maryland
health services
cost review commission

641st Meeting of the Health Services Cost Review Commission

April 15, 2026

(The Commission will begin in public session at 12:00 pm for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 pm)

CLOSED SESSION
12:00 pm

1. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on March 11, 2025

Specific Matters

For the purpose of public notice, here is the docket status.

Docket Status – Cases Closed

2690A Johns Hopkins Health System
2691A Johns Hopkins Health System
2692A Johns Hopkins Health System
2693A Johns Hopkins Health System
2666A University of Maryland Medical Center- Second Extension Request
2667A University of Maryland Medical Center- Second Extension Request

2. Docket Status – Cases Open

2689N Luminis Health Doctors Community Medical Center
2694A Johns Hopkins Health System

3. Confidential Data Request: Oregon Health and Science University

4. Confidential Data Request: Johns Hopkins Bloomberg School of Public Health

Subjects of General Applicability

5. Report from the Executive Director
    a. Model Monitoring
    b. Policy Calendar Update

c. Health System Transformation Update
d. Legislative Report
e. Quality Program and Non-Financial Metrics
f. Update on Care Transformation Initiatives
g. FY 2025 Systems Financial Performance

6. Draft Recommendation: Inpatient Length of Stay
7. Revisit Select Volume Realignment Policy
8. Hearing and Meeting Schedule

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

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

REPORT OF MARCH 11, 2026, CLOSED SESSION

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

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

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

ITEM II
CLOSED CASES

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

ITEM III
OPEN CASE

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

STATEMENT OF COUNSEL

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

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

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

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

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

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

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

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

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

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

No action was taken on these agenda items.

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

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

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

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

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

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

No action was taken on these agenda items.

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

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

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

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

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

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

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

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

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

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

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

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

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

ITEM VII
ADVENTIST HEALTHCARE GERMANTOWN EMERGENCY CENTER ACTION

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

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

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

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

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

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

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

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

Mr. Henderson presented the staff's draft recommendation:

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

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

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

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

Testimonies:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ITEM VIII
REPORT FROM THE EXECUTIVE DIRECTOR

Model Monitoring

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

Policy Calendar Update

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

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

Health System Transformation Update

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

Legislative Report

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

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

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

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

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

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

No action was taken on these agenda items.

ITEM IX
PRESENTATION: FY 2025 CLINICIAN COST SCHEDULE RESULTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

No action was taken on these agenda items.

ITEM X
DRAFT RECOMMENDATION: HEALTHCARE OUTCOME PAYMENT EFFORT

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

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

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

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

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

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

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

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

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

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

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

No action was taken on these agenda items.

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

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

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

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

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

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

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

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

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

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

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

Testimonies:

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

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

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

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

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

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

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

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

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

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

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

ITEM XII
FINAL RECOMMENDATION: MEDICARE PERFORMANCE ADJUSTMENT (MPA)

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

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

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

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

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

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

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

ITEM XIII
HEARING AND MEETING SCHEDULE

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

There being no further business, the meeting was adjourned.

Closed Session Minutes
of the
Health Services Cost Review Commission
March 11, 2026

Chairman Sharfstein stated the reasons for Commissioners to move into administrative session, under the authority of the General Provisions Article §3-103 and §3-104 for the purpose of discussing the administration of the Model and updating the Commission on the current staff investigation.

Upon a motion made in public session, Chairman Sharfstein called for an adjournment into closed session.

The administrative session was called to order by motion at 12:00 p.m.

In addition to Chairman Sharfstein, Commissioners Blum, Elliott, Johnson, Maine, McCann and Sabi were in attendance.

Staff members in attendance were Jon Kromm, Jerry Schmith, William Henderson, Claudine Williams, Christa Speicher, Alyson Schuster, Cait Cooksey, Erin Schurmann, Bob Gillion, Karen Teague, Steven Crocker and William Hoff.

Also attending were Assistant Attorneys General Stan Lustman and Ari Elbaum, Commission Counsel.

Item I

Ms. Erin Schurmann, Associate Director, Strategic Initiatives and Mr. Steven Crocker, Chief, Audit & Integrity, updated the Commission and the Commission discussed the Regional Partnership performance.

Item II

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, updated the Commission, and the Commission discussed the TCOC model monitoring.

Item III

Mr. Henderson also updated the Commission, and the Commission discussed the FY26 Hospital Financial Condition through January 2026.

The Closed Session was adjourned at 12:50 p.m.

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

April 15, 2026

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2026
SYSTEM	*	FOLIO:	2504
BALTIMORE, MARYLAND	*	PROCEEDING:	2694A

I. INTRODUCTION

On February 27, 2026, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Johns Hopkins Howard County Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a global price arrangement with Carrum Health, Inc. for joint replacement and joint replacement consult services, hip and knee replacement, cardiovascular, CAR-T and spine surgery. The Hospitals request that the Commission approve the arrangement for one year beginning April 1, 2026.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in

payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination with Carrum Health, Inc. for joint replacement and joint replacement consult services, hip and knee replacement, cardiovascular, CAR-T and spine surgery for a one-year beginning April 1, 2026. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Request to Access HSCRC Confidential Patient Level Data from The Oregon Health and Science University

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by **Oregon Health & Science University** for the Data for **Calendar Years 2012 through 2021** be approved, with the understanding that components of this work were **previously approved at the HSCRC Public Meeting on March 8, 2023** for the project *"Risk Prediction and Optimizing Outcomes to 1-Year After Firearm Injury Among Children,"* and **previously approved at the HSCRC Public Meeting on July 30, 2025** for the project *"A Multi-State Evaluation of Emergency Department Pediatric Readiness."*
2. This access will include limited confidential information for subjects meeting the criteria for the research.

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Final Staff Recommendation for a

Request to Access HSCRC Confidential Patient Level Data from

The Oregon Health and Science University

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

This is a final recommendation for Commission consideration at the April 15, 2026, Public Commission Meeting.

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SUMMARY STATEMENT

Oregon Health & Science University (OHSU) requests access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient) and Hospital Outpatient Data Sets (Outpatient) collected by the Health Services Cost Review Commission (HSCRC) to support two large, federally funded projects evaluating emergency department (ED) pediatric readiness and pediatric firearm injury outcomes. This request represents a **renewal of work previously approved by the Board of Commissioners on March 8, 2023 and July 30, 2025**; there are **no changes** to the research aims, study design, or the confidential data elements required for these analyses. The projects aim to assess how ED pediatric readiness influences survival, quality of care, healthcare utilization, and costs for children receiving emergency services, and to develop risk-prediction models and systems-level strategies to reduce morbidity and mortality associated with firearm injuries in children. Collectively, these studies will inform clinical practice, emergency care systems, and national health policy to optimize pediatric emergency care.

OBJECTIVE

This request includes two ongoing, unchanged research initiatives:

1. **A Multi-State Evaluation of Emergency Department Pediatric Readiness**
   This project evaluates pediatric emergency care readiness using statewide and multi-state data across two major readiness survey periods (2012–2014 and 2019–2021). Objectives include: assessing guideline uptake; examining associations between ED readiness and outcomes; evaluating costs; and developing survival-based, validated measures of pediatric readiness. Findings will inform the National Pediatric Readiness Project (NPRP), Emergency Medical Services for Children (EMSC), trauma system guidelines, and national health policy.

2. **Risk Prediction and Optimizing Outcomes to 1-Year After Firearm Injury Among Children**
   Using three national cohorts, this project develops machine-learning and geospatial prediction models for firearm injury, recidivism, healthcare utilization, and 1-year mortality. It also evaluates which ED and hospital characteristics most influence survival after firearm injury. These findings will inform primary, secondary, and tertiary prevention strategies and guide revisions to trauma triage guidelines, trauma center verification standards, and pediatric readiness policy.

Together, these projects address critical scientific gaps and have direct implications for reducing preventable mortality, improving emergency care quality, and guiding national pediatric health policy.

Oregon Health and Science University received approval from the Maryland Department of Health (MDH) Institutional Review Board (IRB) on March 10, 2026, and the MDH Strategic Data Initiative (SDI) office on June 30, 2025.

(The Data will not be used to identify individual patients. All PHI will remain at the University of Utah for the purpose of record linkage and will be destroyed immediately after linkage is complete. The de-identified limited dataset will be retained by Oregon Health & Science University until project completion on December 31, 2026. At that time, all Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.)

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"), which includes representatives from HSCRC and the MDH Environmental Health Bureau. The Review Committee evaluates whether:

1. The proposed study or research is in the public interest;
2. The study or research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
5. The organization has adequate data security procedures in place to ensure protection of patient

OHSU requests approval to use confidential patient-level data for **Calendar Years 2012 through 2021**. These data years are essential for constructing the study cohorts, performing probabilistic linkages with vital statistics, examining pre- and post-survey pediatric readiness periods, and estimating longitudinal outcomes. The limited PHI variables requested include **date of birth, patient home ZIP code, and all relevant service dates** (date of service, discharge dates, procedure dates). These fields are required for linkage and for generating distance, timing, and survival-related variables. All PHI will remain exclusively at the University of Utah Data Coordinating Center and will be destroyed following linkage; only de-identified limited datasets will be provided to OHSU for analysis, in accordance with the approved Data Security Plan.

The Review Committee unanimously agreed to recommend approval. As with all confidential data approvals, OHSU will provide annual progress reports and will submit the final project report to the HSCRC prior to public release.

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by **Oregon Health & Science University** for the Data for **Calendar Years 2012 through 2021** be approved, with the understanding that components of this work were **previously approved at the HSCRC Public Meeting on March 8, 2023** for the project *"Risk Prediction and Optimizing Outcomes to 1-Year After Firearm Injury Among Children,"* and **previously approved at the HSCRC Public Meeting on July 30, 2025** for the project *"A Multi-State Evaluation of Emergency Department Pediatric Readiness."*

2. This access will include limited confidential information for subjects meeting the criteria for the research.

Request to Access HSCRC Confidential Patient Level Data from Johns Hopkins University Bloomberg School of Public Health for the AIDS Linked to the Intravenous Experience (ALIVE) Study

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by the Johns Hopkins University Bloomberg School of Public Health for access to the Data for Calendar Years 2015 through 2026 be approved, with the understanding that the ALIVE Study data linkage was previously approved at the HSCRC Public Meeting on October 9, 2024.
2. This access will include limited confidential information for subjects meeting the criteria for the research.

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Final Staff Recommendation for a Request to Access HSCRC Confidential Patient Level Data Request from Johns Hopkins University Bloomberg School of Public Health for the AIDS Linked to the Intravenous Experience (ALIVE) Study.

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

This is a final recommendation for Commission consideration at the April 15, 2026, Public Commission Meeting.

SUMMARY STATEMENT

Johns Hopkins University Bloomberg School of Public Health requests access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient) and Hospital Outpatient Data Sets (Outpatient) collected by the Health Services Cost Review Commission (HSCRC) to support continued linkage of clinical encounter, diagnostic, procedural, outcome, and cost data for participants in the **AIDS Linked to the Intravenous Experience (ALIVE) Study**, an ongoing observational cohort of adults in Baltimore with a history of injection drug use. This request represents a **revision/renewal of a previously approved data request**, which was approved at the **HSCRC Public Meeting on October 9, 2024**. The ALIVE cohort (established in 1988) uses biannual study visits, clinical evaluations, surveys, and biospecimen collection to characterize injection-drug-use patterns, HIV and co-infection morbidity, overdose incidence, and long-term health outcomes in Baltimore. The continuation of HSCRC data linkages—via CRISP—will allow the research team to ascertain and validate hospital-based healthcare utilization, critical clinical outcomes, and emerging public health events such as overdose episodes and blood-borne infection outbreaks. This application seeks to expand the approved linkage window to include **Calendar Years 2015 through 2026**, the maximum allowable period for continued annual linkage. All ALIVE participants provide informed consent authorizing linkage to medical records and health registries.

BACKGROUND

The purpose of this request is to continue annual linkage of ALIVE participants to HSCRC's grouped inpatient and outpatient confidential discharge data through CRISP. These data enable the study team to analyze clinical outcomes, healthcare utilization, and cost patterns among individuals at high risk for overdose, HIV progression, and other comorbidities.
The public health benefit is significant: ALIVE addresses two of Maryland's most critical public health challenges, **the overdose epidemic and the HIV epidemic**. The HSCRC datasets will provide essential information for evaluating:

- Clinical encounters and outcomes
- Hospital-based diagnoses and procedures
- Overdose events and management
- Disease incidence and progression
- Costs and patterns of healthcare utilization
- Burden of comorbidities
- Blood-borne infection outbreaks

These insights support evidence-based clinical interventions, policy development, and predictive modeling that will benefit Maryland's public health systems and communities. Johns Hopkins University Bloomberg School of Public Health received IRB approval on **January 18, 2024**, and MDH Strategic Data Initiative (SDI) approval on **February 4, 2026.**

(The Data will not be used to identify individual patients. Identifiers used for CRISP linkage will be destroyed immediately following linkage. De-identified HSCRC case-mix data linked to ALIVE study IDs will be retained until the study is completed. In accordance with the ALIVE IRB protocol, all study data will be securely stored and subsequently destroyed 10 years after the study concludes, and a Certification of Destruction will be submitted to the HSCRC.)

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REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee included representatives from the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements listed below and to assist HSCRC staff in making recommendations for approval to the Commission at its monthly public meeting:

1. The proposed study or research is in the public interest;
2. The study or research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
5. The organization has adequate data security procedures in place to ensure protection of patient confidentiality.

The Review Committee voted unanimously to give Johns Hopkins University Bloomberg School of Public Health, access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by the Johns Hopkins University Bloomberg School of Public Health for access to the Data for Calendar Years 2015 through 2026 be approved, with the understanding that the ALIVE Study data linkage was previously approved at the HSCRC Public Meeting on October 9, 2024.

2. This access will include limited confidential information for subjects meeting the criteria for the research.

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Update on Medicare FFS Data & Analysis

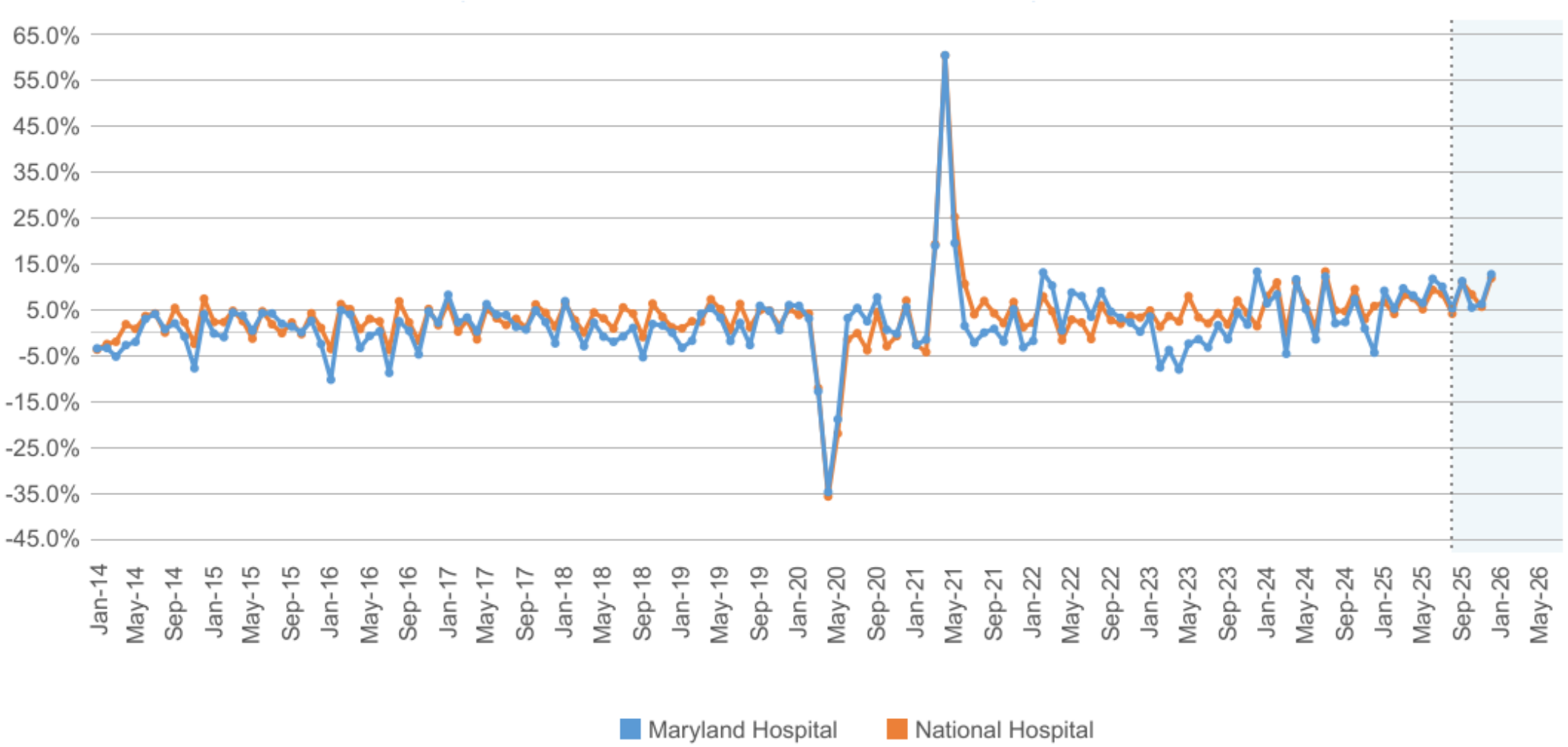
April 2026 Update

Data through December 2025, Claims paid through February 2026

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Hospital Spending per Capita

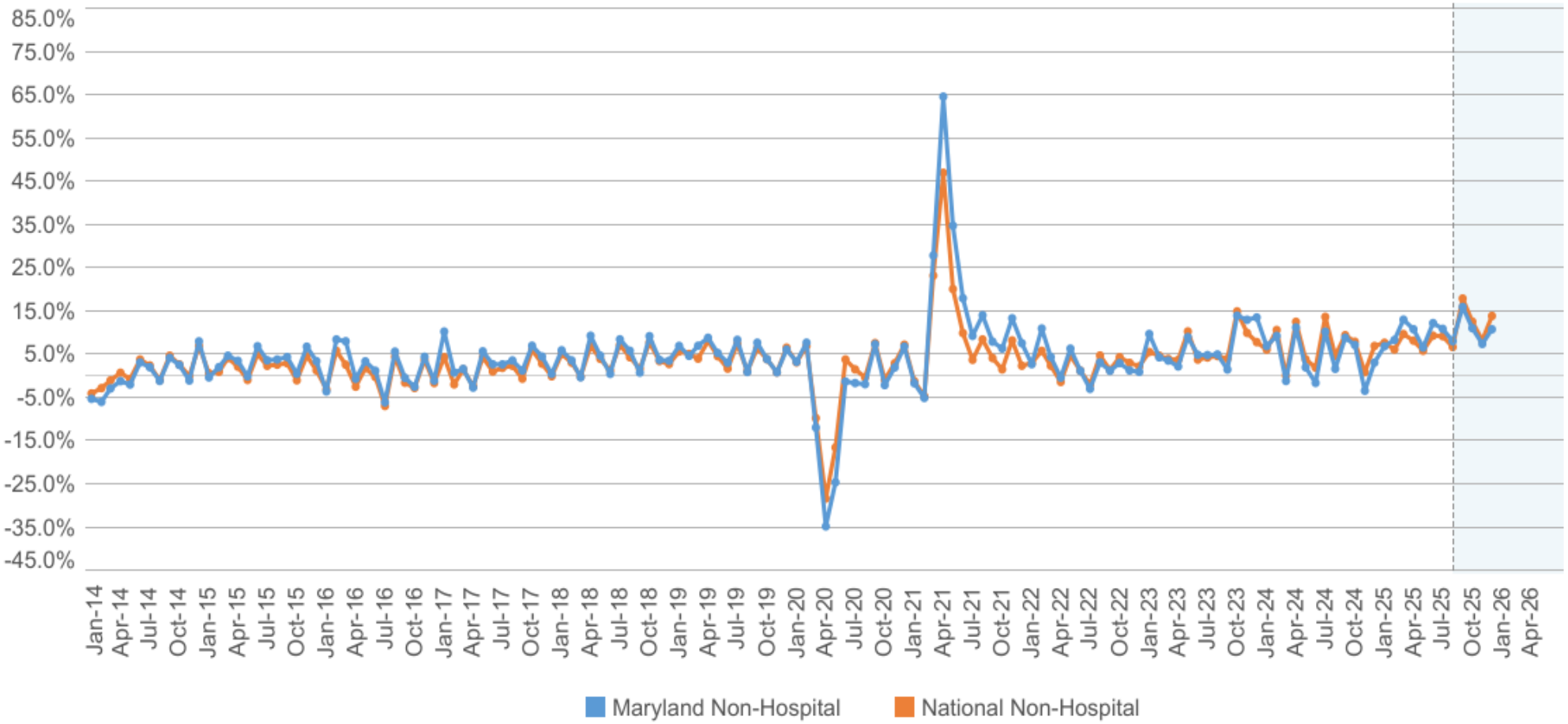
Actual Growth Trend (CY month vs. Prior CY month)



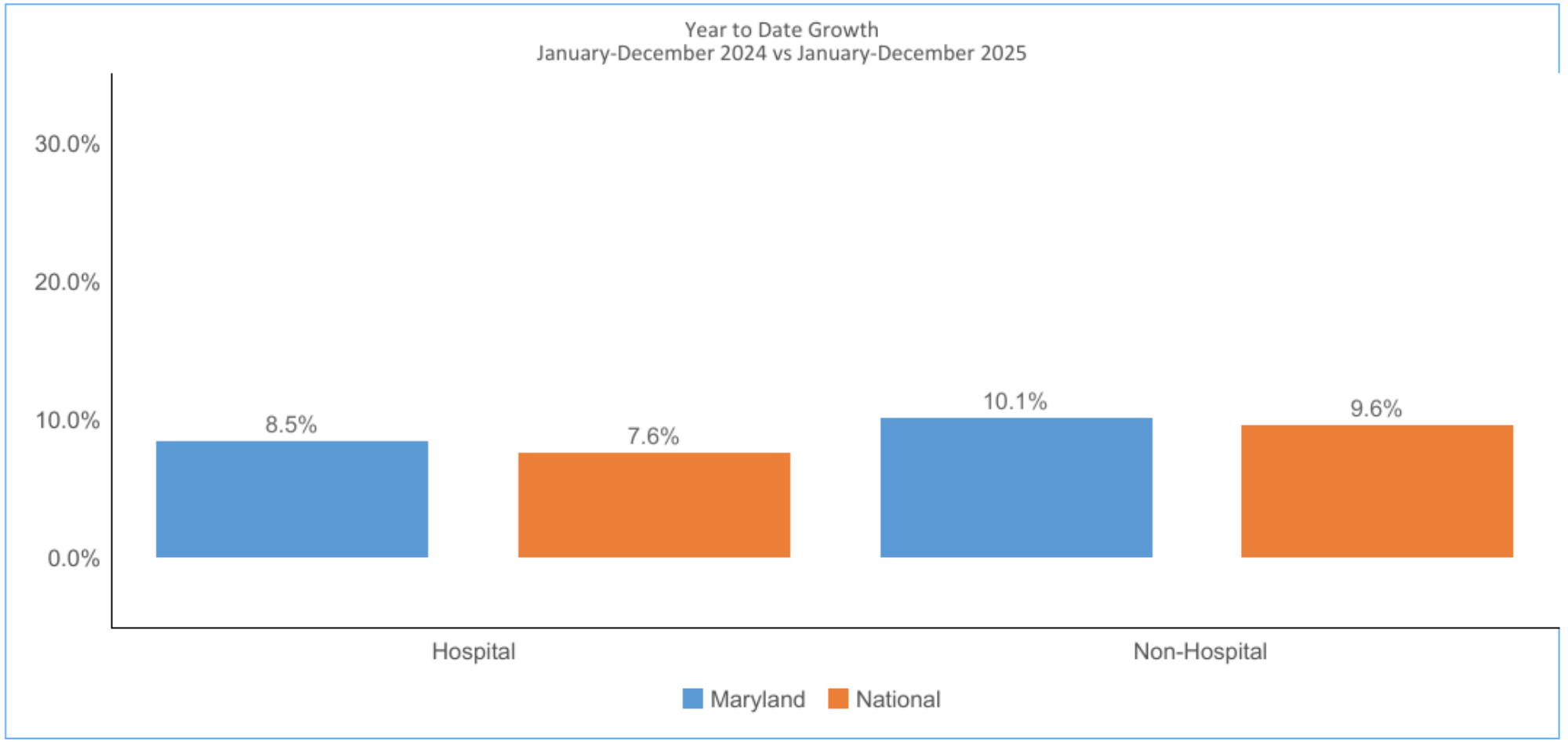
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)

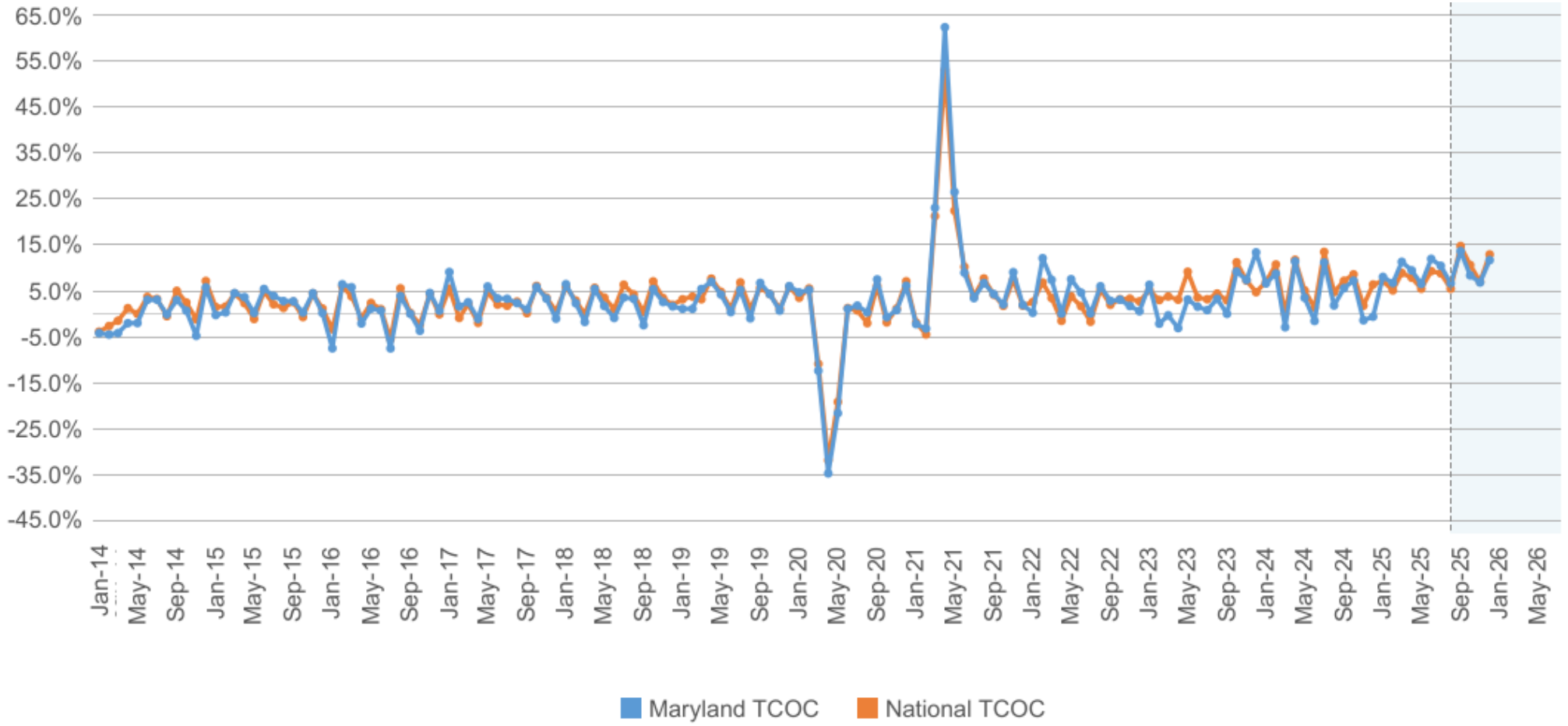


Medicare Hospital and Non-Hospital Payments per Capita



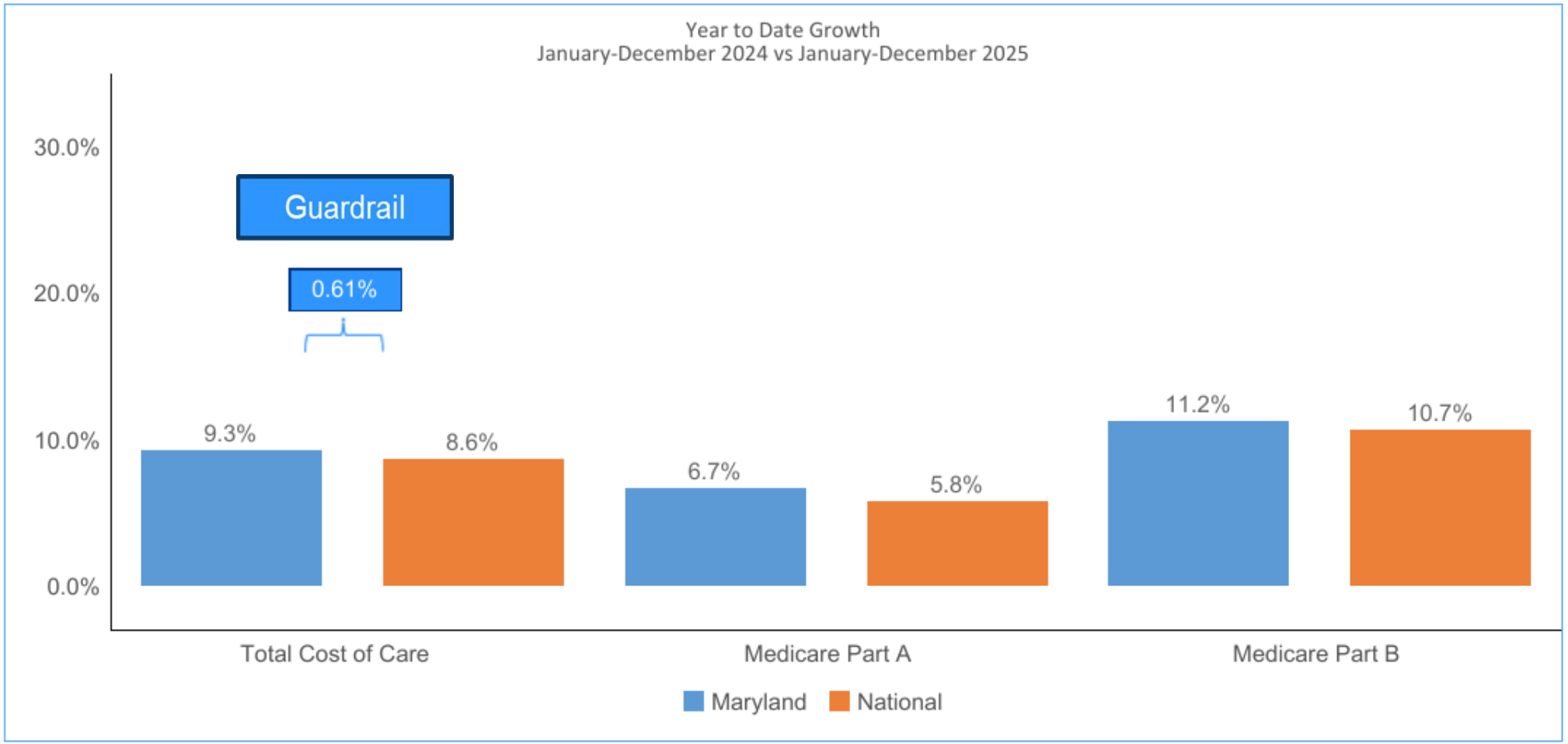
Medicare Total Cost of Care Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)



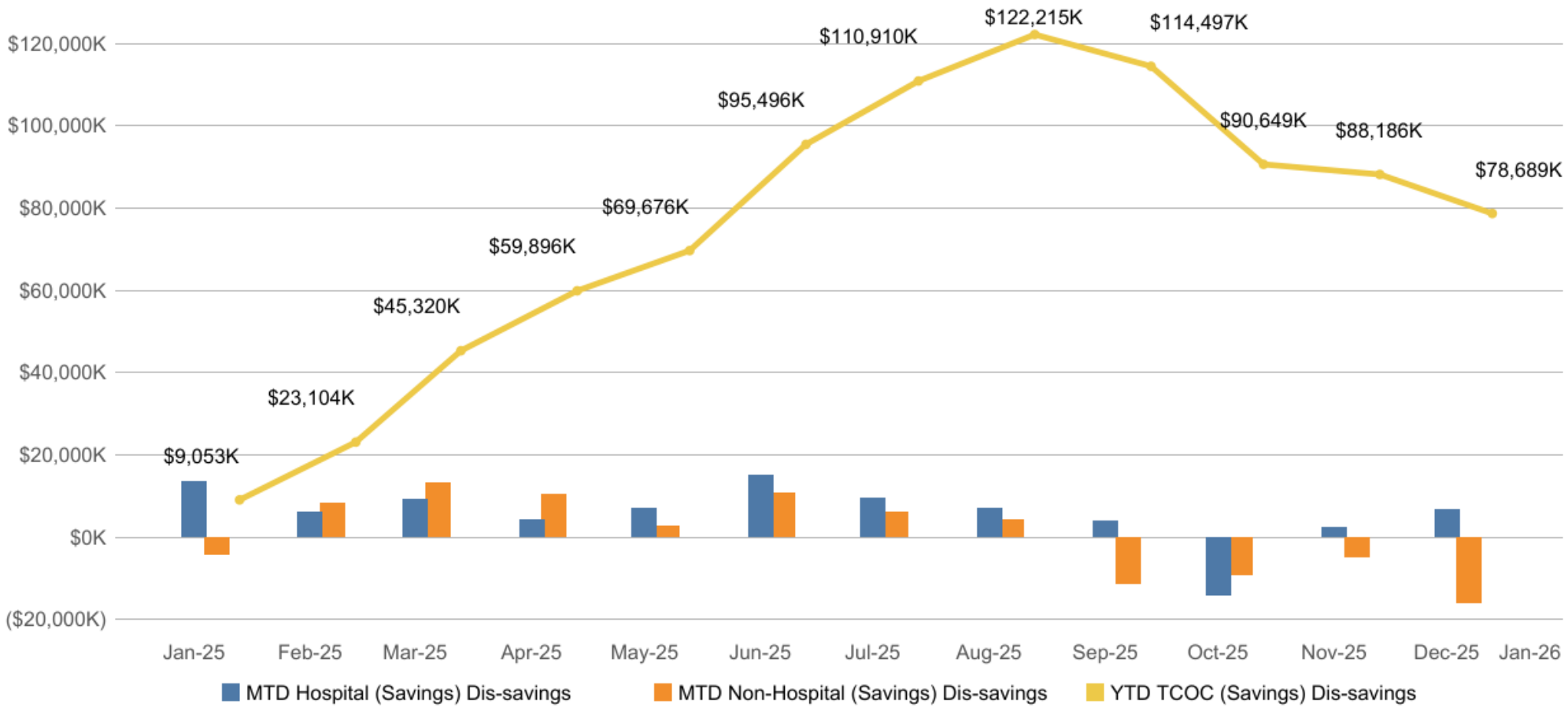
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through December 2025



A positive number represents dissavings/excess growth

maryland health services cost review commission

HSCRC AHEAD Model Policy Timeline
April 2026

HSCRC AHEAD Model Policy Timeline

Policy Updates Already Planned	The timeline for these items has already been discussed at HSCRC meetings - **COMPLETE**
Required Changes for AHEAD Implementation	The AHEAD Model will require changes to some core HSCRC financial policies.
AHEAD-Related Policy Changes	Policy development work not explicitly required by the AHEAD Model, but where policy changes can promote success.
Policy Changes Involving Multiple Agencies	These items involve significant leadership outside HSCRC, with a role for HSCRC in policy development and implementation.*

** Coordinated by Regulatory Working Group*

Key to Timeline Descriptions

S: Staff HSCRC staff are working on policy development and implementation.
W: Workgroup The policy topic will be discussed by an HSCRC workgroup.
C: Call for Public Input The HSCRC will request public comment for policy topics, *i.e.,* that will not ultimately require a Commission vote.
T: Topic discussed at Commission Meeting The Commission will discuss ideas for policy topics as generated by a call for public input.
D: Draft Recommendation HSCRC staff present a draft recommendation at the Commission meeting.
P: Public Comment for Recommendation Stakeholders submit comments in response to a draft recommendation.
F: Final Vote HSCRC staff present a final recommendation for Commission discussion and vote.
Italics indicate that timeline is contingent upon CMMI action.

Required Changes for AHEAD Implementation

	Oct. 2025	Nov. 2025	Dec. 2025	Jan. 2026	Feb. 2026	Mar. 2026	Apr. 2026	May 2026	Jun. 2026
B. HSCRC Policy Changes Required for AHEAD Implementation									
Global Budget Carveouts				*W*	*C/W*	*W*	*S*	*D*	*F*
Aligning Quality Metrics with CMS	*S*	*S*	*S*	*S*	*S*	*S*	*S*	*S*	*S*
Major Capital Program	*S*	*T*	*S*	*S*	*S*	*S*	*S*	*S*	*S*
Medicare Hospital Global Budget supplemental payments and exclusions	*S*	*S*	*S*	*S*	*S*	*S*	*S*	*S*	*S*
Care Innovation (HOPE)				C	W	D	P	F	S
GBR 2028 Policy Review				S	S	S	S	S	S

- Today's Agenda
  - N/A
- May Agenda
  - Care Innovation (HOPE): Final Recommendation

Key to Table		
S: Staff	T: Topic Discussed at Commission Meeting	F: Final Vote
W: Workgroup	D: Draft Recommendation	*Italics indicate timeline is contingent upon CMMI action.*
C: Call for Public Input	P: Public Comment for Recommendation	

AHEAD-Related HSCRC Policy Changes

	Oct. 2025	Nov. 2025	Dec. 2025	Jan. 2026	Feb. 2026	Mar. 2026	Apr. 2026	May 2026	Jun. 2026
C. AHEAD-Related HSCRC Policy Changes									
Physician Costs			C	T					
Efficiency Policy (shifted to November)									
Preventable Utilization - Length of Stay	S	W	S	S	T	S	D	P	F
Health System Transformation Policy				S	C	T	S	S	S

- Today's Agenda
  - Length of Stay Policy: Draft Recommendation
    Draft recommendation shifted from March agenda.
- May Agenda
  - N/A

Key to Table		
S: Staff	T: Topic Discussed at Commission Meeting	F: Final Vote
W: Workgroup	D: Draft Recommendation	*Italics indicate timeline is contingent upon CMMI action.*
C: Call for Public Input	P: Public Comment for Recommendation	

Multi-Agency Priorities: Updates and Upcoming Opportunities

Workstream	Status
Maryland-Specific Metrics for AHEAD	Awaiting measure feedback from CMMI
Graduate Medical Education and Workforce*	Hosting focus groups in April; draft report anticipated for June
Denials	Adverse Decisions Workgroup met March 30th; report due December 2026
Medicare Advantage Market Stabilization*	Qualified plans notified in February; differential for CY 2027 under development; metrics under development
Post-Acute Strategy*	Hosting focus groups in March and April; draft report anticipated for June
Cost-Shifting*	Will be part of FY 2028 update factor; metrics under development
All-Payer Total Cost of Care Growth and Primary Care Investment Targets*	Next All-Payer Targets Advisory Committee meeting April 17th and Primary Care Investment Workgroup April 27th; draft recommendations due to the Governor in May
Choice and Competition*	Preliminary information-gathering in progress; draft report anticipated for June
ED Wait Times Commission	Next Commission meeting scheduled for April 30th, Throughput Best Practices Subgroup for May 14th, Capacity and Access Subgroup for May 28th

*Coordinated by Regulatory Working Group

Health System Transformation

Call for Comment: Health System Transformation

To support Maryland's success under AHEAD, the state may be able to reduce excess capacity where it exists to create or realign resources for health access, improved health outcomes and achieve statewide TCOC savings.

In February 2026, HSCRC solicited public comment on a set of questions to inform the principles and parameters of a potential draft policy for facility transformations.

Areas for comment:

- Focus geographic areas
- Focus hospitals
- Additional services
- Emergency department wait times
- Savings expectations
- Other considerations

Commenters

- Adventist Healthcare
- Alkermes
- Ascension Saint Agnes
- CareFirst
- LifeBridge
- Health Means Everything Consumer Alliance
- Maryland Hospital Association
- MedStar Health
- National Alliance on Mental Illness, Maryland
- University of Maryland Medical System

Themes from the Comment Letters

- Facility conversions should be data-driven and regional, with metrics on:
  - Access, *e.g.,* drive times, delays in care
  - Current and future trends in demographics, utilization, etc.
  - Availability of key services to decrease need for acute care, *e.g.,* primary care and pediatrics, obstetrics, behavioral health
  - Impact on vulnerable populations, disparities, equity and the local economy
- Facility conversions should be responsive to the community and involve:
  - Meaningful consumer engagement, *e.g.,* community advisory boards, public input sessions, communications campaigns to increase awareness
  - Priorities identified by Community Health Needs Assessments (CHNAs)
- Savings generated by facility conversions should be reinvested, with considerations for:
  - Bed conversions, *e.g.,* sub-acute, post-acute, behavioral, ambulatory
  - Services including population health, identified gaps in care, supporting social determinants of health, CHNA-identified needs

Looking Ahead

- Though certain themes emerged, commenters stressed a wide range of priorities regarding facility transitions.
- Facilities have transitioned successfully to date under the current approach.
- The HSCRC will be working with CMMI to revisit all its policies.
- HSCRC will conduct follow-up conversations with commenters, as well as commissioners, to gain additional insight on the themes and ideas presented in the comments.
- Staff and commissioners will revisit at a future Commission meeting to discuss whether a formal policy is warranted.

