Joshua Sharfstein, MD
Chairman

James N. Elliott, MD
Vice-Chairman

Jonathan Blum, MPP

Ricardo R. Johnson

David N. Maine, MD

Nicki McCann, JD

Farzaneh Sabi, MD

Jonathan Kromm, PhD
Executive Director

William Henderson
Director
Medical Economics & Data Analytics

Gerard J. Schmith
Director
Revenue & Regulation Compliance

Claudine Williams
Director
Healthcare Data Management & Integrity

MINUTES OF THE 640th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION MARCH 11, 2026

Chairman Joshua Sharfstein, M.D. called the public meeting to order at 12:00 p.m. In addition to Chairman Sharfstein, also in attendance were Vice Chairman James Elliott, M.D., Jon Blum, M.P.P., David Maine, M.D., Nicki McCann, J.D., Ricardo Johnson, J.D., and Farzaneh Sabi, M.D. Upon motion made by Commissioner Sabi and seconded by Commissioner McCann, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 1:20 p.m.

REPORT OF MARCH 11, 2026, CLOSED SESSION

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed during the March 11, 2026, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM FEBRUARY 11, 2026, PUBLIC MEETING AND CLOSED SESSION

Upon motion made by Commissioner Blum and seconded by Commissioner McCann, the Commission voted unanimously to approve the minutes of the February 11, 2026, Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
CLOSED CASES

2687A Johns Hopkins Health System
2688A Johns Hopkins Health System

ITEM III
OPEN CASE

2689N Luminis Health Doctors Community Medical Center
2690A Johns Hopkins Health System
2691A Johns Hopkins Health System
2692A Johns Hopkins Health System
2693A Johns Hopkins Health System
2694A Johns Hopkins Health System
2666A University of Maryland Medical Center- Second Extension Request
2667A University of Maryland Medical Center- Second Extension Request

STATEMENT OF COUNSEL

Mr. Stan Lustman, Assistant Attorney General, centered his remarks on the legal distinction between matters of general applicability and specific matters. He noted system-wide policies like hospital update factors apply to everyone. The Commission Legal Counsel determined that the January vote on Medicare Advantage (MA) discounts was a specific matter. This is because the HSCRC does not regulate MA plans, and the proposed policy would provide a financial advantage to only a subset of payers and plans, i.e., Medicare Advantage, rather than to the entire payer industry. In addition, the application of the proposed policy would also be restricted in applying to only a subset of Medicare Advantage plans.

Counsel views recusal as a structural safeguard to ensure the Commission's decisions are perceived as independent and in the public interest, rather than a judgment on an individual Commissioner's integrity. Because five commissioners had professional ties to MA plans, a potential appearance of impropriety was identified. To prevent a total stalemate, since four affirmative votes are required for action, Maryland law allows the least conflicted commissioners to participate for quorum purposes, which in this case included Chairman Sharfstein and Commissioner Sabi.

A conflict arose when Commissioner Johnson declined to follow the advice to recuse, prompting Chairman Sharfstein to make a formal public disclosure of the disagreement. Mr. Lustman noted that while Commissioner Johnson intends to challenge the specific matter designation with the Ethics Commission, the Ethics Commission's leadership has so far supported the advice from the Office of the Attorney General's. This process of Commissioner recusals based on the advice of legal counsel has been a standard HSCRC practice for over 50 years. In this case, Commission leadership and two Commissioners (Commissioners McCann and Maine), who were advised to recuse themselves, adhered to the advice of legal counsel.

Mr. Lustman noted that the Commission's legitimacy depends on a process that prioritizes the public interest above all else. He asserted that until the Ethics Commission provides clear guidance to the contrary, Commissioners should continue to follow the Attorney General's advice on recusals. This ensures that further votes necessary to implement Medicare Advantage policies remain legally sound and ethically transparent.

Commissioner Johnson expressed his appreciation for the work of Commission Counsel, emphasizing a shared commitment to a process defined by high integrity, equity, and the inclusion of all appropriate voices. He framed his position not as a personal conflict, but as a professional necessity to ensure the Commission operates under a transparent and fair framework that serves the best interests of Maryland residents.

Commissioner Johnson maintained his disagreement with Counsel's legal interpretation of the recusal rules and specific matter designation. He confirmed his intent to resolve the dispute through further discussions with the Ethics Commission. He noted that while they may disagree on the technicalities of the law, both parties remain united in their ultimate goal of protecting the public interest.

Commissioner McCann stated there was procedural confusion that arose during the January meeting, specifically regarding the scope of Commissioner recusals. She noted that while she and Commissioner Maine accepted their recusal from the Medicare Advantage vote, they were also excluded from the room during the vote on the Cost Shift policy. Commissioner McCann characterized this broader exclusion as a process issue rather than a strictly ethical one, suggesting that the boundaries of the recusal may have been applied too broadly or unclearly in that moment.

She noted that this lack of clarity contributed to significant confusion for the public and stakeholders following the meeting. For those not privy to the private legal discussions, it was unclear why Commissioners were barred from participating in the Cost Shift policy vote alongside the Medicare Advantage matter. She urged the Commission to be more thoughtful and precise in its future processes to ensure that recusals are handled transparently and limited to the specific matters intended.

Chairman Sharfstein responded by acknowledging Commissioner McCann's point regarding the procedural confusion. He clarified that the issue arose because there was only one unified vote during the meeting, rather than separate votes for the Medicare Advantage and Cost Shift policies. This structural choice explains why recused Commissioners were excluded from the entire proceeding. He also suggested that once the legal and ethical questions are settled, the Commission could revisit the matter. He proposed the possibility of splitting the motion into two separate pieces for a new vote. This approach would allow for greater clarity and ensure that commissioners are only recused from the specific portions of the policy where a conflict actually exists.

Chairman Sharfstein concluded by thanking the legal team for their clear guidance, while acknowledging the high level of intensity surrounding the recusal debate. He stated his commitment to follow the formal advice provided by the Office of the Attorney General to maintain the Commission's integrity and recommended that all Commissioners adhere to this advice from legal counsel, even as the specific disputes are being resolved through the Ethics Commission.

