maryland
health services
cost review commission

Final Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2028

January 14, 2026

This document contains the staff final recommendations for updating the Quality-Based Reimbursement Program for RY 2028.

P: 410.764.2605 4160 Patterson Avenue | Baltimore, MD 21215 hscrc.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	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 (SFY) 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

FINAL RECOMMENDATIONS

This document puts forth the RY 2028 Quality-Based Reimbursement (QBR) final policy recommendations for consideration. The policy provides timeline options for incrementally transitioning the hospital QBR program to the CMS national Hospital Value Based Purchasing ("HVBP") program for Medicare FFS global budgets; the transition will also include better 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 provided valuable input on these recommendations and longer-term priorities that should be considered as Maryland transitions to the AHEAD Model.

Final Recommendations for RY 2028 QBR Program:

1. Update Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.
2. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and set the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 32 percent.
    a. Retrospectively evaluate the preset cut-point using more recent data to calculate national average score for RY 2027 and RY 2028.
    b. Based on concurrent analysis of national hospital performance, adjust the RY26 QBR cut-point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.
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; 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.

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 (2019-2026) and the current AHEAD model (CY 2026-CY 2035). Under the new AHEAD model the state will transition in CY 2028 (Performance Year 3) to CMS establishing hospital global budgets for Medicare FFS and to the HSCRC establishing hospital global budgets for all other payers (i.e., non-Medicare FFS). Under the Medicare FFS hospital global budgets, hospitals will be held accountable for quality under the CMS quality programs and through additional AHEAD incentives, while the state may maintain quality programs for all other payers. HSCRC staff is collaborating with CMMI, hospitals, the Maryland Hospital Association (MHA), state leaders, other state health agencies, and the broad array of stakeholders on the Performance Measurement Workgroup to develop a transition plan that increases the alignment between the state's performance based payment programs and the CMS national programs over the initial years of the AHEAD model.

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

The 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 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

QBR program addresses efficiency through the overall hospital global budgeting methodology combined with the hospital Integrated Efficiency policy.

Under the TCOC Model, Maryland has been required to request a waiver each year from CMS hospital pay-for-performance programs, including the HVBP Program. CMS assesses and grants these waivers based on a report showing that Maryland's results continue to meet or surpass those of the nation. Currently, CMMI has reviewed the exemption request and does not have any questions, but has not yet provided final written confirmation. Throughout the TCOC Model, the state has been 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, the QBR policy has been adapted over the years to address these areas of concern raised by CMMI in order to maintain the waiver from the national programs.

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. Below is the staff's current understanding of the quality program expectations for the transition period and beyond.

For RY 2028, which will assess CY 2026 performance, staff will work 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. In a detailed or targeted sense, alignment can mean an exact replication of the CMS quality programs; in a broader sense, alignment can mean harmonizing with national hospital quality program priorities and intentions.

This final policy recommends options on where to align QBR measures and domain weights in anticipation of the transition to the HVBP program for Medicare FFS. In addition to the Quality Program Guiding principles that were established at the start of the APM, the

following criteria were proposed for evaluating what measures to include in the policy and the weights:

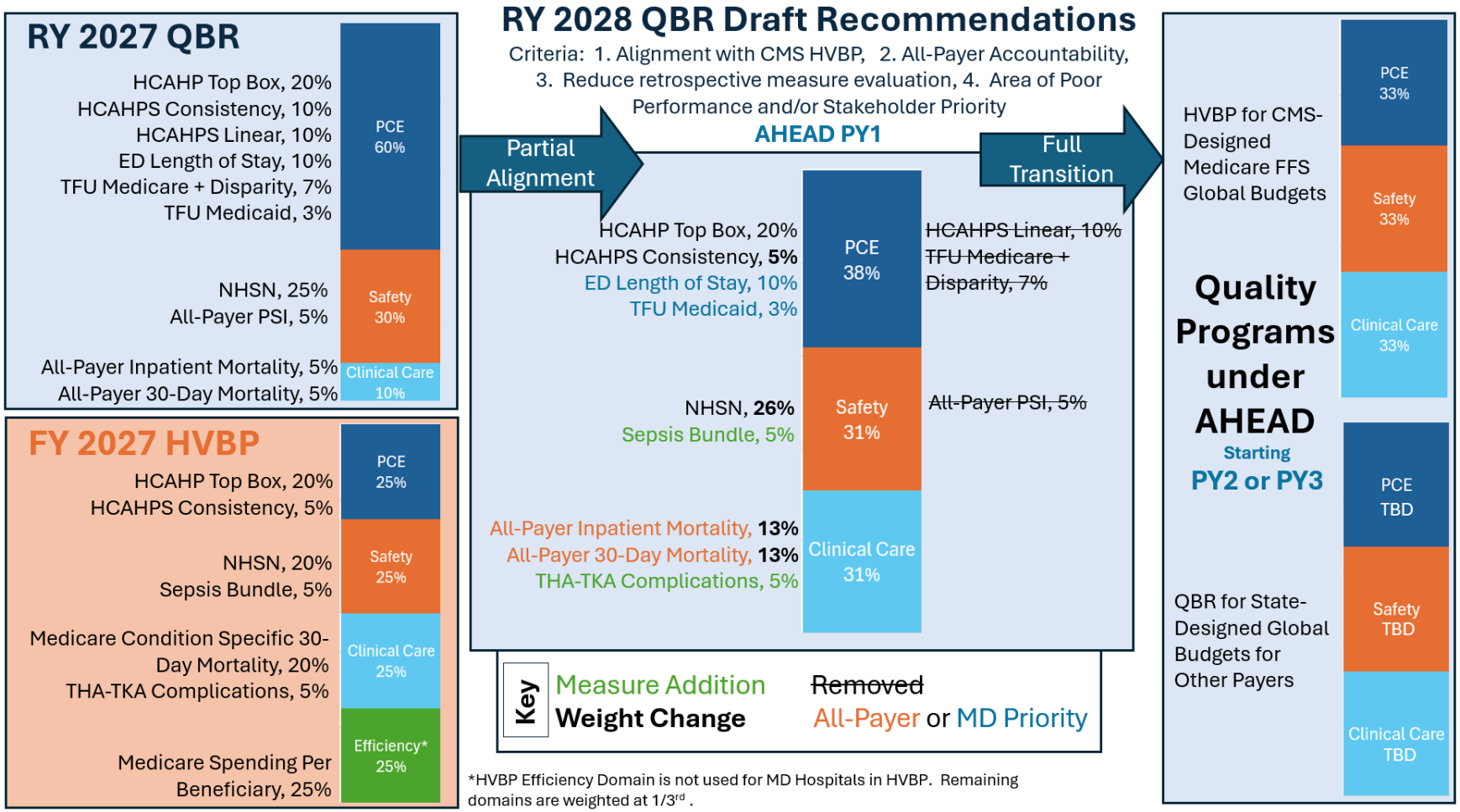
1. Alignment with CMS programs
2. Maintenance of all-payer accountability and incentives for quality
3. Reduction of retrospective measure evaluations to the extent possible
4. Attention to areas of poor performance and/or priority area for State, hospitals, payers, or other stakeholders

Staff has and will continue to vet details of this transition across all of the RY 2028 quality policies with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies. Staff will also seek input from the ED Wait Time Reduction Commission and subgroups on use of ED LOS measures for payment and/or monitoring.

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

Figure 1 provides a summary of the current HVBP and QBR programs and the proposed recommendations for changes for RY 2028 and beyond. Specifically, the current QBR and HVBP programs are shown on the left side of the figure. The middle of the figure shows the draft proposal for RY 2028 QBR, including measures being added, maintained, or deleted to better align QBR with the HVBP program. These decisions were based on the criteria outlined above and included in the figure below. As discussed throughout this draft policy, staff is seeking input on these changes. 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 starting in the 2nd or 3rd performance year (PY) under the AHEAD model.

Figure 1. QBR-HVBP Domains and Measures with Proposed Updates to Align with CMS Under the AHEAD Model



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

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 2 presents RY 2027 QBR measures and domain weights compared to those used in the HVBP Program.

Figure 2. RY 2027 QBR and Domain Weights Compared to the CMS HVBP Program

Domain	Maryland RY 2027 QBR Domain Weights and Measures	CMS FFY 2028 HVBP Domain Weights and Measures
Clinical Care	**10 percent** Two measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality	**25 percent** Six measures: Five condition-specific mortality measures; THA/TKA complications
Person and Community Engagement	**60 percent** 1. Six HCAHPS categories, top-box score and consistency, 3 categories for linear scores; 2. TFU (Medicare, Medicaid, disparities improvement); 3. ED LOS	**25 percent** Six HCAHPS measures top-box score and consistency
Safety	**30 percent** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**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 measure[1], the performance standards range from the 50th percentile of hospital performance

[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.

(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 and assesses rewards and penalties to hospitals in a revenue neutral manner retrospectively based on the distribution of final scores, the QBR Program has used a preset scale to determine each hospital's revenue adjustment and is not necessarily 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, 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.

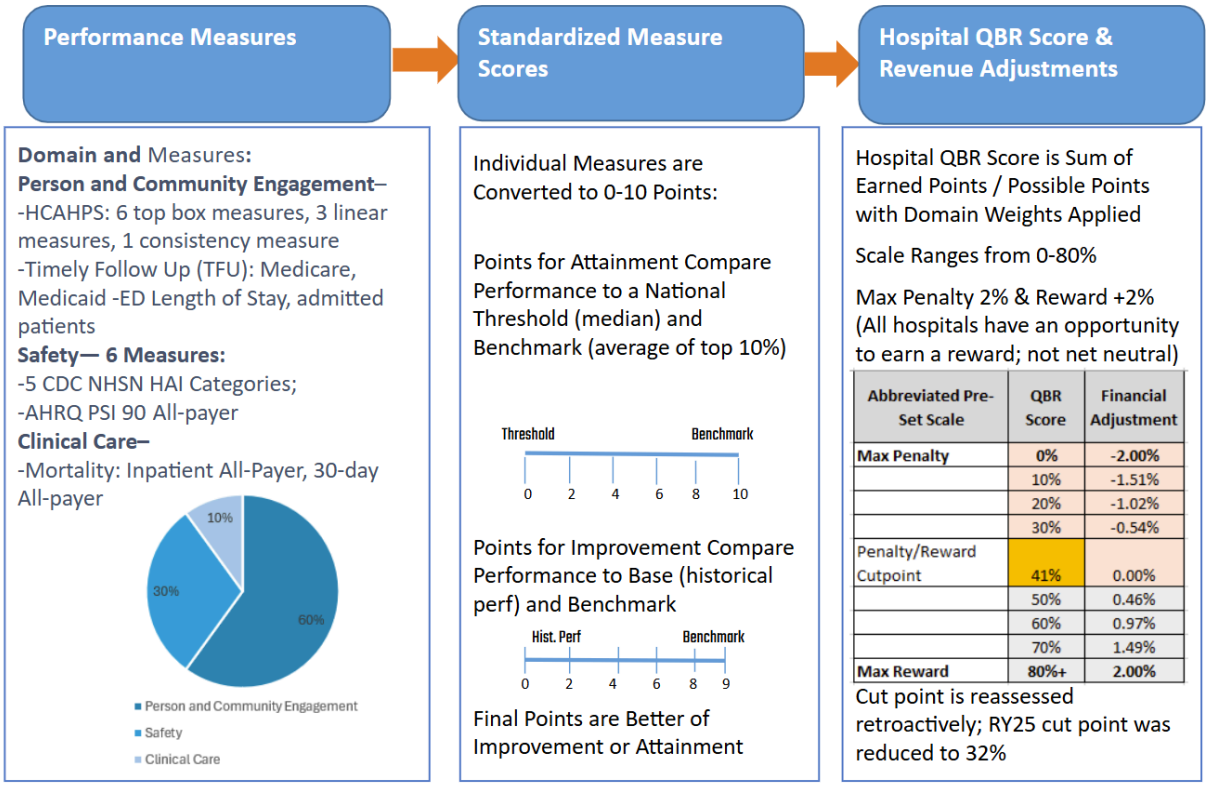
As a recap, the method for calculating hospital QBR scores and associated inpatient revenue adjustments involves:

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 2027 are summarized in Figure 3.

Figure 3. RY 2027 QBR Policy Methodology Overview



Appendix B 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 final policy provides three options on where to align QBR measures and domain weights in anticipation of the transition to the HVBP 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 the options for measure alignment. The domain and measure weights are then discussed at the end since they

are interrelated decisions, along with revenue adjustment estimates based on several options for Commissioner consideration.

A. Person and Community Engagement Domain

The Person and Community Engagement domain currently weighted at 60 percent of the QBR score and measures performance using the HCAHPS patient survey (top-box, consistency, and linear scores are all assessed), three measures of timely follow-up (TFU) after discharge for an acute exacerbation of a chronic condition, 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]

In RY 2024, HCAHPS linear scores were added as 20 percent of the PCE domain (i.e., 10 percent of overall QBR score). for the following domains: the nurse communication, doctor communication, responsiveness of staff, and care transition. The addition of the linear measures was designed to further incent hospital focus on HCAHPS by providing credit for improvements along the continuum and not just improvements in top-box scores. The

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

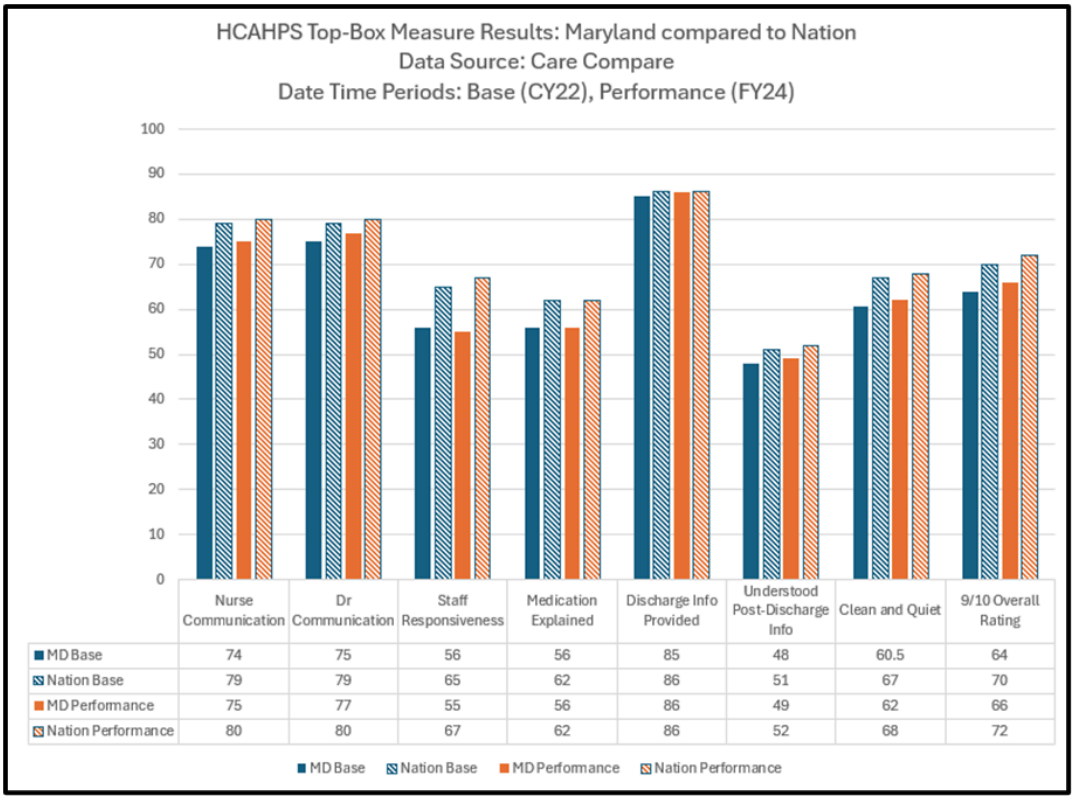
[3] For more information on the HVBP Program's performance standards and top-box and consistency scoring, please see https://qualitynet.cms.gov/inpatient/hvbp/performance.

inclusion of the HCAHPS linear measures is unique to the QBR policy and not aligned with the HVBP program.