Adventist HealthCare

March 6, 2026

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

Dear Dr. Kromm,

Adventist HealthCare (AHC) appreciates the opportunity to provide comments regarding potential health system transformation policies to support Maryland's success under the AHEAD Model. We support the state's goals of improving health outcomes, protecting access to care, and achieving sustainable total cost of care savings.

As the Commission considers future policy, decisions regarding hospital capacity and service alignment should be grounded in transparent, data-driven analysis of community need. Healthcare access is fundamentally local and should be evaluated at the regional or county level, with particular attention to disparities in healthcare infrastructure and investment across the state.

It is also important to recognize the inherent complexity of attempting to realign healthcare capacity primarily through regulatory policy in a system where providers are privately operated and patients ultimately determine where care is delivered. As Adam Smith described through the concept of the "invisible hand," consumer choice can play an important role in signaling which services are most valued by communities. While Maryland's all-payer model relies on thoughtful regulation, maintaining some connection to market signals—such as elements of fee-for-service utilization—can provide useful information about where demand truly exists and where capacity adjustments may be appropriate. Incorporating both regulatory oversight and real-world utilization patterns can help ensure that transformation efforts align with how patients actually access care.

Identifying Focus Geographic Areas

HSCRC should identify geographic areas for potential transformation using objective, population-based metrics that assess healthcare supply relative to community need.

Key measures should include:

- Hospital investment per capita
- Hospital beds per capita relative to risk-adjusted population need
- Provider-to-population ratios
- Emergency department utilization and wait times
- Population growth and projected healthcare demand
- Travel time and patient access patterns

- Availability of ambulatory care services

Healthcare resources across Maryland are not evenly distributed, and statewide averages can obscure significant regional disparities in access. Some areas of the state have substantially higher hospital investment per capita, while others remain comparatively under-resourced.

HSCRC should therefore evaluate regional healthcare supply relative to population need, including projected latent demand. Establishing minimum regional access thresholds would help ensure that transformation efforts do not exacerbate existing disparities in access to care.

Identifying Focus Hospitals

If HSCRC identifies hospitals for potential transition, the process should be transparent, collaborative, and grounded in regional access considerations.

Key factors to consider include:

- The hospital's role in providing access within its region
- Regional hospital investment per capita
- Financial sustainability
- The hospital's service to vulnerable populations and charity care levels
- Availability of alternative services within reasonable travel time

Because hospital global budgets effectively function as a statewide allocation of hospital funding, it is important that hospital revenue be evaluated relative to the population served and regional access needs.

Transformation efforts should prioritize equitable regional distribution of hospital funding and infrastructure.

Additional Services

If a hospital transitions services or reduces inpatient capacity, replacement services should be designed using a data-driven assessment of regional healthcare needs.

HSCRC should evaluate:

- Service utilization patterns
- Population health needs
- Wait times for key services
- Access to ambulatory care settings

Replacement services should focus on ensuring that patients continue to have timely access to essential services such as primary care, behavioral health, urgent care, and maternal health services.

Replacement capacity should be operational prior to any reduction in inpatient services to prevent gaps in access.

Emergency Department Wait Times

Emergency department performance should be a central consideration in any facility transition.

Maryland's emergency department wait time challenges are largely driven by constraints in acute and post-acute care capacity, which create downstream bottlenecks in patient flow.

Before approving any facility transition, HSCRC should require regional modeling of emergency department demand and capacity, including impacts on surrounding hospitals.

In many cases, emergency department utilization can be reduced by expanding appropriate lower-cost care settings, such as urgent care, orthopedic urgent care, or expanded ambulatory services. Ensuring adequate access to these alternatives can reduce pressure on emergency departments while improving patient experience.

Savings Expectations

Savings generated through system transformation should be approached carefully to ensure that access to care is not inadvertently reduced.

Before savings are returned to purchasers, HSCRC should first confirm that regional healthcare infrastructure is adequately resourced relative to population need. Maryland's healthcare system should ensure that sufficient capacity exists to meet both current demand and projected future demand.

In regions where hospital investment per capita is already below statewide benchmarks, savings should be retained by providers and reinvested in healthcare infrastructure and ambulatory capacity to improve access.

Only in areas where healthcare infrastructure is demonstrably over-resourced relative to population need should savings be returned to purchasers or reallocated to under resourced areas of the state. This approach aligns incentives while protecting access to medically necessary care.

Other Considerations

Several additional considerations are important to successful health system transformation:

Accurate capacity measurement
Capacity assessments should consider staffed beds, peak demand periods, and operational constraints, rather than relying solely on licensed beds or annual average occupancy.

Patient flow and system capacity
Emergency department boarding, ambulance offload delays, and post-acute placement capacity should be evaluated across the entire regional care system.

Administrative complexity
HSCRC should seek opportunities to simplify the regulatory framework where possible. Complex overlapping policies and administrative requirements create unnecessary overhead that could otherwise be directed toward patient care.

Population health transition timelines
Population health investments can reduce acute care demand, but the impact often occurs over extended time horizons. Transformation policies should include a clear glidepath with checkpoints to ensure that reductions in hospital capacity do not occur faster than reductions in healthcare demand.

Conclusion

Maryland has long been recognized as a national leader in healthcare payment and delivery reform. As HSCRC considers policies to support health system transformation under the AHEAD Model, it is critical that decisions remain grounded in transparent data analysis, regional access considerations, and projected population health needs.

A framework that evaluates healthcare infrastructure on a regional, per-capita basis while ensuring adequate access before capacity reductions occur will allow Maryland to continue advancing a healthcare system that is both sustainable and equitable.

Sincerely,

Katie Eckert

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

cc: Jonathan Kromm, PhD, Executive Director, HSCRC
Joshua Sharfstein, MD, HSCRC Chairman
James N. Elliott, MD, HSCRC Vice-Chairman
Jonathan Blum, MPP
Ricardo R. Johnson, JD
David N. Maine, MD
Nicki McCann, JD
Farzaneh Sabi, MD

March 6, 2026

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

Dear Mr. Kromm:

On behalf of Alkermes, I am submitting these comments for consideration for the "Call for Comments: Discussion on Health System Transformation" policy development. Specifically for principle and parameter "*Other considerations: What other considerations should the HSCRC employ in supporting health system transformations to improve access to care and health outcomes while reducing costs?"*

Alkermes respectfully requests consideration be given to implementing policies through the AHEAD model to expand the use of FDA-approved long-acting injectables or extended-release medications used to treat serious mental illness when they are administered in a hospital emergency department or inpatient psychiatric settings. Although payment for these medications may be included in the hospital's daily rate for medical assistance, LAIs are more expensive than the oral forms and may be cost-prohibitive given the confines of the global budget structure. To improve access and outcomes for the those suffering from Serious Mental Illness (SMI) and reduce costs, we request consideration be given to carving these medications out of the hospital daily budget.

Long-acting injectables (LAIs) represent a vital clinical tool for individuals living with conditions such as schizophrenia and bipolar disorder where consistent medication adherence is essential for stability and recovery. LAIs reduce the risks associated with missed doses, relapse, overdose, and repeated hospitalizations, supporting more continuous treatment engagement following discharge.

The Maryland Department of Health has affirmed that earlier initiation of LAIs in the inpatient setting may reduce readmissions for certain participants. Clinically, initiating LAI antipsychotics for conditions like schizophrenia while the patient is still hospitalized is associated with fewer inpatient readmissions, fewer inpatient days, fewer emergency department visits, and fewer criminal justice system encounters compared to discharging a patient with a prescription for oral antipsychotics. Studies show reduced relapse rates and improved treatment adherence.

While the benefits and cost savings are significant, LAIs may be cost prohibitive under Maryland's hospital financing system. Hospitals managing costs within their daily budgets may opt to use the oral, lower cost option, to save money. Several states, recognizing the benefits of LAIs in treating SMI, have taken steps to improve access, particularly for individuals in hospital settings. The states listed below have adopted budget amendments or submitted State plan amendments to the Centers for Medicare and Medicaid Services that carve FDA approved long-acting injectables or extended-release medications administered for a serious mental illness out of the hospital daily rate.

State Medicaid Plans with Inpatient Payment Carveout for LAIs		
State	Condition	Links to State Policies
Massachusetts	Serious Mental Illness	• Notice of Agency Final Action • Billing Instructions • LAI Inpatient Carveout Drug List/ »J » Codes
Virginia	Serious Mental Illness & Substance Use Disorders	• Virginia Governor's Budget Language (Line Item MMMMM) • Billing Instructions
Georgia	Serious Mental Illness	• HB 916 Appropriations Act (Line items 1036, 1123 • State Plan Amendment
Illinois	Serious Mental Illness & Substance Use Disorders	• Public Act 102-0043 • Illinois Dept Health & Family Services Notice • PA Required - SMI

Alkermes respectfully requests the HSCRC consider incentivizing the use of LAIs in hospital emergency room and inpatient psychiatric settings to improve treatment, access, and outcomes for those suffering with SMI while reducing costs.

We stand ready to assist. Please contact me at Tammy.Cravener@Alkermes.com or 610-585-5492 should you need additional information.

Sincerely,

Tammy Cravener
Vice President, Policy and Government Relations
Alkermes

Ascension
Saint Agnes

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

March 6, 2026

Dear Dr. Kromm,

On behalf of Ascension Saint Agnes, I am writing today to respond to the request for comments from the Health Services Cost Review Commission (HSCRC) regarding Health System Transformation as the state seeks to realign resources for health access, improved health outcomes and achieve statewide total cost of care savings under the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. The HSCRC has requested comments related to the following questions:

- **Identifying focus geographic areas**: How should HSCRC identify regions of the state where such health system transformation offers the opportunity to improve access to care and health outcomes, while lowering overall costs? What specific metrics should be utilized?
- **Identifying focus hospitals**: Should the HSCRC focus on discussions with specific types of hospitals? If so, which ones are in the best position to make this transition and why? Alternatively, should the HSCRC establish a process to identify focus hospitals within key geographic areas? And if so, what should that process look like?
- **Additional services**: If an acute care hospital closes or transitions to a different type of facility, how should HSCRC assess the type and quantity of new services to replace the previous services, to assure that the overall access to care improves?
- **Emergency department wait times**: How can HSCRC assure that facility transitions will not further increase emergency department wait times?
- **Savings expectation**: What share of savings should be returned to healthcare purchasers? What share should be redirected to the health of the community served by the health system? How should the various priorities for savings be balanced to align incentives across all parties to promote efficient and effective healthcare delivery?

Ascension Saint Agnes
900 S. Caton Avenue
Baltimore, MD 21229
667-234-6000

- **Other considerations**: What other considerations should the HSCRC employ in supporting health system transformations to improve access to care and health outcomes while reducing costs?

Ascension Saint Agnes supports the HSCRC's interest in soliciting feedback on how best to realign resources now that Maryland's hospitals have been operating under global budgets for over a decade. Ascension Saint Agnes was an early adopter of transforming our care delivery model to one focused on prevention, managing individuals with chronic disease better in the community, and creating more seamless transitions across the care continuum. Over the past decade, Ascension Saint Agnes has implemented the following innovative programs:

- **Investments in post-acute**. Developed and implemented a post-acute network to better manage patient transitions and an outpatient palliative care service.
- **Transportation**. Created the Chaperone Program to link trained volunteers with vulnerable patients for support and ride share.
- **Food Rx**. Provides a food prescription based on chronic disease, acuity and social needs. The pilot project showed decreased hospital and ED utilization.
- **Chronic Disease Home Monitoring Kits**. Provides home monitoring devices and education materials for heart failure, COPD and diabetes management.
- **Violence prevention**. Program designed to impact community violence and hospitalizations resulting from street violence and intimate partner violence.
- **Workforce development**. Partnered with Southwest Development Corp., Turnaround Tuesday, and Goodwill for job training and recruitment.
- **Hospital/Legal Partnership**. Partners with a local organization to host free community events to complete wills, POA, and Advanced Directives.
- **Mobile Health Unit**- Provides primary care services in geographies with unmet need. Works with patients to close social barriers to care and connect them to wrap around services.
- **Homelessness Support**- Partnered with People Encouraging People to connect patients experiencing housing instability with resources and temporary shelter.
- **Peer Recovery**- Embedded peer recovery coaches in the Emergency Department to connect individuals with substance use treatment.

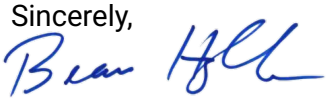
As the HSCRC reviews this issue, Ascension Saint Agnes would encourage the staff and commissioners to consider the following:

- **Projected bed needs by region over the next 10-20 years**. To our knowledge, a comprehensive review of the current bed capacity, anticipated population and utilization trends by region, and projected future need has not been completed by the state. Such a review would help ensure that capacity exists where it will need to and that capital funding for aging and/or new facilities is appropriately allocated.

- **Review of broader healthcare infrastructure, not just hospital beds**. Some areas of the state which may have additional hospital capacity lack the community resources to effectively reduce capacity further or adequately compensate for a hospital closure. Before the HSCRC considers reducing additional capacity it needs to ensure that alternative access points exist in those communities.
- **Assessment of Freestanding Medical Facility (FMF) conversions**. An assessment should be completed of the impact on the community where FMFs have been created, including the impact on access and outcomes in addition to cost savings. Maryland has been a leader nationally but we need to fully understand the impact before additional conversions are pursued.
- **Ability to repurpose vacant patient care units in existing facilities**. Ascension Saint Agnes has been focused on reducing unnecessary utilization since the start of the Model, realizing appreciable reductions in volume over time. We have engaged in discussions with the state, behavioral health providers, and others to explore ways in which these patient care units could be repurposed, leveraging our existing footprint and modern facilities to meet the needs of the community.

Thank you again for the opportunity to provide comments. If you have any questions, please do not hesitate to contact me.

Sincerely,



Beau Higginbotham

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, Vice Chairman
Jon Blum
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi

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

March 6, 2026

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

Dear Executive Director Kromm:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to comment on potential principles for health system transformation. We support the Health Services Cost Review Commission (HSCRC)'s efforts to evaluate opportunities for realignment of the state's health resources in a manner that promotes access to care, improved health outcomes and lower costs for Marylanders. As the state and stakeholders consider realigning healthcare resources, they should consider the following variables.

- The state should center the needs of individual communities. We encourage the state to develop guiding principles for realignment to ensure any proposed changes better serve the health demands of the community. These may include requirements that project proposals outline data that demonstrate a clear need for proposed services.

- Communities should be engaged directly in the state's realignment projects. Marylanders have a valuable perspective and deserve a voice as the state pursues the transformation of healthcare delivery services.

- Realignment proposals should consider a fuller definition of healthcare that is inclusive of social drivers of health. For example, non-medical factors such as transportation should be assessed when considering realignment.

- While innovation should be encouraged, the state cannot afford and should not enable innovation that delivers benefits only to specific populations. Proposals should be evaluated through an equity lens and the potential impacts on health disparities should be measured to ensure existing disparities are not exacerbated.

- Finally, HSCRC should evaluate realignment proposals holistically, including downstream impacts and opportunities across the full care continuum. Resulting changes in utilization patterns, cost impacts, consumer choice and access, and economic impacts should all be considered.

Thank you for the opportunity to comment on this topic. We look forward to additional discussions on how to best align health resources to support access, improve patient outcomes and lower healthcare costs.

Sincerely,

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

LIFEBRIDGE HEALTH®

CARE BRAVELY

March 10, 2026

Jon Kromm, HSCRC Executive Director
4160 Patterson Ave
Baltimore, MD 21215

Dear Jon -

LifeBridge Health appreciates the opportunity to provide input on the Health Services Cost Review Commission's (HSCRC) regarding hospital capacity and opportunities to transform facilities to improve access and achieve system savings. The ability to develop a framework designed to create the best and most efficient use of hospital capacity while continuing investment in community-based care and regional coordination to meet statewide healthcare needs is important to Maryland's AHEAD Model participation.

In addition to engagement of hospitals statewide, we also believe coordination with the Maryland Healthcare Commission (MHCC), the Maryland Insurance Administration (MIA), and, where appropriate, federal partners, is essential to address any potential operational barriers that may exist and extend beyond the HSCRC's current regulatory authority.

Understanding Community Need and Access

An important initial step in any transformation policy development must be a thorough community impact assessment of how Maryland's Total Cost of Care model has affected the delivery of patient care, including utilization trends and associated sites-of-care while also understanding access for vulnerable populations to key core services such as emergency, behavioral health, pediatrics, obstetrics, and maternal and fetal medicine.

Although evaluating occupancy and Average Daily Census (ADC) are standard measures in highlighting capacity and utilization, these metrics in isolation often fail to measure and appreciate the required capacity required for hospitals that provide complex acute care. Facilities must maintain reserve capacity to support regional referrals, high-acuity patients, and associated surgical variabilities. We encourage the commission to use broader and more comprehensive system indicators, where possible, to evaluate the capacity needs within a facility, such as:

- Emergency department visits per 1,000 population
- Drive times to emergency and essential services
- Seasonal utilization patterns and surge capacity needs

Recognition to Health System Integration Opportunities

Transformation should not be myopically focused solely on an individual hospital to realize a reduction in capacity. Increased latitude to shift services and associated global budget revenue

within the hospitals of a healthcare system should also be considered. A system-level approach provides greater flexibility to align services across campuses and levels of care. The Commission, for example, might allow for a voluntary process that allows health systems to identify to consolidate care within a system through service-line consolidation that affords an ability to return productivity savings back to the system over a defined period-of-time.

Impact to Patient Care

Any redesign of capacity must cautiously weigh real trade-offs to potential delays in the delivery of patient care. The demographic and socio-economic characteristics of communities play a critical role in any patient's ability to effectively access and receive care. As an example, limiting hospital services is likely to result in the need for increases to patient transfers, most notably from emergency room settings. This has the ability of increasing wait times across a spectrum of services while patients wait for required transfer transportation or space/resource availability of the accepting provider facility. Geographic limitations and regional modeling are particularly important when addressing potential access barriers as rural regions are likely to not have the same service abilities as many urban providers.

Savings Goals & Expectations

While ultimately generating system cost-savings is a primary goal of health transformation and redesign, at the outset facilities are likely to need to invest additional capital to design facilities capable of a changed delivery model and associated volume changes. Repurposing space or consolidating services does not eliminate the numerous fixed infrastructure costs inherently present. Allowing hospitals to retain a portion of realized savings or directing out-year savings into a statewide transformation fund would enable sustainable results on a long-term basis.

In closing, contemplating health transformation extends well beyond consideration of reducing perceived excess hospital bed capacity and requires thorough and comprehensive study before policy development and decision-making can occur. Collaboration of numerous agencies, including HSCRC, MHCC, MIA and even the State legislature are needed to address barriers the extend beyond the current authority of the HSCRC. Above all, careful consideration of the complex dynamics of communities and the corresponding abilities of patients to continue to access care effectively must be at the forefront of any developed policy.

LifeBridge is supportive of efforts to evaluate health transformation and look forward to continuing to engaging and partnering with HSCRC in advancing success in our new AHEAD Model agreement. As always, don't hesitate to reach-out directly as we are always happy to discuss.

Sincerely,

Jennifer Nickoles
President and CEO, LifeBridge Health
cc: Joshua Sharfstein, M.D., HSCRC Chairman

HEALTH MEANS EVERYTHING
CONSUMER ALLIANCE

March 6, 2026

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

Re: Health System Transformation

Dear Dr. Kromm and HSCRC Commissioners:

Thank you for the opportunity to provide written testimony on the questions posed for health system transformation, in the context of seeking to support Maryland's success under the AHEAD Model.

Health System Transformation

Maryland's transition toward the AHEAD model provides an optimal opportunity for the state to consider expanded access to health care, improved health outcomes, and statewide health care savings. With respect to the principles for health system transformation discussed at the February Health Services Cost Review Commission (HSCRC) meeting, Health Means Everything (HME) is supportive of the HSCRC's efforts to reduce excess capacity while expanding access to care. While HME understands the importance of considerations for facility transformation, we believe that the consumer perspective must remain central to any decisions that affect access to care. System changes should not be pursued for cost containment alone; rather they should be considered in ways that are responsive to community needs.

As such, HME recommends that the HSCRC consider the following principles to inform decision making on health systems transformation:

1. **Transformation efforts should align with community needs. Transformation strategies should be equity centered, data driven, and require meaningful consumer consideration.**

2. **Savings generated by hospital restructuring should be strategically reinvested into the community. For each instance of change or transformation, the HSCRC should calculate a percentage of the accrued savings that will be reinvested into the community. Nonprofit hospitals are already required to develop Community Health Needs Assessments. This requirement could be extended to all hospitals and expanded to require explicit re-investment goals.**

Transformation Effort Strategy

As the state works toward making facility transformation decisions, strategies should be equitable, data-driven, and grounded in consumer concerns. Hospital transformation or restructuring may require difficult adjustments among health systems and communities. To achieve this end, the HSCRC should ensure that any developed transformation strategies are accompanied by transparency measures that clearly demonstrate value to health and community outcomes, rather than mere cost reduction. This could include developing measurable transformation goals, requiring accountability from oversight groups with consumer representation built into the groups, requiring publicly reported data published by hospitals to highlight clear changes made, and clearly clarifying benefits to communities.

Transformation strategies should also require meaningful consumer engagement. The HSCRC should develop policies that require opportunities for the community to engage. This could include developing structured public input opportunities, developing consumer or community advisory boards, and making relevant data and information public and easily accessible, including by proactive release of information to media outlets that may be positioned to alert consumers to these opportunities and impacts. Consumers should have the opportunity to speak to changes that may ultimately impact the way in which they access care.

HEALTH MEANS EVERYTHING
CONSUMER ALLIANCE

Strategic Saving Reinvestments

Savings generated through transformation will understandably face competing prioritization, including hospital stability, Medicare savings requirements, and infrastructure needs. While the exact proportion of savings that should be directed toward the community could be based on any number of factors, the HSCRC should calculate a percentage of savings that serves as a proactive, ongoing framework rather than an ad hoc moving target. The methodology can utilize geographic targeting relative to the given community experiencing facility transformation changes, guided by documented needs identified through Community Health Needs Assessments, utilization patterns, and gaps in access. The percentage of savings reinvested into the community should be substantial enough that the community gains access to services better aligned with changing needs, such as outpatient care options, behavioral health care, urgent care, or community-based prevention.

In all health transformation policy decisions, health equity should serve as a central component. Measures should be built into transformation strategies to ensure that changes do not exacerbate geographical, racial, or socioeconomic disparities in health care access and outcomes. Community reinvestments should explicitly consider underserved individuals, and savings reinvestments should be developed and distributed in a way that ensures consumers across all payer types benefit, with no consumers bearing an unequal share of the impact. As transformation occurs, communities should not be left with less.

We appreciate your thoughtful approach to this issue, and are happy to provide further input should it be of use in your deliberations.

Thank you for your consideration,

Ashiah Parker,
Chair, Health Means Everything Consumer Alliance

MedStar Health

8094 Sandpiper Circle
Suite O
Nottingham, MD 21236

MedStarHealth.org

March 12, 2026

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

Dear Executive Director Kromm,

On behalf of MedStar Health, Inc (MedStar) and the system's seven Maryland hospitals, thank you for the opportunity to provide comments on the Potential Principles and Parameters for the development of a Health System Transformation & Facility Conversion policy presented at the February 11, 2026, Health Services Cost Review Commission meeting. Included in this letter are MedStar's responses to each of the six questions that the HSCRC is seeking stakeholder input on, however, MedStar wishes to provide some general comments in addition to directly responding to each question.

Prioritizing development of the fundamental policies necessary for January 1, 2028 implementation is key to success.

MedStar understands the desire to manage resources across the state and solve issues related to access to care as part of this new AHEAD model. However, now is not the time to take on this expansive new policy. These topics are challenging and complicated and resolving these issues fully, or in part, through system transformation efforts will take significant time and resources to study and develop meaningful and actionable policies that will be fully supported by stakeholders. Therefore, MedStar has concerns over the HSCRC's prioritization of this policy development between now and January 1, 2028, when the major changes are implemented under the AHEAD Model. The limited resources and capacity of the HSCRC and stakeholders should be prioritized to ensure payment and other foundational policies are prepared for AHEAD before embarking on the development of any new far-reaching policies. MedStar believes the focus of the HSCRC and the industry over the next 18 months should be on the January 1, 2028, transition within the new AHEAD model. Our focus should be on the innumerable questions and concerns related to the new structure with CMS managing the GBR for Medicare and the HSCRC continuing to regulate rates and the GBR for Medicaid and commercial payors. The future stability of the rate setting system and Maryland's hospitals and health systems depends on it. Without stability, the quality and availability of health care Marylander's have come to expect will be at risk.

In response to the specific questions posed for comment and feedback, MedStar offers the following additional thoughts for consideration.

1. **Identifying focus geographic areas:** how should HSCRC identify regions of the state where such health system transformation offers the opportunity to improve access to care and health outcomes, while lowering overall costs? What specific metrics should be utilized?

   MedStar Response

   Any analysis conducted by the HSCRC to identify geographic areas in Maryland where health system transformation could be appropriate should be done objectively and in collaboration with stakeholders - hospital/health systems, community physicians & other providers, patient advocacy groups, and other community leaders – and needs to include an assessment of the availability and appropriateness of care across the continuum, not just hospital capacity.

   Metrics can include: provider ratios (primary care & specialists) to population, number of hospital beds, hospital occupancy rates, average patient travel times, average patient appointment wait times, rate of insurance coverage, out of pocket healthcare costs, preventative care use rates, emergency department use rates and wait times, & rates of potentially avoidable hospital utilization. Behavioral health, post acute and other areas of need beyond acute care should also be considered.

   MedStar urges the HSCRC to consider health equity when making any assessment that identifies a geographic area in Maryland as suitable for health system transformation or facility conversion. Despite the successes of the Maryland Demonstration Model in its various iterations, significant health disparities and inequities remain across the state from the rate of adequately insured individuals, to the availability and ease of access to healthcare services. It is no surprise that some of the most disadvantaged communities in Maryland also have the most opportunity for total cost of care savings and reductions in hospital capacity when assessed on a number of metrics. These communities, lacking other pathways to healthcare services, rely on hospitals often as their point of access to the healthcare system while conversely, communities that are socioeconomically more advantaged have greater access to healthcare services in a setting that is most appropriate and most cost effective.

2. **Identifying focus hospitals:** should the HSCRC focus on discussions with specific types of hospitals? If so, which ones are in the best position to make this transition and why? Alternatively, should the HSCRC establish a process to identify focus hospitals within key geographic areas? And if so, what should that process look like?

   MedStar Response

   If the development of a facility conversion policy moves forward, MedStar urges HSCRC to abandon any pre-conceived notions regarding which hospitals & what types of facilities might be in the best position to make a transition and instead let any identification of potential hospitals that may be appropriate for conversion be guided solely through an objective data driven analysis. Such an analysis needs to include a comprehensive evaluation of the healthcare delivery system across the continuum of care in any given region. The metrics stated in the response to question 1 should be included in any such evaluation, in addition to other factors such as cost of care, occupancy rates, volume declines under GBR and the Maryland Total Cost of Care Model, and observed/projected demographic trends. The identification of any facilities through such an analysis needs to be applied uniformly, regardless of geographic region, and the HSCRC should not limit the identification of any such hospitals to 'key geographic areas'. Success under the AHEAD Model in continuing to improve healthcare delivery in Maryland and limiting growth in

healthcare costs is an endeavor that requires effort across the state and across all stakeholders in the healthcare system, it is not something that will be achieved by limiting healthcare transformation activities of such a magnitude to only certain regions identified by the state.

3. **Additional services:** if an acute care hospital closes or transitions to a different type of facility, how should HSCRC assess the type and quantity of new services to replace the previous services, to assure that the overall access to care improves?

   MedStar Response

   While MedStar appreciates the HSCRCs intent of ensuring that there is adequate access to healthcare services across Maryland, health system organizational decisions around service offerings need to be made in concert with stakeholders in the communities these hospitals serve, align with the strategic vision and goals of any such health system as they drive to improve the health of their communities, and be based on the needs of the community both now and in the future. Hospitals through their community needs assessments and other partnerships and interactions are well-positioned to provide valuable perspectives.

4. **Emergency department wait times:** how can HSCRC assure that facility transitions will not further increase emergency department wait times?

   MedStar Response

   By its nature, the elimination of services at a facility through conversion from an acute care hospital will likely have a negative impact on emergency department wait times in the region. Eliminating hospital beds and emergency department treatment spaces will not improve emergency department wait times. However, through investments in post-acute care availability and care management, funded through the savings generated from the facility transition, the increase in emergency department wait times any facility conversion is likely to cause could potentially be mitigated.

5. **Savings expectation:** what share of savings should be returned to healthcare purchasers? What share should be redirected to the health of the community served by the health system? How should the various priorities for savings be balanced to align incentives across all parties to promote efficient and effective healthcare delivery?

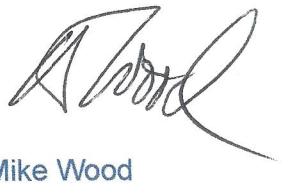
   MedStar Response

   The HSCRC should prioritize the redirection of any total cost of care savings to further population health activities and address access issues in the community where such a conversion takes place. As well intentioned and thoughtful any facility conversion might be, the elimination of any acute care hospital capacity in a community will have effects downstream and could threaten patient care access and outcomes. Mitigating this requires a corresponding investment in the health of any such community before, during, and after any such facility conversion. Further, achieving the goals of the AHEAD model is going to require substantial investments in population health and care transformation across the state at a time when hospitals and health systems continue to struggle financially in the post-pandemic landscape and are facing substantial revenue impacts from federal reimbursement policy changes. Commercial payors in Maryland have long accrued financial benefit from the elimination of cost shifting under the state's all-payor model and the constraints on hospital revenue growth that global budget revenue places on health systems. The expected reduction in Medicaid coverage as a result of the OBBB act will mean more

uninsured residents and will increase the cost of uncompensated care on providers. Before any savings generated through facility conversions is returned to insurance carriers, the HSCRC must ensure that adequate financial resources are provided to Maryland's health care providers – on whose shoulders success or failure under the AHEAD Model will ultimately rest.

MedStar appreciates the opportunity to comment on this topic which is of critical importance to Maryland's hospitals and health systems. If you have any questions regarding any of the above or wish to discuss any of MedStar's comments further, please do not hesitate to contact me. MedStar stands ready to collaborate with the HSCRC and other stakeholders in the development of policies that serve Marylander's healthcare needs and set the state up for success in achieving the goals and requirements of the AHEAD Model.

Sincerely,



Mike Wood
Vice President of Revenue Management & Reimbursement
MedStar Health

cc: Susan Nelson, MedStar Health
William Henderson, HSCRC

Maryland
Hospital Association

March 4, 2026

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the set of questions raised by the Health Services Cost Review Commission (HSCRC) to inform the principles and parameters of a potential draft policy for health system transformation. The questions being contemplated by the Commission are important and any potential health system transformation policy should be carefully considered and incorporate hospital and community input.

Any policy that leads to the closure or conversion of hospitals would have significant implications for access to acute care services, the state's health care system, and the health and well-being of Marylanders. Should HSCRC move forward with this effort, we would encourage it to devote the time necessary to engage in a thoughtful, transparent policy design process with robust hospital and health system input to ensure any transformation efforts strengthen the state's health care system and communities and avoid any unintended negative impacts.

We offer the following principles for policy development consideration.

1. **The process for establishing and implementing any policy should be led by hospitals and health systems with input from local stakeholders.** Hospitals are uniquely positioned to inform transformation efforts as they will be the most directly impacted by the policy and are deeply embedded in their communities. They engage in strategic planning, conduct community health needs assessments, and collect robust data that can be evaluated to determine if their communities could be better served by transformation and how to reallocate resources to ensure continued access to acute care services in the event of a facility transition or closure. Given that health care delivery is regionally nuanced and community needs vary across the state, input from stakeholders within the community served by the hospitals/systems of focus should be prioritized. The Commission could consider standing up hospital-led regional advisory committees to receive input from stakeholders and inform policy development and implementation.

2. **Any transformation and realignment policy should:**

a. **Clearly define, evaluate, and establish excess capacity.** Before developing and implementing a policy, there must be a transparent and comprehensive evaluation of capacity. HSCRC should define capacity and demonstrate that excess capacity exists based on metrics generally accepted by stakeholders. Access and utilization across the full care continuum (primary care, behavioral health and other specialties, post-acute, urgent care, etc.) should be factored into this evaluation.

b. **Explore opportunities to incentivize hospital transformations.** To the greatest extent practicable, hospitals and health systems should retain the ability to decide whether to initiate any transformation effort, consistent with HSCRC's historical approach to facility conversions. This approach will ensure hospital/system investment in decision-making, support continuity of internal transformation efforts already underway that are informed by community needs, and facilitate well-planned and effective transitions that meet intended goals. If federal or state policy action ultimately requires transitions, any compulsory transition process needs to ensure there is significant engagement with impacted hospitals and time to support a managed transition.

c. **Consider key access, quality of care, and health outcome implications.** The potential impacts of any transformation efforts should be thoroughly explored and well understood. HSCRC should consider any impacts on access to acute care and specialist services, patient travel and wait times, and health equity, as well as the central role hospitals play in connecting patients to social support services.

d. **Prioritize access preservation over returning savings to health care purchasers.** The state is expected to see a marked uptick in the uninsurance rate due to federal policy changes impacting Medicaid and Marketplace enrollment. HSCRC should ensure that hospitals/systems are adequately resourced to meet any resulting increased demand for services and are able to reinvest any savings from transformation efforts to improve the health of their communities. As Chair Sharfstein noted at the February Commission meeting, hospital transformation should leave the population better off.

e. **Consider future utilization needs and ensure system resilience.** Transformation efforts must not be solely based on an evaluation of current capacity and should also consider how changes in policy, demographics, and disease burden will impact future demand for acute care services across the state. Key factors include how Maryland communities are expected to grow and age, the prevalence of chronic diseases, trends in health insurance enrollment, and the need to ensure the system has adequate capacity to address surges in volumes (e.g., COVID-19, respiratory diseases).

f. **Consider economic and workforce impacts.** Hospitals are anchor institutions that are heavily invested in their communities. Maryland hospitals and health systems across the state employ over 223,000 Marylanders, directly and indirectly, and are often the single-largest employer in their community. Understanding the economic implications of potential facility closures and transitions will be critical.

g. **Reallocate resources in a manner that supports ED throughput and other priorities.** It is important to ensure that hospital closures or transitions do not unintentionally place further strain on emergency department wait times or result in limited access to care in the hospital service area. Resources could be reallocated to support hospital and health system-led initiatives to repurpose acute care beds for sub-acute or post-acute services or strengthen care delivery in other settings, such as providing enhanced support for freestanding ambulatory facilities. Any transformation policy should address regulatory barriers that could inhibit these efforts.

Thank you for the opportunity to comment on this important matter.

MHA urges HSCRC staff and Commissioners to carefully consider our comments and those provided by Maryland hospitals and health systems before proceeding with policy development. We look forward to continuing to engage with HSCRC on this topic and other policies in the coming months.

Sincerely,

Tequila Terry
Senior Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi

March 6, 2026

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

Re: Discussion on Health System Transformation policy development, Long-acting injectable antipsychotic medications

Mr. Kromm:

NAMI Maryland and our 11 local affiliates across the state represent a network of more than 60,000 families, individuals, community-based organizations, and service providers. NAMI Maryland is a 501(c)(3) non-profit dedicated to providing education, support, and advocacy for people living with mental illnesses, their families, and the wider community. We respectfully submit these comments in response to the Call for Comments: Discussion on Health System Transformation policy development, specifically, under "*Other considerations: What other considerations should the HSCRC employ in supporting health system transformations to improve access to care and health outcomes while reducing costs?"*

Many people living with serious mental illness (SMI) struggle with medication adherence, often due to the symptoms of their mental health conditions or to trouble with consistently accessing healthcare providers and pharmacies. One way to help those individuals obtain and maintain access to antipsychotic medications is through long-acting injectables (LAIs) or extended-release medications. LAIs are often administrated in inpatient clinical settings or in hospital emergency departments. NAMI Maryland requests that the HSCRC consider expanding the use of FDA-approved LAIs through the AHEAD model. Expanded use of LAIs will reduce overall treatment costs of SMI for Medicaid eligible individuals by ensuring they can get the medications they need without delays or gaps in access.

A hospital's daily rate for medical assistance can already include LAIs, but the nature of hospital global budget structures often makes LAIs cost-prohibitive; LAIs cost more per dosage, but those dosages, by definition, last much longer than orally administered antipsychotics. However, a carveout for LAIs would reduce overall costs of treatment by reducing the negative outcomes that result from nonadherence with antipsychotic medications, such as repeat emergency department admissions and inpatient psychiatric care.

Stephanie Slowly-Little
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

At least four states have already adopted budget amendments or secured State Plan Amendments to carveout FDA-approved LAIs or similar extended-release medications for the treatment of SMI: Georgia, Massachusetts, Illinois, and Virginia. We hope that Maryland can join the growing number of states who are ensuring that our loved ones and neighbors living with SMI can consistently access antipsychotic medications.

We thank you for considering this approach to expanding use of LAIs through the AHEAD model. We are happy to discuss this in more detail.

Sincerely,

Stephanie Slowly-Little, MSW/LCSW-C

Executive Director

Stephanie Slowly-Little
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

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

CORPORATE OFFICE

March 11, 2026

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

RE: UMMS comments to inform the principles and parameters of a potential draft policy for facility transformations under the AHEAD Model

Dear Jon:

On behalf of the University of Maryland Medical System ("UMMS") and its member hospitals, I am submitting comments in response to the Health Services Cost Review Commission's ("HSCRC" or "Commission") questions to inform the principles and parameters of a potential draft policy for facility transformation under the Achieving Healthcare Efficiency through Accountable Design ("AHEAD") Model. As always, our policy comments are grounded in our commitment to delivering high-value care, fairness in access to care, and improved outcomes in the communities we serve. In service of that commitment, UMMS, more than any other health system, has proactively sought to utilize facility transformations to more effectively utilize existing resources to advance care delivery models for our communities. In the now 13 years since Global Budgets were implemented, UMMS has completed three, and committed to one additional, facility transformations which have allowed us to redeploy resources toward a more effective care model that aligns with community needs. From these transitions we have successfully, without new resources, undertaken major capital initiatives for overdue hospital replacements, redesigned and expanded access points for behavioral health, rehabilitation, and chronic condition management, and right-sized hospital-based capacity while expanding ambulatory access points. For UMMS, these facility transformations have been an essential component of our broader commitment to our communities and advancing Model goals.

UMMS believes that transforming delivery systems is an essential component of achieving Model goals. We have championed that concept over the last decade of the model and view delivery system transformation as a solution that, if done correctly, delivers on savings requirements while stabilizing the State access model. Through the lens of our experiences to date, UMMS offers the following thoughts on the principles and parameters of a facility transformation policy.

Target underutilized hospital-based capacity for consolidation to drive savings and delivery system transformation, as coverage of fixed cost related to under-utilized hospital-based capacity is not an effective use of funds in the model. UMMS has been a leader in transforming community care delivery models while delivering savings via facility transformations under the Maryland TCOC Model, and we have been consistent in our commentary that regulatory policy should push hospitals and health systems with underutilized capacity to transform. The primary objective of any facility transformation policy should be to identify geographies and hospitals where disproportionate resources are dedicated to covering the fixed cost of maintaining underutilized hospital-based capacity and to redeploy those funds toward a more effective and accessible care model.

Facility transformation must start with objective understanding of access needs across care settings by community or region. Establish a statewide process to understand access needs, evaluate bed capacity on those terms, and make recommendations on reductions in capacity. In terms of "identifying focus geographic areas" and "identifying focus hospitals", UMMS has been consistent, in both our own policy comments and our joint policy thoughts with the Johns Hopkins Health System ("JHHS"), in expressing the need for the HSCRC, in partnership with the Maryland Health Care Commission ("MHCC"), to undertake an objective evaluation of bed needs on a semi-regular basis that both (1) provides recommendations on reductions in capacity and (2) develops incentives for implementation. We would stress that an objective assessment of both near and long-term capacity needs should contemplate both the demographic realities of an aging population and the evolving role of traditional hospital-based capacity as community-based care models expand.

Regulatory definitions of allowed services should be flexible when thinking about facility transitions. In UMMS's experience with facility transitions that reduce inpatient-based capacity, it has been important to have the regulatory flexibility to consider options such as emergency and urgent care capabilities, dedicated observation beds, outpatient operating and procedure rooms, outpatient clinics, and specialty services such as psychiatric and rehabilitation, depending on the specific access needs of the community.

Reinvestment of freed resources into both acute and community-based access needs is a necessary component of transformation that should be balanced with system savings. Every facility transformation that UMMS has undertaken has begun with a mission-oriented evaluation of how to best utilize existing funds to evolve the care delivery model with a goal of more effectively meeting the needs of the communities we serve. We have utilized facility transitions to fund long-overdue rightsizing and replacements of aged acute facilities, expand access to behavioral health services in underserved communities, add ambulatory services in underserved areas, and expand community-based access points and care models to manage chronic conditions. Recognizing that facility transformations should be accretive to Model savings targets, UMMS would urge the HSCRC to set "redeployment/reinvestment of existing funds towards a more effective care model", which includes both hospital-based and community-based needs, as a front-of -mind priority when considering what share of the benefit from facility transformations should be kept as savings vs. reinvested in the community care model.