No action was taken on these agenda items.

ITEM IV
TOOLS FOR IDENTIFYING AND ADDRESSING PREVENTABLE ILLNESS AND UTILIZATION IN MARYLAND

Ms. Megan Priolo, DrPH, MHS, Executive Director of Chesapeake Regional Information System for our Patients (CRISP), Ms. Kate Talbert, CRISP Director of Reporting Analytics presented on *CRISP Tools to Support the Identification and Reduction of Potentially Avoidable Utilization* and Dr. Morgan Henderson, PhD, Director, Analytics & Research from the Hilltop Institute presented on the *Hilltop's Prediction Tools* (see "*CRISP Tools to Support the Identification and Reduction of Potentially Avoidable Utilization" and "Hilltop's Prediction Tools*" available on the HSCRC website).

Ms. Talbert presented an overview of the Health Information Exchange's (HIE) current and future tools designed to manage avoidable hospital utilization. As Maryland's state designated HIE, CRISP provides a suite of reporting services that allow hospitals and primary care providers to stratify populations by demographics, chronic conditions, and location. These tools, such as the Potentially Avoidable Utilization (PAU) Reports and the Value-Based Care Insights (VBCI) tool, help providers benchmark performance against national standards.

She highlighted point-of-care tools that provide real-time data to clinicians. The Event Notification Delivery (SEND) system and Population Explorer leverage CRISP's data lake to deliver customizable alerts regarding hospital admissions, discharges, and risk indicators like social needs. CRISP is currently expanding its analytical capabilities by integrating more clinical data, such as non-controlled dispensed medications and Social Determinants of Health (SDOH) screenings.

She also focused on predictive analytics, specifically the Hilltop Pre-Avoidable Hospitalization (Pre-H) risk scores. These scores estimate the probability of a beneficiary experiencing an avoidable medical event within the next 30 days.

Dr. Morgan Henderson presented on the state's predictive modeling infrastructure, which has been operational since 2019. This system generates monthly risk scores for approximately 2 million Marylanders, specifically targeting those enrolled in Medicaid and Medicare Fee-for-Service. Hilltop currently maintains three core predictive models: the "Pre" model (avoidable hospital events), the "Pre-DC" model (severe diabetes complications), and a "Pre-Hospice Eligibility" model.

No action was taken on these agenda items.

ITEM V
2666A UNIVERSITY OF MARYLAND MEDICAL CENTER-SECOND EXTENSION REQUEST

Mr. Chris Konsowski, Chief, Hospital Rate Regulation, presented 2666A University of Maryland Medical Center second extension request (see "*2666A University of Maryland Medical Center-Second Extension Request"* available on the HSCRC website).

Mr. Konsowski reported that while staff previously granted a three-month extension for the alternative rate arrangement between UMMC and Aetna regarding transplant services, the two parties have yet to finalize their negotiations. Consequently, UMMC is requesting an additional extension to June 30, 2026, to provide time to reach an agreement. However, staff noted that performance under the existing arrangement has been unfavorable, adding a layer of scrutiny to the ongoing request.

Mr. Konsowski presented the staff's recommendation for UMMC's second extension request.

- Approve UMMC's request for an additional three-month extension for the alternative rate arrangement between UMMC and Aetna, provided that if the negotiations are not completed before the expiration of this extension, the arrangement will end and no

further services may be provided under the arrangement until a new application is approved.

Chairman Sharfstein requested a motion to adopt the staff's Recommendation for the three months extension of the alternative rate arrangement between UMMC and Aetna. Commissioner McCann moved to approve the staff's Recommendation, seconded by Vice Chairman Elliott. **The motion passed unanimously in favor of the staff's Recommendation.**

ITEM VI
2667A UNIVERSITY OF MARYLAND MEDICAL CENTER-SECOND EXTENSION REQUEST

Mr. Chris Konsowski, Chief, Hospital Rate Regulation, presented 2667A University of Maryland Medical Center Second Extension Request (see "*2667A University of Maryland Medical Center Second Extension Request"* available on the HSCRC website).

Mr. Konsowski reported that although a previous extension was granted for the alternative rate arrangement between the University of Maryland Medical Center (UMMC) and Optum regarding transplant services, the parties have failed to finalize their negotiations before the March 31, 2026, deadline. In response, UMMC is requesting an additional three-month extension to June 30, 2026, to allow more time for these discussions. Notably, staff findings indicate that the experience under the current arrangement has been unfavorable, suggesting that the request for more time comes amidst concerns regarding the agreement's ongoing performance.

Mr. Konsowski presented the staff's Recommendation for UMMC's second extension request.

- Approve UMMC's request for a three-month extension for the alternative rate arrangement between UMMC and Optum, provided that if the negotiations are not completed before the expiration of this extension, the arrangement will end and no further services may be provided under the arrangement until a new application is approved.

Chairman Sharfstein requested a motion to adopt the staff's Recommendation for UMMC three months extension of the alternative rate arrangement between UMMC and Optum. Commissioner Sabi moved to approve the staff's Recommendation, seconded by Commissioner Blum. **The motion passed unanimously in favor of the staff's Recommendation.**

ITEM VII
ADVENTIST HEALTHCARE GERMANTOWN EMERGENCY CENTER ACTION

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics presented Adventist Healthcare Germantown Emergency Center Action (see "*Adventist Healthcare Germantown Emergency Center Action*" available on the HSCRC website).

Dr. Jon Kromm, Executive Director, opening remarks provided essential context for the Commission's review of the facility closure proposed by Adventist. He clarified that the Commission's role is not to vote on the closure itself, but rather to address the financial

implications and the impact the closure would have on other hospitals in the system. The proposed process follows a specific sequence designed for stakeholder transparency:

- **Preliminary Approval:** The Commission is asked to give preliminary approval of the Staff's draft recommendations regarding the financial terms.
- **Stakeholder Engagement:** This approval allows the Adventist team to engage with impacted stakeholders to expose and manage specific concerns.
- **Reporting and Reaffirmation:** Adventist will then return to the Commission with a report on those concerns and their mitigation strategies, at which point the Commission can take a final vote to reaffirm the plan.

