maryland
health services
cost review commission

Performance Measurement Workgroup

January 21, 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--Draft December/Final February
  - Draft Readmission Reduction Incentive Program (RRIP) Policy--Draft January/Final March
- Emergency Department Priorities
  - ED LOS Measurement
- Inpatient Length of Stay Incentive

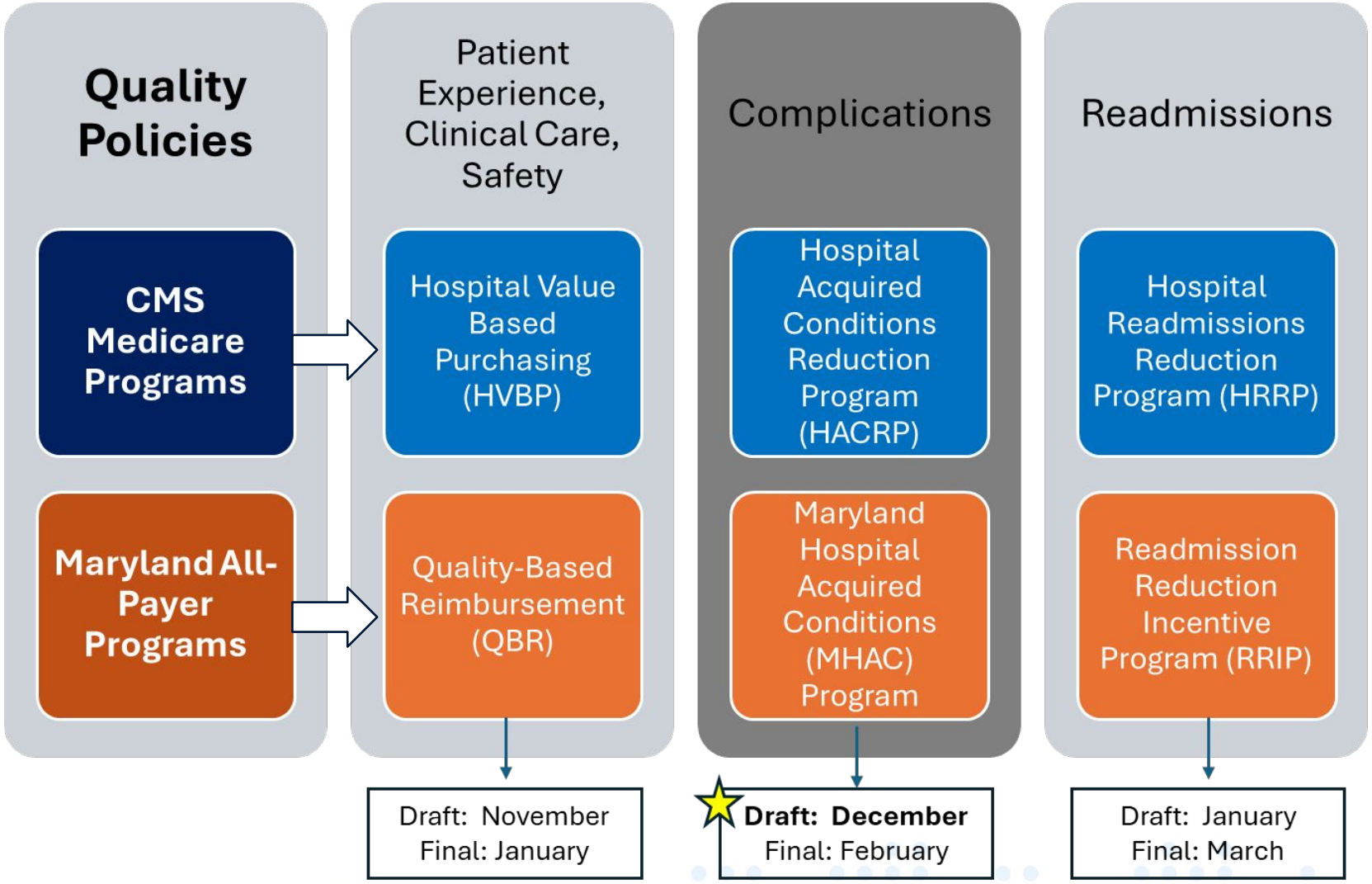
Workgroup Learning Agreements

- **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.

HSCRC RY 2028 Policy Timelines

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

Approved RY 2028 Final Recommendations

- 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.
- Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and set the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 32 percent.
  - Retrospectively evaluate the preset cut-point using more recent data to calculate national average score for RY 2027 and RY 2028.
  - Based on concurrent analysis of national hospital performance, adjust the RY26 QBR cut-point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.
- 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.

RY 2028 QBR Draft Recommendations

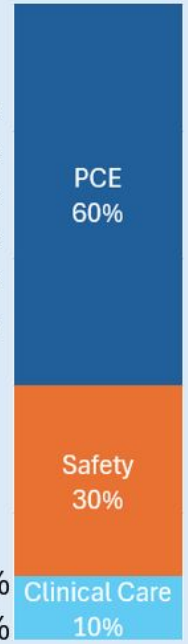
Criteria: 1. Alignment with CMS HVBP, 2. All-Payer Accountability, 3. Reduce retrospective measure evaluation, 4. Area of Poor Performance and/or Stakeholder Priority

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%



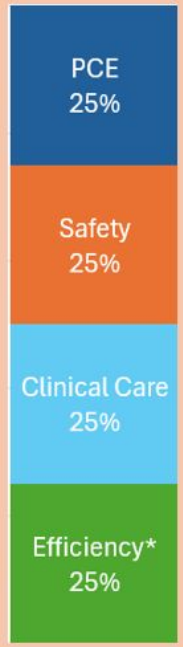
FY 2027 HVBP

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%



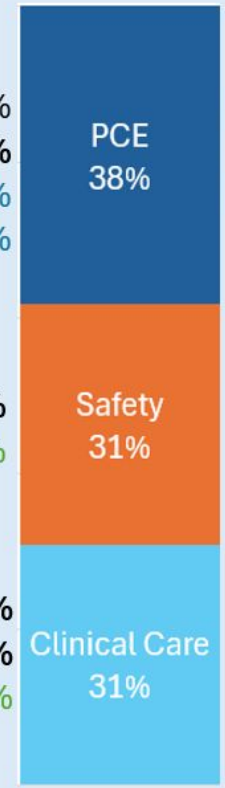
Partial Alignment

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%

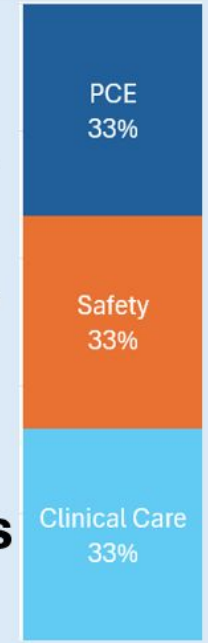


~~HCAHPS Linear, 10%~~
~~TFU Medicare + Disparity, 7%~~

~~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 .

