maryland
health services
cost review commission

633rd Meeting of the Health Services Cost Review Commission

July 30, 2025

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

CLOSED SESSION
12:00 pm

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

PUBLIC MEETING
1:00 pm

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

Specific Matters

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

Docket Status – Cases Closed

2668R Johns Hopkins Howard County Medical Center - Application Withdrawn
2681N Luminis Health Doctors Community Medical Center
2672A Johns Hopkins Health System
2673A Johns Hopkins Health System
2674A Johns Hopkins Health System

2. Docket Status – Cases Open

2675A Johns Hopkins Health System
2676A Johns Hopkins Health System
2677A Johns Hopkins Health System
2678A Johns Hopkins Health System

Informational Subjects

3. Presentation: Revolutionizing Heart Failure Care

Subjects of General Applicability

4. Report from the Executive Director
    a. Summary of GME RFI Submissions

b. Update on Stakeholder Feedback Process

5. Recommendation: Release of HSCRC Confidential Patient-Level Data
6. Recommendation: Additional Funding Considerations for FY 2026
7. Recommendation: Updates to the Consumer Financial Assistance and Medical Debt Regulations
8. Materials Only: Community Benefits Report - FY 2023 Activities
9. Hearing and Meeting Schedule

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MINUTES OF THE
632nd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
JUNE 11, 2025

Chairman Joshua Sharfstein called the public meeting to order at 12:00 p.m. In addition to Chairman Sharfstein, in attendance were Vice Chairman James Elliott, M.D., Maulik Joshi, D.Ph., Nicki McCann, J.D., and Ricardo Johnson. Joining by Zoom: Commissioner Adam Kane, Esq. Upon motion made by Commissioner Johnson and seconded by Vice Chairman Elliott, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 1:10 p.m.

Commissioner Adam Kane, Esq.

During Commissioner Adam Kane's final meeting with the Health Services Cost Review Commission on June 11, 2025, Chairman Sharfstein extended a heartfelt recognition of his service. He presented Commissioner Kane with a plaque for his "distinguished service" and "steadfast leadership," especially throughout the COVID-19 pandemic. The commendation honored his consistent dedication to the health and welfare of Maryland's residents during his tenure as Commissioner from 2017 to 2020 and again from 2023 to 2025, as well as his time as Chairman from 2020 to 2023.

Commissioner Kane expressed his sincere appreciation for the plaque and apologized for not being present in person. Reflecting on his nearly eight-year tenure, he extended his gratitude to Governors O'Malley, Hogan, and Moore for the opportunity to serve. He also acknowledged the four executive directors he worked with—Donna Kinzer, Chris Peterson, Katie Wunderlich, and Jon Kromm—praising them and the entire talented staff. Commissioner Kane conveyed how much he enjoyed being involved with the "bold experiment" of Maryland's unique healthcare model and getting to know the dedicated community of industry participants, payers, and others striving to do the right thing for the state's healthcare system and its citizens. He concluded by thanking everyone and expressing his hope for the Commission's continued success in the future.

REPORT OF JUNE 11, 2025, CLOSED SESSION

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed on June 11, 2025, in the Closed Session.

INNOVATION IN MARYLAND UPDATE

Chairman Sharfstein provided a brief update on the AIM contest. He described it as a relatively modest initiative, funded by approximately $10,000 in donated prize money from various foundations. Despite its small scale, the contest successfully generated numerous ideas and drew participation from people across the state. He expressed his excitement and pleasant surprise that many of the submitted ideas are now actively being implemented, noting that the contest provided a valuable boost.

ITEM I
REVIEW OF THE MINUTES FROM MAY 14, 2025, PUBLIC MEETING AND CLOSED SESSION

Upon motion made by Commissioner Joshi and seconded by Vice Chairman Elliott, the Commission voted unanimously to approve the minutes of May 14, 2025, for the Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
OPEN CASES

2668R	Johns Hopkins Howard County Medical Center
2681N	Luminis Health Doctors Community Medical Center
2672A	Johns Hopkins Health System
2673A	Johns Hopkins Health System
2674A	Johns Hopkins Health System
2644A	Johns Hopkins Health System – Request for Extension
2675A	Johns Hopkins Health System

2671N – Luminis Health Doctors Community Hospital (Recusal: Vice Chairman Elliott)

Ms. Deon Joyce, Chief, Hospital Rate Regulation, presented the partial rate application for Luminis Health Doctors Community Hospital.

On April 17, 2025, Luminis Health on behalf of Luminis Health Doctors Community Medical Center (LHDCMC) and Luminis Health Anne Arundel Medical Center (LHAAMC) submitted a partial rate application to the Commission requesting that the rates of LHDCMC and LHAAMC be revised to reflect that the outpatient infusion clinics at LHAAMC will operate as an off-site provider-based “child” of LHDCMC for purposes of the federal 340B Prescription Drug Discount program. Luminis Health requests the following:

1. In Fiscal Year (FY) 2025, a total of $662,882 be transferred from LHAAMC's Global Budget Revenue (GBR) cap to LHDCMC's GBR.
2. In FY 2026, a total of $29,577,979 be transferred from LHAAMC's GBR to LHDCMC's GBR.
3. The new Unit Rates on LHDCMC's Rate Order to be as follows:
    - CL-340 set at $52.4321 (equivalent to LHAAMC's FY 2025 rate)
    - LAB-340 set at $1.78 (equivalent to LHAAMC's FY 2025 rate)
4. Exclusion from Rate Realignment:
    - The Commission will exclude the new unit rate revenue from rate realignment.
5. An adjustment of Rate Order Volumes:
    - That volumes in the rate orders for both LHAAMC and LHDCMC be adjusted to ensure revenue neutrality regarding rate capacity.

Ms. Joyce presented the staff's recommendations as follows:

- Luminis Health request be approved because it will enable LHDCMC to provide lower cost services to current oncology patients; and it will generate future savings to the Maryland healthcare system and for oncology patients through lower drug costs at the LHAAMC location.
- Approval is contingent upon LHDCMC applying for and receiving provider-based status from the Centers for Medicare and Medicaid Services for the infusion clinics at the LHDCMC site.
- The following rates for the infusion clinic services provided at LHAAMC be approved and added to LHDCMC's approved rate order:
    - Clinic rates of $52.43 per RVU be approved effective June 23, 2025
    - Laboratory rates of $1.73 per RVU be approved effective June 23, 2025

In addition, Staff will collaborate with Luminis Health to implement the necessary revenue adjustments in the RY 2026 rate orders.

Chairman Sharfstein requested a motion to adopt the staff recommendation. Commissioner Johnson moved to approve the staff's Recommendation, seconded by Commissioner McCann.

Vice Chairman Elliott was recused from this vote. **The motion passed unanimously in favor of the staff's recommendation.**

2644A – Hopkins Request for Extension (Recusal: Chairman Sharfstein and Commissioner McCann)

Ms. Daniela Tamayo, Rate Analyst I, Hospital Rate Regulation, presented The Johns Hopkins Health System's request for extension on their alternative rate arrangement.

On February 5, 2025, in accordance with the authority granted to it by the Commission, staff approved a 3-month extension of the Commission's approval of the alternative rate arrangement between the Johns Hopkins Health System (JHHS) and Optum Health (Optum) (Proceeding 2644A). The extension expires on June 30, 2025. However, JHHS and Optum have not yet completed negotiations to extend the arrangement.

Ms. Tamayo presented the staff recommendation that the Commission grant JHHS's request for a two-month extension of its approval, provided that if the negotiations are not completed before the expiration of this extension, the arrangement will end, and no further services may be provided under the arrangement until a new application is approved.

Vice Chairman Elliott requested a motion to adopt the staff recommendation. Commissioner Johnson moved to approve the staff's Recommendation, seconded by Commissioner Joshi. Chairman Sharfstein and Commissioner McCann were recused from this vote. **The motion passed unanimously in favor of the staff's recommendation.**

ITEM III
REPORT FROM THE EXECUTIVE DIRECTOR

Update on Financial Assistance/Medical Debt Regulations and Graduate Medical Education Study

Dr. Jon Kromm, Executive Director, announced two key developments. First, he outlined the plan to finalize updates to HSCRC's financial assistance and medical debt regulations, intending to align them with recent legislative changes. He noted that a new workgroup will use a previously drafted version from September 2023 as a starting point, hold two additional meetings, and solicit public comment before presenting the proposed regulations for a commission vote in July, with a goal for final adoption in the fall.

Second, Dr. Kromm stated that a Request for Information (RFI) would be published imminently to explore alternative options for funding Graduate Medical Education (GME). This RFI will seek

diverse opinions and stakeholder feedback on structuring a new funding program, which will then be brought back to the commissioners for their consideration.

New Paradigms in Care Delivery

Ms. Christa Speicher, Deputy Director, Payment Reform, presented a high-level overview of the New Paradigms initiative, designed to provide one-time matching funds to hospitals. This funding, delivered through an adjustment to hospital rates for implementation in FY 2026, aims to accelerate innovative solutions that can avert the need for traditional hospitalization. The program supports transformative projects that might otherwise be considered too expensive or speculative for hospitals to undertake. The initiative drew significant interest, receiving 16 distinct proposals across a wide range of clinical focus areas, including palliative care, sepsis, heart failure, and maternal health.

To illustrate the types of projects being considered, Ms. Speicher highlighted two examples focused on heart failure. The first proposes a clinic-based alternative to hospitalization that uses IV diuresis and extensive case management. The second involves creating a fully integrated heart failure network to connect all care settings—from home to hospital—using multidisciplinary teams, standardized communication, and remote patient monitoring to reduce fragmentation and allow for early intervention. She concluded by stating that the Commission is currently in discussions with potential awardees and expects to announce the selections by the end of June.

No action was taken on these agenda items.

ITEM IV
FINAL RECOMMENDATION: CONFIDENTIAL DATA REQUEST

Mr. Curtis Wills, Analyst, Healthcare Data Management and Integrity, presented the staff's Final Recommendation: Confidential Data Request (see "Final Recommendation: Confidential Data Request" available on the HSCRC website).

Mr. Wills presented the staff's Final Recommendation regarding a data request from the University of Maryland School of Medicine's Shock, Trauma and Anesthesiology Research Center and the National Study Center for Trauma and Emergency Medical Services. The centers are requesting access to HSCRC's confidential inpatient and outpatient hospital data for their Injury Outcome Data Evaluation System (IODES). The primary goal is to analyze injuries sustained by patients treated in Maryland by linking the hospital data with other sources like police crash reports and EMS run sheets. Mr. Wills emphasized that this is an "umbrella project"

designed to improve public health and that the data will not be used to identify individual patients or hospitals.

After review by the HSCRC Confidential Data Review Committee and noting that the project had already received approval from the Maryland Department of Health's Institutional Review Board and its Strategic Data Initiative Office, the staff's recommendation is to approve the data release. If approved, the University must file annual progress reports, submit a copy of its final report for HSCRC review before public release, and securely destroy all data upon project completion, providing a certificate of destruction.

Mr. Wills presented the staff's Final Recommendation:

1. Request by UMSOM for the data for Calendar Years (CYs) 2020 through 2023 be approved by the Commission; and
2. That the access will include limited confidential information for subjects meeting the criteria for the research.

Chairman Sharfstein asked Dr. Kaushik to explain the purpose of the study. Dr. Kaushik explained that the IODES is a data repository at the National Study Center used to conduct various studies on emergent injuries and illnesses. He stated that they are requesting the HSCRC data because it provides a comprehensive, statewide view, encompassing patients seen at multiple different locations. By integrating this data, researchers can build a complete picture of the burdens that various injuries and illnesses place on the state of Maryland. Ultimately, this enhanced understanding will be used to improve the quality of patient care and advance research capabilities in the field.

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

ITEM V
FINAL RECOMMENDATION: CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS (CRISP) FUNDING

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, presented the Staff's Final Recommendation for CRISP Funding (see "Final Recommendation for CRISP Funding" available on the HSCRC website).

Mr. Henderson presented the staff's final recommendation for CRISP's FY 2026 funding, confirming that it remains unchanged from the previously circulated draft recommendation. He

noted that the Commission did not receive any public comment letters on the proposal. Mr. Henderson addressed a question that was raised previously about whether the funding was sufficient for CRISP to support new projects, such as the AIM initiatives. After follow-up discussions, both HSCRC staff and CRISP leadership concluded that the proposed budget has enough flexibility to support these and other new activities. Therefore, the staff's final recommendation is to approve the funding for CRISP for FY 2026 as originally drafted.

Mr. Henderson presented the staff's Final Recommendation regarding CRISP Funding, as follows:

- Commission approval of $12,060,000 in funding through hospital rates in FY 2026 to support the HIE and continue the investments made in the TCOC Model initiatives through both direct funding and obtaining federal MES matching funds.

- Staff anticipates actual CRISP spending of $13,060,000 but proposes to use $1,000,000 of prior reserves, limiting the actual assessment to $12,060,000.

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

ITEM VI
FINAL RECOMMENDATION: UPDATE FACTOR FOR RATE YEAR 2026

Mr. Jerry Schmith, Principal Deputy Director, Hospital Rate Revenue and Regulations, Mr. William Henderson, Principal Deputy Director, Medical Economics & Data Analytics, Mr. Allan Pack, Principal Deputy Director, Quality and Population Based Methodologies, and Ms. Caitlin Cooksey, Deputy Director, Hospital Rate Regulation, presented the staff's Final Recommendation for the Update Factor for Rate Year 2026 (see "Final Recommendation for the Update Factor For Rate Year 2026" available on the HSCRC website).

Ms. Cooksey began the presentation by outlining the staff's final update factor recommendation for Rate Year (RY) 2026, noting there were minimal changes from the initial draft. For **Global Budget Revenues (GBR)**, the proposal includes:

- An inflation increase of **3.36 percent**.
- A total overall revenue increase of **5.68 percent**.
- A new requirement for hospitals to report on improvement targets and outcomes within their high-value care plans.

- Proposed revisions to both the demographic adjustment and uncompensated care underpayments for RYs 2023 through 2025, aimed at reducing potentially avoidable utilization.
- Modifications to the Integrated Efficiency Policy, establishing a new threshold to exempt hospitals in the fourth quartile from penalties.
- A transition to a percentage-based allocation model for the deficit assessment, with **14.5 percent** applied to hospitals and the remainder to payers, to ensure greater predictability and equity.

For **Non-Global Budget Revenues**, which include psychiatric hospitals and Mount Washington Pediatric Hospital, the staff's update factor recommendations are:

- An overall update of **3.36 percent**.
- Suspension of the **0.8 percent productivity offset**, a change from the draft recommendation.

Ms. Cooksey's reported receiving 11 timely comment letters from various stakeholders, with two additional letters received late but not introducing new themes. The comments generally focused on several key areas:

Additional Inflation Funding

- **MHA and University of Maryland** requested additional inflation, citing concerns that the proposed 3.36 percent might be conservative. MHA sought an additional 0.67 percent, while University of Maryland requested 0.52 percent, based on the current underfunding calculated via the inflation catch-up methodology.
- **Staff Response:** While acknowledging the 0.52 percent of underfunding, staff is not recommending additional inflation at this time, as it does not trigger the 1 percent guardrail adopted in last year's methodology.

Fully Funding Age-Adjusted Demographic Growth

- **MHA and member hospitals** requested full funding for age-adjusted demographic growth, estimating it at 0.65 percent per year (2.6 percent over four years), beyond the proposed 0.76 percent demographic adjustment correction.
- **Staff Response:** Staff proposes moving forward with the 0.76 percent demographic adjustment correction and is committed to collaborating with stakeholders on potential policy revisions for age-adjusted funding this calendar year. However, they noted that

the request necessitates a fundamental methodological change requiring robust stakeholder engagement.

Medicaid Deficit Assessment Increase

- **MHA and member hospitals** requested that hospitals are not required to directly remit any portion of the $150 million increase to the deficit assessment.
- **Staff Response:** Given the total RY 2026 deficit assessment of $504 million, staff believes passing the entire burden to payers and patients would be inequitable. Therefore, they propose transitioning to a percentage-based allocation, similar to past trends, to ensure fair distribution. The estimated impact on hospitals is approximately $8 million, or 0.04 percent of total revenue.

Uncompensated Care (UCC) Fund Revision

- **MHA and member hospitals** supported the proposed correction to the UCC fund calculation.
- **Staff Response:** Staff appreciated their support and confirmed that, if approved, the correction would be implemented as a one-time adjustment in RY 2026.

Reinvestment of Medicare Savings

- **MHA and several member hospitals** highlighted estimated CY 2024 Total Cost of Care savings of approximately $795 million, advocating for reinvestment to stabilize operations amidst various cost pressures (e.g., tariffs, Medicaid cuts, payer denials, rising staff and liability costs, cybersecurity).
- **Staff Response:** Staff is proposing a recommendation consistent with the formulaic update factor methodology and is not recommending reinvestment of savings beyond what is outlined in the final recommendation.

Integrated Efficiency Policy Modification

- **MHA and several member hospitals** supported staff's recommendation to modify the Integrated Efficiency Policy, limiting penalties to fourth-quartile hospitals also identified as UCC outliers and supporting the use of historical standard deviation. MedStar Health encouraged broader stakeholder engagement, and LifeBridge Health requested a suspension of the policy for RY 2026.
- **Staff Response:** Staff appreciates the broad support for the policy revision. While the policy has undergone revisions approximately every two years, staff agrees that a review every three to five years is appropriate, with this year's focus on market shift and

demographic changes. Staff does not agree with suspending the policy, emphasizing the Commission's ongoing obligation to ensure reasonable hospital costs and charges, as supported by the Federal government's AHEAD methodology.

Suspension of Productivity Adjustment for Non-GBR Hospitals

- **MHA and member hospitals** requested the suspension of the productivity adjustment for non-GBR hospitals, citing recruitment and retention challenges and concerns about financial strain from a lower inflation factor.
- **Staff Response:** Staff recognizes that non-GBR hospitals face similar cost pressures to GBR hospitals. Analysis of Mount Washington Pediatric Hospital and Sheppard Pratt (which represent the largest revenue bases among specialty hospitals) showed significant inpatient volume declines relative to 2019, particularly in neonatology statewide for Mount Washington and across various Diagnostic Related Groups (DRGs) (e.g., bipolar, eating disorders) for Sheppard Pratt, consistent with statewide trends. To address these systemic declines and ensure these valuable resources can respond to community needs, staff proposes suspending the productivity adjustment for these hospitals in RY 2026.

CareFirst Concerns Regarding Large Funding Increase

- **CareFirst** opposed the draft recommendations, expressing concern about the large funding increase in RY 2025 and its impact on guardrail performance, suggesting a prioritization of hospital revenues over consumer affordability.
- **Staff Response:** Staff appreciates CareFirst's concern for consumer protection and aims for recommendations that consider hospitals, payers, and patients. For this reason, staff is not recommending any additional increase beyond the formulaic approach outlined.

Calendar Year Growth and Savings Estimates

The CY growth from 2024 is 6.38 percent. This figure saw a minor correction from 6.45 percent in the draft due to a missing one-time adjustment. Staff modeled four guardrail scenarios, yielding an average savings of **$686 million**. Scenarios 1 and 2, which use pre-pandemic trends, are more conservative and are estimated to be above the 1 percent guardrail in CY 2025. The latter two scenarios, using post-pandemic trends, are less conservative.

Commissioner Johnson asked when the volumes drop for non-GBR hospitals, why does staff use 100 percent variable cost? Mr. Schmith explained that HSCRC has always applied a 100 percent variable cost factor to non-Global Budget Revenue hospitals, meaning that when their volumes increased, they received full credit, but conversely, when volumes dropped significantly during the pandemic, the Commission took away 100 cents on a dollar. This effectively meant that the fixed costs of these hospitals were already removed from their funding during the prior volume declines, which they have not yet recovered from. Therefore, suspending the 0.8 percent productivity offset—an amount typically applied by the federal government to reduce the fixed portion of volume increases—is necessary to avoid further penalizing these hospitals for fixed costs that have already been accounted for in their reduced revenue base due to unrecovered volumes.

Commissioner McCann asked for an explanation on the age adjustment and scaling methodology. Mr. Pack explained that the demographic adjustment, initiated in 2015, uses a per capita test that attributes population to hospitals based on market share, then adjusts for age by examining per-member-per-year expenses relative to the statewide average, generating differential age-adjusted rates. These rates are then "scaled back" so that the state's total demographic adjustment matches overall population growth, not age-adjusted growth, which reduced the available adjustment by 0.65 percent for this past year. He further noted that age is not the only factor for comprehensive risk adjustment, and historically, the demographic adjustment has always been fully funded without a variable cost factor, suggesting both the risk adjustment model and the application of variable cost factors warrant reevaluation in any future revisions.

Chairman Sharfstein asked for clarification on the timing of the proposed review of the demographic adjustment that Ms. Cooksey mentioned. He also sought to confirm if this review would involve a comprehensive risk adjustment beyond just age, or if it would be limited solely to the age adjustment. Mr. Pack clarified that the review would encompass more than just the age adjustment, focusing on overall practice pattern changes and benchmarking against national performance data sets. He noted this comprehensive approach is necessary because the Maryland model itself influences aging growth trends. He confirmed that they anticipate having a recommendation on revisions to both the demographic adjustment and the market share policy this calendar year. This timeline aligns strategically with the planned January 1st implementation of the AHEAD model, which specifically allows for risk-adjusted growth rather than solely population-based growth, making the connection between the two initiatives sensible.

Chairman Sharfstein questioned the unusual trend of fewer behavioral health hospitalizations in Maryland, asking if the staff had discussed this with the Health Department and what factors

might be behind it, given that general mental health isn't widely perceived as improving. Ms. Cooksey confirmed they hadn't discussed the behavioral health hospitalization trend with the Health Department but had with the hospitals. She suggested that increased use of telemedicine is likely driving these trends, particularly for less severe behavioral health conditions.

Chairman Sharfstein noted that the trend was interesting and suggested the staff contact the Health Department to compare observations, particularly on telehealth's impact, even if public hospital data might not be directly comparable.

Chairman Sharfstein observed that the staff's recommended increase would trip the Total Cost of Care guardrail test in the two most conservative scenarios, and he asked for an explanation of the staff's rationale and how the guardrail test works. Dr. Kromm explained that the guardrail test is a key component of the Total Cost of Care model, and while tripping it doesn't automatically terminate the model, the critical factor is how close Maryland's performance is to the guardrail's limit. Being significantly above the line, unlike being just close, makes it much harder to mitigate the risk and adhere to the model's long-standing principles.

Mr. Schmith explained that the persistent problem with the guardrail test is that the staff consistently aims for an annual increase lower than the national average, causing them to fall significantly behind. Consequently, in the following year, they often exceed the guardrail while attempting to catch up, creating a continuous cycle of falling behind and then overshooting.

Ms. Melony Griffith, President and Chief Executive Officer of MHA, highlighted the severe financial strain on hospitals due to rising costs including tariffs, potential Medicaid cuts, increased payer denials, and escalating staffing and medical liability expenses noting that actual costs have consistently outpaced rate increases. With an average operating margin of less than 1 percent, far below the 3 percent industry benchmark needed for sustainability, and facing significant uncertainty about the future of the Maryland model, she stressed that hospitals must achieve financial health to effectively plan and continue providing care.

Ms. Griffith clarified that much of the proposed update is not new funding but rather addresses a $150 million increase to the Medicaid deficit assessment and corrects historical underfunding in demographic growth and uncompensated care. While appreciating these identified corrections, she urged the Commission to also rectify the persistent underfunding of inflation and age-adjusted population growth, which has consistently hampered hospitals.

She argued that additional funding for these areas is justified by the model's substantial excess savings, now exceeding $450 million above the 2024 target. She concluded by stating that this

year's update presents a vital opportunity to ensure hospitals' financial sustainability, keep their doors open, and provide assurance that the staff will leverage its global budget authority to meet the pressing needs of the hospital field.

Ms. Tequila Terry, Senior Vice President of Care Transformation and Finance of MHA, commended the staff's recommendation to suspend the productivity adjustment for specialty hospitals, affirming that non-Global Budget Revenue (GBR) hospitals are vital and face the same cost pressures as other hospitals. She noted that while the proposed 5.6 percent GBR revenue growth appears significant, nearly a third of it stems from the Medicaid deficit assessment increase and technical corrections for past underfunding of demographic adjustments and uncompensated care. Excluding these, the true new funding update for hospitals is much lower at 3.92 percent, which is considerably less than the RY 2025 update.

She emphasized that the current demographic adjustment methodology only funds overall population growth, resulting in an estimated 2.6 percent (or 0.65 percent annually) of age-adjusted population growth going unfunded over the last four years. She appreciated the staff's acknowledgment of the need for changes and their work on long-term refinement but urged the Commission to take immediate action in the RY 2026 update to address this unfunded age-adjusted growth while the long-term policy change is still being considered.

Ms. Terry expressed concern that the Q1 Global Insights inflation forecast of 3.36 percent is too low, citing a consistent pattern of conservative estimates that have led to significant underfunding for hospitals, particularly post-COVID. Despite an additional 1 percent inflation catch-up provided in RY 2025 (triggered by the 1 percent cumulative underfunding guardrail), hospitals are still underfunded by 0.52 percent since the model's inception. Given the current economic volatility and unprecedented uncertainty, she requested the Commission suspend the guardrail and provide a 0.52 percent true-up for underfunded inflation in this year's update for both GBR and non-GBR hospitals. She concluded by reiterating MHA's commitment to healthier outcomes and affordable care, stressing the staff's responsibility to ensure rates are reasonably related to costs and adequately fund hospitals, especially amid potential federal investment changes and rising costs for consumers.

Mr. Arin Foreman, Vice President and Deputy Chief of Staff for CareFirst BlueCross BlueShield, acknowledged the complex pressures facing the staff in its update factor decision, including consumer affordability, hospital economic challenges, federal funding cuts, and the transition to the AHEAD model. While understanding the staff's intent to correct prior period errors, he expressed sticker shock at the 5.7 percent recommended increase, arguing it deprioritizes affordability for consumers.

He clarified his understanding that the demographic adjustment correction represents new money that will permanently impact hospital revenue, unlike the Medicaid deficit assessment increase, which he views as a pass-through. Regardless of the breakdown, he emphasized that the 5.7 percent figure is what the public perceives and faces. He criticized the staff's recommendation for ignoring HSCRC's own internal scenarios, which evaluate if Maryland beats the national average and if consumers are treated fairly. He warned that proceeding with such rate increases would strain household budgets in an unpredictable economy, especially given the ongoing federal scrutiny as the total cost of care model concludes.

Mr. Forman presented compelling statistics from a Healthcare Value Hub and Robert Wood Johnson Foundation survey: more than 4 in 5 Maryland adults are worried about affording medical costs, and 48 percent delayed or skipped care due to cost in the past year. He underscored the importance of remaining grounded in these impacts. He then pointed out that the HSCRC has been "historically generous" to hospitals over the past 12 months, adding $540 million to rates outside normal methodologies through various adjustments like inflation catch-up, expanded set-aside funding, and surge funding. While recognizing the need to adequately fund hospitals, Mr. Forman stressed the necessity of striking a balance through a robust governance structure and adherence to well-developed methodologies.

Commissioner McCann asked how much of $541 million added to hospital rates last year constituted permanent funding. Mr. Pack estimated that less than $400 million for surge funding is not permanent.

Chairman Sharfstein asked if the proposed elimination of the inflation corridor is a permanent change that would ensure full catch-up for future inflation deviations, or if it is a one-time adjustment. Ms. Terry articulated MHA's long-standing opposition to the inflation corridor approach, advocating strongly for its removal this year due to the unique, unprecedented point in time where inflation is significantly impacting hospital costs. She emphasized MHA's consistent stance that hospitals should be fully caught up on inflation adjustments, regardless of whether actual inflation exceeds or falls short of estimates. While pushing for the current removal of the guardrail, Ms. Terry did acknowledge that if the state faced a risk of missing a key obligation to the federal government, they would support necessary measures, including potentially re-implementing a corridor or clawing back funds as seen in past scenarios, to ensure compliance with the Maryland Model. She recommended the guardrails be removed for this year, with the option to revisit their necessity in the future based on the model's performance.

Commissioner McCann asked Ms. Terry whether MHA would still be requesting additional revenue if the challenges with the market shift and demographic policies, which MHA

highlighted in its February 3rd comment letter, had been addressed. Ms. Terry explained that while a new methodology might resolve some issues, the most pressing concern is inflation. She noted that the market shift and demographic policies wouldn't address the underfunding of inflation. She emphasized that the hospital field is currently grappling with unprecedented economic volatility, citing factors like tariffs, new federal immigration policies, and tax cuts, all of which are inflationary. This volatility directly leads to higher costs for supplies and resources needed to provide quality care, which is the primary worry for hospitals. She acknowledged the importance of working on other policies but reiterated that the current inflationary environment is what concerns the field most.

Commissioner Johnson asked Ms. Terry how MHA would handle overinflation and how they would want the Commission to handle overinflation. Ms. Terry stated that if the body overpaid in inflation, they should correct it by taking back the excess funds, just as they should provide funds if inflation is underpaid, always considering the current savings targets and federal obligations. She emphasized that if overpayment occurs while financial targets are met, the body retains the flexibility to decide the appropriate action based on real-time circumstances. Currently, she believes the core issue is the historical underfunding of inflation, and there's a clear opportunity to address it.

Commissioner Kane asked for clarification on how the 0.65 percent demographic adjustment is determined and if MHA is familiar with the AHEAD model proposed risk adjustment methodology and how it connects to that 0.65 percent calculation. Ms. Terry clarified that the 0.65 percent demographic adjustment represents the average of the historic underfunded demographic adjustment over the past four years, totaling 2.6 percent in age-adjusted population growth. She stated she was unfamiliar with the AHEAD model risk adjustment methodology and therefore could not speak to it.

Dr. Kromm confirmed that the current CMMI-publicized hospital global budget methodology does implement risk-adjusted demographic adjustments, primarily utilizing HCC scores for its Medicare-only population. While acknowledging the challenge of extrapolating this to a full risk adjustment for broader populations, he stated that HSCRC staff have been actively researching CMMI's future direction and exploring other appropriate risk adjustment approaches within health services, considering multiple factors. He also asserted that Commissioners' are in support of the work to incorporate risk adjustment into the demographic adjustment policy.

Commissioner Johnson expressed concern regarding the consistent "baseline up" approach to the update factor, specifically noting that the industry frequently identifies underfunded areas, but overfunded areas are less commonly found and often delayed in correction. He questioned the logic of consistently increasing the update factor (e.g., for inflation) without a reciprocal

willingness to decrease it when overfunded. He concluded that from a governance perspective, the Commission needs to seriously reconsider this imbalanced approach to the update factor and inflation adjustments.

Commissioner McCann asserted that there is a definitive correlation between increased age and increased inpatient utilization, a relationship she states is consistently supported by various data sources, including CMS and commercial data. She emphasized the importance of acknowledging this established correlation. Mr. Henderson countered that despite the aging population, there's a significant national secular trend toward *less* inpatient utilization. He cited data showing a 13 percent reduction in national inpatient days today compared to 2013, noting that sources like Kaiser also indicate a decrease in total inpatient utilization, even with the aging Baby Boomer demographic. He emphasized that this downward trend, influenced by factors beyond age (like the millions spent on drugs), is a pretty significant factor observed over the last decade.

Commissioner Kane acknowledged the immense complexity and ongoing efforts to refine the demographic methodologies. He admitted his prior misunderstanding that the demographic adjustment had fully accounted for the effects of aging, realizing now that population growth had stripped out that effect. Given the significant work involved and the impending new AHEAD model, he questioned the value of further refining the current methodology versus seeking a reasonable compromise. However, due to the current inconsistency and uncertainty surrounding the AHEAD model's exact nature and start date, he advocates for continued work on it.

Chairman Sharfstein noted that less risk-adjusted funding would necessitate providing more money for utilization, as was done for this year's surge. He suggested that if a robust risk adjustment policy had been in place, this patch might not have been necessary. He clarified that this doesn't mean the issue has been ignored; rather, it has been addressed differently while working toward a fully vetted and sensible adjustment.

Commissioner Joshi echoed Commissioner McCann's sentiments, acknowledging the immense and ongoing financial pressure on hospitals, compounded by significant uncertainty. Given that the age-adjusted policy cannot be resolved within a few months, he urged the staff to identify what other areas—such as inflation, physician costs, or other policies—could be addressed within the next 45 days, before the next meeting. He emphasized the need for swift action to alleviate the considerable pressure on Maryland's hospital system.

Chairman Sharfstein noted that the Commissioners had put forward several distinct proposals for consideration:

1. **"No Catch-Up" Inflation Adjustment:** Commissioner Johnson proposed to adopt the staff's recommended update methodology and forego any retroactive inflation adjustments or UCC error corrections**.**

2. **Suspend the Inflation Corridor:** Commissioner McCann also proposed to release 0.52 percent in underfunded inflation and suspend the 1 percent corridor on a one-time, extraordinary basis.

3. **Increase for Age/Risk Adjustment (0.65 percent):** Commissioner McCann put forward a motion to incorporate a 0.65 percent increase as a preliminary adjustment. This measure is intended to establish budgetary predictability for hospitals and insurance providers while an age or risk adjustment policy is developed and finalized by January 1, 2026.

4. **Staff's Final Recommendation:** The proposal presented by the HSCRC staff, without modifications.

5. **Staff Recommendation with Additional July Consideration:** Commissioner Joshi moved to adopt the staff's Final Recommendation and, at the same time, solicit more public feedback to explore additional spending ahead of the July meeting. The aim is to foster a more comprehensive discussion, particularly regarding physician costs and other investment opportunities.

6. **Permanent Respiratory Surge Funding:** Commissioner McCann proposed to make the respiratory surge funding from the previous year a permanent part of the update factor.

Chairman Sharfstein called a motion for the proposal to adopt the calculated methodology going forward without any retroactive "catch-up" for past inflation or UCC. **Commissioner Johnson moved to adopt the motion, but it failed for lack of a second.**

Chairman Sharfstein called a motion to suspend the 1 percent inflation corridor. Commissioner McCann moved to adopt the motion to which was seconded by Vice Chairman Elliott. **The motion subsequently failed with two votes in favor (Commissioner McCann, Vice Chairman Elliott) and four votes in opposition (Commissioners Joshi, Johnson, Kane, and Sabi via proxy).**

Chairman Sharfstein called for a motion to increase the update by 0.65 percent as a placeholder for an age or risk adjustment policy to be developed by January 1, 2026. Commissioner McCann moved to adopt the motion, seconded by Commissioner Kane. **The motion**

subsequently failed with three votes in favor (Vice Chairman Elliott, Commissioners McCann, Kane) and four votes in opposition (Commissioners Joshi, Johnson, Sabi via proxy and Chairman Sharfstein).

Chairman Sharfstein called for a motion on the staff's Final Recommendation, with no modifications. **No motion was made or moved by any Commissioner.**

Chairman Sharfstein called for a motion to approve the staff's Final Recommendation with the modification to hold additional public comment to consider further spending in the July meeting. Commissioner Johnson moved to adopt the motion and was seconded by Commissioner Joshi. **The motion passed unanimously to approve the staff's Final Recommendation with modifications.**

Chairman Sharfstein called for a motion to make the amount of last year's respiratory surge funding permanent. **Commissioner McCann moved to adopt the motion, but it failed for a lack of a second.**

ITEM VII
HEARING AND MEETING SCHEDULE

July 30, 2025, Time to be determined
4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:30 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

June 11, 2025

Chairman Sharfstein stated the reasons for Commissioners to move into administrative session, under the authority provided by the General Provisions Article §3-103 and §3-104, for the purposes of discussing the administration of the Model and the FY25 Hospital unaudited financial performance.

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 12:05 p.m.

In addition to Chairman Sharfstein, Commissioners Elliott, Joshi, Johnson, and McCann were in attendance.

Also, attending by Zoom: Commissioner Kane.

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

Joining by Zoom: Deb Rivkin.

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

Item I

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

Item II

Mr. Henderson also updated the Commission, and the Commission discussed the FY2025 Hospital Financial Condition through April FY25.

Item III

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

The Closed Session was adjourned at 12:55 p.m.

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

July 30, 2025

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:	2485
BALTIMORE, MARYLAND	*	PROCEEDING:	2675A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on May 28, 2025, on behalf of its member hospitals, Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global price arrangement for bariatric surgery, joint replacement, oncology surgical procedures and neurosurgery with BridgeHealth Medical Inc. The System requests approval of the arrangement for a period of one year beginning July 1, 2025.

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 the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for bariatric surgery, joint replacement, oncology surgical procedures and neurosurgery for a one-year period commencing July 1, 2025, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). 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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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

July 30, 2025

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:	2486
BALTIMORE, MARYLAND	*	PROCEEDING:	2676A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on June 27, 2025, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital ("the Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement for Executive Health Services with Under Armour, Inc. for a period of one year beginning August 1, 2025.

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 the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Executive Health Services with Under Armour for a one-year period commencing August 1, 2025. 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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Application for an Alternative Method of Rate Determination

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July 30, 2025

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ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2025
SYSTEM	*	FOLIO:	2487
BALTIMORE, MARYLAND	*	PROCEEDING:	2677A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on June 27, 2025, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital ("the Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement with Accarent Health for bariatric surgery, oncology surgical procedures, anal rectal surgery, spine surgery, thyroid parathyroid, joint replacement, neurosurgery procedures, Craniotomy, Ventricular Assist Devices (VAD) procedures, pancreas surgery, cardiovascular services, musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, Cochlear implants, gall bladder surgery, CAR-T, ankle repairs, hernia and nephrectomy for a period of one year beginning August 1, 2025.

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

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VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for bariatric surgery, oncology surgical procedures, anal rectal surgery, spine surgery, thyroid parathyroid, joint replacement, neurosurgery procedures, Craniotomy, VAD procedures, pancreas surgery, cardiovascular services, musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, Cochlear implants, gall bladder surgery, CAR-T, ankle repairs, hernia and nephrectomy with Accarent Health for a one-year period commencing August 1, 2025. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

July 30, 2025

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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:	2488
BALTIMORE, MARYLAND	*	PROCEEDING:	2678A

I. INTRODUCTION

Johns Hopkins Health System ("System') filed an application with the HSCRC on June 10, 2025, on behalf of its member hospitals, Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global price arrangement for cardiovascular, joint replacement procedures, bypass, cardiac cath, defribillators, Percutaneous Coronary Intervention (PCI) cardiac valves, Transcatheter Aortic Valve Replacement (TAVRs) and oncology evaluation services with Health Design Plus, Inc. The System requests approval of the arrangement for a period of one year beginning August 1, 2025.

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.

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VI. STAFF RECOMMENDATION

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THE DAY CLINIC

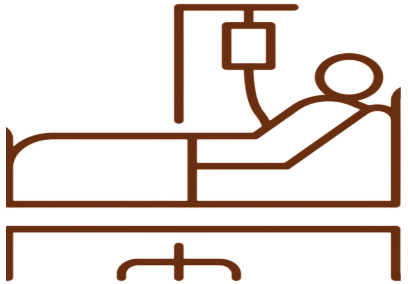
&

LUMINIS HEALTH

New Paradigms in Care Delivery

PRESENTATION TO THE HEALTH SERVICES COST REVIEW COMMISSION - JULY 30, 2025

“Gasping for air, waiting for hours in a crowded emergency room, and ultimately admitted to the hospital…”



This is the sad fate of heart failure patients today.

WE CAN DO BETTER.

By providing a safe, effective, clinic-based alternative we will dramatically improve the lives of patients, reduce hospital admissions, and save an extraordinary amount of money.

Why are Heart Failure Patients Hospitalized?

The heart can’t pump blood and compensatory mechanisms cause fluid retention, shortness of breath and swelling

Patients call 911, cardiologist, primary care or urgent care

Current outpatient facilities don’t have the capacity or capability to manage worsening heart failure

Emergency department referral is the “easy button” and currently the only real option

The vast majority of patients are admitted to the hospital for the removal of excess fluid using intravenous (IV) diuretics

High rates of rehospitalization in spite of treatment

There’s a better way….

Led by Dr. Parakh, Johns Hopkins Bayview established a pioneering IV diuresis clinic in 2011.

Publication showing this approach was safe (limited adverse events), effective (~1.5L removed) and low cost (~$12k saved / episode).

Since then, additional hospital - based clinics established, but only account for 14% of IV diuresis treatment in the US.

https://onlinelibrary.wiley.com/doi/10.1002/ejhf.2727

CLINICAL RESEARCH STUDY

THE AMERICAN JOURNAL of MEDICINE®

The Diuresis Clinic: A New Paradigm for the Treatment of Mild Decompensated Heart Failure

Sunal Makadia, MD,[a] Tanya Simmons, RN, BSN, CHFN,[b] Sharon Augustine, CRNP,[b] Lara Kovell, MD,[a] Che Harris, MD,[a] Abednego Chibungu, MD,[a] Kapil Parakh, MD, MPH, PhD[a]

[a]Johns Hopkins University School of Medicine, Baltimore, Md; [b]Johns Hopkins Bayview Medical Center, Baltimore, Md.

Current Care

- Patient weight increasing
- Cardiologist refers patient to ER
- Significant ER wait times / time to admit
- Registration, EKG, labs, assessment
- IV diuresis, admission to hospital
- Discharge after average of 3 days

Expensive, time -consuming, cumbersome and uncomfortable

The Day Clinic

- Patient weight increasing
- Cardiologist refers patient to the clinic
- Patient seen the same day
- Registration, EKG, point of care labs, etc
- IV diuresis, counselling, GDMT titration
- Discharge to home in 2 to 3 hours

Efficient, delightful, patient -centered and cost -effective

DAY CLINIC

Scale of the Opportunity for Impact

Anne Arundel County

Heart Failure Admissions:	1,531
Average Cost per Visit:	$16,221
Total Cost of HF Admissions:	$24.8M
Heart Failure Readmission Rate:	20%

Maryland

Heart Failure Admissions:	16,070
Average Cost per Visit:	$18,130
Total Cost of HF Admissions:	$291.2M
Heart Failure Readmission Rate:	20%

Partnership with Luminis Health

The teams at Luminis Health and The Day Clinic have a strong prior working relationship.

We have rapidly formed a collaborative team and are ahead of our work plan.

Our clinical collaboration includes engaging the cardiology community around AAMC, collaborating ER providers and hospitalists, and sharing clinical information with one another; all with the aim of reducing potentially avoidable utilization.

Luminis has made meaningful resources available to The Day Clinic including IT support, billing support, data analysis, real estate services, group purchasing, and executive level engagement.

A Tech-Enabled Approach

Proactive Management

Data from scales, BP monitors, and wearables provides insights between visits. Can anticipate and arrange for repeat clinic visits reducing hospitalizations even further.

Impactful

Telemedicine can help deliver care such as GDMT titration which is associated with improved outcomes. This increases efficiency and impact.

Scalable

Infrastructure will be built to be scalable from the ground up with considerations for privacy, security as well as thoughtful applications of artificial intelligence.

Collaborating with Cardiologists Drives Rapid Scale

As we have engaged community cardiologists, there is resounding excitement at the prospect of having the Day Clinic as a resource for their patients. They clearly see the problem and the need.

Data shows that 50 - 70% of patients will be referred by cardiology.

The Day Clinic will develop strong, symbiotic relationships with cardiology practices to drive growth .

The Day Clinic takes away time consuming patients from a cardiology practice and engages those patients in a collaborative care management process

The Day Clinic provides useful summaries of data, saves the practice time and makes referrals smooth, becoming “the easy button”.

DAY CLINIC

The Day Clinic Objectives

Improved Outcomes

Comprehensive care (IV diuresis, education, medication reconciliation, RPM and care coordination), leading to better management and improved outcomes.

75% lower hospitalization and better quality of life

Shared Cost Savings

By reducing hospitalizations and readmissions, the day clinic will offer health plans a cost-effective alternative to expensive inpatient care.

$12,000 or more per avoided hospital visit

High Patient Satisfaction

Patients prefer the convenience and personalized attention of outpatient diuresis clinics over hospital stays and will seek it out.

We will achieve the best net promoter score in healthcare

The Work Ahead and the Opportunity to Rapidly Scale Statewide

- We are well on our way executing against our work to establish the clinic.
- We are finalizing our clinic office location, designing the space, hiring clinical staff and entering contracts for solutions like our EHR.
- We expect to be seeing patients in 9 months.

- The key challenge is the lack of a payment model that can sufficiently value the care model.
- The fee-for-service payment levels are insufficient to run the clinic and to enable scaling. The relatively limited Medicare Advantage population complicates the picture.
- Our work over the coming year will be to collaborate with partners to develop a payment structure that rewards avoided hospital visits and on-going patient management.

Final Thoughts

We know this model of care works. The real-world experience and supporting published evidence proves it.

As we showed on a previous slide, the impact on outcomes and costs will be powerful.

The impact on patients - spending far fewer days in the hospital - will be a dramatic improvement to their quality of life.

With the right payment approach supporting this care model, we can rapidly scale it statewide.

DAY CLINIC

Discussion

We are passionate about creating a scalable, tech-enabled, safe and effective outpatient alternative to hospitalization for heart failure.

Join us as we work to lower costs, increase revenue, engage providers and improve the lives of patients and caregivers.

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Graduate Medical Education (GME) Funding in Maryland

Summary of Responses to HSCRC Request for Information (RFI)

July 30, 2025

GME Background

Background

- Maryland faces a growing physician shortage
- GME expansion is essential to address workforce gaps
- HSCRC has long supported GME programs
- HSCRC released an RFI in June 2025
- Eight organizations responded
  - Broad support for GME programs
    - Emphasis on primary care and underserved areas
    - Need for predictable, sustainable funding
    - Incentive-based retention favored over mandates
  - Opposition to competitive slot allocation

Summary of Recommendations Across Organizations

- Expand GME programs equitably across Maryland
- Fund both new and existing programs fairly
- Focus on primary care, psychiatry, and rural access
- Use data-driven planning over competition
- Incentivize, don’t mandate, in-state retention
- Reassess funding levels to match CMS benchmarks
- Acknowledge GME programs operating above cap
- Extend new program development window (aligned with CMS)
- Invest in non-physician roles (radiology, diagnostics, etc)

Organization Specific Responses

MedChi and MDAFP

Key Priorities:

- Expand GME to address projected shortages
- Prioritize primary care training
- Strengthen MLARP funding beyond current $1–3M

Recommendations:

- Use HSCRC's authority to fund MLARP sustainably

Maryland Hospital Association

Concerns:

- Current GME funding is inadequate

Pilot Program Recommendations:

- Provide predictable upfront funding’
- Support both new and existing programs
- Allocate slots based on community needs, not competition
- Avoid strict in-state retention requirements

TidalHealth

Federal Alignment:

- Support a federal-style GME model focused on rural areas

Funding Strategy:

- Annual per-resident payments + one-time startup funds
- Pay funds upon resident arrival

Retention Approach:

- Use loan repayment/fellowship stipends, not mandates

University of Maryland Medical System (UMMS)

Funding Reform:

- Reassess funding for existing programs first
- Remove or review residency caps every 3–5 years

Participation Guidelines:

- Focus on underserved specialties and HPSAs
- Avoid automatic clawbacks based on retention

Recommendation:

- Convene a teaching hospital workgroup to shape policy

Luminis Health

Funding Gaps:

- Missed ~$1046M over 6 years under GBR

Policy Recommendations:

- Follow Medicare phased model
- Fund based on regional need, not competition
- Oppose funding cuts based on “efficiencies”

Retention View:

- Favor incentives, not retention mandates

Lifebridge Health

Support for GME Expansion:

- Focus on high-need specialties (eg, pediatrics, OB/GYN)

Innovative Ideas:

- APP support and residency rotation pool for community hospitals

Challenges:

- $9.5M shortfall at Sinai in FY25
- High Medicaid mix complicates recruitment

Johns Hopkins Health System (JHHS)

Policy Goals:

- Build a balanced, innovative workforce
- Include existing GME programs in funding reform

Implementation Strategy:

- 1–2 year rollout; review every 3–5 years
- Require “demonstration of need”, not competition

Retention Stance:

- Oppose state retention mandates; risk institutional disadvantage

Adventist HealthCare

Funding Recommendations:

- Follow Medicare-based formula (per-resident x FTEs)
- Avoid efficiency penalties for new GME funds (first 5 years)

Participation Guidelines:

- Prioritize access-need specialties and HPSAs
- Encourage loan-repayment pairing, not retention rules

Other Considerations:

- Extend comment periods and align with Maryland's cost-control goals

MARYLAND AHEAD MODEL:

OUTLINE FOR A REVISED APPROACH UNDER AHEAD

John M. Colmers

Chair, Milbank Memorial Fund

Managing Director, Berkley Research Group

OUTLINE

- Framing
- Assumptions
- Principles
- Framework
  - Participating Payers
  - Model Changes

FRAMING

- Why me?
- Why now?
- My own view of changes needed to current model to meet the AHEAD model

- This will require a lot of work from a lot of people.

ASSUMPTIONS

- Relative stability over time
- Time is of the essence
- Transition to global payments from unit rate-payment (starting with Medicare)
- All payer global budgets remain **aligned**
- Medicare specific savings targets in HGB
- Likely Medicaid turmoil and increased UCC

PRINCIPLES

- Clear, measurable incentives
- Clear time horizon
- Delivery system changes that permit achievement of key outcomes
- Stable cost sharing for patients
- All payers aligned
- All providers aligned
- Sufficient funding for necessary care
- Administratively straightforward
- Equitable payments
- Support needed capital investments

VOLUME AND PAU CHANGES

Volume

- Risk based demographic adjustment to global payments
- Updated market shift, including variable cost factors / perhaps vary by clinical service
- Innovation services treated separately and equitably (85-90 % in GBR)
- TBD: Payments outside of HGB
  - Rates or add on to HGB?
- Continue annual respiratory volume adjustment
- Maintain Rx drug policy

PAU: A new approach

- Preventable utilization
- Calculate expected preventable illness reduction for each hospital
- They can reduce it at their hospital or others via all-payer CTI (with a clear plan) or lose it
- System wide improvements allow reduction across the board in expectations

PARTICIPATING PAYERS

- Optional, but not required
- Payers that meet conditions are provided with an enhanced differential payment – cost justified.
- Conditions:
  - Example: shift to global payments from unit rate-payment for global budget (85-90%)
  - Example: participate in all-payer programs
  - Example: payers have responsible physician rates, coverage for hospice
  - Example: prior auth. standards, denials, other administrative simplicities
- Medicare qualifies by contract

DELIVERY SYSTEM REDESIGN & EFFICIENCY

Delivery System Redesign

- Need more change in how care is delivered
- New policy on low volume hospitals
  - Greater flexibility for systems
  - Safeguards against hospitals bringing in unnecessary admissions.
- Focus primarily on hospitals in systems to internalize decision making

Efficiency

- **Option A:** eliminate current efficiency policy, do a rebasing process
- **Option B**: update the efficiency policy
  - Reasonable spending to accomplish preventable reductions is a safe harbor
  - Phase out revenue for reform (phase it into the spending for preventable reductions)
  - Increase spending in most efficient hospitals

QUALITY & LOS REDUCTION

Quality Metrics

- Need to vastly simplify
- Parallel the national model as much as possible
- Establish parallel approach for participating payers
- Create LIMITED focused approaches
  - Proven dramatic result in readmissions
  - ER wait time

LOS Reduction

- Establish adjusted LOS reduction target (if any) for all hospitals
- Reduce or lose

PHYSICIAN COSTS & GME

Physician Costs

- Essential to hospital services
- Link to Participating Payer
- Establish reasonable standards
- Focus on hospital-based physicians
- Statutory change?

Medical Education

- Updated GME to meet state's needs
- More closely aligned to Medicare

CAPITAL & POST ACUTE

Capital

- Need re-evaluation of Capital Policy
- Make consistent with Delivery System Redesign

Post Acute

- Uniform statewide quality program w/ enhanced rates for high quality nursing homes from Medicaid
- Incentives for hospitals to refer to high quality nursing homes
- Bundles for common conditions
- Linked to ongoing state policy to support noninstitutional care

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Final Staff Recommendation for a Request to Access HSCRC Confidential Patient Level Data from

Oregon Health and Science University for the Components of Emergency Department Pediatric Readiness Associated with Short and Long-Term Survival among Children: A Mixed Methods Evaluation.

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

Oregon Health and Science University 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 identify the specific components of ED pediatric readiness most closely aligned with survival among children receiving emergency care, quantify these factors in a single metric, and identify readiness practices among EDs with better-than-expected survival. The results will guide targeted improvements in EDs, emergency care systems, and national health policy to optimize survival among children requiring emergency services. This data request builds on an National Institute of Child Health and Human Development (NICHD) R24 grant for ED pediatric readiness, a Health Resources and Services Administration (HRSA) grant on ED pediatric readiness, and an established multidisciplinary team to conduct this mixed methods study. The aim of this project is to build two multi-state cohorts of children receiving emergency care and use machine learning to identify the components of ED pediatric readiness predictive of short- and long-term survival and to empirically develop a global measure of ED pediatric readiness and compare it to the weighted Pediatric Readiness Score for predicting short- and long-term survival in children.

