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636th Meeting of the Health Services Cost Review Commission

November 12, 2025

(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 October 8, 2025

Specific Matters

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

Docket Status – Cases Closed

2681A Johns Hopkins Health System
2682A Johns Hopkins Health System

2. Docket Status – Cases Open

2657A Johns Hopkins Health System- Extension Request

Subjects of General Applicability

3. Report from the Executive Director
    a. Model Monitoring
    b. AHEAD Model Update
    c. RY 2026 Uncompensated Care Policy Update
4. Final Adoption: Updates to the Consumer Financial Assistance and Medical Debt Regulations
5. Draft Recommendation: Demographic Adjustment
6. Draft Recommendation: Quality Based Reimbursement (QBR) Program - RY 2028
7. Hearing and Meeting Schedule

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MINUTES OF THE
635th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
OCTOBER 8, 2025

Chairman Joshua Sharfstein 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., Maulik Joshi, D.Ph., Nicki McCann, J.D., Ricardo Johnson, J.D., and Farzaneh Sabi, M.D. Upon motion made by Commissioner McCann and seconded by Commissioner Blum, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 1:10 p.m.

REPORT OF OCTOBER 8, 2025, CLOSED SESSION

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed on October 8, 2025, in the Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM SEPTEMBER 10, 2025, PUBLIC MEETING AND CLOSED SESSION

Upon motion made by Commissioner Sabi and seconded by Commissioner Blum, the Commission voted unanimously to approve the minutes of September 10, 2025, for the Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
CLOSED CASES

2679A Johns Hopkins Health System
2680A University of Maryland Medical Center – WITHDRAWN

ITEM III
OPEN CASES

2681A Johns Hopkins Health System
2682A Johns Hopkins Health System

ITEM IV
PRESENTATION: GREATER BALTIMORE REGIONAL INTEGRATED CRISIS SYSTEM (GBRICS)- REGIONAL PARTNERSHIP CATALYST PROGRAM

Ms. Crista Taylor, President & CEO, Ms. Adrienne Breidenstine, Vice President of Policy and Communication, and Ms. Chauna Brocht, Director of Crisis Services, Behavioral Health System of Baltimore, presented on The Center Maryland Regional Crisis System.

Ms. Taylor detailed the success of the five-year Regional Partnership Catalyst Program, a collaborative effort led by BHSB involving 17 hospitals across Baltimore City and Baltimore, Howard, and Carroll counties. The program's goals were to expand the region's crisis response infrastructure to reduce unnecessary emergency department (ED) visits and minimize police interactions for individuals in behavioral health crises.

The project implemented the national Crisis Now model, which focuses on providing:

1. **Someone to Call:** The region launched a 988-call center, now handling over 4,000 calls monthly with a high-resolution rate.
2. **Someone to Respond:** Mobile crisis services were expanded to be available 24/7, successfully resolving most situations in the community.
3. **Somewhere to Go:** An Open Access network was established, enabling 41 clinics to offer same-day or next-day appointments that 988 call-takers can schedule directly.

Ms. Taylor highlighted the program's long-term sustainability, achieved through a statewide 25-cent telecom fee creating a 988 Trust Fund, a new Medicaid billing rate for mobile crisis services, and a self-sufficient model for the Open Access clinics.

Commissioner McCann expressed pride in the program, praising the unprecedented collaboration between the 17 hospitals and four jurisdictions. She noted the hospitals' selfless commitment, acting solely as a financial pass-through for community funds. She credited the project's success to its intentional, narrow focus, specifically recognizing current and former HSCRC staff for their thoughtful grant design.

No action was taken on this agenda item.

ITEM V
REPORT FROM THE EXECUTIVE DIRECTOR
Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee-for-Service (FFS) data through June 2025 (for claims paid through August 2025). The data showed that Maryland's Medicare hospital spending per capita growth was unfavorable 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 unfavorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail is 1.57 percent above the nation through June 2025, and that Maryland Medicare hospital and non-hospital growth through June resulted in savings of $97 million.

AHEAD Model Update

Executive Director Dr. Jon Kromm reported that significant foundational work for the AHEAD model is underway. The draft State Agreement from the Center for Medicare and Medicaid Innovation (CMMI) is being finalized, the draft Hospital Participation Agreement has been distributed for feedback, and implementation plans are in development.

Dr. Kromm explained that critical policy work is proceeding, focusing on the Demographic Adjustment (DA). Currently, the total DA funding pool is determined by statewide population growth and then distributed to hospitals based on their specific age-adjusted population changes. The AHEAD model fundamentally changes this by allowing the total funding pool to be risk adjusted. The HSCRC must build an entirely new methodology for this, and a workgroup will meet later this month to begin designing the new risk-adjustment policy.

No action was taken on these agenda items.

ITEM VI
PRESENTATION: EPISODE QUALITY IMPROVEMENT PROGRAM (EQIP) PERFORMANCE (CY2024)

Ms. Christa Speicher, Deputy Director, Payment Reform, Ms. Megan Priolo, Executive Director of CRISP, and Mr. Gene Ransom, CEO of MedChi, presented the EQIP Performance for CY2024 (see "EQIP Performance CY2024" available on the HSCRC website).

Mr. Ransom reported that Episode Quality Improvement Program (EQIP) has saved money for the third consecutive year and has widespread support from payers, physicians, and the federal government. The program provides a methodology for practitioners to manage an entire episode of care with the goal of performing under a target price. Uniquely, EQIP includes three

quality measures that ensure patients receive extra services, such as medication reconciliation, and providing more holistic care.

He attributed the program's success to its collaborative three-partner structure:

- **HSCRC:** The referee that sets the rules and manages policy.
- **CRISP:** The data utility that provides practitioners with necessary data and tools.
- **MedChi:** The partner focused on physician education, outreach, and engagement.

Ms. Priolo presented the outstanding results from Program Year 3 (PY3), a year of significant growth:

- **Participation:** The number of participating entities nearly doubled from 64 to 117.
- **Financial Savings:** Total savings increased by 70 percent to $62.6 million.
- **Success Rate and Payouts:** 57 percent of entities achieved shared savings (up from 48 percent last year), with $29.1 million distributed to successful practitioners.

She also outlined future plans, including a massive expansion in Program Year 5 from 50 to 120 available episodes. To support this growth, the HSCRC has created the EQIP Practice Transformation Program Grant (PTPG) to provide targeted resources to smaller, under-resourced practices.

Vice Chairman Elliott asked how this year's savings will be reinvested. Mr. Ransom supported reinvesting the funds and suggested the Commission hold a work session to decide how the gross savings of $62 million should be used.

Chairman Sharfstein asked for clarification on how savings are calculated and why the amount distributed to providers is significantly less than the gross savings. Mr. Ransom explained that providers receive a percentage of the savings based on quality performance, the government retains its share, and the total is adjusted for any necessary corrections.

Chairman Sharfstein also noted that the program's quality measures focus on population health rather than the clinical quality of the episode itself. He expressed concern that a financial incentive to lower costs could unintentionally harm care quality. He strongly encouraged the team, as they develop future policy, to incorporate quality measures directly tied to the clinical outcomes of the care episode to ensure savings do not lead to negative patient consequences.

No action was taken on these agenda items.

ITEM VII
PRESENTATION: SUMMARY OF PHYSICIAN COST REPORT

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, and Mr. Bob Heacox (i3 Consultant) presented the Summary of Physician Cost Report (see "Summary of Physician Cost Report" available on the HSCRC website).

Mr. Henderson presented an update on the Clinician Cost Schedule (CCS), a new data collection tool designed to provide a much clearer and more standardized view of hospital spending on physicians. He explained that the Commission's current data on this topic is highly summarized. The goal of the CCS is to gather more granular information to better understand the scale and nature of hospital subsidies for clinician costs, specifically:

- Capture not just the total cost, but also the volume of work (in Full-Time Equivalents, or FTEs) to understand efficiency.
- Break down costs by clinician specialty (e.g., primary care, hospitalists, anesthesiology).
- Categorize costs by different physician arrangement types (e.g., directly employed, contracted, or part of a related entity).
- Understand the net cost by accurately matching physician compensation with the professional fee revenue they generate.
- Ultimately, break down this data by payer.

Mr. Henderson shared the aggregate results from the second pilot of the CCS, which used FY 2024 data from 38 of the state's 45 hospitals. He noted this data would not be released at a hospital-specific level to allow hospitals to refine their reporting without immediate policy implications. A major caveat is that Johns Hopkins was among the seven hospitals excluded from this aggregate data due to the complexity of their faculty practice plan structure.

The key aggregate findings from the 38 participating hospitals were:

- **Total Clinicians**: 5,100 clinician FTEs (which includes both physicians and Advanced Practice Providers like PAs and NPs).
- **Total Compensation**: $1.5 billion in total compensation was paid to these clinicians.
- **Offsetting Revenue**: $600 million in professional fee revenue was collected, offsetting a portion of the compensation costs.
- **Net Cost**: This leaves a net cost, or subsidy, of approximately $900 million.

It's important to note that this figure currently excludes the costs of clinician support, such as office staff, due to inconsistent reporting during the pilot phase.

The presentation provided a deeper look at where the money is going:

- **By Employment Type**: The largest portion of the total $1.5 billion in compensation ($820 million) was for clinicians in "related entities" of the hospital, followed by directly employed ($400M) and contracted ($270M).
- **Average Per Hospital**: The average net cost (subsidy) per hospital was $23.4 million. This figure represents about 7.5 percent of the average hospital's regulated revenue, which is consistent with other data and helps explain the common gap between a hospital's regulated margin and its lower total margin.
- **By Specialty**: About 50 percent of the net subsidy is spent on hospital-based specialties like anesthesiology, hospitalists, and emergency medicine. Primary care accounted for 6percent of the net spend, with the remainder split between various surgical and non-surgical specialties.

Mr. Henderson acknowledged several challenges from the pilot, including inconsistent definitions for benefits, mapping to standard specialty categories, and a lack of payer mix data. These issues are being addressed for the first official, mandatory reporting year.

The timeline going forward is:

- **October 2025:** Release a public file with the aggregate FY 2024 pilot data.
- **December 15, 2025:** The deadline for hospitals to submit their mandatory FY 2025 CCS data.
- **February/March 2026:** The HSCRC staff aims to present the first official, comprehensive FY25 results to the commission.
- **Future Plan:** The goal is to begin incorporating this clean, standardized data into the Commission's methodologies, initially for informational purposes.

It was noted that the data does not yet capture how clinicians are paid (e.g., salaried vs. volume-based), a point Chairman Sharfstein suggested would be important for future policy considerations.

Mr. Heacox explained the philosophy behind the Clinician Cost Schedule's (CCS) development. He noted that while hospitals are generally supportive and want to submit this data, they are also cautious and want to understand how each piece of information will be used. To build trust and avoid creating a rumor mill, his team adopted a deliberate, iterative strategy: they would not

ask for a piece of data unless they were prepared to do something with it. The process has been a learning experience over three versions, with each iteration being refined based on the feedback and confusion from the prior one, leading to much greater confidence in the current tool.

Commissioner Sabi inquired on differentiating between costs for direct patient care (like salaries) versus non-direct costs. Her primary concern is the significant and growing expense of on-call stipends, which she argues are not payments for hands-on patient care. She asked the Staff to determine who should be responsible for bearing the financial burden of these mandatory, non-direct care expenses. Mr. Heacox confirmed that the current version of the CCS is now specifically designed to capture this crucial on-call data. He stated that the new submission template asks hospitals for specific details on on-call coverage, including:

- The number of hours committed.
- The specific specialties providing the on-call service.
- The type of remuneration being given for that coverage.

Chairman Sharfstein emphasized that as the CCS matures, future data requests should be directly linked to potential policy questions. Mr. Heacox noted that the goal is to understand how Maryland differs and to identify tools or strategies used in other states that might not be available here. He confirmed that these issues, especially the on-call cost breakdown and the challenge of interstate benchmarking, are high priorities for their ongoing work.

No action was taken on these agenda items.

ITEM VIII
DRAFT RECOMMENDATION FOR MARKET SHIFT REFINEMENT

Mr. Allan Pack, Principal Deputy Director, Quality and Population-Based Methodologies presented the staff's Draft Recommendation for Market Shift Refinement (see "Draft Recommendation for Market Shift Refinement" available on the HSCRC website).

Mr. Pack's presented the proposed refinements to the Market Shift policy. This policy was designed to ensure hospital funding follows patient choice and maintains market competition within Maryland's global budget system. The proposals address three primary areas of concern: variable cost factor, definitions of markets and service line exclusions.

Variable Cost Factor

The Market Shift policy adjusts hospital funding for changes in patient volume but only accounts for variable costs (like drugs and supplies), not fixed costs.

- The historical variable cost factor was a flat 50 percent, which Maryland Hospital Association (MHA) argued was not precise enough.
- Following an MHA suggestion, the HSCRC used actual cost data from annual filings and ran statistical regressions to determine the true variability of costs for different services.
- Staff recommends immediately replacing the 50 percent standard with four more precise, newly calculated variable cost factors:

Inpatient Medical: 57 percent	**Inpatient Surgical:** 66 percent
Outpatient Medical: 54 percent	**Outpatient Surgical:** 63 percent

Definitions of Markets

The state is divided into thousands of small markets where minor, random patient fluctuations can trigger market shift adjustments that don't reflect a true change in preference, leading to statistical instability. This is especially a problem in the inpatient market.

- The inpatient market suffers from low statistical reliability.
- Analysis showed that removing a few low-volume, low-reliability service lines from the calculation significantly improves the policy's stability.
- Staff recommends removing seven service lines from the market shift policy (e.g., Gynecological Surgery, Ventilator Support) and consolidating Spinal Surgery with Neurological Surgery. Volume changes for these removed services would be handled using the same method as the Out-of-State Volume policy, where a revenue adjustment only occurs after a material change in volume.

Service Line Exclusions

The standard market shift policy works well for gradual changes but struggles to account for major, sudden realignments (e.g., a large insurer changing its hospital network), which have previously been handled on an ad hoc basis.

- Large, abrupt volume shifts can cause financial instability for hospitals because the corresponding market shift adjustment is often delayed and imprecise.
- Create a formal process for hospitals to request a temporary exclusion from the market shift calculation during a period of major realignment.

Mr. Pack presented the staff's Draft Recommendation for Market Shift Refinement as follows;

1. Effective immediately, adopt for all volume policies the newly calculated variable cost factors for inpatient medical (57 percent) and surgical (66 percent) and outpatient medical (54 percent) and surgical (63 percent) in lieu of the historical standard of 50 percent.
2. For CY 2026 performance assessments, remove from the Market Shift the following service lines: Endocrinology Surgery; ENT Surgery; Gynecological Surgery; Ophthalmologic Surgery; Thoracic Surgery; Urological Surgery; and Ventilator Support, and consolidate Spinal Surgery and Neurological Surgery. Any volume changes for services removed from the Market Shift as a result of this recommendation shall be adjudicated similar to the Out-of-State Volume policy, i.e., a revenue adjustment will only occur when the volume change is material, i.e., 1 percent of service line revenue when volume increases, 3 percent of service line revenue when volume decreases
3. Officially establish the process described herein, by which Service Line Exclusions from the Market Shift policy can be triggered and adjudicated provided one of the following criteria is met:
    a. Facility Conversions
    b. Intersystem Shifts
    c. Payer Driven Volume Shifts
    d. Material Provider Initiated Shifts
    e. CON Approved Service Line Expansions

Commissioner Johnson questioned why payer-driven volume shifts are excluded from the standard market shift adjustment, only to be addressed by a separate policy. Mr. Pack clarified that the separate policy is designed for integrated systems like Kaiser, who can provide the precise claims data needed for an accurate funding reallocation. He was not confident non-integrated carriers could provide data with the same reliability, which is essential for a precise adjustment. For other major carrier shifts, the standard market shift policy would still act as a fail-safe, though it would be less accurate and not occur in real time. He acknowledged the concern and agreed that a policy for non-integrated carriers could be a future development.

Chairman Sharfstein asked for a practical explanation of the Interclass Correlation Coefficient (ICC) statistic. He wanted to understand what it means when one service line has a high ICC, and another has a low ICC. Mr. Pack explained that the ICC score helps distinguish between a genuine market change and random statistical variation. A high ICC means a volume shift is more likely due to a genuine change in the market, such as patient choice or superior service offerings at the receiving hospital. It indicates a reliable, stable pattern. A low ICC, often found in services with low patient volume, means a shift is more likely due to random variation.

Chairman Sharfstein also presented a scenario to test the concept: If a doctor goes on vacation and their patient volume temporarily goes to another hospital, why wouldn't that be considered a valid market shift, since the volume did, in fact, move. Mr. Pack clarified that the problem with treating random variation as a market shift is that it could unfairly penalize a hospital's funding. If the system incorrectly labels a temporary dip as a permanent market loss, the hospital may never get the funding back, even after the doctor returns from vacation and the patient volume normalizes.

No action was taken on these agenda items.

ITEM IX
DRAFT RECOMMENDATION FOR SELECT HOSPITAL VOLUME REALIGNMENT

Mr. Allan Pack, Principal Deputy Director, Quality and Population-Based Methodologies, presented the staff's Draft Recommendation for Select Hospital Volume Realignment, (see "Draft Recommendation for Select Hospital Volume Realignment" available on the HSCRC website). Commissioner Sabi recused herself from the discussion.

Mr. Pack noted that Kaiser Permanente (KP), as Maryland's second-largest insurer and an integrated health system, periodically makes significant changes to its core hospital partnerships. In the past, the HSCRC's method of estimating the financial impact of these realignments in advance and reconciling them later proved inaccurate.

He also demonstrated why the standard market shift policy is unsuitable for these events. The policy can misinterpret a deliberate business decision such as two hospitals in one system consolidating services and incorrectly attribute the resulting volume change to a competing hospital. This flaw highlights the need for a separate, more direct method to handle large-scale, payer-driven shifts.

To avoid past inaccuracies, Mr. Pack presented a unique, temporary solution designed to precisely measure the impact of Kaiser's upcoming realignment. The process will unfold in three phases:

Phase 1: Identification and Carve-Out (January 1, 2026)

- The HSCRC will identify 19 hospitals where KP has a material presence (defined as over $5 million in revenue and 2 percent of the hospital's Global Budget).

- Effective January 1, 2026, all of KP's patient volume and associated revenue will be removed from the global budgets of these facilities.

Phase 2: Data Collection via Fee-for-Service (Jan. 1, 2026 – June 30, 2027)

- For the next 18 months, these hospitals will be reimbursed for services provided to KP patients on a fee-for-service basis.
- This temporary model bypasses the standard policies, allowing the system to accurately track where KP's patient volume shifts in real-time.
- The 18-month period is necessary to gather a full year of data and account for the typical data lag before final calculations can be made.

Phase 3: Rebuilding Global Budgets (July 2027)

- Using verified data from 2026, the HSCRC will permanently integrate the new KP volume distribution into the global budgets of the affected hospitals.
- From this point forward, the new baselines will be subject to the standard market shift and demographic adjustment policies.

The total volume added back to the system in July 2027 will equal the volume removed in January 2026, ensuring the realignment does not create artificial growth. For any hospital that has experienced a significant KP shift before the official start date, the HSCRC will perform a one-time assessment to provide any necessary funding adjustments.

Mr. Pack presented the staff's Draft Recommendation for Select Hospital Volume Realignment as follows;

1. From January 1, 2026, through June 30, 2027, remove, for select hospitals, KP volumes and revenues evaluated in the Market-shift policy from global budget revenues.
2. Allow removed KP volumes and revenues to be reimbursed in real time through a volume-variable evaluation, using HSCRC rates.
3. On July 1, 2027, build back into global budgets removed KP volumes and revenues based on volumes reimbursed through a volume variable evaluation from January 1, 2026, through December 31, 2026.

Commissioner McCann asked how the policy will account for hospitals at capacity that lose KP volume only to backfill it with other patients, therefore experiencing no real net loss. She also asked if the realignment includes patients admitted through the emergency room, questioning whether mandatory transfers to core hospitals would create significant ED throughput delays.

Ms. Allison Taylor (a Kaiser Representative, via Zoom) confirmed that the goal is for planned procedures to take place at KP's core hospitals. Regarding the more complex issue of patients admitted through a non-core emergency room, she stated it would likely be handled on a case-by-case basis, acknowledging the sensitivity around transfer delays. However, she was committed to taking the concerns back to provide more specific answers to the workgroup.

Chairman Sharfstein asked for clarification on the process of removing volume from global budgets during a payer shift. Specifically, the revenue removed from both the hospital losing the patients and the hospital gaining them and whether 100 percent of the revenue is removed. Mr. Pack confirmed that yes, the adjustment is made for both hospitals. However, he clarified that it is not 100 percent of the revenue. Only the variable cost portion (proposed at 59 percent) is removed from the losing hospital's budget. The fixed-cost portion of the revenue remains, meaning the hospital does not need to backfill those patients just to cover its fixed costs.

No action was taken on these agenda items.

ITEM X
DRAFT RECOMMENDATION: EMERGENCY DEPARTMENT (ED) BEST PRACTICES POLICY

Ms. Tina Simmons, Associate Director for Quality Methodologies, presented the staff's Draft Recommendation on the ED Best Practices Policy (see "Draft Recommendation on the ED Best Practices Policy" available on the HSCRC website).

Ms. Simmons presented a draft recommendation to continue the current Calendar Year (CY) 2025 ED Best Practice policy for CY 2026, including:

- Continue the implementation and expansion of the two best practices they have already selected.
- Continue to be required to report data on their progress.
- Continue to be subject to a penalty for non-reporting, but not for performance. The policy remains a pay-for-reporting model for now.

The HSCRC will receive the 2025 data in December of this year and plans to return in the spring of 2026 with a more detailed analysis of the program's full impact.

The recommendation to roll over the existing policy is based on three main factors:

1. The full data set for 2025 will not be submitted until December, leaving no time to analyze the program's impact and design a new performance-based policy for 2026.
2. There is still uncertainty about how various quality programs will align under the new AHEAD model. Continuing the current program avoids making significant changes that might conflict with the future structure.
3. This continuation gives hospitals more time to "hardwire" the best practices they have already implemented and foster the necessary culture change to support them.

Ms. Simmons shared preliminary data from two hospitals, emphasizing that even with limited data, the focused attention on ED metrics is showing significant positive results.

Hospital	Project Implemented	Outcome Results	Success Story
Bayview Medical Center	Patient Flow Throughput Council	• **ED Boarding Time:** Decreased by 33 percent, from over 12 hours to 8 hours. • **Patient Walkout Rate:** Decreased from 26.4 percent to 19.7 percent.	The hospital directly attributes these key metric improvements to the new council
Suburban Hospital	Daily Huddles and a Bed Capacity Alert System	• **ED Length of Stay:** Decreased by 24 minutes. • **Inpatient Length of Stay:** Decreased from 5.5 days to 5.4 days.	Suburban Hospital achieved these improvements despite experiencing notable increases in both ED and inpatient patient volumes during the same period.

Ms. Simmons presented the staff's Draft Recommendation for ED Best Practices Policy, as follows:

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve ED and hospital throughput and reduce ED length of stay (LOS).
    - For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice. Weighting of tiers will be determined in CY 2026 after CY 2025 data is collected and analyzed.

2. Require hospitals to select two Best Practices to implement and report data on for RY 2028.
    - Failure to implement and report data to the Commission by December 31st, 2026, will result in a 0.1 percent penalty on all-payers, inpatient revenue to be assessed in January 2027.
3. HSCRC intends to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the CY 2025 and CY2026 Best Practice program impact is assessed.

No action was taken on these agenda items.

ITEM XI
HEARING AND MEETING SCHEDULE

November 12, 2025, Time to be determined
4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:15 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission
October 8, 2025

Chairman Sharfstein stated the reasons for Commissioners to move into administrative session, under the authority provided by the General Provisions Article §3-103 and §3-104, for the purposes of discussing the administration of the Model, the FY26 Hospital unaudited financial performance, Regional Partnership Program and the AHEAD model update.

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, Joshi, Johnson, McCann, and Sabi.

Staff members in attendance were Jon Kromm, William Henderson, Allen Pack, Claudine Williams, Alyson Schuster, Cait Cooksey, Erin Schurmann, Christa Speicher and William Hoff.

Joining by Zoom: Deb Rivkin, Laura Goodman and Assistant Attorney General Rhonda Edwards.

Item I

Ms. Erin Schurman, Associate Director, Strategic Initiatives, updated the Commission on the Regional partnership program.

Item II

Dr. Jon Kromm, Executive Director updated the Commission on the status of the AHEAD model.

Item III

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

Item IV

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

The Closed Session was adjourned at 12:35 p.m.

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Alternative Method of Rate Determination

Johns Hopkins Health System

Request for Extension

November 12, 2025

Johns Hopkins Health System- Request for Extension

- On July 25, 2025 staff approved a 3-month extension of the alternative rate arrangement between Johns Hopkins Health System (JHHS) and Cigna Health Corporation (Cigna), Proceeding 2657A. The extension expires on November 30, 2025.
- On October 21, 2025 JHHS requested the Commission extend the rate arrangement an additional two months to complete contract negotiations with Cigna.
- Staff's review of historical data has shown the rate agreement has been favorable.
- Staff recommends the 2-month extension be granted contingent upon completion of negotiations by January 31, 2026. If negotiations are not completed by this date, staff recommends that no more services be provided under arrangement until a new application is submitted.

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Request For Extension of Approval

Johns Hopkins Health System

November 12, 2025

Background

On July 25, 2025, in accordance with the authority granted to it by the Commission, staff approved a 3-month extension of the Commission's approval of the alternative rate arrangement between the Johns Hopkins Health System (JHHS) and Cigna Health Corporation (Cigna), for solid organ and bone marrow transplants and ventricular assist device (VAD) services, Proceeding 2657A. The extension expires on November 30, 2025. However, JHHS and Cigna have not yet completed negotiations to extend the arrangement.

Request

JHHS requests that the Commission extend its approval for an additional two months, to January 31, 2026, to complete negotiations.

Findings

Staff found that the experience under the current arrangement has been favorable.

Staff Recommendation

Staff recommends that the Commission grant JHHS's request for a two-month extension of its approval, 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.

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Update on Medicare FFS Data & Analysis

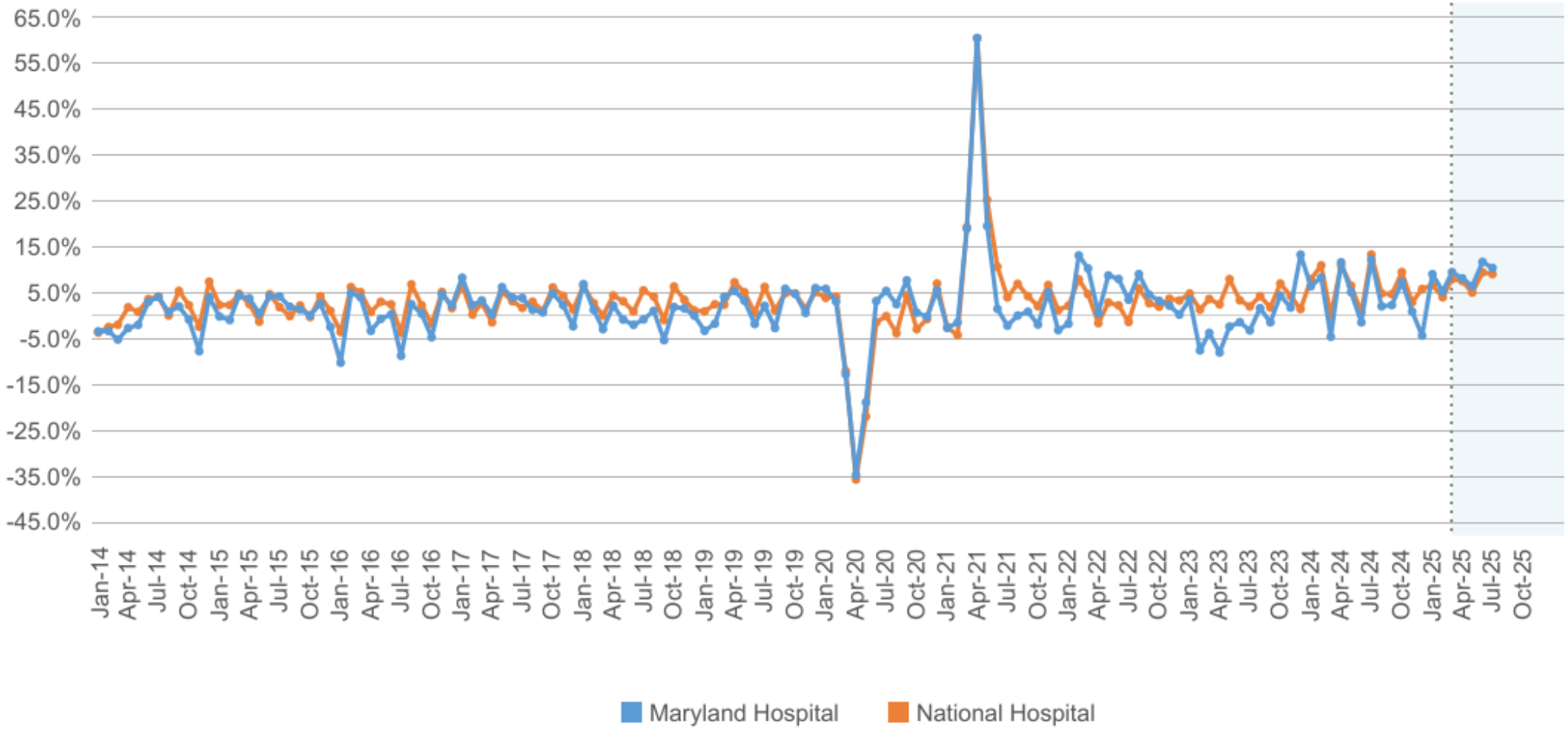
November 2025 Update

Data through July 2025, Claims paid through September 2025

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

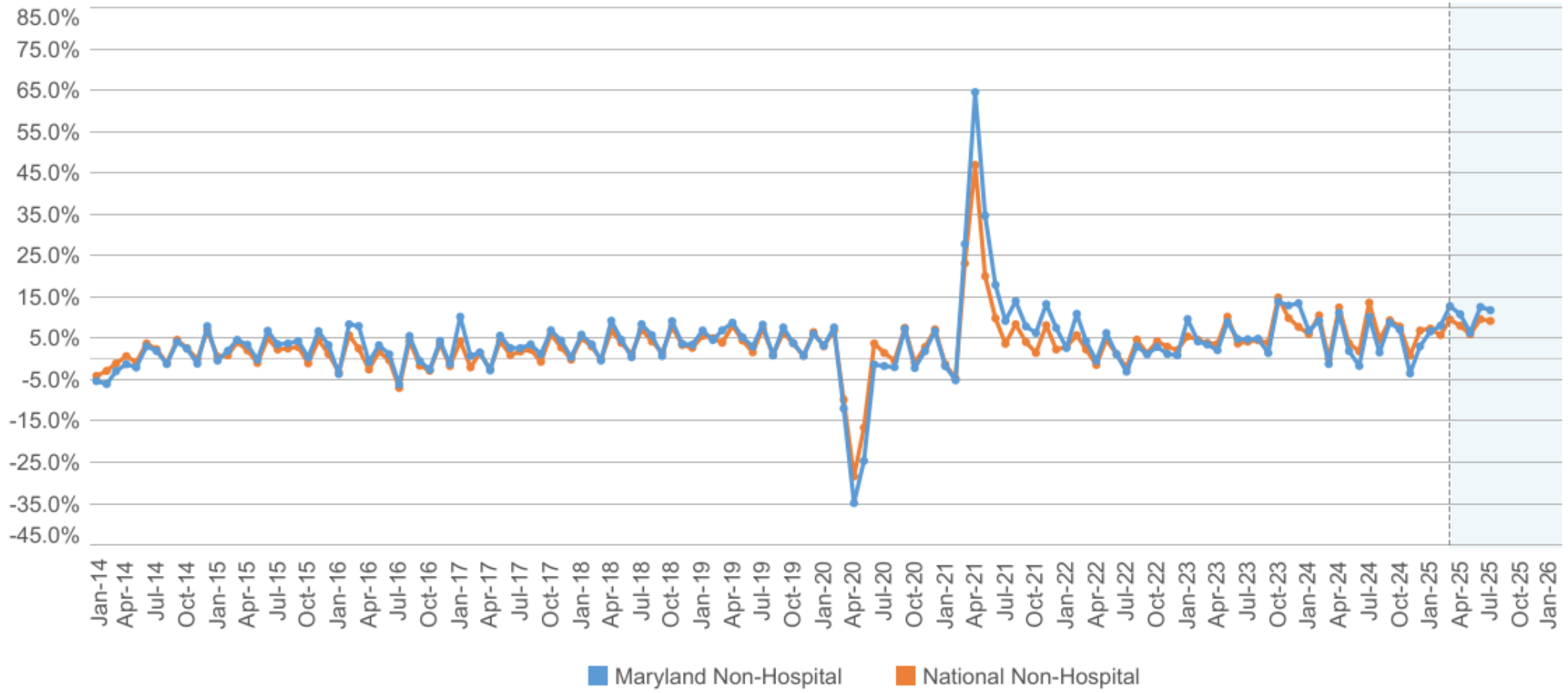
Actual Growth Trend (CY month vs. Prior CY month)



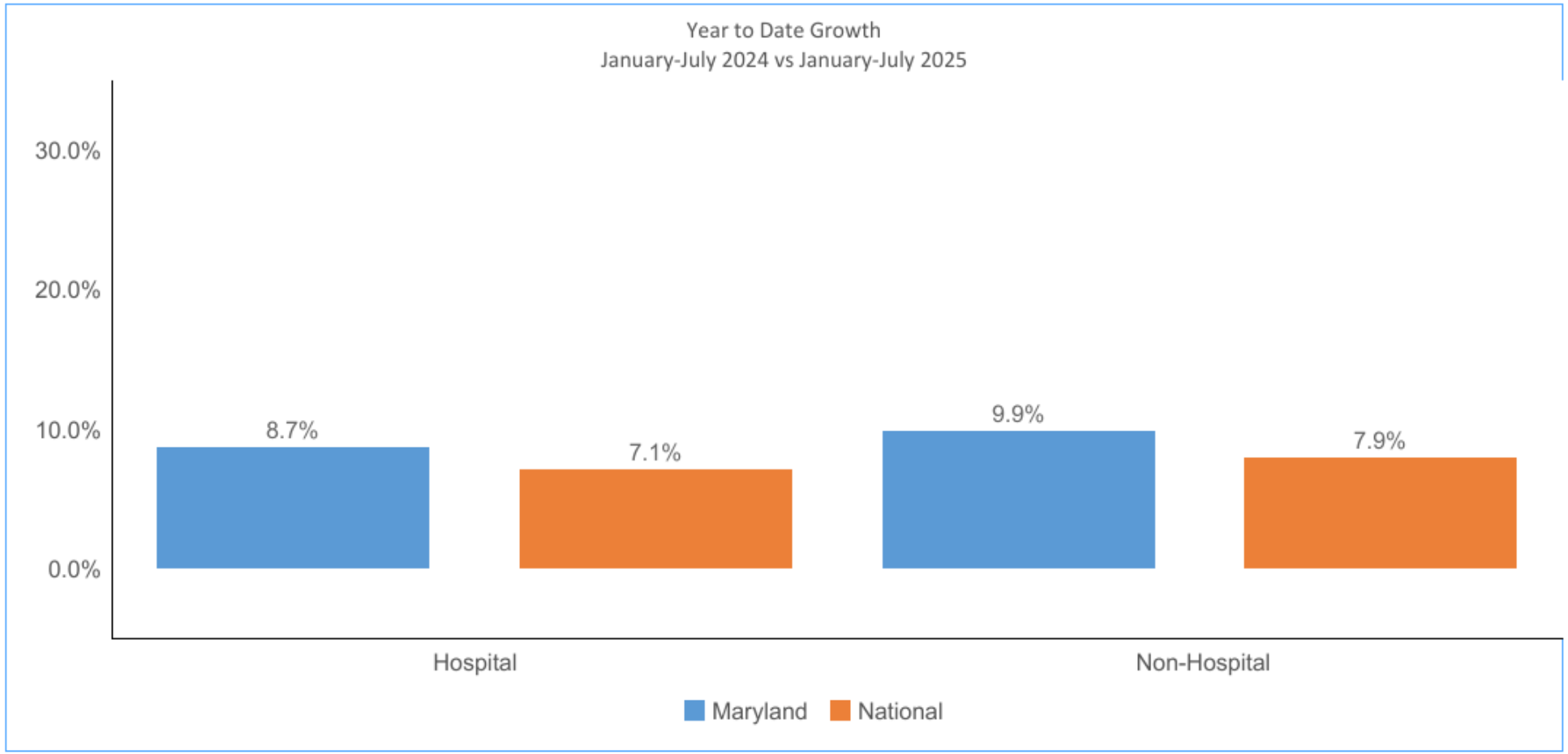
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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

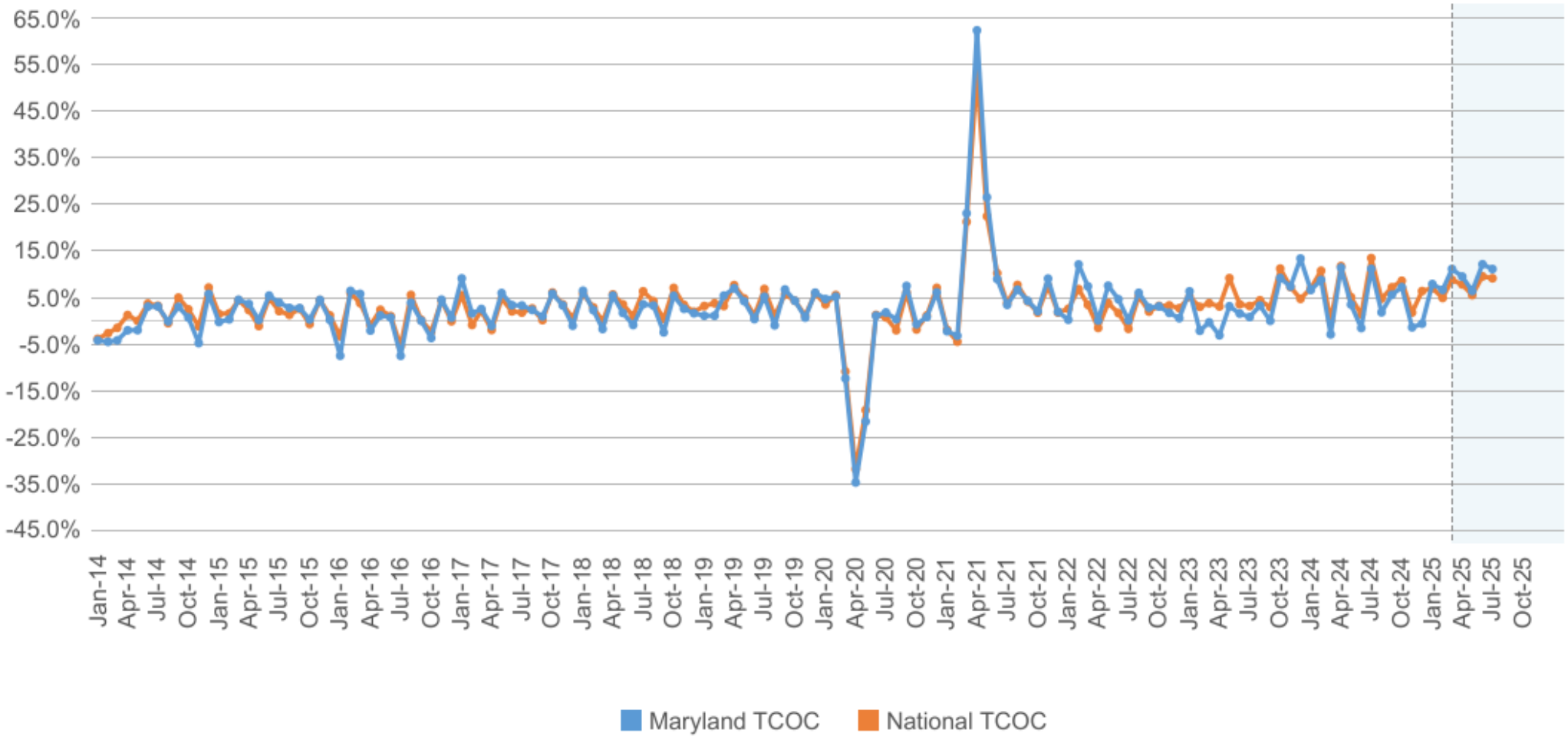


Medicare Hospital and Non-Hospital Payments per Capita



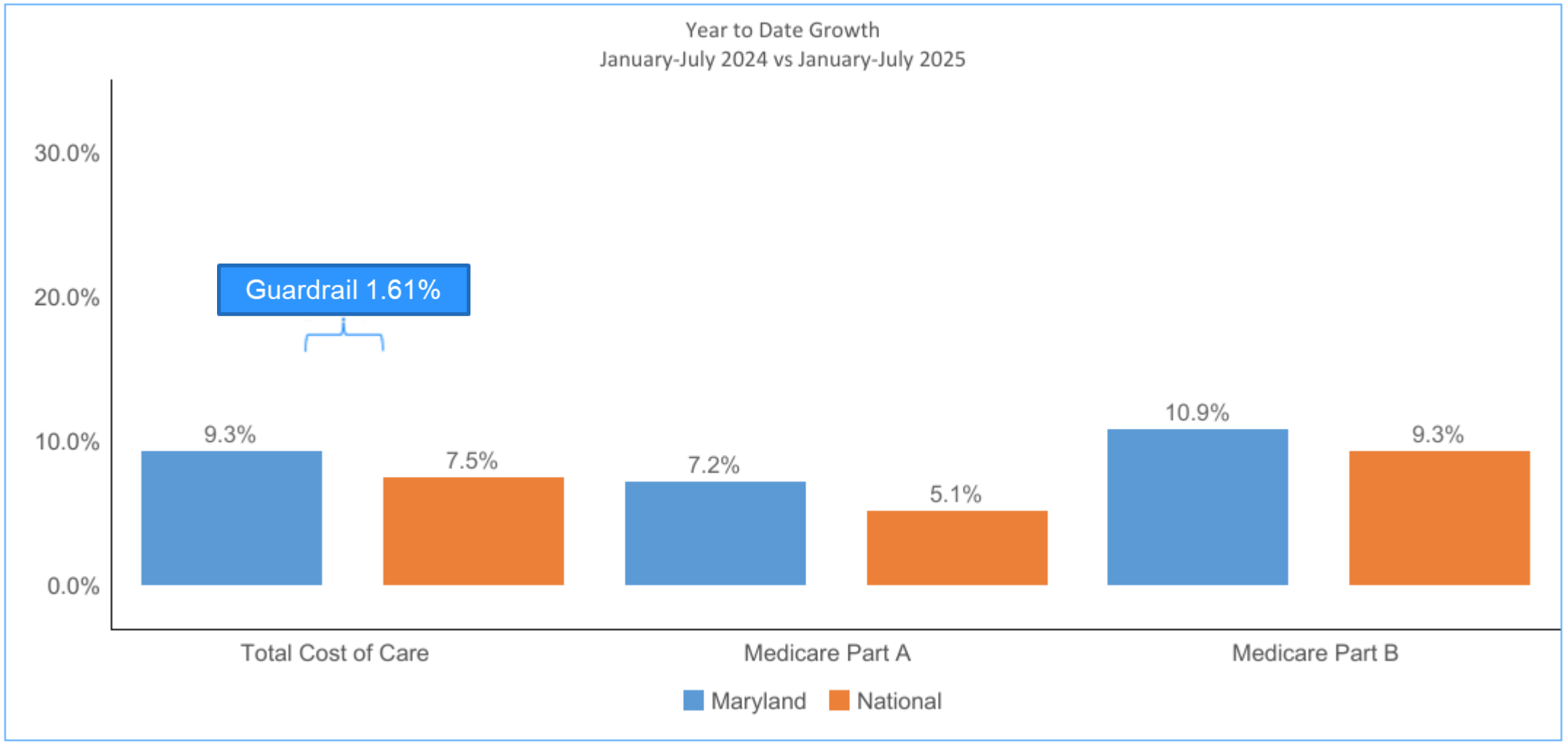
Medicare Total Cost of Care Spending per Capita

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



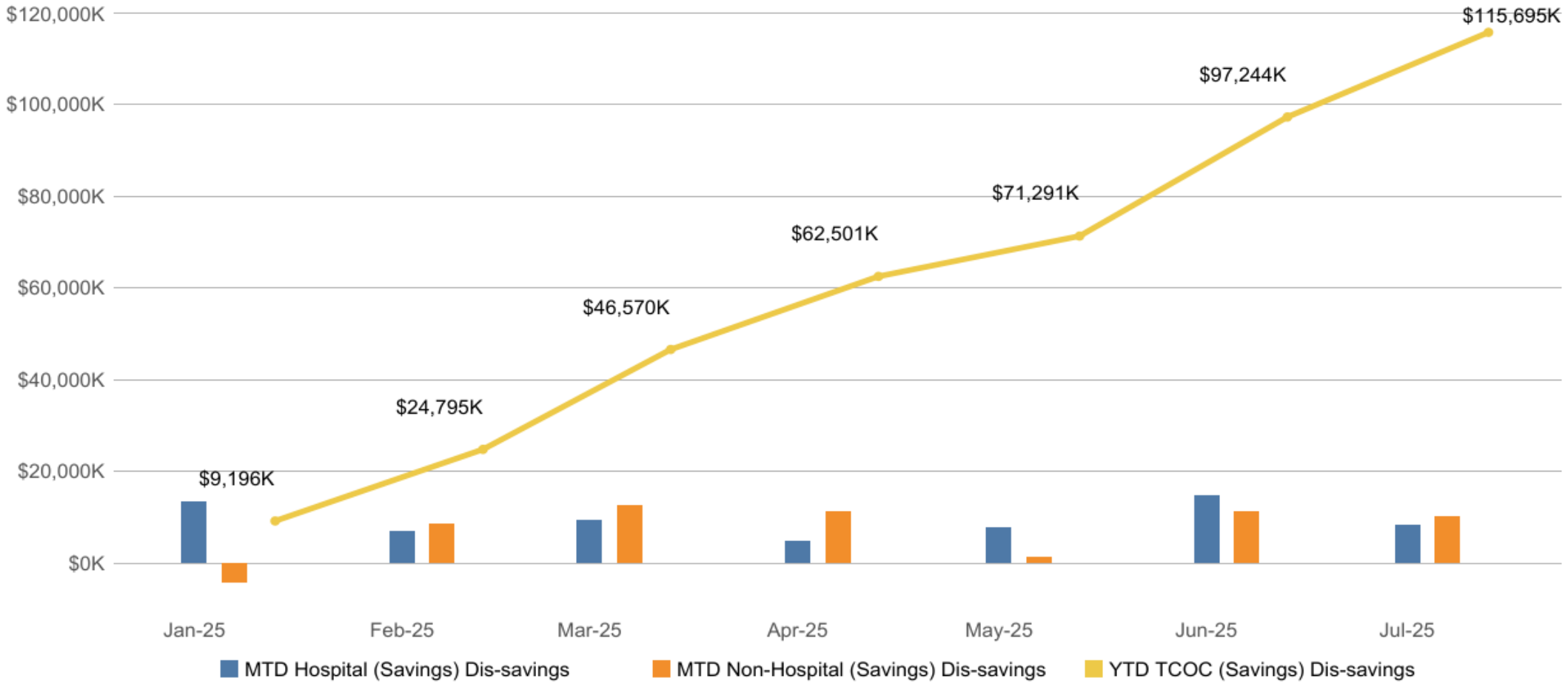
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through July 2025



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AHEAD Model Policy Timeline

HSCRC Workplan

November 2025

HSCRC AHEAD Model Policy Timeline (2025-2026)

A. Policy Updates Already Planned

- The timeline for these items has already been discussed at HSCRC meetings.

B. Required Changes for AHEAD Implementation

- The AHEAD Model will require changes to some core HSCRC financial policies.

C. AHEAD-Related Policy Changes

- Policy development work not explicitly required by the AHEAD Model, but where policy changes can promote success.

D. Policy Changes Involving Multiple Agencies

- These items involve significant leadership outside HSCRC, with a role for HSCRC in policy development and implementation.

