maryland
health services
cost review commission

639th Meeting of the Health Services Cost Review Commission

February 11, 2026

(The Commission will begin in public session at 12:00 pm for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 pm)

CLOSED SESSION
12:00 pm

1. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on January 14, 2026

Specific Matters

For the purpose of public notice, here is the docket status.

Docket Status – Cases Closed

2685A Johns Hopkins Health System
2686A Johns Hopkins Health System-WITHDRAWN

2. Docket Status – Cases Open

2687A Johns Hopkins Health System
2688A Johns Hopkins Health System
2689N Lumini Health Doctors Community Medical Center
2690A Johns Hopkins Health System
2691A Johns Hopkins Health System
2692A Johns Hopkins Health System
2693A Johns Hopkins Health System

3. Final Recommendation: Request to Access HSCRC Confidential Patient Level Data from Johns Hopkins Bloomberg School of Public Health in Assessing the Health Impacts of Guaranteed Income in Maryland

Informational Session

4. Presentation from Maryland Community Health Resources Commission

Subjects of General Applicability

5. Report from the Executive Director
    a. Model Monitoring
    b. Policy Calendar Update
    c. Inpatient Length of Stay Presentation
    d. Health System Transformation Discussion
    e. Legislative Report

6. Final Recommendation: MHAC - RY 2028

7. Hearing and Meeting Schedule

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AMENDED MINUTES OF THE 638th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION JANUARY 14, 2026

Chairman Joshua Sharfstein called the public meeting to order at 12:00 p.m. In addition to Chairman Sharfstein, also in attendance were Vice Chairman James Elliott, M.D., Jon Blum, M.P.P., David Maine, M.D., Nicki McCann, J.D., Ricardo Johnson, J.D., and Farzaneh Sabi, M.D. Upon motion made by Commissioner McCann and seconded by Commissioner Blum, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 1:10 p.m.

ANNOUNCEMENT

Chairman Sharfstein announced the resignation of Commissioner Joshi after four years of service, specifically praising his leadership on initiatives regarding emergency department wait times. In his place, the Commission welcomed Dr. David Maine, CEO of Mercy Health Services. Dr. Maine continues a long tradition of Mercy leadership serving on the HSCRC Board. Chairman Sharfstein formally introduced Commissioner Maine and invited him to share his vision for the role.

Commissioner Maine expressed his gratitude to the Governor and the Commission. Highlighting his 18-year tenure at Mercy Health Services and his perspective as a practicing physician, he emphasized that Maryland stands at a pivotal moment with the transition to the AHEAD model. He view this as an opportunity to build upon the state's legacy of healthcare innovation while prioritizing access, stability, and value.

REPORT OF JANUARY 14, 2026, CLOSED SESSION

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed during the January 14, 2026, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM DECEMBER 10, 2025, PUBLIC MEETING AND CLOSED SESSION

Upon motion made by Commissioner Blum and seconded by Commissioner Johnson, the Commission voted unanimously to approve the minutes of the December 10, 2025, Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
CLOSED CASES

2683A Johns Hopkins Health System

2684A University of Maryland Medical Center

ITEM III
OPEN CASE

2685A Johns Hopkins Health System
2686A Johns Hopkins Health System-WITHDRAWN
2687A Johns Hopkins Health System
2688A Johns Hopkins Health System
2689N Luminis Health Doctors Community Medical Center

ITEM IV
PRESENTATION: MDH SECRETARY MEENA SESHAMANI-COMMENTS ON AHEAD MODEL AND MULTI-AGENCY WORK

Secretary Meena Seshamani's update on the AHEAD model transition emphasized a multi-agency strategy to manage the increased federal savings requirements while maintaining market stability. The new agreement with CMS requires Maryland to achieve significantly higher Medicare savings than the previous model, creating a ripple effect of financial pressure across the healthcare ecosystem. To mitigate financial pressure, the Governor established a multi-agency workgroup to coordinate policy and ensure the burden is shared across the healthcare ecosystem.

The first major policy pillar addressed by the Secretary is Medicare cost-shifting, a strategy designed to offset the reduction in federal reimbursement. Under the approved recommendation, Maryland will shift $435 million to commercial rates over a seven-year period, effectively covering about half of the projected savings requirement. This shift will be phased in starting in 2028 at a rate of $87 million per year, which is estimated to increase commercial hospital rates by approximately 1.8 percent by 2032. This approach aims to preserve hospital solvency while keeping commercial rate growth predictable for businesses and families.

In tandem with cost-shifting, Secretary Seshamani highlighted the Medicare Advantage (MA) Stabilization Plan, which addresses the growing risk of insurance carriers leaving the Maryland market. The policy utilizes the HSCRC's rate-setting authority to provide Qualified Plans with an 11.55 percent discount on hospital rates (a public payer differential). This financial incentive is intended to lower the cost of doing business for MA plans in Maryland, encouraging them to maintain robust coverage options and supplemental benefits for seniors, particularly in underserved regions.

To ensure accountability, the Secretary explained that eligibility for this rate relief is tied to specific quality and access metrics. Eligible plans must meet CMS Star Rating thresholds and serve a significant portion of beneficiaries in counties with high social and medical risks. By aligning these two policies – cost-shifting to stabilize hospital revenue and MA discounts to preserve insurance competition – the state aims to navigate the AHEAD model's rigorous savings targets without compromising the quality of care or the long-term sustainability of Maryland's unique "all-payer" system.

Chairman Sharfstein asked Secretary Seshamani to elaborate on her long-term vision for the AHEAD model, specifically focusing on the tangible benefits it is expected to deliver to the people of Maryland. Secretary Seshamani framed the AHEAD model as a vital tool within the Moore-Miller administration's broader mission to build a "world-class health system." She emphasized that the model's ultimate success will be measured by its ability to improve affordability, expand access to care, and directly address healthcare disparities across the state. By leveraging the model to make strategic investments in primary care, the state aims to pivot toward a more proactive system that keeps residents healthy and out of the hospital, rather than simply treating them once they are ill.

In addition to primary care, the Secretary highlighted the role of innovation and technology in tackling systemic challenges like emergency department wait times and hospital lengths of stay. She referenced her previous work with Care Transformation Initiatives to illustrate how the state can support providers in developing smarter ways to spend healthcare dollars while achieving better clinical outcomes. Ultimately, she envisions a collaborative partnership between state agencies, healthcare providers, and the federal government to ensure that Maryland remains a national leader in healthcare delivery and health equity.

Commissioner Blum asked Secretary Seshamani and Executive Director John Kromm about the benchmarks for evaluating the success of the new policy recommendations, specifically, what metrics would be utilized to determine if the $435 million Medicare cost-shift is the appropriate long-term strategy for the state. Additionally, he sought clarity on how the Commission will measure the effectiveness of the Medicare Advantage stabilization plan in supporting insurers and beneficiaries. Secretary Seshamani acknowledged that monitoring the impact of both the cost-shifting and Medicare Advantage policies is a critical component of the workgroup's formal recommendations. She noted that the state must continuously evaluate these measures to ensure they are functioning as intended while maintaining overall system stability. Additionally, she highlighted that the state is looking beyond hospital rates to explore how value-based payment frameworks can be expanded to better support physicians and other clinicians.

Dr. Kromm responded that the Commission is committed to developing a formal set of key metrics to ensure the AHEAD model aligns with the vision of a world-class health system. He noted that while these metrics must be vetted by stakeholders and will likely evolve over time, the primary focus will remain on tracking improvements in healthcare access and managed affordability. He noted that the multi-agency workgroup will be responsible for monitoring these complex outcomes throughout the year and reporting their findings back to the public and the Commission.

Secretary Seshamani expressed her appreciation for the Commission's partnership and recognized the complex work involved in balancing diverse stakeholder inputs while navigating the transition to the AHEAD model. She acknowledged that while the new model is a major priority, it represents only one part of the HSCRC's ambitious broader agenda to improve healthcare throughout Maryland. Closing on a note of collaboration, she reaffirmed that the Department of Health and the Commission remain deeply intertwined and committed to working together to enhance the quality of care for all Marylanders.

No action was taken on these agenda items.

ITEM V
FINAL RECOMMENDATION: GOVERNOR'S DIRECTIVE

AMENDED MINUTES:

Commissioners Maine and McCann recused themselves from the discussion and vote pertaining to the Medicare Advantage portion of the Governor's December 2025 Directive. Both Commissioners participated in the discussion portion of the meeting concerning the commercial payer reimbursement portion of the Directive.

Chairman Sharfstein outlined the structured approach for the deliberation on the staff's Final Recommendation: Multi-Agency Regulatory Working Group Proposal (see "Final Recommendation: Multi-Agency Regulatory Working Group Proposal" available on the HSCRC website), stating that the Commission would divide the session into two distinct sections, beginning first with a focused examination of the Medicare cost-shift plan.

Dr. Jon Kromm, Executive Director, began by detailing the collaborative process used to develop the cost-shift proposal, which involved a series of open listening sessions and a multi-agency workgroup. This process gathered input from a diverse range of stakeholders beyond the typical HSCRC community, ensuring that various perspectives were considered. After gathering feedback, a draft was refined and reviewed with Governor Moore before being finalized as the policy recommendation presented to the Commission.

The technical core of the proposal involves using the annual Update Factor to increase commercial payer hospital rates by approximately $87 million per year starting in Fiscal Year 2028. This phased-in approach continues through 2032, resulting in a cumulative total of $435 million being maintained in the rate system. By the end of this period, the total impact is projected to be roughly a 1.8 percent adjustment on commercial insurance premiums.

This $435 million target was strategically chosen because it represents approximately half of the anticipated federal Medicare fee-for-service savings expectations, while also accounting for equivalent impacts on Medicare Advantage and Medicaid. By shifting these costs to the commercial market, the state aims to offset the reduction in federal funding and maintain the financial solvency of Maryland's hospitals as they transition to the AHEAD model.

Dr. Kromm clarified that while the Governor has provided the high-level policy directive, the responsibility now falls to the HSCRC to develop the specific methodology for execution. This includes creating the technical framework for the annual Update Factor adjustments and establishing metrics to monitor the policy's impact.

Commissioner Maine raised a technical concern regarding the potential for the absolute Medicare savings requirements to increase if the United States Per Capita Cost (USPCC) trends higher than currently projected. He sought clarification on whether the policy's core intent is to maintain a fixed 50 percent cost-sharing responsibility between the state and the commercial market, or if the $435 million figure is a hard cap, emphasizing the importance of

understanding if the commercial cost-shift will remain static or fluctuate in tandem with federal savings targets. Dr. Kromm explained that the multi-agency workgroup intentionally established the policy around a fixed dollar amount rather than a floating percentage to ensure market stability and provide a predictable impact on insurance premiums. While acknowledging that federal savings expectations fluctuate based on USPCC trends, he emphasized that locking in the broad strokes with a set figure prevents constant, unpredictable volatility for stakeholders.

Dr. Kromm agreed with Commissioner Maine that the Commission must remain flexible, noting that staff will track performance trends as part of the metrics previously discussed with Commissioner Blum. He clarified that while the current plan is set at a specific dollar amount, the HSCRC will monitor whether that figure remains appropriate relative to actual federal trends and could revisit the policy in the future if a significant upward or downward adjustment is warranted.

Chairman Sharfstein initiated the discussion on Medicare Advantage (MA) stabilization by addressing critical board governance and conflict-of-interest protocols. He announced that Commissioners McCann and Maine would recuse themselves from both the deliberation and the upcoming vote on the MA policy to maintain the integrity of the proceedings. He disclosed that Commissioner Johnson had been formally advised by the Office of the Attorney General to recuse himself as well; however, he noted that Commissioner Johnson had chosen to decline that advice and would continue to participate in the session.

Dr. Kromm explained that the Medicare Advantage (MA) stabilization plan was developed to address a disconnect between federal reimbursement methodologies and Maryland's unique hospital rate-setting system. Stakeholders expressed that MA plans face significant financial headwinds in Maryland, which threatens the availability of these options for seniors. The state's goal is twofold: to provide a financial mechanism that accounts for this discrepancy and to protect the specific value propositions, such as limited out-of-pocket costs that MA plans offer to Maryland beneficiaries.

The policy utilizes the HSCRC's authority to grant a substantial 11.55 percent rate discount on hospital costs for Qualified Plans. To ensure these benefits support the state's residents and promote health equity, Dr. Kromm outlined three strict eligibility criteria:

- **Maryland Resident Beneficiaries:** At least 50 percent of the plan's beneficiaries must reside in Maryland.
- **Commitment to Low-Income Populations:** Plans must demonstrate a commitment to low-income populations, requiring that either 5,000 beneficiaries or 20 percent of their Maryland membership live in the state's eight lowest-income jurisdictions.
- **Quality and Financial Sustainability:** Plans must achieve a CMS Star Rating of at least 3.5 by the 2028 data release.

Dr. Kromm noted that higher star ratings are not only better for patient care but also critical for the financial health of the plans, as federal reimbursement levels are heavily tied to these

performance scores. By setting this threshold, the state ensures it is only subsidizing high-performing, stable insurance options.

The implementation of this rate relief is scheduled to begin in calendar year 2027. Initially, the cost of this discount will be offset by both Medicaid and commercial rates, but from 2028 onward, the burden will shift entirely to commercial payers. Once the plan is fully active, it is projected to result in an additional 0.75 percent increase in commercial hospital rates, serving as a targeted investment to maintain a competitive and equitable insurance market for Maryland's elderly population.

Commissioner Blum asked whether the multi-agency workgroup considered a step-down approach, where the 11.55 percent rate subsidy would decrease as plan quality improves. He noted that since Maryland's Medicare Advantage star ratings have historically lagged behind the national average, a declining subsidy could incentivize plans to elevate their performance and star ratings over time. Dr. Kromm explained that the workgroup carefully selected the 3.5-star rating as a challenging but achievable target designed to push Maryland's historically lower-performing plans toward improvement. While the group discussed whether the subsidy should be adjusted as performance rises, they decided that the current financial impact of such improvements is too difficult to predict. The idea of a step-down subsidy would be added to the state's long-term monitoring list, allowing the Commission to revisit and potentially refine the policy as they observe how the market responds.

Vice Chairman Elliott asked for clarification on the specific impact of the MA Stabilization Plan, specifically weighing its effect on consumer premium affordability versus plan profitability. Dr. Kromm clarified that while the Stabilization Plan is designed to improve the financial environment for insurers, its primary objective is not to guarantee specific profitability for individual plans. He explained that many factors contribute to a plan's profit margins, and the state's intent is specifically to mitigate the unique headwinds created by the transition to the AHEAD model. By providing this rate relief, the Commission aims to preserve a diverse range of MA options, including both zero-premium and higher-premium products, to ensure that Maryland beneficiaries continue to have access to the specific supplemental benefits and out-of-pocket protections they value.

Vice Chairman Elliott followed with another question regarding whether the multi-agency workgroup had considered reducing physician fees in conjunction with the reduction in hospital rates for MA plans. He expressed concern that cutting payments to doctors could create access problems, particularly for primary care physicians, and sought to clarify if such reductions were part of the state's future strategy for the AHEAD model. Dr. Kromm clarified that the current proposal is silent regarding physician payments because the 11.55 percent discount applies exclusively to hospital rates rather than physician fees. He emphasized that while the state is granting rate relief for hospital services under qualified plans, this policy does not mandate or include any corresponding reductions to physician reimbursement.

Chairman Sharfstein requested a motion to adopt the staff's Final Recommendation. Commissioner Sabi moved to approve the Governor's Directive, seconded by Vice Chairman Elliott. **The motion passed unanimously in favor of the staff's Final Recommendation**.

ITEM VI
REPORT FROM THE EXECUTIVE DIRECTOR

Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee-for-Service (FFS) data through September 2025 (for claims paid through November 2025). The data showed that Maryland's Medicare hospital spending per capita growth was unfavorable when compared to the nation. Ms. Joyce stated that Medicare non-hospital spending per capita and Total Cost of Care (TCOC) spending per capita were also unfavorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail is 1.35 percent above the nation through September 2025, and that Maryland Medicare hospital and non-hospital growth through September resulted in savings of $122 million.

Policy Calendar Update

Dr. Kromm presented the updated HSCRC Policy Calendar for 2026, framing it as a tool for transparency that outlines the Commission's ambitious transition to the AHEAD model. He noted that while many recurring items remain stable, the January agenda was specifically updated to include the final vote on the Respiratory Surge Policy and the Demographic Factor Adjustment, both of which are critical for ensuring hospital budgets accurately reflect current population health needs.

A significant portion of the presentation focused on required changes for the new model, specifically the need to rethink existing programs like Care Transformation Initiatives (CTIs) and Potentially Avoidable Utilization (PAU). During the discussion, a key concern was raised regarding uncompensated care (charity care and bad debt), which is expected to rise due to state legislative changes (HB1/SB981). Dr. Kromm agreed to add this to the Policy Calendar, noting that while the Commission is still modeling the exact impact of these coverage shifts, establishing a formal zone on the calendar for this discussion is essential for helping the market prepare for potential rate adjustments.

Physician Costs Comments Summary

Dr. Kromm's update on physician costs highlighted the growing financial pressure on Maryland hospitals caused by escalating professional fees. He noted that stakeholders identified several systemic drivers for these rising costs, including decades of flat or declining Medicare and Medicaid reimbursement and commercial rates that often lag behind other states. However, he pointed out that while unit rates for some specialties may be lower in Maryland, higher per-capita utilization complicates the financial picture, suggesting that any future subsidies must be evaluated holistically rather than just looking at individual service costs.

The discussion also touched on significant structural shifts in the medical workforce, specifically the increased acquisition of physician practices by private equity firms and the ongoing challenges in recruitment and retention. These workforce issues are particularly acute in rural areas, where hospitals struggle to compete for talent. Dr. Kromm noted that while these challenges are national in scope, they have a direct impact on the financial stability of Maryland

hospitals, as they are increasingly forced to subsidize physician groups to maintain essential services.

There was notable disagreement among stakeholders regarding the HSCRC's role in regulating or funding physician costs. While some believe the Commission should focus narrowly on hospital-based specialties like anesthesia, hospital medicine, and emergency medicine, others argued for a broader focus on primary care physicians who are essential for the population health goals of the AHEAD model. Despite these differing views, a common theme emerged: any financial support provided to physicians must be applied fairly and paired with strict accountability for both costs and clinical outcomes.

Dr. Kromm concluded by emphasizing that there is broad support for physician-related policies, provided they directly advance the goals of the state's healthcare model, such as improving access and quality. He stated that any new funding must be integrated with efforts to reduce underlying cost drivers to prevent unchecked growth in hospital expenditures. He also noted that these comments and the Commission's internal discussions will be synthesized into a formal report for the public and state legislators to guide future policy decisions.

Commissioner Maine emphasized that the escalating costs associated with healthcare providers in acute care settings have become an extraordinary cost driver, far outstripping inflation and placing immense stress on the hospital system. He noted that while existing hospital funding mechanisms provide some support, the financial environment in Maryland has drifted significantly from national norms, necessitating a more direct and specific evaluation of these costs. He advocated for moving beyond anecdotal evidence to develop data-driven policies that protect hospital stability and ensure access to care, suggesting that the current strain warrants a targeted policy response to safeguard the delivery of high-quality services.

Commissioner Blum emphasized that a critical next step for the Commission is to establish a precise definition of the specific problem they are attempting to solve regarding physician costs. He noted that this clarity is essential for determining whether the intended outcomes should focus on improving access, managing costs, or enhancing the patient experience.

Commissioner McCann echoed the importance of a precise problem definition, specifically pointing to the University of Maryland Medical System (UMMS) comment letter as a valuable resource for identifying Maryland's unique challenges. She noted that while rising physician costs are a national trend, the specific tools available to Maryland hospitals to address these costs are limited by the state's unique regulatory structure. Consequently, she argued that the Commission must focus on why this financial pressure is felt more acutely in Maryland than elsewhere to develop effective, localized solutions.

Commissioner Sabi emphasized that addressing physician costs is a complex challenge requiring clear accountability and tailored measurement strategies for different types of clinicians. She argued that for hospital-based physicians, the focus should be on service availability and operational outcomes, such as ensuring consistent care quality regardless of the day of the week. Conversely, for primary care and outpatient physicians, she stressed that any additional funding must be linked to their success in improving population health and preventing

avoidable hospital visits. She maintained that if the state is to invest more resources into physician support, it must first establish what specific quality, access, and outcome improvements it expects in return.

Chairman Sharfstein concluded by reinforcing the need for a results-oriented approach, emphasizing that any policy adjustments must focus on outcomes that directly impact people receiving care. He distinguished between policy inputs such as the specific ways Maryland's system differs from other states and actual clinical or access outcomes, arguing that the latter must justify any new spending. He asserted that if the legislature provides the authority to direct funds toward physician costs, the Commission's primary responsibility is to ensure the state is effectively buying the specific improvements in stability and care quality that the public deserves.

Healthcare Outcome Payment Effort

Ms. Christa Speicher, Deputy Director, Payment Reform, presented an initial framework for redesigning Maryland's value-based programs to align with the new AHEAD model. She emphasized that the transition from the previous Total Cost of Care model requires a significant evolution of Care Transformation Initiatives (CTIs) and programs focused on Potentially Avoidable Utilization (PAU). The primary goal is to reconcile the federal government's interest in innovative value-based programming with the existing capabilities and infrastructure that Maryland hospitals have built over the last several years.

Her presentation highlighted that the new AHEAD-era programs must move beyond simple cost-savings targets to incorporate broader federal requirements for quality, equity, and multi-payer alignment. She noted that while CTIs have been successful in driving hospital-physician collaborations, the next iteration must be more flexible to support the ambitious primary care and population health goals mandated by the Center for Medicare and Medicaid Innovation (CMMI). This includes rethinking how hospitals are incentivized to manage patient health outside of the traditional hospital setting.

A key focus of the proposed framework is the integration of Accountable Care Organization (ACO) principles into the state's rate-setting structure. By evolving the CTI program, the HSCRC aims to create a more robust value-based payment ecosystem that encourages hospitals to partner with community providers to reduce total cost of care while improving patient outcomes. Ms. Speicher stressed that this redesign is not just a regulatory update but a necessary step to ensure that Maryland remains a national leader in healthcare innovation under the AHEAD contract.

She indicated that the staff would be launching a formal stakeholder workgroup process to vet these initial thoughts. The staff intends to bring back more specific recommendations later in the year, ensuring that the transition for hospitals and providers is predictable and well-supported.

Dr. Kromm noted that a major historical challenge in value-based programming has been finding the right balance of not being too prescriptive regarding specific solutions, while remaining firm on the underlying goals and principles. He emphasized that the upcoming workgroup process will focus on establishing clear expectations for outcomes and defining exactly how these

programs will be evaluated. This includes creating a standardized method for counting savings to ensure the state remains in good standing with federal regulators.

A significant advantage of the AHEAD model, according to Dr. Kromm, is the state's unique ability to flex across different programs; unlike more rigid models, not every individual initiative is required to yield immediate savings. He cited the Episode Quality Improvement Program (EQIP) as a prime example of how this flexibility allows the state to support innovation. However, he cautioned that this flexibility must be matched with high levels of rigor in tracking whether anticipated savings are actually materializing over time.

He acknowledged that tracking these financial impacts across different patient attribution models will be technically complex. Staff plans to leverage the progress made over the last few years in the Care Transformation Initiative (CTI) program, specifically its improved evaluation frameworks, to build a more sophisticated monitoring system. The goal of the new work group is to return to the Commission with a fully baked framework that provides both the technical rigor and the strategic clarity necessary for the AHEAD model's success.

No action was taken on these agenda items.

ITEM VII
FINAL REOMMENDATION: CONFIDENTIAL DATA REQUEST

Mr. Curtis Wills, Analyst, Healthcare Data Management and Integrity, presented the staff's Final Recommendation: Confidential Data Request (see "Final Recommendation: Confidential Data Request" available on the HSCRC website).

Mr. Wills presented a confidential data request from the University of Maryland School of Medicine, seeking access to statewide inpatient and outpatient hospital discharge datasets. The proposed study aims to evaluate long-term outcomes for young adults who have participated in coordinated specialty care programs for early psychosis. While these programs are known to be effective during the standard two-year treatment window, there is currently a significant research gap regarding whether patient gains are sustained after the transition out of formal care.

The research will specifically investigate patterns of healthcare utilization and identify key predictors of relapse or continued recovery following program completion. By analyzing this data, investigators hope to develop evidence-based practices for care transitions and long-term support. The ultimate goal of the study is to inform mental health policy and optimize recovery systems for individuals experiencing early psychosis, especially given the high national rates of treatment dropout.

The request has already secured approval from the Maryland Department of Health and received an IRB exemption from the University of Maryland Baltimore. The HSCRC Confidential Data Review Committee recommends approval, provided the University adheres to strict security protocols, including annual progress reports and a pre-publication review by the HSCRC. All data must be destroyed by October 3, 2026, and the University must certify this destruction to ensure patient confidentiality is maintained.

Mr. Wills presented the staff's Final Recommendation for the Confidential Data Request as follows:

1. Staff recommends that the request by the University of Maryland School of Medicine for the Data for Calendar Years 2018 through 2025 be approved;
2. That this access will include limited confidential information for subjects meeting the criteria for the research.

Chairman Sharfstein asked Dr. Phalen to articulate the specific value of this research to the State of Maryland. Dr. Phalen noted that while Maryland and Montgomery County are actively investing in a growing network of early psychosis clinics, the current two-year limit on patient participation is largely arbitrary and lacks long-term data. He emphasizes that the period following a patient's exit from these programs is currently a total black box, leaving providers uncertain about whether the duration of care is sufficient or if gains are sustained. He views this initiative as a vital opportunity to shed light on long-term outcomes and determine the most effective timeline for treatment.

Chairman Sharfstein requested a motion to adopt the staff's Final Recommendation. Commissioner Maine moved to approve the staff's Final Recommendation, seconded by Commissioner Johnson. **The motion passed unanimously in favor of the staff's Final Recommendation.**

ITEM VIII
FINAL RECOMMENDATION: SURGE POLICY

Ms. Prudence Akindo, Associate Director, Financial Methodologies, presented the staff's Final Recommendations for the Surge Policy (see "Final Recommendation: Surge Policy" available on the HSCRC website).

Ms. Akindo presented and outlined the staff's response to stakeholder feedback regarding the Surge Policy methodology and final recommendations for hospital funding. The Commission received input from nine hospital systems, the Maryland Hospital Association (MHA), and other groups, which were categorized into five main areas: data duration, calculation methodology, length of stay (LOS) incentives, funding timing, and alignment with broader policies. A primary point of consensus was the shift to using a full 12 months of data for surge calculations. Staff agreed with stakeholders that this alignment with standard HSCRC volume methodologies better accounts for seasonal fluctuations and actual demonstrated need, while noting that the resulting impact on commercial insurance premiums remains minimal (between 0.0 percent and 0.1 percent).

Regarding calculation methodology, the staff recommended shifting the weighting of surge funding to favor Equivalent Case Mix Adjusted Discharges (ECMADs) over patient days. While the current placeholder methodology uses a 66 percent weighting for patient days, the new recommendation proposes reversing this to 66 percent ECMADs, starting in Rate Year (RY) 2027. This change is intended to de-emphasize patient days and prevent unintended incentives

that might encourage longer hospital stays. To ensure stability, staff and stakeholders agreed to keep the existing methodology in place for the remainder of RY 2026 before transitioning to the new weights.

A significant portion of the presentation addressed the controversial intersection between surge funding and inpatient length of stay (LOS). Staff expressed concern that 50 percent of current surge funding goes to hospitals with LOS levels exceeding national benchmarks, potentially disincentivizing efficiency. While stakeholders cautioned against a punitive LOS policy due to factors beyond hospital control (such as post-acute care capacity), staff argued that statewide LOS has remained constant despite declining admissions and stable patient acuity. Consequently, staff suggested that if a formal LOS incentive policy is not established by June 2026, the surge policy should either be suspended or amended to only account for case growth.

Ms. Akindo presented data showing that the perceived increase in patient complexity is largely a result of shifting low-acuity cases to outpatient settings rather than a fundamental change in the inpatient population's health needs. Since the Total Cost of Care model is designed to incentivize these shifts, the staff maintains that hospital patient days should be decreasing alongside admissions. This data serves as the justification for moving away from volume-based funding that rewards longer stays, ensuring that the surge policy supports genuine volume increases rather than internal inefficiencies.

Stakeholders requested that funding be provided in the same year as the surge occurs to ensure resources are available for patient care. In response, staff recommended providing an additional $64 million in surge funding in January 2026 rather than delaying until July. This ensures the policy remains consistent with the Commission’s practice of utilizing relevant data as soon as it is available, providing hospitals with timely adjustments to cover the costs of increased volume.

Based upon completion of the full 12-month RY 2025 surge funding calculations, and the various analyses done to assess the blended approach, Ms. Akindo presented the staff’s Final Recommendation for the Surge Policy as follows:

1. Funding provided in RY 2026 should be based on the full fiscal year evaluation, as this comports with the initial intention of the surge policy to assess the extent to which GBR budgeted volumes across the entire year may offset infectious disease surges. Staff will consider timing and measurement period against any full rate review funding awarded (or other relevant funding mechanisms) and discount the funding as needed.

2. Moving forward, staff recommends a 9-month estimate of surge funding be built into July rate orders and then reconciled in January rate orders based on the full fiscal year evaluation. Staff will consider timing and measurement period against any full rate review funding awarded (or other relevant funding mechanisms) and discount the funding as needed.

3. In RY 2027 and thereafter, any surge funding provided should be based on 66 percent ECMAD evaluation and 33 percent patient day evaluation, as there are analyses to

support the need for some consideration of patient days, but to a lesser extent than ECMADs.

4. Staff defer to the Commissioners to consider amending the cap on surge funding in RY 2026, as the Update Factor recommendation was clear that the value regardless of the full year assessment is set at $100.4 million. Options are as follows:

    a. **Full Rate Year Allotment:** $164.6 based on 12 months of RY 2025 volume data with 66 percent patient day, 33 percent ECMAD evaluation to be implemented in January 2026 rate orders **(Staff Recommendation)**.

    b. **Full Rate Year Allotment and Advancement to New Weighting Approach**: $124.8 based on 12 months of RY 2025 volume data with 33 percent patient day, 66 percent ECMAD evaluation to be implemented in January 2026 rate orders.

5. Given the concern over the Surge Funding Policy's potential to increase IP LOS, staff recommends the adoption of an independent IP LOS incentive to be developed in concert with the Performance Measurement Workgroup. Staff proposes that:

    a. If an IP LOS incentive is not established by June 30, 2026, the surge policy be suspended until an IP LOS incentive is approved; or

    b. If an IP LOS incentive is not established by June 30, 2026, the Surge policy be amended to only account for case growth (100 percent ECMAD evaluation).

6. Hospitals accepting Surge funding should maintain or increase their staffing capacity to meet the needs of patients in Maryland.

7. Hospitals should coordinate with respiratory virus prevention activities with the Maryland Department of Health.

Commissioner Blum asked for clarification on whether the Commission must vote annually to approve the surge funding amount or if the policy, once approved, will continue automatically until it is formally changed. Mr. Allan Pack, Principal Deputy Director, Quality and Population-Based Methodologies, explained that while the policy would typically flow automatically each year with the value cited in the Update Factor, the Commission retains the authority to change or redistribute the funding based on changing circumstances or needs. He illustrated this by comparing it to the PAL program, where Commissioners eventually shifted from reducing revenue to redistributing it within the Update Factor context.

Testimonies:

Mr. Patrick Carlson, Vice President of Care Transformation and Finance, MHA, expressed support for the staff's recommendation to increase surge funding based on a full 12 months of

data, totaling approximately $164.6 million for RY 2026. He emphasized that this funding is essential for hospitals to maintain access to life-saving care during prolonged periods of high volume driven by COVID-19, influenza, and other respiratory conditions. To ensure hospitals can meet current cost pressures and care needs, he advocated for the updated funding to be provided within the current year.

Regarding the calculation methodology, Mr. Carlson agreed with maintaining the current weighting of two-third patient days and one-third ECMADs for the remainder of RY 2026. He argued that any shift in this weighting should be delayed until RY 2027 to ensure the policy remains fair and predictable for hospitals. Following these points, he transitioned the presentation to his colleague to address specific concerns regarding the proposed inpatient length of stay incentive.

Ms. Amanda Wright, Director of Quality and Clinical Care, MHA, expressed strong opposition to the staff's proposal to link surge funding to a new inpatient length of stay (LOS) incentive. She argued that length of stay is primarily driven by systemic barriers outside of a hospital's direct control, such as limited post-acute care capacity, payer denials, and legal hurdles like guardianship. She emphasized that these challenges are particularly acute for patients with respiratory conditions who often require extended care and difficult-to-secure placements in long-term care facilities.

Ms. Wright cited data from the Emergency Department Wait Time Reduction Commission, which found that patients awaiting post-acute placement face delays ranging from 2 to 16 days. These bottlenecks in discharging patients to skilled nursing or long-term care facilities directly contribute to inpatient congestion. Because these delays are caused by external resource gaps and workforce shortages rather than hospital inefficiency, she contended that implementing a performance-based incentive would unfairly penalize hospitals for factors they cannot change through clinical practice alone.

