# Regulatory Working Group Policy Recommendation: Cost-Shifting and Medicare Advantage

## Stakeholder Comments: Listening Sessions and Feedback on Draft Policy Proposal

*December 2025*

The policy recommendation can be found at https://hscrc.maryland.gov/Pages/ahead-model.aspx.

# Comments Received for the Listening Sessions

Adventist HealthCare

November 5, 2025

Meena Seshamani, MD, Ph.D
Maryland Department of Health
201 W. Preston Street
Baltimore, Maryland 21201

**Re: Adventist HealthCare Comments on Cost Shift and Medicare Advantage Market Stabilization Initiatives**

Dear Dr. Seshamani:

Adventist HealthCare appreciates the opportunity to provide comments on the Cost Shift and Medicare Advantage (MA) Market Stabilization initiatives, and we strongly support a collaborative stakeholder process to ensure continued access to medically necessary care during Maryland's transition to the AHEAD Model.

**Cost Shift Policy Questions**

1. **What threshold deficit should be set for cost-shifting?**
   There should be no threshold deficit. The reduction in the federal subsidy must be covered dollar for dollar. Maryland hospitals already lag the nation in financial performance and sustainability. Without a full offset, hospitals will be forced to reduce services to remain viable, jeopardizing access to medically necessary care in our communities.

2. **How much should be allowed to shift, balancing impact across the healthcare sector (e.g., purchasers, consumers, providers, payers)?**
   The shift should cover 100% of the federal subsidy reduction to hospitals to preserve systemwide stability.

   Maryland's commercial hospital rates remain well below national and regional benchmarks, even though commercial premiums are comparable. Assertions that Maryland premiums must rise significantly to accommodate the cost shift are therefore questionable.

3. **What is the mechanism for shifting the savings responsibility?**
   The mechanism should be predictable, transparent, and flexible—responsive to evolving conditions. Hospitals must have clarity on the cost shift mechanism in writing before signing AHEAD participation agreements, which cannot be terminated once executed.

4. **What timeline should be set for shifting?**
   The shift should be initiated concurrently with the federal subsidy reduction to prevent funding and access gaps.

5. **How should the shifting mechanism be enacted (e.g., statute, executive order, agency policy – which agency or agencies)?**
   The HSCRC already holds the authority to set hospital rates. The most efficient approach would be to direct HSCRC to ensure a dollar-for-dollar cost shift through existing regulatory channels for the immediate future. Alternative options could be explored as long as a basic framework is in place to provide a documented, committed solution prior to hospitals signing participation agreements in CY2025.

6. **What other considerations must be addressed, and what is their potential financial impact?**
   The potential impact is significant if the cost-shift policy is not finalized before hospitals sign AHEAD participation agreements—15-year commitments without termination options.

   Each Maryland hospital's rate structure is based on a legacy framework, meaning the level of federal subsidy embedded in rates varies widely. Hospitals like Adventist draw down a smaller portion of the federal subsidy, so any reduction would have a disproportionate and immediate effect on access, financial stability, and the overall success of Adventist HealthCare and the future AHEAD Model.

**Medicare Advantage Market Stabilization**

1. **What are the key concerns for MA stability and what approaches should be considered to address those concerns?**
   Adventist HealthCare is concerned that the Medicare Advantage market is not financially or structurally healthy outside of Maryland, and that efforts to stabilize it locally could unintentionally overinflate the Maryland MA market beyond natural market dynamics. It is critical that Maryland's regulatory framework not artificially sustain MA performance in ways that mask broader plan design weaknesses or distort the intent of the state's model.

   Proposals to stabilize MA through broker premium subsidies do not directly benefit patient care and risk diverting funds from direct patient care.

   Furthermore, the priority of the state should be focused on more pressing issues such as resolving the cost-shift framework which is essential for hospital participation in the AHEAD model. Stabilizing MA before addressing the cost shift could undermine hospital solvency and the future of the Model.

2. **What level of upfront investment would be necessary for MA plans to implement programs?**
   Any upfront investment should be carefully targeted and conditioned on transparency and measurable outcomes tied to total cost of care reduction.

3. **What eligibility criteria should be required for MA plans to participate?**
   MA plans should be required to demonstrate full transparency on denials, utilization management, and spending on care management and total cost-of-care reduction initiatives.

4. **What other considerations must be addressed, and what is their potential financial impact?** Financial impacts should be modeled jointly with the cost-shift framework to ensure balanced, transparent, and sustainable funding across the delivery system.

Sincerely,

Katie Eckert

Katie Eckert, CPA
Senior Vice President, Strategic Operations
Adventist HealthCare

cc:
Perrie Briskin, Medicaid Director, Maryland Department of Health
Dr. Elizabeth Kromm, Assistant Secretary for Population Health & Strategic Initiatives, Maryland Department of Health
Jonathan Kromm, PhD, Executive Director, HSCRC
Michele Eberle, Executive Director, Maryland Health Benefit Exchange
Dr. Douglas Jacobs, Executive Director, Maryland Health Care Commission
Marie Grant, Commissioner, Maryland Insurance Administration

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
F 202.331.7487
ahip.org

November 5, 2025

**RE: Medicare Advantage Market Stabilization**

Dear Members of the Maryland Multi-Agency Regulatory Working Group:

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. Our members are committed to serving the more than 35 million seniors and people with disabilities who have chosen to enroll in MA. On behalf of our members, we appreciate the opportunity to offer the following comments as Maryland considers how, in the new AHEAD model, the Medicare Advantage market in the state can be improved.

More than 35 million Americans – including nearly 300,000 Maryland residents – choose Medicare Advantage (MA) because it offers access to affordable, high-quality plan options, often with coverage for extra benefits not covered by traditional fee-for-service (FFS) Medicare, such as vision, hearing, and dental. Seniors and individuals with disabilities who enroll in MA continue to express high rates of satisfaction with their plan, which is why enrollment in MA has continued to grow.

Today, more than half of eligible Medicare beneficiaries nationally choose MA. However, MA plans face unique challenges in Maryland that prevent beneficiaries from enjoying the full value of MA and threaten the long-term viability and sustainability of the program in the State. The low enrollment and market participation in Maryland compared to other parts of the country are clear signals that something must be done.

We applaud the State's leadership and commitment to addressing some of these challenges, including funding opportunities to help offset plan costs and advancing health system transformation through the AHEAD model. However, we believe a long-term solution to address the underlying structural challenges facing MA plans in Maryland is necessary to ensure a robust, competitive, and stable MA market.

We urge the Maryland Department of Health to work closely with the Centers for Medicare & Medicaid Services (CMS) and stakeholders to identify opportunities under the AHEAD model to develop and implement long-term solutions. They should prioritize:

- Maintaining robust competition and consumer choice of MA plans.
- Aligning payment structures to reflect Maryland's unique environment.
- Ensuring long-term financial stability of the MA market in Maryland.

We believe there are opportunities to ensure that Maryland seniors continue to benefit from the high-quality, affordable coverage that MA provides, while advancing the State's goals for improved population health and cost containment.

Sincerely,

Mark Hamelburg
Senior Vice President, Federal Programs
AHIP

ALTERWOOD ADVANTAGE
Quality Care. Better Health.

10090 Red Run Boulevard
Second Floor
Owings Mills, MD 21117

November 5, 2025

The Honorable Meena Seshamani
Secretary
Maryland Department of Health
201 West Preston Street
Baltimore, MD 2120

**SUBJECT: AHEAD Regulatory Working Group-Medicare Advantage Stabilization**

Dear Secretary Seshamani:

Thank you for the opportunity to provide written comments to the AHEAD Regulatory Working Group regarding Medicare Advantage stabilization in Maryland. Alterwood Advantage is the newest Medicare Advantage Plan in Maryland serving over 10,000 Medicare beneficiaries. We launched our Medicare Advantage product in 2022 with LifeBridge Health as our majority owner with the goal of meeting the needs of Maryland's Medicare beneficiaries.

Medicare Advantage is an important source of supplemental coverage for Medicare beneficiaries. Traditional Medicare fee-for-service does not cover some services that are important to Medicare beneficiaries and there are cost-sharing requirements that can make accessing care difficult. According to the Kaiser Family Foundation, 9 out of 10 Medicare beneficiaries nationally have some type of supplemental coverage and those that do not face barriers to care. Increasingly, that source of supplemental coverage is Medicare Advantage. It is particularly important for low-income beneficiaries who cannot afford a more expensive Medigap policy or who do not have access to retiree coverage. Medicare Advantage is a important tool for low-income, high need beneficiaries who need protections from Medicare's cost sharing requirements and access to supplemental benefits like dental, vision, hearing aids, and transportation that traditional Medicare fee for service doesn't cover.

There have been ongoing discussions with the Maryland Insurance Administration and the Maryland Department of Health since 2018 about the structural payment issues in the State of Maryland which limit the ability of Medicare Advantage Plans to survive. As Maryland commits to a new 10-year model under AHEAD, it is imperative that we stabilize the Medicare Advantage market in Maryland and ensure that Maryland beneficiaries have the same level of protections and coverage as their counterparts in other states.

In 2024 the Maryland Medicare Advantage plans had operating losses of $388 million. The significant and sustained losses are across virtually all Medicare Advantage Plans and demonstrate a market that is not functioning. Alterwood's cumulative underwriting loss is over $50 million between 2022 and 2024. Alterwood anticipates a loss of between $30 million to $35 million in 2025, which would continue into 2026. We have taken internal steps to try to stem these losses such as increasing member premiums, reducing supplemental benefits, and re-contracting with providers. Cost shifting to other insurance products is not an option nor does the prescriptive federal Medicare Advantage payment methodology accommodate Maryland's high cost. While we are committed to serving our vulnerable beneficiaries, these financial losses are unsustainable over the long run.

As we have recently entered the 2026 Annual Enrollment Period several national plans operating in Maryland have declared their intentions to reduce or eliminate their offerings, which could displace over 50,000 Medicare beneficiaries. We are committed to the Maryland Medicare beneficiaries that we serve today but have serious concerns about our ability to inherit these displaced beneficiaries from other plans. Anticipating this problem back in August we requested from CMS an enrollment cap, but were denied. The only other course of action to avoid a massive influx of enrollment was to discontinue paying broker commissions for new enrollments. While not ideal for the marketplace, we cannot take on more losses.

We were pleased to see that the AHEAD Model includes language directing Maryland to propose ideas to the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage market stabilization. Given the urgent need for stabilization in Maryland's Medicare Advantage market, we request the state and CMS include more specific language in the State Agreement to address this problem.

Two potential policy solutions could serve as a foundation for developing strategies to resolve the underlying financial challenges in the state:

1. CMS Benchmark modification: Low Medicare Advantage penetration in Maryland is primarily a result of the technical disconnect in Medicare's methodology for paying Medicare Advantage plans and Maryland's Total Cost of Care (TCOC) Model. This methodology artificially underpays Medicare Advantage plans by not factoring in the unique all-payer hospital model in Maryland, where plans cannot negotiate hospital rates, and plan specific utilization reductions do not result in direct cost savings to the plan. The Draft AHEAD Model Terms could include a provision under which CMS would set the Medicare Advantage benchmarks for each Maryland county as if the Maryland TCOC Model were not in effect. We expect that such a change would materially increase the benchmarks in many counties across the state. Under this scenario, Medicare Advantage

plans would still be required to meet all CMS actuarial standards as well as the 85 percent Medical Loss Ratio (MLR) threshold. We believe this is an appropriate bridge to hospital global budgets in the AHEAD Model while the current methodology is in transition.

There is precedent for CMS to modify the methodology used to set Medicare Advantage benchmarks in order to account for unique regional circumstances. For example, for over a decade CMS has made benchmark adjustments for Medicare Advantage plans operating in Puerto Rico due to the low Medicare Part B enrollment in the territory and propensity for individuals with zero claims—factors that distort the utilization and cost data used to set benchmarks. Specifically, CMS bases the county rates in Puerto Rico on the costs of individuals in Traditional Medicare who have both Medicare Parts A and B and apply an adjustment to account for the propensity of individuals with zero claims. These modifications have set the precedent by CMS to address unique market conditions and have demonstrated success in stabilizing and improving the Medicare Advantage market for beneficiaries in Puerto Rico. We believe similar types of adjustments to benchmarks in Maryland are warranted and could prove effective.

2. Reinstating the Hospital Medicare Advantage Grant Program: The State has been a trailblazer in creating access to affordable health care to protect Maryland's most vulnerable. After the passage of the Affordable Care Act, Maryland was in the first wave of states to expand Medicaid and to build its marketplace through the Maryland Health Benefit Exchange (MHBE). The legislature has created several programs through MHBE to keep coverage affordable, including the State Reinsurance Program. In recognition of the challenges experienced by Medicare Advantage plans in Maryland due to the national benchmarking methodology, the State of Maryland has previously provided stabilization funding to Medicare Advantage plans. In FY2020 and FY2021, the HSCRC created a grant program for Medicare Advantage plans and in 2023 the Maryland General Assembly provided additional funding in recognition for the need to stabilize the Maryland market. We propose that the HSCRC temporarily re-establish the grant program for FY2026 and FY2027, to stabilize the Medicare Advantage market. This would have a minimal impact on the waiver test and provide a temporary bridge as a more permanent solution is sought with CMS.

Further, it is important to ensure that the new Model Agreement does not inadvertently worsen Medicare Advantage conditions. The State should clarify with CMS that Maryland will align hospital payments by Medicare Advantage Plans with Medicare rates consistent with how other public payers are treated. It would be impossible for Medicare Advantage Plans to shoulder any cost shifting from public payers to commercial.

Thank you for your continued interest in understanding the Maryland Medicare Advantage marketplace and the ever-changing dynamics that affect this important population of Maryland healthcare beneficiaries. These are currently unprecedented circumstances. We would be happy to discuss this further with you in greater detail. Please contact me if you need additional information.

Sincerely,

Mark Puente
President

CC: Perrie Briskin, Medicaid Director, MD Department of Health
Michele Eberle, Executive Director, MD Health Benefit Exchange
Marie Grant, Commissioner, MD Insurance Administration
Dr. Douglas Jacobs, Executive Director, MD Health Care Commission
Dr. Jon Kromm, Executive Director, Health Services Cost Review Commission
Laura Goodman, Associate Director, Health Services Cost Review Commission

**CareFirst BlueCross BlueShield**
10455 Mill Run Circle
Owings Mills, MD 21117-5559
**carefirst.com**

November 5, 2025

Multi-Agency Regulatory Working Group
Maryland Department of Health
201 W. Preston Street
Baltimore, MD 21201

Dear Members of the Maryland Multi-Agency Regulatory Working Group:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to comment on the critical topics raised by the working group. Actions taken on both cost-shifting and Medicare Advantage stabilization will directly impact the health, financial security, and peace of mind of Maryland families, employers, and seniors. Below, we have provided our comments on how Marylanders experience these issues, and we urge the working group to keep consumers' access, affordability, and stability at the center of this process.

## Cost-Shifting

CareFirst has supported the Maryland Model throughout its various iterations. Maryland families and businesses have long benefited from the all-payer nature of the model, rooted in equitable financing across payers. Maryland consumers benefit from the model because it is the only state in the nation where cost-shifting from public payers to private payers does not occur. As Maryland prepares to enter the AHEAD model, we are concerned by the state's immediate step to begin cost-shifting. Cost-shifting would undermine one of the most valuable protections for Maryland consumers before the new model even begins.

Prior to convening multiple state agencies to develop a cost-shifting methodology, the State should first develop a data-driven perspective of the level of hospital access communities truly need and the most efficient and equitable way to finance that access. By identifying cost-reduction and modernization opportunities first, Maryland can stabilize hospital operations without exposing working families and local businesses to unnecessary price increases.

After completing a thoughtful analysis on access and cost opportunity, the State could consider supporting struggling hospitals with cost-shifting as a last resort. If the State simply starts with cost-shifting without evaluating and fixing the underlying cost structure, it will burden Marylanders with higher out-of-pocket costs and unravel 50 years of progress created by the model.

## Medicare Advantage

While all-payer rate-setting has driven value for most Marylanders, unfortunately the Maryland Model has disadvantaged Maryland seniors and individuals with disabilities who rely on Medicare. This has resulted in frequent coverage disruptions, fewer low-cost coverage options, and reduced benefits compared to neighboring states.

Nationally, more than 55% of Medicare beneficiaries enroll in a Medicare Advantage plan, which provides a richer benefit package than traditional Medicare at a lower cost. Almost every

Medicare Advantage member (more than 95%) has access to vision, dental, and hearing coverage, and approximately 76% of Medicare Advantage beneficiaries receive prescription drug coverage at no additional cost.[1] Supplemental benefits offered through Medicare Advantage are even more important for individuals with dual special needs, more than 80% of whom receive meal benefits and transportation benefits through their plan. Studies have shown that Medicare Advantage beneficiaries spent an average of $3,486 less on total healthcare costs annually than those in Fee-for-Service (FFS) Medicare.[2] If Maryland residents enrolled in Medicare Advantage at the same rate as the rest of the nation and had benefits that were as rich as the rest of the nation, out-of-pocket costs for Marylanders would be lower by $700 million per year.

Several studies have examined the amount by which Maryland Medicare Advantage plans are underfunded. Whether calculated based on a repricing of Maryland utilization, a medical loss ratio analog, or other methodologies, the result is typically that Maryland Medicare Advantage plans receive between $400 million and $600 million less revenue as a result of the Model. In other markets, that revenue is used to provide richer benefits and lower cost-sharing for seniors. In addition to this cost, Maryland residents have had to navigate ongoing plan exits due to market volatility and dysfunctional economics. This year alone, roughly 100,000 Marylanders will experience this directly when they receive termination of coverage notices and are forced to select new plans to continue seeing their doctors and filling prescriptions.[3]

For years, CareFirst and others have raised concerns about the impact that the model has on Medicare Advantage access. Fixing the Medicare Advantage benchmark set by the Centers for Medicare & Medicaid Services (CMS) is outside the state's authority, but it can correct for the market implications it has generated by reducing the amount Medicare Advantage plans have to pay hospitals.

Therefore, we recommend that the Working Group:

1. Reduce hospital rates for Medicare Advantage plans by $400-$600 million;
2. Fund this adjustment using the collective funding levers available: (1) reducing hospital payments for MA plans; (2) grants through the HSCRC; (3) enhanced funding allocation in the State budget; and (4) a differential adjustment for other payers. While we have historically opposed the use of the differential adjustment, except as a last resort, we believe this is the last opportunity to avoid a market collapse that would be detrimental to the health of seniors and individuals with disabilities, and has the potential to strengthen the durability of the overall healthcare ecosystem in Maryland;
3. Tailor this solution to focus on contracts with predominant enrollment in Maryland to assure Maryland dollars stay with Maryland populations and are not extracted and used to benefit payers and populations primarily in other states; and

[1] https://www.kff.org/medicare/medicare-advantage-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/#:~:text=The%20average%20out%2Dof%2Dpocket,drugs%20covered%20under%20Part%20D.
[2] https://bettermedicarealliance.org/wp-content/uploads/2025/06/2025-Beneficiary-Spending-Report-2.pdf
[3] https://marylandmatters.org/2025/10/13/thousands-of-maryland-seniors-notified-of-the-end-of-their-medicare-advantage-plans/

4. Act promptly. With plans exiting the market, seniors receiving termination letters, a population that continues to age into Medicare eligibility, and a state that has fallen well behind the nation, the time to act is now. Plans must have certainty by January 2026 to prepare 2027 Medicare Advantage bids to CMS and reduce the risk of even more plans withdrawing from the Maryland market.

**Summary**

CareFirst believes that the State must confront a critical question, before placing a premature focus on cost-shifting that bypasses important systemic work to protect Marylanders. If working families and local employers will no longer experience clear benefits from the model, and if Maryland seniors and individuals with disabilities continue to be denied access to richer, more stable benefits at a lower cost, what is the continued purpose of an all-payer rate-setting model? The State has an obligation to ensure that the model serves these stakeholders. Likewise, as a not-for-profit healthcare company, CareFirst has both a fiduciary duty and a mission-driven responsibility to advocate for policies that will deliver the best balance of affordable, quality healthcare for our members. We take that responsibility seriously and believe the model's success must ultimately be measured by how well it serves the people of Maryland and not simply by its longevity or its ability to bolster institutions.

Sincerely,

Arin D. Foreman
Vice President, Deputy Chief of Staff
CareFirst BlueCross BlueShield
1501 S. Clinton Street
Baltimore, MD 21224

Maryland

**MDH Maryland-Model -MDH- <mdh.maryland-model@maryland.gov>**

# Re: AHEAD Model: Upcoming Listening Sessions on Cost-Shifting and Medicare Advantage

2 messages

**Rosenberg, Andrew** <Arosenberg@healthra.net> Tue, Oct 28, 2025 at 5:57 PM
To: "mdh.maryland-model@maryland.gov" <mdh.maryland-model@maryland.gov>

Speaking on behalf of the independent agent community, I believe the domino effect of the failing medicare advantage model in MD should be recognized.

With over 100,000 Maryland medicare advantage members losing their plan at the end of this calendar year, they are looking to the agent community to assist them with the “medicare maze”. The majority of the remaining medicare advantage carriers in MD have made their products non-commissionable for 2026 because they do not want to attract those orphaned beneficiaries due to financial constraints of the MAPD payment methodology in MD. That decision, understandably based off of financial solvency, causes a downstream domino effect:

Carriers are attempting to use a non-commissionable status on their products as a way of controlling the faucet. The growing concern here is that Maryland medicare beneficiaries have come to rely on independent agents to present all of their options and help them navigate the medicare maze from an unbiased stance, and those agents have grown to rely on standard commissions from the carriers for the work that they do in the field. Due to the latest commission decisions by some of the Maryland medicare advantage options, we are facing a few issues:

1. Local, feet on the ground, gents are out of business and not assisting thousands of clients that desperately need help with over 100k beneficiaries being terminated from their current plans. The agents have had to find work that can pay the mortgage.

2. This is in effect steering beneficiaries to inferior (benefit) plans that are still paying commissions by way of national call centers.

I believe that a payment fix of any kind would cause the carriers to turn the commissions back on which would reset the market and allow the displaced beneficiaries to find the proper home for 2026 before they show up at the pharmacy next year only to find out their plan terminated at the end of the year and they have no coverage to pick up their prescriptions with.

**Andrew Rosenberg**
**Health Resource Advisors, Inc.**

O: 888.888.7511 | F: 866.369.8953 | C: 410.868.0083

www.healthresourceadvisors.com | arosenberg@healthra.net

**From:** Maryland Insurance Administration <MDInsuranceAdmin@public.govdelivery.com>
**Date:** Monday, October 20, 2025 at 3:47 PM
**To:** "arosenberg@healthra.net" <Arosenberg@Healthra.net>
**Subject:** AHEAD Model: Upcoming Listening Sessions on Cost-Shifting and Medicare Advantage


Good afternoon,

On September 23, 2025, Governor Moore issued a directive to create a working group of State regulatory agencies, with the aim of achieving the goals and objectives of the State of Maryland under the AHEAD Model (attached). The working group process will prioritize stakeholder insight, input and guidance to the greatest extent possible, with the aim of promoting market stability, health care affordability, access and quality throughout Maryland.

The first two topic areas the working group will address are the need for cost-shifting policies and policies for Medicare Advantage stabilization. The working group will hold listening sessions to gather stakeholder input on these topics in late October and early November, then develop and post a policy proposal for public comment by mid-November. After public comment is received and integrated, a final proposal will be submitted for the Governor's consideration in early December, with a policy decision from the Governor anticipated in late December.