OBJECTIVE

This project will identify the essential aspects of ED pediatric readiness for improving short- and long-term survival among children with injury and acute medical illness. This project will generate a survival-based, prioritized roadmap for implementing the various components of ED pediatric readiness, a survival-based global measure of ED readiness for EDs to track their progress. This project will influence pediatric national health policy through the National Pediatric Readiness Project (NPRP), Emergency Medical Services for Children (EMSC), national and state trauma center verification criteria, and national field trauma triage guidelines, providing direct conduits for translating the results of this project into clinical practice. The results will affect how ED pediatric readiness is measured, characterized, and prioritized to guide EDs in raising their level of pediatric readiness, further optimizing the US emergency care system for children.

Oregon Health and Science University received approval from the Maryland Department of Health (MDH) Institutional Review Board (IRB) on March 11, 2025, and the MDH Strategic Data Initiative (SDI) office on June 30, 2025.

(The Data will not be used to identify individual patients. The Data will be retained by Oregon Health and Science University until project completion on April 30, 2028. 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 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 Oregon Health and Science University 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 recommend that the request by Oregon Health and Science University for the Data for Calendar Year 2018 through 2022 be approved, previously approved at the HSCRC Public meeting on March 8, 2023.

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

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Additional Spending or Investments for FY 2026

June 2025

Recap of Comment Letters

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Background

In the June HSCRC Meeting, staff made a recommendation regarding the FY 2026 Update Factor. In approving the recommendation, Commissioners requested that staff analyze additional options for update factor rate adjustments and post for additional comments from stakeholders on specific proposals.

This presentation outlines the following:

- Current savings target status
- Summary of comments received by stakeholders
- Options for savings over target for consideration by Commissioners

Savings Status

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Current Savings Projections

- Maryland started the year with a cumulative savings relative to the nation of $795M.
- Hospital trend has been higher in Maryland than for the nation in the first quarter of CY 2025.
- Based on annualizing the first three months of Medicare cost data and accounting for the FY 2026 update factor, our cumulative savings target status relative to nation projected for CY 2025 is $630M. Preliminary results through April show further deterioration.
- Based on the signed AHEAD state agreement, the projected savings target for CY 2026 is $525M–this is a savings floor as we consider preparedness for the AHEAD Model.
- To responsibly manage to this threshold, we recommend leaving at least $50M of flex to account for further deterioration of the savings results–that would mean not exceeding $50M-$55M in increased Medicare costs.

Summary of Comment Letters

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Comment Letters Received:

Following the June meeting, we requested comment on additional rate adjustments for respiratory surge, inflation corridors, physician costs, and AHEAD preparedness. We received comment letters from the following:

- The Maryland Hospital Association
- CareFirst
- Johns Hopkins Health System
- LifeBridge Health
- Saint Agnes
- Luminis Health
- MedChi
- CRISP
- Adventist Health
- Meritus Medical Center
- Johns Hopkins School of Nursing (2 letters)
- MedStar Health
- University of Maryland Medical System
- Audacious Capital
- TidalHealth

Surge Funding

- The Maryland Hospital Association, JHHS, UMMS, MedStar, Adventist, Luminis, and Meritus all supported an annual Surge Policy. Specific comments further suggested including all volumes in the winter months, re-running using updated ECMAD methodology. One hospital suggested capping the value at 0.25 percent to ensure predictability.
- CareFirst opposed an annual surge policy, but urged the Commission to make the policy two-sided should it get adopted.

HSCRC Staff Response: Staff recommended a respiratory surge policy that reflects variable increase since 2019, consistent with the COVID surge policy in 2024. However, staff agree that evolving this approach to use an ECMAD methodology and determining how to account for decreases in respiratory volume in future years are important considerations.

Inflation Corridor Comments

- The Maryland Hospital Association and all hospital comment letters supported the idea of suspending or narrowing the corridor to provide the current inflation value of 0.52 percent.
- Meritus suggested narrowing the risk corridor to 0.25 percent (+/-) and funding the remaining 0.27 percent.
- CareFirst opposed providing further funding for inflation.

HSCRC Staff Response: Staff supports the idea of a corridor as a stabilizing mechanism for rates. Further, adjustments to historical inflation should be two-sided. Meritus' comments suggest an approach that would narrow but maintain a corridor.

Physician Cost Comments

- The Maryland Hospital Association and all hospital comment letters received supported the idea of adding physician costs to GBRs through a standardized mechanism, specifically hospital based physicians including: ED physicians, hospitalists, anesthesiologists, and radiologists.
  - Saint Agnes suggested this should move through workgroup engagement.
  - TidalHealth champions a rural GME policy
- CareFirst opposed adding physician cost to GBRs until a complete analysis is reviewed.

HSCRC Response: Staff have noted that physician costs are a financial challenge for hospitals and is currently analyzing cost report data. Staff are planning a report to commissioners in the fall. Staff agree that this analysis, along with stakeholder-informed options for addressing future cost growth should shape an eventual approach to this cost driver. The HSCRC will need to resolve limitations of our authority to directly address physician costs through rates.

Risk Adjustment Comments

- The Maryland Hospital Association and all hospital comment letters supported the idea of risk adjusting the demographic adjustment.
- Several hospitals requested forward funding of 0.65 percent until further analyses are complete. Hospitals maintained that the VCF should remain at 100 percent.
- LifeBridge Health and Audacious Capital suggested the use of HCCs in the methodology calculation.
- CareFirst suggested that a risk adjustment requires a methodological change and should go through a workgroup prior to implementation.

HSCRC Staff Response: Staff concurs with CareFirst that there should be a workgroup to discuss any deviation from the current Demographic Adjustment policy. The proposal to add funds now for age adjustment alone does not consider other risk factors besides age, secular trends in the rate of hospitalization, or the appropriate variable cost factor to apply.

AHEAD Preparation Comments

- Johns Hopkins School of Nursing submitted two comment letters focusing on:
  - Leveraging CRISP Data Infrastructure to Improve Cardiovascular Health in Maryland: Data-Driven Approach to Individual and Community Risk which could be achieved by Neighborhood Nursing which is already being piloted in Baltimore city
  - Implementing an AI Smart Food Program to Enhance Access to Nutritious Foods for Maryland SNAP Recipients which tackles food insecurity in Maryland by leveraging AI to create a ‘smart surplus marketplace’
  - Similar programs are being piloted in Delaware and Florida

AHEAD Preparation Comments

- CRISP submitted a comment letter encouraging the Commission to consider a sustainability fund. The purpose of the fund would ensure ongoing operations, support innovation, and provide an administrative vehicle for programmatic support for priority areas, such as access to Healthy Food via health related social needs screening.

  HSCRC Staff Response: Staff agrees that building infrastructure to support population health improvement, particularly through CRISP, would bolster Maryland's ability to be successful under the AHEAD Model.

Options for Savings Over Target

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Options and Considerations

Respiratory Surge Policy

Increases in volume at the system level are largely attributable to increased seasonal respiratory volume. The surge funding in 2024 addressed this through recognizing use rate growth of those conditions in the prior year, but an ECMAD-based methodology may be more appropriate in the long term. Additionally, as in 2024, the HSCRC should ensure that hospitals maintain or expand capacity for managing respiratory cases and follow MDH guidance to prevent respiratory illness.

Option: Develop new policy approach	Conduct workgroup to determine new methodology for permanent respiratory volume policy
Option: Advance a blended approach that moves toward an ECMAD methodology	Phase a transition over three years such that for FY 2026 (FY2025 performance assessment) each hospital receives an adjustment equivalent to two-thirds what it would receive under the 2024 methodology and one-third what it would receive under an ECMAD basis. In this example, rates would be adjusted by approximately $100.5M for FY 2026.

Options and Considerations

Reconciliation of Inflation

Preserving a corridor for inflation reconciliation provides an amount of predictability for that is protective of hospitals when the projection overestimates inflation.

Option: No Change	Preserves 1% corridor
Option: Reduce corridor to 0.25%, cost is $59 million	Amend the corridor to a lower threshold of 0.25%, and consider not applying the corridor if inflation is overfunded AND all savings tests are met. This would result in a rate impact of 0.27 percent (approximately $59M) for FY2026.

Population Health Investments

While making additional investments in CRISP would be advantageous, that has to be balanced with available resources in the context of eroding savings performance.

Options and Considerations

Risk-adjusted Demographic

The demographic adjustment policy does not take into account risk to set the statewide adjustment to rates in line with the TCOC Agreement (it does adjust for age in allocating across hospitals). The demographic adjustment should comprehensively address the relative risk of Maryland. Workgroup process is set to start review of initial data and consider potential approaches, with plan to return to commission this year. Staff recommend allowing the policy development process to move forward.

Hospital-based Physician Costs

Medicare fee-for-service professional fees for hospital-based physicians have been inadequate in recent years. HSCRC has conducted analysis on cost reports and will share in the fall. Additionally, HSCRC requires additional authority to provide direct funding in this area. Staff recommend allowing the policy development process to move forward.

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June 27, 2025

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

Dear Dr. Kromm,

Meritus Medical Center ("Meritus") appreciates the opportunity to comment in response to the Health Services Cost Review Commission (Commission) staff's request for comments on the additional spending or investments for FY 2026.

1. **Inflation Corridor**. If the HSCRC were to remove the corridor this year, what should be the approach in future years, if inflation is above or below what is projected? If inflation is overfunded, should the Commission consider not recalibrating when its various savings targets are met?

   We recommend the Commission adopt a recalibrated corridor with a narrower threshold**,** setting the guardrail at ±0.25% rather than the current ±1.0%. Under this approach:

   - If actual inflation falls within ±0.25% of the projection, no adjustment would be made.
   - If inflation exceeds +0.25%**,** hospitals should receive a partial inflation catch-up**,** with payouts reduced to remain within the 0.25% margin.
   - If inflation falls below -0.25%**,** the Commission should recoup the overfunding**,** except in cases where state savings targets are exceeded**.**

2. **Risk Adjustment**. The HSCRC announced a process for developing a proposal to risk adjusting the Demographic Adjustment, population growth for a vote in 2025. Questions include:
   a. Should risk assessments be based on national utilization so as to remove TCOC Model impacts?
   b. Should TCOC Model impacts play any role in determining the total available funding provided by the Demographic Adjustment?
   c. If national assessments of utilization reflect incentives to provide services in a Hospital Outpatient Department should the Commission consider additional adjustments to neutralize the lack of site neutral incentives in the national market?
   d. In the event that the Commission cannot incorporate a frequently updated risk adjusted beneficiary count so as to adjust for more than just the aging of the population, should the Commission consider utilizing the growth in Medicare's Hierarchical Condition Categories (HCC's) either for the Medicare only population or extrapolated across the entire Maryland population?

e. If the Commission elects to change the governor on total funding through the Demographic Adjustment from population growth to risk adjusted population growth, should the Commission also consider changing the allocation methodology, which currently uses age adjusted growth.
f. The variable cost factor applied to the Demographic Adjustment is currently 100%. Should future modifications to the policy consider using a variable cost factor more in line with other volume policies, i.e., 50%?
g. Should HSCRC add funding to global budgets in advance of this process. If so, how much and why?

We recommend that the Commission amend the current Demographic Adjustment policy to transition from population growth to risk-adjusted population growth. However, the Commission should not introduce additional utilization-based variables into the population growth calculation, as doing so could undermine the foundational principles of the Total Cost of Care (TCOC) Model.

We also recommend that the Commission maintain the current variable cost factor at 100%. This level appropriately reflects the fixed and semi-fixed costs hospitals must absorb to serve a growing and increasingly complex population.

Given the success of the TCOC model in reducing avoidable utilization, we believe that a portion of age-adjusted population growth that exceeds total population growth should be funded. This recognizes that Maryland hospitals are serving a more complex patient population even as overall utilization remains stable.

Up to 0.5% of funding should be distributed using the current methodology, which ensures predictability and equity across providers.

Lastly, we encourage the Commission to develop and implement a revised risk-adjusted policy prior to January 1, 2026, in close collaboration with industry stakeholders to ensure alignment with the goals of the TCOC Model and the financial sustainability of the hospital system.

3. **Physician Costs**. It is widely understood that rising physician costs are stressing hospital finances. The HSCRC is working on understanding the nature and extent of physician costs for hospitals, and there are legal constraints on the Commission's ability to directly reimburse for physician costs. Are there specific physician costs intrinsic to the operations of the hospital that the HSCRC should consider providing funding for? If so, what physician specialties should be evaluated and under what authority?
   a. Given the complexity of identifying physician subsidies net of professional reimbursements, if the Commission elects to provide additional funding, should the Commission provide an across-the-board increase to hospitals in line with average hospital experience or tailor the adjustment to align with hospital's unique net losses, taking into account things like payer mix and hospital size?
   b. Given the role of payers in addressing physician costs, which are unregulated by HSCRC, how can HSCRC support hospitals while encouraging others to improve their efforts on this challenge?

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c. Can HSCRC support hospitals in addressing physician costs in ways that support value-based care? If so, how?
d. What other ideas do you have for addressing physician costs?

The Commission should conduct a comprehensive comparison of all hospitals' financials from FY 2019 to FY 2024, focusing on total physician subsidies or losses related to key hospital-based specialties: anesthesiology, hospital medicine, emergency medicine, and radiology. These specialties are intrinsic to core hospital operations and essential for maintaining 24/7 access to inpatient and emergency care. Based on this analysis, we recommend a one-time adjustment of up to 0.25% of GBR funding, proportionate to each hospital's losses in these areas.

Since the COVID-19 pandemic, physician workforce costs have risen significantly due to a combination of factors:

- Increased burnout and early retirements
- Rising malpractice insurance premiums
- Private equity-driven market consolidation
- Worsening physician shortages across several specialties

While the HSCRC does not regulate physician reimbursement directly, hospitals are required to absorb growing physician costs to maintain vital services. This situation is placing considerable financial strain on hospitals statewide and threatens access to care, especially in rural and underserved communities.

4. **Surge Funding**. Should the Surge Funding policy become an annual HSCRC policy whereby hospitals are provided funding for volume changes based on their growth in respiratory illness related to RSV, pneumonia, and influenza?
   a. Related to respiratory season, what can reasonably be expected of hospitals in terms of prevention of respiratory disease?

The Commission should permanentize the Surge Funding policy to provide temporary one-time funding adjustment to eligible hospitals. Instead of focusing only on respiratory disease, the Commission should compare all volumes to the previous fiscal winter months. Hospitals become overburden with volumes during the winter months and staffing may be impacted as well due to illness, which requires internal surge contracts or additional agency staffing. Staffing costs balloon during the winter months to handle the surge volumes and rates do not adequately cover these additional volumes and expenses. The funding should be maxed out 0.25% to provide predictably to the model.

The Commission should formalize the Surge Funding policy as an annual, temporary, one-time funding mechanism to assist hospitals in managing the seasonal spike in volumes. However, rather than limiting the policy to respiratory-related conditions such as RSV,

pneumonia, and influenza, the Commission should consider comparing all-cause volume increases during winter months to the same period in the prior fiscal year.

Hospitals consistently experience a seasonal surge in patient volumes during the winter. This strain is compounded by workforce challenges, as staff illness and burnout often necessitate internal surge staffing or increased reliance on costly agency contracts. These operational pressures are not adequately reflected in current rates and can create significant financial strain even under global budget constraints.

We recommend capping the annual surge adjustment at 0.25% of a hospital's GBR to provide predictability and limit exposure, while still acknowledging the real and recurring cost pressures hospitals face each winter.

5. **Preparing for AHEAD.** As part of AHEAD model preparation, we believe federal partners may be interested in projects that use the state's unique information technology platform to support cardiovascular disease prevention and access to healthy food.
   a. How can the state data infrastructure be linked to clinical and community programs to advance cardiovascular health in Maryland?
   b. How can the state data infrastructure be tied to community programs to support nutrition and access to healthy food?
   c. How can Maryland leverage CRISP and other data resources to support such efforts – and measure the outcomes?
   d. What other innovative ideas for statewide programs to prevent chronic disease could be included in AHEAD preparations?

   Given the ongoing uncertainty surrounding the AHEAD model and the significant financial pressures currently facing hospitals, we believe the Commission's immediate focus should remain on stabilizing the existing model, addressing inflationary shortfalls, and ensuring adequate funding for core hospital operations. At this time, investments in new data infrastructure or statewide initiatives should not divert limited resources from these foundational priorities.

   While we support the long-term goal of advancing population health and chronic disease prevention, particularly in areas such as cardiovascular disease and nutrition access, these efforts must be carefully sequenced and fully aligned with the state's fiscal realities and the readiness of the AHEAD model.

We appreciate the opportunity to provide comments on these important funding discussions.

Sincerely,

Joshua Repac

Joshua Repac
Chief Financial Officer
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cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi

Adventist HealthCare

June 27,2025

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

Dear Dr. Kromm

We appreciate the opportunity to provide comments in response to the Commission's request regarding additional spending or investments for FY2026.

We remain deeply concerned that despite Maryland's significant success in generating excess Medicare savings under the Total Cost of Care (TCOC) Model, those resources have not been reinvested to address persistent access gaps in medically necessary acute care. In CY2024 alone, the State exceeded its Medicare savings target by 137%, generating $459 million in excess savings—bringing the total excess to $1.3 billion since 2019. Early trends suggest CY2025 is on a similar trajectory.

These figures represent real resources that could have been used to improve access, expand infrastructure in high-growth regions, and alleviate unprecedented cost pressures on hospitals. Instead, these dollars remain unused.

We respectfully urge the Commission to take immediate action to reinvest excess savings through targeted, equitable, and administratively feasible strategies that strengthen access and align with the goals of the TCOC Model and prepare hospitals for a successful transition to the AHEAD Model.

Access Barriers and the Need for Timely Policy Response

As outlined in previous comment letters, longstanding policy constraints continue to prevent funding from following patients or supporting regional access needs. While HSCRC has corrected errors related to demographic and uncompensated care funding, no structural policy changes have been made despite broad field input in early 2025.

Resolving complex, systemic challenges—such as demographic risk adjustment, market shift recalibration, and physician subsidies—will require thoughtful engagement and adequate time. These longstanding issues cannot realistically be addressed within a matter of weeks. In parallel, meaningful policy refinement depends on a clear understanding of where access to medically necessary acute care is falling short. Yet the State still lacks a framework to systematically assess and monitor these access

gaps. We believe it is both timely and appropriate to prioritize a more pragmatic, near-term approach to ensure savings are reinvested in ways that protect and expand access to care medically necessary acute care.

Immediate Policy Solutions to Reinvest Excess Savings

Given the magnitude of excess savings, we strongly recommend that the Commission consider the following recommendations to ensure resources are immediately reinvested to support access:

- **Release Age-Adjusted Demographic Funding**: Lift the cap and align demographic funding with actual population growth and aging trends. HSCRC already has the data to direct funds to high-growth areas, enabling hospitals to build the infrastructure needed to meet rising demand—especially for aging seniors.

- **Fully Fund Inflation During Periods of Excess Savings**: In a capped environment, underfunding inflation weakens access and undermines the long-term viability of global budgets. The existing update factor methodology could support a 0.52% catch-up adjustment. There is no reason to cap inflation funding during times of excess savings.

- **Address Base Rate Inequities**: Many of today's funding disparities stem from how global budgets were initially set in 2014, favoring hospitals with higher baseline volumes and infrastructure rather than using actuarial estimates and regional per capita planning. Using the existing efficiency methodology, HSCRC can correct inequitable base rates, particularly in under-resourced regions facing barriers to medically necessary acute care access.

These practical solutions can be implemented quickly and would directly support access to medically necessary acute care.

Physician Costs Must Be Funded

Physician subsidies have become an unavoidable and growing cost of hospital-based care. While this may not have been true in the 1970s when HSCRC regulation began, the business environment has changed dramatically. Across the country, hospitals support physician costs through commercial margins and volume growth—options that are unavailable in Maryland. Meanwhile, Maryland has some of the lowest professional reimbursement rates in the nation which drives a higher subsidy requirement.

As a result, physician subsidies are increasingly borne by hospitals. At Adventist HealthCare, these costs have grown 27% above funded inflation, eroding sustainable margins. This is not a new issue, but it is one that must be addressed structurally in the policy framework. In the interim, releasing excess savings as outlined above is a pragmatic step forward.

Refine Surge Funding to Meet System Demands

Adventist HealthCare supports the concept of permanent surge funding but recommends refining the FY25 methodology. The retrospective approach used last year was inconsistent with HSCRC's ECMAD-based volume policies and failed to address real-time access gaps. A real-time or prospective, ECMAD-based approach—aligned with existing policies—would better support timely access to care.

Ensure Acute Care Access Before Launching New Initiatives

While Adventist values long-term population health investments, access to medically necessary acute care must remain the top funding priority for hospitals. Many population health initiatives take years to deliver results at scale and cannot replace the resources required for today's patients.

Redirecting excess savings to programs without near-term impact risks worsening current access gaps. Adventist recommends completing a statewide access assessment before committing funds to long-term strategies that may inadvertently reduce real-time access to medically necessary acute care.

Conclusion: Prioritize Funding Medically Necessary Acute Care and Hospital Sustainability in the Transition to AHEAD

For more than 115 years, Adventist HealthCare has served our communities in Montgomery and Prince George's counties with a mission to extend God's care through physical, mental, and spiritual healing. We are proud to provide high-quality, low-cost care to our community.

While we appreciate HSCRC staff's recent policy adjustments, we urge the Commission to take bold, immediate steps to reinvest excess savings and address growing acute care access barriers. Failing to do so risks compounding structural inequities, restricting acute care access and increased financial strain as Maryland prepares to enter the AHEAD Model.

Now is the time to course-correct so that Maryland's hospitals can meet today's needs and prepare for a sustainable future.

Sincerely,

Katie Eckert

Katie Eckert, CPA
Senior Vice President, Strategic Operations
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cc: Joshua Sharfstein, MD
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June 27, 2025

Jonathan Kromm, PhD, MHS
Executive Director
Health Services Cost Review Commission
Submitted via email to hscrc.payment@maryland.gov

RE: HSCRC Opportunity for Comment on Additional spending or investments for FY 2026

Dear Executive Director Kromm:

The Chesapeake Regional Information System for our Patients ("CRISP"), the state designated health information exchange ("HIE") and health data utility ("HDU") for Maryland, appreciates the opportunity to comment on HSCRC's questions related to additional spending or investments for FY2026.

Overview

CRISP submits comments to the HSCRC on additional investments for FY 2026 as we transition from the Maryland Model to the federal AHEAD Model (States Advancing All-Payer Health Equity Approaches and Development). **The State should consider strategies to sustain the data exchange and initiatives enabled by CRISP. CRISP proposes the concept of a sustainability fund. The fund would ensure ongoing operations, support innovation, and offer an administrative vehicle for programmatic support for priorities identified by the State and Maryland provider community. CRISP has efficient processes to meet Maryland's short- and long-term goals through (1) our model of public-private partnership and (2) our robust, broad-based governance structure.** CRISP has historically enabled the State to fund priority initiatives, for example COVID testing or Integrated Care Network (ICN) care coordination supports. ICN supported the All-Payer Model and served as a steppingstone to the TCOC Model.

Background

As the nation's leading HIE, CRISP helps Maryland drive health care transformation through real-time care coordination, quality and efficiency improvement, population health promotion, and value-based payment. These efforts closely align with the federal vision to shift the health care paradigm from a system that focuses on sick care to one that fosters prevention, wellness, and chronic disease management. CRISP connects thousands of providers across Maryland for improved care management and better health outcomes. CRISP users access data hundreds of thousands of times each week, equipping health care providers with better information about the patients they serve. Providers use data at the point of care, through robust care team alerts and notifications, and comprehensive analytic reports. Dataset linkage is at the core of CRISP capabilities. CRISP integrates clinical data from its HIE with the HSCRC's best in the nation longitudinal case mix data. This enables us to create tools for improving whole person care patterns across payers and over time.

Collective Partnership and Broad-Based Governance for Maryland

The current federal environment threatens Maryland's long history of innovation in health care finance. CRISP's unique position can help protect and promote Maryland's interests. The State and Maryland's provider community collaborated over many years to develop CRISP. Our unique partnership ensures we meet the needs of Marylanders and their providers by supporting access to high-value care. We have an unprecedented track record of success in implementing technology projects. As a private, non-profit entity, CRISP has a degree of independence from political and budgetary pressures. Our broad-based Board of Directors and robust Committee structure ensure public input into decision making.

CRISP Lacks Resiliency to Weather Cuts

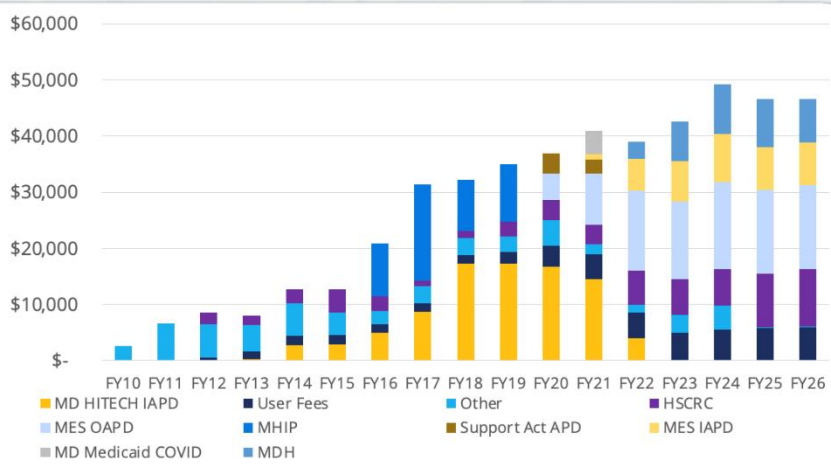
CRISP is core to the delivery of primary, specialty, acute, and long-term care in Maryland. Despite this, CRISP narrowly pieces together funding from an array of sources each year, as shown in the figure below. CRISP is extremely lean. Our funding model tightly aligns revenues and expenses. CRISP approves its annual operating budget to keep net revenue as low as possible, minimizing the financial burden on providers, payers, and the State. The resulting low reserves limit our ability to weather a significant revenue shock.

The all-payer Maryland Model's evolution potentially affects CRISP core funding at a time when policymakers, providers, and community partners need our data infrastructure to understand the health care environment, prepare for changes, and monitor impact. For example, absent the HSCRC assessment, CRISP would lose $13 million annually. The Maryland Department of Health (MDH) accounts for an additional $13 million of annual CRISP funding through combined sources. MDH is also likely facing budget pressure. Because some of the HSCRC assessment and MDH funding serves as the State share for federal Medicaid match, this would translate to a total $42 million loss annually. In the future, CRISP could shift its funding to rely more extensively on user fees. However, that would take time. CRISP's lack of cash reserve means we are unable to weather a dramatic loss of revenue. Cuts to our capabilities and services would be immediate.

Long-term Funding Trend

HSCRC CRISP Funding	
FY 2013	$1,313,755
FY 2014	$1,166,278
FY 2015	$1,650,000
FY 2016	$3,250,000
FY 2017	$2,360,000
FY 2018	$2,360,000
FY 2019	$2,500,000
FY 2020	$5,390,000
FY 2021	$5,170,000
FY 2022	$9,240,000
FY 2023	$6,300,000
FY 2024	$6,500,000
FY 2025	$9,420,000
FY 2026	**$13,060,000**

**Requested funding not including $1M to be used from reserves*



5

Sustainability for CRISP and Programs Supported through Shared Infrastructure

The uncertain future of the Maryland Model combined with the significant savings currently available to the HSCRC create new impetus to ensure stable funding for CRISP and programs supported through shared infrastructure. The HSCRC could explore leveraging CRISP as a protected administrative vehicle to fund initiatives that advance Maryland's short- and long-term health goals. Following are examples.

Core Funding for CRISP Infrastructure. *The HSCRC could allocate funding to CRISP to establish a sustainability fund for multiple years.* The fund and its interest would provide long-term resilience and flexibility for Maryland's data infrastructure and analytic capabilities while maintaining user fees at manageable levels. We are sensitive to providers' and payers' ability to absorb significant user fee increases while confronting reduced revenue related to Medicare payment and/or Medicaid enrollment cuts.

In addition to ensuring core infrastructure remains, sustainability funding would allow CRISP to innovate. CRISP can power the next wave of responsible artificial intelligence (AI) in health care to identify risk, generate insights, and support intervention. For example, CRISP could develop an AI model to calculate cardiovascular risk scores for every Marylander with personalized prevention programs to slow disease development. As another example, CRISP could develop an AI model to give nutritional information and access to fresh food to people at highest risk for diet-related medical complications. These kinds of personalized solutions empower people to better manage their health, a key tenet of the federal administration's vision.

The sustainability fund could also protect CRISP's unique ability to scale data infrastructure for social service providers such as Advancing Innovation in Maryland (AIM) grantees. Our robust governance, data use agreements, and role-based access enable community-based organizations (CBOs), local health departments, and other non-traditional providers to participate in CRISP. These providers often lack connection capability without CRISP support.

CRISP will remain incremental in our approach. We set quarterly goals aligned with stakeholder expectations and conduct rapid cycle development to learn as we go and adjust to unanticipated needs.

Potential for Programmatic Support. *The HSCRC could include sustainability funding to support programs and initiatives at the discretion of our State partners and our broad governance model*. This would enable the State to encumber resources with a mechanism for their deployment. There is precedent for funding direct services through CRISP, including the $75 million commitment to build shared infrastructure under the ICN program. For example, the State and CRISP governance could support hospital-led partnerships deploying strategies to address community priorities.

Physician Alignment Infrastructure and Incentive Funding. CRISP supports the HSCRC's administration of value-based physician alignment programs such as the Episode Quality Improvement Program (EQIP). Given the uncertainty of Medicare's continued participation in Maryland's physician alignment programs, *the HSCRC could fund CRISP to support ongoing physician alignment infrastructure and incentives.* In FY 2025, the State allocated $1.5 for EQIP infrastructure across CRISP and MedChi. Physicians realized $30 million in shared savings in 2024, the most recent year of results. Support for provider engagement would bolster participation by demonstrating the State's commitment to physician alignment. If Maryland transitions away from EQIP to federal models, provider engagement would help Maryland physicians through the transition.

Access to Healthy Food. CRISP's health related social needs screening and closed-loop referral tools offer point of care information on social needs and interventions, including access to healthy food. Hospitals and CBOs can send, receive, and manage food assistance referrals in their systems of preference. Initiatives identify and refer recently hospitalized individuals with high risk of food insecurity. CRISP connects information on food assistance with clinical outcomes such as A1C and hypertension. *The State could fund CRISP to continue to scale up screening and referral infrastructure.* However, lack of food assistance program capacity remains a challenge. *Thus, if other sources are not available the State could fund direct service food programs through CRISP.*

Medicaid Redetermination Tool. CRISP supports Medicaid redeterminations by linking Medicaid panels with clinical and public health data for Federally Qualified Health Centers (FQHCs) and other Medicaid providers to outreach members at risk for losing coverage. This tool becomes increasingly important if federal Medicaid policy changes require more frequent eligibility redeterminations. *The HSCRC could fund CRISP to expand provider outreach so that more providers—particularly FQHCs and other high-volume Medicaid providers—receive education on*

accessing and using Medicaid redetermination reports. Connecting providers to patient outreach teams can also increase use of these reports.

Conclusion

CRISP is committed to continuing our strong track record of collective collaboration and innovation to support the health and well-being of Marylanders. We suggest the sustainability fund as a strategy to ensure that CRISP remains a collective asset available to policymakers, providers and community partners. We look forward to exploring options with the State and our private partners.

Sincerely,

Megan Priolo, DrPH, MHS

Vice President & Executive Director, CRISP Maryland

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

June 27, 2025

Sent Via: HSCRC.PAYMENT@MARYLAND.GOV
Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Additional Spending or Investments for FY2026 – Call for Comments

Dear Dr. Kromm,

On behalf of MedChi, the Maryland State Medical Society, I would like to add to our letter sent May 30th and provide these additional thoughts on the proposed Rate Year (RY) 2026 annual update for Maryland's hospital payments.

We continue to express our concern that the RY2026 update is overly conservative and will hinder the ability of physicians and hospitals to deliver patient care, thereby undermining the goals of the AHEAD Model. As we stated in our May 30th letter, it is imperative that Maryland advocates for a system that is funded at the appropriate levels and takes into account real-life costs and care needs, especially given the added responsibilities in the AHEAD Model (e.g., investments in workforce, clinical redesign, infrastrucutre and community health) as compared to the current Total Cost of Care (TCOC) Model.

For purposes of this letter, two specific areas of concern for MedChi are: 1) CRISP funding; and 2) age-adjusted demographic growth. CRISP has become a cornerstone of our healthcare delivery system. Through CRISP, physicians and other healthcare practitioners can meet patient care needs in a coordinated and streamlined manner by sharing data and other care services across the entire continuum, including primary, specialty, acute, and long-term care. CRISP is also instrumental in its support of advanced care models, such as EQIP, which provide cost savings to the State. Despite the State continuing to expand the role and functions performed by CRISP, the State has failed to provide sustainable funding, requiring CRISP to operate under a changing patchwork of funding sources. Without sustainable funding and due to the precarious nature of the current funding streams available to it, MedChi is concerned that CRISP may be at risk of being unable to fully support the AHEAD Model and the healthcare delivery system at large. Therefore, MedChi strongly encourages the HSCRC to collaborate with CRISP and stakeholders on developing sustainable funding for CRISP.

In addition, MedChi agrees with the Maryland Hospital Association that an additional 0.65% per year should be included in the update to reflect costs associated with an aging population. While the proposed update factor consists of an additional 0.76%, it is essential to note that the HSCRC itself acknowledges that this increase reflects revised historical data and does not account for

increased future utilization resulting from a continuing aging population. In addition to the data cited from the Maryland Department of Planning, the Maryland Department of Aging notes that the fastest-growing population in Maryland is the 60+ population, with one in every four Marylanders being over the age of 60 by 2030. The time to prepare for this population growth and increased healthcare utilization is now. The HSCRC cannot operate in a silo and must acknowledge this growth and the work being done by other State agencies to ensure that Maryland can appropriately support the healthcare needs of this population.[1] Therefore, we again respectfully request that the HSCRC include an additional 0.65% per year to account for this population growth.

Thank you for the opportunity to comment, and I look forward to continuing our work together.

Sincerely,

Gene Ransom
Chief Executive Officer
MedChi, The Maryland State Medical Society

cc:

Dr. Meena Seshamani, Secretary, Maryland Department of Health
Dr. Joshua Sharfstein, Chairman, HSCRC
Dr. James Elliott, Vice Chairman, HSCRC
Ricardo Johnson, Commissioner, HSCRC
Dr. Maulik Joshi, Commissioner, HSCRC
Adam Kane, Commissioner, HSCRC
Nicki McCann, Commissioner, HSCRC
Dr. Farzeneh Sabi, Commissioner, HSCRC

[1] Longevity Ready Maryland - LRM

Luminis Health

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

June 27th, 2025

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

Dear Dr. Kromm,

On behalf of Luminis Health, thank you for the opportunity to provide comments on potential additional investments for FY 2026. We appreciate the HSCRC's thoughtful work in finalizing the FY 2026 Update Factor. However, we remain concerned that the approved recommendation is overly conservative in light of historical underfunding, excess model savings, and persistent economic and political volatility.

Inflation Corridor

We strongly support the correction of inflation funding when prior-year projections fall short of actual inflation. Underfunded inflation, especially when sustained over time, compounds financial strain on hospitals already operating under tight margins. If unaddressed, this underfunding undermines hospitals' ability to invest in care transformation, workforce stabilization, and quality improvements. Timely correction of underfunded inflation is necessary to maintain the system's stability.

In the event that inflation projections exceed actual inflation, we believe the Commission's response should be contingent upon the broader model context. When model savings exceed targets and waiver guardrails are secure, overfunded inflation should not be automatically recalibrated. This flexibility enables hospitals to reinvest in long-term strategic initiatives that benefit population health and advance total cost of care goals. However, if overfunded inflation contributes to risk of breaching waiver guardrails or failing to meet savings targets, we support a measured claw-back approach.

Risk Adjustment

The development of a risk-adjusted demographic adjustment is a complex and consequential policy change that warrants careful modeling and evaluation. At this stage, it would be premature to commit to specific methodological approaches. The implications of various risk adjustment options, including data sources, population scope, and utilization benchmarks, must be fully analyzed to understand their impact on hospital funding. We recommend that a stakeholder workgroup continue to explore and compare alternative approaches before the Commission finalizes any specific proposal. A data-driven process will be critical to ensure that any changes are equitable, sustainable, and operationally feasible for Maryland hospitals.

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We strongly urge the Commission to release the age-adjusted demographic funding amount of 0.65% proposed by the Maryland Hospital Association during the update factor recommendation process. Maryland hospitals are already facing significant underfunding relative to the care required by our aging population. Since FY2022, LH demographic adjustments have underfunded age-adjusted population changes by $38.7 million. Demographic shifts, particularly the increase in older adults with higher acuity and chronic conditions, have placed mounting pressure on hospital resources, capacity, and workforce.

Delaying this needed funding while a longer-term risk adjustment methodology is being developed only compounds the financial strain. Providing age-adjusted funding now serves as a necessary bridge to support hospitals as they continue to meet the evolving needs of their communities. This is a prudent and targeted investment that maintains system stability while allowing time to fully explore, model, and recommend a comprehensive risk adjustment framework for future years.

Physician Costs

Hospital-based physicians are fundamental to the effective operation and continuous delivery of acute care services. The traditional model of the volunteer medical staff member who is an independent private practice physician conducting daily rounds and remaining on-call around the clock does not exist in today's care delivery system. Contemporary hospital care requires comprehensive, around-the-clock physician coverage across a range of critical specialties, each presenting distinct operational and financial challenges. These are all costs attributed to the health system.

Hospitalists – Medical, Obstetric, and Surgical – serve as the backbone of inpatient medical care, providing 24/7 coverage for medical admissions, coordinating care across multiple specialties, and managing complex discharge planning. These physicians require continuous staffing models that often necessitate premium compensation packages to ensure adequate coverage during nights, weekends, and holidays. The professional fee reimbursement for these services does not match the market rates commanded by these physicians.

Intensivists represent one of the highest-cost physician specialties, providing life-saving critical care services in intensive care units where patient acuity demands immediate availability and specialized expertise. The limited supply of board-certified intensivists nationwide drives compensation costs significantly above general medicine rates.

Emergency medicine physicians, like the hospitalists and intensivists, must maintain continuous departmental coverage, requiring sophisticated scheduling models and premium compensation for overnight and weekend shifts when patient volumes remain high, but staffing is challenging.

Radiology services have evolved beyond traditional diagnostic imaging to include interventional procedures and real-time consultation, requiring both on-site coverage and expensive teleradiology backup systems to ensure 24/7 availability for emergency and critical care needs. In this current environment, the ability to staff in-house radiology services is dramatically limited, given that there are daytime roles being filled at a premium.

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Anesthesia services are essential not only for surgical procedures but also for obstetric care, emergency interventions, and critical care procedures, requiring immediate availability that often necessitates call coverage compensation and specialized training premium pay. Unfortunately, the Maryland supply of anesthesiologists is limited, and demand is high. That supply has been limited by restrictive covenants and the failure of large private equity-based entities.

These services are indispensable to ensuring timely access and high-quality care, yet they impose a substantial and growing financial burden on hospitals that should be considered in the global budget. The complexity of maintaining adequate coverage across these specialties, combined with physician shortage pressures and the premium costs associated with hospital-based practice, creates significant operational expenses. For LH in fiscal year 2020, hospital-based physician expenses exceeded the associated revenue by $43.6 million, with projected losses anticipated to reach $70.1 million in fiscal year 2025, an increase of approximately 60% over five years.

Although these expenses fall outside the regulatory purview of the HSCRC, they are directly tied to the quality, safety, and continuity of inpatient care. Today, these services are an unrecognized cost of delivering care. Maryland ranks in the lowest decile nationally for commercial payer reimbursement of professional services, exacerbating the issue across all these critical specialties. The underfunding particularly impacts specialties requiring continuous coverage models, as hospitals must absorb the costs of maintaining adequate physician staffing regardless of reimbursement levels. It is imperative that Maryland adopt a dedicated funding mechanism that recognizes the essential nature of these comprehensive physician services. Funding should be applied in an across-the-board fashion, with a distribution based on ECMADs, to hold hospitals accountable for managing their physician losses while ensuring adequate coverage across all critical specialties.

Surge Funding

Luminis Health supports making the Surge Funding policy a permanent annual adjustment. Seasonal surges in respiratory-related illnesses—particularly RSV, pneumonia, and influenza—are a recurring challenge that places substantial strain on hospital capacity and resources. These surges are not addressed under existing volume policies, which are not designed to respond to the acute and short-term nature of these volume spikes. Embedding Surge Funding as a standing policy ensures that hospitals have a reliable mechanism to support care delivery during periods of heightened demand, without compromising other essential services. Additionally, to maximize its impact, we recommend that the HSCRC consider accelerating the timing of funding, ideally providing support in closer to real-time or shortly after the surge period concludes. This would better align resources with operational needs and enable hospitals to respond more effectively during high-demand periods.

Other Investments

Cybersecurity has become an increasingly significant risk for Maryland hospitals in recent years. Several incidents across the state have had a substantial impact on hospital operations, underscoring the urgency of addressing this threat. The capital and operational investments required to defend against

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cyberattacks have grown considerably. Luminis Health expects to spend nearly $4 million on cybersecurity in FY25—more than double the $1.8 million spent in FY2020. Supporting these costs within the GBR framework is a necessary investment in safeguarding Maryland's healthcare infrastructure.

The national rise in workplace violence has placed an increasing financial and operational burden on hospitals, requiring significant investments in physical security to protect staff, patients, and visitors. Hospitals across Maryland are enhancing security infrastructure, increasing personnel, and implementing new safety protocols to respond to this growing threat. These are necessary but costly measures that are also not reflected in hospitals' global budgets.

Conclusion

Luminis Health appreciates the HSCRC's work in finalizing the FY 2026 Update Factor. However, additional action is urgently needed to support hospitals as they face increasing financial strain and rising patient needs. Immediate, targeted funding will help ensure Maryland hospitals remain stable, responsive, and able to deliver high-quality care to the communities they serve.

Sincerely,

Michelle Lee
Chief Financial Officer
Luminis Health

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

Ascension Saint Agnes

June 27, 2025

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

Dear Dr. Kromm,

On behalf of Ascension Saint Agnes, I am writing today to respond to the recently released request for comments following the Health Services Cost Review Commission's (HSCRC) most recent public meeting on June 11, 2025.

Inflation corridor. *If the HSCRC were to remove the corridor this year, what should be the approach in future years, if inflation is above or below what is projected? If inflation is overfunded, should the Commission consider not recalibrating when its various savings targets are met?*

Given the ongoing financial pressures being experienced by Maryland's hospitals and the recognition by HSCRC staff that inflation is currently underfunded by 0.52%, Ascension Saint Agnes recommends releasing additional inflation funding to the industry. Maryland's hospitals continue to greatly exceed the savings target established with the Centers for Medicare and Medicaid Services (CMS) Innovation Center under the Total Cost of Care (TCOC) Model. This target should govern the amount of funding available to Maryland's hospitals rather than developing separate calculations that may result in underfunding of the industry and excess savings beyond the target.

Demographic funding. *The HSCRC announced a process for developing a proposal to risk adjusting the Demographic Adjustment, population growth for a vote in 2025.*

Ascension Saint Agnes supports the development of a staff recommendation to fully fund age-adjusted demographic growth in Rate Year (RY) 2026. Refining the current policy was identified as a priority by HSCRC Commissioners at the December retreat and has been the subject of ongoing comments from the industry. Providing adequate funding to hospitals in recognition that additional acute care will be needed to care for an aging population is an important update to the methodology and consistent with the goals of the TCOC Model. Ascension Saint Agnes supports HSCRC staff quickly developing a staff recommendation for Commissioner consideration.

Physician costs. *It is widely understood that rising physician costs are stressing hospital finances. The HSCRC is working on understanding the nature and extent of physician costs for hospitals, and there are legal constraints on the Commission's ability to directly reimburse for physician costs.*

Funding a sufficient physician workforce is critical to operating an acute care hospital and providing the necessary ambulatory network to care for patients in the community. The care model has dramatically changed since the original HSCRC statute was put into place, with physicians increasingly seeking

hospital employment. Ascension Saint Agnes supports the HSCRC establishing a workgroup to examine this issue and make recommendations, including necessary statutory changes, by the end of Calendar Year 2025.

Thank you for the opportunity to provide comments.

Sincerely,

Beau Higginbotham

cc: Dr. Meena Seshamani, Secretary, Maryland Department of Health
Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, Vice Chairman
Jon Blum
Ricardo Johnson
Dr. Maulik Joshi
Nicki McCann
Dr. Farzaneh Sabi

LIFEBRIDGE HEALTH®

CARE BRAVELY

Jon Kromm
Executive Director, HSCRC

June 27, 2025

Jon,

On behalf of LifeBridge Health, I am writing in response to the Commission's request for comments regarding additional funding for hospitals and AHEAD-related preparations. We value the ongoing dialogue with the Commission and are appreciative of recent actions to correct demographic and uncompensated care funding allocations.

In addition to responding to the policy-specific inquiries, LifeBridge urges the Commission to use total cost of care (TCOC) savings as an indicator of the amount of financial relief available to hospitals. These excess savings—now $450 million above target-- present a valuable opportunity to address continued unanticipated financial pressures that have emerged since the establishment of the all-payer rate setting system and global budget revenues.

While we appreciate the Commission's commitment to developing sustainable policy solutions, we urge consideration of immediate financial relief for hospitals, which could be reconciled with a more comprehensive policy framework over time.

We remain committed to working with the Commission to ensure the long-term viability of the Model and, most importantly, to maintain access to high-quality, safe care for all Marylanders. Please see page two of our letter for detailed responses.

Sincerely,

David Krajewski
EVP & CFO, LifeBridge Health

1. **Inflation Corridor**. If the HSCRC were to remove the corridor this year, what should be the approach in future years, if inflation is above or below what is projected? If inflation is overfunded, should the Commission consider not recalibrating when its various savings targets are met?

   We are supportive of a policy that acknowledges both over and underfunding of inflation within certain guardrails but believe the 1% corridor is too high to allow for appropriate additional funding. More importantly, the corridor should be considered in the context of the TCOC savings target, with excess savings being the primary indicator of success.

2. **Risk Adjustment**. The HSCRC announced a process for developing a proposal to risk adjusting the Demographic Adjustment, population growth for a vote in 2025. Questions include:

   a. Should risk assessments be based on national utilization so as to remove TCOC Model impacts?

      We encourage the Commission to present modeling on the impact of risk adjustment based on national utilization compared to basing it on the Maryland population.

   b. Should TCOC Model impacts play any role in determining the total available funding provided by the Demographic Adjustment?

      Hospital rate increases have historically been limited by an assessment of the state's ability to meet the TCOC savings target. The Commission should similarly consider excess savings to determine positive adjustments.

   c. If national assessments of utilization reflect incentives to provide services in a Hospital Outpatient Department should the Commission consider additional adjustments to neutralize the lack of site neutral incentives in the national market?

      We request additional clarification on the intent of this question.

   d. In the event that the Commission cannot incorporate a frequently updated risk adjusted beneficiary count so as to adjust for more than just the aging of the population, should the Commission consider utilizing the growth in Medicare's Hierarchical Condition Categories (HCC's) either for the Medicare only population or extrapolated across the entire Maryland population?

      As noted in our April 24th comment letter to Mr. Pack, LifeBridge supports the use of HCCs, as it aligns with the AHEAD methodology, but in future years, the Commission should continue to explore whether other factors allow for better risk adjustment.

      If the Commission extrapolates the HCC methodology across all-payers, modeling would need to occur to determine appropriateness. Extrapolation has been used in other HSCRC methodologies and may not be appropriate for certain service lines, like OB/GYN. The Commission should also prioritize the use of an all-payer claims database to ensure appropriate risk adjustment.

   e. If the Commission elects to change the governor on total funding through the Demographic Adjustment from population growth to risk adjusted population growth, should the Commission also consider changing the allocation methodology, which currently uses age adjusted growth.

We encourage the Commission to engage the hospital field in a work group process to further understand the impact of changing the allocation methodology as it adjusts the governor of total funding.

f. The variable cost factor applied to the Demographic Adjustment is currently 100%. Should future modifications to the policy consider using a variable cost factor more in line with other volume policies, i.e., 50%?

Unlike other methodologies, such as market shift, that fund increases and decreases in volume at a 50% variable cost factor, hospital GBRs were established under the pretense that volumes for their population existed in the system overall, and a hospital was given full credit for this patient population. Similarly, any new additional population growth should initially be funded at 100%.

g. Should HSCRC add funding to global budgets in advance of this process. If so, how much and why?

The Commission should provide the .65% request submitted by MHA while working on a more precise methodology, which can be reconciled in the January rate orders.

3. **Physician Costs**. It is widely understood that rising physician costs are stressing hospital finances. The HSCRC is working on understanding the nature and extent of physician costs for hospitals, and there are legal constraints on the Commission's ability to directly reimburse for physician costs.

   a. Are there specific physician costs intrinsic to the operations of the hospital that the HSCRC should consider providing funding for? If so, what physician specialties should be evaluated and under what authority?

   At a minimum, the HSCRC should consider providing funding for essential services, such as emergency room and hospitalist services, anesthesia, and OB/GYN, and radiology.

   b. Given the complexity of identifying physician subsidies net of professional reimbursements, if the Commission elects to provide additional funding, should the Commission provide an across-the-board increase to hospitals in line with average hospital experience or tailor the adjustment to align with hospital's unique net losses, taking into account things like payer mix and hospital size?

   To the extent possible, the Commission should attempt to provide funding that considers the unique circumstances of a hospital.

   c. Given the role of payers in addressing physician costs, which are unregulated by HSCRC, how can HSCRC support hospitals while encouraging others to improve their efforts on this challenge? Can HSCRC support hospitals in addressing physician costs in ways that support value-based care? If so, how?

   d. What other ideas do you have for addressing physician costs?

4. **Surge Funding**. Should the Surge Funding policy become an annual HSCRC policy whereby hospitals are provided funding for volume changes based on their growth in respiratory illness related to RSV, pneumonia, and influenza?

a. Related to respiratory season, what can reasonably be expected of hospitals in terms of prevention of respiratory disease?

5. **Preparing for AHEAD.** As part of AHEAD model preparation, we believe federal partners may be interested in projects that use the state's unique information technology platform to support cardiovascular disease prevention and access to healthy food.

   a. How can the state data infrastructure be linked to clinical and community programs to advance cardiovascular health in Maryland?

   b. How can the state data infrastructure be tied to community programs to support nutrition and access to healthy food?

   c. How can Maryland leverage CRISP and other data resources to support such efforts – and measure the outcomes?

   d. What other innovative ideas for statewide programs to prevent chronic disease could be included in AHEAD preparations?

6. Are there any other funding areas that have not been considered in the questions above?

June 27, 2025

Dr. Jon Kromm
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 provide input on additional spending or investments for FY 2026. Recognizing the excessive savings that the model is producing certainly gives the HSCRC the ability to provide hospitals with much needed financial support. We believe that any adjustments should be made effective July 1, 2025, so that hospitals start to see the benefits of these adjustments as soon as possible. JHHS is also committed to working with HSCRC staff and the industry to help with any policy issues that may need to be addressed to implement these adjustments.

JHHS's comments are outlined below.

Inflation Corridor

JHHS supports relaxing the corridor on underfunded inflation and allowing the 0.52% to flow into hospital rates. If the state is meeting or exceeding the savings goals of the model, additional inflation should be included/remain in rates.

Risk Adjustment

JHHS supports the process for developing a more comprehensive demographic policy. We also believe that the risk adjustment should be consistent with the AHEAD model, understanding that there may be complicating factors that would make that more difficult. The basic concept that we are in favor of would be to utilize the age/risk adjusted demographic amount to set the total amount that would be available to fund medically necessary care in the state. We believe that it is important for the HSCRC to continue to collaborate with the hospitals to identify potential refinements to its volume policies, including the demographic adjustment. JHHS believes that funding for age-adjusted demographic growth presents an opportunity to more accurately fund volume changes associated with population growth in the near-term while broader policy changes are considered. Understanding that this could take some time to work through the details, we support the MHA's proposal to fund an additional 0.65%

effective July 1, 2025, until a more complete methodology can be developed and believe that should be done on a hospital specific basis.

Physician Costs

JHHS appreciates the need for the HSCRC to look at physician costs. One concern that we have is that we would not want to reward hospitals business decisions that would result in overpaying for physician services. If there is to be some sort of inclusion of physician expenses, it should be done in a more standardized way and not as a straight pass through.

Surge Funding

JHHS believes that surge funding should be made permanent and should become part of an annual HSCRC policy. It is highly likely that what we have seen in the recent years with respiratory illness has become the new normal and the HSCRC policies should reflect the new normal.

Preparing for AHEAD

JHHS believes that until hospitals are adequately funded for all the above-mentioned items, no additional amounts should be added to rates for expenses that don't currently exist.

Thank you for the opportunity to share comments and feedback. JHHS looks forward to continued collaboration in pursuit of the goals of the Maryland Model.

