maryland
health services
cost review commission

Performance Measurement Workgroup

February 18, 2026

HSCRC Quality Team

Meeting Agenda

- RY 2028 Policies and AHEAD transition
  - Quality Based Reimbursement (QBR) Policy--Approved January
  - Maryland Hospital Acquired Conditions (MHAC) Policy--Approved February
  - Draft Readmission Reduction Incentive Program (RRIP) Policy--Draft January/Final March
- Emergency Department Priorities
  - ED LOS Measurement
- Readmission Reduction Incentive Policy Discussion
  - Out of State Adjustment
  - RRIP RY 2028 final policy and future priorities

Workgroup Learning Agreements

- **Be Present** – Make a conscious effort to know who is in the room, become an active listener. Refrain from multitasking and checking emails during meetings.
- **Call Each Other In As We Call Each Other Out** – When challenging ideas or perspectives give feedback respectfully. When being challenged - listen, acknowledge the issue, and respond respectfully.
- **Recognize the Difference of Intent vs Impact** – Be accountable for our words and actions.
- **Create Space for Multiple Truths** – Seek understanding of differences in opinion and respect diverse perspectives.
- **Notice Power Dynamics** – Be aware of how you may unconsciously be using your power and privilege.
- **Center Learning and Growth** – At times, the work will be uncomfortable and challenging. Mistakes and misunderstanding will occur as we work towards a common solution. We are here to learn and grow from each other both individually and collectively.

REMINDER: These workgroup meetings are recorded.

QBR Next Steps

QBR Next Steps

- RY 2026 revenue adjustments with new cut-point were put into rates in January 2026
- Send out memo on RY 2028 updates and available performance standards
- Update reporting on CRS portal as needed
- Finalize RY 2027 & RY 2028 ED LOS measure (discussing today)
- Determine priorities for RY 2029 alignment/non-medicare

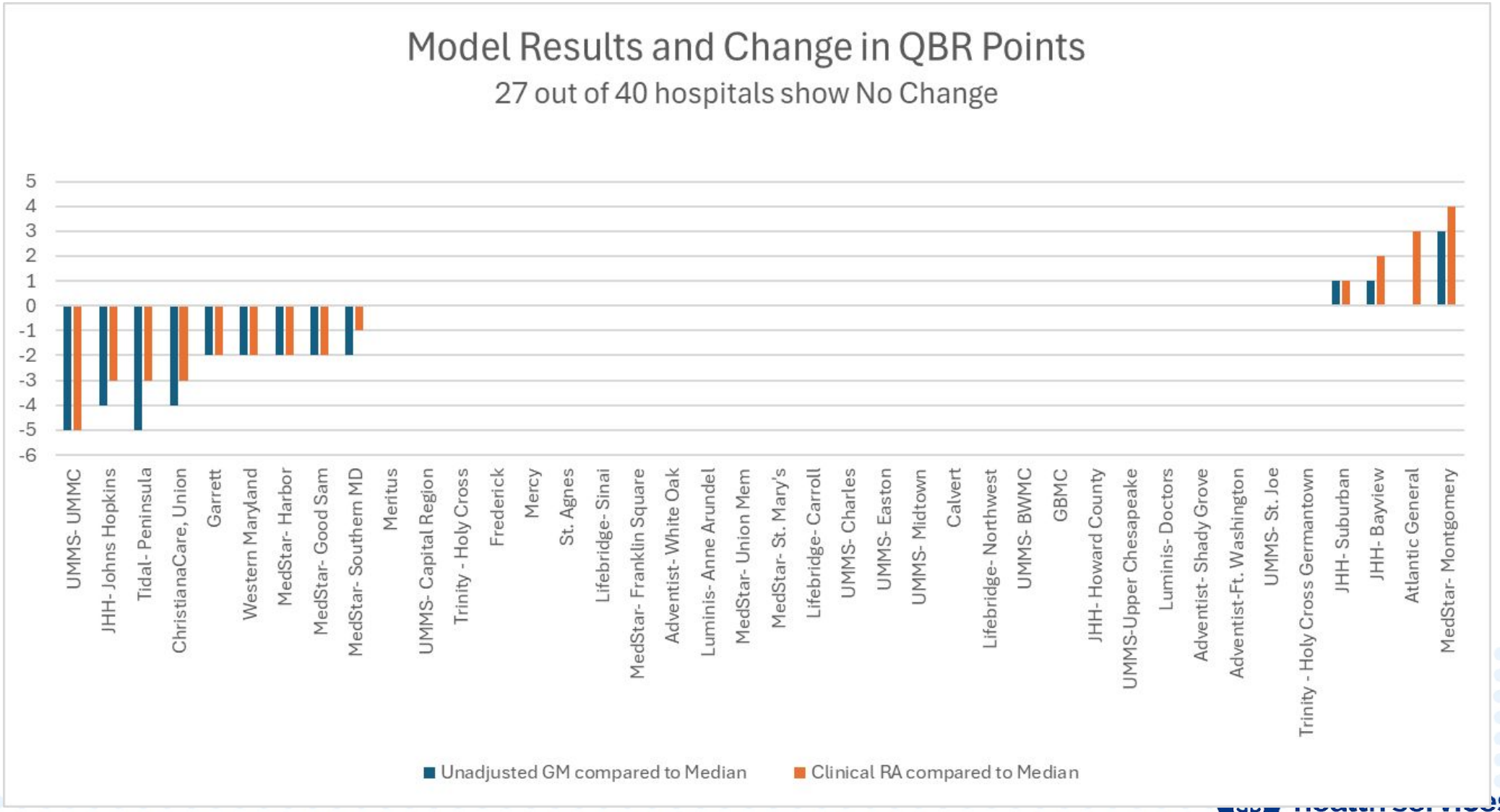
Emergency Department Updates:

ED LOS Risk-Adjustment Measure for RY27 QBR

Development of Risk-Adjusted ED LOS Measure

- Hospital stakeholders requested staff explore risk-adjustment for the ED LOS measure for measuring attainment.
- Mathematica has calculated risk-adjusted ED LOS measure for the Inpatient ED LOS payment measure using current specification (e.g., removal of pediatrics, primary psychiatric dx, etc.).
- Initial models presented focused on patient level factors (see Appendix)
  - With only 41 acute care Maryland hospitals in model, effects of hospital characteristics could not confidently be distinguished from variation in individual hospitals' performance; need national norms to measure effects of hospital-level risk factors.
- Based on results indicating low explanatory power of the models, staff recommended maintaining an improvement only incentive using the unadjusted median.
- Staff have examined additional factors based on feedback, however our recommendation remains the same.

