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Final Recommendation for the Readmission Reduction Incentive Program for Rate Year 2028

March 11, 2026

This document contains the final recommendations for the RY 2028 Readmissions Reduction Incentive Program.

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List of Abbreviations

ADI	Area Deprivation Index
AHEAD	Achieving Healthcare Efficiency through Accountable Design Model
AMA	Against Medical Advice
APR-DRG	All-patient refined diagnosis-related group
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
CRISP	Chesapeake Regional Information System for Our Patients
CY	Calendar year
eCQM	Electronic Clinical Quality Measure
EDAC	Excess Days in Acute Care
FFS	Fee-For-Service
FFY	Federal Fiscal Year
HCC	Hierarchical Condition Category
HRRP	Hospital Readmissions Reduction Program
HSCRC	Health Services Cost Review Commission
HWR	Hospital-Wide Readmission Measure
MCDB	Medical Claims Database
MPR	Mathematica Policy Research
MSA	Metropolitan Statistical Area
NQF	National Quality Forum
PAI	Patient Adversity Index
PMWG	Performance Measurement Workgroup
PQI	Prevention Quality Indicators
PY	Performance Year
RRIP	Readmissions Reduction Incentive Program
RY	Rate Year
SIHIS	Statewide Integrated Healthcare Improvement Strategy
SOI	Severity of illness
TCOC	Total Cost of Care
YTD	Year-to-date

Key Methodology Concepts and Definitions

AHEAD Model: The Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model is a multi-state framework initiated by CMS that aims to drive health care transformation and multi-payer alignment to improve the total health of Maryland's population while lowering costs.

HRRP: The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing program that reduces payments to hospitals with higher-than-expected 30-day readmissions for six specific conditions.

Diagnosis-Related Group (DRG): A system to classify hospital cases into categories that are similar in clinical characteristics and in expected resource use. DRGs are based on a patient's primary diagnosis and the presence of other conditions.

All Patients Refined Diagnosis Related Groups (APR-DRG): Specific type of DRG assigned using 3M software that groups all diagnosis and procedure codes into one of 328 All-Patient Refined-Diagnosis Related Groups.

Severity of Illness (SOI): 4-level classification of minor, moderate, major, and extreme that can be used with APR-DRGs to assess the acuity of a discharge.

APR-DRG SOI: Combination of diagnosis-related groups with severity of illness levels, such that each admission can be classified into an APR-DRG SOI "cell" along with other admissions that have the same diagnosis-related group and severity of illness level.

Observed/Expected Ratio: Readmission rates are calculated by dividing the observed number of readmissions by the expected number of readmissions. Expected readmissions are determined through case-mix adjustment.

Case-Mix Adjustment: Statewide rate for readmissions (i.e., normative value or "norm") is calculated for each diagnosis and severity level. These statewide norms are applied to each hospital's case-mix to determine the expected number of readmissions, a process known as indirect standardization.

Prevention Quality Indicator (PQI): a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Area Deprivation Index (ADI): A measure of neighborhood deprivation that is based on the American Community Survey and includes factors for the theoretical domains of income, education, employment, and housing quality.

Patient Adversity Index (PAI): HSCRC-developed composite measure of social risk incorporating information on patient race, Medicaid status, and the Area Deprivation Index.

Excess Days in Acute Care (EDAC): Capture excess days that a hospital's patients spent in acute care within 30 days after discharge. The measures incorporate the full range of post-discharge use of care (emergency department visits, observation stays, and unplanned readmissions).

Recommendations

These are the final recommendations for the Maryland Rate Year (RY) 2028 Readmission Reduction Incentives Program (RRIP):

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

Introduction

Maryland hospitals have been and are currently funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under agreements with the Centers for Medicare and Medicaid Services (CMS) for the state to operate the All-Payer Model (Calendar (CY) 2014- CY 2018), the current Total Cost of Care (TCOC) Model (CY 2019-CY 2025), and the upcoming AHEAD model (CY 2026- CY 2035). Under the new AHEAD Model, the State will transition in CY 2028 (Performance Year (PY) 3) to CMS establishing hospital global budgets for Medicare FFS and to the HSCRC establishing hospital global budgets for all other payers (i.e., non-Medicare FFS). Under the Medicare FFS hospital global budgets, hospitals will be held accountable for quality under the CMS quality programs and through additional AHEAD incentives, while the state may maintain

quality programs for all other payers. HSCRC staff is collaborating with CMMI, hospitals, the Maryland Hospital Association (MHA), state leaders, other health agencies, and the broad array of stakeholders on the Performance Measurement Workgroup (PMWG) to develop a transition plan that increases alignment between the state's performance based programs and the CMS national programs over the initial years of the AHEAD model.

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

The Readmissions Reduction Incentive Program (RRIP) is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve patient care and value over time that targets all-payer unplanned readmissions. While some hospital readmissions are unavoidable, other hospital readmissions within 30 days result from ineffective initial treatment, poor discharge planning, or inadequate post-acute care and result in poor patient outcomes and financially strained healthcare institutions.[1] The RRIP currently holds up to two percent of hospital inpatient revenue at-risk in penalties and rewards based on achievement of improvement or attainment targets in 30-day case-mix adjusted readmission rates.

[1] Rammohan R, Joy M, Magam S, et al. (May 15, 2023) The Path to Sustainable Healthcare: Implementing Care Transition Teams to Mitigate Hospital Readmissions and Improve Patient Outcomes. Cureus 15(5): e39022. doi:10.7759/cureus.39022

For RRIP, as well as the other State hospital quality programs, updates are vetted with stakeholders and approved by the Commission to ensure the programs remain aggressive and progressive with results that meet or surpass those of the national CMS analogous programs (from which Maryland must receive annual exemptions). For purposes of the RY 2028 RRIP Draft Policy, staff vetted the updated proposed recommendations with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Transitioning to the AHEAD Model

The AHEAD model, which will begin in January 2026, includes a two year transition period where the state will maintain its all-payer rate setting system. The new CMS Medicare FFS hospital global budgets will begin in CY 2028 and at that time, the hospitals will transition to the CMS quality programs for Medicare FFS and the state will administer hospital global budgets and quality programs for all other payers. For RY 2028, which will assess CY 2026 performance, staff is working to assess all of the quality programs to determine opportunities for better alignment with the CMS programs. The initial focus of the state's transition work has been aligning the Quality Based Reimbursement (QBR) program with the Hospital Value-Based Purchasing (HVBP) program. During CY 2026, staff proposes to engage stakeholders to assess opportunities for further alignment with the AHEAD Model.

Under the AHEAD Model, hospital global budgets will be adjusted for readmissions through multiple mechanisms. First, beginning in calendar year (CY) 2028, the AHEAD Hospital Global Budget (HGB) for Medicare FFS will incorporate adjustments based on a hospital's performance under the Hospital Readmission Reduction Program (HRRP). Second, as part of the AHEAD Model, the State submitted a Population Health and Accountability Plan (PHAP) that includes the CMMI-recommended National Committee for Quality Assurance (NCQA) Plan All-Cause Readmissions (PCR) measure, which will be used to assess statewide readmissions performance over the nine-year model period. In addition, the Medicare HGB methodology includes a Community Improvement Bonus (CIB) and an Effectiveness Adjustment (EA). The CIB will assess performance on two measures: the digital Hybrid Hospital Wide Readmission (Hybrid eHWR) measure and Prevention Quality Indicators (PQI-90). The EA, as staff understands it, applies a downward adjustment based on a hospital's Medicare fee-for-service (FFS)

performance relative to other statewide hospitals on the revenue associated with unplanned readmissions, avoidable admissions, and ED utilization out of total revenue. Readmissions are determined using the planned readmission algorithm from CMS' Hospital-Wide All-Cause Unplanned Readmission (HWR) measure, Avoidable admissions are defined by AHRQ's PQI-90 measure, and ED Utilization is measured using the NCQA Emergency Department Utilization (EDU) measure. Last, Maryland may continue to adjust non-Medicare HGB based on readmission performance.

For the RY 2028 RRIP policy, staff proposes to maintain the 4-year improvement target of -5.0 percent through CY 2026 compared to the two year base period of CY 2022 and CY 2023. This will finish out the goal set under the TCOC model and give staff time to engage stakeholders toassess opportunities to align the RRIP with the AHEAD model's readmission evaluation. Specifically, alignment entails consideration of measures, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

Background

Brief History of RRIP Program

Maryland made incremental progress each year throughout the All-Payer Model (2014-2018), ultimately achieving the Model goal for the Maryland Medicare FFS readmission rate to be at or below the unadjusted national Medicare readmission rate by the end of Calendar Year (CY) 2018. Maryland historically performed poorly compared to the nation on readmissions; it ranked 50th among all states in a study examining Medicare data from 2003-2004.[2] In order to meet the All-Payer Model Medicare requirements, the Commission approved the inaugural RRIP program in April 2014 to further bolster the incentives to reduce unnecessary readmissions beyond the incentives already inherent in the global budget system. In addition to the Medicare FFS targets for the State, CMMI historically required the RRIP to address all-payer readmissions. As recommended by the Performance Measurement Work Group (PMWG), the RRIP is more comprehensive than its federal counterpart, the Medicare Hospital Readmission Reduction

[2] Jencks, S. F. et al., "Hospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* Vol. 360, No. 14: 1418-1428, 2009.

Program (HRRP), as it uses an all-cause, all-condition measure and assesses both improvement and attainment, whereas, HRRP uses Medicare-only condition specific readmission measures to assess attainment.[3] Figure 1 below compares the RRIP to the HRRP.

Figure 1. RRIP Compared to 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

With the onset of the Total Cost of Care Model (TCOC) Agreement, each program was overhauled to ensure the policy supported the goals of the Model. For the RRIP policy, the overhaul was completed during 2019, which entailed an extensive stakeholder engagement effort. The major accomplishments of the RRIP redesign were modifications to the inclusion and exclusion criteria for the readmission measure, development of a 5-year (2018-2023) improvement target of -7.5 percent, adjustment of the attainment target based on national Medicare and commercial benchmarks, and the addition of an incentive to reduce within hospital disparities in readmissions. Subsequently, during CY2023, staff reassessed Maryland's performance on readmissions and developed a four-year (2022-2026) improvement target of 5 percent that was approved in the RY2026 policy. This improvement target was set using a range of potential improvement scenarios (e.g., historical improvements trended forward) and updated benchmarking for Medicare and Commercial payers nationally.

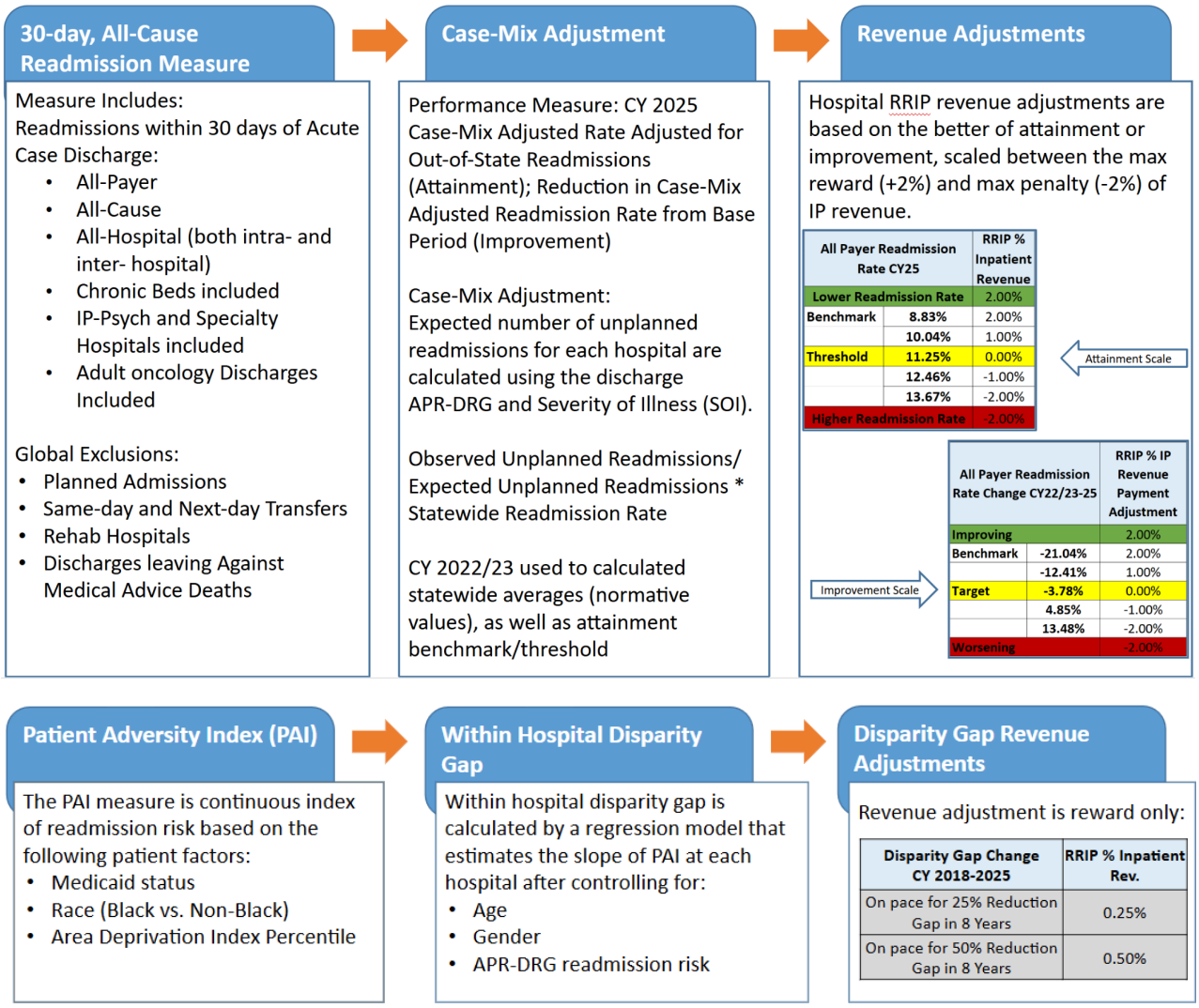
[3] For more information on the HRRP, please see: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program

RRIP Methodology

Figure 2 provides an overview of the current RRIP methodology (also see Appendix I) that converts hospital performance to payment adjustments. In Maryland, the RRIP methodology evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges (e.g., pediatric oncology, patients who leave against medical advice, rare diagnosis groups) from consideration, due to data issues and clinical concerns. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR-DRG) severity of illness (SOI), and the policy determines a hospital's score and revenue adjustment by the better of improvement or attainment.[4] The disparity gap methodology is separate and provides hospitals with the opportunity to earn rewards (no penalties) based on improvement.

[4] See Appendix I for details on the current RRIP methodology.

Figure 2. RRIP Methodology RY2027



Assessment

For RY 2028, there are no proposed changes to the readmission measure, however, staff is recommending that additional analytics continue to be conducted over the coming year to assess impact of observation stays, which staff believe will complement some of the other workstreams the Commission currently is engaging in to improve emergency department length of stay and align with the AHEAD Model's Population Health Accountability Plan (PHAP) readmission

measure. Also, staff is recommending a modification to the calculation of Out-Of-State Ratios used to adjust the readmission measure for attainment.