Two sessions have been scheduled to allow stakeholders to select the session that best fits their schedule; there is no need to attend both, as the topics will be fully covered in each session. The working group asks stakeholders to submit input on either or both topics in writing, and to prepare a brief verbal presentation (3-5 minutes) for discussion during one of the scheduled listening sessions. When submitting comments, please indicate which listening session you will attend, to support effective planning and time management. Comments should be submitted to this email address: mdh.maryland-model@maryland.gov.

Additional information regarding cost-shifting and Medicare Advantage stabilization are in the second attachment, including questions to prompt

responses for public comment.

Please register for the listening sessions using the Zoom links below. While those submitting public comments are welcome to attend both sessions, you will only present at one session–please indicate in your submission which you prefer.

- Listening Session 1: Wednesday, October 29, 2025 from 2 - 3:30 PM
  - Joining link: https://us06web.zoom.us/j/86824723342?pwdw1qbcq4FiklNRUDbeb1alrPUTp7hnv.1
  - Meeting ID: 868 2472 3342
  - Passcode: 206956
- Listening Session 2: Wednesday, November 5, 2025 from 2 - 3:30 PM
  - https://us06web.zoom.us/j/87951842697?pwdoXzKS73WoqGo95sBtNQJE2hrbuXbRp.1
  - Meeting ID: 879 5184 2697
  - Passcode: 845964

Stakeholders who do not submit written comments are welcome to attend either session and will be invited to participate as time allows. All interested parties are encouraged to submit written comments during the public comment period following the release of the draft policy proposal.

On behalf of the working group, we thank you for your partnership in helping shape the health policy landscape under the upcoming AHEAD model. Please do not hesitate to reach out to this email account with any questions.

Kind regards,
Regulatory Working Group

Governor's Directive.pdf

Cost-Shifting and MA Stabilization_Background and Questions.pdf

**MDH Maryland-Model -MDH-** <MDH.Maryland-Model@maryland.gov> Wed, Oct 29, 2025 at 9:34 AM
To: "Rosenberg, Andrew" <Arosenberg@healthra.net>

Mr. Rosenberg,

Many thanks for your submission. On behalf of the Regulatory Working Group, I invite you to speak to your comments during one of the two listening sessions that we have scheduled. The first is today (10/29) from 2:00-3:30; the second is next Wednesday (11/5), also from 2:00-3:30. Each commenter will have 3-5 minutes to speak, and sessions will be recorded.

Please let me know which you are able to attend.

Kind regards,
Laura

[Quoted text hidden]

Secretary Meena Seshamani
Maryland Department of Health
Herbert R. O'Conor State Office Building, 201 West Preston St.
Baltimore, Maryland 21201

Dear Secretary Seshamani and Members of the Regulatory Working Group,

We write to you as members of the Health Means Everything Coalition, focused on affordable, high-quality care for Marylanders. The coalition recently formed to advocate for greater transparency, accountability, and equity in the state's healthcare system on behalf of consumers, particularly amid ongoing state and federal transitions, such as implementation of the AHEAD (Achieving Healthcare Efficiency through Accountable Design) Model and decisions regarding the Medicare Advantage program. The coalition members include grassroots organizations, businesses, public health experts and others interested in a healthcare system for Marylanders that keeps people healthy and prices affordable.

Our recommendations focus on cost-shifting and Medicare Advantage stabilization, as both topics are essential for consumer affordability. **Our chief concern** is avoiding policies that result in Maryland residents bearing the financial burden of preserving hospital budgets, given that residents traditionally have no direct voice in these conversations.

## COST SHIFTING

- The guiding light of the working group must be to ensure Marylanders' ability to access and afford the health care services they need
- While the Maryland model has historically met its savings target, Maryland families and businesses are overburdened with health care costs. When health care becomes unaffordable, health outcomes suffer as people avoid seeking routine care.

- Nearly half of Marylanders reported delaying or skipping care due to cost.[1]
- 82% reported being worried or very worried about affording medical costs from a serious illness or accident.[2]

- Health Means Everything is concerned that a higher Medicare savings target coupled with the new federally led Medicare hospital global budget methodology will result in higher out-of-pocket spending for Maryland's working families and higher cost liabilities for Maryland's employers.
  - As health care providers, purchasers, payers, and other stakeholders seek to constrain overall health care spending, they may pass on an increasing proportion of service costs to consumers.
- Governor Moore's September 23, 2025 letter to Secretary Seshamani identified policies related to cost shifting across health insurance markets as a central focus of this working group. However, those policies should be understood in the context of the broader goals of the AHEAD model, which are to adopt prudent total cost of care goals for purposes of increasing savings and improving outcomes.
- We interpret these goals and Governor Moore's directive to mean that costs that would otherwise be paid by Medicare should not simply be shifted to other payers. Instead, the state should set policy guardrails that prevent hospital global budgets and hospital service payment rates from deviating too far from those established by Medicare. In other words, the state should prevent Medicare Advantage, Medicaid, and commercial rates from rising above or dropping below certain thresholds. Moreover, those thresholds should be set relative to their ultimate impact on costs to the consumer via premium increases, out of pocket cost sharing, etc.
  - Without these types of guardrails in place, health care prices may increase for families enrolled in these different markets. Those prices are

[1] https://healthcarevaluehub.org/wp-content/uploads/MD_CHESS_Infographic_Oct_22.pdf
[2] https://healthcarevaluehub.org/wp-content/uploads/MD_CHESS_Infographic_Oct_22.pdf

passed on in the form of health insurance premiums, deductibles, copays, etc.
    - The goal of the AHEAD model is to drive statewide health transformation that ultimately enhances preventive care and chronic disease management to achieve better population health outcomes and lower total health care spending. This kind of transformation requires improved access to primary care, greater utilization of care in low-cost ambulatory care settings, and will reasonably reduce the acute care capacity in the state. These are positive outcomes for Maryland families, who have seen their health care premiums rise due to increasing hospital rates (among several other factors).
- Policies adopted by the workgroup should facilitate this health system transformation instead of seeking to maintain the status quo.
- The status quo isn't working for Maryland families.

## MEDICARE ADVANTAGE MARKET STABILIZATION

- A competitive Medicare Advantage market is key for ensuring affordable health care coverage for Maryland seniors. However, Medicare Advantage offerings in Maryland are shrinking, forcing seniors to regularly change health plans or absorb the higher-cost, less generous coverage of traditional Medicare.
- Around 25% of Maryland Medicare recipients utilize Medicare Advantage. In most states, at least 50% of Medicare recipients utilize Medicare Advantage.[3]
    - According to CMS' most recent MA penetration data, Maryland counties average 23 percent.[4]

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[3] https://www.kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population-by-plan-type/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[4] https://www.kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population-by-plan-type/?currentTimeframe=0&selectedRows=%7B%22counties%22:%7B%22maryland%22:%7B%22all%22:%7B%7D%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

- Maryland has fewer Medicare Advantage options in comparison to many other states. Additionally, the Medicare Advantage market in Maryland is more expensive than most other states
    - In 2024, Maryland ranked 39th out of all 50 states in total number of MA plans available, with only 35 plans.[5]
    - Moreover, of that list of 11 states with the lowest number of MA plans, Maryland has more than double the eligible MA population (1.1 million) of the state that it is tied with, Utah (475,000). This highlights the disparity in available options between Maryland's Medicare beneficiaries and the other similarly situated states.
- Maryland is seeing reductions in Medicare Advantage moving into 2026
    - Seniors have begun receiving notices that their plans will not be offered in the coming years
    - Reporting indicates that many insurers are leaving or reducing their presence in the market
        - Aetna: Shrinking its coverage to only 3 counties for 2026 (Frederick, Harford, Montgomery)[6]
        - Humana: Entirely exited one of its plans. Another plan, Humana Gold Plus SNP, will no longer be available in Anne Arundel county, Baltimore county, Harford county, Howard county and Baltimore City beginning January 1, 2026 (these are some of the most populated areas in Maryland).[7]

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5 https://www.kff.org/medicare/state-indicator/plans-by-plan-type/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Number%20of%20Medicare%20Advantage%20Plans%22,%22sort%22:%22desc%22%7D

6 https://marylandmatters.org/2025/10/13/thousands-of-maryland-seniors-notified-of-the-end-of-their-medicare-advantage-plans/

7 https://marylandmatters.org/2025/10/13/thousands-of-maryland-seniors-notified-of-the-end-of-their-medicare-advantage-plans/

- Over 100,000 Maryland Residents are set to lose their Medicare Advantage Plans at the end of 2025 if they don't enroll in a new plan by December 31st.[8]

- This isn't an uncommon occurrence in the state --- in 2021 Advantage MD reduced its service area, resulting in 6,000 seniors being cut from MA plans.[9]
- **It is clear that Maryland's MA market is lacking in both competition and consumer choice. Health Means Everything is concerned that these failures are driving up costs and worsening health care access for Maryland's seniors.**
- With continued dysfunction, consumers may feel forced into Traditional Medicare, where they would see higher out of pocket costs and lose coverage for key services that they had under their Medicare Advantage plan. A healthier Medicare market would be beneficial to Maryland consumers by providing consistent, lower cost health coverage options that meet their unique health care needs.
- HSCRC's actions have in the past, and may continue to have, a negative impact on the MA market in Maryland. Maryland has some of the highest Medicare fee-for-service costs in the nation. This includes some of the highest rates for hospital services as set by the HSCRC. Normally this wouldn't be a problem if the federal government reimbursed MA plans proportional to FFS costs. However, the MA program is structured precisely in the opposite way – the MA program sets lower benchmark goals for MA plans to meet in the highest cost areas as a means of breeding competition among the best plans for savings. Maryland leads in this dynamic and MA plans have not been able to crack the code of high FFS costs coupled with intentionally lower reimbursement by CMS, forcing them to make up the difference.

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8 https://marylandmatters.org/2025/10/13/thousands-of-maryland-seniors-notified-of-the-end-of-their-medicare-advantage-plans/

9 https://www.baltimorebrew.com/2021/10/20/johns-hopkins-to-drop-its-medicare-supplement-plans-for-baltimore-city-residents/

- The HSCRC has previously dismissed the argument by saying that MA penetration in other similarly costly areas remains higher.[10] However, that assessment didn't take into account the unique reality that nearly all of Maryland is in the highest cost range – something that even California cannot claim.

- Health Means Everything recognizes and appreciates that the state has previously implemented a grant program to support Medicare Advantage offerings in the state. However, this was a temporary solution that has not led to sustainable and equitable Medicare Advantage access
- Medicare Advantage Stabilization policies should align with the goals of the AHEAD model, centering better health outcomes and lower total health care costs.
- **The Health Means Everything Coalition suggests that the state leverage its AHEAD agreement with CMS to address the misalignment between Medicare Advantage rate setting and the Maryland/AHEAD model. Targeted changes to the MA rate-setting process in Maryland could meaningfully improve plan offerings for Maryland seniors and ultimately support the state's success in the AHEAD model by improving health outcomes.**

We will continue to follow issues like the new Medicaid work requirements, preserving access to Medicare Advantage, and implementation of Maryland's AHEAD Model, and look for places where consumer perspectives might benefit policymakers in the healthcare arena. Above all else, we will seek to platform residents and community advocates in these conversations, to make sure everyday Marylanders are not called on to subsidize multibillion dollar industries.

Thank you for your time and consideration. We look forward to working with you on behalf of Maryland families.

Sincerely,

[10] https://hscrc.maryland.gov/documents/ma%20landscape%20and%20grant%20program%20final.pdf

Ashiah Parker
Chair, Health Means Everything Coalition

November 5, 2025

Meena Seshamani, MD, PhD
Secretary, Maryland Department of Health
201 W. Preston Street,
Baltimore, Maryland 21201

Dear Secretary Seshamani,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the process for cost-shifting as Maryland prepares to move into the Achieving Efficiency Through Accountable Design (AHEAD) model. The most important goal through this transition is to ensure that the model provides sufficient resources to provide access to needed care for Maryland citizens. Decreased federal funding under the AHEAD model will disrupt the current balance of resources, and as a state, we must then rely on higher contributions to that balance – as other states do – to ensure sufficient resources to care for Marylanders.

There are foundational elements of the AHEAD model construct and related impacts to the Maryland healthcare landscape that have not yet been addressed, including Medicaid savings requirements and the substantial uncompensated care increases expected from H.R.1, among others. Given how inter-related these fundamental mechanics are to the cost-shifting discussion, this information must be clarified to appropriately address cost-shifting as proposed by the Regulatory Working Group. Though additional information is needed to address potential cost-shifting mechanics, there must be a commitment on guiding principles as well as variables that will be monitored to ensure this significant change to Maryland's model will result in reasonable rates that protect the efficiency and effectiveness of Maryland hospitals, as required by state statute (Md. Health-General Code Ann. Section 19-220(d)(2)(i)).

JHHS is supportive of the Maryland Hospital Association's comments and testimony on cost-shifting, and additionally proposes the following guiding principles and comments for the workgroup's consideration:

1. Require assurances from the State that a cost-shift will be implemented to the order of magnitude that protects hospitals from financial distress, including assurances that state statute will be modified to allow for this cost-shift. Assurances must also be made that the entirety of the reduced federal funding will be cost-shifted, and that the cost-shift will occur in real-time as much as possible. Given the significant rate reductions contemplated by the AHEAD agreement as proposed and the already constrained hospital margins statewide, hospitals will be unable to absorb further financial losses without impacting service offerings and care delivery, ultimately impacting Marylanders who rely on access to this medically necessary care.

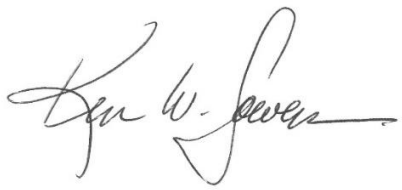
2. Cost-shifting must be predictable and expected to ensure adequate flow of funding to support operations and hospital budget planning. A minimum amount must be cost-shifted in advance of savings expectations and increases to uncompensated care to ensure there is not a significant lag between the reduction in rates and the cost-shift.
3. Policies associated with cost shifting must be continuously evaluated and adjusted, particularly if a phased approach is needed.
4. Hospitals providing appropriate care and services with a disproportionate payor mix of Medicare and Medicaid must be protected from any negative impact given the needs of the vulnerable populations they serve. These hospitals will also be significantly impacted by anticipated increases in uncompensated care, and appropriate cost shifting methodology must be in place to protect access to care for these populations.
5. To assess the impact to patients, require commitment that the State will conduct an independent study to quantify the benefit payors receive today and evaluate whether that benefit accrues to the consumer as well as any financial impact to employers and consumers from cost shifting. Such a study would ensure commercial payors are absorbing an appropriate share of the financial burden as a cost-shift is contemplated. This study should consider 1) consumer premiums in Maryland compared to the nation; 2) risk-based capital of commercial payors compared to statutory requirements and industry standard; and 3) analysis of mandated benefits in Maryland.
6. After implementation of a cost shift, critical model components must be evaluated and addressed, including but not limited to:
    a. Medically necessary care
    b. Underfunded capital
    c. Innovation
    d. Uncompensated care
    e. Financial viability of hospitals
7. Finally, while the above guiding principles must be considered for any cost-shifting policy, JHHS also notes that the State must also consider actions that may lessen the size of the necessary cost-shift if feasible. More specifically, the State should consider the following:
    a. Medicaid: As noted above, Medicaid is a critical consideration in this cost-shifting discussion, but the draft AHEAD state agreement lacks sufficient clarity on Medicaid rates and the financial implications to the overall model as it relates to cost-shifting. The draft state agreement indicates that Medicaid hospital rates should be comparable to Medicare hospital rates (Section 8.d.i.2). However, the agreement also recognizes that this remains unconfirmed until the appropriate Medicaid authorities are obtained (Section 8.d.i.3). If these authorities are not obtained, the cost shifting burden will increase dramatically.
    b. Medicare Advantage: The draft AHEAD state agreement provides that the hospital rates paid by Medicare Advantage will not be the same as Medicare fee for service rates, and could be less than the rates charged to commercial payers (Section 11.i.d). However, the

lower that hospital rates are for Medicare Advantage, the greater the need will be to shift costs to commercial payers.

While the rate reductions Maryland expects to experience under the AHEAD model are substantial, this cost-shift is feasible without disproportionate impact to consumers. Modeling demonstrates that a cost shift of $1.3B – representative of Medicare savings, commensurate Medicaid savings, and the anticipated uncompensated care increase – can be absorbed by Maryland commercial payors without increasing commercial rates beyond other commercial payor rates regionally and nationally.

JHHS urges the Regulatory Working Group to prioritize the above considerations and guiding principles as a cost-shifting approach is designed. As Maryland's unique payment model undergoes substantial changes under the AHEAD model, the State must design financially viable solutions and policies that protect access to care for Marylanders. Until these policy issues and unknowns are resolved, it will be challenging for Maryland hospital boards to approve participation; doing so could run counter to a board's fiduciary responsibility. While JHHS is committed to the goals of the model, these unknowns are existential and substantial, posing significant risk not only to financial viability for all Maryland hospitals, but also to access to quality care for Marylanders. JHHS welcomes further engagement in future discussions or stakeholder forums to provide additional feedback, and looks forward to further collaboration on the fundamental components of the AHEAD model that must be defined and clarified in the coming weeks and months.

Sincerely,



Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

November 5, 2025

Meena Seshamani, MD, PhD
Maryland Secretary of Health
Maryland Department of Health
201 W. Preston Street
Baltimore, Maryland 21201

Dear Secretary Seshamani,

On behalf of the Johns Hopkins Health Plans (JHHP), thank you for the opportunity to provide input on a solution for Medicare Advantage (MA) plans in Maryland. JHHP was established in 1995 as the managed care and health services business of Johns Hopkins Medicine, and now serves over 400,000 lives, including 280,000 Medicaid and 13,000 MA beneficiaries in the state of Maryland. JHHP has been strongly advocating for a solution to this issue for several years and greatly appreciates that the Regulatory Working Group has identified MA as an immediate priority. JHHP offers the following comments and feedback in response to the questions outlined by the Regulatory Working Group.

1. **What are the key concerns for MA stability and what approaches should be considered to address those concerns?**

   The Affordable Care Act (ACA) mandated revisions to the MA methodology that did not account for the unique differences in Maryland's rate-setting, and since then MA plans have faced a disadvantage in the Maryland market. Because Maryland counties rank in the top quartile of FFS costs, the MA payment benchmark for these counties is 95% of the FFS costs. As a result, almost all MA plans have exited, or significantly reduced market presence in the state (see Figure 1) due to financial non-viability. The impact to patients and health systems is substantial. Patients have increased premiums and fewer benefits under Maryland MA plans compared to surrounding states (see Figure 2) and lack continuity of care due to lack of continuity of coverage.

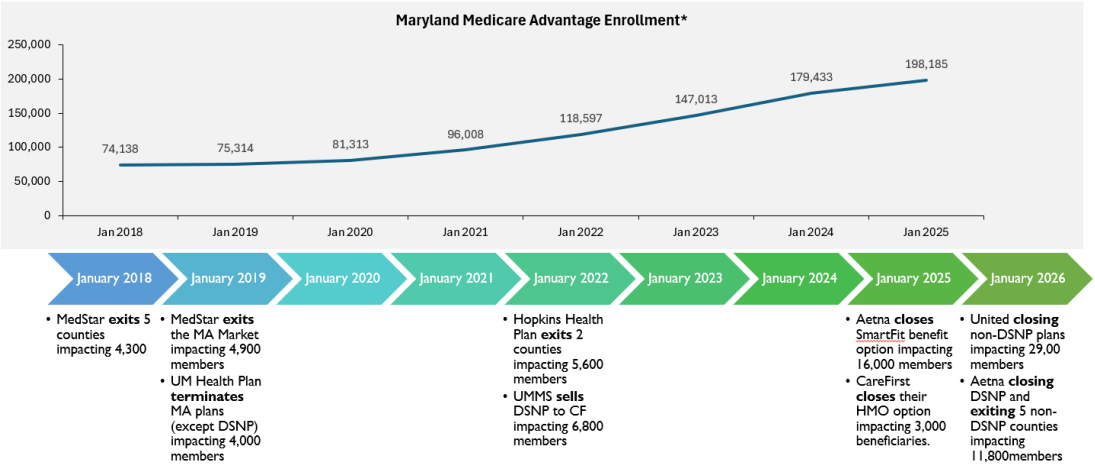



*Figure 1: Maryland MA Market Disruption (CMS MA Enrollment Data, excludes EGWP)*

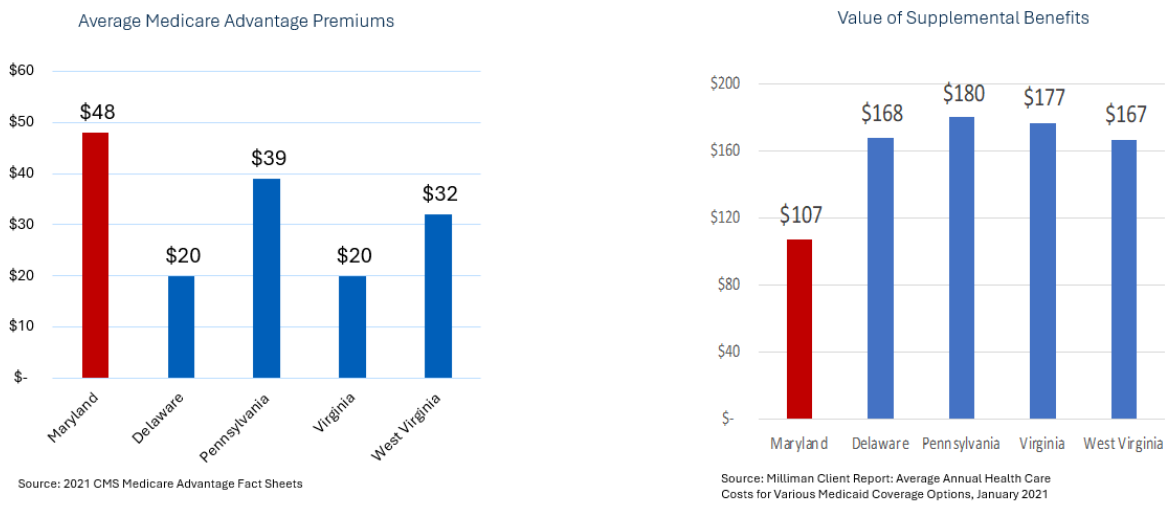



*Figure 2: MA Premiums and Supplemental Benefits in Maryland*

There are several potential solutions to the MA distortion in Maryland, including: a) enhanced funding from the federal government; b) enhanced funding from the state government; c) HSCRC grant program; d) discount to hospital rates; e) differential for commercial payors; or f) redistribution of pricing. Because the amount of funding needed to support MA in Maryland is substantial, the State will likely need to pursue a combination of the above options. Maryland stakeholders are ready and willing to provide feedback and engage in discussion to design a workable solution.

