



maryland
health services
cost review commission

Rate Year 2028 Quality Policies Webinar

Overview of HSCRC's Hospital Quality Programs

May 22, 2026

Purpose of Webinar

- HSCRC and AHEAD Quality Overview
- Overview of HSCRC Pay-for-Performance Quality Programs
- Review of the Rate Year 2028 Approved Programs:
 - Maryland Hospital Acquired Conditions
 - Quality Based Reimbursement
 - Readmissions Reduction Incentive Program
 - Potentially Avoidable Utilization Savings Program
 - Maximum Guardrail
 - Emergency Department Best Practices
- Highlight Other Performance Measurement Initiatives:
 - Emergency Department Wait Time Reduction Commission
 - AHEAD Population Health Accountability
 - Inpatient Length of Stay
 - Quality Monitoring Reports
 - Digital Measures Reporting
 - HCAHPS Learning Collaborative
- CRISP Reporting Services (CRS) Dashboard Overview

Webinar Housekeeping

- Today's session is being recorded and will be posted on the HSCRC Quality Webpage: <https://hscrc.maryland.gov/Pages/quality.aspx>
- Participants should mute microphone if not speaking
- Please submit questions using the chat feature

HSCRC Quality and Population Health Staff Members

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HSCRC and AHEAD Quality Overview

HSCRC - Who We Are



Maryland Health Services Cost Review Commission (HSCRC)

An independent state agency responsible for regulating the quality and cost of hospital services to ensure all Marylanders have access to high value healthcare.

Our Vision

To enhance the quality of healthcare and patient experience, improve population health and health outcomes, and reduce the total cost of care for Marylanders.

Our Role

The HSCRC establishes rates for all hospital services and helps develop the State's innovative efforts to transform the delivery system and achieve goals under the Maryland Health Model.

Maryland's Unique Healthcare System: Overview

Maryland Health Model

All-Payer Hospital Rate Setting System

- The HSCRC has set hospital rates, on an all-payer basis, since the 1970s
- The system can be adjusted to achieve CMS agreement targets and other statewide priorities

Commission Policies

CMS-MD Agreement

- A commitment between the State and Federal Government to use global budgets for hospitals, reform the health care and delivery system, and improve population health.
 - All-Payer Model (2014-2018)
 - Total Cost of Care Model (2019-2025)
 - AHEAD Model (2026-2034)

AHEAD Model Overview

- The AHEAD Model is a CMMI model that builds upon the successes of the Maryland TCOC Model in reducing health care cost growth and improving statewide health outcomes.
 - AHEAD maintains hospital global budgets and quality metrics across payers to better streamline and coordinate efforts around providing better care that improves the overall health of all Marylanders.
 - AHEAD sets goals for primary care spending, which will enhance access to care.
 - AHEAD creates new opportunities for innovation and health, including through options to increase choice and competition, improve quality, and set key goals and key measures for health improvement.
- On November 12, 2025, Maryland and CMS signed an Amended and Restated State Agreement, providing the framework for the Maryland health model over the next 10 years. This agreement reflects months of detailed negotiations with strong engagement from hospitals, payers, providers, and other partners across the state.

In summary, Maryland AHEAD will provide the foundation for continuing to reach the State's goals of access, affordability and quality in health care for all Marylanders.

Hospital Global Budgets and Quality Incentives under AHEAD

CMS will set **Medicare FFS global budgets** starting in 2028; State will continue to set hospital global budgets for other payers.

- Performance Year 1 (CY 2026) and PY2 (CY 2027) are a transition period where the State will continue to set all-payer Hospital Global Budgets.
- In order to smooth the transition, the State will be able to redirect a portion of the total Medicare global budget amount between PY3 (2028) and PY5 (2030).

Hospital Quality Incentives:

- Under the AHEAD model, Maryland hospitals will transition to the CMS hospital quality programs and have additional AHEAD specific adjustments for readmissions and avoidable emergency department visits and inpatient admissions.
- The State will administer hospital quality programs to adjust non-Medicare FFS global budgets that align with CMS programs where feasible, as well as address areas of opportunity for Maryland.
- HSCRC quality team is discussing timelines and additional details on the transition with CMMI.

Overview of Pay-for-Performance Quality Programs

Hospital Quality Adjustments

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

Maryland Hospital Acquired Conditions (MHAC) Program

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

Quality Reimbursement Program (QBR)

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

Readmissions Reduction Incentive Program (RRIP)

Encourages hospitals to reduce readmissions within 30 days of discharge

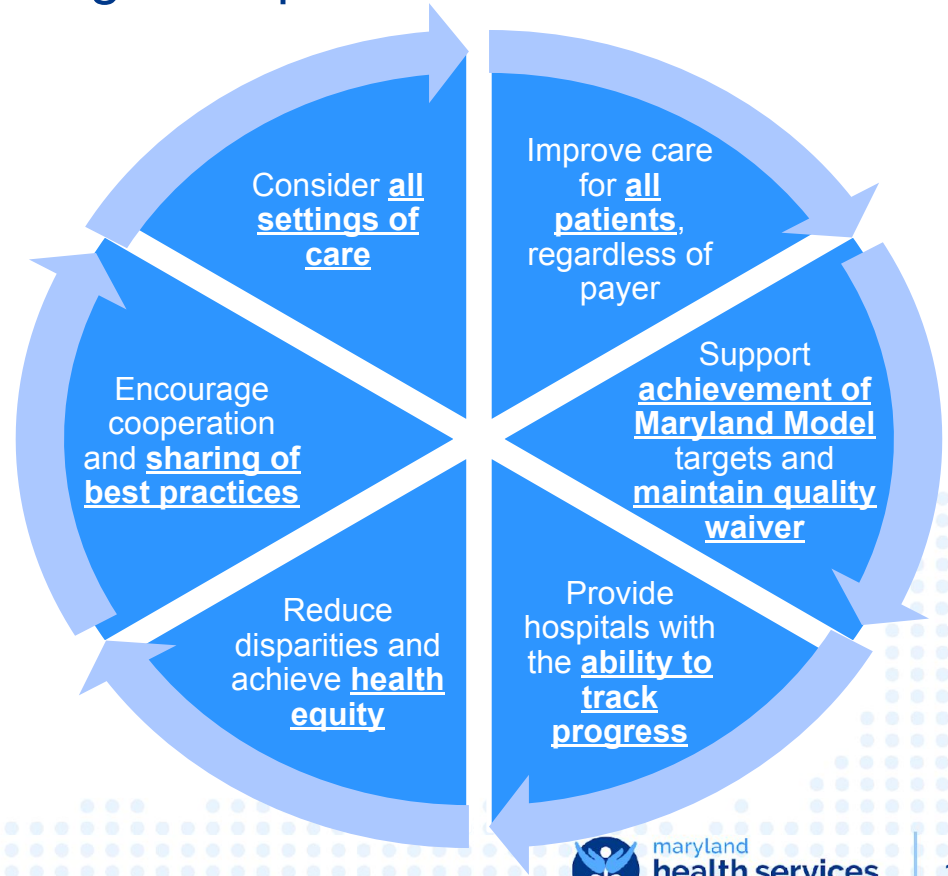
Potentially Avoidable Utilization (PAU)

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

HSCRC's quality programs are similar to federal Medicare pay-for-performance programs, but are, wherever possible, All-Payer (instead of Medicare-only) and tailored to address MD's unique quality improvement strategies

HSCRC Quality Program Guiding Principles

The mission of the HSCRC Quality Programs is to create all-payer financial incentives for Maryland hospitals to provide efficient, high quality patient care, and to support delivery system improvements across the State.



HSCRC Quality Team Stakeholders and Partners

Performance Measurement Workgroup

- Broad stakeholder group of hospital, payer, quality measurement, academic, consumer, and government agency experts and representatives who advise on the development of hospital quality incentives.
 - Subgroups of technical experts convened as needed (e.g., Clinical Adverse Event Measures Subgroup)

hMetrix

- Processes the monthly/quarterly HSCRC Case-Mix data and applies Solventum grouper results to datasets for inpatient and outpatient hospital data.

CRISP Reporting Services

- Hub for all HSCRC quality program reports, including summary level reports showing hospital performance, patient level detail files, and interactive dashboards.
- Digital measures collection

Performance Measurement Contractor (Mathematica)

- Provide measurement and statistical expertise to support development of HSCRC measures, policy development, and program evaluation.

RY 2028 Quality Programs

What does Rate Year 2028 mean?

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

- Each program has a “base” period that is used to prospectively determine performance standards (i.e., threshold and benchmark) and for measuring improvement, if applicable.
 - Threshold = performance needed to avoid penalties
 - Benchmark = performance needed to earn max reward
- The RY 2028 performance periods vary by measure:
 - CY 2026* for HSCRC case-mix measures (e.g., Potentially Preventable Complications, readmissions, mortality).
 - Measures obtained from CMS Care Compare vary in performance period length and have a 9 month delay in being published publicly for HSCRC use.

*Small hospitals are assessed on CYs 2025 and 2026 within the MHAC program.

RY 2028 Quality Program Timelines

HSCRC RY 2028 Performance Based Payment Program Measurement, Performance, and Impact Periods																							
Rate Year (Maryland Fiscal Year)	Q3-23	Q4-23	Q1-24	Q2-24	Q3-24	Q4-24	Q1-25	Q2-25	Q3-25	Q4-25	Q1-26	Q2-26	Q3-26	Q4-26	Q1-27	Q2-27	Q3-27	Q4-27	Q1-28	Q2-28	Q3-28	Q4-28	
Calendar Year	Q1-23	Q2-23	Q3-23	Q4-23	Q1-24	Q2-24	Q3-24	Q4-24	Q1-25	Q2-25	Q3-25	Q4-25	Q1-26	Q2-26	Q3-26	Q4-26	Q1-27	Q2-27	Q3-27	Q4-27	Q1-28	Q2-28	
Maryland Hospital Acquired Conditions			Base Period: MHAC										Performance Period: MHAC (CYs 25 & 26 for small hospitals)						Rate Year Impacted by MHAC Results				
Quality Based Reimbursement Program (QBR)					Base Period: Hospital Compare (HCAHPS measures, All NHSN Measures, SEP-1 Bundle)						Performance Period: Hospital Compare (HCAHPS measures, All NHSN Measures, SEP-1 Bundle)								Rate Year Impacted by QBR Results				
					Base Period: QBR IP and 30-Day Mortality, Medicaid Timely Follow-Up						Performance Period: QBR IP and 30-Day Mortality, Medicaid Timely Follow-Up												
					Base Period: Emergency Department Length of Stay						Performance Period: Emergency Department Length of Stay												
		Performance Period: THA/TKA Complications*																					
Readmission Reduction Incentive Program (RRIP)	Base Period: RRIP (CYs 2022-2023)													Performance Period: RRIP						Rate Year Impacted by RRIP 30-Day Readmission Results			
PAU Savings														PAU Savings Performance Period						Rate Year Impacted by PAU Savings Results			

*Base Period for THA/TKA Complications is CY 2018 Q2- CY 2021 Q1

RY 2028 Maryland Hospital Acquired Condition (MHAC) Program

Maryland Hospital Acquired Conditions (MHAC) Program



Purpose

To improve patient care and hospital decision-making by adjusting GBRs based on 16 identified potentially preventable complications (PPCs) and 10 patient safety indicators (PSIs); **complications acquired during a hospital stay** that were not present on admission

- PPCs and PSIs can lead to **poor patient outcomes, longer hospital stays, increased costs, permanent harm, and death.**
- **Examples of PPCs** include improper administration of medication, hospital-acquired pneumonia
- **Examples of PSIs** include pressure ulcers and postoperative sepsis



How it Works: Revenue-at-Risk

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



Federal Alignment

The MHAC Program is **similar to the federal Medicare HAC Reduction Program (HACRP)** but is all-payer, uses a Maryland-specific list of PPC measures, and does not relatively rank hospitals in assigning financial rewards and penalties.

RY 2028 MHAC Changes

Assess hospital performance on AHRQ Patient Safety Index Composite (PSI-90) in addition to Solventum PPCs.

- Move AHRQ PSI-90 measure from the Quality Based Reimbursement Program to MHAC to align better with CMS programs.
- Weigh the AHRQ PSI-90 measure similarly to weight used in CMS complications program (i.e., 1/6th of MHAC score).

RX 2028 Data Details

1. “Base” Period: July 2023-June 2025 (i.e., FYs 24 and 25)
 - a. Used for calculation of the threshold and benchmark (i.e., performance standards) and the normative values for case-mix adjustment
 - b. Used to determine small hospitals
2. Performance Period: CY 2026
 - a. Smaller hospitals have two year performance period (CY25 & CY26)
3. Grouper Versions
 - a. Solventum APR-DRG Version 43
 - b. PPCs: Solventum PPC Grouper Version 43
 - c. PSI-90: AHRQ v2025 until v2026 becomes available

Complication Measures

PPC Composite: 16 Potentially Preventable Complications

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

Hospitals are not evaluated on PPCs for which they have 0 at-risk during the performance period.

PSI-90 Composite: 10 Patient Safety Indicators

03- Pressure Ulcer Rate	06- Iatrogenic Pneumothorax Rate	08- In-Hospital Fall-Associated Fracture Rate	09- Perioperative Hemorrhage or Hematoma Rate
10- Postoperative Acute Kidney Injury Requiring Dialysis Rate	11- Postoperative Respiratory Failure Rate	12- Perioperative Pulmonary Embolism or DVT Rate	13- Postoperative Sepsis Rate
14- Postoperative Wound Dehiscence Rate	15- Abdominopelvic Accidental Puncture or Laceration Rate		

To be evaluated on PSI-90, hospitals must have at least one PSI-90 component with >= 25 eligible discharges AND at least seven PSI-90 components with >= 3 eligible discharges.

Risk-Adjustment and Standardized Scores

Formula to calculate **PPC composite** score:

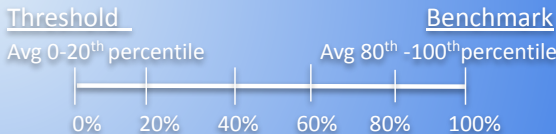
$$PPC\ Composite_j = \frac{(\sum_{i=1}^{16} ObservedPPC_{ij} * SolventumCostWeight_i)}{(\sum_{i=1}^{16} ExpectedPPC_{ij} * SolventumCostWeight_i)}$$

Solventum cost weights used as proxy for patient harm. Expected PPCs calculated by applying statewide average PPC rate by APR-DRG SOI cell (norms) from base to hospitals' patient mix in performance period. Only APR-DRG SOI cells with >31 at-risk discharges statewide are included. Catastrophic cases (>6 PPCs) are excluded.

Details on **PSI-90** scoring: [AHRQ All-Payer PSI 90 Scoring Methodology](#)

The PSI-90 and PPC Composite Measures are converted to 0-100 percent score by comparing **CY 2026*** hospital performance to a statewide threshold and benchmark.

***Small hospitals will be assessed on CYs 25 & 26**



July 2023- June 2025 data used to calculate statewide averages (norms) and threshold/benchmark for both composite measures.

MHAC Score and Revenue Adjustments

MHAC Score is calculated by weighting the PPC percent score at 5/6th and the PSI-90 percent score at 1/6th.

Hospital's MHAC Score is compared to a preset revenue adjustment scale.

Cut point for rewards/penalties is average statewide MHAC score based on modeling; cut point will be updated to the average MHAC score during performance period.

MHAC Score	Inpatient Revenue Adjustment
0%	-2.00%
10%	-1.74%
20%	-1.49%
30%	-1.23%
40%	-0.97%
50%	-0.72%
60%	-0.46%
70%	-0.21%
78%	0.00%
80%	0.18%
84%	0.55%
90%	1.09%
100%	2.00%

PPC Composite Measure

PPC performance is measured using the PPC Composite measure:

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

The **expected number** of PPCs for each hospital is calculated using the base period statewide PPC rate or normative value for each diagnosis and severity of illness category (APR-DRG-SOI) and multiplying that by the number of at-risk discharges a hospital has in each category during the performance period.

Normative values for calculating expected numbers are included in the MHAC Summary reports on the CRS portal

See the appendix of the MHAC Final Recommendation or annual memo for details on how to calculate expected numbers.

RY 2028 Payment PPC Cost Weights

PPC Number	PPC Description	v43 cost weight
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	0.2686
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1.1056
5	Pneumonia & Other Lung Infections	1.8785
6	Aspiration Pneumonia	0.8525
7	Pulmonary Embolism	1.2373
9	Shock	1.1623
16	Venous Thrombosis	1.5094
28	In-Hospital Trauma and Fractures	0.5629

PPC Number	PPC Description	v43 cost weight
35	Septicemia & Severe Infections	1.2404
37	Post-Operative Infection & Deep Wound Disruption without Procedure	1.5822
41	Post-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D	0.8325
42	Accidental Puncture/Laceration During Invasive Procedure	1.4690
47	Encephalopathy	0.8396
49	Iatrogenic Pneumothorax	0.4363
60	Major Puerperal Infection and Other Major Obstetric Complications	0.7028
61	Other Complications of Obstetrical Surgical & Perineal Wounds	0.0921

Note: Cost weights are a proxy for patient harm

PPC Inclusion/Exclusion Criteria

1. Adjustments are made to improve measurement fairness and stability; whenever possible, these adjustments are done prospectively
2. For each hospital, discharges will be excluded if:
 - a. The discharge has > 6 PPCs (i.e., catastrophic cases)
 - b. The discharge is in an APR-DRG SOI group with less than 31 statewide discharges
3. For each hospital, PPCs will be excluded if:
 - a. During the performance period, the PPC has 0 at-risk discharges
4. Two years of performance data (CY 24 & 25) are used for small hospitals (i.e., hospitals with less than 21,500 at-risk discharges and/or 22 expected PPCs across all payment program PPCs)

All-Payer Patient Safety Index Composite Measure

PSI-90 is composite measure of 10 AHRQ-specified PSIs of in-hospital complications and adverse events following surgeries, procedures, and childbirth:

- PSI 03 Pressure Ulcer
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall with Hip Fracture Rate
- PSI 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

RY 2028 uses AHRQ v2025 specifications until AHRQ v2026 is released around August of performance year, at that point the base and performance results will be updated to latest version.

PSI 90 Inclusion/Exclusion Criteria

Hospitals that do not meet the following criteria will be excluded from PSI 90 performance assessment.

1. At least one PSI component within the PSI 90 has ≥ 25 eligible discharges,
2. AND At least seven PSI components have ≥ 3 eligible discharges.

The MHAC score will be calculated using 100% of their PPC performance for those who do not meet the PSI minimum sample size criteria.

Note: Two years of performance data (CY 24 & 25) are used for small hospitals as defined by the PPC small hospital criteria.

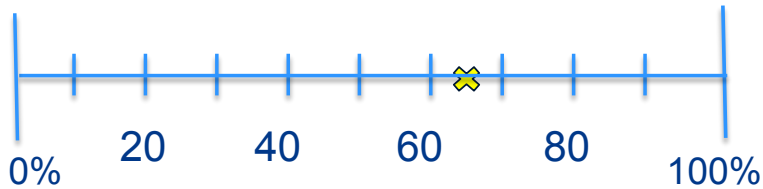
PPC Composite and PSI-90 Performance conversion to MHAC Score

Threshold = 1.4951

(Base Year Avg of Bottom Quintile)

Benchmark = 0.5364

(Base Year Avg of Top Quintile)



PPC Performance= 0.8449

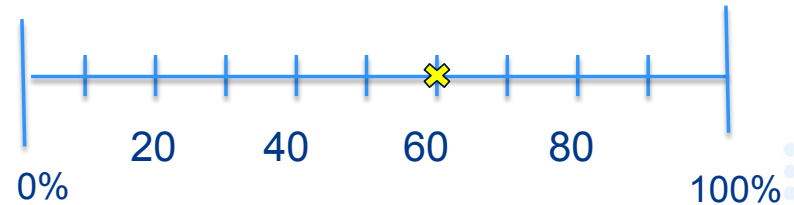
Calculates to PPC score of **67.65%**

Threshold = 1.3230

(Base Year Avg of Bottom Quintile)

Benchmark = 0.6759

(Base Year Avg of Top Quintile)



PSI-90 Performance= 0.9320

Calculates to PSI-90 score of **60.32%**

$$\text{MHAC Score} = \left(\frac{5}{6}\right) * 67.65 + \left(\frac{1}{6}\right) * 60.32 = 66.43\%$$

Assessing Hospital Performance

Performance Standards:

- Threshold:
 - Performance needed to avoid penalties
 - Average of hospital scores in the **bottom** 20th percentile of statewide performance
- Benchmark:
 - Performance needed for full reward
 - Average of hospital scores in the **top** 20th percentile of statewide performance

The performance standards are determined using base period data.