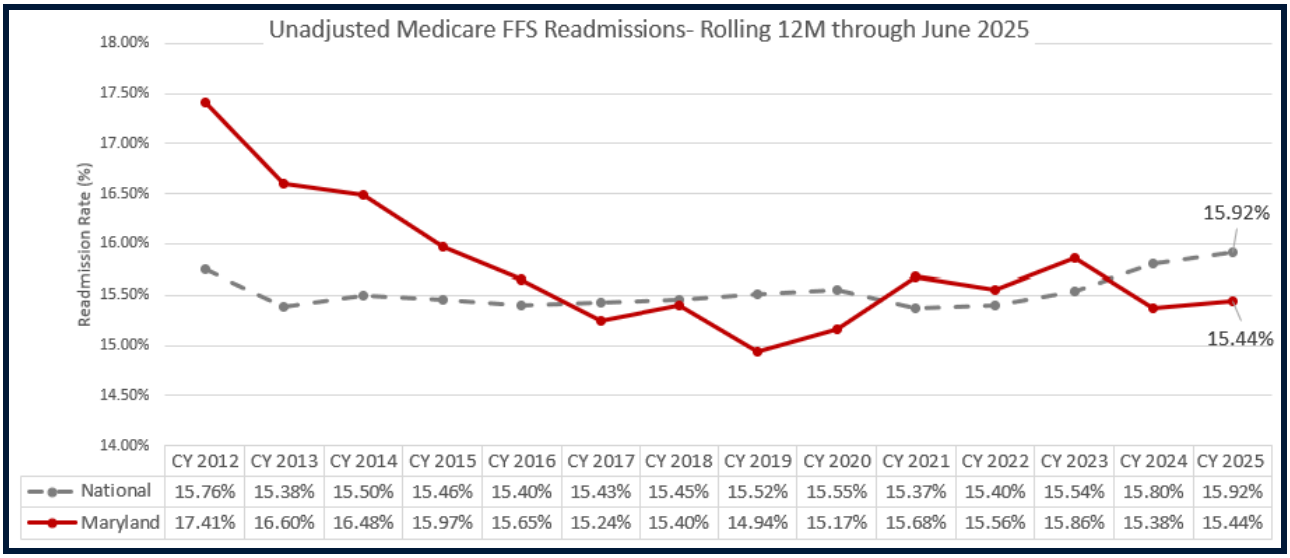
Current Statewide Year To Date Performance

Readmission performance is assessed in several ways using different measure specifications. First, we present data on the unadjusted, all-cause Medicare readmission rate (the original "Waiver Test"), which shows that Maryland currently has a slightly lower unadjusted readmission rate than the nation. Second, we present Maryland and national performance on the CMMI-adapted Hospital-Wide Readmission (HWR) measure for Maryland (the revised "Waiver Test"). Third, we present the all-payer, case-mix–adjusted readmission results used for the Readmissions Reduction Incentive Program (RRIP). Fourth, we present the condition-specific readmission results used for the Hospital Readmission Reduction Program (HRRP). Finally, we present performance on the NCQA Plan All-Cause Readmissions (PCR) measure, which will be used to assess statewide performance under the AHEAD Model. Also, please refer to the RY 2028 Quality Based Reimbursement policy for discussion of the state's collection of digital quality measures in alignment with the CMS. Specifically, the state is requiring submission of the Core Clinical Data Elements (CCDE) used for the digital Hybrid HWR measure and could consider augmenting the RRIP all-payer measure with EHR data elements in the future. Below we present the currently available data using the measures from CMMI, CMS, and HSCRC.

Medicare FFS Performance

At the end of 2018, Maryland had an unadjusted Medicare FFS readmission rate of 15.40 percent, which was below the national rate of 15.45 percent. This was the measure that CMMI used to assess Maryland's successful performance on readmissions under the All-Payer Model. Under the TCOC model, Maryland is required to maintain a Medicare FFS readmission rate that is below the nation. While the unadjusted Maryland Medicare rate was higher than the nation starting in 2021, the CY2025 rolling 12 months readmission data, which is presented in Figure 3, shows Maryland's readmission rate at 15.44 percent, which is lower than the Nation's performance at 15.92 percent.

Figure 3. Maryland and National Medicare FFS Unadjusted Readmission Rates

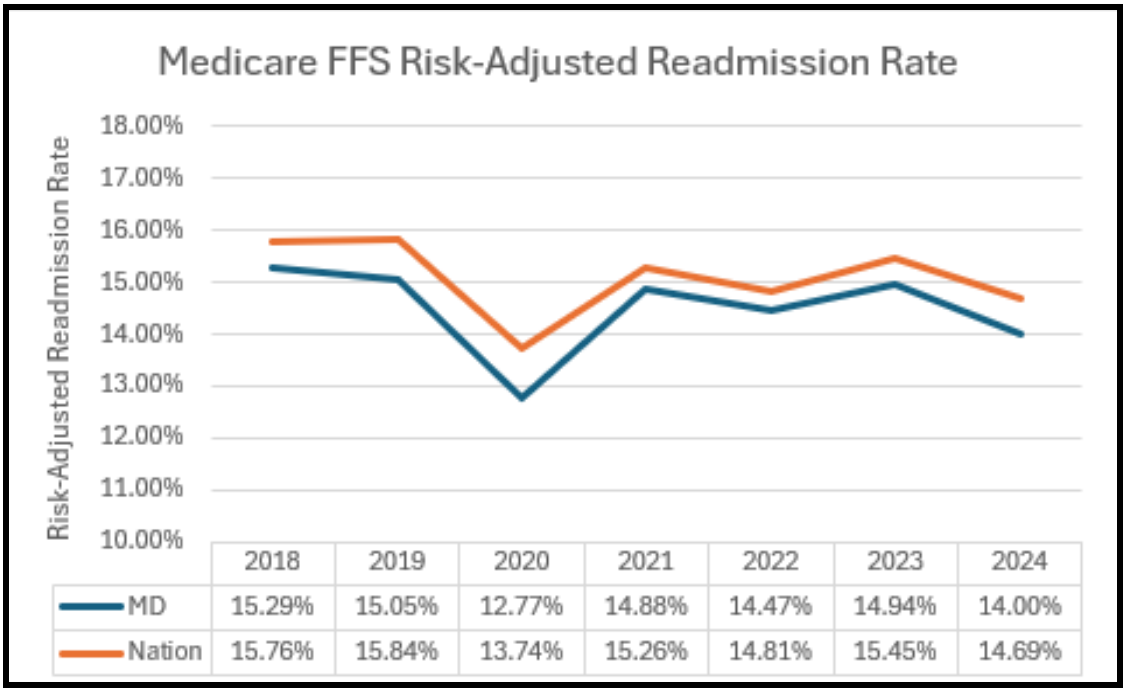


	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%	15.54%	15.80%	15.92%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%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

Hospital Wide Readmission Measure Performance

Because of concerns about changes in patient acuity, CMMI agreed to switch to a risk-adjusted readmission measure to compare Medicare FFS performance in Maryland compared to the Nation. Beginning with CY 2023 performance, CMMI calculated a risk-adjusted hospital wide readmission (HWR) measure modified to include Medicare FFS beneficiaries under the age of 65 and a few other adjustments. Figure 4 provides the Maryland and National results on readmissions for CY 2018 and CY 2024 from CMMI using this modified HWR measure. Based on this data, the State has met its contractual goal of performing better in CY 2024 than in CY 2018 and performing better than the nation in CY 2024. Since 2018, Maryland has reduced Medicare readmissions by 8.44 percent, while the nation has reduced readmissions by 6.79 percent. While the contractual test does not require Maryland to be statistically better than the nation, the analysis by CMMI found that Maryland was statistically better than the nation in CY 2024. Currently staff are awaiting the final report for CY 2025 performance, however, 12-month data through August 2025 indicates Maryland continues to outperform the nation on this risk-adjusted readmission measure.

Figure 4. Maryland and National Medicare FFS Hospital-Wide Readmission Measure Performance



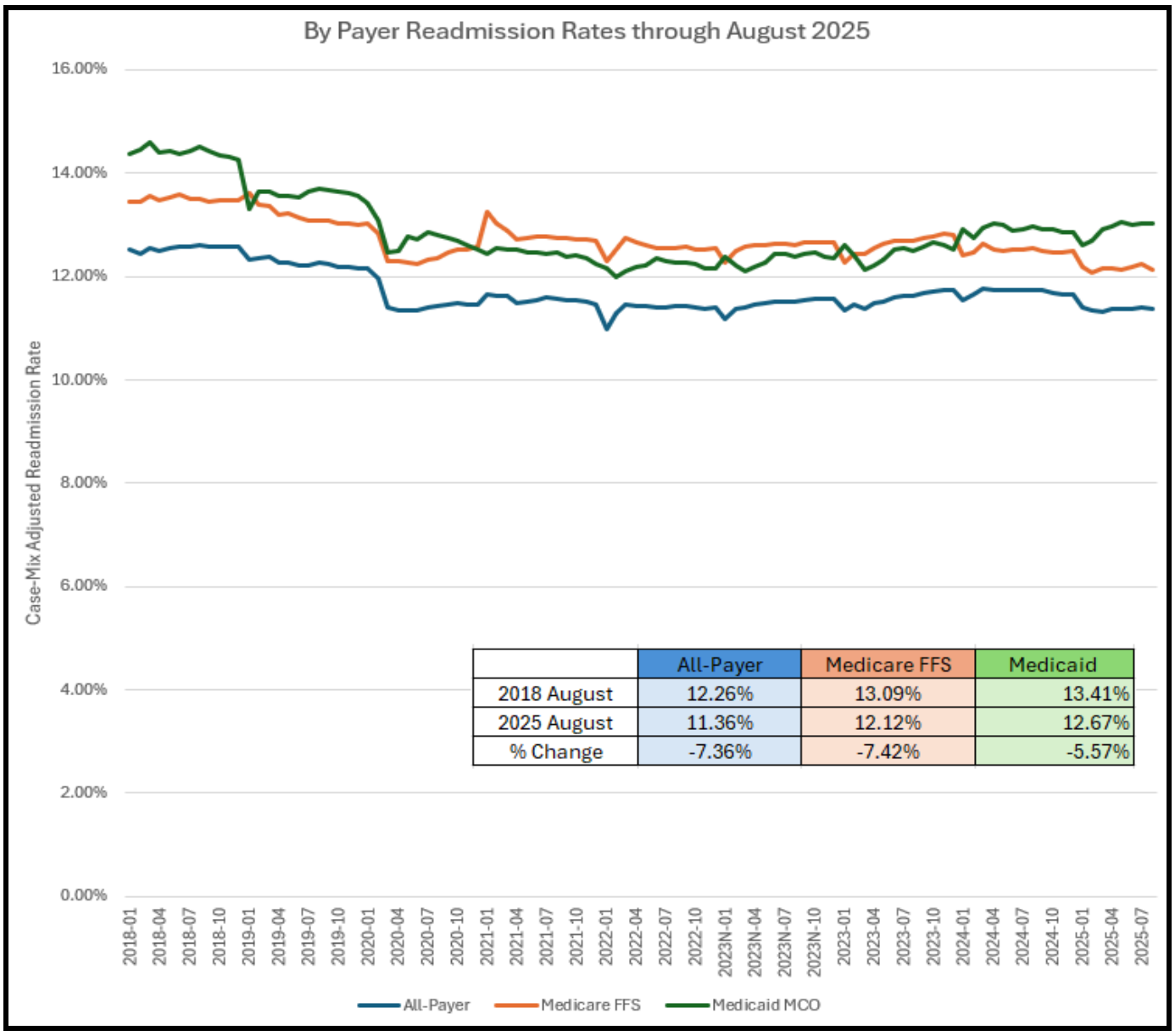
	2018	2019	2020	2021	2022	2023	2024
MD	15.29%	15.05%	12.77%	14.88%	14.47%	14.94%	14.00%
Nation	15.76%	15.84%	13.74%	15.26%	14.81%	15.45%	14.69%

https://hscrc.maryland.gov/pages/default.aspx

All-Payer Readmission Performance

Maryland has also performed well statewide over time on RRIP performance standards as shown in Figure 5. Through August of 2025 compared to August of 2018, All-Payers, Medicare FFS, and Medicaid beneficiaries saw a reduction in readmissions of 7.36 percent, 7.42 percent, and 5.57 percent, respectively.

Figure 5. Statewide Change in Case-Mix Adjusted Readmission Rates by Payer, 2018 through August 2025



	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%

The RY 2027 RRIP program assesses improvement from a two-year base period of CYs 2022 and 2023 to CY 2025, and attainment performance in CY 2025 based on historical standards. Statewide there has been a 1.56 percent improvement in 2025 YTD compared to the

CY2022/2023 base period. As illustrated in Figure 6 below, 22 hospitals are on target to reach the improvement goal of a 3.78 percent reduction, and as shown in Figure 7, 12 hospitals are on target to have a readmission rate below the attainment threshold of 11.25 percent. Hospitals performing well on either improvement or attainment will receive a revenue adjustment equal to the better of these evaluations, in line with the policy aim of simultaneously incentivizing excellent performance and constant improvement. Overall there are 24 unique hospitals on track to receive a scaled reward for CY 2025 performance. The most recent data through November shows that the statewide readmission rate has only decreased by 0.43% from the two-year base period of CY 2022-CY2023. During this time, there has been a 22.37% decrease in readmissions for the Medicare FFS population, however, the Medicaid (FFS and MCO) population has seen an increase in readmissions by 23.14%. Staff are analyzing the case-mix dataset to understand what's driving the increase in Medicaid utilization.

Figure 6. By-Hospital Change in All-Payer Case Mix Adjusted Readmission Rates, 2022/2023- 2025 YTD Through August

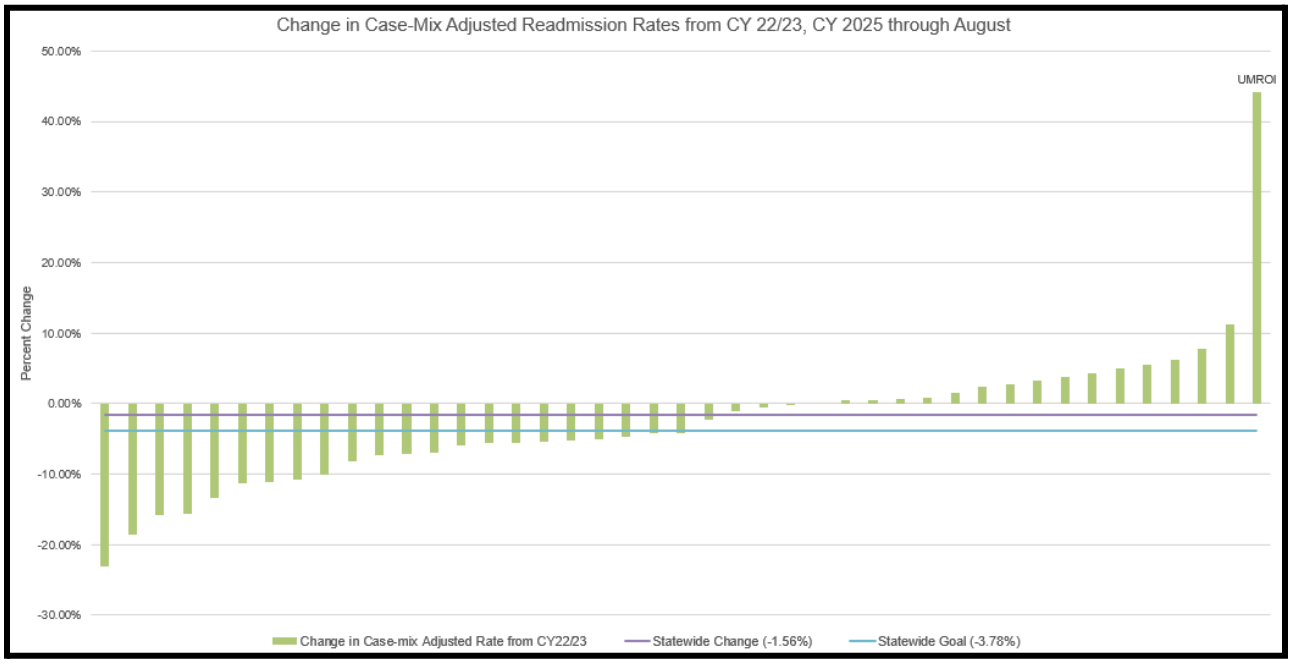
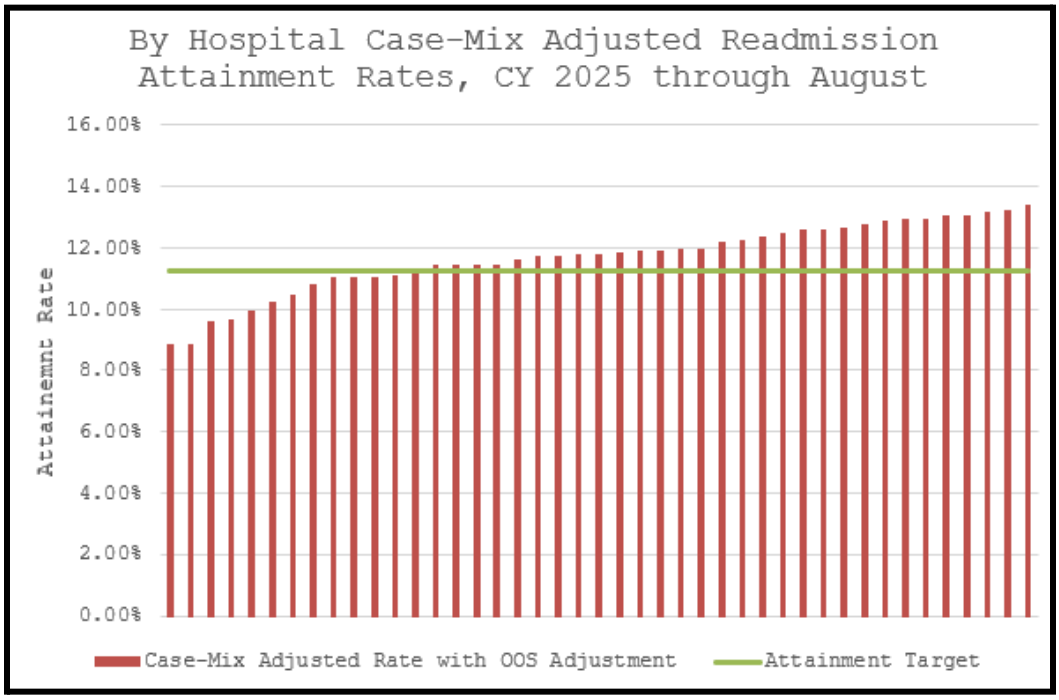


