maryland
health services
cost review commission

Performance Measurement Workgroup

December 17, 2025

HSCRC Quality Team

Meeting Agenda

- AHEAD Update
- RY 2028 Final Quality Based Reimbursement (QBR) Policy
- RY 2028 Draft Maryland Hospital Acquired Conditions (MHAC) Policy
- RY 2028 Draft Readmission Reduction Incentive Program and AHEAD Population Health Accountability Plan
- Inpatient Length of Stay Incentive
- ED Updates
  - ED LOS Risk-Adjustment Measure for RY27 QBR
  - ED Best Practices Final Policy--approved

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.

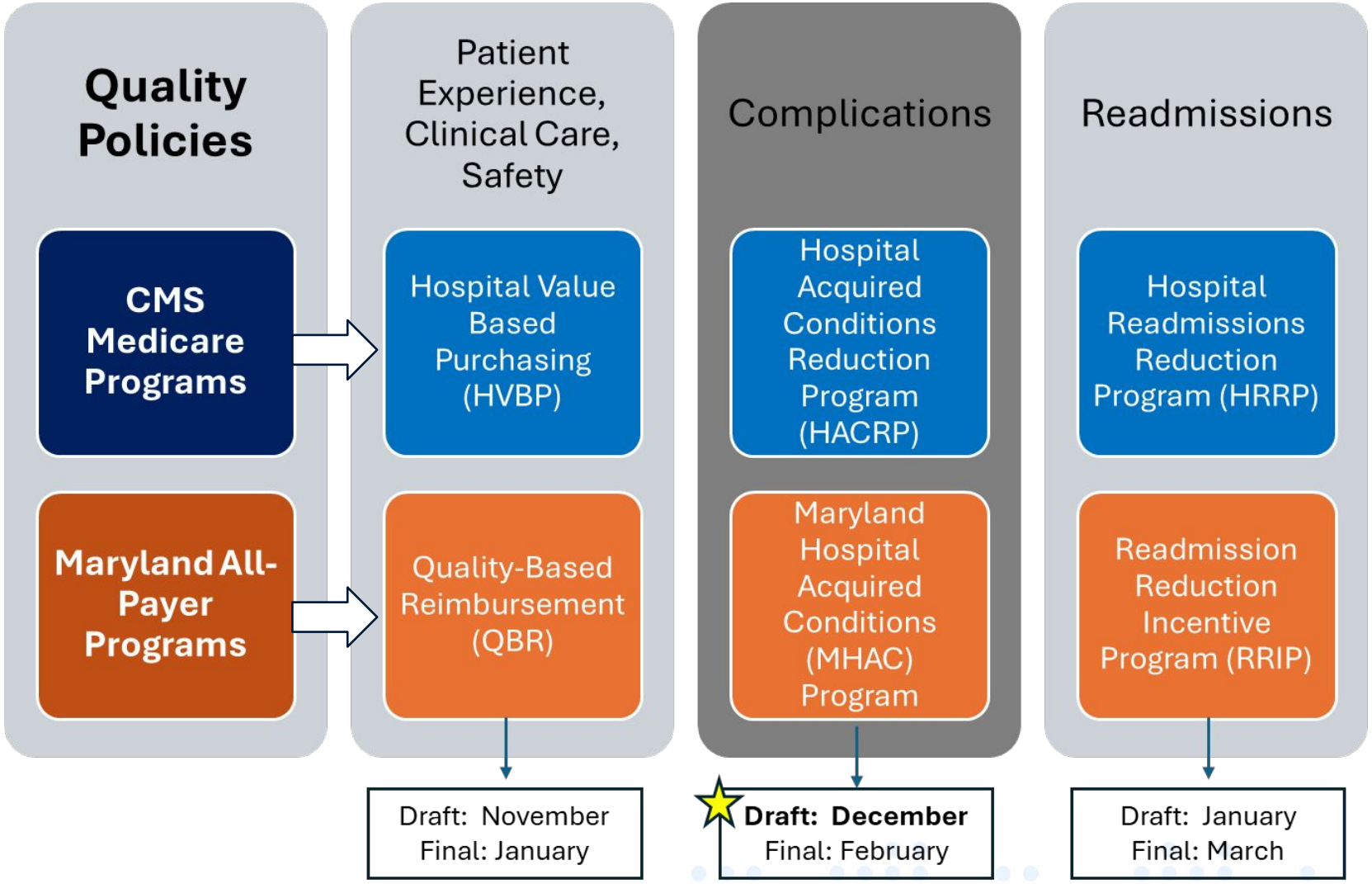
REMINDER: These workgroup meetings are recorded.

AHEAD Updates and HSCRC RY 2028 Policy Timelines

AHEAD Updates and Transition Timelines

- Maryland will enter the AHEAD Model beginning in 2026.
- CMS will set **Medicare FFS global budgets** starting in 2028.
  - Performance Year 1 (2026) and PY2 (2027) will be 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 re-direct a portion of the total Medicare global budget amount between PY3 (2028) and PY5 (2030).
- The State will continue to set **non-Medicare FFS global budgets** with quality adjustments.
- **All hospitals have signed AHEAD participation agreements with CMMI**

Quality Policy Portfolio & RY 2028 Policy Calendar



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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.

RY 2028 QBR Policy and HVBP Alignment

QBR RY 2028 Draft Recommendations

1. Update Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.
2. Hold 2 percent of inpatient revenue at-risk (rewards and penalties) and maintain the revenue adjustment scale of 0 to 80 percent with prospective cut-point at 41 percent.
    a. Retrospectively evaluate 41 percent cut-point using more recent data to calculate national average score for RY 2026 and RY 2027.
    b. Based on concurrent analysis of national hospital performance, adjust the RY26 QBR cut-point to 32.68% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.
3. Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures; add a bonus incentive of $150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.

Criteria for QBR Alignment and Proposed Alignments

Alignment Criteria:

1. Alignment with CMS HVBP program
2. Maintain all-payer accountability and incentives for quality
3. Reduce retrospective measure evaluations to the extent possible
4. Areas of poor performance and/or priority area for State, hospitals, payers, or other stakeholders

Proposed Alignments:

- Lower weight on PCE domain/HCAHPS
- Removal of HCAHPS Linear measures
- Removal of Medicare TFU and disparity gap measures
- Removal/shift of PSI Composite from QBR to MHAC
- Addition of sepsis bundle (all-payer)
- Addition of THA-TKA complication measure (Medicare only)

RY 2028 QBR Draft Recommendations

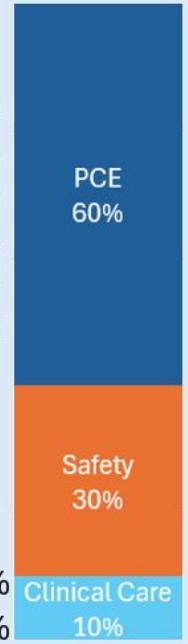
Criteria: 1. Alignment with CMS HVBP, 2. All-Payer Accountability, 3. Reduce retrospective measure evaluation, 4. Area of Poor Performance and/or Stakeholder Priority

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%



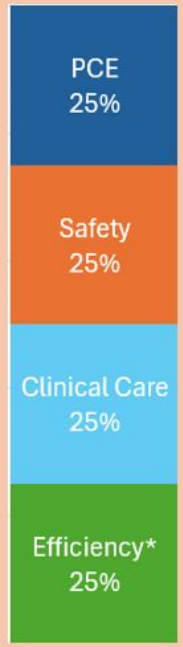
FY 2027 HVBP

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%



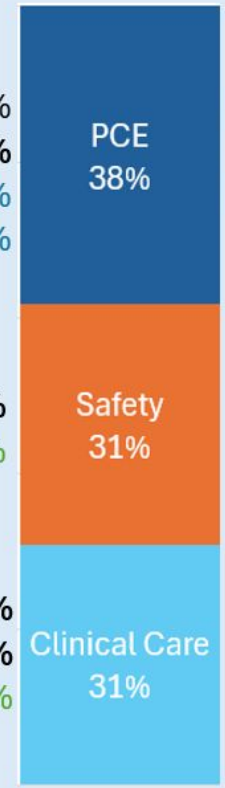
Partial Alignment

AHEAD PY1

HCAHP Top Box, 20%
HCAHPS Consistency, **5%**
ED Length of Stay, 10%
TFU Medicaid, 3%

NHSN, **26%**
Sepsis Bundle, 5%

All-Payer Inpatient Mortality, **13%**
All-Payer 30-Day Mortality, **13%**
THA-TKA Complications, 5%

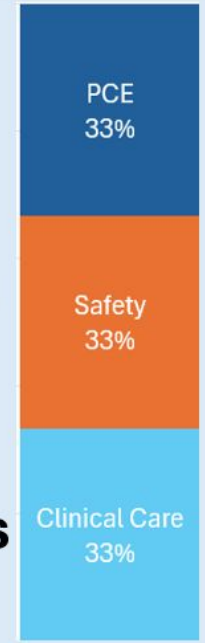


~~HCAHPS Linear, 10%~~
~~TFU Medicare + Disparity, 7%~~

~~All-Payer PSI, 5%~~

Full Transition

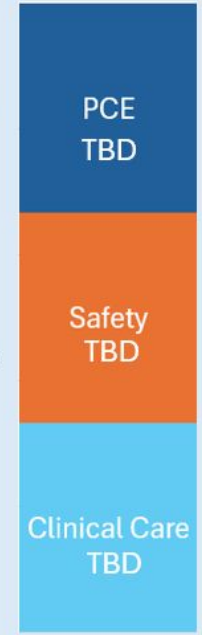
HVBP for CMS-Designed Medicare FFS Global Budgets



Quality Programs under AHEAD

Starting PY2 or PY3

QBR for State-Designed Global Budgets for Other Payers



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 .

Commissioner Questions on QBR Draft for Discussion

- Could quality programs be suspended during transition?
- Should State use CMS program results and apply to non-Medicare GBRs?
- Should domain weight from efficiency be wholly applied to HCAHPS/PCE?
- Should QBR be weighted more heavily (i.e., >2 percent) since progress has been limited on HCAHPS and ED LOS?

Amended and Restated Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model Maryland State Agreement: https://hscrc.maryland.gov/Pages/ahead-model.aspx

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

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

Medicaid Feedback on Overall Quality Under AHEAD

Medicaid feedback also provided in a letter:

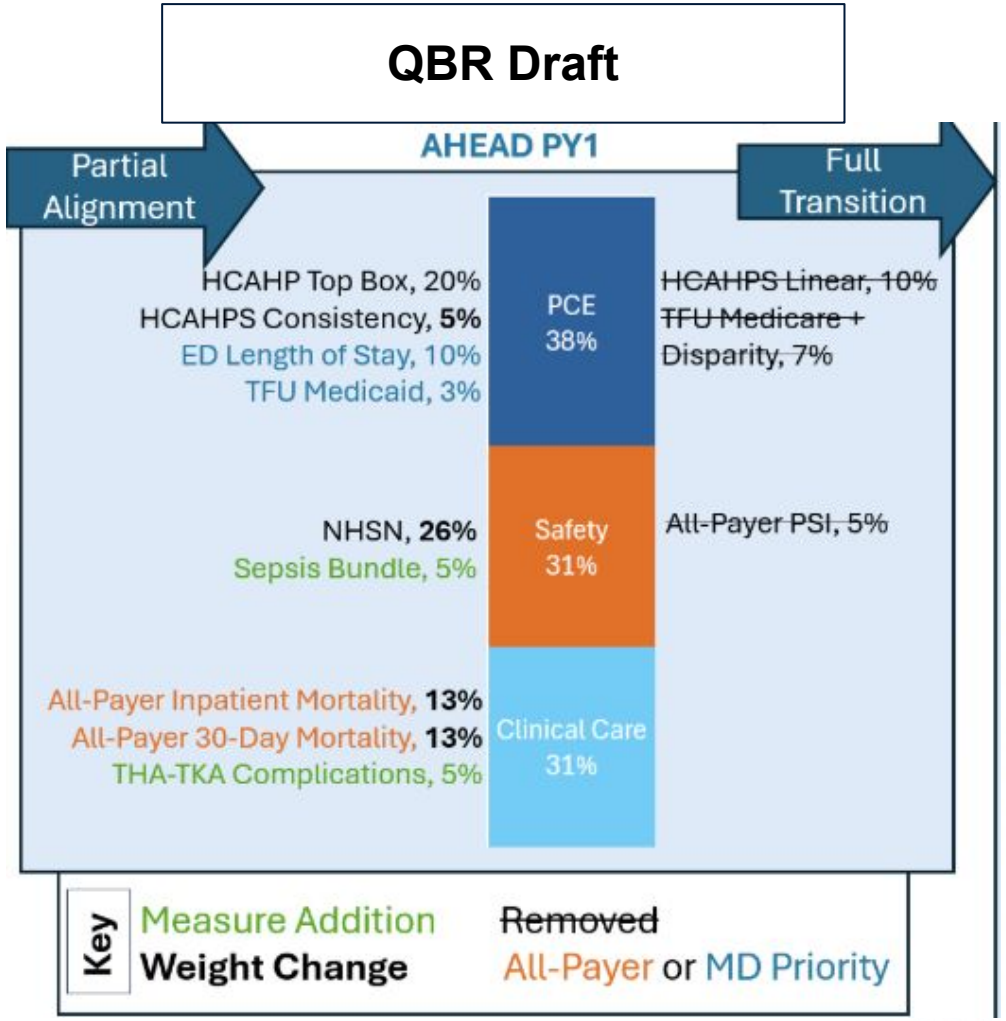
- Strongly urges continuation of hospital quality programs relevant to Medicaid by HSCRC
- Highlights measures such as Pediatric Quality Indicators in PAU and Medicaid Timely Follow up in QBR are particularly relevant for Medicaid
- Notes that an annual report submitted by the state must demonstrate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

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

Domain Weighting

MHA specified the following domain and measure weights:

- **Person and Community Engagement Domain** (33.3%):
  - HCAHPS Top Box (23.3%)
  - HCAHPS Consistency (10%)
- **Clinical Care Domain:** (33.3%)
  - All Payer 30-Day Mortality Measure (14.15%)
  - All Payer Inpatient Mortality Measure (14.15%)
  - THA-TKA Complication Measure (5%)
- **Safety Domain:** (33.3%)
  - NHSN (26%)
  - Sepsis Bundle (7.3%)



State-Based Monitoring Program

MHA and hospitals suggest developing a monitoring program with the following measures:

- ED LOS (Medstar notes understanding of need to include this, but recommends monitoring of Medicaid TFU)
- IP LOS
- Medicaid Timely Follow-Up (should Medicare TFU be in monitoring?)
- Any new measures proposed by HSCRC

Staff response:

- Provide discussion in final policy on monitoring recommendation but maintain draft recommendations for Commissioner vote
  - Would suggest monitoring plan be more fully developed, final recommendation may provide additional details on this for Commissioner consideration
- IP LOS draft is a separate and distinct incentive from QBR program, which will addressed independent of QBR recommendation

Discussion

Final policy will be presented at January Commission meeting

- Should staff modify domain weights?
- How should monitoring be accomplished? Where should performance be reported?
- Should revised cut-point be used for prospective cut-point? 32% vs 32.68%?
- Other items we should consider?