2. **What level of upfront investment would be necessary for MA plans to implement programs?**

The challenge with MA in Maryland is not caused by inadequate upfront investment. If there were long-term gains to be earned through MA, plans would increase their investment in programs. Rather, the issue relates to solving the payment distortion created with ongoing operations of an MA plan in the state of Maryland. JHHP posits that the goal is not to create incentives for upfront programmatic investment, but to make MA plans viable by closing the gap between the financial losses created by the premium distortion and what Maryland MA plans would otherwise be paid if the premium distortion was resolved. If the impact of the premium was neutralized, MA plan benchmarks would be 16% greater and would receive an additional $530M (see Figure 3).

| | | Current[2] | | | | Projected[3] | | | Impact | |
|---|---|---|---|---|---|---|---|---|---|---|
| County | Beneficiaries[1] | Current FFS | Current Quartile | Benchmark | Maryland Premium | Adjusted FFS | Adjusted Quartile | Benchmark | Variance in Benchmark | Total Net Impact |
| | a | b | c | d = b * c | | e | f | g = b * f | h = g - d | k = a * j * 12 |
| ALLEGANY | 2,329 | $1,440 | 95.0% | $1,368 | 21% | $1,136 | 107.5% | $1,548 | $180 | $5,031,164 |
| ANNE ARUNDEL | 14,941 | 1,396 | 95.0% | 1,326 | 19% | 1,129 | 107.5% | 1,501 | 175 | 31,291,160 |
| BALTIMORE | 29,851 | 1,505 | 95.0% | 1,429 | 25% | 1,128 | 107.5% | 1,618 | 188 | 67,374,752 |
| BALTIMORE CITY | 30,795 | 1,610 | 95.0% | 1,529 | 36% | 1,025 | 115.0% | 1,851 | 322 | 118,989,663 |
| CALVERT | 1,902 | 1,313 | 95.0% | 1,247 | 17% | 1,090 | 115.0% | 1,510 | 263 | 5,992,030 |
| CAROLINE | 1,054 | 1,450 | 95.0% | 1,377 | 20% | 1,163 | 107.5% | 1,559 | 181 | 2,292,150 |
| CARROLL | 4,200 | 1,421 | 95.0% | 1,350 | 17% | 1,184 | 100.0% | 1,421 | 71 | 3,582,079 |
| CECIL | 2,886 | 1,427 | 95.0% | 1,356 | 18% | 1,168 | 107.5% | 1,535 | 178 | 6,179,561 |
| CHARLES | 4,690 | 1,356 | 95.0% | 1,288 | 20% | 1,089 | 115.0% | 1,559 | 271 | 15,262,911 |
| DORCHESTER | 1,704 | 1,439 | 95.0% | 1,367 | 19% | 1,170 | 100.0% | 1,439 | 72 | 1,471,469 |
| FREDERICK | 7,218 | 1,347 | 95.0% | 1,279 | 13% | 1,171 | 100.0% | 1,347 | 67 | 5,832,332 |
| GARRETT | 1,438 | 1,162 | 107.5% | 1,249 | 14% | 1,000 | 115.0% | 1,336 | 87 | 1,503,886 |
| HARFORD | 6,514 | 1,475 | 95.0% | 1,401 | 21% | 1,171 | 100.0% | 1,475 | 74 | 5,763,600 |
| HOWARD | 8,233 | 1,304 | 95.0% | 1,238 | 16% | 1,089 | 115.0% | 1,499 | 261 | 25,758,686 |
| KENT | 494 | 1,501 | 95.0% | 1,426 | 21% | 1,180 | 100.0% | 1,501 | 75 | 444,976 |
| MONTGOMERY | 35,289 | 1,261 | 100.0% | 1,261 | 15% | 1,068 | 115.0% | 1,451 | 189 | 80,123,110 |
| PRINCE GEORGE'S | 35,980 | 1,350 | 95.0% | 1,283 | 20% | 1,082 | 115.0% | 1,553 | 270 | 116,602,833 |
| QUEEN ANNE'S | 783 | 1,379 | 95.0% | 1,310 | 18% | 1,125 | 107.5% | 1,482 | 172 | 1,619,236 |
| ST. MARY'S | 2,339 | 1,351 | 95.0% | 1,283 | 19% | 1,099 | 107.5% | 1,452 | 169 | 4,738,615 |
| SOMERSET | 1,233 | 1,331 | 95.0% | 1,264 | 17% | 1,111 | 107.5% | 1,431 | 166 | 2,461,352 |
| TALBOT | 926 | 1,494 | 95.0% | 1,419 | 19% | 1,208 | 100.0% | 1,494 | 75 | 829,800 |
| WASHINGTON | 6,321 | 1,340 | 95.0% | 1,273 | 16% | 1,130 | 107.5% | 1,440 | 167 | 12,704,926 |
| WICOMICO | 3,861 | 1,325 | 95.0% | 1,259 | 16% | 1,112 | 107.5% | 1,424 | 166 | 7,672,232 |
| WORCESTER | 2,014 | 1,372 | 95.0% | 1,304 | 16% | 1,153 | 107.5% | 1,475 | 172 | 4,145,235 |
| Total | 206,995 | 1,405 | | 1,346 | | 1,096 | | 1,559 | | $527,667,757 |

Note 1: Per CMS CPSC enrollment data for July 2025 excluding EGWP and Institional and Chronic Plans

Note 2: Per CMS 2026 Ratebook: Benchmark is not adjusted for star ratings, risk adjustment or actual bid amounts

Note 3: FFS is adjusted to reflected estimate FFS payment reductions and % of assumed hospital costs. The projected quartile is based on 2026 quartile cutoffs.

*Figure 3: Impact of the Maryland Waiver on MA Benchmarks*

**3. What eligibility criteria should be required for MA plans to participate?**

This challenge is unique to Maryland and impacts Maryland plans and patients; because any potential solutions will also operate within the construct of Maryland's unique system, any solutions should also remain local. Provider-sponsored plans and local, community-based plans are the only MA plans that maintain consistent MA presence in Maryland. These plans have demonstrated an ongoing commitment to Maryland's vulnerable populations despite financial challenges, and this commitment should be recognized in the process of designing a solution. JHHP would also note that the success of MA plans relies on quality, Accountable Care Capabilities (ACCs), medical management, etc., which require partnership with provider groups and health systems. Health plans with these local partnerships already in place should be prioritized. To reflect this commitment and prioritization of Maryland MA plans, JHHP proposes implementing criteria to ensure eligibility is limited to local plans.

Finally, solutions should be applicable to the individual MA market only and should not include employer group waiver plans (EGWP).

**4. What other considerations must be addressed, and what is their potential financial impact?**

Member impact and equity should remain at the forefront of any policy discussions around MA. MA is largely a product for low- and moderate-income members who cannot easily afford Medicare supplemental insurance; these communities often consist of minority and disadvantaged populations. A portion of this population receives subsidies from Medicaid, but there is a large portion of this population who do not qualify for a Medicaid subsidy and for whom MA is the only other option for comprehensive affordable coverage.

At the center of the Johns Hopkins Medicine (JHM) mission is a commitment to patients and vulnerable populations. For JHM, it has always been crucial to support patients not only through care delivery, but also through coverage. To this end, as a provider-sponsored plan, JHHP administers government programs in an effort to cover and care for Maryland's most vulnerable populations. JHHP entered into the MA market and has maintained our MA plan because this vulnerable population requires a solution. The cumulative losses that our MA plan has experienced are substantial, but JHHP is encouraged that the State plans to implement an MA policy solution that addresses these losses and creates long-term financial viability. JHHP urges the Regulatory Working Group to take action immediately to prevent further erosion of MA, and looks forward to further collaboration on this issue in pursuit of a solution that Maryland's vulnerable seniors both want and need.

Sincerely,

James P. Holland
President, Johns Hopkins Health Plans

Maryland

**MDH Maryland-Model -MDH- <mdh.maryland-model@maryland.gov>**

# Cost Shifting and Medicare Advantage

2 messages

**Terris King** <terrisk@comcast.net> Tue, Oct 28, 2025 at 11:35 PM
To: MDH Maryland-Model -MDH- <MDH.Maryland-Model@maryland.gov>
Cc: Joshua Sharfstein <Joshua.Sharfstein@gmail.com>

To: Secretary **Meena** Seshamani, MD, PhD
Regulatory Working Group

Thank you for allowing me to participate in this listening session.

As a retired Senior Executive, Center for Medicare and Medicaid Services, I concluded Maryland's Total Cost of Care strategy as inclusive of formalized Community-Based, hospital system partnerships in its most vulnerable, high-cost communities. I was also certain that the vast majority of savings accrued by the Total Cost of Care program were being allocated to underserved communities.

As a current leader of a faith-led comcommunity-based initiative, I now know these formal partnerships are virtually non-existent. Community leaders and representative organizations are often not invited to the decision-making table of major hospital systems when plans impacting the community are being developed.

In addition, most community organizations have a limited understanding of the savings allocation formulas.

Where does the money saved by Maryland during AHEAD go?

Lastly, I haven't seen a plan or a series of evidence based plans identifying how some of the Marand healthcare ecosystem will address chronic diseases within our state and save money through AHEAD with communities.

1. Can Excellent Health Outcomes for All, once known as the Health Equity Index (HEI), developed by the Centers for Medicare & Medicaid Services (CMS), will be used in partnership with Maryland to mitigate cost-shifting and to increase access to chronic disease care. (Bonus for Care of Sickest)

2. Can this process be used to identify and reduce excess capacity in acute care hospitals (Are all hospitals allocated the same number of beds per thousand. And should they be equal). Can savings from excess capacity be used to create more primary care volume and community-based partnerships to manage chronic diseases and reduce readmissions and hospitalizations.

3. Through AHEAD develop policies that determine the percentage and allocations provided to initiatives that focus on social drivers of health. The remaining amount will be used to lower insurance costs and healthcare prices in underserved communities.

4. Should all Maryland healthcare funding, including grants, be used to achieve the saving projections?

5. After making final insurance and AHEAD program decisions, will materials be provided for consumers? Can an advisory group review materials before distribution to ensure clarity?

6: Can support be provided for beneficiaries who face network changes, such as temporary fixes or grants to encourage carrier participation, while a permanent solution is developed?

7. Would a series of summits be helpful for the leadership and community-based organizations of the most vulnerable neighborhoods to inform them of insurance changes, options, Maryland assistance, and AHEAD?

Let me know if I can be of further assistance.

Rev. Dr. Terris King ScD

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**MDH Maryland-Model -MDH-** <MDH.Maryland-Model@maryland.gov> Wed, Oct 29, 2025 at 9:26 AM
To: Terris King <terrisk@comcast.net>
Cc: Joshua Sharfstein <Joshua.Sharfstein@gmail.com>

Good morning Dr. King,

Thank you for your submission. Additionally, we look forward to your participation in this afternoon's listening session. Please be prepared to speak for 3-5 minutes. The session will be recorded.

In the meantime, don't hesitate to reach out with any questions.

Kind regards,
Laura
[Quoted text hidden]

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

October 28, 2025

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

**RE: Comments on cost shifting and Medicare Advantage questions**

Dear Dr. Kromm:

Thank you for the opportunity to provide comment. **Kaiser Permanente requests the opportunity to address the Health Services Cost Review Commission (HSCRC, or the Commission) at the November 5 listening session.**

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for over 825,000 members. In Maryland, we deliver care to approximately 475,000 members.

Our initial thoughts on the Governor's Regulatory Workgroup Questions are as follows:

**Cost-Shifting:**

- **What threshold deficit should be set for cost-shifting?**
  Kaiser Permanente proposes that the HSCRC model several different scenarios and solicit stakeholder feedback. This approach would allow the State and stakeholders to see the impact of a cost-shifting proposal at several levels of cost-shifting. The Maryland Health Benefit Exchange (MHBE) has effectively used this approach when setting and evaluating parameters for the State Reinsurance Program and the State Subsidy Program, which will take effect in 2026 unless Congress acts to extend the enhanced premium tax credits. We recommend the same approach here.

- **How much should be allowed to shift, balancing impact across the healthcare sector (e.g., purchasers, consumers, providers, payers)?**
  The State has been a trailblazer in creating access to affordable health care to protect Maryland's most vulnerable. After the passage of the Affordable Care Act, Maryland was in the first wave of states to expand Medicaid and to build its marketplace: the MHBE. The

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., one of the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 40 hospitals and more than 600 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

legislature has created several programs through MHBE to keep coverage affordable, including the State Reinsurance Program, Young Adult Health Insurance Subsidies Program, and forthcoming State-Based Individual Subsidy Program. The State also established the Prescription Drug Affordability Board to lower prescription drug costs.

In order to maintain that tradition, and as noted above, we recommend that the HSCRC model several scenarios for cost-shifting to make sure the policy balances hospital financial stability with consumer affordability.

- **What is the mechanism for shifting the savings responsibility?**
  We think the public payor differential is the right mechanism.

- **What timeline should be set for shifting?**
  We think cost-shifting should not occur before January 1, 2028 when the AHEAD Model changes are implemented.

- **How should the shifting mechanism be enacted (e.g., statute, executive order, agency policy – which agency or agencies?)?**
  We recommend that a cost-shift be enacted by agency policy at the HSCRC since this gives the greatest flexibility to change the methodology as needed. If the HSCRC uses the public payor differential as noted above, it already has this authority and no further action is needed.

- **What other considerations must be addressed, and what is their potential financial impact?**
  The modeling noted above should include projected increases in uncompensated care and the changes in enrollment across commercial, MHBE, and Medicaid plans due to the impacts of H.R. 1.

**Medicare Advantage Market Stabilization:**

- **What are the key concerns for MA stability and what approaches should be considered to address those concerns?**
  - **Benchmark modification**: As you are aware, low Medicare Advantage (MA) penetration is primarily a result of the technical disconnect in Medicare's methodology for paying MA plans and Maryland's Total Cost of Care (TCOC) Model. This methodology artificially underpays MA plans by not factoring in the unique all-payer hospital model in Maryland, where plans cannot negotiate hospital rates and plan specific utilization reductions do not result in direct cost savings to the plan. The Draft AHEAD Model Terms could include a provision under which the Centers for Medicare & Medicaid Services (CMS) would set the MA benchmarks for each Maryland county as if the Maryland TCOC Model were not in effect. We expect such a change would materially increase the benchmarks in many counties across the state. Under this scenario, MA plans would still be required to meet all CMS actuarial standards as well as the 85 percent Medical Loss

Ratio (MLR) threshold. We believe this is an appropriate bridge to hospital global budgets in the AHEAD Model while the current methodology is in transition.

There is precedent for CMS to modify the methodology used to set MA benchmarks in order to account for unique regional circumstances. For example, for over a decade CMS has made benchmark adjustments for MA plans operating in Puerto Rico due to the low Medicare Part B enrollment in the territory and propensity for individuals with zero claims—factors that distort the utilization and cost data used to set benchmarks. Specifically, CMS bases the MA county rates in Puerto Rico on the costs of individuals in Traditional Medicare who have both Medicare Parts A and B and applies an adjustment to account for the propensity of individuals with zero claims. These modifications have demonstrated success in stabilizing and improving the MA market for beneficiaries. We believe similar types of adjustments to benchmarks in Maryland are warranted and could prove effective.

- **State Affordability Program**: To continue to keep coverage accessible and affordable for all Marylanders, the state could establish its own program focused on protecting access to MA. In recognition of the challenges experienced by MA plans in Maryland due to the national benchmarking methodology, the State of Maryland has historically provided stabilization funding to MA plans as the industry pursues a long-term solution with CMS. In 2020, the HSCRC created a grant program for MA plans and in 2022 and 2023 the Maryland General Assembly provided additional funding. We propose that the HSCRC reestablish the grant program for 2026 to stabilize the MA market. This approach would provide a bridge as a more permanent solution is sought.

- **What level of upfront investment would be necessary for MA plans to implement programs?**
  Kaiser Permanente's Maryland MA plan lost $186 million in 2024. While we are committed to the market, we need a solution that supports our long-term viability. We welcome the opportunity to discuss what upfront investment is needed in further detail.

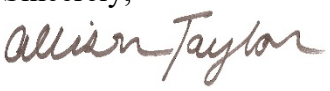
- **What eligibility criteria should be required for MA plans to participate?**
  All MA plans should have the opportunity to participate, and we support a requirement that a plan commit to implementing specific population health initiatives in order to receive any targeted funding.

- **What other considerations must be addressed, and what is their potential financial impact?**
  MA plans need a decision from the State in early 2026 in order to coordinate with CMS on any changes to the benchmark methodology and to support planning for 2027 bids.

* * *

Thank you for the opportunity to comment. Please feel free to contact Allison Taylor at Allison.W.Taylor@kp.org or (919) 818-3285 with questions.

Sincerely,



Allison Taylor
Director of Government Relations
Kaiser Permanente

The League of Life and Health Insurers of Maryland

15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

October 10, 2025

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

**Re: Recommendations from Carriers on Governor Moore's Interagency Workgroup**

Dear Executive Director Kromm:

The League of Life & Health Insurers of Maryland is the state trade association representing life and health insurance companies in the State. We are writing to add our recommendations to the Health Services Cost Review Commission (HSCRC) on items we would collectively like to see included during Governor Moore's interagency workgroup.

The Maryland Model has succeeded for nearly 50 years on the basis of all-payer rate setting. The model has created financial stability for hospitals and has kept rates affordable for consumers because the HSCRC has governed the model under a robust set of financial targets imposed by the federal government in exchange for the ability to set Medicare rates. Once all-payer rate setting is lost in 2028, the HSCRC will need a new governing paradigm. Our members believe that the State should make the following changes:

1. The State should set a clear, objective, and fair limit on HSCRC update factors. For example, the State could build on the all-payer hospital growth rate test in the existing Model and limit hospital cost growth to the growth rate in gross state product. This test should be rebased and evaluated annually.

2. The State must create greater predictability for consumers. Premiums are set for a 12-month contract period. Historically, the HSCRC has made a single rate adjustment at the start of the fiscal year. However, over the past 24 months, the HSCRC has made a number of 'off-cycle' rate increases. Due to their unexpected nature, these rate increases cannot be reflected in premiums, and their frequency has begun to jeopardize the stability of the insurance market. The State should delay the implementation of approved hospital rate increases by a minimum of 6-12 months to allow payers to accurately reflect costs in premiums. This would contribute to market stability.

3. The State must correct the discontinuities between the Model and the Medicare Advantage payment system. The State has already calculated that the Model has lowered Medicare Advantage plan revenue by about 5 percent. The consequence is that the Model has denied

Maryland residents access to zero-premium Medicare plans and supplemental benefits that has become the norm across the country. This problem has been discussed for more than half a decade. And yet the State has failed to correct the problems created for Medicare Advantage plans in the Total Cost of Care Model negotiations, the first AHEAD Model negotiation, and the second AHEAD Model negotiation. As a result, more than 100,000 Maryland residents are expected to lose their current Medicare Advantage Plans when they expire at the end of 2025. Frankly, Medicare Advantage beneficiaries do not need another workgroup. They need a solution.

League members believe that the HSCRC should include a standing agenda item at Commission meetings and workgroups to update Commissioners and stakeholders on the status of conversations with CMMI as well as accept written comments. The HSCRC should also provide and periodically update projections on how much savings will be needed each year. This would create value and transparency into one of the Governor's charges: prioritizing policy changes regarding cost shifts that may be necessary to meet the negotiated Medicare savings requirements.

On behalf of the health plans operating in Maryland and supporting Maryland residents, we are very grateful for your attention on this matter. If you have any questions or would like to speak with us further on these topics, please reach out to me at mcelentano@fblaw.com.

Very truly yours,

Matthew Celentano
Executive Director

CC:
Fagan Harris, Chief of Staff to Governor Moore
Jonny Dorsey, Deputy Chief of Staff to Governor Moore
Senator Bill Ferguson, President of the State Senate
Delegate Adrienne Jones, Speaker of the House of Delegates
Senator Pamela Beidle, Chair of the Senate Finance Committee
Delegate Joseline Pena-Melnyk, Chair of the House Health & Government Operations Committee

Maryland

**MDH Maryland-Model -MDH- <mdh.maryland-model@maryland.gov>**

## Comment

**peter mattes** <mattesinsurance@yahoo.com>
To: mdh.maryland-model@maryland.gov

Tue, Oct 28, 2025 at 2:15 PM

The COVID-19 pandemic led to sweeping expansions of government health insurance subsidies under the Affordable Care Act. While these measures helped families through a crisis, their continuation has created fiscal strain and weakened accountability. It is time for states and the federal government to restore pre-pandemic standards for health insurance subsidies, including rigorous income verification and stronger employer responsibility. During COVID-19, relaxed income verification rules allowed many to receive subsidies without proper documentation. As the economy recovers, maintaining these leniencies risks misuse and inefficiency. Reinstating clear verification—through tax returns or pay statements—will ensure that assistance goes only to those who truly qualify. At the same time, large employers with over 50 full-time employees must again bear their share of responsibility. The intent of the Affordable Care Act was to balance coverage between public programs and employer-provided insurance. However, expanded subsidies have enabled some companies to shift employees onto government plans, transferring private costs to taxpayers. Restoring pre-COVID subsidy levels would reestablish the proper balance of accountability. Health care accessibility is a public good, but it must be managed with fiscal prudence and fairness. Pandemic-era expansions were temporary by design, not a permanent shift in policy. Returning to pre-COVID structures—verifying income, controlling spending, and reaffirming employer obligations .

Thank you,
Peter G Mattes, MAS
Mattes Insurance & Financial Services, LLC

November 4, 2025

Health Services Cost Review Commission
AHEAD Regulatory Working Group
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear HSCRC AHEAD Regulatory Working Group,

Thank you for the opportunity to submit public comments on the need for cost-shifting policies and policies for Medicare Advantage stabilization. Maryland Citizens' Health Initiative is a consumer advocacy nonprofit with a mission to advocate for policies that further access to quality, affordable health care for all Marylanders. Our Maryland Health Care for All Coalition is the largest health consumer advocacy coalition in Maryland and is comprised of hundreds of faith, business, labor, community, and health care organizations across the state. We are proud to have a history of collaborating with the HSCRC, as our president, Vincent DeMarco, chaired the HSCRC Consumer Outreach Task Force which helped communicate and gather feedback from communities around the state when Maryland's hospital system switched to global budgets, and our staff and Board members have served on HSCRC work groups.

Under Maryland's all-payer hospital system, consumers have benefited from increased access to hospitals and clinicians and better price transparency. The system has simplified negotiations between insurers and health systems. Maryland's HSCRC has also been able to create an uncompensated care pool for the uninsured. As you consider the new AHEAD model agreement with the federal government, we urge you put as your top consideration how to best protect Marylanders from the potential threats of skyrocketing health insurance premiums, decreasing access to hospitals and clinicians, and increasing health inequity. Marylanders have benefited from the simplicity of each payer paying the same amount for the same service within a hospital. We are fortunate in Maryland to have the HSCRC and urge the workgroup to retain as much from the Total Cost of Care Model as possible that had the greatest positive impact to consumers. As you consider communication strategies to the public we encourage you to do robust message testing to ensure the information is understandable and to work with trusted messengers to spread the word. Thank you very much for your leadership and attention to protecting consumers.

Sincerely,

Stephanie Klapper
Maryland Citizens' Health Initiative
Deputy Director

Jessie Haviland
Maryland Citizens' Health Initiative
Social Work Fellow

MedChi

*The Maryland State Medical Society*
1211 Cathedral Street
Baltimore, MD 21201-5516
410.539.0872
Fax: 410.547.0915
1.800.492.1056
www.medchi.org

November 14, 2025

*Sent via email: mdh.maryland-model@maryland.gov*
The Honorable Meena Seshamani
Secretary
Maryland Department of Health
201 West Preston Street
Baltimore, Maryland 21201

RE: State Regulatory Workgroup – AHEAD Model – Cost Shifting Policies

Dear Secretary Seshamani and Members of the Regulatory Workgroup:

On behalf of our physician members, MedChi, The Maryland Medical Society, appreciates the opportunity to share our concerns regarding cost-shifting policies under the AHEAD Model. We applaud the State for scheduling these sessions to gather input on these critical topics.

