816v3	3503e	X	X	Required
ICU Venous Thromboembolism Prophylaxis	VTE-2	CMS190v12	N/A	X	X	Self-Selected
Safe Use of Opioids - Concurrent Prescribing	Safe use of opioids	CMS506v6	3316e	X	X	Required
Severe Obstetric Complications	PC-07	CMS1028v2	N/A	X	X	Required
Venous Thromboembolism Prophylaxis	VTE-1	CMS108v12	N/A	X	X	Self-Selected

Appendix 8: Case Mix Review Update

CY 2023 Summary of Each Hospital's Overall Accuracy

	Hospital												AT				
Summary Category	#51	#52	#53	#54	#55	#56	#57	#58	#59	#60	#61	#62	50th	75th	90th	SO	PB
Overall	76	77	91	85	58	87	85	82	72	52	91	90	84	89	91	82	95
Inpatient	91	77	96	92	73	89	88	86	69	63	91	95	89	92	96	84	95
Outpatient	63	78	87	80	46	86	82	79	74	43	92	85	80	86	91	79	95

CY 2023 Hospital Inpatient Data Abstract Performance

	Hospital												AT				
Inpatient Category	#51	#52	#53	#54	#55	#56	#57	#58	#59	#60	#61	#62	50th	75th	90th	SO	PB
1 Overarching	90	77	97	87	77	92	87	87	70	73	97	97	87	96	97	85	95
2 Infreq HR APR-DRGs	81	50	95	91	64	100	80	95	57	68	90	95	86	95	99	78	95
3 HR Surg APR-DRGs	86	67	100	95	86	93	90	95	52	38	95	100	92	95	100	75	95
4 HR Non-Resp APR-DRGs	95	79	95	100	77	87	90	75	75	81	95	95	89	95	99	86	95
5 HR Resp APR-DRGs	90	86	95	95	71	90	90	85	90	67	95	90	90	94	95	86	95
6 Coding Issues	95	79	90	95	71	83	85	65	65	62	85	100	84	94	99	82	95
7 Targeted PPCs	94	0	100	100	70	100	90	100	61	67	83	100	92	100	100	66	95
8 Palliative Care	90	72	100	77	67	79	85	70	70	57	85	95	78	89	99	82	95
11 Disposition	100	90	90	91	81	79	100	95	75	57	85	85	88	94	100	83	95

CY 2023 Outpatient Data Abstract Review Performance

	Hospital												AT				
Outpatient Category	#51	#52	#53	#54	#55	#56	#57	#58	#59	#60	#61	#62	50th	75th	90th	SO	PB
1 OA Ambulatory Surg	100	95	100	100	100	100	90	96	100	100	100	100	100	100	100	92	95
2 OA Observation	32	50	90	90	4	95	50	96	75	26	100	100	83	96	100	61	95
3 OA Emergency Dept	63	80	100	100	0	100	90	100	95	12	100	95	95	100	100	60	95
4 OA Clinic/Other	65	100	100	100	75	100	90	95	95	100	100	100	100	100	100	83	95
5 Drugs	65	100	100	100	10	100	100	100	95	30	100	100	100	100	100	63	95
7 Excision Lesions	70	70	75	70	65	60	65	25	30	50	65	60	65	70	74	79	95
9 Other Charging	75	90	100	100	0	100	100	95	75	55	100	100	98	100	100	65	95
10 Diabetes	95	95	95	100	50	95	100	100	100	35	95	100	95	100	100	73	95
11 Wound Care	100	80	90	60	70	50	80	65	70	6	75	85	73	84	97	71	95
12 Infusion	20	95	95	50	80	40	95	40	70	50	85	95	75	95	95	68	95
15 Emergency Dept Observation	6	25	5	5	64	95	30	11	0	0	90	0	9	56	94	60	95

CY 2023 Emergency Department Wait Times

	Inpatient Cases (n = 1,717)		Outpatient Cases (n = 1,255)	
ED Departure Times	Cases	Percent	Cases	Percent
Departure within 2 hours	50	3%	102	8%
Departure 2 to 4 hours	100	6%	189	15%
Departure 4 to 6 hours	127	7%	207	16%
Departure 6 to 12 hours	668	39%	392	31%
Departure greater than 12 hours	707	41%	335	27%
ED Departure Time Missing	76	4%	8	1%
Discharge before noon (departure time known)	578	34%	454	36%

CY 2024 Upcoming Reviews

- HSCRC will notify facilities by mid-September 2025
- Reviews will begin in October 2025

Appendix 9: New 42 CFR Suppression Policy for Public Use Files

Reminder: New 42 CFR Suppression Policy for Public Use Files

- Date Effective: Beginning September 2, 2025
- Platform: CRS Portal and PUF Data requests
- Data Impacted: Inpatient and Outpatient, CY 2016 and onwards

Key Policy Changes		
Method	**Diagnosis Code-Based Flagging:**	**Procedure Code-Based Flagging:**
Old	**Visit flagged as 42 CFR only if Primary Diagnosis was 42 CFR**	**Visit flagged as 42 CFR if any one procedure code was 42 CFR.**
New	**Visit flagged as 42 CFR if ANY diagnosis is 42 CFR.**	**Visit flagged as 42 CFR only if ALL procedure codes are 42 CFR.**

% of Total Records Identified as 42 CFR (January 2016- May 2025)		
Data Type	**Old Method**	**New Method**
IP	**2.17%**	**12.72%**
OP	**0.69%**	**1.32%**

Appendix 10: FY 2026 SOGI Data Collection Update

Reminder: FY 2026 SOGI Data Collection Update

📌 Background

- New data items was added to improve Sexual Orientation and Gender Identity (SOGI) reporting:
  - 546 – Gender Identity
  - 547 – Sexual Orientation
  - 548 – Sex Assigned at Birth

🆕 New Reporting Code Option - “Unable to obtain from the patient”

- Gender Identity: Code “9”
- Sexual Orientation: Code “11”
- Sex Assigned at Birth: Code “6”
- These codes are used when the patient is clinically or cognitively unable to self-report (e.g., patient is unconscious, mental health crisis, emergency situations).

Reminder: FY 2026 SOGI Data Collection Update

Scenario	System Behavior
✅ Valid SOGI value entered	No error
❌ Invalid value entered	Error: "If value is reported and is invalid"
❌ No value for patient 18+	Error: "If value is not reported and age is 18 years or older"
✅ Code used appropriately	No error

✅ Staff Action Items

- Use “Unable to obtain” codes only when appropriate.
- Ensure patients 18+ have a valid SOGI entry or a valid exception code.
- Train staff on:
  - When to use each code
  - Avoiding invalid entries
- Monitor for recurring errors and escalate as needed.

Reminder: FY 2026 DSR Implementation Timeline

Test/Sandbox (Test folder)

August 1, 2025, Onwards

- **FY 2026** DSR
- **FY 2026** Lookup rules
- With July Discharges

Production (Submit Folder)

Aug 2025

- **FY 2025** DSR
- FY26 Jul Monthly and Jul – Aug Monthly

Oct 1, 2025

- **FY2026** DSR with mandatory **SOGI** variables
- FY 26 Q1 (Jul – Sep Monthly) Onwards