maryland
health services
cost review commission

638th Meeting of the Health Services Cost Review Commission

January 14, 2026

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

CLOSED SESSION
12:00 pm

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on December 10, 2025

Specific Matters

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

Docket Status – Cases Closed

2683A Johns Hopkins Health System
2684A University of Maryland Medical Center

2. Docket Status – Cases Open

2685A Johns Hopkins Health System
2686A Johns Hopkins Health System-WITHDRAWN
2687A Johns Hopkins Health System
2688A Johns Hopkins Health System
2689N Lumini Health Doctors Community Medical Center

Subjects of General Applicability

3. Presentation: MDH Secretary Meena Seshamani - Comments on AHEAD Model and Multi-Agency Work
4. Final Recommendation: Multi-Agency Regulatory Working Group Proposal
5. Report from the Executive Director

a. Model Monitoring
b. Policy Calendar Update
    i. Physician Costs Comments Summary
    ii. Healthcare Outcome Payment Effort

6. Final Recommendation: Confidential Data Request
7. Final Recommendation: Surge Policy
8. Final Recommendation: Demographic Adjustment
9. Final Recommendation: Quality Based Reimbursement (QBR) Policy
10. Draft Recommendation: Readmissions Reduction Incentive Program (RRIP)
11. Hearing and Meeting Schedule

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MINUTES OF THE
637th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
DECEMBER 10, 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., and Farzaneh Sabi, M.D. Via Zoom were Commissioners Nicki McCann, J.D. and Richardo Johnson, J.D. Upon motion made by Commissioner Sabi and seconded by Vice Chairman Elliott, the Commissioners voted unanimously to enter Closed Session. The Public Meeting was reconvened at 1:00 p.m.

REPORT OF DECEMBER 10, 2025, CLOSED SESSION

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed during the December 10, 2025, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM NOVEMBER 12, 2025, PUBLIC MEETING AND CLOSED SESSION

Upon motion made by Commissioner Sabi and seconded by Commissioner Johnson, the Commission voted unanimously to approve the minutes of the November 12, 2025, for the Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
CLOSED CASES

2657A Johns Hopkins Health System – Extension Request
2682A Johns Hopkins Health System

ITEM III
OPEN CASE

2683A Johns Hopkins Health System
2684A University of Maryland Medical Center

ITEM IV
REPORT FROM THE EXECUTIVE DIRECTOR

New Staff Announcement

Dr. Jon Kromm, Executive Director, announced two new hires:

- **Ms. Nancy Chiles Shaffer** joins the HSCRC as an Associate Director in the Center for Healthcare Data Management and Integrity, where she will lead all activities related to HSCRC datasets, including developing clinical and financial reporting requirements, monitoring data quality, and responding to data issues. She comes to the HSCRC from the Centers for Medicare & Medicaid Services, where she led agency-wide data initiatives, developed technical guidance to improve data collection and analysis, and oversaw the federal evaluation of the Medicare-Medicaid Financial Alignment Initiative. Nancy holds a Master's in Epidemiology and a Ph.D. in Gerontology from the University of Maryland, Baltimore.
- **Ms. Brianna Jones** joins the HSCRC as the new Human Resources Officer. She is responsible for recruitment, supporting staff with HR matters, and assists with fiscal administrative duties as needed. Ms. Jones has over 25 years of professional experience, including more than 10 years with the State of Maryland as an HR Representative at MDOT, supporting various offices such as the Office of Procurement, Office of Administration, and Office of Planning and Engineering. She holds a Master of Business Administration and the Society for Human Resource Management (SHRM-CP) certification.

Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee-for-Service (FFS) data through August 2025 (for claims paid through October 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 1.55 percent above the nation through July 2025, and that Maryland Medicare hospital and non-hospital growth through June resulted in savings of $127 million.

HSCRC AHEAD Model Policy Timeline

Dr. Kromm introduced a new monthly reporting structure for the Executive Director's Report, centered on a comprehensive policy timeline. This timeline serves as the staff's official work plan and is divided into four specific tracks: updates that are already planned, changes required for the AHEAD model implementation, policies likely to be impacted by AHEAD, and collaborative efforts involving multiple state agencies. A detailed document will accompany these reports to provide more granular explanations of each work track.

To improve clarity, the staff is utilizing a Gantt chart format to visualize the lifecycle of policy development. This chart emphasizes critical milestones for public and industry engagement, including periods for stakeholder input, the release of draft recommendations, and public comment windows. The timeline concludes each action with a final vote by the Commission.

A major focus of his presentation was the Global Budget Revenue 2028 Policy Review, described as a significant catch-all category for hospital global budget rules under CMMI. Dr.

Kromm noted that this area will require extensive future discussion as it involves everything from technical rate order adjustments to major financial policy shifts. He emphasized that much of this work is dependent on the timing and clarity of guidance received from federal partners at CMMI.

He highlighted immediate priorities, noting that Market Shift and Surge policies were ready for Draft Recommendations and discussion during the current session. He also signaled a forthcoming call for public input regarding physician costs. While multi-agency work will receive less granular updates than internal policies, the staff remains committed to sharing progress on those broader initiatives as they evolve.

Commissioner Blum asks whether the Commission should proactively drive CMMI's agenda to ensure they follow Maryland's pace, or if the Commission will remain reactive to federal policy decisions. He wants to understand how the staff envisions the strategic interplay and balance of power between state and federal authorities during this transition.

Dr. Kromm responded by characterizing the relationship as a two-way street rather than a hierarchy where one side leads and the other reacts. He emphasized that both state and federal staff maintain a regular meeting cadence to co-manage the agenda, with Maryland staff actively highlighting priorities to help CMMI determine what to focus on first. According to Kromm, this collaborative effort will eventually result in a combined plan that will be reflected in the Commission's formal policy timeline once further details are solidified.

Physician Costs

Dr. Kromm addressed the critical issue of physician costs, transitioning from recent data collection to the development of a formal policy framework. He proposed that the Commission issue a call for public comments to establish a set of governing principles. This initiative aims to define how the state should approach potential solutions and funding mechanisms for physicians as Maryland moves further into its healthcare transformation.

The first set of principles focuses on the strategic alignment of funding with the Commission's core mission. He suggested that initial efforts should prioritize hospital-based physicians, which are essential for efficient operations, as the Commission has the most direct line of sight into these costs. He emphasized that any financial support must be tied to the broader goals of the Maryland Model, specifically requiring that physician funding contribute to improved clinical quality, better health outcomes, and the reduction of overall system costs.

Dr. Kromm also highlighted the need for affordability and equity across different hospital staffing structures. He proposed that physician funding be strictly paired with efforts to mitigate underlying cost drivers to maintain the model's affordability. He insisted that these policies must be applied fairly to all hospital-based physicians, regardless of whether they are directly employed or contracted, ensuring that the financial impact reaches the physicians directly involved in care delivery.

He concluded with a focus on regulatory coordination and a call for Commissioner feedback and stressed that any new physician funding must be coordinated with CMS to ensure that Medicare

and Medicaid participate appropriately within the context of the AHEAD model. He invited the Commissioners to provide guidance on these five example principles to help shape the formal request for public comment and ensure the state's approach is both comprehensive and legally sound.

Commissioner Blum asked whether the Commission should mandate a standardized minimum model for physician staffing that hospitals must adopt to qualify for funding, or if the policy should remain flexible to accommodate each hospital's unique existing staffing structures.

Dr. Kromm responded by expressing skepticism toward a one-size-fits-all mandate, suggesting instead that while a qualitative staffing model would be too difficult to standardize across diverse hospitals, the Commission could use statistical benchmarking (such as a state average) to create a functional standard while still allowing for varied hospital structures.

Commissioner Sabi emphasized that a one-size-fits-all mandate is impractical because hospital staffing structures vary significantly based on local needs and geography. She advocated for a flexible policy that respects these diverse operational realities while ensuring that funding is tied to high-value clinical outcomes. She also advocated for a framework that supports long-term sustainability and equity across the state rather than just providing a simple financial pass-through.

Commissioner Joshi expressed general support for the proposed principles but offered two specific refinements regarding physician scope and cost expectations. He cautioned against drawing artificial lines that might exclude physicians who split their time between inpatient and ambulatory settings, such as anesthesiologists or behavioral health specialists. Additionally, while he agreed with targeting underlying cost drivers, he urged a balanced approach that acknowledges certain costs like supply chain expenses that may be beyond a hospital's immediate control.

Update on RY 2026 Allocation

Dr. Kromm provided an update on the status of the $100.4 million physician staffing funding, noting that staff are now analyzing a full year of 2025 cost data to determine if the final allocation needs adjustment. He clarified that the current session was for discussion only and not a vote. The goal is to release a Draft Recommendation for public comments. He requested moving the final vote up from February to January to provide greater operational flexibility for fiscal year adjustments and to finalize a policy that has been under deliberation for a significant amount of time.

Ms. Prudence Akindo, Associate Director, Financial Methodologies, presented the update on RY2026 allocation. She noted that Maryland hospitals are currently facing significant volume surges driven by respiratory conditions, including influenza, RSV, and COVID-19. Data from the Maryland Department of Health indicates that the largest spikes in hospitalizations occurred between 2024 and 2025, with projections suggesting continued strain due to active flu seasons in the Southern Hemisphere and abroad. In response, the Commission voted to reinstate Surge funding in July, initially capping the RY 2026 allotment at $100.4 million. This figure was based on nine months of RY 2025 data and utilized a blended distribution model that weighed two-

thirds toward patient days, and one-third toward Equivalent Case Mix Adjusted Discharges (ECMADs).

Staff expressed concern that the heavy reliance on patient days diverges from standard HSCRC policies and could inadvertently incentivize longer hospital stays. To evaluate whether patient days are a necessary metric for capturing hospital strain, staff and consultants conducted a four-part analysis. They looked for correlations between 1) occupancy and length-of-stay (LOS), 2) the impact of seasonality on Surge-funded hospitals, 3) variations in LOS during Surge vs. non-Surge months, and 4) comparisons between Surge and non-Surge cases of similar acuity. The goal was to determine if standard case mix weights (ECMADs) alone were sufficient to capture the resource intensity of respiratory surges.

The analysis yielded conflicting results regarding the necessity of using patient days. Questions one and four supported the metric: question one found a strong positive correlation between average daily census and length-of-stay, while question four revealed that respiratory surge cases have a significantly longer average LOS (4.4 days) compared to non-surge cases of similar acuity (2.9 days). However, questions two and three undermined the need for the patient-day metric, finding that LOS for surge cases was not consistently higher in winter months and that seasonal variations were minimal. Ultimately, while some data supports patient days, the majority of the findings suggest that ECMADs effectively capture most variations.

Upon receiving the full 12 months of RY 2025 data, staff recalculated the Surge funding requirement, which rose to $164.6 million. However, because the Commission previously capped the RY 2026 funding at the nine-month estimate of $100.4 million, staff had to perform a normalization process. This involved redistributing the full 12-month data trends to fit within the lower approved cap. This ensures that the final allotments reported to the hospitals remain consistent with the funding limit set by the Commissioners in July.

Ms. Akindo concluded with a summary of the main takeaways for future implementation. While the current RY 2026 allotments are now finalized using the approved blended methodology, she indicated that the analysis provides a foundation for revisiting surge models. Because the evidence was mixed with only two of the four questions supporting the inclusion of patient days and there remains an open discussion about whether future surge funding should shift more toward case mix adjusted metrics to avoid the potential pitfalls of incentivizing increased length-of-stay.

Draft Recommendation on Future Surge Consideration

Ms. Akindo presented the staff Draft Recommendations regarding how the Commission should handle surge funding for Rate Year (RY) 2026 and beyond.

The recommendations are summarized across the following five areas:

1. Staff recommends that the RY 2026 Surge funding be based on a full 12-month evaluation of data rather than the initial 9-month estimate. While the total funding is currently capped at $100.4 million, staff has redistributed this amount among hospitals

using the most recent 12-month data to ensure the allocation accurately reflects actual hospital experience while staying within the established budget.

2. Staff is presenting two alternative options for the Commission to consider for public comment, both of which would involve raising the current $100.4 million cap:
    - **Option 1 ($164.6M):** Increase the cap to the full amount identified by 12 months of data using the current weight of 2/3 patient days and 1/3 ECMADs.
    - **Option 2 ($124.8M):** Increase the cap to a middle ground based on a reversed weighting approach (2/3 ECMADs and 1/3 patient days), which aligns with the goal of reducing incentives for longer hospital stays.
3. Starting in RY 2027, staff recommends a permanent shift in the Surge Funding formula. Based on their statistical analysis, they propose moving to a 66 percent ECMAD and 33 percent patient day split. This change is designed to "de-emphasize" patient days, addressing concerns that the previous model might have encouraged hospitals to increase a patient's length-of-stay to secure more funding.
4. To improve the accuracy of the Surge policy, staff recommends a new annual cycle. A Surge estimate based on 9 months of data would be built into hospital rates every July. This amount would then be reconciled the following year based on full 12-month data. Additionally, staff recommends that any Surge Funding be net of other awards, meaning they would deduct funding already received by hospitals through full rate applications or other mechanisms.
5. The Commission should adopt an independent Inpatient LOS Incentive developed with the Performance Measurement Workgroup. By creating a separate mechanism to improve length-of-stay performance across the state, the Commission can further mitigate the risks of using patient days in surge calculations. This broader initiative aims to improve patient satisfaction, financial sustainability, and the transition of care to Hospital at Home or post-acute providers.

No action was taken on these agenda items.

ITEM V
FINAL RECOMMENDATION: MARKETSHIFT IMPROVEMENT (VCF, GEOGRAPHIES, EXCLUSIONS)

Mr. Allan Pack, Principal Deputy Director, Quality and Population-Based Methodologies presented the staff's Final Recommendation: Marketshift Improvement (VCF, Geographies, Exclusions) (see "Final Recommendation: Marketshift Improvement (VCF, Geographies, Exclusions)" available on the HSCRC website).

Mr. Pack reviewed staff Final Recommendation which focuses on refining the Market Shift methodology, the system used to adjust hospital revenues when patients move between facilities. His presentation centered on transitioning from broad estimates to more precise,

empirical data while addressing stakeholder feedback on how to handle unique volume changes.

A primary recommendation is the replacement of the generic 50 percent variable cost factor (VCF) with four distinct, empirically derived categories: Inpatient Medical, Inpatient Surgical, Outpatient Medical, and Outpatient Surgical. This change ensures that revenue adjustments more accurately reflect the actual costs associated with specific types of care. While some stakeholders suggested an even more granular approach with over 40 factors, Mr. Pack dismissed this to avoid unnecessary administrative complexity, noting that the data did not justify such extreme segmentation.

While staff originally intended to remove six specific service lines from the Market Shift model due to low volume and statistical unreliability, Mr. Pack recommended tabling this action. He agreed with stakeholders that these exclusions should not be handled in isolation. Instead, they will be addressed as part of a broader, more comprehensive engagement regarding all services to be carved out of population-based payments under the upcoming AHEAD model, which may involve up to 15 percent of total hospital volumes.

To account for unique shifts in hospital volume, the recommendation includes five specific triggers that allow a service to be temporarily excluded from Market Shift calculations. These triggers cover events such as inter-system shifts and new Certificate of Need (CON) approvals. Notably, Mr. Pack accepted a "friendly amendment" to include new facility designations, such as Stroke Centers, provided the hospital can prove the volume is truly new to the system. To ensure data integrity, hospitals must provide at least six months' notice before these exclusions are implemented.

Initially focused on Kaiser’s integrated model, the recommendation was expanded to allow all payers to utilize payer-initiated Market Shift adjustments. This change acknowledges that shifts caused by a carrier moving a hospital out of network impacts the entire system. To qualify, these shifts must be material, representing more than one (1) percent of a hospital's Global Budget Revenue (GBR). Mr. Pack noted that while this is a fair expansion, the Commission may need to develop future tools to compel non-integrated payers to provide the necessary data for these realignments.

Mr. Pack concluded by addressing the concept of a latent demand trigger, which would account for underlying community health needs that are not currently being met. While he views this as a critical evolution for the model's long-term sustainability, he is not recommending its implementation at this time. He emphasized that more work is required to define and quantify latent demand accurately before it can be formally integrated into the state's hospital payment policies.

Mr. Pack presented the staff’s Final Recommendation for the Marketshift Improvements (VCF, Geographies, Exclusions) as follows:

1. Effective immediately, adopt for all volume policies the newly calculated VCF 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. Once a more comprehensive discussion with the field takes place on what service lines should be prioritized for exclusion, given the limited flexibility under the current Model (5 percent) and the AHEAD Model (15 percent),
    - Remove the following service lines from the Market Shift Policy: Endocrinology Surgery; ENT Surgery; Gynecological Surgery; Ophthalmologic Surgery; Thoracic Surgery; Urological Surgery; and Ventilator Support,
    - Consolidate Spinal Surgery and Neurological Surgery.
3. 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, such as 1 percent of service line revenue when volume increases or 3 percent of service line revenue when volume decreases)
4. 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:
    - Facility Conversions
    - Intersystem Shifts
    - Payer Driven Volume Shifts
    - Material Provider Initiated Shifts
    - CON Approved Service Line Expansions

Commissioner Blum asked whether the proposed policy changes would materially increase the scale of financial transfers between hospitals or if the impact would remain relatively minor. He specifically sought to understand if these updates would disrupt the historical trend of small year-to-year dollar shifts within the Market Shift methodology. Mr. Pack responded that while the baseline for annual revenue realignment is typically around $50 million, the new higher variable cost factors could theoretically increase that figure to approximately $59 million. He noted that while the service line exclusions will allow for greater precision in money following the patient, the total order of magnitude remains uncertain and could be further influenced by changes in hospital behavior.

As follow up question, Commissioner Blum also asked whether a payer would be required to prove that a volume shift has already occurred or merely demonstrate an intention to shift that volume in the future. Mr. Pack responded that the policy is primarily intended to be prospective, requiring payers to submit a plan in advance to ensure patient access and verify that shifted volume is going to appropriate facilities. This forward-looking approach allows the Commission

to confirm that physician access remains stable even if a hospital is cut from a network. However, he noted that the Commission maintains the flexibility to perform retrospective assessments on the back end to verify actual volume changes.

Commissioner Johnson noted that the Commission staff already possesses the data and analytical capabilities necessary to estimate volume shifts without requiring a formal plan from external parties. Mr. Pack stated that while HSCRC can easily track volume shifts between regulated Maryland hospitals, staff face significant blind spots when volume moves to unregulated or out-of-state facilities. He argues for retaining the right to request a plan to ensure the Commission can accurately account for these less visible shifts.

Comments:

Mr. Patrick Carlson, Vice President of Care Transformation and Finance for the MHA, presented and expressed strong support for the staff's recommendations, viewing them as essential for the financial sustainability of hospitals as they manage fluctuating patient volumes.

Mr. Carlson noted that the updated Market Shift policy is a critical improvement because it ensures revenue follows the patient**.** He specifically applauds the move away from a one-size-fits-all financial model toward a more nuanced, service-specific approach developed in collaboration with the hospital industry.

- **Support for Variable Cost Factors (VCF):** He strongly supports replacing the flat 50 percent VCF with four specific calculated factors based on service line and setting. He believes this will more accurately fund the actual costs associated with volume changes.

- **Precision in Funding:** He emphasizes that these changes make the policy more precise, ensuring that hospitals have the appropriate resources to manage the specific types of patients they are seeing.

- **Data Reliability:** MHA supports efforts to better isolate true shifts in volume between hospitals to ensure the policy is applied fairly and accurately.

- **Strategic Alignment with the AHEAD Model:** He agrees with the decision to delay or consolidate certain service line exclusions until there is more clarity on the AHEAD Model's 85 percent revenue requirement, ensuring the state policy aligns with federal mandates.

- **Collaborative Development:** He highlights the successful collaboration between HSCRC staff and the hospital field over several months to reach these recommendations.

Mr. Adam Kellerman, Director of Healthcare Payment for the MHA, focused on the technical execution of the temporary exclusions within the Market Shift policy. He emphasizes the need for stability, hospital-led requests, and alignment with federal models.

While supporting the principle that revenue follows the patient, Mr. Kellerman expresses concern that certain volume exclusions could cause financial instability. He advocates for a hospital-centric approach to exclusion requests and warns of the administrative complexity introduced by the transition to the federal AHEAD model.

- **Standardized Process for Exclusions:** He supports creating a formal process for handling large, purposeful volume shifts that the standard methodology might miss, but warns that these must be handled carefully to avoid unintended consequences for patient access.
- **Predictability and Stability:** Using the Kaiser recommendation as a benchmark for predictable shifts, he notes that other payer-driven changes (like network shifts) are less predictable. He argues that excluding these volumes prematurely could introduce financial instability for hospitals.
- **Hospital-Led Requests:** He insists that any request to exclude volume from the Market Shift assessment should come directly from the affected hospitals, rather than being driven solely by payers or staff.
- **Payer Accountability:** He suggests that if payers drive volume shifts, they should be required to complete access impact analyses to ensure patient care isn't disrupted.
- **The Backfill Provision:** He urges the HSCRC to allow hospitals to backfill lost volumes (to address unmet community needs) in *all* payer-driven shift scenarios, similar to the specific allowance made in the Kaiser recommendation.
- **Alignment with AHEAD/CMS:** He warns against the dual complexity of having different financial methodologies for Medicare (via CMS) and other payers (via HSCRC). He calls for strict alignment between state and federal systems to reduce the administrative burden on hospitals.

Mr. Dewan Clayborn, President & CEO, Central Maryland Chamber Conduit of Commerce, primarily advocated for increased transparency and accessibility in the Commission's decision-making process. He argued that the current two-to-three-week window for public comment is insufficient for small and medium-sized business owners to review complex policies while managing their daily operations. To bridge this gap, he proposed that the Commission allow consumers to provide input much earlier in the process before draft recommendations are finalized to ensure policy shifts that reflect the needs of Maryland residents and employers.

To make healthcare policy more digestible, Mr. Clayborn recommended that the HSCRC implement a system similar to the fiscal notes used by the Maryland General Assembly. He suggested that complex budget methodologies should be translated into a clear, consumer-friendly format that explains the impact of policy changes in dollars and cents. This would allow the average business owner and patient to understand how hospital global budget adjustments and pricing decisions directly affect their healthcare costs and access.

Regarding the specific Market Shift Policy, Mr. Clayborn supported the principle that revenue should follow the patient to their chosen facility. However, he expressed a strong concern that

patients who continue to use a hospital experiencing a loss of volume should not be forced to subsidize those losses through higher costs. He urged the HSCRC to rigorously monitor how these shifts impact affordability and equity, particularly as the state transitions toward the AHEAD model and navigates changes in Medicare and Medicaid.

Dr. David Fakunle, representing Morgan State University and the "Health Means Everything Coalition," offered a public health-focused critique centered on the human element of policymaking. He emphasized that healthcare is a critical pillar of the broader public health system and urged the Commission to adopt a philosophy of co-creation rather than top-down regulation. By framing policy through the lens of those most in need, he advocated for a system that actively integrates the lived experiences of diverse consumers.

Dr. Fakunle challenged the Commission to work smart, not just hard by leveraging the wisdom and experience of the community. He argued that a broader spectrum of consumer perspectives would provide the Commission with the knowledge and awareness needed to make more effective decisions. He called for a higher standard of accountability and transparency, suggesting that deeper collaboration with the public would ultimately strengthen the Commission's significant efforts.

Steve Ports, representing CareFirst, expressed strong support for the final recommendations, framing the Market Shift updates as an essential evolution of Maryland's unique all-payer system. He applauded the HSCRC staff for breaking ground on complex regulatory issues that haven't been resolved at the federal level or in other states. For CareFirst, these refinements are vital to ensure that hospital revenues accurately reflect the actual volume of patients served.

The primary focus of Mr. Ports' remarks was the payer-initiated Market Shift provision. He emphasized that the policy initially designed for Kaiser should indeed apply to all payers to correct revenue misalignments as quickly as possible when volume shifts occur. He confirmed that CareFirst is prepared to provide the necessary plans and data to support these adjustments whenever their network changes meet the Commission's criteria.

Mr. Ports acknowledged the earlier debate regarding the necessity of formal plans. While asserting CareFirst's readiness to comply with data requests, he echoed Commissioner Johnson's suggestion that the Commission could also explore using existing data to identify shifts. He concluded by supporting the Commission's authority to utilize these various tools to ensure "timely realignment," ultimately aiming for a system where hospital funding is precisely tied to patient movement.

Commissioner Johnson highlighted the delay or inaccuracies in accounting for volume shifts, he noted it don't just affect hospital or payer finances, they directly harm individual consumers. He argues that if the Commission fails to adjust revenue quickly when volume leaves a facility, the patients remaining at that hospital are unfairly forced to pay higher charges to cover the overhead of a shrinking patient base.

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

ITEM VI
FINAL RECOMMENDATION: SELECT VOLUME REALIGNMENT

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

The Final Recommendations, summarized from the December 2025 staff presentation, center on a structured, 18-month transition plan to realign global budgets with actual patient flow following Kaiser Permanente's shift to Core Hospitals.

Mr. Pack outlined a proposal for hospital volume realignment designed to shift funding for Kaiser Permanente patients from non-Core Hospitals (where Kaiser does not operate) to Core Hospital. The initiative aims to align hospital budgets with actual patient flow, ensuring that facilities inheriting a surge in Kaiser volume are reimbursed in real time to prevent margin issues, while those losing volume do not retain funding for services they no longer provide.

To ensure accuracy and address stakeholder concerns, the staff refined the scope of the project using Kaiser-submitted claims data rather than relying solely on self-reported hospital data. While 50 facilities were initially identified as having Kaiser volume, the recommendation was narrowed from 19 to 13 material hospitals. Specific exclusions were made for specialty hospitals like Shock Trauma and Shady Grove (due to unique or behavioral services), as well as hospitals where over 96.85 percent of Kaiser volume is emergency-related, as these services are less likely to be successfully realigned.

Financially, the realignment affects approximately $590 million in revenue. Data suggests that 84 percent of Kaiser volume is not expected to move, leaving only about 7 to 11 percent of total associated revenue in question. To mitigate financial shocks, the Commission is applying a "variable cost factor" to the revenue being moved. Furthermore, the HSCRC will conduct retrospective assessments to "hold harmless" hospitals that successfully backfill their lost Kaiser capacity with other latent demand or demographic growth, ensuring they are not unfairly penalized for the transition.

A significant point of contention involved the inclusion of emergency room care. While hospitals suggested carving out ER services, Mr. Pack stated that Kaiser intends to transfer stabilized patients to Core Hospitals to improve system throughput. He noted that Kaiser's inpatient length-of-stay at Core Hospitals is typically one day shorter than at non-Core Hospitals, which should ultimately improve overall system capacity and reduce emergency department boarding.

The 18-month implementation timeline begins in January, during which Kaiser volumes will be reimbursed through a real-time fee-for-service evaluation. This period allows for 12 months of

clean data collection plus "run out" time to accurately calculate the permanent realignment. By July 1, 2027, the adjusted volumes will be built back into the hospitals' global budgets and managed through standard market-shift methodologies moving forward.

Mr. Pack presented the staff's Final Recommendation for the Select Volume Realignment as follows:

1. From January 1, 2026, through June 30, 2027, remove, for select hospitals, Kaiser volumes and revenues evaluated in the Market Shift policy from global budget revenues. A variable cost factor will be employed. Select hospitals are defined as follows:
    - Greater than 5 percent of total Kaiser Revenue statewide regardless of Kaiser share of GBR **(NEW!)**
    - Greater than $5 million in annual charges and greater than 2 percent of global budget revenue, however;
        i. Various Exclusions **(NEW!)**;
        ii. Specialty Hospitals – Shock Trauma, Shady Grove Hospital;
    - Hospital with a preponderance of Kaiser revenue attributable to non-elective care (i.e., > 96.85 percent of charges have an EMG rate center charge – top quartile for prior list of material Kaiser hospitals);
2. Allow removed Kaiser volumes and revenues to be reimbursed in real time through a volume-variable evaluation, using HSCRC rates. A variable cost factor will be employed;
3. On July 1, 2027, build back into global budgets removed Kaiser volumes and revenues based on volumes reimbursed through a volume variable evaluation from January 1, 2026, through December 31, 2026;
4. Apply retrospective adjustments (both permanent and one-time) if hospitals can verify that Kaiser volumes were replaced with other volumes that are currently unsupported by Demographic, Marketshift, or related adjustment **(NEW!)**.

Vice Chairman Elliott asked how will the methodology be handled when a facility loses the Kaiser Core Hospital status. Mr. Pack noted that while Kaiser's Core Hospital designations have changed in the past, he does not anticipate any further shifts during the upcoming 18-month transition period. He explained that previous shifts at hospitals like GBMC and St. Agnes were managed through a manual process of prospective budget adjustments followed by retrospective settlements. However, because the current realignment involves a much larger scale of 13 to 16 hospitals, the staff have developed a more creative real-time fee-for-service approach to ensure accuracy. If a hospital were to lose its Core status in the future, the Commission would either return to that traditional adjustment method or apply this new real-time model to follow the volume.

Comments:

Ms. Allison Taylor, Head of Government Relations, Kaiser Foundation Health Plan, expressed support for the realignment proposal, emphasizing that it was developed through collaborative meetings with Commission staff and affected hospitals to address their specific concerns. She explained that since Kaiser does not own hospitals in the Mid-Atlantic region, the Core Hospital model is essential for creating a curated network where Kaiser physicians can directly manage patient care. This model is a central component of their high-quality ratings, as it allows them to best serve their members within their unique integrated care and coverage framework.

Addressing operational benefits, Ms. Taylor highlighted that Kaiser patients in Core Hospitals experience a length-of-stay that is typically one to one and a half days shorter than the state average. This efficiency is driven by their ability to coordinate care more effectively and utilize advanced urgent care centers. These centers allow Kaiser to admit patients directly to Core Hospitals, bypassing traditional emergency departments entirely, which she noted should improve overall system throughput and reduce wait times for all patients.

She characterized the proposal as a good-faith effort by Kaiser to act as a team player in the Maryland healthcare system. By working with the HSCRC to create this market-based funding shift, Kaiser aims to mitigate the financial friction caused when they intentionally move patient volumes. She urged a favorable vote, noting that the shift impacts a relatively small percentage of total revenue while significantly enhancing the care delivery model for their members living in those communities.

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

ITEM VII
FINAL RECOMMENDATION: EMERGENCY DEPARTMENT (ED) BEST PRACTICES POLICY

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

Ms. Simmons presented the update on Emergency Department (ED) hospital throughput best practices, noting that the final recommendation remains largely consistent with the initial draft. She reminded Commissioners that hospitals are currently implementing two self-selected best practices from a list of six and are required to submit their first full set of data by December 31, 2025. The core of her recommendation is to maintain this current monitoring phase throughout 2026 to allow hospitals more time to optimize and "hardwire" these processes.

The decision to extend the monitoring period into Calendar Year (CY) 2026 is intended to provide staff with enough time to fully analyze the incoming data and understand the impact of

these practices. Ms. Simmons noted that preliminary results from October already showed some improvements in throughput, but more data is needed to justify future policy changes.

This extension also considers the upcoming AHEAD transition, ensuring that hospitals are not overwhelmed by shifting quality programs while they are still refining their current ED workflows.

Stakeholder feedback was generally supportive of this steady state approach, with most hospitals favoring the continuation of the current policy. While one stakeholder suggested discontinuing the policy due to the high volume of work required, Ms. Simmons explained that the staff addressed this concern by keeping the requirements stable rather than adding new ones. Additionally, she mentioned that the ED Wait Time Reduction Commission will be involved in CY 2026 to help determine how to best leverage these efforts for longer-term state goals.

Ultimately, the final recommendation keeps the policy as a pay-for-reporting model rather than pay-for-performance. This means the only penalty hospitals face is for failing to submit data, which allows the focus to remain on learning and implementation rather than financial punishment. This approach provides a clear path for evaluation throughout CY 2026 before the Commission decides on more stringent accountability measures or permanent changes to the throughput standards.

Ms. Simmons presented the staff's Final Recommendation for the ED Best Practice as follows;

1. Building upon the ongoing work of staff and key stakeholders, continue the specifications developed by the Best Practice subgroup on the six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length-of-stay (LOS).
2. For each Best Practice identified, continue three tiers with corresponding measures that reflect the fidelity and intensity of each best practice. Weighting of tiers for future performance years will be determined in CY 2026 after CY 2025 data is collected and analyzed. Require hospitals to maintain and report data on the two implemented Best Practices for Rate Year (RY) 2028.
3. Failure to implement and report data to the Commission by December 31, 2026, will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2027. Staff intends to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the CY 2025 and CY 2026 Best Practice program impact is assessed.

Commissioner Blum asked how the staff and work group identified these specific best practices and whether they looked at successful benchmarks from across the country rather than just within Maryland. He noted that many of the cited practices have been part of the quality conversation for a long time and is curious how the Commission plans to benchmark performance against national standards. Ms. Simmons responded that the current list of best practices was developed through extensive research into nationally vetted, evidence-based practices that have been proven effective across the country. She emphasized that while the

program is currently in a monitoring phase to encourage collaboration and engagement among hospitals, the staff intends to conduct more formal national benchmarking and data analysis throughout CY 2026. This future work will focus on determining whether there are standard national measures that can be applied to the Maryland data to further drive results and evaluate local performance.

Comments

Ms. Tequila Terry, Senior Vice President of Care Transformation and Finance of MHA, expressed appreciation for the ongoing partnership with the Commission staff and highlighted the industry's general alignment with the proposed best practice monitoring approach. She noted that hospitals are deeply committed to improving throughput but emphasized the significant administrative and operational burden currently facing clinical teams. By allowing hospitals to continue focusing on the two practices they have already selected, she believes the Commission is providing the necessary stability for these initiatives to become hardwired into hospital culture.

Ms. Terry remarked on the importance of coordinating these new requirements with the broader transition to the AHEAD model. She cautioned that hospitals are navigating multiple complex quality programs and regulatory shifts simultaneously, and it is vital that the HSCRC maintain awareness of this total volume of work. Her support for the 2026 monitoring plan was rooted in the idea that it prevents overloading hospitals while still maintaining the focus on the critical state goal of reducing emergency department wait times.

Ms. Terry underscored the value of the collaborative process used to refine the policy, specifically praising the move to a pay-for-reporting rather than a pay-for-performance model at this early stage. She suggested that this approach allows hospitals to share data and lessons learned in a non-punitive environment, which ultimately leads to more effective implementation of evidence-based practices. This cooperation, she noted, is essential for identifying which strategies actually work across Maryland’s diverse healthcare ecosystem before moving toward more rigid financial accountability.

Amanda Wright, Director of Quality and Clinical Care of MHA, emphasized the critical need for alignment with federal standards as Maryland transitions toward the AHEAD model. She expressed concern that as Medicare's program design evolves, any misalignment in state-level quality programs could lead to fragmentation and an unfair performance evaluation for hospitals. Consequently, she urged the HSCRC to use Medicare’s standards for reporting and timelines as the primary benchmark to reduce the growing administrative burden on clinical staff.

Regarding the future of the policy, Ms. Wright supported the plan to evaluate data from 2025 and 2026 but recommended that the Commission publish interim findings for public feedback. She argued that this transparent approach is necessary to ensure the policy remains responsive to the actual hospital realities and evolving national standards before any long-term decisions are made for the years beyond 2028.

She highlighted the cumulative penalty risk hospitals face across multiple quality initiatives. She requested that the Commission provide more strategic support, time, and resources to help

hospitals implement these best practices effectively. For the policy to be sustainable, she concluded that the HSCRC must balance its quality goals with a comprehensive approach that minimizes administrative strain and ensures transparency throughout the evaluation process.

Chairman Sharfstein asked Ms. Wright whether Medicare have a best practice policy and if so, how did the Medicare Best practices align with the six best practices in this policy. Ms. Wright clarified that while Medicare may not have an identical best practice policy, it utilizes several outcome measures related to emergency department performance. Specifically, she noted that the upcoming Emergency Care Access and Timeliness (ECAT) release from CMS will introduce standardized measures for throughput and length-of-stay beginning in 2027.

Commissioner Joshi expressed support for the learning process but urged the Commission to maintain a sharp focus on actual results rather than just the execution of interventions. He pointed out that since this is a natural effort rather than a controlled scientific trial, the state might not capture the full nuances of how these practices are implemented; however, he insisted that the true measure of success must be a decrease in patient wait times. Emphasizing that millions of dollars are being invested in these initiatives, he argued that publishing papers or perfecting designs is insufficient if the outcomes do not improve, and he called for a rigorous evaluation of the interim design to ensure the program delivers tangible value.

Commissioner Sabi emphasized that the collaboration and learning involved in these initiatives are essential components of basic, high-quality hospital operations. While acknowledging that it may be difficult to isolate the impact of any single action, she suggested that the ultimate success of the program depends on all interventions working together as a fully loaded system. She reiterated that the primary goal remains improving emergency department wait times as the definitive final outcome.

Commissioner Johnson expressed skepticism regarding the low financial stakes of the policy, questioning why the penalty for failing to report data is set at only 0.1 percent of revenue. He argued that because both the Commission and the legislature have identified emergency department wait times as a serious issue, the accountability measures should be more significant to reflect that urgency. While he supports the long-term goal of tying incentives to outcomes, he believes that, at a bare minimum, hospitals should face a higher penalty for failing to implement basic best practices and submit the required data.

Ms. Simmons responded that the 0.1% percent penalty was selected by reviewing historical HSCRC policies that utilized similar accountability measures for reporting requirements. She explained that staff looked at previous ranges of revenue at risk for other programs and chose 0.1 percent because it felt like a reasonable starting point for a brand-new initiative. The goal was to establish a baseline of compliance for data submission before considering more substantial financial stakes as the policy matures.

Chairman Sharfstein requested a motion to adopt the staff's Final Recommendation. Vice Chairman Elliott moved to approve the staff's Final Recommendation, seconded by

Commissioner Joshi. **The motion passed unanimously in favor of the staff's recommendation.**

ITEM VIII
PRESENTATION: HCAHPS LEARNING COLLABORATIVE PANEL AND REPORT HIGHLIGHTS

Mr. Jonathan Sachs, MBA, FACHE, PCC, HSCRC Consultant, presented the progress of a year-long collaborative effort between Maryland hospitals and the MHA to improve patient experience and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. He emphasized that the initiative has transitioned from a simple meeting of experts to a high level of learning collaborative, by grounding their work in patient stories including those from survivors of major trauma. The group has focused on the human element of hospital care while leveraging data from national vendors like Press Ganey and NRC to drive improvements.

A primary key learning highlighted by Mr. Sachs is the direct correlation between patient experience and clinical quality and safety. He provided evidence that top-performing hospitals in patient experience see significantly lower rates of adverse events, such as a 16 percent reduction in total falls and an 8 percent reduction in pressure injuries. This data has prompted a shift in mindset across the state; rather than treating patient complaints as a separate administrative issue, hospitals like Frederick Health are now categorizing patient dissatisfaction as a form of psychological harm**,** applying the same Six Sigma and Plan-Do-Study-Act (PDSA) cycles to experience as they do to medical errors.

Mr. Sachs also addressed the necessity of infrastructure to support best practices, noting that simply knowing what to do is not enough if the environment is not prepared. He used the analogy of planting a palm tree in a Minnesota winter to explain why some hospitals struggle to see results despite following the same protocols as their peers. Success requires a dedicated senior leader, clear reporting on process measures (such as the frequency of nurse rounding), and a structured system for coaching and validation to ensure that improvements are sustainable across all nursing units.

Ms. Teresa Brown, Quality Methodologist at The Maryland Healthcare Commission (MHCC), presented the launch of a new interactive Tableau dashboard designed to provide more timely and granular analysis of HCAHPS data. She explained that while the state has followed CMS methodology for years, the traditional aggregate data often arrived with significant delays. To bridge this gap, the MHCC began requiring patient-level data in 2022, allowing for a more immediate and detailed look at how different demographics and hospital characteristics impact patient experience scores across Maryland.

Ms. Brown remarked that substantial updates were made to the HCAHPS survey in January 2025. This update introduced new survey modes, most notably adding a web-based option to the traditional mail and telephone methods. Because of this break in series, the first phase of the dashboard focuses exclusively on unadjusted top box data from post-January 2025 results. She noted that while current external comparisons are limited, the dashboard's utility will grow as more data is integrated and the Commission determines how to bridge the old and new survey formats.

The dashboard offers a high degree of transparency, featuring a landing page where users can filter results by hospital, domain, and specific questions. It includes a dynamic key findings box that updates in real-time based on user selections and identifies top-performing hospitals to encourage clinical collaboration. A critical feature of this tool is the ability to stratify results by patient demographics, including age, race, ethnicity, language, gender, and education levels. To protect patient privacy while maintaining actionability, the system uses data suppression for cohorts smaller than 11, providing denominator ranges instead of exact figures for very small groups.

Ms. Brown outlined an ambitious timeline for the dashboard's evolution. Phase two will focus on integrating historical data and adding patient mix and mode adjustments to allow for fairer comparisons between facilities. The MHCC also plans to link this data to other quality initiatives, such as emergency department throughput programs. Having officially launched the tool and completed initial training via the CRISP portal, the MHCC expects the next major data update in January 2026, marking a significant step toward data-driven, real-time improvements in Maryland's healthcare landscape.

Dr. Giora Netzer, representing the University of Maryland Medical System, emphasized the unique nature of collaborative learning, noting that Maryland has become the envy of the rest of the country by fostering this level of cooperation. By bringing together patient experience leaders, the MHA, and the HSCRC, the state has created a high-energy dialogue and a unified community dedicated to sharing best practices. He expressed deep gratitude for the platform, which has opened robust lines of communication that were previously unavailable.

Dr. Netzer's indicated that there is a necessary paradigm shift regarding how patient experience is viewed within the medical hierarchy. He argued that patient experience is not a secondary metric but is fundamentally integral to the overall quality of care. By engaging with national thought leaders, the collaborative reinforced the idea that psychological safety and physical safety are inseparable; one cannot provide high-quality clinical care without addressing the patient's experience and emotional well-being.

Dr. Netzer highlighted that this initiative has helped hospitals recognize patient experience as an essential administrative and clinical need, distinct from simply chasing an HCAHPS score. He noted that the collaborative effort has empowered institutions to lean in and support one another through process improvement. This shift from competition to collective problem-solving allows hospitals to address the systemic challenges of healthcare delivery more effectively than they could individually.

No action was taken on these agenda items.

ITEM IX
DRAFT RECOMMENDATION: MARYLAND HOSPITAL ACQUIRED CONDITIONS POLICY

Dr. Alyson Schuster, Ph.D., Deputy Director, Quality Methodologies, presented the staff's Draft Recommendations for the Maryland Hospital Acquired Conditions (MHAC) Policy (see "Draft

Recommendations Maryland Hospital Acquired Conditions Policy" available on the HSCRC website).

Dr. Schuster presented the staff Draft Recommendations for the Maryland Hospital Acquired Conditions (MHAC) program for Rate Year (RY) 2028. She described the strategic alignment of Maryland's quality programs with national CMS standards as the state transitions toward the AHEAD model. Dr. Schuster emphasized that alignment should not only be direct (using identical measures to reduce administrative burden) but also intentional, allowing Maryland the flexibility to address non-Medicare priorities and innovative quality goals that national programs might overlook.

A key proposal for RY 2028 is the inclusion of the AHRQ Patient Safety Index (PSI) Composite measure. By adding this to the MHAC program and weighing it at one-sixth of the total score, Maryland aligns more closely with the national Hospital Acquired Conditions Reduction Program (HACRP). However, Dr. Schuster noted a distinct difference: while the federal program is penalty-only, Maryland intends to maintain its unique scaling approach, which offers both rewards and penalties of up to 2 percent of inpatient revenue. This ensures the program remains net-positive for hospitals that show high performance or significant improvement.

Dr. Schuster also compared the technical grouper used to identify complications. Since 2014, Maryland has utilized the Potentially Preventable Complications (PPC) grouper, which differs from the federal focus on Healthcare-Associated Infections (HAI) monitored via the NHSN. For the upcoming cycle, staff recommends maintaining the 16 clinically significant PPC measures currently in use. She cautioned that while Maryland generally outperforms the nation on PSI measures, benchmarking against state standards (rather than national ones) can make rewards harder to achieve, a factor the Commission may revisit in final policy discussions.

Regarding Readmissions, Dr. Schuster noted that the state must decide how to align with the Population Health Accountability Plan (PFAP) under the AHEAD model. Current thinking involves aligning the state's Readmission Reduction Incentive Program (RRIP) with the PFAP's all-payer, all-condition goals. While federal programs often use a 3 percent revenue risk and a penalty-only structure, Maryland is currently weighing whether to adopt these stricter federal parameters or maintain its current incentive-based structure to avoid destabilizing hospital finances during the transition.

Dr. Schuster advocated for Maryland to serve as a laboratory for innovation, particularly in the realm of digital measures. While the immediate priority is stabilizing the transition to CMS-aligned Medicare programs, she suggested that the state should eventually explore digital quality metrics for areas like maternal morbidity that are critical to the non-Medicare population. By 2030, CMS aims to move entirely to digital reporting; Dr. Schuster stated Maryland can lead this shift while ensuring that all-payer quality remains a central focus of the state's healthcare mandate.

No action was taken on these agenda items.

ITEM X
DRAFT RECOMMENDATION: MEDICARE PERFORMANCE ADJUSTMENT

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, presented the Draft Recommendation: Medicare Performance Adjustment (see "Draft Recommendation: Medicare Performance Adjustment" available on the HSCRC website).

Mr. Henderson detailed the Draft Recommendations for the Medicare Performance Adjustment (MPA) for the upcoming year. He explained that the MPA is a critical annual policy that determines hospital-level rewards or penalties based on the total cost of care for Medicare beneficiaries. Because the Commission is legally required to approve this adjustment each year, the focus of the current proposal is to ensure a smooth transition as the state moves toward new regulatory frameworks.

As Maryland transitions to the AHEAD model, the MPA will only exist for two more years (2026 and 2027) before being fully incorporated into the Medicare global budget in 2028. Because of this limited lifespan, Mr. Henderson noted that both the staff and stakeholders agreed it would be inefficient to spend time significantly revising or tweaking a policy that has already undergone extensive adjustments over the last decade.

Consequently, the primary recommendation is a continuation of the existing policy. The 2026 MPA will maintain the same attribution methodology and the same plus or minus 2 percent revenue range used in 2025. By keeping the core mechanics of the program stable, the Commission aims to provide hospitals with predictability during a period of broader systemic change. Mr. Henderson characterized this approach as a straightforward carry-over designed to minimize administrative churn.

The only technical update mentioned involves a rebasing of quality measures. This change is intended to align the MPA's internal quality metrics with the broader quality policies that were updated after the original MPA standards were set. Mr. Henderson clarified that while this is the only actual change to the data handling, it does not represent a radical shift in the policy's intent or the financial risk shared by the hospitals.

Regarding the timeline, the staff will submit a formal letter to CMS by the end of the month outlining this proposal. CMS typically has 30 days to respond, and Mr. Henderson expressed confidence that the federal government will approve the status quo approach. A public comment window is open until December 22nd; however, unless substantive or radical feedback is received, the staff expects to finalize the policy as presented while continuing broader discussions on the future of all-payer design programs under the AHEAD model.

No action was taken on these agenda items.

ITEM XI
HEARING AND MEETING SCHEDULE

January 14, 2026, Time to be determined
4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:10 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission
December 10, 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 discussing the administration of the Model and to update the Commission on a current staff investigation.

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

The administrative session was called to order by motion at 12:05p.m.

In addition to Chairman Sharfstein, Commissioners Blum, Elliott, Joshi, and Sabi were in attendance.

Joining by Zoom: Commissioner McCann.

Staff members in attendance were Jerry Schmith, William Henderson, Allen Pack, Claudine Williams, Christa Speicher, Alyson Schuster, Geoff Dougherty, Cait Cooksey, Erin Schurmann, and William Hoff.

Joining by Zoom: Jon Kromm, Deb Rivkin, Laura Goodman and Assistant Attorneys General Stan Lustman and Ari Elbaum Commission Counsel.

Item I

Ms. Erin Schurman, Associate Director, Strategic Initiatives, updated the Commission on the Regional Partnership review.

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 October 2025.

The Closed Session was adjourned at 12:25p.m.

maryland
health services
cost review commission

Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

January 14, 2026

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2025
SYSTEM	*	FOLIO:	2495
BALTIMORE, MARYLAND	*	PROCEEDING:	2685A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on November 26, 2025, on behalf of its member hospitals (the "Hospitals"), Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, to add additional liver transplant and Mon-Mycloablative Unrelated Bone Marrow Transplant to the global rate arrangement, Proceeding 2681A, with One Team Health, an international TPA, approved at the Health Services Cost Review Commission's October 8, 2025 public meeting. The effective date for the approval for the additional procedures is January 1, 2026.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination to add additional liver transplant and Mon-Mycolablative Unrelated Bone Marrow Transplant to the currently approved arrangement with an effective date of January 1, 2026. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

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Final Recommendation: Governor's Directive

Policy for Cost-Shifting and Medicare Advantage Stabilization

January 13, 2026

Cost-Shifting and MA Stabilization: Public Input Process

- October 20, 2025: Call for public comment and notice of listening sessions
- October 29, 2025 and November 5, 2025: Listening sessions
- November 21, 2025: Draft policy recommendations released for public comment
- December 2, 2025: Public comments due
- December 30. 2025: Final policy recommendation, as approved by the Governor, released to the public

Commenters across both rounds included members of agency standing workgroups, payers, hospitals, providers, community advocates, unions, insurance brokers and others.

Cost-Shifting and MA Stabilization: Policy Recommendation

Cost-Shifting

- Use HSCRC's annual update factor process to increase commercial hospital rates by $87 million each calendar year from FY 2028 to FY 2032
- This will increase commercial premiums by approximately 1.8 percent by FY 2032.
- Maintain the $435 million in rates after 2032
- Amounts to half the anticipated Medicare FFS savings and the equivalent impact on MA and Medicaid

Medicare Advantage (MA) Stabilization

- Through the HSCRC's rate-setting authority, reduce hospital costs for qualified MA plans
- Qualified Plans will be designated annually in Q1 for the following year, starting in 2026:
  - At least 50 percent of MA beneficiaries in the relevant H-contract reside in Maryland
  - At least 5,000 beneficiaries or 20 percent of MA beneficiaries residing in Maryland in that H-contract reside in eight jurisdictions*
  - Have a star rating of at least 3.5 (2028 plan year data release)
- Qualified Plans will receive an additional 11.55 percent in rate relief, starting in CY 2027
- Will be offset by both Medicaid and commercial rates in CY 2027; CY 2028 and beyond, just commercial
- Once fully implemented, anticipated to increase commercial rates by 0.75 percent

* Allegany, Baltimore City, Caroline, Dorchester, Garrett, Somerset, Washington, Wicomico. Plans may request a waiver to come into compliance with the county-level requirement by 2028.

Cost-Shifting and MA Stabilization: Next Steps

- Cost-Shifting
  - Implementation: Increase commercial hospital rates by $87 million via the annual update factor process, starting in FY 2028
  - Monitoring: Identify sources and specifications for annual monitoring activities including commercial insurance affordability; hospital affordability, access and viability; emerging opportunities for value-based reimbursement for physicians and population health investment
- Medicare Advantage
  - Implementation:
    - Plan Qualification: By January 23, 2026, finalize plan qualification criteria; by February 20, 2026, identify final Qualified Plans for 2027
    - Rate Relief: Identify avenue to provide 11.55 percent in additional rate relief for Qualified Plans for the FY 2027 update factor
  - Monitoring: Identify sources and specifications for annual monitoring activities including commercial insurance affordability; total cost of MA rate relief and impact on underserved individuals; impact on MA plan availability, enrollment and quality; additional requirements to improve the efficiency of the MA market or promote population health or quality outcomes

Maryland
DEPARTMENT OF HEALTH

Decision Memorandum
AHEAD Regulatory Working Group Proposal on Cost-Shifting and Medicare Advantage

Following Governor Moore's September 23, 2025 directive instructing a multi-agency state team to develop proposals on cost-shifting and Medicare Advantage (MA), the resulting Regulatory Working Group–including the Maryland Department of Health (MDH), the Health Services Cost Review Commission (HSCRC), the Maryland Insurance Administration (MIA), the Maryland Health Care Commission (MHCC) and the Maryland Health Benefit Exchange (MHBE)–led an extensive stakeholder engagement effort to develop a policy framework on: 1) cost shifts that may be necessary to meet the negotiated Medicare savings requirements under AHEAD; and 2) stabilization of the MA market.

The multi-agency Regulatory Working Group recommended the policy solutions below for cost-shifting and MA stabilization. Changes to the proposed policies following the public comment period are noted in the summaries below, and the finalized proposal is appended to this memo. The Governor has approved the policy recommendations as finalized.

Cost-Shift Policy
The policy will cost-shift $435 million, approximately half of the amount required to offset decreased reimbursement from Medicare and Medicaid under the new AHEAD model. This figure divides the AHEAD savings responsibility between hospitals and payers. It is estimated that this amount will increase commercial rates by approximately 1.8 percent over seven years, with an annual incremental increase in premiums of about 0.35 percent from 2028 to 2032. The HSCRC will use its annual update factor process to increase commercial hospital rates by $87 million every calendar year (CY) from 2028 through 2032. After this period, the resulting $435 million cost-shift will be maintained in rates. In response to stakeholder concerns that higher commercial rates under the policy would negatively affect provider reimbursement, the Regulatory Working Group expanded the reporting requirements of the final policy proposal to include identification of avenues to provide resources to physicians through value-based programs.

Medicare Advantage Policy
The MA stabilization policy leverages the HSCRC's rate-setting authority to reduce hospital costs for qualified MA plans and maintain hospital funding by increasing commercial rates. Plan eligibility will be determined by factors such as a percentage of eligible beneficiaries in relevant H-contracts, counties with high proportions of underserved beneficiaries and minimum ratings in Centers for Medicare and Medicaid Services' (CMS) quality star program. This proposal emphasizes supporting access to MA plans, particularly for low-income consumers.

Qualified plans will be designated in the first quarter of each year for the following year, starting in 2026.

During the HSCRC's annual update factor process, qualified plans will be confirmed and awarded an additional 11.55 percent in rate relief for their beneficiaries starting in CY 2027. This amount will be offset by increases in rates for other payers. Once fully implemented, this is estimated to increase commercial rates by 0.75 percent. In response to stakeholder suggestions regarding changes to the eligibility criteria for qualified plans, the Regulatory Working Group added a waiver option, which will allow plans to request a waiver to come into compliance with the county-level criteria by 2028.

Overall Impact

Total increases to commercial rates across both proposals will amount to 2.55 percent by 2032, with the largest single year increases occurring in 2028, at 0.6 percent combined for the two programs.

Maryland
DEPARTMENT OF HEALTH

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The multi-agency Regulatory Working Group recommended the policy solutions below for cost-shifting and MA stabilization. Changes to the proposed policies following the public comment period are noted in the summaries below, and the finalized proposal is appended to this memo. The Governor has approved the policy recommendations as finalized.

Cost-Shift Policy
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Overall Impact

Total increases to commercial rates across both proposals will amount to 2.45 percent by 2032, with the largest single year increases occurring in 2028, at 0.55 percent combined for the two programs.

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

December 2025

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Governor's Directive

In November 2025, the State of Maryland and the Center for Medicare and Medicaid Innovation (CMMI) executed an Amended and Restated Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model Maryland State Agreement (AHEAD Model). The AHEAD Model will test whether a flexible framework that includes statewide accountability targets for all-payer and Medicare Fee-For-Service (FFS) cost growth, primary care investment and population health outcomes results in improved population health and healthier living, enhanced quality outcomes and lowered growth of health care costs.

The AHEAD Model constitutes a shift from the prior Total Cost of Care Model. Among other components, and in addition to modifying Maryland-specific hospital quality programs to align with national requirements, AHEAD will transition rate-setting authority for Medicare FFS from the Maryland Health Services Cost Review Commission (HSCRC) to CMMI under the AHEAD hospital global budget approach. The HSCRC will continue to set hospital rates and implement global budgets for all other payers.

Achieving success under the AHEAD Model demands a coordinated and proactive approach across multiple state agencies. On September 23, 2025, Governor Wes Moore directed the Secretary of Health to form a Regulatory Working Group composed of representatives from the Maryland Department of Health (MDH), Maryland Insurance Administration (MIA), HSCRC, Maryland Health Care Commission (MHCC) and the Maryland Health Benefit Exchange (MHBE) to collaborate on policy proposals that will enable the State of Maryland to achieve the goals and objectives set forth in the AHEAD Model. The Working Group is also charged with assessing and addressing impacts on constituencies throughout the health care landscape, including hospitals, health care providers, insurers, individuals and employers, that arise from the implementation of House Resolution 1 (H.R. 1) and AHEAD.

The Working Group will address six priority topics over the course of its work, including:

- Cost-Shifting Policy
- Medicare Advantage Market Stabilization
- Choice and Competition
- Workforce and Graduate Medical Education
- Post-Acute Care
- Total Cost of Care Growth and Primary Care Investment Targets

The Working Group process will prioritize stakeholder insight, input and guidance to the greatest extent possible through listening sessions, opportunities for public comment and the integration of stakeholder input during the development of policy proposals. Details of the workgroup process and timeline are provided in the multi-agency workplan, as submitted to the Governor in October 2025. The Working Group will provide regular updates on the progress of discussion to members of the General Assembly designated by the Senate President and Speaker of the House as directed in Chapter 615 of the Acts of 2025. A final report with identified policy solutions and proactive steps will be submitted to the Governor by June 2026.

The Governor's Directive identified three core values for the process:

1. Health care quality, access, outcomes and affordability are paramount;
2. No critical health infrastructure should shoulder this burden alone, and the savings requirement will not be borne exclusively by hospitals; and
3. The State will operate as it always does–by being data-driven and heart-led.

Overview of Policy Recommendation

This document focuses on the first two policy areas identified in the Governor's Directive: 1) a framework for cost-shifting to help the State achieve the AHEAD savings targets; and 2) Medicare Advantage (MA) market stabilization.

The Working Group respectfully recommends that the Governor request the relevant agencies and commissions to implement the following:

> **(1) Cost-Shifting Proposal** - A $435 million annual cost increase to commercial rates for hospitals to replace dollars lost under other payers (*i.e.*, Medicare FFS and Medicaid), with the amount to be phased in steadily from 2028 to 2032, amounting to $87 million each year. By 2032, it is estimated that this will increase commercial premiums by 1.8% or an annual increase in premiums of 0.30%.
>
> **(2) Medicare Advantage Proposal** - A solution that leverages the HSCRC's rate-setting authority to reduce hospital costs for qualified MA plans and maintain hospital funding by increasing commercial rates. Plan eligibility would be determined by factors such as a percentage of eligible beneficiaries in relevant H-contracts, counties with high proportions of underserved

beneficiaries and minimum ratings in Centers for Medicare and Medicaid Services' (CMS) quality star program. Qualified plans would be designated in the first quarter of each year for the following year, starting in 2026. During the HSCRC's annual update factor process, Qualified Plans would be confirmed and awarded an additional 11.55% rate relief for their beneficiaries, and this amount would be offset by increases in rates for other payers. Once fully implemented, this is estimated to increase commercial rates by 0.75%.

Both solutions would also require an annual report on key related factors. The Working Group recommends that these policies remain in place unless changed through a multi-agency public policy process similar to the one by which these recommendations were developed. The remainder of this document provides the background for these recommendations as well as the specific detail for each recommendation that will guide future actions.

Background

Cost-Shifting

Historical Policy

Since the 1970s, the Maryland model has been built on an all-payer concept, where all payers pay the same rate for hospital care with the exception of certain small policy-driven adjustments.[1] Maryland has experienced multiple benefits from the all-payer approach, including a more even distribution of hospital costs across payers, expanded and more equitable access to high-quality care for residents across the state, a reduction in the impact of uncompensated care on hospitals and significantly higher per-service reimbursement rates for Medicare and Medicaid. As a result, commercial payers in Maryland incur approximately 20% lower hospital costs compared to demographically similar areas across the country.[2] These reduced costs are passed along in reduced premiums to Maryland consumers.

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[1] At the inception of the first Medicare waiver in 1977, a payer differential was established based on business practices of payers that helped to avert bad debt to hospitals such as prompt payment and insuring high-risk individuals. It is referred to as a differential rather than a discount, because the differential in payments is built into hospitals' rate structures. The public payer differential is 5.7% for all public payers. Payers may also be eligible for an additional 2% prompt pay discount. Additionally, the Medicare Performance Adjustment-Savings Component has been a Medicare-specific adjustment that allows the State to produce Medicare-FFS-specific savings without impacting rates set for other payers. There is no permanent adjustment in place under the Medicare Performance Adjustment.

[2] Based on HSCRC commercial total cost of care benchmarking but consistent with data available elsewhere. More information can be found in the benchmarking section of this page: https://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx

To date, Maryland has achieved Medicare FFS savings targets by setting all-payer hospital rates in a way that maintained Maryland's higher per service Medicare FFS reimbursement levels while incentivizing reductions in hospital utilization relative to the nation. This has allowed the State to accomplish three key goals: 1) total costs per capita have remained in line with Medicare FFS savings targets; 2) hospitals have remained relatively financially stable while maintaining patient access and quality of care; and 3) commercial hospital rates have remained lower relative to other states. This approach is effective as long as the combination of: 1) incremental savings related to lower cost trend due to reductions in hospital utilization already achieved; and 2) new savings related to continued reduction in hospital utilization compared to national growth rates are sufficient to achieve Medicare FFS targets while maintaining patient access and quality of care. However, if this is no longer feasible, hospital per service reimbursement levels will decline and hospital financial stability will be at risk.

The term "cost-shift" is used throughout this document and reflects impact from a payer perspective. However, from a hospital perspective this same mechanism is a revenue shift; that is, greater revenue comes from one set of payers, and less from others.

Savings Targets Under AHEAD

The AHEAD Model sets a Medicare FFS savings goal that requires Maryland to reduce Medicare FFS spend by 2.66% compared to national trends by Calendar Year (CY) 2032. This has typically been expressed as $460 million, which is the projected impact of a 2.66% trend reduction using current national trend estimates. Because Medicaid and MA rates are tied to Medicare FFS, the Medicare FFS target drives additional changes in those programs.[3] HSCRC has estimated the impact under AHEAD at $870 million versus national trends across all three programs.

The AHEAD Model requires the State to continue building on the successful reductions in hospital utilization achieved under the TCOC Model; each additional dollar of savings is likely to be harder to generate as easier solutions have already been implemented. However, this challenge is mitigated by the fact that the required rate of savings is declining. Through 2023 Maryland achieved reductions of 4.62% over 10 years during TCOC; over the first seven years, the reduction was 3.89%. The savings target under the original AHEAD Model agreement signed in 2024 was 1.15% over nine years. In comparison, the

[3] Medicaid payment rates cannot exceed Medicare FFS payment rates. This requirement has been most recently emphasized via a Presidential Memoranda released on June 6, 2025, which directed the Secretary of Health and Human Services to "[ensure] Medicaid payments rates are not higher than Medicare, to the extent permitted by applicable law." Medicare Advantage rates follow Medicare FFS payment rates because the benchmark for how premiums for MA plans are determined is based on Medicare FFS rates.

current agreement includes a seven-year target of 2.66%, roughly two-thirds of the rate achieved in the first seven years of TCOC.

It is also important to note that the required savings are relative to national metrics, which are trending up. In their modeling for AHEAD, CMMI assumed average national trends of 4.99%. To achieve the 2.66% reduction over the seven-year window the State needs to manage trends down to a 4.70% annual increase, a relatively small change.

Factors in Establishing a Cost-Shifting Policy

Given the savings targets, the State identified a need to define a cost-shifting policy, acknowledging that savings resulting from hospital utilization changes alone may not be sufficient and to plan a controlled transition of costs to commercial payers. A policy that explicitly adopts cost-shifting will be a significant departure from State historical practice and may impact affordability through increased premiums and cost-shares in the commercial market.

AHEAD Model Concepts: The AHEAD Model does not have the same restrictions on cost-shifting policy as the TCOC Model. However, the stated goal of the AHEAD Model is to improve the total health of a state's population while lowering costs.[4] Achieving savings solely through a cost-shift approach would dilute the focus of the State and hospitals on reducing acute care costs through incentivizing population health improvements and investing in primary care.

Current Level of Utilization Performance: A complete analysis of care management opportunities is beyond the scope of this discussion; however, HSCRC analyses indicate that hospital utilization, as measured by Inpatient (IP) Days per 1000, is between the 25th and the 50th national percentiles in most regions in Maryland. The readmission rate is above the 25th national percentiles in all regions in Maryland and above the average national percentile for many. The State believes that decreasing both metrics to the 25th percentile is possible while improving health, maintaining access and improving quality.[5]

Long-Term Investments in Care Transformation: The State and hospitals have been investing in care transformation and primary care over the life of the Model and expect that some of these investments will produce greater savings over the long term. For example, in 2019, the State began investing in the Maryland Primary Care Program (MDPCP) under the TCOC Model, with the investment reaching

[4] CMS.gov AHEAD Model, accessed November, 2025
[5] Metrics are derived from HSCRC's benchmarking process as described in footnote 2.

approximately $200 million annually in recent years. According to an analysis conducted for prior Joint Chairmen's Reports on MDPCP, the program performance reflected a net cost of $75 million in 2022, which reduced to a net cost of $31 million in 2023 and became a net savings of $22 million in 2024.[6] In addition, the 2024 TCOC report by Mathematica reflected reductions in admissions and improvements on timely follow-up after acute exacerbation of a chronic condition.[7] Benefits of this kind typically take years to accrue. The State anticipates continuing and expanding care transformation investments under AHEAD.

Medicare Advantage Market Stabilization

Also known as Medicare Part C, MA is a program that provides an alternative to traditional Medicare FFS, through plans offered by private health insurers. MA plans are required to include coverage for all of the benefits within Medicare Parts A and B, except hospice. Many MA plans also provide prescription benefits typically included under Medicare Part D, as well as benefits not included in FFS, such as vision, hearing or dental services. In addition, MA plans may include 'supplemental benefits,' such as transportation, gym memberships or financial support for meal or nutrition services. Beneficiaries in Medicare FFS are generally responsible for premiums for both Part B and Part D, as well as 20% coinsurance after their deductible is met, with no cap on out-of-pocket costs. For example, in 2026, a hospital stay of under 60 days would be subject to a deductible of $1,736 for a beneficiary of Medicare FFS, and additional payments may be required if the beneficiary has more than one hospital stay per year. In contrast, MA plans may offer zero-dollar premium options for Part B and often have annual limits on out-of-pocket costs. However, MA plans are permitted to establish preferred provider networks, which are narrower than Medicare FFS, and they may apply utilization management tools, such as prior authorization and referral requirements, to a broader set of services than Medicare FFS.

Determining MA Plan Payments

CMS pays MA plans a premium for each beneficiary. Premiums are based on two factors; the 'benchmark' for the county in which the plan will operate and the plan's 'bid.' Benchmarks are set annually by CMS and are based on the FFS spending within each county in the United States, with adjustments for geographic area and risk. The benchmark represents the maximum amount that CMS will pay any MA plan for each enrolled beneficiary. Counties are divided into four groups, or 'quartiles,' based on their level of FFS spend. Higher cost counties get lower benchmarks; for example, in the highest cost

[6] HSCRC analysis of MDPCP program developed to support the Joint Chairmen's Report
[7] Evaluation of the Maryland Total Cost of Care Model: Progress Report

tier of counties, the benchmark is set at 95% of the risk-adjusted FFS spending. The lowest cost tier is set at 115% of the risk-adjusted FFS spending–these areas are typically rural, and the high payment is intended to attract plans into rural areas by subsidizing the plan's operations.

MA plans generate and offer bids for counties they select based on their estimate of the cost of providing coverage in that area. If the bid amount is lower than the benchmark, CMS retains a portion of the savings. The remainder is returned to the MA plan's enrollees through either reduced cost sharing or supplemental benefits offered by the plan. If the bid amount is above the benchmark, the balance is covered by beneficiaries in the form of a premium, which would be in addition to any Medicare Part B premium. MA plans with high quality ratings, also known as 'star ratings,' may receive positive adjustments to the benchmark and higher levels of rebate.

Maryland MA Market Overview

The breadth of coverage offered, and the limits on out-of-pocket costs, make MA an attractive option for many Medicare beneficiaries. Accordingly, enrollment in MA has increased steadily over the past 15 years. A recent analysis indicates that 51 percent of Medicare beneficiaries nationally, and 25% of Maryland beneficiaries, are enrolled in MA plans.[8] Although MA enrollment in Maryland has historically been lower than national levels, the Maryland market has seen steady growth over the past several years with enrollment increasing by 115% since 2020 to 298,000 Marylanders in September 2025.

In line with national trends, multiple carriers have already limited their footprint in Maryland for 2026. The impact of these changes on consumers can be significant, including reduced access to benefits, increased costs and disrupted access to their known care providers. Further, beneficiaries in these circumstances who consider transitioning to Medicare FFS may find that they are no longer eligible for guaranteed issue of a Medigap plan unless they quickly enroll through a special enrollment period.[9] Medigap plans provide supplemental coverage that assist beneficiaries with out-of-pocket costs such as deductibles and copays, so a lack of access to this coverage can have a significant impact.

Historically, MA plans in Maryland have struggled to be financially profitable. MIA analysis shows that, in 2024, plans would have needed to increase revenue by over $200 million to cover their medical expenses, and increase by over $551 million to also cover administrative expenses and generate margins.

[8] Medicare Advantage Market Growth Slows Amid Intensified Headwinds, Chartis, March 25, 2025, accessed June 5, 2025

[9] See Code of Maryland Regulations 31.10.06.09-1B(2).

Potential Impact of the AHEAD Model on MA

CMMI is concerned about the impact of the Maryland Model on MA and included provisions in the AHEAD Model agreement for the State to propose solutions. The Governor's Directive requires the State to explore options to stabilize the MA market in Maryland and to ensure that Maryland residents continue to have access to MA as an option for their coverage. Under the AHEAD Model agreement, Maryland has the opportunity to propose solutions to CMMI to improve the MA market in the state.

Any policy solutions for MA stabilization will need to be considered within the framework of cost-shifting and may require approval by CMMI or CMS, even for temporary stabilization efforts. The State is committed to developing a policy in time for MA plans to make decisions for the CY 2027 plan year, *i.e.*, in early 2026.

Stakeholder Engagement Process

The Working Group scheduled two listening sessions on the topics of cost-shifting policy and MA stabilization, held virtually on October 29th and November 5th. Email messages with instructions for submitting comments and participating in each session were sent to a wide range of stakeholders including State agencies, members of agency standing workgroups, payers, hospitals, providers and community advocates. Further, recipients were invited to share the emailed information broadly within their own networks, in an effort to maximize outreach.

Stakeholders were asked to submit written comments on one or both topics, and to also prepare a short verbal summary of their comments for presentation at one of the listening sessions. Stakeholders who did not choose to submit written input were invited to attend the sessions and to speak as time allowed. The initial email invitation also included the timeline and process for developing policy proposals, setting a mid-November goal for publicly posting the draft proposal and early December for submission of the final recommendation to the Governor, with a decision from the Governor anticipated in late December.

The Working Group developed and distributed via email a draft policy proposal on November 21, 2025, with a request for written comments by December 2, 2025.

Stakeholder Comments

Listening Sessions

Over 130 participants attended each listening session. Written and verbal comments reflected a consensus that policy proposals must thoughtfully balance health care accessibility and affordability, keeping in mind the needs of a wide range of stakeholders, including consumers, employers, hospitals, providers and payers. In addition, respondents agreed that policy proposals must be sufficiently flexible to allow adaptation and refinement over time, given the difficulty of predicting impacts of recent and ongoing changes in state and federal health care policy. (See Appendix A for a list of respondents and link to comment letters).

Input on the development of a cost-shifting policy emphasized the need to consider likely changes in Medicaid eligibility and levels of uncompensated care, other impacts of H.R. 1 and hospital rate changes related to the planned transition to a CMMI-led methodology for the Medicare FFS portion of hospital global budgets in CY 2028. Respondents provided varying estimates for the magnitude of these changes, the recommended amount of shift and the associated timeline. Representatives of the commercial market suggested that a cost-shift policy would be burdensome for consumers and potentially undermine the value of the Model; as such, they indicated that such a policy should only be considered as a last resort. In contrast, hospital representatives proposed a full cost-shift of the potential reduction in Medicare FFS, Medicaid and MA payments, estimated at $855 million (later recalculated to approximately $870 million), and anticipated that such a policy would have minimal impacts on affordability. Several respondents suggested that the payer differential, which currently exists within the HSCRC's regulatory authority, would be an appropriate mechanism to effect these changes. Multiple respondents highlighted the need for close tracking and ongoing study of the impacts of any cost-shifting policy across the health care sector.

Stakeholder input regarding the stabilization of the MA market in Maryland encompassed both short- and long-term concerns. Suggested long-term solutions included recommendations that the State negotiate changes to CMS' benchmarking process (described above) in Maryland in an attempt to address perceived misalignment between how CMS pays MA plans and the Maryland Model, provide additional State support for MA plans through grant programs and consider aligning hospital payments by MA plans with Medicare rates. In addition, multiple respondents observed that MA carriers in Maryland are following a national trend of adjusting plan benefits and premiums, limiting broker commissions and withdrawing from selected markets, in response to struggles with financial instability.

Several stakeholders noted that plan withdrawals are estimated to impact approximately 100,000 Maryland MA enrollees in 2026. Representatives of some of the remaining MA plans in Maryland expressed concern about their ability to absorb and adequately serve these beneficiaries. Although the listening sessions were intended to consider input for long-term MA market stabilization, respondents also requested that the Working Group agencies evaluate options to address these more immediate-term needs, including suggestions such as a temporary 'grant' or 'bridge' program, while a longer-term solution is developed.

Finally, several commenters offered suggestions for improved stakeholder communication and engagement, including targeted outreach to strengthen partnerships with community organizations, particularly in underserved areas, establishing consistent and timely opportunities for sharing information with and seeking input from regulatory agencies and ensuring that any changes are communicated clearly and with sufficient time for thoughtful implementation. Stakeholders representing commercial payers and employers particularly emphasized the importance of predictability and timely information to allow their members to make informed decisions balancing quality of care with affordability and long-term stability for their consumers.

Comments on Draft Policy Proposals

The Working Group received 18 comment letters in response to the draft proposal, with input from representatives of hospitals, primary care providers, consumer advocates, unions, commercial payers and insurance brokers.

The proposed cost-shifting policy generated mixed responses, with hospital representatives expressing concern that the amount of the proposed shift would be insufficient to support hospital financial stability, and payer representatives asserting that hospital cost structures should be evaluated before considering cost-shifting as a last resort. Several stakeholders also highlighted the anticipated impacts of H.R. 1 on both insurance coverage and uncompensated care. In addition, consumer advocates expressed concern about the potential impact of increases to commercial premiums, and primary care providers highlighted the possibility that increased commercial payer costs could result in decreased payments to providers.

Recommended adjustments to the cost-shifting proposal included establishing a 'cap' or guardrails on the growth of commercial rates, increasing the amount of shifted cost or making the amount flexible for future increases as necessary and eliminating the proposed cost-shift, with a preference for evaluating opportunities within hospital cost structures or further decreases in utilization. Several stakeholders recommended taking additional time to evaluate the need for and scope of any cost-shifting policy,

including some recommendations for external evaluations of the system. Additionally, certain commenters noted the potential disproportionate impact of the increase to the differential in markets with a relatively-high public payer mix, recommending the State investigate how to smooth out the impact as part of its implementation activities.