Options for Commissioner Consideration

1. **Staff draft recommendation:** Align domain weights and measures more fully with HVBP but maintain slightly higher weight on the PCE domain to accommodate ED LOS and Medicaid TFU; reduce the Clinical Care and Safety domains proportionally to account for additional measures.
2. **MHA-Hospital recommendation:** Align the domain weights and measures fully with the HVBP program but maintain the all-payer inpatient and 30-day mortality measures. *All Maryland specific measures (e.g., ED LOS, TFU) should be monitored and publicly reported.*
3. **Staff recommendation without Sepsis and THA-TKA:** Align domain weights and measures more fully with HVBP but maintain ED LOS and Medicaid TFU in the PCE domain; monitor Sepsis bundle and THA-TKA complication measures due to clinical and measurement concerns.

Weighting Options			
Domains	**Current**	**Option 1 & 3**	**Option 2**
PCE	60%	38%	33%
Clinical	10%	31%	33%
Safety	30%	31%	33%

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

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

Next Steps

- Implement updated RY 2026 revenue adjustments with new cut-point
- Send out memo on RY 2028 updates and available performance standards
- Update reporting on CRS portal as needed
- Finalize RY 2027 ED LOS measure
- 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 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.)

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

Inpatient model

- 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
- ED stays with valid ED dates and times
  - Excludes maternity, trauma, burns, psychiatric, pediatric, homeless, chronic conditions, rehab
  - Excludes stays over 30 days long
  - Does not winsorize outlier values