Sincerely,

Ed Beranek

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

cc: Dr. Joshua Sharfstein, Chair
Dr. James Elliott, Vice Chairman
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi

JOHNS HOPKINS
SCHOOL of NURSING

To: Health Services Cost Review Commission (HSCRC)
From: Sarah Szanton, Dean and Natalia Barolín, Sr. Health Policy Adviser
Date: June 27, 2025
Subject: Re: Additional Spending or investments for FY 2026: Preparing for AHEAD

We have provided comment below in response to questions 5a – d for suggested investments as the HSCRC prepares for AHEAD:

Leveraging CRISP Data Infrastructure to Improve Cardiovascular Health in Maryland: Data-Driven Approach to Individual and Community Risk

The HSCRC can improve cardiovascular health outcomes at the individual and community levels by leveraging CRISP's data infrastructure to target both individual and community risk in a tiered approach. By combining CRISP's individual and community health data with other data sources, such as SDOH data and patient input, Maryland can identify high-risk populations, assess social needs, and map both available resources and service gaps (such as food pantries) to comprehensively improve cardiovascular health statewide.

Individual Risk Stratification Strategy

For individuals, the system would work as follows:

- An authorized entity would access cardiovascular (CVD) risk data that stratifies Marylanders as low, rising, or high risk
- This data would integrate CRISP information with geo-maps of social determinants of health assets (food pantries, Farmer's Markets, full-service grocery stores)
- **Low CVD risk individuals** would receive access to an app—available via smartphones, library kiosks, or community locations like laundromats—providing nutrition guidance, activity recommendations, and screening information, plus home blood pressure monitors
- The app would not just dispense advice, it would capture individual health goals, respond to questions, and offer neighborhood-specific resources using people's own goals as its north star.
- **Rising risk individuals** would receive home blood pressure monitors and personalized coaching through the app in addition to the services accessed by low risk individuals.
- **High risk individuals** would receive all previous interventions plus in-person visits with home visiting nurses and community health workers.

Integrating CRISP data with information from people's lived experiences would enable appropriate "tiering" and personally tailored interventions based on behavioral science principles that drive sustainable change.

Community-Level Intervention Strategy

For communities, CRISP would identify high-risk areas for cardiovascular disease by combining health data with geo-mapping of social determinants, including food availability and access to physical activity spaces. High-risk neighborhoods would receive dedicated support from a nurse and community health worker team with nurse practitioner support as needed.

Neighborhood Nursing: A Ready Implementation Vehicle

Neighborhood Nursing, already recognized with an Advancing Innovation in Maryland Award, provides an established framework for this initiative. The program leverages community strengths to tailor health and social care for populations at greatest risk for cardiovascular disease and poor nutrition.

This solution is turnkey because:

- It is already being piloted in Baltimore
- Expansion to a rural area has started and suburban neighborhood is planned
- Early results show the need and the promise—in the first 6 months of the Johnston Square pre-pilot, 89% of people screened had stage 1-2 hypertension despite having prescribed medications and most having primary care. They didn't access it or didn't have ways to monitor their blood pressure or get fresh good.
- The RN and CHW team model has successfully provided clinical and social support for hypertension management, including connections to nutritional resources.

Implementation Partners and Investment Needs

Health Care Access Maryland (HCAM) implements Neighborhood Nursing, bringing extensive experience addressing complex health and social needs in historically underserved populations. The Johns Hopkins School of Nursing (JHSON) provides concept leadership, data infrastructure development, implementation guidance, and evaluation.

With a $40 million investment, HCAM and JHSON are prepared to:

- Expand to 9 new neighborhoods (3 urban, 3 rural, 3 suburban) over 3-5 years
- Develop interoperable data infrastructure linking to state systems

- Measure outcomes in cardiovascular health, nutrition, priority HEDIS measures, and SIHIS Domain goals
- Create a predictive "knowledge infrastructure" informed by implementation, including the qualitative data of peoples and communities own goals, to inform resource planning and allocation

Care Coordination and Expected Outcomes

Neighborhood Nursing connects to the broader healthcare system by:

- Helping individuals access existing primary care
- Providing direct primary care through telehealth or neighborhood-assigned nurse practitioners
- Facilitating appropriate specialty referrals (cardiologists, nephrologists, etc.)
- Providing CHW support in referring and navigating access to social needs resources and ensuring needs are met through ongoing support and engagement
- Creating the infrastructure for the CHW and RN team to more effectively coordinate resources between social needs services, health systems, and others systems shaping CVD outcomes.

These connections will improve cardiovascular health across Maryland, prevent disease complications as well as the development of CVD in the first place among those who are low and rising risk. Through this improved care model, Maryland can reduce hospitalizations and demand on our overstretched health systems and workforce, and emergency department wait times while increasing appropriate primary and specialty care utilization to improve health.

We appreciate the opportunity to comment and look forward to partnering with the state to improve the health and well-being of all Marylanders.

JOHNS HOPKINS
SCHOOL of NURSING

To: Health Services Cost Review Commission (HSCRC)
From: Sarah Szanton, Dean, Natalia Barolín, Sr. Health Policy Adviser, and Bethany Hall-Long, former Governor of Delaware
Date: June 27, 2025
Subject: Re: Additional Spending or investments for FY 2026: Preparing for AHEAD

We have provided comment below in response to questions 5a – d for suggested investments as the HSCRC prepares for AHEAD:

Implementing an AI Smart Food Program to Enhance Access to Nutritious Foods for Maryland SNAP Recipients

The Health Services Cost Review Commission (HSCRC) could address food insecurity and the health of Marylanders by implementing a program that uses the same model that Priceline did with hotels and airlines but does it with food that will spoil if not sold. The SNAP Smart Food Program is an innovative AI-driven platform that could connect Maryland's 670,866 SNAP recipients with affordable, nutritious food options while reducing food waste and extending the purchasing power of SNAP benefits. At an annual cost of $6.54 per SNAP participant (total $4,386,707 for year one), this program represents a cost-effective approach to addressing food insecurity and improving health outcomes for low-income Marylanders.

The Challenge: Food Insecurity in Maryland

Maryland faces significant challenges in food access and nutrition. One in three Marylanders experiences food insecurity. Food insecurity is directly linked to poor health outcomes, particularly cardiovascular disease, diabetes, and other chronic conditions that drive healthcare utilization and costs. Addressing this issue aligns with HSCRC's mission to promote efficient, high-quality healthcare delivery while controlling costs.

The Solution: r4's AI Smart Food Program

The r4 SNAP Smart Food Program leverages artificial intelligence to create a "Smart Surplus Marketplace" that benefits all stakeholders in the food system:

How It Works

1. Data Integration and Analysis: The system collects anonymized SNAP recipient shopping data to create local demand signals.

2. AI-Powered Forecasting: r4's AI technology forecasts demand and identifies optimal SNAP-eligible items by store location.

3. Smart Surplus Marketplace: Producers and retailers allocate surplus inventory at discounted prices to SNAP recipients, reducing waste while increasing sales.

4. Digital Consumer Interface: SNAP recipients access the SNAP Smart Shopper™ mobile app to receive personalized recommendations, digital coupons, nutrition information, and healthy recipes.

5. Improved Purchasing Power: The program delivers 2-3 times greater buying power for healthier foods through targeted discounts.

Benefits for Maryland

- For SNAP Recipients: Increased purchasing power for nutritious foods, personalized nutrition guidance, and improved food access

- For the Healthcare System: Better nutrition leading to improved health outcomes and reduced healthcare utilization

<u>Less relevant for the HSCRC but still important societal benefits:</u>

- For Retailers and Producers, particularly in low-income areas that struggle to keep grocery stores open: Reduced food waste, lower disposal costs, improved inventory management, and increased sales
- For the Environment: Significant reduction in food waste supporting sustainability goals. Estimates vary for the percentage of food that is thrown out by grocery stores but it is often 30% with the highest rate being apples, strawberries and yogurt. These items could be nutritious food for people on SNAP.

This program has already been implemented by Delaware and is being piloted in Florida. If the state of Maryland wanted to also include people that CRISP identifies as high utilizers of health care who are not part of SNAP, this could also be part of a Maryland-specific program. The HSCRC has an opportunity to address food insecurity while improving health outcomes and reducing healthcare costs. This innovative approach aligns data infrastructure with public health goals of reducing diet-related health conditions.

Maryland
Hospital Association

June 27, 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 in response to the Health Services Cost Review Commission's (HSCRC) call for public comments on additional spending or investments for FY 2026. We appreciate HSCRC's engagement to identify necessary near-term investments missing from the RY 2026 update approved by the Commission earlier this month.

Hospitals and health systems need additional funding relief at the outset of RY 2026 to continue to care for Marylanders at the same level while addressing both unprecedented cost pressures and Model transition uncertainties. The areas of investment identified by HSCRC in the call for comments—and, in particular, those related to the inflation corridor, risk-adjusted demographic growth, physician costs, and respiratory surge funding—could help address unmet needs and support hospitals and health system efforts to care for their communities.

We offer the following recommendations for consideration by HSCRC staff and Commissioners.

Inflation Corridor

MHA supports suspension of the inflation corridor and the provision of an additional 0.52% in catch-up funding for past underfunded inflation in RY 2026. This may help to offset challenging financial conditions and exceptional cost pressures hospitals and health systems are facing related to tariffs, potential cuts to Medicaid funding, rising insurer denials, and increasing physician costs. We believe the corridor should continue to be suspended in future rate years if the state is meeting its Medicare TCOC savings targets under the Model. While inflation has consistently been underfunded in recent years, exacerbating financial pressures on hospitals, the Commission should only claw back an overfunding of inflation when necessary to meet savings requirements so that hospitals can maintain essential investments in staffing, services, and care delivery.

Risk Adjustment

The questions presented by the Commission regarding potential changes to the methodology for risk adjustment highlight the complexity of adopting an alternative to the age-adjusted approach

for funding demographic growth. MHA is supportive of HSCRC's efforts to pursue a more comprehensive risk adjustment approach for the future; hospitals cannot afford to wait for long-term policy refinements. For this reason, MHA recommends an additional 0.65% in funding to account for the average annual amount of age-adjusted demographic growth between 2020 and 2024. Such action must occur in the near term to more accurately fund volume changes associated with population growth. This incorporates one important risk factor (age) into the demographic adjustment while longer-term policy refinements are being considered.

If there is a preference for aligning the variable cost factor (VCF) applied to demographic growth with the VCF used in other volume policies, a more appropriate VCF must be utilized to recognize a greater share of overall costs as variable than the existing methodology, which assumes all costs are 50% variable. MHA previously requested that HSCRC adopt an approach that uses the annual filing to calculate VCF percentages by rate center, applies the calculated rate center-specific VCFs to service line/rate center charges, and calculates service-line specific VCFs to apply statewide. Evaluating costs on a service line basis would more accurately fund hospitals for changes in volume. We also encourage HSCRC to explore whether volume growth due to demographic change is inherently different from other types of volume growth and if additional funding is required to offset greater fixed costs before modifying the existing demographic adjustment policy.

Finally, the Commission presented a few questions about accounting for TCOC Model impacts and site neutral incentives in the demographic adjustment. We would appreciate clarification on what is being considered and the rationale for such adjustments in order to provide meaningful feedback on these changes.

Physician Costs

Hospitals have seen a significant spike in financial losses due to costs associated with employing or contracting with physicians—addressing the rising costs for essential physician coverage remains a top priority for our member hospitals and health systems.

Physician costs are an essential acute care hospital expense and MHA urges HSCRC to act swiftly to provide a means for hospitals to cover these costs in global budget revenue (GBR) payment policies. HSCRC should enable hospitals to cover physician subsidies through an increase in hospital rates. A long-term solution may require adoption of policy levers and contracting approaches that increase professional reimbursement and reduce losses for physician services. In recognition of this need, HSCRC could approve a methodology that initially provides full coverage of physician subsidies 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. Alternatively, the Commission could consider establishing a floor for physician reimbursement based on a percentage of the Medicare fee schedule and adjusting commercial differentials to enforce these requirements.

Any approach adopted by HSCRC should include the use of a reasonable benchmark and standardized methodology for physician costs applicable to all Maryland hospitals. At a minimum, the policy should provide funding for physician services that are necessary to operate

an acute care hospital, including but not limited to hospitalists, emergency department physicians, anesthesiologists, and behavioral health specialists.

Surge Funding

MHA supports a permanent surge funding policy to provide funding to hospitals through rates to address increased hospital volumes associated with growth in respiratory illnesses including RSV, pneumonia, and influenza. The increased intensity of the 2024-2025 respiratory season is indicative of a new normal and is expected to continue in the upcoming season and in years to come.

Under a permanent policy, the amount of funding provided to each hospital should be based on the most recent case mix data. Additionally, the permanent policy should provide funding to all hospitals that experience growth in respiratory volumes, unlike the RY 2026 surge policy which reduced the availability of surge funding for hospitals that experienced offsetting declines in volume for other health care services.

Policy changes at the federal level and a reduction in vaccination rates may limit the ability of hospitals to implement impactful respiratory disease prevention efforts. Accordingly, MHA respectfully requests that the Commission not impose requirements on hospitals that are challenging and costly to implement with limited impact.

Other Investments

In our May 21 comment letter on the RY 2026 annual payment update, we detailed the exceptional cost pressures Maryland hospitals face. Among these, cybersecurity and campus security have emerged as exceptional challenges. Investment in these areas is critical to safeguard patients, staff, and visitors amidst growing sophisticated cyberattacks and a national rise in workplace violence in hospital settings. Both areas require significant and ongoing capital and operational investments that are not adequately provided for under the standard GBR and rate-setting methodologies. We encourage HSCRC to adopt funding approaches that better support hospitals in protecting the safety of their patients, data, and workforce.

Finally, before pursuing new AHEAD model preparation funding initiatives, including worthy efforts such as leveraging Maryland's unique information technology platform to support cardiovascular disease prevention and access to healthy food, we believe it is imperative to ensure basic, foundational resources are available for hospitals to adequately manage existing, escalating, cost burdens. Without first stabilizing hospital financial footing, layering on new initiatives may unintentionally weaken the ability of hospitals to deliver core services and meet Model goals.

Adequate funding is essential to maintain high-quality patient care and ensure a steady foundation for Maryland's hospital system.

****

In closing, MHA emphasizes additional investments in these areas are critical and necessary as we work together to advance the health and wellbeing of Marylanders.

Thank you for the opportunity to comment on this important matter. If you have any questions, please do not hesitate to contact me.

Sincerely,

Melony G. Griffith
President & CEO

cc: Dr. Joshua Sharfstein, Chair
Dr. James Elliot
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
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Susan K. Nelson
Executive Vice President and
Chief Financial Officer

June 27, 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's seven Maryland acute care hospitals, I write in response to the Health Services Cost Review Commission's request for stakeholder comments on the topic of Additional Spending or Investments for FY2026. MedStar fully supports the comments made in the letter submitted by the Maryland Hospital Association and urges the HSCRC to take action during the July 2025 meeting to address near-term investments missing from the approved FY26 update factor. Overall financial performance of Maryland's hospitals is lagging behind hospitals nationally while the state has achieved a TCOC savings rate of approximately $800 million for calendar year 2024, approximately $500 million over the required level. Now is the time to invest a portion of these excess savings in Maryland's hospitals to further strengthen financial performance as we continue to look forward to the AHEAD model.

Making this additional investment in hospitals could be accomplished in a number of ways; however, it is imperative for the additional funding to be effective July 1, 2025. Therefore, the solution needs to be something that can be acted on quickly. As such, MedStar suggests the following:

1. Inclusion of 0.5% - 1.0% as a placeholder to fund age adjusted population changes, with a commitment to revise the Demographic Methodology over the next several months
2. Suspension of the inflation corridor, allowing for an unfunded inflation catch-up of 0.52%
3. Re-running the Surge Funding methodology using updated data

MedStar urges the HSCRC to consider the above actions to ensure the state's hospitals are fully funded and able to address the care needs of our patients. Re-investing a portion of these excess savings into strengthening the hospitals is a critical investment in the foundation of the model which is necessary to address escalating costs and to ensure Marylanders continue to have access to high quality patient care.

Again, thank you for the opportunity to provide input on these important topics. MedStar will work collaboratively with the Commission, staff, and other stakeholders to provide input related to the

other more detailed technical questions posed in your letter. If you have any questions or would like to discuss any of these topics 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
Adam Kane, Esq.
Maulik Joshi, DrPh
Ricardo R. Johnson, JD
Nicki McCann, JD
Farzaneh Sabi, MD

To: HSCRC.Payment@maryland.gov
Subject: Comments on FY 2026 Additional Spending — *Preparing for AHEAD*
From: Chris Brandt, Audacious Capital

Executive Summary

Maryland's All-Payer / Total Cost of Care model has delivered $1.6 billion in cumulative Medicare hospital savings (2014-2023) and reduced inpatient admissions 13 percent per 1,000 residents—more than double the national decline—according to the RTI International Evaluation (2024). Maryland also ranks among the top states for population-health outcomes and commercial-insurance affordability (United Health Foundation, *America's Health Rankings* 2024).

These outcomes rest on two pillars:

1. **Globally budgeted hospitals** that align incentives with shifting care to the appropriate setting and quality rather than growing volume.
2. **CRISP's statewide longitudinal data fabric,** containing over a decade of clinical and claims data for approximately 98 percent of Maryland residents.

Challenges remain. Despite a 13 percent reduction in licensed beds since 2010, legacy fixed costs keep Maryland's cost-per-case above national benchmarks, attracting federal scrutiny.

Maryland's data infrastructure has been key to driving outcomes and policy development. As the state pursues its transition into AHEAD, it should prioritize investment in the data and the functionality of CRISP.

The success of CRISP is underpinned by the Maryland rate setting model. Rate setting creates the funding and incentive for hospitals to collaborate to build out the exchange of clinical data among otherwise competing hospitals and downstream providers. It is of particular note that CRISP has expanded to partnering with a growing list of community based organizations focused on addressing social determinants of health.

CRISP's success in Maryland is no accident. The Maryland model fostered its growth. In much of the US, HIEs are failing or severely limited in service offerings.

As the state transitions to AHEAD, funding for data and CRISP is unclear, and thus the HSCRC should capture funds today to ensure it continues to function.

Whatever model Maryland ultimately adopts, it has a distinct competitive advantage by maintaining and growing its data sharing capabilities. In particular, CRISP's unparalleled longitudinal dataset is under-leveraged, particularly in the age of machine learning.

Recommendations

1. Unlock the Full Value of CRISP (Foundational)

Our unique, complete records on care delivery and social services for Marylanders, housed in CRISP, have enabled us to surpass the country in care coordination, using relatively simple, algorithmic technology - combined with a capitated / all-payer VBC model under CMMI and HSCRC.

More sophisticated use cases, particularly in predictive modeling, is difficult because of the glut of unstructured data in clinical records. Modern large language models (and other AI tools) address the challenge of unstructured data. We have an extraordinary opportunity to press our advantage. To do so:

- **Innovation Sandbox.** Give appropriately vetted partners access to limited, de-identified, or synthetic data under a streamlined, standard agreement. These innovators include AI companies as well as biotechnology companies who can use the large dataset to help to predict clinical utilization, identify gaps in care, match patients with relevant clinical trials (at the time of care) and help to identify markets for new therapies.
- **Facilitate adoption of successful innovations in the clinical workflow.** CRISP uniquely touches nearly all care givers along the continuum in Maryland. CRISP could play a larger role in alerting clinicians – at the point and time of care – of novel therapies, clinical trials, or other innovations, for which a given patient may be eligible / benefit from.
- **Independent oversight.** A multi-stakeholder sub-committee—including consumer advocates should monitor progress and help to celebrate and build visibility around winning solutions.

CRISP delivers more than 15 million encounter alerts each month and stores 10+ years of labs, radiology, notes, encounters, and many claims, covering ≈ 98 percent of Maryland residents (CRISP Annual Report 2023). Additionally, the system connects all of the state's acute care facilities, much of the ambulatory capacity in the state as well as labs, pharmacies, and public health agencies. Unlocking this asset underpins every other AHEAD ambition as well as many that we haven't yet imagined.

2. Create and Fund a Maryland Preventive Care Utility (MPCU)

Problem we're solving – Approximately 33,000 super-utilizers drive about 20 percent of Baltimore-area hospital costs, partly as a function of fragmented upstream care and lack of focus my entrenched stakeholders pulled in multiple directions. Similar problematic patients exist in other parts of the state. The MPCU is intended to be a targeted effort to apply modern tech and methodologies to address a costly population; identify and amplify best practices.

Governance & funding

- Majority-hospital board seats alongside payers, public-health leaders, and community-based organizations and technology leaders.
- Begin in Baltimore metro; scale statewide - or sunset - after proof of concept.
- Capitalize via an *illustrative* 0.1 percent GBR assessment, HSCRC innovation funds, and private grants.

  The utility would play a coordinating role, explicitly monitoring the most costly of utilizers, seeking to engage patients and address gaps in care and coverage.

Core programs

1. **Primary care** - the healthcare utility would provide primary care as last resort; i.e. the utility should not displace existing business - but supplement.
2. **Cardiovascular-disease management** – CRISP algorithms flag uncontrolled BP/LDL; MDPCP teams deliver coaching. Adopt cost-effective models such as **The Day Clinic**, which provides rapid IV diuresis for heart-failure patients at substantially lower cost than inpatient admission.)
3. **Food-as-Medicine** – Hunger Vital Sign screening plus produce-prescription benefit / funding.
4. **Community Prevention Pool** – consider other SDOH enhancements - transport, housing stabilisation, and social-care navigation.

   MPCU's analytics layer should be developed with open-source tools so workflows can be reused statewide.

Tech backbone & metrics – CRISP APIs drive identification, alerts, closed-loop referrals; success measured at 12 & 24 months on ED visits, inpatient days, clinical control (BP, A1c), and equity gaps.

3. Enhance Patient-Facing Engagement

CMMI calls for **consumer-grade HIE tools** that let people access longitudinal records, actionable insights, and navigation aids. CRISP should publish open APIs and a reference consumer portal while welcoming market innovators.

Example resource: **b.well Connected Health**—a Baltimore-based engagement platform—illustrates the type of partner that could accelerate this work without mandating a single-vendor solution. B.well has inked key partnerships with Walgreens, Samsung and most recently, Google, notable consumer-facing firms which are not directly engaged with Maryland hospitals.

4. Measure What Matters

Invest in collaborative work with CMS on leading indicators (e.g., medication-possession ratio) plus 12- and 24-month total-cost benchmarks so MPCU pilots aren't penalized for early iinvestment.
We support HSCRC's plan to migrate the demographic adjustment toward risk-adjusted population growth—leveraging CRISP's real-time HCC feeds so funding reflects changing acuity, not just aging.

- **Federal alignment.** CMS seeks a larger governance role and has rejected proposals relying on state-set per-case rates. A transparent, outcome-focused measurement suite meets federal expectations while preserving Maryland's rate-setting flexibility.

5. Address Excess Fixed Costs and High Cost-per-Case

Maryland has reduced licensed acute-care beds by **13 percent** since 2010 (Maryland Health Care Commission Bed Inventory, 2010 vs 2023), yet legacy fixed costs remain in rates—especially in Greater Baltimore—elevating the cost-per-case metric under federal scrutiny.

1. **System-level GBRs** empower multi-hospital systems to retire excess capacity As the system becomes more efficient, share that efficiency with the financing system. This was actually done a bit at the early stages of GBR.
2. **Glidepath for right-sizing** links bed de-licensure to community-care reinvestment.
3. **Capital-shift incentives & benchmarking** offer rate add-ons for de-licensed beds and publish fixed-cost-per-case outlier reports.
4. **Align with CMS.** Without jeopardizing hospital solvency, savings from right-sizing fixed capacity can help finance upstream investments as well as, prospectively, an incrementally lower premium paid by CMS, if required.

Catalytic Innovation Assets in Maryland

In addition to CRISP, the following are key assets which provide comparative advantage in Maryland for innovative improvement in the care delivery system**:**

- **Johns Hopkins University (JHU) and Johns Hopkins Technology Ventures (JHTV)** – Building a 110-faculty Data Science & AI hub and commercializing breakthroughs such as Thrive Earlier Detection and Pylarify.
- **Techstars Health AI Accelerator** – Hosts ~12 startups yearly; > 300 applicants in its inaugural cohort (Techstars Press Release 2025).
- **Blackbird Labs** – $100 million nonprofit accelerator translating academic science into biotech companies (Bisciotti Foundation Announcement 2023).
- **Healthworx (CareFirst)** – $150 million venture arm; co-runs **1501 Health** accelerator with LifeBridge Health (CareFirst Annual Report 2024).

- **UMMS iHarbor Innovation Center** – Digital-health lab whose *Gallion* platform won a 2025 Modern Healthcare Innovators Award (UMMS Press Release 2025).

Conclusion

Data liquidity, system-wide prevention, and rationalized capacity will keep Maryland ahead of national cost trends. By unlocking CRISP, standing up the MPCU, empowering consumers, and right-sizing fixed costs, HSCRC can extend Maryland's record of savings and quality gains.

Conflict-of-Interest Statement

I serve as a voluntary commissioner on the Maryland State Public Health Commission and as a volunteer board member of UM St. Joseph Medical Center (HSCRC-regulated). Through Audacious Capital, I am an investor in several health-care and technology companies, and I serve as an independent board member for b.well Connected Health and CareSave Technologies (ShiftMed).

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

June 30, 2025

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

Dear Executive Director Kromm:

CareFirst BlueCross BlueShield ("CareFirst") appreciates the opportunity to comment in response to the Health Services Cost Review Commission (Commission)'s call for public comments on additional spending or investments for FY 2026.

Just last month, the Commission approved the largest hospital rate increase in its history; it would be gratuitous to immediately create even more inflation. Consumers and businesses feel these impacts directly as they navigate economic pressure which, sadly, often impacts healthcare decision-making.

The Commission must balance the dual mandates of ensuring hospitals' financial viability and providing access to affordable hospital services to Maryland residents. The Commission has heard about financial pressures facing the hospital industry. Through April 2025, the statewide average fiscal year-to-date rate regulated hospital operating margin was 7.3 percent, and total operating margins – including unregulated costs outside the Commission's statutory authority – were 2.4 percent. Thankfully, this is not an industry in crisis.

Below, we have provided comments on the specific topics raised by the Commission:

1. **The Commission should not change the inflation corridor.** Last year, the Commission approved a 'catch-up inflation' policy that provided substantial funding to hospitals during a short period of underfunding, despite tolerating long periods of overfunding. Not even a year later, the Commission is considering vacating that policy with no sound rationale. We understand policies are evaluated every few years, but this simply lacks face validity. Any revision this soon would send a message that policies can be created in years when they yield positive adjustments for hospitals, but those same policies can be waived or ignored if their application prevents hospitals from receiving more money. As such, we urge the Commission to follow the policy and not change the inflation corridor.

2. **Age-adjusted demographic growth is reasonable but needs to undergo the policymaking process.** CareFirst agrees that demographic growth should be age-adjusted. However, we urge the Commission to study the impact of demographic aging on hospital utilization rates. Technological developments have yielded lower hospital utilization rates across all age strata. According to AHRQ's data (Hospital Cost and Utilization Project: Fast Stats), the hospitalization rate for people aged 45-64 was 15% lower in 2022 than it was prior to the start of the model, a pattern that holds across age bands. While it is true that the population is older, people are using hospital services at lower rates as they age. Constructing a statistically valid age-adjuster will

require precise methodological work, which is consistent with the historical approach of the Commission.

3. **Physician costs are outside the Commission's regulatory authority.** Physician costs are a significant expense for health systems. Some of those costs are necessary to run a hospital – e.g. physician costs which are not reimbursed under a separate fee schedule – and could be funded through the regulated system. However, most physician costs are not regulated by the Commission and therefore cannot be funded as part of the rate setting system. We support a process to analyze and disentangle hospital and physician services, but until such time as that work is completed, the Commission should not put money directly into rates for services that are presumably outside the scope of its authority.

4. **Any annual Surge Funding policy, if adopted, should not be upside-only.** The suggestion that the Commission is evaluating a policy to annually evaluate respiratory illness growth is a slippery slope. The global budgets were adopted over ten years ago to cover the cost to deliver a set of services over time, inclusive of prevention to drive down hospital utilization rates. If the Commission chooses to make this an annual evaluation, this indicates a step toward volume variability and would serve as an admission that the global budget does not work for the service line.

As a final reminder, the Commission approved a 5.7 percent update factor for hospital global budgets under a month ago, following a year in which over $540 million was added to hospital rates in addition to the normal update factor. Still, the Commission's "Call for Additional Spending" searches for more ways to increase the healthcare affordability burden on consumers.

We urge the Commission to apply its approved policies and allow ample time for thoughtful, comprehensive policy development on new issues. Thank you for the opportunity to comment.

Sincerely,

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

June 27,2025

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

Dear Dr., Kromm

We appreciate the opportunity to provide comments in response to the Commission's request regarding additional spending or investments for FY2026.

While in FY26 there are new/additional investments and spending such as cybersecurity and security costs to address workplace violence, there continues to be significant concern that overall, the System is not providing adequate funding levels needed to provide access and care for our patients and communities.

TidalHealth Inc. has provided significant input over the last several years related to funding gaps and inequities under the Total Cost of Care Model. For FY26 funding considerations, these foundational issues, that we reiterated in our February 3, 2025 letter to the Commission, should be addressed before consideration of any new initiatives.

Excerpt from the February 3, 2025 letter to the Commission

There are foundational issues that exist in the current Total Cost of Care Model that need to be fixed to ensure that we can meet what is required in the AHEAD Model, but most importantly, for us to be able to provide medically necessary care to our patients. These issues continue to be raised by us and others and without correcting the foundation will create major roadblocks for further improvement and meeting the goals of the AHEAD Model.

These foundational Issues are around adequacy of the global budget revenue by recognizing full inflation and appropriate volume growth, while addressing inefficient Hospitals.

(1) Adequacy of the update factors given the rising cost pressures and increase in payor denial

The cost pressures referenced in the Maryland Hospital Associations letter related to growth in physician hospital-based subsidies. Deferring capital needs, and increased payor denials is something we are experiencing, as well as other cost pressures. COVID funding masked the true financial picture and in FY26, we will need adequate funding for us to maintain a small operating profit. It is also necessary to proactively fund our GME program, as requested for several years, through a Rural GME Policy so we can plan and provide stabilization to our financial outlook.

Additionally. The HSCRC should move forward with the financial feasibility study that was supposed to be performed given the continued declines in hospital margins.

(2) Fully recognizing demographic growth in methodologies

In FY 25, only .25% of the actual 4.25% of age adjusted population growth was funded statewide with TidalHealth Peninsula Regional Hospital("THPR") being funded only .38% of their actual 6.85% of age adjusted population growth. This is only a recent year example, but the cumulative impact is material.

This gap in funding significantly contributed to the excess total cost of care savings. This has harmed the State as a whole, but certain areas of the State, like the Eastern Shore of Maryland, have been impacted more given their demographics. Current excess savings should be used to fund this differential, and policies should be revised to adequately fund for these changes going forward.

(3) Rebalancing the funding between efficient/non-efficient hospitals.

There is a wide disparity in base rates between hospitals. The cumulative funding difference between Tidal and other non-efficient Hospitals, especially

in other rural areas, has created community inequities that should be corrected. Several recommendations would be:

- **(a) Create a standard base rate for all hospitals before add-ons, such as Graduate Medical Education, Labor Market differences, etc.;**
- **(b) Reduce excess Hospitals/Services in areas of the State by enforcing current policies and creating new policies that provide an equitable funding structure to free up funding to be redistributed; and**
- **(c) Aligning HSCRC and Maryland Health Care Commission work around healthcare system needs to address adequacy of services in different counties and regions in the State.**

We hope you strongly reconsider the industry request for additional inflation and demographic funding. We also believe you could quickly address some of the inequity by releasing additional dollars to low cost/efficient providers. We are planning to provide comments on the GME policy considerations in detail, and we continue to strongly advocate for a Rural GME Policy.

Thank you for allowing us to provide comments and we urge you to act quickly given the prior information that has been shared by TidalHealth, Inc.

Sincerely,

Kathy Talbot

Kathy Talbot

Vice President of Finance and Chief Revenue Integrity Officer

TidalHealth, Inc.

cc: Joshua Sharfstein, MD

Maulik Joshi, DrPH

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CORPORATE OFFICE

June 27, 2025

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

RE: UMMS Comment Letter Regarding Additional Spending or Investments for FY 2026

Dear Jon:

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, UMMS is writing in response to the Commission's call for comments regarding additional spending or investments for FY 2026. As previously discussed, now more than ever, through Commissioner leadership, it is critical to ensure alignment between the industry and HSCRC. As we expressed in previous communications, the nearly $800 million of Model savings represents the significant underfunding of a Maryland hospital industry that has continued for three consecutive years. Statewide total margins at 1.7% as of fiscal year to date April 2025 remain below targeted margins and despite the corrections in the annual payment update, fiscal year 2026 will prove to be challenging due to the ongoing growth of physician costs and deferred spending from prior years.

For several years, the industry has requested focused policy development to address aging population and physician costs, and the Commission's questions posed are both relevant and important. At this time, however, UMMS will refrain from providing detailed comments and urges the Commission to act quickly to approve an approach to funding that is 'shelf-ready' for July 1, 2025. UMMS is readily available to provide input as early as July through HSCRC workgroups all matters provided.

UMMS supports MHA's position and offers the following comments:

Inflation Corridor
UMMS supports the release of the .52% unfunded inflation. A fixed revenue model should have zero unfunded inflation. Excess funded inflation should be evaluated based upon the financial health of hospitals and the status of savings targets.

Risk Adjustment
UMMS continues to support MHA's position to provide an additional 0.65% in demographic funding effective July 1, 2025. UMMS is readily available to engage in further policy development work recognizing risk adjustment has complexities, but funding for aging should not be withheld during the development process.

Physician Costs

UMMS appreciates the HSCRC's acknowledgement of this financial challenge and welcomes the opportunity to collaborate in this important policy development. Fee schedule increases for both Medicare and Medicaid have failed to keep pace with inflation, requiring increased subsidies for critical hospital physician services, including emergency room, anesthesiology, imaging and many more.

Surge Funding

Surge funding should be provided on a permanent basis and updated each year for the most recent experience until such time as the surge has leveled off. Fiscal year 2025 should be reviewed quickly. Additionally, the permanent policy should provide funding to all hospitals that experience growth in respiratory volumes, unlike the RY 2026 surge policy which reduced the availability of surge funding for hospitals that experienced offsetting declines in volume for other health care services. Hospital population health investments focused on high-risk populations and community outreach vaccine efforts are ongoing preventative work.

Preparing for AHEAD

Adequately funding hospitals critical operating investments must come before addressing new AHEAD preparation funding initiatives.

UMMS believes that Maryland's unique information technology platform should be leveraged to support cardiovascular disease prevention and access to health food only after current needs regarding ongoing population health efforts and reporting/tools around at-risk, value-based are met and optimized. A stakeholder group should be established to determine the timeline and resource needs for longer term efforts around further chronic disease management and prevention We caution against overextending the platform without first ensuring that current tools are functionally integrated and widely adopted across health systems and community partners.

In closing, alignment between the hospitals and the Commission is critical. Now is the time, given the considerable excess savings, for Commissioners to provide a permanent investment in hospitals to stabilize the system's overall financial health and provide a solid foundation for success under the AHEAD model.

Sincerely,

Alicia Cunningham
SVP, Reimbursement & Revenue Advisory Services
University of Maryland Medical System

cc: Joshua Sharfstein, MD Chairman
James Elliott, MD, Vice Chairman
Adam Kane
Nicki McCann, JD
Maulik Joshi, DrPH
Ricardo R. Johnson
Fabi Sabi, MD

Allan Pack, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Mohan Suntha, MD, UMMS President and CEO
Joseph Hoffman, UMMS Interim Chief Financial Officer

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

maryland health services cost review commission

Request

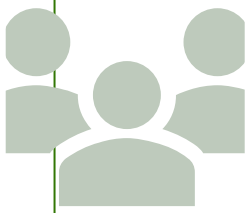
- Forward the proposed “draft” regulations to Annapolis to allow for publication in the Maryland Register and for an additional 30-day public comment period.
- Timeline:
  - August: Forward to AELR
  - September: Receive and review public comments*
  - October: Return to Commissioners with final regulations for approval
  - November: Promulgation of regulations stops before session begins

* Comments that result in substantive changes would require re-starting the process.

2025 Regulations Update Process

Over the past two months, HSCRC staff facilitated a workgroup process to gather input on updates to the HSCRC's financial assistance and medical debt regulations.

The purpose of this workgroup process was to align regulations with **changes to statute during the 2022-2025 legislative sessions**.



HSCRC received comments across three drafts of the regulations via:

- Written comment period 1: June 12 – 26
- Workgroup 1: July 1
- Written comment period 2: July 3 – 17
- Workgroup 2: July 23

2025 Regulations Update Process (continued)

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

- **Previous stakeholder workgroup meetings and public comment periods** resulted in a version of the regulations that was published on the HSCRC website, voted on by HSCRC Commissioners, and sent to AELR in September 2023.
- These regulations **never came up for a final vote in 2023** because:
  - HSCRC needed additional time for extensive input from the Department of Labor, which has a unit that specializes in debt collection. This delayed the initial stakeholder workgroup process.
  - HSCRC needed to re-submit to AELR with formatting changes, which re-started the process.
  - HSCRC was unable to re-submit due to the freeze on regulations changes that goes into effect before session starts.

Key areas of workgroup discussion and clarification

HSCRC staff's goal was to create a standardized, streamlined hospital payment process. Key issues discussed were:

Definition of Income:

- Level of income was changed in statute from individual to household income for income-based payment plans. HSCRC staff applied this income definition to financial assistance to provide alignment and clarity.
- Commenters supported applying the definition of household across all uses of income and accounting for reasonably predictable changes in income throughout the year.

Key areas of workgroup discussion and clarification (continued)

HSCRC staff's goal was to create a standardized, streamlined hospital payment process. Key issues discussed were:

Documentation of Income:

- Commenters emphasized minimizing the burden on patients in a way that does not place undue burden on hospitals.
- HSCRC staff aligned documentation of income requirements and allowances across income-based payment plan and financial assistance process.

Key areas of workgroup discussion and clarification (continued)

HSCRC staff's goal was to create a standardized, streamlined hospital payment process. Key issues discussed were:

Implementation of asset tests:

- Hospitals are explicitly permitted in statute to consider certain assets in making financial assistance eligibility determinations. The scope of this asset test has been modified in statute since 2023.
- Commenters agreed with defining monetary assets but had widely varying interpretations of the language in statute.
- HSCRC staff defined "monetary assets" in alignment with statute and specified how asset tests should be applied by hospitals.

Questions?

- hannah.friedman-bell1@maryland.gov

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Commentary on Public Comments on Financial Assistance and Medical Debt Regulations

July 2025

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

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Introduction

This document contains comments received from the public on draft changes to the current COMAR 10.37.10.26, the Health Services Cost Review Commission's regulations on "Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies" and HSCRC staff responses to those comments. This document includes the following:

1. Direct quotes from written comments received by June 26 on the first draft shared with stakeholders by June 12 ("formal comments").
2. Direct quotes from written comments received by July 17 on the second draft shared with stakeholders on July 3 ("formal comments").
3. Summary of comments received during HSCRC's workgroup meeting on July 23, 2024 ("informal comments").

This document is grouped by topic area, with areas discussed most heavily listed first. The final section includes two groups of comments:

1. **Comments pertaining to previously considered areas of regulations.** Previous stakeholder workgroup meetings and public comment periods resulted in a version of the regulations that was published on the HSCRC website, voted on by HSCRC Commissioners, and sent to AELR in September 2023 (see "Commentary on Public Comments on Financial Assistance and Medical Debt Regulations" section). As stated in written outreach to workgroup members, HSCRC did not intend to return to sections of the regulations that had already been edited and remained untouched by statute since September 2023. To help stakeholders track the different changes to regulations, HSCRC even provided a marked-up version of the different drafts of the regulations when providing the second draft of the regulations on July 3.
2. **Comments on language pulled directly from statute.** HSCRC regulations are intended to clarify and provide details on how to implement language in statute, but the statute is the ultimate source of legal requirements and authority. The comments in this section are on language in the proposed regulations that comes directly from statute. Language in regulations should mirror the language in statute, whenever possible.

Documentation of Income

Formal Comment: *University of Maryland Medical System*

Hospitals should not be required to obtain tax returns to verify income or household size.

Formal Comment: *Maryland Hospital Association*

We recommend allowing attestation for both financial assistance and payment plan determinations.

Response: Attestation is now explicitly allowed for financial assistance under 10.37.10.06A.(4) and thus for payment plan determinations as well through 10.37.10.05D(2).

Formal Comment: *MidAtlantic Collectors Association*

Seeking clarification if, in the absence of documentation, a hospital and/or its third party vendor may use a reliable external third party database to independently obtain information to confirm data about a patient's household, household income, or similar to make a preliminary financial assistance determination.

Response: Information obtained through a reliable external third party database should be covered by "available information" under 10.37.13.06A.(4)(b).

Formal Comment: *Economic Action Maryland Fund, 1199 SEIU, High Note Consulting, LLC, Maryland Center on Economic Policy, Community Development Network of Maryland Greater Baltimore Democratic Socialists of America, Maryland Legal Aid, CASH Campaign of Maryland, and Progressive Maryland*

These regulations should minimize placing the onus of working through the payment plans and financial assistance processes on patients. Requiring hospitals to use the same process for establishing eligibility for financial assistance as they do to establish the 5% monthly payment threshold for payment was not contemplated as part of statute.

Formal Comment: *University of Maryland Medical System*

HSCRC should clarify what using the same process for establishing eligibility for financial assistance as they do to establish the 5% monthly payment threshold for payment means.

Informal Comment: *University of Maryland Medical System*

Hospitals may have separate teams, including teams that are constituted of third-party partners, for managing financial assistance applications and engaging patients on payment plans. Requiring consideration of the same information may therefore be challenging.

Response: The General Assembly has consistently linked the sections of statute that pertain to medical debt and financial assistance together. HSCRC is aligning the definitions of income across 10.37.13 (in Section 10.37.13.15B(7)) and requiring hospitals to use information collected for financial assistance to determine the 5% monthly payment threshold for income-based payment plans (in Section 10.37.13.05D(2)). In doing so, HSCRC is harmonizing Health-General Article, §19-214.1, which pertains to medical debt, and Health-General Article, §19-214.2, which pertains to financial assistance. Additionally, HSCRC believes that this requirement simplifies the financial assistance and payment plan processes, and

that this benefit outweighs the challenges some hospitals may face in increasing coordination between their teams.

Formal Comment: *Health Education and Advocacy Unit*

Language should be added to 10.37.13.06(I) making clear that hospitals cannot require documentation that presents an undue barrier to the patient's receipt of financial assistance. As written, the language suggests that hospitals can require consumers to validate any information provided in the application, which could be onerous.

Response: This language is from previous updates to regulations, as reflected in September 2023 Public Pre-Meeting Materials. Hospitals may require documentation that verifies income.

Formal Comment: *University of Maryland Medical System*

Suggest including a definition of "monetary assets" that hospitals should apply for the purposes of asset testing.

Formal Comment: *Economic Action Maryland Fund, 1199 SEIU, High Note Consulting, LLC, Maryland Center on Economic Policy, Community Development Network of Maryland Greater Baltimore Democratic Socialists of America, Maryland Legal Aid, CASH Campaign of Maryland, and Progressive Maryland*

The definition of Monetary Assets should directly reflect the "including but not limited to deferred compensation plans, or nonqualified deferred compensation plan" language in statute. Monetary assets should not include pre-paid higher education funds in a Maryland 529 program account.

Formal Comment: *Health Education and Advocacy Unit*

To provide clarity and uniformity, we recommend defining monetary assets. We recommend this definition: *"Monetary assets" include cash and cash equivalents, such as cash on hand, bank deposits, investment accounts, accounts receivable (AR), and notes receivable, all of which can readily be converted into a fixed or precisely determinable amount of money. "Monetary assets" does not include equity in a primary residence, or retirement assets that the IRS has granted preferential tax treatment as a retirement count, including deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans.*

Response: The definition of monetary assets in these regulations under 10.37.13.01B.(11) directly reflects language in statute, with clarifying language added that reflects HEAU's recommendation.

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Scope of Regulations

Formal Comment: *University of Maryland Medical System*

(10.37.13.06 A.(1)(f)) instructs that free and reduced cost medically necessary care shall be provided to all qualified Maryland residents. This would still allow hospitals to establish exclusions for financial assistance for non-urgent or elective services for non-Maryland residents.

Response: HSCRC has added language to 10.37.13.06 A.(1)(g) to clarify that hospitals may not exclude non-urgent or elective, but medically necessary, care from their financial assistance policy. People that do not meet the definition of "Qualified Maryland resident" under 10.37.13.01B.(13) are not covered by this regulation.

Formal Comment: *University of Maryland Medical System*

HB 268 removes language that would limit medical debt to costs billed by a hospital, thereby expanding the definition without providing any limits for what types of care constitute medical debt. Is a hospital expected to assess medical debt incurred from other healthcare providers? If yes, how are hospitals expected to validate medical debt from other healthcare providers? Requiring and reviewing documentation of medical debt from third parties creates an undue burden on patients and hospitals

Formal Comment: *Health Education and Advocacy Unit*

Chapter 498, Laws of Maryland 2025, prohibits the placement of a lien on a patient's primary residence for medical debt. Medical debt is broadly defined in Chapter 498 and not limited to hospital services regulated by the HSCRC. As drafted, this regulation suggests a limitation on the scope of the lien protection.

Response: Under sections 10.37.13.01B. (5) and (9), medical debt is limited to HSCRC-regulated hospital services, for the purpose of these regulations.

Formal Comment: *University of Maryland Medical System*

HB 328 removes language that limits the provision of reduced-cost medically necessary care and payment plans to the service area of the hospital. Does this preclude a hospital's ability to limit the application of free and reduced-cost medically necessary care to Maryland residents?

Response: The hospital shall provide free and reduced cost medically necessary care to all qualified Maryland residents, regardless of their citizenship or immigration status, as stated in section .06A.(e). People that do not meet the definition of "Qualified Maryland resident" under 10.37.13.01B.(13) are not covered by this regulation.

Formal Comment: *MidAtlantic Collectors Association*

The definition of “hospital services” should clarify that they do not include services independent clinicians provide at hospital facilities more or less seamlessly with a hospital’s own employed staff. Seeking further clarification on what “(e)” means in regard to “identified physician services.”

Response: HSCRC has included language in Section 10.37.13.01B(6)(g) to now explicitly state that hospital services do not include physician services that are billed separately.

Formal Comment: *MidAtlantic Collectors Association*

These regulations should confirm how “medically necessary care” aligns with the Emergency Medical Treatment and Labor Act of 1986 (“EMTALA”). “Medically necessary care” should include any care provided that is subject to EMTALA.

Response: HSCRC has included language in Section .01B.(10) to now state "(10) “Medically necessary care”, including care provided in accordance with the Emergency Medical Treatment and Labor Act of 1986 (“EMTALA”), means care that is...".

Formal Comment: *University of Maryland Medical System*

A definition of “qualified Maryland resident” should be provided.

Formal Comment: *Health Education and Advocacy Unit*

The regulations provide that consumers that work or go to school in Maryland are eligible for income-based payment plans. The HEAU believes those same consumers should be eligible for financial assistance. Adding a definition for “qualified Maryland residents” to include those here for school or work would address this.

Informal comment: *Representatives from Johns Hopkins Health System, London Eligibility and London Disability, Health Education and Advocacy Unit, MidAtlantic Collectors Association*

The definition of "qualified Maryland residents” should be flexible enough to account for patients without housing and should not be interpreted to require hospitals to verify addresses, including through documentation.

Response: HSCRC has added a definition of "qualified Maryland residents" based on stakeholder input and feedback.

Application of Asset Tests

Formal Comment: *University of Maryland Medical System*

We do not support a change that would require hospitals to include assets in a patient's income for the purposes of determining eligibility for financial assistance or payment plans. Asset testing creates an administrative burden for patients and hospitals and could discourage patients from requesting a payment plan.

Formal Comment: *Maryland Hospital Association*

Current law allows asset tests to be used for financial assistance but is silent for payment plans. We recommend the asset test for both. Assets should be included in the eligibility determination so that hospitals can ensure that free or reduced cost care is available to the patients who need it.

The regulations should be revised to clarify how the asset test may be applied in coordination with the income threshold requirements for free or reduced-cost care. We recommend that the HSCRC create a formula to include assets in the definition of income.

Formal Comment: *Economic Action Maryland Fund, 1199 SEIU, High Note Consulting, LLC, Maryland Center on Economic Policy, Community Development Network of Maryland Greater Baltimore Democratic Socialists of America, Maryland Legal Aid, CASH Campaign of Maryland, and Progressive Maryland*

HSCRC seems to suggest that if it is not expressly prohibited, asset tests may be used for payment plans. HSCRC is suggesting that even though clear limits have been placed on the use of these tests in statute, HSCRC chooses to expand beyond the law in its interpretation.

Informal Comment: *Representative of Economic Action Maryland Fund*

10.37.10.06J should include a reference to the definition of monetary assets to ensure that it is clear that asset tests are limited to monetary assets.

Response: The statute as currently written does not ban the use of asset test for payment plans. HSCRC has clarified its expectations of how the asset tests are applied using the definition of "income" and "monetary assets" in section 10.37.10.01B.(7) and (11), as well as adjusting the existing language in section 10.37.10.06J.

Formal Comment: *Economic Action Maryland Fund, 1199 SEIU, High Note Consulting, LLC, Maryland Center on Economic Policy, Community Development Network of Maryland Greater Baltimore Democratic Socialists of America, Maryland Legal Aid, CASH Campaign of Maryland, and Progressive Maryland*

As drafted, HSCRC's regulations go far beyond the legislative intent of the law passed by the General Assembly in 2024. As passed, hospitals may choose to either use an asset test or to use income-based eligibility–not both. The term "ONLY" limits the option to one not both.

Response: HSCRC does not agree with this interpretation of the law. HSCRC believes that income is central to both financial assistance and income-based payment plan determinations. For example, under section .06A.(1)(c), hospitals must use 'family income" to determine eligibility for financial assistance, so hospitals must include consideration of "income" in their determination. Furthermore, this interpretation would increase variation between hospitals - a concern expressed by consumer advocates previously - and make navigating the financial assistance and payment plan processes even more complicated for those involved. HSCRC believes our definition of income under 10.37.10.01B.(7), which allows for but does not require consideration of assets, both aligns with language of the law and maximizes simplicity.

Definition of Income

Formal Comment: *Health Education and Advocacy Unit*

In .05G generally, the term "adjusted" should be added before "gross monthly income" and "tax household" should be added where currently missing. The regulations should contain a provision allowing for Reasonably Predictable Changes in income, as allowed by federal Medicaid regulations, to account for consumers with varying monthly income. 10.37.13.05(G)(1)(d) should allow for the division of yearly income by 12, even in instances where the consumer's monthly income is a higher amount.

Only the income of those in the tax household should be included in the calculation of income, and only the members of the tax household are counted when determining the patient's share of the income-based payment responsibility.

Formal Comment: *Maryland Hospital Association*

The definition of "household" should apply to both financial assistance and payment plan determinations.

Response: HSCRC has added a definition of household and family under section 10.37.13.01B.(6), which is explicitly limited to those living in the same dwelling. HSCRC has also added a definition of income under section 10.37.13.01B.(7) that incorporates the meaning of "adjusted" ("If a hospital uses state or federal tax returns to verify income, hospitals shall take into consideration adjustments listed on Schedule 1 of Form 1040" and "gross" ("before taxes"). This definition applies across the whole chapter 10.37.13 of regulations, including for determining financial assistance eligibility and payment plans payment amounts.

Impact on UCC

Formal Comment: *University of Maryland Medical System*

HB 765 allows a hospital to sell medical debt to a non-profit for the purposes of debt cancellation. How would this impact a hospital's uncompensated care?

Response: HSCRC has ensured our Uncompensated Care (UCC) policy subject matter experts are aware of these changes. Impacts on UCC were considered as part of statute changes during legislative session. HSCRC cannot change what is in statute.

Updates to Maryland Uniform Financial Assistance Application

Formal Comment: *MidAtlantic Collectors Association*

Request for the workgroup to consider updates to Maryland's uniform financial assistance application to align with Maryland's updated financial assistance and medical debt collections laws, to include consumer friendly explanations and frequently asked questions and making application available electronically to assist consumers in reviewing, completing, and gathering information about the hardship and application processes. A form that offers clear explanations of the categories may also facilitate a smoother process for all to understand what a hardship is, what options are available, and what supporting documentation would be helpful for a hospital and/or its vendors to review to truly be of assistance to patients.

Response: HSCRC will update the Uniform Financial Assistance Application to align with regulations when they are enacted.

Standard Attestation Form

Formal Comment: *London Eligibility and London Disability*

Consider developing a "standard" Attestation form and explain which income and assets and tax returns can be attested to and signature requirements (Ex: minor, incapacitation). Anecdotally, many hospitals are not making patients aware that Attestation is an option and some hospitals may be requiring witnessed signatures, notaries, and other administrative burdens not required by the statute.

Response: There is no requirement for or prohibition against use of attestation in place of documentation from the patient, and for that reason, the HSCRC does not feel that it is urgent to develop a distinct uniform attestation sheet. Instead, the HSCRC will focus its resources over the next year on refining the existing

Uniform Financial Assistance Application. Prohibitions against certain actions, such as requiring witnessed signatures, notaries, etc., should be enumerated under statute rather than created under regulations.