Responses to the proposed MA stabilization policy were similarly mixed, with some respondents expressing reluctance to 'subsidize' plans and other respondents calling for more immediate action in 2026. Stakeholders who were supportive of the MA proposal suggested adjusting eligibility requirements to allow greater plan participation, such as broadening the definition of lower-income counties, removing the county-level threshold, adding more counties or reducing the required star rating from 3.5 to 3.0. In contrast, stakeholders who expressed concern or opposition to the proposed policy cited challenges with MA plans, such as high levels of care denials and utilization review procedures, and recommended additional requirements in these areas if the policy proposal were implemented. Additionally, it may be difficult to forecast the needed budget for the policy, as MA enrollment increases due either to the policy itself or federal actions to promote MA.

Finally, several stakeholders noted the significance of these changes to Maryland's longstanding all-payer model and expressed concern about potential negative impacts on population health, preventative care and access to care for all communities. Organizations focused on the needs of health care consumers in particular stressed the importance of close monitoring and routine evaluations of impacts in these areas as policy proposals are implemented. Commenters also raised concern about the anticipated effects of H.R. 1, including increases to uncompensated care and increased volatility in rate-setting due to more-frequent Medicaid eligibility verifications.

Response to Stakeholder Comments on Draft Policy Proposal

The Working Group was pleased to receive robust feedback across a wide array of stakeholder respondents. As noted earlier, commenters were divided in their response to both proposals, citing concerns about access, affordability and the financial stability of both hospitals and MA plans. Certain groups advocated for more-immediate action, and others suggested delaying and monitoring or even canceling the policies. (See Appendix A for a list of respondents and link to comment letters.)

Generally, the reporting aspects of this policy recommendation provide an opportunity for the State to assess and address emerging concerns raised by commenters regarding affordability and access, such as the impact of H.R. 1 and MA prior authorization policies. The Working Group also views the

recommended monitoring activities as an avenue to identify when policy changes may be required, as opposed to fixing timelines in this recommendation.

In addition, the component agencies of the Working Group are already addressing many of these topics, as part of their ongoing regulatory work. For example, the HSCRC–in consultation with MHCC–has already begun more work on a more formal assessment of access as part of ongoing development of global budget policies. With regard to H.R. 1, the State has established a comprehensive, cross-agency team led by MDH and Department of Human Services (DHS), as well as MHBE and MD Benefits, to implement the bill's requirements in partnership with providers, plans and stakeholders, with the goal of mitigating disruption to coverage and access to benefits.

Lastly, the Working Group appreciated additional suggestions provided by commenters–such as smoothing the impact of the differential change vis-a-vis public payer mix and updating the uncompensated care policy, among others–and will prioritize these as the agencies shift from policy design to implementation planning.

Cost-Shifting

Following review of public comment, which lacked any consensus for alternative policy approaches, the Working Group intends to finalize the cost-shifting recommendation largely as proposed, with the following notations. In response to feedback from the provider community, while not a change to the policy, the Working Group would like to identify avenues to provide resources to physicians through value-based programs and has identified that as another area of reporting within the recommendation below. The Working Group appreciated the suggestion that the State set caps or guardrails on commercial rate growth. While not specifically a cap or guardrail, the Working Group will be launching a public process to inform all-payer TCOC growth targets–as required by the AHEAD Model–starting in January 2026. In response to comments suggesting flexibility for the cost-shifting figure, as noted below, one of the State's guiding principles is that this policy foster predictability to the extent feasible.

Medicare Advantage

The Working Group proposes one change to the Medicare Advantage policy recommendation, in response to stakeholder comments and with regard to the eligibility requirements for plan participation. The policy will maintain that at least 50% of an H-contract's members need to reside in Maryland, and it will also keep the county-level requirements to prioritize access for vulnerable populations. The proposed change will give plans–both existing and new entrants to the Maryland market–an opportunity to apply for a

waiver committing to come into compliance with the county-level requirements in 2028 if they are not currently in compliance. The State intends to maintain all other qualifying criteria, including the 3.5-star rating threshold and starting the policy to support plans in the CY 2027 plan year. Initiating rate support at this late date for the CY 2026 plan year would require an unanticipated increase on Medicaid and commercial rates.

Policy Proposals

The two issues addressed in this policy recommendation–cost-shifting and MA stabilization–require state-level investment. The Working Group is challenged to identify a source or sources of funding for these policies that are both meaningful enough to achieve their aims while not increasing budgetary pressure on consumers, risking the AHEAD Model's financial tests or putting pressure on the State's General Fund, particularly in the context of the anticipated impact of H.R. 1 on Medicaid. In developing these policies, MDH, MIA, MHCC, MHBE and HSCRC considered three primary funding options: cost-shifts from commercial (*i.e.,* non-MA, non-Medicare FFS, non-Medicaid) plans, hospital revenue and State General Funds.

Cost-Shifting

The AHEAD Model agreement details the methodology for calculating the Medicare FFS total cost of care savings targets against which Maryland's performance under the Model will be assessed. Savings targets are moderate in the early years before accelerating in the later years, reaching a maximum of 2.66% in 2032, which is equivalent to approximately $460 million. Failing to meet the annual Medicare FFS TCOC target may result in changes in payment to the State, issuance of a warning notice and enforcement action notice and potentially even a requirement for the State to submit a Corrective Action Plan describing action the State will take to correct its non-compliance.

As described above, the savings in Medicare FFS also require equivalent trend reductions in Medicaid and MA, resulting in a total target of approximately $870 million. The Governor's Directive indicated that the Working Group should maintain affordability and access while not allowing any segment of the health care system to bear all the burden. To balance these concerns and address the various pressures on commercial insurance rates and hospital funding, the Working Group adopted the following principles:

- The approach should support the overall goals of the model;

- The approach should value predictability for payers, hospitals, Maryland consumers and businesses;
- Any effect on annual premiums for consumers and businesses should serve the goal of maintaining affordability and not lead to further loss in coverage; and
- Annual amounts must be finalized in time for payer and hospital rate-setting.

Policy Recommendation - Cost-Shifting

The Working Group recommends a cost-shift approach that commits to a fixed level of cost-shift now and establishes criteria for future revisions. The Working Group respectfully submits the following recommendation for the Governor's consideration:

1. Request that the HSCRC:
    a. During the Fiscal Year (FY) 2028 HSCRC update factor process, whereby hospital revenues are adjusted for items like inflation and population related volume growth, increase commercial hospital rates by $87 million annually beginning January 1, 2028.[10] This will increase hospital commercial revenue to offset anticipated slower growth in governmental payer revenue.
    b. During the annual update factor process, increase another $87 million for each year from 2029 to 2032 such that by 2032, the total is equal to $435 million or half the anticipated required Medicare FFS savings when those savings are extended across all public payers (Medicare FFS, Medicaid and MA).
    c. Maintain the cost-shift, as described herein, unless modified by the Working Group through a public policy process similar to the one by which this recommendation was established based on cost drivers identified through the monitoring activities described below.
    d. Implement the change through a combination of the available policy tools (*e.g.,* payer differential) as determined to be appropriate by the HSCRC.

[10] The annual update factor policy is a revenue update that incorporates adjustments for items like inflation and population related volume growth hospital revenue under Global Budget Revenues (GBR). This policy is a stakeholder involved process that begins early in the calendar year and culminates with a Commission vote in June to ensure implementation for the next fiscal year, which begins in July. Beginning January 1, 2028 the Medicare FFS payments will transition to Hospital Global Budget Methodologies, but the remaining population will remain under a GBR methodology. There will still be an annual update factor policy/process to help determine the appropriate revenue update for the next fiscal year.

2. Direct the Working Group to report back to the Governor annually on the following related to cost-shift:
    a. The affordability of commercial insurance compared to other states to assess the impact of existing cost-shifts and other policies on Maryland's historic premium cost advantage.
    b. Metrics regarding hospital affordability, health care access and hospital viability that could be used to assess the need to change the cost-shift in future periods, considering other changes in the market impacting these topics such as Medicare reimbursement levels, uncompensated care and clinical delivery trends.
    c. Strategies the State could pursue to provide resources to value-based physician programs such as MDPCP and Episode Quality Improvement Program (EQIP) that promote high quality, cost effective care through enhanced reimbursement to physicians and also generate total-cost-of-care savings to payers and reduce the need for hospitals to underwrite physician expenses.
    d. The opportunity for additional investments in population health that could reasonably be expected to result in declines in spending over the life of the model.

Discussion

MIA and the HSCRC modeled the impact on commercial premiums of cost-shifting $435 million of public payer payments to commercial payers. Based on this modeling, commercial premiums would be expected to increase by approximately 1.8% over seven years, with an annual incremental increase in premiums of approximately 0.35% from 2028 to 2032. This would be in addition to increases due to other health cost drivers, *e.g.,* anticipated reductions in federal credits for the ACA market and the cost of emerging drugs.

The recommendation to implement the cost-shift on a steady basis is intended to provide predictability for insurers, consumers and businesses, as well as to provide some forward funding to hospitals against the savings under AHEAD that are concentrated in the later years.

Under existing HSCRC tools, the impact of this cost-shift on commercial patient costs and insurance premiums will be greatest in those markets where fewer consumers have coverage through commercial insurance, because in those areas a smaller group of commercial patients is covering added costs for a larger group of public patients. The HSCRC estimates the 1.8% total increase could range from 1% to 4% by market. As part of the implementation of the cost-shift policy, the HSCRC and MIA will work to better

understand the potential for these impacts, including approaches to mitigate the disproportionate effect across markets.

Medicare Advantage

The ultimate aim of stabilizing the MA market in Maryland is to prevent further disruption and foster continuity of care for Marylanders who select MA for their health coverage, particularly for low-income Marylanders. The goal of the Working Group is to determine a mechanism and funding source(s) to mitigate the unique challenges faced by MA plans in Maryland.

Although MA offerings are shrinking nationwide, MA plans have historically struggled to make a profit in Maryland. Commenters stated that several plans that operated in 2025 are departing Maryland or decreasing their service areas in 2026; they estimated that this could leave as many as 100,000 older adults needing to seek coverage with a different plan or switch to Medicare FFS. As described above, in 2024 Maryland MA plans were $551 million away from covering administrative expenses and generating margins. However, there are many reasons why Maryland plans struggle, and many plans outside Maryland also struggle. Therefore, the Working Group does not believe the State should subsidize all MA plan losses.

Instead, the HSCRC quantified the amount of lost premium in Maryland by calculating the difference between the actual weighted state average MA benchmark and the benchmark that would be generated if each Maryland county had the benchmark of demographically similar counties in the rest of the country under the national Medicare FFS reimbursement system.[11] This calculation indicates that weighted average Maryland premiums are approximately 4.6% below the levels of their geographic peers. This correlates to an estimated funding shortfall of approximately $350 million.

Policy Recommendation - Medicare Advantage

The Working Group proposes a solution that leverages the HSCRC's rate-setting authority to generate reduced hospital costs equal to this amount for qualified plans and maintain hospital funding by increasing commercial rates. The Working Group respectfully submits the following recommendation for the Governor's consideration:

1. Request that the HSCRC and MIA designate Qualified Plans each year as follows:

[11] Similar counties were derived from the counties used in the HSCRC's Medicare benchmarking process, the same process used to evaluate Maryland utilization performance as discussed in footnote 2.

a. Qualified Plans will meet all of the following:
    i. At least 50% of MA beneficiaries in the relevant H-contract reside in Maryland;
    ii. At least (1) 5,000 beneficiaries or (2) 20% of MA beneficiaries residing in Maryland in that H-Contract reside in these eight jurisdictions: Allegany, Baltimore City, Caroline, Dorchester, Garrett, Somerset, Washington and Wicomico;[12]
        1. Plans not meeting the county-level requirements outlined in 1.a.ii, above, may submit a waiver request, with a commitment to coming into compliance by the 2028 plan year, *i.e.,* with sufficient enrollment in qualifying counties by CY 2028 Q1, to qualify for the program in CY 2029 and beyond.
        2. Waiver submissions requesting to come into compliance after CY 2028 will not be considered.
    iii. After the release of 2028 plan year data - at least 3.5 stars in the Medicare Stars quality program.[13]
b. To allow for the inclusion of resulting savings in MA bids, Qualified Plans will be designated for the following year in the first quarter of each year, starting in 2026, using the most recent available beneficiary counts.
c. For 2027, finalize plan qualification criteria, via memo, by January 23, 2026 and identify final Qualified Plans for CY 2027 by February 20, 2026.

2. Request that the HSCRC:
    a. During the HSCRC's annual update factor process, starting with FY 2026, award Qualified Plans an additional 11.55% rate relief implementing the change through a combination of the available policy tools (*e.g.*, payer differential) as determined to be appropriate by the HSCRC. (11.55% is derived by calculating the impact of closing the 4.6% premium gap noted above across the 40% of MA plan costs that are at hospitals.)
    b. Offset the cost of this rate relief to hospitals by increasing rates for other payers sufficient to offset the impact. This offset must be sufficient to cover the rate relief in commercial and Medicaid revenue in CY 2027 and just commercial revenue

[12] These areas were selected based on an evaluation across a set of metrics related to income.
[13] Specific Star standard may be subject to change based on program adjustments during federal rulemaking.

thereafter. The HSCRC will also establish a plan to monitor, on an ongoing basis, the amount of rate relief provided by plan and hospital, the amount of offset at a statewide and by hospital level and report publicly on the impact and if feasible, implement remedies to reduce the variability among hospitals.

c. Make any necessary request to CMS or CMMI to implement this change and to offset any cost to Medicare FFS such that Medicare FFS will not bear any of the cost of the MA rate relief. In the event CMS/CMMI does not approve the needed changes, the Working Group will revise this proposal.
d. Unless modified through a multi-agency public policy process similar to the one by which this request was established, continue this process into the future.
e. Consider, and if feasible, implement an alternative approach.

3. Direct the Working Group to monitor the impact of rate relief to MA plans and report back to the Governor annually on the following:
    a. The impact on the affordability of commercial insurance compared to other states to assess the impact of existing MA rate relief and other policies on Maryland's historic premium cost advantage in order to frame the decision regarding continued MA rate relief.
    b. Total cost of MA rate relief including an assessment of trends and the degree to which rate relief is supporting MA for underserved individuals.
    c. The impact of changes in the MA rate relief on metrics regarding MA plan availability, enrollment and quality.
    d. Plans to add to the requirements for Qualified Plans to improve the efficiency of the MA market or promote population health or quality outcomes.

Discussion

The plan eligibility criteria were selected to ensure the benefits accrue to low-income Marylanders by providing rate relief only to Qualified Plans that provide services primarily to Maryland residents and who serve a significant number of residents in lower-income areas. The addition of a waiver option giving plans a two-year window to come into compliance with the county-level requirement has the potential to both mitigate disruption as well as increase plan options available to Marylanders.

As of September 2025, plans representing approximately half of the MA beneficiaries in Maryland would qualify, resulting in a program cost of approximately $175 million. This amount is likely to increase if this program is effective in stabilizing the MA market.

MIA and the HSCRC estimated the impact on commercial premiums of providing $175 million of rate relief to MA and adding the cost to commercial payers. Based on this modeling, the impact on commercial premiums would be an increase by approximately 0.5% in CY 2027 and a further 0.25% in CY2028 resulting in a total increase of 0.75%. This would bring total increases across both proposals to 2.55% by 2032 with the largest single year increases occurring in 2028, at 0.60% combined for the two programs. This would be in addition to increases due to other health cost drivers, *e.g.,* anticipated reductions in federal credits for the ACA market and the cost of emerging drugs.

Effective January 1, 2028, CMMI will take responsibility for setting Medicare FFS global budgets. Due to operational changes related to this shift, the cost of the rate relief to MA will be borne by Medicaid and commercial payers for 2027 and only commercial payers starting in 2028. Medicaid would experience an increase in 2027 totaling approximately $60 million.

Similar to the cost-shift, under existing HSCRC tools the impact of this MA rate relief on commercial patient costs and insurance premiums will vary by market, in this case depending on the penetration of MA plans. The HSCRC will adopt an approach providing rate relief to minimize this impact on the consumer based on various factors including the predictability of the outcome, the feasibility under relevant legislation.

Additionally, the federal government released its annual MA and Part D rulemaking and advance notice in late November. Pending finalization, the effects of any resulting rule changes by CMS–*e.g.,* star ratings, risk adjustment processes–may require changes to this approach.

Appendix A. List of Stakeholder Respondents

Comment letters can be found on the HSCRC AHEAD Model Website: https://hscrc.maryland.gov/Pages/ahead-model.aspx.

Respondent Name	Listening Session	Policy Proposal
1199SEIU and Economic Action MD		X
Adventist HealthCare	X	X
AHIP	X	
Alterwood Advantage	X	X
CareFirst	X	X
Health Means Everything Coalition	X	X
Health Resource Advisors	X	X
Johns Hopkins Health Plans	X	X
Johns Hopkins Health System	X	X
Kaiser Permanente Mid-Atlantic	X	X
Dr. Terris King	X	
League of Life & Health Insurers of Maryland	X	X
Maryland Academy of Family Physicians		X
Maryland Health Care for All! Coalition	X	X
Maryland Hospital Association	X	X
Maryland Primary Care Physicians		X
Mattes Insurance & Financial Services, LLC	X	
MedChi	X	
MedStar Health		X
National Association of Benefits and Insurance Professionals of Maryland	X	
Dr. Mercy Obamogie		X
Step Up Maryland	X	
United States of Care		X
University of Maryland Medical System	X	X

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Report from the Executive Director

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Update on Medicare FFS Data & Analysis

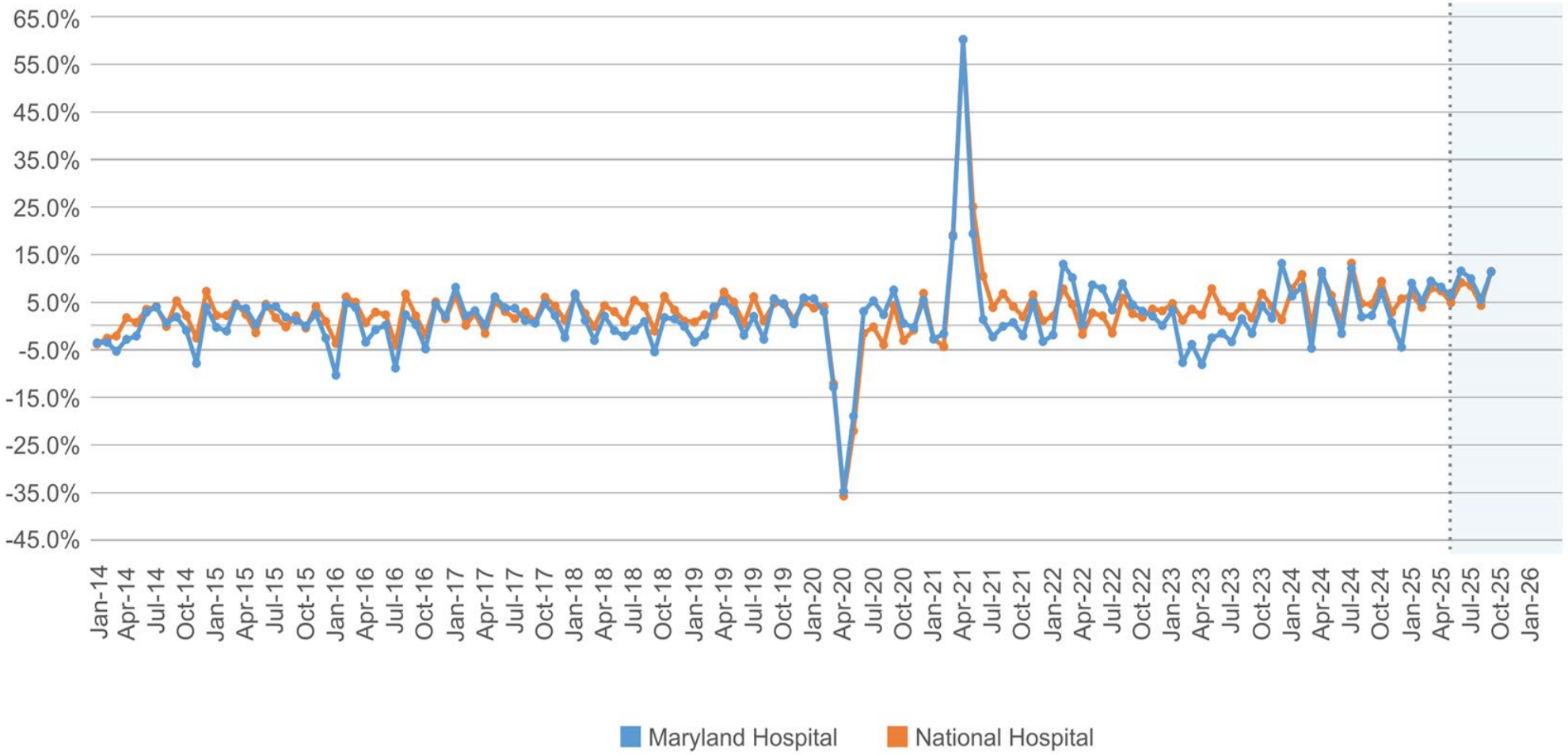
January 2026 Update

Data through September 2025, Claims paid through November 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

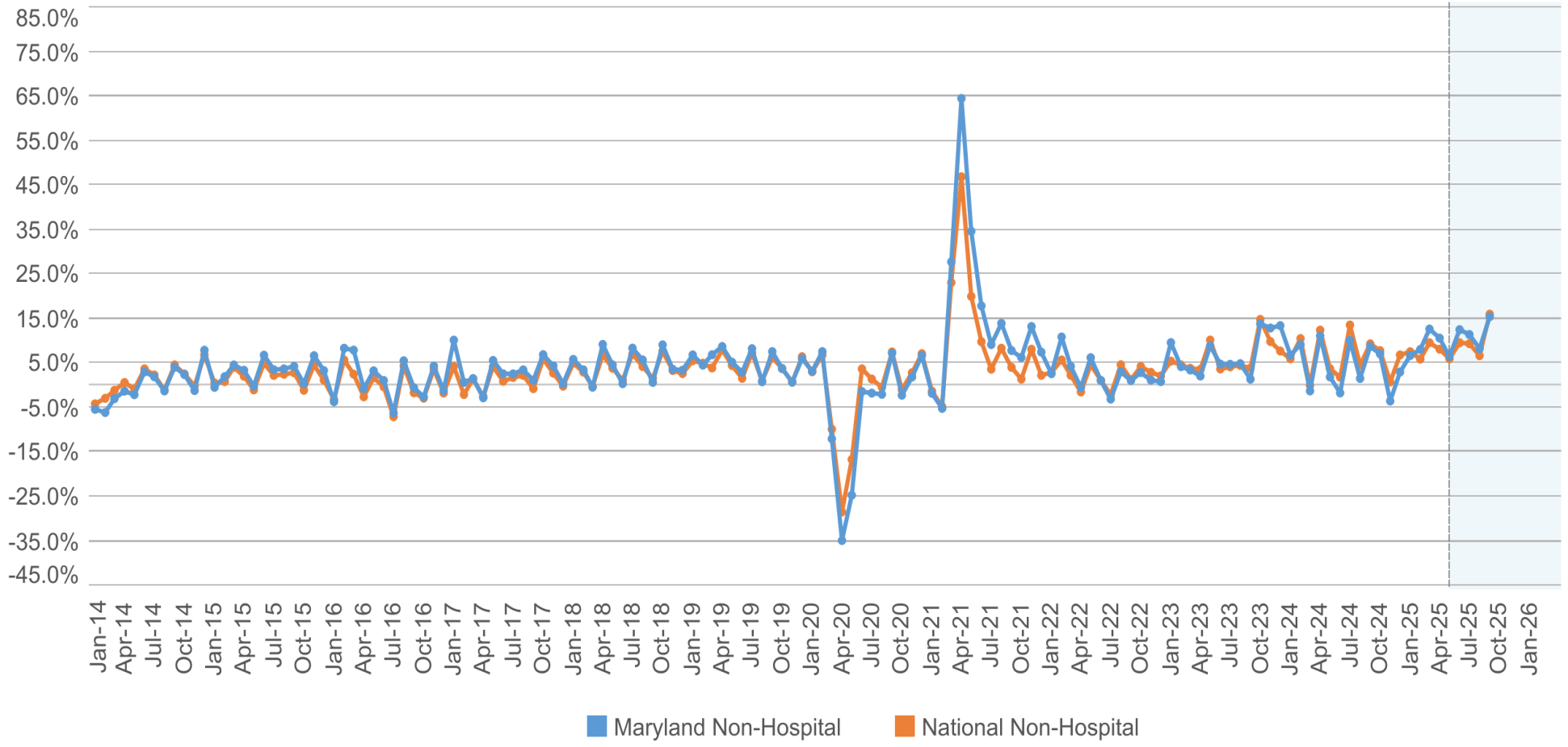
Actual Growth Trend (CY month vs. Prior CY month)



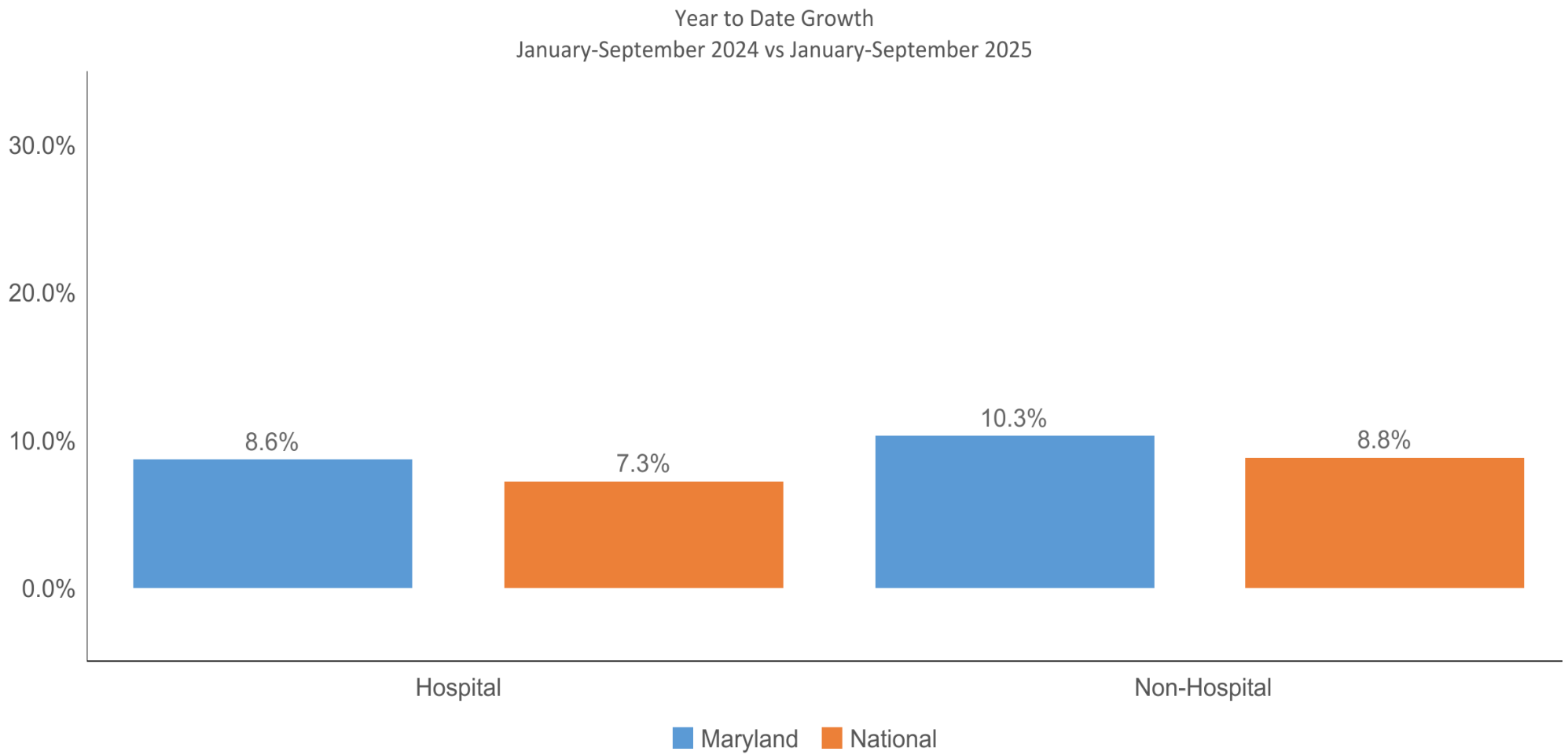
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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

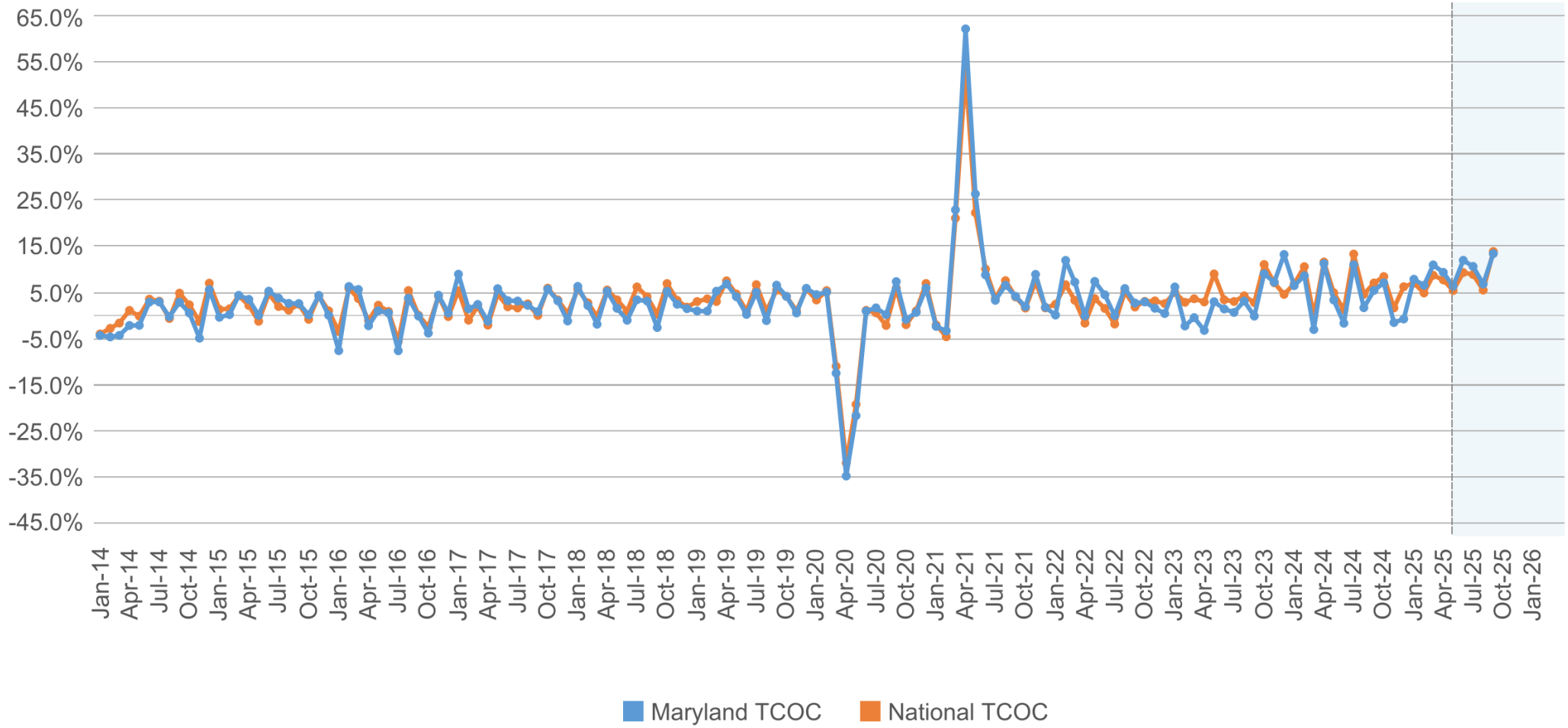


Medicare Hospital and Non-Hospital Payments per Capita



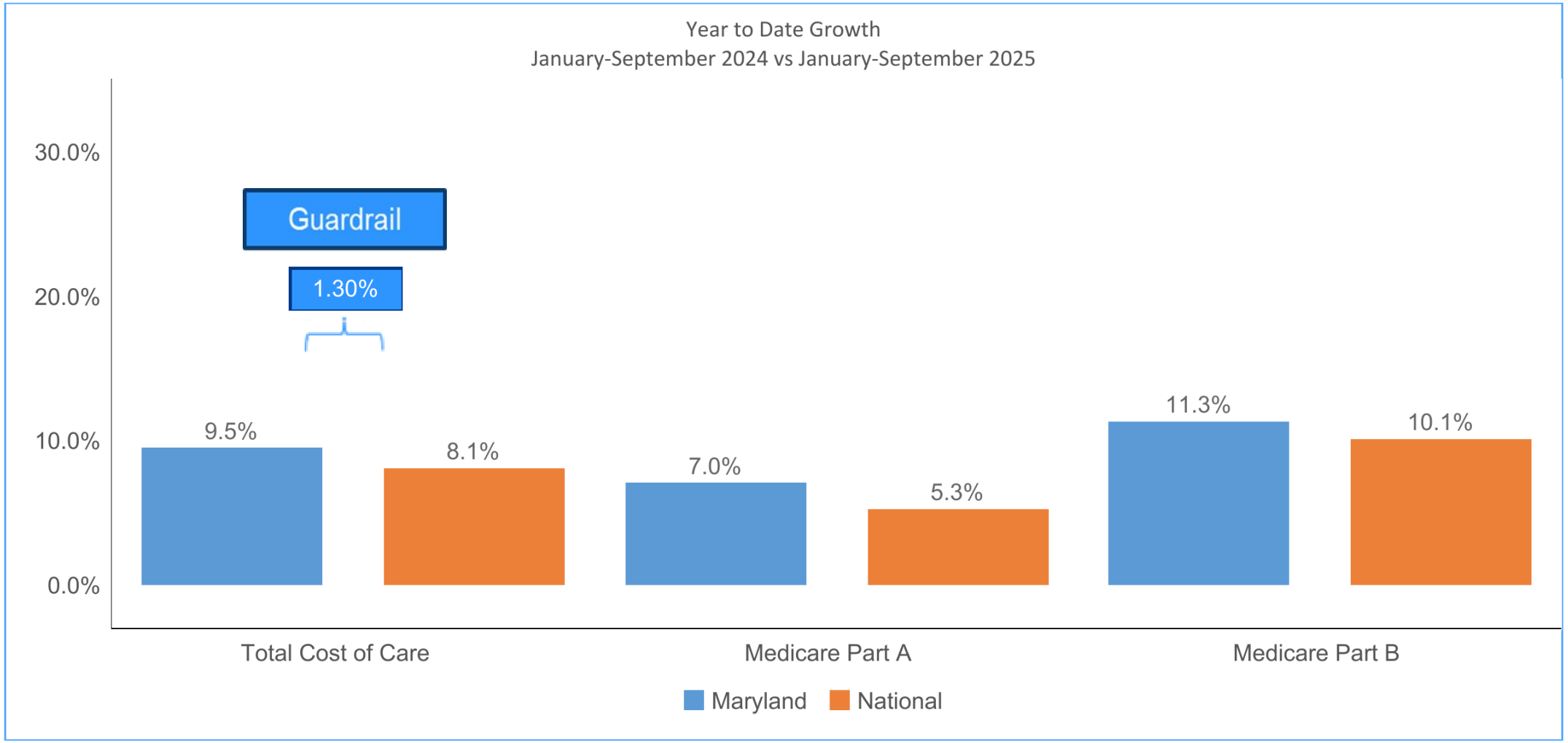
Medicare Total Cost of Care Spending per Capita

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



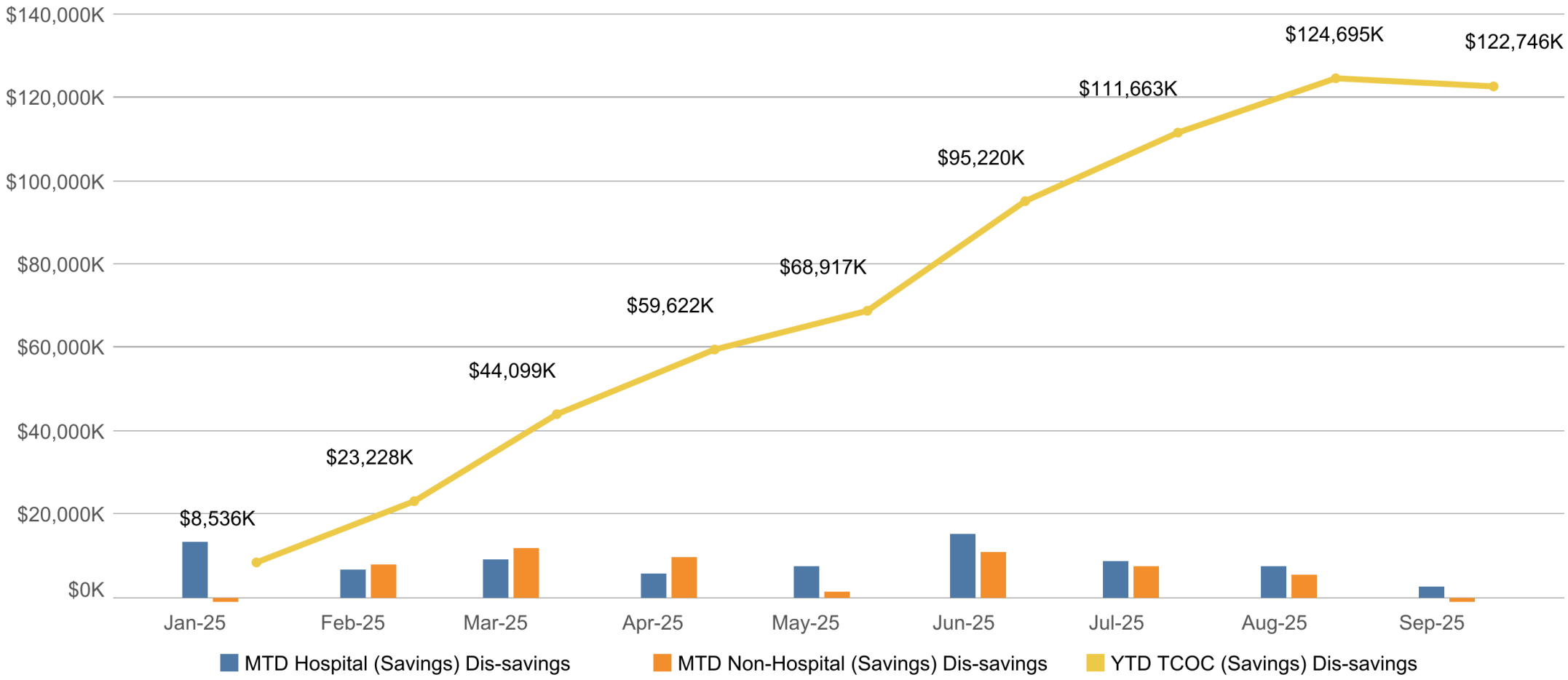
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through September 2025



A positive number represents dissavings/excess growth

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HSCRC AHEAD Model Policy Timeline

Commission Update

January 2026

HSCRC AHEAD Model Policy Timeline

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

** Coordinated by Regulatory Working Group*

Key to Timeline Descriptions

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

HSCRC Policy Updates Already Planned

	Oct. 2025	Nov. 2025	Dec. 2025	Jan. 2026	Feb. 2026	Mar. 2026	Apr. 2026	May 2026	Jun. 2026
A. HSCRC Policy Updates Already Planned									
Market Shift	D	P	F						
Demographic Factor	W	D	P	F					
Respiratory Surge (FY 2025 Allocation)	S	C	T						
Respiratory Surge (FY 2026 and Future Allocation)		W	D	F					

- Today's Agenda
  - Demographic Factor: Final Vote
  - Respiratory Surge (FY 2026 onward): Final Vote
- February Agenda
  - N/A

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

Required Changes for AHEAD Implementation

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

- Today's Agenda
  - Care Innovation: Discuss Call for Public Input *(will be merged with Preventable Utilization initiatives)*
- February Agenda
  - N/A

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

AHEAD-Related HSCRC Policy Changes

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

- Today's Agenda
  - Physician Costs: Topic Discussion
  - Preventable Utilization: Discuss Call for Public Input
- February Agenda
  - Length of Stay: Draft Recommendation

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

Multi-Agency Priorities: Updates and Upcoming Opportunities

Workstream	Status
Maryland-Specific Metrics for AHEAD	Awaiting measure feedback from CMMI
Graduate Medical Education and Workforce*	*Slated to kick off Spring 2026*
Denials	Initial meeting of the Adverse Decisions Workgroup held November 2025; report due December 2026
Medicare Advantage Market Stabilization*	Policy recommendation approved by Governor December 2025; Commissioner consideration January 2026
Post-Acute Strategy*	*Slated to kick off Spring 2026*
Cost-Shifting*	Policy recommendation approved by Governor December 2025; Commissioner consideration January 2026
All-Payer Total Cost of Care Growth and Primary Care Investment Targets*	Advisory Committee selected; meetings scheduled for January, February and April
Choice and Competition*	*Slated to kick off early 2026*
ED Wait Times Commission	Strategic planning meeting held January 7, 2026

*Coordinated by Regulatory Working Group

Discussion: Principles for Physician Payment

Physician Payment: Call for Public Input

During the December Commission meeting, staff put out a request for public comment on potential principles for future policymaking, which the following examples for consideration:

1. Funding for physicians should focus on hospital-based physicians necessary for the administration of an efficient hospital.
2. Funding for physicians should facilitate the goals of the Maryland Model, including improving quality, improving health outcomes and reducing overall costs.
3. Funding for physicians should be paired with efforts to reduce underlying cost drivers.
4. Funding for physicians should be available fairly to all hospital-based physicians.
5. Funding for physicians should be coordinated with CMS so that Medicare and Medicaid participate.

Comments were due in early January. Staff received comments from 11 stakeholders.

Also, initial summary data from new clinical cost reporting has been released and can be found here, this was discussed in the October Commission meeting and additional background can be found in those materials.

Commenters

- Ascension St. Agnes
- CareFirst
- ChristianaCare, Union
- Frederick Health
- Garrett Regional
- Kaiser Permanente
- Johns Hopkins Health System
- Luminis Health
- Maryland Hospital Association
- MedStar Health
- University of Maryland Medical System

Physician Payment: Underlying Issues

Commenters cited several underlying issues that contribute to rising costs of physicians as a financial challenge facing hospitals as physicians are integral to hospital care

- Physician Rates
  - Lower commercial physician rates relative to other states
  - Flat or declining Medicare and Medicaid reimbursement
  - However, one comment noted that, while Maryland physician rates tend to be low, relative to other states, Maryland physicians bill more units per capita resulting in similar per capita reimbursement to other states. This commenter was not supportive of further subsidies for physician costs, absent accountability for outcomes or costs.
- Increased acquisition by private equity
- Challenges in recruiting and retaining physicians

Physician Payment: Ideas and Principles

There was disagreement whether physician costs should be considered by the HSCRC.

Among those who supported HSCRC involvement, there was broad support for: 1) policies related to physicians should support the goals of the model, *i.e.,* improving quality, improving health outcomes and reducing overall costs; and 2) funding for physicians should be paired with efforts to reduce underlying cost drivers.

- There are various views on which physician types to include in a physician policy involving the HSCRC.
  - The three most cited were anesthesiologists, hospitalists and emergency medicine physicians.
  - Other suggestions included pathologists, general surgeons and infectious disease physicians–or to apply a broader definition.
  - Some commenters noted that specialities not traditionally associated with the hospital, such as primary care, are important to hospital operations.
  - Whatever the definition, commentators emphasized that opportunities for funding should offered fairly.

- Viewpoints on regulation varied considerably.
  - Many commenters called for accountability around cost and/or outcomes to be included in any action, but other commenters called for minimizing new regulatory requirements.
  - Some commenters recommended embedding changes in a value-based payment framework.
  - Most commenters did not think models should be made dependent on CMS review and/or approval, but many acknowledge that the State should attempt to obtain Medicare and Medicaid participation.

MedStar Health

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Susan K. Nelson
Executive Vice President and
Chief Financial Officer

January 5, 2026

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

Dear Executive Director Kromm,

On behalf of MedStar Health, Inc. (MedStar) and its seven Maryland hospitals, thank you for the opportunity to provide comments on the principles for physician payment released by the Health Services Cost Review Commission (HSCRC). Since the beginning of medicine, physicians have been at the foundation of caring for patients, and this remains true even in today's modern and technologically advanced healthcare system. To ensure that our patients have access to the healthcare services they need – whether its primary care or highly specialized services – hospitals and health systems must invest significantly in employing or contracting with physicians incurring significant expense. The costs incurred by hospitals and health systems to maintain physician coverage to provide hospital care such as hospitalists, emergency department physicians and radiologists have been growing and are now placing increasing financial strain on Maryland's hospitals and placing them on a path to financial instability. We do not believe that further regulation is the answer. Understanding the drivers of these cost increases and utilizing any new flexibilities created by the AHEAD model & the new cost shift recommendations in Maryland should be explored with the goal of enhancing innovation and addressing the root causes of physician shortages in Maryland. MedStar appreciates the HSCRC's public recognition of the financial situation hospitals are experiencing and the challenges associated with increasing physician costs and stands ready to collaborate with stakeholders to develop a policy solution. In general, MedStar supports the seven principles distributed by the HSCRC to guide any policy solution addressing hospital physician costs and provides below additional considerations for the HSCRC and staff.

Any policy solution to address increases in physician costs should be paired with efforts to reduce the underlying cost drivers.

We support this principle aimed at identifying and addressing the root cause of the cost drivers. Numerous factors are contributing to the increasing financial losses incurred by hospitals to maintain and contract with physicians in Maryland which in fiscal year 2024 totaled $890 million excluding Johns Hopkins Health System (see Maryland Hospital Association comments). While not a comprehensive list, these include:

1. Maryland's low/inadequate commercial reimbursement for physician services as referenced in MHA's comment letter. The impact of the low reimbursement drives up losses and has a compounding impact as it makes recruiting physicians into the state more difficult driving up the compensation costs/subsidies necessary to attract physicians to the state.
2. Physician shortages across many of the hospital-based physician specialties drive up costs.
3. The impact of private equity physician practice acquisition activity in Maryland
4. Flat or declining Medicare/Medicaid physician reimbursement over the past ten years

Each of these reasons has its own fact pattern and history. We recommend the following actions are undertaken to identify further information about these drivers of increasing physician costs:

- The benchmark data on physician reimbursement in MD vs. the rest of the country has been noted for several years. We recommend HSCRC undertake a study to analyze the reasons for the extremely low physician services reimbursements from commercial payors in Maryland as compared to the rest of the country.
- You and your team have noted that Maryland trains a large number of physicians; however, the state does not retain this talent to fill areas of shortage and is a net exporter of newly trained physician talent. Improved retention of physicians trained in the state would have a positive impact on reducing physician shortages and is a significant area of opportunity. A detailed analysis of the reasons physicians leave the state following training should be undertaken to design solutions to address these retention challenges.
- Data is needed to understand the full impact of private equity ownership of physician practices across the state. This is only one area where private equity is driving up the costs of health care in the state. Data transparency and analysis is needed to understand this growing trend and its impact on healthcare costs.
- These flat or declining physician reimbursements from Medicare and Medicaid are not unique to Maryland. Health systems across the country utilize cost shifting to balance these impacts. This further highlights the importance of addressing the costing shift opportunity available under the new model.

While MedStar appreciates that any one policy solution may not address all of the above challenges facing our healthcare system and hospital's ability to fund physician coverage, the causes of this issue should remain at the center of the development of any policy solution. The HSCRC has the responsibility to ensure hospital rates for services are reasonable, related to cost, and adequate and the four challenges listed above are creating very real costs for Maryland hospitals. To date, current rates for hospitals have not been calibrated to account for these financial pressures and are inadequate for providing hospitals with the funding needed to deliver hospital care to patients and achieve the goals of the AHEAD Model.

Any policy solution should support care delivery innovations that solve broader challenges of the healthcare delivery system. Any policy changes should be designed to preserve hospitals' ability to innovate and develop appropriate strategies and operations decisions which meet the unique needs and opportunities in their individual community.

MedStar believes that the draft HSCRC principles on a physician cost policy solution serve as a solid foundation for policy development and is supportive of them overall. However, the rapidly evolving healthcare landscape and the upcoming challenges that hospitals will need to navigate as the AHEAD Model begins requires that hospitals and health systems be able to operate with maximum flexibility to meet patient care needs and create operational efficiencies. Maryland hospitals operate in a financially challenging environment, an environment which since the pandemic has only increased financial burden on hospitals, with slim operating margins and ability to fund unanticipated costs. To be successful, hospitals must be able to capitalize on efficiencies they can create across the care continuum and strategically deploy resources in order to maximize access to care and delivery of

services. Hospital services and prices are already highly regulated by numerous government regulatory bodies. MedStar cautions against any policy proposal or development that would increase the regulatory burden placed on health systems and which might lead to unintended negative consequences for providers and patients in Maryland. To this end, MedStar would offer a friendly amendment to the HSCRC's principles with the addition of an eighth core principle: **Any hospital eligibility requirements for physician funding should preserve hospital care delivery strategy and innovation and support each hospital's flexibility in meeting community care needs.**

Again, MedStar wishes to thank the HSCRC for their continued focus on this critical topic and for elevating the need for a policy solution on this issue to the forefront of the conversation. MedStar would welcome the opportunity to collaborate with the HSCRC & the state on the development of any such solution.

If you have any questions or wish to discuss any of the above further, please do not hesitate to contact me directly.

Sincerely,

Susan K. Nelson
Executive Vice President & Chief Financial Officer
MedStar Health

cc: Joshua Sharfstein, MD
James Elliott, MD
Jonathon Blum, MPP
Maulik Joshi, DrPh
Ricardo R. Johnson, JD
Nicki McCann, JD
Farzaneh Sabi, MD

Ascension
Saint Agnes

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

January 5, 2026

Dear Dr. Kromm,

On behalf of Ascension Saint Agnes, I am writing today to respond to the request for comments from the Health Services Cost Review Commission (HSCRC) regarding proposed principles for physician payment. In its request for comments, the HSCRC outlined the following principles for potential consideration as it determines whether additional steps need to be taken to address the rising costs of physician services for hospitals:

1. Funding for physicians should focus on hospital-based physicians necessary for the administration of an efficient hospital.
2. Funding for physicians should facilitate the goals of the model, including improving quality, improving health outcomes, and reducing overall costs.
3. Funding for physicians should be paired with efforts to reduce underlying cost drivers.
4. Funding for physicians should support care delivery innovations that solve broader challenges of the health care delivery system.
5. Funding for physicians should be available fairly to all hospital-based physicians.
6. Funding for physicians should be aligned with EQIP, MDPCP, and/or other value-based payment programs within the state.
7. Funding for physicians should be coordinated with CMS so that Medicare and Medicaid participate.

Ascension Saint Agnes appreciates the opportunity to comment on this important issue and would like to raise the following points for the HSCRC's consideration.

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

Physician Costs Far Exceed Insurer Reimbursement

At the October meeting of the HSCRC, staff presented data from Maryland hospitals demonstrating that they collectively spend $1.5 billion annually on the physician enterprise but only receive $600 million in reimbursement offset from insurers. This isn't surprising given that Maryland physicians receive some of the lowest commercial reimbursement in the country.

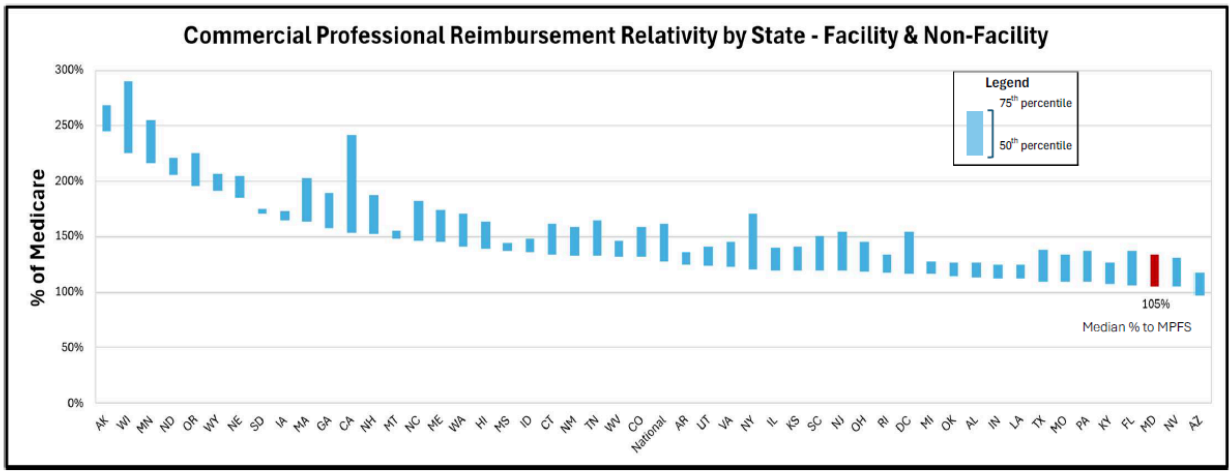
Figures 1 and 2 below demonstrate that Maryland physicians rank:

- 47th out of 49 in the nation for commercial physician reimbursement as a percent of Medicare overall.
- 48th out of 49 in the Nation for commercial physician reimbursement as a percent of Medicare for non-facility/office visits specifically.

At a time when commercial insurers already reimburse Maryland hospitals at significantly lower levels than their counterparts nationally due to the all-payer model, it is unreasonable for Maryland's commercial insurers to similarly reimburse physicians at such low and financially unsustainable levels.

Figure 1 – National Review of Physician Reimbursement – Overall

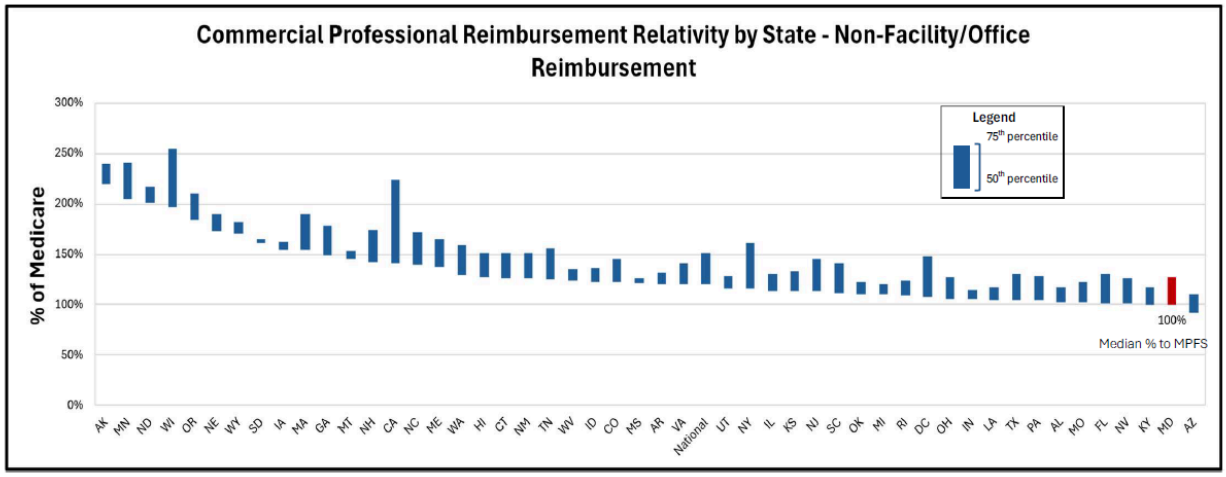
Maryland ranks 47th out of 49 in the Nation for commercial physician reimbursement as a percent of Medicare.



Source: Merative / Truven 2024, data unavailable for Vermont or Delaware, includes DC, ranking based on median percent of Medicare

Figure 2 - National Review of Physician Reimbursement – Non-Facility/Office

Maryland ranks 48th out of 49 in the Nation for commercial physician reimbursement as a percent of Medicare.



Source: Merative / Truven 2024, data unavailable for Vermont or Delaware, includes DC, ranking based on median percent of Medicare

HSCRC Precedent to Fund Physicians

While the HSCRC lacks the statutory authority to set physician reimbursement, HSCRC policies such as Revenue for Reform (R4R) have set the precedent that regulated revenue may be used to support physician costs.

In the R4R policy, it specifically carves out a Physician Spending Safe Harbor which allows the hospital to include spending on primary care, mental health providers, and dental providers in a Health Professional Shortage Area or a Medically Underserved Area. It is unclear why the HSCRC's statutory authority may be allowed for this purpose but not allowed to address physician losses for hospital-based physicians.

Hospitals Cannot Continue to Absorb Financial Losses

In addition to mounting physician losses, the recently negotiated Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model agreement with the Centers for Medicare and Medicaid Innovation (CMMI) contemplates $870 million in Medicare and Medicaid payment cuts to Maryland hospitals over the next several years. This is in addition to significant Medicaid payment reductions due to Medicaid disenrollments precipitated by HR 1, bringing the total cuts to Maryland hospitals to over $1 billion.

Although the magnitude of these cuts is well known, the proposal for the state to only shift $435 million to the commercial insurers leaves Maryland hospitals in a position of determining which clinical programs or community access points may need to be reduced or eliminated, all while the commercial insurers continue to reimburse Maryland's hospitals and physicians at some of the lowest rates in the country.

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

Sincerely,

Beau Higginbotham
President & CEO

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

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January 5, 2026

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

Dear Executive Director Kromm:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to comment on principles for potential state initiatives regarding physician costs. As noted in your Call for Comments, the Health Services Cost Review Commission (the Commission) has regulatory authority over hospital costs, not physician costs, and therefore does not have the authority to increase regulated hospital rates based on the cost of unregulated services.

Moreover, the Commission's own data shows that aggregate physician costs in Maryland are at or above economically comparable regions. While Maryland physician rates tend to be low, relative to other states, Maryland physicians bill a much higher rate of RVUs per capita. The Commission's own study, as well as data from the Bureau of Labor Statistics or the Census Bureau, shows that aggregate physician reimbursement is adequate in Maryland.

We understand that health systems in Maryland incur substantial losses by employing physicians, but that is not unusual or unique to Maryland. Reimbursement systems in Maryland and the rest of the country split the cost of a service into a bill for the physician service and a bill for a hospital service. The hospital portion is typically higher, enabling the hospital to employ physicians at a salary that exceeds the aggregate revenues generated by the physician. While an odd feature of American healthcare financing, it is the norm in the rest of the nation. The Commission has shown that aggregate subsidies in Maryland are roughly equivalent to the rest of the country.

The Commission has historically evaluated total hospital operating margins (net of regulated profits and unregulated losses) to assess the financial health of the industry. Total operating margins were deemed within a reasonable, sustainable range and improving, even before the data reflects a generous update factor in 2025 and numerous other off-cycle rate increases. As such, the Commission's Call for Comments searching for ways to increase funding for services outside its regulatory purview lacks justification.

Under AHEAD, the Commission has an opportunity to experiment with transformational payment reforms to improve care and outcomes for patients. If the Commission seeks to improve outcomes through payment model design, they should be calling on the industry for comments about the next steps in the evolution of value-based payment, such as capitation, or how we might set new standards for enhanced primary care models in Maryland. These have the potential to drive systemic changes, improve care, and reduce costs – all consistent with AHEAD's goals.

The Commission should not simply provide further subsidies for physician costs without accountability for outcomes or costs.

Thank you again for the opportunity to comment on this topic. We look forward to working with the state on issues that can further the AHEAD model's goals of improving quality and health outcomes while lowering costs.

Sincerely,

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

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4000 Nexus Drive
Wilmington, DE 19803
www.christianacare.org

January 5, 2026

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

Submitted by email:

Re: Draft Recommendation: Principles for Physician Payment

Dear Dr. Kromm:

ChristianaCare, Union Hospital welcomes the opportunity to provide feedback on the principles for physician payment recently released by the Health Services Cost Review Commission (HSCRC). We appreciate the Commission's acknowledgement of the substantial financial losses Maryland's hospitals – including ChristianaCare, Union Hospital – incur due to the rising costs of employing or contracting with essential physicians.

As a community-based full-service hospital, ChristianaCare, Union Hospital experiences firsthand the unsustainable pressures associated with employing or contracting with hospital-based and specialty physicians necessary to provide daily, lifesaving care. The current global budget and rate structure does not include a funding mechanism that enables hospitals to recover expenditures for physician services that are not fully reimbursed by payers. Without policy intervention, these losses are not sustainable, especially as the state and its providers transition to the AHEAD Model.

ChristianaCare, Union Hospital strongly supports the principles articulated by HSCRC as a foundation for a policy solution. Any approach should ensure that hospitals receive adequate, standardized, and broadly available support to cover losses on essential physician services required to operate an acute care hospital, with the flexibility necessary to reflect the specific needs of our communities. Furthermore, any support should be paired with efforts to address underlying cost drivers, which include policies or contracting approaches that increase professional reimbursement and reduce losses for physician services.

Consistent with the recommendations of the Maryland Hospital Association (MHA), ChristianaCare, Union Hospital supports HSCRC adopting a funding mechanism that enables hospitals to recover expenditures for physician services not fully reimbursed by payers through an increase in

hospital rates. ChristianaCare, Union Hospital also supports complementary strategies to address underlying cost drivers, including consideration of professional reimbursement floors tied to the Medicare physician fee schedule and adjustments to commercial payment differentials. Such approaches would help stabilize hospital finances while promoting longer-term sustainability and alignment with value-based care objectives.

ChristianaCare, Union Hospital appreciates the opportunity to provide input and stands ready to work with HSCRC, MHA, and state partners to identify and implement a policy solution that preserves access to essential care for the communities we serve.

Sincerely,

Meredith D. Tweedie

Meredith Stewart Tweedie, J.D.
Vice President of Government Affairs, Policy & Regulatory Strategy
ChristianaCare™

Frederick Health
400 West Seventh Street
Frederick, MD 21701
240-566-3300

January 5, 2026

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

Dear Dr. Kromm:

On behalf of Frederick Health and the patients and communities we serve, I am writing to provide comments on the principles for physician payment recently released by the Health Services Cost Review Commission (HSCRC). As a community hospital in a growing county, Frederick Health is acutely aware of the mounting financial pressures associated with maintaining essential physician coverage. We appreciate the Commission's recognition of these challenges and urge swift policy action to ensure hospitals like ours can continue to provide high-quality, accessible care.

Losses on Physician Services are Significant and Rising

Frederick Health, like many Maryland hospitals, faces unsustainable growing costs to employ or contract with physicians necessary for daily, lifesaving care. The current global budget and rate structure does not provide a mechanism for hospitals to recover expenditures for physician services that are not fully reimbursed by payers. These losses are unsustainable, especially as Maryland transitions to the AHEAD Model. Without relief, hospitals such as Frederick Health risk financial instability that could threaten our ability to sustain core operations and preserve access to care for our community.

Many of these services are provided by independent physician groups that would not be able to provide services unless the Hospital agrees to make them whole through the payment of a subsidy. In such cases, the Hospital has no opportunity to bill for any offsetting professional revenue. Instead, the subsidy is a cost the Hospital must absorb to provide the associated regulated services to its patients. As an example, the Hospital contracts an anesthesia group to provide hospital-based anesthesia services. The subsidy to continue providing these services grew by $1.3M in FY25 and is expected to grow an additional $4.5M in FY26. No part of this cost has been considered by the Commission to be a "hospital cost," and there is nothing included in the Hospital's rates to cover it.

We appreciate HSCRC's efforts to collect and analyze data on clinical compensation costs. The data presented at the October 8 Commission meeting, as well as our own internal analysis, confirm that the net losses associated with physician services are substantial and growing. Hospital-based clinicians, including anesthesiologists, hospitalists, and emergency medicine physicians, account for the greatest share of these losses. As shared in previous comment letters and onsite visits with HSCRC leadership, Frederick Health continues to subsidize hospital-based provider costs that have deteriorated operating margins and days cash on hand, thus preventing reinvestment in workforce to retain and recruit at staffing levels that prevent

burnout and delays in care. Total subsidized cost of hospital-based provider services is expected to grow from $24 million in FY25, to approximately $32 million in FY26. The increased cost of providers employed or contracted, without adequate reimbursement, jeopardizes our ability to provide care and in addition, prompts the need to reduce capital spending on routine clinical care and aging plant infrastructure.

Principles for a Policy Solution

Frederick Health supports the principles outlined below as a foundation for policy action. Any solution should:

- Provide adequate support for hospitals to cover losses on physician services, using a reasonable benchmark and standardized methodology.
- Appropriately consider provider subsidy costs as hospital costs required to provide regulated services when establishing reasonable regulated revenue rates.
- Be available to all hospitals, with flexibility to address the unique needs of different communities and provider types.
- Pair financial support with efforts to address underlying cost drivers, including policies to improve physician reimbursement rates.
- Consider a funding mechanism that enables hospitals to recover expenditures for physician services not fully reimbursed by payers.
- Consider a funding mechanism for non-teaching hospitals that provides funding for hospital-based physician costs proportionate to GME funding.
- Support establishing a floor for physician reimbursement based on a percentage of the Medicare physician fee schedule.

HSCRC's Statutory Authority

While HSCRC may not have the authority to directly regulate physician charges, we believe the Commission can and should provide support for physician costs through hospital rates and global budgets under its existing statutory authority. For example, the Commsission should treat the subsidy the Hospital pays its contracted anesthesiology group the same way it teats any other surgery-related costs (e.g., employed and agency nurses) in assessing whether the Hospitals' total costs are reasonable and whether the hospital's aggregate rates are reasonably related to the hospitals' aggregate cost. In other words, the subsidy is a legitimate cost the hospital incurs to operate its regulated service lines and therefore should be considered by the Commission when determining whether the Hospital has sufficient resources to operate its regulated services. This in no way asks the Commission to review and set physician charges or to otherwise regulate physicians. If there is uncertainty, Frederick Health supports legislative action to clarify the Commission's authority.

Frederick Health

Frederick Health
400 West Seventh Street
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240-566-3300

Maryland hospitals, including Frederick Health, are facing unsustainable financial losses due to the rising costs of employing or contracting physicians. Set-aside funding provided in FY25 while helpful, was not permanent. The subsidies described above have continued and escalated far above previous years. This crisis threatens our ability to sustain core operations and preserve access to care for the communities we serve. We urge the Commission to act swiftly to address this issue and stand ready to support efforts to identify and implement a policy solution.

Sincerely,

Hannah Jacobs

Hannah Jacobs
Sr. Vice President and Chief Financial Officer
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E: 203178

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Frederick, MD 21701

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

Maryland

MDH Maryland-Model -MDH- <[redacted]>

FW: Council on Financial Policy: MHA Request for Feedback | HSCRC Principles for Physician Payment

3 messages

Boucot, Mark <[redacted]> Tue, Dec 30, 2025 at 12:35 PM
To: "MDH.Maryland-Model@maryland.gov" <[redacted]>
Cc: "Terry, Tequila" <[redacted]>, "Boothe, Amy" <[redacted]>, "Carlson, Patrick" <[redacted]>, "akellermann[redacted]" <[redacted]>

Happy New Year and thank you for sending the information request from the CFP.

For the MHA folks, I apologize that we have missed the commentary that you requested by 12-18-25.

From our perspective at GRMC, below is our feedback for the physician payment principles:

1. We believe the top two priorities are principle #5 and principle #1.

   To have a broad impact, inclusion of CMS is paramount. Further, alignment of physician incentives to the Maryland Model will contribute to the success.

2. We are not sure about the inclusion of principle #4, as various hospital-based physician services can have varying effects on cost reduction initiatives.

For example, hospital-based pathologists would have minimal ability to control costs compared to hospital-based surgeons.

3. We feel strongly that #2 and #3 are the most appropriate principles related to physician funding, which accounts for quality and not a flat payment rate. Further, we maintain that quality-based incentives should be structured to improve patient safety, optimize where patients are treated in the continuum, reduce in-patient utilization, and ultimately assure effective patient outcomes. In evaluating #2 and #3, the GRMC perspective is that funding for physicians should be merit-based on adherence to quality initiatives that are centered on reducing readmissions, reducing hospital acquired conditions, and support initiatives that are part of a value-based payment program.

4. When considering the “necessary” physicians for hospital operations, we feel that emergency room, hospitalists, anesthesia, pathologists, general surgery, and infectious disease providers should all be included in the scope of provider payments. Following the proposed net approach, which accounts for the professional payments reducing the cost, is a fair methodology. This should be a net payment method – not gross charges and should be an all-in rate for provider costs including benefits and additional direct provider expenses. Notwithstanding, each hospital will need to assure FMV for provider total compensation.

Thank you for the opportunity to comment.

Best Regards,

Mark Boucot, CEO

Amy Boothe, CFO-COO

KAISER PERMANENTE®

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

January 2, 2026

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

RE: Principles for Physician Payment

Dear Dr. Kromm:

Kaiser Permanente appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) Draft Principles for Physician Payment. The Commission's October Clinician Cost Schedule report concluded that professional fees only covered about 40% of the cost of clinician services. Based on data from 38 hospitals, the Commission determined that the total direct cost of clinician services for the survey period was $1.49 billion, of which only $600 million was covered by offsetting revenue from professional fees bills to payors. Accordingly, the analysis determined that $890 million (~60%) of clinician services was unreimbursed.

The report notes that in order to understand the overall nature of net unreimbursed costs of clinician services borne by hospitals, the HSCRC needs to define types of arrangements hospitals use to employ and contract physicians and other healthcare providers. KP agrees that accounting for this factor is critical to accurately evaluating the nature of these unreimbursed costs.

Kaiser Permanente is an integrated healthcare delivery system that provides health plan coverage and coordinated medical services for its members. KP has over 750,000 members in the Mid-Atlantic States Region, which includes Maryland. KP is the largest Medicare Advantage and second largest Commercial insurance carrier in the state. While KP does not operate its own hospital facilities in Maryland, it partners with a network of "core hospitals." Although KP members can access emergency services at any hospital and utilize non-emergent services when clinically appropriate in non-core hospitals, the majority of hospital utilization for KP members occurs at core hospitals.

KP's partnership arrangement with core hospitals is unique: KP physicians and staff are embedded in these hospitals to provide direct care to KP members and coordinate their care within their integrated delivery system. Since the physicians and staff are Kaiser Permanente employees, KP pays the salary and benefits of these health care providers. As a result, the cost of clinician services for KP members seen at core hospitals is covered by Kaiser Permanente.

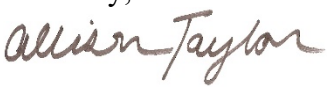
This model provides a significant benefit to the hospitals that KP works with, preventing the hospitals from having to employ or contract with additional providers to care for these patients. This is even more important given that hospitals are incurring growing financial losses across the physician enterprise, partly due to low professional fee reimbursement from other commercial payers.

The KP model is also advantageous for hospital patients. Because Kaiser Permanente is uniquely able to partner with hospitals on care coordination, KP patients who are seen at a core hospital have a 1-1.5-day shorter length of stay than other patients and are far less likely to be readmitted. Kaiser Permanente's mid-Atlantic health plans are consistently rated among the best in the nation for patient outcomes.

Kaiser Permanente supports the draft Principles for Physician Payment, which align with our value proposition of improving quality and health outcomes while reducing overall system costs.

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

Sincerely,



Allison Taylor
Director of Government Relations
Kaiser Permanente

Luminis Health℠

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LuminisHealth.org

January 2, 2026

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

Re: Principles for Physician Payment

Dear Dr. Kromm,

Thank you for the opportunity to provide comment and feedback on the proposed principles for physician payment. The rising cost of physicians outpaces inflation and the continual evolution of the delivery of care have become more than significant to the operations of hospitals. We appreciate the Commission's engagement in this important policy discussion.

Historically, volunteer medical staff affiliated with hospitals provided care within the hospital setting based on their participation in the medical staff organization. Patients admitted to the hospital by the volunteer medical staff received comprehensive services—nursing, pharmacy, imaging, care management, and operative care when needed. In return, physicians were expected to provide call and coverage for acute care needs. These expectations were defined in medical staff bylaws and approved by the health system's board. That relationship has fundamentally changed.

Today, it is best characterized as transactional. Coverage of clinical services is no longer tied to medical staff privileges; instead, coverage must be acquired as a direct purchased service where hospitals must bear the costs of these services without necesary funding sources. Physicians now often hold dual roles—both as medical staff members and as employed or contracted providers. The responsibility for admissions, discharges, and consultative services—required 24 hours per day, 365 days per year—now falls squarely on the health system.

Labeling these services simply as "hospital-based" or "non-hospital-based" is overly simplistic and, at times, misleading. The financial and operational demands associated with these clinical services, combined with the evolving relationship between clinicians and health systems, have reshaped how organizations manage efficiency, quality, patient experience, and their broader community mission. These services, much like nursing or pharmacy, are now embedded into the essential cost infrastructure of every health system; however, the reimbursement model does not fully recognize them. Furthermore, efforts to reduce costs without recognizing the operational realities overlook the complex challenges facing our organizations. A clear distinction must be made between call coverage and staffing the hospital and both costs must be recognized as the HSCRC evaluates policies to support these fundamental clinical structures.

Every health system, with well-measured volumes and acuity, relies on clinical services of the types described above. Funding for physician services should align with longstanding policies that guide equitable distribution of resources across systems.

In addition to our perspectives above, we also offer some specific feedback on the principles as you have outlined them as follows:

Principle 1: Funding for physicians should focus on hospital-based physicians necessary for the administration of an efficient hospital.

We disagree that this principle adequately encompasses the concepts of modern healthcare and encourage the Commission to think more globally, rather than narrowly defining physicians as "hospital-based", or in considering only physician costs that are categorized as necessary for the administration of a hospital. As we have previously described, the operations of a hospital and the evolution of the physician relationships have resulted in a different operating model and cost structure that are not considered in this principle.

Furthermore, the objectives for funding physician costs should be to ensure access to care, improving quality and improving health outcomes. The investment in physicians is not necessarily correlated to reducing costs or improving the efficiency of a hospital and the funding of such physician costs should not be treated as a reward or incentive for hospital efficiency. It would therefore be inappropriate to utilize hospital efficiency as a factor in funding physicians.

Principle 2: Funding for physicians should facilitate the goals of the Maryland Model, including improving quality, improving health outcomes and reducing overall costs.

We concur that the funding of physicians should facilitate the goals of the Maryland model to improve quality and improve health outcomes. In addition to the goals outlined in Principle 2, we strongly believe that the Maryland Model also includes these core goals:

- Ensuring high-value care
- Improving access to care
- Promoting health equity

Achieving these goals, along with proposed structures within the AHEAD model requires the deployment of physicians across **both** acute and ambulatory care settings. To truly "facilitate the goals of the Maryland Model, the physician coverage obligations borne by health systems must be explicitly recognized and adequately funded.

Principle 3 - Funding for physicians should be paired with efforts to reduce underlying cost drivers.