She recommended that any length of stay initiative remain limited to "monitoring only" while the state focuses on improving data infrastructure and addressing systemic barriers. She urged the staff to align its efforts with the ongoing work of the AHEAD model and regulatory working groups, which advocate for collaborative engagement and better statistical modeling before introducing performance incentives. By focusing first on strengthening the transition to national CMS programs and post-pandemic data analysis, the State can avoid creating unrealistic expectations that risk compromising care for the most complex patients.

Chairman Sharfstein observed that while the staff proposal linked respiratory surge funding and the length of stay policy, the two issues are conceptually distinct. He suggested that it was not necessary to fully debate the length of stay policy during the current meeting, as a more comprehensive discussion could take place once all relevant information is gathered.

Commissioner Blum asked Mr. Carlson whether the proposed policy options, specifically the weighting of factors like length of stay versus total volume, effectively target hospitals with the greatest financial and operational need. He wants to understand if these different

methodological approaches improve or worsen the policy's ability to direct funding to the institutions most impacted by the surge.

Mr. Carlson clarified that the MHA's primary concern is the timing of any changes, urging the Commission to delay methodology shifts until the following year. He acknowledged that patient days are a clear factor driving surge costs, noting the ongoing debate over how much weight they should carry compared to general case mix measures. He argued that since patient days are a significant driver of need, they must remain an integral part of the funding methodology.

Vice Chairman Elliott noted that while the Surge Policy itself is a positive step, he expressed significant concern regarding its connection to the length of stay comments. He argued that the Surge and Length of Stay policies are separate issues and suggested that they should perhaps be decoupled rather than attached in the same recommendation. He questioned whether the length of stay components should be excluded from the current recommendation entirely.

Chairman Sharfstein suggested that Vice Chairman Elliott could offer an amendment to officially decouple the length of stay issue from the Surge Policy recommendation. He expressed a desire to see a full staff analysis and a separate proposal on length of stay, noting that making one policy contingent upon another is somewhat unusual. He emphasized that while the conversation on length of stay must continue with a full review of the data, the immediate goal should be separating the two topics for the purpose of the current vote.

Commissioner Johnson asked for an explanation of the reasoning behind not shifting to a 100 percent ECMAD-based weighting for the Surge Policy. Ms. Akindo explained that implementing a 100 percent ECMAD weighting is difficult because the initial basis of the methodology relies on operational hospital standard charge data. She noted that ECMADs are primarily utilized to measure year-over-year opportunities rather than serving as the sole foundation for the calculation. The funding approach involves balancing these factors by looking at the lesser of the group's patient days to ensure the methodology remains grounded in actual hospital experience.

Mr. Pack explained that while staff analysis identifies ECMADs as a superior measurement for surges, the specific weighting is ultimately a matter of judgment rather than an exact statistic. He noted that the current recommendation simply inverts the previous ratio to two-thirds ECMADs and one-third patient days to better prioritize case-based metrics. He compared this to the Integrated Efficiency policy, where the Commission previously chose a 50/50 split because there is no absolute formula for balancing different efficiency measures.

Chairman Sharfstein requested a motion to adopt the staff's Final Recommendation on the Surge Policy. Commissioner McCan made a motion to approve the staff's recommendation with one amendment to remove any connection between the surge policy and the length of stay incentive, deferring that issue until further analysis can be completed.

The amended motion was seconded by Vice Chairman Elliott. In favor of the motion were Vice Chairman Elliott, Commissioners Blum, Maine, McCann and Sabi. The motion was opposed by Commissioner Johnson. **The motion passed in favor of the Staff's recommendation.**

ITEM IX
FINAL RECOMMENDATION: DEMOGRAPHIC ADJUSTMENT

Mr. Allan Pack, Principal Deputy Director, Quality and Population-Based Methodologies presented the staff's Final Recommendation: Demographic Adjustment (see "Final Recommendation: Demographic Adjustment" available on the HSCRC website).

Mr. Pack's presentation focused on the refinements to the Demographic Adjustment, the system's primary mechanism for funding hospital volume growth. Historically, this Adjustment only covered population growth, under the assumption that the increased needs of an aging population were naturally offset by clinical innovations and technology. However, as the state transitions to the AHEAD model which allows for risk-adjusted tests, staff evaluated whether to formally account for the aging factor. While Maryland's demographics suggest aging could increase utilization by 12 percent, he noted that innovation, such as the rise of GLP-1 medications for cardiovascular health, continues to act as a significant counterbalance.

The presentation outlined three potential paths forward: maintaining the status quo, using the last ten years of national data to modify population growth, or adopting a predictive forecast. Staff recommended the second option, proposing a 0.1 percent national demand modifier. Mr. Pack explained that the data supports a small incremental increase beyond population growth, the proposed revisions to the second approach did not improve the results, and the added complexity of the third approach was unwarranted due to data limitations and the subjectivity of its projections.

Mr. Pack addressed MHA's recommendation for an age-adjusted growth statistic, which would cost approximately $130 million annually. He expressed serious concerns with this metric, noting that it fails to account for year-over-year utilization changes or the factors that offset aging. He also critiqued the use of the NASHP budget tool and Vizient's SG2 forecast, citing data reliability issues and the inability of regulators to verify proprietary hospital data. He noted that any reliable methodology must be verifiable and account for all risks, not just age.

His presentation proposed excluding certain volumes, such as oncology drugs and out-of-state cases, from the demographic adjustment. He argued that providing population-based funding for out-of-state patients who are already reimbursed through separate volume policies would be redundant and illogical. By refining the denominator of what the adjustment applies to, the staff aims to ensure that funding is precisely targeting Maryland's actual population growth without over-reimbursing specific carved-out services.

Mr. Pack admitted that projecting the exact impact of aging and innovation is inherently difficult. He recommended that the Commission revisit this 0.1 percent modifier every two to three years, or even sooner if significant shifts occur, such as changes in Medicare global budget controls. This iterative approach acknowledges the complexity of the demographic adjustment while maintaining a commitment to a data-driven, verifiable funding model.

Mr. Pack presented the staff's Final Recommendation on the Demographic Adjustment as follows:

1. Apply a national demand modifier of 0.1 percent to the Demographic Adjustment policy, starting with the RY 2026 policy. Funding adjustment will be implemented July 1, 2026, in concert with the RY 2027 Update Factor.
2. Revisit the national demand analysis every 2-3 years to determine if the calculation requires updating and if a retrospective adjustment to prior year Demographic Adjustments is warranted.
3. Discontinue the application of the Demographic Adjustment to volumes that are adjudicated through a distinct volume variable methodology and are not part of population-based payments. Funding adjustment will be implemented July 1, 2026, in concert with the RY 2027 Update Factor, once non-population-based volumes are established (estimates of discontinuing the application of the Demographic Adjustment to services outside of population-based payments are listed in Appendix 6 of the Recommendation).

Chairman Sharfstein sought to clarify whether the staff is asking the Commission to adopt the general principle of excluding certain volumes from the Demographic Adjustment now, even if the specific application of that principle occurs later. The actual implementation would happen once the specific amounts for non-population-based payments are identified. Mr. Pack confirmed that the staff is indeed asking the Commission to adopt the principle at this time. He clarified that the actual application would proceed once staff have successfully itemized all specific volumes that are to be carved out of Maryland's population-based payments.

Testimonies:

Mr. Arin Foreman, Vice President and Deputy Chief of Staff, CareFirst BlueCross BlueShield, expressed his appreciation for the staff's thorough work on the refinements to the Demographic Adjustment. He acknowledged that the core intent of the Global Budget allotment is to fund care for a specific population and that the costs, composition, and healthcare utilization of that population inevitably evolve over time. Because of these changes, he emphasized that the policy refinement is necessary to ensure funding accuracy. He noted that the staff has developed a reasonable approach and formally stated his support for the Commission's adoption of the recommendation as written.

Mr. Patrick Carlson, Vice President of Care Transformation and Finance, MHA, emphasized that as the state transitions to the AHEAD model, the demographic adjustment is a critical policy lever for ensuring hospitals have sufficient resources. He noted that this adjustment is the primary tool available to account for the shifting healthcare needs driven by both population growth and an aging demographic. With nearly 20 percent of Marylanders expected to be 65 or older by 2030, he stressed the urgency of having a policy that is responsive to an increase in patients with multiple chronic conditions.

He noted that the current methodology is insufficient because it effectively caps adjustments at overall unadjusted population growth, thereby failing to capture the true intensity of the aging population's needs. Because older populations naturally require more healthcare services, Mr. Carlson reiterated the MHA's longstanding position that the methodology should be changed to

fully fund age-adjusted demographic growth. He suggested that without this change, the system might not adequately support the rising utilization levels projected for the coming years. He maintained that the goal must be a more comprehensive capture of demographic shifts to maintain community health standards.

Mr. Adam Kellerman, Director of Healthcare Payment, MHA, began by questioning whether the staff's proposed 0.1 percent modifier would adequately address the state's growing utilization needs. He argued that the recommendation relies too heavily on historical trends from 2013 to 2023, which may not be predictive of the future. While the Commission's analysis suggests a decline in inpatient utilization, he pointed to Vizient projections that forecast significant growth in both inpatient and outpatient volumes over the next decade.

He highlighted specific technical concerns regarding the assumptions used to reduce the modifier from 0.4 percent to 0.1 percent. He questioned the assumptions related to Medicare Advantage morbidity and site neutrality incentives, which significantly lowered the final modifier result. Additionally, he noted that the staff's focus on Medicare and commercial data ignores the substantial utilization growth stemming from Medicaid expansion, potentially leaving a gap in the funding model.

Regarding the proposal to exclude non-population-based volumes from the demographic adjustment, Mr. Kellerman urged the Commission to maintain the current practice. He cautioned that combining a modest demand modifier with new exclusions would result in a net negative revenue adjustment. He argued that such a reduction is counterintuitive at a time when Maryland's population is aging and becoming clinically more complex, suggesting these changes should only be made as part of broader discussions about the AHEAD model transition.

He expressed appreciation for the staff's direct engagement with the MHA team but emphasized the need for ongoing monitoring. He supported the recommendation to re-examine the modifier periodically to ensure that historical assumptions actually hold true in the coming years. He reiterated the MHA's commitment to working with the Commission to better align Maryland's methodologies with CMS standards as the state moves toward 2028.

Commissioner Johnson asked how the MHA selected the SG2 projections for their proposal and whether they utilize these specific datasets in any of their other methodologies. Mr. Kellerman explained that the MHA chose Vizient's SG2 data because it is a nationally recognized, comprehensive dataset that includes all payers. He stated that the goal was to perform stress testing to see if the staff's historical data approach holds up against forward-looking projections used by both providers and payers. He noted the use of SG2 as an effort to ensure the policy reflects future utilization trends rather than just past experiences.

Chairman Sharfstein asked MHA to clarify their reasoning for why a demographic adjustment should or should not be applied to volumes that are already reimbursed through separate volume-variable agreements. Mr. Kellerman argued that since the Commission is already planning a broader review of budget exclusions for the AHEAD model, it should delay any changes to volume variable agreements until that formal discussion occurs. He believes that

maintaining the current practice for now avoids premature policy shifts before a comprehensive framework is finalized.

Commissioner Johnson questioned the logic of using national comparisons, arguing instead that the Demographic Adjustment should be based solely on Maryland-specific data and innovation levels. He suggested that the staff's analysis should focus on the technological improvements and practice patterns happening within the state rather than relying on national demand modifiers. He expressed that a comparison to the rest of the country is irrelevant to the specific needs and performance of Maryland's healthcare system.

Mr. Pack explained that relying solely on Maryland data would create a circularity problem, where the state's own policy-driven successes like reducing admissions would lead to lower future funding, effectively penalizing hospitals for efficiency. He argued that using national data provides an external benchmark of how utilization changes in a more typical fee-for-service environment, which is necessary to objectively assess the impact of aging. By using this national demand modifier, the system can provide a fair adjustment that reflects broader trends without being distorted by Maryland's specific global budget incentives.

Commissioner McCann expressed a significant level of discomfort with the current recommendation, highlighting that her external consultations revealed a shared level of confusion among other experts, and leading her to question whether the policy truly fulfills the Commission's original goal of providing hospitals with predictability and stability for future demand. While acknowledging the staff's tremendous effort, she suggested that the staff might need more time to meet with stakeholders or, alternatively, should only approve the policy on a temporary basis with a mandatory reevaluation in one year. She offered these options for discussion rather than making a formal recommendation, emphasizing that she was not yet confident that the body was in the same place regarding the policy's intent and impact.

Chairman Sharfstein addressed the Commissions uncertainty regarding the 0.1 percent modifier, asking for a more concrete timeframe for re-evaluating the policy's accuracy. He sought a defined framework for a reasonable review path that would be responsive to the concerns raised about the policy's potential unpredictability. Mr. Pack cautioned against a mandatory annual review, explaining that yearly data can be distorted by temporary blips like natural disasters rather than reflecting long-term trends. He recommended revisiting the policy next year as the state transitions to the AHEAD model and Medicare hospital payments shift to a new adjustment framework, followed by a regular cadence of every two to three years. He also clarified that the 0.1 percent modifier would specifically apply to the non-Medicare population, as the Medicare portion will be governed by a separate risk-adjusted growth mechanism.

Mr. Pack proposed a friendly amendment to his own recommendation, committing to an update of the analysis in one year using 2024 data to determine if the results differ significantly from the proposed 0.1 percent modifier. He clarified that this one-year check-in would serve as a report back to the Commissioners to ensure the data remains consistent, while a more comprehensive, bigger look at the overall assessment and methodology would occur on a longer cadence of every two to three years. This approach aims to provide immediate

transparency and verification of the current findings without requiring a full overhaul of the policy on an annual basis.

Chairman Sharfstein requested a motion to adopt the staff's Final Recommendation with Mr. Pack's amendment as stated above. Commissioner Johnson moved to approve the staff's recommendation, seconded by Commissioner Blum.

In favor were Vice Chairman Elliott, Commissioners Blum, Maine, Johnson and Sabi. The motion was opposed by Commissioner McCann. **The motion passed in favor of the staff's Final Recommendation.**

ITEM X
FINAL RECOMMENDATION: QUALITY-BASED REIMBURSEMENT POLICY

Dr. Alyson Schuster, Ph.D., Deputy Director, Quality Methodologies, presented the staff's Final Recommendations for the Quality-Based Reimbursement (QBR) Policy (see "Final Recommendations Quality-Based Reimbursement Policy" available on the HSCRC website) for Rate Year (RY) 2028.

She emphasized a strategic shift toward more balanced weighting across the program's three domains: Person and Community Engagement (PCE), Safety, and Clinical Care. While current policy heavily weights PCE at 60 percent, the staff recommended reducing it to 38 percent to better align with the CMS National Quality Program. Despite this alignment, staff advocated for retaining Maryland-specific measures such as Emergency Department (ED) length of stay and Medicaid timely follow-up to address unique local challenges and support the goals of the new AHEAD model, specifically in care coordination.

A significant portion of the presentation addressed stakeholder feedback regarding multi-payer alignment and administrative complexity. While hospitals generally pushed for an even 1/3 weighting across all domains to match federal standards, staff proposed a slightly higher weight for the PCE domain to accommodate the unique Maryland metrics. Dr. Schuster noted that the Maryland Department of Health supports these additions, as they provide critical oversight for Medicaid and uninsured populations that are not always the focus of federal Medicare-centric programs.

She also clarified the complex timeline of the transition to the AHEAD model. RY 2028 adjustments will be based on 2026 performance data and will affect hospital revenues from July 2027 through June 2028. She explained that while CMS will begin setting Medicare fee-for-service global budgets in 2028, Maryland's state agreement allows for a transition period where revenue adjustments based on CMS quality programs will not fully commence until 2029 or 2030, ensuring a smoother transition for hospitals.

Technical disagreements regarding use of specific clinical measures were also highlighted, particularly concerns from the University of Maryland Medical System and MedStar. These systems questioned the inclusion of the "sepsis bundle" and "hip/knee arthroplasty complication" measures, which were previously excluded but are now recommended for reintegration to ensure federal alignment. MedStar also argued that adding complex metrics like

Medicaid timely follow-up creates unnecessary clinical compliance burdens, though the Quality Team maintained that the high priority of this metric justifies their inclusion in the payment program.

Dr. Schuster provided the Commission with three potential policy options for consideration, illustrating how different domain weights and measure selections would impact hospital revenue adjustments. By reducing the PCE domain from 60 percent to 38 percent and removing certain Maryland-specific HCAHPS and safety indicators, the staff aimed to bridge the gap between state-level innovation and national standards. She concluded by emphasizing that these adjustments are intended to create a predictable and fair quality incentive structure as the state enters a new regulatory era.

Dr. Schuster presented the staff's Final Recommendation on the Quality-Based Reimbursement Policy as follows:

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 the cut-point at 32 percent.
    a. Retrospectively evaluate the preset cut-point using more recent data to calculate national average score for RY 2027 and RY 2028.
    b. Based on concurrent analysis of national hospital performance, adjust the RY 2026 QBR cut point to 32 percent to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.
    c. 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. A bonus incentive of $150,000 is added to rates for hospitals that fully meet the State-specified expedited reporting timeline and all required measures are reported.

Commissioner Blum asked Dr. Schuster to confirm if her proposal suggests that the Commission should always reserve the authority to add quality measures that reflect the state's specific policy priorities. Dr. Schuster confirmed that the core principle of the staff recommendation is to balance alignment with national programs while maintaining the independence to adopt specific measures that address Maryland's unique concerns and populations beyond just Medicare.

reaffirmed the commitment of Maryland's hospitals to safe, equitable care while thanking the HSCRC quality team for their collaborative and inclusive approach to policymaking. She formally expressed MHA's support for the staff's QBR recommendation, highlighting their appreciation for the domain weight changes that align more closely with the CMS Hospital Value-Based Purchasing program, and the retrospective adjustment of the RY 2026 cut-point. While supportive of the current recommendation, she urged the Commission to adopt the CMS timeline for eCQM submissions starting in RY 2029. Additionally, she noted that the MHA has proposed a state-based monitoring program to complement these quality incentives, signaling a desire for continued partnership in refining the state's quality landscape.

Amanda Wright, Director of Quality and Clinical Care, MHA, emphasized that as Maryland transitions to the AHEAD Model, it is critical to align state quality programs like QBR with federal requirements. She argued that this alignment is necessary to avoid duplicative reporting and conflicting incentives that could burden hospitals during a demanding regulatory shift. By using alignment as a guiding principle, the state can create a clearer framework for determining which quality metrics should carry financial penalties and which are better suited for alternative oversight structures.

She proposed the creation of a state-based monitoring or pay-for-reporting program for measures that are important to Maryland but not included in the CMS Hospital Value-Based Purchasing program. Under this model, metrics such as post-acute capacity and care coordination would be tracked via statewide dashboards and public reports rather than being tied to immediate payment penalties. This approach would allow the state to analyze data and understand performance drivers before introducing financial risk, ensuring a more stable transition for healthcare systems.

Ms. Wright suggested that shifting certain priorities to a monitoring strategy would maintain accountability and transparency without increasing the clinical and administrative burden on hospitals. This strategy aligns with previous recommendations regarding emergency department wait times and seeks to prevent payer misalignment. She noted this balanced approach will reduce revenue volatility while still addressing the system-level drivers essential for the success of the AHEAD transition.

Commissioner McCann asked for clarification on whether MHA is recommending the immediate implementation of the monitoring and reporting program or if they are simply flagging it as a consideration for the future transition to the AHEAD model in 2028. Ms. Wright clarified that MHA would ideally like to see the monitoring and pay-for-reporting program implemented as early as RY 2028, but she acknowledged that this might not be immediately feasible and remains open to further discussion. She explained that this approach would allow the state to reevaluate its overarching quality structure and better align Medicare, Medicaid, and commercial incentives during the complex transition to the AHEAD model. She noted that this strategy mirrors the federal Inpatient Quality Reporting program, which allows CMS to study hospital data for a period of time before deciding whether to integrate specific measures into formal payment and penalty policies.

Commissioner Blum suggested that the proposed pay-for-reporting concept should primarily apply to new measures being introduced to the system, rather than the established priority measures currently in place. Chairman Sharfstein asked whether the current discussion regarding the monitoring and reporting framework specifically pertained to the introduction of new quality measures. Dr. Schuster clarified that the current proposal is not about adding new measures, but rather about maintaining existing priorities like Emergency Department length of stay and Medicaid timely follow-up.

Chairman Sharfstein requested a motion to adopt the staff's Final Recommendation. Commissioner Johnson moved to approve the staff's recommendation, seconded by Commissioner Blum. **The motion passed unanimously in favor of the staff's Final Recommendation.**

ITEM XI
DRAFT RECOMMENDATION: READMISSIONS REDUCTION INCENTIVE PROGRAM

Ms. Princess Collins-Taylor, Chief, Quality Initiatives, presented the staff's Draft Recommendation on the Readmissions Reductions Incentive programs (RRIP) (see "Draft Recommendation: Readmissions Reduction Incentive Program" available on the HSCRC website) for Rate Year (RY) 2028.

The recommendation proposes to largely maintain the existing framework while introducing key adjustments for the transition to the AHEAD model. The policy retains the maximum 2 percent reward or penalty for hospital performance on the all-cause, all-payer 30-day readmissions measure. It sets a 5 percent improvement target based on a blended 2022–2023 base period and an attainment target at the 65th percentile. Notably, staff recommends removing the specific disparity gap financial incentive, moving instead to a monitoring-only approach for that measure.

Data performance shows that Maryland continues to outperform the nation on a risk-adjusted basis for Medicare fee-for-service readmissions. On an unadjusted basis, the state's readmission rate is lower than the national average through 2025; however, both Maryland and the nation have seen an increase in unadjusted readmissions since the start of the Total Cost of Care model in 2018. Statewide across all payers, there has been a 5.5 percent reduction in readmissions since 2018, though recent data shows a slight 1.63 percent uptick in the Medicaid population, which the staff is currently investigating.

As the state transitions to the AHEAD model, staff is evaluating how to reconcile Maryland's all-payer, all-condition approach with CMS's more limited Hospital Readmissions Reduction Program (HRRP), which only tracks six conditions for Medicare beneficiaries. Ms. Collins-Taylor indicated that staff currently favors aligning with the NCQA Plan All-Cause Readmission (PCR) measure used in the AHEAD Population Health Accountability Plan. This alignment would directly incentivize hospitals to meet the AHEAD's statewide goals while avoiding the unintended consequences of applying Medicare-specific social risk adjustments to the entire Maryland hospital group.

A significant technical update involves the out-of-state adjustment within the attainment methodology. Following hospital concerns, staff discovered that some readmissions were being double-counted as both in-state and out-of-state, artificially inflating readmission rates. The proposed modification to correct this double counting is estimated to increase statewide net revenue by approximately $4.4 million, shifting the total statewide penalty from roughly $27.9 million down to $23.5 million based on modeled RY 2026 data.

The RY 2028 draft policy serves as a bridge, maintaining the 2 percent revenue-at-risk structure while refining technical calculations and preparing for deeper alignment with federal AHEAD metrics. Throughout 2026, staff will continue to engage stakeholders to finalize which specific AHEAD measures will replace or augment current state metrics. The removal of the disparity incentive reflects this shift toward a broader evaluation framework that will be refined as the state moves toward new population health goals.

No action was taken on these agenda items.

ITEM XII
HEARING AND MEETING SCHEDULE

February 11, 2026, Time to be determined
4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned.

Closed Session Minutes
of the
Health Services Cost Review Commission
January 14, 2026

Chairman Sharfstein stated the reasons for Commissioners to move into administrative session, under the authority provided by the General Provisions Article §3-103 and §3-104 for discussing the administration of the Model, the AHEAD model update and the current staff investigation of the Regional Partnership.

Upon a motion made in public session, Chairman Sharfstein called for an adjournment into closed session.

The administrative session was called to order by motion at 12:10p.m.

In addition to Chairman Sharfstein, Commissioners Blum, Elliott, Maine, McCann and Sabi were in attendance.

Staff members in attendance were Jon Kromm, Jerry Schmith, William Henderson, Allen Pack, Claudine Williams, Christa Speicher, Alyson Schuster, Cait Cooksey, Erin Schurmann, and William Hoff.

Also attending were Assistant Attorneys General Stan Lustman and Ari Elbaum, Commission Counsel.

Item I

Ms. Erin Schurman, Associate Director, Strategic Initiatives, updated the Commission on the Regional Partnership review.

Item II

Dr. Jon Kromm, Executive Director updated the Commission on the status of the AHEAD model.

Item III

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, updated the Commission, and the Commission discussed the TCOC model monitoring.

Item IV

Mr. Henderson also updated the Commission, and the Commission discussed the FY26 Hospital Financial Condition through November 2025.

The Closed Session was adjourned at 12:40p.m.

maryland
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cost review commission

Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

February 11, 2026

maryland
health services
cost review commission

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2025
SYSTEM	*	FOLIO:	2497
BALTIMORE, MARYLAND	*	PROCEEDING:	2687A

I. INTRODUCTION

On December 31, 2025, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospitals are requesting approval to continue to participate in a revised global price arrangement with Quality Health Management for cardiovascular services. The Hospitals request that the Commission approve the arrangement for one year beginning February 1, 2026.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

V. STAFF EVALUATION

Staff found that there was no activity under this arrangement for the prior year. However, staff believes that the Hospitals can achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services with Quality Health Management for the period beginning February 1, 2026. The Hospitals must file a renewal application annually for continued participation.

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

maryland
health services
cost review commission

Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

February 11, 2026

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2025
SYSTEM	*	FOLIO:	2498
BALTIMORE, MARYLAND	*	PROCEEDING:	2688A

I. INTRODUCTION

On December 31, 2025, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a revised global price arrangement with Cigna Health Corporation for solid organ and bone marrow transplants, ventricular assist device (VAD) and CAR-T services. The Hospitals request that the Commission approve the arrangement for one year beginning February 1, 2026.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant, VAD and CAR-T services with Cigna Health Corporation for the period beginning February 1, 2026. The Hospitals must file a renewal application annually for continued participation.

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

Request to Access HSCRC Confidential Patient Level Data from Johns Hopkins Bloomberg School of Public Health Final Staff Recommendation

Staff Recommendation

- HSCRC staff recommends that the request by Johns Hopkins Bloomberg School of Public Health for the data for Calendar Year 2022 be approved.
- This access will include limited confidential information for subjects meeting the criteria for the research.

maryland
health services
cost review commission

Final Staff Recommendation for a Request to Access HSCRC Confidential Patient Level Data from Johns Hopkins Bloomberg School of Public Health in Assessing the Health Impacts of Guaranteed Income in Maryland

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

This is a final recommendation for Commission consideration at the February 11, 2026, Public Commission Meeting.

SUMMARY STATEMENT

Johns Hopkins Bloomberg School of Public Health (JHU) requests access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient) and Hospital Outpatient Data Sets (Outpatient) collected by the Health Services Cost Review Commission (HSCRC). This request will facilitate linking participants of the Baltimore Young Families Success Fund (BYFSF) guaranteed income initiative to claims within the Maryland All-Payer Claims Database. Beyond documenting the feasibility of this linkage, the study aims to provide evidence regarding the long-term impact of poverty-reducing policies. This work, part of the Bloomberg American Health Initiative, will serve as a foundation for researchers to link claims data to larger populations from similar initiatives nationwide. Ultimately, this project seeks to determine if health and equity outcomes, including adolescent health, addiction, and violence, can be linked to guaranteed income programs to provide policymakers with evidence of the broader health benefits of poverty reduction.

OBJECTIVE

This project evaluates the feasibility of assessing the health impacts of the BYFSF through linking claims data from the Maryland All-Payer Claims Database to consenting program participants (n=70). Researchers will attempt to link specific indicators including, but not limited to: service utilization for physical, mental, and behavioral health; health insurance stability; guideline-concordant vaccinations for adults and children; medication access; and premature morbidity and mortality. The research team will collaborate with the Chesapeake Regional Information System for our Patients (CRISP) and the Maryland Medical Care Database (MCDB) to obtain a de-identified dataset. This final file will allow researchers to assess the viability of tracking participant health via claims data.

Johns Hopkins Bloomberg School of Public Health received approval from the Maryland Department of Health (MDH) Institutional Review Board (IRB) on July 19, 2025, and the MDH Strategic Data Initiative (SDI) office on January 7, 2026.

(The Data will not be used to identify individual patients. The Data will be retained by Johns Hopkins School of Public Health *until project completion on September 30, 2026. At that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.)*

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee is composed of representatives from HSCRC and the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements listed below and to make recommendations for approval to the HSCRC at its monthly public meeting.

1. The proposed study or research is in the public interest;
2. The study or research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
5. The organization has adequate data security procedures in place to ensure protection of patient confidentiality.

The Review Committee unanimously agreed to recommend that Johns Hopkins Bloomberg School of Public Health be given access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by Johns Hopkins Bloomberg School of Public Health be approved.

2. This access will include limited confidential information for subjects meeting the criteria for the research.

Maryland
DEPARTMENT OF HEALTH

A Statewide Approach to Community Health & Cost Control: The Power of Partnerships

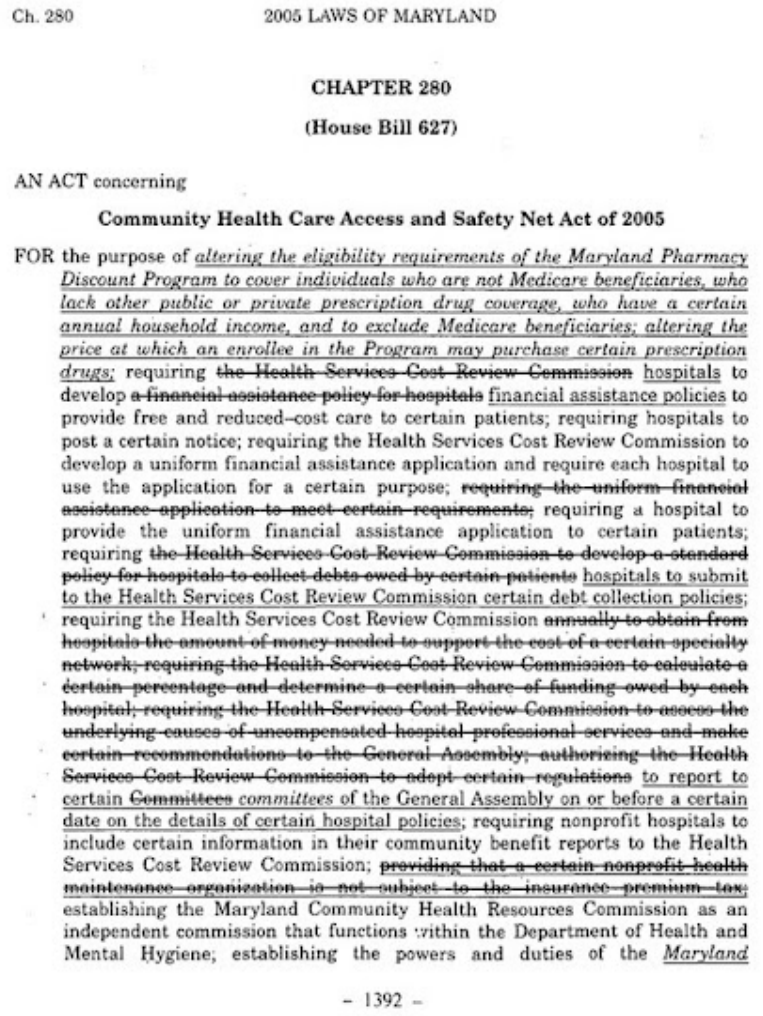
February 11, 2026

Destiny-Simone Ramjohn, PhD, Chair

Mark Luckner, Executive Director

CHRC Statutory Foundation

- The **Maryland Community Health Resources Commission** was created by the General Assembly via the Community Health Care Access and Safety Net Act of 2005
- CHRC **statutory charge**
  - Expand access in underserved communities
  - Strengthen safety net provider capacity
  - Reduce avoidable emergency department use



Ch. 280 2005 LAWS OF MARYLAND

CHAPTER 280

(House Bill 627)

AN ACT concerning

Community Health Care Access and Safety Net Act of 2005

FOR the purpose of *altering the eligibility requirements of the Maryland Pharmacy Discount Program to cover individuals who are not Medicare beneficiaries, who lack other public or private prescription drug coverage, who have a certain annual household income, and to exclude Medicare beneficiaries; altering the price at which an enrollee in the Program may purchase certain prescription drugs;* requiring ~~the Health Services Cost Review Commission~~ hospitals to develop ~~a financial assistance policy for hospitals~~ financial assistance policies to provide free and reduced–cost care to certain patients; requiring hospitals to post a certain notice; requiring the Health Services Cost Review Commission to develop a uniform financial assistance application and require each hospital to use the application for a certain purpose; ~~requiring the uniform financial assistance application to meet certain requirements;~~ requiring a hospital to provide the uniform financial assistance application to certain patients; requiring ~~the Health Services Cost Review Commission to develop a standard policy for hospitals to collect debts owed by certain patients~~ hospitals to submit to the Health Services Cost Review Commission certain debt collection policies; requiring the Health Services Cost Review Commission ~~annually to obtain from hospitals the amount of money needed to support the cost of a certain specialty network; requiring the Health Services Cost Review Commission to calculate a certain percentage and determine a certain share of funding owed by each hospital; requiring the Health Services Cost Review Commission to assess the underlying causes of uncompensated hospital professional services and make certain recommendations to the General Assembly; authorizing the Health Services Cost Review Commission to adopt certain regulations~~ to report to certain ~~Committees~~ *committees* of the General Assembly on or before a certain date on the details of certain hospital policies; requiring nonprofit hospitals to include certain information in their community benefit reports to the Health Services Cost Review Commission; ~~providing that a certain nonprofit health maintenance organization is not subject to the insurance premium tax;~~ establishing the Maryland Community Health Resources Commission as an independent commission that functions within the Department of Health and Mental Hygiene; establishing the powers and duties of the *Maryland*

– 1392 –

Maryland's Community Health Investment Engine

- Strategic, accountable investment platform aligned with state health equity priorities
- Targeted funding to high-need communities to drive measurable system outcomes
- Statewide competitive process with data-driven selection
- Performance-based funding tied to clinical and utilization metrics
- Milestone disbursements with structured monitoring and authority to recover funds

Maryland
DEPARTMENT OF HEALTH

CHRC Priority Investment and Intervention Areas

CHRC directs resources to community interventions that drive system performance:

- Access to primary and behavioral health care
- Community health workers and care coordination
- Home-based and supportive services
- Transportation, nutrition, and legal supports that address social drivers of health

Maryland
DEPARTMENT OF HEALTH

Independent CRISP analysis confirms significant reductions in avoidable utilization.