RY 2028 MHAC Draft Policy

RY 2028 Draft 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 the program under a non-Medicare FFS quality program.

Comparison of MHAC and CMS Hospital Acquired Conditions Reduction Program (HACRP)

	Maryland MHAC Program	CMS HACRP Program
Revenue at Risk	**Rewards and Penalties:** Up to **2 percent** of inpatient revenue for **rewards or penalties** based on preset scale.	**Penalty Only: Full 1 percent penalty** applied to Medicare hospital revenue for **worst performing quartile** of hospitals.
Measures	16 All-Payer Potentially Preventable Complications (PPCs)	5 CDC NHSN Healthcare-Associates Infections AHRQ Patient Safety Indicator Composite (PSI-90) for Medicare
Scoring Calculation	**PPC Composite:** Weighted sum of the hospital's observed divided by the weighted sum of the hospital's expected for each payment PPC measure for which a hospital has any expected. **Performance Standard:** Convert the PPC composite to a percent score by comparing results to a threshold and benchmark, which is set at average of 20th and 80th percentiles from the base period.	**Total HAC Score:** Sum of winsorized z-scores for each measure the hospital is eligible. Hospitals need only one qualifying measure to be included. Each measure is equally weighted. Relatively rank hospitals and penalize the worst performers.
RY 2028 Time Periods	Base: July 2023 through June 2025 Performance: CY 2026* *CYs 2025 and 2026 for small hospitals	PSI-90: July 2024 through June 2026. CDC NHSN HAIs: January 2025 through December 2026

RY 2028 MHAC Measure Recommendations

- **PPCs:** Maintain the RY 2027 all-payer PPC composite that includes a focused list of 16 clinically significant PPC measures.
- **AHRQ PSI-90:** Add all-payer AHRQ PSI-90 composite measure weighted similarly to CMS HACRP (i.e., 1/6th of MHAC score).
- **NHSN HAIs:** Maintain the NHSN HAI measures in the QBR program.

Re-convene the Clinical Adverse Events Measures subgroup in Spring of 2026 to assess available complication measures for use in a state program for non-Medicare payers.

Draft policy and appendix slides provide performance on complication measures under consideration. HSCRC will send out excel with hospital modeled results under different scenarios.

Payment PPCs List and PSI Composite Measures

Payment PPC	PSI-90
3- Acute Pulmonary Edema and Resp Failure w/o Ventilation	11- Postoperative Respiratory Failure
4- Acute Pulmonary Edema, Resp Failure w/ventilation	11- Postoperative Respiratory Failure
5- Pneumonia and other lung infections	
6- Aspiration pneumonia	
7- Pulmonary Embolism	12- Perioperative Pulmonary Embolism or Deep Vein Thrombosis
9- Shock	
16- Venous Thrombosis	12- Perioperative Pulmonary Embolism or Deep Vein Thrombosis
28- In-Hospital Trauma and Fractures	08- In Hospital Fall-Associated Fracture

Non-Medicare Payment PPCs

Payment PPC	PSI-90
35- Septicemia & Severe Infections	13- Postoperative Sepsis
37- Perioperative Infection & Deep Wound Disruption Without Procedure	14-Postoperative Wound Dehiscence
41- Perioperative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D	09- Postoperative Hemorrhage or Hematoma
42- Accidental Puncture/Laceration During Invasive Procedure	15- Abdominopelvic Accidental Puncture or Laceration
47- Encephalopathy	
49- Iatrogenic Pneumothorax	06- Iatrogenic Pneumothorax
60- Major Puerperal Infection and Other Major Obstetric Complications	
61- Other Complications of Obstetrical Surgical & Perineal Wounds	
	10 Postoperative Acute Kidney Injury Requiring Dialysis
	03 Pressure Ulcer

Modeled Revenue Adjustments

Penalties remain similar when the PSI-90 is added but rewards are reduced by almost $10 M statewide due to use of state performance standards.

Net revenue adjustments using FY 2025 HACRP scores and MD revenue adjustment scaling with rewards and penalties is estimated to be -$27.4 M.

RY 2026 Modeling	PPCs Only	PPCs and PSIs
Net Total $	**$30,107,361**	**$19,680,755**
Penalty $	-$42,239,158	-$42,753,131
Percent Inpatient	-0.36%	-0.36%
Reward $	$72,346,519	$62,433,886
Percent Inpatient	0.61%	0.53%

RY 2028 Draft 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 the program under a non-Medicare FFS quality program.

Readmissions Updates

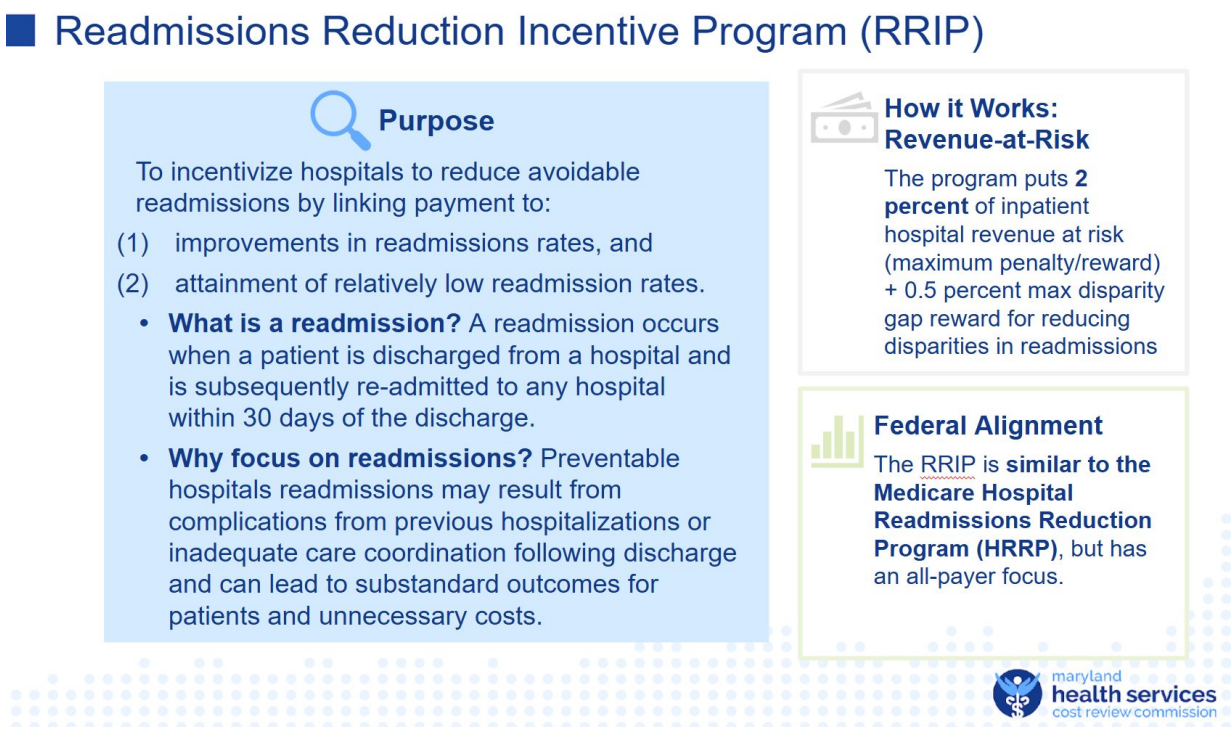
AHEAD PHAP

RY 2028 RRIP Priorities

AHEAD's Population Health Accountability Plan

Background

- Under the Maryland Model (2014-25), CMMI required the State to reduce Medicare FFS readmissions and hold hospitals accountable for all-payer readmissions.
- Health Services Cost Review Commission (HSCRC) administers an all-payer, pay-for-performance program (Readmission Reduction Incentive Program (RRIP) to incentivize hospitals to reduce readmissions.
- For the AHEAD model, the State Health Equity Plan is not being referred to as the Population Health Accountability Plan (PHAP) which was submitted on October 15th.



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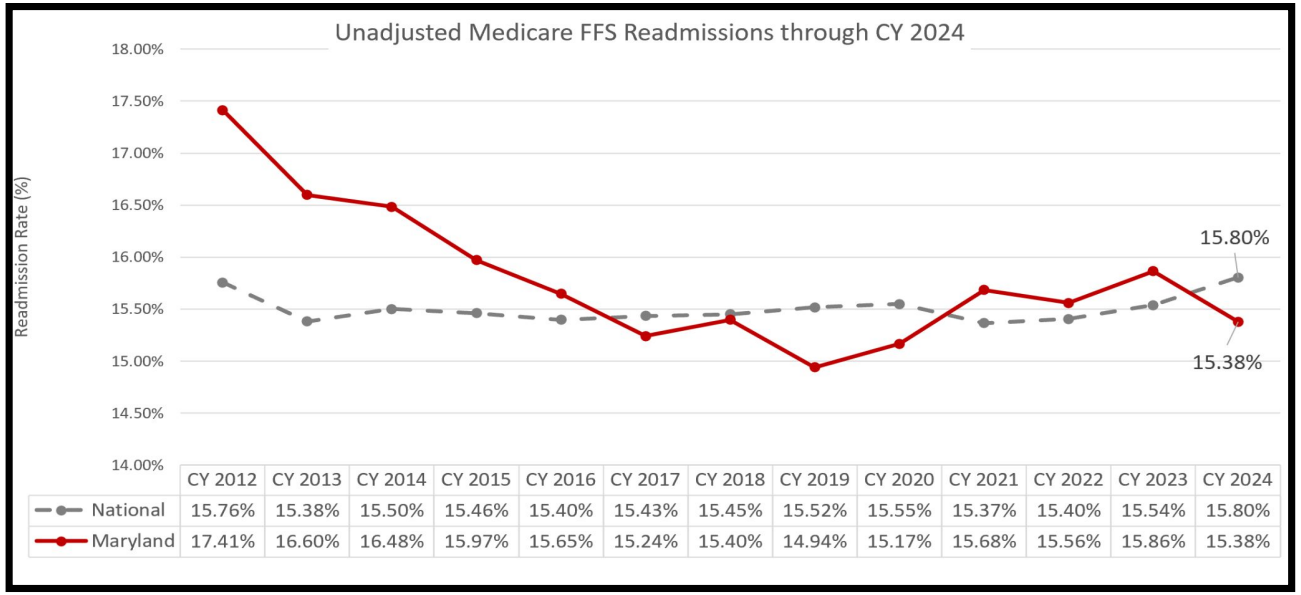
Maryland Performance

- Maryland has made significant progress in reducing readmissions over the past decade
  - MD is performing better than the Nation on the Medicare unadjusted and risk-adjusted readmission (not shown) measures used for the TCOC model.
  - Since 2018, RRIP Readmissions have gone down by 7.63 percent across all-payers, with greater reductions for Medicare FFS and Medicaid MCOs.
- **AHEAD targets should take into account the significant improvements already achieved in Maryland.**



	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%	15.54%	15.80%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%	15.86%	15.38%

RRIP Case-Mix Adjusted Readmissions

	All-Payer	Medicare FFS	Medicaid MCO
2018	12.59%	13.53%	14.20%
2024	11.63%	12.45%	12.82%
% Change	-7.63%	-7.97%	-9.73%

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Domain	Measure	2023 Baseline	Target for 2027 (PY2)	Target for 2036 (PY10)
Population Health	CDC HRQOL-4 Healthy Days Core Module (Self-reported Health Status)	16.5% with poor or fair health	16.5% with poor or fair health	16.5% with poor or fair health
Prevention and Wellness	Colorectal Cancer Screening	49.3%	50.7% with screening	54.6% with screening
Chronic Conditions	Hemoglobin A1c Control for Patients with Diabetes (>9.0%)	67.8%	65.8% with poor control	60.3% with poor control
Behavioral Health	Follow-up After Hospitalization for Mental Illness	64.3% at 30 days; 38.0% at 7 days	64.8% follow-up at 30 days; 38.5% at 7 days	66.8% follow-up at 30 days; 40.5% at 7 days
Utilization	Plan All-Cause Unplanned Readmission	O/E= 1.01	O/E=1.00	O/E=0.98
“Optional”	Food Insecurity	16.4% food insecure	16.4% food insecure	15.0% food insecure

NCQA Plan All-Cause Readmissions (PCR) Specifications

CMMI Recommended Measure

Measure Component	Description
Description	The risk adjusted ratio of Observed/Expected unplanned all-cause readmissions based on discharges between January 1 and December 1 of the measurement year at the plan level.
Numerator	The observed numerator is all unplanned eligible **observation stays and readmissions within 30 days** of an eligible discharge. The expected numerator is weighted based on measure specifications.
Denominator	The eligible population is **any acute inpatient or observation stay** discharge occurring during the measurement year after removing exclusions listed below; **patients must be 18 or older** during month of discharge date
Exclusions	**Hospice and/or death** at any time during the measurement year; **Perinatal admissions, potentially planned procedures, organ transplant, chemotherapy, and psychiatric/rehab facilities and transfer/**inpatient admission are also excluded.
Continuous Enrollment	The year prior to index admission up until 30 days post index admission.
Outliers	**Medicaid and Medicare: Individuals with four or more admissions** during the measurement year. Commercial: Individuals with **three or more admissions** during the measurement year.
Risk adjustment	This measure is risk-adjusted and can be stratified by **age, payer and SNF/DE status** based on predetermined weights within the specifications.