HSCRC AHEAD Model Policy Timeline (2025-2026)

	25-Oct	25-Nov	25-Dec	26-Jan	26-Feb	26-Mar	26-Apr	26-May	26-Jun	26-Jul	26-Aug	26-Sep	26-Oct	26-Nov	26-Dec	27-Jan
A. HSCRC Policy Updates Already Planned																
Market Shift	D		F	--->												
Demographic Factor	W	D	W/F	W/F					---> (Possibly Retrospective to Jan 1)							
Respiratory Surge			D	F	-> FY25 Imp.		D	F	---> FY26 Impact							
B. HSCRC Policy Changes Required for AHEAD Implementation																
Global Budget Carveouts									--->							
Aligning Quality Metrics with CMS																
Major Capital Program		F									D		F		--->	
Medicare Hospital Global Budget supplemental payments and exclusions																
Care Innovation				P		D		F	--->							
GBR 2028 Policy Review															--->	
C. AHEAD-Related HSCRC Policy Changes																
Physician Costs	P															
Efficiency Policy					P	P										
Preventable Utilization - Length of Stay	W		D		F	--->			--->						--->	
Preventable Utilization - Avoidable Use				P	W	W	D	F	--->							
Health System Transformation Policy						P										
D. Multi-Agency Priorities																
Maryland-Specific Metrics for AHEAD																
GME/Workforce Strategy							P	P	D	P	P	P	F			
Denials																
Medicare Advantage	P	P/D	F													
Post-Acute Strategy							P	P	D	P	P	P	F			
Cost-Shifting	P	P/D	F													
TCOC and Primary Care Targets				P	P		P	D				F				
Choice and Competition				P	P	P	D	P	P			F				--->
Emergency Department Wait Times	W	D	W										F			

Key
P: Public Input
W: Workgroup
D: Draft Recommendation
F: Final Recommendation

HSCRC Policy Work Currently Underway

Item	Center(s)	Description
Updating the Marketshift Methodology *Anticipated implementation: January 2026*	Population-Based Methodologies	Better reflect the different variable costs of different types of services and to consolidate those markets that are statistically unstable, in response to hospital concerns..
Risk-Adjusting the Demographic Factor *Anticipated implementation: July 2026, retrospective to January 2026*	Population-Based Methodologies	Develop a methodology to risk-adjust the demographic adjustment for the update factor.
Respiratory Surge *2024-2025 allocation finalized in December 2025*	Population-Based Methodologies	Adopt a methodology to distribute approved funds for the 2024-2025 respiratory season, then to determine the methodology going forward.

HSCRC Core Policy Changes for AHEAD

Item	Center(s)	Description
Global Budget Carveouts *Anticipated implementation: July 2026*	Population-Based Methodologies, Medical Economics and Data Analytics	Determine services that could be carved out of global budgets and still meet AHEADs' 85-percent hospital revenue population-based requirement.
Aligning Quality Metrics with CMS *Policy development in 2026; payment adjustments starting in 2028*	Population-Based Methodologies, Medical Economics and Data Analytics	Adapt and align Maryland hospital quality programs with national policies, including considerations for Medicaid and commercial programs.
Major Capital Program *Policy development and implementation in 2026*	Population-Based Methodologies	Assure existing commitments and develop an approach for future investments.
Medicare Hospital Global Budget Supplemental Payments and Exclusions *Policy development and implementation in 2026*	Population-Based Methodologies, Medical Economics and Data Analytics	Work with stakeholder to coordinate funding across Medicare and HSCRC global budgets, to evaluate funding for items such as disproportionate share hospital payments and graduate medical education.
Care Innovation *Early 2026*	Medical Economics and Data Analytics, Population-Based Methodologies	Expand and transition innovative incentive programs, *e.g.,* Care Transformation Initiatives and Regional Partnerships, such as GBRICS.
GBR 2028 Policy Review *Implementation as appropriate upon review*	Hospital Rate Regulation, Medical Economics and Data Analytics, Population-Based Methodologies, Health Data Management and Integrity	Review each global budget policy and input to determine potential updates as a result of changes due to AHEAD, then effectuate across data collection, rate-setting, policy evaluation and quality.

Major Capital Policy: Existing Commitments

The Commission is committed to honoring capital funding requests that have been approved and have a go-live date after 2026 and will work with impacted hospitals and CMMI to account for obligated rate increases.

AHEAD-Related HSCRC Policy Changes

Item	Center(s)	Description
Physician Costs *Data presentation October 2025*	Medical Economics and Data Analytics, Population-Based Methodologies	Provide policymakers with cost-analysis data on hospital-based physicians.
Efficiency Policy *Policy development and implementation in 2026*	Population-Based Methodologies	Seek public input on options to update the efficiency policy.
Preventable Utilization *Length of stay: Policy development in 2025-2026; payment adjustments in 2027* *Avoidable use: Policy development early 2026*	Population-Based Methodologies	Develop policies for length of stay, as well as avoidable use.
Health System Transformation Policy *Policy development starting in early 2026*	Medical Economics and Data Analytics, Population-Based Methodologies	Identify needed changes under AHEAD for system transformation, *e.g.,* excluding latent demand-based service line changes from Marketshift and broader facility changes.

Multi-Agency Priorities

*Coordinated by Regulatory Working Group

Item	Participating Agencies	Description
Maryland-Specific Measures for AHEAD *Policy development spring 2026*	MDH (Population Health), HSCRC, MHCC, MIA	Statewide population health and quality measures will be selected and designed to be mutually-reinforcing with hospital quality programs.
GME/Workforce Strategy* *Policy development spring 2026*	MHCC, MDH, HSCRC	Statewide workforce development strategy will incorporate comments received by HSCRC regarding potential new approaches to GME.
Denials	MIA, MDH (Medicaid), HSCRC	Work with insurers on best practices for denials.
Medicare Advantage* *Policy discussions 2025; implementation 2026-2027*	MIA, MDH, HSCRC	Maryland has the opportunity to propose/implement stabilization options with an eye on the decision timeframe for the CY 2027 plan year.
Post-Acute Strategy* *Policy development spring 2026*	MHCC, MDH, HSCRC	A multi-agency approach to strengthen quality and availability of post-acute options will facilitate discharge and placement.
Cost-Shifting* *Policy discussions 2025; implementation in 2028*	Governor's Office, MIA, MDH, MHCC, HSCRC	Achieving the savings targets under the AHEAD Model may require shifting costs to commercial consumers.
TCOC and Primary Care Targets* *Policy development early 2026; due September 2026*	MHCC, MDH, HSCRC, MIA	AHEAD requires all-payer targets for TCOC growth and primary care investment, in addition to existing Medicare FFS targets starting in 2028.
Choice and Competition* *Policy plans due December 2026; implementation 2029*	HSCRC, MDH (Medicaid), HSCRC, MHCC, MIA, PDAB	Maryland needs to select and implement policies to enhance choice and competition, to be effected prior to CY 2029.

Multi-Agency Priorities: Updates and Upcoming Opportunities

- Cost-Shifting and Medicare Advantage
  - Stakeholder listening sessions held late October and early November
  - Draft policy proposal under development for public comment
  - Governor's decision anticipated prior to the end of the year
- All-Payer Total Cost of Care Growth and Primary Care Investment Targets
  - Stakeholder engagement opportunities forthcoming (anticipated for January)
  - Executive Order due December 2025
  - Draft targets and methodology for CY 2027-CY 2030 due May 2026
  - Final targets and methodology for CY 2027-CY 2030 due September 2026

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Rate Year 2026 Uncompensated Care Report

November 3, 2025

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

This document contains the staff report for RY 2024 Uncompensated Care Policy. There are no proposed changes in methodology and thus no need for a formal Commission vote at this time.

Table of Contents

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
The purpose of the Uncompensated Care (UCC) policy is to equitably share the financial burden of providing hospital care to patients that are uninsured or underinsured and cannot afford to pay for their care. By including this cost in statewide hospital rates, the HSCRC can ensure that all Marylanders can access care at all hospitals in Maryland.	Funding UCC in the State of Maryland is two fold. 1). Through the UCC markup to hospital rates based on statewide Actual UCC, applied uniformly to acute care hospital rates statewide. For RY 2026, the determined UCC amount to be built into rates for Maryland hospitals is 3.99 percent. 2). Hospital contributions to/from the UCC fund based on a 50/50 blend of Hospital-specific actual UCC and calculated predicted UCC rates.	Under the current HSCRC policy, UCC above the statewide average is funded by a statewide pooling system whereby regulated Maryland acute care hospitals draw funds from the pool should they experience a greater-than-average level of UCC and pay into the pool should they experience a less-than-average level of UCC. This ensures that the cost of UCC is shared equally across all hospitals within the State. For RY 2026, 18 regulated acute care hospitals will pay into the pool while 23 will withdraw from the pool.	UCC is paid by patients and insurers through rates. Therefore, with the incorporation of predicted UCC, the policy incentivizes hospitals to responsibly collect payments from patients and payers who can afford to pay. This prevents UCC costs from rising too quickly, protecting the sustainability of the UCC fund, which in turn ensures that UCC funding remains available for those who truly need it while constraining growth of health care rates for all patients and payers.	The UCC policy represents an underlying historical tenet of health equity in the State, as it ensures that Marylanders, regardless of insurance status, can access care at any hospital and there is no need for public hospitals. All hospitals receive funding from all payers for uncompensated care costs. Hospitals with high volumes of low-income patients are not at a financial disadvantage compared to hospitals with higher income patients, allowing low-income patients to access care at any of the state's hospitals.

INTRODUCTION

The Uncompensated Care Policy was created by the HSCRC to recognize the financial burden borne by hospitals from the continued provision of high quality hospital care to patients who cannot afford to pay for it and to create a financial reimbursement for the provision of Uncompensated Care (UCC) into the rates the Commission sets for hospitals.[1] The UCC policy is a foundational element of equity built into the all-payer system and continued under the Total Cost of Care Model. The purpose of this report is to provide background on the UCC policy and

[1] Maryland has a unique all-payer rate setting system for hospitals, administered by the HSCRC. Acute general hospitals in Maryland must charge patients (and insurers) the rate set by the HSCRC for health care services.

to provide hospital-specific values for the UCC built into statewide rates as well as the amount of funding that will be made available for the UCC pool, the latter of which ensures the burden of uncompensated care is shared equitably across all hospitals.

Uncompensated Care (UCC) is hospital care provided for which no compensation is received, typically a combination of charity care and bad debt.

Charity Care

Charity care services are "those Commission regulated services rendered for which payment is not anticipated".[2] Charity care is provided to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill. There are two types of charity care that may occur across all payers:

1. **Free care** is care for which the patient is not responsible for any out-of-pocket expenses for hospital care. Hospitals are required statutorily to provide free care to patients with a household income less than 200% of the Federal Poverty Level .[3]
2. **Reduced-cost care** is care for which the patient is only responsible for a portion of out-of-pocket expenses and is required for patients with household income between 200 and 300% of the FPL.[4] Reduced-cost care is also required for patients that have a financial hardship[5] and have household incomes below 500% of the FPL. Financial hardship is defined by statute as medical debt, incurred by a household over a 12-month period, which exceeds 25% of household income.[6] There is no prescribed discount that hospitals must provide to patients between 200% and 500% of the FPL. Per statute "if a patient is eligible for reduced-cost medically necessary care, the hospital shall apply the reduction that is most favorable to the patient."[7]

Bad Debt

The other type of Hospital UCC is bad debt, which is for "Commission regulated services rendered for which payment is anticipated and credit is extended to the patient" but the payment is not made. Unpaid cost shares for patients that do not meet the free thresholds can be charged as bad debt after the hospital makes a reasonable attempt to collect those charges.[8] However, there are several reasons that a hospital may not include bad debts into uncompensated care, most notably denials.[9]

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[2] HSCRC Accounting and Budget Manual Section 100, "Accounting Principles and Concepts", p. 39, August 2008, Available at: https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-100-FINAL-08-01-10.pdf

[3] Md. Code, § 19-214.1(b)(2) (i) of the Health General Article

[4] COMAR 10.37.10.26 A-2 (2)(a)(ii)

[5] Md. Code, § 19-214.1(a)(2) of the Health General Article

[6] Md. Code, § 19-214.1(b)(4) of the Health General Article

[7] Md. Code, § 19-214.1(b)(5) of the Health General Article

[8] Bad debt includes unpaid cost share expenses reduced by a reduced-cost care discount for patients eligible for reduced-cost care. The HSCRC requires hospitals to make "a reasonable collection effort" before writing-off bad debt. HSCRC Accounting and Budget Manual Section 100, "Accounting Principles and Concepts", p. 39, August 2008, Available at: https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-100-FINAL-08-01-10.pdf

[9] These include: a) Contractual allowances and adjustments associated with Commission approved differentials—i.e., prompt payment, SAAC, and the differential granted to Medicare and Medicaid.; b) Administrative, Courtesy and Policy Discounts and Adjustments - These include, but are

HSCRC's UCC policy assures access to hospital services in the State for those patients who cannot readily pay for them and equitably distributes the burden of uncompensated care costs across all hospitals and all payers. This approach ensures that hospitals with high volumes of low-income patients are not at a financial disadvantage.

For RY 2026, the determined UCC amount to be built into rates for Maryland hospitals is 3.99 percent. Under the current HSCRC policy, UCC above the statewide average is funded by a statewide pooling system whereby regulated Maryland hospitals draw funds from the pool should they experience a greater-than-average level of UCC and pay into the pool should they experience a less-than-average level of UCC. This ensures that the cost of UCC is shared equally across all hospitals within the State.

METHODOLOGY

The UCC methodology is a cornerstone of the HSCRC's all payer system. In addition to equitably supporting financial assistance for low income patients, the policy incentivizes hospitals to responsibly collect payments from patients and payers who can afford to pay. This prevents UCC costs from rising too quickly, protecting the sustainability of the UCC fund, which in turn ensures that UCC funding remains available for those who truly need it while constraining growth of health care rates for all patients and payers.[10]

The HSCRC prospectively calculates the amount of uncompensated care provided in hospital rates at each regulated Maryland hospital using a multi-step process:

1. **Statewide Actual UCC in All-Payer Hospital Rates:** HSCRC builds UCC funding into hospital rates based on the total amount of charity care and bad debt reported by all acute hospitals for the previously completed fiscal year. The UCC markup to hospital rates is based on statewide actual UCC, expressed as a percent of gross patient revenue, and is applied uniformly to acute care hospital rates statewide. For example, in RY 2026, HSCRC staff will use RY 2024 statewide UCC experience of 3.99 percent to determine the UCC amount built into all hospital rates.

2. **Hospital Payments or Contributions to the UCC Fund**

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not limited to, reductions from established rates for courtesy discounts, employee discounts, administrative decision discounts, discounts to patients not meeting charity policy guidelines, undocumented charges and, payments for services denied by third party payers; c) Charges for medically unnecessary hospital services;). Charges written off that are not the result of a patient's inability to pay or where the hospital has not expended a reasonable collection effort - 08/01/08 SECTION 100 ACCOUNTING PRINCIPLES AND CONCEPTS I

[10] Other states have struggled to maintain sustainable uncompensated care funds. One example is New Jersey. H S Berliner, S Delgado, "The rise and fall of New Jersey's uncompensated care fund", J Am Health Policy. Sep-Oct 1991;1(2):47-50. https://pubmed.ncbi.nlm.nih.gov/10112731/.

The UCC Fund is used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC.

i. **Hospital-Specific Actual UCC:** HSCRC uses gross patient revenue as reported on the hospitals' annual financial filings for the previous year to determine the hospital-specific actual UCC for each hospital[11]. (See Appendix II).

ii. **Hospital-Specific Predicted UCC:** This step involves use of a logistic regression model to predict UCC. HSCRC allows a 9-month runout period for charity care and bad debt Write-Off reporting. This means hospitals have 9 months from the end of a fiscal year to report charity care and bad debt that occurred in that fiscal year in their Write-Off data submissions to the Commission. HSCRC then uses that amount to predict the UCC amount built into hospital rates for the next fiscal year using area deprivation Index (ADI),[12] payer type, and site of care as independent variables in the logistic regression. An expected UCC dollar amount is calculated for every patient encounter. UCC dollars are summed at the hospital level, and summed UCC dollars are divided by hospital total charges to establish the hospital's estimated UCC level. Incorporating predicted UCC into the methodology provides hospitals with a financial incentive to collect payments so that UCC does not rise too quickly and UCC funds remain available for those who truly need it. Because UCC is paid by patients and insurers through rates, uncontrolled increases in UCC could increase hospital rates for everyone.

iii. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step i) and the hospital-specific predicted UCC (described in step ii). All individual hospital values for payment or withdrawal from the UCC Fund are then normalized to ensure that the UCC fund is redistributive in nature. (See Appendix I).

iv. **Determining hospital contribution/withdrawals:** The 50/50 blend (step iii) for each hospital is subtracted from the amount of state-wide actual UCC funding provided in rates (step 1) and multiplied by the hospital's global budget revenue (GBR) to determine how much each hospital will either withdraw from or pay into the statewide UCC Fund. The Fund is the mechanism through which HSCRC ensures the burden of uncompensated care is shared by all hospitals. Specifically, if a hospital's 50/50 blend is less than the statewide average UCC rate (determined in step 1), the hospital will pay into the UCC Fund. Conversely, if a hospital's 50/50 blend is greater than the statewide average UCC rate, the hospital will withdraw from the Fund.

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[11] Before ACA, HSCRC based the Actual UCC included in pool funding calculations on a 3-year rolling average. This smooths the year over year hospital-specific changes in UCC. In anticipation of large decreases in UCC in 2014, HSCRC adjusted their policy to use 1 year of data, to avoid carrying over higher UCC amounts

[12] "The Area Deprivation Index ...allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest …. including] factors for...income, education, employment, and housing quality." https://www.neighborhoodatlas.medicine.wisc.edu/

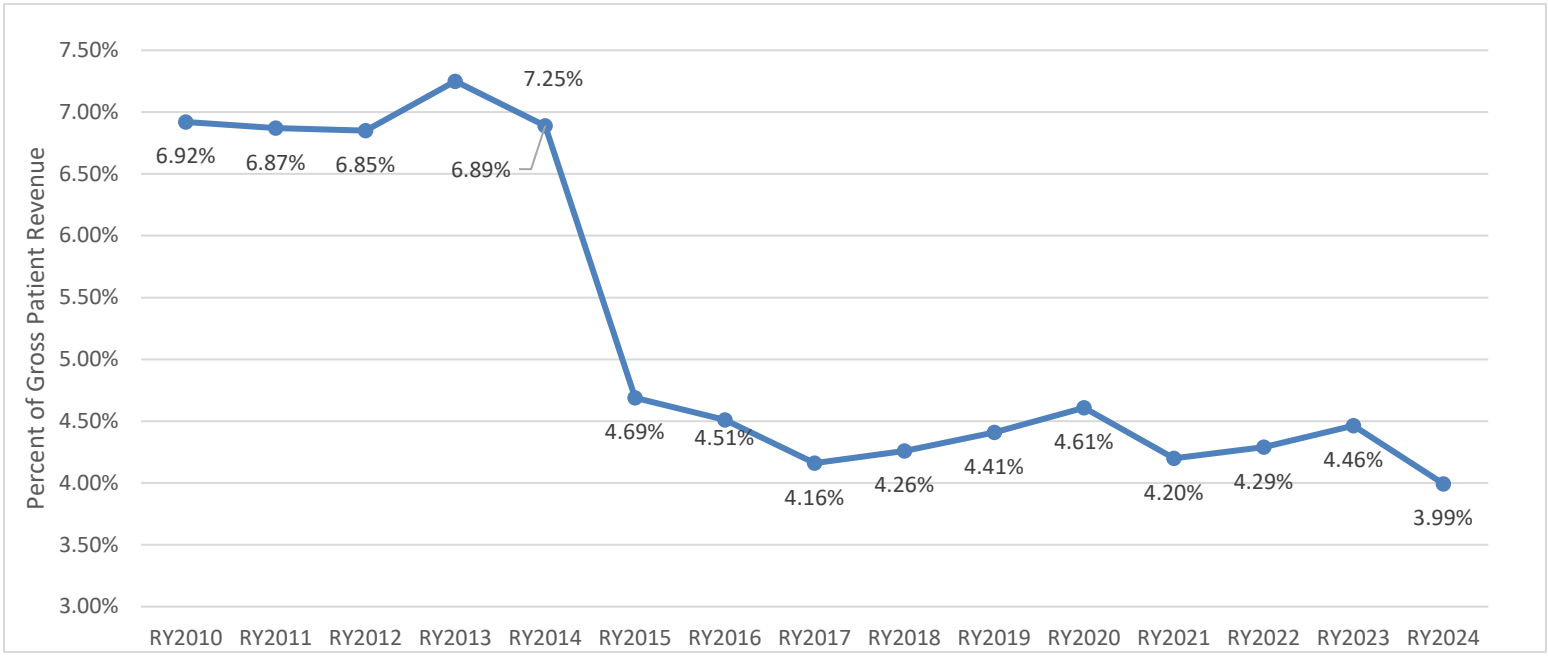
Exhibit 1: UCC Methodology Example ($ Millions)

		Step 1		Step 2 (i)	Step 2 (ii)	Step 2 (iii)	Step 2 (iv)
	A	B	C = A X B	D	E	F = Avg D & E	G = (F-B) X A
	GBR	Prior Year Statewide UCC Rate	UCC Funding Provided in Rates	Prior Year Hospital-Specific UCC Rate	Predicted Hospital-specific UCC Rate	Hospital-Specific 50/50 Blend	(Payment) or Withdrawal from UCC Fund
Hospital A	$300	5%	$15	3%	4%	3.50%	($4.50)
Hospital B	$300	5%	$15	7%	6%	6.50%	$4.50

ASSESSMENT

Based on RY 2024 audited reports, the HSCRC has determined that the percentage of UCC to incorporate in hospitals' rates to fund the UCC pool is 3.99 percent, 0.47 percentage points lower than last year's UCC rate of 4.46 percent. The graph below shows the changes in Actual Statewide UCC incorporated in hospital rates since RY 2010. RY 2014 and RY 2017 were characterized by a drastic decline in UCC due to Medicaid expansion through the ACA. As the effects of ACA implementation waned, UCC slowly increased between RY 2018 and RY 2020. The COVID pandemic characterized by a decline in ED utilization brought about further declines in UCC in RY 2021. The continuous uptick in UCC between RY 2022 and RY 2023 were driven by increases in emergency department (ED) utilization as the COVID-19 pandemic phased out. RY 2024 shows further decline in UCC largely driven by decreases in hospital's bad debt reserve requirements.

Exhibit 2: Actual Statewide UCC in Rates (RY 2010 – RY 2024)



IMPLEMENTATION

Based on the preceding analysis, HSCRC staff will implement the following for RY 2026:

1. Decrease the statewide UCC provision in rates from 4.46% to 3.99% effective July 1, 2025.
2. Continue to use the regression modeling approach previously approved by the Commission.
3. Continue to apply a 50/50 blend of RY 2024 audited UCC levels and RY 2024 predicted UCC levels to determine hospital-specific adjustments for the UCC Fund.

FUTURE CONSIDERATIONS

The Commission anticipates an increase in UCC as early FY 2026 given recent federal changes to Medicaid and recent state legislation designed to increase patient protections for Marylanders. The federal "One Big Beautiful Bill Act" (OBBBA) which includes work requirements for adults, more frequent Medicaid eligibility redeterminations and new cost-sharing obligations will cause some Marylanders who previously qualified for Medicaid under ACA to lose healthcare coverage increasing the hospital's UCC burden. Also, reduced retroactive Medicaid coverage from three to one month for many Medicaid beneficiaries increases the risk of UCC and places a financial burden on families for services received during the gap in coverage.

State legislation passed this year requiring hospitals to provide sliding scale discounts up to 500 percent of the Federal Poverty Level, prohibiting lawsuits to collect debts of $500 or less, extending the grace period before legal action can be taken from 180 to 240 days, and banning adverse credit reporting, wage garnishment, and property liens against certain low-income patients is likely to also cause an increase in UCC and hospital rates.

Appendix I. Hospital Uncompensated Care Provision for RY 2026

HOSPID	HOSPNAME	FY2025 GBR Permanent Revenue	FY 2024 UCC Based on FY 2025 GBR Permanent Revenue	FY 2024 Percent UCC from the RE Schedule	Percent Predicted UCC (Adjusted)	Predicted UCC Amounts (Based on FY 2025 GBR Permanent Revenue)	50/50 Blend Percent	50/50 Blend Adjusted to FY 2024 UCC Based on FY 2025 GBR Permanent Revenue Level	Percent UCC
210001	Meritus Medical Cntr	$507,302,030	$ 23,005,717	4.53%	4.15%	$ 21,075,796	4.34%	$ 23,982,173	4.73%
210002	UMMC	$1,929,804,254	$ 73,862,750	3.83%	2.50%	$ 48,242,776	3.16%	$ 66,430,475	3.44%
210003	UM-Prince George's Hospital	$450,626,000	$ 32,473,204	7.21%	4.08%	$ 18,406,817	5.65%	$ 27,680,844	6.14%
210004	Holy Cross	$620,977,886	$ 40,276,297	6.49%	5.37%	$ 33,333,387	5.93%	$ 40,046,724	6.45%
210005	Frederick Memorial	$440,525,242	$ 20,119,991	4.57%	4.23%	$ 18,632,488	4.40%	$ 21,082,957	4.79%
210008	Mercy Medical Cntr	$697,629,727	$ 31,575,598	4.53%	3.38%	$ 23,578,149	3.95%	$ 30,005,928	4.30%
210009	Johns Hopkins	$3,174,123,493	$ 97,570,423	3.07%	2.85%	$ 90,354,677	2.96%	$ 102,239,056	3.22%
210011	St. Agnes Hospital	$527,466,835	$ 34,161,895	6.48%	4.69%	$ 24,743,915	5.58%	$ 32,047,206	6.08%
210012	Sinai Hospital	$966,525,543	$ 22,645,093	2.34%	2.59%	$ 25,077,944	2.47%	$ 25,963,313	2.69%
210015	MedStar Franklin Square	$693,253,672	$ 22,964,181	3.31%	2.91%	$ 20,151,547	3.11%	$ 23,456,746	3.38%
210016	Washington Adventist Hospital	$393,083,217	$ 22,547,451	5.74%	3.82%	$ 15,026,127	4.78%	$ 20,441,587	5.20%
210017	Garrett Co Memorial	$94,740,995	$ 6,401,719	6.76%	4.34%	$ 4,110,989	5.55%	$ 5,719,350	6.04%
210018	MedStar Montgomery	$223,918,421	$ 8,714,553	3.89%	3.11%	$ 6,973,274	3.50%	$ 8,534,829	3.81%
210019	Peninsula Regional	$629,559,549	$ 31,714,756	5.04%	3.62%	$ 22,786,079	4.01%	$ 29,650,717	4.71%
210022	Suburban	$451,353,198	$ 16,291,015	3.61%	3.15%	$ 14,202,205	3.38%	$ 16,589,578	3.68%
210023	Anne Arundel Medical Cntr	$762,845,011	$ 13,496,553	1.77%	3.11%	$ 23,688,590	2.44%	$ 20,230,262	2.65%
210024	MedStar Union Memorial	$503,480,368	$ 11,603,491	2.30%	2.93%	$ 14,761,609	2.62%	$ 14,343,709	2.85%
210027	Western Maryland	$393,237,899	$ 19,598,242	4.98%	3.50%	$ 13,745,181	4.24%	$ 18,140,206	4.61%
210028	MedStar St. Mary's	$238,434,967	$ 9,207,510	3.86%	3.39%	$ 8,072,659	3.62%	$ 9,401,129	3.94%
210029	JH Bayview	$837,008,184	$ 37,714,583	4.51%	3.87%	$ 32,362,433	4.19%	$ 38,124,806	4.55%
210030	UM-SRH at Chestertown	$53,982,691	$ 2,648,499	4.91%	3.92%	$ 2,118,101	4.41%	$ 2,593,228	4.80%
210032	Union Hospital of Cecil Co	$205,769,175	$ 3,764,621	1.83%	3.73%	$ 7,670,737	2.78%	$ 6,221,310	3.02%
210033	Carroll Co Hospital Cntr	$280,649,695	$ 3,924,588	1.40%	2.65%	$ 7,427,617	2.02%	$ 6,176,071	2.20%

210034	MedStar Harbor Hospital Cntr	$224,405,547	$ 12,338,745	5.50%	4.35%	$ 9,756,045	4.92%	$ 12,020,483	5.36%
210035	UM-Charles Regional	$189,551,312	$ 11,768,883	6.21%	4.09%	$ 7,746,291	5.15%	$ 10,617,065	5.60%
210037	UM-SRH at Easton	$295,917,032	$ 8,634,284	2.92%	2.98%	$ 8,807,843	2.95%	$ 9,489,241	3.21%
210038	UMMC - Midtown	$275,707,182	$ 10,502,224	3.81%	2.63%	$ 7,249,741	3.22%	$ 9,657,806	3.50%
210039	Calvert Health Med Cntr	$187,887,770	$ 3,319,254	1.77%	3.34%	$ 6,281,906	2.56%	$ 5,223,429	2.78%
210040	Northwest Hospital Cntr	$310,598,806	$ 8,634,304	2.78%	2.76%	$ 8,586,629	2.77%	$ 9,368,902	3.02%
210043	UM-BWMC	$538,290,322	$ 23,941,550	4.45%	3.14%	$ 16,909,525	3.79%	$ 22,224,681	4.13%
210044	GBMC	$520,665,136	$ 12,263,909	2.36%	3.08%	$ 16,040,079	2.72%	$ 15,398,545	2.96%
210048	Howard County General	$389,779,108	$ 18,714,910	4.80%	3.66%	$ 14,251,274	4.23%	$ 17,934,973	4.60%
210049	UM-Upper Chesapeake	$452,880,561	$ 18,592,506	4.11%	3.01%	$ 13,617,486	3.56%	$ 17,523,573	3.87%
210051	Doctors Community	$311,236,651	$ 15,646,868	5.03%	5.88%	$ 18,313,839	5.46%	$ 18,476,035	5.94%
210056	MedStar Good Samaritan	$318,721,363	$ 12,653,915	3.97%	3.42%	$ 10,909,268	3.70%	$ 12,819,350	4.02%
210057	Shady Grove Adventist Hospital	$536,303,051	$ 29,618,216	5.52%	4.11%	$ 22,049,234	4.82%	$ 28,109,237	5.24%
210060	Fort Washington Medical Center	$69,106,162	$ 5,155,062	7.46%	6.25%	$ 4,315,701	6.85%	$ 5,152,488	7.46%
210061	Atlantic General	$136,431,777	$ 6,301,192	4.62%	4.28%	$ 5,840,679	4.45%	$ 6,605,682	4.84%
210062	MedStar Southern MD	$342,698,161	$ 16,924,419	4.94%	3.59%	$ 12,300,634	4.26%	$ 15,899,642	4.64%
210063	UM-St. Joseph Med Cntr	$488,243,767	$ 16,709,702	3.42%	2.56%	$ 12,487,145	2.99%	$ 15,884,297	3.25%
210065	HC-Germantown	$175,457,894	$ 10,511,760	5.99%	5.36%	$ 9,400,280	5.67%	$ 10,832,977	6.17%
Statewide	**Total**	**$20,840,179,651**	**$ 828,514,431**	**3.99%**	**3.36%**	**$ 701,406,702**	**3.67%**	**$ 832,340,605**	**3.99%**

Appendix II. Actual UCC Summary Statistics

The table below shows the Actual UCC Statewide and by hospital between RY 2024 and RY 2023– It does not reflect predicted UCC rates

HOSPID	HospName	RY2024 % UCC	RY2023 % UCC	Variance Over/Under
210001	Meritus	4.53%	4.02%	**0.51%**
210002	UMMS- UMMC	3.83%	3.75%	**0.08%**
210003	UMMS- Capital Region	7.21%	6.92%	**0.29%**
210004	Trinity - Holy Cross	6.49%	7.43%	**-0.94%**
210005	Frederick	4.57%	4.99%	**-0.42%**
210008	Mercy	4.53%	4.39%	**0.14%**
210009	JHH- Johns Hopkins	3.07%	3.19%	**-0.12%**
210011	Saint Agnes	6.48%	6.40%	**0.08%**
210012	Lifebridge- Sinai	2.34%	2.64%	**-0.30%**
210015	MedStar- Franklin Square	3.31%	4.07%	**-0.76%**
210016	Adventist White Oak Medical Center	5.74%	7.96%	**-2.22%**
210017	Garrett Co Memorial	6.76%	5.05%	**1.71%**
210018	MedStar- Montgomery	3.89%	4.52%	**-0.63%**
210019	Tidal- Peninsula	5.04%	3.59%	**1.45%**
210022	JHH- Suburban	3.61%	3.66%	**-0.05%**
210023	Luminis- Anne Arundel	1.77%	6.08%	**-4.31%**
210024	MedStar- Union Mem	2.30%	3.38%	**-1.08%**
210027	UPMC Western Maryland	4.98%	4.43%	**0.55%**
210028	MedStar- St. Mary's	3.86%	3.54%	**0.32%**
210029	JHH- Bayview	4.51%	5.40%	**-0.89%**
210030	UMMS- Chestertown	4.91%	5.10%	**-0.19%**
210032	ChristianaCare, Union	1.83%	4.77%	**-2.94%**
210033	Lifebridge- Carroll	1.40%	2.99%	**-1.59%**
210034	MedStar- Harbor	5.50%	5.31%	**0.19%**
210035	UMMS- Charles	6.21%	6.08%	**0.13%**
210037	UMMS- Easton	2.92%	3.20%	**-0.28%**
210038	UMMS- Midtown	3.81%	3.89%	**-0.08%**
210039	Calvert	1.77%	2.11%	**-0.34%**
210040	Lifebridge- Northwest	2.78%	3.19%	**-0.41%**
210043	UMMS- BWMC	4.45%	4.52%	**-0.07%**
210044	GBMC	2.36%	2.59%	**-0.23%**
210048	JHH- Howard County	4.80%	4.44%	**0.36%**
210049	UMMS-Upper Chesapeake	4.11%	4.25%	**-0.14%**
210051	Luminis- Doctors	5.03%	13.38%	**-8.35%**

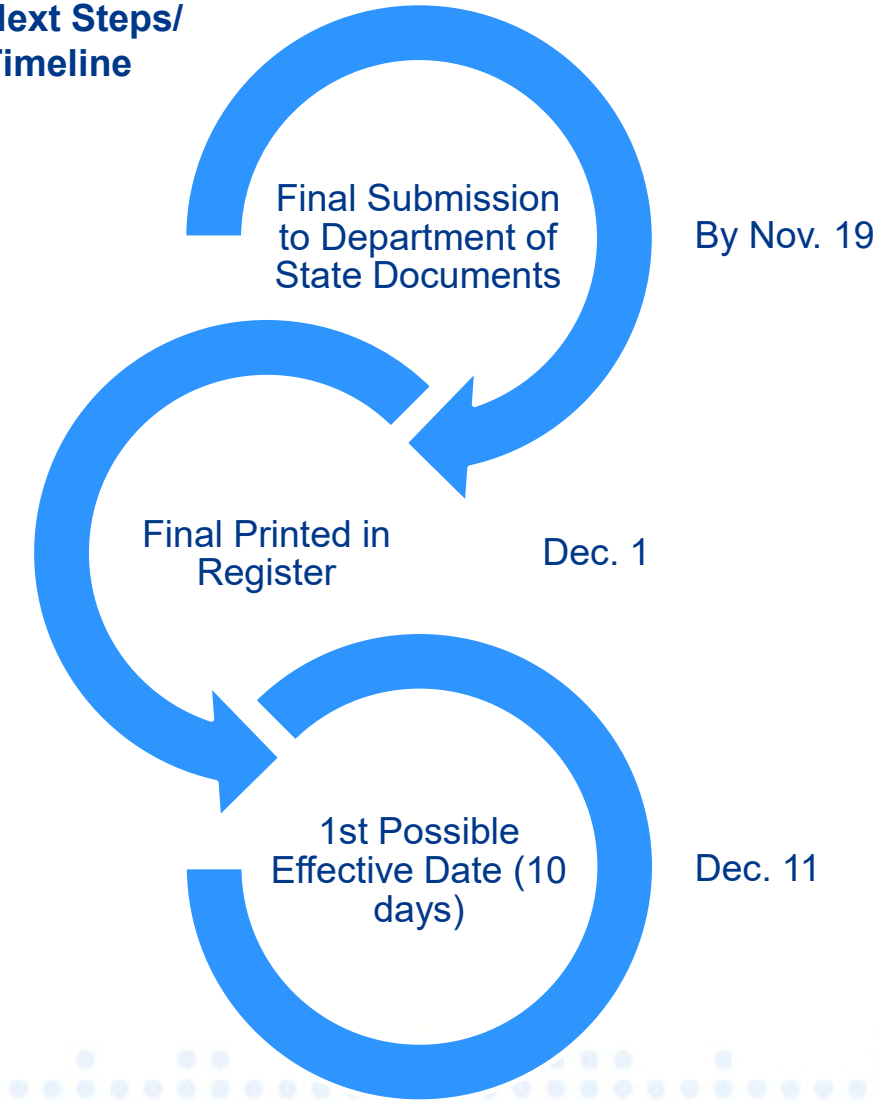
210056	MedStar- Good Sam	3.97%	4.17%	**-0.20%**
210057	Adventist Shady Grove Medical Center	5.52%	5.57%	**-0.05%**
210058	UMMS- UMROI	3.41%	3.43%	**-0.02%**
210060	Adventist Fort Washington Medical Center	7.46%	7.08%	**0.38%**
210061	Atlantic General	4.62%	3.93%	**0.69%**
210062	MedStar- Southern MD	4.94%	4.67%	**0.27%**
210063	UMMS- St. Joe	3.42%	3.65%	**-0.23%**
210064	Lifebridge- Levindale	5.34%	6.38%	**-1.04%**
210065	Trinity - Holy Cross Germantown	5.99%	6.91%	**-0.92%**
218992	UM-Shock Trauma	6.35%	6.18%	**0.17%**
	Statewide	3.99%	4.46%	**-0.47%**

Note: Free-Standing EDs and/or Medical Centers, Behavior Health and Specialty Hospitals are not included in this analysis
Source: HSCRC RE Schedules

2025 Updates to HSCRC's Financial Assistance and Medical Debt Regulations

Request: Approve Regulations for Promulgation

Next Steps/ Timeline



Approval by Commissioners will update these regulations for the first time in 5+ years, after multiple Statute changes and two rounds of HSCRC workgroups (in 2023 and 2025). This update will provide additional avenues and protections for patients paying for hospital services, at a critical time for Marylanders.

Note: HSCRC staff emphasized that the purpose of the 2025 workgroup was to discuss areas of regulations that were impacted by changes made to statute since September 2023 and not to revisit issues that were raised and thoroughly vetted previously.

Response to Public Comments (UMMS)

After Commission approval in July 2025, HSCRC staff forwarded proposed “draft” regulations to AELR to allow for publication in the Maryland Register and for an additional 30-day public comment period. Comments received are summarized below.

Summary of Comment Received	Response
General theme: Repetitive information across materials in the following policy areas, as well as changes to font size requirements, creates an administrative and financial burden and opens the door to version control concerns in the future. • Sharing information on how to apply for a payment plan • Reconsideration of the denial of free or reduced-cost care • Establising a process for making payment plans available to all patients • Description of payment plans	These changes are either part of statute and thus not subject to change by the HSCRC or are outside the scope of the language HSCRC focused on in the 2025 work group. Furthermore, we believe the additional cost to hospital is worth the additional information provided to patients.
Better understand how other hospitals interpret requirements around deceased patients.	This is language from statute and thus not subject to change by the HSCRC. Sharing of information and perspectives is a matter for hospitals to consider.

The following reflects the final version of the regulations we proposed for publication in the Maryland Register in the July 2025 HSCRC Commission meeting. Publication in the Register provided for a 30-day written comment period, during which we received one comment letter from the University of Maryland Medical System (UMMS). The comment was not substantive in nature but related to disclosure of policy information and appropriate font size. The regulations as outlined below are now ready for adoption, which is what staff will request at the November 2025 public meeting.

TITLE 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207 and 19-214.1 Annotated Code of Maryland

.26 [Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies] ***Working Capital Differentials—Payment of Charges.***

[A. Hospital Information Sheet.

(1) Each hospital shall develop an information sheet that:

(a) Describes the hospital's financial assistance policy;

(b) Describes a patient's rights and obligations with regard to hospital billing and collection under the law;

(c) Provides contact information for the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:

(i) The patient's hospital bill;

(ii) The patient's rights and obligations with regard to the hospital bill, including the patient's rights and obligations with regard to reduced-cost, medically necessary care due to a financial hardship;

(iii) How to apply for free and reduced-cost care; and

(iv) How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill;

(d) Provides contact information for the Maryland Medical Assistance Program;

(e) Includes a statement that physician charges, to both hospital inpatients and outpatients, are generally not included in the hospital bill and are billed separately;

(f) Informs patients that the hospital is permitted to bill outpatients a fee, commonly referred to as a "facility fee", for their use of hospital facilities, clinics, supplies and equipment, and nonphysician services, including but not limited to the services of nonphysician clinicians, in addition to physician fees billed for professional services provided in the hospital;

(g) Informs patients of their right to request and receive a written estimate of the total charges for the hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided and billed for by the hospital;

(h) Informs a patient or a patient's authorized representative of the right to file a complaint with the Commission or jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office against a hospital for an alleged violation of Health-General Article, §§19-214.1 and 19-214.2, Annotated Code of Maryland, which relate to financial assistance and debt collection; and

(i) Provides the patient with the contact information for filing the complaint.

(2) The information sheet shall be in:

(a) Simplified language in at least 10-point type; and

(b) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

(3) The information sheet shall be provided to the patient, the patient's family, or the patient's authorized representative:

(a) Before the patient receives scheduled medical services;

(b) Before discharge;

(c) With the hospital bill;

(d) On request; and

(e) In each written communication to the patient regarding collection of the hospital bill.

(4) The hospital bill shall include a reference to the information sheet.

(5) The Commission shall:

(a) Establish uniform requirements for the information sheet; and

(b) Review each hospital's implementation of and compliance with the requirements of this section.

A-1. Hospital Credit and Collection Policies.

(1) Each hospital shall submit to the Commission, at times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients.

(2) The policy shall:

(a) Prohibit the charging of interest on bills incurred by self-pay patients before a court judgment is obtained;

(b) Describe in detail the consideration by the hospital of patient income, assets, and other criteria;

(c) Describe the hospital's procedures for collecting any debt;

(d) Describe the circumstances in which the hospital will seek a judgment against a patient;

(e) Provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free care on the date of service, in accordance §A-1(3) of this regulation;

(f) If the hospital, has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free care on the date of the service for which the judgment was awarded or the adverse information was reported, require the hospital to seek to vacated the judgment or strike the adverse information;

(g) Provide a mechanism for a patient to file with the hospital a complaint against the hospital or an outside collection agency used by the hospital regarding the handling of the patient's bill;

(h) Provide detailed procedures for the following actions:

(i) When a patient debt may be reported to a credit reporting agency;

(ii) When legal action may commence regarding a patient debt;

(iii) When garnishments may be applied to a patient's or patient guarantor's income; and

(iv) When a lien on a patient's or patient guarantor's personal residence or motor vehicle may be placed.

(3) Beginning October 1, 2010, as provided by Health-General Article, §19-214.2(c):

(a) A hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who, within a 2-year period after the date of service, was found to be eligible for free care on the date of service;

(b) A hospital may reduce the 2-year period under §A-1(3)(a) of this regulation to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for free care at the time of service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the required information; and

(c) If a patient is enrolled in a means-tested government health care plan that requires the patient to pay out-of-pocket for hospital service, a hospital shall have a refund policy that complies with the terms of the patient's plan.

(4) For at least 120 days after issuing an initial patient bill, a hospital may not report adverse information about a patient to a consumer reporting agency or commence civil action against a patient for nonpayment unless the hospital documents the lack of cooperation of the patient or the guarantor of the patient in providing information needed to determine the patient's obligation with regard to the hospital bill.

(5) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient.

(6) A hospital may not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill. If a hospital holds a lien on a patient's primary residence, the hospital may maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt.

(7) If a hospital delegates collection activity to an outside collection agency, the hospital shall:

(a) Specify the collection activity to be performed by the outside collection agency through an explicit authorization or contract;

(b) Specify procedures the outside collection agency must follow if a patient appears to qualify for financial assistance; and

(c) Require the outside collection agency to:

(i) In accordance with the hospital's policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the outside collection agency regarding the handing of patient's bill; and

(ii) If a patient files a complaint with the collection agency, forward the complaint to the hospital.

(8) The Board of Directors of each hospital shall review and approve the financial assistance and debt collection policies of the hospital every 2 years. A hospital may not alter its financial assistance or debt collection policies without approval by the Board of Directors.

(9) The Commission shall review each hospital's implementation of and compliance with the hospital's policy and the requirements of §A-1(2) of this regulation.

A-2. Hospital Financial Assistance Responsibilities.

(1) Definitions.

(a) In this regulation, the following terms have the meanings indicated.

(b) Terms Defined.

(i) "Financial hardship" means medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

(ii) "Medical debt" means out-of-pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs billed by a hospital.

(2) Financial Assistance Policy.

(a) On or before June 1, 2009, each hospital and, on or before October 1, 2010, each chronic care hospital under the jurisdiction of the Commission shall develop a written financial assistance policy for providing free and reduced-cost care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill. A hospital shall provide notice of the hospital's financial assistance policy to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the hospital bill. The financial assistance policy shall provide at a minimum:

(i) Free medically necessary care to patients with family income at or below 200 percent of the federal poverty level;

(ii) Reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level, in accordance with the mission and service area of the hospital;

(iii) A maximum patient payment for reduced-cost care not to exceed the charges minus the hospital mark-up;

(iv) A payment plan available to patients irrespective of their insurance status with family income between 200 and 500 percent of the federal poverty level who request assistance; and

(v) A mechanism for a patient, irrespective of that patient's insurance status, to request the hospital to reconsider the denial of free or reduced care, including the address, phone number, facsimile number, email address, mailing address, and website of the Health Education and Advocacy Unit, which can assist the patient or patient's authorized representative in filing and mediating a reconsideration request.

(b) A hospital whose financial assistance policy as of May 8, 2009, provides for free or reduced-cost medical care to a patient at an income threshold higher than those set forth above may not reduce that income threshold.

(c) Presumptive Eligibility for Free Care. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the following means-tested social services programs are deemed eligible for free care, provided that the patient submits proof of enrollment within 30 days unless the patient or the patient's representative requests an additional 30 days:

(i) Households with children in the free or reduced lunch program;

(ii) Supplemental Nutritional Assistance Program (SNAP);

(iii) Low-income-household energy assistance program;

(iv) Primary Adult Care Program (PAC), until such time as inpatient benefits are added to the PAC benefit package;

(v) Women, Infants and Children (WIC); or

(vi) Other means-tested social services programs deemed eligible for hospital free care policies by the Maryland Department of Health and the HSCRC, consistent with HSCRC regulation COMAR 10.37.10.26.

(d) A hospital that believes that an increase to the income thresholds as set forth above may result in undue financial hardship to it may file a written request with the Commission that it be exempted from the increased threshold. In evaluating the hospital's request for exemption, the Commission shall consider the hospital's:

(i) Patient mix;

(ii) Financial condition;

(iii) Level of bad debt experienced;

(iv) Amount of charity care provided; and

(v) Other relevant factors.

(e) Based on staff's evaluation of the written request for an exemption, the Executive Director shall respond in writing within a reasonable period of time approving or disapproving the hospital's exemption request.

(f) A hospital denied an exemption request shall be afforded an opportunity to address the Commission at a public meeting on its request. Based on arguments made at the public meeting, the Commission may approve, disapprove, or modify the Executive Director's decision on the exemption request.

(3) Each hospital shall submit to the Commission within 60 days after the end of each hospital's fiscal year:

(a) The hospital's financial assistance policy developed under this section; and

(b) An annual report on the hospital's financial assistance policy that includes:

(i) The total number of patients who completed or partially completed an application for financial assistance during the prior year;

(ii) The total number of inpatients and outpatients who received free care during the immediately preceding year and reduced-cost care for the prior year;

(iii) The total number of patients who received financial assistance during the immediately preceding year, by race or ethnicity and gender;

(iv) The total number of patients who were denied financial assistance during the immediately preceding year, by race or ethnicity and gender;

(v) The total cost of hospital services provided to patients who received free care; and

(vi) The total cost of hospital services provided to patients who received reduced-cost care that was covered by the hospital as financial assistance or that the hospital charged to the patient.