*smaller APR-DRG cells removed from models

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+

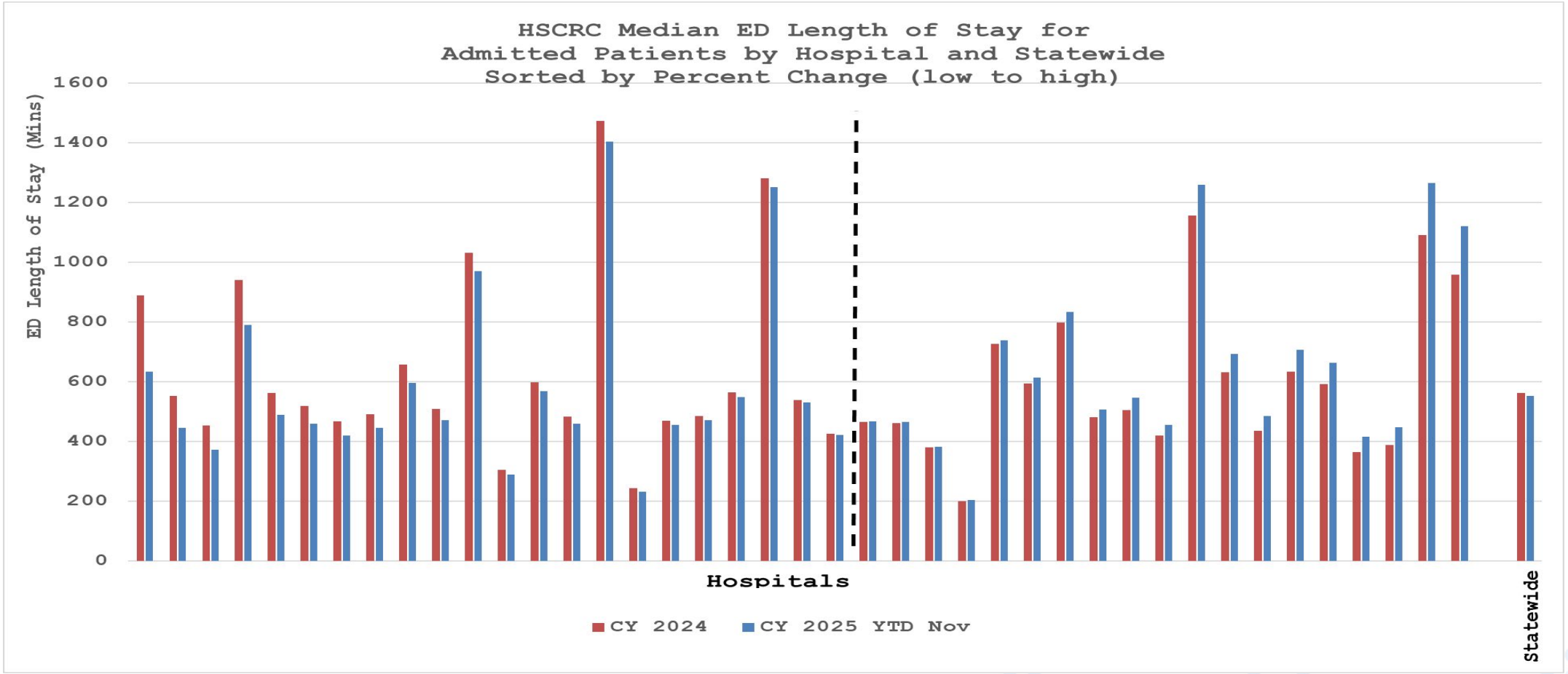
Visit characteristics

- 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

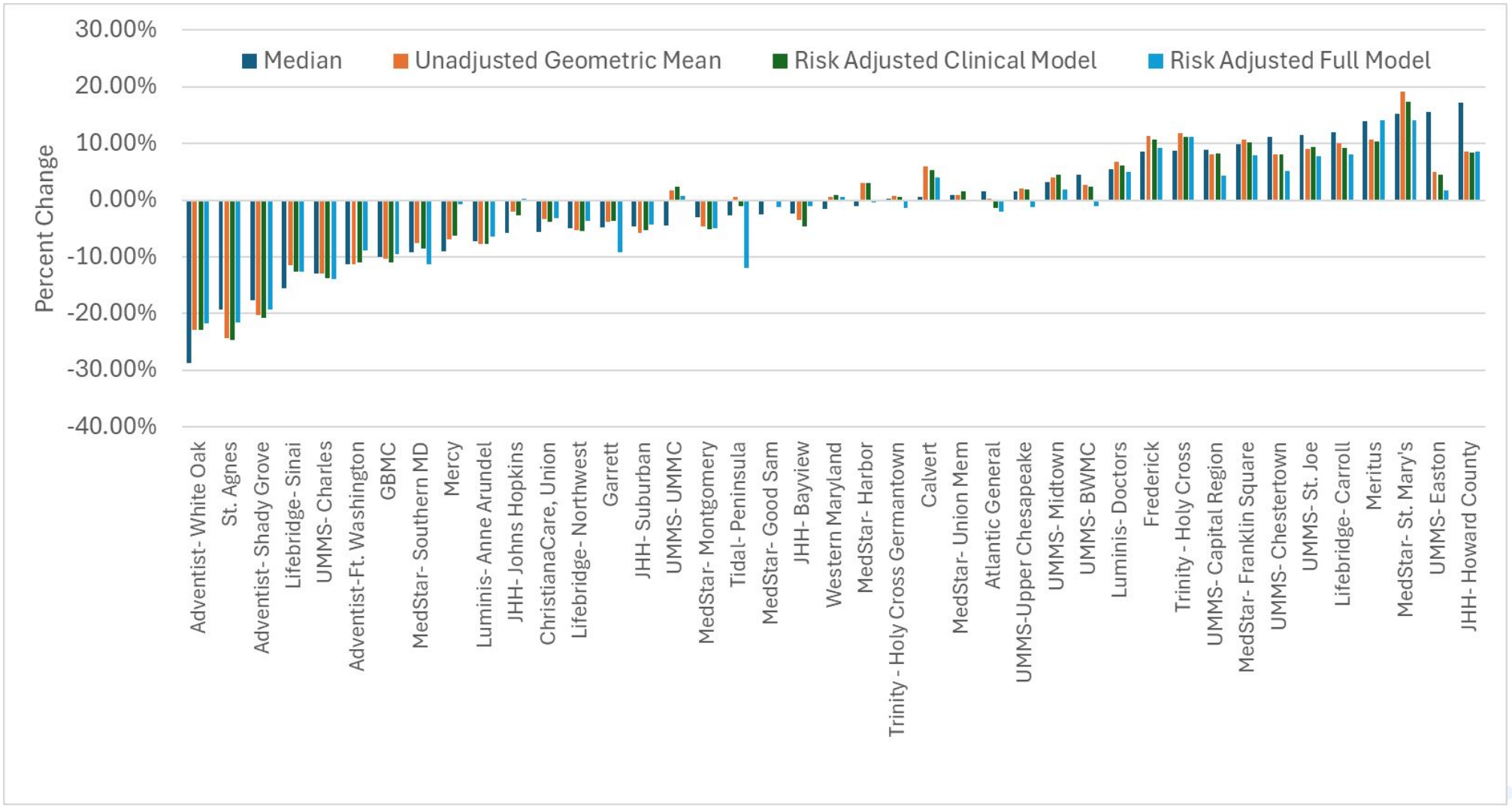
Hospital choice

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

ED LOS for Admitted Patients CY 2024 vs. CY 2025



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

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
  - Could reconsider attainment if ED LOS is maintained in payment after RY 2028 or use the new CMS measure for ED

RY 2028 MHAC Draft Policy

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.

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.

Topics for Today

- Analysis of Composite PPCs scores
- PPC-PSI Overlap
- Next steps for AHEAD alignment in RY 2029
  - Timeline for Clinical Adverse Event Measures subgroup

Question 1: Why do so many hospitals have perfect MHAC scores under composite methodology?

- Under the composite methodology, 13 hospitals have perfect MHAC scores (100%) compared with 0 hospitals under the previous methodology.
- To understand why, let's examine:
  - 1) Methodological differences
  - 2) What's required to get a 100% MHAC score under each methodology
  - 3) Distribution of hospital results

PPC Composite Score

- Sum of hospital's observed PPCs divided by sum of expected PPCs across 16 payment PPCs, both numerator and denominator weighted by each PPC's Solventum Cost Weight

$$PPC\ Composite_j = \frac{\left(\sum_{i=1}^{15} ObservedPPC_{ij} * 3MCostWeight_i\right)}{\left(\sum_{i=1}^{15} ExpectedPPC_{ij} * 3MCostWeight_i\right)}$$

- Does not explicitly weight PPC measures by volume, but PPC measures with higher expected PPCs receive more weight.
  - Expected PPCs increase as volume increases

MHAC Methodological Differences

Aspect	Previous Methodology	Composite Methodology
PPC Exclusion Criteria	Exclude PPC measures with <2 expected PPCs or <20 at risk discharges	Exclude PPCs with 0 at-risk discharges
PPC Measure "Volume" Weights	PPC measures not weighted by volume	PPC measures with greater expected PPCs at hospital receive a larger weight
PPC Measure Solventum Cost Weights	PPC measures are weighted by Solventum Cost Weights	In calculation of PPC composite score, PPC measures are weighted by 3M Cost Weights
Benchmarks and Thresholds	For each of the 16 payment PPC measures, calculate a benchmark and threshold	Calculate a benchmark and threshold for the PPC Composite
Measure Scores (0 to 100 points) **Definitions:**	For each of 16 payment PPC measures, hospitals receive: • 0 points if hospital O/E ratio > threshold • 1 to 99 points if hospital O/E ratio between benchmark and threshold • 100 points if hospital O/E ratio < benchmark	Calculate the hospital's PPC composite score and assign points as follows: • 0 points if composite score > threshold • 1 to 99 points if composite score between benchmark and threshold • 100 points if composite score < benchmark