Analysis results for Maryland versus the nation on "top-box" performance (Figure 3) for eight HCAHPS measures and on linear measure performance for four measures (Figure 4) are provided below. 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 (VBP FFY 2027 through FFY 2029). Figure 4 below reveals that:

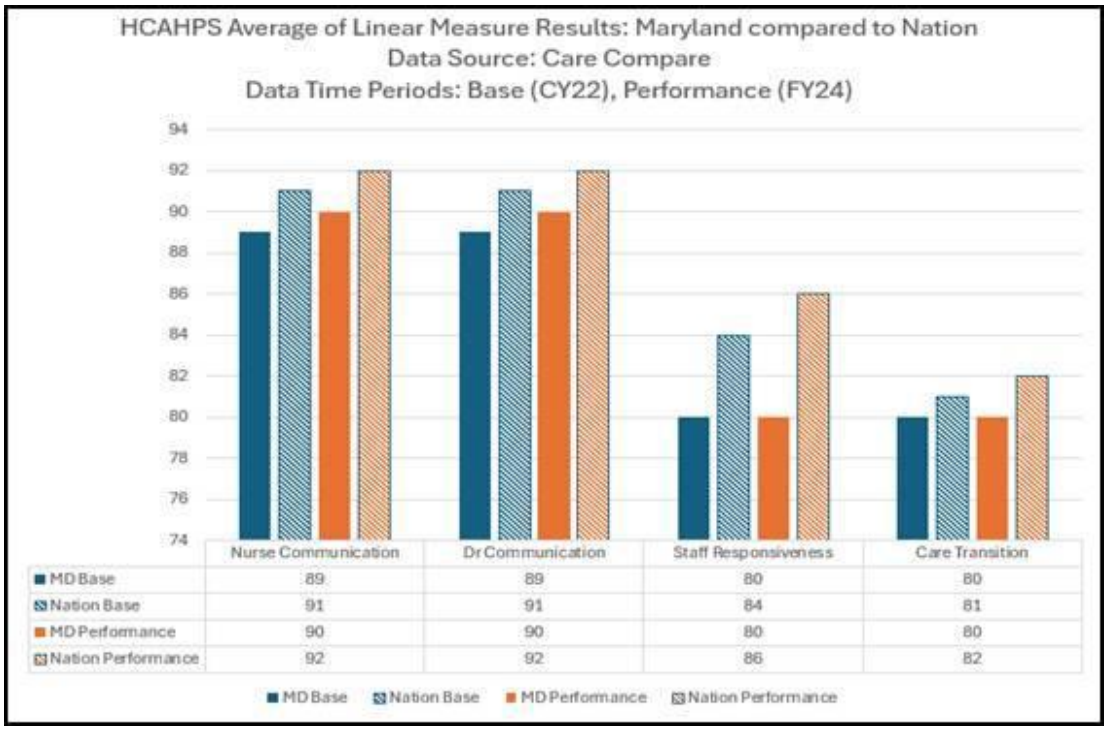
- Both the nation and Maryland had little change in performance from the base to the performance periods for all of the HCAHPS categories (changes ranged from -1 percent to +2 percent).
- Maryland had slightly worse performance on Staff Responsiveness and remained the same on Medication Explained; the state improved slightly on Nurse and Doctor Communication, Understood Post Discharge Instructions, Clean and Quiet, and Overall Hospital Rating.
- The nation improved slightly on all categories with the exception of Medication Explained which remained the same.

Figure 4. Top-box HCAHPS Results: Maryland Compared to the Nation, CY 2022 vs 7/1/23-6/30/24



Analysis of linear measures in Figure 5 indicates that State performance continues to lag the nation and has improved only slightly or remained the same compared to the CY 2022 base period, consistent with national trends and trends seen in top-box scores. The linear measures were updated for the RY 2027 policy in light of the CMS changes to the HCAHPS instrument to include three measures–doctor communication, nurse communication and medication explained. Since linear scores are not improving in Maryland relative to the nation, and in an effort to align with the HVBP program, staff and stakeholders are proposing to remove the HCAHPS linear measures.

Figure 5. Linear Measure HCAHPS Results: Statewide and National Average, CY 2022 vs 7/1/23-6/30/24



Based on CMMIs concerns over HCAHPS performance, the HSCRC and MHA have been convening an HCAHPS Learning Collaborative with hospitals over the last year. Appendix C provides an overview of this work, which was also presented at the December Commission meeting. One of the key deliverables is a statewide HCAHPS dashboard built on patient level HCAHPS data collected by MHCC. The HCAHPS dashboard, which was 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. For example, MHCCs most recent analysis continues to show differences in respondent rates and results when stratified by race and by the Medical, Surgical and Maternity service lines. Other next steps for the HCAHPS Learning Collaborative are to continue to meet quarterly to share best practices and consider expanding best practice incentives to focus on patient experience.

Emergency Department Length of Stay

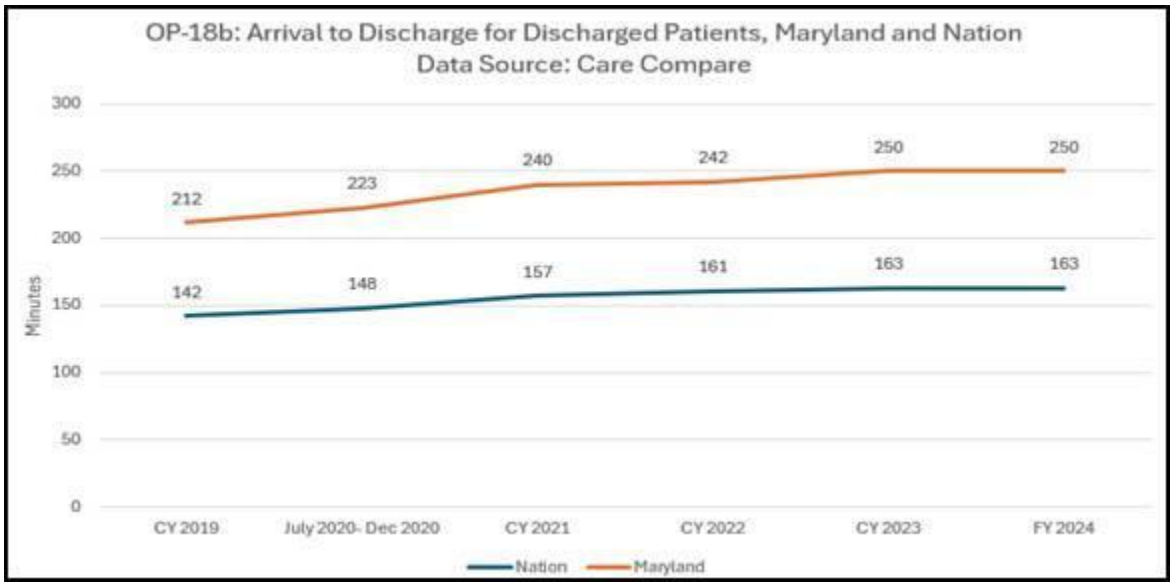
ED length of stay (LOS)--i.e., wait times–has been a significant concern in Maryland, predating Maryland's adoption of hospital global budgets instituted in 2014,[4] with multiple underlying causes and potential adverse outcomes in patient experience and quality.

[4] 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.

Concerns about unfavorable ED throughput data have been shared by many Maryland stakeholders, including the HSCRC, the MHCC, payers, consumers, emergency department and other physicians, hospitals, the Maryland Institute of Emergency Medical Services Systems, and the Maryland General Assembly, with around a dozen legislatively mandated reports on the topic since 1994. 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, current collection of ED LOS data, and other ED initiatives. In 2024, the Maryland General Assembly established the ED Wait Time Reduction Commission to address this issue; the ED Commission is co-chaired and staffed by the HSCRC but has a mandate that requires broader health system innovation. 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.

Publicly available data on CMS Care Compare reveals Maryland's previous poor performance compared to the nation on patients admitted (data no longer collected by CMS after 2019), and on outpatient ED measures for patients not admitted. As shown in Figure 6 below, Maryland's performance has worsened over time as has that of the nation, and Maryland's wait times remain higher than that of the nation.

Figure 6. Maryland and National Performance on ED Wait Times for Discharged Patients



The Commissioners voted to include an ED LOS measure weighted at 10 percent of the QBR program for RYs 2026-2027 (CYs 2024 and 2025 performance). Staff convened subgroups to develop data collection specifications and the performance standards. Specifically, HSCRC now collects patient-level date and time stamps to calculate ED LOS through the HSCRC case-mix process and is working to develop a data monitoring tool for ED LOS for stakeholders and hospitals. For RY 2026, the ED wait time or length of stay (LOS) measure developed for QBR program assesses percent improvement from CY 2023 to CY 2024 using the measure definition as outlined below:

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

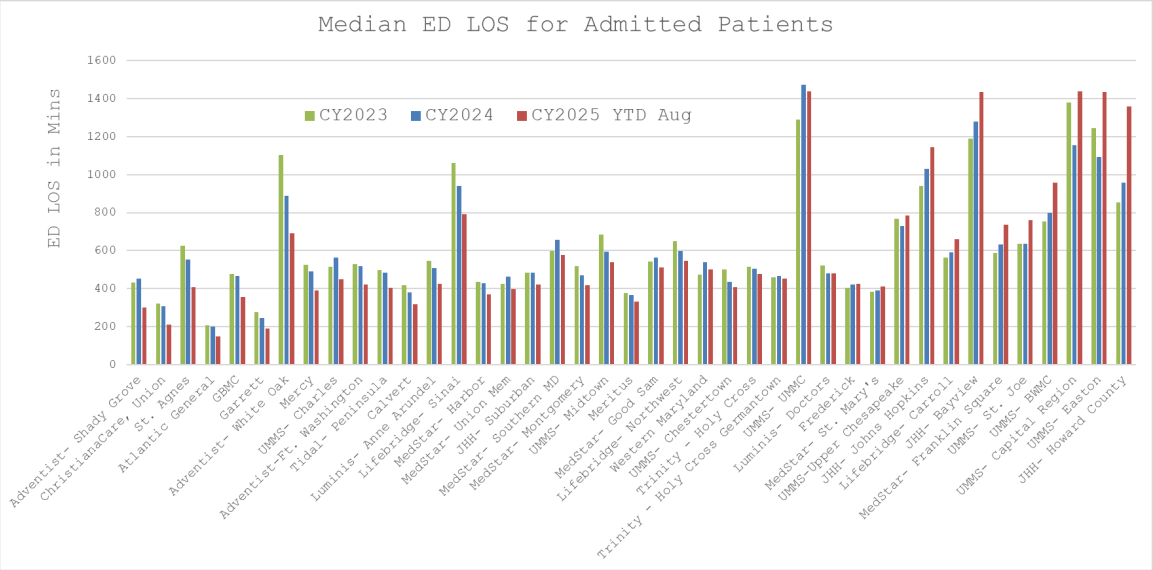
Population: All non-psychiatric, non-trauma, adult ED patients who are admitted to Inpatient bed and discharged from hospital during reporting period

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

- Hospitals with CY2023 Median that is lower (better) than statewide median have threshold of 0 percent and benchmark of -5 percent.
- Hospitals with CY2023 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 2024 will not be penalized for degradations in performance between 2023 and 2024.

For RY 2027, staff is finalizing a risk-adjusted measure while still providing monthly monitoring reports on the unadjusted measure to hospitals. Figure 7 shows the annual median ED LOS for admitted patients for CY 2023, CY2024, and CY2025 through August. The figure is sorted by percent improvement from CY 2024 to CY 2025 YTD. While the median hospital improvement is higher in RY 2027 YTD, the graph does show that a handful of hospitals with the highest baseline ED LOS median (CY 2024) are either increasing or showing small improvements.

Figure 7. Median ED LOS by Hospital, CY 2023 - CY 2025



While there have been more substantial improvements in CY 2025 YTD than were seen in from CY2023 to CY2024, staff does not recommend raising the performance standards with less than a quarter remaining in the performance period, and the forward shift of the base period to CY 2024. Thus, the staff is proposing the following for RY 2027 as part of the RY 2028 draft policy for stakeholder, HSCRC Commissioner, and ED Commission input:

- Maintain measure specifications from RY2026 (monitoring reports released monthly using this measure through the CRISP portal). Maintain improvement goal from RY2026 (i.e., 0 to -5% and 0 to -10% based on median in 2024).
- Develop and assess how to best use a risk-adjusted ED LOS measure.

While for RY 2028 staff recommends continuing to include the ED LOS measure in payment, ED subgroup hospital representatives have mixed opinions on its inclusion. While some hospitals believe this is actionable, others would prefer that ED LOS be a monitoring measure to better align with the national programs. Also, discussions with stakeholders continue on whether an inpatient LOS measure would be a stronger incentive to address hospital throughput concerns. However, as with readmissions, multiple payment incentives that are complimentary may be needed to address the overall concern of throughput, which makes the financial stability of hospital global budgets more difficult.

It is also worth noting 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 assess 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 if there are no improvements in ED LOS, the HSCRC could consider the CMS measure for future inclusion in a payment program to adjust global budgets for non-Medicare FFS. However, at this time and given the intense focus and public scrutiny of ED wait times, HSCRC staff is recommending to continue the current ED LOS measure in payment even though it is not in alignment with the CMS quality payment programs. Based on input from stakeholders and further IP LOS discussions, the staff may modify this recommendation for the final policy and longer term strategy.

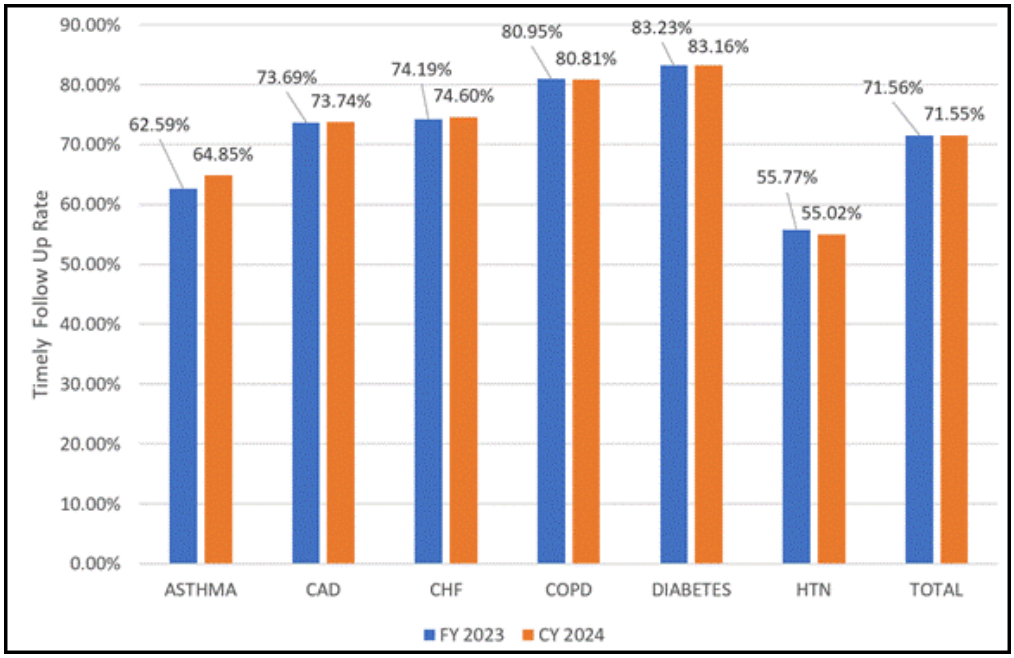
Timely Follow-Up After Discharge

Under the TCOC model, the state was required by CMMI to develop a Statewide Integrated Health Improvement Strategy (SIHIS) that addressed care transformation. Given the development of the Maryland Primary Care model and other provider strategies under the TCOC model, the state proposed improvements in timely follow up after hospitalization using a National Quality Forum-endorsed measure originally developed for health plans. To ensure the SIHIS goal was met, the HSCRC introduced this measure for Medicare beneficiaries into the RY 2023 QBR Program within the PCE domain, expanded the measure to Medicaid in RY 2025, and added a Medicare within-hospital disparity gap measure in RY 2026.[5] The measure assesses the percentage of ED visits, observation stays, and inpatient admissions for one of six conditions in which a follow-up was received within the time frame recommended by clinical practice. Figure 8 shows Maryland's performance in SFY 2023 compared to CY 2024 for each chronic condition and all conditions combined within the Medicare population. Statewide there was a slight decrease in Medicare rates from in SFY 2023 to CY 2024 (71.56% to 71.55%) across all conditions combined. For Asthma, CAD and CHF there were increases in the rates of

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

timely follow-up by 3.61 percent, 0.07 percent and 0.55 percent, respectively. However, for CAD, CHF, Diabetes and Hypertension there were slight decreases in follow up.

Figure 8. Medicare FFS: Maryland Timely follow up



*Maryland numbers are claims-based and built on the CMS Claim and Claim Line Feed data with a four month runout. CAD=Coronary artery disease; CHF= Congestive heart failure; COPD=Chronic obstructive Pulmonary disease; HTN= Hypertension.

Figure 9 shows the annual performance on the total TFU measure for Maryland and the nation (national data is based on the Chronic Condition Warehouse 5 percent sample). Comparing CY 2018 to CY 2024, the nation has seen a 3.71 percent increase and Maryland has seen a 0.08 percent decrease in timely follow-up rates; however, Maryland still performed about 2.15 percent better than the nation in CY 2024.

Figure 9. Medicare FFS: Timely Follow-Up Rate, Maryland vs Nation*

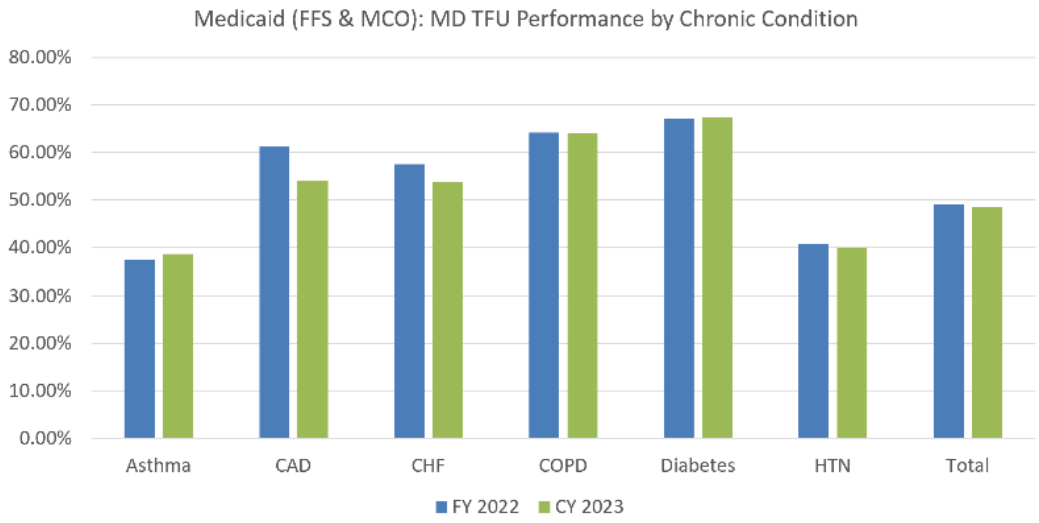
TFU Rates	CY2018	CY2019	CY2020	CY2021	CY2022	CY2023	CY2024
Maryland	70.85%	71.45%	67.90%	70.07%	70.59%	70.29%	70.79%
US	66.82%	69.00%	64.75%	67.68%	67.26%	68.35%	69.30%

*Maryland and national numbers are from the CMS Chronic Conditions Warehouse.