Figure 7. By-Hospital Case Mix Adjusted Readmission Rates, YTD 2025

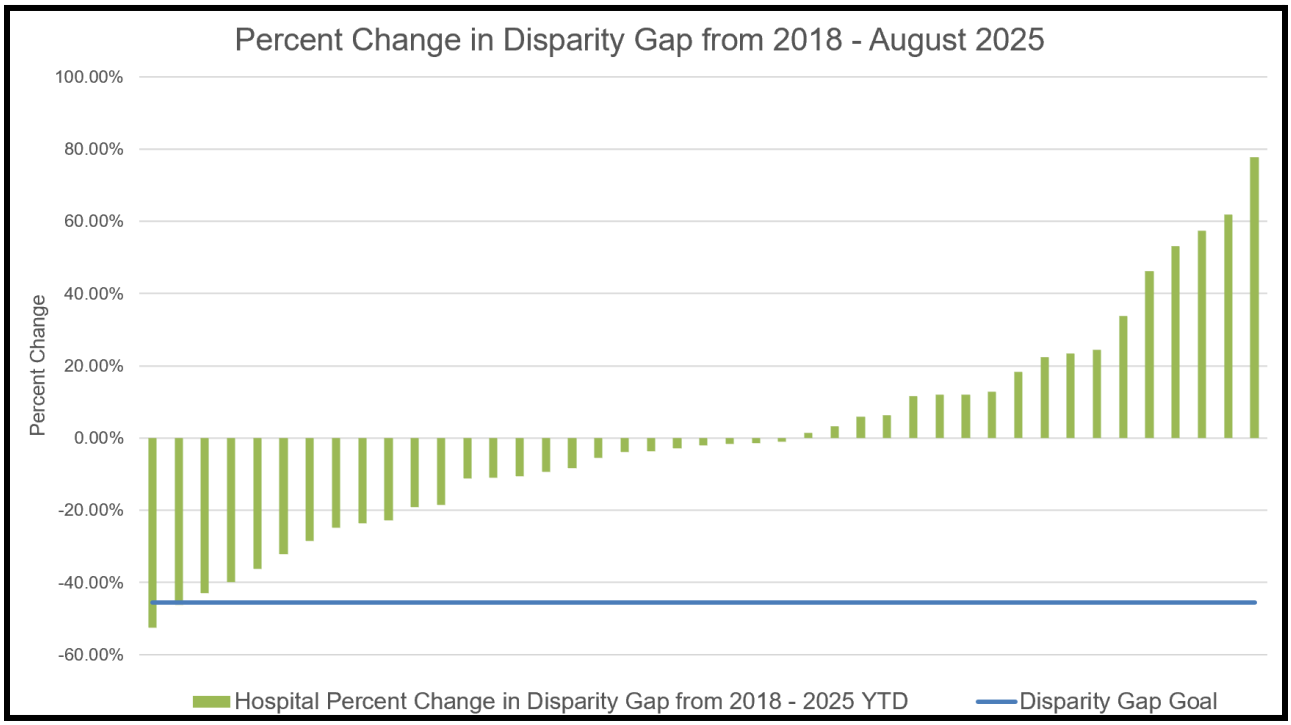


Disparities in Readmissions

Beginning in RY 2021, Maryland hospitals could be rewarded for reducing disparities in readmissions using HSCRC developed methodology. The reduction in readmission disparities was included as a Statewide Integrated Health Improvement Strategy (SIHIS) goal under the TCOC model. Specifically, the goal was to have at least half of Maryland hospitals achieve at least a 50 percent reduction from CY 2018 to CY 2026. For RY 2027, through August of 2025, 25 hospitals have reduced readmission disparities by an average of -18.40 percent, with a range of reductions from -1.01 percent to -52.50 percent. Via the disparity gap component of the RRIP, two hospitals are on track for receiving rewards for reducing their disparities in readmissions by at

least -45.47 percent in CY 2025 compared to CY 2018, as seen below in Figure 8. For RY 2028, to better align with the National readmissions program, the RRIP draft recommendation is to monitor reductions in readmissions disparities in readmissions by reporting performance quarterly at Commission meetings. For details on the measure used to assess disparities in readmissions, see Appendix V.

Figure 8. By-Hospital Changes in Readmission Disparities, CY 2025 through August compared to CY 2018



Hospital Readmission Reduction Program Performance

The CMS Hospital Readmission Reduction Program (HRRP) assesses readmissions for Medicare using six condition specific, all-cause readmissions measures and comparing performance of hospitals within peer groups based on proportion of dually eligible Medicare beneficiaries. For FFY 2025, CMMI provided proxy payment adjustment factors to estimate how Maryland hospitals would have performed under the HRRP program. The Maryland data from CMMI was compared with national HRRP data found on Care Compare (Figure 9). The Maryland data indicates that 84

percent of hospitals in the state would receive a penalty, with the median penalty among those that would have been penalized of 0.20 percent (minimum penalty 0.01 percent and maximum penalty 1.07 percent). While the national data indicates that a lower percentage of hospitals would receive a penalty (79 percent), the median penalty among those that were penalized is higher at 0.27 percent (minimum penalty 0.01 percent and maximum penalty 3 percent). Furthermore, the average penalty for Maryland hospitals was lower than the nation for each of the five dual eligible peer groups. Thus despite the higher proportion of hospitals in Maryland that would be penalized for excess readmissions, on average Maryland hospitals have lower excess readmissions as shown by the lower penalties that Maryland hospitals would receive. Given these condition specific measures use multiple years of data through the June of 2023, these results are not surprising since the unadjusted Medicare test also showed favorable results over the same time period.

Figure 9. FFY 2025 HRRP Performance, Maryland vs Nation

FY 2025 (July 1, 2020 - June 30, 2023)		Maryland	Nation
Percent of Hospitals with Penalty		83.72%	78.59%
Median Penalty*		0.20%	0.27%
Average Penalty*		0.30%	0.41%
Average Penalty by Dual Peer Group			
Low Proportion	1	0.23%	0.32%
	2	0.26%	0.35%
	3	0.28%	0.32%
	4	0.16%	0.31%
High Proportion	5	0.05%	0.31%
*Calculated among those penalized only.			

National Committee for Quality Assurance Plan All-Cause Readmission Measure

As mentioned above in the “Transitioning to AHEAD” section, the Population Health Accountability Plan (PHAP) will assess statewide readmission performance using the National Committee for Quality Assurance Plan All-Cause Readmission (NCQA PCR) measure based on CMMIs directive. Furthermore, CMMI also required that the Statewide goal be all-payer rather than

Medicare specific. The NCQA readmission measure was originally designed as a health plan measure (i.e., HEDIS). Figure 10 provides a comparison of the RRIP and NCQA readmission measure, both of which look at all-cause unplanned readmissions for all eligible patients (i.e., not condition specific). The biggest differences between the measures is that the NCQA readmission measure includes both inpatient and observation visits as both index and readmissions, and the by-payer risk adjustment method used for the NCQA measure. HSCRC worked with contractors to adapt this health plan measure to calculate a Maryland statewide observed to expected ratio using claims data for Medicare FFS, Medicare MA, Medicaid, and Commercial.

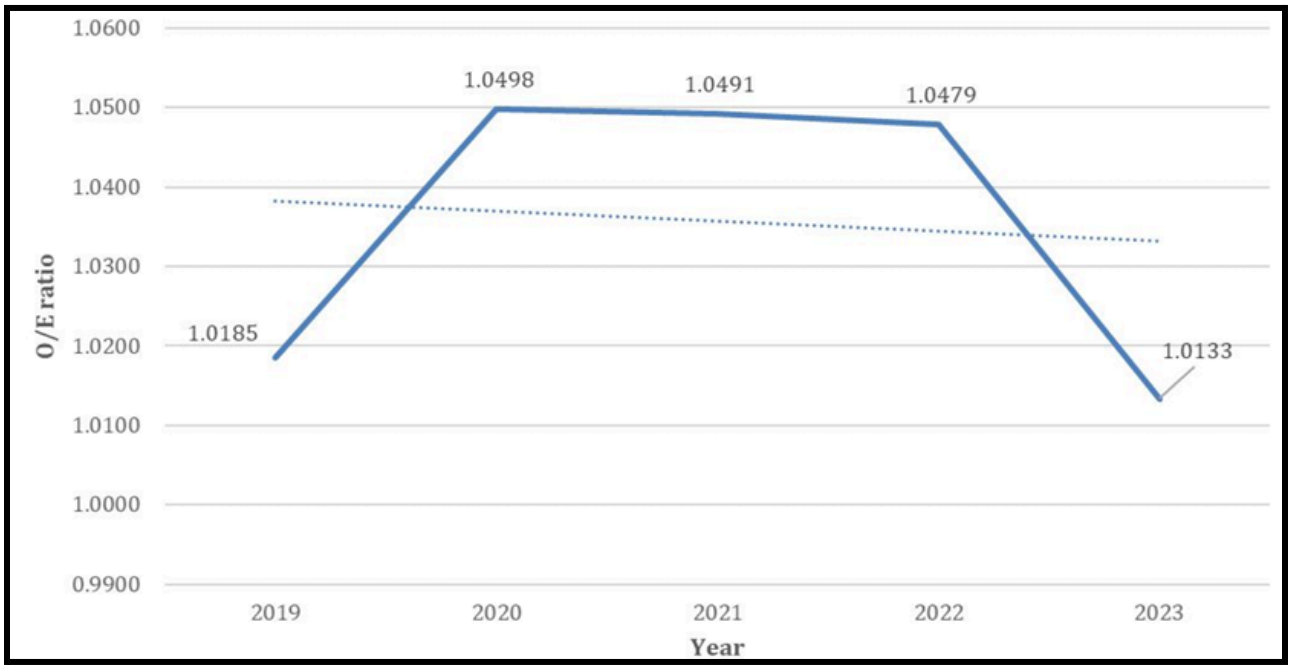
Figure 10. Comparison of the NCQA PCR and RRIP Readmission Measures

Feature	Maryland RRIP	NCQA PCR
Readmission Type	All-cause, unplanned inpatient readmissions	All-cause, unplanned inpatient **and observation** readmissions
Numerator	Number of observed unplanned readmissions	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	Number of expected unplanned readmissions based on discharge APR-DRG and SOI	Any acute inpatient or observation stay discharge occurring during the measurement year; patients must be 18 or older during the month of discharge date and have 365 days on continuous enrollment before index admission and 30 days after index.
Exclusions	CMS Planned Readmission Logic, Bone marrow transplants and liquid tumor patients, Left AMA, transfers, newborn DRGs	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/IP admission. Patients with 4+ inpatient admissions in a year.
Risk-Adjustment	Case-mix and APR DRG SOI level	Risk-adjusted by IP vs. observation status, discharge condition, age, gender, surgical procedure, and SNF and dual eligibility status based on predetermined weights by payer

Figure 11 below presents Maryland's all-payer observed to expected ratio, which shows that from 2019 to 2023, Maryland saw a 0.51 percent decrease in readmissions. However, given the

increase in readmissions during COVID, this trend should be interpreted with caution. Thus, staff also utilized NCQA and other readmission benchmarks calculated by the HSCRC to propose targets for improvement to the [insert MCHE reference and that they were body to review]. Based on staff analyses, historical improvements in readmissions (i.e., gains the state has already made since 2013), and stakeholder input, a readmission goal of a 3.07 percent reduction in the O/E ratio between 2023 and 2034 was submitted to CMMI in the PHAP proposal. This is currently under review by CMMI. Staff believes that the Commission should consider whether the non-Medicare global budget adjustments for readmissions should align with the final PHAP goal or the HRRP program. Staff is currently working with contractors to adapt the NCQA readmission measure to the case-mix dataset to see if it can be used for RRIP in the future.

Figure 11. Maryland Performance on NCQA PCR measure, CY 2019- CY 2023



Out of State Adjustment Concerns

The RRIP policy assesses attainment by adjusting the all-payer readmission rate to account for out-of-state (OOS) readmissions which is defined as “Total number of Medicare FFS

Readmissions/ Number of in-state readmissions". The RRIP methodology uses Medicare FFS OOS ratios calculated via the Chronic Conditions Warehouse (CCW) dataset, which are used as a proxy for all-payer OOS readmission patterns. Without an OOS readmission adjustment, hospitals across the State could not be compared fairly as some hospitals may have higher OOS readmissions (e.g., border hospitals, systems with OOS hospitals). Hospitals have raised concerns about the accuracy and use of the OOS readmission ratio within the RRIP.

Staff investigated the issues brought by hospitals regarding the accuracy and use of the OOS readmission ratios and uncovered that there are two issues that need to be addressed. First, readmission cases are being captured as a readmission in both the in-state case-mix dataset as well as in the CCW's OOS ratio (i.e., are being double counted). Second, as hospitals suggested, transfers out of state that are then transferred back to Maryland flag a readmission in the Case-Mix dataset, even though they represent a continuation of care rather than a true unplanned readmission event. Furthermore, transfers into Maryland also present the concern of being treated as eligible for a readmission although they should not be eligible as the transfer represents a continuation of care rather than a true admission that is eligible for a readmission (i.e., transferring hospital has an inflated denominator). Appendix II provides examples of cases that are double counted and Appendix III provides an example of how OOS transfers that are then transferred back to Maryland are flagged for a readmission in the Case-Mix dataset.

In collaboration with stakeholders, Staff was able to identify an approach to adjusting readmissions that addresses both the OOS readmissions and the OOS transfer issue. Staff has coined this approach as the "OOS Utilization Adjustment". Details on the OOS Utilization Adjustment Methodology are provided in Appendix IV. To appropriately account for OOS readmissions and transfers, staff recommends adjusting the case-mix readmission rate by the OOS Utilization Adjustment, for RY 2027 and beyond. Applying the Utilization Adjustment to the RY 2026 results (most recent full year of data that is available for modeling) yields a statewide net adjustment of ~$30.5M, consisting of ~$47.9M in net penalties and ~$17.4M in net rewards. Revenue adjustment comparisons of the Utilization Adjustment to the revenue adjustments that were put into rates (i.e., incorrect OOS ratios) and the updated OOS ratios are included in Appendix IX. Additional discussion of the OOS readmission and transfer impact and whether RY

2026 should be adjusted is discussed in the stakeholder feedback section with options for Commissioner consideration

Hospital Scores and Revenue Adjustments

This section provides an overview of the RRIP and HRRP revenue adjustment methodology and then presents modeling of hospital scores and revenue adjustments for the RY 2027 program and the final RY 2025 RRIP and estimated FFY 2025 HRRP results for Maryland hospitals.

Comparison of RRIP and HRRP Scoring and Revenue Adjustment Methodology

Under the RRIP, hospitals are scored based on their performance on the case-mix adjusted readmission measure that compares each hospital's observed readmissions to expected readmissions for all-payers. Hospital revenue adjustments are based on the better of improvement in readmission rate or attainment of relatively low readmission rate. Improvement in the readmission rate is determined by calculating the percentage change in the readmission rate in the performance period compared to the readmission rate in the base period; the attainment rate is calculated as the case-mix adjusted rate in the performance period further adjusted by the Medicare OOS ratio. The improvement and attainment rates are compared to predetermined improvement and attainment targets. The 65th percentile of best performers in the base period is the threshold to begin receiving rewards for attainment, which allows hospitals in the top-third of Maryland performance to earn financial rewards. The improvement target is set based on the modeling of various improvement scenarios (e.g., historical trends, commercial and Medicare benchmarking). Comparing a hospital's performance to the targets, the policy determines a hospital's final revenue adjustment as the better of revenue adjustments for improvement or attainment, with scaled rewards and penalties up to two percent of a hospital's inpatient revenue.