Our foremost concern will always be to ensure that, in managing costs and growth, patients and physicians do not bear the unintended consequences of these policies. Specifically, we are concerned that efforts to limit the total cost of care could lead to even lower commercial insurance payments and/or increased burdens of utilization reviews, as insurers attempt to offset lower payments from public payers. Such downstream effects would continue to threaten the viability of physician practices and patient access to care.

According to the Maryland Health Care Commission's (MHCC) draft report on *Insurer and Provider Concentration in Maryland*, the State's health insurance market is already highly concentrated, with one carrier controlling 78.3% of the small group market share and 65.3% of the individual market share. This level of market dominance has translated into some of the lowest negotiated commercial payment rates in the country. The MHCC draft report identifies Maryland's commercial payment rates as the third lowest nationally, exceeded only by those of Delaware and Alabama. Equally concerning is the rapid decline in independent physician practices across Maryland. Between 2018 and 2023, the State experienced a 45.9% decrease in independent physician practices, a trend that reflects declining payment rates, increasing administrative burdens, and consolidation pressures. If physician practices continue to close or if Maryland cannot attract physicians to practice in the State, the State risks losing access to necessary healthcare services, a reality that has already been evident, given the absence of some specialties

in certain areas and long wait times for appointments. Access to care for patients will continue to suffer and potentially worsen if economic pressures continue to squeeze physicians' ability to maintain viable practices in Maryland.

MedChi urges policymakers to ensure that the implementation of AHEAD does not exacerbate these market dynamics. Strong guardrails must be established to prevent insurers from continuing to shift costs to physicians. The risk of further diminishing healthcare access to Maryland citizens cannot be tolerated. The success of the AHEAD Model must support the sustainability of physician practices across all specialties and settings to ensure optimal patient access to care.

Sincerely,

Eric Wargotz MD

Eric Wargotz, M.D., FCAP
President

Maryland
Hospital Association

November 4, 2025

Meena Seshamani, M.D., Ph.D.
Secretary, Maryland Department of Health
Herbert R. O'Conor State Office Building
201 West Preston Street
Baltimore, MD 21201

**Re: AHEAD Regulatory Working Group – Cost-Shifting Policy**

Dear Secretary Seshamani,

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, thank you for the opportunity to comment on the cost-shifting policy that the multi-agency Regulatory Working Group is developing. There are many policy issues related to the forthcoming transition to the AHEAD Model and the impact of H.R.1 that need to be addressed, and we appreciate the state's prioritization of this policy issue given its vital importance for our health system and communities.

Of all the important policy issues the Working Group has been charged with tackling, cost shifting is perhaps the most pressing. Maryland hospitals are being asked to execute legal agreements with the Centers for Medicare & Medicaid Services (CMS) committing them to participate for a decade in the AHEAD Model at a time when a significant amount of uncertainty remains regarding the financial methodologies under the Model. It is critical that the state has a clear policy framework for cost shifting in place before the AHEAD Participation Agreement signature deadline.

A responsible cost-shifting policy is in the best interest of the state, Marylanders, and the entire health care system. Maryland must adopt a policy that allows for necessary rebalancing of costs across the system to support Marylanders' access to essential hospital services, the financial stability of hospitals, and the state's success under AHEAD. We urge the Regulatory Working Group to consider the following comments as it develops its proposal for the Governor in the coming weeks.

**Guiding Principles for Cost Shifting**

MHA and its member hospitals identified several guiding principles to serve as the foundation for the Working Group's cost shifting policy framework and methodology.

*The cost-shifting policy framework and methodology must*:

1. Enable hospitals to maintain the level of services they currently provide, address unmet needs in their community, improve population health, and achieve financial stability to support these objectives
2. Ensure the burden of lower contributions from public payers (Medicare FFS, Medicare Advantage, and Medicaid) is not borne solely by hospitals given the limited opportunity to generate savings through reduced hospital utilization
3. Strive for balance between access to care for communities and affordability for employers and consumers
4. Advance an approach to cost shifting that can increase commercial revenue to fully offset the reduction in payments from public payers
5. Allow for incremental cost shift increases corresponding with lower contributions from public payers
6. Use a methodology that provides predictability and sufficient flexibility to respond to changing conditions
7. Exclude the cost-shifting policy adjustment from the all-payer hospital revenue growth limit

**Stable Hospitals Are Critical to Communities**

As the state plans its cost-shifting approach, it is important to consider the more than 5 million people who are cared for at hospitals each year. From delivering 65,000 babies to treating about 1.1 million in emergency departments, hospitals are caring for Maryland 24/7/365. No Marylander is turned away due to inability to pay, including some 358,900 uninsured and even more underinsured Marylanders. Hospitals provide life-saving interventions for emergencies (e.g., injuries, trauma, stroke, heart attack), deliver high-quality care for acute illnesses and injuries, manage complex conditions using advanced technology and specialized expertise, and ensure smooth transitions to post-acute or rehabilitation care for recovery. These services are especially critical for areas of the state where there are limited options for health care services.

Additionally, hospitals are leading interventions to promote healthy lifestyles through campaigns on nutrition, exercise, and smoking cessation. To support healthy communities, hospitals provide screenings and early detection for chronic diseases like diabetes and cancer. For patients impacted by social drivers of health, hospitals are addressing housing, food security, and transportation and partnering with organizations to support underserved and at-risk populations. In addition, hospitals are leading vaccination drives and public health initiatives to prevent disease outbreaks.

In addition to the acute care and community wellness role that hospitals play, hospitals are also economic hubs of their communities. As major employers, hospitals directly and indirectly employ over 223,000 Marylanders and contribute $35 billion in economic impact every year. The cost-shifting policy will not only affect access to health care services but will have implications on the economic viability of communities around the state.

**The Pressing Need for Cost Shifting**

Maryland hospitals are confronting substantial reductions in payments from public payers as a result of the forthcoming transition to AHEAD while marked declines in Medicaid and Marketplace enrollment due to changes in the federal policy landscape are looming. Together these policy changes not only have the potential to weaken the financial stability of hospitals but are also likely to cause an influx of sicker patients who require more emergency services. Cost shifting will help mitigate the effects of these hurdles on hospitals and communities across the state.

*Significant Reductions in Payments under AHEAD*

Under the renegotiated terms of the AHEAD Model, Maryland is expected to achieve $460 million in Medicare savings through progressively greater annual savings targets between 2026 and 2033. Though these savings requirements pertain to spending on a total cost of care basis, the AHEAD State Agreement memorializes CMS' intent to ensure these targets are met through reductions to Medicare hospital global budget payments. These savings are projected to result in corresponding reductions in hospital payments from Medicaid and Medicare Advantage, which taken together with the Medicare savings, amounts to a total hospital payment reduction of $855 million over the next seven years. This increased savings requirement on the state, however, cannot be borne exclusively by hospitals as noted in Governor Moore's Sept. 23 directive establishing the Working Group.

*Limited Opportunities to Reduce Hospital Utilization*

Medicare total cost of care savings under AHEAD can be driven by three primary mechanisms: (1) reductions in Medicare hospital global budget payments, (2) reductions in nonhospital or out-of-state hospital utilization, and (3) movement of care to lower-cost, nonhospital settings. Maryland hospitals have achieved significant reductions in avoidable utilization under the All-Payer and Total Cost of Care models through care transformation, population health initiatives, and community partnerships, so the opportunities for further utilization reduction without compromising access or quality are now limited. According to a recent HSCRC analysis, per-capita hospital utilization in Maryland decreased by 10% between 2013 and 2023 after accounting for changes in the demographics of the population, compared to a 3% increase in hospital utilization nationally over the same period. The state cannot sustain a health care system that relies on further reducing hospital utilization to meet savings goals, especially given we expect an increased demand for hospital services as the population grows and ages.

*Reduced Enrollment and Increased Uncompensated Care*

Maryland's Medicaid program, which serves more than 1.5 million residents, including 331,000 adults covered through the ACA expansion, faces significant risks under provisions of H.R.1 (OBBBA). Provisions such as federal work requirements, stricter renewal processes, immigrant eligibility restrictions, and reduced retroactive coverage could cause 175,000 to 235,000 Marylanders to lose coverage between FY 2027 and FY 2028, representing a 12% to 15% decline in enrollment. These provisions would also reduce federal Medicaid funding by up to $2.7 billion annually and cut hospital Medicaid payments by $5.5 billion over the next decade, according to an estimate from the Maryland Department of Health (MDH). Medicaid coverage losses, coupled with the expected decline in Marketplace enrollment due to the anticipated loss

of federal enhanced premium tax credits, will result in greater use of emergency departments for non-emergent care needs and higher levels of uncompensated care across the state—two issues the state and Maryland hospitals have worked so hard to address in recent years. Without coverage, Marylanders may delay or forgo necessary care altogether, which will adversely affect health outcomes and lead to higher long-term health care costs.

Increases in uncompensated care will exacerbate the financial strain hospitals are experiencing due to substantial and persistent cost pressures associated with inflation, payer denials, and physician costs, and steep increases in technology and drug costs, while the aging population and increasing prevalence of chronic disease are expected to drive higher utilization and costs. These challenges directly affect care quality and jeopardize the ability of hospitals to sustain essential services and respond to the growing needs of their communities. Moreover, they have left hospitals resource constrained at a time when they need to be strengthened to maintain access, drive population health improvements, and continue to deliver high quality care under AHEAD.

**Market Capacity for Cost Shifting**

MHA and Maryland hospitals are committed to ensuring health care coverage and services are both accessible and affordable to Marylanders. A reasonable increase in commercial reimbursement and premiums over time would allow the state to remain competitive on affordability, provide predictability for payers, and maintain the hospital infrastructure that preserves access to timely and necessary health care for our communities.

*Commercial Hospital Reimbursement*

Maryland has achieved more than $650 million in cumulative Medicare TCOC savings through CY 2024 while improving quality, reducing unnecessary utilization, and expanding access to care. Although these savings have been primarily driven by significant reductions in hospital expenditures, they have historically accrued to the benefit of commercial payers, not hospitals and health systems. Furthermore, under the All-Payer and TCOC Models, Maryland hospital cost growth has been limited to 3.58% annually, well below the national hospital cost growth rate of 4.8% over the last decade. Commercial hospital reimbursement rates have remained comparatively low while hospitals have absorbed rising costs and federal payment constraints. As the state transitions to the AHEAD Model, it is necessary for commercial payers to share the responsibility of preserving access by maintaining the financial stability of the hospitals that serve Marylanders.

MHA believes that cost shifting is both affordable and manageable. Our preliminary analysis indicated that the average commercial hospital reimbursement rate in Maryland in FY 2024 was approximately 178% of Medicare fee-for-service rates. We modeled the increase in commercial revenue necessary to fully offset the $460 million Medicare TCOC savings requirement under AHEAD and corresponding reductions in hospital payment from Medicaid and Medicare Advantage, which amounts to a total reduction of $855 million. This modeling suggests that even after applying a full cost shift that accounts for the reduction in payments from public payers,

average commercial hospital reimbursement rates in Maryland would still be well below regional benchmarks according to Milliman (250%) and RAND (324%).[1,2]

It is important to note, however, that this estimated increase in commercial hospital reimbursement rates does not account for other factors that should be considered in determining the appropriate level of cost shifting. These include the lower inflationary adjustment and other revenue adjustments applied under CMS' methodology for Medicare hospital global budget payments or the aforementioned impacts of H.R.1. Nonetheless, the comparison to national reimbursement rates demonstrates that the market can support an increase at this level.

*Impact on Commercial Insurance Premiums*

The estimated impact on commercial insurance premiums would be limited given hospital costs represent a fraction of total premiums. A gradual increase in reimbursement rates over the next seven years would result in a modest increase in premiums that the market can support and that is justified to preserve access to essential hospital care. In fact, according to data from the Kaiser Family Foundation (KFF), the average annual premium for an individual enrolled in an employer-sponsored commercial insurance plan in Maryland in 2023 was $7,870, 4% less than the United States average and less than other states in the region including Pennsylvania (3%), Virgina (3%), West Virginia (10%), New York (17%), and New Jersey (23%), as well as the District of Columbia (11%).[3]

**Preserving Access & Improving Health for the Future**

Implementation of the state's cost-shifting policy will have direct consequences for access preservation and quality of care. Without the ability to rebalance payment reductions from public payers, Maryland hospitals will experience resource constraints and financial conditions that could limit service availability, reduce responsiveness to community needs, and constrain necessary investments in population health initiatives. The result will be diminished access to timely and essential hospital care.

In recent conversations about the current environment, hospital leaders from across the state have expressed their desire to continue to meet the full range of acute care needs of the communities they serve. They have also expressed concerns about forthcoming changes further straining operating budgets and limiting resources to a point where they may need to consider scaling back certain services and programs or eliminating them altogether. Behavioral health services, obstetrical services, cardiology services, and other subsidized community programs that generate limited revenue but provide a critical public health benefit are among those services at risk. These reduced offerings would be most likely to affect our neediest communities as they are generally served by hospitals with a greater proportion of Medicare and Medicaid patients (higher public payer mix).

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[1] Milliman, 2024. White Paper – Commercial Reimbursement Benchmarking, available here
[2] RAND, 2024. Prices Paid to Hospitals by Private Health Plans, available here
[3] Kaiser Family Foundation, 2024. Average Annual Single Premium per Enrolled Employee For Employer-Based Health Insurance, available here; based on the Medical Expenditure Panel Survey (MEPS)

Significant financial pressures will also make it increasingly difficult for hospitals and health systems to invest in the population health, preventive health, and chronic disease management initiatives central to the state's success under AHEAD and necessary to continue meaningful progress in reducing overall health care costs and improving the health and wellbeing of all Marylanders. The ability of hospitals to engage in these vital investments depends on their financial health and sustainability.

An important feature of our all-payer model has been to maintain equitable access to health care services for all Marylanders and avoid the two-tiered system where uninsured and underinsured patients can only receive services from safety-net hospitals. A framework for cost shifting is essential to maintain this environment of equitable hospital access and support the economic viability of the communities hospitals serve.

**Conclusion**

Thank you for your leadership during this transition. A successful transition from the long-standing all-payer system requires a balanced cost-shifting policy to safeguard access to care, maintain affordability, and facilitate the state's success under the AHEAD Model. We look forward to continuing to engage with the Regulatory Working Group on this important issue and others over the coming weeks and months.

Sincerely,

Melony G. Griffith
President & CEO

cc: Perrie Briskin, Medicaid Director, Maryland Department of Health
Michele Eberle, Executive Director, Maryland Health Benefit Exchange
Marie Grant, Commissioner, Maryland Insurance Administration
Dr. Douglas Jacobs, Executive Director, Maryland Health Care Commission
Dr. Elizabeth Kromm, Assistant Secretary, Maryland Department of Health
Dr. Jon Kromm, Executive Director, Health Services Cost Review Commission
Laura Goodman, Associate Director, Health Services Cost Review Commission

National Association of Benefits and Insurance Professionals
NABIP
Maryland Chapter
PO Box 4593, Lutherville, MD 21094

October 27, 2025

Maryland Insurance Administration
Marie Grant, Commissioner
200 St. Paul Street, #2700
Baltimore, MD 21202

RE: Listening Session October 29, 2025 on AHEAD Model and Medicare Advantage Market

Dear Commissioner Grant,

As President of the National Association of Benefits and Insurance Professionals of Maryland (NABIP MD) in response to the request from Governor Moore's working group to achieve the objectives of the State under the AHEAD model, I respectfully offer the following comments on the subject of the Medicare Advantage market.

While the Q&A on Medicare Advantage seeks market stabilization in this area, its focus is 'a need for financial support to stabilize the market.' NABIP MD agrees; however, we wish to advise the working group of a market development that is not addressed in the discussion of this subject. That is a relatively new practice by certain Medicare Advantage insurers of removing producers compensation for representing consumers in the procurement of Medicare Advantage products.

Since its introduction many years ago, navigation of the Medicare Advantage market by consumers has become much more complicated. Consumers must identify their preferred providers for different health care needs. Similarly, with respect to pharmaceutical coverage, consumers must review their prescriptions (often a lengthy list) and identify insurers that offer the best combination of cost and coverage. These consumers are not sophisticated purchasers of health care, and they need knowledgeable and experienced guidance, which is often provided in the form of licensed health insurance producers in the State.

NABIP MD recognizes the limitations of State law in addressing the Medicare Advantage market, and we are not seeking any kind of commission or compensation mandate at this time. At the same time, we hope the working group understands that health insurance producers cannot provide their services without compensation, and that a fee-based arrangement is simply unworkable in this market.

We wish only to advise the working group that the absence of health insurance producers who serve their clients in the analysis and selection of Medicare Advantage plans will not inure to the benefit of Maryland citizens who wish to consider Medicare Advantage for their health care needs.

A number of our members have expressed concern about this development, and I expect them to participate in your listening session on October 29th. Please know that these licensed Maryland insurance producers have considerable experience representing consumers in this complex insurance market, and our members who will join your listening session can provide specific examples of the services that consumers need for making informed decisions.

Respectfully,

Melissa Coles

Melissa Coles, President
410-935-5705 (cell)

Secretary Meena Seshamani
Maryland Department of Health
Herbert R. O'Conor State Office Building, 201 West Preston St.
Baltimore, Maryland 21201

Dear Secretary Seshamani and Members of the Regulatory Working Group,

We write to you as members of the Health Means Everything Coalition, focused on affordable, high-quality care for Marylanders. The coalition recently formed to advocate for greater transparency, accountability, and equity in the state's healthcare system on behalf of consumers, particularly amid ongoing state and federal transitions, such as implementation of the AHEAD (Achieving Healthcare Efficiency through Accountable Design) Model and decisions regarding the Medicare Advantage program. The coalition members include grassroots organizations, businesses, public health experts and others interested in a healthcare system for Marylanders that keeps people healthy and prices affordable.

Our recommendations focus on cost-shifting and Medicare Advantage stabilization, as both topics are essential for consumer affordability. **Our chief concern** is avoiding policies that result in Maryland residents bearing the financial burden of preserving hospital budgets, given that residents traditionally have no direct voice in these conversations.

## COST SHIFTING

- The guiding light of the working group must be to ensure Marylanders' ability to access and afford the health care services they need
- While the Maryland model has historically met its savings target, Maryland families and businesses are overburdened with health care costs. When health care becomes unaffordable, health outcomes suffer as people avoid seeking routine care.
    - Nearly half of Marylanders reported delaying or skipping care due to cost.[1]
    - 82% reported being worried or very worried about affording medical costs from a serious illness or accident.[2]
- Health Means Everything is concerned that a higher Medicare savings target coupled with the new federally led Medicare hospital global budget methodology will result in

[1] https://healthcarevaluehub.org/wp-content/uploads/MD_CHESS_Infographic_Oct_22.pdf

[2] https://healthcarevaluehub.org/wp-content/uploads/MD_CHESS_Infographic_Oct_22.pdf

higher out-of-pocket spending for Maryland's working families and higher cost liabilities for Maryland's employers.
    - As health care providers, purchasers, payers, and other stakeholders seek to constrain overall health care spending, they may pass on an increasing proportion of service costs to consumers.
- Governor Moore's September 23, 2025 letter to Secretary Seshamani identified policies related to cost shifting across health insurance markets as a central focus of this working group. However, those policies should be understood in the context of the broader goals of the AHEAD model, which are to adopt prudent total cost of care goals for purposes of increasing savings and improving outcomes.
- We interpret these goals and Governor Moore's directive to mean that costs that would otherwise be paid by Medicare should not simply be shifted to other payers. Instead, the state should set policy guardrails that prevent hospital global budgets and hospital service payment rates from deviating too far from those established by Medicare. In other words, the state should prevent Medicare Advantage, Medicaid, and commercial rates from rising above or dropping below certain thresholds. Moreover, those thresholds should be set relative to their ultimate impact on costs to the consumer via premium increases, out of pocket cost sharing, etc.
    - Without these types of guardrails in place, health care prices may increase for families enrolled in these different markets. Those prices are passed on in the form of health insurance premiums, deductibles, copays, etc.
    - The goal of the AHEAD model is to drive statewide health transformation that ultimately enhances preventive care and chronic disease management to achieve better population health outcomes and lower total health care spending. This kind of transformation requires improved access to primary care, greater utilization of care in low-cost ambulatory care settings, and will reasonably reduce the acute care capacity in the state. These are positive outcomes for Maryland families, who have seen their health care premiums rise due to increasing hospital rates (among several other factors).
- Policies adopted by the workgroup should facilitate this health system transformation instead of seeking to maintain the status quo.
- The status quo isn't working for Maryland families.

## MEDICARE ADVANTAGE MARKET STABILIZATION

- A competitive Medicare Advantage market is key for ensuring affordable health care coverage for Maryland seniors. However, Medicare Advantage offerings in Maryland are shrinking, forcing seniors to regularly change health plans or absorb the higher-cost, less generous coverage of traditional Medicare.

- Around 25% of Maryland Medicare recipients utilize Medicare Advantage. In most states, at least 50% of Medicare recipients utilize Medicare Advantage.[3]
    - According to CMS' most recent MA penetration data, Maryland counties average 23 percent.[4]
- Maryland has fewer Medicare Advantage options in comparison to many other states. Additionally, the Medicare Advantage market in Maryland is more expensive than most other states
    - In 2024, Maryland ranked 39th out of all 50 states in total number of MA plans available, with only 35 plans.[5]
    - Moreover, of that list of 11 states with the lowest number of MA plans, Maryland has more than double the eligible MA population (1.1 million) of the state that it is tied with, Utah (475,000). This highlights the disparity in available options between Maryland's Medicare beneficiaries and the other similarly situated states.
- Maryland is seeing reductions in Medicare Advantage moving into 2026
    - Seniors have begun receiving notices that their plans will not be offered in the coming years
    - Reporting indicates that many insurers are leaving or reducing their presence in the market
        - Aetna: Shrinking its coverage to only 3 counties for 2026 (Frederick, Harford, Montgomery)[6]
        - Humana: Entirely exited one of its plans. Another plan, Humana Gold Plus SNP, will no longer be available in Anne Arundel county, Baltimore county, Harford county, Howard county and Baltimore City beginning

[3] https://www.kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population-by-plan-type/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[4] https://www.kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population-by-plan-type/?currentTimeframe=0&selectedRows=%7B%22counties%22:%7B%22maryland%22:%7B%22all%22:%7B%7D%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[5] https://www.kff.org/medicare/state-indicator/plans-by-plan-type/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%20Number%20of%20Medicare%20Advantage%20Plans%22,%22sort%22:%22desc%22%7D

[6] https://marylandmatters.org/2025/10/13/thousands-of-maryland-seniors-notified-of-the-end-of-their-medicare-advantage-plans/

January 1, 2026 (these are some of the most populated areas in Maryland).[7]

    - Over 100,000 Maryland Residents are set to lose their Medicare Advantage Plans at the end of 2025 if they don't enroll in a new plan by December 31st.[8]
- This isn't an uncommon occurrence in the state --- in 2021 Advantage MD reduced its service area, resulting in 6,000 seniors being cut from MA plans.[9]
- **It is clear that Maryland's MA market is lacking in both competition and consumer choice. Health Means Everything is concerned that these failures are driving up costs and worsening health care access for Maryland's seniors.**
- With continued dysfunction, consumers may feel forced into Traditional Medicare, where they would see higher out of pocket costs and lose coverage for key services that they had under their Medicare Advantage plan. A healthier Medicare market would be beneficial to Maryland consumers by providing consistent, lower cost health coverage options that meet their unique health care needs.
- HSCRC's actions have in the past, and may continue to have, a negative impact on the MA market in Maryland. Maryland has some of the highest Medicare fee-for-service costs in the nation. This includes some of the highest rates for hospital services as set by the HSCRC. Normally this wouldn't be a problem if the federal government reimbursed MA plans proportional to FFS costs. However, the MA program is structured precisely in the opposite way – the MA program sets lower benchmark goals for MA plans to meet in the highest cost areas as a means of breeding competition among the best plans for savings. Maryland leads in this dynamic and MA plans have not been able to crack the code of high FFS costs coupled with intentionally lower reimbursement by CMS, forcing them to make up the difference.
    - The HSCRC has previously dismissed the argument by saying that MA penetration in other similarly costly areas remains higher.[10] However, that assessment didn't take into account the unique reality that nearly all of Maryland is in the highest cost range – something that even California cannot claim.

