



Final Recommendation for the Readmission Reduction Incentive Program for Rate Year 2027

April 9, 2025

This document contains staff final recommendations for the RY 2027 Readmission Reduction Incentive Program. The document also includes staff final recommendations on modifications to the RY 2026 Readmission Reduction Incentive Program.

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List of Abbreviations

ADI	Area Deprivation Index
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
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
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

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).

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
<p>The quality programs operated by the Health Services Cost Review Commission, including the Readmission Reduction Incentive Program (RRIP), are intended to drive improvements in patient outcomes and to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care on an all-payer basis. Thus, HSCRC’s quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.</p>	<p>The RRIP policy is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time.</p>	<p>The RRIP policy currently holds up to 2 percent of hospital revenue at-risk for performance relative to predetermined attainment or improvement goals on readmissions occurring within 30-days of discharge, applicable to all payers and all conditions and causes.</p>	<p>This policy affects a hospital’s overall GBR and also affects the rates paid by payers at that particular hospital. The HSCRC quality programs are all-payer in nature and improve quality for all patients that receive care at the hospital.</p>	<p>Currently, the RRIP policy measures within-hospital disparities in readmission rates, using an HSCRC-generated Patient Adversity Index (PAI), and provides rewards for hospitals that meet specified disparity gap reduction goals. The broader RRIP policy continues to reward or penalize hospitals on the better of improvement and attainment, which incentivizes hospitals to improve poor clinical outcomes that may be correlated with health disparities. It is important that persistent health disparities are not made permanent.</p>

Recommendations

These are the final recommendation for the Maryland Rate Year (RY) 2027 Readmission Reduction Incentives Program (RRIP):

1. Maintain the all-payer, 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 with a blended base period of CY 2022 and CY 2023.
3. Retroactively apply a blended base period of CY 2022 and CY 2023 to the RY 2026 policy.
4. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
5. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
6. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards:
 - a. beginning at 0.25 percent of IP revenue for hospitals on pace for 50 percent reduction in disparity gap measure over 8 years, and;
 - b. capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
7. Monitor emergency department and observation revisits by adjusting readmission measure and through the all-payer Excess Days in Acute Care measure. Consider future inclusion of ED and/or observation stay revisits in the RRIP measure.
8. Update the RRIP policy in future years to align with statewide AHEAD model goals for readmissions.

Introduction

Maryland hospitals are 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 the All-Payer Model agreement with the Centers for Medicare & Medicaid Services (CMS) beginning in 2014, and continuing under the current Total Cost of Care (TCOC) Model agreement, which took effect in 2019. Under the global budget system, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk in Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, 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. It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Commission's quality programs reward 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 2 percent of hospital revenue at-risk in penalties and rewards based on achievement of improvement or attainment targets in 30-day case-mix adjusted readmission rates. In addition, the disparity gap component of the RRIP policy rewards hospitals up to 0.5% of their IP revenue for reducing disparities in readmissions based on race (Black vs Non-Black), ADI (high area

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

deprivation vs low deprivation), and Medicaid status (Medicaid beneficiary vs Non-Medicaid beneficiary).

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 2027 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.

This final policy recommends extending the four-year (2022-2026) improvement target that was approved in the RY2027 policy. However, based on stakeholder concerns, staff has assessed volume and readmission trends and is recommending that an updated two-year blended base period be used to assess improvement for RY2027 and retrospectively for RY2026. In addition to presenting these analyses, the assessment section of this policy also discusses the issue of revisits to the emergency department/observation following an inpatient admission. This final policy does not recommend any changes to the current case-mix adjustment readmission measure and recommends no updates to the disparity gap measurement or goals for improvement. In future years, the RRIP policy will be updated to align with the new AHEAD model and any statewide readmission improvement targets.

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

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.

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. Despite the Medicare FFS targets for the State, CMMI requires 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 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

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 (i.e., historical improvements trended forward) and updated benchmarking for Medicare and Commercial payers nationally.

RRIP Methodology

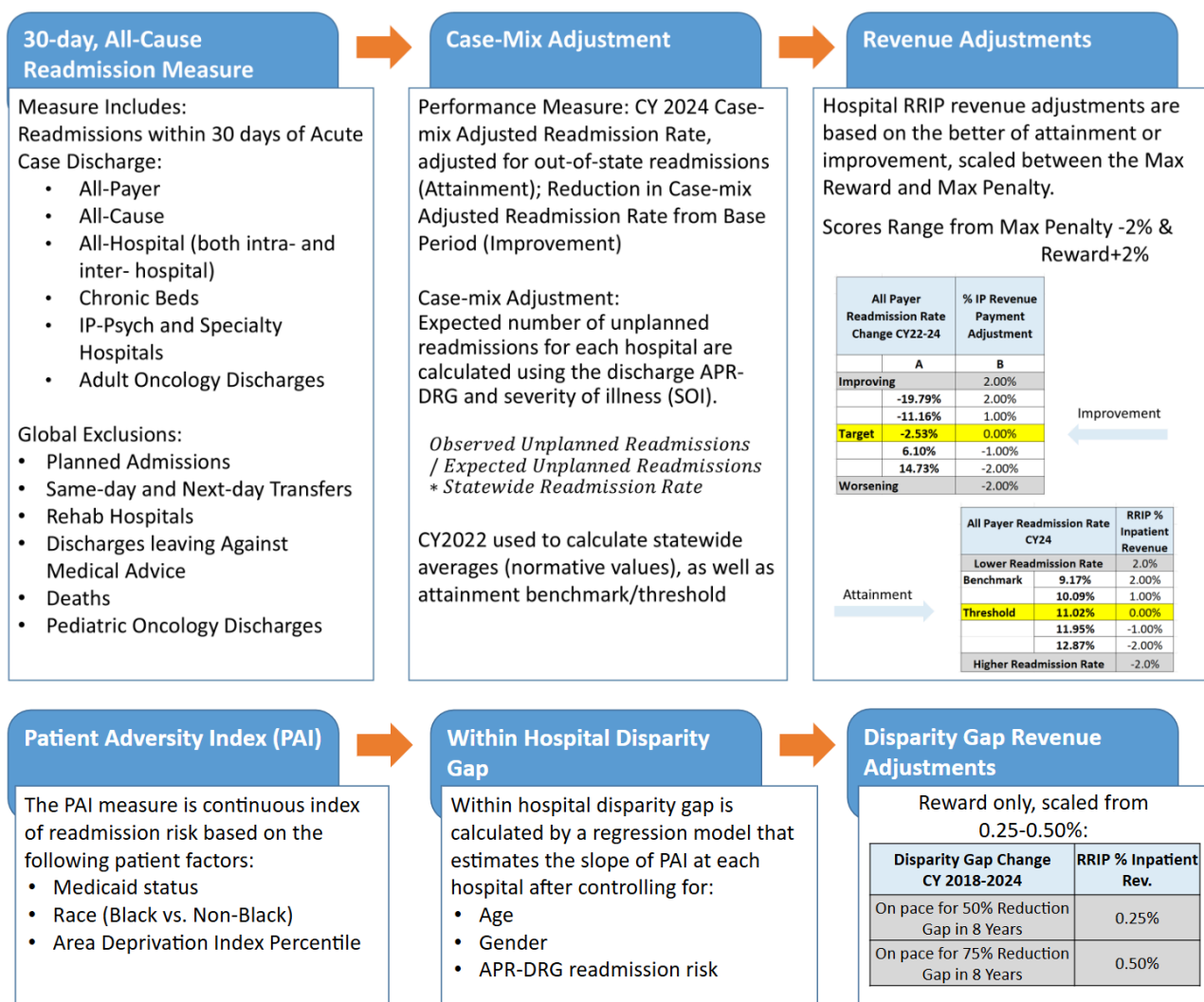
Figure 1 provides an overview of the current RRIP methodology (also see Appendix I) that converts hospital performance to payment adjustments. In Maryland, the RRIP methodology evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges (e.g., pediatric oncology, patients who leave against medical advice, rare diagnosis

³ For more information on the HRRP, please see:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program>

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.

Figure 1. RRIP Methodology RY26



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

Assessment

For RY 2027, the main policy decision is to determine the base period from which to assess improvement for CY 2025 readmission rates. In order to assess the most appropriate base year for improvement, this section assesses readmissions performance and provides improvement scenarios for consideration. While there are no proposed changes to the readmission measure, staff is recommending that additional analytics continue to be conducted over the coming year to assess hospital revisits to the emergency department and/or observation, which staff believes will complement some of the other workstreams the Commission currently is engaging in to improve emergency room length of stay and address concerns raised by CMMI about higher use of observation status in Maryland. Finally, staff provides performance on the disparity gap measure and recommends to continue this targeted focus on high adversity patients.

Current Statewide Year To Date Performance

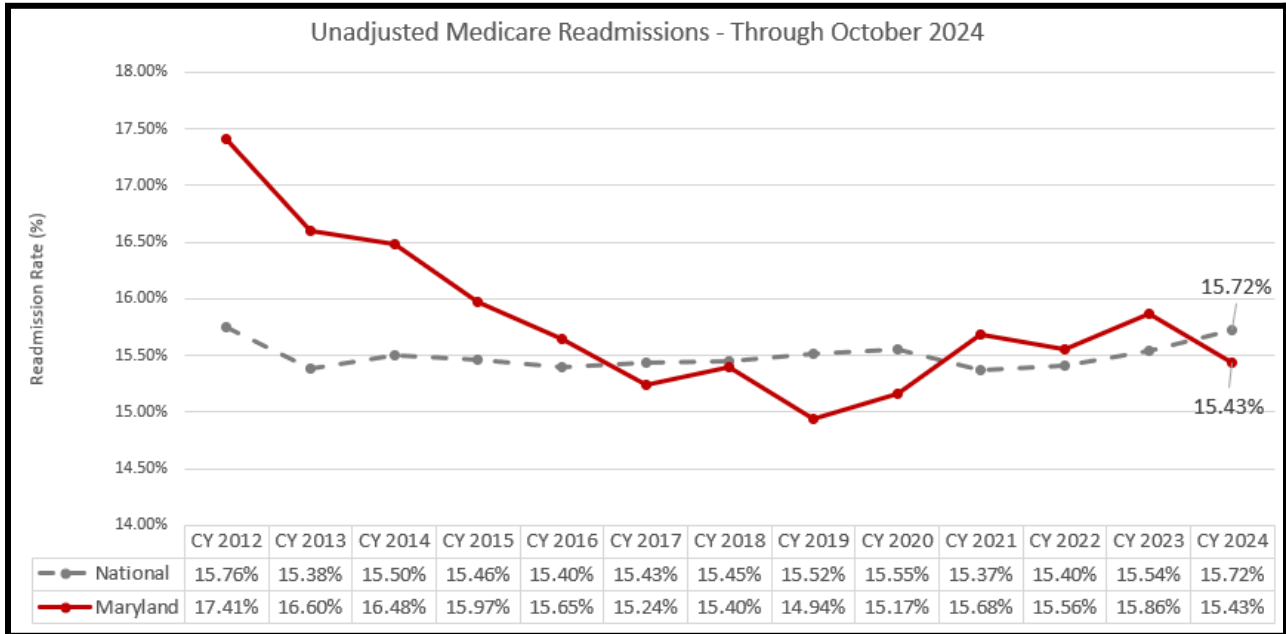
Readmission performance is assessed in several ways. First, we present data on the unadjusted, all-cause Medicare Readmission Rate (the original “Waiver Test”), which shows that Maryland currently has a slightly lower unadjusted readmission rate than the nation. Next, Maryland and the Nation’s performance on the CMMI adaptation of the Hospital-Wide Readmission measure for Maryland is presented (the new “Waiver Test”). Last, we present the all-payer, case mix adjusted readmission results used for the RRIP.

