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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

Informational Session

1. Presentation: TBD

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 Performance
    f. *Materials Only* - FY 2025 Systems Financial Performance
6. Draft Policy: In Patient Length of Stay
7. Revisit Select Volume Realignment Policy
8. Hearing and Meeting Schedule

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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.

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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.

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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.

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?

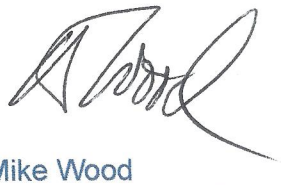
   MedStar Response

   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

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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.

P: 410.764.2605 4160 Patterson Avenue | Baltimore, MD 21215 hscrc.maryland.gov

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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.

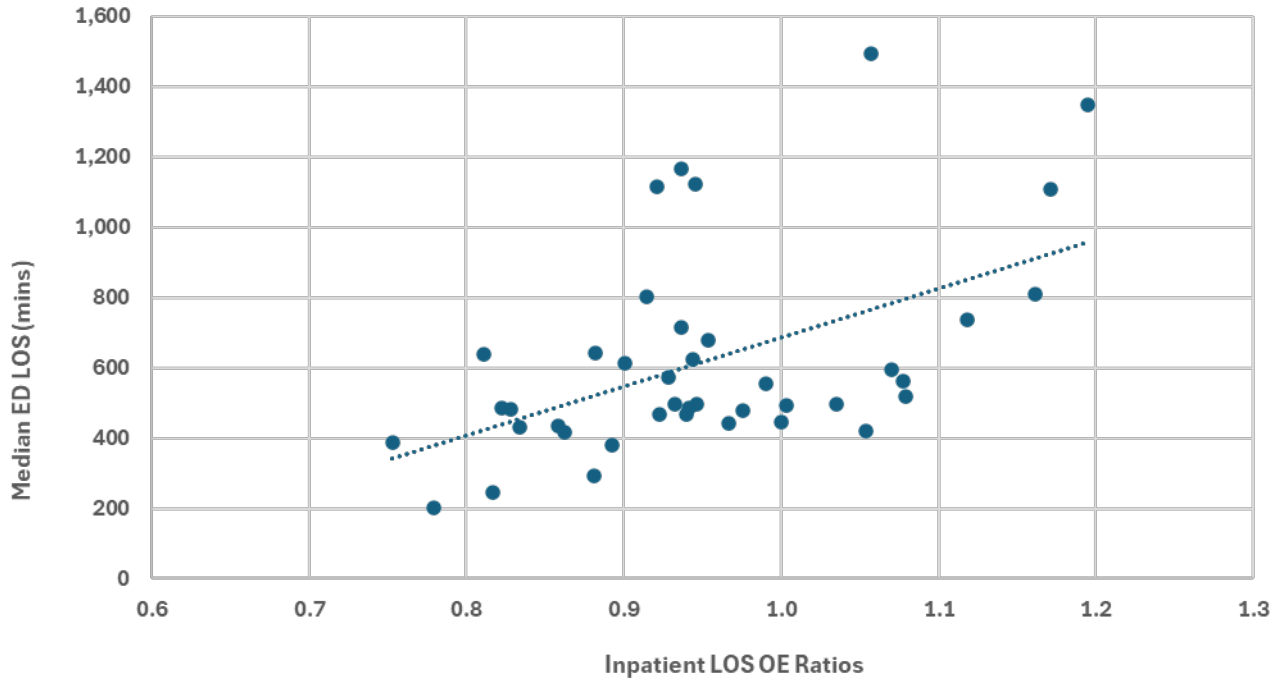
While incentives exist to improve IP LOS through global budgets and TCOC accountability, those incentives have not prevented marked growth in IP LOS. Thus, staff believe an additional top-line revenue incentive, similar to RRIP for readmissions, is necessary to optimize care delivery and accelerate progress 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