Require an assessment of how the facility transformation improves both acute and community-based access in the community. As we discussed at the outset, every facility transformation conversation begins with an objective evaluation of hospital-based bed need. It must also include a nuanced understanding of both (1) how the transformation moves the community's access/care delivery model forward and (2) how the acute care needs of the community will continue to be met.

Recognize that investment will need to be made in facilities that are expected to meet the ongoing acute care need in communities where facility transformations occur. It is important to recognize that, even for facilities that are significantly underutilized, there are very few instances in the State where a facility transformation can occur without overt planning for accommodating the acute volumes that are currently being served by that facility. In every transformation that UMMS has undertaken, we have had to make an investment at the receiving facility to enable the facility transformation. UMMS had to build multiple floors at UMMC, UM Shore Easton, and UM Upper Chesapeake Medical Center to enable the transformations of UM Rehab & Ortho, UM Shore Dorchester, and UM Harford Memorial respectively. Every facility transformation that UMMS has undertaken has also included new regulated or unregulated outpatient surgery capacity. While the result is an overall reduction in hospital-based capacity and footprint, these transformations could not be achieved without investment in (and funding for) additional capacity at the receiving facilities.

There must be alignment between financial incentives and desired outcomes. As we have discussed throughout, UMMS has proactively pursued facility transformations as opportunities to fund through existing resources mission-oriented initiatives to evolve the care delivery model in the communities we serve. With the experience of four facility transformations as context, we cannot stress enough that the financial burden of meeting the three-part requirement of (1) meeting the ongoing access needs, (2) redeploying funds into community-based resources/care transformation, and (3) generating system savings is a primary roadblock to overcome when contemplating these transformations. For any facility transformation policy to be impactful, there must be clear alignment between financial incentives and desired outcomes.

UMMS is committed to delivering high-value care, fairness in access to care, and improved outcomes in the communities we serve, consistent with the goals of both Maryland's current Total Cost of Care Model and the forthcoming AHEAD Model. We believe strongly that managing the fixed cost of under-utilized hospital-based capacity is not an effective use of resources in the model, and more than any other health system, we have proactively sought to utilize facility transformations to advance the care models in the communities we serve. UMMS strongly believes that well-thought-out state processes for assessing capacity needs and facility transformation are essential to the long-term success of the Model, and we look forward to collaborating with our state partners on this important issue.

Sincerely,

Alicia Cunningham
Senior Vice President, Corporate Finance & Revenue Advisory Services
University of Maryland Medical System

Legislative Update
April 2026

HB390/SB282 Budget Bill - Operating

- Reserves $250,000 of HSCRC budget pending submission of a report on on efforts to stabilize the Medicare Advantage (MA) market in Maryland under AHEAD.
  - Due January 15, 2027
- Provides for a $500,000 grant to CRISP for distribution to DrFirst
- Effective July 1, 2026

HB392/SB284 Budget Reconciliation and Financing Act 2026

- Provision requiring HSCRC to examine whether financial assistance to MA plans is required to maintain viability in CY 2026 and whether hospital rates should be adjusted (up to $140 million) to provide such assistance.
- Provision empowering a transfer of $10 million from the Nurse Support Program Assistant Fund to the General Fund.
- Effective June 1, 2026

Anticipated Reporting Requirements*

- Report on Financing for Long-acting Injectable (LAI) Medication - MDH is lead, in conjunction with Behavioral Health Administration and HSCRC.
  - Due September 1, 2026.
- Workgroup on nursing home performance and development of a public scorecard - MDH is lead, in collaboration with HSCRC and CRISP.
  - Due December 15, 2026.
- Report on efforts to stabilize the MA market in Maryland under the AHEAD mode - HSCRC is lead, in consultation with MDH.
  - Due January 15, 2027.
- Report on hospital and other regulated health facility contracts with agencies that provide temporary staffing - HSCRC is lead.
  - Due January 1, 2027 for hospitals that have a FY ending June 30, 2026, and June 30, 2027 for hospitals with FY ending any other date.

*Subject to change pending publication of 2026 Joint Chairmen's Report, anticipated May 2026

Disposition of Bills

HB 372 SB 169	**Hospitals – Emergency Pregnancy-Related Medical Conditions – Procedures**	Status:
Requires hospitals to conduct screening on a patient presenting at an emergency department to determine whether the patient has an emergency pregnancy-related medical condition, and establishing requirements and prohibitions related to the treatment and transfer of a patient who has an emergency pregnancy-related medical condition.		Passed Effective 10/1/26

HB 1563	**Emergency Room Services and Post Acute Care - Coverage and Studies**	Status:
Empowers MIA to include data on adverse decisions and grievances in the annual summary report, to examine patterns of adverse decisions or grievances related to services in emergency departments, and allows review by an independent review organization. Requires MHCC in conjunction with HSCRC to conduct studies quantifying bed capacity in hospitals and post-acute settings, as well as clinically appropriate transitions between acute and post acute care.		Passed Effective 6/1/2026

Disposition of Bills

SB 792	**Hospitals - Immigration Enforcement Action - Policy Requirement**	Status:
Requires hospitals to adopt a policy describing the protocol of the hospital when there is an immigration enforcement action, to make the policy available to all staff members and to provide annual training to ensure the staff's knowledge and understanding of the policy.		Passed Effective 6/1/2026

HB 624 SB 411	**Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)**	Status:
Requires hospitals to establish and maintain clinical staffing committees, implement clinical staffing plans aligned with accreditation standards set forth by accrediting bodies and the Centers for Medicare and Medicaid Services Conditions of Participation.		Passed Effective 10/1/26

Questions?

Janice Lepore

Chief of Policy and Government Affairs

Janice.Lepore1@maryland.gov

maryland
health services
cost review commission

Quality Program and Non-Financial Metrics

April 2026 Commission Meeting

Purpose

- Today's presentation will provide performance on select measures included in HSCRC quality and potentially avoidable utilization policies:
  - Provide an overview of statewide performance on key measures over the Total Cost of Care model (CY2018-CY2025).
  - Highlight hospital performance under most recent HSCRC payment programs.
  - Promote accountability and transparency in performance.
- Moving forward, staff plan to include quarterly updates in the HSCRC Commission meeting packets and present highlights at the public meeting.
  - Staff are looking for Commissioner and stakeholder input on today's presentation and future public updates.

Hospital Quality Programs

The following are the HSCRC's four main hospital quality payment incentive programs:

Maryland Hospital Acquired Conditions (MHAC) Program

Encourages hospitals to reduce infections and complications acquired during a hospital stay

Quality Reimbursement Program (QBR)

Focuses on patient experience, patient safety, and clinical quality outcomes

Readmissions Reduction Incentive Program (RRIP)

Encourages hospitals to reduce readmissions within 30 days of discharge

Potentially Avoidable Utilization (PAU)

Focuses on improving patient care and health through reducing potentially avoidable utilization

HSCRC's quality programs are similar to federal Medicare pay-for-performance programs, but are, wherever possible, All-Payer (instead of Medicare-only) and tailored to address MD's unique quality improvement strategies

1. Readmissions

- 1.1. Statewide Medicare Fee For Service Readmission Rates
- 1.2. Statewide Case-Mix Adjusted Readmission Rates
- 1.3. Hospital Case-Mix Adjusted Readmission Rates
  - 1.3.a. Hospital Improvement Rates
  - 1.3.b. Hospital Attainment Rates
- 1.4. Hospital Readmission Disparities

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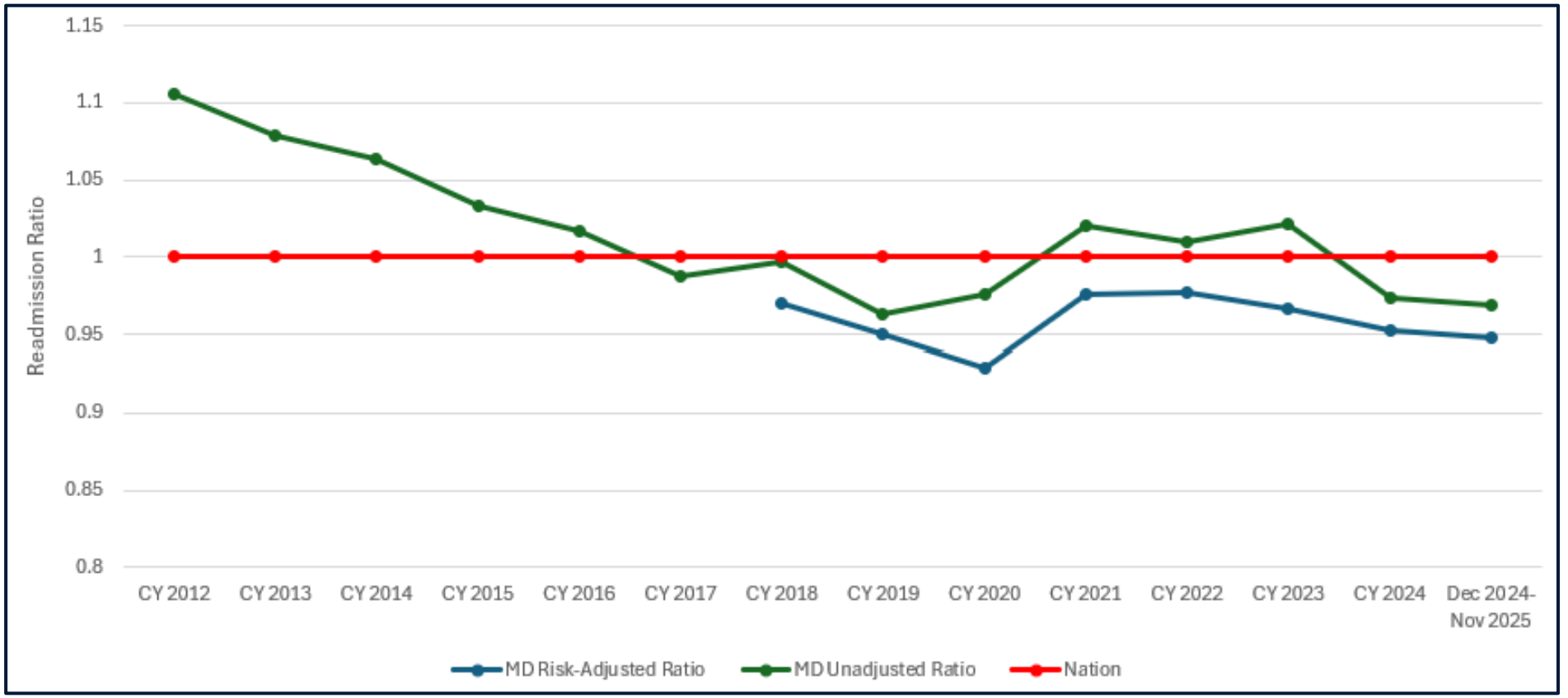
1. Readmissions

- 1.1. Statewide Medicare Fee For Service Readmission Rates
- 1.2. Statewide Case-Mix Adjusted Readmission Rates
- 1.3. Hospital Case-Mix Adjusted Readmission Rates
  - 1.3.a. Hospital Improvement Rates
  - 1.3.b. Hospital Attainment Rates
- 1.4. Hospital Readmission Disparities

1.1. Maryland performs better than the Nation on Medicare Fee for Service readmissions



This metric was used to assess MD performance under the All-Payer (unadjusted) and Total Costs of Care (risk-adjusted) Models.

Source: CMMI Reporting, updated quarterly

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1. Readmissions

- 1.1. Statewide Medicare Fee For Service Readmission Rates
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  - 1.3.a. Hospital Improvement Rates
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- 1.4. Hospital Readmission Disparities

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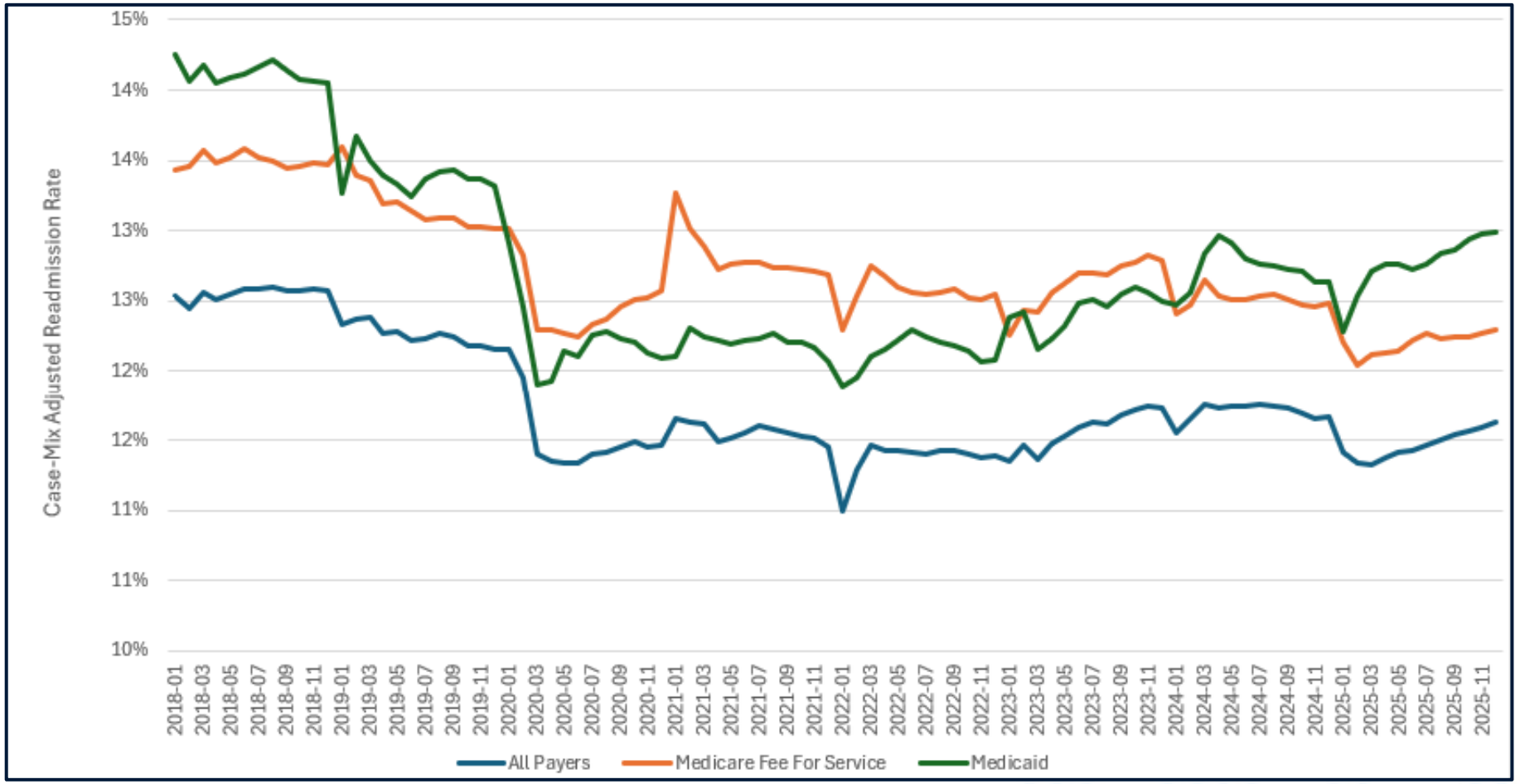
1.2. Readmissions improved for All Payers, Medicare Fee for Service, and Medicaid since start of TCOC Model (CY2018-CY2025)



Medicaid has experienced annual increases in readmission rates since CY 2021.

Medicare FFS readmissions have declined annually since CY 2023.

Source: HSCRC Case-Mix Data, updated monthly
Note: This case-mix adjusted metric accounts for diagnosis and acuity of admissions; used for the readmission pay-for-performance program for MD hospitals.

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1. Readmissions

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  - 1.3.b. Hospital Attainment Rates
- 1.4. Hospital Readmission Disparities

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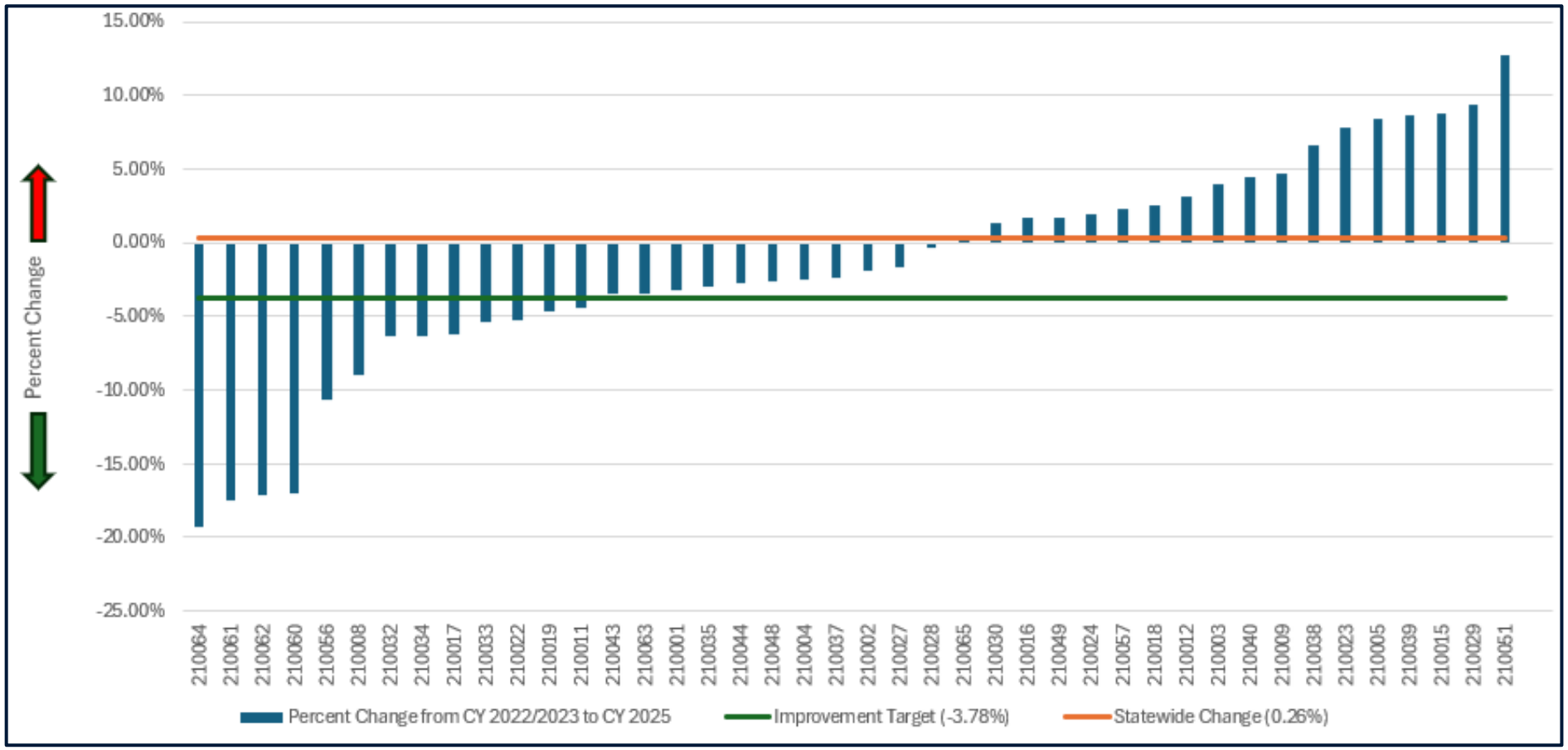
1.3.a. Despite a slight increase statewide, majority of hospitals (24 out of 42) reduced readmissions in CY 2025



13 hospitals met the improvement target needed to avoid financial penalties and qualify for rewards under the Readmission Reduction Incentive program.

Source: HSCRC Case-Mix Data, updated monthly

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1. Readmissions

- 1.1. Statewide Medicare Fee For Service Readmission Rates
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  - 1.3.a. Hospital Improvement Rates
  - 1.3.b. Hospital Attainment Rates
- 1.4. Hospital Readmission Disparities

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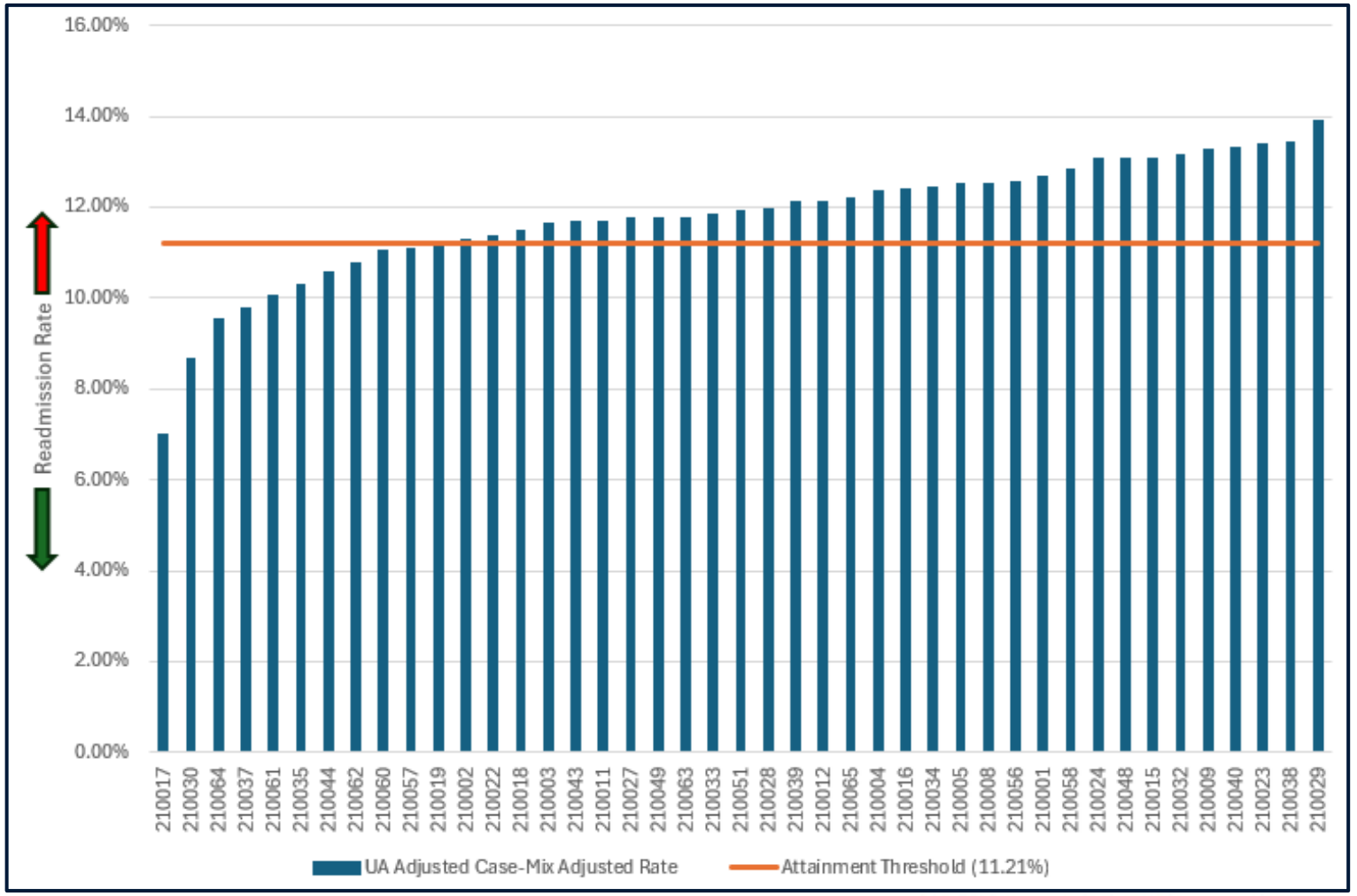
1.3.b. Hospital performance varied from 7-14 percent in CY 2025*



10 hospitals have readmissions that were below the attainment target needed to avoid financial penalties and qualify for rewards under the Readmission Reduction Incentive program.

Source: HSCRC Case-Mix Data, updated monthly

*These are preliminary numbers using the CY 2024 Utilization Adjustment which will be updated to CY 2025 for final results. The Utilization Adjustment (UA) accounts for out of state utilization for fair comparison of hospitals.

1. Readmissions

- 1.1. Statewide Medicare Fee For Service Readmission Rates
- 1.2. Statewide Case-Mix Adjusted Readmission Rates
- 1.3. Hospital Case-Mix Adjusted Readmission Rates
  - 1.3.a. Hospital Improvement Rates
  - 1.3.b. Hospital Attainment Rates
- 1.4. Hospital Readmission Disparities

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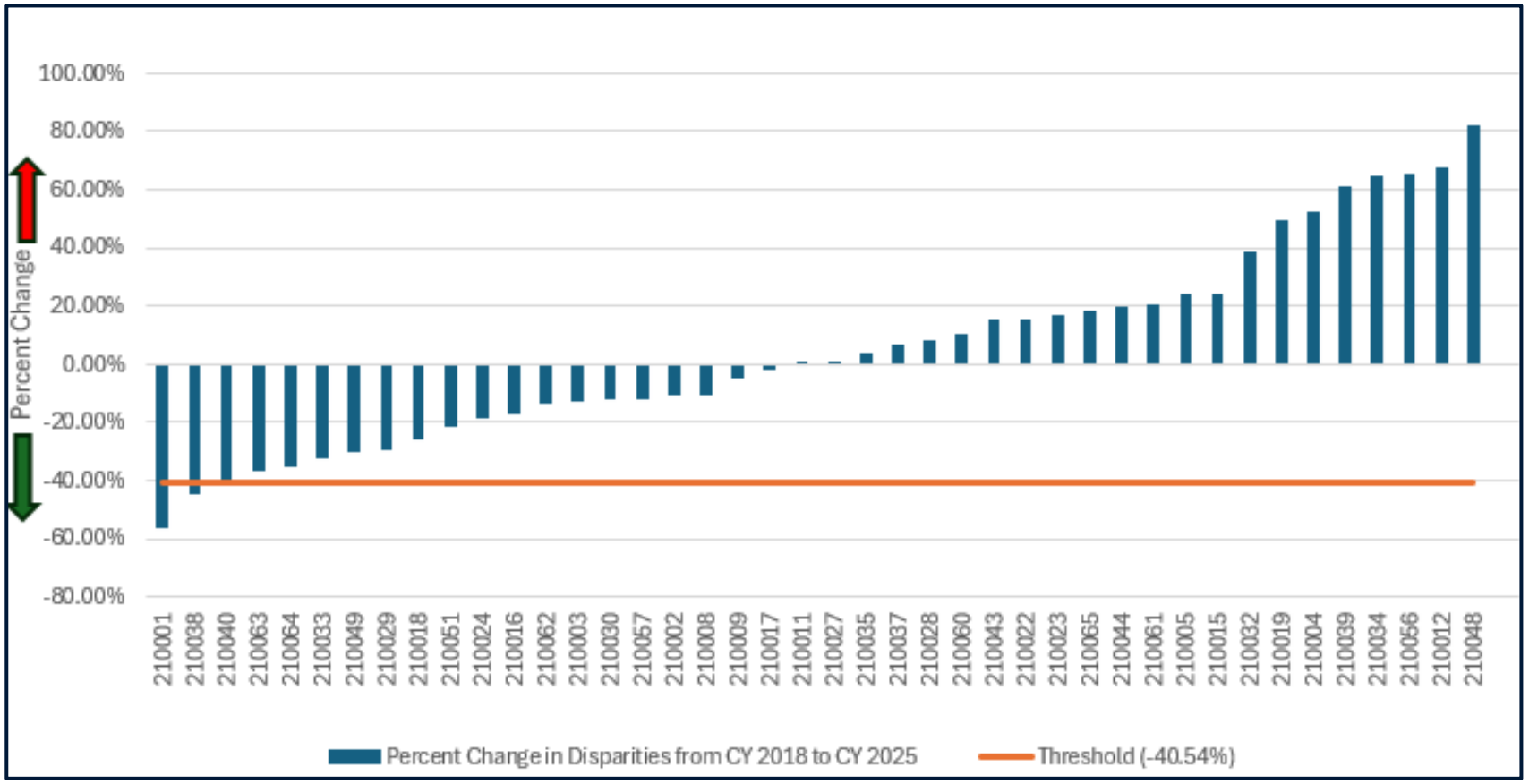
1.4. Twenty hospitals reduced readmission disparities in CY 2025



Two hospitals met the disparity reduction goal to qualify for a financial reward under the Readmission Reduction Incentive program.

Source: HSCRC Case-Mix Data, updated monthly
Note: Disparities are measured using HSCRC's Patient Adversity Index, which assesses race, medicaid status, and neighborhood deprivation. Additional information on the Disparity Gap Methodology can be found here: RY 2022 RRIP Policy

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2. Select Quality-Based Reimbursement (QBR) Measure Performance

- 2.1. Hospital Consumers Assessment Healthcare Providers and Systems (HCAHPS) Patient Experience Survey
  - 2.1.a. MD vs Nation
  - 2.1.b. By Hospital
- 2.2. Emergency Department Length Of Stay (ED LOS) for Admitted Patients
- 2.3. Timely Follow-Up After Acute Exacerbations of Chronic Conditions (TFU)
  - 2.3.a. Statewide Medicare vs Nation by Condition
  - 2.3.b. By Hospital Medicare and Medicaid Performance across All Conditions
  - 2.3.c. By Hospital Medicare Disparities

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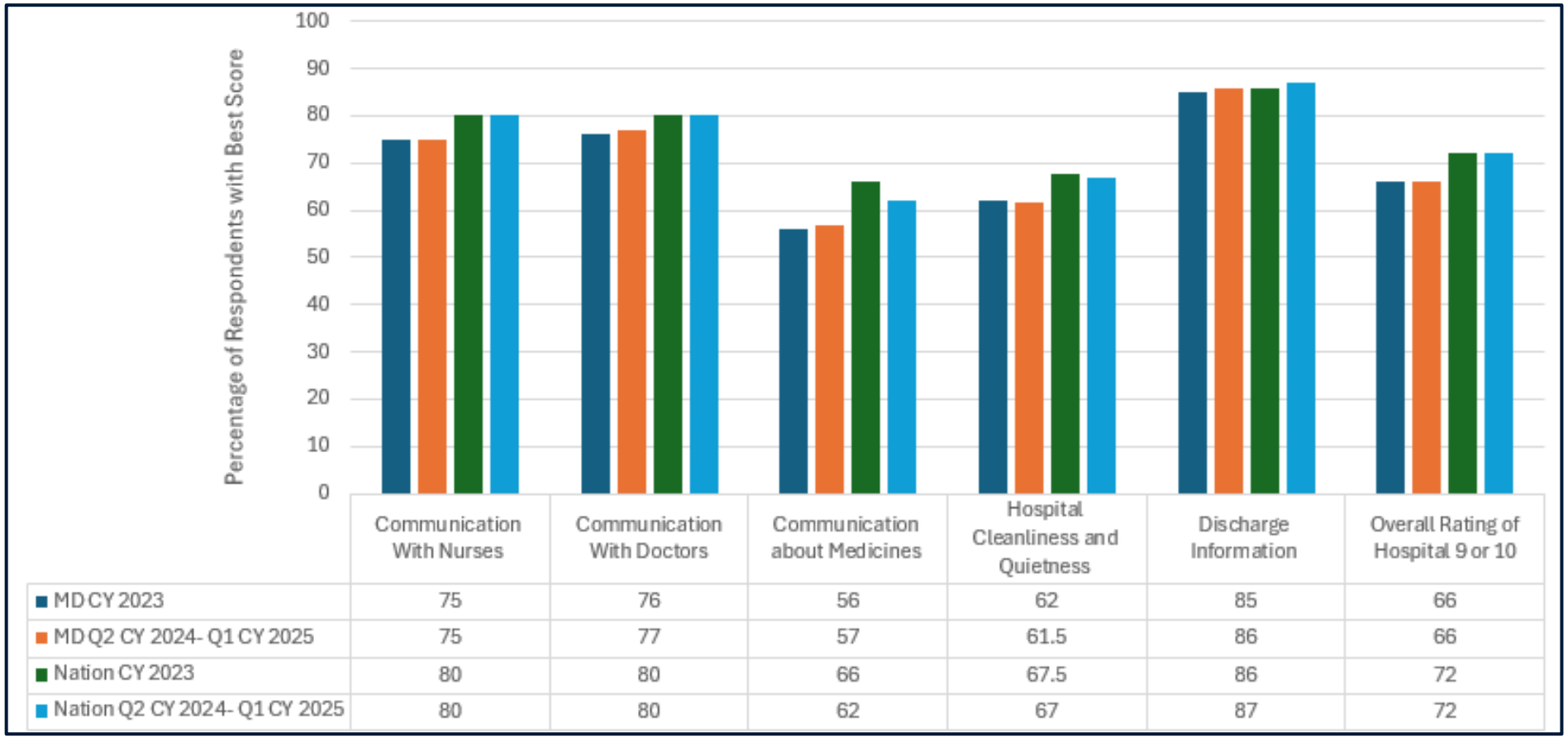
2.1.a. Maryland performs worse than the Nation on patient experience across all HCAHPS domains



	Communication With Nurses	Communication With Doctors	Communication about Medicines	Hospital Cleanliness and Quietness	Discharge Information	Overall Rating of Hospital 9 or 10
MD CY 2023	75	76	56	62	85	66
MD Q2 CY 2024- Q1 CY 2025	75	77	57	61.5	86	66
Nation CY 2023	80	80	66	67.5	86	72
Nation Q2 CY 2024- Q1 CY 2025	80	80	62	67	87	72

Maryland improved slightly on Communication with Doctors and Communication about Medicines in most recent data compared to CY 2023.

Source: CareCompare, updated quarterly

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  - 2.3.b. By Hospital Medicare and Medicaid Performance across All Conditions
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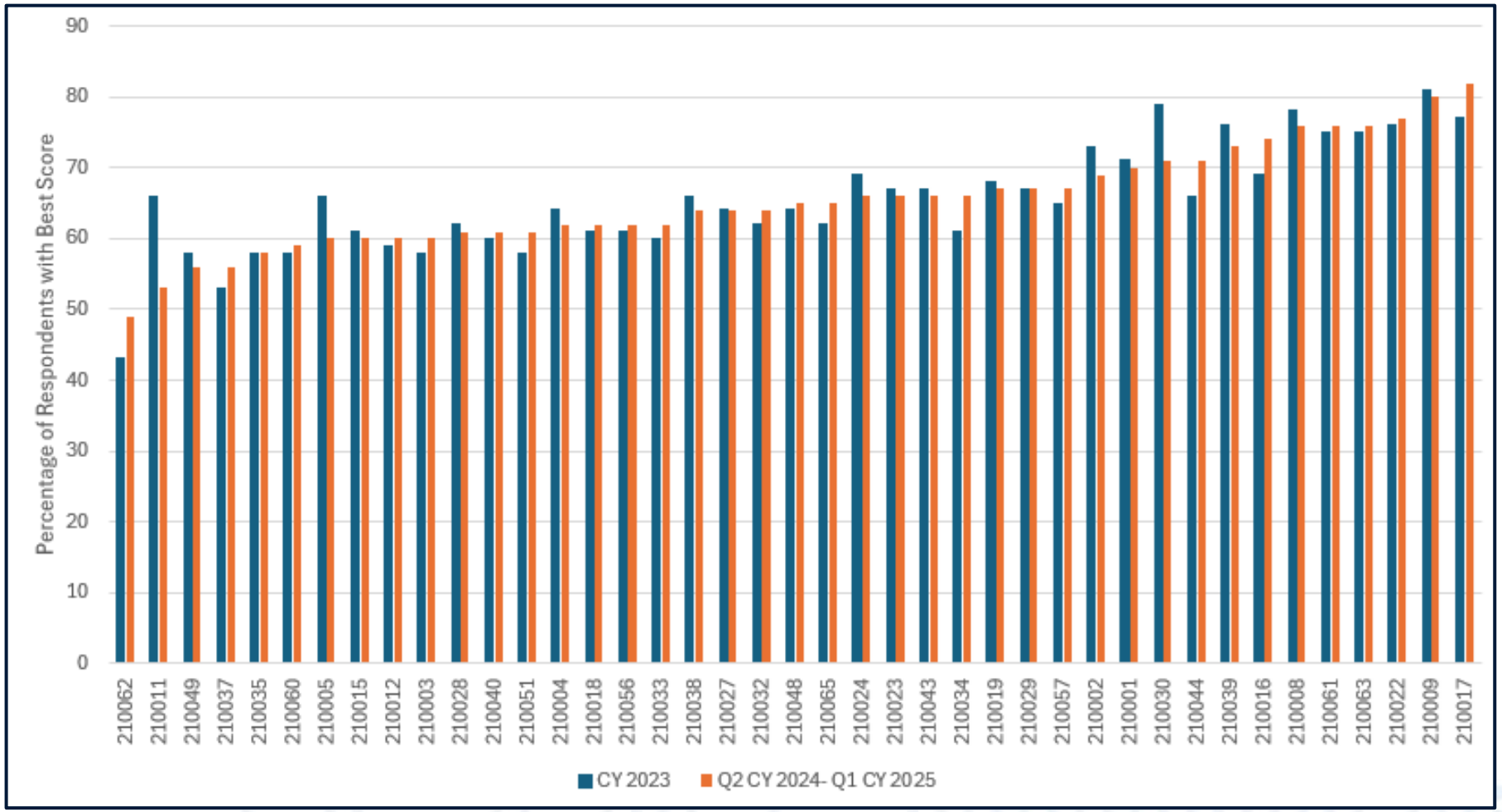
2.1.b. Hospitals vary on percent of respondents that give a 9/10 score for overall hospital rating



21 hospitals improved from CY 2023 and could qualify for financial reward under the Quality Based Reimbursement Program.