In contrast, the HRRP uses six condition specific readmission measures and calculates excess readmissions by hospital for each condition for Medicare beneficiaries.[5] For each HRRP condition,

[5] The six condition specific measures are 1. Acute Myocardial Infection (AMI) 2. Coronary Artery Bypass Grafting (CABG) 3. Coronary Obstructive Pulmonary Disease (COPD) 4. Heart Failure (HF) 5. Total Hip Arthroplasty and Total Knee Arthroplasty (THA/TKA) 6. Pneumonia (PN)

CMS applies a hierarchical logistic regression model that adjusts for patient's age and sex, diagnoses and comorbidities from claims, and a hospital-specific random effect to generate both observed readmissions and expected readmissions. The performance metric is the Excess Readmission Ratio (ERR) which is the ratio of observed to expected readmissions; values greater than 1.0 indicate worse-than-expected performance. For each HRRP condition, the program then compares hospitals' ERRs to those with similar proportions of dual eligibles (i.e., peer groups) and penalizes those with excess readmissions up to three percent of base operating DRG payments for all Medicare inpatient discharges. HRRP assesses readmissions based on peer groups to improve adjustment for social risk given that differences in hospitals' patient populations are not fully captured by claims-based risk adjustment. The actual penalty received is proportional to the excess readmission for each condition (i.e., higher penalties mean greater excess readmissions compared to others in peer group).

Maryland's RRIP and Estimated HRRP Revenue Adjustments

In the Assessment Section, readmission performance in the RY 2027 program is presented. In Figure 12 below, the RY 2027 year-to-date (YTD) revenue adjustments are estimated using performance through August. Statewide the net revenue adjustment is a reduction of approximately $18 million or -0.14 percent of inpatient revenue. Specifically, 19 out of 44 hospitals would receive a penalty with the average penalty being -0.57 percent of inpatient revenue (penalties range from -1.34 percent to -0.10 percent), the other 25 hospitals would receive a reward with the average reward being 0.78 percent (rewards range from 0.04 percent to 2 percent). By-hospital results are presented in Appendix VI.

Figure 12. Summary of Statewide Estimated RRIP RY 2027 YTD through August Revenue Adjustments[6]

Statewide Summary	Improvement Scaling		Attainment Scaling		Final Adjustment	
Net Adjustments	-$33,119,595.00	-0.26%	-$82,476,354.24	-0.65%	-$17,879,167.24	-0.14%
Penalty	-$53,891,691.00	-0.43%	-$91,995,937.24	-0.73%	-$42,882,684.24	-0.34%
Reward	$20,772,096.00	0.16%	$9,519,583.00	0.08%	$25,003,517.00	0.20%

[6] These estimates do not include the update to the new out of state adjustment being recommended for RY 2027 and beyond.

Revenue adjustments for RY 2026 RRIP performance is shown in Figure 13, however, an error was identified in the OOS ratios used to calculate the attainment rates. Figure 14 provides a statewide summary of Final RY 2026 RRIP performance using the originally intended OOS readmission ratios which staff will implement in the RY 2027 (i.e., starting in July 2026). By-hospital comparisons of revenue adjustments with incorrect and updated OOS readmission ratios are in Appendix VII. Further discussion of the correction of this error and the change to the OOS utilization methodology is included in the Stakeholder Feedback section. As with RY 2027 YTD estimates, there was a net negative revenue adjustment statewide. Prior to RY 2026, which updated the base period to be post-COVID (i.e., CY 2022-2023) and provided a new readmission improvement goal, the statewide net revenue adjustments had been positive for all years of the RRIP program.

Figure 13. Summary of Final Statewide RY 2026 Revenue Adjustments in Rates[7],[8]

Statewide Summary	Improvement Scaling		Attainment Scaling		Final Adjustment	
Net Adjustments	-$45,899,899	-0.36%	-$100,545,103	-0.80%	-$27,938,378	-0.22%
Penalty	-$57,893,582	-0.46%	-$110,027,989	-0.87%	-$45,138,690	-0.36%
Reward	$11,993,683	0.09%	$9,482,886	0.08%	$17,200,312	0.14%

Figure 14. Summary of Final Statewide RY 2026 Revenue Adjustments[9],[10]

Statewide Summary	Improvement Scaling		Attainment Scaling		Final Adjustment	
Net Adjustments	-$45,899,899	-0.36%	-$100,934,927	-0.80%	-$28,796,745	-0.23%
Penalty	-$57,893,582	-0.46%	-$109,019,144	-0.86%	-$45,156,858	-0.36%
Reward	$11,993,683	0.09%	$8,084,217	0.06%	$16,360,113	0.13%

CMMI has provided proxy payment adjustment factors that estimate how Maryland hospitals would perform under the HRRP. However, the most recent data available is FFY 2025. The Maryland data indicates that 84 percent of hospitals in the state would receive a penalty, with the

[7] These estimates do not include the update to the new out of state adjustment being recommended for RY 2027 and beyond.
[8] These results are incorrect due to the use of the incorrect OOS ratios.
[9] These estimates do not include the update to the new out of state adjustment being recommended for RY 2027 and beyond.
[10] These results reflect the updated OOS readmission ratios (i.e., addresses Staff's error).

median penalty of 0.20 percent among those that would have been penalized (minimum penalty 0.1 percent and maximum penalty 1.07 percent); HRRP does not provide rewards.

To allow for comparison to the most recent HRRP performance, the RY 2025 RRIP performance is presented rather than the RY 2026 or RY 2027 YTD results presented above. In RY 2025, Maryland hospitals received revenue adjustments to their global budgets for their CY 2023 readmissions performance compared to the improvement target of 7.50 percent and attainment target of 11.32 percent. Statewide, the total net adjustments was approximately $14M, with penalties of approximately $28M and rewards of approximately $42M. Specifically, about 55 percent of the hospitals received a scaled penalty and the remaining 45 percent received a scaled reward; the average penalty was -0.64 percent (penalties ranged from -1.52 percent to -0.15 percent) and the average reward was 0.53 percent (rewards ranged from 0.03 percent to 1.24 percent). Figure 14 below shows a comparison of estimated FFY 2025 HRRP and final RY 2025 RRIP revenue adjustments, which both assessed readmission performance in CY 2023; by hospital results are in Appendix VIII.

Figure 14. Comparison of Final RY 2025 RRIP and Estimated FFY 2025 HRRP Revenue Adjustments

Program	Statewide Net Total	%	Penalties	%	Rewards	%
RRIP	$ 14,102,128.30	0.12%	$ (28,215,336.00)	-0.24%	$ 42,317,464.30	0.36%
HRRP	$ (23,305,042.30)	-0.20%	$ (23,305,042.30)	-0.20%	0	-

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

Overall, given the changes to the RRIP program starting in RY 2026 and the lack of CMS data past FFY 2025, it is difficult to compare the current program with the CMS HRRP. However, staff supports the continued inclusion of rewards in the RRIP program and will analyze the RY 2026 RRIP and FFY 2026 HRRP when available.

Stakeholder Feedback

Comment letters to the Draft RRIP Policy were received from Health Means Everything Consumer Alliance (HME), the Maryland Hospital Association (MHA), the Maryland Department of Health (MDH), Adventist Health, Luminis Health, and Garrett Regional Medical Center. Overall, commenters expressed broad

support for maintaining the RRIP framework for RY 2028. Several commenters supported the OOS revision that addressed the double counting issue; Hospitals and MHA requested retrospective application of the correction prior to RY 2027. Commenters also provided recommendations regarding future alignment of RRIP with either the NCQA Plan All-Cause Readmission (PCR) measure or the Medicare Hospital Readmissions Reduction Program's measures under the AHEAD model. Figure 15 provides an overview of the comments received and is followed by a discussion of the feedback along with staff's responses.

Figure 15. Summary of Stakeholder Comment Letters

Stakeholder Comment Letters for RY 2028 RRIP	Adventist	MHA	Luminis Health	Garrett	MDH	HME
Fully align with HRRP but maintain the reward incentive	X					
Align with PHAP goal (NCQA PCR measure)					X	X
Transparency on OOS ratio revision and financial impacts	X					
Apply OOS revision retrospectively (# of years varies by letters)	X	X	X	X		
Model revenue adjustment using HRRP, NCQA PCR, and HWR measures		X				

Overall Support for RY 2028 RRIP Framework: HME and MHA expressed support for maintaining the current RRIP core structure for RY 2028; Adventist supported the current RRIP core structure for RY 2028 only if full alignment with HRRP is infeasible. Commenters noted that RRIP has been associated with sustained reductions in readmissions and emphasized the importance of maintaining the incentive during the transition period to the AHEAD model's quality programs for Medicare beneficiaries. Adventist supported maintaining the current revenue at risk structure for RY 2028 and encouraged preserving upside reward potential in future years to sustain incentives for quality improvement.

Staff Response: Staff appreciates stakeholders' support for maintaining the program in RY 2028.

OOS Readmission Double Counting Correction: MHA, Garrett, Luminis Health, and Advenist supported addressing the identified double counting of readmissions in the OOS Readmission Ratio. Commenters stated that the issue has disproportionately affected border hospitals and resulted in overstated readmission rates and financial penalties.

Adventist supported correcting the issue beginning in RY 2027, but requested additional transparency regarding revised calculations and financial impacts before finalizing policy decisions.

Garrett and Luminis Health specifically requested that the corrections be applied for RY 2026 and prior rate years retrospectively. MHA similarly recommended applying the correction to multiple prior years, citing precedent for retrospectively correcting errors.

Staff Response: Staff acknowledges that border hospitals may have experienced disproportionate negative impacts under the prior OOS readmission ratio methodology. The identified issue, however, reflects a methodological limitation in how OOS readmissions were incorporated into the calculation, rather than an implementation or calculation error by staff.

The OOS ratio was developed using the best available data at the time. Upon further analysis due to concerns raised by hospitals, staff identified an opportunity to refine the methodology to better account for the double counting of readmissions and also identified the OOS transfer concern. The proposed OOS Utilization Adjustment, which is a refinement to the methodology, is intended to address these limitations and improve the accuracy and fairness of the assessment of hospital performance moving forward. Additional discussion of the OOS utilization ratio is included in the Assessment section above.

There is precedent for the HSCRC to apply retrospective adjustments when correcting staff errors, while methodological refinements are generally applied prospectively. For example, in the Annual Payment Update for RY 2026, HSCRC implemented a retrospective revision to remedy a data issue impacting Uncompensated Care funding determinations for RY 2023 through RY 2025. The retrospective revision was made because staff used the average Area Deprivation Index (ADI) for each zip code for all patients and not just those with a missing ADI value, as intended by the approved policy. Again this was a retrospective change to correct an error, and not a change to the methodology, and only hospitals that needed to contribute less or who earned more were retrospectively changed (i.e., those hospitals with a negative impact were not changed). An example of a methodological refinement that was made prospectively would be the update made to the Variable Cost Factor (VCF). Staff worked with the industry to address concerns raised about the VCF and determined that the single VCF of 50% was not covering variable costs. Thus staff developed updated VCFs for different types of services. Because this was a methodological refinement and not a staff or implementation error, the refinement was only applied prospectively.

This distinction between correcting errors versus refining methodology guides staff's recommendation to apply the OOS Utilization Adjustment to RY 2028 and beyond. Being that the RY 2027 results have not been finalized, staff compromised on making the adjustment to RY 2027 given the disproportionate impacts to border hospitals. This is consistent with other quality policies as well.

While staff recommend only applying the OOS Utilization Adjustment beginning in RY 2027, staff presents three options for Commissioners' consideration pertaining to RY 2026. Given the implementation error, RY 2026 results need to be corrected, thus Commissioners' could decide to apply the new OOS Utilization Adjustment retrospectively since it better captures impacts of both OOS readmissions and transfers. The three options for RY 2026 are as follows:

1. Maintain the current RY 2026 results and not correct the staff implementation error (not recommended by staff).
2. Correct the error using the originally intended OOS readmission ratio (i.e., recalculating the attainment rates using the OOS ratios that would have been implemented absent the error).
3. Implement the newly proposed OOS Utilization Adjustment.

Figure 16 summarizes the impacts of each of the Options for the affected hospitals only (i.e., other hospitals would not have any revenue adjustment changes). If Option 2 or Option 3 are chosen, Commissioners also need to decide on whether to retrospectively remove additional revenue for hospitals with higher penalties or lower rewards. Staff recommend updating revenue adjustments for only those hospitals whose performance improves with the application of either the originally intended OOS readmission ratios or the newly proposed OOS Utilization Adjustment (i.e., only implement changes for hospitals receiving a higher reward or lesser penalty). Staff believes this approach is consistent with the precedent of how staff errors have been handled previously and note that the overall percentage adjustment is relatively small. Furthermore, RY 2026 revenue adjustments have already been incorporated into budgeting and operational planning and applying either the originally intended OOS ratios or OOS Utilization Adjustment for hospitals that will have worsened performance may cause financial instability and operational disruption at this stage.

Staff notes that Garrett has the largest percentage impact under the newly proposed OOS utilization adjustment. While Garrett requested that the adjustment be applied retrospectively for additional rate years, staff do not have readily available data to estimate the impacts prior to RY 2026. Notably, however, in two of the three rate years preceding RY 2026, Garrett received the full two percent reward and thus application of the OOS Utilization Adjustment in those years would not change the revenue adjustments. Also, note that if Option 2 is chosen and negatively impacted hospitals are included, Garrett would be the only hospital negatively impacted that would otherwise receive a larger reward under the OOS utilization adjustment. This presents a concern for Staff and may warrant special consideration.

Figure 16. Summary of Impacts for the Hospitals Affected by Change in OOS Adjustment

RY 2026 Revenue Adjustments by Option		Option 1: Maintain what went into rates and do not fix staff error		Option 2: Correct error but do not update OOS methodology				Option 3: Update RY 2026 using the new OOS utilization adjustment			
		Revenue Adjustment		Revenue Adjustment		Difference from Rates		Revenue Adjustment		Difference from Rates	
HOSPITAL ID	HOSPITAL NAME	$	%	$	%	$	%	$	%	$	%
210017	Garrett	-$22,236	-0.07%	-$181,061	-0.57%	-$158,825	-0.50%	$508,240	1.60%	$530,476	1.67%
210035	UMMS- Charles	-$84,173	-0.08%	$147,303	0.14%	$231,476	0.22%	$778,604	0.74%	$862,777	0.82%
210039	Calvert	-$679,575	-0.80%	-$450,219	-0.53%	$229,356	0.27%	-$433,229	-0.51%	$246,346	0.29%
210051	Luminis- Doctors	$585,123	0.30%	$585,123	0.30%	$0	0.00%	$780,163	0.40%	$195,040	0.10%
210049	UMMS-Upper Chesapeake	-$2,993,814	-1.15%	-$2,655,383	-1.02%	$338,431	0.13%	-$2,759,515	-1.06%	$234,299	0.09%
210044	GBMC	$1,402,356	0.51%	$1,484,848	0.54%	$82,492	0.03%	$1,484,848	0.54%	$82,492	0.03%
210030	UMMS- Chestertown	$216,606	2.00%	$203,610	1.88%	-$12,996	-0.12%	$216,606	2.00%	$0	0.00%
210018	MedStar- Montgomery	-$482,409	-0.45%	-$557,451	-0.52%	-$75,042	-0.07%	-$482,409	-0.45%	$0	0.00%
210058	UMMS- UMROI	-$202,066	-0.23%	-$202,066	-0.23%	$0	0.00%	-$224,517	-0.25%	-$22,452	-0.03%
210057	Adventist- Shady Grove	-$2,022,306	-0.56%	-$2,166,756	-0.60%	-$144,450	-0.04%	-$2,311,207	-0.64%	-$288,901	-0.08%
210002	UMMS- UMMC	-$9,277,409	-0.59%	-$9,434,653	-0.60%	-$157,244	-0.01%	-$11,950,561	-0.76%	-$2,673,152	-0.17%
210037	UMMS- Easton	$2,324,864	1.68%	$1,923,548	1.39%	-$401,316	-0.29%	$2,075,771	1.50%	-$249,093	-0.18%
210003	UMMS- Capital Region	$1,073,652	0.33%	$422,954	0.13%	-$650,698	-0.20%	-$97,605	-0.03%	-$1,171,257	-0.36%
210061	Atlantic General	$4,984	0.01%	-$134,567	-0.27%	-$139,551	-0.28%	-$284,085	-0.57%	-$289,069	-0.58%
		Statewide Impact									
STATEWIDE	**$ 12,634,054,157**	**-$27,938,378**	-0.22%	**-$28,796,745**	-0.23%	-$858,367	-0.01%	**-$30,480,871**	-0.24%	-$2,542,494	-0.02%
Penalty		-$45,138,690	-0.36%	-$45,156,858	-0.36%	-$18,168	0.00%	-$47,917,830	-0.38%	-$2,779,141	-0.02%
Reward		$17,200,312	0.14%	$16,360,113	0.13%	-$840,199	-0.01%	$17,436,959	0.14%	$236,647	0.00%
		Statewide Impact if Negatively Impacted Hospitals Held Harmless									
STATEWIDE	**$ 12,634,054,157**	**-$27,938,378**	-0.22%	**-$27,056,623**	-0.21%	$881,755	0.01%	**-$25,786,948**	-0.20%	$2,151,430	0.02%
Penalty		-$45,138,690	-0.36%	-$44,486,730	-0.35%	$651,960	0.01%	-$44,551,636	-0.35%	$587,054	0.00%
Reward		$17,200,312	0.14%	$17,430,107	0.14%	$229,795	0.00%	$18,764,688	0.15%	$1,564,376	0.01%

OOS Transfers: MHA expressed concern regarding the identification of OOS transfers across payers, noting that inconsistencies may exist for Medicare Advantage, Medicaid, and commercial populations. MHA encouraged staff to pursue a comprehensive, multi-payer approach to improve the accuracy and fairness of the OOS transfer calculation.