System-level impact

- 75 percent of grants sustained
- $59.7 million leveraged

CRISP
Chesapeake Regional Information System for our Patients

Pathways to Health Equity Pilot

- 11,051 patients served
- 19 percent reduction in inpatient visits
- 14 percent reduction in ED visits
- 26 percent reduction in readmissions

HERC Early Results

- 9,038 patients served
- 24 percent reduction in inpatient visits
- 11 percent reduction in ED visits
- 27 percent reduction in readmissions

Maryland
DEPARTMENT OF HEALTH

"To every patient, every time, we will provide the care that we would want for our own loved ones."

Maryland
GBMC

Introduction

HealthCare Made Easy

As a Pathways grantee, we connected **1,500** people with advanced primary care

Population

- Low income, minority, medically underserved
- People with diabetes, hypertension, obesity
- Frail, elderly individuals who need in-home care
- Individuals with barriers to care and other social drivers that impact health and wellbeing

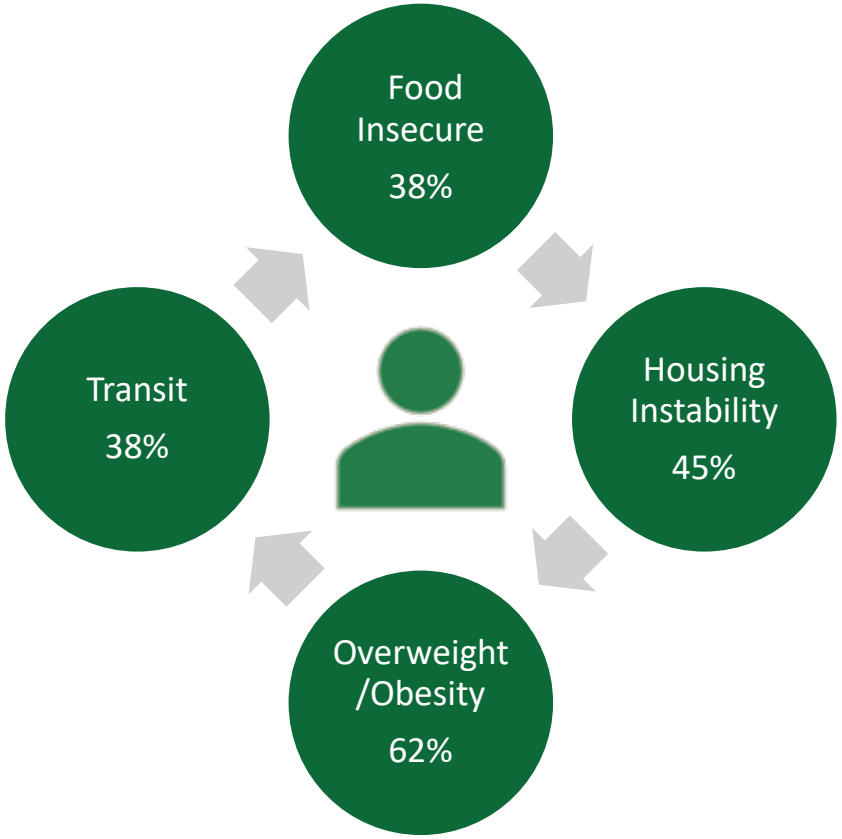
HERC Service Target: **3,025** new patients

"To every patient, every time, we will provide the care that we would want for our own loved ones."

Maryland GBMC

Community Partners & Social Drivers of Health (SDOH)

57% of patients have a SDOH requiring intervention



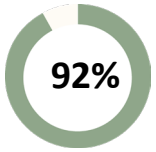
Community Partners

- Govans Ecumenical Development Corporation (GEDCO)
- Mack Lewis Foundation
- Maryland Volunteer Lawyers Services (MVLS)
- The BIT Center
- University of Maryland/Hair Network
- Baptist Ministers Conference of Baltimore

Maryland
DEPARTMENT OF HEALTH

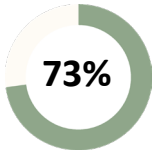
Pathways Outcomes

Chronic Condition Screenings and Control

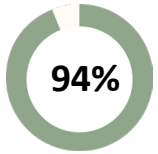


Weight screened

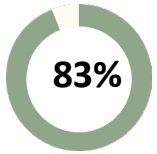
Blood pressure screened



Blood pressure controlled



Diabetics controlled



Depression & Anxiety screened

Community Interventions


98 Events


4,300 received education


57,076+ pounds of food

Reductions in Hospital Utilization

Inpatient Charges


$8,729,096

52% reduction

ED Charges


$1,471,241

26% reduction

REDUCTIONS DATA SOURCE: Data provided by CRISP using HSCRC IP and OP Casemix data including all inpatient discharges and outpatient hospital visits at Maryland acute care hospitals. Analysis includes all visit types combined: IP, ED, OBS>23, and OP Visits.

"To every patient, every time, we will provide the care that we would want for our own loved ones."

GBMC


If you want to go fast, go alone.
If you want to go far,
GO TOGETHER.
African Proverb

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Report from the Executive Director

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Update on Medicare FFS Data & Analysis

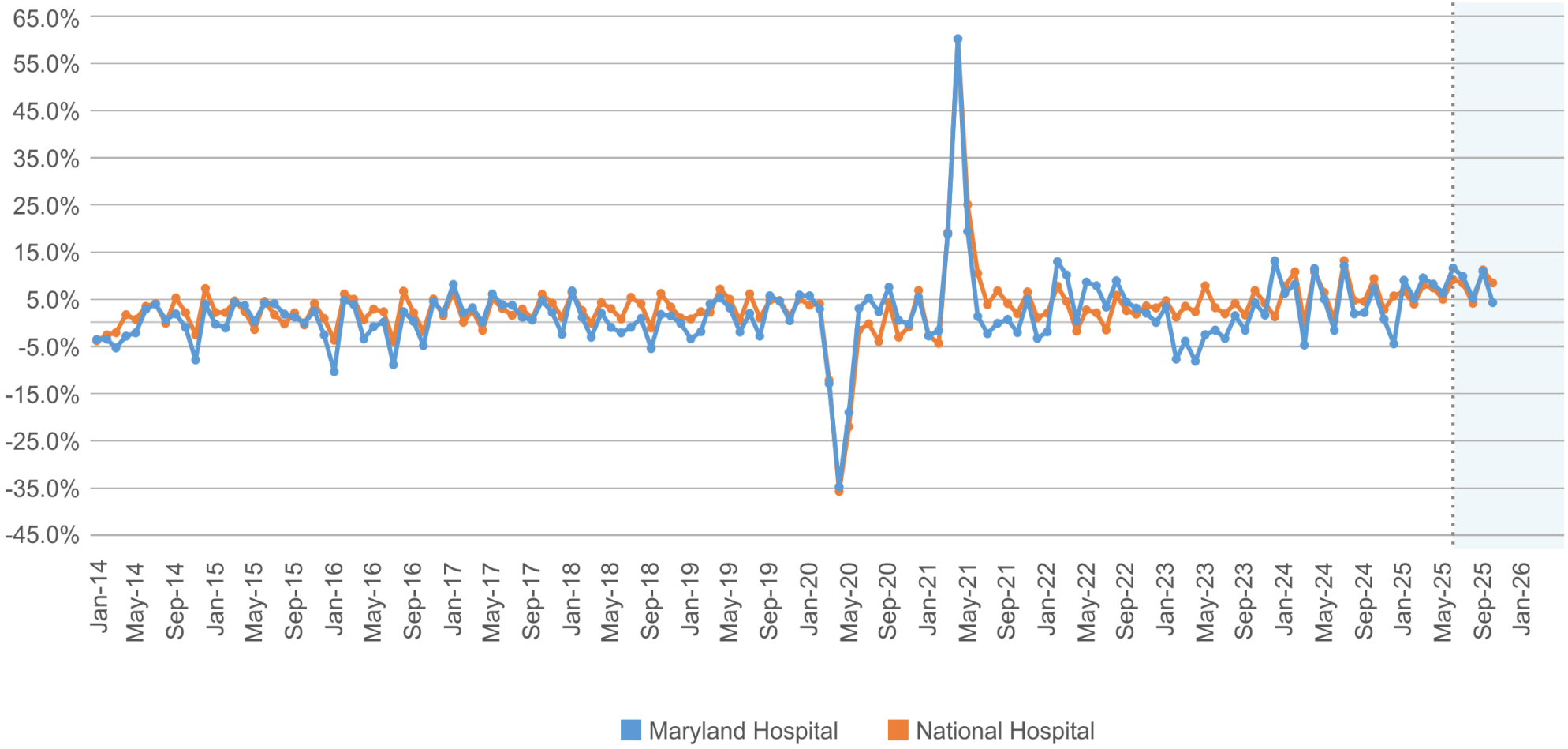
February 2026 Update

Data through October 2025, Claims paid through December 2025

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Hospital Spending per Capita

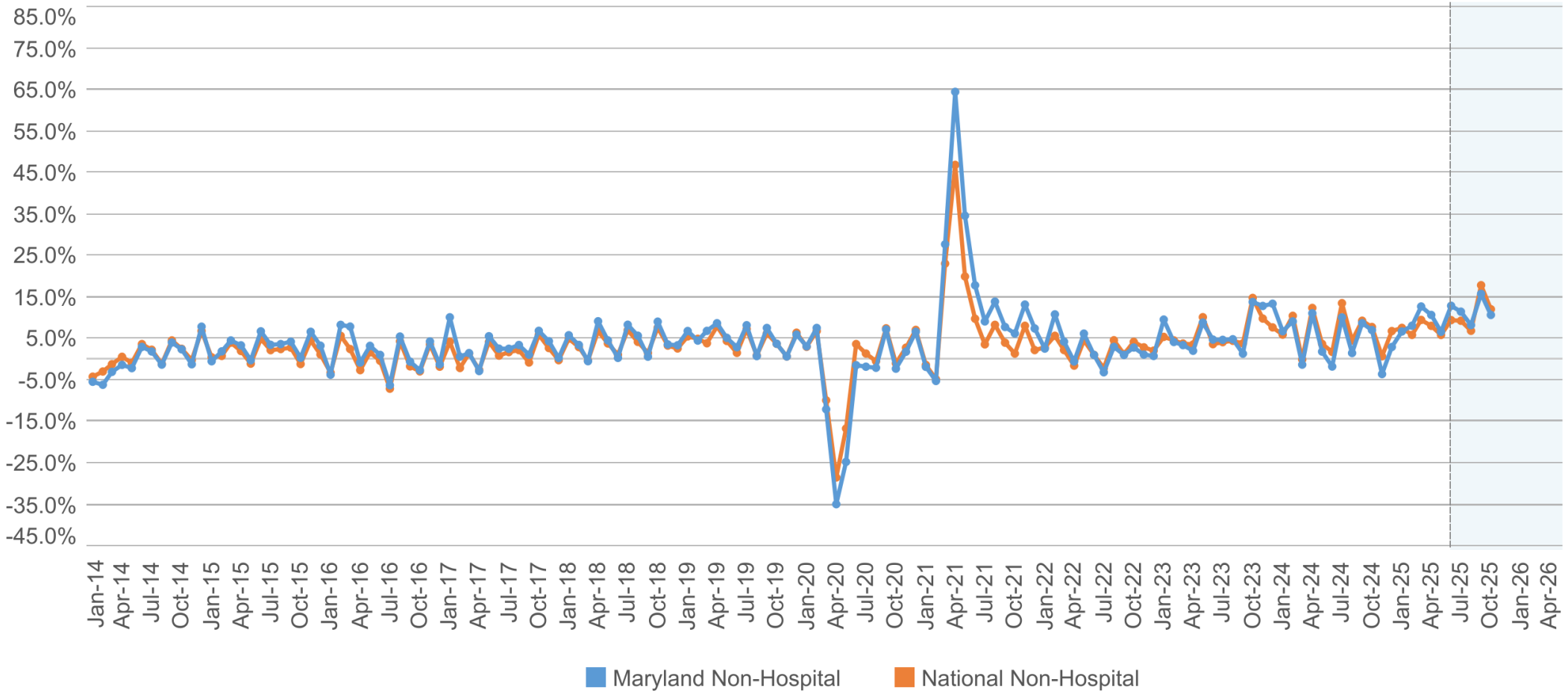
Actual Growth Trend (CY month vs. Prior CY month)



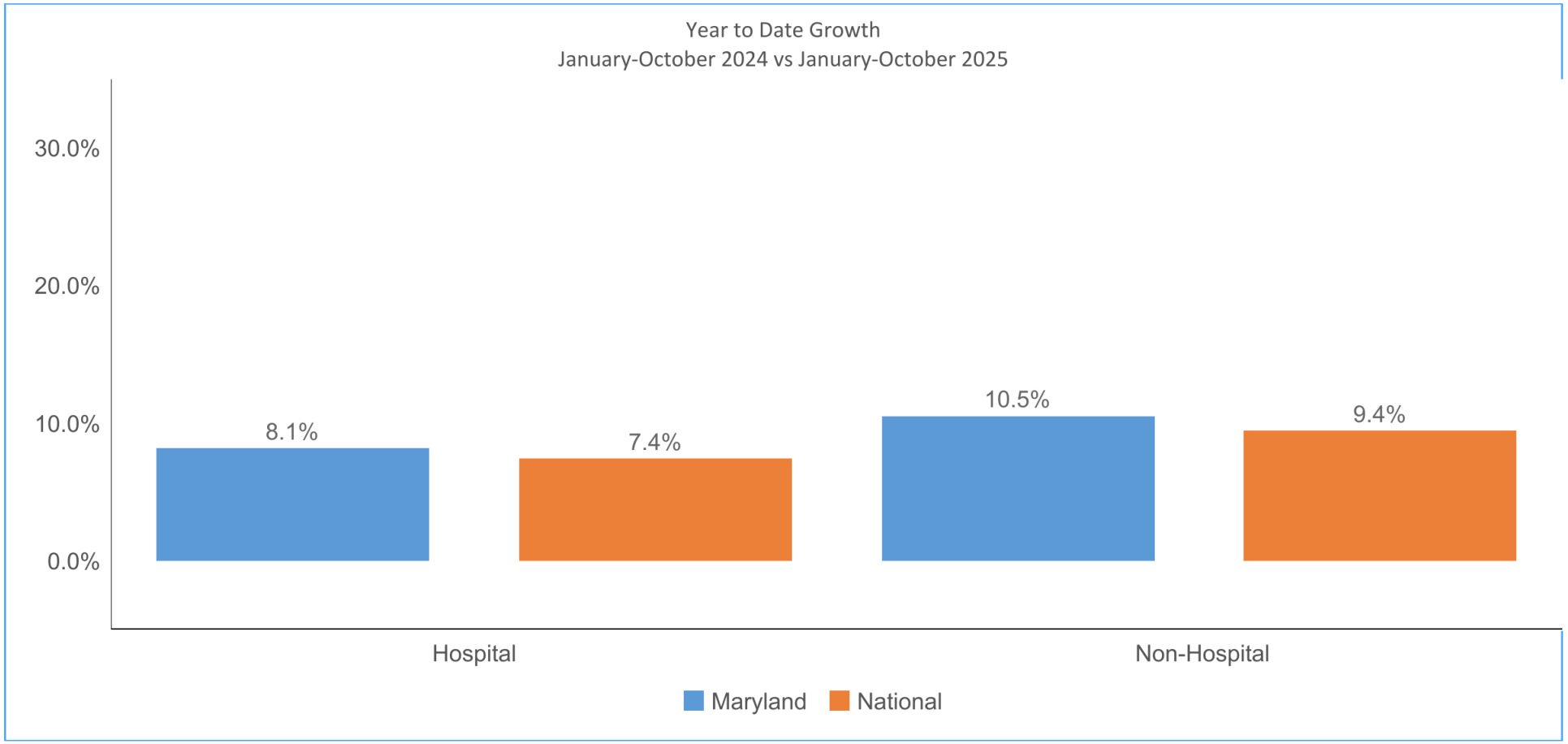
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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

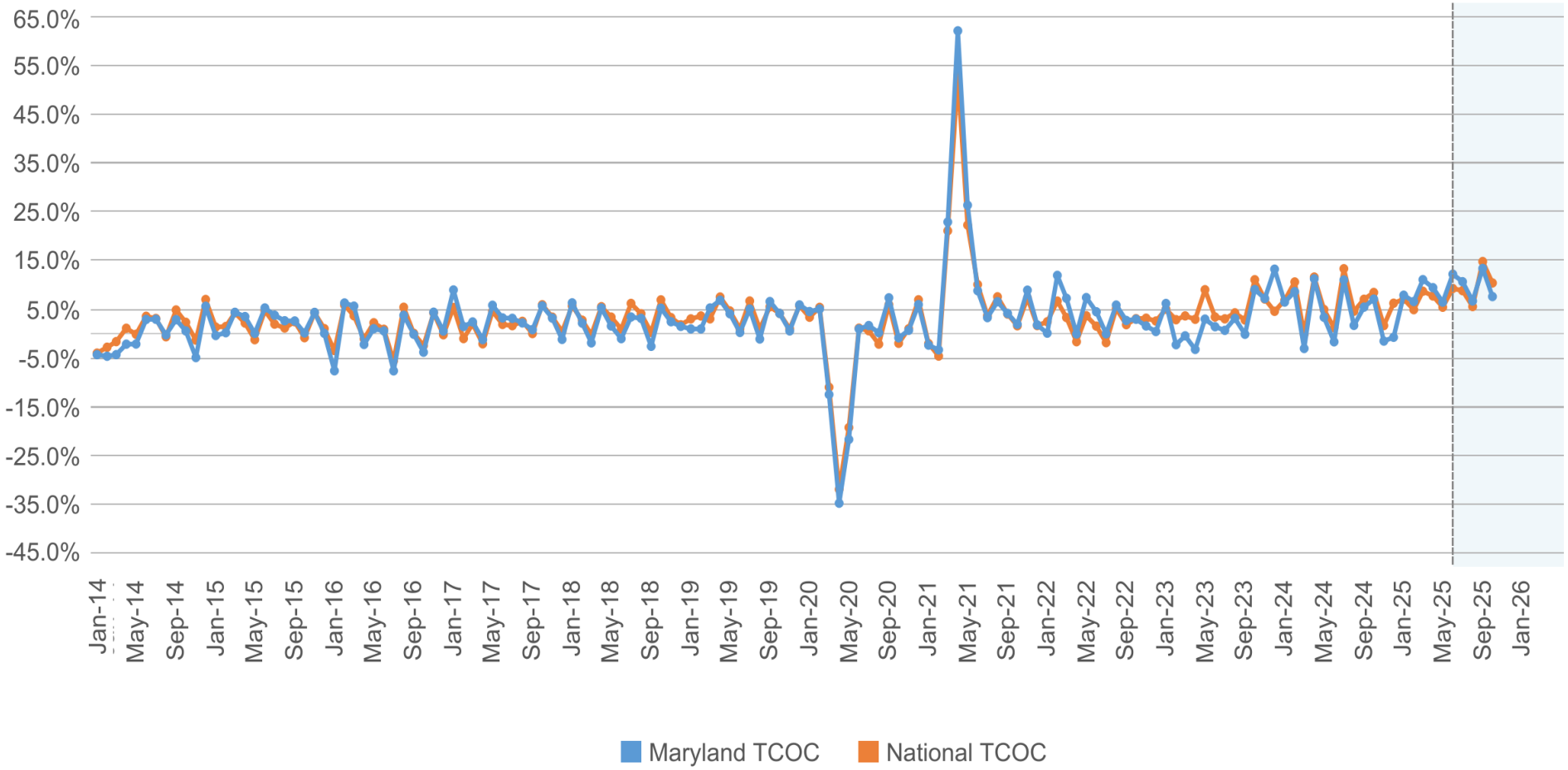


Medicare Hospital and Non-Hospital Payments per Capita



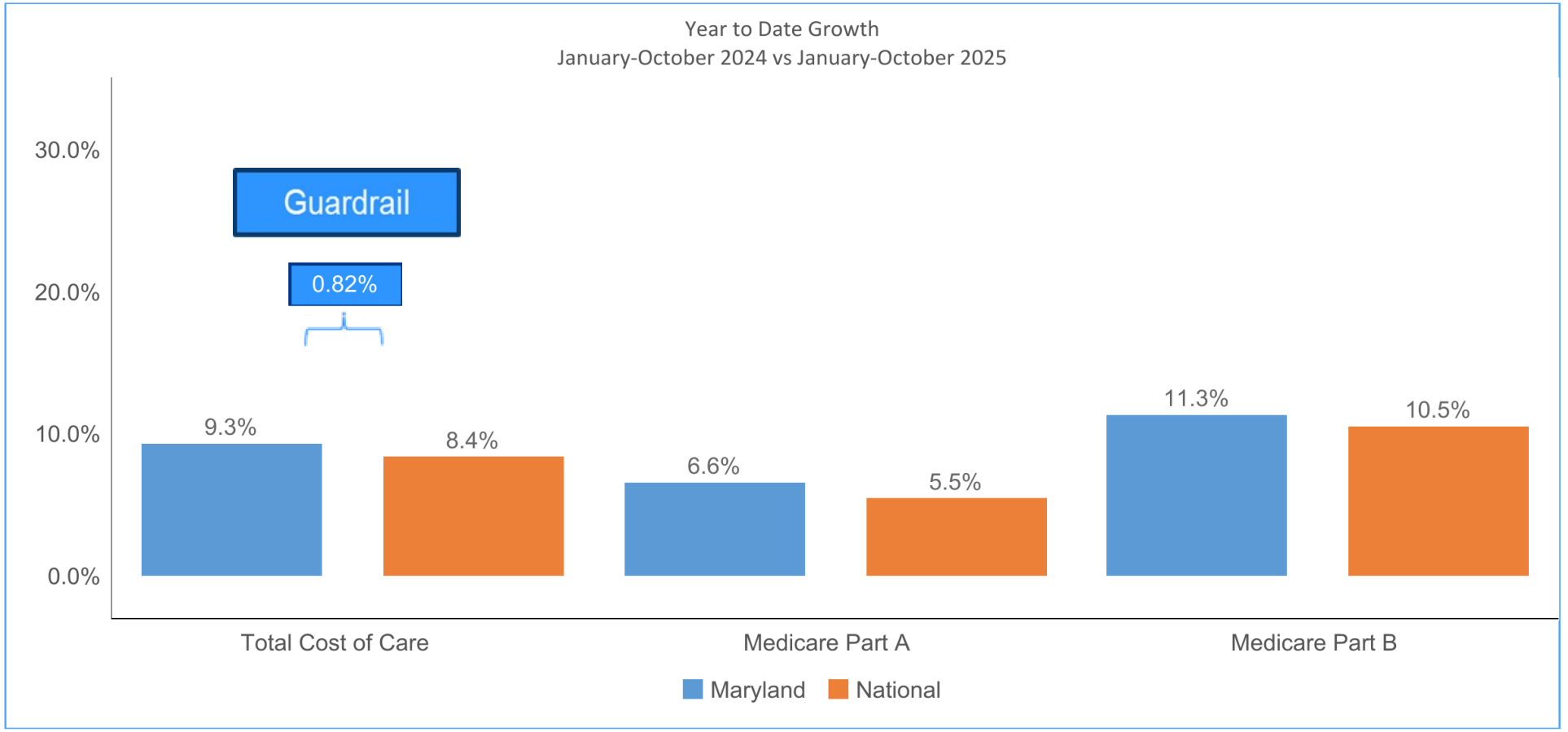
Medicare Total Cost of Care Spending per Capita

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



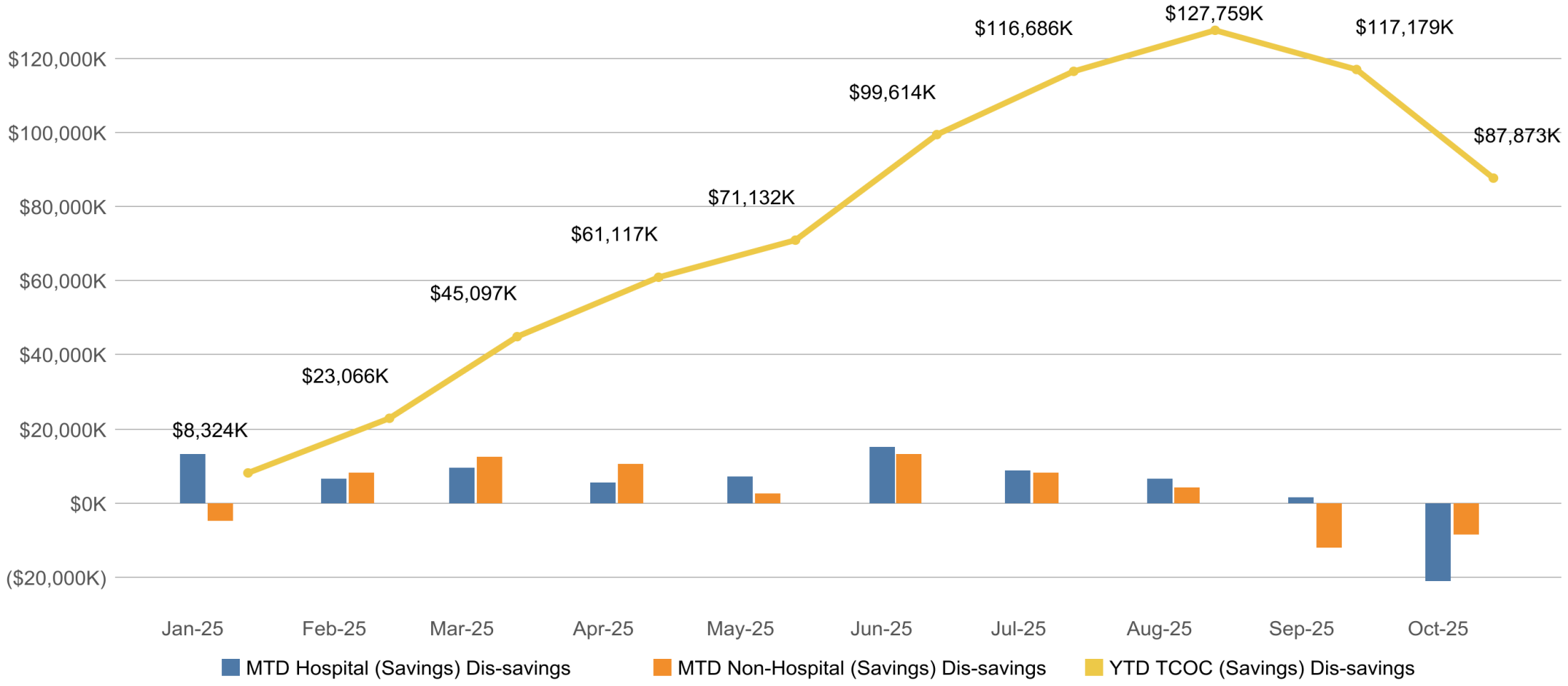
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through October 2025



A positive number represents dissavings/excess growth

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HSCRC AHEAD Model Policy Timeline

Commission Update

February 2026

HSCRC AHEAD Model Policy Timeline

Policy Updates Already Planned	The timeline for these items has already been discussed at HSCRC meetings.
Required Changes for AHEAD Implementation	The AHEAD Model will require changes to some core HSCRC financial policies.
AHEAD-Related Policy Changes	Policy development work not explicitly required by the AHEAD Model, but where policy changes can promote success.
Policy Changes Involving Multiple Agencies	These items involve significant leadership outside HSCRC, with a role for HSCRC in policy development and implementation.*

** Coordinated by Regulatory Working Group*

Key to Timeline Descriptions

S: Staff HSCRC staff are working on policy development and implementation.
W: Workgroup The policy topic will be discussed by an HSCRC workgroup.
C: Call for Public Input The HSCRC will request public comment for policy topics, *i.e.,* that will not ultimately require a Commission vote.
T: Topic discussed at Commission Meeting The Commission will discuss ideas for policy topics as generated by a call for public input.
D: Draft Recommendation HSCRC staff present a draft recommendation at the Commission meeting.
P: Public Comment for Recommendation Stakeholders submit comments in response to a draft recommendation.
F: Final Vote HSCRC staff present a final recommendation for Commission discussion and vote.
Italics indicate that timeline is contingent upon CMMI action.

HSCRC Policy Updates Already Planned

	Oct. 2025	Nov. 2025	Dec. 2025	Jan. 2026	Feb. 2026	Mar. 2026	Apr. 2026	May 2026	Jun. 2026
A. HSCRC Policy Updates Already Planned									
Market Shift	D	P	F						
Demographic Factor	W	D	P	F					
Respiratory Surge (FY 2025 Allocation)	S	C	T						
Respiratory Surge (FY 2026 and Future Allocation)		W	D	F					

Items completed as of January 2026.