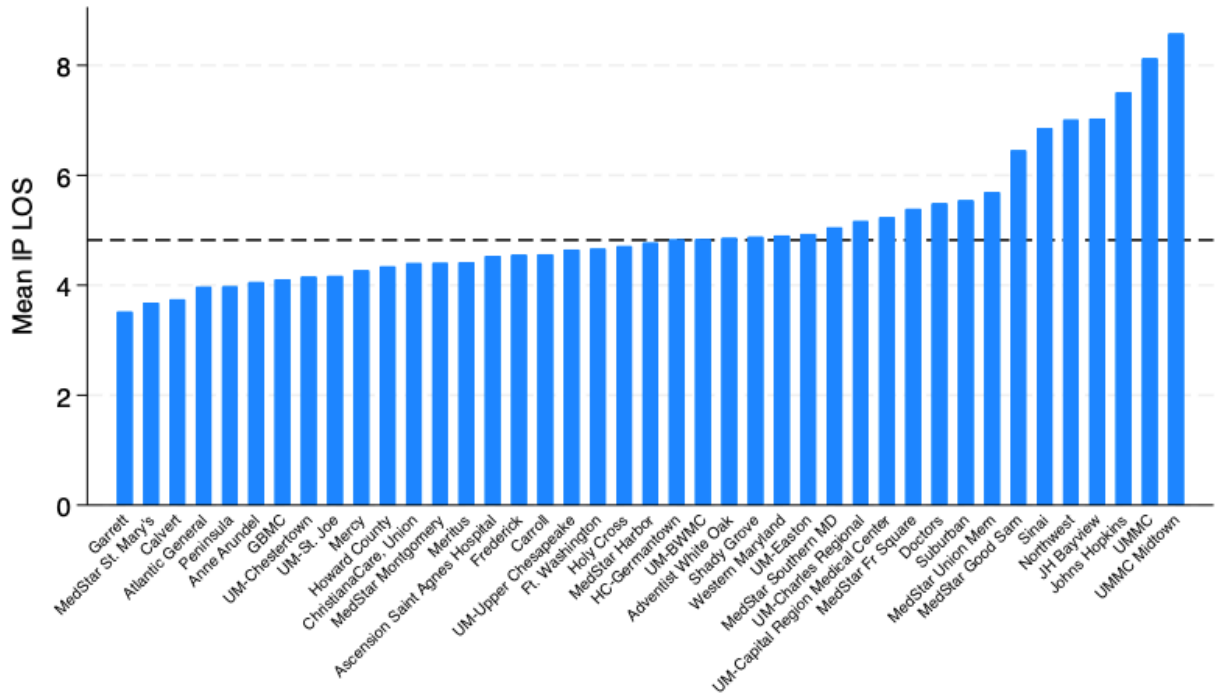
Source: FY25 IP LOS OE & HCUP 2023 norms adjusting for APR-DRG/SOI vs ED Median LOS, 2025