Source: CareCompare, updated quarterly

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2. Select Quality-Based Reimbursement (QBR) Measure Performance

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  - 2.3.b. By Hospital Medicare and Medicaid Performance across All Conditions
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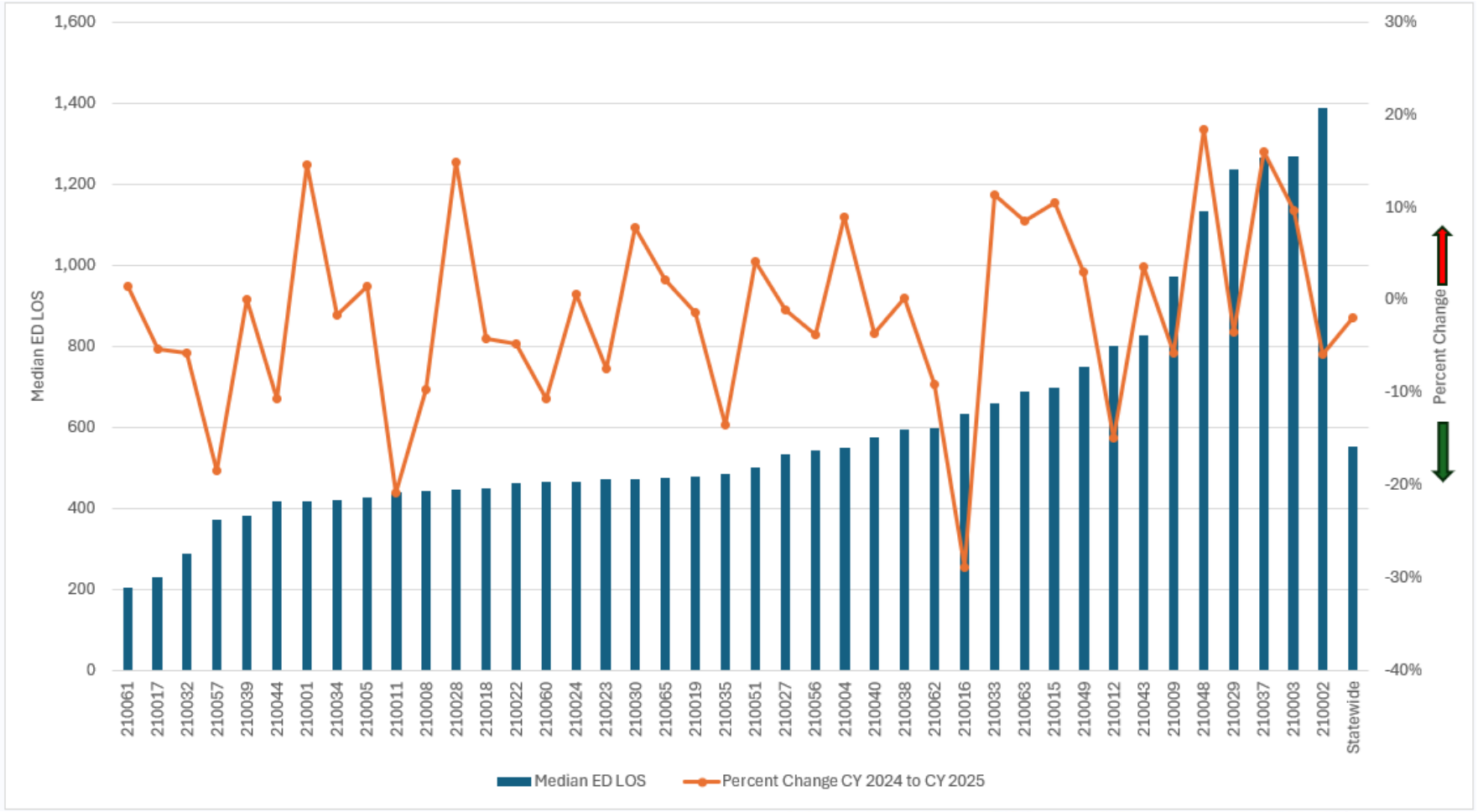
2.2. Half of hospitals improved on ED LOS for admitted patients in CY 2025 compared to CY2024



Source: HSCRC Case-Mix data, updated monthly

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2. Select Quality-Based Reimbursement (QBR) Measure Performance

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  - 2.3.c. By Hospital Medicare Disparities

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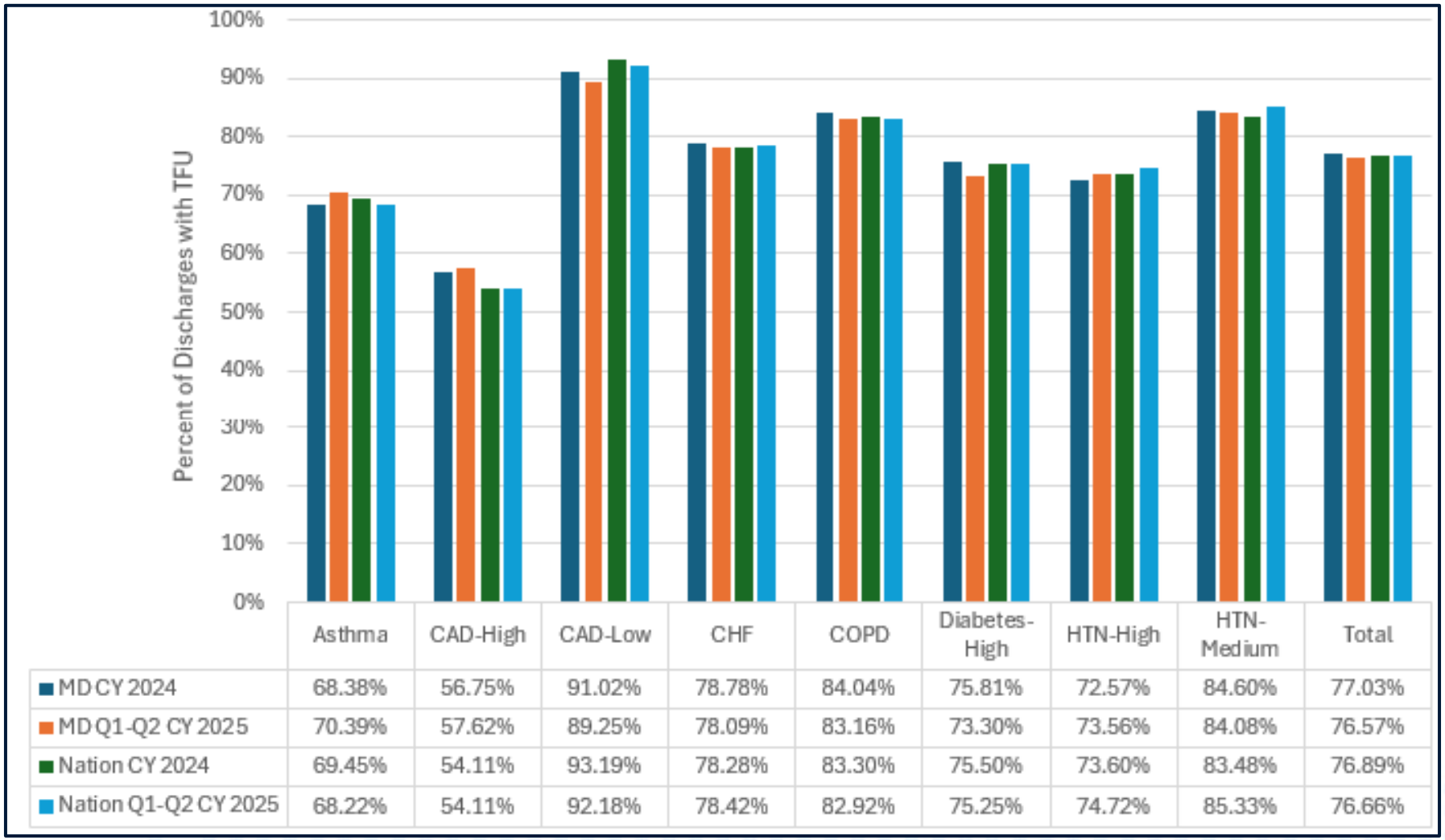
2.3.a Maryland performs on par with the Nation on timely follow-up across 6 chronic conditions



	Asthma	CAD-High	CAD-Low	CHF	COPD	Diabetes-High	HTN-High	HTN-Medium	Total
MD CY 2024	68.38%	56.75%	91.02%	78.78%	84.04%	75.81%	72.57%	84.60%	77.03%
MD Q1-Q2 CY 2025	70.39%	57.62%	89.25%	78.09%	83.16%	73.30%	73.56%	84.08%	76.57%
Nation CY 2024	69.45%	54.11%	93.19%	78.28%	83.30%	75.50%	73.60%	83.48%	76.89%
Nation Q1-Q2 CY 2025	68.22%	54.11%	92.18%	78.42%	82.92%	75.25%	74.72%	85.33%	76.66%

In CY 2025 Maryland performed better than the nation on timely follow up for asthma, high acuity coronary artery disease, and COPD.

Source: Chronic Conditions Warehouse (CCW), updated biannually
Note: Acuity classifications (Low, Medium, and High) are defined using ICD-10 codes

2. Select Quality-Based Reimbursement (QBR) Measure Performance

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  - 2.3.b. By Hospital Medicare and Medicaid Performance across All Conditions
  - 2.3.c. By Hospital Medicare Disparities

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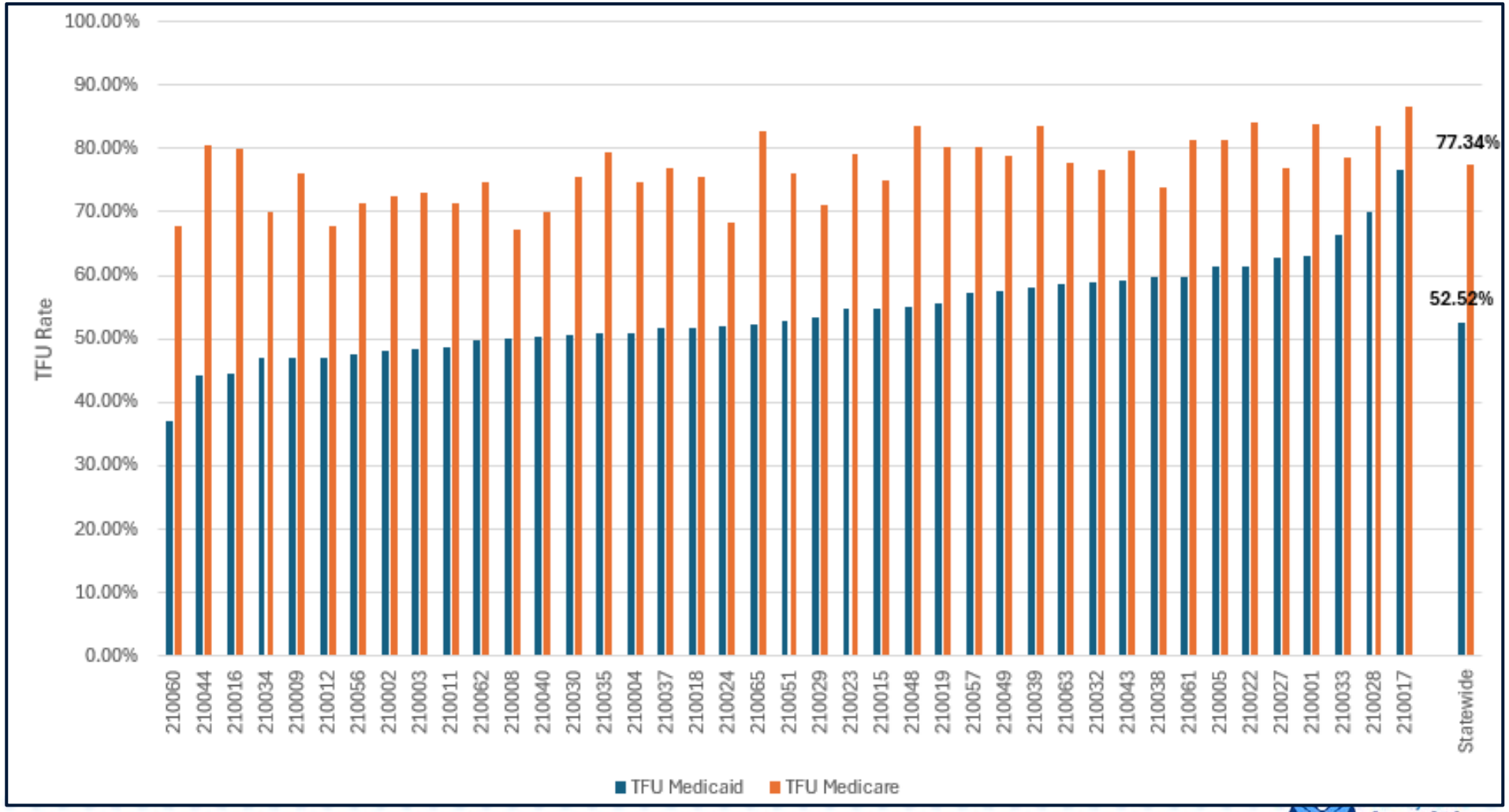
2.3.b. Percent of discharges with timely follow up is higher for Medicare FFS compared to Medicaid MCO & FFS



Source: Medicaid Claims, updated monthly; CCLF for Medicare FFS, updated monthly

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2. Select Quality-Based Reimbursement (QBR) Measure Performance

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  - 2.3.b. By Hospital Medicare and Medicaid Performance across All Conditions
  - 2.3.c. By Hospital Medicare Disparities

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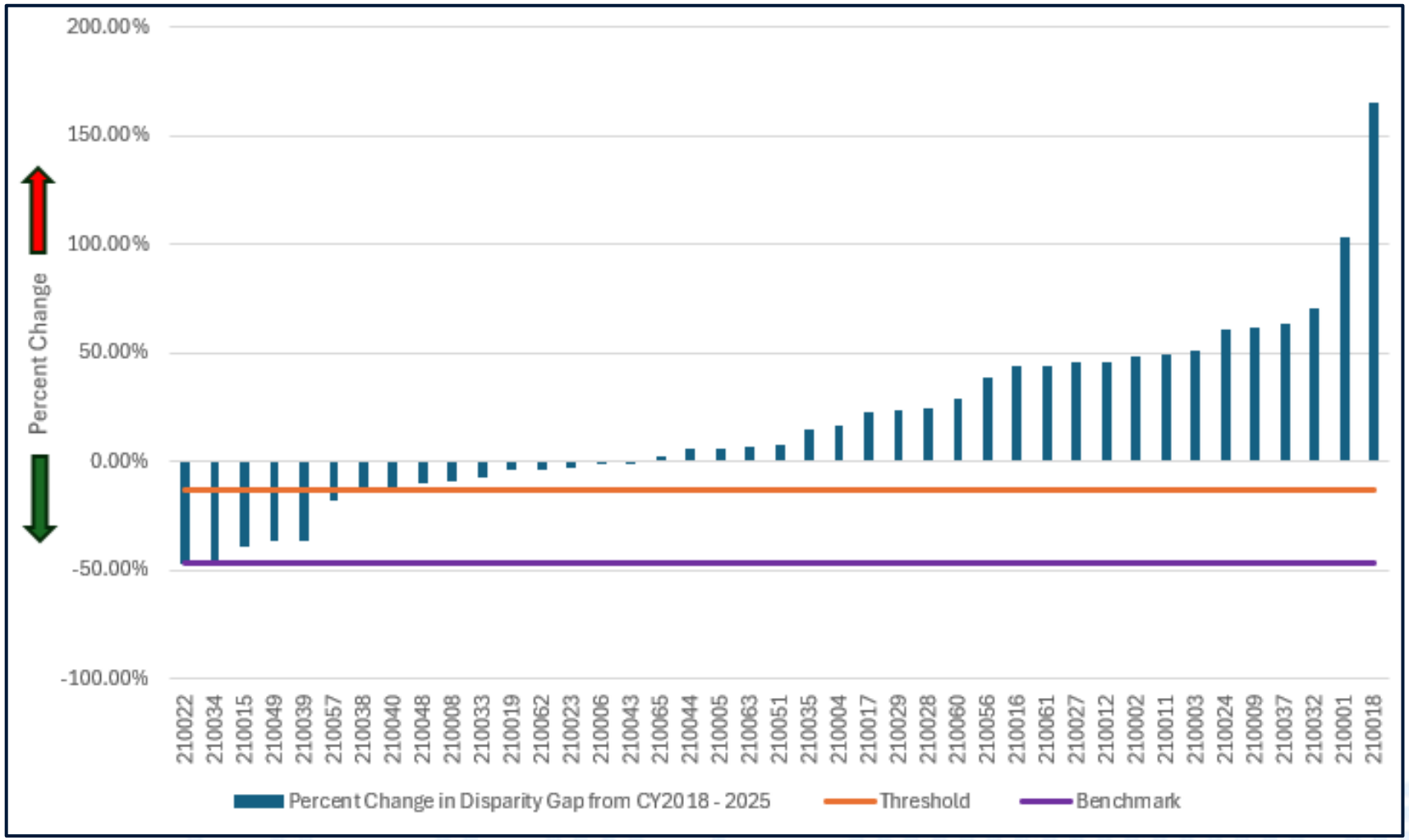
2.3.c. Most hospitals have worsening disparities in timely follow-up for the Medicare FFS population



8 hospitals met the minimum improvement target (threshold) to avoid financial penalties and quality for rewards (1 hospital met improvement benchmark to receive full reward).

Source: CCLF and Case-Mix

Note: Disparities are measured using HSCRC's Patient Adversity Index, which assesses race, medicaid status, and neighborhood deprivation.

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3. Complications Performance

- 3.1. Statewide Potentially Preventable Complications (PPC)
- 3.2. By Hospital Potentially Preventable Complications (PPC) Composite
- 3.3. Statewide Patient Safety Indicator (PSI- 90) Composite
- 3.4. By Hospital Patient Safety Indicator (PSI- 90) Composite

3. Complications Performance

- 3.1. Statewide Potentially Preventable Complications (PPC)
- 3.2. By Hospital Potentially Preventable Complications (PPC) Composite
- 3.3. Statewide Patient Safety Indicator (PSI- 90) Composite
- 3.4. By Hospital Patient Safety Indicator (PSI- 90) Composite

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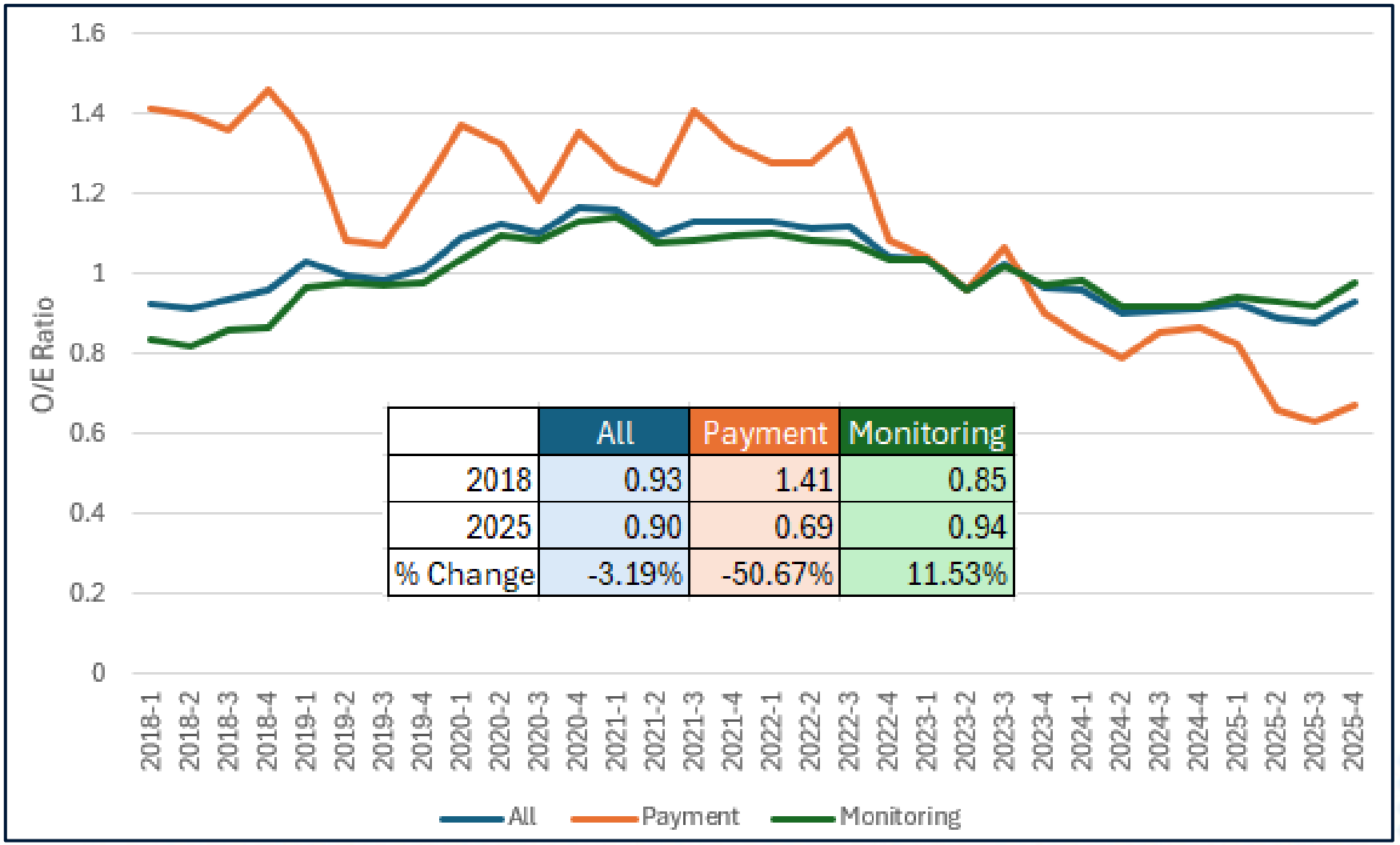
3.1. Maryland has seen over 50% decrease in PPCs in payment program from 2018; monitored PPCs had increases.



	All	Payment	Monitoring
2018	0.93	1.41	0.85
2025	0.90	0.69	0.94
% Change	-3.19%	-50.67%	11.53%

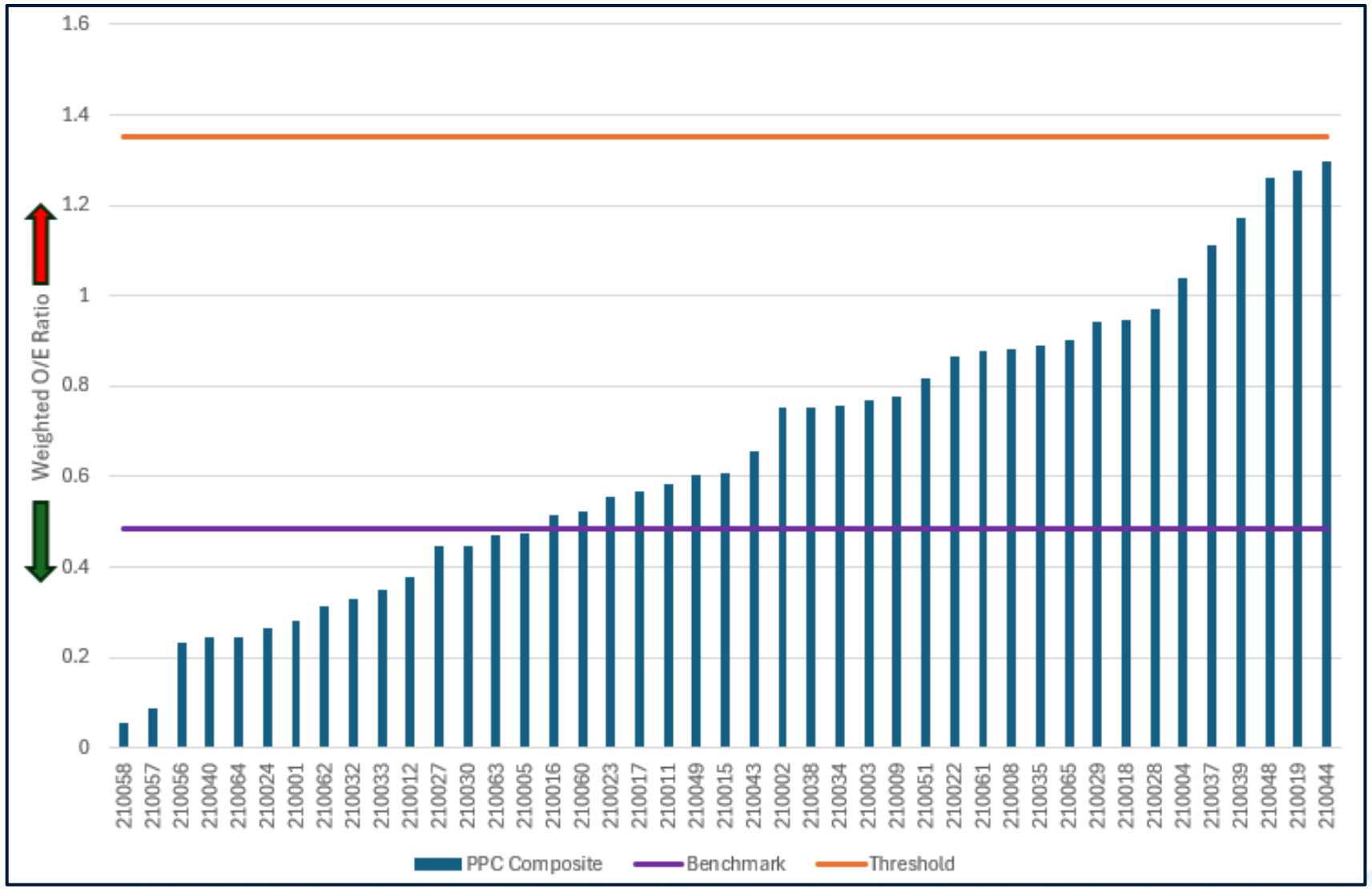
Payment PPCs include 16 complications that were focused during the TCOC Model. All other PPCs were monitored but not included in the Complications payment program.

Source: HSCRC Case-Mix Data, updated quarterly

3. Complications Performance

- 3.1. Statewide Potentially Preventable Complications (PPC)
- 3.2. By Hospital Potentially Preventable Complications (PPC) Composite
- 3.3. Statewide Patient Safety Indicator (PSI- 90) Composite
- 3.4. By Hospital Patient Safety Indicator (PSI- 90) Composite

3.2. Much variation across hospitals on PPC performance, 15 hospitals met or exceeded benchmark for full 2% MHAC reward



The PPC composite measure is an Observed to Expected ratio weighted by hospital expected volume and PPC cost weights as a proxy for patient harm.

Source: HSCRC Case-Mix Data using Solventum PPC Grouper Version 42, updated monthly

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3. Complications Performance

- 3.1. Statewide Potentially Preventable Complications (PPC)
- 3.2. By Hospital Potentially Preventable Complications (PPC) Composite
- 3.3. Statewide Patient Safety Indicator (PSI- 90) Composite
- 3.4. By Hospital Patient Safety Indicator (PSI- 90) Composite

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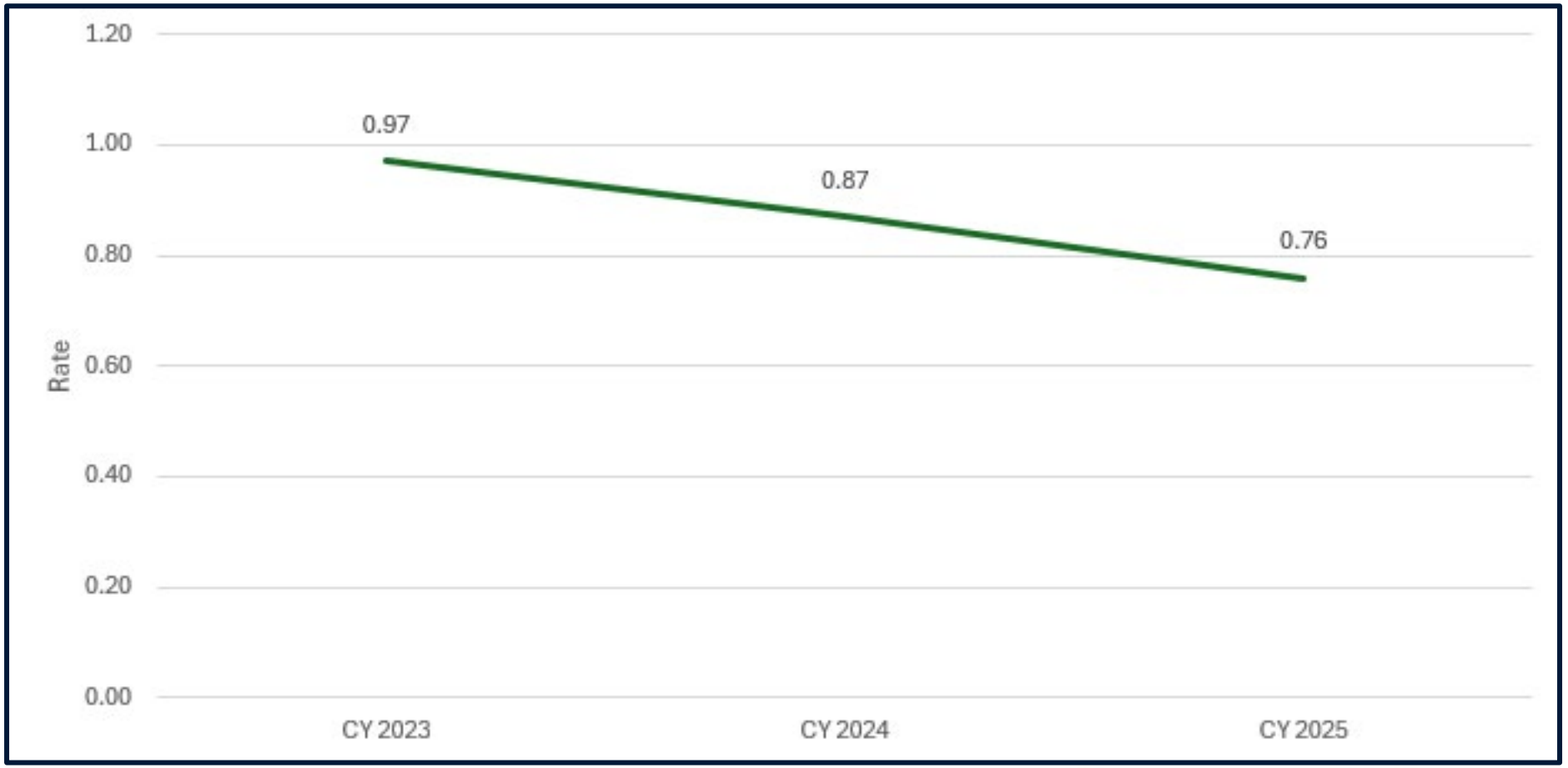
3.3. Maryland improved on the the Patient Safety Index Composite by 21.65 percent from CY 2023 to CY 2025



Source: HSCRC Case-Mix Data using AHRQ PSI Version v2025, updated monthly

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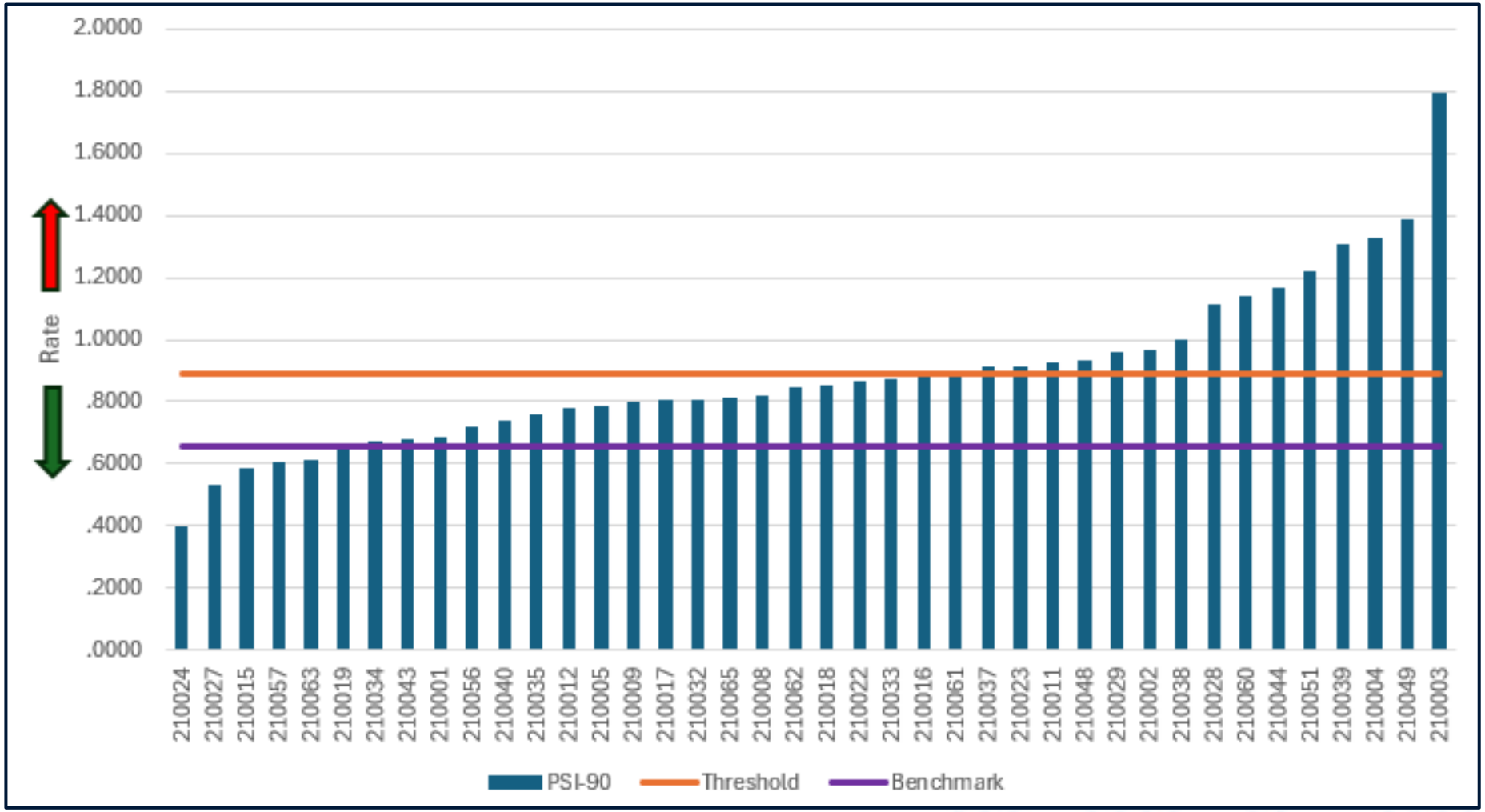
3. Complications Performance

- 3.1. Statewide Potentially Preventable Complications (PPC)
- 3.2. By Hospital Potentially Preventable Complications (PPC) Composite
- 3.3. Statewide Patient Safety Indicator (PSI- 90) Composite
- 3.4. By Hospital Patient Safety Indicator (PSI- 90) Composite

3.4. Wide variability across hospitals on PSI-90 performance



15 hospitals did not meet the minimum threshold to avoid penalties, 6 hospitals met or exceeded the benchmark to receive maximum reward.

Source: Case-Mix using AHRQ PSI Version v2025, updated monthly

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4. Potentially Avoidable Utilization

Potentially Avoidable Utilization includes Readmissions and Avoidable Admissions as measured by AHRQ Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI)

- 4.1. Statewide Performance on Risk-Adjusted Overall PQI Composite
- 4.2. Statewide Percent Change in Individual PQI Risk-Adjusted Rates
- 4.3. CY 2025 Hospital PQI/PDI Risk-Adjusted Rates per 1000 population
- 4.4. Statewide PAU Revenue Percent for PQI/PDIs and Readmissions
- 4.5. Hospital PAU Revenue Percent for PQI/PDIs and Readmissions

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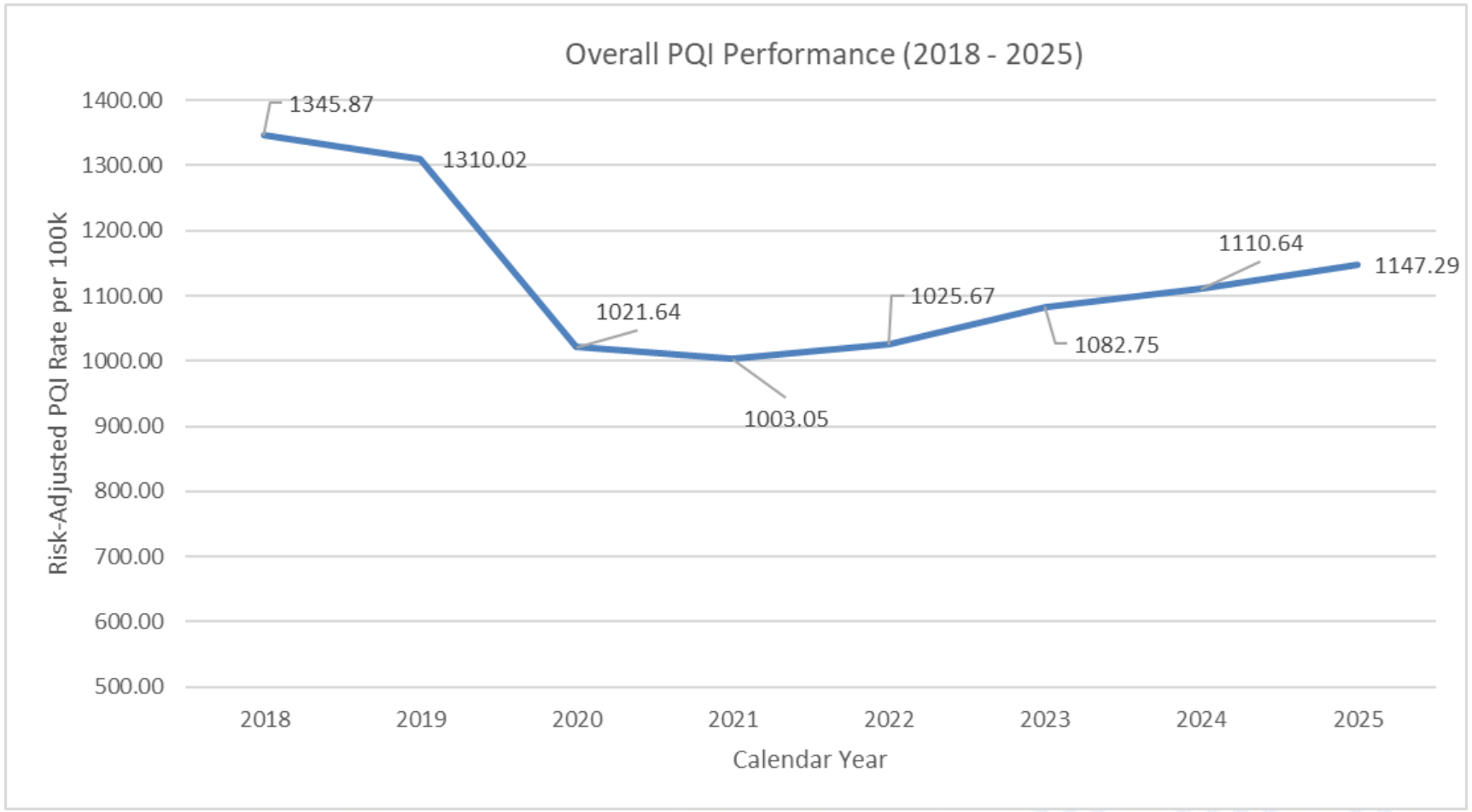
- 4.4. Statewide PAU Revenue Percent for PQI/PDIs and Readmissions
- 4.5. Hospital PAU Revenue Percent for PQI/PDIs and Readmissions

4.1. Avoidable admissions to Maryland hospitals declined by about 15 percent for All-Payers since start of TCOC Model (CY2018-CY2025)



PQI rates have trended slightly upwards since the drastic decrease seen in CY 2020 and CY 2021. Between CY 2024 and CY 2025 there was about a 3% increase.

Source: HSCRC Case-Mix Data using AHRQ Grouper Version 2024

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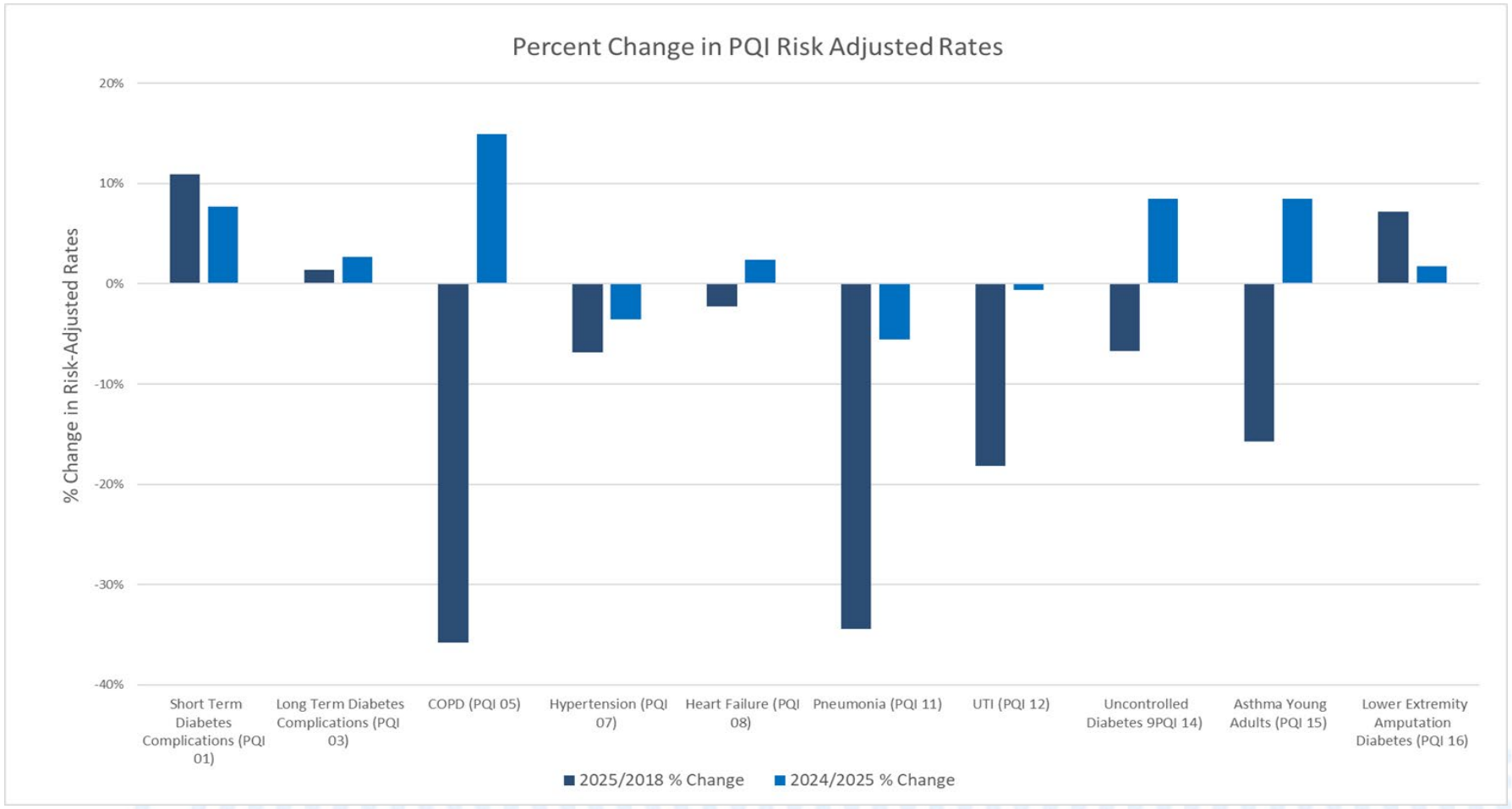
- 4.5. Hospital PAU Revenue Percent for PQI/PDIs and Readmissions

4.2. Avoidable admissions for COPD and pneumonia PQIs had the largest declines since CY 2018; short and long term diabetes complications and lower extremity amputations have increased.



While COPD PQIs significantly declined in CY 2025 from the CY 2018, these PQIs experienced the largest growth between 2024 and 2025.

Asthma and Diabetes related PQIs also increased between CY 2024 and CY 2025.