Threshold and Benchmark for the composite PPC and PSIs are included in the MHAC Calculation Sheet on the CRS Portal.

Score & Revenue Adjustment Scale

MHAC revenue adjustment scale ranges from 0% to 100%

- Picture is abbreviated scale for illustrative purposes.
- The preliminary cut point of 78% was the average score estimated through historical modeling; cut point will be reassessed and updated to the final CY 2026 statewide average
- Final MHAC score and cut point will be rounded to a percent with two decimal points.

Maximum penalty and reward is 2% of inpatient revenue.

MHAC Score	Inpatient Revenue Adjustment
0%	-2.00%
10%	-1.74%
20%	-1.49%
30%	-1.23%
40%	-0.97%
50%	-0.72%
60%	-0.46%
70%	-0.21%
78%	0.00%
80%	0.18%
84%	0.55%
90%	1.09%
100%	2.00%

PPC and PSI summary and detail level performance reports and MHAC calculation sheet are on the CRS portal.

RY 2028 Quality-Based Reimbursement (QBR) Program

Quality Based Reimbursement (QBR) Program



Purpose

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

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



How it Works: Revenue-at-Risk

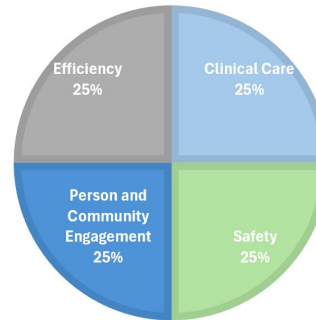
The Program puts **2 percent** of inpatient hospital revenue at risk (maximum penalty/reward)



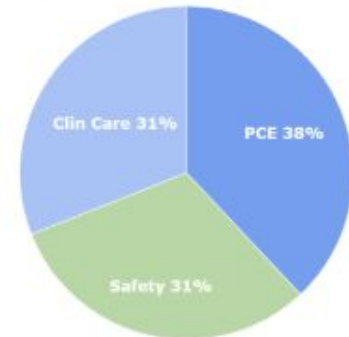
Federal Alignment

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

VBP DOMAIN WEIGHTS



QBR DOMAIN WEIGHTS



RY 2028 Data Details

HSCRC Measures

Base Period: July 2024-June 2025 (i.e. FY 2025)

- a. Used for calculation of the performance standards
- b. Used to calculate improvement

Performance Period: CY 2026

grouper Version: Solventum APR-DRG Version 43

CMS Care Compare Measures

Base Period: CY 2024 (HCAHPS, NHSN, Sep-1)
CY 2018 Q2 - CY 2021 Q1 (THA/TKA)

Performance Period:

CY 2024 Q4 - CY 2025 Q3 (HCAHPS, NHSN, Sep-1)

CY 2023 Q2 - CY 2026 Q2 (THA/TKA)

RY 2028 QBR Changes

- **Better align with CMS HVBP:**

- Measure removals- Medicare timely follow up, PSI 90, HCAHPS linear measures from the Person and Community Engagement domain; PSI 90 from the Safety domain.
- Measure additions- Total Hip/Knee Arthroplasty complications to the Clinical Care domain; Sepsis Bundle to the Safety domain
- Domain weight adjustments- Decrease weight on the Person and Community Engagement domain (60% to 38%) and increase weights on Clinical Care (10% to 30%) and Safety Domains (30% to 31%)

- **Address State/ All-Payer Priorities:**

- Maintain Medicaid timely follow up and ED Length of stay measures in the Person and Community Engagement domain; maintain all-payer inpatient and 30-day mortality measures in the Clinical Care domain.

RY 2027 QBR

HCAHP Top Box, 20%
 HCAHPS Consistency, 10%
 HCAHPS Linear, 10%
 ED Length of Stay, 10%
 TFU Medicare + Disparity, 7%
 TFU Medicaid, 3%

NHSN, 25%
 All-Payer PSI, 5%

All-Payer Inpatient Mortality, 5%
 All-Payer 30-Day Mortality, 5%



FY 2027 HVBP

HCAHP Top Box, 20%
 HCAHPS Consistency, 5%

NHSN, 20%
 Sepsis Bundle, 5%

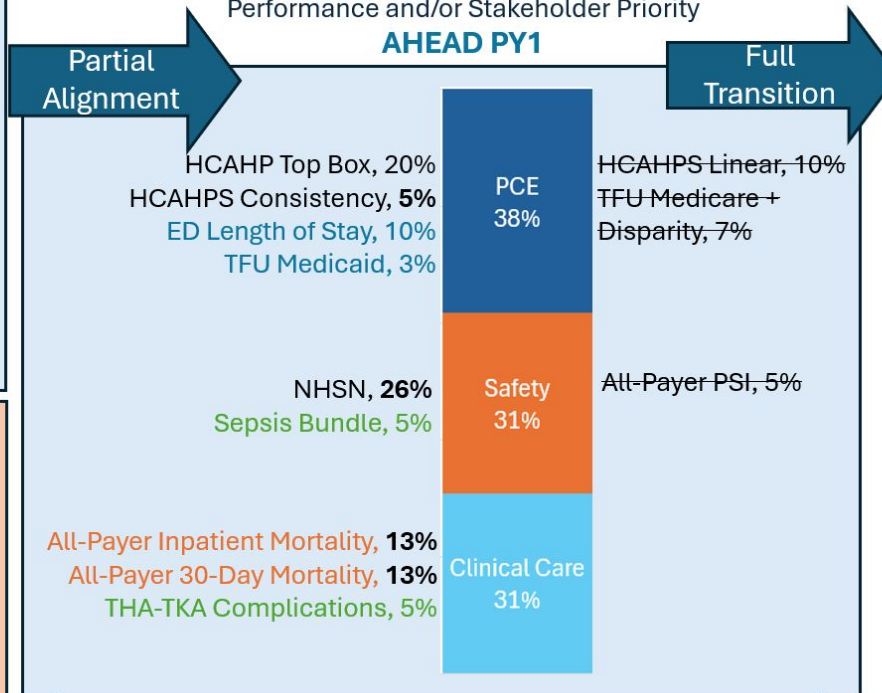
Medicare Condition Specific 30-Day Mortality, 20%
 THA-TKA Complications, 5%

Medicare Spending Per Beneficiary, 25%



RY 2028 QBR Draft Recommendations

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



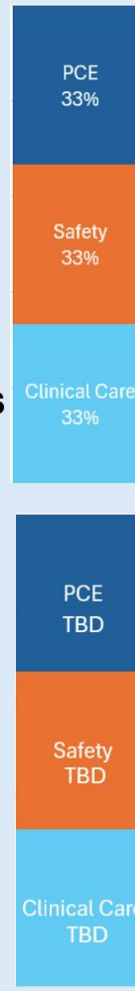
Key Measure Addition
 Weight Change
 Removed
 All-Payer or MD Priority

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

HVBP for CMS-Designed Medicare FFS Global Budgets

Quality Programs under AHEAD Starting PY2 or PY3

QBR for State-Designed Global Budgets for Other Payers



Overview of QBR



Domains and Measures:

Person and Community Engagement—

- HCAHPS: 6 top box measures, 1 consistency measure
- Timely Follow Up (TFU): Medicaid
- ED Length of Stay, admitted patients

Safety—

- 5 CDC NHSN HAI Categories
- Sepsis Bundle (SEP-1)

Clinical Care—

- Mortality: Inpatient All-Payer, 30-Day All-payer
- THA/TKA Complications

Domain	Percentage
PCE Domain	38%
Clinical Care Domain	31%
Safety Domain	31%

Individual Measures are Converted to 0-10 Points:

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

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

Final Points are Better of Improvement or Attainment

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

Scale Ranges from 0-80%

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

Abbreviated Preset Scale	QBR Score	Revenue Adjustment
Max Penalty	0%	-2.00%
	10%	-1.38%
	20%	-0.75%
Penalty/Reward Cutpoint	32%	0.00%
	40%	0.33%
	50%	0.75%
	60%	1.17%
	70%	1.58%
Max Reward	80%+	2.00%

32% cut point for rewards/penalties is national average QBR score based on historical modeling; cut point will be updated using more recent data to calculate national average QBR score

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

QBR Program Inclusion Rules

- **Hospitals must have at least 100 HCAHPS survey responses** to be included in the QBR program.
- For hospitals with measures that have **no base period data, attainment only scores** will be used to evaluate performance.
- Domain weighting is adjusted based on data availability (i.e., if no safety score, PCE domain weighted at 55% and Clinical Care domain weighted at 45%)

It is imperative that hospitals review the data in the Care Compare Preview Reports as soon as it is available from CMS.

Also due to AHEAD, hospitals should track CMS timelines and review all data submitted for IQR and CMS hospital quality programs.

QBR Measure Data Sources

CMS Measures from Care Compare (Updated Quarterly)	HSCRC Case-Mix Measures (Updated Monthly on CRS Portal)
HCAHPS (Top Box Scores, Consistency)	TFU (Medicaid)
NHSN HAI Measures (CLABSI, CAUTI, SSI- Hysterectomy & Colon, C-Diff, MRSA)	ED LOS for Admitted Patients
Sepsis Bundle	Mortality (Inpatient & 30-Day)
THA/TKA	



Person and Community Engagement (PCE)
Domain (38% of QBR)

Patient survey – Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) (20% of QBR)

- The HCAHPS survey is administered to a random sample of adult patients in the medical, surgical and maternity service lines between 48 hours and six weeks after discharge; the survey is not restricted to Medicare beneficiaries.
- HCAHPS can be implemented in six different survey modes: mail, telephone, mail with telephone follow-up, web with mail follow-up, web with telephone follow-up, or web with mail and telephone follow-up.
- Hospitals must survey patients throughout each month of the year. The survey is available in official English, Spanish, Chinese, Russian, Vietnamese, Portuguese, German, Tagalog, and Arabic versions.
- HCAHPS results are adjusted for the effects of both mode of survey administration and patient-mix; generally speaking, HCAHPS adjustments for survey mode are larger than adjustments for patient mix.

Note: This data is sourced from CareCompare
MHCC collects patient level data used for the CRISP HCAHPS dashboard

HCAHPS Scoring Methodology

1. The performance standards range from the 50th percentile of hospital performance (threshold) to the mean of the top decile (benchmark)
 - *National Top box performance standards provided by CMS.*
2. Each measure is assigned a score of zero to 10 points for attainment and zero to nine for improvement
 - *Due to two measures being suspended for redevelopment, HCAHPS points are multiplied by 8/6 to maintain the 80 points for topbox as CMS is doing for HVBP.*
3. The higher of attainment and improvement points on each measure is used to get total score for HCAHPS

HCAHPS Consistency Scoring Methodology (5% of QBR)

1. The lowest domain score is determined by the domain in which the hospital performs the worst
2. All 20 points are awarded if all domain rates are greater than or equal to the threshold
 - a. If any domain rate is less than or equal to the Floor rate (worst-performing hospital's baseline domain rate), 0 consistency points are awarded
 - b. If the lowest domain rate is greater than the Floor but less than the threshold, 0-20 consistency points are rewarded based on the performance relative to the Floor

Timely Follow-up After Acute Exacerbations of Chronic Conditions (3% of QBR)

- NQF endorsed health plan measure that looks at percentage of ED, observation stays, and inpatient admissions for one of the following six conditions, where a follow-up was received within time frame recommended by clinical practice:
 - Hypertension: 14 days for high-acuity or 30 days for medium acuity
 - Asthma: 14 days
 - Heart Failure: 14 days
 - CAD: 7 days for high-acuity or 6 weeks for low acuity
 - COPD: 30 days
 - Diabetes: 14 days

Note: Acuity is determined by ICD-10 code.

New RY28: Only **Medicaid** is included in the payment program.

Summary and Detail-Level reports are posted to the CRS portal monthly.

ED LOS Measure (10% of QBR)

Incentive assesses percent improvement from CY 2025 to CY 2026

- **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 ED patients who are admitted to Inpatient bed and discharged from hospital during reporting period
- **Scoring:** Use attainment calculation for percent change to convert improvement into a 0 to 10 point score
 - Hospitals with CY2025 Median that is lower (better) than statewide median (551 mins) have Threshold of 0 percent and benchmark of *-5 percent*.
 - Hospitals with CY2025 Median that is higher (worse) than statewide median (551 mins) have Threshold of 0 percent and benchmark of *-10 percent*.
 - Hospitals with CY 2026 ED LOS better than the 2018 National CMS ED1b results (255 mins) will not receive a penalty for declines in performance and will receive full 10 points for the measure.

See appendix slides for RY2028 measure exclusions

Important Updates related to QBR ED LOS



CY 2025 Data Release:

Preliminary data through December released in February, **CY 2025 Final data was posted in May.**



RY 2027 & RY 2028

Goal: Maintain improvement goal: **not declining in performance** (0 to -5% and 0 to -10% based on median). Rates below national average get full points.



Risk-Adjustment:

After review, staff recommend **no risk-adjustment methodology** for RY 2027 and RY2028.



Future Transition:

Evaluate potential transition to **ECAT digital measures** to replace current ED LOS measure.





Clinical Care Domain
(31% of QBR)

Maryland IP Mortality Measure (13% of QBR)

- Maryland measures **inpatient** mortality, risk-adjusted for:
 - 3M risk of mortality (ROM)
 - Sex, age, and age-squared
 - Transfers from another acute hospital within MD
 - Palliative Care status
- Measure inclusion/exclusion criteria provided in calculation sheet and user guide.
 - Subset of APR-DRGs which account for 80% of all mortalities.
 - Specific high mortality APR-DRGs and very low mortality APR-DRGs are removed.
- All-Payer
- Hospitals evaluated using **risk-adjusted survival rate**

Detail- and Hospital-level reports are provided on CRS portal monthly.

Maryland 30-Day Mortality Measure (13% of QBR)

- 30-day, all-payer, all-condition, all-cause mortality
 - Captures deaths that occurs within 30 days of a hospital admission, regardless of where death occurs
- Uses MD Vital Statistics death data merged with MD IP Case-mix records and Medicaid and CCLF Medicare claims to identify hospice (in addition to using discharge disposition (PAT_DISP = 50 or 51) and type of daily service (DAILYSER = 10))
- Measure was developed based on CMS condition specific mortality and the Maryland IP mortality measure

Detail- and Hospital-level reports provided on CRS portal quarterly.

Total Hip Arthroplasty, Total Knee Arthroplasty (THA/TKA) Complications (5% of QBR)

- **Measure:** Hospital level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)
- **Population:** Medicare FFS beneficiaries
- **Denominator:** Medicare FFS beneficiaries aged 65 years and older who are hospitalized for elective primary THA and/or TKA procedures; must have 12 months of continuous Medicare Part A and B enrollment prior to the THA and/or TKA procedure.
 - Denominator excludes patients:
 - Without at least 90 days post-discharge enrollment in Medicare FFS
 - Who discharged AMA
 - Who had >2 THA and/or TKA procedure codes during the index hospitalization
- **Numerator:** pts who experience a complication with an elective primary THA and/or TKA procedure. If any Medicare beneficiary has a complication occurring during the index admission (not coded present on arrival), or during a readmission up to 90 days post-date of the index admission, the measure will include them in the numerator.



Safety Domain
(31% of QBR)

NHSN Hospital Acquired Infections (HAI) Measures (26% of QBR)

Complications:

1. Catheter-associated urinary tract infections (CAUTI)
2. Central line-associated bloodstream infections (CLABSI)
3. Surgical site infections (SSI)
 - a. Colon surgeries
 - b. Abdominal hysterectomies
4. Clostridioides difficile (C.diff)
5. Methicillin-resistant Staphylococcus aureus (MRSA)

Performance measure: Standardized infection ratio (SIR)

- A SIR >1 means that more infections were observed than predicted.
- A SIR <1 means fewer infections were observed than predicted.
- A SIR = 1 means there was no difference from the national baseline.
-

Population: All-Payers

Sep-1 Early Management Bundle Process Measure (5% of QBR)

Measure: Percentage of Medicare FFS patients who received appropriate care for severe sepsis and/or septic shock

“All-or-Nothing” Measure: To pass the measure, a hospital must achieve 100% compliance with all required bundle elements (including 3-hour and 6-hour bundle components) for a case.

Key SEP-1 Process Measure Algorithm (2026)

- Time Zero (T0): The earliest documentation of clinical symptoms for severe sepsis or septic shock.
- 3-Hour Bundle (Within 3 hours of T0):
 - Measure serum lactate level.
 - Obtain blood cultures prior to administration of broad-spectrum antibiotics.
 - Administer broad-spectrum antibiotics.
 - Administer 30 mL/kg crystalloids for hypotension OR initial lactate .
- 6-Hour Bundle (Within 6 hours of T0):
 - Remeasure lactate if initial lactate was elevated (>2mmol/L).
 - Reassess volume status and tissue perfusion (documented by specific exam findings).
 - Administer vasopressors (if patient is still hypotensive after initial fluid resuscitation).^d

Note: This data is sourced from CareCompare

Overall Score & Revenue Adjustment Scale

1. Assess performance on each measure in the domain relative to threshold and benchmark for both improvement and attainment unless otherwise stated (0-10 points)
2. For each domain, calculate the points a hospital earned divided by the total possible points multiplied by the domain weight to get score for domain
3. Add weighted domain scores to get total hospital QBR score (0-100 percent)
4. Convert the total hospital QBR score into a revenue adjustment using the preset scale*.

Abbreviated Preset Scale	QBR Score	Financial Adjustment
Max Penalty	0%	-2.00%
	10%	-1.38%
	20%	-0.75%
Penalty/Reward Cutpoint	32%	0.00%
	40%	0.33%
	50%	0.75%
	60%	1.17%
	70%	1.58%
Max Reward	80%	2.00%

*32% cutpoint will be reassessed using updated national performance and may be retrospectively increased or decreased.

RY 2028 Measurement Methodology Recap

- Measures are converted to 0-10 points using performance standards
- Final score is the better of attainment or improvement
- QBR Score: Sum of earned points/possible points with domain weights
- Preset Scale of 0-80%, with 32% cutpoint
- Max penalty and reward at 2%
- PCE Domain (38%)
 - HCAHPS top-box and consistency
 - TFU- Medicaid
 - ED LOS for Admitted Patients
- Safety Domain (31%)
 - Sep-1 Bundle
 - 6 NHSN HAI measures
- Clinical Care Domain (31%)
 - IP Mortality
 - 30-Day Mortality
 - THA/TKA

NOTE: Bonus \$150k for hospitals that report eQMs on HSCRC's expedited schedule

RY 2028 Readmissions Reduction Incentive Program (RRIP)

Readmissions Reduction Incentive Program (RRIP)



Purpose

To incentivize hospitals to reduce avoidable readmissions by linking payment to (1) improvements in readmissions rates, and (2) attainment of relatively low readmission rates.

- **What is a readmission?** A readmission occurs when a patient is discharged from a hospital and is subsequently re-admitted to any hospital within 30 days of the discharge.
- **Why focus on readmissions?** Preventable hospitals readmissions may result from complications from previous hospitalizations or inadequate care coordination following discharge and can lead to substandard care quality for patients and unnecessary costs.



How it Works: Revenue-at-Risk

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



Federal Alignment

The RRIP is **similar to the Medicare Hospital Readmissions Reduction Program (HRRP)** but has an all-payer focus.