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

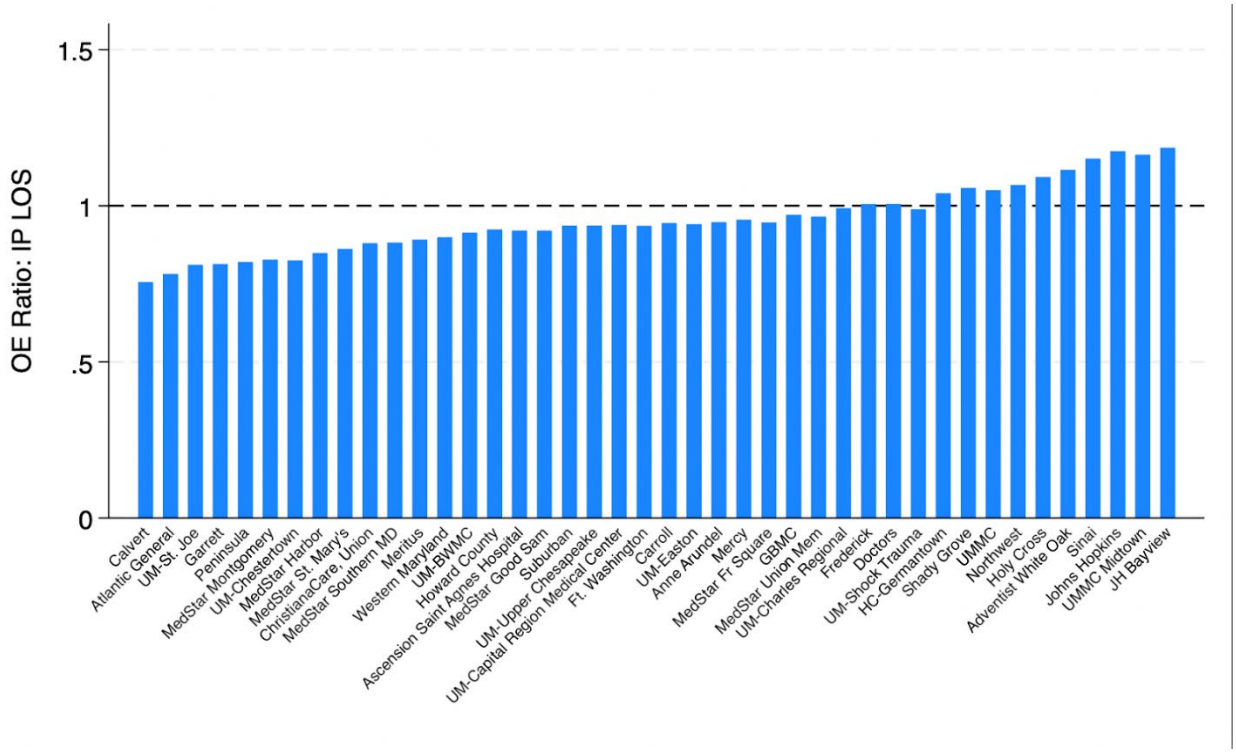


Source: HSCRC FY2025 Casemix

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.

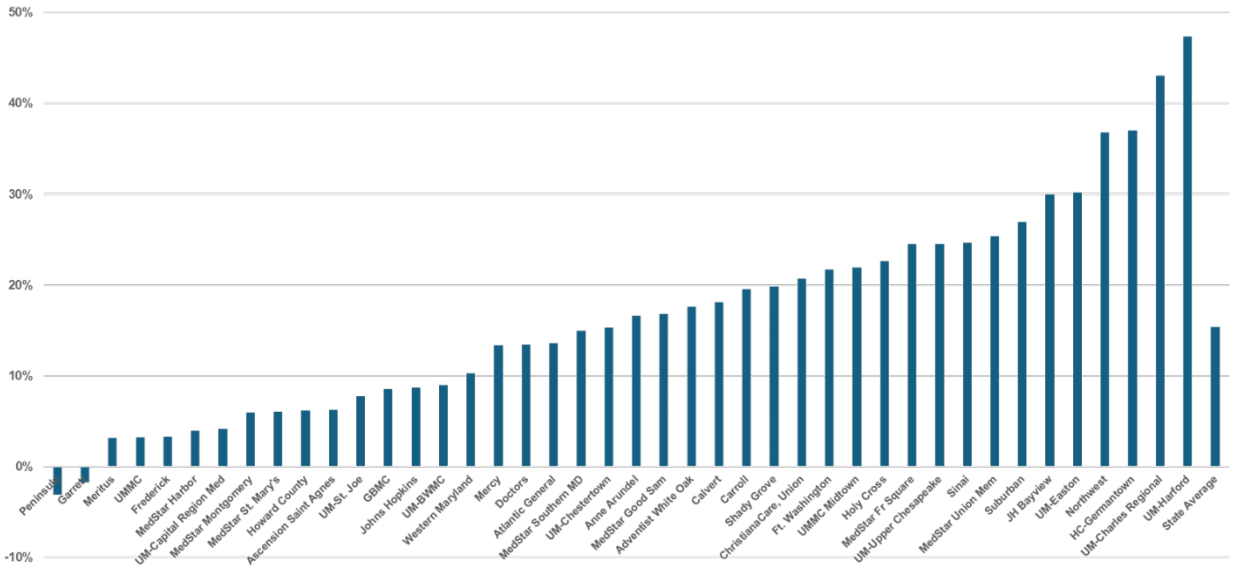
Figure 3. IP LOS Observed/Expected Ratios for Maryland Hospitals, FY2025