Source: HSCRC Case-Mix Data using AHRQ Grouper Version 2024

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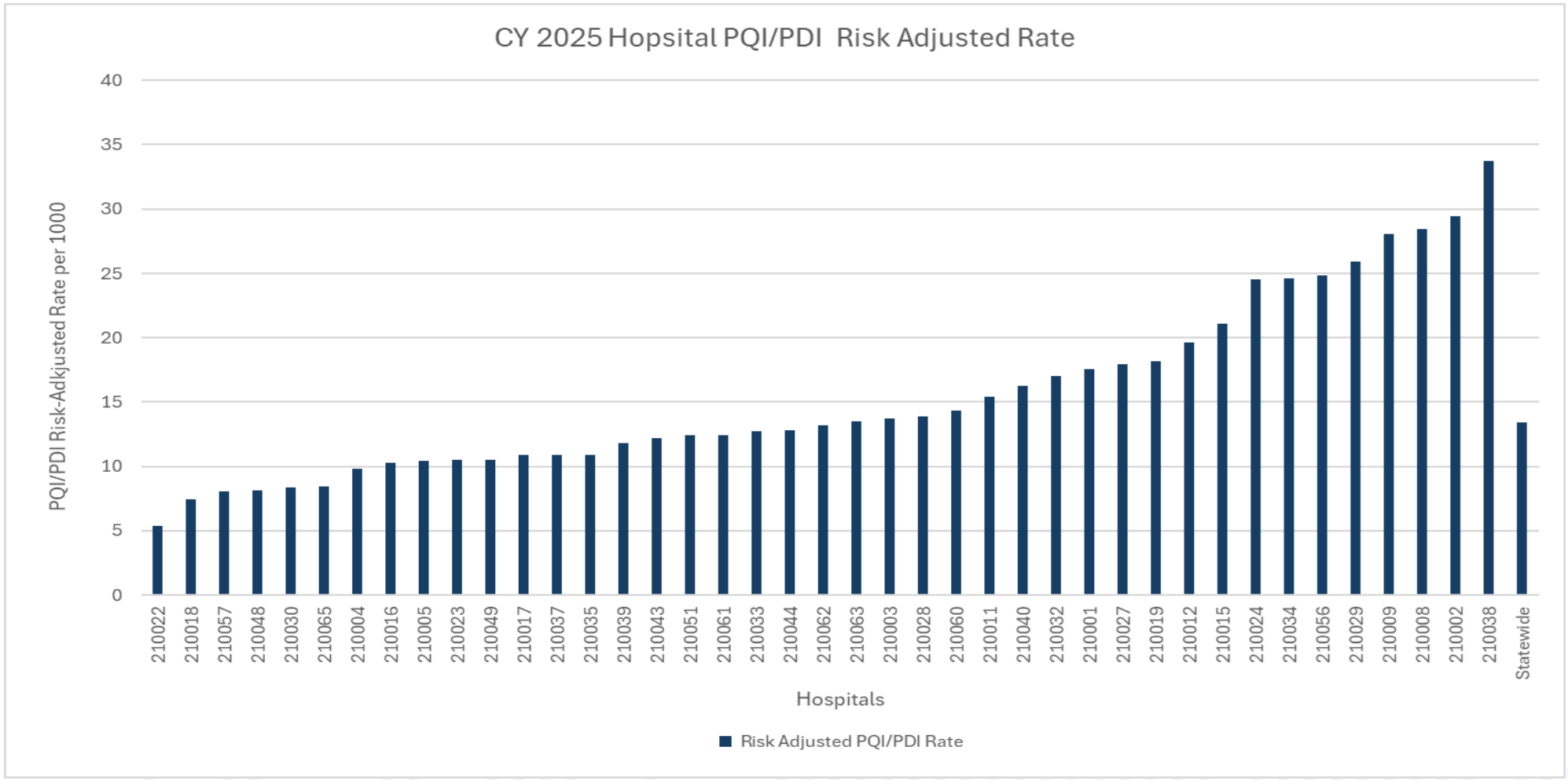
- 4.1. Statewide Performance on Risk-Adjusted Overall PQI Composite
- 4.2. Statewide Percent Change in Individual PQI Risk-Adjusted Rates
- 4.3. CY 2025 Hospital PQI/PDI Risk-Adjusted Rates per 1000 population
- 4.4. Statewide PAU Revenue Percent for PQI/PDIs and Readmissions
- 4.5. Hospital PAU Revenue Percent for PQI/PDIs and Readmissions

4.3. There is significant variation in risk-adjusted PQI/PDI rates by hospital across Maryland in CY 2025



Source: HSCRC Case-Mix Data using AHRQ Grouper Version 2024

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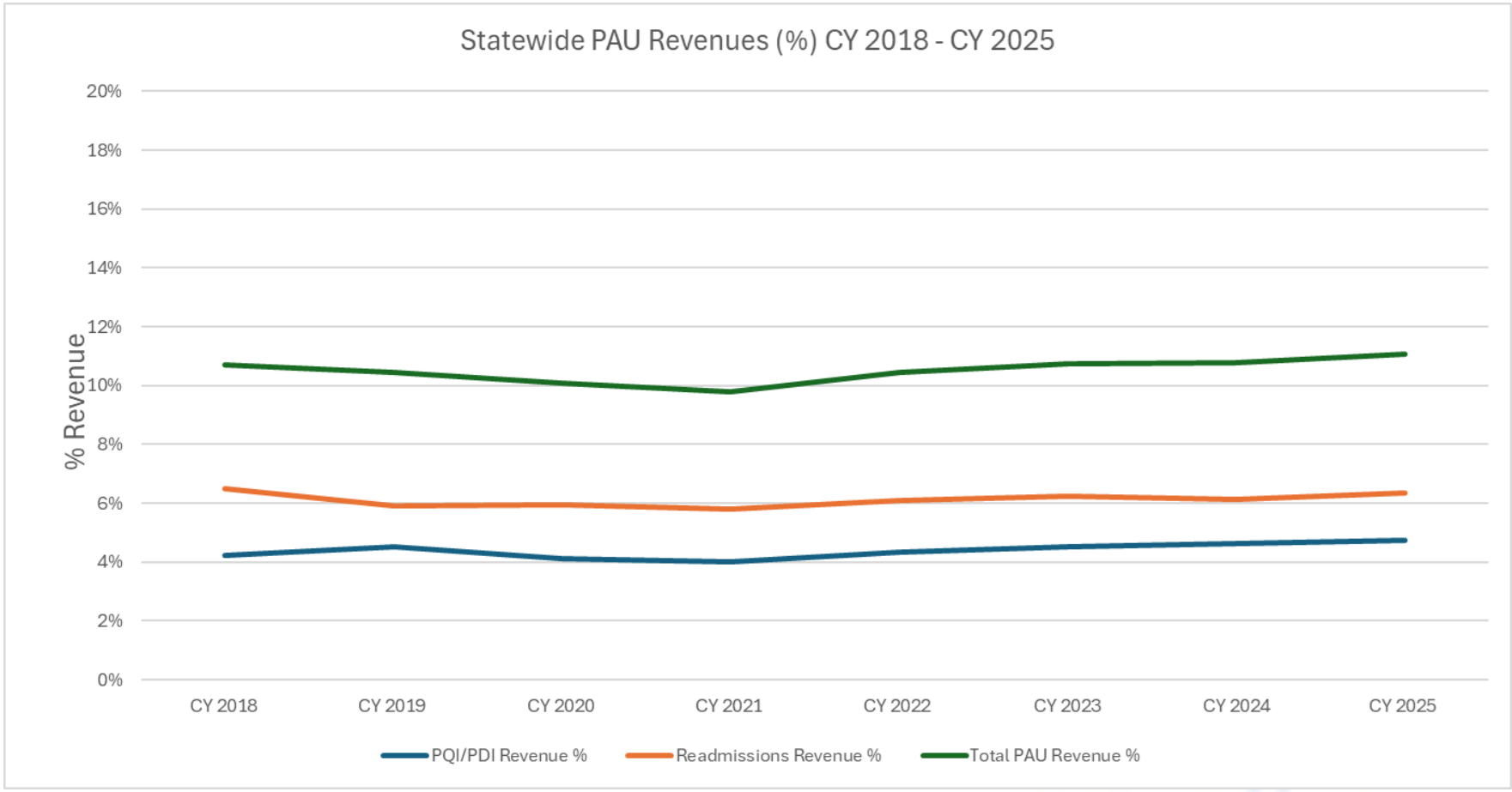
4. Potentially Avoidable Utilization

Potentially Avoidable Utilization includes Readmissions and Avoidable Admissions as measured by AHRQ Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI)

- 4.1. Statewide Performance on Risk-Adjusted Overall PQI Composite
- 4.2. Statewide Percent Change in Individual PQI Risk-Adjusted Rates
- 4.3. CY 2025 Hospital PQI/PDI Risk-Adjusted Rates per 1000 population
- 4.4. Statewide PAU Revenue Percent for PQI/PDIs and Readmissions
- 4.5. Hospital PAU Revenue Percent for PQI/PDIs and Readmissions

4.4. PAU revenues have remained relatively flat since 2018 with readmissions constituting the larger share of PAU revenue



In CY 2025, PAU constitutes about 11 percent of total hospital revenue statewide.

Source: HSCRC Case-Mix Data using AHRQ Grouper Version 2024

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4. Potentially Avoidable Utilization

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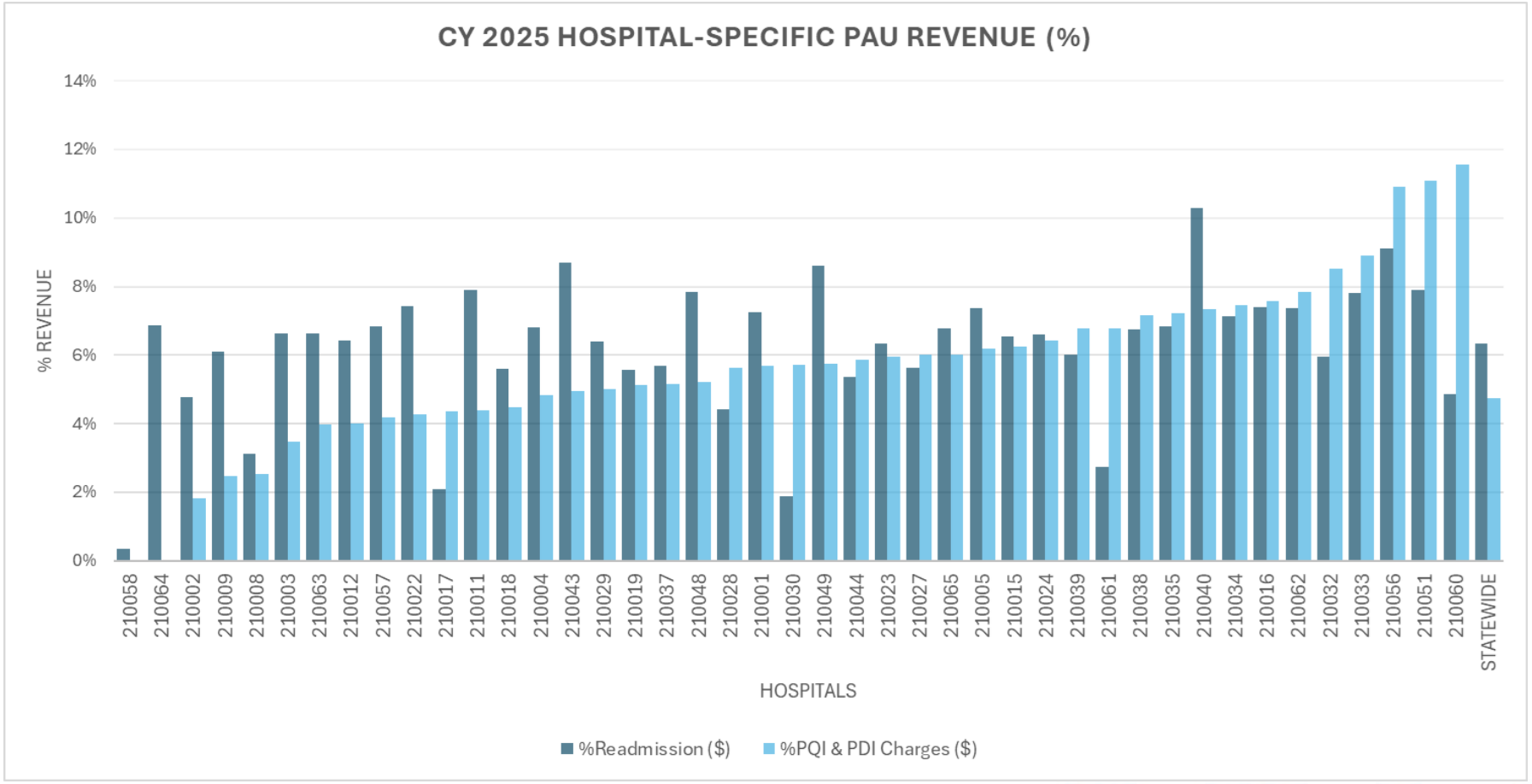
- 4.5. Hospital PAU Revenue Percent for PQI/PDIs and Readmissions

4.5. Significant variation in total PAU revenue across Maryland hospitals



Significant variation in revenue also exist by type of PAU, readmissions versus PQIs, across hospitals.

Source: HSCRC Case-Mix Data using AHRQ Grouper Version 2024

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Conclusions

Over the course of the TCOC Model Maryland has:

- Reduced readmission rates for All Payers, Medicare FFS and Medicaid FFS & MCO.
- Reduced hospital acquired complications as measured by PPCs and PSIs.
- Reduced avoidable admissions as measured by AHRQ PQIs.

Maryland's overall progress under the TCOC model still indicates the need to improve on:

- Patient Experience
- Medicare and Medicaid Timely Follow Up
- ED length of stay

Performance variability across hospitals also indicates opportunities for improvement and value of sharing best practices.

Future Updates

- Staff will provide quarterly updates on Quality Program and other non-financial metrics at HSCRC Commission meetings.
  - Provides transparency and public accountability
  - First quarter of CY 2026 data will be available in July and presented at the August Commission meeting.
- Staff will present this slide deck at the May 2026 Performance Measurement Workgroup to receive additional feedback from stakeholders
  - Should any measure be removed or included (e.g., NHSN, Mortality, ED LOS for discharged patients)?
  - Seeking input on ways to present the data and changes over time under the AHEAD model and other resources for monitoring statewide and by hospital performance.

Hospital CCN Key

Hospital ID	Hospital
210001	Meritus
210002	UMMS- UMMC
210003	UMMS- Capital Region
210004	Trinity - Holy Cross
210005	Frederick
210008	Mercy
210009	JHH- Johns Hopkins
210011	Saint Agnes
210012	Lifebridge- Sinai
210015	MedStar- Franklin Square
210016	Adventist- White Oak
210017	Garrett
210018	MedStar- Montgomery
210019	Tidal- Peninsula
210022	JHH- Suburban
210023	Luminis- Anne Arundel
210024	MedStar- Union Mem
210027	Western Maryland
210028	MedStar- St. Mary's
210029	JHH- Bayview
210032	ChristianaCare, Union
210033	Lifebridge- Carroll
210034	MedStar- Harbor
210035	UMMS- Charles
210037	UMMS- Easton
210038	UMMS- Midtown
210039	Calvert
210040	Lifebridge- Northwest
210043	UMMS- BWMC
210044	GBMC
210048	JHH- Howard County
210049	UMMS-Upper Chesapeake
210051	Luminis- Doctors
210056	MedStar- Good Sam
210057	Adventist- Shady Grove
210060	Adventist-Ft. Washington
210061	Atlantic General
210062	MedStar- Southern MD
210063	UMMS- St. Joe
210065	Trinity - Holy Cross Germantown

2025 CTI Results: Review and Discussion

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Background

- The CTI program is a mechanism – established in 2019 – by which the HSCRC redistributes federal Medicare funds among hospitals, under an agreement with CMS. The program aims to encourage hospitals to innovate in the care of Medicare patients.
- Each hospital may propose a set of “CTIs” – care transformation initiatives – targeted at a specific population of patients. If those patients wind up experiencing lower costs, the hospital is credited with savings.
- At the end of the year, all of the savings across all of the hospitals are considered, and those hospitals with the most savings receive extra Medicare funds (the “winning hospitals”), while those with the least savings lose Medicare funds (the “losing hospitals”).
- By requirement with CMS, the amount balances out, so there is no extra Medicare spending.

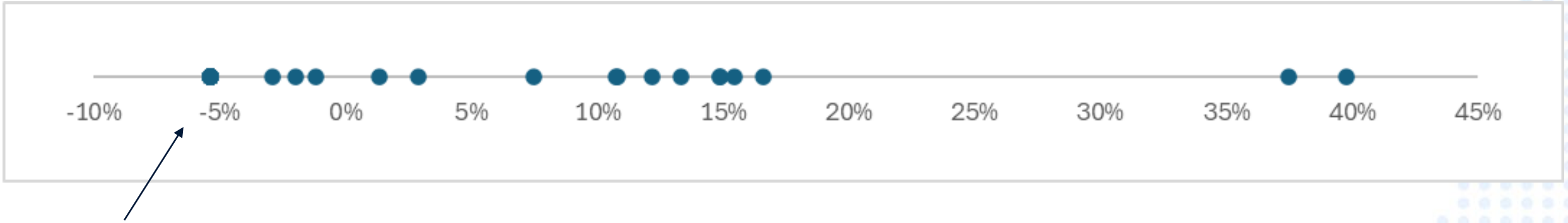
The Commission's Intent: Incentivizing greater efficiency while limiting volatility

- The Commission's expectation was for there to be winning hospitals and losing hospitals, but with limits to the amount of wins and losses each year.
- In March 2024, the Commission voted unanimously, with the support of the Maryland Hospital Association, to include a 2.5 percent stop loss provision to limit the amount of Medicare funds each hospitals could lose.
- This provision was not a hard cap on losses, as additional losses would be spread across all the losing hospitals.
- However, at the time, such additional losses were understood to lead to "slightly higher" losses – but not major, material changes.

2025 Results: Volatility

- The results from 2025 demonstrate significant volatility compared to prior years – with double the amount of money – more than $160 million – to shift between hospitals than had ever shifted in the past.
- 27 hospitals would lose 5.36 percent of Medicare revenue – far more than 2.5 percent.

Preliminary Net CTI (Losses) Gains by Hospital as a % of Medicare Savings



27 hospitals at the maximum effective stop loss of 5.36%

2025 Results: Assessment

- The volatility in the results was not intended, expected, or reasonable.
  - Not intended, given the Commission's discussions and votes
  - Not expected, by the Commission or hospitals
  - Not reasonable, given the need for relative year to year stability in revenues and budgets.

The 2025 results reflect several concerns related to the CTI program.

The CTI program encouraged hospitals to innovate in multiple domains, and there are success stories of important changes to practice that improved health and lowered costs.

Nonetheless, 2025 has brought to light several challenges:

1. The zero-sum nature of the program — without a hard cap on gains and losses — created the potential for greater volatility.
2. Hospitals were permitted to define large populations for total cost of care impact, even if the specific activities were not affecting the entire population.
3. Hospital programs were subject to limited review.

The CTI Program Is Sunsetting

- The CTI program is ending in June of 2026. There is one more payment year before the program is fully compete.
- Future efforts to encourage innovation should learn the lessons of the CTI program. These include:
    1. Avoid a zero-sum design without a hard cap on gains and losses.
    2. An alternative approach is to set a clear budget for the program.
    3. Define specific interventions and affected populations well.
    4. Add a review step to assure reasonableness.

Legal Context

- HSCRC's legal mandate is to set rates that are reasonable and in the public interest.
- The Commission has authority to review the rates in order to achieve a reasonable result.
- The Commission has the authority to promote alternative methods of rate determination and payment in the public interest.
- The Commission may update the methodology for the two remaining years of CTI payments.

Next Steps

- The Commission staff will put forward alternative approaches to the Commission for the CTI program and make a recommendation.
- The staff will aim to find reasonable alternatives consistent with the intent of the CTI program.
- The Commission recognizes that refinement of the methodology will have a differential impact on certain hospitals, which warrants careful consideration.
- Interested parties may submit written comment to the TCOC Workgroup by April 25th, and staff will make a recommendation at the May Commission meeting.

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Update on Hospital Financial Condition for FY25

Public Presentation

April 2026

Sources and Levels of Analysis

Sources	Levels of Analysis	Unit of Analysis
• Hospital Financial Statements • HSCRC receives annual audited system-level financial information which also support balance sheet analysis.	Level 1: Hospital Operating Regulated Business	Hospital
	Level 2: Hospital Operating Regulated Entity, All Business	Hospital

• HSCRC Annual Cost Report
  • HSCRC receives annual hospital level information.
  • This information is reconciled to the system level financials and is subject to certain special audit procedures although it is not itself audited, and there may be some fluidity in terms of how costs are allocated between entities.
  • Income statement only.
	Level 3: Parent Health System Operating All Businesses	System

	Level 4: Total Margin - Parent Health System Operating All Businesses + Non-Operating Results	System

System-Level Reporting

- Attached presentation reflects a review of audited system results that are received on an annual basis.
  - System results are typically only reviewed annually upon receipt of June fiscal year audited financials.
  - Most ongoing HSCRC review focuses on hospital regulated entities.
- For System-level review only primarily Maryland domiciled systems are included as otherwise non-Maryland operations of large out-of-state systems would swamp the results.
- System-level review is important because:
  - Nearly all hospitals are now part of larger entities with varying legal structures, organization charts and business strategies all of which impacts the strategy of the hospital and how costs are reported.
  - Audit opinions are restricted to the consolidated financial statements, individual entity information is displayed only for informational purposes therefore the numbers are most authoritative at the consolidated level (the HSCRC could require hospital-entity level audits but that would add significant cost to financial reporting).
  - Debt is issued at the “obligated group” level which is often the system or some other aggregation but rarely the hospital. Cash and Investments are also typically managed on a system basis.

Simplified Metric Definitions*

- All data is fiscal year, where applicable prior calendar year results are incorporated for calendar year hospitals
- Statewide Total for metrics refers to the value calculated at a total state level, which is equivalent to a weighted average of the results.
- Metrics reflect a narrow subset of possible metrics. Staff selected metrics balancing their relevance with simplicity of presentation. Other metrics would be included in a more comprehensive review.

- Margin (Hospital and System Level)
  - (Revenue – Expenses) / Revenue
  - Higher is stronger
  - Addresses whether current revenues cover current expenses
- Days Cash on Hand (System Level)
  - (Cash + Investments) / Cash Operating Expenses
  - Higher is stronger
  - Restricted cash and investments are excluded, board-designated are included
  - Addresses resources available to the organization
- Debt to Capitalization (System Level)
  - Debt / (Debt + Unrestricted Net Assets)
  - Lower is stronger
  - Addresses borrowing capacity/burden
- Average Age of Plant (System Level)
  - Accumulated Depreciation / (Depreciation), where "Accumulated Depreciation" is the total depreciation recorded over the life of all non-retired assets per the balance sheet
  - Lower is stronger
  - Addresses level of capital investment
  - Considerations – measure will age if asset mix moves to long-lived assets, measure will age if assets are being moving towards retirement. Presentation includes an additional measure on assets per equivalent inpatient day.
  - Alternative Metric - Metric = Net Property Plant and Equipment / Equivalent Inpatient Days (EIPD), adjusted for capital expenditure inflation, where "EIPD" converts outpatient revenue into an inpatient day statistic based on relative revenue.

*Some accounting terms have been simplified for presentation purposes, specific line items used in audited financial statements may be more precisely named

Points of Comparison

- Presentation focuses on comparison of Maryland hospital performance over time.
  - For a longer-term perspective Staff have included references to the HSCRC's FY 2004 Financial Conditions Report (this year was chosen as the report was available)
- Presentation does not benchmark against national or other external reference points because:
  - Obtaining timely national data can be challenging in terms of comparability and time lags.
    - Medicare Cost report data is significantly lagged.
    - Bond rating data is at a system level and not necessarily a representative sample.
  - National data may not provide an appropriate reference point due to differences in the Maryland and national environments:
    - Lack of for-profit hospitals
    - GBR incentives
    - Maryland rate regulatory system
- Historically, HSCRC staff released a Financial Conditions Report that included targets, presentation includes these as a point of reference.

Margin Overview

FY25 Comparison: Margin Comparison Across All Entity Levels

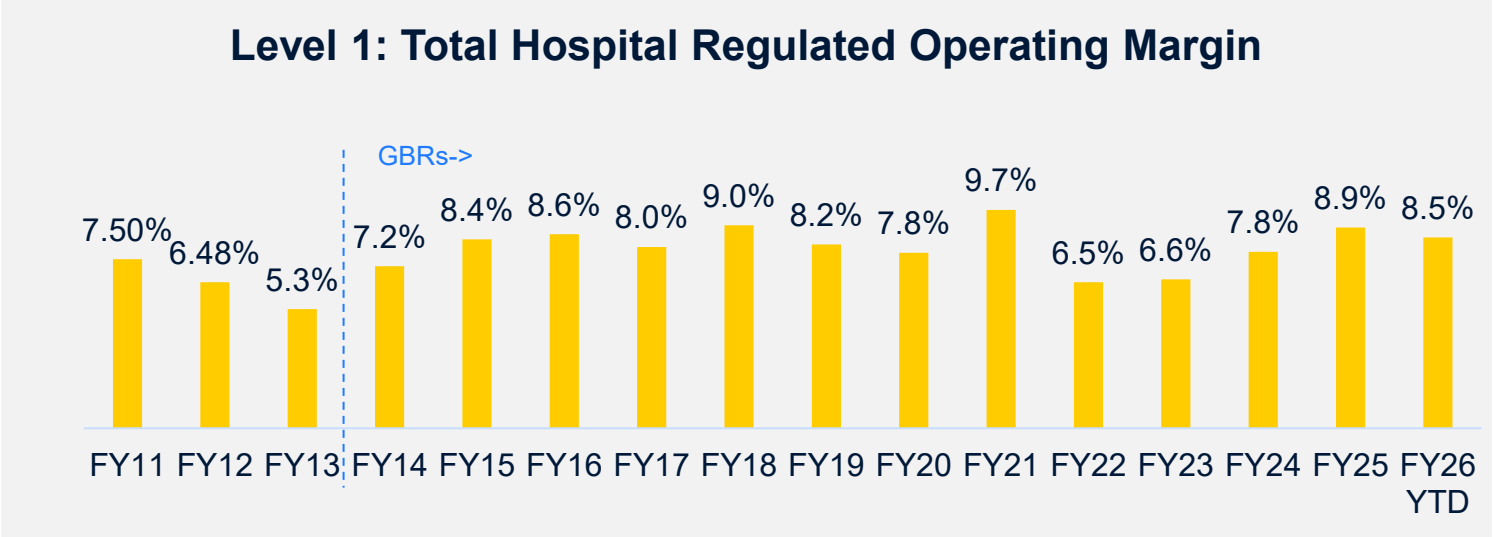
Health System*	Level 1 Regulated Operating Margin	Level 2 Regulated Entity Operating Margin	Level 3 Health System Operating Margin	Level 4 Health System Total Margin
System A	10.03%	3.10%	1.62%	2.11%
System B	10.58%	0.88%	-4.96%	1.26%
System C	12.23%	3.58%	-2.77%	0.52%
System D	9.89%	-6.09%	-4.24%	2.03%
System E	2.42%	3.44%	2.00%	5.43%
System F	12.55%	2.11%	-1.05%	3.13%
System G	13.18%	4.88%	1.90%	6.58%
System H	10.22%	1.24%	2.44%	5.83%
System I	4.81%	4.25%	3.90%	7.83%
System J	15.66%	9.21%	-1.14%	3.09%
System K	14.62%	3.28%	-3.05%	6.57%
System L	8.28%	1.08%	0.63%	4.03%
2025 Statewide Totals	**8.30%**	**2.37%**	**1.22%**	**4.97%**
2024 Statewide Totals	**7.18%**	**0.97%**	**0.98%**	**4.91%**
% of Maryland Regulated Operating Revenue**	100%	89%	52%	52%
% of Hospitals Losing Money	5%	39%	NA	NA
% of Systems Losing Money	0%	8%	50%	0%

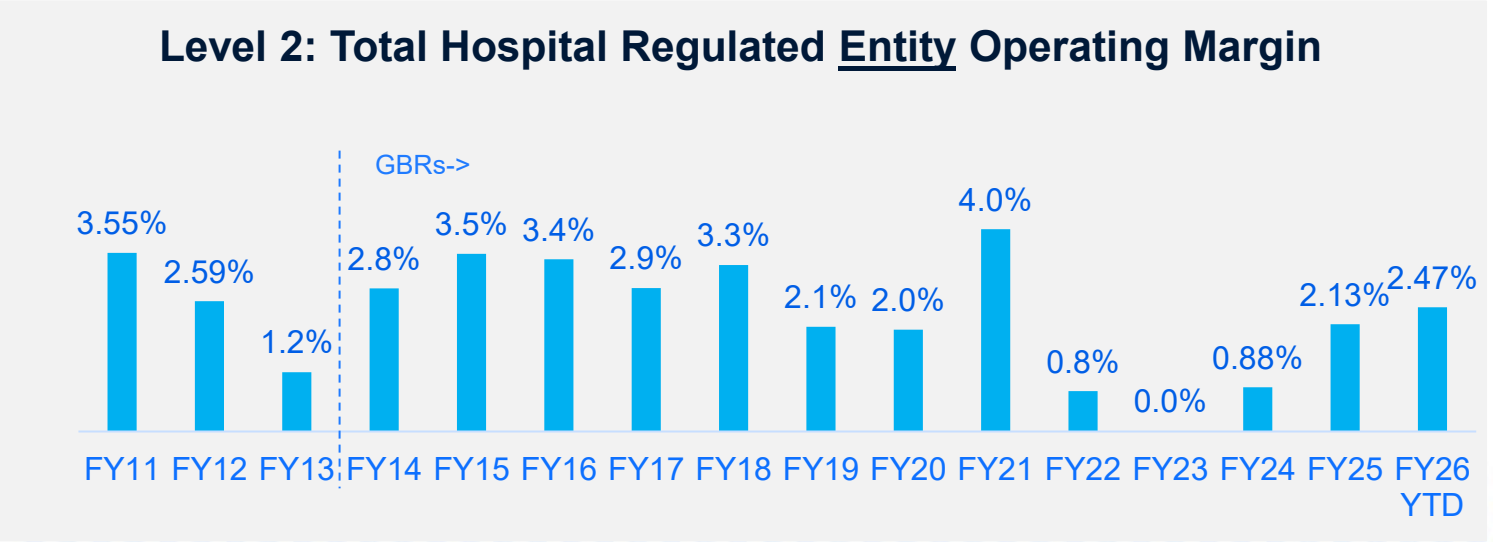
- Financial performance can not be evaluated solely on a single level, it is important to look across them all.
- Although regulated revenue accounts for the majority of health system revenue, regulated operating margins are not necessarily correlated with Regulated Entity and Health System operating margins. For example, health systems may take varying allocation approaches resulting in different relationships between margins at different levels within the system.
- Academic hospitals report more physician costs as regulated due to the inclusion of teaching costs within regulated reimbursement.
- Health systems make varying investment decisions in the non-regulated space:
  - Level of investment out-of-state
  - Level of investments in physicians
- Systems losing money at Level 3 represent 17% of revenue, indicating the largest challenge is with smaller systems (although some of these institutions are thriving).

Source: All Levels except Level 1 from System Audited Financial data. Level 1 data from Hospital Annual Filing data.
*Trinity, Ascension, Garrett, Christiana Union, and Western Maryland have been excluded as system level financials are not primarily reflective of Maryland institutions. However, their hospitals are included in the "% of hospitals losing money" row.
** Excluding System I, System Operating revenue is 62% of Maryland regulated revenue

Hospital Level Results (unit of organization is hospital)

Hospital Margins FY2011 to FY2026* (Level 1 and Level 2)



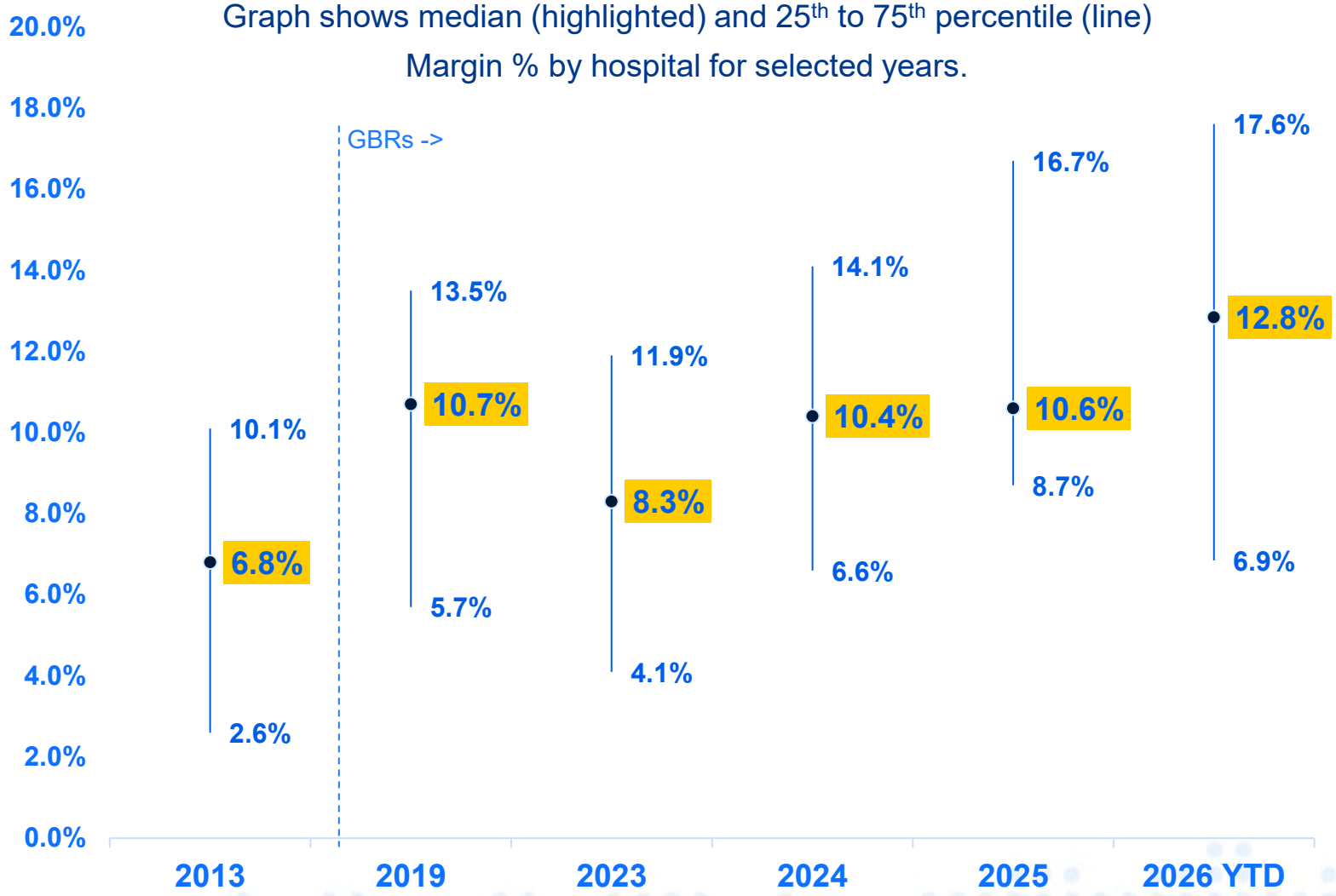


- Level 1 margins are strong in all periods, FY22 and FY23 margins were relatively weak but still greater than 6%. FY25 margins are some of the highest since 2011 and FY26 margins are on a similar track.
- Unregulated costs, particularly physician costs, pull total margins down, this phenomenon has increased in recent years.
- In the weakest years Level 2 margins have remained positive in total.
- In the past the HSCRC has identified 2.75% as a target operating margin (2004 HSCRC Financial Conditions report)
- Average margins do not tell the whole story, subsequent slides look at margin distribution

*All years except FY26 per Hospital Annual Filings. FY26YTD from unaudited monthly reports through December 2025.
To estimated audited margin, FY26YTD regulated margin has been inflated by 2% to reflect typical increase from unaudited to audited result

Distribution and Median of Hospital Regulated Operating Margins* (Level 1)

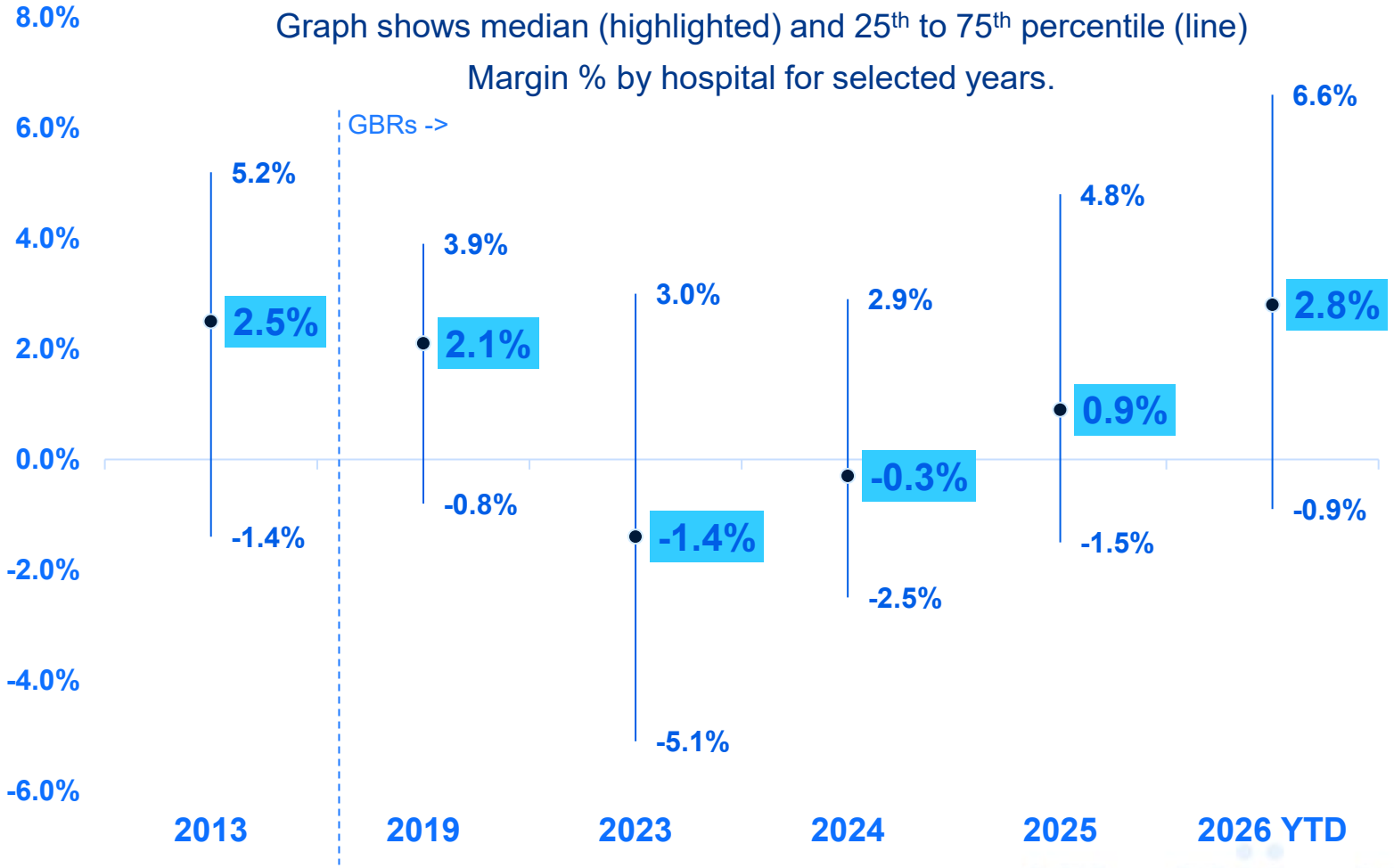
Graph shows median (highlighted) and 25th to 75th percentile (line) Margin % by hospital for selected years.



- While Level 1 regulated margins declined in FY23, they were still slightly above pre-GBR (FY13) levels. Margins rebounded in FY24 and FY25 and are continuing that recovery in the first half of FY26.
- Distribution now matches pre-pandemic level (FY26 distribution is likely wider due to partial year).