(4) Financial Hardship Policy.

(a) Subject to §A-2(3)(b) and (c) of this regulation, the financial assistance policy required under this regulation shall provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship.

(b) A hospital may seek and the Commission may approve a family income threshold that is different than the family income threshold under §A-2(C)(1) of this regulation.

(c) In evaluating a hospital's request to establish a different family income threshold, the Commission shall take into account:

(i) The median family income in the hospital's service area;

(ii) The patient mix of the hospital;

(iii) The financial condition of the hospital;

(iv) The level of bad debt experienced by the hospital;

(v) The amount of the charity care provided by the hospital; and

(vi) Other relevant factors.

(d) If a patient has received reduced-cost, medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household:

(i) Shall remain eligible for reduced-cost, medically necessary care when seeking subsequent care at the same hospital during the 12-month period beginning on the date on which the reduced-cost, medically necessary care was initially received; and

(ii) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced-cost care, shall inform the hospital of the patient's or family member's eligibility for the reduced-cost, medically necessary care.

(5) If a patient is eligible for reduced-cost medical care under a hospital's financial assistance policy or financial hardship policy, the hospital shall apply the reduction in charges that is most favorable to the patient.

(6) A notice shall be posted in conspicuous places throughout the hospital including the billing office informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

(7) The notice required under §A-2(6) of this regulation shall be in:

(a) Simplified language in at least 10-point type; and

(b) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

(8) Each hospital shall use a Uniform Financial Assistance Application in the manner prescribed by the Commission in order to determine eligibility for free and reduced-cost care.

(9) Each hospital shall establish a mechanism to provide the Uniform Financial Assistance Application to patients regardless of their insurance status. A hospital may require from patients or their guardians only those documents required to validate the information provided on the application.

(10) Asset Test Requirements. A hospital may, in its discretion, consider household monetary assets in determining eligibility for financial assistance in addition to the income-based criteria, or it may choose to use only income-based criteria. If a hospital chooses to utilize an asset test, the following types of monetary assets, which are those assets that are convertible to cash, shall be excluded:

(a) At a minimum, the first $10,000 of monetary assets;

(b) A "safe harbor" equity of $150,000 in a primary residence;

(c) Retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including, but not limited to, deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans;

(d) One motor vehicle used for the transportation needs of the patient or any family member of the patient;

(e) Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act; and

(f) Prepaid higher education funds in a Maryland 529 Program account.

(11) Monetary assets excluded from the determination of eligibility for free and reduced-cost care under these provisions shall be adjusted annually for inflation in accordance with the Consumer Price Index.

(12) In determining the family income of a patient, a hospital shall apply a definition of household size that consists of the patient and, at a minimum, the following individuals:

(a) A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return;

(b) Biological children, adopted children, or stepchildren; and

(c) Anyone for whom the patient claims a personal exemption in a federal or State tax return.

(13) For a patient who is a child, the household size shall consist of the child and the following individuals:

(a) Biological parents, adoptive parents, stepparents, or guardians;

(b) Biological siblings, adopted siblings, or step siblings; and

(c) Anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

A-3. Patient Complaints. The Commission shall post a process on its website for a patient or a patient's authorized representative to file with the Commission a complaint against a hospital for an alleged violation of Health-General Article, §19-214.1 or 19-214.2, Annotated Code of Maryland. The process established shall include the option for a patient or a patient's authorized representative to file the complaint jointly with the Commission and the Health Education and Advocacy Unit. The process shall conform to the requirements of Health-General Article, §19-214.3, Annotated Code of Maryland.

B. Working Capital Differentials—Payment of Charges.**]**

A. Definitions.

(1) In this regulation, the following terms have the meanings indicated.

(2) Terms Defined.

(a) "Debt collector" has the meaning stated in COMAR 10.37.13.01.

(b) "Hospital" means a "facility" as defined in Health-General Article, §19- 301, Annotated Code of Maryland.

(c) "Income-based payment plan" means a payment plan based on the patient's household income as set forth in COMAR 10.37.13.05.

(d) "Payment plan" has the meaning stated in COMAR 10.37.13.01.

[(1)**]** *B.* A third-party payer may obtain a discount in rates established by the Commission if it provides current financing monies in accordance with the following terms.

[(a)**]** *(1)* (text unchanged)

[(b)**]** *(2)* A third-party payer that provides current financing equal to the average amount of outstanding charges for discharged patients plus the average daily charges times the average length of stay, shall be entitled to a 2.25-percent discount. The current financing provided **[**in here**]** *to hospitals* corresponds to a third party's paying on admission.

[(c)**]** *(3)*—**[**(e)**]***(5)* (text unchanged)

[(2)**]** *C.* The third-party payer shall promptly provide the Commission with a verified record of the detailed calculation of the current financing and of each recalculated balance as adjustments are made. The detailed calculations shall become a part of the public record. The Commission may, at any time, evaluate the amount of current financing monies provided to a hospital to assure that it meets the discount of requirements specified in **[**§B(1)**]** *§B of this regulation*. If the Commission finds that the amount of current financing is inconsistent with the requirements of **[**§B(1)**]** *§B* of this regulation, the Commission may, at its sole discretion, require an adjustment to the working capital advance or to the discount.

[(3)**]** *D. Discounts.*

(1) A payer or self-paying patient, who does not provide current financing under **[**§B(1)(a)—(e)**]** *§B* of this regulation, shall receive a 2-percent discount if payment is made at the earlier of the end of each regular billing period or upon discharge from the hospital.

(2) Payment within 30 days of the earlier of the end of each regular billing period or discharge entitles a payer or self-pay patient to a 1-percent discount.

(3) For those payers not subject to Insurance Article, §15-1005, Annotated Code of Maryland, after 60 days from the date of the earlier of the end of each regular billing period or discharge, interest or late payment charges may accrue on any unpaid charges at a simple rate of 1 percent per month.

(4) The interest or late payment charges may be added to the charge on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that.

(5) For patients that have entered into a hospital income-based payment plan under COMAR 10.37.13.05, the interest rate shall be established in accordance with the Guidelines set forth in COMAR 10.37.13.05.

[(4)**]** *E.* Hospital Billing Responsibilities.

[(a) A patient shall be given a bill for services at the earlier of the end of each regular billing period or upon discharge or dismissal (when dismissal for outpatients is analogous to discharge for inpatients).

(b) This bill shall cover substantially all care rendered and should, except for some last day ancillary services and excepting arithmetic errors, represent the full charge for the patient's care. In addition, a notice shall be posted prominently at the billing office of the hospital clearly notifying all patients of the availability of the discounts mentioned above.

(c) The bill and the notice shall state that the:

(i) Charge is due within 60 days of discharge or dismissal;

(ii) Patient shall receive a 2-percent discount by paying upon discharge or a 1-percent discount by paying within 30 days; and

(iii) Payers not subject to Insurance Article, §15-1005, Annotated Code of Maryland, may be subject to interest or late payment charges at a rate of 1 percent per month beginning on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that.**]**

(1) A patient shall be given a bill for services at the earlier of the end of each regular billing period or upon discharge or dismissal, when dismissal for outpatients is analogous to discharge for inpatients.

(2) This bill shall cover substantially all care rendered and should, except for some last day ancillary services and excepting arithmetic errors, represent the full charge for the patient's care.

(3) A notice shall be posted prominently at the billing office of the hospital clearly notifying all patients of the availability of the discounts referred to in §D of this regulation.

(4) The bill and the notice shall state that the patient shall receive a 2-percent discount by paying upon discharge or a 1-percent discount by paying within 30 days of discharge.

[(5) Hospital Written Estimate.

(a) On request of a patient made before or during treatment, a hospital shall provide to the patient a written estimate of the total charges for the hospital services, procedures, and supplies that reasonably are expected to be provided and billed to the patient by the hospital.

(b) The written estimate shall state clearly that it is only an estimate and actual charges could vary.

(c) A hospital may restrict the availability of a written estimate to normal business office hours.

(d) The provisions set forth in §B(5)(a)—(c) of this regulation do not apply to emergency services.**]**

[C.**]** *F.* (text unchanged)

10.37.13 Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies

Authority: Health-General Article, §§19-214.2, 19-214.3, 19-207, and 19-219, Annotated Code of Maryland

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Credit and collection policy" means a hospital's policy on the collection of medical debt.

(2) Debt Collector.

(a) "Debt collector" means a person who engages directly or indirectly in the business of:

(i) Collecting for, or soliciting from another, medical debt;

(ii) Giving, selling, attempting to give or sell to another, or using, for collection of medical debt, a series or system of forms or letters that indicates directly or indirectly that a person other than the hospital is asserting the medical debt; or

(iii) Employing the services of an individual or business to solicit or sell a collection system to be used for collection of medical debt.

(b) "Debt collector" includes a "collection agency" as defined in Business Regulation Article, §7-101, Annotated Code of Maryland.

(3) "Financial hardship" means medical debt, incurred by a family over a 12-month period, that exceeds 25 percent of family income.

(4) "Hospital" has the meaning stated in Health-General Article, §19- 301(f), Annotated Code of Maryland.

(5) Hospital Services.

(a) "Hospital services" means:

(i) Inpatient hospital services as enumerated in 42 C.F.R. §409.10, as amended;

(ii) Emergency services, including services provided at a freestanding medical facility licensed under Health Occupations Article, Title 19, Subtitle 3A, Annotated Code of Maryland

(iii) Outpatient services provided at a hospital as defined in COMAR 10.37.10.07-2;

(iv) Outpatient services, as specified by the Commission in COMAR 10.37.10.07-2, provided at a freestanding medical facility licensed under Health-General Article, Title 19, Subtitle 3A, Health-General Article, Annotated Code of Maryland that has received a certificate of need under Health-General Article, §19–120(o)(1), Annotated Code of Maryland, or an exemption from obtaining a certificate of need under Health-General Article, §19–120(o)(3), Annotated Code of Maryland; and

(v) Identified physician services for which a facility has Commission–approved rates on June 30, 1985.

(b) "Hospital services" includes a hospital outpatient service:

(i) Of a hospital that, on or before June 1, 2015, is under a merged asset hospital system;

(ii) That is designated as a part of another hospital under the same merged asset hospital system to make it possible for the hospital outpatient service to participate in the 340B Program under the federal Public Health Service Act; and

(iii) That complies with all federal requirements for the 340B Program and applicable provisions of 42 C.F.R. §413.65.

(c) "Hospital services" does not include:

(a) Outpatient renal dialysis services;

(b) Outpatient services provided at a limited service hospital as defined in Health-General Article, §19–301, Annotated Code of Maryland except for emergency services; or

(c) Physician services that are billed separately.

(6) Household.

(a) "Household" means, at a minimum, for an adult patient, the patient and the following individuals that live in the same dwelling:

(i) A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return;

(ii) Biological children, adopted children, or stepchildren; and

(iii) All individuals on the same federal or State tax return, including anyone for whom the patient claims a personal exemption in a federal or State tax return.

(b) "Household" means, at a minimum, for a patient who is a child, the patient and the following individuals that live in the same dwelling:

(i) Biological parents, adoptive parents, stepparents, or guardians;

(ii) Biological siblings, adopted siblings, or step siblings; and

(iii) All individuals on the same federal or State tax return, including anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

(c) The terms "household" and "family" are synonymous for the purposes of this chapter.

(7) Income.

(a) "Income" means total taxable income, before taxes.

(b) "Income" includes:

(i) If a hospital uses state or federal tax returns to verify income, the adjustments listed on Schedule 1 of Form 1040; and

(ii) If a hospital utilizes an asset test, the value of household monetary assets, consistent with Regulation 06J of this chapter.

(8) "Initial bill" means the first billing statement provided to an individual by a hospital after the care, whether inpatient or outpatient, is provided and the individual has left the hospital.

(9) "Medical debt" means out-of-pocket expenses, including co-payments, coinsurance, and deductibles, for hospital services that are regulated by the Commission that are billed to a patient or a co-signer for the patient, excluding amounts contractually paid by another payer such as insurers, including Medicare, Medicaid, or CHIP .

(10) "Medically necessary care" including care provided in accordance with the Emergency Medical Treatment and Labor Act of 1986), means care that is:

(a) Directly related to diagnostic, preventative, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability or health condition;

(b) Consistent with current accepted standards of good medical practice; and

(c) Not primarily for the convenience of the patient, the patient's family, or the provider.

(11) Monetary Assets.

(a) "Monetary assets" means assets in excess of $100,000 that can readily be converted into a fixed or precisely determinable amount of money, including cash and cash equivalents.

(b) "Monetary assets" include cash on hand, bank deposits, investment accounts, accounts receivable, and notes receivable.

(c) "Monetary assets" do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment, including deferred–compensation plans qualified under the Internal Revenue Code or nonqualified deferred–compensation plans.

(12) Payment Plan.

(a) "Payment plan" means an agreement between a patient, or a guarantor, to pay for a hospital service over a period of time.

(b) "Payment plan" includes:

(i) An "income-based payment plan" set forth in Regulation .05 of this chapter; and

(ii) A "non-income-based payment plan" set forth in Regulation .05W of this chapter.

(13) "Qualified Maryland resident" means someone who lives in Maryland for more than 6 months of the year or whose primary residence is in Maryland, including those in Maryland for school or work.

(14) Written.

(a) "Written" means communications in paper form and communications delivered electronically, including through electronic mail, a secure web, or mobile based application such as a patient portal.

(b) "Written" does not include oral communications, including communications delivered by phone.

.02 Electronic Delivery of Written Communications.

A. A patient may opt out of receiving written communications required by Regulations .03—.08 of this chapter through electronic delivery methods, such as through email or a patient portal.

B. A hospital or debt collector who communicates with a patient electronically must include in such communication, or attempt to communicate, a clear and conspicuous statement describing a reasonable and simple method by which the patient can opt out of further electronic communications by the hospital or debt collector.

C. A hospital or debt collector may not require, directly or indirectly, that the patient, in order to opt out of electronic communication, pay any fee or provide any information other than:

(1) The patient's opt out preferences; and

(2) The email address, telephone number for text messages, or other electronic-medium address subject to the opt-out request.

D. If a hospital or debt collector receives notice from a patient that the patient is opting out of receiving written communications through electronic delivery methods, the hospital or the debt collector:

(1) May not provide the written communications required by Regulations .03—.08 of this chapter through electronic delivery methods; and

(2) Shall deliver the written communications through non-electronic delivery methods.

E. Notice of Patient Opting Out of Written Communications.

(1) If a hospital receives notice from a patient that the patient is opting out of receiving written communications through electronic delivery methods, and the hospital uses a debt collector with respect to that patient, the hospital shall immediately inform the debt collector that the patient is opting out of electronic delivery methods.

(2) If a debt collector receives notice from a patient that the patient is opting out of receiving written communications through electronic delivery methods, the debt collector shall immediately inform the hospital that controls that patient account that the patient is opting out of electronic delivery methods.

.03 Hospital Information Sheet.

A. Each hospital shall develop an information sheet that:

(1) Describes clearly:

(a) The hospital's financial assistance policy as required in Regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland; and

(b) A patient's legal rights and obligations with regard to hospital billing and collection;

(2) Informs the patient, the patient's family, the patient's authorized representative, or the patient's legal guardian:

(a) That the hospital is permitted to bill outpatients a fee, commonly referred to as a facility fee, for their use of hospital facilities, clinics, supplies, and equipment, and nonphysician services, including but not limited to the services of nonphysician clinicians, in addition to physician fees billed for professional services provided in the hospital;

(b) Of the patient's right to request and receive a written estimate of the total charges for the hospital non-emergency services, procedures, and supplies that reasonably are expected to be provided and billed for by the hospital, in addition to the good faith estimate requirements in 42 U.S.C §2799B-6, the No Surprises Act;

(c) Of the patient's right to file a complaint with the Commission or jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office against a hospital for an alleged violation of Health-General Article, §§19-214.1 and 19-214.2, Annotated Code of Maryland;

(d) Of the availability of an income-based payment plan; and

(e) That physician charges, to both hospital inpatients and outpatients, are generally not included in the hospital bill and are billed separately;

(3) Provides contact information for:

(a) The individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:

(i)The patient's hospital bill;

(ii) The patient's rights and obligations with regard to the hospital bill, including the patient's rights and obligations with regard to reduced-cost medically necessary care due to a financial hardship;

(iii) How to apply for financial assistance;

(iv) How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill; and

(v) How to apply for a payment plan;

(b) The Maryland Medical Assistance Program;

(c) Filing a complaint with the Commission or jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office against a hospital for an alleged violation of Health-General Article, §§19-214.1 and 19-214.2, Annotated Code of Maryland; and

(4) Includes a section that allows the patient to initial that the patient has been made aware of the financial assistance policy.

B. The information sheet shall be written in:

(1) Simplified language;

(2)At least 12-point type; and

(3) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes at least 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

C. The information sheet shall conform with Health-General Article, §19–342(d)(7) and (10), Annotated Code of Maryland.

D. The information sheet shall be provided in writing to the patient, the patient's family, the patient's authorized representative, or the patient's legal guardian:

(1) Before the patient receives scheduled medical services;

(2) Before discharge;

(3) With the hospital bill;

(4) On request; and

(5) In each written communication to the patient regarding collection of the hospital bill.

E. The hospital bill shall include a reference to the information sheet.

F. The Commission shall:

(1) Establish uniform requirements for the information sheet; and

(2) Review each hospital's implementation of and compliance with the requirements of this regulation.

.04 Hospital Credit and Collection Responsibilities.

A. Each hospital shall submit to the Commission, at times prescribed by the Commission, the hospital's credit and collection policy.

B. The policy shall:

(1) Provide for active oversight by the hospital of any contract for collection of debts on behalf of the hospital;

(2) Prohibit the hospital from selling any debt, except as permitted by Health-General Article, §19–214.2(m), Annotated Code of Maryland and §O of this regulation;

(3) Prohibit the hospital from:

(a) Engaging in collection activities on 100 percent of the outstanding amount of the Commission-set charge for debt sold under §O of this regulation and Health-General Article, §19-214.2(m), Annotated Code of Maryland; and

(b) Collecting on judgments entered into on patient debt that was sold under §O of this regulation and Health-General Article, §19-214.2(m), Annotated Code of Maryland;

(c) Reporting adverse information to a consumer reporting agency;

(d) Filing a civil action to collect a debt against a patient within 240 days after the initial bill is provided;

(e) Filing a civil action to collect a debt against a patient whose outstanding hospital medical debt is at or below $500;

(f) Forcing the sale or foreclosure of a patient's primary residence to collect medical debt;

(g) Requesting a lien against a patient's primary residence in an action to collect medical debt;

(h) Requesting the issuance of or otherwise knowingly taking action that would cause a court to issue a body attachment against a patient or an arrest warrant against a patient, if the hospital files an action to collect medical debt; and

(i) Requesting a writ of garnishment of wages or filing an action that would result in an attachment of wages against a patient to collect medical debt if the patient is eligible for free or reduced-cost medically necessary care, in accordance with Regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland;

(4) In accordance with Health-General Article, §19-214.2(c), Annotated Code of Maryland and §G of this regulation, provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free medically necessary care within 240 days after the initial bill was provided under Health General Article, §19-214.1, Annotated Code of Maryland and §G of this regulation;

(5) If the hospital has obtained a judgment against or had reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free medically necessary care, in accordance with Regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland, within 240 days after the initial bill was provided, require the hospital to seek to vacate the judgment or strike the adverse information;

(6) Provide a mechanism for a patient to:

(a) Request the hospital to reconsider the denial of free or reduced–cost care; and

(b) File with the hospital a complaint against the hospital or a debt collector used by the hospital regarding the handling of the patient's bill;

(7) For a patient who is eligible for free or reduced cost-care under the hospital's financial assistance policy, prohibit the hospital from:

(a) Charging interest on the debt owed on a bill for the patient before a court judgement is obtained; or

(b) Collecting fees or any other amount that exceeds the approved charge for the hospital service as established by the Commission;

(8) Establish a process for making payment plans available to all patients in accordance with Regulation .05 of this chapter and Health-General Article, §19-214.2(e)(3), Annotated Code of Maryland;

(9) Provide detailed procedures for the following actions:

(a) When garnishments may be applied to a patient's or patient guarantor's income in accordance with §I of this regulation and Health-General Article, §19-214.2(f)(4), Annotated Code of Maryland;

(b) When a lien on a patient's or patient guarantor's personal residence, excluding a primary resident in accordance with §I of this regulation and Health-General Article, §19-214.2(g)(2), Annotated Code of Maryland, or motor vehicle may be placed;

(c) The hospital's procedures for collecting any medical debt, consistent this regulation;

(d) The circumstances in which the hospital will seek a judgment against a patient for the patient's medical debt, subject to §I of this regulation and Health-General Article, §19–214.2, Annotated Code of Maryland;

(e) The consideration by the hospital of patient income, assets, and other criteria set forth in this regulation; and

(10) Comply with Health-General Article, §24-2502, Annotated Code of Maryland.

C. Consistent with Health-General Article, §19-214.2(e)(5), Annotated Code of Maryland, a hospital shall demonstrate that it attempted in good faith to meet the requirements of Health-General Article, §19-214.2(e), Annotated Code of Maryland, and the Guidelines set forth in Regulation .05 of this chapter before the hospital:

(1) Files an action to collect the patient's medical debt; or

(2) Delegates collection activity to a debt collector for a patient's medical debt.

D. The hospital shall be deemed to have demonstrated that it attempted to act in good faith under Health-General Article, §19-214.2(e)(5)(i)(2), Annotated Code of Maryland and §C(2) of this regulation if, before delegating collection of a patient's medical debt to a debt collector, the hospital:

(1) Provides the information sheet before the patient receives scheduled medical services and before discharge in accordance with Health-General Article, §19-214.2(e)(1) and (2), Annotated Code of Maryland, and in Regulation .03D(1) and (2) of this chapter; and

(2) Establishes a process for making payment plans available to all patients in accordance with Health-General Article, §19-214.2(e)(3), Annotated Code of Maryland and Regulation .05 of this chapter.

E. In delegating any or all collection to a debt collector for a patient's medical debt, the hospital may rely on a debt collector to engage in various activities, including:

(1) Facilitating and servicing payment plans in accordance with the Guidelines, including receiving and forwarding any payments received under a payment plan approved by the hospital; and

(2) Such other activities as the hospital may direct in collecting and forwarding payments under a payment plan.

F. A hospital may not seek legal action to collect a patient's medical debt until the hospital has established and implemented a payment plan policy that complies with the Guidelines.

G. As provided by Health-General Article, §19-214.2(c), Annotated Code of Maryland:

(1) A hospital shall provide:

(a) For a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who was found to be eligible for free medically necessary care within 240 days after the initial bill is provided to the patient; and

(b) The refund to the patient not later than 30 days after determining that the patient was eligible for free medically necessary care.

(2) If a patient is enrolled in a means-tested government health care plan that requires the patient to pay out-of-pocket for hospital service, a hospital shall have a refund policy that complies with the terms of the patient's plan.

H. Consumer Reporting.

(1) A hospital may not commence civil action against a patient for nonpayment or delegate collection activity to a debt collector, if the hospital:

(a) Was notified in accordance with federal law by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days;

(b) Is processing a requested reconsideration of the denial of free or reduced-cost medically necessary care under Regulation .06A(1)(c)(v) of this chapter and Health-General Article, §19-214.1(b)(2)(iv), Annotated Code of Maryland, that was appropriately completed by the patient or has completed the reconsideration within the immediately preceding 60 days; or

(c) Sold the debt under §O of this regulation and Health-General Article, §19-214.2(m).

(2) A hospital shall comply with Health-General Article, §24-2502, Annotated Code of Maryland.

(3) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient, including if the debt was sold under §O of this regulation and Health-General Article, §19-214.2(m), Annotated Code of Maryland.

(4) Not later than November 1, 2025, a hospital that had reported adverse information about a patient to a consumer reporting agency shall instruct the consumer reporting agency to delete the adverse information about the patient.

I. Civil Action.

(1) Deceased Patients.

(a) A hospital may not make a claim against the estate of a deceased patient to collect medical debt if the deceased patient was known by the hospital to be eligible for free medically necessary care, in accordance with Regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland, or if the value of the estate after tax obligations are fulfilled is less than half of the medical debt owed.

(b) A hospital may offer the family of the deceased patient the ability to apply for financial assistance.

(2) A hospital may not file an action to collect medical debt until the hospital determines whether the patient is eligible for free or reduced-cost medically necessary care under Regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland.

(3) At least 45 days before filing an action against a patient to collect medical debt, but not within 240 days after the initial bill is provided, a hospital shall send written notice of the intent to file an action to the patient.

(4) The notice required in §I(3) of this regulation shall:

(a) Be sent to the patient by certified mail and first class mail;

(b) Be in simplified language;

(c)Be in at least 12-point type;

(d) Include:

(i) The name and telephone number of the hospital, the debt collector, if applicable, and an agent of the hospital authorized to modify the terms of the payment plan, if any;

(ii) The amount required to cure the nonpayment of medical debt, including past due payments, interest, penalties, and fees;

(iii) A statement recommending that the patient seek debt counseling services;

(iv) Telephone numbers and internet addresses of the Health Education Advocacy Unit of the Office of the Attorney General, available to assist patients experiencing medical debt; and

(v) An explanation of the hospital's financial assistance policy;

(e) Be provided in the patient's preferred language or, if no preferred language is specified, English and each language spoken by a limited English proficient population that constitutes at least 5 percent of the population within the jurisdiction in which the hospital is located as measured by the most recent federal census; and

(f) Be accompanied by:

(i) An application for financial assistance under the hospital's financial assistance policy, along with instructions for completing the application for financial assistance, specific instructions about where to send the application, and the telephone number to call to confirm receipt of the application;

(ii) Language explaining the availability of an income-based payment plan to satisfy the medical debt that is the subject of the hospital debt collection action; and

(ii) The information sheet required under Regulation .03 of this chapter and Health-General Article, §19-214.1(f), Annotated Code of Maryland.

J. Delegation of Collection to a Debt Collector. If a hospital delegates collection activity to a debt collector, the hospital shall:

(1) Specify the collection activity to be performed by the debt collector through an explicit authorization or contract;

(2) Require the debt collector to abide by the hospital's credit and collection policy;

(3) Specify procedures the debt collector must follow if a patient appears to qualify for financial assistance under Regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland; and

(4) Require the debt collector to:

(a) In accordance with the hospital's credit and collection policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the debt collector regarding the handling of patient's bill;

(b) If a patient files a complaint with the debt collector, forward the complaint to the hospital; and

(c) Along with the hospital, be jointly and severally responsible for meeting the requirements of this regulation, Regulation .06 of this chapter, and Health-General Article, §19-214.2, Annotated Code of Maryland.

K. Consent to Assume Liability for Medical Debt.

(1) A spouse or another individual may not be held liable for the medical debt of an individual 18 years old or older unless the individual voluntarily consents to assume liability for the patient's medical debt.

(2) The consent shall be:

(a) Made on a separate document signed by the individual;

(b) Not solicited in an emergency room or during an emergency situation; and

(c) Not required as a condition of providing emergency or non-emergency health care services.

L. The Board of Directors of each hospital shall review and approve the hospital's financial assistance policy required under Regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland and debt collection policy required under Regulation .04 of this chapter and Health-General Article, §19-214.2, Annotated Code of Maryland at least every 2 years. A hospital may not alter its financial assistance or credit and collection policies without approval of the Board of Directors.

M. The Commission shall review each hospital's implementation of and compliance with the hospital's policy and the requirements of §B of this regulation.

N. Reporting Requirements.

(1) Each hospital shall annually submit to the Commission within 120 days after the end of each hospital's fiscal year a report including:

(a) The total number of patients by race or ethnicity, gender, and zip code of residence against whom the hospital or a debt collector used by the hospital, filed an action to collect medical debt;

(b) The total number of patients by race or ethnicity, gender, and zip code of residence with respect to whom the hospital has and has not reported or classified a bad debt;

(c) The total dollar amount of charges for hospital services provided to patients but not collected by the hospital for patients covered by insurance, including the out-of-pocket costs for patients covered by insurance, and patients without insurance; and

(d) For hospital debts owed by patients of the hospital that the hospital sold to a governmental unit, contractor, or nonprofit organization under Health-General Article, §19-214.2(m), Annotated Code of Maryland and §O of this regulation:

(i) The total dollar amount of the debt sold by the hospital for the reporting year;

(ii) The total dollar amount paid by the hospital to the unit, contractor, or nonprofit organization who purchased the debt; and

(iii) The total number of patients whose debt was sold, in full or in part, to the unit, contractor, or nonprofit organization who purchased the debt.

(2) The Commission shall post the information submitted under §N(1) of this regulation on its website.

O. Selling Medical Debt.

(1) Consistent with Health-General Article, §19-214.2(m), Annotated Code of Maryland, a hospital may sell debt owed to the hospital by a patient for hospital services to a governmental unit, an entity that is under contract with the governmental unit, or to a nonprofit organization that is exempt from taxation under 26 U.S.C. §501(c)(3) of the Internal Revenue Code for the sole purpose of canceling the debt.

(2) The contract between the hospital and the governmental unit, entity that is under contract with the governmental unit, or nonprofit organization purchasing the debt shall state that the sole purpose of the sale of the debt is to cancel the debt.

(3) The patient is not responsible to the hospital, the governmental unit, the entity that is under contract with the governmental unit, or the nonprofit organization for any amount of the debt that is sold, or any interest, fees, or costs associated with the debt or the sale.

(4) Debt sold under this regulation and Health-General Article, §19-214.2(m), Annotated Code of Maryland:

(a) Must be for hospital services provided at least 2 years before the date of the sale;

(b) May not be expected to yield additional reimbursements from a third-party payor;

(c) May not be subject to an open appeal with an insurance company; and

(d) Must be for an individual whose family income is at or below 500 percent of the federal poverty level or who has medical debt exceeding 5 percent of the patient's family income, as determined by the governmental unit, contractor, or nonprofit organization purchasing the debt.

(5) Debt sold under this regulation and Health-General Article, §19-214.2(m), Annotated Code of Maryland, may be sold with a reduction of Commission charges.

(6) The Commission shall treat the amount of payments to hospitals under this subsection as an offset to uncompensated care amounts reported by hospitals.

(7) The purchaser of the debt shall:

(a) Notify the patient that the debt has been canceled; and

(b) If the hospital obtained a judgment against the patient or reported adverse information to a consumer reporting agency about the patient, seek to vacate the judgment or strike the adverse information.

(8) If a hospital sells hospital medical debt under this regulation and Health-General Article, §19-214.2(m), Annotated Code of Maryland, the hospital must immediately dismiss actions pending against a patient for collection of that debt.

.05 Guidelines for Hospital Payment Plans.

A. Scope.

(1) As described in this regulation, the Guidelines for Hospital Payment Plans apply to any income-based payment plan offered by a hospital to a patient to pay for medically necessary hospital services after the services are provided.

(2) "Income" in this regulation means household monthly income.

(3) Prepayment Plans. Nothing in the Guidelines prevents a hospital from offering patients arrangements to make payments prior to service, provided that:

(a) A hospital may not require or steer a patient to enter into such an arrangement solely to avoid the application of these Guidelines;

(b) Before a hospital requests pre-payment for a hospital service, the hospital shall:

(i) Comply with the notice provisions of Health-General Article, §19-214.1, Annotated Code of Maryland, and Regulations .03 and .06 of this chapter;

(ii) Advise the patient about the availability of financial assistance;

(iii) Process any request for financial assistance; and

(iv) Advise the patient about the availability of income-based payment plans, including information about the 5 percent cap on monthly payment amounts under §F(1) of this regulation; and

(c) Such an arrangement terminates once the hospital service is rendered.

(4) Unregulated Services. These Guidelines apply only to hospital services that are regulated by the Commission. These Guidelines do not apply to services that are not regulated by the Commission, including physician services.

(5) Limitation of the Guidelines. These Guidelines do not prevent hospitals from extending payment plans for services, such as physician services, or at times that are outside the parameters of the Guidelines. Except as otherwise required by law or regulation, payment plans that are outside the parameters of these Guidelines are not subject to the Guidelines.

B. Access to Income-Based Payment Plans.

(1) Availability of Income-Based Payment Plans. Maryland hospitals shall make income-based payment plans available to all patients who are Maryland residents, including individuals temporarily residing in Maryland due to work or school, irrespective of their:

(a) Insurance status;

(b) Citizenship status;

(c) Immigration status; or

(d) Eligibility for reduced-cost medically necessary care, including reduced-cost medically necessary care due to financial hardship, under Regulation .06 of this chapter.

(2) Treatment of Nonresidents and Unregulated Services.

(a) These Guidelines do not prevent a hospital from extending payment plans to patients who are not described in §B(1) of this regulation.

(b) These Guidelines do not prevent a hospital from extending payment plans to patients for services that are not regulated by the Commission.

(c) Except as required by §U of this regulation or by other law or regulation, payment plans for patients which are not described in §B(1) of this regulation and payment plans for services that are not regulated by the Commission are not subject to the Guidelines under this regulation.

C. Notice Requirements.

(1) Notice of Availability of an Income-Based Payment Plan.

(a) Posted Notice.

(i) A notice shall be posted in conspicuous places throughout the hospital, including the billing office, informing Maryland residents of the availability of an income-based payment plan and whom to contact at the hospital for additional information.

(ii) If the hospital uses a vendor to assist with financial assistance eligibility, billing, or debt collection, such as a debt collector or eligibility vendor, the hospital shall ensure that the vendor posts a notice in a conspicuous place on their website or online payment portal, informing Maryland residents of the availability of an income-based payment plan and whom to contact at the hospital or debt collector for additional information. Placement on the website or online payment portal should be based on the best interest of the patient.

(b) Information Sheet. A written notice of the availability of an income-based payment plan shall be contained in the information sheet required under Regulation .03 of this chapter, including clarity on the availability of income-based payment plans for Maryland residents, and, if payment plans for non-residents are included in the hospital's credit and collection policy, the availability of such plans for non-residents.

(c) Before a Prepayment Plan. Before a patient enters into a prepayment plan as described in §A(2) of this regulation for a medically necessary hospital service, a hospital shall provide a written notice of the availability of an income-based payment plan to a patient.

(d) On a Bill. On the same page of the bill that includes the amount due and due date, the hospital shall provide notice that a lower monthly payment amount may be possible through an income-based plan, in the same font and style as the total amount due notification.

(e) Online Payment Portal. On both the page of the online payment portal that states the amount due, and where the consumer enters the amount being paid by the consumer, the hospital shall provide, in the same font and style as the amount due

notification, notice informing Maryland residents of the availability of an income-based monthly payment plan and information, including a telephone number and email address, in order to contact the hospital for additional information.

(2) Notice of Terms Before Execution. A hospital shall provide written notice of the terms of an income-based payment plan to a patient before the patient agrees to enter the income-based payment plan. The terms of the income-based payment plan shall include:

(a) The amount of medical debt owed to the hospital;

(b) The interest rate applied to the income-based payment plan and the total amount of interest expected to be paid by the patient under the income-based payment plan;

(c) The amount of each periodic payment expected from the patient under the income-based payment plan;

(d) The number of periodic payments expected from the patient under the income-based payment plan;

(e) The expected due dates for each payment from the patient;

(f) The expected date by which the account will be paid off in full;

(g) The treatment of any missed payments, including missed payments and default as described in §P and T of this regulation;

(h) That there are no penalties for early payments; and

(i) Whether the hospital plans to apply a periodic recalculation of monthly payment amounts as described in §N of this regulation and the process for such recalculation.

(3) Notice of Plan After Execution. A hospital shall promptly provide a written income-based payment plan, including items listed in §C(2) of this regulation, to the patient following execution by all parties. The income-based payment plan shall be provided to the patient at least 20 days before the due date of the patient's first payment under the income-based payment plan.

D. Financial Assistance.

(1) Before entering into an income-based payment plan with a patient, hospitals shall evaluate if the patient is eligible for financial assistance, including free and reduced-cost medically necessary care, including reduced-cost medically necessary care due to financial hardship, in accordance with Regulation .06 of this chapter.

(2) Hospitals shall:

(a) Apply the financial assistance reduction before entering into an income-based payment plan with a patient; and

(b) Use any information collected for determining financial assistance under Regulation .06 of this chapter to establish the 5 percent monthly payment threshold for payment plans under Regulation .05F of this chapter.

E. Offer Required. Hospitals must offer income-based payment plans that meet the requirements of these Guidelines.

F. Monthly Payment Amounts.

(1) Under an income-based payment plan subject to these Guidelines, a hospital may not require a patient to make total payments in a month that exceed 5 percent of the lesser of the patient's household income.

(2) §F(1) of this regulation applies to total amounts due under the plan, including both principal and interest, but does not apply to any catch-up payments, such as payments described under §P(1) of this regulation.

(3) A hospital shall calculate the monthly payment amount threshold under §F(1) of this regulation by dividing income level by household size and multiplying by .05 percent.

(4) Determining the Household Size.

(a) The hospital shall determine the size of the patient's household using the number reported on tax returns, if provided the number of tax filers and dependents listed on the tax return provided by the patient. For example, if a married couple files jointly and has three dependents, the number of tax filers and dependents would equal five.

(b) If a patient files as an individual and the patient is not a dependent and has no dependents, the number of tax filers would equal one.

(c) If the patient has not provided a tax return, the hospital shall ask the patient to provide the number of individuals in the household.

G. Expenses. A hospital may reduce the amount of the monthly payment due under an income-based payment plan upon consideration of household expense information provided by a patient.

H. Application to Multiple Income-based Payment Plans.

(1) Hospitals. A hospital shall ensure that the total monthly payment amount for all income-based payment plans provided to a patient by the hospital, when added up collectively, does not exceed the income limitation under §F(1) of this regulation.

(2) Hospital System. A hospital system shall ensure that the total monthly payment amount for all income-based payment plans provided to a patient by all hospitals in the hospital system, when added up collectively, does not exceed the income limitation under §F(1) of this regulation.

I. Duration of Income-Based Payment Plan. The duration of an income-based payment plan, in months, is determined by the total amount owed, and interest, if interest applies, divided by the total amount of the payment due each month, subject to the limitation that no monthly payment may exceed 5 percent of the patient's income as calculated under §F(1)of this regulation.

J. Solicitation of Early Payments Prohibited. Hospitals may not solicit, steer, or mandate patients to pay an amount in excess of the monthly payment amount provided for in an income-based payment plan.

K. Application of Partial Payments. A hospital shall apply partial payments in a manner most favorable to the patient.

L. Interest and Fees.

(1) No Interest for Patients Eligible for Financial Assistance. For a patient who is eligible for free or reduced-cost medically necessary care under the hospital's financial assistance policy under Regulation .06 of this chapter and Health-General Article,

§19–214.1, Annotated Code of Maryland, the hospital may not charge interest or fees on any medical debt amount owed under an income-based payment plan.

(2) Allowable Interest. A hospital may charge interest under an income-based payment plan for a patient who is not eligible for free or reduced-cost medically necessary care, as described in §L of this regulation. A hospital is not required to charge interest for a payment plan.

(3) Interest Rate.

(a) An income-based payment plan may not provide for interest in excess of an effective rate of simple interest of 6 percent per annum on the unpaid principal balance of the payment plan.

(b) A hospital may not set an interest rate that results in negative amortization.

(c) Payers subject to Insurance Article, §15-1005, Annotated Code of Maryland, shall comply with its provisions.

(4) Timing. Interest may not begin before 240 days after the initial bill is provided.

(5) Late payments. A hospital may not charge additional fees or interest for late payments.

M. Early Payment.

(1) Prepayment Allowed.

(a) Patients may, on a voluntary basis, pre-pay, in whole or in part, any amounts owed under an income-based payment plan.

(b) Any prepayment made under §M(1) of this regulation is not subject to the monthly income payment limitations of §F(1) of this regulation.

(2) No Fees or Penalties. A hospital may not assess fees or otherwise penalize early payment of an income-based payment plan.

N. Limited Modifications of Income-based Payment Plans.

(1) Change in Income. If a patient with an income-based payment plan notifies a hospital that the patient's income has changed, then the hospital shall offer to modify the income-based payment plan to meet the requirement of §N(6) of this regulation.

(2) Expenses. Before modifying an income-based payment plan, a hospital shall consider information provided by a patient about changes in household expenses in considering a patient request to modify a payment plan.

(3) No Increase in Interest Rate. A hospital may not increase the interest rate on an income-based payment plan when making a modification to an income-based payment plan under this Guideline.

(4) Limitation on Payment Amount. A hospital may not modify an income-based payment plan in a way that requires a patient to make a monthly payment that exceeds the percent of the patient's income used to set the monthly payment amount under the initial income-based payment plan as provided for in §F of this regulation.

(5) Change in Duration. The duration of a modified income-based payment plan, in months, is determined by the total amount owed, and interest, if interest applies, divided by the total amount of the payment due each month, subject to the limitation under §F of this regulation.

(6) Process for Modifying an Income-Based Payment Plan.

(a) Prompt Response to Patient Request. If a patient requests a modification to the terms of the payment plan, the hospital shall respond in a timely manner and may not refer the outstanding balance owed to a collection agency or for legal action until 30 days after providing a written response to the patient's request for a modification of the payment plan.

(b) Reconsideration for Financial Assistance. If a patient makes a request for modification of a payment plan, the hospital shall consider if such patient is eligible for financial assistance, including free medically necessary care, reduced-cost medically necessary care, and reduced-cost care due to financial hardship under Regulation .06 of this chapter. The hospital will apply the financial assistance reduction in its modification of the payment plan.

(c) Mutual Agreement. A hospital may not modify a payment plan without mutual agreement between the hospital and the patient before the changes are made.

(d) Notice of Terms. The hospital shall provide the patient with a written notice of all payment plan terms, consistent with the requirements of §C of this regulation, upon modifying a payment plan under this Guideline.

O. Hospital-Initiated Changes to Income-Based Payment Plans Based on Changes to Patient Income.

(1) Recalculation Allowed. A hospital may, in the terms of an initial income-based payment plan under §C(2) of this regulation that exceeds 3 years in length, provide for periodic recalculations to the amount of the monthly payments and the duration of the payment plan based on changes in the patient's income as subject to and calculated under §N(5) of this regulation.

(2) Notice Included in Initial Income-Based Payment Plan.

(a) The hospital may only recalculate payment amounts under an income-based payment plan if the hospital included the process for such recalculation in the notice provided to the patient before they entered into the income-based payment plan, in accordance with §C(2) of this regulation.

(b) The patient's agreement to enter into the income-based payment plan after receiving that notice constitutes consent to the payment recalculations allowed under §P of this regulation.

(3) Limitations on Modification Apply. The provisions of §N of this regulation relating to limitations of payment plan modifications apply to payment recalculations for income-based payment plans under §O of this regulation.

(4) Frequency of Recalculation. A hospital may not seek a recalculation of the monthly payment amount under an income-based payment plan, as provided for under §O(1) of this regulation more than once every 3 years.

(5) Treatment of Missing Information. If a patient does not provide income information on the request of the hospital seeking to make a change to an income-based payment plan under §O of this regulation and the patient is in good standing on the patient's

payments under the income-based payment plan, the hospital may not change the monthly payment amounts under the income-based payment plan.

P. Treatment of Missed Payments.

(1) First Missed Payment.

(a) A hospital may not deem a patient to be noncompliant with an income-based payment plan if the patient makes at least 11 scheduled monthly payments within a 12-month period.

(b) Subject to §P(1)(c) of this regulation, the hospital shall permit the patient to repay the missed payment amount at any time, as determined by the patient, including through a set of partial payments.

(c) No later than 30 days after the first missed payment in a 12-month period, the hospital shall notify the patient of the missed payment and inform the patient that the patient may be in default if they do not pay the amount of the missed payment within 12 months or if they miss additional payments within the 12-month period. The notice will give the patient the option to pay the missed payment by paying the amount of the missed payments in one of the following ways:

(i) 11 increments over the subsequent 11 months;

(ii) A single payment; or

(iii) Another approach, as specified by the patient.

(d) With respect to a patient that has missed a single monthly payment in a 12-month period, the hospital shall provide the patient with a method to designate whether any amount of a payment paid in the subsequent 12-month period is to be applied to the amount of missed payment or applied in a different manner.

(e) With respect to a patient that has missed a single monthly payment in a 12-month period, if the hospital receives a payment and the patient has not designated how that payment is to be applied, the hospital shall first apply the amount to any payment that is due in the 31-day period following the date the payment is received. If there is no payment due in the next month, the hospital shall apply the amount of the payment to the missed payment. If the amount of the payment exceeds the amount of any payment that is due in the 31-day period following the date the payment is received, the excess amount shall be applied to the missed payment.

(f) The hospital may consider a patient to be in default on the income-based payment plan if the missed payment is not repaid in full by the end of the 12-month period that begins on the date of the missed payment under §P(1) of this regulation.

(2) Additional Missed Payments.

(a) A hospital may forbear the amount of any additional missed payments that occur in a 12-month period.

(b) If a hospital forbears the amount of any additional missed payments that occur in a 12-month period, the hospital shall allow the patient to continue to participate in the income-based payment plan.

(c) If a hospital forbears the amount of any additional missed payments that occur in a 12-month period, the hospital may not refer the outstanding balance owed to a collection agency or for legal action.

(d) The hospital shall recapitalize the amount of any missed payments that were subject to forbearance under this §P of this regulation as additional payments at the end of the income-based payment plan, thereby extending the length of the income-based payment plan.

(e) The hospital shall provide written notice to the patient of the treatment of the missed payments, including any extension of the length of the income-based payment plan.

Q. Treatment of Loans and Extension of Credit. After a hospital service is provided to the patient, a hospital, hospital affiliate, or third-party in partnership with a hospital may not make any loan or extension of credit to the patient in connection with a medically necessary hospital service that is inconsistent with the guidelines for payment plans in this regulation resulting from that service.

R. Application of Credit Provisions of Maryland Commercial Law Article and Licensing Provisions of Financial Institutions Article. An income-based payment plan is an extension of credit subject to Maryland credit regulations under Commercial Law Article, Title 12, Annotated Code of Maryland and any applicable licensing provisions of Financial Institutions Article, Title 11, Annotated Code of Maryland.

S. Books and Records. A hospital shall retain books and records on income-based payment plans for at least 3 years after the income-based payment plan is closed.

T. Default.

(1) If a patient defaults on an income-based payment plan and the parties are unable to agree to a modification, then the hospital shall follow the provisions of its credit and collection policy established in accordance with Regulation .04 of this chapter, before a hospital may write this medical debt off as bad debt.

(2) With respect to the amounts covered by the income-based payment plans, a patient who is on an income-based payment plan and is not in default on that payment plan may not be considered in arrears on their debt to the hospital when the hospital is making decisions about scheduling health care services.

U. Non-Income-Based Payment Plans.

(1) Other Payment Plans Allowed. A hospital may offer a non-income-based payment plan under these Guidelines, but must first offer the patient an income-based payment plan.

(2) Application of Guidelines. Consistent with the Guidelines for Hospital Payment Plans and consistent with the intent of Health-General Article, §19-214.2, Annotated Code of Maryland, the following provisions of this regulation apply to non-income-based payment plans in the same manner such provisions apply to income-based payment plans:

(a) §A of this regulation, regarding scope;

(b) §B of this regulation, regarding access to payment plans;

(c) §C(2) of this regulation, regarding notice of payment plan terms before execution;

(d) §C(3) of this regulation, regarding notice of plan after execution;

(e) §D of this regulation, regarding financial assistance;

(f) §L of this regulation, regarding interest and fees;

(g) §M(1)(a) and (2) of this regulation, regarding early payments;

(h) §N(6) of this regulation, regarding modifications of payment plans;

(i) §Q of this regulation, relating to treatment of loans and extensions of credit;

(j) §R of this regulation, relating to the application of credit provisions of Maryland Commercial Law Article and the licensing provisions of Financial Institutions Article;

(k) §S of this regulation, relating to books and records; and

(l) §T of this regulation, relating to default.

(3) Notice.