PCR Measure: Observed to Expected Ratio

PCR measure is a risk-adjusted ratio that compares the observed readmission count to the expected readmission count. The expected count is calculated by assessing the risk of the hospital stay by payer based on the patient and the nature of the hospitalization - **age, gender, observation stay status, surgical procedure, and discharge condition.**

The measure is reported as an observed-to-expected (O/E) ratio. For the O/E ratio, **lower** is better.

- O/E ratio < 1.0 means that there were **fewer** readmissions than expected given the case mix
- O/E ratio = 1.0 means that the number of readmissions was the **same** as expected given the case mix
- O/E ratio > 1.0 means that there were **more** readmissions than expected given the case mix

Rates presented use the NCQA Measure Year 2024 specifications.

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To note, there were significant differences in the risk adjustment model for commercial from 2023 to 2024.

Plan All-Cause Readmissions (PCR) Calculation

A. Index hospital stays (IHS): Count of discharges eligible for readmission after exclusions

B. Observed readmissions: Count of IHS followed by at least one readmission within 30 days of discharge

C. Expected readmissions: Sum of readmission risk based on risk adjustment rates of each IHS

D. O/E ratio: Count of observed readmissions/ Count of expected readmissions

Calendar Year 2023			
A. Count of IHS	**B. Count of observed readmissions**	**C. Count of expected readmissions**	**D. O/E ratio**
A	**B**	**C**	**D=B/C**
205,088	**19,427**	**19,172**	**1.0133**

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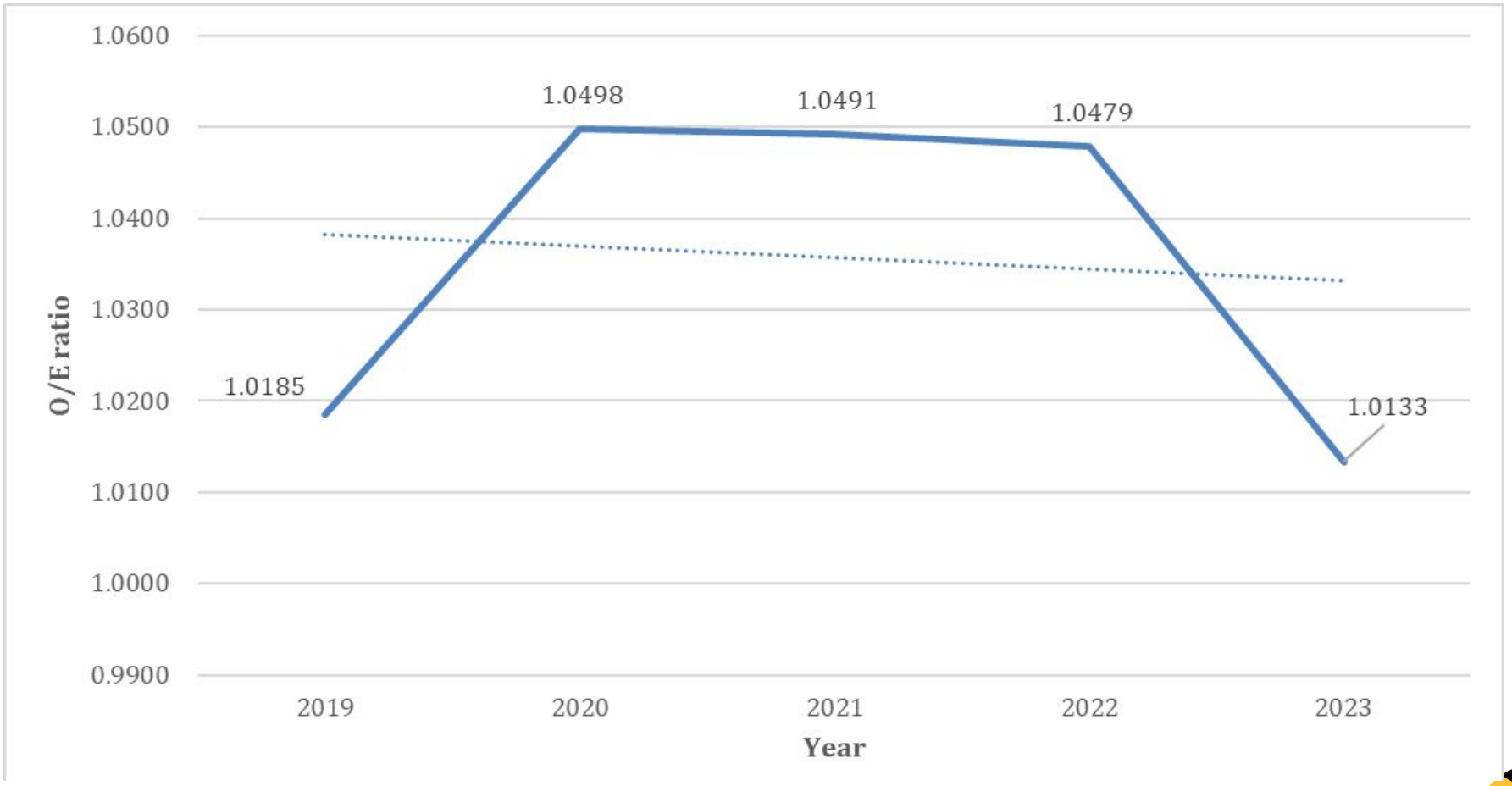
Plan All-Cause Unplanned Readmission (Claims)



Percent change (2019-2023): -0.51%

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Data Source: Maryland Medicaid 2019-2023, Maryland Medicare CCW 2019-2023, Commercial and Medicare Advantage from MCDB 2019-2023.

Target Setting Options

Approach 1: Time trend approach applying current O/E ratio trend

Approach 2: National approach (NCQA commercial and Medicaid benchmarks; HSCRC Medicare FFS and commercial benchmarks)

Approach 3: Time trend approach applying RRIP target (5% based on HSCRC benchmarking analysis for Medicare FFS and Commercial, historical trends, and opportunity analysis)

Approach	Year	O/E ratio	Change from 2023	Estimated Readmission Rate
Baseline	2023	1.0133		9.60%
1	2034	1.0002	-1.29%	9.47%
2	2034	0.9822	-3.07%	9.30%
3	2034	0.9620	-5.06%	9.11%

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RY 2028 RRIP Priorities

RY 2028 AHEAD Transition RRIP Discussion Points

- What steps should the state take for alignment?
  - With which measure should we aim to align? AHEAD's NCQA measure or HRRP's condition specific measure?
  - If HRRP, should there be changes to the revenue adjustment methodology (i.e., no rewards with max penalty at 3%)?
- What will measurement look like once Medicare FFS global budgets are set by CMS?
  - Do we maintain all-payer measurement or non-Medicare FFS payers only?

HRRP vs RRIP

Feature	Maryland RRIP	National HRRP
Population	All patients, all payers	Medicare Fee-for-Service beneficiaries only
Conditions Measured	All-conditions, including psychiatric and adult oncology	Six specific conditions (i.e., AMI, COPD, HF, Pneumonia, CABG, THA/TKA)
Readmission Definition	30-day, all-cause, unplanned admissions	30-day, all-cause, unplanned admissions
Performance Measures	Both improvement (relative change) and attainment (absolute performance, adjusted for out-of-state readmissions)	Attainment only, stratified by percent duals
Incentives	Scaled **rewards and penalties,** capped at ±2% of inpatient revenue	**Scaled penalties only**, capped at 3% of Medicare payments
Data Source	State-based case-mix data (with unique patient identifiers across hospitals)	CMS Medicare claims data

RY 2028 Readmissions Staff Recommendations

- Maintain all-payer, all-cause readmission measure for CY 2026.
- Improvement Target: Maintain the statewide 4-year improvement target of -5% improvement through CY 2026 with a CY22/23 base.
- Attainment Target: Maintain attainment target at the 65th percentile of statewide performance.
  - Revise OOS ratios used for attainment to not double count readmissions for RY 2028 and retrospectively for RY 2027
- Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
- Monitor RRIP disparities (i.e., no reward only incentive).
- **Assess opportunities for AHEAD alignment of readmission measure, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.**

Inpatient Length of Stay

Potential Policy Development Timeline

PMWG Discussion #4	12/17/25
Presentation of draft policy to Commission	1/14/26
Final PMWG Discussion	01/21/26
Presentation of final policy to Commission	03/11/26

Risk Adjustment Considerations

- Stakeholders noted that payer and discharge disposition are potential confounders.
- Hospital OEs stratified by Medicare, Medicaid, commercial, discharge to home, and post-acute discharge are all correlated at >= 0.9 with the aggregate OE
- The majority of hospitals w/ aggregate OE > 1 had an OE > 1 on all stratified measures
- Based on these findings and policy considerations, post-acute status is not an appropriate risk adjustment variable
- Staff will review cell sizes after stratifying by payer to confirm feasibility of including in risk adjustment
- To assess the effect of extreme LOS values, OE ratios were estimated after winsorizing the top 1% of LOS. Resulting hospital OEs were correlated at 0.99 with raw OE ratios.

LOS Revenue Adjustment: Improvement

- Rewards will be available for hospitals with improvement exceeding 3.58% in 2026.
- Based on stakeholder feedback, those under the target will receive a negative adjustment of up to 1%

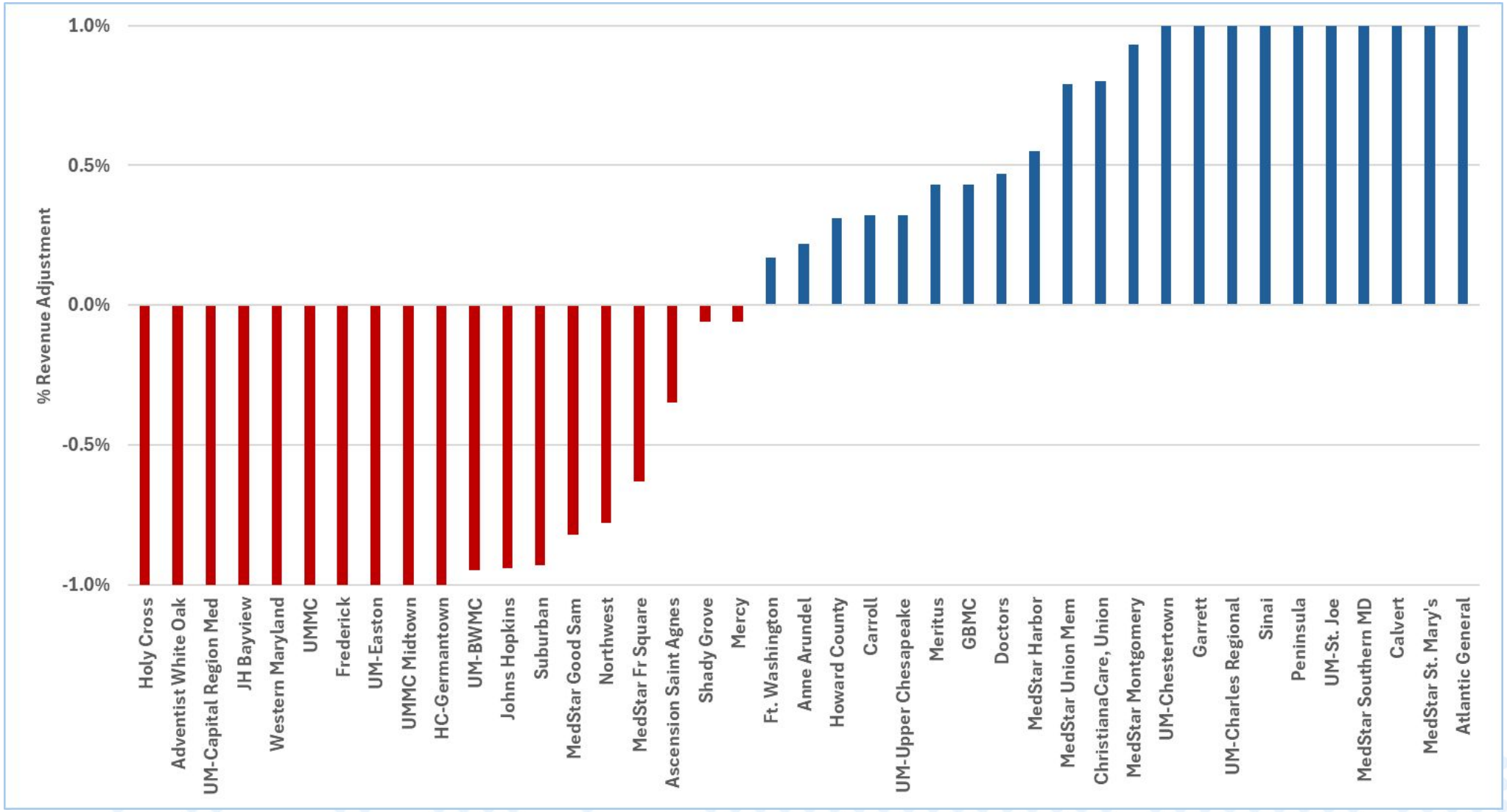
All Payer LOS Rate Change FY/25-26		LOS % IP Revenue Payment Adjustment
Improving		
	-8.40%	1.0%
	-7.44%	0.8%
	-5.51%	0.4%
Target	-3.58%	0.0%
	-1.65%	-0.4%
	0.28%	-0.8%
	1.24%	-1.0%
Worsening		

LOS Revenue Adjustment: Attainment

- The threshold for LOS attainment is set at 4.23 days, and the benchmark (90th percentile) is 3.86 days
- Hospitals with mean risk-adjusted LOS of 4.23 days or lower will receive a positive adjustment
- Based on stakeholder feedback, hospitals with performance below the threshold will receive a negative adjustment of up to 1% of inpatient revenue - symmetrical scaling

All Payer LOS Rate CY26		LOS % Inpatient Revenue Payment Adjustment
Lower LOS Rate		1.0%
Benchmark	3.86	1.0%
	3.93	0.8%
	4.08	0.4%
Threshold	4.23	0.0%
	4.38	-0.4%
	4.53	-0.8%
	4.60	-1.0%
Higher LOS Rate		1.0%

Revenue Adjustment by Hospital: Best of Improvement or Attainment, 2025



APR-DRG/SOI norms from HCUP NIS 2021. Performance period is FY25.