*All years except FY26 per Hospital Annual Filings. FY26YTD from unaudited monthly reports through December 2025. Data excludes FMFs and FSEs
FY26YTD regulated margin has been inflated by 2% to estimate audited to reflect typical increased from unaudited to audited result

Distribution and Median of Total Hospital Operating Margins* (Level 2)

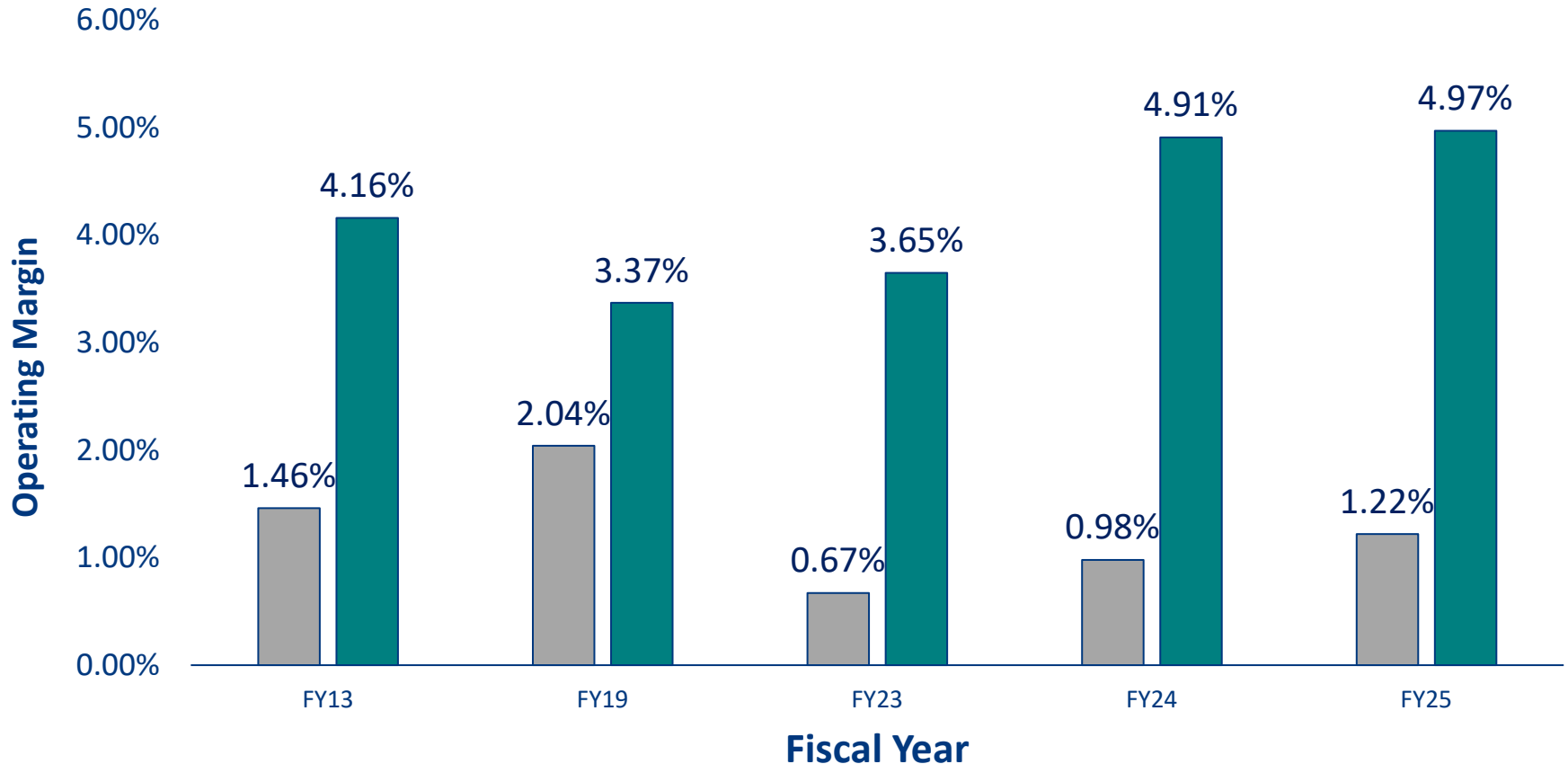


- Only hospitals at or below the 25th percentile were losing money both in 2013 (pre-GBR) and 2019. 2025 and 2026 margins are more comparable to 2019 levels.
- In the most recent years a significant group of hospitals are losing money due to high unregulated costs.
- However, results at this level are very sensitive to (a) how a system reports its physician costs and (b) how much overhead cost is allocated from parent entities.
- Systems that can leverage shared services are likely to be more efficient over the long term.

*All years except FY26 per Hospital Annual Filings. FY26YTD from unaudited monthly reports through December 2025. Data excludes FMFs and FSEs

System Level Results (unit of organization is system, Maryland-domiciled systems only)

State-Wide Health System Operating (Level 3) and Total (Level 4) Margins



FY25 Comparison: Health System Operating Margins (Level 3) and Total Margins (Level 4)

	Health System Operating Margin	Health System Total Margin
System A	1.62%	2.11%
System B	-4.96%	1.26%
System C	-2.77%	0.52%
System D	-4.24%	2.03%
System E	2.00%	5.43%
System F	-1.05%	3.13%
System G	1.90%	6.58%
System H	2.44%	5.83%
System I	3.90%	7.83%
System J	-1.14%	3.09%
System K	-3.05%	6.57%
System L	0.63%	4.03%
2025 Totals	**1.22%**	**4.97%**
% of Systems Losing Money	**50%**	**0%**

- After considering non-operating income, system margins were almost 5% in 2025, due to strong investment returns (which make up almost all non-operating income).
- HSCRC does not formally consider investment returns in its methodologies, but they are a source of additional security. As Maryland regulated revenue makes up over 50% of total revenue, investment balance reflect regulated rates to a significant degree.
- Investment returns are volatile but over the long term are positive, particularly for institutions with large portfolios, therefore, shorter-term volatility is not a reason to exclude them from all consideration.
- Some institutions carry debt that could be paid down or off given their investment balances. This is a sound financial strategy given differing returns on investments versus interest costs. However, this strategy does not currently benefit rate payers as the interest cost is considered a regulated cost but the interest income is excluded from consideration. Debt service requirements are also often cited as a reason to increase regulated rates.

FY2024 Health System Bond Ratings (Level 4)

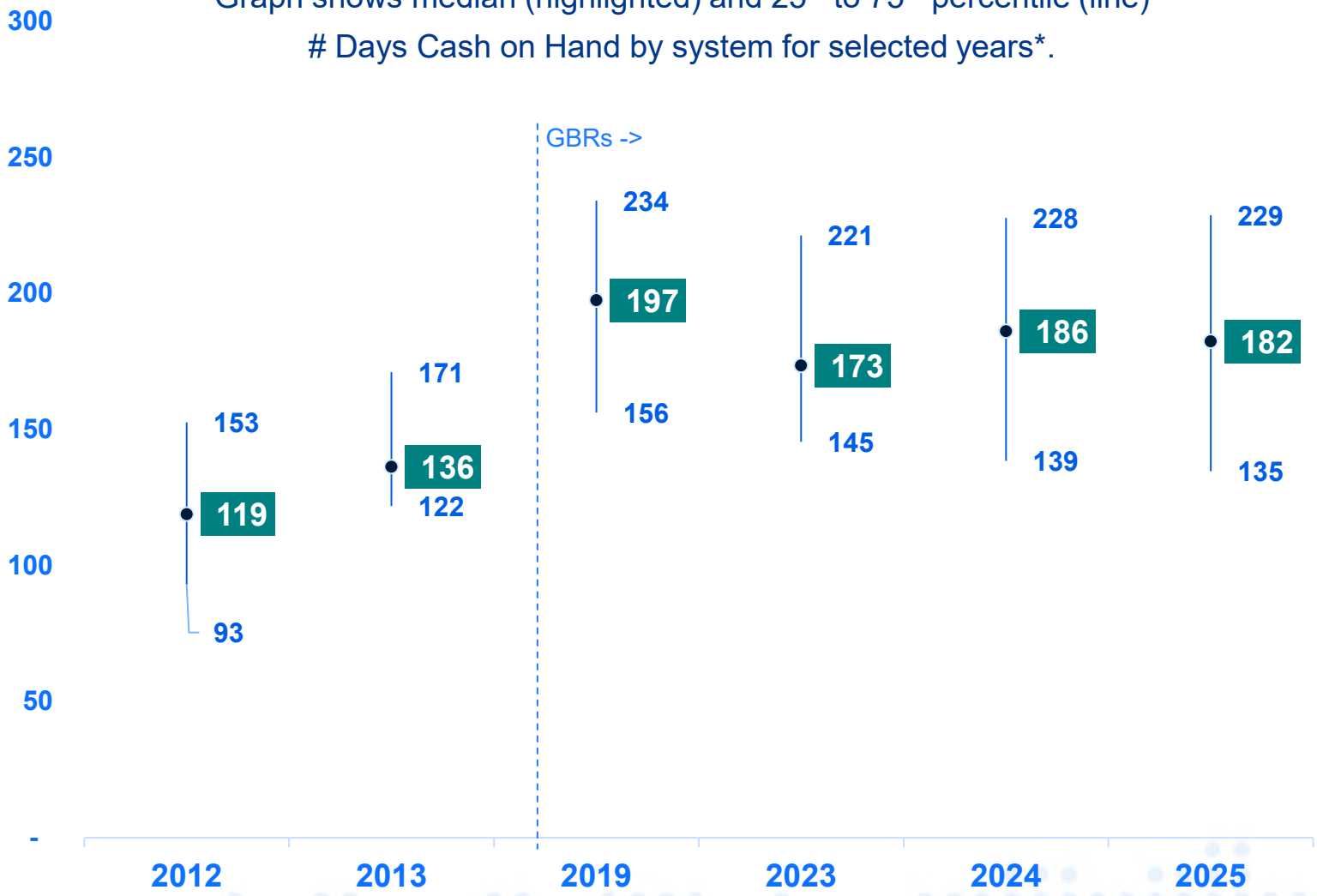
	FY25 Moody's	FY25 S & P	FY25 Fitch	Rating Change (Since Last Report)
System A	Baa3	BBB	NR	
System C	Baa1	NR	NR	
System D	Baa1	NR	BBB	Downgrade
System E	NR	A-	A	Downgrade
System F	Aa2	AA-	AA-	
System G	A1	A+	NR	
System H	A3	A-	NR	
System I	A2	A	NR	
System J	A3	A-	NR	
System K	NR	A-	A	
System L	Baa1	A-	NR	Downgrade
System M	A2	A	NR	

- All Systems remain investment grade
- 3 systems experienced downgrades from 1 or more agencies as shown by red values.

Source: Echo Financial Products, Maryland Not-For-Profit Healthcare Peer Report for Fiscal Years 2025. www.echo-fp.com

Balance Sheet, Liquidity: # Days Cash on Hand (**Level 4**)

Graph shows median (highlighted) and 25th to 75th percentile (line)
Days Cash on Hand by system for selected years*.

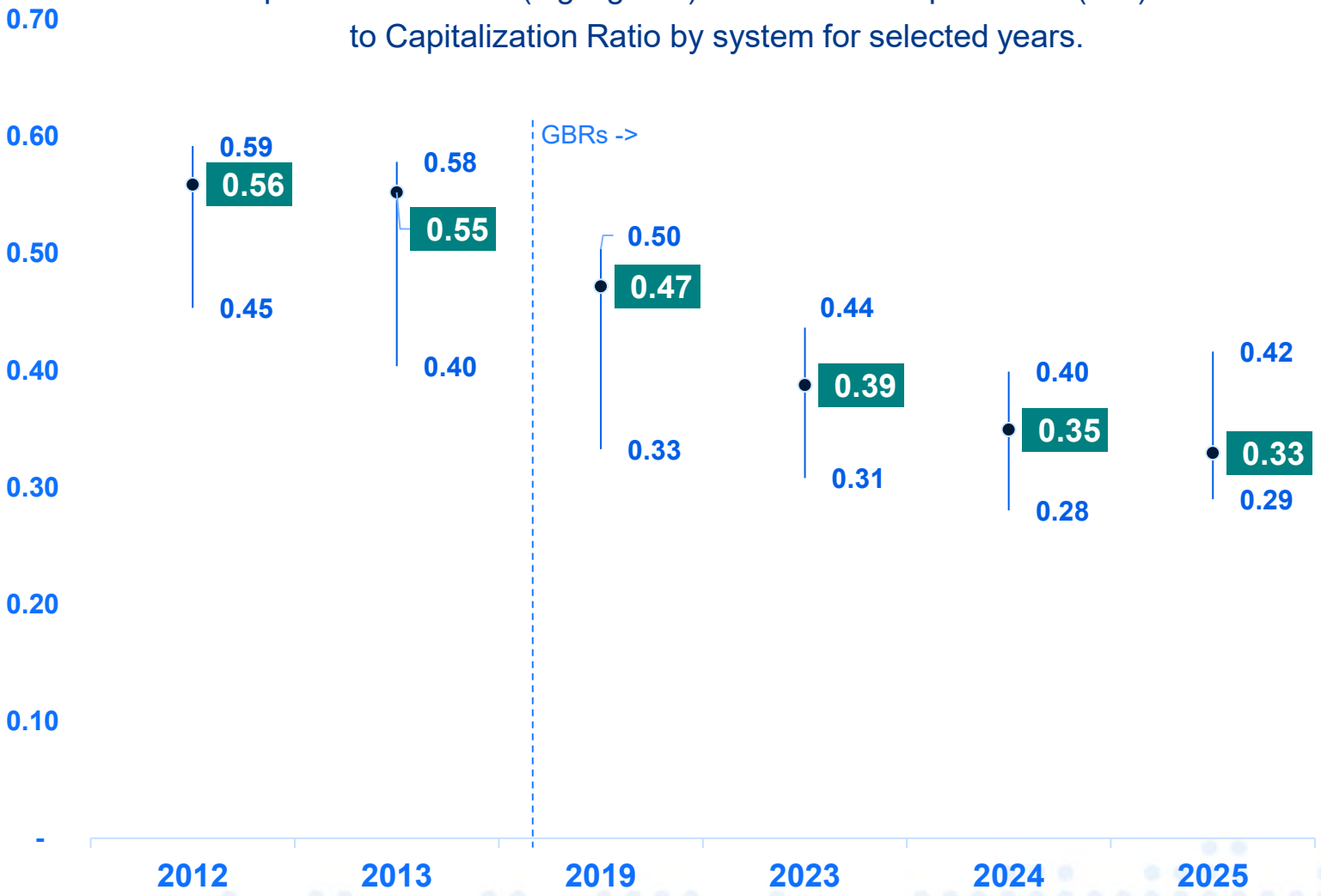


- Use of operating expenses in the denominator means the measure is inflation adjusted.
- Balances grew from 2013 to 2019 and have remained stable since, despite pandemic and inflation.
- Hospitals have observed rating agencies are looking for much higher cash balances in recent years given national averages. Rating agencies have also acknowledged the HSCRC's role in securing hospital financial strength.
- 2004 HSCRC Financial Conditions report discusses 115 days as a target and observed statewide median performance of 78 days.

* Selected prior year numbers have been restated for comparability, changes are not material.

Balance Sheet, Financing: Debt to Capitalization (**Level 4**)

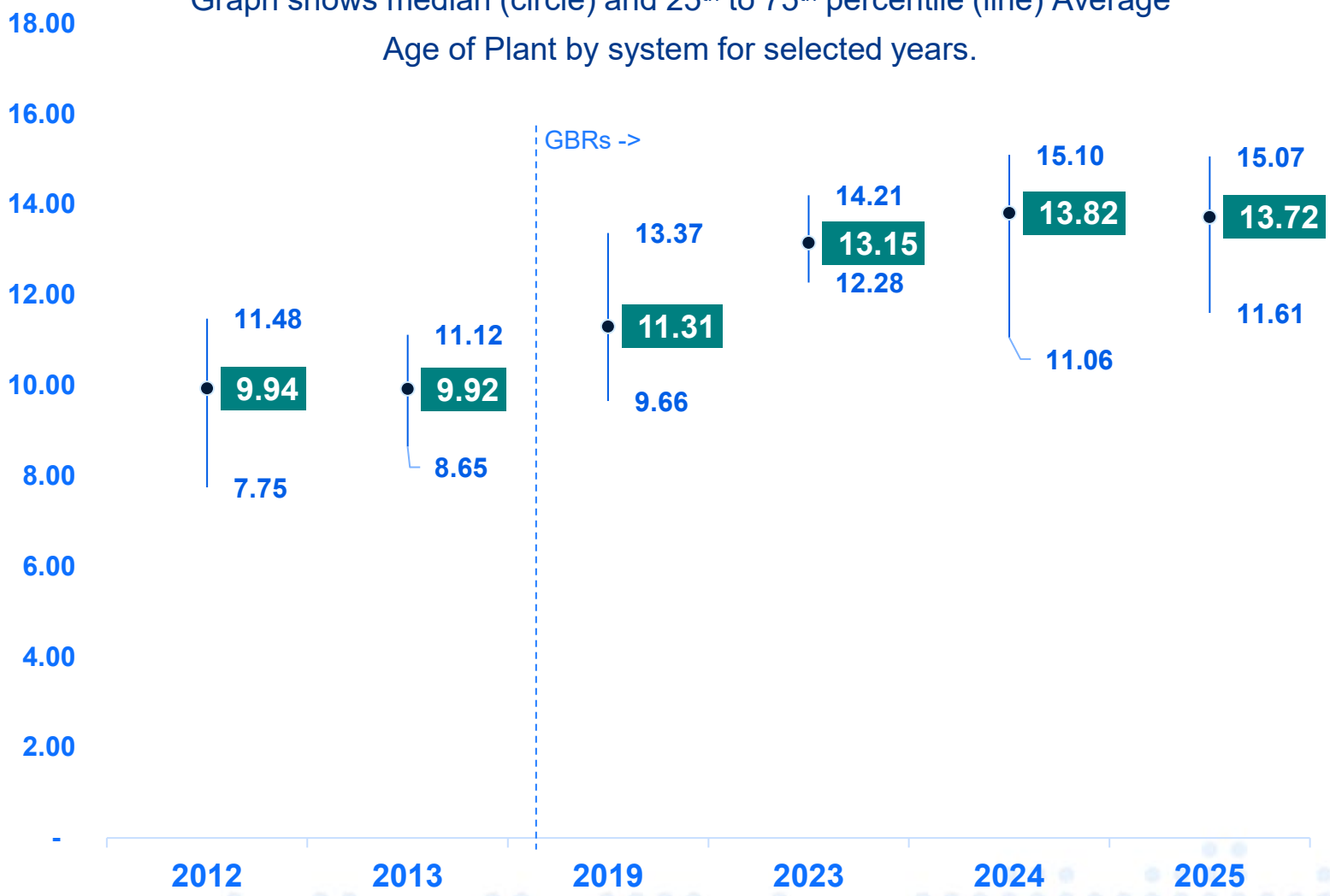
Graph shows median (highlighted) and 25th to 75th percentile (line) Debt to Capitalization Ratio by system for selected years.



- Debt position has improved across the spectrum of institutions over the life of the model.
- 2004 HSCRC Financial Conditions report discusses 0.40 as a target value and observed statewide median performance of 0.39.

Balance Sheet, Capital: Average Age of Plant (**Level 4**)

Graph shows median (circle) and 25th to 75th percentile (line) Average Age of Plant by system for selected years.

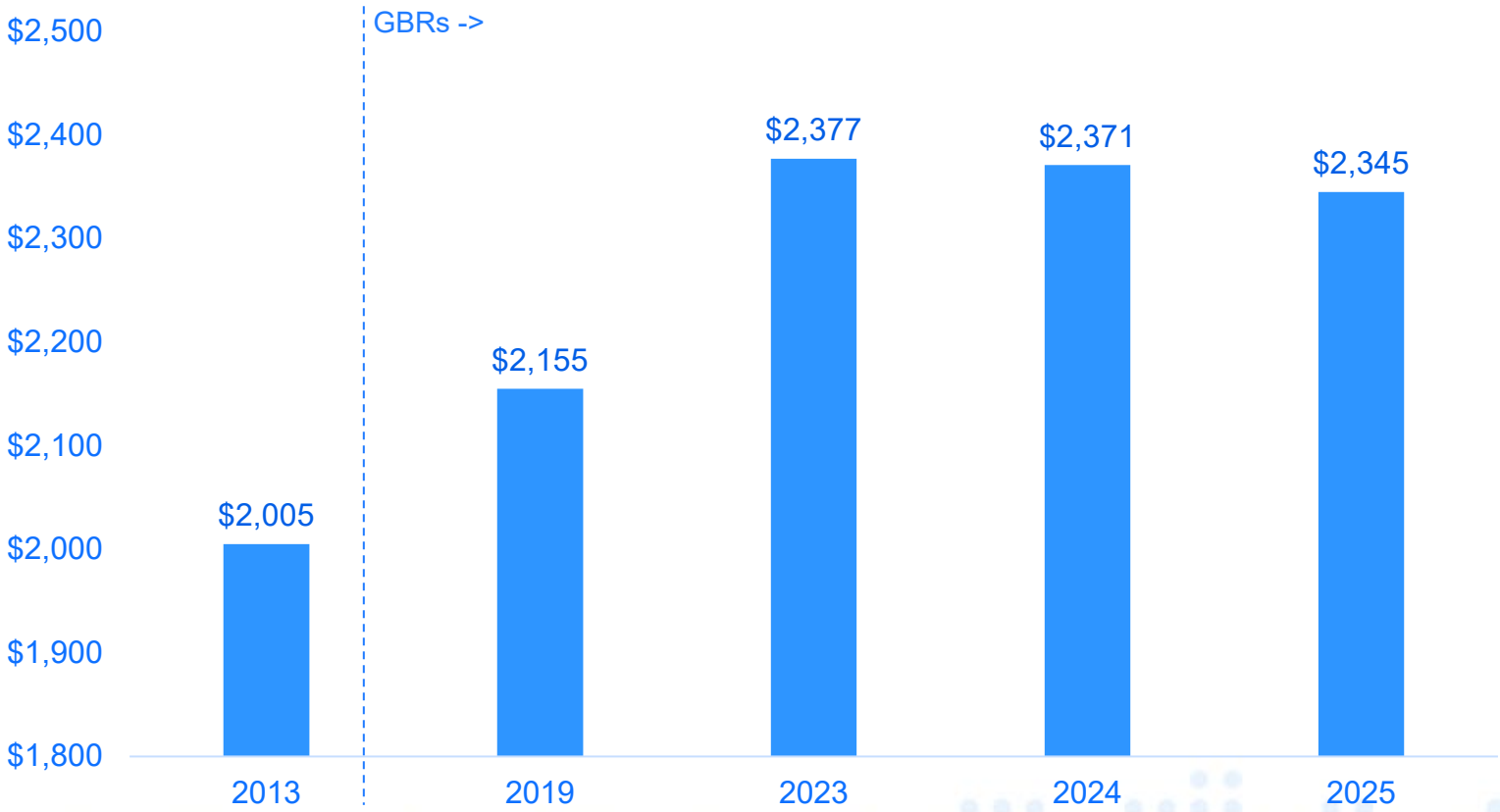


- Data reflects system-level so includes non-hospital and non-Maryland assets.
- Median Average Age of Plant has increased materially, particularly in the last few years.
- Increase is greatest in smaller institutions.
- Capital investment reflects the point in the capital cycle – as capital investment has gone down; debt and cash and investment positions have improved.
- Declining volumes would result in older average age of plant as short-term asset are rationalized more quickly.
- 2004 HSCRC Financial Conditions report discusses 8.5 years as a target value and observed statewide median performance of 10.9 years.

Source: Hospital System Audited Financial Statements

Capital Investment In Relation to Volume (**Level 4**)

Inflation Normalized PP&E per EIPD has increased by 17% since 2013 – Statewide Total



- Metric measures the ratio of system level invested capital per unit of service delivered in the MD system.
- Metric shows significantly more investment in capital versus unit of service delivered in 2025 compared to 2019 or 2013.

Summary

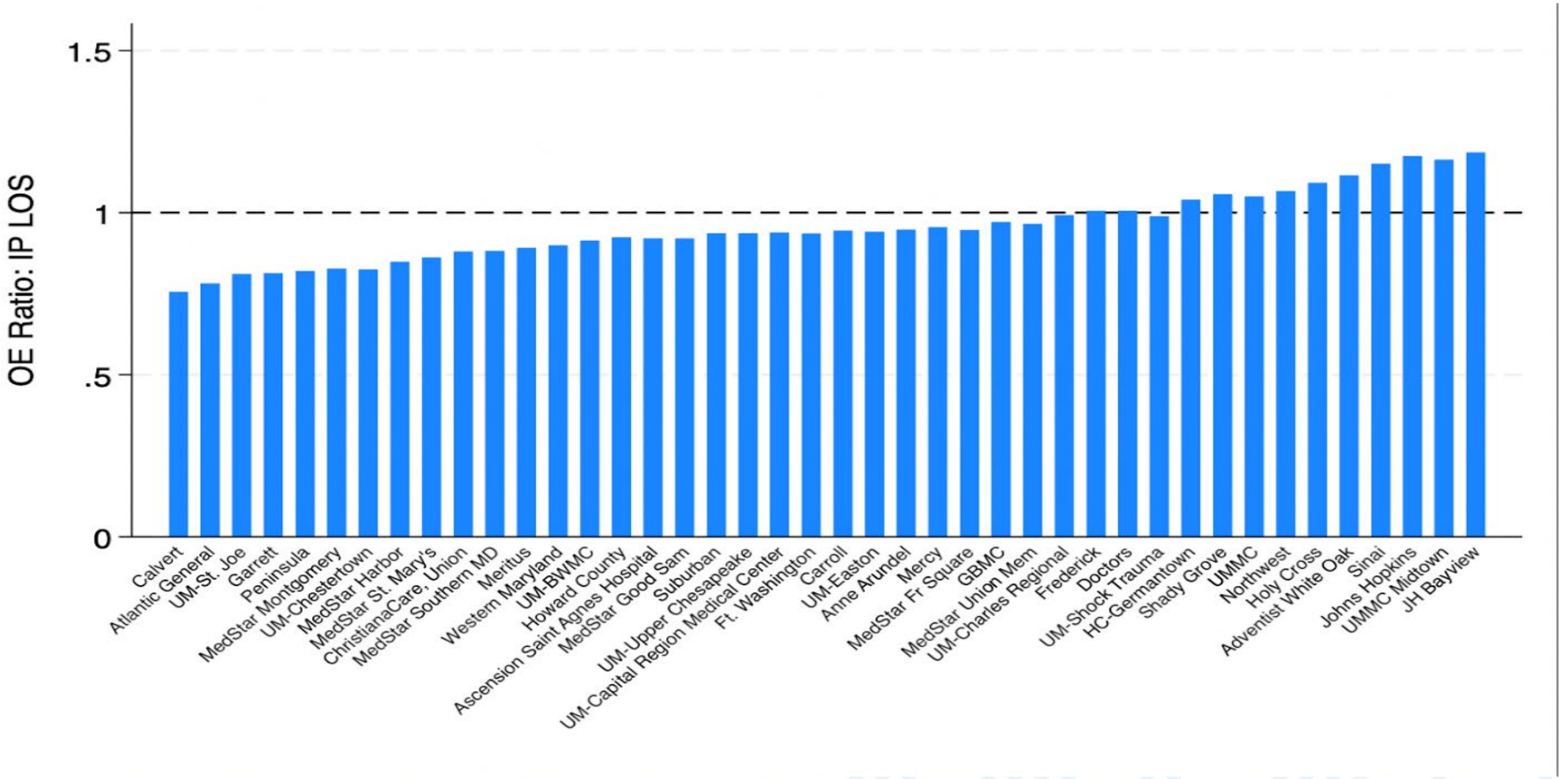
- There are many considerations in evaluating health system financial performance. Results need to be evaluated across hospital, hospital entity and system level, and no one view is definitive.
- Overall, the current state of health system financial performance is a mixed picture
  - Regulated operating margins are above pre-global budget model levels after a few years of weakness
  - However, total operating margins have fallen since the start of the global budget model, primarily driven by increasing non-regulated physician costs.
  - Cash and debt positions are stronger than prior to the global budget model.
  - The age of plant shows a worsening position, while fixed assets per unit of volume do not show a deficit compared to prior years.
- No hospitals are facing imminent solvency questions, but several hospitals in smaller systems are at financial risk over the next several years, particularly related to managing non-regulated physician costs.
- Due to challenges with establishing an appropriate benchmark, Staff have not compared system results to national averages. These challenges include the timeliness of data and the standard of comparison.

Inpatient Length of Stay Policy

Background

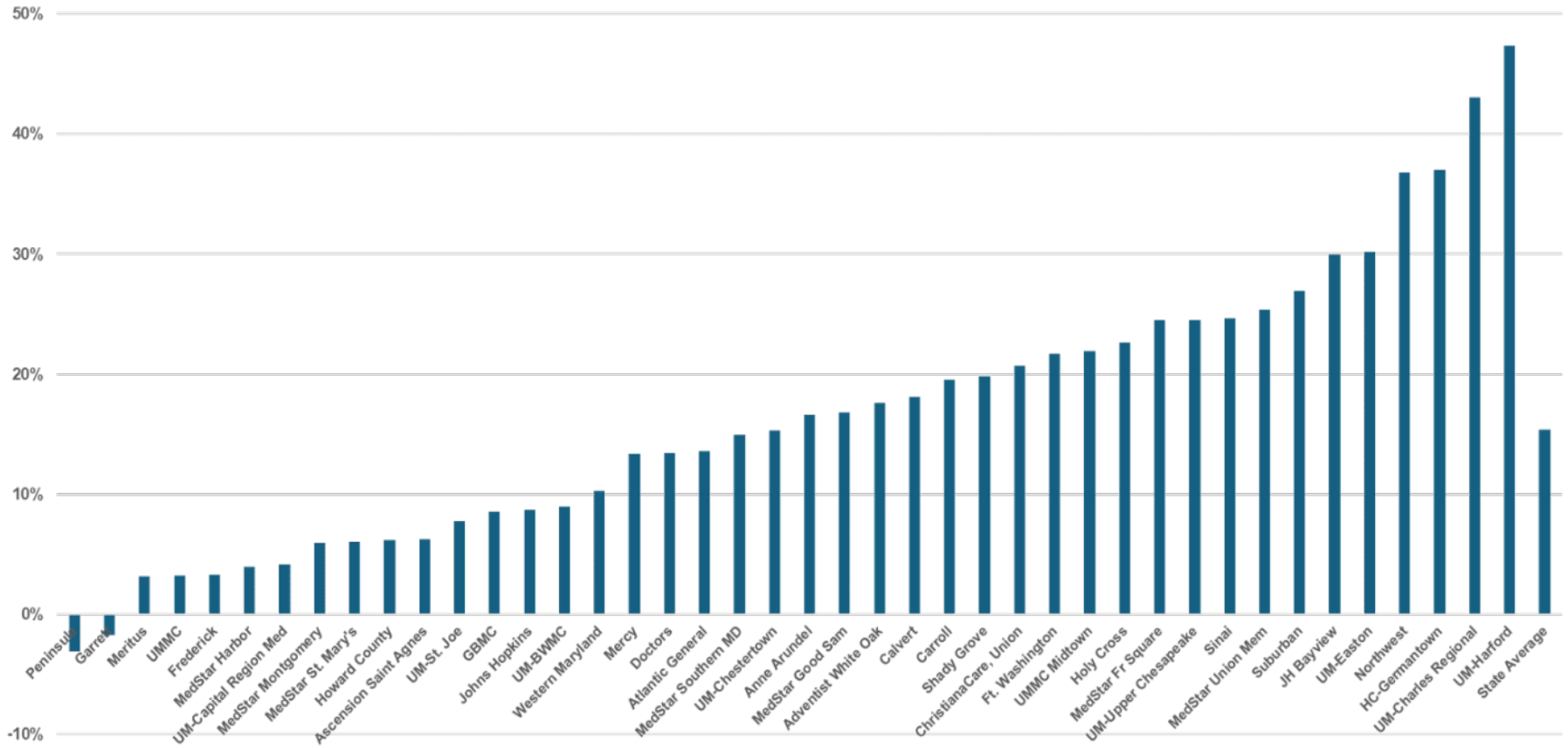
- Global budgets and TCOC accountability incentivize hospitals to reduce preventable hospital admissions and lower inpatient length of stay (IP LOS)
- While the Maryland Model has been successful in reducing hospital admissions, it has been less effective in reducing IP LOS
- Many hospitals in Maryland have an average IP LOS higher than National
- Although admission volumes have declined, the concurrent increase in IP LOS has resulted in a net rise in inpatient resource utilization as measured by total bed days
- Unconstrained increases in IP LOS may undermine the financial sustainability of global budgets
- Maryland's emergency departments are currently among the most crowded in the nation, and managing IP LOS is a critical for improving ED wait times.
- The IP LOS policy serves as a counterbalance to the surge policy's incentives. The surge policy could unintentionally increase inpatient LOS, pushing more Maryland hospitals above the national average

25% of MD Hospitals Have Risk-Adjusted IP LOS Higher Than National Average



Source: HSCRC FY2025 Casemix, risk adjusted for APR-DRG, and payer using 2023 HCUP norms

Between 2018 and 2024, IP LOS Increased at Most Hospitals

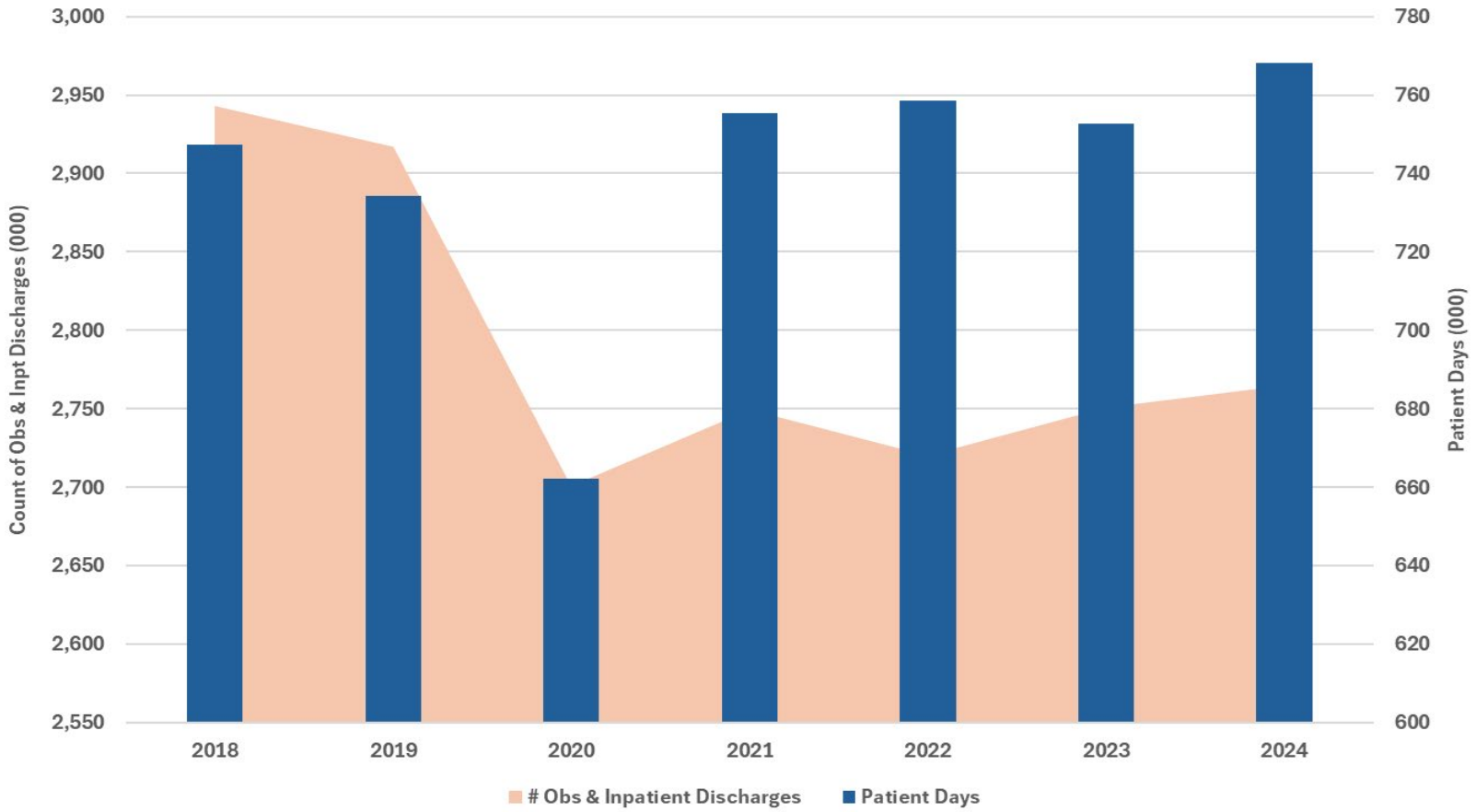


15 Hospitals had IP LOS increase of more than 20 percent between 2018 and 2024

Only two of the State's hospitals experienced decreases during the period

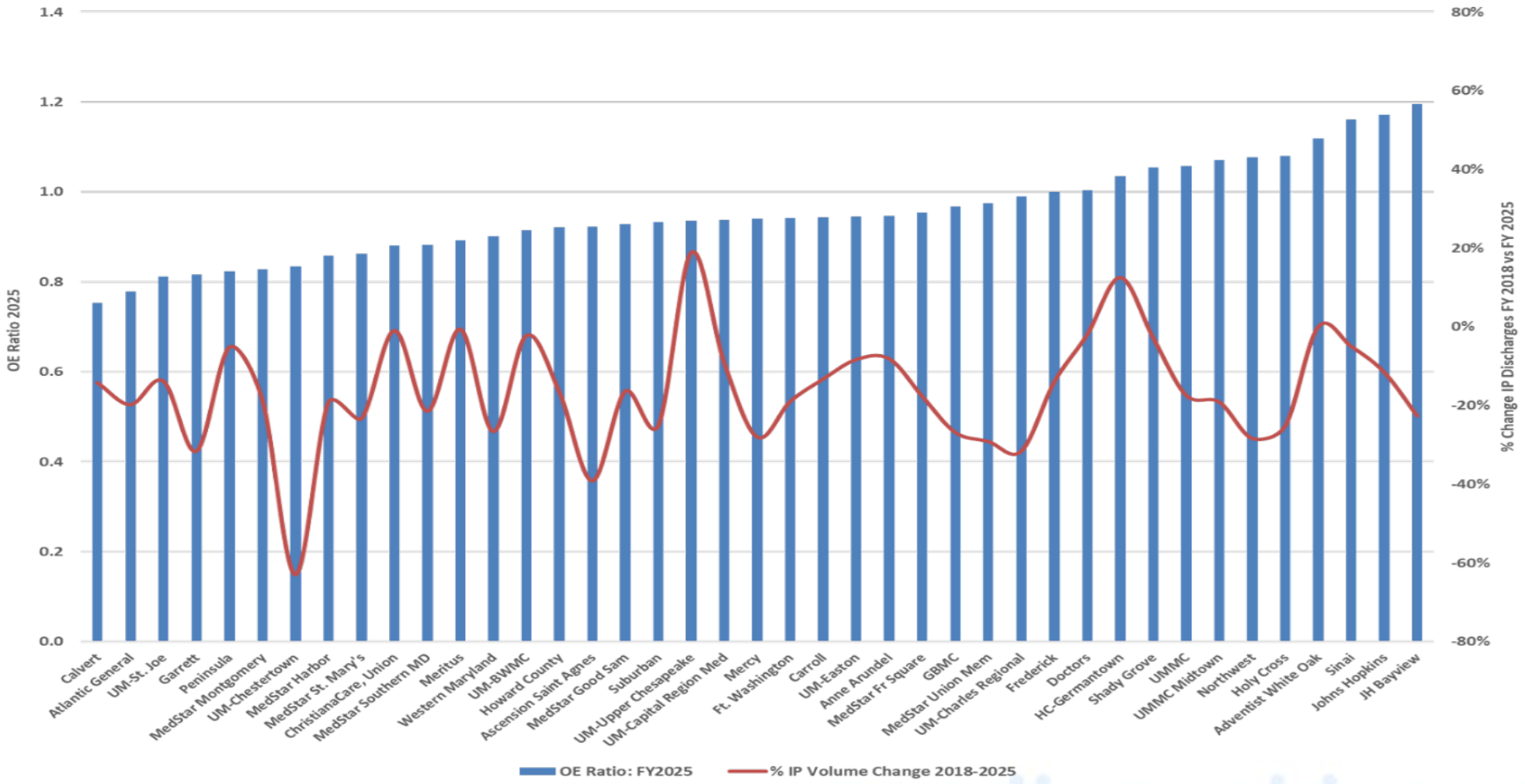
Source: HSCRC FY2018 & FY 2024 Casemix.