Key		
S: Staff	T: Topic Discussed at Commission Meeting	F: Final Vote
W: Workgroup	D: Draft Recommendation	*Italics indicate timeline is contingent upon CMMI action.*
C: Call for Public Input	P: Public Comment for Recommendation	

Required Changes for AHEAD Implementation

	Oct. 2025	Nov. 2025	Dec. 2025	Jan. 2026	Feb. 2026	Mar. 2026	Apr. 2026	May 2026	Jun. 2026
B. HSCRC Policy Changes Required for AHEAD Implementation									
Global Budget Carveouts				*W*	*C/W*	*W*	*S*	*D*	*F*
Aligning Quality Metrics with CMS	*S*	*S*	*S*	*S*	*S*	*S*	*S*	*S*	*S*
Major Capital Program	*S*	*T*	*S*	*S*	*S*	*S*	*S*	*S*	*S*
Medicare Hospital Global Budget supplemental payments and exclusions	*S*	*S*	*S*	*S*	*S*	*S*	*S*	*S*	*S*
Care Innovation				C	W	D	F	S	S
GBR 2028 Policy Review				S	S	S	S	S	S

- Today's Agenda
  - N/A
- March Agenda
  - Care Innovation: Draft Recommendation

Key		
S: Staff	T: Topic Discussed at Commission Meeting	F: Final Vote
W: Workgroup	D: Draft Recommendation	*Italics indicate timeline is contingent upon CMMI action.*
C: Call for Public Input	P: Public Comment for Recommendation	

AHEAD-Related HSCRC Policy Changes

	Oct. 2025	Nov. 2025	Dec. 2025	Jan. 2026	Feb. 2026	Mar. 2026	Apr. 2026	May 2026	Jun. 2026
C. AHEAD-Related HSCRC Policy Changes									
Physician Costs			C	T					
Efficiency Policy							*C*	*S*	*S*
Preventable Utilization - Length of Stay	S	W	S	S	T	D	P	F	
Preventable Utilization - Avoidable Use				C	W	D	F	S	S
Health System Transformation Policy				S	C	T	S	S	S

- Today's Agenda
  - Length of Stay: Commission Discussion
  - Health System Transformation: Call for Public Input
- March Agenda
  - Length of Stay: Draft Recommendation
  - Avoidable Use: Draft Recommendation *(as part of Care Innovation)*
  - Health System Transformation: Discussion

Key		
S: Staff	T: Topic Discussed at Commission Meeting	F: Final Vote
W: Workgroup	D: Draft Recommendation	*Italics indicate timeline is contingent upon CMMI action.*
C: Call for Public Input	P: Public Comment for Recommendation	

Multi-Agency Priorities: Updates and Upcoming Opportunities

Workstream	Status
Maryland-Specific Metrics for AHEAD	Awaiting measure feedback from CMMI
Graduate Medical Education and Workforce*	*Slated to kick off Spring 2026*
Denials	Next meeting of the Adverse Decisions Workgroup will be scheduled for February or March; report due December 2026
Medicare Advantage Market Stabilization*	Qualified Plans will be notified late February; metrics under development.
Post-Acute Strategy*	*Slated to kick off Spring 2026*
Cost-Shifting*	Will be part of FY 2028 update factor; metrics under development.
All-Payer Total Cost of Care Growth and Primary Care Investment Targets*	Advisory Committee selected; meetings scheduled for February 5th, February 23rd and April 10th
Choice and Competition*	*Slated to kick off early 2026*
ED Wait Times Commission	Next Commission meeting scheduled for March 4th

*Coordinated by Regulatory Working Group

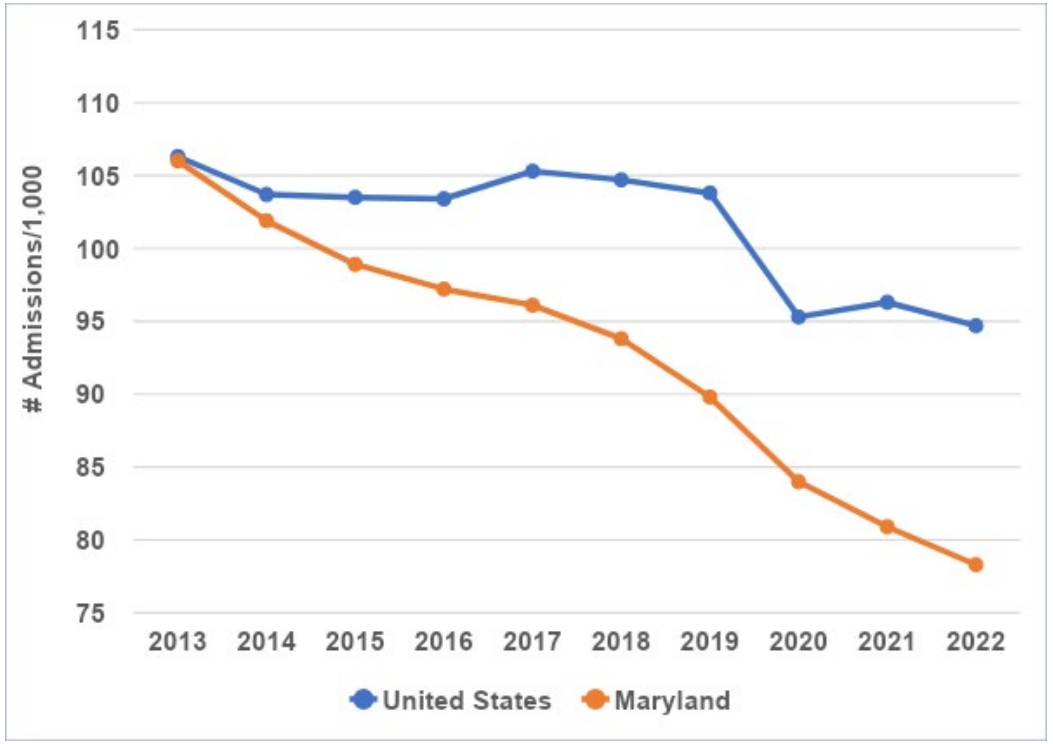
Discussion: Inpatient Length of Stay

Background

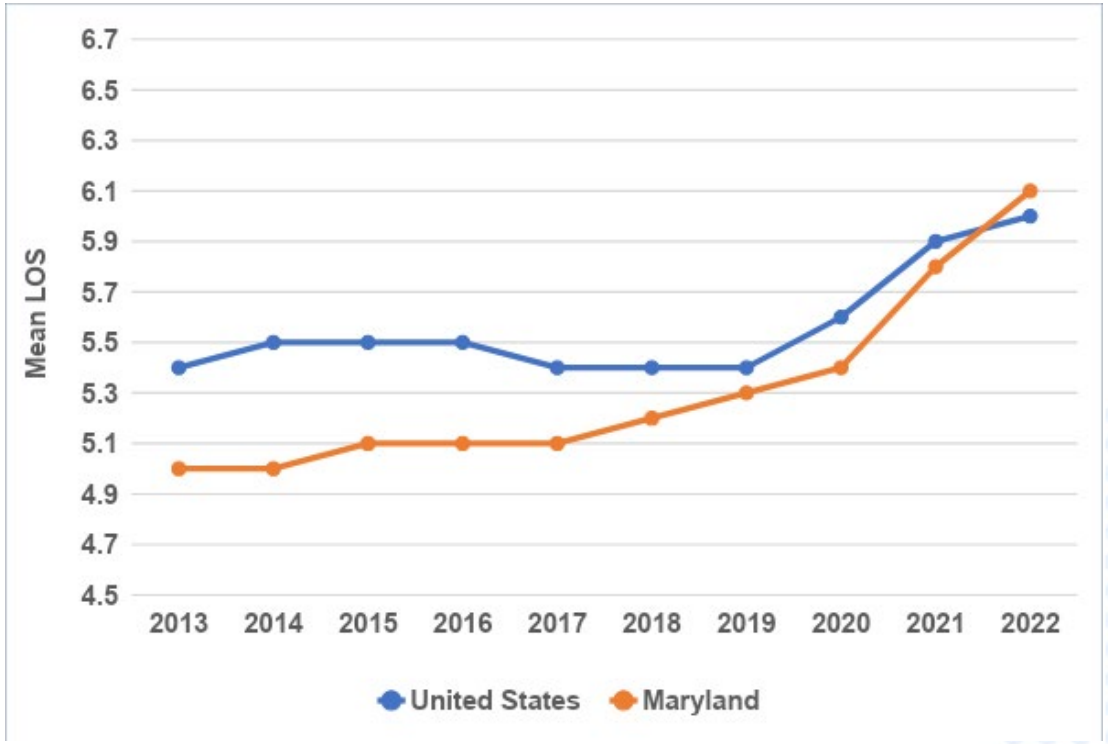
- Global budgets and TCOC accountability create generalized incentives for hospitals to reduce preventable admission volume, inclusive of excess inpatient length of stay (IP LOS)
  - By contrast, the DRG model creates a singular focus on reducing IP LOS
- However, while admission volume has fallen, longer IP LOS has resulted in an overall increase in IP utilization as measured by bed days, thus reducing functional inpatient capacity and making global budgets less financially sustainable
- ~⅔ of hospitals perform better than the nation on Medicare IP LOS; ~⅓ do not.
  - Hospitals with higher LOS are consistently identified regardless of risk adjustment model
  - External factors such as geography, payer mix and clinical acuity do not appear to explain variance across hospitals

Hospital Admissions and LOS, MD vs National, 2013 - 2022

Hospital Admissions per 1,000 Population, 2013-2022



Unadjusted Mean Hospital IP LOS, 2013-2022



Source: https://www.kff.org/state-category/providers-service-use/hospital-utilization/

- Admission rates have dropped in recent years while IP LOS increased

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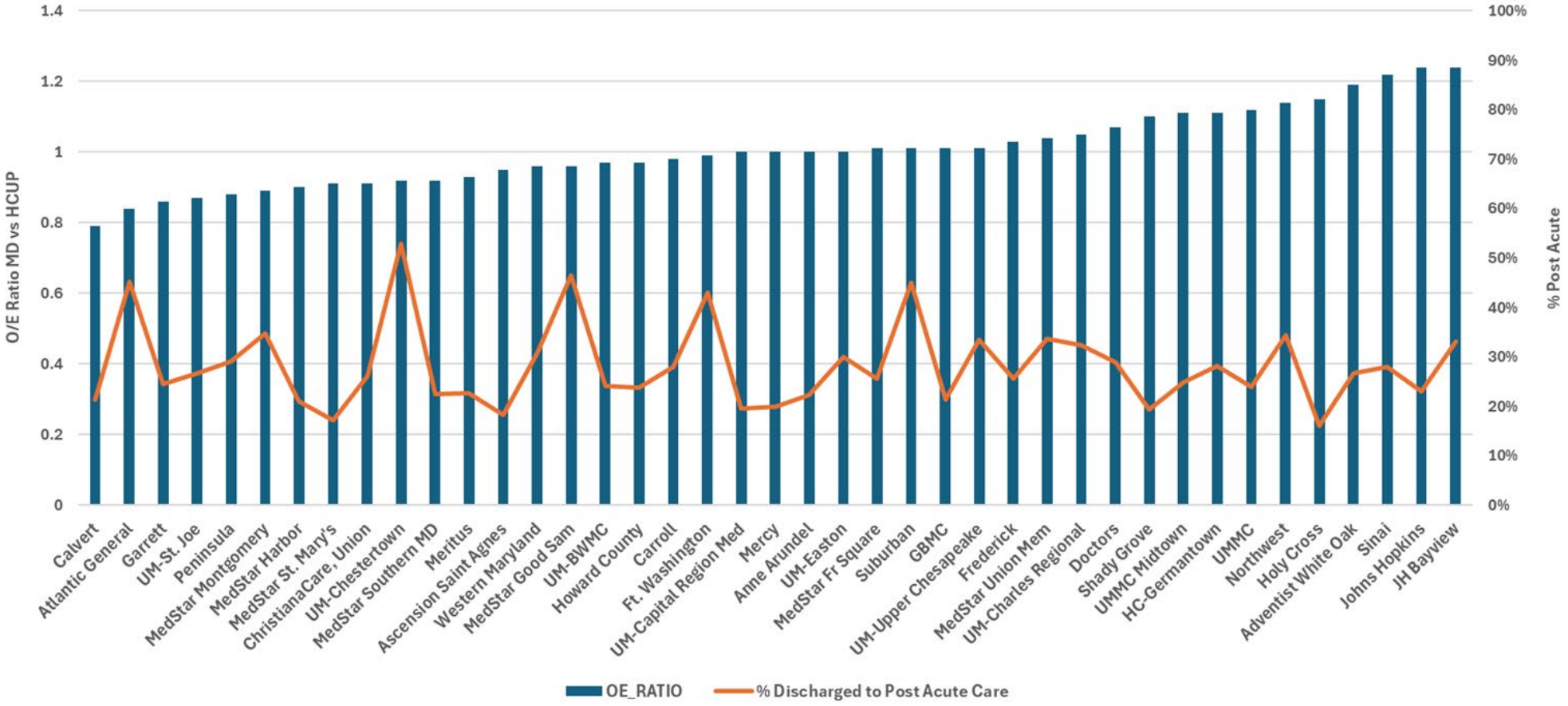
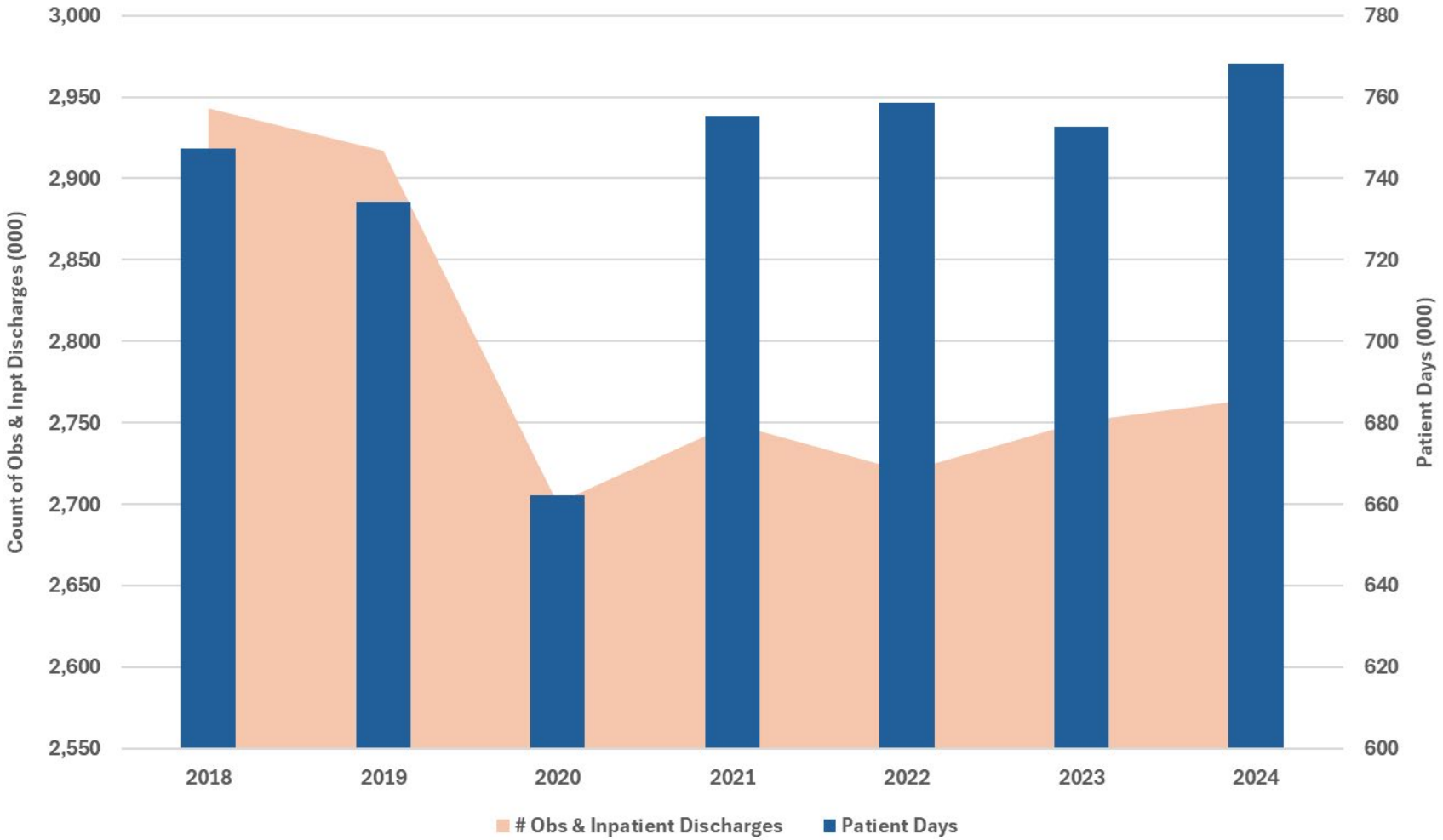
One Third of MD Hospitals Have LOS Higher Than US Average



- 18 out of 41 hospitals have an all-payer IP LOS that exceeds national norms (higher than 1.0 O/E), resulting in 28,952 extra patient days
- Eliminating excess bed days would create additional bed capacity of 79
- Percentage of discharges to post-acute settings is not correlated with IP LOS performance

Source: HSCRC 2025 FY Inpatient Casemix vs HCUP National Dataset 2021 Norms

IP/OBS Patient Days Are Rising Even While Discharges Fall



- LOS exacerbation since the pandemic has reached a critical point because all volume reductions have been eclipsed by growth in ALOS
- Additional analyses do not suggest that rising acuity levels explain LOS exacerbation

Source: HSCRC Casemix

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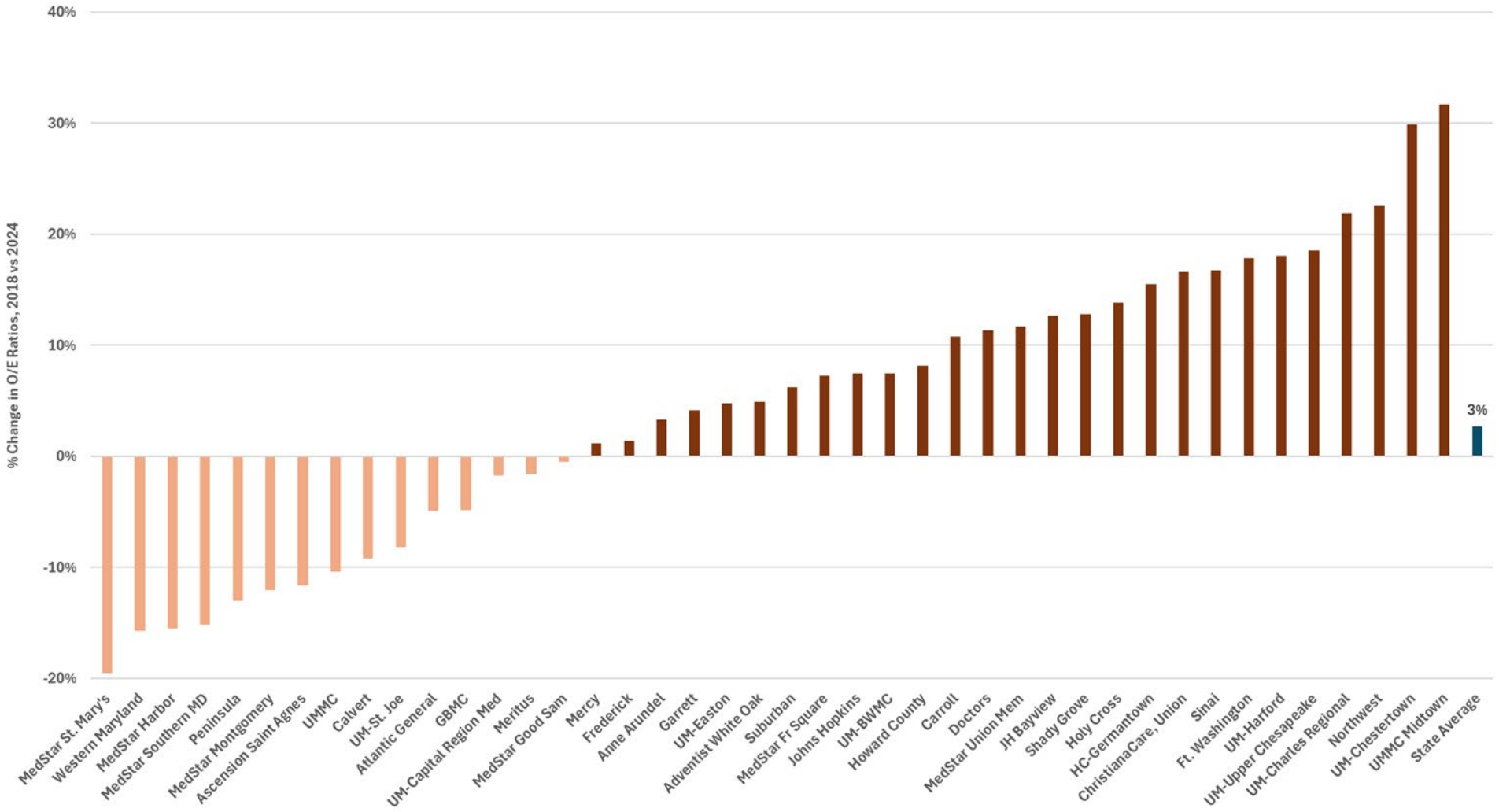
Change in LOS Over Time for IP-Only Procedures, 2018 vs 2024



Based on HSCRC Casemix Inpatient Data, adjusted for severity of illness and APR_DRG using 2018 norms

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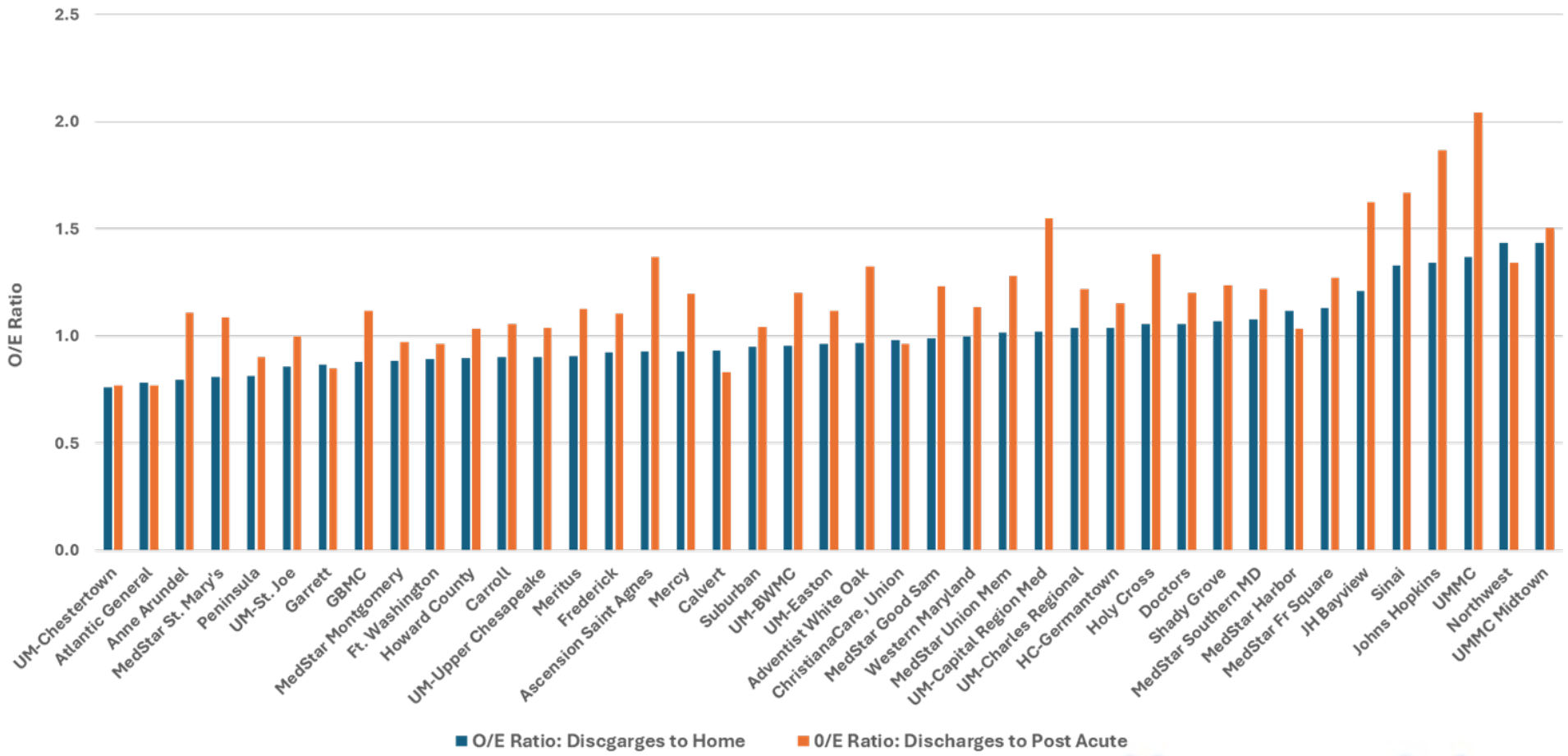
LOS for Routine and Post-Acute Discharges Is Correlated



Hospitals with longer IP LOS often had worse performance for both patients discharged to home and to post-acute care.

This suggests excess LOS could be significantly impacted by hospital factors rather than post-acute availability.

Source: HSCRC Casemix FY 2025_vs39 and HCUP 2021 APR-DRG vs 39

Rationale for an Inpatient LOS Policy

- Model incentives have not adequately constrained LOS growth
- Reducing excess IP LOS is critical to:
  - Optimizing capacity
  - Supporting affordability and financial sustainability
  - Preventing unintended LOS tradeoffs from surge policy implementation.
- Reducing IP LOS is likely the most effective lever to reduce ED boarding and can improve patient safety and outcomes, increase hospital capacity and operational efficiency, and lower costs while improving profitability.

Systematic review has shown that multicomponent interventions such as standardized admission orders, effective clinical pathways, exceptional operational efficiency, and excellent case management reduced inpatient LOS

AHRQ (2021), Interventions to Decrease Hospital Length of Stay. (Retrieved 02032026 from: https://www.ncbi.nlm.nih.gov/books/NBK574435/pdf/Bookshelf_NBK574435.pdf

Next Steps

- Review Commissioner Feedback with Performance Measurement Work Group
- Present draft policy to Commissioners in March or April
- Convene additional workgroup engagements based on stakeholder comment letters
- Present final policy to Commissioners in May or June
- Implement policy approach upon approval

Discussion: Health System Transformation

Discussion: Health System Transformation

To support Maryland's success under AHEAD, the state may be able to reduce excess capacity where it exists to create or realign resources for health access, improved health outcomes and achieve statewide TCOC savings.

HSCRC will solicit public comment on a set of questions that can inform the principles and parameters of a potential draft policy for facility transformations.

Comments on the potential principles are due to MDH.Maryland-Model@maryland.gov on or by March 6th.

Discussion: Health System Transformation

HSCRC is seeking public comment to inform initial policy development:

- **Identifying focus geographic areas:** How should HSCRC identify regions of the state where such health system transformation offers the opportunity to improve access to care and health outcomes, while lowering overall costs? What specific metrics should be utilized?
- **Identifying focus hospitals:** Should the HSCRC focus on discussions with specific types of hospitals? If so, which ones are in the best position to make this transition and why? Alternatively, should the HSCRC establish a process to identify focus hospitals within key geographic areas? And if so, what should that process look like?
- **Additional services:** If an acute care hospital closes or transitions to a different type of facility, how should HSCRC assess the type and quantity of new services to replace the previous services, to assure that the overall access to care improves?

Discussion: Health System Transformation

HSCRC is seeking public comment to inform initial policy development:

- **Emergency department wait times:** How can HSCRC assure that facility transitions will not further increase emergency department wait times?
- **Savings expectation:** What share of savings should be returned to healthcare purchasers? What share should be redirected to the health of the community served by the health system? How should the various priorities for savings be balanced to to align incentives across all parties to promote efficient and effective healthcare delivery?
- **Other considerations:** What other considerations should the HSCRC employ in supporting health system transformations to improve access to care and health outcomes while reducing costs?

Legislative Update

	January	February	March	April
Key Dates	• Session Starts: January 14	• Senate Introduction Deadline: February 9 • House Introduction Deadline: February 13	• Crossover Date: March 23	• Last Day of Session (Sine Die): April 13
What to Expect	• Briefings to Legislative Committees on Key Topics • Bill Hearings in House of Origin	• Bill Hearings • Amendments to Bills • Votes on Bills in the House of Origin • Agency / Department Budget Hearings	• Amendments to Bills • Votes on Bills in the House of Origin • Bill Hearings in Opposite Chamber • Votes on Bills in Opposite Chamber	• Votes on Bills in Opposite Chamber • Conference Committees • Final Votes on Bills in Original Chamber

Sample of Bills Currently Being Monitored

HB 390 SB 282	**Budget Bill FY 2027**	Hearing Status:
Governor's proposed appropriations for FY 2027.		Appropriations Budget and Taxation

HB 392 SB 284	**Budget Bill FY 2027**	Hearing Status:
Budget Reconciliation and Financing Act of 2026		Appropriations Budget and Taxation

Sample of Bills Currently Being Monitored

SB 246	**Health Services Cost Review Commission – Term of Office of Members**	Hearing Status:
Authorizes members to continue to serve for 6 months after the end of their term, rather than until a successor is appointed and qualifies.		Finance 1/27

HB 616 SB 515	**Health Services Cost Review Commission – Health Facilities – Jurisdiction and Rate Setting**	Hearing Status:
Expands the jurisdiction of HSCRC to include the costs for a facility associated with employing or contracting with physicians or other professional providers for which the facility does not receive corresponding offsetting professional revenue, requiring HSCRC to take this information into account when assessing facility resources to meet its financial requirements.		Finance 2/24

Sample of Bills Currently Being Monitored

HB 494	**Health Insurance – Primary Care Investment Targets – Reimbursement and Reporting**	Hearing Status:
Requires certain entities to provide reimbursement to health care providers in a manner that meets the annual primary care investment targets, and to provide a description of the entity's progress in meeting the targets when filing a premium rate or rate change with the Commissioner.		Health 2/12

HB 599	**Health – Licensure of Hospitals – Ownership Requirements**	Hearing Status:
Requires hospitals to qualify as a nonprofit organization under federal law and to be registered as a nonprofit organization in the State as a condition of licensure, limits transfer of ownership of a licensed hospital to nonprofit organizations.		Health 2/11

Sample of Bills Currently Being Monitored

HB 362 SB 169	**Hospitals – Emergency Pregnancy-Related Medical Conditions – Procedures**	Hearing Status:
Requires hospitals to conduct screening on a patient presenting at an emergency department to determine whether the patient has an emergency pregnancy-related medical condition, and establishing requirements and prohibitions related to the treatment and transfer of a patient who has an emergency pregnancy-related medical condition.		Finance 1/21 Health 2/11

HB 795	**Health Insurance – Artificial Intelligence – Grievance Process and Reporting (AI Health Insurance Accountability Act of 2026)**	Hearing Status:
Requires a carrier's internal grievance process to provide for human review of grievances resulting from adverse decisions made using artificial intelligence, algorithm or other software tools, and requiring carriers to support certain information on such grievances, and to provide a model review process		Health 2/19

Questions?

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Final RY 2028 Maryland Hospital Acquired Conditions Policy

February 11, 2028

HSCRC Quality Team

Overview of MHAC Policy & RY 2028 Recommendations

- Policy holds 2 percent of hospital revenue at-risk for rewards/penalties for hospital acquired complications that occur during a hospital stay, as a result of treatment, rather than the underlying progression of disease.
    - Examples: sepsis, pulmonary embolisms, surgical-site infections.
- Measure recommendations:
    - Continue assessing performance using the Solventum Potentially Preventable Complication (PPC) measures and composite methodology approved in RY 2027.
    - Add all-payer AHRQ PSI-90 composite measure weighted similarly to CMS HACRP (i.e., 1/6th of MHAC score).
    - Maintain the NHSN HAI measures in the QBR program.
- Revenue adjustment recommendations:
    - Do not adopt HACRP methodology of 1 percent IP revenue penalty for worse quartile of hospitals; continue to provide hospitals with potential for both scaled rewards and penalties of up to 2 percent inpatient revenue.

Summary of Stakeholder Feedback

Specific Comments in Letters	HME	MHA	UMMS	Adventist	JHHS
Maximize multi-payer alignment: reduce administrative complexity, ensure manageable timelines, maintain quality incentives	X	X	X	X	X
3-year Transition time is too lengthy					X
Discontinue for RY 2028, or continue the use of Solventum PPCs for RY 2028 and then discontinue		X	X	X	X
AMC concerns with PPCs			X		
Include AHRQ PSI-90 for RY2028	X	X	X		X
Monitoring AHRQ PSI-90 until full alignment with HACRP				X	
Consider weight of PSI-90					X
Add NHSN measures in RY 2029		X		X	
Maintain rewards in RY 2028 and beyond; communicate rewards and penalty structures for non-Medicare well in advance.		X		X	
2 percent revenue at-risk contingent on there being no other additional revenue at-risk for RY 2028			X		
Evaluate revenue at risk compared to other states and consider a more balanced approach that risks less hospital revenue					X

Medicaid Feedback on Overall Quality Under AHEAD

Medicaid feedback also provided in a letter:

- Strongly urges continuation of hospital quality programs relevant to Medicaid by HSCRC
- Highlights measures such as Pediatric Quality Indicators in PAU and Medicaid Timely Follow up in QBR are particularly relevant for Medicaid
- Notes that an annual report submitted by the state must demonstrate that value-based programs for Medicaid and commercial payers meet or exceed previous results
- Medicaid director notes that if quality performance assessments for Medicaid are diminished in any capacity under AHEAD, Medicaid will develop and implement Medicaid-specific hospital quality and payment programs

General Concerns of AHEAD Transition

Stakeholder Questions and Feedback:

- **Commission Discussion:** Can quality programs be suspended during transition?
- **MHA and Hospitals:** RY 2028 Quality policies should maximize multi-payer alignment in order to reduce administrative complexity, ensure manageable timelines, while maintaining quality incentives. Establish Monitoring program for Maryland-Specific Measures.
- **Hopkins:** 3-Year Transition is too lengthy (i.e., transition in CY 2027, not CY 2028).

Staff Response:

- AHEAD model agreement requires continuation of all-payer quality programs during the PYs 1 and 2, with specific language that starting in CY 2028 the revenue adjustments will be under applicable quality program and revenue adjustments based on Medicare programs can begin in either CY 2029 or 2030.
- Policy recommends incremental alignment with HACRP with addition of all-payer PSI composite.
- Staff will work with stakeholders to further align quality policies with CMS, while reserving the ability to depart from national measures or revenue adjustment methodology (e.g., to address areas of importance specific to Maryland and model or populations of interest such as Medicaid).
- Staff will work with stakeholders to determine whether transition to Medicare policies in CY 2027 is feasible and fair.