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

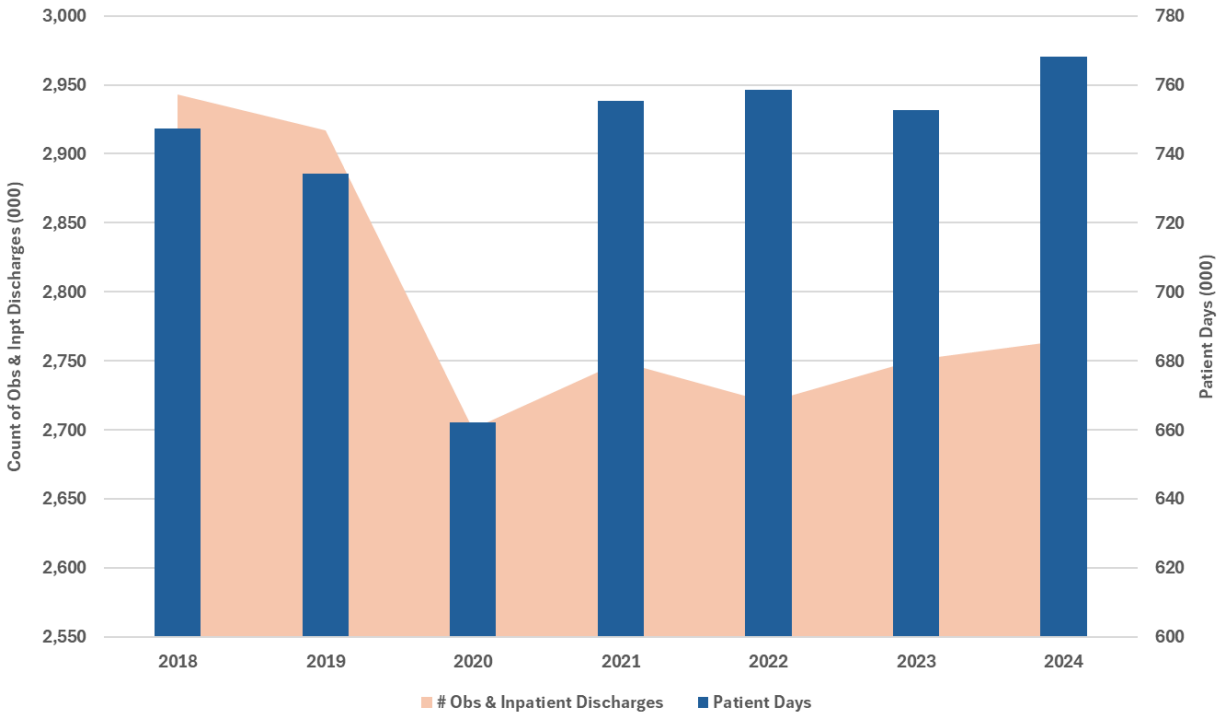
There are several potential reasons for rising IP LOS, including some related to factors largely beyond the control of hospitals. Staff evaluated these explanations empirically to ensure that the policy incentivizes an outcome that is meaningfully responsive to hospital-led interventions.

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).