Medicare FFS Performance

At the end of 2018, Maryland had an unadjusted FFS Medicare readmission rate of 15.40 percent, which was below the national rate of 15.45 percent. This is 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 CY2024 YTD readmission data, which is presented in Figure 2, shows Maryland’s

readmission rate at 15.56 percent, which is slightly lower than the Nation's performance at 15.63 percent.

Figure 2. Maryland and National Medicare FFS Unadjusted Readmission Rates

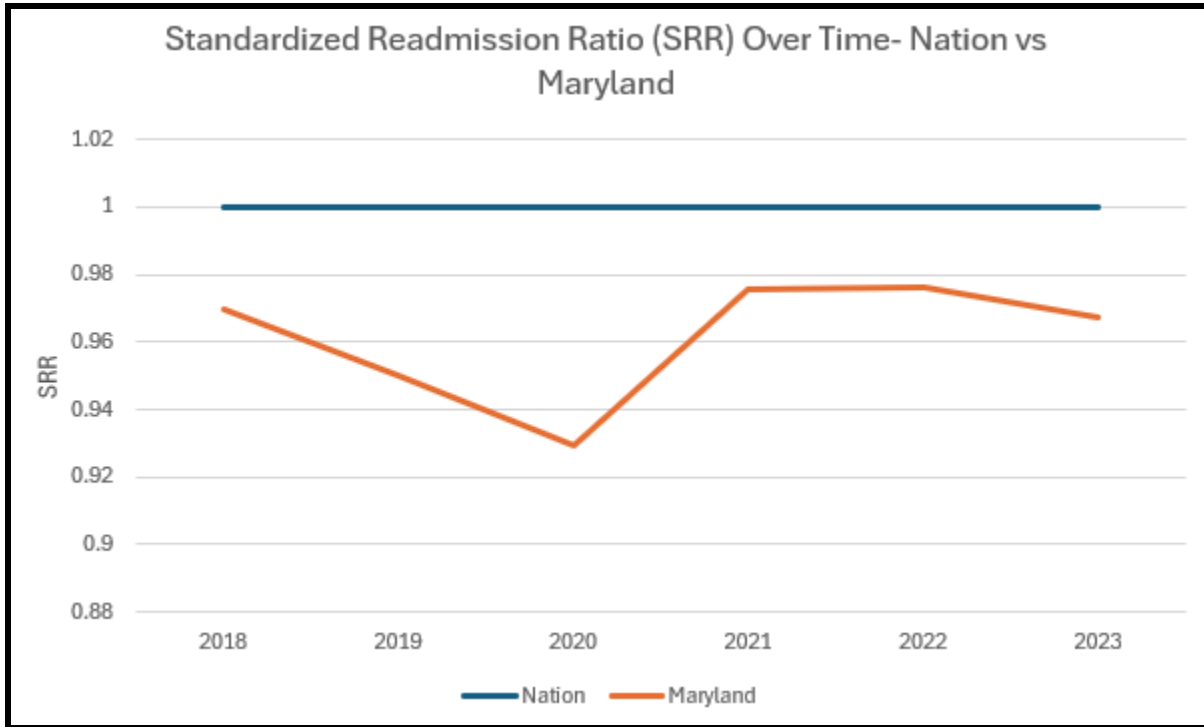


Hospital Wide Readmission Measure Performance

Because of concerns about changes in acuity, CMMI agreed to switch to a risk-adjusted readmission measure to compare Medicare performance in Maryland compared to the Nation. Below in Figure 3, Maryland and the Nation's performance on the CMMI adapted HWR measure is presented. The presented statistic is the Standardized Risk Ratio which indicates how observed readmission rates compare to the expected rates; a ratio less than 1 indicates lower than expected readmission rates. Since Maryland's SRR and confidence intervals for all years⁵ are below 1, the State performed better than the Nation within this measure in CYs 2018-2023.

⁵ When this analysis was provided to Staff, Lewin was in the process of calculating 2018 confidence intervals, but the 2018 SRR was 0.9700, which is also better than the Nation's.

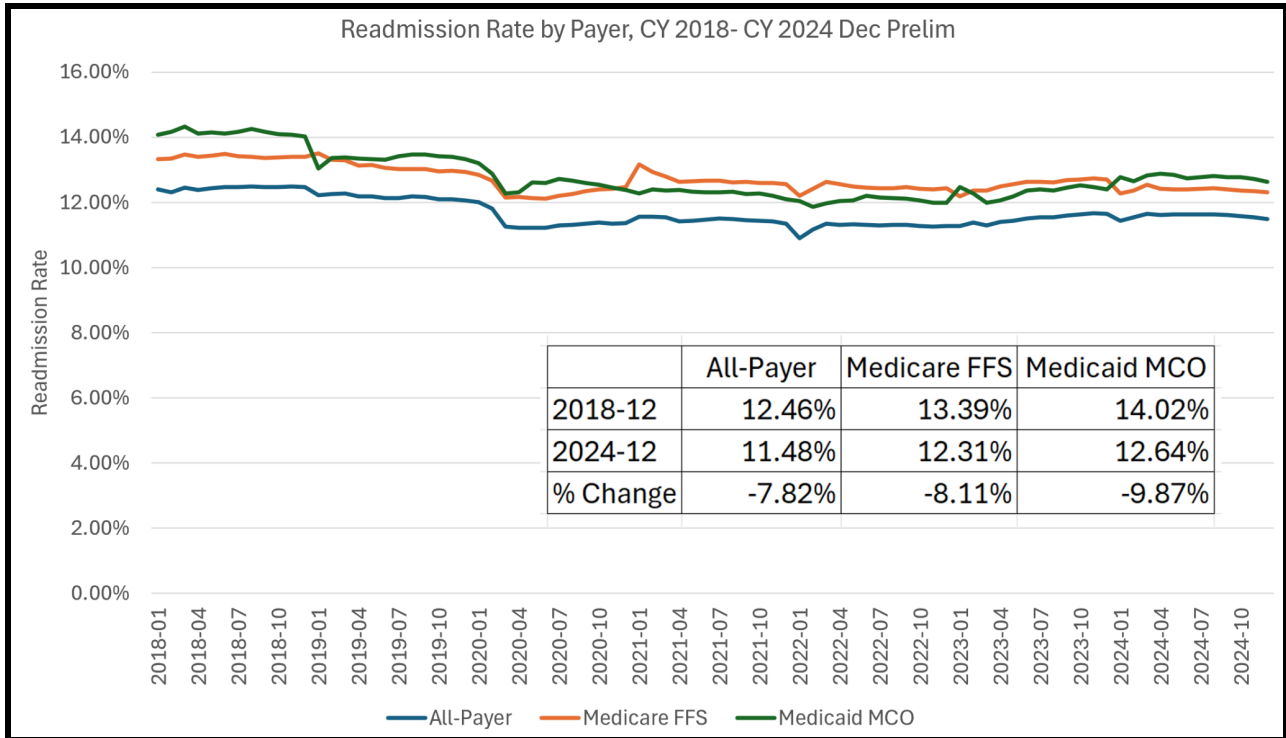
Figure 3. Maryland and National Medicare FFS Hospital-Wide Readmission Measure Performance



All-Payer Readmission Performance

Maryland has also performed well statewide over time on RRIP performance standards as shown in Figure 4. In CY 2024 YTD All-payer, Medicare FFS, and Medicaid MCO readmission rates were reduced by 7.82 percent, 8.11 percent and 9.87 percent from CY2018 YTD, respectively.

Figure 4. Statewide Improvement in Case-Mix Adjusted Readmission Rates by Payer, December 2018 YTD through December 2024 Prelim YTD



The RY 2026 RRIP program assesses improvement from CY 2022 to CY 2024, and attainment performance in CY 2024 based on historical standards. As illustrated in Figure 5 below, 13 hospitals are on target to reach the improvement goal of a 2.53 percent reduction, and as shown in Figure 6, 7 hospitals are on target to have a readmission rate below the attainment threshold of 11.02 percent. Hospitals performing well on both improvement and 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 only 16 unique hospitals on track to receive a scaled reward for CY 2024 performance, which concerns staff given that the State performs better than the Nation on an unadjusted basis and that the overall improved performance in Maryland relative to the Nation is not driven by improvement of a few large facilities (i.e., some of the largest facilities have worse readmission rates in 2024 than they did in CY 2022, thereby not skewing the statewide results positively). CY

2024 YTD performance indicates that most hospitals are experiencing an increase in readmissions from CY 2022 (N=25/43), as illustrated in Figure 5 below. Stakeholders expressed concerns that the CY2022 base period had an unusually low readmission rate and requested that the staff consider updating the base period to CY2023, as is discussed further in the next section.