Alignment with Federal Law

Formal Comment: *Maryland Hospital Association*

To the extent possible, we recommend that the state financial assistance sheet not duplicate and be consistent any federal requirements (IRS 501r) related to patient disclosures.

Informal comment: *MidAtlantic Collectors Association*

HSCRC should consider, reference, incorporate, and/or dovetail existing pertinent legal standards under both Internal Revenue Code 501 and EMTALA specifications that may already speak to some of the compliance expectations related to activities regulated by Maryland's medical debt protection laws and regulations.

Response: HSCRC confirmed the State financial assistance sheet is consistent with federal requirements. Our regulations are intended to reflect and clarify implementation and fulfillment of Maryland law and statutory requirements. Furthermore, we think it could be confusing to incorporate federal law rather than spelling out requirements applicable to Maryland. This is because federal law is not entirely applicable to Maryland -- for example, federal law refers to hospital charges that may not exceed the "amounts generally billed" to insured patients. In Maryland, what is billed are the charges that are set by the HSCRC.

Alignment with Relevant Legal Case(s)

Informal comment: *MidAtlantic Collectors Association*

These regulations may need to note the recent court decision suggesting that the Fair Credit Reporting Act may preempt any state law restricting the ability to credit report medical debt. Specifically, the July 11, 2025, decision in the Cornerstone Credit Union League case stated, among other things, that "any state law purporting to prohibit a CRA from furnishing a credit report with coded medical information would be inconsistent with the FCRA and therefore preempted." Concerned particularly about section 10.37.13.04B.(3)(c).

Informal comment: *Representative from Economic Action Maryland Fund*

This case is likely to be contested, should allow for the legal process to play out.

Response: The federal case referenced deals primarily with CRA's furnishing of credit reports, and not the relationship between hospitals and CRAs, so it is HSCRC's position that this area of regulations may not be the right place to address these changes. It would also be prudent to wait to see how the case plays out over the next few months, so HSCRC believes it is not the right time to address this concern regardless.

Additional Comments

Addressed Previously by the HSCRC

Formal Comment: *Health Education and Advocacy Unit*

It is unclear why hospitals would consider expenses when calculating income-based payment plans because expenses are not a component of the calculation. For the same reason, unless the expenses are medical in nature and could be considered for determining reduced-cost care based on financial hardship, expenses should not be considered when modifying income-based payment plans. See 10.37.13.05(P)(2).

Response: As noted in HSCRC's September 2023 Public Pre-Meeting Materials, "Ability to pay is a cornerstone of credit. In the development of the payment plan guidelines, stakeholders noted that household expenses may affect a patient's ability to pay back medical debt under a payment plan. The only expense implicitly addressed in the law was medical debt that meets the definition of financial hardship (this topic is addressed in guideline (5)(a)). HSCRC staff included this language to encourage hospitals to consider patient circumstances." HSCRC has added language to clarify the intent behind section 10.37.13.05.G.

Formal Comment: *MidAtlantic Collectors Association*

There are numerous types of vendors who work by and on behalf of hospitals in regard to patient registration, access management, assisting patients in applying for and following the processes to obtain various forms of governmental assistance for medical bills, and who handle typical customer service, billing and coding functions. We recommend clearly "excepting" companies who perform these and other "non-collections" revenue cycle and patient eligibility and access management services from the broad definitions of "debt collector."

Response: As reflected on page 17 of the Commentary on Public Comments on Financial Assistance and Medical Debt Regulations in the September 2023 Public Pre-Meeting Materials, this concept was brought to

the attention of, and considered by, HSCRC previously. In this round of regulations updates, HSCRC did not intend to return to the sections of the regulations that were discussed previously.

Formal Comment: *Health Education and Advocacy Unit*

It is important for consumers to understand and appreciate that the payment plans available to them are accessible and offer them a fair and reasonable payment amount and timeline for repayment. Suggest adding language in 10.37.13.03(A)(2)(d) – "of the availability of an income-based payment plan with monthly payments capped at 5% of the patient's household's adjusted gross monthly income" – to 10.37.13.05(A)(2)(b)(iv), 10.37.13.04(I)(6)(f)(ii), .05(C)(1)(b) and (d), and .05(W)(3)(c).

Response: As reflected on page 24-25 of the Commentary on Public Comments on Financial Assistance and Medical Debt Regulations in the September 2023 Public Pre-Meeting Materials, the content and requirements of the payment plan notice was considered by HSCRC previously. In this round of regulations updates, HSCRC did not intend to return to the sections of the regulations that were discussed previously.

Formal Comment: *Health Education and Advocacy Unit*

10.37.13.04(D) could be read to eviscerate the clear statutory requirement that before filing a debt collection action or delegating collection activity to a debt collector, a hospital "shall demonstrate that it attempted in good faith to meet the requirements of" the debt collection statute and the guidelines. Md. Code Ann., Health-Gen. § 19-214.2(d). The regulation appears to bless some hospitals' current practice of providing simple notice about consumer protections; this amounts to minimum efforts and do not by themselves establish that the hospital has acted in good faith. It is contrary to the statute as passed by the General Assembly and constrains the statutory requirement of good faith. A hospital that does not seek to facilitate a consumer's access to payment plans is not acting in good faith.

Formal Comment: *Economic Action Maryland Fund, 1199 SEIU, High Note Consulting, LLC, Maryland Center on Economic Policy, Community Development Network of Maryland Greater Baltimore Democratic Socialists of America, Maryland Legal Aid, CASH Campaign of Maryland, and Progressive Maryland*

As drafted, 10.37.13.04(D) undermines the clear statutory requirement that before filing a debt collection action or delegating a collection activity to a debt collector, a hospital "shall demonstrate that it attempted in good faith to meet the requirements of" the debt collection statute and guidelines. It seems to accept some hospitals' current practice of providing notice and developing a process as sufficient despite clear barriers that remain in accessing financial assistance let alone payment plans. This regulatory interpretation is inconsistent with clear legislative intent of the General Assembly. The language is also weak because it

does not state that the information sheet be provided with each hospital bill, upon request, and in each written communication regarding the collection of medical debt.

Response: As reflected on pages 16-17 of the Commentary on Public Comments on Financial Assistance and Medical Debt Regulations in the September 2023 Public Pre-Meeting Materials, HSCRC considered this concept previously. HSCRC did not intend to return to the sections of the regulations that were discussed previously in the current round of regulations updates.

Formal Comment: *Health Education and Advocacy Unit*

Reiterate objection to the interpretation that income-based payment plans do not have to be provided to patients if they make payments in advance of services; urge the HSCRC to add another condition to .05(A)(2) requiring that hospitals comply with any provider-carrier contract terms and conditions regarding the collection of amounts in advance of claims processing procedures.

Response: As reflected on page 32 of the Commentary on Public Comments on Financial Assistance and Medical Debt Regulations in the September 2023 Public Pre-Meeting Materials, HSCRC considered comments on the Early Payment section of regulations previously. HSCRC did not intend to return to the sections of the regulations that were discussed previously in the current round of regulations updates.

Formal Comment: *Health Education and Advocacy Unit*

Reiterate objection to non-income-based payment plans being offered in lieu of the statutorily required plans. That said, hospitals should be required to comply with the partial payments stipulations in these regulations when offering non-income-based payment plans.

Response: As reflected on pages 36-37 of the Commentary on Public Comments on Financial Assistance and Medical Debt Regulations in the September 2023 Public Pre-Meeting Materials, HSCRC considered this comment previously. HSCRC did not intend to return to the sections of the regulations that were discussed previously in the current round of regulations updates.

Formal Comment: *University of Maryland Medical System*

Hospitals are required to amend their information sheet to include instructions for how to apply for a payment plan. This information is already readily available in the financial assistance policy and on the hospital bill.

Updates to the information sheet will require hospitals to make changes to Epic workflows and incur translation fees. Changing the font size will increase the size of the document, which will increase print and mailing fees associated with providing the information sheet with hospital bills.

Response: The changes addressed in these comments were part of the updates to regulations included in the September 2023 Public Pre-Meeting Materials. HSCRC did not intend to return to the sections of the regulations that were discussed previously in the current round of regulations updates.

Formal Comment: *MidAtlantic Collectors Association*

Could communications that are, delivered via other electronic means like chat, texting, messaging, or other method be added to the list – potentially with a proviso, subject to applicable laws?

Suggest reference to Regulation F, 12 CFR Part 1006, which establishes ground rules for debt collectors communicating electronically. Request that in the event a patient who has opted into electronic communications wishes to opt out, any expression or change of communication preferences be provided in writing, including electronic form, not orally, to assure that the patient's communication preferences are understood, documented, and recorded. Companies maintaining online resources are expected to take steps to assure those resources are ADA compliant and accessible. Many also host "IVR" or "interactive voice response" resources that can convert text-to-speech or speech-to-text to accommodate individuals with visual challenges.

Final regulations should be flexible enough to allow hospitals and their debt collectors to harness artificial intelligence and other emerging technologies to accommodate all consumers regardless of how they prefer to communicate (while creating and maintaining documentation of consumers' preferences).

Response: As reflected on page 11 of the Commentary on Public Comments on Financial Assistance and Medical Debt Regulations in the September 2023 Public Pre-Meeting Materials, HSCRC considered similar comments on written communications previously. HSCRC did not intend to return to the sections of the regulations that were discussed previously in the current round of regulations updates.

Directly from statute

Formal Comment: *Health Education and Advocacy Unit*

We request removal of the word "immediately" in .06(A)(1)(b)(iii) because it is unnecessary and suggests an urgency that isn't consistent with the consumer's right to seek financial assistance within 240 days from the initial bill.

Formal Comment: *University of Maryland Medical System*

HB 268 prohibits a hospital from filing a civil action to collect a debt at or below $500. This limits a hospital's ability to collect debt.

Hospitals are required to include a mechanism for patients to request the hospital to reconsider the denial of free or reduced-cost care in their credit and collection policy. This information is already readily available in the financial assistance policy and on the financial assistance application.

Hospitals are required to establish a process for making payment plans available to all patients in the credit and collection policy. This information is already readily available in the financial assistance policy and payment plan policy.

Hospitals are prohibited from making a claim against the estate of a deceased patient if the patient was known by the hospital to be eligible for free medically necessary care and hospitals may offer the family of a deceased patient the ability to apply for financial assistance. UMMS would like to understand how other hospitals interpret this language.

Hospitals are required to describe the payment plans required under Health-General Article, §19-214 and 10.37.13.05. This information is already readily available in the payment plan policy

Response: We believe an MHA workgroup would be the best forum for hospitals to share strategies and best practices delated to implementation of these regulations.

TITLE 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

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

Notice of Proposed Action

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

[A. Hospital Information Sheet.

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

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

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

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

(i) The patient's hospital bill;

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

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

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

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

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

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

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

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

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

(2) The information sheet shall be in:

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

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

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

(a) Before the patient receives scheduled medical services;

(b) Before discharge;

(c) With the hospital bill;

(d) On request; and

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

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

(5) The Commission shall:

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

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

A-1. Hospital Credit and Collection Policies.

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

(2) The policy shall:

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

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

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

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

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

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

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

(h) Provide detailed procedures for the following actions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Require the outside collection agency to:

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

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

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

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

A-2. Hospital Financial Assistance Responsibilities.

(1) Definitions.

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

(b) Terms Defined.

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

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

(2) Financial Assistance Policy.

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

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

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

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

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

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

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

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

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

(ii) Supplemental Nutritional Assistance Program (SNAP);

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

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

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

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

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

(i) Patient mix;

(ii) Financial condition;

(iii) Level of bad debt experienced;

(iv) Amount of charity care provided; and

(v) Other relevant factors.

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

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

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

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

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

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

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

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

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

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

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

(4) Financial Hardship Policy.

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

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

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

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

(ii) The patient mix of the hospital;

(iii) The financial condition of the hospital;

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

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

(vi) Other relevant factors.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. For purposes of this regulation, the terms "debt collector", "hospital", "income-based payment plan", and "payment plan" have the meaning given such terms in COMAR 10.37.13.01.

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

[(a)**]** *(1)* A third-party payer that provides current financing equal to the average amount of outstanding charges for bills from the end of each regular billing period and for discharged patients shall be entitled to a 2-percent discount. For purposes of this regulation, a regular billing period shall be based on a 30-day billing cycle. The current financing provided **[**in here**]** *to hospitals* corresponds to a third party's paying on discharge.

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

[(c)**]** *(3)* Outstanding charges shall be calculated by an amount equal to the hospital's current average daily payment by the payer, multiplied by the hospital's and third party payer's processing and payment time. The precise calculation shall be made in accordance with the guidelines specified by Commission staff.

[(d)**]** *(4)* Upon request from an applicant, the Commission may approve an alternative method of calculating current financing monies.

[(e)**]** *(5)* The third-party payer shall adjust the current financing advance to reflect Commission rate orders and changes in volume associated with the particular payer and hospital. This adjustment shall be made within 45 days of a rate order or at such other time as circumstances warrant. In the absence of a rate order, the adjustment shall be made at least annually.

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

[(3)**]** *D.* A payer or self-paying patient, who does not provide current financing under §B**[**(1)(a)—(e)**]** of this regulation, shall receive a 2-percent discount if payment is made at the earlier of the end of each regular billing period or upon discharge from the hospital. Payment within 30 days of the earlier of the end of each regular billing period or discharge entitles a payer or self-pay patient to a 1-percent discount. For those payers not subject to Insurance Article, §15-1005, Annotated Code of Maryland, after 60 days from the date of the earlier of the end of each regular billing period or discharge, interest or late payment charges may accrue on any unpaid charges at a simple rate of 1 percent per month. The interest or late payment charges may be added to the charge on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that. *For patients that have entered into a hospital income-based payment plan under COMAR 10.37.13.05 , the interest rate shall be established in accordance with the Guidelines.*

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

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

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

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

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

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

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

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

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

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

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

(5) Hospital Written Estimate.

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

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

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

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

C.**]** *F.* GME Discounts. In those instances where a teaching hospital is reimbursed separately for the costs associated with the provision of graduate medical education (GME), the Commission shall calculate the percentage of the hospital's rates that these GME payments represent and provide notice of the amounts that may be credited toward the payment for services rendered. At all times, total payment received by the teaching hospital shall be in accordance with Commission-approved rates.

TITLE 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

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

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

Notice of Proposed Action

.01 Definitions

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

B. Terms Defined:

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

(2) Debt Collector.

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

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

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

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

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

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

(4) "Hospital" means a facility defined in Md. Code Ann., Health-Gen. §19- 301(f).

(5) "Hospital services" means:

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

(b) Emergency services, including services provided at a freestanding medical facility licensed under Subtitle 3A of title 19 of Md. Code Ann., Health-Gen. ;

(c) Outpatient services provided at a hospital (as defined in COMAR 10.37.10.07-01);

(d) Outpatient services, as specified by the Commission in COMAR 10.37.10.07-02, provided at a freestanding medical facility licensed under Subtitle 3A of title 19 of Md. Code Ann., Health-Gen. that has received:

(i) A certificate of need under Md. Code Ann., Health-Gen § 19–120(o)(1); or

(ii) An exemption from obtaining a certificate of need under Md. Code Ann., Health-Gen §19–120(o)(3); and

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

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

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

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

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

(g) "Hospital services" does not include:

(i) Outpatient renal dialysis services; or

(ii) Outpatient services provided at a limited service hospital as defined in Md. Code Ann., Health-Gen § 19–301, except for emergency services; or

(iii) Physician services that are billed separately.

(6) Household.

(a)"Household" means, at a minimum:

(1) For an adult patient, the patient and the following individuals that live in the same dwelling:

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

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

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

(2) For a patient who is a child, the patient and the following individuals that live in the same dwelling:

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

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

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

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

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

(a) If a hospital uses state or federal tax returns to verify income, hospitals shall take into consideration adjustments listed on Schedule 1 of Form 1040.

(b) If a hospital utilizes an asset test, "income" includes the value of household monetary assets, consistent with section .06J of this regulation.

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

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

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

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

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

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

(11) "Monetary assets" means assets in excess of $100,000 that can readily be converted into a fixed or precisely determinable amount of money, including cash and cash equivalents, such as cash on hand, bank deposits, investment accounts, accounts receivable (AR), and notes receivable. Monetary assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment, including deferred–compensation plans qualified under the Internal Revenue Code or nonqualified deferred–compensation plans.

(12) "Payment plan" means an agreement between a patient (or a guarantor) to pay for a hospital service over a period of time, including an "income-based payment plan" under regulation .05 of this chapter and a "non-income-based payment plan" under §W of regulation .05 of this chapter.

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

(14) "Written" Communications.

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

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

.02 Electronic Delivery of Written Communications

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

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

C. A hospital or debt collector may not require, directly or indirectly, that the patient, in order to opt out of electronic communication, pay any fee or provide any information other than the patient's opt out preferences and the email address, telephone number for text messages, or other electronic-medium address subject to the opt-out request.

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

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

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

E.

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

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

.03 Hospital Information Sheet

A. Each hospital shall develop an information sheet that:

(1) Describes clearly:

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

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

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

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

(b) of the patient's right to request and receive a written estimate of the total charges for the hospital non-emergency services, procedures, and supplies that reasonably are expected to be provided and billed for by

the hospital, in addition to the good faith estimate requirements in the Public Health Service Act § 2799B-6, the No Surprises Act;

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

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

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

(3) Provides contact information for:

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

(i)The patient's hospital bill;

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

(iii) How to apply for financial assistance;

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

(v) How to apply for a payment plan;

(b) the Maryland Medical Assistance Program;

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

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

B. The information sheet shall be in:

(1) Simplified language in at least 12-point type; and

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

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

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

(1) Before the patient receives scheduled medical services;

(2) Before discharge;

(3) With the hospital bill;

(4) On request; and

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

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

F. The Commission shall:

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

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

.04 Hospital Credit and Collection Responsibilities.

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

B. The policy shall:

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

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

(3) Prohibit the hospital from:

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

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

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

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

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

(f) Forcing the sale or foreclosure of a patient's primary residence to collect medical debt;
(g) Requesting a lien against a patient's primary residence in an action to collect medical debt;
(h) Requesting the issuance of or otherwise knowingly taking action that would cause a court to issue a body attachment against a patient or an arrest warrant against a patient, if the hospital files an action to collect medical debt; and
(i) Requesting a writ of garnishment of wages or filing an action that would result in an attachment of wages against a patient to collect medical debt if the patient is eligible for free or reduced-cost medically necessary care, in accordance with regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland.

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

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

(6) Provide a mechanism for a patient to:

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

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

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

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

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

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

(9) Provide detailed procedures for the following actions:

(a) When garnishments may be applied to a patient's or patient guarantor's income in accordance with section .04I of this regulation and Health-General Article, §19-214.2(f)(4), Annotated Code of Maryland;

(b) When a lien on a patient's or patient guarantor's personal residence, excluding a primary resident in accordance with section .04I. of this regulation and Health-General Article, §19-214.2(g)(2), Annotated Code of Maryland, or motor vehicle may be placed;

(c) the hospital's procedures for collecting any medical debt, consistent with section .04 of this regulation;

(d) the circumstances in which the hospital will seek a judgment against a patient for the patient's medical debt, subject to §.04 I. of this regulation and Health-General Article, §19–214.2, Annotated Code of Maryland;

(e) the consideration by the hospital of patient income, assets, and other criteria under section .04 of this regulation;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

H. Consumer Reporting.

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

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

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

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

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

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

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

I. Civil Action

(1) Deceased patients.

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

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

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

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

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

(b) Be in simplified language and in at least 12-point type;

(c) Include:

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

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

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

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

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

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

(e) Be accompanied by:

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

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

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

J. If a hospital delegates collection activity to a debt collector, the hospital shall:

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

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

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

(4) Require the debt collector to:

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

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

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

K. A spouse or another individual may not be held liable for the medical debt of an individual 18 years old or older unless the individual voluntarily consents to assume liability for the patient's medical debt. The consent shall be:

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

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

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

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

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

N. Reporting Requirements.

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

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

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

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

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

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

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

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

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

O. Selling Medical Debt.

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

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

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

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

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

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

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

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

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

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

(7) The purchaser of the debt shall:

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

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

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

.05 Guidelines for Hospital Payment Plans.

A. Scope.

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

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

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

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

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

(i) Comply with the notice provisions of Health General 19-214.1 and regulation .03 and .06 of this chapter;

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

(iii) Process any request for financial assistance; and

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

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

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

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

B. Access to Income-Based Payment Plans.

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

(a) Insurance status;

(b) Citizenship status;

(c) Immigration status; or

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

(2) Treatment of Nonresidents and Unregulated Services.

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

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

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

C. Notice Requirements.

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

(a) Posted Notice.

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

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

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

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

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

(e) Online Payment Portal. On both the page of the online payment portal that states the amount due, and where the consumer enters the amount being paid by the consumer, the hospital shall provide, in the same font and style as the amount due notification, notice informing Maryland residents of the availability of an income-based monthly payment plan and information, including a telephone number and email address, in order to contact the hospital for additional information.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Use any information collected for determining financial assistance under section .06 under this regulation to establish the 5% monthly payment threshold for payment plans under section .05F. of this regulation.

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

F. Monthly Payment Amounts.

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

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

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

(4) Determining the Household Size. The hospital shall determine the size of the patient's household using the number reported on tax returns, if provided the number of tax filers and dependents listed on the tax return provided by the patient. For example, if a married couple files jointly and has three dependents, the number of tax filers and dependents would equal five. If a patient files as an individual and the patient is not a dependent and has no dependents, the number of tax filers would equal one. If the patient has not provided a tax return, the hospital shall ask the patient to provide the number of individuals in the household.

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

H. Application to Multiple Income-based Payment Plans.

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

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

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

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

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

L. Interest and Fees.

(1) No Interest for Patients Eligible for Financial Assistance. For a patient who is eligible for free or reduced-cost medically necessary care under the hospital's financial assistance policy under regulation .06 of this chapter and Health-General Article, §19–214.1 Annotated Code of Maryland, the hospital may not charge interest or fees on any medical debt amount owed under an income-based payment plan;

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

(3) Interest Rate. An income-based payment plan may not provide for interest in excess of an effective rate of simple interest of 6 percent per annum on the unpaid principal balance of the payment plan. A hospital may not set an interest rate that results in negative amortization. Payers subject to Insurance Article, §15-1005, Annotated Code of Maryland, shall comply with its provisions.

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

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

M. Early Payment.

(1) Prepayment Allowed.

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

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

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

N. Limited Modifications of Income-based Payment Plans.

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

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

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

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

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

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

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

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

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

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

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

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

(2) Notice Included in Initial Income-Based Payment Plan. The hospital may only recalculate payment amounts under an income-based payment plan if the hospital included the process for such recalculation in the notice provided to the patient before they entered into the income-based payment plan, in accordance with §C(2) of this regulation. The patient's agreement to enter into the income-based payment plan after receiving that notice constitutes consent to the payment recalculations allowed under §P of this regulation.

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

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

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

P. Treatment of Missed Payments.

(1) First Missed Payment.

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

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

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

(i) 11 increments over the subsequent 11 months;

(ii) a single payment; or

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

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

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

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

(2) Additional Missed Payments.

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

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

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

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

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

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

R. Application of Credit Provisions of Maryland Commercial Law Article and Licensing Provisions of Financial Institutions Article. An income-based payment plan is an extension of credit subject to Maryland credit regulations under Commercial Law

Article, Title 12, Annotated Code of Maryland and any applicable licensing provisions of Financial Institutions Article, Title 11, Annotated Code of Maryland.

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

T. Default.

(1)If a patient defaults on an income-based payment plan and the parties are not able to agree to a modification, then the hospital shall follow the provisions of its credit and collection policy established in accordance with regulation .04 of this chapter, before a hospital may write this medical debt off as bad debt.

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

U. Non-Income-Based Payment Plans.

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

(2) Application of Guidelines: Consistent with the guidelines for hospital payment plans and consistent with the intent of Health General 19-214.2, the following provisions of this regulation apply to non-income-based payment plans in the same manner such provisions apply to income-based payment plans:

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

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

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

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

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

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

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

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

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

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

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

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

(3) Notice

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

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

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

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

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

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

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

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

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

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

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

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

(6) Default.

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

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

V. Steering:

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

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

.06 Hospital Financial Assistance Responsibilities.

A. Financial Assistance Policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Income Documentation.

(a) Hospitals shall accept generally acceptable forms of documentation that verify income, such as tax returns, pay stubs, and W2s to evaluate if the patient is eligible for financial assistance, including free and reduced-cost medically necessary care, including reduced-cost medically necessary care due to financial hardship, in accordance with regulation .06 of this chapter;

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

(c) Hospitals may accept patient attestation of the patient's monthly or annual income and the number of filers and dependents on their tax return without documentation. Such an attestation shall include the patient's income and the number of filers and dependents on their tax return. If the patient provides an attestation of income the hospital is not required to conduct any additional income verification.

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

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

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

(b) Supplemental Nutritional Assistance Program (SNAP);

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Financial Hardship Policy.

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

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

- *(a) Shall remain eligible for reduced-cost medically necessary care when seeking subsequent care at the same hospital during the 12-month period beginning on the date on which the reduced-cost medically necessary care was initially received; and*
- *(b) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced-cost medically necessary care, shall inform the hospital of the patient's or family member's eligibility for the reduced-cost medically necessary care.*

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

- *(a) For a patient with family income of at least 201 percent but not more than 250 percent of the federal poverty level, by 75 percent;*
- *(b) For a patient with family income of more than 250 percent but not more than 300 percent of the federal poverty level, by 60 percent;*
- *(c) For a patient with family income of more than 300 percent but not more than 350 percent of the federal poverty level, by 50 percent;*
- *(d) For a patient with family income of more than 350 percent but not more than 400 percent of the federal poverty level, by 45 percent;*
- *(e) For a patient with family income of more than 400 percent but not more than 450 percent of the federal poverty level, by 40 percent;*
- *(f) For a patient with family income of more than 450 percent but not more than 500 percent of the federal poverty level, by 35.*

D. The Commission may, by regulation, establish income thresholds higher than those in section .06 of this chapter, taking into account the hospital's:

(a) Patient mix;
(b)Financial condition;
(c)Level of bad debt experienced;
(d) Amount of financial assistance provided; and
(e) Other relevant factors.

E.

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

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

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

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

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

G. Each hospital shall use a Financial Assistance Application in the manner prescribed by the Commission in order to determine eligibility for free and reduced-cost medically necessary care.

H. Each hospital shall use a Financial Assistance Application that meets the requirements of this regulation and is consistent with the Uniform Financial Assistance Application.

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

J. Asset Test Requirements. A hospital may utilize a monetary asset test when determining eligibility for financial assistance, using the definition of monetary assets as defined in section .01B.(11) of this regulation.

.07 Patient Complaints.

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

.08 Hospital Written Estimate.

A. In addition to the good faith estimate requirements in PHS Act Sec. 2799B-6, the No Surprises Act, on request of a patient made before or during treatment, a hospital shall provide to the patient a written estimate of the total charges for the hospital services, procedures, and supplies that reasonably are expected to be provided and billed to the patient by the hospital.
B. The written estimate shall state clearly that it is only an estimate and actual charges could vary.
C. A hospital may restrict the availability of a written estimate to normal business office hours.
D. The provisions set forth in §A—C of this section do not apply to emergency services.

.09 Other Obligations.

This chapter does not diminish any obligations of a debt collector, as defined by under COMAR 10.37.13.01, under other applicable laws or regulations, including, without limitation, any requirement for the debt collector to obtain a collection agency license from the State Collection Agency Licensing Board in accordance with Business Regulation Article, Title 7, subtitle 3 Annotated Code of Maryland.

JOSHUA SHARFSTEIN
Chair

Health Services Cost Review Commission

maryland
health services
cost review commission

Maryland Hospital Community Benefit Report: FY 2023

May 29, 2025

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List of Abbreviations

ACA	Affordable Care Act
BMI	Body Mass Index
CBR	Community Benefit Report
CBSA	Community Benefit Service Area
CHNA	Community Health Needs Assessment
CMMI	Center for Medicare and Medicaid Innovation
DME	Direct Medical Education
ED	Emergency Department
FPL	Federal Poverty Level
FY	Fiscal Year
GBR	Global Budget Revenue
GME	Graduate Medical Education
HCB	Hospital Community Benefit
HSCRC	Health Services Cost Review Commission
IRS	Internal Revenue Service
NSP	Nurse Support Program
PSA	Primary Service Area
SIHIS	Statewide Integrated Health Improvement Strategy
UCC	Uncompensated Care

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Executive Summary

Tax-exempt hospitals are required to provide "community benefit" as a condition of their federal tax-exemption. The term "community benefit" refers to initiatives, activities, and investments undertaken by hospitals to improve the health of the communities they serve. Hospitals submit information on their community benefit activities to the federal government each year. In addition, Maryland law[1] requires Maryland's nonprofit hospitals to report annual community benefit information to the Health Services Cost Review Commission (HSCRC). Maryland law builds on the federal requirements, providing the State with more information than is available through the federal reports.

In this report, the HSCRC summarizes fiscal year (FY) 2023 information submitted by hospitals, representing the HSCRC's 20th year reporting on Maryland hospital community benefit (HCB) data. The report describes how the State's reporting requirements differ from federal requirements, provides an overview of recent updates made to the reporting instructions, and highlights HSCRC programs that impact hospitals' community benefit spending. To better serve our community partners, staff reorganized this year's report to highlight key data points and make the information easier to use.

Key Highlights

- **Reporting Compliance:** All 49 nonprofit Maryland hospitals submitted their required FY 2023 community benefit reports.[2]
- **Community Benefit Expenditures:** Maryland hospitals reported $2.28 billion in total community benefit in FY 2023, an increase of around 11% from FY 2022.
    - **Rate Support for Hospital Community Benefits:** About 41% of the total HCB expenses are built into hospital rates, which are reimbursed by health care payers, including Medicare, Medicaid, commercial insurance, and patients. Roughly 59% ($1.3 billion) of the total hospital HCB spending comes directly from the hospitals without any rate support.
    - **Indirect Costs:** Hospital community benefit spending includes both direct and indirect costs (i.e., overhead costs). There is significant variation between hospitals in the indirect cost ratios associated with hospital-based community benefit activities. Indirect costs, as a percentage of total direct costs, ranged from 21 to 145% for hospital-based community benefit activities. Three hospitals reported that indirect costs of hospital-based community benefit activities exceeded the direct costs of providing those activities. Due to concerns about the variation in indirect costs and the high amount of indirect costs reported by some

[1] MD. CODE. ANN., Health-Gen. § 19-303.
[2] There are 49 hospitals but only 47 narrative reports (45 reports from single hospitals and 2 reports that each cover 2 hospitals).

hospitals, the HSCRC has updated the community benefit reporting instructions for FY 2024.

- **Community Health Needs Assessments (CHNAs):** Under federal law, hospitals are required to conduct CHNAs every three years. CHNAs identify priority health needs and include implementation strategies to address them. All Maryland hospitals reported complying with this requirement. Hospitals reported spending 37.2% of their net community benefit on CHNA-related activities. Hospitals identified “Social Determinants of Health - Health Care Access and Quality” as the most frequently addressed CHNA priority area. Hospitals continued to show wide variation in the percentage of net community benefit spent on CHNA-related activities. To address this, staff updated reporting instructions for FY 2024.

Introduction

This report presents the results of an annual assessment of community benefit investments and activities of Maryland's nonprofit hospitals. Maryland law requires the Health Services Cost Review Commission (HSCRC) to submit this report annually.[3] This report is based on hospital community benefit (HCB) data submitted to the HSCRC by each hospital. The reports submitted by individual hospitals are posted on the HSCRC's website.[4]

This report explains the HCB reporting requirements and provides a summary of the fiscal year (FY) 2023 data that hospitals submitted to the HSCRC. This report also describes how the State's reporting requirements differ from federal requirements, provides an overview of recent updates made to Maryland's reporting instructions, and highlights HSCRC programs that impact hospitals' community benefit spending. To better serve our community partners, staff reorganized this year's report to highlight key data points and make the information easier to use.

Federal and State Authority over Community Benefits

Federal Tax Exemption and Reporting Requirements

Maryland's hospitals are nonprofit tax-exempt organizations. The federal Internal Revenue Code defines tax-exempt organizations as those that are organized and operated exclusively for specific religious, charitable, scientific, and educational purposes.[5] In order to maintain federal tax-exempt status, a hospital must provide "community benefits"[6] and report their community benefit activities to the Internal Revenue Service (IRS) annually. The IRS has no requirement for the minimum amount of community benefit that a hospital must provide to qualify for federal tax-exempt status.[7] In addition, every tax-exempt hospital, whether independent or part of a hospital system, must conduct a community health needs assessment

[3] MD. CODE. ANN., Health-Gen. § 19-303.
[4] https://hscrc.maryland.gov/Pages/init_cb.aspx
[5] 26 U.S.C. § 501(c)(3). Nonprofit hospitals have been required to demonstrate community benefits to qualify for federal tax-exempt status since 1969. The Internal Revenue Service (IRS) specifies categories of activities that qualify as community benefits in Schedule H of form 990. Under federal tax law, hospitals are required to: conduct a CHNA, including an implementation strategy; have a written financial assistance policy for medically necessary and emergency care; limit hospital charges for those eligible for financial assistance; and comply with billing and collections requirements. Source: James, J. (2016, February 25). Nonprofit hospitals' community benefit requirements, Health Affairs Health Policy Brief. DOI: 10.1377/hpb20160225.954803. Maryland law requires additional reporting of community benefit information. MD. CODE. ANN., Health-Gen. § 19-303. Maryland law adds requirements that exceed the federal requirements related to financial assistance and medical debt collection. MD. CODE. ANN., Health-Gen. §§ 19-214.1 and 19-214.2.
[6] A hospital must report community benefits to demonstrate to the IRS that they are a "charitable" organization, and thus eligible for tax exempt status. Historically, the IRS considered hospitals to be "charitable" if they provided charity care to the extent that they were financially able to do so. Ruling 56-185, 1956-1 C.B. 202. However, in 1969, the IRS modified the "charitable" standard to focus on "community benefits" rather than "charity care." Rev. Ruling 69-545, 1969-2 C.B. 117. "Charity care," now referred to as "financial assistance," is a category of community benefit.
[7] Congressional Research Service. (2024, April 15). Legal requirements for Section 501(c)(3) hospitals, page 4. https://crsreports.congress.gov/product/pdf/R/R48027

(CHNA) at least once every three years.[8] CHNAs are discussed in more detail later in this report. Hospitals must also report information about their CHNAs to the IRS.

Tax-exempt hospitals (also referred to as nonprofit hospitals) are generally exempt from federal income and unemployment taxes, as well as state and local income, property, and sales taxes. In addition, nonprofit hospitals may raise funds through tax-deductible donations and tax-exempt bond financing. Table 1 shows the number of Maryland hospitals that reported claiming each type of tax exemption in their FY 2023 HCB report.

Table 1. Tax Exemptions

Tax Exemption	Number of Hospitals
Federal corporate income tax	47
State corporate income tax	47
State sales tax	44
Local property tax (real and personal)	42
Other	5

The five hospitals that selected "Other" indicated that they also claimed an exemption from the federal unemployment insurance tax. One hospital reported claiming exemptions from some property taxes—depending on usage—but not from all local property taxes. The HSCRC conducted a tax benefit assessment of Maryland hospitals in 2020, calculating an overall net tax benefit of about $704 million for the year ending June 30, 2019.[9]

Overview of Maryland Reporting Requirements

Maryland law requires hospitals to report their HCB activities to the HSCRC annually, and the HSCRC is required to submit an annual statewide summary report to the General Assembly. This report contains the community benefit data for FY 2023,[10] marking the HSCRC's 20th year reporting on Maryland HCB.

Maryland's HCB reporting requirements are more extensive than the federal requirements. Maryland law defines "community benefit" as a planned, organized, and measured activity that is intended to meet

[8] Hospitals that do not conduct a CHNA every three years are subject to an annual penalty of up to $50,000 and loss of their tax-exempt status. 26 U.S.C. § 501(r)(3); 26 U.S.C. § 4959. Tax-exempt hospitals must report information on their CHNA on Schedule H of IRS Form 990. This reporting requirement was added by the Affordable Care Act.
[9] The HSCRC study is available here: https://hscrc.maryland.gov/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY19/HSCRC%20Hospital%20Tax%20Benefit%20Report%20July%202020.pdf. Other researchers have published articles and reports on the national scale of the benefit of hospital tax exempt status. "There is debate in the literature regarding the calculation of tax exemption value, particularly concerning federal and state corporate income taxes." Zare, H. & Anderson, G. (2024). Beyond the bottom line: Assessing charity care, community benefits, and tax exemptions in nonprofit hospitals. *Journal of Healthcare Management 69*(6), 439-454. DOI: 10.1097/JHM-D-24-00080. This results in different estimates by different researchers.
[10] The reporting period for these financial data is July 1, 2022, through June 30, 2023. Several hospitals are on a calendar financial year and report their most recent calendar year's data instead.

identified community health needs within a service area.[11] Hospitals must report their community benefit activities in categories that are specified by the HSCRC, including community health services; health professions education; research; financial contributions to other organizations; community-building activities, including partnerships with community-based organizations; financial assistance (i.e., free and reduced cost care); and mission-driven health services.[12] These categories are generally aligned with federal reporting categories (see Appendix A for a comparison of the federal and state reporting categories). The HSCRC also requires hospitals to report on health disparities and the types of tax exemptions claimed by the hospital in the preceding year.

Hospitals are also required to report information about their CHNA, including the amount of community benefit activities that are connected to community needs identified in the hospital's CHNA. The CHNA should influence the hospital's community benefit activities so that the hospital is serving identified community needs.

Maryland law requires hospitals to include the following information in their community benefit reports (CBRs):

- The hospital's mission statement
- A list of the hospital's activities to address the identified community health needs
- The costs of each community benefit activity
- A description of how each of the listed activities addresses the health needs of the hospital's community
- A description of efforts to evaluate the effectiveness of each community benefit activity
- A description of gaps in the availability of providers to serve the community
- A description of the hospital's efforts to track and reduce health disparities in the community
- A description of the process the hospital used to develop their CHNA
- A list of the unmet community health needs identified in the most recent CHNA
- A list of tax exemptions the hospital claimed during the preceding taxable year[13]

Hospitals submit a narrative report that contains descriptive information on their community benefit activities and a financial report on community benefit expenditures. The financial reports collect information about direct and indirect costs of community benefits, categorized by type of community benefit activity. Hospitals should use data from audited financial statements to calculate the cost of each community benefit category

[11] MD. CODE. ANN., Health-Gen. § 19-303(a)(3); COMAR 10.37.01.03.
[12] The categories of community benefits are described in detail in the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. The FY 2023 version of this document is available here: https://hscrc.maryland.gov/Documents/CommBen/FY%202023/FY%202023%20Community%20Benefit%20Guidelines%20and%20Definitions%20FINAL.pdf. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of IRS Form 990, Schedule H. https://www.irs.gov/pub/irs-pdf/f990sh.pdf.
[13] MD. CODE. ANN., Health-Gen. § 19-303(c)(4). Each hospital also reports to the HSCRC on the geographic region where the hospital offers its community benefit programs. This is referred to as the hospital's community benefit service area (CBSA). More information on how hospitals determined their CBSAs is in Appendix G.

contained in the financial reports and to limit reporting to only those hospital services reported on the IRS Form 990 Schedule H. Hospitals also submit their financial assistance policies. Each hospital's narrative and financial reports and financial assistance policies are posted on the HSCRC's website.[14]

Updates to Maryland's Reporting Instructions

In response to legislation, the HSCRC updated the reporting instructions in FY 2022, requiring hospitals to:

1. Report on initiatives that directly address needs identified in the CHNA
2. Within the financial report, itemize all physician subsidies claimed by type and specialty
3. List the types of tax exemptions claimed
4. Self-assess the level of community engagement in the CHNA process

After reviewing the results of the FY 2022 HCB reports, the HSCRC identified potential reporting issues with data related to indirect costs and CHNA-aligned spending. The HSCRC's Commissioners directed staff to convene a short-term technical workgroup[15] to review the reporting instructions. As a result of workgroup deliberations, staff made technical corrections to the reporting instructions for the FY 2024 reports, including adjustments to directions for reporting physician subsidies, CHNA-identified community needs, and justifications for certain indirect costs. Those changes will be reflected in next year's report.

State Authority over Hospital Community Investments

State law requires hospitals to submit community benefit data to the HSCRC. The HSCRC has the authority to fine hospitals for failing to report accurate and timely information in their annual CBRs. All hospitals were compliant with the State community benefit reporting requirement for FY 2023.[16] Appendix B lists the hospitals submitting CBRs by hospital system. Maryland law does not provide regulatory authority over the quantity or quality of the community benefit activities or the CHNA. Maryland's HCB reporting requirements have no bearing on a nonprofit hospital's exemption from state income taxes; state tax exemption is based on the federal determination of the hospital's tax-exempt status.

Hospital Investments in Community Health and Rate Setting

Maryland has a unique statewide all-payer hospital rate-setting system. In contrast to the HSCRC's limited authority over community benefits, Maryland's hospital rate-setting system is a powerful tool for directing hospital investment in community health. The HSCRC uses the rate-setting system to direct hospital

[14] https://hscrc.maryland.gov/Pages/init_cb.aspx; https://hscrc.maryland.gov/Pages/hsp-fap.aspx.
[15] https://hscrc.maryland.gov/Pages/Community-Benefit-Workgroup.aspx.
[16] The HSCRC received 49 financial reports and 47 narrative reports. The University of Maryland Medical System submits one narrative report for its two hospitals on the Eastern Shore and another report for its two hospitals in Harford County.

investment in activities that align with state and community priorities. The following are current HSCRC programs that use the hospital rate-setting system to direct hospital spending on community health.

- **Revenue for Reform:** Hospitals the HSCRC identifies as inefficient are required to invest in community health activities or return funds to payers. These hospitals may only use the funds for community health activities that are approved by the HSCRC and the Maryland Department of Health (the Department). This funding remains in a hospital's global budget revenue (GBR) year after year, creating sustainable long-term funding for population health activities. Revenue for Reform is a new program and was not in place in FY 2023, the year covered by this report.
- **Behavioral Health Regional Partnership Catalyst Program:** The HSCRC approved $79.1 million in cumulative funding over a five-year period (FY 2021–FY 2025) for three behavioral health programs that are focused on expanding access to crisis services. Hospitals applied for this funding and had to demonstrate that they developed meaningful community partnerships and would maintain those partnerships throughout the program. This program has funded new behavioral health crisis centers and other services on the Eastern Shore, in Prince George's County, and in the greater Baltimore metropolitan region.
- **Maternal and Child Health Initiative:** The HSCRC assessed $40 million in funding over four years (FY 2022–FY 2025) to support maternal and child health interventions led by Medicaid managed care organizations and the Department's Prevention and Health Promotion Administration (PHPA). This funding supports new services not previously offered to Medicaid participants and continued efforts to reduce health care disparities. The Department has until the end of CY 2027 to spend the available funds.
- **Nurse Support Programs (NSP):** The HSCRC maintains two programs to develop and maintain the nursing workforce in Maryland. All Maryland hospitals receive funding through NSP I to support recruitment and retention of clinical nurses. In FY 2023, $19.1 million was included in hospital rates for NSP I activities. NSP II is funded through an $18.8 million hospital assessment aimed at expanding faculty and educational capacity at Maryland nursing schools. The Maryland Higher Education Commission (MHEC) administers NSP II on behalf of the HSCRC. Both programs have been implemented for over 20 years.

The HSCRC plans to continue to work with the Department in future years to develop programs that invest in the health of Maryland communities. The HSCRC increases hospital rates to fund these programs (or, in the case of Revenue for Reform, does not lower rates). Health care payers (including Medicare, Medicaid, private insurers, and patients) fund these activities through their payment of hospital claims.

To the extent these hospital investments fit the definition of "community benefit," hospitals may include them in their CBRs. Hospitals identify expenditures on these and other programs that the HSCRC includes in the annual calculation of each hospital's rates so that the HSCRC can determine the percentage of each hospital's community benefit that is funded through rates. These data are discussed later in this report.

Alignment of Hospital Community Benefit Activities with State/Federal Models

Maryland and the federal Center for Medicare and Medicaid Innovation (CMMI) have entered several agreements that support Maryland's all-payer hospital rate setting system, enhanced primary care, population health investments, and other aspects of the health care delivery system. Under the current Total Cost of Care Model agreement, Maryland agreed to four population health goals: 1) reducing the mean body mass index (BMI) for Maryland residents as it pertains to diabetes; 2) improving opioid overdose mortality; 3) decreasing asthma-related emergency department (ED) visits for children; and 4) reducing the severe maternal morbidity rate. All 49 hospitals reported that their community benefit activities addressed at least one of these goals, and most hospitals addressed more than one goal (Table 2). Reducing the mean BMI was the goal most frequently addressed by community benefit activities. Please note that hospitals may have other initiatives addressing these goals that do not count as community benefit.

Table 2. Number of Hospitals with Community Benefit Activities Addressing Population Health Goals under the Total Cost of Care Model, FY 2023

Goal	Number of Hospitals
Diabetes – Reduce the mean BMI for Maryland residents	43
Opioid Use Disorder – Improve overdose mortality	32
Maternal and Child Health – Reduce severe maternal morbidity rate	26
Maternal and Child Health – Decrease asthma-related ED visit rates for children aged 2-17	9

Maryland recently entered the AHEAD Model with CMMI, which will replace the Total Cost of Care Model in 2026. The State is working with stakeholders to develop the population health goals that will be used under the AHEAD Model. The HSCRC will adjust the hospital community benefit reporting instructions to collect information on the alignment between hospital community benefit investments and the AHEAD Model population health goals after those goals are established.

Spending on Community Benefits

Maryland hospitals provided approximately $2.28 billion in total community benefit activities in FY 2023.[17] This is an increase of approximately 11% over FY 2022. Hospital spending on community benefit grew faster than hospital revenue between FY 2022 and FY 2023.[18] In inflation-adjusted (real) dollars, Maryland community benefit expenditures were $943.3 million in FY 2004 (6.9% of operating expenses),[19] which is a significant increase in community benefit investment over the past 20 years.

Rate Support for Community Benefit Activities

As described earlier in this report, the HSCRC ensures that hospitals have funding for community benefit activities that are State priorities. The HSCRC increases hospital GBRs (and, relatedly, hospital rates) to fund these activities.[20] **Approximately $945 million of the $2.3 billion in community benefit reported in FY 2023, or 42% of HCB activities, was funded by health care payers through hospital rates. Approximately $1.3 billion of HCB activities was not funded through rates.** This equates to 6.6% of total hospital operating expenses. This is similar to the $1.22 billion in community benefit that was not rate-supported in FY 2022 (approximately 6.2% of operating expenses). Figures 1 and 2 show the trend of community benefit expenses with and without rate support. Appendix C details the amounts that were included in rates and funded by all payers for FY 2023.

Appendix D presents the total amount of community benefit reported and the amount of community benefit recovered through HSCRC-approved rate support.[21] Hospitals differ in their amount of community benefit not supported by rates compared to their total operating expenses. The total amount of community benefit expenditures without rate support as a percentage of total operating expenses ranged from 1.8% (Mt. Washington Pediatric Hospital) to 31.2% (McNew Family Medical Center), with an average of 7.6%. This is slightly higher than the average of 7.1% in FY 2022. Nine hospitals reported providing community benefit that exceeded 10% of their operating expenses, the same number as in FYs 2021 and 2022.

[17] This amount excludes expenditures on community benefit activities that are offset by revenue.
[18] The HSCRC approved a 3.25% increase in revenue for hospital global budgets for FY 2023. See https://hscrc.maryland.gov/Documents/RY23%20Final%20UF%20Recommendation.docx.pdf.
[19] FY 2004 community benefit expenses were $586.5 million. Inflated by CPI to FY 2023, this equals $943.3 million.
[20] The HSCRC sets the rates that most hospitals can charge payers for hospital services. For general acute care and chronic care hospitals, these rates are paid by Medicare, Medicaid, commercial insurance, and individuals who pay all or a portion of their hospital bill out of their own pocket. For pediatric and psychiatric hospitals, the HSCRC only sets rates for commercial insurers.
[21] Some hospital community benefits activities, such as clinics, generate revenue that offsets the amount of community benefit. Hospitals report the full amount of community benefit that they provide and any offsetting revenue that is not funded through rates. The HSCRC calculates the amount of hospital community benefit from rates using data that is separate from the hospital CBRs. This is intended to align HSCRC reporting with hospital reporting on the IRS Form 990 and avoid accounting confusion among programs that are not funded by hospital rate setting.

