



646th Meeting of the Health Services Cost Review Commission

October 21, 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 September 9, 2026

Specific Matters

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

Docket Status – Cases Closed

2702A Johns Hopkins Health System

1. Docket Status – Cases Open

2703N TidalHealth Peninsula Regional
2704A University of Maryland Medical Center
2705A Johns Hopkins Health System

Subjects of General Applicability

2. Report from the Executive Director
 - a. Model Monitoring
 - b. Policy Calendar
 - c. Medicaid Update
3. Final Recommendation: Confidential Patient Level Data from the Maryland Department of Health Prescription Drug Monitoring Program
4. Draft Report: Assessment Changes Under Split Global Budgets

5. Draft Recommendation: Bridge Adjustment
6. Draft Recommendation: Quality Based Reimbursement
7. Uncompensated Care Report RY 2027 (Materials only)
8. Hearing and Meeting Schedule

645th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
SEPTEMBER 09, 2026

Chairman Sexton called the public meeting to order at 12:00 p.m. In addition to Chairman Sexton, also in attendance were Commissioners Jonathan Blum, M.P.P., Nicki McCann, J.D., David Maine, M.D., and Farzaneh Sabi, M.D. Ricardo Johnson, J.D. was absent. Joining via Zoom was Commissioner Benjamin Stallings, M.D. Upon a motion made by Commissioner Stallings 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 Sexton opened by introducing himself as the new Chairman of the Health Services Cost Review Commission (HSCRC), acknowledging his prior 18-year history in the system, which included eight years as a commissioner and involvement in key task forces. As he recognized that the healthcare landscape has shifted toward a new hybrid model, he noted that he is currently bringing himself up to speed on these developments. He expressed gratitude to staff and colleagues for their support and guidance during his transition into this role.

He also highlighted his long-standing commitment to Maryland's unique healthcare system, emphasizing that its primary strength lies in expanding access to high-quality care, particularly for vulnerable populations. While advocating for the preservation of these foundational benefits, he acknowledged the heightened anxiety surrounding the implementation of the new hybrid model. To navigate these unknowns, he pledged to maintain a thorough, objective, and transparent process that welcomes outside feedback and aligns with the Commission's historical precedent.

He acknowledged the challenge of balancing diverse, strongly held stakeholder perspectives when making complex policy trade-offs. He urged everyone to remain focused on the core objective: improving healthcare for Maryland residents. To ensure long-term success, he stressed that the delivery system must remain sustainable, affordable, and accessible to all who rely on it, expressing optimism about collaborating with stakeholders to achieve these shared goals.

Mr. William Henderson introduced himself in his new role as Acting Executive Director of the HSCRC and welcomed Mr. Ryan Sullivan, a University of Maryland alumnus and lifelong Marylander, to the Medical Economics and Data

Kevin J. Sexton
Chair

Jonathan Blum, MPP

Ricardo R. Johnson

David N. Maine, MD

Nicki McCann, JD

Farzaneh Sabi, MD

Benjamin Z. Stallings II MD

William Henderson
Acting Executive Director

Gerard J. Schmith
Director
Revenue & Regulation Compliance

Claudine Williams
Director
Healthcare Data Management & Integrity

Analysis team. Mr. Sullivan will support the Rural Health Transformation Program and offer project management across the Commission.

REPORT OF SEPTEMBER 09, 2026, CLOSED SESSIONS

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed during the September 09, 2026, Closed Sessions.

ITEM I **REVIEW OF THE MINUTES FROM JULY 22, 2026, PUBLIC MEETING AND CLOSED SESSIONS**

Upon motion made by Commissioner Maine and seconded by Commissioner McCann, the Commission voted unanimously to approve the minutes of the July 22, 2026, Public Meeting and Closed Sessions and to unseal the Closed Session minutes.

ITEM II **CLOSED CASES**

2699A	University of Maryland Medical Center
2700A	University of Maryland Medical Center

ITEM III **OPEN CASE**

2701R	Brook Lane
2702A	Johns Hopkins Health System
2703N	TidalHealth Peninsula Regional

ITEM IV **REPORT FROM THE EXECUTIVE DIRECTOR**

Model Monitoring:

Mr. William Henderson, Acting Executive Director, updated the Commission on two key topics: Total Cost of Care (TCOC) Model monitoring and the upcoming HSCRC policy calendar. He explained that standard Model monitoring results were being paused for the month while staff collaborated with CMS to rework their analysis under the new AHEAD model framework, which features different data sets and targets. After receiving an official report from CMMI in August, staff began reviewing the data and submitting follow-up questions. Mr. Henderson noted that preliminary figures show Maryland is in a strong position relative to its targets and expressed confidence that a fully vetted public update would be presented at the October meeting.

POLICY CALENDAR UPDATE

Mr. Henderson outlined the HSCRC's shift from AHEAD policy negotiation to implementation, focusing on adapting Maryland's Multi-payer Global Budget system to align with CMS's Medicare Fee-for-Service model ahead of the 2028 changeover. Emphasizing a "minimum viable product" strategy, he prioritized practical, incremental updates over disruptive overhauls, such as changing to a calendar-year budget framework, to ensure a fully operational system by January 1, 2028. The key transition objectives include protecting non-Medicare payer affordability, maintaining core performance incentives, and publishing finalized guidance early to give hospitals a clear, nine-month operational planning window.

Addressing transition risks, Mr. Henderson highlighted the practical challenge of translating broad policy concepts into precise operational mechanics, warning against technical missteps beneath the surface. He stressed that evaluating long-term model performance requires tracking healthcare access alongside affordability to verify that falling utilization stems from genuine health improvements rather than care barriers. To systematically address these complexities, he noted staff will organize their efforts across six operational domains: rate assessments, financial policies, quality programs, care innovation, model operations, and multi-agency state initiatives.

He presented the implementation schedule leading up to the January 2028 CMMI go-live date, anchored by CMS's final 2028 methodology release in January 2027 and the Fiscal Year 2028 update factor approval in June 2027. He stated draft recommendations will be rolled out through early 2027 with extended comment periods, followed by final policy presentations between January and March 2027. Implementation will be supported by bi-weekly Payment Model Workgroup meetings, an upcoming report on physician spending, the submission of an all-payer TCOC target to CMMI, and safety-net bridge policies designed to cushion hospitals against financial cliffs during the transition.

No action was taken on this agenda item.

ITEM V **FINAL STAFF RECOMMENDATION REQUEST TO ACCESS HSCRC CONFIDENTIAL DATA: PRIMARY CARE COALITION**

Chairman Sexton and Commissioner Blum recused themselves.

Mr. Curtis Wills, Assistant Chief, Healthcare Data Management and Integrity, presented the *Final Staff Recommendation Request To Access HSCRC Confidential Data: Primary Care Coalition* (see "*Final Staff Recommendation Request To Access HSCRC Confidential Data: Primary Care Coalition*" available on the HSCRC website).

Mr. Wills presented a final staff recommendation to grant the Primary Care Coalition continued access to HSCRC confidential inpatient and outpatient hospital discharge data on behalf of the

Nexus Montgomery Collaborative. Originally created under a FY 2016 Regional Partnership Implementation Grant, Nexus Montgomery comprises six participating hospitals working together to reduce avoidable utilization, enhance care coordination, strengthen skilled nursing facility transitions, support behavioral health response, and track maternal health outcomes. The requested dataset covers Calendar Years (CYs) 2021 through 2026 and will enable the collaborative to measure utilization trends, assess program effectiveness, calculate return on investment, and better identify population-level health needs.

As a condition of approval, the Primary Care Coalition must submit annual progress reports detailing any updates to project goals, methodology, data security, or confidentiality issues, alongside a final report prior to releasing any public findings. He stated that HSCRC staff formally recommend approving the data release for CYs 2021 through 2026 to support the collaborative's ongoing research and operational goals.

Mr. Wills presented the staff's Recommendations as follows:

1. The request from the Primary Care Coalition for access to the basic inpatient and outpatient confidential discharge data for CYs 2021 through 2026 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.

Commissioner McCann requested a motion to adopt the staff's recommendation. Commissioner Stallings moved to approve the staff's recommendation, seconded by Commissioner Sabi. **The motion passed unanimously 4-0 in favor of the staff's recommendation with Chairman Sexton and Commissioner Blum recused.**

ITEM VI **QUALITY PROGRAMS STRATEGY DISCUSSION**

Dr. Alyson Schuster, Ph.D., Deputy Director, Quality Methodologies, presented the *Quality Programs Strategy Discussion* (see "*Quality Programs Strategy Discussion*" available on the HSCRC website).

Dr. Schuster opened her presentation by reviewing the 12-year evolution of quality programs under the Maryland Model. Since 2014, Maryland has operated under a federal waiver exempting its hospitals from national quality programs, allowing the HSCRC to administer four state-specific, all-payer initiatives: Maryland Hospital Acquired Conditions (MHAC), Quality Based Reimbursement (QBR), Readmission Reduction Incentive Program (RRIP), and Potentially Avoidable Utilization (PAU). These programs are built on core guiding principles such as setting prospective targets, fostering inter-hospital collaboration, providing transparent progress tracking, and addressing care continuum health equities. They successfully met all federal quality benchmarks while holding 6 percent of all-payer global budget revenue at risk.

Despite achieving overall model targets, Dr. Schuster emphasized that significant hospital-level performance variability persists across key outcomes, including patient experience (HCAHPS) and emergency department (ED) throughput. This variance highlights both the necessity of maintaining financial incentives to guard against potential efficiency trade-offs under global budgets, and the need for broader cross-sector collaboration. Because factors influencing care transitions and avoidable admissions often extend beyond hospital walls, the Commission's quality framework encourages hospitals to partner with community organizations, local health departments, and outpatient providers to improve population health.

Beginning in 2028, Maryland hospitals will transition to Medicare fee-for-service Global Budgets, requiring them to eventually adopt CMS's national quality programs. However, to prevent administrative overload and accommodate multi-year performance measurement windows, the state requested that CMMI delay this official transition until Calendar Year (CY) 2030. In the interim (2028–2029), CMMI will apply Maryland's state-level quality adjustments to Medicare global budgets. Meanwhile, for non-Medicare (multi-payer) Global Budgets, the state retains the flexibility to maintain its own quality incentive structures, with staff recommending that the Commission preserve the 6 percent revenue-at-risk threshold across both budget streams.

Dr. Schuster outlined the spectrum of alignment between Maryland's existing programs and national CMS frameworks across measures, scoring methodologies, and revenue adjustments. While many Maryland measures (such as HCAHPS and healthcare-associated infections) directly mirror national standards, others address state-specific priorities like ED length of stay and Medicaid timely post-discharge follow-up. A key point of discussion is the MHAC program's Potentially Preventable Complications (PPC) metric; staff are considering removing PPCs for Rate Year 2029 to better align with CMS's Patient Safety Indicators (PSI). Unlike CMS's penalty-only structures, Maryland's methodology incorporates both prospective rewards and penalties, providing predictability and financial upside for participating hospitals.

She detailed upcoming policy milestones, beginning with draft policy presentations scheduled through the fall. Key staff proposals include maintaining QBR incentives for ED length of stay and health equity metrics, refining readmission measures to mirror national standards, and sunsetting the pay-for-reporting requirement on ED best practices in favor of a state-led learning collaborative. She solicited specific guidance from commissioners regarding the continuation of non-Medicare quality incentives, the retention of a dual reward-and-penalty revenue structure, and the appropriate financial weighting for state-specific priority metrics.

No action was taken on this agenda item.

ITEM VII **EPISODE QUALITY IMPROVEMENT PROGRAM (EQIP) PERFORMANCE**

Ms. Christa Speicher, Deputy Director, Payment Reform, Mr. Gene Ransom, CEO, MedChi, and Ms. Alice Sowinski Rice, Director of Program Administration, CRISP presented the *EQIP Performance* (see “*EQIP Performance*” available on the HSCRC website).

Ms. Speicher, Mr. Ransom, and Ms. Sowinski Rice presented the Episode Quality Improvement Program (EQIP) Performance Year 4 results. Ms. Speicher highlighted EQIP as Maryland's bundled payment program operated alongside CRISP since 2022. She noted that the program has achieved significant success, widespread physician and hospital engagement, and strong stakeholder support compared to national models. Staff attributes EQIP's success to the strategic partnership between the HSCRC, CRISP, and MedChi. In this model, the HSCRC establishes strategy, performance measures, program design, and cost-savings evaluations. CRISP acts as the core administrator by leveraging Maryland's Health Information Exchange, providing analytical dashboards, managing the enrollment portal, and working directly with providers. Finally, MedChi drives physician recruitment and ongoing practice support, which Ms. Speicher cited as the crucial driver behind the program's unprecedented participation levels.

Mr. Ransom, Chair of the EQIP subgroup, reflected on the program's origins and collaborative structure among CRISP, the HSCRC, and MedChi. He noted that this multi-organizational partnership has been fundamental to driving the program's continued progress and coordination. He also announced an agreement between CMMI and the HSCRC, resolving a 2022 data error that affected approximately 1,000 practitioners regarding their Advanced Payment Model (APM) and Quality Payment Program (QPP) status. Under the resolution, CMS agreed to waive the 9 percent MIPS penalties previously applied to affected Medicare payments. To address missed APM bonuses, the HSCRC will open an application process in the fall of 2026 to verify affected entities, with compensatory payments scheduled for early 2027.

Ms. Rice presented key performance data for Performance Year 4 (CY 2025) of EQIP. In 2025, EQIP added four new episode categories and 52 entities, expanding total participation to 128 entities and increasing volume by 10 percent to 160,000 episodes. The program generated \$96 million in total positive savings, a 60 percent increase over the previous year, with three-quarters of participants contributing to savings. After applying statutory adjustments, the total distributed shared savings reached nearly \$36 million.

Across its four-year history, EQIP has touched over \$2.1 billion in Medicare expenditures and generated \$214 million in cumulative total savings, delivering \$97 million in direct participant payouts. Notably, Performance Year 4 alone accounted for 44 percent of all shared savings generated in program history, driven by an efficiency rate that grew from 5 cents saved per dollar in Year 1 to 15 cents in Year 4. Looking forward to Performance Year 5 and beyond, participation continues to expand, reaching 205 active entities and nearly 5,000 care partners. Preliminary applications for 2027 indicate further expansion, with 270 entities and over 7,800 care partners submitting requests pending CMS vetting.

To align with national CMS Advanced APM requirements, an all-cause hospital-wide readmission measure was added to the core EQIP quality set, expanding to four total metrics which includes advanced care plans, medication documentation, and BMI screening. Initial reporting on this readmission measure will be available via the CRISP portal, with final performance results expected in late 2027.

Ms. Rice provided updates on the Practice Transformation Grant Program, an initiative designed to assist historically lower-performing practices through targeted coaching, workflow optimization, care management assistance, and EHR analytics. Survey results from participating practices indicate high satisfaction and early improvements in quality reporting workflows. Moving forward, program administrators plan to refine and scale this practice transformation model to sustain long-term engagement across broader value-based care initiatives.

Mr. Ransom detailed MedChi's year-round operational role in supporting EQIP, emphasizing an inclusive strategy that assists all providers regardless of membership status or medical discipline. In the fall, MedChi focuses on identifying new bundle opportunities, clinical redesign, and addressing coverage gaps, including developing non-physician episodes like physical therapy. Through the winter and summer, staff members conduct targeted outreach to specialty societies, health systems, and private practices to drive enrollment. This hands-on alignment strategy yielded high engagement in the latest phase, with 145 out of 181 targeted organizations successfully enrolling in the program.

To eliminate barriers for smaller and independent practices, MedChi established dedicated, zero-cost entities to help providers participate without financial strain. Starting with eight entities in 2024, the initiative grew to nine in 2026 and is expanding to 13 entities to accommodate demand without diluting the financial savings performance of existing groups. MedChi has also partnered with hospitals to integrate specialized, hospital-employed physicians into these entities alongside private practitioners. He noted MedChi serves as an administrative proxy for both large, multi-state corporate practices unaccustomed to Maryland's unique model and small private practices needing technical assistance to run reports and navigate program mechanics.

No action was taken on this agenda item.

ITEM VIII

FINAL RECOMMENDATION: THE AHEAD TRANSITION FUNDING DISTRIBUTION

Mr. Jerry Schmith, Principal Deputy Director, Hospital Rate Revenue and Regulations presented the *Final Recommendation: The AHEAD Transition Funding Distribution* (see "*Final Recommendation: The AHEAD Transition Funding Distribution*" available on the HSCRC website).

Mr. Schmith presented the staff's Final Recommendation for distributing \$100 million in funding over the next two years (\$50 million annually) to help Maryland hospitals cover costs associated with transitioning to the new AHEAD model. While the overall funding amount was previously approved during the July 2026 meeting, the specific allocation methodology had not been finalized. To determine the most equitable approach, staff issued a request for public comments seeking feedback on how funds should be distributed, specific allocation models, and appropriate accountability measures.

Staff requested for feedback on three options: 1) allocating funds strictly by hospital revenue, 2) favoring smaller non-system hospitals through weighted distribution, or 3) setting aside a portion of funds for neutral service providers such as CRISP or the Maryland Hospital Association (MHA). Staff received 16 responses spanning six major categories from hospitals, insurers, and public entities. After reviewing all submitted feedback, staff synthesized the responses to construct a balanced, two-part funding formula.

Under the staff recommendation, each eligible hospital will receive a base allocation of \$500,000, totaling \$21.5 million and accounting for roughly 40% of the annual \$50 million distribution. The remaining \$28.5 million will be distributed based on each facility's gross patient revenue. Freestanding Medical Facilities and Shock Trauma will not receive separate \$500,000 base payments; instead, their revenues will be rolled into the totals of their parent health systems for calculation under the revenue-based portion of the formula.

To ensure accountability without creating an undue administrative burden, each participating hospital must submit an annual attestation signed by its Chief Financial Officer by July 31 of the following year. This document will enumerate and briefly describe how the transitional funds were utilized. Health systems operating multiple hospitals are permitted to streamline this reporting process by submitting a single, combined system-level attestation.

Mr. Schmith presented the staff's Final Recommendations for the allocations of one-time funding in RY 2027 and RY 2028 as follows:

1. A \$500,000 fixed cost element awarded to all acute care hospitals totaling \$21.5 million. Staff believes there is a fixed cost element to AHEAD preparation regardless of the size and scale of each facility.
2. The remaining \$28.5 million allocated based on the Gross Patient Revenue of each facility.
3. Freestanding Medical Facilities and Shock Trauma revenues are included in their parent facilities.
 - a. Cambridge and Queen Anne's included in Easton
 - b. Grace included in Sinai
 - c. McCready included in Peninsula
 - d. Bowie included in Capital Region
 - e. Aberdeen included in Upper Chesapeake
 - f. Shock Trauma included in University of Maryland Medical Center
4. Each hospital will be required to submit an attestation signed by the CFO, by July 31 following each of RY2027 and RY2028, enumerating how these funds were used during

the year and including a brief description of each item. Systems may submit a single attestation.

Q&A:

Commissioner Sabi questioned the automatic duration of the funding agreement, asking whether the plan requires an evaluation at the end of the first year rather than automatically extending into the second year. Mr. Schmith confirmed Commissioner Sabi's understanding, stating that staff intend to review the program's progress at the end of the first year and adjust if necessary. He noted that recommendations could change for the second year, potentially even increasing the \$50 million allocation if needed based on how the funds are spent and feedback from hospitals claiming the initial amount was insufficient.

Testimony:

Ms. Allison Taylor, speaking on behalf of the League of Life and Health Insurers of Maryland, the state trade association for commercial insurance, expressed support for Maryland's successful transition to the AHEAD model. She acknowledged and appreciated that HSCRC staff incorporated stakeholder feedback when developing the proposed fixed allocation for hospital readiness funding. However, Ms. Taylor raised concerns regarding the financial mechanism used for the transition funds, noting that adding extra funding to rates outside of the standard update factor process creates challenges for commercial insurers. She requested that future funding requests be handled annually and fully integrated into the official update factor framework. She urged the Commission to evaluate any potential additional spending for Rate Year 2028 within that standardized update process. Ms. Taylor also voiced support for requiring hospital attestations regarding the use of the funds, though she noted the League had requested more detailed reporting to verify how the dollars are spent.

Mr. Tyler Brody, speaking on behalf of Health Means Everything, stated that the \$50 million transition funding provides a crucial opportunity to direct resources toward communities and facilities with the greatest need. He voiced support for the distribution methodologies that prioritize smaller non-system hospitals, rural facilities, and institutions carrying the highest uncompensated care burdens. He encouraged the Commission to push beyond simple financial accounting and establish true accountability centered on patient and community impact. He also argued that accountability should evaluate whether patients experience improved care access, affordability, and overall quality. To achieve this, he recommended incorporating consumer-facing metrics into the framework, such as financial assistance application and approval rates, uncompensated care levels, wait times, and patient experience measures.

Chairman Sexton requested a motion to adopt the staff's Final Recommendation. Commissioner Maine moved to approve the staff's final recommendation, seconded by Commissioner Sabi.

The motion passed unanimously in favor of the staff's final recommendation with Chairman Sexton voting in favor as proxy for Commissioner Johnson.

ITEM IX
FINAL RECOMMENDATION: UPDATES TO THE ACCOUNTING AND BUDGET MANUAL

Mr. Wayne Nelms, Chief, Audit & Integrity, presented the *Final Recommendation: Update to the Accounting and Budget Manual* (see “*Final Recommendation: Update to the Accounting and Budget Manual*” available on the HSCRC website).

Mr. Nelms presented the Final Recommendation for updates to the Accounting and Budget Manual. He explained that a workgroup comprising hospital representatives, the Maryland Hospital Association, health insurers, and industry consultants convened on November 6, 2025, to review the labor and delivery relative value units (RVUs) and rate center guidelines. The initiative focused on three primary objectives: streamlining manual content, addressing operational gaps, and enhancing overall usability.

He addressed post-draft comments from Greater Baltimore Medical Center (GBMC) regarding further defining incision time and distinguishing billing for emergent versus urgent procedures. He noted that because extensive consensus had already been reached across multiple meetings with clinicians, administrators, billing personnel, and payers, staff declined to make unilateral post-workgroup adjustments.

Mr. Nelms presented the staff’s Final Recommendation as follows:

1. That the revisions to the Accounting and Budget Manual be approved. These revisions are specific to CMS guidelines and the current practices at the HSCRC; and
2. That the revisions to the Accounting and Budget Manual be effective October 1, 2026.

Chairman Sexton requested a motion to adopt the staff’s final recommendation. Commissioner Blum moved to approve the staff’s final recommendation, seconded by Commissioner Maine.

The motion passed unanimously in favor of the staff’s final recommendation with Chairman Sexton voting in favor as proxy for Commissioner Johnson.

ITEM X
HEARING AND MEETING SCHEDULE

October 21, 2026,

Time to be determined
4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:25 p.m.

**Closed Session Minutes
of the
Health Services Cost Review Commission
September 9, 2026**

Chairman Sexton stated the reasons for Commissioners to move into administrative session, under the authority provided by the General Provisions Article §3-103, §3-104 and §3-305(b)7 for the purpose of discussing the administration of the Model and receiving legal advice from Counsel.

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

The administrative session was called to order by motion at 12:06 p.m.

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

Joining on Zoom: Commissioner Stallings

Staff members in attendance were William Henderson, Jerry Schmith, Claudine Williams, Anthony Martell and William Hoff.

Joining on Zoom: Erin Schurmann, Christa Speicher, Laura Goodman, Alyson Schuster and Jonathan Thornhill.

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

Item I

Mr. Stan Lustman, Commission Counsel, provided legal advice to the Commissioners regarding the effects of federal action.

Item II

Mr. William Henderson, Acting Executive Director, updated the Commission on the status of the AHEAD model.

Item III

Mr. Henderson 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 June 2026.

The Closed Session was adjourned at 1:03 p.m.

PARTIAL-RATE APPLICATION

Teneshia J. Richards-Brooks
Analyst, Rate Setting
Revenue & Regulation Compliance
Email Address: Teneshia.Richards-Brooks@maryland.gov

Staff Recommendation:

Introduction

On August 28, 2026, TidalHealth Inc. submitted a partial rate application requesting an inpatient rate for Renal Dialysis (RDL) services.

The hospital requested the rate be set at \$1,495.17 per treatment. The hospital anticipates volume to be 2,760 procedures annually. The Hospital requests a waiver of the 60-day notice requirement under COMAR 10.37.10.07(A) for the opening of a new service, so that the rate can be effective with its July 1, 2026 rate order. Additionally, the rate not be subject to rate realignment until a full year of volume and expense data is available. The hospital is not requesting an addition to its Global Budget Revenue associated with this rate request.

Staff Evaluation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. Based on the information received, Tidal Health requested an RDL service rate of \$ 1,495.17 per RVU, while the statewide median rate for RDL service for FY 2027 is \$1412.12 per RVU.

Recommendation

After reviewing the Tidal Health application, the staff recommends:

1. That the RDL rate of \$1,412.12 per RVU be approved effective July 1, 2026;
2. That the Commission waive COMAR 10.37.10.07(A), which requires that a hospital file a rate application for a new service at least 60 days before its operational opening;
3. That the RDL rate center will not be rate realigned until a full year of volume and expense is available; and
4. That no changes be made to the Hospital's Global Budget Revenue for the RDL services.

Questions?



-IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
PENINSULA REGIONAL	*	DOCKET: 2026
MEDICAL CENTER	*	FOLIO: 2513
SALISBURY, MARYLAND	*	PROCEEDING: 2703N

Staff Recommendation
October 21, 2026

Introduction

On August 28, 2026, TidalHealth Inc. submitted a partial rate application requesting a rate for Renal Dialysis (RDL) services. The purpose of this rate application is to establish a rate for inpatients who need renal dialysis services.

The Hospital requests that the rate be set at \$1,495.17 per treatment. The Hospital anticipates volume to be 2,760 procedures annually. The Hospital requests a waiver of the 60-day notice requirement under COMAR 10.37.10.07(A) for the opening of a new service, so that the rate can be effective with its July 1st FY2027 rate order. The Hospital is not requesting an increase to its Global Budget Revenue associated with this rate request.

Staff Findings

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. Based on the information received, Tidal Health requested an RDL service rate of \$ 1,495.17 per RVU, while the statewide median rate for RDL service is \$1412.12 per RVU.

Recommendation

After reviewing the Tidal Health application, the staff recommends:

1. That the RDL rate of \$1,412.12 per RVU be approved effective July 1, 2026;
2. That the Commission waive COMAR 10.37.10.07(A), which requires that a hospital file a rate application for a new service at least 60 days before its operational opening;
3. That the RDL rate center not be rate realigned until a full year of volume and expense is available; and
4. That no changes be made to the Hospital's Global Budget Revenue for the RDL services.



maryland
health services
cost review commission

Application for an Alternative Method of Rate Determination

University of Maryland Medical Center

October 21, 2026

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
UNIVERSITY OF MARYLAND MEDICAL	*	DOCKET:	2026
CENTER	*	FOLIO:	2514
BALTIMORE, MARYLAND	*	PROCEEDING:	2704A

I. INTRODUCTION

On September 1, 2026, University of Maryland Medical Center ("the Hospital") filed a renewal application for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital is requesting approval to continue to participate in a global price arrangement with Cigna Health Corporation for solid organ and blood and bone marrow transplants. The Hospital requests that the Commission approve the arrangement for one year beginning October 1, 2026.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University of Maryland Faculty Physicians, Inc. ("FPI"), which is a subsidiary of the University of Maryland Medical System. FPI 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 updated 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 Hospital will continue to submit bills to FPI for all contracted and covered services. FPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between FPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract. FPI maintains it has been active in similar types of fixed fee contracts for several years, and that FPI 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 Hospital can continue to achieve a favorable performance.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination with Cigna Health Corporation. for solid organ transplant and blood and bone marrow transplants for one-year beginning October 1, 2026. The Hospital 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 Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital 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.



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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

October 21, 2026

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW
DETERMINATION	*	COMMISSION
JOHNS HOPKINS HEALTH	*	DOCKET: 2026
SYSTEM	*	FOLIO: 2515
BALTIMORE, MARYLAND	*	PROCEEDING: 2705A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on September 30, 2026 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital ("the Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement with Accarent Health for bariatric surgery, oncology surgical procedures, anal rectal surgery, spine surgery, thyroid parathyroid, joint replacement, neurosurgery procedures, Craniotomy, Ventricular Assist Devices (VAD) procedures, pancreas surgery, cardiovascular services, musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, Cochlear implants, gall bladder surgery, CAR-T, ankle repairs, hernia, and nephrectomy for a period of one year beginning November 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 bariatric surgery, oncology surgical procedures, anal rectal surgery, spine surgery, thyroid parathyroid, joint replacement, neurosurgery procedures, Craniotomy, VAD procedures, pancreas surgery, cardiovascular services, musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, Cochlear implants, gall bladder surgery, CAR-T, ankle repairs, hernia and nephrectomy with Accarent Health for a one-year period commencing November 1, 2026. The Hospitals will need to file a renewal application for review to be considered 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.



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Report from the Interim Executive Director

Medicare FFS TCOC Target: Estimated 2026 Target

2023 Spend PBPY	A	\$14,107
2023 Spend PBPY at National Acuity	B = A / Normalized State Average HCC Score (.9774)	\$14,433
Actual 2024 USPCC	C	7.01%
Actual 2025 USPCC	D	7.69%
2026 Projected USPCC Trend	E	5.27%
Savings Component	F	(0.13%)
2026 Projected USPCC Trend with Savings Component	G	5.14%
Apply Weighted Trend (1/3 US dollars, 2/3 percentage-based/MD dollars for PYs)	H	4.96%
Cumulative Trend	I=(1+C)*(1+D)*(1+H)	20.95%
2026 Target	J=B*(1+I)	\$17,458
2026 Final Target at Maryland Acuity, PBPY	K=J*Normalized State Average Risk Score (.9760)	\$17,039

This is April 2025 estimate with the IME adjustment. This value is used to set the target and will get trued up if **Observed** USPCC is different by greater than 0.5%

Estimated Year-to-Date Savings Position Through June 2026

Maryland Actuals						Target			
Calendar Year Comparison									
	PBPY Part A	PBPY Part B	PBPY Total	Annual Trend	Cumulative Trend	USPCC Annual Trend	Savings Target	Cumulative Trend ¹	Pct Pt. (Savings) Above Target
2023	\$5,914	\$8,193	\$14,107						
2024	\$6,249	\$8,557	\$14,807	5.0%	5.0%	7.0%			
2025	\$6,648	\$9,307	\$15,955	7.8%	13.1%	7.7%		15.4%	-2.3%
Year-to-Date Jun Comparison, with Completion (assuming 1 month of run out)									
	PBPY Part A	PBPY Part B	PBPY Total	Annual Trend	Cumulative Trend				
2023	\$2,912	\$3,999	\$6,912			7.0%			
2024	\$3,093	\$4,105	\$7,198	4.1%	4.1%				
2025	\$3,311	\$4,500	\$7,811	8.5%	13.0%	7.7%		15.4%	-2.4%
2026	\$3,432	\$4,533	\$7,965	2.0%	15.2%	5.3%	-0.13%	20.8%	-5.5%

1. Will not recalculate from the USPCC annual trend as it also includes the impact of risk adjustment and regression to the mean adjustments.

- Calculation uses OACT USPCC trends to set target. Current 2026 trend target is based on April 2025 USPCC release. 2025 and 2024 amounts are based on April 2026 USPCC release.
- Calculation has been reviewed with CMMI. Only minor differences were identified.
- Six months of data with limited run out (completion factors have been applied).
- Target will adjust downwards once the final USPCC trend is amended. As of May 2026, OACT lowered 2026 projection by about 1.2% points versus May 2025 (used in target) of which ~0.4% would be recognized in 2026 scoring.
- State does not have good insight into national trends. TCOC-model national data appear to show low trends. Low MD trend likely reflects some national phenomenon since 50% of the spend is non-hospital.

HSCRC AHEAD Model Workplan October 2026

Workplan Updates

- Completed
 - All-Payer Total Cost of Care Growth and Primary Care Investment Targets
 - Medicare Advantage Stabilization Operationalization
- Current
 - Adjustments and Assessments Report (draft)
 - Bridge Adjustment (draft)
 - Quality-Based Reimbursement Policy (draft)
 - Rate Model Development for Multi-Payer GBR
 - Uncompensated Care Forward Funding Implementation Plan
 - Cost-Shifting Operationalization
- Upcoming
 - Core Volume Policies (draft): Market Shift, Demographic, Surge
 - Maryland Hospital-Acquired Conditions Policy (draft)
 - Physician Costs Report
 - Bed Capacity Report
 - Reports on Health Workforce Development and Strengthening Post-Acute Care (MHCC-led)
 - Choice and Competition (MHCC-led)

HSCRC Workplan (FY 2027)

	Sept. 2026	Oct. 2026	Nov. 2026	Dec. 2026	Jan. 2027	Feb. 2027	Mar. 2027	Apr. 2027	May 2027	Jun. 2027
Strategy										
Strategy Discussions: Workplan and Quality	R									
Transition Support										
Bridge Adjustment		D				F				
Assessments and Adjustments										
Planning Report for Multi-Payer Global Budget Revenue Transition		R					R			F
Financial Policies										
Core Volume Policies: Market Shift, Demographic, Surge			D			F				
Funding Appropriateness Policies: Full Rate, Integrated Efficiency, Capital				D		F				
Incremental Volume Policies: Repatriation, Out-of-State, Deregulation					D		F			
Carve-Outs (Drug and Service), Potentially-Avoidable Utilization					D		F			
Quality Programs										
Quality-Based Reimbursement and Emergency Department Wait Times		D		F						
Maryland Hospital-Acquired Conditions			D		F					
Readmissions Reduction Incentive Program				D		F				
Potentially-Avoidable Utilization										F
Care Innovation										
Healthcare Outcomes Payment Effort: Regional and Statewide Initiatives										
Model Operations										
Model Development							R			
Administrative										
Medicare Fee-for-Service Hospital Global Budget										
Analyses and Evaluations		R	R	R	R					
Physician Costs				R						
Bed Capacity				R						
Multi-Agency and Legislative Initiatives										
Health Workforce Development		R								
Strengthening Post-Acute Care		R								
Choice and Competition				R						
All-Payer Total Cost of Care Growth Target	R									
All-Payer Primary Care Investment Target	R									
Medicare Advantage Stabilization				R						

Medicaid Update

Topics

- AHEAD Model and H.R. 1 Rulemaking
- Anticipated H.R. 1-Related Coverage Losses
- Medicaid Quality Pledge

AHEAD Model

Under AHEAD, Medicare fee-for-service (FFS) rates will be set by CMMI, separately from other payers.

- The AHEAD Model State Agreement commits CMS and the State to change Medicaid rates commensurate with Medicare rate changes, consistent with federal statute and regulation.
- HSCRC will need to do a comparison calculation to evaluate parity between payer rates.
- It is expected that this calculation will need to show that effective Medicaid and Medicare Advantage rates are equal to or below Medicare FFS.
- Exact compliance rules for Medicaid are unknown due to the federal rulemaking process, *i.e.*, state-directed payments (SDPs) and provider taxes.

Background: Medicaid Authorities prior to H.R. 1

HSCRC and other state agencies have recently provided comments on Medicaid rulemaking stemming from two H.R. 1 provisions: State-Directed Payments and Provider Taxes.

State-Directed Payments

SDPs permit states to implement contractual Medicaid managed care arrangements that direct certain expenditures, *i.e.*, in support of delivery system and payment reform, as well as performance improvement.

Prior to H.R. 1, SDPs were limited to 100 percent of average commercial rates for value-based purchasing models, delivery system reform or performance improvement initiatives or parameters for provider payments.

Maryland leverages SDP authority to operate the Medicaid Advanced Primary Care Program and the Medicaid Quality Innovation Program, as well as to pay HSCRC rates for hospital services.*

Provider Taxes

Provider taxes apply to revenue generated from health care-related taxes that finance a state's non-federal share of Medicaid expenditures.

Provider taxes are imposed: 1) on a permissible class of health care items and services; 2) on all providers within a certain class ("broad-based"); 3) equally to all providers within the class ("uniformity"); and 4) without guarantee that health care providers will get their tax payments back ("hold harmless").

CMS can permit waivers of the broad-based and uniformity requirements.

In Maryland, hospital assessments function as a component of HSCRC rate-setting calculations for prospective global budgets, rather than a provider tax under Medicaid rules.

* Because the HSCRC rates equal 100 percent of Medicare, a formal "pre-print" is not required.

H.R. 1 Rulemaking: State-Directed Payments

- The State-Directed Payment proposed rule would:
 - Limit Medicaid payment for SDPs to 100 percent of the total published Medicare payment rate in states that expanded Medicaid under the Affordable Care Act, such as Maryland; and
 - Tie compliance to a federal standard at the individual claim or service level.
- Implications
 - Potential to complicate Medicaid value-based care initiatives by limiting Medicaid payment to national Medicare rates (IPPS/OPPS) that are not applicable to the AHEAD Model
 - Measuring compliance at a per-claim level contradicts AHEAD's value-based (*i.e.*, per capita) metrics.
 - These implications have drawn attention from other states and national organizations, generating a robust body of comments to CMS.

H.R. 1 Rulemaking: Provider Taxes

- Provider Tax proposed rule would:
 - Increase Medicaid penalties for states that enact and impose new provider taxes or increase existing tax amounts after July 4, 2025, in alignment with H.R. 1 requirements
 - Introduce a new provider class for “services of health insurers other than MCOs”
 - Implement new and complex compliance and reporting requirements
- Implications
 - States would have needed to have submitted provider tax waivers—*e.g.*, for broad-based and uniformity requirements—prior to September 30, 2025. States could not have anticipated this change.
 - CMS would deduct the full amount of the tax collected, *i.e.*, not just the excess amount, from states exceeding the stipulated (“hold harmless”) threshold.
 - The proposed rule leaves uncertainty around definition of provider tax, particularly taxes on health insurers.
 - Taxes on health insurers—the proposed new provider class—imposed after July 4, 2025 would have a hold harmless threshold of zero percent, even though states could not have anticipated this change.
 - Similar to the SDP proposed rule, the provider tax proposed rule generated comments from states and national organizations.

H.R. 1 Rulemaking: Community Engagement

- Affected Populations
 - Legally-present immigrants lost Medicaid eligibility on October 1, 2026 and remain eligible for Emergency Medicaid Services. *Estimated coverage losses - 4,500 legally-present adults.*
 - ACA expansion adults will be subject to work requirements and six-month eligibility renewals starting January 1, 2027. The CMS definition of Medical Frailty requires consideration of their medical condition *as well as* their ability to work. *Estimated coverage losses - 152,000 ACA adults.*
- FY 2027 Impact
 - Previous estimates ranged from 27,200 to 39,400 individuals losing coverage across both populations in FY 2027, with an impact to hospital uncompensated care ranging from \$10.7 million to \$12.4 million.
 - Following the release of the interim final rule for work requirements, these numbers are expected to increase by a small amount.
- FY 2028 Impact
 - The impact of work requirements and six-month redeterminations begins to ramp up in summer 2027.