RY 2028 RRIP Changes

- **Modified methodology:** Attainment rates are adjusted using the Out of State Utilization Adjustment (OOS UA) to fairly compare hospitals
 - $OOS\ UA = CCW\ Readmission\ Rate / CCW\ Readmission\ Rate\ with\ MD\ Claims\ only$
 - New methodology better accounts for out of state readmissions and transfers that previous methodology. New methodology will also be applied to RY 2027.
- Removal of disparity gap measure from payment program
- Updated performance standards:
 - Attainment Target = 11.07%
 - Improvement Target = -5%

RX 2028 Data Details

1. Base Period: CYs 2022 and 2023
 - a. Used for calculation of the performance standards for improvement and attainment and normative values for case-mix adjustment
 - b. Used to calculate improvement
2. Performance Period: CY 2026
3. Grouper Version
 - a. Solventum APR-DRG Version 43

30-day, All-Cause Readmission Measure

Readmission within 30 days of Inpatient Discharge:

- All-Payer
- All-Cause
- All-Condition
- All Maryland Hospitals, including Psychiatric and Specialty hospitals
- Chronic Beds Included
- Adult Oncology Included*

Global Exclusions:

- Planned Admissions (CMS 2025 v4)
- Deliveries and newborns
- Rehabilitation cases
- Same-day and Next-day Transfers
- Discharges leaving Against Medical Advice
- Diagnosis and severity of illness groupings with less than 2 discharges statewide

*see RY 2028 policy for detailed oncology specifications

Case-Mix Adjustment

Performance Measure: CY 2026 Observed Unplanned Readmissions/ Expected Unplanned Readmissions * Statewide Readmission Rate in Base.

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

Base Period: CY 2022/23 used to calculate statewide averages (normative values), as well as attainment benchmark/threshold.

Attainment: Case-Mix Adjusted Rate Adjusted for Out-of-State Utilization.

Improvement: Reduction in Case-Mix Adjusted Readmission Rate from Base.

Revenue Adjustments

Hospital revenue adjustments are based on the better of attainment or improvement; scaled rewards and penalties of up to 2 percent of inpatient revenue.

All Payer Readmission Rate		RRIP % Inpatient Revenue Payment Adjustment
Lower Readmission Rate		2.0%
Benchmark	8.60%	2.00%
	9.84%	1.00%
Threshold	11.07%	0.00%
	12.31%	-1.00%
	13.55%	-2.00%
Higher Readmission Rate		-2.0%

Attainment Scale

All Payer Readmission Rate Change CY22/23-26		RRIP % IP Revenue Payment Adjustment
Improving		2.00%
Benchmark	-22.26%	2.00%
	-13.63%	1.00%
Target	-5.00%	0.00%
	3.63%	-1.00%
	12.26%	-2.00%
Worsening		-2.00%

Improvement Scale

Performance Metric

- Case-Mix Adjusted Inpatient Readmission Rate
 - All-Payer, All-condition admissions
 - All-Cause, 30-Day readmissions
 - All-Hospital (both intra- and inter- hospital)
 - Chronic beds and readmissions to specialty hospitals included
- Exclusions:
 - Same-day and next-day transfers
 - Rehabilitation Hospitals
 - Pediatric Oncology discharges
 - Planned readmissions – CMS Planned Readmission Logic (v4 2025), rehab and OB deliveries
 - Deaths, Left AMA
- Risk-Adjustment
 - Indirect standardization by Solventum diagnosis and severity of illness category

Summary and detail-level* reports are posted to the CRS portal monthly.

*Patients who opt-out of CRISP data-sharing and/or experience SUD are excluded from patient-level reports

Case-Mix Adjustment

- Hospital performance is measured as:

$$\text{Case-Mix Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions)}}{\text{(Expected Readmissions)}} \quad * \text{ Statewide Base Year Readmission Rate}$$

- Observed readmissions: observed, unplanned readmissions within 30 days of a discharge
- Expected readmissions: statewide rate for readmissions is calculated for each APR-DRG-SOI level, these statewide norms are applied to each hospital's case-mix to determine the expected number of readmissions

Norms file to calculate expected values is available on the CRS Portal within the RRIP Summary Workbook.

Measuring the Better of Attainment or Improvement

- RRIP continues to measure the better of attainment or improvement due to concerns that hospitals with low readmission rates may have less opportunity for improvement.
- RRIP adjustments are scaled, with maximum penalties up to 2% of inpatient revenue and maximum rewards up to 2% of inpatient revenue.

Rate Year	Performance Year	Improvement Target (from CY 2022-2023)	Attainment Reward Threshold
RY 2028	CY 2026	-5.00%	11.07%

Attainment threshold is 65th percentile of readmission rate in 2022 & 2023, further adjusted for out-of-state utilization with improvement target

Revenue Adjustment Scales

Hospitals revenue adjustments are based on the better of improvement or attainment

Improvement Scale

All Payer Readmission Rate Change CY22/23-26		RRIP % IP Revenue Payment Adjustment
Improving		2.00%
Benchmark	-22.26%	2.00%
	-13.63%	1.00%
Target	-5.00%	0.00%
	3.63%	-1.00%
	12.26%	-2.00%
Worsening		-2.00%

Attainment Scale

All Payer Readmission Rate		RRIP % Inpatient Revenue Payment Adjustment
Lower Readmission Rate		2.0%
Benchmark	8.60%	2.00%
	9.84%	1.00%
Threshold	11.07%	0.00%
	12.31%	-1.00%
	13.55%	-2.00%
Higher Readmission Rate		-2.0%

Measuring Disparities

- In previous rate years, hospitals were incentivized to reduce disparities in readmissions and timely follow up (TFU)
 - 0.5% reward only incentive for readmissions; 3.33% of QBR score for TFU disparities
- With AHEAD alignment, these measures are now being monitored
 - Hospital performance will be provided quarterly in public Commission packet and other venues
- Summary reports provided for both measures on CRS portal
 - Monitoring reports with hospital performance on disparity gap metrics are available on the CRS portal
 - RRIP detail-level reports include the Patient Adversity Index components used to calculate the disparity gap

Potentially Avoidable Utilization (PAU) Savings Policy

Potentially Avoidable Utilization (PAU) Savings Program



Purpose

- To encourage hospitals to **focus on improved care coordination and enhanced community-based care** by holding hospitals accountable for potentially avoidable utilization
- Designed to encourage hospitals to look at **upstream, community-based factors** that influence utilization



How it Works

“Potentially avoidable utilization” is defined as hospital care that is unplanned and may be prevented through improved care quality, care coordination, or effective community-based care



Methodology

The HSCRC examines the following measures in its PAU calculations:

- **30-day readmissions (uses similar logic as RRIP)** – All Hospital All Cause 30-Day Readmissions with adjustment for planned admissions
- **Avoidable admissions** – Ambulatory-care sensitive conditions identified with AHRQ Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs) (e.g. admissions for diabetes complications, admissions for urinary tract infections)

PAU Measures

Per Capita Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs)

•**Measure definition:** AHRQ Prevention Quality Indicators, which measure adult (18+) ambulatory care sensitive conditions. AHRQ Pediatric Quality Indicators focuses on preventable hospitalizations among pediatric patients

•**Data source:** Inpatient and observation stays \geq 24 hours

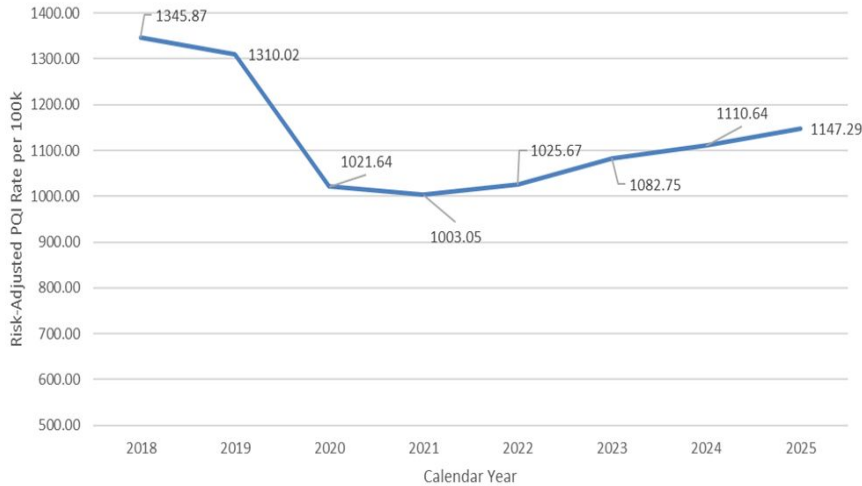
Revenue from PAU Readmissions

•**Measure definition:** 30-day unplanned readmissions measured at the index or hospital

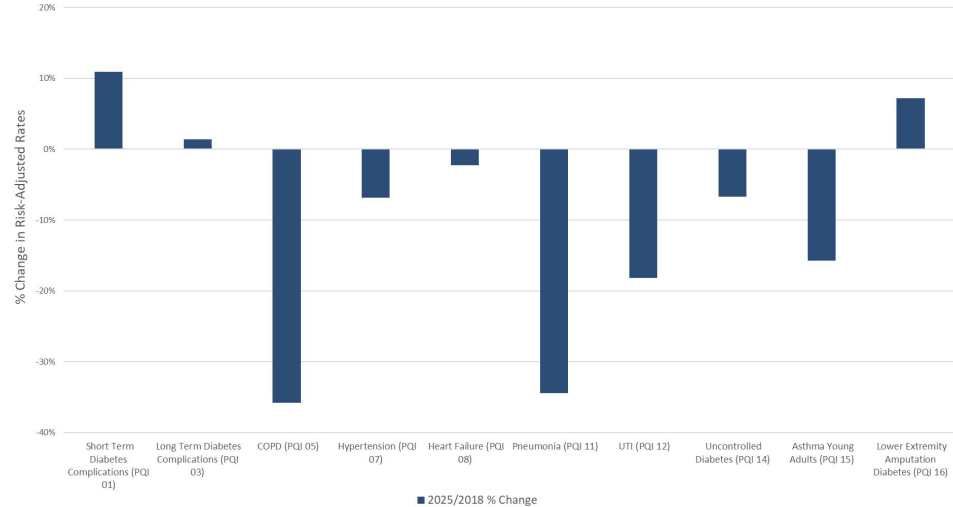
•**Data Source:** Inpatient and observation stays \geq 24 hours

Prevention Quality Indicator (PQI) Performance (2018 - 2025)

Overall PQI Performance (2018 - 2025)



Percent Change in PQI Risk Adjusted Rates (2018 - 2025)



** AHRQ v2024 Software

- As of December 2025, Maryland has experienced a 15% decrease across all PQIs from its 2018 baseline rate of 1346 admits per 100k residents
 - The current PQI rate is 10% above the required SIHIS goal

Change from PAU Shared Savings Policy to PAU Redistribution Policy

- The PAU Program was originally a statewide reduction necessary to achieve required savings in the Model and to recoup the ~\$200M built into rates for “infrastructure” investments (e.g., care management)
 - To date, the Commission has generated a 3:1 investment on the “infrastructure” funding through the Shared Savings Program
 - Future ongoing reductions may cause access issues
- At the June 2024 Commission Meeting, the Commission approved staff proposed revisions to the PAU Shared Savings policy, so that rewards for hospitals are capped at 0% with minor scaling reductions for hospitals with below average PAU performance
 - Effectively discontinues system savings aspect of the policy while not providing upside to hospitals that may not have improved PAU performance under the Model

Hospitals	PAU Shared Savings Policy	PAU Redistribution Policy
Hospital A (Average PAU Performance)	-0.37%	0%
Hospital B (Above Average PAU Performance)	-0.28%	0.00%
Hospital C (Below Average PAU Performance)	-0.49%	-0.12%
Hospital D (Below Average PAU Performance)	-0.52%	-0.15%
RY 2025 Statewide PAU	-0.37%	-0.07%

RY 2028 Maximum Guardrail under Maryland Hospital Performance-Based Programs

Maximum Guardrail for RY 2028

RY 2028 Quality Program Revenue Adjustments	Max Penalty	Max Reward
MHAC	-2.0%	2.0%
RRIP	-2.0%	2.0%
QBR	-2.0%	2.0%

- Designed to mitigate the detrimental financial impact of unforeseen large adjustments in Maryland quality programs (QBR, MHAC, RRIP and PAU)
 - Calculated as: percent of **Maryland Medicare revenue at-risk for quality (6%)** multiplied by the percent of **Maryland revenue attributable to inpatient services**
- RY 2028 Guardrail: $6\% \times 59\%^* = 3.54\%$
- The quality adjustments are applied to inpatient revenue centers, similar to the approach used by CMS.
- It must be determined if new quality incentives will count toward the maximum penalty guardrail

*FY2025 % IP Services

RY 2028 Emergency Department Best Practices



The Best Practices policy is centered around a set of six Hospital Best Practices that are designed to improve the emergency department (ED) and hospital throughput and reduce ED length of stay (LOS). Each best practice includes three levels (tiers) with measures showing how well and how fully it's being implemented. Year 1 (RY2027/CY2025) was a partial year, and Year 2 (RY 2028/CY2026) is focused on starting implementation, developing reports, and collecting and analyzing data; no points will be assigned to these tiers.



Hospital Requirements for RY2028 (CY2026)

- Hospitals will continue the two Best Practices implemented and reported on in Year 2 with a focus on hardwiring and expanding implementation.
- Hospitals must notify HSCRC in writing if they wish to change Best Practice selections from Year 1.



Key Dates and Requirements

December 15, 2026: Final Deadline

- Missing this deadline will result in a 0.1% penalty on inpatient revenue in January 2027
- Extraordinary events (e.g., cyberattacks, disasters) will be handled under the exception policy.



Ongoing Work

- The subgroup will work to update the reporting templates
- The subgroup will focus on analysis of the reports and sharing of best practices.
- They'll also study how the practices affect LOS and make future recommendations about tying performance to payment.

CY25 & CY26 ED-Hospital Throughput Best Practices

Interdisciplinary Rounds & Discharge Planning

Standard Daily Shift Huddles

Bed Capacity Alerts

Clinical Pathways and Observation Management

Expedited Care Bucket

Patient Flow throughput Council

CY 2025 ED-Hospital Throughput Best Practice Hospital Selections

Standardized Daily/Shift Huddles

20 hospitals implemented

10 had ED LOS improvement

Patient Flow Throughput Performance Council

19 hospitals implemented

9 had ED LOS improvement

Expedited Care Intervention

16 hospitals implemented

9 had ED LOS improvement

Interdisciplinary Rounds & Discharge Planning

13 hospitals implemented

8 had ED LOS improvement

Bed Capacity Alert System

10 hospitals implemented

7 had ED LOS improvement

Clinical Pathways & Observation Mgmt

4 hospitals implemented

3 had ED LOS improvement

- Not reflected is improvement in other metrics (IP LOS, ED Boarding, LWBS, etc.).
- In Year 2, the subgroup will discuss the feasibility of tracking secondary metrics via the Best Practices Report or ED LOS Dashboard.

Other Performance Measurement Initiatives



Emergency Department Wait Time Reduction Commission



ED Wait Time Reduction Commission:

Collaborate on behavioral health, post-acute, primary care, and other areas of opportunity.

Improve Access

Maryland Primary Care Program

Expand Behavioral Health Framework

SNF/Post-Acute

Implement Hospital Payment Programs to Improve Clinical Care

MD Hospital Quality Policies

ED Hospital Throughput "Best Practices" Incentives

Increase Transparency

MHCC Public Quality Reporting

CRISP ED LOS Dashboard

Reduce Avoidable Utilization

Programs to optimize high value care and reduce avoidable utilization



Reducing the number of people who need the ED

Improving throughput within the hospital

Improving the hospital discharge process and post-ED community resources

Increasing Transparency

Workforce Issues



Commission Priorities & Subcommittees - CY 2026

1. Standardize Bed Capacity & Occupancy Metrics

Inputs: Updates from MHCC, MIEMSS, HSCRC on availability of bed capacity data and occupancy metrics.

Outcome: Develop recommendations re: standardization and uses of metrics for monitoring and making policy recommendations. Align work with HB1563 requirements.

Subgroup Action Items (Capacity & Access):

- Bed Count and Capacity Analysis.
- Recommendations for alternate capacity types.

3. ED-Hospital Throughput Modeling

Inputs: Review HSCRC modeling work on impact of interventions on ED LOS.

Outcome: Consider need for additional analysis to prioritize interventions ripe for policy development and consider making recommendations to hospital industry, payers, regulators and others based on modeling.

Subgroup Action Items (Data & Best Practices):

- Develop modeling to estimate impact of interventions on Inpatient and ED LOS.

2. Post-Acute Access

Inputs: Review current work in space from MDH, MHCC, HSCRC, and Multi-Agency Working Group.

Outcome: Develop recommendations and key considerations for regulators developing post-acute strategy.

Subgroup Action Items (Capacity & Access):

- Recommendations on Post-Acute Care Opportunities (aligned with MHCC).

4. ED-Hospital Throughput Best Practices

Inputs: Review HSCRC Best Practices policy and Yr 1 Reporting.

Outcome: Consider recommendations on additional best practices to consider and/or other key performance indicators needed for policy development and monitoring.

Subgroup Action Items (Data & Best Practices):

- Summarize hospital best practice submissions.
- Recommend refinements to (QBR) ED LOS pay-for-performance methodology.

AHEAD Population Health Accountability

Statewide Accountability Targets

The State remains accountable for performance on **several targets.**

All-payer and primary care investment targets did not exist under the TCOC Model. AHEAD also includes more extensive population health requirements.

Medicare FFS TCOC Target

All Payer TCOC Growth Target

Medicare FFS Primary Care Investment Target

All-Payer Primary Care Investment Target

Statewide Quality and Population Health Targets

All-Payer Revenue Limit*

Maryland will establish this target before 2027.

Maryland will establish this target for PYs 2-5 before 2027.

* Hospital revenue only, not included in enforcement provisions.

Statewide Accountability Targets: Quality and Population Health

Measures and Targets

- Under AHEAD, Maryland is required to set and meet Statewide Quality and Population Health Targets*, including five statewide core and one required supplemental measure.
- The Amended and Restated State Agreement confirms Maryland's six measure selections

NEW

Mechanisms for Success

- Maryland and its hospitals must each outline Population Health Plans ("Statewide" and "Hospital" "Population Health Accountability Plan" (PHAP)).
- **Population Health Trust** can be used to fund population health improvement using public/private funds. Funded activities will align with the Statewide Quality and Population Health Plan and the State Health Improvement Plan (SHIP).

NEW

*See Appendix for additional details



Inpatient Length of Stay

Inpatient Length of Stay Policy--Draft Policy presented in April

- Maryland's emergency departments are currently among the most crowded in the nation, and managing IP LOS is a critical for improving ED wait times.
- Global budgets and TCOC accountability incentivize hospitals to reduce preventable hospital admissions and lower inpatient length of stay (IP LOS).
- While the Maryland Model has been successful in reducing hospital admissions, it has been less effective in reducing Bed Days and IP LOS.
- Unconstrained increases in IP LOS may undermine the financial sustainability of global budgets.
- The policy is designed to recognize hospitals that have invested in managing LOS over the past several years, while encouraging progress for those with little improvement and performance worse than the nation.
 - Staff are recommending monitoring only for CY2026 with potential future payment incentives up to 1 percent of IP revenue.

See Appendix for additional info



CY 2026 Monitoring Reports

Measures for Monitoring in CY 2026

- Excess Days in Acute Care (EDAC)- excess days that a hospital's patients spent in acute care within 30 days after discharge (ED visits, Obs stays, unplanned readmissions)
- IP Diabetes Screening- Reports % of patients that were screened for HbA1c that met the American Diabetes Association's (ADA) eligibility criteria for screening
- ED MVP- Reports hospital utilization of multi-visit patients (MVPs)
- Sepsis Dashboard- Reports performance on various Sepsis measures
- TFU Medicare- TFU for Medicare FFS Patients
- TFU Medicare Disparities- Change in TFU Disparities based on PAI components
- Readmission Disparities- Change in Readmission Disparities based on PAI components

Summary and detail-level reports
are posted to the CRS portal
monthly.