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[7] https://marylandmatters.org/2025/10/13/thousands-of-maryland-seniors-notified-of-the-end-of-their-medicare-advantage-plans/

[8] https://marylandmatters.org/2025/10/13/thousands-of-maryland-seniors-notified-of-the-end-of-their-medicare-advantage-plans/

[9] https://www.baltimorebrew.com/2021/10/20/johns-hopkins-to-drop-its-medicare-supplement-plans-for-baltimore-city-residents/

[10] https://hscrc.maryland.gov/documents/ma%20landscape%20and%20grant%20program%20final.pdf

- Health Means Everything recognizes and appreciates that the state has previously implemented a grant program to support Medicare Advantage offerings in the state. However, this was a temporary solution that has not led to sustainable and equitable Medicare Advantage access
- Medicare Advantage Stabilization policies should align with the goals of the AHEAD model, centering better health outcomes and lower total health care costs.
- **The Health Means Everything Coalition suggests that the state leverage its AHEAD agreement with CMS to address the misalignment between Medicare Advantage rate setting and the Maryland/AHEAD model. Targeted changes to the MA rate-setting process in Maryland could meaningfully improve plan offerings for Maryland seniors and ultimately support the state's success in the AHEAD model by improving health outcomes.**

We will continue to follow issues like the new Medicaid work requirements, preserving access to Medicare Advantage, and implementation of Maryland's AHEAD Model, and look for places where consumer perspectives might benefit policymakers in the healthcare arena. Above all else, we will seek to platform residents and community advocates in these conversations, to make sure everyday Marylanders are not called on to subsidize multibillion dollar industries.

Thank you for your time and consideration. We look forward to working with you on behalf of Maryland families.

Sincerely,

Charly Carter
Founder, Step Up Maryland
Member, Health Means Everything

UNIVERSITY of MARYLAND MEDICAL SYSTEM

**Mohan Suntha, MD, MBA**
**President and Chief Operating Officer**
**University of Maryland Medical System**
**The Marlene and Stewart Greenebaum Professor of Radiation Oncology**
**University of Maryland School of Medicine**

**250 W. Pratt Street, 24th Floor**
**Baltimore, Maryland 21201**

November 4, 2025

Dear Members of the AHEAD Regulatory Workgroup,

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, thank you for the opportunity to provide comments as the Regulatory Working Group grapples with the reduction in federal healthcare resources available to our State contemplated by (1) the savings expectations of the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model and (2) the expected impact of H.R.1 on Medicaid funding and uncompensated care.

Because we serve so many communities in Maryland in so many ways, UMMS is deeply invested in delivering Maryland citizens a care model that achieves the goals of high-value care, fairness in access to care, and equitable outcomes. Throughout the Total Cost of Care Model, we committed to working in partnership with our communities to ensure that they have appropriate access to needed care, directing differential effort toward our most underserved communities.

The first, and most important goal, of the Maryland Model is providing appropriate resources to deliver the healthcare services that Maryland citizens need. Maryland is not over-resourced overall compared to other states. To achieve this, Maryland's all-payer model traditionally has relied upon every payer, both government and commercial, to contribute equally to regulated hospital costs. The result of this dynamic is that governmental payers cover more of a fair share of their cost of services, while private payers contribute less than they would in a non-all-payer system. The regulatory changes and federal funding reductions contemplated by AHEAD and H.R.1 represent a foundational disruption to our historic resource balance, seeking to deliver more than $1 billion in federal savings for the Medicare and Medicaid programs. Without comprehensive and proactive policy, Maryland's hospital industry will see further erosion of tight operating margins and experience a significant threat to its ability deliver the services Marylanders need.

Downward governmental payer funding pressure is not unique in healthcare. CMS's participation in Maryland's all-payer model has been a unique benefit that has precluded Maryland hospitals from necessitating what happens nationally: negotiation of higher commercial rates to compensate

for underpayment from public payers. Unfortunately, as CMS's relationship to Maryland is poised to change to a more national model with less government payment, our regulatory environment must evolve to utilize the same strategies as other states and ensure resources are equitable and sustainable for all Maryland hospitals. As the Work Group contemplates policy options to sustainably fund a care delivery model that meets the access needs of Maryland citizens, we implore our state's policy experts utilize the tools available to them to ensure access to a care delivery model that can meet their needs is available to all Maryland communities. Not doing so produces unnecessary risk for Maryland citizens in terms of access to high quality hospital services.

I cannot emphasize enough that equitable access to healthcare is a strength of the Maryland model that can only be maintained by ensuring an adequately funded healthcare system. Consistent with the three core values outlined by Governor Moore's directive establishing the Regulatory Working Group, UMMS recommends that the following principles drive the work:

1. **Clear, objective rules governing when to implement cost shifts.** Comprehensive policy is needed to address specific hospital resource issues such as increases to uncompensated care and hospital rate reductions that result from AHEAD savings requirements. A transparent, methodological approach should be developed that considers the timing and magnitude of any adjustment, promoting a data-driven approach.

2. **Ensure the financial viability of efficient, effective hospitals** Resource-starved hospitals will not be able to deliver care Marylanders need. We have absorbed years of depressed operating performance, unable to invest in critical facility needs, program improvements, innovative technology and population health strategies. Ensuring sufficient resources to support an appropriate care model is the statutory charge of the Maryland model. Upholding this regulatory commitment is critical as declines in federal funding throughout the life of the contract, necessitating adjustments to commercial payer contributions to maintain access to critical health services in Maryland. The State may also need to explore legislative or regulatory pathways to maintain flexibility and protect access to care.

3. **Equitable treatment of all hospitals, including those with a greater proportion of patients with Medicare and Medicaid.** The strength of Maryland's All-Payer Model has been ensuring broad-based access to services regardless of payer type or ability to pay. As the state assesses the policy trade-offs associated with the implementation of AHEAD, UMMS encourages policy makers to prioritize maintaining access to critical clinical services across the state, including our underserved and rural communities. This may necessitate differential treatment of hospitals with higher governmental payer mixes to ensure that a two-tiered system of hospitals isn't created based on the types of patients that are served. Alternative funding mechanisms should be considered to ensure safety-net and high proportion public payer hospitals have appropriate financing. Additionally, as cost-shift and rate disparities emerge within the State, policy will need to consider how to maintain this equity among all hospitals, even should payer behaviors change.

4. **Ensure payers are paying their fair share for clinical services and have accountability for the outcomes of the model.** Commercial hospital payments in Maryland are low compared to national levels and commercial payers have seen significant savings over the life of this model compared to national peers, but it is unclear if these lower hospital

payments have been passed along to Marylanders as lower premiums and cost share burden. After a cost-shifting policy takes effect, consumer affordability should be studied as part of this process to ensure that commercial payers are providing value to consumers as part of the model. This will require commercial payer partnership and data transparency to maintain our all-payer system's benefits and truly prioritize the impact to Maryland consumers.

In addition to the above principles, UMMS would like to offer the following perspectives for consideration in response to the specific questions raised by the Regulatory Working Group:

1. **What threshold deficit should be set for cost-shifting?** There should not be any threshold to enact cost-shifting. Direct reductions to hospital global budgets with the AHEAD Medicare/Medicaid cost savings targets, and changes to uncompensated care threaten hospital financial solvency. Prior to any of these funding reductions, Maryland hospitals are operating on currently thin operating margins. Statewide there is a 2.2% operating margin, with at least $1 billion in Medicare/Medicaid cuts anticipated that would represent a 6% reduction to hospital payments nearly eroding average margin statewide. To sustain and save our health system we need to ensure the entirety of the $1B reduction from government payers can be cost shift and any policy can monitor and adjust for future changes that may shortfall provider funding and risk access. Without an equitable cost-shift to commercial payers, hospitals will be forced to reduce services and patient access will be negatively impacted.

2. **How much should be allowed to shift, balancing impact across the healthcare sector (e.g., purchasers, consumers, providers, payers**)? The AHEAD Model solely tasks hospitals with the delivery of Medicare/Medicaid savings and performance to population health, primary care and transformational goals set by the federal government. Hospitals will be asked to achieve these goals on a fixed revenue base, without the benefit of full rate updates for all payers and with declining payments from governmental payers. The cost-shift should be borne by the commercial payers, who bear little burden under the Model but reap significant benefits. Only after study and with stringent regulation, as proposed in principle four above, should minimal circumstance be passed along to consumers via increased patient cost sharing or premiums. Commercial payer reimbursement for hospital care is already far below the national average (197% of Medicare Fee Schedule vs. national median of 269%) yet data is unavailable reliably proved any financial or more comprehensive benefit to Maryland consumers. The Maryland Insurance Administration (MIA) needs to hold payers accountable to allow the benefits of the Maryland system to flow to consumers.

Furthermore, should Maryland commercial hospital rates increase to accommodate a total cost shift to ensure Hospital solvency, estimates indicate the outcomes would still ensure hospital rates are below peer states. With an appropriate cost shift, 197% of Medicare Fee Schedule for Commercials increase go to 233%, per initial estimates. For Marylanders, this would still ensure commercial hospital rates as a percentage of Medicare were:

- Still 13% lower than national median of 269%,
- Still 5%-20% lower than PA, DC, VA, and,
- Still 30%-40% lower than NY, DE, WV.

Initial estimates indicate a cost shift required to cover a $1 billion decrease in government payments shifted to commercial hospital payments would only inflate payments to commercially insured Marylanders by 4% annually for five years. This would be lower than or within range of commercial rate increases historically before the MIA, prior to AHEAD and any disruption to Maryland's healthcare access.

To maintain Maryland's healthcare system, UMMS believes this level of total cost shift is achievable, appropriate and fair relative to the benefits commercial payers receive through this model. Other states do not limit cost shifts, do not guarantee hospital cost growth below national benchmarks and do not restrict volume growth funding through global budgets like in Maryland. This model continues to be a good deal for commercial insurers, we need to ensure that value makes its way to commercial insurance consumers while also guaranteeing access to excellent health facilities.

3. **What is the mechanism for shifting the savings responsibility?** The Health Services Cost Review Commission (HSCRC) already has the regulatory tools available to create an increased cost-shift by changing the payer differential. This tool has been utilized in the past in specific circumstances and is the most logical mechanism to address the financial challenges associated with the reductions in federal funding.

4. **What timeline should be set for shifting?** The cost-shift policy should begin implementation January 1, 2027, to prospectively address the expected increase in uncompensated care due to the passage of H.R.1.

5. **How should the shifting mechanism be enacted (e.g., statute, executive order, agency policy – which agency or agencies?)?** The HSCRC already has the regulatory authority necessary to effectuate a cost-shift. Statutory changes may be necessary, however, to reflect the shift away from the All-Payer Model and to strengthen or change MIA's authority to ensure policy objectives can be met, and data transparency is available. UMMS hopes Maryland will enable all available legislative tools to ensure the appropriate policy can be enacted and any updates to statute necessary for this new era of our system are available.

6. **What other considerations must be addressed, and what is their potential financial impact?** The Regulatory Working Group, working with the Maryland General Assembly, needs to ensure that the MIA has the tools and data necessary to thoroughly review the financials of Maryland's commercial health plans and the benefits they are offering consumers. This promotes transparency that any cost-shift is not resulting in decreased benefits for consumers or that unreasonable premium increases can be monitored. Finally, the Regulatory Working Group needs to continually consider the tasks ahead of Maryland hospitals with new population health and other investment requirements under the AHEAD Model. It is critical to not only maintain our current access to hospitals but also to consider the investments, changes and transformation that will be asked of our health system throughout AHEAD. We should continually reexamine and monitor if Maryland's hospitals are being adequately funded to support the goals outlined in the AHEAD agreement.

Thank you again for the opportunity to comment on this important issue. UMMS continues to be a willing partner to collaborate with you and our other state agencies to promote the success of the AHEAD Model.

Sincerely,

Dr. Mohan Suntha, MD
President and Chief Executive Officer
University of Maryland Medical System

# Feedback Received on the Draft Policy Proposal

Adventist HealthCare

December 2, 2025

Meena Seshamani, MD, PhD
Secretary, Maryland Department of Health
Herbert R. O'Conor State Office Building
201 West Preston Street
Baltimore, Maryland 21201

**Re: Comments on Cost-Shifting and Medicare Advantage Proposal**

Dear Secretary Seshamani,

Adventist HealthCare appreciates the opportunity to comment on the Regulatory Working Group's proposed cost-shifting and Medicare Advantage (MA) policy framework. We also note at the outset that we **strongly support the Maryland Hospital Association's (MHA) comment letter**.

We remain committed to a collaborative, data-driven process that protects access to medically necessary care. **However, as drafted, the proposal falls short and does not provide the stability, financial adequacy, or access protections required for Maryland hospitals to remain solvent under a transition to AHEAD.**

## Cost Shift Proposal

### A. The Proposal Funds Less than Half the Federal Shortfall — Which Will Directly Reduce Hospital Services and Access

The proposed **$435 million partial cost shift** replaces only a portion of the projected federal funding reduction. Maryland hospitals already operate with **some of the most constrained margins in the country**, and any reduction in revenue without a full, dollar-for-dollar offset will immediately force reductions to services, program closures, or access limitations. Additionally, the proposal does not account for the impact of Medicaid disenrollment—projected to create an additional **$490 million shortfall**—meaning the proposal effectively funds **only one-third of the total projected deficit**. A partial cost shift—*especially one implemented on a delayed timeline*—will leave hospitals without the resources necessary to maintain services, meet rising community needs, or invest in population health.

### B. The Proposal Relies on Unsupported Assertions Regarding Existing "Equitable Access"

The draft proposal assumes that Maryland has already achieved expanded equitable access, yet there is **no independent, data-driven regional access analysis** to support this claim. In reality, Maryland continues to exhibit:

- **Low utilization**,
- **Long wait times**, and

- **Population health outcomes that lag national benchmarks**.

These indicators strongly suggest that past Model "savings" may have resulted from **constrained access rather than improved efficiency or population health**. Although the proposal cites utilization metrics on page 4, it omits readily available throughput, access, and outcomes data—an incomplete approach that obscures true system performance.

Maryland is overdue for a **comprehensive regional access assessment** to establish a factual baseline before drawing policy conclusions about equity or access.

### C. Maryland's Reimbursement Structure Has Withheld More Funding Than It Has Captured

Market analysis indicates that while the Model has captured **$2–3 billion** in federal funds, Maryland hospitals have forfeited **$4–5 billion** in commercial reimbursement relative to national norms. As a result, Maryland hospitals operate with a persistent **$1 billion annual structural deficit**, even as they are expected to meet the same or higher expectations for access, quality, and population health as hospitals in other states

Preliminary actuarial reviews show that Maryland's **commercial insurers have capacity to absorb moderate price increases in premiums**, given historically low hospital payment levels and strong risk-based capital positions. This further underscores the feasibility—and necessity—of a **full dollar-for-dollar offset** of federal funding reductions.

### D. The Proposal Ignores the True Financial Condition of Maryland Hospitals

The Working Group's reliance on regulated margins alone provides an incomplete picture of hospital financial health. **HSCRC's own October 2025 analysis** shows that the "unregulated" physician enterprise—essential for staffing and 24/7 operations—results in **more than $1 billion in statewide annual losses**.

A hospital "without physicians" is a fiction. Excluding these unavoidable costs from financial assessments obscures the true condition of hospitals. Combined with Maryland's suppressed margins, these unregulated losses leave hospitals **no capacity to absorb any unfunded reductions** without directly impacting access, quality, and service availability.

Moreover, statewide hospital operating profits were approximately **$490 million in FY2025** and **$200 million in FY2024**. Under the proposal, hospitals would be responsible for **$435 million** of the $870 million shortfall—effectively putting **nearly all hospital operating margins at risk** and creating a disproportionate risk burden on hospitals relative to payers.

## Medicare Advantage Proposal

### A. MA Plans Are Not Stable Nationally, and Subsidizing Them Risks Diverting Funds from Patient Care

MA plans across the country face increasing instability, including aggressive utilization controls, rising denial rates, and network contraction. While MA coverage theoretically offers lower out-of-pocket costs and supplemental benefits, these advantages often do not materialize for many beneficiaries.

Before committing **$150+ million annually** to subsidize for-profit MA plans, the State should evaluate whether supplemental benefits—**vision, dental, hearing, and other supports**—could be delivered more effectively through novel **state-administered options** that provide greater value, transparency, and equity.

**B. Any Subsidy Must Be Accompanied by Robust Accountability**

If an MA subsidy is pursued, it must be paired with strict accountability standards, including:

- Timely access to care,
- Lower denial rates,
- Adequate networks,
- Beneficiary protections, and
- Demonstrated contributions to total cost-of-care improvement.

Without these guardrails, Maryland risks financing for-profit MA plans' financial performance rather than patient care.

**Need for an Independent Actuarial Analysis Before Any Policy Is Finalized**

Given the scale of fiscal and access implications for employers, families, and hospitals, Maryland should commission an **independent third-party actuarial analysis** to:

- Evaluate commercial premium levels relative to national norms,
- Assess plan capital levels and capacity to absorb a full cost shift,
- Assess regional access adequacy for medically necessary care
- Holistically assess healthcare infrastructure, policy and outcomes in Maryland on a regional basis.

Early MHA and HSCRC findings already indicate adequate commercial premium capacity to fund the **full federal shortfall**.

**Statutory and Contractual Requirements**

The AHEAD State Agreement requires Maryland to ensure:

- **No negative consequences to Medicare providers**,
- **No negative consequences to Medicare FFS beneficiaries**, and
- **Adequate resources for hospitals to remain solvent**.

Maryland law (Health-General §19-220(d)) similarly requires that nonprofit hospitals be permitted to charge rates that enable effective, efficient, and **solvent** provision of care. A partial cost-shift solution cannot meet these obligations.

## Conclusion

Adventist HealthCare reiterates our commitment to partnering with the State to ensure Maryland's success under AHEAD. To achieve that goal, the proposals must be strengthened to:

1. **Fully offset** federal funding reductions so hospital revenues remain whole and ensure **equitable, sustainable financing** across all hospitals; and
2. Commission an independent assessment that is **complete, accurate, and regionally specific** on access, outcomes, and financial health in Maryland- not just state average utilization metrics;
3. Evaluate whether supplemental MA benefits—**vision, dental, hearing, and other supports**—could be delivered more effectively through novel **state-administered options**
4. Protect **patient access to medically necessary care**, particularly in underserved communities.

We welcome continued discussion and stand ready to work with the State on a responsible, data-driven framework that preserves stability and ensures Marylanders continue to receive high-quality, equitable care.

Sincerely,

Katie Eckert

Katie Eckert, CPA
Senior Vice President, Strategic Operations
Adventist HealthCare

cc: Perrie Briskin, Medicaid Director, Maryland Department of Health
Michele Eberle, Executive Director, Maryland Health Benefit Exchange
Marie Grant, Commissioner, Maryland Insurance Administration
Dr. Douglas Jacobs, Executive Director, Maryland Health Care Commission
Dr. Elizabeth Kromm, Assistant Secretary, Maryland Department of Health
Dr. Jon Kromm, Executive Director, Health Services Cost Review Commission
Laura Goodman, Associate Director, Health Services Cost Review Commission

ALTERWOOD ADVANTAGE
Quality Care. Better Health.

10090 Red Run Boulevard
Second Floor
Owings Mills, MD 21117

December 2, 2025

The Honorable Meena Seshamani
Secretary
Maryland Department of Health
201 West Preston Street
Baltimore, MD 2120

**SUBJECT: Comments on the Proposal of the Regulatory Working Group on Cost Shifting and Medicare Advantage Stabilization**

Dear Secretary Seshamani:

Thank you for convening the Regulatory Working Group and considering proposals to stabilize the Medicare Advantage market in Maryland. Our letter provides additional context and makes specific comments and recommendations related to the Working Group Proposal.

First and foremost, our hospital payment model needs to work for Maryland consumers. Without a stable Medicare Advantage market, Maryland Medicare beneficiaries do not have access to the same cost sharing protections and supplemental benefits as their counterparts in other states. It is important to remember that Medicare beneficiaries *choose* to enroll in Medicare Advantage because they need the benefits provided and cannot afford other Medigap coverage. We are at crossroads – without immediate action by the Regulatory Working Group, low-income Medicare beneficiaries will lose access to their supplemental coverage as we will see continued Medicare Advantage Plan withdrawals. As Maryland commits to a new 10-year model under AHEAD, it is imperative that we stabilize the Medicare Advantage market in Maryland through both short-term solutions to immediately stabilize the market and long-term sustainable policy change.

The financial losses among Maryland Medicare Advantage Plans are unique and stem from our hospital regulatory model. The challenges have been significant, long-standing and market wide. Outside of Maryland, the Medicare Advantage market is entirely different with a level of participation, risk pool and market dynamics that are not comparable to Maryland's small and volatile market. As with any program of its scale, Medicare Advantage has its challenges. These national challenges should not prevent the Regulatory Working Group from addressing Maryland's unique challenges.

The Maryland model needs to enable *both* providers and payers to be able to meet the needs of Maryland consumers. The Cost Shifting policy and Medicare Advantage Stabilization proposals should not be either or. The Regulatory Working Group must address both. We appreciate that the Regulatory Working Group proposal acknowledges the significant losses among Maryland Medicare Advantage plans. It is not reasonable to expect any organization to shoulder this level of sustained loss. This is clearly a systemic problem that no organization can manage their way out of, making immediate policy action essential.

**Specific Comments and Recommendations**:

We appreciate the efforts of the Regulatory Working Group to develop the Medicare Advantage Market stabilization proposal. We are concerned that, as written, it does not move quickly enough to prevent the displacement of Maryland Medicare beneficiaries in 2026, nor does it fully address losses necessary to achieve stabilization. We offer the following specific recommendations:

1. **Immediate Action**: Market stabilization requires the Regulatory Working Group to move quickly to address the market disruption (service area reductions, plan withdrawals) expected in 2026. The stabilization policy needs to be launched quickly with a simplified design, providing a temporary bridge proposal for 2026. There is precedent for a simplified bridge program as a grant that we believe provides the most effective way to move forward quickly. We are open to the combination of strategies for immediate action beyond just grants; however, immediate strategies need to be simple and easy to implement in 2026. To be effective any stabilization strategy needs to be clear and understandable to the industry so they can easily be quantifiable and achieve the market stability that is the goal. Longer-term solutions can consider more complex policy change that require more thorough analysis and vetting. Longer-term solutions could even require those that may need legislative action.