(a) Notice of Terms Before Execution. In addition to complying with the terms of §C(2) of this regulation, the hospital must include notice that the patient may apply for an income-based payment plan at any time in the notice of terms before execution of a non-income-based payment plan.

(b) Notice of Plan After Execution. The hospital must include the notice required in §U(3)(a) of this regulation in the notice of the payment plan after execution that is required by §C(3) of this regulation.

(c) Notice with Bills. Each bill for a non-income-based payment plan shall include a notice that informs the patient that income-based payment plans are available, which could result in lower monthly payments and provides information on how to apply for such plans.

(4) Consent. Before entering into a non-income-based repayment plan with a patient, the hospital must obtain consent from the patient that records that the patient affirms the following:

(a) The hospital offered the patient an income-based payment plan;

(b) The income-based payment plan limits monthly payment amounts to 5 percent of the patient's monthly income;

(c) The income-based payment plan may result in lower monthly payment amounts than the monthly payment amounts under the non-income-based repayment plan;

(d) The patient has the opportunity to disclose their income and determine the payment amount under the income-based payment plan; and

(e) The patient is declining to enter an income-based payment plan and is consenting to enter a non-income-based repayment plan.

(5) Modification of a Non-Income-Based Payment Plan: In addition to complying with the terms of §N(6) of this regulation, before modifying a non-income-based payment plan:

(a) The hospital shall offer the patient an income-based payment plan; and,

(b) If the patient declines the income-based payment plan, obtain the consent required under §U(4) of this regulation.

(6) Default on a Non-Income-Based Payment Plan.

(a) If the patient defaults on a non-income-based payment plan, the hospital must offer an income-based payment plan to the patient before the hospital follows the provisions of its credit and collection policy to collect the debt.

(b) The offer provided under §U(6)(a) of this regulation must be sent separately from a bill.

V. Steering.

(1) A hospital may not steer patients to non-income-based payment plans, or third-party credit providers, in such a manner that discourages patients from entering into income-based payment plans.

(2) A hospital may not steer patients to revolving credit products in such a manner that discourages patients from entering into either income-based payment plans or non-income based payment plans under this regulation.

.06 Hospital Financial Assistance Responsibilities.

A. Financial Assistance Policy.

(1) Requirements.

(a) Each hospital and each chronic care hospital under the jurisdiction of the Commission shall develop a written financial assistance policy for providing free and reduced-cost medically necessary care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill.

(b) A hospital shall provide written notice of the hospital's financial assistance policy to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the hospital bill.

(i) The required notice shall state that the patient has up to 240 days after the day the patient receives the initial hospital bill to apply for financial assistance from the hospital.

(ii) The hospital shall obtain documentation ensuring that the patient or the patient's authorized representative acknowledges the patient's receipt of the notice before discharging the patient.

(iii) If a patient chooses not to apply for financial assistance, the patient's documented acknowledgement shall indicate that the patient is not applying for financial assistance on the day of the acknowledgment but may apply within 240 days immediately following the patient's receipt of the initial hospital bill.

(c) The financial assistance policy shall provide at a minimum:

(i) Free medically necessary care to patients with family income at or below 200 percent of the federal poverty level, consistent with the provisions of §A(2) of this regulation;

(ii) Reduced-cost medically necessary care to patients with family income between 200 and 300 percent of the federal poverty level, consistent with the provisions of §A(2) of this regulation;

(iii) A description of the payment plan required under Health-General Article, §19-214.2(d), Annotated Code of Maryland and Regulation .05 of this chapter; and

(iv) A mechanism for a patient, irrespective of that patient's insurance status, to request the hospital to reconsider the denial of free or reduced-cost medically necessary care, including the address, phone number, facsimile number, email address, mailing address, and website of the Health Education and Advocacy Unit, which can assist the patient or patient's authorized representative in filing and mediating a reconsideration request.

(d) If a patient is eligible for reduced-cost medically necessary care under §A(1)(c)(ii) of this regulation, the hospital shall, at a minimum, reduce the patient's out-of-pocket expenses for the hospital services:

(i) For a patient with family income of at least 201 percent but not more than 250 percent of the federal poverty level, by 75 percent; and

(ii) For a patient with family income of more than 250 percent but not more than 300 percent of the federal poverty level, by 60 percent.

(e) The hospital shall provide free and reduced-cost medically necessary care to all qualified Maryland residents, regardless of their citizenship or immigration status.

(f) The hospital shall provide free and reduced-cost medically necessary care under §A(1)(c) of this regulation to all qualified Maryland residents, regardless of whether the patient resides in the hospital's service area.

(g) The financial assistance policy applies to all medically necessary hospital services provided to qualified Maryland residents. Hospitals may not exclude non-urgent or elective, but medically necessary, care from their financial assistance policy.

(2) The financial assistance policy shall calculate a patient's eligibility for free medically necessary care under §A(1)(c)(i) of this regulation and Health-General Article, §19-214.1(b)(2)(i), Annotated Code of Maryland, or reduced-cost medically necessary care under §A(1)(c)(ii) of this regulation and Health-General Article, §19-214.1(b)(2)(ii), Annotated Code of Maryland, at the date of service or updated, as appropriate, to account for any change in the financial circumstances of the patient that occurs within 240 days after the initial bill is provided.

(3) The hospital shall consider any change in the patient's financial circumstance in accordance with Health-General Article, §19-214.1(b)(11), Annotated Code of Maryland.

(4) Income Documentation.

(a) Hospitals shall accept generally acceptable forms of documentation that verify income, such as tax returns, pay stubs, and W2s to evaluate if the patient is eligible for financial assistance, including free and reduced-cost medically necessary care, including reduced-cost medically necessary care due to financial hardship, in accordance with this regulation .

(b) Hospitals shall use available information, including information provided by the patient, to approximate the patient's income if the patient has not provided their tax returns, pay stubs, W2s, or another form of documentation.

(c) Income Attestations.

(i) Hospitals may accept patient attestation of the patient's monthly or annual income and the number of filers and dependents on their tax return without documentation.

(ii) Such an attestation shall include the patient's income and the number of filers and dependents on their tax return.

(iii) If the patient provides an attestation of income the hospital is not required to conduct any additional income verification.

(d) A hospital's inability to obtain complete income information does not preclude the hospital's ability to reasonably predict a patient's income for the purposes of providing financial assistance. For example, a hospital may multiply income reported at the monthly level by 12 to determine income at the annual level, allowing for reasonably predictable changes in income throughout the year.

(5) Presumptive Eligibility for Free Medically Necessary Care. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the following means-tested social services programs are deemed eligible for free medically necessary care:

(a) Households with a child in the free or reduced lunch program and is eligible for the program based on the household's income;

(b) Supplemental Nutritional Assistance Program (SNAP);

(c) Low-income-household energy assistance program;

(d) Primary Adult Care Program (PAC), until such time as inpatient benefits are added to the PAC benefit package;

(e) Women, Infants and Children (WIC); or

(f) Other means-tested social services programs deemed eligible for hospital free medically necessary care policies by the Maryland Department of Health and the Commission, consistent with this regulation.

B. Hospital Reports. Each hospital shall submit to the Commission within 120 days after the end of each hospital's fiscal year:

(1) The hospital's financial assistance policy developed in accordance with this regulation; and

(2) An annual report on the hospital's financial assistance policy that includes:

(a) The total number of patients who completed or partially completed an application for financial assistance during the prior year;

(b) The total number of inpatients and outpatients who received free medically necessary care during the immediately preceding year and reduced-cost medically necessary care for the prior year;

(c) The total number of patients who received financial assistance during the immediately preceding year, by race or ethnicity and gender;

(d) The total number of patients who were denied financial assistance during the immediately preceding year, by race or ethnicity and gender;

(e) The total cost of hospital services provided to patients who received free medically necessary care; and

(f) The total cost of hospital services provided to patients who received reduced-cost medically necessary care that was covered by the hospital as financial assistance or that the hospital charged to the patient.

C. Financial Hardship Policy.

(1) Subject to Regulation .05D of this chapter, the financial assistance policy required under §A of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland, shall provide reduced-cost medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship.

(2) If a patient has received reduced-cost medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household:

(a) Shall remain eligible for reduced-cost medically necessary care when seeking subsequent care at the same hospital during the 12-month period beginning on the date on which the reduced-cost medically necessary care was initially received; and

(b) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced-cost medically necessary care, shall inform the hospital of the patient's or family member's eligibility for the reduced-cost medically necessary care.

(3) If a patient is eligible for reduced-cost medically necessary care under a hospital's financial hardship policy, the hospital shall, at a minimum, reduce the patient's out-of-pocket expenses for hospital services:

(a) For a patient with family income of at least 201 percent but not more than 250 percent of the federal poverty level, by 75 percent;

(b) For a patient with family income of more than 250 percent but not more than 300 percent of the federal poverty level, by 60 percent;

(c)For a patient with family income of more than 300 percent but not more than 350 percent of the federal poverty level, by 50 percent;

(d) For a patient with family income of more than 350 percent but not more than 400 percent of the federal poverty level, by 45 percent;

(e) For a patient with family income of more than 400 percent but not more than 450 percent of the federal poverty level, by 40 percent; and

(f) For a patient with family income of more than 450 percent but not more than 500 percent of the federal poverty level, by 35.

D. The Commission may, by regulation, establish income thresholds higher than those in this regulation:

(a) Patient mix;

(b) Financial condition;

(c) Level of bad debt experienced;

(d) Amount of financial assistance provided; and

(e) Other relevant factors.

E. Notice Requirements.

(1) A notice shall be posted in conspicuous places throughout the hospital including the billing office informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

(2) If the hospital uses a vendor to assist with financial assistance eligibility, billing, or debt collection, such as a debt collector or eligibility vendor, that vendor shall post a notice in a conspicuous place on their website or online payment portal, informing patients of their right to apply for financial assistance, providing a link to the financial assistance application, and providing information on how to submit the application. Placement on the website or online payment portal should be based on the best interest of the patient.

F. The notice required under §E of this regulation shall be in:

(1) Simplified language;

(2) At least 10-point type; and

(3) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes at least 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

G. Financial Assistance Application. Each hospital shall:

(1) Use a Financial Assistance Application in the manner prescribed by the Commission in order to determine eligibility for free and reduced-cost medically necessary care;

(2) Use a Financial Assistance Application that meets the requirements of this regulation and is consistent with the Uniform Financial Assistance Application; and

(3) Establish a mechanism to provide a Financial Assistance Application to patients regardless of their insurance status. A hospital may require from patients or their guardians only those documents required to validate the information provided on the application.

H. Asset Test Requirements. A hospital may utilize a monetary asset test when determining eligibility for financial assistance, using the definition of monetary assets as defined in Regulation 01B of this chapter.

.07 Patient Complaints.

A. The Commission shall post a process on its website for a patient or a patient's authorized representative to file with the Commission a complaint against a hospital for an alleged violation of Health-General Article, §§19-214.1 or 19-214.2, Annotated Code of Maryland.

B. The process established by the Commission shall include the option for a patient or a patient's authorized representative to file the complaint jointly with the Commission and the Health Education and Advocacy Unit.

C. The process shall conform to the requirements of Health-General Article, §19-214.3, Annotated Code of Maryland.

.08 Hospital Written Estimate.

A. In addition to the good faith estimate requirements set forth in the Public Health Service Act, 42 U.S.C §2799B-6, the No Surprises Act, on request of a patient made before or during treatment, a hospital shall provide to the patient a written estimate of the total charges for the hospital services, procedures, and supplies that reasonably are expected to be provided and billed to the patient by the hospital.

B. The written estimate shall state clearly that it is only an estimate and actual charges could vary.

C. A hospital may restrict the availability of a written estimate to normal business office hours.

D. The provisions set forth in §A—C of this regulation do not apply to emergency services.

.09 Other Obligations of Debt Collectors.

This chapter does not diminish any obligations of a debt collector, as defined under Regulation .01 of this chapter, under other applicable laws or regulations, including, without limitation, any requirement for the debt collector to obtain a collection agency license from the State Collection Agency Licensing Board in accordance with Business Regulation Article, Title 7, Subtitle 3, Annotated Code of Maryland.

JOSHUA SHARFSTEIN

Chair

Health Services Cost Review Commission

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Demographic Adjustment Draft Recommendation

November 12, 2025

Demographic Adjustment Overview

Purpose

- Designed to **adjust for hospital volume changes due to population changes**, without allowing for increases in hospital volume due to potentially avoidable utilization (PAU)
- Generally **provides additional funding to the system** because population is growing - serves as **governor** to total new volume funding

Adjustment is relative to current Maryland experience only, so no overall secular changes are accounted for

How it Works

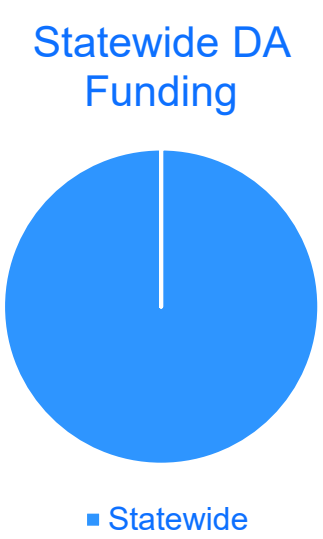
Uses ZIP code population projections by age cohort to apportion anticipated hospital volume growth, allocated by a hospital's market share so that hospitals gaining market share will gain more demographic adjustment

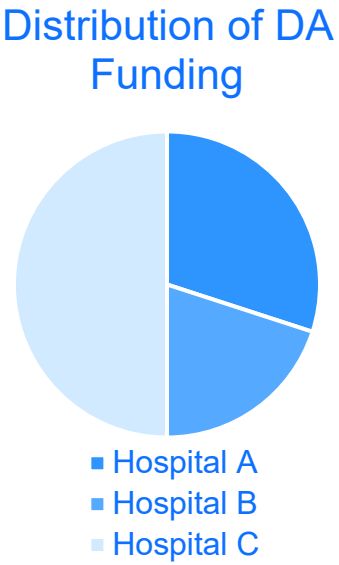
Methodology

1. **Base population estimates** attributed by hospital's share of volume in a given ZIP code and age cohort
2. **Age adjusted population growth rates** are calculated by ZIP code and age cohort, adjusted for Statewide age costs
3. **Hospital-specific age adjusted population growth** is calculated by multiplying hospital-specific base population by age-adjusted population growth rates, using ZIP codes and adjusted by age cohort
4. **Age Adjusted Growth Scaled to Population Growth** incorporates adjustments for potentially avoidable utilization and a scaling adjustment to ensure the Demographic Adjustment is not more than population growth - no variable cost factor is applied

Two Estimates Drive the Demographic Adjustment

Statewide population growth determines the **amount of funding** to be provided via the Demographic Adjustment, while age-adjusted population growth determines the **distribution of the funding** at the hospital level





Statewide population growth determines the "size of the pie."

Example: Maryland population grew by 2% YoY so statewide Demographic Adjustment funding is capped at 2% of in-state revenue.

Focus of Policy Revision

The distribution of funding at the hospital level is based on the **share of age-adjusted population growth**.

Example: Hospital C above is attributed 50% of the total age-adjusted population growth statewide because of its market share, and therefore receives 50% of total DA funding.

Many Factors Impact Hospital Utilization and Costs

While the statewide population growth **doesn't account for all factors** impacting hospital utilization and the costs to treat patients, it has served as a **reasonable governor** for determining the statewide funding to be provided under a per capita Model.

Other Factors Impacting Hospital Utilization & Costs to Treat Patients

The Volume Workgroup explored if there was a more nuanced governor available to account for aging and other factors that **might offset or increase the effect of aging**. This necessitated **national assessments** because Maryland utilization patterns reflect TCOC Model impacts.

Note (1): Population aging is used to determine the distribution of Demographic Adjustment funding. Other factors listed above are not directly considered in the Demographic Adjustment Methodology.

Guiding Principles for Demographic Adjustment Review

	Guiding Principle	Comment
1	Account for Year-Over-Year Changes in Hospital Use Rates	The current age-adjusted growth statistic is based on an evaluation of current year variation in per member per year (PMPY) spending. If average PMPY spending changes each year in line with secular trends, using the current age-adjusted growth statistic will fail to account for changes in trend
2	Account for Total Risk Change	Aging is one of the most significant factors in changing hospital use rates, but it is not the only factor. To accurately modify population growth projections for changing risk profiles, total risk change should be accounted for.
3	Align with AHEAD Methodology When Possible	The AHEAD Financial Specifications calls for Medicare Hospital Global Budgets to be adjusted for population growth that is risk adjusted for changes in Hierarchical Condition Categories (HCC's), which is risk adjustment model that accounts for aging and several other factors (e.g., disability status, diagnoses). While HCC's (or a similar grouper) is not available on a total population level, the AHEAD Model is clearly declaring its intention to adjust population growth for total risk change.
4	Do Not Build in All TCOC Model Impacts into Estimating Future Demand	One particular approach to assessing use rate changes would be to longitudinally assess changes in utilization in Maryland since the start of Global Budgets in 2014. While this might make sense for various types of services that have generated savings and the State would not want to unwind through a revision to the Demographic Adjustment (e.g., site neutral service offerings), using Maryland experience for all use rate change would build in Model effects and would create an unsustainable Model that might compromise access. Conversely, as part of this methodology review staff did not want to replicate national use rates that the Maryland Model was intended to fix, like the preference for hospital-based outpatient procedures.
5	Consider Baseline Methodology Decisions that have Impact on Population Governor in Demographic Adjustment	Similar to other reviews of methodologies, staff took this opportunity to review all the underpinnings of the population governor in the current Demographic Adjustment policy. Due to timing constraints, staff did not review the distribution logic in the Demographic Adjustment, nor did it review if there were better data sources to more accurately project population change.

Utilization Analysis & Potential Risk Adjustment Methodology

- **Using inpatient days and equivalent inpatient days per thousand as well as Medicare and Milliman commercial claims data, separate models were developed for inpatient and outpatient utilization in Maryland and nationally, resulting in four distinct models.**
- **Each model initially determined the per capita utilization for 2013 and 2023 through regression analysis, controlling for age, sex, and disability status.**
- **Secular population-level utilization changes (or changing practice patterns), were estimated by applying the regression-based estimates to a fixed population distribution derived from Maryland census data.**
  - **Specifically, changes in Maryland's utilization patterns from 2013 to 2023 were estimated by comparing the 2013 and 2023 regression results that were applied to the 2023 Maryland population distribution.**
  - **Non-Maryland estimates were calculated similarly, using non-Maryland regression results and the same Maryland census distribution, which enabled demographically-standardized comparisons.**
- **Finally, Maryland's demographic changes and its impact on utilization were estimated by keeping the utilization year estimates constant at 2013 and comparing both the calculated utilization for 2013 and 2023 Maryland census distributions**

How to Read these Tables:

- **Down a column**: Shows the impact of population changes (aging) assuming fixed practice patterns.
- **Across a row**: Shows the impact of health practice pattern changes (e.g., shift away from inpatient care) assuming a fixed population.
- **Along the diagonal**: Reflects the combined impact of both population aging and changes in practice patterns.

Maryland Inpatient Days		Utilization Pattern Year											Util Pattern Change (2023/2013)
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	
Demo Year	2013	**481**	446	434	448	440	430	445	374	419	396	391	-18.5%
	2014	487	452	441	454	446	436	451	379	424	401	396	-18.7%
	2015	494	459	447	460	451	441	456	383	429	406	401	-18.8%
	2016	500	466	453	467	457	447	461	388	434	411	406	-18.8%
	2017	507	472	459	472	462	452	466	392	439	415	411	-18.9%
	2018	513	478	465	478	467	457	471	396	444	420	416	-19.0%
	2019	519	485	471	484	472	462	476	400	449	425	420	-19.1%
	2020	525	491	477	489	477	467	481	405	454	429	425	-19.1%
	2021	532	498	484	496	483	473	486	409	459	434	430	-19.1%
	2022	535	502	488	499	485	476	488	411	462	437	433	-19.1%
	2023	**540**	507	493	504	489	480	492	415	466	441	**437**	**-19.2%**
Demo Change		**12.4%**	13.7%	13.5%	12.3%	11.2%	11.6%	10.5%	10.9%	11.1%	11.4%	11.6%	**-9.1%**

Corresponds to -20% on next slide once adjustment for MA morbidity is accounted for; -9.1% = -10% on next slide

Results in Summary

Exhibit: Changes in hospital inpatient and outpatient utilization in Maryland and non-Maryland, 2013-2023

Setting (Metric)	Utilization Pattern Change	Maryland Demographic Composition Change	Combined Change
Maryland			
Inpatient Utilization (Days)	-20%	+12%	-10%
Outpatient Utilization (EIPDs)	-15%	+6%	-10%
Total Utilization (EIPDs)	-18%	+10%	**-10%**
Non-Maryland			
Inpatient Utilization (Days)	-16%	+12%	-5%
Outpatient Utilization (EIPDs)	+7%	+5%	+12%
Total Utilization (EIPDs)	-5%	+9%	**+3%**
Difference (Maryland minus non-Maryland)			
Inpatient Utilization (Days)	-4%	+0%	-4%
Outpatient Utilization (EIPDs)	-22%	+1%	-21%
Total Utilization (EIPDs)	-12%	+1%	-12%

Observations:

- In Maryland, including demographic impacts, hospital utilization decreased by **10%** from 2013 to 2023.
- Had Maryland followed the same utilization patterns as other states but experienced its own demographic changes, total hospital utilization would have increased by **3%.**
- After accounting for Maryland's performance relative to the nation in services that MedPac indicated could be done safely in a physician office (66 ambulatory payment categories), the national utilization change of 3% decreases to **~1%.**

Staff Recommendations on DA Considerations

	Policy Consideration	Contingencies	Staff Recommendation
1.	Fund Age-Adjusted Demographic Growth currently calculated in Demographic Adjustment policy		**Reject -** Staff do not recommend funding an additional 0.65% per year for "age adjusted growth" as it does not account for year over year secular changes and it does not account for complete risk change. Additionally, staff are concerned that utilizing a flawed statistic to inflate volume growth will potentially incentivize hospitals to grow avoidable volumes, e.g., readmissions, PQIs, and inpatient length of stay.
2.	Fund HCC Adjusted Population Growth for Medicare	May require assessing the degree to which Maryland HCCs are not indicative of risk change due to suboptimal nature of input risk variables	**Reject -** Staff believe, at this time, it is unwise to utilize a Medicare risk adjustment model that Maryland hospitals may have underreported values for. Additionally, data isn't available to support populations other than Medicare so this would result in an inconsistent adjustment.
3.	Fund Population Growth with National Demand Modifier Applied	Will necessitate similar future assessments to ensure retrospective analysis of 1% demand growth over 10 years is indicative of ongoing trends	**Support -** Staff believe this is the most reasonable modifier to population growth that can be applied on all-payer basis for the next two calendar years, as the State transitions into a bifurcated Model where CMMI will adjust Medicare volumes with the HCC risk adjustment model and the HSCRC continues to adjust volumes for population growth and an assessment for appropriate national demand changes.
4.	Apply Variable Cost Factor to DA Funding	May require additional assessments to determine if longer term fixed costs need to be accounted if a variable cost factor is applied	**Reject -** Staff believe the exact value to account for variable costs and necessary fixed costs for ongoing population related volume growth is not currently established, nor easily ascertained. Thus, does not recommend applying a variable cost factor at this time.
5.	Exclude DA Funding from Volume Variable Services	Will require a future workgroup engagement to establish all volumes that will be carved out of population based payments moving forward.	**TBD -** Staff believe that the application of a population growth statistic on volumes adjudicated through a separate volume variable policy is flawed. Thus, staff recommend against applying the demographic adjustment in that instance. However, the extent of volume carved out of population based payments is still under development and subject to contractual requirements in the AHEAD State Agreement, so staff recommends delaying the implementation until carved out volumes are known.

Draft Recommendations

1. Apply a national demand modifier of 0.1 percent to the Demographic Adjustment policy, starting with the RY 2026 policy. Funding adjustment will be implemented July 1, 2026 in concert with the RY 2027 Update Factor.
2. Revisit the national demand analysis every 2-3 years to determine if the calculation requires updating and if a retrospective adjustment to prior year Demographic Adjustments is warranted.
3. Discontinue the application of the Demographic Adjustment to volumes that are adjudicated through a distinct volume variable methodology and are not part of population based payments. Funding adjustment will be implemented July 1, 2026 in concert with the RY 2027 Update Factor once non-population based volumes are established

Comments on this draft recommendation are due by Wednesday November 19, 2025, via email to allani.pack@maryland.gov.

Appendix

Appendix A: Demographic Adjustment Example

- The calculation is performed across all of Maryland's zip codes and for 8 age cohorts so age cost weights can be applied
- Final age-adjusted growth is discounted by potentially avoidable utilization and an adjustment to ensure statewide growth equals population growth – PAU adjustment only affects distribution, not overall governor

Zip Code	Age Cohort	Base Year ECMADs for Hospital	Total ECMADs for All Hospitals	Share of ECMADs	Base Population	Allocated Base Population	State Total Hospital Revenue per Capita	Age Cost Weights	Projected Population Growth Rate of Cohort	Age Adjusted Population Growth Rates	Hospital Age Adjusted Population Growth	Hospital Overall Age Adjusted Population Growth	Hospital PAU %	Hospital Specific PAU Adjusted Growth Rate	Statewide Per capita Efficiency Adjustment
		STEP 1a			Step1b		Step2a		Step2b		Step 3		Step 4		
A	B	C	D	E = C/D	F	G=F * E	H	I=H/H(total)	J	K=J*I	L=G*K	M=sum(L)/sum(G)	N	O=M*(1-N)	P=O*50%
00000	0-4	30	60	50%	3,713	1,857	$1,577	0.68	0.77%	0.52%	10				
00000	05-14	45	100	45%	23,471	10,562	$119	0.05	-0.07%	0.00%	(0)				
00000	15-44	100	210	48%	8,902	4,239	$3,798	1.63	-1.16%	-1.89%	(80)				
00000	45-55	20	35	57%	7,533	4,305	$2,822	1.21	1.18%	1.43%	61				
00000	55-64	25	40	63%	7,450	4,657	$3,413	1.46	0.16%	0.23%	11				
00000	65-74	25	30	83%	4,517	3,764	$5,162	2.21	2.73%	6.04%	227				
00000	75-84	55	70	79%	2,282	1,793	$7,337	3.14	2.42%	7.60%	136				
00000	85+	60	80	75%	1,044	783	$8,009	3.43	1.32%	4.53%	35				
Total	Total	360	625	58%	58,913	31,959	$2,335				401	1.3%	14%	1.08%	0.54%

Scaling adjustment to get to population growth

Annual average discount across Model (RY14-RY22) = ~0.60%

Max = 0.95% in RY 2017

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Appendix B: Results of Changes in Maryland Outpatient Days per Thousand Due to Demographics and Changing Practice Patterns

Maryland Outpatient EIPDs		Utilization Pattern Year											Util Pattern Change (2023/2013)
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	
Demo	2013	**407**	405	396	406	414	369	387	296	332	338	345	-15.2%
Year	2014	411	409	400	410	418	373	391	299	335	341	349	-15.2%
	2015	414	412	403	413	421	376	394	301	338	344	352	-15.1%
	2016	417	415	406	416	424	379	397	304	341	346	354	-15.1%
	2017	420	418	409	418	426	382	399	306	344	349	357	-15.0%
	2018	423	421	412	421	429	385	402	308	346	352	360	-14.9%
	2019	425	423	414	423	431	388	405	310	349	354	362	-14.8%
	2020	427	425	417	426	433	391	407	312	351	357	364	-14.7%
	2021	430	428	419	428	435	394	409	314	353	359	367	-14.6%
	2022	430	429	420	429	436	395	410	315	355	360	368	-14.5%
	2023	**432**	431	422	430	438	397	412	317	357	362	**370**	**-14.4%**
Demo Change		**6.1%**	6.4%	6.4%	5.9%	5.6%	7.6%	6.5%	7.0%	7.3%	7.2%	7.1%	**-9.2%**

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Appendix C: Results of Changes in Maryland Total EIPDs per Thousand Due to Demographics and Changing Practice Patterns

Maryland Total EIPDs		Utilization Pattern Year											Util Pattern Change (2023/2013)
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	
Demo	2013	**888**	851	831	855	855	800	832	670	751	733	737	-17.0%
Year	2014	898	861	840	864	864	809	841	677	759	741	745	-17.1%
	2015	908	870	849	873	872	817	849	684	767	749	753	-17.1%
	2016	918	880	859	882	880	826	858	691	776	757	760	-17.1%
	2017	927	890	868	891	888	834	866	698	783	764	768	-17.1%
	2018	936	899	877	899	896	843	873	705	791	772	775	-17.2%
	2019	944	908	885	907	903	850	880	711	798	779	782	-17.2%
	2020	953	916	894	915	911	858	888	717	805	786	789	-17.2%
	2021	961	926	903	923	918	867	895	723	812	793	797	-17.1%
	2022	966	930	908	927	921	871	898	726	816	797	801	-17.1%
	2023	**973**	938	915	934	927	877	904	732	822	803	**807**	**-17.1%**
Demo Change		**9.5%**	10.2%	10.1%	9.3%	8.5%	9.7%	8.6%	9.2%	9.5%	9.5%	9.5%	**-9.1%**

Appendix D: Results of Changes in National Inpatient Days per Thousand Due to Demographics and Changing Practice Patterns

Non-Maryland Inpatient Days		Utilization Pattern Year											Util Pattern Change (2023/2013)
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	
Demo	2013	**484**	456	437	459	446	444	457	414	450	432	423	-12.5%
Year	2014	490	462	443	465	452	450	462	419	455	437	428	-12.7%
	2015	496	468	449	471	457	455	467	424	460	441	432	-12.9%
	2016	503	474	456	476	463	461	473	429	464	446	437	-13.1%
	2017	509	480	461	482	469	466	478	433	469	451	441	-13.3%
	2018	515	487	468	488	474	471	483	438	474	455	446	-13.5%
	2019	521	492	474	493	480	477	488	442	478	460	450	-13.7%
	2020	528	499	480	499	486	482	493	447	482	464	455	-13.9%
	2021	534	505	487	505	492	488	499	452	487	469	460	-14.0%
	2022	538	509	491	508	496	491	502	454	489	471	462	-14.2%
	2023	**543**	514	496	513	501	496	506	458	493	475	**466**	**-14.3%**
Demo Change (2023/2013)		**12.3%**	12.8%	13.5%	11.8%	12.2%	11.6%	10.7%	10.6%	9.5%	10.0%	10.0%	**-3.8%**

Appendix E: Results of Changes in National Outpatient Days per Thousand Due to Demographics and Changing Practice Patterns

Non-Maryland Outpatient EIPDs		Utilization Pattern Year											Util Pattern Change (2023/2013)
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	
Demo Year	2013	**429**	417	411	425	424	428	458	377	440	450	463	7.8%
	2014	432	420	414	428	427	432	461	380	444	453	466	7.8%
	2015	435	423	417	431	430	435	464	383	446	456	469	7.9%
	2016	437	425	420	433	433	438	467	385	449	459	472	7.9%
	2017	439	428	422	436	435	440	469	387	452	461	474	8.0%
	2018	442	431	425	438	438	443	472	390	454	464	477	8.0%
	2019	444	433	427	441	440	445	474	392	457	466	480	8.1%
	2020	446	435	430	443	443	448	477	394	459	469	482	8.1%
	2021	448	438	432	445	445	450	479	396	461	471	484	8.2%
	2022	449	439	434	446	446	452	480	397	462	472	485	8.2%
	2023	**450**	441	436	448	448	454	482	399	464	474	**487**	**8.3%**
Demo Change (2023/2013)		**4.9%**	5.8%	6.1%	5.6%	5.7%	5.9%	5.3%	5.9%	5.5%	5.5%	5.4%	**13.6%**

Appendix F: Results of Changes in National Total EIPDs per Thousand Due to Demographics and Changing Practice Patterns

Non-Maryland Total EIPDs		Utilization Pattern Year											Util Pattern Change
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	(2023/2013)
Demo	2013	**913**	873	848	884	870	873	915	791	890	882	886	-3.0%
Year	2014	922	882	857	893	879	881	924	799	898	890	894	-3.1%
	2015	931	891	866	901	888	890	932	806	906	897	901	-3.2%
	2016	940	900	875	910	896	898	940	814	914	905	909	-3.3%
	2017	948	908	883	918	904	906	947	820	920	912	916	-3.4%
	2018	957	917	893	926	913	914	955	828	928	919	923	-3.5%
	2019	965	925	901	934	921	922	963	834	934	926	930	-3.7%
	2020	974	934	910	942	929	930	970	841	941	933	937	-3.8%
	2021	982	943	919	950	937	938	978	848	948	940	944	-3.9%
	2022	987	948	925	955	942	943	982	852	951	944	947	-4.0%
	2023	**994**	955	932	962	949	950	988	857	957	949	**953**	**-4.1%**
Demo Change (2023/2013)		**8.8%**	9.5%	9.9%	8.8%	9.0%	8.8%	8.0%	8.4%	7.5%	7.7%	7.6%	**4.4%**

Appendix G: Estimates for Revisions to RY 2026 Demographic Adjustment

HOSPID	Curremt RY 2026 Demographic Adjustment	RY 2026 Demographic Adjustment with 0.1% Demand Modifier	Estimated %of Revenue Not Attriubtable to Population Based Pamyments (CY 2024)	RY 2026 Demographic Adjustment with .1%Demand Modifier & Deduction for Revenue Not Attriubtable to Population Based Payments
210001	1.41%	1.50%	22.48%	1.17%
210002	1.03%	1.10%	23.32%	0.84%
210003	1.29%	1.38%	8.75%	1.26%
210004	1.03%	1.10%	8.92%	1.01%
210005	4.17%	4.45%	4.12%	4.26%
210006	1.56%	1.66%	5.19%	1.58%
210008	0.81%	0.87%	6.85%	0.81%
210009	0.79%	0.85%	29.05%	0.60%
210010	0.78%	0.84%	5.51%	0.79%
210011	1.27%	1.35%	4.37%	1.29%
210012	0.77%	0.82%	6.06%	0.77%
210013	-0.80%	-0.80%	1.39%	-0.79%
210015	1.00%	1.07%	6.85%	0.99%
210016	2.31%	2.47%	4.42%	2.36%
210017	0.81%	0.87%	34.04%	0.57%
210018	1.78%	1.90%	7.35%	1.76%
210019	1.46%	1.56%	21.05%	1.23%
210022	2.79%	2.97%	11.57%	2.63%
210023	1.79%	1.91%	2.83%	1.86%
210024	1.42%	1.51%	3.65%	1.46%
210027	-0.52%	-0.52%	29.24%	-0.37%
210028	1.82%	1.94%	4.23%	1.86%
210029	1.32%	1.40%	10.70%	1.25%
210030	1.91%	2.03%	3.53%	1.96%
210032	2.62%	2.79%	16.64%	2.33%
210033	2.16%	2.31%	8.18%	2.12%
210034	0.78%	0.83%	2.02%	0.81%
210035	2.91%	3.10%	3.71%	2.98%
210037	2.71%	2.89%	2.28%	2.83%
210038	0.34%	0.37%	3.07%	0.36%
210039	1.92%	2.05%	6.57%	1.92%
210040	1.15%	1.22%	2.00%	1.20%
210043	2.28%	2.43%	1.99%	2.38%
210044	0.65%	0.69%	3.33%	0.67%
210045	0.58%	0.62%	6.14%	0.58%
210048	2.10%	2.24%	3.40%	2.16%
210049	2.38%	2.54%	3.52%	2.45%
210051	2.15%	2.30%	6.57%	2.15%
210055	0.42%	0.45%	6.81%	0.42%
210056	0.99%	1.05%	1.08%	1.04%
210057	1.26%	1.35%	3.31%	1.30%
210058	0.68%	0.73%	3.35%	0.70%
210060	1.63%	1.74%	11.09%	1.55%
210061	2.87%	3.07%	29.80%	2.15%
210062	1.95%	2.08%	6.96%	1.94%
210063	1.57%	1.67%	3.39%	1.62%
210064	0.57%	0.61%	3.96%	0.59%
210065	2.06%	2.20%	5.56%	2.08%
210087	0.28%	0.30%	3.34%	0.29%
210088	1.47%	1.57%	5.71%	1.48%
210333	-0.26%	-0.26%	10.01%	-0.23%
Statewide	1.51%	1.61%		1.47%

maryland health services cost review commission

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Draft Recommendation for Demographic Adjustment Refinement

November 12, 2025

Health Services Cost Review Commission
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This document contains the draft staff recommendations for updating the Demographic Adjustment methodology. Please submit comments on this draft to the Commission by Wednesday November 19, 2025, via email to allani.pack@maryland.gov.

Key Methodology Concepts, Definitions, and Abbreviations

1. Achieving Healthcare Efficiency through Accountable Design (AHEAD) -
2. CMS - Centers for Medicare & Medicaid Services
3. CY - Calendar year
4. Equivalent Case Mix Adjusted Discharges (ECMADS) – Often referred to as casemix, ECMADS are a volume statistic that account for acuity, as not all services require the same level of care and resources.
5. FFS - Fee-for-service
6. FY - Fiscal Year, typically refers to a State fiscal year from July 1 through the following June 30
7. FFY - Federal fiscal year refers to the period of October 1 through September 30
8. Global Budget Revenue (GBR) - a single, fixed-income budget for hospitals to cover all services for all payers, including Medicare, Medicaid, and commercial insurance. The goal is to control costs, improve quality of care, and ensure a stable financial environment for hospitals.
9. HSCRC or Commission - Health Services Cost Review Commission
10. RY - Rate year, which is July 1 through June 30 of each year
11. TCOC - Total Cost of Care, which is a measure of beneficiary's total healthcare spending, regardless of site of service
12. Total Patient Revenue (TPR) - a revenue constraint system developed by the HSCRC and available to sole community provider hospitals and hospitals operating in regions of the State characterized by an absence of densely overlapping services areas, which provided hospitals with a financial incentive to manage their resources efficiently and effectively in order to slow the rate of increase in the cost of health care.
13. Variable Cost Factor – The percentage of charges required to reimburse a hospital for the variable costs (supplies, drugs, etc.) associated with increases in volume. The historical standard by which the industry and the Commission evaluate volume funding adequacy is 50 percent, as prior analyses indicated that 50 percent of all service charges on average covers fixed costs and 50 percent covers variable costs. The Commission is currently considering a revision to the calculated variable cost factor, which would result in an effective variable cost factor of 59 percent.

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Executive Overview

Since 2014, Maryland has transformed its healthcare payment system through the All-Payer Model and the Total Cost of Care Model, shifting from volume-based reimbursement to a population-based approach that emphasizes per capita hospital spending and quality outcomes. Central to this transformation is the Global Budget Revenue (GBR) system and its Demographic Adjustment policy, which allocates funding based on age-adjusted population growth to align with statewide per capita targets. However, as Maryland's population ages—projected to reach 26 percent aged 60 and older by 2030—stakeholders have raised concerns that the current methodology may not fully account for utilization changes tied to aging and other risk factors. HSCRC staff, supported by the *Volume Workgroup* and an actuarial analysis of 2013–2023 data, found that while demographics alone would have increased hospital utilization by 10 percent, practice pattern changes reduced utilization by 18 percent, resulting in a net 10 percent decline. National comparisons suggest that Maryland's utilization would have risen only modestly under national trends, supporting a conservative adjustment of 0.1 percent annually to account for national demand growth. To maintain alignment with the Total Cost of Care and AHEAD Models, HSCRC staff recommend applying this 0.1 percent modifier beginning in Rate Year(RY)) 2026, reassessing it every two to three years, and excluding non-population-based revenues from the Demographic Adjustment. These updates ensure the policy continues to balance equitable hospital funding with the Model's goals of efficiency, sustainability, and accountability.

Introduction

Since 2014, Maryland has transformed its healthcare system through the All-Payer Model (2014) and the Total Cost of Care Model (2019). This shift moved the state from volume-based payments to a population-based model, focusing on total hospital spending per capita and various outcomes, including readmissions, in-hospital complications, potentially avoidable utilization, and overall cost of care. The state successfully met all contractual targets through 2024.[1]

A crucial element of this transformation was the Global Budget Revenue (GBR) methodology, which provided hospitals with annual prospective budgets. To address population-related utilization changes and market shifts, the HSCRC developed the Demographic Adjustment and Market Shift methodologies at the outset of the All-Payer Model. The Market Shift Adjustment accounts for changes in patient choice and is zero-sum, meaning volume adjustments must have an equal offsetting value.

The Demographic Adjustment aims to provide funding for age-adjusted population growth or decline at the zip code or county level, anticipating utilization changes based on demographic shifts. This adjustment serves as the primary policy mechanism or governor for recognizing system-wide volume changes within the Model. Currently, this policy is capped by Maryland Department of Planning estimates of statewide population growth to align with the per capita nature of the All-Payer and Total Cost of Care Model tests, which are not risk-adjusted.

However, concerns have arisen that population growth adjustments without risk adjustment, particularly for an aging population, may not adequately account for changes in healthcare utilization rates. The Maryland Department of Planning reports that the population aged 60 and older increased from 15 percent of all Marylanders in 2000 to 23 percent in 2020, with a projected increase to 26 percent by 2030.[2] This aging rate is slightly above national forecasts. Hospital representatives have noted that the current Demographic Adjustment generates an age-adjusted growth statistic, primarily for distributing population growth, which has been 0.65 percent higher (approximately $130 million) than the average annual population growth of 0.33 percent (approximately $65 million) incorporated into hospital rates since the 2020 census.

Conversely, HSCRC staff and other stakeholders acknowledge that while statewide population growth does not capture all factors influencing hospital utilization, it has served as a reasonable guide for determining statewide funding under a per capita model. This is supported by the consistent finding in the HSCRC *Volume Scorecard* analytic that hospitals generally have been overfunded for volume changes within the Model. Additionally, staff and stakeholders point to numerous other factors beyond aging that influence future hospital use rates, such as patient acuity, shifts in care settings, innovation and technology, and socioeconomic factors. The new Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model also recognizes the multifaceted nature of projecting future hospital use rates.

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[1] Limiting all-payer hospital spending per capita in line with the growth of the economy, saving Medicare a total of at least $795 million by keeping Maryland's Medicare per beneficiary growth below the national growth rate (currently the state has cumulatively saved $3.6 billion), reducing Medicare readmissions to the national average (currently 2.7% lower than national average; 4.7% on a risk adjusted basis), reducing hospital acquired complications by 30 percent (currently the State has reduced from 2018 to 2024 by 41 percent), moving virtually all hospital payment methodologies to approved population based approaches, and effectively incentivizing hospitals to engage in site neutral activities that improve the affordability of the system.

[2] https://aging.maryland.gov/Pages/LRM.aspx#:~:text=Why%20Maryland%20Needs%20a%20Multisector,and%20purposeful%20lives.%E2%80%8B%E2%80%8B

This is evident in its incorporation of the Hierarchical Condition Category risk adjustment model into the CMS-designed Demographic Adjustment policy, which considers aging and various other cost-influencing variables like gender, dual eligible status, disability status, and medical conditions.

This policy recommendation will detail the work staff did with the *Volume Workgroup* and the methods by which staff and stakeholders concluded that modifications to the Demographic Adjustment policy are necessary, especially concerning the effective cap on statewide funding.

Background

In 2011, the HSCRC introduced a demographic adjustment for the 10 rural hospitals operating under the Total Patient Revenue (TPR) System, the predecessor to the GBR methodology. This adjustment utilized age-adjusted county projections and was initially set at 25 percent of the projected age-adjusted population change, due to reductions for a 50 percent variable cost factor and a 50 percent productivity adjustment.

The current Demographic Adjustment policy was fully implemented for the remaining hospitals in Rate Year 2015. In subsequent years, the Commission incorporated the full value of statewide population growth into the adjustment calculation with no variable cost factor and applied it to all revenue (regardless of whether or not revenue was adjusted for through a non-population based methodology). To better distribute funding to areas experiencing faster aging, an age-weighting formula was later integrated. While this formula increased potential statewide funding, it was not intended to be the sole determinant of statewide funding, as it did not account for complete risk change or year-over-year utilization trends.

Moving into *Volume Workgroup* engagement, staff utilized the following principles to guide its review of the Demographic Adjustment methodology:

Table 1: Guiding Principles for Demographic Adjustment Review

	Guiding Principle	Comment
1.	Account for Year-Over-Year Changes in Hospital Use Rates	The current age-adjusted growth statistic is based on an evaluation of current year variation in per member per year (PMPY) spending. If average PMPY spending changes each year in line with secular trends, using the current age-adjusted growth statistic will fail to account for changes in trend
2.	Account for Total Risk Change	Aging is one of the most significant factors in changing hospital use rates, but it is not the only factor. To accurately modify population growth projections for changing risk profiles, total risk change should be accounted for.
3.	Align with AHEAD Methodology When Possible	The AHEAD Financial Specifications calls for Medicare Hospital Global Budgets to be adjusted for population growth that is risk adjusted for changes in Hierarchical Condition Categories (HCC's), which is risk adjustment model that accounts for aging and several other factors (e.g., disability status, diagnoses). While HCC's (or a similar grouper) is not available on a total population level, the AHEAD Model is clearly declaring its intention to adjust population growth for total risk change.
4.	Do Not Build in All TCOC Model Impacts into Estimating Future Demand	One particular approach to assessing use rate changes would be to longitudinally assess changes in utilization in Maryland since the start of Global Budgets in 2014. While this might make sense for various types of services that have generated savings and the State would not want to unwind through a revision to the Demographic Adjustment (e.g., site neutral service offerings), using Maryland experience for all use rate change would build in Model effects and would create an unsustainable Model that might compromise access.
5.	Consider Baseline Methodology Decisions that have Impact on Population Governor in Demographic Adjustment	Similar to other reviews of methodologies, staff took this opportunity to review all the underpinnings of the population governor in the current Demographic Adjustment policy. Due to timing constraints, staff did not review the distribution logic in the Demographic Adjustment, nor did it review if there were better data sources to more accurately project population change.

Overview of Demographic Adjustment Calculation

The Demographic Adjustment calculation starts by defining a hospital's virtual patient service area (VPSA). This is achieved by aggregating the hospital's service volume across all zip codes for eight distinct age groups within the State.[3] The HSCRC then uses this service area distribution to assign population to each hospital. This assignment is based on the proportional share of casemix-adjusted services a hospital provides to patients in each zip code, relative to all hospitals (i.e., market share).

Next, the HSCRC calculates the estimated population change for the attributed population using population projections.[4] An age weight is applied to each age/zip code cohort within the hospital's VPSA. This adjusts for differences in the cost per capita for each age cohort and accounts for changes due to population aging.

A portion of the existing service volume is considered potentially avoidable utilization (PAU). The HSCRC removes this hospital-specific portion of the base volume to prevent any growth allowance for PAU when projecting a hospital's expected volume growth driven by demographic changes. The remaining statewide age-adjusted population growth is then compared to population growth estimates from the state's Department of Planning. Each hospital's Demographic Adjustment is subsequently multiplied by a pro-rata reduction factor. This factor accounts for expected per capita efficiencies, which are necessary to achieve the overall per capita savings targets outlined in the All-Payer and Total Cost of Care Models. Essentially, the final statewide Demographic Adjustment matches the Department of Planning's growth estimates. The outcome of this process is the population-driven volume growth that will be incorporated into each hospital's global budget for the upcoming fiscal year.

Summary:

1. Calculate base population estimates for the current calendar year for each hospital based on a hospital's share of volume, as measured by equivalent case-mix adjusted discharges, in a given zip code age cohort.
2. Calculate age adjusted population growth rates by multiplying statewide age cost weights with zip/age population growth rates.
3. Calculate hospital specific age adjusted population growth by multiplying hospital specific base population by age adjusted population growth rates for each zip/age cohort and calculating total projected age adjusted population growth
4. Calculate final demographic adjustment by applying efficiency adjustments
    a. Reduce age adjusted population growth by hospital specific PAUs as a percent of total all-payer revenue
    b. Reduce PAU/age adjusted population growth by pro-rata per capita efficiency adjustment reduction

Below is an example calculation with just one zip code for a GBR hospital to arrive at the statewide per capita efficiency adjustment.

[3] The eight age cohorts (0 to 4, 5 to 14, 15 to 44, 45 to 54, 65 to 74, 75 to 84, 85+) within each zip code provide more specific cost trends than would otherwise result from an overall distribution since population growth trends and health care use within these cohorts differ significantly.