Next Steps

- Review PMWG stakeholder feedback
- Evaluate using more current state/Medicare norms
- Present draft policy to commissioners
- Update policy based on stakeholder comment letters
- Implement monitoring and reporting

Emergency Department Updates:

ED LOS Risk-Adjustment Measure for RY27 QBR

ED Best Practices Final Policy

ED LOS Measure-Development of Risk-Adjusted Measure

Development of Risk-Adjusted ED LOS Measure

- Hospital stakeholders have requested staff to explore risk-adjustment for the ED LOS measure
- 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.)
- For discussion today:
  - Overview of modeling
  - Risk-Factors included: Clinical model only vs. model with additional elements
  - Use of ED LOS for improvement vs. attainment
  - Preliminary results
  - Next steps

Risk-Adjustment Objectives

- Develop a measure of hospitals' ED length of stay that can identify opportunities for improvement by accounting for differences in their patient and visit characteristics
- Test exclusions and risk factors that permit fair comparisons across hospitals and over time

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 exponentiated mean of logs – reduces influence of outliers and approximates median if lognormally distributed

Inpatient model

- Calendar Year 2023, 2024 models fit
  - Coefficients for 2023 applied to 2024
- Admission APR-DRG, APR-MDC, admission risk of mortality and secondary psych diagnosis are clinical risk adjusters
- Includes inpatient admissions with observation stays
- ED stays with valid ED dates and times
  - Excludes maternity, trauma, burns, psychiatric, pediatric, homeless, chronic conditions, rehab
  - Excludes stays over 30 days long

Risk Factors Considered

Clinical characteristics

- Risk of mortality: On admission to inpatient stay
- APR-MDC: Admitting major diagnostic category from 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

- Primary 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

Initial patient model

Variable	DF	Type 1 SS	Mean square	F-stat	Probability
Ambulance Arrival	1	523.3942	523.394169	1093.97	<.0001
Admitting MDC	23	1345.695	58.508493	122.29	<.0001
Observation Stay	1	3356.597	3356.596948	7015.77	<.0001
Risk of Mortality	4	933.0807	233.270167	487.57	<.0001
Admitting APR-DRG	230	7341.201	31.918265	66.71	<.0001
Payer Group	4	250.8228	62.705707	131.06	<.0001
Sex	2	25.9258	12.9629	27.09	<.0001
Admission Source	9	237.7842	26.420462	55.22	<.0001
Age Group	14	100.2438	7.160271	14.97	<.0001
Arrival Hour	23	416.5561	18.111134	37.85	<.0001
Weekend Arrival	1	92.81218	92.812182	193.99	<.0001
Secondary Psych	1	56.76543	56.765426	118.65	<.0001
ED Census	1	447.8915	447.891489	936.16	<.0001
Observation Stay after ED	1	1468.379	1468.378806	3069.12	<.0001

R-square = .117

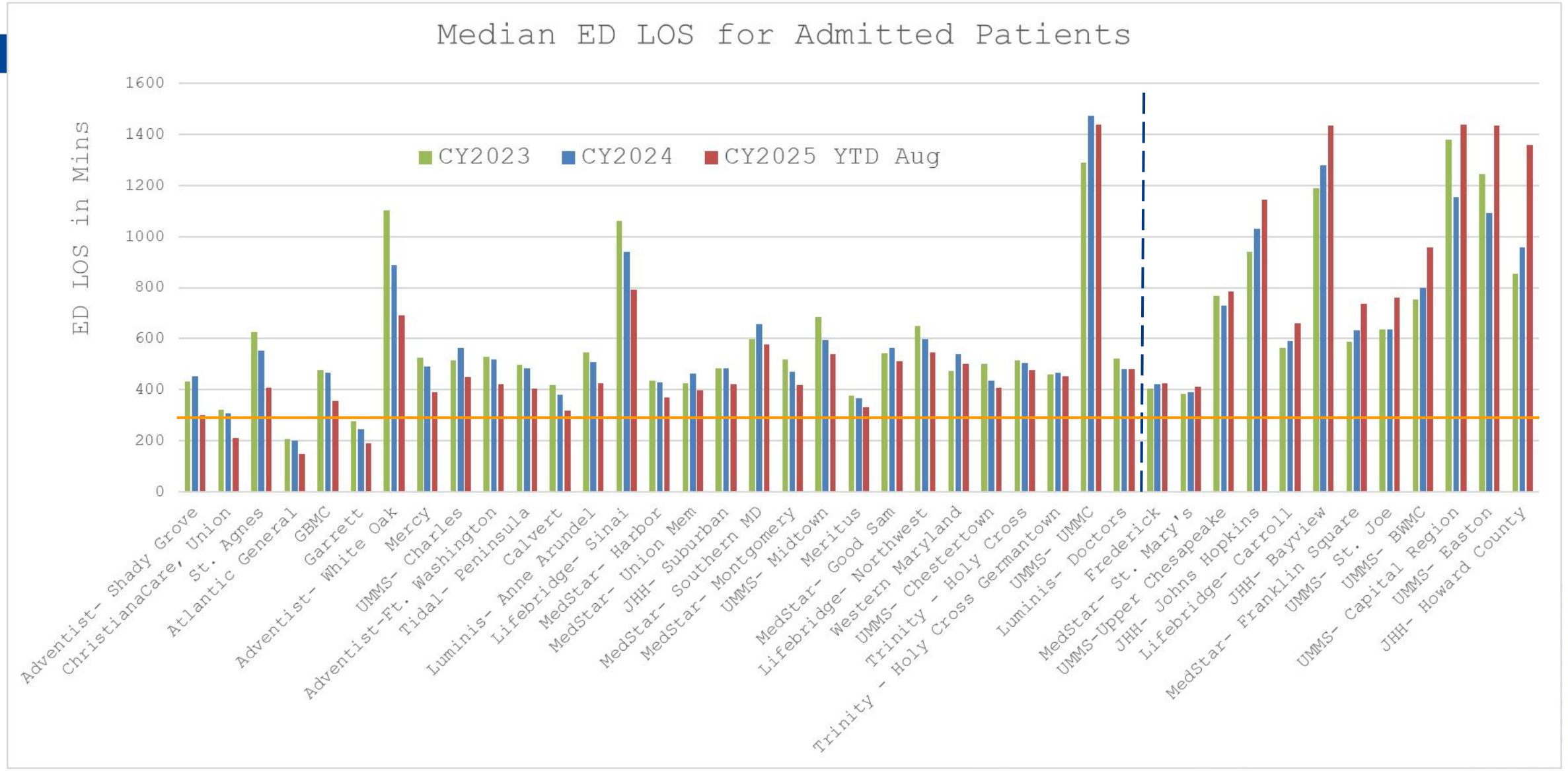
- With observation stay: 20 percent longer
- Medicare and Medicaid LOS is longer
- Shortest stays are at mid-day (controlling for census)
- ROM level 4 LOS is shorter than other ROM
- Secondary psych LOS is 3 percent longer
- Ambulance arrivals are 7 percent shorter
- Observation stay begins after ED stay: 64 percent shorter

Clinical model

Variable	DF	Type 1 SS	Mean square	F-stat	Probability
Admitting MDC	23	1477.887	64.255971	129.06	<.0001
Risk of Mortality	4	1283.087	320.771809	644.26	<.0001
Admitting APR-DRG	230	8588.52	37.341392	75	<.0001
Secondary Psych	1	103.6928	103.692824	208.26	<.0001

R-square = .080

Clinical model contains 3 of the 4 most powerful predictors from the full model (other is observation stay/ obs stay after ED) and retains much of its explanatory power



Sorted by percent change 2024 to 2025 ytd
Hospitals on left of line showed improvement
Hospitals to right of line showed increases
**CY 2025 Q1 data was not final data; will be updated by end of the month

2019 National Rate

Use of Risk-Adjusted ED LOS Variable in QBR

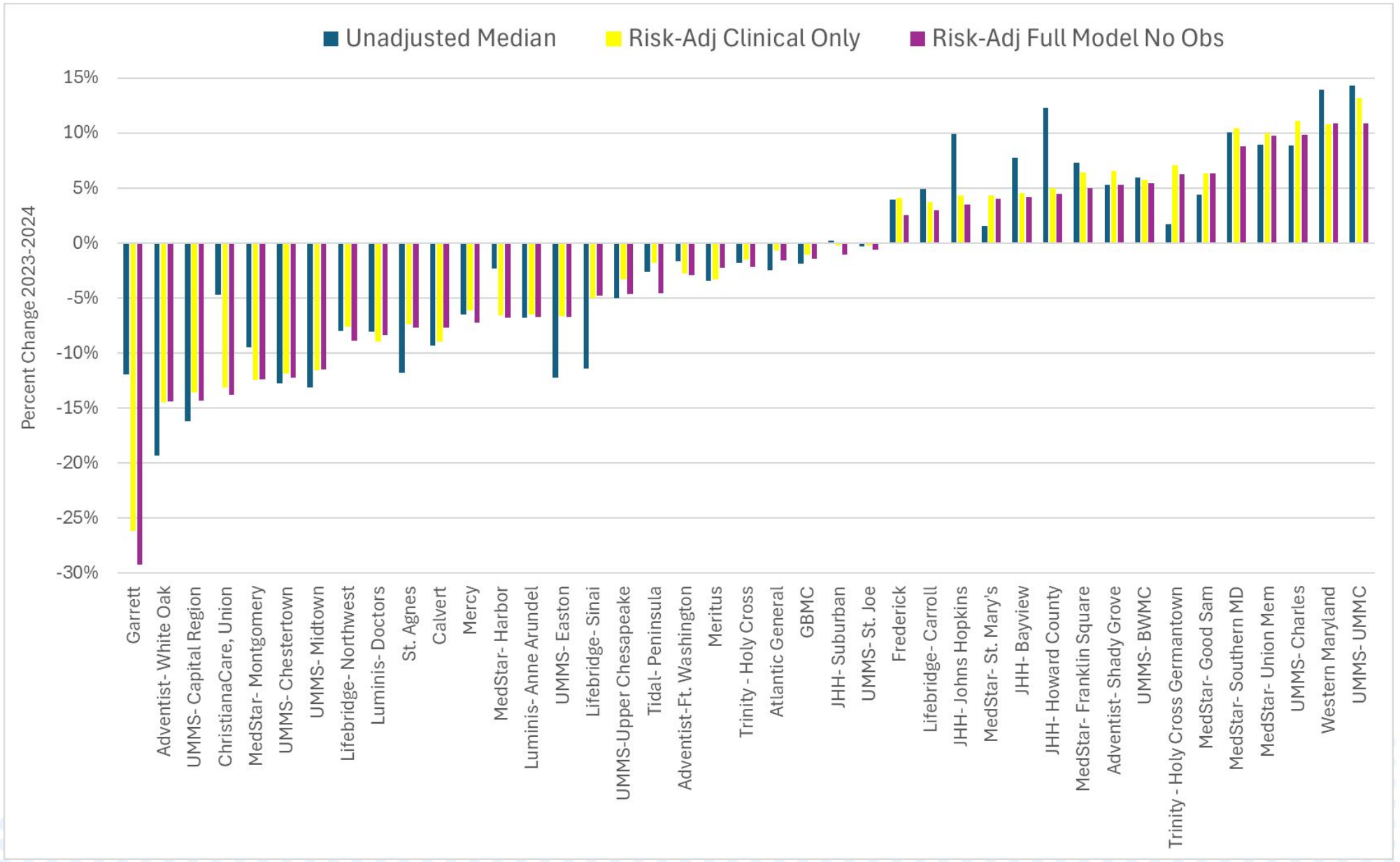
Attainment: Provide QBR credit for better performers

Improvement: Provide QBR credit for improvement

- ED Risk-Adjustment only accounts for small amount of the variation seen across hospital performance in both Clinical and Full Models.
- 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 2024) and provide those with rates below national average the full points.

Staff suggestion: Use risk-adjusted clinical model to assess improvement in ED LOS controlling for changes in patient mix over time for RY 2027; continue to assess impact of observation stays and additional risk-adjusters for RY 2028.