Digital Measures Reporting Requirements

Detailed reporting and submission information may be found on the [CRISP website](#)

Maryland Statewide Digital Measure Reporting Infrastructure: Important to Achieving Maryland's Quality Goals

- In June 2022, Maryland is first state to begin receiving digital data statewide from hospitals
- CMS [Digital Quality Measurement Strategic Roadmap](#): 7 yr timeline for fully digital reporting
- Maryland is targeting quality improvement priorities using digital measures
- For more information: [CRISP eCQM website](#) and [HSCRC Quality page](#)
- QBR RY 2028 Approved Recommendation: Add a bonus incentive of \$150,000 in hospital rates for hospitals that fully meet the State-specified **expedited** reporting timeline (after 6 months of a reporting year and then quarterly thereafter), provided that all required measures are reported. Bonus applies to:
 - eCQMs CY 2026 measures
 - CCDE Q3 2026-Q2 2027 for all-payer (Patients >17 years of age) Hospital Wide Readmission and Hospital Wide Mortality Hybrid measures
- Hospital unable to comply with reporting requirements because of circumstances beyond their control must submit an [Exceptional Circumstances Exemption Request](#)

HSCRC Digital Measures Reporting Requirements CY 2026: Electronic Clinical Quality Measures (eCQM) (see appendix for reporting timeline)

Title	Short Name	CMS eCQM ID	2024	2025	2026	HSCRC* (CY 2026)	CMS (CY 2026)
Anticoagulation Therapy for Atrial Fibrillation/Flutter	STK-3	CMS71	X	X	X	Self-Selected	Self-Selected
Antithrombotic Therapy By End of Hospital Day 2	STK-5	CMS72	X	X	X	Self-Selected	Self-Selected
Cesarean Birth	PC-02	CMS334	X	X	X	Required	Required
Discharged on Antithrombotic Therapy	STK-2	CMS104	X	X	X	Self-Selected	Self-Selected
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Facility IQR)	IP-ExRad	CMS1074		X	X	Self-Selected	Self-Selected
Global Malnutrition Composite Score	GMCS	CMS986	X	X	X	Self-Selected	Self-Selected
Hospital Harm - Acute Kidney Injury	HH-AKI	CMS832		X	X	Self-Selected	Self-Selected
Hospital Harm - Opioid-Related Adverse Events	HH-ORAE	CMS819	X	X	X	Self-Selected	Self-Selected
Hospital Harm - Pressure Injury	HH-PI	CMS826		X	X	Self-Selected	Self-Selected
Hospital Harm - Severe Hyperglycemia	HH-Hyper	CMS871	X	X	X	Required	New Required
Hospital Harm - Severe Hypoglycemia	HH-Hypo	CMS816	X	X	X	Required	New Required

HSCRC Digital Measures Reporting Requirements CY 2026: Electronic Clinical Quality Measures (eCQMs) and Hybrid Measures (see appendix for reporting timeline)

Title	Short Name	CMS ID	2024	2025	2026	HSCRC*	CMS
ICU Venous Thromboembolism Prophylaxis	VTE-2	CMS190	X	X	X	Self-Selected	Self-Selected
Safe Use of Opioids - Concurrent Prescribing	Safe use of opioids	CMS506	X	X	X	Required	Required
Severe Obstetric Complications (risk adjusted)	PC-07	CMS1028	X	X	X	Required	Required
Venous Thromboembolism Prophylaxis	VTE-1	CMS108	X	X	X	Self-Selected	Self-Selected
Hospital Harm - Postoperative Respiratory Failure	HH-RF	CMS1218			X	Self-Selected	Self-Selected
Hospital Harm - Falls with Injury	HH-FI	<u>CMS1017</u>			X	Self-Selected	Self-Selected
Core Clinical Data Elements for the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data	Hybrid HWR	<u>CMS529</u>	X	X	X	Required age 18+	Required age 65+
Core Clinical Data Elements for the Hybrid Hospital-Wide All-Condition All-Procedure Risk-Standardized Mortality Measure	Hybrid HWM	<u>CMS844</u>	X	X	X	Required age 18+	Required age 65+
Emergency Care Access and Timeliness (Hospital Outpatient Reporting Program)	ECAT	CMS1244				Required 2027?***	Required 2028



HCAHPS Collaborative

HCAHPS Collaborative

The Patient Experience Learning Collaborative, a partnership between the HSCRC and MHA, was formed to investigate strategies for improving Maryland hospital HCAHPS scores, which generally lag behind other states despite significant financial incentives.

Additional info can be found here:
<https://hscrc.maryland.gov/Pages/Patient-Experience-Learning-Collaborative.aspx>

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

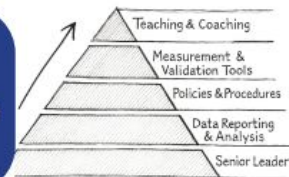


1 Quality and Safety Indicator

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.

CRS Quality Dashboards

CRISP Reporting Services (CRS)

- CRS hosts reports and dashboards for the HSCRC Quality Programs
 - portal.crisphealth.org
- Reports are typically refreshed with new data on the 2nd Friday of each month; dashboards typically on 4th Friday
- Summary reports are provided for all HSCRC measures (e.g., mortality, readmissions, TFU, etc.)
- Detail-level reports are provided for all case-mix based measures (e.g., PSI-90, PPCs, ED LOS)

Quality Policy Reports Available

RRIP

- Readmissions Static and Tableau Reports
- Patient Adversity Index and Disparity Gap Reports
- EDAC Monitoring Reports

QBR

- QBR Scoring and Calculation Sheet
- Timely Follow-Up Medicare, Medicaid, and Disparity Reports
- IP Mortality Reports
- 30-Day All-Cause Mortality
- ED LOS

PAU

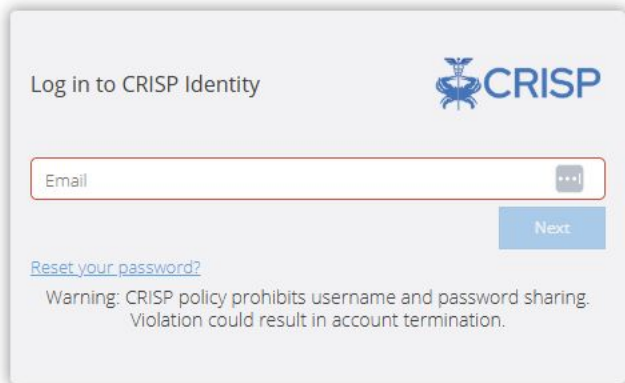
- Reference Reports
- Savings Reports
- ED Multi-Visit Patient Reports
- Avoidable Admissions Tableau
- MPA PQI Summary
- Attributed PQI and PDI

MHAC

- MHAC Static Summary and Details Reports

CRS Login Page

You can access CRS via the HIE Portal (idp.crisphealth.org) with your CRISP User ID, password, and accepting the Authy two factor authentication notification.



Log in to CRISP Identity 

Email

Next

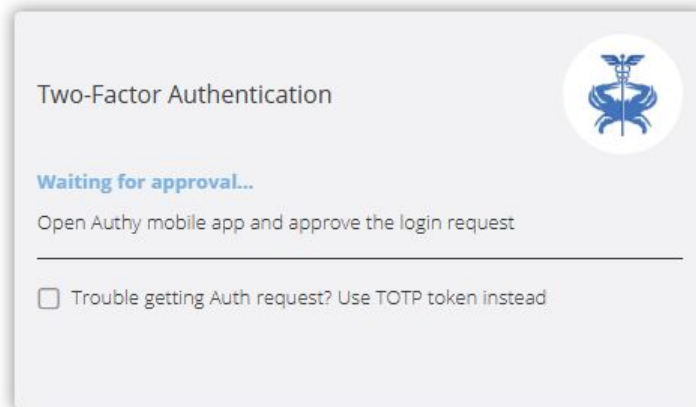
[Reset your password?](#)


Warning: CRISP policy prohibits username and password sharing. Violation could result in account termination.

Questions or Concerns? Please contact the CRISP Customer Care Team at support@crisphealth.org or (877) 952-7477.

© hMetrix

If you do not have access to CRS, please reach out to support@crisphealth.org or the CRS Point of Contact for your organization.



Two-Factor Authentication 

Waiting for approval...

Open Authy mobile app and approve the login request

Trouble getting Auth request? Use TOTP token instead

CRISP Homepage



Connecting Providers with Technology to Improve Patient Care

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SWITCH HIE

MY HIE ADMIN(S)

SEND FEEDBACK

PRODUCT UPDATES

AUSTIN ROZARIO

LOGOUT

HOME

Search Applications & Reports



This query portal is for authorized use only. By using this system, all users acknowledge notice of, and agree to comply with, CRISP's Participation Agreement ("PA") and CRISP Policies and Procedures. Click here to review the policies and procedure. CRISP uses a privacy monitoring tool to ensure all users are adherent to an approved policy or use case. By continuing to use this system you indicate your awareness of and consent to these terms and conditions of use.

Q Patient Search

First Name * Last Name *

Date of Birth * Gender

SSN

Reset

Search

Search Results

First Name	Last Name	Date of Birth	Gender	Address	Match Score
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No records found

Your Dashboard

For applications requiring patient context, please start by using the Patient Search interface above.

Reports

Manage Referrals

Delegator Dashboard Staging

SBIRT Staging

EDAS Staging

The "Reports" card in the CRISP Portal is the accessway to CRS Reports.

CRS Homepage



Connecting Providers with Technology to Improve Patient Care

CRISP REPORTING SERVICES

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Your Dashboard



All-Payer Population



Medicare Population



HSCRC Regulatory Reports



Public Health



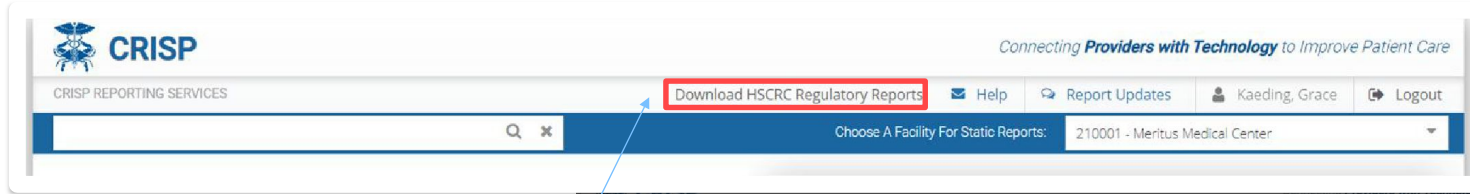
Favorites

♥ Favorites

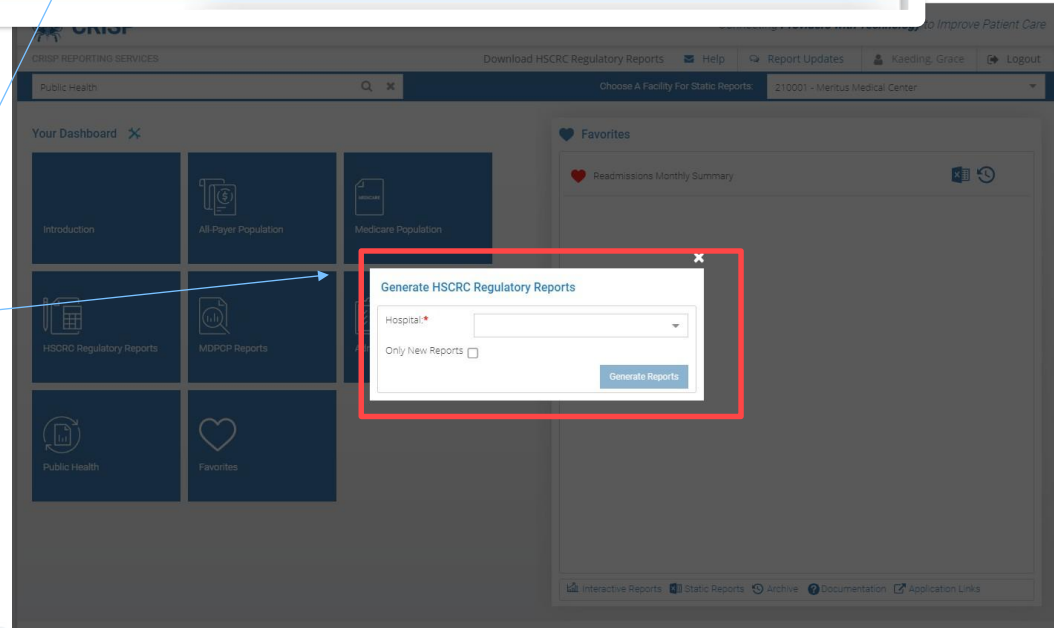


maryland
health services
cost review commission



CRS Homepage



Users can download all the Static HSCRC Regulatory Reports at once. By clicking on the Download HSCRC Regulatory Reports button, the Generate HSCRC Regulatory Reports pop-out window will appear. Users can select multiple hospitals. To download the most recent reports, click the Only New Reports check box.



CRS HSCRC Regulatory Reports

Search Reports...  



















Populations & Programs

- All-Payer Population
- Medicare Population
- HSCRC Regulatory Reports**
- Public Health
- Favorites

Reports

- CDS-A Reports
- Demographic Adjustment
- Repatriation Market Shift Adjustment Report
- Hospital Population Health Programs
- Market Shift
- Maryland Hospital Acquired Conditions (MHAC)
- Potentially Avoidable Utilization (PAU)
- Quality Financial Impact Dashboard
- RY26 Quality Based Reimbursement (QBR)
- RY27 Quality Based Reimbursement (QBR)
- Readmissions**
- HCAHPS Dashboard (Unadjusted)
- RY28 Quality Based Reimbursement (QBR)

Readmissions

- RY28 Readmissions Summary 
- RY27 Readmissions Summary    
- RY27 Readmissions Patient Level Details   
- RY27 Readmissions Patient Level Details - Base Period  
- RY27 Readmissions Disparity Gap Report   
- Excess Days in Acute Care Monitoring Report   
- Excess Days in Acute Care Monitoring Patient Level Details  

CRS Dashboard Overview - HSCRC Regulatory Reporting

- Readmissions Dashboard
- Quality Financial Impact Dashboard (QFID)
- HCAHPS Dashboard
- Sepsis Dashboard
- ED LOS Dashboard

Readmissions Dashboard

Readmissions Dashboard

The screenshot displays the Readmissions Dashboard interface. On the left, a sidebar titled "Populations & Programs" lists categories: All-Payer Population, Medicare Population, HSCRC Regulatory Reports, Public Health, and Favorites. The main content area is divided into "Reports" and "Readmissions". The "Readmissions" section contains a list of reports with interactive icons. Two callouts are present: "Launches Tableau Dashboard" pointing to a bar chart icon, and "Downloads Static Excel Report" pointing to a download icon.

Report Name	Tableau Dashboard	Excel Report
RY28 Readmissions Summary	Yes	Yes
RY27 Readmissions Summary	Yes	Yes
RY27 Readmissions Patient Level Details	Yes	Yes
RY27 Readmissions Patient Level Details - Base Period	Yes	Yes
RY27 Readmissions Disparity Gap Report	Yes	Yes
Excess Days in Acute Care Monitoring Report	Yes	Yes
Excess Days in Acute Care Monitoring Patient Level Details	Yes	Yes

Readmissions Dashboard – Landing Page

Purpose:

Helps hospitals identify readmission counts and performance

Performance Tracking:

Mirrors the static Readmissions report to show improvement, attainment, and revenue scales alongside interactive line graphs

Filters:

Allows users to filter populations by Hospital, Payer and Need Type (High Utilizer or Rising Need)

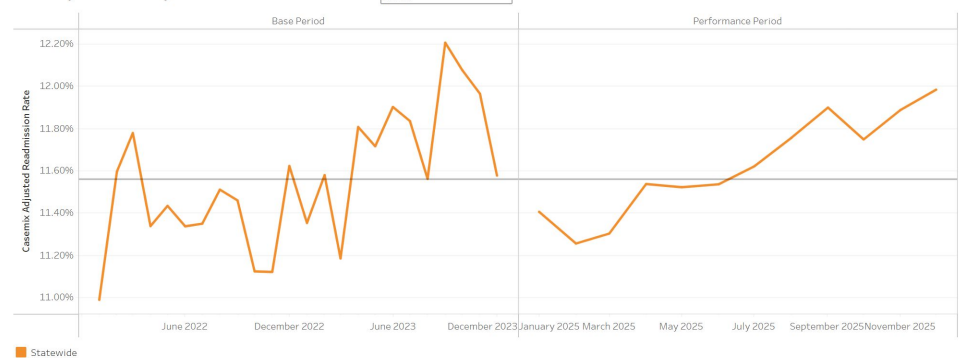
Readmissions Landing Page

RY2027 Readmission Reduction Incentive Program
 Base Period: CY2223 (January - December)
 Performance Period: CY2025 (January - December)
 APR DRG Group: v42 (Base and Performance)
 Readmissions through December 2025

Hospital Name: Statewide | Payer: (All) | Need Type: Any

	Improvement				Attainment		Revenue Adjustment	
	Casemix Adjusted Readmission Rate		Readmission Ratio (Q/E)		Casemix Adjusted Rate with OOS Adjustment	Out of State (OOS) Ratio	Improvement Scaling	Attainment Scaling
	Base Period	Performance ..	Base Period	Performance ..				
Statewide	11.56%	11.62%	1.000	1.005				

Monthly Casemix Adjusted Readmission Rates



Readmissions Dashboard – Readmission Trends and Locations

Purpose:

Helps hospitals compare readmissions by Zip code

Color coding:

Zip codes with higher readmission counts are colored with higher saturation

Filters:

Allows users to filter populations by Hospital, Payer, Need Type, Discharge Date, Service Lines, APR DRGs, Diagnosis, and Race

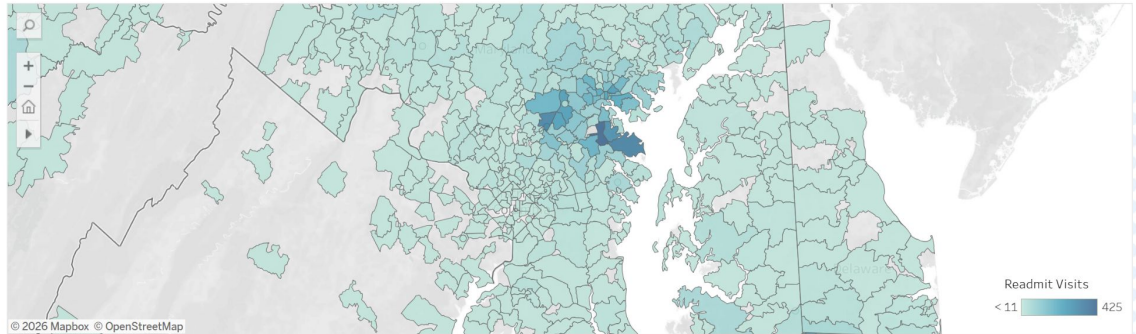
Readmission Trends and Locations

RY2027 Readmission Reduction Incentive Program
 Base Period: CY2223
 Performance Period: CY2025
 APR DRG Grouper v42 (Base and Performance)
 Readmissions through December 2025

Hospital Name	Payer	Need Type	Discharge Date
(All)	(All)	Any	2025
Index APR ServiceLine	Index APR Value	Primary Diagnosis	Race
(All)	(All)	(All)	(All)

Patient Location

Select a hospital in the table below to filter the map to show the patient zip code for the visits with a readmission to the selected hospital



Readmissions with Index Visit Discharge from All

		2025												Total	
		January	February	March	April	May	June	July	August	Septem..	October	Novemb..	Decemb..		
210009	Johns Hopkins Hospital	Readmit Visits	296	255	316	306	324	324	308	314	333	321	326	334	3,757
		Patients	272	242	286	283	297	299	284	293	310	298	302	305	2,699