Figure 1. FY 2013–FY 2023 Community Benefit Expenses with and without Rate Support (in Millions, Inflation Adjusted)

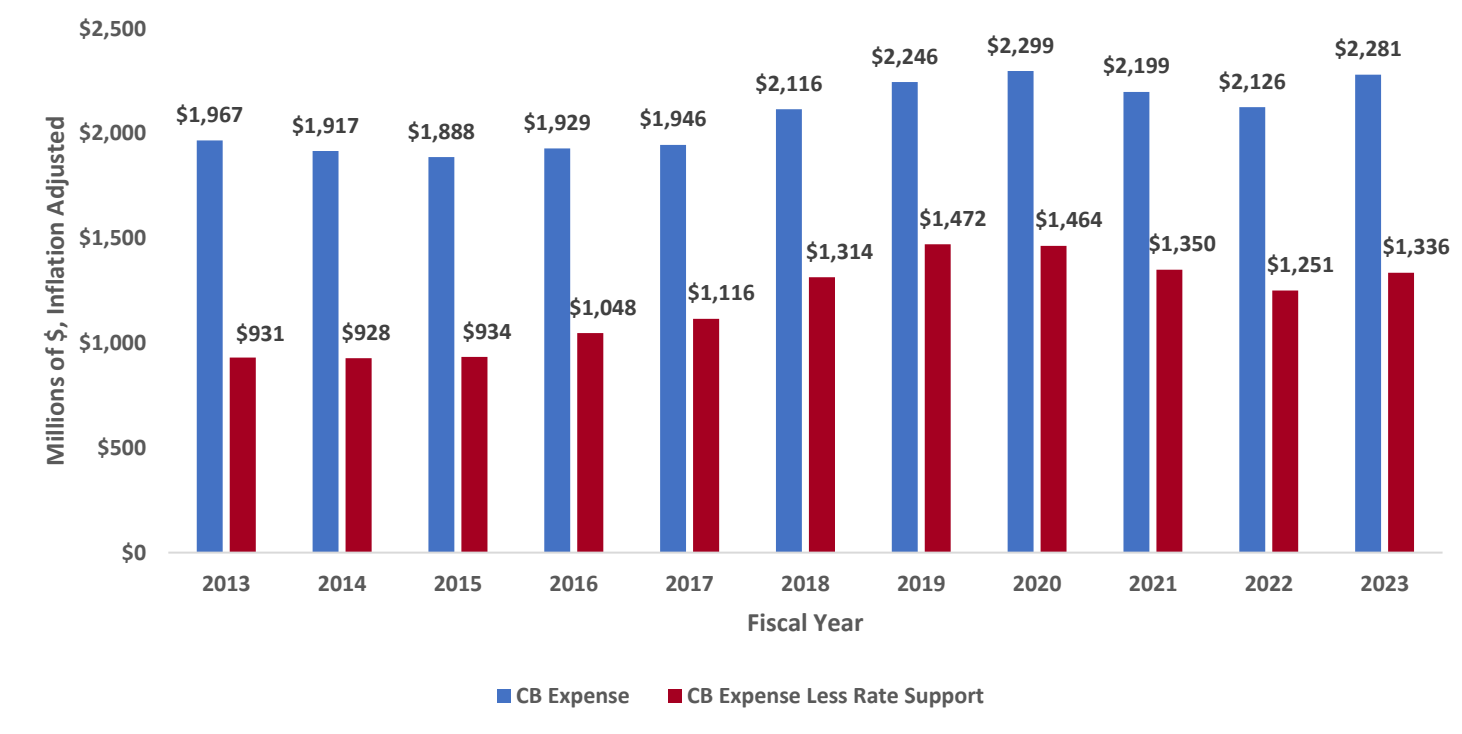


Figure 2. FY 2012–FY 2023 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support

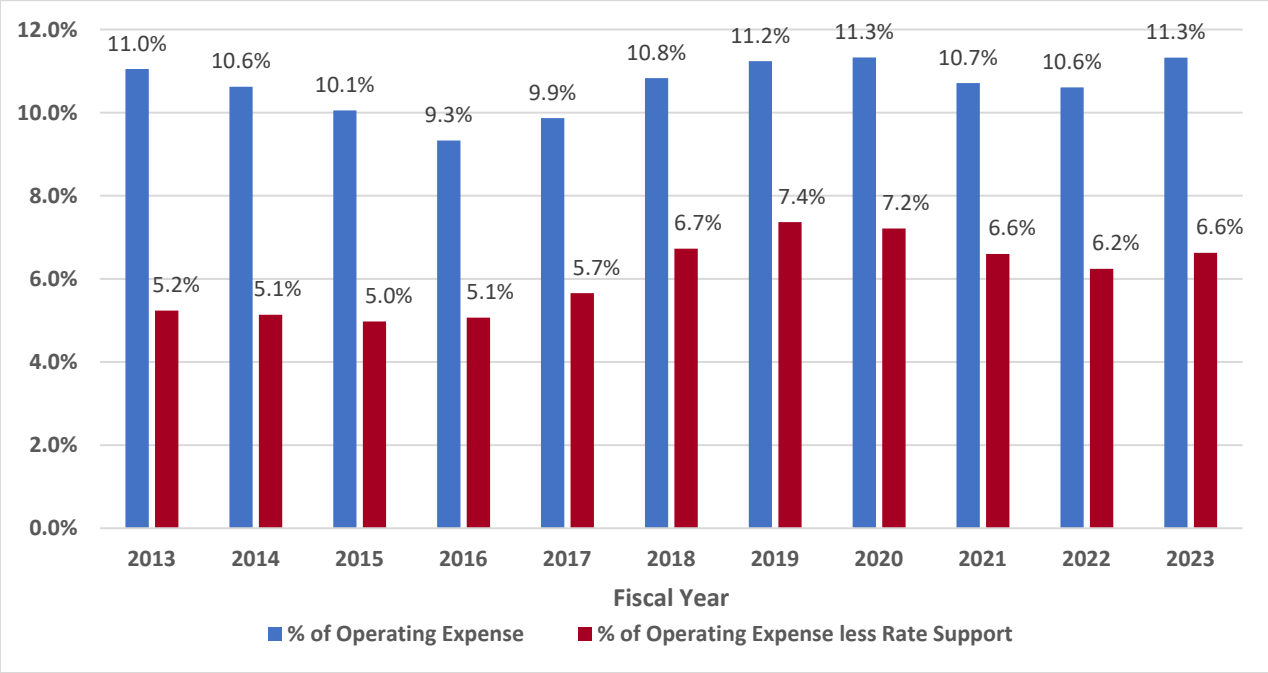
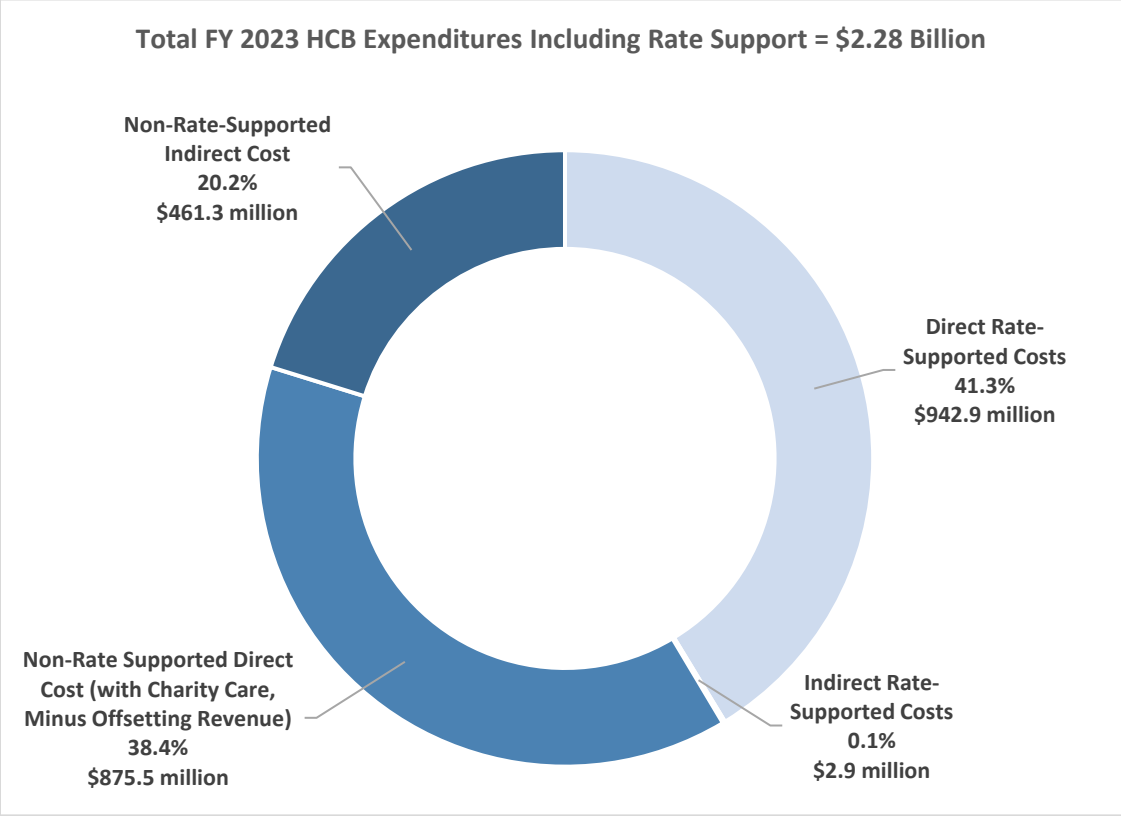


Figure 3 shows hospitals' total rate-supported and non-rate-supported direct and indirect costs in FY 2023 as a percentage of total HCB expenditures. Rate-supported direct and indirect costs accounted for roughly 41% of total expenditures.

Figure 3. Total Direct and Indirect Costs by Rate Support Status for All Hospitals, FY 2023



Examples of the community benefit costs that the HSCRC builds into hospital rates include the following:

- Financial assistance for low-income patients (free and reduced cost care)
- Graduate medical education (GME)
- The HSCRC's Nurse Support Programs, which support nursing education, recruitment, and retention programs in the State
- The Regional Partnership Catalyst Program for behavioral health crisis services

The following sections provide additional information on financial assistance, GME, and nurse support programs.

Financial Assistance

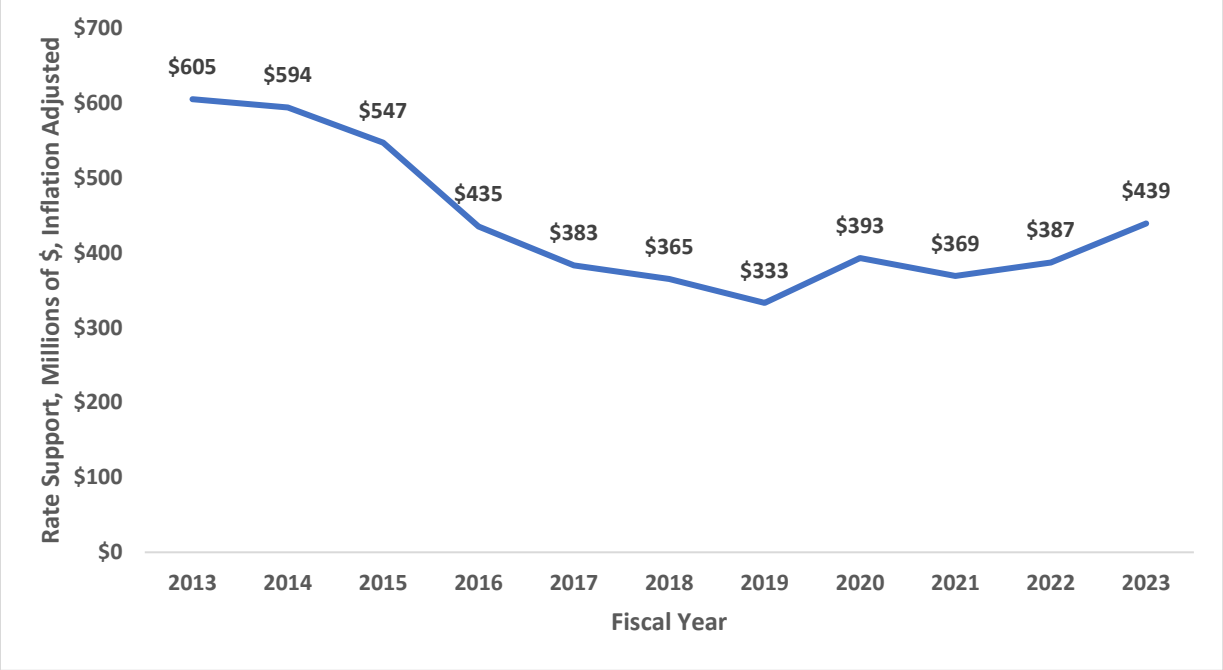
Maryland law requires general acute care and chronic care hospitals to provide financial assistance to patients with low income.[22] This is the third largest category of HCB spending, representing approximately 20% of total HCB spending ($452 million) in FY 2023. Almost all of this spending is accounted for in rates.

Figure 4 shows the amount built into hospital rates for financial assistance provided to low-income patients from FY 2013 through FY 2023. The amounts built into hospital rates for financial assistance are based on the amount of financial assistance that the hospitals provided to patients two years prior to the fiscal year. For example, the amount of rate support provided to hospitals for financial assistance in FY 2023 is based on the amount of financial assistance the hospitals provided to patients in FY 2021.[23]

As insurance coverage expanded under the Affordable Care Act (ACA) in 2014 and subsequent years, hospital patients needed less financial assistance. However, the need for financial assistance has increased since FY 2019, resulting in larger amounts of funding being included in hospital rates for financial assistance. Rate support for financial assistance continued to increase in FY 2023. See Appendix E for more details on the financial assistance methodology.

[22] MD. CODE. ANN., Health-Gen. § 19-214.1and COMAR 10.37.10.26(A-2).
[23] The HSCRC calculates this amount as a percentage of total statewide hospital revenue, adjusted for inflation.

Figure 4. Rate Support for Financial Assistance (in Millions, Inflation-Adjusted), FY 2013–FY 2023



Maryland law sets minimum eligibility standards for patient income based on family income. Hospitals must provide free care to patients under 200% of the federal poverty level (FPL), reduced cost care to patients under 300% of the FPL, and reduced cost care to patients under 500% of the FPL with medical debt that exceeds 25% of their annual income.[24] Hospitals may provide financial assistance to other patients. If a hospital is more generous in either the eligibility criteria in their financial assistance policy or in the amount of assistance they provide to patients who qualify, that could increase their spending on financial assistance.

Staff reviewed hospital financial assistance policies and compared the income thresholds for patient eligibility for free and reduced cost care in the policies with the eligibility requirements in law (Table 3). As with prior years, staff noted variation in the content and format of the financial assistance policy documents.

[24] MD. CODE. ANN., Health-Gen. § 19-214.1(b)(2)(i); COMAR 10.37.10.26(A-2)(2)(a) and COMAR 10.37.10.26(A-2)(3).

Table 3. Number of Hospitals with Expanded Financial Assistance Eligibility Criteria

Type of Financial Assistance	Statutory Eligibility Criteria	# of Hospitals That Provide Financial Assistance to a Higher Income Level
Free Care	Family income at or below 200% FPL	19
Reduced Cost Care	Family income between 201% and 300% FPL[25]	41
Reduced Cost Care due to Financial Hardship	Family income between 301% and 500% FPL, and the medical debt incurred by the family over a 12-month period exceeds 25% of the family's income[26]	22

Workforce: Graduate Medical Education and Nurse Support Programs

The HSCRC builds the cost of GME into hospital rates, as well as the cost of nursing workforce education and retention programs. GME is the cost of educating physician residents and interns. GME costs include the direct costs (i.e., direct medical education, or DME) of wages and benefits for residents and interns, faculty supervisory expenses, and allocated overhead. In FY 2023, DME costs in Maryland totaled $437 million.[27]

The HSCRC's Nurse Support Program I (NSP I) and NSP II are aimed at addressing the short- and long-term nursing shortages affecting Maryland hospitals. In FY 2023, the HSCRC provided just over $19 million in hospital rate adjustments for NSP I and just under $19 million for NSP II. See Appendix C for detailed information about the funding provided to specific hospitals through these programs.

Table 4 presents HCB expenditures for health professions education by activity. As with prior years, the education of physicians and medical students (including the DME expenses described above) made up most expenses in this category. The second highest category was the education of nurses and nursing students, totaling $53 million, including the NSP expenses described above.

[25] COMAR 10.37.10.26(A-2)(2)(a)(ii).
[26] MD. CODE. ANN., Health-Gen. § 19-214.1
[27] The HSCRC's annual cost report.

Table 4. Health Professions Education Activities and Costs, FY 2023

Health Professions Education	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Physicians and Medical Students	$596,228,227	$393,768,365
Nurses and Nursing Students	$52,949,989	$32,144,499
Other Health Professionals	$30,640,738	$20,477,282
Scholarships and Funding for Professional Education	$4,603,458	$2,963,417
Other	$2,434,818	$1,262,268
Total	**$686,857,230**	**$450,615,831**

Categories of Community Benefit Activities

Hospitals must report on their community benefit activities in the following categories[28] defined by the HSCRC:

- **Medicaid Costs:** The cost of the Medicaid Deficit Assessment.
- **Community Health Improvement Services:** Activities that are carried out to improve community health (such as community health education, health screenings, and clinics for uninsured people).
- **Health Professionals Education:** Educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional or continuing education that is necessary to retain state license or certification by a professional board.
- **Mission-Driven/Subsidized Health Services:** Services provided to the community that were never expected to result in cash inflows that the hospital undertakes as a direct result of its community or mission-driven initiatives—or which would otherwise not be provided in the community if the hospital did not perform these services, including physician subsidies that address gaps in physician availability.
- **Research**: Clinical research and community and health services research.
- **Cash Donations and In-Kind Contributions:** Resources donated by the hospital to organizations outside the hospital.
- **Community-Building Activities:** Activities that address the underlying causes of health problems and improve health status and quality of life services.
- **Community Benefit Operations:** Costs associated with staff, community health needs and/or assets assessment, and other costs associated with community benefit strategy and operations.

[28] The categories of community benefits are described in detail in the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. The FY 2023 version of this document is available here: https://hscrc.maryland.gov/Documents/CommBen/FY%202023/FY%202023%20Community%20Benefit%20Guidelines%20and%20Definitions%20FINAL.pdf. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of IRS Form 990, Schedule H. https://www.irs.gov/pub/irs-pdf/f990sh.pdf

See Appendix F for a detailed combined spreadsheet showing all hospitals' costs, rate support, and offsetting revenue across all categories.

As in FY 2022, hospitals spent the highest amount of their community benefit investments on mission-driven health services, health professions education, and financial assistance (Table 5).[29]

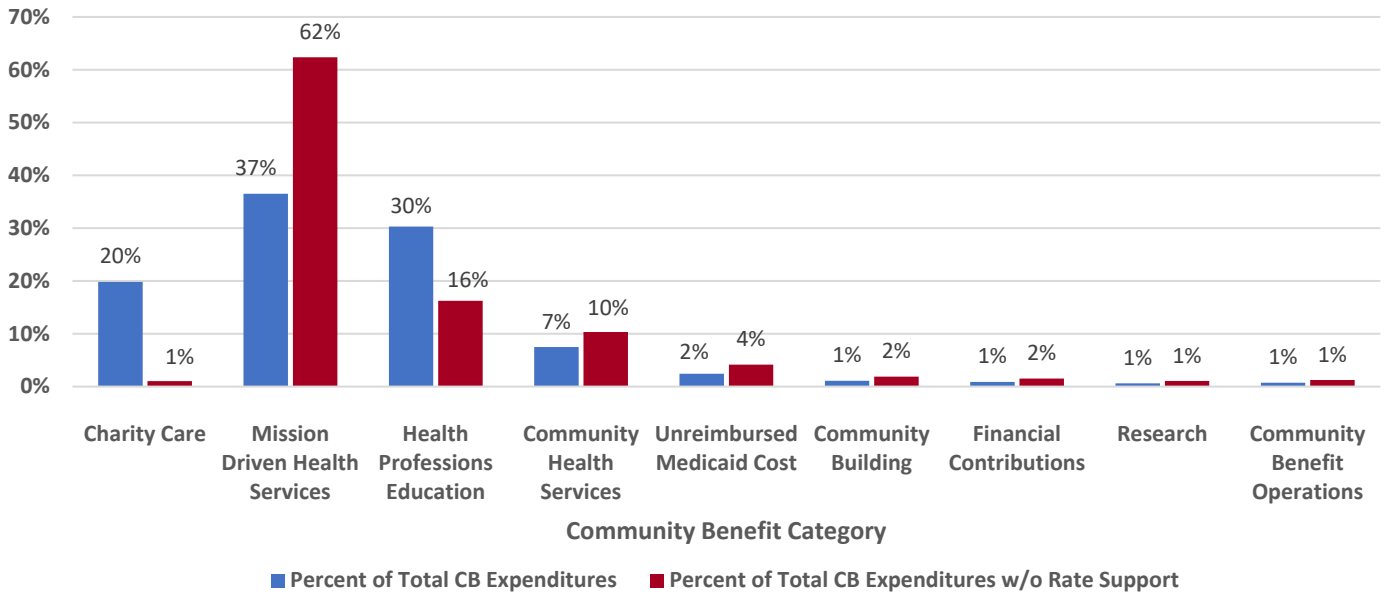
Table 5. Total Community Benefit Expenditures, FY 2023

Community Benefit Category	Total Community Benefit Expense[30]	Category as % of Total CB Expenditures	Total Community Benefit Expense Less Rate Support	Category as % of Total CB Expenditures Less Rate Support
Medicaid Deficit Assessment	$55,466,167	2.43%	$55,466,167	4.15%
Community Health Improvement Services	$170,611,890	7.48%	$138,016,988	10.33%
Health Professions Education	$691,682,793	30.32%	$217,089,010	16.25%
Mission-Driven Health Services	$832,747,261	36.50%	$832,747,261	62.35%
Research	$14,178,301	0.62%	$14,178,301	1.06%
Financial Contributions	$20,126,907	0.88%	$20,126,907	1.51%
Community Building	$25,226,682	1.11%	$25,226,682	1.89%
Community Benefit Operations	$16,801,859	0.74%	$16,801,859	1.26%
Foundation	$2,251,660	0.10%	$2,251,660	0.17%
Financial assistance	$452,369,804	19.83%	$13,692,246	1.03%
Total	**$2,281,463,324**	**100%**	**$1,335,597,081**	**100%**

Accounting for rate support significantly affects the distribution of expenses by category. Figure 5 shows expenditures for each community benefit reporting category as a percentage of total community benefit expenditures in FY 2023. Figure 5 also shows the percentage of expenditures by category for FY 2023 less the amount supported through rates.

[29] The FY 2023 total includes: net community benefit expenses of $833 million in mission-driven health care services (subsidized health services), $692 million in health professions education, $452 million in charity care, $170 million in community health services, $56 million in Medicaid deficit assessment costs, $25 million in community-building activities, $20 million in financial contributions, $14 million in research activities, $17 million in community benefit operations, and $2 million in foundation-funded community benefits.
[30] This amount excludes expenditures on community benefit activities that are offset by revenue.

Figure 5. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2023



Direct and Indirect Costs

Total hospital community benefit spending includes both the direct cost of the activity provided in the community and indirect costs. Indirect costs represent the proportion of total community benefit costs that are not attributed to products and/or services but are necessary for general operations, including salaries for human resources and finance departments, insurance, and overhead expenses.[31] The HSCRC's reporting instructions allow hospitals to report two indirect cost ratios: one for hospital/facility-based activities and one for activities in the community.[32] The "community-based" rate should be lower than the hospital-based rate and should exclude the costs of hospital buildings, the billing office, laundry, and other cost centers that should apply only to hospital-based programs. Table 6 presents the indirect cost ratios reported by each hospital for each community benefit category.

[31] The HSCRC specifies the methodology for calculating the indirect cost ratio. The cost ratio that hospitals report for community benefit should align with the cost ratio that they report on Schedule M of their annual cost report to the HSCRC. Staff followed up with hospitals whose indirect costs did not align with Schedule M. Many hospitals reported manually reducing their indirect cost ratio for community benefits, as they felt the ratio derived from their Schedule M was inappropriately high for community benefits activities.
[32] Some indirect costs are reported as a fixed dollar amount while others are a calculated percentage of the hospital's reported direct costs.

There is significant variation between hospitals regarding the indirect cost ratios associated with hospital-based community benefit activities. Indirect costs, as a percentage of total direct costs, ranged from 21 to 145% for hospital-based community benefit activities. Three hospitals reported that indirect costs of hospital-based community benefit activities exceeded the direct costs of providing those activities to the communities they serve (see the "Hospital-Based CB Activities" column in Table 6). There is less variation between hospitals in their reported indirect cost ratios for community-based services, but there are a few outliers. Three hospitals report indirect cost ratios greater than 25% for community-based services.

Due to concerns about the variation in indirect costs and the high amount of indirect costs reported by some hospitals, the HSCRC convened a workgroup in 2024 to discuss changes to hospital reporting. As a result of that workgroup, the HSCRC has updated the community benefit reporting instructions for FY 2024. The FY 2024 report will include additional analysis on indirect costs.

Table 6. Hospital-Reported Indirect Cost Ratios, FY 2023 (Indirect Costs as a Percentage of Direct Costs)

Hospital Name	Indirect Cost Ratio	
	Hospital-Based CB Activities	Community-Based CB Activities
Univ. of Maryland Shore Medical Center at Chestertown	144.8%	19.4%
Adventist Rehabilitation	109.4%	15.0%
Univ. of Maryland Shore Medical Center at Easton	104.9%	11.0%
Univ. of Maryland Charles Regional Medical Center	91.8%	20.2%
Univ. of Maryland Capital Region Medical Center	90.7%	12.9%
Ascension Saint Agnes Hospital	89.5%	10.0%
Mercy Medical Center, Inc.	84.4%	10.0%
MedStar Harbor Hospital Center	84.3%	
J. Kent McNew Family Medical Center	83.3%	
Univ. of Maryland Medical Center Midtown Campus	82.7%	13.1%
MedStar Southern Maryland Hospital	82.5%	
Frederick Memorial Hospital	81.1%	81.1%
Greater Baltimore Medical Center	80.6%	
MedStar Montgomery General Hospital	77.4%	
CalvertHealth Medical Center	76.5%	31.9%
MedStar St. Mary's Hospital	76.4%	
Univ. of Maryland Baltimore Washington Medical Center	74.0%	12.2%
Univ. of Maryland St. Joseph's Medical Center	72.8%	15.4%
Adventist Fort Washington Medical Center	71.5%	15.0%

Hospital Name	Indirect Cost Ratio	
	Hospital-Based CB Activities	Community-Based CB Activities
Univ. of Maryland Rehabilitation & Orthopaedic Institute	71.1%	13.3%
Sheppard & Enoch Pratt Hospital	70.6%	
MedStar Good Samaritan Hospital	70.1%	
Howard County General Hospital	69.8%	18.2%
Doctors Community Hospital	68.4%	
Meritus Medical Center	66.2%	15.0%
MedStar Franklin Square Hospital	66.1%	
Adventist Shady Grove Medical Center	64.9%	15.0%
Mt. Washington Peds	64.2%	10.3%
Suburban Hospital	64.2%	24.2%
Adventist White Oak Hospital	63.7%	15.0%
TidalHealth McCready Pavilion	63.3%	
UPMC Western Maryland Hospital	63.1%	55.9%
MedStar Union Memorial Hospital	62.8%	
Sinai Hospital of Baltimore	60.0%	12.0%
Carroll Hospital Center	60.0%	12.0%
Northwest Hospital	60.0%	12.0%
Levindale Hebrew Geriatric Center & Hospital	60.0%	
Garrett Regional Hospital	58.3%	
Univ. of Maryland Medical Center	57.7%	
Univ. of Maryland Upper Chesapeake Medical Center	53.6%	9.4%
Anne Arundel General Hospital	53.0%	
TidalHealth Peninsula Regional Medical Center	52.7%	
Johns Hopkins Bayview Med. Center	51.6%	16.8%
The Johns Hopkins Hospital	45.1%	15.1%
ChristianaCare, Union Hospital	41.0%	
Atlantic General Hospital	35.3%	
Holy Cross Germantown Hospital	31.3%	10.0%
Holy Cross Hospital	28.9%	10.0%
Univ. of Maryland Harford Memorial Hospital	21.4%	3.8%

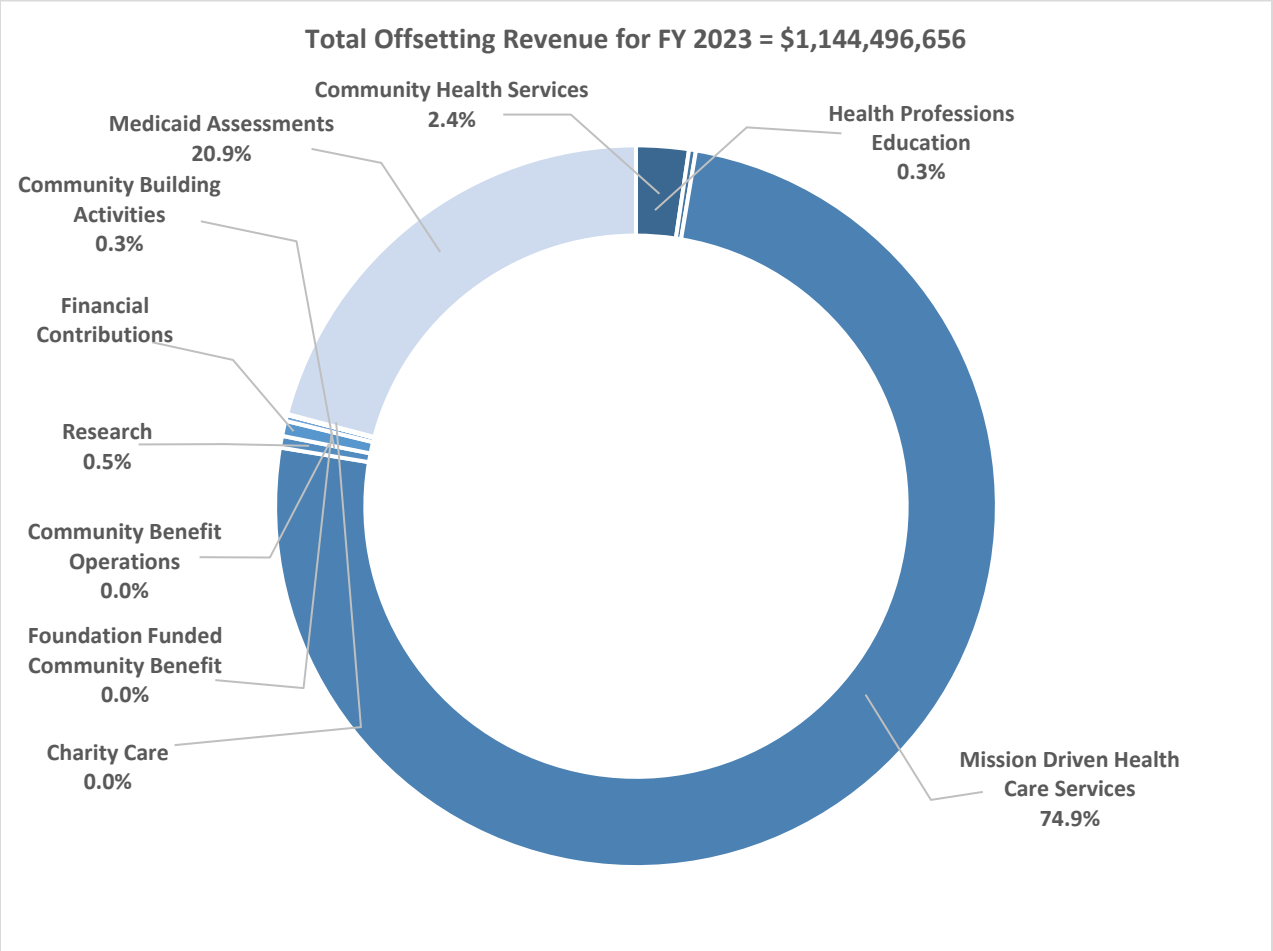
Offsetting Revenue and Mission-Driven Health Services

This report removes offsetting revenue from reported total community benefits. Offsetting revenue is defined as any revenue generated by the activity or program. For example. any payment by patients for services provided to those patients in a sliding-scale clinic would offset the total reported community benefit expenditures reported by the hospital for that clinic. Other examples include restricted grants or

contributions to the hospital that are used to fund a portion of the hospital's community benefit. Hospitals report offsetting revenue to the HSCRC in their annual community benefit reports.

Hospitals reported over $1.1 billion in offsetting revenue for community benefit activities—the majority for mission-driven health services, which are, by definition, intended to be services provided to the community that are not expected to result in revenue.[33] Figure 6 presents the total FY 2023 offsetting revenue by community benefit category.

Figure 6. Offsetting Revenue by Category of Community Benefit Activity for Maryland Hospitals, FY 2023



Offsetting revenue is different from rate-supported activities (described above). In general, hospitals do not report rate support as offsetting revenue. The Medicaid Deficit Assessment is the exception. The Medicaid

[33] See the HSCRC's FY 2023 Community Benefit Reporting Guidelines and Standard Definitions.

deficit assessment (shown as “Medicaid assessments” in Figure 6, above) is a broad-based uniform assessment to hospital rates that is set by the Maryland General Assembly. The hospitals pay this assessment, but a portion of it is reimbursed back to the hospital through all-payer rates, which is then reported as offsetting revenue.

Table 7 presents offsetting revenue for mission-driven health services by hospital. As noted above, mission-driven health services is the community benefit category that generates the most offsetting revenue. However, mission-driven health services are not intended to create revenue. Instead, mission-driven health services are intended to be services that hospitals undertake as a direct result of their community or mission-driven initiatives, or because the services would otherwise not be provided in the community. The hospitals are sorted by the proportion of total expenditures for mission-driven health services that are offset by revenue. Nine hospitals did not report any offsetting revenue from mission-driven health services. Sixteen hospitals reported offsetting revenue for 50% or more of their mission-driven expenditures. After removing offsetting revenue, mission-driven health services remain the largest category of community benefit activities, as shown in Table 5, above.

Table 7. Mission-Driven Health Services Expenditure and Offsetting Revenue among Maryland Hospitals, FY 2023

Hospital Name	Total Expenditure on Mission Driven Services	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Community Benefit for Mission Driven Services
Adventist White Oak Hospital	$165,575,734	$150,707,818	91.0%	$14,867,916
Adventist Rehabilitation	$4,508,647	$3,617,646	80.2%	$891,001
Univ. of Maryland Shore Medical Center at Easton	$141,706,998	$111,222,862	78.5%	$30,484,136
Univ. of Maryland Shore Medical Center at Chestertown	$30,469,877	$22,244,572	73.0%	$8,225,304
Greater Baltimore Medical Center	$170,562,741	$116,052,850	68.0%	$54,509,891
MedStar Montgomery General Hospital	$17,894,531	$11,811,733	66.0%	$6,082,798
MedStar Franklin Square Hospital	$64,397,866	$41,868,138	65.0%	$22,529,728
Univ. of Maryland Baltimore Washington Medical Center	$41,875,612	$26,950,303	64.4%	$14,925,309
Atlantic General Hospital	$17,116,247	$10,991,416	64.2%	$6,124,831
Meritus Medical Center	$137,757,697	$88,293,942	64.1%	$49,463,755
MedStar Union Memorial Hospital	$25,746,992	$15,425,365	59.9%	$10,321,627
MedStar Harbor Hospital Center	$24,784,837	$14,786,099	59.7%	$9,998,738
MedStar Good Samaritan Hospital	$18,669,793	$10,935,530	58.6%	$7,734,263
MedStar Southern Maryland Hospital	$33,622,261	$18,793,989	55.9%	$14,828,272
Adventist Shady Grove Medical Center	$39,210,469	$21,787,060	55.6%	$17,423,408
Ascension Saint Agnes Hospital	$42,726,363	$23,579,043	55.2%	$19,147,320
MedStar St. Mary's Hospital	$21,270,308	$9,740,190	45.8%	$11,530,118
Mt. Washington Pediatric Hospital	$536,688	$235,885	44.0%	$300,803
UPMC Western Maryland Hospital	$103,990,266	$45,525,798	43.8%	$58,464,468

Hospital Name	Total Expenditure on Mission Driven Services	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Community Benefit for Mission Driven Services
Univ. of Maryland Medical Center	$25,483,164	$11,155,391	43.8%	$14,327,773
TidalHealth Peninsula Regional Medical Center	$68,538,838	$29,797,432	43.5%	$38,741,406
Sinai Hospital of Baltimore	$42,779,529	$17,513,782	40.9%	$25,265,747
Lifebridge Northwest Hospital Center	$13,627,318	$4,963,145	36.4%	$8,664,173
ChristianaCare, Union Hospital	$31,700,752	$10,753,067	33.9%	$20,947,685
CalvertHealth Medical Center	$7,029,192	$2,260,287	32.2%	$4,768,905
Garrett Regional Hospital	$9,833,353	$2,957,668	30.1%	$6,875,685
Adventist Fort Washington Medical Center	$7,136,290	$2,087,722	29.3%	$5,048,568
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$3,215,838	$888,976	27.6%	$2,326,862
Univ. of Maryland Charles Regional Medical Center	$13,593,313	$3,686,898	27.1%	$9,906,415
Univ. of Maryland Capital Region Medical Center	$40,524,900	$10,616,400	26.2%	$29,908,500
Univ. of Maryland Medical Center Midtown Campus	$20,198,907	$3,973,133	19.7%	$16,225,774
Holy Cross Hospital	$10,742,646	$1,813,349	16.9%	$8,929,297
Anne Arundel General Hospital	$45,832,486	$6,303,566	13.8%	$39,528,920
Johns Hopkins Bayview Med. Center	$11,011,509	$1,095,942	10.0%	$9,915,567
Suburban Hospital	$16,577,683	$1,155,059	7.0%	$15,422,624
Sheppard & Enoch Pratt Hospital	$23,294,284	$1,038,876	4.5%	$22,255,407
Mercy Medical Center	$22,054,316	$771,483	3.5%	$21,282,833
The Johns Hopkins Hospital	$19,196,912	$339,222	1.8%	$18,857,690
Levindale Hebrew Geriatric Center & Hospital	$1,050,671	$17,957	1.7%	$1,032,714
Doctors Community Hospital	$13,929,205	$2,591	0.0%	$13,926,614
Frederick Memorial Hospital	$43,063,214	$0	0.0%	$43,063,214
Univ. of Maryland Harford Memorial Hospital	$5,733,481	$0	0.0%	$5,733,481
Carroll Hospital Center	$11,159,707	$0	0.0%	$11,159,707
TidalHealth McCready Pavillion	$39,305	$0	0.0%	$39,305
Howard County General Hospital	$18,013,817	$0	0.0%	$18,013,817
Univ. of Maryland Upper Chesapeake Medical Center	$12,526,680	$0	0.0%	$12,526,680
Univ. of Maryland St. Joseph's Medical Center	$45,307,943	$0	0.0%	$45,307,943
Holy Cross Germantown Hospital	$3,599,269	$0	0.0%	$3,599,269
J. Kent McNew Family Medical Center	$1,224,310	$0	0.0%	$1,224,310
Total	**$1,690,442,758**	**$857,762,187**	**50.7%**	**$832,680,571**

Mission-Driven Health Services: Physician Gaps in Availability

As noted above, the mission-driven health services category is the largest category of community benefits reported by Maryland hospitals. The mission-driven health services category includes subsidies that

hospitals provide to physicians to address gaps in physician availability to serve the hospital's uninsured population. Maryland law requires hospitals to justify the reporting of spending on physician subsides as a community benefit.[34] Hospitals must provide a written description of gaps in the availability of providers to serve their uninsured populations by specialty. Since FY 2021, hospitals have been required to separately itemize all physician subsidies claimed by type and specialty. The most frequently reported gaps were obstetrics and gynecology (reported by 31 hospitals), followed by psychiatry, other specialties, and internal medicine. Five hospitals reported no gaps in the availability of physicians to serve their uninsured population. See Table 8.

Table 8. Number of Hospitals Reporting Gaps in Physician Availability by Specialty

Gap in Physician Availability, by Specialty	Number of Hospitals
No gaps reported	5
Obstetrics & Gynecology	31
Psychiatry	30
Other	29
Internal Medicine	26
Emergency Medicine	24
Surgery	21
Pediatrics	19
Neurology	19
Cardiology	14
Oncology-Cancer	14
Anesthesiology	13
Endocrinology, Diabetes & Metabolism	10
Ophthalmology	10
Family Practice/General Practice	10
Orthopedics	9
Urology	9
Radiology	8
Otolaryngology	7
Neurological Surgery	6
Physical Medicine & Rehabilitation	5
Pathology	5
Plastic Surgery	4
Preventive Medicine	3
Geriatrics	2
Medical Genetics	1

[34] MD. CODE. ANN., Health-Gen. § 19-303(c)(4)(vi).

Community Health Needs Assessments

Federal law requires hospitals to conduct a CHNA every three years and develop an implementation plan for addressing the community needs identified in the CHNA.[35] The CHNA evaluates the health needs of the community the hospital serves and identifies needs, gaps, assets, and resources as they relate to the health of the community. CHNAs are supposed to be developed with robust community input. CHNAs help the hospital set priorities for community benefits expenditures.

Appendix G shows maps indicating the coverage of hospitals' primary service areas and community benefit service areas (CBSAs), two ways of defining the community each hospital serves, as well as describing the ways hospitals reported identifying their CBSAs. Hospitals report details about these communities, which help inform decisions about HCB activities. Appendix H contains demographic statistics on each Maryland county, similar to the measures hospitals may use. See Appendix I for a list of the data sources hospitals reported on their FY 2024 narrative survey that they use in their HCB efforts.

Maryland requires hospitals to include information about their CHNA in their annual CBRs. The goal of this reporting is to provide transparency about 1) the extent to which the hospital's community benefit activities are aligned with their CHNA and 2) the level of community involvement in the development of the CHNA.

Spending on CHNA-Related Activities

Hospitals reported spending 37.2% of their net community benefit spending on CHNA-related activities. Note that not all community benefit activities are expected to align with the CHNA. While CHNAs help identify community health needs and priorities, some community benefit activities may address broader community well-being, even if they do not directly relate to those specific identified needs. Further, because CHNAs are conducted every three years, community benefit activities may address emerging community health needs, e.g., the COVID-19 pandemic.

There was wide variation between individual hospitals, ranging from -0.3% to 81.2% of total community benefit spent on CHNA related activities. This wide variation was similar to what was reported in FY 2022, the first year that hospitals reported this information. It is unclear whether this variation reflects true differences across hospitals or whether hospitals are using different criteria to determine whether activities are CHNA-related. To address this concern, staff convened a workgroup in the summer of 2024 and updated the instructions for FY 2024 reporting to provide additional clarification around what activities may count as CHNA-related, with the goal of having more comparable reporting across hospitals. Table 9

[35] Loyola University Chicago. (2024). *Background on community health needs assessment*. https://hsd.luc.edu/ipath/communityhealthneedsassessment/backgroundoncommunityhealthneedsassessment/#:~:text=The%20CHNA%20process%20helps%20not,the%20basis%20of%20tax%20exemption

presents each hospital's net total community benefit spending, the net total spent on CHNA-related activities, and the percentage of total spending on CHNA-related activities.

Table 9. CHNA Spending[36] as a Percentage of Net Community Benefit, FY 2023

Hospital	Total CB Spent on CHNA Priority Area Programs	Total CB Spending	Spending on CHNA as Percentage of Total CB
TidalHealth McCready Pavillion	$463,026	$569,926	81.2%
The Johns Hopkins Hospital	$294,673,159	$366,842,384	80.3%
MedStar Union Memorial Hospital	$36,524,578	$49,500,236	73.8%
UPMC Western Maryland Hospital	$55,526,483	$76,846,674	72.3%
MedStar Franklin Square Hospital	$45,645,923	$64,715,265	70.5%
Howard County General Hospital	$25,528,880	$36,557,318	69.8%
MedStar St. Mary's Hospital	$14,075,779	$20,644,933	68.2%
Johns Hopkins Bayview Med. Center	$71,781,220	$107,131,629	67.0%
Garrett Regional Hospital	$7,742,302	$11,567,923	66.9%
Suburban Hospital	$24,798,448	$37,663,565	65.8%
MedStar Harbor Hospital Center	$16,919,600	$25,891,745	65.3%
MedStar Southern Maryland Hospital	$17,529,085	$28,203,383	62.2%
MedStar Good Samaritan Hospital	$15,435,506	$26,431,968	58.4%
Mercy Medical Center	$41,474,355	$73,752,855	56.2%
MedStar Montgomery General Hospital	$8,211,584	$14,867,749	55.2%
Holy Cross Germantown Hospital	$3,734,771	$7,783,802	48.0%
Meritus Medical Center	$31,496,141	$66,551,271	47.3%
TidalHealth Peninsula Regional Medical Center	$23,943,154	$68,944,409	34.7%
Doctors Community Hospital	$11,483,619	$34,995,799	32.8%
Levindale Hebrew Geriatric Center & Hospital	$1,731,058	$5,536,488	31.3%
Sinai Hospital of Baltimore	$28,028,248	$92,712,551	30.2%
Mt. Washington Pediatric Hospital	$467,315	$1,574,578	29.7%
Holy Cross Hospital	$14,067,533	$50,599,565	27.8%
Carroll Hospital Center	$5,667,650	$22,533,952	25.2%
Adventist Rehabilitation	$437,533	$1,829,981	23.9%
Univ. of Maryland Upper Chesapeake Medical Center	$4,636,897	$22,452,379	20.7%
Lifebridge Northwest Hospital	$4,287,078	$24,425,906	17.6%
Univ. of Maryland Harford Memorial Hospital	$1,646,469	$9,837,007	16.7%
Anne Arundel General Hospital	$10,907,404	$70,148,046	15.5%
Sheppard & Enoch Pratt Hospital	$5,615,391	$36,721,183	15.3%
J. Kent McNew Family Medical Center	$357,001	$2,733,218	13.1%
Univ. of Maryland Baltimore Washington Medical Center	$3,212,874	$27,931,663	11.5%
Adventist Shady Grove Medical Center	$3,593,163	$40,032,662	9.0%

[36] Offsetting revenue has been removed.

Hospital	Total CB Spent on CHNA Priority Area Programs	Total CB Spending	Spending on CHNA as Percentage of Total CB
Univ. of Maryland Charles Regional Medical Center	$1,285,244	$14,618,252	8.8%
Univ. of Maryland St. Joseph's Medical Center	$4,817,340	$58,245,151	8.3%
Univ. of Maryland Shore Medical Center at Chestertown	$638,545	$10,087,696	6.3%
Adventist White Oak Hospital	$1,444,947	$31,922,588	4.5%
Frederick Memorial Hospital	$2,483,434	$56,892,363	4.4%
Ascension Saint Agnes Hospital	$1,993,893	$52,882,154	3.8%
Univ. of Maryland Shore Medical Center at Easton	$1,372,541	$38,023,876	3.6%
Adventist Fort Washington Medical Center	$198,654	$7,102,621	2.8%
Univ. of Maryland Capital Region Medical Center	$1,175,691	$45,637,576	2.6%
Univ. of Maryland Medical Center Midtown Campus	$687,688	$34,323,489	2.0%
CalvertHealth Medical Center	$169,709	$8,942,397	1.9%
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$138,810	$9,020,727	1.5%
Atlantic General Hospital	$70,452	$8,415,352	0.8%
Univ. of Maryland Medical Center	$1,506,692	$282,975,200	0.5%
ChristianaCare, Union Hospital	$120,720	$23,264,049	0.5%
Greater Baltimore Medical Center[37]	-$232,104	$70,577,819	-0.3%
Total	**$849,515,484**	**$2,281,463,324**	**37.2%**

Hospitals also described the community benefit initiatives undertaken to address CHNA-identified needs in the community. Table 10 summarizes the CHNA priority area categories most commonly addressed by hospital initiatives in FY 2023. Appendix J shows the number of hospitals reporting initiatives to address each of the full list of CHNA-identified community health needs.

Table 10. Top 5 CHNA Priority Area Categories Addressed by Hospitals

CHNA Priority Area	Number of Hospitals
Social Determinants of Health - Health Care Access and Quality	35
Settings and Systems - Community	32
Health Conditions - Diabetes	31
Health Conditions - Mental Health and Mental Disorders	31
Health Behaviors - Preventive Care	31

[37] Staff followed up with Greater Baltimore Medical Center to confirm that this net negative amount was correct. Because the value is negative, it indicates that the CHNA priority area programs generated more offsetting revenue than their cost to the hospital.

CHNA Development Process

All Maryland nonprofit hospitals reported conducting CHNAs within the past three fiscal years, as required by federal law. See Appendix K for the dates on which hospitals completed their last CHNAs.

Federal law requires hospitals to use input from individuals who represent the broad interests of the community served by the hospital in their CHNA. Each hospital records the process for assessing community needs and the findings from that process in a CHNA document that is made available to the public. Hospitals also produce a plan for implementing activities to address the identified community needs,[38] which some include directly in the CHNA document and others provide separately. All Maryland nonprofit hospitals reported adopting an implementation strategy. The CHNA document must also note any community needs that were identified in prior CHNAs that have not been met and explain why they were not addressed.

The CHNA document includes descriptions of the people and organizations with whom the hospital collaborated on the assessment of community health needs. Hospitals reported collaborating with a broad set of community organizations when developing their CHNAs. Table 11 shows the number of hospitals that reported collaborating with various external organizations. See Appendices L and M for more detail on these external participants.

[38] 26 U.S.C. § 501(r)(3)(A)-(B).

Table 11. Number of Hospitals that Collaborated with Selected Types of External Organizations for Their Most Recent CHNA, FY 2023

Collaborator Type	Number of Hospitals	% of Hospitals
Post-Acute Care Facilities	19	40%
Local Health Departments	45	96%
Local Health Improvement Coalitions	42	89%
Other Hospitals	35	74%
Behavioral Health Organizations	40	85%

Community Benefit Administration

Hospitals report information on how they staff CHNA and HCB activities, whether they audit their community benefit data, the role of the hospital board in their community benefit report, and whether community benefit is included in the hospital's strategic planning process.

Conducting CHNAs, developing implementation plans, and reporting HCB takes time and resources. Hospitals have different approaches to staffing the administration of their community benefit activities and reporting responsibilities. Most hospitals have invested in staff who are dedicated to community benefit and/or population health. These staff play a key role in hospital CHNAs and community benefit activities, as shown in Table 12.

Table 12. Number of Hospitals Reporting Staff in the Following Categories Contributing to CB or CHNA Operations

Staff Category	Number of Hospitals	Percentage of Hospitals
Population Health Staff	45	96%
Community Benefit Staff	43	91%
Community Benefit/Pop Health Director	45	96%

Appendix N details the types of staff involved in hospital CHNAs. Appendix O details the types of staff involved in HCB activities.

All hospitals conducted some form of audit on the financial data they submitted to the HSCRC (Table 13). These audits were mostly performed by hospital or hospital system staff, but 12 hospitals used third-party auditors.

Table 13. Hospital Audits of CBR Financial Spreadsheet

Staff or Entity Conducting Audit	Number of Hospitals Completing Audit	
	Yes	No
Hospital Staff	42	5
System Staff	38	9
Third-Party	12	35
No Audit	0	47
Two or More Audit Types	37	10
Three or More Audit Types	8	39

Each nonprofit hospital is governed by a board. The majority (37) of the CBRs were reviewed by the hospital boards (Table 14). Of the 10 CBRs that were not reviewed by the board, common reasons were timing or because the board had delegated this authority to executive or financial staff or an external firm. For example, several hospitals reported that their board meets only twice per year and did not have the opportunity to review before the report deadline. These responses were very similar to what was reported in FY 2022.

Table 14. Hospital Board Review of the CBR

Board Review/Approval	Number of Hospitals	
	Yes	No
Financial Report (Spreadsheet)	37	10
Narrative Report	37	10

Conclusion

Maryland's community benefit reporting requirements are more extensive than the federal requirements. All 49 nonprofit hospitals in Maryland submitted the required information for FY 2023. Maryland hospitals' FY 2023 community benefit expenditures totaled almost $2.3 billion, or $1.3 billion after accounting for activities that are funded through hospital rates set by the HSCRC. Total community benefit expenditures as a percentage of hospital operating expenses increased from 10.6% in FY 2022 to 11.3% in FY 2023. When the rate-supported activities are removed, community benefit expenses grew from 6.2% to 6.6% of operating expenses over the same period. All hospitals reported claiming exemption from federal and state income taxes.

All hospitals submitted a CHNA and CHNA implementation strategy. Most hospitals reported collaborating with local health departments and health improvement coalitions, other hospitals, and behavioral health

organizations on their CHNAs. Encouragingly, most hospitals have dedicated staff for community benefit and/or population health. Most reported that both hospital and system staff audit community benefit financial report data, the hospital board reviews the financial spreadsheet and the narrative report, and they have incorporated community benefit investments into their strategic plan.

Staff identified the following areas for continued review:

- There continues to be a wide variation in the percentage of net community benefit hospitals spent on CHNA-related activities. Staff convened a workgroup in the summer of 2024 to gather feedback for improving the consistency and comparability of reporting in this area, made corresponding clarifications to the FY 2024 reporting instructions, and convened a hospital training webinar. FY 2024 submissions were due in January 2025, and staff will review the results to determine whether further reporting clarifications are needed.
- There continues to be a wide variation in indirect cost ratios. Staff completed an additional validation step for the FY 2023 report, comparing the indirect cost ratio reported on the CBR with the ratio reported on the HSCRC's Annual Cost Report Schedule M. As a result of this step, several hospitals made corrections to their initial submission, while other hospitals provided explanations for the variation. This issue was also discussed in the workgroup, and technical corrections were made to the FY 2024 reporting instructions. While the additional validation step resulted in some improvements for the FY 2023 report, staff will review the results of the upcoming FY 2024 report to determine whether further clarifications are needed. In the FY 2024 report, staff also intend to conduct additional analyses showing what expenditures would be if a consistent indirect cost ratio was applied across hospitals.

Appendix A. Comparison of Federal and State Community Benefit Categories

Activities the Federal Government Defines as HCB (Schedule H)	Activities Maryland Includes as HCB (this list is not exclusive)
Net, unreimbursed costs of financial assistance (free or reduced cost care)**	Financial assistance
Participation in means-tested government programs, such as Medicaid**	Hospital contribution to the Medicaid Deficit Assessment
Health professions education	Health professions education
Health services research	Research
Subsidized health services	Mission-driven health service
Community health improvement activities	A community health service An operation related to a planned, organized, and measured activity that is intended to meet identified community health needs within a service area A planned, organized, and measured activity that is intended to meet identified community health needs within a service area is funded by a foundation
Cash or in-kind contributions to other community groups.	A financial contribution Financial or in-kind support of the Maryland Behavioral Health Crisis Response System.
Community-building activities. Example: Investments in housing	A community-building activity, including partnerships with community-based organizations

Appendix B. Hospitals Submitting Community Benefit Reports

Maryland Hospitals that Submitted CBRs in FY 2023, by System

Adventist HealthCare	**Luminis Health**
Adventist HealthCare Fort Washington Medical Center	Anne Arundel Medical Center
Adventist HealthCare Rehabilitation	Doctors Community Hospital
Adventist HealthCare Shady Grove Medical Center	McNew Family Health Center
Adventist HealthCare White Oak Medical Center	**MedStar Health**
Ascension	MedStar Franklin Square Medical Center
Saint Agnes Healthcare, Inc.	MedStar Good Samaritan Hospital
Christiana Care Health System, Inc.	MedStar Harbor Hospital
Christiana Care, Union Hospital	MedStar Montgomery Medical Center
Independent Hospitals	MedStar Southern Maryland Hospital Center
Atlantic General Hospital	MedStar St. Mary's Hospital
CalvertHealth Medical Center	MedStar Union Memorial Hospital
Frederick Health Hospital	**TidalHealth**
Greater Baltimore Medical Center	TidalHealth McCready Pavilion[39]
Mercy Medical Center	TidalHealth Peninsula Regional
Meritus Medical Center	**Trinity Health**
Sheppard Pratt	Holy Cross Germantown Hospital
Johns Hopkins Health System	Holy Cross Hospital
Howard County General Hospital	**University of Maryland Medical System**
Johns Hopkins Bayview Medical Center	UM Baltimore Washington Medical Center
Johns Hopkins Hospital	UM Capital Region Health
Suburban Hospital	UM Charles Regional Medical Center
Jointly Owned Hospitals	UM Rehabilitation & Orthopaedic Institute
Mt. Washington Pediatric Hospital[40]	UM Shore Regional Health
LifeBridge Health	UM St. Joseph Medical Center
Carroll Hospital Center	UM Upper Chesapeake Health
Levindale Hebrew Geriatric Ctr. & Hospital of Balt.	UMMC Midtown Campus
Northwest Hospital Center, Inc.	University of Maryland Medical Center
Sinai Hospital of Baltimore, Inc.	**UPMC**
	UPMC Western Maryland
	West Virginia University Health System
	GRMC, Inc., DBA Garrett Regional Medical Ctr.

[39] The TidalHealth McCready Pavilion is a Freestanding Medical Facility associated with Peninsula Regional.
[40] Jointly owned by the University of Maryland Medical System and Johns Hopkins.