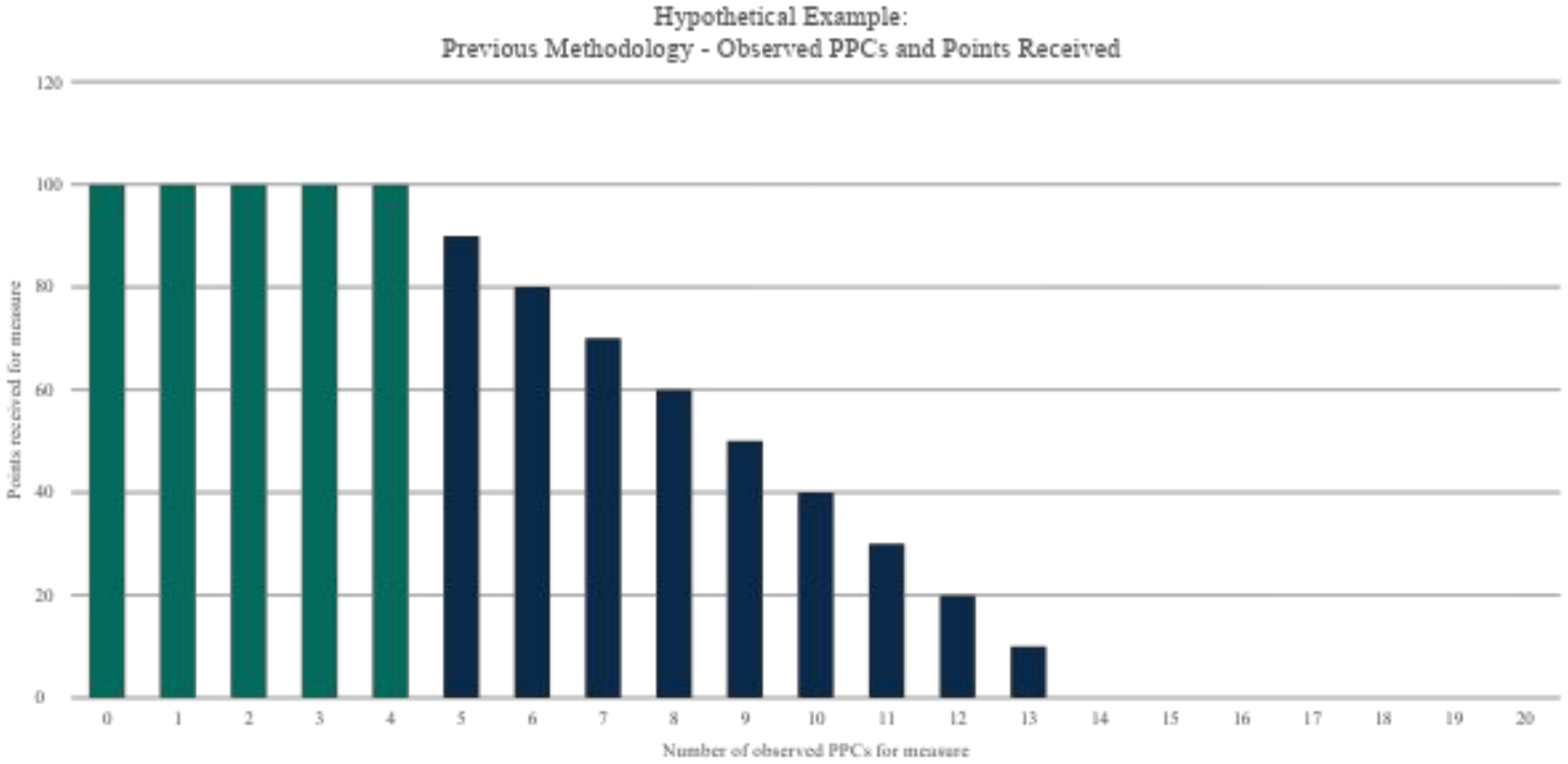
Benchmark: average score of best-performing 20% of Maryland hospitals during base period
Threshold: average score of worst-performing 20% of Maryland hospitals during base period

MHAC Methodological Differences

Aspect	Previous Methodology	Composite Methodology
MHAC Score (0% to 100%)	Equals weighted number of points assigned to each payment PPC measure divided by weighted points possible, weighted by Solventum Cost Weight	Equals number of points assigned to PPC composite
MHAC Percentage (-2% to +2%)	Equals: • Between -2% and 0% if hospital's MHAC score < average MHAC score • 0% if hospital's MHAC score = average MHAC score • Between 0% and +2% if hospital's MHAC score > average MHAC score	
Outlier performance	• Hospitals performing better than benchmark get 100 points regardless of degree better • Hospitals performing worse than threshold get 0 points regardless of degree worse	• Hospitals get full credit for having 0 observed PPCs, even if much better than benchmark • Hospitals get full penalty for each additional observed PPC, even if way worse than threshold

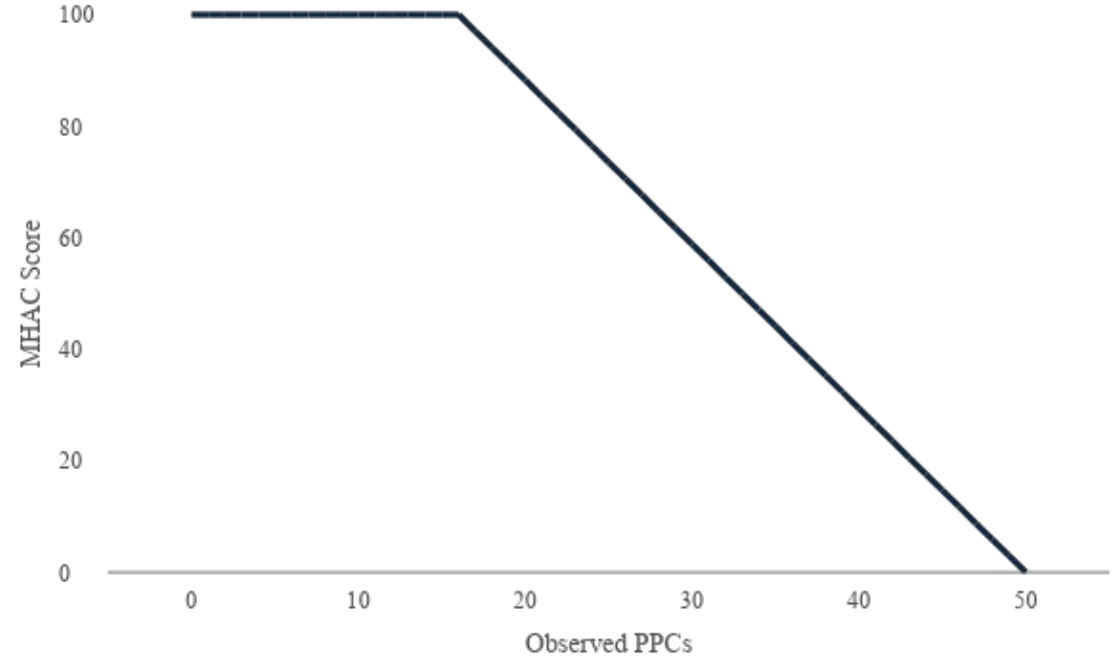
Note:
Higher MHAC scores indicate better performance