Measure Alignment with CMS HACRP Program

Stakeholder Feedback:

- PPCs are not included in the CMS quality programs.
  - Specific concerns on PPCs: Lack of specific value of PPCs and cost of proprietary grouper (JHHS), Plateau on improvement and AMC concerns (UMMS)
- Overlap/duplication of measures across PPC and PSIs.
- HME supports use of both the PPCs and PSIs for comprehensiveness and inclusion of medical admissions in policy

Staff acknowledges the lack of alignment with CMS in using PPCs:

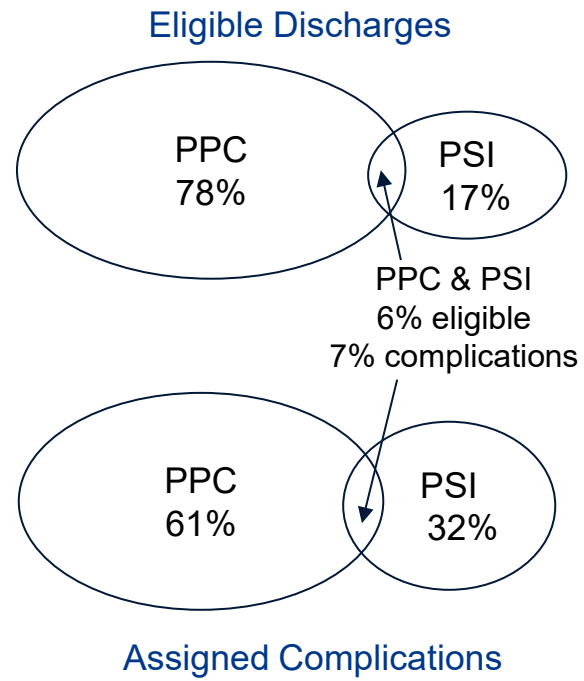
- Recommends including both PPCs and PSIs as both capture unique events for similar complications:
  - PPCs assess medical and surgical patients and areas such as maternal complications not assessed by PSIs;
  - PSI composite includes some additional areas of clinical importance (previously in QBR).
- Staff requests time to conduct a review of complication measures before discontinuing use of PPCs; plan to convene subgroup this year to consider CMS overall strategic direction and evaluate measures for inclusion in MD program.
  - Will consider concerns on value and proprietary costs in assessment of future measures for inclusion

Unique PPCs	Similar PPCs and PSIs		Unique PSIs
			PSI 10 Postoperative Acute Kidney Injury w/Dialysis
			PSI 3 Pressure Ulcer
	PPC 3 Acute Pulmonary Edema and Resp Failure w/o Ventilation	PSI 11 Postoperative Respiratory Failure	
	PPC 4 Acute Pulmonary Edema, Resp Failure w/ventilation	PSI 11 Postoperative Respiratory Failure	
	PPC 7 Pulmonary Embolism	PSI 12 Postoperative Pulmonary Embolism or DVT	
	PPC 16 Venous Thrombosis	PSI 12 Postoperative Pulmonary Embolism or DVT	
	PPC 28 In-Hospital Trauma and Fractures	PSI 8 In Hospital Fall and Fracture	
	PPC 35 Septicemia & Severe Infections	PSI 13 Postoperative Sepsis Rate	
	PPC 37 Post-Operative Infection & Deep Wound Disruption Without Procedure	PSI 14 Postoperative Wound Dehiscence	
	PPC 41 Peri-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D	PSI 9 Perioperative Hemorrhage or Hematoma	
	PPC 42 Accidental Puncture/ Laceration During Invasive Procedure	PSI 15 Abdominopelvic Accidental Puncture or Laceration	
	PPC 49 Iatrogenic Pneumothorax	PSI 6-Iatrogenic pneumothorax	
PPC 5 Pneumonia and Other Lung Infections			
PPC 6 Aspiration Pneumonia			
PPC 47 Encephalopathy			
PPC 9 Shock			
PPC 60 Major Puerperal Infection and Other Major Obstetric Complications			
PPC 61 Other Complications of Obstetrical Surgical & Perineal Wounds			

Additional Important Clinical Areas

Maternal Complications

Post-Surgical Focus of PSI



Revenue Adjustment Methodology: Maintain Rewards/Penalties

Stakeholder Feedback:

- In general, hospitals want to maintain scaled rewards and penalties:
  - Rewards can be used for investments in quality improvement (Adventist).
  - Request to communicate approach for revenue adjustments for planning/budgeting (MHA).
  - Supports 2 percent at risk if no additional $ at-risk for HSCRC programs for RY 2028 (UMMS).
  - Evaluate and potentially decrease at risk revenue by comparing to other states (JHHS).
- HME supports policy and highlights that “programs like MHAC serve as a vital guardrail in a global budget environment”.

Staff responses:

- Commission has historically supported both rewards and penalties; staff would support continuation of rewards but requests hospitals to provide rationale to support deviation from the CMS methodology, for example:
  - Evidence that rewards used to invest in quality measure infrastructure,
  - Rewards promote better patient care or lead to focus on areas of poor performance or populations of importance to the state such as the Medicaid population, etc.
- Staff cannot prospectively guarantee additional policies will not recommend more revenue at risk.
- CMMI still requires Maryland to meet aggregate at-risk requirements for quality.
- Staff agrees with HME support for quality policies given global budgets.

Recap: Comparison of MHAC and CMS Hospital Acquired Conditions Reduction Program (HACRP)

	Maryland MHAC Program	CMS HACRP Program
Revenue at Risk	**Rewards and Penalties:** Up to **2 percent** of inpatient revenue for **rewards or penalties** based on preset scale.	**Penalty Only: Full 1 percent penalty** applied to Medicare hospital revenue for **worst performing quartile** of hospitals.
Measures	16 All-Payer Potentially Preventable Complications (PPCs); proposed addition of PSI 90.	5 CDC NHSN Healthcare-Associates Infections AHRQ Patient Safety Indicator Composite (PSI-90) for Medicare
Scoring Calculation	**PPC Composite:** Weighted sum of the hospital's observed divided by the weighted sum of the hospital's expected for each payment PPC measure for which a hospital has any expected. **Performance Standard:** Convert the PPC composite to a percent score by comparing results to a threshold and benchmark, which is set at average of 20th and 80th percentiles from the base period.	**Total HAC Score:** Sum of winsorized z-scores for each measure the hospital is eligible. Hospitals need only one qualifying measure to be included. Each measure is equally weighted. Relatively rank hospitals and penalize the worst performers.
RY 2028 Time Periods	Base: July 2023 through June 2025 Performance: CY 2026* *CYs 2025 and 2026 for small hospitals	PSI-90: July 2024 through June 2026. CDC NHSN HAIs: January 2025 through December 2026

RY 2028 Final Recommendations for MHAC Program

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 a quality program for revenue adjustments to Maryland hospital global budgets (HGB).

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Final Recommendation for the Maryland Hospital Acquired Conditions Program for Rate Year 2028

February 11, 2026

This document contains the final recommendations for the RY 2028 Maryland Hospital Acquired Conditions Program.

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List of Abbreviations

AHEAD	State's Achieving Healthcare Efficiency through Accountable Design Model
AHRQ	Agency for Health Care Research and Quality
APR-DRG	All Patients Refined Diagnosis Related Groups
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DRG	Diagnosis-Related Group
FFY	Federal Fiscal Year
FY	State Fiscal Year
HAC	Hospital-Acquired Condition
HACRP	Hospital Acquired Conditions Reduction Program (CMS)
HAI	Hospital Associated Infection
HGB	Hospital Global Budgets
HSCRC	Health Services Cost Review Commission
ICD	International Statistical Classification of Diseases and Related Health Problems
Medicare FFS HGB	Medicare fee-for-service hospital global budgets
Maryland HGB	Maryland hospital global budgets (i.e., global budgets run by state for commercial, medicaid, etc)
MHAC	Maryland Hospital-Acquired Condition
NHSN	National Healthcare Safety Network
NQF	National Quality Forum
PMWG	Performance Measurement Work Group
POA	Present on Admission
PPC	Potentially Preventable Complication
PSI	Patient Safety Indicator
QBR	Quality-Based Reimbursement
RY	Rate Year
SIR	Standardized Infection Ratio
SOI	Severity of Illness
TCOC	Total Cost of Care
HVBP	Hospital Value-Based Purchasing (CMS)
YTD	Year to Date

Key Methodology Concepts and Definitions

Potentially Preventable Complications (PPCs): 3M originally developed 65 PPC measures, which are defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness. PPCs, like national claims-based hospital-acquired condition measures, rely on **present-on-admission codes** to identify these post-admission complications.

At-risk discharge: Discharge that is eligible for a PPC based on the measure specifications

Diagnosis-Related Group (DRG): A system to classify hospital cases into categories that are similar clinically and in expected resource use. DRGs are based on a patient's primary diagnosis and the presence of other conditions.

All Patients Refined Diagnosis Related Groups (APR-DRG): Specific type of DRG assigned using 3M software that groups all diagnosis and procedure codes into one of 328 All-Patient Refined-Diagnosis Related Groups.

Severity of Illness (SOI): 4-level classification of minor, moderate, major, and extreme that can be used with APR-DRGs to assess the acuity of a discharge.

APR-DRG SOI: Combination of Diagnosis Related Groups with Severity of Illness levels, such that each admission can be classified into an APR-DRG SOI "cell" along with other admissions that have the same Diagnosis Related Group and Severity of Illness level.

Case-Mix Adjustment: Statewide rate for each PPC (i.e., normative value or "norm") is calculated for each diagnosis and severity level. These statewide **norms** are applied to each hospital's case-mix to determine the expected number of PPCs, a process known as **indirect standardization**.

Observed/Expected Ratio: PPC rates are calculated by dividing the observed number of PPCs by the expected number of PPCs. Expected PPCs are determined through case-mix adjustment.

Diagnostic Group-PPC Pairings: Complications are measured at the diagnosis and Severity of Illness level, of which there are approximately 1,200 combinations before one accounts for clinical logic and PPC variation.

Zero norms: Instances where no PPCs are expected because none were observed in the base period at the Diagnosis Related Group and Severity of Illness level.

Final Recommendations

This document puts forth the final RY 2028 Maryland Hospital Acquired Conditions (MHAC) policy recommendations for consideration. This policy discusses the AHEAD transition and potential options for incremental alignment of MHAC with the CMS Hospital Acquired Complications Reduction Program.

The Final recommendations for the RY 2028 Maryland Hospital Acquired Conditions (MHAC) program are as follows:

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 a quality program for revenue adjustments to Maryland hospital global budgets (HGB).

Introduction

Maryland hospitals have been and are currently funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under agreements with the Centers for Medicare & Medicaid Services (CMS) for the state to operate the All-Payer Model (CY 2014-CY 2018), the Total Cost of Care (TCOC) Model (2019-2026), and the current AHEAD model (CY 2026-CY 2035). Under the new AHEAD Model the state will transition in CY 2028 (Performance Year 3) to CMS establishing hospital global budgets for Medicare FFS and to the HSCRC establishing hospital global budgets for all other payers (i.e., non-Medicare FFS). Under the Medicare FFS hospital global budgets, hospitals will be held accountable for quality under the CMS quality programs and through additional AHEAD incentives, while the state may maintain quality programs for all other payers. HSCRC staff is collaborating with CMMI, hospitals, the Maryland Hospital Association (MHA),state leaders, other state health agencies, and the broad array of stakeholders on the Performance Measurement Workgroup to develop a transition plan that increases the alignment between the state's

performance based payment programs and the CMS national programs over the initial years of the AHEAD model.

Under global budget systems, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk under Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. It is important under global budgets to ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Commission's quality programs to date have rewarded quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

The Maryland Hospital Acquired Conditions (MHAC) program is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time. The program currently holds 2 percent of hospital revenue at-risk for in-hospital complications that may occur during a hospital stay as a result of treatment rather than the underlying progression of disease. The MHAC program uses the Solventum Potentially Preventable Complication (PPC) measures of in-hospital complications such as sepsis, respiratory failure, pulmonary embolisms, and surgical-site infections.

Transitioning to the AHEAD Model

The AHEAD Model, which will begin in January 2026, includes a two year transition period where the state will maintain its all-payer rate setting system. The new CMS hospital global budgets will begin in CY 2028 and at that time the hospitals will be transitioned to the CMS quality programs for Medicare FFS and the state will administer quality programs for other payers. For RY 2028, which will assess CY 2026 performance, staff is working to assess all of the quality programs to determine opportunities for better alignment with the CMS programs. The initial focus of the state's transition work has been on aligning the Quality Based Reimbursement (QBR) program with the Hospital Value-Based Purchasing (HVBP) program; this effort also has implications for early steps to align the MHAC program with the CMS Hospital Acquired Conditions Reduction Program (HACRP) program. In-hospital complications are assessed in both the QBR and MHAC programs, as well as their CMS counterparts. Thus, changes to these policies and an evaluation of hospital complication measures should be considered in tandem. Appendix A provides a high-

level overview on quality assessments in the AHEAD Model, including a visual timeline for transitioning to the CMS quality programs in FFY 2029 or FFY 2030, with the earlier year transition contingent upon system implementation readiness.

This final policy recommends options on early steps to align the MHAC program with HACRP in advance of the transition to the new AHEAD global budget system for Medicare FFS. The Assessment section of this final MHAC policy includes an evaluation of performance on payment PPCs, as well as performance on the Agency for Healthcare Research and Quality's Patient Safety Index (AHRQ PSI) measures and the National Healthcare Surveillance Network Hospital Acquired Infections that are used in the CMS HACRP. For the RY 2028 MHAC policy, staff proposes to maintain the RY 2027 PPC composite measure and adding the all-payer AHRQ PSI composite. Previously, the all-payer AHRQ PSI measure was included in the QBR policy for Maryland but the Medicare PSI measure is included in the CMS HACRP program. Thus, to better align the Maryland programs with the CMS programs, staff recommends moving the AHRQ PSI composite into the MHAC program but maintaining its all-payer focus for CY 2026 measurement. The recommendation to maintain PPCs, which have been used in Maryland since the start of the APM in 2014, is based on their all-payer focus and broader assessment of complications than the PSIs or NHSN HAIs. However, staff recognizes that long term, additional work needs to be done to assess the appropriateness of continuing to use the PPCs given they are not used by CMS.

Thus, during CY 2026, staff proposes to engage stakeholders to assess opportunities for further alignment with CMS quality programs under Medicare FFS HGB and to develop a complications program for other state payers (i.e., Maryland HGB). Specifically, alignment entails consideration of measures, measurement domains and weighting, performance standards, performance periods, and revenue adjustment methodology. In a detailed or targeted sense, alignment can mean an exact replication of the CMS quality programs; in a broader sense, alignment can mean harmonizing with national hospital quality program priorities and intentions.

In addition to the Quality program Guiding Principles established at the beginning of the APM, the following criteria are proposed for deciding what measures to include in the policy and the weights:

1. Alignment with CMS quality programs
2. Maintenance of all-payer accountability and incentives for quality
3. Reduction of retrospective measure evaluations to the extent possible

4. Attention to areas of poor performance and/or priority area for State, hospitals, payers, or other stakeholders

Staff will continue to vet details of this transition across all of the RY 2028 quality policies with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Background

Overview of the MHAC Policy and Comparison with CMS Hospital Acquired Conditions Reduction Program

Because of the state's unique all-payer hospital model and its global budget system, Maryland does not participate in the federal pay-for-performance programs. Instead, the state administers the Maryland Hospital Acquired Conditions (MHAC) program, which relies on quality indicators validated for use with an all-payer inpatient population. The MHAC program was first implemented for Rate Year 2011. Measures used are based on a classification system developed by 3M Health Information Systems (3M), now Solventum. To identify potentially preventable complications (PPCs), the system uses the present-on-admission (POA) variable for eligible secondary diagnosis codes available in claims data to identify conditions not POA. The PPC system originally comprised specifications for 65 PPCs,[1] defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness. For example, the program holds hospitals accountable for venous thrombosis and sepsis that occur during inpatient stays. These complications can lead to 1) poor patient outcomes, including longer hospital stays, permanent harm, and death; and 2) increased costs.

The MHAC program is designed to provide incentives to improve patient care by adjusting hospital budgets based on PPC performance. The program currently evaluates performance on a composite of 16 clinically significant PPCs. As discussed further below, the PPCs not included in the payment program are

[1] In RY 2020, 45 out of 65 PPCs or PPC combinations were included in the program as 3M had discontinued some PPCs and others were deemed not suitable for a pay-for-performance program. The re-designed RY 2021 policy reduced the PPCs assessed to a focused list of 15 PPCs that were clinically actionable and had higher rates and greater variation across hospitals, and/or were clinically significant. In RY 2025, the policy was updated to include PPC 47 Encephalopathy, so there are now 16 payment PPCs.

monitored for changes and possible adoption back into the program. The program provides both rewards and penalties, holding up to 2 percent of hospital inpatient revenue at risk and based on performance.

Figure 1 below provides a comparison of the MHAC and HACRP programs. The CMS HACRP was established by the Affordable Care Act (ACA) of 2010 and implemented in FFY 2015. While the MHAC program and its national analog are similar in that they both evaluate hospital acquired conditions, there are some key differences, e.g., MHAC provides the potential for rewards so that all hospitals have an incentive to improve performance.

Figure 1. RY 2027 Maryland MHAC Program vs. FFY 2027 CMS HACRP Program

	Maryland MHAC Program	CMS HACRP Program[2]
Rewards/ Penalties	Provides rewards/penalties to hospitals based on performance of hospital-acquired conditions.	Reduces payments to hospitals based on their performance on measures of hospital-acquired conditions.
Revenue at Risk	Up to 2 percent of inpatient revenue for rewards or penalties based on preset scale	1 percent of Medicare hospital revenue for worst performing quartile of hospitals after performance period
Measures	16 Clinically significant PPCs	5 CDC NHSN HAI measures 1 AHRQ PSI 90 composite measure (Medicare)
Scoring Calculation	PPC composite score is calculated as the sum of the hospital's observed PPCs times the Solventum Cost Weight for each payment PPC measure divided by the sum of the hospital's expected PPCs times the Solventum Cost Weight for each payment PPC measure. $PPC\ Composite_j = \frac{(\sum_{i=1}^{16} ObservedPPC_{ij} * SolventumCostWeight_i)}{(\sum_{i=1}^{16} ExpectedPPC_{ij} * SolventumCostWeight_i)}$ Performance standard: Convert the PPC composite to a scaled score by comparing results to the threshold and benchmark that is set at average of 20th and 80th percentiles from the base period.	• Measure results- Standardized Infection Ratio (SIR) for each of 5 CDC NHSN HAI measure = Observed/Predicted CMS PSI 90 composite = weighted average of 10 component PSI measures. • Transform to scores- Winsorize results: Limit the distribution of measure results at the 5th and 95th percentiles to reduce outliers. Calculate each measure score as the z-score of winsorized results. $z = \frac{(x - \mu)}{\sigma}$ X=hospital score μ=national mean σ = std dev Total HAC score = Sum of z-scores for each measure the hospital is eligible. Hospitals need only one qualifying measure to be included. Each measure is equally weighted.

[2] For additional technical details, please see https://qualitynet.cms.gov/inpatient/hac. Last accessed 11/24/2025.

	Maryland MHAC Program	CMS HACRP Program[2]
Base and Performance Periods	Base: July, 2022-June 2024 Performance: CY 2025* *CYs 2024 and 2025 for small hospitals	PSI 90 performance is July 1, 2023, to June 30, 2025. CDC NHSN HAI measures' performance is January 1, 2024, to December 31, 2025

While some of the PSIs in the AHRQ measure evaluate the same complications as the Solventum PPCs, there is a key difference in patient scope: PSIs are limited to surgical cases, while similar PPCs assess these complications for surgical medical patients who meet the measure specification inclusion criteria. Appendix B provides data showing the variability in overlap in the patient populations and complication occurrences between the PSIs and PPCs. For example, it shows that for Iatrogenic Pneumothorax (PSI 6 and PPC 49), 66.1 percent of eligible discharges and 26.9 percent of assigned complications are included in both measures, but an additional 14.2 percent of discharges and 22.8 percent of Iatrogenic Pneumothorax cases are identified by the PSI measure only and 19.7 percent of eligible discharges and 50.3 percent of cases are identified by the PPC measure only. In addition, while PSI 13 focuses on post-operative sepsis, PPC 35 focuses on all sepsis cases and also other severe infections; only 5.6 percent of discharges are eligible and 6.8 percent of the sepsis cases are identified by both measures.

Exemption from Federal Hospital-Acquired Condition Programs

In order to maintain an all-payer quality program for in-hospital complications, the state must submit an annual report to CMS demonstrating that Maryland's MHAC program targets and results continue to be aggressive and progressive, i.e., that Maryland's performance meets or surpasses that of the nation. Specifically, the state must ensure that the improvements in complication rates observed under the All-Payer Model through 2018 are maintained throughout the TCOC model. An exemption request has been submitted to CMS for FFY 2026. CMS has granted Maryland exemptions from the federal pay-for-performance programs (including the HAC Reduction Program) each year through FFY 2025; if updated information regarding the RY 2026 exemption request is received, it will be included in the final policy. Staff will continue to need to submit an exemption request during the initial transition years under AHEAD and plan to include a discussion of alignment of complications measures and potentially transition away from PPCs used under the APM and TCOC model as contractual measures.

MHAC Scoring Methodology

In an effort to improve the comprehensiveness and fairness of the MHAC program, the methodology for calculating hospital scores and applying revenue adjustments was modified in RY 2027. Specifically, the HSCRC staff worked with Mathematica to develop a composite PPC measure that weights both the observed PPC count and the expected PPC count by the Solventum cost weights and then sums across the PPCs to get a weighted observed to expected ratio. This weighted O/E ratio is then compared to a threshold and benchmark to calculate the MHAC score (i.e., if better than the benchmark MHAC score is 100 percent, if worse than the threshold then the MHAC score is 0 percent, and those performing between the threshold and benchmark receive a relative score). This differs from RY 2021 through RY 2026 where the O/E ratio for each PPC was compared to a threshold and benchmark to calculate points, applying the Solventum cost weights to the points, and then adding up across the PPCs.[3]

Figure 2 provides an overview of the three steps in the MHAC methodology (also see Appendix C) that converts hospital performance to standardized scores, and then payment adjustments, as outlined below:

Step 1. For the PPCs identified for payment, clinically-determined global and PPC-specific exclusions, as well as volume based diagnosis-severity of illness and hospital-level exclusions are applied to ensure fairness in assignment of complications.

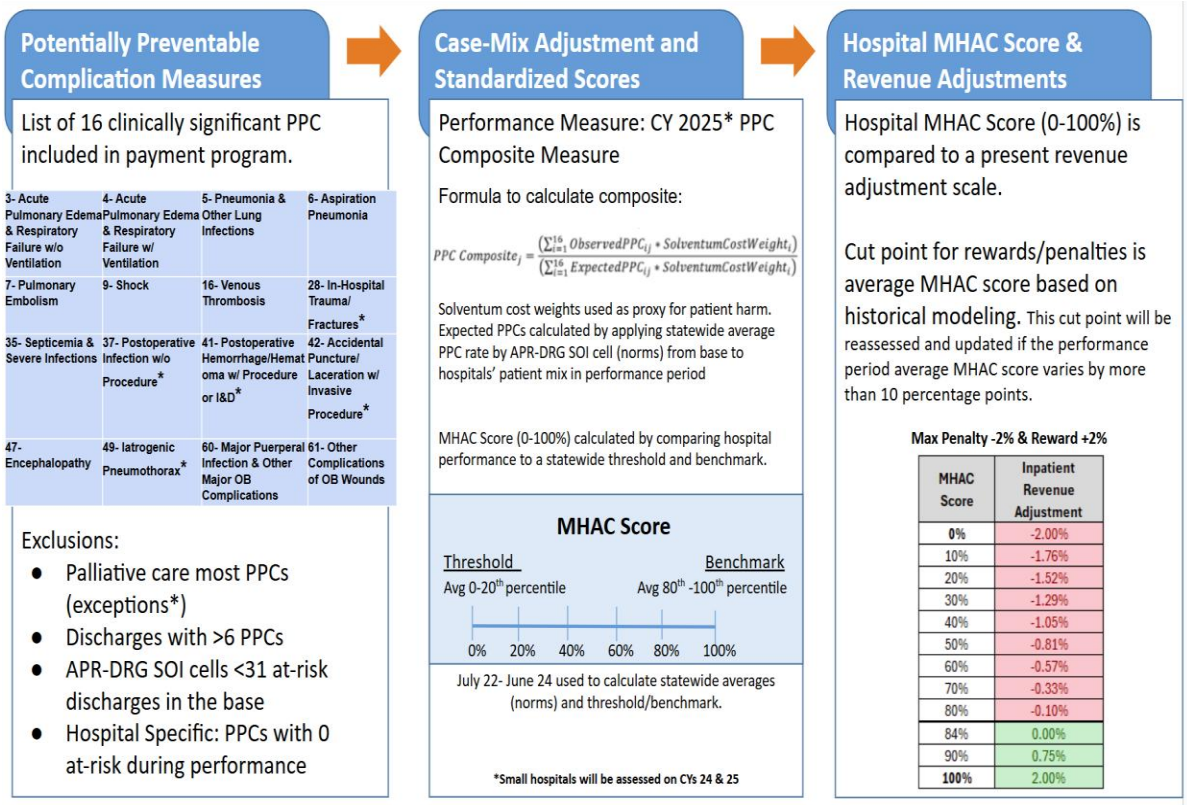
Step 2. Case-mix adjustment is used to calculate observed to expected ratios that are then converted to a standardized point score (from 0-100 points) based on each hospital's attainment levels using a similar scoring methodology that is used for CMS Value-Based Purchasing and Maryland QBR program. Specifically, a composite PPC measure is used that weights both the observed PPC count and the expected PPC count by the Solventum cost weights and then sums these across the PPCs to get a weighted observed to expected ratio. This weighted O/E ratio is then compared to a threshold and benchmark to calculate the MHAC score (i.e., if better than the benchmark MHAC score is 100 percent, if worse than the threshold then the MHAC score is 0 percent, and those performing between the threshold and benchmark receive a relative score).

Step 3. The hospital's earned score is then compared to a linear scale to calculate the revenue adjustment percent. The scale is set prospectively and concurrently monitored so that hospitals can track potential revenue adjustments during the performance period; this scaling approach differs from national programs that relatively rank hospitals after the performance period.

[3] The RY 2027 policy outlines the PPC Composite testing results.

Additionally, the MHAC scaling differs in that it provides an opportunity for rewards, as opposed to HACRP that reduces payments by 1 percent for hospitals in the worst-performing quartile.

Figure 2. Overview Rate Year 2027 MHAC Methodology



Assessment

This section provides an overview of performance for Maryland hospitals on complications measures, including Solventum PPCs, all-payer and medicare PSIs, and NHSN HAIs. Following the performance results, the staff recommendations on complication measures for RY 2028 is summarized. Staff then provides modeling of scores and revenue adjustments comparing the current methodology, HACRP, and the staff recommendation. The staff recommendations are based on the alignment considerations outlined above, the quality program guiding principles, and timing considerations related to staff resource limits and

Commission priorities. Last, there is a discussion on staff priorities for CY 2026 for measuring in-hospital complications in CY 2027 to further align Maryland's program with the CMS HAC Reduction Program and/or develop a new complications program for all other payers.

Maryland Performance on Potentially Preventable Complications

Performance trends below show the observed to expected ratios for the PPCs currently included in the RY 2027 MHAC program. Under the All-Payer Model (APM), Maryland exceeded the contractual requirement of a 30 percent reduction in all PPCs. Throughout the TCOC Model, Maryland has continued to meet the contractual requirement on complications by maintaining the APM improvements for complications included in the payment program (i.e., not exceeding the CY 2018 PPC rates).

Currently there are sixteen PPCs included in the RY 2027 payment policy:

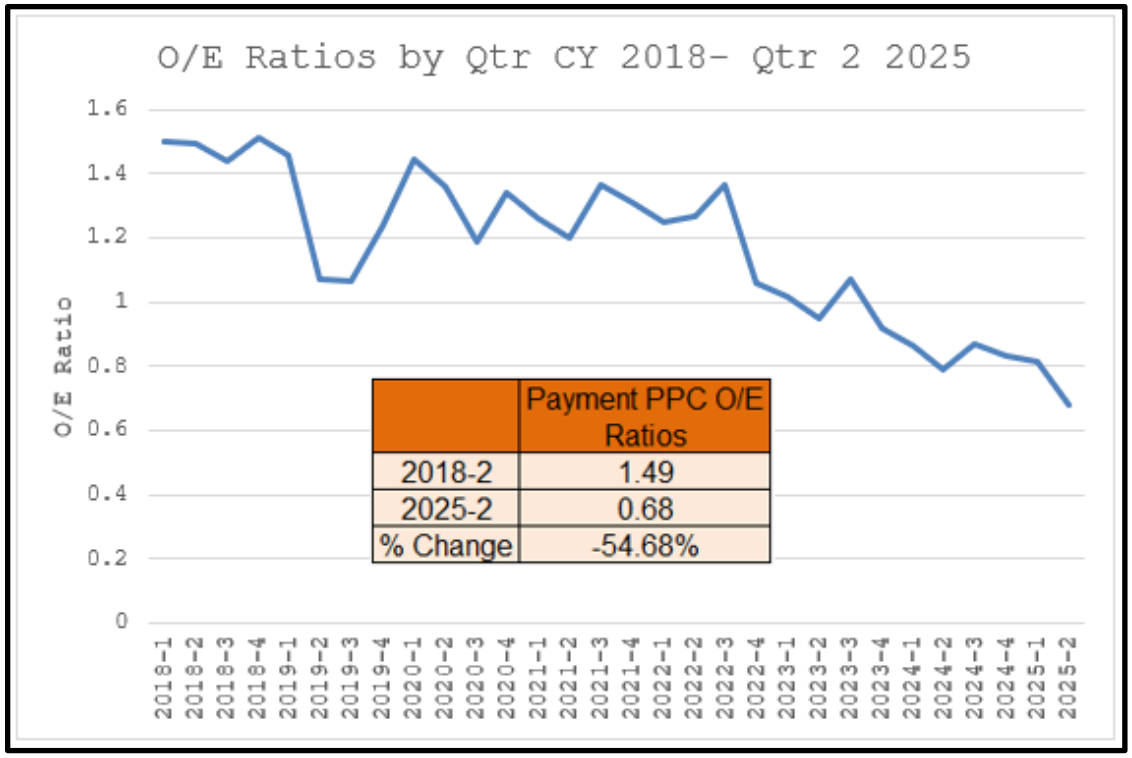
3	Acute Pulmonary Edema and Resp Failure w/o Ventilation
4	Acute Pulmonary Edema, Resp Failure w/ventilation
5	Pneumonia and Other Lung Infections
6	Aspiration Pneumonia
7	Pulmonary Embolism
9	Shock
16	Venous Thrombosis
28	In-Hospital Trauma and Fractures
35	Septicemia & Severe Infections
37	Post-Operative Infection & Deep Wound Disruption Without Procedure
41	Peri-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D
42	Accidental Puncture/ Laceration During Invasive Procedure
47	Encephalopathy
49	Iatrogenic Pneumothorax
60	Major Puerperal Infection and Other Major Obstetric Complications
61	Other Complications of Obstetrical Surgical & Perineal Wounds

The MHAC program was redesigned at the start of the TCOC model to focus on a smaller number of complication measures that met criteria developed by the Clinical Adverse Events Measures subgroup that was convened by the HSCRC. All other PPCs are still monitored and reconsidered annually for adoption back into the program. Appendix D provides the criteria that is used to select and re-evaluate complications for inclusion in the payment program versus monitoring, along with the statewide results for payment, monitoring, and all PPCs. Because CMS does not use the PPC measures, staff will need to evaluate whether PPCs will continue to be used as the state transitions to AHEAD for non-Medicare global budget

revenue adjustments. For RY 2028, staff is not recommending any changes to the payment PPCs as discussed further below.

Figure 3 below shows the statewide observed to expected (O/E) ratio from 2018 through CY 2025 YTD (July) for the payment PPCs. The O/E ratio presents the count of observed PPCs divided by the calculated number of expected PPCs (which is generated using statewide historical averages by diagnosis and severity of illness level and applying them to the case-mix of discharges a hospital experiences during the performance period). An O/E ratio of greater than 1 indicates that there are more PPCs than expected, and conversely, an O/E ratio less than one indicates that there are fewer PPCs than expected. Overall, there has been almost a 55 percent decrease in the O/E ratio since 2018.