Percent Change by Hospital



See Handout

Change to geometric mean contributes to the differences in results

Handout includes models with observation variables

Next Steps Risk-Adjustment

- Review CY 2025 YTD risk-adjusted results
- Finalize RY 2027 risk-adjusted ED LOS measure and implement reporting
- Determine if ED LOS with risk-adjustment will be included in RY 2028 for payment or monitoring

ED Hospital Best Practice Policy Final Recommendations

Final Recommendations for RY 2028–**Approved on 12/10/2025**

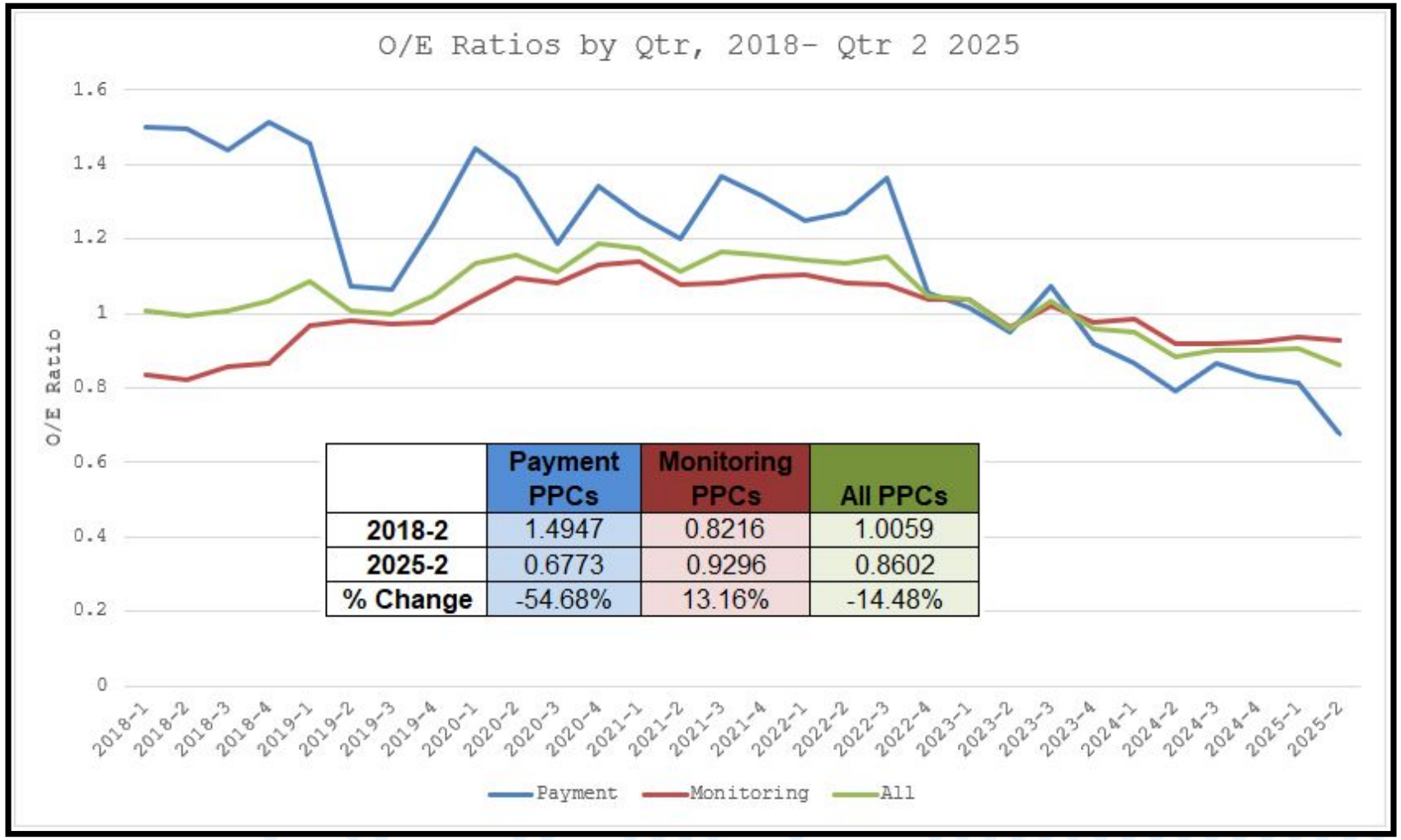
1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    - For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice. Weighting of tiers will be determined in CY 2026 after CY 2025 data is collected and analyzed.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2028.
    - Failure to implement and report data to the Commission by December 31st 2026 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2027.
3. We intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the CY 2025 and CY 2026 Best Practice program impact is assessed.

THANK YOU!

Next Meeting: January 21, 2025

Appendix

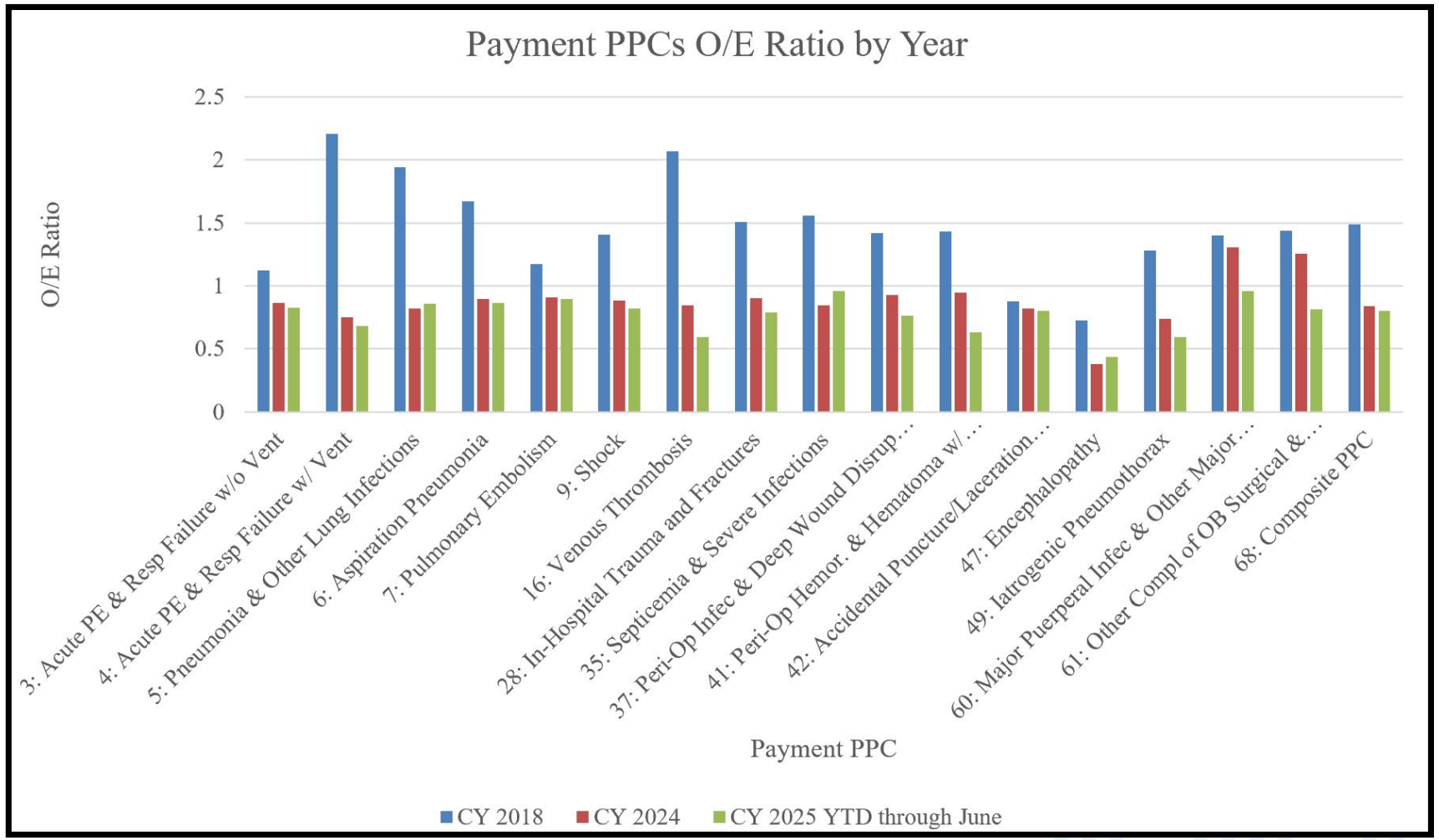
Overall Statewide PPC Performance Trends 2018 through 2025 Q2



	Payment PPCs	Monitoring PPCs	All PPCs
2018-2	1.4947	0.8216	1.0059
2025-2	0.6773	0.9296	0.8602
% Change	-54.68%	13.16%	-14.48%

- For All PPCs, statewide performance has improved since 2018.
- Payment PPCs continue to improve, particularly since 2022 Q3 (post-covid)
- Monitored PPCs have shown increases since 2018.

Performance on 16 Payment PPCs



- All PPCs improved between CY 2018 and CY 2025 YTD through June
- All PPCs had annual reductions between CY24 and CY25 except PPCs 5, 35 and 47 which had slight increases
- All PPCs in CY 2025 have O/E ratios less than 1, indicating all are less than expected.

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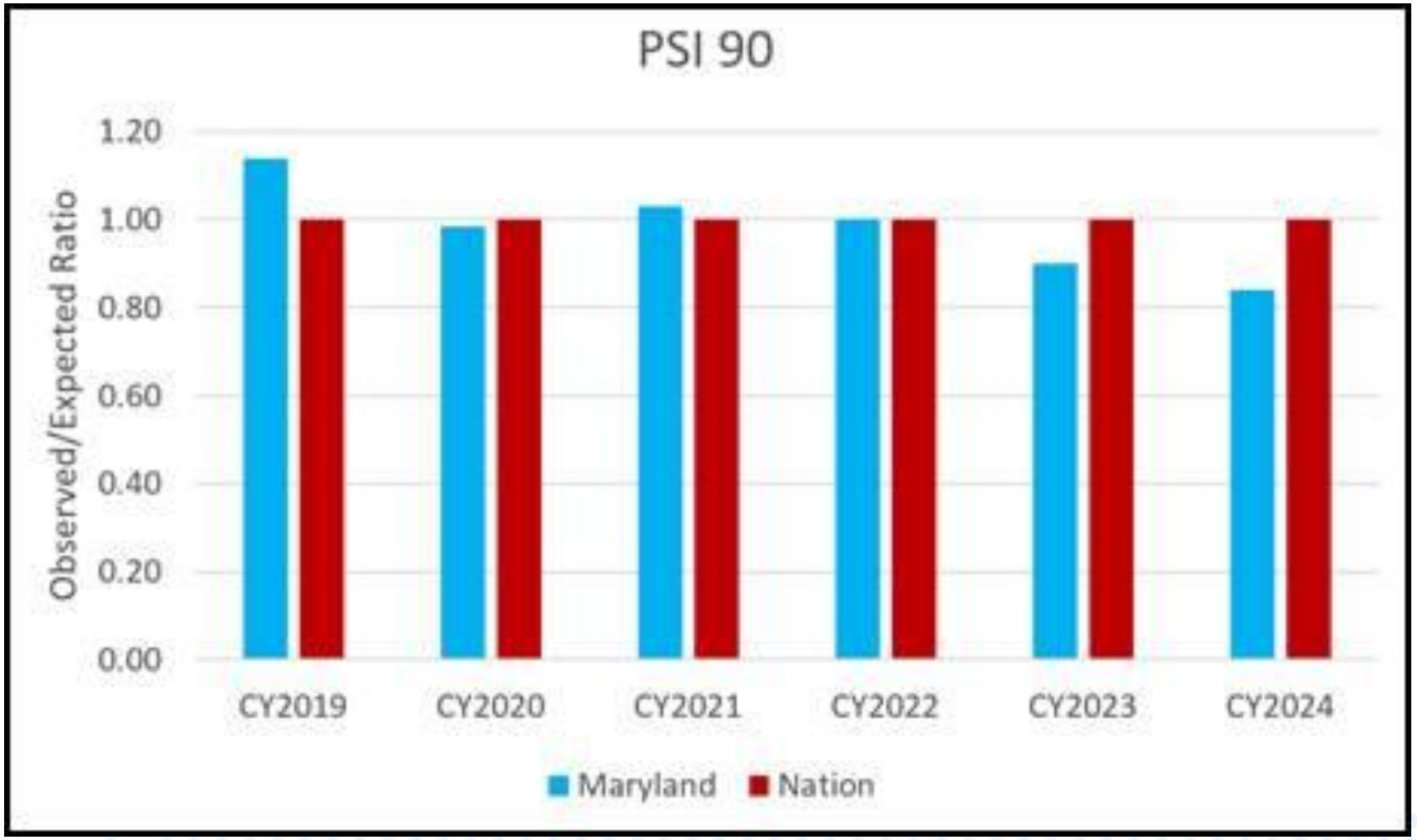
Maryland All-Payer PSI 90 Performance Improved Over Time and is Better (Lower) than the Nation in CY 2023-CY 2024



Compared to the nation, Maryland has performed better than or on par on the overall PSI-90 composite in four of the last six years, 2019-2024.

In CY 2024, Maryland had almost 20 percent fewer complications than expected on an all-payer basis.