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Appendix C. FY 2023 Funding through Rates for HCB Activities

Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Financial Assistance	Total Rate-Supported Community Benefit Activities
Adventist Fort Washington Medical Center	$0	$63,872	$63,872	$454,879	$2,245,578	$2,828,202
Adventist Rehabilitation	$0	$45,203	$0	$0	$0	$45,203
Adventist Shady Grove Medical Center	$0	$495,127	$495,127	$732,276	$12,323,361	$14,045,891
Adventist White Oak Hospital	$0	$331,339	$331,339	$473,991	$10,097,266	$11,233,936
Anne Arundel General Hospital	$7,146,295	$699,722	$699,722	$0	$5,004,158	$13,549,898
Atlantic General Hospital	$0	$122,135	$122,135	$561,465	$1,122,610	$1,928,344
CalvertHealth Medical Center	$0	$163,995	$163,995	$0	$2,757,010	$3,085,000
Carroll Hospital Center	$0	$199,007	$199,007	$208,923	$2,902,386	$3,509,323
ChristianaCare, Union Hospital	$0	$251,514	$251,514	$0	$1,587,375	$2,090,403
Doctors Community Hospital	$0	$253,009	$253,009	$288,379	$14,399,742	$15,194,139
Frederick Memorial Hospital	$0	$388,588	$388,588	$832,321	$5,891,400	$7,500,897
Garrett County Memorial Hospital	$0	$66,256	$66,256	$0	$2,677,588	$2,810,100
Greater Baltimore Medical Center	$6,614,075	$526,376	$526,376	$427,540	$3,709,101	$11,803,468
Holy Cross Germantown Hospital	$0	$131,583	$131,583	$180,799	$3,428,100	$3,872,065
Holy Cross Hospital	$2,692,852	$554,475	$554,475	$807,969	$20,676,698	$25,286,469
Howard County General Hospital	$0	$320,588	$320,588	$871,180	$7,973,000	$9,485,356
J Kent McNew Family Medical Center	$0	$9,364	$0	$0	$0	$9,364
Johns Hopkins Bayview Med. Center	$29,014,221	$754,929	$754,929	$1,511,135	$30,503,000	$62,538,214
Levindale Hebrew Geriatric Center & Hospital	$0	$55,385	$55,385	$0	$2,494,444	$2,605,214
Lifebridge Northwest Hospital Center	$0	$274,312	$274,312	$240,378	$6,124,376	$6,913,378
MedStar Franklin Square Hospital	$10,902,334	$604,526	$604,526	$500,602	$17,362,008	$29,973,997
MedStar Good Samaritan Hospital	$2,648,628	$287,494	$287,494	$238,767	$10,187,092	$13,649,475
MedStar Harbor Hospital Center	$1,732,317	$169,385	$169,385	$165,457	$8,406,708	$10,643,252
MedStar Montgomery General Hospital	$0	$189,414	$189,414	$0	$6,094,996	$6,473,824
MedStar Southern Maryland Hospital	$0	$296,310	$296,310	$2,417,778	$9,816,141	$12,826,539
MedStar St. Mary's Hospital	$0	$246,867	$246,867	$210,044	$5,866,438	$6,570,216

Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Financial Assistance	Total Rate-Supported Community Benefit Activities
MedStar Union Memorial Hospital	$12,558,450	$453,671	$453,671	$376,133	$11,690,948	$25,532,873
Mercy Medical Center	$4,685,348	$619,895	$619,895	$490,746	$21,995,243	$28,411,126
Meritus Medical Center	$5,024,792	$429,741	$429,741	$1,178,916	$12,015,919	$19,079,109
Mt. Washington Pediatric Hospital	$0	$63,655	$0	$0	$264,092	$327,747
Sheppard Pratt	$2,990,329	$152,435	$0	$0	$8,741,514	$11,884,279
Sinai Hospital of Baltimore	$19,586,748	$897,075	$897,075	$1,552,902	$15,116,995	$38,050,795
St. Agnes Hospital	$6,826,946	$434,080	$434,080	$478,434	$15,382,432	$23,555,972
Suburban Hospital	$607,064	$370,255	$370,255	$696,192	$7,067,394	$9,111,160
The Johns Hopkins Hospital	$138,125,253	$2,759,868	$2,759,868	$5,231,027	$55,925,900	$204,801,916
TidalHealth McCready Pavillion	$0	$5,296	$5,296	$0	$106,900	$117,492
TidalHealth Peninsula Regional Medical Center	$5,502,090	$508,153	$508,153	$1,684,395	$10,293,900	$18,496,691
UM Capital Region	$5,547,887	$376,230	$376,230	$3,230,297	$7,790,313	$17,320,957
Univ. of Maryland Baltimore Washington Medical Center	$773,097	$475,475	$475,475	$0	$8,287,000	$10,011,047
Univ. of Maryland Charles Regional Medical Center	$0	$169,385	$169,385	$408,173	$2,498,000	$3,244,943
Univ. of Maryland Harford Memorial Hospital	$0	$109,164	$109,164	$0	$2,167,000	$2,385,328
Univ. of Maryland Medical Center	$168,321,811	$1,980,238	$1,980,238	$2,947,123	$29,197,000	$204,426,410
Univ. of Maryland Medical Center Midtown Campus	$3,674,217	$238,163	$238,163	$1,723,233	$4,254,000	$10,127,776
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$1,587,928	$128,091	$128,091	$0	$1,726,000	$3,570,110
Univ. of Maryland Shore Medical Center at Chestertown	$0	$44,183	$44,183	$0	$1,026,000	$1,114,366
Univ. of Maryland Shore Medical Center at Easton	$150,000	$238,163	$238,163	$0	$4,294,758	$4,921,084
Univ. of Maryland St. Joseph's Medical Center	$0	$416,739	$416,739	$347,151	$7,208,373	$8,389,002
Univ. of Maryland Upper Chesapeake Medical Center	$0	$347,850	$347,850	$0	$4,258,000	$4,953,700
UPMC Western Maryland Hospital	$0	$357,297	$357,297	$1,126,299	$13,719,300	$15,560,193
Total	**$436,712,683**	**$19,075,878**	**$18,805,221**	**$32,594,902**	**$438,677,558**	**$945,866,242**

Appendix D. FY 2023 Community Benefit Analysis

Table D1. Hospital Operating Expenses and Community Benefit Expenses

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense
Adventist Fort Washington Medical Center	$63,947,008	$7,102,621	11.11%
Adventist Rehabilitation	$63,524,116	$1,829,981	2.88%
Adventist Shady Grove Medical Center	$450,979,711	$40,032,662	8.88%
Adventist White Oak Hospital	$329,144,866	$31,922,588	9.70%
Anne Arundel General Hospital	$647,110,000	$70,148,046	10.84%
Ascension Saint Agnes Hospital	$537,591,223	$52,882,154	9.84%
Atlantic General Hospital	$166,422,837	$8,415,352	5.06%
CalvertHealth Medical Center	$160,772,982	$8,942,397	5.56%
Carroll Hospital Center	$279,472,729	$22,533,952	8.06%
ChristianaCare, Union Hospital	$192,302,239	$23,264,049	12.10%
Doctors Community Hospital	$247,220,000	$34,995,799	14.16%
Frederick Memorial Hospital	$413,459,000	$56,892,363	13.76%
Garrett Regional Hospital	$63,327,026	$11,567,923	18.27%
Greater Baltimore Medical Center	$624,194,000	$70,577,819	11.31%
Holy Cross Germantown Hospital	$139,664,351	$7,783,802	5.57%
Holy Cross Hospital	$526,196,350	$50,599,565	9.62%
Howard County General Hospital	$331,650,000	$36,557,318	11.02%
J. Kent McNew Family Medical Center	$8,727,322	$2,733,218	31.32%
Johns Hopkins Bayview Med. Center	$760,312,000	$107,131,629	14.09%
Levindale Hebrew Geriatric Center & Hospital	$81,606,195	$5,536,488	6.78%
Lifebridge Northwest Hospital Center	$317,819,933	$24,425,906	7.69%
MedStar Franklin Square Hospital	$682,540,830	$64,715,265	9.48%
MedStar Good Samaritan Hospital	$317,400,224	$26,431,968	8.33%
MedStar Harbor Hospital Center	$230,578,957	$25,891,745	11.23%
MedStar Montgomery General Hospital	$228,602,542	$14,867,749	6.50%
MedStar Southern Maryland Hospital	$306,906,165	$28,203,383	9.19%
MedStar St. Mary's Hospital	$201,299,285	$20,644,933	10.26%
MedStar Union Memorial Hospital	$516,967,157	$49,500,236	9.58%
Mercy Medical Center	$579,752,405	$73,752,855	12.72%
Meritus Medical Center	$517,495,595	$66,551,271	12.86%
Mt. Washington Pediatric Hospital	$68,508,229	$1,574,578	2.30%
Sheppard & Enoch Pratt Hospital	$275,498,276	$36,721,183	13.33%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense
Sinai Hospital of Baltimore	$954,434,934	$92,712,551	9.71%
Suburban Hospital	$374,467,000	$37,663,565	10.06%
The Johns Hopkins Hospital	$3,060,451,000	$366,842,384	11.99%
TidalHealth McCready Pavillion	$9,044,100	$569,926	6.30%
TidalHealth Peninsula Regional Medical Center	$480,411,000	$68,944,409	14.35%
Univ. of Maryland Baltimore Washington Medical Center	$474,046,000	$27,931,663	5.89%
Univ. of Maryland Capital Region Medical Center	$379,857,000	$45,637,576	12.01%
Univ. of Maryland Charles Regional Medical Center	$149,018,616	$14,618,252	9.81%
Univ. of Maryland Harford Memorial Hospital	$99,813,000	$9,837,007	9.86%
Univ. of Maryland Medical Center	$2,022,919,000	$282,975,200	13.99%
Univ. of Maryland Medical Center Midtown Campus	$268,702,000	$34,323,489	12.77%
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$124,385,000	$9,020,727	7.25%
Univ. of Maryland Shore Medical Center at Chestertown	$45,865,000	$10,087,696	21.99%
Univ. of Maryland Shore Medical Center at Easton	$298,925,000	$38,023,876	12.72%
Univ. of Maryland St. Joseph's Medical Center	$409,862,000	$58,245,151	14.21%
Univ. of Maryland Upper Chesapeake Medical Center	$314,183,000	$22,452,379	7.15%
UPMC Western Maryland Hospital	$353,692,553	$76,846,674	21.73%
Total, All Hospitals	**$20,151,069,758**	**$2,281,463,324**	**11.32%**

Table D2. Rate-Supported Community Benefit, Including Financial Assistance

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[41]	Amount of Community Benefit Amount included in Rates[42]	Total CB not included in hospital rates[43]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
	A	B	C	D=B-C	E=D/A	F	G=F/A
Adventist Fort Washington Medical Center	$63,947,008	$7,102,621	$2,828,202	$4,274,419	6.68%	$657,109	1.03%
Adventist Rehabilitation	$63,524,116	$1,829,981	$45,203	$1,784,778	2.81%	$108,409	0.17%
Adventist Shady Grove Medical Center	$450,979,711	$40,032,662	$14,045,891	$25,986,771	5.76%	$15,449,975	3.43%
Adventist White Oak Hospital	$329,144,866	$31,922,588	$11,233,936	$20,688,652	6.29%	$12,021,241	3.65%
Anne Arundel General Hospital	$647,110,000	$70,148,046	$13,549,898	$56,598,149	8.75%	$5,004,158	0.77%
Ascension Saint Agnes Hospital	$537,591,223	$52,882,154	$23,555,972	$29,326,182	5.46%	$19,737,929	3.67%
Atlantic General Hospital	$166,422,837	$8,415,352	$1,928,344	$6,487,008	3.90%	$737,899	0.44%
CalvertHealth Medical Center	$160,772,982	$8,942,397	$3,085,000	$5,857,396	3.64%	$2,757,101	1.71%
Carroll Hospital Center	$279,472,729	$22,533,952	$3,509,323	$19,024,629	6.81%	$2,902,386	1.04%
ChristianaCare, Union Hospital	$192,302,239	$23,264,049	$2,090,403	$21,173,646	11.01%	$1,370,679	0.71%
Doctors Community Hospital	$247,220,000	$34,995,799	$15,194,139	$19,801,660	8.01%	$14,399,742	5.82%

[41] Excludes expenditures on community benefit activities that are offset by revenue.
[42] Includes funding for financial assistance, DME, NSPI, NSPII, & Regional Partnership Catalyst Grant.
[43] The values in this column have been calculated by subtracting the total rate support each hospital received for charity care and the DME, NSPI, NSPII, & Regional Partnership Catalyst funding programs from the hospital's total community benefit expense. Hospitals' offsetting revenue has already been subtracted from the total community benefit expense value.

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[41]	Amount of Community Benefit Amount included in Rates[42]	Total CB not included in hospital rates[43]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
Frederick Memorial Hospital	$413,459,000	$56,892,363	$7,500,897	$49,391,466	11.95%	$1,283,823	0.31%
Garrett Regional Hospital	$63,327,026	$11,567,923	$2,810,100	$8,757,823	13.83%	$3,646,138	5.76%
Greater Baltimore Medical Center	$624,194,000	$70,577,819	$11,803,468	$58,774,352	9.42%	$3,709,101	0.59%
Holy Cross Germantown Hospital	$139,664,351	$7,783,802	$3,872,065	$3,911,737	2.80%	$3,618,340	2.59%
Holy Cross Hospital	$526,196,350	$50,599,565	$25,286,469	$25,313,096	4.81%	$29,603,040	5.63%
Howard County General Hospital	$331,650,000	$36,557,318	$9,485,356	$27,071,962	8.16%	$7,972,509	2.40%
J. Kent McNew Family Medical Center	$8,727,322	$2,733,218	$9,364	$2,723,854	31.21%	$101,407	1.16%
Johns Hopkins Bayview Med. Center	$760,312,000	$107,131,629	$62,538,214	$44,593,415	5.87%	$30,503,000	4.01%
Levindale Hebrew Geriatric Center & Hospital	$81,606,195	$5,536,488	$2,605,214	$2,931,274	3.59%	$2,494,444	3.06%
Lifebridge Northwest Hospital Center	$317,819,933	$24,425,906	$6,913,378	$17,512,528	5.51%	$6,124,376	1.93%
MedStar Franklin Square Hospital	$682,540,830	$64,715,265	$29,973,997	$34,741,268	5.09%	$17,362,008	2.54%
MedStar Good Samaritan Hospital	$317,400,224	$26,431,968	$13,649,475	$12,782,493	4.03%	$10,187,092	3.21%
MedStar Harbor Hospital Center	$230,578,957	$25,891,745	$10,643,252	$15,248,493	6.61%	$8,406,708	3.65%
MedStar Montgomery General Hospital	$228,602,542	$14,867,749	$6,473,824	$8,393,925	3.67%	$6,094,996	2.67%
MedStar Southern Maryland Hospital	$306,906,165	$28,203,383	$12,826,539	$15,376,844	5.01%	$9,816,141	3.20%
MedStar St. Mary's Hospital	$201,299,285	$20,644,933	$6,570,216	$14,074,716	6.99%	$5,967,196	2.96%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[41]	Amount of Community Benefit Amount included in Rates[42]	Total CB not included in hospital rates[43]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
MedStar Union Memorial Hospital	$516,967,157	$49,500,236	$25,532,873	$23,967,363	4.64%	$11,690,948	2.26%
Mercy Medical Center	$579,752,405	$73,752,855	$28,411,126	$45,341,729	7.82%	$21,995,243	3.79%
Meritus Medical Center	$517,495,595	$66,551,271	$19,079,109	$47,472,161	9.17%	$12,269,867	2.37%
Mt. Washington Pediatric Hospital	$68,508,229	$1,574,578	$327,747	$1,246,830	1.82%	$264,092	0.39%
Sheppard & Enoch Pratt Hospital	$275,498,276	$36,721,183	$11,884,279	$24,836,905	9.02%	$8,741,514	3.17%
Sinai Hospital of Baltimore	$954,434,934	$92,712,551	$38,050,795	$54,661,756	5.73%	$15,116,994	1.58%
Suburban Hospital	$374,467,000	$37,663,565	$9,111,160	$28,552,405	7.62%	$7,067,000	1.89%
The Johns Hopkins Hospital	$3,060,451,000	$366,842,384	$204,801,916	$162,040,468	5.29%	$55,926,000	1.83%
TidalHealth McCready Pavillion	$9,044,100	$569,926	$117,492	$452,434	5.00%	$106,900	1.18%
TidalHealth Peninsula Regional Medical Center	$480,411,000	$68,944,409	$18,496,691	$50,447,718	10.50%	$10,358,300	2.16%
Univ. of Maryland Baltimore Washington Medical Center	$474,046,000	$27,931,663	$10,011,047	$17,920,616	3.78%	$8,287,000	1.75%
Univ. of Maryland Capital Region Medical Center	$379,857,000	$45,637,576	$17,320,957	$28,316,619	7.45%	$6,996,000	1.84%
Univ. of Maryland Charles Regional Medical Center	$149,018,616	$14,618,252	$3,244,943	$11,373,310	7.63%	$2,497,665	1.68%
Univ. of Maryland Harford Memorial Hospital	$99,813,000	$9,837,007	$2,385,328	$7,451,679	7.47%	$2,167,000	2.17%
Univ. of Maryland Medical Center	$2,022,919,000	$282,975,200	$204,426,410	$78,548,790	3.88%	$29,197,000	1.44%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[41]	Amount of Community Benefit Amount included in Rates[42]	Total CB not included in hospital rates[43]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
Univ. of Maryland Medical Center Midtown Campus	$268,702,000	$34,323,489	$10,127,776	$24,195,713	9.00%	$4,254,000	1.58%
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$124,385,000	$9,020,727	$3,570,110	$5,450,617	4.38%	$1,726,000	1.39%
Univ. of Maryland Shore Medical Center at Chestertown	$45,865,000	$10,087,696	$1,114,366	$8,973,330	19.56%	$1,026,000	2.24%
Univ. of Maryland Shore Medical Center at Easton	$298,925,000	$38,023,876	$4,921,084	$33,102,793	11.07%	$4,670,000	1.56%
Univ. of Maryland St. Joseph's Medical Center	$409,862,000	$58,245,151	$8,389,002	$49,856,149	12.16%	$6,812,000	1.66%
Univ. of Maryland Upper Chesapeake Medical Center	$314,183,000	$22,452,379	$4,953,700	$17,498,679	5.57%	$4,258,000	1.36%
UPMC Western Maryland Hospital	$353,692,553	$76,846,674	$15,560,193	$61,286,481	17.33%	$14,905,333	4.21%
Total, All Hospitals	**$20,151,069,758**	**$2,281,463,324**	**$945,866,242**	**$1,335,597,082**	**6.63%**	**$452,369,804**	**2.24%**

Appendix E. Methodology for Rate Support for Uncompensated Care, including Financial Assistance

Financial assistance amounts reported by hospitals in their community benefit reports (CBRs) may not match the financial assistance amounts applied in their global budgets for the same year. The financial assistance amounts in rates are part of the HSCRC's uncompensated care (UCC) policy, which is a prospective policy applied at the beginning of the rate year. In contrast, the amounts reported by hospitals in their CBRs are retrospective.

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

1. **Statewide Actual UCC in All-Payer Hospital Rates:** The HSCRC builds UCC funding into hospital rates based on the total amount of charity care and bad debt reported on all acute hospitals' RE Schedules for the previous year. The change in hospital rates based on statewide actual UCC, as a percent of gross patient revenue, is applied uniformly to acute care hospital rates statewide.
2. **Hospital Payments or Contributions to the UCC Fund** The UCC Fund is then used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC.
    i. **Hospital-Specific Actual UCC:** The HSCRC uses gross patient revenue as reported on the hospitals' RE Schedules for the previous year to determine the hospital-specific actual UCC for each hospital.
    ii. **Hospital-Specific Predicted UCC:** The HSCRC uses a mathematical model to predict a hospital's expected amount of UCC. This model takes into account Area Deprivation Index (ADI), payer type, and site of care.
    iii. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step i) and the hospital-specific predicted UCC (described in step ii). All individual hospital values for payment or withdrawal from the UCC Fund are then normalized such that the statewide 50/50 blend equals the prior year actual UCC rate that was built into statewide hospital rates (step 1 for the prior year). This ensures that the UCC fund is redistributive in nature.
    iv. **Determining hospital contribution/withdrawals:** The 50/50 blend (step iii) for each hospital is subtracted from the amount of state-wide actual UCC funding provided in rates (step 1) and multiplied by the hospital's global budget revenue (GBR) to determine how

much each hospital will either withdraw from or pay into the statewide UCC Fund. The Fund is the mechanism through which the HSCRC ensures the burden of uncompensated care is shared by all hospitals. Specifically, if a hospital's 50/50 blend is less than the statewide average UCC rate (determined in step 1), the hospital will pay into the UCC Fund. Conversely, if a hospital's 50/50 blend is greater than the statewide average UCC rate, the hospital will withdraw from the Fund.

Table E1. UCC Methodology Example ($ Millions)

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

The use of blended actual and predicted UCC to determine the amount of hospital contributions and withdrawals from the UCC funds serves to balance the policy goals of reimbursing hospitals for UCC provided to low-income patients while also incentivizing hospitals to minimize bad debt by encouraging them to use reasonable means to collect debt from patients who can afford to pay. Incorporating predicted UCC into this methodology provides hospitals with a financial incentive to collect payments (rather than writing debt off as bad debt without attempting to collect) so that UCC costs do not rise too quickly. This approach is critical to supporting Maryland's unique UCC system and ensuring access to care for low-income patients in the long run.

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Appendix F. FY 2023 Hospital Community Benefit Aggregate Data

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[44] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
Unreimbursed Medicaid Costs							
T99	**Medicaid Assessments**	**$295,626,867**	[45]		**$238,997,382**	**$55,466,167**	**$55,466,167**
Community Health Services							
A10	Community Health Education	$16,586,183	$8,318,251	$1,168,901	$2,720,697	$21,014,836	$12,696,586
A11	Support Groups	$2,313,576	$1,767,865	$860	$4,915	$4,075,666	$2,307,801
A12	Self-Help	$1,476,507	$662,923		$226,850	$1,912,581	$1,249,657
A20	Community-Based Clinical Services	$24,494,852	$6,700,082		$10,143,430	$21,051,504	
A21	Screenings	$3,008,461	$2,069,624		$1,028,063	$4,050,023	$1,980,399
A22	One-Time/Occasionally Held Clinics	$972,719	$83,166		$27	$1,055,858	$972,692
A23	Clinics for Underinsured and Uninsured	$7,507,569	$3,384,861		$1,736,399	$9,156,032	$5,771,171
A24	Mobile Units	$1,609,452	$553,326		$1,471,904	$690,874	$137,548
A30	Health Care Support Services	$75,038,638	$27,107,234	$9,023,985	$7,838,474	$85,283,412	$58,176,179
A40	Other	$9,635,784	$4,243,382	$685,510	$1,751,807	$11,441,849	$7,198,467
A99	**Total**	**$142,643,741**	**$54,890,714**	**$10,879,256**	**$26,922,565**	**$159,732,634**	**$104,841,920**
Health Professions Education							
B10	Physicians/Medical Students	$397,318,606	$202,459,862	$619,923	$2,930,318	$596,228,227	$393,768,365
B20	Nurses/Nursing Students	$36,029,551	$20,805,489	$3,885,052		$52,949,989	$32,144,499
B30	Other Health Professionals	$20,620,925	$10,163,456		$143,643	$30,640,738	$20,477,282

[44] "Net Community Benefit" refers to hospitals' costs minus their offsetting revenue and rate support totals.
[45] Blank cells indicate a value of 0.

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[44] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
B40	Scholarships/Funding for Professional Education	$3,284,005	$1,640,041	$320,588		$4,603,458	$2,963,417
B50	Other	$1,709,214	$1,172,550		$446,946	$2,434,818	$1,262,268
B99	**Total**	**$458,962,301**	**$236,241,399**	**$4,825,563**	**$3,520,907**	**$686,857,230**	**$450,615,831**
	Mission-Driven Health Services						
C99	**Mission-Driven Health Services Total**	**$1,537,041,477**	**$153,401,280**	**$66,690**	**$857,695,497**	**$832,680,571**	**$679,279,291**
	Research						
D10	Clinical Research	$13,313,308	$4,383,266		$5,751,402	$11,945,173	$7,561,907
D20	Community Health Research	$1,142,112	$380,425		$34,937	$1,487,600	$1,107,175
D30	Other	$663,270	$279,573		$197,315	$745,528	$465,955
D99	**Total**	**$15,118,691**	**$5,043,264**		**$5,983,654**	**$14,178,301**	**$9,135,037**
	Financial Contributions						
E10	Cash Donations	$12,975,236	$4,734		$1,500	$12,978,470	$12,973,736
E20	Grants	$5,898,467			$3,384,457	$2,514,010	$2,514,010
E30	In-Kind Donations	$2,427,066	$29,500		$74,215	$2,382,351	$2,352,851
E40	Cost of Fund Raising for Community Programs	$6,578,376			$4,326,301	$2,252,075	$2,252,075
E99	**Total**	**$27,879,146**	**$34,234**		**$7,786,473**	**$20,126,907**	**$20,092,673**
	Community-Building Activities						
F10	Physical Improvements and Housing	$1,234,790	$295,018		$134,362	$1,395,446	$1,100,428
F20	Economic Development	$1,468,921	$443,861		$12,500	$1,900,282	$1,456,421
F30	Community Support	$6,990,614	$2,720,876	$878,623	$2,374,570	$6,458,297	$3,737,421
F40	Environmental Improvements	$678,749	$341,310		$1,000	$1,019,059	$677,749
F50	Leadership Development/Training for Community Members	$411,572	$315,612			$727,185	$411,572
F60	Coalition Building	$3,931,888	$2,133,076		$82,121	$5,982,843	$3,849,767

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[44] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
F70	Advocacy for Community Health Improvements	$1,197,008	$230,622			$1,427,631	$1,197,008
F80	Workforce Development	$3,314,487	$1,337,859		$491,189	$4,161,156	$2,823,298
F90	Other	$718,577	$557,584			$1,276,161	$718,577
F99	**Total**	**$19,946,606**	**$8,375,819**	**$878,623**	**$3,095,742**	**$24,348,059**	**$15,972,241**
Community Benefit Operations							
G10	Assigned Staff	$9,094,011	$4,674,055		$6,558	$13,761,508	$9,087,453
G20	Community Health/Health Assets Assessments	$483,350	$365,026		$11,085	$837,291	$472,265
G30	Other	$1,741,784	$475,132		$13,856	$2,203,060	$1,727,928
G99	**Total**	**$11,319,145**	**$5,514,213**		**$31,499**	**$16,801,859**	**$11,287,646**
Financial Assistance							
H00	**Total Financial assistance**	**$452,369,804**					
Foundation-Funded Community Benefits							
J10	Community Services	$1,273,727	$458,484		$83,082	$1,649,128	$1,190,644
J20	Community Building	$687,718	$282,822		$379,855	$590,685	$307,863
J30	Other		$11,846			$11,846	
J99	**Total**	**$1,961,445**	**$753,152**		**$462,937**	**$2,251,660**	**$1,498,507**
Total Hospital Community Benefits							
A99	Community Health Services	$142,643,741	$54,890,714	$10,879,256	$26,922,565	$159,732,634	$104,841,920
B99	Health Professions Education	$458,962,301	$236,241,399	$4,825,563	$3,520,907	$686,857,230	$450,615,831
C99	Mission Driven Health Care Services	$1,537,041,477	$153,401,280	$66,690	$857,695,497	$832,680,571	$679,279,291
D99	Research	$15,118,691	$5,043,264		$5,983,654	$14,178,301	$9,135,037
E99	Financial Contributions	$27,879,146	$34,234		$7,786,473	$20,126,907	$20,092,673
F99	Community-Building Activities	$19,946,606	$8,375,819	$878,623	$3,095,742	$24,348,059	$15,972,241

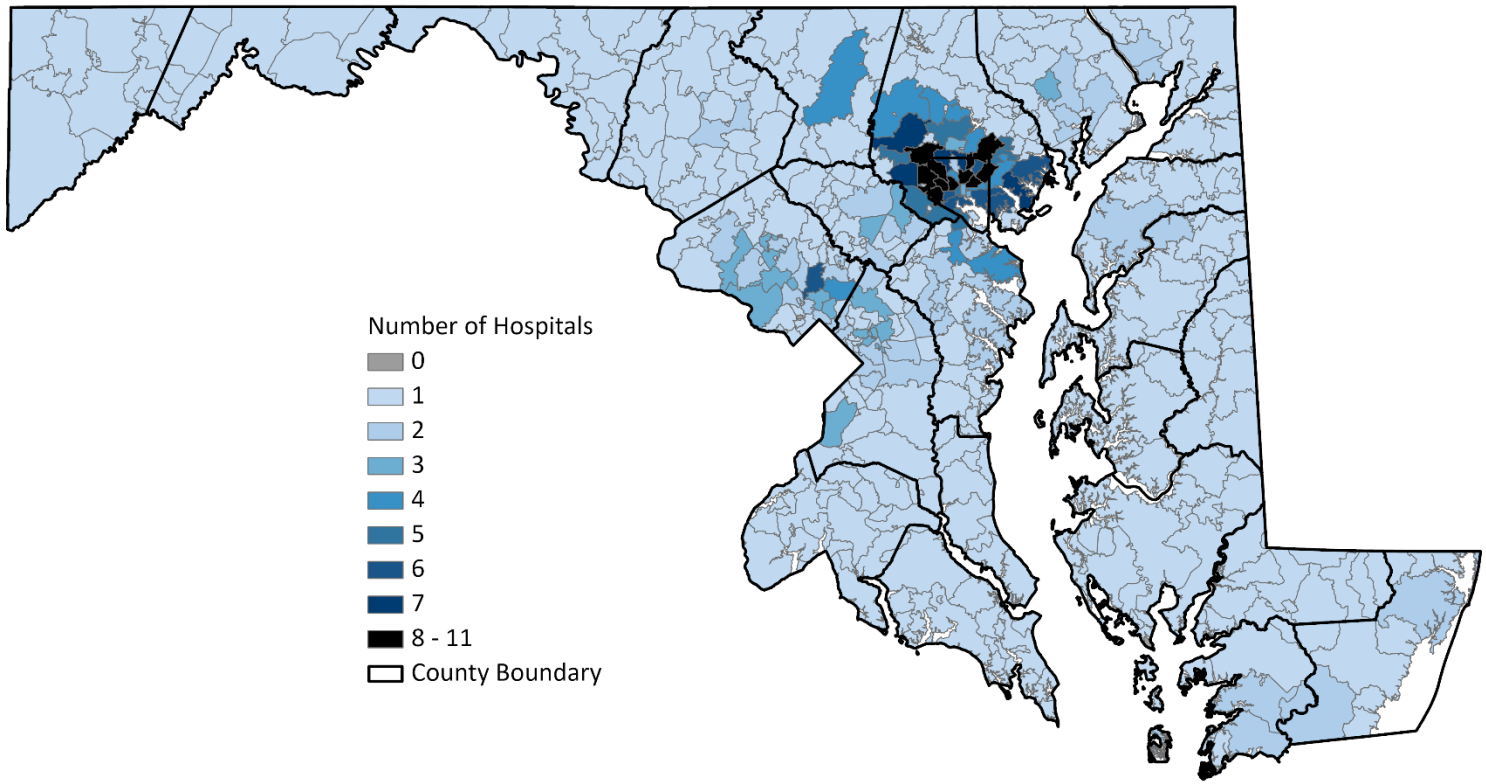
Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[44] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
G99	Community Benefit Operations	$11,319,145	$5,514,213		$31,499	$16,801,859	$11,287,646
H99	Financial assistance					$452,369,804	$452,369,804
J99	Foundation Funded Community Benefit	$1,961,445	$753,152		$462,937	$2,251,660	$1,498,507
T99	Medicaid Assessments	$295,626,867			$238,997,382	$55,466,167	$55,466,167
K99	**Total Hospital Community Benefit**	**$2,510,499,419**	**$464,254,075**	**$16,650,132**	**$1,144,496,656**	**$2,264,813,192**	**$1,800,559,117**

Appendix G. Primary Service Areas and Community Benefit Service Areas

A primary service area (PSA) is the geographical region from which a hospital primarily draws its patients. The HSCRC determines a PSA for each hospital. Figure 1 shows how many hospitals claim each ZIP code in Maryland in their PSAs.[46] Other than the areas in and around Baltimore City/County and some areas around Washington, D.C., most ZIP codes are claimed by only one hospital.

[46] For FY 2023, only three ZIP codes were not claimed to be in the PSA of at least one hospital: 20892 in southern Montgomery County (the National Institutes of Health), 21241 in western Baltimore City (the Social Security Administration), and 21627 in southern Dorchester County (Crocheron, MD, which had a population of 27 in 2020). Note that each of these ZIP codes is very small and therefore difficult to see on this map.

Figure G1: Hospitals Claiming the ZIP Code in Their PSAs, FY 2023*



Hospitals also report the methodology used to determine their community benefit service area (CBSA),[47] which may differ from their PSA. Maryland hospitals considered multiple factors when defining their CBSAs, with the most common factors being patient utilization patterns, such as ZIP codes with the highest percentages of hospital discharges and emergency department (ED) visits. Nine hospitals based their CBSAs on their PSAs, shown above.[48] Other hospitals defined their CBSAs by geographic proximity to the hospital, regions served by the hospital's community benefit programs, and demographic factors, including areas with high needs indicated by social determinants of health and areas with higher proportions of medically underserved or uninsured/underinsured residents. Table G1 summarizes the methods used by hospitals to determine their CBSAs.

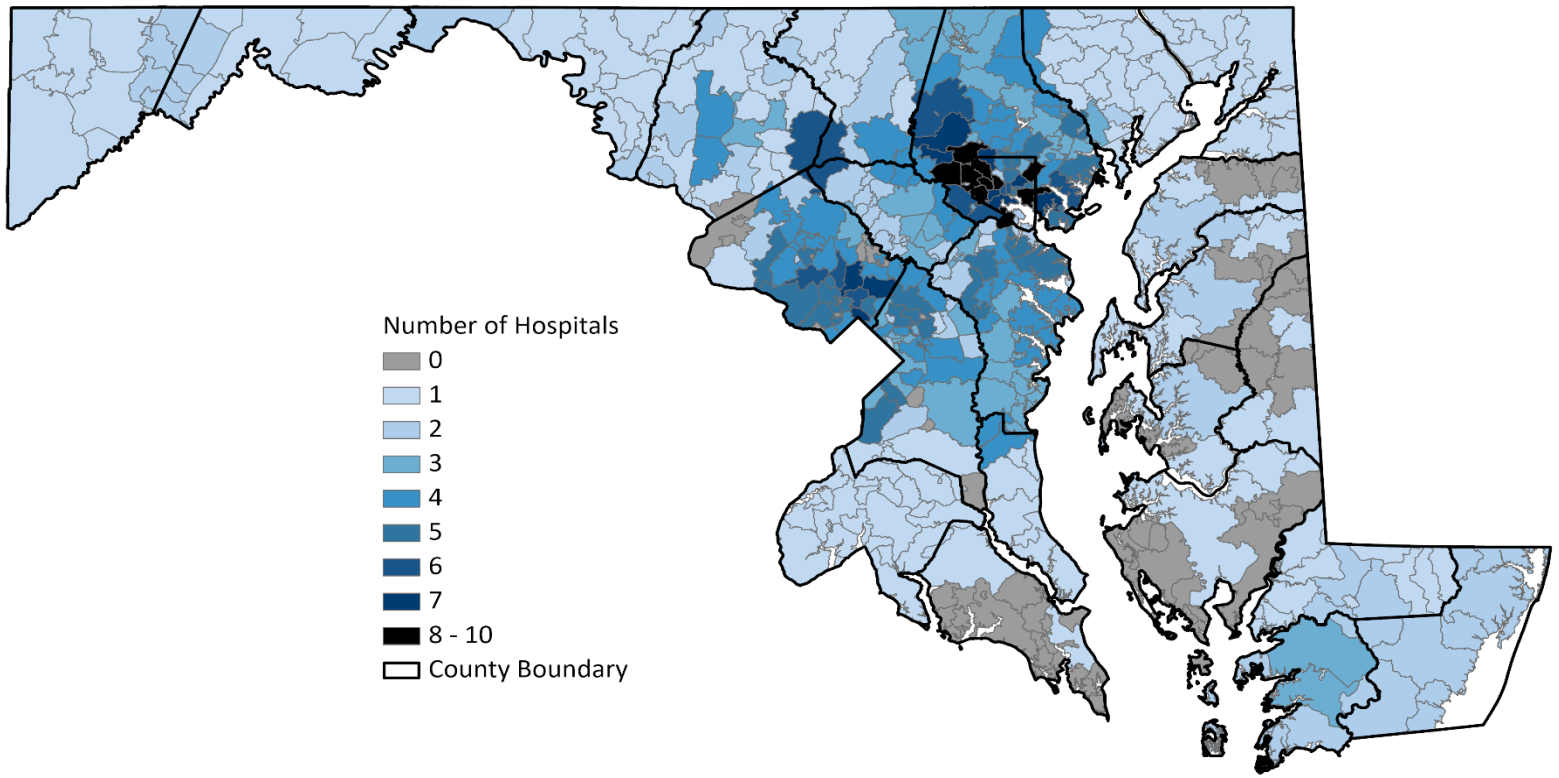
Table G1. Methods Used by Hospitals to Identify Their CBSAs, FY 2023

CBSA Identification Factor	Number of Hospitals[49]
Patterns of Hospital Utilization by Patients	36
ZIP Codes in Their Global Budget Revenue Agreement (Primary Service Area)	9
ZIP Codes in Financial Assistance Policy	7
Other Method	25

Figure G2 displays the number of hospitals that claim each ZIP code as part of their CBSA. Most zip codes in Maryland were included in at least one hospital's CBSA.[50] Most ZIP codes in Baltimore City, Baltimore County, Montgomery County, Prince George's County, Anne Arundel County, and Howard County were claimed by three or more hospitals, with numerous ZIP codes in Baltimore City were claimed by eight or more hospitals. This is a marked change from the CBSAs reported in FY 2022, when only one uninhabited ZIP code in central Maryland was not claimed by a hospital. This difference likely stems at least in part from the fact that the University of Maryland Rehabilitation and Orthopaedic Institute claimed every ZIP code in the State as part of its CBSA in FY 2022 but did not do so in FY 2023.

[47] Hospitals report the CBSA zip codes and selection methodology to the HSCRC and include that information in their federally mandated CHNAs (26 CFR § 1.501(r)-3(b)).
[48] The PSA is the geographic region where the hospital draws most of its patients. The PSA for each general acute care and chronic care hospital is defined in the hospital's Global Budget Agreement with the HSCRC. For specialty hospitals, the PSA is defined as the ZIP codes in which 60% of discharges are reported.
[49] Hospitals used multiple factors to determine their CBSA. As a result, the numbers in this column do not sum to 47.

Figure G2. Number of Hospitals Claiming the ZIP Code in Their CBSAs, FY 2023



Appendix H. Community Statistics by County

Hospitals report details about the communities located in their CBSAs/CHNAs, which help inform decisions about HCB activities. Table 1 displays examples of the county-level demographic measures used by the hospitals.

The following measures in Table 1 were derived from the five-year (2018-2022) average estimates of the U.S. Census Bureau's American Community Survey: median household income, percentage of families below the federal poverty level (FPL), percentage uninsured, percentage with public health insurance, mean travel time to work, percentage that speak a language other than English at home, percentage by racial categories, and percentage by ethnicity categories. Total population was derived from the 1-year and 5-year average American Community Survey estimates. The life expectancy three-year average (2019-2021) and the crude death rate (2021) were derived from the Department's Vital Statistics Administration, and the numerator for the percentage of the population enrolled in Medicaid was pulled from the Maryland Medicaid DataPort.

Table H1. Community Statistics by County

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Maryland		98,461	6.2	5.9	34.0	28.7	32.0	19.8	56.6	32.5	10.9	78.2	941.4
Allegany	2	55,248	9.6	4.0	49.5	38.8	22.6	3.3	91.2	9.3	2.0	74.2	1394.0
Anne Arundel	8	116,009	4.1	4.5	28.7	21.0	30.3	12.6	73.7	20.3	8.7	79.1	849.1
Baltimore	12	88,157	7.0	5.3	35.8	30.7	28.7	14.9	60.1	32.4	6.1	77.2	1119.0
Baltimore City	16	58,349	14.5	5.5	46.8	52.0	30.1	10.3	31.9	63.6	5.9	71.0	1296.0
Calvert	1	128,078	2.8	3.2	27.4	19.4	40.9	4.9	83.9	15.2	4.6	78.6	911.6
Caroline	1	65,326	9.8	6.8	49.7	42.3*	31.6	8.3	80.5	16.0	8.2	75.7	1302.0
Carroll	3	111,672	3.5	2.9	27.7	17.2	35.4	5.9	92.3	5.1	4.1	78.5	1082.0
Cecil	1	86,869	7.2	3.9	37.1	31.0	29.1	6.6	89.0	9.2	4.9	74.2	1206.0
Charles	1	116,882	3.7	4.0	29.3	25.6	44.2	9.8	43.1	53.8	6.7	77.2	877.6
Dorchester	1	57,490	8.7	5.2	54.9	46.0*	26.5	5.9	67.5	30.7	6.1	75.0	1511.0
Frederick	5	115,724	4.6	4.5	27.4	19.4	33.7	15.5	82.0	12.5	11.0	80.2	789.6
Garrett	1	64,447	7.3	5.8	46.2	32.6*	25.0	3.1	97.5	1.4	1.3	76.6	1394.0

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Harford	2	106,417	4.7	3.5	31.0	22.3	32.3	7.5	80.5	16.8	5.0	78.2	989.8
Howard	4	140,971	3.7	3.9	24.8	18.2	29.5	26.5	57.0	22.3	7.5	82.8	595.6
Kent	1	71, 635	5.1	4.3	44.6	28.7*	25.8	5.4	81.2	15.4	4.7	76.4	1641.0
Montgomery	9	125,583	4.9	6.7	29.2	23.0	33.0	41.9	54.1	21.0	20.0	83.5	660.3
Prince George's	7	97,935	6.2	10.5	34.4	31.8	36.0	28.9	17.9	64.3	20.0	78.4	801.0
Queen Anne's	2	108,332	3.7	5.0	35.0	19.7*	34.9	5.4	90.1	7.1	4.6	79.3	1035.0
Saint Mary's	1	113,668	6.6	4.0	29.4	24.2	30.1	7.0	80.8	16.9	5.7	77.3	920.1
Somerset	3	52,149	15.6	3.9	53.2	42.5*	24.0	5.5	57.6	43.4	4.0	74.5	1276.0
Talbot	2	81,667	6.3	4.4	48.0	25.9*	26.4	8.7	83.8	13.6	7.3	79.0	1474.0
Washington	1	73,017	8.6	5.5	42.7	36.0	29.7	8.2	85.1	14.7	6.2	75.3	1307.0
Wicomico	2	69,421	8.0	6.5	43.7	41.9	23.1	11.4	67.9	29.1	5.7	75.0	1207.0
Worcester	2	76,689	5.1	5.8	48.1	29.6*	23.8	6.6	84.2	14.3	3.8	79.2	1392.0
Source	[51]	[52]	[53]	[54]	[55]	[56]*	[57]	[58]	[59]	[60]	[61]	[62]	[63]

[51] As reported by hospitals in their FY 2023 Community Benefit Narrative Reports.
[52] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Median Household Income (Dollars), https://data.census.gov/cedsci/.
[53] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months is Below the Federal Poverty Level – All Families.
[54] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage.
[55] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage.
[56] American Community Survey 1-Year Estimates 2022, ACS Demographic and Housing Estimates, Total Population (denominator) and The Maryland Medicaid DataPort – Eligibility Exploratory Dashboards Standard Report, December 2022 enrollment, the Hilltop Institute (numerator). Starred values used American Community Survey 5-Year Estimates 2022, ACS Demographic and Housing Estimates, Total Population for the denominator because 2022 ACS 1-Year Estimates were unavailable for these counties.
[57] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes).
[58] American Community Survey 5-Year Estimates 2018 – 2022, Language Spoken at Home, Population 5 Years and Over, Speak a Language Other Than English.
[59] American Community Survey 5-Year Estimates 2018 – 2022, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – White.
[60] American Community Survey 5-Year Estimates 2018 – 2022, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – Black or African American.
[61] American Community Survey 5-Year Estimates 2018 – 2022, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race).
[62] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2021, Table 7. Life Expectancy at Birth by Race, Hispanic Origin, Region, and Political Subdivision, Maryland, 2019 – 2021. An updated 2022 Vital Statistics Report was unavailable at the time of publication.
[63] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2021, Table 32B. Crude Death Rates by Race and Hispanic Origin, Region and Political Subdivision, Maryland, 2021. An updated 2022 Vital Statistics Report was unavailable at the time of publication.

Appendix I. Sources of Community Health Measures Reported by Hospitals

Other community health data sources reported by hospitals include the following:

- Baltimore Neighborhood Indicators Alliance
- CDC Behavioral Risk Factor Surveillance System
- CDC Chronic Disease Calculator
- CDC Interactive Atlas of Heart Disease and Stroke
- CDC Mental Health Surveillance and PRC Survey
- CDC National Center for Health Statistics
- CDC Wonder Database
- Center for Applied Research and Engagement Systems
- Commission on Cancer
- Community surveys, focus groups, and interviews
- Conduent - Healthy Communities Institute
- County and local health departments' community health statistics
- Cigarette Restitution Fund Program – Cancer in Maryland Report
- Feeding America
- Findings from health and human services needs assessments completed by contracted entities
- Health Resources and Services Administration
- Healthy Communities Institute
- Internal emergency department and health services quality data
- Kaiser Family Foundation analyses
- Local community foundations
- Local health improvement coalitions
- Local police and public school systems data
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Center on Economic Progress
- Maryland Chronic Disease Burden

- Maryland Department of Health
- Maryland Department of Planning
- Maryland Hospital Association
- Maryland Office of Minority Health and Health Disparities
- Maryland Physician Workforce Study
- Maryland Sexually Transmitted Infections Program
- Maryland State Health Improvement Plan (SHIP)
- Maryland Vital Statistics
- Maryland Youth Risk Behavior Survey
- Measure of America Opportunity Index by County
- Meritus Health Cancer Registry Report
- National Cancer Institute
- National Institutes of Health
- Nielsen/Claritas
- Performance data from community health improvement initiatives
- Robert Wood Johnson Foundation – County Health Rankings
- Robert Wood Johnson Foundation – City Health Dashboard
- State of Maryland's Health Care Workforce Report
- United Way – United for ALICE (Asset-Limited, Income Constrained, Employed)
- University of Maryland School of Social Work
- University of Wisconsin School of Medicine and Public Health – Neighborhood Atlas
- U.S. Census Bureau – American Community Survey
- U.S. Census Bureau – Decennial Census population estimates
- U.S. Department of Health and Human Services – Healthy People 2030
- Washington Co. Public Schools Youth Risk Behavior and High School Trend Reports

Appendix J. FY 2023 CHNA Priority Area Categories Addressed through CB Initiatives

CHNA Priority Area	Number of Hospitals
Social Determinants of Health - Health Care Access and Quality	35
Settings and Systems - Community	32
Health Conditions - Diabetes	31
Health Conditions - Mental Health and Mental Disorders	31
Health Behaviors - Preventive Care	31
Health Conditions - Cancer	26
Health Conditions - Heart Disease and Stroke	25
Health Behaviors - Drug and Alcohol Use	25
Health Behaviors - Nutrition and Healthy Eating	23
Settings and Systems - Transportation	22
Social Determinants of Health - Economic Stability	21
Health Conditions - Pregnancy and Childbirth	20
Social Determinants of Health - Social and Community Context	20
Health Conditions - Addiction	19
Settings and Systems - Health Care	17
Social Determinants of Health - Education Access and Quality	17
Health Behaviors - Health Communication	16
Health Behaviors - Physical Activity	16
Health Behaviors - Violence Prevention	14
Populations - Children	14
Populations - Workforce	14
Health Conditions - Overweight and Obesity	11
Populations - Older Adults	11
Settings and Systems - Housing and Homes	11
Social Determinants of Health - Neighborhood and Built Environment	11
Health Conditions - Infectious Disease	10
Health Behaviors - Injury Prevention	10
Populations - Infants	10
Health Behaviors - Vaccination	9
Populations - Parents or Caregivers	9
Settings and Systems - Workplace	9
Populations - Adolescents	8

CHNA Priority Area	Number of Hospitals
Populations - People with Disabilities	8
Populations - Women	8
Health Behaviors - Emergency Preparedness	7
Settings and Systems - Hospital and Emergency Services	7
Settings and Systems - Schools	7
Settings and Systems - Public Health Infrastructure	6
Health Conditions - Chronic Kidney Disease	5
Health Conditions - Chronic Pain	5
Settings and Systems - Environmental Health	5
Settings and Systems - Health Insurance	5
Health Conditions - Respiratory Disease	4
Health Behaviors - Child and Adolescent Development	4
Health Behaviors - Family Planning	4
Health Conditions - Arthritis	3
Health Conditions - Sexually Transmitted Infections	3
Health Conditions - Health Care-Associated Infections	2
Health Conditions - Sensory or Communication Disorders	2
Health Behaviors - Sleep	2
Health Behaviors - Tobacco Use	2
Populations - Men	2
Settings and Systems - Global Health	2
Settings and Systems - Health IT	2
Settings and Systems - Health Policy	2
Health Conditions - Blood Disorders	1
Health Conditions - Osteoporosis	1
Populations - LGBT	1
Health Conditions - Dementias	0
Health Conditions - Foodborne Illness	0
Health Conditions - Oral Conditions	0
Health Behaviors - Safe Food Handling	0

*Data Source: As reported by hospitals on their FY 2023 financial reports.