Figure 3. Payment PPCs Observed to Expected Ratios by Quarter CY 2018 to CY 2025 YTD July

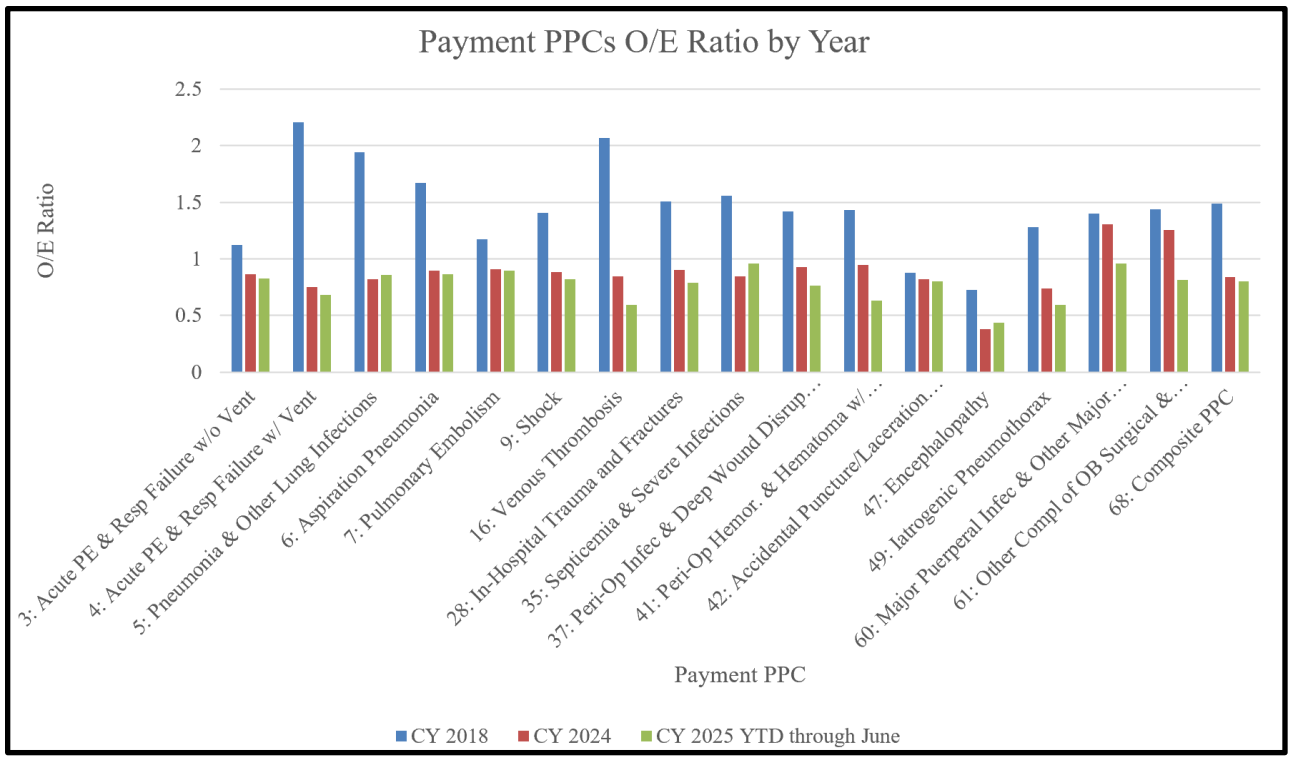


	Payment PPC O/E Ratios
2018-2	1.49
2025-2	0.68
% Change	-54.68%

Figure 4 indicates how Maryland is performing relative to CY 2018 on each of the individual payment PPCs, which is the time period used to assess any backsliding on performance under the TCOC Model. Each of the PPCs included in the payment program have shown reductions since 2018, and most have had

continued but much more modest reductions from CY 2023 and CY 2024. In CY 2025, all PPCs have an O/E ratio less than 1, indicating that statewide there are fewer PPCs than expected.

Figure 4. Payment PPCs Observed to Expected Ratios by Year, 2018, 2024, 2025



Maryland Performance on AHRQ Patient Safety Index Measures

The PSI-90 composite measure, which is one sixth of the national HACRP program, focuses on a subset of ten AHRQ-specified PSIs of in-hospital complications and adverse events following surgeries, procedures, and childbirth. Maryland's statewide performance compared to the nation on the PSI 90 Composite measure and the individual measures within the Composite for CY 2023 and CY 2024 are summarized below and illustrated in Figures 5 and 6[4].These data show:

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

- Compared to the nation, Maryland is better on the overall PSI-90 composite and on eight of the ten PSI indicators on an all-payer basis.
- Compared to 2023, Maryland has improved on the overall PSI-90 composite and on seven of the 10 indicators in 2024 on an all-payer basis.
- Compared to the nation, Maryland has performed better than or on par on the overall PSI-90 composite in four of the last six years, 2019-2024. In CY 2024, Maryland had almost 20 percent fewer complications than expected on an all-payer basis.

Figure 5. All-Payer PSI 90 Composite and Component Indicators for Maryland Compared to the Nation in 2024, and Maryland's performance over time 2023-2024

PSI Name	Maryland 2024 Compared to the Nation 2024	Maryland 2024 Compared to Maryland 2023
PSI 90 Composite	Better	Improved
PSI 3 Pressure Ulcer	Worse	Improved
PSI 6-Iatrogenic pneumothorax	Better	Improved
PSI 8 In Hospital Fall and Fracture	Better	Worse
PSI 9 Perioperative Hemorrhage or Hematoma	Better	Improved
PSI 10 Postoperative Acute Kidney Injury w/Dialysis	Better	Worse
PSI 11 Postoperative Respiratory Failure	Better	Improved
PSI 12 Postoperative Pulmonary Embolism or DVT	Better	Improved
PSI 13 Postoperative Sepsis Rate	Better	Improved
PSI 14 Postoperative Wound Dehiscence	Better	Worse
PSI 15 Abdominopelvic Accidental Puncture or Lac	Worse	Improved

Figure 6. Maryland All-Payer State vs National PSI-90 Composite Performance

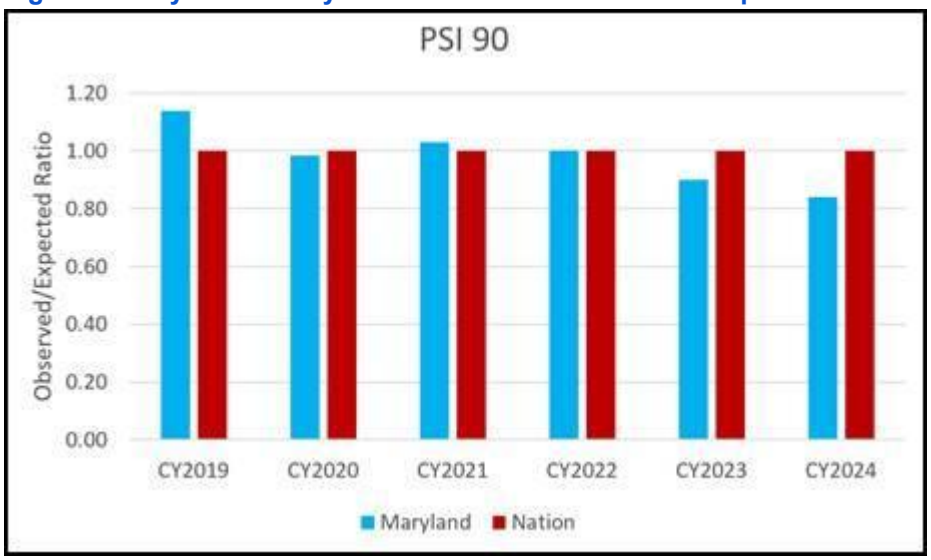
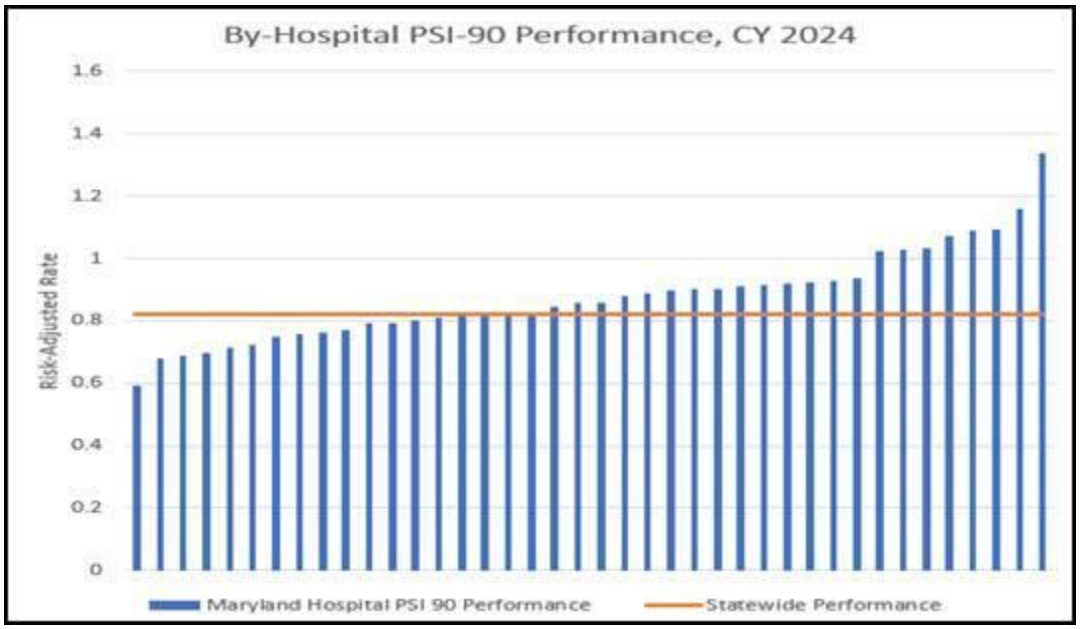


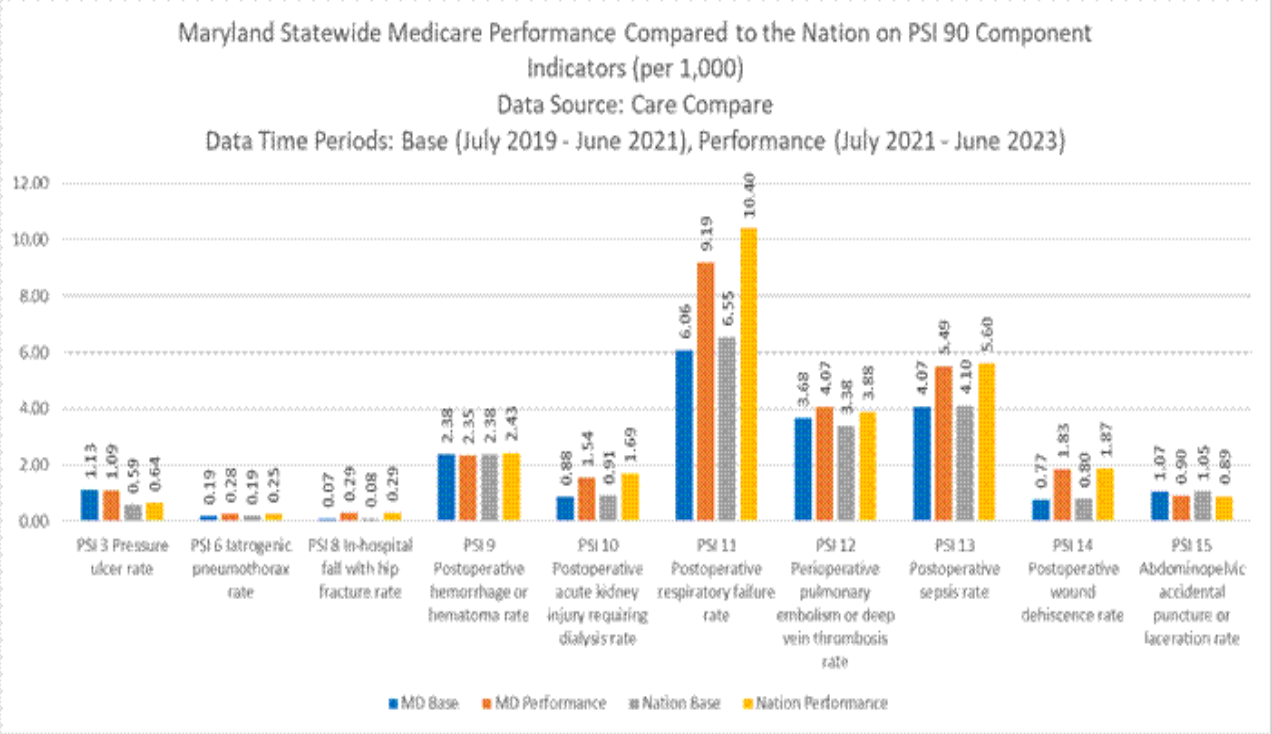
Figure 7 below illustrates the hospital-level performance on the all-payer PSI-90 composite measure for CY 2024; consistent with last year, the variation in performance by hospital suggests there may be opportunity for improvement on this measure.

Figure 7. PSI-90 Composite All-payer Hospital-Level Performance, CY 2024



CMS Care Compare publishes PSI-90 component indicator rates per 1,000 for Medicare patients for the nation and by state. Based on the data available at the time of the RY 2026 exemption request (Figure 8), Maryland rates are lower (better) or on par with the nation for all component indicators for both the base and performance periods with exception of PSI 3 Pressure Ulcer. While the HACRP uses the Medicare PSIs, staff recommends continuing to use the all-payer PSIs from QBR in the MHAC program and note that there is moderate correlation between the all-payer and Medicare versions of the PSI measure.

Figure 8. Maryland Statewide Medicare Performance Compared to the Nation on PSI-90 Component Indicators (per 1,000), July 2019-June 2021 Compared to July 2021-June 2023



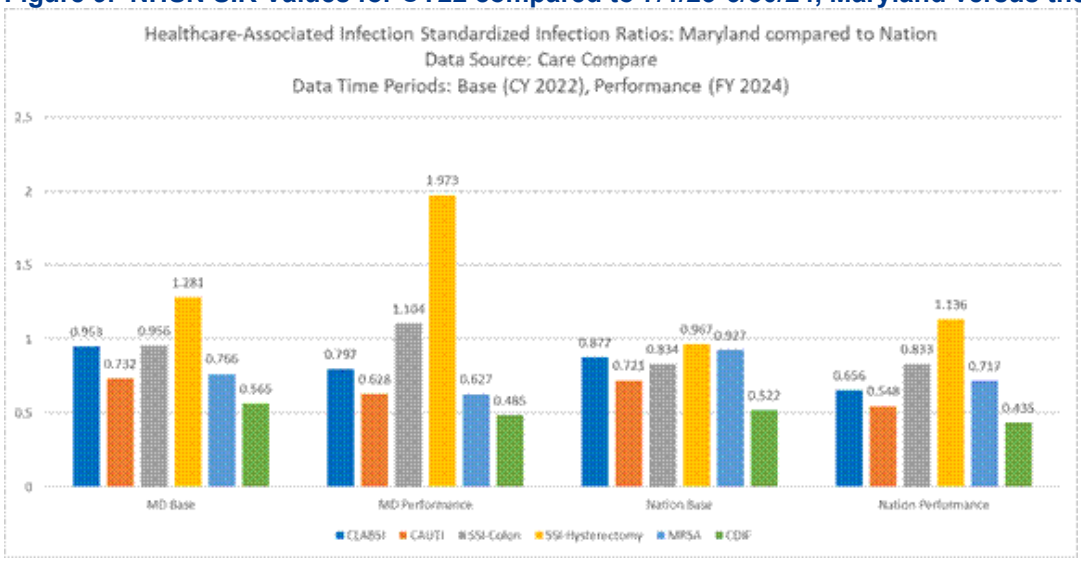
Maryland Performance on NHSN Healthcare-Associated Infections

The CDCs National Healthcare Safety Network (NHSN) tracks healthcare-associated infections, such as central-line associated bloodstream infections and catheter-associated urinary tract infections. Care Compare has updated the Centers for Disease Control (CDC) National Health Safety Network Healthcare Associated Infection (HAI) Standardized Infection Ratio (SIR) data tables for the nation and by state through

June 2024. Figure 9 below shows how Maryland performs relative to the nation, and how performance has changed over time for both Maryland and the nation.

- For the most recent time period, Maryland's performance is favorable compared to that of the nation on MRSA.
- Maryland is worse (higher SIRs) on SSI-hysterectomy, SSI-colon, and slightly worse on CAUTI, CDIF and CLABSI but given small sample sizes for some of these measures, most differences are not statistically significant.
- Both Maryland and the nation improved from the base to the performance period on four of the six HAI categories–CAUTI, CLABSI, CDIF and MRSA, and worsened on SSI-colon and SSI-hysterectomy.

Figure 9. NHSN SIR Values for CY22 compared to 7/1/23-6/30/24, Maryland versus the Nation



In Maryland the NHSN HAIs are included in the Quality Based Reimbursement (QBR) program, whereas nationally the NHSN measures are included in both the HVBP and HACRP program for Medicare FFS. The RY2023 QBR policy discusses NHSN concerns including the small cell size issues and surveillance bias (i.e., higher testing for infections results in higher rates of identified infections). Given these concerns, staff is hesitant and would like stakeholder input over the coming year on whether to align fully with the nation and use of the NHSN measures in two payment programs (QBR and MHAC), and/or what other measures should be considered for non-Medicare FFS quality policies. For the RY 2028 policy, staff is not

recommending inclusion of the NHSN measures in the MHAC program due to these concerns and inclusion of the measures in QBR.

Digital Measures

The state and CMS are moving towards digital measures to reduce measurement burden and enhance measures with data from electronic health records. By 2030, the CMS goal is for all quality measures to be fully digital. Further, CMS noted the following in their 2022 Digital Quality Measures (dQM) Roadmap:

> *dQMs are designed to reduce administrative burden and costs, reduce the likelihood of manual data entry and interpretation errors, and provide more timely quality assessments by enabling automated, standardized data analysis directly from electronic data sources.*[5]

As discussed in the QBR policy, the state is aligning the hospital digital measure reporting requirements with CMS but providing a small financial incentive for more timely reporting during the performance year and requiring the core clinical data elements for hybrid measures on an all-payer basis. Figure 10 provides a summary of the Electronic Clinical Quality Measures (eCQM) reporting requirements for CY 2026. As the state evaluates future options for complication measures, staff believes that digital measures should be considered to address areas of interest to stakeholders such as maternal morbidity or newer NHSN digital measures such as Hospital Onset Bacteremia.

Figure 10. CY 2026 Required Maryland and CMS Electronic Clinical Quality Measures (eCMQ) Reporting

- **Five eCQMs selected by CMS and three self-selected**
- **CMS-mandated eCQMs (Maryland is aligning with CMS)**:
  - **Safe Use of Opioids—Concurrent Prescribing**: (CMS506)
  - **Cesarean Birth**: (PC-02)
  - **Severe Obstetric Complications**: (PC-07)
  - **Hospital Harm—Severe Hyperglycemia**:newly required by CMS
  - **Hospital Harm—Severe Hypoglycemia**: newly required by CMS

[5] Centers for Medicare & Medicaid Services. 2022. "Digital Quality Measurement Strategic Roadmap." https://ecqi.healthit.gov/sites/default/files/CMSdQMStrategicRoadma p_032822.pdf.

Complication Measure Summary

In summary, the measure recommendations for the RY 2028 MHAC policy are the following:

- Maintain the use of RY 2027 PPCs given all-payer focus and broader applicability (i.e., medical and surgical patients included). Continue to use the new composite measure that offers a superior scoring approach, resulting in hospital specific scores with significantly increased content validity and reliability and better distinguishes hospital performance such that all hospitals are held accountable for PPCs that are most germane to the types of patients and services they provide.
- Add the all-payer AHRQ PSI composite to the MHAC program, since the Commission has already approved of its removal from QBR. The staff recommends the all-payer measure because the all-payer rate setting system is still in place for CY 2026 and the higher volume of discharges allows only one year of data to be needed. While some of the PPCs and PSIs address similar types of complications, staff believes adding the PSI composite as currently used in QBR is appropriate as it provides additional incentive weight for clinically important areas such as sepsis and adds areas of focus not included in the payment PPCs. Staff recommends that the all-payer PSI measure be weighted proportionally to its weight in the HACRP program (i.e., 1/6th of the total MHAC score); thus limiting the impact of the PSI measure on MHAC scores but ensuring hospitals focus on this CMS measure.
- Maintain the NHSN HAI measures in the QBR program but do not add to the MHAC program at this time given measurement concerns related to these surveillance measures.
- Re-convene the Clinical Adverse Events Measures subgroup in Spring of 2026 to assess available complication measures for use in a state program for non-Medicare payers. Assessment should consider alignment with CMS and the state's investments in PPCs, as well as opportunities to focus on non-Medicare priority areas such as maternal complications, digital measures, or areas of poor performance.

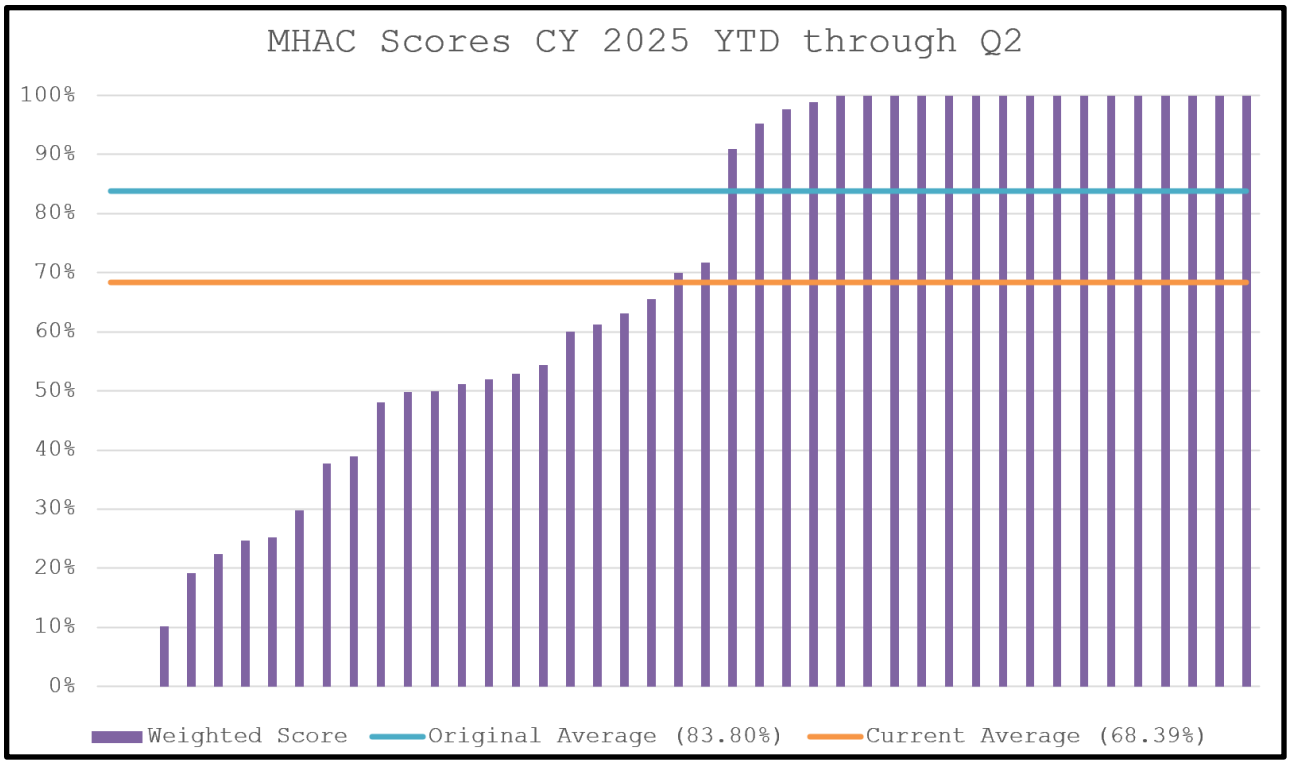
Hospital Scores and Revenue Adjustments

This section provides an overview of the MHAC and HACRP revenue adjustment methodology and then presents modeling of hospital scores and revenue adjustments for the current MHAC methodology, the estimated HACRP results for Maryland hospitals, and the proposed RY 2028 final recommendations.

Comparison of MHAC and HACRP Scoring and Revenue Adjustment Methodology

The MHAC scoring methodology was significantly updated in RY 2027 based on stakeholder concerns. As discussed above, the approved RY 2027 MHAC policy recommended the use of a PPC composite measure that includes all payment PPCs for the one year performance period (two years for small hospitals) but weights the PPCs by the hospital's expected number of PPCs. This addressed concerns about construct validity as it ensured inclusion of lower volume complications but weighted hospital scores by largest areas of opportunity. Over the last year, staff has explored concerns about academic medical centers being disadvantaged under the PPC risk-adjustment methodology and impact of prospective versus concurrent normative values. Based on these results, staff does not recommend any changes to the methodology at this time but will continue to support hospitals that submit clinical concerns to Solventum. The total MHAC score is then determined by comparing the PPC composite results to a threshold and benchmark, which is the average of the hospital scores in the top and bottom 1/5th (i.e., the scores below and above the 20th and 80th percentiles) of scores calculated during the two year historical base period. If a hospital scores better than the benchmark, then the score is 100 percent and if the hospital scores worse than the threshold the hospital scores 0 percent, with all those in between receiving a score relative to the threshold and benchmark. Figure 11 provides RY 2027 YTD through June results by hospital, along with the current average score. In order to convert the scores to revenue adjustments, a linear scale from 0 to 100 percent is used and the cut point is the average hospital score. The RY 2027 policy recommended a preliminary cut point of 84 percent based on modeling; however, the actual average score will be used instead of this placeholder and is provided in the monthly reports for hospitals to track (currently 68 percent). The scaling distributes both rewards and penalties up to 2 percent of all-payer inpatient revenue.

Figure 11. MHAC Scores CY 2025 YTD through June



The HACRP scoring and revenue adjustments differ significantly from the MHAC methodology. First, each eligible measure is weighted equally and the performance periods are two years for all hospitals and measures. Thus, for FFY 2028, the performance periods for NHSN and PSI started in January 2024 and July 2023, respectively (i.e., 12 and 18 months of the performance period will elapse by the end of CY 2026). To calculate the scores, measure results are truncated at the 5th and 95th percentile and then results across measures are standardized using z-scores that compare each hospital's results to the national mean, divided by the standard deviation and summed across eligible measures. Then hospitals with a total HAC score greater than the 75th percentile (i.e., the worst-performing quartile) are subject to a full 1 percent payment reduction for all Medicare FFS patients. Unlike the MHAC program, the HACRP program does not provide rewards to hospitals.

Based on estimated results from CMMI for FFY 2025 HACRP, as shown in Figure 12, the state performed better than the 75th percentile of national performance (0.3178 vs 0.3667). The by-hospital results indicate that 16 of 43 Maryland hospitals would have been penalized under HACRP. However, it should be noted

again, that there are concerns about small cell sizes and other biases in the NHSN measures since they were originally designed for surveillance purposes and not payment. Furthermore, small or unique hospitals such as UMD Chestertown, UMD Rehabilitation and Orthopedic Institute, and Levindale are included in hospitals that would be penalized but are not measured on most of the measures. For example, UMD Chestertown is only measured on c dif and had three observed cases in two years, exceeding the expected of 1.55 cases. However, the HSCRC does remain concerned that some of the larger hospitals in the State do appear to have opportunities for improvements on some of the complication measures relative to the nation.

Figure 12. HACRP Total HAC Scores, Maryland Compared with the Nation, FFY 2025

National 75th percentile Total HAC Score with and without Maryland Hospitals	Average Total HAC Score for Maryland Hospitals
0.3667 with MD 0.3652 without MD	0.3178

Figure 13 provides the RY 2025 MHAC and estimated FFY 2025 HACRP revenue adjustments for Maryland hospitals. As discussed above, HACRP assesses a full 1 percent penalty to the 16 out of 43 hospitals that are in the worst-performing quartile nationally. Staff believes the MHAC program should continue to provide scaled rewards and penalties for RY 2028 but welcomed stakeholder feedback on total revenue at risk (+/- 2 percent) and the option to not relatively rank MD hospitals retrospectively. Modeling of HACRP scores using the HSCRC scaling approach has been suggested by stakeholders. Using FFY 2025 HACRP scores and a linear scale using the minimum and maximum actual scores and average score based on national data, the net revenue adjustments are -$27.4 million with -$38.6 M in penalties and +$11.2 M in rewards. It also should be noted that FFY 2026 scores under HACRP are not yet available on Care Compare.

Figure 13. Maryland's FFY 2025 Estimated HACRP and RY 2025 Final MHAC Revenue Adjustments

Program	Statewide Net Total	%	Penalties	%	Rewards	%
MHAC	$ 39,309,084	0.33%	$ (8,879,421)	-0.07%	$ 48,188,505	0.41%
HACRP	$ (63,317,885)	-0.53%	$ (63,317,885)	-0.53%	$ -	-

Scores and Revenue Adjustment Modeling Results

Staff has modeled hospital scores using RY 2026 base (July 2021-June 2023) and performance (CY 2024) periods. Staff has also modeled and compared the revised RY 2027 MHAC methodology to the previous methodology and continues to support the use of the composite (results not shown). Figure 14 provides the statewide revenue adjustments with and without the addition of the all-payer PSI measure. Specifically, the PSI data for CY 2024 was compared to a benchmark and threshold that was calculated in the same way as the MHAC performance standards (i.e., average of the top and botto quintile from base period) and 0-100 points was assigned based on attainment only. The PPC and PSI scores were then combined by weighting the PPCs as 5/6th and PSI as 1/6th of the overall score. The cut point was the average statewide score for each scenario (i.e., 80% for PPC only and 78% for PPCs and PSI). The figure shows that penalties remain similar when the PSI composite is added but rewards are reduced by almost $10 M statewide. Appendix E provides the by-hospital results for both models.

Figure 14. Estimated Revenue Adjustments with and without AHRQ PSI-90

RY 2026 Modeling	PPCs Only	PPCs and PSIs
Net Total $	**$30,107,361**	**$19,680,755**
Penalty $	-$42,239,158	-$42,753,131
Percent Inpatient	-0.36%	-0.36%
Reward $	$72,346,519	$62,433,886
Percent Inpatient	0.61%	0.53%

Stakeholder Feedback and Responses

Comment letters to the MHAC Draft policy were received from the Health Means Everything Consumer Alliance, Maryland Hospital Association, University of Maryland Medical System, Adventist Health, and the Johns Hopkins Health System. In general, the letters were supportive of the RY 2028 recommendation, with caveats as discussed in detail below, but the hospital industry all firmly stated that the program should not use the Solventum Potentially Preventable Complication measures after this year. Figure 15 provides an overview of the comments received and is followed by a discussion of the feedback, along with staff responses.

Figure 15. Summary of Stakeholder Comment Letters

Specific Comments in Letters	HME	MHA	UMMS	Advent-ist	JHHS
Maximize multi-payer alignment: reduce administrative complexity, ensure manageable timelines,maintain quality incentives	X	X	X	X	X
3-year Transition time is too lengthy					X
Continue the use of Solventum PPCs for RY 2028 and then discontinue and/or discontinue for RY 2028		X	X	X	X
AMC concerns with PPCs			X		
Include AHRQ PSI-90 for RY2028	X	X	X		X
Monitoring AHRQ PSI-90 until full alignment with HACRP				X	
Consider weight of PSI-90					X
Add NHSN measures in RY 2029		X		X	
Maintain rewards in RY 2028 and beyond; communicate rewards and penalty structures for non-Medicare well in advance.		X		X	
2 percent revenue at-risk contingent on there being no other additional revenue at-risk for RY 2028			X		
Evaluate revenue at risk compared to other states and consider a more balanced approach that risks less hospital revenue					X

General Concerns on AHEAD transition: All hospital letters highlighted the importance of maximizing multi-payer alignment in order to reduce administrative complexity, and to ensure manageable timelines, while maintaining quality incentives. JHHS specifically states that a three year transition period is too lengthy (i.e., not moving fully to CMS programs until CY 2028). Additionally, in the November Commission meeting, questions were raised about the possibility of suspending the quality programs during the transition period to Medicare global budgets, or applying the CMS hospital quality results to the non-Medicare global budgets. Finally, staff continues to collaborate with Medicaid staff and received a general letter on HSCRC quality programs (i.e., not specifically commenting on the MHAC program) that urges the continued inclusion of all-payer measures, particularly those impacting the Medicaid program such as maternal child health measures of obstetric complications improvement, pediatric potentially avoidable

utilization, and improved care coordination and handoffs as measured by the Medicaid TFU measure.

Staff Response:

Staff notes that the AHEAD model agreement includes the language below that requires continuation of the quality programs during the PYs 1 and 2 (defined transition timeline) while Medicare global budgets are finalized, and to further include all-payer measures as well as measures designed to improve population health. With regard to the transition period being too lengthy, staff believes the contract terms with the defined transition period provides the necessary flexibility to develop and operationalize the Medicare FFS and non-Medicare FFS global budgets and their related quality program updates. Furthermore, staff believes that work needs to be done with CMMI to assess feasibility of moving to CMS programs for CY 2027 performance, while staff pursues further alignment across all quality programs for non-Medicare payers.

> *h. CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology for PY1 and PY2: Hospital Quality and Value-Based Programs.*
>
> - *For PY1 and PY2, the State will develop and administer hospital quality and value-based payment programs in accordance with the requirements of this Agreement. The State hospital quality and value-based payment programs will include all-payer measures. In the limited cases when all-payer measures are not feasible, the State may include Medicare-specific measures. The State hospital quality and value-based payment programs must include a performance measure designed to improve population health.*

Aligning MHAC Measures With HACRP program and Discontinuing use of Solventum PPCs: All hospital comment letters supported aligning the MHAC program with the HACRP program now or next year. Specifically hospitals would like to discontinue using the Solventum PPCs for the following reasons:

- PPCs are not included in the CMS quality programs.
- There is duplication across PPC and PSI measures.
- PPCs are a proprietary methodology and hospitals have reported that significant investments have been made to cover the grouper, IT routines/reporting systems, and staffing resources to ensure documentation accuracy, coding queries, etc that could be better spent on quality improvement initiatives and patient care.
- Continued AMC concerns related to PPCs (UMMS).