Medicaid Quality Pledge: Investing in Health Outcomes

- CMS recently launched a Medicaid quality initiative focused on health outcomes, to:
 - Prioritize health outcomes over process, with a focus on prevention, chronic disease management and behavioral health;
 - Streamline quality measure inventories to reduce burden without sacrificing accountability;
 - Advance digital quality measurement, using near-real-time data instead of claims and chart abstraction where feasible; and
 - Align financial accountability with outcomes-oriented measures.*
- Maryland signed onto the voluntary Medicaid Quality Pledge and will center its efforts around the AHEAD population health metrics.

* Centers for Medicare and Medicaid Services. (2026, September 25). *CMS Refocuses Medicaid Quality on Health Outcomes, Launches Innovative Partnership with 37 States* [Press release]. <https://www.cms.gov/newsroom/press-releases/cms-refocuses-medicaid-quality-health-outcomes-launches-innovative-partnership-37-states>

Final Staff Recommendation to Access HSCRC Confidential Patient Level Data from The Maryland Department of Health Prescription Drug Monitoring Program

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request from MDH Prescription Drug Monitoring Program for access to the grouped inpatient and outpatient confidential discharge data for Calendar Years 2021 through 2025 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.



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**Final Staff Recommendation for Access to the
HSCRC Confidential Patient Level Data Request from
The Maryland Department of Health Prescription Drug Monitoring
Program**

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

This is a Final Recommendation for Commission consideration at the October 21, 2026, Public Commission Meeting.

SUMMARY STATEMENT

The Maryland Department of Health Prescription Drug Monitoring Program (PDMP), within the Office of Population Health Improvement (OPHI), requests new access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient and Outpatient) for Calendar Year 2025, and continued access to previously approved confidential data for Calendar Years 2021 through 2024. The request supports critical public health surveillance activities, including linking HSCRC Case Mix data with PDMP records to improve understanding of substance use disorder (SUD), opioid prescribing patterns, non-fatal overdose events, and related health conditions across Maryland. The data will be used to support research, education, quality improvement, and planning of public health interventions. The PDMP also seeks continued access to confidential data required for the HSCRC's "Hospital Events: Non-Fatal Overdose and SUD" dashboard managed by CRISP.

Under this request, HSCRC data will be transferred from hMetrix to the Chesapeake Regional Information System for our Patients (CRISP), which will serve as the data custodian and storage environment. CRISP will use its Enterprise Identification (EID) and Master Patient Index (MPI) algorithms to accurately link inpatient and outpatient HSCRC data with PDMP data. This linkage is essential for identifying unique individuals and conducting robust surveillance analyses. Consistent with federal protections, the PDMP acknowledges that the dataset will not include 42 CFR Part 2-protected information or other sensitive data categories, such as records related to reproductive health encounters.

The PDMP intends to use the data to identify trends in overdose, substance use, mental health conditions, withdrawal episodes, opioid initiation, treatment engagement, and other factors relevant to preventing morbidity and mortality associated with substance use. The data will also support grant-related reporting, such as the OD2A Surveillance section, and inform strategic planning for local jurisdictions. All public reporting and inter-agency data sharing will use aggregate, suppressed data following HSCRC standards.

CRISP and MDH will continue to maintain the highest levels of PHI protection, including secure storage in the CRISP Microsoft Azure environment, controlled jumpbox access, mandatory HIPAA and data security training, strict user authorization protocols, encryption, two-factor authentication, and adherence to Maryland DoIT security policies. Neither CRISP nor PDMP will share identifiable HSCRC data outside approved personnel. All work will remain compliant with HIPAA, the Privacy Act, Freedom of Information requirements, and applicable state and federal regulations.

BACKGROUND

The PDMP is requesting authorization to link HSCRC confidential inpatient and outpatient Case Mix data with PDMP prescription records in order to enhance Maryland's statewide surveillance of opioid-related morbidity, substance use trends, and non-fatal overdose patterns. Accurate linkage of individual patients across datasets is essential for identifying risk factors, monitoring clinical care patterns, and designing public health interventions that reduce overdose risk and improve treatment access.

CRISP, an existing HSCRC data custodian, will receive Case Mix data files via secure transfer from hMetrix and store them within CRISP's Azure-based jumpbox environment. PDMP epidemiologists will analyze linked data through the jumpbox to conduct surveillance, fulfill federally funded reporting requirements, and contribute aggregate metrics to HSCRC's Non-Fatal Overdose and SUD dashboard. These analyses support statewide monitoring of SUD visit types, overdose drug categories, ED utilization, demographic risk factors, geographic disparities, mental health comorbidities, pregnancy-related concerns, injuries, and other public health indicators.

Requested confidential data elements include patient demographics, geographic identifiers, visit dates, diagnostic codes (ICD), procedure codes (CPT), overdose and SUD visit types, ED visit indicators, discharge data, date of death, payment method, Medicare/Medicaid status, and hospital identifiers. All analyses will follow cell-suppression rules, remove identifiable information from public use outputs, and ensure that sensitive case-level data never leave CRISP's secure environment. No 42 CFR Part 2 data will be included.

CRISP and MDH maintain robust physical, administrative, and technical safeguards consistent with prior HSCRC-approved DUAs. These include encrypted environments, role-based access controls, session timeout protocols, audit logs, DoIT security policy compliance, and breach-reporting procedures. CRISP will provide data destruction certification upon completion of the project. PDMP will update HSCRC regarding staff changes and ensure only authorized epidemiologists access raw data.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Case Mix data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee included representatives from 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 assist HSCRC staff in making recommendations for approval to the Commission 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 voted unanimously to grant the Maryland PDMP access to the Case Mix data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC describing any changes in project goals, data handling procedures, analytic design, duration, or unexpected events pertaining to data confidentiality. The PDMP must also provide HSCRC a copy of any final report prior to public release.

STAFF RECOMMENDATION

1. The request from the Maryland Department of Health Prescription Drug Monitoring Program for access to the grouped inpatient and outpatient confidential discharge data for Calendar Years 2021 through 2025 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.



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Assessment Changes Under Split Global Budgets FY 2028 & Beyond

October 21, 2026

Assessments Included in Base Year HGBs under FFS

1. Medicaid Deficit Assessment
2. Healthcare Coverage Fund
3. CRISP Assessment
4. Nurse Support Program I
5. Nurse Support Program II
6. HSCRC User Fees
7. MHCC User Fees

These assessments are updated every year as part of each hospital's rate structure. This list is HSCRC staff's understanding of assessments that will be included in the base year of each hospital's Medicare Global Budget.

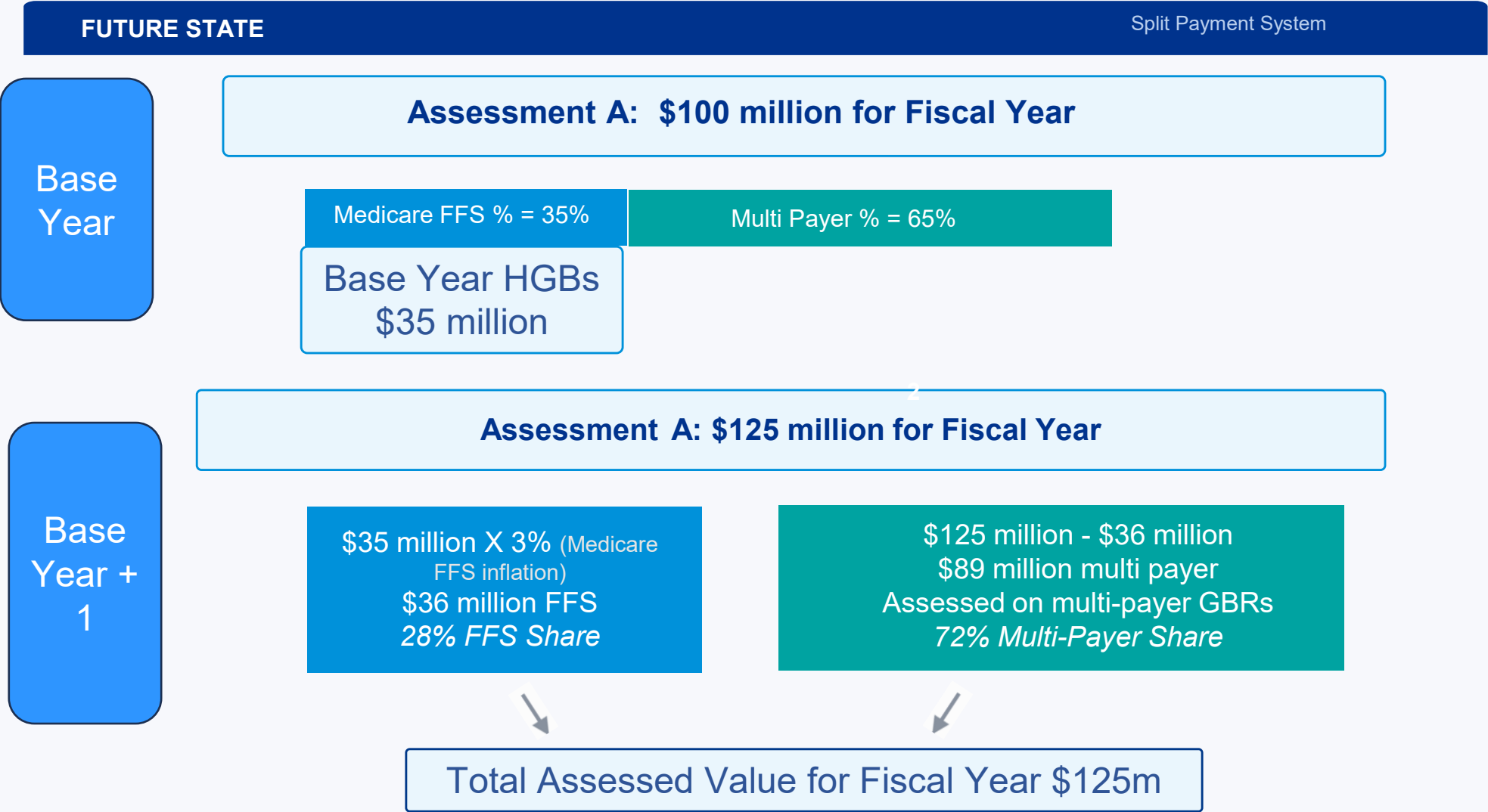
Source: [Appendix A Maryland specifications](#)

Overview of Issue

1. Beginning January 2028, HSCRC will not have regulatory authority over Medicare payments and therefore, will not have control over what the Medicare portion of assessments.
2. There is assessment funding in the Medicare baseline. In this report Staff are addressing the technical question of how much funding we will deem to be included in the baseline to use in future decisions.
3. As assessments are evaluated in the future the Commission may need to consider:
 - a. The impact of Medicare funding increases which don't match our desired increases in the assessment
 - b. Decisions regarding whether to reduce the total size of the assessment based on Medicare funding levels or change the relative funding due from other payers.

Future Assessment Calculation Under Split Payment Systems

ILLUSTRATIVE EXAMPLE



Note: Dollar values are dummy numbers; actual inflation factors and amounts are to be determined.

Other Assessments Items

Ongoing Assessments

- Calculation shown on previous slide would be done for each assessment
- Continue review of Medicare proportion to understand Medicare share
Significant shift to the multi-payer share may require Commission discussion.
 - Healthcare Coverage Fund & Medicaid Deficit Assessment are tied to Legislation
- Future share split is determined by HGB inflation AND share of Medicare recipients

Future New Assessments

- Assessments not included in Base Year HGBs will need to be assessed on the multi-payer GBRs
- Funding levels for future assessments will be decided at creation of assessment

Assessments in FY 2028

- Staff will determine appropriate split of assessments in FY 2028 as part of operationalizing strategy work



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Assessment Changes Under Split Global Budgets

October 21, 2026

Please submit comments to hscrc.payment@maryland.gov by COB November 11, 2026

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Overview

Beginning in January 2028, CMS will assume hospital rate-setting for Medicare FFS; the HSCRC will continue to set rates for all other payers in the state. CMS is currently developing a methodology for the Medicare FFS hospital global budgets (Medicare HGBs), which will be similar to but not quite equivalent to the HSCRC's global budget revenue system. As a result, HSCRC staff are reviewing all policies and procedures under the existing all-payer GBRs, to determine what, if anything, will need to be changed or updated to prepare for this transition. Once this process is complete the HSCRC will use these policies to establish future multi-payer global budget revenue (Multi-payer GBRs) that cover all payers except Medicare FFS. The focus of this report is to provide guidance on the process by which assessments will be handled under a split payment system beginning in 2028.

Assessments

Assessments can be defined as an amount imposed on a hospital pursuant to Maryland law, regulation, or HSCRC authority, calculated in accordance with applicable HSCRC requirements, and remitted directly from the hospitals for a specified program, fund, administrative function or other purpose. Assessments are included in hospital global budgets, meaning amounts collected by the hospital are then remitted to the relevant entity. The following section outlines the assessments that have been included in Version 3.2 of Financial Specifications for the CMS-Designed Medicare FFS Hospital Global Budget Methodology, Maryland Addendum as published by CMMI. These assessments will be included in base year calculations of the CMS Hospital Global Budgets. Staff recognize that this list has not been finalized and will be updated as necessary pending finalization of the specifications.

Healthcare Coverage Fund

The Healthcare Coverage fund was established in 2007 in Maryland Health - General § 15-701. Maryland General Article § 19-214(d) currently defines the assessment value as 1.25 percent Projected Regulated Net Patient Revenue.

Deficit Assessment

The Medicaid Deficit Assessment was enacted through the Maryland Budget Reconciliation and Financing Act (BRFA) legislation in response to fiscal pressures from the Great Recession in 2009. The assessment amount is determined each legislative session as part of the BRFA. .

HSCRC User Fees

HSCRC collects user fees from hospitals and related institutions whose rates are regulated by the Commission. The fees are intended to only cover the Commission's actual documented direct costs of

carrying out its statutory and regulatory responsibilities. The current methodology and statute is defined in Health- General Article § 19-213 as introduced and approved by HB 510 in 2022.

MHCC User Fees

MHCC collects user fees from hospitals, nursing homes, payors, and health care practitioners to cover MHCC's actual costs to fulfil its statutory and regulatory duties. The methodology is laid out in statute at Health-General Article § 19-111 and in regulations at COMAR 10.25.02 and 10.25.03

Nurse Support Program I

The Nurse Support Program I provides noncompetitive funding to all hospitals to strengthen Maryland's acute care nursing workforce through strategic investments in recruitment, retention, education, leadership development, and professional advancement. NSP I funding is currently calculated by taking 0.1 percent of gross patient revenue from the most recently available fiscal year cost report data.

Nurse Support Program II

The Nurse Support Program II provides competitive funding to Maryland's higher education institutions to strengthen nursing education and expand nursing school capacity, helping ensure a qualified pipeline of nurses is ready to enter the workforce. NSP II funding is currently calculated by taking 0.1 percent of gross patient revenue of the most recently available fiscal year cost report data. Hospitals pay this assessment to the Maryland Higher Education Commission (MHEC) which administers the program on behalf of the HSCRC.

CRISP Funding

This assessment provides funding for CRISP (Chesapeake Regional Information System for our Patients), Maryland's statewide health information exchange (HIE). The assessment supports a robust, secure technical platform that enables the exchange and use of health information across the health care system, supporting innovative use cases that improve care delivery, increase efficiency, and help control health care costs. CRISP's funding needs are reviewed annually, with the assessment determined based on system needs for HIE operations, reporting, and program administration supporting the Maryland Model and HSCRC.

Future Assessment Calculation Under a Split Payment System

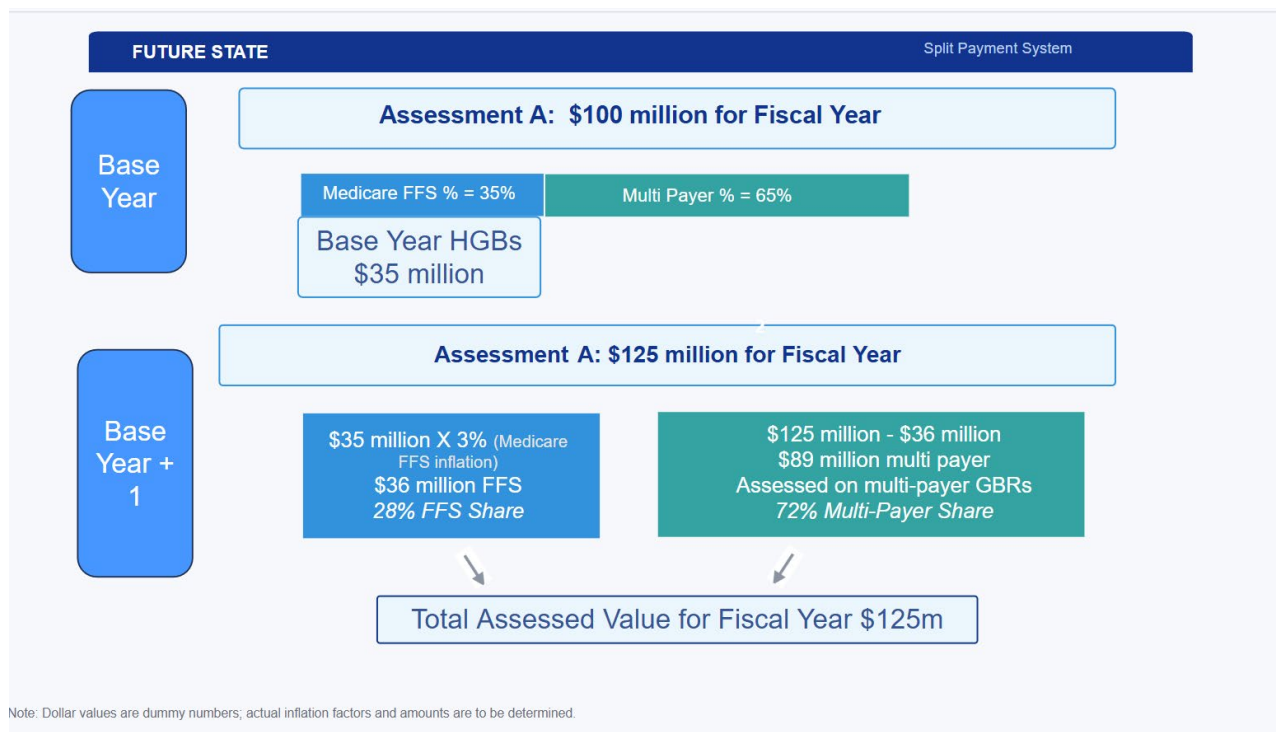
Beginning in 2028, a portion of the aforementioned assessments will be included in the Medicare HGBs. As such, staff will need to consider and acknowledge that some level funding has been included and will be

inflated on a go forward basis. As a result, the calculation of each assessment moving forward will need to be adjusted accordingly. The following steps will need to be taken to determine the adjustment.

1. Determine the percent of FFS revenue associated with each assessment included in the base year for Medicare FFS
2. In the following year, take the FFS value from the previous year and inflate that value by the inflation applied to Medicare HGBs for that hospital.
3. The answer in item 2 above is then reduced from the total assessment value for the current year (as determined under the relevant process for that assessment) to determine the value to be assessed on the Multi-payer GBRs.
4. Repeat the process every year thereafter to determine appropriate FFS split.

The figure below provides an illustration of how Staff intend to adjust each assessment beginning in 2028.

Figure 1



The calculation outlined in Figure 1 will need to be completed for each assessment outlined in this report each year. Staff will need to continue to review the Medicare proportion to understand the Medicare share moving forward. Significant shifts to the multi-payer share may require Commission discussion. For

example, if Medicare funding levels are growing slower than the growth in a specific adjustment a discussion may be warranted to ensure the result is not over-burdening commercial payers.

Additional Considerations

In addition to the items noted in this report, there are several other areas of consideration relating to assessments.

Medicaid and Medicare Advantage Rate Compliance

Future rates including assessments will also need to consider Medicare Advantage and Medicaid growth since those populations will be subject to certain limitations in relation to Medicare rates in future years of the Model (e.g. Medicaid Upper Payment Limits), these limitations will be assessed as part of the Update Factor evaluation.

Future New Assessments

Assessments that are not included in the Medicare Hospital Global Budgets will need to be assessed on the multipayer GBRs. The State will not have oversight of the Medicare FFS population and therefore will not have the authority to institute new assessments on that population.

Assessment in FY 2028

Medicare HGBs will operate on a calendar-year basis, beginning January 1, 2028, while the State's fiscal year (FY) runs from July 1 through June 30. As a result, FY 2028 will span two different payment systems: the existing All-Payer GBR system will remain in effect from July 1 through December 31, 2027, and the bifurcated system, including Medicare HGBs, will take effect on January 1, 2028.

HSCRC staff will need to consider the implications of this transition when developing policies and assessing the impact of assessments and other requirements for FY 2028. This will include accounting for the different methodologies and time periods that apply during the first and second halves of the fiscal year.

The transition to the bifurcated system represents a significant change in how these policies will apply across the fiscal year. Additional guidance regarding assessments and other policy considerations will be developed over the coming year with regard to FY 2028 specifically to provide stakeholders with greater clarity as implementation approaches.

Draft Recommendation: Bridge Adjustment

Overview

- Background
- Considerations
- Options
- Recommendation

Recommendation Overview

- The Bridge Adjustment gives the State the ability to smooth the transition from State-defined to CMS-defined Medicare FFS global budgets
 - Adjustment must be revenue neutral
- Goal is to support hospitals during the transition and avoid steep cliffs, providing time to adapt
- Key decision points
 - What is the adjustment applied to?
 - Total budgets, Repricing, specific adjustments
 - How much should the transition be smoothed?
 - How should the adjustment be calculated to shift revenue from one hospital to another ensuring revenue neutrality?

Background

To adjust for the effects of Medicare FFS transitioning from the CMS Approved State- Designed All-Payer Hospital Global Budget Methodology to the CMS-Designed Medicare FFS Hospital Global Budget Methodology for any particular hospital, for PYs 3, 4, and 5, the State may modify the Medicare FFS Hospital Global Budget amount for a Participant Hospital as calculated in accordance with the CMS-Designed Hospital Global Budget Methodology as follows:

- a. For PY3, the State can redistribute no more than 30 percent of the total Medicare hospital global budget revenue for participant hospitals to other participant hospitals for that PY....
- b. For PY4, the State can redistribute no more than 20 percent of the total Medicare hospital global budget revenue for participant hospitals to other participant hospitals for that PY.
- c. For PY5, the State can redistribute no more than 10 percent of the total Medicare hospital global budget revenue for participant hospitals to other participant hospitals for that PY.

Amended and Restated AHEAD Model Maryland State Agreement, Section 12(b)(ii)

Considerations

Implementation Timeline

- CMMI specifications finalized January 2027
- CMMI HGB amounts finalized in 2027 (specifics are unclear)
- Finalized HGBs (with bridge adjustment) to hospitals by late 2027

State-defined Medicare HGB

- An estimate of a Maryland hospital's GBR associated with Medicare Fee for Service (FFS) patients as calculated under Maryland methodologies.

State-weight

- This variable places a relative weight on the State-defined Medicare HGB and a corresponding weight on the CMS-defined HGB.
- Allows the bridge adjustment to vary the weight of the State-defined HGB in future years and create a gradual path towards the CMS-defined HGBs.

Level of Adjustment

- The Bridge Adjustment could technically be applied to any combination of adjustments under CMMI's methodology, including the Repricing Adjustment.

Options for Adjustment

Option 1

Applies a bridge adjustment to spread the aggregate (state-level) difference between CMMI and state global budgets across all hospitals as weighted by a glide path factor (i.e. state weight).

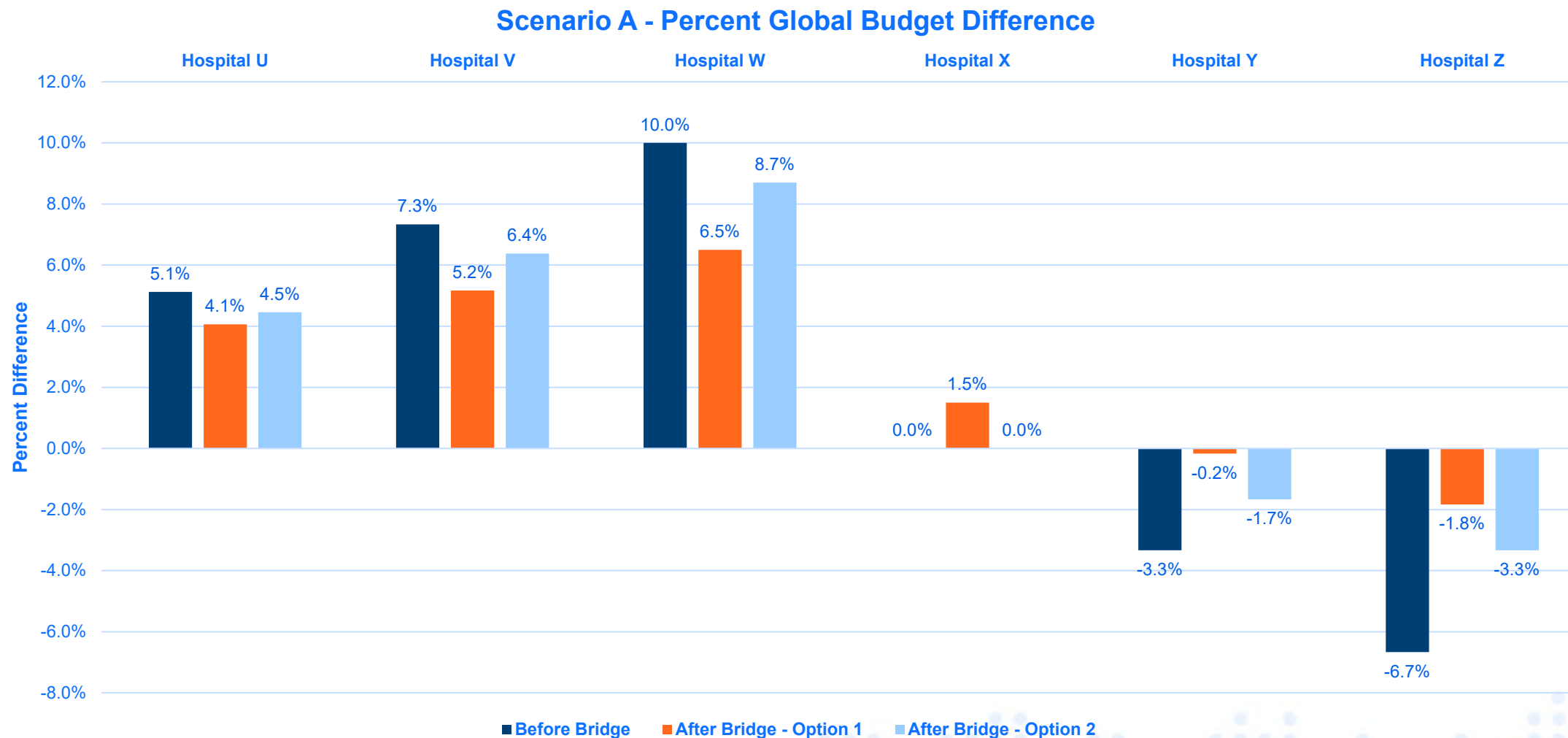
Option 2

Creates a pool of bridge funding from hospitals with a CMMI global budget higher than their state global budget based on a glide path factor (i.e. state weight) and distributes the pool based on proportional changes in global budgets to hospitals with a CMMI global budget less than their state global budget, up to a maximum associated with the glide path factor.

Scenario A: Total Medicare FFS HGB CMMI > Maryland by 3.0%

Scenario A: Total Medicare FFS Hospital GB CMMI > Maryland	Hospital-specific global budget (CMMI) (\$M)	Hospital-specific global budget (State) (\$M)	Percent Difference before Bridge	Percent Difference After Bridge - Option 1	Percent Difference After Bridge - Option 2
Hospital U	\$841	\$800	5.1%	4.1%	4.5%
Hospital V	\$161	\$150	7.3%	5.2%	6.4%
Hospital W	\$275	\$250	10.0%	6.5%	8.7%
Hospital X	\$250	\$250	0.0%	1.5%	0.0%
Hospital Y	\$290	\$300	-3.3%	-0.2%	-1.7%
Hospital Z	\$140	\$150	-6.7%	-1.8%	-3.3%
Total	\$1,957	\$1,900	3.0%	3.0%	3.0%

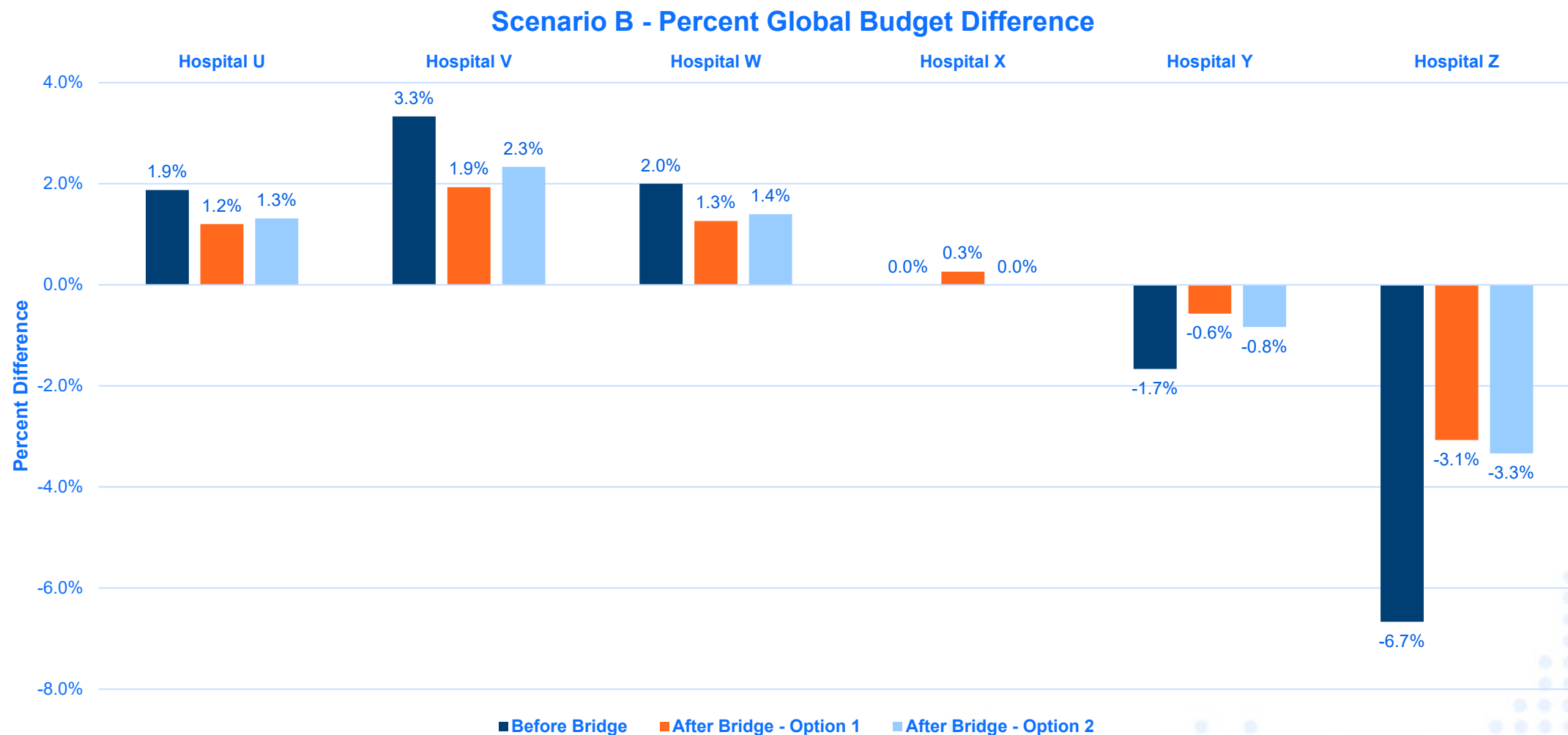
Modeling: Total Medicare FFS HGB CMMI > Maryland by 3.0%



Scenario B: Total Medicare FFS Hospital GB CMMI > Maryland by 0.5%

Scenario B: Total Medicare FFS Hospital GB CMMI < Maryland	Hospital-specific global budget (CMMI) (\$M)	Hospital-specific global budget (State) (\$M)	Percent Difference before Bridge	Percent Difference After Bridge - Option 1	Percent Difference After Bridge - Option 2
Hospital U	\$815	\$800	1.9%	1.2%	1.3%
Hospital V	\$155	\$150	3.3%	1.9%	2.3%
Hospital W	\$255	\$250	2.0%	1.3%	1.4%
Hospital X	\$250	\$250	0.0%	0.3%	0.0%
Hospital Y	\$295	\$300	-1.7%	-0.6%	-0.8%
Hospital Z	\$140	\$150	-6.7%	-3.1%	-3.3%
Total	\$1,910	\$1,900	0.5%	0.5%	0.5%

Modeling: Total Medicare FFS Hospital GB CMMI > Maryland by 0.5%



Stakeholder Engagement

- Discussed Bridge Adjustment during Payment Models Workgroup meetings
 - Level of Bridge Adjustment – Total HGBs, Repricing Adjustment, specific adjustments
 - Staff are concerned applying Bridge Adjustment to specific adjustments adds unnecessary complexity
 - Stakeholders support the goal of the Bridge Adjustment to phase-in CMS-defined HGBs, not to negate changes

Staff Recommendation

- Commissioners discuss and consider the two options outlined here
- Commissioners discuss and consider whether the Bridge Adjustment should compare the State-defined global budgets to:
 - CMMI-defined global budgets as a whole or
 - The Repricing Adjustment only
- Commissioners approve state weight range, and then the specific weight be determined when finalized HGBs are available. Recommended ranges are:
 - PY3 (2028) 50% - 85%
 - PY4 (2029) 25%- 65%
 - PY5 (2030) 0% - 35%.
- Commissioners approve a bridge adjustment policy that staff can implement without seeking additional Commission approval in late 2027.



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Draft Recommendation: Bridge Adjustment

October 21, 2026

Please submit all comment letters for this recommendation to
hscrc.payment@maryland.gov by November 11, 2026.

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Draft Recommendation: Bridge Adjustment

Background

As outlined in the Amended and Restated AHEAD Model Maryland State Agreement (State Agreement), Medicare FFS global budgets will be set according to methodology established by the Center for Medicare and Medicaid Innovation (CMMI), rather than the HSCRC, starting January 1, 2028. To facilitate this, Section 12(b)(ii) states the following:

“To adjust for the effects of Medicare FFS transitioning from the CMS Approved State- Designed All-Payer Hospital Global Budget Methodology to the CMS-Designed Medicare FFS Hospital Global Budget Methodology for any particular hospital, for PYs 3, 4, and 5, the State may modify the Medicare FFS Hospital Global Budget amount for a Participant Hospital as calculated in accordance with the CMS-Designed Hospital Global Budget Methodology as follows:

- a. For PY3, the State can redistribute no more than 30 percent of the total Medicare hospital global budget revenue for participant hospitals to other participant hospitals for that PY....
- b. For PY4, the State can redistribute no more than 20 percent of the total Medicare hospital global budget revenue for participant hospitals to other participant hospitals for that PY.
- c. For PY5, the State can redistribute no more than 10 percent of the total Medicare hospital global budget revenue for participant hospitals to other participant hospitals for that PY.”

This adjustment will heretofore be called the “Bridge Adjustment.”

As referenced in the language, the purpose of this adjustment is to ease the transition for hospitals as they move from State- to CMMI-designed global budgets. In practice, this means adjusting global budgets to reflect a blend of the trended historical State and CMMI-set global budget amounts during PY3, 4, and 5. This language establishes the State’s legal authority to determine whether the blend weighs CMMI’s or the State’s global budget more. It also requires that:

- Total redistributed amount is capped at a certain, decreasing percent each year (30 percent, 20 percent, 10 percent in PY3, PY4, PY5, respectively).
- The total redistributed amount must be net neutral; total spending cannot exceed CMMI’s established total Medicare hospital global budget revenue.

Recommendation Overview

HSCRC staff recommend the Commission review and consider two options for the Bridge Adjustment to ease the transition to CMMI-designed global budgets. These options differ primarily in how they distribute aggregate state-level funding differences across individual hospitals and the extent to which they provide a smoothing effect to changes in a hospital’s global budget. In addition to options for how to calculate a Bridge Adjustment, there are options for applying the Bridge Adjustment holistically to total global budgets, to the Repricing Adjustment, or to specific adjustment components. Staff also recommend establishing state

weights that determine the magnitude of a smoothing effect as flexible ranges rather than fixed percentages. The Bridge Adjustment will need to be implemented in coordination with CMMI in late 2027 and it may not be feasible to review specific outcomes and seek a Commission decision at that time.

Considerations

Implementation Timeline

CMMI released version 3.2 of Financial Specifications for the CMS-Designed Medicare FFS Hospital Global Budget Methodology and will release finalized specifications in mid-January 2027, according to Section 12.a.v of the State Agreement. CMMI has released preliminary HGBs estimates for Maryland hospitals based on FY2024 data. CMMI has stated that they plan to provide updated preliminary HGB estimates based on CY2025 data and eventually 'final' HGBs based on finalized specifications and CY2026 data. The timeline for both is unclear, but the final HGBs are likely to be provided in 2027. The State will apply the bridge adjustment and provide updated HGB values to CMMI in late 2027. CMMI will then provide finalized HGBs for CY2028 to Maryland hospitals by December 2027, as required in Section 12.b.v of the State Agreement. Therefore, the bridge adjustment policy will be implemented in late 2027 after additional information is provided to the State and Maryland hospitals. Given the tight implementation timeline in late 2027, HSCRC staff recommend the Commission approve a bridge adjustment policy that staff can implement without seeking additional Commission approval in late 2027.

State-defined Medicare HGB

To calculate the Bridge Adjustment, HSCRC staff will compare two global budget values for Maryland hospitals: the CMS-defined HGB and a State-defined Medicare HGB. The State-defined Medicare HGB is an estimate of a Maryland hospital's GBR associated with Medicare Fee for Service (FFS) patients as calculated under Maryland methodologies.

State-weight

This draft recommendation describes several options for the Commission to consider. All options use a state-weight or glide-path factor. This variable places a relative weight on the State-defined Medicare HGB and a corresponding weight on the CMS-defined HGB. For example, if the state-weight is 65%, the corresponding weight for CMS-defined budgets is 35% (100%-65%). This allows the bridge adjustment to vary the weight of the State-defined HGB in future years and create a gradual path towards the CMS-defined HGBs.