Appendix K. Dates of Most Recent CHNAs

Hospital	Date Most Recent CHNA was Completed
CalvertHealth	Nov-23
Holy Cross Germantown	Oct-22
Holy Cross Hospital	Oct-22
Adventist HealthCare Fort Washington Medical Center	Oct-22
Adventist HealthCare Rehab	Oct-22
Adventist Shady Grove	Oct-22
Adventist White Oak	Oct-22
Garrett Regional Medical Center	Aug-22
UPMC Western MD	Jun-22
Suburban Hospital	Jun-22
UM BWMC	Jun-22
Howard County General Hospital	Jun-22
UM Capital Region Health	Jun-22
UM Shore Regional Medical Center	May-22
Sheppard Pratt	May-22
TidalHealth McCready Pavilion	May-22
TidalHealth Peninsula Regional	May-22
ChristianaCare Union Hospital	May-22
Meritus Medical Center	May-22
Atlantic General	May-22
Frederick Health Hospital	May-22
Anne Arundel Medical Center	Dec-21
Doctors Community Medical Center	Dec-21
McNew Family Health Center	Dec-21
Carroll Hospital Center	Jun-21
LifeBridge Levindale	Jun-21
MedStar Franklin Square	Jun-21
MedStar Good Samaritan	Jun-21
MedStar Harbor Hospital	Jun-21
MedStar Montgomery	Jun-21
MedStar Southern MD	Jun-21
MedStar St. Mary's	Jun-21

Hospital	Date Most Recent CHNA was Completed
MedStar Union Memorial	Jun-21
Northwest Hospital Center	Jun-21
Sinai Hospital of Baltimore, Inc.	Jun-21
St. Agnes HealthCare	Jun-21
UM Charles Regional	Jun-21
UMMC Midtown	Jun-21
University of Maryland Medical Center	Jun-21
UM Rehab & Ortho	Jun-21
UM Upper Chesapeake Health	Jun-21
UM St. Joseph Medical Center	Jun-21
Johns Hopkins Hospital	Jun-21
Greater Baltimore Medical Center	Jun-21
Mercy Medical Center	Jun-21
Johns Hopkins Bayview Medical Center	May-21
Mt Washington Pediatric Hospital	May-21

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Appendix L. CHNA External Participants and Their Level of Community Engagement During the CHNA Process

CHNA Participant Category	Level of Community Engagement					
	Informed - To provide the community with balanced & objective info to assist in understanding the problem, alternatives, opportunities and/or solutions	**Consulted -** To obtain community feedback on analysis, alternatives and/or solutions	**Involved -** To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	**Collaborated -** To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	**Delegated -** To place the decision-making in the hands of the community	**Community Driven/Led -** To support the actions of community initiated, driven and/or led processes
Other Hospitals	16	25	18	25	8	10
Local Health Department	25	30	25	28	8	14
Local Health Improvement Coalition	22	26	18	25	8	15
Maryland Department of Health	18	16	5	12	3	3
Other State Agencies	7	8	4	10	0	0
Local Govt. Organizations	17	24	13	18	3	4
Faith-Based Organizations	19	22	21	21	2	7
School - K-12	18	20	15	17	3	2
School - Colleges, Universities, Professional Schools	19	19	16	17	3	3
Behavioral Health Organizations	21	26	15	20	3	9
Social Service Organizations	17	21	12	19	1	7
Post-Acute Care Facilities	8	12	5	6	0	0
Community/Neighborhood Organizations	19	24	15	18	2	5
Consumer/Public Advocacy Organizations	8	10	4	7	0	1
Other	16	22	11	7	1	4

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Appendix M. CHNA External Participants and the Recommended CHNA Practices They Engaged in

CHNA Participant Category	Recommended Practices							
	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals	30	30	25	33	20	27	17	18
Local Health Department	33	33	34	40	28	28	19	22
Local Health Improvement Coalition	34	24	16	40	21	26	18	21
Maryland Department of Health	11	11	19	15	8	12	3	13
Other State Agencies	14	9	4	11	2	11	4	9
Local Govt. Organizations	27	21	8	28	10	17	18	14
Faith-Based Organizations	29	20	7	30	11	24	18	12
School - K-12	24	19	11	26	15	16	18	13
School - Colleges, Universities, Professional Schools	21	19	12	24	9	17	16	10
Behavioral Health Organizations	29	22	13	32	15	24	17	19
Social Service Organizations	25	19	10	29	13	20	15	15
Post-Acute Care Facilities	11	12	2	15	0	7	3	7
Community/Neighborhood Organizations	25	22	9	31	14	17	17	13
Consumer/Public Advocacy Organizations	13	11	5	11	3	8	7	7
Other	7	11	8	19	8	11	9	4

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Appendix N. Hospitals Involving Staff/Departments in CHNA Efforts

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
CB/Community Health/Population Health Director (facility level)	1	12	32	31	28	27	32	33	15	3
CB/Community Health/Population Health Director (system level)	8	6	26	29	30	26	29	27	19	5
Senior Executives (CEO, CFO, VP, etc.) (facility level)	1	1	37	33	28	21	37	28	6	5
Senior Executives (CEO, CFO, VP, etc.) (system level)	5	6	13	23	26	12	21	11	1	4
Board of Directors or Board Committee (facility level)	8	2	13	15	16	9	26	13	3	11
Board of Directors or Board Committee (system level)	13	6	3	10	12	3	13	6	1	9
Clinical Leadership (facility level)	2	0	31	25	26	23	41	33	11	2
Clinical Leadership (system level)	15	7	16	17	19	10	24	19	4	2
Population Health Staff (facility level)	5	9	31	24	22	19	30	31	16	2
Population Health Staff (system level)	14	7	21	23	23	19	23	22	15	3
Community Benefit staff (facility level)	1	11	34	33	29	29	34	33	23	2
Community Benefit staff (system level)	5	11	20	26	27	21	22	21	17	8
Physician(s)	4	0	24	19	19	17	36	27	7	2
Nurse(s)	7	0	29	23	19	21	37	34	7	0
Social Workers	10	0	23	16	18	20	33	34	6	0
Hospital Advisory Board	3	19	11	13	13	11	19	18	3	3
Other (specify)	12	1	6	6	6	7	7	7	3	2

Appendix O. Hospitals Reporting Community Benefit Internal Participants and Their Roles

Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting Health Needs That Will Be Targeted	Selecting the Initiatives That Will Be Supported	Determining How to Evaluate the Impact of Initiatives	Providing Funding for CB Activities	Allocating Budgets for Individual Initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other
CB/Community Health/Population Health Director (facility level)	2	11	32	33	32	19	31	31	33	3
CB/Community Health/Population Health Director (system level)	8	7	30	28	29	16	20	17	27	3
Senior Executives (CEO, CFO, VP, etc.) (facility level)	2	0	41	41	25	38	38	10	21	1
Senior Executives (CEO, CFO, VP, etc.) (system level)	14	7	20	20	18	20	20	9	15	2
Board of Directors or Board Committee (facility level)	7	3	18	22	9	12	7	5	15	3
Board of Directors or Board Committee (system level)	12	8	15	15	4	7	4	3	7	2
Clinical Leadership (facility level)	3	0	34	32	22	9	10	25	21	0
Clinical Leadership (system level)	10	7	24	21	12	5	7	10	12	0
Population Health Staff (facility level)	4	10	25	26	29	11	12	29	30	1
Population Health Staff (system level)	13	7	19	19	25	7	13	18	24	0
Community Benefit staff (facility level)	3	10	26	26	28	13	17	31	32	1
Community Benefit staff (system level)	5	11	17	18	24	4	7	16	24	3
Physician(s)	10	0	24	22	17	4	4	24	21	4
Nurse(s)	9	0	25	24	20	7	8	29	24	0
Social Workers	16	1	20	20	13	5	5	25	19	0
Hospital Advisory Board	8	17	16	14	4	5	3	2	11	2
Other (specify)	13	1	6	5	6	3	2	8	7	0

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Emergency Department Initiatives Update

July Commission Meeting

Slides will not be presented but are included in packet for public dissemination

July Data 2025 Reporting

Monthly, public reporting of three measures:

- ED1-like measure: ED arrival to inpatient admission time for all admitted patients
- OP18-like measure: ED arrival to discharge time for patients who are not admitted
- EMS turnaround time (from MIEMSS): Time from arrival at ED to transfer of patient care from EMS to the hospital

Data received for 44 out of 44 hospitals

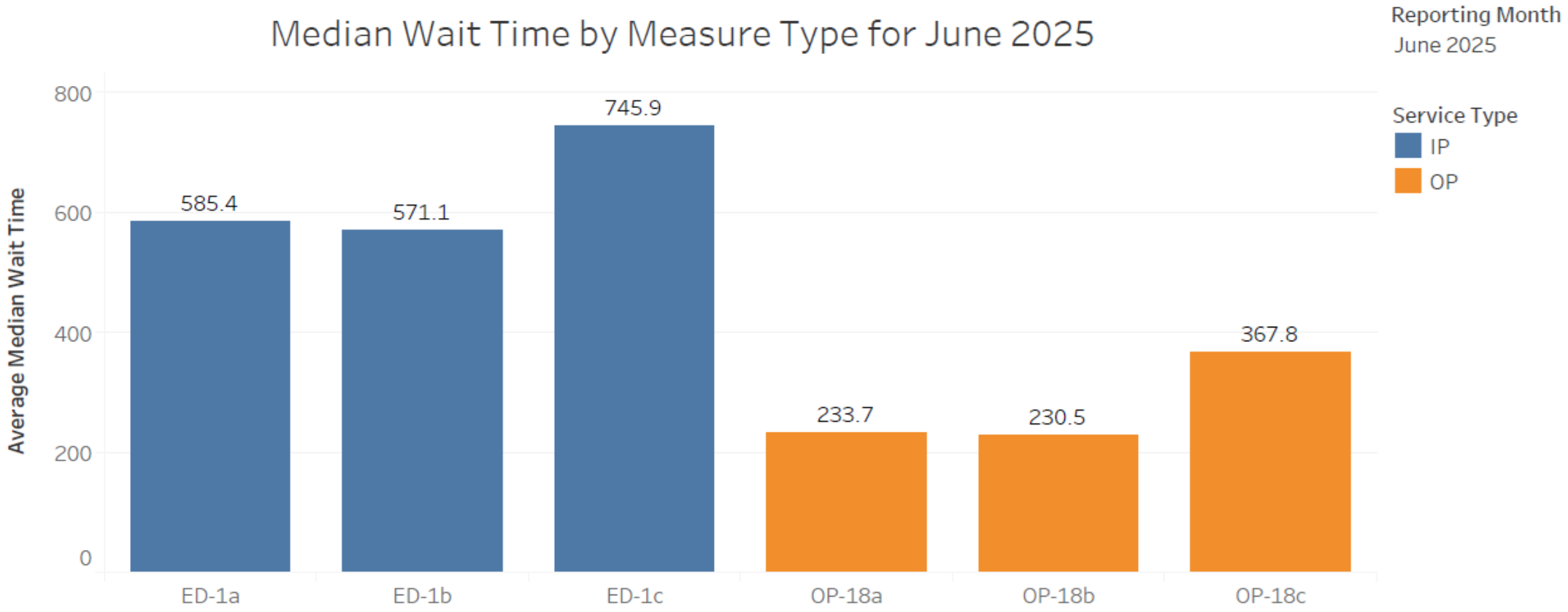
- These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month)
- These data are being collected for hospital quality improvement and have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital
- Data may be updated over time if issues are identified or specifications change

Graphs:

- Rolling median (June 2023-Latest Month) and change from June 2023/first month provided
- Latest month grouped by CMS ED volume category (Volume data is from CMS Care Compare or imputed by hospital, volume categories were recently updated on CMS Care Compare.)
- Graphs have not been QAed by hospitals due to fast turnaround time

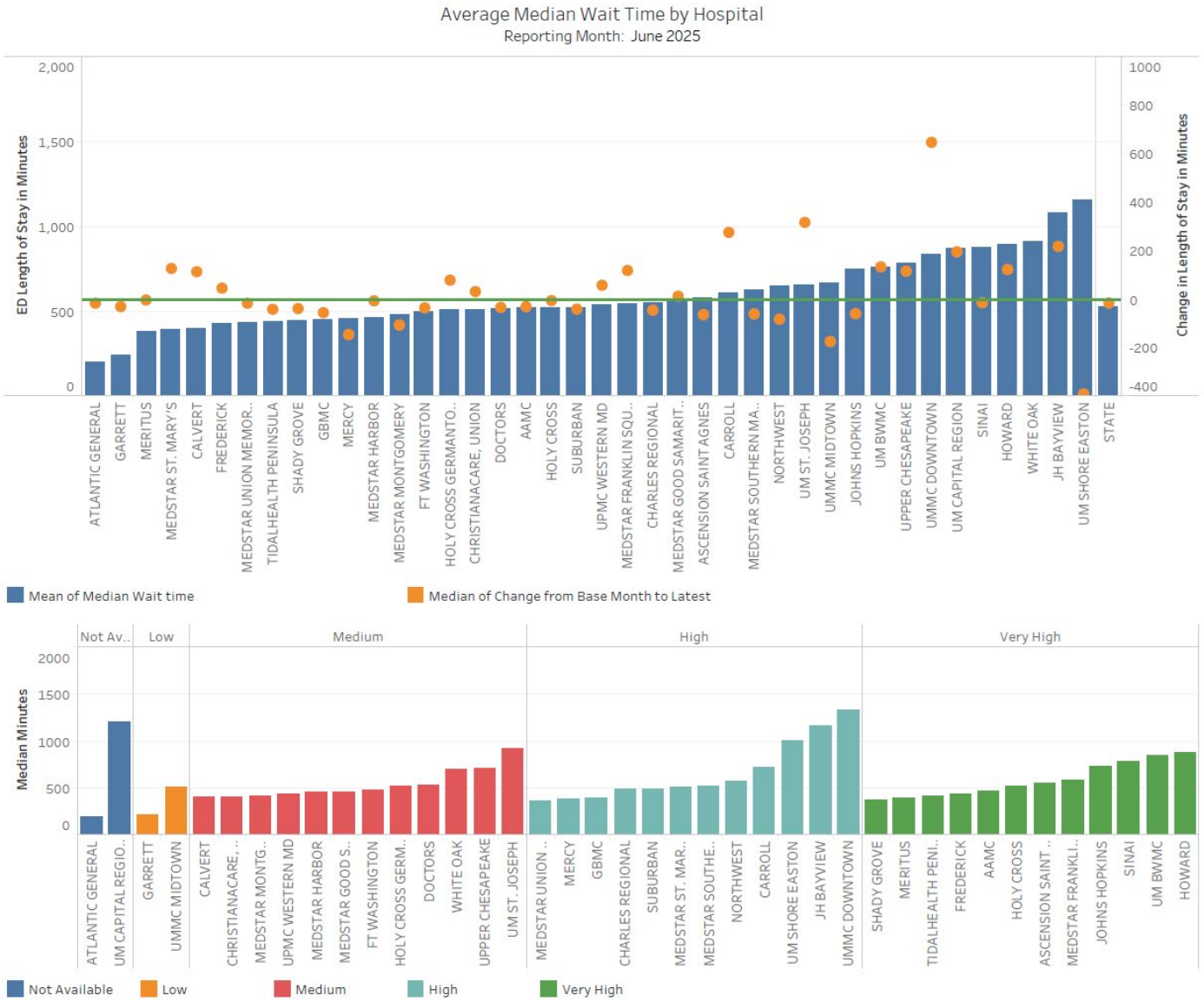
ED Median Wait Time

Hospital Name
All



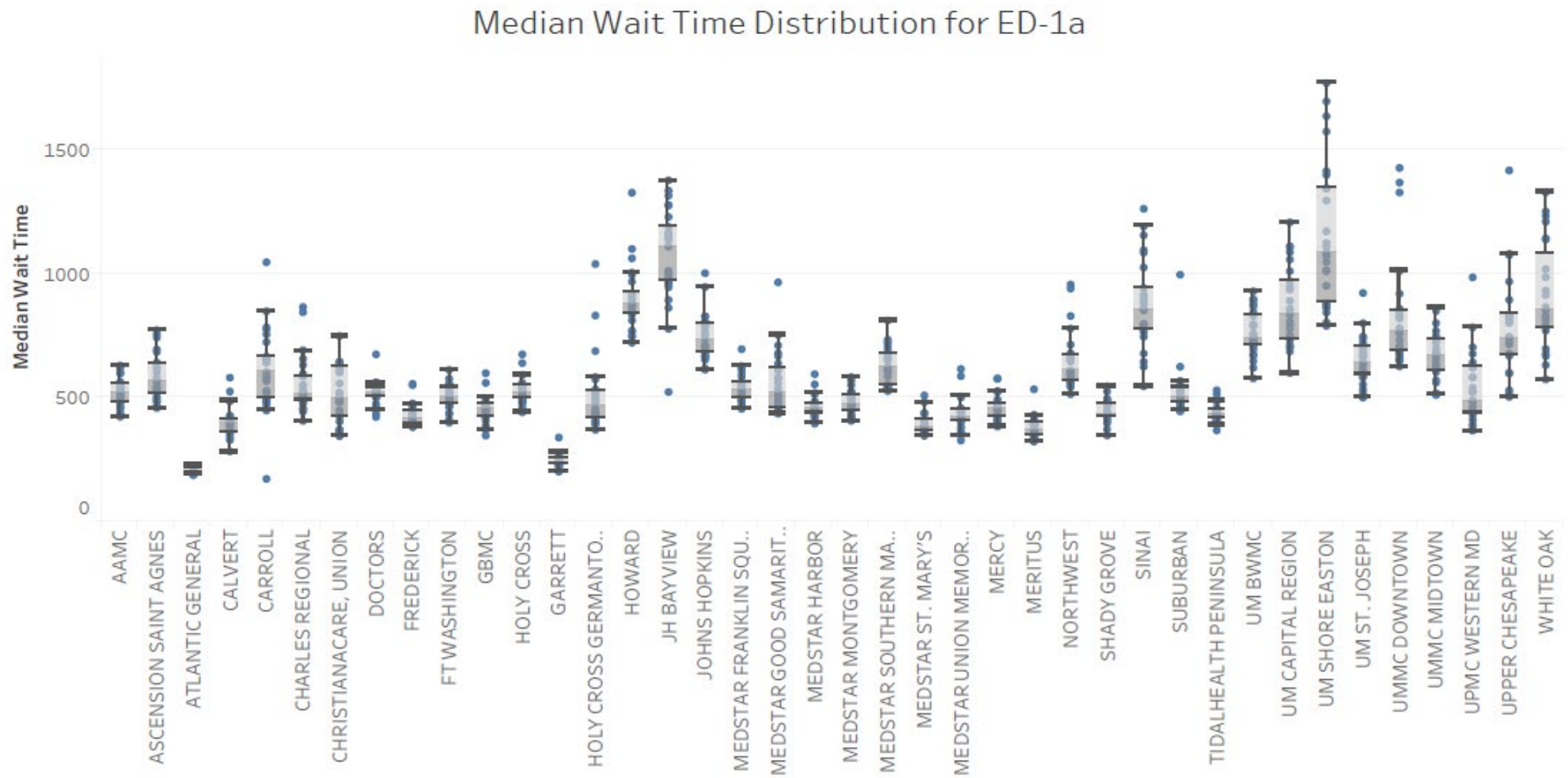
Ed1a Update

Measure
ED-1a



Ed1a Update

Measure
ED-1a



Ed1a Update

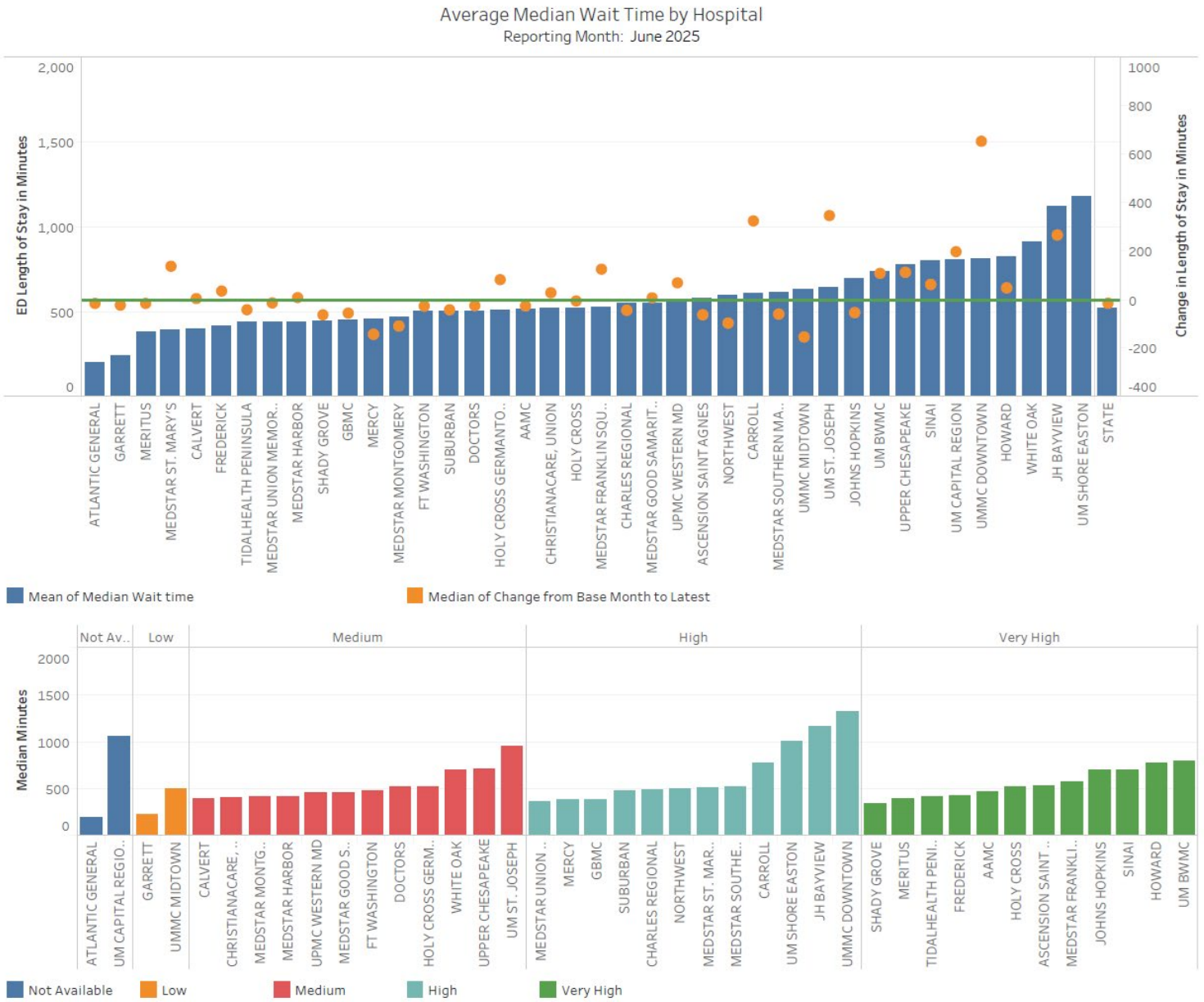
Average Median Wait Time All Hospitals for ED-1a

Measure
ED-1a

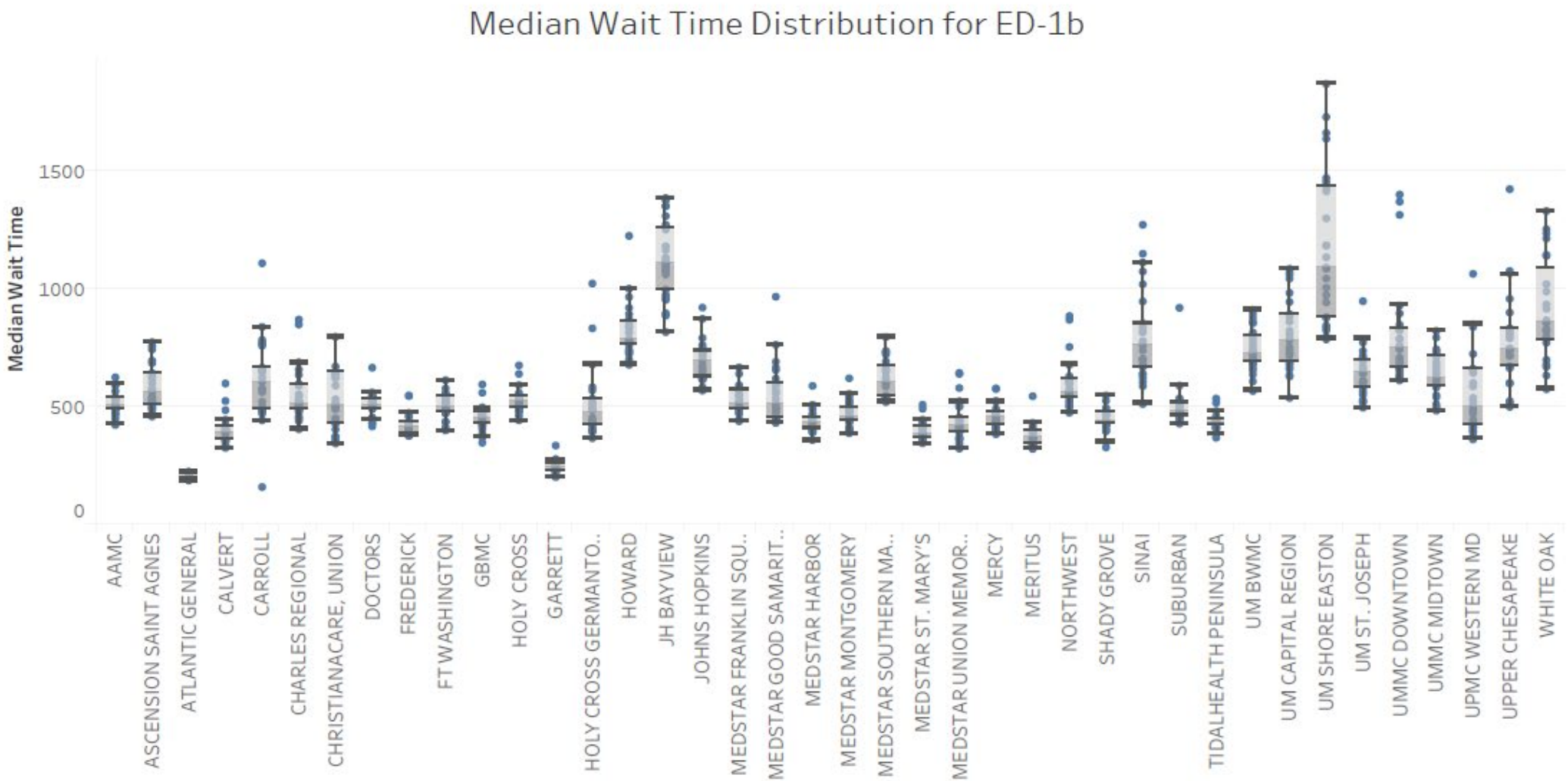
Change from Base
-678 819

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025
AAMC	493	532	540	534	563	601	629	597	530	544	501	480	550	521	512	504	437	422	522	619	556	481	454	428	464
ASCENSION SAINT AGNES	601	564	545	574	641	576	755	772	684	694	742			524	518	504	495	457	487	629	618	467	484	531	539
ATLANTIC GENERAL	210	218	221	212	195	189	216		190	191	199	199	200	210	202	203	212	198	193	206	224	203	213	186	195
CALVERT	282	383	411	425	405	409	484	426	408	402	375	389	423	395	356	332	328	341	358	524	580	353	367	365	397
CARROLL	447	527	481	640	602	470	654	848	656	649	783	519	171	493	586	493	576	488	775	653	1,046	755	566	665	724
CHARLES REGIONAL	527	486	497	453	492	455	508	656	631	551	475	514	548	526	514	596	585	518	691	865	844	508	443	405	483
CHRISTIANACARE, UNION	369	351	370	343	360	448	641	601	645	557	748	520	483	431	496	488	480	504	604	626	625	625	625	421	402
DOCTORS	561	514	537	503	559	529	555	559	513	512	500	500	522	509	474	447	421	433	463	524	674	539	528	533	529
FREDERICK	392	388	382	395	416	432	464	550	476	381	386	402	395	391	397	425	435	382	418	462		555	422	441	439
FT WASHINGTON	503	434	488	493	550	539	611	460	476	556	524	435	536	553	510	398	514	516	576	485	472	483		410	469
GARRETT			244		246	244	277	254	231	237	207	228	223	257	232	228	264	227	209	255	274	338	225	200	215
GBMC	439	467	456	475	482	420	476	559	497	474	454	457	428	425	483	458	445	405	418	471	598	461	369	346	385
HOLY CROSS	524	481	540	513	547	518	546	559	496	524		496	498	501	526	529	490	460	482	639	674	591	480	440	520
HOLY CROSS GERMANTO..	435	393	428	369	483	414	573	687	499	437		533	401	483	441	453	400	394	582	831	1,039	513	423	494	515
HOWARD	748	770	765	834	968	921	902	889	721	845	811	747	915	1,062	877	900	869	857	996	1,100	1,327	845	1,004	880	872
JH BAYVIEW	945	1,007	1,153	968	1,135	1,276	1,229	1,277	1,315	1,001	1,110	862	522	1,110	1,144	1,161	777	959	894	1,377	1,335	1,012	988	1,189	1,164
JOHNS HOPKINS	794	680	652	697	704	708	661	804	786	710	663	666	617	790	827	797	828	808	753	1,002	946	765	680	612	736
MEDSTAR FRANKLIN SQUA..	463	467	493	492	532	509	560	596	539	512	537	532	454	532	554	552	485	510	616	615	695	627	547	481	583
MEDSTAR GOOD SAMARIT..	441	479	522	456	559	506	667	965	752	637	442	434	450	610	581	576	614	503	486	679	710	536	472	437	455
MEDSTAR HARBOR	458	553	474	518	513	402	441	457	436	437	432	434	451	466	424	470	394	484	439	594	475	477	442	418	453
MEDSTAR MONTGOMERY	518	461	486	495	525	497	505	569	518	480	471	419	405	427	469	443	426	464	479	582	550	473	418	453	413
MEDSTAR SOUTHERN MA..	585	544	539	530	542	554	660	733	695	673	719	622	624	651	606	543	654	613	653	811	725	707	539	601	526
MEDSTAR ST. MARY'S	380	351	362	354	362	382	436	437	363	372	390	367	382	345	367	359	391	355	383	412	481	411	400	412	508
MEDSTAR UNION MEMORI..	375	456	412	326	407	400	504	500	439	410	446	347	425	455	441	420	448	383	443	615	586	435	409	359	360
MERCY	526	577	575	407	450	423	466	492	461	476	463	470	417	419	458	479	434	436	422	456	522	402	401	385	382
MERITUS	393	370	354	386	379	345	368	430	370	354	354	335	338	322	324	335	366	344	394	425	533	412	399	395	391
NORTHWEST	645	778	669	566	602	608	661	940	713	593	668	584	651	608	547	568	679	542	549	829	956	602	513	561	564
SHADY GROVE	408	427	446	435	545	494	428	437	403	470	396	419	469	468	472	477	524	433	436	488	492	429		346	371
SINAI	796	796	877	861	764	856	791	1,155	1,085	942	904	887	1,025	914	1,095	852	774	677	745	1,191	1,262	644	624	545	783
SUBURBAN	527	462	467	480	537	469	499	521	497	445	475	567	485	490	510	539	484	500	996	624	546	548	499	445	488
TIDALHEALTH PENINSULA		453	448	447	432	430	445	450	438	406	424	390	434	441	440	411	431	458	485	529	514	425	367	412	413
UM BWMC	711	740	691	708	717	647	756	895	758	731	725	743	830	868	789	670	620	577	671	895	929	732	796	878	846
UM CAPITAL REGION	1,010	853	858	751	890	734	835	1,057	936	838	736	778	701	806	793	686	705	599	713	970	1,110	948	1,109	1,087	1,207
UM SHORE EASTON	1,399	951	1,344	1,414	1,109	789	1,574	1,770	1,084	1,124	843	868	877	881	861	1,047	1,295	1,070	1,171	1,696	1,636	1,345	803	1,013	1,010
UM ST. JOSEPH	604	600	641	667	687	499	621	739	580	585	672	663	701	709	519	639	746	532	592	721	676	552	800	605	922
UMMC DOWNTOWN	680	625	648	688	658	650	670	768	687	758	731	780	705	1,010	819	846	831	858	849	842	919	707	1,427	1,368	1,328
UMMC MIDTOWN	685	849	800	658	768	560	698	677	748	669	631	516	510	734	602	613	644	677	626	860	723	741	569	516	512
UPMC WESTERN MD	383	430	438	481	522	523	489	676	580	392	368	539	461	634	582	620	488	411	703	783	985	642	366	455	442
UPPER CHESAPEAKE	598	669	599	834	801	968	1,075	1,417	721	741	834	822	811	744	738	502	516	529	670	1,080	894	831	743	678	715
WHITE OAK	1,251	865	1,143	855	1,328	1,210	794	825	677	1,233	1,138	932	914	817	1,018	631	770	784	856	986	830	667		573	696

Ed1b Update


Average Median Wait Time by Hospital
Reporting Month: June 2025
ED Length of Stay in Minutes
Change in Length of Stay in Minutes
2,000
1,500
1,000
500
0
1000
800
600
400
200
0
-200
-400
ATLANTIC GENERAL
GARRETT
MERITUS
MEDSTAR ST. MARY'S
CALVERT
FREDERICK
TIDALHEALTH PENINSULA
MEDSTAR UNION MEMOR..
MEDSTAR HARBOR
SHADY GROVE
GBMC
MERCY
MEDSTAR MONTGOMERY
FT WASHINGTON
SUBURBAN
DOCTORS
HOLY CROSS GERMANTO..
AAMC
CHRISTIANACARE, UNION
HOLY CROSS
MEDSTAR FRANKLIN SQU..
CHARLES REGIONAL
MEDSTAR GOOD SAMARIT..
UPMC WESTERN MD
ASCENSION SAINT AGNES
NORTHWEST
CARROLL
MEDSTAR SOUTHERN MA..
UMMC MIDTOWN
UM ST. JOSEPH
JOHNS HOPKINS
UM BWMC
UPPER CHESAPEAKE
SINAI
UM CAPITAL REGION
UMMC DOWNTOWN
HOWARD
WHITE OAK
JH BAYVIEW
UM SHORE EASTON
STATE
Mean of Median Wait time
Median of Change from Base Month to Latest
Not Av..
Low
Medium
High
Very High
Median Minutes
2000
1500
1000
500
0
ATLANTIC GENERAL
UM CAPITAL REGIO..
GARRETT
UMMC MIDTOWN
CALVERT
CHRISTIANACARE, ..
MEDSTAR MONTG..
MEDSTAR HARBOR
UPMC WESTERN MD
MEDSTAR GOOD S..
FT WASHINGTON
DOCTORS
HOLY CROSS GERM..
WHITE OAK
UPPER CHESAPEAKE
UM ST. JOSEPH
MEDSTAR UNION ..
MERCY
GBMC
SUBURBAN
CHARLES REGIONAL
NORTHWEST
MEDSTAR ST. MAR..
MEDSTAR SOUTHE..
CARROLL
UM SHORE EASTON
JH BAYVIEW
UMMC DOWNTOWN
SHADY GROVE
MERITUS
TIDALHEALTH PENI..
FREDERICK
AAMC
HOLY CROSS
ASCENSION SAINT ..
MEDSTAR FRANKLI..
JOHNS HOPKINS
SINAI
HOWARD
UM BWMC
Not Available
Low
Medium
High
Very High

Ed1b Update


Median Wait Time Distribution for ED-1b
Median Wait Time
1500
1000
500
0
AAMC
ASCENSION SAINT AGNES
ATLANTIC GENERAL
CALVERT
CARROLL
CHARLES REGIONAL
CHRISTIANACARE, UNION
DOCTORS
FREDERICK
FT WASHINGTON
GBMC
HOLY CROSS
GARRETT
HOLY CROSS GERMANTO..
HOWARD
JH BAYVIEW
JOHNS HOPKINS
MEDSTAR FRANKLIN SQU..
MEDSTAR GOOD SAMARIT..
MEDSTAR HARBOR
MEDSTAR MONTGOMERY
MEDSTAR SOUTHERN MA..
MEDSTAR ST. MARY'S
MEDSTAR UNION MEMOR..
MERCY
MERITUS
NORTHWEST
SHADY GROVE
SINAI
SUBURBAN
TIDALHEALTH PENINSULA
UM BWMC
UM CAPITAL REGION
UM SHORE EASTON
UM ST. JOSEPH
UMMC DOWNTOWN
UMMC MIDTOWN
UPMC WESTERN MD
UPPER CHESAPEAKE
WHITE OAK

Ed1b Update

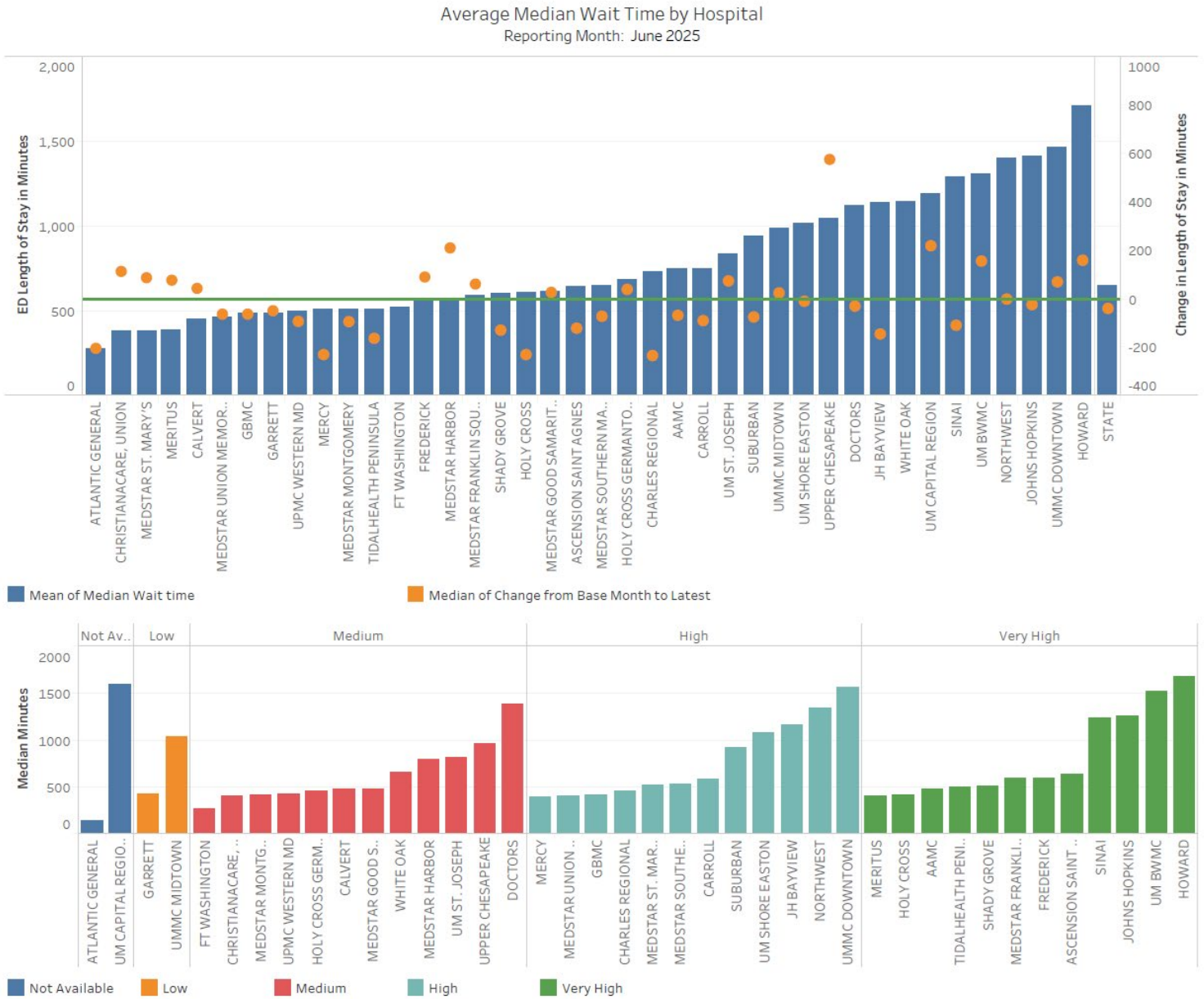
Average Median Wait Time All Hospitals for ED-1b

Measure
ED-1b

Change from Base
-678 822

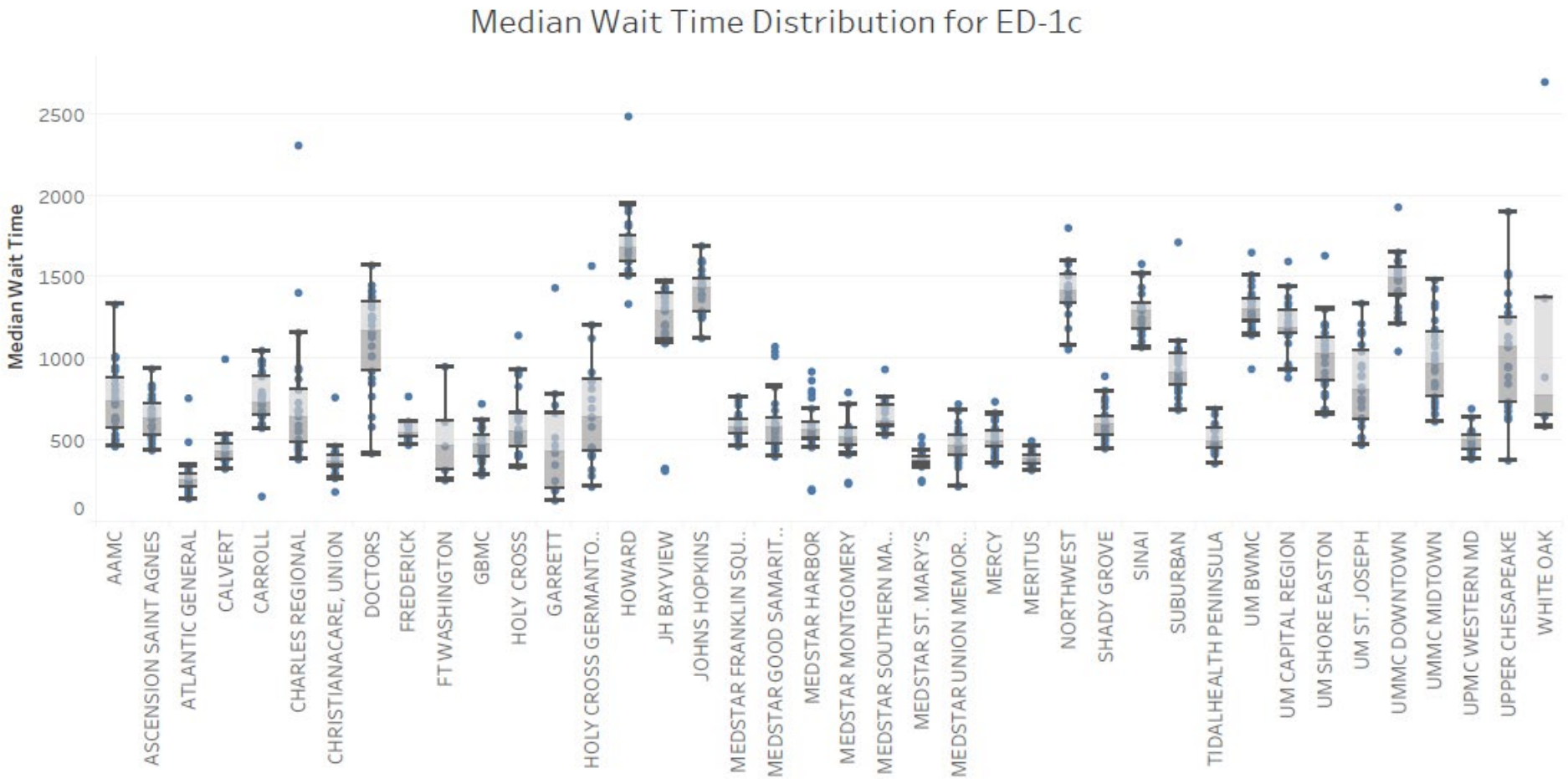
Hospital Name	June 2023	July 2023	August 2023	Septemb er 2023	October 2023	Novemb er 2023	Decemb er 2023	January 2024	Februar y 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	Septemb er 2024	October 2024	Novemb er 2024	Decemb er 2024	January 2025	Februar y 2025	March 2025	April 2025	May 2025	June 2025
AAMC	488	527	536	529	565	597	623	591	528	539	495	471	528	508	486	502	430	421	508	591	536	488	449	429	464
ASCENSION SAINT AGNES	599	563	541	573	641	576	755	772	683	694	741			525	515	503	495	457	491	626	617	467	483	530	538
ATLANTIC GENERAL	209	203	222	212	195	189	216		190	190	199	199	199	210	202	201	214	197	194	208	223	202	213	186	195
CALVERT		386	403	420	390	408	484	443	404	395	369	391	407	392	353	332	324	341	358	523	597	353	365	357	392
CARROLL	441	520	470	623	603	158	653	837	648	648	782	500	480	487	574	479	574	487	769	663	1,107	757	560	663	767
CHARLES REGIONAL	526	484	499	449	489	456	507	656	634	551	474	516	544	526	516	596	588	515	687	868	847	504	439	403	484
CHRISTIANACARE, UNION	372	351	370	343	356	450	640	627	669	588	795	530	493	445	510	491	488	509	620	641	640	640	640	425	402
DOCTORS	541	503	525	499	559	523	547	543	510	509	489	491	429	493	453	449	415	431	447	505	664	539	515	520	518
FREDERICK	388	376	378	391	410	427	458	546	472	375	379	397	390	381	394	423	431	380	409	457		544	413	435	425
FT WASHINGTON	503	434	488	493	550	539	611	469	476	556	524	435	536	553	510	398	514	516	576	482	472	482		412	478
GARRETT			244		246	244	277	255	227	236	206	229	223	256	246	231	264	227	209	253	265	334	219	200	223
GBMC	438	467	455	475	481	417	476	558	496	475	454	455	429	427	480	459	444	405	424	468	593	459	369	346	384
HOLY CROSS	524	482	540	513	544	518	546	557	495	524		496	499	500	523	527	491	460	481	638	674	590	478	441	520
HOLY CROSS GERMANTO..	435	396	427	365	487	414	568	677	498	436		533	398	488	441	453	400	392	582	831	1,021	511	423	495	519
HOWARD	722	734	729	776	871	839	836	785	676	785	741	699	855	964	813	816	771	758	918	999	1,223	768	891	767	772
JH BAYVIEW	895	951	1,107	885	1,097	1,250	1,179	1,270	1,307	973	1,059	815	1,117	1,085	1,109	1,349	1,072	1,383	1,080	1,374	1,349	995	962	1,131	1,163
JOHNS HOPKINS	746	631	613	650	672	652	617	744	732	667	623	626	581	722	734	726	790	760	706	919	871	712	618	567	694
MEDSTAR FRANKLIN SQUA..	445	471	492	484	516	471	570	585	538	492	522	512	437	516	547	546	483	499	568	590	665	638	556	475	572
MEDSTAR GOOD SAMARIT..	440	474	512	449	556	494	654	965	761	664	442	430	450	594	571	556	592	497	487	618	689	531	476	434	449
MEDSTAR HARBOR	407	506	424	454	391	357	399	447	416	432	415	406	436	445	415	445	489	505	453	587	470	462	401	390	417
MEDSTAR MONTGOMERY	520	459	478	477	525	438	490	540	495	454	448	404	398	402	460	442	508	433	456	619	553	479	386	446	413
MEDSTAR SOUTHERN MA..	584	542	536	525	540	533	654	735	691	668	720	622	604	652	616	537	546	597	645	794	725	731	518	600	526
MEDSTAR ST. MARY'S	368	350	362	356	362	385	436	443	361	366	390	369	385	344	367	380	437	349	379	405	490	418	406	409	507
MEDSTAR UNION MEMORI..	367	442	397	321	398	389	498	503	434	413	425	342	410	435	419	638	522	367	441	642	578	454	408	362	355
MERCY	523	576	574	404	450	421	464	490	461	476	462	469	416	417	458	474	434	436	423	461	521	400	398	386	382
MERITUS	404	371	357	386	377	341	368	430	364	352	347	334	339	320	322	337	360	341	395	427	543	415	399	388	390
NORTHWEST	595	676	613	558	575	561	600	883	624	549	609	551	600	559	518	526	628	506	498	752	867	562	473	536	500
SHADY GROVE	408	424	446	434	546	493	427	437	397	468	395	419	465	468	472	474	524	429	433	471	489	423		326	347
SINAI	638	636	759	699	675	765	737	1,110	945	852	814	819	1,018	834	1,072	777	666	622	693	1,147	1,270	603	586	510	702
SUBURBAN	510	441	445	457	516	455	485	506	474	429	456	534	457	472	493	507	466	479	918	588	528	520	484	427	470
TIDALHEALTH PENINSULA		452	446	447	429	430	447	448	437	405	423	383	429	440	434	406	429	458	480	533	515	422	367	411	412
UM BWMC	684	704	681	683	699	635	740	893	747	721	698	734	813	855	764	654	606	565	664	874	909	726	776	853	794
UM CAPITAL REGION	859	752	781	714	809	683	793	981	882	821	679	721	632	740	730	627	658	536	666	943	1,068	891	1,083	1,042	1,058
UM SHORE EASTON	1,452	941	1,468	1,428	1,182	784	1,634	1,867	1,089	1,132	823	832	878	875	843	1,042	1,297	1,083	1,182	1,727	1,659	1,412	795	972	1,003
UM ST. JOSEPH	598	562	641	656	640	494	607	771	583	550	669	650	715	694	517	608	735	520	577	692	705	527	784	601	946
UMMC DOWNTOWN	658	610	625	669	636	622	651	747	662	742	707	758	697	928	787	825	786	846	827	822	894	685	1,398	1,368	1,312
UMMC MIDTOWN	647	792	735	614	742	547	676	664	726	640	617	509	493	716	581	590	603	624	588	820	711	687	539	482	495
UPMC WESTERN MD	373	417	411	473	599	503	430	722	520	394	360	585	536	655	641	659	473	396	837	848	1,062	659	365	487	444
UPPER CHESAPEAKE	599	662	598	831	789	956	1,074	1,421	717	739	826	809	803	747	738	498	514	523	669	1,064	898	829	741	669	713
WHITE OAK	1,251	865	1,142	855	1,328	1,212	795	825	677	1,233	1,138	932	914	817	1,018	631	770	784	856	987	826	668		573	697

Ed1c Update


Average Median Wait Time by Hospital
Reporting Month: June 2025
ED Length of Stay in Minutes
Change in Length of Stay in Minutes
Mean of Median Wait time
Median of Change from Base Month to Latest
Median Minutes
Not Av..
Low
Medium
High
Very High
Not Available
Low
Medium
High
Very High