[4] HSCRC obtains its projections from a private vendor, Claritas, who provides zip code and age specific population estimates for current year and 5-year population projections.

Table 2: Demographic Example:

Zip Code	Age Cohort	Base Year ECMADs for Hospital	Total ECMADs for All Hospitals	Share of ECMADs	Base Population	Allocated Base Population	State Total Hospital Revenue per Capita	Age Cost Weights	Projected Population Growth Rate of Cohort	Age Adjusted Population Growth Rates	Hospital Age Adjusted Population Growth	Hospital Overall Age Adjusted Population Growth	Hospital PAU %	Hospital Specific PAU Adjusted Growth Rate	Statewide Per capita Efficiency Adjustment
		STEP 1a			Step1b		Step2a		Step2b		Step 3			Step 4	
A	B	C	D	E = C/D	F	G=F * E	H	I=H/H(total)	J	K=J*I	L=G*K	M=sum(L) /sum(G)	N	O=M*(1-N)	P=O*50%
00000	0-4	30	60	50%	3,713	1,857	$1,577	0.68	0.77%	0.52%	10				
00000	05-14	45	100	45%	23,471	10,562	$119	0.05	-0.07%	0.00%	(0)				
00000	15-44	100	210	48%	8,902	4,239	$3,798	1.63	-1.16%	-1.89%	(80)				
00000	45-55	20	35	57%	7,533	4,305	$2,822	1.21	1.18%	1.43%	61				
00000	55-64	25	40	63%	7,450	4,657	$3,413	1.46	0.16%	0.23%	11				
00000	65-74	25	30	83%	4,517	3,764	$5,162	2.21	2.73%	6.04%	227				
00000	75-84	55	70	79%	2,282	1,793	$7,337	3.14	2.42%	7.60%	136				
00000	85+	60	80	75%	1,044	783	$8,009	3.43	1.32%	4.53%	35				
Total	Total	360	625	58%	58,913	31,959	$2,335				401	1.3%	14%	1.08%	0.54%

Methodology Assessment

In this section, staff will analyze current concerns and/or potential advancements to the Demographic Adjustment methodology.

Age Adjusted Growth

Staff analysis began by considering the hospital field's request for an additional 0.65 percent for the RY 2026 Demographic Adjustment, representing the annual reduction between age-adjusted growth and population growth. The Demographic Adjustment is currently funded at 1.50 percent in rates in RY 2026, comprising 0.74 percent for CY 2024 over CY 2023 population growth and 0.76 percent for prior-year restatements of population growth from the Maryland Department of Planning. The hospital field's request would increase the CY 2024 growth of 0.74 percent to 1.39 percent and the total Demographic Adjustment from 1.50 percent to 2.15 percent (an increase of approximately $130 million).

Staff have consistently argued that this statistic is based on a false premise for two main reasons:
a) It relies on current-year variations in per-member per-year spending, thus failing to account for year-over-year secular changes.
b) It does not consider other changes in risk that could either amplify or mitigate the effects of aging, such as technological advancements that reduce hospitalization rates.

In essence, the age-adjusted growth statistic was created to allocate population funding, not to impact total funding (i.e., the population governor). In light of these concerns, staff conducted several analyses to demonstrate that while age cost weights are appropriate for distributing population growth, they are not suitable for adjusting total funding via the Demographic Adjustment. The *Volume Workgroup* understood the importance of a retrospective analysis of Maryland and the nation encompassing age and non-age factors. To perform this analysis, staff engaged an actuarial consultancy firm that utilized the following approach:

1) **Measures** - Inpatient days per thousand for inpatient services was selected as was equivalent inpatient days (EIPDs)[5] per thousand for outpatient services - drugs were excluded because they do not reliably convert to EIPDs.[6] This allowed the evaluation to have a consistent measurement across inpatient and outpatient, namely total EIPDs (or the sum of inpatient days and EIPDs).
2) **Data Sources** - For the aged 65 and older or disabled[7] population, hospital claims from the Medicare Fee-For-Service 5 percent Sample or Limited Data Set (2013-2023) were utilized. For the under 65 non-disabled population, hospital claims from Milliman's Consolidated Health Cost Guidelines Sources Database (2013-2023) were utilized. And to evaluate population change, the Claritas database, which is currently used to project zip code population growth in the Demographic Adjustment, was utilized.
3) **Principal Methodology** - Separate models were developed for inpatient and outpatient utilization in Maryland and nationally, resulting in four distinct models (see table 3 for one example model).
    a) Each model initially determined the per capita utilization for 2013 and 2023 through regression analysis, controlling for age, sex, and disability status.
    b) After establishing hospital use rates for demographic groupings of patients, the methodology estimated secular population-level utilization changes (or changing practice patterns),[8] while controlling for demographic changes. This was achieved by applying the regression-based estimates to a fixed population distribution derived from Maryland census data. Specifically, changes in Maryland's utilization patterns from 2013 to 2023 were estimated by comparing the 2013 and 2023 regression results that were applied to the 2023 Maryland population distribution. Non-Maryland estimates were calculated similarly, using non-Maryland regression results and the same Maryland census distribution, which enabled demographically-standardized comparisons.
    c) Finally, Maryland's demographic changes and its impact on utilization were estimated by keeping the utilization year estimates constant at 2013 and comparing both the calculated utilization for 2013 and 2023 Maryland census distributions (see table 4 below for summary results of the four models)
4) **Medicare Advantage Discount** - For the Medicare population, Medicare FFS data was used to fit the models. Given the growth and favorable selection in Medicare Advantage, Medicare FFS has become increasingly morbid. Therefore, using estimates from the Medicare Payment Advisory Commission (MedPAC), the results of the 4 models were reduced by approximately 1 percent over the ten year evaluation so the FFS-calibrated models could be used to estimate utilization for the entire Medicare population.
5) **Sensitivity Tests** - Alternative data sources, utilization metrics, and fixed demographic and census years, as well as an alternative fully interacted regression specification were utilized to determine if results changed materially. Sensitivity test findings were directionally consistent with primary analysis

[5] Calculated as total outpatient allowed charges divided by average inpatient cost-per-day (CPD), a standard measurement that allows for comparisons across inpatient and outpatient services.

[6] While this is a limitation in the methodology, it is not an acute concern because HSCRC policies currently carve out a significant share of outpatient drugs from population based payments through the CDS-A volume policy for high cost outpatient drugs.

[7] A person was considered disabled if enrolled in Medicare and initially eligible for a reason other than age.

[8] Changing practice patterns is defined as changes in hospital utilization reflecting evolving medical practices, technologies, or policies, rather than changes in population demographics.

Table 3: Example: Results of Changes in Maryland Inpatient Days per Thousand Due to Demographics and Changing Practice Patterns[9]

Maryland Inpatient Days		Utilization Pattern Year											Util Pattern Change (2023/2013)
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	
Demo	2013	**481**	446	434	448	440	430	445	374	419	396	391	-18.5%
Year	2014	487	452	441	454	446	436	451	379	424	401	396	-18.7%
	2015	494	459	447	460	451	441	456	383	429	406	401	-18.8%
	2016	500	466	453	467	457	447	461	388	434	411	406	-18.8%
	2017	507	472	459	472	462	452	466	392	439	415	411	-18.9%
	2018	513	478	465	478	467	457	471	396	444	420	416	-19.0%
	2019	519	485	471	484	472	462	476	400	449	425	420	-19.1%
	2020	525	491	477	489	477	467	481	405	454	429	425	-19.1%
	2021	532	498	484	496	483	473	486	409	459	434	430	-19.1%
	2022	535	502	488	499	485	476	488	411	462	437	433	-19.1%
	2023	**540**	507	493	504	489	480	492	415	466	441	**437**	**-19.2%**
Demo Change		**12.4%**	13.7%	13.5%	12.3%	11.2%	11.6%	10.5%	10.9%	11.1%	11.4%	11.6%	**-9.1%**

How to Read these Tables:
- **Down a column**: Shows the impact of population changes (aging) assuming fixed practice patterns.
- **Across a row**: Shows the impact of health practice pattern changes (e.g., shift away from inpatient care) assuming a fixed population.
- **Along the diagonal**: Reflects the combined impact of both population aging and changes in practice patterns.

As shown above, this methodology isolates the extent to which:a) utilization changes are driven by demographics, i.e., from 2013 to 2023 Maryland's changing demographics contributed to a 12 percent increase in inpatient utilization; and b) utilization changes are driven by changing practice patterns (once demographic changes are controlled for), i.e., from 2013 to 2023 Maryland's shifting practice patterns decreased inpatient utilization by 19 percent. Taken together, these isolated influences on hospital use rates can then be combined to see the net effect (-9 percent), and the same analysis can be performed on national data but with Maryland demographics, permitting a demographically-standardized comparison.

Table 4: Summary Results of Changes in Maryland and National EIPDs per Thousand Due to Demographics and Changing Practice Patterns

[9] For the other Maryland and national models, see appendices 1-5

Setting (Metric)	Utilization Pattern Change	Maryland Demographic Composition Change	Combined Change
Maryland			
Inpatient Utilization (Days)	-20%	+12%	-10%
Outpatient Utilization (EIPDs)	-15%	+6%	-10%
Total Utilization (EIPDs)	-18%	+10%	**-10%**
Non-Maryland			
Inpatient Utilization (Days)	-16%	+12%	-5%
Outpatient Utilization (EIPDs)	+7%	+5%	+12%
Total Utilization (EIPDs)	-5%	+9%	**+3%**
Difference (Maryland minus non-Maryland)			
Inpatient Utilization (Days)	-4%	+0%	-4%
Outpatient Utilization (EIPDs)	-22%	+1%	-21%
Total Utilization (EIPDs)	-12%	+1%	-12%

The summary results table above highlights the following key findings for Maryland from 2013 to 2023:

- Overall Maryland hospital utilization, including demographic impacts, decreased by 10 percent.
- If Maryland had followed the utilization patterns of other states while experiencing its own demographic changes, total hospital utilization would have increased by 3 percent.
- Maryland's inpatient utilization patterns decreased by 4 percent more than other states.
- Maryland's outpatient utilization patterns decreased by 22 percent more than other states.

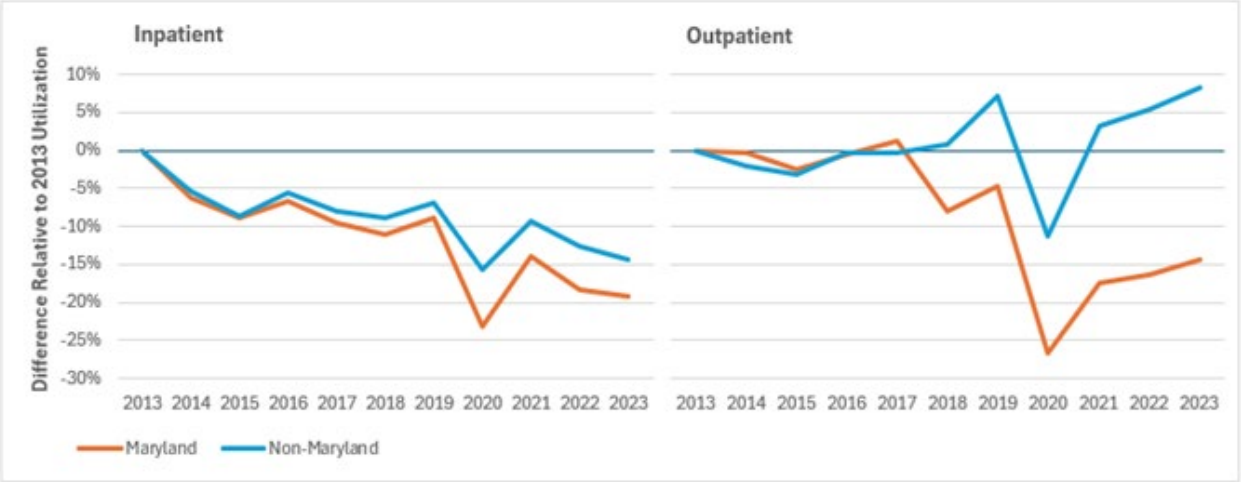
Staff do not believe that Maryland's performance over the past ten years should be used to modify the population governor in the Demographic Adjustment, as that builds in the incentives of the Model and its impacts into future volume funding allotments. Additionally, it would inappropriately accrue all savings to payers, and it would fail to recognize that hospitals have to make ongoing investments in order to maintain reductions in utilization, e.g., case managers, mobile integrated homes, sub-acute hospital alternatives. Finally, if the utilization declines experienced across the first ten years of Model are not replicated, building in this performance into future Demographic Adjustments could result in access to care issues.

Staff suggest that any retrospective evaluation of demographic and practice pattern changes used to modify the population governor in the Demographic Adjustment should be based on a national assessment. This means that if Maryland's utilization patterns mirrored national trends, while experiencing its own demographic shifts, total hospital utilization would have increased by approximately 3 percent, or 0.3 percent annually. Consequently, the Demographic Adjustment would incorporate Maryland's population growth along with changes in national demand for hospital services (around 0.3 percent per year).

However, it's important to note a key caveat: national outpatient demand is partly influenced by a lack of

site-neutral incentives, which are inherent in the Maryland Model. This difference[10] is likely a major factor in the greater variation observed between Maryland's and national outpatient use rates (refer to Table 5 below).

Table 5: Hospital Utilization Patterns in Maryland and Non-Maryland Relative to 2013, Adjusted for Changes in Demographic Composition



To address concerns regarding the absence of site-neutral incentives, staff, in collaboration with actuarial consultants, conducted an additional analysis. This analysis estimated the potential reduction in national hospital use rates from 2016-2023 if the nation had mirrored Maryland's utilization trends in selected service areas where the potential for site neutrality is well established . These service areas were 66 ambulatory payment categories (APCs) identified by MedPac[11] as services that could be safely performed in a physician's office and considered for site-neutral payment. For detailed results, please refer to Table

[10] "These payment differences encourage arrangements among providers, such as consolidation of physician practices with hospitals, that result in care being billed from settings with the highest payment rates, which increases total Medicare spending and beneficiary cost sharing without significant improvements in patient outcomes" - https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf

[11] https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf

6 below.

Table 6: Hospital Utilization Patterns in Maryland and Non-Maryland, using Maryland patterns for Services Under Site-Neutral Consideration

	Utilization Pattern Change			
	Primary Results (2023 vs 2013; all ages)	Subset Results (2023 vs 2016; Medicare only)	Using MD pattern for site neutral services (2023 vs 2016; Medicare Only)	Impact (Difference)
Maryland Total Utilization (EIPDs)	-18%	-12%	-12%	-
Non-Maryland Total Utilization (EIPDs)	-5%	-8%	-10%	**-1.9%**

Analysis suggests that the observed differences in hospital use rates between Maryland and the rest of the nation are likely due to the national incentive for hospitals to shift low-acuity services to outpatient departments for higher facility fees. Specifically, if national utilization for these services, where the appropriateness of site-neutrality is strongly established, had mirrored Maryland's pattern, overall national utilization changes would have been 2 percent lower - staff only quantified the impact of these services where the appropriateness of site neutrality was well documented by Medpac; however, it is likely there are significant additional services where the MD utilization pattern is appropriate and national utilization is only driven by national payment incentives to increase outpatient hospital utilization. This finding, combined with the earlier observation that Maryland's total hospital utilization would have increased by 3 percent if it had followed other states' utilization patterns while experiencing its own demographic shifts, indicates that any adjustments to the Demographic Adjustment to account for national demand should not exceed 1 percent over a decade, or 0.1 percent annually, assuming historic patterns continue.

Additional Considerations

While staff did not evaluate the accuracy of the Demographic Adjustment's distribution logic, a task recommended for a future workgroup, staff's review of the population governor's appropriateness brought three additional considerations to the *Volume Workgroup:*

1) **Hierarchical Condition Categories (HCC)** - HCC is a risk adjustment methodology that allows CMS to evaluate total population risk change for Medicare Advantage beneficiaries, it is also often applied to Medicare FFS populations. Theoretically, staff could apply an HCC risk adjustment to the portion of the Demographic population that is attributable to Medicare FFS, as the beneficiary count and HCC risk scores are known statistics. In the future, Medicare FFS global budgets will utilize HCC risk scores, in line with the AHEAD Model Financial Specifications;[12] however, staff have concerns about using the HCC risk assessments now because Maryland has historically not focused on optimizing the input variables in the HCC risk adjustment model, most notably diagnosis codes. If HCC risk adjustments for the Medicare FFS population (and no other modifications) were applied to the current RY 2026 Demographic Adjustment of 1.50 percent, the resulting value would be approximately 0.97 percent.
2) **100 Percent Variable Cost Factor** - historically the Demographic Adjustment has not applied a variable cost factor, despite the fact that some of the volume change to ongoing population

[12] https://www.cms.gov/files/document/ahead-tech-specs-v30.pdf

growth may not necessitate additional fixed costs. While staff are concerned about potentially overfunding fixed costs, there are many cases in which a hospital may incur costs over and above the newly established variable cost factor of 59 percent, e.g., enough population volume growth requires opening a floor that was previously shelf space.

3) **Population Based Payment Carveouts** - historically the Demographic Adjustment has been applied to all hospital global budget revenue; however, a portion of a hospital's revenue is attributable to services that are evaluated in distinct volume variable methodologies, e.g., out-of-state volumes through the Out-of-State policy, high cost drug volumes through the CDS-A policy, and to some extent quaternary services through the Complexity and Innovation policy. Staff are concerned that applying volume adjustments to these revenues based on Maryland population growth is unreasonable and will result in double payment for volume change.

Implications and Policy Options

To summarize all of the potential revisions to the population governor in the Demographic Adjustment policy, staff have created the following table:

Table 7: Summary of Policy Options and Staff Recommendations

	Policy Consideration	Contingencies	Staff Recommendation
1.	Fund Age-Adjusted Demographic Growth currently calculated in Demographic Adjustment policy		**Reject -** Staff do not recommend funding an additional 0.65% per year for "age adjusted growth" as it does not account for year over year secular changes and it does not account for complete risk change. Additionally, staff are concerned that utilizing a flawed statistic to inflate volume growth will potentially incentivize hospitals to grow avoidable volumes, e.g., readmissions, PQIs, and inpatient length of stay.
2.	Fund HCC Adjusted Population Growth for Medicare	May require assessing the degree to which Maryland HCCs are not indicative of risk change due to suboptimal nature of input risk variables	**Reject -** Staff believe, at this time, it is unwise to utilize a Medicare risk adjustment model that Maryland hospitals may have underreported values for. Additionally, data isn't available to support populations other than Medicare so this would result in an inconsistent adjustment.
3.	Fund Population Growth with National Demand Modifier Applied	Will necessitate similar future assessments to ensure retrospective analysis of 1% demand growth over 10 years is indicative of ongoing trends	**Support -** Staff believe this is the most reasonable modifier to population growth that can be applied on all-payer basis for the next two calendar years, as the State transitions into a bifurcated Model where CMMI will adjust Medicare volumes with the HCC risk adjustment model and the HSCRC continues to adjust volumes for population growth and an assessment for appropriate national demand changes.
4.	Apply Variable Cost Factor to DA Funding	May require additional assessments to determine if longer term fixed costs need to be accounted if a variable cost factor is applied	**Reject -** Staff believe the exact value to account for variable costs and necessary fixed costs for ongoing population related volume growth is not currently established, nor easily ascertained. Thus, does not recommend applying a variable cost factor at this time.
5.	Exclude DA Funding from Volume Variable Services	Will require a future workgroup engagement to establish all volumes that will be carved out of population based payments moving forward.	**TBD -** Staff believe that the application of a population growth statistic on volumes adjudicated through a separate volume variable policy is flawed. Thus, staff recommend against applying the demographic adjustment in that instance. However, the extent of volume carved out of population based payments is still under development and subject to contractual requirements in the AHEAD State Agreement, so staff recommends delaying the implementation until carved out volumes are known.

Recommendations

Staff recommend the following updates to the Demographic Adjustment policy:

1. Apply a national demand modifier of 0.1 percent to the Demographic Adjustment policy, starting with the RY 2026 policy. Funding adjustment will be implemented July 1, 2026 in concert with the RY 2027 Update Factor.
2. Revisit the national demand analysis every 2-3 years to determine if the calculation requires updating and if a retrospective adjustment to prior year Demographic Adjustments is warranted.
3. Discontinue the application of the Demographic Adjustment to volumes that are adjudicated through a distinct volume variable methodology and are not part of population based payments. Funding adjustment will be implemented July 1, 2026 in concert with the RY 2027 Update Factor once non-population based volumes are established (estimates of discontinuing the application of the Demographic Adjustment to services outside of population based payments are listed in Appendix 6).

Appendix 1. Results of Changes in Maryland Outpatient Days per Thousand Due to Demographics and Changing Practice Patterns

Maryland Outpatient EIPDs		Utilization Pattern Year											Util Pattern Change (2023/2013)
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	
Demo Year	2013	**407**	405	396	406	414	369	387	296	332	338	345	-15.2%
	2014	411	409	400	410	418	373	391	299	335	341	349	-15.2%
	2015	414	412	403	413	421	376	394	301	338	344	352	-15.1%
	2016	417	415	406	416	424	379	397	304	341	346	354	-15.1%
	2017	420	418	409	418	426	382	399	306	344	349	357	-15.0%
	2018	423	421	412	421	429	385	402	308	346	352	360	-14.9%
	2019	425	423	414	423	431	388	405	310	349	354	362	-14.8%
	2020	427	425	417	426	433	391	407	312	351	357	364	-14.7%
	2021	430	428	419	428	435	394	409	314	353	359	367	-14.6%
	2022	430	429	420	429	436	395	410	315	355	360	368	-14.5%
	2023	**432**	431	422	430	438	397	412	317	357	362	**370**	**-14.4%**
Demo Change		**6.1%**	6.4%	6.4%	5.9%	5.6%	7.6%	6.5%	7.0%	7.3%	7.2%	7.1%	**-9.2%**

Appendix 2. Results of Changes in Maryland Total EIPDs per Thousand Due to Demographics and Changing Practice Patterns

Maryland Total EIPDs		Utilization Pattern Year											Util Pattern Change (2023/2013)
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	
Demo Year	2013	**888**	851	831	855	855	800	832	670	751	733	737	-17.0%
	2014	898	861	840	864	864	809	841	677	759	741	745	-17.1%
	2015	908	870	849	873	872	817	849	684	767	749	753	-17.1%
	2016	918	880	859	882	880	826	858	691	776	757	760	-17.1%
	2017	927	890	868	891	888	834	866	698	783	764	768	-17.1%
	2018	936	899	877	899	896	843	873	705	791	772	775	-17.2%
	2019	944	908	885	907	903	850	880	711	798	779	782	-17.2%
	2020	953	916	894	915	911	858	888	717	805	786	789	-17.2%
	2021	961	926	903	923	918	867	895	723	812	793	797	-17.1%
	2022	966	930	908	927	921	871	898	726	816	797	801	-17.1%
	2023	**973**	938	915	934	927	877	904	732	822	803	**807**	**-17.1%**
Demo Change		**9.5%**	10.2%	10.1%	9.3%	8.5%	9.7%	8.6%	9.2%	9.5%	9.5%	9.5%	**-9.1%**

Appendix 3. Results of Changes in National Inpatient Days per Thousand Due to Demographics and Changing Practice Patterns

Non-Maryland Inpatient Days		Utilization Pattern Year											Util Pattern Change
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	(2023/2013)
Demo	2013	**484**	456	437	459	446	444	457	414	450	432	423	-12.5%
Year	2014	490	462	443	465	452	450	462	419	455	437	428	-12.7%
	2015	496	468	449	471	457	455	467	424	460	441	432	-12.9%
	2016	503	474	456	476	463	461	473	429	464	446	437	-13.1%
	2017	509	480	461	482	469	466	478	433	469	451	441	-13.3%
	2018	515	487	468	488	474	471	483	438	474	455	446	-13.5%
	2019	521	492	474	493	480	477	488	442	478	460	450	-13.7%
	2020	528	499	480	499	486	482	493	447	482	464	455	-13.9%
	2021	534	505	487	505	492	488	499	452	487	469	460	-14.0%
	2022	538	509	491	508	496	491	502	454	489	471	462	-14.2%
	2023	**543**	514	496	513	501	496	506	458	493	475	**466**	**-14.3%**
Demo Change (2023/2013)		**12.3%**	12.8%	13.5%	11.8%	12.2%	11.6%	10.7%	10.6%	9.5%	10.0%	10.0%	**-3.8%**

Appendix 4. Results of Changes in National Outpatient Days per Thousand Due to Demographics and Changing Practice Patterns

Non-Maryland Outpatient EIPDs		Utilization Pattern Year											Util Pattern Change
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	(2023/2013)
Demo	2013	**429**	417	411	425	424	428	458	377	440	450	463	7.8%
Year	2014	432	420	414	428	427	432	461	380	444	453	466	7.8%
	2015	435	423	417	431	430	435	464	383	446	456	469	7.9%
	2016	437	425	420	433	433	438	467	385	449	459	472	7.9%
	2017	439	428	422	436	435	440	469	387	452	461	474	8.0%
	2018	442	431	425	438	438	443	472	390	454	464	477	8.0%
	2019	444	433	427	441	440	445	474	392	457	466	480	8.1%
	2020	446	435	430	443	443	448	477	394	459	469	482	8.1%
	2021	448	438	432	445	445	450	479	396	461	471	484	8.2%
	2022	449	439	434	446	446	452	480	397	462	472	485	8.2%
	2023	**450**	441	436	448	448	454	482	399	464	474	**487**	**8.3%**
Demo Change (2023/2013)		**4.9%**	5.8%	6.1%	5.6%	5.7%	5.9%	5.3%	5.9%	5.5%	5.5%	5.4%	**13.6%**

Appendix 5. Results of Changes in National Total EIPDs per Thousand Due to Demographics and Changing Practice Patterns

Non-Maryland Total EIPDs		Utilization Pattern Year											Util Pattern Change
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	(2023/2013)
Demo	2013	**913**	873	848	884	870	873	915	791	890	882	886	-3.0%
Year	2014	922	882	857	893	879	881	924	799	898	890	894	-3.1%
	2015	931	891	866	901	888	890	932	806	906	897	901	-3.2%
	2016	940	900	875	910	896	898	940	814	914	905	909	-3.3%
	2017	948	908	883	918	904	906	947	820	920	912	916	-3.4%
	2018	957	917	893	926	913	914	955	828	928	919	923	-3.5%
	2019	965	925	901	934	921	922	963	834	934	926	930	-3.7%
	2020	974	934	910	942	929	930	970	841	941	933	937	-3.8%
	2021	982	943	919	950	937	938	978	848	948	940	944	-3.9%
	2022	987	948	925	955	942	943	982	852	951	944	947	-4.0%
	2023	**994**	955	932	962	949	950	988	857	957	949	**953**	**-4.1%**
Demo Change (2023/2013)		**8.8%**	9.5%	9.9%	8.8%	9.0%	8.8%	8.0%	8.4%	7.5%	7.7%	7.6%	**4.4%**

Appendix 6. Estimates for Revisions to RY 2026 Demographic Adjustment

HOSPID	Curremt RY 2026 Demographic Adjustment	RY 2026 Demographic Adjustment with 0.1% Demand Modifier	Estimated %of Revenue Not Attritubtable to Population Based Pamyments (CY 2024)	RY 2026 Demographic Adjustment with .1%Demand Modifier & Deduction for Revenue Not Attriubtable to Population Based Payments
210001	1.41%	1.50%	22.48%	1.17%
210002	1.03%	1.10%	23.32%	0.84%
210003	1.29%	1.38%	8.75%	1.26%
210004	1.03%	1.10%	8.92%	1.01%
210005	4.17%	4.45%	4.12%	4.26%
210006	1.56%	1.66%	5.19%	1.58%
210008	0.81%	0.87%	6.85%	0.81%
210009	0.79%	0.85%	29.05%	0.60%
210010	0.78%	0.84%	5.51%	0.79%
210011	1.27%	1.35%	4.37%	1.29%
210012	0.77%	0.82%	6.06%	0.77%
210013	-0.80%	-0.80%	1.39%	-0.79%
210015	1.00%	1.07%	6.85%	0.99%
210016	2.31%	2.47%	4.42%	2.36%
210017	0.81%	0.87%	34.04%	0.57%
210018	1.78%	1.90%	7.35%	1.76%
210019	1.46%	1.56%	21.05%	1.23%
210022	2.79%	2.97%	11.57%	2.63%
210023	1.79%	1.91%	2.83%	1.86%
210024	1.42%	1.51%	3.65%	1.46%
210027	-0.52%	-0.52%	29.24%	-0.37%
210028	1.82%	1.94%	4.23%	1.86%
210029	1.32%	1.40%	10.70%	1.25%
210030	1.91%	2.03%	3.53%	1.96%
210032	2.62%	2.79%	16.64%	2.33%
210033	2.16%	2.31%	8.18%	2.12%
210034	0.78%	0.83%	2.02%	0.81%
210035	2.91%	3.10%	3.71%	2.98%
210037	2.71%	2.89%	2.28%	2.83%
210038	0.34%	0.37%	3.07%	0.36%
210039	1.92%	2.05%	6.57%	1.92%
210040	1.15%	1.22%	2.00%	1.20%
210043	2.28%	2.43%	1.99%	2.38%
210044	0.65%	0.69%	3.33%	0.67%
210045	0.58%	0.62%	6.14%	0.58%
210048	2.10%	2.24%	3.40%	2.16%
210049	2.38%	2.54%	3.52%	2.45%
210051	2.15%	2.30%	6.57%	2.15%
210055	0.42%	0.45%	6.81%	0.42%
210056	0.99%	1.05%	1.08%	1.04%
210057	1.26%	1.35%	3.31%	1.30%
210058	0.68%	0.73%	3.35%	0.70%
210060	1.63%	1.74%	11.09%	1.55%
210061	2.87%	3.07%	29.80%	2.15%
210062	1.95%	2.08%	6.96%	1.94%
210063	1.57%	1.67%	3.39%	1.62%
210064	0.57%	0.61%	3.96%	0.59%
210065	2.06%	2.20%	5.56%	2.08%
210087	0.28%	0.30%	3.34%	0.29%
210088	1.47%	1.57%	5.71%	1.48%
210333	-0.26%	-0.26%	10.01%	-0.23%
Statewide	1.51%	1.61%		1.47%

maryland
health services
cost review commission

RY 2028 Quality Based Reimbursement Draft Policy

November 12, 2025

HSCRC Quality Team

RY 2028 QBR Draft Policy Updates

- RY 2028 Draft Policy outlines proposed options for aligning CMS HVBP
  - Overall calculation for Total Performance Score unchanged from RY 2027 QBR
  - Measure deletions/additions
  - Domain and measure weight updates
- Digital Measures Incentive
- RY 2026 cut-point adjustment
- RY 2028 Draft Recommendations

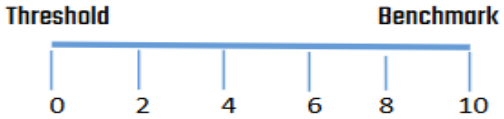
QBR RY 2027: Calculating the Total Performance Score (TPS)

Performance Measures → **Standardized Measure Scores** → **Hospital QBR Score & Revenue Adjustments**

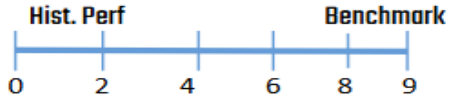
Domain and Measures:
Person and Community Engagement–
-HCAHPS: 6 top box measures, 3 linear measures, 1 consistency measure
-Timely Follow Up (TFU): Medicare, Medicaid -ED Length of Stay, admitted patients
Safety— 6 Measures:
-5 CDC NHSN HAI Categories;
-AHRQ PSI 90 All-payer
Clinical Care–
-Mortality: Inpatient All-Payer, 30-day All-payer

Individual Measures are Converted to 0-10 Points:

Points for Attainment Compare Performance to a National Threshold (median) and Benchmark (average of top 10%)



Points for Improvement Compare Performance to Base (historical perf) and Benchmark



Final Points are Better of Improvement or Attainment

Hospital QBR Score is Sum of Earned Points / Possible Points with Domain Weights Applied

Scale Ranges from 0-80%

Max Penalty 2% & Reward +2% (All hospitals have an opportunity to earn a reward; not net neutral)

Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	**0%**	**-2.00%**
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	41%	0.00%
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	**80%+**	**2.00%**

Cut point is reassessed retroactively; RY25 cut point was reduced to 32%

Alignment Transition Timeline Options

Hospital Quality Programs

Based on our understanding of new State Agreement and CMMI discussions, quality team believes the following:

- Maryland hospitals will move to CMS hospital quality programs for Medicare FFS either for FY 2029 or FY 2030 payment adjustments (i.e, performance period mid-2025 through CY2027 or mid-2026 through CY2028).
- CY 2026 performance under Maryland all-payer policies (and maybe CY 2027).
- State may continue non-Medicare FFS quality adjustments and will report annually to CMMI on the quality programs including measures, performance, revenue adjustments.
- State will align non-Medicare FFS quality programs with the CMS programs to reduce hospital burden where feasible and appropriate, but also consider focus areas where the State could deviate from CMS based on State, payer, or other stakeholder priorities.

Transition to CMS and Non-Medicare Quality Programs	Earlier Transition	Later Transition
CMS Performance Period	Mid-year 2025 – End of 2027	Mid-year 2026 – End of 2028
HSCRC Performance Period	2027	2028 Non-Medicare Policies
Adjustment Period	2029	2030
Medicaid & Commercial Alignment with Medicare	Partial Alignment focused on QBR-HVBP	Further Alignment as determined in collaboration with stakeholders
All-Payer Rev Adjustments implemented by CMS	1 year	2 years

Person and Community Engagement Domain Alignment

- **HCAHPS:**
  - Align with HVBP by only including top-box and consistency assessment (i.e., remove linear given no evidence the inclusion of linear resulted in improvements).
- **ED LOS:**
  - Staff is recommending to maintain the ED LOS measure in the QBR program due to the considerable concern about ED wait times from patients and the state legislature.
  - Based on input from stakeholders and further Inpatient LOS discussions, the staff may modify this recommendation for the final policy.
- **Timely Follow-Up– Medicare, Medicaid and Disparity Gap:**
  - Feedback from hospital representatives on PMWG supported removal of the measures as the state moves toward aligning the QBR program with the HVBP program.
  - However, given the new AHEAD Medicaid primary care model and lower rates of follow up for Medicaid, staff has met with Medicaid to discuss continuing a payment incentive on this measure and/or how this measure could be monitored to ensure focus on care coordination.

Safety Domain Alignment

- **CDC NHSN Measures:**
  - The RY 2027 QBR policy maintained the Safety domain weighting of 30 percent, five percent higher than HVBP program; NHSN measures are also included in CMS HACRP program but not MHAC.
  - Given NHSN concerns (e.g., measures small cell sizes, surveillance bias, lack of statistical significance), staff requests stakeholder input on whether to align fully and use NHSN measures in both QBR and MHAC.
- **PSI 90 Composite Measure:**
  - PMWG stakeholders support removing the measure from the QBR program to align with the HVBP
  - Staff believes this measure should be maintained in payment since it measures serious complications (e.g., post-surgical sepsis, pressure ulcers), AHRQ produces an all-payer and Medicare version of the measure. (i.e., meaning no measurement concerns), and it is included in the Medicare FFS quality programs.
  - If PSI measure is removed from QBR, staff supports adding to MHAC program for overall alignment.
- **Sepsis Management Bundle:**
  - Maryland continues to perform well compared to the nation on Sepsis Bundle.
  - Despite concerns about the Sepsis bundle measure, CMS has continued its use; staff and the PMWG stakeholders recommend adopting the Sepsis bundle measure in the Safety domain.

Clinical Care Domain Alignment

- **Mortality Measures:**
  - Staff is recommending to maintain the all-payer mortality measures for the coming year while still under all-payer rate setting and to provide time to evaluate other options for assessing mortality.
  - PMWG stakeholders support maintaining all-payer mortality measurement, with some supporting the IP measure vs. others supporting the 30-day measure since CMS uses 30-day measures; these two measures show moderate correlation.
  - Staff notes that the Medicare Condition Specific mortality measures have two-year performance periods that are almost complete (FFY 2028 7/2024-6/2026).
- **THA/TKA Complications Measure:**
  - PMWG members lended their support to further align with the CMS HVBP policy, and staff supports re-adoption the THA/TKA complication measure into QBR.

RY 2028 QBR Draft Recommendations

Criteria: 1. Alignment with CMS HVBP, 2. All-Payer Accountability, 3. Reduce retrospective measure evaluation, 4. Area of Poor Performance and/or Stakeholder Priority

RY 2027 QBR

HCAHP Top Box, 20%
HCAHPS Consistency, 10%
HCAHPS Linear, 10%
ED Length of Stay, 10%
TFU Medicare + Disparity, 7%
TFU Medicaid, 3%

NHSN, 25%
All-Payer PSI, 5%

All-Payer Inpatient Mortality, 5%
All-Payer 30-Day Mortality, 5%

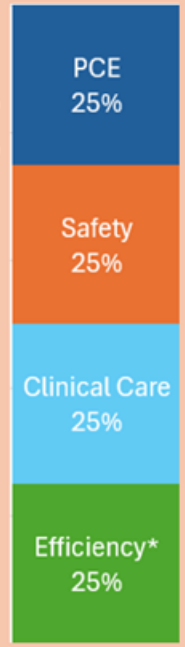
FY 2027 HVBP

HCAHP Top Box, 20%
HCAHPS Consistency, 5%

NHSN, 20%
Sepsis Bundle, 5%

Medicare Condition Specific 30-Day Mortality, 20%
THA-TKA Complications, 5%

Medicare Spending Per Beneficiary, 25%



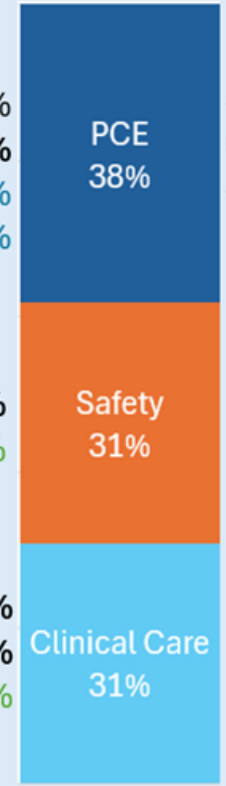
Partial Alignment

AHEAD PY1

HCAHP Top Box, 20%
HCAHPS Consistency, **5%**
ED Length of Stay, 10%
TFU Medicaid, 3%

NHSN, **26%**
Sepsis Bundle, 5%

All-Payer Inpatient Mortality, **13%**
All-Payer 30-Day Mortality, **13%**
THA-TKA Complications, 5%

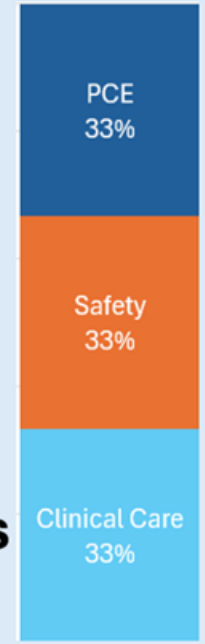


~~HCAHPS Linear, 10%~~
~~TFU Medicare + Disparity, 7%~~

~~All-Payer PSI, 5%~~

Full Transition

HVBP for CMS-Designed Medicare FFS Global Budgets



Quality Programs under AHEAD

Starting **PY2 or PY3**

QBR for State-Designed Global Budgets for Other Payers

Key

Measure Addition
Weight Change
~~Removed~~
All-Payer or MD Priority

*HVBP Efficiency Domain is not used for MD Hospitals in HVBP. Remaining domains are weighted at 1/3rd .

Revenue Adjustment Methodology- Retrospective Adjustment

- QBR uses a preset scale so that hospitals can track financial performance in quality programs.
- Scale ranges from 0 percent to 80 percent, and the staff estimate the cut-point for penalties and rewards as to not overly reward or penalize hospital performance compared to the nation.
- Establishing this cut-point prospectively has become more difficult post-COVID:
  - RY 2024 through RY 2027 policies indicated that the cut-point would be reassessed retrospectively with more recent national data.
  - Staff recommends continuing this or determining another method for determining cut-point.
- Methodology for determining QBR scaling cut-point retrospectively
  - The current methodology estimates QBR scores for all hospitals nationally, calculates the mean using HCAHPS and NHSN data for hospitals nationally and state averages for MD specific measures, and then applies the QBR measure weights.
  - For RY 2026, staff has shifted to using the median instead of the mean, which is less sensitive to outliers.

Based on this analysis, for RY 2026 staff recommend the cut-point be set at 32.68 percent pending additional analyses on differences between QBR and HVBP revenue adjustments.

Revenue Adjustment Methodology Going Forward

- Analyzing HVBP vs. QBR Revenue Adjustments:
  - For FFY 2026, CMS provided estimated HVBP scores for Maryland hospitals.
  - Analysis includes weighting each domain at 1/3rd of the final score.
  - HSCRC staff will use the scores to estimate all-payer revenue adjustments for Maryland hospitals.
  - While the HVBP estimates would apply only to the Medicare FFS base operating revenue, the HSCRC will use all payer inpatient revenue for reference to compare across programs.
  - The HVBP estimates will be net of the 2 percent withhold that the program uses to fund the revenue neutral rewards.
- Analyzing impact of alignment of domain weights and measures:
  - For the final policy, staff will model different scenarios that iteratively look at the recommended changes and will review the results with stakeholders.
  - For purposes of this draft policy, the staff notes that the following two scenarios will be modeled presented and compared the the HVBP and RY 2026 QBR estimates:
    - Scenario 1: Matched HVBP measures and domain weights fully.
    - Scenario 2: Add back in ED LOS and Medicaid TFU by increasing PCE domain weight and reducing Clinical care and Safety equally.

QBR RY 2028 Draft Recommendations

1. Update Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.
2. Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures; add a bonus incentive of $150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.
3. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and maintain the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 41 percent.
    a. Retrospectively evaluate 41 percent cut-point using more recent data to calculate national average score for RY 2026 and RY 2027.
    b. Based on concurrent analysis of national hospital performance, adjust the RY26 QBR cut-point to 32.68% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.

maryland
health services
cost review commission

Draft Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2028

November 12, 2025

This document contains the staff draft recommendations for updating the Quality-Based Reimbursement Program for RY 2028. **Comments are due by COB Tuesday, 12/2/2025 and may be submitted to hscrc.quality@maryland.gov.**

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LIST OF ABBREVIATIONS

AHEAD	State's Achieving Healthcare Efficiency through Accountable Design Model
APR DRG	All Patient Refined Diagnosis Related Group
CDC	Centers for Disease Control & Prevention
CAUTI	Catheter-associated urinary tract infection
CCDE	Core Clinical Data Elements (for digital hybrid measures)
CDIF	Clostridium Difficile Infection
CLABSI	Central Line-Associated Bloodstream Infection
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-Related Group
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
ED-1 Measure	ED Time of Arrival to Departure for Admitted Patients
ED-2 Measure	Time of Order to Admit until Time of Admission ED Patients
EDDIE	Emergency Department Dramatic Improvement Effort
FFY	Federal Fiscal Year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commission
LOS	Length of Stay
MIEMSS	Maryland Institute for Emergency Medical Services Systems
MRSA	Methicillin-Resistant Staphylococcus Aureus
NHSN	National Health Safety Network
PQI	Prevention Quality Indicators
PY	Performance Year
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year (Coincides with State Fiscal Year (SFY) July-Jun; signifies the timeframe in which the rewards and/or penalties would be assessed)
SIR	Standardized Infection Ratio
SSI	Surgical Site Infection
TFU	Timely Follow Up after Acute Exacerbation of a Chronic Condition
THA/TKA	Total Hip/Knee Arthroplasty Risk Standardized Complication Rate
HVBP	Hospital Value-Based Purchasing

DRAFT RECOMMENDATIONS

This document puts forth the RY 2028 Quality-Based Reimbursement (QBR) draft policy recommendations for consideration. The policy provides timeline options for incrementally transitioning the hospital QBR program to the CMS national Hospital Value Based Purchasing ("HVBP") program for Medicare FFS global budgets; the transition will also include better alignment of the state QBR program with HVBP that will be applicable for patients of all other payers (i.e., non-Medicare FFS). Staff has and will continue to vet these recommendations with the Performance Measurement Workgroup (PMWG) and also greatly benefits from feedback provided by Commissioners and other stakeholders on draft recommendations and longer-term priorities that should be considered as Maryland transitions to the AHEAD Model.

Draft Recommendations for RY 2028 QBR Program:

1. Update Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.
2. Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures; add a bonus incentive of $150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.
3. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and maintain the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 41 percent.
    a. Retrospectively evaluate 41 percent cut-point using more recent data to calculate national average score for RY 2026 and RY 2027.
    b. Based on concurrent analysis of national hospital performance, adjust the RY26 QBR cut-point to 32.68% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.

1. INTRODUCTION

Maryland hospitals have been and are currently funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under agreements with the Centers for Medicare & Medicaid Services (CMS) for the state to operate the All-Payer Model (CY 2014-CY 2018), the current Total Cost of Care (TCOC) Model (2019-2026) and the upcoming AHEAD model (CY 2026-CY 2035). Under the new AHEAD model the state will transition in CY 2028 (Performance Year 3) to CMS establishing hospital global budgets for Medicare FFS and to the HSCRC establishing hospital global budgets for all other payers (i.e., non-Medicare FFS). Under the Medicare FFS hospital global budgets, hospitals will be held accountable for quality under the CMS quality programs and through additional AHEAD incentives, while the state may maintain quality programs for all other payers. HSCRC staff is collaborating with CMMI, hospitals, the Maryland Hospital Association (MHA), state leaders, other state health agencies, and the broad array of stakeholders on the Performance Measurement Workgroup to develop a transition plan that increases the alignment between the state's performance based payment programs and the CMS national programs over the initial years of the AHEAD model.

Under global budget systems, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk under Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. It is important under global budgets to ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Commission's quality programs to date have rewarded quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

The Quality-Based Reimbursement (QBR) program is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time. The QBR program is analogous to the HVBP

program. Both the QBR and HVBP programs hold 2 percent of inpatient hospital revenue at-risk for performance by hospitals on measures of patient experience, clinical care, and safety. The HVBP program also holds hospitals accountable for efficiency by including the Medicare Spending per Beneficiary (MSPB) domain, while the QBR program addresses efficiency through the overall hospital global budgeting methodology combined with the hospital Integrated Efficiency policy.

Under the TCOC Model, Maryland has been required to request a waiver each year from CMS hospital pay-for-performance programs, including the HVBP Program. CMS assesses and grants these waivers based on a report showing that Maryland's results continue to meet or surpass those of the nation. Currently, CMMI is reviewing the RY 2026 waiver request and if feedback is received it will be included in the final policy. Throughout the TCOC Model, the state has been granted exemptions from the national quality programs but CMS has noted Maryland's lagging performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and Maryland's need to focus on areas such as the Medicaid population, ED throughput, and non-hospital settings of care. In order to maintain the waiver, the QBR policy has been adapted over the years to address these areas of concern raised by CMMI in order to maintain the waiver from the national programs.

Transitioning to the AHEAD Model

The AHEAD model is anticipated to begin in January 2026; however, the first two years of the model will be a transition period with the new CMS hospital global budgets beginning in CY 2028. Below is the staff's current understanding of the quality program expectations for the transition period and beyond.

For RY 2028, which will assess CY 2026 performance, staff will work to align the Maryland quality policies with the Medicare FFS quality programs. This work includes establishing timelines for changes to the current programs, implementing transition to national hospital quality programs for Medicare FFS, and updating priorities for quality, and linkages between hospital and statewide population health and quality targets. Specifically, alignment entails consideration of measures, measurement domains and weighting, performance standards, performance periods and revenue adjustment timelines. In a detailed or targeted sense, alignment can mean an exact replication of the CMS quality

programs; in a broader sense, alignment can mean harmonizing with national hospital quality program priorities and intentions.

This draft policy recommends options on where to align QBR measures and domain weights in anticipation of the transition to the HVBP program for Medicare FFS. The following criteria are proposed for deciding what measures to include in the policy and the weights:

1. Alignment with CMS HVBP program
2. Maintain all-payer accountability and incentives for quality
3. Reduce retrospective measure evaluations to the extent possible
4. Areas of poor performance and/or priority area for State, hospitals, payers, or other stakeholders

Staff has and will continue to vet details of this transition across all of the RY 2028 quality policies with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies. Staff will also seek input from the ED Wait Time Reduction Commission and subgroups on use of ED LOS measures for payment and/or monitoring.