YTD Ad Hoc Estimates



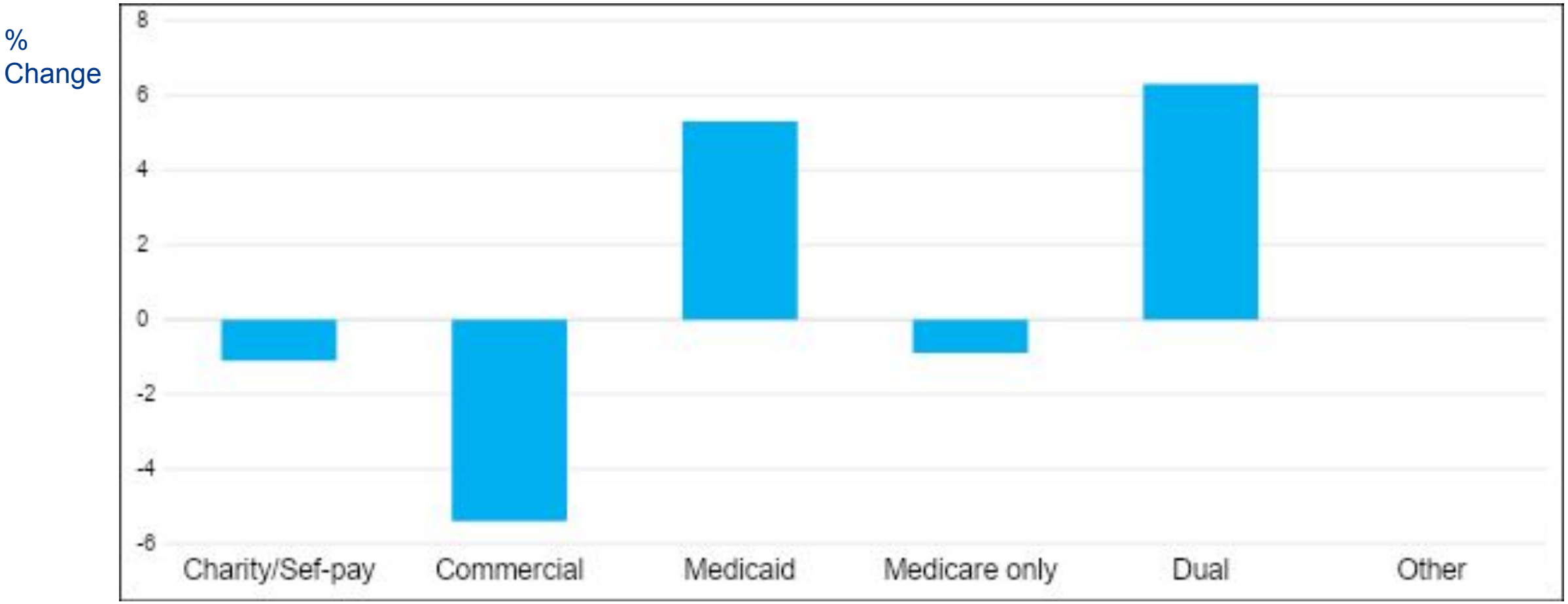
Risk adjustment changes: New risk factors

- Secondary Medicaid (Dual status)
- Inpatient Capacity
  - Based on occupied beds compared to staffed beds on arrival date
  - Compared staffed and total beds as denominator
  - Based on MIEMSS data from April 2024 to December 2025
- Surge
  - Based on daily arrivals to ED
  - Replaces hourly census
- Seasonal
  - Quarter of arrival

Methods

- Univariate analyses
  - Relation of capacity and surge variables to log ED LOS
- Multivariate modeling
  - Add variables to full risk adjustment model
- Analysis of changes
  - Correlation of hospital changes in median or geometric mean ED LOS

Payer impacts on ED LOS



Marginal impact in multivariate model, 2023 – 2025, Other is reference

Dual is similar to Medicaid and should be added if including a payer adjustment

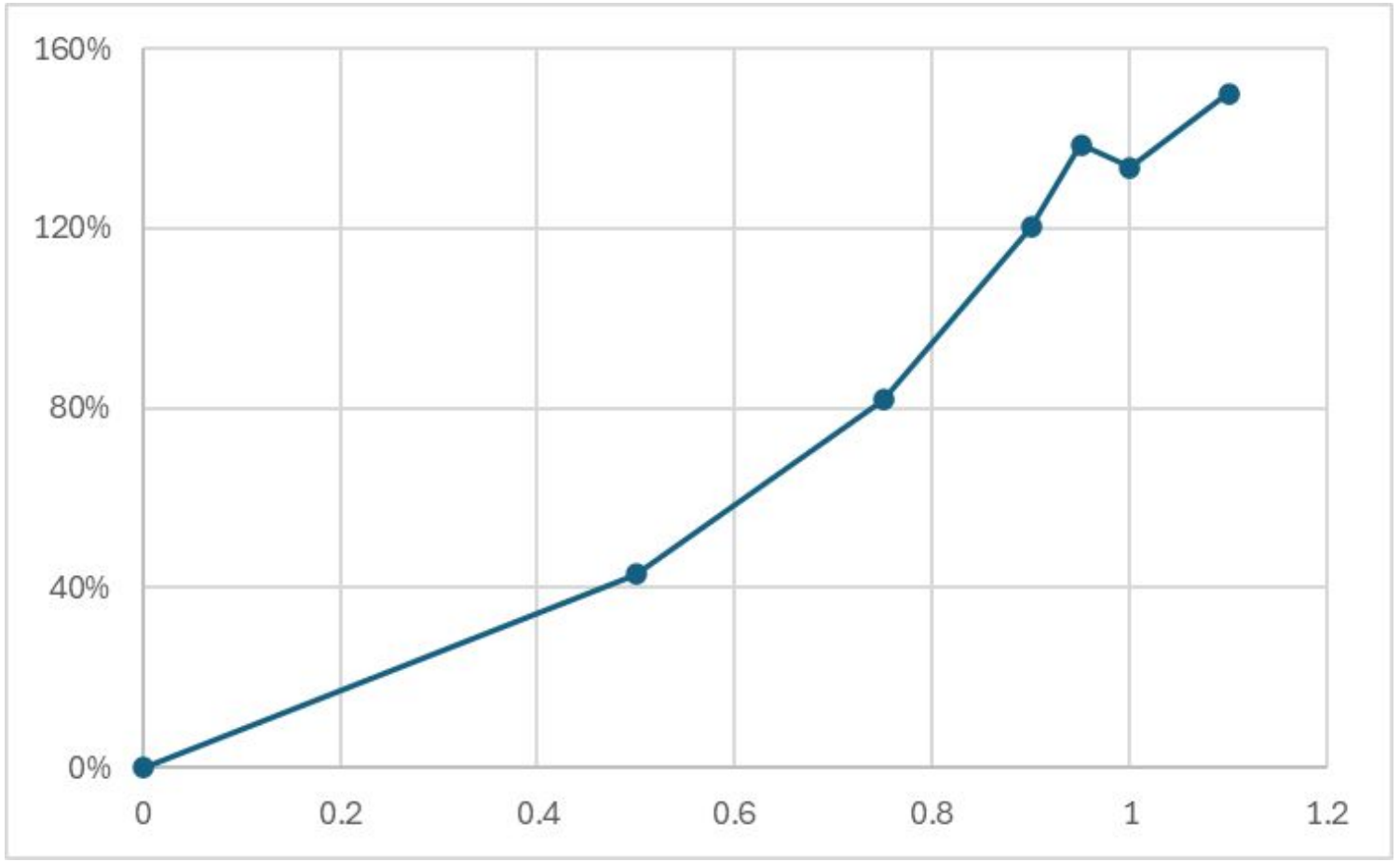
Relative contribution of bed occupancy and ED arrival volume

Variable	R-square
Occupied/Staffed Acute Beds*	.0423
Occupied/Total Acute Beds*	.0091
Staffed ratio piecewise linear*	.0481
ED arrival volume**	.0008
ED arrival volume piecewise linear**	.0013