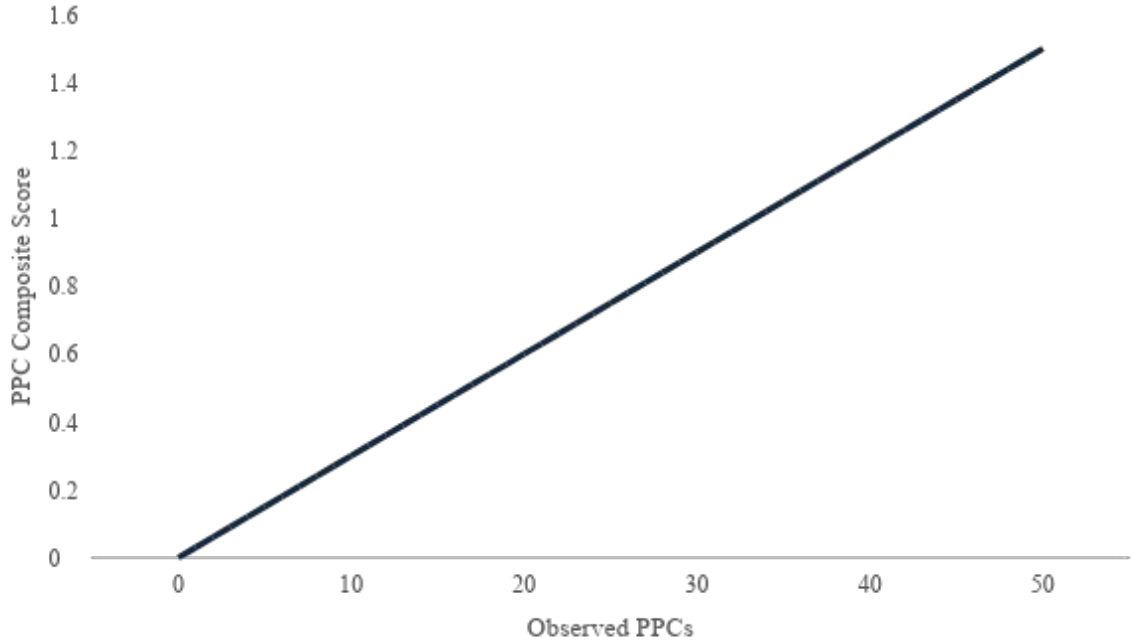
Outlier Performance: Previous Methodology



Outlier Performance: Composite Methodology

Note: This is a hypothetical example





How to obtain a perfect MHAC Score

- **Previous Methodology:** Perform better than the benchmark on all 16 payment PPC measures

- **Composite Methodology:** Perform better than the benchmark on the PPC composite

Previous Methodology: Elusive Perfect Score

- Hospitals performed better than the benchmark for about 30% of PPC measures

Methodology	Percent of PPC measures with 100 points	Percent of PPC measures with 0 points	Average number of points received for PPC measures (before weighting)
Previous Methodology (CY 2024)	30.1%	5.4%	72.7

- However, in CY 2024, no hospital performed better than the benchmark on all 16 payment PPCs
  - One hospital performed better than benchmark on 9 measures
  - Two hospitals performed better than benchmark on 8 measures
  - One hospital performed better than benchmark on 7 measures

Composite Methodology: Perfect Scores

- Hospitals on average perform better in the performance period than the base period from which the benchmark and threshold are calculated as shown below.

Methodology	Percent of hospitals w/ PPC Composites receiving 100 points	Percent of hospitals w/PPC composites receiving 0 points	Average number of points received for PPC composite
Composite Methodology (CY 2024)	31.0% (13 out of 42 hospitals)	0%	80.8

- Thirteen hospitals performed better than the benchmark on the PPC composite.

- Among the 13 hospitals with perfect MHAC scores under the composite methodology, the average MHAC score under the previous methodology was about 89%.

Question 2: Which hospitals would perform better under composite methodology?

- Hospitals would tend to perform better under the composite methodology if:
  - Perform notably better than benchmark on multiple PPC measures
  - Perform relatively well on PPC measures with the most expected PPCs
  - Do not perform notably worse than threshold on any PPC measures
  - Perform well on PPC measures with <2 expected PPCs

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

Replicate PPC-PSI Overlap

- Testing overlap using two years data, applying exclusions such as individual admissions with >6 PPCs and hospitals not in program
  - This differs from previous overlap analysis
  - Numbers currently being QAed because they seem lower than anticipated

Previous results, example:

Measures Compared	Measure Inclusion	Numerator Cases		Denominator Cases	
		Frequency	Percent	Frequency	Percent
PSI 13: Postoperative Sepsis Rate PPC 35: Septicemia & Severe Infections	PSI and PPC	132	11%	25,838	6%
	PSI Only	305	26%	104,487	26%
	PPC Only	727	62%	270,936	68%