One of the primary keys to success in the current hospital operating model is the reduction of costs. Hospitals throughout the state have already implemented initiatives with a focus on reducing the underlying costs of operations including physician costs to the extent possible. As a state, Maryland has established its own set of quality metrics and encouraged hospitals to meet risk-adjusted performance targets. Health systems have built structures that support improved care and enable financial benefit under HSCRC policies. These performance-based incentives are already integrated into relationships between clinicians and health systems. Therefore, new models of quality improvement or cost reduction beyond those that already exist is unnecessary, creates further complexity and may in fact be counterproductive to efficient operations.

Principle 5 - Funding for physicians should be coordinated with CMS so that Medicare and Medicaid participate.

We concur that funding for physicians ideally should be coordinated with CMS so that Medicare and Medicaid participate. However, as we continue to move forward with a bifurcated system under the AHEAD model, there will likely be some divergence of policies or methodologies, and the Commission should consider a funding mechanism that could be independent of CMS. Specifically, the Commission should not limit its approach to policies or methodologies due to timing or to other differences with CMS. Instead, we encourage the Commission to boldly consider a policy that meets the principles and objectives of the unique Maryland model.

Sincerely,

S. Michelle Lee
EVP and Chief Financial Officer
Luminis Health

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, MD Vice Chairman
Jonathan Blum, MPP
Ricardo Johnson
Dr. Maulik Joshi
Nicki McCann, JD
Dr. Farzaneh Sabi

Maryland
Hospital Association

January 5, 2026

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the principles for physician payment recently released by the Health Services Cost Review Commission (HSCRC). We know that *Care Takes All of Us* and appreciate the Commission's recognition of the substantial financial losses hospitals incur due to the rising costs of employing or contracting with essential physicians and urge swift policy action to address this important issue.

It is becoming increasingly expensive for Maryland hospitals to maintain essential physician coverage. Physicians are critical to the ability of hospitals to provide lifesaving, acute care and other health care services that communities rely on. Given this, the exorbitant costs of employing or contracting with physicians and the corresponding financial losses are unavoidable since hospitals require sufficient medical staff to perform the basic functions of providing daily, lifesaving care to patients. The current global budget and rate structure does not include a funding mechanism that enables hospitals to recover expenditures for physician services that are not fully reimbursed by payers. These losses are not sustainable, especially as the state and its providers transition to the AHEAD Model. Without relief, hospitals will face financial instability and resource constraints that threaten their ability to sustain core operations and preserve access to care in every community.

MHA stands ready to support efforts to identify a policy solution. In the meantime, we offer the following comments for consideration as the Commission evaluates its engagement on this issue.

Losses on Physician Services are Significant and Rising

We appreciate HSCRC's efforts to collect actionable data through the clinician cost schedule (CCS) as part of regular hospital reporting and to leverage that data to inform policy discussions. Initial data presented by HSCRC at the Oct. 8 Commission meeting indicates a substantial net loss to hospitals associated with these expenses. Staff shared that in FY 2024, 38 of Maryland's 45 acute care hospitals incurred $1.49 billion in clinical compensation costs, but generated only $600 million in offsetting revenue, resulting in a net loss of $890 million .[1] Hospital-based

[1] These figures do not include clinician support costs.

clinicians, based on HSCRC's definition alone, accounted for $453 million (51%) in net losses, while surgical specialists ($233 million), non-surgical specialists ($155 million), and primary care providers ($54 million) accounted for relatively smaller losses. Among hospital-based physicians, anesthesiologists ($131 million), hospitalists ($108 million), and emergency medicine physicians ($63 million) contribute to the greatest losses.

An MHA survey of 38 of its member hospitals produced similar findings and found that net losses attributable to hospital-based physicians across all specialties grew by 55% between FY 2013, or the most recent period for which data was available, and FY 2023.[2]

Drivers of Increased Losses on Physician Services

As noted above, in recent years, Maryland hospitals have seen a significant increase in financial losses due to the rising costs associated with employing and contracting with physicians who are critical to the healthcare services provided by hospitals and health systems. This trend can largely be attributed to two factors: low physician reimbursement from commercial payers and an increase in private equity acquisitions of physician practices.

The Hilltop Institute, in a December 2025 report prepared for the Maryland Health Care Commission (MHCC), highlighted Maryland's relatively low physician reimbursement rates compared to other states.[3] The report cites a 2020 Health Care Cost Institute (HCCI) study that found, in 2017, Maryland's commercial physician reimbursement rates averaged 104% of Medicare rates, the third lowest among all states, and significantly lower than the national average of 122%.[4] While the data is based on claims from 2017, Hilltop notes, more recent data supports this finding. Another MHCC report found that average commercial reimbursement rates varied by provider specialty, with average payments for certain specialties including ophthalmology, dermatology, gastroenterology, psychiatry, and pediatrics lower than Medicare rates in 2021.[5] The same report found that reimbursement from all commercial payers declined from 2019 to 2020, and again from 2020 to 2021. Beyond the financial strain on hospitals, low reimbursement rates can threaten access to essential hospital care by making it more difficult to recruit and retain physicians. This further exacerbates workforce shortages and gaps in care, especially in underserved areas.

The expanding role of private equity in physician practice acquisitions is also a challenge. When private equity firms enter local markets, the costs hospitals incur to contract essential physician services often rise significantly. In certain regions of Maryland, private equity-backed physician practices now account for more than 30% of the market. Analyses show that such acquisitions frequently drive-up costs for both patients and employers. A national study shows that these acquisitions were associated with price increases in eight of 10 specialties, including oncology at 16.4%, gastroenterology at 14%, obstetrics/gynecology at 8.8%, and radiology at 8.2%.[6] These

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[2] Survey included 38 hospitals. Base years differ due to respondent data availability; 30 hospitals (FY 2013), 7 hospitals (FY 2016), 1 hospital (FY 2017). In comparing base years to FY 2023, MHA adjusted for inflation.
[3] 2025. The Hilltop Institute. Insurer and Provider Concentration in Maryland. Available here.
[4] 2020. HCCI. Comparing Commercial and Medicare Professional Services Prices. Available here.
[5] 2021. MHCC. Payments for Professional Services in Maryland (In-Network services only). Available here.
[6] 2023. American Antitrust Institute; Petris Center; Washington Center for Equitable Growth. Monetizing medicine: private equity and competition in physician practice markets. Available here.

price increases add financial strain, particularly in hospital-based specialties where rising contractual costs place an even heavier burden on hospitals. The continued growth of private equity-backed practices introduces new pressures that add to hospitals' financial responsibilities and can affect access to care. Ongoing monitoring will be important to understand how these dynamics evolve over the next several years.

Principles for a Policy Solution

The set of principles shared by HSCRC lays a strong foundation for a policy solution. Any approach advanced by the state should provide sufficient support for hospitals to preserve access to essential care by covering losses on physician services, include a reasonable benchmark and standardized methodology, and be designed to address needs at all hospitals.

At a minimum, the policy should provide funding for physician services that are necessary to operate an acute care hospital and preserve access to essential hospital care, including but not limited to hospitalists, emergency department physicians, anesthesiologists, behavioral health specialists, radiologists, gastroenterologists, infectious disease specialists, intensivists, and obstetricians. The approach should include flexibility to tailor support based on which provider types and services are most needed in specific communities. Furthermore, any support should be paired with efforts to address underlying cost drivers, which could include policies or contracting approaches that increase professional reimbursement and reduce losses for physician services.

MHA supports a funding mechanism that enables hospitals to recover expenditures for physician services not fully reimbursed by payers through an increase in hospital rates. The policy could initially provide full funding for losses on physician services with a gradual decrease over time to incentivize improvements in negotiated contractual arrangements and encourage adoption of other policy solutions to address low physician reimbursement. MHA also would support efforts to establish a floor for physician reimbursement based on a percentage of the Medicare physician fee schedule and adjusting commercial differentials to enforce these requirements to more directly address a root cause of losses on physician services

HSCRC's Statutory Authority

Along with the principles for physician payment, HSCRC shared that it cannot provide funding to support physician costs under Maryland statute. While the Commission may not have the authority to directly regulate physician charges, it has the responsibility to ensure the rates set for regulated hospital services are reasonably related to the hospital's aggregate costs.[7] Given the expenses associated with employing or contracting with hospital-based physicians are essential to the operation of hospitals and their ability to provide regulated acute care services, these costs must be considered when determining whether regulated rates are sufficient. Therefore, we believe HSCRC can provide support for physician costs through hospital rates and global budgets under its existing authority. If there is any uncertainty on this matter, MHA supports a legislative remedy to clarify the Commission's statutory authority.

[7] *See* Section 19-219 of the Health-General Article.

Maryland hospitals are facing unsustainable financial losses due to the rising costs of employing and contracting with physicians. This growing crisis threatens hospitals' ability to sustain core operations and preserve access to care for the communities they serve. MHA urges swift action to address this important issue and ensure every Marylander has access to necessary care. We welcome the opportunity to support the state's efforts to identify a policy solution.

Sincerely,

Melony G. Griffith
President & CEO

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

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CORPORATE OFFICE

January 5, 2026

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

Re: HSCRC development of principles to support decision-making on potential physician cost initiatives.

Dear Dr. Kromm:

The University of Maryland Medical System (UMMS) appreciates the opportunity to provide input to the Health Services Cost Review Commission as it considers principles to inform potential state initiatives related to hospital-based physician costs. UMMS values the Commission's willingness to engage stakeholders on this complex issue and recognizes the statutory and policy constraints under which the Commission operates. We view this process as an important step in ensuring that Maryland's unique model remains sustainable in the face of evolving workforce, market, and care delivery dynamics.

UMMS is deeply committed to the State of Maryland and to preserving access to high-quality, efficient care for the communities we serve across the state. As the largest academic health system in Maryland, we experience firsthand the essential role hospital-based physicians play in maintaining access, safety, and quality, particularly as hospitals are increasingly relied upon to deliver care under constrained revenue growth and shifting payment incentives. Our comments are offered in the spirit of collaboration and are intended to support shared goals of sustaining access to care, advancing quality and outcomes, and preserving the long-term success of Maryland's Model framework.

I. Policies to address physician expenses should prioritize Maryland's rate-setting statute to ensure charges are reasonable to costs and hospitals are financially viable. Alignment to Model goals with CMS should be incorporated when possible, and only after the primary statutory obligation is met first.

A core reality of hospital operations is that physician costs are structural, not discretionary. Before Model priorities, hospitals must be able to ensure coverage for acute services, day-to-day

efficiencies and optimized throughput, access to trauma and emergency care, and other critical hospital operating requirements are met.

The amount that UMMS invests annually in physician support is growing faster than regulated revenue and non-physician components of hospital cost due to national labor market dynamics. These investments are overwhelmingly tied to essential hospital operations, not discretionary growth or margin generating activity.

Key facts HSCRC policy must acknowledge:

- Physician compensation is market-driven, not Maryland-driven and Hospitals must pay national market rates to recruit and retain physicians
- Nearly all hospital-based physician roles generate operating losses, but unavoidable, this dynamic is not well understood or accounted for in our rate-regulation policies.
- Investments in most hospital-based and acute coverage required specialties do not accrue to unregulated profitability. Unregulated profitability is largely driven by geographic market strength and elective services volume.
- The AHEAD Model is a test for CMS innovation, population health improvement goals and primary care access expansion efforts will be limited when hospitals must first fund core patient operations and services to communities.

The historical assumption embedded in statute—that hospitals could operate without compensating physicians for call, coverage, care coordination, or medical leadership—is increasingly less economically and operationally viable and our ability as a state to uphold rate-setting statute is at risk.

II. Maryland's Model has changed physician incentives and hospital efficiency incentives are fundamentally divergent under global budgets from a competitive physician market.

Under Maryland's Model, incentives to grow volume are limited by global budgets and corresponding policies. Consequently, physicians may require higher subsidies to cover care in the hospital as their billing is constrained in turn with volumes. The price hospitals must pay to recruit, retain and incentivize physicians does not reduce as volumes do, and if it were to, Maryland would risk further supply issues with high-value physician care.

In contrast, in non-regulated states, hospitals subsidize physicians for some effective throughput and coverage needs, but also because increased volume generates downstream margin and revenue. Physician recruitment and market competitiveness is tied to growth strategies Maryland hospitals are structurally disincentivized from pursuing under the global budget system. UMMS does not see this dynamic as positive, as these strategies often leave lower income, rural and other disadvantaged communities with distinct access issues. Rather, UMMS implores the State to

consider how we may better align physician incentives with our rate-setting system, while maintaining a healthy supply in Maryland.

B. Maryland's physician supply is impacted by policy actions and the private insurance marketplace. Policies should be evaluated for downstream effects on physician supply.

Maryland is not insulated from national physician markets—and in some cases, the model exacerbates competitive disadvantages. High-demand specialties (e.g., spine surgery, orthopedics, GI, neurosurgery) can command substantial hospital support outside Maryland. As mentioned prior, inside Maryland, hospitals lack financial flexibility to recruit those physicians. As a result, physicians choose to practice elsewhere, constraining access, innovation, and efficiency. The inability to align physician incentives with inpatient program development materially affects Maryland's competitiveness as a clinical destination.

Further exacerbating supply, payer market consolidation in Maryland allows for rates to be constrained below national markets. Maryland currently ranks X in physician payment, despite being X in income nationally. Certain physician specialties are incentivized to form large groups to negotiate more sustainable payments, these contracted groups in turn may be the lone or few suppliers of required hospital services, such as radiology, anesthesiology or urology care, further distorting the market dynamics and cost optimization available to hospitals. A dominant commercial payer with little competitive pressure to raise rates will impact hospital financial pressures in years to come. Small and mid-sized physician practices that can localize, partner and collaborate with hospitals on population goals are reducing. The physician supply trend of consolidation into large entities with greater pricing power provides fewer contracting options for hospitals and increased expense/subsidy. This is not a hospital-created problem—it is a market structure outcome that directly drives physician costs.

III. Employed vs. Contracted physician costs should remain at the operational discretion of hospitals and are market-driven, not discretionary.

Hospitals already deploy the most cost-effective, operational model available on a specialty-by-specialty basis. HSCRC should not attempt to dissect or regulate this across the state. Some services are more efficient when contracted (e.g., emergency medicine groups with national revenue cycle scale and expertise).Others are more efficient when employed (e.g., anesthesiology when private-equity models inflate costs to hospitals or a physician need is more specialized) Decisions are made case-by-case, balancing, Cost, Quality, Coverage reliability, teaching and ability to meet non-billable hospital needs.

From a policy standpoint, HSCRC should assume hospitals are already being highly disciplined stewards of physician related expenses, as with other expenses, because these costs directly erode

operating margin. Further regulation or attempt to dissect between appropriate employed vs. contracted physician expense will not result in more complete policy and increase administrative burden on hospitals.

Sincerely,

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services

cc:

William Henderson

Christa Speicher

Dr. Joshua Sharfstein, Chair

Jonathan Blum

Dr. James Elliot

Ricardo Johnson

Dr. Maulik Joshi

Nicki McCann

Dr. Farzaneh Sabi

January 8, 2026

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

Dear Dr. Kromm,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to comment on the principles for physician payment released by the Health Services Cost Review Commission (HSCRC).

JHHS aligns with the Maryland Hospital Association's comments on the principles for physician payment. Nationally and in Maryland, there is a clear and indisputable trend towards hospitals and health systems playing an increasingly large role in supporting physician payment. This issue is highly complex and will involve detailed analysis and discussion of various related considerations. JHHS urges the HSCRC to ensure a thoughtful and holistic approach to any policy-related discussions on the issue of physician payment and welcomes the opportunity to share further feedback on these complex topics as the discussion evolves.

JHHS appreciates the opportunity to provide feedback on this issue and looks forward to further collaboration on critical considerations as the State prepares to move into the AHEAD model.

Sincerely,

Ed Beranek

Ed Beranek
Vice President, Revenue Management and Reimbursement
Johns Hopkins Health System

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Jonathan Blum
Nicki McCann
Dr. Farzaneh Sabi

Healthcare Outcome Payment Effort

Foundational Context

- AHEAD is designed to reward prevention of illness and accompanying unnecessary hospital utilization.
- Taking advantage of this fundamental incentive is critical for success in meeting the goals of improving health outcomes and reducing costs.
- Feedback from stakeholders on the strengths and weaknesses of PAU, CTIs, and other HSCRC initiatives has led to the development of a next generation framework.

Planning Stages

- HSCRC is in the early stages of designing and developing this proposal.
- This draft is intended as a starting point and will be advanced through the TCOC workgroup process.
- We are actively seeking feedback to refine and strengthen the proposal.
- Stakeholder engagement is critical to the success of this effort and will shape how we support hospitals and health systems in improving population health under AHEAD.

Key Principles

- Align with AHEAD's goal to drive state and regional health care transformation to improve the total health of a state's population while lowering costs
- Offer clarity for hospitals and others about return on investments to prevent illness and accompanying utilization
- Build on progress to date in CTIs and PAU policy
- Key role for HSCRC to be an outcome buyer of successful projects, with up front funds to be provided by philanthropy, hospital funds, other state funds, HSCRC care innovation awards, among other sources.

Revised CTI and PAU Program

- Replaces the CTI program while providing a framework for maintaining the underlying efforts.
- Creates a new Potentially Avoidable Utilization (PAU) program, by combining the current HSCRC PAU program with a voluntary, upside only, incentive-based program.
- Hospitals define populations, implement interventions that are qualified for the program in advance, and demonstrate reduced ER and hospital expenditures.
- Hospitals can then receive a portion of the outcome payments for a fixed future period to continue the work.

Regional and Statewide Initiatives

- Rewards statewide and regional innovations that reduce illness and accompany hospital utilization.
- Each project addresses a specific population, with specific targets for reduced hospital utilization.
- Each project, if successful, would be able to claim a portion of the reduced costs as outcome payments for fixed future period to continue the work.
- Each project would be would be reviewed, qualified in advance, and endorsed by a vote of the HSCRC.
- Some of these projects may relate to AHEAD opportunities to move savings forward.

Next Steps

- **January**
  - Workgroup meeting on January 28, 2026 from 8-10am
    - Link to register here
- **February**
  - Comments due by 2/13
  - Additional TCOC workgroup meeting on 2/18 to discuss comments
  - Review comments and present revised policy at 2/25 TCOC workgroup meeting
- **March**
  - Draft commission recommendation
  - Review comments received from commission meeting with TCOC workgroup
- **April**
  - Final commission vote and program buildout
- **July**
  - Outcome payment program start July 1, 2026

Request to Access HSCRC Confidential Patient Level Data from The University of Maryland School of Medicine Final Staff Recommendation

STAFF RECOMMENDATION

- HSCRC staff recommends that the request by the University of Maryland School of Medicine for the Data for Calendar Years 2018 through 2025 be approved.
- This access will include limited confidential information for subjects meeting the criteria for the research.

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Final Staff Recommendation for a

Request to Access HSCRC Confidential Patient Level Data from

The University of Maryland School of Medicine

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

This is a final recommendation for Commission consideration at the July 30, 2025, Public Commission Meeting.

SUMMARY STATEMENT

The University of Maryland School of Medicine (UMSOM) requests access to the Statewide Confidential Hospital Discharge Data Sets (Inpatient) and Hospital Outpatient Data Sets (Outpatient) collected by the Health Services Cost Review Commission (HSCRC) to examine long-term outcomes among young adults following participation in Coordinated Specialty Care (CSC) programs for early psychosis. CSC programs have demonstrated positive impacts on clinical and functional outcomes during the standard two-year treatment period; however, little is known about whether these gains are sustained after treatment ends. This gap in knowledge is particularly concerning given high rates of treatment dropout and the absence of a unified national strategy for care transition. The proposed study will identify predictors of relapse, regression, or continued recovery post-CSC and evaluate patterns of healthcare utilization following program completion. Findings will inform evidence-based practices for care transition and continuity of support, ultimately guiding improvements in mental health systems and policy to optimize long-term recovery for individuals experiencing early psychosis.

OBJECTIVE

This project will characterize patterns of healthcare service use and mortality among participants in two Coordinated Specialty Care (CSC) programs for early psychosis during treatment and up to two years post-discharge. By linking CSC program data with statewide hospital discharge and outpatient datasets, we will describe post-treatment trajectories of service utilization, rehospitalization, and mortality, and generate survival curves to illustrate longitudinal outcomes. This analysis will provide stakeholders with critical insights into what happens after CSC, addressing a major gap in understanding continuity of care for young adults with early psychosis. In addition, this project will compare service use and mortality between individuals who complete CSC treatment and those who leave early, using regression models to identify differences in outcomes and potential risk factors. Results will inform strategies for improving care transitions, reducing relapse and mortality, and guiding policy and programmatic decisions to optimize long-term recovery for this vulnerable population. UMSOM received approval from the Maryland Department of Health (MDH) Strategic Data Initiative (SDI) office on November 14, 2025.

(The Data will not be used to identify individual patients. The Data will be retained by UMSOM *until project completion on October 3, 2026. At that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.)*

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

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

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

The Review Committee unanimously agreed to recommend that UMSOM be given access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by the University of Maryland School of Medicine for the Data for Calendar Years 2018 through 2025 be approved.

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

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Surge Funding Policy - Stakeholder Comments & Final Recommendation

January 2026

Summary of Public Comments

Topics	LifeBridge Health	Luminis Health	Adventist HealthCare	MHA	UMMS	HME Consumer Alliance	JHHS	CareFirst	MedStar
Use of Full-Year Data for Funding Calculations	✓	✓	✓	✓	✓	✓	✓		✓
Methodology for Calculating Surge Funding	✓	✓	✓	✓	✓		✓		✓
Length of Stay Incentives				✓	✓		✓	✓	
Timing and Process for Funding Adjustments			✓		✓			✓	✓
Alignment with Broader Policy Initiatives			✓	✓			✓		

- Staff received comment letters from nine stakeholders regarding the Draft Recommendation on Surge Funding
- The comments from stakeholders can be broadly categorized into five areas of concern.

Use of Full-Year Data for Funding Calculations Comments

Overall Summary: Stakeholders broadly support using a full 12 months of data to calculate surge funding, emphasizing that funding should reflect actual, demonstrated need and not be constrained by arbitrary caps. Health Means Everything (HME) Consumer Alliance expresses concern about increased consumer costs if funding is expanded

Staff Response: ***Staff agree with utilizing a full 12 months of data in alignment with all other HSCRC volume methodologies, which assess volume changes across an entire year. Global Budget Revenue (GBR) volumes are budgeted prospectively and are intended to account for 12 months of actual experience, including seasonal fluctuations in demand. Therefore, assessments regarding volume surges should also be conducted on a 12-month basis to avoid arbitrary budget caps and to account for all available resources provided through a global budget.***

Adjusting GBRs based on the inadequacy of prospective budgeted volumes—considering the totality of the global budget rather than a subset or season—is consistent with the foundational language of the GBR contracts.

The impact of providing additional surge funding to consumers is minimal. As demonstrated by various staff analyses, this funding is necessary to support additional volumes not initially accounted for in hospital budgeted GBRs, particularly given the rise in respiratory-related conditions.

Comments were received from:	LifeBridge Health	Luminis Health	Adventist HealthCare	MHA	UMMS	HME	MedStar	JHHS

See appendix for comment details.

Pro Forma Impact of Surge Funding on Commercial Premiums

Similarly, the potential additional Surge Funding would be expected to **increase commercial insurance premiums by 0.0% to 0.1%** if all of the costs were passed on to consumers.

		$100M Funding Option	$125M Funding Option	$165M Funding Option	
Total Surge Funding	$	100,373,126	124,832,046	164,631,651	A
Surge Funding included in Rates		100,373,126	100,373,126	100,373,126	B
Incremental Surge Funding		-	24,458,920	64,258,525	C = A - B
FY 2025 Actual Total Hospital Charges	$	23,018,649,505	23,018,649,505	23,018,649,505	D
Incremental Surge Funding as a % of Charges		0.0%	0.1%	0.3%	E = C / D
Hospital Spend as a % of Total Healthcare Spend	$	37%	37%	37%	F
Expected Impact of Surge Funding on Commercial Premiums		**0.0%**	**0.0%**	**0.1%**	G = E * F

Sources:
HSCRC Experience Data
Hospital Spend as a % of Total per Maryland Insurance Administration (MIA)

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Methodology for Calculating Surge Funding (ECMADs vs. Patient Days) Comments

Overall Summary: Stakeholders generally support shifting toward a higher weight for ECMADs in the methodology, while maintaining some degree of blending with patient days. The most common proposal is a 33% ECMADs/66% patient days weighting for future years, with some advocating for a predominantly ECMAD-based approach to avoid unintended incentives related to length of stay or a 100% patient day approach given the nature of the surge cases. Some stakeholders also recommend having a transition period if there is a shift in methodology.

Staff Response: ***The current weighting methodology—66% patient days and 33% ECMADs—was established as a placeholder during last year's respiratory surges. At that time, the Commission expressed a desire to deemphasize patient days to avoid relying on antiquated volume statistics for global budget adjustments. Consequently, staff were directed during the July 2025 public meeting to analyze more appropriate weighting options.***

Staff conducted various analyses to estimate the degree to which surge situations account for LOS increases and based on those findings, staff recommend a revised methodology of 66% ECMADs and 33% patient days. This approach more fully utilizes ECMADs to avoid unintended consequences, such as inpatient length-of-stay exacerbation, while acknowledging that ECMADs may not capture all patient days associated with peak flu season case profiles.

Given that RY 2026 revenue adjustments have already been issued under the original weighting, Staff and stakeholders agree that the current methodology should remain in place for the remainder of RY 2026.

Moving forward, staff recommend adopting the new weighting for RY 2027 surge funding and beyond, with full funding to occur in the next fiscal year.

66% ECMAD 33% Patient Days	33% ECMAD 66% Patient Days	50% ECMAD 50% Patient Days	0% ECMAD 100% Patient Days
▪ **Staff Recommendation for RY 2027** ▪ LifeBridge ▪ Adventist	▪ JHHS ▪ Luminis[1] ▪ MedStar ▪ MHA ▪ UMMS	▪ Luminis[1]	▪ Luminis[1]

Comments were received from:	LifeBridge Health	Luminis Health	Adventist HealthCare	MHA	UMMS	JHHS	MedStar

See appendix for comment details.

[1] Luminis supports the 100% patient day methodology or a 50/50 blended methodology, but at a minimum requests maintaining the 33% ECMADs / 66% patient day split.

Length of Stay Incentives Comments

Overall Summary: Several stakeholders cautioned against implementing a separate IP LOS incentive policy, stating that such a policy could penalize hospitals for factors beyond their control. They recommend monitoring the length of stay rather than introducing independent incentives and favor approaches that minimize unintended consequences. If an IP LOS policy were to be implemented, stakeholders believe it should be done as a separate recommendation and allow for extensive workgroup and stakeholder engagement. Other stakeholders were supportive of the development of a LOS policy.

Staff Response: ***While the IP LOS Incentive Policy and the Surge Funding Policy are being developed independently, staff believe it is important to highlight the significant interaction between the two.***

There is a concern that providing surge funding may inadvertently disincentivize hospitals from managing length of stay (LOS) efficiently, which could negatively impact quality outcomes such as ED wait times and patient satisfaction. Currently, approximately 50% of surge funding for RY 2025 is allocated to hospitals with IP LOS levels exceeding national norms.

Staff acknowledge that hospitals cannot control every factor impacting LOS and that longer stays are sometimes necessary for optimal health outcomes. However, the overall growth in IP LOS is a concern that warrants further investigation. Notably, while admission volumes have declined over the course of the Model, patient days have remained relatively constant despite stable acuity levels (see next slide).

Key areas identified for improvement include; post-acute care discharges, behavioral health placements, the impact of prior authorization, and general throughput efficiency

Given the concern over the Surge Funding Policy's potential to increase IP LOS, staff are considering two additional recommendations for workgroup discussion

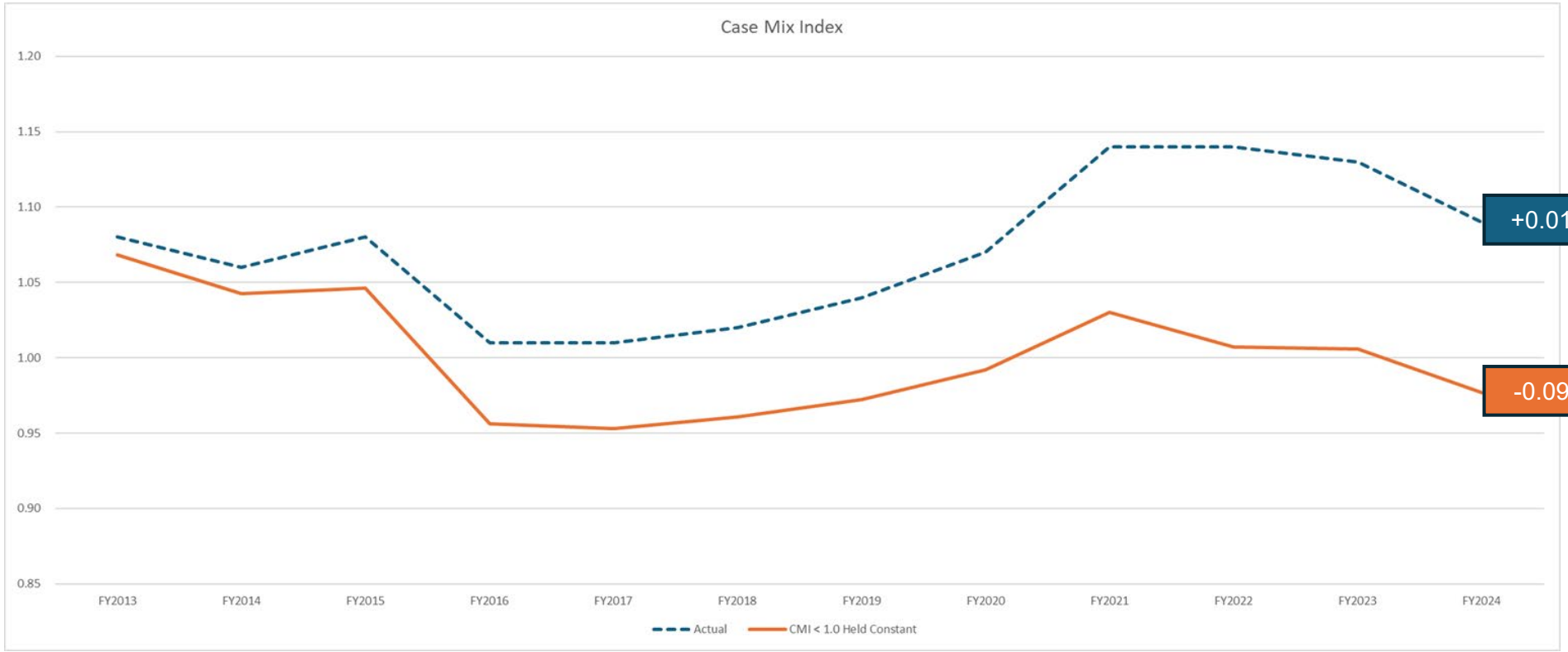
- ***If an IP LOS incentive is not established by June 30th, the surge policy be suspended until an IP LOS incentive is approved; alternatively,***
- ***If an IP LOS incentive is not established by June 30th, the Surge policy will be amended to only account for case growth (100% ECMAD evaluation)***

Comments were received from:	MHA	UMMS	JHHS	CareFirst

See appendix for comment details.

Adjusted CMI Trend

While actual statewide Case Mix Index has increased slightly, Staff's analysis suggests that the **shift of low-acuity cases** out of the IP setting is a larger driver of the increase than a more complex and older population.



- The **dotted blue line** represents actual statewide Case Mix Index, based on APR DRGs, calculated using the HSCRC data tapes.
- From FY2013 to FY2024, **actual CMI increased by 0.01**.

- The **orange line** represents the CMI if all DRGs with a CMI < 1.0 and a decline in admissions from FY2013 are held constant at FY2013 levels.
- This -0.09 indicates the **change in CMI if the shifts of low acuity cases to other settings had not occurred**.

Timing and Process for Funding Adjustments Comments

Overall Summary: Stakeholders generally support timely and transparent adjustment processes. There is broad support for using prospective estimates with reconciliation based on full-year data to ensure funding reflects actual experience and supports hospital needs. Many advocate for implementing incremental funding in January rate orders and providing surge funding in the same year rather than delaying to future rate years. CareFirst notes general concerns about the policy development process and recommendations for a more thoughtful and inclusive approach.

Staff Response: ***Staff understand the necessity of making resources available to hospitals so that they can continue to provide high quality care to patients. The intent of the surge policy is to provide hospitals with funding for additional costs incurred due to volume surges in the prior year. Delaying funding until July will be inconsistent with the intent of the policy. Staff already have the full 12-month amount necessary to fund surge, reconciling this amount in January is in keeping with the intent of the surge policy and follows the same timing and funding approach of the Quality Based Reimbursement (QBR) Policy and CDS-A.***

Staff also recommend issuing an additional $64M in lieu of $24M, as the former maintains the same weighting approach that was used in the RY 2026 Update Factor (or July rate orders).

RY 2026 Incremental Surge Funding	Timing & Process for Funding	Comments
$24M or $64M	***January RY 2026***	Provides all funding for volume surges in the prior year within the next year as intended by the Surge Funding Policy and follows the same timing and funding approach of the Quality Based Reimbursement (QBR) Policy and CDS-A
	July RY 2027	Would not be considered off-cycle adjustments as funding is handled in concert with the update factor thereby, ensuring total affordability for consumers and purchasers of healthcare services
		Con: Inconsistent with the Commission's typical practice of not delaying an adjustment when the relevant data is readily available
Staff Recommendation		
$64M	***January RY 2026***	**Aligns with current weighting and historical rate setting practice of adjusting rates as soon as data is available.**

Comments were received from:	Adventist HealthCare	UMMS	MedStar	CareFirst

See appendix for comment details.

Final Recommendations & Policy Considerations

- Funding provided in rate year 2026 should be based on the full fiscal year evaluation as this comports with the initial intention of the surge policy to assess the extent to which GBR budgeted volumes across the entire year may offset infectious disease surges.
    - Staff will consider timing and measurement period against any full rate review funding awarded (or other relevant funding mechanisms) and discount as needed
- Moving forward, staff recommend a 9-month estimate of surge funding be built into July rate orders and then reconciled in January rate orders based on the full fiscal year evaluation.
    - Staff will consider timing and measurement period against any full rate review funding awarded (or other relevant funding mechanisms) and discount as needed
- Staff defer to the Commissioners to consider amending the cap on surge funding in RY 2026, as the Update Factor recommendation was clear that the value regardless of the full year assessment is set at $100.4M. Options are as follows:
    - Full Rate Year Allotment- $164.6 based on 12 months of RY 2025 volume data with 66 percent patient day, 33 percent ECMAD evaluation to be implemented in January 2026 rate orders **(Staff Recommendation)**
    - Full Rate Year Allotment and Advancement to New Weighting Approach- $124.8 based on 12 months of RY 2025 volume data with 33 percent patient day, 66 percent ECMAD evaluation to be implemented in January 2026 rate orders
- Moving forward, staff recommend a 9-month estimate of surge funding be built into July rate orders and then reconciled in January rate orders based on the full fiscal year evaluation.
    - Staff will consider timing and measurement period against any full rate review funding awarded (or other relevant funding mechanisms) and discount as needed
- In RY 2027 and thereafter, any surge funding provided should be based on **66 percent ECMAD** evaluation and **33 percent patient day** evaluation, as there are analyses to support the need for some consideration of patient days, but to a lesser extent than ECMADs.
- Given the concern over the Surge Funding Policy's potential to increase IP LOS, staff recommend the adoption of an independent IP LOS incentive to be developed in concert with the Performance Measurement Workgroup. Staff propose that:
    - If an IP LOS incentive is not established by June 30, 2026, the surge policy be suspended until an IP LOS incentive is approved; alternatively,
    - If an IP LOS incentive is not established by June 30, 2026, the Surge policy be amended to only account for case growth (100% ECMAD evaluation)
- Hospitals accepting Surge funding should maintain or increase their staffing capacity to meet the needs of patients in Maryland.
- Hospitals should coordinate with respiratory virus prevention activities with Maryland Department of Health.

Appendix - Detailed Stakeholder Comments

Alignment with Broader Policy Initiatives Comments

Overall Summary: Stakeholders stress the importance of aligning surge funding policies with broader initiatives and caution against adding complexity during transitions.

Staff Response: ***Staff agree that the Surge Funding policy should align with broader initiatives and not add complexities as we transition to the AHEAD model***

Moving forward Staff will work with stakeholders to promote app, roaches under the Medicare and Non-Medicare HGBs that are analogous. Medicare's risk adjustment policies address some of this risk, but this may require additional consideration by CMS, a matter we plan to raise with them.

Comments were received from:	Adventist HealthCare	MHA	JHHS

See appendix for comment details.

Proposed Surge Funding Allotments

Reason for Allotment	*Update Factor Cap*	*Update Factor Cap*	*Full RY 2025 Allotment*	*Full RY 2025 Allotment*
Weighting	*1/3 ECMADs & 2/3 Patient Days*	*1/3 ECMADs & 2/3 Patient Days*	*1/3 ECMADs & 2/3 Patient Days*	*2/3 ECMADs & 1/3 Patient Days*
Data Period	*9-Months*	*12-Months*	*12-Months*	*12-Months*
Hospital Name	*Currently in Rates*	*Staff Report Out*	*Staff Recommendation*	*For Commissioner Consideration*
Johns Hopkins	$14,026,512	$20,028,816	$32,851,194	$22,570,701
Anne Arundel	$10,757,326	$9,461,990	$15,519,523	$11,685,614
Sinai	$7,775,162	$5,966,732	$9,786,613	$11,032,604
Peninsula	$7,345,706	$7,708,399	$12,643,290	$9,343,320
Carroll	$6,984,378	$6,109,941	$10,021,504	$7,651,843
Northwest	$6,639,657	$5,977,732	$9,804,655	$6,818,479
Frederick	$4,222,455	$4,636,930	$7,605,476	$6,493,282
Howard County	$4,532,684	$4,579,463	$7,511,219	$6,256,406
St. Agnes	$6,370,364	$5,053,142	$8,288,146	$6,012,547
Meritus	$3,689,794	$4,038,899	$6,624,587	$5,510,801
MedStar Fr Square	$3,218,330	$4,323,254	$7,090,986	$5,074,017
ChristianaCare, Union	$3,125,891	$3,009,902	$4,936,831	$3,923,947
HC-Germantown	$3,772,741	$2,017,206	$3,308,614	$3,454,816
MedStar Montgomery	$2,593,083	$2,194,885	$3,600,043	$2,969,056
UMMC Midtown	$472,761	$2,220,150	$3,641,482	$2,846,283
Mercy	$2,585,403	$2,214,963	$3,632,975	$2,579,710
MedStar Southern MD	$1,477,679	$1,792,849	$2,940,625	$2,468,371
UM-BWMC	$3,045,663	$2,956,685	$4,849,545	$2,424,773
MedStar St. Mary's	$1,844,500	$1,810,546	$2,969,652	$2,138,372
MedStar Union Mem	$1,592,907	$1,665,239	$2,731,320	$1,365,660
UMMC & Shock Trauma	$0	$1,464,988	$2,402,869	$1,201,434
Suburban	$2,245,992	$645,416	$1,058,610	$529,305
UM-Chestertown	$384,810	$294,731	$483,416	$241,708
MedStar Harbor	$641,407	$169,880	$278,637	$139,318
Garrett	$0	$30,386	$49,839	$99,678
UM-Charles Regional	$427,480	$0	$0	$0
UM-Easton	$600,441	$0	$0	$0
Statewide	**$100,373,126**	**$100,373,126**	**$164,631,651**	**$124,832,046**

Staff report out for RY 2026:

- Prior Commissioner vote caps total RY 2026 surge funding at $100.4M based on 9-month evaluation
- Staff recommend using 12-month evaluation
  - Funding is normalized so it is equivalent to the 9-month cap (see third column in table)

Other options for Commissioner consideration:

- New cap based on surge policy modelling using 12-months of RY 25 data and prior weighting approach (Staff recommendation)
  - 2/3 patient days, 1/3 ECMADs
  - Identifies $164.6M growth in respiratory surge cases
- New cap based on surge policy modelling using 12-months of RY 25 data and newly proposed weighting approach
  - 2/3 ECMADs, 1/3 patient days
  - Identifies $124.8M growth in respiratory surge cases

Pro Forma Impact of Surge Funding on Per Diem Charges

The potential incremental surge funding being discussed **does not have a material impact on costs**. Staff estimate that providing $24M in incremental Surge Funding would **increase average charges per patient day by $8 or 0.1%.** Providing $64M in incremental Surge Funding would result in a **$21 or 0.3% increase**

		$100M Funding Option [1]	$125M Funding Option [2]	$165M Funding Option [3]	
Total Surge Funding	$	100,373,126	124,832,046	164,631,651	A
Surge Funding included in Rates		100,373,126	100,373,126	100,373,126	B
Incremental Surge Funding		-	24,458,920	64,258,525	C = A - B
FY 2025 Actual Total Hospital Charges	$	23,018,649,505	23,018,649,505	23,018,649,505	D
FY 2025 Actual Patient Days		3,104,699	3,104,699	3,104,699	E
FY 2025 Actual Charges per Patient Day	$	7,414	7,414	7,414	F = D / E
FY 2025 Charges + Incremental Surge	$	23,018,649,505	23,043,108,425	23,082,908,030	G = D + C
FY 2025 Actual Patient Days		3,104,699	3,104,699	3,104,699	E
FY 2025 Charges + Surge per Patient Day	$	7,414	7,422	7,435	H = G / E
% Variance from Baseline			0.1%	0.3%	

Source: HSCRC Experience Data

[1] $100M 9-month amount currently in rates using 33% ECMADs and 66% patient days
[2] $125M RY25 12-month evaluation using 66% ECMADs and 33% patient days
[3] $165M RY25 12-month evaluation using 33% ECMADs and 66% patient days

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Use of Full-Year Data for Funding Calculations Comments

Overall Summary: Stakeholders broadly support using a full 12 months of data to calculate surge funding, emphasizing that funding should reflect actual, demonstrated need and not be constrained by arbitrary caps. Equity considerations, such as payer mix and support for hospitals serving vulnerable populations, are highlighted as essential. HME expresses concern about increased consumer costs if funding is expanded.

Organization	Summary of Comments
LifeBridge Health	LifeBridge endorses revising surge funding to reflect 12 months of volume experience, noting the full-year analysis shows greater respiratory case growth than the initial 9 months
Luminis Health	Luminis supports recognizing surge volume growth for the entire 12-month period, calling the 9-month cap arbitrary
Adventist HealthCare	Adventist recommends funding based on a full 12 months of actual experience, with reconciliation in January rate orders. They also urge that funding reflect full actuarial estimates and equity considerations for hospitals serving vulnerable populations
MHA	MHA urges updating funding to reflect the full year of RY2025 data, not just the first nine months/ They also stress funding should match resource needs and not be arbitrarily capped
HME	HME opposes increasing surge funding if global budgets already sufficiently fund higher volumes, warning about rising consumer costs and advocating for robust analysis before retrospective increases. HME also requests that the HSCRC clarify how funding adjustments will impact consumer costs
UMMS	UMMS strongly urges amending the funding cap to reflect a full 12 months of respiratory surge volume, stating that partial-year caps intentionally underfund necessary care and create inconsistency. UMMS also advocates for providing the full $164.6 million based on a 12-month evaluation period
MedStar	MedStar strongly supports using 12 months of data for FY2025, urges HSCRC not to deviate from this precedent, and recommends implementing the full $164M in funding
JHHS	Supports the full rate year allotment ($164.6M) based on 12 months of data, and urges amending/removing the cap for RY2026 to avoid underfunding care

Methodology for Calculating Surge Funding (ECMADs vs. Patient Days) Comments

Overall Summary: Stakeholders generally support shifting toward an ECMAD-based methodology, with some recommending a blend with patient days. The most common proposal is a 66% ECMADs/33% patient days weighting for future years, with some advocating for a 50/50 blend or a predominantly ECMAD-based approach to avoid unintended incentives related to length of stay. Some stakeholders also recommend having a transition period if there is a shift in methodology.

Organization	Summary of Comments
LifeBridge Health	Life Bridge supports a shift to a predominantly ECMAD-based approach, aligning with other HSCRC methodologies and avoiding incentives related to length of stay
Luminis Health	Luminis suggests a 50/50 blend of patient days and ECMADs for future periods rather than 66% patient days/33% ECMADs based on the HSCRC mixed results of which calculation is more predictive of added resources
Adventist HealthCare	Adventist supports 66% ECMADs/33% patient days weighting starting in Rate Year 2027, stating that it promotes consistency and supports statewide efforts to improve length-of-stay performance
MHA	MHA urges to keep using the existing methodology of assigning 2/3 weight to patient days and 1/3 to ECMADs and suggests the change methodology should be considered only in RY2027 and rate years there after
UMMS	UMMS believes the Staff analysis does not justify change to the 66% patient days and 33% ECMAD funding logic and is merited at this time
JHHS	JHHS suggests on having a transition period if there is shift of weighting in methodology approach from 66% patient days and 33% ECMAD evaluation
MedStar	MedStar endorses using the existing approved methodology for FY2026, with changes considered only for FY2027 and beyond

Length of Stay Incentives Comments

Overall Summary: Stakeholders caution against policies that incentivize longer hospital stays or penalize hospitals for factors beyond their control. They recommend monitoring the length of stay rather than introducing independent incentives and favor approaches that minimize unintended consequences. Some recommend having an independent ALOS incentive and call for public input, strong safeguards, and incentives to improve throughput, coordination, and ED wait times.

Organization	Summary of Comments
MHA	MHA opposes independent incentives for length of stay because inpatient length of stay is driven by clinical needs and some factors outside hospitals' control, such as caring for complex and aging patients, payer delays, workforce shortages, etc. MHA also has concerns related to the inpatient length of stay incentive proposal, stating that the data being utilized does not capture shifts in patient acuity
UMMS	UMMS recommends that the adoption of an independent Average Length of Stay (ALOS) incentive be evaluated separately, not as part of the surge funding policy
JHHS	JHHS suggests to thoughtfully weight the LOS impacts before inclusion and check the policy for possible penalization of hospitalization for providing care to respiratory patients that may have longer LOS
CareFirst	CareFirst supports an independent inpatient length-of-stay (LOS) policy, urges robust public input and comment periods, and expects that with proper incentives and quality safeguards it will improve throughput, system coordination, and ED wait times

Timing and Process for Funding Adjustments Comments

Overall Summary: Stakeholders generally support timely and transparent adjustment processes. There is broad support for using prospective estimates with reconciliation based on full-year data to ensure funding reflects actual experience and supports hospital needs. Many advocate for implementing incremental funding in January rate orders and providing surge funding in the same year rather than delaying to future rate years. CareFirst notes general concerns about the policy development process and recommendations for a more thoughtful and inclusive approach.

Organization	Summary of Comments
Adventist HealthCare	Adventist recommends a prospective estimate in July, with reconciliation in January based on full-year data to ensure funding reflects actual experience and supports hospital needs
UMMS	UMMS urges providing surge funding in RY2026 by implementing the incremental $64.2 million in hospitals' January 2026 rate orders, aligning funding with the full-year evaluation period
MedStar	MedStar suggests to provide hospital with the surge funding in FY26 and not delayed until future rate years
CareFirst	CareFirst critiques the development of this policy, stating that the recommendation was rushed and fundamentally flawed

Alignment with Broader Policy Initiatives Comments

Overall Summary: Stakeholders stress the importance of aligning surge funding policies with broader initiatives, such as the AHEAD model and national CMS programs, and caution against adding complexity during transitions. JHHS suggests the policy may be unnecessary and recommends having a comprehensive review of whether other volume policies in place are working as expected.

Organization	Summary of Comments
MHA	MHA emphasizes alignment with AHEAD and national programs
Adventist HealthCare	Adventist values collaborative engagement and alignment with broader policy initiatives
JHHS	JHHS believes this policy may be unnecessary if age-adjusted demographic and market-shift policies work, and urges a comprehensive review of volume policies before the CMMI AHEAD transition

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Final Recommendation for the Surge Funding Policy

January 14, 2026

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This document contains staff final recommendations for the Surge Funding Policy

Key Methodology Concepts, Definitions, and Abbreviations

1. Average Daily Census (ADC) – Monthly Inpatient volume by cost center divided by days in the month
2. Average Length of Stay (ALOS) – Sum of length of stay divided by number of admissions
3. CMS - Centers for Medicare & Medicaid Services
4. CY - Calendar year
5. Equivalent Case Mix Adjusted Discharges (ECMADS) – Often referred to as case-mix, ECMADS are a volume statistic that account for acuity, as not all services require the same level of care and resources.
6. FFS - Fee-for-service
7. FY - Fiscal Year, typically refers to a state fiscal year from July 1 through the following June 30
8. FFY - Federal fiscal year refers to the period of October 1 through September 30
9. 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.
10. HSCRC or Commission - Health Services Cost Review Commission
11. Length of Stay (LOS) – Monthly Inpatient volume by cost center divided by the number of licensed beds for the month
12. Major Diagnostic Category (MDC) – A classification system used in healthcare to group patients with similar principal diagnoses for billing and reporting purposes
13. Respiratory syncytial virus (RSV) – also called human orthopneumovirus, is a virus that causes infections of the respiratory tract
14. RY - Rate year, which is July 1 through June 30 of each year
15. TCOC - Total Cost of Care, which is a measure of beneficiary's total healthcare spending, regardless of site of service

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Executive Overview

This draft policy recommendation reflects updates to the RY 2026 Respiratory Surge Funding policy reinstated by the Commission at the July 2025 Commission meeting. It also reflects additional assessments made by staff with stakeholder engagement to justify the limited use of patient days in the surge model.

Introduction

Maryland's global budget system, which provides hospitals with annual prospective budgets, guarantees Maryland hospitals a greater source of financial stability should significant changes in volumes occur. Typically, the GBR is a revenue cap that disincentivizes hospitals from growing unnecessary volumes and limits revenues to population-related utilization growth. The RY 2020 GBR did not include additional volumes for a pandemic such as COVID-19, and because of large surges in COVID-19 related cases, hospitals found themselves with insufficient revenue in their original GBRs to treat those cases.

At the height of the COVID-19 pandemic, Staff recommended and the Commission approved additional funding in hospital GBRs for the treatment of COVID-19 related cases, if the volume for those cases caused the hospital to exceed its original GBR. Under normal circumstances, hospitals experiencing volume increases would reduce charges to ensure that they do not overcharge their GBRs. However, given the unpredictability and huge surges in COVID-19 volumes (which had not been accounted for in hospital GBRs), providing additional COVID-19 revenues enabled hospitals to maintain their charges as volumes rose, thereby providing hospitals with significant funding relief.

Staff suspended the COVID Surge Policy because COVID had become endemic after the Omicron surge in 2022. However, in response to growing industry concerns, staff conducted studies revealing that COVID continues to create periodic strain on GBR volumes particularly with the confluence of other respiratory illnesses such as influenza, pneumonia, and RSV. The growth in respiratory conditions in RY 2024 and RY 2025 led to the reinstatement of the surge policy and given future projected increases in volumes for these cases, the Commission has tasked staff with creating a more formal approach for surge funding.

This policy recommendation will detail the work staff have done with the Volume Workgroup and the methods by which staff and stakeholders concluded that modifications to the surge policy are necessary, especially as they relate to the use of patient days in surge funding calculations.

Background

Maryland hospitals are experiencing surges in volumes related to respiratory conditions like influenza, RSV, and COVID. Respiratory illness outbreaks in Maryland are routinely reported to local health departments and MDH. The Maryland Emerging Infectious Program (EIP) divides respiratory illness outbreaks into COVID-19 and non-COVID-19 respiratory outbreaks. During the 2024-2025 influenza season, 480 COVID-19 outbreaks and 534 non-COVID-19 respiratory outbreaks were reported. The most reported outbreak was influenza (65.7%), followed by influenza-like illness (12.7%), RSV (9.2%), and pneumonia (8.4%) with the number of outbreaks peaking in early February.[1]

A review of volume changes from 2019-2024 show a significant rise in respiratory volumes with 2024 being the first year since the COVID-19 pandemic that respiratory volumes had returned to a 2019 baseline causing use rate growth beyond market shift. Considering these sustained cost increases in respiratory cases, staff proposed and the Commission approved the reinstatement of the Surge policy in RY 2024. The surge funding in RY 2024 recognized use rate growth of respiratory conditions in the prior

[1] Annual Maryland Influenza Season Summary: 2024-2025 https://health.maryland.gov/phpa/influenza/fluwatch/Past%20Flu%20Season%20Summaries/2024-2025%20Influenza%20Summary.pdf See Appendix 1 with for graph of influenza hospitalizations in Maryland by week and season

year using unit rates measured in patient days.

Commissioner directives involved creating a more permanent approach to surge funding, advancing a blended approach that allowed hospitals to receive adjustments equivalent to two thirds of what they would receive under the RY 2024 methodology which used patient days exclusively, and one third of what they would receive under a case-mix adjusted weighting methodology, or an ECMAD based approach. The decision to use ECMADs in surge funding calculations was based on staff concerns that using patient days as the volume statistic diverges from typical HSCRC policies and potentially rewards hospitals for longer LOS and/or creates a perverse incentive to not manage LOS in order to access additional funding. Commissioners expressed a desire that patient days be further de-emphasized, hence, directing staff to assess the necessity of using patient days in future surge funding calculations.

Overview of Surge Funding Calculation

Surge funding as determined during the COVID-19 pandemic was calculated as follows:

COVID Surge Funding = COVID Standard Charges - (Hospital GBR - Non-COVID Standard Charges)

The COVID and non-COVID standard charges were assessed by counting the rate center units for cases with a COVID ICD-10 code and all other ICD-10 codes, respectively. The rate center units were then multiplied by the relevant rates included in the hospitals' most recent rate order. Assessing the additional COVID revenues using the standard rate on the rate order ensured that hospitals did not have to lower their charges as volumes rose due to the COVID surge.

The table below shows an example of a hospital with a GBR of $360 million, where $60 million of non-COVID volume has dissipated. In the first example, the hospital charges $80 million for COVID units (assessed at the standard charges), which exceeds the revenue associated with dissipated volume ($60 million, again assessed at standard charges) and thus the hospital receives net COVID funding of $20 million. In the second example, the hospital charges only $20 million for COVID and the dissipated volume covers the additional COVID volume in its entirety. In this case, while the hospital receives no additional revenue - no revenue is removed from the hospital GBR either, GBR compliance notwithstanding. According to the formula, the hospital receives the greater of $0 or COVID Volume – (GBR – Non-COVID Volumes).

Table 1: COVID-19 Surge Funding Calculation

	GBR	Non-COVID Standard Charges	COVID Standard Charges	Additional GBR Funding for COVID Surge
	A	*B*	*C*	*D = C - (A - B)*
Example 1	$360M	$300M	$80M	$20M
Example 2	$360M	$300M	$20M	($40M)

Expansion of surge funding to include all respiratory cases

Staff reinstated the surge funding policy that existed during the COVID public health emergency in RY 2024 with the following amendments:

1. Broaden the definition of surge funding to include all respiratory cases (not just COVID cases) and calculated growth from a 2019 base period. Respiratory cases as defined include all cases with a respiratory major diagnostic category (MDC) and sepsis cases with co-occurring COVID diagnosis.

2. In order to avoid funding volume growth twice, offset any potential surge funding by the full-rate review rewards that hospitals received in rate year 2025 as well as other applicable revenue adjustments.

If a hospital were in an overcharge position such that its volumes multiplied by its standard rates exceed its GBR, it could be eligible for surge funding. After meeting that criterion, a hospital would receive the lesser of that overage relative to its GBR or the growth in all respiratory volumes from rate year 2019 to rate year 2024.

Table 2: Respiratory Surge Funding Calculation

	GBR	Standard Charges	Standard Revenue over/under charge	FY19 Respiratory MDC and Sepsis Patients with COVID	FY24 Respiratory & Sepsis Patients with COVID	Growth in FY19 -FY24 respiratory Volumes (Using patient days)	Additional GBR Funding for Respiratory Surge
	A	*B*	*C = B - A*	*D = FY19 Respiratory volumes * standard rates*	*E = FY24 Respiratory volumes * standard rates*	*F = E - D*	*G = (if C AND F > 0 , then take the lesser of C and F, otherwise cap at $0)*
Example 1	$480M	$520M	$40M	$30M	$34M	$4M	$4M
Example 2	$393M	$397M	$4M	$19M	$18M	($1M)	$ -
Example 3	$85M	$79M	($6M)	$7M	$10M	$3M	$ -

Blended approach to surge funding using ECMADs and Patient Days

In July 2025, there was growing concern that the use of patient days in surge funding calculations potentially rewards hospitals for longer LOS and/or creates a perverse incentive to not manage LOS in order to access additional funding. Thus, Commissioners approved the reinstatement of the surge funding policy with a blended approach where two thirds of the weight is applied to surge calculations using patient days (as described above) and one third weight applied to calculations using ECMADs (calculated as described above but with the use of ECMADs as the volume statistic). Staff were also directed to perform further studies and engage in stakeholder workgroups to determine ways to further deemphasize the use of patient days in surge funding calculations.

Initial calculations using 9 months of rate year 2025 data and the blended approach rendered $100.4 million in additional funding to hospitals for all respiratory conditions in rate year 2026.[2] Per Commission vote, the 100.4 million in Rate year 2026 is capped and only its distribution amongst hospitals that qualify can be changed.

Methodology Assessment

In this section, Staff will analyze current concerns and/or potential advancements to the Surge funding policy.

RY 2026 Surge Funding Cap

In November 2025, Staff utilized the final 12-months of rate year 2025 case-mix data, which was not available when Commissioners approved a $100.4M allotment for surge funding in RY 2026 based on the blended approach of patient days and ECMADs. Surge funding using 12 months of data and the same blended approach identified approximately a $164.6 million growth in respiratory cases.[3] However, because the Commission vote caps the total rate year 2026 surge funding at the 9-month amount ($100.4 million), staff have normalized the surge amount such that it is equivalent to the 9 month cap approved by the Commission.[4] This results in a slightly different distribution across hospitals, but staff recommend using this value as the baseline for Commissioner consideration, as it comports with the initial intention of the surge policy to assess the extent to which the GBR budgeted volumes across the entire year may offset infectious disease surges.

Additional analyses performed by staff to assess the necessity of patient days in surge calculations (discussed below in this report) support an alternative blended approach using two thirds ECMADs and one third patient days. This approach results in $124.8 million[5] growth in respiratory cases for RY 2025 volumes and addresses the Commission's desire to de-emphasize the use of patient days in surge funding calculations.

The update factor recommendation was clear that surge funding regardless of the full year assessment, is capped at $100.4 million. Hence, Staff will defer to Commissioners to consider amending the cap on surge funding. The various options Commissioners may consider are as follows:

[2] See column 2 in Table 3

[3] See column 4 in Table 3

[4] See column 3 in Table 3

[5] See column 5 in Table 3

Table 3: Surge Funding Allotments

Reason for Allotment	*Update Factor Cap*	*Update Factor Cap*	*Full RY 2025 Allotment*	*Full RY 2025 Allotment*
Weighting	*1/3 ECMADs & 2/3 Patient Days*	*1/3 ECMADs & 2/3 Patient Days*	*1/3 ECMADs & 2/3 Patient Days*	*2/3 ECMADs & 1/3 Patient Days*
Data Period	*9-Months*	*12-Months*	*12-Months*	*12-Months*
Hospital Name	*Currently in Rates*	*Staff Report Out*	*Staff Recommendation*	*For Commissioner Consideration*
Johns Hopkins	$14,026,512	$20,028,816	$32,851,194	$22,570,701
Anne Arundel	$10,757,326	$9,461,990	$15,519,523	$11,685,614
Sinai	$7,775,162	$5,966,732	$9,786,613	$11,032,604
Peninsula	$7,345,706	$7,708,399	$12,643,290	$9,343,320
Carroll	$6,984,378	$6,109,941	$10,021,504	$7,651,843
Northwest	$6,639,657	$5,977,732	$9,804,655	$6,818,479
Frederick	$4,222,455	$4,636,930	$7,605,476	$6,493,282
Howard County	$4,532,684	$4,579,463	$7,511,219	$6,256,406
St. Agnes	$6,370,364	$5,053,142	$8,288,146	$6,012,547
Meritus	$3,689,794	$4,038,899	$6,624,587	$5,510,801
MedStar Fr Square	$3,218,330	$4,323,254	$7,090,986	$5,074,017
ChristianaCare, Union	$3,125,891	$3,009,902	$4,936,831	$3,923,947
HC-Germantown	$3,772,741	$2,017,206	$3,308,614	$3,454,816
MedStar Montgomery	$2,593,083	$2,194,885	$3,600,043	$2,969,056
UMMC Midtown	$472,761	$2,220,150	$3,641,482	$2,846,283
Mercy	$2,585,403	$2,214,963	$3,632,975	$2,579,710
MedStar Southern MD	$1,477,679	$1,792,849	$2,940,625	$2,468,371
UM-BWMC	$3,045,663	$2,956,685	$4,849,545	$2,424,773
MedStar St. Mary's	$1,844,500	$1,810,546	$2,969,652	$2,138,372
MedStar Union Mem	$1,592,907	$1,665,239	$2,731,320	$1,365,660
UMMC & Shock Trauma	$0	$1,464,988	$2,402,869	$1,201,434
Suburban	$2,245,992	$645,416	$1,058,610	$529,305
UM-Chestertown	$384,810	$294,731	$483,416	$241,708
MedStar Harbor	$641,407	$169,880	$278,637	$139,318
Garrett	$0	$30,386	$49,839	$99,678
UM-Charles Regional	$427,480	$0	$0	$0
UM-Easton	$600,441	$0	$0	$0
Statewide	**$100,373,126**	**$100,373,126**	**$164,631,651**	**$124,832,046**

Staff will also consider the timing and measurement period against any full rate review funding awarded (or other relevant funding mechanisms) and discount that funding as needed.

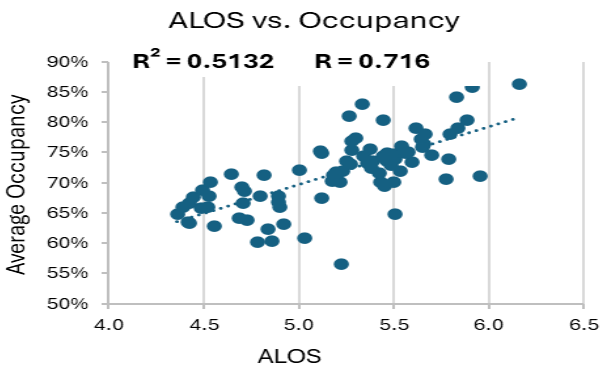
Do patient days need to be factored in the surge funding policy?

Staff are concerned that using patient days as the volume statistic diverges from typical HSCRC policies and could potentially reward hospitals for longer LOS and/or create a perverse incentive to not manage LOS in order to access additional funding. To assess the necessity of using patient days in surge funding calculations, staff developed four distinct questions to which analyses were performed using both hospital case-mix and hospital experience data to gain a more holistic picture.[6]

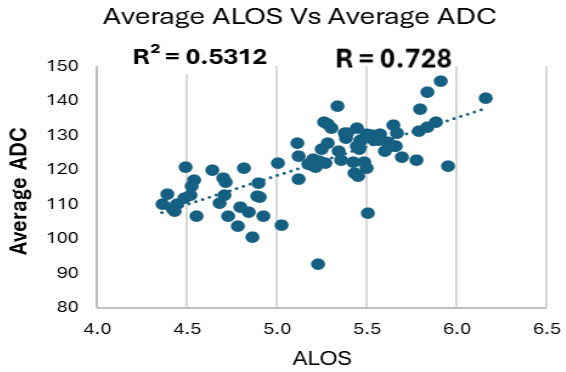
Question 1: What is the correlation between ALOS, ADC, and Occupancy?

Staff ran two linear regression models[7] on the correlation between average length of stay (ALOS) and occupancy rate (graph 1a.) and the correlation between average daily census (ADC) and ALOS (graph 1b.). Staff wanted to test the degree to which ALOS increases as occupancy and/or ADC increases, as this might suggest that at various census thresholds, LOS management is compromised and ECMADS may not capture that phenomenon entirely.

Graph 1a. Correlation between ALOS and Occupancy



Graph 1b. Correlation between ALOS and ADC



As shown on the graphs above, both models produced correlation coefficients of 0.72 and 0.73, respectively, indicating that longer patient stays have a relatively strong positive correlation to increased occupancy and ADC. However, because neither was a perfect correlation it is not reliable to conclude that patient days are the sole factor contributing to hospital resource strain. At the same time, ADC and occupancy do exhibit a statistically significant relationship with ALOS and explain over 50 percent of the variation in ALOS as shown by the R square statistics (51% in graph 1a, and 53% in graph 1b) suggesting that patient days should be utilized to some extent in surge funding calculations.

Question 2: Does ALOS and Occupancy increase in surge months (i.e., winter)?

To test whether increases in ALOS, ADC, and occupancy rates tended to occur concurrently during the respiratory season, which might suggest that at various census thresholds, LOS management is compromised (which may not be captured using calendar year based ECMADS), staff used hospital experience data[8] for those hospitals slated to receive surge funding and compared their monthly ALOS and occupancy rates in FY24.

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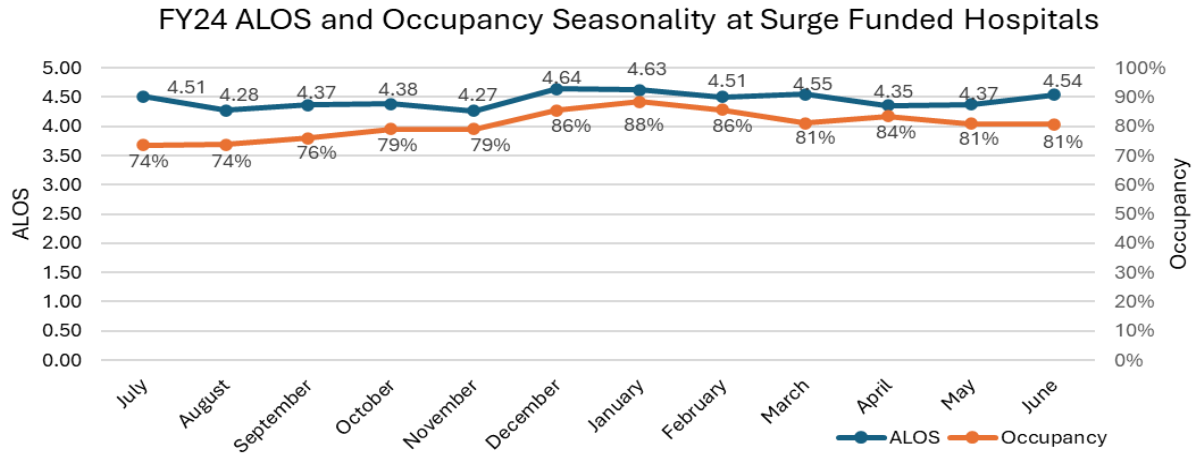
[6] See Appendix 2 for table summarizing all four questions, the corresponding analyses, and the results

[7] Linear regression models used statewide hospital experience data limited to the PEDS, MIS, MSG, and DEF rate centers

[8] Used statewide hospital experience data limited to the PEDS, MIS, MSG, and DEF rate centers for hospitals receiving surge funding only

As shown on the graph below, monthly ALOS in FY24 ranged between 4.27 and 4.64 throughout the year for hospitals that received surge funding with very minor increases occurring from December to March. The variation is so minimal that staff cannot definitively conclude that seasonality influences ALOS, ADC, and occupancy rates, suggesting that hospital-specific factors, rather than a universal seasonal surge, drive resource strain. Consequently, based on this analysis staff recommend de-emphasizing patient days in surge funding calculations.

Graph 2: ALOS and Occupancy Rates at Surge Hospitals during Surge Months

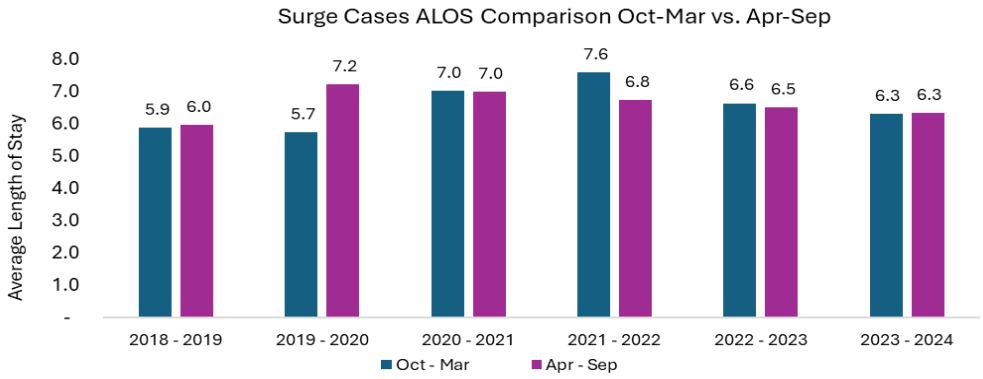


Question 3: How does LOS for surge cases compare during surge months to non-surge months?

Staff used hospital case-mix data to test whether the LOS for respiratory cases was different during the respiratory season (fall and winter months) versus non respiratory season (spring and summer months).[9] If LOS for surge cases tends to be higher during the respiratory season, it could suggest that calendar year weights are not properly capturing LOS exacerbations that occur during the respiratory season.

As shown on the bar chart below, results of this analysis did not support the need to include patient days in surge funding calculations since ALOS was not consistently higher for surge cases during the respiratory season. The minimal variations in ALOS between respiratory versus non-respiratory seasons annually suggest that annual ECMAD weights properly capture length of stay exacerbations even during the fall/winter months.

Graph 3: ALOS Comparison Between Surge and Non-surge Months



[9] The case mix data was limited to cases with a respiratory MDC (04) or a respiratory principal diagnosis (A419 or A4189).

Question 4: Do non-surge cases with similar ECMAD weights have a lower ALOS than surge cases?

Staff assessed the ECMADs and LOS variations between surge versus non-surge cases of similar weight. If the LOS for surge cases tend to be higher than that of non-surge cases with a similar ECMAD weight, then it could suggest that the ECMADs for surge cases are underweighted. Staff used the hospitals' case-mix data to identify surge cases[10] and non-surge cases.[11] The analysis resulted in an ALOS for surge cases at 4.4 days, while that of non-surge cases was at 2.9 days. The results of the analysis suggest that patient days should be used in surge funding calculations, as surge cases tend to experience longer LOS than non-surge cases. However, it is important to acknowledge that included in the non-surge category are cases with higher drugs and supply charges, which would drive up the ECMAD weight but not necessarily have a lower LOS case profile.

Per the results of these analyses conducted to assess the use of patient days in the surge model as shown above, the response to two questions (Q1 and Q4) support the use of patient days in some capacity, while the majority strongly support the use of ECMAD in the surge model. Therefore, Staff recommend that RY 2027 surge funding calculations be based on a blended approach with two thirds weight applied to the ECMADs approach and one third weighting on patient days, as opposed to the inverse that is currently being used in the RY2026 surge funding policy. This also aligns with Commissioner discussions on de-emphasizing the use of patient days because their use could potentially reward hospitals for longer LOS and/or create a perverse incentive to not manage LOS in order to access additional funding.

Additional Considerations

Staff believe that patient days should be considered in the evaluation of surge funding for all the reasons stated above. However, staff are concerned that several hospitals with longer inpatient length of stay performance may not have qualified for additional funding if length of stay were better optimized. Specifically, 46 percent of the funding provided in the full year RY 2025 assessment will be distributed to hospitals that have length of stay that exceeds national average performance, as evaluated by RY 2025 case-mix data using 2021 Healthcare Cost and Utilization Project (HCUP) norms. Additional analyses, e.g., Medicare Part A 2024 claims, adjusted for age, gender, MS-DRG, comorbidities, using National Norms, yield similar findings.

In light of this concern, staff recommend that Commissioners adopt an independent IP LOS incentive that has been developed in concert with the Performance Measurement Workgroup to improve LOS performance more broadly in the State. Additional benefits of this policy proposal include: increased financial sustainability of the model; greater incentives to create value-based care arrangements with post-acute providers, and hospital alternatives such as hospital at home; and improved hospital throughput, emergency department LOS, and patient satisfaction.

Stakeholder Feedback

Staff received comment letters from nine stakeholders and several verbal comments and questions from Commissioners. The comments from stakeholders and Commissioners can be broadly categorized into five areas of concern.

[10] Cases with a respiratory MDC (04) or a respiratory principal diagnosis (A419 or A4189)

[11] The case mix data cases with an ECMAD weight between 1.5 and 1.6 (the average weight range for all identified surge cases)

Table 4: Summary of Public Comments

Topics	LifeBridge Health	Luminis Health	Adventist HealthCare	MHA	UMMS	HME	JHHS	CareFirst	MedStar
Use of Full-Year Data for Funding Calculations	✓	✓	✓	✓	✓	✓	✓		✓
Methodology for Calculating Surge Funding	✓	✓	✓	✓	✓		✓		✓
Length of Stay Incentives				✓	✓		✓	✓	
Timing and Process for Funding Adjustments			✓		✓			✓	✓
Alignment with Broader Policy Initiatives			✓	✓			✓		

Staff will address each stakeholder comment area below

1. **Use of Full-Year Data for Funding Calculations Comments**: Stakeholders broadly support using a full 12 months of data to calculate surge funding, emphasizing that funding should reflect actual, demonstrated need and not be constrained by arbitrary caps. HME expresses concern about increased consumer costs if funding is expanded

Table 5: Summary of Use of Full Year Data for Funding Comments

Organization	Summary of Comments
LifeBridge Health	LifeBridge endorses revising surge funding to reflect 12 months of volume experience, noting the full-year analysis shows greater respiratory case growth than the initial 9 months
Luminis Health	Luminis supports recognizing surge volume growth for the entire 12-month period, calling the 9-month cap arbitrary
Adventist HealthCare	Adventist recommends funding based on a full 12 months of actual experience, with reconciliation in January rate orders. They also urge that funding reflect full actuarial estimates and equity considerations for hospitals serving vulnerable populations
MHA	MHA urges updating funding to reflect the full year of RY2025 data, not just the first nine months/ They also stress funding should match resource needs and not be arbitrarily capped
HME	HME opposes increasing surge funding if global budgets already sufficiently fund higher volumes, warning about rising consumer costs and advocating for robust analysis before retrospective increases. HME also requests that the HSCRC clarify how funding adjustments will impact consumer costs
UMMS	UMMS strongly urges amending the funding cap to reflect a full 12 months of respiratory surge volume, stating that partial-year caps intentionally underfund necessary care and create inconsistency. UMMS also advocates for providing the full $164.6 million based on a 12-month evaluation period
MedStar	MedStar strongly supports using 12 months of data for FY2025, urges HSCRC not to deviate from this precedent, and recommends implementing the full $164M in funding
JHHS	Supports the full rate year allotment ($164.6M) based on 12 months of data, and urges amending/removing the cap for RY2026 to avoid underfunding care

Staff Response: *Staff agree with utilizing a full 12 months of data in alignment with all other HSCRC volume methodologies, which assess volume changes across an entire year. Global Budget Revenue (GBR) volumes are budgeted prospectively and are intended to account for 12 months of actual*

experience, including seasonal fluctuations in demand. Therefore, assessments regarding volume surges should also be conducted on a 12-month basis to avoid arbitrary budget caps and to account for all available resources provided through a global budget.

