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Medicare Performance Adjustment Calendar Year 2026

Final Recommendation

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Recommendations for CY 2026 MPA Policy

This recommendation does not introduce any changes from the approved Medicare Performance Adjustment (MPA) policy from calendar year 2025 (CY 2025). The relevant policies will remain unchanged from the prior year. Staff recommend maintaining the current approach as the MPA is sunsetting when Medicare fee-for-service global budgets are implemented in 2028.

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to (1) Attribute 95 percent of all Maryland Medicare beneficiaries to some Maryland hospital; (2) Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and (3) Determine a payment adjustment based on the difference between the hospitals actual attributed TCOC and the benchmark.	This MPA recommendation maintains the current policy and related MPA Framework without modification.	The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care. Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments are a discount on the amount paid by CMS and not on the amount charged by the hospital. In other words, this policy does not change the GBR or any other rate-setting policy that the HSCRC employs and – uniquely – is	This policy does not affect the rates paid by payers other than Medicare Fee-for-service. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service area.	This policy holds hospitals accountable for cost and quality of Medicare beneficiaries in the hospital's service area. Focusing resources to improve total cost of care provides the opportunity to focus the hospital on addressing community health needs, which can lower total cost of care.

		applied only on a Medicare basis.		

Introduction to MPA Policies

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for total cost of care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area.

The MPA includes three "components": (a) a Traditional Component, which holds hospitals accountable for the Medicare total cost of care (TCOC) of an attributed patient population, (b) a Reconciliation Component, which rewards hospitals for the care redesign interventions and (c) a Savings Component that allows the Commission to adjust hospital rates to achieve the Medicare Total Cost of Care Model (the Model) savings targets.

The Traditional Component is governed via annual updates to the MPA policy adopted by the Commission. This document represents the update for Calendar Year 2026 (also known as MPA Year 8). The Efficiency and Savings Component are governed via the MPA Framework adopted by the Commission in October 2019[1] (as amended in the MPA Year 6 recommendation adopted in 2024). These three components are added together and applied to the amount that Medicare pays each respective hospital. The MPA is applied as a discount or inflator to the amount that Medicare pays on each claim submitted by the hospital.

MPA Traditional Component

Recap of Current Program

The following recaps the traditional MPA as it was implemented for Calendar Year 2024, it is included as a reference. The approaches described were adopted incrementally in the Calendar Year 2021, 2022, 2023, 2024 and 2025 MPA policies, and those policies remain in effect except where changes are specifically denoted in the next section.

The first step in the process is to attribute beneficiaries to hospitals. The current attribution is as follows:

1. Hospitals, except Academic Medical Centers (AMCs) are attributed the costs and beneficiaries in zip codes that comprise 60% of their volume. AMCs are assigned all zip codes for Baltimore City for their geographic attribution. Beneficiaries in zip codes claimed by more than one hospital are allocated according to the hospital's share of equivalent case-mix adjusted discharges (ECMADs)

[1] Available, starting on page 10, here: MPA Framework

for inpatient and outpatient discharges among hospitals claiming that zip code. ECMADs are calculated from Medicare FFS claims for Calendar Year 2019. ECMADs are also used in calculating the volumes in the 60% test.

2. Zip codes not assigned to any hospital under step 1 are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed a 30-minute drive-time from the hospital's PSA.
3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.
4. A second layer is added for AMCs. AMCs are also attributed where beneficiaries with a case-mix index (CMI) greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as to the hospital under the standard attribution. The AMC outcome becomes a blend of this approach and the standard geographic approach.

The MPA then penalizes, or rewards hospitals based on their attributed TCOC. Hospitals are rewarded if the TCOC growth of their attributed population is less than national growth. Beginning in 2021, the HSCRC scaled the growth rate target for hospitals based on how expensive that hospital's service area is during the baseline period relative to other geographic areas elsewhere in the nation. This policy is intended to ensure that hospitals which are expensive relative to their peers bear the burden of meeting the Medicare savings targets, while hospitals that are already efficient relative to their peers bear proportionally less of the burden. The TCOC growth rate adjustments are shown in Table 1 below.