Staff Response: Staff recognizes the importance of accurately capturing both OOS readmissions and transfers across payer types. The proposed OOS Utilization Adjustment is an initial step in addressing OOS utilization that cannot be captured in the Case-Mix data using Medicare FFS data. Staff will continue to work with stakeholders to explore opportunities to incorporate other payers' data sources and refine the methodology as access to additional data sources becomes available. However, as with the currently proposed methodological refinement, changes based on inclusion of additional payers should not be applied retrospectively.

Alignment Under the AHEAD Model: HME and MDH supported aligning the RRIP readmissions measure with the NCQA PCR measure included in Maryland's PHAP. Commenters emphasized that the AHEAD model establishes statewide population health and utilization targets that apply across payers, including commercial and Medicaid populations. Commenters stated that aligning RRIP with the PCR measure and statewide goal would directly support the State's commitment under AHEAD by tying hospital financial incentives to the same all-payer, all-condition, and all-cause measure used to assess statewide performance. Additionally, commenters expressed concern that aligning RRIP with HRRP's condition specific measures could narrow the scope of accountability to select Medicare diagnoses and potentially create competing or fragmented incentives.

Adventist expressed a preference for aligning the future RRIP measure with the HRRP condition-specific measures. Adventist noted that greater alignment between state and federal programs could reduce administrative complexity and simplify reporting and tracking for hospitals.

MHA didn't specify support for a specific alignment option but requested that HSCRC provide comparative by-hospital modeling of Maryland hospitals' performance on the HRRP, NCQA PCR, and HWR measures before making future policy decisions. MHA emphasized that comparative modeling will help hospitals understand the implications of the potential alignment pathways and prepare for future rate year policy decisions.

Staff Response: Staff appreciates the feedback regarding alignment options and will continue to engage stakeholders in discussions to assess measure design, financial implications, and consistency with AHEAD Model requirement prior to recommending changes for future rate years. In general, staff believes that alignment with the all-payer PHAP goal is warranted to ensure achievement of the statewide biannual goals required under AHEAD. Staff are exploring what elements of the NCQA measure can and should be applied to RRIP. For example, alignment with the NCQA PCR measure could involve adding in observation stay data but maintaining current RRIP risk-adjustment, or could involve adding observation and the NCQA PCR risk-adjustment. Furthermore, staff support the alignment with PHAP measure because of concerns about applying the Medicare condition specific readmission measure to other payer populations, as opposed to an all-condition measure.

During CY 2026, staff will work with contractors to further evaluate feasibility of potential alignment with options including:

1. Assess adaptation of the NCQA PCR measure specifications for use with Case-Mix data rather than claims data.
2. Evaluate whether the HWR measure and the HRRP condition-specific measures could be adapted for application to all-payer or non-Medicare populations using case-mix data.
3. Determine all-payer or non-Medicare FFS performance goals for Maryland hospitals (i.e., improvement and/or attainment goals) and the revenue adjustment methodology for non-Medicare HGBs.

Staff will provide updates as they become available on the progress for determining the policy for RY 2029.

Recommendations

These are the final recommendations for the Maryland Rate Year (RY) 2028 Readmission Reduction Incentives Program (RRIP):

1. Maintain the 30-day, all-payer, all-cause, all-condition readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 compared to two-year base period of CY 2022 and CY 2023.
3. Attainment Target - Maintain the attainment target whereby hospitals performing at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
    a. Adjust case-mix readmission rate by the Out of State (OOS) Utilization Adjustment to account for OOS readmissions and transfers for RY 2027 beyond.

4. Maintain scaled rewards and penalties of up to 2 percent of inpatient revenue.
5. Monitor reductions in within-hospital readmission disparities and provide regular updates on by-hospital performance to stakeholders.
6. Assess opportunities for AHEAD alignment of readmission measure, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

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Appendix I. RRIP Readmission Measure and Revenue Adjustment Methodology

Introduction: RRIP Redesign Subgroup

As part of the ongoing evolution of the All-Payer Model's pay-for-performance programs to further bring them into alignment under the Total Cost of Care Model, HSCRC convened a work group to evaluate the Readmission Reduction Incentive Program (RRIP). The work group consisted of stakeholders, subject matter experts, and consumers, and met six times between February and September 2019. The work group focused on the following six topics, with the general conclusions summarized below:

1. Analysis of Case-mix Adjustment and trends in Eligible Discharges over time to address concern of limited room for additional improvement;
    - Case-mix adjustment acknowledges increased severity of illness over time
    - Standard Deviation analysis of Eligible Discharges suggests that further reduction in
    - readmission rates is possible
2. National Benchmarking of similar geographies using Medicare and Commercial data;
    - Maryland Medicare and Commercial readmission rates and readmissions per capita are on par with the nation
3. Updates to the existing All-Cause Readmission Measure;
    - Remove Eligible Discharges that left against medical advice (~7,500 discharges)
    - Include Oncology Discharges with more nuanced exclusion logic
    - Analyze out-of-state ratios for other payers as data become available
4. Statewide Improvement and Attainment Targets under the TCOC Model;
    - 7.5 percent Improvement over 5 years (2018-2023)
    - Ongoing evaluation of the attainment threshold at 65th percentile
5. Social Determinants of Health and Readmission Rates; and
    - Methodology developed to assess within-hospital readmission disparities
6. Alternative Measures of Readmissions
    - Further analysis of per capita readmissions as broader trend; not germane to the RRIP policy because focus of evaluation is clinical performance and care management post-discharge
    - Observation trends under the All-Payer Model to better understand performance given variations in hospital observation use; future development will focus on incorporation of Excess Days in Acute Care (EDAC) measure in lieu of including observations in RRIP policy
    - Electronic Clinical Quality Measure (eCQM) may be considered in future to improve risk adjustment

Methodology Steps

1) Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra- and inter-hospital) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and planned admissions.[11] Unique patient identifiers from CRISP are used to be able to track patients across hospitals for readmissions.

The measure is similar to the readmission rate that is calculated by CMMI to track Maryland performance versus the nation, with some exceptions. The most notable exceptions are that the HSCRC measure includes psychiatric patients in acute care hospitals, and readmissions that occur at specialty hospitals. In comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, an additional adjustment is made to account for differences in case-mix. See below for details on the readmission calculation for the RRIP program.

2) Inclusions and Exclusions in Readmission Measurement

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 4.0. The HSCRC has also added all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs, rather than principal diagnosis.[12] Planned admissions are counted as eligible discharges in the denominator, because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.[13]
- Exclude bone marrow transplants and liquid tumor patients by making these discharges not eligible to have an unplanned readmission or count as an unplanned readmission.[14]
- Exclude patients with a discharge disposition of Left Against Medical Advice (PAT_DISP = 71, 72, or 73 through FY 2018; 07 FY 2019 onward)
- Rehabilitation cases as identified by APR-860 (which are coded under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after readmission logic is run.
- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission, but can be a readmission for a previous admission.

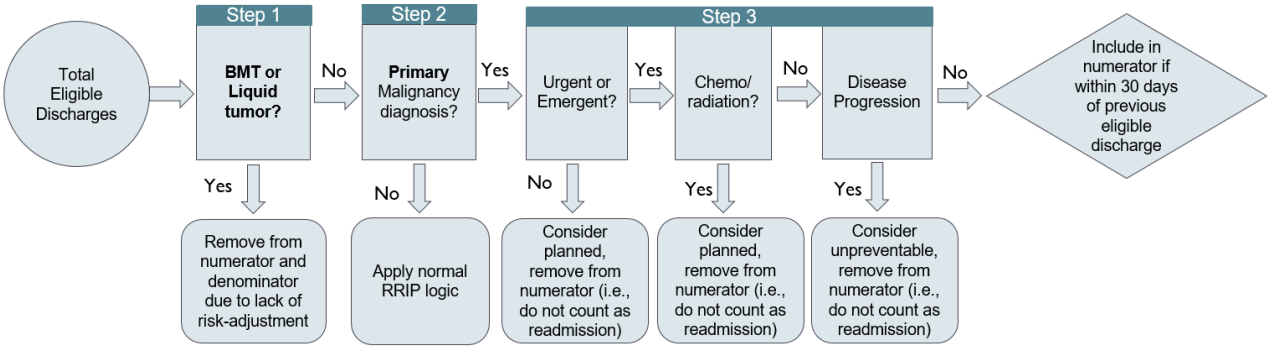
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[11] Planned admissions defined under [CMS Planned Admission Logic version 4 – updated March 2018].
[12] **Rehab** DRGs: 540, 541, 542, 560, and 860; **OB Deliveries and Associated DRGs**: 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.
[13] **Newborn APR-DRGs:** 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.
[14] **Bone Marrow Transplant:** Diagnosis code Z94.81 or CCS Procedure code 64; **Liquid Tumor:** Diagnosis codes C81.00-C96.0. See section below for additional details on the oncology logic.

- APR-DRG-SOI categories with less than two discharges statewide are removed.
- A hospitalization within 30 days of a hospital discharge where a patient dies is counted as a readmission; however, the readmission is removed from the denominator because the case is not eligible for a subsequent readmission.
- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same or next day as the admission date of the subsequent admission, are removed from the denominator. Thus, only one admission is counted in the denominator, and that is the admission to the transfer hospital (unless otherwise ineligible, i.e., died). It is the second discharge date from the admission to the transfer hospital that is used to calculate the 30-day readmission window.
- Beginning in RY 2019, HSCRC started discharges from chronic beds within acute care hospitals.
- In addition, the following data cleaning edits are applied:
    - Cases with null or missing CRISP unique patient identifiers (EIDs) are removed.
    - Duplicates are removed.
    - Negative interval days are removed.
      HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, hospitals are required to make sure 99.5 percent of inpatient discharges have a CRISP EID.

Additional Details on Oncology Logic:

Flow Chart for Revised Oncology Logic



*Items that are **bolded** are adaptations from NQF measure

This updated logic replaces the RY 2021 measure logic that removes all oncology DRGs from the dataset, such that an admission with an oncology DRG cannot count as a readmission or be eligible to have a readmission.

Step 1: Exclude discharges where patients have a bone marrow transplant procedure, bone marrow transplant related diagnosis code, or liquid tumor diagnosis. This logic varies from the NQF cancer hospital measure which risk-adjusts for bone marrow transplant and liquid tumors. HSCRC staff recommended removing these discharges (similar to current DRG exclusion) because the current indirect standardization approach did not allow for additional risk-adjustment but based on conversations with clinicians staff agreed these cases were significantly more complicated and at-risk for an unpreventable readmission.

Step 2: Flag discharges with a primary malignancy diagnosis to apply cancer specific logic for determining readmissions. This varies from the NQF cancer hospital measure that flags patients with primary or secondary malignancy diagnosis being treated in a cancer specific hospital. Staff thinks we should only flag those with a primary diagnosis since in a general acute care hospital there may be differences in the types of patients with a secondary malignancy diagnosis. Further, we remove the bone marrow and liquid tumor discharges regardless of malignancy diagnosis, thus ensuring the most severe cases are removed. Last, our initial analyses did not show a large impact on overall hospital rates when primary vs primary and secondary malignancies were flagged. It should be noted however that the current modeling in this policy uses readmission rates where both primary and secondary are flagged.

Step 3: Flag planned admissions using additional criteria beyond the CMS planned admission logic:

a) Nature of admission of urgent or emergent considered unplanned, all other nature of admission statuses are planned
b) Any admission with primary diagnosis of chemotherapy or radiation is considered planned
c) Any admission with primary diagnosis of metastatic cancer is not considered preventable, and thus gets excluded from being a readmission

In step 3, admissions are deemed not eligible to be a readmission but they are eligible to have a subsequent unplanned readmission.

3) Details on the Calculation of Case-Mix Adjusted Readmission Rate

Data Source:

To calculate readmission rates for RRIP, inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) are used for the measurement period, with an additional 30 day runout. To calculate the case-mix adjusted readmission rate for CY 2023 performance period, data from January 1 through December 31, plus 30 days in January of the next year are used. CY 2022 data are used to calculate the normative values, which are used to determine a hospital's expected readmissions, as detailed below.

Please note that, the base year readmission rates are not "locked in", and may change if there are CRISP EID or other data updates. The HSCRC does not anticipate changing the base period data, and does not anticipate that any EID updates will change the base period data significantly; however, the HSCRC has decided the most up-to-date data should be used to measure improvement. For the performance period, the CRISP EIDs are updated throughout the year, and thus, month-to-month results may change based on changes in EIDs.

SOFTWARE: APR-DRG Version 42 for CY 2018-CY 2025.

Calculation:

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

Numerator: Number of observed hospital-specific unplanned readmissions.

Denominator: Number of expected hospital specific unplanned readmissions based upon discharge APR-DRG and Severity of Illness. See below for how to calculate expected readmissions, adjusted for APR-DRG SOI.

Risk Adjustment Calculation:

Calculate the Statewide Readmission Rate without Planned Readmissions.

- Statewide Readmission Rate = Total number of readmissions with exclusions removed / Total number of hospital discharges with exclusions removed.

For each hospital, enumerate the number of observed, unplanned readmissions.

For each hospital, calculate the number of expected unplanned readmissions at the APR-DRG SOI level (see Expected Values for description). For each hospital, cases are removed if the discharge APR-DRG and SOI cells have less than two total cases in the base period data.

Calculate at the hospital level the ratio of observed (O) readmissions over expected (E) readmissions. A ratio of > 1 means that there were more observed readmissions than expected, based upon a hospital's case-mix. A ratio of < 1 means that there were fewer observed readmissions than expected based upon a hospital's case-mix.

Multiply the O/E ratio by the base year statewide rate, which is used to get the case-mix adjusted readmission rate by hospital. Multiplying the O/E ratio by the base year state rate converts it into a readmission rate that can be compared to unadjusted rates and case-mix adjusted rates over time.

Expected Values:

The expected value of readmissions is the number of readmissions a hospital would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals,

given its mix of patients as defined by discharge APR-DRG category and SOI level. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being “eligible” for a readmission. All discharges will either have zero readmissions or will have one readmission. The readmission rate is the proportion or percentage of admissions that have a readmission.

The rates of readmissions in the normative database are calculated for each APR-DRG category and its SOI levels by dividing the observed number of readmissions by the total number of eligible discharges. The readmission norm for a single APR-DRG SOI level is calculated as follows:

Let:

N = norm
P = Number of discharges with a readmission
D = Number of eligible discharges
i = An APR DRG category and a single SOI level

$$N_i = \frac{P_i}{D_i}$$

For this example, the expected rate is displayed as readmissions per discharge to facilitate the calculations in the example. Most reports will display the expected rate as a rate per one thousand.

Once a set of norms has been calculated, the norms are applied to each hospital’s DRG and SOI distribution. In the example below, the computation presents expected readmission rates for a single diagnosis category and its four severity levels. This computation could be expanded to include multiple diagnosis categories, by simply expanding the summations.