Adjusting GBRs based on the inadequacy of prospective budgeted volumes—considering the totality of the global budget rather than a subset or season—is consistent with the foundational language of the GBR contracts.

The impact of providing additional surge funding to consumers is minimal. As demonstrated by the Pro-forma calculations below, the potential incremental surge funding under either scenario does not have a material impact on costs. As shown on table 6a below, Staff estimate that providing an additional $24 million in incremental Surge Funding would increase average charges per patient day by 0.1%, while a $64 million increment would result in a 0.3% increase. Similarly, as shown in table 6b, the potential additional Surge Funding would be expected to increase commercial insurance premiums by 0.0% and 0.1% if all of the costs were passed on to consumers.

Table 6a: Pro Forma Impact of Surge on Per Diem Charges[12]

		$100M Funding Option	$125M Funding Option	$165M Funding Option	
Total Surge Funding	$	100,373,126	124,832,046	164,631,651	A
Surge Funding included in Rates		100,373,126	100,373,126	100,373,126	B
Incremental Surge Funding		-	24,458,920	64,258,525	C = A - B
FY2025 Actual Total Hospital charges	$	23,018,649,505	23,018,649,505	23,018,649,505	D
FY2025 Actual Patient Days		3,104,699	3,104,699	3,104,699	E
FY2025 Actual Charges per Patient Day	$	7,414	7,414	7,414	F = D / E
FY2025 Charges + Incremental Surge	$	23,018,649,505	23,043,108,425	23,082,908,030	G = D + C
FY2025 Actual Patient Days		3,104,699	3,104,699	3,104,699	E
FY2025 Charges + Surge per Patient Day	$	7,414	7,422	7,435	H = G / E
% Variance from Baseline			0.1%	0.3%	

Table 6b: Pro Forma Impact of Surge Funding on Commercial Premiums[13]

		$100M Funding Option	$125M Funding Option	$165M Funding Option	
Total Surge Funding	$	100,373,126	124,832,046	164,631,651	A
Surge Funding included in Rates		100,373,126	100,373,126	100,373,126	B
Incremental Surge Funding		-	24,458,920	64,258,525	C = A - B
FY2025 Actual Total Hospital Charges	$	23,018,649,505	23,018,649,505	23,018,649,505	D
Incremental Surge Funding as a % of Charges		0.0%	0.1%	0.3%	E = C / D
Hospital Spend as a % of Total Healthcare Spend	$	37%	37%	37%	F
Expected Impact of Surge Funding on Commercial Premiums		**0.0%**	**0.0%**	**0.1%**	G = E * F

[12] Hospital Experience Data

[13] HSCRC Experience data and Hospital Spend as a % of Total per Maryland Insurance Administration (MIA)

2. **Methodology for Calculating Surge Funding Comments:** Stakeholders generally support shifting toward a higher weight for ECMADs in the methodology, while maintaining some degree of blending with patient days. The most common proposal is 33% ECMADs and 66% patient days weighing for future years, with some advocating for a predominantly ECMAD-based approach to avoid unintended incentives related to length of stay or a 100% patient day approach given the nature of the surge cases. Some stakeholders also recommend having a transition period if there is a shift in methodology.

Table 7: Summary of Methodology for Calculating Surge Funding Comments

Organization	Summary of Comments
LifeBridge Health	Life Bridge supports a shift to a predominantly ECMAD-based approach, aligning with other HSCRC methodologies and avoiding incentives related to length of stay
Luminis Health	Luminis suggests a 50/50 blend of patient days and ECMADs for future periods rather than 66% patient days/33% ECMADs based on the HSCRC mixed results of which calculation is more predictive of added resources
Adventist HealthCare	Adventist supports 66% ECMADs/33% patient days weighting starting in Rate Year 2027, stating that it promotes consistency and supports statewide efforts to improve length-of-stay performance
MHA	MHA urges to keep using the existing methodology of assigning 2/3 weight to patient days and 1/3 to ECMADs and suggests the change methodology should be considered only in RY2027 and rate years there after
UMMS	UMMS believes the Staff analysis does not justify change to the 66% patient days and 33% ECMAD funding logic and is merited at this time
JHHS	JHHS suggests on having a transition period if there is shift of weighting in methodology approach from 66% patient days and 33% ECMAD evaluation
MedStar	MedStar endorses using the existing approved methodology for FY2026, with changes considered only for FY2027 and beyond

Staff Response: *The current weighting methodology—66% patient days and 33% ECMADs—was established as a placeholder during last year's respiratory surges. At that time, the Commission expressed a desire to deemphasize patient days to avoid relying on antiquated volume statistics for global budget adjustments. Consequently, staff were directed during the July 2025 public meeting to analyze more appropriate weighting options.*

Staff conducted various analyses to estimate the degree to which surge situations account for LOS increases and based on those findings, staff recommend a revised methodology of 66% ECMADs and 33% patient days. This approach more fully utilizes ECMADs to avoid unintended consequences, such as inpatient length-of-stay exacerbation, while acknowledging that ECMADs may not capture all patient days associated with peak flu season case profiles.

Given that RY 2026 revenue adjustments have already been issued under the original weighting, Staff and stakeholders agree that the current methodology should remain in place for the remainder of RY 2026. Staff defer to the Commission on whether the additional $64M should be funded in the current fiscal year or accounted for in the RY 2027 Update Factor.

Moving forward, staff recommend adopting the new weighting for RY 2027 surge funding and beyond, with full funding to occur in the following fiscal year.

3. **Length of Stay Incentives Comments:** Several stakeholders cautioned against implementing a separate IP LOS incentive policy, stating that such a policy could penalize hospitals for factors beyond their control. They recommend monitoring the length of stay rather than introducing independent incentives and favor approaches that minimize unintended consequences. If an IP

LOS policy were to be implemented, stakeholders believe it should be done as a separate recommendation and allow for extensive workgroup and stakeholder engagement. Other stakeholders were supportive of the development of an IP LOS policy.

Table 8: Summary of Length of Stay Incentives Comments

Organization	Summary of Comments
MHA	MHA opposes independent incentives for length of stay because inpatient length of stay is driven by clinical needs and some factors outside hospitals' control, such as caring for complex and aging patients, payer delays, workforce shortages, etc. MHA also has concerns related to the inpatient length of stay incentive proposal, stating that the data being utilized does not capture shifts in patient acuity
UMMS	UMMS recommends that the adoption of an independent Average Length of Stay (ALOS) incentive be evaluated separately, not as part of the surge funding policy
JHHS	JHHS suggests to thoughtfully weight the LOS impacts before inclusion and check the policy for possible penalization of hospitalization for providing care to respiratory patients that may have longer LOS
CareFirst	CareFirst supports an independent inpatient length-of-stay (LOS) policy, urges robust public input and comment periods, and expects that with proper incentives and quality safeguards it will improve throughput, system coordination, and ED wait times

Staff Response: *While the IP LOS Incentive Policy and the Surge Funding Policy are being developed independently, staff believe it is important to highlight the significant interaction between the two.*

There is a concern that providing surge funding may inadvertently disincentivize hospitals from managing length of stay efficiently, which could negatively impact quality outcomes such as ED wait times and patient satisfaction. Currently, approximately 50% of surge funding for RY 2025 is allocated to hospitals with IP LOS levels exceeding national norms.

Staff acknowledge that hospitals cannot control every factor impacting LOS and that longer stays are sometimes necessary for optimal health outcomes. However, the overall growth in IP LOS is a concern that warrants further investigation. Notably, while admission volumes have declined over the course of the Model, patient days have remained relatively constant despite stable acuity levels as shown on table 9 below.

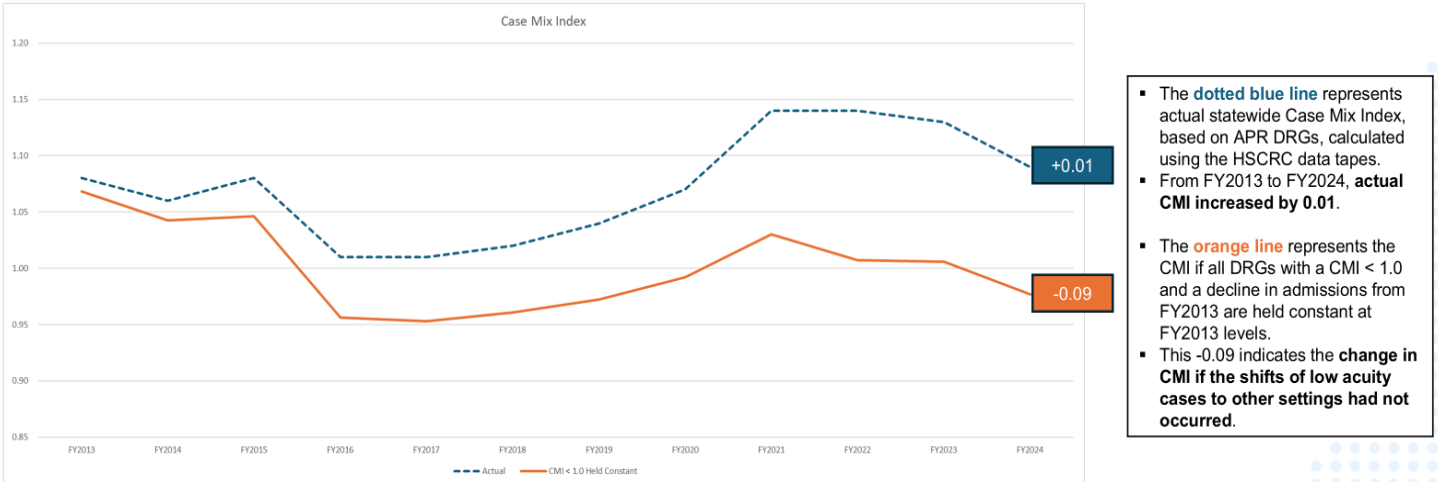
Key areas identified for improvement include; post-acute care discharges, behavioral health placements, the impact of prior authorization, and general throughput efficiency.

Given the concern over the Surge Funding Policy's potential to worsen IP LOS, staff are considering two additional recommendations

1) *If an IP LOS incentive is not established by June 30, 2026, the surge policy be suspended until an IP LOS incentive is approved; alternatively,*
2) *If an IP LOS incentive is not established by June 30 , 2026 the Surge policy will be amended to only account for case growth (100% ECMAD evaluation)*

Table 9: Adjusted Case-mix Index Trend

While actual statewide Case Mix Index has increased slightly, Staff's analysis suggests that the **shift of low-acuity cases** out of the IP setting is a larger driver of the increase than a more complex and older population.



4. **Timing and Process for Funding Adjustments Comments:** Stakeholders generally support timely and transparent adjustment processes. There is broad support for using prospective estimates with reconciliation based on full-year data to ensure funding reflects actual experience and supports hospital needs. Many advocate for implementing incremental funding in January rate orders and providing surge funding in the same year rather than delaying to future rate years. CareFirst notes general concerns about the policy development process and recommends what it characterizes as a more thoughtful and inclusive approach.

Table 10: Summary of Timing and Process for Funding Adjustments Comments

Organization	Summary of Comments
Adventist HealthCare	Adventist recommends a prospective estimate in July, with reconciliation in January based on full-year data to ensure funding reflects actual experience and supports hospital needs
UMMS	UMMS urges providing surge funding in RY2026 by implementing the incremental $64.2 million in hospitals' January 2026 rate orders, aligning funding with the full-year evaluation period
MedStar	MedStar suggests to provide hospital with the surge funding in FY26 and not delayed until future rate years
CareFirst	CareFirst critiques the development of this policy, stating that the recommendation was rushed and fundamentally flawed

Staff Response: *Staff understand the necessity of making resources available to hospitals so that they can continue to provide high quality care to patients. The intent of the surge policy is to provide hospitals with funding for additional costs incurred due to volume surges in the prior year. Delaying funding until July will be inconsistent with the intent of the policy. Staff already have the full 12-month amount necessary to fund surge, reconciling this amount in January is in keeping with the intent of the surge policy and follows the same timing and funding approach of the Quality Based Reimbursement (QBR) Policy and CDS-A.*

Reconciliations in July would not be considered off-cycle adjustments as funding is handled in concert with the update factor thereby ensuring total affordability for consumers and purchasers of healthcare services. However, choosing to reconcile in July would be inconsistent with the Commission's typical practice of not delaying an adjustment when the relevant data is readily available.

5. **Alignment with Broader Policy Initiatives Comments:** Stakeholders stress the importance of aligning surge funding policies with broader initiatives and caution against adding complexity during transitions.

Table 11: Summary of Alignment with Broader Policy Initiatives Comments

Organization	Summary of Comments
MHA	MHA emphasizes alignment with AHEAD and national programs
Adventist HealthCare	Adventist values collaborative engagement and alignment with broader policy initiatives
JHHS	JHHS believes this policy may be unnecessary if age-adjusted demographic and market-shift policies work, and urges a comprehensive review of volume policies before the CMMI AHEAD transition

Staff Response: *Staff agree that the Surge Funding policy should align with broader initiatives and not add complexities as we transition to the AHEAD model. Moving forward, staff will work with stakeholders to promote approaches under the Medicare and Non-Medicare Hospital Global Budgets (HGBs) that are more aligned with those broader initiatives. Medicare's risk adjustment policies address some of this risk, but more may need to be considered in consultation with CMS.*

Recommendations

Based upon completion of the full 12-month rate year 2025 surge funding calculations and the various analyses done to assess the blended approach, Staff's recommendation is as follows:

1. Funding provided in rate year 2026 should be based on the full fiscal year evaluation as this comports with the initial intention of the surge policy to assess the extent to which GBR budgeted volumes across the entire year may offset infectious disease surges. Staff will consider timing and measurement period against any full rate review funding awarded (or other relevant funding mechanisms) and discount the funding as needed.

2. Moving forward, staff recommend a 9-month estimate of surge funding be built into July rate orders and then reconciled in January rate orders based on the full fiscal year evaluation. Staff will consider timing and measurement period against any full rate review funding awarded (or other relevant funding mechanisms) and discount the funding as needed.

3. In RY 2027 and thereafter, any surge funding provided should be based on 66 percent ECMAD evaluation and 33 percent patient day evaluation, as there are analyses to support the need for some consideration of patient days, but to a lesser extent than ECMADs.

4. Staff defer to the Commissioners to consider amending the cap on surge funding in RY 2026, as the Update Factor recommendation was clear that the value regardless of the full year assessment is set at $100.4M. Options are as follows:

    a. Full Rate Year Allotment- $164.6 based on 12 months of RY 2025 volume data with 66 percent patient day, 33 percent ECMAD evaluation to be implemented in January 2026 rate orders **(Staff Recommendation)**

   b. Full Rate Year Allotment and Advancement to New Weighting Approach- $124.8 based on 12 months of RY 2025 volume data with 33 percent patient day, 66 percent ECMAD evaluation to be implemented in January 2026 rate orders

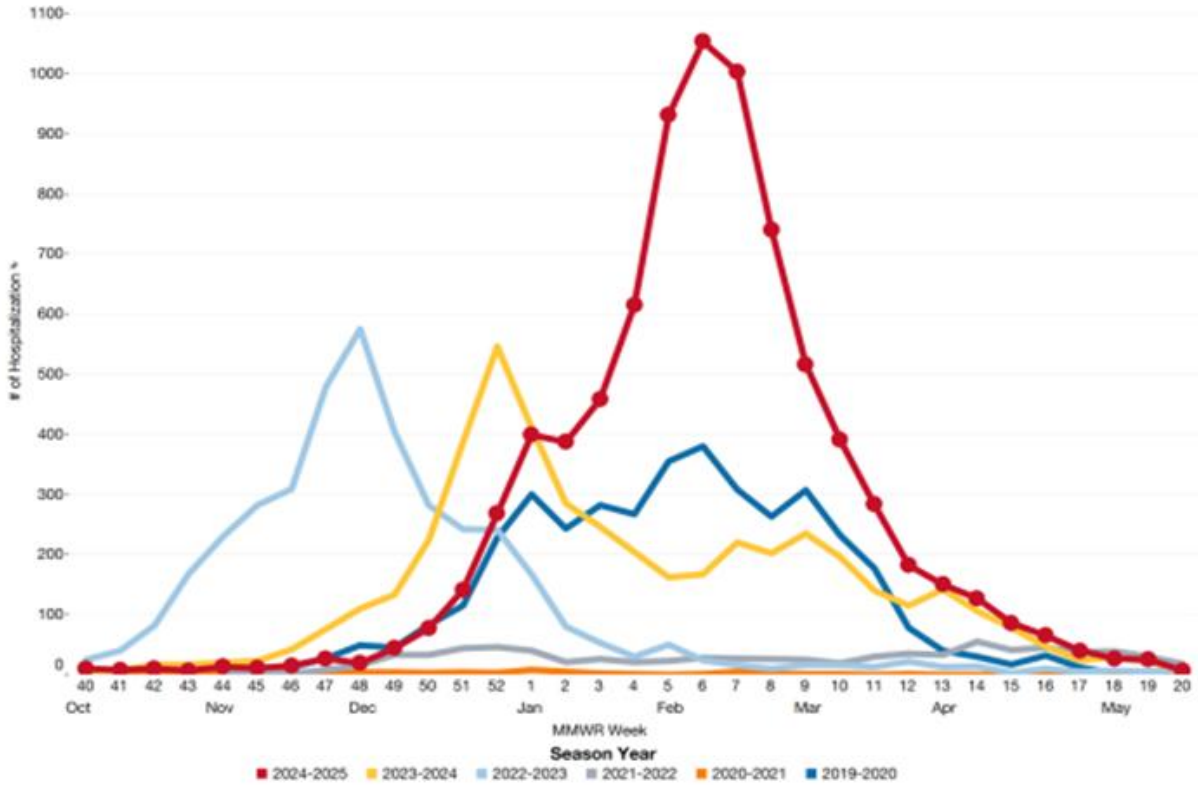
5. Given the concern over the Surge Funding Policy's potential to increase IP LOS, staff recommend the adoption of an independent IP LOS incentive to be developed in concert with the Performance Measurement Workgroup. Staff propose that:
   a) If an IP LOS incentive is not established by June 30, 2026, the surge policy be suspended until an IP LOS incentive is approved; alternatively,
   b) If an IP LOS incentive is not established by June 30, 2026, the Surge policy be amended to only account for case growth (100% ECMAD evaluation)

6. Hospitals accepting Surge funding should maintain or increase their staffing capacity to meet the needs of patients in Maryland.

7. Hospitals should coordinate with respiratory virus prevention activities with the Maryland Department of Health.

Appendix 1: Influenza Associated Hospitalizations in Maryland by week and Season

Figure 18: Influenza-Associated Hospitalizations in Maryland by Week and Season



Appendix 2: Summary of Analyses to Support the Use of patient days

Supporting Questions	Analysis	Reason for Analysis	Takeaway
What is the correlation between ALOS, ADC, and Occupancy?	Ran linear regression comparison of statewide ALOS to average occupancy and ALOS to ADC for and ADC for DEF, MIS, MSG, and PED volumes.	If ALOS increases as ADC increases, it might suggest that a various census thresholds, LOS management is comprised and ECMADS may not capture that.	The correlation for ALOS vs Occupancy and ALOS vs ADC were both relatively strong (.7). This could support the need to use patient days in the calculation.
Does ALOS, ADC and occupancy increase in surge months (fall/winter)?	Compared ALOS, occupancy, and ADC for DEF, MIS, MSG, and PED rate centers by month for hospitals that received surge funding.	If ALOS and ADC increases tend to occur concurrently during the respiratory season, it might suggest that a various census thresholds, LOS management is comprised and ECMADS may not capture that.	In FY24, there was minimal variation in ALOS by month, which ranged between 4.27 and 4.64 for hospitals that received surge funding. This does not support the need to use patient days in the calculation.
How does LOS for surge cases compare during surge months (fall/ winter) to non-surge months?	Compared ALOS for surge cases (MDC = 04(Respiratory) or PRINDIAG = A419 or A4189) by quarters Q4 & Q1 (Oct-Mar) vs Q2 & Q3 (Apr-Sept).	If LOS for surge cases is different during the respiratory season, it might suggest that calendar year-based weights are not capturing broad based LOS exacerbation in the winter months	The ALOS was not consistently higher in Q4 & Q1 (Oct-Mar) vs Q2 & Q3 (Apr-Sept) for surge cases. This does not support the need to use patient days in the calculation.
Do non-surge cases with similar ECMAD weights have a lower LOS than surge cases?	Compare cases LOS for non-surge cases with an ECMAD weight of ~1.5 to the LOS for surge cases.	If LOS for surge cases is higher than non-surge cases with a similar ECMAD weight, this could suggest that the ECAMDS are underweighted for surge cases.	Surge cases have a longer LOS in comparison to non-surge cases with similar ECMAD weights. This could support the need to use patient days in the calculation.

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December 17, 2025

Allan Pack, Principal Deputy Director, Population-Based Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Allan,

LifeBridge Health appreciates the HSCRC's movement toward a permanent surge funding policy, and the opportunity to comment on the final FY2026 funding methodology. We are supportive of the Commission revising the funding amount to reflect twelve months of volume experience.

Staff's 12-month RY 2025 analysis demonstrates materially greater growth in respiratory cases than was evident based on nine months of data, reinforcing the importance of basing the final January reconciliation on complete annual experience. Given the updated analysis reflects more unfunded volume growth than initially observed, we encourage the Commission to update the amount of available statewide funding based on this analysis.

We also support the proposed shift in weighting toward a predominantly ECMAD-based approach beginning on July 1. This approach is more consistent with all other HSCRC volume methodologies. It also captures resource intensity without creating unintended incentives related to length of stay.

In summary, our recommendations support the policy option presented by staff that incorporates the full RY2025 allotment using 12 months of data.

Thank you for your consideration. Please contact Michael Myers or Laura Russell with questions.

Sincerely,

David Krajewski, CFO and EVP, LifeBridge Health
cc: Joshua Sharfstein, M.D., HSCRC Chairman
Jon Kromm, HSCRC Executive Director

Adventist HealthCare

December 18, 2025

Prudence Akindo
Allan Pack
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Akindo and Mr. Pack:

Re: Draft Recommendations – Surge Funding Policy

Adventist HealthCare appreciates the opportunity to comment on HSCRC staff's draft recommendations to the Surge Funding Policy. We are grateful for the thoughtful and data-driven analysis to better recognize hospital volume pressures during respiratory surges.

While Adventist HealthCare is not directly impacted by the policy this year, we believe it is important to provide comments on how this policy should be applied in future years and to highlight potential precedents that may be established based on its implementation this year. Our feedback is intended to support a framework that ensures fairness, consistency, and sustainability for all hospitals over time.

We strongly support staff's efforts to refine the surge funding methodology. Aligning surge volumes with ECMAD-based approaches, consistent with other HSCRC volume policies, while maintaining a limited role for patient days, is both reasonable and appropriate. Adventist HealthCare agrees with the recommended weighting of 66 percent ECMADs and 33 percent patient days beginning in Rate Year 2027. Additionally, we recommend revising the previously established surge funding estimate so that funding reflects a full 12 months of actual experience, with a similar reconciliation process applied in future years.

Changes to the Surge Funding Policy

Adventist HealthCare recommends revising the current cap on surge funding so that hospitals are funded based on a full 12 months of actual experience rather than an estimate. Each year, an estimate should be applied in the July rate orders, followed by a true-up in the January rate orders once complete data is available. While we appreciate staff's proposal to include a prospective surge funding estimate with reconciliation occurring the following July, we recommend applying the reconciliation in the January rate order. This approach ensures timely recognition of surge pressures and improves accuracy and predictability.

Consistent with staff's analysis, we agree that ECMADs should remain the primary driver of all volume-based methodologies, including surge funding. Including a patient-day component weighted lower than ECMADs appropriately reflects real capacity constraints during respiratory surges. Overall, we support the proposed 66 percent ECMAD and 33 percent patient-day weighting as an approach that promotes consistency and supports statewide efforts to improve length-of-stay performance.

As the Commission finalizes this policy, we encourage careful consideration of funding adequacy. We believe surge funding should reflect the full actuarial estimates of medically necessary care and not be constrained by caps that fall below demonstrated need. Establishing limits below staff-supported funding levels could unintentionally set a precedent for under-resourcing essential services during periods of heightened demand and may disproportionately affect hospitals serving communities with higher Medicaid and uninsured rates. We respectfully recommend ensuring that final funding reflects both the quantitative analysis and the imperative to sustain equitable access to medically necessary care.

Recommendations

Adventist HealthCare has the following recommendations:

1. Adopt staff's recommendation to weight surge funding based on 66 percent ECMADs and 33 percent patient days beginning in RY 2027.
2. Include a prospective surge funding estimate in the July rate order with a reconciliation based on a full fiscal year evaluation in the January rate order each year.
3. Revise the FY 2026 surge estimate and provide funding based on 12 months of actual experience.
4. Ensure that surge funding levels reflect staff's full actuarial estimates of medically necessary care and that equity considerations, including payer mix and regional access, are reviewed prior to establishing any caps.

Conclusion

Adventist HealthCare values HSCRC staff's thoughtful analysis and collaborative engagement in refining the Surge Funding Policy. We appreciate the transparency of the Volume Subgroup discussions and the opportunity to provide input on this important issue. We support the move toward a more ECMAD-focused methodology and urge the Commission to provide surge funding based on 12 months of actual experience to ensure hospitals are appropriately funded for sustained surge-related pressures.

Thank you for your consideration and for the opportunity to comment. Please do not hesitate to contact us with any questions or for further discussion.

Sincerely,

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

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

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10455 Mill Run Circle
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December 18, 2025

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

Dear Executive Director Kromm:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to comment on the Draft Recommendation for Surge Funding Policy.

The Surge Funding Policy was flawed from the beginning. The Health Services Cost Review Commission (HSCRC) did not follow its history of collaborative, thoughtful policymaking in March 2025 when this was rushed to a vote without appropriate stakeholder input and consideration. This is evidenced by the clean-up work proposed throughout the current draft recommendation. The staff have shown that the policy rewards hospitals with higher-than-average length of stay instead of those with higher patient volume. Typically, policies are revisited every two to three years with slight modifications. This recommendation comes just months later and proposes adjustments to the units of measure, months of data used in the calculation, funding allotment, and timing of implementation. Policies should not be proposed or approved when the appropriate process is not followed.

Global budgets were established in part in recognition of seasonality and fluctuation in hospital volumes, borrowing lessons learned through Total Patient Revenue methodologies piloted at Maryland's rural hospitals over decades. Surges in specific service types never warranted sweeping revenue adjustments in the past; it is unclear what is different now. While we certainly understand both that hospitals should be appropriately funded to provide necessary, high-quality care to patients and that increased patient demand puts a strain on hospital expenses, HSCRC staff have demonstrated on numerous occasions through the volume scorecard that the approved funding in hospital global budgets is more than adequate. The surge policy selects a subset of services that have increased without accounting for retained revenue from hospital services that have declined during the same period.

Finally, we support the Staff's recommendation to adopt an independent inpatient length of stay policy and look forward to reviewing the details of a proposal. We understand this is a complicated issue that requires thoughtful consideration of unintended consequences; thus, the staff should invite public input and provide adequate comment periods in its development. An independent inpatient length of stay policy that has the appropriate financial incentives and guards against negative quality outcomes could drive improvements in throughput, system coordination, ED wait times, among other outcomes.

Thank you for the opportunity to comment on the Surge Funding Policy.

Sincerely,

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

HEALTH MEANS EVERYTHING
CONSUMER ALLIANCE

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

RE: DRAFT RECOMMENDATIONS ON SURGE FUNDING AND HOSPITAL ACQUIRED CONDITIONS PROGRAM

Dear Dr. Kromm and HSCRC Commissioners:

Health Means Everything appreciates the opportunity to comment on the draft recommendations for Surge Funding and the Hospital Acquired Conditions program. In keeping with our organization's mission, our comments focus principally on potential cost and access impacts for consumers, as well as consumer health outcomes.

Surge Funding

Hospital capacity and access are vital during respiratory virus season, and HME appreciates that the HSCRC has taken steps during and after the COVID-19 pandemic to ensure that Maryland hospitals can meet the needs of Maryland families. With respect to the draft recommendations discussed at the December HSCRC meeting, **HME encourages the HSCRC to avoid increasing consumer costs (by increasing surge funding) if global budgets are already sufficiently funding higher patient volumes during the annual respiratory season.**

Surge funding is included in hospital global budgets. Thus, increasing surge funding also increases global budgets and hospital service rates. These costs are ultimately passed down to Maryland consumers through premiums and other rising expenses. As we have noted in previous comments to the Commission, Marylanders' health care costs are already too high and we are concerned that the HSCRC continually increases hospital

global budgets and adds to consumers' cost burden.[12] The Governor's workgroup is also poised to increase costs further for commercially insured consumers in order to support both AHEAD model implementation and stabilize the state Medicare Advantage market. **HME's overarching concern is that the HSCRC is continually increasing consumer costs through individual policy decisions, without sufficiently analyzing or discussing how consumers will be impacted, or how that impact compares to hospitals' financial status.**

As we have discussed in previous comments, right-sizing hospital payments to current utilization patterns is one important way that the HSCRC can pass savings down to consumers. The HSCRC's own analysis demonstrates that age-adjusted Maryland hospital utilization has decreased by 10%, and outpatient utilization has decreased even more substantially.[3] During the same period, the HSCRC has consistently increased hospital global budgets. The goal of the state's hospital rate setting authority should be to balance global budgets while minimizing costs to consumers, not to maintain hospital budgets at a given level when service use is changing. HME strongly recommends that the HSCRC implement policies to account for reductions in overall utilization of hospital services and examine whether global budgets accurately reflect the needs of Marylanders today.

With all of this in mind, **HME does not believe that the HSCRC should increase the surge funding cap or implement policies that allow for retrospective increases in surge funding unless robust analyses clearly conclude that such extra funding is vital for ensuring access to care.** We further note that such policies undermine the overall goal of hospital global budgets by retrospectively increasing funding if volumes increase. HME warns against finalizing policies that encourage hospitals to maximize admissions.

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1 https://www.kff.org/health-costs/state-indicator/expenses-per-inpatient-day/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Expenses%20per%20Inpatient%20Day%22,%22sort%22:%22desc%22%7D

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

3 https://hscrc.maryland.gov/Documents/November%202025%20PUBLIC%20PREMEETING%20-%20finalv3.pdf. Page 44

Finally, we urge the HSCRC to discuss more transparently and clearly how policy changes, such as those recommended for surge funding, would impact consumer costs. The pre-meeting materials do not explain how the policy recommendations would translate to hospital payment rates, or how such increases in hospital funding would impact premiums, copays, and other out-of-pocket spending.

Maryland Hospital Acquired Conditions Program

Health Means Everything is supportive of the HSCRC's efforts to update the Maryland Hospital Acquired Conditions (MHAC) program, which provides important incentives for hospitals to provide high-quality care and prevent infection. This program serves as an important guardrail to ensure that the adoption of global budgets does not result in safety risks or lower quality of care for Marylanders. HME recognizes and appreciates Maryland's performance on both the Potentially Preventable Complications (PPCs) measure and AHRQ's Patient Safety Indicator (PSI) 90 composite measure under the all-payer model. Notably, the state exceeded the contractual requirement of a 30% reduction in all PPCs and outperformed the national PSI-90 composite in four of the last six years. The HSCRC's data further demonstrates that the state's performance has improved significantly throughout participation in the model. These results demonstrate that the MHAC contributes to improved patient outcomes and reduced hospital costs.

As highlighted by the HSCRC staff, the PCC composite measure and PSI-90 composite measure evaluate performance among different conditions and cohorts of patients. As such, **HME supports the recommendation to use both PCC and PSI to assess hospital acquired complications and calculate adjustments to hospital global budgets.** We believe that measuring complications across both medical and surgical patients is essential for incentivizing quality and safety for all patients. By taking this comprehensive approach, hospitals are encouraged to invest in processes and protocols that promote infection control and patient safety across all units instead of focusing just on those that are measured by one measure or the other. HME strongly

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believes that hospitals should be incentivized to invest in these improvements each year, and that programs like MHAC serve as a vital guardrail in a global budget environment.

HME also supports the HSCRC's efforts to advance the successful implementation of the AHEAD Model, which we are hopeful will continue to improve the health of Maryland consumers while controlling health care costs. HME appreciates that the HSCRC continues to prioritize the health and quality of hospital care for Marylanders by aligning the well-established and successful MHAC program with the HACRP requirements under the AHEAD model. We encourage the HSCRC to continue comprehensively measuring hospital acquired conditions, as well as implementing an aligned program that continues to incentivize annual improvements in quality and safety.

Thank you again for your efforts, and for the opportunity to provide comment as you continue to hone these policies. We look forward to continuing to work with you on behalf of Marylanders.

Sincerely,

Ashiah Parker
Chair, Health Means Everything

December 18, 2025

Allan Pack, MPA
Principal Deputy Director, Quality and Population-Based Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Prudence Akindo, MHA
Associate Director, Financial Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Pack and Ms. Akindo:

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the draft recommendation for surge funding policy. JHHS appreciates staff's efforts to update policies to better reflect the resources required to meet the current needs of Maryland patients. JHHS agrees that a more permanent approach to surge funding is needed and is supportive of the full rate year allotment option as outlined by staff; this approach would distribute $164.6M in funding based on 12 months of RY25 volume data with 66% patient day and 33% ECMAD evaluation. JHHS offers the following additional comments.

1. JHHS urges the Commission to consider amending/removing the cap on surge funding in RY2026, as staff's calculations reflect that additional funding is required to meet the needs of Maryland patients. If acknowledged that $164M in funding is required to support related volume and this amount is not granted to hospitals, this would amount to the underfunding of care in the State, which is not aligned with the responsibility of hospitals nor the Commission.
2. At this time, JHHS is supportive of the methodology approach that considers 66% patient days and 33% ECMAD evaluation. Both components should be taken into consideration under the policy. However, this approach should continue to be re-evaluated based on the needs of the model and of patients. If there is a shift in weighting, a transition period may be needed.
3. Length of stay (LOS) impacts must be thoughtfully weighed before inclusion in this policy. While some hospitals may have less of a focus on length of stay due to global budget mechanics, other hospitals – including JHHS hospitals – are strained for capacity and have implemented concerted efforts to reduce LOS. Volume surges drive over-occupancy, and over-occupancy drives increased LOS. Boarding then increases, which is included in LOS calculations. This policy should not penalize hospitals for providing care to respiratory patients that may have longer LOS.

Generally, JHHS agrees with the intent of the surge funding policy and offers the above feedback on weighting and amount to ensure sufficient resources for hospitals to meet the needs of patients. Further, JHHS would note that if other volume policies were working as intended, such as age-adjusted demographic and market shift policies, this particular policy may not be necessary. JHHS appreciates staff's efforts to date to ensure the alignment of and updates to volume policies moving forward and encourages a large-scale assessment of volume policies and their interactions as the State prepares to move into the CMMI AHEAD model.

Sincerely,

Ed Beranek

Ed Beranek
Vice President, Revenue Management and Reimbursement
Johns Hopkins Health System

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Jonathan Blum
Nicki McCann
Dr. Farzaneh Sabi
Jon Kromm

Luminis Health℠

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December 17, 2025

Allan Pack
Principal Deputy Director, Quality and Population-based Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Allan,

On behalf of Luminis Health and its hospitals Anne Arundel Medical Center and Doctors Community Medical Center, I am writing in response to the draft staff recommendation on Surge Funding Policy, dated December 10, 2025. Luminis appreciates the opportunity to provide feedback on this important policy. We would also like to thank the HSCRC staff for its work on this policy and the in-depth analysis of determining how to fund respiratory and Covid related volume growth.

Generally, Luminis supports the policy recommendations the HSCRC staff has brought forward with a few comments noted below:

1. We agree with the HSCRC staff in limiting the adjustment to hospitals that would be above its GBR target if charging at approved rates.
2. We strongly believe that the surge volume growth for the entire 12-month period should be recognized and that the use of the 12 month period is consistent with a fair and reasonable data-driven policy approach. Capping the funding based on the 9-month period previously considered and presented at the July 2025 HSCRC public meeting would be arbitrary and irrational; and would not take into consideration the full effect of the surge volumes.
3. Luminis feels it is imperative to have the FY2025 adjustment finalized in the FY2026 rate order for the 12-month period. The HSCRC staff has calculated the adjustments and already made the 9-month adjustment so it would be feasible to finalize FY2025 in FY2026 rate orders.
4. We understand the HSCRC staff position to not entirely base the adjustment on patient days, but it should be noted that the comparable base period (FY2019) did not have Covid cases in it and likely had a different utilization pattern. Therefore, Luminis recommends that the calculation should be 100% patient days or at least remain consistent to the current methodology of 66.7% patient days and 33.3% ECMADs when compared to FY2019.
5. Luminis supports the HSCRC position that the Surge Policy should continue in future rate periods and as the comparison period moves forward and away from FY2019 it would be reasonable to have a blend of ECMADs and patient days in the calculation, but rather than a 66/33% weighting, Luminis would suggest a 50% weighting. The 50% blend is based on the HSCRC mixed results of which calculation is more predictive of added resources.

Luminis Health℠

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We thank you again for your transparency and effort in working with Maryland hospitals to provide fair and balanced methodologies.

With best regards,

Michelle Lee
EVP and Chief Financial Officer
Luminis Health
443-481-6452

cc: Prudence Akindo, Associate Director- Financial Methodologies, HSCRC

MedStar Health

8094 Sandpiper Circle
Suite O
Nottingham, MD 21236

MedStarHealth.org

December 17, 2025

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

Dear Executive Director Kromm,

On behalf of MedStar Health, Inc. (MedStar) and its seven Maryland hospitals, thank you for the opportunity to provide comments on the Draft RY2026 Surge Funding Policy presented during the December 2025 HSCRC Public Meeting. MedStar is appreciative of HSCRC staff's collaboration with the industry in the development of this policy recommendation and their receptiveness to stakeholder feedback. MedStar supports the overall goal of the RY2026 surge funding policy and believes providing Maryland's hospitals with funding to account for surges in respiratory illness patient care volume is critical to adequate hospital financial performance. Consistent with the recommendations included in the comment letter from the Maryland Hospital Association, MedStar makes the following comments related to the staff's draft recommendation for consideration.

Surge Funding

In line with the FY2025 surge funding policy and the action taken during the July 2025 HSCRC meeting to increase hospital rates by $100.4M, **MedStar believes the HSCRC should provide hospitals with the $164M of funding as calculated by the staff, based on a full 12 months of data from FY2025.** The surge funding policy for FY2025 utilized 12 months of fiscal year data to calculate the amount of hospital funding needed to cover the unexpected respiratory patient volume surges that occurred in the prior year. The HSCRC should not deviate from this precedent when assessing surge volumes in FY25 and providing funding to hospitals in FY26. The funding provided preliminarily in July based on 9 months of data, should be updated to reflect the full 12 months impact from FY25, using the existing approved methodology. Based on this methodology, and 12 months of data, the resulting $164M of statewide funding should be implemented. Any changes in methodology should only be considered when evaluating funding for FY2027 and beyond as the methodology for our current fiscal year has already been established.

Implementation Timing

During the December meeting, commissioners discussed the potential to delay any additional funding based on the surge funding calculation until RY27 or beyond. **MedStar believes the full amount of funding should be provided to hospitals in FY26 and not delayed until future rate years.** Delaying the funding for this volume would be inconsistent with the intent of the surge funding policy, which is intended to provide hospitals with funding for costs incurred in a prior year (FY25). Delaying any portion of this funding to FY27 would create an unnecessary 2 year lag between the costs incurred and the ultimate funding of those costs. MedStar therefore urges the HSCRC to fully fund these costs in FY26, using the methodology recommended in the Staff Recommendation, namely an estimate based on 9 months of data in July rate orders followed by a reconciliation using 12 months of data to be implemented in the same year (as noted, similar to the QBR process).

If you have any questions or wish to discuss any of the above further, please do not hesitate to contact me directly.

Sincerely,

Mike Wood
Vice President – Revenue Management & Reimbursement
MedStar Health

cc: Joshua Sharfstein, MD
James Elliott, MD
Jonathon Blum, MPP
Maulik Joshi, DrPh
Ricardo R. Johnson, JD
Nicki McCann, JD
Farzaneh Sabi, MD

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CORPORATE OFFICE

December 18, 2025

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

RE: UMMS Comment Letter on Surge Funding Draft Recommendation

Dear Jon:

On behalf of the University of Maryland Medical System ("UMMS") and its member hospitals, I am submitting comments in response to the Health Services Cost Review Commission's ("HSCRC") Surge Funding Draft Recommendation. We appreciate the time spent by HSCRC Staff developing the Surge Funding Draft Recommendation, but we urge the Commission to address two key issues necessary to align this recommendation with the intentions of the surge funding policy:

1. Amend the $100.4 million surge funding cap to reflect a full 12 months of respiratory surge volume by adopting Recommendation 2b: $164.6 million based on 12 months of RY2025.

2. Provide this funding in RY2026 by implementing the incremental $64.2 million on hospitals' January 1, 2026 rate orders.

Below are UMMS comments regarding the draft recommendations:

The RY2025 surge funding should be based on a full fiscal year evaluation and reflected in RY2026 approved Global Budget Revenue

UMMS cannot emphasize enough that these are necessary volumes that merit funding. Because these volumes are consistent with the surge funding policy definition and intention, the Commission cannot delay funding or use artificial caps based on partial periods to restrict the funding required to cover the cost of providing this care. We agree with and emphasize the Staff's statement that providing $164.6 million based on a full 12-month evaluation of RY2025 "comports with the intention of the surge policy." In other policies, such as the market shift, funding for partial periods is always replaced by a full 12-month evaluation period. This is the only way to ensure that hospital global budgets appropriately reflect volumes which merit funding, as is the case for respiratory surge volumes. Capping funding for RY2025 based on a 9-month partial evaluation would both

represent an intentional decision to underfund necessary care and create inconsistency in terms of treatment of these volumes in other years. Surge funding for the COVID period and RY2024 rightly evaluated incremental funding based on a based on a 12-month evaluation period, and the recommendation would provide funding based on a 12-month evaluation period for RY2026 respiratory surge volumes and going forward. UMMS cannot comprehend why RY2025 would be held out as the only year that is capped at a 9-month funding level. For these reasons, UMMS urges the Commission to provide the full $164.6 million based on a 12-month evaluation period ensure that these funds are available to hospitals in RY2026.

Staff analysis of Average Length of Stay (ALOS) for surge cases supports the continuation of the RY2024 and FY2025 funding mechanism and does not justify a change to the 66% patient days and 33% ECMAD funding logic.

The intention of the surge funding policy is to provide appropriate funding to cover the cost of providing this necessary care. In the case of respiratory surge volumes, these are difficult to manage cases that put significant pressure on hospital Emergency Departments and inpatient capacity. Funding for these volumes should have a goal of aligning with the actual utilization or cost of doing the work. UMMS is committed to providing effective, quality care for its community members and would strongly dispute any notion that we would manipulate length of stay on these cases for the purpose of accessing additional funding.

With the goal of providing appropriate funding for these volumes in mind, UMMS supports the need for an analytic approach to understanding whether ECMADs are assigning appropriate case weight to surge volumes but would emphasize that the four Questions that Staff analyzed regarding patient days do not carry equal weight in that assessment. An ECMAD weight is based on the full 12-month utilization profile of a set of cases, and concern arises when a subset of those volumes has a utilization profile that diverges from the broader profile of cases with similar acuity, suggesting that the ECMAD case weight may be underestimating expected utilization for that subset of cases. Questions #1 and #4 directly assess the ECMAD vs. utilization dynamic and both support the need for ongoing evaluation of patient days for respiratory surge cases. Staff's Question #4 suggests that ALOS for a surge case is more than 50% higher than other cases with similar acuity, and Question #1 adds that this issue gets exacerbated when volumes put stress on capacity. Questions #2 and #3 simply suggest that this dynamic is consistent across all respiratory surge volumes and not limited to surge volumes that occur in the winter months. While this dynamic may change over time, based on these observations, UMMS would not conclude from this analysis that a change in the current 66% patient days and 33% ECMADs funding mechanism is merited at this time.

The adoption of an independent ALOS incentive should be evaluated by the Commission as a separate recommendation.

UMMS understands that Length of Stay evaluations and potential incentive models are being considered within the Performance Measures Workgroup. That work is a broader scope of discussion, separate and not limited to respiratory surge volumes. We assume that this work will be presented to the Commission as a separate, stand-

alone recommendation for Commission consideration and stakeholder input. UMMS would recommend striking Recommendation #5 or at least revising it so that it is not a directive to adopt a policy that has not yet been developed and evaluated with appropriate stakeholder input. This would allow the surge funding to be evaluated as a stand-alone policy and allow the ALOS work to proceed as an independent policy decision.

UMMS believes strongly that volume policies must provide hospitals with the appropriate resources to provide medically necessary care to Marylanders. This is essential to the broader success of the Maryland Model. The respiratory surge volumes are a particularly direct example of care that hospitals absolutely should provide to patients in need, and the surge funding policy is designed with an intention to cover the cost of providing that care. We believe that the above changes to the Surge Funding Draft Recommendation better accomplish this goal, while also recognizing that our broader goal should be to establish a more permanent funding mechanism for these volumes. UMMS looks forward to ongoing collaboration with our State partners on this important issue.

Sincerely,

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

cc: Joshua Sharfstein, MD Chairman
James N. Elliott, MD, Vice Chairman
Jonathan Blum, MPP
Ricardo R. Johnson
Maulik Joshi, DrPH
Nicki McCann, JD
Farzaneh Sabi, MD

Maryland
Hospital Association

December 18, 2025

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for Surge Funding Policy. We applaud the Commission's decision to reinstate and make permanent the surge funding policy recognizing the increased volume of patients with respiratory conditions that hospitals have and will continue to care for.

Unfortunately, the increased intensity of the respiratory season in recent years is becoming the new normal, necessitating a permanent policy responsive to this reality. This policy and routine statewide monitoring of RSV, COVID, pneumonia, influenza, and other life-threatening respiratory illnesses are especially critical as changing federal guidance, losses of coverage, and narrower vaccine eligibility requirements may lead to a reduction in vaccination rates and higher burden of respiratory illnesses in the 2025-2026 respiratory season and future years. The funding from this policy will ensure hospitals can deliver life-saving care to all Marylanders.

RY 2026 Funding

As stated in the draft recommendation, HSCRC previously approved $100.4 million in surge funding for hospitals in RY 2026 based on increased volumes from the first nine months of RY 2025. The amount of funding provided to hospitals under this policy should not be restricted because of the limited data available to the Commission at the time of the July meeting. As with all volume policies, funding should be based on available recent and complete data. As such, the previously approved funding amount should be updated to reflect the experience of the full year. This will ensure the level of support for hospitals is commensurate with the resources needed to address the increased volumes associated with the growth in respiratory illnesses, consistent with the policy's intent.

We also urge HSCRC staff and Commissioners to use the existing calculation methodology—assigning two-thirds weight to patient days and one-third to equivalent case-mix adjusted discharges (ECMADs)—as the basis of RY 2026 hospital funding allocations, resulting in a total funding allocation of $164.6 million when using the full year of RY 2025 data. A change in the methodology should only be considered for the policy in RY 2027 and rate years thereafter.

Inpatient Length of Stay

In their draft recommendation, staff express concern that using patient days to measure volume for the purposes of determining surge funding could potentially reward hospitals for longer length of stay or create a perverse incentive to not manage length of stay to access additional funding. Staff then recommend that Commissioners adopt an independent length of stay incentive to improve length of stay more broadly in the state.

Hospitals are committed to optimizing management of inpatient length of stay and achieving reductions whenever possible. The use of patient days in the surge policy is not a factor or incentive that will impact how hospitals manage care for their patients. Moreover, MHA does not support adoption of an independent incentive to improve length of stay as inpatient length of stay is driven by clinical need and other factors largely out of hospitals' control.

Unique patient care needs and other systemic challenges constrain hospitals' ability to shorten length of stay. The following examples regularly occur when hospitals are caring for patients that are outside hospitals' control.

- ***Complex and Aging Patients:*** Longer inpatient stays may be needed to stabilize patients with complex medical needs, including multiple comorbidities and behavioral health needs. This trend is worsening as Maryland's population continues to age and require more extensive hospital services.
- ***Long-Term and Post-Acute Care Access***: Limited availability of skilled nursing, rehabilitation, and home health services can delay safe discharges. And for the more complex patients who require medical care after discharge, services may not be readily available in the community, particularly for patients who are in socio-economically disadvantaged areas.
- ***Workforce Shortages:*** Staffing constraints for nurses, care managers, and social workers may slow discharge planning and coordination.
- ***Payer Delays***: Prior authorization processes, denials, documentation requirements, and other payer practices can extend hospital stays unnecessarily.
- ***Guardianship and Legal Barriers***: Patients who require guardianship or legal decision-making authority before discharge, court proceedings, appointments of guardians, and coordination with state agencies can extend impatient stays well beyond clinical needs.
- ***Community Resource Gaps:*** Insufficient housing, transportation, and social supports hinder timely transitions out of the hospital.

Because hospitals have a limited ability to impact inpatient length of stay, any independent length of stay initiative should have a monitoring-only focus. With hospitals transitioning to the national CMS Medicare quality programs under AHEAD, HSCRC must prioritize alignment with the national incentive programs and reduction of administrative complexity. Hospitals must devote significant time and resources to implement the transition to AHEAD. All efforts should be aligned to focus on a safe, effective transition. Introducing new policies could further exacerbate hospitals' ability to provide high quality care and access due to financial constraints. There are other efforts underway or planned within the Emergency Department Wait Time Reduction Commission and AHEAD Regulatory Working Group to address barriers that impact

hospital wait times and length of stay including post-acute care. As improvements in access to post-acute care will help to reduce inpatient length of stay, these efforts should be prioritized.

There are, moreover, concerning design features in the inpatient length of stay incentive proposed during the Performance Measurement Workgroup. The proposed, the revenue adjustment methodology would have relied on calendar year (CY) 2018 statewide averages and severity of illness categories within APR-DRG classifications to establish expected length of stay benchmarks. These data are over seven years old and reflect pre-pandemic utilization patterns. The data do not capture profound shifts in patient acuity, case mix, and discharge barriers that have emerged during and since the pandemic. Using out-of-date baseline data would embed unrealistic expectations into the revenue model and could inadvertently penalize hospitals serving higher-acuity or socially complex populations. More recently, staff indicated they are considering baseline data from CY 2021 or CY 2022. The policy should be designed to monitor trends using more recent post-pandemic data or adjustment factors to ensure that length of stay benchmarks reflect current realities and best serve patients and the hospitals they depend on.

Hospitals remain committed to implementing evidence-based best practices for inpatient length of stay management. Because inpatient length of stay is driven by patient care needs and broader systemic factors, the surge policy and any inpatient length of stay or other related initiatives must reflect these limitations.

Thank you for the opportunity to comment on this important policy. We look forward to continuing to work together on policy development in the coming months. If you have any questions, please do not hesitate to contact me.

Sincerely,

Patrick D. Carlson

Patrick Carlson
Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. Maulik Joshi
Nicki McCann
Dr. Farzaneh Sabi
Prudence Akindo
Allan Pack

maryland
health services
cost review commission

Demographic Adjustment Final Recommendation

January 14, 2026

Summary of Public Comments

Topics	MHA	UMMS	JHHS	Frederick Health	Adventist	CareFirst	HME
Fund Age Adjusted Population growth	✓	✓	✓	✓	✓	✓	✓
Use SG2 to Fund Projected Future Utilization Growth	✓	✓		✓			
Incorporate National Demand Modifier	✓	✓	✓	✓	✓		✓
Continue Including Volume Variable Funding in DA	✓	✓	✓	✓	✓		
AHEAD Alignment & Other comments	✓	✓	✓		✓		

- Staff received comment letters from seven stakeholders regarding the Draft Recommendation on the Demographic Adjustment.
- The comments from stakeholders can be broadly categorized into five areas of concern.

Introduction – Factors Driving Hospital Demand

- The Demographic Adjustment is intended to reflect factors that impact demand for hospital services (as opposed to price). These factors can be broadly categorized in 3 buckets:
  - The size of the population served
  - The age of the population served
  - Changes in technology, clinical practices and population health (aside from aging)
- Historically, for various reasons, the HSCRC has only considered the first item (age is used to distribute funding but does not change the total amount provided).
- There has been considerable concern that the failure to acknowledge age has resulted in systematic underfunding. During this process, the HSCRC demonstrated that excluding the impact of aging has not resulted in systematic underfunding as it has been offset by the third factor. This is consistent with evidence from national data sets, which has been acknowledged by many of the commenters.

Introduction – The Future of the Demographic Adjustment

- Having ruled out existing underfunding, the discussion has moved to the appropriate future funding formula. There are three potential options:
  A. Continue the current practice of assuming that age will be offset by other changes in demand
  B. Add a factor for age and other considerations based on average historical experience (past is prologue)
  C. Build into the future process a dynamic estimate of changing hospital demand (considering clinical risk and other demand drivers).
- While experience of the model to date has shown that approach A is adequate, Staff have proposed moving to option B to acknowledge the various drivers of population demand.
- A few commenters argued for returning to Approach A while others argued for either revising the estimate derived for Approach B or moving for Approach C.
- Staff have not changed their proposal based on the comments because:
  - We believe the data supports a small incremental increase beyond population growth
  - We do not believe the proposed revisions to approach B were an improvement
  - We believe that the added complexity of moving to Approach C is not merited given the limitations on available data and the subjectivity involved in any projection approach
- The following slides address the comments in more detail.

Fund Age Adjusted Population Growth Comments

Overall Summary: Many Stakeholders strongly support fully funding age-adjusted population growth, averaging about 0.65% annually, stating that the current methodology underfunds aging-related utilization. They also argue that the Demographic Adjustment serves as the sole means to finance anticipated increases in utilization driven by an aging population. In contrast, CareFirst and HME oppose additional funding, citing efficiency gains, technology improvements, and sufficient current funding.

Staff Response: ***Staff did not conduct new analysis on the age adjusted growth statistic cited in the comments supporting this approach. This value was specifically designed to distribute population funding, not to function as a governor for statewide funding.***

As has been discussed in both the Volume Workgroup and the November Commission meeting, the age-adjusted growth statistic in the Demographic Adjustment is inappropriate for two reasons: it fails to account for year-over-year growth, thus missing broader secular trends, and it only considers one factor (aging) that affects changes to hospital utilization.

Instead, Staff analyses for this Workgroup engagement have focused on the proposed approaches that more comprehensively account for aging and other important factors that impact population-level risk. The slides that have been presented before on this topic are included in an appendix.

Comments were received from:	MHA	UMMS	JHHS	Frederick Health	Adventist	CareFirst	HME

See appendix for comment details.

Incorporate National Demand Modifier Comments

Overall Summary: Stakeholders raised concerns that HSCRC's analysis understates demographic impacts and overstates practice pattern changes. They question the reasonableness of assumptions, noting in particular that reliance on historical trends and a 3% projected growth rate is too conservative. Some highlight national all-payer data and suggest incorporating a national demand modifier to more explicitly account for Medicaid, which based on stakeholder modelling would result in a 0.28% national modifier versus staff's proposal of 0.1%.

Staff Response: ***Staff again thank stakeholders for providing an alternative to the 0.1% national demand modifier statistic outlined in the Draft Recommendation. We appreciate that this alternative accounts for year-over-year growth and non-aging factors, fulfilling the necessary requirements for consideration. However, staff do not believe there is a basis for changing the approach used:***

- ***Staff's approach relies on claims data, while the proposed approach relies on Medicare cost report data; there is significant research into the challenges of cost report data (see box), and Staff believe the claims-based approach is preferable.***
- ***Staff believe the answers are effectively the "same" given the level of precision feasible in deriving these estimates. For example, using a different source of population estimates changes the outcomes of the stakeholder modeling from 0.28%* to 0.19% or 0.23% (depending on the method used, see next slide). Staff believe the relatively narrow range of the various estimate should provide comfort, and that using the claims-based estimate as the point estimate is preferable.***

Examples of literature on the challenges of cost report data:

1. The Medicare Cost Report and the limits of hospital accountability: improving financial accounting data - highlights the general issue of cost reports not being audited
2. Hospitals in Some States Under Report Medicaid Discharge Counts in Cost Report Data - shows the disconnect in claims-based discharges and those in cost reports (within Medicaid)
3. Statewide Hospital Discharge Data: Collection, Use, Limitations, and Improvements - in 28 studies using discharge data, only 7 used cost reports, and all of those 7 supplemented with another source (typically HCUP).

Comments were received from:	MHA	UMMS	JHHS	Frederick Health	Adventist	HME

** Staff were unable to replicate the commenter calculation of 0.28% but assume it uses a credible source of population data.*
See appendix for comment details.

Use SG2 to Fund Projected Future Utilization Growth Comments

Overall Summary: Stakeholders broadly cited independent forecasts like Sg2 showing 4.5% inpatient and 17.4% outpatient growth from 2025–2035, supporting a higher national demand modifier (0.52%–0.64% annually) versus the proposed 0.10%. They emphasize the need for prospective forecasts to ensure hospitals are adequately resourced in 2026 to close the gap between age-adjusted growth and the scaled Demographic Adjustment.

Staff Response: ***Staff thank stakeholders for providing an alternative to the 0.10% national demand modifier statistic outlined in the Demographic Adjustment Draft Recommendation. We appreciate that this alternative accounts for year-over-year growth and non-aging factors, fulfilling the necessary requirements for consideration.***

However, staff are concerned that the proposal is not viable for the following reasons:

1. ***Proprietary Data: The specifics of the Sg2 forecast are proprietary and not available to non-hospital entities, making external vetting difficult.***
2. ***Variability: Sg2's annual ten-year forecasts exhibit significant variation (as shown in the accompanying table). This suggests the statistic may not be sufficiently reliable or predictable to serve as a volume governor in a capitated model.***
3. ***Additional Hospital Industry Methodological Concerns: Initial proposal by MHA and other hospital stakeholders resulted in double counting within the existing HSCRC methodology for population growth, as it included both base population growth and other factors.***
   - ***Subsequent proposals from MHA that were presented to HSCRC staff after the issuance of their comment letter raised additional methodological issues. After working with MHA to better understand their new modeling, staff determined that when it accounted for the methodological issues staff perceived (population growth and population weighting), HSCRC modelling yielded a range from 0.04 to 0.12 percent, which aligns with the staff's proposed national demand modifier of 0.10 percent.***

Comments were received from:	MHA	UMMS	Frederick Health

See appendix for comment details.

Summary of Annual SG2 Report Projections

SG2 Report Year	Forecast Period	Population	IP Discharges 10-Year Growth	OP Visits 10-Year Growth
2021	2019 - 2029	NA	-1%	14%
2022	2022 - 2032	13%	8%	16%
2023	2023 - 2033	10%	2%	16%
2024	2024 - 2034	13%	3%	17%
2025	2025 - 2035	14%	5%	18%

Continue Including Volume Variable Funding in DA Comments

Overall Summary: Stakeholders urge HSCRC to continue to apply Demographic Adjustments to all revenues until the scope of services carved out of Global Budgets is fully established.

Staff Response: ***Staff have some serious concerns regarding the current request.***

We believe that applying Maryland population growth projections to volumes evaluated under a fee-for-service methodology is double counting since fee-for-service reimbursement automatically includes demographic driven volume growth, particularly when non-Maryland populations are being considered, i.e., out-of-state volumes.

Staff could not find an analogous adjustment in a fee-for-service context and could not identify a clear policy rationale for this approach.

Comments were received from:	MHA	UMMS	JHHS	Frederick Health	Adventist

See appendix for comment details.

Final Recommendations

1. **Apply a national demand modifier of 0.10 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.**

Appendix –Concerns with Age Adjusted Growth Detailed Stakeholder Comments & Sg2 Analysis Details

maryland health services cost review commission

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

Population Aging[1]

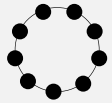
Use Rates

Acuity

Shifts in Care Settings

Innovation & Technology

Socioeconomic Factors



Other Factors

This workgroup will explore if there is a more nuanced governor available to account for aging and other factors that **might offset or increase the effect of aging**. Will necessitate **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.

Use of Age Cost Weights in Demographic Adjustment

Age cost weights are used in the Demographic Adjustment to reflect the **differential costs** of treating patients in different age cohorts. Population growth in more expensive cohorts will result in more funding than population growth in less expensive cohorts.

Example Calculation – FY2026 Data:

		A
0 – 4	$2,224	0.69
5 – 14	499	0.16
15 – 44	1,873	0.58
45 – 54	2,708	0.84
55 – 64	4,320	1.35
65 – 74	6,583	2.05
75 – 84	9,235	2.88
85+	10,381	3.23
Total	$3,212	1.00

B

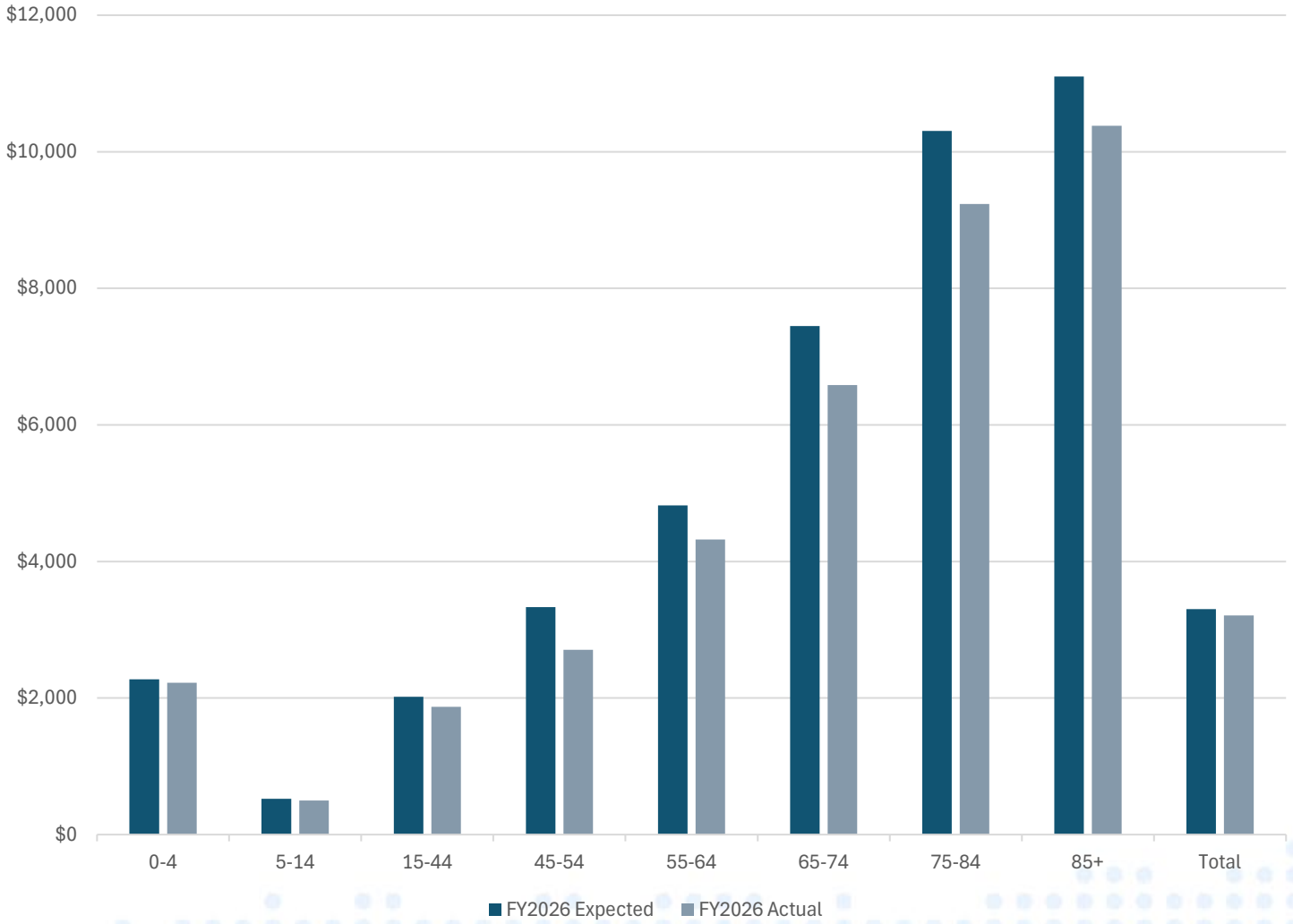
C

A Cost weights are **calculated for each age cohort** by dividing the age cohort revenue per capita by statewide overall revenue per capita.

B The **older age cohorts** receive the **largest cost weights** given their increased utilization and need for more intensive services.

C Statewide the **average revenue per capita** was $3,212. This receives a cost weight of 1.00.

Inflation-adjusted per capita costs have declined for all age cohorts



- FY2026 expected is calculated as FY2015 actual revenue per capita trended forward with 10 years of inflation to FY2026 dollars. This value represents funding per capita with **no underlying change in costs** of treating patients vs. the FY2015 baseline.
- For all age cohorts, FY2026 actual revenue is less than FY2026 expected, meaning **across the board, per capita costs have declined** (after adjusting for inflation).
- Using age cost weights to fund aging in the Demographic Adjustment would ignore these **secular declines in revenue per capita.**

Illustrative Example

Last Year's Test

A professor gives a test and the class average is 50 percent.

As a result, the professor applies a 20 percent curve to bring the class average to 70 percent.

This is reasonable as it brings the class average to a C.

This Year's Test

The professor gives the same test the next year and the class average is 90 percent.

It would be unreasonable for the professor to apply the same 20 percent curve from last year, as something changed year over year that resulted in better performance.

It's possible that the class is smarter, the material was taught differently, or something else caused the variation in performance, but regardless the 20 percent curve should not be applied.

What This Means in the Context of Age Cost Weights:

One should not take a "fix" from one specific year (like the "aging bonus" or the "20-point curve") and apply it forever. The situation changes every year. Using age cost weights to fund aging through the Demographic Adjustment would be flawed because it **permanently bakes in an assumption about costs**, ignoring data that shows spending across all age cohorts is decreasing. A **more sophisticated approach** would be needed that would account for secular declines in cost, PAU, and other factors.

Fund Age Adjusted Population Growth Comments

Overall Summary: Many Stakeholders strongly support fully funding age-adjusted population growth, averaging about 0.65% annually, stating that the current methodology underfunds aging-related utilization. They also argue that the Demographic Adjustment serves as the sole means to finance anticipated increases in utilization driven by an aging population. In contrast, CareFirst and HME oppose additional funding, citing efficiency gains, technology improvements, and sufficient current funding.

Organization	Summary of Comments
MHA	MHA recommends HSCRC to fully fund estimated age-adjusted population growth and supported an adjustment of 0.65% to account for average annual amount of age adjusted growth between 2020–2024 as the current methodology insufficiently accounts for age-adjusted population growth. They believe discounting this statistic for efficiency is unnecessary since existing PAU scaling and other policy levers with GBR adjustments already promote efficiency.
UMMS	UMMS emphasizes that the Demographic Adjustment methodology should be risk-adjusted to account for aging and socioeconomic factors and proposed an age-adjustment factor, which has averaged 0.65% above pure population growth annually since 2020, serves as a relatively appropriate risk adjustor.
JHHS	JHHS stresses that the current Demographic Adjustment methodology insufficiently accounts for age-adjusted population growth, as it effectively caps adjustments at unadjusted population growth projections. They argue that since global budgets are not case-mix adjusted, the Demographic Adjustment is the only mechanism to fund expected utilization growth due to aging. JHHS supports fully funding estimated age-adjusted growth in the interim and is open to a more comprehensive risk adjustment approach in the future.
Adventist	Adventist highlights that age-adjusted population growth has exceeded total population growth by about 0.65% annually and argues that the Demographic Adjustment should fully fund this growth to reflect increasing acuity and resource intensity. They caution that underfunding risks access constraints, especially in aging markets, and emphasize that Demographic Adjustments under AHEAD are intended to account for both population size and medical risk and encourage HSCRC to explore incorporating additional non-age-related demographic and social risk factors—such as sex, race, and socioeconomic status.
Frederick Health	Frederick Health states that the current methodology caps Demographic Adjustments at unadjusted population growth, leaving a significant gap between age-adjusted growth and the scaled adjustment provided. Since this adjustment is the only mechanism for revenue tied to aging-related utilization, they strongly support fully funding estimated age-adjusted growth in the interim while broader refinements are developed.
CareFirst	CareFirst believes additional funding for age-adjusted growth is not currently needed because improvements in technology, population health, and care transformation have reduced reliance on hospital services.
HME	HME opposes the provision of additional funding due to aging as they feel Maryland hospitals are sufficiently funded to respond to the state's aging population.

Incorporate National Demand Modifier Comments

Overall Summary: Stakeholders raised concerns that HSCRC's analysis understates demographic impacts and overstates practice pattern changes. They question the reasonableness of assumptions, noting in particular that reliance on historical trends and a 3% projected growth rate is too conservative and urging forward-looking demand estimates. Some highlight national all-payer data and suggest incorporating a national demand modifier to account for Medicaid.

Organization	Summary of Comments
MHA	MHA raises concerns that HSCRC understates demographic impacts and overstates practice pattern changes. They question if the Medicare Advantage adjustment is necessary given Maryland's low enrollment and non inclusion of Medicaid, which saw a dramatic increase in enrollment during the evaluation period due to the Affordable Care Act. Also, MHA have conducted an analysis of all-payer data and suggested National demand modifier should account for Medicaid, which would increase it to 0.28%.
UMMS	UMMS believe HSCRC's retrospective analysis (2013–2023) fails to account for future expectations in terms of both expected demand and total risk. It assumes a 3% national growth rate for the next decade, which is too conservative.
JHHS	JHHS believes the current Demographic Adjustment Policy's reliance on historical growth to set prospective adjustments is problematic because use-rate growth reflects more than demographics. They suggest reconsidering whether future adjustments should be based on historical trends or incorporate actual forward-looking utilization growth estimates for greater accuracy.
Frederick Health	Frederick Health appreciates HSCRC's empirical approach but raises concerns that the analysis understates demographic impacts and overstates practice pattern changes. They question the appropriateness of Medicare Advantage adjustments given Maryland's lower enrollment and note the omission of Medicaid data, which saw significant growth. Additionally, MHA's review of national all-payer data indicates higher utilization growth than HSCRC estimates, supporting the need for a larger national demand modifier.
Adventist	Adventist suggested using quality and access indicators alongside utilization metrics to ensure lower use rates are not achieved at the expense of care quality. They explained that to fully assess whether lower use reflects healthier populations versus constrained access, complementary outcome and throughput indicators should be reviewed in tandem, for example, diabetes prevalence or control, obesity and BMI trends, ambulatory care–sensitive condition rates, ED wait and boarding times, and mortality.
HME	HME cites HSCRC's analysis showing age-adjusted hospital utilization in Maryland decreased by 10%, with outpatient utilization declining even more. They note that global budgets have increased during this period, meaning hospitals have been funded based on outdated utilization patterns. This supports their position that additional demographic funding is unnecessary.

Incorporate National Demand Modifier Comments cont.

Overall Summary: Stakeholders raised concerns that HSCRC's analysis understates demographic impacts and overstates practice pattern changes. They question the reasonableness of assumptions, noting in particular that reliance on historical trends and a 3% projected growth rate is too conservative. Some highlight national all-payer data and suggest incorporating a national demand modifier to more explicitly account for Medicaid, which based on stakeholder modelling would result in a 0.28% national modifier versus staff's proposal of 0.1%.

Algebra	Variable	US Population	US wo Maryland Population	Notes
A	2013 Population	316,128,839	310,240,464	https://data.census.gov/table?q=United+States&g=010XX00US&y=2023
B	NASHP 2013 Adjusted Patient Discharges	64,298,340	63,183,885	https://tool.nashp.org/
C=B/A*1000	2013 Adjusted Discharges Per 1000 Population	203.4	203.7	
D	2023 Population	334,914,896	328,722,456	https://data.census.gov/table?q=United+States&g=010XX00US&y=2023
E	NASHP 2023 Adjusted Discharges	70,737,422	69,764,234	https://tool.nashp.org/
F=E/D*1000	2023 Adjusted Discharges Per 1000 Population	211.2	212.2	
G=F/C-1	2013-2023 % Growth in National Discharges Per 1000	3.84%	4.21%	
H	Conservative Site Neutral Discount	1.90%	1.90%	Staff Recommendation based on Medpac Report: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf
I=G-H	Potential National Demand Modifier Over 10 Years	1.94%	2.31%	
J=I/10	Potential National Demand Modifier 1 Year	0.19%	0.23%	In line with staff proposal but utilizes conservative site neutral opportunity and is reliant on national cost report data

Comments were received from:	MHA	UMMS	JHHS	Frederick Health	Adventist	HME

See appendix for comment details.

Use SG2 to Fund Projected Future Utilization Growth Comments

Overall Summary: Stakeholders broadly cited independent forecasts like Sg2 showing 4.5% inpatient and 17.4% outpatient growth from 2025 - 2035, supporting a higher national demand modifier (0.52%-0.64% annually) versus the proposed 0.10%. They emphasize the need for prospective forecasts to ensure hospitals are adequately resourced in 2026, thereby closing the gap between age-adjusted growth and the scaled Demographic Adjustment.

Organization	Summary of Comments
MHA	MHA questions HSCRC's reliance on historical trends without projecting future utilization, noting that other forecasts e.g., Sg2 predict significantly higher growth, 4.5% inpatient and 17.4% outpatient from 2025–2035. MHA estimates total growth of 8.3% over the decade and recommends applying a 0.64% annual national demand modifier, rather than the 0.10% proposed, starting with RY 2026 to ensure hospitals are adequately resourced.
UMMS	UMMS strongly recommends using prospective forecasts rather than retrospective data and cited Kaufman Hall Consulting's (earlier Sg2) 2025 Impact of Change Forecast which states 4.5% inpatient growth and 17.4% outpatient growth from 2025–2035. Equivalent to 8.3% total growth or 0.83% annually, UMMS supports applying a 0.64% annual national demand modifier.
Frederick Health	Frederick Health notes that the draft recommendation relies on historical trends without projecting future utilization, despite Frederick County's expected significant demographic growth, especially among those over 75. They point to independent forecasts like Sg2, which project much higher inpatient and outpatient growth, and agree with MHA that applying these projections would justify a national demand modifier closer to 0.52% annually, rather than the proposed 0.10% in RY 2026 to close the gap between age-adjusted growth and the scaled Demographic Adjustment in current FY26 rates.

Continue Including Volume Variable Funding in DA Comments

Overall Summary: Stakeholders urge HSCRC to continue to apply Demographic Adjustments to all revenues until the scope of services carved out of Global Budgets is fully established.

Organization	Summary of Comments
MHA	MHA urges HSCRC to maintain the policy of applying Demographic Adjustments to all revenues.
JHHS	JHHS supports continuing to apply the Demographic Adjustment to all revenues.
Frederick Health	Frederick Health support MHA's request to maintain the policy of applying Demographic Adjustments to all revenues to ensure hospitals are adequately resourced for community needs.
UMMS	UMMS suggests not to discontinue the application of the Demographic Adjustment to volumes that are not part of population-based payments until the definition and methodology treatment of those volumes are known and evaluated on these terms.
Adventist	Adventist does not support moving forward with any carveouts until additional workgroup discussion and analysis occur. Adventist explains that the extent of volumes to be carved out of population-based payments remains under development.

AHEAD Alignment & Other comments

Overall Summary: Stakeholders suggest that the Demographic Adjustment should be aligned with AHEAD methodologies when applicable. Other recommendations include support in postponing HCC risk score application, utilizing variable cost factors, evaluating alternative sources for population data, and incorporating regional variation in Demographic Adjustment.