Figure 5. By-Hospital Change in All-Payer Case Mix Adjusted Readmission Rates, 2022- 2024 YTD Through December Preliminary

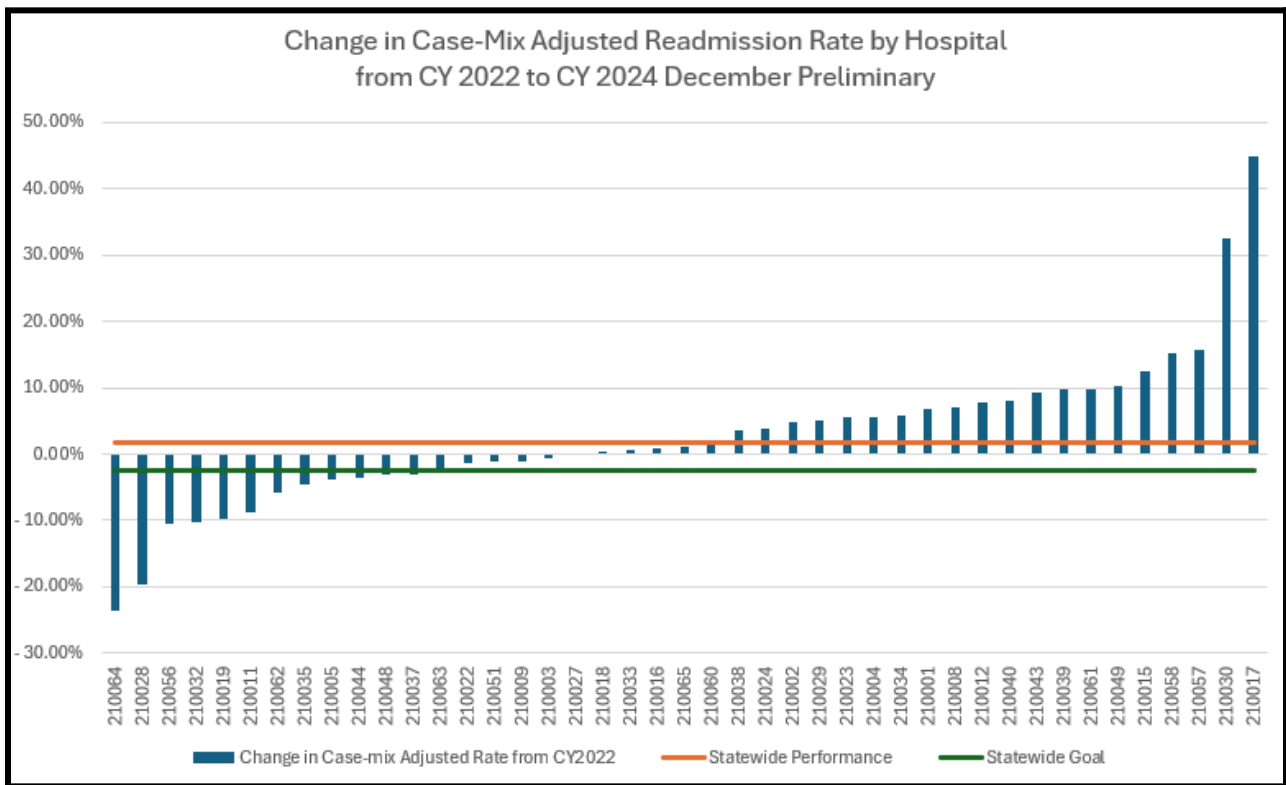
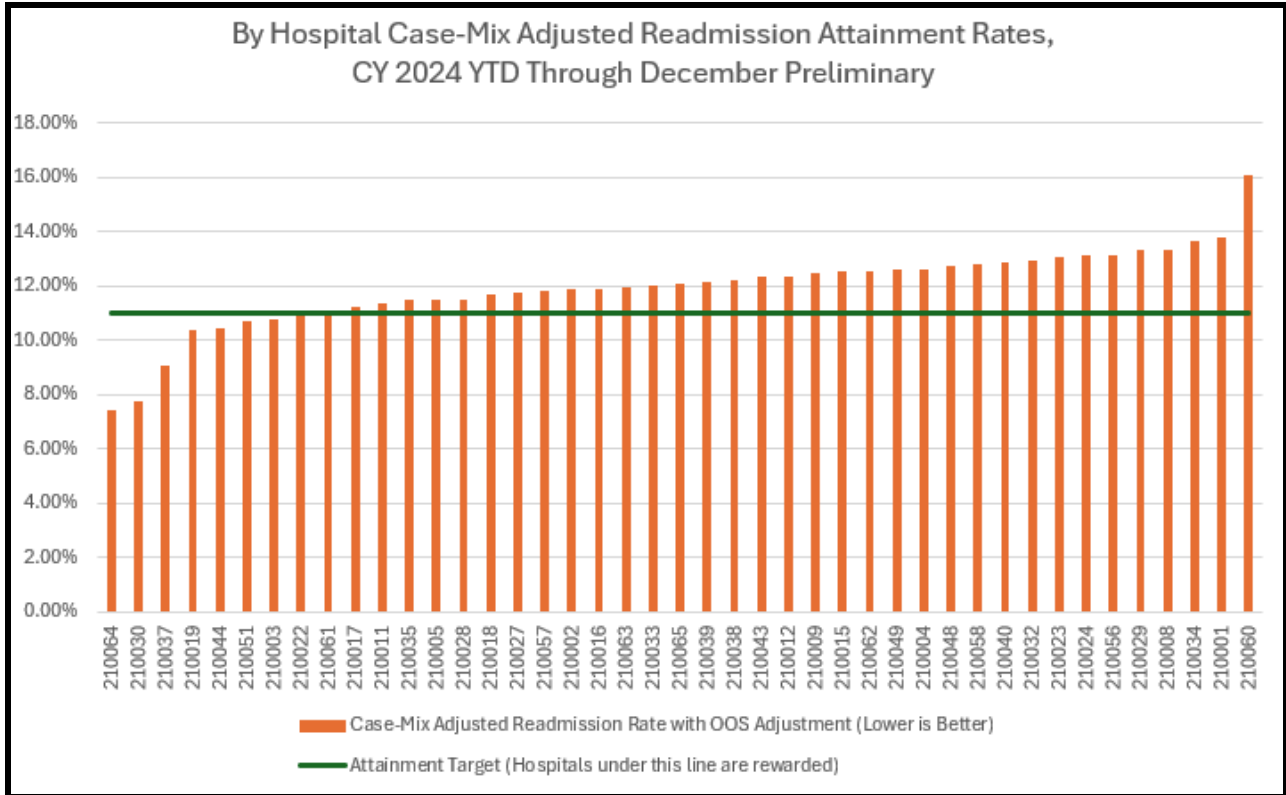


Figure 6. By-Hospital Case Mix Adjusted Readmission Rates, YTD 2024



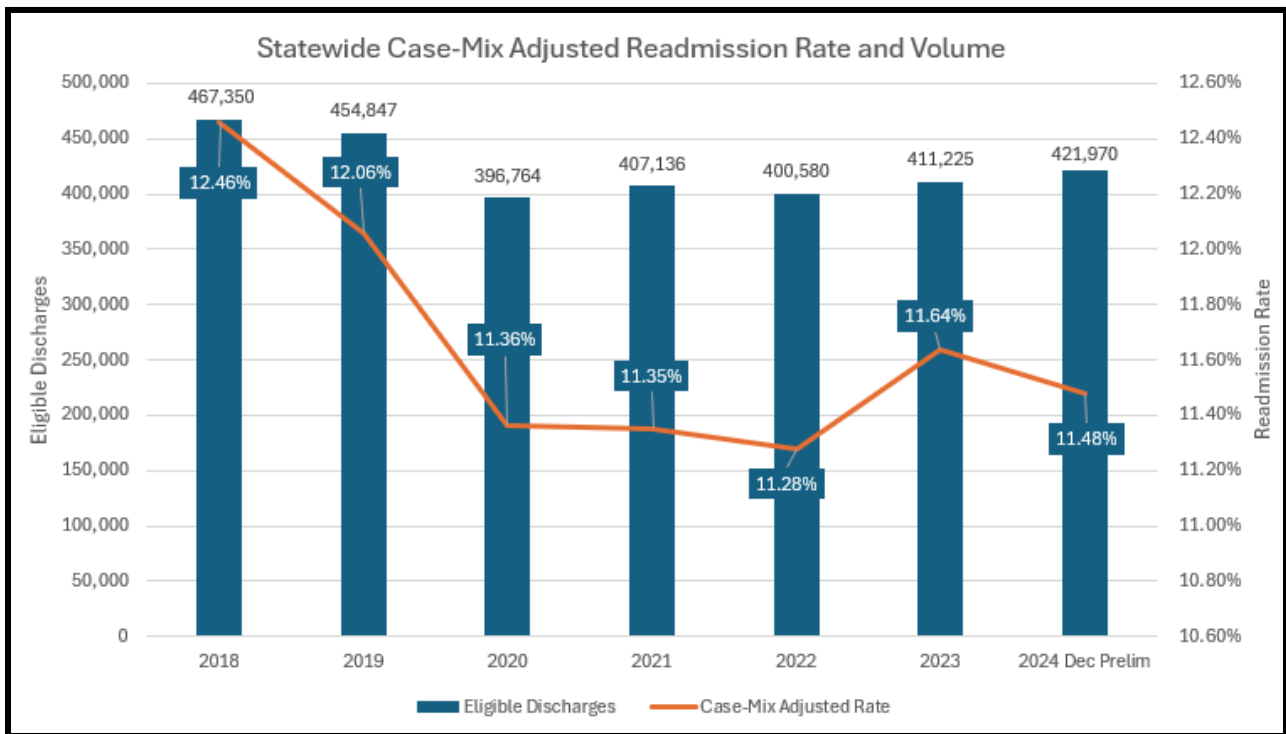
Base Period Concerns

Historically, readmission improvement has been measured over multiple years with a fixed base (e.g., CY2013 was the base for CYs2014-2016 and CY2016 was the base for CYs2017-2018 in the All-Payer Model, 2018 base for 2019-2023 in the TCOC Model). The fixed base was used to address concerns that hospitals may not be able to make incremental annual improvements and so that large improvements in one year that are maintained receive credit under the policy. In the RY 2026 policy, a 5 percent improvement target over 4 years from 2022 base through the 2026 performance period was approved.