Below are the high level details of quality assessments in the AHEAD Model, based on staff's current understanding of new the AHEAD State Agreement requirements and discussions with CMMI staff:

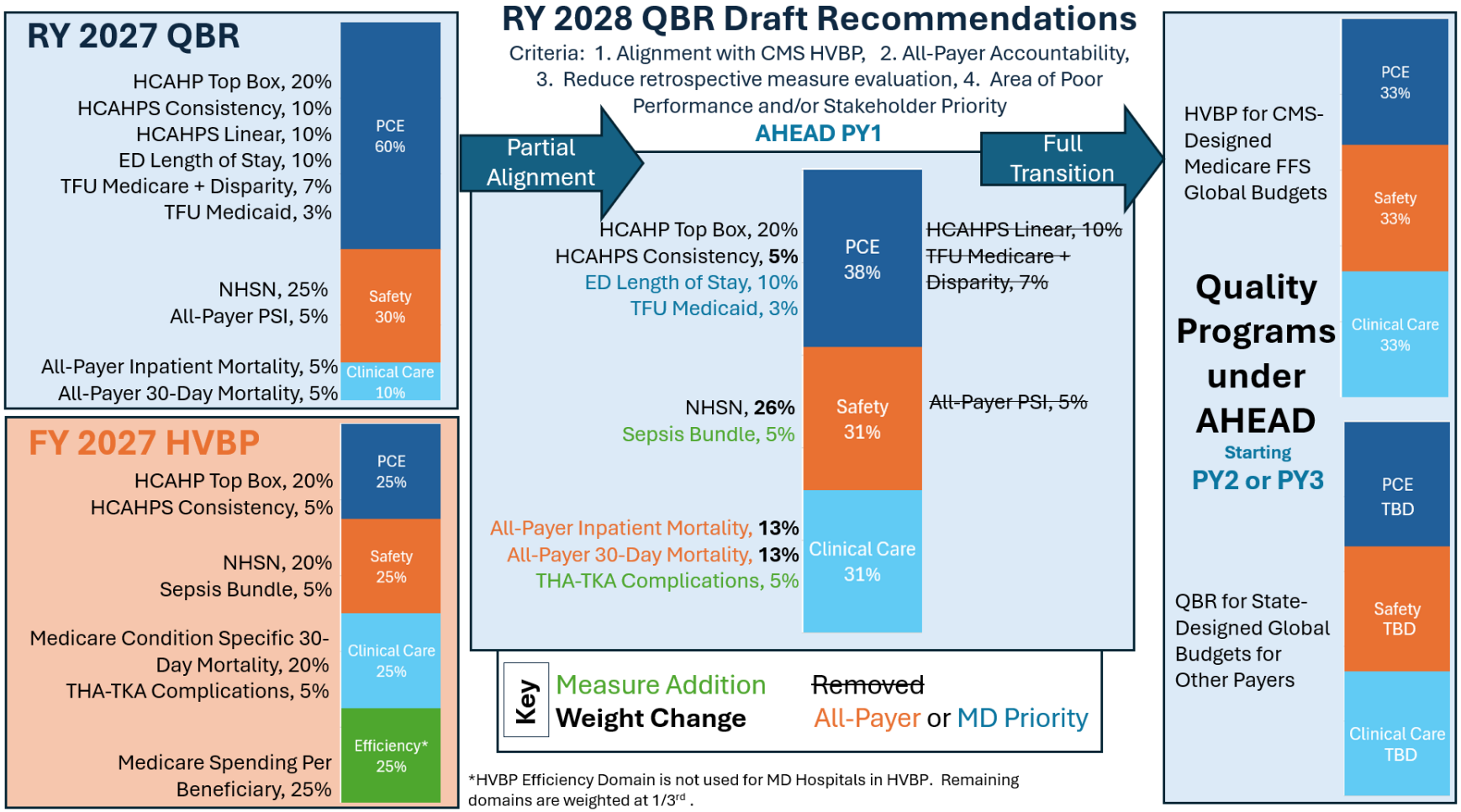
- Maryland hospitals will move to CMS hospital quality programs for Medicare FFS either for FY 2029 or FY 2030 payment adjustments (i.e, performance period mid-2025 through CY2027 or mid-2026 through CY2028). Staff will need to continue to request a waiver from CMMI for the all-payer programs.
- RY 2028 (i.e., CY 2026 performance) will be under Maryland all-payer policies and CMS will implement the revenue adjustments in CY 2028 for the Medicare FFS global budgets (and HSCRC will implement for all other payers).
- State may continue quality adjustments to hospital global budgets for all other payers (i.e., non-Medicare FFS) and is required to report annually to CMMI on the quality programs including measures, performance, revenue adjustments.
- State will align non-Medicare FFS quality programs with the CMS programs to reduce hospital burden where feasible and appropriate, but also consider focus

areas where the State could deviate from CMS based on State, payer, or other stakeholder priorities.

Appendix A provides a visual timeline for transitioning to the CMS quality programs in FY 2029 or FY 2030. At this time, staff is working with CMMI and the industry to determine the timelines for the transition and to develop the quality policies that will be implemented for the state administered hospital global budgets for all payers except Medicare FFS.

Figure 1 provides a summary of the current HVBP and QBR programs and the proposed recommendations for changes for RY 2028 and beyond. Specifically, the current QBR and HVBP programs are shown on the left side of the figure. The middle of the figure shows the draft proposal for RY 2028 QBR, including measures being added, maintained, or deleted to better align QBR with the HVBP program. These decisions were based on the criteria outlined above and included in the figure below. As discussed throughout this draft policy, staff is seeking input on these changes. The far right hand side of the figure shows that Maryland hospitals will be assessed under QBR for non-Medicare FFS and the HVBP program starting in the 2nd or 3rd performance year (PY) under the AHEAD model.

Figure 1. QBR-HVBP Domains and Measures with Proposed Updates to Align with CMS Under the AHEAD Model



*HVBP Efficiency Domain is not used for MD Hospitals in HVBP. Remaining domains are weighted at 1/3rd .

2. BACKGROUND

Overview of the QBR Program

The QBR Program, implemented in 2010, includes potential scaled penalties or rewards of up to 2 percent of inpatient revenue. The program assesses hospital performance against national standards for measures included in the CMS HVBP program and Maryland-specific standards for other measures unique to our all-payer system. Figure 2 presents RY 2027 QBR measures and domain weights compared to those used in the HVBP Program.

Figure 2. RY 2027 QBR and Domain Weights Compared to the CMS HVBP Program

Domain	Maryland RY 2027 QBR Domain Weights and Measures	CMS FFY 2028 HVBP Domain Weights and Measures
Clinical Care	**10 percent** Two measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality	**25 percent** Six measures: Five condition-specific mortality measures; THA/TKA complication
Person and Com-munity Engage-ment	**60 percent** 1. Six HCAHPS categories, top-box score and consistency, 3 categories for linear scores; 2. TFU (Medicare, Medicaid, disparities improvement); 3. ED LOS	**25 percent** Six HCAHPS measures top-box score and consistency
Safety	**30 percent** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**25 percent** Six measures: Five CDC NHSN HAI measure categories; Sepsis Bundle measure
Efficiency	N/A	**25 percent** One measure: Medicare spending per beneficiary

The QBR Program assesses hospital performance by comparing each measure to national or state performance standards. For all measures, except the ED LOS measure[1],

[1] The ED LOS performance standards are still being finalized for CY 2025/RY 2027 performance but staff is proposing that improvement performance standards remain the same as CY 2025/RY 2026 but that a risk-adjusted measure be implemented and attainment be considered.

the performance standards range from the 50th percentile of hospital performance (threshold) to the mean of the top decile (benchmark). Each measure is assigned a score of zero to ten points, then the points are summed and divided by the total number of available points, and weighted by the domain weight. A total score of 0 percent means that performance on all measures is below the performance threshold and has not improved, whereas a total score of 100 percent means performance on all measures is at or better than the mean of the top decile (about the 95th percentile). This scoring method is the same as that used for the HVBP Program. Unlike the HVBP Program, however, which ranks all hospitals relative to one another and assesses rewards and penalties to hospitals in a revenue neutral manner retrospectively based on the distribution of final scores, the QBR Program has used a preset scale to determine each hospital's revenue adjustment and is not necessarily revenue neutral. This gives Maryland hospitals predictability and an incentive to work together to achieve high quality of care, instead of competing with one another for better rank.

The preset revenue adjustment scale for QBR program ranges from 0 to 80 percent and the cut-point at which a hospital earns rewards or receives a penalty is based on an analysis of the HVBP Program scores and how hospitals nationally would perform in the Maryland QBR program. While we have tried to prospectively set the revenue adjustment scale, this became more difficult during and after the COVID Public Health Emergency. Thus, from RY 2024, the cut-point is estimated prospectively and then reassessed retrospectively with more recent national data. While this is inconsistent with the guiding principle to provide hospitals with a way to monitor revenue adjustments during the performance year, it protects Maryland hospitals from excessive penalties. The final policy for RY 2028 will recommend amending the RY 2026 final cut-point based on more recent analyses.

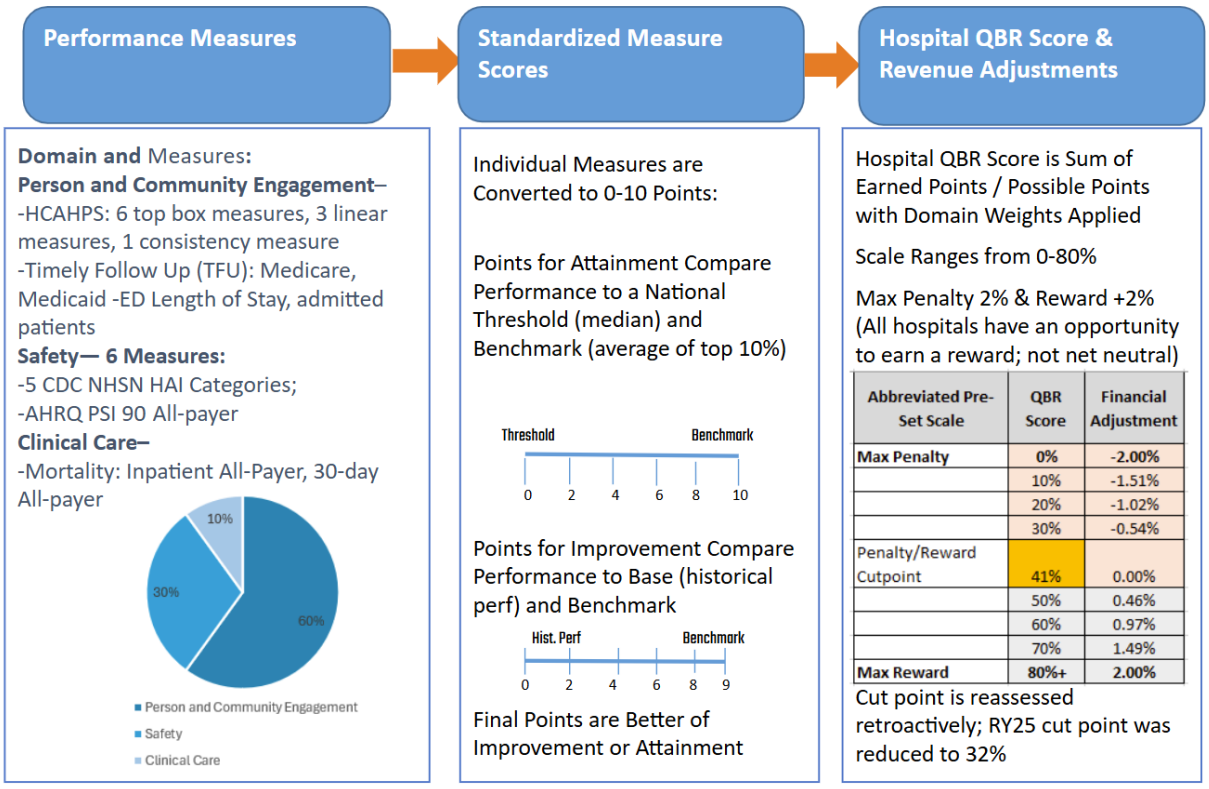
As a recap, the method for calculating hospital QBR scores and associated inpatient revenue adjustments involves:

1. Assessing performance on each measure in the domain.
2. Standardizing measure scores relative to performance standards.
3. Calculating the total points a hospital earned divided by the total possible points for each domain.

4. Finalizing the total hospital QBR score (0 to 100 percent) by weighting the domains, based on the overall percentage or importance the HSCRC placed on each domain.
5. Converting the total hospital QBR scores into revenue adjustments using the preset revenue adjustment scale (range of 0 to 80 percent). This preset scale may be retrospectively adjusted after analysis of the data relative to more current National data but is shown here for illustrative purposes.

This method and program steps for determining hospital scores and revenue adjustments for RY 2027 are summarized in Figure 3.

Figure 3. RY 2027 QBR Policy Methodology Overview



Appendix B contains more background and technical details about the QBR Program.

3. ASSESSMENT

The purpose of this section is to present an assessment of Maryland's performance on measures used in the QBR program compared to the nation where possible. This draft policy recommends options on where to align QBR measures and domain weights in anticipation of the transition to the HVBP program for Medicare FFS. The following criteria are proposed for deciding what measures to include in the policy and the weights:

1. Alignment with CMS HVBP program
2. Maintain all-payer accountability and incentives for quality
3. Reduce retrospective measure evaluations to the extent possible
4. Areas of poor performance and/or priority area for State, hospitals, payers, or other stakeholders

Below we present each Domain and the performance on measures within the domain. After each domain is reviewed, there is a section that summarizes the options for measure alignment. The domain and measure weights are then discussed at the end since they are interrelated decisions, along with revenue adjustment estimates.

A. Person and Community Engagement Domain

The Person and Community Engagement domain currently weighted at 60 percent of the QBR score and measures performance using the HCAHPS patient survey (top-box, consistency, and linear scores are all assessed), three measures of timely follow-up (TFU) after discharge for an acute exacerbation of a chronic condition, and an ED LOS measure for non-psychiatric patients admitted to the hospital). In comparison, the HVBP weights the PCE domain at 25 percent of the HVBP score and only includes HCAHPS top-box and consistency assessment.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Patient experience is a critical component of healthcare quality. Patients come to the hospital during an acute episode often feeling scared, stressed, and confused about what is occurring. The HCAHPS survey is a standardized, publicly reported survey that

measures patient's perceptions of their hospital experience. Research shows that when patients report higher performance on HCAHPS questions, there are fewer safety events such as falls or pressure ulcers.[2] In keeping with the HVBP Program, the QBR Program scores hospitals on the percent of respondents who indicate the highest performance category (i.e., top-box scores) and HCAHPS consistency across across the following HCAHPS measures: (1) communication with nurses, (2) communication with doctors, (3) communication about medicine, (4) hospital cleanliness and quietness, (5) discharge information, and (6) overall hospital rating.[3]

In RY 2024, HCAHPS linear scores were added as 20 percent of the PCE domain (i.e., 10 percent of overall QBR score). for the following domains: the nurse communication, doctor communication, responsiveness of staff, and care transition. The addition of the linear measures was designed to further incent hospital focus on HCAHPS by providing credit for improvements along the continuum and not just improvements in top-box scores. The inclusion of the HCAHPS linear measures is unique to the QBR policy and not aligned with the HVBP program.

Analysis results for Maryland versus the nation on "top-box" performance (Figure 3) for eight HCAHPS measures and on linear measure performance for four measures (Figure 4) are provided below. Staff notes that the composite care transition measure and responsiveness of hospital staff measure are being updated by CMS beginning in CY 2025 and therefore cannot be included in the HCAHPS scoring for CYs 2025 through 2027 (VBP FFY 2027 through FFY 2029). Figure 4 below reveals that:

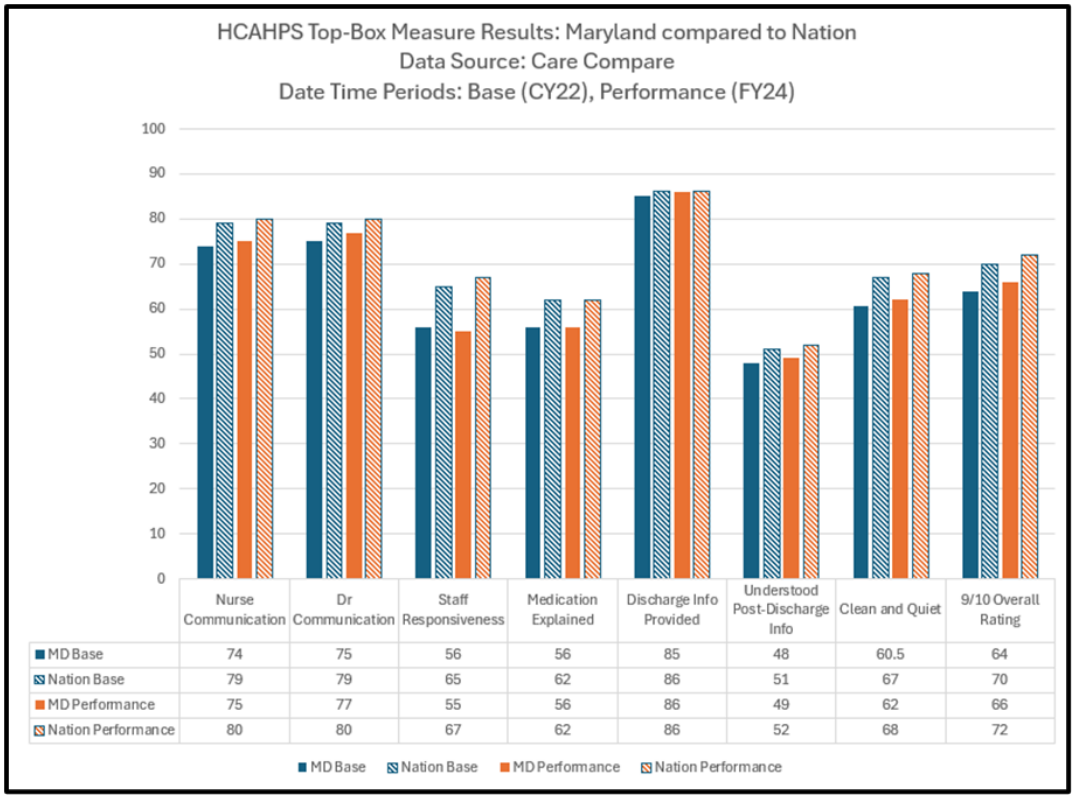
- Both the nation and Maryland had little change in performance from the base to the performance periods for all of the HCAHPS categories (changes ranged from -1 percent to +2 percent).
- Maryland had slightly worse performance on Staff Responsiveness and remained the same on Medication Explained; the state improved slightly on Nurse and Doctor Communication, Understood Post Discharge Instructions, Clean and Quiet, and Overall Hospital Rating.

[2] Report by Press Ganey, March 12, 2025, found at: https://www.pressganey.com/news/new-data-reveals-link-workforce-px-safety-aha/#:~:text=Chicago,quality%20care%20to%20every%20patient; last access November 16, 2025.

[3] For more information on the HVBP Program's performance standards and top-box and consistency scoring, please see https://qualitynet.cms.gov/inpatient/hvbp/performance.

- The nation improved slightly on all categories with the exception of Medication Explained which remained the same.

Figure 4. top-box HCAHPS Results: Maryland Compared to the Nation, CY 2022 vs 7/1/23-6/30/24



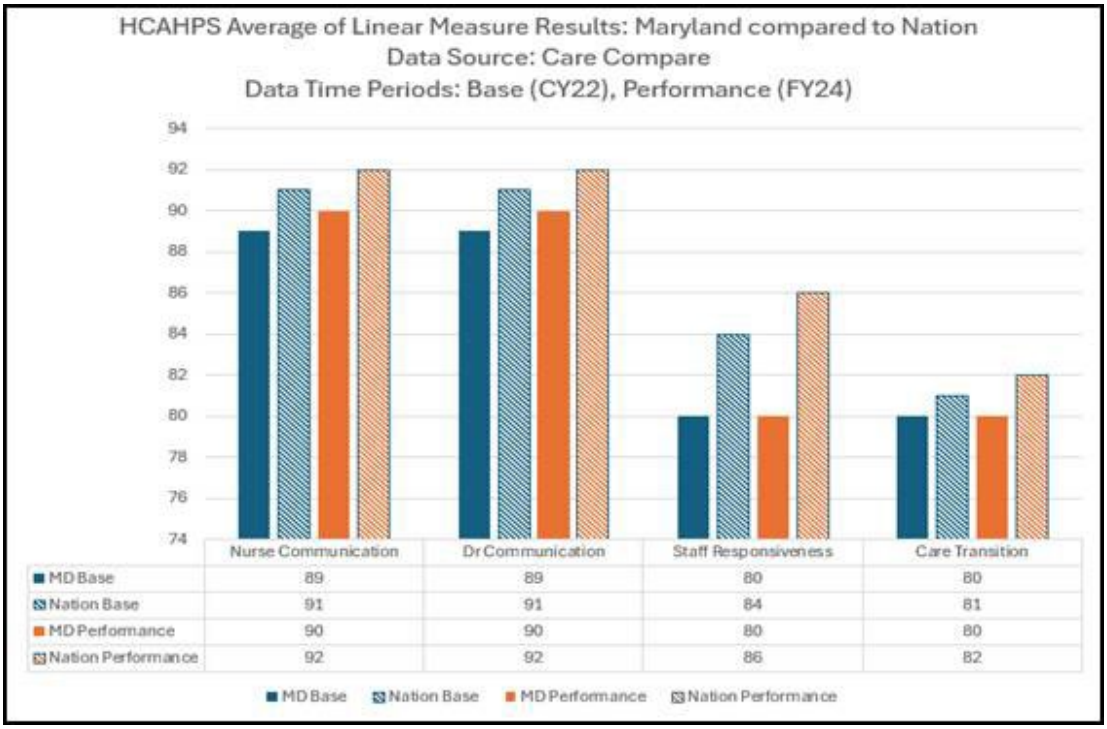
	Nurse Communication	Dr Communication	Staff Responsiveness	Medication Explained	Discharge Info Provided	Understood Post-Discharge Info	Clean and Quiet	9/10 Overall Rating
MD Base	74	75	56	56	85	48	60.5	64
Nation Base	79	79	65	62	86	51	67	70
MD Performance	75	77	55	56	86	49	62	66
Nation Performance	80	80	67	62	86	52	68	72

Analysis of linear measures in Figure 5 indicates that State performance continues to lag the nation and has improved only slightly or remained the same compared to the CY 2022 base period, consistent with national trends and trends seen in top-box scores. The linear measures were updated for the RY 2027 policy in light of the CMS changes to the HCAHPS instrument to include three measures–doctor communication, nurse communication and medication explained. Since linear scores are not improving in Maryland relative to the nation, and in an effort to align with the HVBP program, staff and stakeholders are proposing to remove the HCAHPS linear measures.

Based on CMMIs concerns over HCAHPS performance, the HSCRC and MHA have been

convening an HCAHPS Learning Collaborative with hospitals over the last year. Appendix D provides an overview of this work. One of the key deliverables is a statewide HCAHPS dashboard built on patient level HCAHPS data collected by MHCC. While MHCC has conducted partial analyses of this data, the HCAHPS dashboard will allow for interactive, analyses with more timely data and the ability for hospitals to drill down and compare performance for subgroups. For example, MHCCs most recent analysis continues to show differences in respondent rates and results when stratified by race and by the Medical, Surgical and Maternity service lines. This updated analysis is detailed in Appendix D.

Figure 5. Linear Measure HCAHPS Results: Statewide and National Average, CY 2022 vs 7/1/23-6/30/24



Emergency Department Length of Stay

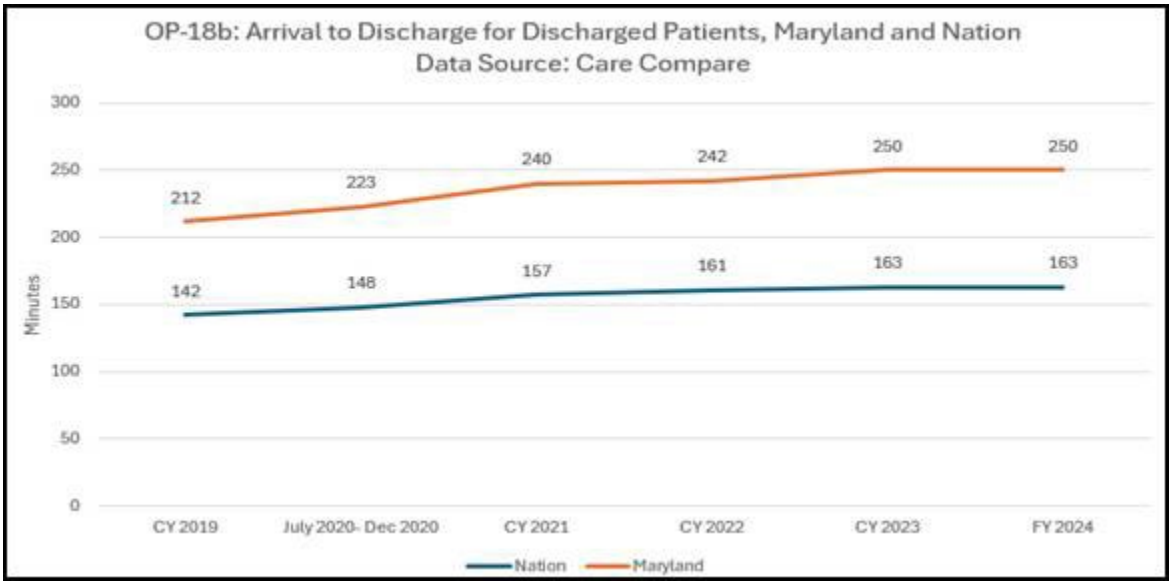
ED length of stay (LOS)--i.e., wait times–has been a significant concern in Maryland, predating Maryland's adoption of hospital global budgets instituted in 2014,[4] with multiple underlying causes and potential adverse outcomes in patient experience and quality.

Concerns about unfavorable ED throughput data have been shared by many Maryland stakeholders, including the HSCRC, the MHCC, payers, consumers, emergency department and other physicians, hospitals, the Maryland Institute of Emergency Medical Services Systems, and the Maryland General Assembly, with around a dozen legislatively mandated reports on the topic since 1994. Historically, the HSCRC has taken several steps to address emergency department length of stay concerns, including the inclusion of an ED LOS measure in QBR, current collection of ED LOS data, and other ED initiatives. In 2024, the Maryland General Assembly established the ED Wait Time Reduction Commission to address this issue; the ED Commission is co-chaired and staffed by the HSCRC but has a mandate that requires broader health system innovation. As part of the HSCRC and ED Commission work, the HSCRC Commission approved a new ED and Hospital Throughput Best Practice Policy, which is designed to assess process measures associated with best practices that can improve patient throughput.

Publicly available data on CMS Care Compare reveals Maryland's previous poor performance compared to the nation on patients admitted (data no longer collected by CMS after 2019), and on outpatient ED measures for patients not admitted. As shown in Figure 6 below, Maryland's performance has worsened over time as has that of the nation, and Maryland's wait times remain higher than that of the nation.

[4] Under alternative payment models, such as hospital global budgets or other hospital capitated models, some stakeholders have voiced concerns that there may be an incentive to reduce resources that lead to ED throughput issues.

Figure 6. Maryland and National Performance on ED Wait Times for Discharged Patients



The Commissioners voted to include an ED LOS measure weighted at 10 percent of the QBR program for RYs 2026-2027 (CYs 2024 and 2025 performance). Staff convened subgroups to develop data collection specifications and the performance standards. Specifically, HSCRC now collects patient-level date and time stamps to calculate ED LOS through the HSCRC case-mix process and is working to develop a data monitoring tool for ED LOS for stakeholders and hospitals. For RY 2026, the ED wait time or length of stay (LOS) measure developed for QBR program assesses percent improvement from CY 2023 to CY 2024 using the measure definition as outlined below:

Measure: Percent change in the median time from ED arrival to physical departure from the ED for patients admitted to the hospital

Population: All non-psychiatric, non-trauma, adult ED patients who are admitted to Inpatient bed and discharged from hospital during reporting period

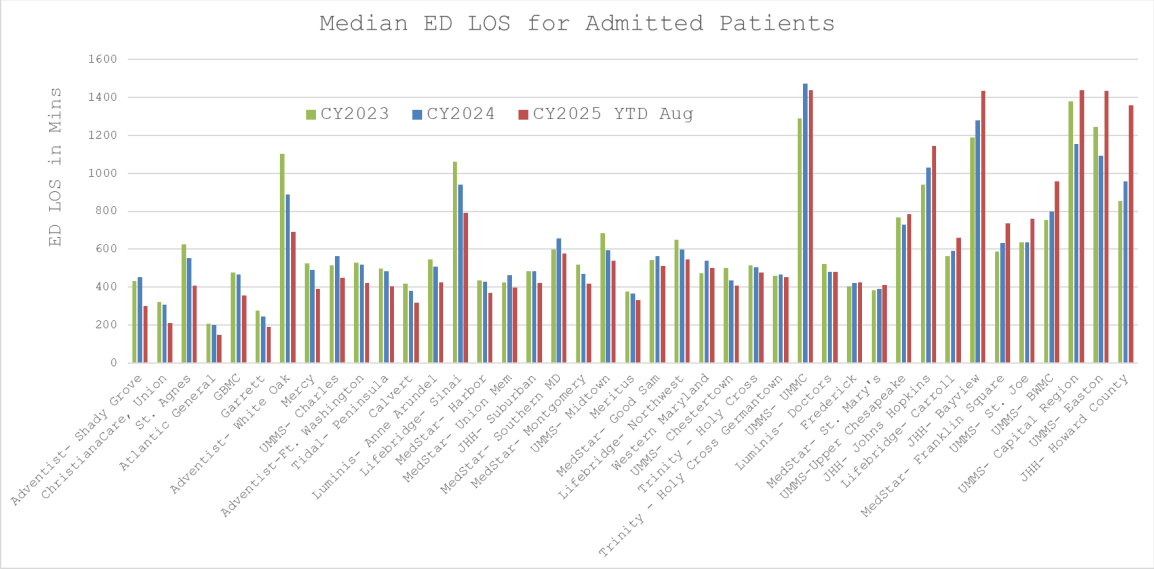
Scoring: Use attainment calculation for percent change to convert improvement into a 0 to 10 point score:

- Hospitals with CY2023 Median that is lower (better) than statewide median have threshold of 0 percent and benchmark of -5 percent.

- Hospitals with CY2023 Median that is higher (worse) than statewide median have a threshold of 0 and a benchmark of -10.
- Hospitals performing better than the 2019 national median in 2024 will not be penalized for degradations in performance between 2023 and 2024.

For RY 2027, staff is working to develop a risk-adjusted measure while still providing monthly monitoring reports on the unadjusted measure to hospitals. Figure 7 shows the annual median ED LOS for admitted patients for CY 2023, CY2024, and CY2025 through August. As indicated the figure is sorted by percent improvement from CY 2024 to CY 2025 YTD. While the median hospital improvement is higher in RY 2027 YTD, the graph does show that a handful of hospitals with the highest baseline ED LOS median (CY 2024) are either increasing or showing small improvements. Based on these results, staff has een exploring use of a risk-adjusted ED LOS measure although preliminary results using RY 2026 data do not show large differences in results. Staff aim to finalize this analysis for the final RY 2028 QBR policy.

Figure 7. Median ED LOS by Hospital, CY 2023 - CY 2025



While there have been more substantial improvements in CY 2025 YTD than were seen in from CY2023 to CY2024, staff does not recommend raising the performance standards with less than a quarter remaining in the performance period, and the forward shift of the base period to CY 2024. Thus, the staff is proposing the following for RY 2027 as part of

the RY 2028 draft policy for stakeholder, HSCRC Commissioner, and ED Commission input:

- Maintain measure specifications from RY2026 (monitoring reports released monthly using this measure through the CRISP portal). Maintain improvement goal from RY2026 (i.e., 0 to -5% and 0 to -10% based on median in 2024).
- Develop and assess how to best use a risk-adjusted ED LOS measure.

While for RY 2028 staff recommends continuing to include the ED LOS measure in payment, ED subgroup hospital representatives have mixed opinions on its inclusion. While some hospitals believe this is actionable, others would prefer that ED LOS be a monitoring measure to better align with the national programs. Also, discussions with stakeholders continue on whether an inpatient LOS measure would be a stronger incentive to address hospital throughput concerns. However, as with readmissions, multiple payment incentives that are complimentary may be needed to address the overall concern of throughput, which makes the financial stability of hospital global budgets more difficult.

It is also worth noting that CMS is planning to retire the OP-18 ED LOS measure and OP-22 Left without Being Seen measure in CY 2028. Instead, CMS has developed a new electronic clinical quality measure (eCQM) on ED Access and Timeliness that can be submitted by hospitals in CY 2027 on a voluntary basis and CY 2028 it will be mandatory. This measure includes all ED visits in the denominator and assess gaps in ED care as defined by whether any of the following occurred:

1. The patient waited longer than 60 minutes to be placed in a treatment area, or
2. The patient left the ED without being evaluated, or
3. The patient with an order to admit boarded in the ED longer than 240 minutes, or
4. The patient had an ED LOS longer than 480 minutes.

As part of the state's eCQM data collection, which is discussed below, this measure could be considered long term for monitoring and if there are no improvements in ED LOS, the HSCRC could consider the CMS measure for future inclusion in a payment program to adjust global budgets for non-Medicare FFS. However, at this time and given the intense focus and public scrutiny of ED wait times, HSCRC staff is recommending to continue the current ED LOS measure in payment even though it is not in alignment with the CMS quality payment programs. Based on input from stakeholders and further IP LOS

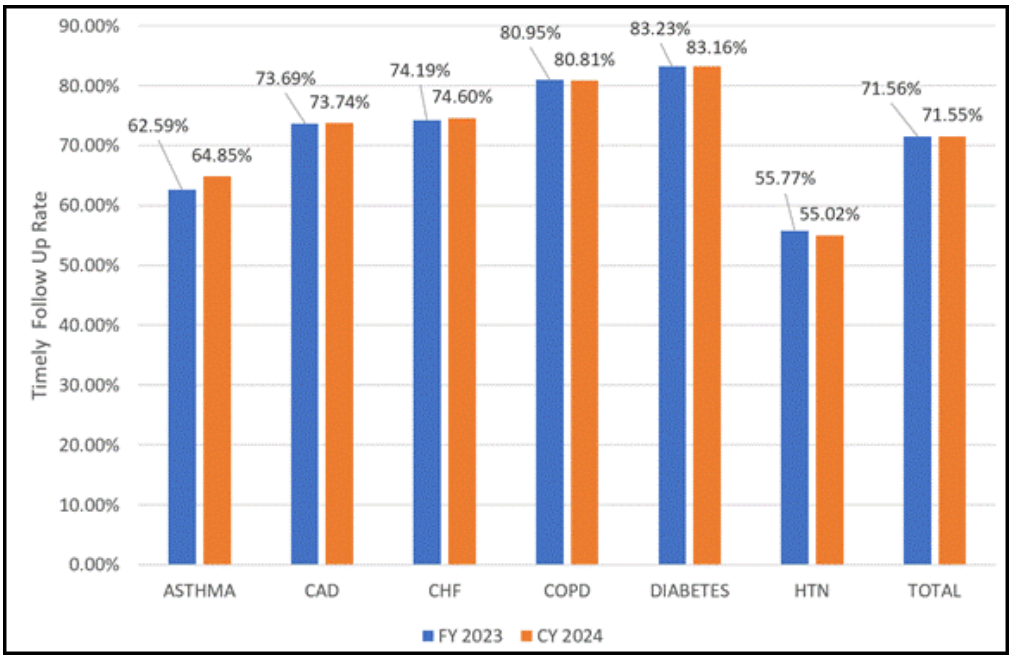
discussions, the staff may modify this recommendation for the final policy and longer term strategy.

Timely Follow-Up After Discharge

Under the TCOC model, the state was required by CMMI to develop a Statewide Integrated Health Improvement Strategy (SIHIS) that addressed care transformation. Given the development of the Maryland Primary Care model and other provider strategies under the TCOC model, the state proposed improvements in timely follow up after hospitalization using a National Quality Forum-endorsed measure originally developed for health plans. To ensure the SIHIS goal was met, the HSCRC introduced this measure for Medicare beneficiaries into the RY 2023 QBR Program within the PCE domain, expanded the measure to Medicaid in RY 2025, and added a Medicare within-hospital disparity gap measure in RY 2026.[5] The measure assesses the percentage of ED visits, observation stays, and inpatient admissions for one of six conditions in which a follow-up was received within the time frame recommended by clinical practice. Figure 8 shows Maryland's performance in SFY 2023 compared to CY 2024 for each chronic condition and all conditions combined within the Medicare population. Statewide there was a slight decrease in Medicare rates from in SFY 2023 to CY 2024 (71.56% to 71.55%) across all conditions combined. For Asthma, CAD and CHF there were increases in the rates of timely follow-up by 3.61 percent, 0.07 percent and 0.55 percent, respectively. However, for CAD, CHF, Diabetes and Hypertension there were slight decreases in follow up.

[5]The SIHIS goal is to achieve a 75 percent TFU rate for Medicare FFS beneficiaries across the six specified conditions and respective time frames.

Figure 8. Medicare FFS: Maryland Timely follow up



*Maryland numbers are claims-based and built on the CMS Claim and Claim Line Feed data with a four month runout. CAD=Coronary artery disease; CHF= Congestive heart failure; COPD=Chronic obstructive Pulmonary disease; HTN= Hypertension.

Figure 9 shows the annual performance on the total TFU measure for Maryland and the nation (national data is based on the Chronic Condition Warehouse 5 percent sample). Comparing CY 2018 to CY 2024, the nation has seen a 3.71 percent increase and Maryland has seen a 0.08 percent decrease in timely follow-up rates; however, Maryland still performed about 2.15 percent better than the nation in CY 2024.

Figure 9. Medicare FFS: Timely Follow-Up Rate, Maryland vs Nation*

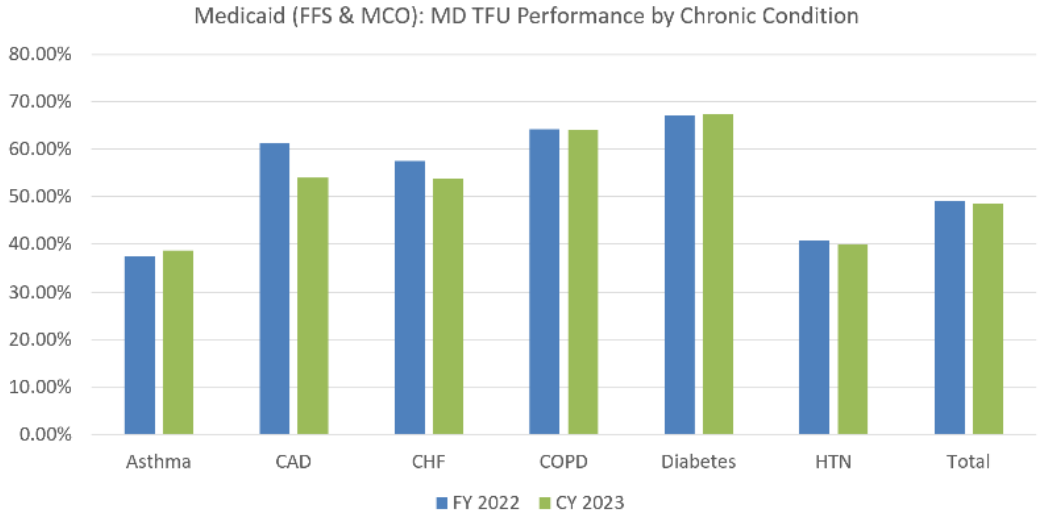
TFU Rates	CY2018	CY2019	CY2020	CY2021	CY2022	CY2023	CY2024
Maryland	70.85%	71.45%	67.90%	70.07%	70.59%	70.29%	70.79%
US	66.82%	69.00%	64.75%	67.68%	67.26%	68.35%	69.30%

*Maryland and national numbers are from the CMS Chronic Conditions Warehouse.

With regard to the Medicare within-hospital TFU gap adopted in RY 2026, staff notes that there were no hospitals improving sufficiently to earn the incentive.

As part of the SIHIS proposal, staff said they would explore expanding the TFU rates for chronic conditions to other payers and adding follow-up after a hospitalization for behavioral health. In CY 2022, staff worked with CRISP and Maryland Medicaid to provide hospitals monthly Medicaid TFU reports on the CRS portal. Beginning in RY 2025, the HSCRC introduced the Medicaid TFU measure into the QBR program as a distinct measure from Medicare due to the large differences in performance. Figure 10 shows Maryland's performance over time for each chronic condition and all conditions combined for Medicaid patients. Similarly to Medicare, Medicaid TFU has gone down slightly over time with less than 50 percent of Medicaid enrollees receiving follow up.

Figure 10. Maryland Medicaid Timely Follow-Up by Condition



QBR-HVBP Alignment: PCE Domain Measures

In an effort to align the QBR program with HVBP, staff and stakeholders discussed the following:

- **HCAHPS:** Align with HVBP by only including top-box and consistency assessment (i.e., remove linear given no evidence the inclusion of linear resulted in improvements).
- **ED LOS:** Despite this not being included in the HVBP, staff are recommending to maintain the ED LOS measure in the QBR program due to the considerable concern about ED wait times from patients and the state legislature. Based on

input from stakeholders and further IP LOS discussions, the staff may modify this recommendation for the final policy.

- **Timely Follow-Up:** Staff discussed the TFU measures with the PMWG stakeholders. Feedback from hospital representatives on PMWG supported removal of the measures as the state moves toward aligning the QBR program with the HVBP program. However, given the new AHEAD Medicaid primary care model and lower rates of follow up for Medicaid, staff has met with Medicaid to discuss continuing a payment incentive on this measure and how this measure could be monitored to ensure focus on care coordination.

Discussion of domain weighting with and without the additional ED LOS and/or Medicaid TFU is below, after discussion of each individual QBR domain.

B. Safety Domain

The QBR Safety domain contains five measures from six CDC NHSN HAI categories and the AHRQ Patient Safety Index Composite (PSI-90).[6] This domain is weighted at 30 percent of the total QBR score. In the FY 2026 HVBP program, CMS added the Sepsis and Septic Shock Management Bundle (SEP-1), a measure that has been publicly reported on Care Compare since July 2018. However, staff proposed not adopting this measure in the QBR program based on stakeholder input, inclusion of sepsis mortality in all-payer, all-cause mortality measure in QBR, and Maryland's favorable performance on the sepsis bundle. Instead, the staff proposed a Sepsis Dashboard to allow the State and hospitals to monitor performance on a comprehensive set of measures for sepsis patients. Another difference between the HVBP and QBR safety domain is that QBR has maintained the use of the AHRQ PSI measure rather than moving this measure to a standalone complications program, i.e., the MHAC program. Staff noted in the final QBR policy for RY 2027 that the PSI 90 composite measure would remain in the Safety Domain and that consolidation of the Safety Domain with the MHAC program may be considered for future years. For the RY 2028 draft, PMWG stakeholders support removing the measure from the QBR program in order to align with the HVBP program. However, staff believe this measure should be maintained in payment. Thus, if the PSI measure is

[6] For use in the QBR Program, as well as the HVBP program, the SSI Hysterectomy and SSI Colon measures are combined.

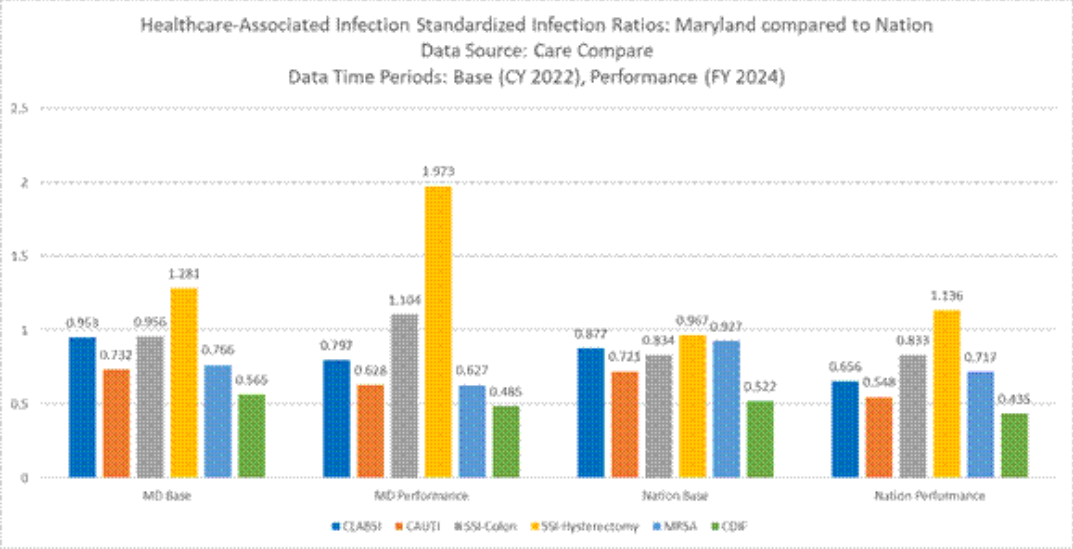
removed from QBR, the measure should be added to the MHAC program to align the CMS HAC reduction program.

CDC NHSN HAI Measures

The CDCs National Healthcare Safety Network (NHSN) tracks healthcare-associated infections, such as central-line associated bloodstream infections and catheter-associated urinary tract infections. Care Compare has updated the Centers for Disease Control (CDC) National Health Safety Network Healthcare Associated Infection (HAI) Standardized Infection Ratio (SIR) data tables for the nation and by state through June 2024. Figure 11 below shows how Maryland performs relative to the nation, and how performance has changed over time for both Maryland and the nation.

- For the most recent time period, Maryland's performance is favorable compared to that of the nation on MRSA.
- Maryland is worse (higher SIRs) on SSI-hysterectomy, SSI-colon, and slightly worse on CAUTI, CDIF and CLABSI.(see CDC statistical significance analysis of changes below)
- Both Maryland and the nation improved from the base to the performance period on four of the six HAI categories–CAUTI, CLABSI, CDIF and MRSA, and worsened on SSI-colon and SSI-hysterectomy

Figure 11. NHSN SIR Values for CY22 compared to 7/1/23-6/30/24, Maryland versus the Nation



It should be noted that while the QBR program weighs the NHSN measures similarly to HVBP, the NHSN measures are included in both the HVBP and HACRP program for Medicare FFS. The RY2023 QBR policy discusses NHSN concerns including the small cell size issues and surveillance bias (i.e., higher testing for infections results in higher rates of identified infections). As described in Appendix E, many of the NHSN measure result changes over time or large differences compared to the nation, are not statistically significant which is not assessed in the HVBP and QBR payment programs. Given these concerns, staff is hesitant and would like stakeholder input over the coming year on whether to align fully with the nation and use of the NHSN measures in two payment programs (QBR and MHAC), and on what measures should be considered for non-Medicare FFS quality policies.

Patient Safety Indicator Composite (PSI-90)

The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators assess the quality and safety of care for adults in the hospital by measuring 18 in-hospital complications and adverse events following surgeries, procedures, and childbirth. PSI-90 is a composite that focuses on a subset of ten AHRQ-specified PSIs such as post-operative sepsis, iatrogenic pneumothorax, and pressure ulcers . CMS removed the PSI-90 measure from the HVBP program in FFY 2024 but retained the measure in the Hospital Acquired Conditions Reduction Program. Maryland does not have PSI-90 in the MHAC program. As stated previously, staff believes the measure should be retained in the state's performance based payment program portfolio and would recommend adopting it into the MHAC program if it is removed from the QBR program.