Organization	Summary of Comments
MHA	MHA recommends that any Demographic Adjustment changes for 2026–2027 be reassessed before CMS takes over Medicare global budgets in 2028 to ensure utilization needs of the changing population. They also urge HSCRC to consider implications of any changes in Demographic Adjustments policy as part of broader discussions about additional exclusions from hospital global budgets under AHEAD.
JHHS	JHHS emphasizes that as Maryland transitions to the AHEAD model, Demographic Adjustment policies must align with future requirements. They recommend reevaluating any changes for 2026–2027, before CMS assumes Medicare global budgets in 2028 to ensure adequacy.
Adventist	Adventist supports postponing HCC risk score application until AHEAD implementation, agrees with staff not to apply a variable cost factor, as it would complicate methodology and distort funding balance, warns that demographic change varies by region, with some markets facing capacity constraints and urges exploring alternative data sources for age-adjusted estimates, presenting ranges or sensitivity analyses to account for uncertainty and strengthen methodology.
UMMS	UMMS suggests establishing the steps and timeline for reviewing potential changes to the Demographic Adjustment Methodology after CMS assumes responsibility for Medicare population under AHEAD.

AHEAD Alignment & Other comments

Overall Summary: Stakeholders suggest that the Demographic Adjustment should be aligned with AHEAD methodologies when applicable. Other recommendations include support in postponing HCC risk score application, utilizing variable cost factors, evaluating alternative sources for population data, and incorporating regional variation in Demographic Adjustment.

Staff Response: ***Staff agree that the Demographic Adjustment should align with AHEAD methodologies to the furthest extent possible. To achieve this alignment, staff have taken the following actions:***

1. Advanced a total risk adjustment
2. Not recommended incorporating a variable cost factor.
3. Signaled that future Demographic Adjustments should utilize more sophisticated risk adjustment for Medicare and non-Medicare HGB's.

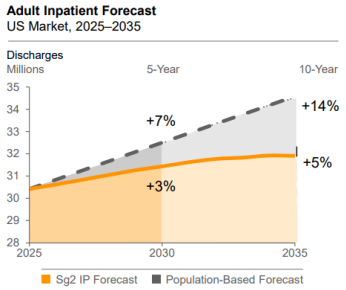
Moving forward, staff will work with stakeholders to ensure that approaches analogous to the Medicare HGB Demographic Adjustment are utilized and that population funding is clearly delineated between Medicare and non-Medicare global budgets.

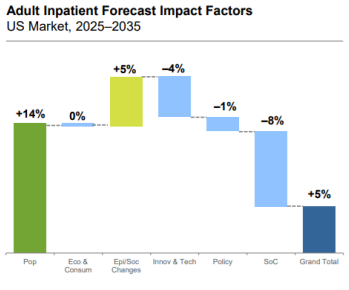
If authorized, staff will explore alternative sources for population data in a future year, which could potentially better address regional variation in population growth. However, staff notes that the gold standard for population growth estimates is the U.S. Census Bureau. Claritas, the proprietary dataset the Commission currently uses to distribute population funding, relies on the Census Bureau for all of its estimates but uses a zip code level, which already accounts for regional variation at a granular level.

Comments were received from:	MHA	UMMS	JHHS	Adventist

See appendix for comment details.

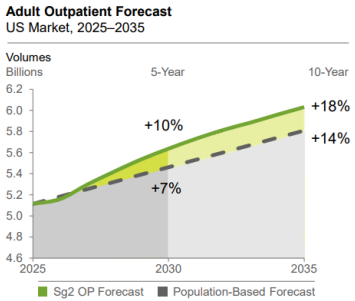
Methodology for calculating total projected growth based on Sg2 “Impact Factors”

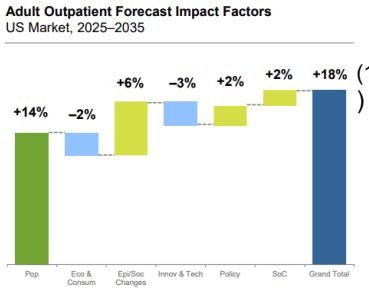




(4.5%)

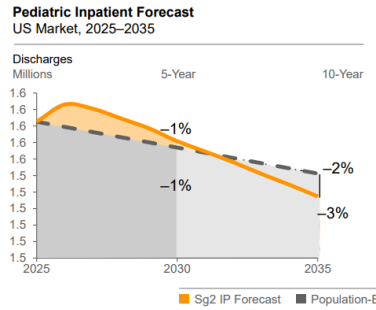
Inpatient	2025-2035	SG2 US 18+	14.0%	-9.5%	4.5%
Inpatient	2025-2035	Spotlight MD 18+	10.2%		0.7%

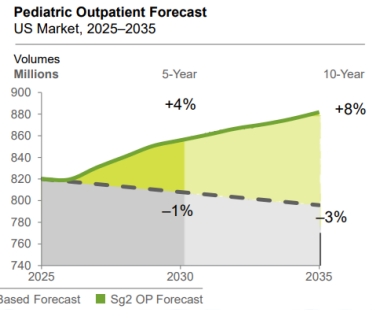




(17.4%)

Outpatient	2025-2035	SG2 US 18+	14.0%	3.4%	17.4%
Outpatient	2025-2035	Spotlight MD 18+	10.2%		13.6%





Inpatient	2025-2035	SG2 US 0-17	-3.0%	1.0%	-2.0%
Inpatient	2025-2035	Spotlight MD 0-17	-4.0%		-3%
Outpatient	**2025-2035**	**SG2 US 0-17**	**-3.0%**	**11%**	**8.0%**
Outpatient	2025-2035	Spotlight MD 0-17	-4.0%		7%

Note: The “Projected 10-year Growth” column is the first step in both National and MD Calculations on slides 7 and 8.

maryland health services cost review commission

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Final Recommendation for Demographic Adjustment Refinement

January 14, 2026

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
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This document contains the final staff recommendations for updating the Demographic Adjustment methodology. A Commissioner vote on this matter is expected during the January 2026 Commission meeting.

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. FFY - Federal fiscal year refers to the period of October 1 through September 30
7. FY - Fiscal Year, typically refers to a State fiscal year from July 1 through the following June 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.

Table of Contents

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 Models' goals of efficiency, sustainability, and accountability.

Introduction

The shift of Maryland's health care system since 2014 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 demand 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. Therefore, while age is used to allocate funding between hospitals it does not drive the total amount of funding.

However, concerns have arisen that population growth adjustments without risk adjustment, particularly

[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.

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. 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 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.

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

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

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, so as a hospital's market share grows so will their share of demographic funding).

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.

[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.

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 so that the statewide Demographic Adjustment is equivalent to unadjusted population growth.

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

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)

[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 given that 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.

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, the remaining Medicare FFS population has become increasingly higher-acuity. 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

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
		2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	(2023/2013)
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.

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

Table 4: Summary Results of Changes in Maryland and National EIPDs per Thousand Due to Demographics and Changing Practice Patterns[10]

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.

[10] The Maryland Inpatient *Combined Change* value of -10% differs from the -9.1% referenced in table 3, because the former also accounts for Medicare Advantage morbidity discount to recognize that as Medicare Advantage increases its penetration, the remaining Medicare Fee-For-Service population has higher morbidity owing to the documented favorable selection in the Medicare Advantage market.

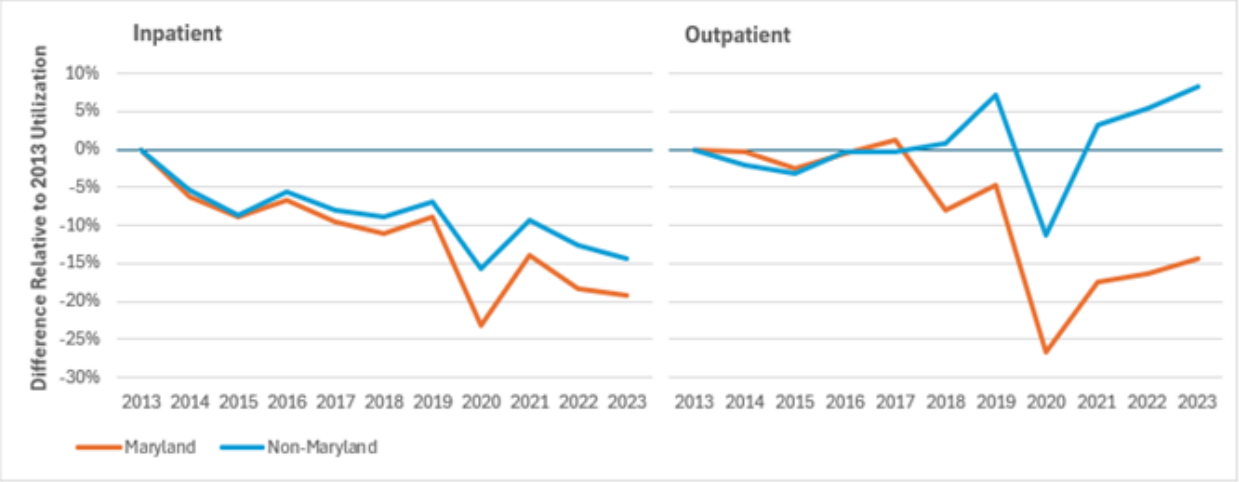
- Maryland's inpatient utilization patterns decreased by 4 percent more than other states.
- Maryland's outpatient utilization patterns decreased by 22 percent more than other states.

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 the 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[11] 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 national site-neutral incentives, staff, in collaboration with

[11] "These payment differences encourage arrangements among providers, such as consolidation of physician practices with hospitals, which result in care being billed from settings with the highest payment rates. The net effect of these arrangements 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

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[12] 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 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 primarily 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;[13] however, staff have concerns about using the HCC risk assessments now

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

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

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 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.

Stakeholder Feedback

The Demographic Adjustment is intended to reflect factors that impact demand for hospital services (as opposed to price). These factors can be broadly categorized in 3 buckets:

- The size of the population served
- The age of the population served

- Changes in technology, clinical practices, and population health (aside from aging)

Historically, for various reasons, the HSCRC has only considered the first factor (age is used to distribute funding but does not change the total amount provided).

There has been considerable concern that the failure to acknowledge age has resulted in systematic underfunding. During this process, the HSCRC demonstrated that excluding the impact of aging has not resulted in systematic underfunding as it has been offset by the third factor. This is consistent with evidence from national data sets, and many commenters acknowledged this in their comment letters.

Having ruled out existing underfunding, the discussion in the Volume Workgroup moved to the appropriate future funding formula. There are three potential options:

A. Continue the current practice of assuming that age will be offset by other changes in demand
B. Add a factor for age and other considerations based on average historical experience (past is prologue)
C. Building into the future process a dynamic estimate of changing hospital demand (considering clinical risk and other demand drivers).

While experience of the model to date has shown that approach A is adequate, Staff have proposed moving to option B to acknowledge the various drivers of population demand. A few commenters argued for returning to Approach A while others argued for either revising the estimate derived for Approach B or moving to Approach C. Staff have not changed their proposal based on the comments because:

- Staff believe the data supports a small incremental increase beyond population growth
- Staff do not believe the proposed revisions to approach B were an improvement
- Staff believe that the added complexity of moving to Approach C is not merited given the limitations on available data and the subjectivity involved in any projection approach

The remainder of this section will address the seven stakeholder comment letters in more detail, which can be broadly categorized into five thematic areas of concern:

Table 8: Summary of Stakeholder Comments

Topics	MHA	UMMS	JHHS	Frederick Health	Adventist	CareFirst	HME
Fund Age Adjusted Population growth	✓	✓	✓	✓	✓	✓	✓
Use SG2 to Fund Projected Future Utilization Growth	✓	✓		✓			
Incorporate National Demand Modifier	✓	✓	✓	✓	✓		✓
Continue Including Volume Variable Funding in DA	✓	✓	✓	✓	✓		
AHEAD Alignment & Other comments	✓	✓	✓		✓		

1. Fund Age Adjusted Population Growth Comments: Many Stakeholders strongly support fully funding age-adjusted population growth, averaging about 0.65 percent annually, stating that the current methodology underfunds aging-related utilization. They also argue that the Demographic Adjustment serves as the sole means to finance anticipated increases in utilization driven by an aging population. In contrast, CareFirst and HME oppose additional funding, citing efficiency gains, technology improvements, and sufficient current funding.

Table 9: Fund Age Adjusted Population Growth Comments Summary:

Organization	Summary of Comments
MHA	MHA recommends HSCRC to fully fund estimated age-adjusted population growth and supported an adjustment of 0.65% to account for average annual amount of age adjusted growth between 2020–2024 as the current methodology insufficiently accounts for age-adjusted population growth. They believe discounting this statistic for efficiency is unnecessary since existing PAU scaling and other policy levers with GBR adjustments already promote efficiency.
UMMS	UMMS emphasizes that the Demographic Adjustment methodology should be risk-adjusted to account for aging and socioeconomic factors and proposed an age-adjustment factor, which has averaged 0.65% above pure population growth annually since 2020, serves as a relatively appropriate risk adjustor.
JHHS	JHHS stresses that the current Demographic Adjustment methodology insufficiently accounts for age-adjusted population growth, as it effectively caps adjustments at unadjusted population growth projections. They argue that since global budgets are not case-mix adjusted, the Demographic Adjustment is the only mechanism to fund expected utilization growth due to aging. JHHS supports fully funding estimated age-adjusted growth in the interim and is open to a more comprehensive risk adjustment approach in the future.
Adventist	Adventist highlights that age-adjusted population growth has exceeded total population growth by about 0.65% annually and argues that the Demographic Adjustment should fully fund this growth to reflect increasing acuity and resource intensity. They caution that underfunding risks access constraints, especially in aging markets, and emphasize that Demographic Adjustments under AHEAD are intended to account for both population size and medical risk and encourage HSCRC to explore incorporating additional non-age-related demographic and social risk factors—such as sex, race, and socioeconomic status.
Frederick Health	Frederick Health states that the current methodology caps Demographic Adjustments at unadjusted population growth, leaving a significant gap between age-adjusted growth and the scaled adjustment provided. Since this adjustment is the only mechanism for revenue tied to aging-related utilization, they strongly support fully funding estimated age-adjusted growth in the interim while broader refinements are developed.
CareFirst	CareFirst believe additional funding for age-adjusted growth is not currently needed because improvements in technology, population health, and care transformation have reduced reliance on hospital services.
HME	HME opposes the provision of additional funding due to aging as they feel Maryland hospitals are sufficiently funded to respond to the state's aging population.

Staff Response: *Staff have considered this approach and analyzed the growth statistic cited in the comments supporting this approach. However, the value was specifically designed to distribute population funding, not to function as a governor for statewide funding.*

As has been discussed in both the Volume Workgroup and the November Commission meeting, the age-adjusted growth statistic in the Demographic Adjustment is inappropriate for two reasons: it fails to account for year-over-year growth, thus missing broader secular trends, and it only considers one factor (aging) that affects changes to hospital utilization.

Given these limitations of the adjusted growth growth statistic, staff conducted new analyses for the December workgroup engagement focused on the proposed approaches that more comprehensively account for aging and other important factors that impact population-level risk. Since commenters, including the Maryland Hospital Association (MHA), have advanced new proposals that align with the prerequisites staff have identified for amending the Demographic Adjustment, i.e., it must account for for year-over-year growth and consider factors other than aging that affect changes to hospital utilization, staff consider the request to fund age adjusted growth with no consideration of secular factors and other factors other than aging resolved.

2. Use Sg2, a Division of Vizient, to Fund Projected Future Utilization Growth Comments: Stakeholders broadly cited independent forecasts like Sg2 showing 4.5 percent inpatient and 17.4 percent outpatient growth from 2025–2035, supporting a higher national demand modifier (0.52 percent–0.64 percent annually) versus the proposed 0.10 percent. They emphasize the need for prospective forecasts to ensure hospitals are adequately resourced in 2026 to close the gap between age-adjusted growth and the scaled Demographic Adjustment.

Table 10: Use Sg2 to Fund Projected Future Utilization Growth Comments Summary:

Organization	Summary of Comments
MHA	MHA questions HSCRC's reliance on historical trends without projecting future utilization, noting that other forecasts e.g., Sg2 predict significantly higher growth, 4.5% inpatient and 17.4% outpatient from 2025–2035. MHA estimates total growth of 8.3% over the decade and recommends applying a 0.64% annual national demand modifier, rather than the 0.10% proposed, starting with RY 2026 to ensure hospitals are adequately resourced.
UMMS	UMMS strongly recommends using prospective forecasts rather than retrospective data and cited Kaufman Hall Consulting's (earlier Sg2) 2025 Impact of Change Forecast which states 4.5% inpatient growth and 17.4% outpatient growth from 2025–2035. Equivalent to 8.3% total growth or 0.83% annually, UMMS supports applying a 0.64% annual national demand modifier.
Frederick Health	Frederick Health notes that the draft recommendation relies on historical trends without projecting future utilization, despite Frederick County's expected significant demographic growth, especially among those over 75. They point to independent forecasts like Sg2, which project much higher inpatient and outpatient growth, and agree with MHA that applying these projections would justify a national demand modifier closer to 0.52% annually, rather than the proposed 0.10% in RY 2026 to close the gap between age-adjusted growth and the scaled Demographic Adjustment in current FY26 rates.

Staff Response: *Staff thanks stakeholders for providing an alternative to the 0.1 percent national demand modifier statistic outlined in the Demographic Adjustment Draft Recommendation. We appreciate that this alternative accounts for year-over-year growth and non-aging factors, fulfilling the necessary requirements for consideration. However, staff are concerned that the proposal is not viable for the following reasons:*

1. *Proprietary Data: The specifics of the Sg2 forecast are proprietary and not available to non-hospital entities, making external vetting difficult.*
2. *Variability: Sg2's annual ten-year forecasts exhibit significant variation (as shown in table 11). This suggests the statistic may not be sufficiently reliable or predictable to serve as a volume governor in a capitated model.*

Table 11: Summary of Annual Sg2 Report Projections

SG2 Report Year	Forecast Period	Population	IP Discharges 10-Year Growth	OP Visits 10-Year Growth
2021	2019 - 2029	NA	-1%	14%
2022	2022 - 2032	13%	8%	16%
2023	2023 - 2033	10%	2%	16%
2024	2024 - 2034	13%	3%	17%
2025	2025 - 2035	14%	5%	18%

3. *Additional Hospital Industry Methodological Concerns: The initial proposal by MHA and other hospital stakeholders resulted in double counting within the existing HSCRC methodology for population growth, as it included both base population growth and other factors, such as aging and technological improvements, that affect hospitalizations. Subsequent proposals from MHA that utilize Sg2 data and were presented to HSCRC staff after the issuance of their comment letter raised additional methodological issues. HSCRC met with MHA to better understand the underlying assumptions of their new proposals. After working with MHA to better understand their new modeling, staff determined that when it accounted for the methodological issues staff perceived (population growth and population weighting), HSCRC modelling yielded a range from 0.04 to 0.12 percent, which aligns with the staff's proposed national demand modifier of 0.10 percent.*

3. Incorporate National Demand Modifier Comments: Stakeholders raised concerns that HSCRC's analysis understates demographic impacts and overstates practice pattern changes. They question the reasonableness of assumptions, noting in particular that reliance on historical trends and a 3 percent projected growth rate is too conservative. Some highlight national all-payer data and suggest incorporating a national demand modifier to more explicitly account for Medicaid, which based on stakeholder modelling would result in a 0.28 percent national modifier versus staff's proposal of 0.1 percent.

Table 12: Incorporate National Demand Modifier Comments Summary

Organization	Summary of Comments
MHA	MHA raises concerns that HSCRC understates demographic impacts and overstates practice pattern changes. They question if the Medicare Advantage adjustment is necessary given Maryland's low enrollment and non inclusion of Medicaid, which saw a dramatic increase in enrollment during the evaluation period due to the Affordable Care Act. Also, MHA have conducted an analysis of all-payer data and suggested National demand modifier should account for Medicaid, which would increase it to 0.28%.
UMMS	UMMS believe HSCRC's retrospective analysis (2013–2023) fails to account for future expectations in terms of both expected demand and total risk. It assumes a 3% national growth rate for the next decade, which is too conservative.
JHHS	JHHS believes the current Demographic Adjustment Policy's reliance on historical growth to set prospective adjustments is problematic because use-rate growth reflects more than demographics. They suggest reconsidering whether future adjustments should be based on historical trends or incorporate actual forward-looking utilization growth estimates for greater accuracy.
Frederick Health	Frederick Health appreciates HSCRC's empirical approach but raises concerns that the analysis understates demographic impacts and overstates practice pattern changes. They question the appropriateness of Medicare Advantage adjustments given Maryland's lower enrollment and note the omission of Medicaid data, which saw significant growth. Additionally, MHA's review of national all-payer data indicates higher utilization growth than HSCRC estimates, supporting the need for a larger national demand modifier.
Adventist	Adventist suggested using quality and access indicators alongside utilization metrics to ensure lower use rates are not achieved at the expense of care quality. They explained that to fully assess whether lower use reflects healthier populations versus constrained access, complementary outcome and throughput indicators should be reviewed in tandem, for example, diabetes prevalence or control, obesity and BMI trends, ambulatory care–sensitive condition rates, ED wait and boarding times, and mortality.
HME	HME cites HSCRC's analysis showing age-adjusted hospital utilization in Maryland decreased by 10%, with outpatient utilization declining even more. They note that global budgets have increased during this period, meaning hospitals have been funded based on outdated utilization patterns. This supports their position that additional demographic funding is unnecessary.

Staff Response: *Staff again thanks stakeholders for providing an alternative to the 0.1 percent national demand modifier statistic outlined in the Draft Recommendation. We appreciate that this alternative accounts for year-over-year growth and non-aging factors, fulfilling the necessary requirements for consideration. However, staff does not believe there is a basis for changing the approach used for the following reasons:*

A. Staff's approach relies on claims data while the proposed approach relies on Medicare cost report data, and there is significant research into the challenges of cost report data.[14] As such, staff believe the claims-based approach is preferable.

B. Staff believe the answers are effectively the "same" given the level of precision feasible in deriving these estimates. For example, using a different source of population estimates changes the outcomes of the stakeholder modeling from 0.28 percent to 0.19 percent or 0.23 percent (depending on whether or not Maryland is included in the assessment). Staff believe the relatively narrow range of the various estimates should provide comfort, and that using the claims-based estimate as the point estimate is preferable.

[14] Examples of literature on the challenges of cost report data:
The Medicare Cost Report and the limits of hospital accountability: improving financial accounting data - highlights the general issue of cost reports not being audited
Hospitals in Some States Under Report Medicaid Discharge Counts in Cost Report Data - shows the disconnect in claims-based discharges and those in cost reports (within Medicaid)
Statewide Hospital Discharge Data: Collection, Use, Limitations, and Improvements - in 28 studies using discharge data, only 7 used cost reports, and all of those 7 supplemented with another source (typically HCUP).

4. Continue Including Volume Variable Funding in DA Comments: Stakeholders urge HSCRC to continue to apply Demographic Adjustments to all revenues until the scope of services carved out of Global Budgets is fully established.

Table 13: Continue Including Volume Variable Funding in DA Comments Summary

Organization	Summary of Comments
MHA	MHA urges HSCRC to maintain the policy of applying Demographic Adjustments to all revenues.
JHHS	JHHS supports continuing to apply the Demographic Adjustment to all revenues.
Frederick Health	Frederick Health support MHA's request to maintain the policy of applying Demographic Adjustments to all revenues to ensure hospitals are adequately resourced for community needs.
UMMS	UMMS suggests not to discontinue the application of the Demographic Adjustment to volumes that are not part of population-based payments until the definition and methodology treatment of those volumes are known and evaluated on these terms.
Adventist	Adventist does not support moving forward with any carveouts until additional workgroup discussion and analysis occur. Adventist explains that the extent of volumes to be carved out of population-based payments remains under development.

Staff Response: *Staff have some serious concerns regarding the current request. We believe that applying Maryland population growth projections to volumes evaluated under a fee-for-service methodology is double counting since fee-for-service reimbursement automatically includes demographic driven volume growth, particularly when non-Maryland populations are being considered, i.e., out-of-state volumes.*

Staff could not find an analogous adjustment in a fee-for-service context and could not identify a clear policy rationale for this approach.

5. AHEAD Alignment & Other Comments: Stakeholders suggest that the Demographic Adjustment should be aligned with AHEAD methodologies when applicable. Other recommendations include support in postponing HCC risk score application, utilizing variable cost factors, evaluating alternative sources for population data, and incorporating regional variation in Demographic Adjustment

Table 14: AHEAD Alignment & Other Comments Summary

Organization	Summary of Comments
MHA	MHA recommends that any Demographic Adjustment changes for 2026–2027 be reassessed before CMS takes over Medicare global budgets in 2028 to ensure utilization needs of the changing population. They also urge HSCRC to consider implications of any changes in Demographic Adjustments policy as part of broader discussions about additional exclusions from hospital global budgets under AHEAD.
JHHS	JHHS emphasizes that as Maryland transitions to the AHEAD model, Demographic Adjustment policies must align with future requirements. They recommend reevaluating any changes for 2026–2027, before CMS assumes Medicare global budgets in 2028 to ensure adequacy.
Adventist	Adventist supports postponing HCC risk score application until AHEAD implementation, agrees with staff not to apply a variable cost factor, as it would complicate methodology and distort funding balance, warns that demographic change varies by region, with some markets facing capacity constraints and urges exploring alternative data sources for age-adjusted estimates, presenting ranges or sensitivity analyses to account for uncertainty and strengthen methodology.
UMMS	UMMS suggests establishing the steps and timeline for reviewing potential changes to the Demographic Adjustment Methodology after CMS assumes responsibility for Medicare population under AHEAD.

Staff Response: *Staff agree that the Demographic Adjustment should align with AHEAD methodologies to the furthest extent possible. To achieve this alignment, staff have taken the following actions:*

A. *Advanced a total risk adjustment*
B. *Not recommended incorporating a variable cost factor.*
C. *Signaled that future Demographic Adjustments should utilize more sophisticated risk adjustment for Medicare and non-Medicare HGB's.*

Moving forward, staff will work with stakeholders to ensure that approaches analogous to the Medicare HGB Demographic Adjustment are utilized and that population funding is clearly delineated between Medicare and non-Medicare global budgets.

If authorized, staff will explore alternative sources for population data in a future year, which could potentially better address regional variation in population growth. However, staff note that the gold standard for population growth estimates is the U.S. Census Bureau. Claritas, the proprietary dataset the Commission currently uses to distribute population funding, relies on the Census Bureau for all of its estimates but uses a zip code level, which already accounts for regional variation at a granular level.

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

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	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%**

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	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 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%

November 19, 2025

Allan Pack
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Pack,

Re: Draft Recommendations – Demographic Adjustment Policy

Adventist HealthCare (AHC) appreciates the opportunity to comment on HSCRC staff's draft refinements to the Demographic Adjustment. We commend the significant time and analysis invested in this work and value the collaborative approach through the Volume Subgroup.

We appreciate staff's recognition of Maryland's aging population, which is projected to grow faster than national trends. This demographic shift will increase demand for medically necessary care and create pressure on hospital capacity, particularly in regions like Montgomery County, where occupancy and access challenges already exist. The proposed 0.10 percent national demand modifier is a thoughtful interim step, but is too modest to meaningfully close the gap between population growth and higher per-capita utilization associated with an older population. **Adventist recommends fully funding age-adjusted demographic growth of 0.65 percent.**

National Demand Modifier

Based on Claritas, age-adjusted population growth has exceeded total population growth by about 0.65 percent annually over the past several years. HSCRC's analysis also shows that if Maryland had tracked national utilization patterns while experiencing Maryland's demographics, hospital use would have been roughly 3 percent higher over the decade, or about 0.30 percent per year. Staff attribute about two-thirds of that difference to national incentives that keep low-acuity services in hospital outpatient departments. If national use of clearly site-neutral services had mirrored Maryland's, they estimate national growth would have been about 2 percent lower over the decade. We acknowledge that sentiment, though it does not follow that a 1 percent modifier over ten years is sufficient.

Maryland's policy-driven site-of-care shifts can sometimes move low-acuity encounters out of hospital outpatient departments and into unregulated settings, reducing measured hospital use even as hospitals continue to support the system. However, regulatory and payment constraints limit wholesale movement of low-acuity services, and hospitals cannot readily deregulate service lines without material reductions to global budgets. Capacity and workforce constraints mean demand often appears as ED boarding, delayed admissions, and out-migration rather than counted discharges, suppressed

throughput is not the same as absent need. As the population ages, hospitals also absorb higher acuity backfill and greater resource intensity per case.

Under global budgets, GBR revenue is not acuity or risk adjusted, leaving the Demographic Adjustment as the principal tool to recognize demographic pressure. Notably, under AHEAD, the Demographic Adjustment is expressly intended to reflect both changes in population size and medical risk and acuity as utilization becomes more complex. Consistent with that framework, Maryland's Demographic Adjustment should better account for acuity pressure now by fully funding age-adjusted demographic growth. Underfunding the Demographic Adjustment risks access constraints in faster-aging markets.

Risk Adjustment

We agree with staff that Maryland is not yet positioned to apply Hierarchical Condition Category (HCC) risk scores and support postponing this step until the AHEAD Model is implemented and coding practices align with HCC methodology. In addition, we encourage HSCRC to continue exploring additional non-age-related demographic and social risk factors such as sex, race, and socioeconomic status into future refinements to ensure the policy reflects broader population health needs and aligns with the AHEAD demographic adjustment.

Variable Cost Factor

We support staff's recommendation not to apply a variable cost factor to the Demographic Adjustment. Adding a variable cost factor would complicate the methodology and could distort the balance of variable and fixed funding needed to meet demographic-driven demand.

Scope of Volume

AHC does not support moving forward with any carve-outs until additional Workgroup discussion and analysis occur. The extent of volumes to be carved out of population-based payments remains under development and is subject to contractual requirements in the AHEAD State Agreement. Accordingly, we recommend delaying implementation until carved-out volumes are known and further analysis can be completed, and we request that carve-outs not be implemented within the Demographic Adjustment until that work is complete.

Regional Access and Quality Implications

Demographic change is not uniform across Maryland, and several markets, such as Montgomery County, are already capacity constrained. Sustained occupancy and access pressures indicate that medically necessary care may be suppressed when statewide funding is capped to headcount. Over the past decade, Maryland hospital utilization declined, while a national pattern applied to Maryland's demographics implied growth. Some of this decline reflects successful care transformation, which we support; however, some may represent unmet medically necessary care in aging communities. We note that the current analysis focuses on utilization metrics. To fully assess whether lower use reflects healthier populations versus constrained access, complementary outcome and throughput indicators

should be reviewed in tandem, for example, diabetes prevalence or control, obesity and BMI trends, ambulatory care–sensitive condition rates, ED wait and boarding times, and mortality. If Maryland's target is to achieve hospital use near the 15th percentile, corresponding health and quality indicators should also be trending at comparable levels. We recommend monitoring these quality metrics alongside utilization to ensure that lower use rate growth is not achieved at the expense of quality.

Population Estimates

Accuracy in the underlying population inputs is essential. We understand that Claritas is currently used for age-adjusted estimates, which drive the distribution step. However, we respectfully ask staff to explore alternative vendors or datasets that may provide more reliable age-adjusted estimates at the ZIP-code level for Maryland. If another source proves more reliable, adopting it would strengthen the methodology. Given that demographic estimates carry uncertainty that may exceed the precision implied by the policy's estimates, we also recommend presenting ranges or conducting sensitivity analyses to ensure allocations are robust to reasonable estimation error.

Recommendations

Adventist HealthCare has the following comments on the Draft Demographic Adjustment Policy:

1. Fully fund age-adjusted demographic growth at 0.65 percent as an interim step.
2. Postpone HCC risk adjustment until Maryland transitions to the AHEAD Model.
3. Do not apply a variable cost factor to the Demographic Adjustment.
4. Retain all volumes in the Demographic Adjustment until further review.
5. Consider regional access, latent demand, and other demographic factors including sex, race, and socioeconomic status in future refinements.
6. Explore alternative population estimate sources besides Claritas.

Conclusion

Adventist HealthCare is grateful for staff's effort to refine the Demographic Adjustment and appreciates the extensive analytical work provided. We recommend fully funding age-adjusted demographic growth of 0.65% while additional refinements to the policy take place. We value the opportunity to contribute to changes in the Demographic Adjustment and stand ready to support further analysis as Maryland advances this policy.

Sincerely,

Katie Eckert

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

cc: Jonathan Kromm, PhD, Executive Director, HSCRC
Joshua Sharfstein, MD, HSCRC Chairman
James N. Elliott, MD, HSCRC Vice-Chairman
Jonathan Blum, MPP
Ricardo R. Johnson, JD
Maulik Joshi, DrPH
Nicki McCann, JD
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carefirst.com

November 24, 2025

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

Dear Executive Director Kromm:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for Demographic Adjustment Refinement. We appreciate the staff's in-depth study of demographic trends and their implications on hospital finances. Over the past six months, in response to concerns from hospitals, the HSCRC staff completed a detailed analysis of utilization and demographic trends. The process was collaborative, and evidence driven. The study's conclusion is convincing and clear – hospitals have been adequately funded at existing levels, even accounting for the aging of the population. There is no basis – or need – to provide additional funding to hospitals.

There is a strong consensus that global budgets should adequately fund the volume that occurs from population growth and the aging of the population. Maryland residents are older now on average than they were at the beginning of the model; however, due to improvements in technology, population health, and care transformation, Marylanders do not rely as heavily on hospital services as they did a decade ago. The HSCRC staff's analysis demonstrates that Marylanders use approximately 3% fewer hospital services now than a decade ago, accounting for aging of the population. Consequently, Maryland hospitals have been provided with adequate funding.

Unfortunately, despite its clear conclusion, the staff suggests providing hospitals with 0.1% per year in additional funding anyway. The staff cites that, nationally, hospitalizations increased on an age-adjusted basis. During workgroups and other discussions, staff hypothesized that the Maryland Model incentivized hospitals to shift services to non-hospital settings at a much faster rate than the national. Thus, Maryland outpatient hospitalizations had a net decline as services shifted to ambulatory surgical centers. In the rest of the nation, hospitals grew outpatient volumes in line with their financial incentives. This is a success Maryland should be proud of because it benefits Marylanders. That success should not be used to penalize Marylanders through price increases on their health care.

CareFirst disagrees with the staff's notion that Maryland hospitals should be funded based on the needs of the national population and not Marylanders. Maryland hospitals should be funded on the basis of Maryland utilization patterns and population changes.

Once again, we appreciate the staff's comprehensive study on this issue. We urge the HSCRC to reject the staff's recommendation to provide an additional 0.1%, given that no evidence has been provided to

suggest that hospitals have been underfunded.

Sincerely,

Arin D. Foreman
Vice President, Deputy Chief of Staff
CareFirst BlueCross BlueShield
1501 S. Clinton Street
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HEALTH MEANS EVERYTHING
CONSUMER ALLIANCE

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

RE: DRAFT RECOMMENDATIONS FOR DEMOGRAPHIC ADJUSTMENT

Dear Dr. Kromm and HSCRC commissioners:

Health Means Every (HME) generally supports the goal of ensuring hospital global budgets sufficiently fund demographic-related changes in utilization and demand for care. While HME appreciates that the recommended adjustment is modest, **HME does not recommend finalizing this proposal. We are concerned that a 0.1% adjustment may unnecessarily increase Maryland families' health care costs.** Additionally, we are concerned that the application of a 0.1% national demand modifier to Maryland hospitals' global budgets does not accurately represent hospital care needs in the State of Maryland.

The HSCRC's analysis demonstrates that age-adjusted Maryland hospital utilization has decreased by 10%, and outpatient utilization has decreased even more substantially. During the same period, the HSCRC has consistently increased hospital global budgets (and therefore increased costs for Maryland consumers). In other words, the state has been paying hospitals based on utilization patterns from a decade ago while actual utilization has decreased significantly. These trends suggest that Maryland hospitals are sufficiently funded to respond to the state's aging population and positive demographic adjustments are not currently needed.

HSCRC staff indicated during the November public meeting that they believe the application of a 0.1% national demand modifier is warranted because national trends suggest that hospital service demand and utilization may increase as the state's

population ages. HME appreciates the HSCRC's efforts to ensure that the state's aging population continues to have access to hospital care, however, national trends are not a valid barometer for health care demand in the state of Maryland. Maryland is unique in that it is the only state that has been participating in a Total Cost of Care model for over 10 years. Given that the state has intentionally shaped policy to improve population health and reduce costly health care utilization, it is reasonable that utilization patterns have changed even as the population ages. The HSCRC should consider the unique results of Maryland's TCOC participation over the past 10 years and shape future policies accordingly, instead of incorporating national data.

In fact, HME believes that Maryland families should benefit from the savings accrued under the Maryland model. Right-sizing hospital payments to current utilization patterns is one important way the HSCRC can pass savings down to consumers. HME recommends the following:

1. **The HSCRC should implement a 1.0% demographic adjustment instead of the proposed 1.1%. We strongly urge the HSCRC to avoid increasing consumer costs unnecessarily.**
2. **The HSCRC should ensure that Maryland families benefit from the savings achieved under the Maryland model.**

As noted in our comments on the October public meeting proposals, HME strongly recommends that the HSCRC include a discussion of consumer cost impacts in all future policy proposals. Any modification to the demographic adjustment, regardless of its size, will directly affect hospital global budgets and consumers' health care costs. Despite the fact that consumers will be directly impacted, the HSCRC has not included any discussion of how the proposed demographic adjustment would increase consumers' health care costs. Given the complexity of this proposal, we are concerned the average consumer in Maryland may have difficulty discerning the implications of the proposed change, and thus will struggle to participate in the policymaking process. HME recommends the following:

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1. **The HSCRC should prepare a detailed fiscal note or cost analysis quantifying the anticipated impact of this recommended policy change and all future recommendations on consumer expenses. The HSCRC should present estimates clearly so that consumers can easily understand how this recommendation could impact them financially.**
2. **The HSCRC should ensure future policy recommendations include a discussion of impact on consumers with a sufficient timeframe for review and comment.**

We appreciate your expertise and effort on these difficult topics, and your consideration of our comments. We look forward to continuing to work with you on behalf of Maryland families.

Sincerely,

Ashiah Parker
Chair, Health Means Everything

Ed Beranek
Vice President of Revenue Management and Reimbursement
Jberane1@jhmi.edu

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS HEALTH SYSTEM

November 21, 2025

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

Dear Dr. Kromm,

Thank you for the opportunity for Johns Hopkins Health System (JHHS) to provide comments to the Health Services Cost Review Commission (HSCRC) on the Draft Recommendation for Demographic Adjustment Refinement.

JHHS appreciates the HSCRC staff's recognition that there are limitations in the existing demographic adjustment methodology and consideration of policy changes to better account for the impacts of aging on utilization.

Maryland's population is aging and becoming more complex with an increased burden of chronic disease. This population will have a greater need for hospital services, and the demographic adjustment must be responsive to this need. It is critically important to ensure hospitals have sufficient resources to meet the growing needs of their communities. JHHS supports the need for continuous review of existing policies including the Demographic Policy and JHHS thanks staff for their hard work.

JHHS believes that the current demographic adjustment methodology insufficiently accounts for age-adjusted population growth by effectively capping the statewide adjustment at the Department of Planning's projections for unadjusted population growth. Since global budget revenue is not adjusted for case mix and the demographic adjustment is the only population-based adjustment that provides additional revenue for expected utilization growth due to population growth and aging, it is essential that the adjustment accurately reflects the true age adjusted growth. JHHS recognizes there are risk factors other than age that impact utilization and is supportive of a more comprehensive risk adjustment approach in the future to better align with CMS's methodology for Medicare hospital global budgets; however, the HSCRC should fully fund estimated age-adjusted growth in the interim while longer-term policy refinements are being developed.

The current demographic policy utilizes historical experience to determine the prospective adjustments that should be made to account for use rate growth, however there are other factors beyond demographic changes that account for that use rate growth. This raises the question of whether the policy should consider historical growth to estimate future growth or instead use actual utilization growth estimates to factor into the adjustment moving forward.

Finally, as Maryland moves into the AHEAD model, it will be important to ensure state policies are aligned with that model. Any changes to the demographic adjustment implemented for 2026 and 2027, including the level of the national demand modifier, should be reevaluated before CMS assumes responsibility for Medicare hospital global budgets in 2028 to ensure the methodology is sufficiently accounting for the utilization needs of the changing population. JHHS also believes that the demographic adjustment should be applied to all revenues.

JHHS appreciates the opportunity to comment on the Demographic Adjustment Refinements. Policy. The demographic policy must accurately reflect true age-adjusted growth in the state. As Maryland prepares to move into the AHEAD model, Maryland must also align state policies to be more responsive to changes in volumes and must fund these changes at a reasonable level. JHHS appreciates staff's efforts to formulate these policy refinements and looks forward to further collaboration to improve existing methodologies.

Sincerely,

Ed Beranek

Ed Beranek
Vice President
Revenue Management and Reimbursement
Johns Hopkins Health System

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Jonathan Blum
Nicki McCann
Dr. Farzaneh Sabi

Maryland
Hospital Association

November 21, 2025

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for Demographic Adjustment Refinement. We appreciate staff's recognition of the limitations in the existing demographic adjustment methodology and consideration of policy changes to better account for the impacts of aging on utilization.

Maryland's population is aging and, at the same time, becoming more complex with an increased burden of chronic disease. This population will have a greater need for hospital services and the demographic adjustment must be responsive to this need. In response to feedback from MHA and other stakeholders that the methodology needs to provide additional funding to account for age-adjusted demographic growth, staff are proposing a 0.10% "national demand modifier". However, the draft recommendation also proposes discontinuing application of the demographic adjustment to volumes subject to volume variable methodologies. **The combined effect of these proposed changes is a net reduction to the statewide RY 2026 demographic adjustment from 1.51% to 1.47%** at a time when the state's population is aging and it is critically important to ensure hospitals have sufficient resources to meet the growing needs of their communities.

We offer the following comments for consideration by HSCRC.

Age-Adjusted Population Growth

The current demographic adjustment methodology insufficiently accounts for age-adjusted population growth by effectively capping the statewide adjustment at the Department of Planning's projections for unadjusted population growth. A well-designed demographic adjustment is essential to ensure that hospitals are resourced to care for patients in need of a greater level of health care services. Global budget revenue is not adjusted for case mix and the demographic adjustment is the only population-based adjustment that provides additional revenue for expected utilization growth due to population growth and aging. While we recognize there are risk factors other than age that impact utilization and are supportive of a more comprehensive risk adjustment approach in the future to better align with CMS's methodology for Medicare hospital global budgets, HSCRC should fully fund estimated age-adjusted growth while longer-term policy refinements are being developed. For this reason, MHA has supported

an adjustment of 0.65% to account for the average annual amount of age-adjusted growth between 2020 and 2024. Discounting this statistic to account for expected efficiencies in care delivery is unnecessary given the current methodology already includes a potentially avoidable utilization (PAU) scaling factor, and HSCRC deploys several other policy levers and GBR adjustments to drive efficiency.

Analysis of Historical Utilization Trends

MHA appreciates the empirical approach in the draft recommendation to evaluate the extent to which the current demographic adjustment accounts for utilization changes due to aging. The actuarial analysis that serves as the foundation of the draft recommendation is novel, effectively attributing historical utilization trends to two factors (demographic changes and changing practice patterns) and calculating the national age-adjusted utilization growth rate using Maryland's demographics. However, based on a preliminary assessment, **MHA is concerned that the analysis understates the impact of demographic changes on utilization and overstates the impact of changes in practice patterns.**

The analysis in the draft recommendation concludes that had Maryland followed the same utilization patterns as other states but experienced its own demographic changes, total hospital utilization would have increased by 4.4% from 2013 to 2023. After accounting for favorable selection into Medicare Advantage (MA) plans, this estimate drops to just 3%. We question the magnitude of this adjustment and whether an MA adjustment is necessary given the state's significantly lower MA enrollment rate compared to the nation. At a minimum, this adjustment must be appropriately weighted to reflect differences in enrollment. In addition, this analysis relies on a sample of Medicare and commercial data, but does not include Medicaid, which saw a dramatic increase in enrollment during the evaluation period due to the Affordable Care Act. An MHA analysis of all-payer data from the National Academy for State Health Policy's (NASHP) Hospital Cost Tool shows non-Maryland national adjusted discharge per capita growth of 4.7% between 2013 and 2023, suggesting there is national utilization growth not accounted for in HSCRC's analysis.[1] If the same discount for site neutral incentives were applied to this 4.7% figure instead of the 3% estimate, the resulting national demand modifier would be substantially higher at 2.8% over a decade or .28% annually instead of .10% annually.

Projections of Future Utilization Trends

Furthermore, MHA questions the analytical focus on national historical utilization trends without an accompanying projection of future utilization trends. The draft recommendation applies a modest adjustment for national demand that relies on a key assumption that the historical utilization trends from 2013 to 2023 observed in their analysis will continue over the next decade. **While the HSCRC analysis does not project future utilization trends, other projections of future national utilization trends differ significantly from the historical trends HSCRC observed in their analysis**. HSCRC's analysis found that national inpatient utilization declined by 5%, and outpatient utilization increased by 12% from 2013 to 2023 when accounting for utilization pattern and demographic composition changes. In comparison, Sg2, a Vizient company, projects 4.5% growth in inpatient volumes and 17.4% growth in outpatient

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

volumes nationally between 2025 and 2035 after accounting for changes in the population and other factors that impact utilization including innovation and technology and policy, among others.[2] Using their estimates of inpatient and outpatient utilization, MHA estimates total utilization growth of 8.3% over the decade.[3] If the same discount for site neutral incentives were applied to this figure instead of the 3% estimate, the resulting national demand modifier would be substantially higher at 6.4% over a decade or 0.64% annually, in comparison to the 1% or .10% adjustment included in the draft recommendation. **Given the importance of ensuring hospitals are sufficiently resourced to meet the needs of the communities they serve, MHA urges HSCRC to consider, at a minimum, applying a 0.64% national demand modifier to the demographic adjustment, starting with the RY 2026 policy**.

Any changes to the demographic adjustment implemented for 2026 and 2027, including the level of the national demand modifier, should be reevaluated before CMS assumes responsibility for Medicare hospital global budgets in 2028 to ensure the methodology is sufficiently accounting for the utilization needs of the changing population. MHA also urges HSCRC to keep in place the long-standing policy to apply the demographic adjustment to all revenues and consider the implications of a potential change to this policy as part of broader discussions about additional exclusions from hospital global budgets under AHEAD.

Thank you for the opportunity to comment on these important policy changes. We look forward to continuing to work together on HSCRC policy development in the coming months. If you have any questions, please do not hesitate to contact me.

Sincerely,

Patrick Carlson
Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. Maulik Joshi
Nicki McCann
Dr. Farzaneh Sabi
Allan Pack

[2] Sg2 2025 Impact of Change Forecast Highlights. Available here.
[3] Sg2's projected utilization for adult and pediatric separately. To estimate total utilization growth, MHA calculated a weighted growth rate using adult and pediatric populations and charge ratios of inpatient and outpatient charges.

Frederick Health

Frederick Health
400 West Seventh Street
Frederick, MD 21701
240-566-3300

November 21, 2025

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

Dear Dr. Kromm:

On behalf of Frederick Health, I am writing to comment on the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for Demographic Adjustment Refinement. We appreciate the analysis completed by staff and the effort to consider policy changes that better reflect the impact of aging, as well as other factors, on utilization.

Our community, like the rest of Maryland, is aging and becoming more medically complex, with higher acuity and comorbidities. This trend will increase demand for hospital services, and the demographic adjustment must adequately account for this reality. While we appreciate the proposed 0.10% "national demand modifier," we are concerned that discontinuing the application of the demographic adjustment to volumes subject to volume-variable methodologies, combined with this modest modifier, results in a net reduction of the statewide RY 2026 demographic adjustment. This reduction comes at a time when it is critical to ensure hospitals have sufficient resources to meet growing community needs.

The current methodology does not sufficiently account for age-adjusted population growth, effectively capping the statewide adjustment at unadjusted population growth projections. For Frederick Health, the demographic adjustment is the only mechanism that provides additional revenue for expected utilization growth due to aging. The gap between the age adjusted growth and the scaled adjustment provided is material for Frederick. While we agree that other factors can impact utilization, we strongly support fully funding estimated age-adjusted growth in the interim while longer-term refinements are developed.

We appreciate HSCRC's empirical approach but are concerned that the analysis understates the impact of demographic changes and overstates changes in practice patterns. Additionally, adjustments for Medicare Advantage enrollment may not be appropriate given Maryland's lower enrollment rates compared to the nation. The omission of Medicaid data, which saw significant enrollment growth, further limits the analysis. MHA's review of national all-payer data suggests higher utilization growth than HSCRC's estimates, which would justify a larger national demand modifier.

The draft recommendation relies heavily on historical trends without projecting future utilization. Frederick County population is expected to continue dramatic demographic growth with specific increase in aging over 75 over the next decade. Independent forecasts, such as those from Sg2, project significantly higher growth in inpatient and outpatient volumes over the next decade. As noted by MHA, applying these projections would support a national demand modifier closer to 0.52% annually rather than 0.10%.

Given the importance of ensuring hospitals like Frederick Health are adequately resourced to meet community needs, we urge the HSCRC to consider applying a 0.52% national demand modifier starting with RY 2026, to offset the existing gap between the age adjusted and scaled demographic adjustment in current FY26 rates. In addition, we concur with the MHA request to maintain the current policy of applying demographic adjustments to all revenues.

Thank you for the opportunity to provide input on these critical policy changes. We look forward to continuing to work collaboratively on HSCRC policy development. Please feel free to contact me with any questions.

Sincerely,

Hannah Jacobs

Hannah Jacobs
Sr. VP / CFO
Frederick Health

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot Ricardo Johnson
Dr. Maulik Joshi
Nicki McCann
Dr. Farzaneh Sabi
Allan Pack

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CORPORATE OFFICE

November 21, 2025

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

RE: UMMS Comment Letter on Demographic Adjustment Draft Recommendation

Dear Dr. Kromm:

On behalf of the University of Maryland Medical System ("UMMS") and its member hospitals, I am submitting comments in response to the Health Services Cost Review Commission's ("HSCRC") Demographic Adjustment Draft Recommendation. I want to start by re-emphasizing two guiding thoughts from our May 2025 comment letter on the Fiscal Year 2026 Update Factor:

1. **The Commission must act proactively to provide appropriate resources to ensure access to medically necessary services, which is a core enabling factor to achieve the Model's value-based goals.** The Commission, in its demographic funding decision, should prioritize providing sufficient resources to address these needs, as hospitals must come from a position of financial stability to maximally engage in the Model's transformative goals.

2. **The annual demographic adjustment methodology should be risk-adjusted**. The impact of demographics on hospital global budgets must appropriately account for changing demographic and socioeconomic factors, including the risks associated with an aging population, which the current Demographic Adjustment methodology fails to do.

While we appreciate the time spent by HSCRC Staff developing the Demographic Adjustment Draft Recommendation, we are deeply concerned that the retrospective 2013-2023 analysis that drives the 0.1% National Demand Modifier recommendation is significantly out of line with prospective national forecasts and does not achieve the guiding factors outlined above. UMMS instead supports the Maryland Hospital Association ("MHA") recommendation to utilize the Kaufman Hall Consulting (formerly Sg2) Impact of Change Forecast – which is prospective, valid, produced annually, and is risk-adjusted for factors beyond population/aging – as the basis for the HSCRC's proposed National Demand Modifier, rather than a retrospective analysis of 2013-2023 trends. After applying the proposed site neutrality discount, this would produce a 0.64% add-on to the Demographic Adjustment, starting in Fiscal Year 2026, which is also consistent

with the industry's original request to provide 0.65% additional Demographic funding based on the average annual age-adjusted portion of the Demographic Adjustment for 2020-2024. For this reason, UMMS would also be supportive of using the age-adjusted rate from the current Demographic Adjustment methodology as an alternative option.

UMMS acknowledges that Staff's analysis of national trends over the past 10 years (2013-2023) aligns with similar national analyses, including the Kaiser Family Foundation ("KFF") *Key Facts About Hospitals,* published in February 2025[1]. KFF's report cited a (4.3%) decline in inpatient days per 1,000 nationally and a 12.1% increase in outpatient visits per 1,000 from 2013 to 2023, in line with the (5%) and 12% numbers cited by the Staff's analysis. **However, while these retrospective trends can be useful, most national data sources indicate that hospital utilization trends for the next 10 years will not look like the last 10 years:**

- Claritas Pop-Facts projects that the over 65 population will be 21% of Maryland's population by 2031, vs. 17% in 2023 and 13% in 2013. This is consistent with national trends and projections.[2]

- CMS's projection of National Health Expenditure data projects that hospital expenditures will grow 15% faster over the next 10 years (2023 to 2033) than the previous 10 years (2013-2023).[3]

- Kaufman Hall Consulting's 2025 Impact of Change Forecast projects a 4.5% increase in inpatient utilization and a 17.4% increase in outpatient utilization from 2025 to 2035. This is an 8.3% total hospital-based growth when blended by Maryland FY25 revenue (60% inpatient and 40% outpatient), or 0.83% annually. [4]

UMMS is concerned that Staff's use of a 3% ten-year national growth rate observed over 2013-2023 as its assumption for national growth over the next 10 years, which drives the 0.1% proposed annual National Demand Modifier, is out of step with broadly available national projections. The obvious risk of being that conservative is to underfund expected demographic change, which is counter to the goal of properly resourcing hospitals to ensure access to care and achieve the Model's value-based goals. UMMS particularly agrees with the MHA's concern that Staff's retrospective analysis is so divergent from Kaufman Hall Consulting's prospective 10-year forecast, which we would consider the most robust prospective measure that is widely available. It is produced annually (most recently in June 2025) based on broad, valid data sources (HCUP, CMS Limited Data Sets, proprietary all-payer claims from 1,300+ participating hospitals) and accounts for multiple risk factors in addition to population/demographic factors (epidemiology/sociocultural changes, economy & consumerism, policy, innovation & technology, systems of care).

[1] *Key Facts About Hospitals*. Kaiser Family Foundation, published February 19, 2026.
[2] Claritas Pop-Facts Premier 2013 estimate, 2023 estimate, 2031 projections for Maryland.
[3] CMS National Healthcare Expenditures Historical and Projections - Data.
[4] Kaufman Hall/Sg2 2025 Impact of Change Forecast.

Staff have consistently stated in their guiding principles for reviewing the Demographic Adjustment that the Adjustment must (1) address expected year-over year change in hospital use rates, (2) account for total risks, i.e. beyond population/demographic projections, and (3) be based on national utilization trends to avoid building all TCOC impact into estimating future demand. We believe the Kaufman Hall Consulting 10-year forecast accomplishes these goals in a valid way that is readily available on an annual basis, while a 2013-2023 retrospective analysis fails to account for future expectations in terms of both expected demand and total risk. In addition, we maintain our original position that the age-adjustment factor in the current Demographic Adjustment methodology, which has averaged 0.65% above pure population growth annually since 2020, serves as a relatively appropriate risk adjustor as well.

For these reasons, UMMS believes that Staff should either (1) revise the Draft Recommendation to replace the 3% national growth rate based on 2013-2023 experience rate with the Kaufman Hall Consulting 10-year forecast of 8.3% in its calculation of the National Demand Modifier, or (2) utilize the age-adjusted growth rate as originally requested (which would eliminate the need for a National Demand Modifier). In addition, UMMS has the following comments to offer on specifics of the Demographic Adjustment Draft Recommendation:

UMMS supports the concept of holding Maryland's Model performance outside of the calculation.

UMMS agrees with Staff's opinion that Maryland's positive performance over the past ten years should not be used to modify the population governor in the Demographic Adjustment in any way, as that would effectively penalize hospitals for their successes under the Model.

Do not discontinue the application of the Demographic Adjustment to volumes that are not part of population-based payments until the definition and methodology treatment of those volumes are known and evaluated on these terms.

While UMMS understands the intention, to is important to consider this decision in the context of each volume methodology. For example, UMMS does not agree with excluding volumes that are subject to methodologies with materiality thresholds (such as Out of State), as this potentially underfunds any change that occurs within the materiality thresholds.

Define the process and timeline for evaluating changes to the Demographic Adjustment Methodology once the Centers for Medicare and Medicaid Services ("CMS") takes responsibility for the Medicare population under AHEAD.

The proposed changes to the Demographic Adjustment are to an all-payer Global Budget, which will no longer be in effect after January 1, 2028. A comprehensive evaluation of the Demographic Adjustment will have to occur in time for the Fiscal Year 2028 Global Budgets.

Because we serve so many communities in so many ways, UMMS is deeply invested in the success of the Maryland Model, and we believe strongly that the Commission must act proactively to provide hospitals with the appropriate resources to ensure access for Marylanders and achieve the Model's value-based goals. We believe that revising the Draft Recommendation to apply a more appropriate National Demand risk-adjustor better accomplishes these goals, while also recognizing that the Demographic Adjustment will require more comprehensive evaluation as CMS takes control of the Medicare global budget on January 1, 2028. UMMS looks forward to collaborating with our State partners to work toward the broader goal of improving the health of Maryland citizens.

Sincerely,

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

cc: Joshua Sharfstein, MD Chairman
James N. Elliott, MD, Vice Chairman
Jonathan Blum, MPP
Ricardo R. Johnson
Maulik Joshi, DrPH
Nicki McCann, JD
Farzaneh Sabi, MD

maryland
health services
cost review commission

RY 2028 Quality Based Reimbursement Final Policy

January 15, 2026

HSCRC Quality Team

RY 2028 Final Recommendations for Commissioner Vote

Same recommendations as draft; stakeholder feedback incorporated and additional options provided for Commissioner Consideration

- 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.
- Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and set the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 32 percent.
  - Retrospectively evaluate the preset cut-point using more recent data to calculate national average score for RY 2027 and RY 2028.
  - Based on concurrent analysis of national hospital performance, adjust the RY26 QBR cut-point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.
- 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.

Stakeholder Comments

Summary of Stakeholder Comment Letters for QBR	MHA	UMMS	Med-Star	Advent-ist	JHHS
Maximize multi-payer alignment, reduce administrative complexity, ensure manageable timelines, maintain quality incentives	**X**	**X**	**X**	**X**	**X**
• Reweight domains to more closely align with HVBP (i.e., 1/3rd)	X	X	X	X	X
• Transition time is too lengthy					X
PCE Domain: HCAHPS top box and Consistency only, monitor Medicaid TFU	X	X	X	X	X
• Understand inclusion of ED Wait Times in payment due to importance			X		
Safety Domain: Maintain NHSN, Shifting/removing PSI 90	X	X	X	X	X
• Continue to exclude Sepsis bundle (clinical concerns re. antibiotic overuse)		X			
• Add Sepsis bundle for CMS alignment	X		X	X	X
Clinical Care Domain: Maintain IP and 30 day mortality measures	X	X	X		X
• Continue to exclude THA/TKA		X			
• Replace inpatient with more stable 30-day measure in future years		X			
Separate Monitoring Program for state-specific measures	X	X	X	X	X
Digital Measures: Support RY 2028 incentive, default to CMS requirements starting RY 2029	X				
Adopt 32% Cut-Point for RY 2026. Modify Reward/Penalty Cut-Point for RY2027 and use as prospective cutpoint	X	X	X	X	X
Maintain or Consider less revenue at risk and align with other states		X (maintain)			X (less)
Remove Medicare patients from non-Medicare quality programs					X

Medicaid Feedback on Overall Quality Under AHEAD

Medicaid feedback also provided in a letter:

- Strongly urges continuation of hospital quality programs relevant to Medicaid by HSCRC
- Highlights measures such as Pediatric Quality Indicators in PAU and Medicaid Timely Follow up in QBR are particularly relevant for Medicaid
- Notes that an annual report submitted by the state must demonstrate that value-based programs for Medicaid and commercial payers meet or exceed previous results
- Medicaid director notes that if quality performance assessments for Medicaid are diminished in any capacity under AHEAD, Medicaid will develop and implement Medicaid-specific hospital quality and payment programs

General Concerns of AHEAD Transition

Stakeholder Questions and Feedback:

- **Commission Discussion:** Can quality programs be suspended during transition?
- **MHA and Hospitals:** RY 2028 Quality policies should maximize multi-payer alignment in order to reduce administrative complexity, ensure manageable timelines, while maintaining quality incentives. Establish Monitoring program for Maryland-Specific Measures.
- **Hopkins:** 3-Year Transition is too lengthy (i.e., transition in CY 2027, not CY 2028).

Staff Response:

- AHEAD model agreement requires continuation of all-payer quality programs during the PYs 1 and 2, with specific language that starting in CY 2028 the revenue adjustments will be under applicable quality program and revenue adjustments based on Medicare programs can begin in either CY 2029 or CY 2030.
- Policy recommends several areas of alignment but maintains slightly higher weight on the PCE domain so that ED LOS and Medicaid TFU can be maintained in payment.
- Staff will work with stakeholders to further align the MHAC and RRIP policies and determine whether transition to Medicare policies in CY 2027 is feasible and fair.

Align QBR Domain Weighting and Measures with HVBP

Stakeholder Feedback:

- **MHA and Most Hospitals:**
  - Align domain weights with HVBP modeling for MD hospitals (1/3rd weight for each domain).
  - Remove all MD specific measures and monitor through non-payment program.
- **UMMS:** Continue exclusion for Sepsis Bundle and THA-TKA.
- **Medstar:** Exclude Medicaid TFU, understand rationale for ED LOS.

Staff Response:

- Staff have made following changes to align with HVBP:
  - Reduce PCE domain weight from 60 to 38 percent; increase weight on safety and clinical care.
  - Remove HCAHPS linear measures, Medicare TFU and disparity gap metric, all-payer Patient Safety Index (PSI)
  - Add in Sepsis bundle and THA-TKA measures
- Support continued inclusion of the ED LOS and Medicaid TFU to balance the state's priorities to improve in areas of poor performance and to support improvements in population health management.

Options for Commissioner Consideration

1. **Staff draft recommendation:** Align domain weights and measures more fully with HVBP but maintain slightly higher weight on the PCE domain to accommodate ED LOS and Medicaid TFU; reduce the Clinical Care and Safety domains proportionally to account for additional measures.
2. **MHA-Hospital recommendation:** Align the domain weights and measures fully with the HVBP program but maintain the all-payer inpatient and 30-day mortality measures. *All Maryland specific measures (e.g., ED LOS, TFU) should be monitored and publicly reported.*
3. **Staff recommendation without Sepsis and THA-TKA:** Align domain weights and measures more fully with HVBP but maintain ED LOS and Medicaid TFU in the PCE domain; monitor Sepsis bundle and THA-TKA complication measures due to clinical and measurement concerns.

Weighting Options			
Domains	**Current**	**Option 1 & 3**	**Option 2**
PCE	60%	38%	33%
Clinical	10%	31%	33%
Safety	30%	31%	33%

Figure 22. Statewide Modeling of All-Payer Revenue Adjustments by Option

Statewide RY 2026 Modeling	Staff Recommendation	MHA-Hospital Recommendation	Staff Recommendation Minus Sepsis and THA-TKA
Option #	1	2	3
Net Revenue Adjustments	-$13,901,981	-$12,734,618	-$13,283,560
Net %	-0.11%	-0.10%	-0.11%
Total Penalties	-$33,764,918	-$37,583,539	-$36,490,684
Penalty %	-0.27%	-0.30%	-0.29%
Total Rewards	$19,862,937	$24,848,921	$23,207,124
Reward %	0.16%	0.20%	0.19%

RY 2028 Final Recommendations for Commissioner Vote

- 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.
- Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and set the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 32 percent.
  - Retrospectively evaluate the preset cut-point using more recent data to calculate national average score for RY 2027 and RY 2028.
  - Based on concurrent analysis of national hospital performance, adjust the RY26 QBR cut-point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.
- 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.

maryland
health services
cost review commission

Final Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2028

January 14, 2026

This document contains the staff final recommendations for updating the Quality-Based Reimbursement Program for RY 2028.

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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

FINAL RECOMMENDATIONS

This document puts forth the RY 2028 Quality-Based Reimbursement (QBR) final 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). The Performance Measurement Workgroup (PMWG), Commissioners, and other stakeholders provided valuable input on these recommendations and longer-term priorities that should be considered as Maryland transitions to the AHEAD Model.

Final 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 to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and set the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 32 percent.
    a. Retrospectively evaluate the preset cut-point using more recent data to calculate national average score for RY 2027 and RY 2028.
    b. Based on concurrent analysis of national hospital performance, adjust the RY26 QBR cut-point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.
3. 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.

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 Total Cost of Care (TCOC) Model (2019-2026) and the current 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 has reviewed the exemption request and does not have any questions, but has not yet provided final written confirmation. 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 began in January 2026; however, the first two years of the model will be a transition period with the new CMS hospital global budgets for Medicare FFS 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 final policy recommends options on where to align QBR measures and domain weights in anticipation of the transition to the HVBP program for Medicare FFS. In addition to the Quality Program Guiding principles that were established at the start of the APM, the

following criteria were proposed for evaluating what measures to include in the policy and the weights:

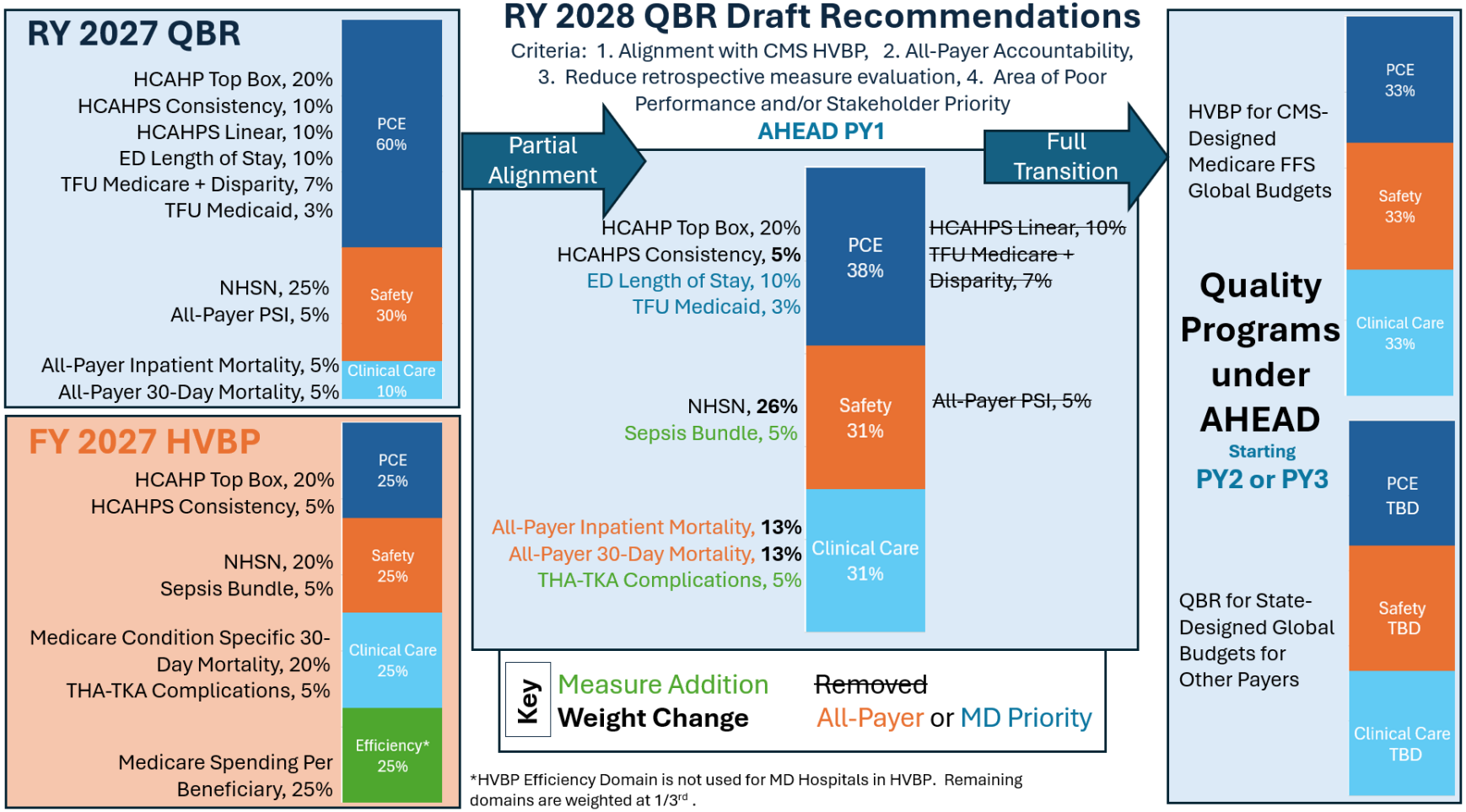
1. Alignment with CMS programs
2. Maintenance of all-payer accountability and incentives for quality
3. Reduction of retrospective measure evaluations to the extent possible
4. Attention to areas of poor performance and/or priority area for State, hospitals, payers, or other stakeholders

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.

Appendix A provides a high-level overview on quality assessments in the AHEAD Model, including a visual timeline for transitioning to the CMS quality programs in FFY 2029 or FFY 2030, with the earlier year transition contingent upon system implementation readiness.

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 complications
Person and Community Engagement	**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*

*Currently this measure is not calculated for MD hospitals by CMS. Instead the domains are each weighted as 1/3rd in the estimated HVBP scores provided by CMS for MD hospitals.

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], the performance standards range from the 50th percentile of hospital performance

[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.

(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.

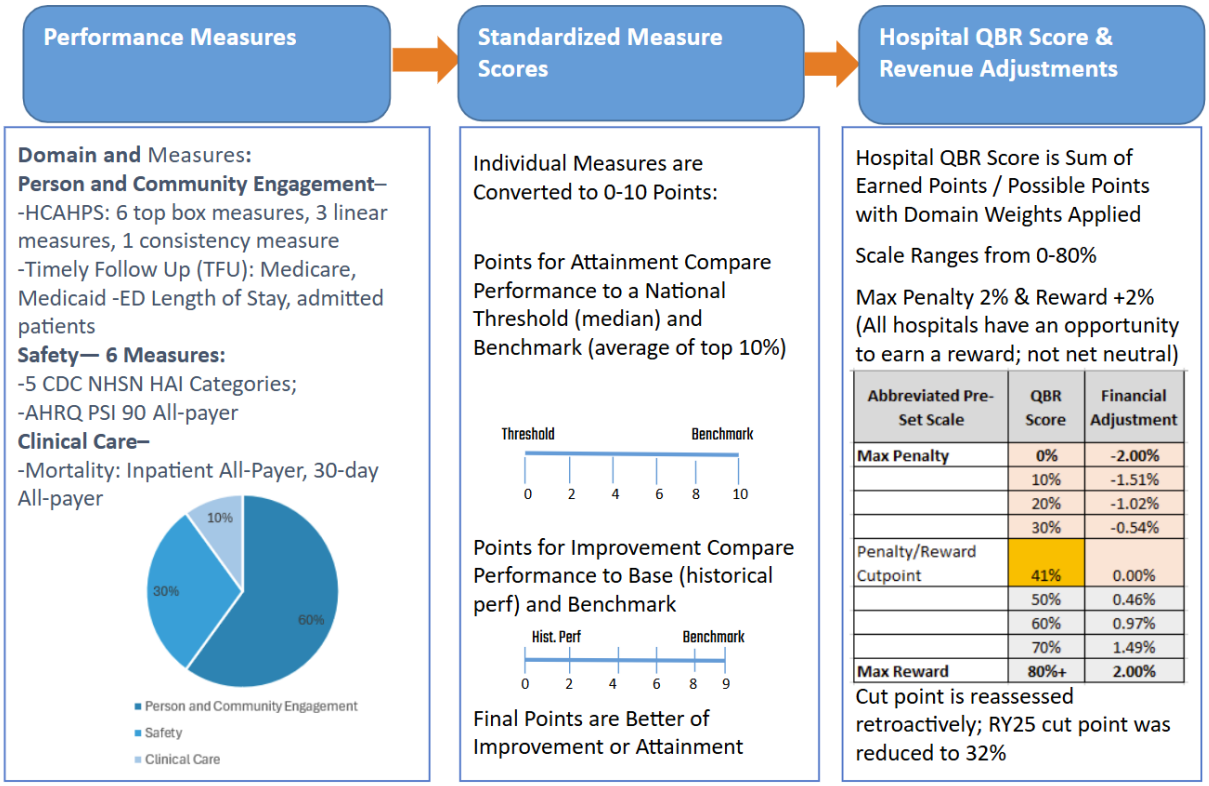
As a recap, the method for calculating hospital QBR scores and associated inpatient revenue adjustments involves:

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 final policy provides three options on where to align QBR measures and domain weights in anticipation of the transition to the HVBP program for Medicare FFS.

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 based on several options for Commissioner consideration.

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

[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.

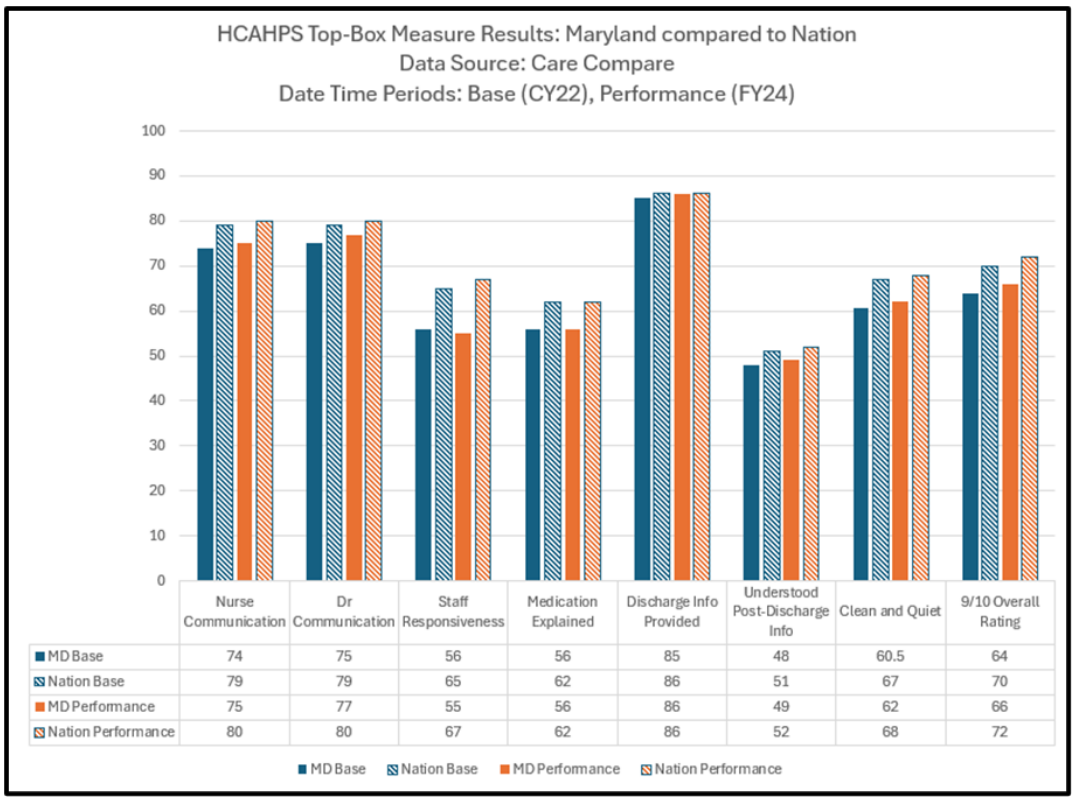
[3] For more information on the HVBP Program's performance standards and top-box and consistency scoring, please see https://qualitynet.cms.gov/inpatient/hvbp/performance.