Under the RY 2026 policy, hospitals have worse performance in the RRIP than has been seen in previous years and hospitals have raised whether using a fixed base year to assess improvement (unlike other quality programs) is appropriate in general and whether CY 2022 is a representative

year to use as the base in particular. Members of PMWG expressed concern with the use of CY 2022 as the base period due to its historically low volumes and low readmission rate, which is illustrated in Figure 7 below.⁶ While staff agrees the volumes are much lower in CY2022 compared to pre-pandemic levels, the volumes in CY2023 are also lower, but the readmission rate is higher. Thus, staff is recommending a blended base period of CY 2022 and CY 2023 for the RY 2027 policy, and to apply this base period retroactively to the RY 2026 policy. Additional discussion on this issue is included in the Stakeholder Feedback section below. Future iterations of the policy, which will have to consider rebasing due to a new statewide improvement goal, may consider rebasing beyond CY 2022 and CY 2023 and whether the base period should be fixed or advanced forward annually.

Figure 7. Statewide Case-Mix Adjusted Readmission Rate, CY 2018-2024 YTD



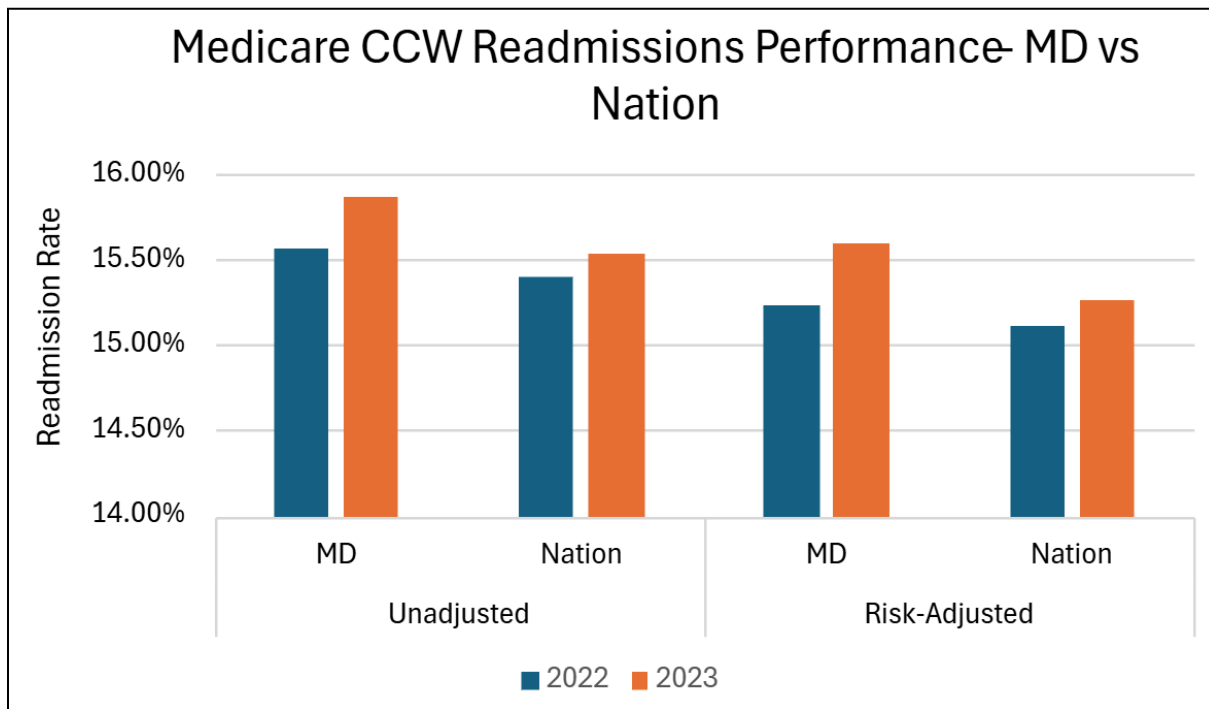
As shown below in Figure 8, both Maryland and the Nation experienced a degradation in readmission rates in CY 2023 on both an unadjusted and risk-adjusted basis. The unadjusted

⁶ Due to the COVID-19 PHE, CY 2020 readmission performance has not been evaluated in RRIP policies and therefore should not be considered as a potential base period.

readmission rates are provided monthly by CMMI presented above. However, the risk-adjusted rates presented here are calculated by the HSCRC using the CCW data using slightly different risk-adjusters (e.g., Elixhauser comorbidity flags) due to data availability and not the CMMI adapted HWR risk adjusted measure, as we do not have 2024 readmission rates under this methodology at this time.

While both the Nation and the State saw a degradation in readmission rates from CY 2022 to CY 2023, the State saw a greater degradation while simultaneously performing worse than the Nation in both years, which led staff to reject the idea of moving the base period to CY 2023. Staff believes that blending CY 2022 and CY 2023 takes into account the secular degradation in readmission rates that occurred in CY 2023 without excusing the worsening rates and poor performance compared to the Nation. Further, blending CY 2022 and CY 2023 for the base period provides more stable norms by using a longer time period to establish them; this approach was approved in the RY 2021 MHAC policy to address an identical concern of unstable rates.⁷

Figure 8. Maryland and National Readmissions Performance, Unadjusted and Risk-Adjusted



⁷ [RY 2021 MHAC Policy](#), two year base period decision is detailed on pages 20-21.

Statewide modeled revenue adjustments with base period of CY 2022 only, a blended two year base period, and CY 2023 only base period for RY 2026 YTD and estimated RY 2027 are presented below in Figure 9; hospital results are included in Appendix II.

Figure 9. Statewide RY 2026 and RY 2027 Modeled Revenue Adjustments

RY 2026 YTD Revenue Adjustments	<u>CY 2022 Base Period</u> Attainment Target: 11.02% Improvement Target: -2.53%	<u>CY2022/2023 Blended Base Period</u> Attainment Target: 11.31% Improvement Target: -2.53%	<u>CY 2023 Base Period</u> Attainment Target: 11.48% Improvement Target: -2.53%
Net Adjustments (\$), (%)	~ -\$56M, -0.47%	~ -\$34M, -0.30%	~-\$4M, -0.03%
Penalties (\$), (%)	~ -74M, -0.63%	~ -\$53M, -0.45%	~-\$32M, -0.27%
Rewards (\$), (%)	~ \$18M, 0.15%	~ 18M, 0.15%	~\$29M, 0.24%

RY 2027 Estimated Revenue Adjustments (difference between RY26 YTD and these estimates are improvement target)	<u>CY 2022 Base Period</u> Attainment Target: 10.88% Improvement Target: -3.78%	<u>CY2022/2023 Blended Base Period</u> Attainment Target: 11.16% Improvement Target: -3.78%	<u>CY 2023 Base Period</u> Attainment Target: 11.33% Improvement Target: -3.78%
Net Adjustments (\$), (%)	~ -\$66M, -0.56%	~ -\$49M, -0.41%	~-\$23M, 0.19%
Penalties (\$), (%)	~ -\$82M, -0.70%	~ -\$64M, -0.54%	~-\$45M, -0.38%
Rewards (\$), (%)	~ 16M, 0.14%	~ \$15M, 0.12%	~\$22M, 0.18%

Revisits to Emergency Department and Observation Stays

Improvement in readmission rates under the model should result in better patient experience. However, the current readmission measure only counts a readmission if the patient returns to the hospital and is admitted into an inpatient bed. Thus, revisits to the emergency department or for an observation stay after an initial inpatient admission are not considered; revisits that occur after an initial or index ED visit or an observation stay are also not considered. This potentially has an impact on hospital throughput and ED boarding as ED hospital staff have anecdotally indicated that they are doing more testing and diagnostics in the ED that previously may have been done during the inpatient admission to determine whether an admission is really necessary. While this might be appropriate clinically, if these revisits represent quality of care or care coordination concerns, these are not being identified for payment incentives at this time (only exception is PAU, which includes observation stays ≥ 24 hours as inpatient stays). When staff looked at this previously for just observation stays, we found that while readmission rates increased when observation stays were included, the correlation between the readmission rates with and without observation stays was 0.986 in 2018. More recently, staff have been working with MPR to explore observation revisits on a risk-adjusted basis and continue to discuss with stakeholders and experts the clinical rationale for observation use. Also, it should be noted that at this time the national program does not include observation stays in their readmission measures. Thus, for RY 2027, staff recommends that the RRIP readmission measure remain an inpatient only measure. However, staff is continuing to assess this issue to ensure that hospitals are not being rewarded for “gaming” through use of observation, discuss clinical and operational factors impacting patient status during revisits, and will continue to collaborate with CMMI to better understand observation use in Maryland. As discussed below in the AHEAD section, the inclusion of observation is recommended by CMMI so staff will need to address this concern in the coming year.

Excess Days in Acute Care (EDAC)

As discussed above, stakeholders remain concerned about emergency department and observation revisits, especially given the global budget incentives to avoid admissions. Another approach for addressing this issue would be to adopt the Excess Days in Acute Care measure into payment. The EDAC measure captures the number of days that a patient spends in the

hospital within 30 days of discharge, and includes emergency department and observation stays by assigning ED visits a half-day length of stay and assigning observation hours rounded up to half-day units.⁸ Staff have worked with our methodological contractor to adapt the Medicare Excess Days in Acute Care (EDAC) condition-specific measures to an all-cause, all-payer measure for potential program adoption in future years. This work was completed and monitoring reports for this measure are posted on the CRISP portal on a monthly basis for hospital monitoring and input. However, the EDAC measure has been criticized by some PMWG members because of the time element associated with the readmission. Specifically, the concern is that readmissions with a longer length of stay (which would represent worse performance) may indicate a less preventable readmission. While staff will consider this concern, it could also be countered that a longer readmission represents a more serious quality of care issue from the initial admission. As staff continue to assess observation revisits, EDAC should be monitored.

Digital Measures/Electronic Clinical Quality Measure (eCQM)

Under the Inpatient Quality Reporting program, CMS transitioned from the claims-based 30-day Hospital Wide Readmission (HWR) measure to the digital Hybrid HWR measure. Initially, the July 1, 2023-June 30, 2024 reporting of the hybrid measure for Medicare patients for Federal Fiscal Year 2026 payment year was mandatory; however, CMS shifted the requirement to be voluntary reporting, with mandatory reporting postponed to the July 2024 to June 2025 reporting period. The HWR 30-day readmission hybrid measure merges electronic health record data elements with a set of 13 Core Clinical Data Elements (CCDE) consisting of six vital signs and seven laboratory test results; hospitals must map these 13 CCDE to the patient electronic health record (EHR). The claims and CCDE data are then submitted and used to calculate measure results. For the initial year beginning July 1, 2023, HSCRC required hospitals to submit the hybrid HWR measure data to the State for Medicare patients. Beginning with July 1, 2024 discharges, Maryland expanded the measure submission to include all-payers and patients aged 18 and above. To prepare for this update, CRISP and Medisolv (CRISP's digital measure subcontractor) have updated the data collection infrastructure and are ready to receive data on the expanded

⁸ Additional information on the EDAC measures and methodology can be found here: <https://www.qualitynet.org/inpatient/measures/edac/methodology>

measure with the first submission scheduled to begin in January 2025. However, some hospitals and stakeholders have previously signaled that some hospitals' EHRs may not be ready to submit data on the expanded measure. HSCRC staff will continue to monitor the issues voiced by hospitals and identify strategies as needed to progress on expansion of the Hybrid measure, and will also consider options for augmenting the RRIP all-payer measure with EHR data elements in the future.