With regard to the Medicare within-hospital TFU gap adopted in RY 2026, staff notes that there were no hospitals improving sufficiently to earn the incentive.

As part of the SIHIS proposal, staff said they would explore expanding the TFU rates for chronic conditions to other payers and adding follow-up after a hospitalization for behavioral health. In CY 2022, staff worked with CRISP and Maryland Medicaid to provide hospitals monthly Medicaid TFU reports on the CRS portal. Beginning in RY 2025, the 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. Similarly to Medicare, Medicaid TFU has gone down slightly over time with less than 50 percent of Medicaid enrollees receiving follow up.

Figure 10. Maryland Medicaid Timely Follow-Up by Condition



QBR-HVBP Alignment: PCE Domain Measures

In an effort to align the QBR program with HVBP, staff and stakeholders discussed the following:

- **HCAHPS:** Align with HVBP by only including top-box and consistency assessment (i.e., remove linear given no evidence the inclusion of linear resulted in improvements).
- **ED LOS:** Despite this not being included in the HVBP, staff are recommending to maintain the ED LOS measure in the QBR program due to the considerable concern about ED wait times from patients and the state legislature. Based on input from stakeholders and further IP LOS discussions, the staff recognizes that

the majority of hospitals do not support this recommendation and defer to the Commissioners for final decision.

- **Timely Follow-Up:** Staff discussed the TFU measures with the PMWG stakeholders. Feedback from hospital representatives on PMWG supported removal of the measures as the state moves toward aligning the QBR program with the HVBP program. However, given the new AHEAD Medicaid primary care model and lower rates of follow up for Medicaid, staff has met with Medicaid to discuss continuing a payment incentive on this measure and how this measure could be monitored to ensure focus on care coordination. Again, as with ED LOS, the staff recognize that the majority of hospitals do not support this recommendation and defer to the Commissioners for final decision.

Discussion of domain weighting with and without the additional ED LOS and/or Medicaid TFU is below, after discussion of each individual QBR domain.

B. Safety Domain

The QBR Safety domain contains five measures from six CDC NHSN HAI categories and the AHRQ Patient Safety Index Composite (PSI-90).[6] This domain is weighted at 30 percent of the total QBR score. In the FY 2026 HVBP program, CMS added the Sepsis and Septic Shock Management Bundle (SEP-1), a measure that has been publicly reported on Care Compare since July 2018. However, staff proposed not adopting this measure in the QBR program based on stakeholder input, inclusion of sepsis mortality in all-payer, all-cause mortality measure in QBR, and Maryland's favorable performance on the sepsis bundle. Instead, the staff proposed a Sepsis Dashboard to allow the State and hospitals to monitor performance on a comprehensive set of measures for sepsis patients. Another difference between the HVBP and QBR safety domain is that QBR has maintained the use of the AHRQ PSI measure rather than moving this measure to a standalone complications program, i.e., the MHAC program. Staff noted in the final QBR policy for RY 2027 that the PSI 90 composite measure would remain in the Safety Domain and that consolidation of the Safety Domain with the MHAC program may be considered for future years. For the RY 2028 draft, PMWG stakeholders support removing the measure from the QBR program in order to align with the HVBP program. However, staff believe this measure should be maintained in payment. Thus, if the PSI measure is

[6] For use in the QBR Program, as well as the HVBP program, the SSI Hysterectomy and SSI Colon measures are combined.

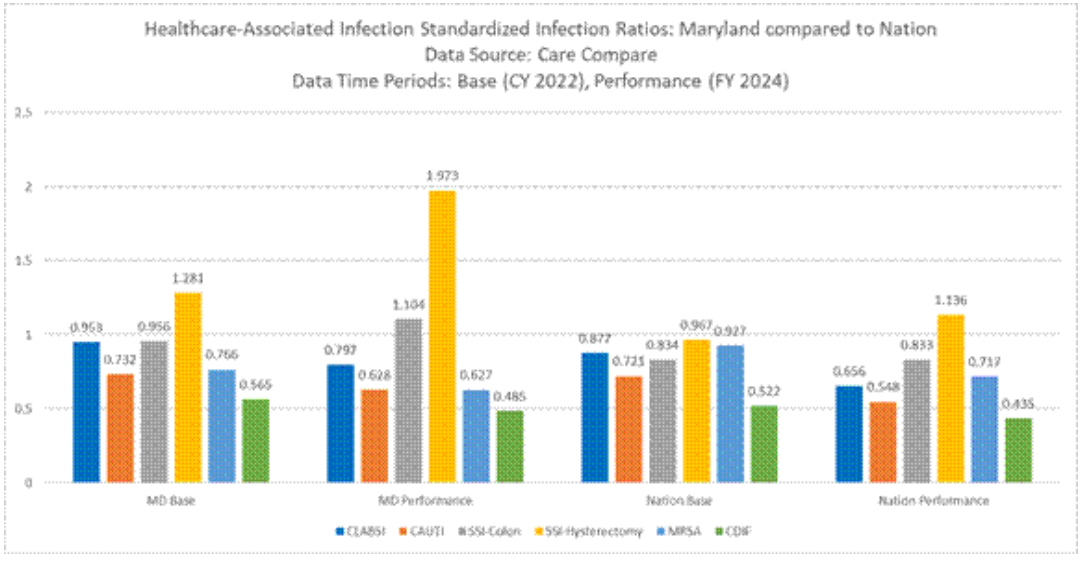
removed from QBR, the measure should be added to the MHAC program to align the CMS HAC reduction program.

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 June 2024. 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, Maryland's performance is favorable compared to that of the nation on MRSA.
- Maryland is worse (higher SIRs) on SSI-hysterectomy, SSI-colon, and slightly worse on CAUTI, CDIF and CLABSI.
- Both Maryland and the nation improved from the base to the performance period on four of the six HAI categories–CAUTI, CLABSI, CDIF and MRSA, and worsened on SSI-colon and SSI-hysterectomy

Figure 11. NHSN SIR Values for CY22 compared to 7/1/23-6/30/24, Maryland versus the Nation



It should be noted that while the QBR program weighs the NHSN measures similarly to HVBP, the NHSN measures are included in both the HVBP and HACRP program for Medicare FFS. The RY2023 QBR policy discusses NHSN concerns including the small cell size issues and surveillance bias (i.e., higher testing for infections results in higher

rates of identified infections). As described in Appendix D, 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. Given these concerns, staff is hesitant and would like stakeholder input over the coming year on whether to align fully with the nation and use of the NHSN measures in two payment programs (QBR and MHAC), and on what measures should be considered for non-Medicare FFS quality policies.

Patient Safety Indicator Composite (PSI-90)

The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators assess the quality and safety of care for adults in the hospital by measuring 18 in-hospital complications and adverse events following surgeries, procedures, and childbirth. PSI-90 is a composite that focuses on a subset of ten AHRQ-specified PSIs such as post-operative sepsis, iatrogenic pneumothorax, and pressure ulcers . CMS removed the PSI-90 measure from the HVBP program in FFY 2024 but retained the measure in the Hospital Acquired Conditions Reduction Program. Maryland does not have PSI-90 in the MHAC program. As stated previously, staff believes the measure should be retained in the state's performance based payment program portfolio and would recommend adopting it into the MHAC program if it is removed from the QBR program.

The Agency for Research and Quality publishes all-payer risk-adjusted PSI 90 data by state and for the nation using the hospital Healthcare Cost and Utilization Project (HCUP) data. Figure 18 below, indicates that Maryland has improved over time and performs better than the Nation based on the most currently available CY 2023 data. Maryland's statewide performance compared to the nation on the PSI 90 composite measure and the individual measures within the composite for CY 2023 and CY 2024 are summarized below and illustrated in Figures 11 and 12[7]. These data show:

- Maryland is better on the overall composite and on eight of the ten PSI indicators than the nation
- Maryland has improved on the overall composite and on seven of the 10 indicators in 2024 compared to 2023
- Maryland has performed better than or on par with the nation on the overall PSI 90 composite in four of the last six years, 2019-2024

Figure 12. All-Payer PSI 90 Composite and Component Indicators for Maryland

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

Compared to the Nation in 2024, and Maryland's performance over time 2023-2024

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

Figure 13 Maryland All-Payer State vs National PSI-90 Composite Performance

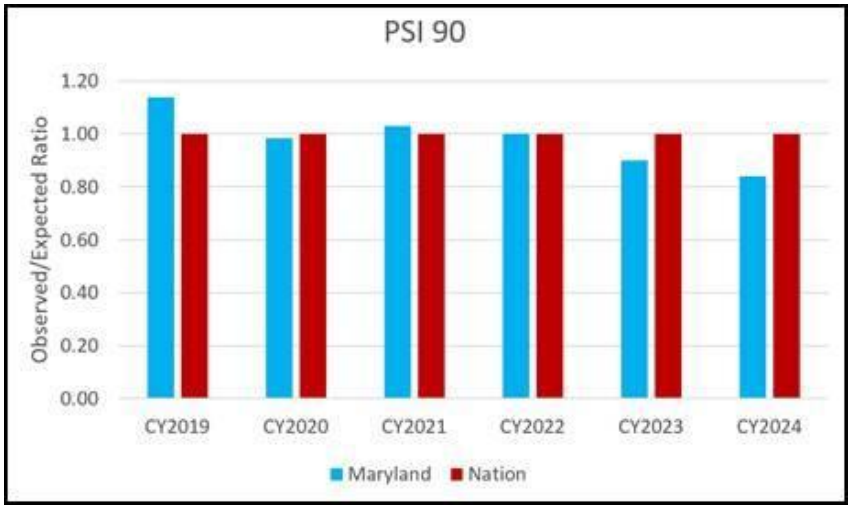
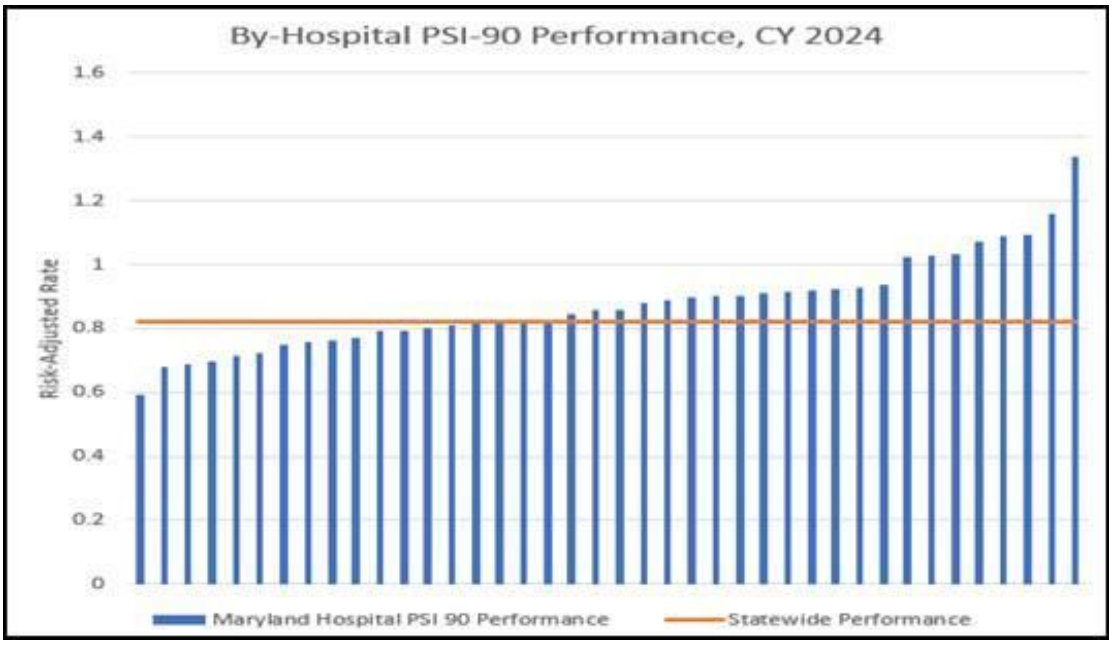


Figure 14 below illustrates the hospital-level performance on the all-payer PSI-90 composite measure for CY 2024; consistent with last year, the variation in performance by hospital suggests there may be opportunity for improvement on this measure.

Figure 14. PSI-90 Composite All-payer Hospital-Level Performance, CY 2024



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.[8] [9] 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.[10] 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 programs include the sepsis PSI, PPC, and sepsis mortality. Instead of adding

[8] Found at: https://www.cdc.gov/sepsis/about/index.html. last accessed 8/6/2025.
[9] 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.
[10] Found at: https://www.endsepsis.org/2023/08/17/end-sepsis-sep-1-response/. Last accessed 11/26/2025.

the Sepsis Bundle to QBR, HSCRC staff recommended development and dissemination of a hospital Sepsis Dashboard for monitoring in lieu of adopting the measure. Maryland continues to perform well compared to the Nation on Sepsis Bundle and the Sepsis PSI, as illustrated in Figure 15 and Figure 16 below. Despite the concerns, staff and most PMWG stakeholders recommend adopting the Sepsis Bundle measure in the Safety domain to align with the HVBP program since CMS recommends its continued inclusion.

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

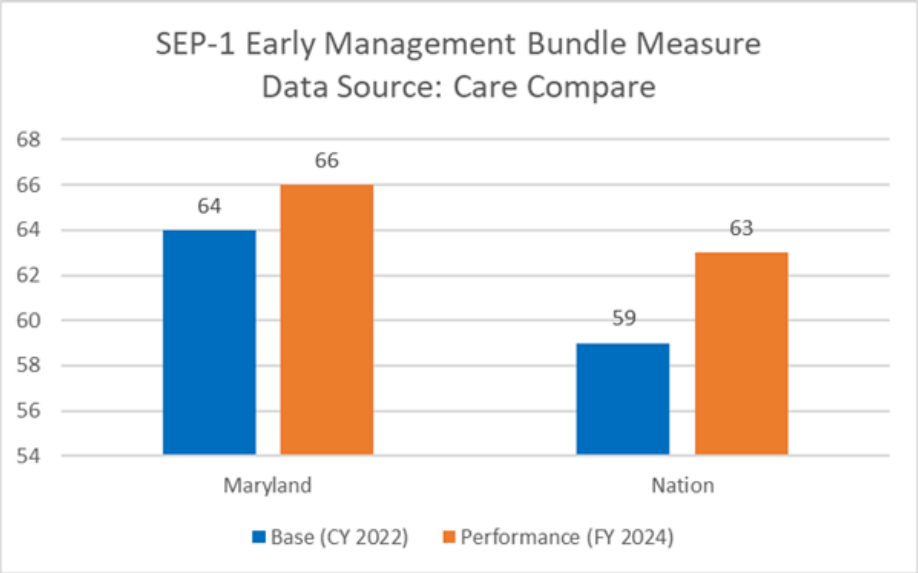
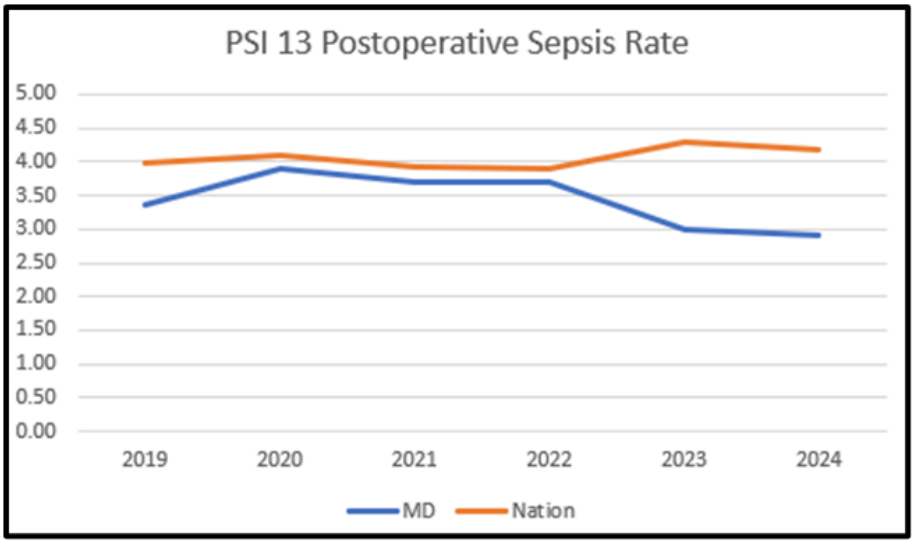


Figure 16. PSI 13 Postoperative Sepsis, Maryland vs. the Nation 2019-2024



QBR-HVBP Alignment: Safety Domain Measures

In an effort to align the QBR program with HVBP balanced with the underlying quality program principles to measure and incent improved safety for patients of all payers, staff and stakeholders discussed the issues below:

- **CDC NHSN Measures:** The RY 2027 QBR policy maintained the Safety domain weighting of 30 percent, five percent higher than HVBP program. However, the NHSN measures are included in both the HVBP and HACRP program for Medicare FFS. The RY2023 QBR policy discusses NHSN concerns including the small cell size issues noted above as well as surveillance bias (i.e., higher testing for infections results in higher rates of identified infections) and assessment of Maryland performance. Given these concerns, staff is hesitant and would like stakeholder input over the coming year on whether to align fully with the nation and use of the NHSN measures in two payment programs (QBR and MHAC) and what measures should be considered for non-Medicare FFS quality policies.
- **PSI 90 Composite Measure:** For the RY 2028, PMWG stakeholders support removing the measure from the QBR program in order to align with the HVBP program. However, staff believe this measure should be maintained in payment since it measures serious complications (e.g., post-surgical sepsis, pressure ulcers), AHRQ produces an all-payer and Medicare version of the measure (i.e., meaning no measurement concerns), and it is included in the Medicare FFS quality programs. Thus, the staff recommended the PSI 90 Composite measure should be added to MHAC in the RY 2028 draft MHAC policy, which was presented to the Commission in December 2025..
- **Sepsis Management Bundle:** Maryland continues to perform well compared to the nation on Sepsis Bundle and the Sepsis PSI, as illustrated in Figure 19 and Figure 20 above. Despite concerns about the Sepsis bundle measure, CMS has continued its use. Thus, staff and most PMWG stakeholders recommend adopting the Sepsis bundle measure in the Safety domain to align with the HVBP program. See Stakeholder Feedback section for additional discussion.