Readmissions Dashboard – Service Line Analysis

Purpose:

Evaluate readmissions by service line of the index visit

Service Line Deep Dive:

Selecting a service line automatically filters the dashboard to display the top 5 APR-DRGs

Filters:

Allows users to filter populations by Hospital, Payer, Service Lines, APR DRGs, Diagnosis, Race and Discharge Date Need Type

Service Line Readmission Analysis

RY2027 Readmission Reduction Incentive Program
Base Period: CY2223
Performance Period: CY2025
APR DRG Group v42 (Base and Performance)
Readmissions through December 2025

Hospital Name: (All) Payer: (All) Need Type: Any Discharge Date: (All) Race: (All)

Index APR ServiceLine	Eligible Discharges	Total Number of Readmissions	Percent Readmissions	Intra Readmissions	Intra Readmit Rate	Inter Readmissions	Inter Readmit Rate	Readmission Ratio (O/E)
Grand Total	767,844	94,316	12.28%	66,019	8.60%	28,200	3.67%	1.036
General Medicine	89,431	13,811	15.44%	9,625	10.76%	4,167	4.66%	1.050
Gastroenterology	57,058	9,745	17.08%	7,187	12.60%	2,545	4.46%	1.086
Infectious Disease	60,761	9,527	15.68%	6,960	11.45%	2,561	4.21%	1.079
Pulmonary	66,055	9,045	13.69%	6,751	10.22%	2,283	3.46%	0.965
Cardiology	51,803	8,668	16.73%	5,865	11.32%	2,796	5.38%	1.065
General Surgery	63,145	8,192	12.97%	6,246	9.89%	1,942	3.08%	1.066
Neurology	42,178	4,726	11.20%	2,999	7.11%	1,724	4.09%	1.020
Psychiatry	38,060	4,710	12.38%	1,904	5.00%	2,802	7.36%	0.935
Hematology	15,898	3,585	22.55%	2,968	18.67%	615	3.87%	0.967
Orthopedic Surgery	43,086	3,369	7.82%	2,094	4.86%	1,271	2.95%	0.962
Oncology	18,234	3,045	16.70%	2,156	11.82%	888	4.87%	1.025

Index Visit Service Line: All (All)

Index APR Code	Index APR Value	Eligible Discharges	Total Number of Rea.	Percent Re admissi ons	Intra Read missions	Intra Readmit Rate	Inter Read missions	Inter Readmit Rate	Readmissi on Ratio (O /E)
720	SEPTICEMIA AND DISS..	42,499	6,948	16.35%	5,116	12.04%	1,830	4.31%	1.061
194	HEART FAILURE	19,445	4,020	20.67%	2,754	14.16%	1,258	6.47%	1.046
133	RESPIRATORY FAILURE	14,528	2,570	17.69%	1,991	13.70%	578	3.98%	0.946
469	ACUTE KIDNEY INJURY	10,583	1,974	18.65%	1,428	13.49%	544	5.14%	1.066
466	MALFUNCTION, REACT..	8,589	1,974	22.98%	1,453	16.92%	519	6.04%	1.014

Index Visit Service Line: All (Statewide)

Index APR Code	Index APR Value	Eligible Discharges	Read..	Percent Re admissi ons	Intra Read missions	Intra Readmit Rate	Inter Read missions	Inter Readmit Rate	Readmissi on Ratio (O /E)
720	SEPTICEMIA AND DISS..	222,884	32,939	14.78%	22,707	10.19%	10,208	4.58%	0.995
194	HEART FAILURE	115,544	23,235	20.11%	15,611	13.51%	7,583	6.56%	1.030
133	RESPIRATORY FAILURE	55,242	10,654	19.29%	7,698	13.94%	2,952	5.34%	1.006

Index Visit: 710 - INFECTIOUS AND PARASITIC DISEASES INCLUDING HIV WITH O.R. PROCEDURE

Readmit APR Code	Readmit Lead APR DRG Description	Total Number of Readmissions	Intra Readmissions	Inter Readmissions
720	SEPTICEMIA AND DISSEMIN..	224	142	82
721	POST-OPERATIVE, POST-TR..	87	69	18
710	INFECTIOUS AND PARASITIC..	64	43	21
466	MALFUNCTION, REACTION, ...	46	25	21
469	ACUTE KIDNEY INJURY	41	27	14

Index Visit: 710 - INFECTIOUS AND PARASITIC DISEASES INCLUDING HIV WITH O.R. PROCEDURE

Readmit APR Code	Readmit Lead APR DRG Description	Readmissi..	Intra Readmissions	Inter Readmissions
720	SEPTICEMIA AND DISSEMIN..	1,070	673	397
710	INFECTIOUS AND PARASITIC..	303	187	116
721	POST-OPERATIVE, POST-TR..	269	210	59

Readmissions Dashboard - Users with PHI access

Length of Discharge to Readmission:

Allows hospitals to compare their performance with the state

Patient Level Details:

Extract detailed, patient-level data

5b. Casemix Adjusted Hospital ... 6.Service Line Readmission An... 7. Length of Discharge to Read...

Length of Discharge to Readmission

Hospital Name	Payer	Need Type	Discharge Date
(Meritus Medical Center)	(All)	Any	2025
Index APR Service Line	Index APR DRG	Primary Diagnosis	Race
(All)	(All)	(All)	(All)

mix Adjusted Hospital ... 6.Service Line Readmission An... 7. Length of Discharge to Read... 8.Forecasting 9. Patient Level D

Patient Level Details

Hospital Name	Payer	Need Type	Discharge Date	Index APR ServiceLine
(None)	(None)	Any	2025	(All)
Sort Order	Race			
Total Number of Readmissions	(All)			

Quality Financial Impact Dashboard (QFID)

Quality Financial Impact Dashboard (QFID)

Search Reports... Q X

Populations & Programs

- All-Payer Population
- Medicare Population
- HSCRC Regulatory Reports
- Public Health
- Favorites

Reports X

- CDS-A Reports
- Demographic Adjustment
- Repatriation Market Shift Adjustment Report
- Hospital Population Health Programs
- Market Shift
- Maryland Hospital Acquired Conditions (MHAC)
- Potentially Avoidable Utilization (PAU)
- Quality Financial Impact Dashboard**
- RY26 Quality Based Reimbursement (QBR)
- RY27 Quality Based Reimbursement (QBR)
- Readmissions
- HCAHPS Dashboard (Unadjusted)
- RY28 Quality Based Reimbursement (QBR)

Quality Financial Impact Dashboard

Quality Financial Impact Dashboard

Quality Financial Impact Dashboard (QFID) - Landing Page

Purpose:

High-level insight into YTD performance across all quality programs and estimated revenue adjustments

System-Wide View:

Select multiple hospitals simultaneously to view their combined overall financial impact

Visual Benchmarking:

Green and red indicators show how close a hospital is from reward or penalty cut-points

Deep Dives:

Detailed breakdowns of scores for each individual quality program with historical comparisons

Quality Financial Impact Dashboard

Hospital: ALL 210001 - Meritus Medical Center, 210002 - UM Medical Center, 21 Data Through: Dec 2025 Apply

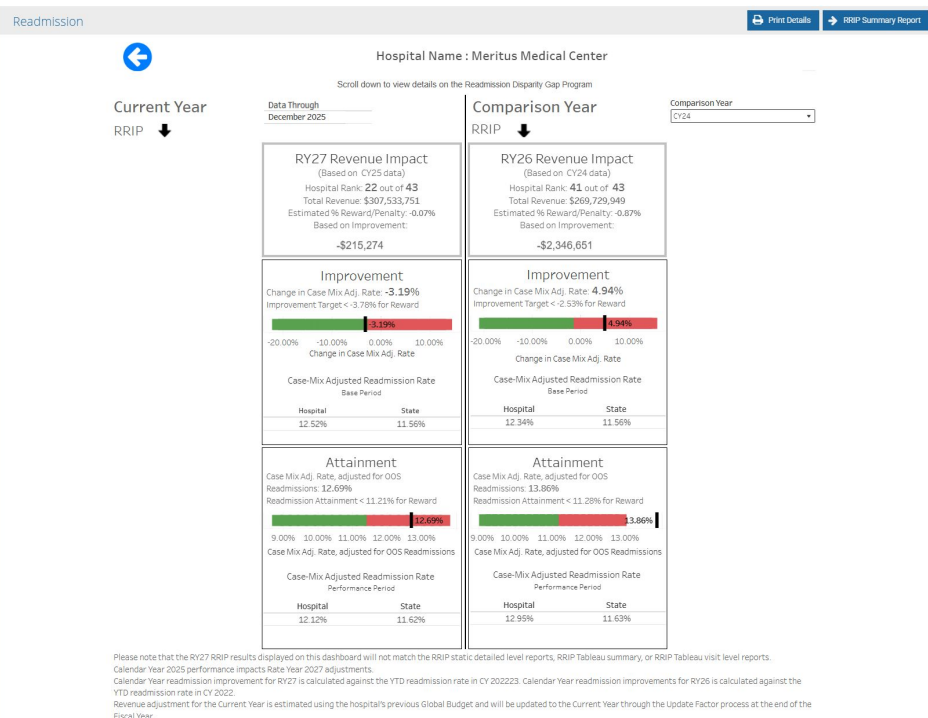
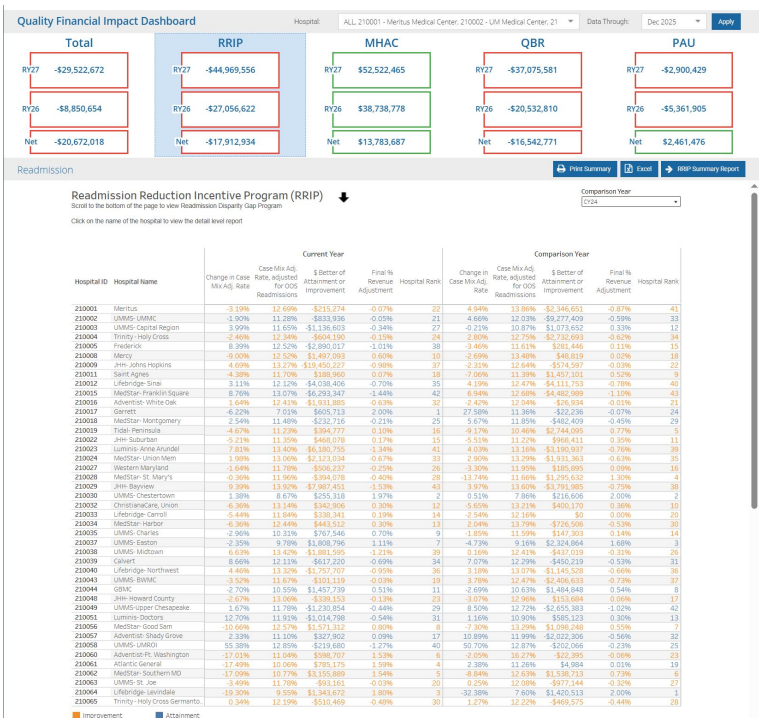
Total	RRIP	MHAC	QBR	PAU
RY27 -\$29,522,672	RY27 -\$44,969,556	RY27 \$52,522,465	RY27 -\$37,075,581	RY27 -\$2,900,429
RY26 -\$8,850,654	RY26 -\$27,056,622	RY26 \$38,738,778	RY26 -\$20,532,810	RY26 -\$5,361,905
Net -\$20,672,018	Net -\$17,912,934	Net \$13,783,687	Net -\$16,542,771	Net \$2,461,476

Total

Click on the name of the hospital to view the detail level report

Hospital ID	Hospital Name	RRIP			MHAC			QBR			Total Quality Revenue Adjustment			PAU		
		Current Year	Comparison Year	% Change	Current Year	Comparison Year	% Change	Current Year	Comparison Year	% Change	Current Year	Comparison Year	% Change	Current Year	Comparison Year	% Change
210001	Meritus	\$1,047,646	-\$2,346,651	144.64%	\$6,150,675	\$2,157,840	185.04%	\$0	\$1,969,029	-100.00%	\$7,190,321	\$1,780,218	304.35%	-\$97,927	-\$193,297	49.10%
210002	UMMS-UMMC	-\$833,936	-\$9,277,409	91.01%	-\$1,667,873	\$0		-\$14,010,131	-\$13,680,247	-2.41%	-\$10,511,941	-\$22,957,656	28.08%	-\$182,105	-\$74,759	75.10%
210003	UMMS-Capital Region	\$1,186,403	\$1,075,652	-93.86%	-\$334,872	-\$807,598	38.35%	\$4,270,975	-\$57,884	-1095.63%	-\$5,950,449	-\$11,310	-3919.15%	\$0	\$0	
210004	Trinity - Holy Cross	\$694,130	-\$2,733,693	77.89%	\$4,088,211	\$0		-\$5,678,384	\$4,211,267	-34.27%	\$10,351,796	-\$6,963,960	-48.65%	\$0	\$0	
210005	Frederick	-\$2,890,017	-\$201,446	-1126.85%	\$5,722,807	\$0		-\$228,912	-\$921,097	75.15%	\$2,603,877	-\$639,651	507.08%	\$0	\$0	
210008	Mercy	\$1,497,093	\$48,819	2966.62%	-\$1,272,529	-\$244,094	-421.33%	-\$848,353	\$488,189	-273.79%	\$623,789	\$292,914	-312.96%	\$0	\$0	
210009	JHH - Johns Hopkins	-\$19,450,227	-\$574,597	-3285.02%	-\$3,770,962	-\$6,384,413	40.93%	\$5,358,736	\$2,106,856	154.55%	\$17,862,453	-\$4,852,154	-268.13%	-\$889,128	-\$1,042,931	14.14%
210011	Saint Agnes	\$188,960	-\$1,457,101	-87.03%	\$3,023,362	\$2,241,694	34.87%	-\$1,214,744	\$504,381	-340.84%	\$1,997,578	\$4,203,176	-52.47%	-\$20,562	-\$163,231	87.10%
210012	Lifefridge - Sinai	-\$4,038,406	-\$4,111,753	1.78%	\$11,538,304	\$3,865,751	198.48%	-\$980,756	-\$316,289	-210.08%	\$6,519,141	-\$562,291	1259.39%	-\$85,400	-\$123,521	30.30%
210015	MedStar - Franklin Square	-\$6,293,347	-\$4,482,989	-40.38%	\$4,064,453	\$2,716,963	49.60%	-\$1,311,114	-\$1,222,633	-7.24%	-\$3,540,008	-\$2,988,659	-18.45%	-\$145,808	-\$293,136	50.10%
210016	Adventist - White Oak	-\$1,931,885	-\$26,934	-7072.66%	\$5,182,357	\$2,518,796	106.16%	\$1,665,264	\$1,508,278	-22.74%	\$4,415,736	\$3,995,140	10.53%	\$0	\$0	
210017	Garrett	\$605,713	-\$22,236	2824.02%	\$381,599	\$0		\$605,713	\$635,300	-4.66%	\$1,593,026	\$613,064	159.85%	\$0	\$0	
210018	MedStar - Montgomery	-\$232,716	-\$482,409	51.76%	-\$797,083	\$0		-\$199,471	\$1,039,860	-119.18%	-\$1,230,070	\$557,451	-320.66%	\$0	\$0	
210019	Tidal - Peninsula	\$394,777	\$2,741,095	65.61%	-\$6,908,597	\$475,168	-1553.93%	-\$3,934,407	-\$34,564	-461.97%	-\$9,448,227	-\$3,753,827	-325.06%	\$0	\$0	
210022	JHH - Suburban	\$468,078	\$968,411	-51.67%	\$1,266,563	\$0		\$2,120,117	-\$387,364	647.32%	\$1,321,631	\$581,047	127.46%	\$0	\$0	
210023	Lummis - Anne Arundel	-\$6,180,755	-\$3,190,937	-93.70%	\$6,226,880	\$1,399,534	344.93%	-\$2,536,877	\$503,832	-603.52%	-\$2,490,752	-\$1,287,571	-93.45%	\$0	\$0	
210024	MedStar - Union Mem	-\$2,123,034	-\$1,931,363	-9.92%	\$6,337,416	\$0		-\$253,497	\$61,313	-513.45%	\$3,960,885	-\$1,870,050	311.61%	\$224,346	-\$470,856	52.10%
210027	Western Maryland	-\$506,237	\$1,885,895	-372.32%	\$4,049,893	\$3,717,895	8.93%	-\$890,976	-\$413,099	-115.68%	\$2,652,680	\$3,490,691	-24.01%	-\$138,901	\$0	
210028	MedStar - St. Mary's	-\$394,078	-\$1,295,632	-130.42%	-\$788,156	\$398,656	-297.70%	-\$9,852	\$259,126	-103.80%	-\$1,192,086	-\$1,953,414	-161.03%	\$0	\$0	
210029	JHH - Bayview	-\$7,987,451	-\$3,791,985	-110.64%	-\$3,654,289	\$0		-\$4,228,650	-\$4,803,181	11.96%	-\$15,870,490	-\$8,595,166	-84.64%	\$278,012	-\$518,838	46.10%
210030	UMMS - Chestertown	\$255,318	\$216,606	17.87%	\$259,206	\$0		\$514,524	\$216,606	137.54%	\$0	\$0		\$0	\$0	
210032	ChristianCare - Union	\$342,906	\$400,170	-14.31%	\$2,286,040	\$1,185,690	92.80%	\$502,929	\$666,951	-24.59%	\$3,131,875	\$2,252,811	39.02%	\$0	\$0	
210033	UMedridge - Carroll	\$338,341	\$0		\$3,561,487	\$889,183	300.59%	\$71,230	-\$650,215	110.95%	\$3,971,058	-\$238,968	1561.75%	-\$8,733	-\$13,711	36.10%
210034	MedStar - Harford	\$443,532	-\$728,586	163.08%	-\$1,771,405	-\$2,284,611	-107.77%	\$946,188	\$452,383	109.16%	\$1,212,265	\$2,010,458	-39.79%	-\$152,443	-\$230,702	33.10%
210035	UMMS - Charles	\$767,546	\$147,203	421.07%	-\$592,107	\$941,734	-170.34%	-\$504,387	\$715,474	-29.50%	-\$328,480	\$723,563	-220.25%	\$0	\$0	
210037	UMMS - Eastern	\$1,808,796	-\$2,324,864	-22.20%	-\$2,004,341	\$0		-\$1,389,560	-\$1,388,285	-759.61%	-\$1,385,114	\$2,186,479	-163.95%	\$0	\$0	
210038	UMMS - Midtown	-\$1,881,595	-\$437,019	-330.55%	-\$1,711,054	\$0		-\$1,337,332	\$14,097	-9596.38%	\$3,389,982	-\$422,922	-701.56%	\$228,532	-\$333,127	31.10%

Quality Financial Impact Dashboard (QFID) - RRIP

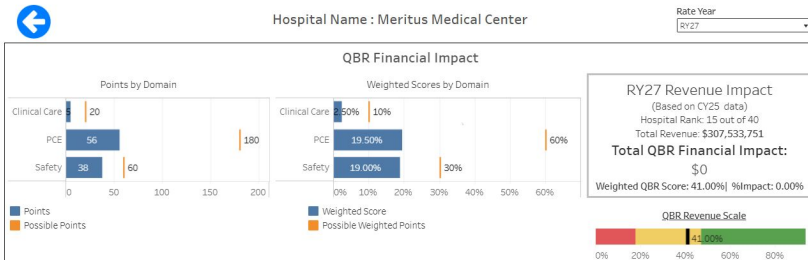
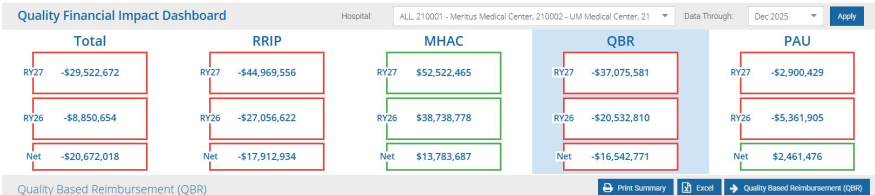


Total Number of Hospitals: Current Year - 43, Comparison Year - 43

Please note that the RV27 RRIP results displayed on this dashboard will not match the RRIP state detailed level reports, RRIP Tableau summary, or RRIP Tableau visit level reports. Calendar Year readmission improvement for RV27 is calculated against the YTD readmission rate in CY 2022. Calendar Year readmission improvements for RV26 is calculated against the YTD readmission rate in CY 2022. Revenue adjustment for the Current Year is estimated using the hospital's previous Global Budget and will be updated to the Current Year through the Update Factor process at the end of the Fiscal Year.