The Agency for Research and Quality publishes all-payer risk-adjusted PSI 90 data by state and for the nation using the hospital Healthcare Cost and Utilization Project (HCUP) data. Figure 18 below, indicates that Maryland has improved over time and performs better than the Nation based on the most currently available CY 2023 data. Maryland's statewide performance compared to the nation on the PSI 90 composite measure and the individual measures within the composite for CY 2023 and CY 2024 are summarized below and illustrated in Figures 11 and 12[7]. These data show:

- Maryland is better on the overall composite and on eight of the ten PSI indicators

[7] Data provided by MHCC used for the Maryland Hospital Performance Guide published on the MHCC website.

than the nation

- Maryland has improved on the overall composite and on seven of the 10 indicators in 2024 compared to 2023
- Maryland has performed better than or on par with the nation on the overall PSI 90 composite in four of the last six years, 2019-2024

Figure 12. All-Payer PSI 90 Composite and Component Indicators for Maryland Compared to the Nation in 2024, and Maryland's performance over time 2023-2024

PSI Name	Maryland 2024 Compared to the Nation 2024	Maryland 2024 Compared to Maryland 2023
PSI 90 Composite	Better	Improved
PSI 3 Pressure Ulcer	Worse	Improved
PSI 6-Iatrogenic pneumothorax	Better	Improved
PSI 8 In Hospital Fall and Fracture	Better	Worse
PSI 9 Perioperative Hemorrhage or Hematoma	Better	Improved
PSI 10 Postoperative Acute Kidney Injury w/Dialysis	Better	Worse
PSI 11 Postoperative Respiratory Failure	Better	Improved
PSI 12 Postoperative Pulmonary Embolism or DVT	Better	Improved
PSI 13 Postoperative Sepsis Rate	Better	Improved
PSI 14 Postoperative Wound Dehiscence	Better	Worse
PSI 15 Abdominopelvic Accidental Puncture or Lac	Worse	Improved

Figure 13 Maryland All-Payer State vs National PSI-90 Composite Performance

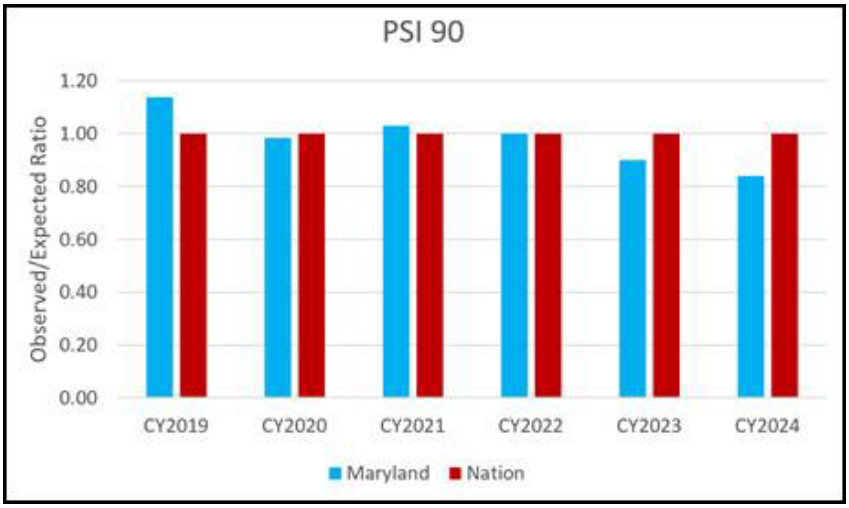
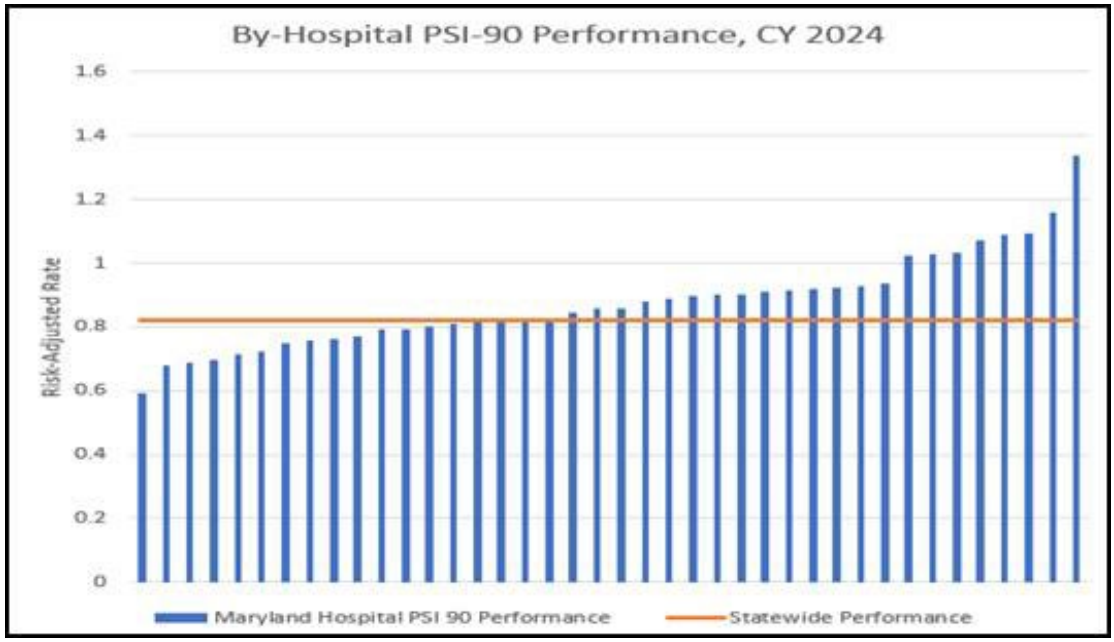


Figure 14 below illustrates the hospital-level performance on the all-payer PSI-90

composite measure for CY 2024; consistent with last year, the variation in performance by hospital suggests there may be opportunity for improvement on this measure.

Figure 14. PSI-90 Composite All-payer Hospital-Level Performance, CY 2024



Sepsis Early Management Bundle (Sep-1)

Approximately 1.7 million adults in the U.S. and 30,000 Marylanders develop sepsis each year accounting for 350,000 deaths in the U.S. and 1,100 in Maryland annually.[8] [9] It is the leading cause of hospitalization and mortality, with one in three people who die in the hospital having sepsis during their stay. Given this clinical significance, Medicare adopted the Sepsis Bundle measure into the HVBP program in FY 2026 despite concerns about this specific measure being raised by multiple professional societies and sepsis advocacy groups. Concerns with this measure include the bundle's potential to promote overuse of antibiotics and

[8] Found at: https://www.cdc.gov/sepsis/about/index.html. last accessed 8/6/2025.
[9] Found at: https://health.maryland.gov/newsroom/Pages/Sepsis-Awareness-Month-Highlights-Leading-Cause-Of-Deaths-In-US-Hospitals.aspx. last accessed 8/6/2025.

questionable link between the bundle and mortality.[10] Thus, in the RY 2026 QBR policy, the Commission approved the staff and stakeholder recommendation to *not* adopt the Sepsis Bundle measure despite Maryland performing well on the measure. In part, this decision was also because the Maryland quality payment programs include the sepsis PSI, PPC, and sepsis mortality. Instead of adding the Sepsis Bundle to QBR, HSCRC staff recommended development and dissemination of a hospital Sepsis Dashboard for monitoring in lieu of adopting the measure. Maryland continues to perform well compared to the Nation on Sepsis Bundle and the Sepsis PSI, as illustrated in Figure 15 and Figure 16 below. Despite the concerns, staff and the PMWG stakeholders recommend adopting the Sepsis Bundle measure in the Safety domain to align with the HVBP program since CMS recommends its continued inclusion.

[10] Found at: https://www.endsepsis.org/2023/08/17/end-sepsis-sep-1-response/. Last accessed 11/26/2025.

Figure 15. Maryland vs. the Nation, Sep-1 Measure July 2023-June 2024 Compared to CY 2022

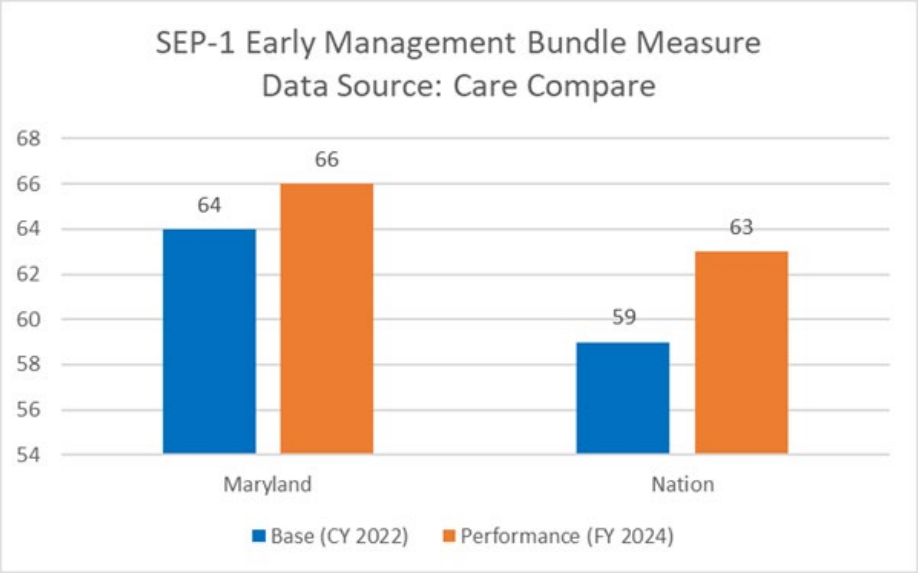
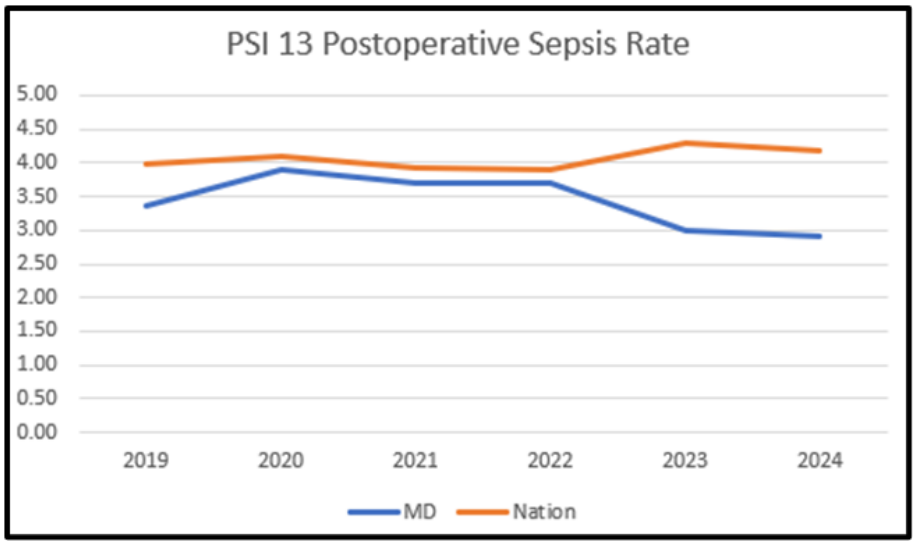


Figure 16. PSI 13 Postoperative Sepsis, Maryland vs. the Nation 2019-2024



QBR-HVBP Alignment: Safety Domain Measures

In an effort to align the QBR program with HVBP balanced with the underlying quality program principles to measure and incent improved safety for patients of all payers, staff and stakeholders discussed the issues below:

- **CDC NHSN Measures:** The RY 2027 QBR policy maintained the Safety domain weighting of 30 percent, five percent higher than HVBP program. However, the NHSN measures are included in both the HVBP and HACRP program for Medicare FFS. The RY2023 QBR policy discusses NHSN concerns including the small cell size issues noted above as well as surveillance bias (i.e., higher testing for infections results in higher rates of identified infections) and assessment of Maryland performance. Given these concerns, staff is hesitant and would like stakeholder input over the coming year on whether to align fully with the nation and use of the NHSN measures in two payment programs (QBR and MHAC) and what measures should be considered for non-Medicare FFS quality policies.
- **PSI 90 Composite Measure:** For the RY 2028 draft, PMWG stakeholders support removing the measure from the QBR program in order to align with the HVBP program. However, staff believe this measure should be maintained in payment since it measures serious complications (e.g., post-surgical sepsis, pressure ulcers), AHRQ produces an all-payer and Medicare version of the measure (i.e., meaning no measurement concerns), and it is included in the Medicare FFS quality programs. Thus, if the PSI measure is removed from QBR, the staff recommend the measure should be added to the MHAC program to align the CMS HAC reduction program.
- **Sepsis Management Bundle:** Maryland continues to perform well compared to the nation on Sepsis Bundle and the Sepsis PSI, as illustrated in Figure 19 and Figure 20 above. Despite concerns about the Sepsis bundle measure, CMS has continued its use. Thus, staff and the PMWG stakeholders recommend adopting the Sepsis bundle measure in the Safety domain to align with the HVBP program.

C. Clinical Care Domain

This domain, weighted at 10 percent of the RY 2027 QBR score, currently includes:

- Inpatient, all-payer, all-condition mortality measure
- 30-Day all-payer, all-condition mortality measure

Of note, Maryland's QBR mortality measure currently differs from the HVBP Program that uses five condition-specific, 30-day mortality measures for Medicare beneficiaries. In

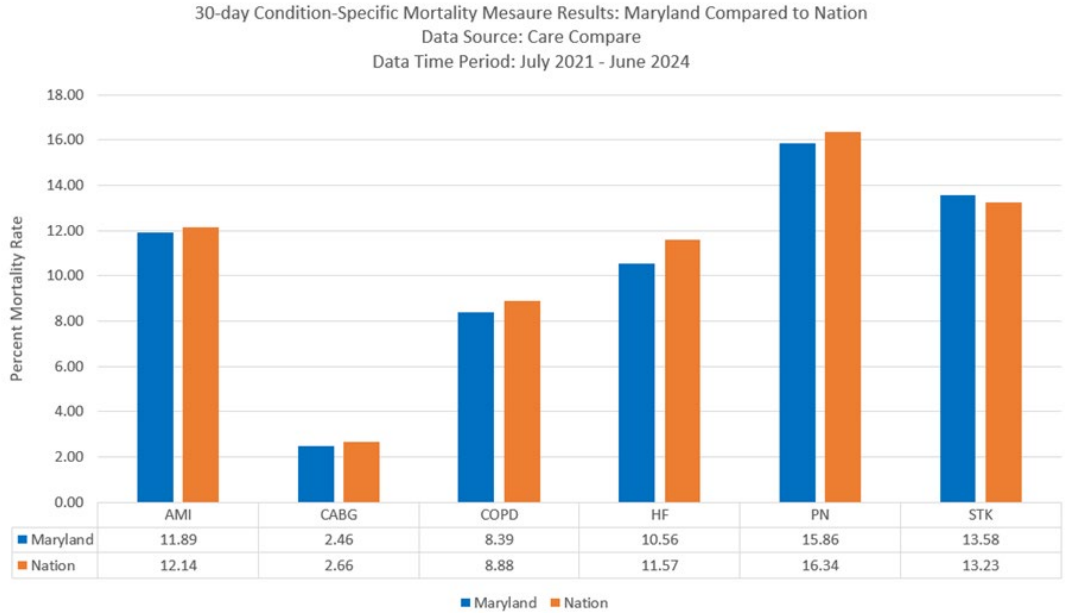
addition, the HVBP includes a Medicare Total Hip Arthroplasty-Total Knee Arthroplasty (THA/TKA) Complications measure. This measure was removed from QBR for RYs 2026 and 2027 due to concerns about the measure related to the proportion of procedures performed in the hospital versus on an outpatient basis in Maryland relative to the nation (i.e., higher proportion in outpatient in MD may make those remaining in IP higher acuity than the procedures done nationally). Rather than continuing this measure in payment, a proposal to monitor performance on the measure and consider potential alternative measures in the future was approved. As discussed below, staff is recommending to maintain the all-payer mortality measures for the coming year while still under all-payer rate setting and to provide time to evaluate other options for assessing mortality for non-Medicare FFS quality. However, to further align with the HVBP policy staff propose re-adopting the THA/TKA complication measure into QBR.

Mortality

CMS 30-Day Condition-Specific Mortality Measures

On the CMS 30-day condition-specific mortality measures used in the HVBP program and for Stroke, Maryland performs essentially on par with the Nation (Figure 17). Specifically, Maryland performs slightly better on 30-day mortality for AMI, CABG, and HF, COPD, and PN, and slightly worse on Stroke.

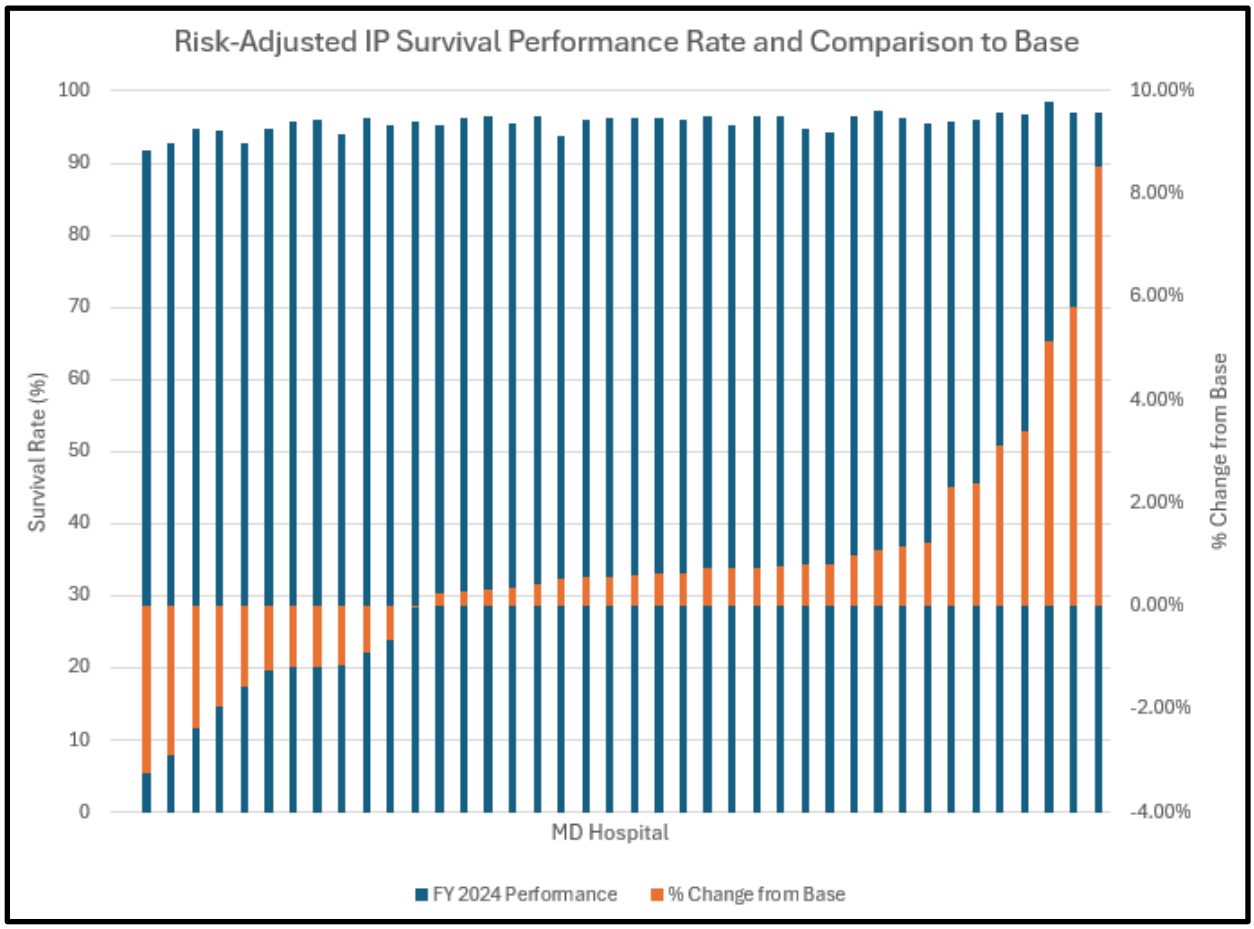
Figure 17. Maryland vs. National Hospital Performance on CMS Condition-Specific Mortality Measures



QBR Inpatient, All-payer, All-condition Mortality Measure

For the QBR all-payer inpatient mortality measure, which assesses hospital services where 80 percent of the mortalities occur (the DRGs with the top 80% of deaths), the statewide risk-adjusted survival rate increased from 95.27 percent in the base period of SFY 2023 to 95.66 percent in the CY 2024 performance period. As illustrated in Figure 18 below, the majority of hospitals have improved in CY 2024 when compared to SFY 2023 on the Inpatient Mortality measure (with 10 out of 40 hospitals having worsened slightly) .

Figure 18. Maryland Hospital Performance, SFY 2023 vs CY 2024 QBR Inpatient All Condition, All Payer Mortality Measure



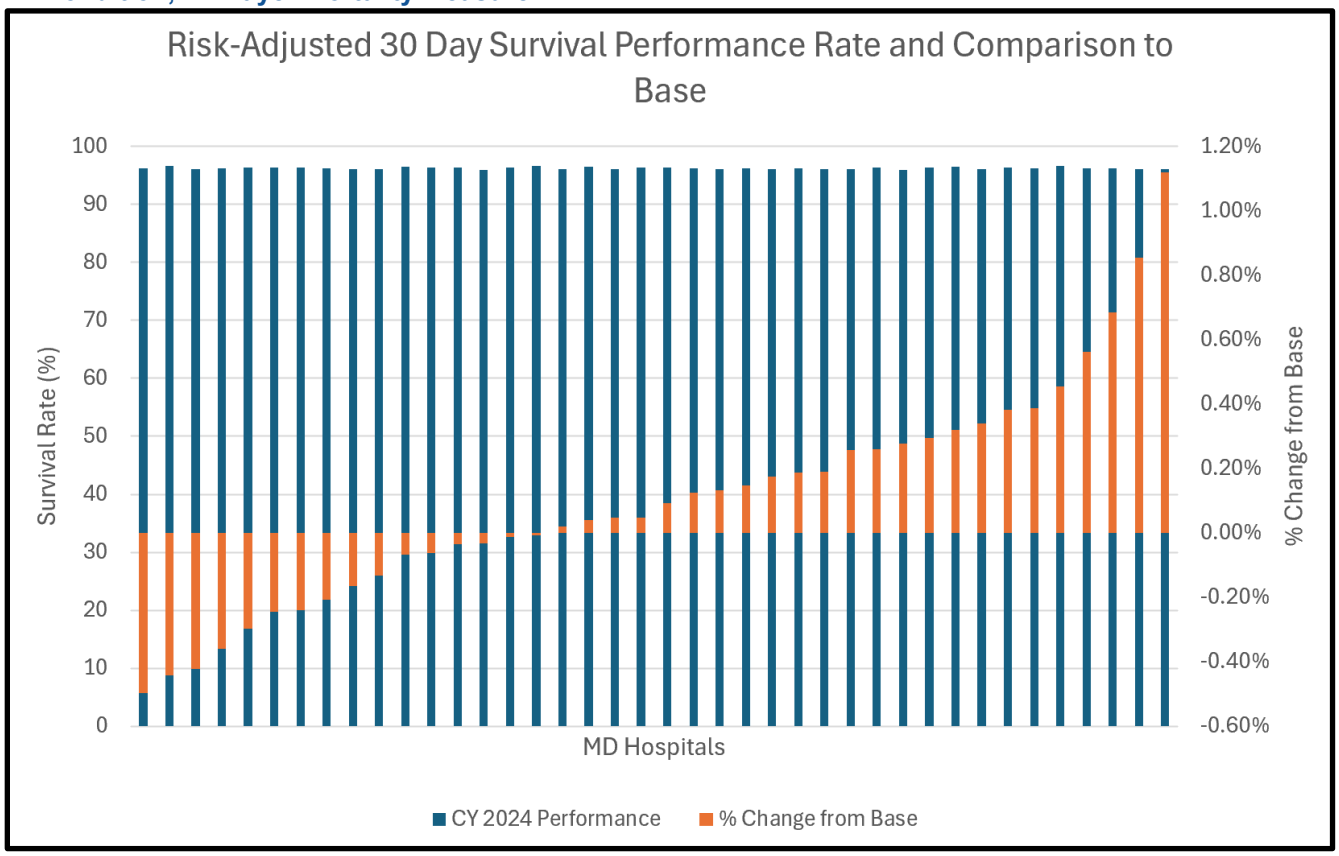
Note: The graph displays hospital performance in the blue bars and hospital improvement from the FY 2023 base in orange bars. For example, the hospital on the far right had a survival rate of over 95% in CY 2024 and saw an increase in their survival rate of almost 9% when compared to their performance in FY 2023.

30-Day Inpatient, All-payer, All-condition Mortality Measure

HSCRC began reporting the 30-day, all-payer, all-condition, all-cause mortality measure to hospitals through the CRISP portal in CY 2023. The measure was developed by Mathematica based on the CMS 30-day Medicare, all-cause mortality measure and adapted for use of all-payer, APR DRG patient-level data. Staff believes that expansion to a 30-day measure in the QBR Program better captures and incentivizes the quality of care

delivered by a hospital, expanding beyond the walls of the hospital. In CY 2024, as shown in Figure 19 below, survival rates range from ~96 percent to ~97 percent with 24 hospitals improving and six hospitals declining compared to SFY 2023; the statewide average survival rate for the measure improved by 0.10 percent in 2024.

Figure 19. Maryland Hospital Performance, SFY 2023 vs CY 2024 30-Day, All Cause All Condition, All Payer Mortality Measure



Note: The graph displays hospital performance in the blue bars and hospital improvement from the FY 2023 base in the orange bars. For example, the hospital on the far right had a survival rate of over 95% in CY 2024 and saw an increase in their survival rate of about 1.15% when compared to their performance in FY 2023.

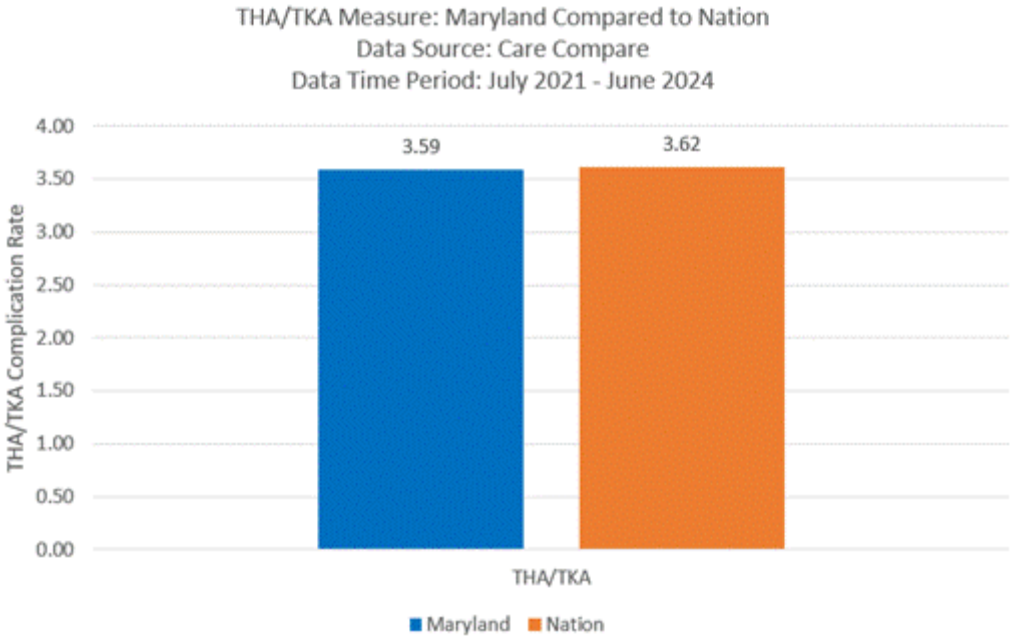
Last, as part of the digital measures initiative staff plans to consider transitioning from the fully claims-based mortality measure to the hybrid 30-day mortality measure (claims plus Core Clinical Data Elements) in the future. To date, the vast majority of hospitals working with their electronic health record (EHR) vendors have been able to adapt measures specifically for Maryland's all-payer measurement environment for patients 18 years and older. Staff believes it is important to continue the all-payer digital measures data

collection and follow the CMS lead on the timing of digital measures adoption in payment programs. In order to support the collection of all-payer hybrid data elements and other electronic Clinical quality measures (eCQMs) staff support continuing the digital measure incentive that was implemented in the RY 2027 QBR policy. For CY 2026, Maryland has aligned the digital measures reporting with the CMS requirements except that we are requesting data sooner, and the hybrid data elements are required on an all-payer basis, i.e., for patients 18 years and older. The incentive of $150,000 will be provided in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline and all-payer hybrid data elements, provided that all required measures are reported. Appendix F provides additional information on the digital measures data collection requirements for CY 2026.

Hip and Knee Arthroplasty Complications

As stated above, this measure was removed from QBR for RYs 2026 and 2027 due to concerns about the measure related to the proportion of procedures performed in the hospital versus on an outpatient basis in Maryland relative to the nation (i.e., higher proportion in outpatient in MD may make those remaining in the inpatient setting higher acuity than the procedures done nationally). Based on the most current data available on CMS Care Compare, July 2021 through June 2024, Maryland hospital performance is on par with the nation for the THA/TKA measure (Figure 20).

Figure 20. Maryland THA/TKA Measure Performance Compared to the Nation, 7/1/21-3/31/24



QBR-HVBP Alignment: Clinical Care

In an effort to align the QBR program with HVBP balanced with the underlying quality program principles to measure and incent improved clinical care for patients of all payers, staff and stakeholders discussed the issues below:

- **Mortality Measures:** Staff is recommending to maintain the all-payer mortality measures for the coming year while still under all-payer rate setting and to provide time to evaluate other options for assessing mortality for non-Medicare FFS quality. While several PMWG stakeholders supported maintaining all-payer mortality, some suggested only maintaining the IP measure and others suggested only maintaining the 30-day measure since CMS does 30-day measures. Staff note that the correlation between the IP and 30-day measure is moderate and seek further stakeholder input on this draft recommendation.
- **THA/TKA Complications Measure:** PMWG members lended their support to further align with the CMS HVBP policy staff's proposed recommendation to re-adopt the THA/TKA complication measure into QBR.

Domain and Measure Weighting

Staff is working to analyze data that yields a comparison of the domain weights and measures for the current RY 2027 QBR program, proposed RY 2028 program, and the FFY 2028 HVBP program. As discussed above, staff supports reweighting the domains and measures to be more aligned with the HVBP program. While the HVBP program has four domains with each weighted at 25 percent, the CMS estimated HVBP scores for Maryland hospitals do not include the efficiency domain as discussed previously in the Introduction and outlined in Appendix D, and instead is proposing to weight each domain as 1/3rd of hospitals' total scores. Staff proposes to align with the 1/3rd weighting of each domain with adjustments for proposed inclusion of the ED LOS and Medicaid TFU measures in the PCE domain; the staff recommends that these measures be included at similar weights as they are in the RY 2027 QBR program (10 percent of QBR score for ED LOS and 3 percent for Medicaid TFU).

If these measures are included, there are two options for domain weights under consideration: 1. Weight each domain the same, such that the addition of ED LOS and/or Medicaid TFU in the PCE Domain reduces the weight on HCAHPS top-box and consistency, or; 2. Increase the PCE domain weight to accommodate ED LOS and Medicaid TFU, and reduce the Clinical Care and Safety domains proportionally to account for the additional measures. Staff recommends Option 2 which would entail lowering HCAHPS top-box and consistency slightly but would maintain them at equal weighting to other hospitals nationally by reducing the weights in the Clinical Care and Safety Domains. Based on updated analyses, staff will discuss modeled revenue adjustments under HVBP and the impact of the proposed changes with the PMWG in the November meeting and then include the stakeholder discussion and results in the final policy.

Figure 21. Comparison of RY 2027 QBR, Proposed RY 2028, and CMS HVBP Domain Weights and Measures

Domain	Approved Maryland RY 2027 QBR Domain Weights and Measures	Maryland RY 2028 Proposed QBR Domain Weights and Measures	CMS FFY 2028 HVBP Domain Weights and Measures
Clinical Care	**10 percent** Two All-Payer Mortality Measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality	**31 percent** Two All-Payer Mortality Measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality; Add THA/TKA complications	**25 percent** Five Medicare Mortality measures: Condition-specific mortality measures; THA/TKA complications
Person and Community Engagement	**60 percent** Six HCAHPS categories, top-box score and consistency, 3 categories for linear scores ; TFU (Medicare, Medicaid, disparities improvement); ED LOS	**38 percent** Six HCAHPS measures top-box and consistency; Maintain ED LOS measure and Medicaid Timely Follow-Up.	**25 percent** Six HCAHPS measures top-box score and consistency
Safety	**30 percent** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**31 percent** Six measures: Five CDC NHSN HAI measure categories; Add Sepsis Bundle measure; Remove all-payer PSI 90 and move to the MHAC program.	**25 percent** Six measures: Five CDC NHSN HAI measure categories; Sep 1 Bundle measure
Efficiency	N/A	N/A	**25 percent** One measure: Medicare spending per beneficiary*

*Currently this measure is not calculated for MD hospitals. Instead the domains are each weighted as 1/3rd in the estimated HVBP scores provided by CMS for MD hospitals.

Revenue Adjustment Methodology

The revenue adjustments for QBR are calculated using a preset scale so that hospitals can prospectively and concurrently track financial performance in quality programs. The scale ranges from 0 percent to 80 percent, and the staff estimate

the cut-point for penalties and rewards as to not overly reward or penalize Maryland hospitals for performance compared to the nation. However, establishing this cut-point prospectively has become more difficult post-COVID. Thus, the RY 2024 through RY 2027 policies indicated that the cut-point would be reassessed retrospectively with more recent national data and staff recommend continuing this retrospective assessment or determining another method for determining cut-point.

Methodology for Determining QBR Scaling Cut-Point

The current methodology for retrospectively determining the cut-point, which is the point on the scale where penalties end and rewards start, is to estimate QBR scores for all hospitals nationally and calculate the mean. This method uses HCAHPS and NHSN data for hospitals nationally but state averages for MD specific measures, and then applies the QBR measure weights. For RY 2026, staff has shifted to using the median, less sensitive to outliers, and the analysis results are in Appendix D.

Analyzing HVBP vs. QBR Revenue Adjustments

For FFY 2026, CMS provided estimated HVBP scores for Maryland hospitals. Analyzing these scores entails weighting each domain at 1/3rd of the final score. Using these scores, HSCRC staff then will estimate all-payer revenue adjustments for Maryland hospitals. While the HVBP estimates would apply only to the Medicare FFS base operating revenue, the HSCRC will use all payer revenue for reference to compare across programs. Also it should be noted that the HVBP estimates will be net of the 2 percent withhold that the program uses to fund the revenue neutral rewards.

Impact of Alignment of Domain Weights and Measures

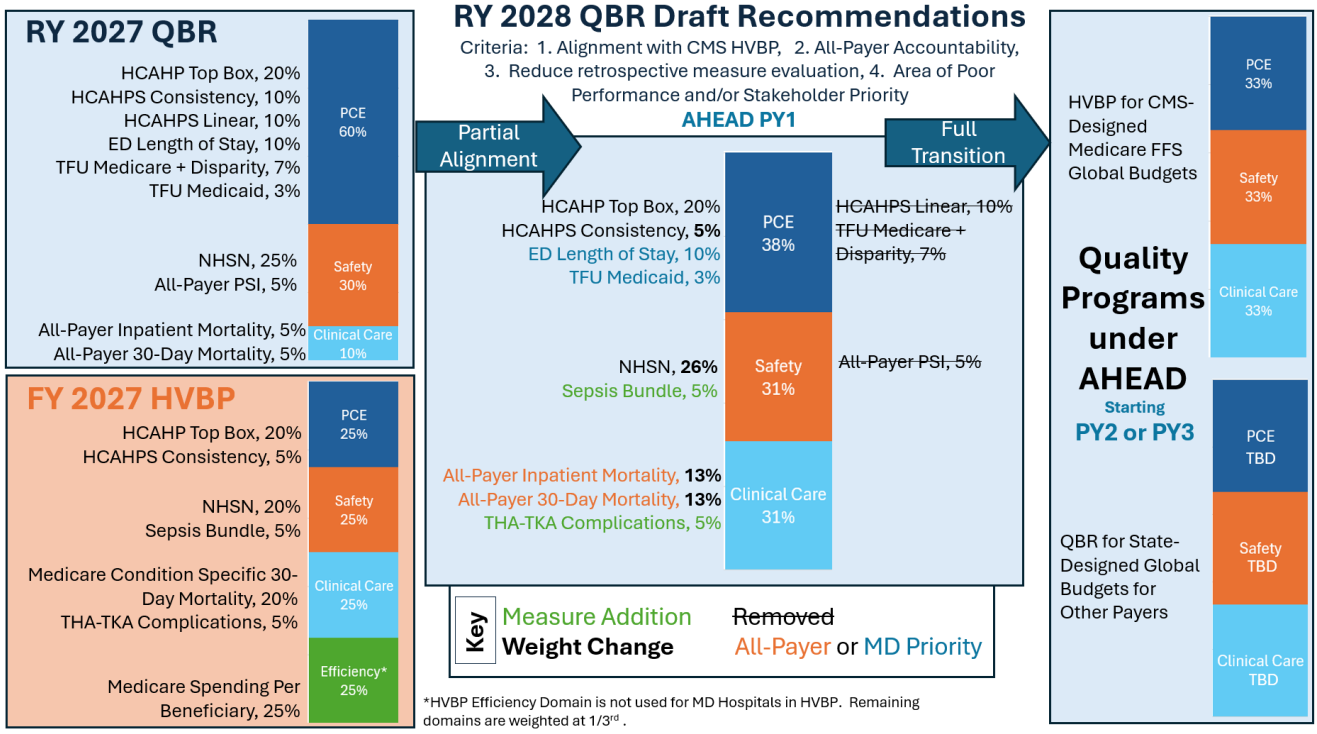
Staff will model different scenarios that iteratively look at the recommended changes and will review the results with stakeholders. For purposes of this draft policy, the staff notes that the following two scenarios will be modeled presented

and compared the the HVBP and RY 2026 QBR estimates , as illustrated in Figure 22:

Scenario 1: Matched HVBP measures and domain weights fully.

Scenario 2: Add back in ED LOS and Medicaid TFU by increasing PCE domain weight and reducing Clinical care and Safety equally.

Figure 22. QBR-HVBP Domains and Measures with Proposed Updates to Align with CMS Under the AHEAD Model



As staff continues to work on these analyses, it is important for stakeholders and Commissioners to provide input on measure inclusion and domain weights based on the criteria discussed above and not merely based on the potential impact on modeled hospital revenue. Finally, staff believes the modeling results will also be impacted by the cut-point methodology and the fact that HVBP allows hospitals to earn rewards above 2 percent of inpatient revenue.

DRAFT RECOMMENDATIONS FOR RY 2028 QBR PROGRAM

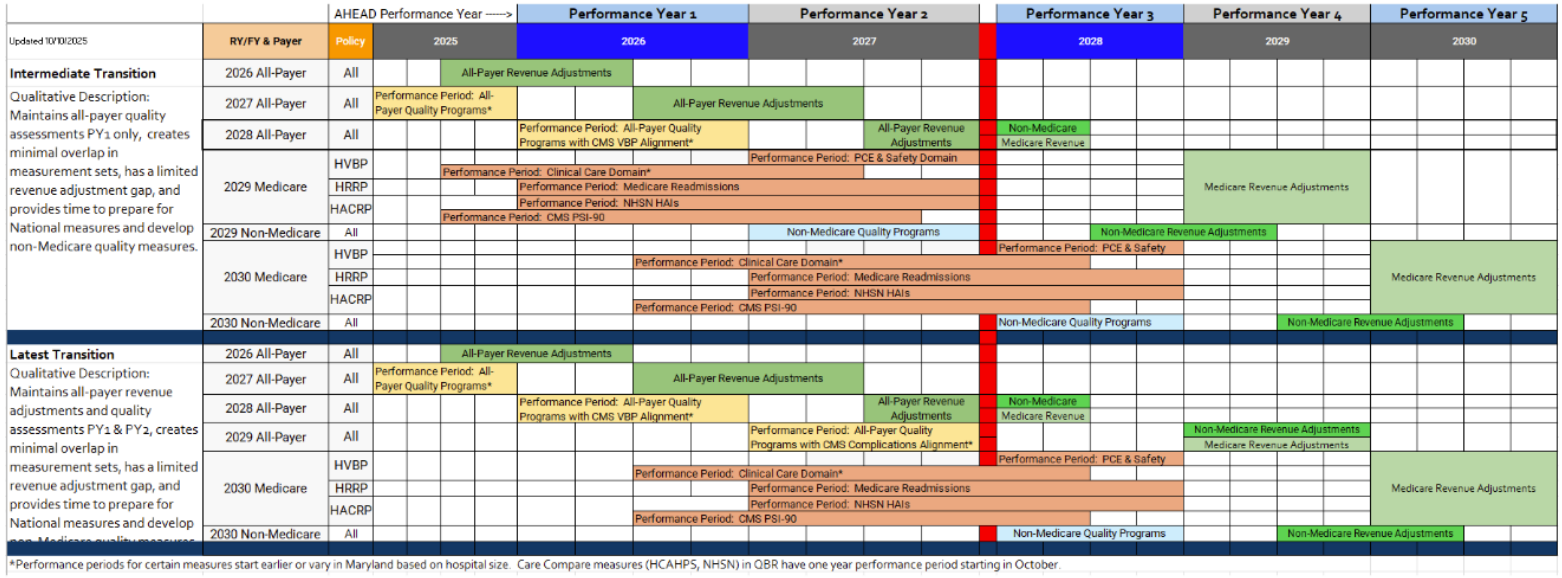
Draft Recommendations for RY 2028 QBR Program:

1. Update Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.
2. Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures; add a bonus incentive of $150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.
3. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and maintain the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 41 percent.
    a. Retrospectively evaluate 41 percent cut-point using more recent data to calculate national average score for RY 2026 and RY 2027.
    b. Based on concurrent analysis of national hospital performance, adjust the RY26 QBR cut-point to 32.68% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.

APPENDIX A: QUALITY PROGRAM TRANSITION TIMELINES

Potential Timelines

Color Key	Performance	Revenue
	All Payer	All-Payer
	Medicare FFS	Medicare
	Non-Medicare	Non-Medicare



*Performance periods for certain measures start earlier or vary in Maryland based on hospital size. Care Compare measures (HCAHPS, NHSN) in QBR have one year performance period starting in October.

Intermediate option means hospital performance is already under some of the CMS quality measures (i.e., condition specific mortality, THA-TKA, CMS PSI). Other measures start CY2026 (i.e., condition specific readmissions and NHSN)

APPENDIX B: QBR PROGRAM BACKGROUND

Maryland's QBR Program, in place since July 2009, uses measures that are similar to those in the federal HVBP Program, under which all other states have operated since October 2012. Similar to the HVBP Program, the QBR Program currently measures performance in Clinical Care, Safety, and Person and Community Engagement (PCE) domains, which comprise 10 percent, 30 percent, and 60 percent of a hospital's total QBR score, respectively. For the Safety and Person and Community Engagement domains, which constitute the largest share of a hospital's overall QBR score (85 percent), performance standards are the same as those established in the HVBP Program. The Clinical Care Domain, in contrast, uses a Maryland-specific mortality measure and benchmarks. In effect, Maryland's QBR Program, despite not having a prescribed national goal, reflects Maryland's rankings relative to the Nation by using HVBP benchmarks for the majority of the overall QBR score.

In addition to structuring two of the three domains of the QBR Program to correspond to the HVBP Program, the HSCRC has increasingly emphasized performance relative to the Nation through benchmarking, domain weighting, and scaling decisions. For example, beginning in RY 2015, the QBR Program began using national benchmarks to assess performance for the Person and Community Engagement and Safety domains. Subsequently, the RY 2017 QBR policy increased the weighting of the Person and Community Engagement domain, which was measured by the national HCAHPS survey instrument to 50 percent. The weighting was increased to raise incentives for HCAHPS improvement, as Maryland has consistently lagged behind the Nation on these measures. In RY 2020, ED-1b and ED-2b wait time measures for admitted patients were added to this domain, with the domain weight remaining at 50 percent. In RY 2021, the domain weight remained constant, but the ED-1b measure was removed from the program. For RY 2022, ED-2b was removed from QBR because CMS no longer required submission of the measure for the Inpatient Quality Reporting Program.

The QBR domain weights remained constant from RY2023 to RY2025 at 50 percent for PCE, 15 percent for Clinical Care, and 35 percent for Safety; modifications were approved to the current weights for RY 2026 and maintained in RY 2027. Although the QBR Program has many similarities to the HVBP Program, it does differ because Maryland's

unique model agreements and autonomous position allow the state to be innovative and progressive. Figure B.1. below illustrates the QBR RY2025-2027 measurement domains and weights compared to the HVBP program.

Figure B.1. RY 2025- RY 2027 QBR measures and domain weights compared with those used in the CMS HVBP Program

Domain	Maryland RY 2026 QBR domain weights and measures	Maryland RY 2027 QBR domain weights and measures	CMS HVBP domain weights and measures
Clinical Care	**10 percent (-5% from RY 2025)** Two measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality,	**10 percent** Two measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality,	**25 percent** Five measures: Four condition-specific mortality measures; THA/TKA complications
Person and Community Engagement	**60 percent (+10% from RY 2025)** 10 measures: • Eight HCAHPS categories top-box score and consistency, and four categories linear score; • TFU Medicare, Medicaid, disparities improvement; • ED LOS0	**60 percent** 8 measures: • Six HCAHPS categories top-box score and consistency, and four categories linear score; • TFU Medicare, Medicaid, disparities improvement; • ED LOS0	**25 percent** Eight HCAHPS measures top-box score.
Safety	**30 percent (-5% from RY 2025)** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**30 percent (-5% from RY 2025)** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**25 percent** Five measures: CDC NHSN HAI measures
Efficiency	n.a.	n.a.	**25 percent** One measure: Medicare spending per beneficiary

Note: Details of HVBP measures can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019. It involves (1) assessing performance on each measure in the domain; (2) standardizing measure scores relative to performance standards; (3) calculating the total points a hospital earned divided by the total possible points for each domain; (4) finalizing the total hospital QBR score (0–100 percent) by weighting the domains based on the overall percentage or importance the HSCRC has placed on each domain; and (5) converting the total hospital QBR scores into revenue adjustments, using a preset scale ranging from 0 to 80 percent.

QBR program revenue at risk

The HSCRC sets aside a percentage of hospital inpatient revenue to be held "at risk" based on each hospital's QBR Program performance. Hospital performance scores are translated into rewards and penalties in a process called scaling.[11] Rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered permanent revenue. The HSCRC previously approved scaling a maximum reward of 2 percent and a penalty of 2 percent of the total approved base revenue for inpatients across all hospitals.

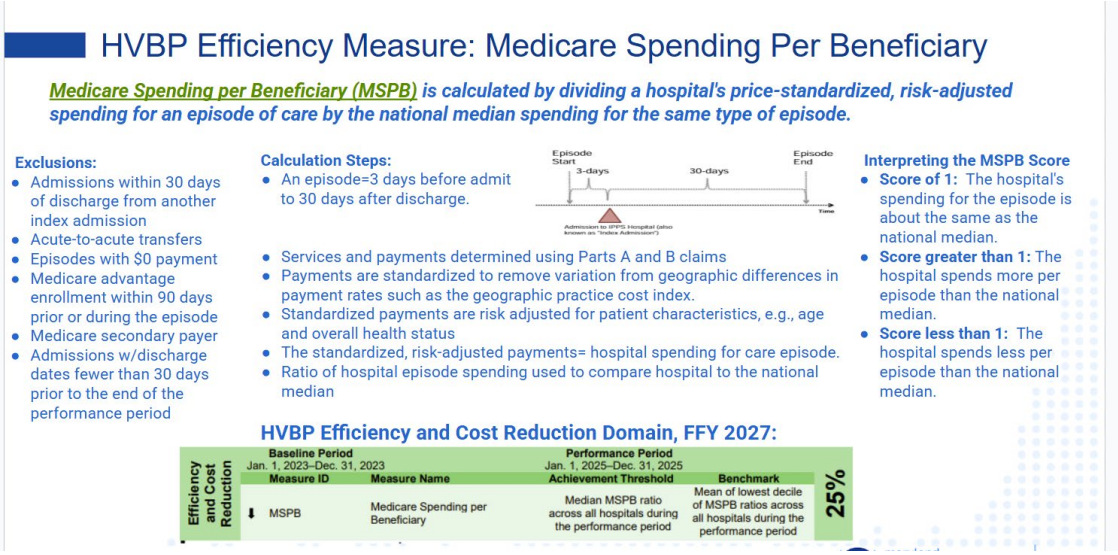
HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the HVBP Program, where feasible,[12] enabling the HSCRC to use data submitted directly to CMS. Maryland implemented an efficiency measure outside of the QBR Program, based on an Integrated Efficiency policy, which includes adjustments to rates based on cost per case efficiency, total cost of care performance, and changes in potentially avoidable utilization (PAU). Under the AHEAD Model, HSCRC staff will continue to work with key stakeholders to develop updates to efficiency measure(s) under the state global budgets applicable to payers other than Medicare FFS that incorporate population-based cost outcomes.