* Univariate model 2024 - 2025

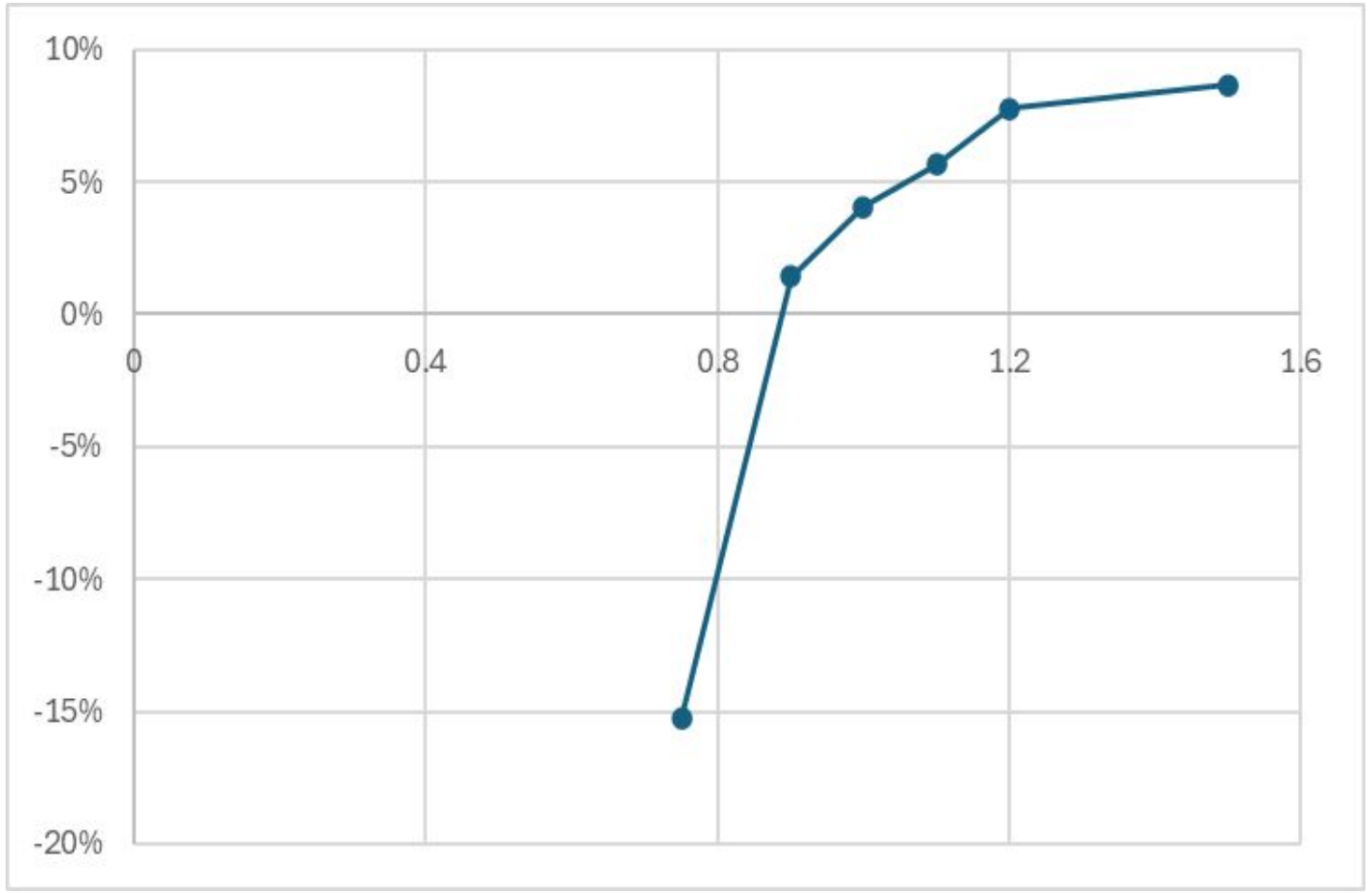
** Univariate model 2023 - 2025

Occupancy and ED-LOS impact



* Univariate model 2024 - 2025

Volume and ED-LOS impact

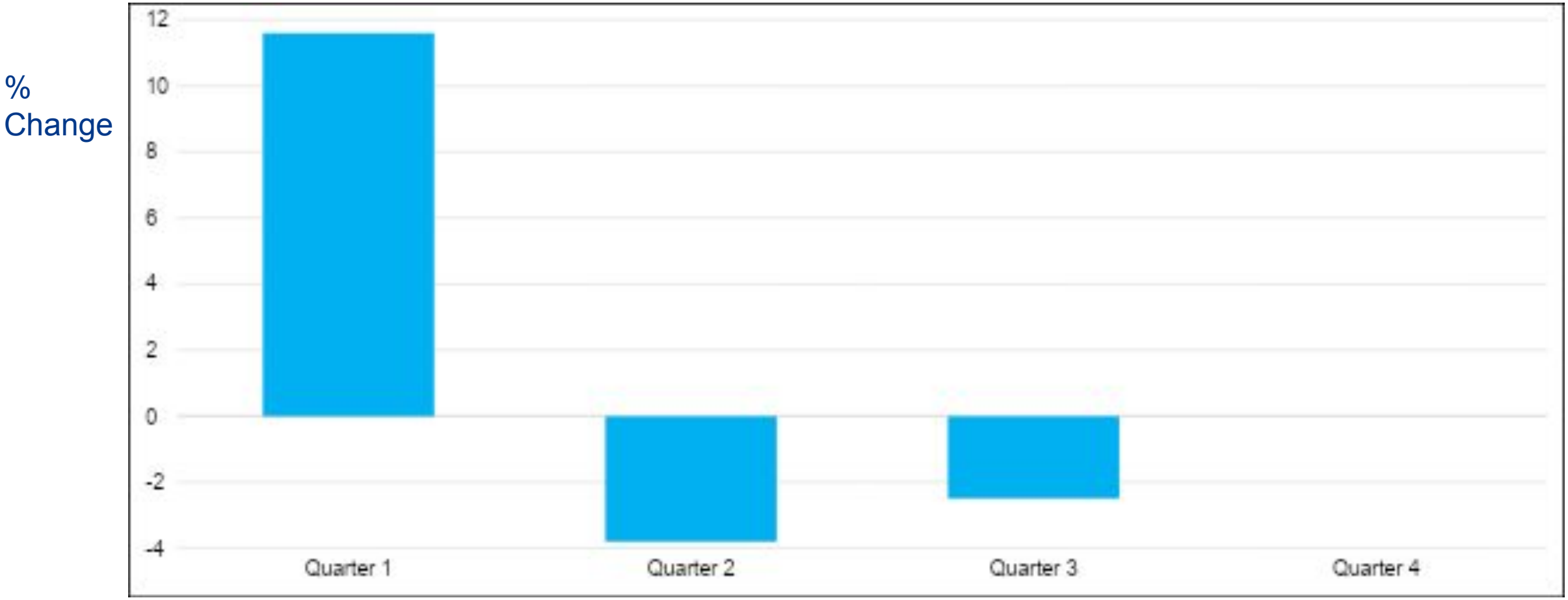


* Univariate model 2023 - 2025

ED arrivals and change in ED LOS: 2024 - 2025

Correlation	Correlation Coefficient
Change in median ED LOS with change in arrival volume	-0.27
Change in median ED LOS with arrival volume	0.21
Change in median ED LOS with change in flu volume	0.06
Median ED LOS with arrival volume	0.23

Seasonal Effects on ED-LOS: 2023 - 2025



Quarter dummy added to full log ED LOS model: Average marginal effect over 3 years

Conclusions

- Medicaid secondary payer is as strongly related to ED LOS as Medicaid primary payer
  - Medicaid primary payer predicts 5% longer LOS, secondary is 6% longer
- Inpatient bed use appears more strongly related to ED LOS than volume of ED arrivals
- Relation of both inpatient bed use and arrival volume to ED LOS are nonlinear
- High volume hospitals appear weakly more likely to experience increase in median ED LOS
- Winter (Q1) is associated with longer ED LOS even controlling for arrival volume
  - Using volume and clinical variables preferable to seasonality as risk adjuster
- Recommendation: Focus on improvement only with unadjusted ED LOS
  - Additional risk factor analysis does not seem to warrant risk-adjustment due to low explanatory value; attainment model is not recommended currently.
  - Inpatient occupancy rate is considered an opportunity for improvement.

Discussion

- **Overall goal: Improve ED LOS for patients in Maryland hospitals**
- **Should we use unadjusted median or risk-adjusted model?**
  - Differences between median and geometric mean are concern for capturing improvement
  - End of the day, patients experience actual and not risk-adjusted LOS
  - Current risk-adjustment model does not address hospital level factors
- **Reconsider attainment if ED LOS is maintained in payment after RY 2028 or use the new CMS digital measure for ED (i.e., ECAT)**
  - Explore whether elements of ECAT can be recreated using case-mix
  - Voluntary reporting in 2027, mandatory reporting in 2028

ECAT Measure Proposed for RY 2027 (voluntary) and RY 2028

The numerator is comprised of ED visits meeting the denominator criteria and where the patient experiences any of the following quality gaps in access:

1. The patient waited longer than 60 minutes (1 hour) after arrival to the ED to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination, or

2. The patient left the ED without being evaluated, or

3. The patient boarded (time from Decision to Admit order to ED departure for admitted patients) in the ED for longer than 240 minutes (4 hours), or

4. The patient had an ED length of stay (LOS) (time from ED arrival to ED departure as defined by the ED departure timestamp indicating when the patient physically left the ED) of longer than 480 minutes (8 hours).