Table 1: Scaled Growth Rate Adjustment

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
1st Quintile (-15% to + 1% Relative to Benchmark)	0.00%
2nd Quintile (+1% to +10% Relative to Benchmark)	-0.25%
3rd Quintile (+10% to +15% Relative to Benchmark)	-0.50%
4th Quintile (+15% to +21% Relative to Benchmark)	-0.75%
5th Quintile (+21% to +28% Relative to Benchmark)	-1.00%

Historically, hospitals were required to beat the national TCOC growth rate each year. But in 2021, the HSCRC changed the way that the TCOC is calculated for hospitals. The HSCRC will trend the hospital's baseline TCOC forward based on the national growth rate and the TCOC adjustment factors. This was intended to create more predictability for hospitals. A hospital can now predict what their target will be two or three years out. An example of the methodology to calculate the TCOC targets is shown in Table 2 below. This example covers 2019 to 2021, for each additional year another year of trend similar to item C in

Table 2 is added. Each additional year is also adjusted for the Growth Adjustment Factor (item D in Table 2).

Table 2: Calculation of the MPA Targets

Variable	Source
A = 2019 TCOC	Calculation from attributed beneficiaries
B = 2020 National TCOC Growth	Input from national data
C = 2021 National TCOC Growth	Input from national data (assumed to be 3% in example below)
D = Growth Rate Adjustment Factor	From Growth Rate Table (applies to 2021 and all subsequent years)
E = MPA TCOC Target	A x (1 + B) x (1 + C - D) = E

Example Calculation of MPA Targets

Hospital	Quintile	Target Growth Rate	2019 TCOC	2020 MPA Target	2021 MPA Target
Hospital A	1	3% - 0.00% = 3.00%	$11,650	$12,000	$12,359
Hospital B	2	3% - 0.25% = 2.75%	$11,193	$11,529	$11,846
Hospital C	3	3% - 0.50% = 2.50%	$11,169	$11,504	$11,792
Hospital D	4	3% - 0.75% = 2.25%	$11,204	$11,540	$11,800
Hospital E	5	3% - 1.00% = 2.00%	$10,750	$11,073	$11,294

The hospital is rewarded or penalized based on how their actual TCOC compares with their TCOC target. Starting last year, as described below, the rewards and penalties were scaled such that the maximum reward or penalty was 2%, which will be achieved at a 6% performance level. Essentially, each percentage point by which the hospital exceeds its TCOC benchmark results in a reward or penalty equal to one-third of the percentage. An example of the hospital's rewards/penalties is shown in the table below.

Table 3: Example of MPA Reward & Penalty Calculations (excluding quality adjustments)

Variable	Input
E = MPA Target	See previous section
F = 2021 MPA Performance	Calculation
G = Percent Difference from Target	(E - F) / E
H = MPA Reward or Penalty	(G / 3%) x 1%
I = Revenue at Risk Cap	Greater / lesser of H and + / - 2%

Example MPA Performance Calculations				
Hospital	**MPA Target**	**MPA Performance**	**% Difference**	**Reward (Penalty)**
Hospital A	$12,359	$12,235	-1.00%	0.33%
Hospital B	$11,846	$11,941	0.80%	-0.27%
Hospital C	$11,792	$11,556	-2.00%	0.67%
Hospital D	$11,800	$11,033	-6.50%	2.00%
Hospital E	$11,294	$11,859	5.00%	-1.67%

In addition, the agreement with CMS requires that a quality adjustment be applied that reflects hospital quality outcomes, this is in addition to the revenue-at-risk for Total Cost of Care. These quality adjustments are derived from those in the Commission's all-payor Readmission Reductions Incentive Program (RRIP) and Maryland Hospital Acquired Conditions (MHAC) program.

In the MPA Year 6 final recommendation, the Commission approved two changes to MPA policy beginning in 2024. MPA policy was revised to include an increase in the maximum revenue-at-risk as well as the addition of a population health measure to the quality adjustment included in the Traditional MPA. The amount of revenue-at-risk for Total Cost of Care performance under the Traditional MPA increased from 1% to ±2%. Increasing the revenue at risk under the MPA had been a stated goal of the Center for Medicare and Medicaid Services (CMS) for several years. The translation between actual results and the revenue-at-risk would not be changed from the current 3:1 ratio. Therefore, the revenue-at-risk would be reached at ±6%.