- Lack of specific value of PPCs (JHHS), meaningful improvements have plateaued and results may reflect improved clinical documentation (UMMS).

All of the hospitals support adopting the AHRQ PSI measure into the MHAC program, although Adventist recommends maintaining the Solventum PPCs for RY 2028 if the state cannot fully align with the HACRP program (i.e., use PSI and NHSN measures). JHHS also recommends comparing the weight of the PSI-90 measure from QBR to what we are recommending in MHAC. In terms of the CDC NHSN measures, MHA specifically suggests that the NHSN measures be used next year in place of the PPCs to align with HACRP to reduce burden and allow hospitals to focus on measures that are "meaningful, actionable, and comparable across state and federal programs".

However, the HME consumer alliance supports the recommendation to use both the PPCs and PSIs in the policy and specifically highlights the importance of a comprehensive approach that assesses complications across both medical and surgical patients, especially in a global budget environment:

> "By taking this comprehensive approach, hospitals are encouraged to invest in processes and protocols that promote infection control and patient safety across all units instead of focusing just on those that are measured by one measure or the other. HME strongly believes that hospitals should be incentivized to invest in these improvements each year, and that programs like MHAC serve as a vital guardrail in a global budget environment."

The PPCs also include maternal health measures that Medicaid has said are important to include in hospital quality programs.

Staff Response:

Staff agrees with the goal of greater alignment of the Maryland and CMS quality policies and need for administrative simplicity especially during transition to AHEAD and acknowledges the lack of alignment between the MHAC program that uses the PPC measures and the HACRP program that uses the NHSN measures and Medicare PSI 90 measure, but maintains that a comprehensive review of complication measures is warranted before making major changes to the current program. With regard to the PSI 90 composite measure, the QBR program previously included the all-payer AHRQ PSI composite measure (the PSI measure was included in both HVBP and HACRP but was removed from HVBP in FFY 2023). To better align QBR with HVBP, the Commission approved removing the AHRQ all-payer PSI measure in the RY 2028 QBR policy along with the staff recommendation to consider moving the AHRQ all-payer PSI

measure from the QBR to the MHAC program. While this may more directly highlight the similarities between the PPC and PSI measures and potential duplication, it is not a deviation from the previous policy. Nevertheless, the concern has been raised before, which is why the staff did look at the overlap of the measures. With regard to the PPC measures having plateaued in their impact or lacking specific value, or more so reflecting documentation improvement versus clinical improvement, staff has requested and received input through the last several years on quality improvement interventions undertaken by hospitals directly and indirectly leading to reduction in PPCs. Examples include incorporation of an aspiration risk Assessment for all inpatients and major projects on pulmonary embolism/deep vein thrombosis prevention. Staff appreciates the HME consumer alliances support to include the PPCs because of the comprehensiveness of the measures, but also acknowledges the input from hospitals on the financial costs incurred by hospitals for using a proprietary measure grouper. To help with this assessment, staff would also like to understand the additional costs incurred for the PPC grouper compared to the APR-DRG grouper in general.

Staff plans to reconvene the Clinical Adverse Event Measures (CAEM) subgroup beginning in the first half of 2026. This subgroup will consider the CMS overall direction and plan to evolve the national quality and safety measurement programs, and within this context evaluate measure criteria and measures that should be considered for inclusion in quality policies for adjustments to payments under Maryland HGB (e.g., Medicaid, commercial) with a specific focus on measures related to hospital complications, mortality, and digital measures. While staff agrees with the idea of alignment with the CMS programs, we also want to ensure that the quality programs are comprehensive and address areas of concern for other populations and service lines that may be less applicable to Medicare FFS (e.g., maternity, pediatrics). Furthermore, the staff believes that it may not be necessary to adopt all of the Medicare measures into the Maryland HGB quality programs or duplicate measures across programs. Specifically, staff notes that the NHSN measures are included in QBR and that issues have been raised regarding the use of these surveillance measures for payment. Staff would like to engage stakeholders to understand if the NHSN measures should be included in both the QBR and MHAC program as recommended by MHA in their stakeholder letter. With regard to concerns about PPC performance measurement for Academic Medical Centers (AMCs), based on analysis to date, staff has not identified results that substantiate concerns that AMC specific procedures are driving their MHAC results but encourage hospitals to continue to submit clinical feedback to Solventum (such as procedures that should be excluded) and can continue to explore risk-adjustment concerns issue if PPCs are maintained. Again the goal of the CAEM group will be to assess these issues, and make short-term alignment recommendations and longer term recommendations on measures or criteria for determining

whether to include unique measures for Maryland HGB adjustments. Data sources, administrative burden, fragmentation, cost, and disproportionate impacts on performance measurement for AMCs should all be considered when making these recommendations, as well as the movement towards digital measures. The recommendations from CAEM will then be brought to PMWG for additional input, reviewed with Commissioners, and outlined in the RY 2027 exemption request to CMMI for their input as well. As staff have consistently communicated, staff believe strongly in aligning of quality incentives across payers to reduce hospital burden and maximize quality improvement efforts in key areas, however there may be reasons to deviate from the CMS programs that also reduce complexity (i.e., avoiding duplication of measures across programs), address areas of State concern (e.g., ED length of stay, maternal complications), and ensure all-payer hospital quality is appropriately assessed and incentivized in Maryland's hospital global budget system. The recently passed RY 2028 QBR policy is an example of both alignment and the maintenance of specific incentives for Medicaid and to address areas of concern unique to Maryland.

Feedback on Revenue Adjustment Methodology: As discussed in this policy, the MHAC program and HACRP differ in revenue at-risk and methodology for revenue adjustments. The stakeholder feedback letters included the following comments:

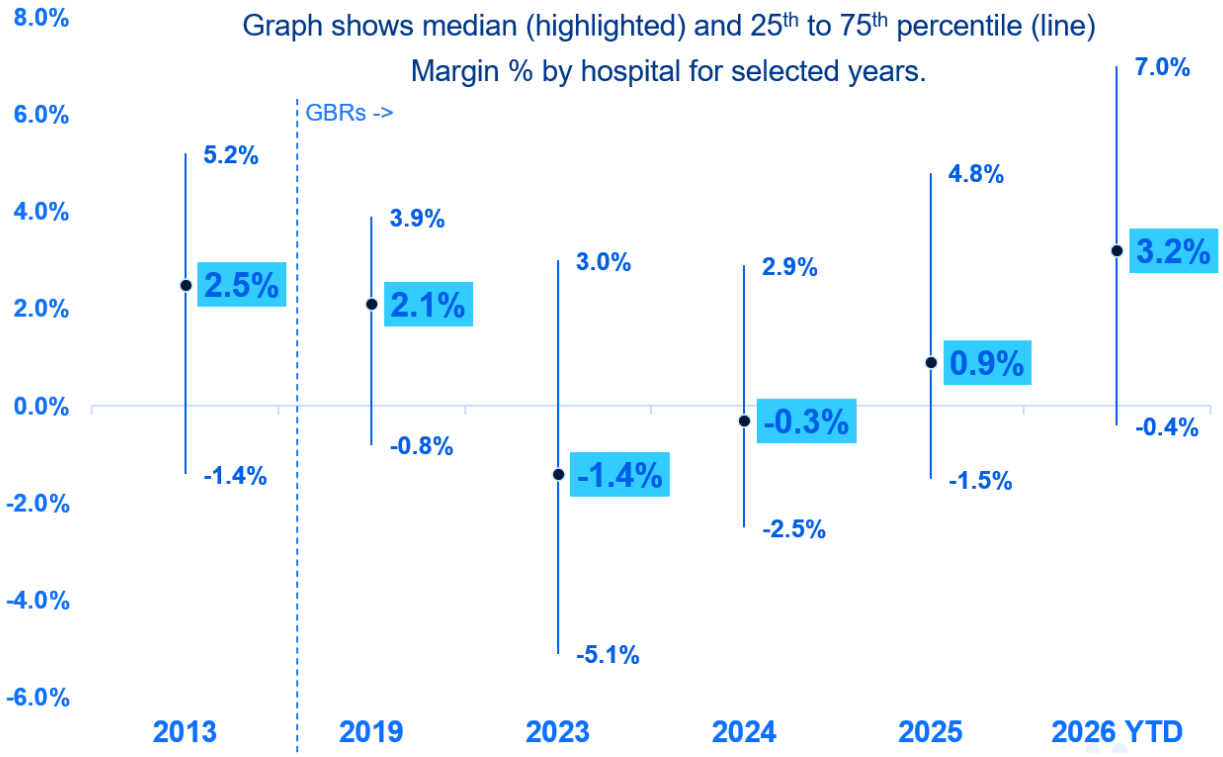
- MHA requests that HSCRC proactively communicate reward and penalty structures for non-Medicare payers well in advance to support clarity for hospital planning and budgeting.
- UMMS supports use of statewide performance standards and 2 percent at risk for both rewards and penalties contingent upon there being no additional at-risk to other HSCRC programs for RY 2028.
- Adventist supports alignment on measures and methodology with CMS, but encourages the Commission to maintain reward potential for RY 2028 and in the future so that hospitals can use rewards to invest in quality improvement initiatives.
- JHHS encourages HSCRC to evaluate revenue at-risk in Maryland compared to other states to determine if there is opportunity for quality improvement to be driven with less revenue at-risk, given "hospitals face substantial rate reductions under AHEAD amidst already strained financial conditions".
- HME supports the current program and highlights that "programs like MHAC serve as a vital guardrail in a global budget environment".

Staff Responses:

The current core quality programs in Maryland have both rewards and penalties, do not relatively rank hospitals, provide reporting for tracking of progress, and encourage the sharing of best practices across hospitals. Under the hospital global budgets, the Commission has approved policies that have supported the inclusion of both rewards and penalties. Moving forward, staff would support the inclusion of both rewards and penalties but would need help from hospitals to provide Commissioners with rationale to vote for this deviation from the CMS methodology. For example, such rationale may include: evidence that rewards are being used to invest in quality measure infrastructure, or quality improvement initiatives that are leading to better patient care and/or being used to focus on areas of poor performance, or to address populations of importance to the state such as the Medicaid population, etc. Thus, while staff understands MHAs request for the HSCRC to give more clarity on the reward and penalty structures, the Commissioners will finalize these decisions when voting for specific policies.

In terms of revenue at-risk, the staff appreciate UMMS support for the current 2 percent revenue at-risk and cannot prospectively guarantee that additional policies will not put additional revenue at risk but suggest that feedback can be provided for any new policies in RY 2028 recommending additional revenue at-risk. Staff also note that for quality, CMS requires us to meet revenue at-risk requirements that may not include other incentives outside of the core quality policies and current PAU measurement. Last, staff understands the financial uncertainty related to the transition to AHEAD but the Commission and state more generally has been working closely with the industry to manage these changes and the industry remains in a stronger overall financial position as a result. Specifically, staff have promulgated several policies in the past few years, e.g., respiratory surge funding and an inflation catch up methodology, that have returned hospital profitability to levels similar to those experienced before COVID (see Figure 16 below). Additionally, a statewide Regulatory Working Group—consisting of the Maryland Department of Health (MDH), Maryland Insurance Administration (MIA), HSCRC, Maryland Health Care Commission (MHCC), Maryland Health Benefit Exchange (MHBE), and numerous public stakeholders—recently convened. The group recommended that half of the required Medicare Total Cost of Care savings under the AHEAD Model be cost-shifted to commercial payers. This approach is intended to shield hospitals from more significant revenue reductions that could negatively affect financial performance.

Figure 16. Distribution and Median of Total Hospital Operating Margins



Finally, staff agree with the HME consumer alliance that under a global budget system, financial incentives for quality are an important guardrail and caution against comparing quality revenue at-risk between states with and without global budget systems.

Final Recommendations

The Final recommendations for the RY 2028 Maryland Hospital Acquired Conditions (MHAC) program are as follows:

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 a quality program for revenue adjustments to Maryland hospital global budgets (HGB).

Appendix A: Quality Program Transition under AHEAD

Below are the high-level details of quality assessments in the AHEAD Model, based on staff's current understanding of the new AHEAD State Agreement requirements and discussions with CMMI staff:

- Maryland hospitals will move to CMS hospital quality programs for Medicare FFS either for FFY 2029 or FFY 2030 payment adjustments (i.e, performance period mid-2025 through CY2027 or mid-2026 through CY2028). Staff will need to continue to request a waiver from CMMI for the all-payer programs.
- RY 2028 (i.e., CY 2026 performance) will be under Maryland all-payer policies and CMS will implement the revenue adjustments in CY 2028 for the Medicare FFS global budgets (and HSCRC will implement for all other payers).
- State may continue quality adjustments to hospital global budgets for all other payers (i.e., non-Medicare FFS) and is required to report annually to CMMI on the quality programs including measures, performance, revenue adjustments.
- State will align non-Medicare FFS quality programs with the CMS programs to reduce hospital burden where feasible and appropriate, but also consider focus areas where the state could deviate from CMS based on State, payer, or other stakeholder priorities.

Figure A1. provides a potential timelines for quality program transition.

Figure A1. Timeline Options for Quality Program Transition

Potential Timelines

Color Key	Performance	Revenue
	All Payer	All-Payer
	Medicare FFS	Medicare
	Non-Medicare	Non-Medicare

		AHEAD Performance Year ⟶	Performance Year 1								Performance Year 2								Performance Year 3				Performance Year 4				Performance Year 5			
Updated 10/10/2025	RY/FY & Payer	Policy	2025				2026				2027								2028				2029				2030			
Intermediate Transition	2026 All-Payer	All					All-Payer Revenue Adjustments																							
Qualitative Description: Maintains all-payer quality assessments PY1 only, creates minimal overlap in measurement sets, has a limited revenue adjustment gap, and provides time to prepare for National measures and develop non-Medicare quality measures.	2027 All-Payer	All	Performance Period: All-Payer Quality Programs*								All-Payer Revenue Adjustments																			
	2028 All-Payer	All					Performance Period: All-Payer Quality Programs with CMS VBP Alignment*								All-Payer Revenue Adjustments				Non-Medicare Medicare Revenue											
	2029 Medicare	HVBP									Performance Period: PCE & Safety Domain												Medicare Revenue Adjustments							
		HRRP					Performance Period: Clinical Care Domain*																							
		HACRP					Performance Period: Medicare Readmissions																							
	2029 Non-Medicare	All					Performance Period: NHSN HAIs																							
	2030 Medicare	HVBP					Performance Period: CMS PSI-90																							
		HRRP									Non-Medicare Quality Programs												Non-Medicare Revenue Adjustments							
		HACRP																	Performance Period: PCE & Safety								Medicare Revenue Adjustments			
	2030 Non-Medicare	All									Performance Period: Clinical Care Domain*																			
											Performance Period: Medicare Readmissions																			
											Performance Period: NHSN HAIs																			
											Performance Period: CMS PSI-90																			
																			Non-Medicare Quality Programs				Non-Medicare Revenue Adjustments							
Latest Transition	2026 All-Payer	All					All-Payer Revenue Adjustments																							
Qualitative Description: Maintains all-payer revenue adjustments and quality assessments PY1 & PY2, creates minimal overlap in measurement sets, has a limited revenue adjustment gap, and provides time to prepare for National measures and develop non-Medicare quality measures.	2027 All-Payer	All	Performance Period: All-Payer Quality Programs*								All-Payer Revenue Adjustments																			
	2028 All-Payer	All					Performance Period: All-Payer Quality Programs with CMS VBP Alignment*								All-Payer Revenue Adjustments				Non-Medicare Medicare Revenue											
	2029 All-Payer	All									Performance Period: All-Payer Quality Programs with CMS Complications Alignment*												Non-Medicare Revenue Adjustments Medicare Revenue Adjustments							
	2030 Medicare	HVBP																	Performance Period: PCE & Safety								Medicare Revenue Adjustments			
		HRRP					Performance Period: Clinical Care Domain*																							
		HACRP									Performance Period: Medicare Readmissions																			
	2030 Non-Medicare	All									Performance Period: NHSN HAIs																			
											Performance Period: CMS PSI-90																			
																			Non-Medicare Quality Programs				Non-Medicare Revenue Adjustments							

*Performance periods for certain measures start earlier or vary in Maryland based on hospital size. Care Compare measures (HCAHPS, NHSN) in QBR have one year performance period starting in October.

Intermediate option means hospital performance is already under some of the CMS quality measures (i.e., condition specific mortality, THA-TKA, CMS PSI). Other measures start CY2026 (i.e., condition specific readmissions and NHSN)

Appendix B: PPC and PSI Overlap

In advance of the RY 2021 MHAC policy, a comparison of performance of individual PPCs considered "overlapping" with PSI 90 component measures was completed. This analysis was repeated for the RY 2028 policy and the results of this updated analysis is presented below in Figure B.1. Results show significant variability in the Numerator and Denominator populations and ~~their performance rates~~ for each "overlapping" set of PSI/PPC combinations; payment PPCs are highlighted in grey. Some of this variability is attributable to known differences in populations and specification logic. For example, both PSI 13 and PPC 38 measure Sepsis rates, however, PSI 13 is limited to postoperative Sepsis while PPC 38 covers all inpatient Sepsis cases. Other differences include Age and Major Diagnostic Category (MDC) variables. Overall, these data suggest the measure specifications are not sufficiently aligned for PSIs and PPCs to be considered comparable across most of the "overlapping" measure sets. Instead, measures within each measure set should be compared to their own historical performance rates in order to understand trends. This has implications if the PSIs were to replace PPCs in the future and would require generating historical performance data for the PSIs. Of final note, while PPCs are more comprehensive in some of their constructs, they lack national comparative performance data and benchmarks. Staff believes that inclusion of both PPCs and PSIs provides for comprehensive measurement of complications acquired in the hospital while making progress toward aligning with the HACRP program.

Figure B.1. PPC-PSI Overlap Analysis Results, 2026

Measures Compared	Measure Inclusion	Numerator Cases		Denominator Cases	
		Frequency	Percent	Frequency	Percent
PSI 03: Pressure Ulcer PPC 31: Pressure Ulcers	PSI and PPC	305	42.1%	307,871	56.6%
	PSI Only	85	11.7%	221,786	40.8%
	PPC Only	334	46.1%	14,388	2.6%

Measures Compared	Measure Inclusion	Numerator Cases		Denominator Cases	
		Frequency	Percent	Frequency	Percent
PSI 06: Iatrogenic Pneumothorax Rate PPC 49: Iatrogenic Pneumothorax	PSI and PPC	52	26.9%	574,470	66.1%
	PSI Only	44	22.8%	123,661	14.2%
	PPC Only	97	50.3%	171,304	19.7%
PSI 08: In Hospital Fall with Hip Fracture Rate PPC 28: In-Hospital Trauma and Fractures	PSI and PPC	135	57.0%	727,412	81.9%
	PSI Only	4	1.7%	113	0.0%
	PPC Only	98	41.4%	160,956	18.1%
PSI 09: Perioperative Hemorrhage or Hematoma Rate PPC 41: Peri-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Procedure	PSI and PPC	45	16.5%	97,744	46.1%
	PSI Only	182	66.9%	24,721	11.7%
	PPC Only	45	16.5%	89,447	42.2%
PSI 11: Postoperative Respiratory Failure Rate PPC 03: Acute Pulmonary Edema and Respiratory Failure without Ventilation	PSI and PPC	23	2.2%	52,099	10.0%
	PSI Only	392	37.2%	13,759	2.6%
	PPC Only	639	60.6%	454,842	87.4%

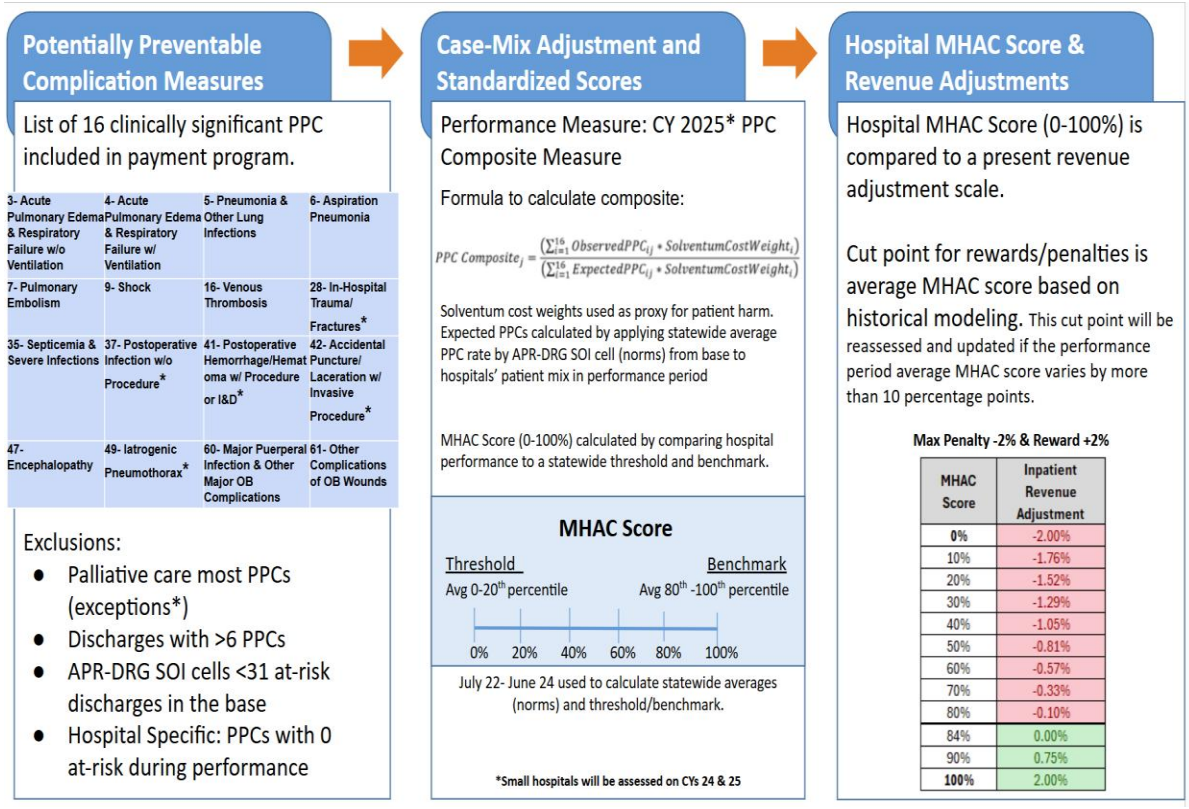
Measures Compared	Measure Inclusion	Numerator Cases		Denominator Cases	
		Frequency	Percent	Frequency	Percent
PSI 11: Postoperative Respiratory Failure Rate PPC 04: Acute Pulmonary Edema and Respiratory Failure with Ventilation	PSI and PPC	59	10.2%	55,750	10.7%
	PSI Only	356	61.4%	10,108	1.9%
	PPC Only	165	28.4%	454,682	87.3%
PSI 12: Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate PPC 07: Pulmonary Embolism	PSI and PPC	144	21.2%	118,992	17.1%
	PSI Only	405	59.6%	40,983	5.9%
	PPC Only	130	19.1%	536,775	77.0%
PSI 12: Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate PPC 16: Venous Thrombosis	PSI and PPC	48	8.1%	73,951	15.7%
	PSI Only	501	84.5%	86,024	18.2%
	PPC Only	44	7.4%	312,272	66.1%
PSI 13: Postoperative Sepsis Rate PPC 35: Septicemia & Severe Infections	PSI and PPC	47	6.8%	16,421	5.6%
	PSI Only	221	32.1%	48,771	16.7%

Measures Compared	Measure Inclusion	Numerator Cases		Denominator Cases	
		Frequency	Percent	Frequency	Percent
	PPC Only	420	61.0%	226,453	77.6%
PSI 14: Postoperative Wound Dehiscence Rate PPC 37: Post-Procedural Infection and Deep Wound Disruption without Procedure	PSI and PPC	12	3.0%	24,354	16.4%
	PSI Only	71	17.7%	18,155	12.2%
	PPC Only	319	79.4%	105,763	71.3%
PSI 14: Postoperative Wound Dehiscence Rate PPC 38: Post-Procedural Infection and Deep Wound Disruption with Procedure	PSI and PPC	18	9.1%	24,562	16.6%
	PSI Only	65	33.0%	17,947	12.1%
	PPC Only	114	57.9%	105,849	71.3%
PSI 15: Unrecognized Abdominopelvic Accidental Puncture or Laceration Rate PPC 42: Accidental Puncture/Laceration During Invasive Procedure	PSI and PPC	109	61.9%	131,525	14.4%
	PSI Only	21	11.9%	1,331	0.1%
	PPC Only	46	26.1%	782,256	85.5%

Appendix C. RY 2027 MHAC Program Methodology

In April 2025 the Commission approved staff recommendations for the Rate Year (RY) 2027 MHAC program. Figure C.1 below provides a summary overview of the approved RY 2027 MHAC methodology.

Figure C.1. Overview of RY 2027 Approved MHAC Methodology



The MHAC policy was redesigned in RY 2021 to modernize the program in alignment with the new Total Cost of Care Model. The RY 2027 final recommendations maintained the current complication measures but updated the methodology for calculating hospital scores and applying revenue adjustments. These changes are intended to address small cell size concerns and comprehensiveness of the program.

The methodology for the MHAC program measures hospital performance using the PPC composite Observed (O) /Expected (E) ratio. Expected number of PPCs are calculated using historical data on statewide PPC rates by All Patient Refined Diagnosis Related Group and Severity of Illness Level (APR-DRG SOI). See below for details on how the expected number of PPCs are calculated for each hospital.

Observed and Expected PPC Values

The MHAC scores are calculated using the ratio of $Observed : Expected$ PPC values.

Given a hospital's unique mix of patients, as defined by APR-DRG category and Severity of Illness (SOI) level, the HSCRC calculates the hospital's expected PPC value, which is the number of PPCs the hospital would have experienced if its PPC rate were identical to that experienced by a normative set of hospitals.

The expected number of PPCs is calculated using a technique called indirect standardization. For illustrative purposes, assume that every hospital discharge is considered "at-risk" for a PPC, meaning that all discharges would meet the criteria for inclusion in the MHAC program. All discharges will either have no PPCs, or will have one or more PPCs. In this example, each discharge either has at least one PPC, or does not have a PPC. The unadjusted PPC rate is the percent of discharges that have at least one PPC.

The rates of PPCs in the normative database are calculated for each diagnosis (APR-DRG) category and severity level by dividing the observed number of PPCs by the total number of admissions. The PPC norm for a single diagnosis and severity level is calculated as follows:

Let:

N = norm

P = Number of discharges with one or more PPCs

D = Number of "at-risk" discharges

i = A diagnosis category and severity level

$$N_i = \frac{P_i}{D_i}$$

In the example, each normative value is presented as PPCs per discharge to facilitate the calculations in the example. Most reports will display this number as a rate per one thousand discharges.

Once the normative expected values have been calculated, they can be applied to each hospital. In this example, the normative expected values are computed for one diagnosis category and its four severity levels.

Consider the following example in Figure C.2 for an individual diagnosis category.

Figure C.2. Expected Value Computation Example for one Diagnosis Category

A Severity of illness Level	B At-risk Discharges	C Observed Discharges with PPCs	D PPCs per discharge (unadjusted PPC Rate)	E Normative PPCs per discharge	F Expected # of PPCs	G Observed: Expected Ratio
			= (C / B)	(Calculated from Normative Population)	= (B x E)	= (C / E) rounded to 4 decimal places
1	200	10	.05	.07	14.0	0.7143
2	150	15	.10	.10	15.0	1.0000
3	100	10	.10	.15	15.0	0.6667
4	50	10	.20	.25	12.5	0.8000
Total	**500**	**45**	**.09**		**56.5**	**0.7965**

For the diagnosis category, the number of discharges with PPCs is 45, which is the sum of discharges with PPCs (column C). The overall rate of PPCs per discharge in column D, 0.09, is calculated by dividing the total number of discharges with PPCs (sum of column C) by the total number of discharges at risk for PPCs (sum of column B), i.e., 0.09 = 45/500. From the normative population, the proportion of discharges with PPCs for each SOI level for that diagnosis category is displayed in column E. The expected number of PPCs for each severity level shown in column F is calculated by multiplying the number of at-risk discharges (column B) by the normative PPCs per discharge rate (column E). The total number of PPCs expected for this diagnosis category is the expected number of PPCs for the severity levels.

In this example, the expected number of PPCs for the APR DRG category is 56.5, which is then compared to the observed number of discharges with PPCs (45). Thus, the hospital had 11.5 fewer observed discharges with PPCs than were expected for 500 at-risk discharges in this APR DRG category. This difference can be expressed as a percentage difference as well.

All APR-DRG categories and their SOI levels are included in the computation of the observed and expected rates, except when the APR-DRG SOI level has less than 30 at-risk discharges statewide.

MHAC Exclusions

The following exclusions are applied:

- Discharge is in an APR-DRG SOI cell has less than 31 statewide discharges; and
- Discharge has more than 6 PPCs (i.e., a catastrophic case, for which complications are probably not preventable).

Potentially Preventable Complications (PPCs) in Payment

During the RY 2021 MHAC redesign, the number of complication measures was reduced from 45+ to a subset of 14 complications that were clinically significant and actionable, as well as meeting measurement criteria such as higher statewide rates, variation across hospitals, and validity and reliability of individual PPCs. The PPCs not selected for payment are considered "monitoring PPCs" and are evaluated annually by staff and stakeholders to determine whether they should be put back into the payment program. For RY 2027, the same payment PPCs are being included as were included in the RY 2026 policy, as shown in Figure C.3. However, the two pneumonia related PPCs, which were combined previously into a single PPC referred to as PPC 67, are now assessed individually in RY 2027. Additional discussion on PPC selection for RY27 and discussion of the future of the program can be found in the policy and PMWG meeting documentation. Hospitals are now accountable for all 16 PPCs as long as they have at least one at-risk discharge for each PPC during the performance period (i.e., there is no longer a requirement of at least two expected and 20 at-risk and PPC inclusion is no longer determined during the base period).

Figure C.3. RY 2027 Payment PPCs

PPC Number	PPC Title
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation
5	Pneumonia and Other Lung Infections
6	Aspiration Pneumonia
7	Pulmonary Embolism
9	Shock
16	Venous Thrombosis
28	In-Hospital Trauma and Fractures
35	Septicemia & Severe Infections
37	Post-Operative Infection & Deep Wound Disruption without Procedure

PPC Number	PPC Title
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D
42	Accidental Puncture/Laceration During Invasive Procedure
47	Encephalopathy
49	Iatrogenic Pneumothorax
60	Major Puerperal Infection and Other Major Obstetric Complications
61	Other Complications of Obstetrical Surgical & Perineal Wounds

Performance Metric and Scoring

As stated above, for RY 2027, the performance on PPCs is assessed using a single composite measure that weights the component measures by the Solventum cost weights (as has been done previously) and the hospital-specific expected PPCs (new). Staff worked with Mathematica to test multiple ways to create a composite measure that better addressed small cell size issues and did not remove PPCs for a hospital with lower expected values. Specifically, Mathematica used data from FY 2018 through FY 2024 to model six iterations of Maryland hospital results under the existing methodology and three composite options. To inform decision making, staff assessed the content validity, predictive validity, and reliability of each composite option vs. the existing methodology across the six iterations of results. composite Option 1, which provides relatively higher weight within the composite for PPC measure based on hospital-specific expected numbers, was found to improve content validity and reliability the most and was selected for use in the program. By including all PPCs for a hospital with any at-risk discharges in the performance period, the modeling done by Mathematica shows that the number of payment PPCs evaluated increased for hospitals of all sizes. Figure C.4. shows the change in the average number of PPCs evaluated under the previous and new composite methodology by hospital size.

Figure C.4. Number of PPCs Evaluated Under Previous Method Vs. composite

Hospital Category	Number of Hospitals	Average Number of PPC Measures Evaluated using Previous Methodology	Average Number of PPC Measures Evaluated using composite Methodology

Small Hospitals	5	3.6	13.2
Medium Hospitals	13	10.5	14.2
Large Hospitals	24	13.7	15

Instead of scoring (i.e., assigning 0 to 100 points) at the individual PPC level, there is now only one threshold and benchmark value used to assess hospital performance on the PPC composite measure. The threshold and benchmark for the PPC composite measure are calculated using the base period data. As shown in the equation below, the PPC composite score is calculated as the sum of the hospital's observed PPCs times the Solventum Cost Weight for each payment PPC measure divided by the sum of the hospital's expected PPCs times the Solventum Cost Weight for each payment PPC measure.

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

The composite does not explicitly weight PPC measures by volume, but PPC measures with higher expected PPCs receive more weight. The expected PPCs for a PPC measure generally increases as the volume of at-risk discharges increases.