C. Clinical Care Domain

This domain, weighted at 10 percent of the RY 2027 QBR score, currently includes:

- Inpatient, all-payer, all-condition mortality measure
- 30-Day all-payer, all-condition mortality measure

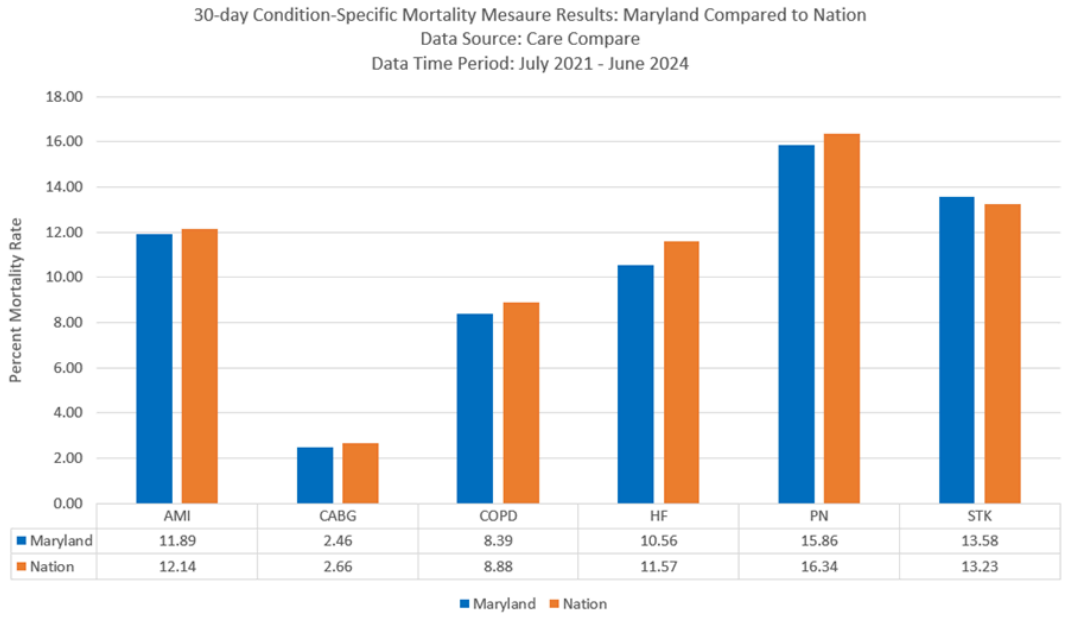
Of note, Maryland's QBR mortality measure currently differs from the HVBP Program that uses five condition-specific, 30-day mortality measures for Medicare beneficiaries. In addition, the HVBP includes a Medicare Total Hip Arthroplasty-Total Knee Arthroplasty (THA/TKA) Complications measure. This measure was removed from QBR for RYs 2026 and 2027 due to concerns about the measure related to the proportion of procedures performed in the hospital versus on an outpatient basis in Maryland relative to the nation (i.e., higher proportion in outpatient in MD may make those remaining in IP higher acuity than the procedures done nationally). Rather than continuing this measure in payment, a proposal to monitor performance on the measure and consider potential alternative measures in the future was approved. As discussed below, staff is recommending to maintain the all-payer mortality measures for the coming year while still under all-payer rate setting and to provide time to evaluate other options for assessing mortality for non-Medicare FFS quality. However, to further align with the HVBP policy staff propose re-adopting the THA/TKA complication measure into QBR.

Mortality

CMS 30-Day Condition-Specific Mortality Measures

On the CMS 30-day condition-specific mortality measures used in the HVBP program and for Stroke, Maryland performs essentially on par with the Nation (Figure 17). Specifically, Maryland performs slightly better on 30-day mortality for AMI, CABG, and HF, COPD, and PN, and slightly worse on Stroke.

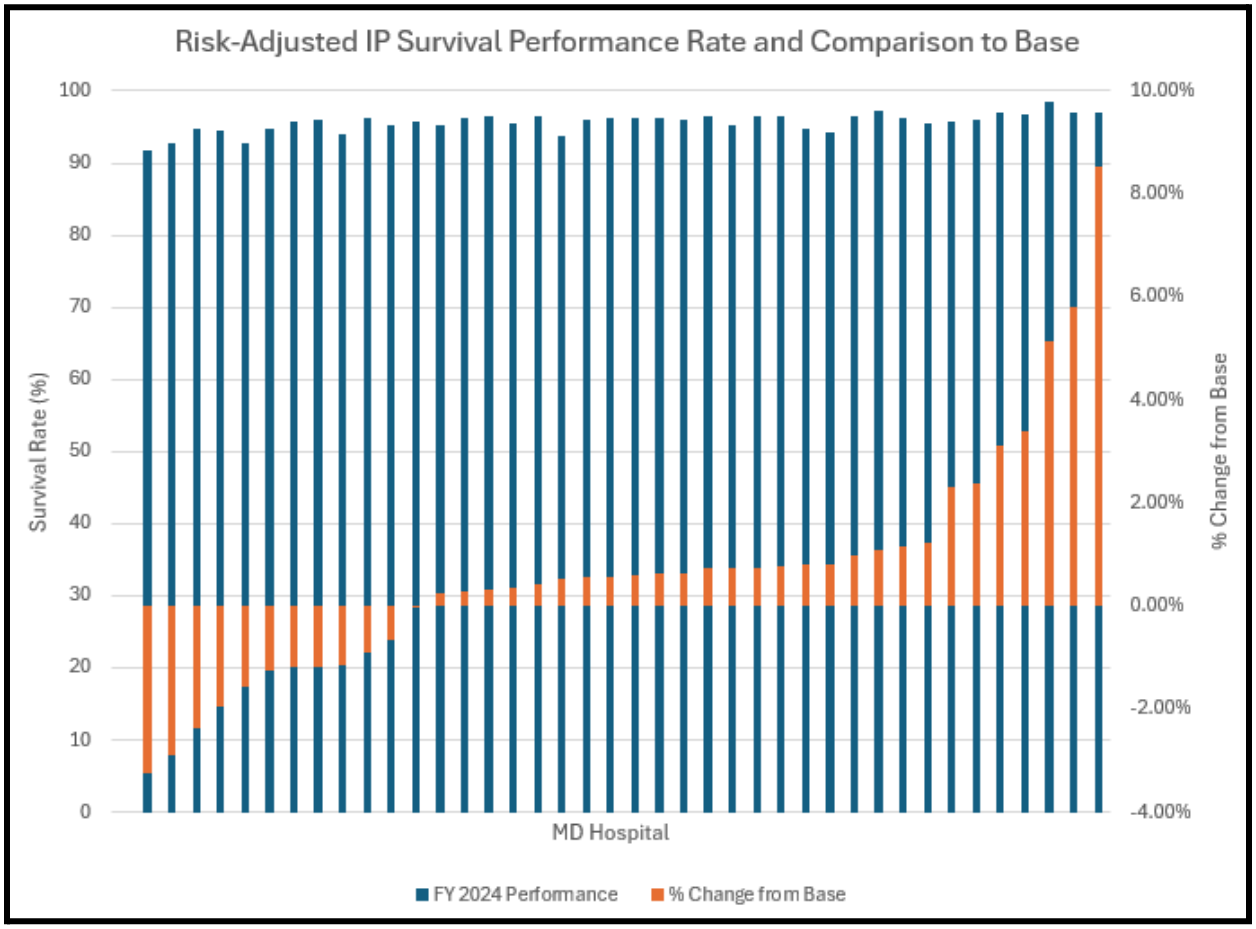
Figure 17. Maryland vs. National Hospital Performance on CMS Condition-Specific Mortality Measures



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

For the QBR all-payer inpatient mortality measure, which assesses hospital services where 80 percent of the mortalities occur (the DRGs with the top 80% of deaths), the statewide risk-adjusted survival rate increased from 95.27 percent in the base period of SFY 2023 to 95.66 percent in the CY 2024 performance period. As illustrated in Figure 18 below, the majority of hospitals have improved in CY 2024 when compared to SFY 2023 on the Inpatient Mortality measure (with 10 out of 40 hospitals having worsened slightly) .

Figure 18. Maryland Hospital Performance, SFY 2023 vs CY 2024 QBR Inpatient All Condition, All Payer Mortality Measure

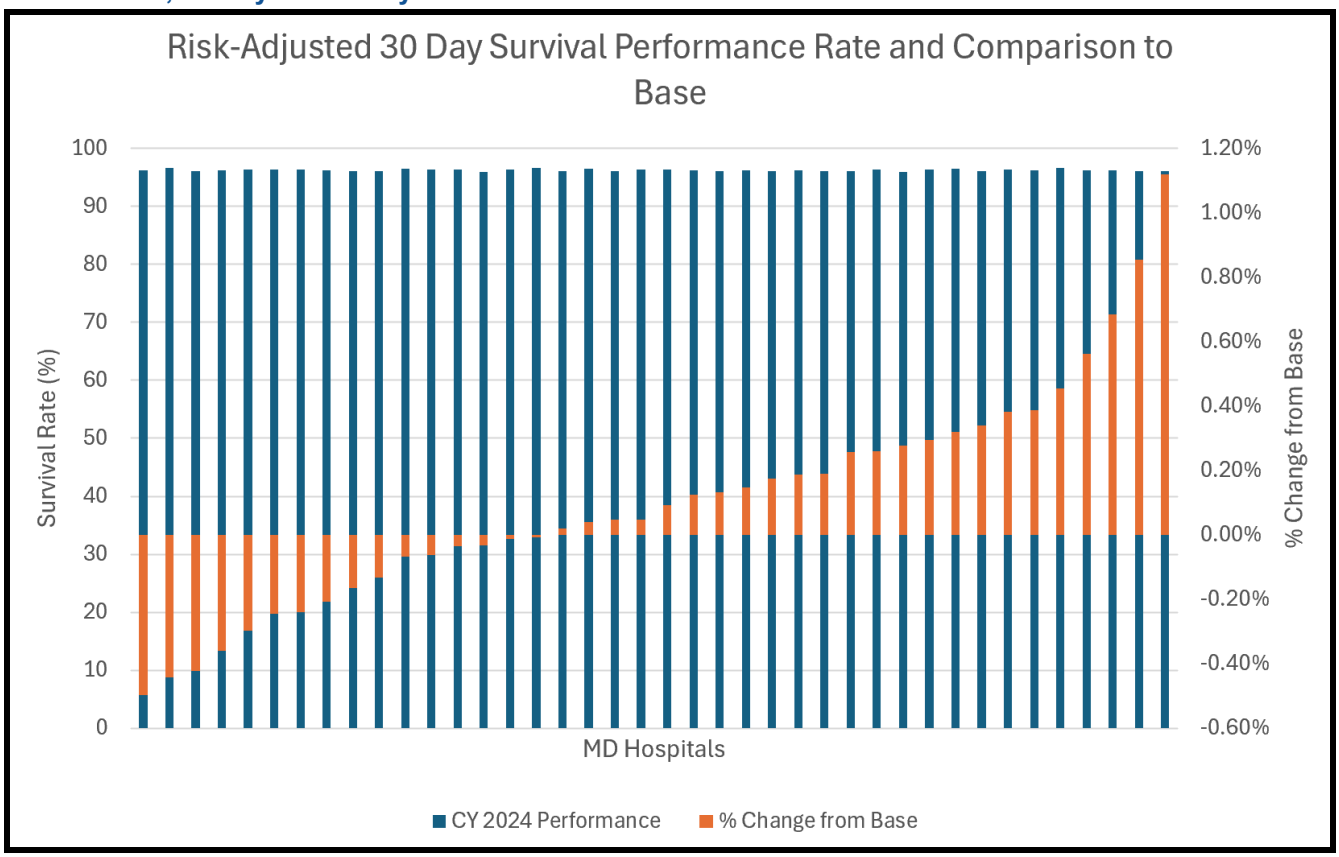


Note: The graph displays hospital performance in the blue bars and hospital improvement from the FY 2023 base in orange bars. For example, the hospital on the far right had a survival rate of over 95% in CY 2024 and saw an increase in their survival rate of almost 9% when compared to their performance in FY 2023.

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 2024, as shown in Figure 19 below, survival rates range from ~96 percent to ~97 percent with 24 hospitals improving and six hospitals declining compared to SFY 2023; the statewide average survival rate for the measure improved by 0.10 percent in 2024.

Figure 19. Maryland Hospital Performance, SFY 2023 vs CY 2024 30-Day, All Cause All Condition, All Payer Mortality Measure



Note: The graph displays hospital performance in the blue bars and hospital improvement from the FY 2023 base in the orange bars. For example, the hospital on the far right had a survival rate of over 95% in CY 2024 and saw an increase in their survival rate of about 1.15% when compared to their performance in FY 2023.

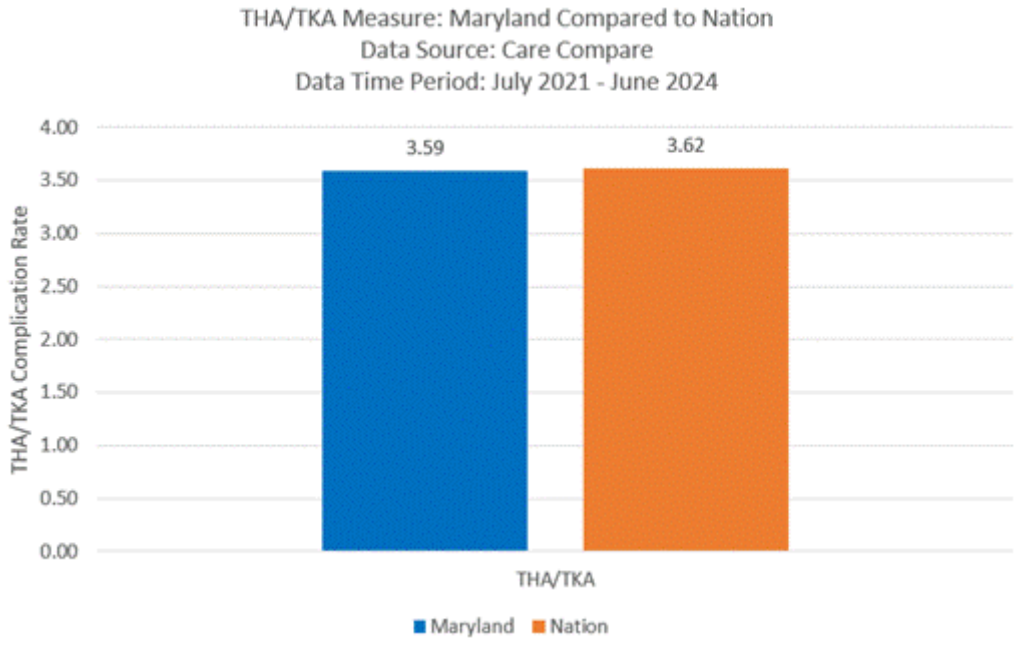
Last, as part of the digital measures initiative staff plans to consider transitioning from the fully claims-based mortality measure to the hybrid 30-day mortality measure (claims plus Core Clinical Data Elements) in the future. To date, the vast majority of hospitals working with their electronic health record (EHR) vendors have been able to adapt measures specifically for Maryland's all-payer measurement environment for patients 18 years and older. Staff believes it is important to continue the all-payer digital measures data collection and follow the CMS lead on the timing of digital measures adoption in payment programs. In order to support the collection of all-payer hybrid data elements and other electronic Clinical quality measures (eCQMs) staff support continuing the digital measure incentive that was implemented in the RY 2027 QBR policy. For CY 2026, Maryland has aligned the digital measures reporting with the CMS requirements except that we are requesting data sooner, and the hybrid data elements are required on an all-payer basis, i.e., for patients 18 years and older. The incentive of $150,000 will be provided in hospital

rates for hospitals that fully meet the State-specified expedited reporting timeline and all-payer hybrid data elements, provided that all required measures are reported. Appendix E provides additional information on the digital measures data collection requirements for CY 2026.

Hip and Knee Arthroplasty Complications

As stated above, this measure was removed from QBR for RYs 2026 and 2027 due to concerns about the measure related to the proportion of procedures performed in the hospital versus on an outpatient basis in Maryland relative to the nation (i.e., higher proportion in outpatient in MD may make those remaining in the inpatient setting higher acuity than the procedures done nationally). Based on the most current data available on CMS Care Compare, July 2021 through June 2024, Maryland hospital performance is on par with 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



QBR-HVBP Alignment: Clinical Care

In an effort to align the QBR program with HVBP balanced with the underlying quality program principles to measure and incent improved clinical care for patients of all payers, staff and stakeholders discussed the issues below:

- **Mortality Measures:** Staff is recommending to maintain the all-payer mortality measures for the coming year while still under all-payer rate setting and to provide time to evaluate other options for assessing mortality for non-Medicare FFS quality. While several PMWG stakeholders supported maintaining all-payer mortality, some suggested only maintaining the IP measure and others suggested only maintaining the 30-day measure since CMS does 30-day measures. Staff notes that the correlation between the IP and 30-day measure is moderate and that stakeholders recommended continued refinement of these measures in the future, with emphasis on the 30-day measure over inpatient.
- **THA/TKA Complications Measure:** Majority of PMWG members lended their support to further align with the CMS HVBP policy staff's proposed recommendation to re-adopt the THA/TKA complication measure into QBR. See Stakeholder Feedback section for additional discussion.