In addition to increasing the revenue-at-risk, MPA policy was revised to add a population health metric to the quality adjustment included in the Traditional MPA and include it in the Calendar Year 2024 and future MPA adjustments according to the formula below (adjusted for 2% revenue-at-risk):

TCOC results x 1/3 (capped at 2% of Medicare revenue) x (1 + 2 x (RRIP + MHAC Reward/Penalty + Population Health Quality Measure) where the Population Health Quality Measure is scaled to generate a result of ±4%.

This formula will result in total revenue-at-risk of ±2.32% of Medicare payments.

In the MPA Year 7 final recommendation, the Commission approved a retroactive adjustment to correct the MPA savings target for Calendar Years 2020 to 2024 (CY2020 to CY2024) to reflect newly available information on non-claims-based payments (NCBPs) resulting in a one-time increase to hospital rewards estimated at approximately $22.0 M from Medicare only, through Calendar Year 2023. The corrected 2024 targets were used in setting payments for that year which began July 1 of 2025. This adjustment in the MPA savings target is replicated on a go-forward basis beginning in Calendar Year 2025.

MPA Framework Reconciliation Component

Recap of Current Program

In the MPA Framework recommendation Staff noted that under GBRs hospitals do not capture utilization savings that occur outside their GBR and therefore any successes they achieve help the State meet the TCOC Model savings target but do not help the hospitals. The Commission adopted the MPA Framework recommendation and implemented the CTI program as a response to this disconnect. The recommendation noted the following principles to strengthen hospital incentives:

- Hospitals should keep the savings from their CTIs up to 100% to the extent feasible.
- Incentives should be structured to reward participation in CTIs and penalize non-participation.
- New and Existing CTIs that transform care across the entire delivery system should be supported.

The Framework also included the use of the MPA-RC to pay incentives earned under CTIs and to offset those incentives by reducing Medicare Fee-for-service payments to all hospitals to create a net zero adjustment (the Offset). This approach was adopted as per the Staff's October 2019 Final MPA Framework Recommendation, "First, it mitigates the possibility that these care transformation payments will result in a net increase in the TCOC run rate. Second, when a hospital captures the savings from their CTIs, the resulting increased costs will be spread as an offset across all hospitals resulting in non-participating hospitals being penalized for their non-participation. Additionally, the Offset incents participation in care redesign by encouraging participation through limited downside risk and minimizing administrative barriers. In December of 2023 (MPA Year 6 recommendation), the Framework was amended to include a cap on the

downside risk of a hospital under the CTI program to 2.5% of total Medicare Payments and redistribute additional risk across all hospitals to maintain the overall savings neutrality in the program.

In the MPA year 7 recommendation, HSCRC revisited the CTI offset to incorporate an attainment aspect. The Commission approved tiering the stop loss applied during the offset in a way that mirrors the Traditional MPA Scaled Growth Adjustment. This will provide greater protection for hospitals with less opportunity without eliminating the incentive for all hospitals to drive savings. Table 4 shows the tiers.

Table 4: Scaled Stop Loss Tiers

Hospital Performance vs. Benchmark	Stop Loss
1st Quintile (-15% to + 1% Relative to Benchmark)	1.250%
2nd Quintile (+1% to +10% Relative to Benchmark)	1.875%
3rd Quintile (+10% to +15% Relative to Benchmark)	2.500%
4th Quintile (+15% to +21% Relative to Benchmark)	3.125%
5th Quintile (+21% to +28% Relative to Benchmark)	3.750%

Modeling using Year 2 CTI adjustments showed this change would have had the impact of shifting approximately $5 million from the highest cost quintiles to the lowest cost quintiles. Although as the portfolio of CTIs implemented changes each year the actual future impact could be less or more. However, consistent with stakeholder feedback that changes should not be applied to periods that have already been implemented, Staff implemented this change for CTIs starting July 1, 2025.

Future Areas of Focus

With no changes proposed for the Calendar Year 2026 MPA Recommendation, HSCRC staff will continue ongoing discussions with stakeholders and subject matter experts on the future of care redesign programs. Stakeholders will continue to participate in HSCRC-led workgroups throughout 2026 to provide feedback and engage in comprehensive discussions.