Ed1c Update

Measure
ED-1c



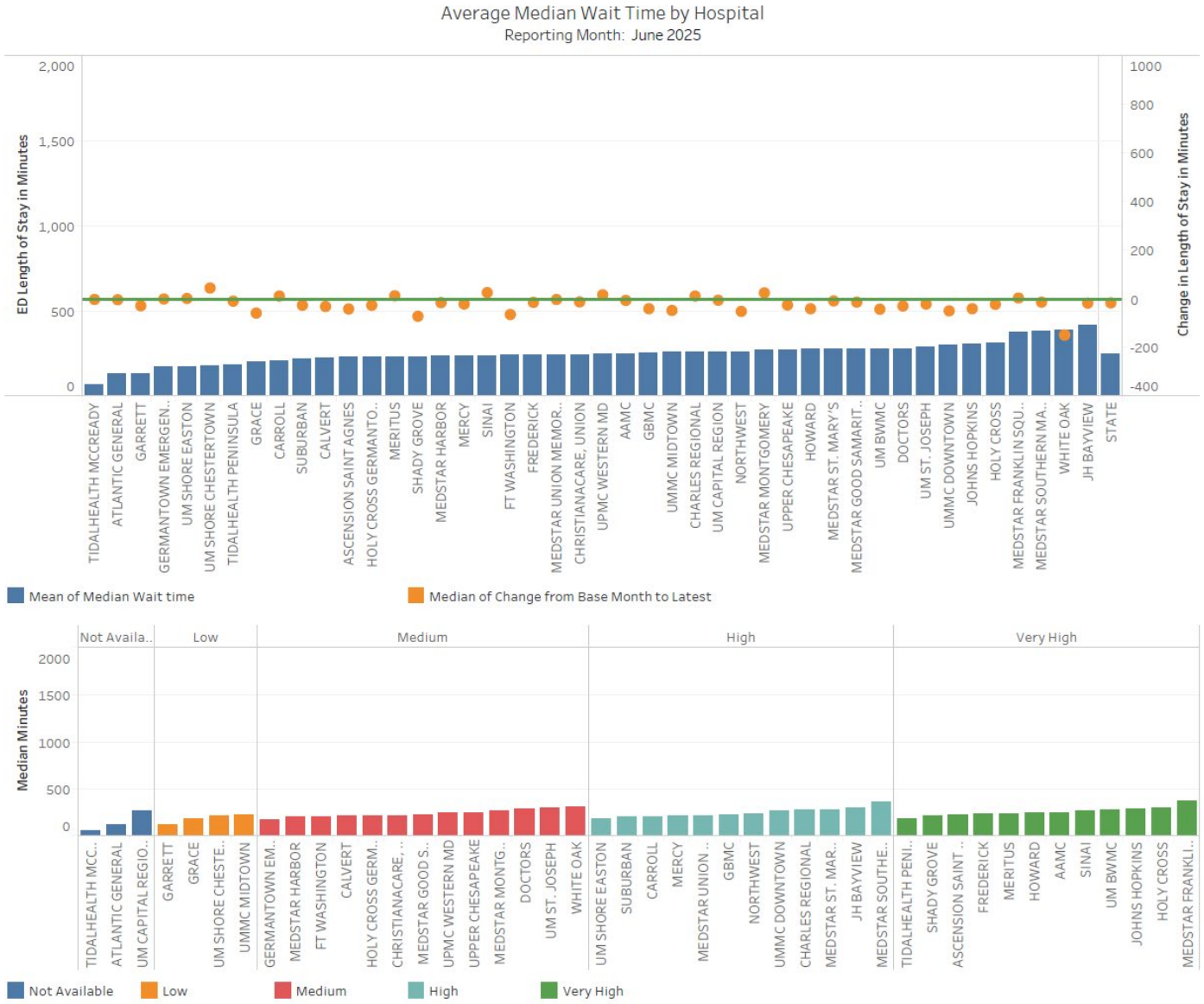
Ed1c Update

Measure
ED-1c

Change from Base
-2,113 1,629

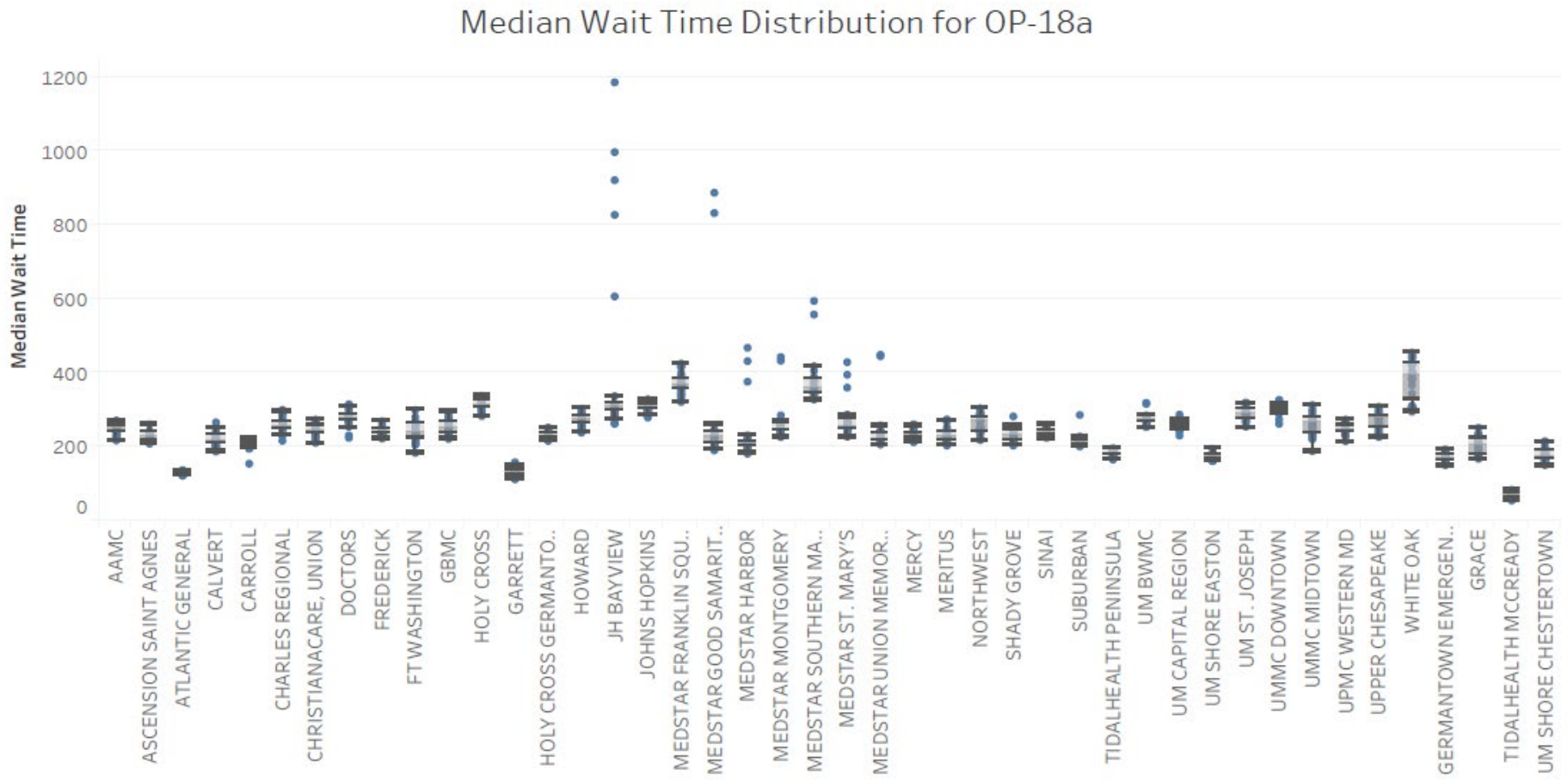
Hospital Name	June 2023	July 2023	August 2023	Septemb er 2023	October 2023	Novemb er 2023	Decemb er 2023	January 2024	Februar y 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	Septemb er 2024	October 2024	Novemb er 2024	Decemb er 2024	January 2025	Februar y 2025	March 2025	April 2025	May 2025	June 2025
AAMC	535	883	719	643	1,335	951	1,009	1,017	757	790	629	578	812	618	740	627	507	500	751	845	1,005	929	463	481	468
ASCENSION SAINT AGNES	755	939	631	691	652	531	682	745	698	574	839			505	666	587	523	454	439	818	779	480	526	593	635
ATLANTIC GENERAL		345	160	262	286	490	255			254		242	210	322	177	253	182	759	182	204	301	257	255	217	142
CALVERT	425	379	457	471	508	427	501	369	449	458	393	389	490	427	410	325	486	381	376	533	337	380	398	999	469
CARROLL	665	667	764	893	598	156	724	988	989	717	924	906	652	781	963	1,051	759	650	799	601	766	735	646	684	576
CHARLES REGIONAL	682	678	487	810	1,407	406	1,161	647	466	2,311	946	436	555	877	383	688	481	593	931	448	682	732	560	506	449
CHRISTIANACARE, UNION	290	184	268		424	422	764	431	463	388	331	375	355	340	405	296	369	343	356	367	367	367	367	372	404
DOCTORS	1,414	1,316	1,167	1,019	1,418	1,453	1,347	1,208	1,134	850	1,079	881	1,575	1,015	925	770	644	583	420	1,249	1,377	1,152	1,262	1,241	1,385
FREDERICK	506	517	540	514	613	534	586	609	613	557	514	586	471	606	501	520	531	507	594	531		770	594	602	597
FT WASHINGTON																				953	465	613		317	255
GARRETT							470	717	428	786	131	350			252	200	668		191		1,437	517	192		422
GBMC	480	387	479	476	508	526	498	621	578	471	398	573	376	318	509	445	619	483	363	585	725	514	383	285	418
HOLY CROSS	642	416	518	568	903	559	532	933	831	400		526	495	671	920	623	341	412	495	660	571	1,145	545	406	413
HOLY CROSS GERMANTO..	410	320	643	400	412	458	1,208	919	643	818		215	584	447	697		444	1,209	753	861	1,572	1,127	873	282	450
HOWARD	1,524	1,512	1,338	1,597	1,699	1,602	1,701	1,815	1,728	1,519	1,603	1,547	1,598	1,740	1,545	1,831	2,490	1,904	1,717	1,937	1,946	1,643	1,659	1,757	1,684
JH BAYVIEW	1,309	1,205	1,440	1,376	1,383	1,394	1,475	1,316	1,348	1,147	1,294	1,115	1,431	1,214	1,394	328	322	324	312	1,396	1,204	1,096	1,097	1,398	1,165
JOHNS HOPKINS	1,281	1,294	1,284	1,510	1,458	1,470	1,453	1,606	1,694	1,396	1,368	1,436	1,251	1,546	1,592	1,487	1,284	1,462	1,445	1,592	1,396	1,256	1,128	1,273	1,258
MEDSTAR FRANKLIN SQUA..	532	465	500	532	627	662	469	642	542	583	589	627	531	577	641	586	526	558	744	716	767	599	531	549	594
MEDSTAR GOOD SAMARIT..	446	502	590	549	608	522	827	1,045	725	577	401	588	441	637	684	556	600	602	456	1,076	1,018	581	433	462	474
MEDSTAR HARBOR	577	868	923	761	806	520	695	531	603	458	540	572	562	561	508	567	193	191	201	598	478	556	607	502	788
MEDSTAR MONTGOMERY	512	472	498	532	531	722	550	795	588	568	579	465	413	468	488	242	233	570	577	481	550	464	489	574	419
MEDSTAR SOUTHERN MA..	609	575	586	573	601	714	683	717	754	722	713	622	710	617	532	538	545	669	761	936	738	617	581	607	538
MEDSTAR ST. MARY'S	434	356	356	339	359	374	415	379	376	430	396	353	351	374	364	244	255	391	388	477	370	351	376	437	522
MEDSTAR UNION MEMORI..	464	681	473	358	475	431	612	470	530	407	553	371	480	518	525	222	217	523	453	575	723	393	426	335	402
MERCY	622	648	738	490	458	531	518	556	398	456	577	492	464	435	544	624	503	491	394	413	668	479	479	352	393
MERITUS	329	344	317	385	423	395	363	434	397	362	413	340	337	348	374	323	445	373	363	397	462	383	397	497	407
NORTHWEST	1,337	1,510	1,454	1,058	1,435	1,275	1,347	1,523	1,805	1,343	1,604	1,413	1,518	1,450	1,529	1,582	1,522	1,415	1,442	1,358	1,375	1,082	1,187	1,080	1,337
SHADY GROVE	633	805	526	760	450	573	592	497	739	594	589	552	607	471	466	658	705	609	895	611	530	550		544	505
SINAI	1,337	1,336	1,108	1,400	1,248	1,151	1,299	1,248	1,584	1,309	1,525	1,308	1,073	1,310	1,174	1,440	1,300	1,520	1,179	1,315	1,215	1,326	1,179	1,146	1,229
SUBURBAN	1,000	849	875	865	1,029	718	868	760	912	686	1,040	1,025	804	830	795	1,108	921	1,053	1,717	1,060	973	1,066	886	812	926
TIDALHEALTH PENINSULA		659	490	441	473	415	415	567	440	596	465	605	581	565	562	691	576	429	516	453	477	559	358	458	497
UM BWMC	1,359	1,400	1,349	1,654	1,216	1,176	1,146	1,271	1,255	1,183	1,360	1,483	1,310	1,191	1,378	1,288	1,319	1,365	938	1,252	1,447	1,228	1,354	1,276	1,516
UM CAPITAL REGION	1,379	1,445	1,189	1,169	1,299	1,191	1,147	1,272	1,146	931	959	950	1,212	1,096	1,155	1,234	884	968	1,224	1,192	1,299	1,342	1,151	1,334	1,599
UM SHORE EASTON	1,085	974	769	1,304	875	842	917	1,121	661	878	1,215	1,052	857	1,635	1,125	1,160	692	684	789	1,091	1,200	1,028	1,013	1,212	1,076
UM ST. JOSEPH	739	1,159	627	899	1,216	520	756	473	516	961	806	702	626	893	586	1,341	1,088	827	947	1,169	484	1,047	1,154	637	814
UMMC DOWNTOWN	1,491	1,410	1,419	1,222	1,510	1,519	1,541	1,249	1,599	1,253	1,286	1,605	1,047	1,482	1,390	1,653	1,539	1,319	1,526	1,653	1,553	1,480	1,932	1,412	1,562
UMMC MIDTOWN	1,001	1,341	1,431	1,078	1,317	664	1,238	698	767	830	855	661	721	1,134	941	925	975	1,163	740	1,484	1,094	1,183	841	616	1,026
UPMC WESTERN MD	513	520	508	510	525	484	560	640	695	437	428	539	403	517	468	552	556	386	442	526	486	434	404	501	421
UPPER CHESAPEAKE	377	1,135	679	1,513	948	1,283	1,096	848	1,096	953	1,404	1,231	1,243	629	735	1,325	734	708	1,136	1,904	645	890	1,528	1,073	953
WHITE OAK			2,701																	888	1,373	652		588	649

OP18a Update



OP18a Update

Measure
OP-18a



OP18a Update

Average Median Wait Time All Hospitals for OP-18a

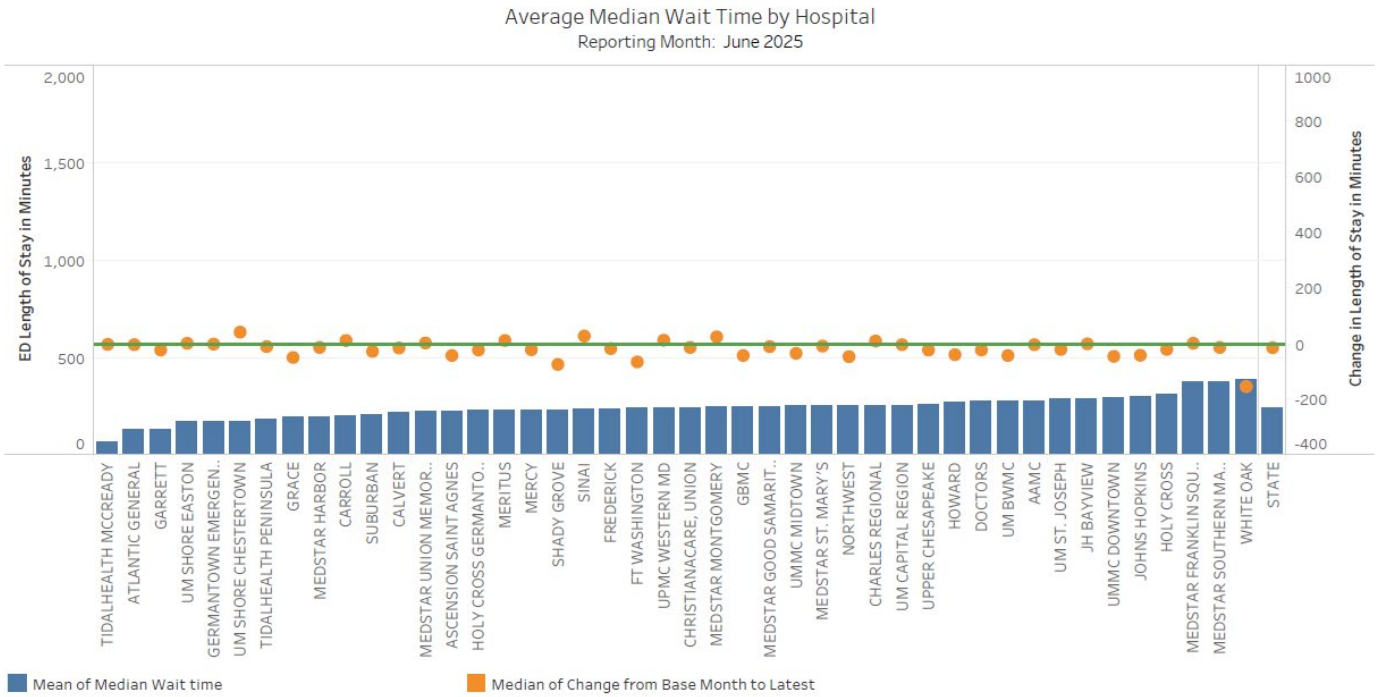
Measure
OP-18a

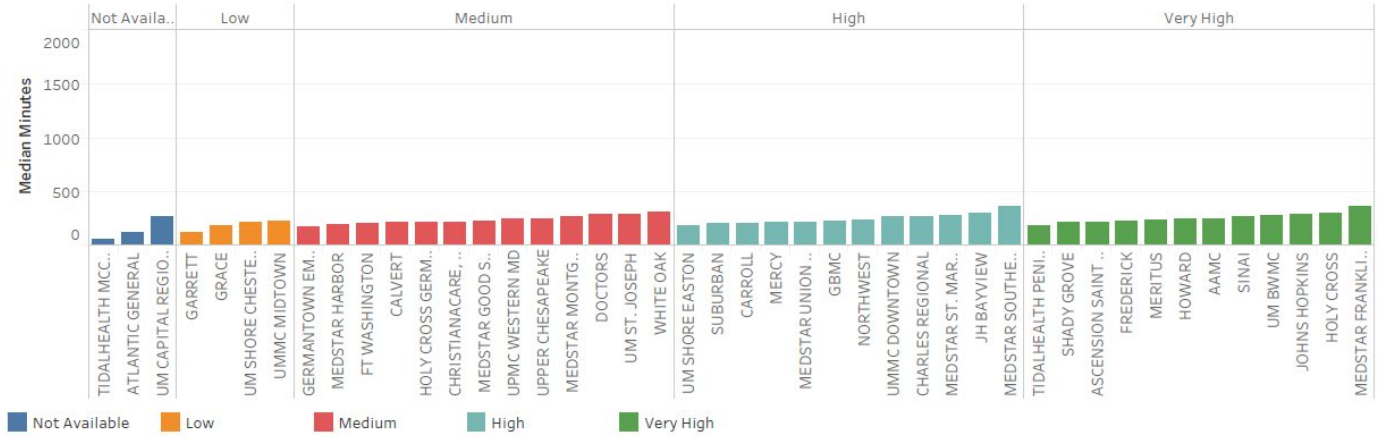
Change from Base
-160 875

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025
AAMC	258	255	260	254	266	263	271	268	256	258	253	241	255	258	241	239	226	217	239	255	236	242	230	227	253
ASCENSION SAINT AGNES	261	238	236	243	220	226	239	238	232	227	233			237	211	219	222	212	216	239	230	214	208	212	221
ATLANTIC GENERAL	124	127	131	133	128	123	134		125	122	128	132	126	129	128	131	137	127	128	134	136	126	131	127	122
CALVERT	247	229	240	233	253	235	266	218	215	216	220	227	211	218	220	205	199	187	211	223	204	197	207	200	217
CARROLL	194	203	201	201	221	154	212	209	211	209	210	203	203	213	213	215	205	198	212	216	221	211	196	213	207
CHARLES REGIONAL	254	253	232	216	230	234	258	261	252	258	253	267	300	291	292	260	247	246	276	296	286	264	267	234	267
CHRISTIANACARE, UNION	229	234	222	211	211	234	271	265	272	258	260	266	273	244	258	240	239	250	230	244	244	244	244	235	218
DOCTORS	311	288	280	265	281	285	315	302	290	254	270	288	270	272	267	273	224	231	266	286	301	273	290	279	283
FREDERICK		249	248	236	240	244	265	269	256	234	240	237	241	236	249	244	234	222	230	235		252	232	234	236
FT WASHINGTON	268	238	262	247	260	259	299	280	266	259	250	240	224	237	235	207	224	218	229	228	209	217		183	205
GARRETT			145		150	147	158	134	132	138	124	135	135	132	130	124	129	121	113	119	126	127	112	118	118
GBMC	267	257	261	273	279	266	287	276	294	294	266	247	236	241	248	254	233	234	234	237	251	231	221	223	228
GERMANTOWN EMERGEN..	162	156	159	150	167				190	175	178	165	171	161	173	178	173	167	185	188	193	168		156	163
GRACE	236	251	226	221	228	206	233	227	209	215	212	222	193	195	205	206	175	173	186	201	180	179	175	167	179
HOLY CROSS	320	304	335	333	327	314	329	337	324	315		322	338	320	322	303	310	296	303	305	310	288	283	288	299
HOLY CROSS GERMANTO..	242	227	252	233	235	228	245	234	226	227		222	220	217	229	223	227	218	219	226	240	217	221	220	217
HOWARD	290	290	303	252	275	263	296	280	271	269	280	278	282	283	260	250	271	259	286	283	276	255	241	238	251
JH BAYVIEW	312	312	308	281	283	262	264	298	276	297	313	286	607	304	337	1,187	828	998	922	298	301	314	309	316	296
JOHNS HOPKINS	328	319	318	309	312	303	305	313	311	309	319	315	327	311	319	315	302	297	295	312	300	302	282	279	289
MEDSTAR FRANKLIN SQUA..	357	373	382	365	374	385	416	416	332	350	355	365	367	393	372	360	345	341	399	419	425	382	337	321	362
MEDSTAR GOOD SAMARIT..	239	237	244	228	239	207	239	241	215	210	201	190	196	203	222	833	888	210	224	245	260	227	212	206	227
MEDSTAR HARBOR	213	213	211	202	214	181	196	200	184	202	203	210	210	220	210	204	376	468	432	223	231	215	195	195	199
MEDSTAR MONTGOMERY	232	226	247	238	259	246	262	268	249	244	229	249	247	246	240	443	433	256	256	269	285	249	239	259	258
MEDSTAR SOUTHERN MA..	367	344	331	328	340	329	388	381	358	360	374	348	345	348	382	595	558	343	387	418	406	373	347	363	355
MEDSTAR ST. MARY'S	284	269	272	251	254	249	265	265	252	233	247	232	429	231	238	360	395	227	246	260	287	257	268	244	277
MEDSTAR UNION MEMORI..	218	227	230	221	241	219	241	235	229	217	236	210	207	220	215	445	449	213	214	243	258	217	225	206	217
MERCY	232	241	231	219	218	222	233	249	236	237	225	253	234	233	239	233	226	222	224	261	256	229	237	220	212
MERITUS	225	207	207	221	211	203	225	231	221	218	221	219	219	213	221	228	245	230	268	271	274	252	243	241	239
NORTHWEST	288	291	304	279	291	290	299	272	271	273	277	272	271	258	252	250	237	220	237	250	249	223	218	224	238
SHADY GROVE	282	256	252	242	247	246	238	217	203	206	228	234	222	217	234	231	224	220	232	243	233	230		215	212
SINAI	232	240	250	232	233	233	243	236	229	232	227	231	224	231	226	238	238	244	243	245	251	250	247	246	259
SUBURBAN	227	216	227	217	219	210	209	214	213	206	208	217	201	209	208	213	206	205	286	217	212	212	206	205	202
TIDALHEALTH MCCREADY			62	73	83	67	75	68	74	70	69	74	73	60	72	62	63	71	73	67	60	72	61	54	61
TIDALHEALTH PENINSULA		184	190	196	195	191	192	184	190	182	182	177	185	183	191	178	168	179	188	180	182	168	165	171	176
UM BWMC	316	319	285	282	277	280	278	272	269	276	278	280	267	282	255	257	263	253	282	265	270	259	266	283	275
UM CAPITAL REGION	265	277	271	265	269	260	287	274	262	259	258	269	265	256	263	243	243	230	250	264	263	261	265	250	261
UM SHORE CHESTERTOWN	169	175	164	180	193	150	189	199	180	164	168	174	164	176	163	168	166	161	183	211	186	178	180	186	215
UM SHORE EASTON	178	165	172	174	163	161	178	195	164	173	164	174	167	174	178	174	166	161	164	181	172	180	184	168	181
UM ST. JOSEPH	313	305	313	319	319	291	318	302	295	287	284	296	293	291	269	268	267	254	276	300	283	272	279	259	293
UMMC DOWNTOWN	310	312	306	299	292	293	304	316	327	298	303	296	291	301	290	311	298	297	299	298	297	303	325	274	262
UMMC MIDTOWN	266	294	277	279	270	237	301	313	284	270	247	260	223	267	249	259	235	231	233	278	273	254	282	188	220
UPMC WESTERN MD	233	236	248	250	272	260	259	256	256	250	238	240	230	255	258	270	240	239	248	257	273	246	215	230	251
UPPER CHESAPEAKE	278	280	278	270	280	282	308	303	294	277	287	297	288	263	280	249	236	226	261	272	236	242	249	257	254
WHITE OAK	455	404	420	397	452	402	426	445	439	397	386	444	430	425	367	382	384	344	295	311	308	307		303	308

OP18b Update

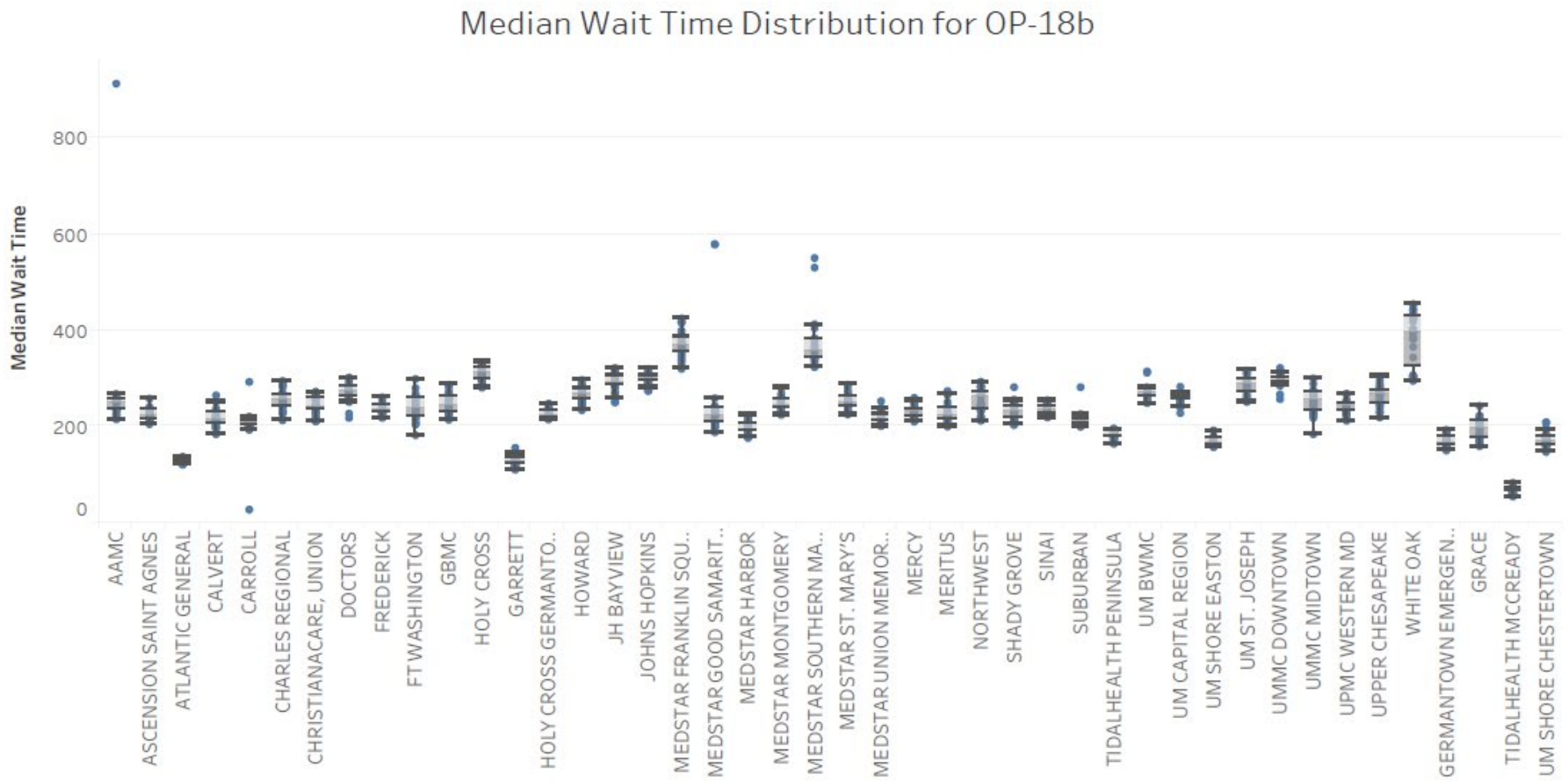
Measure
OP-18b





OP18b Update

Measure
OP-18b



OP18b Update

Average Median Wait Time All Hospitals for OP-18b

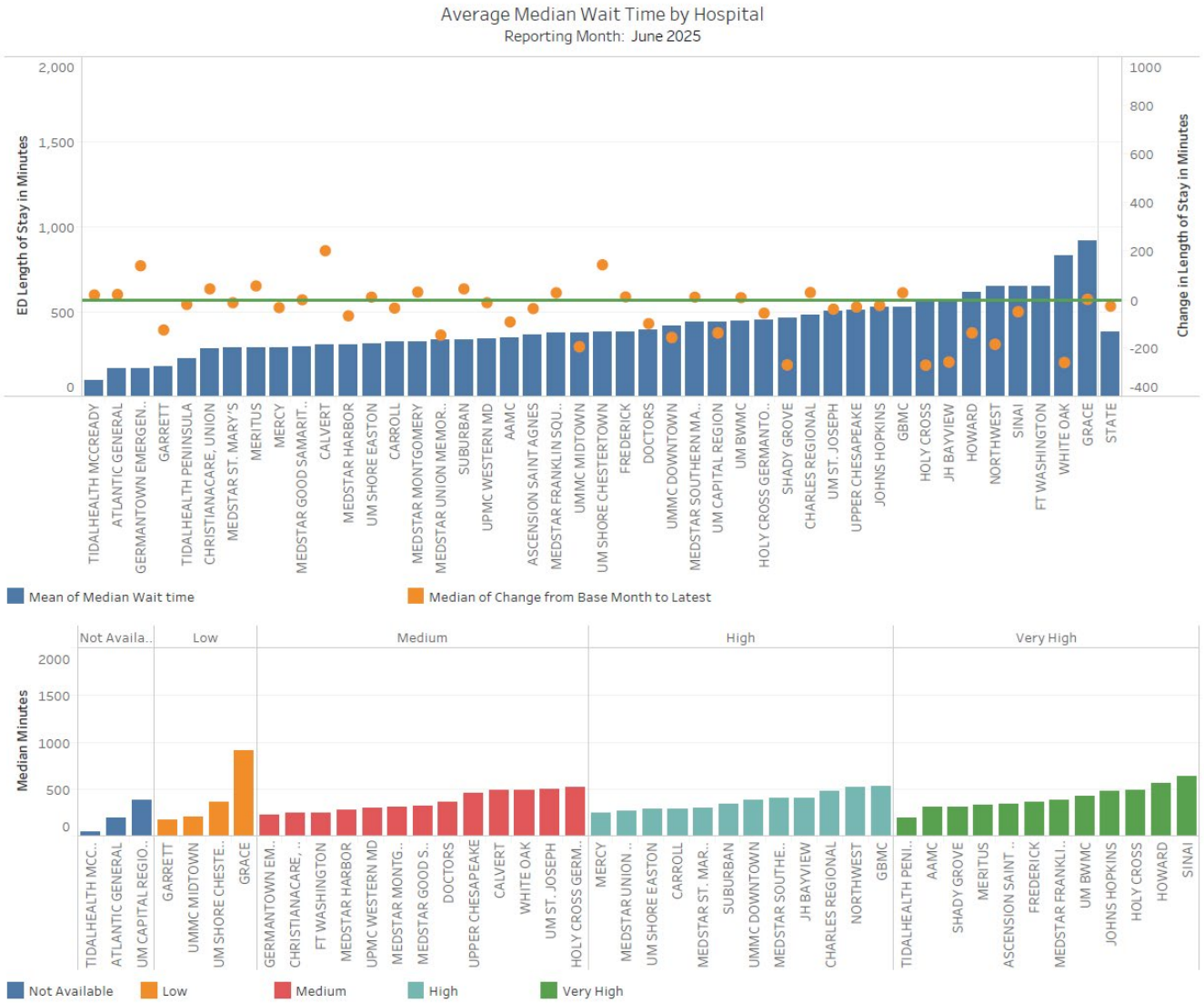
Measure
OP-18b

Change from Base
-166.0 660.0

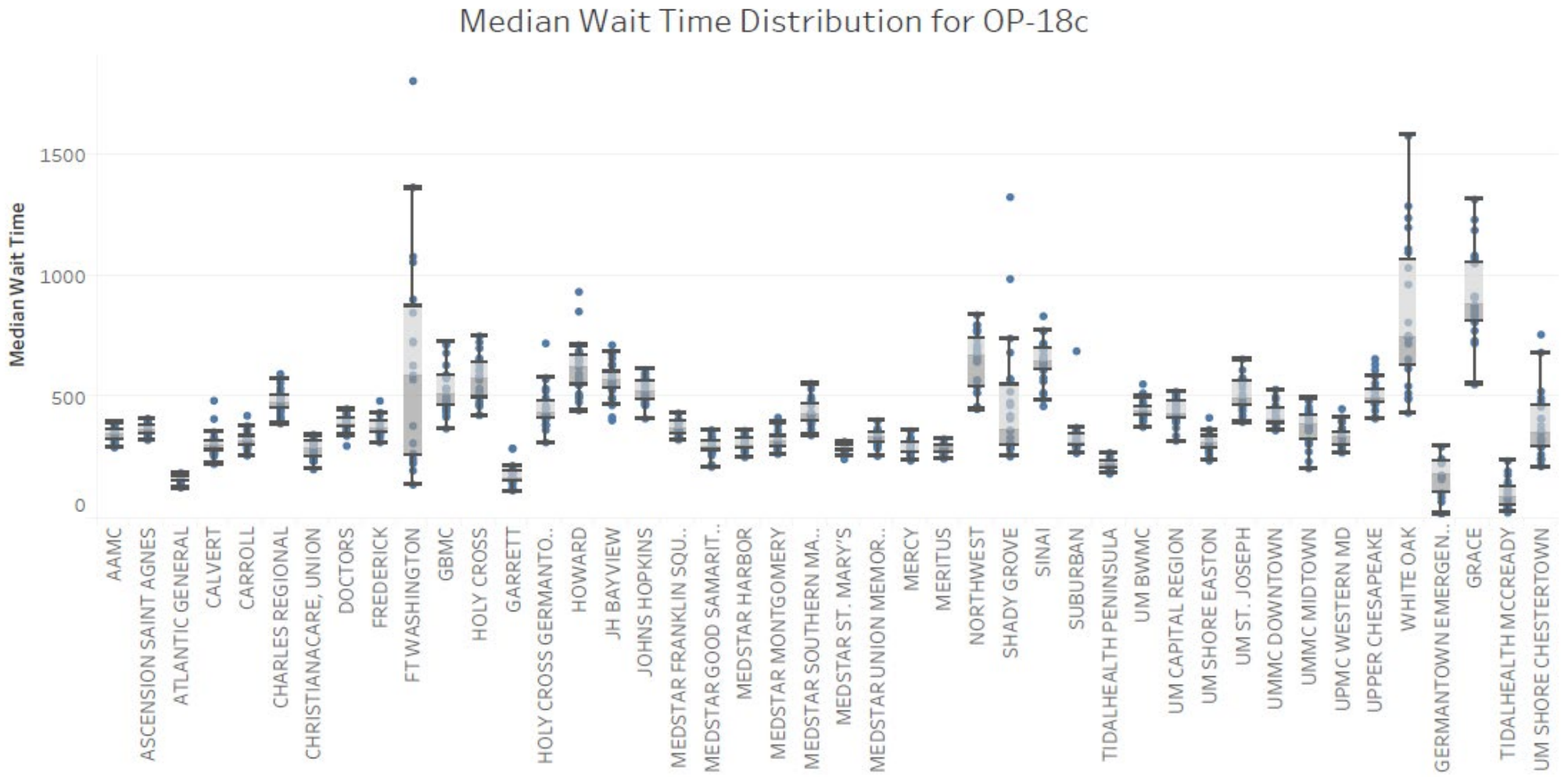
Hospital Name	June 2023	July 2023	August 2023	Septemb er 2023	October 2023	Novemb er 2023	Decemb er 2023	January 2024	Februar y 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	Septemb er 2024	October 2024	Novemb er 2024	Decemb er 2024	January 2025	Februar y 2025	March 2025	April 2025	May 2025	June 2025
AAMC	254.0	251.0	257.0	248.0	256.0	260.0	268.0	266.0	254.0	259.0	251.0	237.0	914.0	254.0	234.0	235.0	223.0	215.0	239.0	255.0	234.0	240.0	228.0	224.0	252.0
ASCENSION SAINT AGNES	258.0	235.0	232.0	241.0	216.0	225.0	225.0	234.0	228.0	224.0	230.0			235.0	208.0	217.0	219.0	211.0	214.0	236.0	228.0	212.0	205.0	207.0	217.0
ATLANTIC GENERAL	123.0	126.0	130.0	132.0	127.0	122.0	134.0		124.0	121.0	127.0	132.0	125.0	128.0	127.0	130.0	137.0	127.0	128.0	134.0	136.0	126.0	131.0	127.0	121.0
CALVERT		229.0	237.0	231.0	251.0	233.0	265.0	216.0	212.0	212.0	218.0	224.0	209.0	216.0	218.0	204.0	197.0	184.0	209.0	220.0	202.0	196.0	205.0	198.0	215.0
CARROLL	193.0	201.0	200.0	201.0	220.0	27.0	210.0	207.0	209.0	207.0	209.0	202.0	202.0	212.0	213.0	214.0	203.0	197.0	210.0	293.0	220.0	209.0	195.0	212.0	206.0
CHARLES REGIONAL	250.0	247.0	230.0	213.0	226.0	232.0	255.0	259.0	247.0	253.0	250.0	264.0	295.0	287.0	287.0	256.0	240.0	242.0	271.0	292.0	282.0	258.0	262.0	230.0	261.0
CHRISTIANACARE, UNION	230.0	234.0	222.0	211.0	211.0	234.0	272.0	265.0	272.0	257.0	260.0	265.0	272.0	243.0	257.0	240.0	239.0	249.0	229.0	241.0	241.0	241.0	241.0	235.0	218.0
DOCTORS	302.0	272.0	274.0	260.0	285.0	280.0	301.0	291.0	280.0	251.0	263.0	280.0	264.0	266.0	258.0	268.0	218.0	227.0	258.0	280.0	294.0	274.0	283.0	274.0	281.0
FREDERICK		246.0	245.0	232.0	235.0	239.0	256.0	261.0	251.0	229.0	234.0	233.0	235.0	229.0	244.0	239.0	232.0	218.0	227.0	232.0		247.0	227.0	228.0	230.0
FT WASHINGTON	268.0	238.0	261.0	247.0	260.0	259.0	299.0	280.0	265.0	259.0	250.0	240.0	224.0	237.0	235.0	207.0	224.0	217.0	228.0	228.0	209.0	217.0		182.0	204.0
GARRETT			138.0		145.0	144.0	156.0	133.0	132.0	137.0	123.0	134.0	134.0	130.0	131.0	122.0	127.0	120.0	113.0	118.0	128.0	125.0	110.0	116.0	117.0
GBMC	262.0	248.0	255.0	265.0	273.0	259.0	282.0	269.0	287.0	286.0	257.0	240.0	230.0	235.0	243.0	248.0	227.0	226.0	225.0	230.0	246.0	225.0	214.0	217.0	221.0
GERMANTOWN EMERGEN..	162.0	156.0	159.0	150.0	167.0				190.0	175.0	178.0	165.0	171.0	161.0	173.0		173.0	167.0	185.0	188.0	193.0	167.0		156.0	162.0
GRACE	220.0	243.0	218.0	209.0	212.0	199.0	223.0	215.0	200.0	203.0	197.0	210.0	185.0	185.0	197.0	198.0	168.0	169.0	182.0	198.0	173.0	172.0	167.0	159.0	172.0
HOLY CROSS	315.0	298.0	330.0	328.0	324.0	309.0	326.0	334.0	322.0	313.0		320.0	333.0	318.0	321.0	300.0	308.0	294.0	301.0	304.0	309.0	287.0	281.0	285.0	296.0
HOLY CROSS GERMANTO..	237.0	224.0	248.0	232.0	232.0	225.0	242.0	230.0	223.0	226.0		220.0	219.0	215.0	227.0	220.0	225.0	217.0	218.0	223.0	239.0	216.0	220.0	218.0	216.0
HOWARD	284.0	287.0	297.0	247.0	268.0	259.0	289.0	275.0	264.0	265.0	275.0	273.0	277.0	276.0	254.0	245.0	265.0	254.0	282.0	277.0	274.0	250.0	238.0	234.0	246.0
JH BAYVIEW	290.0	290.0	288.0	268.0	272.0	252.0	250.0	285.0	259.0	286.0	306.0	281.0	289.0	288.0	322.0	319.0	311.0	317.0	308.0	290.0	293.0	305.0	299.0	306.0	291.0
JOHNS HOPKINS	320.0	312.0	308.0	299.0	304.0	297.0	298.0	302.0	304.0	302.0	313.0	305.0	318.0	300.0	308.0	305.0	294.0	287.0	289.0	303.0	292.0	296.0	275.0	274.0	280.0
MEDSTAR FRANKLIN SQUA..	357.0	373.0	384.0	369.0	376.0	387.0	417.0	416.0	331.0	349.0	354.0	363.0	367.0	393.0	373.0	360.0	346.0	340.0	400.0	421.0	425.0	381.0	337.0	320.0	360.0
MEDSTAR GOOD SAMARIT..	234.0	231.0	239.0	225.0	234.0	202.0	237.0	238.0	210.0	208.0	198.0	188.0	190.0	200.0	220.0	580.0	579.0	207.0	223.0	243.0	259.0	223.0	210.0	203.0	225.0
MEDSTAR HARBOR	204.0	204.0	201.0	190.0	203.0	176.0	189.0	193.0	178.0	193.0	198.0	201.0	206.0	213.0	204.0	194.0	186.0	187.0	196.0	218.0	224.0	212.0	190.0	188.0	192.0
MEDSTAR MONTGOMERY	230.0	224.0	245.0	233.0	256.0	243.0	258.0	265.0	246.0	240.0	228.0	246.0	244.0	244.0	239.0	240.0	230.0	255.0	253.0	268.0	280.0	246.0	237.0	257.0	256.0
MEDSTAR SOUTHERN MA..	366.0	342.0	328.0	324.0	335.0	325.0	384.0	377.0	356.0	359.0	372.0	343.0	343.0	346.0	382.0	531.0	551.0	338.0	381.0	413.0	405.0	365.0	342.0	360.0	354.0
MEDSTAR ST. MARY'S	283.0	268.0	271.0	250.0	251.0	247.0	263.0	263.0	250.0	231.0	245.0	231.0	242.0	231.0	236.0	242.0	252.0	225.0	245.0	258.0	287.0	256.0	267.0	242.0	276.0
MEDSTAR UNION MEMORI..	211.0	221.0	226.0	218.0	235.0	215.0	237.0	232.0	225.0	212.0	230.0	205.0	203.0	214.0	210.0	216.0	214.0	208.0	211.0	239.0	253.0	213.0	222.0	201.0	215.0
MERCY	230.0	238.0	229.0	217.0	215.0	219.0	233.0	247.0	233.0	236.0	222.0	251.0	233.0	231.0	239.0	230.0	224.0	221.0	222.0	260.0	256.0	228.0	235.0	219.0	210.0
MERITUS	223.0	205.0	205.0	219.0	209.0	200.0	224.0	229.0	220.0	216.0	219.0	215.0	216.0	212.0	219.0	226.0	244.0	228.0	266.0	269.0	274.0	251.0	241.0	239.0	236.0
NORTHWEST	280.0	282.0	293.0	270.0	284.0	283.0	293.0	266.0	263.0	266.0	270.0	266.0	267.0	253.0	246.0	245.0	232.0	214.0	233.0	245.0	246.0	219.0	212.0	221.0	235.0
SHADY GROVE	282.0	256.0	252.0	241.0	247.0	245.0	238.0	217.0	203.0	206.0	227.0	234.0	222.0	217.0	234.0	231.0	223.0	220.0	232.0	240.0	231.0	228.0		213.0	209.0
SINAI	226.0	236.0	245.0	226.0	228.0	230.0	240.0	232.0	225.0	228.0	223.0	226.0	219.0	225.0	222.0	233.0	234.0	241.0	240.0	243.0	249.0	247.0	245.0	241.0	255.0
SUBURBAN	226.0	214.0	224.0	214.0	217.0	207.0	207.0	211.0	211.0	204.0	205.0	215.0	200.0	207.0	206.0	211.0	204.0	203.0	282.0	215.0	210.0	210.0	203.0	203.0	200.0
TIDALHEALTH MCCREADY			62.0	73.0	83.0	66.0	75.0	67.0	73.0	70.0	68.0	74.0	72.0	60.0	72.0	62.0	63.0	71.0	72.0	67.0	59.0	72.0	61.0	54.0	61.0
TIDALHEALTH PENINSULA		184.0	190.0	195.0	196.0	190.0	191.0	183.0	190.0	181.0	182.0	176.0	184.0	182.0	189.0	177.0	168.0	178.0	188.0	180.0	182.0	167.0	164.0	170.0	175.0
UM BWMC	312.0	315.0	282.0	279.0	271.0	277.0	274.0	269.0	264.0	273.0	274.0	277.0	263.0	278.0	253.0	251.0	258.0	249.0	278.0	262.0	267.0	253.0	261.0	278.0	271.0
UM CAPITAL REGION	261.0	273.0	267.0	260.0	264.0	256.0	283.0	270.0	259.0	253.0	254.0	267.0	263.0	253.0	260.0	241.0	241.0	228.0	248.0	262.0	261.0	258.0	263.0	248.0	259.0
UM SHORE CHESTERTOWN	166.0	171.0	160.0	176.0	184.0	147.0	185.0	196.0	177.0	161.0	167.0	167.0	162.0	170.0	159.0	164.0	160.0	157.0	177.0	208.0	179.0	173.0	175.0	178.0	209.0
UM SHORE EASTON	176.0	162.0	169.0	171.0	161.0	159.0	175.0	192.0	161.0	169.0	162.0	169.0	164.0	170.0	173.0	171.0	162.0	157.0	162.0	177.0	169.0	177.0	179.0	165.0	179.0
UM ST. JOSEPH	308.0	296.0	309.0	314.0	313.0	289.0	317.0	298.0	290.0	281.0	279.0	293.0	291.0	286.0	263.0	264.0	262.0	251.0	272.0	297.0	280.0	269.0	275.0	257.0	289.0
UMMC DOWNTOWN	301.0	306.0	298.0	293.0	289.0	290.0	299.0	311.0	319.0	294.0	297.0	292.0	285.0	294.0	287.0	307.0	293.0	292.0	297.0	295.0	292.0	300.0	322.0	267.0	257.0
UMMC MIDTOWN	254.0	276.0	267.0	265.0	262.0	231.0	289.0	300.0	271.0	263.0	243.0	251.0	218.0	262.0	239.0	254.0	229.0	225.0	229.0	274.0	271.0	249.0	272.0	184.0	221.0
UPMC WESTERN MD	229.0	232.0	246.0	244.0	268.0	249.0	251.0	249.0	247.0	244.0	227.0	234.0	222.0	248.0	247.0	256.0	231.0	232.0	241.0	251.0	268.0	238.0	212.0	223.0	243.0
UPPER CHESAPEAKE	269.0	275.0	272.0	265.0	275.0	276.0	304.0	296.0	285.0	269.0	279.0	290.0	283.0	257.0	273.0	244.0	230.0	219.0	257.0	266.0	229.0	236.0	242.0	251.0	248.0
WHITE OAK	455.0	403.0	419.0	395.0	452.0	402.0	426.0	444.0	438.0	396.0	386.0	443.0	429.0	425.0	366.0	382.0	383.0	344.0	295.0	307.0	305.0	304.0		297.0	303.0

OP18c Update

Measure
OP-18c



OP18c Update



OP18c Update

Average Median Wait Time All Hospitals for OP-18c

Measure
OP-18c

Change from Base
-590 1,072

Hospital Name	June 2023	July 2023	August 2023	Septemb er 2023	October 2023	Novemb er 2023	Decemb er 2023	January 2024	Februar y 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	Septemb er 2024	October 2024	Novemb er 2024	Decemb er 2024	January 2025	Februar y 2025	March 2025	April 2025	May 2025	June 2025
AAMC	394	383	353	385	393	372	363	349	344	330	322	331		360	353	356	323	292	312	354	302	341	321	311	304
ASCENSION SAINT AGNES	379	342	389	330	371	384	387	391	402	365	373			346	360	339	411	344	347	360	334	323	409	372	344
ATLANTIC GENERAL	164	179	175	151	156	136	158		171	149	159	139	185	167	182	156	147	127	174	141	182	165	165	154	187
CALVERT		282	302	302	318	270	328	283	301	307	292	288	256	266	289	224	310	263	272	410	301	289	335	356	485
CARROLL	322	423	323	260	296	339	325	329	286	320	381	330	299	260	271	319	304	371	319	362	315	347	320	335	289
CHARLES REGIONAL	444	433	419	453	476	487	475	414	521	410	502	488	472	446	536	504	487	475	507	557	461	572	595	391	475
CHRISTIANACARE, UNION	202	236	238	260	253	250	237	341	306	316	324	345	287	277	308	270	236	275	291	315	315	315	315	302	248
DOCTORS	451	363	389	393	380	397	404	447	411	389	397	432	386	380	299	414	357	369	376	340	399	434	389	432	354
FREDERICK		343	335	376	426	395	435	484	433	396	435	373	350	382	401	368	327	342	352	313		356	360	358	356
FT WASHINGTON	729	847	1,078					1,801	629	381		590	267	139	1,363	1,055	902	572	724	310	227	236		197	250
GARRETT			288		288	167	154	144	166	169	167	188	193	217	145	202	179	190	127	123	115	190	191	163	165
GBMC	506	681	587	631	534	714	592	586	576	723	482	417	463	498	462	488	452	484	581	426	528	370	443	442	536
GERMANTOWN EMERGEN..	87	69							246	105		18				178	295	178		177	161	228		164	228
GRACE	912	845	1,083	1,313	1,187	909	859	837	833	1,050	814	872	1,074	877	876	1,230	808	721	552	912	1,061	732	812	773	915
HOLY CROSS	751	609	726	701	586	642	524	577	569	633		427	651	504	469	507	462	614	660	472	586	425	505	535	483
HOLY CROSS GERMANTO..	579	496	386	364	426	434	383	406	415	454		429	313	411	420	535	454	385	465	721	431	450	436	573	525
HOWARD	687	445	503	550	571	496	549	714	644	479	582	667	623	647	504	513	660	682	689	933	596	852	626	653	552
JH BAYVIEW	659	678	714	598	635	684	630	593	601	574	583	417	492	562	571	546	568	528	466	535	548	498	565	561	404
JOHNS HOPKINS	496	488	583	595	564	540	612	598	508	550	466	546	557	520	572	580	484	520	467	523	504	532	474	411	474
MEDSTAR FRANKLIN SQUA..	353	365	337	324	328	370	405	406	398	366	364	403	342	398	333	372	334	367	391	389	433	406	337	362	383
MEDSTAR GOOD SAMARIT..	324	333	292	314	364	285	337	351	315	273	298	259	280	291	305	222	212	274	292	281	316	274	273	282	325
MEDSTAR HARBOR	333	336	322	346	361	279	316	330	297	310	282	338	289	296	284	305	284	252	291	337	358	288	281	282	268
MEDSTAR MONTGOMERY	276	320	302	345	386	309	392	416	322	396	313	282	319	290	292	288	313	323	286	314	364	337	265	328	309
MEDSTAR SOUTHERN MA..	390	426	422	399	467	432	479	491	398	412	429	534	388	370	436	366	342	430	501	555	488	468	425	436	402
MEDSTAR ST. MARY'S	302	293	310	271	289	295	297	290	293	269	275	244	276	259	281	284	301	278	263	287	280	264	316	303	291
MEDSTAR UNION MEMORI..	401	332	307	325	359	299	359	346	342	303	371	359	320	357	346	351	316	318	310	336	339	337	288	295	257
MERCY	276	302	287	274	289	275	269	324	326	258	333	319	285	307	271	321	266	238	271	295	271	257	360	244	245
MERITUS	269	251	246	262	266	301	284	293	256	283	300	291	305	254	302	292	299	291	292	313	292	286	297	284	327
NORTHWEST	700	776	698	767	677	669	713	739	680	776	795	661	837	797	648	645	459	566	517	570	450	541	461	453	518
SHADY GROVE	574	294	741	1,323	466	411	288	330	478	288	574	255	522	423	265	986	361	683	294	363	308	332		298	307
SINAI	692	672	648	717	622	518	698	659	833	773	722	634	579	657	490	714	609	771	638	462	564	648	511	660	644
SUBURBAN	300	322	359	299	362	300	291	308	295	277	346	305	279	325	334	306	323	269	689	352	372	373	309	295	346
TIDALHEALTH MCCREADY			24	52	140	99	74	133	74	37	195	121	113	103	84	48	41	36	89	151	112	179	87	237	45
TIDALHEALTH PENINSULA		202	225	254	189	270	227	208	197	226	226	237	232	221	259	211	217	240	219	226	235	201	200	230	184
UM BWMC	413	469	377	446	420	446	553	443	440	434	397	404	516	442	451	437	499	481	426	431	448	457	461	379	423
UM CAPITAL REGION	508	473	488	522	406	491	514	465	397	497	455	425	436	407	411	430	341	320	423	408	450	425	482	397	373
UM SHORE CHESTERTOWN	214	313	411	329	382	293	363	411	459	324	239	757	244	523	683	221	263	247	481	351	469	295	295	496	359
UM SHORE EASTON	276	265	330	314	275	258	307	366	274	307	304	296	311	301	415	332	334	344	238	334	284	344	348	328	288
UM ST. JOSEPH	537	656	548	611	576	451	469	479	420	471	461	508	559	575	511	565	467	463	578	446	397	424	494	441	500
UMMC DOWNTOWN	531	419	448	500	416	365	443	450	455	363	391	376	399	491	374	409	404	377	391	429	465	393	403	400	377
UMMC MIDTOWN	398	440	420	483	379	390	426	492	444	416	376	398	313	361	364	403	399	307	275	321	306	380	458	235	206
UPMC WESTERN MD	309	415	289	398	337	399	353	349	451	372	338	367	325	348	351	352	345	303	274	288	306	287	271	296	298
UPPER CHESAPEAKE	473	556	526	495	482	585	657	634	611	525	538	498	495	494	505	494	411	474	418	499	475	501	526	472	445
WHITE OAK	748	655	545	1,198	963	634	737	1,237	1,032	1,109	1,286	750	1,575	746	746	807	1,095	753	719	515	496	435		616	491

EMS Turnaround Times: April Performance

- 30 hospitals reported the 90th percentile of turnaround time was <=35 minutes
- 19 hospitals reported the 90th percentile of turnaround time was 35-60 minutes
- 3 hospitals reported the 90th percentile of turnaround time was over 60 minutes
- Hospitals with improving performance
  - (Average to high performing): Charles Regional, Easton, Fort Washington Medical Center, Good Samaritan Hospital, Suburban Hospital, Union Hospital, Upper Chesapeake Health Aberdeen
  - (Low performing to average): Northwest Hospital
- Hospitals with declining performance
  - (High performing to average): NA
  - (Average to low performing): NA

EMS Turnaround Times: April 2025 Performance

90th Percentile: 0-35 Minutes

Atlantic General Hospital
Bowie Health Center
CalvertHealth Medical Center
Cambridge Free-Standing ED
Charles Regional +
Chestertown
Easton +
Fort Washington Medical Center +
Frederick Health Hospital
Garrett Regional Medical Center
Germantown Emergency Center
Good Samaritan Hospital +
Grace Medical Center
Holy Cross Germantown Hospital
Holy Cross Hospital
Johns Hopkins Hospital PEDIATRIC
McCready Health Pavilion
Meritus Medical Center
Montgomery Medical Center
Peninsula Regional
Queenstown Emergency Center
R Adams Cowley Shock Trauma Center
Shady Grove Medical Center
St. Mary's Hospital
Suburban Hospital +
Union Hospital +
Union Memorial Hospital
Upper Chesapeake Health Aberdeen +
Walter Reed National Military Medical Center
Western Maryland

>35 Minutes

Anne Arundel Medical Center
Baltimore Washington Medical Center
Carroll Hospital Center
Franklin Square
Greater Baltimore Medical Center
Harbor Hospital
Howard County Medical Center
Johns Hopkins Bayview
Johns Hopkins Hospital ADULT
Laurel Medical Center
Mercy Medical Center
Midtown
Northwest Hospital +
Sinai Hospital
St. Agnes Hospital
St. Joseph Medical Center
University of Maryland Medical Center
Upper Chesapeake Medical Center
White Oak Medical Center

>60 Minutes

Capital Region Medical Center
Doctors Community Medical Center
Southern Maryland Hospital

(+): Hospital improved by one or more categories; **(-)**: Hospital declined by one or more

maryland
health services
cost review commission

TO:
HSCRC Commissioners

FROM:
HSCRC Staff

DATE:
July 30, 2025

RE:
Hearing and Meeting Schedule

August 2025 No Meeting

September 10, 2025 In person at HSCRC office and Zoom webinar

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

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