Clinical Adverse Event Measures Subgroup

Interested parties should email hscrc.quality@maryland.gov by 2/6/2026

- Convene group for 3-4 meetings to review currently available and future complication measures
- Discuss data sources, reporting burden, Medicare alignment, and non-Medicare areas of concern
- Create criteria for inclusion in a non-Medicare quality program
- Provide recommendations to PMWG for measures in RY 2029 and beyond
- Anticipated start date April 2026, updates presented at May and final recommendations at August PMWG

Readmissions Updates

Recap of OOS Ratio Issue

RY 2028 RRIP Priorities

OOS Ratio Calculation and Adjustment

OOS readmission ratio:

- Defined as **Medicare CCW** total readmissions/***in-state*** readmissions
- Example Calculation: 70 total readmissions/42 in-state readmissions = 1.67 OOS ratio

Attainment OOS Adjusted Rate:

- Defined as **Case-Mix Adjusted** Rate x **CCW** OOS Ratio = Attainment Rate
- Example Calculation: 8.35% x 1.67 = **13.94%**

Analysis and Results

Analysis: Compared CCW-MD readmissions only (as a proxy for the case-mix dataset) to CCW-All Hospital readmissions

Results: We found that there are cases that are being double counted, once in the case-mix dataset (as an in-state readmission) and once in the OOS ratio (as an OOS readmission, i.e., not in the denominator); specifically, the cases are those that are OOS readmissions with all hospitals and in-state readmission with only MD hospitals

Solution

For each hospital, identify and exclude cases that are OOS readmissions with all hospitals and in-state readmission with only MD hospitals (i.e., double counted readmissions)

Adjustment to OOS ratio calculation: # of Medicare CCW total readmissions/ (# of Medicare CCW in-state readmissions + # of readmissions that are double counted)

Must be done in the base period (impacting the attainment target) and the performance period

Examples of Cases that are Double Counted

- Within 30 days of an index visit, there was an OOS readmission followed by an in-state readmission
  - In case-mix, this is an *in-state* readmission
  - In the CCW, this is an *OOS* readmission

- In-state readmission is transferred to OOS hospital
  - In case-mix this is an *in-state* readmission
  - In the CCW, this is an *OOS* readmission*

<u>Our change will reclassify these “double counted” readmissions as in-state readmissions *only*</u>

*In CCW logic, pts who are transferred OOS during an in-state readmission are considered a readmission only to the transfer-receiving hospital

Modified OOS Ratio Calculation and Adjustment Example

There are *14* cases that are double counted
(i.e., counted in case mix as in-state and CCW as out of state)

Current Calculation

- OOS Ratio= 70 total readmissions /42 in-state= 1.67
- Case-Mix Adjusted Rate: 8.35%
- Attainment Rate: 8.35%*1.67 = 13.94%

Proposed Modified Calculation

- OOS Ratio= 70/(42+*14 that were counted as out of state in CCW*) = 1.25
- Case-Mix Adjusted Rate: 8.35%
- Attainment Rate: 8.35%*1.25 = 10.44%

OOS Transfer Issue

- Hospitals have raised issues with OOS transfers
  - OOS transfers that are transferred back into MD are considered readmissions in case-mix
- Staff have investigated the OOS transfer issue raised by hospitals
  - using CCW data, we've found 35 and 21 cases in 2023 and 2024, respectively for Medicare FFS
  - request for non-Medicare FFS data to understand if this is a larger issue in the non-Medicare FFS population

RY 2028 RRIP Priorities

Readmission Reduction Incentive Program (RRIP) Draft Policy

The Draft Policy mainly proposes continuation of RY 2027 policy and discusses options for future alignment with CMS and other AHEAD considerations.

- Maintain the current all-payer, 30-day, all-cause readmission measure.
- Maintain the 4-year improvement target that was established in CY 2022 of 5.0 percent through 2026, but with improvement measured from a two-year base period (CY 2022 and CY 2023) as approved in the RY 2027 policy.
- Maintain attainment methodology with modification to the adjustment for out-of-state readmissions.
- Maintain the scaled rewards and penalties of 2 percent of inpatient revenue for the better of improvement or attainment.
- Removal of the revenue adjustment incentive for the readmission disparity gap measure; development of monitoring policy to continue assessing readmission disparities by race, Medicaid status, and neighborhood deprivation.
- Provides comparison of RRIP to the CMS Hospital Readmission Reduction Incentive Program (HRRP) and highlights other AHEAD readmission requirements.

RY 2027 RRIP Methodology

30-day, All-Cause Readmission Measure

Measure Includes:
Readmissions within 30 days of Acute Case Discharge:

- All-Payer
- All-Cause
- All-Hospital (both intra- and inter- hospital)
- Chronic Beds included
- IP-Psych and Specialty Hospitals included
- Adult oncology Discharges Included

Global Exclusions:

- Planned Admissions
- Same-day and Next-day Transfers
- Rehab Hospitals
- Discharges leaving Against Medical Advice Deaths

Case-Mix Adjustment

Performance Measure: CY 2025 Case-Mix Adjusted Rate Adjusted for Out-of-State Readmissions (Attainment); Reduction in Case-Mix Adjusted Readmission Rate from Base Period (Improvement)

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

Observed Unplanned Readmissions/ Expected Unplanned Readmissions * Statewide Readmission Rate

CY 2022/23 used to calculated statewide averages (normative values), as well as attainment benchmark/threshold

Revenue Adjustments

Hospital RRIP revenue adjustments are based on the better of attainment or improvement, scaled between the max reward (+2%) and max penalty (-2%) of IP revenue.