Consider the following example for a single diagnosis category.

Expected Value Computation Example – Individual APR-DRG

A Severity of Illness Level	B Eligible Discharges	C Discharges with Readmission	D Readmissions per Discharge (C/B)	E Normative Readmissions per Discharge	F Expected # of Readmissions (A*E)
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
Total	**500**	**45**	**.09**		**56.5**

For the diagnosis category, the number of discharges with a readmission is 45, which is the sum of discharges with readmissions (column C). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of eligible discharges with a readmission (sum of column C) by the total number of discharges at risk for readmission (sum of column B), i.e., 0.09 = 45/500. From the normative population, the proportion of discharges with readmissions for each severity level for that diagnosis category is displayed in column E. The expected number of readmissions for each severity level shown in column F is calculated by multiplying the number of eligible discharges (column B) by the normative readmissions per discharge rate (column E) The total number of readmissions expected for this diagnosis category is the sum of the expected numbers of readmissions for the 4 severity levels.

In this example, the expected number of readmissions for this diagnosis category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had 11.5 fewer actual discharges with readmissions than were expected for this diagnosis category. This difference can also be expressed as a percentage or the O/E ratio.

4) Revenue Adjustment Methodology

The RRIP assesses improvement in readmission rates from base period, and attainment rates for the performance period with an adjustment for out-of-state readmissions. The policy then determines a hospital's revenue adjustment for improvement and attainment and takes the better of the two revenue adjustments, with scaled rewards of up to 2 percent of inpatient revenue and scaled penalties of up to 2 percent of inpatient revenue. The figure below provides a high level overview of the RY 2027 RRIP methodology for reference.

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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.

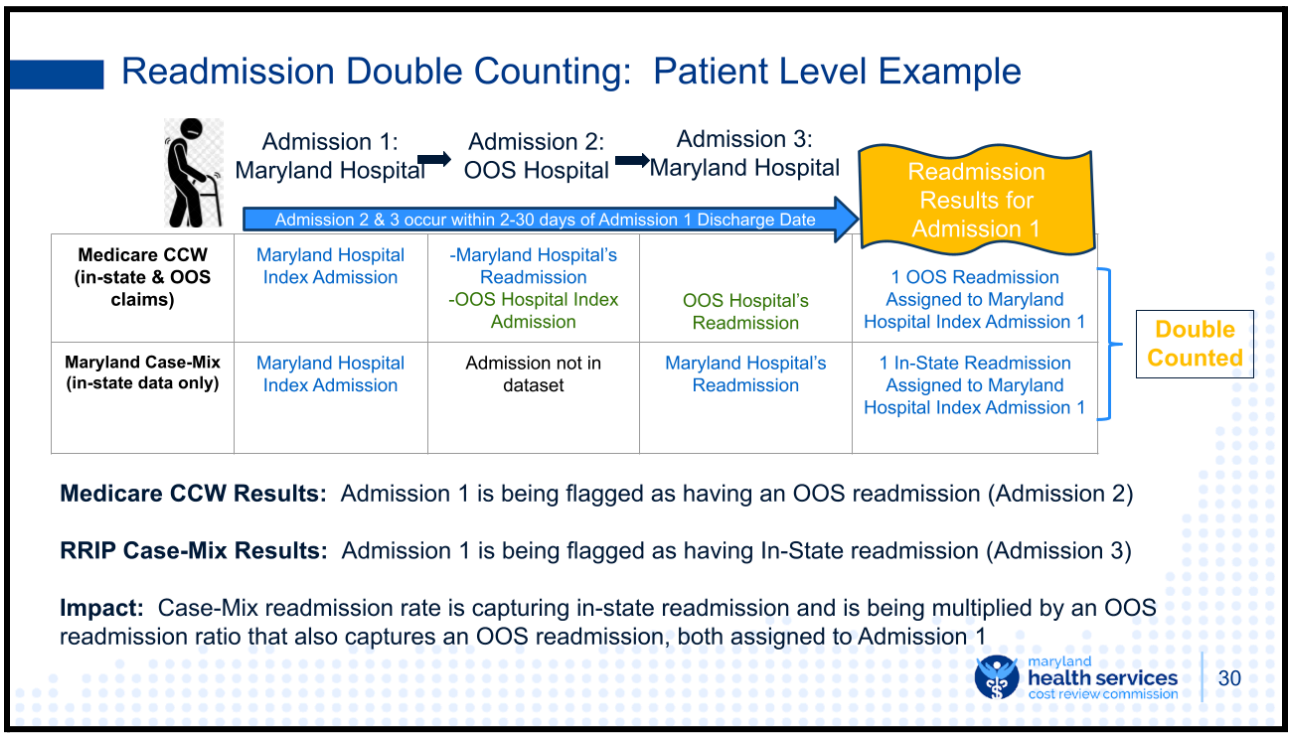
All Payer Readmission Rate CY25		RRIP % Inpatient Revenue
Lower Readmission Rate		2.00%
Benchmark	8.83%	2.00%
	10.04%	1.00%
Threshold	11.25%	0.00%
	12.46%	-1.00%
	13.67%	-2.00%
Higher Readmission Rate		-2.00%

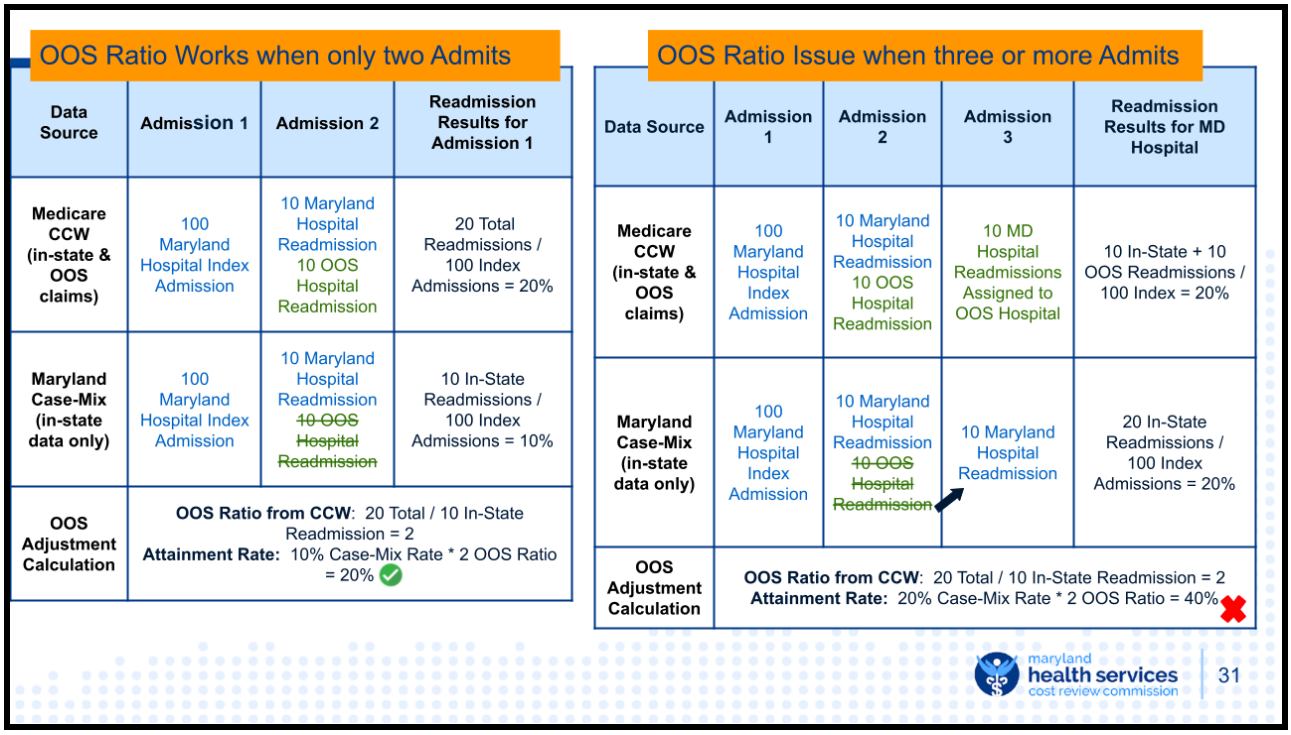
Attainment Scale

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%

Appendix II. Example of Double Counting Issue





OOS Ratio Works when only two Admits

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

OOS Ratio Issue when three or more Admits

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

The readmission adjustment ratio accounts for this issue by multiplying the case-mix adjusted readmission rate by the ratio of readmissions observed in the CCW with MD only claims (which has been validated as a proxy for the case-mix dataset) and the CCW with all claims. This ratio adjusts the case-mix adjusted rate to reflect the additional readmission utilization attributable to OOS activity that is not already captured in the MD case-mix data.

Appendix III. Example of OOS Transfer Issue

Readmission OOS Transfer Issue: Patient Level Example



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

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

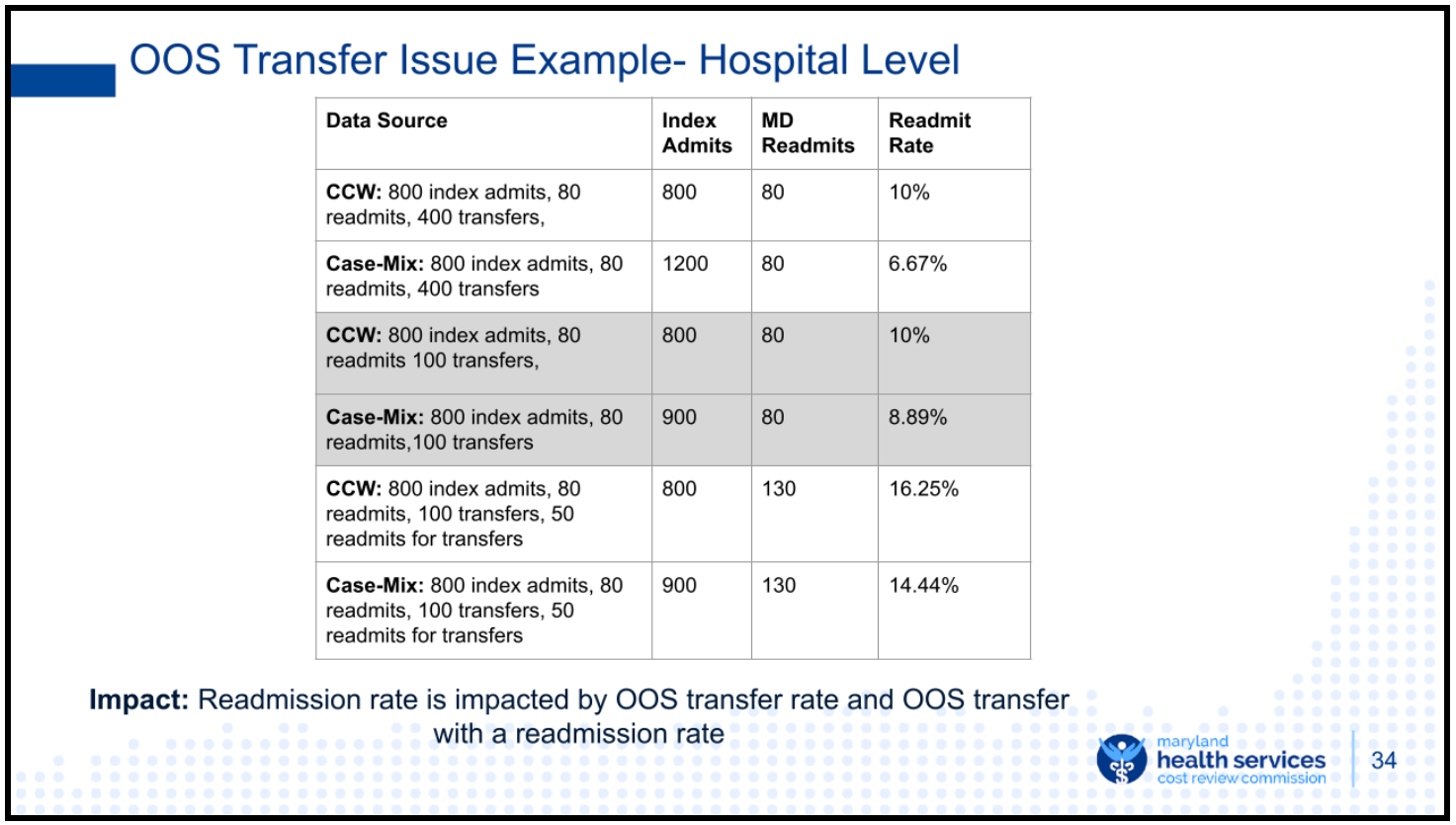
Results for Admission 1

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

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

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

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



The transfer adjustment ratio accounts for this issue by multiplying the case-mix adjusted readmission rate by the ratio of admissions between the CCW with all claims and the CCW with MD only claims (which has been validated as a proxy for the case-mix dataset). This ratio proportionally corrects denominator inflation due to misclassified transfers.

Appendix IV. Out of State (OOS) Utilization Adjustment Methodology

I. Purpose

The purpose of the OOS Utilization Adjustment is to account for OOS utilization that cannot be captured in the Case-Mix dataset. Without an OOS utilization adjustment, hospitals across the State could not be compared fairly being that some hospitals may have higher OOS utilization (e.g., border hospitals, systems with OOS hospitals).

Because the HSCRC does not have access to comprehensive all-payer OOS claims data, this methodology uses Medicare Chronic Conditions Warehouse (CCW) claims data as a proxy to estimate the impact of OOS utilization on readmission rates.

II. Data Sources

Staff uses Medicare fee-for-service claims data obtained through CMMI from the Chronic Conditions Warehouse (CCW). Data availability is as follows:

- Quarterly preliminary files include:
  - 100% of Maryland claims
  - 100% of border state claims
  - 5% sample of national claims
- Annual final files include (expected each April):
  - 100% of national Medicare claims for the prior calendar year

Due to the 30-day readmission run-out requirement, staff applies readmission logic to December–November CCW claims data to ensure complete capture of 30-day readmissions.

For example, in April 2026, staff expects to receive 100% of national claims for January–December 2025. Readmission logic will be applied to December 2024–November 2025 claims to allow for full 30-day follow-up.

III. Definitions

For purposes of this adjustment:

- **CCW All Claims Readmission Rate**:
  The Medicare readmission rate calculated using all available national claims (Maryland,

border states, and national claims).

- **CCW MD Only Claims Readmission Rate**:
  The Medicare readmission rate calculated using only Maryland claims.

- **Readmission Logic**:
  The code is from GDIT based on the V6 report. The HSCRC has maintained the logic consistently since 2018.

- **OOS Readmission Adjustment Ratio:** $\frac{\#\ of\ CCW\ All\ Claims\ Readmissions}{\#\ of\ CCW-MD\ Only\ Readmissions}$ This ratio corrects for the inflation of the # of readmissions

- **OOS Transfer Adjustment Ratio:** $\frac{\#\ of\ CCW-MD\ Only\ Admissions}{\#\ of\ CCW\ All\ Claims\ Readmissions}$ This ratio corrects for the inflation of the # of eligible discharges

IV. OOS Utilization Adjustment Formula

The OOS Utilization Adjustment is calculated as: $\frac{CCW\ All\ Claims\ Readmission\ Rate}{CCW\ MD\ Only\ Claims\ Readmission\ Rate}$

The OOS Utilization Adjustment reflects the combined effect of the OOS Readmission Adjustment Ratio and the OOS Transfer Adjustment Ratio. The OOS Utilization Adjustment ratio estimates the relative impact of out-of-state utilization (transfers and readmissions) on readmission rates using Medicare as a proxy for all-payer patterns.

V. Application to Case-Mix Readmission Rates

The OOS Utilization Adjustment is applied by being multiplied by the Case-Mix Adjusted Readmission Rate to calculate the attainment rate.