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.
- The nation improved slightly on all categories with the exception of Medication Explained which remained the same.

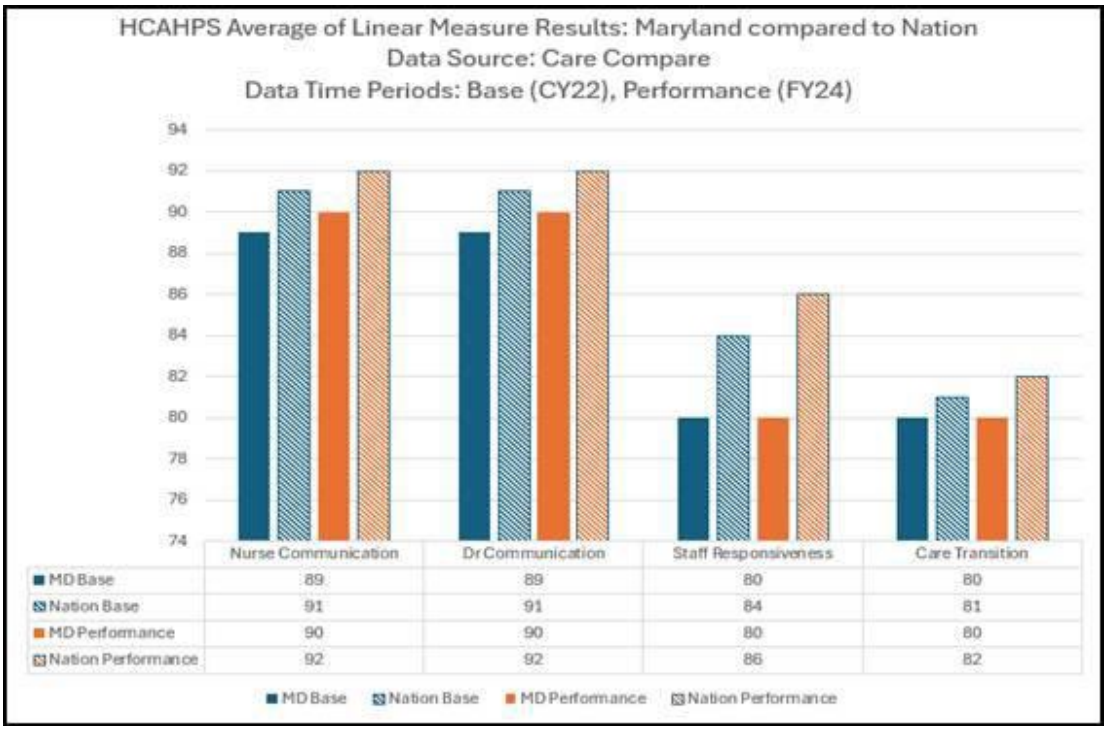
Figure 4. Top-box HCAHPS Results: Maryland Compared to the Nation, CY 2022 vs 7/1/23-6/30/24



	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.

Figure 5. Linear Measure HCAHPS Results: Statewide and National Average, CY 2022 vs 7/1/23-6/30/24



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 C provides an overview of this work, which was also presented at the December Commission meeting. One of the key deliverables is a statewide HCAHPS dashboard built on patient level HCAHPS data collected by MHCC. The HCAHPS dashboard, which was initially released through the CRISP Reporting Services portal in December 2025, allows 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. Other next steps for the HCAHPS Learning Collaborative are to continue to meet quarterly to share best practices and consider expanding best practice incentives to focus on patient experience.

Emergency Department Length of Stay

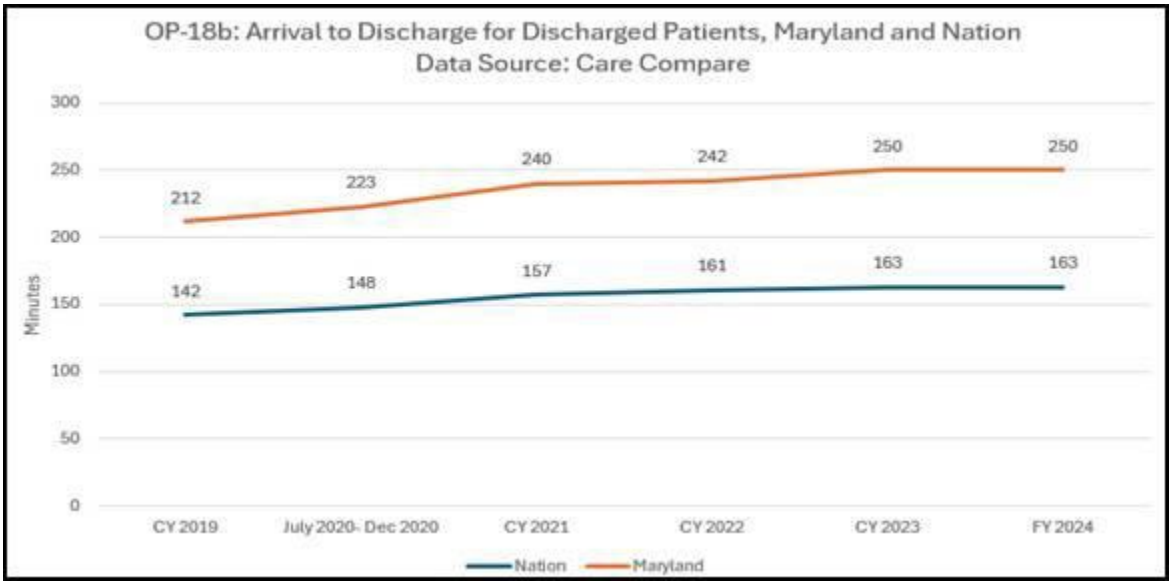
ED length of stay (LOS)--i.e., wait times–has been a significant concern in Maryland, predating Maryland's adoption of hospital global budgets instituted in 2014,[4] with multiple underlying causes and potential adverse outcomes in patient experience and quality.

[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.

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.

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

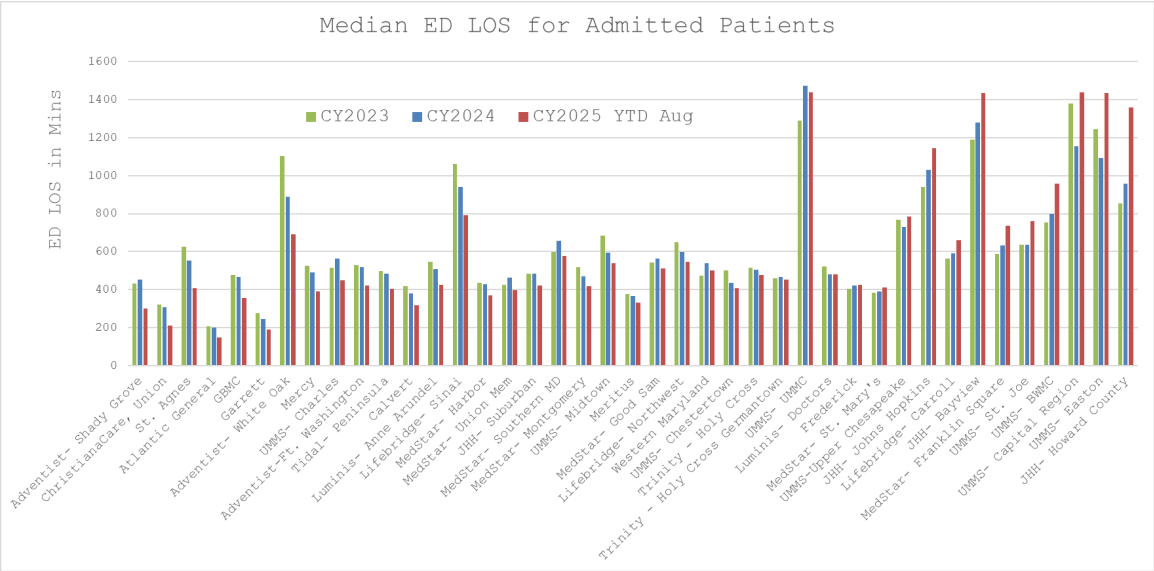
Population: All non-psychiatric, non-trauma, adult ED patients who are admitted to Inpatient bed and discharged from hospital during reporting period

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 finalizing 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. 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.

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.

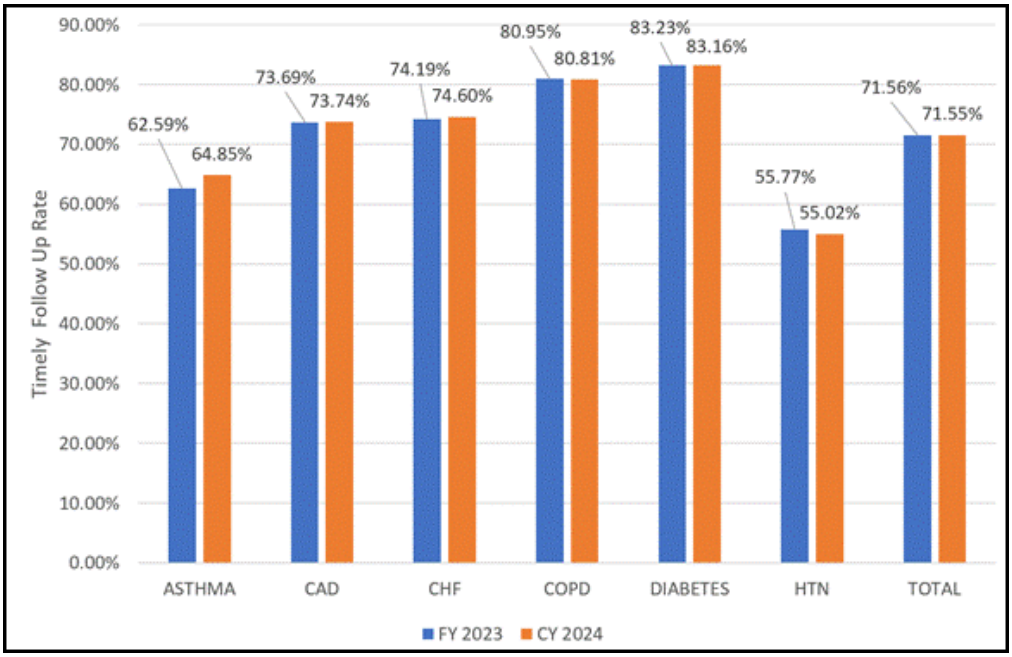
Timely Follow-Up After Discharge

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

[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.

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.

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*

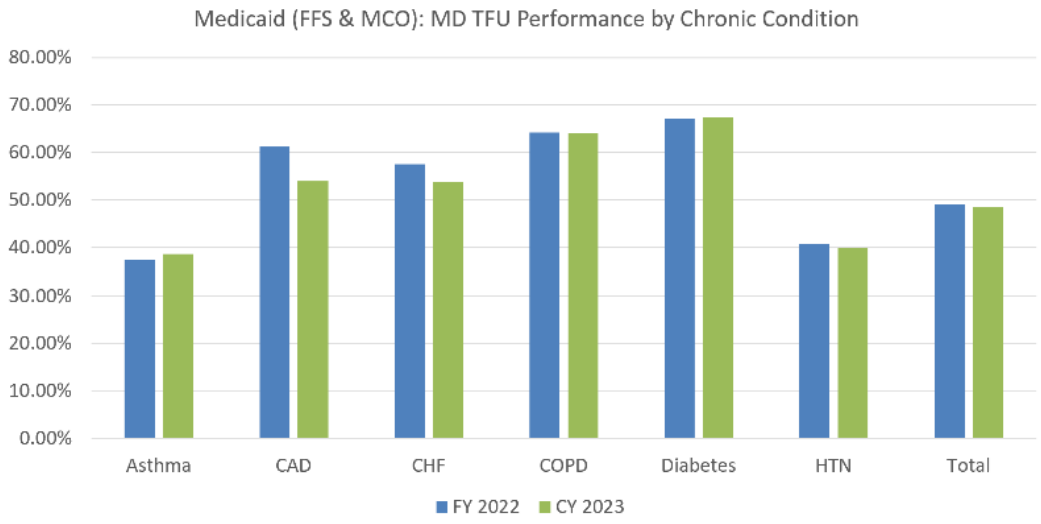
TFU Rates	CY2018	CY2019	CY2020	CY2021	CY2022	CY2023	CY2024
Maryland	70.85%	71.45%	67.90%	70.07%	70.59%	70.29%	70.79%
US	66.82%	69.00%	64.75%	67.68%	67.26%	68.35%	69.30%

*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 recognizes that

the majority of hospitals do not support this recommendation and defer to the Commissioners for final decision.

- **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. Again, as with ED LOS, the staff recognize that the majority of hospitals do not support this recommendation and defer to the Commissioners for final decision.

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.

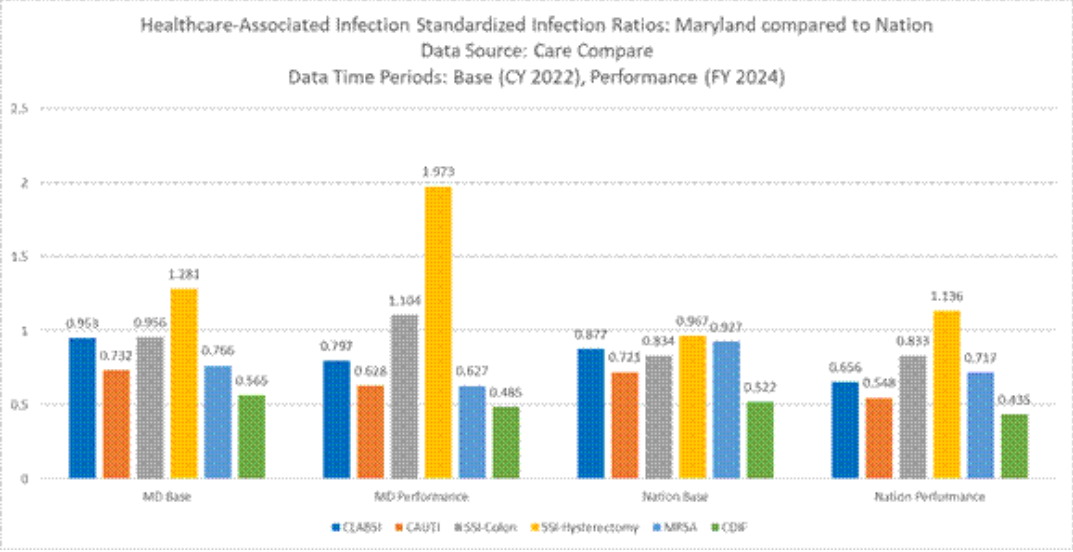
removed from QBR, the measure should be added to the MHAC program to align the CMS HAC reduction program.

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.
- 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 D, 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 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

[7] Data provided by MHCC used for the Maryland Hospital Performance Guide published on the MHCC website.

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

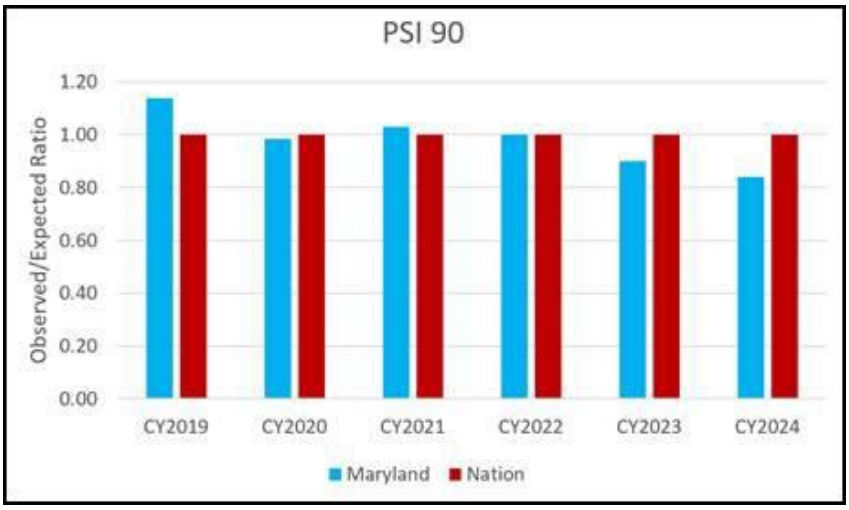
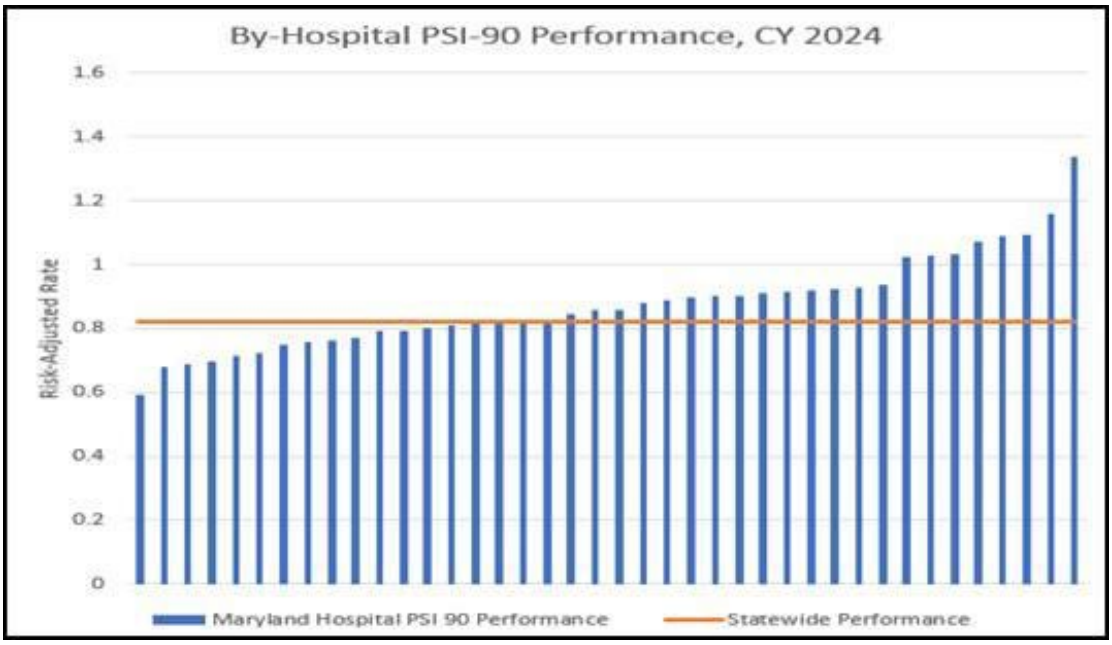


Figure 14 below illustrates the hospital-level performance on the all-payer PSI-90 composite measure for CY 2024; consistent with last year, the variation in performance by hospital suggests there may be opportunity for improvement on this measure.

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 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

[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.
[10] Found at: https://www.endsepsis.org/2023/08/17/end-sepsis-sep-1-response/. Last accessed 11/26/2025.

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 most PMWG stakeholders recommend adopting the Sepsis Bundle measure in the Safety domain to align with the HVBP program since CMS recommends its continued inclusion.

Figure 15. Maryland vs. the Nation, Sep-1 Measure July 2023-June 2024 Compared to CY 2022

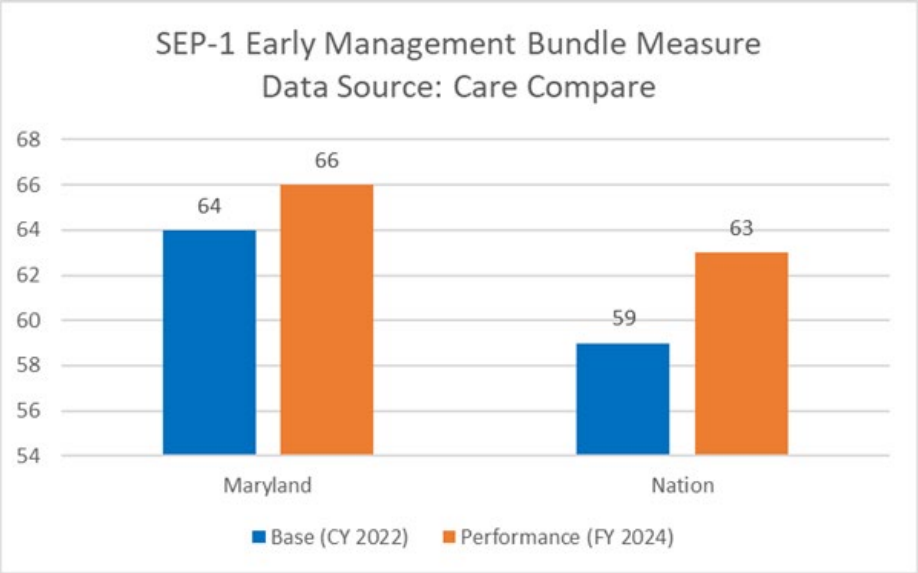
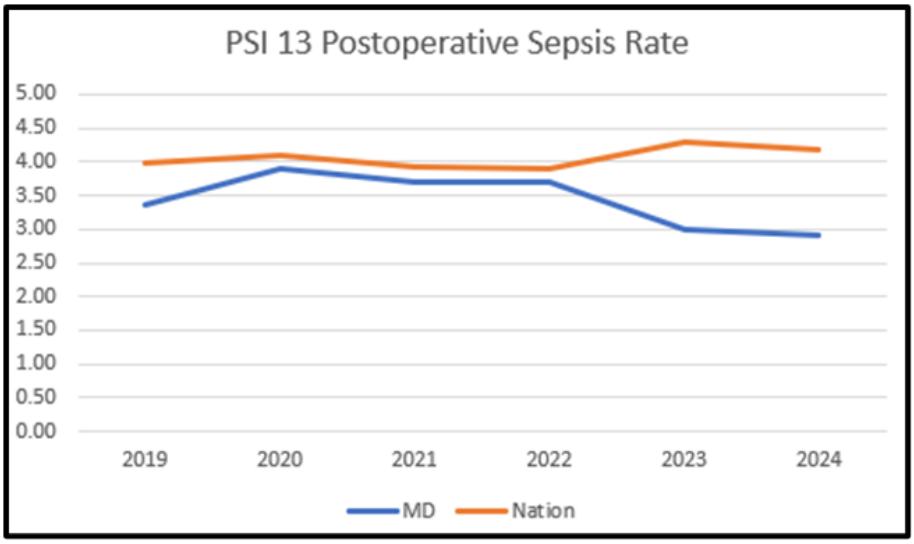


Figure 16. PSI 13 Postoperative Sepsis, Maryland vs. the Nation 2019-2024



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, 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, the staff recommended the PSI 90 Composite measure should be added to MHAC in the RY 2028 draft MHAC policy, which was presented to the Commission in December 2025..
- **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 most PMWG stakeholders recommend adopting the Sepsis bundle measure in the Safety domain to align with the HVBP program. See Stakeholder Feedback section for additional discussion.

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

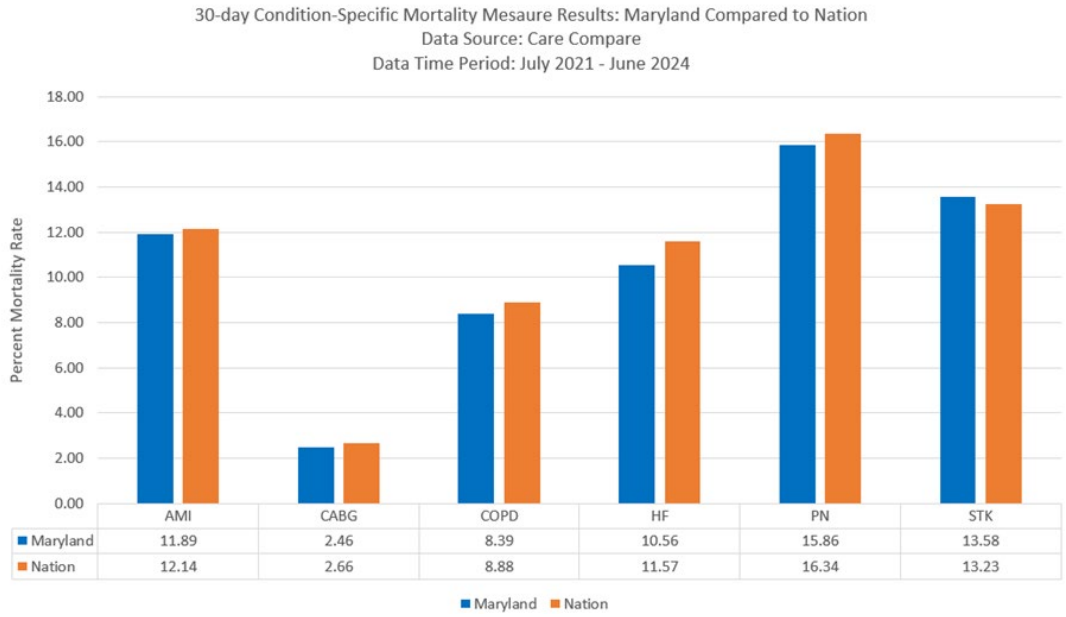
Of note, Maryland's QBR mortality measure currently differs from the HVBP Program that uses five condition-specific, 30-day mortality measures for Medicare beneficiaries. In addition, the HVBP includes a Medicare Total Hip Arthroplasty-Total Knee Arthroplasty (THA/TKA) Complications measure. This measure 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.

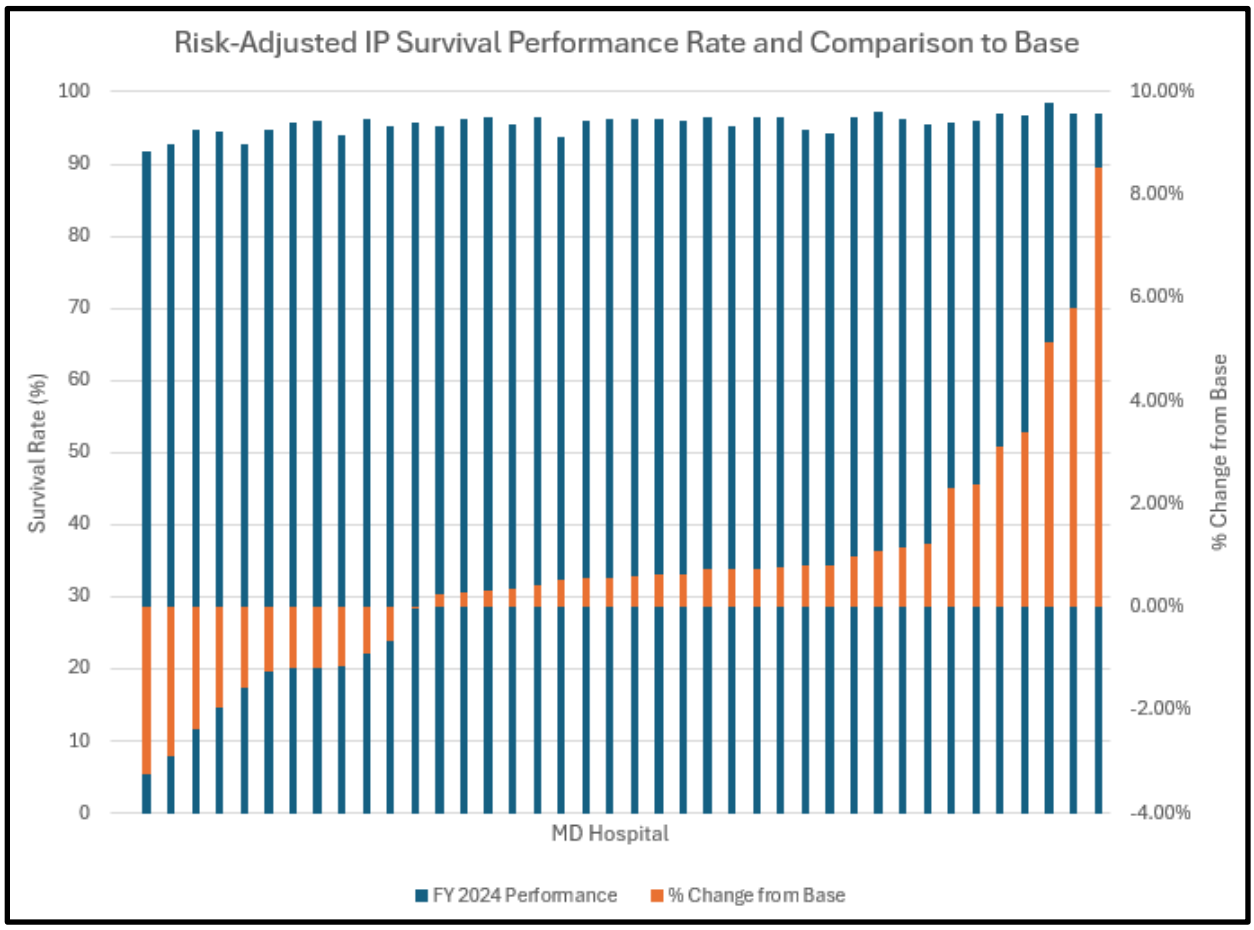
Figure 17. Maryland vs. National Hospital Performance on CMS Condition-Specific Mortality Measures



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

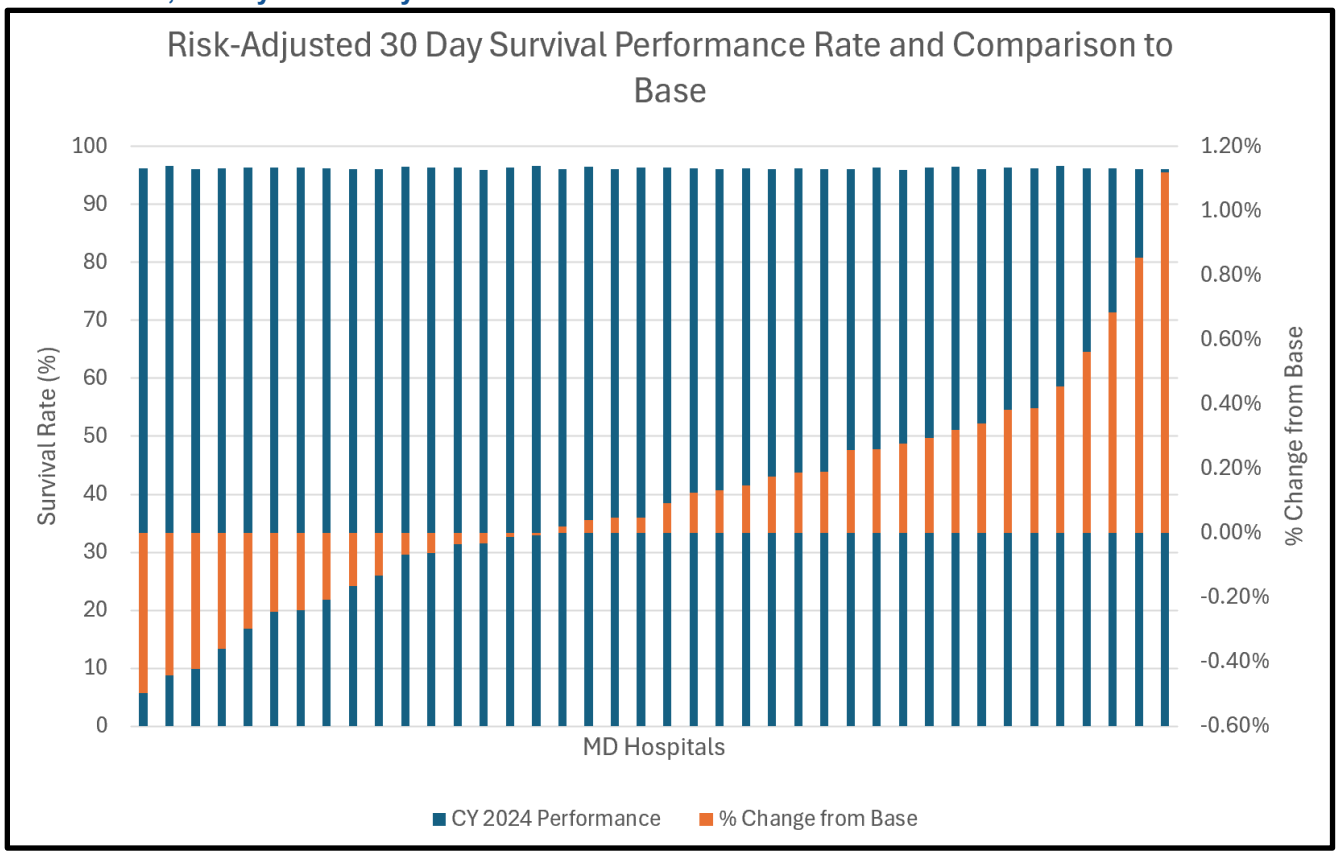


Note: The graph displays hospital performance in the blue bars and hospital improvement from the FY 2023 base in orange bars. For example, the hospital on the far right had a survival rate of over 95% in CY 2024 and saw an increase in their survival rate of almost 9% when compared to their performance 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.

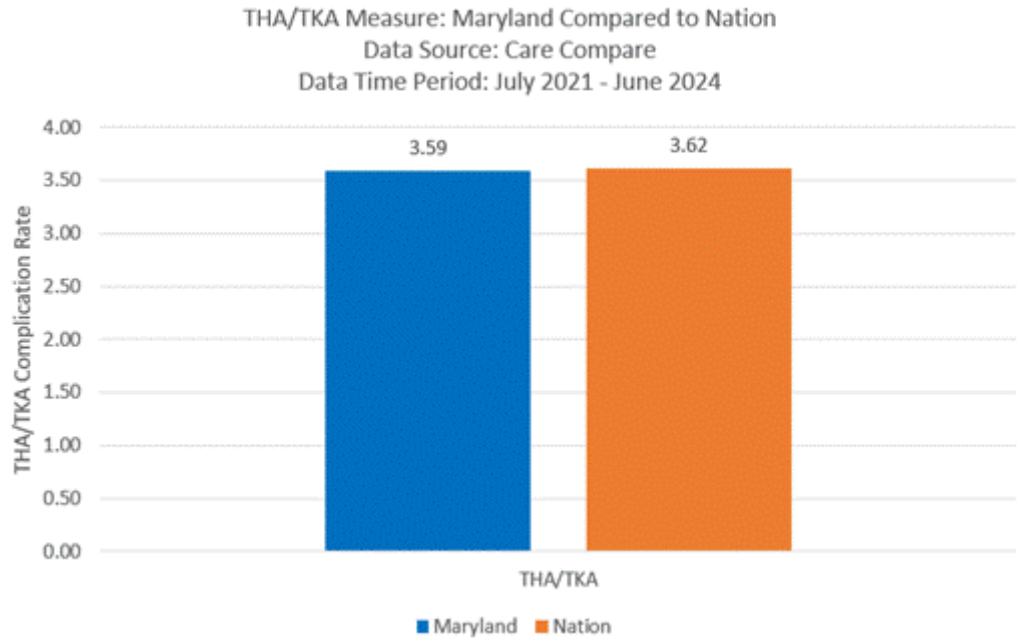
Last, as part of the digital measures initiative staff plans to consider transitioning from the fully claims-based mortality measure to the hybrid 30-day mortality measure (claims plus Core Clinical Data Elements) in the future. To date, the vast majority of hospitals working with their electronic health 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 E 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 notes that the correlation between the IP and 30-day measure is moderate and that stakeholders recommended continued refinement of these measures in the future, with emphasis on the 30-day measure over inpatient.
- **THA/TKA Complications Measure:** Majority of 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. See Stakeholder Feedback section for additional discussion.

D. Domain and Measure Weighting

Staff has analyzed different options for domain and measure weighting based on the draft recommendations that were presented at the November Commission meeting and in response to stakeholder input. As discussed above, staff supports reweighting the domains and measures to be more aligned with the HVBP program. For example, staff propose to align by lowering the weight on PCE domain, removing HCAHPS linear measures, and removing Medicare TFU. 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, and instead weights each domain as 1/3rd of hospitals' total scores.

Based on stakeholder discussions, and as discussed in the Stakeholder Feedback section, there are two options for domain weights under consideration: 1. Weight each domain at 1/3rd (i.e., equally and aligned with CMS approach), 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. While staff continues to support Option 2, which would entail lowering HCAHPS top-box and consistency slightly but would maintain them at equal weighting to other hospitals nationally, the impact of these different weights on hospital revenue adjustments is minimal. Modeling of these options and additional

discussion is included in the following Revenue Adjustment Modeling and Stakeholder feedback sections.

E. 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 setting 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 score to use as cutpoint. 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 values for MD specific measures, less sensitive to outliers, and the analysis results are in Appendix F.

QBR vs. HVBP Revenue Adjustments

For FFY 2026, CMS provided estimated HVBP scores for Maryland hospitals. As discussed, these scores do not include an efficiency domain and weight each of the remaining domains at 1/3rd of the final score. Using these scores, HSCRC staff has estimated all-payer revenue adjustments for Maryland hospitals. While the HVBP estimates would apply only to the Medicare FFS base operating revenue, the HSCRC has used all payer revenue for reference to compare across programs. Also, it should be noted that the HVBP estimates are net of the 2 percent withhold that the program uses to fund the revenue neutral rewards.

Figure XYZ provides a comparison of the QBR RY 2026 and HVBP FFY 2026 revenue adjustments. Given the large differences between QBR and HVBP, staff modeled all of the differences iteratively as shown in Appendix G. This indicates that the scaling parameters for HVBP is the largest factor associated with over 60 percent of the difference between the QBR and HVBP scores. Domain weighting is the second biggest factor,

which staff has proposed to address. While the removal of Maryland specific measures and addition of the Sepsis Bundle and THA-TKA complication measure, have much smaller contributions to the differences in scores. This is also supported by the RY 2028 modeling shown below.

Figure 21. Statewide RY 2026 QBR and FFY 2026 HVBP All-Payer Revenue Adjustment Estimates for Maryland Hospitals

RY/FFY	Program	Statewide Net Total	%	Penalties	%	Rewards	%
2026	QBR	$ (20,532,810)	-0.16%	$ (34,934,361)	-0.28%	$ 14,401,550	0.11%
	VBP	$ 51,181,610	0.41%	$ (17,406,631)	-0.14%	$ 68,588,240	0.54%

Estimates for MD hospitals' performance in National programs is applied to All-Payer revenue for comparison; CMS would apply adjustments to Medicare FFS revenue.

RY 2028 Modeling

Staff modeled different scenarios that were reviewed with the Performance Measurement Workgroup and took into consideration the Commissioner and Stakeholder feedback. Based on the discussion, three options are presented here for Commissioner consideration. The modeling uses RY 2026 timeframes and is comparable to the RY 2026 and FFY 2026 QBR and HVBP modeling shown above. Specifically the following three options are presented:

1. **Staff draft recommendation:** Align the domain weights and measures more fully with the HVBP program but maintain slightly higher weight on the PCE domain to accommodate ED LOS and Medicaid TFU and reduce the Clinical Care and Safety domains proportionally to account for the additional measures.
    a. Domain weights: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.
2. **MHA-Hospital recommendation:** Align the domain weights and measures fully with the HVBP program but maintain the all-payer inpatient and 30-day mortality measures. All Maryland specific measures (e.g., ED LOS, TFU) should be monitored and publicly reported.
    a. Domain weight: Person and Community Engagement (PCE) - 33.3 percent, Safety (NHSN measures) - 33.3 percent , Clinical Care - 33.3 percent.
3. **Staff recommendation without addition of HVBP measures not in QBR:** Align the domain weights more fully with the HVBP program but maintain ED LOS and

Medicaid TFU in the PCE domain and monitor Sepsis bundle and THA-TKA complication measures.

a. Domain weights: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.

Figure 22 provides the statewide revenue adjustments for the three options outlined above using the 32 percent cutpoint (while cutpoint could vary for each option, staff wanted to make the results comparable to the current year). The options do not vary substantially across options at the Statewide level. Appendix H provides the results by hospital. Compared to the current RY 2026 QBR revenue adjustments, Option 1 (staff recommendation) reduces the net statewide revenue adjustments from -$20.5 M to -$13.2 M. If the cutpoint was changed to the National average for each model, staff estimate the revenue adjustments would be more positive.

Figure 22. Statewide Modeling of All-Payer Revenue Adjustments by Option

Statewide RY 2026 Modeling	Staff Recommendation	MHA-Hospital Recommendation	Staff Recommendation Minus Sepsis and THA-TKA
Option #	1	2	3
Net Revenue Adjustments	-$13,901,981	-$12,734,618	-$13,283,560
Net %	-0.11%	-0.10%	-0.11%
Total Penalties	-$33,764,918	-$37,583,539	-$36,490,684
Penalty %	-0.27%	-0.30%	-0.29%
Total Rewards	$19,862,937	$24,848,921	$23,207,124
Reward %	0.16%	0.20%	0.19%

4. STAKEHOLDER FEEDBACK AND STAFF RESPONSES

Comment letters to the QBR Draft policy were received from the Maryland Hospital Association, University of Maryland Medical System, MedStar Health, Adventist Health, and Johns Hopkins Health System, and are summarized in Figure 23 below. A brief discussion of the concerns and staff responses are provided following the Figure.

Figure 23. Summary of Stakeholder Comment Letters

Stakeholder QBR Comment Letters	MHA	UMMS	Med-Star	Advent-ist	JHHS
Maximize multi-payer alignment: reduce administrative complexity, ensure manageable timelines,maintain quality	X	X	X	X	X

Stakeholder QBR Comment Letters	MHA	UMMS	Med-Star	Advent-ist	JHHS
incentives					
• Reweight domains to more closely align with HVBP (i.e., 1/3rd)	X	X	X	X	X
• Transition time is too lengthy					X
PCE Domain: HCAHPS top box and Consistency, monitor Medicaid TFU	X	X	X	X	X
• Understand inclusion of ED Wait Times due to importance			X		
Safety Domain: Maintain NHSN, Shifting/removing PSI 90	X	X	X	X	X
• Continue to exclude Sepsis bundle (re. clinical concerns)		X			
• Add Sepsis bundle for CMS alignment	X		X	X	X
Clinical Care Domain: Maintain IP and 30 day mortality measures	X	X	X		X
• Continue to exclude THA/TKA		X			
• Replace inpatient mortality measure with more stable 30-day measure in future years		X			
Separate Monitoring Program for state-specific measures	X	X	X	X	X
Digital Measures: Support RY 2028 incentive, default to CMS in RY 2029	X				
Modify Reward/Penalty Cut-Point for RY2027 and use as RY 28 cut-point	X	X	X	X	X
Maintain or Consider less revenue at risk and align with other states		X (maintain)			X (less)
Remove Medicare patients from non-Medicare quality programs					X

General Concerns on AHEAD transition: All hospital letters highlighted the importance of maximizing multi-payer alignment in order to reduce administrative complexity, and to ensure manageable timelines, while maintaining quality incentives. Thus, hospitals recommend establishing monitoring program for any state specific measures not included in the CMS quality programs. JHHS specifically states that a three year transition period is too lengthy (i.e., not moving fully to CMS programs until CY 2028). Additionally, in the November Commission meeting, questions were raised about the possibility of suspending the quality programs during the transition period to Medicare global budgets, or applying the CMS hospital quality results to the non-Medicare global budgets. Finally,

staff continues to collaborate with Medicaid staff and received a general letter on HSCRC quality programs (i.e., not specifically commenting on the QBR program) that urges the continued inclusion of all-payer measures, particularly those impacting the Medicaid program such as maternal child health measures of obstetric complications improvement, pediatric potentially avoidable utilization, and improved care coordination and handoffs as measured by the Medicaid TFU measure.

Staff Response:

Staff notes that the AHEAD model agreement includes the language below that requires continuation of the quality programs during the PYs 1 and 2 (defined transition timeline) while Medicare global budgets are finalized, and to further include all-payer measures as well as measures designed to improve population health. With regards to establishing a separate program to monitor state-specific measures, staff believes the state must consider important all-payer measures that address state priorities such as ED LOS and Medicaid TFU already in the QBR payment program. Staff further highlights the inclusion of these measures meets the criteria to include areas of concern/poor performance for the state. However, stakeholders did discuss what a robust monitoring program could look like, including reporting to hospitals and the public, updates to the Commission, and it was suggested that the CMS Inpatient Quality Reporting program be considered as a guide. Staff note that the monitoring for TFU for Medicare and HCAHPS linear measures is already planned, and that there are other existing monitoring reports for other quality areas already available on the CRISP portal. With regard to the transition period being too lengthy, staff believes the contract terms with the defined transition period provides the necessary flexibility to develop and operationalize the Medicare FFS and non-Medicare FFS global budgets and their related quality program updates. Furthermore, staff believe that work needs to be done with CMMI to assess feasibility of moving to CMS programs for CY 2027 performance, while staff pursues further alignment across all quality programs for non-Medicare payers.

h. CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology for PY1 and PY2: Hospital Quality and Value-Based Programs.

1. *For PY1 and PY2, the State will develop and administer hospital quality and value-based payment programs in accordance with the requirements of this Agreement. The State hospital quality and value-based payment programs will include all-payer measures. In the limited cases when all-payer measures are not feasible, the State may include Medicare-specific*

measures. The State hospital quality and value-based payment programs must include a performance measure designed to improve population health.

Aligning QBR Domain Weighting and Measures With HVBP program: All hospital comment letters supported aligning the domain weights with HVBP with each domain weighted equally in the program. Discussion in the November Commission meeting included a question about applying the efficiency domain weight to the PCE domain with continued inclusion of the ED Wait Time measure to better incentivize improvement. Most letters supported aligning the measures with those used in the HVBP, i.e, including only HCAHPS top box and consistency scores in the PCE domain and removing HCAHPS linear measures, ED Wait Time measure, the Medicaid TFU along with Medicare TFU and TFU disparities measures, adding the Sepsis Bundle measure to the Safety domain (and moving the PSI 90 measure to monitoring or MHAC), and adding the THA/TKA complication measure to the Clinical Care domain but also maintaining inclusion of the IP and 30-Day Mortality measures rather than using the CMS 30-day condition-specific mortality measures. UMMS, however, did not support adding the Sepsis Bundle and the THA/TKA measure citing clinical concerns about both measures. The third option provided in the Revenue Adjustment Modeling section provided estimates of impact of not including these measures, which was fairly minimal. Additionally, the MedStar letter did acknowledge the importance of including an incentive for ED wait time improvement because of the state's poor performance but stated the Medicaid TFU measure should be in monitoring. Finally, while not specifically commenting on the QBR program, a letter received from Medicaid regarding the overall hospital quality programs as they transition under AHEAD raised the following issues:

- Strongly urges continuation of hospital quality programs relevant to Medicaid by HSCRC
- Highlights measures such as Pediatric Quality Indicators in PAU and Medicaid Timely Follow up in QBR are particularly relevant for Medicaid
- Notes that an annual report submitted by the state must demonstrate that value-based programs for Medicaid and commercial payers meet or exceed previous results
- Notes that if quality performance assessments for Medicaid are diminished in any capacity under AHEAD, Medicaid will develop and implement Medicaid-specific hospital quality and payment programs

Staff Response:

Staff agrees with greater QBR alignment with the HVBP program for domain weights. Specifically, staff supports the following:

Measures:

- Staff generally agrees with stakeholders and believes it is important to align measures with HVBP, particularly those that assess patients of all-payers or are currently used in the HVBP program; this includes adopting the Sepsis Bundle measure, the THA/TKA Complications measure, and removing the HCAHPS linear measure, TFU Medicare and Disparity measures, and the PSI 90 measure.
- Staff agrees with stakeholder recommendations to continue use of the IP and 30-day All-condition, All-cause mortality measures with a plan to continue future refinement of these measures and further discussion on how to measure mortality for non-Medicare HGB adjustments.
- Staff supports continued inclusion of the ED LOS measure and Medicaid TFU to balance the state's priorities to improve in areas of poor performance in ED LOS, and to support better population health for the Medicaid population where hospitals have leverage. Additionally staff notes the infrastructure to collect these measures already exists through case mix/claims data and CRISP reporting with no additional data abstraction efforts needed from hospitals.

Domain and Measure Weights:

- Staff continues to support the recommendation in the draft recommendation to align the domain weights and measures more fully with the HVBP program but maintain slightly higher weight on the PCE domain to accommodate ED LOS and Medicaid TFU and reduce the Clinical Care and Safety domains proportionally to account for the additional measures:
    - Domain weights: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent , Clinical Care - 31 percent.

Other Revenue Adjustment Methodology Details: Letters received supported the following:

- Digital Measures: Support RY 2028 incentive, align with and default to CMS requirements beginning in RY 2029 (MHA).
- Modify Reward/Penalty Cut-Point for RY2027 and use as RY 28 cut-point since analysis shows a lower cut-point by about 10 percentage points is more

appropriate.

- Maintain (UMMS) or consider less (JHHS) revenue at risk and align with other states.
- Increase QBR revenue at-risk to incentivize greater improvement (Commissioner discussion)
- Remove Medicare patients from non-Medicare quality programs (JHHS)

Staff Responses:

Regarding the more timely and all-payer incentive for **digital measures reporting**, staff supports continued use of the digital measures infrastructure already established to receive more timely and more complete (all-payer hybrid measures) data for these measures; staff notes in particular that CMS has indicated a goal of transition to digital quality measure in the next few years, and the state infrastructure allows Maryland to be a leader in transitioning to digital measures. Also, the state has been collecting digital Severe Obstetric Complications risk adjusted measure providing an opportunity to consider hospital incentives to improve overall and to address differences in populations for this measure, aligning with established priorities and work of other state partners– Medicaid and the Maternal Child Health Bureau.

With regard to **modifying the reward/penalty cut-point**, staff agrees that the revised RY 2026 cut-point of 32.68 percent for RY 2027 and prospectively for RY 2028 is consistent with more recent trends.

For the **revenue at risk** under the program, staff supports continued use of 2 percent of inpatient revenue to continue alignment with CMS HVBP and also to continue to apply this to all-payers as quality incentives for all-payers is required under the AHEAD agreement. Furthermore, staff notes that the AHEAD agreement includes the same provisions for the state to meet the aggregate revenue at-risk requirements during the transition period.

With regard to **removing Medicare patients from non-Medicare state programs**, staff agrees understanding the impact of this is important to consider through discussion and analysis with the AHEAD transition. Staff notes, however, that the current HVBP program has established a precedent and does include all-payer HCAHPS, Sepsis Management Bundle and NHSN measures in performance assessments for Medicare specific revenue adjustments.

5. FINAL RECOMMENDATIONS FOR RY 2028 QBR PROGRAM

Final 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 to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and set the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 32 percent.
    a. Retrospectively evaluate the preset cut-point using more recent data to calculate national average score for RY 2027 and RY 2028.
    b. Based on concurrent analysis of national hospital performance, adjust the RY26 QBR cut-point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.
3. 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.

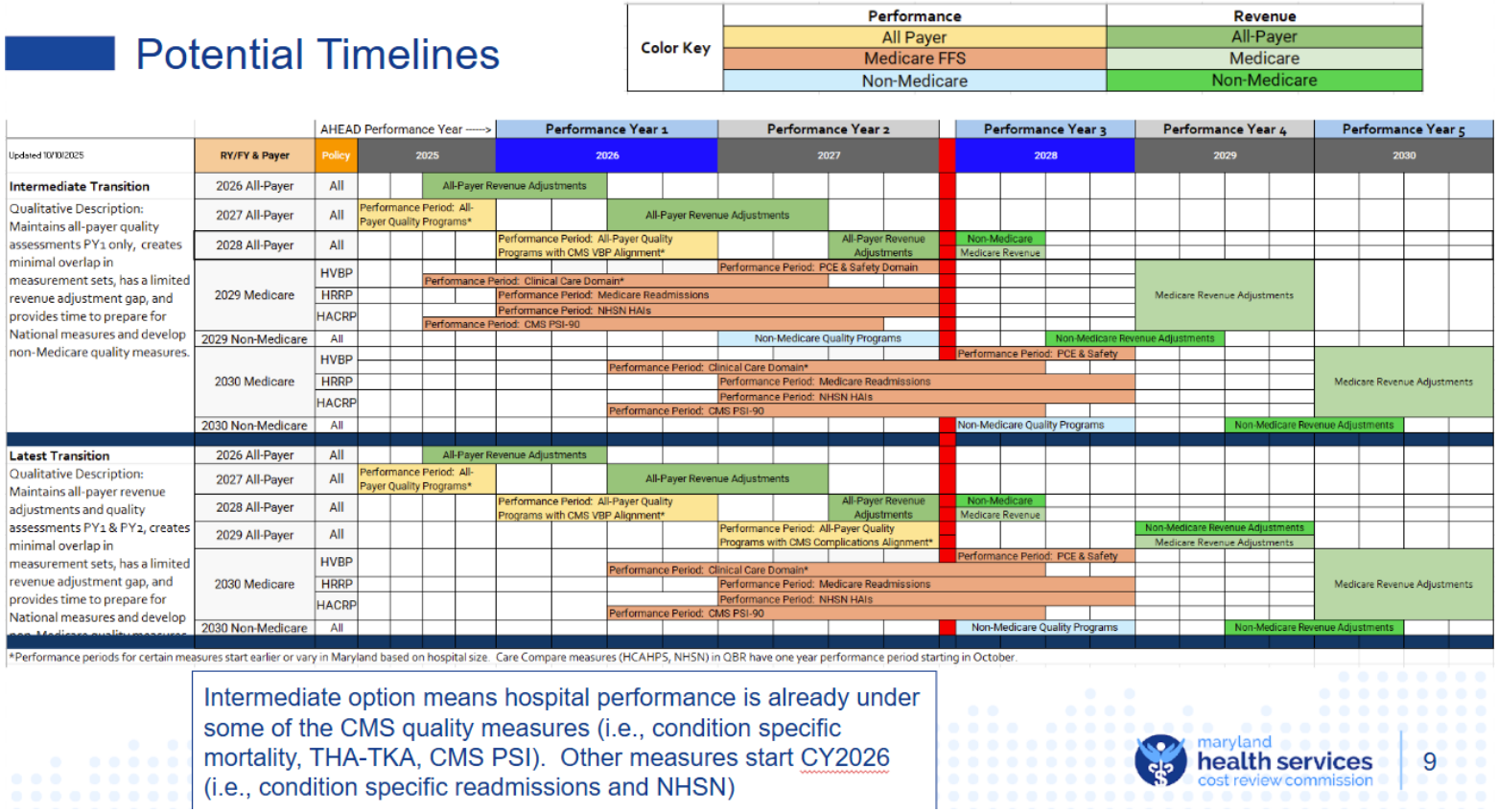
APPENDIX A: QUALITY PROGRAM TRANSITION UNDER AHEAD

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.

Figure A1. provides a potential timelines for quality program transition.

Figure A1. Timeline Options for Quality Program Transition



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.

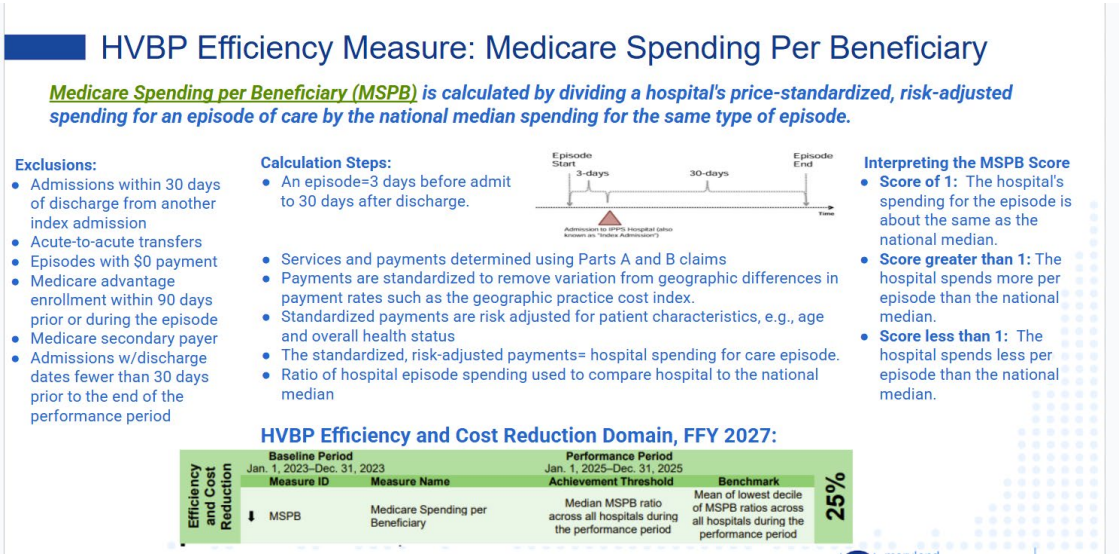
HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the HVBP Program, where feasible,[12] enabling the HSCRC to use data submitted directly to CMS. Maryland implemented 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.

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

[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.



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 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.

[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.

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

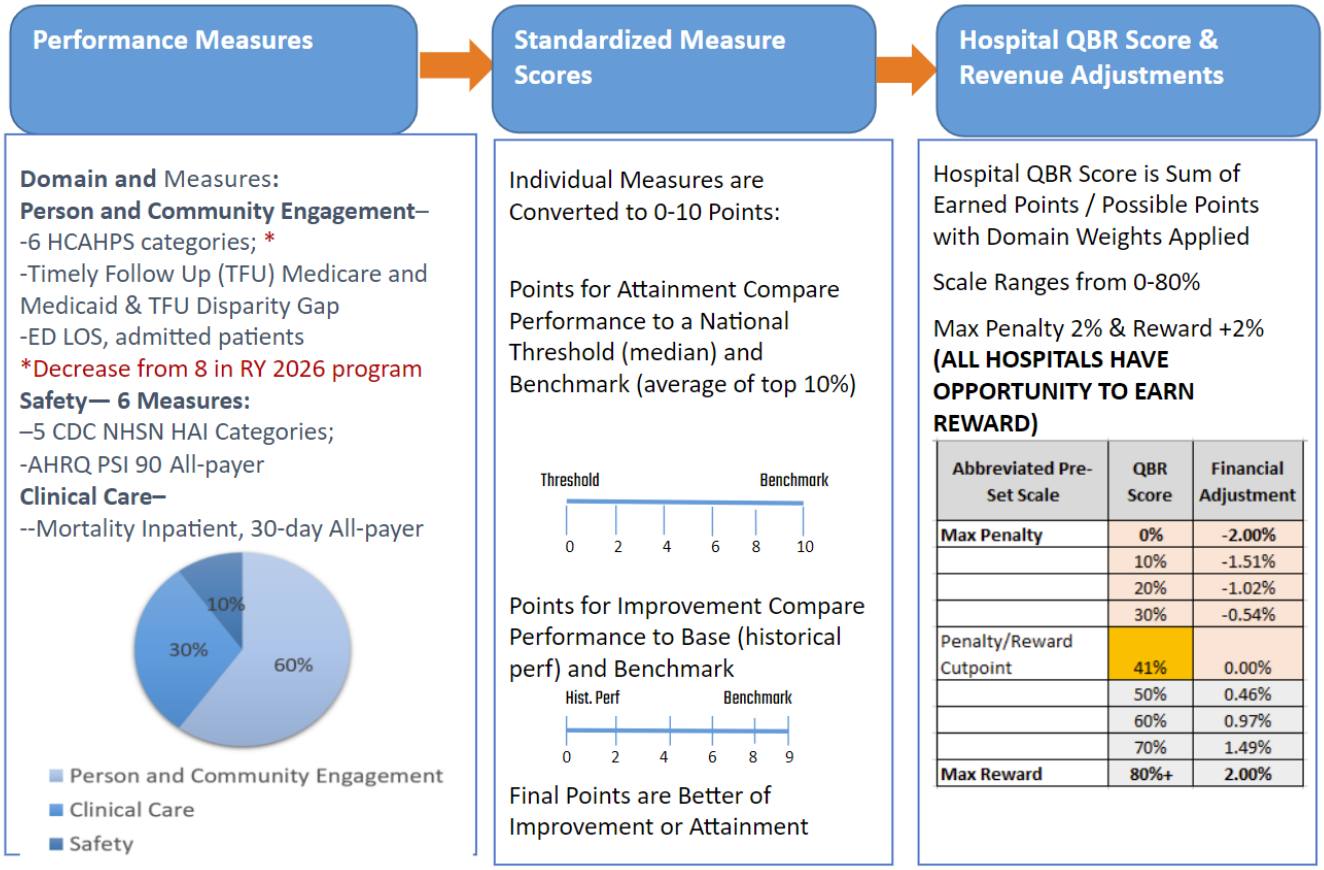


Figure B.4. below details the baseline and performance timelines for the measures in the QBR program for RY 2027.

Figure B.4.QBR RY 2027 timeline: base and performance periods; financial impact

<table>
<tr><td>Rate Year (Maryland Fiscal Year)</td><td>Q3-22</td><td>Q4-22</td><td>Q1-23</td><td>Q2-23</td><td>Q3-23</td><td>Q4-23</td><td>Q1-24</td><td>Q2-24</td><td>Q3-24</td><td>Q4-24</td><td>Q1-25</td><td>Q2-25</td><td>Q3-25</td><td>Q4-25</td><td>Q1-26</td><td>Q2-26</td><td>Q3-26</td><td>Q4-26</td><td>Q1-27</td><td>Q2-27</td><td>Q3-27</td><td>Q4-27</td></tr>
<tr><td>Calendar Year</td><td>Q1-22</td><td>Q2-22</td><td>Q3-22</td><td>Q4-22</td><td>Q1-23</td><td>Q2-23</td><td>Q3-23</td><td>Q4-23</td><td>Q1-24</td><td>Q2-24</td><td>Q3-24</td><td>Q4-24</td><td>Q1-25</td><td>Q2-25</td><td>Q3-25</td><td>Q4-25</td><td>Q1-26</td><td>Q2-26</td><td>Q3-26</td><td>Q4-26</td><td>Q1-27</td><td>Q2-27</td></tr>
<tr><td rowspan="3">Quality Based Reimbursement Program (QBR)</td><td colspan="8">Base Period: Hospital Compare (HCAHPS measures, All NHSN Measures)</td><td colspan="6">Performance Period: Hospital Compare (HCAHPS measures, All NHSN Measures)</td><td colspan="6" rowspan="3">Rate Year Impacted by QBR Results</td></tr>
<tr><td colspan="6"></td><td colspan="6">Base Period: QBR IP and 30-day Mortality, PSI-90, Timely Follow-up Chronic Conditions (Medicare, Medicaid and w/in Hospital Disparity Reduction)</td><td colspan="6">Performance Peirod: QBR IP and 30-day Mortality, PSI-90, Follow-up Chronic Conditions (Medicare, Medicaid and w/in Hospital Disparity Reduction)</td></tr>
<tr><td colspan="8"></td><td colspan="6">Base Period: Emergency Department Length of Stay (Admitted Patients)</td><td colspan="6">Performance Period: Emergency Department Length of Stay (Admitted Patients)</td></tr>
</table>

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
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration 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 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 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

[16] Source: https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions

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 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.

[17] Please see https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions.

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: HCAHPS LEARNING COLLABORATIVE AND ANALYSIS

HCAHPS Learning Collaborative Summary

As discussed in the policy, the HSCRC and MHA have led a HCAHPS Learning Collaborative over the last year. The two-page document below provides a summary of the Purpose, Key Learnings, and Next Steps.

health services cost review commission HCAHPS Learning Collaborative Maryland Hospital Association *Advancing health care and the health of all Marylanders*

Background

The Beryl Institute defines patient experience as the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures performance in patient experience for hospitals nationwide. Maryland hospitals do not perform strongly in HCAHPS compared to most other states. For years, Maryland has incentivized improvement through the Quality Based Reimbursement (QBR) Program. To understand methods to improve, the HSCRC and MHA formed a Learning Collaborative of patient experience leaders in the state to share key learnings to improve HCAHPS performance for hospitals across Maryland.

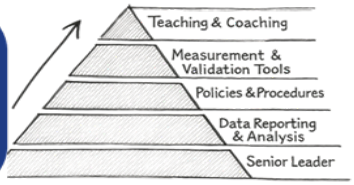
Key Learnings

1 Quality and Safety Indicator

National data from Press Ganey and NRC Health shows the synergies between improvements in HCAHPS and improvements in quality outcomes. HCAHPS performance is also linked with employee engagement and their ratings of safety.

2 Groundwork Needed

Improvement takes time. For lasting improvements in HCAHPS, hospitals should make Infrastructure investments like hiring a dedicated Chief Experience Officer, data reporting strategy, and process measurement tools to set up sustained performance.



3 Identifying Trends Using Statewide Data

Data driven decisions should be used to promote best practice adoption in the appropriate care setting as a part of cycles of learning. The learning collaborative looked for trends in state-wide HCAHPS in service lines, geographic location, size of hospital and patient demographics.

Next Steps

Implement Maryland Hospital HCAHPS Dashboard

The MHCC and HSCRC will publish a quarterly HCAHPS dashboard using patient level HCAHPS results from hospitals. Value for monitoring state performance, stratifying hospital results for comparison, and linking performance to best practices

Continue To Meet Quarterly To Share Best Practices

The Learning Collaborative will continue to meet quarterly to share best practices and learn faster together.

Consider Expanding Best Practice Incentives

Consider incentives for adopting specific supplemental questions on the survey or for adoption of best practices.

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Advancing health care and the health of all Marylanders

Best Practice Highlights

PressGaney

Improve ED Experience

Patients admitted through the ED rate their inpatient experience lower than those admitted directly. The two key drivers for ED Likelihood to Recommend scores are the patient's perception that staff worked together to care for them and that the staff cared for them as a person. Communication improves scores with long ED Wait times.

nrc HEALTH

Maryland Consumer Drivers

HCAHPS Likelihood to Recommend scores are based on three consumer drivers - trust, relevance, and experience. Maryland patients rank reliability as the most important factor for establishing trust. Reliability means a patient's confidence in accessibility of services and coordination of care.

Frederick Health

Treat Dissatisfaction as Harm

Frederick Health shifted its view of harm to include service failures. This transition meant using the same process improvement tools for patient dissatisfaction as used for patient harm. Results of initial pilots using this approach show some HCAHPS question scores improving by as much as 17 points compared to the previous two quarters.

Adventist HealthCare

Hourly Rounding

At Shady Grove Medical Center, hospital leadership have achieved their highest HCAHPS scores in five years through focusing on hourly rounding. Through improved measurement using an electronic rounding platform and regular coaching of nurse leaders, Adventist saw the biggest improvements in HCAHPS scores on the units where more hourly rounding visits took place.

JOHNS HOPKINS MEDICINE

ED Communication Tools

At Howard County Medical Center, ED Likelihood to Recommend Scores declined significantly after patients were in the ED longer than 9 hours. Leaders added technology to improve patient communication, using event messaging indicating where they were in the care process.

University of Maryland Medical Center

Interdisciplinary Bedside Rounds

UMMS is standardizing Interdisciplinary Bedside Rounds (IBR) as a core tactic to improve HCAHPS scores. The systems has created standard work for IBR and found that performing IBRs positively correlated with improvements in physician and nurse communication scores and patient-perceived frequency of rounding.

MedStar Health

Patient Experience Summit

MedStar launched an annual Human Experience Systemwide Summit to educate and train leaders on improving HCAHPS scores.

GBMC HEALTHCARE

Simplified Data Sharing

GBMC distributes a straightforward internal snapshot and unit specific infographic sheet to simplify key drivers for improvement and unit specific patient experience comments.

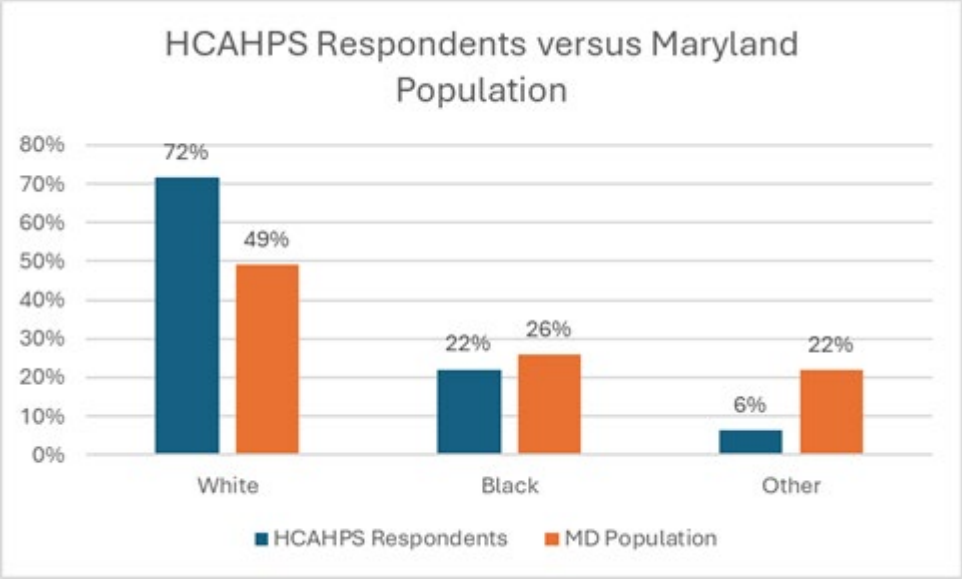
HCAHPS Patient Disparity Analysis

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 C.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 C.1. HCAHPS Responses compared to Maryland Population, as derived from the 2020 Census



When reviewing top-box rating (9 or 10) by race (Figure C.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 C.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 C.3.):

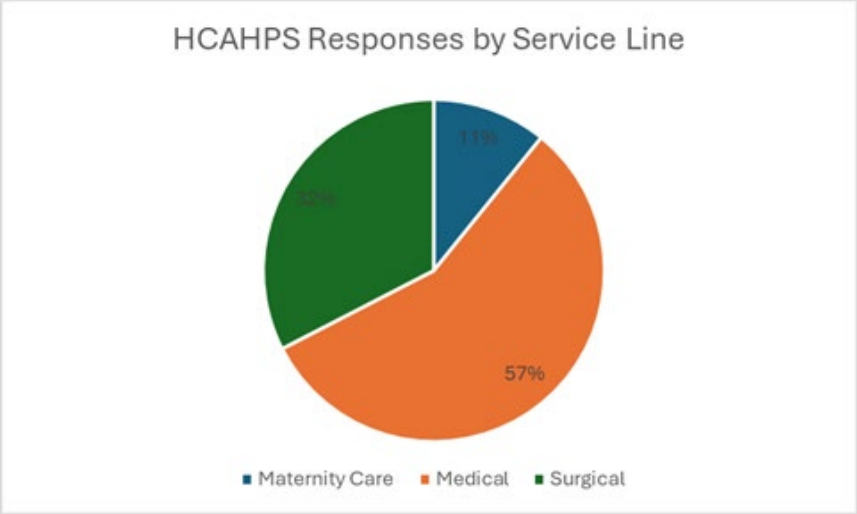
- Maryland responses are lower in the 9 or 10 category than the nation.
- In contrast to top-box recommendation, the Other race category responds the least favorably

Figure C.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 C.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 C.4. Responses by Service Line



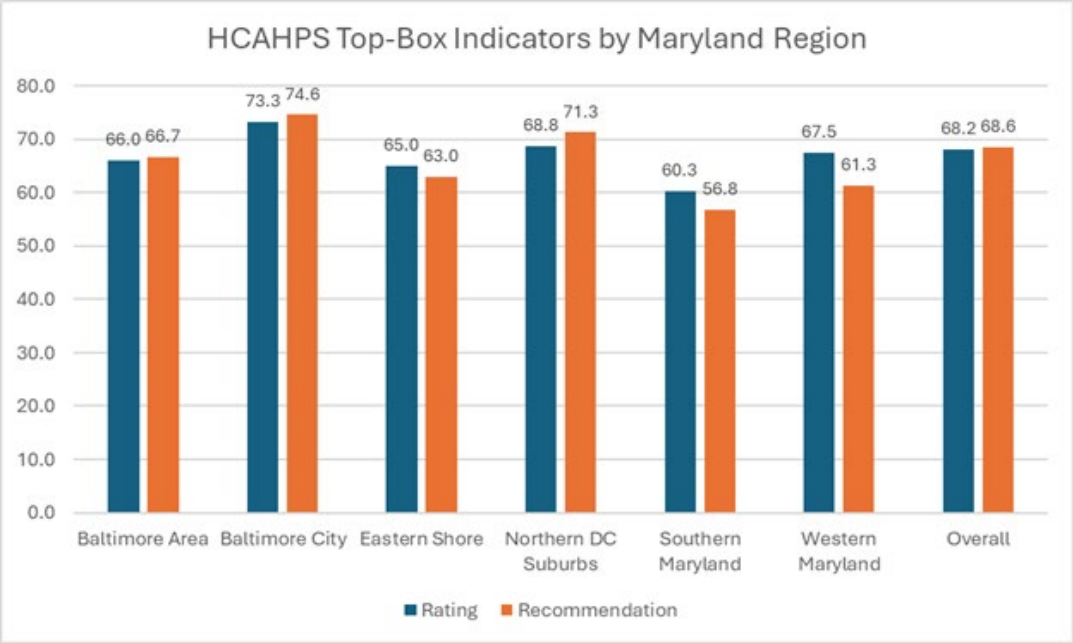
Looking at the overall results, there is minimal variation between race (Figure C.5). When reviewing more granularly, there are significant differences between race and service line. Specifically, the surgical service line consistently has higher results, and the medical service line is the lowest. However, between the race categories within the maternity service line, there is over a six-point difference between black and white respondents.

Figure C.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 C.6).

Figure C.6. Top-Box Rating and Recommendation by Region



APPENDIX D: 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 D.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 D.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 E: 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 E.1. below illustrates the Maryland and CMS CY 2026 reporting requirements.

[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.

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 Department of Health Maternal Child Health Bureau on this important population health improvement priority.

Figure E.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)	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)

Reporting Period/ payment determination	CMS Measures	Maryland Measures
	-30-day mortality -30-day readmissions	-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.