Readmission Disparity Gap Program ↓

Quality Financial Impact Dashboard (QFID) - QBR

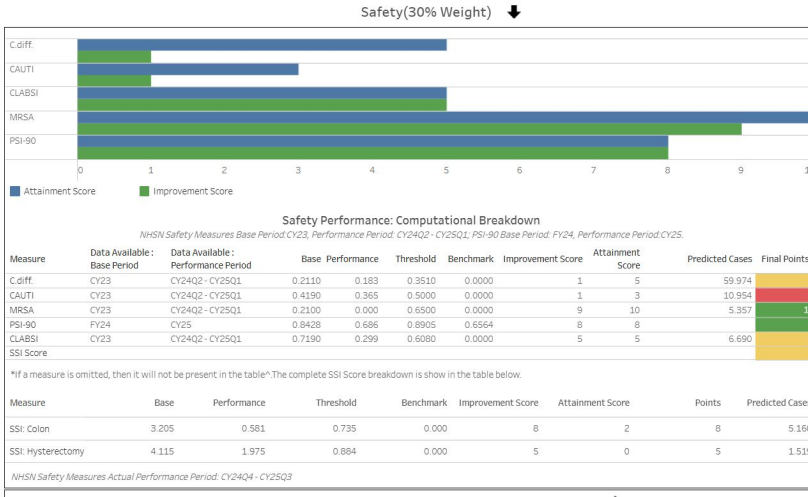


Quality Based Reimbursement(QBR)

Click on the name of the hospital to view the detail level report

Hospital ID	Hospital Name	PCE Domain Score	Clinical Domain Score	Safety Domain Score	QBR Score	\$ Final Revenue Adjustment	% Final Revenue Adjustment	Hospital Rank
210001	Meritus	19.50%	2.50%	19.00%	41.00%	\$0.00	-0.00%	15
210002	UMMS-UMMC	16.75%	2.50%	23.75%	-0.84%	-\$14,010,131.34	-0.84%	35
210003	UMMS-Capital Region	6.75%	0.50%	7.50%	14.75%	-\$4,276,974.71	-1.28%	39
210004	Trinity-Holy Cross	8.50%	2.50%	1.00%	12.00%	-\$8,979,384.34	-1.41%	40
210005	Frederick	11.33%	5.00%	23.00%	39.33%	-\$229,912.28	-0.08%	18
210006	Mercy	24.08%	0.00%	10.00%	34.08%	-\$848,352.62	-0.34%	24
210009	JHH- Johns Hopkins	29.83%	7.00%	9.50%	46.33%	\$5,359,736.04	0.27%	9
210011	SaintAgnes	14.75%	9.00%	8.00%	31.75%	-\$1,214,743.67	-0.45%	27
210012	Lifebridge-Sinai	17.08%	8.00%	12.50%	37.58%	-\$980,755.80	-0.17%	21
210015	MedStar-Franklin Square	11.75%	7.50%	34.75%	-15.50%	-\$1,311,114.01	-0.30%	23
210016	Adventist-White Oak	30.42%	0.50%	17.50%	48.42%	\$1,165,263.76	0.38%	7
210017	Garrett	70.83%	9.00%	0.00%	79.83%	\$805,713.36	2.00%	1
210018	MedStar-Montgomery	23.00%	8.40%	8.40%	37.40%	-\$199,470.97	-0.18%	22
210019	Tidal-Peninsula	16.42%	3.00%	11.50%	30.92%	-\$1,934,407.20	-0.49%	29
210022	JHH-Suburban	34.50%	8.00%	13.50%	56.00%	\$2,120,117.15	0.77%	3
210023	Luminis-Anne Arundel	23.17%	0.00%	6.50%	29.67%	-\$2,536,877.21	-0.55%	30
210024	MedStar-Union Mem	10.92%	7.50%	21.00%	39.42%	-\$154,496.63	-0.08%	18
210027	Western Maryland	20.92%	1.00%	10.00%	31.92%	-\$890,976.39	-0.44%	26
210028	MedStar-St. Mary's	19.92%	6.50%	14.40%	40.82%	\$9,851.95	-0.01%	16
210029	JHH-Bayview	18.42%	1.50%	4.50%	24.42%	-\$4,228,650.30	-0.81%	34
210032	ChristianaCare-Union	23.00%	9.00%	14.50%	49.07%	\$502,928.84	0.44%	6
210033	Lifebridge-Carroll	15.33%	10.00%	16.50%	41.83%	\$71,229.74	0.04%	12
210034	MedStar-Harbor	18.92%	10.00%	24.60%	53.52%	\$946,158.20	0.64%	5
210035	UMMS-Charles	23.00%	3.00%	3.50%	31.50%	-\$504,387.26	-0.46%	28
210037	UMMS-Easton	9.50%	7.50%	9.50%	26.50%	-\$1,199,568.31	-0.73%	33
210038	UMMS-Midtown	11.92%	8.50%	3.00%	23.42%	-\$1,337,332.31	-0.86%	36
210039	Calvert	31.83%	7.50%	15.00%	54.33%	\$608,274.63	0.68%	4
210040	Lifebridge-Northwest	13.58%	10.00%	17.00%	40.58%	-\$37,004.37	-0.02%	17
210043	UMMS-BWMC	16.83%	6.50%	10.00%	33.33%	-\$1,247,128.32	-0.37%	25
210044	GBMC	28.67%	1.00%	41.67%	41.67%	\$85,749.37	0.03%	13
210048	JHH-Howard County	16.33%	1.50%	9.00%	26.83%	-\$1,800,121.62	-0.69%	32
210049	UMMS-Upper Chesapeake	12.42%	9.00%	7.00%	28.42%	-\$1,706,411.21	-0.61%	31
210051	Luminis-Doctors	9.25%	0.00%	6.00%	15.25%	-\$2,367,862.08	-1.26%	38
210056	MedStar-GoodSam	14.33%	9.50%	20.50%	44.33%	\$339,903.76	0.17%	10
210057	Adventist-Shady Grove	24.42%	4.50%	14.50%	43.42%	\$437,202.58	0.12%	11
210060	Adventist-Ft. Washington	41.93%	4.90%	0.00%	46.83%	\$117,393.48	0.30%	8
210061	Atlantic General	37.08%	2.00%	22.80%	61.88%	\$528,388.49	1.07%	2
210062	MedStar-Spalham/MD	17.00%	7.00%	14.00%	38.00%	-\$307,391.76	-0.18%	20
210063	UMMS-St. Joe	20.58%	8.00%	13.00%	41.58%	\$93,160.53	0.03%	13
210065	Trinity-Holy Cross Germa.	18.33%	1.00%	3.50%	22.83%	-\$946,494.12	-0.89%	37

Last updated: 5/6/2026



ED LOS Dashboard

ED LOS Dashboard

Search Reports... Q x





































Populations & Programs

- All-Payer Population
- Medicare Population
- HSCRC Regulatory Reports
- Public Health
- Favorites

Reports

- CDS-A Reports
- Demographic Adjustment
- Repatriation Market Shift Adjustment Report
- Hospital Population Health Programs
- Market Shift
- Maryland Hospital Acquired Conditions (MHAC)
- Potentially Avoidable Utilization (PAU)
- Quality Financial Impact Dashboard
- RY26 Quality Based Reimbursement (QBR)**
- RY27 Quality Based Reimbursement (QBR)**
- Readmissions
- HCAHPS Dashboard (Unadjusted)
- RY28 Quality Based Reimbursement (QBR)

RY27 Quality Based Reimbursement (QBR)

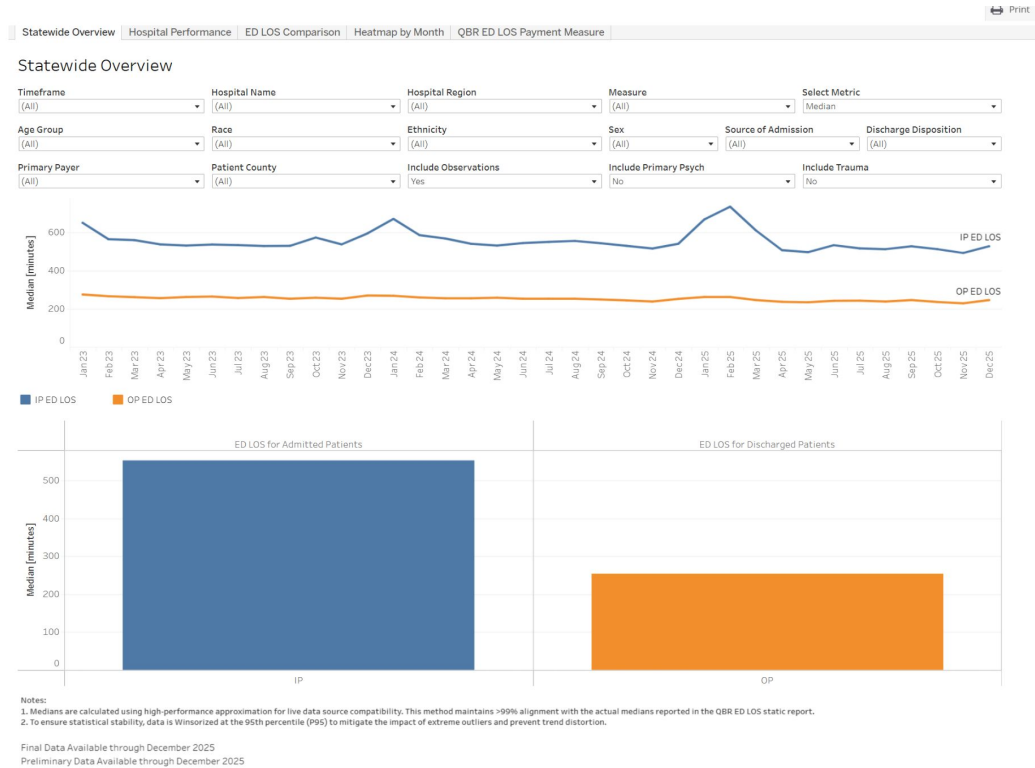
- RY27 ED LOS Report 
- RY27 Summary ED LOS File   
- RY27 Patient Level ED LOS Validation File 
 - 210002 - UM Medical Center  
 - 210009 - Johns Hopkins Hospital  
 - 210017 - WVU Medicine Garrett Regional Medical Center  
- Sepsis 
- RY27 QBR Inpatient Mortality Base Details 
 - 210002 - UM Medical Center  
 - 210009 - Johns Hopkins Hospital  
 - 210017 - WVU Medicine Garrett Regional Medical Center  
- RY27 QBR Inpatient Mortality Details  
 - 210002 - UM Medical Center  
 - 210009 - Johns Hopkins Hospital  
 - 210017 - WVU Medicine Garrett Regional Medical Center  
- RY27 QBR Inpatient Mortality Summary   
- RY27 QBR PSI-90 Details  
 - 210002 - UM Medical Center  
 - 210009 - Johns Hopkins Hospital  

ED LOS Dashboard - Landing Page

Purpose:

Enhance analysis of ED LOS across the state and at individual hospitals

Benchmarks Inpatient and Outpatient ED LOS against statewide medians



ED LOS Dashboard - ED LOS Comparison

Enables users to stratify data and explore ED LOS among different patient groups

ED LOS Comparison

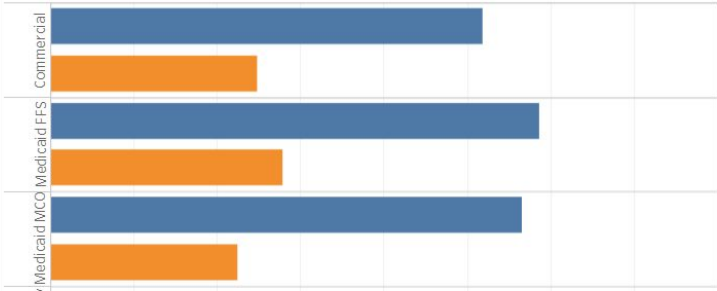
This tab is used to compare IP and OP ED LOS medians side-by-side. Stratify data by visit characteristics to compare between selected groups

Select Measure

Primary Payer

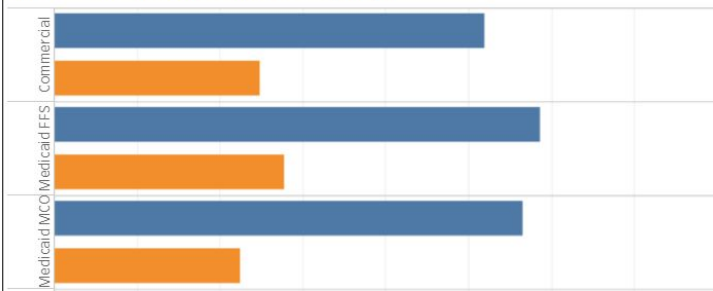
Timeframe (All)	Hospital Name Statewide	Hospital Region (All)
Select Metric Median	Measure (All)	Patient County (All)
Include Observations Yes	Include Primary Psych No	Include Trauma No
Source of Admission (All)	Discharge Disposition (All)	

ED LOS Breakdown by Primary Payer



Timeframe (All)	Hospital Name Statewide	Hospital Region (All)
Select Metric Median	Measure (All)	Patient County (All)
Include Observations Yes	Include Primary Psych No	Include Trauma No
Source of Admission (All)	Discharge Disposition (All)	

ED LOS Breakdown by Primary Payer



ED LOS Dashboard - QBR ED LOS Payment Measure

Includes a dedicated QBR ED LOS tab for direct performance tracking

QBR ED LOS Payment Measure

Timeframe (All) ▼	Select Metric Median ▼	Hospital Name (All) ▼	Hospital Region (All) ▼
Age Group (All) ▼	Race (All) ▼	Ethnicity (All) ▼	Sex (All) ▼
Source of Admission (All) ▼	Discharge Disposition (All) ▼	Primary Payer (All) ▼	Patient County (All) ▼

Note: The Year-over-Year percentage change is calculated based on the visible columns. If a calendar year is filtered out, the calculation will dynamically bridge to the next available previous year

Hospital ID	Hospital Name	CY2023		CY2024		CY2025	
		Value	Value	Percentage Difference from previous year	Value	Percentage Difference from previous year	
210001	Meritus	378.00	365.00	-3.44%	418.00	14.52%	
210002	UMMS- UMMC	1,289.00	1,474.83	14.42%	1,388.50	-5.85%	
210003	UMMS- Capital Region	1,379.86	1,156.60	-16.18%	1,267.71	9.61%	
210004	Trinity - Holy Cross	514.00	505.00	-1.75%	550.52	9.01%	
210005	Frederick	405.00	421.00	3.95%	453.00	7.60%	
210006	UMMS- Aberdeen	439.00	625.00	42.37%			
210008	Mercy	526.00	492.00	-6.46%	444.00	-9.76%	
210009	JHH- Johns Hopkins	939.42	1,032.43	9.90%	970.67	-5.98%	
210011	Saint Agnes	627.00	553.00	-11.80%	438.00	-20.80%	
210012	Lifebridge- Sinai	1,062.43	940.67	-11.46%	801.00	-14.85%	

Sepsis Dashboard

Sepsis Dashboard

The screenshot displays the Sepsis Dashboard interface. On the left, a sidebar titled "Populations & Programs" contains five menu items: "All-Payer Population", "Medicare Population", "HSCRC Regulatory Reports", "Public Health", and "Favorites". The "HSCRC Regulatory Reports" item is highlighted in green. The main content area is titled "Reports" and lists various report categories. The "RY27 Quality Based Reimbursement (QBR)" category is selected and highlighted in blue. This category is expanded to show a list of reports, including "RY27 ED LOS Report", "RY27 Summary ED LOS File", "RY27 Patient Level ED LOS Validation File" (with sub-items for UM Medical Center, Johns Hopkins Hospital, and WVU Medicine Garrett Regional Medical Center), "Sepsis" (highlighted with a red box), "RY27 QBR Inpatient Mortality Base Details" (with sub-items for the same three hospitals), "RY27 QBR Inpatient Mortality Details" (with sub-items for the same three hospitals), "RY27 QBR Inpatient Mortality Summary", and "RY27 QBR PSI-90 Details" (with sub-items for UM Medical Center and Johns Hopkins Hospital). Each report entry includes icons for favorites, download, and other actions. A search bar at the top right contains the text "Search Reports...".

Sepsis Dashboard - Sepsis Summary

A comprehensive view of sepsis-related metrics at state and hospital levels

Sepsis Summary | Sepsis Hospital Level | ICD10 Lookup

Sepsis Summary

Year
2024

Present on Admission filter
Yes

Sepsis Definition filter
All Sepsis (with and without organ dysfunction)

Data Available through December 2025, Readmissions through December 2025

Note: * - This variable is not impacted by Present on Admission filter or Sepsis Definition filter.