Attainment Rate= Case-Mix Adjusted Readmission Rate x OOS Utilization Adjustment

Appendix V. Reducing Disparities in Readmissions

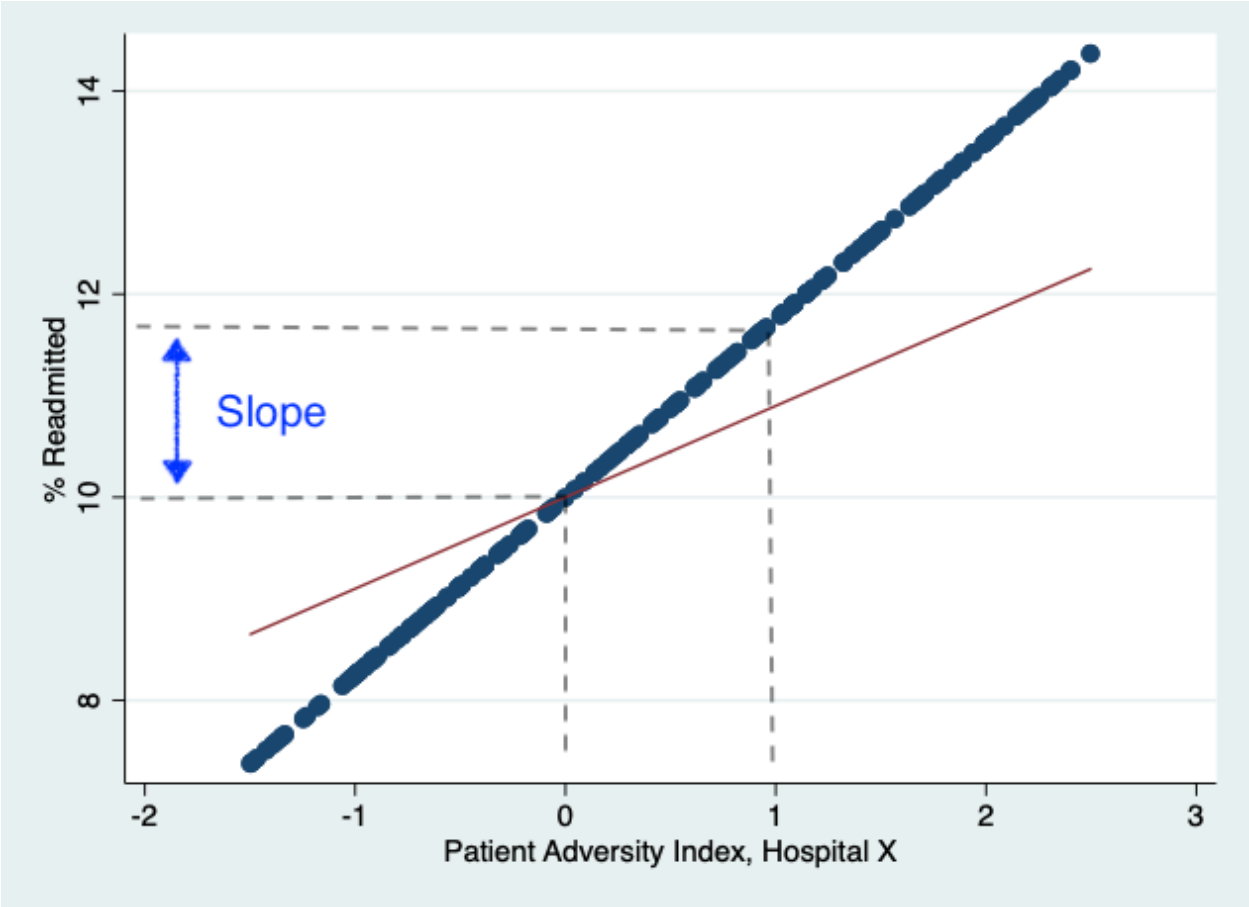
Racial and socioeconomic differences in readmission rates are well documented[15,16] and have been a source of significant concern among healthcare providers and regulators for years. In Maryland, the 2018 readmission rate for Blacks was 2.6 percentage points higher than for whites, and the rate for Medicaid enrollees was 3.4 points higher than for other patients. A 2019 Annals of Internal Medicine paper co-authored by HSCRC staff[17] reported a 1.6 percent higher readmission rate for patients living in neighborhoods with increased deprivation. Maryland hospitals, as well as CMS and the Maryland Hospital Association, historically identified reductions in disparities as a key priority. Thus, staff developed and the Commission approved adding a within-hospital disparity gap improvement goal to the RRIP in RY2021.

Specifically, the RRIP within hospital disparity methodology assesses patient-level socioeconomic exposure using the Patient Adversity Index (PAI), a continuous measure that reflects exposure to poverty, structural racism, and neighborhood deprivation. As shown in Figure 10, the relationship between PAI and readmissions is then assessed for each hospital for the base and performance period, and improvements in the slope of the line or in the difference in readmission rates at two points on the line (e.g., PAI = 1 vs PAI = 0) are compared for the base and performance period to calculate improvement. Additional information on the development of the within-hospital disparity metric can be found in the RY 2021 RRIP policy.[18]

[15] Tsai TC, Orav EJ, Joynt KE. Disparities in surgical 30-day readmission rates for Medicare beneficiaries by race and site of care. *Ann Surg*. 2014;259(6):1086–1090. doi:10.1097/SLA.0000000000000326;
[16] Calvillo–King, Linda, et al. "Impact of social factors on risk of readmission or mortality in pneumonia and heart failure: systematic review." *Journal of general internal medicine* 28.2 (2013): 269-282.
[17] Jencks, Stephen F., et al. "Safety-Net hospitals, neighborhood disadvantage, and readmissions under Maryland's all-payer program: an observational study." Annals of internal medicine 171.2 (2019): 91-98.

[18] RY 2021 RRIP Policy

Figure 10. Hypothetical Example of Relationship between PAI and Readmission Rates



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Appendix VI. RY 2027 Preliminary Revenue Adjustments, CY 2025 YTD through August

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			Improvement Scaling				Attainment Scaling				Final Adjustment		
HOSPITAL ID	HOSPITAL NAME	FY 25 Estimated Permanent Inpatient Revenue	CY22/23-CY25% Change in Case Mix Adjusted Ra	Target	% Revenue Adjustment	$ Revenue Adjustment	CY 2025 Case Mix Adjusted Rate with Out-of-State Adjustment	Target (top 25th %)	% Revenue Adjustment	$ Revenue Adjustment*	$ Better of Attainment or Improvement	RY 27 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainme
210001	Meritus	$269,729,949	-4.15%	-3.78%	0.04%	$107,892	12.65%	11.25%	-1.16%	-$3,128,867	$107,892	0.04%	Imp
210002	UMMS- UMMC	$1,572,442,188	-0.99%	-3.78%	-0.32%	-$5,031,815	11.47%	11.25%	-0.18%	-$2,830,396	-$2,830,396	-0.18%	Att
210003	UMMS- Capital Region	$325,349,234	-2.20%	-3.78%	-0.18%	-$585,629	11.09%	11.25%	0.13%	$422,954	$422,954	0.13%	Att
210004	Trinity - Holy Cross	$440,757,012	-4.65%	-3.78%	0.10%	$440,757	12.00%	11.25%	-0.62%	-$2,732,693	$440,757	0.10%	Imp
210005	Frederick	$255,860,248	5.04%	-3.78%	-1.02%	-$2,609,775	12.39%	11.25%	-0.94%	-$2,405,086	-$2,405,086	-0.94%	Att
210008	Mercy	$244,094,359	-13.42%	-3.78%	1.12%	$2,733,857	11.94%	11.25%	-0.57%	-$1,391,338	$2,733,857	1.12%	Imp
210009	JHH- Johns Hopkins	$1,915,323,836	0.59%	-3.78%	-0.51%	-$9,768,152	12.88%	11.25%	-1.35%	-$25,856,872	-$9,768,152	-0.51%	Imp
210011	St. Agnes	$280,211,776	-10.07%	-3.78%	0.73%	$2,045,546	11.06%	11.25%	0.16%	$448,339	$2,045,546	0.73%	Imp
210012	Lifebridge- Sinai	$527,147,859	0.00%	-3.78%	-0.44%	-$2,319,451	11.83%	11.25%	-0.48%	-$2,530,310	-$2,319,451	-0.44%	Imp
210015	MedStar- Franklin Square	$407,544,466	7.76%	-3.78%	-1.34%	-$5,461,096	12.96%	11.25%	-1.41%	-$5,746,377	-$5,461,096	-1.34%	Imp
210016	Adventist- White Oak	$269,335,289	1.55%	-3.78%	-0.62%	-$1,669,879	12.81%	11.25%	-1.29%	-$3,474,425	-$1,669,879	-0.62%	Imp
210017	Garrett	$31,765,005	-4.98%	-3.78%	0.14%	$44,471	10.00%	11.25%	1.03%	$327,180	$327,180	1.03%	Att
210018	MedStar- Montgomery	$107,202,092	0.85%	-3.78%	-0.54%	-$578,891	11.50%	11.25%	-0.21%	-$225,124	-$225,124	-0.21%	Att
210019	Tidal- Peninsula	$356,375,986	-5.31%	-3.78%	0.18%	$641,477	11.05%	11.25%	0.16%	$570,202	$641,477	0.18%	Imp
210022	JHH- Suburban	$276,688,736	-5.21%	-3.78%	0.17%	$470,371	11.64%	11.25%	-0.32%	-$885,404	$470,371	0.17%	Imp
210023	Luminis- Anne Arundel	$419,860,154	6.17%	-3.78%	-1.15%	-$4,828,392	13.22%	11.25%	-1.63%	-$6,843,721	-$4,828,392	-1.15%	Imp
210024	MedStar- Union Mem	$306,565,594	0.47%	-3.78%	-0.49%	-$1,502,171	13.06%	11.25%	-1.50%	-$4,598,484	-$1,502,171	-0.49%	Imp
210027	Western Maryland	$206,549,734	-4.19%	-3.78%	0.05%	$103,275	11.85%	11.25%	-0.49%	-$1,012,094	$103,275	0.05%	Imp
210028	MedStar- St. Mary's	$99,664,006	-0.27%	-3.78%	-0.41%	-$408,622	13.07%	11.25%	-1.51%	-$1,504,926	-$408,622	-0.41%	Imp
210029	JHH- Bayview	$505,597,983	5.54%	-3.78%	-1.08%	-$5,460,458	13.41%	11.25%	-1.79%	-$9,050,204	-$5,460,458	-1.08%	Imp
210030	UMMS- Chestertown	$10,830,306	3.75%	-3.78%	-0.87%	-$94,224	8.88%	11.25%	1.96%	$212,274	$212,274	1.96%	Att
210032	ChristianaCare, Union	$111,158,432	-10.69%	-3.78%	0.80%	$889,267	12.96%	11.25%	-1.42%	-$1,578,450	$889,267	0.80%	Imp
210033	Lifebridge- Carroll	$166,721,865	-6.95%	-3.78%	0.37%	$616,871	11.75%	11.25%	-0.42%	-$700,232	$616,871	0.37%	Imp
210034	MedStar- Harbor	$137,076,633	-8.10%	-3.78%	0.50%	$685,383	12.26%	11.25%	-0.84%	-$1,151,444	$685,383	0.50%	Imp
210035	UMMS- Charles	$105,216,708	-7.35%	-3.78%	0.41%	$431,389	10.51%	11.25%	0.61%	$641,822	$641,822	0.61%	Att
210037	UMMS- Easton	$138,384,760	-11.32%	-3.78%	0.87%	$1,203,947	8.91%	11.25%	1.94%	$2,684,664	$2,684,664	1.94%	Att
210038	UMMS- Midtown	$140,973,899	0.73%	-3.78%	-0.52%	-$733,064	12.59%	11.25%	-1.11%	-$1,564,810	-$733,064	-0.52%	Imp
210039	Calvert	$84,946,923	3.21%	-3.78%	-0.81%	-$688,070	11.75%	11.25%	-0.42%	-$356,777	-$356,777	-0.42%	Att
210040	Lifebridge- Northwest	$173,564,819	2.78%	-3.78%	-0.76%	-$1,319,093	13.16%	11.25%	-1.58%	-$2,742,324	-$1,319,093	-0.76%	Imp
210043	UMMS- BWMC	$329,675,757	-5.53%	-3.78%	0.20%	$659,352	11.47%	11.25%	-0.18%	-$593,416	$659,352	0.20%	Imp
210044	GBMC	$274,971,840	-5.86%	-3.78%	0.24%	$659,932	10.25%	11.25%	0.83%	$2,282,266	$2,282,266	0.83%	Att
210048	JHH- Howard County	$256,140,273	-5.49%	-3.78%	0.20%	$512,281	12.60%	11.25%	-1.12%	-$2,868,771	$512,281	0.20%	Imp
210049	UMMS-Upper Chesapeake	$260,331,648	2.37%	-3.78%	-0.71%	-$1,848,355	11.87%	11.25%	-0.51%	-$1,327,691	-$1,327,691	-0.51%	Att
210051	Luminis- Doctors	$195,040,841	11.32%	-3.78%	-1.75%	-$3,413,215	11.98%	11.25%	-0.60%	-$1,170,245	-$1,170,245	-0.60%	Att
210056	MedStar- Good Sam	$199,681,457	-11.16%	-3.78%	0.86%	$1,717,261	12.49%	11.25%	-1.02%	-$2,036,751	$1,717,261	0.86%	Imp
210057	Adventist- Shady Grove	$361,126,072	4.36%	-3.78%	-0.94%	-$3,394,585	11.46%	11.25%	-0.17%	-$613,914	-$613,914	-0.17%	Att
210058	UMMS- UMROI	$89,094,194	44.14%	-3.78%	-2.00%	-$1,781,884	11.92%	11.25%	-0.55%	-$88,203	-$88,203	-0.10%	Att
210060	Adventist-Ft. Washington	$37,325,252	-15.78%	-3.78%	1.39%	$518,821	10.87%	11.25%	0.32%	$119,441	$518,821	1.39%	Imp
210061	Atlantic General	$49,839,515	-22.98%	-3.78%	2.00%	$996,790	9.68%	11.25%	1.30%	$647,914	$996,790	2.00%	Imp
210062	MedStar- Southern MD	$210,782,671	-15.62%	-3.78%	1.37%	$2,887,723	11.13%	11.25%	0.10%	$210,783	$2,887,723	1.37%	Imp
210063	UMMS- St. Joe	$305,357,564	-7.16%	-3.78%	0.39%	$1,190,895	11.30%	11.25%	-0.04%	-$122,143	$1,190,895	0.39%	Imp
210064	Lifebridge- Levindale	$71,025,639	-18.58%	-3.78%	1.71%	$1,214,538	9.63%	11.25%	1.34%	$951,744	$1,214,538	1.71%	Imp
210065	Trinity - Holy Cross Germantown	$106,721,583	-0.59%	-3.78%	-0.37%	-$394,870	12.23%	11.25%	-0.81%	-$864,445	-$394,870	-0.37%	Imp

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Appendix VII. By Hospital Comparison of RY 2026 Revenue Adjustments with Incorrect vs Updated OOS Ratios

		INCORRECT OOS READMISSION RATIOS USING ORIGINAL METHODOLOGY (WHAT'S IN RATES)				UPDATED OOS READMISSION RATIOS USING ORIGINAL METHODOLOGY				
		Final Adjustment				Final Adjustment				
HOSPITAL ID	HOSPITAL NAME	$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment		$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	Performance compared to what's in rates ($)	Performance compared to what's in rates (%)
210001	Meritus	-$2,346,651	-0.87%	Imp		-$2,346,651	-0.87%	Imp	$0	0.00%
210002	UMMS- UMMC	-$9,277,409	-0.59%	Att		-$9,434,653	-0.60%	Att	-$157,244	-0.01%
210003	UMMS- Capital Region	$1,073,652	0.33%	Att		$422,954	0.13%	Att	-$650,698	-0.20%
210004	Trinity - Holy Cross	-$2,732,693	-0.62%	Imp		-$2,732,693	-0.62%	Imp	$0	0.00%
210005	Frederick	$281,446	0.11%	Imp		$281,446	0.11%	Imp	$0	0.00%
210008	Mercy	$48,819	0.02%	Imp		$48,819	0.02%	Imp	$0	0.00%
210009	JHH- Johns Hopkins	-$574,597	-0.03%	Imp		-$574,597	-0.03%	Imp	$0	0.00%
210011	St. Agnes	$1,457,101	0.52%	Imp		$1,457,101	0.52%	Imp	$0	0.00%
210012	Lifebridge- Sinai	-$4,111,753	-0.78%	Imp		-$4,111,753	-0.78%	Imp	$0	0.00%
210015	MedStar- Franklin Square	-$4,482,989	-1.10%	Imp		-$4,482,989	-1.10%	Imp	$0	0.00%
210016	Adventist- White Oak	-$26,934	-0.01%	Imp		-$26,934	-0.01%	Imp	$0	0.00%
210017	Garrett	-$22,236	-0.07%	Att		-$181,061	-0.57%	Att	-$158,825	-0.50%
210018	MedStar- Montgomery	-$482,409	-0.45%	Att		-$557,451	-0.52%	Att	-$75,042	-0.07%
210019	Tidal- Peninsula	$2,744,095	0.77%	Imp		$2,744,095	0.77%	Imp	$0	0.00%
210022	JHH- Suburban	$968,411	0.35%	Imp		$968,411	0.35%	Imp	$0	0.00%
210023	Luminis- Anne Arundel	-$3,190,937	-0.76%	Imp		-$3,190,937	-0.76%	Imp	$0	0.00%
210024	MedStar- Union Mem	-$1,931,363	-0.63%	Imp		-$1,931,363	-0.63%	Imp	$0	0.00%
210027	Western Maryland	$185,895	0.09%	Imp		$185,895	0.09%	Imp	$0	0.00%
210028	MedStar- St. Mary's	$1,295,632	1.30%	Imp		$1,295,632	1.30%	Imp	$0	0.00%
210029	JHH- Bayview	-$3,791,985	-0.75%	Imp		-$3,791,985	-0.75%	Imp	$0	0.00%
210030	UMMS- Chestertown	$216,606	2.00%	Att		$203,610	1.88%	Att	-$12,996	-0.12%
210032	ChristianaCare, Union	$400,170	0.36%	Imp		$400,170	0.36%	Imp	$0	0.00%
210033	Lifebridge- Carroll	$0	0.00%	Imp		$0	0.00%	Imp	$0	0.00%
210034	MedStar- Harbor	-$726,506	-0.53%	Imp		-$726,506	-0.53%	Imp	$0	0.00%
210035	UMMS- Charles	-$84,173	-0.08%	Imp		$147,303	0.14%	Imp	$231,476	0.22%
210037	UMMS- Easton	$2,324,864	1.68%	Att		$1,923,548	1.39%	Att	-$401,316	-0.29%
210038	UMMS- Midtown	-$437,019	-0.31%	Imp		-$437,019	-0.31%	Imp	$0	0.00%
210039	Calvert	-$679,575	-0.80%	Att		-$450,219	-0.53%	Att	$229,356	0.27%
210040	Lifebridge- Northwest	-$1,145,528	-0.66%	Imp		-$1,145,528	-0.66%	Imp	$0	0.00%
210043	UMMS- BWMC	-$2,406,633	-0.73%	Imp		-$2,406,633	-0.73%	Imp	$0	0.00%
210044	GBMC	$1,402,356	0.51%	Att		$1,484,848	0.54%	Att	$82,492	0.03%
210048	JHH- Howard County	$153,684	0.06%	Imp		$153,684	0.06%	Imp	$0	0.00%
210049	UMMS-Upper Chesapeake	-$2,993,814	-1.15%	Att		-$2,655,383	-1.02%	Att	$338,431	0.13%
210051	Luminis- Doctors	$585,123	0.30%	Att		$585,123	0.30%	Att	$0	0.00%
210056	MedStar- Good Sam	$1,098,248	0.55%	Imp		$1,098,248	0.55%	Imp	$0	0.00%
210057	Adventist- Shady Grove	-$2,022,306	-0.56%	Att		-$2,166,756	-0.60%	Att	-$144,450	-0.04%
210058	UMMS- UMROI	-$202,066	-0.23%	Att		-$202,066	-0.23%	Att	$0	0.00%
210060	Adventist-Ft. Washington	-$22,395	-0.06%	Imp		-$22,395	-0.06%	Imp	$0	0.00%
210061	Atlantic General	$4,984	0.01%	Att		-$134,567	-0.27%	Att	-$139,551	-0.28%
210062	MedStar- Southern MD	$1,538,713	0.73%	Imp		$1,538,713	0.73%	Imp	$0	0.00%
210063	UMMS- St. Joe	-$977,144	-0.32%	Imp		-$977,144	-0.32%	Imp	$0	0.00%
210064	Lifebridge- Levindale	$1,420,513	2.00%	Att		$1,420,513	2.00%	Att	$0	0.00%
210065	Trinity - Holy Cross Germantown	-$469,575	-0.44%	Imp		-$469,575	-0.44%	Imp	$0	0.00%
STATEWIDE	**$ 12,634,054,157.03**	**-$27,938,378**	-0.22%			**-$28,796,745**	-0.23%		-$858,367	-0.01%
Penalty		-$45,138,690	-0.36%			-$45,156,858	-0.36%		-$18,168	0.00%
Reward		$17,200,312	0.14%			$16,360,113	0.13%		-$840,199	-0.01%

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Appendix VIII. By Hospital FFY 2025 Estimated HRRP and RY 2025 Final RRIP Revenue Adjustments

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Hospital ID	Hospital Name	FFY 2025 HRRP Revenue Adjustment ($)	FFY 2025 HRRP Revenue Adjustment (%)	RY 2025 RRIP Revenue Adjustment ($)	RY 2025 RRIP Revenue Adjustment (%)
210001	Meritus	$ (2,444,359.12)	-0.97%	$ (2,217,563.00)	-0.88%
210002	UMMS- UMMC	$ (736,536.06)	-0.05%	$ 18,266,094.00	1.24%
210003	UMMS- Capital Region	$ (959,427.78)	-0.31%	$ 3,342,523.00	1.08%
210004	Trinity - Holy Cross	$ (413,940.59)	-0.10%	$ (413,941.00)	-0.10%
210005	Frederick	$ (152,737.52)	-0.06%	$ (534,581.00)	-0.21%
210008	Mercy	$ (176,531.62)	-0.08%	$ (3,354,101.00)	-1.52%
210009	JHH- Johns Hopkins	$ (181,890.34)	-0.01%	$ 6,911,833.00	0.38%
210011	St. Agnes	$ (636,911.21)	-0.25%	$ (382,147.00)	-0.15%
210012	Lifebridge- Sinai	$ (467,111.59)	-0.09%	$ (1,972,249.00)	-0.38%
210015	MedStar- Franklin Square	$ -	-0.02%	$ 2,008,056.00	0.54%
210016	Adventist- White Oak	$ (2,598,932.33)	-1.07%	$ (2,161,729.00)	-0.89%
210017	Garrett	$ (11,595.28)	-0.04%	$ (43,482.00)	-0.15%
210018	MedStar- Montgomery	$ -	0.00%	$ 1,037,362.00	1.08%
210019	Tidal- Peninsula	$ -	0.00%	$ 140,150.00	0.04%
210022	JHH- Suburban	$ (399,174.46)	-0.16%	$ (249,484.00)	-0.10%
210023	Luminis- Anne Arundel	$ (1,802,859.22)	-0.49%	$ (2,649,099.00)	-0.72%
210024	MedStar- Union Mem	$ (53,583.46)	-0.02%	$ (1,232,420.00)	-0.46%
210027	Western Maryland	$ -	-0.01%	$ (825,209.00)	-0.45%
210028	MedStar- St. Mary's	$ (582,781.01)	-0.58%	$ 813,884.00	0.81%
210029	JHH- Bayview	$ (660,500.70)	-0.14%	$ 3,632,754.00	0.77%
210030	UMMS- Chestertown	$ -	0.00%	$ 36,299.00	0.48%
210032	ChristianaCare, Union	$ (356,172.27)	-0.42%	$ (636,022.00)	-0.75%
210033	Lifebridge- Carroll	$ -	0.00%	$ (618,811.00)	-0.38%
210034	MedStar- Harbor	$ (12,823.45)	-0.01%	$ 256,469.00	0.20%
210035	UMMS- Charles	$ (214,689.70)	-0.22%	$ 614,793.00	0.63%
210037	UMMS- Easton	$ (49,446.98)	-0.04%	$ 988,940.00	0.80%
210038	UMMS- Midtown	$ (70,209.33)	-0.05%	$ 1,109,307.00	0.79%
210039	Calvert	$ (412,717.83)	-0.51%	$ 129,480.00	0.16%
210040	Lifebridge- Northwest	$ (482,584.16)	-0.30%	$ (1,769,475.00)	-1.10%
210043	UMMS- BWMC	$ -	0.00%	$ (2,018,621.00)	-0.62%
210044	GBMC	$ (685,814.10)	-0.26%	$ 1,081,476.00	0.41%
210048	JHH- Howard County	$ (1,630,127.96)	-0.74%	$ (2,467,221.00)	-1.12%
210049	UMMS-Upper Chesapeake	$ (757,960.20)	-0.32%	$ (1,586,979.00)	-0.67%
210051	Luminis- Doctors	$ (486,803.48)	-0.26%	$ 917,437.00	0.49%
210056	MedStar- Good Sam	$ (130,639.87)	-0.07%	$ 391,920.00	0.21%
210057	Adventist- Shady Grove	$ (1,803,454.74)	-0.54%	$ 367,370.00	0.11%
210058	UMMS- UMROI	$ -	0.00%	$ 242,904.30	0.30%
210060	Adventist-Ft. Washington	$ (238,032.71)	-0.63%	$ (358,938.00)	-0.95%
210061	Atlantic General	$ (85,381.21)	-0.18%	$ (237,170.00)	-0.50%
210062	MedStar- Southern MD	$ (210,921.41)	-0.10%	$ (1,244,436.00)	-0.59%
210063	UMMS- St. Joe	$ (2,896,423.64)	-0.99%	$ (409,595.00)	-0.14%
210064	Lifebridge- Levindale	$ -	0.00%	$ (517,924.00)	-0.76%
210065	Trinity - Holy Cross Germantown	$ (501,966.96)	-0.53%	$ 28,413.00	0.03%

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Appendix IX. By Hospital Comparison of Utilization Adjustment vs Incorrect OOS Ratios using Original Methodology and Updated OOS Ratios using Original Methodology

		INCORRECT OOS READMISSION RATIOS USING ORIGINAL METHODOLOGY (WHAT'S IN RATES)			UPDATED OOS READMISSION RATIOS USING ORIGINAL METHODOLOGY			OOS READMISSION AND TRANSFER ADJUSTMENTS = OOS UTILIZATION ADJUSTMENT (Staff Recommendation)		
		Final Adjustment			Final Adjustment			Final Adjustment		
HOSPITAL ID	HOSPITAL NAME	$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment
210001	Meritus	-$2,346,651	-0.87%	Imp	-$2,346,651	-0.87%	Imp	-$2,346,651	-0.87%	Imp
210002	UMMS- UMMC	-$9,277,409	-0.59%	Att	-$9,434,653	-0.60%	Att	-$11,950,561	-0.76%	Att
210003	UMMS- Capital Region	$1,073,652	0.33%	Att	$422,954	0.13%	Att	-$97,605	-0.03%	Att
210004	Trinity - Holy Cross	-$2,732,693	-0.62%	Imp	-$2,732,693	-0.62%	Imp	-$2,732,693	-0.62%	Imp
210005	Frederick	$281,446	0.11%	Imp	$281,446	0.11%	Imp	$281,446	0.11%	Imp
210008	Mercy	$48,819	0.02%	Imp	$48,819	0.02%	Imp	$48,819	0.02%	Imp
210009	JHH- Johns Hopkins	-$574,597	-0.03%	Imp	-$574,597	-0.03%	Imp	-$574,597	-0.03%	Imp
210011	St. Agnes	$1,457,101	0.52%	Imp	$1,457,101	0.52%	Imp	$1,457,101	0.52%	Imp
210012	Lifebridge- Sinai	-$4,111,753	-0.78%	Imp	-$4,111,753	-0.78%	Imp	-$4,111,753	-0.78%	Imp
210015	MedStar- Franklin Square	-$4,482,989	-1.10%	Imp	-$4,482,989	-1.10%	Imp	-$4,482,989	-1.10%	Imp
210016	Adventist- White Oak	-$26,934	-0.01%	Imp	-$26,934	-0.01%	Imp	-$26,934	-0.01%	Imp
210017	Garrett	-$22,236	-0.07%	Att	-$181,061	-0.57%	Att	$508,240	1.60%	Att
210018	MedStar- Montgomery	-$482,409	-0.45%	Att	-$557,451	-0.52%	Att	-$482,409	-0.45%	Att
210019	Tidal- Peninsula	$2,744,095	0.77%	Imp	$2,744,095	0.77%	Imp	$2,744,095	0.77%	Imp
210022	JHH- Suburban	$968,411	0.35%	Imp	$968,411	0.35%	Imp	$968,411	0.35%	Imp
210023	Luminis- Anne Arundel	-$3,190,937	-0.76%	Imp	-$3,190,937	-0.76%	Imp	-$3,190,937	-0.76%	Imp
210024	MedStar- Union Mem	-$1,931,363	-0.63%	Imp	-$1,931,363	-0.63%	Imp	-$1,931,363	-0.63%	Imp
210027	Western Maryland	$185,895	0.09%	Imp	$185,895	0.09%	Imp	$185,895	0.09%	Imp
210028	MedStar- St. Mary's	$1,295,632	1.30%	Imp	$1,295,632	1.30%	Imp	$1,295,632	1.30%	Imp
210029	JHH- Bayview	-$3,791,985	-0.75%	Imp	-$3,791,985	-0.75%	Imp	-$3,791,985	-0.75%	Imp
210030	UMMS- Chestertown	$216,606	2.00%	Att	$203,610	1.88%	Att	$216,606	2.00%	Att
210032	ChristianaCare, Union	$400,170	0.36%	Imp	$400,170	0.36%	Imp	$400,170	0.36%	Imp
210033	Lifebridge- Carroll	$0	0.00%	Imp	$0	0.00%	Imp	$0	0.00%	Imp
210034	MedStar- Harbor	-$726,506	-0.53%	Imp	-$726,506	-0.53%	Imp	-$726,506	-0.53%	Imp
210035	UMMS- Charles	-$84,173	-0.08%	Imp	$147,303	0.14%	Imp	$778,604	0.74%	Att
210037	UMMS- Easton	$2,324,864	1.68%	Att	$1,923,548	1.39%	Att	$2,075,771	1.50%	Att
210038	UMMS- Midtown	-$437,019	-0.31%	Imp	-$437,019	-0.31%	Imp	-$437,019	-0.31%	Imp
210039	Calvert	-$679,575	-0.80%	Att	-$450,219	-0.53%	Att	-$433,229	-0.51%	Att
210040	Lifebridge- Northwest	-$1,145,528	-0.66%	Imp	-$1,145,528	-0.66%	Imp	-$1,145,528	-0.66%	Imp
210043	UMMS- BWMC	-$2,406,633	-0.73%	Imp	-$2,406,633	-0.73%	Imp	-$2,406,633	-0.73%	Imp
210044	GBMC	$1,402,356	0.51%	Att	$1,484,848	0.54%	Att	$1,484,848	0.54%	Att
210048	JHH- Howard County	$153,684	0.06%	Imp	$153,684	0.06%	Imp	$153,684	0.06%	Imp
210049	UMMS-Upper Chesapeake	-$2,993,814	-1.15%	Att	-$2,655,383	-1.02%	Att	-$2,759,515	-1.06%	Att
210051	Luminis- Doctors	$585,123	0.30%	Att	$585,123	0.30%	Att	$780,163	0.40%	Att
210056	MedStar- Good Sam	$1,098,248	0.55%	Imp	$1,098,248	0.55%	Imp	$1,098,248	0.55%	Imp
210057	Adventist- Shady Grove	-$2,022,306	-0.56%	Att	-$2,166,756	-0.60%	Att	-$2,311,207	-0.64%	Att
210058	UMMS- UMROI	-$202,066	-0.23%	Att	-$202,066	-0.23%	Att	-$224,517	-0.25%	Att
210060	Adventist-Ft. Washington	-$22,395	-0.06%	Imp	-$22,395	-0.06%	Imp	-$22,395	-0.06%	Imp
210061	Atlantic General	$4,984	0.01%	Att	-$134,567	-0.27%	Att	-$284,085	-0.57%	Imp
210062	MedStar- Southern MD	$1,538,713	0.73%	Imp	$1,538,713	0.73%	Imp	$1,538,713	0.73%	Imp
210063	UMMS- St. Joe	-$977,144	-0.32%	Imp	-$977,144	-0.32%	Imp	-$977,144	-0.32%	Imp
210064	Lifebridge- Levindale	$1,420,513	2.00%	Att	$1,420,513	2.00%	Att	$1,420,513	2.00%	Att
210065	Trinity - Holy Cross Germantown	-$469,575	-0.44%	Imp	-$469,575	-0.44%	Imp	-$469,575	-0.44%	Imp