PSI 90 All-payer Performance Compared to the Nation

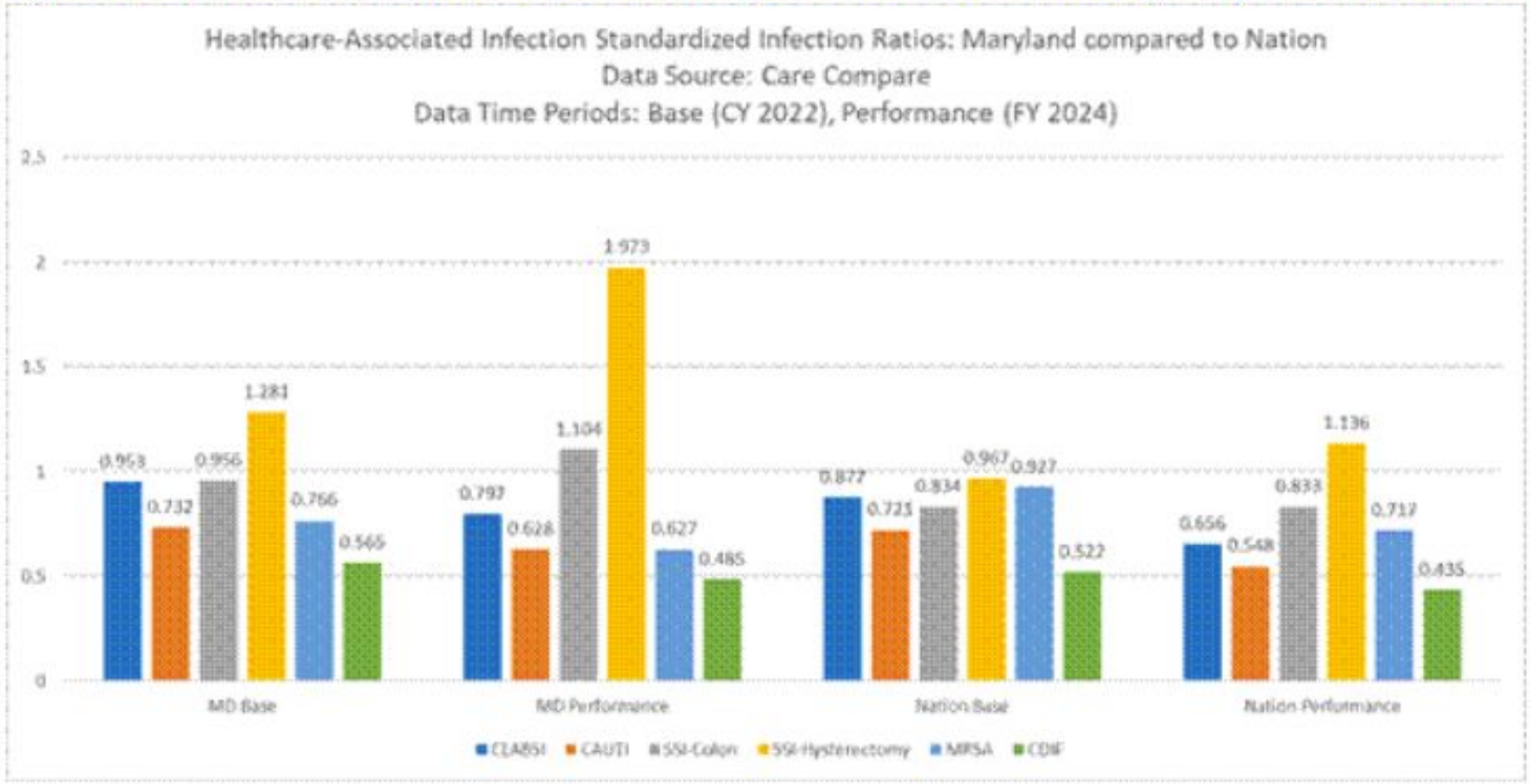
PSI Name	Maryland 2024 Compared to the Nation 2024	Maryland 2024 Compared to Maryland 2023
PSI 90 Composite	Better	Improved
PSI 3 Pressure Ulcer	Worse	Improved
PSI 6-Iatrogenic pneumothorax	Better	Improved
PSI 8 In Hospital Fall and Fracture	Better	Worse
PSI 9 Perioperative Hemorrhage or Hematoma	Better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

Compared to the nation, Maryland is better on the overall PSI-90 composite and on eight of the ten PSI indicators on an all-payer basis.

Compared to 2023, Maryland has improved on the overall PSI-90 composite and on seven of the 10 indicators in 2024 on an all-payer basis.

NHSN HAI Performance

Figure 9. NHSN SIR Values for CY22 compared to 7/1/23-6/30/24, Maryland versus the Nation



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Maryland FFY 2025 Performance on HACRP

National 75th percentile Total HAC Score with and without Maryland Hospitals	Average Total HAC Score for Maryland Hospitals
0.3667 with MD 0.3652 without MD	0.3178

Based on estimated results from CMMI for FFY 2025 HACRP, the state performed better than the 75th percentile of national performance (0.3178 vs 0.3667).

Program	Statewide Net Total	%	Penalties	%	Rewards	%
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%	$ -	-

- The by-hospital results indicate that 16 of 43 Maryland hospitals would have been penalized under HACRP.
- Concerns remain about small cell sizes and other biases in the NHSN measures
- Chestertown is only measured on c dif and had three observed cases in two years, exceeding the expected of 1.55 cases.
- HSCRC does remain concerned that some of the larger hospitals in the State do appear to have opportunities for improvements on some of the complication measures relative to the nation.

Performance Metric: PPC Composite Measure

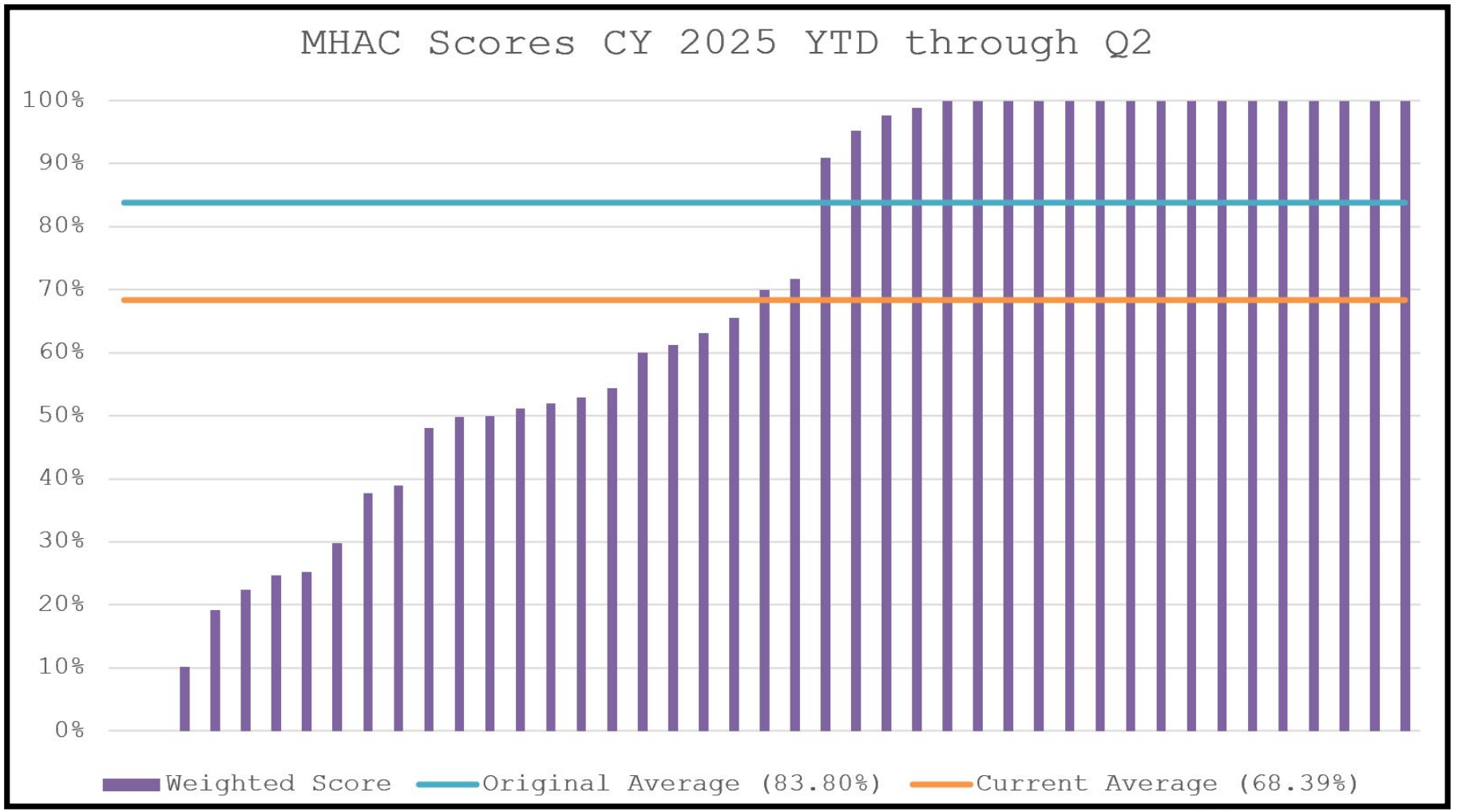
Hospital performance is measured using the PPC Composite measure:

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

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.

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

MHAC Scores CY YTD with Revised Cut Point



- The RY 2027 policy recommended a preliminary cut point of 84 percent based on modeling;
- The actual average score will be used instead of this placeholder and is provided in the monthly reports for hospitals to track.
- Request feedback on composite for discussion in PMWG in January

Rationale

- Data for CY 2025 will be submitted by December 31, 2025. A continuation of monitoring will ensure adequate time to analyze the data and understand the impact of each best practice at individual hospitals and across the state.
- Continued monitoring with reporting accountability rather than a transition to pay for performance will provide time to consider how this program will be integrated into and align with the AHEAD model transition.
- HSCRC believes that with the AHEAD transition in progress, hospitals should continue to hardwire existing practices to ensure consistency and improvement in RY 2028.
- Preliminary results indicate that implementation of these best practices have yielded improvements in hospital throughput.

Feedback to Draft Policy

- Overall many stakeholders have expressed support of the draft policy recommendations through discussion and email communication
  - Representatives for 35 hospitals expressed support of the draft recommendation

- Two comment letters received
  - one letter expressed support with caution to maintain awareness of AHEAD transition
  - one letter suggested that we do not continue the best practice policy in 2026

- ED WTR Commission will discuss how to leverage and support Best Practice efforts in CY 2026

Final Recommendations for RY 2028

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    - For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice. Weighting of tiers will be determined in CY 2026 after CY 2025 data is collected and analyzed.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2028.
    - Failure to implement and report data to the Commission by December 31st 2026 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2027.
3. We intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the CY 2025 and CY 2026 Best Practice program impact is assessed.

Appendix: Best Practices

Examples of Best Practice Success

Discussed Previously at October HSCRC Meeting

Example of ED Hospital Throughput Best Practice Successes

Bayview Hospital Best Practice: Patient Flow/Throughput PI Council

Focus is building capacity and enhancing patient throughput throughout the entire hospital

Application: Bayview created a Hospital Capacity Steering Committee focused on building on capacity and enhancing patient throughput across the entire hospital.

Current Focus #1: Reduced ED Boarding Times

Median ED Boarding Data:

There was a cultural shift enabled by the Hospital Capacity Steering Committee, but it took time to build the foundation, identify root causes, and launch targeted projects.

Where we used to be: Jul–Sep 2024: 12:07 hours median boarding per patient

Where we are currently: Jul–Sep 2025 (mature projects): 8:00 hours median boarding per patient

33% improvement

Current Focus #2: Lower Walkout Rate (combined LWBS, LBT, SAL) as this is an outcome measure that closely correlates with ED boarding and ED wait times.

Walkout Rate Data:

Where we used to be: Feb 2023 – Jan 2024: 26.4% total elopement/walkout rate

Where we are currently: Feb 2024 – Sep 2025: 19.7% total elopement/walkout rate

25% improvement, reflecting more patients staying to complete care rather than leaving due to long waits

These data points tie directly back to the Hospital Capacity Steering Committee and demonstrate how this best practice has helped improve key metrics, especially as we allow time for the projects to mature and for the culture to change around the importance of hospital capacity.

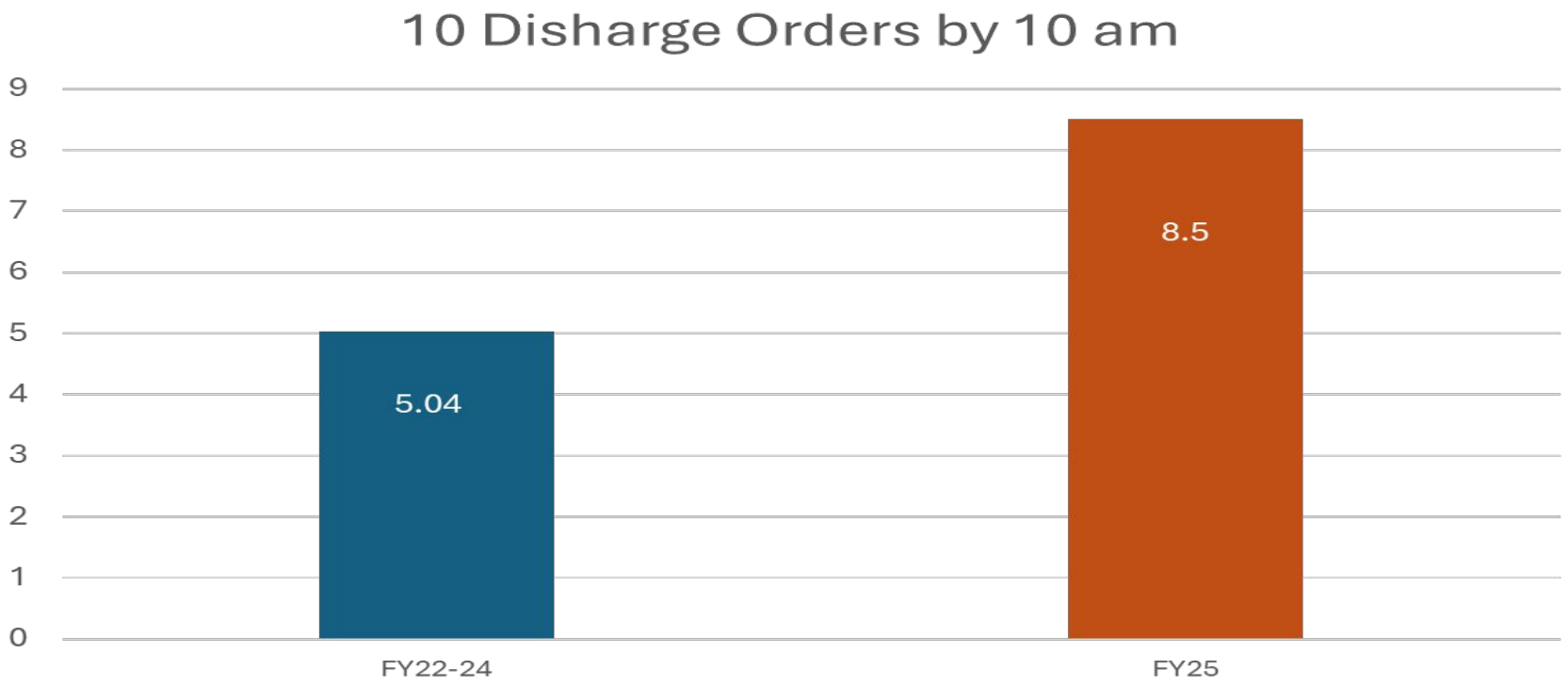
ED Hospital Throughput Best Practice Successes

Suburban Hospital Two Best Practice Submissions: Daily Huddles and Bed Capacity Alert System – impact on Throughput

Application: Suburban has created a Daily Huddle Process focused on a collaborative approach to patient throughput and safety.