Dr. Kromm noted by focusing on the financial aspects and the structured feedback loop, the Commission maintains its oversight of the state's hospital rate-setting stability while allowing the operational transition to proceed through proper channels.

Mr. Henderson presented the financial proposal following Adventist Healthcare's request to transition revenue from the freestanding medical facility, Shady Grove Germantown Emergency Center (GEC), to Shady Grove Medical Center, ahead of the GEC's planned closure on June 30, 2026. Because the Maryland Health Care Commission (MHCC) determined that no Certificate of Need is required for the closure, the HSCRC's role is focused on the financial approach to transferring Global Budget Revenue (GBR). The plan assumes that emergency services will shift primarily to Shady Grove Medical Center (85 percent) and Holy Cross Germantown (15 percent), with a small number of low-acuity visits dissipating to non-hospital sites.

The financial restructuring transfers only the variable costs of care to the adopting facilities, rather than the fixed costs. By eliminating the fixed costs of the GEC and moving services to facilities with lower variable costs, the transition generates an estimated $9.5 million in total savings. Mr. Henderson noted that while the initial funding is prospective, the final allocations will be settled through the market shift process, ensuring that if patient volumes differ from the 85/15 estimate, the hospitals that actually provide the care will receive the appropriate funding.

Staff recommended a 50/50 split of these savings between Adventist and the public interest, a principle consistent with past Commission actions. Under this arrangement, $4.75 million would be retained by Shady Grove for community-focused investments, subject to specific reporting requirements. On the public side, $2 million is designated for Montgomery County for a 10-year period to support local healthcare services relevant to the Germantown population. The remaining $2.75 million in savings will accrue directly to payers, representing a 14 percent reduction in costs for these specific services.

Mr. Henderson presented the staff's draft recommendation:

- Eliminating the GEC's global budget and transferring $15.25 million in permanent revenue to other institutions.

- $2 million annual payment to Montgomery County for 10 years for investment in the health needs of the community under terms agreeable to all parties.
- $4.75 million retained by Shady Grove for discretionary community investment.

Mr. Henderson noted that the terms with the County are still being negotiated; if a mutual agreement cannot be reached regarding the oversight and use of those funds, the matter will be brought back before the Commission for further deliberation.

Commissioner Blum questioned the specific methodology used to model where patients will go once the Germantown Emergency Center closes. He asked for clarification on how the staff calculated the projected shift of those patients to other hospitals versus alternative community-based healthcare settings. Mr. Henderson explained that the methodology began with Adventist analyzing the residency of every GEC patient to forecast their likely future points of care, a process now being reviewed and validated by the HSCRC and Holy Cross. He noted that while they aim for approximate accuracy in this initial agreement, the funding is ultimately trued up retrospectively based on actual patient volume, making the initial projection less critical than the final data.

Testimonies:

Ms. Katie Eckert, SVP, Strategic Operations, stated Adventist Healthcare's full support of the staff's financial recommendations regarding the facility transition. She expressed appreciation for the collaborative efforts of staff, and the rest of the team, in developing the proposal.

Commissioner Maine raised concerns regarding the potential downstream effects if the actual number of patients transitioning to other sites is higher than the assumed 15 percent dissipation rate. He questioned how Adventist is preparing to mitigate the impact on Shady Grove Medical Center's emergency department wait times, throughput, and potential diversion. He asked for the team's perspective on their capacity to handle an unexpected influx of patients should alternative community access points prove insufficient.

Mr. Daniel Cochran, President, Shady Grove Medical Center, explained that the closure of the GEC coincides with the opening of a new patient tower at Shady Grove, which features an expanded emergency department and the ability to repurpose existing ED space for extra capacity if patient volumes exceed projections. To further improve throughput, the hospital is expanding its clinical decision unit to move patients out of ED bays more quickly while medical determinations are being made. He expressed confidence that these operational and structural enhancements will improve patient flow and allow the facility to handle a higher volume of patients more efficiently than it does today.

Dr. Neil Roy, Emergency Room Physician, added that all clinical team members from the GEC have been offered positions within Shady Grove Medical Center or the broader Adventist Healthcare system. Speaking as a clinician who works at both campuses, he noted that there is more than enough existing staff and physician bandwidth to expand services at Shady Grove should patient volumes exceed expectations.

Ms. Eckert clarified that the upcoming opening of a new patient tower in July provides Adventist with a unique safety net, as they will temporarily possess both new and existing emergency room infrastructure. She noted that this dual capacity ensures the hospital can handle any unexpected patient surges that might occur following the GEC closure. She expressed confidence in their extensive modeling, which suggests they can successfully absorb the patient volume while maintaining or even improving current throughput.

Chairman Sharfstein asked the Adventist team to explain the underlying reasoning for the planned closure of the GEC.

Ms. Eckert explained that the decision to close the GEC resulted from a strategic review of community needs and shifting market dynamics. Since the facility opened 20 years ago, the healthcare landscape has changed significantly, most notably with the opening of Holy Cross Germantown Hospital only 2.5 miles away, which reduced emergency visits at the GEC by approximately one-third and lowered the overall acuity of patients. Additionally, the proliferation of urgent care centers and Adventist's own robust investment in primary care, specialists, and imaging in the immediate area have provided residents with alternative access points for non-emergent care.

The timing of the closure is specifically driven by the upcoming expiration of the GEC's facility lease and the necessity of committing to a new ten-year term. Faced with a long-term lease renewal, Adventist evaluated the clinical necessity of the site alongside the impending opening of their new patient tower at Shady Grove Medical Center. The team determined that the current market saturation and their expanded capacity elsewhere made it the right strategic moment to reallocate resources while maintaining their medical office building and ambulatory services in the Germantown community.

Commissioner Sabi acknowledged the complexity of the decision and questioned the projected 85/15 revenue split between Shady Grove and Holy Cross Germantown. Given the GEC's close proximity to Holy Cross, she suggested that EMS drop-offs might shift to that facility more frequently than the current model anticipates. While noting that the figures will eventually be trued up, she expressed concern that the volume currently being estimated for Holy Cross Germantown may be undervalued.