2. **Long Term Stabilization Policy must Fully Neutralize difference in Medicare FFS and Medicare Advantage Plan costs**: The proposal of the Regulatory Working Group is an important step, but insufficient to stem significant financial losses and achieve market stabilization. Regardless of whether the policy proposal is implemented through a differential or other mechanisms, it needs to close the gap between Medicare FFS payments and Medicare Advantage payments.

3. **Plan Criteria**: We believe the criteria for selecting plans to receive the increased differential should be simplified. We agree with the focus on H-Contracts having over 50% of their membership in Maryland but believe the criteria in the Regulatory Working

Group proposal may have unintended consequences. We recommend an administratively simple approach.

Thank you for the opportunity to provide these comments. We look forward to working with you to refine the Regulatory Working Group proposal and stabilize the Medicare Advantage market both now and in the future.

Sincerely,

Mark Puente
President

CC: Perrie Briskin, Medicaid Director, MD Department of Health
Michele Eberle, Executive Director, MD Health Benefit Exchange
Marie Grant, Commissioner, MD Insurance Administration
Dr. Douglas Jacobs, Executive Director, MD Health Care Commission
Dr. Jon Kromm, Executive Director, Health Services Cost Review Commission
Laura Goodman, Associate Director, Health Services Cost Review Commission

**CareFirst BlueCross BlueShield**
10455 Mill Run Circle
Owings Mills, MD 21117-5559
**carefirst.com**

December 2, 2025

Multi-Agency Regulatory Working Group
Maryland Department of Health
201 W. Preston Street
Baltimore, MD 21201

Dear Members of the Maryland Multi-Agency Regulatory Working Group:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to comment on the Multi-Agency Workgroup proposal regarding cost-shifting and Medicare Advantage stabilization. We applaud the State for its efforts to advance the Maryland Model and appreciate the State staff's thoughtful approach to preparing for the AHEAD Model.

## Cost-Shifting

Maryland's unique payment model has delivered value to Marylanders for decades through all-payer rate-setting, which has avoided inequitable cost-shifting. While we recognize that hospital financial stability must be a priority, **we are concerned that the State's proposal for cost-shifting places too much of the public payer savings burden on Marylanders**. Affordability of healthcare for consumers and employers should be a top priority. Cost-shifting directly increases costs for Maryland consumers and should be a last resort, not a first step.

In our previous comment letter, we urged the State to use this moment to rebalance hospital global budgets to underlying supply of and demand for healthcare services. After ten years, hospitals have built up substantial reserves of retained revenues – e.g. revenues collected from Maryland residents for services that they did not need or receive. There are sufficient retained revenues to pay for the Medicare savings without requiring additional price increases. This means that when employers and consumers pay for hospital care, they are already paying for their care and an upcharge for retained revenue; now, the state is proposing to add a layer of additional cost onto that hospital bill to cover cost-shifting. Again, we understand there may be a need for cost-shifting as a last resort in the event of a hospital potential closure or market collapse, but the State moved too quickly to pull that lever in this proposal.

## Medicare Advantage Stabilization

**We support the proposed solution**. CareFirst is grateful that the State has developed a thoughtful proposal to stabilize the Medicare Advantage Market. We understand that staff concluded the Maryland Model reduced Medicare Advantage plan revenues by approximately 4.5% as a result of the extra Medicare subsidy paid to Maryland hospitals. Consequently, Medicare Advantage plans have been unable to sustain competitive benefits offerings for seniors at a low cost across the State. Every major plan in the State operates at a loss, few plans have entered the market because of economic challenges, and many of those that have entered the market are now exiting. As a result, seniors and individuals with disabilities who rely on Medicare have fewer low-cost Medicare Advantage plan options than any other similar state and

have been more likely to lose coverage due to market volatility. The Multi-Agency Workgroup has recommended creating a differential to eliminate the 4.5% revenue reduction created by the Maryland Model. We are supportive of this proposal and believe it will increase access to high-quality, affordable plans for Maryland residents.

**The proposal shifts too much cost onto Maryland consumers and employers.** The State proposes to hold hospitals harmless for the costs of the Medicare Advantage stabilization program by shifting those costs onto the commercial market. Once again, we are concerned that the State resorts first to cost-shifting, before addressing any other source of savings; and historically, we have opposed a payment differential, except as a last resort. However, we believe that this case is a last resort as the market is on the verge of a collapse. Plan exits and service area changes for 2026 will result in roughly 100,000 Marylanders losing access to their Medicare Advantage plan and shifting to another carrier, disrupting care in a time of need. The market is destabilized, and fewer carriers remain to serve a growing senior population. While there is justification for using the payment differential as a last resort in this case, we do believe the impact on consumers should be tempered by reducing the amount made up to hospitals through a charge increase. The State is asking payers to share the burden with hospitals in their cost-shifting proposal – it remains unclear why the same logic would not apply in this Medicare Advantage proposal, especially since hospitals have long benefitted from higher Medicare payments at the expense of Medicare Advantage plans.

Once again, we appreciate the State's convening of the Multi-Agency Regulatory Working Group, as well as the opportunity to comment on the proposals.

Sincerely,

Arin D. Foreman
Vice President, Deputy Chief of Staff
CareFirst BlueCross BlueShield
1501 S. Clinton Street
Baltimore, MD 21224

Poolesville Family Pratice

Physicians Specializing in You

December 1, 2025

Secretary Meena Seshamani
Maryland Department of Health
Herbert R. O'Conor State Office Building, 201 West Preston St.
Baltimore, Maryland 21201

Dear Secretary Seshamani and Members of the Regulatory Working Group,

I appreciate the opportunity to provide feedback on the proposal of the Regulatory Working Group on cost-shifting and Medicare Advantage. I am a practicing family physician in independent practice, taking care of Medicare and Medicare Advantage members. I have also been involved in value-based care programs, including the Maryland Primary Care Program (MDPCP) and Medicare shared savings (MSSP) ACOs for over 10 years.

1. **Cost Shifting Proposal** – It is important that the cost shifting does not fall on the backs of healthcare consumers or physicians. Physicians in Maryland are already among the lowest paid and lowest reimbursed (by commercial insurers) in the country. Cost shifting that increased premiums to consumers or reduces payments to physicians will only add to the healthcare cost and provider supply issues facing Maryland.

2. **Medicare Advantage Proposal** – I believe it is important that market stabilization for Medicare Advantage should not paid for by taxpayers, healthcare consumers, or physicians. Medicare Advantage plans are clearly having financial sustainability issues, but these issues are due to poor management by the plans themselves and should not be subsidized by consumers and taxpayers. Particularly when enrollees have an option of joining traditional Medicare.
   In my experience, Medicare Advantage plans have several serious deficits compared to traditional Medicare. This includes:
   a. **Limited Networks of physicians and other healthcare providers**: Mostly due poor reimbursements and increased administrative burden to practices. I had a patient in a MA plan who was required to travel from Western Montgomery County to Baltimore (1.5 hours away) to see an in-network specialist, while there were numerous of these specialists in the 4 counties he would have crossed on his way to Baltimore.
   b. **Administrative Burden:** Medicare Advantage plans require prior authorizations much more often than traditional Medicare which leads to delayed care and increased administrative costs. MA plans also deny care at higher rates than Medicare, and consumers often have to go through multi-step appeals.
   c. **Misleading Benefits and Advertising:** I have often heard from patients that they were told their specific physicians were in-network by MA plan brokers when these physicians were clearly not in-network. They were also given incorrect information about their covered medications and co-pays, as well as other “free” benefits.

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d. **Non-Coverage of preventive and primary care services:** Many, if not most MA plans, do not pay for some preventive and primary care services that are covered by traditional Medicare. This non-coverage reduces the availability of these services for MA plan enrollees, leading to worse healthcare outcomes, increased overall healthcare costs, and reduces financial viability of primary care practices.
e. **Financial Mismanagement:** MA plans have been plagued by financial mismanagement. A 2024 OIG reported that MA plans exploited health risk assessments (HRAs) and chart reviews to generate medically unsupported diagnoses, which in turn inflated risk-adjusted payments. The OIG estimates that such questionable practices resulted in roughly $7.5 billion in extra payments in 2023 alone. Despite this overbilling by MA Plans, a recent 2025 report, from AM Best, found that elevated health care utilization among MA enrollees led to a $5.7 billion underwriting loss in 2024 for MA plans. This clearly shows that MA plans are not stabilizing or decreasing healthcare costs or utilization.

Due to all of the issues specified above, I urge the working group to not subsidize failing Medicare Advantage plans, when consumers may be better served by traditional Medicare. I would argue that taxpayers and physicians (who are currently struggling to remain in private practice in Maryland) would also benefit from more patients moving back to traditional Medicare.

Sincerely,

Amar Duggirala, DO, MPH
President
Maryland Academy of Family Physicians

Medical Director/Managing Member
Poolesville Family Practice
Amar.Duggirala@poolesvillefamilypractice.com

December 2, 2025

Health Services Cost Review Commission
AHEAD Regulatory Working Group
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear AHEAD Regulatory Working Group,

Thank you for the opportunity to submit public comments on the proposed recommendation. Maryland Citizens' Health Initiative is a consumer advocacy nonprofit whose mission since 1999 has been to advocate for policies that further access to quality, affordable health care for all Marylanders. Our Maryland Health Care for All Coalition is the largest health consumer advocacy coalition in Maryland and is comprised of hundreds of faith, business, labor, community, and health care organizations across the state.

Under Maryland's all-payer hospital system, consumers have benefitted from the Health Services Cost Review Commission (HSCRC) working to balance consumers' health care costs, access to hospitals and clinicians, and quality of health care. The HSCRC helps ensure that hospital rates in Maryland do not increase too quickly. The system has simplified negotiations between insurers and health systems which means Marylanders have some protection from hospital and insurer disputes leading to loss of access. Maryland's HSCRC has also been able to create an uncompensated care pool for the uninsured.

We applaud that the proposed recommendation retains much from the Total Cost of Care Model that has benefitted consumers, including the provision that commercial payers will continue to all pay the same amount for the same service within the same hospital. However, it will be important that any cost-shifting be done in a way that will protect Marylanders from the potential threats of skyrocketing health insurance premiums, decreasing access to hospitals and clinicians, and increasing health inequity. We are very fortunate in Maryland to have the HSCRC in place as a watchdog for consumers.

We are concerned that some consumers will be disproportionately affected by the cost shift on insurance premiums. Recent polling shows that Americans are very concerned about the cost of health care. Under the new model, there will be a 1-4% increase in premiums over 7 years for consumers who are enrolled in commercial insurance. Furthermore, rates will likely be higher in markets where hospitals have the highest levels of public insurance, such as consumers who get coverage from employers that hire in a small geographic area which could include county governments, school boards, and large employers in rural areas. We urge you to consider how to best mitigate the harm that these higher premiums would cause to consumers without intervention, and what policies would most contribute to ensuring health equity.

2600 St. Paul Street Baltimore, MD 21218
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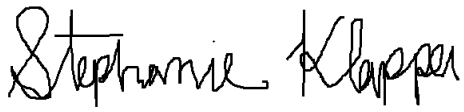
It is also important to ensure that shifting of resources does not inhibit the global budget incentives for hospitals to expand and improve access to health care services in the community to improve population health, particularly related to primary care and behavioral health capacity. With hospitals receiving higher rates for commercial patients, it will be important to create policies to ensure that people enrolled in public health insurance plans receive high-quality and accessible care at hospitals and in their communities.

As you consider communication strategies to the public we encourage you to do robust message testing to ensure the information is understandable, and to work with trusted messengers to spread the word.

Thank you very much for your leadership toward ensuring access to quality, affordable health care for all Marylanders.

Sincerely,



Stephanie Klapper

Deputy Director

Maryland Health Care for All! Coalition

HEALTH MEANS EVERYTHING
CONSUMER ALLIANCE

December 1, 2025

Secretary Meena Seshamani
Maryland Department of Health
Herbert R. O'Conor State Office Building, 201 West Preston St.
Baltimore, Maryland 21201

**Re: Recommendations of the Governor's Regulatory Working Group**

Dear Secretary Seshamani and Members of the Regulatory Working Group,

Health Means Everything (HME) appreciates the opportunity to comment on the Workgroup's proposals. We are concerned that the proposals to address both cost shifting and Medicare Advantage rely primarily on increasing hospital rates and health insurance premiums for commercially insured consumers. **Maryland families are already struggling with the burden of rising health care costs** and we are concerned that, between the implementation of the AHEAD model, these Medicare Advantage changes, and additional forthcoming updates to hospital global budgets, commercial insurance costs will increase rapidly in the coming years without any guardrails to protect Maryland families. It is vital that these burdens are spread across health care sectors. As we noted in our previous recommendations to the Workgroup, **HME strongly recommends that Maryland implement a cap on commercial insurance cost growth.**

**Cost Shifting**

HME is supportive of the Workgroup's efforts to advance the successful implementation of the AHEAD Model, which we are hopeful will continue to improve population health and reduce health care costs for Maryland consumers. However, we are concerned that the burden is disproportionately falling on commercially insured Marylanders without the necessary guardrails. HME strongly urges the Workgroup to cap the allowable increases in commercial health care costs relative to Medicare. Such a cap would protect consumer interests and force

savings to be achieved within the broader health care system and not just shifted from one part of it to another.

The Workgroup acknowledges in its proposal that increases in commercial premiums due to the proposed cost-shifting policy (and Medicare Advantage subsidies) will not reflect additional cost increases consumers are likely to experience. Based on current health care cost trends and recent hospital rate increases imposed by the HSCRC, we expect Marylanders will face significant additional increases in commercial insurance costs.[1]

Since 2023, the HSCRC has increased Maryland hospitals' global budgets by about 14%, despite the fact that hospital service utilization has decreased significantly.[2] During the same period, Medicare increased hospital payments by only about 9%. These steep hospital rate increases are ultimately passed onto consumers in the form of health insurance premiums and other out-of-pocket costs. Marylanders are already struggling with their health care costs, with 48% of those surveyed being somewhat or very worried about affording the cost of prescription drugs.[3] HME is concerned that, given recent behavior by the HSCRC, commercially insured Marylanders may be faced with additional increases in their out-of-pocket costs beyond what is proposed by the Workgroup. Health care costs are already too high and Maryland consumers cannot afford to take on more.

**To protect consumers from unaffordable and unnecessary health care costs, we strongly urge the Workgroup to implement a cap on the commercial cost increases that will be imposed by the Workgroup and the HSCRC throughout the implementation of the AHEAD Model.** We believe imposing such a cap relative to Medicare rates will ensure that implementation of the AHEAD Model does not disproportionately fall on working Maryland families. The Workgroup notes that the goal of implementing this cost-shifting policy is to provide stakeholders with certainty and stability, but without guardrails in place this policy fails to provide such assurances to commercially insured Marylanders.

1 Employers prepare for the highest health benefit cost increase in 15 years. Mercer. September 2025.

2 HSCRC GBR Updates

3 Consumer Healthcare Experience State Surveys (CHESS) Series

Further, HME encourages the Workgroup and the HSCRC to consider right-sizing hospital global budgets to account for reductions in overall utilization of hospital services. The HSCRC's own analyses suggest that Marylanders are using far fewer hospital services than they were ten years ago, and yet the HSCRC has consistently raised hospital global budgets.[4] Available data indicate that Marylanders pay more per hospital day than consumers in other states.[5] This suggests that hospital payment rates in Maryland may be inflated, and thus we recommend examining whether global budgets truly reflect the access needs of Marylanders today. **The goal of the state's hospital rate setting authority should be to pass savings down to consumers, not to maintain hospital budgets at a given level when service use is changing. HME strongly recommends that the Workgroup implement policies to ensure that consumers benefit directly from health care savings achieved through participation in total cost of care models.**

**Medicare Advantage**

Health Means Everything appreciates that the workgroup is proposing to use the state's rate-setting authority to strengthen the Medicare Advantage (MA) market in both the short and medium term. Health Means Everything also acknowledges the workgroup's recognition that the current instability in the MA market is a significant problem requiring action to protect Maryland's seniors and other vulnerable populations who rely on a robust MA market.

**A competitive MA market is essential to ensuring affordable health care coverage for Maryland seniors.** Yet MA offerings in the state are shrinking, forcing seniors either to change plans more frequently or to absorb the higher costs and less generous benefits of traditional Medicare. Maryland is already seeing reductions in MA availability for 2026, and many seniors have begun receiving notices that their plans will no longer be offered.

For example, Aetna will limit its coverage to only three counties in 2026 (Frederick, Harford, and Montgomery) while Humana has fully exited one of its plans.[6] In addition, Humana Gold Plus SNP will no longer be available in Anne Arundel County, Baltimore County, Harford County,

4 HSCRC Meeting Agenda

5 Hospital Expenses per Adjusted Inpatient Day | KFF State Health Facts

6 Thousands of Maryland seniors notified of the end of their Medicare Advantage plans

Howard County, or Baltimore City beginning January 1, 2026. Altogether, more than 100,000 Maryland residents are projected to lose their MA plans at the end of 2025 unless they select a new plan by December 31.[7]

HME appreciates the Workgroup proposing policy solutions to provide meaningful investments in the Maryland MA market. While we agree that this is an urgent problem, we are concerned that the proposed solution would again increase costs for commercially insured Maryland families. As noted previously, raising commercial hospital payment rates ultimately drives up commercial premiums. Maryland families are already feeling the strain, with more than four out of five Marylanders being worried about their ability to afford health care in the future.[8] HME strongly encourages the state to cap increases to commercial rates and to explore MA-focused policy solutions that do not increase costs for commercially insured Marylanders.

HME also recommends that the Workgroup consider the merits of setting the minimum quality standard for increased subsidy at 3.5 stars. The Workgroup provided little justification for this cutoff beyond the fact that it will seemingly exclude half of MA plans currently operating in the state. While HME supports the need to ensure that consumers have access to *quality* coverage in the MA market, that need must also be balanced with meaningfully increasing access to new options for consumers. Current federal regulations effectively require all MA plans to maintain a 3.0 summary star rating in order to avoid sanction.[9] HME encourages the workgroup to further weigh the merits of a 3.5 vs a 3.0 star rating cutoff.

We appreciate your work on the difficult task before you, and your willingness to engage the public in your efforts. If you would like to discuss these matters further, please do not hesitate to reach out. We are a ready and willing partner to you as you move forward.

Sincerely,

Ashiah Parker, Chair
Health Means Everything Consumer Alliance

7 Id.

8 Rising Cost of Care | Health Means Everything

9 42 C.F.R. § 422.504(a)(17)

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December 2, 2025

Meena Seshamani, MD, PhD
Secretary, Maryland Department of Health
Herbert R. O'Conor State Office Building
201 West Preston Street
Baltimore, MD 21201

**Re: Maryland Medicare Advantage**

Dear Secretary Seshamani,

Thank you for convening the Working Group to address the challenges facing Maryland's Medicare Advantage market. As a local brokerage representing over 250 agents statewide, we are witnessing firsthand the confusion and distress among vulnerable Medicare beneficiaries during the first six weeks of the Annual Enrollment Period for CY2026. The recent withdrawal of national Medicare Advantage plans from the Maryland market has left many seniors without affordable options to access the health care services they need.

I appreciate the State's recognition of the disconnect between Maryland's hospital model and the CMS Medicare Advantage payment methodology. However, the unintended consequences of this misalignment are significant, with thousands of Maryland seniors losing their health plans, experiencing disruptions in their continuity of care, paying higher premiums, and receiving fewer benefits as compared to their counterparts in other states. Given the Governor's commitment to *"leave no one behind",* this unfortunate situation presents an opportunity for the Administration to propose a timely solution.

It is perplexing to me that while the State has identified this critical issue, the proposed solutions do not take effect until 2027. This delay jeopardizes the health and well-being of Maryland's most vulnerable seniors in 2026, as we risk further exits of Medicare Advantage plans from the State.

In 2020, the Hogan Administration recognized the market's volatility and implemented a grant program that successfully, albeit temporarily, stabilized the situation. During that period, Medicare Advantage enrollment grew from 100,000 to over 200,000 beneficiaries. Additionally, this intervention generated significant savings through the hospital waiver test, as high-cost beneficiaries transitioned from fee-for-service to Medicare Advantage. Accordingly, since the effectiveness of this approach has already been proven, why wouldn't a similar model be implemented in 2026 while a more permanent solution is crafted for the future?

Maryland's seniors deserve a solution that works for them - one that ensures they can continue to access affordable, high-quality care without disruption. I urge you to reconsider a more immediate, comprehensive response to this growing crisis.

Thank you for your attention to this critical matter.

Sincerely,

Andrew Rosenberg
Principal

December 2, 2025

Meena Seshamani, MD, PhD
Maryland Secretary of Health
Maryland Department of Health
201 W. Preston Street
Baltimore, Maryland 21201

Dear Secretary Seshamani,

On behalf of the Johns Hopkins Health Plans (JHHP), thank you for the opportunity to provide input on Medicare Advantage (MA) market stabilization in Maryland. JHHP appreciates the State's leadership in addressing the long-standing misalignment that has challenged MA plan viability in Maryland. As one of the longest-standing MA plans serving Marylanders, we are deeply committed to advancing health and equity, particularly for low-income and underserved communities, and to protecting beneficiary access to high-quality, affordable care. While MA enrollment in the state does continue to grow, it remains well below the national share, and product affordability and benefit richness lag peers in other states due to the distortions created by the model.

JHHP is supportive of rapid action to stabilize MA and ensure hospital sustainability. To meet the urgency of the moment and deliver timely relief, we encourage a simple, actionable launch that can be refined over time as experience and data accrue. We also urge the State to address the immediate risk that a gap remains for CY2026 if implementation of a solution begins in CY2027; without near-term relief, Maryland will likely see additional plan exits and service-area reductions before the stabilization solution takes effect.

In response to the proposed MA stabilization policy, JHHP offers the following recommendations for the regulatory working group's consideration:

1. **Strengthen equity impact while keeping administration simple at launch**

   Under current criteria, JHHP does not qualify for participation, despite its desire to secure financial stability that will allow more expansive geographies. JHHP urges the State to eliminate the 5,000 lives or 20% of MA beneficiaries residing in target-counties criterion in that H-Contract and adopt statewide, member-centered qualification pathways based on service, including lower-income and low-income Marylanders (e.g., counties with lowest MA penetration, share of dual eligible / low-income subsidy members, proportion in designated equity areas, or Area Deprivation Index thresholds). JHHP would also note that given the availability of Medicaid subsidies, *lower-income* Marylanders rather than lowest-income are most likely to be adversely impacted by MA market disruption. A simplified initial approach for the first year could be based on overall H-contract % of enrollees in Maryland, for example a 60% threshold. Other potential criteria could include counties below a household income threshold, lowest income counties

that represent 50% of the Maryland population, or qualification based on all counties in Maryland.

Because MA is not prevalent in Maryland (leading to lower HEDIS), and benefits are not as rich (leading to lower CAHPS), most Maryland MA plans are 3.0 – 3.5 Stars. JHHP would suggest delaying the 3.5-star qualification threshold for 3 years until momentum, scale, and product design can catch up with the national marketplace.