Reducing Disparities in Readmissions

Racial and socioeconomic differences in readmission rates are well documented^{9,10} 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 staff¹¹ 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, identify reduction in disparities as a key priority over the near term. 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. Hospitals that improve on the within hospital disparity gap and improve

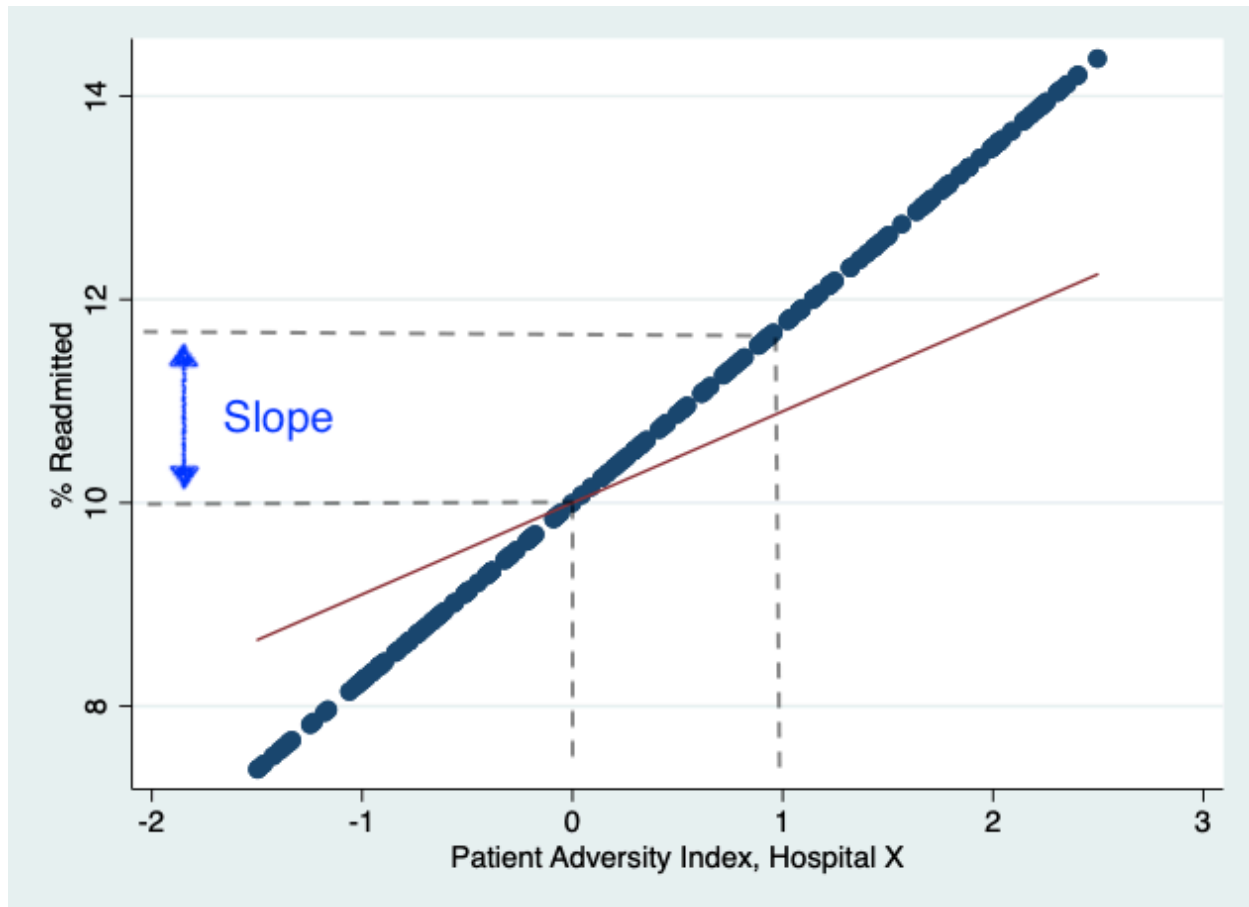
⁹ Tsai TC, Orav EJ, Joynt KE. Disparities in surgical 30-day readmission rates for Medicare beneficiaries by race and site of care. *Ann Surg*. 2014;259(6):1086–1090. doi:10.1097/SLA.0000000000000326;

¹⁰ 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.

¹¹ 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.

on overall readmissions, are eligible for a scaled reward up to 0.50 percent of inpatient revenue. Additional information on the development of the within-hospital disparity metric can be found in the RY 2021 RRIP policy.¹²

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



The RRIP disparity gap improvement goal was set through the end of the TCOC model (CY2026) and aligns with one of the goals in the Statewide Integrated Improvement Strategy. The SIHIS goal is to have half of eligible hospitals achieve a 50 percent reduction in readmission disparities. CY 2023 data shows that 22 hospitals saw a reduction in their within-hospital disparities in readmissions, ranging from a 0.55% reduction to a 34.87% reduction, compared to CY 2018.

¹² [RY 2021 RRIP Policy](#)

Through the RY2025 RRIP-Disparity Gap Program (CY 2023 performance), scaled rewards were provided to two of these hospitals for reducing their disparities in readmissions by the required minimum of 29.29 percent while simultaneously reducing their overall readmission rate, for a statewide total of about \$1.8 million in rewards. CY 2024 YTD data shows that 20 hospitals saw a reduction in their within-hospital disparities in readmissions ranging from a 0.55% reduction to a 39.72% reduction, compared to CY 2018. Despite 20 hospitals reducing readmission disparities from CY 2018, only 1 hospital achieved the disparity gap threshold for rewards (i.e., a reduction of at least 35.16%).

The State remains committed to ensuring hospitals are advancing health equity by continuing to financially incentivize reductions in disparities through the Readmissions Reduction Incentive Program (RRIP) policy and other policies. The ability to set hospital payment incentives specifically for advancing health equity is an important hallmark of the TCOC Model and exemptions from national quality programs. In the RY 2026 Quality Based Reimbursement program, this disparity gap methodology was adapted to the Timely Follow-Up post hospitalization measure and the Commission approved financial incentives for reductions in disparities in follow up for Medicare patients.

For RY 2027, the RRIP disparity gap draft recommendation uses the previously calculated improvement targets pushed forward to CY 2025 performance.

AHEAD Model Considerations

The AHEAD model will begin on January 1st, 2026. As part of the AHEAD model, the state must set Statewide Quality and Equity targets for five mandatory domains and one optional domain. As shown in Table 1 below, CMMI has provided recommended measures for each of the domains. Within the Utilization and Quality Domain, CMMI has recommended readmissions as the measure and at this time the HSCRC and MDH are not proposing a different area of focus for this domain (i.e., State is in agreement to focus on readmissions). However, CMMI has specifically recommended that the National Committee for Quality Assurance's Plan All-Cause Readmission (NCQA PCR) measure be used by AHEAD states to assess statewide performance over the 9-year model. Currently, HSCRC staff are working with Maryland Department of Health, Maryland

Commission on Health Equity’s Data Advisory Committee, and contractors to review the NCQA PCR measure specifications in comparison to the RRIP, CMS HWR measure, and the current CMMI developed readmission measure for MD. Based on this assessment, the state will need to pick a readmission measure and develop biannual statewide targets for improvement. The NCQA readmission measure differs from the RRIP and HWR measure in that it includes observation stays as eligible for a readmission and as a readmission from inpatient. Other differences include differences in inclusion/exclusion criteria and risk adjustment approach. In addition, the data source (claims from payers, HSCRC case-mix) for calculating the readmission measure needs to be determined. Currently staff plan to assess whether it is feasible to use the NCQA specifications with the HSCRC case-mix data with modifications. Staff are also working to compare Medicare results using claims versus HSCRC case mix data. The advantage of using HSCRC case mix data is that it is more timely than claims and is thus used for RRIP so that hospitals can monitor progress during the performance year. However, CMMI will need to approve any measure adaptations to the NCQA readmission measure, including changes to the type of data used to calculate the measure, or approve the use of an alternative measure for this domain through the process outlined in the CMMI contract with Maryland. Ultimately, the staff believes that the RRIP measure and goals should be aligned with the statewide targets as much as possible, while recognizing there may be reasons to have a more aggressive hospital target (e.g., front loading of improvement, need to ensure statewide target is met). Thus, in future years, staff recommends that the RRIP policy be updated to provide as much alignment as possible, set goals for hospitals to try and ensure that the statewide improvement goal is met, while maintaining the ability to provide hospitals with performance results during the performance period.

Table 1.

	Domain	Measure
1	Population Health	<ul style="list-style-type: none"> • CDC HRQOL- 4 Health Days Core Module
2	Prevention and Wellness <i>Choose at least 1 measure</i>	<ul style="list-style-type: none"> • Colorectal Cancer Screening (CCS-AD) • Breast Cancer Screening: Mammography (BCS-AD)

3	Chronic Conditions <i>Choose at least 1 measure</i>	<ul style="list-style-type: none"> Controlling High Blood Pressure (CBP-AD) Hemoglobin A1c Control for Patients with Diabetes (HBDAD)
4	Behavioral Health <i>Choose at least 1 measure</i>	<ul style="list-style-type: none"> Use of Pharmacotherapy for Opioid Use Disorder Antidepressant Medication Management (AMMAD) Follow-Up After Hospitalization for Mental Illness (FUHAD) Follow-Up After ED Visit for Substance Use
5	Health Care Quality and Utilization	<ul style="list-style-type: none"> Plan All-Cause Unplanned Readmission (PCRAD)
<i>Must choose at least 1 focus area</i>		
6	Focus Area 1- Maternal Health Outcomes <i>Choose at least 1 measure</i>	<ul style="list-style-type: none"> Live Births Weighing Less Than 2500 Grams (LBWCH) Prenatal and Postpartum Care: Postpartum care (PPC-AD)
	Focus Area 2- Prevention Measures <i>Choose at least 1 measure</i>	<ul style="list-style-type: none"> Adult Immunization Status Prevalence of Obesity Medical Assistance with Smoking and Tobacco Use Cessation (MSC) ED Visits for Alcohol and Substance Use Disorders
	Focus Area 3- Social Drivers of Health <i>Choose at least 1 measure</i>	<ul style="list-style-type: none"> Food Insecurity Housing Quality

Stakeholder Feedback and Staff Responses

Comment letters on the draft policy were received from the Johns Hopkins Hospital System (JHHS), Garrett Regional Medical Center, and the Maryland Hospital Association (MHA), MedStar Health, and the University of Maryland Medical System (UMMS). Stakeholder feedback was also provided through the PMWG. Specific input provided and staff responses are below.