Ms. Eckert explained that Adventist used a data-driven approach by analyzing patient zip codes, which revealed that the majority of visits originate from areas south of the GEC. Because this patient concentration is located between the freestanding medical facility and the Shady Grove campus, the team anticipates that the existing road infrastructure and major arteries will naturally decant more traffic back to Shady Grove Medical Center. While current models rely on standard zip code data, she expressed a desire to collaborate with EMS on more granular location data to further refine the volume analysis.

Dr. Nina Ashford, Mongomery County Chief of Public Health, detailed the county's extensive safety net infrastructure and how the proposed $2 million annual investment from the HSCRC would bridge critical gaps in care. Drawing on her background at CMS and in population health, she highlighted the Montgomery Cares and Care for Kids programs, which

currently serve 37 percent of the county's uninsured population through a $28 million combined investment. This network of 12 safety net clinics and three Federally Qualified Health Centers (FQHCs) provides primary care, behavioral health, and dental services, with a significant presence of eight sites located specifically in the Germantown and Gaithersburg areas.

However, there is a major systemic gap: these services are not insurance, meaning patients have no coverage for urgent care or emergency room visits when clinics are closed. Dr. Ashford noted that many low-acuity visits at the GEC likely involve safety net clients who perceive their needs as urgent but lack alternative after-hours options. Currently, these patients are forced into high-cost emergency settings for issues that could be managed in a primary or urgent care environment if access were more flexible.

The proposed $2 million investment would be used to "tighten the primary care connection" by supporting clinics in offering same-day, next-day, and weekend appointments. She envisions using these funds to establish telehealth and urgent care light options specifically for Tier 1 visits, as well as enhanced care navigation to guide uninsured patients to the right setting. The goal is to fundamentally reduce the community's dependence on emergency departments for non-emergent needs by providing reliable, low-cost alternatives.

While expressing strong support for the partnership and a commitment to being held accountable to the HSCRC and Adventist, Dr. Ashford urged the Commission to consider making the funding permanent rather than limiting it to a 10-year term. She argued that a true investment in community health requires long-term stability, warning that if the funding expires in a decade, the County will eventually face the same gaps in access and spikes in avoidable emergency utilization.

Commissioner Maine commended the presentation and acknowledged the validity of Dr. Ashford's request for long-term support; he cautioned that it is difficult for the Commission to make binding financial decisions for a period of ten years into the future given the unpredictability of the healthcare landscape. He welcomed the idea of receiving progress reports at 12 or 24-month intervals to monitor how this investment directly benefits the residents of Montgomery County.

Commissioner McCann expressed confidence in the diligence of both Adventist and the Montgomery County Health Department, but she emphasized the need for strict accountability and transparency as these facility closures set a significant precedent. She cautioned against using the rate-setting system to merely replace existing government funding with hospital dollars, stressing that the $2 million must represent a net increase in community investment rather than a substitution for the county's current budget. Highlighting that these funds are ultimately derived from higher hospital rates paid by the public, she called for ongoing reporting to ensure that both the county's allocation and Adventist's retained savings are being used to launch new, impactful health initiatives.

Dr. Ashford expressed full support for a high level of accountability, stating that she has no issue working with both Adventist and the Commission to define clear metrics for success. She addressed the concern regarding fund substitution by clarifying that these specific programs are

designed to save hospitals money by shifting care upstream, creating a functional partnership rather than a simple budgetary swap. To ensure transparency, she welcomed a formal earmark to guarantee the $2 million is used exclusively to enhance the safety net and committed to reporting back as often as necessary to demonstrate the fund's impact on reducing emergency department reliance.

Ms. Eckert emphasized that Adventist Healthcare will take a strictly data-driven approach to accountability, focusing on tracking specific interventions that successfully divert low-acuity patients from emergency departments. She clarified that hospital rates at Shady Grove will not increase as a result of this transition; instead, the funding will be used to expand access in a cost-neutral manner. Ms. Eckert pointed out that the HSCRC already has robust oversight mechanisms in place, including monthly volume reports, six-month market shift analyses, and annual profit margin reviews which will make it immediately transparent if the resources are not being used to increase community access. She reaffirmed that as a faith-based organization, Adventist is committed to transparency and views this restructuring as a direct extension of its mission to meet evolving community health needs.

Mr. Schmith clarified that the proposed financial structure is consistent with the Commission's historical approach of balancing hospital reinvestment with public savings. He detailed the allocation of the estimated $9.5 million in savings, noting that Adventist will retain $4.75 million to reinvest in the community through expanded services, such as operating room capacity. The remaining half of the savings is dedicated to the public interest, with $2 million specifically directed to the Montgomery County Health Department for safety net services and the balance resulting in direct savings for payers. While he noted that the Commission does not always split savings this way, he noted that this particular arrangement effectively supports both institutional growth and community health needs.

Vice Chairman Elliott addressed the long-term sustainability of the proposed funding, suggesting that the Commission should reconsider the strict 10-year cap on the $2 million investment for the county. He noted that an upcoming policy might provide a framework for incorporating this type of funding more permanently into the system. Rather than simply letting the arrangement expire, he recommended that the Commission plan to reevaluate the funding at the 10-year mark to ensure continued support for community health needs if the program proves successful.

Chairman Sharfstein expressed his support for reevaluating the $2 million funding at the 10-year mark rather than implementing an automatic cutoff, noting that a firm decision to terminate the investment now would be premature. He noted that shifting to a reevaluation model would serve as an appropriate component of the broader accountability and reporting structure the Commission intends to develop.

Chairman Sharfstein called for an amendment to the financial proposal regarding the $2 million annual allocation to Montgomery County. Rather than the original plan to automatically terminate the funding after a decade, he proposed that the Commission implement an annual reporting requirement followed by a formal reevaluation at the 10-year mark to determine if the funding should continue. This shift from a hard cutoff to a performance-based review is intended

to provide long-term stability for the County's safety net while maintaining an ongoing accountability structure.