All Payer Readmission Rate CY25		RRIP % Inpatient Revenue
Lower Readmission Rate		2.00%
Benchmark	8.83%	2.00%
	10.04%	1.00%
Threshold	11.25%	0.00%
	12.46%	-1.00%
	13.67%	-2.00%
Higher Readmission Rate		-2.00%

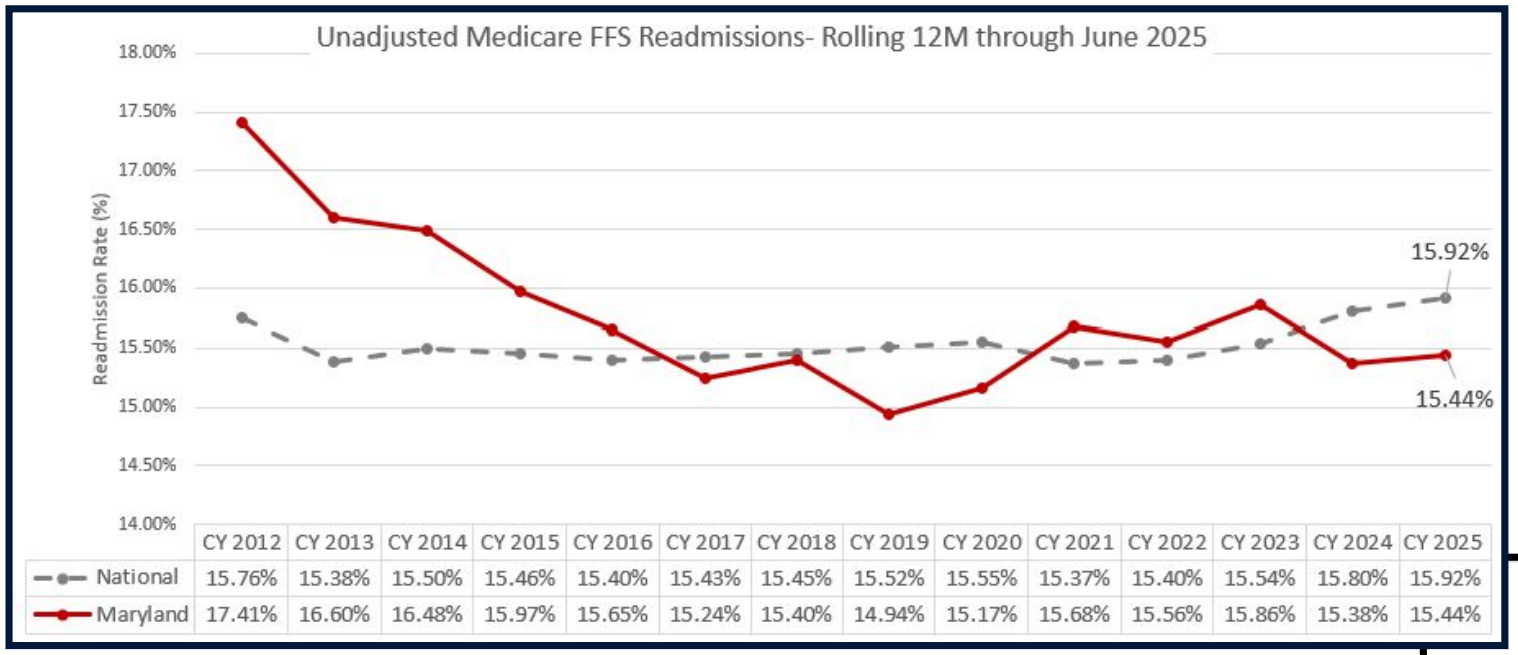
Attainment Scale

Improvement Scale

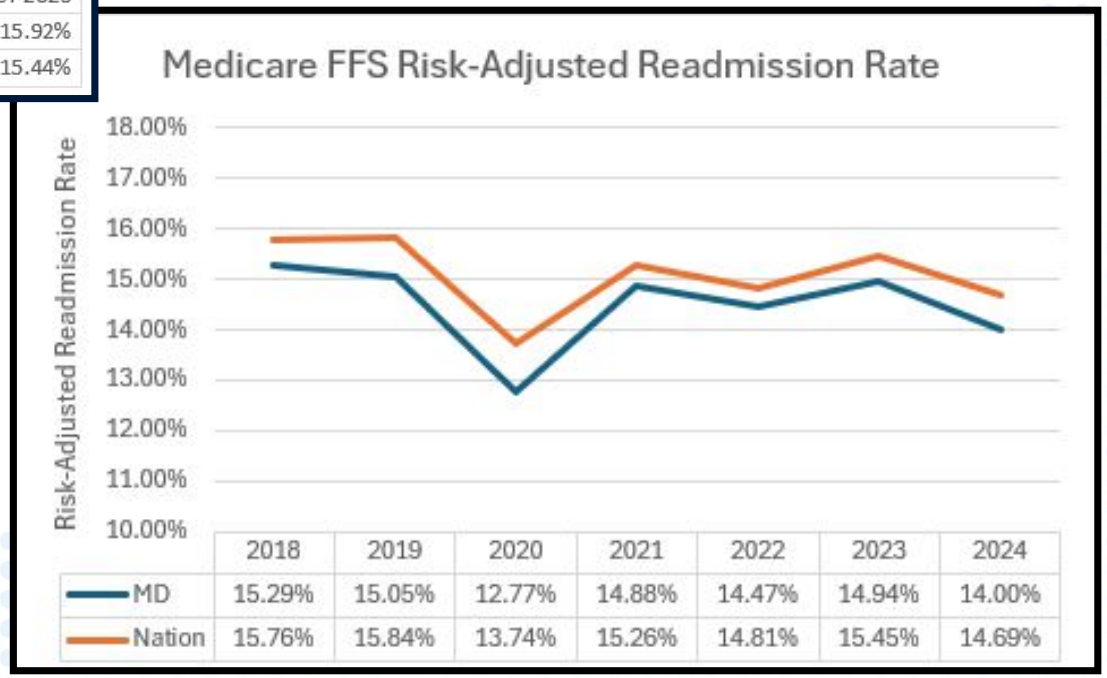
All Payer Readmission Rate Change CY22/23-25		RRIP % IP Revenue Payment Adjustment
Improving		2.00%
Benchmark	-21.04%	2.00%
	-12.41%	1.00%
Target	-3.78%	0.00%
	4.85%	-1.00%
	13.48%	-2.00%
Worsening		-2.00%

Note: Disparity gap incentive of +0.5% included in RY 2027 (not shown here)