D. Domain and Measure Weighting

Staff has analyzed different options for domain and measure weighting based on the draft recommendations that were presented at the November Commission meeting and in response to stakeholder input. As discussed above, staff supports reweighting the domains and measures to be more aligned with the HVBP program. For example, staff propose to align by lowering the weight on PCE domain, removing HCAHPS linear measures, and removing Medicare TFU. While the HVBP program has four domains with each weighted at 25 percent, the CMS estimated HVBP scores for Maryland hospitals do not include the efficiency domain, and instead weights each domain as 1/3rd of hospitals' total scores.

Based on stakeholder discussions, and as discussed in the Stakeholder Feedback section, there are two options for domain weights under consideration: 1. Weight each domain at 1/3rd (i.e., equally and aligned with CMS approach), such that the addition of ED LOS and/or Medicaid TFU in the PCE Domain reduces the weight on HCAHPS top-box and consistency, or; 2. Increase the PCE domain weight to accommodate ED LOS and Medicaid TFU, and reduce the Clinical Care and Safety domains proportionally to account for the additional measures. While staff continues to support Option 2, which would entail lowering HCAHPS top-box and consistency slightly but would maintain them at equal weighting to other hospitals nationally, the impact of these different weights on hospital revenue adjustments is minimal. Modeling of these options and additional

discussion is included in the following Revenue Adjustment Modeling and Stakeholder feedback sections.

E. Revenue Adjustment Methodology

The revenue adjustments for QBR are calculated using a preset scale so that hospitals can prospectively and concurrently track financial performance in quality programs. The scale ranges from 0 percent to 80 percent, and the staff estimate the cut-point for penalties and rewards as to 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, the RY 2024 through RY 2027 policies indicated that the cut-point would be reassessed retrospectively with more recent national data and staff recommend continuing this retrospective assessment or determining another method for setting cut-point.

Methodology for Determining QBR Scaling Cut-Point

The current methodology for retrospectively 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 method uses HCAHPS and NHSN data for hospitals nationally but state averages for MD specific measures, and then applies the QBR measure weights. For RY 2026, staff has shifted to using the median values for MD specific measures, less sensitive to outliers, and the analysis results are in Appendix F.

QBR vs. HVBP Revenue Adjustments

For FFY 2026, CMS provided estimated HVBP scores for Maryland hospitals. As discussed, these scores do not include an efficiency domain and weight each of the remaining domains at 1/3rd of the final score. Using these scores, HSCRC staff has estimated all-payer revenue adjustments for Maryland hospitals. While the HVBP estimates would apply only to the Medicare FFS base operating revenue, the HSCRC has used all payer revenue for reference to compare across programs. Also, it should be noted that the HVBP estimates are net of the 2 percent withhold that the program uses to fund the revenue neutral rewards.

Figure XYZ provides a comparison of the QBR RY 2026 and HVBP FFY 2026 revenue adjustments. Given the large differences between QBR and HVBP, staff modeled all of the differences iteratively as shown in Appendix G. This indicates that the scaling parameters for HVBP is the largest factor associated with over 60 percent of the difference between the QBR and HVBP scores. Domain weighting is the second biggest factor,

which staff has proposed to address. While the removal of Maryland specific measures and addition of the Sepsis Bundle and THA-TKA complication measure, have much smaller contributions to the differences in scores. This is also supported by the RY 2028 modeling shown below.

Figure 21. Statewide RY 2026 QBR and FFY 2026 HVBP All-Payer Revenue Adjustment Estimates for Maryland Hospitals

RY/FFY	Program	Statewide Net Total	%	Penalties	%	Rewards	%
2026	QBR	$ (20,532,810)	-0.16%	$ (34,934,361)	-0.28%	$ 14,401,550	0.11%
	VBP	$ 51,181,610	0.41%	$ (17,406,631)	-0.14%	$ 68,588,240	0.54%

Estimates for MD hospitals' performance in National programs is applied to All-Payer revenue for comparison; CMS would apply adjustments to Medicare FFS revenue.

RY 2028 Modeling

Staff modeled different scenarios that were reviewed with the Performance Measurement Workgroup and took into consideration the Commissioner and Stakeholder feedback. Based on the discussion, three options are presented here for Commissioner consideration. The modeling uses RY 2026 timeframes and is comparable to the RY 2026 and FFY 2026 QBR and HVBP modeling shown above. Specifically the following three options are presented:

1. **Staff draft recommendation:** Align the domain weights and measures more fully with the HVBP program but maintain slightly higher weight on the PCE domain to accommodate ED LOS and Medicaid TFU and reduce the Clinical Care and Safety domains proportionally to account for the additional measures.
    a. Domain weights: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.
2. **MHA-Hospital recommendation:** Align the domain weights and measures fully with the HVBP program but maintain the all-payer inpatient and 30-day mortality measures. All Maryland specific measures (e.g., ED LOS, TFU) should be monitored and publicly reported.
    a. Domain weight: Person and Community Engagement (PCE) - 33.3 percent, Safety (NHSN measures) - 33.3 percent , Clinical Care - 33.3 percent.
3. **Staff recommendation without addition of HVBP measures not in QBR:** Align the domain weights more fully with the HVBP program but maintain ED LOS and

Medicaid TFU in the PCE domain and monitor Sepsis bundle and THA-TKA complication measures.

a. Domain weights: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.

Figure 22 provides the statewide revenue adjustments for the three options outlined above using the 32 percent cutpoint (while cutpoint could vary for each option, staff wanted to make the results comparable to the current year). The options do not vary substantially across options at the Statewide level. Appendix H provides the results by hospital. Compared to the current RY 2026 QBR revenue adjustments, Option 1 (staff recommendation) reduces the net statewide revenue adjustments from -$20.5 M to -$13.2 M. If the cutpoint was changed to the National average for each model, staff estimate the revenue adjustments would be more positive.

Figure 22. Statewide Modeling of All-Payer Revenue Adjustments by Option

Statewide RY 2026 Modeling	Staff Recommendation	MHA-Hospital Recommendation	Staff Recommendation Minus Sepsis and THA-TKA
Option #	1	2	3
Net Revenue Adjustments	-$13,901,981	-$12,734,618	-$13,283,560
Net %	-0.11%	-0.10%	-0.11%
Total Penalties	-$33,764,918	-$37,583,539	-$36,490,684
Penalty %	-0.27%	-0.30%	-0.29%
Total Rewards	$19,862,937	$24,848,921	$23,207,124
Reward %	0.16%	0.20%	0.19%

4. STAKEHOLDER FEEDBACK AND STAFF RESPONSES

Comment letters to the QBR Draft policy were received from the Maryland Hospital Association, University of Maryland Medical System, MedStar Health, Adventist Health, and Johns Hopkins Health System, and are summarized in Figure 23 below. A brief discussion of the concerns and staff responses are provided following the Figure.

Figure 23. Summary of Stakeholder Comment Letters

Stakeholder QBR Comment Letters	MHA	UMMS	Med-Star	Advent-ist	JHHS
Maximize multi-payer alignment: reduce administrative complexity, ensure manageable timelines,maintain quality incentives	X	X	X	X	X

Stakeholder QBR Comment Letters	MHA	UMMS	Med-Star	Advent-ist	JHHS
• Reweight domains to more closely align with HVBP (i.e., 1/3rd)	X	X	X	X	X
• Transition time is too lengthy					X
PCE Domain: HCAHPS top box and Consistency, monitor Medicaid TFU	X	X	X	X	X
• Understand inclusion of ED Wait Times due to importance			X		
Safety Domain: Maintain NHSN, Shifting/removing PSI 90	X	X	X	X	X
• Continue to exclude Sepsis bundle (re. clinical concerns)		X			
• Add Sepsis bundle for CMS alignment	X		X	X	X
Clinical Care Domain: Maintain IP and 30 day mortality measures	X	X	X		X
• Continue to exclude THA/TKA		X			
• Replace inpatient mortality measure with more stable 30-day measure in future years		X			
Separate Monitoring Program for state-specific measures	X	X	X	X	X
Digital Measures: Support RY 2028 incentive, default to CMS in RY 2029	X				
Modify Reward/Penalty Cut-Point for RY2027 and use as RY 28 cut-point	X	X	X	X	X
Maintain or Consider less revenue at risk and align with other states		X (maintain)			X (less)
Remove Medicare patients from non-Medicare quality programs					X

General Concerns on AHEAD transition: All hospital letters highlighted the importance of maximizing multi-payer alignment in order to reduce administrative complexity, and to ensure manageable timelines, while maintaining quality incentives. Thus, hospitals recommend establishing monitoring program for any state specific measures not included in the CMS quality programs. JHHS specifically states that a three year transition period is too lengthy (i.e., not moving fully to CMS programs until CY 2028). Additionally, in the November Commission meeting, questions were raised about the possibility of suspending the quality programs during the transition period to Medicare global budgets, or applying the CMS hospital quality results to the non-Medicare global budgets. Finally, staff continues to collaborate with Medicaid staff and received a general letter on HSCRC quality programs (i.e., not specifically commenting on the QBR program) that urges the

continued inclusion of all-payer measures, particularly those impacting the Medicaid program such as maternal child health measures of obstetric complications improvement, pediatric potentially avoidable utilization, and improved care coordination and handoffs as measured by the Medicaid TFU measure.

Staff Response:

Staff notes that the AHEAD model agreement includes the language below that requires continuation of the quality programs during the PYs 1 and 2 (defined transition timeline) while Medicare global budgets are finalized, and to further include all-payer measures as well as measures designed to improve population health. With regards to establishing a separate program to monitor state-specific measures, staff believes the state must consider important all-payer measures that address state priorities such as ED LOS and Medicaid TFU already in the QBR payment program. Staff further highlights the inclusion of these measures meets the criteria to include areas of concern/poor performance for the state. However, stakeholders did discuss what a robust monitoring program could look like, including reporting to hospitals and the public, updates to the Commission, and it was suggested that the CMS Inpatient Quality Reporting program be considered as a guide. Staff note that the monitoring for TFU for Medicare and HCAHPS linear measures is already planned, and that there are other existing monitoring reports for other quality areas already available on the CRISP portal. With regard to the transition period being too lengthy, staff believes the contract terms with the defined transition period provides the necessary flexibility to develop and operationalize the Medicare FFS and non-Medicare FFS global budgets and their related quality program updates. Furthermore, staff believe that work needs to be done with CMMI to assess feasibility of moving to CMS programs for CY 2027 performance, while staff pursues further alignment across all quality programs for non-Medicare payers.

h. CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology for PY1 and PY2: Hospital Quality and Value-Based Programs.

1. *For PY1 and PY2, the State will develop and administer hospital quality and value-based payment programs in accordance with the requirements of this Agreement. The State hospital quality and value-based payment programs will include all-payer measures. In the limited cases when all-payer measures are not feasible, the State may include Medicare-specific measures. The State hospital quality and value-based payment programs must include a performance measure designed to*

improve population health.

Aligning QBR Domain Weighting and Measures With HVBP program: All hospital comment letters supported aligning the domain weights with HVBP with each domain weighted equally in the program. Discussion in the November Commission meeting included a question about applying the efficiency domain weight to the PCE domain with continued inclusion of the ED Wait Time measure to better incentivize improvement. Most letters supported aligning the measures with those used in the HVBP, i.e, including only HCAHPS top box and consistency scores in the PCE domain and removing HCAHPS linear measures, ED Wait Time measure, the Medicaid TFU along with Medicare TFU and TFU disparities measures, adding the Sepsis Bundle measure to the Safety domain (and moving the PSI 90 measure to monitoring or MHAC), and adding the THA/TKA complication measure to the Clinical Care domain but also maintaining inclusion of the IP and 30-Day Mortality measures rather than using the CMS 30-day condition-specific mortality measures. UMMS, however, did not support adding the Sepsis Bundle and the THA/TKA measure citing clinical concerns about both measures. The third option provided in the Revenue Adjustment Modeling section provided estimates of impact of not including these measures, which was fairly minimal. Additionally, the MedStar letter did acknowledge the importance of including an incentive for ED wait time improvement because of the state's poor performance but stated the Medicaid TFU measure should be in monitoring. Finally, while not specifically commenting on the QBR program, a letter received from Medicaid regarding the overall hospital quality programs as they transition under AHEAD raised the following issues:

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

Staff Response:

Staff agrees with greater QBR alignment with the HVBP program for domain weights. Specifically, staff supports the following:

Measures:

- Staff generally agrees with stakeholders and believes it is important to align measures with HVBP, particularly those that assess patients of all-payers or are currently used in the HVBP program; this includes adopting the Sepsis Bundle measure, the THA/TKA Complications measure, and removing the HCAHPS linear measure, TFU Medicare and Disparity measures, and the PSI 90 measure.
- Staff agrees with stakeholder recommendations to continue use of the IP and 30-day All-condition, All-cause mortality measures with a plan to continue future refinement of these measures and further discussion on how to measure mortality for non-Medicare HGB adjustments.
- Staff supports continued inclusion of the ED LOS measure and Medicaid TFU to balance the state's priorities to improve in areas of poor performance in ED LOS, and to support better population health for the Medicaid population where hospitals have leverage. Additionally staff notes the infrastructure to collect these measures already exists through case mix/claims data and CRISP reporting with no additional data abstraction efforts needed from hospitals.

Domain and Measure Weights:

- Staff continues to support the recommendation in the draft recommendation to align the domain weights and measures more fully with the HVBP program but maintain slightly higher weight on the PCE domain to accommodate ED LOS and Medicaid TFU and reduce the Clinical Care and Safety domains proportionally to account for the additional measures:
    - Domain weights: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.

Other Revenue Adjustment Methodology Details: Letters received supported the following:

- Digital Measures: Support RY 2028 incentive, align with and default to CMS requirements beginning in RY 2029 (MHA).
- Modify Reward/Penalty Cut-Point for RY2027 and use as RY 28 cut-point since analysis shows a lower cut-point by about 10 percentage points is more appropriate.
- Maintain (UMMS) or consider less (JHHS) revenue at risk and align with other states.

- Increase QBR revenue at-risk to incentivize greater improvement (Commissioner discussion)
- Remove Medicare patients from non-Medicare quality programs (JHHS)

Staff Responses:
Regarding the more timely and all-payer incentive for **digital measures reporting**, staff supports continued use of the digital measures infrastructure already established to receive more timely and more complete (all-payer hybrid measures) data for these measures; staff notes in particular that CMS has indicated a goal of transition to digital quality measure in the next few years, and the state infrastructure allows Maryland to be a leader in transitioning to digital measures. Also, the state has been collecting digital Severe Obstetric Complications risk adjusted measure providing an opportunity to consider hospital incentives to improve overall and to address differences in populations for this measure, aligning with established priorities and work of other state partners– Medicaid and the Maternal Child Health Bureau.

With regard to **modifying the reward/penalty cut-point**, staff agrees that the revised RY 2026 cut-point of 32.68 percent for RY 2027 and prospectively for RY 2028 is consistent with more recent trends.

For the **revenue at risk** under the program, staff supports continued use of 2 percent of inpatient revenue to continue alignment with CMS HVBP and also to continue to apply this to all-payers as quality incentives for all-payers is required under the AHEAD agreement. Furthermore, staff notes that the AHEAD agreement includes the same provisions for the state to meet the aggregate revenue at-risk requirements during the transition period.

With regard to **removing Medicare patients from non-Medicare state programs**, staff agrees understanding the impact of this is important to consider through discussion and analysis with the AHEAD transition. Staff notes, however, that the current HVBP program has established a precedent and does include all-payer HCAHPS, Sepsis Management Bundle and NHSN measures in performance assessments for Medicare specific revenue adjustments.

5. FINAL RECOMMENDATIONS FOR RY 2028 QBR PROGRAM

Final Recommendations for RY 2028 QBR Program:

1. Update Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.
2. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and set the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 32 percent.
    a. Retrospectively evaluate the preset cut-point using more recent data to calculate national average score for RY 2027 and RY 2028.
    b. Based on concurrent analysis of national hospital performance, adjust the RY26 QBR cut-point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.
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; 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.