- All key stakeholders are on this daily huddle, including our Hospital President, VPMS, CNO, COO, Nursing leadership, ED Leadership, Hospitalist team, and every service line.
- Focus on initiatives such as increasing early inpatient discharges (goal of 10 discharge orders by 10am) that positively impact patient flow.
- During this huddle, review bed capacity and ED volume so we can respond with appropriate actions.
- This approach builds situational awareness, capacity, and collaboration, while focusing on patient care and safety.

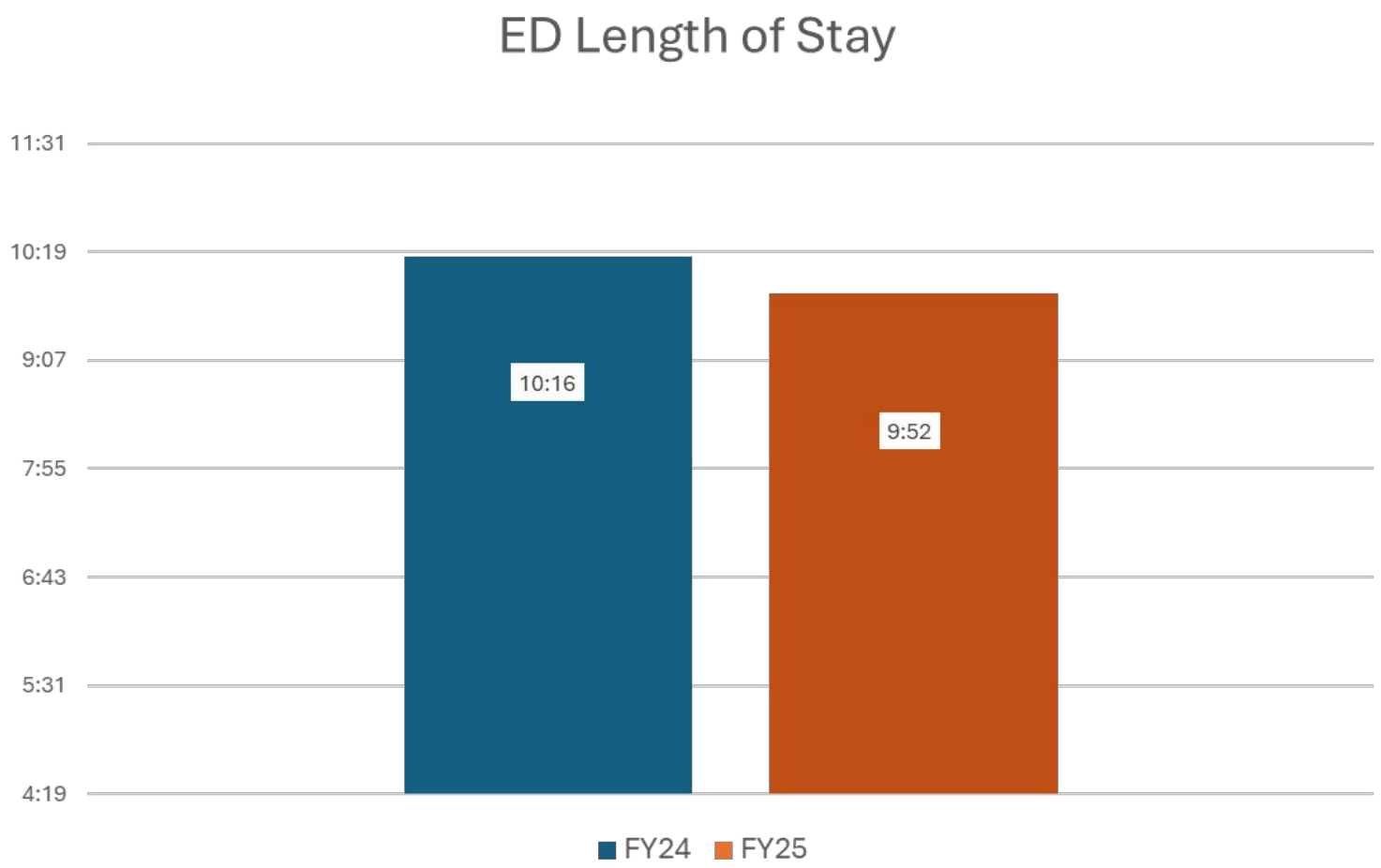
ED Hospital Throughput Best Practice Successes



Goal of entering 10 discharge Orders by 10am

- This opens bed capacity on the medical units earlier in the day
- Which allows us to move patients out of a busy ED and decreases boarding
- The slide illustrates marked improvement in FY25

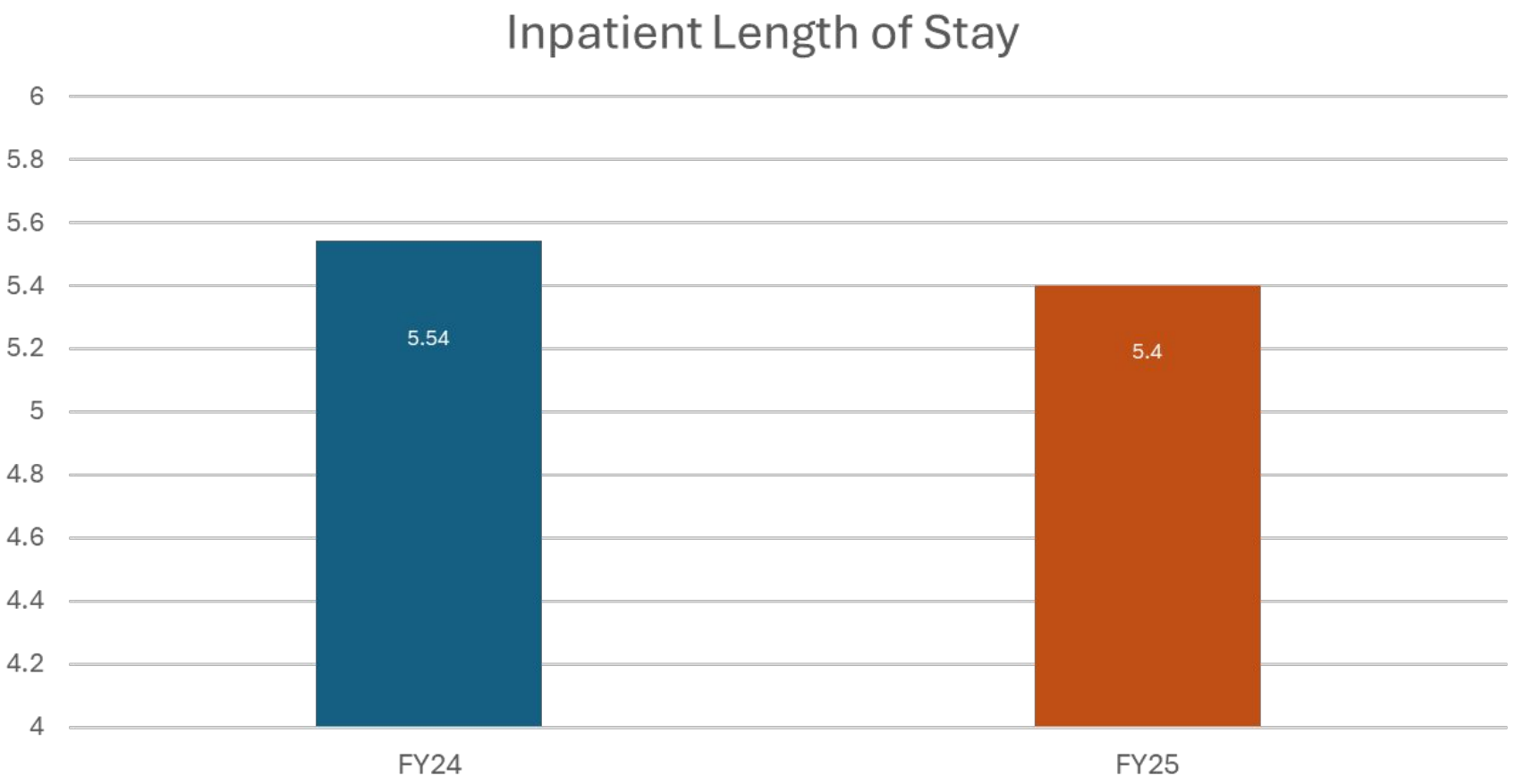
ED Hospital Throughput Best Practice Successes



Goal of decreasing our average Emergency Department length of stay

- This allows us to see more patients in a faster and safer manner
- This improves patient experience and medical care
- The slide illustrates significant improvement in FY25

ED Hospital Throughput Best Practice Successes

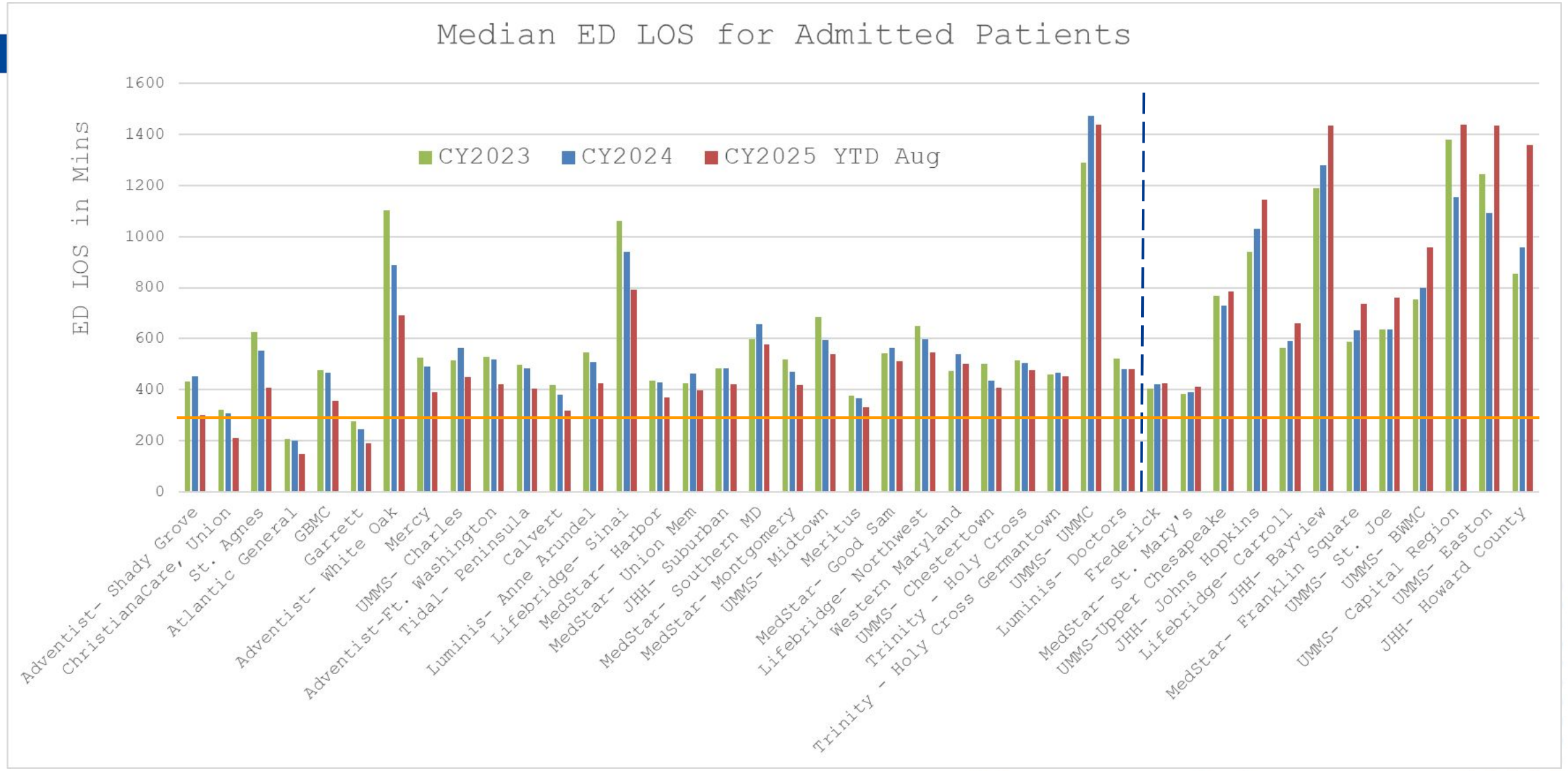


Goal of decreasing our average inpatient length of stay

- This increases bed availability for new patients that need admission
- Which decreases the time a patient boards in the ED
- The slide illustrates small improvement in FY25