ED encounters with ED observation stays are excluded from numerator criteria #3 (boarding) and #4 (ED LOS). To clarify, patients who have a 'decision to admit' after an ED observation stay remain excluded from numerator criteria #3 (boarded) calculations.

Next Steps

- Staff will consider input and finalize decision for RY 2027 by end of February and make that default for RY 2028 ED LOS measure as starting point
- Need input on whether stakeholders want to prioritize additional risk-adjustment for RY 2028 versus development of measure more in line with the new CMS measure (i.e., use case mix data to assess improvement in proportion of patients staying greater than 8 hours).

RY 2028 MHAC Policy

RY 2028 Final Recommendations for MHAC Program

1. Use Potentially Preventable Complication (PPC) composite and all-payer AHRQ Patient Safety Indicator 90 to assess hospital acquired complications.
2. Assess PPC performance using more than one year of data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs).
3. Assess hospital performance based on statewide attainment standards.
4. Set revenue at-risk at a maximum penalty at 2 percent and maximum reward at 2 percent using the average Maryland hospital score as the cut point for start of rewards.
5. Going forward, consider other candidate measures/measure sets that may be important for assessing hospital avoidable, harmful complications and appropriate for use in a quality program for revenue adjustments to Maryland hospital global budgets (HGB).

Topics for Today

- PPC-PSI Overlap
- Next steps for AHEAD alignment in RY 2029
  - Timeline for Clinical Adverse Event Measures subgroup

Measure Alignment with CMS HACRP Program

Stakeholder Feedback:

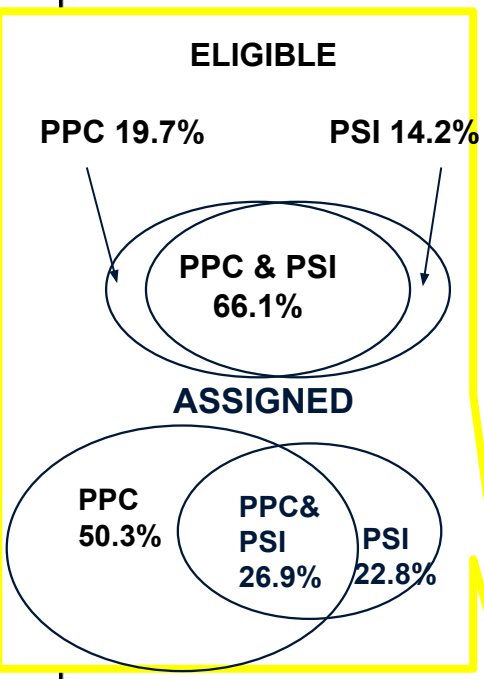
- PPCs are not included in the CMS quality programs.
  - Specific concerns on PPCs: Lack of specific value of PPCs and cost of proprietary grouper (JHHS), Plateau on improvement and AMC concerns (UMMS)
- Overlap/duplication of measures across PPC and PSIs.
- HME supports use of both the PPCs and PSIs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

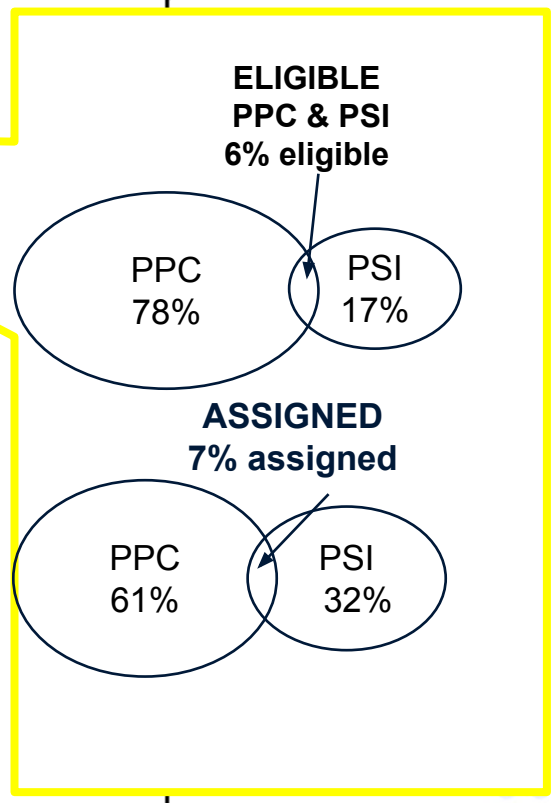
Staff acknowledges the lack of alignment with CMS in using PPCs:

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

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

Additional Important Clinical Areas





Maternal Complications

***See Appendix for Composites overlap. Also see accompanying Excel Workbook.**

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Revenue Adjustment Methodology: Maintain Rewards/Penalties

Stakeholder Feedback:

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

Staff responses:

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

Clinical Adverse Event Measures Subgroup

- Technical subgroup to evaluate complication and mortality measures for Maryland GBRs (i.e., the GBRs for commercial, medicaid, etc.).
- Staff reviewing volunteers and will contact additional experts as needed to ensure group has appropriate quality and safety measurement expertise.
- The group will consider measure validity and reliability, as well as data sources, cost and reporting burden, Medicare alignment, and areas of opportunity specific to Maryland
- Develop create criteria for inclusion of measures in a non-Medicare quality program
- Anticipated start date April 2026, updates presented at monthly PMWG and final recommendations at August/September PMWG

Readmissions Updates

OOS Ratios and Transfers
Stakeholder Feedback
AHEAD Alignment

Attainment Methodology: Out of State Adjustment

- To fairly assess relative performance across hospitals (i.e., attainment), the case-mix adjusted readmission rate is adjusted for out of state readmissions.
  - Prior to RY 2018, readmission performance assessed on improvement only
  - Due to concerns about hospital with low readmission rates having less opportunity for improvement, the attainment goal was added in RY 2018
    - Adjustment of OOS readmissions to fairly compare hospitals as some hospitals may have higher OOS readmissions (e.g., border hospitals, systems with OOS hospitals)
  - Based on CMMI Medicare report that provides count of out of state readmissions
    - Staff validated the reported readmission count using Medicare CCW data in order to assess concerns from hospitals regarding the accuracy of the adjustment
  - Two issues were discovered during this validation:
    - Double counting of out of state readmissions when followed by third admission or transfer back to MD
    - Transfers out of state that are then transferred back to Maryland flag a readmission

Readmission Double Counting: Patient Level Example

Admission 1: Maryland Hospital → Admission 2: OOS Hospital → Admission 3: Maryland Hospital

Admission 2 & 3 occur within 2-30 days of Admission 1 Discharge Date

				Readmission Results for Admission 1
Medicare CCW (in-state & OOS claims)	Maryland Hospital Index Admission	-Maryland Hospital's Readmission -OOS Hospital Index Admission	OOS Hospital's Readmission	1 OOS Readmission Assigned to Maryland Hospital Index Admission 1
Maryland Case-Mix (in-state data only)	Maryland Hospital Index Admission	Admission not in dataset	Maryland Hospital's Readmission	1 In-State Readmission Assigned to Maryland Hospital Index Admission 1

Double Counted

Medicare CCW Results: Admission 1 is being flagged as having an OOS readmission (Admission 2)

RRIP Case-Mix Results: Admission 1 is being flagged as having In-State readmission (Admission 3)

Impact: Case-Mix readmission rate is capturing in-state readmission and is being multiplied by an OOS readmission ratio that also captures an OOS readmission, both assigned to Admission 1