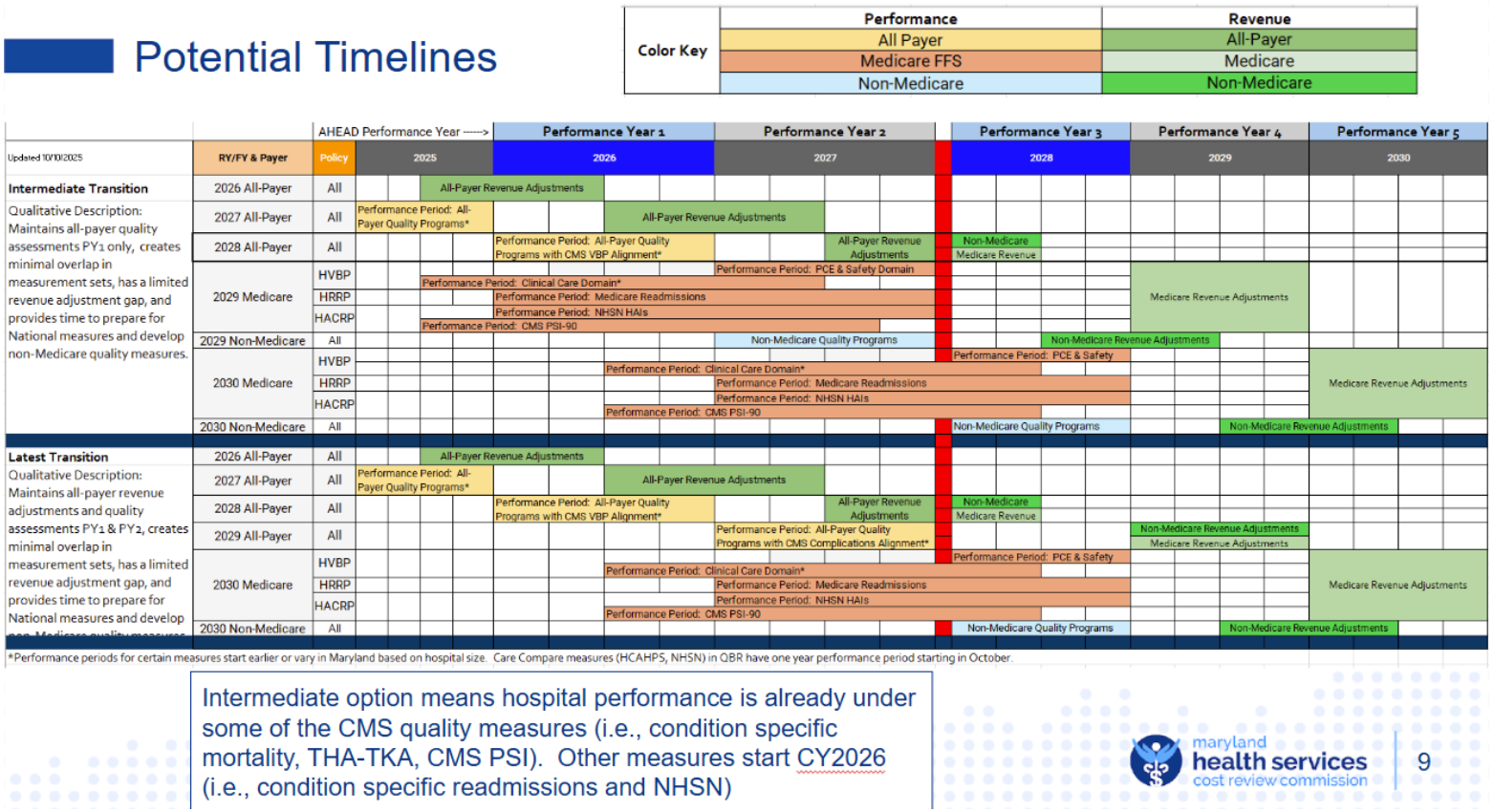
APPENDIX A: QUALITY PROGRAM TRANSITION UNDER AHEAD

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

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

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

Figure A1. Timeline Options for Quality Program Transition



APPENDIX B: QBR PROGRAM BACKGROUND

Maryland's QBR Program, in place since July 2009, uses measures that are similar to those in the federal HVBP Program, under which all other states have operated since October 2012. Similar to the HVBP Program, the QBR Program currently measures performance in Clinical Care, Safety, and Person and Community Engagement (PCE) domains, which comprise 10 percent, 30 percent, and 60 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 HVBP 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 HVBP 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 HVBP 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 to the current weights for RY 2026 and maintained in RY 2027. Although the QBR Program has many similarities to the HVBP Program, it does differ because Maryland's unique model agreements and autonomous position allow the state to be innovative and

progressive. Figure B.1. below illustrates the QBR RY2025-2027 measurement domains and weights compared to the HVBP program.

Figure B.1. RY 2025- RY 2027 QBR measures and domain weights compared with those used in the CMS HVBP Program

Domain	Maryland RY 2026 QBR domain weights and measures	Maryland RY 2027 QBR domain weights and measures	CMS HVBP domain weights and measures
Clinical Care	**10 percent (-5% from RY 2025)** Two measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality,	**10 percent** Two measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality,	**25 percent** Five measures: Four condition-specific mortality measures; THA/TKA complications
Person and Community Engagement	**60 percent (+10% from RY 2025)** 10 measures: • Eight HCAHPS categories top-box score and consistency, and four categories linear score; • TFU Medicare, Medicaid, disparities improvement; • ED LOS0	**60 percent** 8 measures: • Six HCAHPS categories top-box score and consistency, and four categories linear score; • TFU Medicare, Medicaid, disparities improvement; • ED LOS0	**25 percent** Eight HCAHPS measures top-box score.
Safety	**30 percent (-5% from RY 2025)** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**30 percent (-5% from RY 2025)** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**25 percent** Five measures: CDC NHSN HAI measures
Efficiency	n.a.	n.a.	**25 percent** One measure: Medicare spending per beneficiary

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.[11] 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.

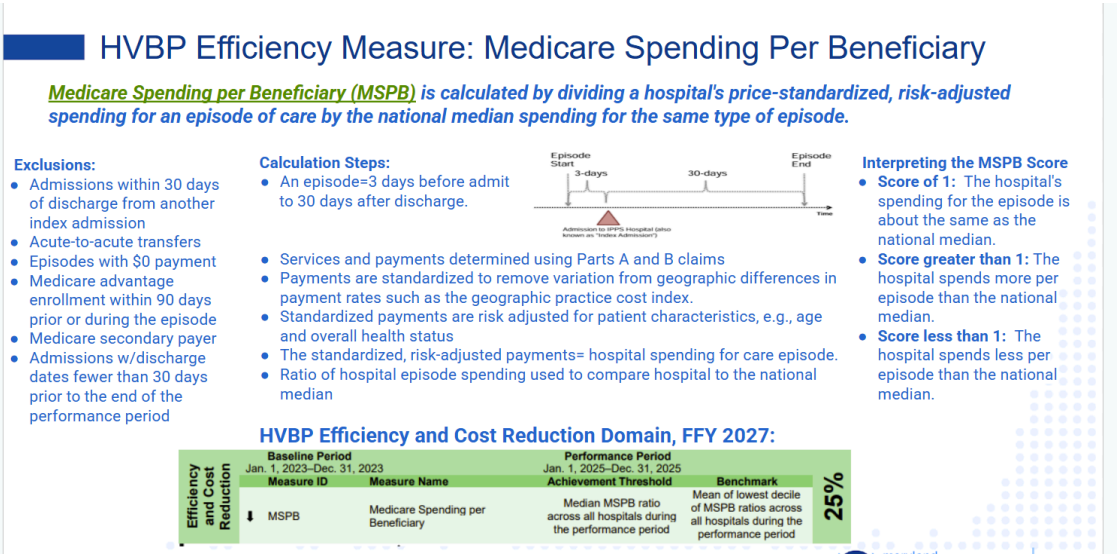
HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the HVBP Program, where feasible,[12] enabling the HSCRC to use data submitted directly to CMS. Maryland implemented 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.

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

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

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



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 theHVBP Program measures.[13] 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.

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.

[13] 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.

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. In RY 2026, a measure of within-hospital TFU disparities reduction as well as the ED1-like measure was added and as stated above, the domain weights were adjusted as follows: Patient and Community Engagement weight was updated to 60%, Safety weight updated to 30% and Clinical Care updated to 10%. 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 2026 (added the ED1 measure), and for RY 2027 (no changes to

domain weights from those of RY 2026, and decreasing number of HCAHPS sub-measures to six)..

Figure B.3. RY 2027 Process for Calculating QBR Scores

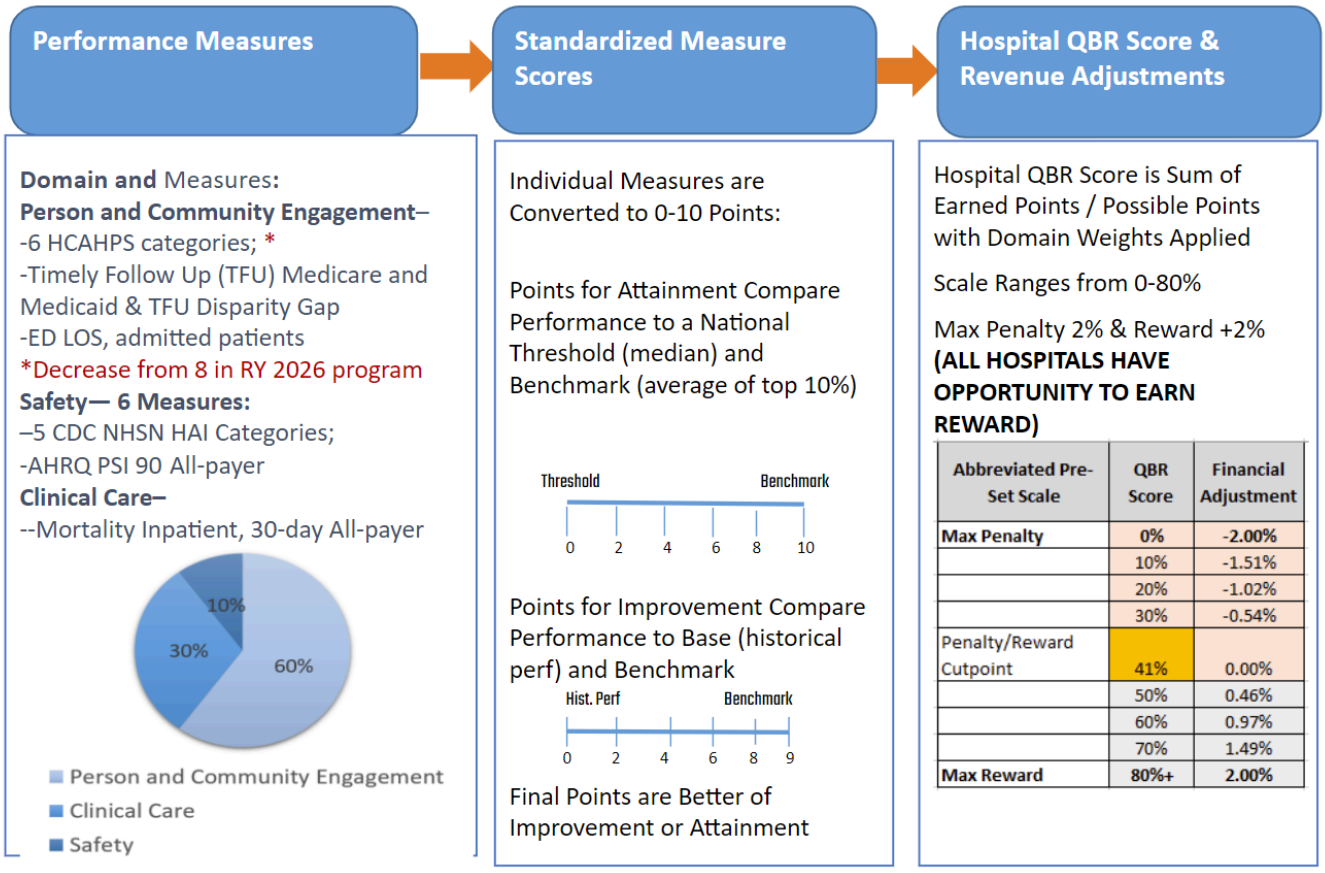


Figure B.4. below details the baseline and performance timelines for the measures in the QBR program for RY 2027.

Figure B.4.QBR RY 2027 timeline: base and performance periods; financial impact

<table>
<tr><td>Rate Year (Maryland Fiscal Year)</td><td>Q3-22</td><td>Q4-22</td><td>Q1-23</td><td>Q2-23</td><td>Q3-23</td><td>Q4-23</td><td>Q1-24</td><td>Q2-24</td><td>Q3-24</td><td>Q4-24</td><td>Q1-25</td><td>Q2-25</td><td>Q3-25</td><td>Q4-25</td><td>Q1-26</td><td>Q2-26</td><td>Q3-26</td><td>Q4-26</td><td>Q1-27</td><td>Q2-27</td><td>Q3-27</td><td>Q4-27</td></tr>
<tr><td>Calendar Year</td><td>Q1-22</td><td>Q2-22</td><td>Q3-22</td><td>Q4-22</td><td>Q1-23</td><td>Q2-23</td><td>Q3-23</td><td>Q4-23</td><td>Q1-24</td><td>Q2-24</td><td>Q3-24</td><td>Q4-24</td><td>Q1-25</td><td>Q2-25</td><td>Q3-25</td><td>Q4-25</td><td>Q1-26</td><td>Q2-26</td><td>Q3-26</td><td>Q4-26</td><td>Q1-27</td><td>Q2-27</td></tr>
<tr><td rowspan="3">Quality Based Reimbursement Program (QBR)</td><td></td><td></td><td></td><td></td><td colspan="4">Base Period: Hospital Compare (HCAHPS measures, All NHSN Measures)</td><td></td><td></td><td></td><td colspan="4">Performance Period: Hospital Compare (HCAHPS measures, All NHSN Measures)</td><td></td><td></td><td colspan="4" rowspan="3">Rate Year Impacted by QBR Results</td></tr>
<tr><td></td><td></td><td></td><td></td><td colspan="2"></td><td colspan="3">Base Period: QBR IP and 30-day Mortality, PSI-90, Timely Follow-up Chronic Conditions (Medicare, Medicaid and w/in Hospital Disparity Reduction)</td><td></td><td colspan="3"></td><td colspan="3">Performance Peirod: QBR IP and 30-day Mortality, PSI-90, Follow-up Chronic Conditions (Medicare, Medicaid and w/in Hospital Disparity Reduction)</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td colspan="2"></td><td colspan="2"></td><td colspan="3">Base Period: Emergency Department Length of Stay (Admitted Patients)</td><td colspan="3">Performance Period: Emergency Department Length of Stay (Admitted Patients)</td><td></td><td></td></tr>
</table>

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.[14] CMS first adopted the composite measure in theHVBP 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 HospitalHVBP program[15] **,** and also adopted by the QBR program (all-payer version) in RY 2023.

AHRQ's specified PSI uses include:

- Assess, monitor, track, and improve the safety of inpatient care
- Comparative public reporting, trending, and pay-for-performance initiatives
- Identify potentially avoidable complications that result from a patient's exposure to the health care system
- Detect potential safety problems that occur during a patient's hospital stay

The discharge weighted average of the observed-to-expected ratios for the following subset of AHRQ's PSIs comprise the PSI-90 composite measure:

- PSI 03 Pressure Ulcer Rate
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall With Hip Fracture Rate
- PSII 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

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[14] Source: https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2020/TechSpecs/PSI%2090%20Patient%20Safety%20and%20Adverse%20Events%20Composite.pdf.

[15] 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).

PSI 90 combines the smoothed (empirical Bayes shrinkage) indirectly standardized morbidity ratios (observed/expected ratios) from selected Patient Safety Indicators. The weights of the individual component indicators are based on two concepts: the volume of the adverse event and the harm associated with the adverse event. The volume weights were calculated based on the number of safety-related events for the component indicators in the all-payer reference population. The harm weights were calculated by multiplying empirical estimates of the probability of excess harms associated with each patient safety event by the corresponding utility weights (1–disutility). Disutility is the measure of the severity of the adverse events associated with each harm (for example, the outcome severity or the least-preferred states from the patient perspective).

The PSI 90 measure scores are converted to program scores, as described in the QBR Score Calculation section of this appendix.

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.[16] 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:

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

[16] Source: https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions

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.[17]

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 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:

[17] Please see https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions.

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.

[NUM(ASM) + NUM(CAD) + NUM(HF) + NUM (COPD) + NUM(DIAB) + NUM(HTN)] / [DENOM(ASM) + DENOM(CAD) + DENOM(HF) + DENOM (COPD) + DENOM(DIAB) + DENOM(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: NUM(HF) / DENOM(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 22025

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

APPENDIX C: HCAHPS LEARNING COLLABORATIVE AND ANALYSIS

HCAHPS Learning Collaborative Summary

As discussed in the policy, the HSCRC and MHA have led a HCAHPS Learning Collaborative over the last year. The two-page document below provides a summary of the Purpose, Key Learnings, and Next Steps.

health services cost review commission HCAHPS Learning Collaborative Maryland Hospital Association
Advancing health care and the health of all Marylanders

Background

The Beryl Institute defines patient experience as the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures performance in patient experience for hospitals nationwide. Maryland hospitals do not perform strongly in HCAHPS compared to most other states. For years, Maryland has incentivized improvement through the Quality Based Reimbursement (QBR) Program. To understand methods to improve, the HSCRC and MHA formed a Learning Collaborative of patient experience leaders in the state to share key learnings to improve HCAHPS performance for hospitals across Maryland.

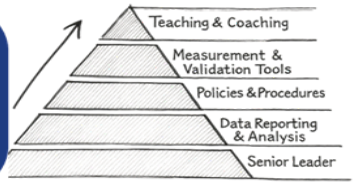
Key Learnings

1 Quality and Safety Indicator

National data from Press Ganey and NRC Health shows the synergies between improvements in HCAHPS and improvements in quality outcomes. HCAHPS performance is also linked with employee engagement and their ratings of safety.

2 Groundwork Needed

Improvement takes time. For lasting improvements in HCAHPS, hospitals should make Infrastructure investments like hiring a dedicated Chief Experience Officer, data reporting strategy, and process measurement tools to set up sustained performance.



3 Identifying Trends Using Statewide Data

Data driven decisions should be used to promote best practice adoption in the appropriate care setting as a part of cycles of learning. The learning collaborative looked for trends in state-wide HCAHPS in service lines, geographic location, size of hospital and patient demographics.

Next Steps

Implement Maryland Hospital HCAHPS Dashboard

The MHCC and HSCRC will publish a quarterly HCAHPS dashboard using patient level HCAHPS results from hospitals. Value for monitoring state performance, stratifying hospital results for comparison, and linking performance to best practices

Continue To Meet Quarterly To Share Best Practices

The Learning Collaborative will continue to meet quarterly to share best practices and learn faster together.

Consider Expanding Best Practice Incentives

Consider incentives for adopting specific supplemental questions on the survey or for adoption of best practices.

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Best Practice Highlights

PressGaney

Improve ED Experience

Patients admitted through the ED rate their inpatient experience lower than those admitted directly. The two key drivers for ED Likelihood to Recommend scores are the patient's perception that staff worked together to care for them and that the staff cared for them as a person. Communication improves scores with long ED Wait times.

nrc HEALTH

Maryland Consumer Drivers

HCAHPS Likelihood to Recommend scores are based on three consumer drivers - trust, relevance, and experience. Maryland patients rank reliability as the most important factor for establishing trust. Reliability means a patient's confidence in accessibility of services and coordination of care.

Frederick Health

Treat Dissatisfaction as Harm

Frederick Health shifted its view of harm to include service failures. This transition meant using the same process improvement tools for patient dissatisfaction as used for patient harm. Results of initial pilots using this approach show some HCAHPS question scores improving by as much as 17 points compared to the previous two quarters.

Adventist HealthCare

Hourly Rounding

At Shady Grove Medical Center, hospital leadership have achieved their highest HCAHPS scores in five years through focusing on hourly rounding. Through improved measurement using an electronic rounding platform and regular coaching of nurse leaders, Adventist saw the biggest improvements in HCAHPS scores on the units where more hourly rounding visits took place.

JOHNS HOPKINS MEDICINE

ED Communication Tools

At Howard County Medical Center, ED Likelihood to Recommend Scores declined significantly after patients were in the ED longer than 9 hours. Leaders added technology to improve patient communication, using event messaging indicating where they were in the care process.

University of Maryland Medical Center

Interdisciplinary Bedside Rounds

UMMS is standardizing Interdisciplinary Bedside Rounds (IBR) as a core tactic to improve HCAHPS scores. The systems has created standard work for IBR and found that performing IBRs positively correlated with improvements in physician and nurse communication scores and patient-perceived frequency of rounding.

MedStar Health

Patient Experience Summit

MedStar launched an annual Human Experience Systemwide Summit to educate and train leaders on improving HCAHPS scores.

GBMC HEALTHCARE

Simplified Data Sharing

GBMC distributes a straightforward internal snapshot and unit specific infographic sheet to simplify key drivers for improvement and unit specific patient experience comments.

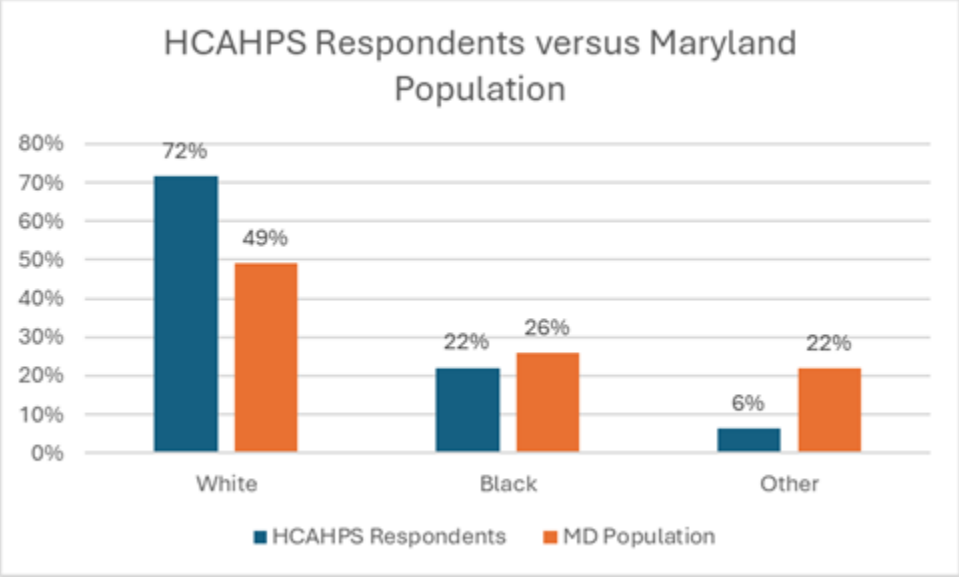
HCAHPS Patient Disparity Analysis

Examining HCAHPS results by demographic, clinical, and geographic characteristics allows focused improvement opportunities. The proportion of HCAHPS responses within the state does not align with the composition of the population. White respondents are more highly represented than Black or other respondent categories relative to their proportion in Maryland's population from the 2020 Census. Survey results are from all discharges from July 2021 through December 2024.

When reviewing top-box recommendation and rating by race from 2021 - 2024 (Figure C.1.):

- Less Black respondents than expected responding "Definitely Yes" and more White respondents than expected responding "Definitely Yes"
- Black respondents are consistently the least favorable with the exception of one data point (Black and White respondents, 2021)

Figure C.1. HCAHPS Responses compared to Maryland Population, as derived from the 2020 Census



When reviewing top-box rating (9 or 10) by race (Figure C.2.):

- Maryland responses are lower in the 9 or 10 category than the nation.
- In contrast to top-box recommendation, the Other race category responds the least favorably

Figure C.2. Top-Box Recommendation by Race

Top-Box Recommendation by Race				
Race	**2021**	**2022**	**2023**	**2024**
White	69.4	68.3	69.1	69.0
Black	69.4	66.0	65.0	66.5
Other	69.8	69.9	70.4	70.5
Overall	**69.4**	**67.9**	**68.3**	**68.6**

When reviewing top-box rating (9 or 10) by race (Figure C.3.):

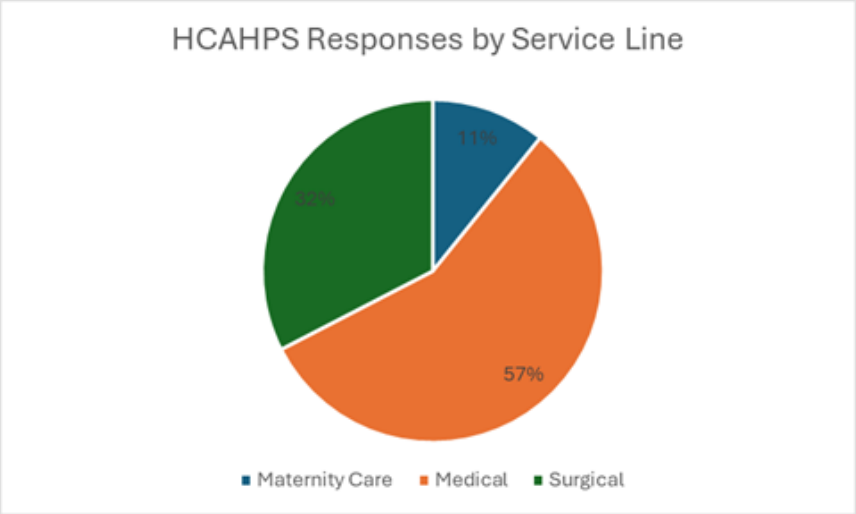
- Maryland responses are lower in the 9 or 10 category than the nation.
- In contrast to top-box recommendation, the Other race category responds the least favorably

Figure C.3. Top-Box Rating by Race

Top-Box Rating by Race				
	2021	**2022**	**2023**	**2024**
White	68.3	67.6	68.9	68.6
Black	68.3	67.1	67.8	67.9
Other	66.6	66.7	67.6	66.2
Overall	**68.2**	**67.5**	**68.6**	**68.3**

For the responses by service line in Maryland (Figure C.4.), there were 11,580 surveys within the Maternity comprising 11% of the total, 60,487 surveys within Medical comprising 57% of the total, and 34,786 surveys within Surgical comprising 33%:

Figure C.4. Responses by Service Line



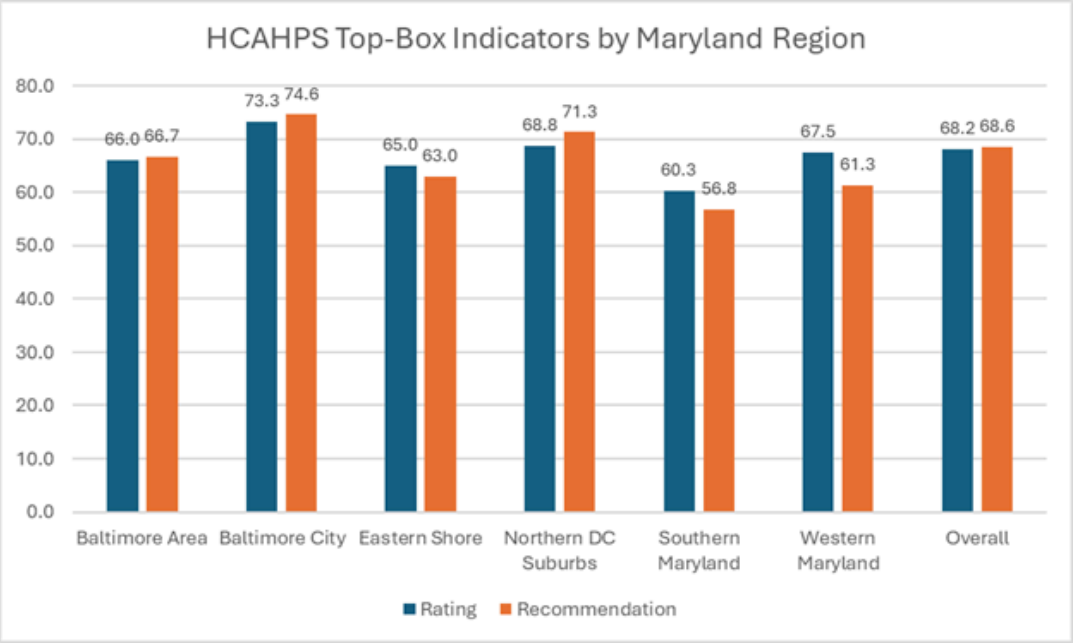
Looking at the overall results, there is minimal variation between race (Figure C.5). When reviewing more granularly, there are significant differences between race and service line. Specifically, the surgical service line consistently has higher results, and the medical service line is the lowest. However, between the race categories within the maternity service line, there is over a six-point difference between black and white respondents.

Figure C.5. Top-Box Rating by Race and Service Line Results

Top-Box Rating by Service Line				
Race	**Maternity**	**Medical**	**Surgical**	**Overall**
White	71.9	63.4	75.7	68.9
Black	65.4	65.6	73.8	66.5
Other	67.3	63.1	73.0	70.2
Overall	**69.6**	**65.1**	**75.2**	**68.4**

Reviewing the results by region, there are higher top-box results in Baltimore City and the Northern DC Suburbs, with lower results in Southern Maryland (Figure C.6).

Figure C.6. Top-Box Rating and Recommendation by Region



APPENDIX D: 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 changes[18]. Figure D.1. below illustrates Maryland's change from CY 2022 to CY 2023 (the most current annual report published by CDC); the data reveal that Maryland's performance had statistically significant improvement (decrease) or 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 -10 percent and 28 percent for four of the HAI categories for CY 2023 compared to CY 2022 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 analyses[19]. 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 D.1. CDC Healthcare-Associated Infections Progress Report, Maryland SIRs, CY 2023 Compared to CY 2022

Maryland Changes in state-specific standardized infection ratios (SIRs) between 2022 and 2023 for NHSN Acute Care Hospitals					
	2022 SIR	**2023 SIR**	**Percent Change**	**Direction of Change, Based on Statistical Significance**	**p-value**
CLABSI	0.946	0.848	-10%	No statistically significant change	0.1189
CAUTI	0.753	0.763	1%	No statistically significant change	0.8575
SSI Colon	0.861	0.890	3%	No statistically Significant change	0.8944
SSI Hysterectomy	1.185	1.515	28%	No statistically significant change	0.2771
MRSA	0.767	0.571	-26%	Statistically significant decrease	0.0165
CDIF	0.570	0.500	-12%	Statistically significant decrease	0.0060

[18] 2022 National and State Healthcare-Associated Infections Progress Report found at: https://www.cdc.gov/healthcare-associated-infections/php/data/progress-report.html?CDC_AAref_Val=https://www.cdc.gov/hai/data/portal/progress-report.html, last accessed 8/15/2024.
[19] See: https://www.cdc.gov/nhsn/datastat/progress-report.html (last accessed 7/23/2025).

APPENDIX E: 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.[20]

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, 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 E.1. below illustrates the Maryland and CMS CY 2026 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

[20] 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.

Severe Obstetric Complications measure beginning in CY 2022, a year ahead of CMS' requirement for hospitals to submit this eCQM; of note, beginning this year, Maryland has worked with CRISP and Medisolv to complete the application of risk adjustment for this 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 E.1. CMS-Maryland CY 202CY 2025 Anticipated eCQM Reporting Requirements

Reporting Period/ payment determination	CMS Measures	Maryland Measures
CY 2025/RY 2027	Three self-selected eCQMs; Three required eCMQs -Safe Use of Opioids -Cesarean Birth -Severe Obstetric Complications Clinical data elements for two hybrid measures for Medicare -30-day mortality -30-day readmissions	Two self-selected eCQMs; Required eCQMs- -Safe Opioids -hypoglycemia -hyperglycemia -Cesarean Birth -Severe Obstetric complications Clinical data elements for two hybrid measures (for all-payers beginning in July 2024-June 2025) -30-day mortality -30-day readmissions
CY 2026/RY 2028	Three self-selected eCQMs; Required eCQMs- -Safe Opioids -hypoglycemia -hyperglycemia -Cesarean Birth -Severe Obstetric complications Clinical data elements for two hybrid measures (for all-payers beginning in July 2024-June 2025) -30-day mortality -30-day readmissions	Three self-selected eCQMs; Required eCQMs- -Safe Opioids -hypoglycemia -hyperglycemia -Cesarean Birth -Severe Obstetric complications Clinical data elements for two hybrid measures (for all-payers beginning in July 2024-June 2025) -30-day mortality -30-day readmissions

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 as of July 1, 2023. The state notes that subsequent transition to and adoption of an all-payer hybrid HWM measure will potentially allow for its use in the QBR program.

APPENDIX F: RY 2026 QBR PERFORMANCE BY HOSPITAL

cut-point = 41%

HOSPID	HOSPITAL NAME	FY25 Estimated Permanent Inpatient Revenue	RY 2026 FINAL Score	% Revenue Impact	$ Revenue Impact
210001	Meritus	$ 269,729,949	49.58%	0.44%	$1,186,812
210002	UMMS- UMMC	$ 1,572,442,188	18.08%	-1.12%	-$17,611,353
210003	UMMS- Capital Region	$ 325,349,234	30.25%	-0.52%	-$1,691,816
210004	Trinity - Holy Cross	$ 440,757,012	16.58%	-1.19%	-$5,245,008
210005	Frederick	$ 255,860,248	26.17%	-0.72%	-$1,842,194
210008	Mercy	$ 244,094,359	36.75%	-0.21%	-$512,598
210009	JHH- Johns Hopkins	$ 1,915,323,836	34.67%	-0.31%	-$5,937,504
210011	St. Agnes	$ 280,211,776	36.25%	-0.23%	-$644,487
210012	Lifebridge- Sinai	$ 527,147,859	31.00%	-0.49%	-$2,583,025
210015	MedStar- Franklin Square	$ 407,544,466	27.17%	-0.67%	-$2,730,548
210016	Adventist- White Oak	$ 269,335,289	45.33%	0.22%	$592,538
210017	Garrett	$ 31,765,005	80.27%	2.00%	$635,300
210018	MedStar- Montgomery	$ 107,202,092	55.27%	0.73%	$782,575
210019	Tidal- Peninsula	$ 356,375,986	35.50%	-0.27%	-$962,215
210022	JHH- Suburban	$ 276,688,736	29.83%	-0.54%	-$1,494,119
210023	Luminis- Anne Arundel	$ 419,860,154	34.83%	-0.30%	-$1,259,580
210024	MedStar- Union Mem	$ 306,565,594	32.55%	-0.41%	-$1,256,919
210027	Western Maryland	$ 206,549,734	28.83%	-0.59%	-$1,218,643
210028	MedStar- St. Mary's	$ 99,664,006	38.35%	-0.13%	-$129,563
210029	JHH- Bayview	$ 505,597,983	16.75%	-1.18%	-$5,966,056
210032	ChristianaCare, Union	$ 111,158,432	46.43%	0.28%	$311,244
210033	Lifebridge- Carroll	$ 166,721,865	25.75%	-0.74%	-$1,233,742
210034	MedStar- Harbor	$ 137,076,633	39.93%	-0.05%	-$68,538
210035	UMMS- Charles	$ 105,216,708	21.08%	-0.97%	-$1,020,602
210037	UMMS- Easton	$ 138,384,760	30.33%	-0.52%	-$719,601
210038	UMMS- Midtown	$ 140,973,899	32.35%	-0.42%	-$592,090
210039	Calvert	$ 84,946,923	63.17%	1.14%	$968,395
210040	Lifebridge- Northwest	$ 173,564,819	29.83%	-0.54%	-$937,250
210043	UMMS- BWMC	$ 329,675,757	31.42%	-0.47%	-$1,549,476
210044	GBMC	$ 274,971,840	36.67%	-0.21%	-$577,441
210048	JHH- Howard County	$ 256,140,273	20.17%	-1.02%	-$2,612,631
210049	UMMS-Upper Chesapeake	$ 260,331,648	22.83%	-0.89%	-$2,316,952
210051	Luminis- Doctors	$ 195,040,841	29.75%	-0.55%	-$1,072,725
210056	MedStar- Good Sam	$ 199,681,457	21.25%	-0.96%	-$1,916,942
210057	Adventist- Shady Grove	$ 361,126,072	32.42%	-0.42%	-$1,516,730
210060	Adventist-Ft. Washington	$ 37,325,252	33.65%	-0.36%	-$134,371
210061	Atlantic General	$ 49,839,515	58.85%	0.92%	$458,524
210062	MedStar- Southern MD	$ 210,782,671	27.50%	-0.66%	-$1,391,166
210063	UMMS- St. Joe	$ 305,357,564	42.92%	0.10%	$305,358
210065	Trinity - Holy Cross Germantown	$ 106,721,583	14.83%	-1.28%	-$1,366,036
	Statewide Total	**$12,463,104,017**			**-$64,871,175**