Level of Adjustment

CMS-designed Medicare HGBs are defined by total Medicare payments received by hospitals in Calendar Year 2026 increased or decreased by a series of adjustments.¹ Adjustments include factors to trend funding from the 2026 base year to the performance year and to implement various aspects of the CMS HGB specification. Most of these adjustments are likely to be similar across hospitals although it is possible that the combination of impacts could be materially inconsistent for some hospitals. However, one adjustment (the “Repricing Adjustment”) will vary significantly by hospital. Under this policy hospitals in the top quartile of a ratio comparing payments received to payments that would have been received if the hospital had been operating under the national Medicare FFS rate structure receive a downward and adjustment while hospitals in the bottom quartile receive increases (this is similar to the State’s Integrated Efficiency policy but does not consider total cost of care and is implemented on an accelerated basis versus the State’s policy).

The Bridge Adjustment could technically be applied to any combination of adjustments, including the Repricing Adjustment. However, doing so would require calculating the impact of individual adjustments and making judgements about whether the Bridge Adjustment should be applied. Staff are inclined towards a simple approach whereby the bridge is applied either to the entire global budget or just to the Repricing Adjustment. Staff believe further evaluation at the adjustment level would add complexity and subjectivity to the process. Other than applying the Bridge Adjustment to total HGB amounts, applying the Bridge Adjustment to only the Repricing Adjustment is the simplest approach but leaves hospitals exposed to gains and losses resulting from other policy differences.

Options for Adjustment

To determine each hospitals’ Bridge Adjustment, HSCRC staff considered several approaches and describe two options as a part of this recommendation. Options are presented using hypothetical values to simplify the discussion and to consider the impacts of a Bridge Adjustment formula. Since the CMMI specifications and process are still being developed, estimates of specific hospital HGBs could be inaccurate at this time.

Option 1 applies a bridge adjustment to spread the aggregate (state-level) difference between CMMI and state global budgets across all hospitals as weighted by a glide path factor (i.e. state weight). This has the effect of redistributing the state-level difference between CMMI and state global budgets proportionally to state hospital-level budgets.

Option 2 creates a pool of bridge funding from hospitals with a CMMI global budget higher than their state global budget based on a glide path factor (i.e. state weight) and distributes the pool based on proportional

¹ Assuming the update factors for 2025 and 2026 exceed the cumulative USPCC trend for 2025 and 2026, as outlined in Section 12.b.i.1 in the State Agreement.

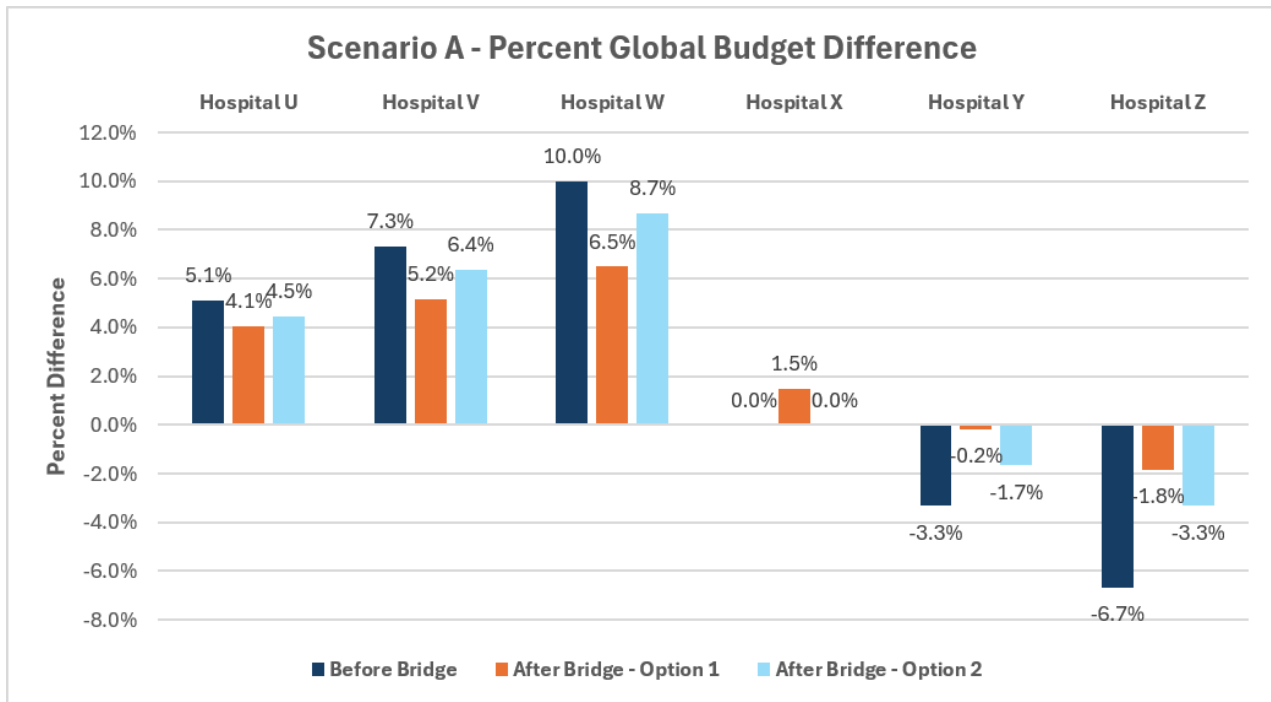
changes in global budgets to hospitals with a CMMI global budget less than their state global budget, up to a maximum associated with the glide path factor. This has the effect of moving funding from hospitals with a CMMI global budget higher than their state global budget to hospitals with a CMMI global budget less than their state global budget.

Either option could be applied if the Bridge Adjustment is applied to total global budgets. If the Bridge Adjustment is applied to the Repricing Adjustment only, HSCRC staff discussed potentially applying a materiality threshold to Option 1 to exclude the middle quartile hospitals (no adjustment), otherwise Option 2 may be preferred as it would not change the budget for hospitals unaffected by the Repricing Adjustment.

The impact of these options varies depending on the aggregate difference between CMMI and State global budgets and the hospital-level difference. Below are the results of modeling the options under two scenarios, one in which the aggregate CMMI budget is higher than the State budget by 3% and one in which the aggregate CMMI budget is higher than the State budget by 0.5%. All scenarios below are based on a glide path factor (state weight) of 50 percent and a cap of 30 percent. Detailed modeling of these options can be found in Appendix A.

Scenario A: Total Medicare FFS HGB CMMI > Maryland by 3.0%

	Hospital-specific global budget (CMMI) (\$M)	Hospital-specific global budget (State) (\$M)	Percent Difference before Bridge	Percent Difference After Bridge - Option 1	Percent Difference After Bridge - Option 2
Hospital U	\$841	\$800	5.1%	4.1%	4.5%
Hospital V	\$161	\$150	7.3%	5.2%	6.4%
Hospital W	\$275	\$250	10.0%	6.5%	8.7%
Hospital X	\$250	\$250	0.0%	1.5%	0.0%
Hospital Y	\$290	\$300	-3.3%	-0.2%	-1.7%
Hospital Z	\$140	\$150	-6.7%	-1.8%	-3.3%
Total	\$1,957	\$1,900	3.0%	3.0%	3.0%

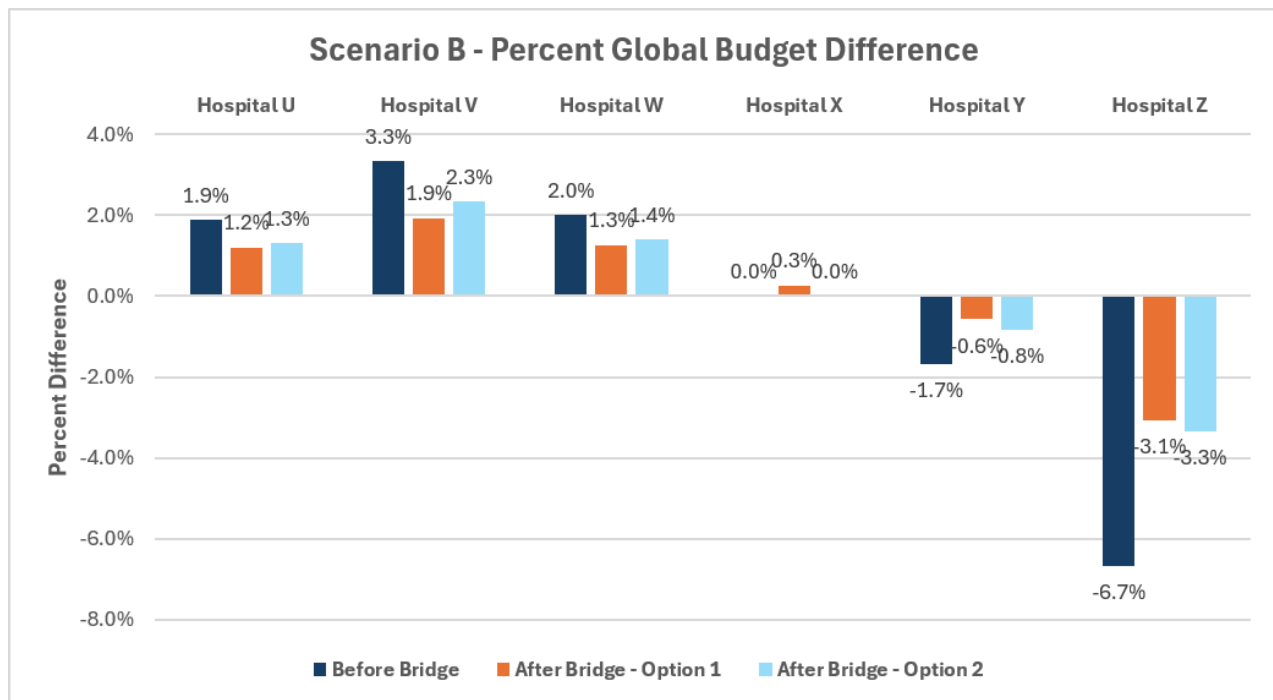


Under Scenario A (state-wide positive change of 3%),² Option 1 smoothes the impact for hospitals Y and Z that have a smaller CMMI global budget, reducing decreases of -3.3 percent and -6.7 percent to -0.2 percent and -1.8 percent, respectively. Hospitals U, V, and W that have a larger CMMI global budget receive smaller increases. Hospital X has a CMMI budget equal to its State budget and under Option 1 receives a 1.5 percent increase to its global budget because the state-level difference is spread to all hospitals. Under Option 2, there is a smaller smoothing effect, with Hospitals Y and Z experiencing -1.7 and -3.3% decreases, respectively. In dollar terms, Hospital Z would face a \$10 million decrease in its global budget, absent a Bridge Adjustment. Option 1 changes the reduction to \$2.75 million and Option 2 changes the reduction to \$5 million.

² Given current modeling (based on FY24), HSCRC staff believe that this is the most likely state wide scenario—in net, hospitals receiving positive adjustments under CMMI's baseline repricing exercise are larger than those receiving negative adjustments.

Scenario B: Total Medicare FFS Hospital GB CMMI > Maryland by 0.5%

	Hospital-specific global budget (CMMI) (\$M)	Hospital-specific global budget (State) (\$M)	Percent Difference before Bridge	Percent Difference After Bridge - Option 1	Percent Difference After Bridge - Option 2
Hospital U	\$815	\$800	1.9%	1.2%	1.3%
Hospital V	\$155	\$150	3.3%	1.9%	2.3%
Hospital W	\$255	\$250	2.0%	1.3%	1.4%
Hospital X	\$250	\$250	0.0%	0.3%	0.0%
Hospital Y	\$295	\$300	-1.7%	-0.6%	-0.8%
Hospital Z	\$140	\$150	-6.7%	-3.1%	-3.3%
Total	\$1,910	\$1,900	0.5%	0.5%	0.5%



Under Scenario B (state-wide positive change of 0.5%), Option 1 smoothes the impact for hospitals Y and Z that have a smaller CMMI global budget, reducing decreases of -1.7 percent and -6.7 percent to -0.6 percent and -3.1 percent, respectively. Hospitals U, V, and W that have a larger CMMI global budget receive smaller increases. Hospital X has a CMMI budget equal to its State budget and under Option 1 receives a 0.3 percent increase to its global budget because the state-level difference is spread to all hospitals. Under Option 2, there is a smaller smoothing effect, with Hospitals Y and Z experiencing -0.8 and -3.3% decreases, respectively. In dollar terms, Hospital Z would face a \$10 million decrease in its global budget, absent a Bridge Adjustment. Option 1 changes the reduction to \$4.61 million and Option 2 changes the reduction to \$5 million.

Stakeholder Engagement

HSCRC staff discussed the Bridge Adjustment during Payment Models Workgroup meetings on September 10, September 23, and October 7.³ In addition to reviewing the options described above, the Workgroup discussed whether the Bridge Adjustment should be applied to specific adjustments or total HGBs. Conceptually, the adjustment could be applied to total HGBs (including all adjustments), the repricing adjustment, or an identified list of adjustments. Stakeholders commented that some adjustments should not be adjusted as well as a desire to understand what elements of the HGB are being phased in due the Bridge Adjustment. Staff agree with the importance of understanding how CMMI-defined HGBs have been constructed, however, applying the adjustment to some adjustments and not others creates unnecessary complexity and potentially mitigates the effectiveness of the Bridge Adjustment in providing hospitals with stability and predictability during the AHEAD transition period.

Other factors raised were whether to apply a hospital-specific limit of the impact of the Bridge Adjustment, whether distribution of the statewide changes should be applied to hospitals whose CMMI and State global budgets differ beyond a certain amount, and the magnitude of the state weight over time.

Stakeholders also commented that the bridge adjustment should be applied to phase in the CMMI-defined HGBs, not to negate or undo changes. Staff concur with this perspective and the state weight, described above, provides a mechanism to adjust the relative speed of the phase-in so that hospitals experience a ramp to new HGBs, rather than a cliff.

Staff will update this section of the recommendation after formal comment letters have been submitted by stakeholders.

³ Materials and recording for those meetings can be found here. <https://hscrc.maryland.gov/Pages/hscrc-workgroup-payment-models.aspx>

Recommendation

HSCRC staff recommend the Commission discuss and consider the two options described above. The options differ in the extent to which they spread differences in aggregate state-level funding across hospitals and the hospital-level impacts of the transition between State- and CMMI-set global budgets.

Additionally, Staff recommend:

- The bridge adjustment will be applied to State-defined and CMMI-defined global budgets as a whole or the Repricing Adjustment only, rather than identifying specific adjustments to which the bridge adjustment will be applied.
- The state weight be set as a range and the specific weight be determined when finalized HGBs are available. Recommended ranges are:
 - PY3 (2028) 50% - 85%
 - PY4 (2029) 25%- 65%
 - PY5 (2030) 0% - 35%.
- HSCRC staff recommend the Commission approve a bridge adjustment policy that staff can implement without seeking additional Commission approval in late 2027

Staff look forward to engaging with stakeholders more on this methodology.

Appendix: Bridge Adjustment Modeling

Option 1

Scenario A: Total Medicare FFS Hospital GB CMMI > Maryland by 3%							
	Hospital-specific global budget (CMMI)	Hospital-specific global budget (State)	State Equivalent HGB	Difference	State GB Weight Applied	Bridge Adjustment Cap Applied	PY3 Final HGB
	<i>A</i>	<i>B</i>	$C = B / [Btotal] * [Atotal]$	$D = C - A$	$E = D * [\% \text{ State GB Weight}]$	$F = E \text{ unless } [Etotal] > Cap, \text{ otherwise } = [Eproportion] * Cap$	$G = A + F$
State GB Weight	50%						
Cap (State Agreement)	30%						
Hospital U	\$841	\$800	\$824.00	-\$17.00	-\$8.50	-\$8.50	\$832.50
Hospital V	\$161	\$150	\$154.50	-\$6.50	-\$3.25	-\$3.25	\$157.75
Hospital W	\$275	\$250	\$257.50	-\$17.50	-\$8.75	-\$8.75	\$266.25
Hospital X	\$250	\$250	\$257.50	\$7.50	\$3.75	\$3.75	\$253.75
Hospital Y	\$290	\$300	\$309.00	\$19.00	\$9.50	\$9.50	\$299.50
Hospital Z	\$140	\$150	\$154.50	\$14.50	\$7.25	\$7.25	\$147.25
Total	\$1,957	\$1,900	\$1,957.00	\$0.00	\$0.00	\$0.00	\$1,957.00
Abs Total				\$82.00	\$41.00	\$41.00	

Scenario B: Total Medicare FFS Hospital GB CMMI > Maryland by 0.5%							
	Hospital-specific global budget (CMMI)	Hospital-specific global budget (State)	State Equivalent HGB	Difference	State GB Weight Applied	Bridge Adjustment Cap Applied	PY3 Final HGB
	<i>A</i>	<i>B</i>	$C = B / [B_{total}] * [A_{total}]$	$D = C - A$	$E = D * [\% \text{ State GB Weight}]$	$F = E \text{ unless } [E_{total}] > \text{Cap, otherwise} = [E_{proportion}] * \text{Cap}$	$G = A + F$
State GB Weight	50%						
Cap (State Agreement)	30%						
Hospital U	\$815	\$800	\$804.21	-\$10.79	-\$5.39	-\$5.39	\$809.61
Hospital V	\$155	\$150	\$150.79	-\$4.21	-\$2.11	-\$2.11	\$152.89
Hospital W	\$255	\$250	\$251.32	-\$3.68	-\$1.84	-\$1.84	\$253.16
Hospital X	\$250	\$250	\$251.32	\$1.32	\$0.66	\$0.66	\$250.66
Hospital Y	\$295	\$300	\$301.58	\$6.58	\$3.29	\$3.29	\$298.29
Hospital Z	\$140	\$150	\$150.79	\$10.79	\$5.39	\$5.39	\$145.39
Total	\$1,910	\$1,900	\$1,910.00	\$0.00	\$0.00	\$0.00	\$1,910.00
Absolute Value Total				\$37.37	\$18.68	\$18.68	

Option 2

Scenario A: Total Medicare FFS Hospital GB CMMI > Maryland by 3%									
	Hospital-specific global budget (CMMI)	Hospital-specific global budget (State)	Difference	Generate funding pool (based on weight)	Calculate Raw Funding Shift	Calculate Funding Shift, Proportional to available pool	Bridge Adjustment without Cap	Bridge Adjustment with Cap Applied	Final HGB
	A	B							
State GB Weight	50%								
Cap (State Agreement)	30%								
Hospital U	\$841	\$800	-\$41.00	-\$20.50	\$0.00	\$0.00	-\$5.32	-\$5.32	\$835.68
Hospital V	\$161	\$150	-\$11.00	-\$5.50	\$0.00	\$0.00	-\$1.43	-\$1.43	\$159.57
Hospital W	\$275	\$250	-\$25.00	-\$12.50	\$0.00	\$0.00	-\$3.25	-\$3.25	\$271.75
Hospital X	\$250	\$250	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$250.00
Hospital Y	\$290	\$300	\$10.00	\$0.00	\$5.00	\$5.00	\$5.00	\$5.00	\$295.00
Hospital Z	\$140	\$150	\$10.00	\$0.00	\$5.00	\$5.00	\$5.00	\$5.00	\$145.00
Total	\$1,957	\$1,900	-\$57.00	-\$38.50	\$10.00	\$10.00	\$0.00	\$0.00	\$1,957.00

Scenario B: Total Medicare FFS Hospital GB CMMI > Maryland by 0.5%									
	Hospital - specific global budget (CMMI)	Hospital - specific global budget (State)	Differenc e	Generat e funding pool (based on weight)	Calculat e Raw Funding Shift	Calculate Funding Shift, Proportion al to available pool	Bridge Adjustme nt without Cap	Bridge Adjustme nt Cap Applied	Final HGB
	A	B							
State GB Weight	50%								
Cap (State Agreemen t)	30%								
Hospital U	\$815	\$800	-\$15.00	-\$7.50	\$0.00	\$0.00	-\$4.50	-\$4.50	\$810.50
Hospital V	\$155	\$150	-\$5.00	-\$2.50	\$0.00	\$0.00	-\$1.50	-\$1.50	\$153.50
Hospital W	\$255	\$250	-\$5.00	-\$2.50	\$0.00	\$0.00	-\$1.50	-\$1.50	\$253.50
Hospital X	\$250	\$250	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$250.00
Hospital Y	\$295	\$300	\$5.00	\$0.00	\$2.50	\$2.50	\$2.50	\$2.50	\$297.50
Hospital Z	\$140	\$150	\$10.00	\$0.00	\$5.00	\$5.00	\$5.00	\$5.00	\$145.00
Total	\$1,910	\$1,900	-\$10.00	-\$12.50	\$7.50	\$7.50	\$0.00	\$0.00	\$1,910.00



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RY 2029 Quality Based Reimbursement Draft Policy

October 21, 2026

HSCRC Quality Team

Hospital All-Payer Quality Programs

The following are HSCRC's main quality payment incentive programs:

Maryland Hospital Acquired Conditions (MHAC) Program

Motivates hospitals to reduce infections and complications acquired during a hospital stay

Quality Reimbursement Program (QBR)

Focuses on patient experience, patient safety, and clinical quality outcomes

Readmissions Reduction Incentive Program (RRIP)

Encourages hospitals to reduce readmissions within 30 days of discharge

Potentially Avoidable Utilization (PAU)

Focuses on improving patient care and health through reducing potentially avoidable utilization

Since start of Model, Maryland has been granted waivers from CMS hospital quality programs through an annual exemption process. Waiver required the State:

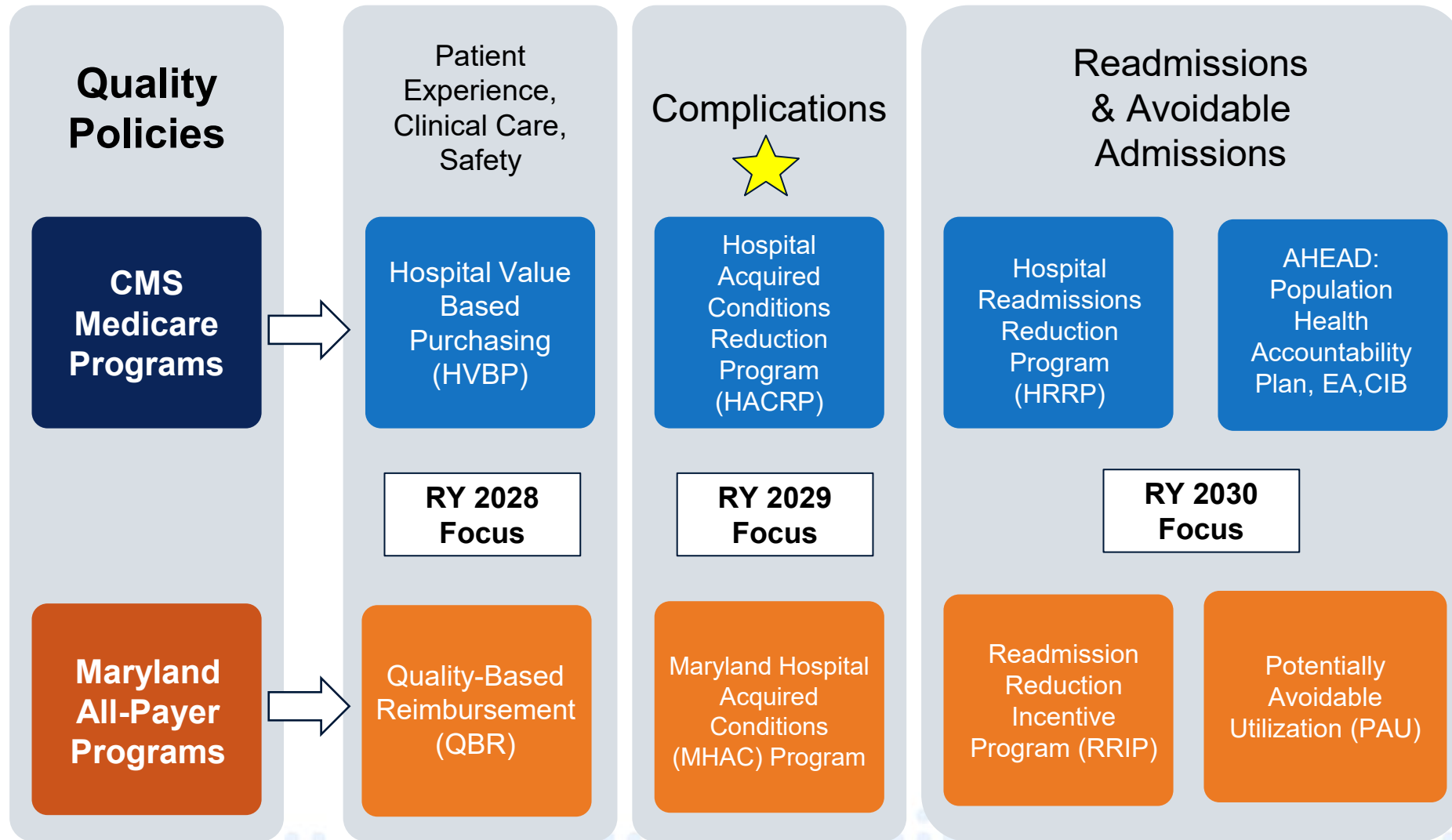
- To implement hospital quality programs that used similar categories of quality measures
- To meet or exceed the revenue at-risk under the CMS quality programs on an all-payer basis (i.e., 6%).

What does Rate Year 2029 Mean?

Rate year indicates the time period when hospital rates are adjusted based on previous quality performance; it lines up with the State fiscal year July-June.

- Each program has a “base” period that is used to prospectively determine performance standards (i.e., threshold and benchmark) and for measuring improvement, if applicable.
 - Threshold = performance needed to avoid penalties
 - Benchmark = performance needed to earn max reward
- The RY 2029 performance periods vary by measure:
 - CY 2027 for HSCRC case-mix measures (e.g., Potentially Preventable Complications, readmissions, mortality).
 - Measures obtained from CMS Care Compare vary in performance period length and have a 9 month delay in being published publicly for HSCRC use.

HSCRC-CMS Alignment Opportunities & Transition Timeline



State must meet requirements for all-payer programs for RY 2028 and RY 2029

MD hospitals will transition to CMS quality programs starting in FY 2030 for Medicare FFS HGBs; HSCRC will maintain quality incentives for multi-payer HGBs.

RY 2029 Quality Program Policy Timelines

Tentative Commission Meeting Timelines										
	September	October	November	December	January	February	March	April	May	June
QBR	RY 2029 Quality Overview	★ Draft		Final						
MHAC			Draft		Final					
RRIP				Draft		Final				
ED Best Practices		Recommend Transition to Learning Collaborative in RY 2029 QBR Policy								
PAU*									Draft	Final

*PAU is included in update factor policy; PMWG will need to discuss future PAU adjustment including potential alignment with AHEAD PAU measures (e.g., effectiveness adjustment)

RY2029 Priorities

QBR

No major changes proposed

Continue ED LOS and Medicaid timely follow-up

MHAC

Consider removing PPCs from payment

Explore methodology alignment

Total amount at-risk



RRIP

Consider measure changes for alignment

Determine improvement and attainment goal

Best Practices

Sunset pay for reporting and develop learning collaborative to address ED and hospital throughput

Assist CMMI and industry with transition to CMS programs and AHEAD quality adjustments

RY 2029 Draft QBR Recommendation

Quality Based Reimbursement (QBR) Program



Purpose

To incentivize quality improvement across three patient-centered quality measurement domains:

1. **Person and Community Engagement**- 6 top box and 1 consistency measure (HCAHPS survey) + ED length of stay + Medicaid timely follow-up (tfu)
2. **Clinical Care** - inpatient mortality + 30-day mortality + elective total hip/knee arthroplasty complications
3. **Safety** - 5 National Healthcare Safety Network (NHSN) Healthcare Associated Infection measures + sepsis bundle
4. **Digital Measures Reporting Incentive**



How it Works: Revenue-at-Risk

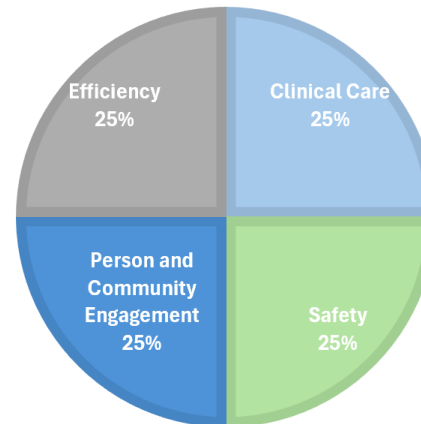
The Program puts **2 percent** of inpatient hospital revenue at risk (maximum penalty/reward)



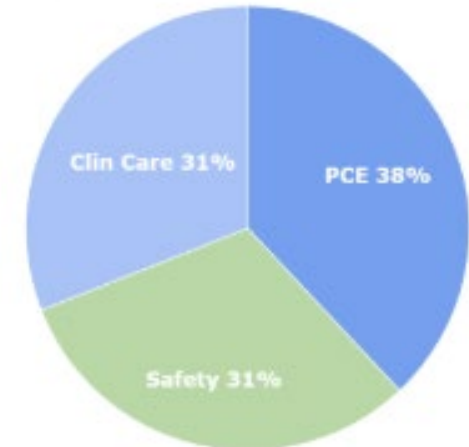
Federal Alignment

The QBR program uses **similar measures to the federal Medicare Value-Based Purchasing (VBP) program** but has an all-payer focus and can adjust domain weights to focus on MD-specific improvements.

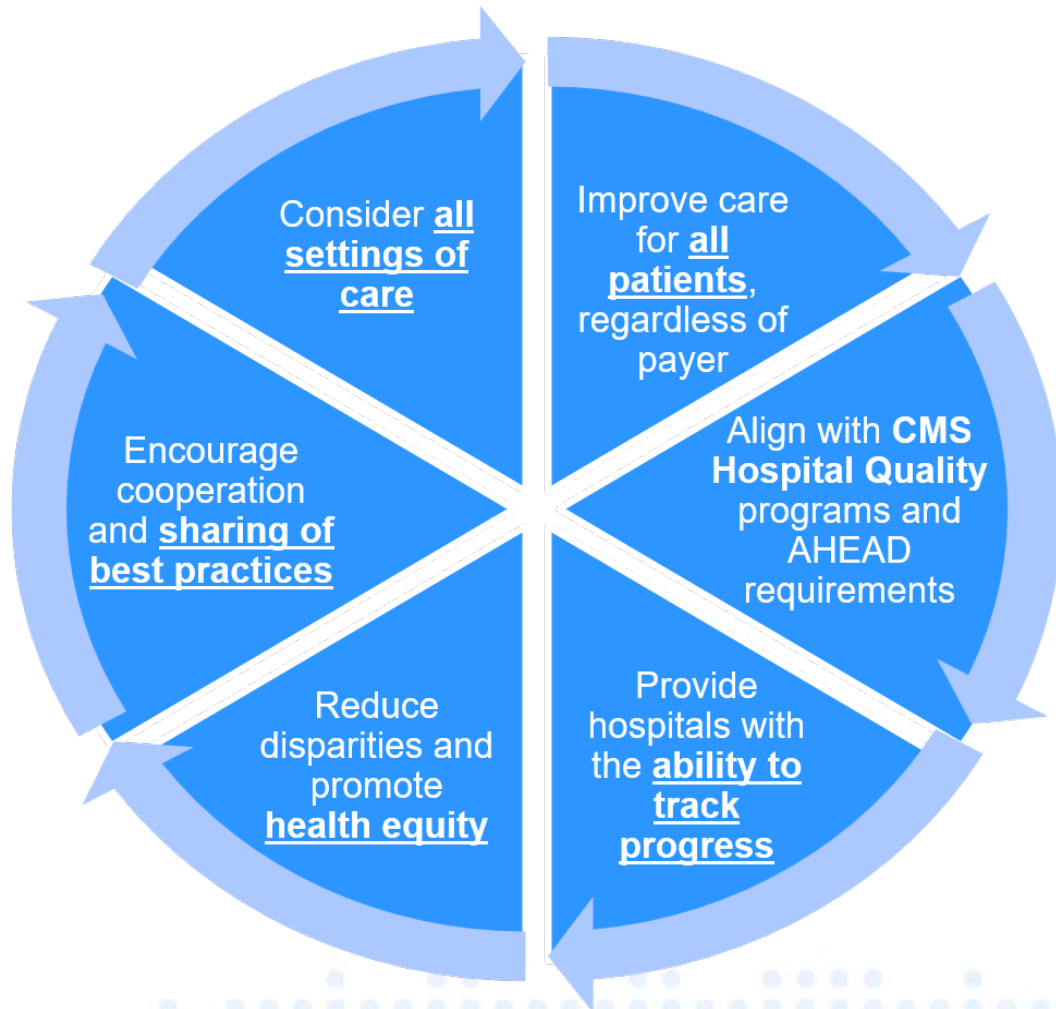
VBP DOMAIN WEIGHTS



QBR DOMAIN WEIGHTS



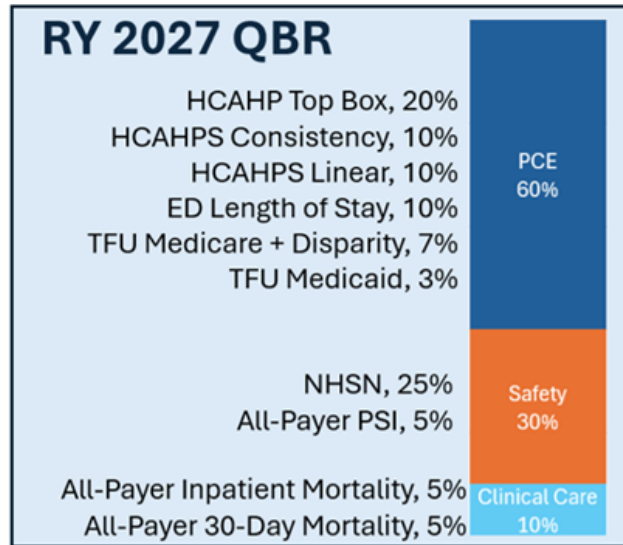
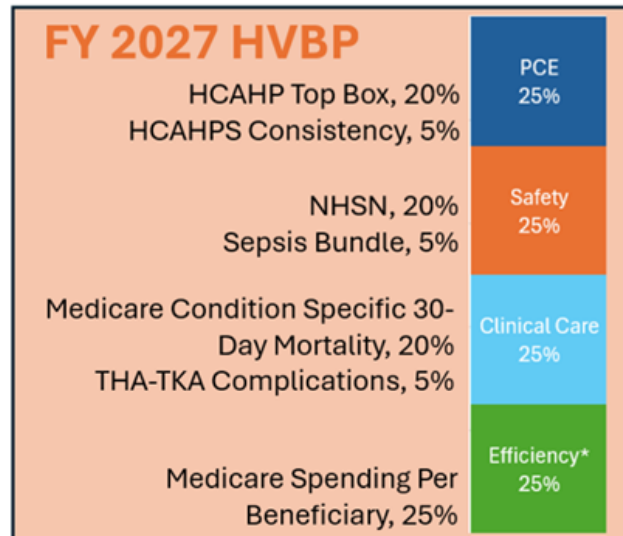
HSCRC Hospital Quality Programs Guiding Principles and CMS Alignment Criteria



In addition to these guiding principles, the following criteria have been adopted for alignment:

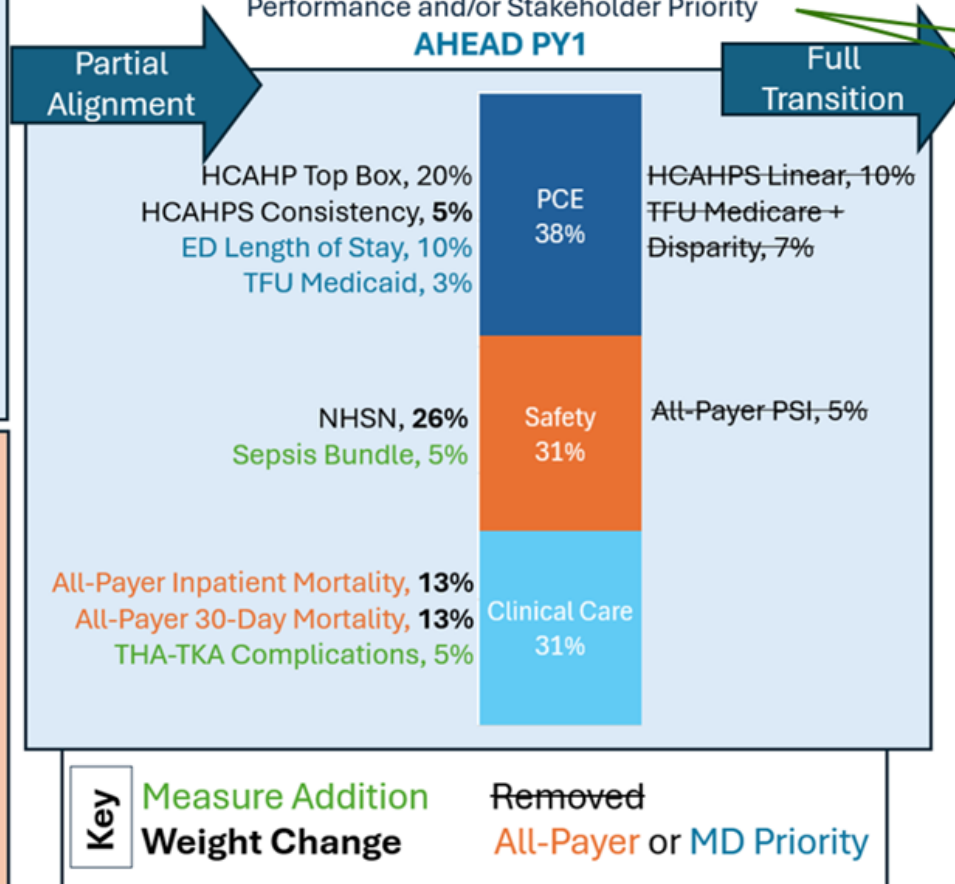
1. Alignment with CMS programs
2. Maintenance of all-payer accountability and incentives for quality
3. Reduction of retrospective measure evaluations to the extent possible
4. Attention to areas of poor performance and/or priority area for State, hospitals, payers, or other stakeholders

Approved RY 2028 QBR Alignment Areas

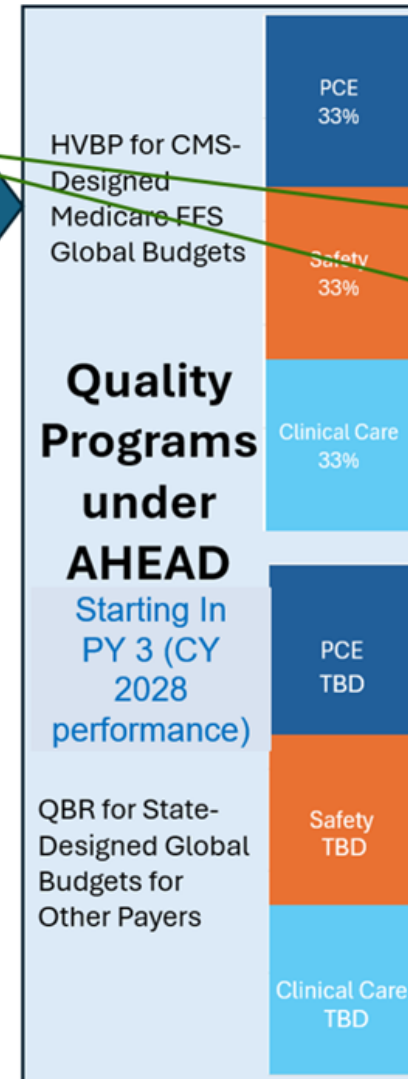


RY 2028 QBR Draft Recommendations

Criteria: 1. Alignment with CMS HVBP, 2. All-Payer Accountability, 3. Reduce retrospective measure evaluation, 4. Area of Poor Performance and/or Stakeholder Priority



*HVBP Efficiency Domain is not used for MD Hospitals in HVBP. Remaining domains are weighted at 1/3rd.