OOS Ratio Works when only two Admits

Data Source	Admission 1	Admission 2	Readmission Results for Admission 1
Medicare CCW (in-state & OOS claims)	100 Maryland Hospital Index Admission	10 Maryland Hospital Readmission 10 OOS Hospital Readmission	20 Total Readmissions / 100 Index Admissions = 20%
Maryland Case-Mix (in-state data only)	100 Maryland Hospital Index Admission	10 Maryland Hospital Readmission ~~10 OOS Hospital Readmission~~	10 In-State Readmissions / 100 Index Admissions = 10%
OOS Adjustment Calculation	**OOS Ratio from CCW**: 20 Total / 10 In-State Readmission = 2 **Attainment Rate:** 10% Case-Mix Rate * 2 OOS Ratio = 20% ✓		

OOS Ratio Issue when three or more Admits

Data Source	Admission 1	Admission 2	Admission 3	Readmission Results for Admission 1
Medicare CCW (in-state & OOS claims)	100 Maryland Hospital Index Admission	10 Maryland Hospital Readmission 10 OOS Hospital Readmission	10 Maryland Hospital Readmission	10 In-State + 10 OOS Readmissions / 100 Index = 20%
Maryland Case-Mix (in-state data only)	100 Maryland Hospital Index Admission	10 Maryland Hospital Readmission ~~10 OOS Hospital Readmission~~	10 Maryland Hospital Readmission	20 In-State Readmissions / 100 Index Admissions = 20%
OOS Adjustment Calculation	**OOS Ratio from CCW**: 20 Total / 10 In-State Readmission = 2 **Attainment Rate:** 20% Case-Mix Rate * 2 OOS Ratio = 40% ✗			

OOS Readmission Double Counting Example- Hospital Level

Using CCW, staff runs readmission logic with all hospitals and then run with only MD hospitals (as proxy for case-mix).

Prior Methodology	Revised Methodology
Case-Mix Readmission Rate: 20%	Case-Mix Readmission Rate: 20%
CMMI report: 20 Total Readmissions and 10 In-State Readmissions	CCW All Hospitals: 20 Total Readmissions and 10 In-State Readmissions
OOS Ratio: 20/10=2	# of readmissions that change from OOS to in-state readmissions with CCW-MD claims: 10
Attainment Rate: 20.00% * 2 = 40.00%	OOS Ratio: 20/10+10 = 1 = 20%
	Attainment Rate: 10% * 2 = 20%

Readmission OOS Transfer Issue: Patient Level Example

Admission 1: Maryland Hospital → Admission 2: OOS Hospital → Admission 3: Maryland Hospital

Admissions 2 & 3 occur within 1-2 days of Previous Admission Discharge Date

Results for Admission 1

Medicare CCW (in-state & OOS claims)	Maryland Hospital Index Admission	Transfer	Transfer	-0 In-State Readmissions for MD Hospital Index Admission 1 -1 MD Index Admission
Maryland Case-Mix (in-state data only)	Maryland Hospital Index Admission	Admission not in dataset	Maryland Hospital's Readmission Maryland Hospital Index Admission	-1 In-State Readmission Assigned to MD Hospital Index Admission 1 -2 MD Index Admissions

Medicare CCW Results: Admission 1 is being flagged as having 2 transfers (Admissions 2 & 3) and no readmission

RRIP Case-Mix Results: Admission 1 is being flagged as having In-State readmission (Admission 3)

Impact: Case-Mix readmission rate is capturing in-state readmission and 2 eligible discharges although the patient transferred OOS and transferred back into MD

OOS Transfer Issue Example- Hospital Level

Data Source	Index Admits	MD Readmits	Readmit Rate
CCW: 800 index admits, 80 readmits, 400 transfers,	800	80	10%
Case-Mix: 800 index admits, 80 readmits, 400 transfers	1200	80	6.67%
CCW: 800 index admits, 80 readmits 100 transfers,	800	80	10%
Case-Mix: 800 index admits, 80 readmits,100 transfers	900	80	8.89%
CCW: 800 index admits, 80 readmits, 100 transfers, 50 readmits for transfers	800	130	16.25%
Case-Mix: 800 index admits, 80 readmits, 100 transfers, 50 readmits for transfers	900	130	14.44%

Data Source	Index Admits	MD Readmits	Readmit Rate
CCW: 400 index admits, 40 readmits, 200 transfers	400	40	10%
Case-Mix: 400 index admits, 40 readmits, 200 transfers	600	40	6.67%
CCW: 400 index admits, 40 readmits, 50 transfers	400	40	10%
Case-Mix: 400 index admits, 40 readmits, 50 transfers	450	40	8.89%
CCW: 400 index admits, 40 readmits, 50 transfers, 25 readmits for transfers	400	65	16.25%
Case-Mix: 400 index admits, 40 readmits, 50 transfers, 25 readmits for transfers	450	65	14.44%

Impact: Readmission rate is impacted by OOS transfer rate and OOS transfer with a readmission rate

OOS Utilization Adjustment

- While staff identified a method for addressing double counting of readmissions, there was still the OOS transfer issue that needed to be addressed
- Working with stakeholders, we were able to identify a more effective approach to adjusting readmission rates to account for OOS readmissions *and* transfers
  - **OOS Utilization Adjustment**= CCW Readmission Rate/ CCW- MD Readmission Rate
    - This will account for any OOS differences seen between CCW and Case-Mix
      - Validated this adjustment method by applying OOS readmission adjustment *and* OOS transfer adjustment

OOS Utilization Adjustment- Validation

	A: CCW Readmission Rate (GOLD STANDARD)	B. CCW- MD Readmission Rate	C. OOS Readmission Ratio: (CCW readmissions/ CCW-MD readmissions)	D. OOS Transfer Ratio: (CCW-MD admissions/CCW admissions)	E. CCW-MD Readmission Rate Adjusted for OOS Readmissions and Transfers E= (B*C*D)=A
Hospital 1	30.00%	16.00%	1000/800=1.25	6000/4000=1.5	30.00%
Hospital 2	24.00%	12.00%	125/100=1.25	400/250=1.6	24.00%

	A: CCW Readmission Rate (GOLD STANDARD)	B. CCW- MD Readmission Rate	C. NEW OOS Utilization Ratio C=A/B	E. CCW-MD Readmission Rate Adjusted for OOS Readmissions and Transfers E= B*C=A
Hospital 1	30.00%	16.00%	1.875	30.00%
Hospital 2	24.00%	12.00%	2	24.00%

Summary of OOS Utilization Adjustment Modeling

RY 2026	What went into rates	OOS Utilization Adjustment
Net Adjustments ($), (%)	-$27,938,378 -0.22%	- $30,567,377 -0.24%
Rewards ($), (%)	$17,200,312 0.14%	$17,412,599 0.14%
Penalties ($), (%)	-$45,138,690 -0.36%	-$47,979,976 -0.38%
# of positively impacted hospitals, range (%)		6, 0.03% - 1.67%
# of negatively impacted hospitals, range (%)		6, -0.03% - -0.58%
# of unimpacted hospitals		31

Note: Validation of these results are pending and therefore preliminary

Timeline for OOS Utilization Adjustment

- Staff receive 100% of MD claims, 100% of border state claims and 5% of National claims from CMMI quarterly (preliminary)
- Staff receive 100% of National Claims at the end of April for prior year (i.e., in April 2026, we are expecting to receive claims for January-December of 2025) (final)
  - Due to 30-day run-out, HSCRC runs CCW readmission data using Dec-Nov (i.e., one month difference from performance period)
- Staff plan to assess OOS Utilization Adjustment using quarterly preliminary claims data vs. using previous years data
- Staff will update OOS Utilization Adjustment with final claims data
  - If there are any data delays that will impact update factor, staff may need to use preliminary data

Stakeholder Feedback

Summary of Stakeholder Feedback

Stakeholder Comment Letters for RRIP	Adventist	MHA	Luminis Health	Garrett	MDH	HME
Fully align with HRRP but maintain the reward incentive	X					
Align with PHAP goal (NCQA PCR measure)					X	X
Transparency on OOS ratio revision and financial impacts	X					
Apply OOS revision retrospectively (# of years varies by letters)	X	X	X	X		
Model revenue adjustment using HRRP, NCQA PCR, and HWR measures		X				

Mistakes vs Refinements to Methodology

- Staff has made retrospective corrections when errors occur (e.g., staff error, data issues, etc.)
- Staff generally does not provide retrospective changes when updates reflect methodological refinements, not errors
  - Methodological refinements are designed to address known limitations
  - Policies are implemented as approved and as intended
  - Consistent with CMS, corrections are applied retrospectively, while policy refinements are implemented prospectively (e.g., refinements to HRRP risk adjustment)

Examples of Errors vs Policy Refinements

Error Example: In the annual payment update for RY 2026, HSCRC applied a revision to remedy a data issue impacting UCC funding determinations for RY23 through RY25

- Error: staff used average ADI by zip code for all patients and not just those with missing ADI as intended by policy.