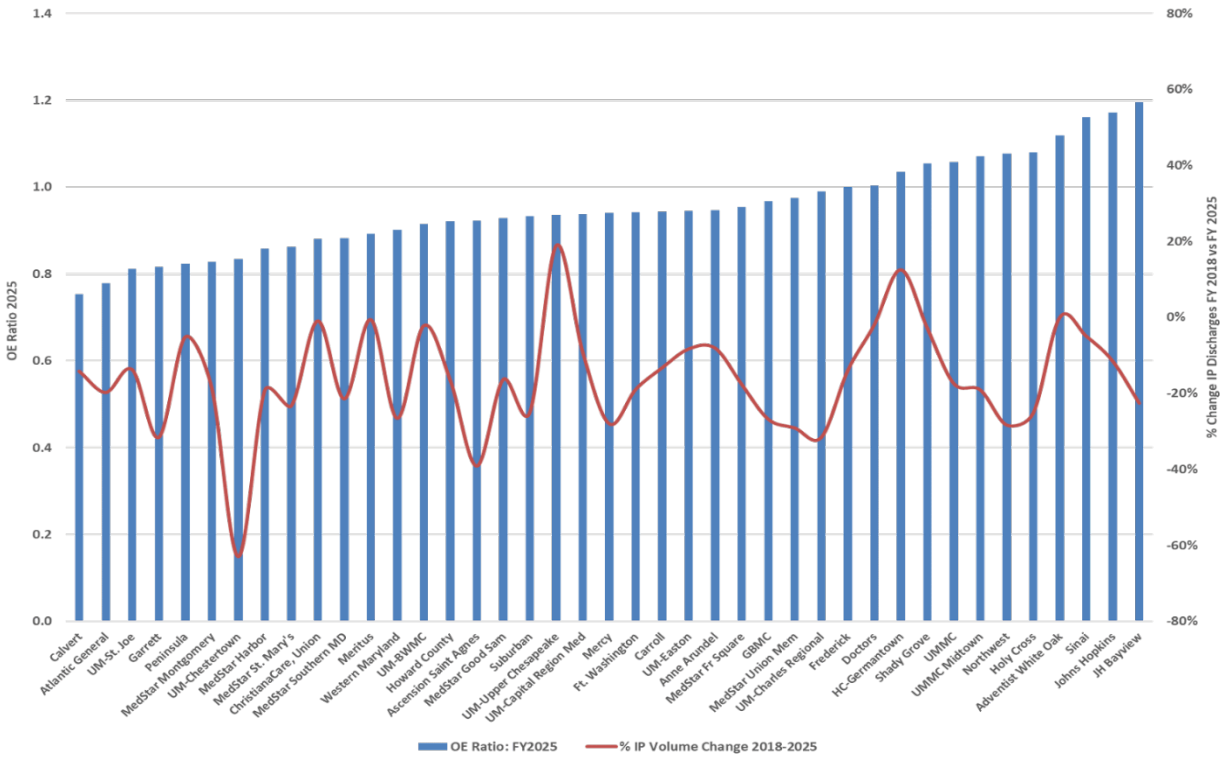
Figure 5. Patient Days vs. Observation and Inpatient Discharges, FY2018-2024



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).

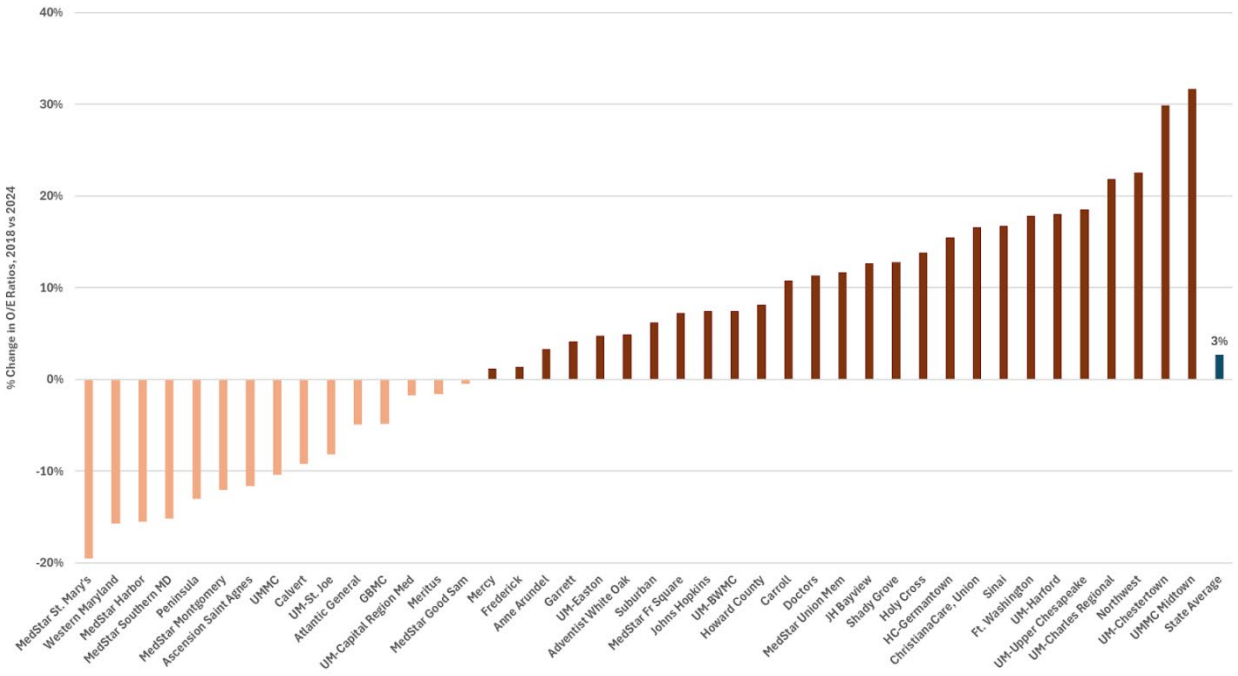
Figure 6. Association Between FY 2025 Inpatient Length of Stay and Volume Changes, 2018-2025