State Performance on Medicare FFS Readmissions



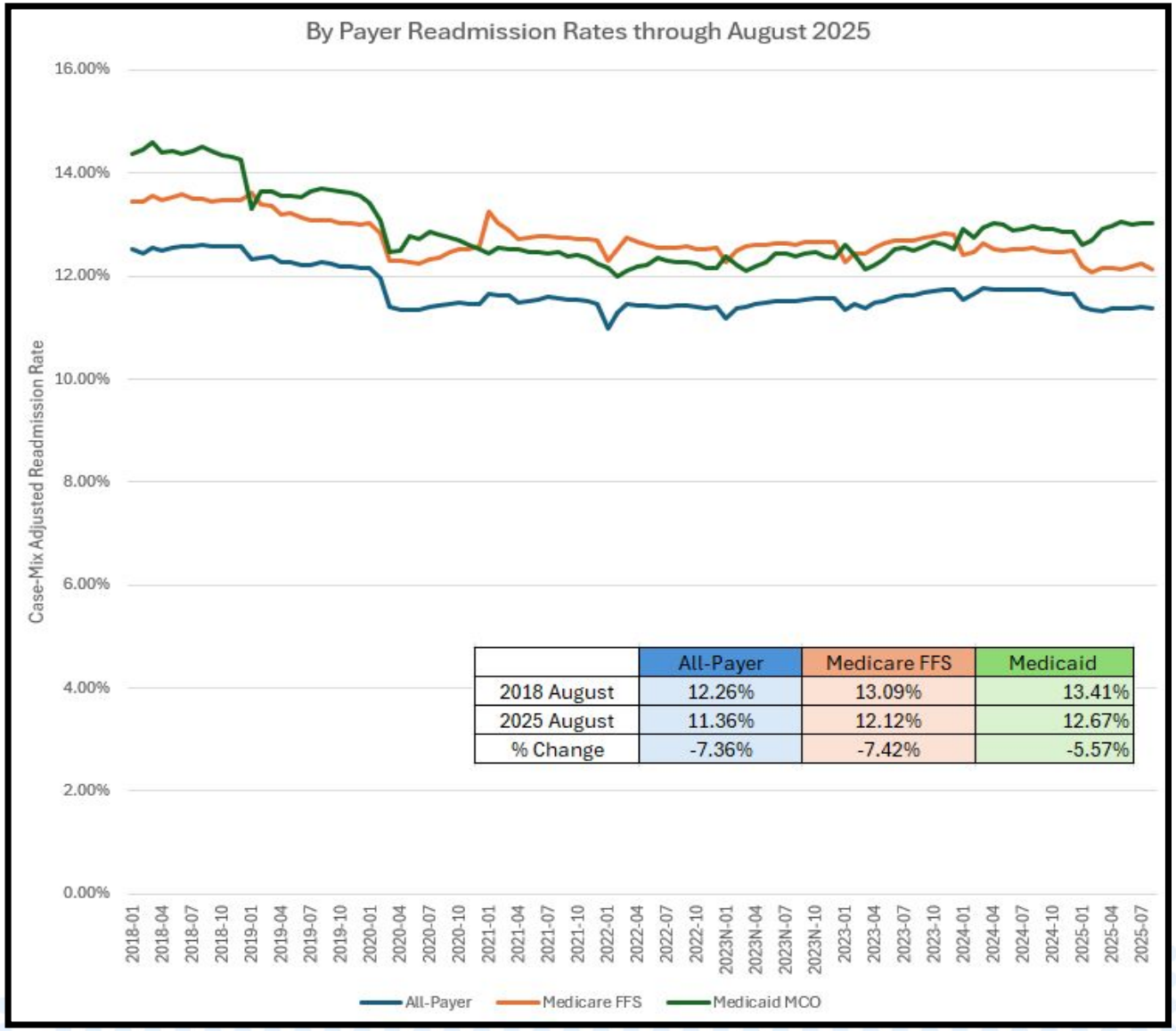
	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%	15.54%	15.80%	15.92%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%	15.86%	15.38%	15.44%



	2018	2019	2020	2021	2022	2023	2024
MD	15.29%	15.05%	12.77%	14.88%	14.47%	14.94%	14.00%
Nation	15.76%	15.84%	13.74%	15.26%	14.81%	15.45%	14.69%

State continues to meet Medicare FFS target of lower readmissions compared to nation.

All-Payer Case-Mix Adjusted Readmissions



	All-Payer	Medicare FFS	Medicaid
2018 August	12.26%	13.09%	13.41%
2025 August	11.36%	12.12%	12.67%
% Change	-7.36%	-7.42%	-5.57%

State continues to improve on All-Payer case-mix adjusted readmissions. Statewide change from CY22-23 through CY 2025 YTD is a 1.63 percent decrease.

AHEAD Alignment

AHEAD: Readmission Incentives and Goals

1. Under AHEAD, Medicare FFS hospital global budgets will be adjusted based on performance on **HRRP's condition-specific measures**
2. AHEAD Population Health Accountability Plan (PHAP) includes statewide, all-payer performance goal using **NCQA's Plan All-Cause readmission measure**
3. Other AHEAD Medicare FFS hospital global budget incentives using the hybrid and/or claims based **CMS' Hospital-Wide Readmission Measure** (i.e., Community Improvement Bonus and Effectiveness Adjustment)

Comparison of RRIP and HRRP

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

Future RRIP AHEAD Alignment

- Staff recommend to finish out the goals set under the TCOC model (through CY 2026) while concurrently engaging stakeholders to assess opportunities to align RRIP with the AHEAD model's readmission evaluation for CY 2028 and beyond for non-Medicare hospital global budgets.
- This will require decisions around:
  - Which measure to align with
  - Improvement and attainment goals
  - Social risk-adjustment
  - Revenue-at-risk

Question for Stakeholders: Should the future RRIP policy align with HRRP or the AHEAD PHAP all-payer readmission goal?

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. Modify Out Of State (OOS) ratios used for attainment to not double count readmissions for RY 2028 and retrospectively for RY 2027.
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.

Note: Comment letters are due Monday, January 26th

Inpatient Length of Stay

Current Status

- Benchmarking
  - Previously used National HCUP 2021 benchmarks.
  - Now updating reports with 2023 HCUP data (released Dec 2025)
- Risk Adjustment
  - Updating calculations to use the same version of APR-DRG for risk adjustments across all datasets
- Financial Impact
  - Penalty/reward structure based on 1% revenue at risk
- Next Steps
  - Present draft policy to commissioners in February 2026

THANK YOU!

Next Meeting: February 18, 2026