Refinement Example: Variable Cost Factor (VCF)

- Staff worked with industry determined that the 50% VCF did not cover variable costs and developed VCFs for different types of services. Did not make retrospective changes for update in methodology.

Summary of Impact of Staff Error

RY 2026	What went into rates (incorrect OOS ratios)	What should've gone into rates (correct OOS ratios)
Net Adjustments ($), (%)	-$27,938,378 -0.22%	- $28,796,745 -0.23%
Rewards ($), (%)	$17,200,312 0.14%	$16,360,113 0.13%
Penalties ($), (%)	-$45,138,690 -0.36%	-$45,156,858 -0.36%
# of positively impacted hospitals, range (%)		4, 0.03% - 0.27%
# of negatively impacted hospitals, range (%)		8, -0.01% - -0.50%
# of unimpacted hospitals		31

AHEAD Model Alignment

RY 2028 Draft RRIP Recommendations

1. Maintain the all-payer, 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 with a blended base period of CY 2022 and CY 2023.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
    a. Adjust case-mix readmission rate by OOS Utilization Adjustment to account for OOS readmissions and transfers, retrospectively for RY 2027 and for RY 2028 and beyond
4. Maintain scaled rewards and penalties of up to 2 percent of inpatient revenue.
5. Monitor reductions in within-hospital readmission disparities and provide quarterly updates on by-hospital performance at Commission Meetings.
6. Assess opportunities for AHEAD alignment of readmission measure, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

CY 2026 Priorities

During CY 2026 Staff will:

1. Work with MPR to adapt all-payer NCQA PCR measure specifications using case-mix data instead of claims
   a. Currently working to match Medicare and case-mix data to identify discrepancies in results
   b. May adapt RRIP measure to match elements of NCQA PCR measure (e.g., inclusion of observation)
2. Determine whether HWR and HRRP could be adapted for non-Medicare
3. Work with CMMI and industry to understand interactions between the different readmission incentives in AHEAD
4. Determine goals for Maryland GBR policy (i.e., improvement or attainment goal) and revenue adjustment methodology

Staff will use PMWG as stakeholder group to vet the RRIP policy development

THANK YOU!

Next Meeting: March 18, 2026

Appendix

Use of Risk-Adjusted ED LOS Variable in QBR

Attainment: Provide QBR credit for better performers

- ED Risk-Adjustment only accounts for small amount of the variation seen across hospital performance in both Clinical and Full Models. Raises concerns on being able to fairly compare across hospitals.

Improvement: Provide QBR credit for improvement

- Staff propose to maintain improvement goal that focuses on not getting worse (i.e., 0 to -5% and 0 to -10% based on median in base) and provide those with rates below national average the full points.
- Staff recommend maintaining this for newly approved RY 2028 goal.

ED visit resulting in inpatient stay

- Logged dependent variable
  - Avoids negative LOS prediction
  - Improves fit
  - Coefficients interpreted as percentages
  - Risk adjusted results reported as geometric mean*

*Geometric mean is exponential mean of logs-reduces influence of outliers and approximates median if lognormally distributed, however improvement results differ somewhat simply based on this change and explanation of the metric is less intuitive to all stakeholders

Inpatient model presented here

- Calendar Year 2024, 2025 YTD models fit
  - Coefficients for 2024 applied to 2025
- Admission APR-DRG, admission risk of mortality and secondary psych diagnosis are clinical risk adjusters
- Includes inpatient admissions with observation stays
- Measure uses currently developed IP ED LOS specifications but handles outliers differently
  - Excludes maternity, trauma, burns, psychiatric, pediatric, chronic conditions, rehab
  - Excludes stays over 30 days long
  - Excludes admission APR-DRG cells with less than 30 discharges statewide
  - Does not truncate outlier values (i.e., winsorize at 95th percentile)

Risk Factors Considered

Clinical characteristics

- Risk of mortality: On admission to inpatient stay
- APR-DRG: Admitting APR-DRG from inpatient stay, if at least 30 stays with this DRG
- Secondary psychiatric diagnosis: From code list

Patient demographics

- Sex: Male, female, unknown
- Age group: 5-year groupings, with 18 – 20, 85+

Visit characteristics

- Payer: Charity, Medicare, Medicaid, Commercial, Other, NA
- Arrived by ambulance: Y/N
- Admission source: Excludes newborns
- Hour of arrival: From ED arrival time
- Weekend arrival: From ED arrival date
- Census: number of ED at visit hour compared to two year average

Hospital choice

- Observation stay: start date not missing
- Observation stay: starts at or after ED discharge

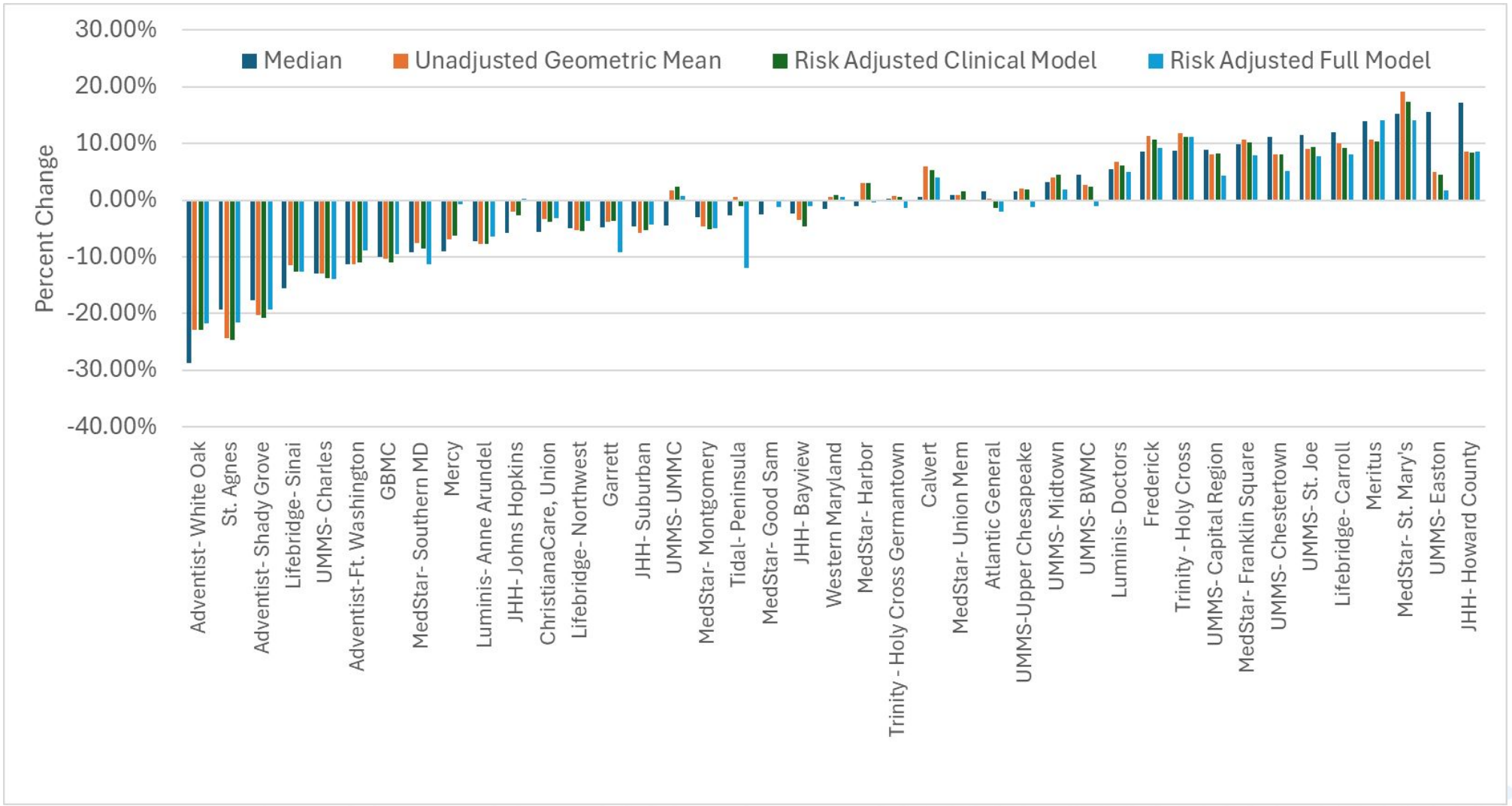
Testing an Inpatient Risk Adjusted Length of Stay Measure