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

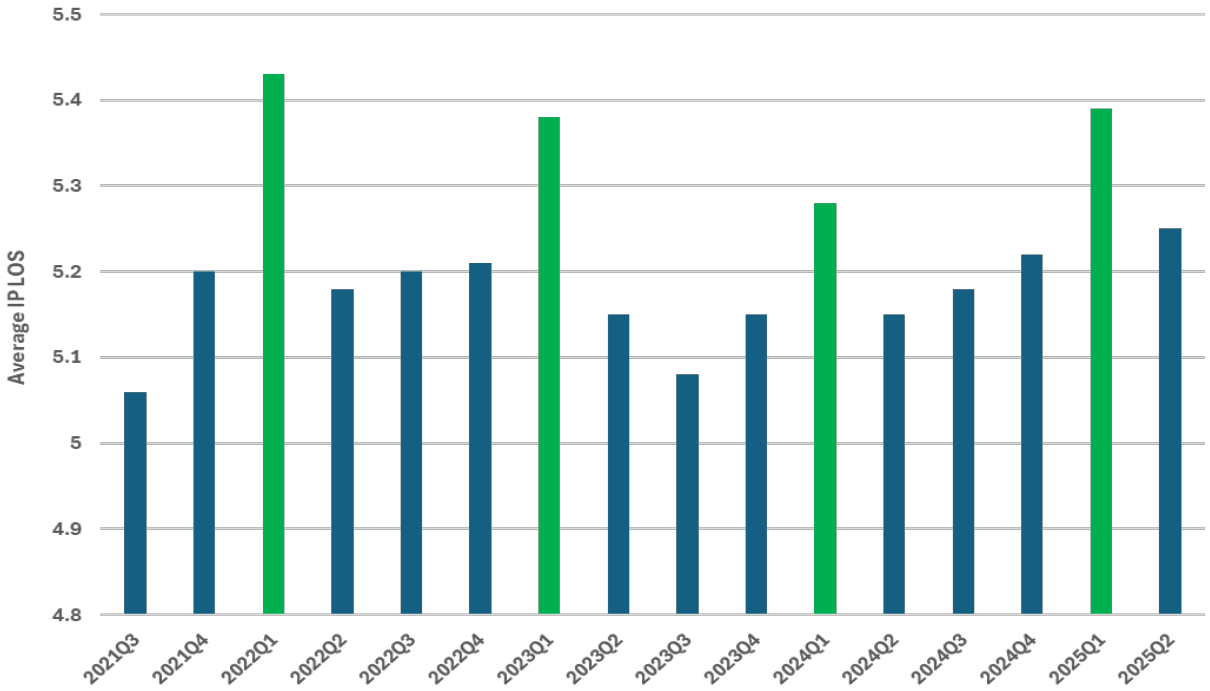


Source: HSCRC Casemix, 2018-2024 FY, risk adjusted by HCUP 2023

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.