There Was a Net Gain in Statewide Bed Days Over Time



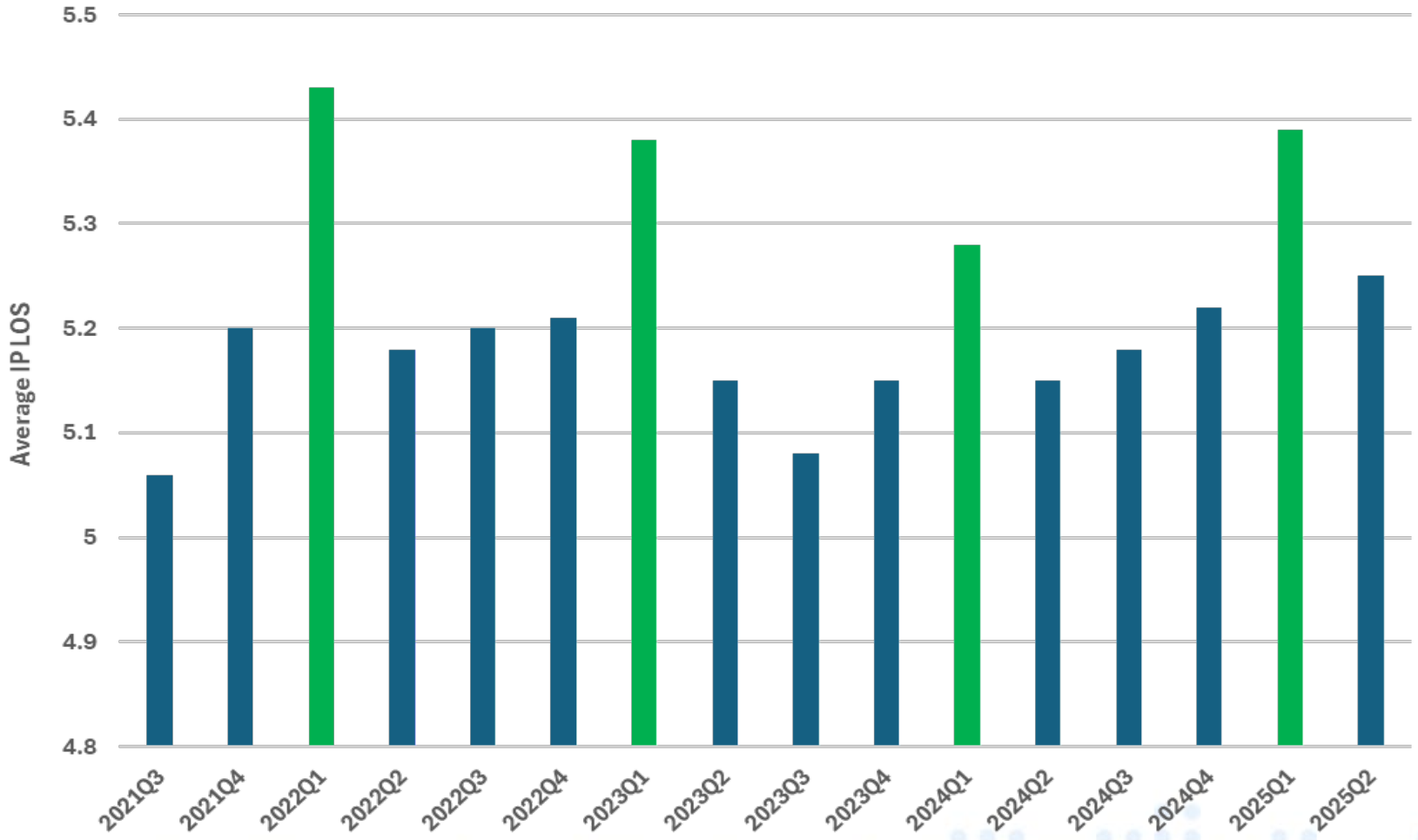
Source: HSCRC Casemix, FY2018-2024

IP LOS and IP Volume Changes Are Minimally Correlated



Source: HSCRC Casemix, 2018-2025FY and HCUP 2023 norms adjusting for APR-DRG/SOI

Longest IP LOS Occurs During Flu Season

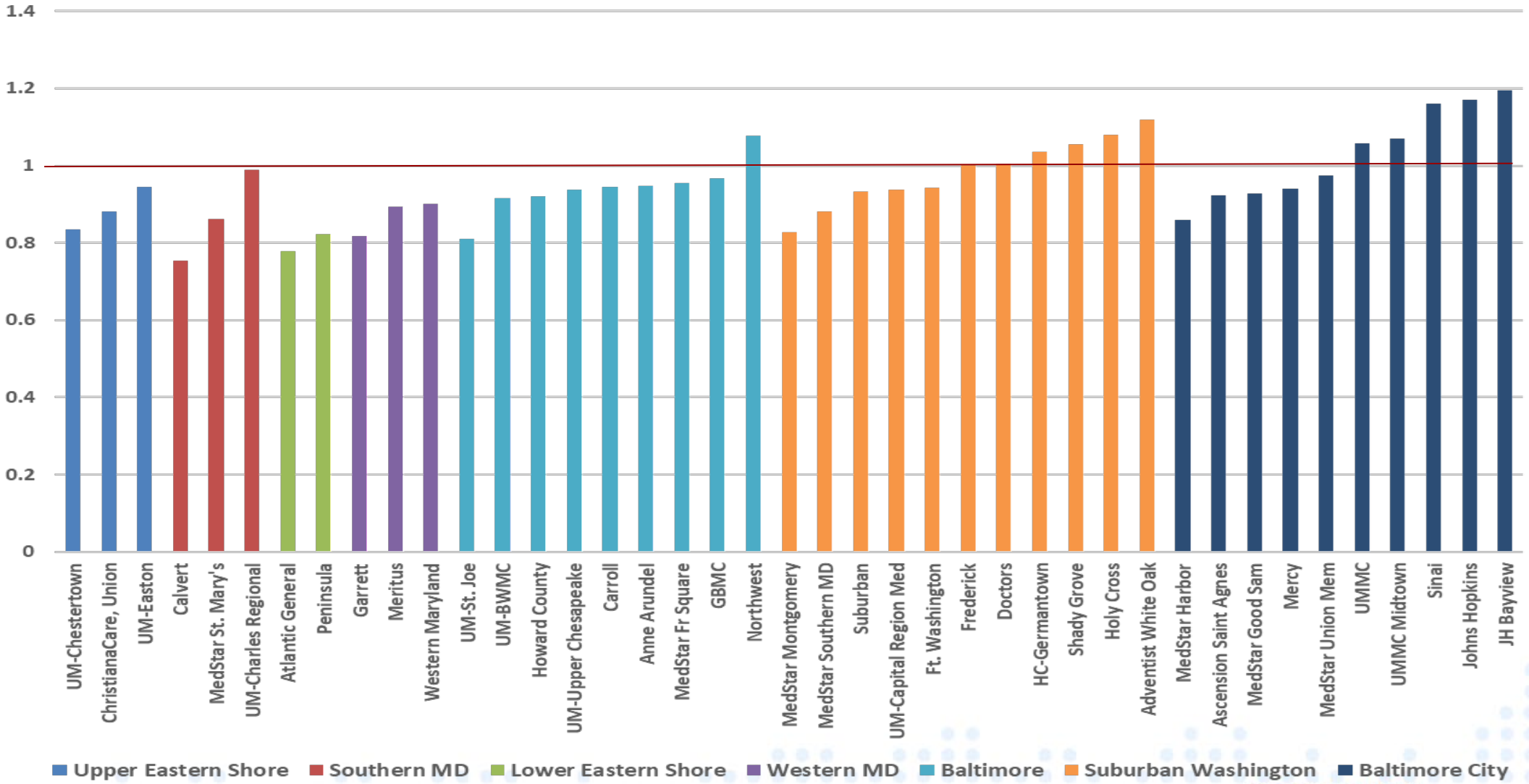


The longest IP LOS consistently occurred in the first quarter of the calendar year, when respiratory illnesses peak.

The second quarter, which coincides with the close of the rate year, typically sees the lowest IP LOS of the year.

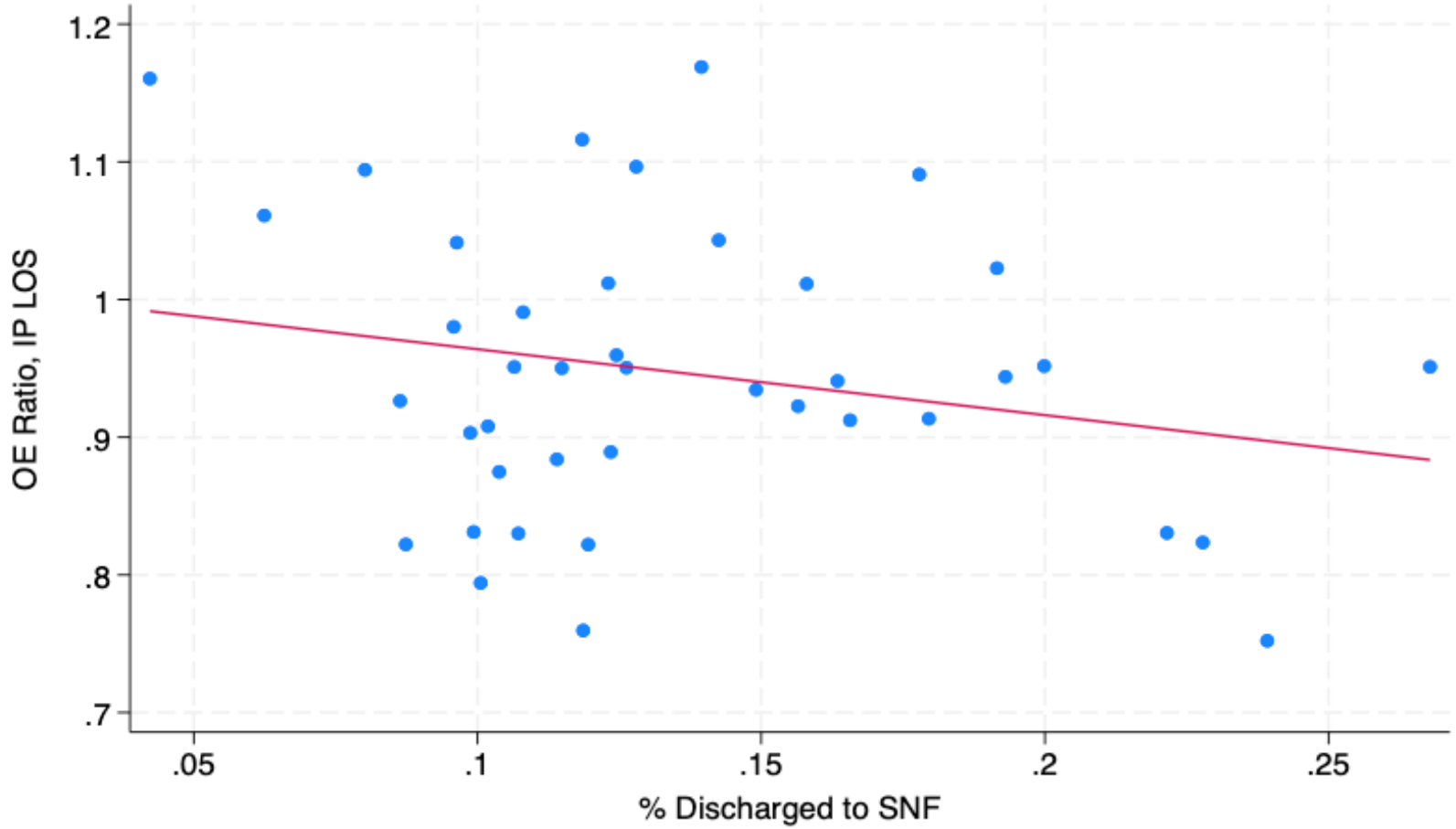
Source: FY2022 - FY2025 HSCRC Casemix

Hospitals With Longer LOS Are Spread Across Several Regions



Source: FY2025 HSCRC Casemix, adjusted with HCUP 2023 norms

IP LOS Is Inversely Correlated with Post-Acute Discharges



This suggests operational issues at some hospitals are lengthening IP LOS for patients regardless of discharge destination.

Source: HSCRC CY2025 Casemix

Overview of the Draft Payment Policy

- The policy is designed to recognize hospitals that have invested in managing LOS over the past several years, while encouraging improvement for those with little improvement and performance worse than the nation.
- The policy introduces scaled penalties and rewards of up to 0.5 percent of all-payer inpatient revenue for CY 2026.
  - This reflects policy start halfway through the performance year
- Revenue at risk will increase to 0.75 percent in RY 2029 and 1 percent in RY 2030.
- To qualify for rewards, hospitals must meet participation expectations for sharing best practices on hospital throughput
  - Hospitals are required to submit reporting under the ED and Hospital Throughput Best Practice Policy to remain eligible for rewards

Measurement Methodology

- Exclusions:
  - Discharges leaving against medical advice
  - Transfers out to other acute care settings
  - Expired cases
  - Shock trauma
  - Chronic and rehabilitation services
  - Unknown discharge dispositions
- Performance will be measured against national averages (expected values) after adjusting for patient risk factors such as diagnosis (APR-DRG), severity of illness (SOI), and payer.
- Expected values are estimated using the 2023 HCUP National Inpatient Sample
- Hospitals will be assessed on both improvement in IP LOS from a fixed base period and actual performance (i.e., attainment) relative to CY2023 national norms during each performance year.

Improvement Scenario Options

#	Estimating Method	Percent Improvement	Annualized Improvement	CY2026 Improvement Threshold
1	Statewide improvement, CY2023-CY2025	-0.90%	-0.18%	-0.54%
2	Mean hospital improvement, CY2023-CY2025	-1.46%	-0.29%	-0.88%
3	Mean hospital improvement among hospitals with reductions, CY2023-CY2025	-4.20%	-0.85%	-2.54%
4	Statewide change if all hospitals with an O/E Ratio greater than 1, improve to 1 in CY 2023	-4.79%	-0.98%	-2.90%
5	Statewide change if all hospitals with an O/E Ratio greater than 1, improve to statewide median in CY2023	-7.94%	-1.64%	-4.84%
6	Improvement from the mean O/E ratio of those greater than 1 in CY2023 to 1	-9.64%	-2.01%	-5.90%
Proposed Improvement Goal		**-5.00%**	**-1.02%**	**-3.03%**

- Improvement goal considerations:
  - what is required to have all hospitals reach the national average?
  - Evaluate historical performance over time to avoid setting an overly aggressive goal that could lead to unintended consequences

Proposed Improvement Scale Based on CY2023 to CY2026 Performance

- CY 2023 - CY 2028 Improvement Goal: 5%
- CY 26 Threshold improvement needed to avoid penalties: - 3.03%
- The improvement needed to receive maximum reward (benchmark) was set at the mean improvement of the top decile from CY2023- CY2025.
- The maximum penalty was linearly extrapolated from the threshold and the maximum reward.

All Payer LOS Rate Change CY2023-2026		LOS % IP Revenue Payment Adjustment
Improving	-9.13%	0.50%
	-8.52%	0.45%
	-7.91%	0.40%
	-7.30%	0.35%
	-6.69%	0.30%
	-6.08%	0.25%
	-5.47%	0.20%
	-4.86%	0.15%
	-4.25%	0.10%
	-3.64%	0.05%
Threshold	**-3.03%**	0.00%
	-2.42%	-0.05%
	-1.81%	-0.10%
	-1.20%	-0.15%
	-0.59%	-0.20%
	0.02%	-0.25%
	0.63%	-0.30%
	1.24%	-0.35%
	1.85%	-0.40%
	2.46%	-0.45%
Worsening	3.06%	-0.50%

Proposed Attainment Scale Based on CY2026 performance

- The attainment target is set at O/E Ratio of 1 from CY 2023, adjusted for the improvement threshold.
- The attainment benchmark (i.e., O/E ratio where hospitals could receive full reward) was set at the average of the top performing decile of hospitals in CY2023 plus the improvement target.
- The maximum penalty was linearly extrapolated from the threshold and the maximum reward.

All-Payer IP LOS O/E Ratio Performance Targets		LOS % IP Revenue Payment Adjustment
Lower	0.7678	0.50%
	0.7880	0.45%
	0.8082	0.40%
	0.8283	0.35%
	0.8485	0.30%
	0.8687	0.25%
	0.8889	0.20%
	0.9091	0.15%
	0.9293	0.10%
	0.9495	0.05%
Target	0.9697	0.00%
	0.9899	-0.05%
	1.0101	-0.10%
	1.0303	-0.15%
	1.0505	-0.20%
	1.0707	-0.25%
	1.0908	-0.30%
	1.1110	-0.35%
	1.1312	-0.40%
	1.1514	-0.45%
Higher	1.1716	-0.50%

Example: Statewide Revenue Adjustments

Summary			
Statewide Revenue		$12,379,325,935	
$ Better of Attainment/ Improvement	Rewards (31 Hosp.)	$16,744,605	Statewide Percent: 0.14%
	Penalties (9 hosp.)	($12,562,197)	Statewide Percent: -0.1%
Net Revenue Adjustment		$4,182,408	Statewide Percent: 0.03%

- To illustrate components of the payment policy, staff treated CY2025 hospital results as if they represented CY2026 performance, and then applied improvement/attainment criteria described in the draft policy.
- Most hospitals performed better than the national average
  - Net statewide adjustments are +0.03 percent (estimated at +$4.1 million).
- Of the 40 hospitals included in the policy, 9 would be penalized a total of 0.10 percent due to increases in IP LOS or improvements less than the improvement threshold and O/E ratios greater than attainment threshold (estimated at -$12.6 million).

Recommendations

1. Implement an all-payer risk-adjusted IP LOS measure for acute-care hospitals.
2. Assess hospital performance on the better of improvement or attainment.
   - **Improvement Target:** Establish a five-year (CY2023 to CY 2028) improvement threshold (i.e., minimum improvement needed to not be penalized and to start earning rewards) to bring all Maryland hospitals to an Observed to Expected Ratio of 1.0 (HCUP national average).
   - **Attainment Target:** Set the attainment threshold at the CY 2023 HCUP national average of 1.0 plus the annual improvement target.
3. Provide scaled rewards and penalties of up to 0.5 percent all-payer inpatient revenue for RY 2028, and increase by 0.25 percent annually for RY2029 (0.75 percent) and RY2030 (1.0 percent).
   - To be eligible for rewards, hospitals are expected to participate in sharing best practices and required to submit reporting for the ED and Hospital Throughput Best Practice Policy.
4. Monitor to ensure the policy is achieving its intended result (lower IP LOS and ED LOS) and for unintended consequences, including readmission rates and emergency department (ED) revisits.

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Inpatient Length of Stay Incentive Program (IP LOS)

Draft Recommendation

April 2026

This document contains the staff draft recommendations. Comments should be sent to geoff.dougherty@maryland.gov by Friday, April 24, 2026.

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List of Abbreviations

Abbreviation	Definition
AHEAD	Achieving Healthcare Efficiency through Accountable Design
APR-DRG	All Patients Refined Diagnosis Related Groups
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
ED	Emergency Department
FY	Fiscal Year
GBR	Global Budget Revenue
HCUP	Healthcare Cost and Utilization Project
HSCRC	Health Services Cost Review Commission
IP	Inpatient
IP LOS	Inpatient Length of Stay
LOS	Length of Stay
MHA	Maryland Hospital Association
O/E	Observed-to-Expected Ratio
PMWG	Performance Measurement Work Group
RRIP	Readmission Reduction Incentive Program
RY	Rate Year
SNF	Skilled Nursing Facility
SOI	Severity of Illness
TCOC	Total Cost of Care

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Key Methodology Concepts and Definitions

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

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

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

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

Observed/Expected (O/E) Ratio: LOS performance is calculated by dividing the observed LOS by the expected LOS. Expected LOS is determined through case-mix adjustment using national norms.

Case-Mix Adjustment: National norms for LOS (i.e., normative value or "norm") are derived from the HCUP National Inpatient Sample by APR-DRG/SOI. Expected LOS for each hospital is derived by summing the LOS norms for each patient discharged during the measurement period.

Risk-Adjusted LOS: Observed LOS divided by Expected LOS, multiplied by the National Base Year Mean LOS.

ED Boarding: The practice of holding admitted patients in the emergency department after they have been assigned an inpatient bed, typically due to lack of available inpatient beds. ED boarding is a direct consequence of constrained inpatient capacity and prolonged inpatient length of stay.

Improvement Score: A measure of change in a hospital's risk-adjusted LOS from the base year to the performance year, expressed as a percentage.

Attainment Score: A measure of a hospital's risk-adjusted LOS relative to a fixed threshold, indicating absolute performance rather than improvement.

Recommendations

These are the draft recommendations for the Inpatient Length of Stay Incentive Program (IP LOS):

1. Implement an all-payer risk-adjusted inpatient length of stay (IP LOS) measure for acute-care hospitals.
2. Assess hospital performance on the better of improvement or attainment.
    a. **Improvement Target:** Establish a five-year (CY2023 to CY 2028) improvement threshold (i.e., minimum improvement needed to not be penalized and to start earning rewards) to bring all Maryland hospitals to an Observed to Expected Ratio ratio of 1.0 (HCUP national average).
    b. **Attainment Target:** Set the attainment threshold at the CY 2023 HCUP national average of 1.0 plus the annual improvement target.
3. Provide scaled rewards and penalties of up to 0.5 percent all-payer inpatient revenue for RY 2028, and increase by 0.25 percent annually for RY2029 (0.75 percent) and RY2030 (1.0 percent).
    a. To be eligible for rewards, hospitals are expected to participate in sharing best practices and required to submit reporting for the ED and Hospital Throughput Best Practice Policy.
4. Monitor to ensure the policy is achieving its intended result (lower IP LOS and ED LOS) and for unintended consequences, including readmission rates and emergency department (ED) revisits.

Introduction

Maryland hospitals have been and are currently funded under an all-payer global budget revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under agreements with the Centers for Medicare and Medicaid Services (CMS) for the state to operate the All-Payer Model (Calendar (CY) 2014- CY 2018), the Total Cost of Care (TCOC) Model (CY 2019-CY 2025), and the current AHEAD model (CY 2026- CY 2035). Maryland's global budget system, which provides hospitals with annual prospective budgets, guarantees Maryland hospitals a greater source of financial stability and provides incentives to shift services to the most appropriate care setting and reduce potentially avoidable utilization. The HSCRC adjusts hospital global budgets for quality of care and patient experience through pay-for-performance policies that assess areas of national focus (e.g., hospital acquired complications, readmissions) and areas of opportunity that are unique to Maryland and global budgets.

This draft Inpatient Length of Stay policy is being proposed to the Commission to address concerns related to significant post-pandemic growth in IP LOS at Maryland hospitals. Extended hospital stays are sometimes unavoidable. in other instances patients remain hospitalized for longer than necessary due to ineffective initial treatment, poor discharge planning, and other hospital-specific factors. This can result in poor patient outcomes and financially strained healthcare institutions. Inpatient LOS is also a key factor in

extended emergency department LOS. Currently, Maryland's emergency departments are among the most crowded in the nation, and managing IP LOS is a critical piece of managing this issue.

While the majority of Maryland hospitals are at or below the national average for IP LOS, incentives in this area are still needed. Maryland has fewer inpatient beds per capita than most states, so absent better performance on IP LOS, hospitals may experience bed capacity issues. Maryland residents are also younger and more affluent than those in other states, suggesting that overall utilization should be well below the national average. Additionally, implementation of an IP LOS policy counterbalances the incentives of the surge policy. Without such a counterweight, it is possible that the surge policy would result in worsening IP LOS that would place more Maryland hospitals above the national average..

Policy development for this and other State hospital incentive programs is vetted with stakeholders and approved by the Commission to ensure the programs strike a balance between driving needed changes and avoiding unanticipated consequences. For purposes of the RY 2028 IP LOS Draft Policy, staff vetted the updated proposed recommendations with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Background

One of the central motivations for this policy is a paradox that has emerged in Maryland hospital utilization trends: even as inpatient admissions have declined—an outcome consistent with the goals of global budgets and Total Cost of Care accountability—overall inpatient utilization, as measured by total bed days, has increased. This divergence arises because reductions in admission volume have been more than offset by increases in the average length of each stay. The result is that hospitals are caring for fewer patients in aggregate, but those patients are occupying beds for longer periods, consuming proportionally more capacity per episode of care.

This dynamic has direct implications for the financial sustainability of the AHEAD model. Global Budget Revenue is premised on the idea that hospitals can manage both the volume and the intensity of inpatient utilization within a fixed envelope of funding. When bed days rise even as admissions fall, it signals that inpatient resources are not being freed up at the rate the model anticipates. Hospitals operating with elevated LOS face constrained physical capacity, which in turn limits their ability to respond to surges in demand, coordinate effectively with post-acute partners, and avoid the boarding of admitted patients in the emergency department. In short, declining admission volume is a necessary but not sufficient condition for model sustainability—it must be accompanied by a proportional reduction in LOS to translate into genuine efficiency gains. The IP LOS incentive is designed to close this gap by targeting the dimension of inpatient utilization that has, to date, been moving in the wrong direction.

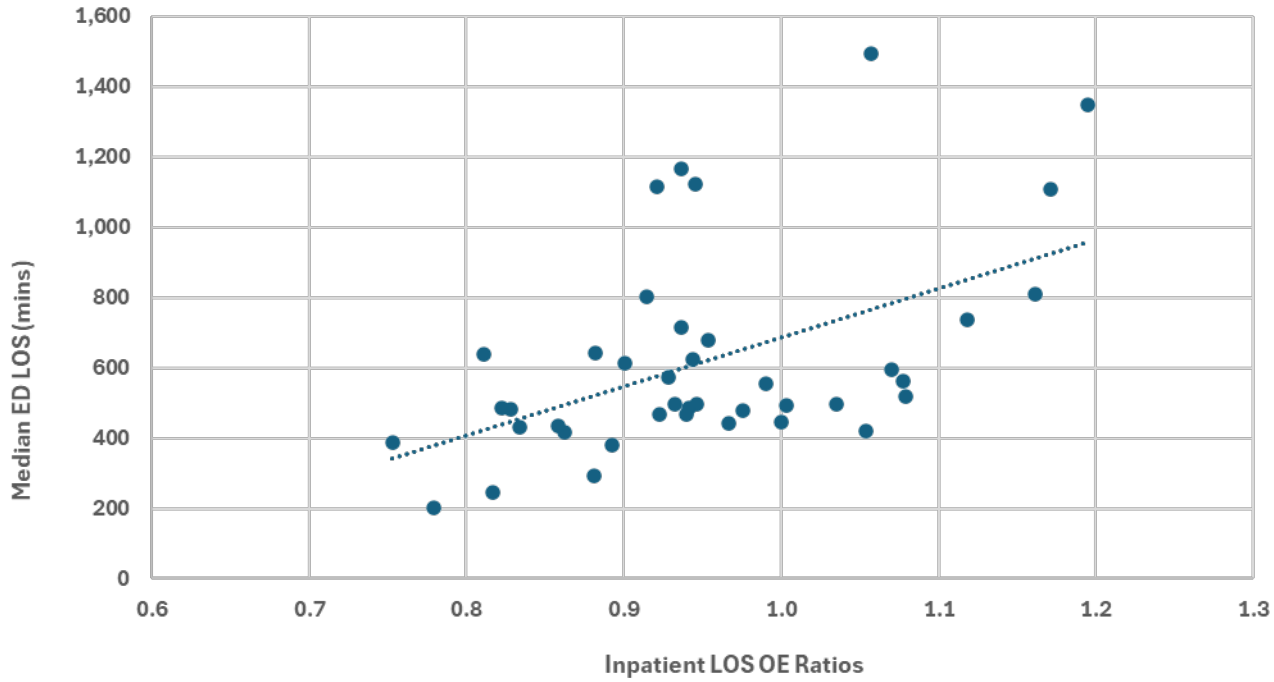
While incentives exist to improve IP LOS through global budgets and TCOC accountability, those incentives have not prevented marked growth in IP LOS. Thus, staff believe an additional top-line revenue incentive, similar to RRIP for readmissions, is necessary to optimize care delivery and accelerate progress toward national norms. This is particularly true now that the recently approved surge policy provides incentives based in part on bed days, which could potentially result in further increases in IP LOS.

Impact on Emergency Department Length of Stay

One of the primary rationales for implementing an IP LOS policy is its potential impact on emergency department operations. When inpatient beds are occupied by patients with prolonged stays, the hospital's capacity to admit new patients from the emergency department is constrained. This creates a "backup" effect where admitted patients must wait—or "board"—in the ED until an inpatient bed becomes available.This boarding accumulation leads to longer wait times for all ED patients, delayed treatment for new arrivals, ambulance diversion, increased patient safety risks, staff burnout and reduced quality of care.

In Maryland, the correlation between IP LOS and ED LOS at the hospital level is 0.5 (Figure 1), indicating moderate correlation. Because of this relationship, staff concluded that achieving the policy's multi-year goal of bringing IP LOS at all Maryland hospitals toward the national average could result in significant reductions in ED boarding hours, improved ED throughput, enhanced patient experience, and better clinical outcomes.

Figure 1. Inpatient and ED Length of Stay for Admitted Patients By Hospital, FY2025



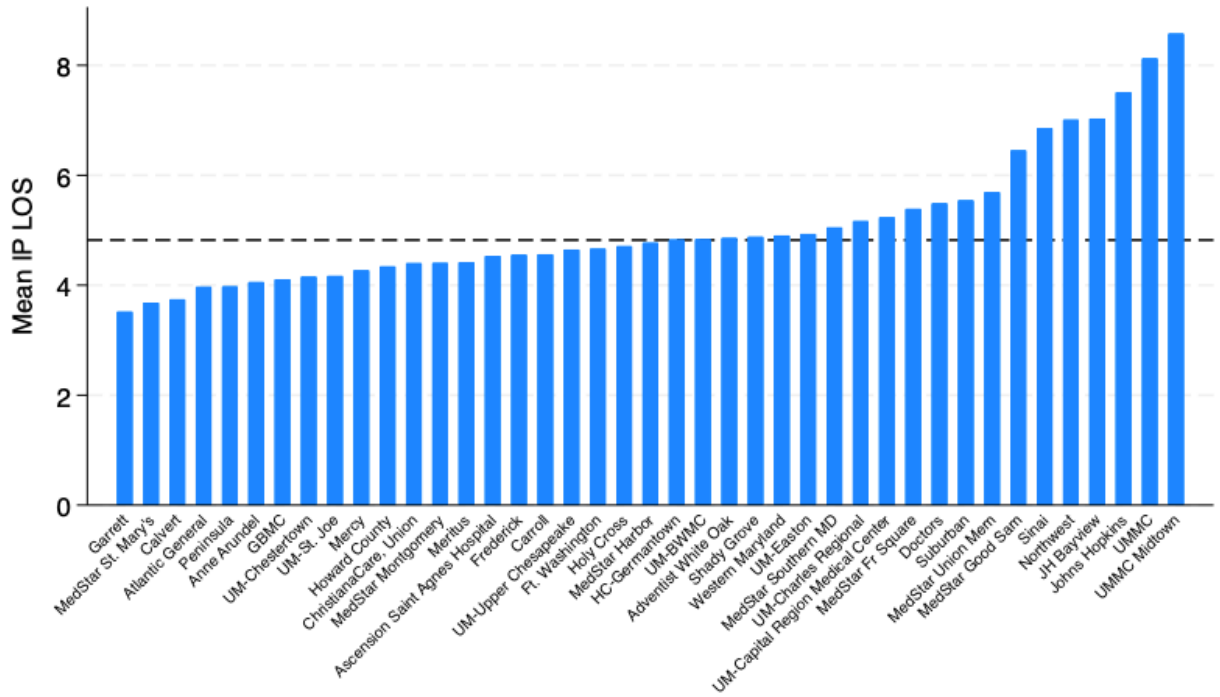
Source: FY25 IP LOS OE & HCUP 2023 norms adjusting for APR-DRG/SOI vs ED Median LOS, 2025

Maryland Hospital Performance

The following section provides an overview of Maryland hospital performance on IP LOS, evaluation of factors that may account for longer IP LOS, and addresses questions and concerns raised by stakeholders.

Staff evaluated IP LOS of Maryland hospitals against the national average using data from the Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample, a representative sample of discharge records from U.S. hospitals maintained by the federal Agency for Healthcare Quality and Research. The most recent survey data is from 2023. In FY2025, patients at 20 of the State's acute-care hospitals experienced IP LOS longer than the most recently available national average (Figure 2), with the highest mean LOS at a Maryland hospital more than 75% higher than the national average.

Figure 2. Mean IP LOS of Maryland Hospitals, FY2025

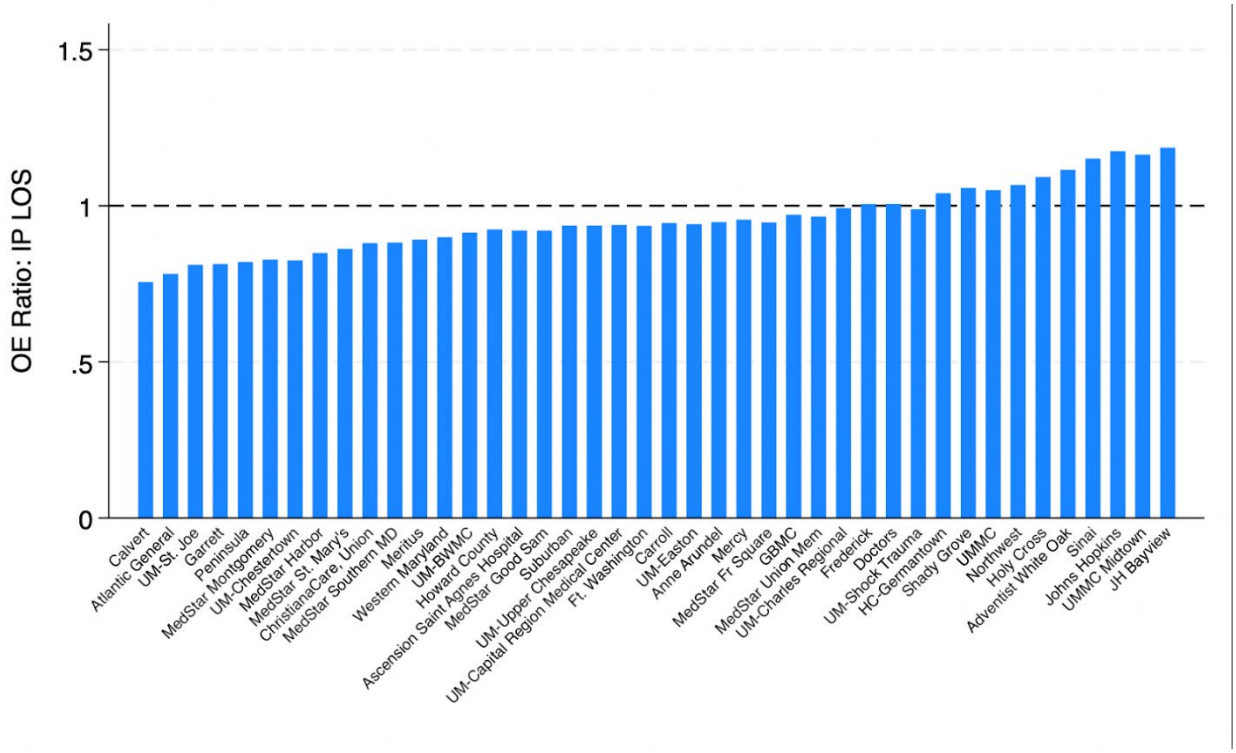


Source: HSCRC FY2025 Casemix

To gauge whether this comparison was impacted by differences in patient acuity between Maryland hospitals and those elsewhere, staff indirectly standardized the IP LOS of Maryland hospitals using national norms by APR-DRG, severity of illness and payer derived from the NIS. In the risk-adjusted analysis, one quarter of Maryland hospitals continued to have IP LOS higher than the national average (Figure 3). Staff

assessed the degree to which hospital performance was influenced by including in the analysis norms calculated on a patient group of less than 30, which can occur when there are few patients in the NIS with a particular combination of APR-DRG, severity indicator and payer. The OE ratios calculated after excluding cells with fewer than 30 patients were correlated at >0.99 with the original ratios, leading staff to conclude that small cell size was not a source of measurement error.

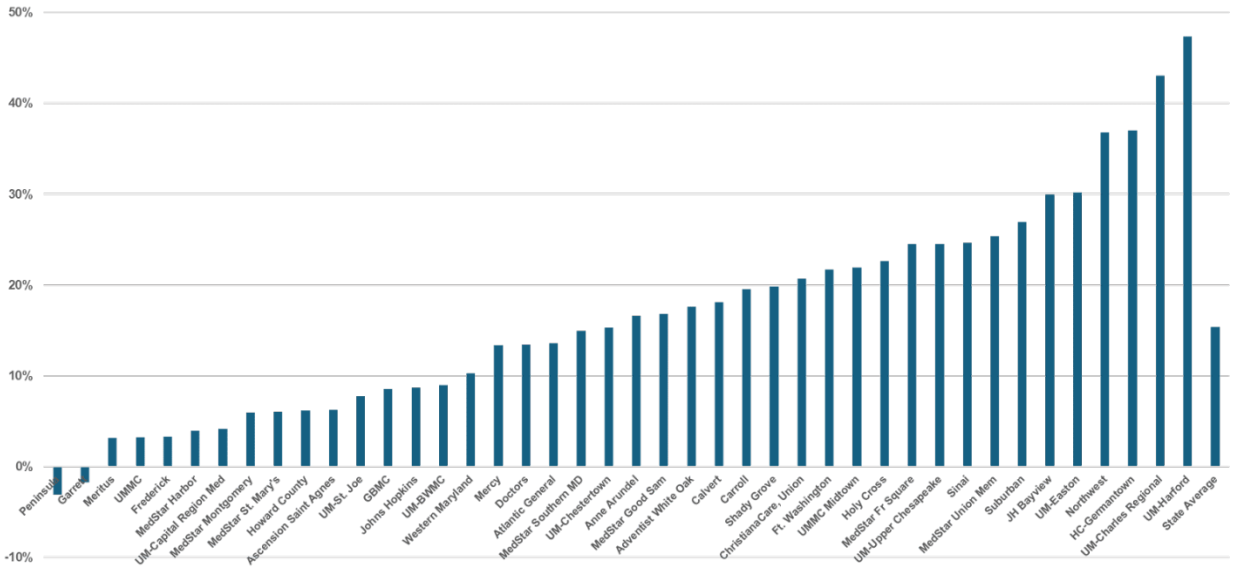
Figure 3. IP LOS Observed/Expected Ratios for Maryland Hospitals, FY2025



Source: HSCRC FY2025 Casemix, risk adjusted for APR-DRG, and payer using 2023 HCUP norms

The performance of Maryland hospitals in FY2025 followed several years of increasing LOS. Between 2018 to 2024, IP LOS at most hospitals in the State increased more than 10%, while some increased more than 20%. Only two of the State's hospitals experienced decreases during the period (Figure 4).

Figure 4. Change in IP LOS for Maryland Hospitals, FY2018-2024



Source: HSCRC Casemix, FY2018-2024

Evaluation of Factors Leading to Longer IP LOS

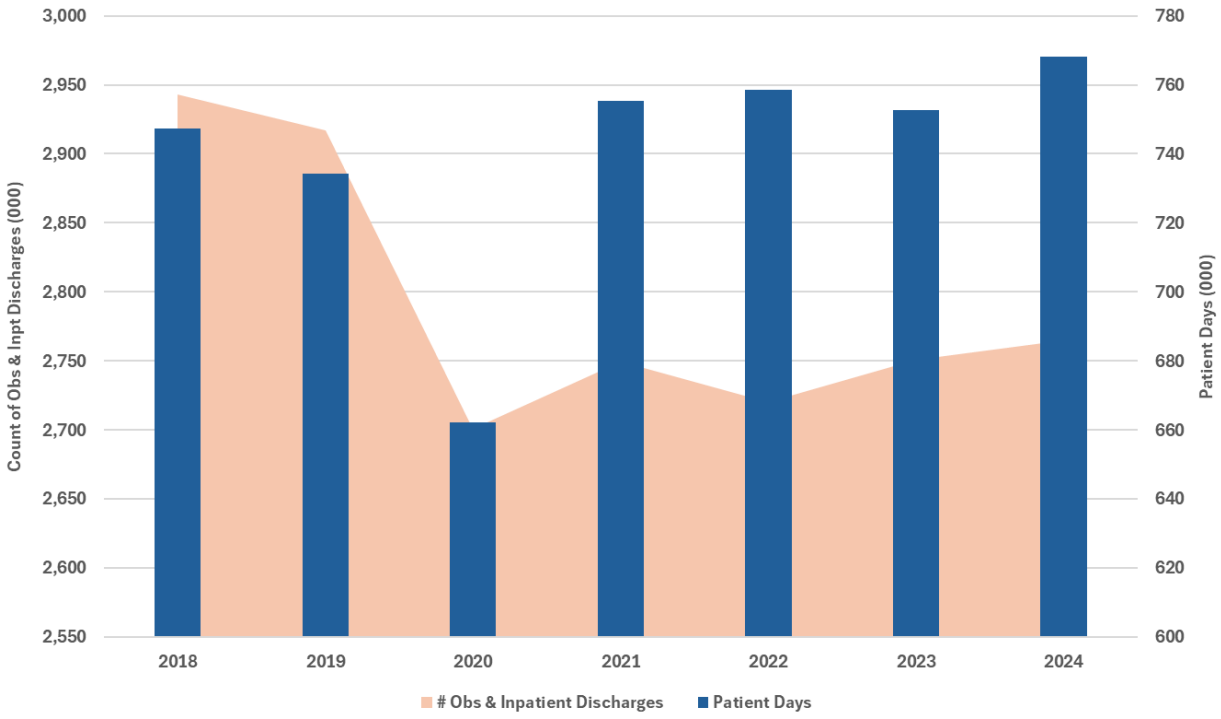
There are several potential reasons for rising IP LOS, including some related to factors largely beyond the control of hospitals. Staff evaluated these explanations empirically to ensure that the policy incentivizes an outcome that is meaningfully responsive to hospital-led interventions.

One leading explanation is that the shift in IP LOS was the result of TCOC Model dynamics, in that incentivizing a reduction in inpatient discharges directed a sizable population of low-acuity patients from inpatient services to lower-acuity settings. This would result in a longer average LOS for the remaining patients due to their higher acuity.

Staff expected that if this theory were correct, Maryland's performance would fall in line with that of the nation after risk adjustment. However, while implementation of risk adjustment moved some Maryland hospitals in line with the national average, a significant portion of facilities remained above the national average.

To address the possibility that this risk-adjustment approach was not completely effective in controlling for patient acuity, staff evaluated the statewide change in both IP discharges and IP bed days over time. If the IP LOS issue were driven by removal of the low-acuity population, one would expect to see discharges fall with bed days falling to a much lesser extent. Instead, there was a net gain in statewide bed days over time, indicating that utilization for higher-acuity patients increased (Figure 5).