The State should also establish participation monitoring to ensure plans serve low-income members across the state and do not concentrate offerings in a few select populous counties.

2. **Launch quickly with a simplified initial design, and provide 2026 bridge relief if needed**

   If the stabilization program cannot be fully effective for 2026, JHHP recommends introducing an interim MA bridge period (e.g., a partial differential on regulated inpatient services, grants, or targeted stop-loss or discounts for Qualified Plans) in 2026 to mitigate plan exits and service-area reductions. Further, initial eligibility and administrative requirements should also be simplified (i.e., automatic application for Qualified Plans with minimal documentation) to ensure timely and consistent support reaches Maryland beneficiaries.

3. **Align MA regulated facility rates to Medicare FFS and neutralize the quartile penalty**

   For MA to be viable and sustainable in Maryland, any proposed solution must meet two conditions: a) MA regulated facility costs must be at or below comparable Medicare FFS levels; and (b) the MA quartile penalty (i.e., the 5% revenue reduction applied in high-cost counties) must be removed or explicitly neutralized for qualifying plans.

   Currently, MA and Medicare FFS pay the same regulated hospital rates, but MA benchmarks are reduced by the quartile penalty factor. The proposed model aims to reduce MA hospital costs via a differential to counteract reduced revenue, however this only works if the differential fully neutralizes the quartile penalty for Qualified Plans and maintains MA costs at or below FFS.

   As an example for illustrative purposes, if Medicare FFS costs decrease by 20%, MA revenue could drop by roughly 15% (20% drop net of removing the 5% quartile penalty). If MA hospital costs drop only 10% under the differential, MA plans would be in a worsening margin position. Recalibration and explicit quartile neutralization are critical to a MA premium fix.

4. **Size and calibrate the differential to close the actual shortfall, and maintain sufficiency over time**

   The initial adjustment should be set to close the measured Maryland shortfall and ensure viable margins after rebates and trend, recognizing that roughly 40% of MA costs are hospital-based. JHHP also urges the State to monitor this over time and commit to recalibration if Medicare FFS costs or MA benchmarks change materially (for example, beginning in 2028). If FFS costs fall significantly, adjust the MA differential to maintain viability, rather than allowing relief to be eroded.

5. **Provide bid-cycle certainty and multi-year stability**

To ensure plans can incorporate the policy into bids with confidence, the State must issue early, binding eligibility decisions aligned with the CMS bid calendar. Notably, it is also critical that Qualified Plan status is certified for an initial four- to five-year period, with clear guardrails and performance monitoring, to reduce administrative burden and support predictable benefits for members.

JHHP appreciates the opportunity to provide feedback on the proposed policy. We believe a streamlined initial policy will deliver immediate, necessary relief to beneficiaries and plans, support hospitals, and protect the long-term viability of MA in Maryland. JHHP thanks the Regulatory Working Group for their efforts to design an MA stabilization solution and stands ready to collaborate on rapid implementation and ongoing evaluation to ensure the program achieves its intended outcomes.

Sincerely,

James P. Holland
President, Johns Hopkins Health Plans

December 2, 2025

Meena Seshamani, MD, PhD
Maryland Secretary of Health
Maryland Department of Health
201 W. Preston Street
Baltimore, Maryland 21201

Dear Secretary Seshamani,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the process for cost-shifting as Maryland prepares to move into the Achieving Efficiency Through Accountable Design (AHEAD) model. As JHHS has noted in previous comments, the most important goal through this transition is to ensure that the model provides sufficient resources to provide access to needed care for Maryland citizens. Decreased federal funding under the AHEAD model will disrupt the current balance of resources, and as a state, we must then rely on higher contributions to that balance – as other states do – to ensure sufficient resources to care for Marylanders. The current cost shifting proposal fails to restore this balance under the new model, in turn threatening access to care for Marylanders.

The current policy proposal shifts only half of the anticipated cost reduction to hospitals under AHEAD, and does not account for the anticipated increases in uncompensated care as a result of HR-1, leaving hospitals to absorb an untenable amount of financial risk in an environment with already strained financial conditions. Modeling indicates that hospitals across the state will be unable to absorb this impact, and there is no other state nationally in which hospitals are expected to do so. JHHS is exceedingly concerned that the proposed cost-shifting policy will harm access for Marylanders as it leads to the collapse of hospitals providing medically necessary care.

It is imperative that the cost-shifting policy contains the flexibility to address 100% of 1) federal Medicaid funding reductions, and 2) increases in uncompensated care. This is increasingly critical given that the State will no longer be under an all-payer model under AHEAD. While the current proposal contains a commercial cost-shift estimate of $435M, establishing a firm figure limits the State's flexibility to adjust their cost-shifting approach over the course of the model, particularly given that many critical components of the AHEAD model remain unknown at this time.

Further, the proposed distribution of risk between hospitals and payers is severely disproportionate. The draft policy proposes a hospital burden of $435M, which essentially places the full operating profits for Maryland hospitals at risk. The total operating profit for hospitals statewide was ~$490M in FY2025, and ~$200M in FY2024. JHHS again cautions that an inadequate commercial cost-shift risks access for our vulnerable populations; a 1-2% additional increase in commercial rates to cover a full cost-shift should outweigh the access risk that only a partial cost-shift creates for Marylanders.

Given the substantial risk the current policy poses to both Marylanders and hospitals, JHHS urges the State to seek support from an external consultant with expertise in health economics and policy design to ensure that any cost-shifting policy protects and preserves access to care in the state. Revision of the proposed policy to adequately cover anticipated financial impacts and protect access is paramount. The sustainability of the AHEAD model hinges on a viable cost-shifting policy, and this policy remains among the most crucial considerations as hospital boards evaluate AHEAD model participation. JHHS appreciates the prioritization of this issue by the regulatory working group, and underscores the importance of implementing a cost-shift that ensures sufficient resources to care for all Marylanders.

Sincerely,

Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

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Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
4000 Garden City Drive
Hyattsville, Maryland 20785

December 2, 2025

The Honorable Wes Moore
Governor of Maryland
100 State Circle
Annapolis, Maryland 21401

**RE: Cost-Shifting and Medicare Advantage Proposals**

Dear Governor Moore:

Kaiser Permanente appreciates the opportunity to comment on the Regulatory Working Group's Cost-Shifting and Medicare Advantage Proposal. Kaiser Permanente is the largest private integrated health care delivery system in the United States.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for over 745,000 members. In Maryland, we deliver care to approximately 430,000 members.

Thank you for your leadership and continued partnership with the Center for Medicare and Medicaid Innovation (CMMI) to facilitate Maryland's participation in the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. We appreciate your work and acknowledge that finding the right balance between Medicare savings under AHEAD, financial stability for hospitals, and affordability for Maryland consumers is both critically important and challenging.

**Cost Shifting:** The State has been a trailblazer in creating access to affordable health care to protect Maryland's most vulnerable. After the passage of the Affordable Care Act (ACA), Maryland was in the first wave of states to expand Medicaid and to build its marketplace: the Maryland Health Benefit Exchange (MHBE). The legislature has created several programs through MHBE to keep coverage affordable, including the State Reinsurance Program, Young Adult Health Insurance Subsidies Program, and forthcoming State-Based Individual Subsidy Program. The state also established the nation's first Prescription Drug Affordability Board to lower prescription drug costs.

In that spirit, we are disappointed that the state is moving in the opposite direction with a proposal to shift costs associated with the Model to commercial plans. This is challenging for consumers, especially in light of other forthcoming market disruptions. The rates for individual

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

health insurance plans under the ACA will increase by an average of 13.4% in 2026, largely due to the impacts of expiring federal tax credits that Congress has not yet extended. Furthermore, we expect more individuals will need to purchase these plans if Medicaid eligibility requirements and funding cuts prohibit individuals from receiving services through that program. Large and small employers will also experience higher rates in 2026, driven in part by factors like inflation and the high cost of prescription drugs. While we appreciate that this policy will not take effect until 2028, it will exacerbate the health care affordability challenges Marylanders will already experience in the coming years.

We appreciate that the cost shift, if adopted, will be implemented through the update factor. Kaiser Permanente is concerned by how often the HSCRC went outside this process since the RY 2025 update factor was adopted, allocating more than an additional $500 million to hospitals. The update factor—rather than ad-hoc additional allocations—is the appropriate place for the HSCRC to address inflationary and additional revenue needs for hospitals. In light of this proposal, we urge the HSCRC to refrain from additional off-cycle rate increases if this policy is adopted.

**Medicare Advantage:** Medicare Advantage (MA) is popular among Medicare beneficiaries as an affordable way to fill the coverage gaps in Medicare's traditional fee-for-service program. The vast majority of Medicare beneficiaries rely on some type of supplemental coverage to fill Medicare's gaps. These gaps include co-pays, deductibles, and benefits such as hearing, vision and dental. Additionally, Medicare Advantage is the only way for beneficiaries to have their prescription drug coverage included as part of a comprehensive benefit.

In 2024, over half of Medicare beneficiaries in the U.S. voluntarily enrolled in Medicare Advantage. Medicare Advantage is especially important for vulnerable low-income and minority beneficiaries, with two-thirds of minority dual eligible (Medicare and Medicaid) beneficiaries choosing Medicare Advantage. However, this is not the case in Maryland, where only 24 percent of Medicare beneficiaries enroll in Medicare Advantage. Maryland's participation rate is one of the lowest in the nation, only slightly higher than Wyoming and Alaska. This is surprising given the strength of managed care in Maryland's other insurance markets.

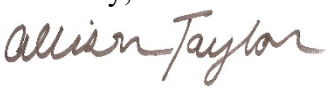
We appreciate the Regulatory Working Group's acknowledgement that Maryland needs a stable Medicare Advantage market to prevent further disruption and foster continuity of care for enrollees. KP has been committed to serving older and vulnerable adults in Maryland by offering Medicare plans in the state since 1987. Our Maryland-domiciled plan is the largest in the state, serving over 75,000 members. KP has continuously offered affordable, comprehensive plans despite the financial challenges of operating a Medicare Advantage plan in Maryland. However, our financial losses—$186 million in 2024 alone—are unsustainable. We are supportive of this proposal generally but are still evaluating whether it will provide enough funding to stabilize our plan.

The current proposal is open to plans who have at least 5,000 beneficiaries or 20% of their beneficiaries living in one of eight jurisdictions: Allegany, Baltimore City, Caroline, Dorchester,

Garrett, Somerset, Washington, and Wicomico. **We recommend that the Working Group expand the proposal to include plans with beneficiaries in Prince George's County.**[2] According to the National Institutes for Health, Prince George's County has by far the lowest uptake of insurance in the state. Accordingly, Prince George's County residents would greatly benefit from stable and consistent Medicare Advantage options.

Thank you for the opportunity to comment. Please feel free to contact me at Allison.W.Taylor@kp.org or (919) 818-3285 with questions.

Sincerely,



Allison Taylor, MPP JD
Head of Government Relations
Kaiser Permanente Mid-Atlantic States Region

[2] This would expand the definition of "Qualified Plan" to include "At least (1) 5,000 beneficiaries or (2) 20% of MA beneficiaries residing in Maryland in that H-Contract reside in these 8 jurisdictions: Allegany, Baltimore City, Caroline, Dorchester, Garrett, Somerset, Washington, Wicomico, or Prince George's."

The League of Life and Health Insurers of Maryland

15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

December 1, 2025

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

**Re: Comments on Regulatory Working Group Proposed Recommendations**

Dear Executive Director Kromm:

The League of Life & Health Insurers of Maryland is the state trade association representing life and health insurance companies in the State. The League appreciates the opportunity to provide comments on the proposed recommendations from the Multi-Agency Regulatory Working Group on cost-shifting and Medicare Advantage.

League members are dismayed that the State of Maryland is considering starting the AHEAD Model with a massive increase in costs on consumers by shifting costs from public to private payers. We recognize that the Federal Government will require the State to create Medicare savings; however, the magnitude of the savings is roughly equivalent to the savings required under the Total Cost of Care Model and the All-Payer Model – a magnitude of savings that the State has comfortably managed without resorting to cost-shifting. In fact, the Maryland Model, in all its various iterations, was created to avoid the need for cost shifting. The Commission's enabling statute requires that "the rates are set equitably among all purchasers or classes of purchasers without undue discrimination or preference." And the State has succeeded for nearly fifty years.

Unfortunately, the State is now proposing to abandon its commitment to equitable rates across payers, potentially in defiance of the Commission's statutory mandate. We urge Governor Moore to reject the Multi-Agency Working Group's proposal to raise prices on Maryland consumers.

We are particularly concerned that the State is choosing to raise prices on consumers before exploring other financing methods. Specifically, the Commission should right-size hospital global budget to current levels of utilization. Under the global budget, hospitals are paid a fixed amount, regardless of the actual number of patients that they treat. If utilization declines, as in fact it has, the hospitals remaining patients must pay not just for the care that they receive but

they also pay extra so that hospitals retain the revenue from care that they do not actually provide. The HSCRC has estimated that nearly $1 billion worth of retained revenue has built up in the State since 2014. If Medicare savings are necessary, the Commission should eliminate retained revenue before they ask consumers to pay even more for hospital care.

Finally on cost shifting, if the State does increase prices on Maryland consumers, it should also create a limit on hospital cost growth in order to ensure that Maryland consumers are protected from price increases on a going forward basis. The Maryland Model had a Medicare total cost of care target imposed on it by CMS. Because rates were set on an all-payer basis, this also ensured that hospital costs remained affordable for consumers.

By starting in 2028, there will be no limit on commercial hospital costs. If the State is going to increase costs on Maryland consumers in order to hold hospitals financially harmless under the model, it should at the very least ensure that even more cost shifting does not occur. The HSCRC should set an all-payer hospital revenue growth limit. Previous versions of the model have included similar targets, although the target has not been updated in ten years. The State should limit hospital cost growth to the underlying growth rate in the economy, as measured by the Gross State Product.

Once again, League members urge the State to reject the Multi-Agency Workgroup's proposal to raise costs on Maryland consumers. Health care costs are already too expensive, and the Model allows hospitals to retain huge revenues, despite providing less care. Cost-shifting is not necessary for the State to be successful under the AHEAD Model and it runs antithetical to the principles that have made the model successful for the past fifty years.

We also encourage the Multi-Agency Workgroup to continue to focus on Medicare Advantage market stability. While League members support targeting underserved areas, we recommend flexibility in criteria to avoid market disruption and ensure continuity of coverage for vulnerable populations. We also believe that benchmark alignment is critical to future success. We would suggest that the state work with CMS to address structural misalignment between MA benchmarks and the AHEAD model, which limits MA plan viability. League members are also sensitive to timing and predictability and believe that designation of qualified Plans in Quarter 1 is critical; we encourage the state to provide clear timelines and communication to allow plans to incorporate discounts into bids.

On behalf of the health plans operating in Maryland and supporting Maryland residents, we are very grateful for your attention on this matter. If you have any questions or would like to speak with us further on these topics, please reach out to me at mcelentano@fblaw.com.

Very truly yours,

Matthew Celentano
Executive Director

MedStar Health

10980 Grantchester Way
8th Floor
Columbia, MD 21075
410-772-6927
**MedStarHealth.org**

**Susan K. Nelson**
Executive Vice President and
Chief Financial Officer

December 2, 2025

Meena Seshamani, MD, PhD
Secretary, Maryland Department of Health
Herbert R. O'Conor State Office Building
201 West Preston Street Baltimore, MD 21201

**Re: Proposal of the Regulatory Working Group: Cost-Shifting and Medicare Advantage**

Dear Secretary Seshamani,

On behalf of MedStar Health, Inc. (MedStar) and its seven Maryland hospitals, thank you for the opportunity to provide comments on the Draft Policy Proposal of the Regulatory Working Group relating to Cost-Shifting and Medicare Advantage sent out on November 21, 2025. The Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, set to begin January 1, 2026 following the execution of the agreement between Maryland and CMMI, presents both significant challenges and opportunities for healthcare in Maryland and actions taken on both topics will directly impact the financial stability of healthcare providers across the state.

MedStar believes the cost shifting policy is critical to ensure hospitals have adequate revenue to care for the needs of Marylanders, invest in achieving the state's population health goals and remain financially viable. The cost shifting policy is also a key component of ensuring the financial risk and responsibility of the AHEAD model is shared across the healthcare ecosystem and not borne solely or disproportionately by hospitals. Financially stable hospitals providing access to needed care for all Marylanders and investing in programs to improve the health of the population are good for the state and good for the citizens. To this end, the proposal to increase commercial rates by $435 million does not go far enough. We write to express support for MHA's comprehensive letter on behalf of the state's hospitals.

**Proposed Commercial Cost Shift to Offset Medicare & Medicaid Payment Reductions**

**Maryland's success under the AHEAD Model will hinge on a cost shifting policy that fully offsets Medicare, Medicaid, and Medicaid Advantage payment reductions from 2026-2032 through increased commercial payments to provide hospitals with the financial resources needed to provide care for their patients and communities and increase & sustain investments in population health.** The Regulatory Working Group proposal to shift $435 million of cost onto commercial payors through an increase in the payment differential on hospital charges accounts for only half of the public payment reductions for hospitals under the life of the AHEAD Model. This proposal to fund only half of the projected $870 million public payor impact will have significant financial implications on Maryland hospitals, threatening access to care for Marylanders as well as the future success of the AHEAD model by limiting key population health investments. The unfunded reduction in public payor revenues, along with the financial pressures already felt by hospitals will be compounded by increases in the uninsured

population due to the Medicaid disenrollment. These pressures have already begun mounting with increased charity care.

**We request a cost shift which fully offsets the $870 million public payor reimbursement reduction.** As MHA points out in their comment letter, commercial rates in Maryland are sufficiently low and able to absorb an increase in reimbursement that would fully offset the $870 million of public payor reductions facing Maryland Hospitals. It is therefore possible to achieve the right balance, whereby access to care is maintained without placing undue burden on commercial payors, or premiums paid by Marylanders.

**Medicare Advantage Policy**

To stabilize Maryland's Medicare Advantage market and ensure that Marylanders have access to Medicare Advantage insurance products, the Regulatory Working Group is proposing an open-ended $150 million annual subsidy for Medicare Advantage carriers through an 11.55% public payer differential reduction. With the expected increase in the Medicare Advantage population this amounts to a blank check and represents a dangerous precedent. The proposal, as written, plans a corresponding increase to the payer differential for other payers to offset the proposed decline for the Medicare Advantage Plans. As such, this proposal is purportedly revenue neutral for hospitals, however, this comes at the expense of fully funding the public payor payment reductions impacting hospitals under the cost shift proposal. **Hospitals should not be impacted by any revenue reductions, directly or indirectly, to support Medicare Advantage plans.**

At a time when Maryland's hospitals are facing significant financial stress and uncertainty, we must take this opportunity to ensure the stability of hospital revenues across the state. The proposals as drafted do not fully fund the public payor revenue decrease, nor do they attempt to address the impact of H.R.1 and the inevitable increases in uncompensated care. At the same time, the proposals support Medicare Advantage plans, which had the largest increase in medical necessity denials across the state from FY2019 to FY2024. This combination of issues embedded in the Regulatory Work Group proposals will not ensure the stability of hospitals revenues and risks success under the AHEAD model.

Again, thank you for the opportunity to comment on these important issues. MedStar continues to be a willing partner working in collaboration with other stakeholders to promote the success of the Maryland Model. If you have any questions or wish to discuss any of the contents of this letter further, please do not hesitate to contact us.

Sincerely,

Susan K. Nelson
Executive Vice President & CFO
MedStar Health

cc: Perrie Briskin, Medicaid Director, Maryland Department of Health
Michele Eberle, Executive Director, Maryland Health Benefit Exchange
Marie Grant, Commissioner, Maryland Insurance Administration
Dr. Douglas Jacobs, Executive Director, Maryland Health Care Commission
Dr. Elizabeth Kromm, Assistant Secretary, Maryland Department of Health
Dr. Jon Kromm, Executive Director, Health Services Cost Review Commission
Laura Goodman, Associate Director, Health Services Cost Review Commission

Maryland
Hospital Association

December 2, 2025

Meena Seshamani, M.D., Ph.D.
Secretary, Maryland Department of Health
Herbert R. O'Conor State Office Building
201 West Preston Street
Baltimore, MD 21201

**Re: Regulatory Working Group Proposal for Cost-Shifting and Medicare Advantage**

Dear Secretary Seshamani,

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, thank you for the opportunity to provide comments on the Regulatory Working Group's recently released proposal for cost shifting and Medicare Advantage (MA).

As we shared in our Nov. 4 letter, a responsible, balanced cost shifting policy is in the best interest of the state, Marylanders, and the entire health care system and can be implemented while maintaining affordability for consumers and commercial payers. We are concerned that the proposed $435 million increase to commercial rates does not adequately rebalance costs across the health care system and will threaten Marylanders' access to essential hospital services, the financial stability of hospitals, and the state's success under AHEAD.

We respectfully urge the Regulatory Working Group to consider the following comments and those offered by hospitals in preparing the proposal for submission to Governor Moore.

Cost Shifting Policy

**It is critical for the state to advance a cost shifting policy that fully offsets AHEAD's Medicare total cost of care savings (TCOC) requirement and corresponding reductions in hospital payments from Medicaid and Medicare Advantage**—estimated at $870 million by the Regulatory Working Group. Given that the state and hospitals will be held accountable for Medicare total cost of care savings starting in January, the policy should be implemented beginning in CY 2026. A delayed cost shift of a lesser magnitude will leave Maryland hospitals in a financial position that may limit their ability to maintain the level of services currently provided to Maryland communities and invest in necessary population health initiatives.

Additionally, we request that the Regulatory Working Group provide additional information on the methodology that was used to estimate the $870 million reduction in hospital payments. We also ask that the Regulatory Working Group advance a policy with sufficient flexibility to update the cost shift allocation to account for revised Medicare savings targets or estimates of corresponding reductions in hospital payments from Medicaid and Medicare Advantage.

*Implications on Access to Care*

As noted in our previous letter, an insufficient cost-shifting policy will have direct consequences for access to hospital care. Without the ability to rebalance payment reductions from public payers, Maryland hospitals will experience financial strain that could require them to scale back services or eliminate them altogether to sustain operations. Behavioral health services, obstetrical services, cardiology services, and subsidized community programs that generate limited revenue but provide critical public health benefits are among those services at risk. These reduced offerings would likely impact the communities that need them most as they are generally served by hospitals with a higher public payer mix.

*Affordability*

MHA shares the Regulatory Working Group's commitment to maintaining the affordability of health care coverage and services. MHA modeling shows that the increase in commercial reimbursement rates necessary to fully offset hospital payment reductions from public payers can be achieved while maintaining affordability for payers, consumers, and businesses given Maryland's significantly lower commercial hospital reimbursement rates.

While Maryland's commercial insurance premiums are 4% lower than the United States average for an individual and more on par with the national average for a family, commercial payers in Maryland incur approximately 20% lower hospital costs compared to demographically similar areas across the country as noted by the Regulatory Working Group.[1]

The average commercial hospital reimbursement rate in Maryland in FY 2024 was approximately 178% of national Medicare fee-for-service rates, well below publicly available regional benchmarks from Milliman (250%) and RAND (324%).[2, 3] This data suggests that commercial payers can pass more of these reduced costs to consumers in the form of lower premiums and bear more of the responsibility of increased rates without raising premiums. As we noted in our public testimony, the state's cost shifting policy must strive for balance between access to care for communities and affordability for employers and consumers.