- Risk adjustment models aim to control for factors affecting the outcome (ED LOS) that are outside the control of the hospital
  - Could include patient-level or hospital–level factors
  - Model geometric mean ED-LOS: closer than mean ED-LOS to median, models of geometric mean explain a higher proportion of ED-LOS variation
- Hospital-level factors could add explanatory power to the risk adjustment model (e.g., trauma level, community characteristics)
  - With only 41 acute care Maryland hospitals in model, effects of hospital characteristics could not confidently be distinguished from variation in individual hospitals' performance
  - Need national norms to measure effects of hospital-level risk factors
  - Elected to base candidate risk adjusted ED-LOS measure on patient characteristics alone
- Patient-level models
  - Tested models with all patient risk factors, all patient factors but observation stay occurrence, and models with only clinical factors
  - Also measured variation by quarter across years to capture seasonal effects

Evaluation of Risk Adjusted Measure

- Inpatient models, clinical risk factors and occurrence of observation stay are most powerful predictors
  - Observation stay occurrence as a risk factor is appropriate in some cases and not in others which are difficult to distinguish.
- Patient load and seasonal effects explain variation within hospital but have small effects on comparisons between hospitals
- Even models with all candidate patient risk factors explain only a small proportion of variation
- Recommend using ED-LOS improvement as performance measure
- Yearly changes in adjusted and unadjusted ED-LOS correlated at >0.99 for clinical risk factors, >0.95 for models with all candidate patient risk factors

Percent Change by Hospital CY 2024 - CY 2025



See Handout

Change to geometric mean contributes to the differences in results

Handout includes models with observation variables

MHAC

PPC-PSI Composite Overlaps

Weighted:

	Weighted Average Numerator Percentage	Weighted Average Denominator Percentage
PPC Only	41.1%	59.5%
PSI Only	45.1%	6.6%
PSI and PPC	13.8%	33.8%

Unweighted:

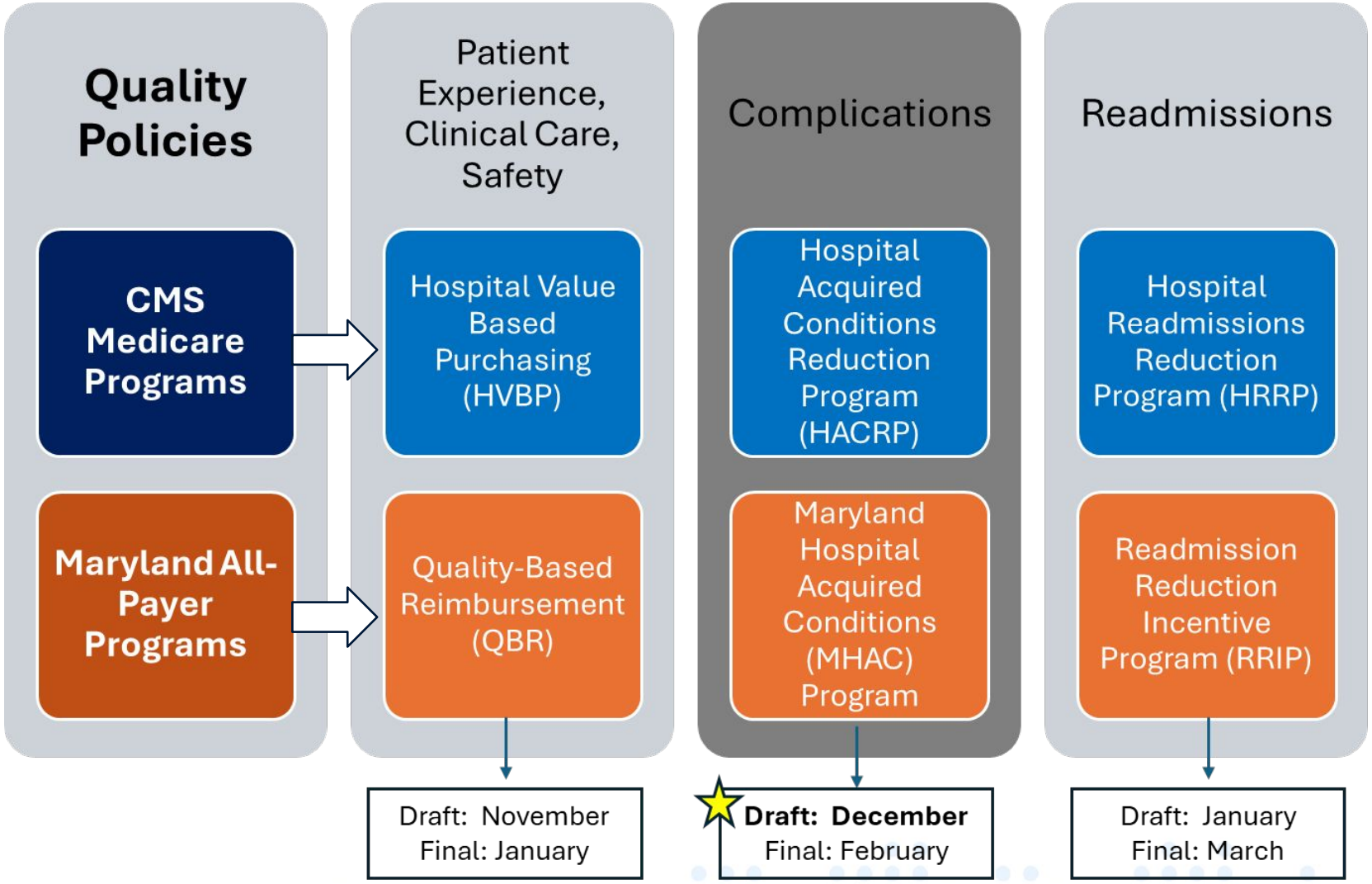
	Unweighted Average Numerator Percentage	Unweighted Average Denominator Percentage
PPC Only	39.0%	63.2%
PSI Only	39.6%	8.4%
PSI and PPC	21.4%	28.4%