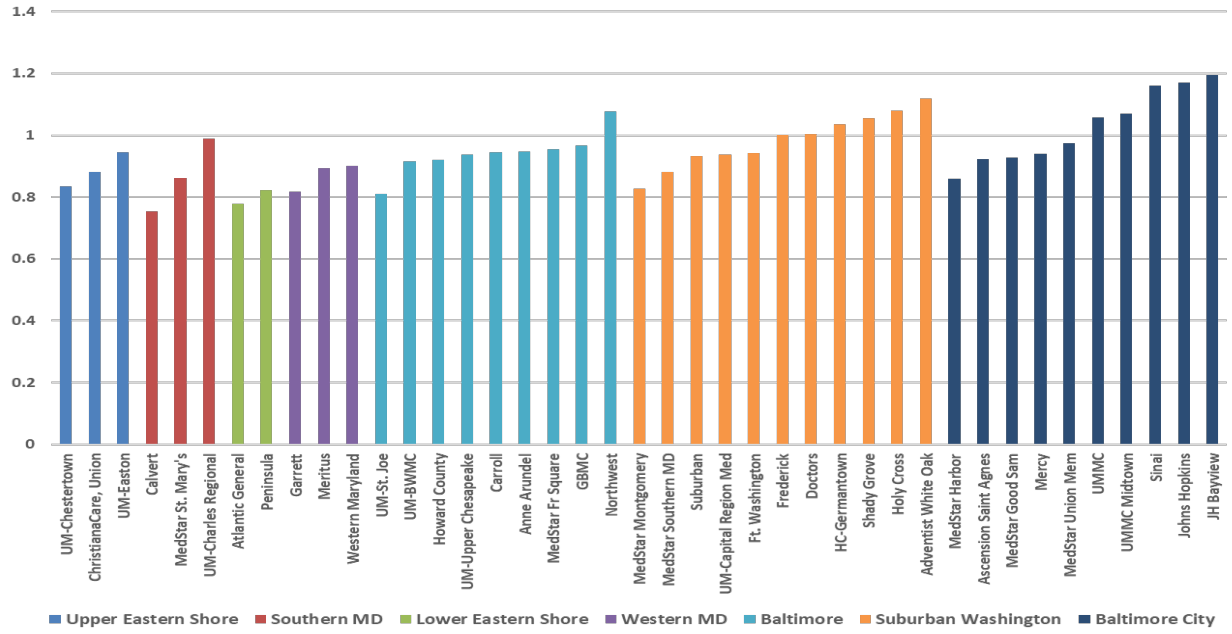
Figure 8. Variation in Inpatient Length of Stay by Calendar-Year Quarter



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.

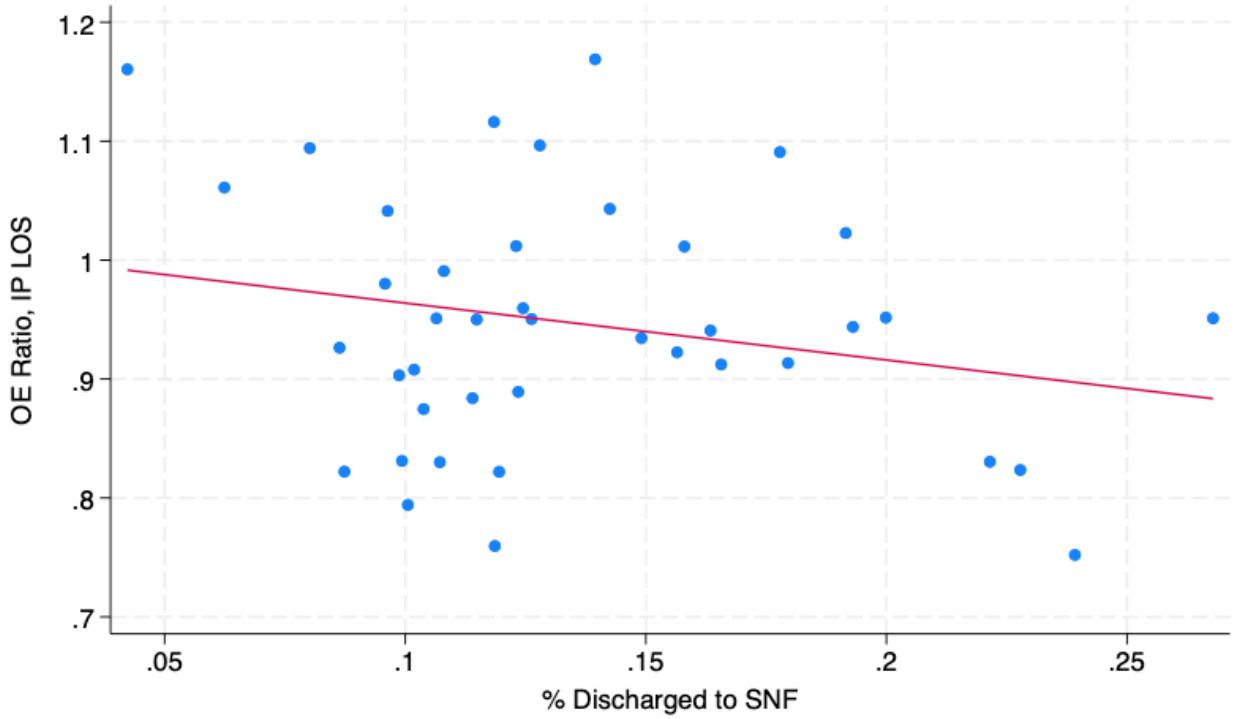
Figure 9. Risk-Adjusted Hospital IP LOS By Region, 2025