*Medicare TCOC Savings Target*

The proposed $435 million increase in commercial rates represents only half of the cost shift allocation needed to offset the reduction in payments from public payers to hospitals due to the Medicare TCOC savings requirement. It should also be noted that the estimated total reduction in payments from public payers ($870 million) assumes an average annual national Medicare per-beneficiary expenditure growth rate of 4.99% and a cumulative savings target of $460 million through Performance Year 7 of AHEAD (CY 2032). Should the actual per-beneficiary Medicare expenditure growth rate as measured by the United States Per Capita Cost (USPCC) exceed this conservative estimate of 4.99%, the state's Medicare savings target and total reduction in hospital payments from public payers over the next seven years will be higher than $460 million

[1] Kaiser Family Foundation, 2024. Average Annual Single Premium per Enrolled Employee For Employer-Based Health Insurance, available here; based on the Medical Expenditure Panel Survey (MEPS)
[2] Milliman, 2024. White Paper – Commercial Reimbursement Benchmarking, available here
[3] RAND, 2024. Prices Paid to Hospitals by Private Health Plans, available here

and $870 million, respectively. The policy should allow for flexibility to modify the cost shifting allocation based on updated USPCC trend data.

*Medicaid Enrollment and Uncompensated Care*

The overarching goal of the Regulatory Working Group, as described in the Governor's Sept. 23 directive, is to address issues related to the implementation of AHEAD and H.R.1. However, the proposed $435 million shift is based *solely* on the estimated reductions in hospital payments from public payers due to the Medicare TCOC savings requirement and does not account for large, anticipated increases in uncompensated care and reductions in enrollment in Medicaid due to H.R.1. Federal work requirements, reduced retroactive coverage, and other changes are expected to result in a 12 to 15% decline in enrollment between FY 2027 and FY 2028. These changes will cut hospital Medicaid payments by $5.5 billion over the next decade according to estimates from the Maryland Department of Health. These impacts will result in greater use of emergency departments for non-emergent care needs and higher levels of uncompensated care statewide. The cost shifting allocation should be updated to account for the disproportionate effect of these policies on hospitals.

*Hospital Utilization Reductions*

In its proposal, the Regulatory Working Group acknowledges that Maryland hospitals have significantly reduced utilization under the TCOC Model and that achieving additional savings through further reductions in utilization under AHEAD will be more difficult. In fact, an MHA analysis of all-payer data from the National Academy for State Health Policy's (NASHP) Hospital Cost Tool found that overall hospital utilization in Maryland decreased by 13 percent between 2013 and 2023, compared to a 10 percent increase in hospital utilization nationally over the same period.[4] Despite this steep decline in utilization, the proposal assumes that hospitals can continue to make progress in curbing unnecessary utilization, specifically by reducing inpatient days per 1,000 and readmissions to the 25$^{th}$ national percentile. On an all-payer basis, however, Maryland's average hospital discharges per capita is fifth lowest in the nation. We value the Model's aims of reducing utilization where possible but question whether these assumptions are reasonable due to the maturity of the Model and the anticipated increased demand for hospital services resulting from the changing demographics of the population and reductions in Medicaid enrollment. Moreover, we remain concerned that further reducing hospital utilization to achieve savings targets may have unintended consequences for access to and quality of care. The state must prioritize preservation of access in discussions about opportunities to achieve efficiencies in delivery of care and in determining the appropriate level of cost shifting.

*Hospital Investments Under AHEAD*

The Regulatory Working Group advanced the position that achieving required TCOC savings solely through a cost shift would detract from state and hospital efforts to lower acute care costs through population health improvements and investments in primary care. There are, however, components of AHEAD other than the Medicare TCOC savings target that incentivize efforts in support of model goals, including the incentives inherent in the fixed revenue structure of hospital global budgets, the all-payer and Medicare primary care investment targets, Population

[4] National Academy for State Health Policy (NASHP). Hospital Cost Tool. Available here.

Health Accountability Plans, and other Medicare hospital global budgets incentives, including the Community Improvement Bonus and TCOC Performance Adjustment. Furthermore, a hospital's ability to invest in population health, preventive health, and chronic disease management initiatives envisioned under AHEAD hinges on their financial health. A cost shifting policy that does not fully offset the reduction in hospital payments from public payers will constrain resources and limit the ability of hospitals to make these critical investments.

Medicare Advantage Policy

The Regulatory Working Group is proposing an annual $150 million subsidy program for Medicare Advantage plans that would begin in 2027, continue indefinitely, and be funded through an additional 11.55% public payer differential for their beneficiaries with the cost offset by increases in rates for other payers. **The proposed subsidies for MA plans should not come at the expense of a cost shifting policy that does not fully offset reductions in hospital payments at this decisive moment for Maryland hospitals**. In its proposal, the Working Group aims to adopt, in a parallel effort, policy solutions for both cost shifting and Medicare Advantage while upholding the values of health care quality, access, outcomes, and affordability. The effort to subsidize MA plans should yield to the priority of ensuring hospitals have the resources needed to sustain operations, preserve access to care for their communities, and successfully transition to AHEAD. Any proposal to subsidize MA plans must have clearly defined goals, be limited in time and scope, establish robust standards that require investments to support the health of members and eliminate wrongful denials, and require carriers to adopt a detailed plan to achieve financial stability without dependence upon state subsidies.

*Policy Duration and Scope of Discounts*

As the policy has been described, the proposed discounts for MA plans are not limited in duration or scope. These subsidies should serve as a temporary fix, not a long-term solution. The discounts provide immediate support but may also contribute to reliance on outside funding and unintentionally delay investments in efficiencies that promote self-sufficiency of plans. The Working Group estimates a program cost of $150 million while also acknowledging that this cost is likely to increase if the subsidies achieve their intended goal of stabilizing the market and that hospitals will bear the risk of a larger-than-anticipated discount. The infinite nature of the subsidies presents a significant risk to hospitals at a time when they can least afford it. To support predictability and plan accountability, any program for MA plans must be time limited, have an annual cap on the amount of funding for subsidies, and specify factors that will be used to reduce and discontinue program funding in future years.

*MA Policy Goals and Criteria for Qualified Plans*

In addition to the criteria specified in the proposal, there should be clearly defined goals for the MA policy and strong guardrails and accountability measures for plan participation. MA plans should be required to demonstrate meaningful investment in population health and member support services. MA plans must also adhere to reasonable utilization review standards, including compliance with benchmarks for medical necessity determinations, prior authorization processes, and minimal rates of prior authorization and claim denials. This is a particular concern as hospitals across the state continue to face a troubling and persistent increase in inappropriate and excessive MA denials: a trend that has worsened in recent years. From FY 2019 to FY 2024,

medical necessity denials for MA plans in Maryland increased by 233%. These denials have caused patient delays and imposed significant administrative burdens and financial strain, exacerbating ongoing sustainability challenges for hospitals. In addition, plans should be required to show measurable improvements in star ratings over time as evidence of their commitment to quality and patient outcomes. Without these safeguards, hospitals risk absorbing the costs of plan incentives without corresponding improvements in care delivery or patient health.

*All-Payer Revenue Limit*

Under the terms of the AHEAD Agreement, the state must limit annual all-payer hospital revenue growth to a specified limit of 3.58% starting in CY 2026. The state must ensure that any revenue support for MA plans is removed from the evaluation of state performance on this target.

Conclusion

Maryland hospitals' ability to provide access to care for our communities 24/7/365 and drive towards the population health objectives of AHEAD depends on a cost shifting policy that sufficiently rebalances costs across the system and supports their financial stability.

Thank you for your continued leadership and support of the hospital field in our ongoing efforts to improve the health and wellbeing of Marylanders. We look forward to continuing to engage with the Regulatory Working Group on these important policy issues and others over the next several months.

Please contact me with any questions.

Sincerely,

Melony G. Griffith
President & CEO

cc: Perrie Briskin, Medicaid Director, Maryland Department of Health
Michele Eberle, Executive Director, Maryland Health Benefit Exchange
Marie Grant, Commissioner, Maryland Insurance Administration
Dr. Douglas Jacobs, Executive Director, Maryland Health Care Commission
Dr. Elizabeth Kromm, Assistant Secretary, Maryland Department of Health
Dr. Jon Kromm, Executive Director, Health Services Cost Review Commission
Laura Goodman, Associate Director, Health Services Cost Review Commission

Maryland

**MDH Maryland-Model -MDH- <mdh.maryland-model@maryland.gov>**

# Comment on Cost Shifting and Medicare Advantage

1 message

**Falana Carter** <fcarter@mpcp.com> Tue, Dec 2, 2025 at 9:15 AM
To: "MDH.Maryland-Model@maryland.gov" <MDH.Maryland-Model@maryland.gov>
Cc: Falana Carter <fcarter@mpcp.com>

Thank you for the opportunity to voice an opinion on a very important topic of cost shifting and Medicare Advantage. I share the similar position of MedChi, as part of an independent Primary Care organization it is difficult to recruit to the state of Maryland due to the low payments to primary care providers who work to help cost save for our patients and commercial insurers.
Much of the burden of cost shavings is placed on the providers with continued decrease in base payments that sustain our independence while striving to keep up with new technology and analytical needs to match the changes in medicine. Cost of care has allowed some incentive for primary care providers to continue high level care.
My concern is that with the cost shifting ,how does that affect how providers are reimbursed and also how shifting the payment rates under CMMI will help primary care providers who are asked to accept lower rates for more complicated patients.

Thank you for your time

Falana P Carter, MD

Maryland Primary Care Physicians

Population Health Director

Clinical Director, Arundel Mills

410-551-0499 Ex 4818

Maryland

**MDH Maryland-Model -MDH- <mdh.maryland-model@maryland.gov>**

# Comments on AHEAD Model: Draft Policy Proposal on Cost-Shifting and Medicare Advantage

1 message

**Mercy Obamogie** <obamogie.mercy@gmail.com> Tue, Dec 2, 2025 at 12:01 PM
To: MDH.Maryland-Model@maryland.gov

To the Regulatory Working Group AHEAD Model

Thanks for the proposal on Cost-Shifting and Medicare Advantage dated November 2025.

As a practicing Family Physician, I am concerned about the long-term effects these changes will have on Family Physicians in private practice, regarding future reimbursement from commercial insurance companies. I fear that these companies, in an attempt to offset the costs that they will incur, may arbitrarily reduce reimbursement to physicians, especially those in primary care. This will further negatively affect access to care, especially for those patients in rural areas, as physicians struggle to meet overhead expenses. My suggestion is that a safeguard be included in the proposal so that the commercial insurance companies do not unilaterally decrease the reimbursement to physicians in future.

--
Mercy Obamogie, MD
Office: (301) 345-5900

**Comments on Work Group Proposals on Cost-Shifting and Medicare Advantage**

1199SEIU, the largest healthcare workers union in the state of Maryland as well as Economic Action MD, a leading voice for economic justice in the state, appreciate the opportunity to share our concerns on the AHEAD Model Regulatory Working Group's policy recommendations on Medicare Advantage stabilization as well as cost shifting policies.

Over the years, our organizations have been strong supporters of the HSCRC and the Maryland model at large. We have proudly collaborated with HSCRC, serving on numerous workgroups in the role of patient and labor advocates. We have always appreciated the work of the HSCRC and strongly believed that the Maryland All-Payer Model, through its many iterations, has successfully increased access to hospital care as well provided price transparency in a way that doesn't exist in other states.

Under the new AHEAD model agreement with the federal government, we acknowledge that key decisions will have to be made, particularly in the areas of cost shifting and Medicare Advantage stabilization.

***However, we believe that the two policy recommendations submitted for review need more time for stakeholder review and an opportunity for a more balanced approach to be considered.***

The two policy recommendations call for consumers and the commercial market to cover all the shifting costs resulting from the changes in the AHEAD model. We believe this to be burdensome for everyday Marylanders during a period where working families can least afford to cover these increased costs.

We propose a more balanced approach, where hospitals, particularly those with the financial means to do so, absorb some of this increased cost burden as well. More time would be needed to study how this cost shift would be shared by hospitals equitably. This additional time would also allow more of an opportunity for different stakeholders and audiences to begin to understand the challenges at hand and provide important feedback.

We appreciate your attention to our concerns and hope you will take these concerns under consideration.

Girume Ashenafi, 1199SEIU United Healthcare Workers East
Marceline White, Economic Action Maryland (formerly Maryland Consumer Rights Coalition)

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

250 W. Pratt Street
24th Floor
Baltimore, MD 21201-6829

CORPORATE OFFICE

December 2, 2025

Dear Members of the Regulatory Working Group,

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, thank you for the opportunity to provide comments on the cost-shifting proposal of the Governor's Regulatory Working Group (the Working Group). The regulatory changes and federal funding reductions contemplated by the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model represent a foundational disruption of both the all-payer nature of the Maryland regulatory model and the historic resource balance that enables hospitals to deliver the high-quality services that Marylanders need. Ensuring sufficient resources to support an appropriate care model is the statutory charge of the Maryland model, and upholding this regulatory commitment is critical to the future of the Maryland healthcare delivery model.

UMMS recognizes the difficult task of balancing the core goals of access, quality, outcomes and affordability as the State navigates an AHEAD Model that seeks to deliver an estimated $870 million federal savings for the Medicare and Medicaid programs that is more than $630 million beyond the $235-$240 million Medicare FFS savings contemplated by the November 2024 agreement (nearly quadrupling expected savings). This increased savings expectation is driven by the combined impact of more than doubling the Medicare FFS savings target and adding the requirement that commensurate savings be generated across other federal payments. This task is made even more difficult by the expected impact of House Resolution 1 (H.R.1) on Medicaid and uncompensated care, which above and beyond the $870 million AHEAD savings requirement and not contemplated by the group's cost-shifting proposal.

As the proposal points out, commercial payers in the Maryland Model benefit from 20% lower costs for hospital-based services, and, even if the entire $870 million AHEAD savings expectation were borne as higher commercial payments, by the Working Group's estimation, commercial premiums would only increase by 3.6% over seven years, or an annual rate of 0.6%. Considering the nominal impact on affordability, UMMS must reiterate that, as we stated in our initial comments, the most important goal of a cost-shifting policy is to ensure appropriate resources for hospitals to maintain access to high-quality healthcare services.

In terms of total spending on hospital-based care, Maryland is not over-resourced compared to other states. The per capita resources available to hospitals in Maryland are in line with the national per capita average and 13% below the per capita average for the Mid-Atlantic region (DC, DE, NJ, NY, PA, VA, WV)[1]. UMMS is deeply concerned that the cost-shifting proposal would distribute half of the $870 million AHEAD Model savings burden to a hospital industry that is already living on significantly less hospital-based resources than our regional peers. For context, the $435 million savings that the cost-shifting proposal expects hospitals to bear was 2.25% of net patient revenue in Fiscal Year 2024, which, if lost, would completely wipe out the 1%-2% operating margins that hospitals have averaged over the past several years.

[1] CMS National Health Expenditure data, 2020.

By asking hospitals to bear the equivalent of their entire operating margin as savings risk, the cost-shifting proposal, as constructed, places disproportionate risk on access and quality of care, even though the affordability equation for commercial payers and beneficiaries would remain favorable when compared to demographically similar areas. There is also no mention of regulatory improvements or increased responsibility to commercial insurers for this extraordinary, long-term government protection. For this reason, UMMS believes that the cost-shifting proposal falls short of both the Governor's directive to strike a balance between access, quality, outcomes and affordability, and the concept of the savings requirement 'not being borne exclusively by hospitals.'

To strike a better risk balance between access, quality, outcomes and affordability, UMMS continues to believe that we need to ensure the entirety of the $870 million AHEAD savings expectation be addressed through a cost shift to sustain access and quality in our healthcare delivery system. Not doing so produces unnecessary risk for Maryland citizens in terms of access to high quality hospital services. At the very least, the entire $630 million beyond the Medicare FFS savings targets contemplated by the original November 2024 AHEAD agreement should be addressed through a cost shift.

UMMS has the following additional concerns regarding the cost-shifting proposal in addition to the proposed handling of AHEAD savings requirements:

1. Regarding the core value in the Governor's Directive to spread the burden of the savings requirement, UMMS is concerned that the cost-shifting proposal, as currently constructed, places the burden entirely on either (1) hospitals or (2) premium increases for Maryland citizens. Considering the value the Maryland Model provides in terms of reduced hospital-based costs for commercial payers, UMMS would ask that the Maryland Insurance Agency implement accountability measures to ensure that value is delivered as lower premiums to Maryland commercial beneficiaries. We also repeat our request that there is a study of commercial benefits and affordability under this model, alongside new data transparency commitments from commercial insurers.

2. UMMS continues to be concerned that the cost-shifting proposal does not address the anticipated impact of H.R.1 on Medicaid payments and enrollment, with implications as early as Calendar Year 2027. UMMS would urge the Working Group to direct the Health Services Cost Review Commission (HSCRC) to make necessary changes to, or commitments to amend, its Uncompensated Care (UCC) policy to address these issues as cost shifts in real-time.

3. UMMS also continues to be concerned that any cost-shifting proposal necessitates differential treatment of hospitals with higher governmental payer mixes to ensure that a two-tiered system of hospitals isn't created based on the types of patients that are served. Alternative funding mechanisms should be considered to ensure safety-net and high proportion public payer hospitals have appropriate financing. Additionally, as cost-shift and rate disparities emerge within the State, policy will need to consider how to maintain this equity among all hospitals, even should payer behaviors change.

4. When establishing cost-shifting policy, it is unreasonable to use the 4.62% Medicare FFS savings achieved from 2014 to 2023 (or the 3.89% savings achieved from 2014 to 2019) as a measuring stick for what might be achievable from 2026 to 2032. Both the November 2024 and November 2025 AHEAD State Agreements set savings targets below those levels because they rightly assume diminishing opportunity to generate savings above and beyond what was achieved over the first ten years of a fixed revenue model. Cost-shifting policy should assume the same. UMMS also believes strongly that it is unreasonable to expect the entire state, in every region, to achieve the 25$^{th}$ percentile utilization

performance expected by the HSCRC analysis, and that a much more nuanced approach to setting utilization benchmarks is necessary if we are to assess real care management opportunity.

UMMS is deeply invested in delivering Maryland citizens a care model that achieves the goals of high-value care, fairness in access to care and equitable outcomes. We cannot emphasize enough that equitable access to healthcare is a strength of the Maryland model that can only be maintained by ensuring an adequately funded healthcare system. An appropriate cost-shift to commercial payers that preserves the broader hospital-based resource base for the State ensures that hospitals will not be forced to reduce services and patient access to high-quality care will not be negatively impacted. We are concerned that the cost-shifting proposal, as constructed, places disproportionate, unnecessary risk to that access model, and we implore our State's policy experts to utilize the cost-shifting tools available to them to ensure access to a care delivery model that meets individuals' needs is available to all Maryland communities. Thank you again for the opportunity to comment on this important issue. UMMS continues to be a willing partner to collaborate with you and our other state agencies to promote the success of the AHEAD Model.

Sincerely,

Mohan Suntha, MD
President and Chief Executive Officer
University of Maryland Medical System

December 2, 2025

The Honorable Meena Seshamani, MD, PhD
Maryland Secretary of Health
Maryland Department of Health
201 West Preston Street
Baltimore, MD 21201

*Submitted to: MDH.Maryland-Model@maryland.gov*

**RE: Response to the Maryland Multi-Agency AHEAD Regulatory Work Group's Cost-Shifting Proposal**

Dear Secretary Seshamani,

Thank you for the opportunity to provide comments in response to the Maryland Multi-Agency Regulatory AHEAD Work Group's Cost-Shifting Proposal.

United States of Care (USofCare) is a non-partisan, non-profit organization working to ensure everyone has access to quality, affordable health care, regardless of health status, social need, or income. From our listening work, we know that affordability tops the list of people's concerns about our country's health care system. Cost concerns are especially acute in Maryland, where more than half (55%) of all people have experienced difficulty affording their health care over the past year and more than four-in-five worry about affording care in the future. Marylanders have long benefitted from the state's unique system of all-payer rate setting and, more recently, its innovative Total Cost of Care Model, which has lowered health care spending by more than $700 million. Unfortunately, due to the increasing cost of care, more is needed to ensure health care remains affordable for Maryland families.

To that end, we believe the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model is strongly positioned to bring together hospitals, primary care providers, plans, consumers, and others to continue and strengthen the affordability gains made under previous Models. USofCare has long supported the AHEAD Model, which we believe will continue to improve Maryland's health care system by curbing health care spending, promoting population health, and improving care coordination statewide.

To meet AHEAD's cost savings goals, the Model requires approximately $870 million in savings be achieved by Maryland's public payers (Medicare Fee-for-Service, Medicaid, and Medicare Advantage) through the Model's hospital global budgets provisions. To offset these savings, the Working Group proposes a "cost-shifting" policy that would increase commercial hospital rates by $87 million annually. This policy would likely result in a 1.8% increase in premiums by 2032, which could be as high as 4% in areas with fewer commercial insured people, further straining the budgets of already cash-strapped people and employers.

While we appreciate the Working Group's efforts to develop a proposal that minimizes impact on everyday people, we believe more can be done to hold people harmless while, at the same time, still ensuring that the AHEAD Model's cost savings goals are met. People have already experienced significant affordability challenges in recent years: premiums for plans offered on the state's individual marketplace are scheduled to increase, on average, by 13.4% next year, and looming uncertainty surrounding the expiration of federal enhanced premium tax credits threatens to double or triple premiums for some families, even after a critical state subsidy kicks

in. Any additional potential premium increases found in this cost-shifting policy threaten to push care even more out of reach for families across the state.

Furthermore, implementing a cost-shifting policy that establishes different payment rates for different insurers threatens to undo much of Maryland's decades-old successful experiment in all-payer rate setting. Re-introducing higher rates for commercial payers would complicate rate negotiations and require additional staff and resources for both providers and payers. It also may encourage hospitals, who until now benefited from equal payment rates regardless of payer, to refocus efforts toward serving populations with better-paying private insurance and away from underserved populations, who tend to be disproportionately enrolled in public insurance plans. As a result, we are concerned that hospitals and other providers may abandon the AHEAD Model's goals of primary care investment and emphasis on population health as a way to lower health care costs if they're assured increased payments under the cost-shifting policy.

Instead of pursuing solutions that may increase people's health care costs, we encourage the Working Group to expand existing efforts that promote overall system financial health while also promoting the AHEAD Model's goals of lowering costs for people and improving health outcomes, such as expanding existing efforts to reduce hospital admissions and improving access to primary care. Given the success of the TCOC Model's hospital global budget provision, we believe hospitals will continue to benefit from these arrangements under AHEAD, thanks to their financial predictability and corresponding opportunities for future investment, without increasing costs for people.

We agree with Governor Moore – no one should be forced to shoulder the costs of this transition alone. At the same time, given the very real affordability crisis facing people and families across Maryland, we believe it's essential that people be held harmless as the state plans for this transition. By learning from and building upon the successes and lessons learned under previous innovations like the Total Cost of Care Model, Maryland can continue to lead the way toward a system of care that lowers costs and improves outcomes for all people under the AHEAD Model.

We thank the members of the Maryland Multi-Agency Regulatory AHEAD Work Group on their commitment to successful implementation of the AHEAD Model. We appreciate the opportunity to provide feedback on its cost-shifting proposal. Please don't hesitate to reach out with any questions.

Sincerely,

Eric Waskowicz
Senior Policy Manager
ewaskowicz@usofcare.org