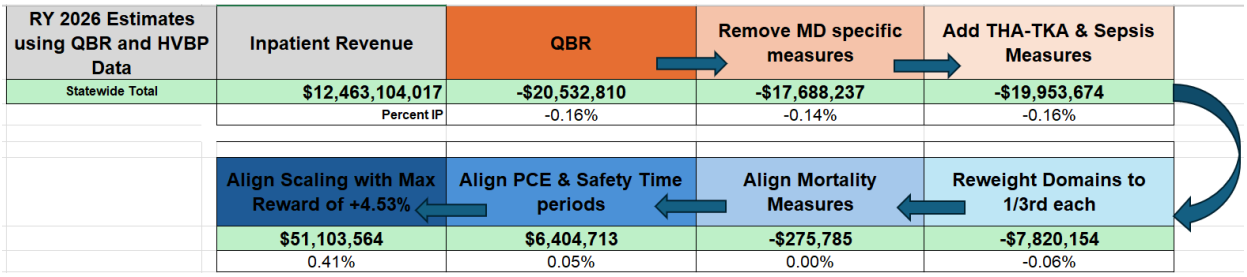
Cut-point = 32

HOSPID	HOSPITAL NAME	FY25 Estimated Permanent Inpatient Revenue	RY 2026 FINAL Score	% Revenue Impact	$ Revenue Impact
210001	Meritus	$ 269,729,949	49.58%	0.73%	$1,969,029
210002	UMMS- UMMC	$ 1,572,442,188	18.08%	-0.87%	-$13,680,247
210003	UMMS- Capital Region	$ 325,349,234	30.25%	-0.11%	-$357,884
210004	Trinity - Holy Cross	$ 440,757,012	16.58%	-0.96%	-$4,231,267
210005	Frederick	$ 255,860,248	26.17%	-0.36%	-$921,097
210008	Mercy	$ 244,094,359	36.75%	0.20%	$488,189
210009	JHH- Johns Hopkins	$ 1,915,323,836	34.67%	0.11%	$2,106,856
210011	St. Agnes	$ 280,211,776	36.25%	0.18%	$504,381
210012	Lifebridge- Sinai	$ 527,147,859	31.00%	-0.06%	-$316,289
210015	MedStar- Franklin Square	$ 407,544,466	27.17%	-0.30%	-$1,222,633
210016	Adventist- White Oak	$ 269,335,289	45.33%	0.56%	$1,508,278
210017	Garrett	$ 31,765,005	80.27%	2.00%	$635,300
210018	MedStar- Montgomery	$ 107,202,092	55.27%	0.97%	$1,039,860
210019	Tidal- Peninsula	$ 356,375,986	35.50%	0.15%	$534,564
210022	JHH- Suburban	$ 276,688,736	29.83%	-0.14%	-$387,364
210023	Luminis- Anne Arundel	$ 419,860,154	34.83%	0.12%	$503,832
210024	MedStar- Union Mem	$ 306,565,594	32.55%	0.02%	$61,313
210027	Western Maryland	$ 206,549,734	28.83%	-0.20%	-$413,099
210028	MedStar- St. Mary's	$ 99,664,006	38.35%	0.26%	$259,126
210029	JHH- Bayview	$ 505,597,983	16.75%	-0.95%	-$4,803,181
210032	ChristianaCare, Union	$ 111,158,432	46.43%	0.60%	$666,951
210033	Lifebridge- Carroll	$ 166,721,865	25.75%	-0.39%	-$650,215
210034	MedStar- Harbor	$ 137,076,633	39.93%	0.33%	$452,353
210035	UMMS- Charles	$ 105,216,708	21.08%	-0.68%	-$715,474
210037	UMMS- Easton	$ 138,384,760	30.33%	-0.10%	-$138,385
210038	UMMS- Midtown	$ 140,973,899	32.35%	0.01%	$14,097
210039	Calvert	$ 84,946,923	63.17%	1.30%	$1,104,310
210040	Lifebridge- Northwest	$ 173,564,819	29.83%	-0.14%	-$242,991
210043	UMMS- BWMC	$ 329,675,757	31.42%	-0.04%	-$131,870
210044	GBMC	$ 274,971,840	36.67%	0.19%	$522,446
210048	JHH- Howard County	$ 256,140,273	20.17%	-0.74%	-$1,895,438
210049	UMMS-Upper Chesapeake	$ 260,331,648	22.83%	-0.57%	-$1,483,890
210051	Luminis- Doctors	$ 195,040,841	29.75%	-0.14%	-$273,057
210056	MedStar- Good Sam	$ 199,681,457	21.25%	-0.67%	-$1,337,866
210057	Adventist- Shady Grove	$ 361,126,072	32.42%	0.02%	$72,225
210060	Adventist-Ft. Washington	$ 37,325,252	33.65%	0.07%	$26,128
210061	Atlantic General	$ 49,839,515	58.85%	1.12%	$558,203
210062	MedStar- Southern MD	$ 210,782,671	27.50%	-0.28%	-$590,191
210063	UMMS- St. Joe	$ 305,357,564	42.92%	0.45%	$1,374,109
210065	Trinity - Holy Cross Germantown	$ 106,721,583	14.83%	-1.07%	-$1,141,921
	Statewide Total	**$12,463,104,017**			**-$20,532,809**

APPENDIX G: ASSESSMENT OF QBR AND HVBP DIFFERENCES

Figure G. 1. below illustrates the iterative impact of changes to the QBR results to reconcile with the HVBP results. The analysis is impacted by the order of the changes and the manually calculated HVBP results vary slightly from the CMMI results. Overall this indicates that the scaling parameters for HVBP is the largest factor associated with over 60 percent of the difference between the QBR and HVBP scores. Domain weighting is the second biggest factor, which staff has proposed to address by changes to the domain weights. Removal of Maryland specific measures and addition of the Sepsis Bundle and THA-TKA complication measure, however, have much smaller contributions to the differences in scores.

Figure G.1. Iterative Impact of Changes in QBR Results Reconciled with HVBP



APPENDIX H: RY 2028 MODELING ESTIMATES BY HOSPITAL

RY 2028 QBR Modeling using RY 2026 Data			Option 1: Staff Recommendation						Option 2: MHA Proposal						Option 3: Staff Recommendation (option 1) w/o Sepsis & THA-TKA					
			38.30%	30.85%	30.85%				33.33%	33.33%	33.33%				38.30%	30.85%	30.85%			
HOSPID	HOSPITAL NAME	Actual IP Revenue	PCE Domain Score	Clinical Domain Score	Safety Domain Score	FINAL Score	% Revenue Impact	$ Revenue Impact	PCE Domain Score	Clinical Domain Score	Safety Domain Score	FINAL Score	% Revenue Impact	$ Revenue Impact	PCE Domain Score	Clinical Domain Score	Safety Domain Score	FINAL Score	% Revenue Impact	$ Revenue Impact
210001	Meritus	$ 269,729,949	45%	29%	62%	45.33%	0.56%	$1,510,488	32%	29%	62%	40.94%	0.37%	$998,001	45%	55%	47%	48.67%	0.69%	$1,861,137
210002	UMMS- UMMC	$ 1,572,442,188	21%	30%	8%	19.83%	-0.76%	-$11,950,561	32%	30%	8%	23.44%	-0.53%	-$8,333,944	21%	30%	3%	18.28%	-0.86%	-$13,523,003
210003	UMMS- Capital Region	$ 325,349,234	39%	5%	43%	29.91%	-0.13%	-$422,954	20%	5%	43%	22.78%	-0.58%	-$1,887,026	39%	5%	50%	31.97%	0.00%	$0
210004	Holy Cross	$ 440,757,012	17%	7%	35%	19.18%	-0.80%	-$3,526,056	8%	7%	35%	16.55%	-0.97%	-$4,275,343	17%	7%	23%	15.58%	-1.03%	-$4,539,797
210005	Frederick	$ 255,860,248	17%	21%	57%	30.31%	-0.11%	-$281,446	19%	21%	57%	32.16%	0.01%	$25,586	17%	21%	44%	26.40%	-0.35%	-$895,511
210008	Mercy	$ 244,094,359	47%	4%	42%	32.22%	0.01%	$24,409	31%	4%	42%	25.61%	-0.40%	-$976,377	47%	4%	40%	31.71%	-0.02%	-$48,819
210009	JHH- Johns Hopkins	$ 1,915,323,836	39%	75%	20%	44.06%	0.50%	$9,576,619	59%	75%	20%	51.33%	0.81%	$15,514,123	39%	75%	23%	45.09%	0.55%	$10,534,281
210011	St. Agnes	$ 280,211,776	34%	50%	35%	39.22%	0.30%	$840,635	12%	50%	35%	32.33%	0.01%	$28,021	34%	50%	48%	43.23%	0.47%	$1,316,995
210012	Lifebridge- Sinai	$ 527,147,859	35%	13%	23%	24.55%	-0.47%	-$2,477,595	14%	13%	23%	16.61%	-0.96%	-$5,060,619	35%	13%	28%	26.10%	-0.37%	-$1,950,447
210015	MedStar- Franklin Square	$ 407,544,466	12%	35%	42%	28.06%	-0.25%	-$1,018,861	15%	35%	42%	30.55%	-0.09%	-$366,790	12%	35%	62%	34.23%	0.09%	$366,790
210016	Adventist- White Oak	$ 269,335,289	50%	33%	60%	48.04%	0.67%	$1,804,546	37%	33%	60%	43.44%	0.48%	$1,292,809	50%	33%	54%	46.19%	0.59%	$1,589,078
210017	Garrett	$ 31,765,005	87%	60%	10%	54.91%	0.95%	$301,768	84%	60%	10%	51.33%	0.81%	$257,297	87%	60%	0%	51.82%	0.83%	$263,650
210018	MedStar- Montgomery	$ 107,202,092	50%	58%	66%	57.60%	1.07%	$1,147,062	33%	58%	66%	52.44%	0.85%	$911,218	50%	58%	83%	62.69%	1.28%	$1,372,187
210019	Tidal- Peninsula	$ 356,375,986	31%	3%	47%	27.24%	-0.30%	-$1,069,128	22%	3%	47%	24.00%	-0.50%	-$1,781,880	31%	3%	54%	29.51%	-0.16%	-$570,202
210022	JHH- Suburban	$ 276,688,736	28%	50%	20%	32.17%	0.01%	$27,669	37%	50%	20%	35.66%	0.15%	$415,033	28%	50%	20%	32.17%	0.01%	$27,669
210023	Luminis- Anne Arundel	$ 419,860,154	40%	0%	33%	25.69%	-0.39%	-$1,637,455	19%	0%	33%	17.44%	-0.91%	-$3,820,727	40%	0%	27%	23.64%	-0.52%	-$2,183,273
210024	MedStar- Union Mem	$ 306,565,594	17%	38%	42%	31.28%	-0.04%	-$122,626	26%	38%	42%	35.44%	0.14%	$429,192	17%	38%	53%	34.52%	0.11%	$337,222
210027	Western Maryland	$ 206,549,734	30%	2%	32%	21.68%	-0.64%	-$1,321,918	39%	2%	32%	24.11%	-0.49%	-$1,012,094	30%	2%	30%	21.17%	-0.68%	-$1,404,538
210028	MedStar- St. Mary's	$ 99,664,006	14%	46%	70%	41.15%	0.38%	$378,723	19%	46%	70%	44.94%	0.54%	$538,186	14%	46%	88%	46.54%	0.61%	$607,950
210029	JHH- Bayview	$ 505,597,983	16%	46%	10%	23.23%	-0.55%	-$2,780,789	24%	46%	10%	26.61%	-0.34%	-$1,719,033	16%	46%	2%	20.76%	-0.70%	-$3,539,186
210032	ChristianaCare, Union	$ 111,158,432	44%	54%	36%	44.65%	0.53%	$589,140	30%	54%	36%	40.05%	0.34%	$377,939	44%	54%	45%	47.42%	0.64%	$711,414
210033	Lifebridge- Carroll	$ 166,721,865	11%	35%	48%	29.78%	-0.14%	-$233,411	11%	35%	48%	31.44%	-0.03%	-$50,017	11%	35%	52%	30.91%	-0.07%	-$116,705
210034	MedStar- Harbor	$ 137,076,633	28%	70%	46%	46.37%	0.60%	$822,460	21%	70%	46%	45.66%	0.57%	$781,337	28%	70%	58%	49.91%	0.75%	$1,028,075
210035	UMMS- Charles	$ 105,216,708	15%	17%	43%	24.09%	-0.49%	-$515,562	21%	17%	43%	27.00%	-0.31%	-$326,172	15%	17%	34%	21.21%	-0.67%	-$704,952
210037	UMMS- Easton	$ 138,384,760	34%	29%	35%	32.96%	0.04%	$55,354	10%	29%	35%	24.72%	-0.45%	-$622,731	34%	29%	42%	35.12%	0.13%	$179,900
210038	UMMS- Midtown	$ 140,973,899	37%	25%	44%	35.28%	0.14%	$197,363	12%	25%	44%	27.00%	-0.31%	-$437,019	37%	25%	38%	33.27%	0.05%	$70,487
210039	Calvert	$ 84,946,923	67%	20%	52%	47.77%	0.66%	$560,650	53%	20%	52%	41.66%	0.40%	$339,788	67%	20%	87%	58.47%	1.10%	$934,416
210040	Lifebridge- Northwest	$ 173,564,819	33%	29%	40%	33.92%	0.08%	$138,852	17%	29%	40%	28.72%	-0.21%	-$364,486	33%	29%	26%	29.60%	-0.15%	-$260,347
210043	UMMS- BWMC	$ 329,675,757	23%	42%	27%	29.81%	-0.14%	-$461,546	27%	42%	27%	31.78%	-0.01%	-$32,968	23%	42%	28%	30.22%	-0.11%	-$362,643
210044	GBMC	$ 274,971,840	27%	13%	52%	30.30%	-0.11%	-$302,469	26%	13%	52%	30.05%	-0.12%	-$329,966	27%	13%	50%	29.78%	-0.14%	-$384,961
210048	JHH- Howard County	$ 256,140,273	10%	13%	37%	18.92%	-0.82%	-$2,100,350	15%	13%	37%	21.39%	-0.66%	-$1,690,526	10%	13%	36%	18.71%	-0.83%	-$2,125,964
210049	UMMS-Upper Chesapeake	$ 260,331,648	20%	21%	32%	23.69%	-0.52%	-$1,353,725	6%	21%	32%	19.50%	-0.78%	-$2,030,587	20%	21%	38%	25.64%	-0.40%	-$1,041,327
210051	Luminis- Doctors	$ 195,040,841	34%	21%	45%	33.31%	0.05%	$97,520	12%	21%	45%	25.94%	-0.38%	-$741,155	34%	21%	28%	28.07%	-0.25%	-$487,602
210056	MedStar- Good Sam	$ 199,681,457	4%	30%	45%	24.64%	-0.46%	-$918,535	6%	30%	45%	27.00%	-0.31%	-$619,013	4%	30%	54%	27.41%	-0.29%	-$579,076
210057	Adventist- Shady Grove	$ 361,126,072	22%	21%	57%	32.15%	0.01%	$36,113	29%	21%	57%	35.50%	0.15%	$541,689	22%	21%	52%	30.71%	-0.08%	-$288,901
210060	Adventist-Ft. Washington	$ 37,325,252	30%	30%	26%	28.78%	-0.20%	-$74,651	34%	30%	26%	30.00%	-0.13%	-$48,523	30%	30%	50%	36.18%	0.17%	$63,453
210061	Atlantic General	$ 49,839,515	66%	25%	50%	48.37%	0.68%	$338,909	53%	25%	50%	42.66%	0.44%	$219,294	66%	25%	73%	55.31%	0.97%	$483,443
210062	MedStar- Southern MD	$ 210,782,671	7%	67%	50%	38.74%	0.28%	$590,191	11%	67%	50%	42.55%	0.44%	$927,444	7%	67%	54%	39.98%	0.33%	$695,583
210063	UMMS- St. Joe	$ 305,357,564	40%	54%	22%	38.55%	0.27%	$824,465	50%	54%	22%	41.94%	0.41%	$1,251,966	40%	54%	20%	38.03%	0.25%	$763,394
210065	Holy Cross Germantown	$ 106,721,583	10%	2%	32%	14.03%	-1.12%	-$1,195,282	15%	2%	32%	16.11%	-0.99%	-$1,056,544	10%	2%	18%	9.82%	-1.39%	-$1,483,430
	Statewide Total	**$12,463,104,017**	**30.7%**	**30.5%**	**39.3%**	**33.3%**	**-0.02%**	**-$13,901,981**	**26.0%**	**30.5%**	**39.3%**	**32.0%**	**-0.09%**	**-$12,734,618**	**30.7%**	**31.2%**	**41.5%**	**34.2%**	**0.01%**	**-$13,283,560**