[11] Scaling refers to the differential allocation of a predetermined portion of base-regulated hospital inpatient revenue based on an assessment of hospital performance.

[12] HVBP measure specifications can be found at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

As noted above in the Assessment Section, in contrast to the QBR program, CMS uses a Medicare Spending per Beneficiary measure in the HVBP program. Figure B.2. measure definition, exclusions, calculation steps, and interpretation of scores.

Figure B.2. HVBP MSPB Measure



QBR score calculation

QBR scores are evaluated by comparing a hospital's performance rate to its base period rate, as well as to the threshold (which is the median, or 50th percentile, of all hospitals' performance during the baseline period) and the benchmark (which is the mean of the top decile, or roughly the 95th percentile, during the baseline period).

Attainment points: During the performance period, attainment points are awarded by comparing a hospital's rates with the threshold and the benchmark. With the exception of the Maryland mortality measure and ED wait time measures, the benchmarks and thresholds are the same as those used by CMS for theHVBP Program measures.[13] For each measure, a hospital that has a rate at or above the benchmark receives 10 attainment points. A hospital that has a rate below the attainment threshold receives 0

[13] One exception is the ED wait time measures. For these measures, attainment points are not calculated; instead, the full 10 points are awarded to hospitals at or below (more efficient) than the national medians for their respective volume categories in the performance period.

attainment points. A hospital that has a rate at or above the attainment threshold and below the benchmark receives 1–9 attainment points.

Improvement points: Improvement points are awarded by comparing a hospital's rates during the performance period to the hospital's rates from the baseline period. A hospital that has a rate at or above the attainment benchmark receives 9 improvement points. A hospital that has a rate at or below the baseline period rate receives 0 improvement points. A hospital that has a rate between the baseline period rate and the attainment benchmark receives 0–9 improvement points.

Consistency points: Consistency points are awarded only in the HCAHPS measure in the Experience of Care domain. The purpose of these points is to reward hospitals that have scores above the national 50th percentile in all eight HCAHPS dimensions. If they do, they receive the full 20 points. If they do not, the dimension for which the hospital received the lowest score is compared to the range between the national 0 percentile (floor) and the 50th percentile (threshold) and is awarded points proportionately.

Domain denominator adjustments: In certain instances, QBR measures will be excluded from the QBR Program for individual hospitals. Hospitals are exempt from measurement for any of the NHSN Safety measures for which there is less than one predicted case in the performance period. If a hospital is exempt from an NHSN measure, its Safety domain score denominator is reduced from 50 to 40 possible points. If it is exempt from two measures, the Safety domain score denominator would be 30 possible points. Hospitals must have at least two of five Safety measures to be included in the Safety domain.

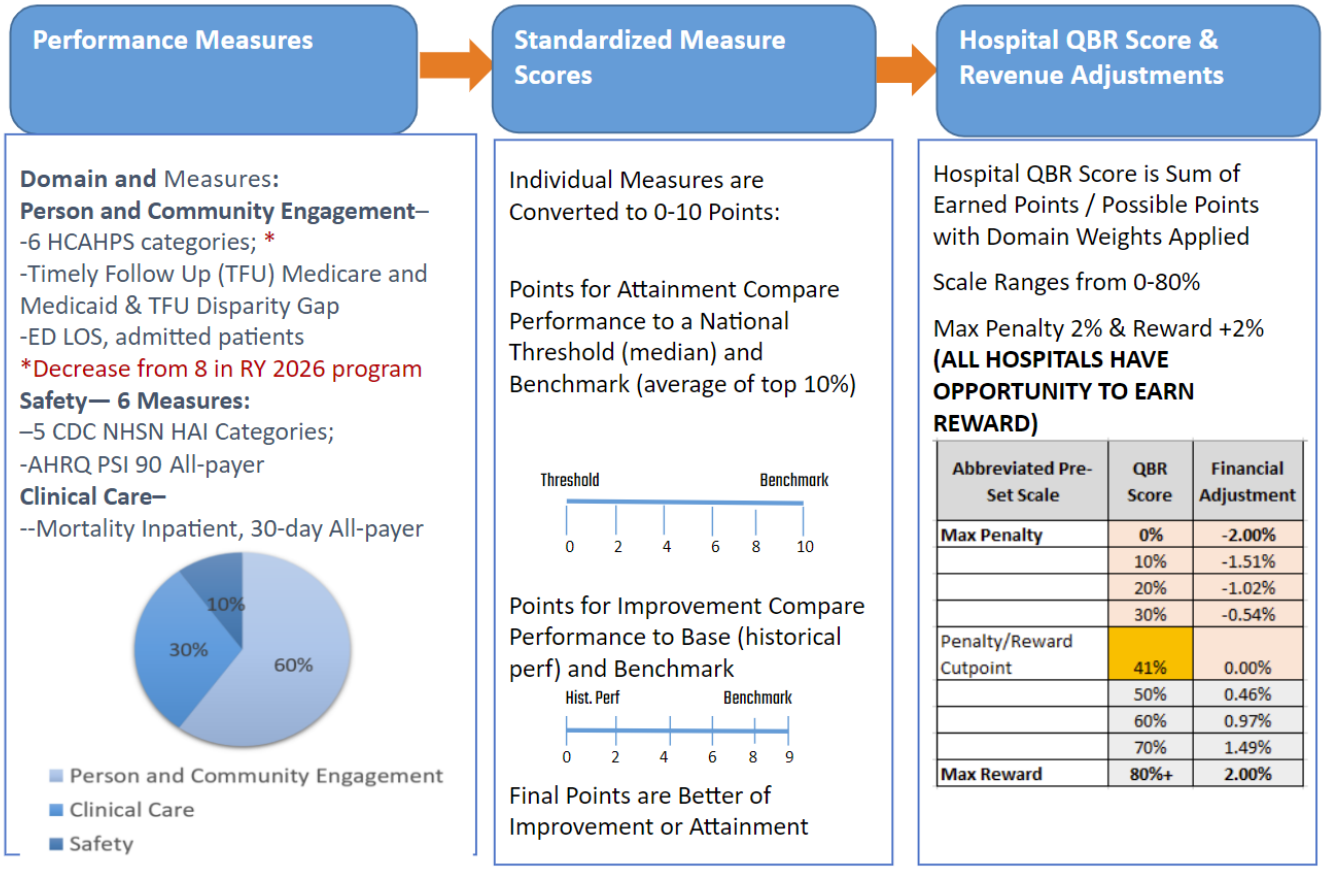
Domain scores: The better of the attainment score and improvement score for each measure is used to determine the measure points for each measure. The measure points are then summed and divided by the total possible points in each domain and multiplied by 100.

Total performance score*:* The total performance score is computed by multiplying the domain scores by their specified weights and then adding those totals together. The total performance score is then translated into a reward or penalty that is applied to hospital revenue.

RY 2023-RY 2027 Updates to the QBR Program

Since RY 2023, the HSCRC has not made fundamental changes to the QBR Program's methodology but implemented the addition of the Follow-Up After Acute Exacerbation of Chronic Conditions measure and PSI-90 composite measures. In RY 2025, Timely Follow Up (TFU) for Medicaid was added. In RY 2026, a measure of within-hospital TFU disparities reduction as well as the ED1-like measure was added and as stated above, the domain weights were adjusted as follows: Patient and Community Engagement weight was updated to 60%, Safety weight updated to 30% and Clinical Care updated to 10%. Figure B.3. shows the steps for converting measure scores to standardized scores for each measure, and then to rewards and penalties based on total scores earned, reflecting the updates through RY 2026 (added the ED1 measure), and for RY 2027 (no changes to domain weights from those of RY 2026, and decreasing number of HCAHPS sub-measures to six)..

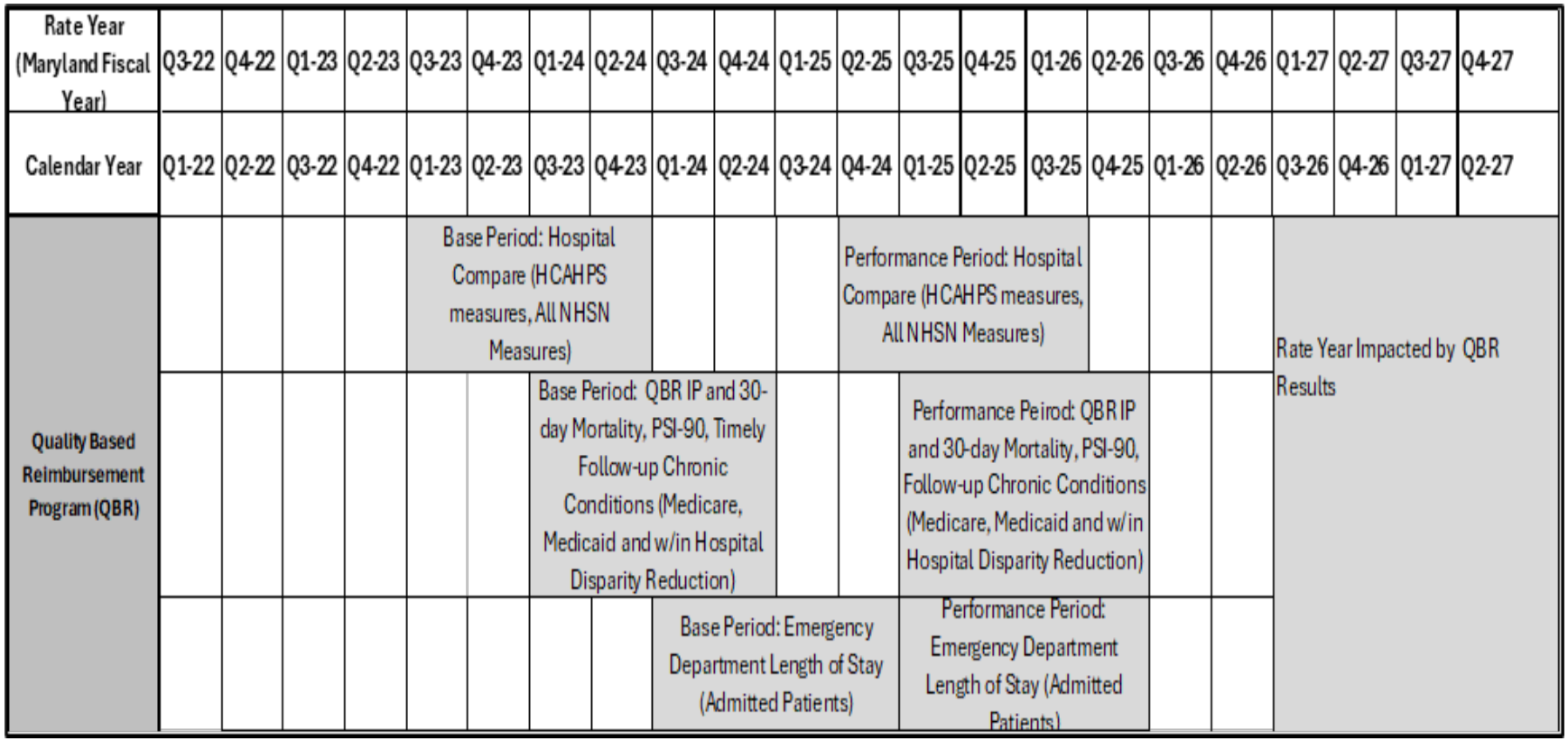
Figure B.3. RY 2027 Process for Calculating QBR Scores



Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	0%	-2.00%
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	41%	0.00%
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	80%+	2.00%

Figure B.4. below details the baseline and performance timelines for the measures in the QBR program for RY 2027.

Figure B.4.QBR RY 2027 timeline: base and performance periods; financial impact



PSI 90 measure (adopted beginning RY 2023)

Newly adopted in RY 2023, the Patient Safety Indicator composite measure was developed by the Agency for Healthcare Research and Quality in 2003.[14] CMS first adopted the composite measure in theHVBP program in FFY 2015 and removed the measure in FY 2019-FY 2022 due to operational constraints from the International Classification of Diseases, Tenth Revision (ICD-10) transition. The HSCRC had used the ICD-9 version of this measure in the QBR program but applied it to Maryland's all-payer population. CMS adopted the updated NQF endorsed ICD-10 version of the measure (Medicare only) that is used beginning with the FY 2023 HospitalHVBP program[15] , and also adopted by the QBR program (all-payer version) in RY 2023.

AHRQ's specified PSI uses include:

- Assess, monitor, track, and improve the safety of inpatient care
- Comparative public reporting, trending, and pay-for-performance initiatives
- Identify potentially avoidable complications that result from a patient's exposure to the health care system
- Detect potential safety problems that occur during a patient's hospital stay

The discharge weighted average of the observed-to-expected ratios for the following subset of AHRQ's PSIs comprise the PSI-90 composite measure:

- PSI 03 Pressure Ulcer Rate
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall With Hip Fracture Rate
- PSII 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate

[14] Source: https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2020/TechSpecs/PSI%2090%20Patient%20Safety%20and%20Adverse%20Events%20Composite.pdf.

[15] For more information on the measure removal and adoption, reference the FY 2018 IPPS/LTCH PPS final rule (82 FR 38242-38244) and (82 FR 38251-38256).

- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

PSI 90 combines the smoothed (empirical Bayes shrinkage) indirectly standardized morbidity ratios (observed/expected ratios) from selected Patient Safety Indicators. The weights of the individual component indicators are based on two concepts: the volume of the adverse event and the harm associated with the adverse event. The volume weights were calculated based on the number of safety-related events for the component indicators in the all-payer reference population. The harm weights were calculated by multiplying empirical estimates of the probability of excess harms associated with each patient safety event by the corresponding utility weights (1–disutility). Disutility is the measure of the severity of the adverse events associated with each harm (for example, the outcome severity or the least-preferred states from the patient perspective).

The PSI 90 measure scores are converted to program scores, as described in the QBR Score Calculation section of this appendix.

Follow-Up After Acute Exacerbation for Chronic Conditions (adopted for RY 2023)

Newly proposed for RY 2023, this measure was developed by IMPAQ on behalf of CMS.[16] Technical details for calculating measure scores are provided below.

Measure full title: Timely Follow-Up After Acute Exacerbations of Chronic Conditions

Measure steward: IMPAQ International

Description of measure: The percentage of issuer-product-level acute events requiring an ED visit or hospitalization for one of the following six chronic conditions: hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes mellitus (Type I or Type II), where follow-up was received within the time frame recommended by clinical practice guidelines in a non-emergency outpatient setting.

Unit of analysis: Issuer-by-product

Numerator statement: The numerator is the sum of the issuer-product-level denominator events (ED visits, observation hospital stays, or inpatient hospital stays) for acute

[16] Source: https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions

exacerbation of the following six conditions in which follow-up was received within the time frame recommended by clinical practice guidelines:

1. Hypertension: Within 7 days of the date of discharge
2. Asthma: Within 14 days of the date of discharge
3. HF: Within 14 days of the date of discharge
4. Coronary artery disease: Within 14 days of the date of discharge
5. Chronic obstructive pulmonary disease: Within 30 days of the date of discharge
6. Diabetes: Within 30 days of the date of discharge

Numerator details: This measure is defined at the issuer-by-product level, meaning that results are aggregated for each qualified insurance issuer and for each product. A product is defined as a discrete package of health insurance coverage benefits that issuers offer in the context of a particular network type, such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity. Issuers are broadly defined as health insurance providers who participate in the Federally Facilitated Marketplaces and health insurance contracts offered in the Medicare Advantage market.

Timely follow-up is defined as a claim for the same patient after the discharge date for the acute event that (1) is a non-emergency outpatient visit and (2) has a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code indicating a visit that constitutes appropriate follow-up, as defined by clinical guidelines and clinical coding experts. The follow-up visit may be an office or telehealth visit and takes place in certain chronic care or transitional care management settings. The visit must occur within the condition-specific time frame to be considered timely and for the conditions specified in the numerator. For a list of individual codes, please see the data dictionary.[17]

The time frames for a follow-up visit for each of the six chronic conditions are based on evidence-based clinical practice guidelines, as laid out in the evidence form.

Denominator statement: The denominator is the sum of the acute events—that is, the issuer-product-level acute exacerbations that require an ED visit, observation stay, or

[17] Please see https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions.

inpatient stay—for any of the six conditions listed above (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes).

Denominator details: Acute events are defined as either an ED visit, observation stay, or inpatient stay. If a patient is discharged and another claim begins for the same condition on the same day or the following day, the claims are considered to be part of one continuous acute event. In this case, the discharge date of the last claim is the beginning of the follow-up interval. The final claim of the acute event must be a discharge to community.

An acute event is assigned to [condition] if:

1. The primary diagnosis is a sufficient code for [condition].

OR

2. The primary diagnosis is a related code for [condition] AND at least one additional diagnosis is a sufficient code for [condition].
    - If the event has two or more conditions with a related code as the primary diagnosis and a sufficient code in additional diagnosis positions, **assign the event to the condition with a sufficient code appearing in the "highest" (closest to the primary) diagnosis position**.

If the visits that make up an acute event are assigned different conditions, the event is assigned the condition that occurs last in the sequence. Following this methodology, only one condition is recorded in the denominator per acute event.

Denominator exclusions: The measure excludes events with:

1. Subsequent acute events that occur two days after the prior discharge but still during the follow-up interval of the prior event for the same reason; to prevent double-counting, the denominator will include only the first acute event
2. Acute events after which the patient does not have continuous enrollment for 30 days in the same product
3. Acute events in which the discharge status of the last claim is not "to community" ("left against medical advice" is not a discharge to community)
4. Acute events for which the calendar year ends before the follow-up window ends (for example, acute asthma events ending less than 14 days before December 31)

5. Acute events in which the patient enters a skilled nursing facility, non-acute care, or hospice care during the follow-up interval

Measure scoring:

1. Denominator events are identified by hospitalization, observation, and ED events with appropriate codes (that is, codes identifying an acute exacerbation of one of the six included chronic conditions).
2. Exclusions are applied to the population from Step 1 to produce the eligible patient population (that is, the count of all qualifying events) for the measure.
3. For each qualifying event, the claims are examined to determine whether they include a subsequent code that satisfies the follow-up requirement for that event (for example, whether a diabetes event received follow-up within the appropriate time frame for diabetes, from an appropriate provider). Each event for which the follow-up requirement was satisfied is counted as one in the numerator. Each event for which the follow-up requirement was not satisfied is counted as zero in the numerator.
4. The percentage score is calculated as the numerator divided by the denominator.

Measure-scoring logic: Following the National Quality Forum's guideline, we use **opportunity-based weighting** to calculate the follow-up measure. This means each condition is weighted by the sum of acute exacerbations that require either an ED visit or an observation or inpatient stay for all of the six conditions that occur, as reflected in the logic below.

[NUM(ASM) + NUM(CAD) + NUM(HF) + NUM (COPD) + NUM(DIAB) + NUM(HTN)] / [DENOM(ASM) + DENOM(CAD) + DENOM(HF) + DENOM (COPD) + DENOM(DIAB) + DENOM(HTN)]

Although the development team designed the measure to aggregate each condition score in the manner described above into a single overall score, programs may choose to also calculate individual scores for each chronic condition when implementing the measure. Individual measure scores would be calculated by dividing the condition-specific numerator by the condition-specific denominator, as in the example for heart failure: NUM(HF) / DENOM(HF).

The follow-up measure scores are converted to QBR scores, as described in the QBR Score Calculation section above.

Updated TFU Measurement Specifications CY 22025

Staff notes that the TFU measure specifications were updated in 2024 and were approved by the CMS-designated Partnership for Quality Measurement. The updated specifications will be adopted for the RY 2027 QBR program and include modifications in the follow up times for some conditions as illustrated below.

1. Hypertension: Follow up within 14 days of the date of discharge for high-acuity patients or within 30 days for medium-acuity patients
2. Asthma: Follow up within 14 days of the date of discharge
3. Heart Failure: Follow up within 14 days of the date of discharge
4. Coronary Artery Disease: Follow up within 7 days of the date of discharge for high-acuity patients or within 6 weeks for low-acuity patients
5. Chronic Obstructive Pulmonary Disease: Follow up within 30 days of the date of discharge
6. Diabetes: Follow up within 14 days of the date of discharge for high-acuity patients

APPENDIX C: RY 2026 QBR PERFORMANCE BY HOSPITAL

cut-point = 41%

HOSPID	HOSPITAL NAME	FY25 Estimated Permanent Inpatient Revenue	RY 2026 FINAL Score	% Revenue Impact	$ Revenue Impact
210001	Meritus	$ 269,729,949	49.58%	0.44%	$1,186,812
210002	UMMS- UMMC	$ 1,572,442,188	18.08%	-1.12%	-$17,611,353
210003	UMMS- Capital Region	$ 325,349,234	30.25%	-0.52%	-$1,691,816
210004	Trinity - Holy Cross	$ 440,757,012	16.58%	-1.19%	-$5,245,008
210005	Frederick	$ 255,860,248	26.17%	-0.72%	-$1,842,194
210008	Mercy	$ 244,094,359	36.75%	-0.21%	-$512,598
210009	JHH- Johns Hopkins	$ 1,915,323,836	34.67%	-0.31%	-$5,937,504
210011	St. Agnes	$ 280,211,776	36.25%	-0.23%	-$644,487
210012	Lifebridge- Sinai	$ 527,147,859	31.00%	-0.49%	-$2,583,025
210015	MedStar- Franklin Square	$ 407,544,466	27.17%	-0.67%	-$2,730,548
210016	Adventist- White Oak	$ 269,335,289	45.33%	0.22%	$592,538
210017	Garrett	$ 31,765,005	80.27%	2.00%	$635,300
210018	MedStar- Montgomery	$ 107,202,092	55.27%	0.73%	$782,575
210019	Tidal- Peninsula	$ 356,375,986	35.50%	-0.27%	-$962,215
210022	JHH- Suburban	$ 276,688,736	29.83%	-0.54%	-$1,494,119
210023	Luminis- Anne Arundel	$ 419,860,154	34.83%	-0.30%	-$1,259,580
210024	MedStar- Union Mem	$ 306,565,594	32.55%	-0.41%	-$1,256,919
210027	Western Maryland	$ 206,549,734	28.83%	-0.59%	-$1,218,643
210028	MedStar- St. Mary's	$ 99,664,006	38.35%	-0.13%	-$129,563
210029	JHH- Bayview	$ 505,597,983	16.75%	-1.18%	-$5,966,056
210032	ChristianaCare, Union	$ 111,158,432	46.43%	0.28%	$311,244
210033	Lifebridge- Carroll	$ 166,721,865	25.75%	-0.74%	-$1,233,742
210034	MedStar- Harbor	$ 137,076,633	39.93%	-0.05%	-$68,538
210035	UMMS- Charles	$ 105,216,708	21.08%	-0.97%	-$1,020,602
210037	UMMS- Easton	$ 138,384,760	30.33%	-0.52%	-$719,601
210038	UMMS- Midtown	$ 140,973,899	32.35%	-0.42%	-$592,090
210039	Calvert	$ 84,946,923	63.17%	1.14%	$968,395
210040	Lifebridge- Northwest	$ 173,564,819	29.83%	-0.54%	-$937,250
210043	UMMS- BWMC	$ 329,675,757	31.42%	-0.47%	-$1,549,476
210044	GBMC	$ 274,971,840	36.67%	-0.21%	-$577,441
210048	JHH- Howard County	$ 256,140,273	20.17%	-1.02%	-$2,612,631
210049	UMMS-Upper Chesapeake	$ 260,331,648	22.83%	-0.89%	-$2,316,952
210051	Luminis- Doctors	$ 195,040,841	29.75%	-0.55%	-$1,072,725
210056	MedStar- Good Sam	$ 199,681,457	21.25%	-0.96%	-$1,916,942
210057	Adventist- Shady Grove	$ 361,126,072	32.42%	-0.42%	-$1,516,730
210060	Adventist-Ft. Washington	$ 37,325,252	33.65%	-0.36%	-$134,371
210061	Atlantic General	$ 49,839,515	58.85%	0.92%	$458,524
210062	MedStar- Southern MD	$ 210,782,671	27.50%	-0.66%	-$1,391,166
210063	UMMS- St. Joe	$ 305,357,564	42.92%	0.10%	$305,358
210065	Trinity - Holy Cross Germantown	$ 106,721,583	14.83%	-1.28%	-$1,366,036
	Statewide Total	**$12,463,104,017**			**-$64,871,175**

cut-point = 32.68%

HOSPID	HOSPITAL NAME	FY25 Estimated Permanent Inpatient Revenue	RY 2026 FINAL Score	% Revenue Impact	$ Revenue Impact
210001	Meritus	$ 269,729,949	49.58%	0.71%	$1,915,083
210002	UMMS- UMMC	$ 1,572,442,188	18.08%	-0.90%	-$14,151,980
210003	UMMS- Capital Region	$ 325,349,234	30.25%	-0.16%	-$520,559
210004	Trinity - Holy Cross	$ 440,757,012	16.58%	-0.99%	-$4,363,494
210005	Frederick	$ 255,860,248	26.17%	-0.41%	-$1,049,027
210008	Mercy	$ 244,094,359	36.75%	0.17%	$414,960
210009	JHH- Johns Hopkins	$ 1,915,323,836	34.67%	0.08%	$1,532,259
210011	St. Agnes	$ 280,211,776	36.25%	0.14%	$392,296
210012	Lifebridge- Sinai	$ 527,147,859	31.00%	-0.11%	-$579,863
210015	MedStar- Franklin Square	$ 407,544,466	27.17%	-0.35%	-$1,426,406
210016	Adventist- White Oak	$ 269,335,289	45.33%	0.53%	$1,427,477
210017	Garrett	$ 31,765,005	80.27%	2.00%	$635,300
210018	MedStar- Montgomery	$ 107,202,092	55.27%	0.95%	$1,018,420
210019	Tidal- Peninsula	$ 356,375,986	35.50%	0.11%	$392,014
210022	JHH- Suburban	$ 276,688,736	29.83%	-0.18%	-$498,040
210023	Luminis- Anne Arundel	$ 419,860,154	34.83%	0.08%	$335,888
210024	MedStar- Union Mem	$ 306,565,594	32.55%	-0.02%	-$61,313
210027	Western Maryland	$ 206,549,734	28.83%	-0.25%	-$516,374
210028	MedStar- St. Mary's	$ 99,664,006	38.35%	0.23%	$229,227
210029	JHH- Bayview	$ 505,597,983	16.75%	-0.98%	-$4,954,860
210032	ChristianaCare, Union	$ 111,158,432	46.43%	0.58%	$644,719
210033	Lifebridge- Carroll	$ 166,721,865	25.75%	-0.43%	-$716,904
210034	MedStar- Harbor	$ 137,076,633	39.93%	0.30%	$411,230
210035	UMMS- Charles	$ 105,216,708	21.08%	-0.72%	-$757,560
210037	UMMS- Easton	$ 138,384,760	30.33%	-0.15%	-$207,577
210038	UMMS- Midtown	$ 140,973,899	32.35%	-0.03%	-$42,292
210039	Calvert	$ 84,946,923	63.17%	1.29%	$1,095,815
210040	Lifebridge- Northwest	$ 173,564,819	29.83%	-0.18%	-$312,417
210043	UMMS- BWMC	$ 329,675,757	31.42%	-0.09%	-$296,708
210044	GBMC	$ 274,971,840	36.67%	0.16%	$439,955
210048	JHH- Howard County	$ 256,140,273	20.17%	-0.77%	-$1,972,280
210049	UMMS-Upper Chesapeake	$ 260,331,648	22.83%	-0.61%	-$1,588,023
210051	Luminis- Doctors	$ 195,040,841	29.75%	-0.19%	-$370,578
210056	MedStar- Good Sam	$ 199,681,457	21.25%	-0.71%	-$1,417,738
210057	Adventist- Shady Grove	$ 361,126,072	32.42%	-0.03%	-$108,338
210060	Adventist-Ft. Washington	$ 37,325,252	33.65%	0.03%	$11,198
210061	Atlantic General	$ 49,839,515	58.85%	1.10%	$548,235
210062	MedStar- Southern MD	$ 210,782,671	27.50%	-0.33%	-$695,583
210063	UMMS- St. Joe	$ 305,357,564	42.92%	0.43%	$1,313,038
210065	Trinity - Holy Cross Germantown	$ 106,721,583	14.83%	-1.10%	-$1,173,937
	Statewide Total	**$12,463,104,017**			**-$25,024,737**

APPENDIX D: HCAHPS COLLABORATIVE AND ANALYSIS

Learning Collaborative

Given concerns on HCAHPS performance, CMS tasked the state with implementing a Statewide HCAHPS performance improvement initiative that leverages input from providers, industry experts, and other stakeholders to develop future improvement goals. Further, CMS noted they are looking for the state to develop these strategies and commit to creating a framework for setting HCAHPS performance improvement goals for future performance years. Key components of the HCAHPS improvement framework include administrative leadership accountability, data analysis and data sharing, and hospital adoption and sharing of best practices.

To address these concerns,the HSCRC and the Maryland Hospital Association (MHA), established an HCAHPS Learning Collaborative to better understand Maryland's persistently low HCAHPS scores, understand the links between patient experience and safety, and to share best practices across Maryland hospitals and from national experts. The HCAHPS Learning Collaborative has met monthly since December 2024 to examine root causes of performance gaps and identify strategies for improvement. The Collaborative's membership included patient experience leaders from hospitals across the state of Maryland, Maryland's health care regulatory bodies, and representatives from national survey vendors.

While the final deliverables from the Collaborative are pending, a central finding is that patient experience is a primary lens through which patients assess care quality and safety of hospital care. However, hospitals sometimes view patient experience outcomes as distinct from quality and safety outcomes. But data presented by Dr. Tejal Gandhi, Chief Safety and Transformation Officer for Press Ganey (largest HCAHPS survey vendor) clearly shows the relationship. Dr. Gandhi shared that being a top patient experience performer on "Staff Worked Together" questions is associated with 10% fewer Total Falls and 10% fewer Injury Falls. In addition, top performers on "Staff provide care in a safe manner" questions are associated with 8% fewer Hospital-Acquired Pressure Injury (HAPI) and 16% fewer Total Falls. Furthermore, Dr. Gandhi's presentation included data indicating that when patients felt safe they would often mention that the medical professionals were friendly, caring, and professional. However, when patients felt unsafe, they mentioned environmental concerns, dismissive attitudes from staff, and administrative errors. Thus, for Maryland to transform its HCAHPS scores, hospitals must continue to recognize and invest in improving the patient experience as a central part of delivering high quality, safe, and reliable hospital care.

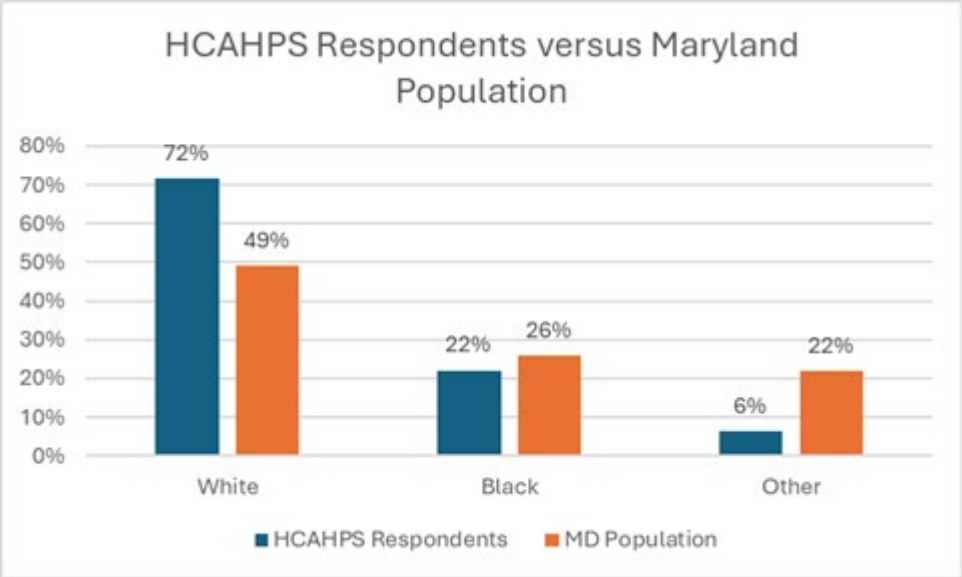
Patient Disparity Analysis

Examining HCAHPS results by demographic, clinical, and geographic characteristics allows focused improvement opportunities. The proportion of HCAHPS responses within the state does not align with the composition of the population. White respondents are more highly represented than Black or other respondent categories relative to their proportion in Maryland's population from the 2020 Census. Survey results are from all discharges from July 2021 through December 2024.

When reviewing top-box recommendation and rating by race from 2021 - 2024 (Figure D.1.):

- Less Black respondents than expected responding "Definitely Yes" and more White respondents than expected responding "Definitely Yes"
- Black respondents are consistently the least favorable with the exception of one data point (Black and White respondents, 2021)

Figure D.1. HCAHPS Responses compared to Maryland Population, as derived from the 2020 Census



When reviewing top-box rating (9 or 10) by race (Figure D.2.):

- Maryland responses are lower in the 9 or 10 category than the nation.
- In contrast to top-box recommendation, the Other race category responds the least favorably

Figure D.2. Top-Box Recommendation by Race

Top-Box Recommendation by Race				
Race	**2021**	**2022**	**2023**	**2024**
White	69.4	68.3	69.1	69.0
Black	69.4	66.0	65.0	66.5
Other	69.8	69.9	70.4	70.5
Overall	**69.4**	**67.9**	**68.3**	**68.6**

When reviewing top-box rating (9 or 10) by race (Figure D.3.):

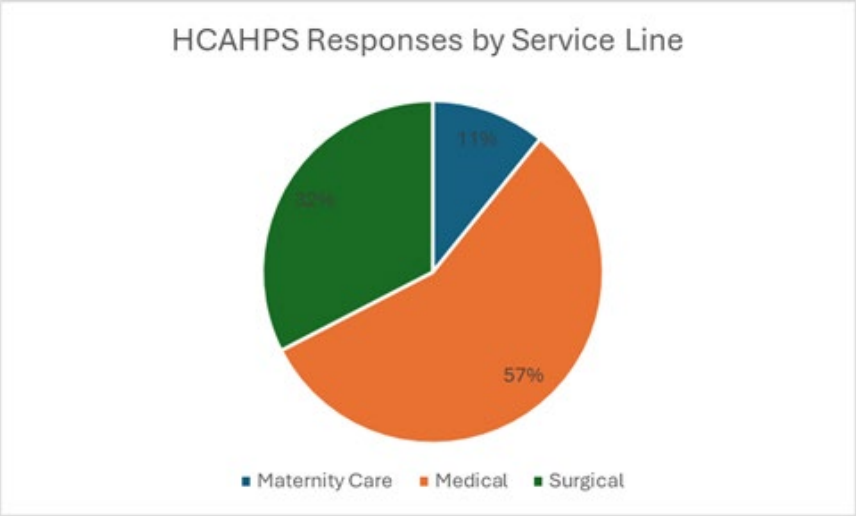
- Maryland responses are lower in the 9 or 10 category than the nation.
- In contrast to top-box recommendation, the Other race category responds the least favorably

Figure D.3. Top-Box Rating by Race

Top-Box Rating by Race				
	2021	**2022**	**2023**	**2024**
White	68.3	67.6	68.9	68.6
Black	68.3	67.1	67.8	67.9
Other	66.6	66.7	67.6	66.2
Overall	**68.2**	**67.5**	**68.6**	**68.3**

For the responses by service line in Maryland (Figure D.4.), there were 11,580 surveys within the Maternity comprising 11% of the total, 60,487 surveys within Medical comprising 57% of the total, and 34,786 surveys within Surgical comprising 33%:

Figure D.4. Responses by Service Line



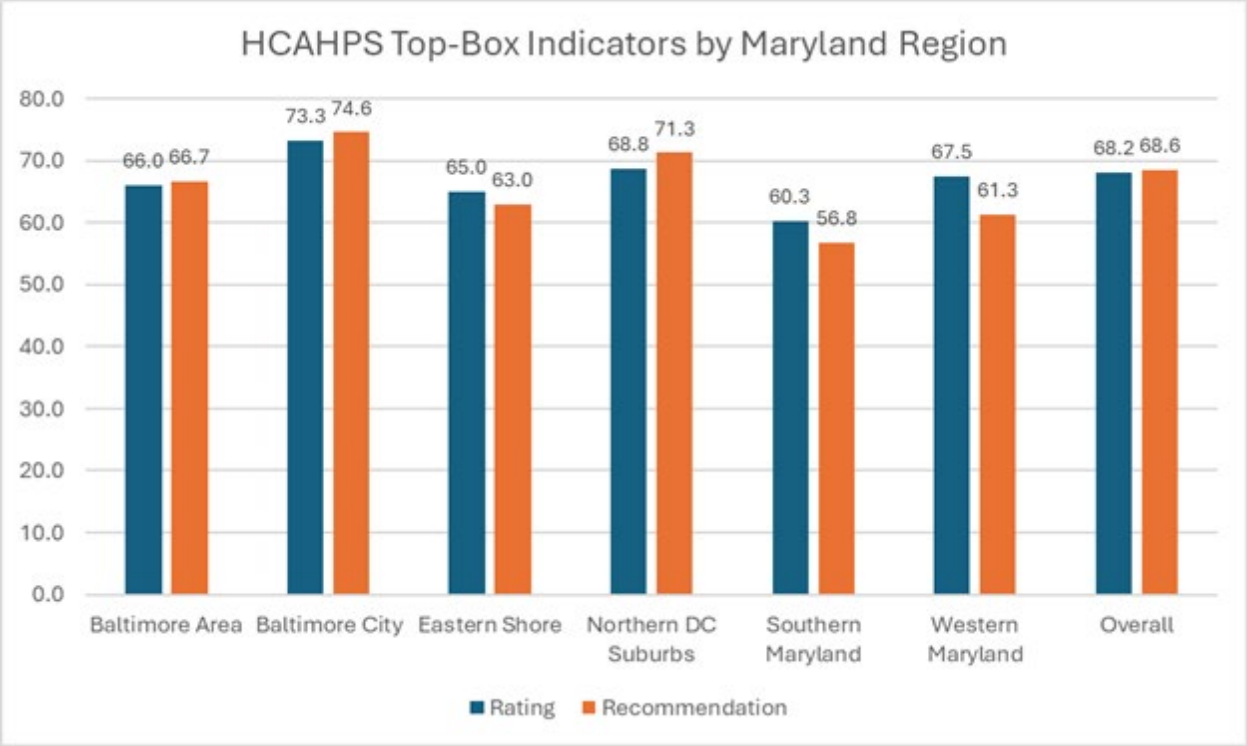
Looking at the overall results, there is minimal variation between race (Figure D.5). When reviewing more granularly, there are significant differences between race and service line. Specifically, the surgical service line consistently has higher results, and the medical service line is the lowest. However, between the race categories within the maternity service line, there is over a six-point difference between black and white respondents.

Figure D.5. Top-Box Rating by Race and Service Line Results

Top-Box Rating by Service Line				
Race	**Maternity**	**Medical**	**Surgical**	**Overall**
White	71.9	63.4	75.7	68.9
Black	65.4	65.6	73.8	66.5
Other	67.3	63.1	73.0	70.2
Overall	**69.6**	**65.1**	**75.2**	**68.4**

Reviewing the results by region, there are higher top-box results in Baltimore City and the Northern DC Suburbs, with lower results in Southern Maryland.

Figure D.6. Top-Box Rating and Recommendation by Region



APPENDIX E: CDC ANALYSIS OF NHSN HAI MEASURES

The CDC also publishes an annual report that includes state-specific performance on HAI measures that includes comparison of performance to the previous year as well as the statistical significance of the changes[18]. Figure E.1. below illustrates Maryland's change from CY 2022 to CY 2023 (the most current annual report published by CDC); the data reveal that Maryland's performance had statistically significant improvement (decrease) or had unchanged performance on all HAI measure SIRs included in the QBR program. Of particular note based on the CDC analysis, SIR differences in Maryland of between -10 percent and 28 percent for four of the HAI categories for CY 2023 compared to CY 2022 were not statistically significant because of small cell sizes in the state; SIR differences year over year have shown similar results for Maryland based on CDC analyses[19]. The issue of whether the differences are statistically significant is important to consider also when comparing Maryland or other relatively smaller states' performance or the nation, or comparing hospital performance to the national standards. For example, the hospital HVBP performance results do not indicate whether differences in performance among hospitals and states compared to the HVBP performance standards are statistically significant.

Figure E.1. CDC Healthcare-Associated Infections Progress Report, Maryland SIRs, CY 2023 Compared to CY 2022

Maryland Changes in state-specific standardized infection ratios (SIRs) between 2022 and 2023 for NHSN Acute Care Hospitals					
	2022 SIR	**2023 SIR**	**Percent Change**	**Direction of Change, Based on Statistical Significance**	**p-value**
CLABSI	0.946	0.848	-10%	No statistically significant change	0.1189
CAUTI	0.753	0.763	1%	No statistically significant change	0.8575
SSI Colon	0.861	0.890	3%	No statistically Significant change	0.8944
SSI Hysterectomy	1.185	1.515	28%	No statistically significant change	0.2771
MRSA	0.767	0.571	-26%	Statistically significant decrease	0.0165
CDIF	0.570	0.500	-12%	Statistically significant decrease	0.0060

[18] 2022 National and State Healthcare-Associated Infections Progress Report found at: https://www.cdc.gov/healthcare-associated-infections/php/data/progress-report.html?CDC_AAref_Val=https://www.cdc.gov/hai/data/portal/progress-report.html, last accessed 8/15/2024.
[19] See: https://www.cdc.gov/nhsn/datastat/progress-report.html (last accessed 7/23/2025).

APPENDIX F: DIGITAL QUALITY MEASURES INFRASTRUCTURE

CMS Roadmap

Maryland is an early adopter of digital measure reporting and has established beginning in CY 2022 statewide infrastructure and reporting requirements, initially for monitoring; Maryland envisions transitioning to the use of digital measures in the QBR program as well as other quality-based payment programs when digital measurement has had sufficient development and implementation is feasible.

Over the past decade, CMS has led efforts to advance the use of data from electronic health records (EHRs) to enhance and expand quality measurement. However, accessing clinical patient data from EHRs for the purpose of quality reporting remains relatively burdensome. Additionally, CMS's current approach to quality measurement does not easily incorporate emerging digital data sources such as patient-reported outcomes (PROs) and patient-generated health data (PGHD). There is a need to streamline the approach to data standardization, collection, exchange, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, quality improvement, and learning.

Advancements in the interoperability of healthcare data from EHRs create an opportunity to dramatically improve quality measurement systems and realize creation of a learning health system. In 2020, the Department of Health and Human Services (HHS) finalized interoperability requirements in CMS's Interoperability and Patient Access final rule and in the Office of the National Coordinator for Health Information and Technology's (ONC's) 21st Century Cures Act final rule. Driven by the Cures Act's goal of "complete access, exchange, and use of all electronically accessible health information," these changes will greatly expand the availability of standardized, readily accessible data for measurement. Most important, CMS's and ONC's interoperability rules and policies require specified healthcare providers and health plans to make a defined set of patient information available to authorized users (patients, other providers, other plans) with no special effort using Fast Healthcare Interoperability Resources (FHIR®) application programming interfaces (APIs). The scope of required patient data and standards that support them will evolve over time, starting with data specified in the United States Core Data for Interoperability (USCDI) Version 1, structured according to the Health Level Seven International (HL7®) FHIR US Core Implementation Guide (US Core IG).

Maryland, like CMS, believes that in the future, interoperability of EHR and other digital health data can fuel a revolution in healthcare delivery and advance Measure Calculation Tools to leverage data beyond just EHRs and across settings and providers. CMS has outlined a roadmap to transition from the current environment to a learning health system powered by advanced analytics applied to all digital health data to optimize patient safety, outcomes, and experience.[20]

Details of Maryland Hospital Digital Measures Implementation

In CY 2021 Maryland implemented statewide infrastructure and required all acute hospitals to report to HSCRC electronic Clinical Quality Measures (eCQM) measures beginning in CY 2022, with planned expansion to other digital measures going forward. The reporting requirements are more aggressive than the National CMS requirements in terms of measures, and the expectation for quarterly data submissions as opposed to annual submissions required by CMS.

HSCRC continues to support more current digital data submission/availability to strengthen hospitals' and the state's ability to use the data for quality tracking and improvement that is actionable. Further, the early adoption and migration to digital data and measures in general will ultimately constitute less burden for hospitals and the State. However, it is also important to note that some hospital stakeholders and Electronic Health Record (EHR) vendors have raised concerns regarding the quarterly data submissions related to EHR vendor system digital measure updates and hospitals' implementation of the updates, and hospitals have submitted Exceptional Circumstances Exemption requests for timeline extensions which have been granted on a case by case basis by the Commission.The Commission will continue to consider and approve timeline extension requests up to the CMS annual submission deadlines. Figure F.1. below illustrates the Maryland and CMS CY 2026 reporting requirements.

Staff notes that, in alignment with the state's goals to improve on maternal health and the SIHIS goal to reduce Severe Maternal Morbidity, the HSCRC required submission of the Severe Obstetric Complications measure beginning in CY 2022, a year ahead of CMS' requirement for hospitals to submit this eCQM; of note, beginning this year, Maryland has worked with CRISP and Medisolv to complete the application of risk adjustment for this measure so it may be used to compare hospital performance in the future. Also, through data/information sharing, staff will continue to collaborate with Maryland's

[20] Please see full details on CMS Digital Quality Measurement Strategic Roadmap: https://ecqi.healthit.gov/sites/default/files/CMSdQMStrategicRoadmap_032822.pdf, last accessed 8/9/2022.

Department of Health Maternal Child Health Bureau on this important population health improvement priority.

Figure F.1. CMS-Maryland CY 202CY 2025 Anticipated eCQM Reporting Requirements

Reporting Period/ payment determination	CMS Measures	Maryland Measures
CY 2025/RY 2027	Three self-selected eCQMs; Three required eCMQs -Safe Use of Opioids -Cesarean Birth -Severe Obstetric Complications Clinical data elements for two hybrid measures for Medicare -30-day mortality -30-day readmissions	Two self-selected eCQMs; Required eCQMs- -Safe Opioids -hypoglycemia -hyperglycemia -Cesarean Birth -Severe Obstetric complications Clinical data elements for two hybrid measures (for all-payers beginning in July 2024-June 2025) -30-day mortality -30-day readmissions
CY 2026/RY 2028	Three self-selected eCQMs; Required eCQMs- -Safe Opioids -hypoglycemia -hyperglycemia -Cesarean Birth -Severe Obstetric complications Clinical data elements for two hybrid measures (for all-payers beginning in July 2024-June 2025) -30-day mortality -30-day readmissions	Three self-selected eCQMs; Required eCQMs- -Safe Opioids -hypoglycemia -hyperglycemia -Cesarean Birth -Severe Obstetric complications Clinical data elements for two hybrid measures (for all-payers beginning in July 2024-June 2025) -30-day mortality -30-day readmissions

In addition to the eCQM reporting requirements, Maryland will also utilize the established infrastructure to continue collecting 30-day Hospital Wide Readmission (HWR) and Hospital Wide Mortality (HWM) hybrid measures required as of July 1, 2023. The state notes that subsequent transition to and adoption of an all-payer hybrid HWM measure will potentially allow for its use in the QBR program.

The next HSCRC Public Meeting is Wednesday,December 10, 2025.

maryland
health services
cost review commission