Vice Chairman Elliott moved to approve the amended recommendation, seconded by Commissioner Sabi. **The motion passed unanimously in favor of the amended staff Recommendation.**

The Commission discussed the appropriate use of the $4.75 million in fixed-cost savings resulting from the closure. Commissioner Maine argued strongly for allowing Adventist to keep these funds to support building blocks of transformation, such as surgical and medical oncology services that require time and capital to develop. He contended that because these are regulated services, existing HSCRC mechanisms would naturally provide a level of oversight and true-up that distinguishes this case from previous unregulated service proposals. Commissioner Johnson expressed skepticism, questioning whether the funds would truly be used for the transition or if they should instead be returned to the public in the form of lower rates, arguing that the primary value of such shifts should always prioritize the patients and consumers.

The discussion also touched on the significant precedent this case sets for future facility closures as the healthcare landscape shifts toward outpatient and minimally invasive care. Commissioner Sabi noted that while the current dollar amount is relatively small, the underlying policy question whether savings from hospital closures should remain in the system or be extracted to lower premiums is a critical long-term concern.

Chairman Sharfstein bridged the divide by suggesting the Commission defer the vote on this specific $4.75 million allocation. He requested that Adventist return the following month with a concrete plan for how the funds will be used and a reasonable accountability structure to demonstrate the value of the investment to the community.

Ms. Eckert emphasized that Adventist Healthcare already has a concrete plan to reinvest the retained savings into the community, specifically by providing hospital access to 24 local providers who have requested it. She clarified that this expansion would be a dollar-for-dollar investment in care that avoids any increase in the current price structure. However, she expressed concern regarding the proposed delay, explaining that establishing financial viability immediately is a critical prerequisite for providing official notice to MHCC and initiating the formal closure process.

Chairman Sharfstein asked for a motion to grant preliminary approval of the financial framework on an amended basis. This amendment specifically incorporates the transition from a fixed 10-year term to a reevaluation model for the $2 million county investment, alongside a requirement for Adventist to return the following month with a detailed plan and accountability structure for the $4.75 million in retained savings. By structuring the vote this way, the Chairman ensured that the Hospital could meet its urgent regulatory timing needs with the MHCC while preserving the Commission’s ability to finalize the specific terms of community reinvestment and long-term oversight.

Commissioner Blum moved to approve the amended preliminary approval, seconded by Commissioner Sabi. **The motion passed unanimously in favor of the amended preliminary approval.**

ITEM VIII
REPORT FROM THE EXECUTIVE DIRECTOR

Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee-for-Service (FFS) data through November 2025 (for claims paid through January 2026). The data showed that Maryland's Medicare hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce stated that Medicare non-hospital spending per capita and Total Cost of Care (TCOC) spending per capita were also favorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail is .80 percent above the nation through November 2025, and that Maryland Medicare hospital and non-hospital growth through October resulted in savings of $93.3 million.

Policy Calendar Update

Dr. Jon Kromm, Executive Director, provided an update on the HSCRC policy calendar, focusing on the shifting timeline for the Healthcare Outcome Payment Effort (HOPE) program. He noted that while the final vote was originally scheduled for April, it has been moved to May 2026. This extension is intended to provide more time for public comment and to incorporate a wide range of perspectives on the program.

Beyond the HOPE program, Dr. Kromm signaled that the entire policy agenda is being recast to align with the mandatory structural changes required for the AHEAD Model transition. He briefly touched on the fact that additional updates for related HSCRC policies would follow as the staff continues to manage these multi-year transitions.

Health System Transformation Update

Dr. Jon Kromm provided an update on the Health System Transformation initiative, noting that the call for public comment yielded a wide range of nuanced perspectives from stakeholders. He granted several extensions to allow for more detailed feedback, which staff is currently aggregating to present at the next meeting. This data will help the Commission determine the next steps for policy development, particularly regarding how Maryland's rules will interact with upcoming CMMI service line adjustments. He highlighted the multi-agency priorities, specifically focusing on the All-payer Total Cost of Care Targets. He also noted that the MHCC has accelerated its work on post-acute care, with further progress reports expected in the coming months.

Legislative Report

Ms. Janice Lepore, Chief, Policy and Government Affairs, provided a legislative update as the General Assembly approaches its critical crossover date, with approximately 35 days remaining

in the Session. She highlighted that several key bills have already successfully passed their chamber of origin and are moving toward Senate hearings, including HB 494, which focuses on primary care investment targets, and HB 599, regarding hospital ownership licensing requirements. Additionally, emergency pregnancy-related medical condition bills (HB 372 and SB 169) have shown significant progress, having passed through both the House and Senate following earlier hearings.

Ms. Lepore noted the Staff is closely monitoring the Budget Reconciliation and Financing Act and the high-profile HB 1563, a bill sponsored by the Speaker of the House concerning emergency room services and post-acute care. The Staff has already provided written testimony for this emergency services bill. While some governance-related legislation, such as the Commission's term of office bill (SB 246), has not progressed since January, the Staff continues to track all relevant jurisdiction and rate-setting updates as the Session enters its final, high-velocity weeks.

Commissioner McCann asked whether the Budget Reconciliation and Financing Act (BRFA) includes provisions to transfer any of the HSCRC's specialized accounts such as those dedicated to maternal and child health or population health into the State's General Fund.

Dr. Kromm responded that the Commission is currently monitoring two specific provisions in the Senate's version of the BRFA that could impact dedicated funding. He identified a potential $6.7 million sweep from maternal and child health and $10 million from the Nurse Support Program, noting that the latter was mislabeled in the initial legislative draft. While clarifying that the HSCRC does not directly administer these specific programs, Dr. Kromm stated that staff is coordinating with the relevant program managers to fully understand the operational implications of these permissive fund transfers.

Commissioner McCann expressed concern over the legislative sweeping of dedicated funds, emphasizing that these are not free government dollars but are instead derived from hospital rates paid directly by patients. She noted that while the Commission has no control over the State's decision to move these assets into the General Fund during a budget crisis, the practice risks undermining the specific, dedicated purposes for which the funds were originally established. Moving forward, she urged the Staff to be more strategic and cautious when creating such accounts, ensuring that the funds are truly ready for immediate expenditure, so they do not remain as sitting targets for future budgetary reallocations.

No action was taken on these agenda items.