**RY 2028
Approved
Updates**

Performance Summary: Most Current Data Available

Patient and Community Engagement Domain

- HCAHPS: Maryland continues to lag behind the nation
- ED Wait times: Maryland has improved slightly but continues to be a state outlier
- Medicaid Timely follow up: Maryland has improved slightly

Clinical Care Domain

- Maryland has improved slightly on IP and 30-Day all-payer
- Maryland performs slightly better on CMS condition-specific measures
- Maryland performs slightly worse on THA/TKA Arthroplasty

Safety Domain

- Maryland performs slightly better than the nation on majority of CDC NHSN HAIs
- Sepsis Bundle: Maryland performs slightly better than the nation

RY 2029 Policy Considerations

- Maryland Specific Measures--ED Length of Stay, Medicaid Timely Follow-Up
- Mortality Measures & Alignment
- Complication measures and data availability
- Revenue Adjustment Methodology
- Digital measure incentive
- ED and Hospital Throughput Learning Collaborative

Maryland Specific QBR Measures

- ED LOS continues to be a legislative, consumer, and regulatory priority
 - Maintain RY 2028 improvement and attainment goals
 - Maintain current revenue at-risk of 10% of the total QBR Scores
 - Consider ECAT measure in future years
- Medicaid Timely Follow-Up
 - Focuses on area of disparity by placing 3% of the total QBR Score at-risk for this measure
 - Consider adding mental health follow-up in future years to align with PHAP measure

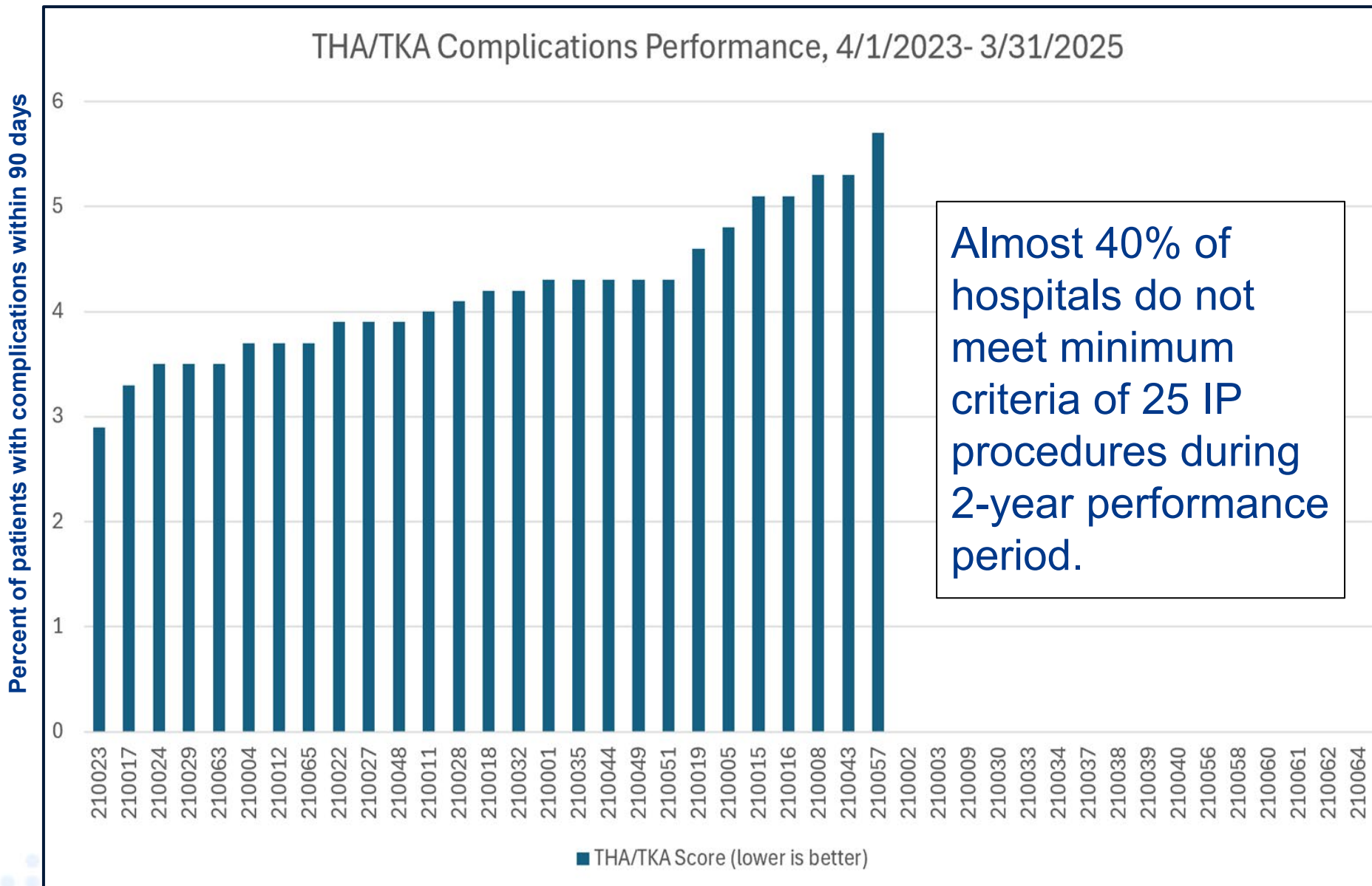
Mortality Measurement

- QBR evaluates all-payer mortality using two, all-condition measures: 30-Day Mortality and IP Mortality
- HVBP evaluates Medicare mortality using 5 condition specific 30-Day Mortality measures (AMI, CABG, CHF, Pneumonia, COPD)
- Draft policy proposes maintenance of the two all-payer mortality measures in RY 2029
 - All-payer, all-condition measurement allows more holistic assessment of important outcome and shorter performance periods.
 - Some stakeholders have expressed a preference for the QBR inpatient measure over the 30 day measure, because the inpatient measure is more within the control of hospitals.
 - 30-day measure is more aligned with the CMS conceptual framework for measuring mortality.

Other Measure Issues: Clinical Care and Safety Domains

- Both QBR and HVBP include the NHSN healthcare associated infections, THA-TKA complications, and the sepsis bundle in the Clinical Care and Safety domain
 - No changes being proposed, despite clinical concerns previously discussed for each of these measures
- Data Availability:
 - The performance period data for the NHSN HAIs and THA-TKA that is posted to Care Compare will use updated methodology and not be comparable to baseline data
 - HSCRC has requested HVBP data file from CMS
 - If data is not provided, HSCRC can work with MHCC to pull NHSN data
 - However, there is no other source of data for THA-TKA (see next slide)

THA-TKA Complications



Staff proposes continued use of measure if data is available for RY 2028 and RY 2029, but will remove and reweight clinical care domain if unavailable

QBR Scale and Cutpoint

- The QBR scale converts hospitals' scores (0-100%) to revenue adjustments.
- The cut point determines the scores that began rewards and penalties
 - Prospective cut point for RY 2028 is 32%
 - Retrospectively evaluate cut point using national performance data to estimate QBR scores and reward hospitals performing better than the national average

This methodology differs from HVBP program that relatively ranks all hospitals after the performance period and scales penalties and rewards around the national median.

Staff propose to continue using a preset scale, despite the need to retrospectively reassess cutpoint (up or down), in order to not relatively rank MD hospitals under QBR.

Abbreviated Preset Scale	QBR Score	Financial Adjustment
Max Penalty	0%	-2.00%
	5%	-1.69%
	10%	-1.38%
	15%	-1.06%
	20%	-0.75%
	25%	-0.44%
	30%	-0.13%
Penalty/Reward Cutpoint	32%	0.00%
	35%	0.13%
	40%	0.33%
	45%	0.54%
	50%	0.75%
	55%	0.96%
	60%	1.17%
	65%	1.38%
	70%	1.58%
	75%	1.79%
Max Reward	80%+	2.00%

Digital Measure Incentive

- Staff propose to maintain the \$150,000 per hospital digital measures incentive
- Incentive is designed to encourage more timely submission of electronic clinical quality measures and all-payer core clinical data elements for hybrid readmission and mortality measures
- See appendix slide for additional details

Development of Learning Collaborative

Staff propose to sunset the Best Practice policy to a learning collaborative. This is supported by the ED Commission and other stakeholders.

Purpose of collaborative:

- To engage hospital leaders, as well as post acute providers, state agencies, and other stakeholders, who can partner to address ED and hospital throughput, care transitions, and capacity alignment opportunities.

Development phase (January-June 2027):

- Identify participants and establish meeting cadence and agenda items.
- Meet with hospitals/health systems/post acute providers/other state agencies to discuss ideas for the collaborative focused on the key drivers identified and recommendations from the ED Wait Time Reduction Commission.
- Focus on bed capacity work and other ongoing data needs that will benefit the collaborative.

Draft Recommendations for RY 2029 QBR Program

1. Maintain 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 revenue adjustment scale from 0 to 80 percent with a preset 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.
3. 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. Add a bonus incentive of \$150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.
4. NEW: Transition the ED and Hospital Throughput Policy to a Learning Collaborative designed to engage stakeholders to identify best practices to address emergency department and hospital throughput, care transitions, and capacity alignment across the care continuum.

APPENDIX

CMS Transition Timeline



Transition Timeline					Performance Year 1					Performance Year 2					Performance Year 3					Performance Year 4					Performance Year 5				
CY -->	Policy	2025			2026				2027				2028				2029				2030								
RY 2027	MHAC, RRIP,	Performance Period (varies by measure)					All-Payer Revenue Adjustments																						
RY 2028					Performance Period (varies by measure)						To Be Determined^																		
RY 2029	QBR, PAU								Performance Period (varies by measure)						TBD Non-Medicare FFS HGBs^			Medicare FFS HGBs											
RY 2030													Performance Period (varies by measure)					TBD Non-Medicare FFS HGBs^											
FY 2030	HVBP												HVBP PCE & Safety Domains*										Medicare Revenue Adjustments**						
								HVBP Mortality Measures & THA-TKA Complications																					
	HRRP								Medicare Condition Specific Readmissions																				
	HACRP							CMS PSI-90																					
								NHSN HAI																					

*Efficiency domain is also on this timeframe. CMMI has indicated MD hospitals may not be measured on efficiency but this needs to be confirmed.

**CMS revenue adjustments for quality programs are implemented on FFY October-September timeframe. AHEAD revenue adjustments implemented on CY; awaiting final decision on whether the timeframe will be moved back one quarter or if multiple years will be averaged.

^ANeed to work with rate setting, CMMI, and stakeholders to figure out timeframe for RY vs. CY revenue adjustments

*State must meet requirements for all-payer programs for RY 2028 and RY 2029

HSCRC RY 2029 Performance Based Payment Program Measurement, Performance, and Impact Periods

Rate Year (Maryland Fiscal Year)	Q3-24	Q4-24	Q1-25	Q2-25	Q3-25	Q4-25	Q1-26	Q2-26	Q3-26	Q4-26	Q1-27	Q2-27	Q3-27	Q4-27	Q1-28	Q2-28	Q3-28	Q4-28	Q1-29	Q2-29	Q3-29	Q4-29
Calendar Year	Q1-24	Q2-24	Q3-24	Q4-24	Q1-25	Q2-25	Q3-25	Q4-25	Q1-26	Q2-26	Q3-26	Q4-26	Q1-27	Q2-27	Q3-27	Q4-27	Q1-28	Q2-28	Q3-28	Q4-28	Q1-29	Q2-29
Quality Based Reimbursement Program (QBR)					Base Period: Hospital Compare (HCAHPS measures, All NHSN Measures, SEP-1 Bundle)							Performance Period: Hospital Compare (HCAHPS measures, All NHSN Measures, SEP-1 Bundle)						Rate Year Impacted by QBR Results				
							Base Period: QBR IP and 30-Day Mortality, Medicaid Timely Follow-Up						Performance Period: QBR IP and 30-Day Mortality, Medicaid Timely Follow-Up									
									Base Period: Emergency Department Length of Stay				Performance Period: Emergency Department Length of Stay									
		Performance Period: THA/TKA Complications*																				

*Base Period for THA/TKA Complications is CY 2019 Q2- CY 2022 Q1

QBR Proposed Domain and Measure Weights Compared to CMS HVBP

	Maryland		Nation	
Domains and Measures	% of QBR Score	% of IP Revenue at Risk	% CMS HVBP Score	%IP Rev at risk
PCE Domain	38%	0.76%	25%	0.5%
<i>HCAHPS Top Box Scores</i>	20%	0.40%	20%	.40%
<i>HCAHPS Consistency</i>	5%	0.10%	5%	.10%
<i>ED Length of Stay</i>	10%	0.20%	N/A	N/A
<i>TFU Medicaid (Medicaid Claims)</i>	3%	0.06%	N/A	N/A
Clinical Care Domain	31%	0.62%	25%	0.5.%
<i>Medicare Condition Specific Mortality (Claims)</i>	N/A	N/A	20.833%	0.416%
<i>Inpatient Mortality (HSCRC Case Mix)</i>	13%	0.26%	N/A	N/A
<i>30-Day All-payer Mortality (HSCRC Case Mix and Maryland Vital Statistics Death Records)</i>	13%	0.26%	N/A	N/A
<i>THA/TKA Complications</i>	5%	0.10%	4.166%	0.083%

	Maryland		Nation	
Domains and Measures	% of QBR Score	% of IP Revenue at Risk	%CMS HVBP Score	%IP Rev at Risk
Safety Domain	31%	0.62%	25%	0.5%
<i>CAUTI</i>	5.2%	0.104%	4.166%	0.083%
<i>C. Diff</i>	5.2%	0.104%	4.166%	0.083%
<i>SSI, Hysterectomy & Colon</i>	5.2%	0.104%	4.166%	0.083%
<i>CLABSI</i>	5.2%	0.104%	4.166%	0.083%
<i>MRSA</i>	5.2%	0.104%	4.166%	0.083%
<i>Severe Sepsis and Septic Shock Bundle</i>	5%	0.10%	4.166%	0.083%
<i>Efficiency</i>	N/A	N/A	25%	0.5%
Total	100%	2.00%	100%	2.00%
Note: IP revenue-at-risk percentages are calculated based on the QBR and HVBP Programs' maximum 2% inpatient revenue at risk.				

QBR RY 2029: Propose Maintaining Digital Measures Positive Incentive for Complete and Timely Reporting

- For CY 2027 HSCRC will require 6 mandatory eCQM Measures and 3 self-selected measures, consistent with CMS requirements (See measures tables on next two slides)
- For July 2027-June 2028, HSCRC will require continued reporting of the Core Clinical Data Elements (CCDE) for Hybrid Hospital Wide Readmission and Hospital Wide Mortality Measures for patients age 18+
- Continue positive incentive for hospitals that report the first six months of data and then quarterly for the third and fourth quarters during the specified reporting windows.
- Hospitals that **do not opt for the expedited reporting bonus** must report all required eCQM data for the CY 2027 reporting period and Hybrid CCDE data for the July 2027 to June 2028 reporting period consistent with the CMS reporting timelines (within 90 days after the annual reporting periods).
- Hospitals unable to comply with the specified measure submissions or non-expedited timelines must submit an Extraordinary Circumstance Exception request in accordance with the [Maryland Hospital Extraordinary Circumstances Exception \(ECE\) Policy](#) for HSCRC's consideration.
- Of note, there are five Optional eCQMs that hospitals can self-select for 2027 that are planned by CMS for mandatory reporting in 2028:
 - Hospital Harm – Pressure Injury
 - Hospital Harm – Acute Kidney Injury
 - Hospital Harm – Falls with Injury
 - Hospital Harm – Postoperative Respiratory Failure
 - Malnutrition Care Score (MCS)



maryland
health services
cost review commission

Draft Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2029

October 21, 2026

This document contains the staff draft recommendations for updating the Quality-Based Reimbursement Program for RY 2029. Comments on the draft are due by COB on Thursday, October 29, 2026 and may be submitted to hscrc.quality@maryland.gov.

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LIST OF ABBREVIATIONS

AHEAD	State's Achieving Healthcare Efficiency through Accountable Design Model
APR DRG	All Patient Refined Diagnosis Related Group
CDC	Centers for Disease Control & Prevention
CAUTI	Catheter-associated urinary tract infection
CCDE	Core Clinical Data Elements (for digital hybrid measures)
CDIF	Clostridium Difficile Infection
CLABSI	Central Line-Associated Bloodstream Infection
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-Related Group
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
ED-1 Measure	ED Time of Arrival to Departure for Admitted Patients
ED-2 Measure	Time of Order to Admit until Time of Admission ED Patients
EDDIE	Emergency Department Dramatic Improvement Effort
FFY	Federal Fiscal Year
HCAHPS Systems	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commission
LOS	Length of Stay
MIEMSS	Maryland Institute for Emergency Medical Services Systems
MRSA	Methicillin-Resistant Staphylococcus Aureus
NHSN	National Health Safety Network
PQI	Prevention Quality Indicators
PY	Performance Year
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year (Coincides with State Fiscal Year July-Jun; signifies the timeframe in which the rewards and/or penalties would be assessed)
SIR	Standardized Infection Ratio
SSI	Surgical Site Infection
TFU	Timely Follow Up after Acute Exacerbation of a Chronic Condition
THA/TKA	Total Hip/Knee Arthroplasty Risk Standardized Complication Rate
HVBP	Hospital Value-Based Purchasing

DRAFT RECOMMENDATIONS

This document puts forth the RY 2029 Quality-Based Reimbursement (QBR) draft policy recommendations for consideration. The policy is minimally changed from the RY 2028 final policy that prioritized alignment of the state QBR program with HVBP that will be applicable for patients of all other payers (i.e., non-Medicare FFS). The Performance Measurement Workgroup (PMWG), Commissioners, and other stakeholders continue to provide valuable input on these recommendations and longer-term priorities that should be considered as Maryland transitions to the AHEAD Model.

Draft Recommendations for RY 2029 QBR Program:

1. Maintain 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 revenue adjustment scale from 0 to 80 percent with a preset 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.
3. 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. Add a bonus incentive of \$150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.
4. Transition the ED and Hospital Throughput Policy to a Learning Collaborative designed to engage stakeholders to identify best practices to address emergency department and hospital throughput, care transitions, and capacity alignment across the care continuum.

1. 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 (2019-2025) and the current AHEAD model (CY 2026-CY 2035). Under the new AHEAD model the State is transitioning 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 or Multi-Payer global budgets). Under the Medicare FFS hospital global budgets, hospitals will be held accountable for quality under the CMS quality programs starting with FFY 2030 revenue adjustments and through additional AHEAD incentives focused on avoidable utilization, while the State will administer quality programs for all other payers. HSCRC staff is collaborating with CMML, hospitals, the Maryland Hospital Association (MHA), State leaders, other State health agencies, and the broad array of stakeholders on the Performance Measurement Workgroup on the transition plan that increases the alignment between the State's performance based payment programs and the CMS national programs under 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 Quality-Based Reimbursement (QBR) 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 QBR program is analogous to the CMS Hospital Value-Based Purchasing (HVBP) program. Both the QBR and HVBP programs hold 2 percent of inpatient hospital revenue at-risk for performance by hospitals on measures of patient experience, clinical care, and safety. The HVBP program also holds

hospitals accountable for efficiency by including the Medicare Spending per Beneficiary (MSPB) domain, while the HSCRC addresses efficiency through the overall hospital global budgeting methodology combined with the hospital Integrated Efficiency policy.

Consistent with the requirement under the previous TCOC Model, Maryland must request a waiver each year from CMS hospital pay-for-performance programs, including the HVBP Program, in Performance years 1-3 (RYs 2027-2029) of the AHEAD Model.. CMS assesses and grants these waivers based on a report showing that Maryland's programs are similar and results continue to meet or surpass those of the nation. Throughout the TCOC Model, the State was granted exemptions from the national quality programs but CMS has noted Maryland's lagging performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and Maryland's need to focus on areas such as the Medicaid population, ED throughput, and non-hospital settings of care. In order to maintain the waiver from the CMS quality programs, the QBR policy has been adapted over the years to address these areas of concern.

Transitioning to the AHEAD Model

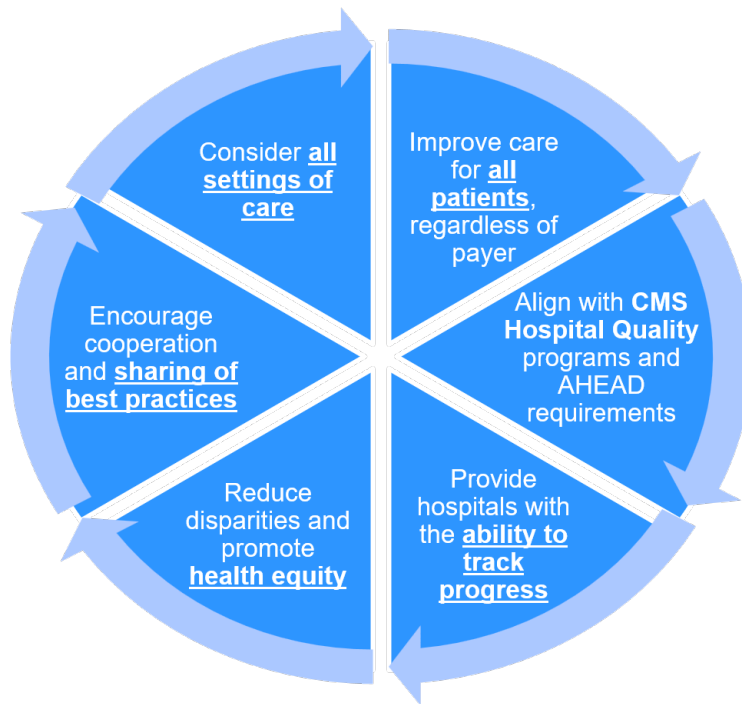
The AHEAD model began in January 2026; however, the first two years of the model will be a transition period with the new CMS hospital global budgets for Medicare FFS beginning in CY 2028 with HVBP quality adjustments applied in FFY 2030. Below is the staff's current understanding of the quality program expectations for the transition period and beyond.

For RYs 2028 and 2029, which assess CYs 2026 and 2027 performance respectively, staff is working to align the Maryland quality policies with the Medicare FFS quality programs. This work includes establishing timelines for changes to the current programs, implementing transition to national hospital quality programs for Medicare FFS, and updating priorities for quality, and linkages between hospital and statewide population health and quality targets. Specifically, alignment entails consideration of measures, measurement domains and weighting, performance standards, performance periods and revenue adjustment timelines. Alignment can entail an exact replication of the CMS quality programs or a broader alignment that harmonizes State program priorities and intents with those of the nation.

The draft policy proposes minimal changes this year (RY 2029) as staff prioritized additional alignment of the state QBR program with CMS Hospital Value-Based Purchasing (HVBP) last year (RY 2028). Since the start of the All-Payer Model (APM), the

State has used and adapted the following Guiding Principles for the State quality programs (Figure 1). The guiding principles include differentiators from CMS and areas of importance to MD that inform decisions on program design. For example, “Encourage Cooperation and Sharing of Best Practices” is why programs do not relatively rank hospitals in the State.

Figure 1. HSCRC Quality Programs Guiding Principles



In addition to these guiding principles, the following criteria have been adopted for alignment::

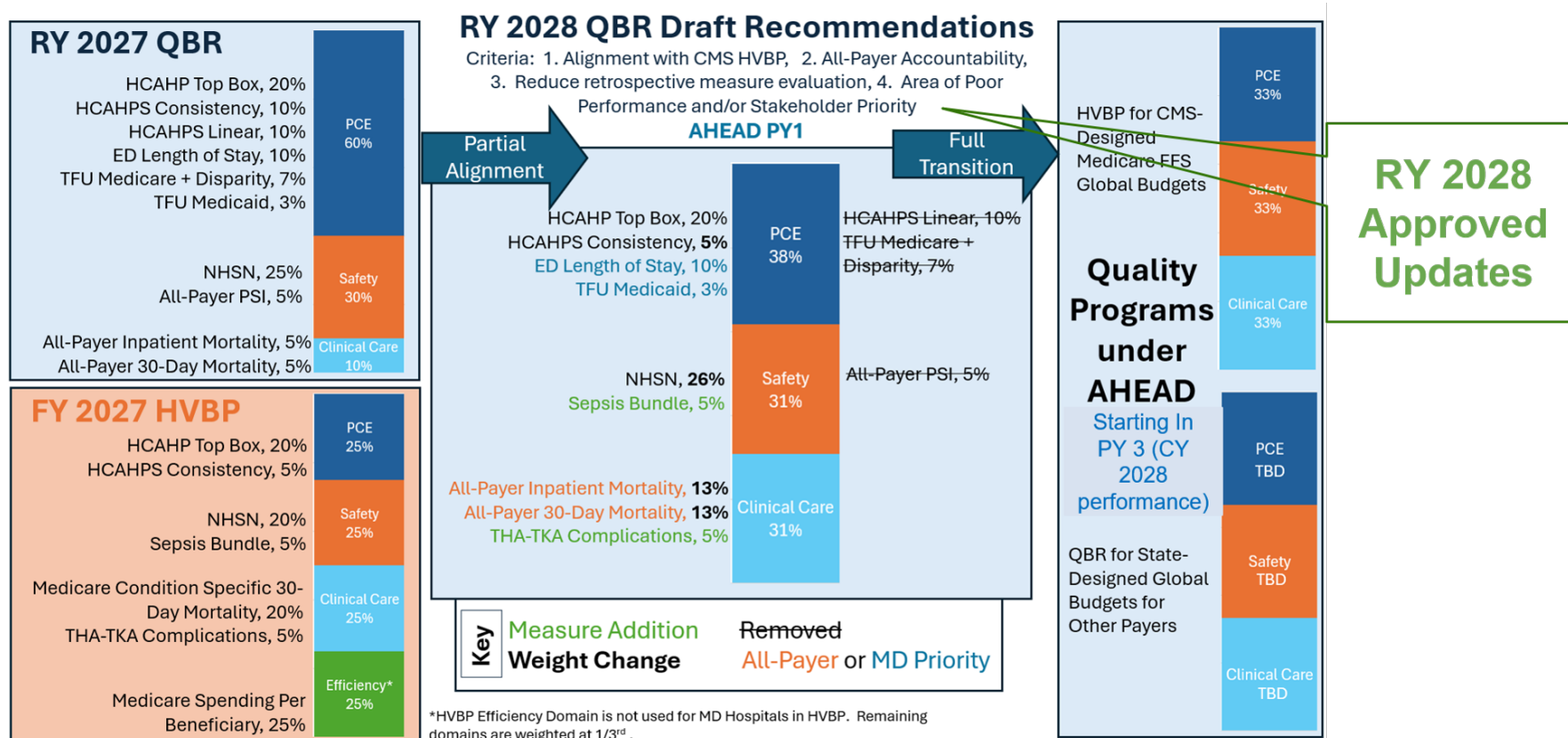
1. Alignment with CMS programs
2. Maintenance of all-payer accountability and incentives for quality
3. Reduction of retrospective measure evaluations to the extent possible
4. Attention to areas of poor performance and/or priority area for State, hospitals, payers, or other stakeholders

Staff has and will continue to vet details of this transition across all of the RY 2029 quality policies with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies, and the Clinical Adverse Events Measures (CAEM) subgroup convened April through August this year to review measures

of complications and mortality to assess what measures should be used under AHEAD and better align the quality programs under AHEAD Model.

Figure 2 provides a summary of the HVBP and QBR programs and the recommendations for RY 2028 and beyond. Specifically, the RY 2027 QBR and HVBP programs are shown on the left side of the figure. The middle of the figure shows the proposed and ultimately approved policy changes for RY 2028 that staff is recommending continue for RY 2029 QBR, including changes to domain weights, as well as measures added, maintained, or deleted to better align QBR with the HVBP program. These decisions were based on the criteria outlined above and at the top of the figure. The far right hand side of the figure shows that Maryland hospitals will be assessed under QBR for non-Medicare FFS and the HVBP program for Medicare FFS starting in the 3rd performance year (PY) under the AHEAD model.

Figure 2. QBR-HVBP Domains and Measures with RY 2028 Approved Updates to Align with CMS Under the AHEAD Model



2. BACKGROUND

Overview of the QBR Program

The QBR Program, implemented in 2010, includes potential scaled penalties or rewards of up to 2 percent of inpatient revenue. The program assesses hospital performance against national standards for measures included in the CMS HVBP program and Maryland-specific standards for other measures unique to our all-payer system. Figure 3 presents RY 2028 QBR measures and domain weights compared to those used in the HVBP Program.

Figure 3. RY 2028 QBR and Domain Weights Compared to the CMS HVBP Program

Domain	Maryland RY 2028 QBR Domain Weights and Measures	CMS FFY 2028-2029 HVBP Domain Weights and Measures
Clinical Care	31 percent Two measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality; THA/TKA complications	25 percent Six measures: Five condition-specific mortality measures; THA/TKA complications
Person and Community Engagement	38 percent 1. Six HCAHPS measures top-box score and consistency 2. TFU (Medicare, Medicaid, disparities improvement); 3. ED LOS	25 percent Six HCAHPS measures top-box score and consistency
Safety	31 percent Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; Sepsis Bundle measure	25 percent Six measures: Five CDC NHSN HAI measure categories; Sepsis Bundle measure
Efficiency	N/A	25 percent One measure: Medicare spending per beneficiary*

*Currently this measure is not calculated for MD hospitals by CMS. Instead the domains are each weighted as 1/3rd in the estimated HVBP scores provided by CMS for MD hospitals.

The QBR Program assesses hospital performance by comparing each measure to national or state performance standards. For all measures, except the ED LOS measure¹,

¹ The ED LOS performance standards are still being finalized for CY 2025/RY 2027 performance but staff is proposing that improvement performance standards remain the same as CY 2025/RY 2026 but that a risk-adjusted measure be implemented and attainment be considered.

the performance standards range from the 50th percentile of hospital performance (threshold) to the mean of the top decile (benchmark). Each measure is assigned a score of zero to ten points, then the points are summed and divided by the total number of available points, and weighted by the domain weight. A total score of 0 percent means that performance on all measures is below the performance threshold and has not improved, whereas a total score of 100 percent means performance on all measures is at or better than the mean of the top decile (about the 95th percentile). This scoring method is the same as that used for the HVBP Program. Unlike the HVBP Program, however, which ranks all hospitals relative to one another after the performance period and assesses rewards and penalties to hospitals in a revenue neutral manner retrospectively based on the distribution of final scores, the QBR Program uses a preset scale to determine each hospital's revenue adjustment and is not revenue neutral. This gives Maryland hospitals predictability and an incentive to work together to achieve high quality of care, instead of competing with one another for better rank.

The preset revenue adjustment scale for QBR program ranges from 0 to 80 percent and the cut-point at which a hospital earns rewards or receives a penalty is based on an analysis of the HVBP Program scores and how hospitals nationally would perform in the Maryland QBR program. While we have tried to prospectively set the revenue adjustment scale, this became more difficult during and after the COVID Public Health Emergency. Thus, from RY 2024 onward, the cut-point is estimated prospectively and then reassessed retrospectively with more recent national data. While this is inconsistent with the guiding principle to provide hospitals with a way to monitor revenue adjustments during the performance year, it protects Maryland hospitals from excessive penalties.

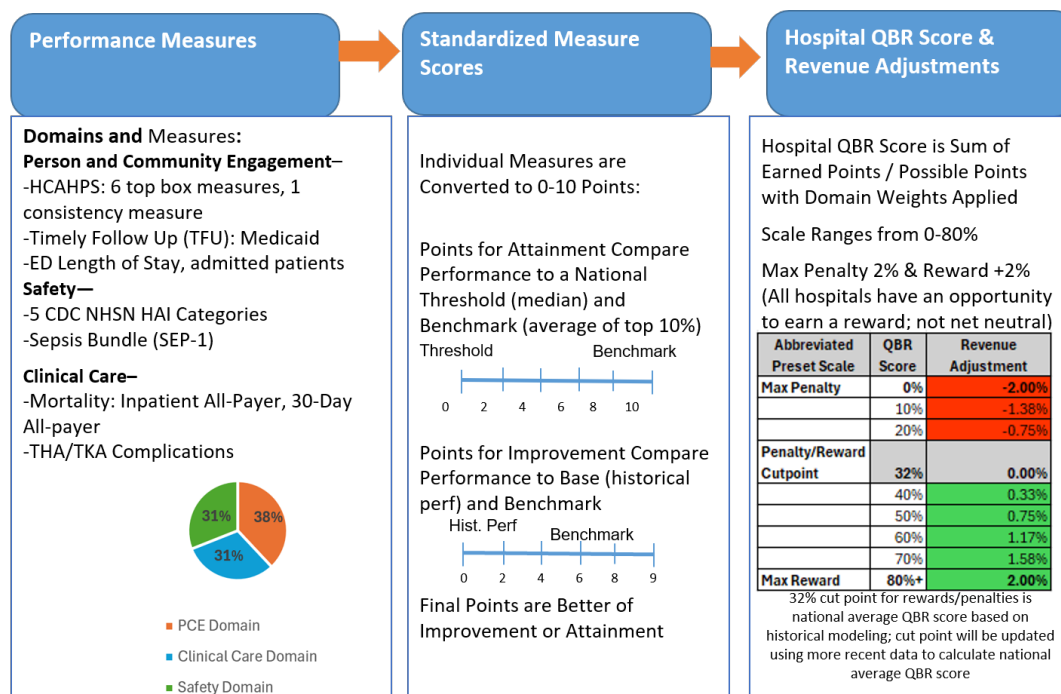
As a recap, the method for calculating hospital QBR scores and associated inpatient revenue adjustments involves:

1. Assessing performance on each measure in the domain.
2. Standardizing measure scores relative to performance standards.
3. Calculating the total points a hospital earned divided by the total possible points for each domain.
4. Finalizing the total hospital QBR score (0 to 100 percent) by weighting the domains, based on the overall percentage or importance the HSCRC placed on each domain.
5. Converting the total hospital QBR scores into revenue adjustments using the preset revenue adjustment scale (range of 0 to 80 percent). This preset scale

may be retrospectively adjusted after analysis of the data relative to more current National data but is shown here for illustrative purposes.

This method and program steps for determining hospital scores and revenue adjustments for RY 2028 are summarized in Figure 4.

Figure 4. RY 2028 QBR Policy Methodology Overview



Note: Care Compare (data.cms.gov) is the data source for all measures except ED LOS, TFU Medicaid, IP Mortality and 30-Day Mortality, which are calculated using the HSCRC case-mix dataset and/or payer claims.

Appendix A contains more background and technical details about the QBR Program.

3. ASSESSMENT

The purpose of this section is to present an assessment of Maryland's performance on measures used in the QBR Program compared to the nation where possible. This draft policy provides measure inclusion recommendations to align QBR measures and domain weights, but also addresses State-specific concerns, in anticipation of the transition to the HVB Program for Medicare FFS.

Below we present each domain and the performance on measures within the domain. After each domain is reviewed, there is a section that summarizes HVB alignment and for measure inclusions for RY 2029. The domain and measure weights are then discussed at the end since they are interrelated decisions.

A. Person and Community Engagement Domain

The Person and Community Engagement domain weighted at 38 percent of the QBR score measures performance using the HCAHPS patient survey (top-box and consistency), timely follow-up (TFU) after discharge for an acute exacerbation of a chronic condition for Medicaid recipients, and an ED LOS measure for non-psychiatric patients admitted to the hospital. In comparison, the HVBP weights the PCE domain at 25 percent of the HVBP score and only includes HCAHPS top-box and consistency assessment.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Patient experience is a critical component of healthcare quality. Patients come to the hospital during an acute episode often feeling scared, stressed, and confused about what is occurring. The HCAHPS survey is a standardized, publicly reported survey that measures patient's perceptions of their hospital experience. Research shows that when patients report higher performance on HCAHPS questions, there are fewer safety events such as falls or pressure ulcers.² In keeping with the HVBP Program, the QBR Program scores hospitals on the percent of respondents who indicate the highest performance category (i.e., top-box scores) and HCAHPS consistency across across the following HCAHPS measures: (1) communication with nurses, (2) communication with doctors, (3) communication about medicine, (4) hospital cleanliness and quietness, (5) discharge information, and (6) overall hospital rating.³

Analysis results for Maryland versus the nation on "top-box" performance (Figure 3) for six HCAHPS measures is provided below.⁴ Staff notes that the composite care transition measure and responsiveness of hospital staff measure are being updated by CMS beginning in CY 2025 and therefore cannot be included in the HCAHPS scoring for CYs 2025 through 2027 (HVBP FY 2027 through FY 2029). Figure 5 below reveals that Maryland's performance continues to lag that of the nation for all areas with the exception

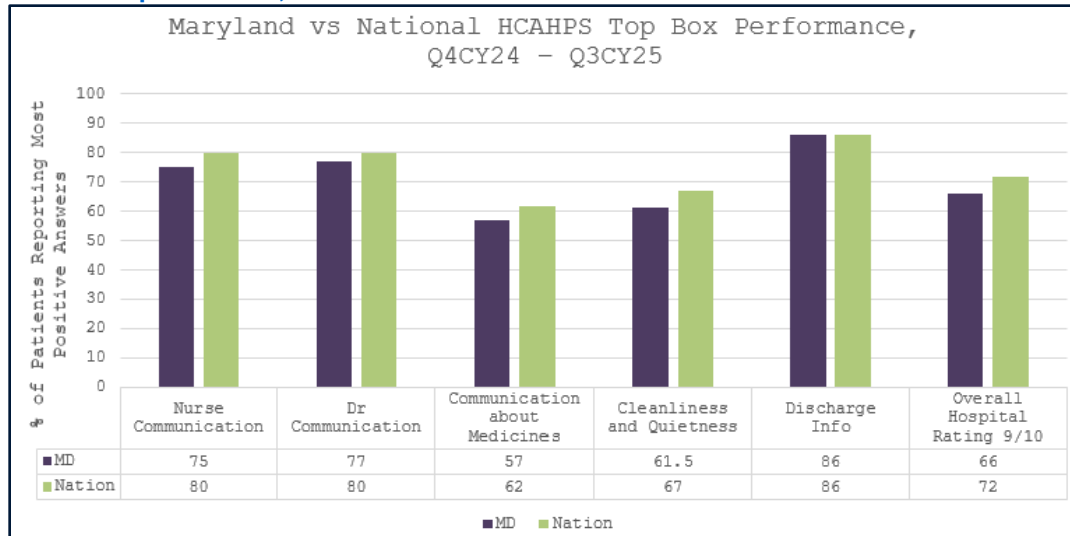
² Report by Press Ganey, March 12, 2025, found at: <https://www.pressganey.com/news/new-data-reveals-link-workforce-patient-safety-aha#:~:text=Chicago.quality%20care%20to%20every%20patient;last%20access%20November%2016%202025>; last access November 16, 2025.