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.

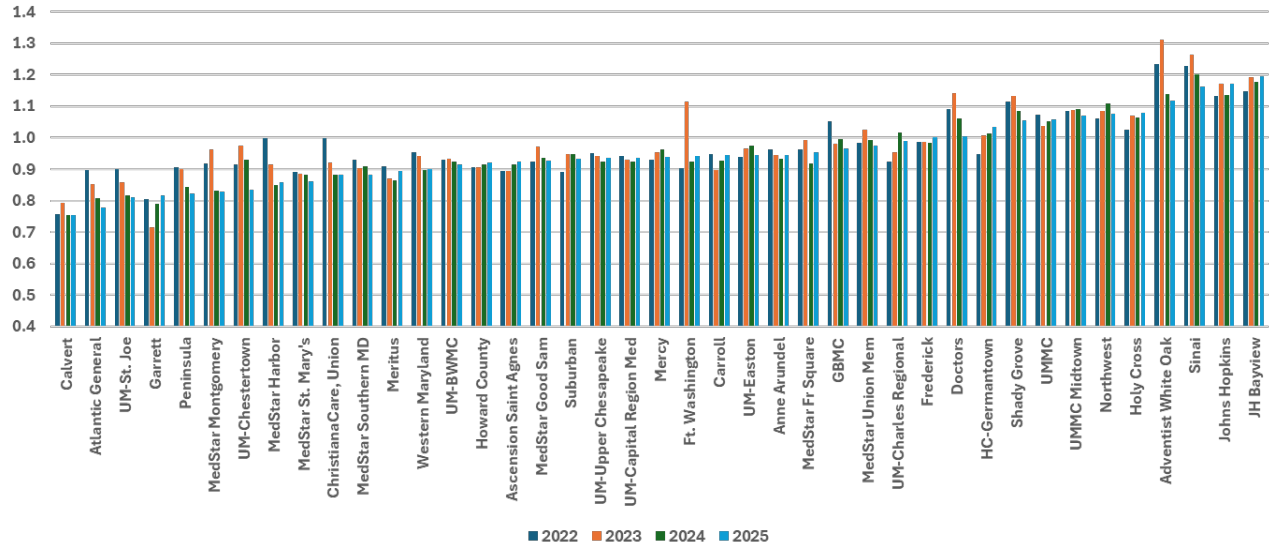
Figure 10. Risk-Adjusted Hospital IP LOS vs. Percent of Patients Discharged to SNF, 2025



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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Select Volume Realignment Policy

Staff Update and Recommendation

April 2026

P: 410.764.2605 4160 Patterson Avenue | Baltimore, MD 21215 hscrc.maryland.gov

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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.

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TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: April 15, 2026

RE: Hearing and Meeting Schedule

May 13, 2026 In person at HSCRC office and Zoom webinar

June 10, 2026 In person at HSCRC office and Zoom webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.