RRIP

		Sep-Aug (incorrect OOS ratios, went into rates)			Sep-Aug (correct OOS ratios)				
		Final Adjustment			Final Adjustment				
HOSPITAL ID	HOSPITAL NAME	$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	How much better they perform with corrected OOS ratios ($)	How much better they perform with corrected OOS ratios (%)
210017	Garrett	-$22,236	-0.07%	Att	-$181,061	-0.57%	Att	-$158,825	-0.50%
210037	UMMS- Easton	$2,324,864	1.68%	Att	$1,923,548	1.39%	Att	-$401,316	-0.29%
210061	Atlantic General	$4,984	0.01%	Att	-$134,567	-0.27%	Att	-$139,551	-0.28%
210003	UMMS- Capital Region	$1,073,652	0.33%	Att	$422,954	0.13%	Att	-$650,698	-0.20%
210030	UMMS- Chestertown	$216,606	2.00%	Att	$203,610	1.88%	Att	-$12,996	-0.12%
210018	MedStar- Montgomery	-$482,409	-0.45%	Att	-$557,451	-0.52%	Att	-$75,042	-0.07%
210057	Adventist- Shady Grove	-$2,022,306	-0.56%	Att	-$2,166,756	-0.60%	Att	-$144,450	-0.04%
210002	UMMS- UMMC	-$9,277,409	-0.59%	Att	-$9,434,653	-0.60%	Att	-$157,244	-0.01%
210001	Meritus	-$2,346,651	-0.87%	Imp	-$2,346,651	-0.87%	Imp	$0	0.00%
210004	Trinity - Holy Cross	-$2,732,693	-0.62%	Imp	-$2,732,693	-0.62%	Imp	$0	0.00%
210005	Frederick	$281,446	0.11%	Imp	$281,446	0.11%	Imp	$0	0.00%
210008	Mercy	$48,819	0.02%	Imp	$48,819	0.02%	Imp	$0	0.00%
210009	JHH- Johns Hopkins	-$574,597	-0.03%	Imp	-$574,597	-0.03%	Imp	$0	0.00%
210011	St. Agnes	$1,457,101	0.52%	Imp	$1,457,101	0.52%	Imp	$0	0.00%
210012	Lifebridge- Sinai	-$4,111,753	-0.78%	Imp	-$4,111,753	-0.78%	Imp	$0	0.00%
210015	MedStar- Franklin Square	-$4,482,989	-1.10%	Imp	-$4,482,989	-1.10%	Imp	$0	0.00%
210016	Adventist- White Oak	-$26,934	-0.01%	Imp	-$26,934	-0.01%	Imp	$0	0.00%
210019	Tidal- Peninsula	$2,744,095	0.77%	Imp	$2,744,095	0.77%	Imp	$0	0.00%
210022	JHH- Suburban	$968,411	0.35%	Imp	$968,411	0.35%	Imp	$0	0.00%
210023	Luminis- Anne Arundel	-$3,190,937	-0.76%	Imp	-$3,190,937	-0.76%	Imp	$0	0.00%
210024	MedStar- Union Mem	-$1,931,363	-0.63%	Imp	-$1,931,363	-0.63%	Imp	$0	0.00%
210027	Western Maryland	$185,895	0.09%	Imp	$185,895	0.09%	Imp	$0	0.00%
210028	MedStar- St. Mary's	$1,295,632	1.30%	Imp	$1,295,632	1.30%	Imp	$0	0.00%
210029	JHH- Bayview	-$3,791,985	-0.75%	Imp	-$3,791,985	-0.75%	Imp	$0	0.00%
210032	ChristianaCare, Union	$400,170	0.36%	Imp	$400,170	0.36%	Imp	$0	0.00%
210033	Lifebridge- Carroll	$0	0.00%	Imp	$0	0.00%	Imp	$0	0.00%
210034	MedStar- Harbor	-$726,506	-0.53%	Imp	-$726,506	-0.53%	Imp	$0	0.00%
210038	UMMS- Midtown	-$437,019	-0.31%	Imp	-$437,019	-0.31%	Imp	$0	0.00%
210040	Lifebridge- Northwest	-$1,145,528	-0.66%	Imp	-$1,145,528	-0.66%	Imp	$0	0.00%
210043	UMMS- BWMC	-$2,406,633	-0.73%	Imp	-$2,406,633	-0.73%	Imp	$0	0.00%
210048	JHH- Howard County	$153,684	0.06%	Imp	$153,684	0.06%	Imp	$0	0.00%
210051	Luminis- Doctors	$585,123	0.30%	Att	$585,123	0.30%	Att	$0	0.00%
210056	MedStar- Good Sam	$1,098,248	0.55%	Imp	$1,098,248	0.55%	Imp	$0	0.00%
210058	UMMS- UMROI	-$202,066	-0.23%	Att	-$202,066	-0.23%	Att	$0	0.00%
210060	Adventist-Ft. Washington	-$22,395	-0.06%	Imp	-$22,395	-0.06%	Imp	$0	0.00%
210062	MedStar- Southern MD	$1,538,713	0.73%	Imp	$1,538,713	0.73%	Imp	$0	0.00%
210063	UMMS- St. Joe	-$977,144	-0.32%	Imp	-$977,144	-0.32%	Imp	$0	0.00%
210064	Lifebridge- Levindale	$1,420,513	2.00%	Att	$1,420,513	2.00%	Att	$0	0.00%
210065	Trinity - Holy Cross Germantown	-$469,575	-0.44%	Imp	-$469,575	-0.44%	Imp	$0	0.00%
210044	GBMC	$1,402,356	0.51%	Att	$1,484,848	0.54%	Att	$82,492	0.03%
210049	UMMS-Upper Chesapeake	-$2,993,814	-1.15%	Att	-$2,655,383	-1.02%	Att	$338,431	0.13%
210035	UMMS- Charles	-$84,173	-0.08%	Imp	$147,303	0.14%	Att	$231,476	0.22%
210039	Calvert	-$679,575	-0.80%	Att	-$450,219	-0.53%	Att	$229,356	0.27%
	Net total	**-$27,938,378**	-0.22%		**-$28,796,745**	-0.23%		**-$858,367**	-0.01%
	Penalties	-$45,138,690	-0.36%		-$45,156,858	-0.36%		-$18,168	0.00%
	Rewards	$17,200,312	0.14%		$16,360,113	0.13%		-$840,199	-0.01%

HSCRC RY 2028 Policy Timelines

Quality Policy Portfolio & RY 2028 Policy Calendar



maryland health services cost review commission

For Discussion: Alignment Prioritization and Phases

- **QBR-HVBP:** HSCRC staff has prioritized CY2026 alignment given lack of evidence higher HCAHPS weight leads to improvement, program complexity, and number of MD-specific measures.
- **MHAC-HACRP:** Given revenue adjustment methodology includes scaled adjustments with rewards, staff propose maintaining program in RY 2028 with possible addition of PSI if removed from QBR. Alignment with HACRP or non-Medicare FFS policy development for RY 2029 will consider continued use of PPCs, PSIs, NHSN, and digital measures, as well as 1 percent penalty only revenue adjustments.
- **RRIP-HRRP:** Staff propose future RRIP policy should align with statewide all-payer readmissions goals under AHEAD vs. HRRP direct alignment; current policy includes improvement goal through CY2026 that could be used for RY 2028 and during CY 2026 focus could be on development of new all-payer measure that aligns with statewide goal for RY 2029. Once developed, penalty only program and weighting of HRRP at 3 percent could be considered.

RY 2025

Program	Statewide Net Total	%	Penalties	%	Rewards	%
QBR	$ (22,306,439)	-0.19%	$ (33,161,827)	-0.28%	$ 10,855,388	0.09%
VBP	$ 33,592,568	0.28%	$ (26,604,218)	-0.22%	$ 60,196,786	0.51%
RRIP	$ 14,102,128	0.12%	$ (28,215,336)	-0.24%	$ 42,317,464	0.36%
HRRP	$ (23,397,753)	-0.20%	$ (23,397,753)	-0.20%	$ -	-
MHAC	$ 39,309,084	0.33%	$ (8,879,421)	-0.07%	$ 48,188,505	0.41%
HACRP	$ (63,317,885)	-0.53%	$ (63,317,885)	-0.53%	$ -	-
HSCRC Programs	$ 31,104,773	0.26%	$ (70,256,584)	-0.59%	$ 101,361,358	0.86%
National Programs	$ (53,123,069)	-0.45%	$ (113,319,856)	-0.96%	$ 60,196,786	0.51%

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