APPENDIX F: 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**

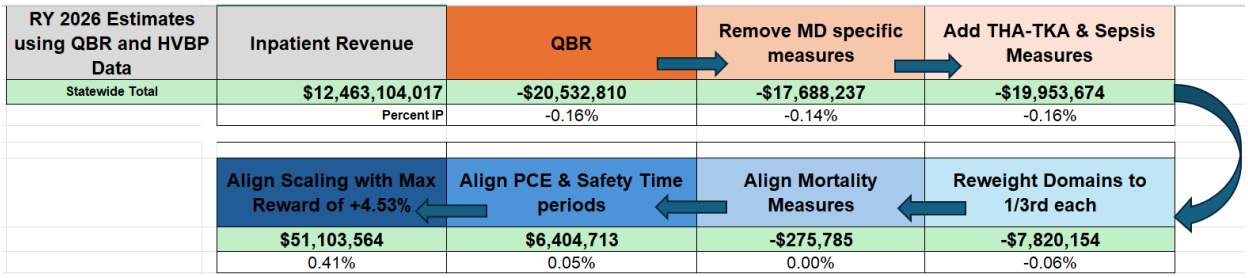
Cut-point = 32

HOSPID	HOSPITAL NAME	FY25 Estimated Permanent Inpatient Revenue	RY 2026 FINAL Score	% Revenue Impact	$ Revenue Impact
210001	Meritus	$ 269,729,949	49.58%	0.73%	$1,969,029
210002	UMMS- UMMC	$ 1,572,442,188	18.08%	-0.87%	-$13,680,247
210003	UMMS- Capital Region	$ 325,349,234	30.25%	-0.11%	-$357,884
210004	Trinity - Holy Cross	$ 440,757,012	16.58%	-0.96%	-$4,231,267
210005	Frederick	$ 255,860,248	26.17%	-0.36%	-$921,097
210008	Mercy	$ 244,094,359	36.75%	0.20%	$488,189
210009	JHH- Johns Hopkins	$ 1,915,323,836	34.67%	0.11%	$2,106,856
210011	St. Agnes	$ 280,211,776	36.25%	0.18%	$504,381
210012	Lifebridge- Sinai	$ 527,147,859	31.00%	-0.06%	-$316,289
210015	MedStar- Franklin Square	$ 407,544,466	27.17%	-0.30%	-$1,222,633
210016	Adventist- White Oak	$ 269,335,289	45.33%	0.56%	$1,508,278
210017	Garrett	$ 31,765,005	80.27%	2.00%	$635,300
210018	MedStar- Montgomery	$ 107,202,092	55.27%	0.97%	$1,039,860
210019	Tidal- Peninsula	$ 356,375,986	35.50%	0.15%	$534,564
210022	JHH- Suburban	$ 276,688,736	29.83%	-0.14%	-$387,364
210023	Luminis- Anne Arundel	$ 419,860,154	34.83%	0.12%	$503,832
210024	MedStar- Union Mem	$ 306,565,594	32.55%	0.02%	$61,313
210027	Western Maryland	$ 206,549,734	28.83%	-0.20%	-$413,099
210028	MedStar- St. Mary's	$ 99,664,006	38.35%	0.26%	$259,126
210029	JHH- Bayview	$ 505,597,983	16.75%	-0.95%	-$4,803,181
210032	ChristianaCare, Union	$ 111,158,432	46.43%	0.60%	$666,951
210033	Lifebridge- Carroll	$ 166,721,865	25.75%	-0.39%	-$650,215
210034	MedStar- Harbor	$ 137,076,633	39.93%	0.33%	$452,353
210035	UMMS- Charles	$ 105,216,708	21.08%	-0.68%	-$715,474
210037	UMMS- Easton	$ 138,384,760	30.33%	-0.10%	-$138,385
210038	UMMS- Midtown	$ 140,973,899	32.35%	0.01%	$14,097
210039	Calvert	$ 84,946,923	63.17%	1.30%	$1,104,310
210040	Lifebridge- Northwest	$ 173,564,819	29.83%	-0.14%	-$242,991
210043	UMMS- BWMC	$ 329,675,757	31.42%	-0.04%	-$131,870
210044	GBMC	$ 274,971,840	36.67%	0.19%	$522,446
210048	JHH- Howard County	$ 256,140,273	20.17%	-0.74%	-$1,895,438
210049	UMMS-Upper Chesapeake	$ 260,331,648	22.83%	-0.57%	-$1,483,890
210051	Luminis- Doctors	$ 195,040,841	29.75%	-0.14%	-$273,057
210056	MedStar- Good Sam	$ 199,681,457	21.25%	-0.67%	-$1,337,866
210057	Adventist- Shady Grove	$ 361,126,072	32.42%	0.02%	$72,225
210060	Adventist-Ft. Washington	$ 37,325,252	33.65%	0.07%	$26,128
210061	Atlantic General	$ 49,839,515	58.85%	1.12%	$558,203
210062	MedStar- Southern MD	$ 210,782,671	27.50%	-0.28%	-$590,191
210063	UMMS- St. Joe	$ 305,357,564	42.92%	0.45%	$1,374,109
210065	Trinity - Holy Cross Germantown	$ 106,721,583	14.83%	-1.07%	-$1,141,921
	Statewide Total	**$12,463,104,017**			**-$20,532,809**

APPENDIX G: ASSESSMENT OF QBR AND HVBP DIFFERENCES

Figure G. 1. below illustrates the iterative impact of changes to the QBR results to reconcile with the HVBP results. The analysis is impacted by the order of the changes and the manually calculated HVBP results vary slightly from the CMMI results. Overall this indicates that the scaling parameters for HVBP is the largest factor associated with over 60 percent of the difference between the QBR and HVBP scores. Domain weighting is the second biggest factor, which staff has proposed to address by changes to the domain weights. Removal of Maryland specific measures and addition of the Sepsis Bundle and THA-TKA complication measure, however, have much smaller contributions to the differences in scores.

Figure G.1. Iterative Impact of Changes in QBR Results Reconciled with HVBP



APPENDIX H: RY 2028 MODELING ESTIMATES BY HOSPITAL

RY 2028 QBR Modeling using RY 2026 Data			Option 1: Staff Recommendation						Option 2: MHA Proposal						Option 3: Staff Recommendation (option 1) w/o Sepsis & THA-TKA					
			38.30%	30.85%	30.85%				33.33%	33.33%	33.33%				38.30%	30.85%	30.85%			
HOSPID	HOSPITAL NAME	Actual IP Revenue	PCE Domain Score	Clinical Domain Score	Safety Domain Score	FINAL Score	% Revenue Impact	$ Revenue Impact	PCE Domain Score	Clinical Domain Score	Safety Domain Score	FINAL Score	% Revenue Impact	$ Revenue Impact	PCE Domain Score	Clinical Domain Score	Safety Domain Score	FINAL Score	% Revenue Impact	$ Revenue Impact
210001	Meritus	$ 269,729,949	45%	29%	62%	45.33%	0.56%	$1,510,488	32%	29%	62%	40.94%	0.37%	$998,001	45%	55%	47%	48.67%	0.69%	$1,861,137
210002	UMMS- UMMC	$ 1,572,442,188	21%	30%	8%	19.83%	-0.76%	-$11,950,561	32%	30%	8%	23.44%	-0.53%	-$8,333,944	21%	30%	3%	18.28%	-0.86%	-$13,523,003
210003	UMMS- Capital Region	$ 325,349,234	39%	5%	43%	29.91%	-0.13%	-$422,954	20%	5%	43%	22.78%	-0.58%	-$1,887,026	39%	5%	50%	31.97%	0.00%	$0
210004	Holy Cross	$ 440,757,012	17%	7%	35%	19.18%	-0.80%	-$3,526,056	8%	7%	35%	16.55%	-0.97%	-$4,275,343	17%	7%	23%	15.58%	-1.03%	-$4,539,797
210005	Frederick	$ 255,860,248	17%	21%	57%	30.31%	-0.11%	-$281,446	19%	21%	57%	32.16%	0.01%	$25,586	17%	21%	44%	26.40%	-0.35%	-$895,511
210008	Mercy	$ 244,094,359	47%	4%	42%	32.22%	0.01%	$24,409	31%	4%	42%	25.61%	-0.40%	-$976,377	47%	4%	40%	31.71%	-0.02%	-$48,819
210009	JHH- Johns Hopkins	$ 1,915,323,836	39%	75%	20%	44.06%	0.50%	$9,576,619	59%	75%	20%	51.33%	0.81%	$15,514,123	39%	75%	23%	45.09%	0.55%	$10,534,281
210011	St. Agnes	$ 280,211,776	34%	50%	35%	39.22%	0.30%	$840,635	12%	50%	35%	32.33%	0.01%	$28,021	34%	50%	48%	43.23%	0.47%	$1,316,995
210012	Lifebridge- Sinai	$ 527,147,859	35%	13%	23%	24.55%	-0.47%	-$2,477,595	14%	13%	23%	16.61%	-0.96%	-$5,060,619	35%	13%	28%	26.10%	-0.37%	-$1,950,447
210015	MedStar- Franklin Square	$ 407,544,466	12%	35%	42%	28.06%	-0.25%	-$1,018,861	15%	35%	42%	30.55%	-0.09%	-$366,790	12%	35%	62%	34.23%	0.09%	$366,790
210016	Adventist- White Oak	$ 269,335,289	50%	33%	60%	48.04%	0.67%	$1,804,546	37%	33%	60%	43.44%	0.48%	$1,292,809	50%	33%	54%	46.19%	0.59%	$1,589,078
210017	Garrett	$ 31,765,005	87%	60%	10%	54.91%	0.95%	$301,768	84%	60%	10%	51.33%	0.81%	$257,297	87%	60%	0%	51.82%	0.83%	$263,650
210018	MedStar- Montgomery	$ 107,202,092	50%	58%	66%	57.60%	1.07%	$1,147,062	33%	58%	66%	52.44%	0.85%	$911,218	50%	58%	83%	62.69%	1.28%	$1,372,187
210019	Tidal- Peninsula	$ 356,375,986	31%	3%	47%	27.24%	-0.30%	-$1,069,128	22%	3%	47%	24.00%	-0.50%	-$1,781,880	31%	3%	54%	29.51%	-0.16%	-$570,202
210022	JHH- Suburban	$ 276,688,736	28%	50%	20%	32.17%	0.01%	$27,669	37%	50%	20%	35.66%	0.15%	$415,033	28%	50%	20%	32.17%	0.01%	$27,669
210023	Luminis- Anne Arundel	$ 419,860,154	40%	0%	33%	25.69%	-0.39%	-$1,637,455	19%	0%	33%	17.44%	-0.91%	-$3,820,727	40%	0%	27%	23.64%	-0.52%	-$2,183,273
210024	MedStar- Union Mem	$ 306,565,594	17%	38%	42%	31.28%	-0.04%	-$122,626	26%	38%	42%	35.44%	0.14%	$429,192	17%	38%	53%	34.52%	0.11%	$337,222
210027	Western Maryland	$ 206,549,734	30%	2%	32%	21.68%	-0.64%	-$1,321,918	39%	2%	32%	24.11%	-0.49%	-$1,012,094	30%	2%	30%	21.17%	-0.68%	-$1,404,538
210028	MedStar- St. Mary's	$ 99,664,006	14%	46%	70%	41.15%	0.38%	$378,723	19%	46%	70%	44.94%	0.54%	$538,186	14%	46%	88%	46.54%	0.61%	$607,950
210029	JHH- Bayview	$ 505,597,983	16%	46%	10%	23.23%	-0.55%	-$2,780,789	24%	46%	10%	26.61%	-0.34%	-$1,719,033	16%	46%	2%	20.76%	-0.70%	-$3,539,186
210032	ChristianaCare, Union	$ 111,158,432	44%	54%	36%	44.65%	0.53%	$589,140	30%	54%	36%	40.05%	0.34%	$377,939	44%	54%	45%	47.42%	0.64%	$711,414
210033	Lifebridge- Carroll	$ 166,721,865	11%	35%	48%	29.78%	-0.14%	-$233,411	11%	35%	48%	31.44%	-0.03%	-$50,017	11%	35%	52%	30.91%	-0.07%	-$116,705
210034	MedStar- Harbor	$ 137,076,633	28%	70%	46%	46.37%	0.60%	$822,460	21%	70%	46%	45.66%	0.57%	$781,337	28%	70%	58%	49.91%	0.75%	$1,028,075
210035	UMMS- Charles	$ 105,216,708	15%	17%	43%	24.09%	-0.49%	-$515,562	21%	17%	43%	27.00%	-0.31%	-$326,172	15%	17%	34%	21.21%	-0.67%	-$704,952
210037	UMMS- Easton	$ 138,384,760	34%	29%	35%	32.96%	0.04%	$55,354	10%	29%	35%	24.72%	-0.45%	-$622,731	34%	29%	42%	35.12%	0.13%	$179,900
210038	UMMS- Midtown	$ 140,973,899	37%	25%	44%	35.28%	0.14%	$197,363	12%	25%	44%	27.00%	-0.31%	-$437,019	37%	25%	38%	33.27%	0.05%	$70,487
210039	Calvert	$ 84,946,923	67%	20%	52%	47.77%	0.66%	$560,650	53%	20%	52%	41.66%	0.40%	$339,788	67%	20%	87%	58.47%	1.10%	$934,416
210040	Lifebridge- Northwest	$ 173,564,819	33%	29%	40%	33.92%	0.08%	$138,852	17%	29%	40%	28.72%	-0.21%	-$364,486	33%	29%	26%	29.60%	-0.15%	-$260,347
210043	UMMS- BWMC	$ 329,675,757	23%	42%	27%	29.81%	-0.14%	-$461,546	27%	42%	27%	31.78%	-0.01%	-$32,968	23%	42%	28%	30.22%	-0.11%	-$362,643
210044	GBMC	$ 274,971,840	27%	13%	52%	30.30%	-0.11%	-$302,469	26%	13%	52%	30.05%	-0.12%	-$329,966	27%	13%	50%	29.78%	-0.14%	-$384,961
210048	JHH- Howard County	$ 256,140,273	10%	13%	37%	18.92%	-0.82%	-$2,100,350	15%	13%	37%	21.39%	-0.66%	-$1,690,526	10%	13%	36%	18.71%	-0.83%	-$2,125,964
210049	UMMS-Upper Chesapeake	$ 260,331,648	20%	21%	32%	23.69%	-0.52%	-$1,353,725	6%	21%	32%	19.50%	-0.78%	-$2,030,587	20%	21%	38%	25.64%	-0.40%	-$1,041,327
210051	Luminis- Doctors	$ 195,040,841	34%	21%	45%	33.31%	0.05%	$97,520	12%	21%	45%	25.94%	-0.38%	-$741,155	34%	21%	28%	28.07%	-0.25%	-$487,602
210056	MedStar- Good Sam	$ 199,681,457	4%	30%	45%	24.64%	-0.46%	-$918,535	6%	30%	45%	27.00%	-0.31%	-$619,013	4%	30%	54%	27.41%	-0.29%	-$579,076
210057	Adventist- Shady Grove	$ 361,126,072	22%	21%	57%	32.15%	0.01%	$36,113	29%	21%	57%	35.50%	0.15%	$541,689	22%	21%	52%	30.71%	-0.08%	-$288,901
210060	Adventist-Ft. Washington	$ 37,325,252	30%	30%	26%	28.78%	-0.20%	-$74,651	34%	30%	26%	30.00%	-0.13%	-$48,523	30%	30%	50%	36.18%	0.17%	$63,453
210061	Atlantic General	$ 49,839,515	66%	25%	50%	48.37%	0.68%	$338,909	53%	25%	50%	42.66%	0.44%	$219,294	66%	25%	73%	55.31%	0.97%	$483,443
210062	MedStar- Southern MD	$ 210,782,671	7%	67%	50%	38.74%	0.28%	$590,191	11%	67%	50%	42.55%	0.44%	$927,444	7%	67%	54%	39.98%	0.33%	$695,583
210063	UMMS- St. Joe	$ 305,357,564	40%	54%	22%	38.55%	0.27%	$824,465	50%	54%	22%	41.94%	0.41%	$1,251,966	40%	54%	20%	38.03%	0.25%	$763,394
210065	Holy Cross Germantown	$ 106,721,583	10%	2%	32%	14.03%	-1.12%	-$1,195,282	15%	2%	32%	16.11%	-0.99%	-$1,056,544	10%	2%	18%	9.82%	-1.39%	-$1,483,430
	Statewide Total	**$12,463,104,017**	**30.7%**	**30.5%**	**39.3%**	**33.3%**	**-0.02%**	**-$13,901,981**	**26.0%**	**30.5%**	**39.3%**	**32.0%**	**-0.09%**	**-$12,734,618**	**30.7%**	**31.2%**	**41.5%**	**34.2%**	**0.01%**	**-$13,283,560**

Adventist HealthCare

December 2nd, 2025

Alyson Schuster
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Alyson Schuster,

Adventist HealthCare (AHC) appreciates the opportunity to provide comments on the draft recommendation for the Rate Year (RY) 2028 Quality-Based Reimbursement (QBR) Program.

The HSCRC has worked collaboratively with hospitals to redesign the RY28 QBR program for greater alignment with the CMS Hospital Value-Based Purchasing (HVBP) Program in preparation for the AHEAD transition. AHC has actively participated in these discussions and appreciates the transparency and engagement. However, the current recommendation does not fully maximize alignment with the CMS HVBP program.

Maximize Alignment with HVBP Program

AHC recognizes the intent of continuing to track Maryland-specific measures; however, these should not remain within the QBR program. Maintaining separate calculation sets creates an unnecessary administrative burden, requiring hospitals to manage multiple reports and dashboards. This duplication also introduces confusion for stakeholders in interpreting performance across programs with similar objectives. Aligning QBR fully with HVBP simplifies reporting and ensures clarity through a unified set of metrics.

While the draft recommendation proposes full alignment in AHEAD PY2 or PY3, initiating this transition in PY1 would allow hospitals to concentrate on core quality measures during the critical preparation phase for the AHEAD model. AHC recommends alignment with HVBP in PY1 and moving all state-specific measures to a monitoring-only program.

Establish a Monitoring-Only Program for State-Specific Measures

AHC recommends creating a monitoring-only program for Maryland-focused measures such as ED LOS and Medicaid Timely Follow-Up. This approach supports alignment between QBR and HVBP while maintaining progress on key state priorities without adding unnecessary administrative complexity. Our hospitals have invested significant resources in these measures and remain committed to improvement.

Additionally, any new measures—such as Inpatient LOS—should be introduced as monitoring-only before inclusion in payment policy. This standard practice allows hospitals to adapt while focusing on the upcoming AHEAD transition. Furthermore, changes to any existing state-specific measures, such as ED LOS, should be

avoided during the transition. This creates stability and avoids additional work for hospitals to change any internal performance monitoring. This also allows HSCRC staff to focus on aligning the other HSCRC/CMS quality programs instead of further refining state-specific measures.

Recommendations

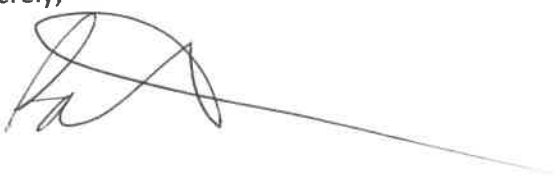
Adventist HealthCare recommends the following actions for the RY28 QBR Draft Recommendation, which will help support the transition to the AHEAD model:

- Remove ED LOS and Medicaid Timely Follow-Up from the QBR program to maximize alignment with HVBP.
- Establish a monitoring-only program for all state-specific measures not aligned with HVBP and avoid any changes to these measures throughout the AHEAD transition

Conclusion

We value HSCRC's partnership and commitment to aligning with the CMS quality programs. As Maryland hospitals prepare for the AHEAD transition, maximizing alignment is critical to reducing administrative burden and ensuring clarity for all stakeholders. This focus allows hospitals to dedicate resources where they matter most—delivering exceptional, high-quality care to every Marylander.

Sincerely,



Patsy M. McNeil, M.D. MBA, FACEP
Adventist HealthCare
Executive Vice President and System Chief Medical Officer

Maryland
DEPARTMENT OF HEALTH
Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

Dec 1, 2025

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

RE: Continuation of Medicaid in Hospital Quality Programs

Dear. Dr. Kromm,

On behalf of the Maryland Medicaid Program and the Maryland Department of Health, I am writing to strongly encourage the continuation of Medicaid in hospital quality programs led and implemented by the Health Services Cost Review Commission (HSCRC) through the duration of the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. Medicaid has historically deferred to the HSCRC to implement hospital quality metrics and payment policies, in lieu of designing and operating its own.

The HSCRC has led all-payer hospital quality programs–including, but not limited to, Readmissions Reduction Incentive Program, Quality-Based Reimbursement and Maryland Hospital-Acquired Conditions program–for over 10 years under the All-Payer and Total Cost of Care (TCOC) Models. The TCOC Model has particularly strengthened the all-payer nature of hospital quality programs by emphasizing measures that have a unique impact on the Medicaid population, e.g., Pediatric Quality Indicators (PDIs) and Timely Follow Up for Medicaid beneficiaries.

Under the AHEAD Model, the State will transition Medicare hospital global budgets from the state-designed hospital quality programs to national Medicare hospital quality programs. Per the AHEAD State Agreement, as amended and with Centers for Medicare & Medicaid Services (CMS) approval, Maryland may continue to operate the state-designed hospital quality programs for Medicaid and commercial payers. An annual report submitted by the State must demonstrate that hospital quality and value-based programs for Medicaid and commercial payers meet or surpass previous results with regard to health outcomes and cost savings.

As the Deputy Secretary for Health Care Financing and Medicaid Director, I am committed to ensuring the existence of meaningful Medicaid quality programs for Maryland acute care hospitals. If quality performance assessments for Medicaid participants are diminished in any capacity because of the

transition to the AHEAD Model, Maryland's Health Care Financing Administration will develop and implement Medicaid-specific hospital quality and payment programs.

Please do not hesitate to reach out with any questions at perrie.briskin@maryland.gov or 443-970-0547.

Sincerely,

Perrie Briskin
Deputy Secretary for Health Care Financing and Medicaid Director

CC: Meena Seshamani, MD, PhD
HSCRC Commissioners
Allan Pack
Alyson Schuster

MedStar Health

10980 Grantchester Way
Columbia, MD 21044

MedStar Franklin Square Medical Center
MedStar Good Samaritan Hospital
MedStar Harbor Hospital
MedStar Montgomery Medical Center
MedStar Southern Maryland Hospital Center
MedStar St. Mary's Hospital
MedStar Union Memorial Hospital
MedStar Georgetown University Hospital
MedStar National Rehabilitation Network
MedStar Washington Hospital Center

MedStarHealth.org

December 2, 2025

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

Dear Dr. Kromm:

On behalf of the 7 MedStar Health Hospitals in Maryland, we would like to thank you for your ongoing partnership in advocating for the highest quality and highest value care for Marylanders.

We write today to provide our perspective on the RY28 Quality Based Reimbursement (QBR) Draft Policy as discussed at the November 19, 2025 HSCRC Performance Measurement Workgroup. We appreciate the complexity of this policy cycle in the context of the foundational changes happening with the AHEAD model transition, and we commend the HSCRC staff for the collaborative and careful approach they bring to this work. We would like to highlight several key considerations as we move toward finalizing the policy.

1. We agree with the HSCRC staff's recommendation to reweight the QBR domains to more closely align with Value Based Purchasing (VBP), and we see the overall alignment of the program with VBP, as much as is feasible in an all-payer context, as a top priority. This alignment is essential for priority setting and performance improvement efforts to be streamlined and maximally impactful.

2. We recognize the critical need to continue to improve ED wait times for Marylanders, and we understand why inclusion of this top priority focus may be a reasonable deviation from the principle that QBR should align with VBP. That said, we feel the inclusion of additional measures, beyond what is included in VBP, should be very infrequent and only for the highest State-wide priorities. We do not believe Medicaid Timely Follow Up meets this standard and do not recommend it would be included in QBR. Ensuring timely follow up for all our patients is an important clinical priority for our hospitals, but inclusion of this measure adds significant methodological and clinical complexity that, in the balance, is not advisable.

Thank you for your consideration of our perspective. Please let us know if we may provide further clarifications and/or if you would like to discuss with our team.

Sincerely,

Stephen T. Michaels, MD
President, MedStar Southern MedStar Hospital

Jonathan Patrick, MD
VP, Clinical Quality Performance, MedStar Health

Rollin J. (Terry) Fairbanks, MD
SVP and Chief Quality & Safety Officer, MedStar Health

December 2, 2025

Alyson Schuster, Ph.D.
Deputy Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Schuster:

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the draft recommendation for the Quality-Based Reimbursement (QBR) Program for Rate Year (RY) 2028. JHHS appreciates staff's thorough discussions of the QBR considerations in the Performance Measurement Workgroup and the opportunity to provide feedback on critical components of the model as the State prepares for significant transition into the AHEAD model.

As noted in JHHS's previous comments, implementation of the AHEAD model in Maryland will require significant and substantial efforts from many stakeholders over the coming years. Given this complexity, JHHS would underscore the key guiding principles endorsed by the hospital field as highlighted by the Maryland Hospital Association (MHA), including 1) maximizing multi-payer alignment; 2) reducing administrative complexity; 3) ensuring manageable timelines; and 4) maintaining quality incentives. JHHS urges the Health Services Cost Review Commission (HSCRC) to ensure policy changes align with these guiding principles as teams across the state work towards a sustainable payment model.

JHHS supports the MHA's comments on the draft policy, and offers the following additional comments and feedback for consideration:

1. While JHHS appreciates that a thoughtful approach is needed to ensure an appropriate transition to the national quality programs under AHEAD, a three-year transition is likely too lengthy a period for hospitals to be in transition, particularly given that the industry is collectively asking for alignment and reduced administrative complexity. Due to the lags in Medicare timelines, delaying the State's quality program transition timeline effectively creates a dynamic with duplicative monitoring of multiple programs and a less efficient use of limited hospital resources.
2. JHHS urges the HSCRC to mirror the national model where possible, inclusive of the national reward and penalty percentages. While a one-time adjustment to better support strategic investment is helpful, meaningful ongoing contributions via rate adjustment have increased potential to impact quality improvement.
3. JHHS is supportive of the MHA's position on QBR domain weights and measure approaches, as well as state-based monitoring and CMS timelines.

4. JHHS supports adjusting the RY26 QBR cut point to 32.68%. At the current cut-point, hospitals have inaccurate revenue impact; though hospitals build in some threshold for no retrospective change during the budgeting process, the variance is substantial (e.g., 3+%) and impacts the accuracy of hospital budgeting processes.
5. While current quality programs under the Total Cost of Care Model have operated as all-payer programs, the AHEAD model will have separate requirements for Medicare quality programs, meaning state-designed quality programs will no longer be truly all-payer. JHHS would urge the HSCRC to consider removing the Medicare adjustments from the state-designed quality program adjustments to ensure rewards or penalties are not duplicated across the separate programs.
6. Finally, JHHS would encourage the HSCRC to evaluate the percentage of revenue currently associated with quality programs in comparison to other states. There may be an opportunity for the State to drive quality improvement through a balanced approach that risks less hospital revenue, which becomes increasingly important as hospitals face substantial rate reductions under AHEAD amidst already strained financial conditions.

In the face of unprecedented and complex changes to key components of the model – many of which currently remain unknown – any policy changes must align with the MHA's proposed guiding principles in order to facilitate a viable and sustainable path forward. JHHS thanks HSCRC staff for the opportunity to provide feedback on this draft recommendation, and looks forward to continued collaboration to further improved quality and access for all Marylanders.

Sincerely,

Angela Green, Ph.D., R.N., F.A.A.N.
Vice President, Quality and Safety
Johns Hopkins Health System

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Jonathan Blum
Nicki McCann
Dr. Farzaneh Sabi
Jon Kromm

Maryland
Hospital Association

December 2, 2025

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we extend our thanks to the Health Services Cost Review Commission (HSCRC) for the opportunity to comment on the Draft Recommendations for the Quality-Based Reimbursement (QBR) Program for RY 2028. We appreciate the Commission's commitment to transparency, inclusive governance, and stakeholder engagement. We welcome the opportunity to provide feedback on these recommendations and to continue to advance quality across Maryland hospitals.

The QBR draft recommendation comes at an unprecedented time in Maryland as the state transitions to the AHEAD Model. Under this new Model, hospitals will be required to move to the national Centers for Medicare & Medicaid Services (CMS) Medicare Inpatient Prospective Payment System and Outpatient Prospective Payment System (IPPS/OPPS) quality programs. Given this, hospitals propose that program elements for QBR align with the federal quality requirements to ease the challenge of simultaneous operation of state-based and federal quality programs and result in equal, improved quality for all patients. More specifically, the hospital field has endorsed key principles that should guide this policy and other state-based quality policies.

- **Maximize Multi-Payer Alignment** – State-based quality policies should align Medicare, Medicaid, and commercial quality approaches to streamline administration.

- **Reduce Administrative Complexity** – Policies should be designed to avoid complexity, administrative burden, and higher costs as the state plans for simultaneous operation of state-based and federal quality programs.

- **Ensure Manageable Timelines** – The state should select quality program policy time frames that enable hospitals to adjust their quality infrastructure to optimize performance in the national quality programs.

- **Maintain Quality Incentives** – State-based quality programs should maintain incentives to improve quality performance.

Additionally, as the state plans the design of other quality programs that coincide with the launch of the AHEAD Model, use of these principles will be essential for a successful and sustainable quality program over the ten-year AHEAD Model.

MHA Proposal for an Alternative Alignment Approach

While the QBR Program draft recommendation includes some areas where the program would align with the Medicare Hospital Value-Based Purchasing Program (HVBP) in CY2026, there is an opportunity to do more to achieve alignment between Medicare, Medicaid, and commercial quality programs. Without additional steps to align the federal and state quality programs, hospitals will face increased burden and complications with the AHEAD Model transition.

To address these concerns, MHA respectfully proposes an alternative approach that is guided by the aforementioned principles with two components:

1. Modification of QBR Domain Weights and Measure Approaches
2. Creation of a State-Based Monitoring Program

QBR Domain Weights & Measure Approaches

While MHA appreciates the intent behind the proposed reweighting of the Person and Community Engagement domain, we urge the Commission to mirror the HVBP program wherever possible to eliminate avoidable operational challenges. MHA recommends the following domain and measure weights:

- **Person and Community Engagement Domain (33.3%)**
  - HCAHPS Top Box (23.3%)
  - HCAHPS Consistency (10%)

- **Clinical Care Domain (33.3%)**
  - All Payer 30-Day Mortality Measure (14.15%)
  - All Payer Inpatient Mortality Measure (14.15%)
  - THA-TKA Complication Measure (5%)*

- **Safety Domain (33.3%)**
  - NHSN (26%)
  - Sepsis Bundle (7.3%)*

*The THA-TKA Complication and Sepsis Bundle measures apply only to Medicare, while all other measures are all-payer.

State-Based Monitoring Program

In addition to mirroring the HVBP domain and measure weights, MHA recommends that HSCRC create a new "State-Based Monitoring Program" for key measures that are of importance to the state but are not in Medicare HVBP. This approach allows the state to maintain alignment with Medicare, track performance trends, and evaluate impacts of other initiatives without imposing payment adjustments during the transition period. MHA recommends the following measures be included in a State-Based Monitoring Program:

- Emergency Department Length of Stay (ED LOS)
- Inpatient Length of Stay (IP LOS)
- Medicaid Timely Follow Up
- Any new measures proposed by HSCRC

For measures in the State-Based Monitoring program, MHA recommends a moratorium be placed on payment policy for measures that are not part of the Medicare HVBP. Hospitals are currently managing significant operational pressures and resource constraints. Introducing Maryland-specific measures with payment implications would increase complexity and risk, especially as these metrics are influenced by external factors such as post-acute care placement and managed care coordination —issues under review by the AHEAD Multi-Agency Regulatory Working Group. Additionally, recent federal legislation (H.R.1) is likely to negatively affect ED utilization and uncompensated care, further straining hospital resources.

Given these considerations, MHA recommends that no payment adjustments be applied to these measures during the transition to the CMS IPPS/OPPS quality system from CY 2026 to 2029, and potentially 2030 if Medicare program alignment is delayed. This approach allows hospitals time to adapt systems, train staff, and reduce administrative complexity while minimizing reporting burden. It also aligns Maryland's QBR program with CMS' HVBP, supports Maryland-specific initiatives through dedicated monitoring, and ensures consistency across federal and state programs.

Digital Measure Incentive

The RY2028 QBR program recommendation proposes maintaining the existing digital measure incentive. MHA and its member hospitals support the continuation of the digital measure incentive in RY2028 and appreciate HSCRC's commitment to aligning electronic clinical quality measure (eCQM) reporting with CMS requirements. We recognize the value of early submission incentives as a tool to promote timely data collection and infrastructure readiness. The benefits of implementing eCQMs in Maryland at a pace that is misaligned with CMS should, however, be balanced with the process complexity and expense that is being created.

Using an accelerated timeline for Maryland-specific eCQM submissions imposes operational challenges for hospitals, requiring extensive coordination, staffing, and system capacity at a time when hospitals face competing priorities and resource constraints. While the incentive helps to mitigate the financial burden, the underlying policy and misaligned timing with CMS adds operational demands and administrative burdens.

MHA urges HSCRC to maintain close engagement with hospitals to ensure future digital reporting requirements remain feasible and aligned with national standards and timing. For RY2029 and beyond, HSCRC should follow the same schedule as CMS for implementation of digital measures. Additionally, any future expansion of digital reporting must be achievable through existing infrastructure and supported by technical assistance and realistic timelines to safeguard operational sustainability.

RY 2028 QBR Reward/Penalty "Cut-Point"

MHA appreciates HSCRC staff's plan to retrospectively adjust the RY 2026 QBR cut-point to 32.68% but suggests additional modifications to better reflect national average performance. The table below presents the retrospective adjustments to the cut-point for national performance over the past three rate years:

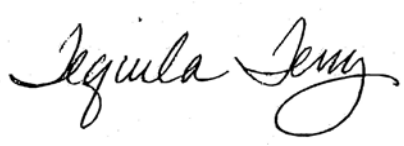
Rate Year	Pre-set Cut-point	Retrospective Adjustment (based on national performance)
RY24	41%	32%
RY25	41%	32%
RY26	41%	32.68%

Given this consistent national trend, MHA recommends using a cut-point of 32% in the RY2028 QBR program. This revised cut point would improve predictability, enhance fairness, and align with HVBP, thereby reducing the likelihood for annual retrospective adjustments within the QBR program.

We value the Commission's commitment to collaborative policymaking and data-driven decisions. As Maryland hospitals prepare for evolving national standards and the AHEAD transition, we look forward to continued partnership with HSCRC to ensure quality programs remain equitable, transparent, and aligned with our shared goal of improving patient care statewide.

Thank you for your consideration of these recommendations.

Sincerely,



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CORPORATE OFFICE

December 2nd, 2025

Alyson Schuster, PhD, MPH, MBA
Deputy Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Schuster:

On behalf of the University of Maryland Medical System (UMMS), thank you for the opportunity to comment on the proposed Rate Year 2028 Quality-Based Reimbursement (QBR) Program. We appreciate the Commission's ongoing collaboration with hospitals and its efforts to position Maryland for success under the forthcoming AHEAD Model.

UMMS supports the direction of the RY 2028 QBR program and offers the following areas of agreement and recommendations for refinement.

Areas of Support

Alignment with Federal Programs / AHEAD Model Readiness

UMMS strongly supports aligning QBR with federal Hospital Value Based Purchasing (HBVP) program. This reduces administrative burden, strengthens comparability across hospitals, and ensures readiness for alignment with AHEAD.

Prospective Payment Scale

We support maintaining the 32.68% cut. The predictability and transparency of this approach are essential for hospital planning. We also support 2% of inpatient revenue at-risk, contingent upon there are no additional at-risk revenue additions to other HSCRC programs for Rate Year 2028.

Alignment with Federal Hospital Value-Based Purchasing (HVBP) Program
UMMS supports alignment with HVBP, including:

- Maintaining the HCAHPS Top-Box and HCAHPS Consistency scores.
- Maintaining all five CDC NHSN hospital-acquired infection measures.
- Removing the all-payer PSI-90 metric from QBR and shifting it to the MHAC program.
- Removing HCAHPS linear scores.

Mortality Metrics
We support continuing the two current all-payer inpatient mortality metrics for RY 2028. We agree that refinements should be explored for future years.

Re-alignment of Weighting Across the Three Domains
UMMS supports revisiting domain weighting to ensure appropriate emphasis across clinical care, safety, and patient experience.

Requested Considerations

1. Future Transition Toward an Improved 30-Day Mortality Metric

UMMS encourages HSCRC to evaluate replacing current inpatient mortality metrics with a more stable and reliable 30-day mortality measure in future program years.
Recent 12-month data (ending September 2025) illustrate that current inpatient mortality metrics show wide variation:

- IQR of 1.6467% (96.9366% vs. 95.2899%)
- Standard deviation of 1.3809%
- A 1.819% difference between threshold and benchmark

By comparison, the 30-day mortality metric displays substantially less variation:

- IQR of 0.3652% (96.5468% vs. 96.1816%)
- Standard deviation of 0.2483%
- Only 0.488% difference between threshold and benchmark

The limited variation reduces the meaningfulness of differentiation between hospitals for rewards and penalties. We recommend reevaluating the risk-adjustment methodology and, if feasible, incorporating national data to strengthen the model. While no changes are advised for RY 2028 due to the January 2026 performance start, we believe this should be a priority for future program years.

2. Equal Weighting Across All Three Domains

UMMS recommends weighting the three QBR domains equally (one-third each), consistent with HVBP. This approach simplifies expectations and reinforces balanced performance across safety, clinical outcomes, and experience.

3. Continued Exclusion of THA/TKA Complication Metric

While the HVBP program includes the THA/TKA complication metric, we recommend continued exclusion of this metric. This metric is for Medicare inpatients age 65 years old and older. The vast majority of hip and knee replacements are now performed in a non-inpatient setting. Only the most complicated cases are still performed in an inpatient setting. Therefore, this metric is not reflective of overall outcomes in for these procedures.

From the most recently available CMS public data (April 2021 – March 2024) 9 out of the 40 QBR hospitals (22.5%) did not have sufficient volume to be included for measurement. An additional 14 hospitals (35%) performed less than 50 included procedures over the 3-year performance period. This results in a single complication over 3 years in a rate greater than 2%, while the threshold and benchmark for these measures are less than 2%.

We recommend the HSCRC develop an all-payer, inpatient and non-inpatient THA/TKA complication measure for subsequent performance years.

4. Continued Exclusion of SEP-1 Sepsis Bundle

As stated in previous comment letters, we recommend excluding the SEP-1 metric from the QBR program. SEP-1 remains a contentious metric in medical literature, with concerns raised about its potential to drive antibiotic overuse and its lack of evidence-based definitions. Please note the appendix for references, as previously submitted.

5. Separate Monitoring Structure for Non-Federally Aligned Measures

To maintain alignment of QBR, MHAC, and RRIP with analogous federal programs—and to support the AHEAD Model—we recommend moving state-specific or non-aligned measures into a separate monitoring structure.

This would apply to measures such as:

- Emergency Department Length of Stay (ED-1b)
- Medicaid Timely Follow-Up

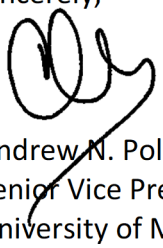
These remain important for Maryland, but tracking them outside of QBR would preserve program integrity and align with the federal program.

Conclusion

UMMS appreciates the HSCRC's thoughtful approach to strengthening the RY 2028 QBR Program and its commitment to a high-quality, nationally aligned quality framework for Maryland. We look forward to continued partnership as the state prepares for AHEAD implementation.

Thank you for considering our comments. We welcome continued dialogue as the program evolves.

Sincerely,



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cc: Joshua Sharfstein, MD, Chairman
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Appendix Citations for SEP-1

Clinical Infectious Diseases, Volume 72, Issue 4, 15 February 2021, Pages 541–552, https://doi.org/10.1093/cid/ciaa059

- *Infectious Diseases Society of America (IDSA and five additional endorsing societies) is concerned about SEP-1's potential to drive antibiotic overuse because it does not account for the high rate of sepsis overdiagnosis and encourages aggressive antibiotics for all patients with possible sepsis, regardless of the certainty of diagnosis or severity of illness*
- *IDSA is also concerned that SEP-1's complex "time zero" definition is not evidence-based and is prone to inter-observer variation*
- *Prompt empiric antibiotics are often appropriate for suspected sepsis without shock, but IDSA believes there is too much heterogeneity and difficulty defining this population, uncertainty about the presence of infection, and insufficient data on the necessity of immediate antibiotics to support a mandatory treatment standard for all patients in this category*
- *IDSA believes guidance on managing possible sepsis without shock is more appropriate for guidelines that can delineate the strengths and limitations of supporting evidence and allow clinicians discretion in applying specific recommendations to individual patients*

JAMA Netw Open. 2021;4(12):e2138596. doi:10.1001/jamanetworkopen.2021.38596

- *SEP-1 implementation was associated with an immediate increase in lactate testing rates, no change in already-increasing rates of broad-spectrum antibiotic use, and no change in the combined outcome of in-hospital death or discharge to hospice.*
- *These findings suggest SEP-1 was not associated with improved sepsis outcomes and that alternate approaches to preventing sepsis deaths in hospitals are needed*

maryland health services cost review commission

RY 2028 Readmissions Reduction Incentive Program Draft Policy

January 14, 2026

HSCRC Quality Team

Readmission Reduction Incentive Program (RRIP) Draft Policy

The Draft Policy mainly proposes continuation of RY 2027 policy and discusses options for future alignment with CMS and other AHEAD considerations.

- Maintain the current all-payer, 30-day, all-cause readmission measure.
- Maintain the 4-year improvement target that was established in CY 2022 of 5.0 percent through 2026, but with improvement measured from a two-year base period (CY 2022 and CY 2023) as approved in the RY 2027 policy.
- Maintain attainment methodology with modification to the adjustment for out-of-state readmissions.
- Maintain the scaled rewards and penalties of 2 percent of inpatient revenue for the better of improvement or attainment.
- Removal of the revenue adjustment incentive for the readmission disparity gap measure; development of monitoring policy to continue assessing readmission disparities by race, Medicaid status, and neighborhood deprivation.
- Provides comparison of RRIP to the CMS Hospital Readmission Reduction Incentive Program (HRRP) and highlights other AHEAD readmission requirements.

RY 2027 RRIP Methodology

30-day, All-Cause Readmission Measure

Measure Includes:
Readmissions within 30 days of Acute Case Discharge:

- All-Payer
- All-Cause
- All-Hospital (both intra- and inter- hospital)
- Chronic Beds included
- IP-Psych and Specialty Hospitals included
- Adult oncology Discharges Included

Global Exclusions:

- Planned Admissions
- Same-day and Next-day Transfers
- Rehab Hospitals
- Discharges leaving Against Medical Advice Deaths

Case-Mix Adjustment

Performance Measure: CY 2025 Case-Mix Adjusted Rate Adjusted for Out-of-State Readmissions (Attainment); Reduction in Case-Mix Adjusted Readmission Rate from Base Period (Improvement)

Case-Mix Adjustment:
Expected number of unplanned readmissions for each hospital are calculated using the discharge APR-DRG and Severity of Illness (SOI).

Observed Unplanned Readmissions/ Expected Unplanned Readmissions * Statewide Readmission Rate

CY 2022/23 used to calculated statewide averages (normative values), as well as attainment benchmark/threshold

Revenue Adjustments

Hospital RRIP revenue adjustments are based on the better of attainment or improvement, scaled between the max reward (+2%) and max penalty (-2%) of IP revenue.

All Payer Readmission Rate CY25		RRIP % Inpatient Revenue
Lower Readmission Rate		2.00%
Benchmark	8.83%	2.00%
	10.04%	1.00%
Threshold	11.25%	0.00%
	12.46%	-1.00%
	13.67%	-2.00%
Higher Readmission Rate		-2.00%

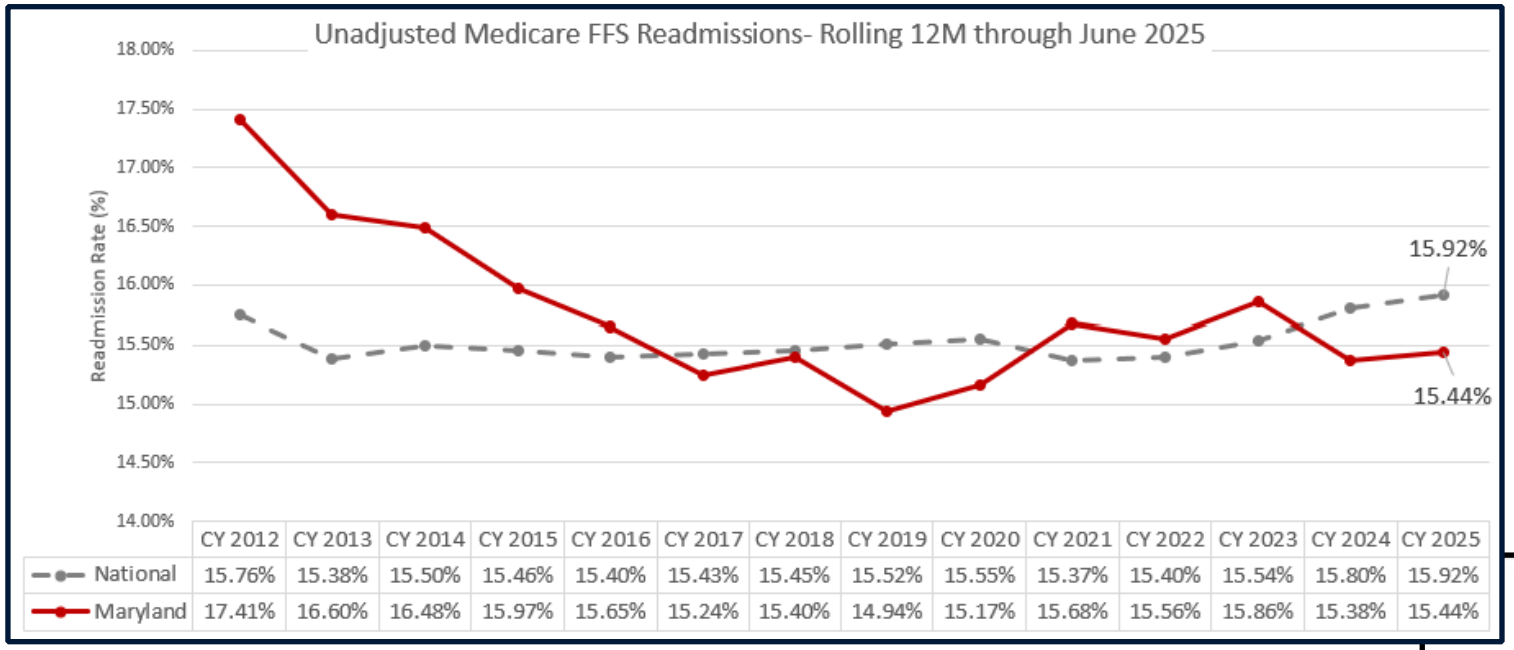
Attainment Scale

All Payer Readmission Rate Change CY22/23-25		RRIP % IP Revenue Payment Adjustment
Improving		2.00%
Benchmark	-21.04%	2.00%
	-12.41%	1.00%
Target	-3.78%	0.00%
	4.85%	-1.00%
	13.48%	-2.00%
Worsening		-2.00%

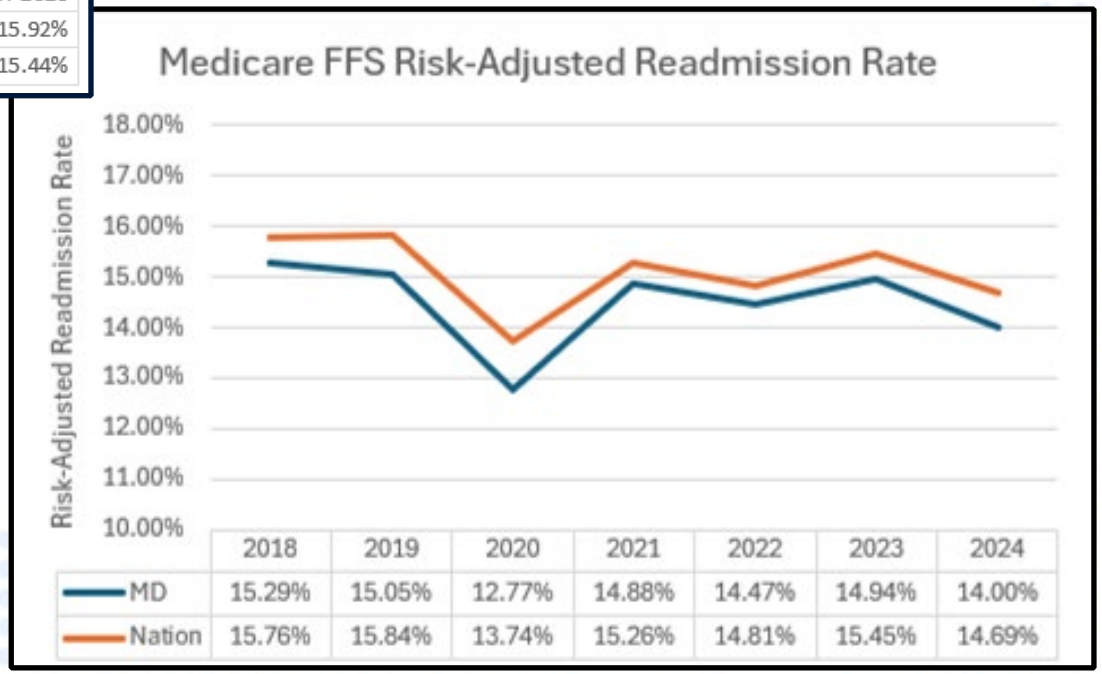
Improvement Scale

Note: Disparity gap incentive of +0.5% included in RY 2027 (not shown here)

State Performance on Medicare FFS Readmissions



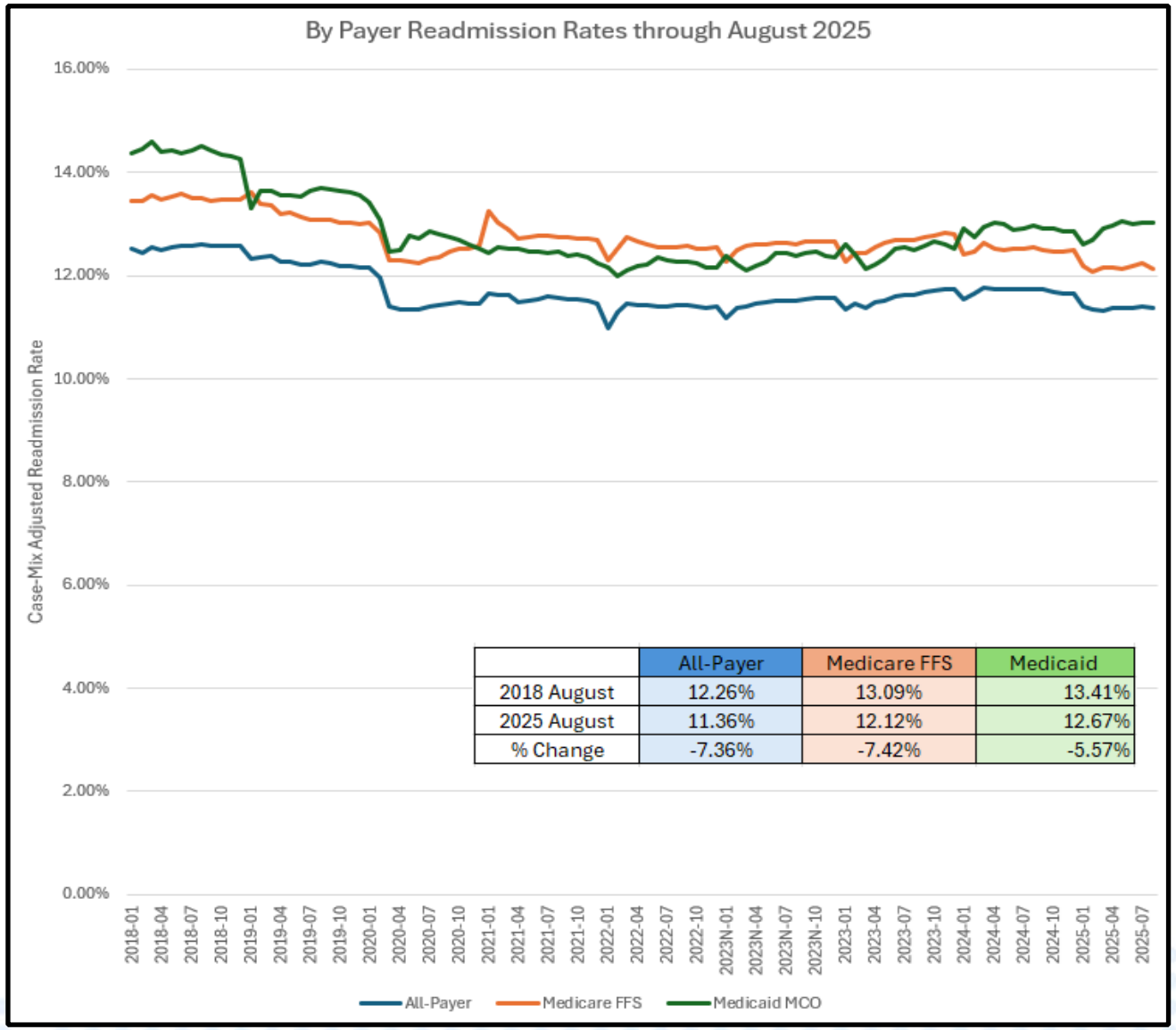
	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%	15.54%	15.80%	15.92%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%	15.86%	15.38%	15.44%



	2018	2019	2020	2021	2022	2023	2024
MD	15.29%	15.05%	12.77%	14.88%	14.47%	14.94%	14.00%
Nation	15.76%	15.84%	13.74%	15.26%	14.81%	15.45%	14.69%

State continues to meet Medicare FFS target of lower readmissions compared to nation.

All-Payer Case-Mix Adjusted Readmissions



	All-Payer	Medicare FFS	Medicaid
2018 August	12.26%	13.09%	13.41%
2025 August	11.36%	12.12%	12.67%
% Change	-7.36%	-7.42%	-5.57%

State continues to improve on All-Payer case-mix adjusted readmissions. Statewide change from CY22-23 through CY 2025 YTD is a 1.63 percent decrease.

AHEAD Alignment

AHEAD: Readmission Incentives and Goals

1. Under AHEAD, Medicare FFS hospital global budgets will be adjusted based on performance on **HRRP's condition-specific measures**
2. AHEAD Population Health Accountability Plan (PHAP) includes statewide, all-payer performance goal using **NCQA's Plan All-Cause readmission measure**
3. Other AHEAD Medicare FFS hospital global budget incentives using the hybrid and/or claims based **CMS' Hospital-Wide Readmission Measure** (i.e., Community Improvement Bonus and Effectiveness Adjustment)

Comparison of RRIP and HRRP

Feature	Maryland RRIP	National HRRP
Population	All patients, all payers	Medicare Fee-for-Service beneficiaries only
Conditions Measured	All-conditions, including psychiatric and adult oncology	Six specific conditions (i.e., AMI, COPD, HF, Pneumonia, CABG, THA/TKA)
Readmission Definition	30-day, all-cause, unplanned admissions	30-day, all-cause, unplanned admissions
Performance Measures	Both improvement (relative change) and attainment (absolute performance, adjusted for out-of-state readmissions)	Attainment only, stratified by percent duals
Incentives	Scaled **rewards and penalties,** capped at ±2% of inpatient revenue	**Scaled penalties only**, capped at 3% of Medicare payments
Data Source	State-based case-mix data (with unique patient identifiers across hospitals)	CMS Medicare claims data

Future RRIP AHEAD Alignment

- Staff recommend to finish out the goals set under the TCOC model (through CY 2026) while concurrently engaging stakeholders to assess opportunities to align RRIP with the AHEAD model's readmission evaluation for CY 2028 and beyond for non-Medicare hospital global budgets.
- This will require decisions around:
  - Which measure to align with
  - Improvement and attainment goals
  - Social risk-adjustment
  - Revenue-at-risk

Question for Commissioners and Stakeholders:
Should the future RRIP policy align with HRRP or the AHEAD PHAP all-payer readmission goal?

Out of State Ratio Concerns

Out of State (OOS) Ratio

- RRIP assesses attainment (i.e., how hospital performs on readmissions relative to peers) by adjusting the all-payer readmission rate to account for OOS readmissions (using Medicare data as a proxy).
- Staff investigation uncovered readmission cases that are being double counted with the use of the current OOS readmission ratio
  - i.e., readmissions being considered an in-state readmission ***and*** an out-of state readmission
- Staff recommend modifying the OOS ratio calculation to remove the double counted readmissions and only count them as in-state readmissions
  - Using RY 2026 time periods for modeling, this modification would've resulted in an ~$4.4M increase in statewide net adjustments with 12 hospitals receiving an increase in rewards and 3 hospitals receiving either a reduction in rewards or increase in penalties

RY 2028 Draft RRIP Recommendations

1. Maintain the all-payer, 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 with a blended base period of CY 2022 and CY 2023.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
    a. Modify Out Of State (OOS) ratios used for attainment to not double count readmissions for RY 2028 and retrospectively for RY 2027.
4. Maintain scaled rewards and penalties of up to 2 percent of inpatient revenue.
5. Monitor reductions in within-hospital readmission disparities and provide quarterly updates on by-hospital performance at Commission Meetings.
6. Assess opportunities for AHEAD alignment of readmission measure, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

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Draft Recommendation for the Readmission Reduction Incentive Program for Rate Year 2028

January 14, 2026

This document contains staff draft recommendations for the RY 2028 Readmission Reduction Incentive Program. The document also includes staff draft recommendations on modifications to the RY 2027 Readmission Reduction Incentive Program. Comments are due by Monday, January 26, 2026 and may be submitted to hscrc.quality@maryland.gov.

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List of Abbreviations

ADI	Area Deprivation Index
AHEAD	Achieving Healthcare Efficiency through Accountable Design Model
AMA	Against Medical Advice
APR-DRG	All-patient refined diagnosis-related group
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
CRISP	Chesapeake Regional Information System for Our Patients
CY	Calendar year
eCQM	Electronic Clinical Quality Measure
EDAC	Excess Days in Acute Care
FFS	Fee-For-Service
FFY	Federal Fiscal Year
HCC	Hierarchical Condition Category
HRRP	Hospital Readmissions Reduction Program
HSCRC	Health Services Cost Review Commission
HWR	Hospital-Wide Readmission Measure
MCDB	Medical Claims Database
MPR	Mathematica Policy Research
MSA	Metropolitan Statistical Area
NQF	National Quality Forum
PAI	Patient Adversity Index
PMWG	Performance Measurement Workgroup
PQI	Prevention Quality Indicators
PY	Performance Year
RRIP	Readmissions Reduction Incentive Program
RY	Rate Year
SIHIS	Statewide Integrated Healthcare Improvement Strategy
SOI	Severity of illness
TCOC	Total Cost of Care
YTD	Year-to-date

Key Methodology Concepts and Definitions

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

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

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

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

Observed/Expected Ratio: Readmission rates are calculated by dividing the observed number of readmissions by the expected number of readmissions. Expected readmissions are determined through case-mix adjustment.

Case-Mix Adjustment: Statewide rate for readmissions (i.e., normative value or "norm") is calculated for each diagnosis and severity level. These statewide norms are applied to each hospital's case-mix to determine the expected number of readmissions, a process known as indirect standardization.

Prevention Quality Indicator (PQI): a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Area Deprivation Index (ADI): A measure of neighborhood deprivation that is based on the American Community Survey and includes factors for the theoretical domains of income, education, employment, and housing quality.

Patient Adversity Index (PAI): HSCRC-developed composite measure of social risk incorporating information on patient race, Medicaid status, and the Area Deprivation Index.

Excess Days in Acute Care (EDAC): Capture excess days that a hospital's patients spent in acute care within 30 days after discharge. The measures incorporate the full range of post-discharge use of care (emergency department visits, observation stays, and unplanned readmissions).

Recommendations

These are the draft recommendations for the Maryland Rate Year (RY) 2028 Readmission Reduction Incentives Program (RRIP):

1. Maintain the all-payer, 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 with a blended base period of CY 2022 and CY 2023.
3. Attainment Target - Maintain the attainment target whereby hospitals performing at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
    a. Modify Out Of State (OOS) ratios used for attainment to not double count readmissions for RY 2028 and retrospectively for RY 2027.
4. Maintain scaled rewards and penalties of up to 2 percent of inpatient revenue.
5. Monitor reductions in within-hospital readmission disparities and provide quarterly updates on by-hospital performance at Commission Meetings.
6. Assess opportunities for AHEAD alignment of readmission measure, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

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 and Medicaid Services (CMS) for the state to operate the All-Payer Model (Calendar (CY) 2014- CY 2018), the current Total Cost of Care (TCOC) Model (CY 2019-CY 2025), and the upcoming AHEAD model (CY 2026- CY 2035). Under the new AHEAD Model, the State will transition in CY 2028 (Performance Year (PY) 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 health agencies, and the broad array of stakeholders on the Performance Measurement Workgroup (PMWG) to develop a transition plan that increases alignment between the state's performance based 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 the Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reductions in unplanned readmissions, 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. Under global budgets, it is important 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 Readmissions Reduction Incentive Program (RRIP) is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve patient care and value over time that targets all-payer unplanned readmissions. While some hospital readmissions are unavoidable, other hospital readmissions within 30 days result from ineffective initial treatment, poor discharge planning, or inadequate post-acute care and result in poor patient outcomes and financially strained healthcare institutions.[1] The RRIP currently holds up to two percent of hospital inpatient revenue at-risk in penalties and rewards based on achievement of improvement or attainment targets in 30-day case-mix adjusted readmission rates.

[1] Rammohan R, Joy M, Magam S, et al. (May 15, 2023) The Path to Sustainable Healthcare: Implementing Care Transition Teams to Mitigate Hospital Readmissions and Improve Patient Outcomes. Cureus 15(5): e39022. doi:10.7759/cureus.39022

For RRIP, as well as the other State hospital quality programs, updates are vetted with stakeholders and approved by the Commission to ensure the programs remain aggressive and progressive with results that meet or surpass those of the national CMS analogous programs (from which Maryland must receive annual exemptions). For purposes of the RY 2028 RRIP Draft Policy, staff vetted the updated proposed recommendations with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Transitioning to the AHEAD Model

The AHEAD model, which will begin in January 2026, includes a two year transition period where the state will maintain its all-payer rate setting system. The new CMS Medicare FFS hospital global budgets will begin in CY 2028 and at that time, the hospitals will transition to the CMS quality programs for Medicare FFS and the state will administer hospital global budgets and quality programs for all other payers. For RY 2028, which will assess CY 2026 performance, staff is working to assess all of the quality programs to determine opportunities for better alignment with the CMS programs. The initial focus of the state's transition work has been aligning the Quality Based Reimbursement (QBR) program with the Hospital Value-Based Purchasing (HVBP) program. During CY 2026, staff proposes to engage stakeholders to assess opportunities for further alignment with the AHEAD Model.

Under the AHEAD Model, hospital global budgets will be adjusted for readmissions through multiple mechanisms. First, beginning in calendar year (CY) 2028, the AHEAD Hospital Global Budget (HGB) for Medicare FFS will incorporate adjustments based on a hospital's performance under the Hospital Readmission Reduction Program (HRRP). Second, as part of the AHEAD Model, the State submitted a Population Health and Accountability Plan (PHAP) that includes the CMMI-recommended National Committee for Quality Assurance (NCQA) Plan All-Cause Readmissions (PCR) measure, which will be used to assess statewide readmissions performance over the nine-year model period. In addition, the Medicare HGB methodology includes a Community Improvement Bonus (CIB) and an Effectiveness Adjustment (EA). The CIB will assess performance on two measures: the digital Hybrid Hospital Wide Readmission (Hybrid eHWR) measure and Prevention Quality Indicators (PQI-90). The EA applies a downward adjustment based on a hospital's Medicare fee-for-service (FFS) performance relative to other

hospitals statewide on the CMS Hospital-Wide All-Cause Unplanned Readmission (HWR) measure and Avoidable Admissions which are defined by AHRQ's PQI-90 measure. Last, Maryland may continue to adjust non-Medicare HGB based on readmission performance.

For the RY 2028 RRIP policy, staff proposes to maintain the 4-year improvement target of -5.0 percent through CY 2026 to finish out the goal set under the TCOC model while concurrently engaging stakeholders to assess opportunities to align the RRIP with the AHEAD model's readmission evaluation. Specifically, alignment entails consideration of measures, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology.

Background

Brief History of RRIP Program

Maryland made incremental progress each year throughout the All-Payer Model (2014-2018), ultimately achieving the Model goal for the Maryland Medicare FFS readmission rate to be at or below the unadjusted national Medicare readmission rate by the end of Calendar Year (CY) 2018. Maryland historically performed poorly compared to the nation on readmissions; it ranked 50th among all states in a study examining Medicare data from 2003-2004.[2] In order to meet the All-Payer Model Medicare requirements, the Commission approved the inaugural RRIP program in April 2014 to further bolster the incentives to reduce unnecessary readmissions beyond the incentives already inherent in the global budget system. In addition to the Medicare FFS targets for the State, CMMI historically required the RRIP to address all-payer readmissions. As recommended by the Performance Measurement Work Group (PMWG), the RRIP is more comprehensive than its federal counterpart, the Medicare Hospital Readmission Reduction Program (HRRP), as it uses an all-cause, all-condition measure and assesses both improvement and attainment, whereas, HRRP uses Medicare-only condition specific readmission measures to assess attainment.[3] Figure 1 below compares the RRIP to the HRRP.

[2] Jencks, S. F. et al., "Hospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* Vol. 360, No. 14: 1418-1428, 2009.
[3] For more information on the HRRP, please see: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program

Figure 1. RRIP Compared to HRRP

Feature	Maryland RRIP	National HRRP
Population	All patients, all payers	Medicare Fee-for-Service beneficiaries only
Conditions Measured	All-conditions, including psychiatric and adult oncology	Six specific conditions (i.e., AMI, COPD, HF, Pneumonia, CABG, THA/TKA)
Readmission Definition	30-day, all-cause, unplanned admissions	30-day, all-cause, unplanned admissions
Performance Measures	Both improvement (relative change) and attainment (absolute performance, adjusted for out-of-state readmissions)	Attainment only, stratified by percent duals
Incentives	Scaled **rewards and penalties,** capped at ±2% of inpatient revenue	**Scaled penalties only**, capped at 3% of Medicare payments
Data Source	State-based case-mix data (with unique patient identifiers across hospitals)	CMS Medicare claims data

With the onset of the Total Cost of Care Model (TCOC) Agreement, each program was overhauled to ensure the policy supported the goals of the Model. For the RRIP policy, the overhaul was completed during 2019, which entailed an extensive stakeholder engagement effort. The major accomplishments of the RRIP redesign were modifications to the inclusion and exclusion criteria for the readmission measure, development of a 5-year (2018-2023) improvement target of -7.5 percent, adjustment of the attainment target based on national Medicare and commercial benchmarks, and the addition of an incentive to reduce within hospital disparities in readmissions. Subsequently, during CY2023, staff reassessed Maryland's performance on readmissions and developed a four-year (2022-2026) improvement target of 5 percent that was approved in the RY2026 policy. This improvement target was set using a range of potential improvement scenarios (e.g., historical improvements trended forward) and updated benchmarking for Medicare and Commercial payers nationally.

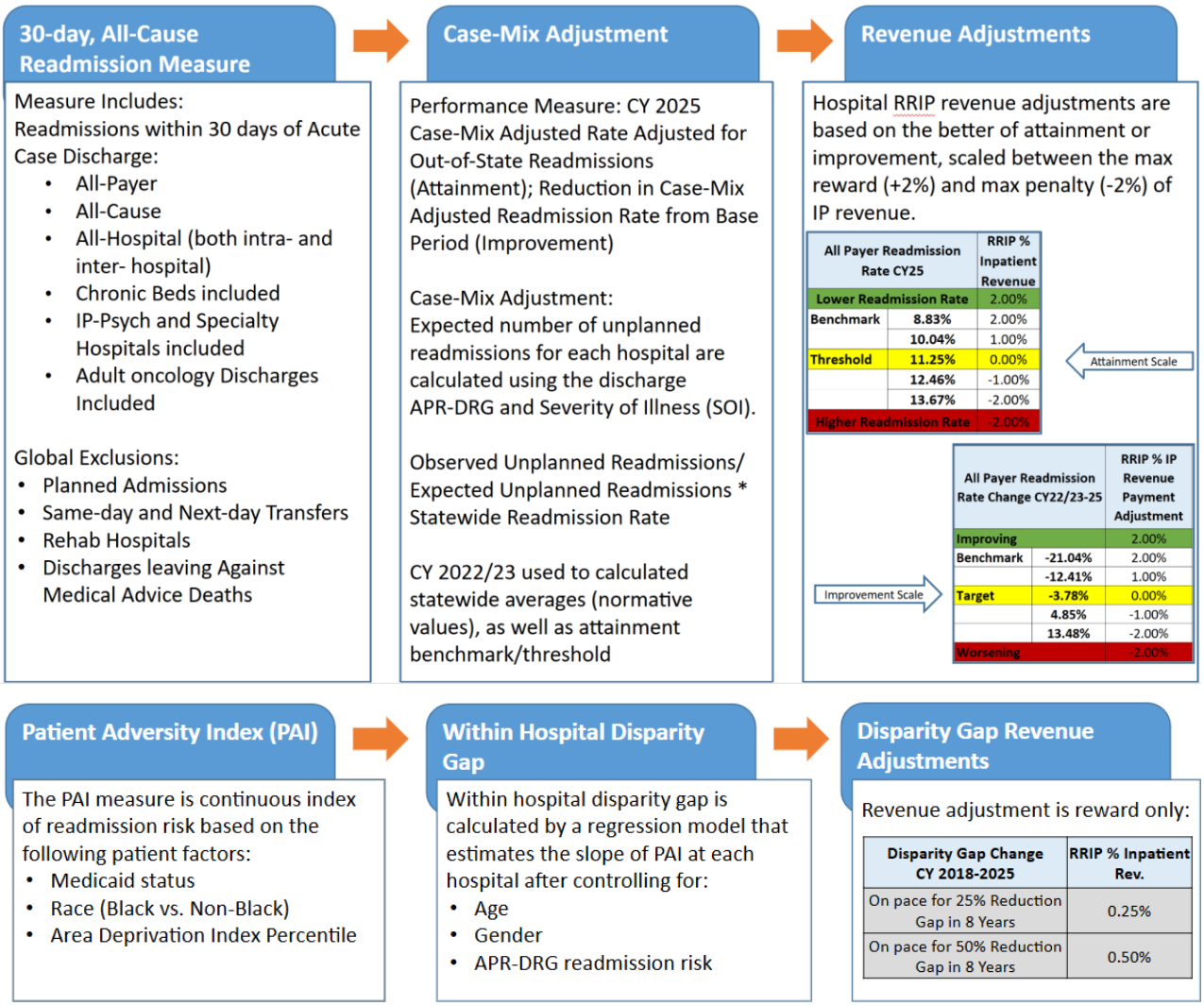
RRIP Methodology

Figure 2 provides an overview of the current RRIP methodology (also see Appendix I) that converts hospital performance to payment adjustments. In Maryland, the RRIP methodology

evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges (e.g., pediatric oncology, patients who leave against medical advice, rare diagnosis groups) from consideration, due to data issues and clinical concerns. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR-DRG) severity of illness (SOI), and the policy determines a hospital's score and revenue adjustment by the better of improvement or attainment.[4] The disparity gap methodology is separate and provides hospitals with the opportunity to earn rewards (no penalties) based on improvement.

[4] See Appendix I for details on the current RRIP methodology.

Figure 2. RRIP Methodology RY2027



Assessment

For RY 2028, there are no proposed changes to the readmission measure, however, staff is recommending that additional analytics continue to be conducted over the coming year to assess impact of observation stays, which staff believe will complement some of the other workstreams the Commission currently is engaging in to improve emergency department length of stay and align with the AHEAD Model's Population Health Accountability Plan (PHAP) readmission

measure. Also, staff is recommending a modification to the calculation of Out-Of-State Ratios used to adjust the readmission measure for attainment.

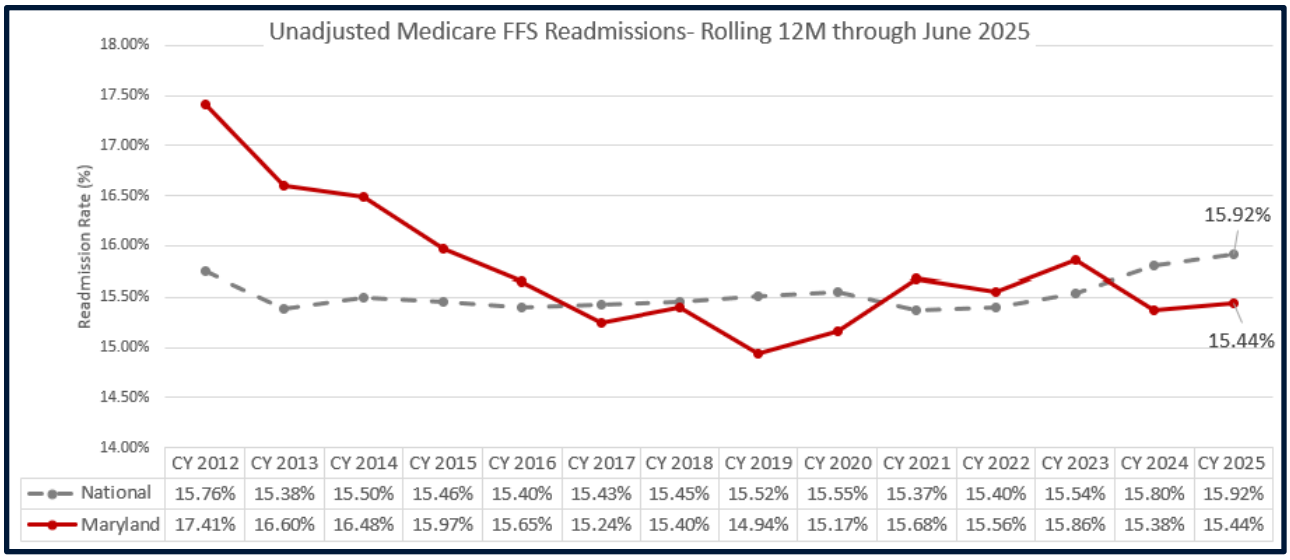
Current Statewide Year To Date Performance

Readmission performance is assessed in several ways using different measure specifications. First, we present data on the unadjusted, all-cause Medicare readmission rate (the original "Waiver Test"), which shows that Maryland currently has a slightly lower unadjusted readmission rate than the nation. Second, we present Maryland and national performance on the CMMI-adapted Hospital-Wide Readmission (HWR) measure for Maryland (the revised "Waiver Test"). Third, we present the all-payer, case-mix–adjusted readmission results used for the Readmissions Reduction Incentive Program (RRIP). Fourth, we present the condition-specific readmission results used for the Hospital Readmission Reduction Program (HRRP). Finally, we present performance on the NCQA Plan All-Cause Readmissions (PCR) measure, which will be used to assess statewide performance under the AHEAD Model. Also, please refer to the RY 2028 Quality Based Reimbursement policy for discussion of the state's collection of digital quality measures in alignment with the CMS. Specifically, the state is requiring submission of the Core Clinical Data Elements (CCDE) used for the digital Hybrid HWR measure and could consider augmenting the RRIP all-payer measure with EHR data elements in the future. Below we present the currently available data using the measures from CMMI, CMS, and HSCRC.

Medicare FFS Performance

At the end of 2018, Maryland had an unadjusted Medicare FFS readmission rate of 15.40 percent, which was below the national rate of 15.45 percent. This was the measure that CMMI used to assess Maryland's successful performance on readmissions under the All-Payer Model. Under the TCOC model, Maryland is required to maintain a Medicare FFS readmission rate that is below the nation. While the unadjusted Maryland Medicare rate was higher than the nation starting in 2021, the CY2025 rolling 12 months readmission data, which is presented in Figure 3, shows Maryland's readmission rate at 15.44 percent, which is lower than the Nation's performance at 15.92 percent.