³ For more information on the HVBP Program's performance standards and top-box and consistency scoring, please see <https://qualitynet.cms.gov/inpatient/hvbp/performance>.

⁴ Staff notes that the composite care transition measure and responsiveness of hospital staff measure included in the prior HCAHPS results are being updated by CMS beginning in CY 2025 and therefore cannot be included in the HCAHPS scoring for CYs 2025 through 2027 (VBP FFY 2027 through FFY 2029).

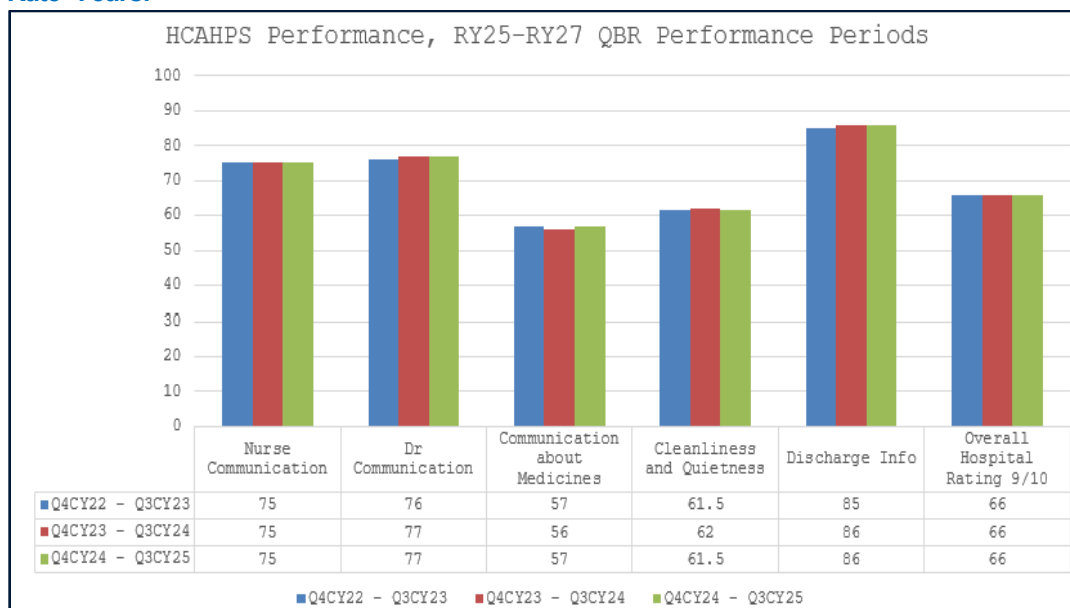
of Discharge Information on which Maryland performs on par.

Figure 5. Top-box HCAHPS Results: Maryland Compared to the Nation, October 1, 2024 to September 30, 2025



Regarding Maryland HCAHPS performance changes over the last three rate years (RYs25-27), Figure 6 below illustrates that Maryland has improved by one percentage point on Communication with Doctors and remained stagnant on the other five domains.

Figure 6. Maryland Performance Changes over the Most Current Three Available Rate Years.



Based on CMMI's concerns over HCAHPS performance, the HSCRC and MHA have been convening an HCAHPS Learning Collaborative with hospitals over the last two years. One of the key deliverables is a statewide HCAHPS dashboard built on patient level HCAHPS data collected by MHCC. The dashboard, initially released through the CRISP Reporting Services portal in December 2025, allows for interactive analyses with more timely data and the ability for hospitals to drill down and compare performance for subgroups, and to predict their final HCAHPS scores and related financial rewards or penalties using an estimated Patient Mix Adjustment for the hospital. MHCCs most recent analysis indicates that since the introduction of the web-based surveys in January 2025, the response rate has been higher on the HCAHPS survey. In addition, the analysis continues to show that medical patients report lower scores on overall rating than the surgical or maternity service lines. In addition, elements of the nurse and doctor communication domain show the highest correlation with overall rating. Specifically, if a patient gives a top-box response for nurse courtesy and respect, they have 7 times higher odds of giving a top-box score for their overall hospital rating. This is the type of finding that can be seen using the patient level data and discussed in the collaborative. The HCAHPS Learning Collaborative will continue to meet quarterly to encourage collaboration amongst hospitals in the State, share best practices and review data on HCAHPS and other quality measures including ED LOS.⁵

Emergency Department Length of Stay

ED length of stay (LOS)—i.e., wait times—has been a significant concern in Maryland, predating Maryland's adoption of hospital global budgets instituted in 2014,⁶ with multiple underlying causes and potential adverse outcomes in patient experience and quality. Historically, the HSCRC has taken several steps to address emergency department length of stay concerns, including the inclusion of an ED LOS measure in QBR; the development of an interactive ED LOS Dashboard accessible to hospital stakeholders on the CRISP portal; and the convening of a multi-discipline, multi-agency stakeholder subgroup focused on driving ED LOS improvement. This subgroup contributed to the development and implementation of an ED-Hospital Throughput Best Practice policy that is proposed to transition to a statewide learning collaborative. In 2024, the Maryland General Assembly

⁵ More information on the HCAHPS Learning Collaborative can be found here: <https://hscrc.maryland.gov/Pages/Patient-Experience-Learning-Collaborative.aspx>

⁶ Under alternative payment models, such as hospital global budgets or other hospital capitated models, some stakeholders have voiced concerns that there may be an incentive to reduce resources that lead to ED throughput issues.

established the ED Wait Time Reduction Commission to address this issue; the ED Commission is co-chaired and staffed by the HSCRC and has a mandate that requires broader health system innovation. The final ED Commission report is due to the legislature on November 1, 2026.

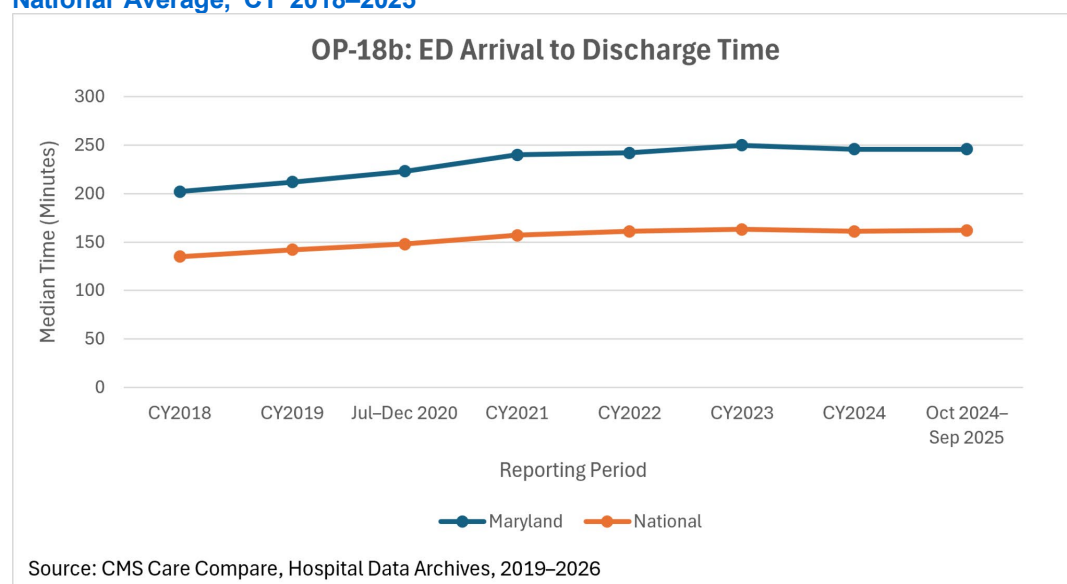
In March of 2025, as part of the HSCRC and ED Commission work, the HSCRC Commission approved a new ED and Hospital Throughput Best Practice Policy, which is designed to assess process measures associated with best practices that can improve patient throughput. With the implementation of this policy, healthcare stakeholders have identified numerous opportunities to improve throughput. However, the policy has been narrowly focused on specific interventions. In an effort to leverage the strong collaboration fostered by this subgroup, the HSCRC is proposing to transition this pay for reporting policy to a learning collaborative to share best practices in 2027. The purpose of the collaborative is to engage hospital leaders, as well as post-acute providers, state agencies, and other stakeholders, to identify best practices to address ED and hospital throughput, care transitions, and capacity alignment across the care continuum. This learning collaborative should consider ways to bring in the perspectives of front-line staff and other stakeholders and to identify minor delays in processes that can add up to more significant delays. Additionally, this collaborative will focus on continued development of initiatives and recommendations that address the key drivers of ED wait times prioritized by the ED Wait Time Reduction Commission. Furthermore, the collaborative should monitor data on ED LOS and related metrics on a regular basis and consider enhancements to the CRISP ED Dashboard. Given the inclusion of the ED LOS measure in the QBR program, staff are including a recommendation in the RY 2029 QBR policy to formally establish this collaborative.

National data on ED LOS have been limited. CMS has reported several ED throughput measures, including ED-1 (overall ED LOS for admitted patients), ED-2 (time from admission decision to hospital admission), OP-18 (time from ED arrival to discharge for patients discharged from the ED) and OP-22 (percentage of ED patients who left without being seen). However, ED-1 and ED-2 were discontinued in 2019 and 2020 respectively, leaving OP-18 as the primary CMS measure currently available for assessing ED LOS. CMS measures are also based on sampled patient records rather than all ED encounters.⁷

⁷ Centers for Medicare & Medicaid Services (CMS), *Hospital Inpatient Quality Reporting Program* and *Hospital Outpatient Quality Reporting Program*, Emergency Department Throughput Measures.

Available CMS data indicate that Maryland has consistently had longer ED LOS than the national average. For OP-18b,⁸ which measures time from ED arrival to discharge, Maryland remained above the national average throughout the available reporting periods (Figure 4). From October 2024–September 2025 (most recently available CMS data), Maryland’s ED LOS for discharged patients was 246 minutes, compared with 162 minutes nationally.⁹ Although not shown, CMS data on ED LOS for admitted patients, discontinued in 2019, similarly shows that Maryland had much longer ED LOS than the nation.

Figure 7. ED Arrival to Discharge Time (OP-18b)¹⁰, Maryland Compared with the National Average, CY 2018–2025



Starting in RY 2026, the HSCRC approved inclusion of an ED LOS measure in the QBR policy. Given the limitations and lack of consistent national ED LOS data, HSCRC developed its own ED LOS reporting process in conjunction with hospital stakeholders in CY 2024. The process requires hospitals to submit patient-level date and time stamps for all ED encounters. These data allow ED LOS to be calculated for QBR, which looks at ED

⁸ OP-18b excludes psychiatric/mental health patients and patients transferred to another facility. Centers for Medicare & Medicaid Services (CMS), *Hospital Data Dictionary*, Emergency Department Throughput Measures.

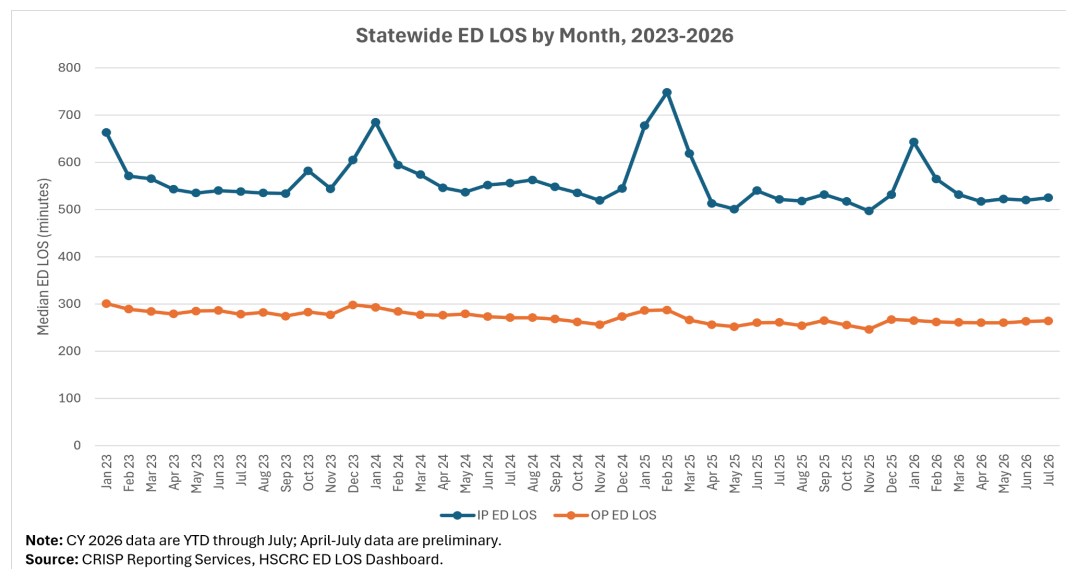
⁹ Centers for Medicare & Medicaid Services (CMS), *Care Compare, Timely and Effective Care - Emergency Department Throughput*, reporting period October 1, 2024–September 30, 2025.

¹⁰ This measures the median time from ED arrival to ED departure for discharged patients, excluding psychiatric/mental health and transferred patients.

LOS for non-psychiatric patients who are admitted to the hospital, as well for all ED encounters and provide more timely monitoring of IP and outpatient (OP) ED LOS.¹¹

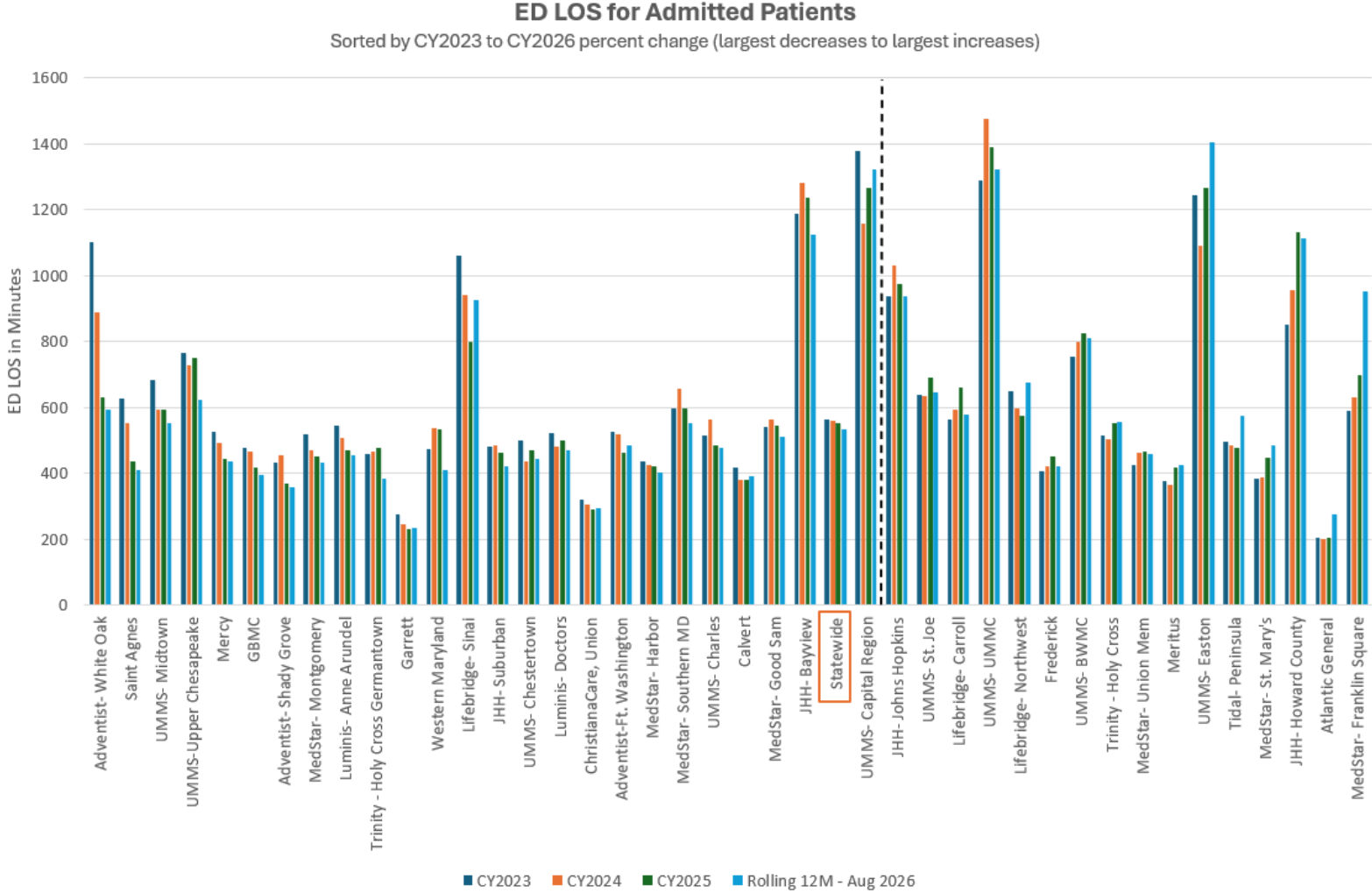
HSCRC data show that statewide IP ED LOS decreased from 562 minutes in 2023 to 551 minutes in 2025, with some seasonal fluctuations, while OP ED LOS decreased from 285 minutes in 2023 to 262 minutes in 2025 (Figure 8). While the statewide changes are modest, hospital-level performance varied considerably, particularly for the IP ED LOS measure used in the HSCRC QBR payment program (Figure 9a). Between 2023 and 2026 (rolling 12-months through August), 25 of 41 hospitals experienced reductions in IP ED LOS, with improvements ranging from 27 to 508 minutes; one hospital had no change, and 15 hospitals experienced increases. While the largest improvements were seen among hospitals with high ED LOS in 2023, more than 50% of hospitals that improved had an ED LOS in 2023 that was less than the statewide median. For OP ED LOS from 2023 through 2025, 36 of 49 hospitals experienced reductions, with improvements ranging from 1 to 106 minutes; 2 had no change, and 11 had increases (Figure 9b).

Figure 8. Statewide Emergency Department Length of Stay by Month, CY 2023–CY 2026 YTD



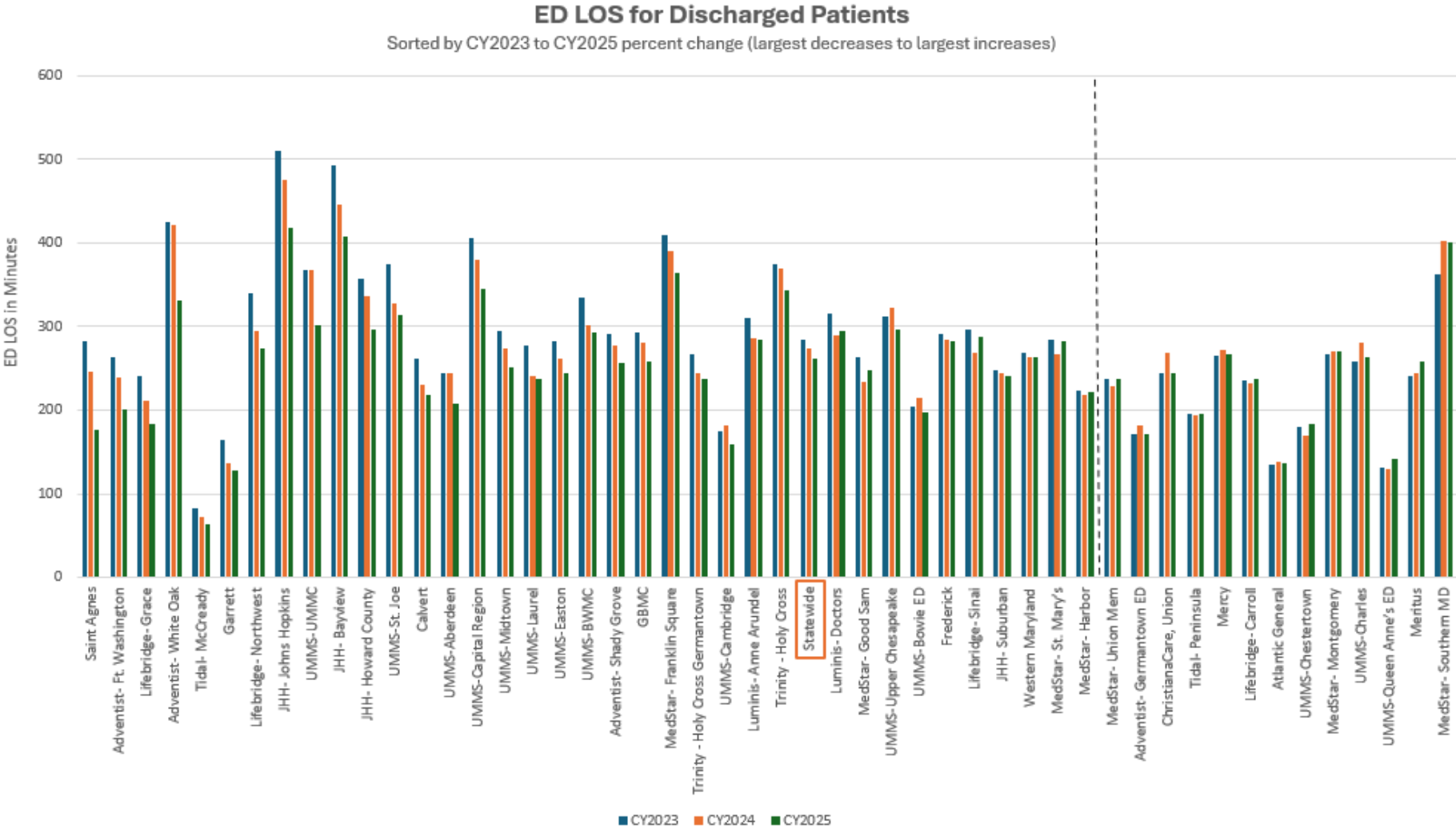
¹¹ Maryland Health Services Cost Review Commission (HSCRC), *Emergency Department Length of Stay Dashboard*, CRISP Reporting Services.

Figure 9a. Emergency Department Length of Stay by Hospital, CY 2023–CY 2026



Source: Staff Analysis of Case-Mix data with date and time stamps

Figure 9b. Emergency Department Length of Stay by Hospital, CY 2023–CY 2025



Source: Staff Analysis of Case-Mix data with date and time stamp

Below is a description of the ED LOS measure and performance standards that have been in place since RY 2026. Staff recommend continuing the same measure and improvement goal for RY 2029.

Measure: Percent change in the median time from ED arrival to physical departure from the ED for patients admitted to the hospital.

Population: All non-psychiatric, non-trauma, adult ED patients who are admitted to Inpatient bed and discharged from hospital during reporting period.

Scoring: Use attainment calculation for percent change to convert improvement into a 0 to 10 point score:

- Hospitals with CY2025 Median that is lower (better) than statewide median have threshold of 0 percent and benchmark of -5 percent.
- Hospitals with CY2025 Median that is higher (worse) than statewide median have a threshold of 0 and a benchmark of -10.

Hospitals performing better than the 2019 national median in 2027 will receive the full 10 points.

It is important to note that CMS is planning to retire the OP-18 ED LOS measure and OP-22 Left without Being Seen measure in CY 2028. Instead, CMS has developed a new electronic clinical quality measure (eCQM) on ED Access and Timeliness that can be submitted by hospitals in CY 2027 on a voluntary basis and CY 2028 it will be mandatory. This measure includes all ED visits in the denominator and assesses gaps in ED care as defined by whether any of the following occurred:

1. The patient waited longer than 60 minutes to be placed in a treatment area, or
2. The patient left the ED without being evaluated, or
3. The patient with an order to admit boarded in the ED longer than 240 minutes, or
4. The patient had an ED LOS longer than 480 minutes.

As part of the state's eCQM data collection, which is discussed below, this measure could be considered long term for monitoring and future inclusion in a payment program to adjust global budgets for non-Medicare FFS. However, at this time HSCRC staff is recommending to continue the current ED LOS measure in payment given the importance of incentivizing improvement in this area.

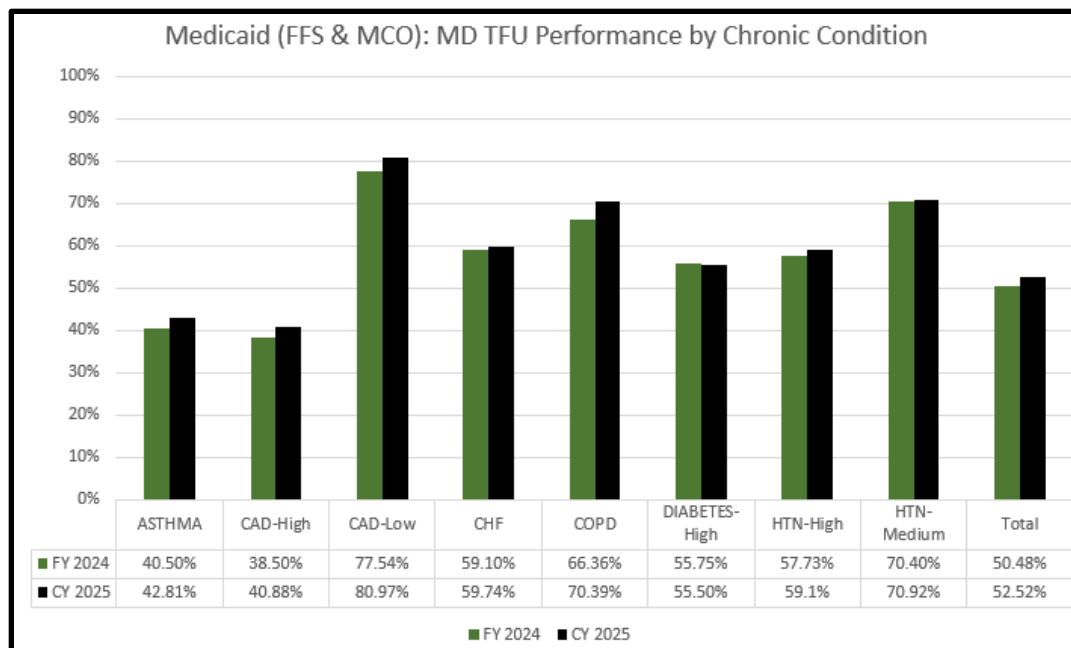
Timely Follow-Up After Discharge

Under the TCOC model, the State was required by CMMI to develop a Statewide Integrated Health Improvement Strategy (SIHIS) that addressed care transformation. In RY 2023, HSCRC introduced within the PCE domain an NQF-endorsed timely follow up measure for Medicare beneficiaries into the QBR Program that assesses the percentage of ED visits, observation stays, and inpatient admissions for six conditions in which a follow-up was received within the time frame recommended by clinical practice for each condition stratified by acuity level for certain conditions; the measure was expanded to Medicaid recipients in RY 2025, and a Medicare within-hospital disparity gap measure was added in RY 2026.¹² The Medicare TFU and disparity gap measures were removed from the RY 2028 QBR Program to better align with the CMS HVBP Program, but TFU for Medicaid was retained because of relatively low rates of follow up. The Medicaid TFU measure is weighted at 3 percent of the total QBR score.

HSCRC introduced the Medicaid TFU measure into the QBR program as a distinct measure from Medicare due to the large differences in performance. Figure 10 shows Maryland's performance over time for each chronic condition and all conditions combined for Medicaid patients. Compared to FY 2024, Medicaid TFU has gone up for all conditions in CY 2025 with the exception of High Acuity Diabetes that declined very slightly by 0.25 percentage points. Overall, Medicaid timely follow up for all conditions improved by greater than 2.0 percent.

¹²The SIHIS goal was to achieve a 75 percent TFU rate for Medicare FFS beneficiaries across the six specified conditions and respective time frames.

Figure 10. Maryland Medicaid Timely Follow-Up by Condition



B. Safety Domain

The QBR Safety domain contains five measures from six CDC NHSN HAI categories and the and the policy added the Sepsis and Septic Shock Management Bundle (SEP-1) measure in RY 2028 to align with HVBP. Staff recommends that these measures be retained for FY 2029.

CDC NHSN HAI Measures

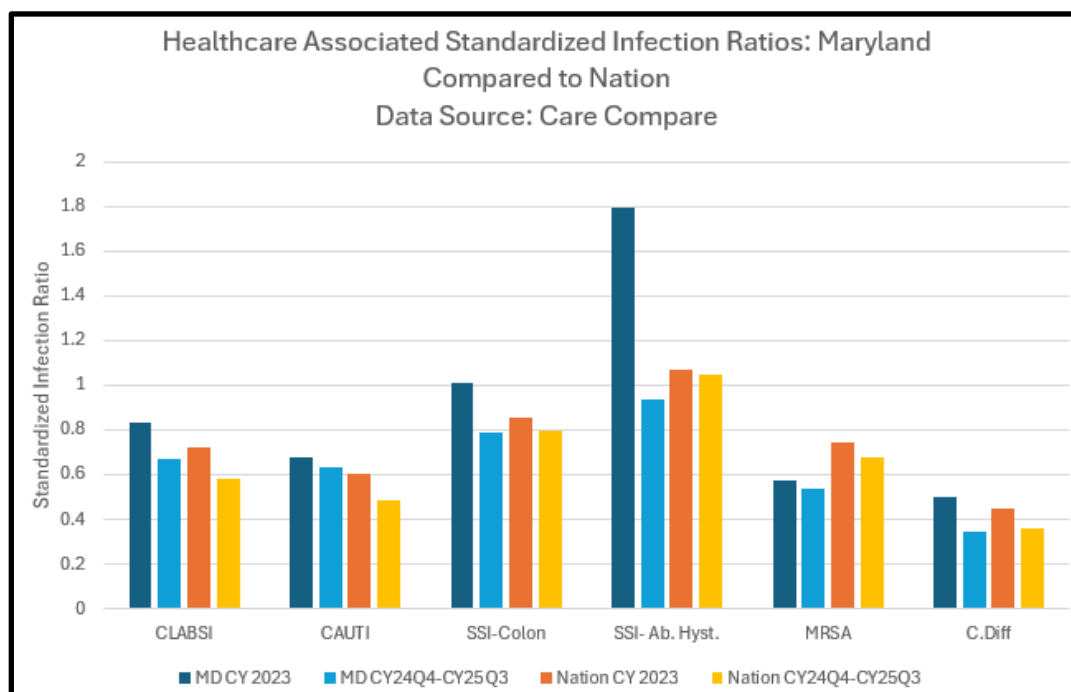
The CDCs National Healthcare Safety Network (NHSN) tracks healthcare-associated infections, such as central-line associated bloodstream infections and catheter-associated urinary tract infections. Care Compare has updated the Centers for Disease Control (CDC) National Health Safety Network Healthcare Associated Infection (HAI) Standardized Infection Ratio (SIR) data tables for the nation and by state through September 2025. Figure 11 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 published on Hospital Compare:

- Maryland and the nation have both improved on all measures from the base period to the performance period.

- Maryland performs better than the nation in the performance period on CDIF, MRSA and SSI-Hyst.
- The nation performs better than Maryland on CLABSI and CAUTI in the performance period.
- Maryland performs on par with the nation on SSI-Colon in the performance period.

Figure 11. NHSN SIR Values for CY23 compared to 10/1/24-9/30/25, Maryland versus the Nation



The QBR program weights the NHSN measures similarly to HVBP. While the measures have also been included in the CMS HACRP program, they have not been included in the MHAC Program. Concerns including small cell size issues and surveillance bias (i.e., higher testing for infections results in higher rates of identified infections) have been raised about these measures. As described in Appendix B, many of the NHSN measure result changes over time or large differences compared to the nation, are not statistically significant which is not assessed in the HVBP and QBR payment programs. Staff will include further discussion of these concerns and whether the NHSN measures should be included as part of the MHAC program in the upcoming RY 2029 MHAC draft policy slated for November Commission meeting. The CAEM subgroup reviewed these measures and concurred with many of the measures' concerns, but some stakeholders supported

inclusion of the measures for the sake of alignment with the CMS hospital quality program measures.

It is also important to note that the NHSN HAI measures have been recently updated to use 2022 data for the baseline used to calculate risk-adjusted rates. For RY 2028 and RY 2029, staff do not have access to the rebased NHSN measures for the base period that are used for HVBP (current base period data on Care Compare, which is where the HSCRC obtains the QBR data for national measures is using the 2015 base). In order to measure hospitals using the 2022 rebased data for the base and performance periods, will require obtaining HVBP data directly from CMS/CMMI. Alternatively, HSCRC may obtain hospital level data to use for the QBR program for the base and performance periods from MHCC through their access to the NHSN system. However, getting the HVBP data feed is preferable since similar measure updates have occurred for the THA-TKA complications measure and the direct feed would allow us to use the exact performance period used for other measures such as HCAHPS. Currently the state uses data for HCAHPS that is one quarter earlier than what is used in the HVBP program due to the lags in when the data is publicly reported on Care Compare.

Sepsis Early Management Bundle (Sep-1)

Approximately 1.7 million adults in the U.S. and 30,000 Marylanders develop sepsis each year accounting for 350,000 deaths in the U.S. and 1,100 in Maryland annually.^{13 14} It is the leading cause of hospitalization and mortality, with one in three people who die in the hospital having sepsis during their stay. Given this clinical significance, Medicare adopted the Sepsis Bundle measure into the HVBP program in FY 2026 despite concerns about this specific measure being raised by multiple professional societies and sepsis advocacy groups. Concerns with this measure include the bundle's potential to promote overuse of antibiotics and questionable link between the bundle and mortality.¹⁵ Thus, in the RY 2026 QBR policy, the Commission approved the staff and stakeholder recommendation to *not* adopt the Sepsis Bundle measure despite Maryland performing well on the measure. In part, this decision was also because the Maryland quality payment

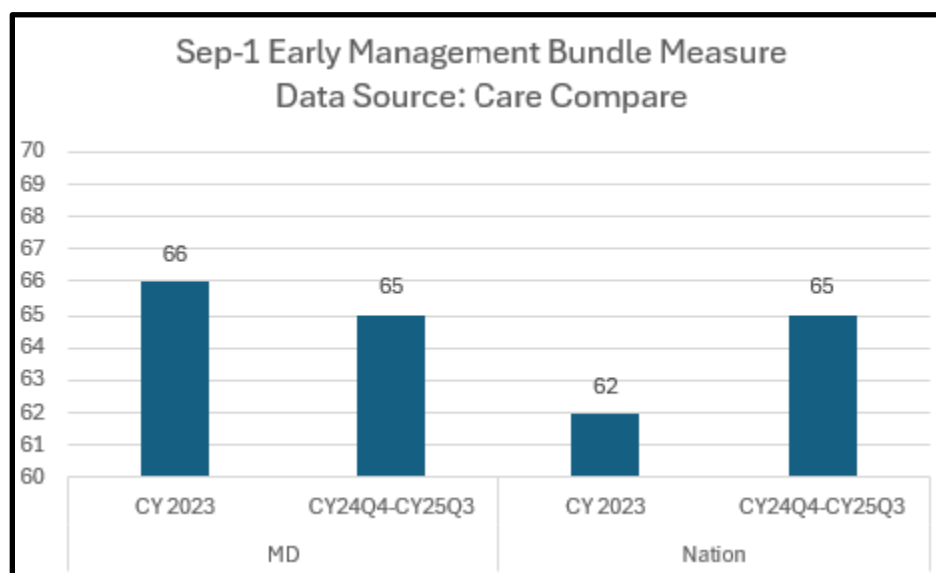
¹³ Found at: <https://www.cdc.gov/sepsis/about/index.html>. last accessed 8/6/2025.

¹⁴ Found at: <https://health.maryland.gov/newsroom/Pages/Sepsis-Awareness-Month-Highlights-Leading-Cause-Of-Deaths-In-US-Hospitals.aspx>. last accessed 8/6/2025.

¹⁵ Found at: <https://www.endsepsis.org/2023/08/17/end-sepsis-sep-1-response/>. Last accessed 11/26/2025.

programs include the sepsis PSI, PPC, and sepsis mortality. Instead of adding the Sepsis Bundle to QBR, HSCRC staff recommended development and dissemination of a hospital Sepsis Dashboard for monitoring in lieu of adopting the measure. In CY 2023, Maryland performed 4 percentage points better than the nation, however the most recent data indicates that Maryland now performs the same as the Nation. The Commission voted to add the Sepsis Bundle measure in the Safety domain in RY 2028 to align with the HVBP Program, and staff recommend that it continue to be included in RY 2029.

Figure 15. Maryland vs. the Nation, Sep-1 Measure July 2023-June 2024 Compared to CY 2022



C. Clinical Care Domain

This domain, weighted at 31 percent of the RY 2028 QBR score, currently includes:

- Inpatient, all-payer, all-condition mortality measure
- 30-Day all-payer, all-condition mortality measure
- THA/TKA Complications

Of note, Maryland's QBR mortality measures currently differ from the HVBP Program that uses five condition-specific, 30-day mortality measures for Medicare beneficiaries. Stakeholders continue to discuss the lack of alignment between QBR and HVBP for mortality. Some stakeholders have expressed a preference for the QBR inpatient measure over the 30 day measure, because the inpatient measure is more within the control of hospitals. However, the 30-day measure is more aligned with the CMS

conceptual framework for measuring mortality. Furthermore, the inpatient measure may be slightly biased against hospitals with longer lengths of stay since the length of the hospitalization impacts risk of death in the hospital. While there is strong correlation overall on how hospitals score on the mortality measures, there are some hospitals with disparate results on each of the measures. Currently, staff recommend continuing both measures with equal weighting but anticipate stakeholder input on this.

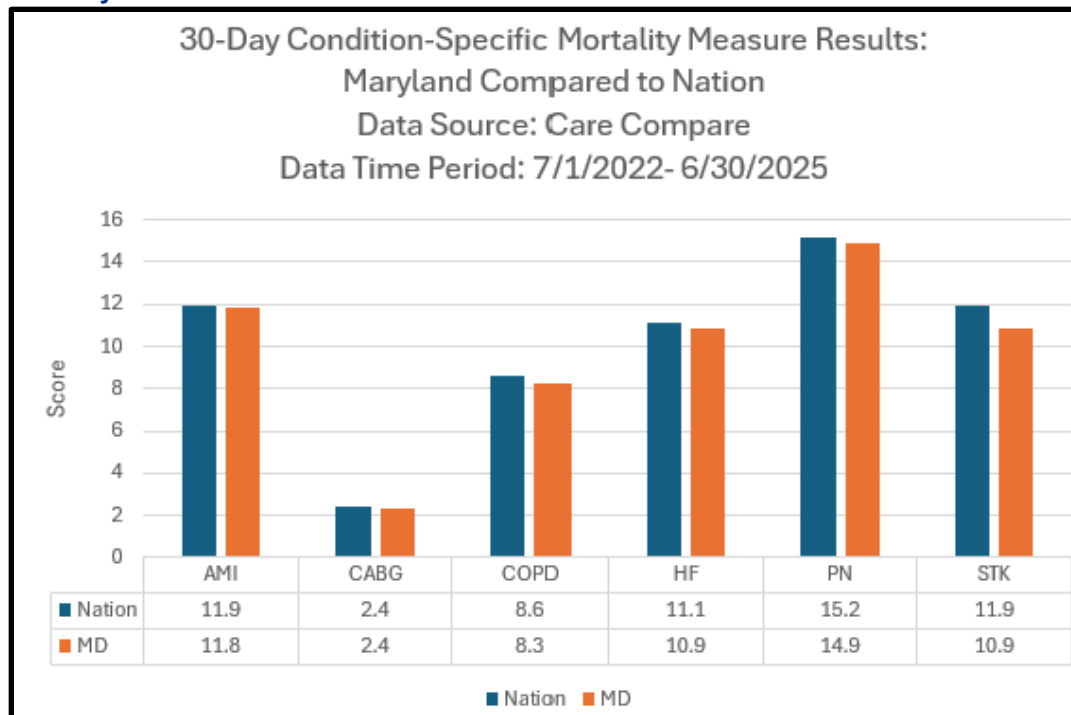
For the Medicare Total Hip Arthroplasty-Total Knee Arthroplasty (THA/TKA) Complications measure, stakeholders have raised concerns about the measure related to the relatively low proportion of inpatient procedures performed versus the high proportion on an outpatient basis in Maryland. Furthermore, in RY 2027 about 37 percent of hospitals, including both large academic hospitals, did not meet the minimum inclusion criteria of performing 25 inpatient procedures during the two year performance period. Despite this concern, in RY 2028 the Commission voted to re-adopt this measure to align with HVBP and staff recommend its continued inclusion in RY 2029. However, the THA-TKA measure has been updated and the current data on Care Compare and the data used by HVBP differ. This is similar to the data concerns for the NHSN HAI measures discussed previously, except that there is no option to obtain this data like there is for NHSN HAIs. Thus, in order to include the measure in the QBR program, staff emphasizes the State's need to obtain the HVBP data from CMS/CMMI for RY 2028 and RY 2029. Lacking the data, staff supports removing the measure from the QBR program retrospectively for RY 2028 and not including the measure in RY 2029-RY 2032.

Mortality Performance

CMS 30-Day Condition-Specific Mortality Measures

On the CMS 30-day condition-specific mortality measures used in the HVBP Program, Maryland performs slightly better (lower) for AMI, COPD, HV, PN and STK, and the same as the nation on CABG (Figure 17).

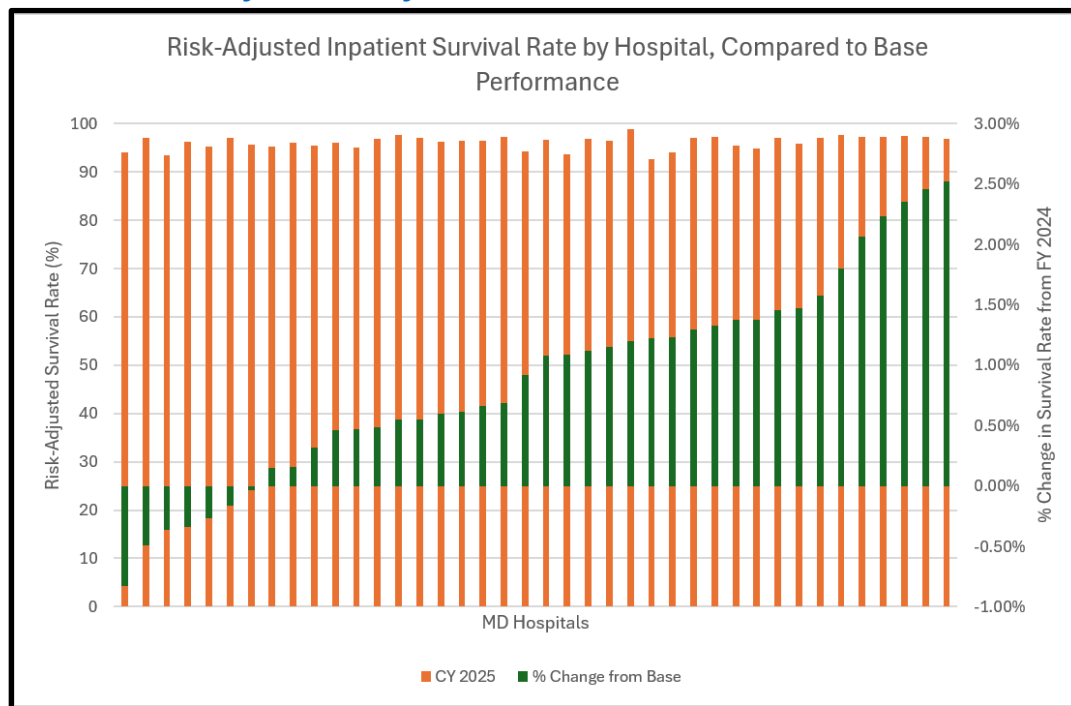
Figure 17. Maryland vs. National Hospital Performance on CMS Condition-Specific Mortality Measures



QBR Inpatient, All-payer, All-condition Mortality Measure

For the QBR all-payer inpatient mortality measure, which assesses diagnoses where 80 percent of the mortalities occur (the DRGs with the top 80% of deaths), the statewide risk-adjusted survival rate increased from 95.43 percent in the FY 2024 base period to 96.15 percent in the CY 2025 performance period. As illustrated in Figure 18 below, the majority of hospitals have improved in CY 2025 compared to FY 2024 on the Inpatient Mortality measure (with 7 out of 40 hospitals having worsened slightly) .

Figure 18. Maryland Hospital Performance, FY 2024 vs CY 2025 QBR Inpatient All Condition, All Payer Mortality Measure

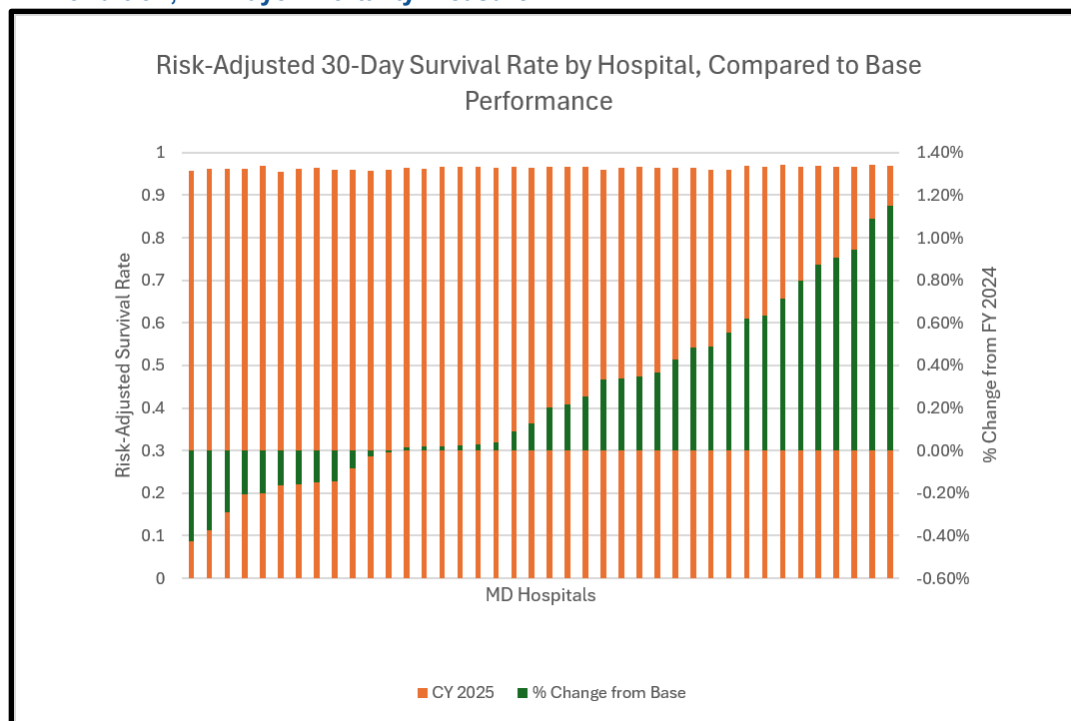


Note: The graph displays hospital performance in the green bars and hospital improvement from the FY 2024 base in orange bars. For example, the hospital on the far right had a survival rate of over 96% in CY 2025 and saw an increase in their survival rate of over 2.5% when compared to their performance in FY 2024.

30-Day Inpatient, All-payer, All-condition Mortality Measure

HSCRC began reporting the 30-day, all-payer, all-condition, all-cause mortality measure to hospitals through the CRISP portal in CY 2023. The measure was developed by Mathematica based on the CMS 30-day Medicare, all-cause mortality measure and adapted for use of all-payer, APR DRG patient-level data. Staff believes that expansion to a 30-day measure in the QBR Program better captures and incentivizes the quality of care delivered by a hospital, expanding beyond the walls of the hospital. In CY 2025, as shown in Figure 19 below, survival rates range from ~96 percent to ~97 percent with 28 hospitals improving and 12 hospitals declining compared to FY 2024; the statewide average survival rate for the measure improved by 0.25 percent in 2025.

Figure 19. Maryland Hospital Performance, FY 2024 vs CY 2025 30-Day, All Cause All Condition, All Payer Mortality Measure

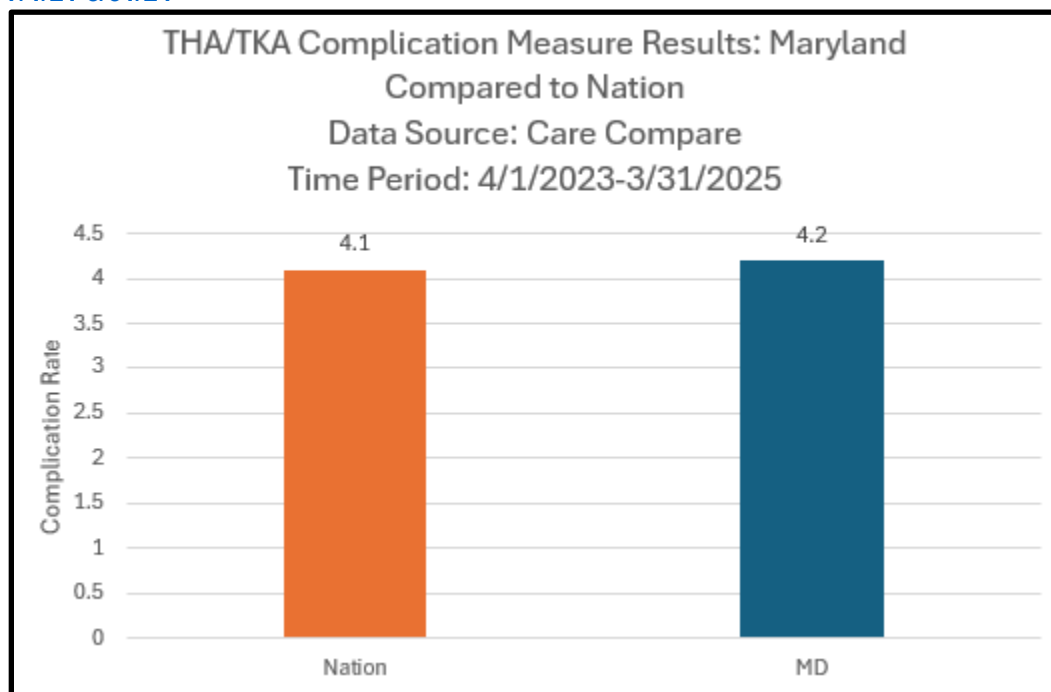


provides additional information on the digital measures data collection requirements for CY 2027.

Hip and Knee Arthroplasty Complications Performance

Based on the most current data available on CMS Care Compare, April 2023 through March 2024, Maryland hospital performance is slightly worse than the nation for the THA/TKA measure (Figure 20).

Figure 20. Maryland THA/TKA Measure Performance Compared to the Nation, 7/1/21-3/31/24



D. Domain and Measure Weighting

For the RY 2028 QBR Program, staff analyzed different options for domain and measure weighting. The approved policy reweighted the domains and measures to be more aligned with the HVBP program, which for Maryland weights each domain at 1/3rd of the HVBP score. Specifically, the PCE domain was decreased from 60 percent to 38 percent of the QBR score, slightly higher than 1/3rd to accommodate the additional Maryland specific measures (ED LOS and Medicaid timely follow up). Figure 21 provides the domain and measure weighting. The ED LOS and Medicaid TFU measures are weighted at 10 and 3 percent of the total QBR score, respectively. For RY 2029, staff recommends maintaining the RY 2028 domain and measure weighting.

Figure 21. RY 2028 QBR Domain and Measure Weights and Corresponding Inpatient Revenue at Risk

Domains and Measures	% of QBR Score	% of IP Revenue at Risk
PCE Domain	38%	0.76%
HCAHPS Top Box Scores	20%	0.40%
HCAHPS Consistency	5%	0.10%
ED Length of Stay	10%	0.20%
TFU Medicaid (Medicaid Claims)	3%	0.06%
Clinical Care Domain	31%	0.62%
Inpatient Mortality (HSCRC Case Mix)	13%	0.26%
30-Day All-payer Mortality (HSCRC Case Mix and Maryland Vital Statistics Death Records)	13%	0.26%
THA/TKA Complications	5%	0.10%
Safety Domain	31%	0.62%
CAUTI	5.2%	0.104%
C. Diff	5.2%	0.104%
SSI, Hysterectomy and Colon	5.2%	0.104%
CLABSI	5.2%	0.104%
MRSA	5.2%	0.104%
Severe Sepsis and Septic Shock: Management Bundle	5%	0.10%
Total QBR	100%	2.00%
<i>Note: IP revenue-at-risk percentages are calculated based on the QBR Program's maximum 2 percent inpatient revenue at risk.</i>		

E. Revenue Adjustment Methodology

The QBR program holds 2 percent of all-payer, inpatient revenue at-risk in rewards and penalties. The 2 percent at-risk is the same as the revenue at-risk for HVBP, although it

applies to all-payer revenue and not just to Medicare FFS revenue as required under the Maryland model. The revenue adjustments for QBR are calculated using a preset scale so that hospitals can prospectively estimate and concurrently track financial performance in quality programs. This significantly differs from the HVBP program that relatively ranks all hospitals and then penalizes the bottom half and rewards the top half. However, given the guiding principle to share best practices, the State has historically not relatively ranked hospitals. Instead, we use a preset scale that ranges from 0 percent to 80 percent, and the staff set the cut-point for penalties and rewards using the methodology described below. Figure 22 shows an abbreviated scale using the RY 2028 prospective cutpoint of 32 percent. The cut point should be set in a way that does not overly reward or penalize Maryland hospitals for performance compared to the nation. However, establishing this cut-point prospectively has become more difficult post-COVID. Thus, since RY 2024, staff have recommended reassessing the cut-point retrospectively with more recent national data and staff recommend continuing to prospectively estimate the cut point and then conducting the retrospective assessment. The RY 2028 policy provided estimates of the revenue adjustments for different scenarios based on the updated domain weighting and measures. Staff is not proposing any changes to the domain weights or measures for RY 2029. Based on stakeholder input on the policy, staff may add revenue adjustment estimates for different scenarios or as requested by Commissioners.

Figure 22. RY 2028 Abbreviated QBR Revenue Adjustment Scale

Abbreviated Preset Scale	QBR Score	Financial Adjustment
Max Penalty	0%	-2.00%
	5%	-1.69%
	10%	-1.38%
	15%	-1.06%
	20%	-0.75%
	25%	-0.44%
	30%	-0.13%
Penalty/Reward Cutpoint	32%	0.00%
	35%	0.13%
	40%	0.33%
	45%	0.54%
	50%	0.75%
	55%	0.96%
	60%	1.17%
	65%	1.38%
	70%	1.58%
	75%	1.79%
Max Reward	80%+	2.00%

Methodology for Determining QBR Scaling Cut-Point

The current methodology for determining the cut-point, which is the point on the scale where penalties end and rewards start, is to estimate QBR scores for all hospitals nationally and calculate the mean score to use as cutpoint. This calculation uses HCAHPS and NHSN data for hospitals nationally and the state median for MD specific measures, and then applies the QBR measure weights. This methodology may need to be re-evaluated for RY 2028 and RY 2029 due to the NHSN and THA-TKA data updates discussed previously.

QBR vs. HVBP Revenue Adjustments

Staff is currently finalizing the RY 2027 QBR adjustments that go into effect on January 1, 2027. Staff will provide the actual RY 2027 QBR revenue adjustments in the final policy with the adjusted cut-point based on methodology described above. However, given the substantial changes to align the QBR policy with HVBP, the RY 2027 revenue adjustments are not reflective of potential revenue adjustments in RY 2029. In the final policy, staff will

use the RY 2027 performance data to estimate what the RY 2029 revenue adjustments would be reflecting the changes implemented in RY 2028. Staff is also requesting that CMMI provide the FY 2027 HVBP results and will provide a comparison if those results are available.

4. DRAFT RECOMMENDATIONS FOR RY 2029 QBR PROGRAM

Draft Recommendations for RY 2029 QBR Program:

5. Maintain 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.
6. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and set the revenue adjustment scale from 0 to 80 percent with a preset 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.
7. 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. Add a bonus incentive of \$150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.
8. Transition the ED and Hospital Throughput Policy to a Learning Collaborative designed to engage stakeholders to identify best practices to address emergency department and hospital throughput, care transitions, and capacity alignment across the care continuum.

APPENDIX A: QBR PROGRAM BACKGROUND

Maryland's QBR Program, in place since July 2009, uses measures that are similar to those in the federal HVB Program, under which all other states have operated since October 2012. Similar to the HVB Program, the QBR Program currently measures performance in Clinical Care, Safety, and Person and Community Engagement (PCE) domains, which comprise 31 percent, 31 percent, and 38 percent of a hospital's total QBR score, respectively. For the Safety and Person and Community Engagement domains, which constitute the largest share of a hospital's overall QBR score (85 percent), performance standards are the same as those established in the HVB Program. The Clinical Care Domain, in contrast, uses a Maryland-specific mortality measure and benchmarks. In effect, Maryland's QBR Program, despite not having a prescribed national goal, reflects Maryland's rankings relative to the Nation by using HVB benchmarks for the majority of the overall QBR score.

In addition to structuring two of the three domains of the QBR Program to correspond to the HVB Program, the HSCRC has increasingly emphasized performance relative to the Nation through benchmarking, domain weighting, and scaling decisions. For example, beginning in RY 2015, the QBR Program began using national benchmarks to assess performance for the Person and Community Engagement and Safety domains. Subsequently, the RY 2017 QBR policy increased the weighting of the Person and Community Engagement domain, which was measured by the national HCAHPS survey instrument to 50 percent. The weighting was increased to raise incentives for HCAHPS improvement, as Maryland has consistently lagged behind the Nation on these measures. In RY 2020, ED-1b and ED-2b wait time measures for admitted patients were added to this domain, with the domain weight remaining at 50 percent. In RY 2021, the domain weight remained constant, but the ED-1b measure was removed from the program. For RY 2022, ED-2b was removed from QBR because CMS no longer required submission of the measure for the Inpatient Quality Reporting Program.

The QBR domain weights remained constant from RY2023 to RY2025 at 50 percent for PCE, 15 percent for Clinical Care, and 35 percent for Safety; modifications were approved at 60 percent for PCE, 10 percent for Clinical Care and 30 percent for Safety for RY 2026 and maintained in RY 2027. Although the QBR Program has many similarities to the HVB Program, it does differ because Maryland's unique model agreements and autonomous position allow the state to be innovative and progressive. Figure A.1. below

compares the CMS FY 2028 HVBP Program with QBR RY 2028 measurement domains and weights updated to better align with the CMS HVBP program.

Figure A1. RY2028 QBR measures and domain weights compared with those used in the CMS HVBP Program

Domains and Measures	QBR Domain and Measure Weights	CMS HVBP Domain Weights
PCE Domain	38%	25%
HCAHPS Top Box Scores	20%	✓
HCAHPS Consistency	5%	✓
ED Length of Stay	10%	N/A
TFU Medicaid (Medicaid Claims)	3%	N/A
Clinical Care Domain	31%	25%
Inpatient Mortality (HSCRC Case Mix)	13%	N/A
30-Day All-payer Mortality (HSCRC Case Mix and Maryland Vital Statistics Death Records)	13%	N/A
THA/TKA Complications	5%	✓
30-Day Medicare Condition-specific Mortality (Medicare Claims)	N/A	✓
Safety Domain	31%	25%
CAUTI (Chart abstracted CMS Care Compare)	5.2%	✓
C. Diff (Chart abstracted CMS Care Compare)	5.2%	✓
SSI, Hysterectomy and Colon (Chart abstracted CMS Care Compare)	5.2%	✓
CLABSI (Chart abstracted CMS Care Compare)	5.2%	✓
MRSA(Chart abstracted CMS Care Compare)	5.2%	✓
Severe Sepsis and Septic Shock: Management Bundle (Chart abstracted, CMS Care Compare)	5%	✓
Medicare Spending Per Beneficiary	N/A	25%

Note: Details of HVBP measures can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html>.

The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019. It involves (1) assessing performance on each measure in the domain; (2) standardizing measure scores relative to performance standards; (3) calculating the total points a hospital earned divided by the total possible points for each domain; (4) finalizing the total hospital QBR score (0–100 percent) by weighting the domains based on the overall percentage or importance the HSCRC has placed on each domain; and (5) converting the total hospital QBR scores into revenue adjustments, using a preset scale ranging from 0 to 80 percent.

QBR program revenue at risk

The HSCRC sets aside a percentage of hospital inpatient revenue to be held “at risk” based on each hospital’s QBR Program performance. Hospital performance scores are translated into rewards and penalties in a process called scaling.¹⁶ Rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital’s update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered permanent revenue. The HSCRC previously approved scaling a maximum reward of 2 percent and a penalty of 2 percent of the total approved base revenue for inpatients across all hospitals.

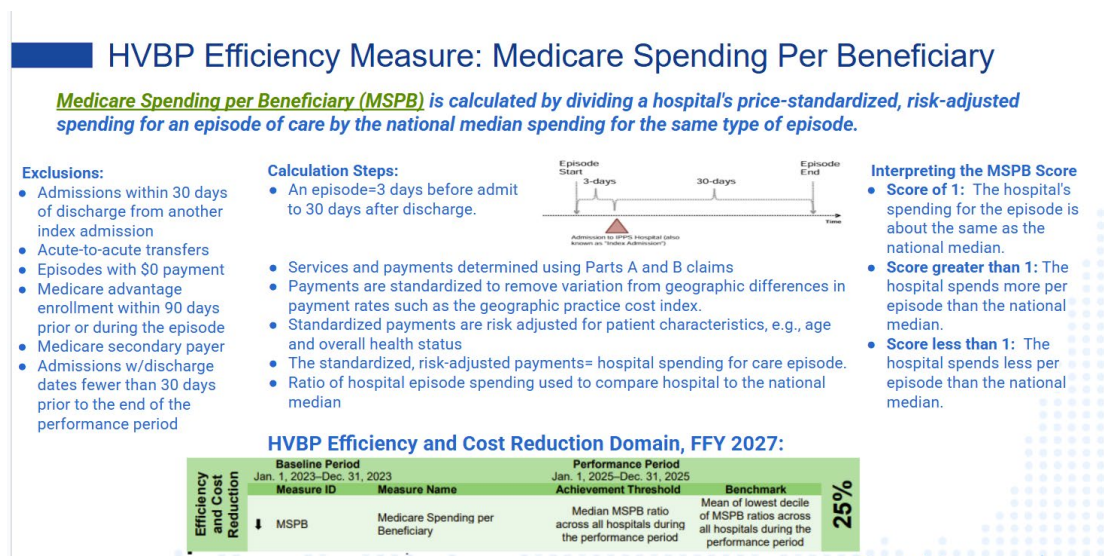
HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the HVBP Program, where feasible,¹⁷ enabling the HSCRC to use data submitted directly to CMS. Maryland implemented an efficiency measure outside of the QBR Program, based on an Integrated Efficiency policy, which includes adjustments to rates based on cost per case efficiency, total cost of care performance, and changes in potentially avoidable utilization (PAU). Under the AHEAD Model, HSCRC staff will continue to work with key stakeholders to develop updates to efficiency measure(s) under the state global budgets applicable to payers other than Medicare FFS that incorporate population-based cost outcomes.

¹⁶ Scaling refers to the differential allocation of a predetermined portion of base-regulated hospital inpatient revenue based on an assessment of hospital performance.

¹⁷ HVBP measure specifications can be found at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

As noted above in the Assessment Section, in contrast to the QBR program, CMS uses a Medicare Spending per Beneficiary measure in the HVBP program. Figure B.2. measure definition, exclusions, calculation steps, and interpretation of scores.

Figure B.2. HVBP MSPB Measure



QBR score calculation

QBR scores are evaluated by comparing a hospital's performance rate to its base period rate, as well as to the threshold (which is the median, or 50th percentile, of all hospitals' performance during the baseline period) and the benchmark (which is the mean of the top decile, or roughly the 95th percentile, during the baseline period).

Attainment points: During the performance period, attainment points are awarded by comparing a hospital's rates with the threshold and the benchmark. With the exception of the Maryland mortality measure and ED wait time measures, the benchmarks and thresholds are the same as those used by CMS for the HVBP Program measures.¹⁸ For each measure, a hospital that has a rate at or above the benchmark receives 10 attainment points. A hospital that has a rate below the attainment threshold receives 0 attainment points. A hospital that has a rate at or above the attainment threshold and below the benchmark receives 1–9 attainment points.

¹⁸ One exception is the ED wait time measures. For these measures, attainment points are not calculated; instead, the full 10 points are awarded to hospitals at or below (more efficient) than the national medians for their respective volume categories in the performance period.

Improvement points: Improvement points are awarded by comparing a hospital's rates during the performance period to the hospital's rates from the baseline period. A hospital that has a rate at or above the attainment benchmark receives 9 improvement points. A hospital that has a rate at or below the baseline period rate receives 0 improvement points. A hospital that has a rate between the baseline period rate and the attainment benchmark receives 0–9 improvement points.

Consistency points: Consistency points are awarded only in the HCAHPS measure in the Experience of Care domain. The purpose of these points is to reward hospitals that have scores above the national 50th percentile in all eight HCAHPS dimensions. If they do, they receive the full 20 points. If they do not, the dimension for which the hospital received the lowest score is compared to the range between the national 0 percentile (floor) and the 50th percentile (threshold) and is awarded points proportionately.

Domain denominator adjustments: In certain instances, QBR measures will be excluded from the QBR Program for individual hospitals. Hospitals are exempt from measurement for any of the NHSN Safety measures for which there is less than one predicted case in the performance period. If a hospital is exempt from an NHSN measure, its Safety domain score denominator is reduced from 50 to 40 possible points. If it is exempt from two measures, the Safety domain score denominator would be 30 possible points. Hospitals must have at least two of five Safety measures to be included in the Safety domain.

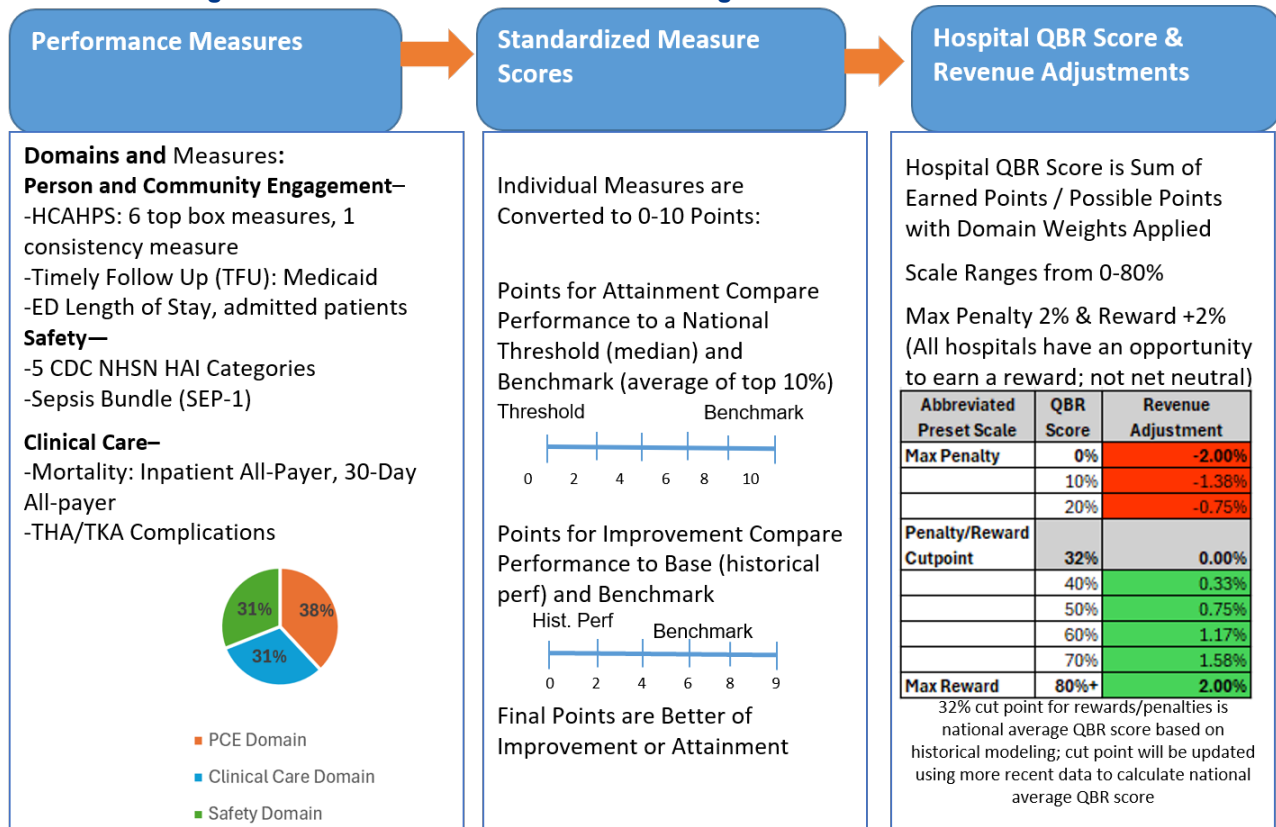
Domain scores: The better of the attainment score and improvement score for each measure is used to determine the measure points for each measure. The measure points are then summed and divided by the total possible points in each domain and multiplied by 100.

Total performance score: The total performance score is computed by multiplying the domain scores by their specified weights and then adding those totals together. The total performance score is then translated into a reward or penalty that is applied to hospital revenue.

RY 2023-RY 2027 Updates to the QBR Program

Since RY 2023, the HSCRC has not made fundamental changes to the QBR Program's methodology but implemented the addition of the Follow-Up After Acute Exacerbation of Chronic Conditions measure and PSI-90 composite measures. In RY 2025, Timely Follow Up (TFU) for Medicaid was added. Figure B.3. shows the steps for converting measure scores to standardized scores for each measure, and then to rewards and penalties based on total scores earned, reflecting the updates through RY 2028.

Figure B.3. RY 2028 Process for Calculating QBR Scores



Note: Care Compare (data.cms.gov) is the data source for all measures except ED LOS, TFU Medicaid, IP Mortality and 30-Day Mortality, which are calculated using the HSCRC case-mix dataset and/or payer claims.

Figure B.4. below details the baseline and performance timelines for the measures in the QBR program for RY 2027.

Figure B.4.QBR RY 2028 timeline: base and performance periods; financial impact

Rate Year (Maryland Fiscal Year)	Q3- 23	Q4- 23	Q1- 24	Q2- 24	Q3- 24	Q4- 24	Q1- 25	Q2- 25	Q3- 25	Q4- 25	Q1- 26	Q2- 26	Q3- 26	Q4- 26	Q1- 27	Q2- 27	Q3- 27	Q4- 27	Q1- 28	Q2- 28	Q3- 28	Q4- 28	
Calendar Year	Q1- 23	Q2- 23	Q3- 23	Q4- 23	Q1- 24	Q2- 24	Q3- 24	Q4- 24	Q1- 25	Q2- 25	Q3- 25	Q4- 25	Q1- 26	Q2- 26	Q3- 26	Q4- 26	Q1- 27	Q2- 27	Q3- 27	Q4- 27	Q1- 28	Q2- 28	
Quality Based Reimbursement Program (QBR)					Base Period: Hospital Compare (HCAHPS measures, All NHSN Measures, SEP-1 Bundle)							Performance Period: Hospital Compare (HCAHPS measures, All NHSN Measures, SEP-1 Bundle)							Rate Year Impacted by QBR Results				
							Base Period: QBR IP and 30-Day Mortality, Medicaid Timely Follow-Up						Performance Period: QBR IP and 30-Day Mortality, Medicaid Timely Follow-Up										
									Base Period: Emergency Department Length of Stay				Performance Period: Emergency Department Length of Stay										
		Performance Period: THA/TKA Complications*																					
*Base Period for THA/TKA Complications is CY 2018 Q2- CY 2021 Q1																							

PSI 90 measure (adopted beginning RY 2023)

Newly adopted in RY 2023, the Patient Safety Indicator composite measure was developed by the Agency for Healthcare Research and Quality in 2003.¹⁹ CMS first adopted the composite measure in the HVBP program in FFY 2015 and removed the measure in FY 2019-FY 2022 due to operational constraints from the International Classification of Diseases, Tenth Revision (ICD-10) transition. The HSCRC had used the ICD-9 version of this measure in the QBR program but applied it to Maryland's all-payer population. CMS adopted the updated NQF endorsed ICD-10 version of the measure (Medicare only) that is used beginning with the FY 2023 Hospital HVBP program²⁰, and also adopted by the QBR program (all-payer version) in RY 2023. The measure was removed from the RY 2028 QBR Program to align with the CMS HVBP program.

Follow-Up After Acute Exacerbation for Chronic Conditions (adopted for RY 2023)

Newly proposed for RY 2023, this measure was developed by IMPAQ on behalf of CMS.²¹ Technical details for calculating measure scores are provided below.

Measure full title: Timely Follow-Up After Acute Exacerbations of Chronic Conditions

Measure steward: IMPAQ International

Description of measure: The percentage of issuer-product-level acute events requiring an ED visit or hospitalization for one of the following six chronic conditions: hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes mellitus (Type I or Type II), where follow-up was received within the time frame recommended by clinical practice guidelines in a non-emergency outpatient setting.

Unit of analysis: Issuer-by-product

Numerator statement: The numerator is the sum of the issuer-product-level denominator events (ED visits, observation hospital stays, or inpatient hospital stays) for acute exacerbation of the following six conditions in which follow-up was received within the time frame recommended by clinical practice guidelines:

¹⁹ Source:

<https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2020/TechSpecs/PSI%2090%20Patient%20Safety%20and%20Adverse%20Events%20Composite.pdf>.

²⁰ For more information on the measure removal and adoption, reference the [FY 2018 IPPS/LTCH PPS final rule](#) (82 FR 38242-38244) and (82 FR 38251-38256).

²¹ Source: <https://impagint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions>

1. Hypertension: Within 7 days of the date of discharge
2. Asthma: Within 14 days of the date of discharge
3. HF: Within 14 days of the date of discharge
4. Coronary artery disease: Within 14 days of the date of discharge
5. Chronic obstructive pulmonary disease: Within 30 days of the date of discharge
6. Diabetes: Within 30 days of the date of discharge

Numerator details: This measure is defined at the issuer-by-product level, meaning that results are aggregated for each qualified insurance issuer and for each product. A product is defined as a discrete package of health insurance coverage benefits that issuers offer in the context of a particular network type, such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity. Issuers are broadly defined as health insurance providers who participate in the Federally Facilitated Marketplaces and health insurance contracts offered in the Medicare Advantage market.

Timely follow-up is defined as a claim for the same patient after the discharge date for the acute event that (1) is a non-emergency outpatient visit and (2) has a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code indicating a visit that constitutes appropriate follow-up, as defined by clinical guidelines and clinical coding experts. The follow-up visit may be an office or telehealth visit and takes place in certain chronic care or transitional care management settings. The visit must occur within the condition-specific time frame to be considered timely and for the conditions specified in the numerator. For a list of individual codes, please see the data dictionary.²²

The time frames for a follow-up visit for each of the six chronic conditions are based on evidence-based clinical practice guidelines, as laid out in the evidence form.

Denominator statement: The denominator is the sum of the acute events—that is, the issuer-product-level acute exacerbations that require an ED visit, observation stay, or inpatient stay—for any of the six conditions listed above (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes).

Denominator details: Acute events are defined as either an ED visit, observation stay, or inpatient stay. If a patient is discharged and another claim begins for the same condition on the same day or the following day, the claims are considered to be part of one continuous

²² Please see <https://impagint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions>.

acute event. In this case, the discharge date of the last claim is the beginning of the follow-up interval. The final claim of the acute event must be a discharge to community.

An acute event is assigned to [condition] if:

1. The primary diagnosis is a sufficient code for [condition]., OR
2. The primary diagnosis is a related code for [condition] AND at least one additional diagnosis is a sufficient code for [condition].
 - If the event has two or more conditions with a related code as the primary diagnosis and a sufficient code in additional diagnosis positions, **assign the event to the condition with a sufficient code appearing in the “highest” (closest to the primary) diagnosis position.**

If the visits that make up an acute event are assigned different conditions, the event is assigned the condition that occurs last in the sequence. Following this methodology, only one condition is recorded in the denominator per acute event.

Denominator exclusions: The measure excludes events with:

1. Subsequent acute events that occur two days after the prior discharge but still during the follow-up interval of the prior event for the same reason; to prevent double-counting, the denominator will include only the first acute event
2. Acute events after which the patient does not have continuous enrollment for 30 days in the same product
3. Acute events in which the discharge status of the last claim is not “to community” (“left against medical advice” is not a discharge to community)
4. Acute events for which the calendar year ends before the follow-up window ends (for example, acute asthma events ending less than 14 days before December 31)
5. Acute events in which the patient enters a skilled nursing facility, non-acute care, or hospice care during the follow-up interval

Measure scoring:

1. Denominator events are identified by hospitalization, observation, and ED events with appropriate codes (that is, codes identifying an acute exacerbation of one of the six included chronic conditions).
2. Exclusions are applied to the population from Step 1 to produce the eligible patient population (that is, the count of all qualifying events) for the measure.

3. For each qualifying event, the claims are examined to determine whether they include a subsequent code that satisfies the follow-up requirement for that event (for example, whether a diabetes event received follow-up within the appropriate time frame for diabetes, from an appropriate provider). Each event for which the follow-up requirement was satisfied is counted as one in the numerator. Each event for which the follow-up requirement was not satisfied is counted as zero in the numerator.
4. The percentage score is calculated as the numerator divided by the denominator.

Measure-scoring logic: Following the National Quality Forum's guideline, we use **opportunity-based weighting** to calculate the follow-up measure. This means each condition is weighted by the sum of acute exacerbations that require either an ED visit or an observation or inpatient stay for all of the six conditions that occur, as reflected in the logic below.

$$\frac{[\text{NUM}(\text{ASM}) + \text{NUM}(\text{CAD}) + \text{NUM}(\text{HF}) + \text{NUM}(\text{COPD}) + \text{NUM}(\text{DIAB}) + \text{NUM}(\text{HTN})]}{[\text{DENOM}(\text{ASM}) + \text{DENOM}(\text{CAD}) + \text{DENOM}(\text{HF}) + \text{DENOM}(\text{COPD}) + \text{DENOM}(\text{DIAB}) + \text{DENOM}(\text{HTN})]}$$

Although the development team designed the measure to aggregate each condition score in the manner described above into a single overall score, programs may choose to also calculate individual scores for each chronic condition when implementing the measure. Individual measure scores would be calculated by dividing the condition-specific numerator by the condition-specific denominator, as in the example for heart failure: $\text{NUM}(\text{HF}) / \text{DENOM}(\text{HF})$.

The follow-up measure scores are converted to QBR scores, as described in the QBR Score Calculation section above.

Updated TFU Measurement Specifications CY 2025

Staff notes that the TFU measure specifications were updated in 2024 and were approved by the CMS-designated Partnership for Quality Measurement. The updated specifications will be adopted for the RY 2027 QBR program and include modifications in the follow up times for some conditions as illustrated below.

1. Hypertension: Follow up within 14 days of the date of discharge for high-acuity patients or within 30 days for medium-acuity patients
2. Asthma: Follow up within 14 days of the date of discharge
3. Heart Failure: Follow up within 14 days of the date of discharge

4. Coronary Artery Disease: Follow up within 7 days of the date of discharge for high-acuity patients or within 6 weeks for low-acuity patients
5. Chronic Obstructive Pulmonary Disease: Follow up within 30 days of the date of discharge
6. Diabetes: Follow up within 14 days of the date of discharge for high-acuity patients

Mortality Reporting

Hospitals will be provided with summary level quarterly reports based on preliminary and final HSCRC case-mix data. In addition, case-level detailed files will be provided to each hospital. These summary and case level reports will be posted through the CRISP Reporting Services portal.

Specifications: Inpatient Mortality Rates using 3M, Health Information Systems Risk of Mortality Adjustment

As 3M Risk of Mortality (ROM) categories—which comprise four levels similar to severity of illness classifications used in the All Patient Refined Diagnosis Related Group (APR DRG) payment classification system—account for risk adjustment for deaths in the hospital, the ROM may provide an appropriate measure of hospital mortality with a broader focus. 3M APR DRGs and ROM are also used as the risk adjustment methodology for other mortality measures, such as those developed by the Agency for Healthcare Research and Quality.

Exclusions

The following categories are removed from the denominators and therefore not included in the mortality rate calculations (excluded from both mortality counts and denominator):

1. APR-DRGs that are NOT in the 80% of cumulative deaths after removing all the exclusions. DRGs are chosen without palliative care discharges and then discharges with palliative care for selected DRGs are added back. All DRGs in the measure that have the same number of observed deaths as the DRG at the 80 percent cut point are included.
2. APR-DRG ROM with a state-wide cell sizes below 20 after removing all the exclusions
3. Rehab hospitals (provider IDs that start with 213)
4. Hospitals without HCAHPS (RY 2021: Levindale, UMROI, McCready)

5. Transfers to other acute hospitals (PAT_DISP=discharge destination 02,05)
6. Age and sex unknown
7. Hospice (Daily service of 10, DAILYSER=10)
8. University of Maryland Shock Trauma Patients (daily service=02, and trauma days>0)
9. Left Against Medical Advice admissions: (PAT_DISP=07).
10. Trauma and Burn admissions: Admissions for multiple significant trauma (MDC=25) or extensive 3rd degree burn (APR DRG = 841 "Extensive 3rd degree burns with skin graft" or 843 "Extensive 3rd degree or full thickness burns w/o skin graft")
11. Error DRG: Admissions assigned to an error DRG 955 or 956
12. Other DRG: Admissions assigned to DRG 589 (Neonate BWT <500G or GA <24 weeks), 591 (NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE), 196 (cardiac arrest) due to high risk of mortality in these conditions
13. "APR DRG 004 (Tracheostomy w MV 96+ hours w extensive procedure or ECMO); starting in RY 2022, remove discharges with primary or secondary procedure code for ECMO (""5A1522F"", ""5A1522G"", ""5A1522H"", ""5A15223"")
14. Medical (non-surgical) Malignancy admissions: Medical admissions with a principal diagnosis of a major metastatic malignancy (see calculation sheet for list of medical malignancies)

Adjustments

The Maryland inpatient hospital mortality measure was developed in conjunction with the Performance Measurement workgroup and other stakeholders. Based on this stakeholder input mortality is assessed using a regression model that adjusts for the following variables:

1. Admission APR DRG with Risk of Mortality (ROM)
2. Age (as a continuous variable) and age squared
3. Gender
4. Palliative Care Status (ICD-10 code = Z51.5)
5. Transfers from another institution defined as source of admission codes (SOURCADM) of

04 = FROM (TRANSFER) A DIFFERENT HOSPITAL FACILITY
(INCLUDES TRANSFERS FROM ANOTHER ACUTE CARE
HOSPITAL (ANY UNIT), FREESTANDING EMERGENCY

DEPARTMENT, MIEMSS-DESIGNATED FACILITY). NOT LIMITED TO ONLY IP SERVICES.

Specifications: 30 Day Mortality Rates

Overview

The measure is a hospital-wide, 30-day risk adjusted mortality rate. It is adapted from a measure developed by a team from Yale University Medical School for use by CMS to measure hospital performance for Medicare cases. This HSCRC measure supplements the inpatient mortality measure currently in use as part of the QBR program. The measure has been adapted for use with the HSCRC's all payer data for the state of Maryland and with objectives of Maryland's quality-based performance programs.

Data sources

Data sources for the measure are used to identify index hospital stays and their characteristics, the mortality outcome, and patient characteristics that result in exclusions.

- HSCRC hospital data: Contains hospital stay records, dates, disposition, admission source, diagnoses and procedures
- CMS and Medicaid hospice data: identifies patients participating in hospice programs and dates of participation
- Maryland vital statistics data: identifies individuals' dates of death

These inputs are linked by the field CRISP EID (a unique identifier which can be linked to all three sources). In addition, the code takes as inputs the lists of ICD-10 diagnosis and procedure codes and crosswalks between these codes and Clinical Classifications Software (CCS) diagnostic and procedure categories (provided below).

Inclusion

Patients ages 95 and younger residing in Maryland and treated in Maryland hospitals who are discharged during the study period are included.

Exclusion

Stays are excluded based on hospice enrollment, All Patients Refined Diagnosis Related Groups (APR DRG) assignment, disposition and death information, principal diagnosis, and random selection for patients with multiple admissions.

- Hospice: patients enrolled before, during, or within 30 days after admission, discharged to hospice are excluded

- If DAILYSER = '10' (HOSPICE) then hospice1=1, where DAILYSER is the Daily Service value from CaseMix IP dataset
- If (DISCDATE < '01JUL2018'D and PAT_DISP in ("29", "53")) , or (DISCDATE >= '01JUL2018'D and PAT_DISP in ("50", "51")) then hospice2=1, where PAT_DISP is the Patient Discharge Disposition from CaseMix IP dataset
 - Prior to FY19, 29 = TO ON-SITE HOSPICE, 53 = TO A HOSPICE FACILITY ;
 - From FY19 and onwards, 50 = TO HOSPICE AT HOME, 51 = TO HOSPICE DEFINED AS A MEDICAL FACILITY (CERTIFIED) PROVIDING HOSPICE LEVEL OF CARE (INCLUDES HOSPICE UNIT OF AN ACUTE CARE HOSPITAL)
- If there is a hospice admission 120 days prior to the index IP visit, or 30 days after the index IP visit either in CCLF claims or MD Medicaid claims, then set hospice3=1.
 - hospice3 = (hspe_within_30days_ip=1);
- APR DRG: Maternal and neonatal and ungroupable admissions are excluded based on APR DRG. Excluded codes are: 863, 636, 633, 630, 631, 639, 640, 603, 613, 611, 591, 593, 588, 589, 602, 608, 607, 614, 612, 609, 623, 621, 625, 622, 626, 583, 634, 581, 580, 955, 956, 196, 560, 540
- Disposition: Transfers, Left Against Medical Advice, inconsistent vital status (death prior to admission or prior to discharge if discharged alive) are excluded
- Diagnosis: Any diagnosis of metastatic cancer (**Cancer Diagnosis list provided below**) or a principal diagnosis indicating low survival probability (ICD10=G931 Anoxic brain damage, not elsewhere classified, R403 Persistent vegetative state, A8100 Creutzfeldt-Jakob disease, unspecified, A8109 Other Creutzfeldt-Jakob disease, G9382 Brain death, R092 Respiratory arrest, I469 Cardiac arrest, cause unspecified with a secondary diagnosis of AMI)) are excluded. Crush, spinal or brain injury, and burns are excluded by mapping the principal diagnosis into CCS software as CCS= 234: Crush, 240: Burns, 233: Intracranial injury 227: Spinal cord injury.
- Other: After these exclusions are imposed, a random admission is selected for each patient with multiple stays, other admissions are excluded

Outcome

Death within 30 days is indicated by subtracting the admission date from discharge date with a disposition indicating inpatient death or, if the patient is not discharged dead, from the date of death taken from the vital statistics file or.

Risk adjustment

Risk adjustment is performed by first classifying each stay into one of 15 service categories. The stay is assigned a surgical service category if a major surgical procedure is performed. Otherwise, the stay is nonsurgical. Non-surgical service categories are assigned based on principal diagnosis as mapped into CCS categories. Surgical service categories are assigned based on principal procedure (except Surgical Cancer, which is based on a major surgical procedure and a cancer principal diagnosis), also mapped into CCS categories.

AHRQ CCS categories for these service lines are presented below.

Non-surgical categories are:

- Non-Surgical: Cancer
- Non-Surgical: Cardiac
- Non-Surgical: Gastrointestinal
- Non-Surgical: Infectious Disease
- Non-Surgical: Neurology
- Non-Surgical: Orthopedics
- Non-Surgical: Pulmonary
- Non-Surgical: Renal
- Non-Surgical: Other

Surgical categories are:

- Surgical: Cancer
- Surgical: Cardiothoracic
- Surgical: Neurosurgery
- Surgical: Other
- Surgical: General

Risk adjustment is performed by estimating logistic regression models for each service category with a random intercept for each index hospital. The risk factors in these models are age and APR DRG-risk of mortality (APR DRG-ROM). In this step, cases for which APR DRG volume is less than 20 are excluded from the model.

Measure

A risk adjusted mortality ratio is calculated separately for each of the 15 service lines. The ratio is the mean predicted probability over the mean expected probability for cases attributed to the hospital during the study period. Predicted probability is calculated as the probability projected from the model including the hospital's intercept, while expected probability is projected without that intercept.

The hospital's overall risk adjusted rate is the product of the statewide mortality rate, calculated over cases in the analytic file used to generate hospital predicted rates, and the weighted logarithmic mean of risk adjusted rates, where weights are the service line shares of cases for that hospital.

Cancer Exclusions Diagnosis List

C153	Malignant neoplasm of upper third of esophagus
C154	Malignant neoplasm of middle third of esophagus
C155	Malignant neoplasm of lower third of esophagus
C158	Malignant neoplasm of overlapping sites of esophagus
C159	Malignant neoplasm of esophagus, unspecified
C160	Malignant neoplasm of cardia
C161	Malignant neoplasm of fundus of stomach
C162	Malignant neoplasm of body of stomach
C163	Malignant neoplasm of pyloric antrum
C164	Malignant neoplasm of pylorus
C165	Malignant neoplasm of lesser curvature of stomach, unspecified
C166	Malignant neoplasm of greater curvature of stomach, unspecified
C168	Malignant neoplasm of overlapping sites of stomach
C169	Malignant neoplasm of stomach, unspecified
C170	Malignant neoplasm of duodenum
C171	Malignant neoplasm of jejunum
C172	Malignant neoplasm of ileum
C173	Meckel's diverticulum, malignant
C178	Malignant neoplasm of overlapping sites of small intestine
C179	Malignant neoplasm of small intestine, unspecified
C220	Liver cell carcinoma
C221	Intrahepatic bile duct carcinoma
C222	Hepatoblastoma
C223	Angiosarcoma of liver

C224	Other sarcomas of liver
C227	Other specified carcinomas of liver
C228	Malignant neoplasm of liver, primary, unspecified as to type
C229	Malignant neoplasm of liver, not specified as primary or secondary
C23	Malignant neoplasm of gallbladder
C240	Malignant neoplasm of extrahepatic bile duct
C241	Malignant neoplasm of ampulla of Vater
C248	Malignant neoplasm of overlapping sites of biliary tract
C249	Malignant neoplasm of biliary tract, unspecified
C250	Malignant neoplasm of head of pancreas
C251	Malignant neoplasm of body of pancreas
C252	Malignant neoplasm of tail of pancreas
C253	Malignant neoplasm of pancreatic duct
C254	Malignant neoplasm of endocrine pancreas
C257	Malignant neoplasm of other parts of pancreas
C258	Malignant neoplasm of overlapping sites of pancreas
C259	Malignant neoplasm of pancreas, unspecified
C3400	Malignant neoplasm of unspecified main bronchus
C3401	Malignant neoplasm of right main bronchus
C3402	Malignant neoplasm of left main bronchus
C3410	Malignant neoplasm of upper lobe, unspecified bronchus or lung
C3411	Malignant neoplasm of upper lobe, right bronchus or lung
C3412	Malignant neoplasm of upper lobe, left bronchus or lung
C342	Malignant neoplasm of middle lobe, bronchus or lung
C3430	Malignant neoplasm of lower lobe, unspecified bronchus or lung
C3431	Malignant neoplasm of lower lobe, right bronchus or lung
C3432	Malignant neoplasm of lower lobe, left bronchus or lung
C3480	Malignant neoplasm of overlapping sites of unspecified bronchus an
C3481	Malignant neoplasm of ovrlp sites of right bronchus and lung
C3482	Malignant neoplasm of ovrlp sites of left bronchus and lung
C3490	Malignant neoplasm of unspecified part of unspecified bronchus or
C3491	Malignant neoplasm of unsp part of right bronchus or lung
C3492	Malignant neoplasm of unsp part of left bronchus or lung
C37	Malignant neoplasm of thymus
C380	Malignant neoplasm of heart
C381	Malignant neoplasm of anterior mediastinum

C382	Malignant neoplasm of posterior mediastinum
C383	Malignant neoplasm of mediastinum, part unspecified
C384	Malignant neoplasm of pleura
C388	Malignant neoplasm of overlapping sites of heart, mediastinum and
C390	Malignant neoplasm of upper respiratory tract, part unspecified
C399	Malignant neoplasm of lower respiratory tract, part unspecified
C450	Mesothelioma of pleura
C452	Mesothelioma of pericardium
C459	Mesothelioma, unspecified
C700	Malignant neoplasm of cerebral meninges
C701	Malignant neoplasm of spinal meninges
C709	Malignant neoplasm of meninges, unspecified
C710	Malignant neoplasm of cerebrum, except lobes and ventricles
C711	Malignant neoplasm of frontal lobe
C712	Malignant neoplasm of temporal lobe
C713	Malignant neoplasm of parietal lobe
C714	Malignant neoplasm of occipital lobe
C715	Malignant neoplasm of cerebral ventricle
C716	Malignant neoplasm of cerebellum
C717	Malignant neoplasm of brain stem
C718	Malignant neoplasm of overlapping sites of brain
C719	Malignant neoplasm of brain, unspecified
C720	Malignant neoplasm of spinal cord
C721	Malignant neoplasm of cauda equina
C7220	Malignant neoplasm of unspecified olfactory nerve
C7221	Malignant neoplasm of right olfactory nerve
C7222	Malignant neoplasm of left olfactory nerve
C7230	Malignant neoplasm of unspecified optic nerve
C7231	Malignant neoplasm of right optic nerve
C7232	Malignant neoplasm of left optic nerve
C7240	Malignant neoplasm of unspecified acoustic nerve
C7241	Malignant neoplasm of right acoustic nerve
C7242	Malignant neoplasm of left acoustic nerve
C7250	Malignant neoplasm of unspecified cranial nerve
C7259	Malignant neoplasm of other cranial nerves
C729	Malignant neoplasm of central nervous system, unspecified

C770	Secondary and unspecified malignant neoplasm of lymph nodes of head
C771	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
C772	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
C773	Secondary and unspecified malignant neoplasm of axilla and upper limb
C774	Secondary and unspecified malignant neoplasm of inguinal and lower limb
C775	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C778	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites
C779	Secondary and unspecified malignant neoplasm of lymph node, unspecified
C7800	Secondary malignant neoplasm of unspecified lung
C7801	Secondary malignant neoplasm of right lung
C7802	Secondary malignant neoplasm of left lung
C781	Secondary malignant neoplasm of mediastinum
C782	Secondary malignant neoplasm of pleura
C7830	Secondary malignant neoplasm of unspecified respiratory organ
C7839	Secondary malignant neoplasm of other respiratory organs
C784	Secondary malignant neoplasm of small intestine
C785	Secondary malignant neoplasm of large intestine and rectum
C786	Secondary malignant neoplasm of retroperitoneum and peritoneum
C787	Secondary malignant neoplasm of liver and intrahepatic bile duct
C7880	Secondary malignant neoplasm of unspecified digestive organ
C7889	Secondary malignant neoplasm of other digestive organs
C7900	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C7901	Secondary malignant neoplasm of right kidney and renal pelvis
C7902	Secondary malignant neoplasm of left kidney and renal pelvis
C7910	Secondary malignant neoplasm of unspecified urinary organs
C7911	Secondary malignant neoplasm of bladder
C7919	Secondary malignant neoplasm of other urinary organs
C792	Secondary malignant neoplasm of skin
C7931	Secondary malignant neoplasm of brain
C7932	Secondary malignant neoplasm of cerebral meninges
C7940	Secondary malignant neoplasm of unspecified part of nervous system
C7949	Secondary malignant neoplasm of other parts of nervous system
C7951	Secondary malignant neoplasm of bone
C7952	Secondary malignant neoplasm of bone marrow
C7960	Secondary malignant neoplasm of unspecified ovary
C7961	Secondary malignant neoplasm of right ovary

C7962	Secondary malignant neoplasm of left ovary
C7970	Secondary malignant neoplasm of unspecified adrenal gland
C7971	Secondary malignant neoplasm of right adrenal gland
C7972	Secondary malignant neoplasm of left adrenal gland
C7981	Secondary malignant neoplasm of breast
C7982	Secondary malignant neoplasm of genital organs
C7989	Secondary malignant neoplasm of other specified sites
C799	Secondary malignant neoplasm of unspecified site
C7A00	Malignant carcinoid tumor of unspecified site
C7A010	Malignant carcinoid tumor of the duodenum
C7A011	Malignant carcinoid tumor of the jejunum
C7A012	Malignant carcinoid tumor of the ileum
C7A019	Malignant carcinoid tumor of the small intestine, unspecified portion
C7A020	Malignant carcinoid tumor of the appendix
C7A021	Malignant carcinoid tumor of the cecum
C7A022	Malignant carcinoid tumor of the ascending colon
C7A023	Malignant carcinoid tumor of the transverse colon
C7A024	Malignant carcinoid tumor of the descending colon
C7A025	Malignant carcinoid tumor of the sigmoid colon
C7A026	Malignant carcinoid tumor of the rectum
C7A029	Malignant carcinoid tumor of the large intestine, unspecified portion
C7A090	Malignant carcinoid tumor of the bronchus and lung
C7A091	Malignant carcinoid tumor of the thymus
C7A092	Malignant carcinoid tumor of the stomach
C7A093	Malignant carcinoid tumor of the kidney
C7A094	Malignant carcinoid tumor of the foregut, unspecified
C7A095	Malignant carcinoid tumor of the midgut, unspecified
C7A096	Malignant carcinoid tumor of the hindgut, unspecified
C7A098	Malignant carcinoid tumors of other sites
C7A1	Malignant poorly differentiated neuroendocrine tumors
C7A8	Other malignant neuroendocrine tumors
C7B00	Secondary carcinoid tumors, unspecified site
C7B01	Secondary carcinoid tumors of distant lymph nodes
C7B02	Secondary carcinoid tumors of liver
C7B03	Secondary carcinoid tumors of bone
C7B04	Secondary carcinoid tumors of peritoneum

C7B09	Secondary carcinoid tumors of other sites
C7B1	Secondary Merkel cell carcinoma
C800	Disseminated malignant neoplasm, unspecified
J910	Malignant pleural effusion

AHRQ CCS Categories by Service Line

Defining Surgical Procedure of Procedure	AHRQ CCS	CCS Description	Surgical Division
36	Lobectomy or pneumonectomy	Cardiothoracic	
42	Other OR Rx procedures on respiratory system and mediastinum	Cardiothoracic	
43	Heart valve procedures	Cardiothoracic	
44	Coronary artery bypass graft (CABG)	Cardiothoracic	
49	Other OR heart procedures	Cardiothoracic	
66	Procedures on spleen	General	
67	Other therapeutic procedures; hemic and lymphatic system	General	
72	Colostomy; temporary and permanent	General	
73	Ileostomy and other enterostomy	General	
74	Gastrectomy; partial and total	General	
75	Small bowel resection	General	
78	Colorectal resection	General	
79	Local excision of large intestine lesion (not endoscopic)	General	
80	Appendectomy	General	
84	Cholecystectomy and common duct exploration	General	
85	Inguinal and femoral hernia repair	General	
86	Other hernia repair	General	
89	Exploratory laparotomy	General	
90	Excision; lysis peritoneal adhesions	General	
94	Other OR upper GI therapeutic procedures	General	
96	Other OR lower GI therapeutic procedures	General	
99	Other OR gastrointestinal therapeutic procedures	General	
105	Kidney transplant	General	
166	Lumpectomy; quadrantectomy of breast	General	

167	MastectomyGeneral		
176	Organ transplantation (other than bone marrow, corneal or kidney)		
	General		
10	Thyroidectomy; partial or complete	Other	
12	Other therapeutic endocrine procedures		Other
13	Corneal transplant	Other	
14	Glaucoma procedures		Other
15	Lens and cataract procedures		Other
16	Repair of retinal tear; detachment	Other	
17	Destruction of lesion of retina and choroid	Other	
20	Other intraocular therapeutic procedures		Other
21	Other extraocular muscle and orbit therapeutic procedures		Other
22	Tympanoplasty	Other	
23	Myringotomy	Other	
24	Mastoidectomy	Other	
26	Other therapeutic ear procedures		Other
28	Plastic procedures on nose	Other	
30	Tonsillectomy and/or adenoidectomy		Other
33	Other OR therapeutic procedures on nose; mouth and pharynx		
	Other		
51	Endarterectomy; vessel of head and neck	Other	
52	Aortic resection; replacement or anastomosis		Other
53	Varicose vein stripping; lower limb	Other	
55	Peripheral vascular bypass	Other	
56	Other vascular bypass and shunt; not heart	Other	
59	Other OR procedures on vessels of head and neck	Other	
60	Embolectomy and endarterectomy of lower limbs	Other	
101	Transurethral excision; drainage; or removal urinary obstruction		
	Other		
103	Nephrotomy and nephrostomy	Other	
104	Nephrectomy; partial or complete	Other	
106	Genitourinary incontinence procedures		Other
112	Other OR therapeutic procedures of urinary tract		Other
113	Transurethral resection of prostate (TURP)	Other	
114	Open prostatectomy	Other	
118	Other OR therapeutic procedures; male genital		Other

119	Oophorectomy; unilateral and bilateral	Other
120	Other operations on ovary	Other
123	Other operations on fallopian tubes	Other
124	Hysterectomy; abdominal and vaginal	Other
125	Other excision of cervix and uterus	Other
129	Repair of cystocele and rectocele; obliteration of vaginal vault	
	Other	
131	Other non-OR therapeutic procedures; female organs	Other
132	Other OR therapeutic procedures; female organs	Other
135	Forceps; vacuum; and breech delivery	Other
144	Treatment; facial fracture or dislocation	Other
160	Other therapeutic procedures on muscles and tendons	Other
164	Other OR therapeutic procedures on musculoskeletal system	
	Other	
172	Skin graft	Other
175	Other OR therapeutic procedures on skin and breast	Other
1	Incision and excision of CNS	Neurosurgery
2	Insertion; replacement; or removal of extracranial ventricular shunt	
	Neurosurgery	
9	Other OR therapeutic nervous system procedures	Neurosurgery
3	Laminectomy; excision intervertebral disc	Orthopedic
142	Partial excision bone	Orthopedic
143	Bunionectomy or repair of toe deformities	Orthopedic
145	Treatment; fracture or dislocation of radius and ulna	Orthopedic
146	Treatment; fracture or dislocation of hip and femur	Orthopedic
147	Treatment; fracture or dislocation of lower extremity (other than hip or femur)	Orthopedic
148	Other fracture and dislocation procedure	Orthopedic
150	Division of joint capsule; ligament or cartilage	Orthopedic
151	Excision of semilunar cartilage of knee	Orthopedic
152	Arthroplasty knee	Orthopedic
153	Hip replacement; total and partial	Orthopedic
154	Arthroplasty other than hip or knee	Orthopedic
157	Amputation of lower extremity	Orthopedic
158	Spinal fusion	Orthopedic
161	Other OR therapeutic procedures on bone	Orthopedic

AHRQ	Diagnosis	CCS	Description	Non-Surgical	Division
11			Cancer of head and neck	Cancer	
12			Cancer of esophagus	Cancer	
13			Cancer of stomach	Cancer	
14			Cancer of colon	Cancer	
15			Cancer of rectum and anus	Cancer	
16			Cancer of liver and intrahepatic bile duct	Cancer	
17			Cancer of pancreas	Cancer	
18			Cancer of other GI organs; peritoneum	Cancer	
19			Cancer of bronchus; lung	Cancer	
20			Cancer; other respiratory and intrathoracic	Cancer	
21			Cancer of bone and connective tissue	Cancer	
22			Melanomas of skin	Cancer	
23			Other non-epithelial cancer of skin	Cancer	
24			Cancer of breast	Cancer	
25			Cancer of uterus	Cancer	
26			Cancer of cervix	Cancer	
27			Cancer of ovary	Cancer	
28			Cancer of other female genital organs	Cancer	
29			Cancer of prostate	Cancer	
30			Cancer of testis	Cancer	
31			Cancer of other male genital organs	Cancer	
32			Cancer of bladder	Cancer	
33			Cancer of kidney and renal pelvis	Cancer	
34			Cancer of other urinary organs	Cancer	
35			Cancer of brain and nervous system	Cancer	
36			Cancer of thyroid	Cancer	
37			Hodgkin's disease	Cancer	
38			Non-Hodgkin's lymphoma	Cancer	
39			Leukemias	Cancer	
40			Multiple myeloma	Cancer	
41			Cancer; other and unspecified primary	Cancer	
43			Malignant neoplasm without specification of site	Cancer	

44	Neoplasms of unspecified nature or uncertain behavior	Cancer
45	Maintenance chemotherapy; radiotherapy	Cancer
96	Heart valve disorders	Cardiac
97	Peri-; endo-; and myocarditis; cardiomyopathy (except that caused by tuberculosis or sexually transmitted disease)	Cardiac
100	Acute myocardial infarction	Cardiac
101	Coronary atherosclerosis and other heart disease	Cardiac
102	Nonspecific chest pain	Cardiac
103	Pulmonary heart disease	Cardiac
104	Other and ill-defined heart disease	Cardiac
105	Conduction disorders	Cardiac
106	Cardiac dysrhythmias	Cardiac
107	Cardiac arrest and ventricular fibrillation	Cardiac
108	Congestive heart failure; nonhypertensive	Cardiac
213	Cardiac and circulatory congenital anomalies	Cardiac
245	Syncope	Cardiac
249	Shock	Cardiac
6	Hepatitis	Gastrointestinal
120	Hemorrhoids	Gastrointestinal
138	Esophageal disorders	Gastrointestinal
139	Gastroduodenal ulcer (except hemorrhage)	Gastrointestinal
140	Gastritis and duodenitis	Gastrointestinal
141	Other disorders of stomach and duodenum	Gastrointestinal
142	Appendicitis and other appendiceal conditions	Gastrointestinal
143	Abdominal hernia	Gastrointestinal
144	Regional enteritis and ulcerative colitis	Gastrointestinal
145	Intestinal obstruction without hernia	Gastrointestinal
146	Diverticulosis and diverticulitis	Gastrointestinal
147	Anal and rectal conditions	Gastrointestinal
148	Peritonitis and intestinal abscess	Gastrointestinal
149	Biliary tract disease	Gastrointestinal
150	Liver disease; alcohol related	Gastrointestinal
151	Other liver diseases	Gastrointestinal
152	Pancreatic disorders (not diabetes)	Gastrointestinal
153	Gastrointestinal hemorrhage	Gastrointestinal
154	Noninfectious gastroenteritis	Gastrointestinal

155	Other gastrointestinal disorders	Gastrointestinal
214	Digestive congenital anomalies	Gastrointestinal
250	Nausea and vomiting	Gastrointestinal
251	Abdominal pain	Gastrointestinal
1	Tuberculosis	Infectious Disease
2	Septicemia (except in labor)	Infectious Disease
3	Bacterial infection; unspecified site	Infectious Disease
4	Mycoses	Infectious Disease
5	HIV infection	Infectious Disease
7	Viral infection	Infectious Disease
8	Other infections; including parasitic	Infectious Disease
9	Sexually transmitted infections (not HIV or hepatitis)	Infectious Disease
76	Meningitis (except that caused by tuberculosis or sexually transmitted disease)	Infectious Disease
77	Encephalitis (except that caused by tuberculosis or sexually transmitted disease)	Infectious Disease
135	Intestinal infection	Infectious Disease
159	Urinary tract infections	Infectious Disease
197	Skin and subcutaneous tissue infections	Infectious Disease
201	Infective arthritis and osteomyelitis (except that caused by tuberculosis or sexually transmitted disease)	Infectious Disease
246	Fever of unknown origin	Infectious Disease
237	Complication of device; implant or graft	Other Conditions
238	Complications of surgical procedures or medical care	Other
Conditions		
198	Other inflammatory condition of skin	Other Conditions
199	Chronic ulcer of skin	Other Conditions
200	Other skin disorders	Other Conditions
48	Thyroid disorders	Other Conditions
49	Diabetes mellitus without complication	Other Conditions
50	Diabetes mellitus with complications	Other Conditions
51	Other endocrine disorders	Other Conditions
53	Disorders of lipid metabolism	Other Conditions
58	Other nutritional; endocrine; and metabolic disorders	Other Conditions
206	Osteoporosis	Other Conditions
92	Otitis media and related conditions	Other Conditions

94	Other ear and sense organ disorders	Other Conditions
124	Acute and chronic tonsillitis	Other Conditions
134	Other upper respiratory disease	Other Conditions
136	Disorders of teeth and jaw	Other Conditions
137	Diseases of mouth; excluding dental	Other Conditions
46	Benign neoplasm of uterus	Other Conditions
160	Calculus of urinary tract	Other Conditions
161	Other diseases of kidney and ureters	Other Conditions
162	Other diseases of bladder and urethra	Other Conditions
163	Genitourinary symptoms and ill-defined conditions	Other Conditions
164	Hyperplasia of prostate	Other Conditions
165	Inflammatory conditions of male genital organs	Other Conditions
166	Other male genital disorders	Other Conditions
167	Nonmalignant breast conditions	Other Conditions
168	Inflammatory diseases of female pelvic organs	Other Conditions
169	Endometriosis	Other Conditions
170	Prolapse of female genital organs	Other Conditions
171	Menstrual disorders	Other Conditions
172	Ovarian cyst	Other Conditions
173	Menopausal disorders	Other Conditions
174	Female infertility	Other Conditions
175	Other female genital disorders	Other Conditions
215	Genitourinary congenital anomalies	Other Conditions
59	Deficiency and other anemia	Other Conditions
60	Acute posthemorrhagic anemia	Other Conditions
61	Sickle cell anemia	Other Conditions
62	Coagulation and hemorrhagic disorders	Other Conditions
63	Diseases of white blood cells	Other Conditions
64	Other hematologic conditions	Other Conditions
247	Lymphadenitis	Other Conditions
54	Gout and other crystal arthropathies	Other Conditions
57	Immunity disorders	Other Conditions
202	Rheumatoid arthritis and related disease	Other Conditions
210	Systemic lupus erythematosus and connective tissue disorders	Other Conditions
211	Other connective tissue disease	Other Conditions

253	Allergic reactions	Other Conditions
84	Headache; including migraine	Other Conditions
93	Conditions associated with dizziness or vertigo	Other Conditions
10	Immunizations and screening for infectious disease	Other Conditions
47	Other and unspecified benign neoplasm	Other Conditions
52	Nutritional deficiencies	Other Conditions
217	Other congenital anomalies	Other Conditions
252	Malaise and fatigue	Other Conditions
255	Administrative/social admission	Other Conditions
256	Medical examination/evaluation	Other Conditions
257	Other aftercare	Other Conditions
258	Other screening for suspected conditions (not mental disorders or infectious disease)	Other Conditions
259	Residual codes; unclassified	Other Conditions
86	Cataract	Other Conditions
87	Retinal detachments; defects; vascular occlusion; and retinopathy	Other Conditions
88	Glaucoma	Other Conditions
89	Blindness and vision defects	Other Conditions
90	Inflammation; infection of eye (except that caused by tuberculosis or sexually transmitted disease)	Other Conditions
91	Other eye disorders	Other Conditions
653	Delirium, dementia, and amnestic and other cognitive disorders	Other Conditions
241	Poisoning by psychotropic agents	Other Conditions
242	Poisoning by other medications and drugs	Other Conditions
243	Poisoning by nonmedicinal substances	Other Conditions
660	Alcohol-related disorders	Other Conditions
661	Substance-related disorders	Other Conditions
663	Screening and history of mental health and substance abuse codes	Other Conditions
114	Peripheral and visceral atherosclerosis	Other Conditions
115	Aortic; peripheral; and visceral artery aneurysms	Other Conditions
116	Aortic and peripheral arterial embolism or thrombosis	Other
Conditions		
117	Other circulatory disease	Other Conditions

118	Phlebitis; thrombophlebitis and thromboembolism	Other Conditions
119	Varicose veins of lower extremity	Other Conditions
121	Other diseases of veins and lymphatics	Other Conditions
248	Gangrene	Other Conditions
78	Other CNS infection and poliomyelitis	Neurology
79	Parkinson`s disease	Neurology
80	Multiple sclerosis	Neurology
81	Other hereditary and degenerative nervous system conditions	Neurology
82	Paralysis	Neurology
83	Epilepsy; convulsions	Neurology
85	Coma; stupor; and brain damage	Neurology
95	Other nervous system disorders	Neurology
109	Acute cerebrovascular disease	Neurology
110	Occlusion or stenosis of precerebral arteries	Neurology
111	Other and ill-defined cerebrovascular disease	Neurology
112	Transient cerebral ischemia	Neurology
113	Late effects of cerebrovascular disease	Neurology
216	Nervous system congenital anomalies	Neurology
235	Open wounds of head; neck; and trunk	Orthopedics
236	Open wounds of extremities	Orthopedics
239	Superficial injury; contusion	Orthopedics
244	Other injuries and conditions due to external causes	Orthopedics
203	Osteoarthritis	Orthopedics
204	Other non-traumatic joint disorders	Orthopedics
205	Spondylosis; intervertebral disc disorders; other back problems	Orthopedics
207	Pathological fracture	Orthopedics
208	Acquired foot deformities	Orthopedics
209	Other acquired deformities	Orthopedics
212	Other bone disease and musculoskeletal deformities	Orthopedics
225	Joint disorders and dislocations; trauma-related	Orthopedics
226	Fracture of neck of femur (hip)	Orthopedics
228	Skull and face fractures	Orthopedics
229	Fracture of upper limb	Orthopedics
230	Fracture of lower limb	Orthopedics

231	Other fractures	Orthopedics
232	Sprains and strains	Orthopedics
56	Cystic fibrosis	Pulmonary
122	Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	Pulmonary
123	Influenza	Pulmonary
125	Acute bronchitis	Pulmonary
126	Other upper respiratory infections	Pulmonary
127	Chronic obstructive pulmonary disease and bronchiectasis	Pulmonary
128	Asthma	Pulmonary
129	Aspiration pneumonitis; food/vomitus	Pulmonary
130	Pleurisy; pneumothorax; pulmonary collapse	Pulmonary
131	Respiratory failure; insufficiency; arrest (adult)	Pulmonary
132	Lung disease due to external agents	Pulmonary
133	Other lower respiratory disease	Pulmonary
55	Fluid and electrolyte disorders	Renal
98	Essential hypertension	Renal
99	Hypertension with complications and secondary hypertension	Renal
156	Nephritis; nephrosis; renal sclerosis	Renal
157	Acute and unspecified renal failure	Renal
158	Chronic kidney disease	Renal

APPENDIX B: CDC ANALYSIS OF NHSN HAI MEASURES

The CDC also publishes an annual report that includes state-specific performance on HAI measures that includes comparison of performance to the previous year as well as the statistical significance of the changes²³. Figure B.1. below illustrates Maryland's change from CY 2023 to CY 2024 (the most current annual report published by CDC); the data reveal that Maryland's performance had statistically significant improvement (decrease) for the CAUTI measure and had unchanged performance on all HAI measure SIRs included in the QBR program. Of particular note based on the CDC analysis, SIR differences in Maryland of between 2 percent and 13 percent for five of the HAI categories for CY 2024 compared to CY 2023 were not statistically significant because of small cell sizes in the state; SIR differences year over year have shown similar results for Maryland based on CDC analyses²⁴. The issue of whether the differences are statistically significant is important to consider also when comparing Maryland or other relatively smaller states' performance or the nation, or comparing hospital performance to the national standards. For example, the hospital HVBP performance results do not indicate whether differences in performance among hospitals and states compared to the HVBP performance standards are statistically significant.