Example of ED Hospital Throughput Best Practice Successes

- Emergency Department wait times continue to be a focus for the University of Maryland Medical System and all of its Member Organizations.
- A tremendous amount of work has gone into addressing ED wait times and the best practices instituted have begun to demonstrate positive results.
- UMMS Member Organizations have implemented and shared best practices including:
  - Daily Huddles
  - Interdisciplinary Rounds
  - Patient Flow Councils
  - Expedited Care
- The Expedited Care efforts in particular have demonstrated significant success as evidenced by:
  - Member Organizations have reduced the number of patients leaving without being seen by 26%
  - ED Arrival to Discharge times (OP-18) have improved by 6% CY to date (August) 2025 compared to CY 2024.
  - Much of this success can be attributed to Rapid Medical Evaluation/Rapid Assessment Zone programs that have emergency medicine physicians and APPs evaluating patients upon arrival.
  - The goal is to assess, initiate care, and potentially discharge patients earlier in their stay, thus saving invaluable bed capacity in the Main ED for those patients that require a bed



Sorted by percent change 2024 to 2025 ytd
Hospitals on left of line showed improvement
Hospitals to right of line showed increases
**CY 2025 Q1 data was not final data; will be updated by end of the month

2019 National Rate

Legislative Report Update

- Interim report was submitted to the legislature on 10/31
- Link to Interim ED Wait Time Reduction Commission Report

HOSPITAL NAME	Actual IP Revenue	$ Revenue Impact						
		QBR	Remove MD specific measures	Reweight Domains to 1/3rd each	Add THA-TKA & Sepsis Measures	Align Mortality Measures	Align PCE & Safety Time periods	Full Alignment (align scaling parameters)
Meritus	$ 269,729,949	$1,915,083	$674,325	$1,348,650	$917,082	$107,892	$134,865	$944,055
UMMS- UMMC	$ 1,572,442,188	-$14,151,980	-$9,277,409	-$10,535,363	-$8,962,920	-$7,075,990	-$6,604,257	-$3,302,129
UMMS- Capital Region	$ 325,349,234	-$520,559	-$1,073,652	-$1,561,676	-$1,984,630	$488,024	$422,954	$1,529,141
Trinity - Holy Cross	$ 440,757,012	-$4,363,494	-$5,377,236	-$5,112,781	-$4,363,494	-$3,349,753	-$4,451,646	-$3,878,662
Frederick	$ 255,860,248	-$1,049,027	-$818,753	-$281,446	-$102,344	-$1,074,613	-$230,274	$409,376
Mercy	$ 244,094,359	$414,960	-$122,047	-$634,645	-$1,074,015	-$659,055	-$707,874	-$170,866
JHH- Johns Hopkins	$ 1,915,323,836	$1,532,259	$13,790,332	$15,897,188	$14,939,526	$18,578,641	$20,302,433	$38,114,944
St. Agnes	$ 280,211,776	$392,296	-$896,678	$840,635	-$84,064	-$1,008,762	-$1,176,889	-$588,445
Lifebridge- Sinai	$ 527,147,859	-$579,863	-$4,164,468	-$2,793,884	-$5,218,764	-$3,531,891	-$2,688,454	-$1,634,158
MedStar- Franklin Square	$ 407,544,466	-$1,426,406	-$448,299	$733,580	-$570,562	$1,344,897	$1,385,651	$3,341,865
Adventist- White Oak	$ 269,335,289	$1,427,477	$1,077,341	$1,238,942	$1,212,009	$700,272	$1,023,474	$2,370,151
Garrett	$ 31,765,005	$635,300	$635,300	$594,006	$247,767	$60,354	$95,295	$241,414
MedStar- Montgomery	$ 107,202,092	$1,018,420	$846,897	$1,318,586	$889,777	$246,565	-$117,922	$150,083
Tidal- Peninsula	$ 356,375,986	$392,014	-$748,390	-$1,639,330	-$1,924,430	-$855,302	-$2,209,531	-$1,568,054
JHH- Suburban	$ 276,688,736	-$498,040	$166,013	$719,391	$332,026	-$1,300,437	-$525,709	$138,344
Luminis- Anne Arundel	$ 419,860,154	$335,888	-$3,442,853	-$4,492,504	-$3,946,685	-$2,225,259	-$1,343,552	-$377,874
MedStar- Union Mem	$ 306,565,594	-$61,313	$337,222	$858,384	$337,222	$1,502,171	$1,747,424	$3,678,787
Western Maryland	$ 206,549,734	-$516,374	-$61,965	-$1,239,298	-$1,094,714	$247,860	$371,790	$1,156,679
MedStar- St. Mary's	$ 99,664,006	$229,227	$438,522	$887,010	$508,286	$179,395	$9,966	$279,059
JHH- Bayview	$ 505,597,983	-$4,954,860	-$3,791,985	-$1,820,153	-$1,921,272	-$2,730,229	-$2,527,990	-$1,516,794
ChristianaCare, Union	$ 111,158,432	$644,719	$244,549	$655,835	$344,591	-$422,402	-$33,348	$255,664
Lifebridge- Carroll	$ 166,721,865	-$716,904	-$683,560	$100,033	-$150,050	$16,672	$266,755	$883,626
MedStar- Harbor	$ 137,076,633	$411,230	$233,030	$973,244	$740,214	$301,569	$534,599	$1,247,397
UMMS- Charles	$ 105,216,708	-$757,560	-$452,432	-$294,607	-$378,780	-$305,128	-$168,347	$84,173
UMMS- Easton	$ 138,384,760	-$207,577	-$899,501	-$332,123	-$691,924	-$774,955	-$595,054	-$304,446
UMMS- Midtown	$ 140,973,899	-$42,292	-$1,015,012	-$690,772	-$507,506	-$648,480	-$803,551	-$535,701
Calvert	$ 84,946,923	$1,095,815	$968,395	$730,544	$314,304	$501,187	$645,597	$1,282,699
Lifebridge- Northwest	$ 173,564,819	-$312,417	-$1,093,458	-$364,486	-$433,912	-$1,041,389	-$919,894	-$590,120
UMMS- BWMC	$ 329,675,757	-$296,708	-$659,352	$296,708	-$230,773	-$197,805	-$98,903	$791,222
GBMC	$ 274,971,840	$439,955	-$137,486	-$412,458	-$467,452	-$384,961	-$274,972	$412,458
JHH- Howard County	$ 256,140,273	-$1,972,280	-$1,792,982	-$1,690,526	-$1,792,982	-$973,333	-$998,947	-$461,052
UMMS-Upper Chesapeake	$ 260,331,648	-$1,588,023	-$2,421,084	-$1,561,990	-$2,108,686	-$2,473,151	-$2,603,316	-$2,264,885
Luminis- Doctors	$ 195,040,841	-$370,578	-$1,755,368	-$1,326,278	-$819,172	$175,537	$351,074	$1,092,229
MedStar- Good Sam	$ 199,681,457	-$1,417,738	-$1,218,057	-$339,458	-$718,853	$918,535	$1,158,152	$2,416,146
Adventist- Shady Grove	$ 361,126,072	-$108,338	$650,027	$1,155,603	$397,239	-$794,477	-$252,788	$686,140
Adventist-Ft. Washington	$ 37,325,252	$11,198	$41,058	$104,511	-$63,453	-$190,359	$268,742	$533,751
Atlantic General	$ 49,839,515	$548,235	$543,251	$543,251	$209,326	$64,791	$304,021	$627,978
MedStar- Southern MD	$ 210,782,671	-$695,583	-$400,487	$1,074,992	$864,209	$1,201,461	$1,201,461	$2,529,392
UMMS- St. Joe	$ 305,357,564	$1,313,038	$1,251,966	$1,557,324	$1,190,895	$1,068,751	$1,557,324	$3,358,933
Trinity - Holy Cross Germantown	$ 106,721,583	-$1,173,937	-$1,195,282	-$1,419,397	-$1,088,560	-$469,575	-$437,558	-$213,443
Statewide Total	**$12,463,104,017**	**-$25,024,738**	**-$22,049,568**	**-$6,914,761**	**-$17,255,526**	**-$4,782,733**	**$2,010,799**	**$51,149,075**

RY 2026 QBR Scaling			Full HVBP Alignment (including max reward of +4.53%)			Full HVBP Alignment (except max reward of +2.00%)		
HOSPID	HOSPITAL NAME	Actual IP Revenue	RY 2026 FINAL Score	% Revenue Impact	$ Revenue Impact	RY 2026 FINAL Score	% Revenue Impact	$ Revenue Impact
210001	Meritus	$ 269,729,949	34.11%	0.35%	$944,055	34.11%	0.16%	$431,568
210002	UMMS- UMMC	$ 1,572,442,188	25.89%	-0.21%	-$3,302,129	25.89%	-0.21%	-$3,302,129
210003	UMMS- Capital Region	$ 325,349,234	35.89%	0.47%	$1,529,141	35.89%	0.21%	$683,233
210004	Trinity - Holy Cross	$ 440,757,012	16.22%	-0.88%	-$3,878,662	16.22%	-0.88%	-$3,878,662
210005	Frederick	$ 255,860,248	31.33%	0.16%	$409,376	31.33%	0.07%	$179,102
210008	Frederick	$ 244,094,359	28.05%	-0.07%	-$170,866	28.05%	-0.07%	-$170,866
210009	JHH- Johns Hopkins	$ 1,915,323,836	57.88%	1.99%	$38,114,944	57.88%	0.88%	$16,854,850
210011	St. Agnes	$ 280,211,776	26.00%	-0.21%	-$588,445	26.00%	-0.21%	-$588,445
210012	Lifebridge- Sinai	$ 527,147,859	24.44%	-0.31%	-$1,634,158	24.44%	-0.31%	-$1,634,158
210015	MedStar- Franklin Square	$ 407,544,466	40.88%	0.82%	$3,341,865	40.88%	0.36%	$1,467,160
210016	Adventist- White Oak	$ 269,335,289	41.77%	0.88%	$2,370,151	41.77%	0.39%	$1,050,408
210017	Garrett	$ 31,765,005	40.00%	0.76%	$241,414	40.00%	0.33%	$104,825
210018	MedStar- Montgomery	$ 107,202,092	31.00%	0.14%	$150,083	31.00%	0.06%	$64,321
210019	Tidal- Peninsula	$ 356,375,986	22.66%	-0.44%	-$1,568,054	22.66%	-0.44%	-$1,568,054
210022	JHH- Suburban	$ 276,688,736	29.66%	0.05%	$138,344	29.66%	0.02%	$55,338
210023	Luminis- Anne Arundel	$ 419,860,154	27.66%	-0.09%	-$377,874	27.66%	-0.09%	-$377,874
210024	MedStar- Union Mem	$ 306,565,594	46.33%	1.20%	$3,678,787	46.33%	0.53%	$1,624,798
210027	Western Maryland	$ 206,549,734	37.11%	0.56%	$1,156,679	37.11%	0.25%	$516,374
210028	MedStar- St. Mary's	$ 99,664,006	33.00%	0.28%	$279,059	33.00%	0.12%	$119,597
210029	JHH- Bayview	$ 505,597,983	24.66%	-0.30%	-$1,516,794	24.66%	-0.30%	-$1,516,794
210032	ChristianaCare, Union	$ 111,158,432	32.33%	0.23%	$255,664	32.33%	0.10%	$111,158
210033	Lifebridge- Carroll	$ 166,721,865	36.66%	0.53%	$883,626	36.66%	0.23%	$383,460
210034	MedStar- Harbor	$ 137,076,633	42.16%	0.91%	$1,247,397	42.16%	0.40%	$548,307
210035	UMMS- Charles	$ 105,216,708	30.22%	0.08%	$84,173	30.22%	0.04%	$42,087
210037	UMMS- Easton	$ 138,384,760	25.78%	-0.22%	-$304,446	25.78%	-0.22%	-$304,446
210038	UMMS- Midtown	$ 140,973,899	23.50%	-0.38%	-$535,701	23.50%	-0.38%	-$535,701
210039	Calvert	$ 84,946,923	50.83%	1.51%	$1,282,699	50.83%	0.66%	$560,650
210040	Lifebridge- Northwest	$ 173,564,819	24.11%	-0.34%	-$590,120	24.11%	-0.34%	-$590,120
210043	UMMS- BWMC	$ 329,675,757	32.44%	0.24%	$791,222	32.44%	0.10%	$329,676
210044	GBMC	$ 274,971,840	31.22%	0.15%	$412,458	31.22%	0.07%	$192,480
210048	JHH- Howard County	$ 256,140,273	26.44%	-0.18%	-$461,052	26.44%	-0.18%	-$461,052
210049	UMMS-Upper Chesapeake	$ 260,331,648	16.44%	-0.87%	-$2,264,885	16.44%	-0.87%	-$2,264,885
210051	Luminis- Doctors	$ 195,040,841	37.11%	0.56%	$1,092,229	37.11%	0.25%	$487,602
210056	MedStar- Good Sam	$ 199,681,457	46.55%	1.21%	$2,416,146	46.55%	0.53%	$1,058,312
210057	Adventist- Shady Grove	$ 361,126,072	31.77%	0.19%	$686,140	31.77%	0.08%	$288,901
210060	Adventist-Ft. Washington	$ 37,325,252	49.77%	1.43%	$533,751	49.77%	0.63%	$235,149
210061	Atlantic General	$ 49,839,515	47.33%	1.26%	$627,978	47.33%	0.56%	$279,101
210062	MedStar- Southern MD	$ 210,782,671	46.33%	1.20%	$2,529,392	46.33%	0.53%	$1,117,148
210063	UMMS- St. Joe	$ 305,357,564	44.88%	1.10%	$3,358,933	44.88%	0.48%	$1,465,716
210065	Trinity - Holy Cross Germant	$ 106,721,583	26.11%	-0.20%	-$213,443	26.11%	-0.20%	-$213,443
	Statewide Total/Average	**$12,463,104,017**	**33.9%**	**0.34%**	**$51,149,075**	**33.9%**	**0.08%**	**$12,844,690**