Figure 3. Maryland and National Medicare FFS Unadjusted Readmission Rates

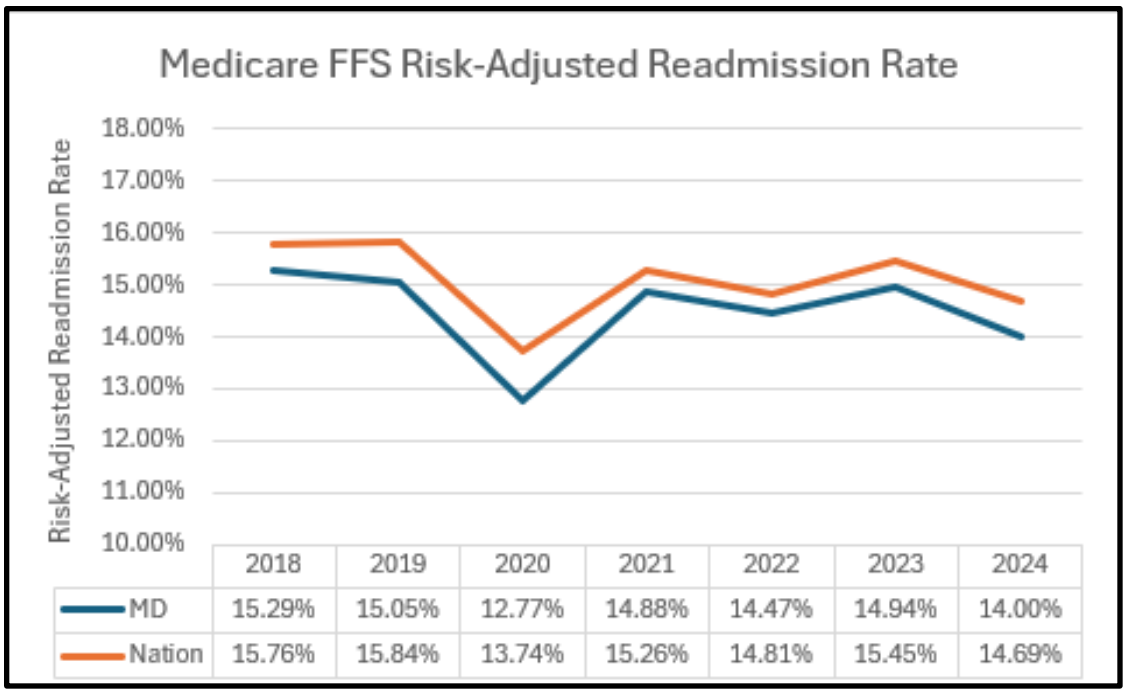


	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%	15.54%	15.80%	15.92%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%	15.86%	15.38%	15.44%

Hospital Wide Readmission Measure Performance

Because of concerns about changes in patient acuity, CMMI agreed to switch to a risk-adjusted readmission measure to compare Medicare FFS performance in Maryland compared to the Nation. Beginning with CY 2023 performance, CMMI calculated a risk-adjusted hospital wide readmission (HWR) measure modified to include Medicare FFS beneficiaries under the age of 65 and a few other adjustments. Figure 4 provides the Maryland and National results on readmissions for CY 2018 and CY 2024 from CMMI using this modified HWR measure. Based on this data, the State has met its contractual goal of performing better in CY 2024 than in CY 2018 and performing better than the nation in CY 2024. Since 2018, Maryland has reduced Medicare readmissions by 8.44 percent, while the nation has reduced readmissions by 6.79 percent. While the contractual test does not require Maryland to be statistically better than the nation, the analysis by CMMI found that Maryland was statistically better than the nation in CY 2024.

Figure 4. Maryland and National Medicare FFS Hospital-Wide Readmission Measure Performance

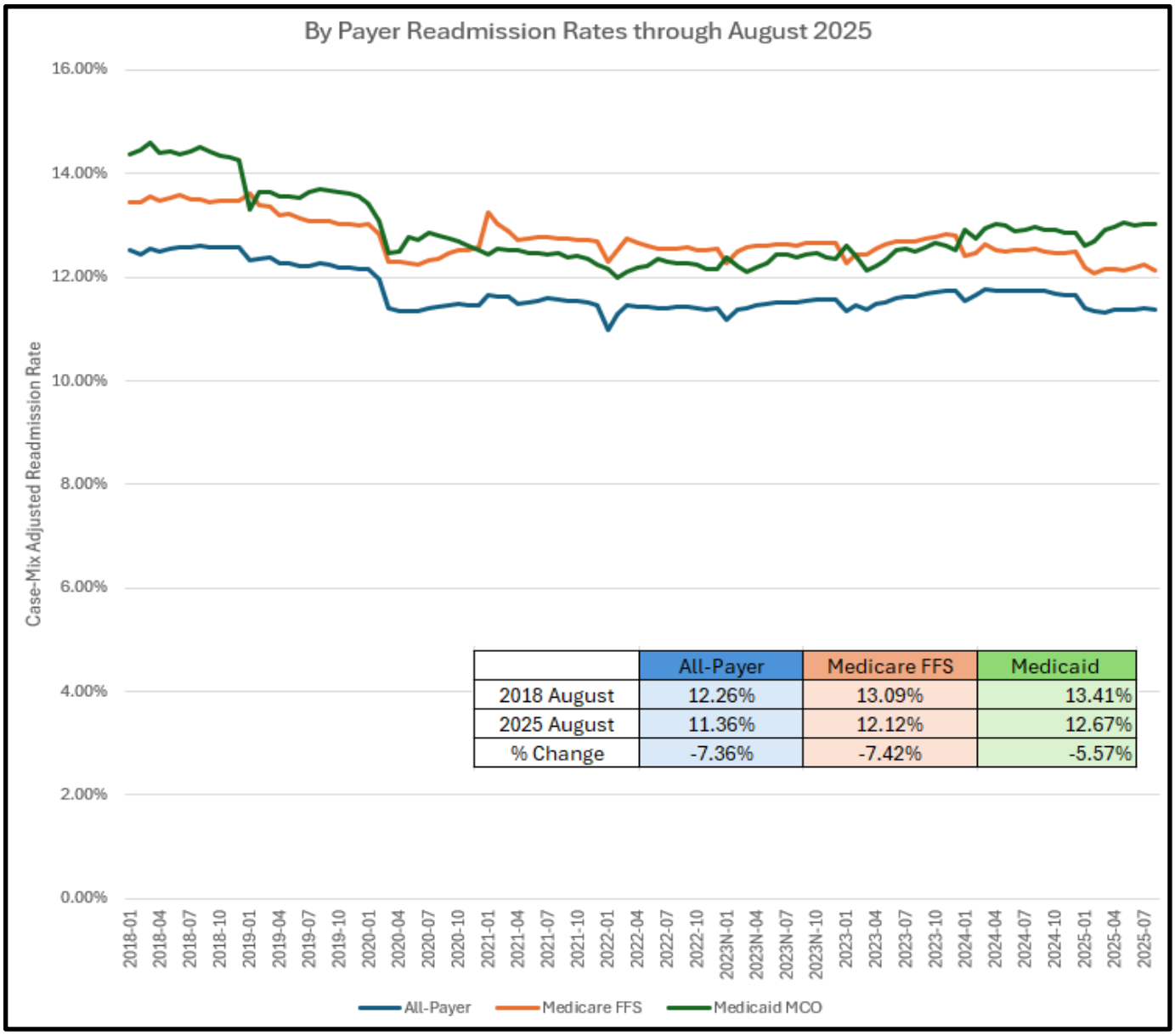


https://hscrc.maryland.gov/pages/default.aspx

All-Payer Readmission Performance

Maryland has also performed well statewide over time on RRIP performance standards as shown in Figure 5. Through August of 2025 compared to August of 2018, All-Payers, Medicare FFS, and Medicaid beneficiaries saw a reduction in readmissions of 7.36 percent, 7.42 percent, and 5.57 percent, respectively.

Figure 5. Statewide Change in Case-Mix Adjusted Readmission Rates by Payer, 2018 through August 2025



	All-Payer	Medicare FFS	Medicaid
2018 August	12.26%	13.09%	13.41%
2025 August	11.36%	12.12%	12.67%
% Change	-7.36%	-7.42%	-5.57%

The RY 2027 RRIP program assesses improvement from a two-year base period of CYs 2022 and 2023 to CY 2025, and attainment performance in CY 2025 based on historical standards. Statewide there has been a 1.56 percent improvement in 2025 YTD compared to the

CY2022/2023 base period. As illustrated in Figure 6 below, 22 hospitals are on target to reach the improvement goal of a 3.78 percent reduction, and as shown in Figure 7, 12 hospitals are on target to have a readmission rate below the attainment threshold of 11.25 percent. Hospitals performing well on either improvement or attainment will receive a revenue adjustment equal to the better of these evaluations, in line with the policy aim of simultaneously incentivizing excellent performance and constant improvement. Overall there are 24 unique hospitals on track to receive a scaled reward for CY 2025 performance.

Figure 6. By-Hospital Change in All-Payer Case Mix Adjusted Readmission Rates, 2022/2023- 2025 YTD Through August

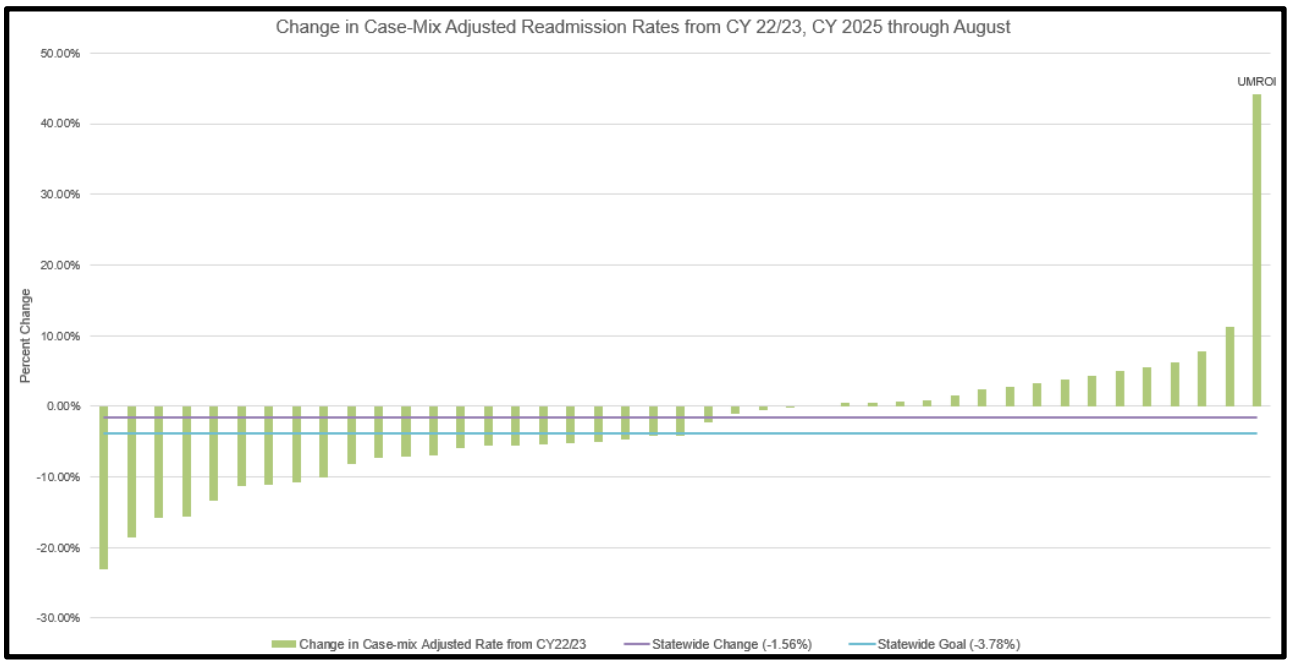
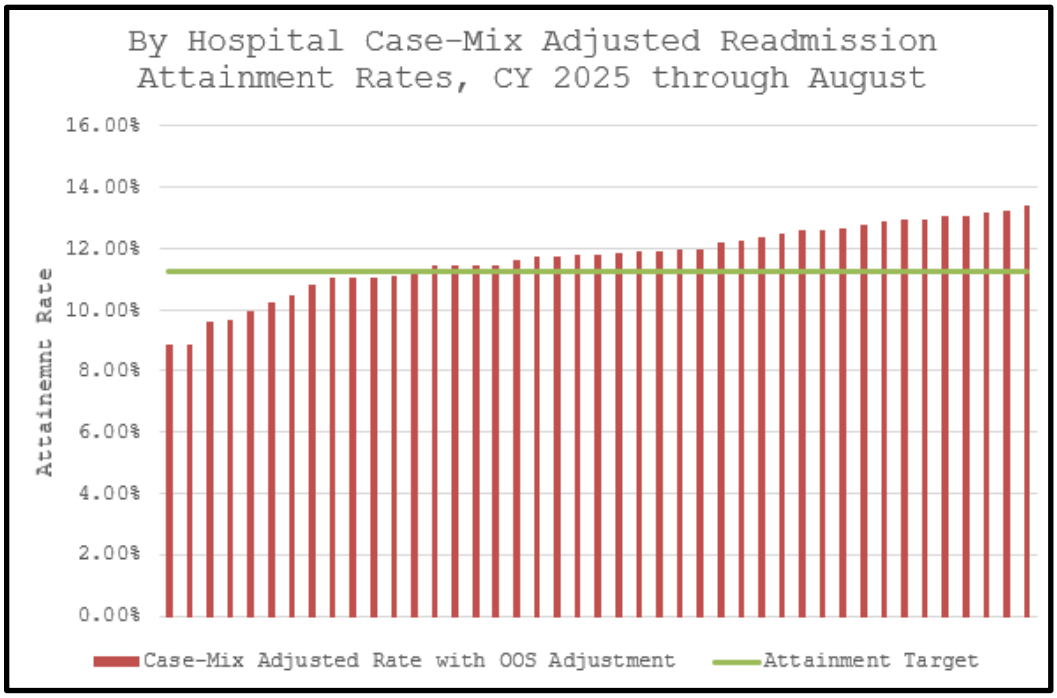


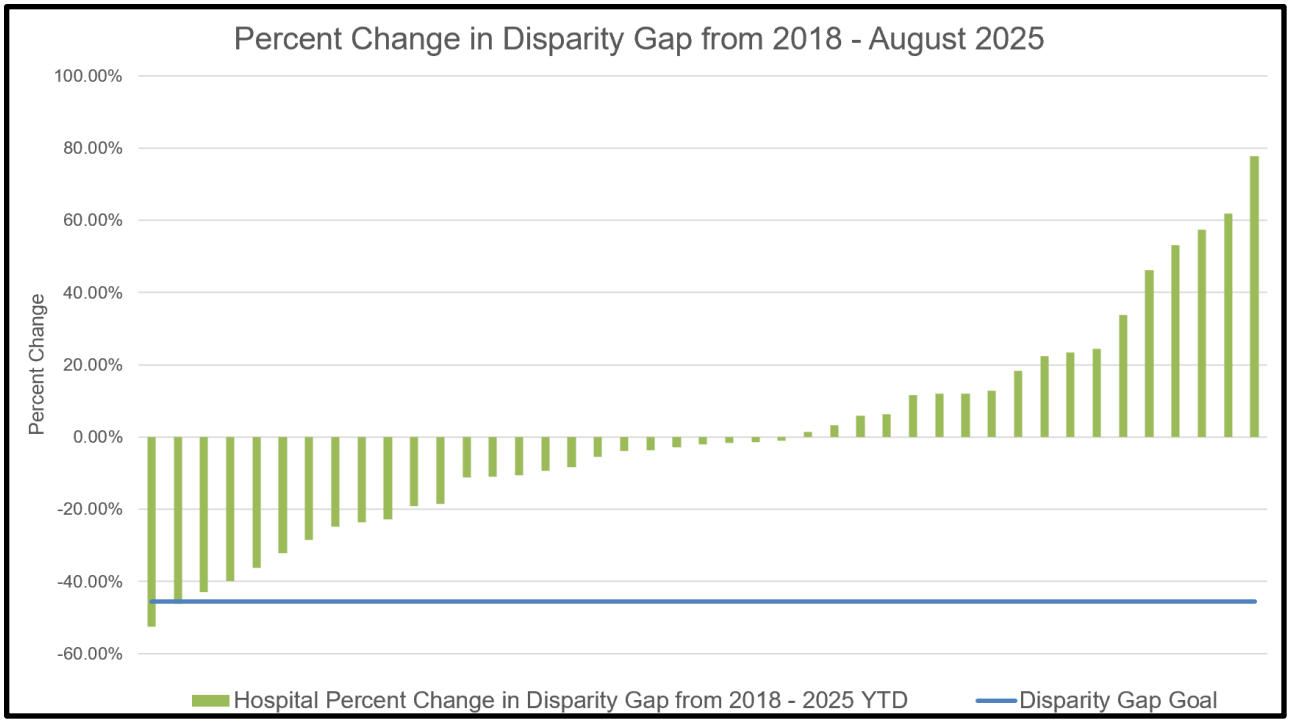
Figure 7. By-Hospital Case Mix Adjusted Readmission Rates, YTD 2025



Disparities in Readmissions

Beginning in RY 2021, Maryland hospitals could be rewarded for reducing disparities in readmissions using HSCRC developed methodology. The reduction in readmission disparities was included as a Statewide Integrated Health Improvement Strategy (SIHIS) goal under the TCOC model. Specifically, the goal was to have at least half of Maryland hospitals achieve at least a 50 percent reduction from CY 2018 to CY 2026. For RY 2027, through August of 2025, 25 hospitals have reduced readmission disparities by an average of -18.40 percent, with a range of reductions from -1.01 percent to -52.50 percent. Via the disparity gap component of the RRIP, two hospitals are on track for receiving rewards for reducing their disparities in readmissions by at least -45.47 percent in CY 2025 compared to CY 2018, as seen below in Figure 8. For RY 2028, to better align with the National readmissions program, the RRIP draft recommendation is to monitor reductions in readmissions disparities in readmissions by reporting performance quarterly at Commission meetings. For details on the measure used to assess disparities in readmissions, see Appendix III.

Figure 8. By-Hospital Changes in Readmission Disparities, CY 2025 through August compared to CY 2018



Hospital Readmission Reduction Program Performance

The CMS Hospital Readmission Reduction Program (HRRP) assesses readmissions for Medicare using six condition specific, all-cause readmissions measures and comparing performance of hospitals within peer groups based on proportion of dually eligible Medicare beneficiaries. For FFY 2025, CMMI provided proxy payment adjustment factors to estimate how Maryland hospitals would have performed under the HRRP program. The Maryland data from CMMI was compared with national HRRP data found on Care Compare (Figure 9). The Maryland data indicates that 84 percent of hospitals in the state would receive a penalty, with the median penalty among those that would have been penalized of 0.20 percent (minimum penalty 0.01 percent and maximum penalty 1.07 percent). While the national data indicates that a lower percentage of hospitals would receive a penalty (79 percent), the median penalty among those that were penalized is higher at 0.27 percent (minimum penalty 0.01 percent and maximum penalty 3 percent). Furthermore, the average penalty for Maryland hospitals was lower than the nation for each of the

five dual eligible peer groups. Thus despite the higher proportion of hospitals in Maryland that would be penalized for excess readmissions, on average Maryland hospitals have lower excess readmissions as shown by the lower penalties that Maryland hospitals would receive. Given these condition specific measures use multiple years of data through the June of 2023, these results are not surprising since the unadjusted Medicare test also showed favorable results over the same time period.

Figure 9. FFY 2025 HRRP Performance, Maryland vs Nation

FY 2025 (July 1, 2020 - June 30, 2023)		Maryland	Nation
Percent of Hospitals with Penalty		83.72%	78.59%
Median Penalty*		0.20%	0.27%
Average Penalty*		0.30%	0.41%
Average Penalty by Dual Peer Group			
Low Proportion	1	0.23%	0.32%
	2	0.26%	0.35%
	3	0.28%	0.32%
	4	0.16%	0.31%
High Proportion	5	0.05%	0.31%
*Calculated among those penalized only.			

National Committee for Quality Assurance Plan All-Cause Readmission Measure

As mentioned above in the "Transitioning to AHEAD" section, the Population Health Accountability Plan (PHAP) will assess statewide readmission performance using the National Committee for Quality Assurance Plan All-Cause Readmission (NCQA PCR) measure based on CMMIs directive. Furthermore, CMMI also required that the Statewide goal be all-payer rather than Medicare specific. The NCQA readmission measure was originally designed as a health plan measure (i.e., HEDIS). Figure 10 provides a comparison of the RRIP and NCQA readmission measure, both of which look at all-cause unplanned readmissions for all eligible patients (i.e., not condition specific). The biggest differences between the measures is that the NCQA readmission measure includes both inpatient and observation visits as both index and readmissions, and the by-payer risk adjustment method used for the NCQA measure. HSCRC worked with contractors

to adapt this health plan measure to calculate a Maryland statewide observed to expected ratio using claims data for Medicare FFS, Medicare MA, Medicaid, and Commercial.

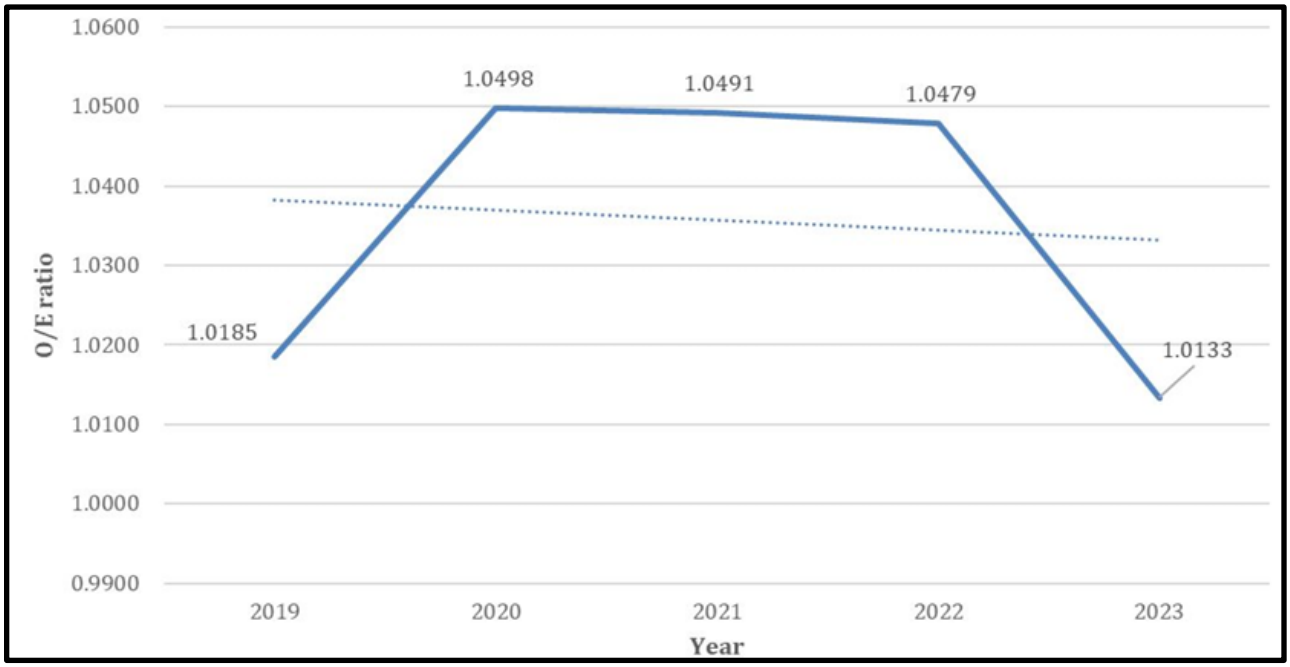
Figure 10. Comparison of the NCQA PCR and RRIP Readmission Measures

Feature	Maryland RRIP	NCQA PCR
Readmission Type	All-cause, unplanned inpatient readmissions	All-cause, unplanned inpatient **and observation** readmissions
Numerator	Number of observed unplanned readmissions	The observed numerator is all unplanned eligible observation stays and readmissions within 30 days of an eligible discharge. The expected numerator is weighted based on measure specifications
Denominator	Number of expected unplanned readmissions based on discharge APR-DRG and SOI	Any acute inpatient or observation stay discharge occurring during the measurement year; patients must be 18 or older during the month of discharge date and have 365 days on continuous enrollment before index admission and 30 days after index.
Exclusions	CMS Planned Readmission Logic, Bone marrow transplants and liquid tumor patients, Left AMA, transfers, newborn DRGs	Hospice and/or death at any time during the measurement year; perinatal admissions, potentially planned procedures, organ transplant, chemotherapy, and psychiatric/rehab facilities and transfer/IP admission. Patients with 4+ inpatient admissions in a year.
Risk-Adjustment	Case-mix and APR DRG SOI level	Risk-adjusted by IP vs. observation status, discharge condition, age, gender, surgical procedure, and SNF and dual eligibility status based on predetermined weights by payer

Figure 11 below presents Maryland's all-payer observed to expected ratio, which shows that from 2019 to 2023, Maryland saw a 0.51 percent decrease in readmissions. However, given the increase in readmissions during COVID, this trend should be interpreted with caution. Thus, staff also utilized NCQA and other readmission benchmarks calculated by the HSCRC to propose targets for improvement to the [insert MCHE reference and that they were body to review]. Based on staff analyses, historical improvements in readmissions (i.e., gains the state has already made since 2013), and stakeholder input, a readmission goal of a 3.07 percent reduction in the O/E ratio between 2023 and 2034 was submitted to CMMI in the PHAP proposal. This is currently under

review by CMMI. Staff believes that the Commission should consider whether the non-Medicare global budget adjustments for readmissions should align with the final PHAP goal or the HRRP program. Staff is currently working with contractors to adapt the NCQA readmission measure to the case-mix dataset to see if it can be used for RRIP in the future.

Figure 11. Maryland Performance on NCQA PCR measure, CY 2019- CY 2023



Out of State Ratio Concerns

The RRIP policy assesses attainment by adjusting the all-payer readmission rate to account for out-of-state (OOS) readmissions which is defined as “Total number of Medicare FFS Readmissions/ Number of in-state readmissions”. The RRIP methodology uses Medicare FFS OOS ratios calculated via the Chronic Conditions Warehouse (CCW) dataset, which are used as a proxy for all-payer OOS readmission patterns. Without an OOS readmission adjustment, hospitals across the State could not be compared fairly as some hospitals may have higher OOS readmissions (e.g., border hospitals, systems with OOS hospitals). Hospitals have raised concerns about the accuracy and use of the OOS readmission ratio within the RRIP.

Staff investigated the issues brought by hospitals regarding the accuracy and use of the OOS readmission ratio and uncovered that there are readmission cases that are being captured as a readmission in both the in-state case-mix dataset as well as in the CCW's OOS ratio (i.e., are being double counted).

To improve the OOS ratio, staff recommends modifying the OOS ratio calculation to rectify the readmissions that were double counted as both in-state and out-of-state readmissions. Appendix II provides examples of cases that are double counting and Appendix III provides modelling of the impact of modifying the OOS ratios on RY 2026 revenue adjustments as this is the most recent data period that was completed. Overall, the statewide impact was an increase in rewards of ~$2.6M, and decrease in penalties of ~$1.8M, resulting in a ~$4.4M increase in the statewide net total compared to what went into rates. These changes would affect 15 hospitals, with 12 hospitals receiving an increase in rewards or a reduction in penalties and 3 hospitals receiving either reduction in rewards or increase in penalties. Staff is recommending that the modifications to the OOS ratio calculation be applied to RY 2027 and from RY 2028 since those revenue adjustments have not yet been implemented. Simultaneously, staff will explore the feasibility of incorporating data from additional payers to further refine the OOS readmission ratio in future RRIP policies.

Hospital Scores and Revenue Adjustments

This section provides an overview of the RRIP and HRRP revenue adjustment methodology and then presents modeling of hospital scores and revenue adjustments for the RY 2027 program and the final RY 2025 RRIP and estimated FFY 2025 HRRP results for Maryland hospitals.

Comparison of RRIP and HRRP Scoring and Revenue Adjustment Methodology

Under the RRIP, hospitals are scored based on their performance on the case-mix adjusted readmission measure that compares each hospital's observed readmissions to expected readmissions for all-payers. Hospital revenue adjustments are based on the better of improvement in readmission rate or attainment of relatively low readmission rate. Improvement in

the readmission rate is determined by calculating the percentage change in the readmission rate in the performance period compared to the readmission rate in the base period; the attainment rate is calculated as the case-mix adjusted rate in the performance period further adjusted by the Medicare OOS ratio. The improvement and attainment rates are compared to predetermined improvement and attainment targets. The 65th percentile of best performers in the base period is the threshold to begin receiving rewards for attainment, which allows hospitals in the top-third of Maryland performance to earn financial rewards. The improvement target is set based on the modeling of various improvement scenarios (e.g., historical trends, commercial and Medicare benchmarking). Comparing a hospital's performance to the targets, the policy determines a hospital's final revenue adjustment as the better of revenue adjustments for improvement or attainment, with scaled rewards and penalties up to two percent of a hospital's inpatient revenue.

In contrast, the HRRP uses six condition specific readmission measures and calculates excess readmissions by hospital for each condition for Medicare beneficiaries.[5] For each HRRP condition, CMS applies a hierarchical logistic regression model that adjusts for patient's age and sex, diagnoses and comorbidities from claims, and a hospital-specific random effect to generate both observed readmissions and expected readmissions. The performance metric is the Excess Readmission Ratio (ERR) which is the ratio of observed to expected readmissions; values greater than 1.0 indicate worse-than-expected performance. For each HRRP condition, the program then compares hospitals' ERRs to those with similar proportions of dual eligibles (i.e., peer groups) and penalizes those with excess readmissions up to three percent of base operating DRG payments for all Medicare inpatient discharges. HRRP assesses readmissions based on peer groups to improve adjustment for social risk given that differences in hospitals' patient populations are not fully captured by claims-based risk adjustment. The actual penalty received is proportional to the excess readmission for each condition (i.e., higher penalties mean greater excess readmissions compared to others in peer group).

[5] The six condition specific measures are 1. Acute Myocardial Infection (AMI) 2. Coronary Artery Bypass Grafting (CABG) 3. Coronary Obstructive Pulmonary Disease (COPD) 4. Heart Failure (HF) 5. Total Hip Arthroplasty and Total Knee Arthroplasty (THA/TKA) 6. Pneumonia (PN)

Maryland's RRIP and Estimated HRRP Revenue Adjustments

In the Assessment Section, readmission performance in the RY 2027 program is presented. In Figure 12 below, the RY 2027 year-to-date (YTD) revenue adjustments are estimated using performance through August. Statewide the net revenue adjustment is a reduction of approximately $18 million or -0.14 percent of inpatient revenue. Specifically, 19 out of 44 hospitals would receive a penalty with the average penalty being -0.57 percent of inpatient revenue (penalties range from -1.34 percent to -0.10 percent), the other 25 hospitals would receive a reward with the average reward being 0.78 percent (rewards range from 0.04 percent to 2 percent). By hospital results are presented in Appendix V.

Figure 12. Summary of Statewide Estimated RY 2027 YTD through August Revenue Adjustments[6]

Statewide Summary	Improvement Scaling		Attainment Scaling		Final Adjustment	
Net Adjustments	-$33,119,595.00	-0.26%	-$82,476,354.24	-0.65%	-$17,879,167.24	-0.14%
Penalty	-$53,891,691.00	-0.43%	-$91,995,937.24	-0.73%	-$42,882,684.24	-0.34%
Reward	$20,772,096.00	0.16%	$9,519,583.00	0.08%	$25,003,517.00	0.20%

In addition to RY 2027 YTD estimates, final RY 2026 RRIP performance are shown in Figure 13. As with RY 2027 YTD estimates, there was a net negative revenue adjustment statewide. Prior to RY 2026, which updated the base period to be post-COVID (i.e., CY 2022-2023) and provided a new readmission improvement goal, the statewide net revenue adjustments had been positive for all years of the RRIP program.

Figure 13. Summary of Final Statewide RY 2026 Revenue Adjustments[7]

Statewide Summary	Improvement Scaling		Attainment Scaling		Final Adjustment	
Net Adjustments	-$45,899,899	-0.36%	-$100,545,103	-0.80%	-$27,938,378	-0.22%
Penalty	-$57,893,582	-0.46%	-$110,027,989	-0.87%	-$45,138,690	-0.36%
Reward	$11,993,683	0.09%	$9,482,886	0.08%	$17,200,312	0.14%

CMMI has provided proxy payment adjustment factors that estimate how Maryland hospitals would perform under the HRRP. However, the most recent data available is FFY 2025. The Maryland data indicates that 84 percent of hospitals in the state would receive a penalty, with the

[6] Note, these estimates do not include the update to the out of state ratio calculation.
[7] Note, these estimates do not include the update to the out of state ratio calculation.

median penalty of 0.20 percent among those that would have been penalized (minimum penalty 0.1 percent and maximum penalty 1.07 percent); HRRP does not provide rewards.

To allow for comparison to the most recent HRRP performance, the RY 2025 RRIP performance is presented rather than the RY 2026 or RY 2027 YTD results presented above. In RY 2025, Maryland hospitals received revenue adjustments to their global budgets for their CY 2023 readmissions performance compared to the improvement target of 7.50 percent and attainment target of 11.32 percent. Statewide, the total net adjustments was approximately $14M, with penalties of approximately $28M and rewards of approximately $42M. Specifically, about 55 percent of the hospitals received a scaled penalty and the remaining 45 percent received a scaled reward; the average penalty was -0.64 percent (penalties ranged from -1.52 percent to -0.15 percent) and the average reward was 0.53 percent (rewards ranged from 0.03 percent to 1.24 percent). Figure 14 below shows a comparison of estimated FFY 2025 HRRP and final RY 2025 RRIP revenue adjustments, which both assessed readmission performance in CY 2023; by hospital results are in Appendix IV.

Figure 14. Comparison of Final RY 2025 RRIP and Estimated FFY 2025 HRRP Revenue Adjustments

Program	Statewide Net Total	%	Penalties	%	Rewards	%
RRIP	$ 14,102,128.30	0.12%	$ (28,215,336.00)	-0.24%	$ 42,317,464.30	0.36%
HRRP	$ (23,305,042.30)	-0.20%	$ (23,305,042.30)	-0.20%	0	-

Estimates for MD hospitals' performance in National programs are applied to All-Payer revenue for comparison; CMS would apply adjustments to Medicare FFS revenue.

Overall, given the changes to the RRIP program starting in RY 2026 and the lack of CMS data past FFY 2025, it is difficult to compare the current program with the CMS HRRP. However, staff supports the continued inclusion of rewards in the RRIP program and will analyze the RY 2026 RRIP and FFY 2026 HRRP when available.

Recommendations

These are the draft recommendations for the Maryland Rate Year (RY) 2028 Readmission Reduction Incentives Program (RRIP):

1. Maintain the all-payer, 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 with a blended base period of CY 2022 and CY 2023.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
    a. Modify OOS ratios used for attainment to not double count readmissions for RY 2028 and retrospectively for RY 2027.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
5. Monitor reductions in within-hospital readmission disparities and provide quarterly updates on by-hospital performance at Commission Meetings.
6. Assess opportunities for AHEAD alignment of readmission measure, improvement and attainment goals, revenue at-risk, and revenue adjustment methodology

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Appendix I. RRIP Readmission Measure and Revenue Adjustment Methodology

Introduction: RRIP Redesign Subgroup

As part of the ongoing evolution of the All-Payer Model's pay-for-performance programs to further bring them into alignment under the Total Cost of Care Model, HSCRC convened a work group to evaluate the Readmission Reduction Incentive Program (RRIP). The work group consisted of stakeholders, subject matter experts, and consumers, and met six times between February and September 2019. The work group focused on the following six topics, with the general conclusions summarized below:

1. Analysis of Case-mix Adjustment and trends in Eligible Discharges over time to address concern of limited room for additional improvement;
    - Case-mix adjustment acknowledges increased severity of illness over time
    - Standard Deviation analysis of Eligible Discharges suggests that further reduction in
    - readmission rates is possible
2. National Benchmarking of similar geographies using Medicare and Commercial data;
    - Maryland Medicare and Commercial readmission rates and readmissions per capita are on par with the nation
3. Updates to the existing All-Cause Readmission Measure;
    - Remove Eligible Discharges that left against medical advice (~7,500 discharges)
    - Include Oncology Discharges with more nuanced exclusion logic
    - Analyze out-of-state ratios for other payers as data become available
4. Statewide Improvement and Attainment Targets under the TCOC Model;
    - 7.5 percent Improvement over 5 years (2018-2023)
    - Ongoing evaluation of the attainment threshold at 65th percentile
5. Social Determinants of Health and Readmission Rates; and
    - Methodology developed to assess within-hospital readmission disparities
6. Alternative Measures of Readmissions
    - Further analysis of per capita readmissions as broader trend; not germane to the RRIP policy because focus of evaluation is clinical performance and care management post-discharge
    - Observation trends under the All-Payer Model to better understand performance given variations in hospital observation use; future development will focus on incorporation of Excess Days in Acute Care (EDAC) measure in lieu of including observations in RRIP policy
    - Electronic Clinical Quality Measure (eCQM) may be considered in future to improve risk adjustment

Methodology Steps

1) Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra- and inter-hospital) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and planned admissions.[8] Unique patient identifiers from CRISP are used to be able to track patients across hospitals for readmissions.

The measure is similar to the readmission rate that is calculated by CMMI to track Maryland performance versus the nation, with some exceptions. The most notable exceptions are that the HSCRC measure includes psychiatric patients in acute care hospitals, and readmissions that occur at specialty hospitals. In comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, an additional adjustment is made to account for differences in case-mix. See below for details on the readmission calculation for the RRIP program.

2) Inclusions and Exclusions in Readmission Measurement

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 4.0. The HSCRC has also added all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs, rather than principal diagnosis.[9] Planned admissions are counted as eligible discharges in the denominator, because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.[10]
- Exclude bone marrow transplants and liquid tumor patients by making these discharges not eligible to have an unplanned readmission or count as an unplanned readmission.[11]
- Exclude patients with a discharge disposition of Left Against Medical Advice (PAT_DISP = 71, 72, or 73 through FY 2018; 07 FY 2019 onward)
- Rehabilitation cases as identified by APR-860 (which are coded under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after readmission logic is run.
- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission, but can be a readmission for a previous admission.

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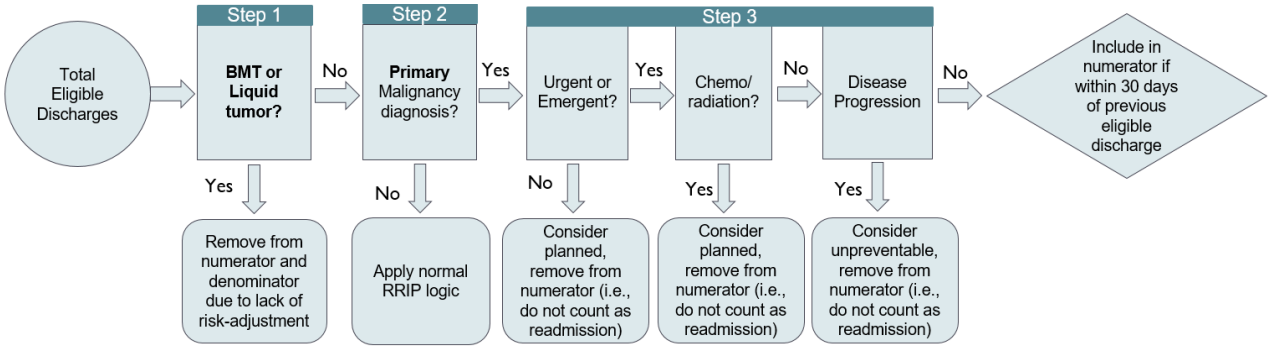
[8] Planned admissions defined under [CMS Planned Admission Logic version 4 – updated March 2018].
[9] **Rehab** DRGs: 540, 541, 542, 560, and 860; **OB Deliveries and Associated DRGs**: 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.
[10] **Newborn APR-DRGs:** 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.
[11] **Bone Marrow Transplant:** Diagnosis code Z94.81 or CCS Procedure code 64; **Liquid Tumor:** Diagnosis codes C81.00-C96.0. See section below for additional details on the oncology logic.

- APR-DRG-SOI categories with less than two discharges statewide are removed.
- A hospitalization within 30 days of a hospital discharge where a patient dies is counted as a readmission; however, the readmission is removed from the denominator because the case is not eligible for a subsequent readmission.
- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same or next day as the admission date of the subsequent admission, are removed from the denominator. Thus, only one admission is counted in the denominator, and that is the admission to the transfer hospital (unless otherwise ineligible, i.e., died). It is the second discharge date from the admission to the transfer hospital that is used to calculate the 30-day readmission window.
- Beginning in RY 2019, HSCRC started discharges from chronic beds within acute care hospitals.
- In addition, the following data cleaning edits are applied:
    - Cases with null or missing CRISP unique patient identifiers (EIDs) are removed.
    - Duplicates are removed.
    - Negative interval days are removed.
      HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, hospitals are required to make sure 99.5 percent of inpatient discharges have a CRISP EID.

Additional Details on Oncology Logic:

Flow Chart for Revised Oncology Logic



*Items that are **bolded** are adaptations from NQF measure

This updated logic replaces the RY 2021 measure logic that removes all oncology DRGs from the dataset, such that an admission with an oncology DRG cannot count as a readmission or be eligible to have a readmission.

Step 1: Exclude discharges where patients have a bone marrow transplant procedure, bone marrow transplant related diagnosis code, or liquid tumor diagnosis. This logic varies from the NQF cancer hospital measure which risk-adjusts for bone marrow transplant and liquid tumors. HSCRC staff recommended removing these discharges (similar to current DRG exclusion) because the current indirect standardization approach did not allow for additional risk-adjustment but based on conversations with clinicians staff agreed these cases were significantly more complicated and at-risk for an unpreventable readmission.

Step 2: Flag discharges with a primary malignancy diagnosis to apply cancer specific logic for determining readmissions. This varies from the NQF cancer hospital measure that flags patients with primary or secondary malignancy diagnosis being treated in a cancer specific hospital. Staff thinks we should only flag those with a primary diagnosis since in a general acute care hospital there may be differences in the types of patients with a secondary malignancy diagnosis. Further, we remove the bone marrow and liquid tumor discharges regardless of malignancy diagnosis, thus ensuring the most severe cases are removed. Last, our initial analyses did not show a large impact on overall hospital rates when primary vs primary and secondary malignancies were flagged. It should be noted however that the current modeling in this policy uses readmission rates where both primary and secondary are flagged.

Step 3: Flag planned admissions using additional criteria beyond the CMS planned admission logic:

a) Nature of admission of urgent or emergent considered unplanned, all other nature of admission statuses are planned
b) Any admission with primary diagnosis of chemotherapy or radiation is considered planned
c) Any admission with primary diagnosis of metastatic cancer is not considered preventable, and thus gets excluded from being a readmission

In step 3, admissions are deemed not eligible to be a readmission but they are eligible to have a subsequent unplanned readmission.

3) Details on the Calculation of Case-Mix Adjusted Readmission Rate

Data Source:

To calculate readmission rates for RRIP, inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) are used for the measurement period, with an additional 30 day runout. To calculate the case-mix adjusted readmission rate for CY 2023 performance period, data from January 1 through December 31, plus 30 days in January of the next year are used. CY 2022 data are used to calculate the normative values, which are used to determine a hospital's expected readmissions, as detailed below.

Please note that, the base year readmission rates are not "locked in", and may change if there are CRISP EID or other data updates. The HSCRC does not anticipate changing the base period data, and does not anticipate that any EID updates will change the base period data significantly; however, the HSCRC has decided the most up-to-date data should be used to measure improvement. For the performance period, the CRISP EIDs are updated throughout the year, and thus, month-to-month results may change based on changes in EIDs.

SOFTWARE: APR-DRG Version 42 for CY 2018-CY 2025.

Calculation:

$$\text{Case-Mix Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions)}}{\text{(Expected Readmissions)}} * \text{Statewide Base Year Readmission Rate}$$

Numerator: Number of observed hospital-specific unplanned readmissions.

Denominator: Number of expected hospital specific unplanned readmissions based upon discharge APR-DRG and Severity of Illness. See below for how to calculate expected readmissions, adjusted for APR-DRG SOI.

Risk Adjustment Calculation:

Calculate the Statewide Readmission Rate without Planned Readmissions.

- Statewide Readmission Rate = Total number of readmissions with exclusions removed / Total number of hospital discharges with exclusions removed.

For each hospital, enumerate the number of observed, unplanned readmissions.

For each hospital, calculate the number of expected unplanned readmissions at the APR-DRG SOI level (see Expected Values for description). For each hospital, cases are removed if the discharge APR-DRG and SOI cells have less than two total cases in the base period data.

Calculate at the hospital level the ratio of observed (O) readmissions over expected (E) readmissions. A ratio of > 1 means that there were more observed readmissions than expected, based upon a hospital's case-mix. A ratio of < 1 means that there were fewer observed readmissions than expected based upon a hospital's case-mix.

Multiply the O/E ratio by the base year statewide rate, which is used to get the case-mix adjusted readmission rate by hospital. Multiplying the O/E ratio by the base year state rate converts it into a readmission rate that can be compared to unadjusted rates and case-mix adjusted rates over time.

Expected Values:

The expected value of readmissions is the number of readmissions a hospital would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals,

given its mix of patients as defined by discharge APR-DRG category and SOI level. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being “eligible” for a readmission. All discharges will either have zero readmissions or will have one readmission. The readmission rate is the proportion or percentage of admissions that have a readmission.

The rates of readmissions in the normative database are calculated for each APR-DRG category and its SOI levels by dividing the observed number of readmissions by the total number of eligible discharges. The readmission norm for a single APR-DRG SOI level is calculated as follows:

Let:

N = norm
P = Number of discharges with a readmission
D = Number of eligible discharges
i = An APR DRG category and a single SOI level

$$N_i = \frac{P_i}{D_i}$$

For this example, the expected rate is displayed as readmissions per discharge to facilitate the calculations in the example. Most reports will display the expected rate as a rate per one thousand.

Once a set of norms has been calculated, the norms are applied to each hospital’s DRG and SOI distribution. In the example below, the computation presents expected readmission rates for a single diagnosis category and its four severity levels. This computation could be expanded to include multiple diagnosis categories, by simply expanding the summations.

Consider the following example for a single diagnosis category.

Expected Value Computation Example – Individual APR-DRG

A Severity of Illness Level	B Eligible Discharges	C Discharges with Readmission	D Readmissions per Discharge (C/B)	E Normative Readmissions per Discharge	F Expected # of Readmissions (A*E)
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
Total	**500**	**45**	**.09**		**56.5**

For the diagnosis category, the number of discharges with a readmission is 45, which is the sum of discharges with readmissions (column C). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of eligible discharges with a readmission (sum of column C) by the total number of discharges at risk for readmission (sum of column B), i.e., 0.09 = 45/500. From the normative population, the proportion of discharges with readmissions for each severity level for that diagnosis category is displayed in column E. The expected number of readmissions for each severity level shown in column F is calculated by multiplying the number of eligible discharges (column B) by the normative readmissions per discharge rate (column E) The total number of readmissions expected for this diagnosis category is the sum of the expected numbers of readmissions for the 4 severity levels.

In this example, the expected number of readmissions for this diagnosis category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had 11.5 fewer actual discharges with readmissions than were expected for this diagnosis category. This difference can also be expressed as a percentage or the O/E ratio.

4) Revenue Adjustment Methodology

The RRIP assesses improvement in readmission rates from base period, and attainment rates for the performance period with an adjustment for out-of-state readmissions. The policy then determines a hospital's revenue adjustment for improvement and attainment and takes the better of the two revenue adjustments, with scaled rewards of up to 2 percent of inpatient revenue and scaled penalties of up to 2 percent of inpatient revenue. The figure below provides a high level overview of the RY 2027 RRIP methodology for reference.

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30-day, All-Cause Readmission Measure

Measure Includes:
Readmissions within 30 days of Acute Case Discharge:

- All-Payer
- All-Cause
- All-Hospital (both intra- and inter- hospital)
- Chronic Beds included
- IP-Psych and Specialty Hospitals included
- Adult oncology Discharges Included

Global Exclusions:

- Planned Admissions
- Same-day and Next-day Transfers
- Rehab Hospitals
- Discharges leaving Against Medical Advice Deaths

Case-Mix Adjustment

Performance Measure: CY 2025 Case-Mix Adjusted Rate Adjusted for Out-of-State Readmissions (Attainment); Reduction in Case-Mix Adjusted Readmission Rate from Base Period (Improvement)

Case-Mix Adjustment:
Expected number of unplanned readmissions for each hospital are calculated using the discharge APR-DRG and Severity of Illness (SOI).

Observed Unplanned Readmissions/ Expected Unplanned Readmissions * Statewide Readmission Rate

CY 2022/23 used to calculated statewide averages (normative values), as well as attainment benchmark/threshold

Revenue Adjustments

Hospital RRIP revenue adjustments are based on the better of attainment or improvement, scaled between the max reward (+2%) and max penalty (-2%) of IP revenue.

All Payer Readmission Rate CY25		RRIP % Inpatient Revenue
Lower Readmission Rate		2.00%
Benchmark	8.83%	2.00%
	10.04%	1.00%
Threshold	11.25%	0.00%
	12.46%	-1.00%
	13.67%	-2.00%
Higher Readmission Rate		-2.00%

Attainment Scale

Improvement Scale

All Payer Readmission Rate Change CY22/23-25		RRIP % IP Revenue Payment Adjustment
Improving		2.00%
Benchmark	-21.04%	2.00%
	-12.41%	1.00%
Target	-3.78%	0.00%
	4.85%	-1.00%
	13.48%	-2.00%
Worsening		-2.00%

Appendix II. Examples of Cases that are Double Counted

Example 1:

Within 30 days, an MD index visit has an OOS readmission followed by another in-state readmission.

In the case-mix dataset, this encounter is an in-state readmission

In the CCW, this is an OOS readmission

Example 2:

Within 30 days, an index visit had an in-state readmission then transferred to an OOS hospital

In the case-mix dataset, this encounter is an in-state readmission

In the CCW, this is an OOS readmission. Due to the CCW logic, patients that are transferred during a readmission are considered a readmission only to the transfer-receiving hospital

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Appendix II. Modelled RY 2026 Revenue Adjustments with OOS Ratio Calculation Modification

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		What went into rates			Revised				
		Final Adjustment			Final Adjustment				
HOSPITAL ID	HOSPITAL NAME	$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	How much better they perform with revised OOS ratios ($)	How much better they perform with revised OOS ratios (%)
210017	Garrett	-$22,236	-0.07%	Att	$273,179	0.86%	Att	$295,415	0.93%
210035	UMMS- Charles	-$84,173	-0.08%	Imp	$810,169	0.77%	Att	$894,342	0.85%
210039	Calvert	-$679,575	-0.80%	Att	-$356,777	-0.42%	Att	$322,798	0.38%
210057	Adventist- Shady Grove	-$2,022,306	-0.56%	Att	-$830,590	-0.23%	Att	$1,191,716	0.33%
210051	Luminis- Doctors	$585,123	0.30%	Att	$1,189,749	0.61%	Att	$604,626	0.31%
210003	UMMS- Capital Region	$1,073,652	0.33%	Att	$1,854,491	0.57%	Att	$780,839	0.24%
210027	Western Maryland	$185,895	0.09%	Imp	$433,754	0.21%	Att	$247,859	0.12%
210049	UMMS-Upper Chesapeake	-$2,993,814	-1.15%	Att	-$2,837,615	-1.09%	Att	$156,199	0.06%
210018	MedStar- Montgomery	-$482,409	-0.45%	Att	-$428,808	-0.40%	Att	$53,601	0.05%
210037	UMMS- Easton	$2,324,864	1.68%	Att	$2,394,056	1.73%	Att	$69,192	0.05%
210015	MedStar- Franklin Square	-$4,482,989	-1.10%	Imp	-$4,360,726	-1.07%	Att	$122,263	0.03%
210058	UMMS- UMROI	-$202,066	-0.23%	Att	-$198,858	-0.22%	Att	$3,207	0.00%
210001	Meritus	-$2,346,651	-0.87%	Imp	-$2,346,651	-0.87%	Imp	$0	0.00%
210004	Trinity - Holy Cross	-$2,732,693	-0.62%	Imp	-$2,732,693	-0.62%	Imp	$0	0.00%
210005	Frederick	$281,446	0.11%	Imp	$281,446	0.11%	Imp	$0	0.00%
210008	Mercy	$48,819	0.02%	Imp	$48,819	0.02%	Imp	$0	0.00%
210009	JHH- Johns Hopkins	-$574,597	-0.03%	Imp	-$574,597	-0.03%	Imp	$0	0.00%
210011	St. Agnes	$1,457,101	0.52%	Imp	$1,457,101	0.52%	Imp	$0	0.00%
210012	Lifebridge- Sinai	-$4,111,753	-0.78%	Imp	-$4,111,753	-0.78%	Imp	$0	0.00%
210016	Adventist- White Oak	-$26,934	-0.01%	Imp	-$26,934	-0.01%	Imp	$0	0.00%
210019	Tidal- Peninsula	$2,744,095	0.77%	Imp	$2,744,095	0.77%	Imp	$0	0.00%
210022	JHH- Suburban	$968,411	0.35%	Imp	$968,411	0.35%	Imp	$0	0.00%
210023	Luminis- Anne Arundel	-$3,190,937	-0.76%	Imp	-$3,190,937	-0.76%	Imp	$0	0.00%
210024	MedStar- Union Mem	-$1,931,363	-0.63%	Imp	-$1,931,363	-0.63%	Imp	$0	0.00%
210028	MedStar- St. Mary's	$1,295,632	1.30%	Imp	$1,295,632	1.30%	Imp	$0	0.00%
210029	JHH- Bayview	-$3,791,985	-0.75%	Imp	-$3,791,985	-0.75%	Imp	$0	0.00%
210030	UMMS- Chestertown	$216,606	2.00%	Att	$216,606	2.00%	Att	$0	0.00%
210032	ChristianaCare, Union	$400,170	0.36%	Imp	$400,170	0.36%	Imp	$0	0.00%
210033	Lifebridge- Carroll	$0	0.00%	Imp	$0	0.00%	Imp	$0	0.00%
210034	MedStar- Harbor	-$726,506	-0.53%	Imp	-$726,506	-0.53%	Imp	$0	0.00%
210038	UMMS- Midtown	-$437,019	-0.31%	Imp	-$437,019	-0.31%	Imp	$0	0.00%
210040	Lifebridge- Northwest	-$1,145,528	-0.66%	Imp	-$1,145,528	-0.66%	Imp	$0	0.00%
210043	UMMS- BWMC	-$2,406,633	-0.73%	Imp	-$2,406,633	-0.73%	Imp	$0	0.00%
210048	JHH- Howard County	$153,684	0.06%	Imp	$153,684	0.06%	Imp	$0	0.00%
210056	MedStar- Good Sam	$1,098,248	0.55%	Imp	$1,098,248	0.55%	Imp	$0	0.00%
210060	Adventist-Ft. Washington	-$22,395	-0.06%	Imp	-$22,395	-0.06%	Imp	$0	0.00%
210062	MedStar- Southern MD	$1,538,713	0.73%	Imp	$1,538,713	0.73%	Imp	$0	0.00%
210063	UMMS- St. Joe	-$977,144	-0.32%	Imp	-$977,144	-0.32%	Imp	$0	0.00%
210064	Lifebridge- Levindale	$1,420,513	2.00%	Att	$1,420,513	2.00%	Att	$0	0.00%
210065	Trinity - Holy Cross Germantown	-$469,575	-0.44%	Imp	-$469,575	-0.44%	Imp	$0	0.00%
210002	UMMS- UMMC	-$9,277,409	-0.59%	Att	-$9,434,653	-0.60%	Att	-$157,244	-0.01%
210061	Atlantic General	$4,984	0.01%	Att	-$9,968	-0.02%	Att	-$14,952	-0.03%
210044	GBMC	$1,402,356	0.51%	Att	$1,264,870	0.46%	Att	-$137,486	-0.05%
	Net total	**-$27,938,378**			**-$23,506,002**			$4,432,375	
	Penalties	-$45,138,690			-$43,349,708			$1,788,981	
	Rewards	$17,200,312			$19,843,706			$2,643,394	

Appendix III. Reducing Disparities in Readmissions

Racial and socioeconomic differences in readmission rates are well documented[12,13] and have been a source of significant concern among healthcare providers and regulators for years. In Maryland, the 2018 readmission rate for Blacks was 2.6 percentage points higher than for whites, and the rate for Medicaid enrollees was 3.4 points higher than for other patients. A 2019 Annals of Internal Medicine paper co-authored by HSCRC staff[14] reported a 1.6 percent higher readmission rate for patients living in neighborhoods with increased deprivation. Maryland hospitals, as well as CMS and the Maryland Hospital Association, historically identified reductions in disparities as a key priority. Thus, staff developed and the Commission approved adding a within-hospital disparity gap improvement goal to the RRIP in RY2021.

Specifically, the RRIP within hospital disparity methodology assesses patient-level socioeconomic exposure using the Patient Adversity Index (PAI), a continuous measure that reflects exposure to poverty, structural racism, and neighborhood deprivation. As shown in Figure 10, the relationship between PAI and readmissions is then assessed for each hospital for the base and performance period, and improvements in the slope of the line or in the difference in readmission rates at two points on the line (e.g., PAI = 1 vs PAI = 0) are compared for the base and performance period to calculate improvement. Additional information on the development of the within-hospital disparity metric can be found in the RY 2021 RRIP policy.[15]

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[13] Calvillo–King, Linda, et al. "Impact of social factors on risk of readmission or mortality in pneumonia and heart failure: systematic review." *Journal of general internal medicine* 28.2 (2013): 269-282.
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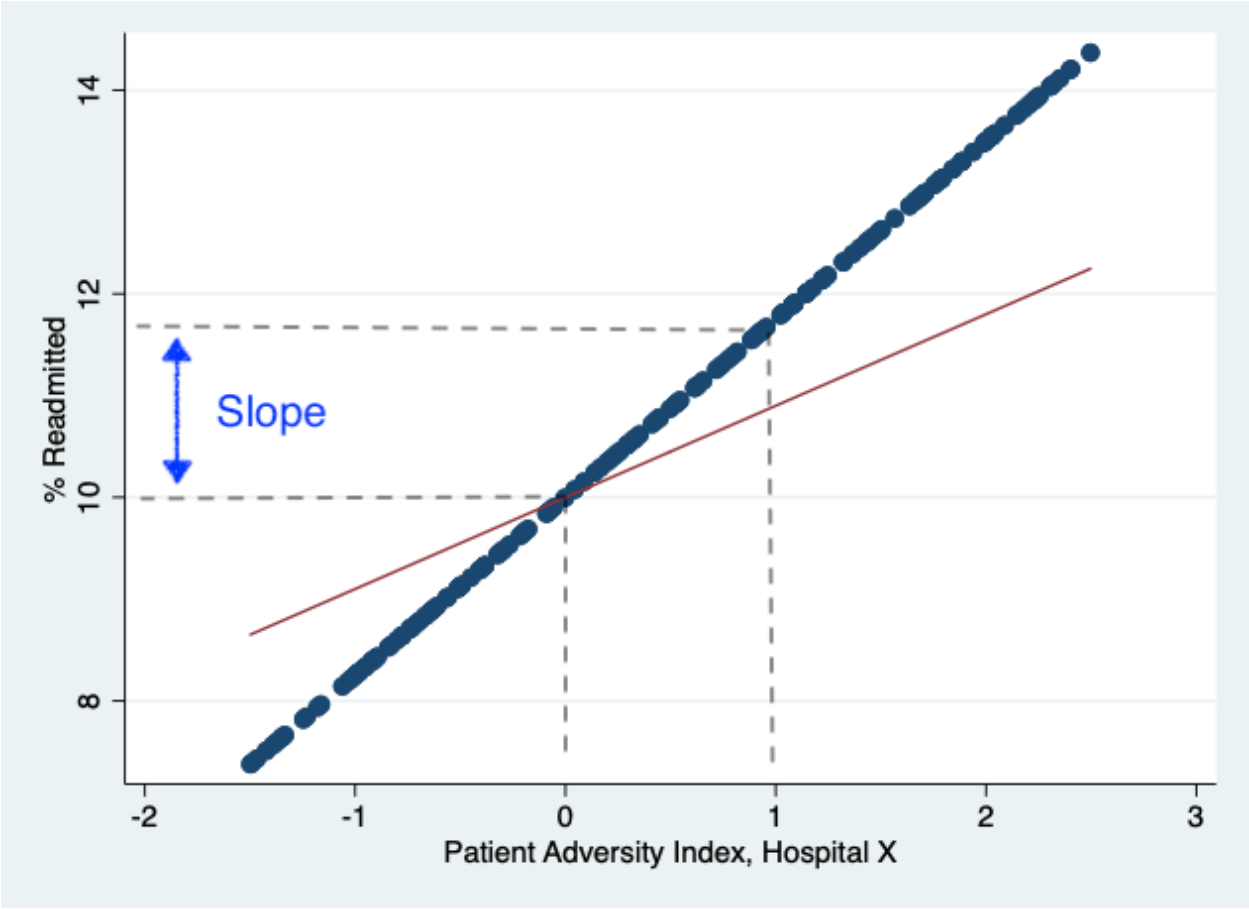
Figure 10. Hypothetical Example of Relationship between PAI and Readmission Rates



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Appendix IV. By Hospital FFY 2025 Estimated HRRP and RY 2025 Final RRIP Revenue Adjustments

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Hospital ID	Hospital Name	FFY 2025 HRRP Revenue Adjustment ($)	FFY 2025 HRRP Revenue Adjustment (%)	RY 2025 RRIP Revenue Adjustment ($)	RY 2025 RRIP Revenue Adjustment (%)
210001	Meritus	$ (2,444,359.12)	-0.97%	$ (2,217,563.00)	-0.88%
210002	UMMS- UMMC	$ (736,536.06)	-0.05%	$ 18,266,094.00	1.24%
210003	UMMS- Capital Region	$ (959,427.78)	-0.31%	$ 3,342,523.00	1.08%
210004	Trinity - Holy Cross	$ (413,940.59)	-0.10%	$ (413,941.00)	-0.10%
210005	Frederick	$ (152,737.52)	-0.06%	$ (534,581.00)	-0.21%
210008	Mercy	$ (176,531.62)	-0.08%	$ (3,354,101.00)	-1.52%
210009	JHH- Johns Hopkins	$ (181,890.34)	-0.01%	$ 6,911,833.00	0.38%
210011	St. Agnes	$ (636,911.21)	-0.25%	$ (382,147.00)	-0.15%
210012	Lifebridge- Sinai	$ (467,111.59)	-0.09%	$ (1,972,249.00)	-0.38%
210015	MedStar- Franklin Square	$ -	-0.02%	$ 2,008,056.00	0.54%
210016	Adventist- White Oak	$ (2,598,932.33)	-1.07%	$ (2,161,729.00)	-0.89%
210017	Garrett	$ (11,595.28)	-0.04%	$ (43,482.00)	-0.15%
210018	MedStar- Montgomery	$ -	0.00%	$ 1,037,362.00	1.08%
210019	Tidal- Peninsula	$ -	0.00%	$ 140,150.00	0.04%
210022	JHH- Suburban	$ (399,174.46)	-0.16%	$ (249,484.00)	-0.10%
210023	Luminis- Anne Arundel	$ (1,802,859.22)	-0.49%	$ (2,649,099.00)	-0.72%
210024	MedStar- Union Mem	$ (53,583.46)	-0.02%	$ (1,232,420.00)	-0.46%
210027	Western Maryland	$ -	-0.01%	$ (825,209.00)	-0.45%
210028	MedStar- St. Mary's	$ (582,781.01)	-0.58%	$ 813,884.00	0.81%
210029	JHH- Bayview	$ (660,500.70)	-0.14%	$ 3,632,754.00	0.77%
210030	UMMS- Chestertown	$ -	0.00%	$ 36,299.00	0.48%
210032	ChristianaCare, Union	$ (356,172.27)	-0.42%	$ (636,022.00)	-0.75%
210033	Lifebridge- Carroll	$ -	0.00%	$ (618,811.00)	-0.38%
210034	MedStar- Harbor	$ (12,823.45)	-0.01%	$ 256,469.00	0.20%
210035	UMMS- Charles	$ (214,689.70)	-0.22%	$ 614,793.00	0.63%
210037	UMMS- Easton	$ (49,446.98)	-0.04%	$ 988,940.00	0.80%
210038	UMMS- Midtown	$ (70,209.33)	-0.05%	$ 1,109,307.00	0.79%
210039	Calvert	$ (412,717.83)	-0.51%	$ 129,480.00	0.16%
210040	Lifebridge- Northwest	$ (482,584.16)	-0.30%	$ (1,769,475.00)	-1.10%
210043	UMMS- BWMC	$ -	0.00%	$ (2,018,621.00)	-0.62%
210044	GBMC	$ (685,814.10)	-0.26%	$ 1,081,476.00	0.41%
210048	JHH- Howard County	$ (1,630,127.96)	-0.74%	$ (2,467,221.00)	-1.12%
210049	UMMS-Upper Chesapeake	$ (757,960.20)	-0.32%	$ (1,586,979.00)	-0.67%
210051	Luminis- Doctors	$ (486,803.48)	-0.26%	$ 917,437.00	0.49%
210056	MedStar- Good Sam	$ (130,639.87)	-0.07%	$ 391,920.00	0.21%
210057	Adventist- Shady Grove	$ (1,803,454.74)	-0.54%	$ 367,370.00	0.11%
210058	UMMS- UMROI	$ -	0.00%	$ 242,904.30	0.30%
210060	Adventist-Ft. Washington	$ (238,032.71)	-0.63%	$ (358,938.00)	-0.95%
210061	Atlantic General	$ (85,381.21)	-0.18%	$ (237,170.00)	-0.50%
210062	MedStar- Southern MD	$ (210,921.41)	-0.10%	$ (1,244,436.00)	-0.59%
210063	UMMS- St. Joe	$ (2,896,423.64)	-0.99%	$ (409,595.00)	-0.14%
210064	Lifebridge- Levindale	$ -	0.00%	$ (517,924.00)	-0.76%
210065	Trinity - Holy Cross Germantown	$ (501,966.96)	-0.53%	$ 28,413.00	0.03%

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Appendix V. RY 2027 Preliminary Revenue Adjustments, CY 2025 YTD through August

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			Improvement Scaling				Attainment Scaling				Final Adjustment		
HOSPITAL ID	HOSPITAL NAME	FY 25 Estimated Permanent Inpatient Revenue	CY22I23-CY25% Change in Case Mix Adjusted Ra	Target	% Revenue Adjustment	$ Revenue Adjustment	CY 2025 Case Mix Adjusted Rate with Out-of-State Adjustment	Target (top 25th %)	% Revenue Adjustment	$ Revenue Adjustment*	$ Better of Attainment or Improvement	RY 27 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainme
210001	Meritus	$269,729,949	-4.15%	-3.78%	0.04%	$107,892	12.65%	11.25%	-1.16%	-$3,128,867	$107,892	0.04%	Imp
210002	UMMS- UMMC	$1,572,442,188	-0.99%	-3.78%	-0.32%	-$5,031,815	11.47%	11.25%	-0.18%	-$2,830,396	-$2,830,396	-0.18%	Att
210003	UMMS- Capital Region	$325,349,234	-2.20%	-3.78%	-0.18%	-$585,629	11.09%	11.25%	0.13%	$422,954	$422,954	0.13%	Att
210004	Trinity - Holy Cross	$440,757,012	-4.65%	-3.78%	0.10%	$440,757	12.00%	11.25%	-0.62%	-$2,732,693	$440,757	0.10%	Imp
210005	Frederick	$255,860,248	5.04%	-3.78%	-1.02%	-$2,609,775	12.39%	11.25%	-0.94%	-$2,405,086	-$2,405,086	-0.94%	Att
210008	Mercy	$244,094,359	-13.42%	-3.78%	1.12%	$2,733,857	11.94%	11.25%	-0.57%	-$1,391,338	$2,733,857	1.12%	Imp
210009	JHH- Johns Hopkins	$1,915,323,836	0.59%	-3.78%	-0.51%	-$9,768,152	12.88%	11.25%	-1.35%	-$25,856,872	-$9,768,152	-0.51%	Imp
210011	St. Agnes	$280,211,776	-10.07%	-3.78%	0.73%	$2,045,546	11.06%	11.25%	0.16%	$448,339	$2,045,546	0.73%	Imp
210012	Lifebridge- Sinai	$527,147,859	0.00%	-3.78%	-0.44%	-$2,319,451	11.83%	11.25%	-0.48%	-$2,530,310	-$2,319,451	-0.44%	Imp
210015	MedStar- Franklin Square	$407,544,466	7.76%	-3.78%	-1.34%	-$5,461,096	12.96%	11.25%	-1.41%	-$5,746,377	-$5,461,096	-1.34%	Imp
210016	Adventist- White Oak	$269,335,289	1.55%	-3.78%	-0.62%	-$1,669,879	12.81%	11.25%	-1.29%	-$3,474,425	-$1,669,879	-0.62%	Imp
210017	Garrett	$31,765,005	-4.98%	-3.78%	0.14%	$44,471	10.00%	11.25%	1.03%	$327,180	$327,180	1.03%	Att
210018	MedStar- Montgomery	$107,202,092	0.85%	-3.78%	-0.54%	-$578,891	11.50%	11.25%	-0.21%	-$225,124	-$225,124	-0.21%	Att
210019	Tidal- Peninsula	$356,375,986	-5.31%	-3.78%	0.18%	$641,477	11.05%	11.25%	0.16%	$570,202	$641,477	0.18%	Imp
210022	JHH- Suburban	$276,688,736	-5.21%	-3.78%	0.17%	$470,371	11.64%	11.25%	-0.32%	-$885,404	$470,371	0.17%	Imp
210023	Luminis- Anne Arundel	$419,860,154	6.17%	-3.78%	-1.15%	-$4,828,392	13.22%	11.25%	-1.63%	-$6,843,721	-$4,828,392	-1.15%	Imp
210024	MedStar- Union Mem	$306,565,594	0.47%	-3.78%	-0.49%	-$1,502,171	13.06%	11.25%	-1.50%	-$4,598,484	-$1,502,171	-0.49%	Imp
210027	Western Maryland	$206,549,734	-4.19%	-3.78%	0.05%	$103,275	11.85%	11.25%	-0.49%	-$1,012,094	$103,275	0.05%	Imp
210028	MedStar- St. Mary's	$99,664,006	-0.27%	-3.78%	-0.41%	-$408,622	13.07%	11.25%	-1.51%	-$1,504,926	-$408,622	-0.41%	Imp
210029	JHH- Bayview	$505,597,983	5.54%	-3.78%	-1.08%	-$5,460,458	13.41%	11.25%	-1.79%	-$9,050,204	-$5,460,458	-1.08%	Imp
210030	UMMS- Chestertown	$10,830,306	3.75%	-3.78%	-0.87%	-$94,224	8.88%	11.25%	1.96%	$212,274	$212,274	1.96%	Att
210032	ChristianaCare, Union	$111,158,432	-10.69%	-3.78%	0.80%	$889,267	12.96%	11.25%	-1.42%	-$1,578,450	$889,267	0.80%	Imp
210033	Lifebridge- Carroll	$166,721,865	-6.95%	-3.78%	0.37%	$616,871	11.75%	11.25%	-0.42%	-$700,232	$616,871	0.37%	Imp
210034	MedStar- Harbor	$137,076,633	-8.10%	-3.78%	0.50%	$685,383	12.26%	11.25%	-0.84%	-$1,151,444	$685,383	0.50%	Imp
210035	UMMS- Charles	$105,216,708	-7.35%	-3.78%	0.41%	$431,389	10.51%	11.25%	0.61%	$641,822	$641,822	0.61%	Att
210037	UMMS- Easton	$138,384,760	-11.32%	-3.78%	0.87%	$1,203,947	8.91%	11.25%	1.94%	$2,684,664	$2,684,664	1.94%	Att
210038	UMMS- Midtown	$140,973,899	0.73%	-3.78%	-0.52%	-$733,064	12.59%	11.25%	-1.11%	-$1,564,810	-$733,064	-0.52%	Imp
210039	Calvert	$84,946,923	3.21%	-3.78%	-0.81%	-$688,070	11.75%	11.25%	-0.42%	-$356,777	-$356,777	-0.42%	Att
210040	Lifebridge- Northwest	$173,564,819	2.78%	-3.78%	-0.76%	-$1,319,093	13.16%	11.25%	-1.58%	-$2,742,324	-$1,319,093	-0.76%	Imp
210043	UMMS- BWMC	$329,675,757	-5.53%	-3.78%	0.20%	$659,352	11.47%	11.25%	-0.18%	-$593,416	$659,352	0.20%	Imp
210044	GBMC	$274,971,840	-5.86%	-3.78%	0.24%	$659,932	10.25%	11.25%	0.83%	$2,282,266	$2,282,266	0.83%	Att
210048	JHH- Howard County	$256,140,273	-5.49%	-3.78%	0.20%	$512,281	12.60%	11.25%	-1.12%	-$2,868,771	$512,281	0.20%	Imp
210049	UMMS-Upper Chesapeake	$260,331,648	2.37%	-3.78%	-0.71%	-$1,848,355	11.87%	11.25%	-0.51%	-$1,327,691	-$1,327,691	-0.51%	Att
210051	Luminis- Doctors	$195,040,841	11.32%	-3.78%	-1.75%	-$3,413,215	11.98%	11.25%	-0.60%	-$1,170,245	-$1,170,245	-0.60%	Att
210056	MedStar- Good Sam	$199,681,457	-11.16%	-3.78%	0.86%	$1,717,261	12.49%	11.25%	-1.02%	-$2,036,751	$1,717,261	0.86%	Imp
210057	Adventist- Shady Grove	$361,126,072	4.36%	-3.78%	-0.94%	-$3,394,585	11.46%	11.25%	-0.17%	-$613,914	-$613,914	-0.17%	Att
210058	UMMS- UMROI	$89,094,194	44.14%	-3.78%	-2.00%	-$1,781,884	11.92%	11.25%	-0.55%	-$88,203	-$88,203	-0.10%	Att
210060	Adventist-Ft. Washington	$37,325,252	-15.78%	-3.78%	1.39%	$518,821	10.87%	11.25%	0.32%	$119,441	$518,821	1.39%	Imp
210061	Atlantic General	$49,839,515	-22.98%	-3.78%	2.00%	$996,790	9.68%	11.25%	1.30%	$647,914	$996,790	2.00%	Imp
210062	MedStar- Southern MD	$210,782,671	-15.62%	-3.78%	1.37%	$2,887,723	11.13%	11.25%	0.10%	$210,783	$2,887,723	1.37%	Imp
210063	UMMS- St. Joe	$305,357,564	-7.16%	-3.78%	0.39%	$1,190,895	11.30%	11.25%	-0.04%	-$122,143	$1,190,895	0.39%	Imp
210064	Lifebridge- Levindale	$71,025,639	-18.58%	-3.78%	1.71%	$1,214,538	9.63%	11.25%	1.34%	$951,744	$1,214,538	1.71%	Imp
210065	Trinity - Holy Cross Germantown	$106,721,583	-0.59%	-3.78%	-0.37%	-$394,870	12.23%	11.25%	-0.81%	-$864,445	-$394,870	-0.37%	Imp

The next HSCRC Public Meeting is Wednesday,February 11, 2026.

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