Comments on RRIP base period

The feedback received on the RRIP base period strongly favored for the most part using CY2023 only as the base for RY2026 and RY2027. The concerns raised in the letters were specifically around use of CY2022 in the blended base, as well as about maintaining a base period for multiple years (i.e., not advancing the base year annually) and using only one year for the base. Here are the comments from each letter:

- Garrett suggests that CY2022's volume and readmission trends are an outlier and thus not an accurate base for comparison in future years.
- JHHS is appreciative of staff considering changing the base from CY 2022 for both RY26 and RY27. They are supportive of a blended CY 2022 and CY 2023 base period, but are not opposed to a CY 2023 base period for both RY 2026 and RY 2027.
- MedStar strongly believes that CY2022 should not be used due to COVID and service mix changes. They also recommend that multiple years be used for the base to increase stability and during discussions have also suggested that the base period should be moved forward annually (i.e., not remain static over multiple RYs). Specifically, they feel that the program should be changed to use CY 2023 as the base period for RY 2026. For RY 2027, they feel it would be reasonable to use a two-year base period (CY23/24) for greater stability, but are not opposed to just using a CY 2023 base period and revisiting the issue of a multi-year base and/or moving the base period forward in the future.
- MHA recommends using only CY2023 as the base period for both RYs. They cite larger readmission improvements from CY2018 to CY2022 (RY2024) than were expected and that readmission rates have started to return to pre-covid levels in CY2023.
- UMMS recommends the use of CY 2023 for the base period for both RY26 and RY27. They provide information about the impact of COVID in CY2022 on admissions/service mix and suggest since performance has improved in CY24 YTD for Maryland compared to the nation, that the estimated penalties are too high. Lastly, they state that the degradation in performance in CY23 was taken into account in the RY2025 RRIP policy, which had much higher penalties than RY2024.

Staff response

Staff believes that the two-year blended base period approach is the best option for both RY 2026 and RY 2027. As was shown in Figure 7 in the assessment section, both the volume of hospital admissions and the readmission rates dropped significantly in 2020 compared to previous years. While the CY2022 volume and readmission rate remained significantly lower than the CY2019 volume and readmission rate, in CY2023 the volume was only slightly higher than in CY2022 but the readmission rate increased more significantly. Then, as volume further increased in CY2024 YTD, the readmission rate decreased compared to CY2023, again showing that there is not as clear of a relationship between hospital admission volume and readmissions and that quality of care could indeed have been worse in CY2023. However, stakeholders still posited that the CY2022 readmission rate may have been low relative to 2023 due to COVID and specifically the Omicron surge in early 2022. Staff analyzed the impact of removing index admissions during the Omicron surge in January and February 2022. The results indicate that the readmission rate does not change very much when those months are removed compared to the full calendar year (i.e., the full CY 2022 readmission rate is 11.28% and the CY2022 readmission rate without January and February is 11.30%). Because it is difficult to fully establish whether CY2022 or CY2023 is an anomaly, staff believe the two-year blended base is the most fair.

The additional concern of using a static base period and then measuring improvement from that base over multiple years can be reconsidered in future years (as well as whether multiple years should be used). However, this original decision was made in consultation with hospitals to provide credit for hospitals that had large improvements early on and maintain those improvements but do not achieve the attainment target, thus receiving rewards for the same improvement for multiple years. Furthermore, the static base also means that hospitals with a decline in performance in one year are not rewarded in a subsequent year for improvements back to where they were in the base. This was particularly important early in the model since Maryland needed to improve for Medicare FFS relative to the nation. While staff are amenable to revisiting this issue, there were benefits to hospitals that improved and maintained that improvement in terms of rewards (or lower penalties) over multiple years but that benefit also comes with the risk that degradations in performance may also result in penalties for multiple years. Last, while it is

true the improvements in CY2022 may have been higher than anticipated, hospitals were rewarded for that improvement.

Comments on Out of State (OOS) Adjustment

Garrett expressed concern that despite having a very low readmission rate within Maryland, that the adjustment for out of state readmissions increases their readmission rate and believes that transfers out of state may account for the high estimate of out of state readmissions. While not mentioned in their comment letter, Medstar also discussed with staff concerns about transfers out of state that subsequently transfer back to a Maryland hospital being counted as readmissions since the case-mix dataset does not see the out of state admission and treat the entire stay with transfers as one admission.

Staff Response

The RRIP policy accounts for readmissions that occur out of state by calculating the ratio of the total readmission to the readmission rate that occurs within Maryland using the Medicare CCW dataset. This ratio is then applied to the all-payer readmission rate for assessment of attainment since otherwise border hospitals, where patients may be more likely to be readmitted outside the state, would have lower readmission rates simply due to geography. In addition, both the RRIP measure and the CCW readmission measure do not count direct transfers as readmissions but instead treat admissions with a transfer as one admission. The hospital that transferred the patient does not have that patient in their readmission denominator, but instead the hospital from which the patient is ultimately discharged is assigned the index admission. Direct transfers are defined as those with an admission date that is the same or up to one day after a previous discharged date. Thus, the high out of state ratio for Garrett and other border hospitals is from admissions that should occur out of state more than 2 days after discharge from the Maryland hospital. However, this does not address the concern raised by Medstar. Medstar maintains that there are patients that they transfer to an out of state hospital for a specific procedure and then bring them back to the local hospital within Maryland before they are discharged. These cases within the HSCRC case mix data would be flagged as a readmission. And while this should not be the case in the Medicare CCW data, there may be care patterns that are being missed by the

transfer logic that Garrett is seeing in their data. Thus, staff have begun to look at the CCW medicare claims to identify cases being flagged as readmissions out of state and will work with hospitals to validate or ensure the transfer logic is working correctly. Staff will also use the CCW medicare data to assess the impact of out of state transfers that are repatriated back to a MD hospital, and will also look into using the Medicaid and All-Payers Claims Database to assess the issue for other payers as well. Future RRIP policy will provide results of these analyses and recommendations to address any issues identified.

Comments on Reducing the Improvement Target

JHHS suggested that staff consider reducing the 5 percent improvement target to encourage and recognize improvement in readmission performance. In addition, UMMS recommends reducing the improvement target goals by one year for both RY26 (retrospectively) and RY27.

Staff Response

The approved RY 2026 policy set a 5% improvement target from CY 2022 through CY 2026. This target was determined based on Medicare and Commercial benchmarks for CY 2022 performance. The CY 2023 Medicare and Commercial benchmarks were calculated and suggest that a 5% improvement target is still reasonable. For example, for Maryland to achieve the 2023 Medicare FFS benchmarked rate for peer regions, there would need to be a 7-8 percent improvement from current readmission. Given the benchmarks, and the proposal of a blended base period with the degradation in readmission rates from CY 2022 to CY 2023, staff is continuing to recommend a 5% improvement target through end of CY2026.. This translates into an improvement goal for RY26/CY24 of 2.53 percent and RY27/CY25 of 3.78 percent.

Comments on RRIP Disparity Gap Measurement

JHHS expressed concern with only one or two hospitals receiving the disparity gap incentives and recommended that staff reconsider the methodology and scale for the disparity gap reward to ensure policy recognizes improvements.

Staff Response

Staff agrees that the disparity gap goals are ambitious, but the program was designed to be such as it is a reward only program. The purpose of this incentive is for hospitals to make continuous improvements in their disparity gap, which requires the reward threshold to be increasingly more difficult to achieve. However, as we transition to the AHEAD model, staff will work with stakeholders with aims of assessing the methodology and targets. Specifically, over the next year, staff will reassess the methodology for calculating the disparity gap to ensure improvements are recognized and provide the hospitals with modeling that more clearly shows the impact of changes in readmissions on the disparity gap. Staff will also assess the improvement targets and scaling, while maintaining the commitment of incentivizing hospitals that continuously make improvements in reducing disparities by race, payer status, and ADI.

Comments on EDAC Measurement and Use in Payment Incentive

JHHS expressed concerns with the EDAC measure and the potential unintended consequences of limiting appropriate and needed care for more severe clinical conditions due the length of the readmission being included in the EDAC measure. They also expressed that hospitals would be penalized for both EDAC and RRIP, especially when patients came to the hospital through the ED.

Staff Response

First, at this time, staff do not intend to propose the EDAC measure be implemented into a payment incentive but remain concerned about hospital revisits to ED and observation. Thus, staff has updated the recommendation to say that we should consider future inclusion of revisits in the readmission measure. This is because CMMI has expressed that they think observation stay revisits should be included into readmission evaluation as part of the ongoing assessment of Maryland readmissions. The specific concerns raised by JHHS about the EDAC measure are below.

JHHS concerns about the excess days in acute care measure include: 1) penalizing hospitals for clinical complexity as reflected in more days of post-discharge care could result in limitation of care and 2) concern that EDAC and RRIP are duplicative, particularly when patients come through the ED. First, the concern about clinical complexity is addressed by risk adjustment, which assesses the expected number of post-discharge days for patients of a specific level of clinical complexity and compares this to the actual post-discharge days. Second, though EDAC includes readmissions, the measure attempts to account for the full range of avoidable post-discharge use rather than focusing only on inpatient readmissions and to account more accurately than the readmission measure for the cost of post-discharge care by including both the length and number of readmissions. To avoid double counting, if ED visits occur on the same day as observation or inpatient stays, only the observation or inpatient stays are included in the measure numerator. Staff do think that EDACs assessment of the severity of the readmission and additional days in the hospital experienced by the patient, is important to monitor.