ITEM IX
PRESENTATION: FY 2025 CLINICIAN COST SCHEDULE RESULTS

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics and Bob Heacox, I3 Contractor, presented the FY 2025 Clinician Cost Schedule Results (see “FY 2025 Clinician Cost Schedule Results” available on the HSCRC website).

Mr. Henderson presented the first official cycle of clinician cost reporting, noting that the project is currently in version 1.5. He defined the four primary objectives: updating the Commission on

data collection progress, identifying challenges in standardizing information, providing high-level summaries, and demonstrating drill-down capabilities. He defined clinicians broadly to include any provider able to bill separately (physicians) and categorized costs into gross (total salary and support) versus net (costs remaining after subtracting professional fee revenue not governed by the HSCRC).

Mr. Henderson described the inherent difficulty of standardizing data across Maryland's diverse hospital landscape. He identified three dimensions of complexity: the wide variety of financial arrangements (from direct employment to complex third-party contracts), differing service portfolios (surgical vs. primary care focus), and vastly different corporate structures (standalone hospitals vs. multi-state systems). These factors lead hospitals to report clinician costs in inconsistent ways, making apple-to-apples comparisons a persistent challenge for staff.

To illustrate these challenges, Mr. Henderson highlighted data variability and the presence of anomalies. He distinguished between two types of outliers: true reporting errors where hospitals might misinterpret instructions or lack the system capability to provide specific granular data and real anomalies that reflect meaningful operational differences. The preliminary data showed a wide range of clinician costs as a percentage of GBR. While most hospitals clustered in the 5 percent to 15 percent range for net costs, one significant outlier showed a gross clinician cost exceeding 30 percent of their GBR. Mr. Henderson concluded that while the data is maturing, it requires further work to resolve inconsistencies. He stressed that understanding whether these spikes are reporting errors or reflections of unique hospital experiences is essential before the Commission can use this data to inform future policy or rate-setting decisions.

Mr. Henderson shared high-level spending figures gathered from 34 Maryland hospitals, excluding Johns Hopkins and certain calendar-year facilities. He reported that total gross clinician costs comprising both regulated and unregulated expenses amounted to approximately $2.3 billion. After accounting for $838 million in offsetting professional fee revenue (Part B billing collected by hospitals), the net clinician cost for these facilities stood at $1.475 billion, representing roughly 9.5 percent of their total GBR.

He explained that many hospitals only report a net figure because they contract with outside physician groups to cover unbilled costs or operational losses that the groups cannot recover through direct billing. Because these external groups do not always share their internal billing data with the hospitals, the Commission currently lacks a complete view of the gross revenue flowing through these private entities, potentially masking the true scale of professional spending.

Further analysis of the $1.475 billion net cost revealed a complex workforce and compensation structure. Physicians account for 82 percent of the net costs, while Advanced Practice Providers (APPs) make up the remaining 18 percent. Notably, only about half of the total costs are tied to direct hospital wages and salaries; the other 50 percent stems from other FTE-related compensation, such as payments to related-party groups or external contractors. Additionally, on-call fees alone were identified as a significant expenditure, totaling approximately $125 million across the reporting hospitals.

Mr. Henderson distinguished between the $475 million in regulated costs, which are explicitly built into hospital rate-setting for administrative and oversight roles, and the $1 billion in unregulated costs. He noted that while unregulated costs are not formally included in rate calculations, they have historically been implicitly covered by the HSCRC through allowed hospital margins. Moving forward, the staff intends to continue standardizing these definitions to better understand how hospital margins are being utilized to subsidize these substantial professional expenses.

Mr. Heacox explained that the impetus for this data investigation was the recurring concern from hospitals that employing physicians had become a significant financial barrier. The premise was that hospitals were consistently losing money on these arrangements, prompting a need for the Commission to define the exact scale of the gross cost a hospital is responsible for regarding any clinician capable of billing, regardless of their specific role. He clarified that while professional fees are collected in hospital settings for certain specialties, such as radiology, these revenues rarely cover the full cost of the clinicians.

The core finding of the multi-year study is that every single hospital investigated is paying more for physician services than they are earning back in associated fees. He noted that staff is now digging into the data to identify if there is a common norm or specific drivers for these losses across different types of hospitals. The extra money hospitals must spend to cover these physician deficits is effectively being diverted from other community health developments that the Commission might otherwise prioritize.

Mr. Henderson detailed the distribution of clinician costs across specialties and addressed the inherent difficulties in isolating hospital-specific expenses from broader health system operations. He categorized unregulated physician costs into four primary groups: hospital-based specialties (35 percent), non-surgical specialties (28 percent), surgical specialties (21 percent), and primary care (16 percent). While hospital-based services like anesthesiology and hospitalist programs represent the largest single block at $635 million in gross costs, he noted that they do not constitute a vast majority, illustrating that the unregulated problem spans the entire spectrum of clinical care.

Mr. Henderson acknowledged that while the current data attempted to simplify the reporting by focusing on regulated versus unregulated categories, it remains difficult to strip out time spent in the hospital versus the community. When asked about his confidence in the data's accuracy for policymaking, he estimated being 100 percent confident in 80 percent accuracy, acknowledging that commonalities found across peer hospitals help identify reporting exceptions.

Further drilldowns revealed that independent hospitals generally face higher costs per FTE than large systems, particularly in specialties like emergency medicine. He presented data on $125 million in annual statewide on-call fees, suggesting that some facilities use these payments as a strategic, albeit expensive, alternative to hiring full-time staff. He also highlighted that academic centers predictably show higher regulated costs due to their complex oversight and administrative structures, though data anomalies persist among certain independent facilities.

Mr. Henderson announced that a public data package would be released within 30 days, though it will be aggregated to protect sensitive information. Moving forward, the standalone reporting process will be integrated into the hospitals' standard annual filings to ensure sustainability. He stated that the staff will continue to refine these definitions and leverage this data for upcoming policy discussions and potential legislative requirements, aiming to eventually answer the ultimate question of how many regulated dollars are being used to subsidize professional physician costs.

No action was taken on these agenda items.