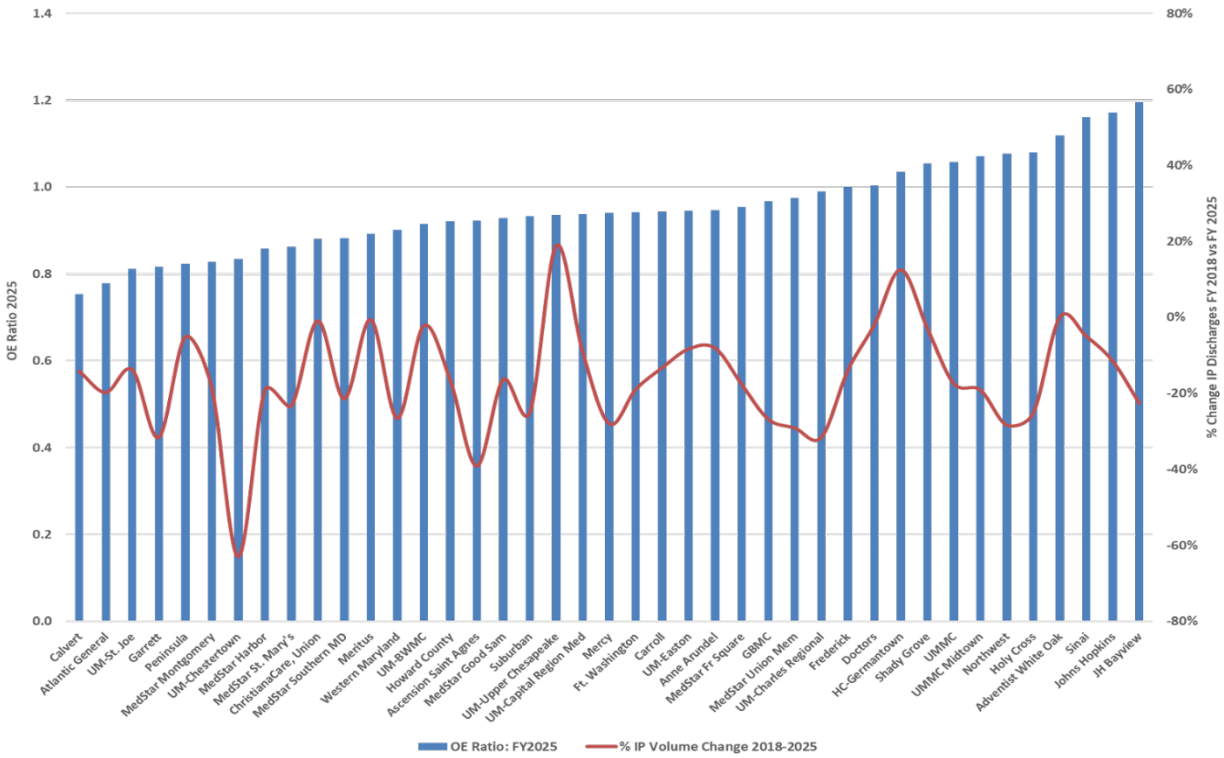
Figure 5. Patient Days vs. Observation and Inpatient Discharges, FY2018-2024



Source: HSCRC Casemix, FY2018-2024

Staff also evaluated the association between inpatient volume changes and CY2025 IP LOS performance. If the shift to lower-acuity settings was behind rising IP LOS, one would expect that the hospitals with the largest volume decreases would have the highest risk-adjusted IP LOS. However, the analysis indicated that IP LOS and volume changes are minimally correlated (Figure 6).

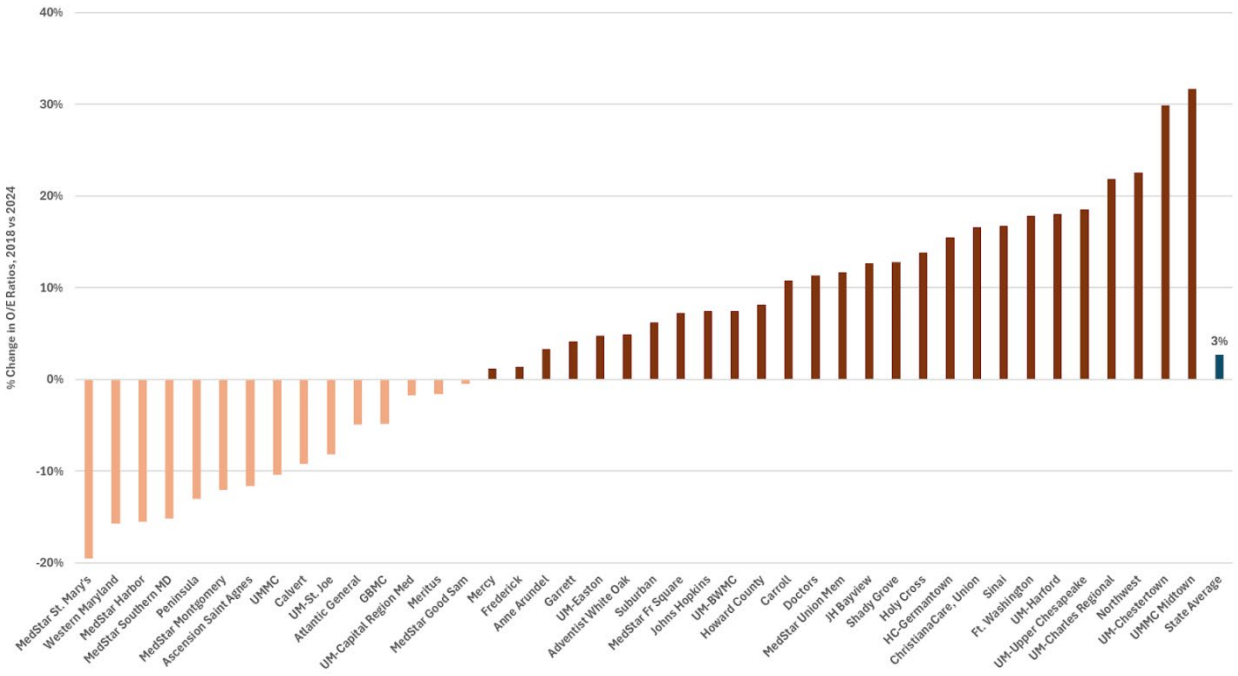
Figure 6. Association Between FY 2025 Inpatient Length of Stay and Volume Changes, 2018-2025



Source: HSCRC Casemix, 2018-2025FY and HCUP 2023 norms adjusting for APR-DRG/SOI

Finally, staff identified several cohorts of patients, including those undergoing heart bypass and other major surgery, whose care has been consistently delivered on inpatient services for the duration of the TCOC Model. Staff hypothesized that if the growth in low-acuity unregulated care were responsible for rising IP LOS, these cohorts would exhibit stable LOS over time. However, significant increases in IP LOS were observed in these inpatient-only cohorts (Figure 7).

Figure 7. Change in IP LOS By Hospital for Inpatient-Only Procedures, 2018 vs 2024 FY

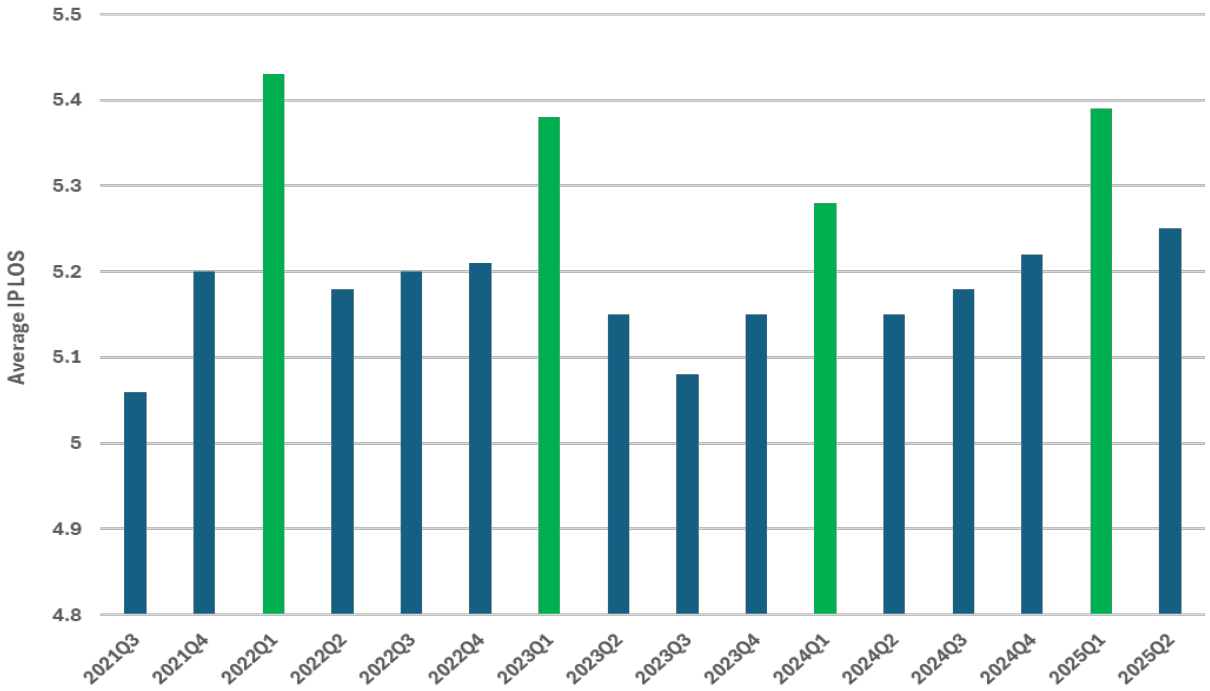


Source: HSCRC Casemix, 2018-2024 FY, risk adjusted by HCUP 2023

Another possibility is that payment practices specific to government insurance programs drive increasing IP LOS. Staff evaluated this theory by comparing hospital IP LOS performance by payer. This analysis indicated that hospitals with risk-adjusted LOS longer than the national average perform similarly regardless of payer, indicating that the issue is likely not related to payer policies.

An additional theory is that the TCOC Model created incentives for hospitals to unnecessarily lengthen LOS at the close of the fiscal year to avoid falling under global budget revenue targets. Staff evaluated this by reviewing quarterly changes in IP LOS for the past several years. This analysis (Figure 8) indicated that there is marked variation in IP LOS by quarter. However, the longest LOS regularly occurs in the first quarter of the calendar year, when respiratory illnesses peak. The second quarter, which coincides with the close of the rate year, typically sees the lowest IP LOS of the year.

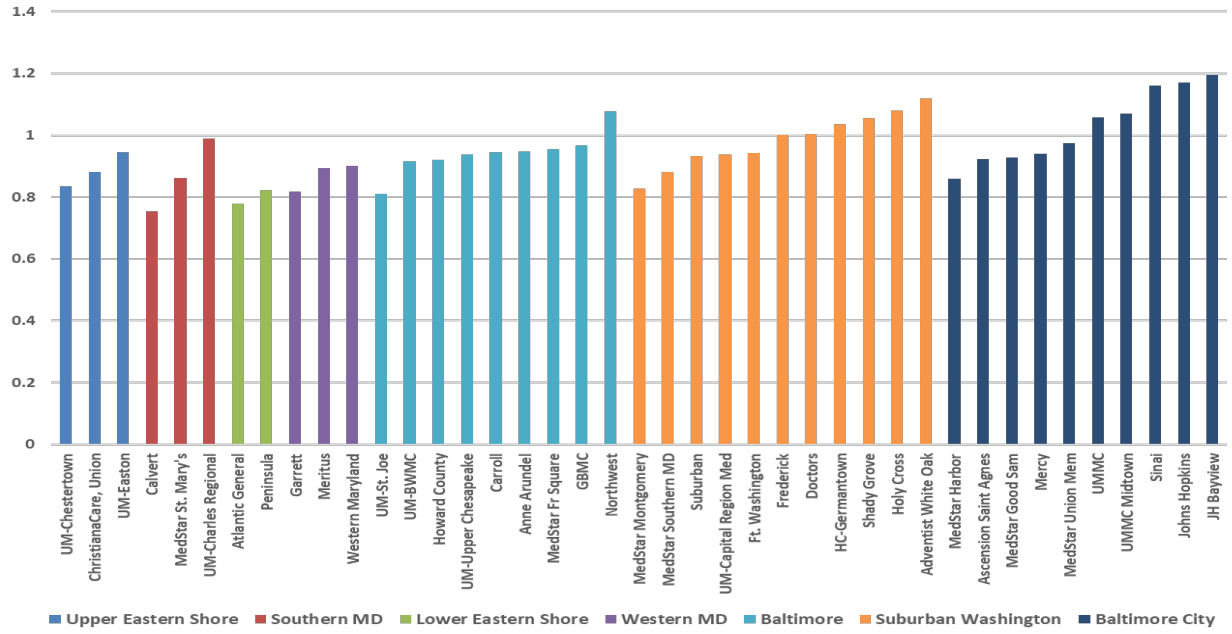
Figure 8. Variation in Inpatient Length of Stay by Calendar-Year Quarter



Source: HSCRC Casemix data, FY2022 - FY2025

Staff also investigated the possibility that IP LOS is associated with differences among patients and within hospitals operating in low-income environments. Risk-adjusted hospital IP LOS was evaluated for each of the state's seven regions. While rural areas generally had lower IP LOS, three of the state's regions, including the affluent Suburban Washington area, contained hospitals with risk-adjusted IP LOS above the national average.

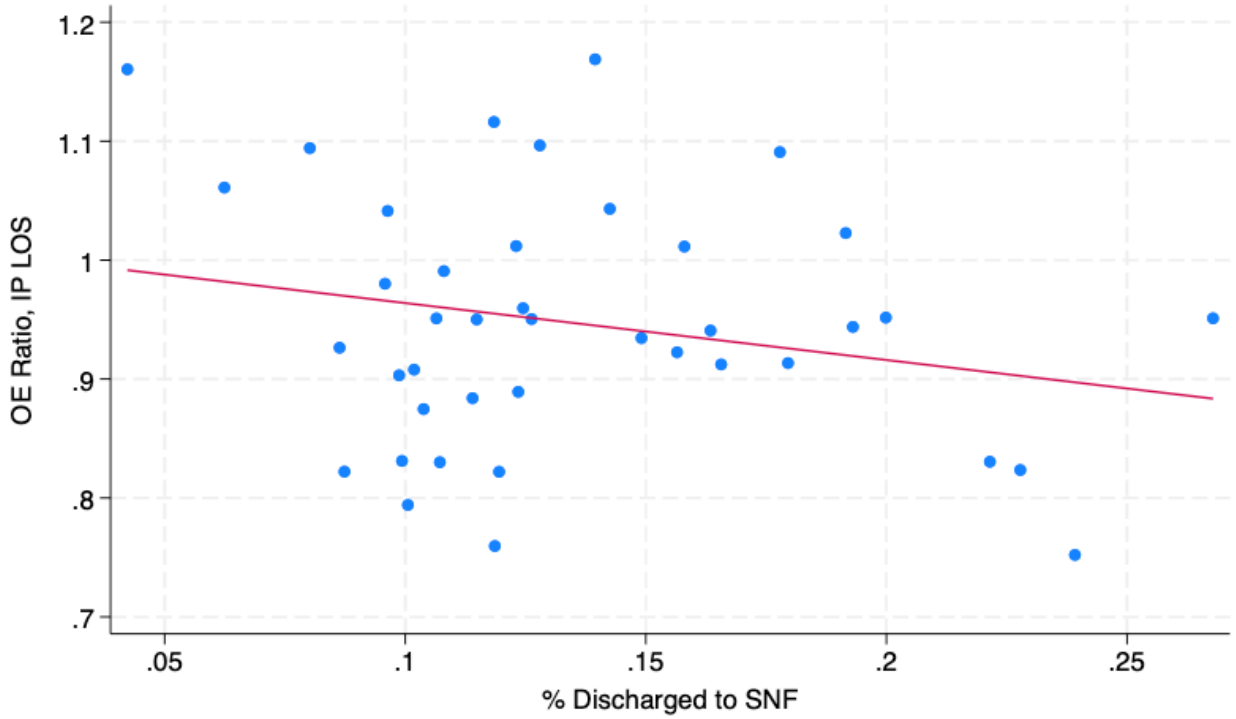
Figure 9. Risk-Adjusted Hospital IP LOS By Region, 2025



Source: 2025 HSCRC Casemix,HCUP 2023 norms adjusting for APR-DRG/SOI (Severity of Illness)

Staff also considered whether post-acute care availability was responsible for elevated IP LOS. Statewide, patients discharged to post-acute care have IP LOS above the national average, while those discharged elsewhere have IP LOS below the national average. However, at the hospital level, IP LOS is minimally (and inversely) correlated with volume of post-acute discharges. This suggests that operational issues at some hospitals are lengthening LOS for patients regardless of discharge destination, and that the IP LOS policy could improve efficiency and patient experience at these facilities.

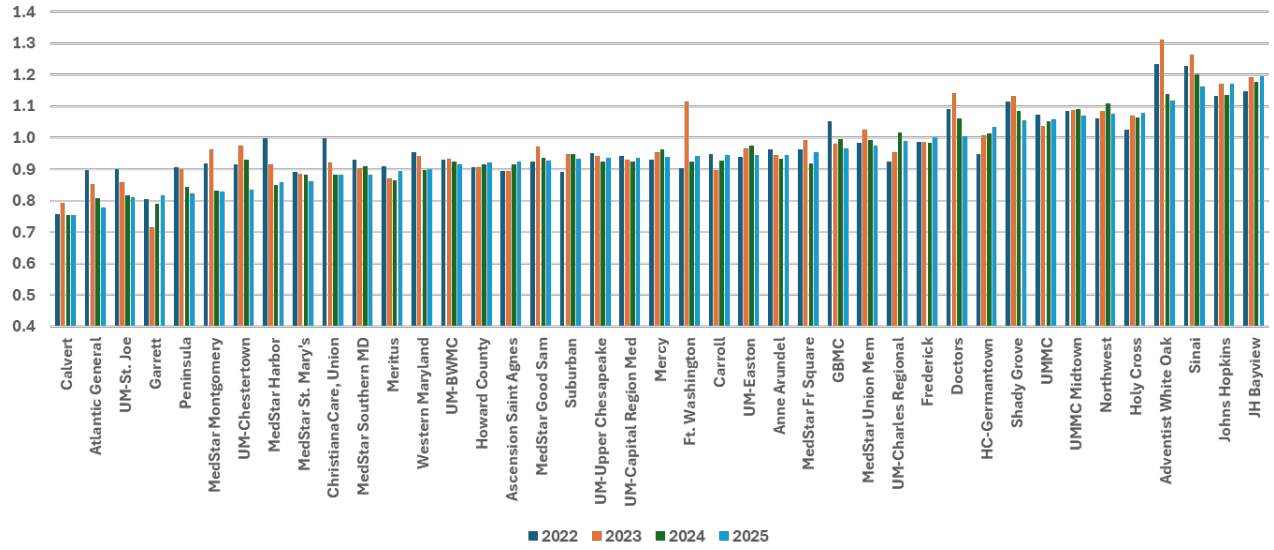
Figure 10. Risk-Adjusted Hospital IP LOS vs. Percent of Patients Discharged to SNF, 2025



Source: CY2025 HSCRC Casemix,HCUP 2023 norms adjusting for APR-DRG/SOI (Severity of Illness)

A final possibility is that the performance of Maryland hospitals as compared to the nation is the result of random variation rather than differences in hospital operations. However, an analysis of risk-adjusted hospital performance over time indicated that hospitals performing below the national average in CY2025 experienced similar performance in prior years (Figure 11). Because of this, staff concluded that the factors driving elevated LOS are related to hospital operations rather than random variation.

Figure 11. Annual Variation in IP LOS, CY2022-2025



Source: 2025 HSCRC Casemix,HCUP 2023 norms adjusting for APR-DRG/SOI (Severity of Illness)

After evaluating several potential causes of rising IP LOS that are unrelated to hospital performance, as well as information on a number of successful hospital-led IP LOS interventions described in peer-reviewed literature, staff concluded that hospital operations are a significant factor in IP LOS, and that a policy incentivizing improvements in IP LOS would benefit patients, hospitals, and the State's healthcare system.

Pay-for Performance Policy Overview

This section provides an overview of the proposed pay-for-performance policy including details on the IP LOS performance measure, performance targets, and revenue adjustment methodology. This draft policy proposes to include scaled penalties and rewards, up to 0.5 percent of all-payer, inpatient revenue. While 1 percent was originally proposed, staff have reduced the revenue at-risk for CY 2026 due to the policy being implemented half way through the year. Modeling of by-hospital performance in CY 2026 is provided below for reference. In RY 2029 and RY 2030, the revenue at-risk will be increased to 0.75 percent and 1 percent, respectively. In order for hospitals to be eligible for a reward, stakeholders have suggested having requirements to share best practices for hospital throughput. Specifically, staff have included a recommendation that hospitals are expected to participate in sharing best practices and required to submit reporting for the ED and Hospital Throughput Best Practice Policy to be eligible for a reward.

Performance Metric

Measurement

The policy will measure all-payer risk-adjusted inpatient length of stay (IP LOS) for acute-care hospitals.

Proposed Exclusions

The following discharge types are excluded from measurement:

Exclusion Category	Rationale
Discharges leaving against medical advice	Patient-driven departure, not reflective of hospital performance
Transfers out	LOS attributed to receiving hospital
Expired cases	Clinical outcomes measure, not LOS efficiency
Shock trauma and discharges from long term care beds	Unique clinical circumstances not comparable to general admissions
Unknown discharge dispositions	Data quality concern

Risk-Adjustment Methodology

Risk adjustment will be applied by deriving normative values (norms) by APR-DRG, SOI, and payer (Commercial, Medicare, Medicaid, Other) from the 2023 HCUP National Inpatient Sample. These norms are then applied to discharge data from HSCRC casemix, and expected IP LOS for each hospital is derived by summing the IP LOS norms for each patient discharged during the measurement period. The performance metric is the Observed IP LOS divided by the Expected IP LOS (O/E Ratio). Hospitals that performed at the same level as the nation will have an O/E Ratio of 1. An O/E Ratio of <1 indicates better performance while a ratio > 1 indicates worse performance compared to the national norm. While the O/E ratio is often multiplied by the unadjusted average from the reference population to obtain the risk-adjusted rate, the pay-for-performance methodology proposed here will use the O/E ratio.

Performance Targets

The performance targets for this policy are modeled similarly to how the targets for the Readmission Reduction Incentive Program were established. Specifically, hospitals will be assessed on both improvement in IP LOS from a fixed base period and actual performance (i.e., attainment) relative to the nation during each performance year. Below are the improvement and attainment targets established based on modeling of opportunity and stakeholder feedback.

Improvement Targets

Figure 12 provides a range of improvement scenarios that were considered and the proposed improvement goal for CY2023 through CY2028. Given this is a new policy, staff believes the improvement goal should both consider what is required to have all hospitals reach the national average, as well as historical performance over time to avoid setting an overly aggressive goal that could lead to unintended consequences. Based on stakeholder feedback, a set base period of CY2023 will be used for measuring improvement in CY 2026. Staff propose a cumulative improvement of 5 percent over 5-years (CY2023-CY2028) based on historical trends and the goals set forth in this policy.

Figure 12. Improvement Scenario Options

#	Estimating Method	Percent Improvement	Annualized Improvement	CY2026 Improvement Threshold
1	Statewide improvement, CY2023-CY2025	-0.90%	-0.18%	-0.54%
2	Mean hospital improvement, CY2023-CY2025	-1.46%	-0.29%	-0.88%
3	Mean hospital improvement among hospitals with reductions, CY2023-CY2025	-4.20%	-0.85%	-2.54%
4	Statewide change if all hospitals with an O/E Ratio greater than 1, improve to 1 in CY 2023	-4.79%	-0.98%	-2.90%
5	Statewide change if all hospitals with an O/E Ratio greater than 1, improve to statewide median in CY2023	-7.94%	-1.64%	-4.84%
6	Improvement from the mean O/E ratio of those greater than 1 in CY2023 to 1	-9.64%	-2.01%	-5.90%
Proposed Improvement Goal		**-5.00%**	**-1.02%**	**-3.03%**

Using the 5 percent improvement goal, figure 13 shows the proposed improvement scale for scaling revenue adjustments based on CY2023 to CY2026 performance. The threshold of -3.03 percent is the improvement needed to avoid being penalized. The improvement needed to receive the maximum reward (benchmark) was set at the mean improvement of the top decile of improvement from CY 2023 to CY 2025. The maximum penalty was linearly extrapolated from the threshold and the maximum reward.

Figure 13. Improvement Scale

All Payer LOS Rate Change CY2023-2026		LOS % IP Revenue Payment Adjustment
Improving	-9.13%	0.50%
	-8.52%	0.45%
	-7.91%	0.40%
	-7.30%	0.35%
	-6.69%	0.30%
	-6.08%	0.25%
	-5.47%	0.20%
	-4.86%	0.15%
	-4.25%	0.10%
	-3.64%	0.05%
Threshold	-3.03%	0.00%
	-2.42%	-0.05%
	-1.81%	-0.10%
	-1.20%	-0.15%
	-0.59%	-0.20%
	0.02%	-0.25%
	0.63%	-0.30%
	1.24%	-0.35%
	1.85%	-0.40%
	2.46%	-0.45%
Worsening	3.06%	-0.50%

Attainment Targets

Figure 14 provides the proposed attainment scaling. The attainment threshold is set at O/E Ratio of 1 from CY 2023, adjusted for the improvement threshold determined above. While the attainment threshold could be set at the O/E ratio of 1.0, staff have historically included the improvement goal into the attainment standards for readmissions to further emphasize improvement. The attainment benchmark (i.e., O/E ratio where hospitals could receive full reward) was set at the average of the top performing decile of hospitals in CY2023 plus the improvement target.

Figure 14. Attainment Scale

All-Payer IP LOS O/E Ratio Performance Targets		LOS % IP Revenue Payment Adjustment
Lower	0.7678	0.50%
	0.7880	0.45%
	0.8082	0.40%
	0.8283	0.35%
	0.8485	0.30%
	0.8687	0.25%
	0.8889	0.20%
	0.9091	0.15%
	0.9293	0.10%
	0.9495	0.05%
Target	0.9697	0.00%
	0.9899	-0.05%
	1.0101	-0.10%
	1.0303	-0.15%
	1.0505	-0.20%
	1.0707	-0.25%
	1.0908	-0.30%
	1.1110	-0.35%
	1.1312	-0.40%
	1.1514	-0.45%
Higher	1.1716	-0.50%

Revenue Adjustment Modeling

Figure 15 provides statewide revenue adjustments using the parameters set above and CY2025 data as a proxy for CY2026 performance. Given that the majority of hospitals perform better than the national average, the net statewide adjustments are +0.3 percent (estimated at +$4.1 million). Of the 40 hospitals included in the policy, 9 would be penalized a total of 0.10 percent due to increases in IP LOS or improvements less than the improvement threshold and O/E ratios greater than attainment threshold (estimated at -$12.6 million). By hospitals modeling is provided in Appendix and an excel modeling workbook has been provided to stakeholders and can be provided upon request.

Figure 15. Statewide Revenue Adjustment, Base 2023 vs CY 2026 (CY 2025 used as proxy)

Summary			
Statewide Revenue		$12,379,325,935	
$ Better of Attainment/ Improvement	Rewards (31 Hosp.)	$16,744,605	Statewide Percent: 0.14%
	Penalties (9 hosp.)	($12,562,197)	Statewide Percent: -0.1%
Net Revenue Adjustment		$4,182,408	Statewide Percent: 0.03%

AHEAD Model Considerations

Staff will discuss inclusion of the IP LOS revenue adjustment in the CMS HGBs. If this is not possible, staff will update the policy so that all-payer performance is used to adjust revenue for State HGBs for non-Medicare revenue.

Recommendations

These are the draft recommendations for the Inpatient Length of Stay Incentive Program (IP LOS):

1. Implement an all-payer risk-adjusted inpatient length of stay (IP LOS) measure for acute-care hospitals.
2. Assess hospital performance on the better of improvement or attainment.
    a. **Improvement Target:** Establish a five-year (CY2023 to CY 2028) improvement threshold (i.e., minimum improvement needed to not be penalized and to start earning rewards) to bring all Maryland hospitals to an Observed to Expected Ratio ratio of 1.0 (HCUP national average).
    b. **Attainment Target:** Set the attainment threshold at the CY 2023 HCUP national average of 1.0 plus the annual improvement target.
3. Provide scaled rewards and penalties of up to 0.5 percent all-payer inpatient revenue for RY 2028, and increase by 0.25 percent annually for RY2029 (0.75 percent) and RY2030 (1.0 percent).
    a. To be eligible for rewards, hospitals are expected to participate in sharing best practices and required to submit reporting for the ED and Hospital Throughput Best Practice Policy.
4. Monitor to ensure the policy is achieving its intended result (lower IP LOS and ED LOS) and for unintended consequences, including readmission rates and emergency department (ED) revisits.

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Appendix: By Hospital Modeling

Modeling of Revenue Adjustments by Hospital (04/08/2026)						Improvement Scaling			Attainment Scaling				Final Adjustment		
HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue**	Base 2023	CY 2026 (CY2025 used as proxy)	Percent change	Target	% Revenue Adjustment	$ Revenue Adjustment	CY 2026 (CY2025 used as proxy)	Target (national average + improvement)	% Revenue Adjustment	$ Revenue Adjustment	$ Better of Attainment or Improvement	RY 25 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment
210001	Meritus	$307,533,751	0.8541	0.8954	4.83%	-3.03%	-0.50%	-$1,537,669	0.8954	0.9697	0.18%	$553,561	$553,561	0.18%	Att
210002	UMMC	$1,667,872,778	1.0161	1.0619	4.50%	-3.03%	-0.50%	-$8,339,364	1.0619	0.9697	-0.23%	-$3,836,107	-$3,836,107	-0.23%	Att
210003	UM-Capital Region Med	$334,294,899	0.9173	0.9796	6.80%	-3.03%	-0.50%	-$1,671,474	0.9796	0.9697	-0.02%	-$66,859	-$66,859	-0.02%	Att
210004	Holy Cross	$402,793,216	1.0649	1.0941	2.74%	-3.03%	-0.47%	-$1,893,128	1.0941	0.9697	-0.31%	-$1,248,659	-$1,248,659	-0.31%	Att
210005	Frederick	$286,140,344	0.9977	1.0118	1.42%	-3.03%	-0.37%	-$1,058,719	1.0118	0.9697	-0.10%	-$286,140	-$286,140	-0.10%	Att
210008	Mercy	$249,515,476	0.9479	0.9273	-2.17%	-3.03%	-0.07%	-$174,661	0.9273	0.9697	0.10%	$249,515	$249,515	0.10%	Att
210009	Johns Hopkins	$1,984,717,053	1.1606	1.1604	-0.01%	-3.03%	-0.25%	-$4,961,793	1.1604	0.9697	-0.47%	-$9,328,170	-$4,961,793	-0.25%	Imp
210011	Ascension Saint Agnes	$269,943,037	0.8858	0.9127	3.04%	-3.03%	-0.50%	-$1,349,715	0.9127	0.9697	0.14%	$377,920	$377,920	0.14%	Att
210012	Sinai	$576,915,177	1.2174	1.0965	-9.93%	-3.03%	0.50%	$2,884,576	1.0965	0.9697	-0.31%	-$1,788,437	$2,884,576	0.50%	Imp
210015	MedStar Fr Square	$437,038,002	0.9292	0.9491	2.14%	-3.03%	-0.42%	-$1,835,560	0.9491	0.9697	0.05%	$218,519	$218,519	0.05%	Att
210016	Adventist White Oak	$306,648,357	1.2210	1.0962	-10.22%	-3.03%	0.50%	$1,533,242	1.0962	0.9697	-0.31%	-$950,610	$1,533,242	0.50%	Imp
210017	Garrett	$30,285,668	0.7628	0.7524	-1.37%	-3.03%	-0.14%	-$42,400	0.7524	0.9697	0.50%	$151,428	$151,428	0.50%	Att
210018	MedStar Montgomery	$110,817,149	0.8871	0.8231	-7.21%	-3.03%	0.34%	$376,778	0.8231	0.9697	0.36%	$398,942	$398,942	0.36%	Att
210019	Peninsula	$394,776,979	0.8689	0.8222	-5.37%	-3.03%	0.19%	$750,076	0.8222	0.9697	0.37%	$1,460,675	$1,460,675	0.37%	Att
210022	Suburban	$275,339,890	0.9518	0.9136	-4.01%	-3.03%	0.08%	$220,272	0.9136	0.9697	0.14%	$385,476	$385,476	0.14%	Att
210023	Anne Arundel	$461,250,402	0.9310	0.9504	2.08%	-3.03%	-0.42%	-$1,937,252	0.9504	0.9697	0.05%	$230,625	$230,625	0.05%	Att
210024	MedStar Union Mem	$316,870,786	1.0017	0.9429	-5.86%	-3.03%	0.23%	$728,803	0.9429	0.9697	0.07%	$221,810	$728,803	0.23%	Imp
210027	Western Maryland	$202,494,635	0.9159	0.9154	-0.05%	-3.03%	-0.24%	-$485,987	0.9154	0.9697	0.13%	$263,243	$263,243	0.13%	Att
210028	MedStar St. Mary's	$98,519,520	0.8914	0.8751	-1.83%	-3.03%	-0.10%	-$98,520	0.8751	0.9697	0.23%	$226,595	$226,595	0.23%	Att
210029	JH Bayview	$522,055,592	1.1801	1.1783	-0.15%	-3.03%	-0.24%	-$1,252,933	1.1783	0.9697	-0.50%	-$2,610,278	-$1,252,933	-0.24%	Imp
210032	ChristianaCare, Union	$114,302,009	0.8831	0.8843	0.14%	-3.03%	-0.26%	-$297,185	0.8843	0.9697	0.21%	$240,034	$240,034	0.21%	Att
210033	Carroll	$178,074,349	0.9044	0.9230	2.05%	-3.03%	-0.42%	-$747,912	0.9230	0.9697	0.12%	$213,689	$213,689	0.12%	Att
210034	MedStar Harbor	$147,837,218	0.8804	0.8307	-5.65%	-3.03%	0.21%	$310,458	0.8307	0.9697	0.34%	$502,647	$502,647	0.34%	Att
210035	UM-Charles Regional	$109,649,404	0.9836	0.9416	-4.27%	-3.03%	0.10%	$109,649	0.9416	0.9697	0.07%	$76,755	$109,649	0.10%	Imp
210037	UM-Easton	$162,954,562	0.9552	0.9652	1.05%	-3.03%	-0.33%	-$537,750	0.9652	0.9697	0.01%	$16,295	$16,295	0.01%	Att
210038	UMMC Midtown	$155,503,757	1.0656	1.1183	4.95%	-3.03%	-0.50%	-$777,519	1.1183	0.9697	-0.37%	-$575,364	-$575,364	-0.37%	Att
210039	Calvert	$89,452,152	0.7606	0.7597	-0.11%	-3.03%	-0.24%	-$214,685	0.7597	0.9697	0.50%	$447,261	$447,261	0.50%	Att
210040	Northwest	$185,021,826	1.0673	1.0228	-4.16%	-3.03%	0.09%	$166,520	1.0228	0.9697	-0.13%	-$240,528	$166,520	0.09%	Imp
210043	UM-BWMC	$337,061,709	0.9321	0.9043	-2.98%	-3.03%	0.00%	$0	0.9043	0.9697	0.16%	$539,299	$539,299	0.16%	Att
210044	GBMC	$285,831,225	0.9812	0.9909	0.99%	-3.03%	-0.33%	-$943,243	0.9909	0.9697	-0.05%	-$142,916	-$142,916	-0.05%	Att
210048	Howard County	$260,887,192	0.9223	0.9072	-1.63%	-3.03%	-0.11%	-$286,976	0.9072	0.9697	0.15%	$391,331	$391,331	0.15%	Att
210049	UM-Upper Chesapeake	$279,739,543	0.9392	0.9353	-0.41%	-3.03%	-0.21%	-$587,453	0.9353	0.9697	0.09%	$251,766	$251,766	0.09%	Att
210051	Doctors	$187,925,562	1.0821	1.0110	-6.57%	-3.03%	0.29%	$544,984	1.0110	0.9697	-0.10%	-$187,926	$544,984	0.29%	Imp
210056	MedStar Good Sam	$196,413,974	0.9262	0.9436	1.88%	-3.03%	-0.40%	-$785,656	0.9436	0.9697	0.06%	$117,848	$117,848	0.06%	Att
210057	Shady Grove	$364,335,482	1.1245	1.0422	-7.31%	-3.03%	0.35%	$1,275,174	1.0422	0.9697	-0.18%	-$655,804	$1,275,174	0.35%	Imp
210060	Ft. Washington	$39,131,159	1.0400	0.9523	-8.43%	-3.03%	0.44%	$172,177	0.9523	0.9697	0.04%	$15,652	$172,177	0.44%	Imp
210061	Atlantic General	$49,382,101	0.8195	0.7937	-3.15%	-3.03%	0.01%	$4,938	0.7937	0.9697	0.44%	$217,281	$217,281	0.44%	Att
210062	MedStar Southern MD	$204,927,843	0.8922	0.8215	-7.92%	-3.03%	0.40%	$819,711	0.8215	0.9697	0.37%	$758,233	$819,711	0.40%	Imp
210063	UM-St. Joe	$310,535,107	0.8241	0.8307	0.79%	-3.03%	-0.31%	-$962,659	0.8307	0.9697	0.34%	$1,055,819	$1,055,819	0.34%	Att
210065	HC-Germantown	$106,347,654	1.0124	1.0437	3.10%	-3.03%	-0.50%	-$531,738	1.0437	0.9697	-0.18%	-$191,426	-$191,426	-0.18%	Att
STATEWIDE		**$12,379,325,935**						**-$23,414,593**				**-$12,527,005**	**$4,182,408**	0.03%	
Penalty								-$33,311,951				-$22,109,224	-$12,562,197	-0.10%	
Reward								$9,897,358				$9,582,219	$16,744,605	0.14%	

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Revisit Select Volume Realignment Policy

April 15, 2026

Update on Implementation

For several months, Staff and Kaiser-impacted hospitals have raised concerns over implementation aspects of the Select Volume Realignment policy. Since approval, both staff and hospitals have encountered a number of implementation challenges and complexities associated with the policy design. Key issues include, but are not limited to:

- **Small cell size concerns:** Removing Kaiser patient-level records of the selected 13 hospitals from market shift calculations may result in statistically unstable or skewed outcomes for certain hospitals on the Statewide marketshift run.
- **Divergent volume trends:** There are mismatched utilization trends between Kaiser and non-Kaiser populations, creating challenges in managing compliance alongside any other volume shifts.
- **Interaction with other policies:** Additional analysis is required to ensure Kaiser volume treated as fee-for-service is not double counted across other policies (e.g., surge, complexity adjustments).
- **Financial reporting challenges:** Hospitals have expressed difficulty in determining appropriate revenue recognition for financial reporting purposes.

These challenges, combined with the timing of the policy alongside the transition to the AHEAD Model, make implementation particularly difficult at this time.

Recommendation

Staff recommend that the Commission reverse the Select Volume Realignment Policy adopted in December 10, 2025 Commission meeting. In its place, staff would handle the adjustments related to these shifts through a payer driven volume shift service line exclusion using an adjustment to the standard market shift approach as outlined in the Market Shift Refinement policy adopted by the Commission in December 2025. This approach is consistent with the Commission's approach prior to the adoption of the Select Volume Realignment Policy. No further Commission action would be required.

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Select Volume Realignment Policy

Staff Update and Recommendation

April 2026

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Overview of Recommendation

Staff are recommending to reverse the Select Volume Realignment Recommendation that was approved by the Commission on December 10, 2025.

Select Volume Realignment Recommendation

Kaiser Permanente is an integrated healthcare delivery system that provides health plan coverage and coordinated medical services to over 750,000 members in the Mid-Atlantic States Region, which includes Maryland. Kaiser Permanente (Kaiser) does not operate its own hospital facilities in Maryland; instead, it partners with a network of Maryland hospitals (Core Hospitals) to provide hospital based services to its members. Kaiser is currently transitioning a portion of its members' hospital based services from facilities outside of its network to Core Hospitals. To help facilitate this realignment and in consideration of the complexity of the previous adjudication process the Select Volume Realignment Policy adopted the following:

- For select hospitals, Kaiser volumes and revenues that are usually evaluated in the Market Shift policy (charges associated with ECMADs) will be removed from global budget revenues for the period of January 1, 2026, through June 30, 2027. Select hospitals are defined as follows:
  - Greater than 5 percent of total Kaiser Revenue statewide regardless of Kaiser share of GBR, i.e., supersedes other required criteria
  - Greater than $5 million in annual charges and greater than 2 percent of global budget revenue, however,
  - Various Exclusions
    - Specialty Hospitals – Shock Trauma, Shady Grove Hospital
    - Hospitals with a preponderance of Kaiser revenue attributable to non-elective care (i.e., >96.85% of charges have an EMG rate center charge – top quartile for prior list of material Kaiser hospitals)
- Allow removed Kaiser volumes and revenues to be reimbursed in real time through a volume-variable evaluation, using HSCRC rates.
- On July 1, 2027, build back into global budgets removed Kaiser volumes and revenues based on volumes reimbursed through a volume variable evaluation from January 1, 2026 through December 31, 2026.

Update on Implementation

For several months, Staff and Kaiser-impacted hospitals have raised concerns over implementation aspects of the Select Volume Realignment policy. Since approval, both staff and

hospitals have encountered a number of implementation challenges and complexities associated with the policy design. Key issues include, but are not limited to:

- **Small cell size concerns:** Removing Kaiser patient-level records of the selected 13 hospitals from market shift calculations may result in statistically unstable or skewed outcomes for certain hospitals on the Statewide marketshift run.
- **Divergent volume trends:** There are mismatched utilization trends between Kaiser and non-Kaiser populations, creating challenges in managing compliance alongside any other volume shifts.
- **Interaction with other policies:** Additional analysis is required to ensure Kaiser volume treated as fee-for-service is not double counted across other policies (e.g., surge, complexity adjustments).
- **Financial reporting challenges:** Hospitals have expressed difficulty in determining appropriate revenue recognition for financial reporting purposes.

These challenges, combined with the timing of the policy alongside the transition to the AHEAD Model, make implementation particularly difficult at this time.

Recommendation

Staff recommend that the Commission reverse the Select Volume Realignment Policy adopted in December 10, 2025 Commission meeting. In its place, staff would handle the adjustments related to these shifts through a payer driven volume shift service line exclusion using an adjustment to the standard market shift approach as outlined in the Market Shift Refinement policy adopted by the Commission in December 2025. This approach is consistent with the Commission's approach prior to the adoption of the Select Volume Realignment Policy. No further Commission action would be required.

The next HSCRC Public Meeting is Wednesday, May 13, 2026.

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