Recommendations

These are the final recommendation for the Maryland Rate Year (RY) 2027 Readmission Reduction Incentives Program (RRIP):

1. Maintain the all-payer, 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 with a blended base period of CY 2022 and CY 2023.
3. Retroactively apply a blended base period of CY 2022 and CY 2023 to the RY 2026 policy.
4. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
5. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.

6. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards:
 - a. beginning at 0.25 percent of IP revenue for hospitals on pace for 50 percent reduction in disparity gap measure over 8 years, and;
 - b. capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
7. Monitor emergency department and observation revisits by adjusting readmission measure and through the all-payer Excess Days in Acute Care measure. Consider future inclusion of ED and/or observation stay revisits in the RRIP measure.
8. Update the RRIP policy in future years to align with statewide AHEAD model goals for readmissions.

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.¹³ 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.¹⁴ Planned admissions are counted as eligible discharges in the denominator, because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.¹⁵
- 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.¹⁶
- 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.

¹³ Planned admissions defined under [CMS Planned Admission Logic version 4 – updated March 2018].

¹⁴ **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.

¹⁵ **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.

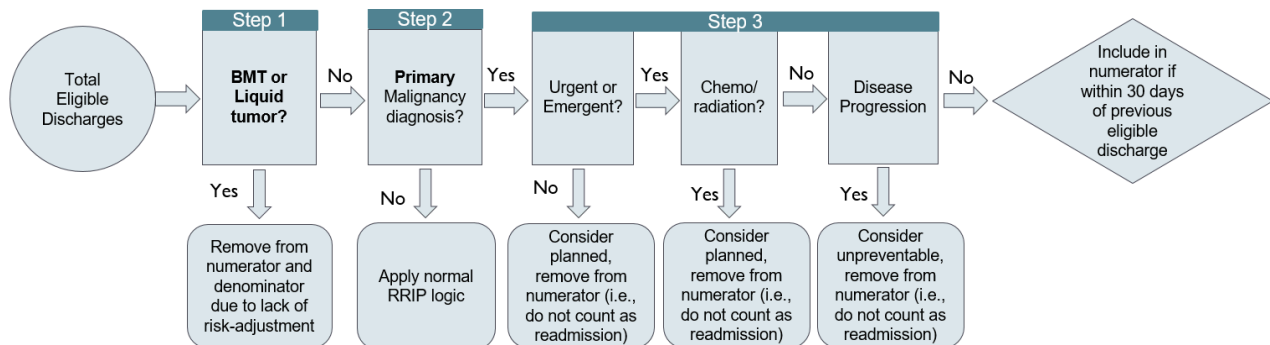
¹⁶ **Bone Marrow Transplant:** Diagnosis code Z94.81 or CCS Procedure code 64; **Liquid Tumor:** Diagnosis codes C81.00-C96.0. See section below for additional details on the oncology logic.

- 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:
 - o Cases with null or missing CRISP unique patient identifiers (EIDs) are removed.
 - o Duplicates are removed.
 - o 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 think 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 runoff. 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.

- o 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

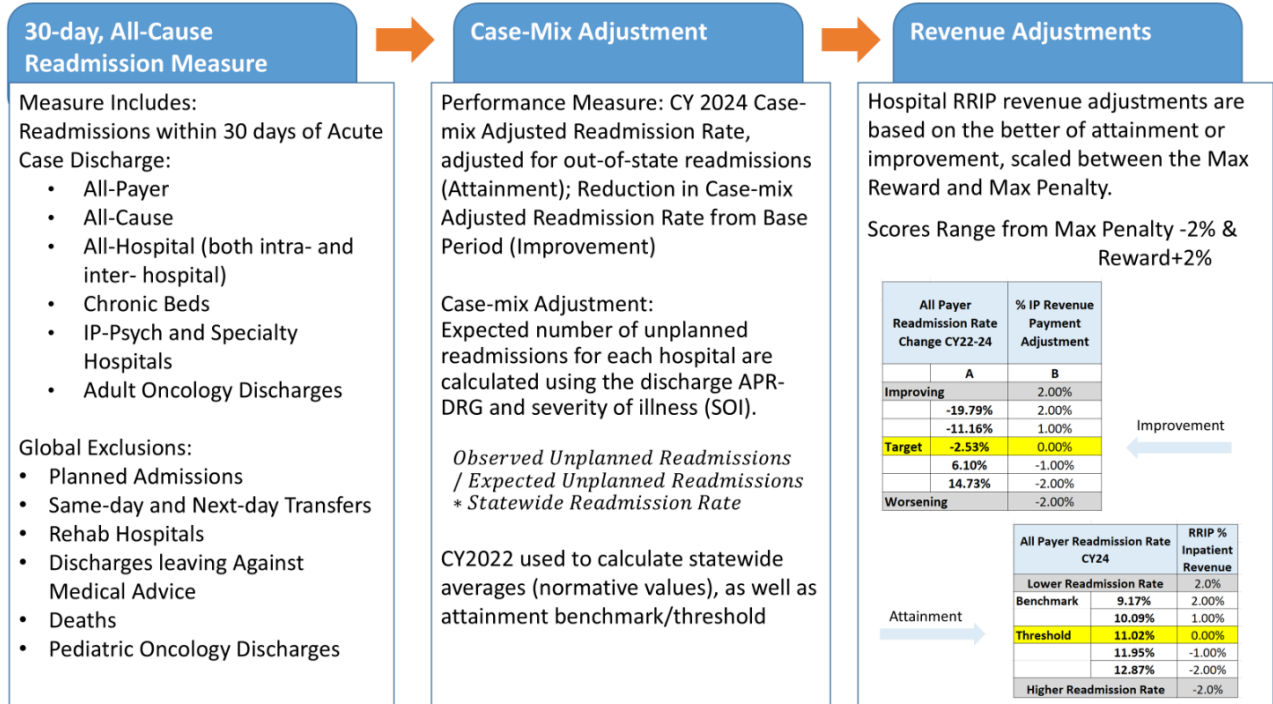
A Severity of Illness Level	B Eligible Discharges	C Discharges with Readmission	D Readmissions per Discharge (C/B)	E Normative Readmissions per Discharge	F Expected # of Readmissions (A*E)
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
Total	500	45	.09		56.5

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 2026 RRIP methodology for reference.



Appendix II. Modelled RY 2026 and RY 2027 Revenue Adjustments

RY 2026 YTD Modelled Revenue Adjustments, CY 2022 Base Period vs CY 2022 & 2023 Base Period vs CY 2023

HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue	CY 2022 Base		CY22/23 Blended Base		CY 2023 Base	
			\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment
210001	Meritus	\$251,995,786	-\$2,696,355	-1.07%	-\$2,393,960	-0.95%	\$1,215	0.00%
210002	UMMS- UMMC	\$1,473,072,120	-\$13,846,878	-0.94%	-\$5,450,367	-0.37%	-\$579,764	-2.00%
210003	UMMS- Capital Region	\$309,492,831	-\$680,884	-0.22%	\$464,239	0.15%	\$2,677,419	1.43%
210004	Trinity - Holy Cross	\$413,940,590	-\$4,346,376	-1.05%	-\$3,684,071	-0.89%	\$151,248	2.00%
210005	Frederick	\$254,562,530	-\$381,844	-0.15%	-\$1,603,744	-0.63%	\$2,472,349	2.00%
210008	Mercy	\$220,664,524	-\$3,199,636	-1.45%	-\$2,030,114	-0.92%	\$1,034,414	1.06%
210009	JHH- Johns Hopkins	\$1,818,903,395	-\$5,274,820	-0.29%	-\$3,637,807	-0.20%	\$618,986	0.20%
210011	St. Agnes	\$254,764,484	\$1,120,964	0.44%	-\$101,906	-0.04%	-\$1,008,546	-1.05%
210012	Lifebridge- Sinai	\$519,012,883	-\$4,982,524	-0.96%	-\$4,515,412	-0.87%	\$41,561	0.11%
210015	MedStar- Franklin Square	\$371,862,302	-\$6,544,777	-1.76%	-\$4,536,720	-1.22%	\$512,445	0.51%

HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue	CY 2022 Base		CY22/23 Blended Base		CY 2023 Base	
			\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment
210016	Adventist- White Oak	\$242,890,872	-\$922,985	-0.38%	-\$48,578	-0.02%	-\$145,665	-0.18%
210017	Garrett	\$28,988,189	-\$579,764	-2.00%	-\$579,764	-2.00%	\$3,016,176	1.43%
210018	MedStar- Montgomery	\$96,052,028	-\$1,258,282	-1.31%	-\$1,181,440	-1.23%	-\$3,439,923	-1.03%
210019	Tidal- Peninsula	\$350,375,491	\$4,169,468	1.19%	\$4,134,431	1.18%	\$0	0.00%
210022	JHH- Suburban	\$249,484,035	-\$99,794	-0.04%	\$948,039	0.38%	\$1,820,045	0.69%
210023	Luminis- Anne Arundel	\$367,930,454	-\$2,943,444	-0.80%	-\$3,164,202	-0.86%	\$6,061,496	1.73%
210024	MedStar- Union Mem	\$267,917,283	-\$3,188,216	-1.19%	-\$1,366,378	-0.51%	-\$170,762	-0.36%
210027	Western Maryland	\$183,379,829	-\$696,843	-0.38%	-\$825,209	-0.45%	-\$8,249,204	-0.56%
210028	MedStar- St. Mary's	\$100,479,485	\$1,969,398	1.96%	\$1,406,713	1.40%	\$1,283,659	0.70%
210029	JHH- Bayview	\$471,786,218	-\$2,736,360	-0.58%	-\$3,208,146	-0.68%	-\$712,775	-0.28%
210030	UMMS- Chestertown	\$7,562,394	\$151,248	2.00%	\$151,248	2.00%	\$1,846,182	0.74%
210032	ChristianaCare, Union	\$84,802,922	\$678,423	0.80%	\$474,896	0.56%	-\$2,605,488	-1.10%
210033	Lifebridge- Carroll	\$162,844,959	-\$602,526	-0.37%	-\$65,138	-0.04%	-\$2,574,599	-0.88%

HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue	CY 2022 Base		CY22/23 Blended Base		CY 2023 Base	
			\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment
210034	MedStar- Harbor	\$128,234,465	-\$1,782,459	-1.39%	-\$1,141,287	-0.89%	-\$1,200,428	-0.29%
210035	UMMS- Charles	\$97,586,229	\$800,207	0.82%	\$985,621	1.01%	-\$151,537	-0.16%
210037	UMMS- Easton	\$123,617,439	\$2,472,349	2.00%	\$2,027,326	1.64%	-\$101,906	-0.04%
210038	UMMS- Midtown	\$140,418,656	-\$688,051	-0.49%	\$224,670	0.16%	\$340,047	0.14%
210039	Calvert	\$80,925,064	-\$517,920	-0.64%	-\$388,440	-0.48%	-\$934,223	-0.18%
210040	Lifefridge-Northwest	\$160,861,387	-\$1,672,958	-1.04%	-\$1,045,599	-0.65%	\$244,267	0.15%
210043	UMMS- BWMC	\$325,584,009	-\$4,558,176	-1.40%	-\$3,190,723	-0.98%	-\$2,869,858	-0.78%
210044	GBMC	\$263,774,655	\$105,510	0.04%	\$184,642	0.07%	\$2,000,794	0.11%
210048	JHH- Howard County	\$220,287,562	\$704,920	0.32%	\$594,776	0.27%	-\$2,417,105	-0.65%
210049	UMMS-Upper Chesapeake	\$236,862,562	-\$3,766,115	-1.59%	-\$2,108,077	-0.89%	-\$1,990,767	-0.79%
210051	Luminis- Doctors	\$187,232,106	\$1,142,116	0.61%	\$1,479,134	0.79%	-\$1,009,310	-0.31%
210056	MedStar- Good Sam	\$186,628,391	\$1,772,970	0.95%	\$1,343,724	0.72%	\$393,172	0.28%
210057	Adventist- Shady Grove	\$333,973,100	-\$4,341,650	-1.30%	-\$2,104,031	-0.63%	-\$377,429	-0.08%
210058	UMROI	\$80,968,088	-\$59,512	-0.07%	-\$1,295,489	-1.60%	-\$1,232,420	-0.46%

HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue	CY 2022 Base		CY22/23 Blended Base		CY 2023 Base	
			\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment
210060	Adventist-Ft. Washington	\$37,782,970	-\$226,698	-0.60%	-\$298,485	-0.79%	\$1,362,957	2.00%
210061	Atlantic General	\$47,434,007	-\$588,182	-1.24%	-\$493,314	-1.04%	-\$112,603	-0.07%
210062	MedStar-Southern MD	\$210,921,411	\$1,708,463	0.81%	\$1,919,385	0.91%	\$969,265	0.44%
210063	UMMS- St. Joe	\$292,568,045	-\$672,907	-0.23%	-\$1,960,206	-0.67%	\$0	0.00%
210064	Lifebridge-Levindale	\$68,147,842	\$1,362,957	2.00%	\$1,362,957	2.00%	-\$525,761	-0.41%
210065	Trinity - Holy Cross Germantown	\$94,710,748	-\$331,488	-0.35%	-\$227,306	-0.24%	\$1,699,117	0.77%
STATEWIDE		\$11,821,284,339	-\$56,029,431		-\$34,944,112		-\$3,863,259	
Penalty			-\$74,188,424		-\$52,645,913		-\$32,410,073	
Reward			\$18,158,993		\$17,701,801		\$28,546,814	

RY 2027 Modelled Revenue Adjustments, CY 2022 Base Period vs CY 2022 & 2023 Base Period vs CY 2023 Base Period

HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue	CY 2022 Base		CY22/23 Blended Base		CY 2023 Base	
			\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment
210001	Meritus	\$251,995,786	-\$3,049,149	-1.21%	-\$2,746,754	-1.09%	-\$2,343,561	-0.93%
210002	UMMS- UMMC	\$1,473,072,120	-\$16,351,101	-1.11%	-\$7,365,361	-0.50%	-\$11,489,963	-0.78%
210003	UMMS- Capital Region	\$309,492,831	-\$1,145,123	-0.37%	\$123,797	0.04%	-\$30,949	-0.01%
210004	Trinity - Holy Cross	\$413,940,590	-\$4,925,893	-1.19%	-\$4,304,982	-1.04%	-\$1,821,339	-0.44%
210005	Frederick	\$254,562,530	-\$763,688	-0.30%	-\$1,934,675	-0.76%	-\$1,094,619	-0.43%
210008	Mercy	\$220,664,524	-\$3,530,632	-1.60%	-\$2,339,044	-1.06%	\$1,390,187	0.63%
210009	JHH- Johns Hopkins	\$1,818,903,395	-\$8,003,175	-0.44%	-\$6,184,272	-0.34%	-\$727,561	-0.04%
210011	St. Agnes	\$254,764,484	\$764,293	0.30%	-\$458,576	-0.18%	-\$458,576	-0.18%
210012	Lifebridge- Sinai	\$519,012,883	-\$5,761,043	-1.11%	-\$5,242,030	-1.01%	-\$1,660,841	-0.32%
210015	MedStar- Franklin Square	\$371,862,302	-\$7,065,384	-1.90%	-\$5,020,141	-1.35%	-\$2,974,898	-0.80%
210016	Adventist- White Oak	\$242,890,872	-\$1,287,322	-0.53%	-\$412,914	-0.17%	-\$24,289	-0.01%
210017	Garrett	\$28,988,189	-\$579,764	-2.00%	-\$579,764	-2.00%	-\$579,764	-2.00%

HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue	CY 2022 Base		CY22/23 Blended Base		CY 2023 Base	
			\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment
210018	MedStar-Montgomery	\$96,052,028	-\$1,431,175	-1.49%	-\$1,315,913	-1.37%	-\$1,219,861	-1.27%
210019	Tidal- Peninsula	\$350,375,491	\$3,678,943	1.05%	\$3,643,905	1.04%	\$5,430,820	1.55%
210022	JHH- Suburban	\$249,484,035	-\$449,071	-0.18%	\$573,813	0.23%	\$1,496,904	0.60%
210023	Luminis- Anne Arundel	\$367,930,454	-\$3,458,546	-0.94%	-\$3,679,305	-1.00%	-\$3,384,960	-0.92%
210024	MedStar- Union Mem	\$267,917,283	-\$3,590,092	-1.34%	-\$1,768,254	-0.66%	-\$1,634,295	-0.61%
210027	Western Maryland	\$183,379,829	-\$971,913	-0.53%	-\$1,081,941	-0.59%	\$1,026,927	0.56%
210028	MedStar- St. Mary's	\$100,479,485	\$1,828,727	1.82%	\$1,255,994	1.25%	\$371,774	0.37%
210029	JHH- Bayview	\$471,786,218	-\$3,396,861	-0.72%	-\$3,915,826	-0.83%	-\$1,085,108	-0.23%
210030	UMMS- Chestertown	\$7,562,394	\$151,248	2.00%	\$151,248	2.00%	\$151,248	2.00%
210032	ChristianaCare, Union	\$84,802,922	\$559,699	0.66%	\$347,692	0.41%	-\$127,204	-0.15%
210033	Lifebridge- Carroll	\$162,844,959	-\$846,794	-0.52%	-\$309,405	-0.19%	\$0	0.00%
210034	MedStar- Harbor	\$128,234,465	-\$1,961,987	-1.53%	-\$1,333,638	-1.04%	-\$718,113	-0.56%

HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue	CY 2022 Base		CY22/23 Blended Base		CY 2023 Base	
			\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment
210035	UMMS- Charles	\$97,586,229	\$663,586	0.68%	\$849,000	0.87%	\$849,000	0.87%
210037	UMMS- Easton	\$123,617,439	\$2,336,370	1.89%	\$1,903,709	1.54%	\$2,472,349	2.00%
210038	UMMS- Midtown	\$140,418,656	-\$884,638	-0.63%	\$14,042	0.01%	\$196,586	0.14%
210039	Calvert	\$80,925,064	-\$647,401	-0.80%	-\$485,550	-0.60%	-\$315,608	-0.39%
210040	Lifebridge-Northwest	\$160,861,387	-\$1,898,164	-1.18%	-\$1,270,805	-0.79%	-\$353,895	-0.22%
210043	UMMS- BWMC	\$325,584,009	-\$5,013,994	-1.54%	-\$3,679,099	-1.13%	-\$1,497,686	-0.46%
210044	GBMC	\$263,774,655	-\$316,530	-0.12%	-\$131,887	-0.05%	\$1,292,496	0.49%
210048	JHH- Howard County	\$220,287,562	\$374,489	0.17%	\$286,374	0.13%	\$660,863	0.30%
210049	UMMS-Upper Chesapeake	\$236,862,562	-\$4,121,409	-1.74%	-\$2,415,998	-1.02%	-\$2,937,096	-1.24%
210051	Luminis- Doctors	\$187,232,106	\$879,991	0.47%	\$1,273,178	0.68%	\$2,302,955	1.23%
210056	MedStar- Good Sam	\$186,628,391	\$1,493,027	0.80%	\$1,063,782	0.57%	-\$279,943	-0.15%
210057	Adventist-Shady Grove	\$333,973,100	-\$4,909,405	-1.47%	-\$2,504,798	-0.75%	-\$4,208,061	-1.26%
210058	UMROI	\$80,968,088	-\$78,944	-0.10%	-\$1,400,748	-1.73%	-\$24,290	-0.03%

HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue	CY 2022 Base		CY22/23 Blended Base		CY 2023 Base	
			\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment
210060	Adventist-Ft. Washington	\$37,782,970	-\$279,594	-0.74%	-\$355,160	-0.94%	-\$11,335	-0.03%
210061	Atlantic General	\$47,434,007	-\$673,563	-1.42%	-\$554,978	-1.17%	-\$237,170	-0.50%
210062	MedStar-Southern MD	\$210,921,411	\$1,392,081	0.66%	\$1,624,095	0.77%	\$2,699,794	1.28%
210063	UMMS- St. Joe	\$292,568,045	-\$1,082,502	-0.37%	-\$2,369,801	-0.81%	-\$2,984,194	-1.02%
210064	Lifebridge-Levindale	\$68,147,842	\$1,362,957	2.00%	\$1,362,957	2.00%	\$1,362,957	2.00%
210065	Trinity - Holy Cross Germantown	\$94,710,748	-\$473,554	-0.50%	-\$369,372	-0.39%	-\$293,603	-0.31%
STATEWIDE		\$11,821,284,339	-\$73,463,000		-\$51,057,405		-\$22,813,922	
Penalty			-\$88,948,411		-\$65,530,991		-\$44,518,782	
Reward			\$15,485,411		\$14,473,586		\$21,704,860	