MHAC Score (0-100 percent)

Each hospital's final MHAC score was previously calculated by adding up the attainment points for each PPC and dividing by the total possible attainment points to get a percent score. Under the new scoring methodology, the PPC composite measure is compared to the threshold and benchmark and the result is the MHAC percent score. The threshold (worse performance) and benchmark (better performance) are calculated by averaging the PPC composite score for all hospitals in the bottom or top 20th percentile of performance in the base period, respectively.

If the PPC composite measure for the performance period is greater than the threshold, the hospital scores zero percent.

If the PPC composite measure for the performance period is less than or equal to the benchmark, the hospital scores 100 percent.

If the PPC composite measure is between the threshold and benchmark, the hospital scores between 0-100 percent. The formula to calculate the MHAC scores is as follows:

- MHAC Score = [99 * ((Hospital's PPC composite measure - Threshold)/ (Benchmark – Threshold))] + 0.5

Small Hospital Criteria Updates

Prior to the RY 2027 policy update, the MHAC program excluded individual PPCs for a hospital that did not meet the minimum criteria of 2 expected and 20 at-risk for any PPC in the two year "base" period. As discussed above, all hospitals with greater than zero at-risk discharges for a given PPC in the performance period, will have that PPC included in the new composite measure. Small hospitals (i.e., a hospital with less than 21,500 at-risk discharges or 22 expected PPCs in the two-year base period) will continue to be assessed using two years data.

Updated Scaling Methodology and Revenue At-Risk

The RY 2027 program uses a continuous scale with a full distribution of potential scores (scale of 0-100%) and the cut point of 84 percent (i.e., score at which penalties end and rewards begin) is based on the average hospital scores from modeling. The previously established "hold harmless zone" where hospitals were not rewarded or penalized, has been removed. Both the minimum and maximum revenue adjustment remain at 2 percent of inpatient revenue. Given the changes to the scoring methodology, the cut point for the revenue adjustment scale will be reassessed based on actual performance scores for RY 2027 and modified if the hospital average score varies by more than 10 percentage points.

RY2027 Base and Performance Periods

The base period is the historical time period used for determining performance standards, including the normative values used to calculate expected PPCs and the threshold and benchmark for scoring

performance. For RY 2027 the base period is July 2022-June 2024. The performance period is CY 2025, but small hospitals will have a two year performance period (CY 2024 and CY 2025).

Appendix D: PPC Criteria and Performance

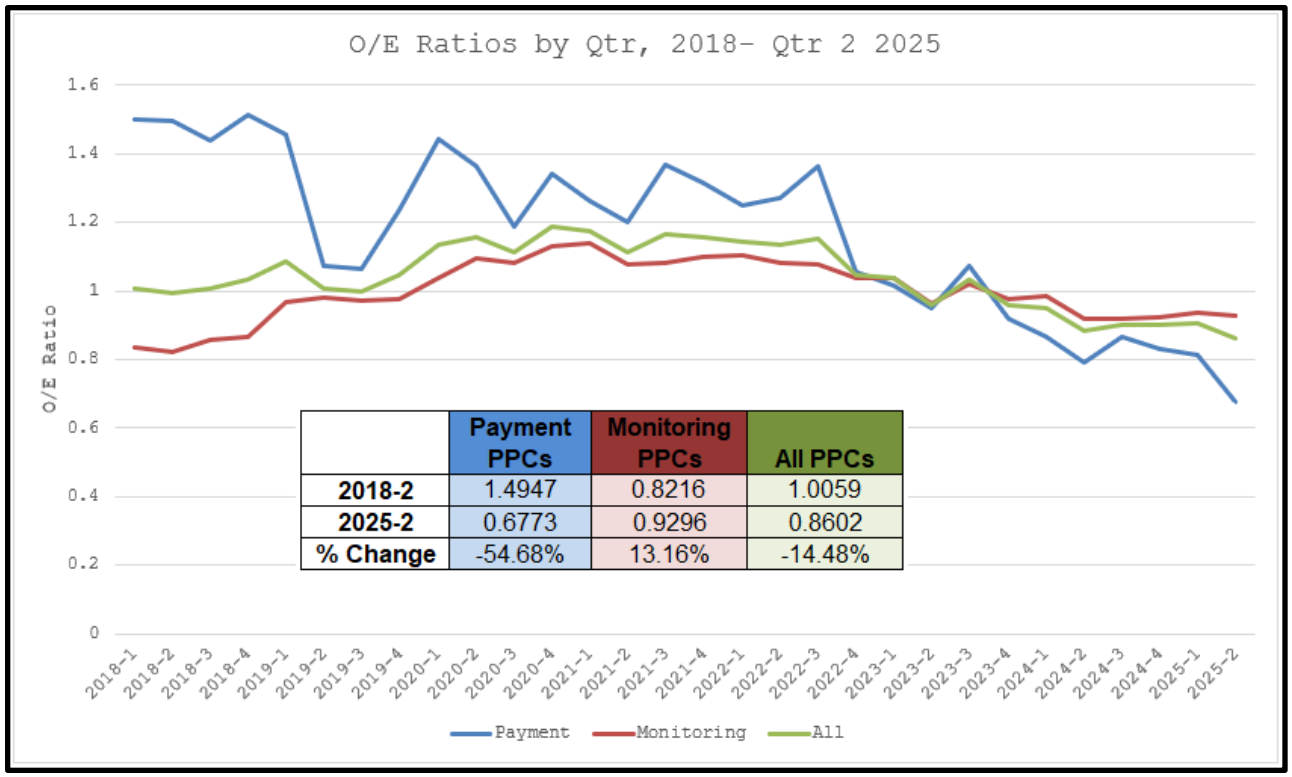
The RY 2021 MHAC policy redesign recommended monitoring the PPCs not selected for the MHAC Payment program. Each year the staff reviews PPCs results with stakeholders and determines whether any of the PPCs should be moved back into the payment program.

To determine whether any monitoring PPCs should be moved back into the payment program, staff and stakeholders have used the criteria listed below.

- PPC Data Analysis/Statistics
  - Greater than 50% increase in O/E ratio since 2018
  - Rate per 1,000 generally 0.5 or above
  - Volume of observed events 100 or above (over two years)
  - Significant variation across hospitals O/E ratios less than 0.85 and greater than 1.15
  - At least half of the hospitals are eligible for the PPC
- Additional Considerations
  - PSI overlap
  - Clinical significance
  - Potential influence of coding practices/changes
  - Opportunity for improvement/actionability
  - All-payer

Figure D.1. provides the quarterly PPC O/E ratios from CY 2018 through 2025 Q2 for monitored PPCs, payment PPCs and overall.

Figure D.1. All PPCs Observed to Expected Ratios by Quarter, CY 2018 to CY 2025 YTD



	Payment PPCs	Monitoring PPCs	All PPCs
2018-2	1.4947	0.8216	1.0059
2025-2	0.6773	0.9296	0.8602
% Change	-54.68%	13.16%	-14.48%

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Appendix E: By Hospital MHAC Modeling

RY 2026 Estimated Scores			PPCs Only			PPCs and PSIs		
Hospital ID	Hospital Name	CY 24 Estimated Inpatient Revenue	MHAC Scores	Percent Adjustment	$ Adjustment	MHAC Scores	Percent Adjustment	$ Adjustment
210001	Meritus	$251,995,786	1.00	2.00%	$5,039,916	0.99	1.91%	$4,808,679
210002	UMMS- UMMC	$1,473,072,120	0.63	-0.42%	-$6,218,162	0.62	-0.41%	-$6,076,374
210003	UMMS- Capital Region	$309,492,831	0.36	-1.11%	-$3,446,840	0.30	-1.24%	-$3,845,051
210004	Trinity - Holy Cross	$413,940,590	0.53	-0.68%	-$2,835,054	0.48	-0.77%	-$3,184,252
210005	Frederick	$254,562,530	0.64	-0.41%	-$1,038,390	0.57	-0.55%	-$1,409,749
210008	Mercy	$220,664,524	0.60	-0.51%	-$1,131,723	0.64	-0.37%	-$827,466
210009	JHH- Johns Hopkins	$1,818,903,395	0.34	-1.14%	-$20,810,465	0.34	-1.12%	-$20,434,519
210011	St. Agnes	$254,764,484	0.82	0.20%	$517,386	0.81	0.27%	$698,318
210012	Lifebridge- Sinai	$519,012,883	1.00	2.00%	$10,380,258	0.96	1.60%	$8,316,472
210015	MedStar- Franklin Square	$371,862,302	1.00	2.00%	$7,437,246	0.94	1.42%	$5,276,126
210016	Adventist- White Oak	$242,890,872	0.96	1.58%	$3,833,611	0.92	1.24%	$3,006,037
210017	Garrett	$28,988,189	0.91	1.13%	$328,258	0.89	1.01%	$292,038
210018	MedStar- Montgomery	$96,052,028	0.55	-0.64%	-$611,637	0.56	-0.57%	-$547,896
210019	Tidal- Peninsula	$350,375,491	0.78	-0.06%	-$193,193	0.80	0.17%	$579,935
210022	JHH- Suburban	$249,484,035	0.70	-0.26%	-$651,946	0.68	-0.27%	-$664,905
210023	Luminis- Anne Arundel	$367,930,454	0.77	-0.08%	-$300,105	0.81	0.24%	$873,462
210024	MedStar- Union Mem	$267,917,283	0.90	1.04%	$2,781,897	0.91	1.17%	$3,123,185
210027	Western Maryland	$183,379,829	1.00	2.00%	$3,667,597	0.96	1.66%	$3,050,593
210028	MedStar- St. Mary's	$100,479,485	0.91	1.07%	$1,076,850	0.87	0.76%	$766,395
210029	JHH- Bayview	$471,786,218	0.67	-0.33%	-$1,571,608	0.62	-0.42%	-$1,989,337
210032	ChristianaCare, Union	$84,802,922	1.00	2.00%	$1,696,058	1.00	2.00%	$1,696,058
210033	Lifebridge- Carroll	$162,844,959	0.88	0.82%	$1,343,433	0.84	0.53%	$863,523
210034	MedStar- Harbor	$128,234,465	1.00	2.00%	$2,564,689	1.00	2.00%	$2,564,689
210035	UMMS- Charles	$97,586,229	0.81	0.09%	$84,700	0.77	-0.02%	-$24,239
210037	UMMS- Easton	$123,617,439	0.81	0.05%	$61,043	0.77	-0.04%	-$50,990
210038	UMMS- Midtown	$140,418,656	0.81	0.05%	$67,920	0.83	0.40%	$564,211
210039	Calvert	$80,925,064	0.68	-0.30%	-$245,568	0.70	-0.22%	-$179,285
210040	Lifebridge- Northwest	$160,861,387	1.00	2.00%	$3,217,228	0.93	1.39%	$2,233,160
210043	UMMS- BWMC	$325,584,009	0.78	-0.07%	-$220,921	0.81	0.28%	$909,865
210044	GBMC	$263,774,655	0.73	-0.17%	-$455,836	0.62	-0.41%	-$1,088,062
210048	JHH- Howard County	$220,287,562	0.46	-0.86%	-$1,887,682	0.44	-0.88%	-$1,933,999
210049	UM Upper Chesapeake	$236,862,562	1.00	2.00%	$4,737,251	0.87	0.79%	$1,875,468
210051	Luminis- Doctors	$187,232,106	0.85	0.47%	$887,645	0.87	0.85%	$1,584,150
210056	MedStar- Good Sam	$186,628,391	1.00	2.00%	$3,732,568	0.98	1.79%	$3,332,974
210057	Adventist- Shady Grove	$333,973,100	1.00	2.00%	$6,679,462	0.94	1.48%	$4,942,847
210058	UMMS- UMROI	$80,968,088	1.00	2.00%	$1,619,362	1.00	2.00%	$1,619,362
210060	Adventist-Ft. Washington	$37,782,970	0.64	-0.41%	-$153,838	0.67	-0.28%	-$104,320
210061	Atlantic General	$47,434,007	0.41	-0.98%	-$466,190	0.46	-0.83%	-$392,687
210062	MedStar- Southern MD	$210,921,411	0.95	1.49%	$3,132,806	0.88	0.91%	$1,913,613
210063	UMMS- St. Joe	$292,568,045	1.00	2.00%	$5,851,361	1.00	2.00%	$5,851,361
210064	Lifebridge- Levindale	$68,147,842	1.00	2.00%	$1,362,957	1.00	2.00%	$1,362,957
210065	Holy Cross Germantown	$94,710,748	0.83	0.26%	$245,017	0.82	0.35%	$328,408

Adventist HealthCare

December 22, 2025

Alyson Schuster
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Alyson Schuster,

Adventist HealthCare (AHC) appreciates the opportunity to provide comments on the draft recommendation for the Rate Year (RY) 2028 Maryland Hospital Acquired Conditions (MHAC) Program.

The HSCRC has been working collaboratively with hospitals to redesign the Maryland quality programs to more closely align with the CMS quality programs. While alignment of the Quality-Based Reimbursement (QBR) program and the CMS Hospital Value-Based Purchasing (HVBP) program has been much of the focus for HSCRC staff, we still actively encourage maximizing alignment between the other programs as well. While we prefer full alignment between the MHAC program and the CMS Hospital Acquired Conditions Reduction Program (HACRP) in RY28, if full alignment cannot be achieved in Year 1 as outlined in the draft policy, we recommend keeping the MHAC program the same for RY28 as it was for RY27.

Continue RY27 MHAC Program for RY28 if Full HACRP Alignment Can't Be Achieved

As recommended with the QBR program, AHC is in support of maximizing alignment between the MHAC program and HACRP program. However, since the draft proposal only includes partial alignment by adding all-payer AHRQ Patient Safety Indicator 90 (PSI-90) but maintaining Potentially Preventable Complications (PPCs), AHC recommends continuing the RY27 program, which measures PPC performance only, for RY28. In addition, we recommend moving AHRQ PSI-90 to monitoring only on an interim basis.

We propose this because PPCs and PSIs both measure complications and are duplicative. Therefore, we do not recommend including them both in the same program. Of the 16 payment PPCs currently in the MHAC program, 10 have at least some sort of overlap with PSIs. Therefore, we recommend maintaining the current MHAC program and moving AHRQ PSI-90 to monitoring only until full alignment can be achieved in PY2.

Maintain Upside Reward Potential in RY28 and Beyond

While AHC is in full support of aligning with the CMS quality programs, we encourage keeping the upside reward potential available in the MHAC program both in Year 1 and in future years. Maintaining upside reward potential incentivizes hospitals to invest in quality improvement initiatives, which aligns

with the program's overarching goals. Flexibility in the revenue at risk keeps the infrastructure and scoring of the programs consistent but allows hospitals to reinvest rewards in areas of opportunity. Therefore, we agree with the draft proposal maintaining the revenue at risk at a maximum penalty at 2 percent and maximum reward at 2 percent for RY28. We also encourage this to continue as greater alignment with HACRP is achieved in future years.

Recommendations

Adventist HealthCare recommends the following actions for the RY28 MHAC Draft Recommendation:

- Maintain the current RY27 MHAC program for RY28 if full alignment can't be achieved in Year 1.
- Move AHRQ PSI-90 to monitoring only until full alignment can be achieved in PY2.
- Keep the revenue at risk at a maximum penalty at 2 percent and maximum reward at 2 percent for RY28 and consider continuing this in future years even as MHAC and HACRP align more closely.

Conclusion

We value HSCRC's partnership and collaborative efforts to align the Maryland quality programs with the CMS quality programs. While we fully support the long-term goal of aligning MHAC with HACRP, we believe maintaining the current MHAC structure for RY28 is the most practical approach given the partial alignment proposed in the draft policy. We look forward to working closely with HSCRC staff to achieve full alignment by next year and to advance shared goals of quality care, program consistency, and improved outcomes across Maryland.

Sincerely,

Katie Eckert

Katie Eckert, CPA
Senior Vice President, Strategic Operations
Adventist HealthCare

cc: Jonathan Kromm, PhD, Executive Director, HSCRC
Joshua Sharfstein, MD, HSCRC Chairman
James N. Elliott, MD, HSCRC Vice-Chairman
Jonathan Blum, MPP
Ricardo R. Johnson, JD
Maulik Joshi, DrPH
Nicki McCann, JD
Farzaneh Sabi, MD

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CONSUMER ALLIANCE

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: DRAFT RECOMMENDATIONS ON SURGE FUNDING AND HOSPITAL ACQUIRED CONDITIONS PROGRAM

Dear Dr. Kromm and HSCRC Commissioners:

Health Means Everything appreciates the opportunity to comment on the draft recommendations for Surge Funding and the Hospital Acquired Conditions program. In keeping with our organization's mission, our comments focus principally on potential cost and access impacts for consumers, as well as consumer health outcomes.

Surge Funding

Hospital capacity and access are vital during respiratory virus season, and HME appreciates that the HSCRC has taken steps during and after the COVID-19 pandemic to ensure that Maryland hospitals can meet the needs of Maryland families. With respect to the draft recommendations discussed at the December HSCRC meeting, **HME encourages the HSCRC to avoid increasing consumer costs (by increasing surge funding) if global budgets are already sufficiently funding higher patient volumes during the annual respiratory season.**

Surge funding is included in hospital global budgets. Thus, increasing surge funding also increases global budgets and hospital service rates. These costs are ultimately passed down to Maryland consumers through premiums and other rising expenses. As we have noted in previous comments to the Commission, Marylanders' health care costs are already too high and we are concerned that the HSCRC continually increases hospital

global budgets and adds to consumers' cost burden.[12] The Governor's workgroup is also poised to increase costs further for commercially insured consumers in order to support both AHEAD model implementation and stabilize the state Medicare Advantage market. **HME's overarching concern is that the HSCRC is continually increasing consumer costs through individual policy decisions, without sufficiently analyzing or discussing how consumers will be impacted, or how that impact compares to hospitals' financial status.**

As we have discussed in previous comments, right-sizing hospital payments to current utilization patterns is one important way that the HSCRC can pass savings down to consumers. The HSCRC's own analysis demonstrates that age-adjusted Maryland hospital utilization has decreased by 10%, and outpatient utilization has decreased even more substantially.[3] During the same period, the HSCRC has consistently increased hospital global budgets. The goal of the state's hospital rate setting authority should be to balance global budgets while minimizing costs to consumers, not to maintain hospital budgets at a given level when service use is changing. HME strongly recommends that the HSCRC implement policies to account for reductions in overall utilization of hospital services and examine whether global budgets accurately reflect the needs of Marylanders today.

With all of this in mind, **HME does not believe that the HSCRC should increase the surge funding cap or implement policies that allow for retrospective increases in surge funding unless robust analyses clearly conclude that such extra funding is vital for ensuring access to care.** We further note that such policies undermine the overall goal of hospital global budgets by retrospectively increasing funding if volumes increase. HME warns against finalizing policies that encourage hospitals to maximize admissions.

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1 https://www.kff.org/health-costs/state-indicator/expenses-per-inpatient-day/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Expenses%20per%20Inpatient%20Day%22,%22sort%22:%22desc%22%7D

2 https://healthcarevaluehub.org/wp-content/uploads/MD_CHESS_Infographic_Oct_22.pdf

3 https://hscrc.maryland.gov/Documents/November%202025%20PUBLIC%20PREMEETING%20-%20finalv3.pdf. Page 44

Finally, we urge the HSCRC to discuss more transparently and clearly how policy changes, such as those recommended for surge funding, would impact consumer costs. The pre-meeting materials do not explain how the policy recommendations would translate to hospital payment rates, or how such increases in hospital funding would impact premiums, copays, and other out-of-pocket spending.

Maryland Hospital Acquired Conditions Program

Health Means Everything is supportive of the HSCRC's efforts to update the Maryland Hospital Acquired Conditions (MHAC) program, which provides important incentives for hospitals to provide high-quality care and prevent infection. This program serves as an important guardrail to ensure that the adoption of global budgets does not result in safety risks or lower quality of care for Marylanders. HME recognizes and appreciates Maryland's performance on both the Potentially Preventable Complications (PPCs) measure and AHRQ's Patient Safety Indicator (PSI) 90 composite measure under the all-payer model. Notably, the state exceeded the contractual requirement of a 30% reduction in all PPCs and outperformed the national PSI-90 composite in four of the last six years. The HSCRC's data further demonstrates that the state's performance has improved significantly throughout participation in the model. These results demonstrate that the MHAC contributes to improved patient outcomes and reduced hospital costs.

As highlighted by the HSCRC staff, the PCC composite measure and PSI-90 composite measure evaluate performance among different conditions and cohorts of patients. As such, **HME supports the recommendation to use both PCC and PSI to assess hospital acquired complications and calculate adjustments to hospital global budgets.** We believe that measuring complications across both medical and surgical patients is essential for incentivizing quality and safety for all patients. By taking this comprehensive approach, hospitals are encouraged to invest in processes and protocols that promote infection control and patient safety across all units instead of focusing just on those that are measured by one measure or the other. HME strongly

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believes that hospitals should be incentivized to invest in these improvements each year, and that programs like MHAC serve as a vital guardrail in a global budget environment.

HME also supports the HSCRC's efforts to advance the successful implementation of the AHEAD Model, which we are hopeful will continue to improve the health of Maryland consumers while controlling health care costs. HME appreciates that the HSCRC continues to prioritize the health and quality of hospital care for Marylanders by aligning the well-established and successful MHAC program with the HACRP requirements under the AHEAD model. We encourage the HSCRC to continue comprehensively measuring hospital acquired conditions, as well as implementing an aligned program that continues to incentivize annual improvements in quality and safety.

Thank you again for your efforts, and for the opportunity to provide comment as you continue to hone these policies. We look forward to continuing to work with you on behalf of Marylanders.

Sincerely,

Ashiah Parker
Chair, Health Means Everything

December 16, 2025

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

Dear Dr. Schuster:

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the draft recommendation for the Maryland Hospital Acquired Condition (MHAC) Program for Rate Year (RY) 2028. JHHS appreciates staff's thorough discussions of the MHAC considerations in the Performance Measurement Workgroup and the opportunity to provide feedback on critical components of the model as the State prepares for significant transition into the AHEAD model.

As noted in JHHS's previous comments, implementation of the AHEAD model in Maryland will require significant and substantial efforts from many stakeholders over the coming years. Given this complexity, JHHS would underscore the key guiding principles endorsed by the hospital field as highlighted by the Maryland Hospital Association (MHA) in prior communication, including 1) maximizing multi-payer alignment; 2) reducing administrative complexity; 3) ensuring manageable timelines; and 4) maintaining quality incentives. JHHS urges the Health Services Cost Review Commission (HSCRC) to ensure policy changes align with these guiding principles as teams across the state work towards a sustainable payment model.

While JHHS generally supports the staff's recommendations, we would like to express our endorsement of the Maryland Hospital Association's (MHA) position and emphasize our strong desire to eliminate PPCs as soon as possible and offer the following comments for additional consideration:

1. While JHHS appreciates that a thoughtful approach is needed to ensure an appropriate transition to the national quality programs under AHEAD, a three-year transition is likely too lengthy a period for hospitals to be in transition, particularly given that the industry is collectively asking for alignment and reduced administrative complexity. Due to the lags in Medicare timelines, delaying the State's quality program transition timeline effectively creates a dynamic with duplicative monitoring of multiple programs and a less efficient use of limited hospital resources.
2. While PPCs have been in quality programs in Maryland for over 14 years they have not been a broadly adopted metric, introducing unnecessary variation. Based on our extensive experience, PPCs have not proven particularly effective in enhancing clinical care improvements that have not already been identified through other surveillance mechanisms, such as incident reporting,

healthcare-associated infection (HAI) surveillance, and Patient Safety Indicators (PSIs) and national benchmarking reviews.

3. Additionally, it is important to acknowledge that the current methodology incurs licensing costs and administrative burden to both the state and hospitals. Therefore, the expedited removal of PPCs is crucial to streamline operations and enhance overall quality of care.
4. While we support the forward movement of moving PSI90 to a the MHAC program we are concerned about the overlap between MHACs and PSIs, consideration of the weighting in the MHAC program compared to the weighing of PSI90 in its prior QBR position will be valuable as well.
5. Finally, JHHS would encourage the HSCRC to evaluate the percentage of revenue currently associated with quality programs in comparison to other states. There may be an opportunity for the State to drive quality improvement through a balanced approach that risks less hospital revenue, which becomes increasingly important as hospitals face substantial rate reductions under AHEAD amidst already strained financial conditions.

Thank you for considering our input on this significant issue. We look forward to further discussions aimed at improving patient safety and healthcare outcomes across Maryland.

Sincerely,

Angela Green, Ph.D., R.N., F.A.A.N.
Vice President, Quality and Safety
Johns Hopkins Health System

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Jonathan Blum
Nicki McCann
Dr. Farzaneh Sabi
Jon Kromm

Maryland
Hospital Association

December 22, 2025

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, we appreciate the opportunity to provide comments to the Health Services Cost Review Commission (HSCRC) on the draft policy proposal for the Rate Year (RY) 2028 Maryland Hospital Acquired Conditions (MHAC) Program.

We commend HSCRC for their continued commitment to advancing patient safety and quality improvement through incentive-based approaches. MHA and our members support the continuation of rewards for hospitals as they work to improve quality of care for Marylanders across the state. We support the RY2028 MHAC Program recommendation and are encouraged by HSCRC's policy design efforts that signal a goal to align with the Centers for Medicare & Medicaid Services (CMS) Hospital Acquired Conditions Reduction Program (HACRP), particularly through the inclusion of the AHRQ Patient Safety Indicators (PSI) 90 measure in the MHAC Program.

We support the staff recommendation and also offer the following feedback for consideration:

1. **Guiding Principles for Quality Policy Design**

   As Maryland prepares for the upcoming transition to the Center for Medicare & Medicaid Services (CMS) national quality programs, MHA urges the Commission to use the guiding principles endorsed by hospital field quality leaders to design MHAC and other HSCRC quality programs:

   - **Maximize Multi-Payer Alignment** – State-based quality policies for Medicaid and commercial should align with CMS Medicare quality design to streamline administration.
   - **Reduce Administrative Complexity** – Policies should be designed to avoid complexity, administrative burden, and higher costs as the state plans for simultaneous operation of state-based and federal quality programs.

- **Ensure Manageable Timelines** – The state should select quality program policy time frames that enable hospitals to adjust their quality infrastructure to optimize performance in the national quality programs.
- **Maintain Quality Incentives** – State-based quality programs should maintain incentives that enable hospitals to design initiatives to improve quality performance.

2. RY2028 Potentially Preventable Complications (PPC) Composite Methodology

MHA supports the continuation of MHAC PPCs for one additional year (RY28) only to allow the hospital field time to partner with Solventum (formerly 3M) on a reasonable exit from the program for RY2029 and beyond. MHA urges the HSCRC to reconsider the ongoing use of the Potentially Preventable Complications (PPCs) composite methodology for evaluating hospital acquired complications. This methodology diverges from the guiding principles widely endorsed by the hospital field as it imposes substantial costs and administrative burden for hospitals. The use of PPCs in the MHAC program requires hospitals to make significant investments to cover costs associated with proprietary grouper software and IT routines and duplicative reporting systems. This methodology design diverts resources away from direct patient care.

3. Planning for RY2029 and Beyond

MHA looks forward to working with the HSCRC on AHEAD Model quality transition planning. In preparation for this immense undertaking, MHA urges HSCRC to identify an alternative approach for RY2029 MHAC that ensures there is alignment with CMS standards including program design, measures, methodologies, performance periods, and reporting timeline. This approach will reduce unnecessary complexity and enhance consistency across payers.

Beginning in RY2029, MHA recommends replacing the PPC composite methodology with the National Healthcare Safety Network (NHSN) measures. NHSN healthcare associated infection measures are nationally standardized, evidence-based, and widely audited, which ensures alignment with national benchmarks and simplifies reporting. This change would also better align the MHAC program for Medicaid and Commercial payers with the CMS HACRP for Medicare. NHSN measures, which are already integral to the CMS HACRP program, would offer a consistent, nationally recognized framework for assessing hospital-acquired conditions. Additionally, the use of NHSN measures would reduce duplicative reporting, measure fragmentation, and allow hospitals to focus on measures that are meaningful, actionable, and comparable across state and federal programs.

We also urge HSCRC to proactively communicate reward and penalty structures for non-Medicare payers well in advance. Early clarity will support hospitals' quality improvement strategies, interventions, and financial planning for a smooth transition. HSCRC should also continue monitoring cumulative program impact as PSI-90 is added to the MHAC program. Finally, HSCRC should maintain timely and transparent data reporting.

As Maryland plans for the transition to the AHEAD Model, we must keep in mind that this will alter quality programming for the next decade. With this change, there is an opportunity to reduce administrative complexity and address costly design requirements in the current MHAC program, while also achieving greater alignment between federal and state programs. Hospitals and health systems are committed to advancing patient safety and look forward to collaborating with HSCRC and to continuing to deliver high quality care and improved outcomes for all Marylanders.

Sincerely,

Tequila Terry
Senior Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. Maulik Joshi
Nicki McCann
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Dianne Feeney

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CORPORATE OFFICE

December 18th, 2025

Alyson Schuster, PhD, MPH, MBA
Deputy Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Schuster:

On behalf of the University of Maryland Medical System (UMMS), thank you for the opportunity to comment on the proposed Rate Year 2028 Maryland Hospital Acquired Condition (MHAC) Program. We appreciate the Commission's ongoing collaboration with hospitals and its efforts to position Maryland for success under the forthcoming AHEAD Model.

UMMS supports the direction of the RY 2028 MHAC program and offers the following areas of agreement and recommendations for refinement.

Areas of Support

Support for One Additional Year of PPCs

We support the recommendation to utilize Potentially Preventable Complications (PPCs) for one additional year during the AHEAD transition. We support this extension due to the resources required for Quality-Based Reimbursement (QBR) alignment in the first year.

Performance Assessment on Statewide Standards

We are in favor of assessing hospital performance against statewide attainment standards, with a maximum of 2% revenue at risk for both rewards and penalties ***contingent upon there being no additional at-risk revenue additions to other HSCRC programs for Rate Year 2028***. We support the use of the average Maryland hospital score for establishing the cut-point.

Incorporation of AHRQ PSI-90
We endorse the addition of the AHRQ Patient Safety Indicator 90 (PSI-90), weighted at 1/6th of the total MHAC score, in alignment with the national Hospital-Acquired Condition Reduction Program (HACRP).

Requested Considerations

Discontinuation of PPCs for RY2029
UMMS recommends discontinuing the use of Potentially Preventable Complications (PPCs) for Rate Year 2029 and transitioning to more nationally aligned measures of safety and harm. While the PPC program has contributed to meaningful reductions in complications across Maryland hospitals in earlier years, current statewide performance data suggest that the achievable improvement in PPCs has largely reached a plateau. The aggregate Observed-to-Expected (O/E) ratios for many PPCs have continuously declined over multiple rate years, indicating that Maryland hospitals have already realized most attainable gains under this methodology.

The current MHAC program focusing on PPCs requires extensive and ongoing investment from Clinical Documentation Improvement (CDI), coding, and Quality teams, as well as licensing and maintenance of proprietary software needed for monitoring and reporting. These administrative demands are increasingly disproportionate to the diminishing marginal benefit that can realistically be achieved through continued PPC measurement. Moreover, the significant staffing resources devoted to documentation accuracy, coding queries, and CDI workflows to support the program could be more effectively deployed toward direct clinical improvement initiatives that prevent harm at the bedside. Redirecting these resources would allow hospitals to focus on interventions with clearer and more immediate impact on patient outcomes.

For these reasons, we encourage HSCRC to retire the PPC methodology after RY2028 and to work with the Performance Measurement Work Group (PMWG) in CY2026 to identify alternative measures that:

- Align more closely with national performance programs and AHEAD priorities,
- Reflect meaningful clinical outcomes rather than documentation-sensitive metrics, and
- Enable more effective deployment of hospital resources toward interventions that directly advance patient safety and the health of Maryland residents.

Collaboration with Academic Medical Centers (AMCs)
We urge continued collaboration with Academic Medical Centers to further refine PPC exclusion logic while PPC measurement remains in use. Academic Medical Centers often care for disproportionately complex, high-risk surgical and medical patients, including transplant, advanced oncology, and quaternary referrals. We encourage HSCRC to continue working with AMCs to refine

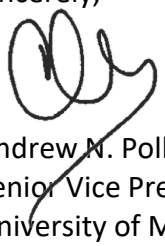
PPC exclusion logic and risk adjustment so that PPC metrics more accurately reflect preventable complications rather than underlying case complexity.

Conclusion

UMMS appreciates the HSCRC's thoughtful approach to strengthening the RY 2028 MHAC Program and its commitment to a high-quality, nationally aligned quality framework for Maryland. We look forward to continued partnership as the state prepares for AHEAD implementation.

Thank you for considering our comments. We welcome continued dialogue as the program evolves.

Sincerely,



Andrew N. Pollak, MD
Senior Vice President and Chief Clinical Officer
University of Maryland Medical System

cc: Joshua Sharfstein, MD, Chairman
Jon Kromm, Executive Director
James Elliott, MD
Adam Kane
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Ricardo R. Johnson
Nicki McCann, JD
Farzaneh Sabi, MD

The next HSCRC Public Meeting is Wednesday, March 11, 2026.

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