Figure B.1. CDC Healthcare-Associated Infections Progress Report, Maryland SIRs, CY 2024 Compared to CY 2023

Maryland Changes in state-specific standardized infection ratios (SIRs) between 2023 and 2024 for NHSN Acute Care Hospitals					
	2023 SIR	2024 SIR	Percent Change	Direction of Change, Based on Statistical Significance	p-value
CLABSI	0.848	0.737	13%	No statistically significant change	0.0619
CAUTI	0.763	0.627	18%	Statistically significant decrease	0.0138
SSI Colon	0.840	0.805	4%	No statistically Significant change	0.7330
SSI Hysterectomy	1.515	1.448	4%	No statistically significant change	0.8373
MRSA	0.571	0.582	2%	No statistically significant change	0.8809

²³CDC 2024 National and State Healthcare-Associated Infections Progress Report found at <https://www.cdc.gov/healthcare-associated-infections/php/data/progress-report.html>.

²⁴ See: <https://www.cdc.gov/healthcare-associated-infections/media/excel/2024-SIR-ACH.xlsx> Tabs 10a, 10b, 10d, 10e, 10f, 10g (last accessed 10/13/2025).

Maryland Changes in state-specific standardized infection ratios (SIRs) between 2023 and 2024 for NHSN Acute Care Hospitals					
	2023 SIR	2024 SIR	Percent Change	Direction of Change, Based on Statistical Significance	p-value
CDIF	0.500	0.455	9%	No statistically significant change	0.0609

APPENDIX C: DIGITAL QUALITY MEASURES INFRASTRUCTURE

CMS Roadmap

Maryland is an early adopter of digital measure reporting and has established beginning in CY 2022 statewide infrastructure and reporting requirements, initially for monitoring; Maryland envisions transitioning to the use of digital measures in the QBR program as well as other quality-based payment programs when digital measurement has had sufficient development and implementation is feasible.

Over the past decade, CMS has led efforts to advance the use of data from electronic health records (EHRs) to enhance and expand quality measurement. However, accessing clinical patient data from EHRs for the purpose of quality reporting remains relatively burdensome. Additionally, CMS's current approach to quality measurement does not easily incorporate emerging digital data sources such as patient-reported outcomes (PROs) and patient-generated health data (PGHD). There is a need to streamline the approach to data standardization, collection, exchange, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, quality improvement, and learning.

Advancements in the interoperability of healthcare data from EHRs create an opportunity to dramatically improve quality measurement systems and realize creation of a learning health system. In 2020, the Department of Health and Human Services (HHS) finalized interoperability requirements in CMS's Interoperability and Patient Access final rule and in the Office of the National Coordinator for Health Information and Technology's (ONC's) 21st Century Cures Act final rule. Driven by the Cures Act's goal of "complete access, exchange, and use of all electronically accessible health information," these changes will

greatly expand the availability of standardized, readily accessible data for measurement. Most important, CMS's and ONC's interoperability rules and policies require specified healthcare providers and health plans to make a defined set of patient information available to authorized users (patients, other providers, other plans) with no special effort using Fast Healthcare Interoperability Resources (FHIR®) application programming interfaces (APIs). The scope of required patient data and standards that support them will evolve over time, starting with data specified in the United States Core Data for Interoperability (USCDI) Version 1, structured according to the Health Level Seven International (HL7®) FHIR US Core Implementation Guide (US Core IG).

Maryland, like CMS, believes that in the future, interoperability of EHR and other digital health data can fuel a revolution in healthcare delivery and advance Measure Calculation Tools to leverage data beyond just EHRs and across settings and providers. CMS has outlined a roadmap to transition from the current environment to a learning health system powered by advanced analytics applied to all digital health data to optimize patient safety, outcomes, and experience.²⁵

Details of Maryland Hospital Digital Measures Implementation

In CY 2021 Maryland implemented statewide infrastructure and required all acute hospitals to report to HSCRC electronic Clinical Quality Measures (eCQM) measures beginning in CY 2022, with planned expansion to other digital measures going forward. The reporting requirements are more aggressive than the National CMS requirements in terms of measures, and the expectation for quarterly data submissions as opposed to annual submissions required by CMS.

HSCRC continues to support more current digital data submission/availability to strengthen hospitals' and the state's ability to use the data for quality tracking and improvement that is actionable. Further, the early adoption and migration to digital data and measures in general will ultimately constitute less burden for hospitals and the State. However, it is also important to note that some hospital stakeholders and Electronic Health Record (EHR) vendors have raised concerns regarding the quarterly data submissions related to EHR vendor system digital measure updates and hospitals' implementation of the updates,

²⁵ Please see full details on CMS Digital Quality Measurement Strategic Roadmap: https://ecqi.healthit.gov/sites/default/files/CMSdQMStrategicRoadmap_032822.pdf, last accessed 8/9/2022.

and hospitals have submitted Exceptional Circumstances Exemption requests for timeline extensions which have been granted on a case by case basis by the Commission. The Commission will continue to consider and approve timeline extension requests up to the CMS annual submission deadlines. Figure C.1. below illustrates the Maryland and CMS CY 2027 reporting requirements.

Staff notes that, in alignment with the state's goals to improve on maternal health and the SIHIS goal to reduce Severe Maternal Morbidity, the HSCRC required submission of the PC 07 Severe Obstetric Complications measure beginning in CY 2022, a year ahead of CMS' requirement for hospitals to submit this eCQM; of note, Maryland working with with CRISP and Medisolv has updated the risk adjustment for the PC 07 measure so it may be used to compare hospital performance in the future. Also, through data/information sharing, staff will continue to collaborate with Maryland's Department of Health Maternal Child Health Bureau on this important population health improvement priority.

Figure C.1. CMS-Maryland CY 2027 Digital Measures Reporting Requirements

Reporting Period/ payment determination	Maryland Measures, Reporting Timelines	CMS Measures, Reporting Timelines
CY 2027/RY 2029	<p>eCQM Measures: For CY 2027, HSCRC requirements are consistent with CMS and include submission of QRDA I files for the eCQM's listed below.</p> <ul style="list-style-type: none"> • eOPI-1: Safe Use of Opioids- Concurrent prescribing • PC-02: Cesarean Birth • PC-07: Severe Obstetric Complications (risk adjusted) • HH-01: Hospital Harm- Severe Hypoglycemia • HH-02: Hospital Harm- Severe Hyperglycemia • HH-ORAE Hospital Harm- Opioid-Related Adverse Events • For the self-selected measures, HSCRC is aligning with CMS and requiring that hospitals 	See Maryland eCQM Measures

Reporting Period/ payment determination	Maryland Measures, Reporting Timelines	CMS Measures, Reporting Timelines
	<p>submit three additional eCQM measures of the hospital's choosing</p> <p>Core Clinical data elements for two hybrid measures (for all-payers age 18+ July 2027-June 2028) -30-day mortality -30-day readmissions</p>	<p>Core Clinical data elements for two hybrid measures (for age 65+ July 2027-June 2028) -30-day mortality -30-day readmissions</p>
	<p><i>eCQM CY 2027 Performance Period Submission Windows for Hospitals to be Eligible for the \$150K Expedited Reporting Bonus for RY 2029 if approved by the Commission.</i></p> <p>Q1 2027 data Open: 7/15/2027 Close: 9/30/2027 Q2 2027 data Open: 7/15/2027 Close: 9/30/2027 Q3 2027 data Open: 10/15/2027 Close: 12/30/2027 Q4 2027 data Open: 1/15/2028 Close: 3/31/2028</p> <p>*Hospitals not opting for the bonus must report by the specified CMS reporting time period.</p> <p><i>Reporting of the CCDE is required in accordance with the timeline below for Hospitals to be eligible for the \$150K expedited reporting bonus for RY 2029 if approved by the Commission:</i></p> <p>Q3 2027 data Open: 1/15/2028</p>	<p><i>eCQM CY 2027 Performance Period Submission window</i> 1-Q4 CY 2027 Open 1/15/2028 Close: 3/31/2028</p> <p><i>Reporting of the CCDE is required in accordance with the timeline below for Hospitals to comply with HSCRC Reporting Requirements</i></p> <p>Q3 2027 to Q2 2028</p>

Reporting Period/ payment determination	Maryland Measures, Reporting Timelines	CMS Measures, Reporting Timelines
	Close: 3/31/2028 Q4 2027 data Open: 1/15/2028 Close: 3/31/2028 Q1 2028 data Open: 4/15/2028 Close: 6/30/2028 Q2 2028 data Open: 7/15/2028 Close: 9/30/2028 *Hospitals not opting for the bonus must report by the specified CMS reporting time period.	Open 7/15/2028 Close: 9/30/2028

In addition to the eCQM reporting requirements, Maryland will also utilize the established infrastructure to continue collecting 30-day Hospital Wide Readmission (HWR) and Hospital Wide Mortality (HWM) hybrid measures required for all patients ages 18+. The State notes that adoption of an all-payer hybrid HWM measure will potentially allow for its use in the QBR program in future years..

Rate Year 2027 Uncompensated Care Report

September 9, 2026

Health Services Cost Review Commission
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Baltimore, Maryland 21215
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This document contains the staff report for RY 2025 Uncompensated Care Policy. There are no proposed changes in methodology and thus no need for a formal Commission vote at this time.

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Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
The purpose of the Uncompensated Care (UCC) policy is to equitably share the financial burden of providing hospital care to patients that are uninsured or underinsured and cannot afford to pay for their care. By including this cost in statewide hospital rates, the HSCRC can ensure that all Marylanders can access care at all hospitals in Maryland.	<p>Funding UCC in the State of Maryland is two fold.</p> <p>1). Through the UCC markup to hospital rates based on statewide Actual UCC, applied uniformly to acute care hospital rates statewide.</p> <p>For RY 2027, the determined UCC amount to be built into rates for Maryland hospitals is 4.01 percent.</p> <p>2). Hospital contributions to/from the UCC fund based on a 50/50 blend of Hospital-specific actual UCC and calculated predicted UCC rates.</p>	<p>Under the current HSCRC policy, UCC above the statewide average is funded by a statewide pooling system whereby regulated Maryland acute care hospitals draw funds from the pool should they experience a greater-than-average level of UCC and pay into the pool should they experience a less-than-average level of UCC. This ensures that the cost of UCC is shared equally across all hospitals within the State.</p> <p>For RY 2027, 16 regulated acute care hospitals will pay into the pool while 25 will withdraw from the pool.</p>	UCC is paid by patients and insurers through rates. Therefore, with the incorporation of predicted UCC, the policy incentivizes hospitals to responsibly collect payments from patients and payers who can afford to pay. This prevents UCC costs from rising too quickly, protecting the sustainability of the UCC fund, which in turn ensures that UCC funding remains available for those who truly need it while constraining growth of health care rates for all patients and payers.	The UCC policy represents an underlying historical tenet of health equity in the State, as it ensures that Marylanders, regardless of insurance status, can access care at any hospital and there is no need for public hospitals. All hospitals receive funding from all payers for uncompensated care costs. Hospitals with high volumes of low-income patients are not at a financial disadvantage compared to hospitals with higher income patients, allowing low-income patients to access care at any of the state's hospitals.

INTRODUCTION

The Uncompensated Care Policy was created by the HSCRC to recognize the financial burden borne by hospitals from the continued provision of high quality hospital care to patients who cannot afford to pay for it and to create a financial reimbursement for the provision of Uncompensated Care (UCC) into the rates the Commission sets for hospitals.¹ The UCC policy is a foundational element of equity built into the all-payer system and continued under the Total Cost of Care Model. The purpose of this report is to provide background on the UCC policy and to provide hospital-specific values for the UCC built into statewide rates as well as the amount of

¹ Maryland has a unique all-payer rate setting system for hospitals, administered by the HSCRC. Acute general hospitals in Maryland must charge patients (and insurers) the rate set by the HSCRC for health care services.

funding that will be made available for the UCC pool, the latter of which ensures the burden of uncompensated care is shared equitably across all hospitals.

Uncompensated Care (UCC) is hospital care provided for which no compensation is received, typically a combination of charity care and bad debt.

Charity Care

Charity care services are “those Commission regulated services rendered for which payment is not anticipated”.² Charity care is provided to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill. There are two types of charity care that may occur across all payers:

1. **Free care** is care for which the patient is not responsible for any out-of-pocket expenses for hospital care. Hospitals are required statutorily to provide free care to patients with a household income less than 200% of the Federal Poverty Level.³
2. **Reduced-cost care** is care for which the patient is only responsible for a portion of out-of-pocket expenses and is required for patients with household income between 200 and 300% of the FPL.⁴ Reduced-cost care is also required for patients that have a financial hardship⁵ and have household incomes below 500% of the FPL. Financial hardship is defined by statute as medical debt, incurred by a household over a 12-month period, which exceeds 25% of household income.⁶ There is no prescribed discount that hospitals must provide to patients between 200% and 500% of the FPL. Per statute “if a patient is eligible for reduced-cost medically necessary care, the hospital shall apply the reduction that is most favorable to the patient.”⁷

Bad Debt

The other type of Hospital UCC is bad debt, which is for “Commission regulated services rendered for which payment is anticipated, and credit is extended to the patient” but the payment is not made. Unpaid cost shares for patients that do not meet the free thresholds can be charged as bad debt after the hospital makes a reasonable attempt to collect those charges.⁸ However, there are several reasons that a hospital may not include bad debts into uncompensated care, most notably denials.⁹

² HSCRC Accounting and Budget Manual Section 100, “Accounting Principles and Concepts”, p. 39, August 2008, Available at: <https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-100-FINAL-08-01-10.pdf>

³ Md. Code, § 19-214.1(b)(2) (i) of the Health General Article

⁴ COMAR 10.37.10.26 A-2 (2)(a)(ii)

⁵ Md. Code, § 19-214.1(a)(2) of the Health General Article

⁶ Md. Code, § 19-214.1(b)(4) of the Health General Article

⁷ Md. Code, § 19-214.1(b)(5) of the Health General Article

⁸ Bad debt includes unpaid cost share expenses reduced by a reduced-cost care discount for patients eligible for reduced-cost care. The HSCRC requires hospitals to make “a reasonable collection effort” before writing-off bad debt. HSCRC Accounting and Budget Manual Section 100, “Accounting Principles and Concepts”, p. 39, August 2008, Available at: <https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-100-FINAL-08-01-10.pdf>

⁹ These include: a) Contractual allowances and adjustments associated with Commission approved differentials—i.e., prompt payment, SAAC, and the differential granted to Medicare and Medicaid.; b) Administrative, Courtesy and Policy Discounts and Adjustments - These include, but are not limited to, reductions from established rates for courtesy discounts, employee

HSCRC's UCC policy assures access to hospital services in the State for those patients who cannot readily pay for them and equitably distributes the burden of uncompensated care costs across all hospitals and all payers. This approach ensures that hospitals with high volumes of low-income patients are not at a financial disadvantage.

For RY 2027, the determined UCC amount to be built into rates for Maryland hospitals is 4.01 percent. Under the current HSCRC policy, UCC above the statewide average is funded by a statewide pooling system whereby regulated Maryland hospitals draw funds from the pool should they experience a greater-than-average level of UCC and pay into the pool should they experience a less-than-average level of UCC. This ensures that the cost of UCC is shared equally across all hospitals within the State.

METHODOLOGY

The UCC methodology is a cornerstone of the HSCRC's all payer system. In addition to equitably supporting financial assistance for low-income patients, the policy incentivizes hospitals to responsibly collect payments from patients and payers who can afford to pay. This prevents UCC costs from rising too quickly, protecting the sustainability of the UCC fund, which in turn ensures that UCC funding remains available for those who truly need it while constraining growth of health care rates for all patients and payers.¹⁰

The HSCRC prospectively calculates the amount of uncompensated care provided in hospital rates at each regulated Maryland hospital using a multi-step process:

- 1. Statewide Actual UCC in All-Payer Hospital Rates:** HSCRC builds UCC funding into hospital rates based on the total amount of charity care and bad debt reported by all acute hospitals for the previously completed fiscal year. The UCC markup to hospital rates is based on statewide actual UCC, expressed as a percent of gross patient revenue, and is applied uniformly to acute care hospital rates statewide. For example, in RY 2027, HSCRC staff will use RY 2025 statewide UCC experience of 4.01 percent to determine the UCC amount built into all hospital rates.
- 2. Hospital Payments or Contributions to the UCC Fund**
The UCC Fund is used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC.

discounts, administrative decision discounts, discounts to patients not meeting charity policy guidelines, undocumented charges and, payments for services denied by third party payers; c) Charges for medically unnecessary hospital services;). Charges written off that are not the result of a patient's inability to pay or where the hospital has not expended a reasonable collection effort - [08/01/08 SECTION 100 ACCOUNTING PRINCIPLES AND CONCEPTS I](#)

¹⁰ Other states have struggled to maintain sustainable uncompensated care funds. One example is New Jersey. H S Berliner, S Delgado, "The rise and fall of New Jersey's uncompensated care fund", J Am Health Policy. Sep-Oct 1991;1(2):47-50. <https://pubmed.ncbi.nlm.nih.gov/10112731/>.

- i. **Hospital-Specific Actual UCC:** HSCRC uses gross patient revenue as reported on the hospitals' annual financial filings for the previous year to determine the hospital-specific actual UCC for each hospital¹¹. (See Appendix II).
- ii. **Hospital-Specific Predicted UCC:** This step involves use of a logistic regression model to predict UCC. HSCRC allows a 9-month runout period for charity care and bad debt Write-Off reporting. This means hospitals have 9 months from the end of a fiscal year to report charity care and bad debt that occurred in that fiscal year in their Write-Off data submissions to the Commission. HSCRC then uses that amount to predict the UCC amount built into hospital rates for the next fiscal year using area deprivation Index (ADI),¹² payer type, and site of care as independent variables in the logistic regression. An expected UCC dollar amount is calculated for every patient encounter. UCC dollars are summed at the hospital level, and summed UCC dollars are divided by hospital total charges to establish the hospital's estimated UCC level. Incorporating predicted UCC into the methodology provides hospitals with a financial incentive to collect payments so that UCC does not rise too quickly and UCC funds remain available for those who truly need it. Because UCC is paid by patients and insurers through rates, uncontrolled increases in UCC could increase hospital rates for everyone.
- iii. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step i) and the hospital-specific predicted UCC (described in step ii). All individual hospital values for payment or withdrawal from the UCC Fund are then normalized to ensure that the UCC fund is redistributive in nature. (See Appendix I).
- iv. **Determining hospital contribution/withdrawals:** The 50/50 blend (step iii) for each hospital is subtracted from the amount of state-wide actual UCC funding provided in rates (step 1) and multiplied by the hospital's global budget revenue (GBR) to determine how much each hospital will either withdraw from or pay into the statewide UCC Fund. The Fund is the mechanism through which HSCRC ensures the burden of uncompensated care is shared by all hospitals. Specifically, if a hospital's 50/50 blend is less than the statewide average UCC rate (determined in step 1), the hospital will pay into the UCC Fund. Conversely, if a hospital's 50/50 blend is greater than the statewide average UCC rate, the hospital will withdraw from the Fund.

¹¹ Before ACA, HSCRC based the Actual UCC included in pool funding calculations on a 3-year rolling average. This smooths the year over year hospital-specific changes in UCC. In anticipation of large decreases in UCC in 2014, HSCRC adjusted their policy to use 1 year of data, to avoid carrying over higher UCC amounts

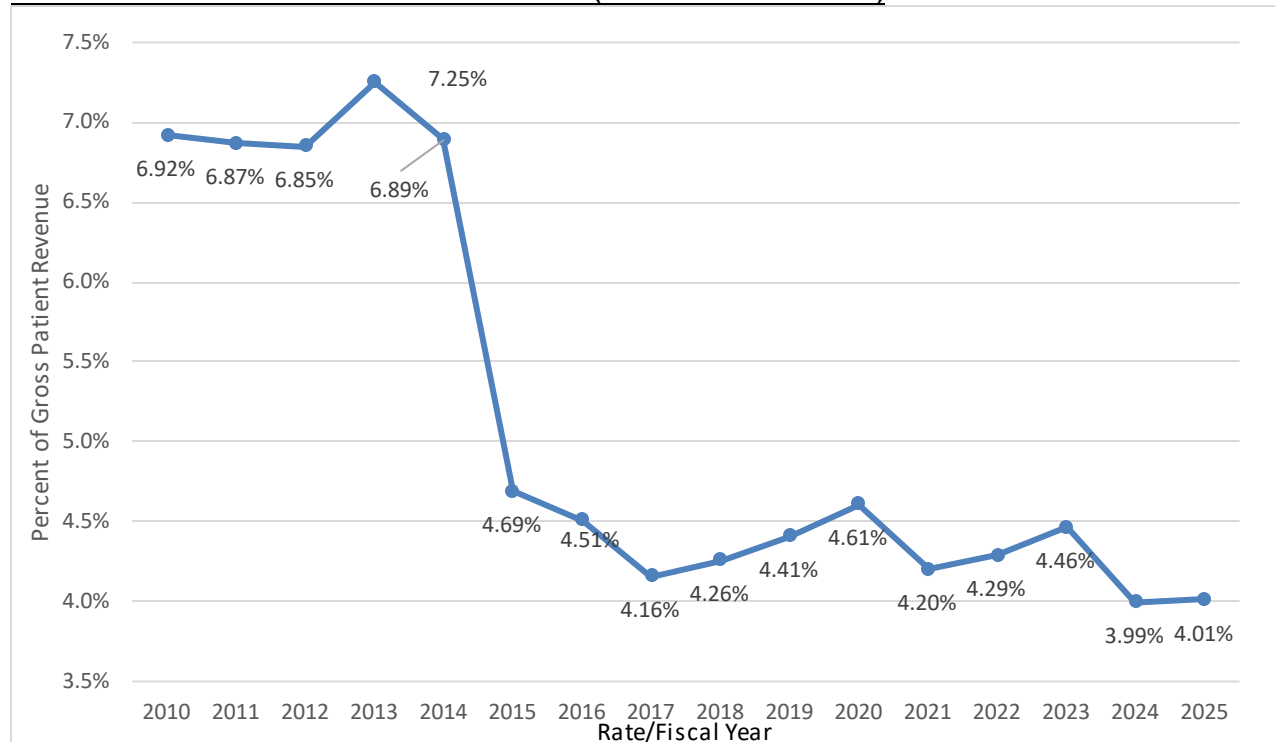
¹² "The Area Deprivation Index ...allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest including] factors for...income, education, employment, and housing quality." <https://www.neighborhoodatlas.medicine.wisc.edu/>

Exhibit 1: UCC Methodology Example (\$ Millions)

		Step 1		Step 2 (i)	Step 2 (ii)	Step 2 (iii)	Step 2 (iv)
	A	B	C = A X B	D	E	F = Avg D & E	G = (F-B) X A
	GBR	Prior Year Statewide UCC Rate	UCC Funding Provided in Rates	Prior Year Hospital-Specific UCC Rate	Predicted Hospital-specific UCC Rate	Hospital-Specific 50/50 Blend	(Payment) or Withdrawal from UCC Fund
Hospital A	\$300	5%	\$15	3%	4%	3.50%	(\$4.50)
Hospital B	\$300	5%	\$15	7%	6%	6.50%	\$4.50

ASSESSMENT

Based on RY 2025 audited reports, the HSCRC has determined that the percentage of UCC to incorporate in hospitals' rates to fund the UCC pool is 4.01 percent, 0.02 percentage points higher than last year's UCC rate of 3.99 percent. The graph below shows the changes in Actual Statewide UCC incorporated in hospital rates since RY 2010. RY 2014 and RY 2017 were characterized by a drastic decline in UCC due to Medicaid expansion through the ACA. As the effects of ACA implementation waned, UCC slowly increased between RY 2018 and RY 2020. The COVID pandemic characterized by a decline in ED utilization brought about further declines in UCC in RY 2021. The continuous uptick in UCC between RY 2022 and RY 2023 were driven by increases in emergency department (ED) utilization as the COVID-19 pandemic phased out. RY 2024 shows further decline in UCC largely driven by decreases in hospital's bad debt reserve requirements. UCC has remained relatively steady between RY 2024 and RY 2025.

Exhibit 2: Actual Statewide UCC in Rates (RY 2010 – RY 2025)

IMPLEMENTATION

Based on the preceding analysis, HSCRC staff will implement the following for RY 2027:

1. Increase the statewide UCC provision in rates from 3.99% to 4.01% effective July 1, 2026.
2. Continue to use the regression modeling approach previously approved by the Commission.
3. Continue to apply a 50/50 blend of RY 2025 audited UCC levels and RY 2025 predicted UCC levels to determine hospital-specific adjustments for the UCC Fund.

ADDITIONAL CONSIDERATIONS

During the FY 2026 Update Factor development process, HSCRC Staff and stakeholders discussed the potential impacts of recent federal actions, including House Resolution 1 (H.R. 1) and federal rulemaking on access to healthcare coverage and, in turn, UCC. Working with Medicaid, HSCRC estimates FY 2027 Medicaid losses to translate into approximately \$11 million of hospital UCC. This number will rise in subsequent fiscal years as the new eligibility requirements come into effect (e.g., six-month redeterminations and work requirements, effective January 1, 2027, and largely manifesting in July 2027 and after).

MHBE initially projected coverage losses in the individual market of 48,000 in 2026. As of April 2026, the individual market had seen an 8 percent decline in year-over-year enrollment, numbering approximately 18,000 individuals. Much of the drop in coverage was for individuals who lost federal tax credits due to immigration status - otherwise, the market was stable due to reinsurance and state subsidy. If further market stability is not provided in advance of CY 2027, further drops in coverage will be seen - having a greater impact on UCC and leading to higher costs across all payers.

A 48,000-beneficiary decline in the marketplace (as originally projected publicly by the end of the 2026 plan year) would correlate to approximately \$117 million in hospital UCC, assuming these enrollees use hospital services similarly to existing uninsured individuals.

Based on the above estimates, which contain considerable uncertainty, the anticipated FY 2027 UCC exposure is \$128 million or approximately 0.50 percent of total hospital global budgets. If this occurs under the current system, the cost of UCC will ultimately be borne by all payers starting in FY 2028; however, due to the data lags, hospitals will bear the cost in the interim. As noted above, one important consideration is that increases to hospital rates in CY 2026 will be included in the base global budgets for Medicare Fee for Service when the Center for Medicare and Medicaid Innovation (CMMI) takes control of Medicare global budgets January 1, 2028, per the AHEAD State Agreement.

Staff put forth at the July Commission Meeting and Commissioners approved a list of opportunities to these address coverage losses. This list included 1). Increasing support for the individual market through the Maryland Reinsurance Program and State subsidies; 2). Utilizing a special fund to facilitate access to primary and preventative care at the State's FQHC's and LHDs;¹³ 3). Using the UCC fund to support hospitals with increases in bad debt due to treatment of uninsured patients and; 4). Developing a memorandum of understanding among the state agencies involved to manage the administration and

¹³ FQHC: Federally Qualified Health Centers. LDH: Local Health Departments

distributions of the funds for market stabilization. More information on this can be found on page 433-439 of the [July 2026 Commission Meeting Packet](#).

Appendix I. Hospital Uncompensated Care Provision for RY 2027

HOSPID	HOSPNAME	FY2027 GBR Permanent Revenue	FY 2025 UCC Based on FY 2027 GBR Permanent Revenue	FY 2025 Percent UCC from the RE Schedule	FY 2025 Percent Predicted UCC (Adjusted)	Predicted UCC Amounts (Based on FY 2027 GBR Permanent Revenue)	50/50 Blend Percent	50/50 Blend, Adjusted	Percent UCC
210001	Meritus Medical Cntr	\$585,462,973	\$26,195,603	4.47%	4.41%	\$25,847,113	4.44%	\$27,446,192	4.69%
210002	UMMC	\$2,168,399,435	\$46,680,327	2.15%	2.72%	\$58,905,561	2.43%	\$55,683,692	2.57%
210003	UM-Prince George's Hospital	\$499,553,469	\$31,901,483	6.39%	4.75%	\$23,725,615	5.57%	\$29,336,517	5.87%
210004	Holy Cross	\$692,501,215	\$41,620,597	6.01%	4.99%	\$34,567,303	5.50%	\$40,179,835	5.80%
210005	Frederick Memorial	\$490,329,644	\$32,175,006	6.56%	4.89%	\$23,959,879	5.72%	\$29,604,313	6.04%
210008	Mercy Medical Cntr	\$762,311,376	\$35,188,321	4.62%	3.70%	\$28,207,193	4.16%	\$33,433,410	4.39%
210009	Johns Hopkins	\$3,564,849,233	\$97,276,136	2.73%	3.09%	\$110,054,313	2.91%	\$109,341,552	3.07%
210011	St. Agnes Hospital	\$567,203,322	\$31,649,024	5.58%	5.03%	\$28,528,532	5.30%	\$31,736,329	5.60%
210012	Sinai Hospital	\$1,039,969,451	\$31,652,112	3.04%	2.61%	\$27,168,275	2.83%	\$31,020,588	2.98%
210015	MedStar Franklin Square	\$792,691,324	\$28,768,819	3.63%	3.18%	\$25,193,631	3.40%	\$ 28,458,618	3.59%
210016	Washington Adventist Hospital	\$481,270,359	\$29,574,028	6.14%	4.15%	\$19,959,070	5.15%	\$26,122,674	5.43%
210017	Garrett Co Memorial	\$104,339,487	\$6,039,081	5.79%	4.65%	\$4,849,075	5.22%	\$5,742,176	5.50%
210018	MedStar Montgomery	\$248,878,723	\$10,656,712	4.28%	3.29%	\$8,177,496	3.78%	\$9,932,750	3.99%
210019	Peninsula Regional	\$688,104,447	\$32,301,612	4.69%	4.02%	\$27,650,400	4.01%	\$31,617,382	4.59%
210022	Suburban	\$498,678,278	\$18,242,362	3.66%	3.57%	\$17,813,839	3.62%	\$19,015,253	3.81%
210023	Anne Arundel Medical Cntr	\$856,996,866	\$18,166,436	2.12%	3.19%	\$27,333,774	2.65%	\$23,995,818	2.80%
210024	MedStar Union Memorial	\$548,024,364	\$20,404,209	3.72%	3.21%	\$17,576,478	3.47%	\$20,030,186	3.65%
210027	Western Maryland	\$413,679,833	\$20,787,684	5.03%	3.93%	\$16,258,376	4.48%	\$19,537,283	4.72%
210028	MedStar St. Mary's	\$266,635,993	\$11,136,302	4.18%	3.71%	\$9,899,635	3.94%	\$11,093,894	4.16%
210029	JH Bayview	\$898,025,530	\$36,966,160	4.12%	3.69%	\$33,096,650	3.90%	\$36,949,596	4.11%
210030	UM-SRH at Chestertown	\$59,603,159	\$3,143,164	5.27%	4.38%	\$2,608,596	4.83%	\$3,033,352	5.09%
210032	Union Hospital of Cecil Co	\$222,859,255	\$10,908,570	4.89%	3.91%	\$8,719,095	4.40%	\$10,351,202	4.64%

210033	Carroll Co Hospital Cntr	\$304,681,341	\$10,236,365	3.36%	3.07%	\$9,351,168	3.21%	\$10,330,037	3.39%
210034	MedStar Harbor Hospital Cntr	\$246,730,257	\$18,047,488	7.31%	4.82%	\$11,900,679	6.07%	\$15,794,009	6.40%
210035	UM-Charles Regional	\$205,088,087	\$14,662,624	7.15%	4.80%	\$9,850,595	5.98%	\$12,927,736	6.30%
210037	UM-SRH at Easton	\$322,274,147	\$12,690,537	3.94%	3.33%	\$10,731,762	3.63%	\$12,352,409	3.83%
210038	UMMC - Midtown	\$302,063,149	\$12,432,386	4.12%	2.88%	\$8,699,835	3.50%	\$11,144,672	3.69%
210039	Calvert Health Med Cntr	\$200,689,369	\$4,819,898	2.40%	3.60%	\$7,233,263	3.00%	\$6,356,574	3.17%
210040	Northwest Hospital Cntr	\$331,288,310	\$14,438,794	4.36%	3.07%	\$10,173,409	3.71%	\$12,979,939	3.92%
210043	UM-BWMC	\$598,441,216	\$25,502,794	4.26%	3.54%	\$21,172,656	3.90%	\$24,615,613	4.11%
210044	GBMC	\$565,159,465	\$16,033,452	2.84%	3.49%	\$19,720,015	3.16%	\$18,855,598	3.34%
210048	Howard County General	\$432,095,254	\$19,363,587	4.48%	4.35%	\$18,787,446	4.41%	\$20,120,022	4.66%
210049	UM-Upper Chesapeake	\$450,469,961	\$17,358,591	3.85%	3.32%	\$14,936,593	3.58%	\$17,031,775	3.78%
210051	Doctors Community	\$344,221,351	\$18,490,641	5.37%	5.22%	\$17,973,018	5.30%	\$19,230,138	5.59%
210056	MedStar Good Samaritan	\$339,177,318	\$18,015,219	5.31%	3.88%	\$13,147,010	4.59%	\$16,434,279	4.85%
210057	Shady Grove Adventist Hospital	\$573,698,386	\$31,464,676	5.48%	4.55%	\$26,101,348	5.02%	\$ 30,359,064	5.29%
210060	Fort Washington Medical Center	\$74,488,844	\$6,678,188	8.97%	6.65%	\$4,955,914	7.81%	\$6,135,571	8.24%
210061	Atlantic General	\$149,794,200	\$6,099,000	4.07%	4.86%	\$7,276,286	4.46%	\$7,053,834	4.71%
210062	MedStar Southern MD	\$374,580,256	\$19,862,055	5.30%	4.17%	\$15,623,021	4.74%	\$18,714,055	5.00%
210063	UM-St. Joseph Med Cntr	\$531,016,704	\$17,224,292	3.24%	2.63%	\$13,967,698	2.94%	\$16,449,975	3.10%
210065	HC-Germantown	\$198,989,784	\$11,975,854	6.02%	5.20%	\$10,346,738	5.61%	\$11,772,448	5.92%
Statewide	Total	\$22,995,315,139	\$916,830,189	4.01%	3.62%	\$832,048,353	3.80%	\$922,320,362	4.01%

Appendix II. Actual UCC Summary Statistics

The table below shows the Actual UCC Statewide and by hospital between RY 2024 and RY 2023 – it does not reflect predicted UCC rates

HOSPID	HospName	RY2025 % UCC	RY2024 % UCC	Variance Over/Under
210001	Meritus	4.47%	4.53%	-0.06%
210002	UMMS- UMMC	2.15%	3.83%	-1.68%
210003	UMMS- Capital Region	6.39%	7.21%	-0.82%
210004	Trinity - Holy Cross	6.01%	6.49%	-0.48%
210005	Frederick	6.56%	4.57%	1.99%
210008	Mercy	4.62%	4.53%	0.09%
210009	JHH- Johns Hopkins	2.73%	3.07%	-0.34%
210011	Saint Agnes	5.58%	6.48%	-0.90%
210012	Lifebridge- Sinai	3.04%	2.34%	0.70%
210015	MedStar- Franklin Square	3.63%	3.31%	0.32%
210016	Adventist White Oak Medical Center	6.14%	5.74%	0.40%
210017	Garrett Co Memorial	5.79%	6.76%	-0.97%
210018	MedStar- Montgomery	4.28%	3.89%	0.39%
210019	Tidal- Peninsula	4.69%	5.04%	-0.35%
210022	JHH- Suburban	3.66%	3.61%	0.05%
210023	Luminis- Anne Arundel	2.12%	1.77%	0.35%
210024	MedStar- Union Mem	3.72%	2.30%	1.42%
210027	UPMC Western Maryland	5.03%	4.98%	0.05%
210028	MedStar- St. Mary's	4.18%	3.86%	0.32%
210029	JHH- Bayview	4.12%	4.51%	-0.39%
210030	UMMS- Chestertown	5.27%	4.91%	0.36%
210032	ChristianaCare, Union	4.89%	1.83%	3.06%
210033	Lifebridge- Carroll	3.36%	1.40%	1.96%
210034	MedStar- Harbor	7.31%	5.50%	1.81%
210035	UMMS- Charles	7.15%	6.21%	0.94%
210037	UMMS- Easton	3.94%	2.92%	1.02%
210038	UMMS- Midtown	4.12%	3.81%	0.31%
210039	Calvert	2.40%	1.77%	0.63%
210040	Lifebridge- Northwest	4.36%	2.78%	1.58%
210043	UMMS- BWMC	4.26%	4.45%	-0.19%
210044	GBMC	2.84%	2.36%	0.48%
210048	JHH- Howard County	4.48%	4.80%	-0.32%
210049	UMMS-Upper Chesapeake	3.85%	4.11%	-0.26%
210051	Luminis- Doctors	5.37%	5.03%	0.34%

210056	MedStar- Good Sam	5.31%	3.97%	1.34%
210057	Adventist Shady Grove Medical Center	5.48%	5.52%	-0.04%
210058	UMMS- UMROI	3.44%	3.41%	0.03%
210060	Adventist Fort Washington Medical Center	8.97%	7.46%	1.51%
210061	Atlantic General	4.07%	4.62%	-0.55%
210062	MedStar- Southern MD	5.30%	4.94%	0.36%
210063	UMMS- St. Joe	3.24%	3.42%	-0.18%
210064	Lifebridge- Levindale	6.04%	5.34%	0.70%
210065	Trinity - Holy Cross Germantown	6.02%	5.99%	0.03%
218992	UM-Shock Trauma	4.40%	6.35%	-1.95%
	<u>Statewide</u>	4.01%	3.99%	0.02%

Note: Free-Standing EDs and/or Medical Centers, Behavior Health and Specialty Hospitals are not included in this analysis
Source: HSCRC RE Schedules

The next HSCRC Public Meeting is Tuesday, November 10, 2026.