ITEM X
DRAFT RECOMMENDATION: HEALTHCARE OUTCOME PAYMENT EFFORT

Ms. Christa Speicher, Deputy Director, Payment Reform, presented the staff's Draft Recommendation: Healthcare Outcome Payment Effort (see "Draft Recommendation: Healthcare Outcome Payment Effort" available on the HSCRC website).

Ms. Speicher presented the draft recommendation for the Healthcare Outcome Payment Effort (HOPE), a new framework designed to succeed the Care Transformation Initiatives (CTIs) ending in June 2026. Built on the foundation of the federal AHEAD model, HOPE aims to create a sustainable, long-term funding stream for programs that improve population health while reducing costs. The Commission intends to act as an outcome purchaser, rewarding successful interventions with earned payouts to ensure Maryland's long-term success in healthcare transformation.

The implementation timeline is aggressive, with a Final Recommendation slated for a Commission vote in May 2026 and performance measurement to begin by July 1st. HOPE features two primary participation pathways: the Care Transformation Framework (CTF) and Regional and Statewide Initiatives (RSI). While CTF is hospital-led and mirrors the current CTI structure, RSI allows non-hospital organizations to lead efforts in partnership with a Maryland hospital. Both pathways share the goal of reducing emergency department and inpatient expenditures, allowing participants to share in the resulting savings.

The financial model for HOPE provides significant predictability, with an annual budget cap of approximately $50 million. Fiscal year 2027 will serve as a transition year, offering one-time infrastructure payments to hospitals that commit to the program and designate population health leadership. Starting in FY 2029, earned outcome payments will be fixed for three-year cycles based on prior performance data. Notably, the Commission has committed to making these payouts regardless of the state's performance on broader federal savings tests, ensuring that successful individual initiatives are reliably rewarded.

The methodology for calculating payouts involves a three-step process: qualifying proposals based on projected savings, measuring actual performance, and adjusting payments to fit within the annual budget. While the initial focus for FY 2028 will be on inpatient and emergency department data using case mix tools, the program intends to expand toward an all-payer environment. Although securing Medicare participation is a high priority, the HSCRC plans to

move forward with Medicaid and commercial payer alignment even if federal alignment via CMS experiences delays.

Proposals will be evaluated by a balanced six-member Review Committee composed of three governmental representatives and three non-governmental experts. This Committee will assess applications based on evidence-based design, alignment with state health priorities, and the likelihood of producing measurable impact without adversely affecting patient experience. Ultimately, the Committee will recommend a diverse portfolio of initiatives across the state to the HSCRC Executive Director, ensuring that the total projected savings remain within the program's fiscal caps.

Commissioner McCann asked for clarification regarding the specific source of the capital used to fund the one-time FY 2027 infrastructure payments for hospitals. Ms. Speicher clarified that the $50 million for infrastructure payments is built directly into hospital rates, but receipt of these funds is contingent upon hospitals formally committing to participate in the HOPE program and designating a population health leader.

Dr. Kromm highlighted that the program is designed to ensure a smooth transition for hospitals that have already invested in infrastructure and need a clear path to maintain those investments. He noted that the initiative aligns with common value-based payment structures where unit costs may increase because the overall impact on total cost reduction is significantly greater. He compared the underlying theory of the HOPE model to existing primary care programs that reward higher value and improved outcomes through adjusted payment rates.

Commissioner Maine suggested that the program should consider allowing established initiatives with existing data from FYs 2026 and 2027 to qualify for the three-year fixed outcome payment cycle earlier than newer programs. He noted that using a historical look-back could provide immediate financial stability for high-quality programs that may have lost funding from other sources, essentially allowing them to skip forward to the multi-year certification phase.

Chairman Sharfstein questioned the staff's conservative approach of capping authorized initiatives based on the assumption that every single project will achieve its full projected savings. He recommended seeking public comments on whether the Commission could instead approve a higher volume of initiatives by assuming a more realistic success rate, such as half or three-quarters of them.

No action was taken on these agenda items.

ITEM XI
DRAFT RECOMMENDATION: READMISSIONS REDUCTION INCENTIVE PROGRAM-RY 2028 POLICY

Ms. Princess Collins-Taylor, Chief, Quality Initiatives, presented the staff's Draft Recommendation on the Readmissions Reductions Incentive programs (RRIP) (see "Draft Recommendation: Readmissions Reduction Incentive Program" available on the HSCRC website) for Rate Year (RY) 2028.

Ms. Collins-Taylor indicated that the final recommendations largely maintains the structure of the RY 2027 program, including a maximum reward or penalty of 2 percent of hospital revenue based on performance. Performance is assessed using the better of attainment or improvement model on all-payer, all-cause readmissions, keeping the 5 percent improvement target and existing attainment thresholds intact.

The Commission received six comment letters from major healthcare organizations, including the Maryland Hospital Association (MHA) and various health systems. The overall tone was supportive, with stakeholders favoring the stability of the current framework for RY 2028. While most organizations supported the status quo, Adventist expressed a desire to eventually transition to CMS's condition-specific measures, provided the program retains its reward incentive rather than becoming penalty-only.

Ms. Collins-Taylor noted the future alignment with the AHEAD model and the Population Health Accountability Plan. Staff proposed aligning the Commission's readmission measures with the NCQA "Plan All-Cause Readmission" measure to ensure the state meets its required biannual goals. In response to requests from the MHA for comparative modeling, staff committed to working with stakeholders through RY 2029 to determine how to best integrate hospital-wide performance with statewide AHEAD requirements.

Staff introduced a refined Out-of-State Utilization Adjustment to address historical inaccuracies in how border-crossing patients were counted. This new methodology corrects two specific technical issues: the double-counting of certain readmissions and the overinflation of denominators due to out-of-state transfers. Although some stakeholders, like MHA, encouraged moving toward a multi-payer data source for this adjustment, staff will continue using Medicare fee-for-service data as a primary step while exploring other sources for future years.

Regarding the timing of these methodology updates, staff recommended applying for the more accurate out-of-state adjustment starting in RY 2027. Regarding a one-time error discovered in the RY 2026 data, staff proposed to only update revenue adjustments for hospitals negatively impacted by the error and not claw back funds from hospitals that benefited, citing the operational challenges of modifying global budgets already in effect.