** - IP Mortality is impacted by Sepsis Definition filter but not impacted by Present on Admission filter

*** - 30 Day Mortality O/E Ratio is not impacted by the Sepsis Definition filter or POA filter; this measure is calculated using all sepsis cases and both POA and non-POA cases

Click on the Hospid to view the detail level report

Year	Hospid	Hospital Name	Inpatient Admissions *	Inpatient Sepsis Admissions	PPC 35 At Risk *	Inpatient Mortality Sepsis Eligible Admissions	Inpatient Mortality Sepsis Death Counts	Inpatient Mortality Sepsis O/E Ratio **	30-Day Mortality Sepsis Eligible Admissions	30-Day Mortality Sepsis Death Counts	30-Day Mortality Sepsis O/E Ratio ***	Inpatient Readmission Sepsis Eligible Admissions	Inpatient Sepsis Readmissions	PSI13 Risk Adjusted Rate *	Sep-1 Score *
2024	210001	Meritus	17,869	2,286	3,762	2,028	133	0.837	1,077	110	Null	1,976	140	0.00322	81
	210002	UMMS- UMMC	25,620	1,696	5,785	1,188	147	1.01742	570	65	Null	1,272	85	0.00347	65
	210003	UMMS- Capital ..	12,935	1,040	2,815	912	146	1.29771	498	88	Null	807	52	0.00512	43
	210004	Trinity - Holy Cr..	28,404	2,502	5,411	2,212	319	1.8313	1,254	172	Null	1,984	136	0.00784	78
	210005	Frederick	17,308	1,678	3,875	1,444	85	0.86179	851	67	Null	1,403	63	0.00773	83
	210008	Mercy	12,325	279	2,103	205	30	1.68557	117	23	Null	212	11	0.00342	95
	210009	JHH- Johns Hop..	42,531	2,131	10,204	1,774	207	0.94929	692	68	Null	1,641	91	0.00365	72
	210011	Saint Agnes	11,370	1,307	2,132	1,105	88	0.73687	596	61	Null	1,058	67	0.00397	Null
	210012	Lifebridge- Sinai	18,141	1,179	6,439	1,015	155	1.3452	525	87	Null	909	73	0.00146	55
	210015	MedStar- Frank..	20,290	2,604	4,864	2,325	153	0.8654	1,323	95	Null	2,304	129	0.0032	35
	210016	Adventist- Whi..	12,748	1,558	2,735	1,367	158	1.08582	830	96	Null	1,328	82	0.00906	84
	210017	Garrett	1,914	241	353	206	13	0.75621	93	14	Null	223	<11	0	71
	210018	MedStar- Mont..	6,382	1,159	1,274	1,063	72	0.74021	574	56	Null	1,015	79	0.00791	46
	210019	Tidal- Peninsula	18,074	2,111	3,566	1,935	160	1.10566	994	96	Null	1,812	107	0.00412	59

Sepsis Dashboard - Continued

Stratification:

Provides sepsis-related admission and readmission counts stratified by Present on Admission (POA) status and ICD-10 Sepsis definitions

Continuous Improvement:

Serves as a starting point for sepsis performance monitoring. Actively seeking end-user feedback and plan to review enhancements later this year

Inpatient Admissions
Inpatient Sepsis Admissions (POA = 0)
Inpatient Sepsis Admissions (POA = 1)
Inpatient Sepsis Admissions Total (Both POA = 0 or POA = 1)
Inpatient Sepsis + Org Dysfunction Admissions (POA = 0)
Inpatient Sepsis + Org Dysfunction Admissions (POA = 1)
Inpatient Sepsis + Org Dysfunction Admissions Total (Both POA = 0 or POA = 1)
PPC 35 (Septicemia & Severe Infections) At Risk
PPC 35 (Septicemia & Severe Infections) Assigned
PPC 35 (Septicemia & Severe Infections) Expected
Inpatient Sepsis Mortality Eligible Admission Counts (POA = 0)
Inpatient Sepsis Mortality Death Counts (POA = 0)
Inpatient Sepsis Mortality Eligible Admission Counts (POA = 1)
Inpatient Sepsis Mortality Death Counts (POA = 1)
Inpatient Sepsis Mortality O/E Ratio (Both POA = 0 or POA = 1)
Inpatient Sepsis + Org Dysfunction Mortality Eligible Admission Counts (POA = 0)
Inpatient Sepsis + Org Dysfunction Mortality Death Counts (POA = 0)
Inpatient Sepsis + Org Dysfunction Mortality Eligible Admission Counts (POA = 1)
Inpatient Sepsis + Org Dysfunction Mortality Death Counts (POA = 1)
Inpatient Sepsis + Org Dysfunction Mortality O/E Ratio (Both POA = 0 or POA = 1)
30-Day Sepsis Mortality O/E Ratio (Both POA = 1 or POA = 0)
Inpatient Readmission Sepsis Eligible Admissions
Inpatient Readmission Sepsis + Org Dysfunction Eligible Admissions
Inpatient Sepsis Readmissions
Inpatient Sepsis + Org Dysfunction Readmissions
PSI13 (Postoperative Sepsis Rate) Observed Rate
PSI13 (Postoperative Sepsis Rate) Expected Rate
PSI13 (Postoperative Sepsis Rate) Risk Adjusted Rate
Sep-1 Score

Data Refresh Cadence

- Dashboards are typically refreshed on a monthly basis
 - **Example:** June final data submitted by hospitals in the first week of September will be available in the CRS portal during the October release
 - **Final Data Lock:** Final case-mix data for the completed calendar year becomes available in April of the following year
- Data for a new Rate Year typically becomes available around June to account for annual logic updates
 - The exact reporting period is denoted within the dashboards

HCAHPS Dashboard

HCAHPS Dashboard (Unadjusted)

Search Reports...

Populations & Programs

- All-Payer Population
- Medicare Population
- HSCRC Regulatory Reports
- Public Health
- Favorites

Reports

- CDS-A Reports
- Demographic Adjustment
- Repatriation Market Shift Adjustment Report
- Hospital Population Health Programs
- Market Shift
- Maryland Hospital Acquired Conditions (MHAC)
- Potentially Avoidable Utilization (PAU)
- Quality Financial Impact Dashboard
- RY26 Quality Based Reimbursement (QBR)
- RY27 Quality Based Reimbursement (QBR)
- Readmissions
- HCAHPS Dashboard (Unadjusted)**
- RY28 Quality Based Reimbursement (QBR)

HCAHPS Dashboard (Unadjusted)

HCAHPS Dashboard (Unadjusted)

HCAHPS Dashboard (Unadjusted) - Landing Page

Purpose:

Provide timely summaries of patient-level HCAHPS data for state and hospital monitoring

Analyze changes in HCAHPS performance over time, allowing stratification by patient and hospital characteristics

Maryland HCAHPS Dashboard

Hospitals Region Bed Size

Discharge Time Period Mode Service Line

Overview

Please click on the measures to see the key findings (* New in 2025 | ** Discontinued in 2025)

Key Findings for the Selected Domain and Filters:

1. Discharge Information has the highest Top-Box score for the selected filters.
2. This Top-Box score is above the statewide average for the selected filters.
3. This Top-Box score is lower than the highest Top-Box score for the selected filters.

Quality Measure (sorted by Top-Box Score)	Top-Box Score (Unadjusted Score)	Highest State Top-Box Score
Discharge Information	86.94%	91.81%
Communication with Doctors	78.59%	85.24%
Communication with Nurses	77.64%	84.44%
Information about Symptoms*	71.80%	80.50%
Care Coordination*	70.94%	82.65%
Willingness to Recommend the Hospital	69.68%	84.25%
Overall Hospital Rating	68.98%	81.17%
Cleanliness of Hospital Environment	68.47%	84.12%
Communication about Medicines	58.66%	66.29%
Quietness of Hospital Environment**	58.09%	78.02%
Responsiveness of Hospital Staff	55.28%	73.25%
Care Transition**	52.41%	64.74%
Restfulness of Hospital Environment*	52.11%	65.52%

* New in 2025 | ** Discontinued in 2025

HCAHPS Dashboard (Unadjusted) - Continued

Segment data by HCAHPS domains and patient demographics

Maryland HCAHPS Dashboard

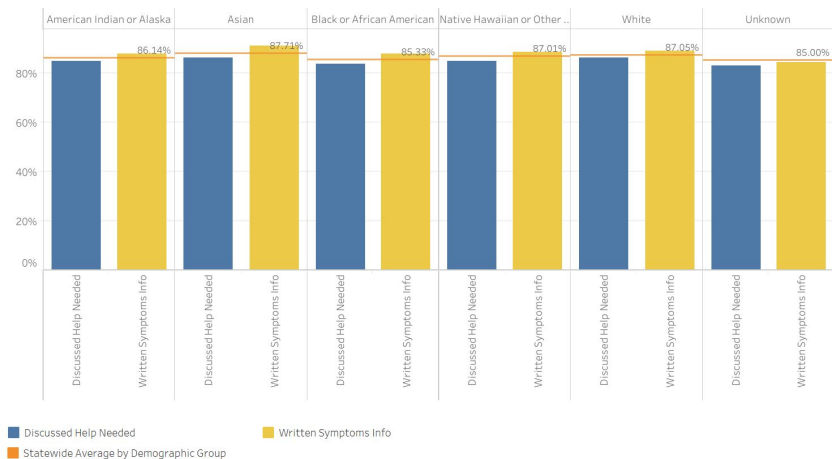
Provider Name: (Multiple values) | Region: (All) | Bed_Size: (All)

Discharge Time Period: Jul, 2021 - Dec, 2025 | Mode: (All) | Service Line: (All) | Domain: Discharge Information | Demographic: Race

Top-Box Performance Score for Discharge Information by Race

Key Findings for the Selected Domain and Filters:

1. Top-Box score given by Race Asian patients are 88.54%, which is higher than other groups.
2. The question "Written Symptoms Info" has the highest Top-Box score among Asian patients of 90.99%



Maryland HCAHPS Dashboard

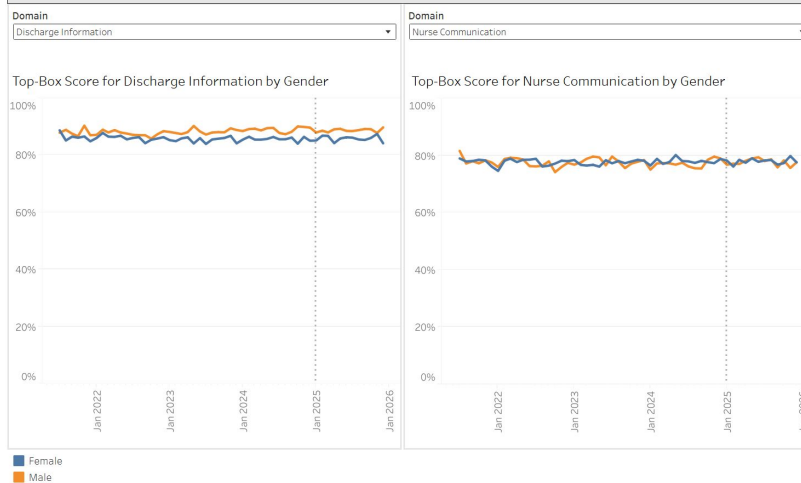
Hospitals: (Multiple values) | Region: (All) | Bed Size: (All)

Discharge Time Period: Jul, 2021 - Dec, 2025 | Mode: (All) | Service Line: (All) | Demographic Category: Gender | Demographic Value: (Multiple values)

Top-Box Score Comparison by Domain

Key Findings for the Selected Domain and Filters:

- The overall average Top-Box score for the Discharge Information domain is 88.34%. The Male group has the highest average Top-Box score for this domain.
- The overall average Top-Box score for the Nurse Communication domain is 77.74%. The Female group has the highest average Top-Box score for this domain.



Data Refresh Cadence and Next Steps

- HCAHPS dashboard data is refreshed on a quarterly basis shortly after data submission
 - The exact reporting period is denoted within the dashboards
- Phased development
 - Phase 1 released in December 2025
 - Phase 2 released in March 2026
 - Phase 3 is actively under development to add CMS comparisons and estimate Patient-Mix and Mode Adjustments

Accessing Reports

- Email your Organization's CRS Point of Contact (POC) to request access to portal:
 - Request should specify hospital and level of access (summary vs. patient-level)
 - Access will be granted to all hospital reports (i.e., not program specific)
- CRS Point of Contact (CFO or designee) confirm and approve access requests for each organization
- Questions regarding **content** of static reports or report **policy** should be directed to the HSCRC quality email (hscrc.quality@maryland.gov)
- Questions regarding **access** issues or **tableau** reports should be directed to CRISP Support email (support@crisphealth.org)

Q & A

- Additional or unanswered questions can be emailed to the HSCRC Quality mailbox: hscrc.quality@maryland.gov
- Thank you again for your participation!

Policies and memos for the Quality programs are on the HSCRC website, click on Quality tab:

hscrc.maryland.gov.

Acknowledgments

Thanks to the Performance Measurement Work Group members, MHA, CRISP, the hospital industry, consumers, and other stakeholders for their work on developing and vetting Maryland's performance-based payment methodologies.



Appendix

Grouper Update: MHAC, RRIP, QBR for RY 2028/CY2026

Rate Year	RY2028
*3M/Solventum APR/PPC Grouper Version	43
Timeline	<p><u>Base Year:</u></p> <ul style="list-style-type: none"> • MHAC (PPCs and PSI-90): FY 2024- FY 2025 • RRIP: CY 2022 and CY 2023 • QBR IP and 30-Day Mortality, TFU Medicaid: FY 2025 • QBR HCAHPS, CDC NHSN measures: CY 2023 <p><u>Performance Year:</u></p> <ul style="list-style-type: none"> • QBR HCAHPS, CDC NHSN measures: Q4 CY 2025- Q3 CY 2026 • All Other Measures: CY 2026 <p><i>(CY 2025-2026 for MHAC small hospitals)</i></p>
Implementation Date	RY 2028 policies begin Jan 1, 2026 in most cases. Look for base and performance period reports on the CRS Portal.

HSCRC Performance Measurement Workgroup

1. Broad stakeholder group of hospital, payer, quality measurement, academic, consumer, and government agency experts and representatives who advise on the development of hospital quality incentives.
2. Meets monthly (3rd Wednesday at 9:30am) from around August through May
 - a. Meetings are public, email hscrc.quality@maryland.gov to be added to listserv
3. Reviews and recommends annual updates to the performance-based payment programs.
4. Considers and recommends strategic direction for the overall performance measurement system
 - a. Create all-payer programs that align with National measures and strategies as appropriate
 - b. Update programs to meet Maryland Model goals
 - c. Incorporate measures specific to State of Maryland concerns such as emergency department length of stay
 - d. Broaden focus to patient-centered population health
 - e. Develop infrastructure to collect digital quality measures

Overview - State Population Health Accountability Plan (PHAP)

PHAP is a required element of the AHEAD Model.

- Based on a template provided by CMMI with narrow range of measure options to choose from across six domains.
- The State was required to set biannual targets for six measures.
- The target-setting and measure selection has occurred through the AHEAD Model governance structure (Maryland's Commission on Health Equity or MCHE).
- If the State fails to reach targets, this is a triggering event that may result in enforcement actions.
- Maryland submitted the measures and targets to CMMI on October 15, 2025.

Final PHAP Measures and Targets

Measure	Data Source	All-Payer 2023 Baseline	All-Payer Target for 2027 (PY2)
Self-Reported Health Status	BRFSS	16.5% with poor or fair health	16.5% with poor or fair health
Colorectal Cancer Screening	Claims w/ supplemental lab data	49.3%	50.7% with screening
Hemoglobin A1c Control for Patients with Diabetes (>9.0%)	Claims w/ supplemental lab data	67.8%	65.8% with poor control
Follow-up After Hospitalization for Mental Illness	Claims	64.3% at 30 days; 38.0% at 7 days	64.8% follow-up at 30 days; 38.5% at 7 days
Plan All-Cause Unplanned Readmission	Claims	O/E= 1.01	O/E=1.00
Food Insecurity	BRFSS	16.4% food insecure	16.4% food insecure

PPC Updates and Feedback

Login procedure for PPC documentation:

[3M™ Web Portal - Login](#)

For first use, at registration page, use the old username of "MDHosp" as your authorization code, complete the fields with your personal information to register

New PPC feedback submission procedure on Solventum HIS support site:

Previously on the 3M site, an “enhancement request” could be submitted after logging in. We anticipate this will be an option on the new Solventum support site. If not available, please submit feedback to the HSCRC.

Exclusions for ED LOS Payment Measure

The following are being excluded from the RY2027 ED LOS measure using in QBR:

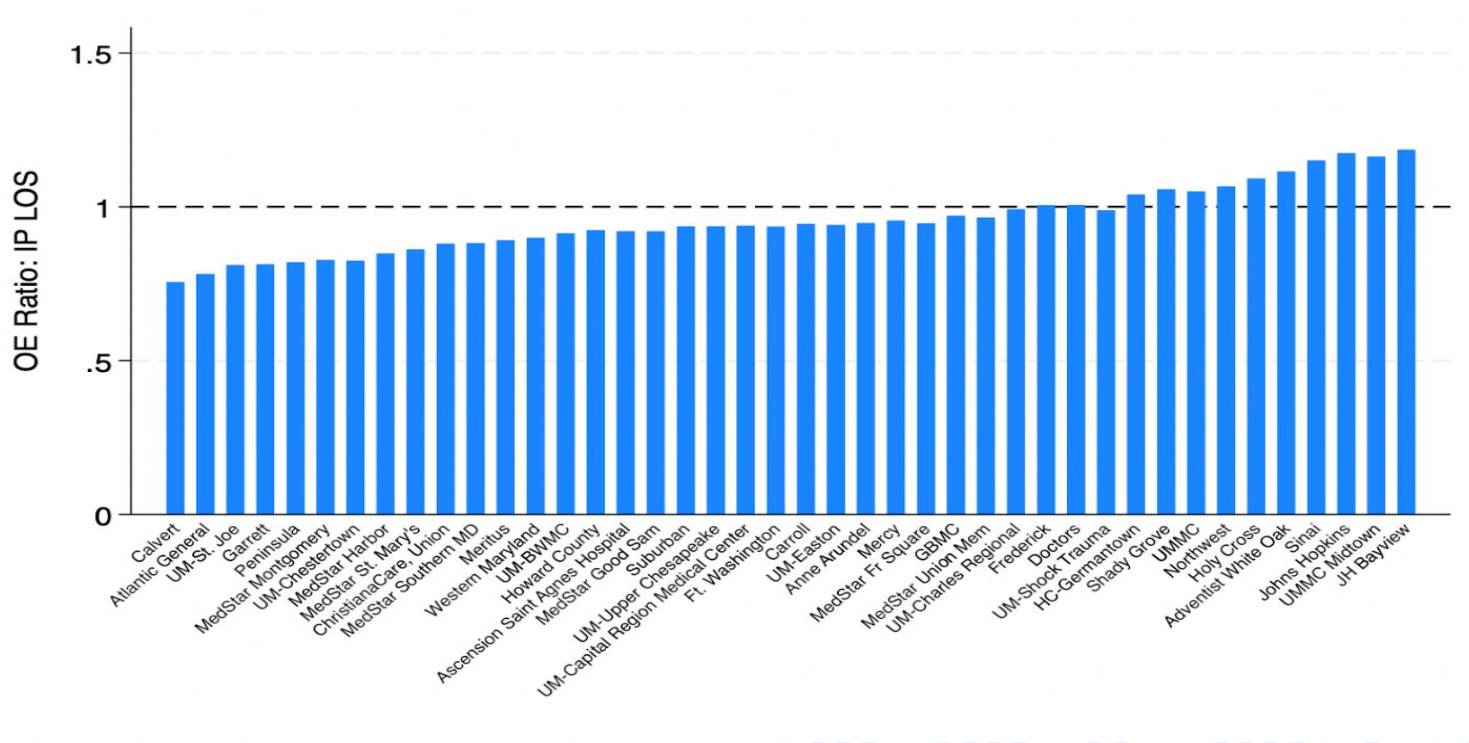
- Exclude pediatric cases
 - Remove discharges age <18
- Exclude Shock Trauma (Hospid: 218992)
- Exclude Burn and Trauma Cases
- Exclude psychiatric discharges for QBR payment measure using The Joint Commission list of primary diagnoses and APR-DRGs:
 - Primary diagnosis codes from TJC were used for the applicable calendar year. These are the specific tables:
 - Table Number 10.01: Mental Disorders-HBIPS/ED
 - Table Number 10.02: Mental Disorders-ED
 - Discharges with a psychiatric or substance abuse related APR-DRG
 - APR-DRGs 740, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 770, 772, 773, 774, 775, 776
- Exclude discharges related to deliveries
- Discharges with a maternal delivery related APR-DRG (Note: not all obstetrical patients are excluded)
 - APR-DRGs 539, 540, 541, 542, 543, 547, 548, 560, 561, 564, 566
- Exclude rehabilitation discharges
 - Daily Service = '08' Rehabilitation
- Exclude Chronic discharges
 - Major service line = CHRONIC and Daily Service = '09' Chronic

Inpatient Length of Stay Update

Background

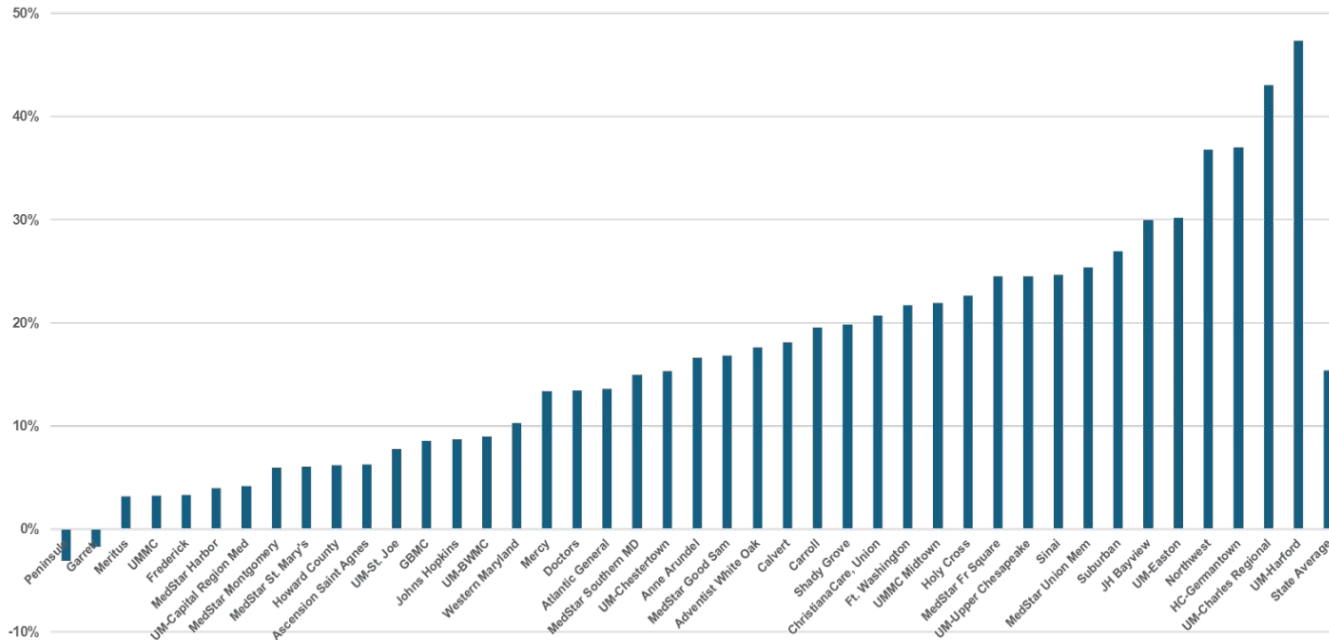
- Global budgets and TCOC accountability incentivize hospitals to reduce preventable hospital admissions and lower inpatient length of stay (IP LOS)
- While the Maryland Model has been successful in reducing hospital admissions, it has been less effective in reducing IP LOS
 - ¼ of Maryland hospitals have an average IP LOS higher than national average
 - Although admission volumes have declined, the concurrent increase in IP LOS has resulted in a net rise in inpatient resource utilization as measured by total bed days
- Unconstrained increases in IP LOS may undermine the financial sustainability of global budgets
- Maryland's emergency departments are currently among the most crowded in the nation, and managing IP LOS is a critical for improving ED wait times.
- The IP LOS policy serves as a counterbalance to the surge policy's incentives. The surge policy could unintentionally increase inpatient LOS, pushing more Maryland hospitals above the national average

25% of MD Hospitals Have Risk-Adjusted IP LOS Higher Than National Average



Source: HSCRC FY2025 Casemix, risk adjusted for APR-DRG, and payer using 2023 HCUP norms

Between 2018 and 2024, IP LOS Increased at Most Hospitals



15 Hospitals had IP LOS increase of more than 20 percent between 2018 and 2024

Only two of the State's hospitals experienced decreases during the period

Source: HSCRC FY2018 & FY 2024 Casemix.

IP LOS Increase Not Caused by Moving Lower-Acuity Patients to OP

Baseline Scenario

Patient	Unit	LOS
1	CCU	6
2	Med/Surg	2

Bed Days: 8
Patients: 2
Mean LOS: 4

Reduced Acuity Scenario

Patient	Unit	LOS
1	CCU	6
2	Med/Surg	2

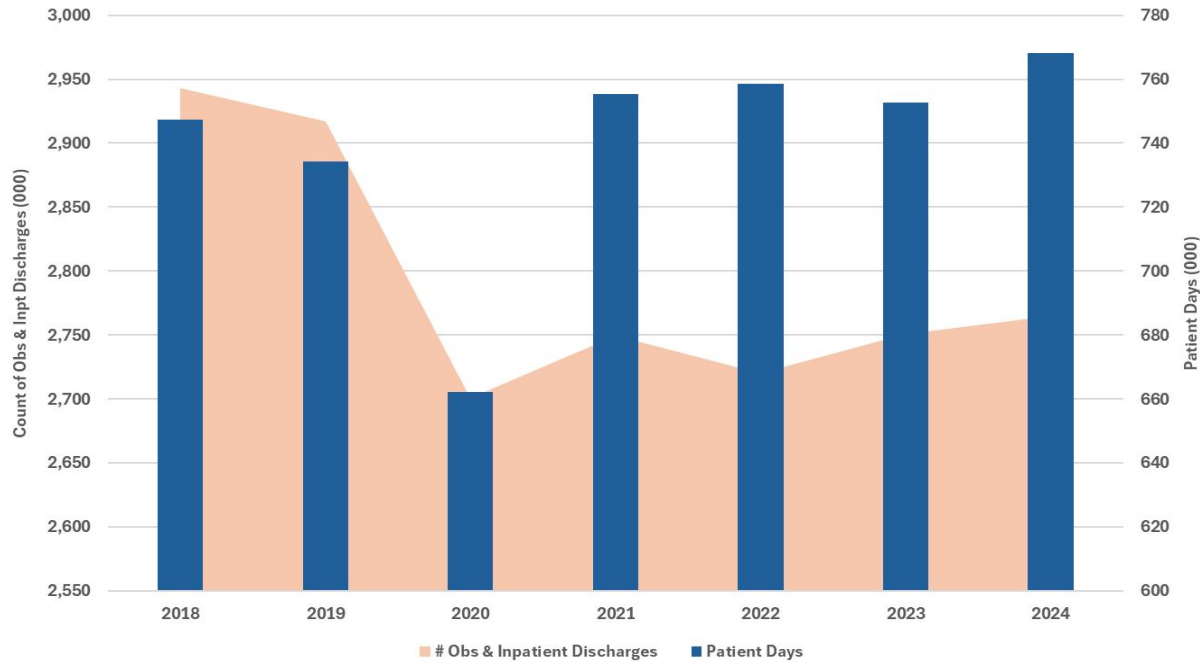
Bed Days: 6
Patients: 1
Mean LOS: 6

Increased Bed Days + Lower Acuity Scenario

Patient	Unit	LOS
1	CCU	8
2	Med/Surg	2

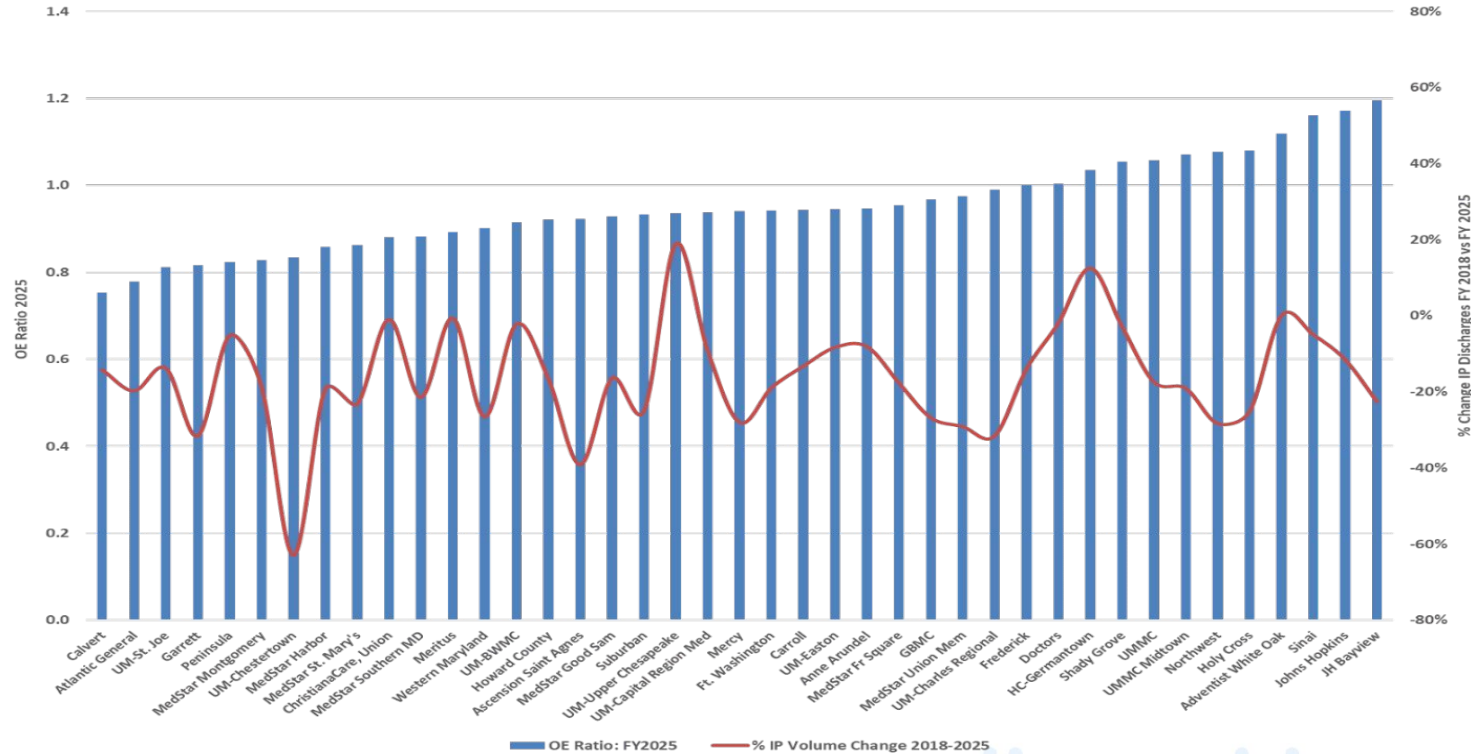
Bed Days: 8
Patients: 1
Mean LOS: 8

There Was a Net Gain in Statewide Bed Days Over Time



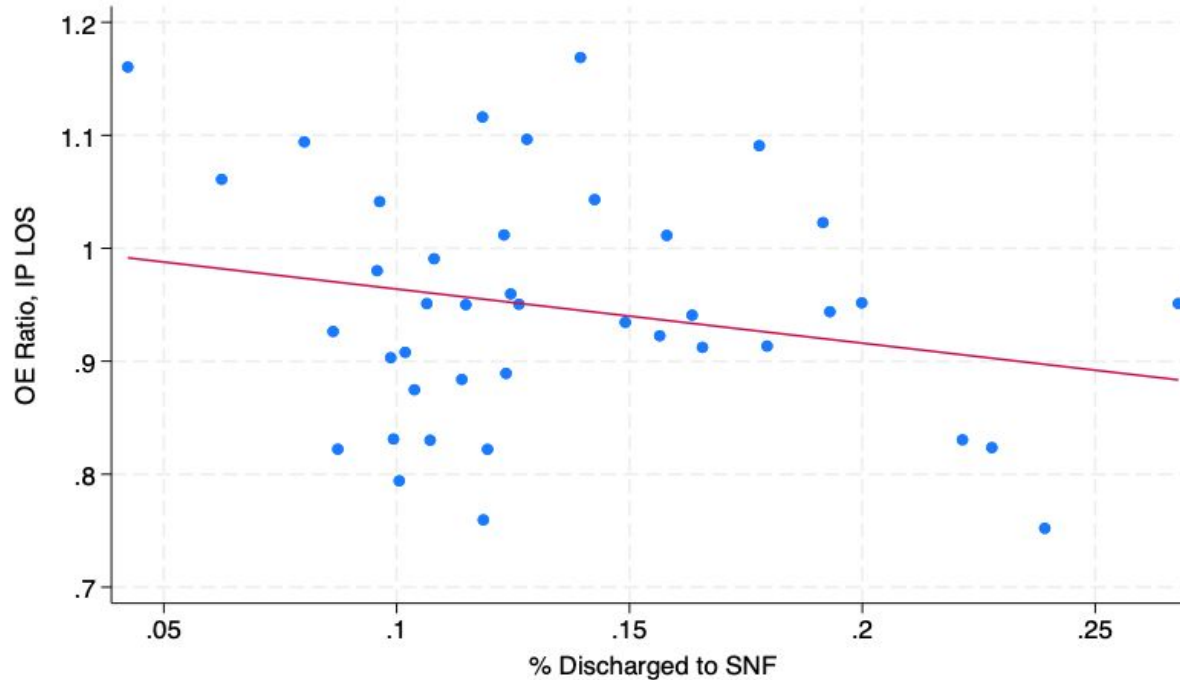
Source: HSCRC Casemix, FY2018-2024

IP LOS and IP Volume Changes Are Minimally Correlated



Source: HSCRC Casemix, 2018-2025FY and HCUP 2023 norms adjusting for APR-DRG/SOI

IP LOS Is Inversely Correlated with Post-Acute Discharges



This suggests operational issues at some hospitals are lengthening IP LOS for patients regardless of discharge destination.

Updated Payment Policy Details

- The policy is designed to recognize hospitals that have invested in managing LOS over the past several years, while encouraging progress for those with little improvement and performance worse than the nation.
- The proposed policy implementation schedule is:
 - CY 2026/RY28: monitoring
 - CY 2027/RY29: Scaled penalties and rewards of up to 0.5 percent of all-payer inpatient revenue
 - CY 2028/RY30: Revenue at risk will increase to 0.75 percent
 - CY 2030/RY31: Revenue at risk increases to 1 percent
- To qualify for rewards, hospitals must meet participation expectations for sharing best practices on hospital throughput
 - Hospitals are required to submit reporting under the ED and Hospital Throughput Best Practice Policy to remain eligible for rewards.

Updated Measurement Methodology

- Exclusions:
 - Discharges leaving against medical advice
 - Transfers out to other acute care settings
 - Expired cases
 - Patients treated at UM Shock Trauma Center
 - Chronic and rehabilitation patients
 - Unknown discharge dispositions
- Performance will be measured against national averages (expected values) after adjusting for patient risk factors such as diagnosis (APR-DRG), severity of illness (SOI), and payer.
- Expected values are estimated using the 2023 HCUP National Inpatient Sample.
- **New: Clinical outliers will be addressed by winsorizing/capping IP LOS values > 30 days**
- **New: DRG/SOI/Payer cells with <2 HCUP observations will be excluded**
- Hospitals will be assessed on improvement from a fixed base period and actual performance (i.e., attainment) relative to CY2023 national norms during each performance year.

Improvement Scenario Options--Updated

#	Estimating Method	Percent Improvement	Annualized Improvement	CY2026 Improvement Threshold
1	Statewide improvement, CY2023-CY2025	-1.05%	-0.21%	-0.63%
2	Mean hospital improvement, CY2023-CY2025	-1.26%	-0.25%	-0.76%
3	Mean hospital improvement among hospitals with reductions, CY2023-CY2025	-3.72%	-0.75%	-2.25%
4	Statewide change if all hospitals with an O/E Ratio greater than 1, improve to 1 in CY 2023	-4.35%	-0.89%	-2.63%
5	Statewide change if all hospitals with an O/E Ratio greater than 1, improve to statewide median in CY2023	-6.56%	-1.35%	-3.99%
6	Improvement from the mean O/E ratio of those greater than 1 in CY2023 to 1	-8.77%	-1.82%	-5.36%
Proposed Improvement Goal		-5.00%	-1.02%	-3.03%

- Improvement goal considerations:
 - what is required to have all hospitals reach the national average?
 - Evaluate historical performance over time to avoid setting an overly aggressive goal that could lead to unintended consequences

Proposed Improvement Scale Based on CY2023 to CY2026 Performance

- CY 2023 - CY 2028 Improvement Goal: 5%
- CY 26 Threshold improvement needed to avoid penalties: - 3.03%
- The difference between the worst decile of improvement from CY23-CY25 was used to set the maximum penalty.
- The maximum reward (benchmark) was linearly extrapolated from the threshold and the maximum penalty.

All Payer LOS Rate Change CY2023-2026		LOS % IP Revenue Payment
Improving	-9.68%	0.50%
	-9.02%	0.45%
	-8.35%	0.40%
	-7.69%	0.35%
	-7.02%	0.30%
	-6.36%	0.25%
	-5.69%	0.20%
	-5.03%	0.15%
	-4.36%	0.10%
	-3.70%	0.05%
Threshold	-3.03%	0.00%
	-2.37%	-0.05%
	-1.70%	-0.10%
	-1.03%	-0.15%
	-0.37%	-0.20%
	0.30%	-0.25%
	0.96%	-0.30%
	1.63%	-0.35%
	2.29%	-0.40%
	2.96%	-0.45%
Worsening	3.62%	-0.50%

Proposed Attainment Scale Based on CY2026 performance

- The attainment target is set at O/E Ratio of 1 from CY 2023, adjusted for the improvement threshold.
- The attainment benchmark (i.e., O/E ratio where hospitals could receive full reward) was set at the average of the top performing decile of hospitals in CY2023 plus the improvement target.
- The maximum penalty was linearly extrapolated from the threshold and the maximum reward.

All-Payer IP LOS O/E Ratio Performance Targets	LOS % IP Revenue Payment Adjustment	
Lower	0.7859	0.50%
	0.8043	0.45%
	0.8227	0.40%
	0.8411	0.35%
	0.8594	0.30%
	0.8778	0.25%
	0.8962	0.20%
	0.9146	0.15%
	0.9329	0.10%
	0.9513	0.05%
Target	0.9697	0.00%
	0.9881	-0.05%
	1.0064	-0.10%
	1.0248	-0.15%
	1.0432	-0.20%
	1.0616	-0.25%
	1.0800	-0.30%
	1.0983	-0.35%
	1.1167	-0.40%
	1.1351	-0.45%
Higher	1.1535	-0.50%

Modeling: Statewide Revenue Adjustments

Modeling Estimates	\$	% of Total Revenue
Net Statewide Revenue Adjustments	\$3,666,665	0.03%
Statewide Penalties	-\$9,683,241	-0.08%
Statewide Rewards	\$13,349,906	0.11%

- To illustrate components of the payment policy, staff treated CY2025 hospital results as if they represented CY2026 performance, and then applied improvement/attainment criteria described in the draft policy.
- Most hospitals performed better than the national average
 - Net statewide adjustments are +0.03 percent (estimated at +\$3.7 million).
- Of the 40 hospitals included in the policy, 11 would be penalized a total of 0.08 percent due to increases in IP LOS or improvements less than the improvement threshold and O/E ratios greater than attainment threshold (estimated at -\$9.6 M).

Next Steps

- Determine if additional modifications to measurement or policy are warranted.
- Finalize policy for June HSCRC Commission meeting including stakeholder feedback, including today's PMWG discussion.
- Develop summary reports and patient-level data files to disseminate to hospitals via CRISP Reporting Services for monitoring.

Digital Hybrid Measure Reporting Timeline Requirements: Core Clinical Data Elements for Hospital Wide Mortality and Readmission Measures, 2025-2026

Hospitals must submit CCDE measures for **all payer hospitalizations for patients aged 18 and older** for July 1, 2025 to June 30, 2026 reporting period;

a. Quarterly Timeline (***compliance required to be Eligible for the \$150K Expedited Reporting Bonus for RY 2027***)

Q3 2025 data	Open: 1/15/2026	Close: 3/31/2026
Q4 2025 data	Open: 1/15/2026	Close: 3/31/2026
Q1 2026 data	Open: 4/15/2026	Close: 6/30/2026
Q2 2026 data	Open: 7/15/2026	Close: 9/30/2026

b. Annual Timeline

Q3, 2025 to Q2, 2026 Open 7/15/2026 Close: 9/30/2026

Digital Hybrid Measure Reporting Timeline Requirements: Core Clinical Data Elements for Hospital Wide Mortality and Readmission Measures, 2026-2027

Hospitals must submit CCDE measures for **all payer hospitalizations for patients aged 18 and older** for July 1, 2026 to June 30, 2027 reporting period;

a. Quarterly Timeline (***compliance required to be Eligible for the \$150K Expedited Reporting Bonus for RY 2028***)

Q3 2026 data	Open: 1/15/2027	Close: 3/31/2027
Q4 2025 data	Open: 1/15/2027	Close: 3/31/2027
Q1 2027 data	Open: 4/15/2027	Close: 6/30/2027
Q2 2027 data	Open: 7/15/2027	Close: 9/30/2027

b. *Reporting of the CCDE is required in accordance with the timeline below for Hospitals to comply with HSCRC Reporting Requirements-* For hospitals that do not opt for expedited reporting bonus, they must report all required CCDE data consistent with the CMS timeline July 1, 2026 to June 30, 2027 Hybrid Measures reporting timeline as follows:

Q3 2026 to Q2 2027 Open 7/15/2027 Close: 9/30/2027