Ms. Collins-Taylor presented the staff's Final Recommendation on Readmissions Reduction Incentive Program (RRIP) Policy for RY 2028 as follows:

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 periods 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 hospital performance to stakeholders.
6. Assess opportunities for AHEAD alignment of readmission measure, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

Commissioner Maine asked for a clear, simple distinction between a methodological refinement and a technical error in the context of the readmissions policy. Ms. Collins-Taylor explained that the staff error was a specific, one-time mistake in the implementation of the RY 2026 policy where the incorrect out-of-state ratios were applied, necessitating a retrospective correction for those affected. In contrast, she defined a methodology refinement as a prospective change made when the Commission identifies and fixes systemic flaws in a policy that had previously been applied exactly as intended.

Testimonies:

Ms. Tequila Terry, Senior Vice President of Care Transformation and Finance, MHA, expressed full support for the staff recommendation and praised the collaborative effort between the Commission and the hospital field. She highlighted several key elements that provide much-needed stability during the transition to the AHEAD model, specifically endorsing the continued use of the all-payer 30-day all-cause readmission measure, the 65th percentile attainment threshold, and the 4-year improvement target. Additionally, she noted the importance of maintaining a focus on health equity through ongoing monitoring of within-hospital disparities and urged the Commission to prioritize early modeling and transparent communication to help hospitals prepare for future federal alignment.

Mr. Patrick Carlson, Vice President of Care Transformation and Finance, MHA, advocated for a more expansive use of the hold harmless principle when applying retrospective policy changes to Rate Year 2026. While he supported the staff's proposal to correct the one-time ratio error, he argued that the broader methodological refinement regarding out-of-state transfers should also be applied to RY 2026 under the same protection.

Mr. Carlson also challenged the rigid distinction between a staff error and a methodology refinement, suggesting it was a distinction without a difference if the original policy was unintentionally penalizing hospitals for transfers. His primary concern was maintaining financial and operational stability; he argued that any retroactive adjustment whether a correction or a refinement should only be implemented if it benefits a hospital or, at the very least, protects them from unanticipated penalties for a performance year that has already passed.

Mr. Carlson urged the Commission to adopt Option 3, which would apply both the ratio correction and the transfer methodology update to RY 2026 while ensuring no hospital suffers a negative financial impact from these retrospective changes.

Ms. Angela Maule, Vice President Quality and Performance Improvement, Garrett County Hospital, noted the disproportionate impact that the current readmission calculation errors have on rural border hospitals. She highlighted that Garrett Regional faces an out-of-state adjustment

factor of over 20 percent more than five times the state average which, combined with the double-counting of readmissions and the misclassification of interstate transfers, led to an inappropriate penalty of over $300,000 (0.3 percent of their Global Budget Revenue) for Rate Year 2026.

Ms. Maule argued that while this amount might seem small to larger systems, it significantly impairs a rural hospital's ability to maintain staffing, clinical services, and quality initiatives. She expressed strong opposition to the staff's recommendation to delay the methodology correction until Rate Year 2027, requesting instead that the Commission apply the fix retroactively to Rate Year 2026. She concluded by noting the irony that Garrett Regional maintains one of the lowest readmission rates in the state yet continues to face financial penalties due to these known, uncorrected calculation flaws.

Commissioner McCann asked Ms. Maule for clarification on Garrett Regional Medical Center's preferred policy path, confirming that they favor Option 3, which applies the out-of-state and transfer methodology changes retroactively to Rate Year 2026. Ms. Maule acknowledged Option 3.

Dr. Schuster clarified that the staff's recommendation is to distinguish between a technical error (applying the wrong numbers), which they propose fixing retroactively, and a policy refinement (changing how transfers are counted), which they believe should be applied prospectively. She noted that the MHA and Garrett Regional are essentially requesting that the Commission apply the more favorable policy refinement retroactively to Rate Year 2026, but only for hospitals that would receive an upside or financial benefit from the change.

Chairman Sharfstein asked for a technical clarification on the specific stage of implementation for the Rate Year 2026 readmissions policy and how its revenue adjustments were finalized. He asked if a retroactive correction to that policy would take effect immediately or be delayed until the start of the next fiscal cycle in July 2026. Dr. Schuster's response clarified that while the policy is for RY 2026, the revenue adjustments were already set in July 2025 based on 2024 data, meaning any corrections would likely be applied to the rates starting July 1, 2026.

Chairman Sharfstein requested a motion to adopt the staff’s Final Recommendation. Commissioner Blum moved to approve the staff’s Final Recommendation, seconded by Commissioner Johnson. **The motion passed unanimously in favor of the staff’s Final Recommendation.**

ITEM XII
FINAL RECOMMENDATION: MEDICARE PERFORMANCE ADJUSTMENT (MPA)

Ms. Christa Speicher, Deputy Director, Payment Reform, presented the staff’s Final Recommendation: Medicare Performance Adjustment (MPA) (see “Final Recommendation: Medicare Performance Adjustment (MPA)” available on the HSCRC website).

Ms. Speicher presented the staff’s Final Recommendation, noting that there are no proposed changes from the Calendar Year (CY) 2025 policy. She highlighted that the proposal received

no stakeholder comments and has already been approved by CMS, allowing the current framework to remain stable for the upcoming year.

Ms. Speicher indicated that staff would continue discussions with stakeholders regarding the broader redesign of care transformation programs. A key component of this transition involves the proposal to end the traditional MPA in 2026, signaling a shift toward future models as the Commission continues to align with new federal requirements.

Ms. Speicher presented the staff's Final Recommendation on the Medicare Performance Adjustment, as follows:

- Relevant policies will remain unchanged from the prior year.
- Maintaining the current approach as the MPA is sunsetting when Medicare fee-for service global budgets are implemented in 2028.

Chairman Sharfstein requested a motion to adopt the staff's Final Recommendation. Commissioner Maine moved to approve the staff's Final Recommendation, seconded by Vice Chairman Elliott. **The motion passed unanimously in favor of the staff's Final Recommendation.**

ITEM XIII
HEARING AND MEETING SCHEDULE

April 15, 2026, Time to be determined
4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned.